MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of November 18, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

Date of Meeting: Wednesday, November 18, 2015
Start Time: 12:10 PM
End Time: 2:37 PM

	Present	ITEM 1: Minutes from September 9, 2015	ITEM 2: Approval of PCMH Certification Program	ITEM 3: Approval of ACO Certification Framework for Public Comment	ITEM 4: Approval of Proposed OPP Regulations
Carole Allen	Yes	2nd	M	Yes	Yes
Stuart Altman*	Yes	Yes	Yes	Yes	Yes
Martin Cohen	Yes	Yes	2nd	Yes	M
David Cutler	Yes	Yes	A	A	A
Wendy Everett	Yes	Yes	Yes	2nd	Yes
Paul Hattis	Yes	M	Yes	Yes	Yes
Rick Lord	Yes	Yes	Yes	M	Yes
Ron Mastrogiovanni	Yes	Yes	Yes	Yes	Yes
Marylou Sudders	Yes	Yes	Yes	Yes	Yes
Kristen Lepore	Yes	Yes	Yes	Yes	Yes
Veronica Turner	Yes	Yes	Yes	Yes	2nd
Summary	**11 Members Attended**	**Approved with 11 votes in the affirmative**	**Approved with 11 votes in the affirmative**	**Approved with 11 votes in the affirmative**	**Approved with 11 votes in the affirmative**

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.
*Chair
(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, November 18, 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; Mr. Rick Lord; Mr. Ron Mastrogiovanni; Ms. Veronica Turner; Ms. Lauren Peters, Designee for Secretary Kristen Lepore, Executive Office of Administration and Finance; and Secretary Marylou Sudders, Executive Office of Health and Human Services.

Chair Altman called the meeting to order at 12:10 PM and reviewed the agenda.

ITEM 1: Approval of Minutes from September 9, 2015

Chair Altman solicited comments on the minutes from September 9, 2015. Seeing none, he called for a motion to approve the minutes, as presented. **Dr. Hattis** made a motion to approve the minutes. After consideration upon motion made and duly seconded by **Dr. Allen**, the Board voted unanimously to approve the minutes from September 9, 2015. Voting in the affirmative were the eleven members present. There were no abstentions and no votes in opposition.

ITEM 2: Executive Director's Report

Mr. David Seltz, HPC Executive Director, welcomed everyone to the new HPC Conference Center, noting that this is the first Board meeting in the new space.

Mr. Seltz reviewed the agenda, noting that his Executive Director Report would include brief updates on the CHART Investment Program and the RPO program.

Mr. Seltz said that the Chair of the Cost Trends and Market Performance (CTMP) Committee would update the Board on the HPC's work relative to performance improvement plans (PIPs). He said that the committee has taken a deliberative approach to developing the process for PIPs.

Mr. Seltz stated that the Chair of the Care Delivery and Payment System Transformation (CDPST) Committee would ask the Board to approve the proposed program design for Patient-Centered Medical Homes (PCMHs). He noted that the CDPST Chair will also present draft standards for the certification of Accountable Care Organizations (ACOs).

Mr. Seltz said the Chair of the Quality Improvement and Patient Protection (QIPP) Committee will present selected findings from the Office of Patient Protection (OPP) 2014 Annual Report as well as proposed technical changes to regulations governing OPP. Mr. Seltz noted that the Board would also hear a presentation on a potential pilot program involving Neonatal Abstinence Syndrome (NAS).

Mr. Seltz stated that all of the votes on the agenda today have been endorsed by the policy committees.

ITEM 2a: CHART Investment Program

Mr. Seltz said the implementation planning process for Phase 2 of the CHART Investment Program is coming to a close. He noted that HPC staff have been traveling to each hospital as programs launch to meet with hospital teams and local representatives.

Mr. Seltz noted that 20 of the 25 programs have launched, with two additional programs launching in December and three in January. He stated that many of the awards that have not yet launched are joint awards involving multiple systems or hospitals.

Mr. Seltz stated that the HPC offered CHART hospitals flexibility for their program launch date, but required a hard deadline for launch by January 31, 2016. Mr. Seltz provided a brief summary of some of the CHART programs launched in November.

Dr. Hattis noted his appreciation for the active involvement of HPC staff. He asked when the hospitals will begin receiving technical support from the HPC to ensure they get the most from the program. Mr. Seltz responded that the hospitals will begin receiving such assistance shortly. He noted that the plan for technical assistance will be further discussed at the next CHICI meeting.

Mr. Seltz stated that many CHART programs have had issues with hiring program staff. He added that the HPC is working with local universities to enhance the placement of recent graduates.

Dr. Altman asked for a summary of evaluation relative to the CHART program. Mr. Seltz responded that the HPC is working with a private firm to design an evaluation approach. He added that a full discussion of this topic will likely be before the Board in January. He noted that the evaluation framework will help the HPC understand the impact of these investments and subsequent policy implications.

ITEM 2b: Registration of Provider Organization Program

Mr. Seltz stated that Initial Registration: Part 2 of Registration of Provider Organization (RPO) launched in June 2015. He noted that RPO staff provided guidance to registrants throughout the process through in-person trainings and 1-on-1 meetings.

Mr. Seltz stated that the deadline to submit materials was October 30, 2015. He noted 50 of 59 organizations have submitted to date. He said that the HPC has been in contact with those who have not filed and informed them about their responsibilities.

Mr. Seltz said that RPO will help the HPC better understand the organization of the Commonwealth's health care system.

Mr. Cohen asked for clarification on why nine organizations had not submitted. Mr. Seltz responded that some organizations requested extensions for the deadline. He noted that others were confused as to whether they were required to submit materials.

ITEM 3: Cost Trends and Market Performance

Dr. Cutler, Chair of the Cost Trends and Market Performance Committee, stated that CTMP has spent a great deal of time discussing the process for performance improvement plans (PIPs). Dr. Cutler introduced Ms. Megan Wulff, Senior Manager for Market Performance, to provide an update on recent Material Change Notices (MCNs).

Ms. Wulff stated that, since April 2013, the HPC has received notice of 51 MCNs, and noted that most were physician group mergers. Since the last Board meeting, the HPC has received five MCN notices:

1. Clinical affiliation between Dana-Farber Cancer Institute (DFCI) and Berkshire Medical Center.
2. Contracting affiliation between Beth Israel Deaconess Care Organization (BIDCO), New England Baptist Hospital (NEBH), and New England Baptist Clinical Integration Organization (NEBCIO).

3. Joint venture between Shield Health Care Group and Anna Jaques Hospital
4. Clinical affiliation between UMass Memorial Accountable Care Organization and Sturdy Memorial Hospital, Sturdy Memorial Associates, Holyoke Medical Center, Western Mass Physician Associates, Community Health Connections, Family Health Center of Worcester, and Community Heartlink.
5. Contracting affiliation between Beth Israel Deaconess Care Organization (BIDCO) and MetroWest Medical Center (MWMC).

Ms. Wulff stated that the HPC decided not to proceed with a CMIR on three pending MCNs:
1. Clinical affiliation between Boston Children's Hospital and Lahey Clinical
2. Clinical affiliation between Boston Children's Hospital and Boston Medical Center
3. Clinical affiliation between Dana-Farber Cancer Institute and Berkshire Medical Center

Ms. Wulff stated that, through a 30-day review of these transactions, the HPC found no evidence that they would negatively impact cost or quality.

Dr. Altman asked how many cost and market impact reviews (CMIRs) the HPC has conducted. Ms. Katherine Mills, Policy Director for Market Performance, responded that four transactions have proceeded to a full CMIR.

Dr. Altman asked for clarification on the review of proposed clinical affiliations. Ms. Mills responded that the HPC looks deeply into transactions aimed at improving care delivery to examine the proposed plan to improve care. She said that the staff also examines the impact of the proposed transaction on cost and market functioning. She noted that the main area of examination for proposed clinical affiliations is possible changes to referral patterns.

Dr. Altman noted that certain changes in referral patterns could lead to substantial increases to prices.

ITEM 3a: Introduction to Performance Improvement Plans

Ms. Mills stated that Chapter 224 included language on PIPs to increase the transparency and accountability of payers and providers in the Massachusetts system. She added that PIPs help providers identify excessive cost growth and create plans to curb that growth. She noted that the HPC has worked with CTMP to create a robust framework to determine which organizations will receive a PIP and what an effective PIP might look like.

Ms. Mills reviewed the PIP process. She noted that the first step is for the Center for Health Information and Analysis (CHIA) to identify payers and providers who threaten the benchmark with excessive cost growth. She noted that, for 2014, this analysis is based on TME data from 2012 and 2013, and preliminary data from 2014. Ms. Mills stated that the HPC must then provide notice to organizations identified by CHIA of their status on the list.

Dr. Allen asked whether the HPC can request a PIP of any provider organization. Ms. Mills responded that the HPC can only request a PIP from entities identified by CHIA as having excessive cost growth.

Mr. Mastrogiovanni asked how the Commonwealth defines excessive cost growth. Ms. Mills responded that CHIA does not have a regulatory definition. She stated that, for 2014, CHIA is defining excessive cost growth as having a TME higher than the health care cost growth benchmark, or 3.6%.

Mr. Lord asked how many organizations CHIA identified as having excessive cost growth. Ms. Mills responded that fewer than 20 providers and five payers are on CHIA's list. She noted that the analysis includes commercial payers, Medicare advantage products, and Medicaid MCOs.

Secretary Sudders asked to go "on the record" to note that CHIA's definition of excessive cost growth for 2014 is "ridiculous." Dr. Altman agreed. Secretary Sudders added that the health care cost growth benchmark is meant to function as a benchmark and not an absolute determination of success or failure. Dr. Altman agreed, noting that the use of the word "excessive" indicates a certain level of growth.

Dr. Altman stated that the HPC can address this lacking definition by conducting a second screening of organizations on CHIA's list. He said excessive growth should be defined as some number over the benchmark and not the benchmark itself.

Dr. Cutler noted that, during the CTMP committee discussion on PIPs, members did not view the benchmark as a hard and fast line. He said that the committee wants to use CHIA's data to find patterns of growth and spending. He said he anticipates that only a small number of organizations will be placed on a PIP. He stated that this process will help the HPC better understand the market.

Dr. Hattis stated that the statute had to define some level of excessive growth. He added that a detailed analysis conducted by the HPC will help determine which organizations really need a PIP. He added that organizations could be on CHIA's list for positive reasons and the HPC must identify that.

Secretary Sudders agreed with Dr. Cutler about the need for further analysis to draw patterns and trends. She asked whether the HPC's notice to organizations of their status on CHIA's list is a public notice. Ms. Mills responded that the notice would not be public, but that the PIPs process would be.

Dr. Altman said the HPC has two options: to consider CHIA an eligibility decider or to work with CHIA to determine better criteria for excessive cost growth.

Dr. Hattis responded that CHIA is the neutral provider of data, and that exercising discretion over who receives a PIP should fall to the HPC.

Dr. Altman noted that some things, such as drug pricing, are out of the provider's control. He added, however, that the area of prescription drugs must also be monitored. He said carving drug prices out of the benchmark sets a bad precedent.

Mr. Mastrogiovanni noted his support for working with CHIA to better define excessive cost growth.

Dr. Allen noted the importance of examining the baseline growth and spending of all organizations to determine how they are changing and what factors they are encountering.

Mr. Seltz noted that the PIP process is a challenging component of Chapter 224. He added that the HPC cannot compare all health plans because they are operating under different conditions.

Dr. Cutler stated that CTMP has reviewed the process with staff and is now working through actual data to determine whether the process needs changes. He noted the need for a nuanced understanding of the current environment to ensure that the HPC properly defines "excessive cost growth."

Ms. Mills stated that after receiving the list from CHIA, the HPC will analyze the findings and verify the information. She added that the Board will receive a copy of the list once the information is verified. At this point, the HPC will send notices to organizations that have been identified by CHIA. The HPC will then work to identify what the agency believes to be real concerns related to cost growth.

Ms. Mills added that the Board will be kept informed throughout this analysis. She noted that the Board will be asked to vote on whether an organization will be required to complete a PIP and if an entity seeks a waiver.

Dr. Everett suggested that CHIA's list not be disclosed until the staff had time to review it and the Board decided that it was valid.

Mr. Mastrogiovanni agreed that, for transparency, the list should be made public once the HPC determines the validity of the entities with excessive cost growth.

Secretary Sudders said that she is uncomfortable putting out notice to providers and payers if the Board has not had a discussion and made decisions around guidance and draft regulations.

Mr. Seltz said that he would be supportive of holding the notice until the HPC had the proper guidance and regulations. He said the HPC has been involved in some of the data validity process with CHIA.

Dr. Altman said the Board needs to do two things: (1) stipulate the rules and regulations around the PIPs process and (2) go through a vetting process and discussion with CHIA about the validity of the data.

Dr. Everett said a compromise would be having CTMP review a revised version of CHIA's original list. She added that the list should be well vetted before it is released to the public.

Dr. Hattis noted that providing the list to commissioners is not the same as releasing it to the public.

Dr. Altman noted that the HPC functions because stakeholders and members of the public take the benchmark and HPC reports seriously.

Dr. Everett suggested that the Board not receive a list based solely on CHIA's data.

Dr. Hattis said the Board should receive the list once the HPC validates the data with CHIA. He added that commissioners should be brought in the loop before the HPC engages in the PIP process.

Mr. Seltz noted that some payers and providers only have excessive cost growth in one particular area. He posited that a PIP would not be appropriate for those organizations. He suggested a compromise would be providing the Board with the original list, including information from the staff on the classification of various entities by their need of a PIP.

Dr. Everett said it goes back to having the context to understand if these entities really need a PIP. She said that the HPC should move the disclosure process farther down the line.

Dr. Allen asked whether the PIPs process is intended to be punitive or an educational improvement opportunity. She said there is an opportunity for the HPC to complete a root cause analysis. She noted that the HPC should not just identify outliers, but also understand what exactly is occurring.

Dr. Altman said that once the HPC validates the information with CHIA, the list should be sent to commissioners before staff release the notices to organizations. He added that, to be consistent with the CMIRs process, the HPC should make the PIP list public after the entities receive notice.

Dr. Hattis said Dr. Altman's remarks were very thoughtful.

Dr. Cutler said giving notice may be coming too early in the PIPs process.

Dr. Altman said that the HPC should get the wording clear to reflect that the PIPs process is not just based on CHIA's data, but also on the individual context of the entity.

Mr. Seltz said there would be some entities who would receive notice that they were initially identified by CHIA, but after review by the HPC there is no further action necessary.

Dr. Altman asked if the HPC will move forward with drafting regulations. Ms. Mills responded that the HPC is in the process of drafting regulations and will continue to discuss this process extensively at the committee level. She said that the HPC plans to release draft regulations in early 2016 after engaging with key stakeholders.

Secretary Sudders reiterated that the HPC should not issue notices to providers without regulations.

Mr. Seltz said that the staff will present a new timeline to the Board after sending out guidance and regulations.

Dr. Cutler left the meeting.

ITEM 4: Care Delivery and Payment System Transformation

Dr. Allen stated that the committee would update the Board on the program design for patient-centered medical homes (PCMHs) and draft standards for accountable care organizations (ACOs), which were endorsed by the Care Delivery Payment System Transformation (CDPST) Committee.

ITEM 4a: Program Design for Patient-Centered Medical Homes

Mr. Seltz introduced Ms. Catherine Harrison, Senior Manager for Care Delivery, to present on the HPC's program design for PCMHs. He noted that PCMH program design has undergone several iterations as the HPC developed the program.

Mr. Seltz stated that the HPC decided to partner with NCQA, a leader in the market, for the PCMH certification process. He noted that NCQA will provide administrative support to reduce the HPC's operational expenses. Mr. Seltz provided a brief summary of the program design development process and the HPC's work with NCQA. He also highlighted the HPC's work with stakeholders to ensure that the program was responsive to the market. He stated that feedback throughout the process led the HPC to reduce additional priority domains for certification from four to one, focused on behavioral health integration.

Ms. Katherine Shea Barrett, Policy Director for Accountable Care, introduced the HPC PRIME Certification Program. She stated that an organization can achieve PRIME certification by having Level 2 or Level 3 NCQA 2011 or 2014 NCQA accreditation as well as proficiency in the behavioral health HPC-specific domain. She said a vast majority of providers in Massachusetts are already Level 2 or Level 3 NCQA 2011. She added that many practices find it difficult to integrate behavioral health because of regulatory and payment barriers. Ms. Barrett noted that the HPC will provide limited technical assistance to help practices with these challenges. She said most of the PCMH PRIME criteria are already NCQA standards or modified versions of them; a small number of them are new criteria defined by HPC in consultation with NCQA.

Ms. Harrison said there are 13 PRIME criteria. She said that these broadly fit into a few categories: (1) integration of behavioral health providers into the practice; (2) screening for depression, anxiety, substance use disorder, developmental delays, and postpartum depression; (3) use of evidence based guidelines; (4) care management; and (5) buprenorphine prescribing capabilities.

Secretary Sudders asked why the last category only includes buprenorphine capabilities. She asked the HPC to broaden this area to include a wider range of drugs. Mr. Seltz responded that the HPC is happy to make that change.

Ms. Harrison said that in order to be PRIME certified, providers must meet seven out of 13 of the criteria. She noted that a practice would receive two points if it has full integration of behavioral health providers on site, as opposed to only having an MOU with a provider, or co-located providers.

Dr. Hattis noted that buprenorphine requires a specific license, which the HPC is seeking to incentivize more primary care providers to obtain, and that methadone cannot be administered in a primary care practice, only in a facility with a federal methadone license. He asked generally if the Board is comfortable if some practices can only provide one type of addiction drug treatment.

Secretary Sudders said she prefers one or more treatments, and noted that there may be upcoming changes in the regulation of methadone.

Dr. Hattis said that he was under the impression that the HPC's criteria was to encourage more providers to be licensed to prescribe buprenorphine.

Secretary Sudders noted there are other treatments for substance use disorder. She said she does not support limiting the PRIME criteria to buprenorphine.

The Secretary noted that last year, Massachusetts providers prescribed 240 million Schedule II and III benzodiazepines and opioids. She noted that the Commonwealth has a long way to go on provider education. She said the language should provide broad options, noting that while suboxone is a tool in the (addiction treatment) toolkit, it is not the only tool.

Dr. Hattis said that he read the criteria as a way to push practices to become trained to deal with the full range of medication assisted treatments (MATs). He said it could read buprenorphine and naltrexone.

Mr. Cohen said the language could be "including, but not limited to." He noted that the point is to stress MATs.

Mr. Seltz said there is an opportunity to strengthen and expand this criterion. He said it is not enough to just have an organization be licensed; they must also have the capability and staff to provide MATs. He said because this is a new criterion, the HPC will have to specify to NCQA how practices can demonstrate that they are meeting it.

Dr. Altman said that one can think about integration in two ways: (1) expanding the knowledge base of PCPs on mental health conditions and affording them some limited ability to prescribe and (2) integrating PCPs more fully with people who are more skilled in that field. He said that the HPC wants to do both.

Secretary Sudders said it comes down to the question of, what is integration? She said that integration to her is across the continuum, like PCP screening for mental health conditions. She said, depending on size, some practices will embed social workers or behavioral health clinicians in their practices. She said during her work on the opioid epidemic, she noticed an emphasis on buprenorphine, while there is a range of treatments. She said the Governor would be worried about a criterion that is too focused.

Dr. Altman said, given the shortage of professionals in these fields, expanding the knowledge base of PCPs is a good idea.

Secretary Sudders said that Dr. Altman should support the Governor's opioid bill that requires continuing education units for all prescribers in the Commonwealth. Dr. Altman said that that would be his pleasure.

Mr. Seltz agreed with Secretary Sudders that integration is a continuum and the criteria will allow the HPC to see what practices are doing and their results, which will allow the HPC to track improvement.

Mr. Lord asked what criteria a case manager must meet in order to qualify to identify and/or coordinate behavioral health needs. Ms. Barrett responded that NCQA requires them to complete a qualified training program, but added that the documentation is vague. She noted that the HPC could be more stringent in this area, but has elected not to be.

Mr. Seltz said that the HPC will discuss the documentation requirements for each criterion at the next CDPST committee meeting.

Ms. Turner asked whether the Board would be asked to vote on the criteria at the day's meeting. Mr. Seltz responded that the Board would be asked to vote to move forward with these criteria and continue to process information.

Ms. Harrison added that NCQA is a key partner in launching PRIME. She said that they will help communicate information on PRIME to practices, giving practices the opportunity to achieve HPC certification as they meet the required level of NCQA recognition and make a commitment to work toward PRIME certification. She said HPC is working with NCQA to launch PCMH PRIME in early 2016.

Ms. Barrett said materials supporting the launch of PRIME will include a value statement to patients, payers, and providers. She said Harvard Pilgrim Health Care has already seen the benefit of this program and is supporting the pathway to PRIME with their infrastructure grants.

Dr. Altman said that we should be focusing on the fact that practices must obtain both NCQA and PRIME certification. He said we are encouraging a more robust primary care delivery system.

Ms. Barrett said the HPC is working through documentation requirements with NCQA and building them into a submission platform. She said practices that are renewing their NCQA recognition can go for PRIME certification concurrently at no additional cost. Practices also can go through only the PRIME certification as an add-on before their NCQA recognition is up for renewal (also at no cost to the practice).

Dr. Allen requested a vote to approve the certification process with the amendments discussed at the meeting. Mr. Cohen seconded Dr. Allen's motion.

Dr. Everett asked that the amendments be clearly stated.

Dr. Allen added that there is a slight word change in criterion #12.

Ms. Barrett said that the Board was voting to endorse the conceptual criteria with an amendment to criterion #12 that says a practice with one or more PCP on staff with a license to prescribe buprenorphine or a range of medication assisted therapies.

Secretary Sudders asked about what would qualify a person to meet criterion #13. Ms. Barrett responded that staff can be more specific at the CDPST meeting.

Mr. Lord said that, after discussion, he is okay with the wording in criterion #13.

Dr. Hattis said he would vote for the amendment to criterion #12, but noted that the HPC's intent to incentivize practices to have a license to prescribe buprenorphine would be weakened.

Dr. Altman asked how the HPC was going to distribute information on the PRIME program. Ms. Barrett responded that the HPC is in the process of receiving expert help about launching a communications and marketing strategy around ACO and PRIME certification.

The board voted to endorse the proposed criteria, as amended. Voting in the affirmative were the ten members present. There were no abstentions and no votes in opposition. Dr. Altman thanked Dr. Allen for her work.

ITEM 4b: Draft Standards for Accountable Care Organizations

Ms. Barrett said Chapter 224 lays the groundwork for this program with the goal of an integrated delivery system. She said this involves balancing minimum standards for ACOs while allowing room for innovation. Ms. Barrett noted that the HPC is also seeking to align with the care delivery and payment reform efforts underway through the Group Insurance Commission and MassHealth in developing this program.

Ms. Barrett reviewed the staff's process to develop ACO criteria, noting consultation with other states, literature reviews, and an examination of Medicare and Medicaid ACO requirements. She said that staff also spoke extensively with stakeholders and academics in the field of accountable care.

Ms. Barrett said that most providers and payers have cautioned the HPC against being too prescriptive in the first year of the program. She said that the HPC heard much feedback on how to hold ACOs accountable to rates of APM adoption and whether nursing homes should be part of ACOs.

Ms. Barrett said that the HPC is working to align with MassHealth ACO requirements. She said that, unlike MassHealth, the HPC's program has an all-payer, all-patient focus, making its standards more general.

Ms. Barrett said that the HPC is proposing a new ACO certification framework, with a mix of mandatory and reporting only criteria. She said that the reporting only criteria may eventually become mandatory criteria.

Ms. Harrison stated that the HPC wanted to align with the state of the market as they decided which criteria should be mandatory versus reporting only. She said stakeholders were primarily focused on the mandatory criteria.

Ms. Harrison reviewed the mandatory criteria. She noted that, for legal and governance structures, the ACO must be a separate legal entity except if the ACO participants are part of the

same health care system. She said the ACO must provide information to HPC about its participating providers, and whether those providers differ by contract (i.e. Medicare, MassHealth, and commercial). She said that the HPC is also requiring a patient representative with meaningful participation on the ACO governing body.

Ms. Harrison said the ACO must demonstrate how it includes different providers in the governance structure, specifically primary care, behavioral health, and specialty providers. She added that the ACO must also have a Patient and Family Advisory Council (PFAC) and a quality committee.

Dr. Everett asked for a brief overview of the CDPST Committee's discussion of these criteria, especially those related to the PFAC and quality committee. Dr. Allen responded that stakeholders stressed the need for meaningful participation of a range of perspectives in the ACO governance structure.

Ms. Barrett added that the HPC received a lot of feedback from ACOs in this area. She noted their concern about the role of a patient/consumer representative on the Board. Ms. Harrison said there was sensitivity around developing a different governance structure to satisfy the HPC's ACO program.

Dr. Altman asked how the HPC program compares to other programs. Ms. Harrison stated that the HPC works closely with MassHealth to ensure that ACOs are not given contradictory guidelines.

Ms. Harrison said the requirements around cross continuum networks revolve around the demonstration of effective, ongoing collaborations with other providers. She said ACOs must show linkages to services and resources throughout the community, and ACOs must show internal capacity to provide behavioral health services or show agreements with external providers with provisions for access and data sharing.

Ms. Harrison said there are two criteria regarding adoption of alternative payment methods. She said for reporting only criteria, the ACO must report the percentage of its primary care revenue or patients that are covered under outcomes-based contracts. She said that ACOs must also participate in an outcomes-based contract for Medicaid patients by the end of 2017. She said this will align with MassHealth's work.

Dr. Altman reiterated the need for the HPC to link payment reform with the launch of the ACO certification program. He added that the HPC needs to work to educate consumers on the benefits of an ACO.

Mr. Cohen said the HPC staff did a great job of balancing being too prescriptive and allowing for innovation.

Dr. Altman suggested that the HPC rename ACO certification, such as PCMH PRIME, to more easily brand it to consumers. Commissioners discussed the requirement that ACOs report the percentage of their primary care revenue or patients that are covered under outcomes-based contracts. Dr. Altman asked for clarification on this requirement.

Ms. Barrett said that the HPC was trying to examine budgets with this requirement. She said that she can only recall two ACOs with outcomes measures associated with them. She said the number of outcome based contracts should not be tied to clinical outcomes, because it can be hard to acquire that data.

Dr. Altman said, when focusing on the financial aspects, the HPC should use a word other than "outcome,' which usually refers to the clinical side.

Secretary Sudders asked about the outcome based contracts for Medicaid patients. Ms. Barrett responded that this requirement was trying to get at the relative increases in ACOs' adoption of alternative payment methods.

Mr. Seltz said that the HPC is working to create a linkage between the PCMH and ACO program. He said that organizations must report about their PCMH recognition and submit a plan for increasing those rates.

Mr. Seltz stated that the HPC will hold a public comment period and public hearing for further discussion of the ACO certification criteria. He noted that staff will also continue to connect with stakeholders.

Dr. Allen asked for a motion to move the ACO certification criteria to a public comment period. Mr. Lord motioned for a vote. Dr. Everett seconded. Voting in the affirmative were the ten members present. There were no abstentions and no votes in opposition.

ITEM 5: Quality Improvement and Patient Protection

Mr. Cohen, Chair of the Quality Improvement and Patient Protection (QIPP) Committee, provided an update on committee activity since the last Board meeting. He noted that the Board would hear a selection on findings from the 2014 OPP Annual Report. He added that the Board would be asked to vote on regulations governing the Office of Patient Protection.

Secretary Sudders thanked Ms. Jen Bosco, Director of OPP, for her work. Secretary Sudders left the meeting. Her designee, Undersecretary Alice Moore, joined the Board at the table.

ITEM 5a: Final Recommended Regulations for the Office of Patient Protection

Ms. Bosco said that the QIPP Committee endorsed two technical changes to regulations governing OPP. First, she said that the staff proposed changes to the Medical Necessity Criteria regulation to reflect 2014 changes in state law. Second, she noted that the staff proposed updates to the Enrollment Waiver regulation to align with state and federal law.

Ms. Bosco highlighted that staff added clarifying language to the proposed regulations since the June Board meeting. She added that the timeframe for carriers to provide requested criteria was also shortened to 21 days.

Mr. Cohen made a motion to approve the final proposed regulations governing the Office of Patient Protection. Ms. Turner seconded the motion. Dr. Altman said the vote passed with unanimous consent.

ITEM 5b: Office of Patient Protection Annual Report

Mr. Seltz highlighted the work completed by Ms. Bosco to develop OPP's Annual Report. He noted that OPP did not release such a report until it was transferred to the HPC in 2013.

Ms. Bosco said insurance companies report the types and outcomes of any member grievances. She said it gives the HPC a picture of the user experience in Massachusetts. There were over 11,000 grievances reported in 2014, noting that grievances could include a coding error, medical necessity criteria, or other complaints. She said that the report focused on the 3,906 complaints identified as internal grievances involving a denied claim due to medical necessity criteria; the carriers resolve about 44% of those complaints internally. Ms. Bosco noted that approximately 25% of the internal reviews involved behavioral health cases. She said that approximately half of medical/surgical cases were resolved in favor of the patient, which only 33% of the behavioral health cases were.

Ms. Bosco said about 13% of patients denied in the internal review process underwent an external review through OPP. She said OPP will continue to educate consumers about the services offered by the agency.

Ms. Bosco said the number of 2014 external reviews was similar to previous years, 286; 46% of those cases were resolved in favor of the consumer

Dr. Altman asked if a large number of the cases involved a consumer asking to stay in in-patient care while their provider was encouraging out-patient care. Ms. Bosco responded that there is a high percentage of those types of cases. She said most often it is the patient wanting to see an out-of-network provider.

Dr. Altman asked if there is a pattern in the non-BH cases. Ms. Bosco said outpatient care was the largest category, followed by pharmacy and fertility treatment. She said they that, in 2014, OPP saw a large number of cases involving high cost Hepatitis C drugs. She said most of those cases were overturned in favor of the patient.

Ms. Bosco said OPP is making legal decisions, not medical ones. OPP has medical experts that it consults to make the clinical evaluation. She noted that a higher number of BH external review cases were resolved in favor of the patient compared to the previous year.

Ms. Bosco concluded that the number of external reviews has been fairly consistent over time.

Dr. Everett said OPP has done really nice work.

Dr. Altman and Director Seltz all thanked Ms. Bosco for her service and wished her the best in her new position.

ITEM 6: Schedule of Next Meeting (December 16, 2015)

Mr. Seltz said there is another full slate of committee meetings in December. He said they will begin to roll out findings from the 2015 Health Care Cost Trends Report.

Dr. Altman concluded the formal agenda. He stated that the next Board meeting will take place on December 16, 2015 at the Health Policy Commission's offices. He adjourned the meeting at 2:37PM.