MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of June 10, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

Date of Meeting: Wednesday, June 10, 2015
Start Time: 12:01 PM
End Time: 2:46 PM

	Present	ITEM 2: Minutes from April 29, 2015	ITEM 4a: Nurse Staffing Regulation	ITEM 4b: OPP Regulations	ITEM 8: Interim Financing
Carole Allen	Yes	Yes	Yes	Yes (2nd)	Yes
Stuart Altman*	Yes	Yes	Yes	Yes	Yes
Martin Cohen	Yes	Yes	Yes	Yes	Yes
David Cutler	Yes	Yes (M)	Yes (2nd)	Yes (M)	Yes
Wendy Everett	Yes	Yes (2nd)	Yes (M)	Yes	Yes
Paul Hattis	Yes	Yes	Yes	Yes	Yes (M)
Rick Lord	Yes	Yes	Yes	Yes	Yes (2nd)
Marylou Sudders	Yes	Yes	Yes	Yes	Yes
Kristen Lepore	Yes	A	Yes	Yes (LP)	Yes (LP)
Veronica Turner	No	A	A	A	A
Summary	**9 Members Attended**	**Approved with 8 votes in the affirmative**	**Approved with 8 votes in the affirmative**	**Approved with 8 votes in the affirmative**	**Approved with 8 votes in the affirmative**

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.
*Chairman
(M): Made motion; (2nd): Seconded motion; (ab): Abstained from Vote; (A): Absent from Meeting

PROCEEDINGS

A regular meeting of the Massachusetts Health Policy Commission was held on Wednesday, June 10, 2015 at 12:00 PM.

Commissioners present included Dr. Stuart Altman (Chair); Dr. Wendy Everett (Vice Chair); Dr. Carole Allen; Dr. David Cutler; Dr. Paul Hattis; Mr. Martin Cohen; and Mr. Rick Lord.

Secretary Marylou Sudders and Ms. Kristen Lepore, Secretary of Administration and Finance, arrived late.

Chair Altman called the meeting to order at 12:01 PM and reviewed the agenda.

Chair Altman welcomed Martin Cohen to the board as the Attorney General's newest appointee and an expert in behavioral health. Mr. Cohen responded that he is happy to be joining the board.

ITEM 1: Overview of the State Conflict of Interest Law

Chair Altman introduced Mr. David Giannotti, Chief of Public Education and Communication from the State Ethics Commission. Mr. Giannotti presented an overview the State Conflict of Interest Law. Following his presentation, Mr. Giannotti answered questions about commissioners' responsibilities under the law.

Chair Altman thanked Mr. Giannotti for his presentation.

ITEM 2: Approval of Minutes from April 29, 2015

Secretary Marylou Sudders arrived at the meeting.

Chair Altman solicited comments on the minutes from April 29, 2015. Seeing none, he called for a motion to approve the minutes, as presented. **Dr. Cutler** made a motion to approve the minutes. After consideration upon motion made and duly seconded by **Dr. Everett**, the board voted unanimously to approve the minutes from April 29, 2015. Voting in the affirmative were the eight members present. There were no abstentions and no votes in opposition.

ITEM 3: Executive Director Report

Mr. David Seltz, Executive Director, reviewed the day's agenda, highlighting a discussion on the proposed regulations for the Office of Patient Protection and a presentation from Hallmark Health on their Phase 1 CHART project.

Mr. Seltz stated that the majority of the meeting would focus on the recommended final regulation governing ICU nurse staffing. He thanked Secretary Sudders and Dr. Everett for their leadership in the Quality Improvement and Patient Protection (QIPP) Committee over the course of a year-long, transparent, inclusive process. He noted that the HPC's goal has been to fulfill its legislative mandate, to stay consistent with the law, and to prioritize patients. He noted that the proposed regulation, which was advanced by the QIPP, accomplishes these goals. Mr. Seltz also thanked the Department of Public Health for their assistance with the regulation.

Mr. Seltz turned the meeting over to Chair Altman.

Dr. Altman thanked Dr. Everett for taking on the responsibility of guiding the committee with the help of the staff.

ITEM 4: Quality Improvement and Patient Protection Update

Dr. Everett thanked Dr. Altman and Mr. Seltz for their introductions. She stated that the QIPP committee would discuss two topics. First, staff would review the recommended final regulation governing ICU nurse staffing. Second, the board would hear a summary of proposed updates to regulations for the Office of Patient Protection.

Dr. Everett reviewed the timeline of the ICU nurse staffing regulation, noting that the full commission voted to release the proposed regulations on January 20, 2015. She stated that there is still one outstanding issue before the commission, the definition of an intensive care unit.

Dr. Everett stated that the legal aspects of the regulation have been reviewed and that the law stands behind these regulations. She further noted that the cost implications have also been assessed. She stated that the HPC has conducted this research to ensure the best possible care for the Commonwealth's patients.

Dr. Everett thanked stakeholders and members of the public for their testimony.

Dr. Everett stated that the final recommended regulation was discussed at QIPP on May 20, 2015. The committee endorsed the regulation and sent it to the board for approval, with the caveat that the board engages in further discussion the definition of an ICU.

Dr. Everett introduced Ms. Lois Johnson, General Counsel, to provide an overview of the final recommended regulation.

ITEM 4a: Final Regulation Governing Nurse Staffing in Hospital ICUs

Ms. Johnson read Section 231 of Chapter 111, the statute governing the nurse staffing regulation. She noted that the law requires a patient assignment limit of 1 or 2 patients per registered nurse in intensive care units depending on the stability of the patient as assessed by an acuity tool and staff nurses. The law requires the Health Policy Commission to promulgate regulations on the implementation and operation of the law including the formulation of the acuity tool.

Ms. Johnson echoed Dr. Everett by stating that stakeholder engagement was prioritized throughout this process.

Ms. Johnson reviewed the HPC's principles in developing the regulation. First, she stated that the recommended final regulation seeks to balance the statutory goal of safe, patient centered care with the flexibility necessary for hospitals to address unique circumstances in each ICU. For that reason, Ms. Johnson stated that guidelines for the development and selection of the acuity tool are not overly prescriptive.

Second, Ms. Johnson stated that the regulation recognizes the role of ICU staff nurses in the implementation of this law. She stated that the final regulation continues to provide an opportunity for ICU staff nurses to participate in the development or selection of the acuity tool and provide input on the tool and its use.

Third, Ms. Johnson noted that the committee recognized potential administrative burden. She stated that the HPC was mindful that the regulation mandates new hospital reporting obligations and sought to require reasonable reporting to support compliance.

Fourth, Ms. Johnson noted that the HPC was cognizant of the companion role of the Department of Public Health, which will certify the acuity tool under the statute and, as the regulatory agency responsible for licensure, will oversee staffing compliance. The recommended final regulation includes certain refinements to reflect deference to the role of DPH and the goal of hewing closely to the HPC's specific statutory charges.

Ms. Johnson highlighted changes made to the regulation since it was last discussed by the board. She noted various wording changes throughout the document that were addressed in public

comment. She explained that the proposed regulation included both the terms, “at all times” and “at any time.” The regulation stated that the patient assignment for each staff nurse shall be one or two ICU patients at all times during a shift. The regulation also stated that the maximum patient assignment for each nurse may not exceed two ICU patients at any time. The HPC received significant comment on this language. Ms. Johnson stated that the language in the proposed regulation was intended to make clear that the statutory requirements apply each day and during each shift. The language was not intended to impose unreasonable requirements that impede the daily dynamic patient care workflow in an ICU. The language was removed from the recommended final regulation.

Ms. Johnson reviewed comments and changes regarding the Advisory Committee for the selection of an acuity tools. She stated that the recommended final regulation reinforces the role of the staff nurse in the development of an acuity tool by requiring the Advisory Committee to have at least 50% direct care ICU staff nurses. Ms. Johnson stated that the HPC also added language governing the implementation of acuity tools across in hospitals with multiple ICUs.

Ms. Johnson noted the recommended removal of language on additional bargaining obligations in response to public comment and the fact that the language is not required by statute.

Ms. Johnson reviewed comments on the timeline laid out in the recommended final regulation. She stated that, given the process requirements that have been incorporated into the regulation, many commenters asked for more time for implementation. The recommended final regulation (approved by the Committee) extends the timeline to comply with certification requirements to March 31, 2016 for academic medical centers and September 30, 2016 for the non-academic medical hospitals.

Ms. Johnson reviewed comment on quality measures, noting that the statute requires the HPC to identify three to five patient safety quality indicators to be measured and publically reported by hospitals. As part of the regulatory process, the committee engaged in an extensive deliberative process with stakeholders and experts to identify appropriate selection criteria for ICU appropriate measures. Based on this input the committee recommended the following four measures: (1) Central Line-Associated Blood Stream Infection (CLABSI); (2) Cather-Associated Urinary Tract Infection (CAUTI); (3) Pressure Ulcers (hospital acquired); and (4) Patient Fall Rate (with or without injury).

Ms. Johnson stated that these are evidence based, nationally recognized, NQF nursing sensitive outcome measures. She noted that the HPC will issue guidance on these measures in the form of a bulletin.

Ms. Johnson noted the recommended removal of the section in the proposed regulation that required acute hospitals to develop a staffing plan because the section was unnecessary given the compliance obligations elsewhere in the regulation.

Ms. Johnson relayed that the committee received comment on whether the law requires that the regulation call for a default ratio of one nurse to one patient. She noted that the regulation reflects the statutory language which states, “the patient assignment for the registered nurse shall be 1:1 or 1:2 depending on the stability of the patient…” The statute does not otherwise require acute hospitals to implement a default staffing ratio. She stated that a 1:1 ratio should occur in

appropriate circumstances based on an assessment of the patient's stability by a staff nurse and the acuity tool.

Ms. Johnson reviewed comments on the definition of "ICU patient." She noted that a few commenters objected to the unit wide application. Ms. Johnson noted that the statute requires compliance in intensive care units not for intensive care patients. The regulation specifies that the staffing requirements apply to all patients being cared for in intensive care units. The HPC recognizes that some acute hospitals, particularly community hospitals, may have patients with lower acuity in an ICU for a variety of reasons. However, the statute requires unit-wide applicability of the staffing limit requirements and the HPC does not have flexibility on this issue.

Ms. Johnson reviewed comments on patient assignment. She proposed several revisions to the section on patient assignment for clarity and precision as well as in response to public comments. This included a recommendation to add a reference to other laws that govern nurse practice, including the State Nurse Practice Act, to clarify that nothing in the regulation limits the application of other relevant state or federal laws.

Ms. Johnson reviewed required elements of the Acuity Tool. She stated that the regulation requires the Acuity Tool to include a defined set of indicators, including clinical indicators of patient stability and staff nurse staff load, for each ICU. The recommended final regulation does not mandate specific indicators, but rather includes examples of clinical or workload indicators.

Ms. Johnson reviewed changes to the regulation for requirements for records of compliance. She noted that the HPC was mindful of the balance between reducing administrative burden and maintaining records for compliance purposes. In consultation with DPH, the HPC clarified the record retention requirements.

Finally, Ms. Johnson highlighted changes to the regulation to provide further flexibility to DPH to implement the nurse staffing law.

Dr. Everett thanked Ms. Johnson for summarizing the changes made to the regulation.

Dr. Everett turned the board's attention to the discussion of the definition of Intensive Care Unit. She noted that this definition is relevant when the HPC considers the inclusion of Pediatric Intensive Care Units (PICUs) and Neonatal Intensive Care Units (NICUs). She stated that testimony was clear that there is a wider range of patients in NICUs and PICUs. Dr. Everett noted that this is different from adult ICUs, coronary care units (CCUs), and burn units.

Dr. Everett stated that the QIPP committee decided that the definition of ICU was an important enough issue that it should be brought to the full board for discussion. Dr. Everett asked Ms. Johnson to review the proposed definition of Intensive Care Unit (ICU).

Ms. Johnson stated that the statute applies to "all intensive care units," including those "within a hospital operated by the Commonwealth." She noted that the term ICU is defined in the statute to have the same meaning as 105 CMR 130.020, the definition section of DPH's hospital licensure regulation. She noted that the DPH regulation defines as ICU as well as Coronary Care Unit

(CCU), Burn Unit, Pediatric Intensive Care Unit (PICU), and Neonatal Intensive Care Unit (NICU).

Ms. Johnson stated that, based on a reasonable interpretation of this statute and DPH hospital licensure regulation, the proposed regulation defines an ICU to include adult ICUs as well as PICUs, NICUs, CCUs and burn units. Based on consultation with DPH, that inclusive definition of ICUs is consistent with DPH's own interpretation of its licensure regulation and its regulatory approach to intensive care services.

Ms. Johnson provided a summary of comments received on the definition of ICUs. She noted that hospitals objected on legal grounds to the inclusion of NICUs, PICUs, ICUs and burn units because such units are separately defined in the licensure regulation and, in particular, raised policy concerns with the application of the nurse to patient staffing ratios in NICUs. They argued from clinical, operational and a patient need perspective, NICUs should not be included in the regulation.

Ms. Johnson stated that other commenters disputed a narrow definition of ICUs. She reviewed comments which stated that the statute contains no explicit exceptions or indications that the law was intended to apply to adult ICUs only.

Ms. Johnson stated that definition of ICU in the proposed regulation was based on a reasonable interpretation of the statute and the DPH licensure regulation.

Dr. Everett reiterated that this is a complicated issue that is critical to the nurse staffing regulation. She stated that it is further complicated by the complexity of the core legislation. Dr. Everett stated that the MNA gave important testimony regarding the complexity of neonates and pediatric patients.

Dr. Everett proposed an amendment to Section 8.12, which is the certification timeline. This amendment is proposed in order to provide hospitals, nurses, policymakers, legislators, and the administration enough time to think through ways to resolve these conflicts in both the legislation and the interpretation.

Dr. Everett read the proposed amendment. "Each acute hospital shall comply with the requirements of the department for certification of an acuity tool for each ICU by the dates below or as may otherwise be specified in the department's requirements for certification."

Dr. Everett echoed Ms. Johnson by stating that the HPC is trying to give the DPH enough flexibility so that their guidance and requirements can be most helpful to the nurses, hospitals and patients. As such, under the proposed amendment, academic medical centers shall comply with the requirements of DPH for certification of an acuity tool for each neonatal intensive care unit no later than January 31, 2017 and for all other units no later than March 31, 2016. All other acute hospitals shall comply with the requirements of the department for certification of an acuity tool for each ICU no later than January 31, 2017. Dr. Everett noted that this further extends the timeline for certification that was presented to the Committee.

Dr. Everett opened up the topic for discussion.

Secretary Sudders thanked Dr. Everett for her work as Chair of the QIPP committee and acknowledged the work of the HPC staff. She reminded the room that this is the second time that nurse staffing regulations have been brought to the HPC. Secretary Sudders thanked ICU nurses for their work as well as hospitals for their continued input in this process.

Secretary Sudders stated that it is the position of the Executive Office of Health and Human Services (EOHHS) and its subordinate agency, DPH, that the definition of ICU includes adult ICUs, PICUs, NICUs, CCUs, and burn units. She stated that EOHHS can find no basis within the general laws, existing DPH regulations or Medicaid regulations, to differentiate adult ICU from all other units. Adult ICUs, PICUs, NICUs, CCUs, and burn units are all physically and identifiably separate units from other patient care areas. All of these units contain special equipment and specially trained staff for the patients who require immediate, concentrated and continuous care.

Secretary Sudders voiced her appreciation for the timeline that has been recommended by the committee for staggered implementation of the acuity tools to give sufficient time to DPH to review and revise existing regulations to ensure that they are as clear as possible.

Dr. Everett thanked Secretary Sudders for her comments.

Dr. Allen commended the HPC staff on their work. She endorsed the changes made to the initial regulation and noted her attendance at all of the committee sessions and public hearings on this topic.

Dr. Allen stated that after listening to testimony, conducting research, reviewing her experience as a pediatrician, and consulting her neonatal colleagues, she concluded that neonatal intensive care units should be excluded from this regulation. Dr. Allen stated the colocation of various NICUs for staffing flexibility adds a layer of complexity to these units. She further stated that the status of NICUs can change rapidly, making the units unpredictable and in need of flexibility. Dr. Allen reviewed the various types of patients in NICUs and how their status may not affect their tenure in the unit. She stated that NICUs are currently following standards that regulate staffing according to the individual infant's acuity level, not the unit as a whole.

Dr. Allen voiced concern about the applicability of the four quality measures to NICU patients, noting that only one of the standards, catheter related blood stream infections, applies to infants. Dr. Allen encouraged DPH to look into infant-sensitive quality measures.

Dr. Allen stated that NICUs are doing a great job. Dr. Allen stated that there is no possible benefit to including NICUs in this regulation. She asked that the HPC consider if NICUs should be included in this regulation and, if they are included, if they should have different quality measures.

Dr. Everett thanked Dr. Allen for her comment. Dr. Everett reminded the board that Secretary Sudders has asked DPH to look at the bed licensure requirements. One of the advantages of extending the date for certification for acuity tools is allowing DPH the time to complete such an assessment.

Dr. Everett also stated that the selection of quality measures remain within the purview of the HPC. She noted that the QIPP Committee and board could elect to add infant-sensitive measures in the future.

Dr. Allen recommended that the HPC consult with the state's Neonatal Advisory Committee on this matter.

Dr. Cutler expressed concern over some of the language in the statute, noting that it would ideally refer to ICU "patients," not "units." He asked whether hospitals would be required to turn away patients if they did not have the proper nurse-to-patient ratio. Ms. Johnson stated that hospitals will need to comply with the nurse staffing ratios. She noted that there may be cases where a hospital does not have enough staff to be in compliance and, therefore, will have to transfer a patient.

Dr. Everett interjected to say that those diversions happen now, in ICUs, emergency departments, and other units in the hospital. She stated that his regulation is not trying to remove any flexibility from the hospital.

Mr. Seltz commented that if hospitals are in compliance with the law then they will not have to turn away more patients. Ms. Johnson added that some hospitals may have to increase staff in order to comply with the regulation. She stated that there is no definite answer about whether hospitals will have to turn away more patients due to the regulation.

Dr. Cutler encouraged DPH to look into this matter. He stated that he does not want there to be an instance when a patient must be turned away because there is not a staff member present.

Secretary Sudders stated that there are already regulations in place surrounding the diversion of patients based on staffing levels. She noted that hospitals have well established protocols for staffing emergencies. Secretary Sudders echoed Ms. Johnson by saying that it is probable that some hospitals will have to increase staffing due to this regulation. She agreed that the DPH will return information on the impact of the regulations.

Dr. Hattis inquired whether the effect of the HPC's amended regulation would be to make the date for compliance with the new staffing regulation co-terminus with the date by when the acuity tools would need to be approved by DPH for each kind of ICU. Secretary Sudders noted that DPH is going to consider the matter further. Dr. Everett responded that the legislation went into effect last fall, and further clarified that the HPC's goal is to give the hospitals and nurses time to create the right acuity tool and to complete the DPH certification process.

Dr. Everett asked if there were any more clarifying questions.

Dr. Everett motioned to approve the final recommended regulation, as amended. The board voted unanimously to approve the amendment. **Dr. Cutler** seconded the motion. Voting in the affirmative were the eight members present. There were no abstentions and no votes in opposition.

Dr. Everett thanked everyone for their participation and cooperation in the nurse staffing regulation process.

ITEM 4b: Proposed Regulations for the Office of Patient Protection

Mr. Seltz introduced Ms. Bosco, Director of the Office of Patient Protection (OPP). Ms. Bosco reviewed proposed changes to two regulations governing OPP. She noted that the changes would ensure that the HPC's regulations are consistent with recent changes in Massachusetts and federal law.

Ms. Bosco reviewed changes to the regulation governing the internal appeals process for individuals who are denied coverage by their insurance company. The proposed changes address access to medical necessity criteria during an internal or external review of a denied claim.

Ms. Bosco reviewed changes to the regulation governing open enrollment waivers. She stated that these changes would create consistency between the 2010 regulation and state and federal laws.

Ms. Bosco asked for questions.

Dr. Altman asked for clarification on OPP's data for specialty drug claim denial. Ms. Bosco replied that each case is different but, in many cases, patients denied specialty drug coverage could seek an external review through OPP if the use of that drug it is medically necessary and not an excluded benefit.

Dr. Altman asked for clarification of the term "medically necessary." Ms. Bosco answered "medically necessary" is defined in statute by the Commonwealth. She added that external review agencies, hired by the HPC, determine whether an appealed treatment meets the medically necessary standard.

Dr. Hattis asked if a concerned consumer is able to access the criteria for what is "medically necessary." Ms. Bosco responded that the Massachusetts' "medically necessary" standard is included with the external review agency's decision for each case.

Dr. Hattis clarified that the reviewer of the appeal is a vendor hired by the state. Ms. Bosco responded that the HPC has hired three external review agencies. Each case is sent at random to one of the three agencies. The agency then selects a specialist that works in the same field as the case, who makes a decision by applying the Commonwealth's "medically necessary" standard and other relevant medical or scientific literature.

Dr. Everett stated that specialty drugs are a very important issue for the Office of Patient Protection. She asked that the topic be added to the agenda for a future meeting.

Dr. Altman congratulated Ms. Bosco on doing a wonderful job on this issue. He also echoed Dr. Everett's point about putting this on the agenda for a later date.

Ms. Bosco thanked everyone for their comments. She presented the proposed timeline for the draft regulations.

Dr. Everett presented the motion to advance the proposed updates to the Office of Patient Protection regulations, as approved by the QIPP committee, to public comment. **Dr. Cutler** motioned to move the regulations to a public comment period. **Dr. Allen** seconded this motion.

Dr. Everett called for a vote in favor of the motion to approve the regulations. The board voted unanimously to approve the motion. Voting in the affirmative were the eight members present. There were no abstentions and no votes in opposition.

ITEM 5: Cost Trends and Market Performance Update

Dr. Cutler introduced Ms. Katherine Mills, Acting Policy Director, Market Performance, to update the commission on recent notices of material change (MCN).

Ms. Mills stated that the HPC has received 41 notices for transactions since it began collecting MCNs in April 2013.

Ms. Mills stated that the HPC has received four new transactions since the April 29, 2015 board meeting. The HPC has reviewed the four new transactions and evaluated whether they were likely to cause an impact on total medical spending, a change in market share, or a difference in quality or access to care. She stated that the HPC has elected not to proceed to a cost market review for three of the transactions; the fourth is still under consideration.

Ms. Mills reviewed an MCN received for the joint venture between UMass Memorial Health Care and Shields Health Care for a new ambulatory surgery center (ASC) in Shrewsbury. The HPC determined that the ASC has the potential to result in cost savings. She stated that there are no anticipated negative impacts on access, quality, or the competitive market.

Ms. Mills reviewed the MCN for the acquisition of Noble Hospital by Baystate Health. She stated that the HPC analysis found that Noble is in financial distress. She added that the acquisition would have less of a market impact than if Noble Hospital were to close. The analysis highlighted that behavioral health and emergency services were being heavily used at Noble Hospital. Ms. Mills stated that Baystate has committed to operating Noble as a general acute care hospital for five years and does not intend to decrease access to behavioral health or emergency department services. Ms. Mills noted that both Noble and Baystate are CHART recipients and that the HPC will be working with them on how best to coordinate these activities.

Ms. Mills reviewed an MCN for a clinical affiliation between Partners HealthCare and Steward Health Care for pediatric and newborn services. The HPC does not anticipate a negative market impact or any impact to quality or access to services.

Ms. Mills paused for questions. Seeing none, Chair Altman moved to the next agenda item.

ITEM 6: Community Health Care Investment and Consumer Involvement Update

Dr. Hattis updated the board on recent activates for the Community Health Care Investment and Consumer Involvement Committee. He stated that the committee met in June to hear an update on CHART Phase 1 closeout.

ITEM 6a: CHART Phase 1 Final Report

Mr. Iyah Romm, Policy Director for Care Delivery Innovation and Investment, presented on the CHART Phase 1 Report. He stated that the HPC would release the report in the coming weeks. He noted that the report details the foundations of the CHART program, reviews CHART Phase 1 projects, and assesses the program's success. Mr. Romm stated that the Phase 1 Report also highlights lessons and initiatives in Phase 1 that will be relevant for Phase 2. He noted that many of the Phase 1 awards came in under cost, resulting in $9.2 million spent of the $10 million allocated for Phase 1.

Mr. Romm noted that the report includes a 40+ page factbook with detailed information on the projects completed by each hospital in Phase 1. Mr. Romm highlighted that the program trained over 2,300 hospital staff, provided more than 400 hours of direct technical assistance, and touched more than 250 units. More than 300 community partners participated and more than 160,000 patients were touched by the CHART initiatives in Phase 1. About 90% of participants in Phase 1 stated that CHART had moved them along the path to system transformation.

Mr. Romm highlighted that in the past weeks, many national programs and organizations had demonstrated interest in the CHART program.

ITEM 6b: CHART Phase 1 Presentation from Dr. Steven Sbardella, Hallmark Health System

Mr. Romm introduced Dr. Steven Sbardella, Vice President of Medical Affairs for Hallmark Health.

Dr. Sbardella presented on Hallmark's project, "Mitigation of Harm: An Integrated Care Strategy to Recognize, Prevent, and/or Reduce Substance Use Disorder in Adults Presenting in the ED/Urgent Care with Back Pain." A copy of his presentation can be found on the HPC's website.

ITEM 6c: CHART Phase 2 Update and Technical Assistance Plan

Mr. Romm reviewed key lessons from CHART Phase 1. He noted that a full conversation on the HPC's CHART Phase 2 technical assistance planning and provider engagement would occur at the July 22, 2015 meeting.

Mr. Romm noted that projects in CHART Phase 1 demonstrated the importance of the composition of transformation teams. He noted that CHART projects ranged from transition teams with that were physician focused to those that were more technical. He stated that CHART was able to bring to these transition teams together and the place a priority on skill development and sustained process improvement.

Mr. Romm noted that the CHART report showed important opportunities for the use of technology to lay the foundation for transformation. He noted that there were some areas, however, where technology was overemphasized and being used to fix behavioral or operational problems.

Mr. Romm highlighted that CHART Phase 1 was a foundational investment to build towards transformation in Phase 2. He focused the commission on key priority areas moving forward, including maximizing appropriate cost utilization, enhancing behavioral health, supporting cross functional coordination, and enhancing leadership.

Mr. Romm stated that the need for technical assistance was most evident in the requirement to collect data on CHART projects. He stated that the greatest complaint he has heard is that CHART is rigorous.

Mr. Romm provided a brief update on Phase 2 of the CHART program.

Dr. Altman reinforced the importance of data collection for the CHART program. He asked that the HPC collect data both on individual institutions and regional projects. Mr. Romm responded that opportunities are emerging to see hospital specific impact as well as statewide impact.

Mr. Cohen asked if there was a plan to disseminate information on the CHART project to participating hospitals as well as other entities. He stated that the knowledge that was shared at this meeting should be shared with others. Mr. Romm responded that the HPC is working on such a plan.

Dr. Everett highlighted the CHART case studies as a means of disseminating information on the program. Mr. Romm stated that case studies would be published throughout Phase 2.

Dr. Altman thanked Mr. Romm for his report.

ITEM 7: Care Delivery and Payment System Transformation Update

Dr. Allen stated that the Care Delivery and Payment System Transformation Committee met prior to the board meeting to discuss Data Submission Manual (DMS) for Initial Registration: Part 2 of the Registration of Provider Organizations (RPO) program.

Dr. Allen welcomed Katie Shea Barrett as the new Policy Director for Accountable Care.

ITEM 7a: Final Data Submission Manual for the Registration of Provider Organizations Program

Ms. Kara Vidal, Senior Manager for the Registration of Provider Organization Program, announced that the HPC is planning to launch Initial Registration: Part 2 in the late summer. Ms. Vidal stated that the day's meeting would focus on the final Data Submission Manual (DSM) for Part 2 registration.

Ms. Vidal stated that the HPC is charged with implementing a RPO by Chapter 224 of the Acts of 2012. As such, Chapter 224 has been used a guidepost to decide what data to collect in this program.

Ms. Vidal stated that, in the statute, there are nine areas in which that RPO is asked to collect data: ownership, governance, operational structure, clinical affiliations, parent entities, corporate

affiliates, community advisory boards, health care professionals, and licensed facilities. She stated that the final DSM includes seven files that capture data on each of the nine areas.

Ms. Vidal reviewed changes made to the DSM following the public comment period. She thanked stakeholders and members of the public for their continued collaboration.

Ms. Vidal reviewed the data elements included for reporting in the DSM.

Dr. Hattis questioned whether nurse practitioners, other licensed providers, and specialists are included in the Physician Roster. She noted that the first year of the program is limited to physicians only. Moving forward, staff will consider other practicioners.

Ms. Vidal reviewed edits to the DSM to reduce the administrative burden on provider organizations.

Ms. Vidal noted that the HPC received public comment on the DSM in April and May 2015. She stated that the HPC received 10 comments, which can be found on the agency's website. She reviewed the key themes from the public comment.

Dr. Altman congratulated Ms. Vidal on this work. He stated that understanding how our health system works is critical, noting that Massachusetts is out in front in this research.

Ms. Vidal updated the commission on the implementation timeline. She noted that the DSM will be released in the next few weeks. This will give participants about four months to complete the registration.

Dr. Altman thanked Ms. Vidal for her presentation.

ITEM 8: Administration and Finance

Mr. Seltz stated that this would be a brief update since the FY16 budget discussion was moved to the July commission meeting.

To comply with Conflict of Interest Law, Mr. Seltz updated the board on two new HPC consultant contracts with organizations that are affiliated with commissioners. He noted that these contracts concern survey work for the HPC's Community Hospital Study and the 2015 Cost Trends Report.

Mr. Seltz reviewed a contract with Tufts University to provide focus groups and a survey for consumers about where they seek health care. He noted that this work will help inform the Community Hospital Study. The total amount of this contract is $93,000. Mr. Seltz provided this notice to the commission in accordance with the statute due to Dr. Hattis' affiliation with Tufts. He noted that Dr. Hattis did not play any role in procuring this contract.

Mr. Seltz reviewed a contract with Associated Industries of Massachusetts (AIM) for a survey of Massachusetts employers about their health insurance purchasing and their knowledge of certain value based health insurance products. This data will help support the HPC's data and analysis of demand side incentives. The total amount of this contract is $4,350. Mr. Seltz provided this

notice to the commission in accordance with the statute due to Commissioner Lord's affiliation with AIM. He noted that Mr. Lord did not play any role in procuring this contract.

Mr. Seltz paused for questions. Seeing none, he moved to the final agenda item.

Mr. Seltz noted that the state's fiscal year closes on June 30, 2015. He asked for interim financing for the HPC to continue operations until the board could vote on the fiscal year 2016 budget on July 22, 2015.

Dr. Hattis made a motion to approve interim financing until July 22, 2015. **Mr. Lord** seconded. The board voted unanimously to approve the motion. Voting in the affirmative were the eight members present. There were no abstentions and no votes in opposition.

ITEM 9: Schedule of Next Commission Meeting (July 22, 2015)

Dr. Altman opened up the meeting to public questions or comments. Seeing none, Dr. Altman adjourned the meeting at 2:46 PM.