MINUTES OF THE CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION COMMITTEE

Meeting of November 12, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Thursday, November 12, 2015, 9:30AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Care Delivery and Payment System Transformation (CDPST) Committee held a meeting on Thursday, November 12, 2015, at the HPC's offices, 50 Milk Street, 8th Floor, Boston, MA.

Members present included Dr. Carole Allen (Chair), Dr. Paul Hattis, Mr. Martin Cohen, Mr. Ron Mastrogiovanni, and Undersecretary Alice Moore, designee for Ms. Marylou Sudders, Secretary of Health and Human Services.

Dr. Allen called the meeting to order at 9:30 AM.

ITEM 1: Approval of minutes

Dr. Allen asked for a motion to approve the minutes from September 16, 2015. **Mr. Mastrogiovanni** made the motion to approve the minutes. **Mr. Cohen** seconded the motion. The members present voted unanimously to approve the minutes.

ITEM 2: Discussion of HPC Health Care Innovation Investment Program

Mr. David Seltz, Executive Director, provided an update on the Health Care Innovation Investment Program (HCII). He said the program will distribute approximately $6 million through two rounds of funding. Mr. Seltz added that the statute charges the HPC to use the HCII money to foster innovation in payment and delivery, to align with other investment programs, and to support further efforts to reach the health care cost growth benchmark.

Mr. Seltz explained that the Community Health Care Investment and Consumer Involvement Committee has spent significant time planning how to maximize the impact of HCII.

The HPC is currently considering eight Challenge areas in which to focus HCII investments. Mr. Seltz added that the goal is to reduce this to two or three areas before releasing a request for proposals. Mr. Seltz noted that several Challenge areas align with the goals of the CDPST committee.

Mr. Seltz stated that the HPC wants to maintain flexibility so as to respond to what the market needs. To this end, the HPC released a survey to key stakeholders. Mr. Seltz stated that, to date, the survey has varied results, but points to a small consensus around the

Challenge areas concerning end of life care, integrating behavioral health, and addressing social determinants of health. He added that the survey is live on the HPC's website.

Dr. Allen asked for clarification on the grants awarded through HCII. Mr. Seltz responded that the HPC is currently planning on distributing the grants in two phases. The first phase will be $3 million with grants in the range of $250,000 to $500,000.

Mr. Cohen asked if there was a possibility to use the grants to leverage partnerships between payers and providers or multiple payers and multiple providers. Mr. Seltz answered in the affirmative.

ITEM 3: PCMH Certification

Dr. Allen stated that one of the main responsibilities of the CDPST Committee is to develop certification processes for patient-centered medical homes (PCMH) and accountable care organizations (ACO).

Ms. Katherine Record, Deputy Director of Behavioral Health Integration & Accountable Care, updated the committee on proposed changes made to the PCMH PRIME certification program. She noted that the HPC is partnering with NCQA to certify practices. She noted that the HPC will also engage a marketing firm to raise awareness ~~on~~ of PRIME Certification.

Ms. Record reviewed the process for an organization to achieve PCMH PRIME recognition. She stated that practices must be NCQA recognized as Level 2 or 3 2011 or 2014 PCMHs and demonstrate capacity along HPC's behavioral health integration criteria to achieve PRIME. Ms. Record added that the HPC will provide technical assistance to practices to help them develop the necessary behavioral health integration capabilities.

Ms. Record noted that a practice must meet at least seven of the HPC's 13 PCMH PRIME criteria to achieve PRIME status.

Ms. Record reviewed stakeholder feedback that encouraged the HPC to start with a broader definition of 'integrated' in terms of behavioral health care. She noted that the HPC is proposing to divide the original criteria on integrated behavioral health providers into two separate criteria: (1) the practice has a memorandum of understanding with and/or co-located behavioral health providers; or (2) the practice integrates BHPs within the practice. Ms. Record explained that co-location was a step away from integration.

Dr. Allen asked for clarification on how the HPC would determine if a BHP was co-located or integrated with a practice. Ms. Record responded that there will be documentation requirements when a practice goes thorough PRIME certification to assess if a BHP is co-located or fully integrated with the practice.

Dr. Allen asked if single employee at a practice could fill the role of both a care manager and a behavioral health provider. Ms. Record replied that yes, as long as the employee was

a dedicated behavioral health provider. Ms. Record also noted that if a practice has a BHP on staff, the practice automatically would receive a point for being co-located with a BHP.

Mr. Cohen commented that he supported the changes to the certification process and that he believed the changes accurately reflected what was happening in the field.

The committee unanimously endorsed the PCMH PRIME certification program as revised.

ITEM 4: ACO Certification

Ms. Catherine Harrison, Senior Manager, Care Delivery, updated the committee on the proposed nine domains for mandatory criteria.

Criteria 1: Legal and Governance Structures

Ms. Harrison stated that this criterion requires that ACOs to operate as separate legal entities whose governing bodies have a fiduciary responsibility to the ACO. Ms. Harrison noted that this mirrors a requirement in Chapter 224. She stated that the HPC anticipates most ACOs already meet this requirement as it was part of the initial CMS guidelines.

Ms. Harrison stated that this domain also requires ACOs to provide information about their participating providers to the HPC for each of the three major payer categories (Medicare, MassHealth, and commercial). Ms. Harrison noted that this criterion is aimed at understanding which organizations are part of the ACO and what differences exist across payers.

Ms. Barrett added that this information will mostly align with the data collected from the Registration of Provider Organization process. The ACO process will only differ where ACOs list different providers on risk contracts with different payers.

Dr. Hattis asked if certification will include information on whether a doctor accepts Medicaid. Ms. Barrett responded that that will be clarified in the final certification. Dr. Hattis noted that from the consumer's perspective, knowing what payment types a provider accepts would be valuable information.

Ms. Harrison stated that the domain further requires that the ACO governance structure includes a patient or consumer representative and ensures that a meaningful level of participation is possible. Ms. Harrison highlighted that this requirement is found in both CMS's ACO models and in Chapter 224. She also noted that the HPC is contemplating ways to support this work through technical assistance and training.

Dr. Hattis asked if the "meaningful participation" statement was in lieu of including a patient or consumer representative. Ms. Harrison replied that the "meaningful participation" was intended to be additive, not to offer an alternative.

Ms. Harrison proceeded to explain the ACO requirements around the meaningful participation of providers. She noted that this was an area in which the HPC will be pushing

the market forward, as not many ACOs currently include this range of participation. Ms. Harrison added that this criterion is especially important to ACOs as it is key to ensuring that all providers are at the table to further the goals of integration.

Ms. Barrett commented that the HPC has heard significant stakeholder feedback in this area and that staff are still working to fully define "meaningful participation" in this context. She noted that the term "governance structure" is used for the purposes of keeping the definition broad.

Ms. Harrison discussed the additional legal and governance structure requirement that ACOs include a patient and family advisory council (PFAC) or similar committee which gives regular feedback to the ACO board.

Dr. Allen noted that the relationship between the ACO and the PFAC seemed unidirectional and suggested that it might be changed to encourage information exchange between the two entities. Ms. Barrett responded that it is critical that a PFAC is representative of the patient population; if one hospital's PFAC is used for a whole ACO, the PFAC would have to reflect that ACO's entire population.

Ms. Harrison explained the final criterion in the legal and governance domain was that ACOs have a quality committee that reports directly to the ACO's board and regularly considers and reviews the patient experience within the ACO.

Dr. Hattis asked for clarification on what "disparities" meant in "disparities for different types of providers within the entity." Ms. Harrison responded that it alluded to disparities in different population types and whether outcomes for one group are better or worse than outcomes in another group. Ms. Barrett added that it was meant to be taken in the broadest sense and not in reference to health care disparities resulting from socio-economics, race, age, or other demographics.

Mr. Mastrogiovanni asked if there was a standard definition of "quality" for ACO certification. Ms. Barrett responded that creating such a standard definition is a future task for the HPC. In the meantime, each ACO will develop its own definition for the metric.

Dr. Allen asked how much latitude an ACO would have in creating this metric. She noted that no uniform definition will make comparing across ACOs difficult. Ms. Barrett responded that this is an area of intensive work by the HPC, CHIA, and MassHealth. She added that doing such comparisons is a logical next step from ACO certification but that the tools to do so are not yet available.

<u>Criteria 2: Risk Stratification and Population Specific Interventions</u>
Ms. Harrison noted that, to meet this criterion, the ACO must have approaches for risk stratification of its patient population based on various criteria (these criteria can be found in the attached power point on slide 31).

Ms. Harrison noted that existing ACOs already have experience with risk stratification. She added that stakeholders have expressed concerns about select risk stratification requirements, such as social determinants of health. She explained that the HPC is researching ways to include these factors in risk stratification without placing an undue burden on the ACO.

Ms. Barrett stated that ACOs will be asked to use data from health assessments and risk stratification or other patient information to design programs targeted at improving health outcomes for patient population. She noted that at least one of these programs should address mental health, addiction, and/or social issues.

Ms. Barrett stated that ACOs were concerned about sharing data on behavioral health due to the confidential nature of the information. She added that some ACOs are using behavioral health in their risk stratification while others are not.

Mr. Cohen noted that the term "social issues" is broad and asked if the HPC was providing any guidance for ACOs. Ms. Barrett responded that this is another area of "stretch" for the ACOs and thus the HPC is open to a wide range of possibilities but would also provide examples to the ACOs.

Mr. Mastrogiovanni asked if there are benchmarks to evaluate progress in mandatory areas. He noted that these evaluations would be difficult to assess without understanding the distinct populations that each ACO serves. Ms. Barrett responded that the goal is to encourage ACOs to launch meaningful programs that would impact patient outcomes and the business operations of the ACO itself.

Mr. Mastrogiovanni noted that there is not always a positive relationship between quality and cost. Ms. Barrett acknowledged this and noted that "financial performance" is included as a metric on which the ACO will have to report.

Undersecretary Moore commented that she had received feedback from stakeholders that innovation should not be discouraged as a result of the ACO certification process. Ms. Barrett added that, with population specific interventions, the HPC is working to understand where the market stands and, as such, is being less proscriptive and open to more innovation. She also commented that the HPC has been intentionally less proscriptive in other areas and that the staff is open to feedback about this issue.

Mr. Mastrogiovanni asked if staff completed research on what other ACOs are doing in regards to innovation. Ms. Barrett responded that significant work had been done exploring what was happening in ACOs in other states. She noted the integration of behavioral health and social issues at Denver Health in Colorado as well as examples in Minnesota and New York. Ms. Barrett added the HPC's ACO program was directly informed by what is working in other states.

Dr. Allen commented on the virtues of device innovation that make such things as telemedicine for rural and home bound patients more possible. Ms. Barrett added that once

ACO certification is launched, a next step will be to share what is working at one ACO with other ACOs.

Criteria 3: Cross Continuum Network

Ms. Harrison explained that the criterion requires ACOs to demonstrate and assess the effectiveness of ongoing collaborations with and referrals to various types of providers. Ms. Harrison highlighted that this criterion is important because it ensures that ACOs have relationships with providers outside of their legal and governance structure that are essential to ensuring total care for the ACOs patients.

Ms. Harrison stated that the HPC is also requiring that an ACO has agreements with mental health providers, addiction specialists, and LTSS providers to address the needs of patient population. These agreements will include provisions for access and data sharing as permitted within current laws and regulations. Ms. Harrison added that this was another area where the HPC was hoping to push the market forward with the certification process.

Dr. Hattis asked for clarification on what the language "demonstrates effectiveness" meant in the criterion. Ms. Harrison responded that technical definitions would be forthcoming as the HPC put the criteria out for public comment. She added that a goal of the criterion is to assess access and gather data on how well patients who have need of specialists are being referred to the right kind of care.

Dr. Hattis noted that it would also be useful to know what it is like to work with the ACO from the specialist's perspective. He noted that it would be beneficial if the HPC could get feedback on the relationship between all types of providers in an ACO.

Dr. Allen noted that the criteria of this domain highlight the limits of PCMH capacity and why ACOs are needed.

Criteria 4: Participation in MassHealth APMs

Ms. Harrison stated that the fourth mandatory domain would require ACOs to participate in an outcomes-based contract for Medicaid patients by the end of Certification Year 2. She noted that there is also a Year 1 reporting only criterion in which ACOs must report on the percent of their revenue that comes from an outcomes-based contract or percent of patients covered by an outcomes-based contract. Ms. Harrison also noted that the requirement is geared toward aligning the HPC certification process with MassHealth's by steering ACOs to adopt the models that MassHealth makes available. Ms. Barrett noted that this criterion applies only to ACOs with Medicaid patients.

Dr. Hattis asked why this would not be done for all patients, commercial and Medicaid, if the EHR has the ability to collect the information.

Criteria 5: PCMH Adoption Rate

Ms. Harrison stated that ACOs must report on NCQA and HPC PCMH recognition rates. Furthermore, the ACOs would be required to create plans to increase these rates and assist practices in fulfilling the HPC's PCMH PRIME criteria. Ms. Harrison noted that this

requirement is designed to further align the two certification programs and ensure that they are mutually reinforcing.

Criteria 6: Analytic Capacity

Ms. Harrison stated that ACOs must regularly take in claims data and perform some level of analysis. She explained that the work must include an analysis of cost, utilization, and quality. She noted that this criterion was designed to get more information to providers and improve overall quality outcomes.

Mr. Cohen asked if current ACOs have the ability to perform this analysis in-house. Ms. Barrett responded that some ACOs do, while many other contract with outside firms to do the work for them. She also noted that some small practices have used reports provided by their carriers.

Criteria 7: Patient and Family Experience and Community Health

Ms. Harrison explained that the ACO must conduct a survey of patient and family experiences on access, communication, coordination, and whole person care and develop plans to improve based on the survey's results.

Mr. Cohen asked if there were criteria for how often the surveys had to be conducted. Staff responded that they were open to suggestions for the time frame and the committee agreed that either annually or biannually would be sufficient.

Dr. Hattis noted that the surveys are internal and the results do not need to be shared with the HPC or the public. He also noted that he could see how, from the consumer prospective, the survey results would be desirable. Dr. Hattis added that this would serve broader goals of transparency in the health care system.

Ms. Barrett responded that this certification process might not be the best mechanism with which to approach assessing quality and care outcomes. However, she noted that these outcomes are of interest to the HPC and that there are other surveys with public results that can help with transparency.

Undersecretary Moore commented that the committee should remind itself of its role in implementing these programs and that the discussion around quality might be brought before the full board.

Ms. Harrison explained that the second criterion in this domain linked the ACO's operation to its community. She noted that ACOs would be required to describe steps they are taking to advance or invest in the population health of one or more communities where it has at least 100 enrollees through a collaborative, integrative, multi-organization approach that accounts for the social determinants of health. She also noted this would be another area of "stretch" for ACOs where the HPC would be trying to push the market forward and thus the criterion is intentionally broad.

Criteria 6: Market and Patient Protection

Ms. Barrett stated that ACOs will have to meet documentation requirements (listed on slide 39 of attached presentation). She also noted that a potentially contentious requirement is that ACOs report ACO-level performance on a quality set associated with each contract and shared savings/losses for commercial and public risk contracts. Ms. Barrett added that statutory language passed in the previous state budget protects this information from public information requests.

Dr. Hattis asked for clarification on the benefit of this confidential information. Ms. Barrett responded it will help flush out the full view of the ACO and determine whether an ACO is doing well on one financial model and poorly on another. She noted that this information can then be used to assess which ACOs are performing well in terms of quality.

Ms. Barrett updated the committee on the funds flow requirement.

ITEM 4d: Timeline

Ms. Barrett reviewed the timeline for certification approval.

Undersecretary Moore made the motion to approve the ACO certification criteria with amendments for advancement to the full Board for vote. Mr. Cohen seconded the motion. The committee voted unanimously to approve the motion.

Dr. Allen adjourned the meeting at 11:00am.