MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

April 27, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from the March 2, 2016 Meeting (VOTE)
- Update on *Gobeille vs. Liberty Mutual Insurance Company* Supreme Court Decision
- Quality Improvement and Patient Protection
- Care Delivery and Payment System Transformation
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Improvement
- Report from the Executive Director
- Schedule of Next Meeting (June 1, 2016)

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on March 2, 2016, as presented.

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- **Quality Improvement and Patient Protection**
  - Update on Out-of-Network Billing
  - Approval of RBPO/ACO Appeal Interim Guidance (VOTE)
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Summary of Out-of-Network Billing Listening Session

- Following the release of the HPC's Policy Brief on Out-of-Network Billing, the Cost Trends and Market Performance (CTMP) and Quality Improvement and Patient Protection (QIPP) Committees held a joint meeting on April 6, 2016 to provide an **opportunity for stakeholders and members of the public to provide comments** to the HPC regarding out-of-network billing

- Representatives from **health plans** and **consumer advocacy groups** provided comments on out-of-network billing, including the following key themes:
  - **Health plans** were mainly in agreement regarding the need for and general direction of solutions to address out-of-network billing concerns (e.g., setting a maximum reasonable price for out-of-network services at an appropriate level)
    - One heath plan said that out-of-network payments cost $134 million in 2014
  - Nearly all commenters discussed out-of-network emergency, radiology, anesthesiology, and pathology ("**ERAP**") and **ambulance** providers; health plans discussed the significant cost implications of these particular types of care
  - There was strong interest expressed in hearing from **providers** on these issues

- Based on continued interest, the HPC is planning to hold **another listening session** with the CTMP and QIPP Committees in order to hear additional comments on out-of-network billing issues
  - *Tentatively scheduled for Wednesday, May 18 at 9:30 AM*

Update on State Policies to Address Out-of-Network Billing Concerns

Florida: New Surprise Billing Law

- Florida Governor Rick Scott recently signed a bipartisan bill into law that prohibits balance billing for patients who unintentionally receive out-of-network care at an in-network facility (in both emergency and nonemergency situations)
- The state will arrange a voluntary dispute resolution process; negotiations will be based on usual and customary rate for the particular geographic area
- The law applies to PPO plans (balance billing already prohibited for HMO plans)

California: Continued Efforts to Expand Balance Billing Protections

- A broad coalition (e.g., payers, consumer advocates, and some providers) is supporting an amended version of a bipartisan bill; however, the bill continues to face some opposition (including from the California Medical Association)
- The bill would establish a binding independent resolution process for insurers and providers where patients received care from out-of-network providers at in-network facilities
- The bill would apply to non-emergency care (balance billing for emergency care is already prohibited)

New York: Preliminary Data Released One Year After Enactment of Law

- Some preliminary data about utilization of the state's binding, independent binding dispute resolution process were recently released
- In 291 disputes over emergency services bills, the amount paid by insurers and providers was determined to be reasonable in 22% and 13% of cases, respectively*
- Plastic surgeons were the specialists most often involved in emergency services disputes
- Data on resolution of non-emergency care bills are currently less robust

*Source: Crain's New York Business, *New York Law to Curb Surprise Billing Shows Promising Results*, ModernHealthcare.com (Apr. 7, 2016), http://www.modernhealthcare.com/article/20160407/NEWS/304079996

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Overview: Appeals Processes for RBPOs and ACOs

Chapter 224 requires the HPC to develop internal appeals and external review processes for RBPOs and ACOs

Office of Patient Protection (OPP) is directed to establish requirements for DOI-certified Risk Bearing Provider Organizations (RBPO) or HPC-certified Accountable Care Organizations (ACO) to implement appeals processes for reviewing consumer complaints as well as an external review process to obtain third party review of such complaints.

Statutory requirement are similar to existing OPP consumer protection rules regarding review of health plan medical necessity determinations but apply to provider determinations on referrals, appropriate treatments and timely access to care

Statutory Requirements

	RBPO	ACO
M.G.L. c. 6D, §15	N/A	(b)(vi) calls for internal appeals plan as required for RBPOs; plan shall be approved by OPP; plan to be included in membership packets
M.G.L. c. 6D, §16	N/A	(a)(8) OPP to establish regs, procedure, rules for appeals re: patient choice, denials of services or quality of care (b) establish external review including expedited review
M.G.L. c. 176O, §24	(a) certified RBPOs shall create internal appeals processes (b) 14 days/3 days for expedited; written decision (b) RBPO shall not prevent patient from seeking outside medical opinion or terminate services while appeal is pending (d) OPP to establish standard and expedited external review process	ACO is to follow M.G.L. c. 176O, §24 when developing internal appeals plan (see M.G.L. c. 6D, §15(b)(vi))

Separate and Distinct Appeals Processes

Provider Decisions - Access

Referral Restrictions

Type or intensity of treatment or services

Timely access to treatment or services

RBPO/ACO Appeals Process (M.G.L. c. 176O, § 24)

Carrier Decisions - Coverage

Out of network services

Cost sharing

Medical necessity of treatment or service

Carrier Appeals Process (M.G.L. c. 176O, §§ 13, 14)

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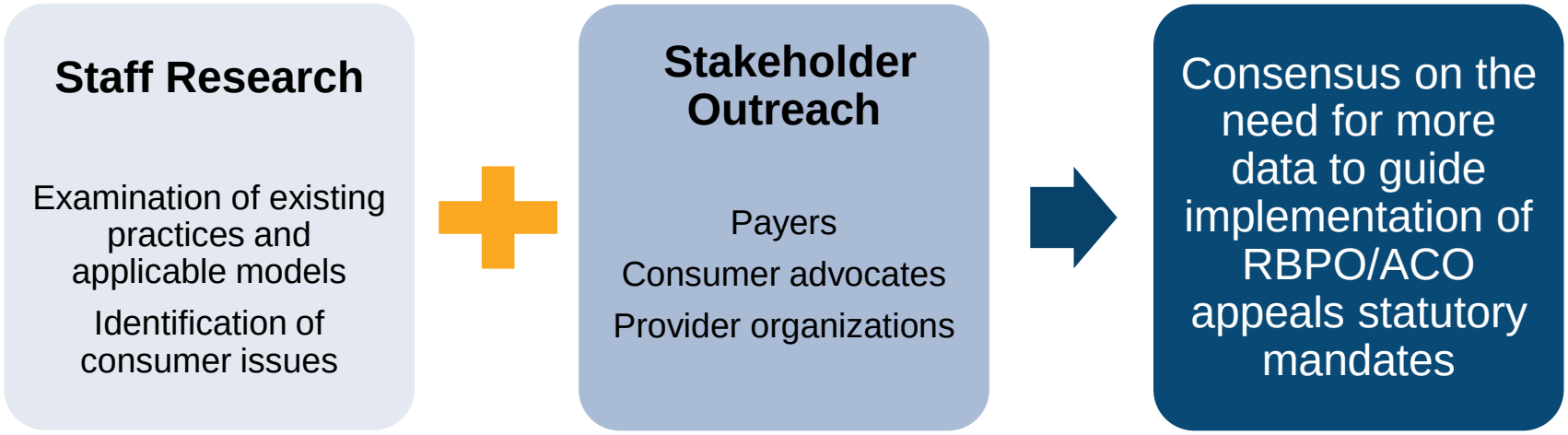
HPC Research and Outreach



Objectives of Interim Guidance

1. Advance consumer protection established in Chapter 224 without duplicating existing rights under carrier insurance appeals
2. Protect patients while recognizing the needs of different providers and minimizing administrative burden and expense
3. Inform consumers about RBPO/ACO providers
4. Build on existing provider mechanisms for addressing complaints
5. Gather and analyze data, to provide foundation for developing appeals processes and rules

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Key Considerations

- Closely Track Statutory Requirements
- Clarify Applicability
- Retain Flexibility in How Provider Organizations Develop Process
- Clarify Types of Issues Appropriate for RBPO/ACO Appeals

Proposed Interim Guidance

Provide Adequate Notice to Patients

- Make notice available in writing at all locations where patients regularly seek care and include a phone number or other contact information for patients to file an appeal and include OPP contact information
- A sample, “Notice to Patients,” accompanies proposed OPP Bulletin

Establish an Appeals Process by September 1, 2016

- Complete process within statutory timeframes
- Provide written notice of decision to patients with OPP contact information

Submit Reports to OPP that include

- Copy of patient notice
- Number, nature, and resolution of appeals handled by the RBPO, classified into designated categories
- Description of the RBPO’s appeals process to resolve patient complaints

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OPP Support of Implementation of Interim Guidance

- Develop FAQ for provider organizations and consumers on RBPO appeals process
- Create and distribute a template for provider reporting
- Develop protocols and tracking system for OPP staff to manage consumer calls on RBPO appeals process

Next Steps

Issue Bulletin Following April Board Meeting

Review data

- Opportunity to consider information gathered by RBPOs/ACOs on consumer appeals
- Consider extending reporting period

Develop Regulation

- Public process including proposed regulation and public comment period

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VOTE: Approval of RBPO/ACO Appeal Interim Guidance

MOTION: That, pursuant to section 24 of chapter 176O of the Massachusetts General Laws and as endorsed by the Quality Improvement Patient Protection Committee, the Commission hereby issues the attached Office of Patient Protection Bulletin on the appeals process requirements for risk-bearing provider organizations.

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Practices participating in PCMH PRIME

2 practices

have fully submitted for PCMH PRIME Certification through NCQA

Fenway South End

Lynn Community Health Center

38 additional practices

have submitted applications to HPC:

Whittier Street Health Center

Family Doctors, LLC

Acton Medical Associates

Emerson PHO (16 sites)

Family Practice Group

Harvard University Health Services

East Boston Neighborhood HC

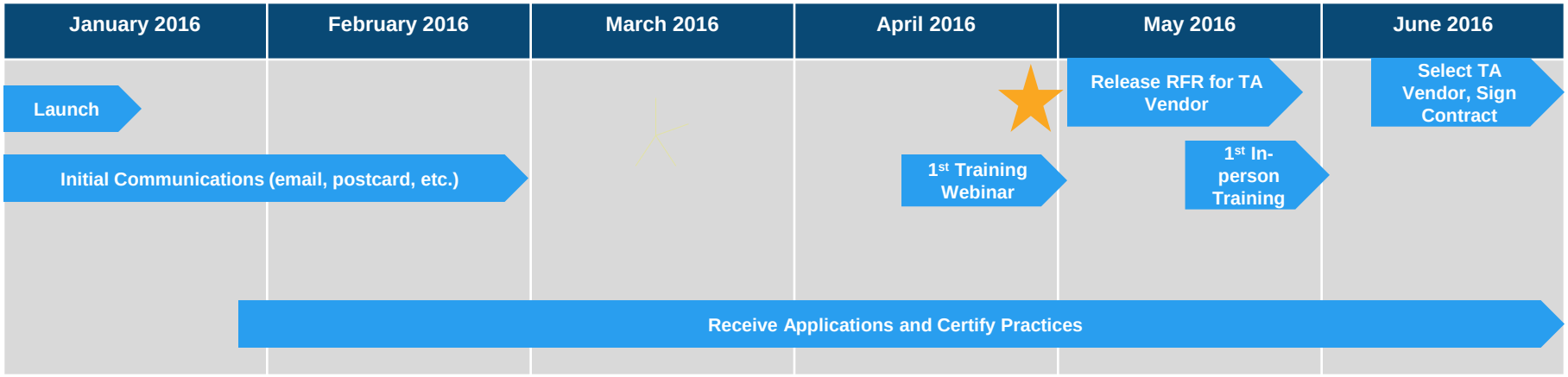
Boston Health Care for the Homeless Program (3 sites)

Community Health Center of Cape Cod

Cambridge Health Alliance (12 sites)

*Includes inquiries from individual practice site staff as well as from corporate/organization-level staff requesting information on behalf of affiliated practice sites.

PCMH PRIME timeline and next steps



Activities

Launch and Communications

- ☑ Load PCMH PRIME criteria into NCQA technical platform
- ☑ Notify practices via email, postcard, web, etc.
- ☑ Begin receiving applications to HPC
- ☐ Continue communications outreach

Training

- ☑ Develop training program and schedule
- ☐ Hold 1st training webinar (April 28)
- ☐ Hold 1st in-person training (May 23-24)

Technical Assistance

- ☑ Develop TA framework and draft RFR
- ☐ Release RFR
- ☐ Select and contract with vendor
- ☐ Work with vendor to design program
- ☐ Begin providing TA

Output

- Application system
- Communications plan

- Training plan and materials

- Vendor selection
- TA program design

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ACO certification program values

Vision of Accountable Care

A health care system that efficiently delivers on the triple aim of better care for individuals, better health for populations, and lower cost through continual improvement through the support of alternative payment.

1. **Care should be seamless** and guided by patients and families
2. Systems should **use evidence-based guidelines and be mindful of waste** so resources can be distributed to those who need it most
3. Support a **pluralism of ACO models** (e.g. community health center-led; primary care physician-led, hospital-led, medical and behavioral health provider partnerships)
4. Encourage medical provider-led ACO **to work with other non-medical providers** in the community
5. Systems should do no harm, **support safe and effective care**
6. Commit to regularly **assess the program** to ensure continuous improvement and market value

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Arc of the ACO certification program

Current market

- Multiple ACO programs in the market
  - Medicare ACOs (i.e., MSSP, Pioneer, Next Gen)
  - Commercial programs (e.g., BCBSMA's AQC)
  - Medicaid ACOs
- General lack of evidence on the relationship between ACO capabilities and outcomes

First year certification focus

- Build baseline knowledge and transparency around current ACO capabilities
- Articulate standards for ACOs to enable payment reform
- Facilitate learning as a program and across ACOs

Vision

- Develop evidence on what advances transparency and efficiency in the market
- Move from structural requirements to quality outcomes and cost performance requirements
- Develop model ACO standards

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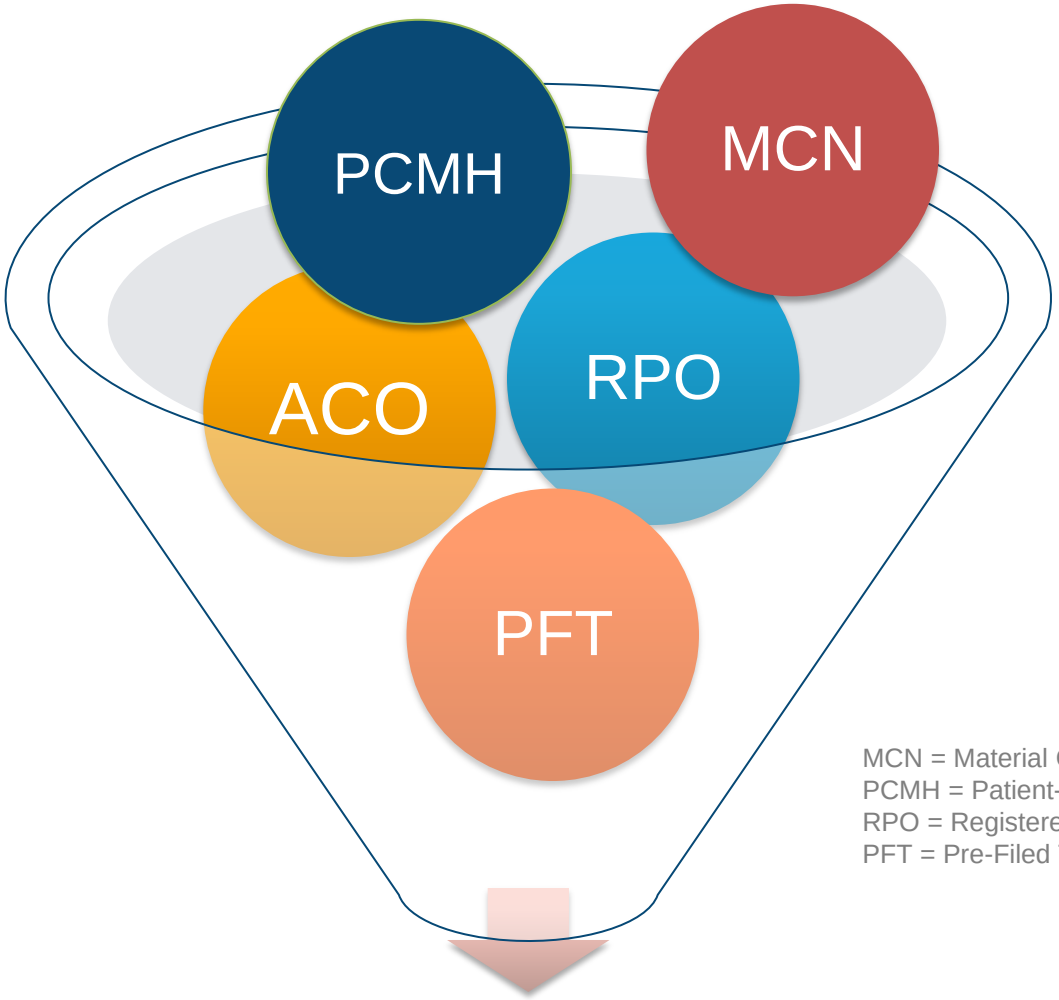
Key themes in public comment

- Reporting burden
- Confidentiality vs. transparency
- Consistency with Medicare legal requirements
- System or care delivery improvement goal/rationale for each criteria
- Plans and advocates perspective vs. providers
- Scope of all-payer certification program vs. plan specific contracts

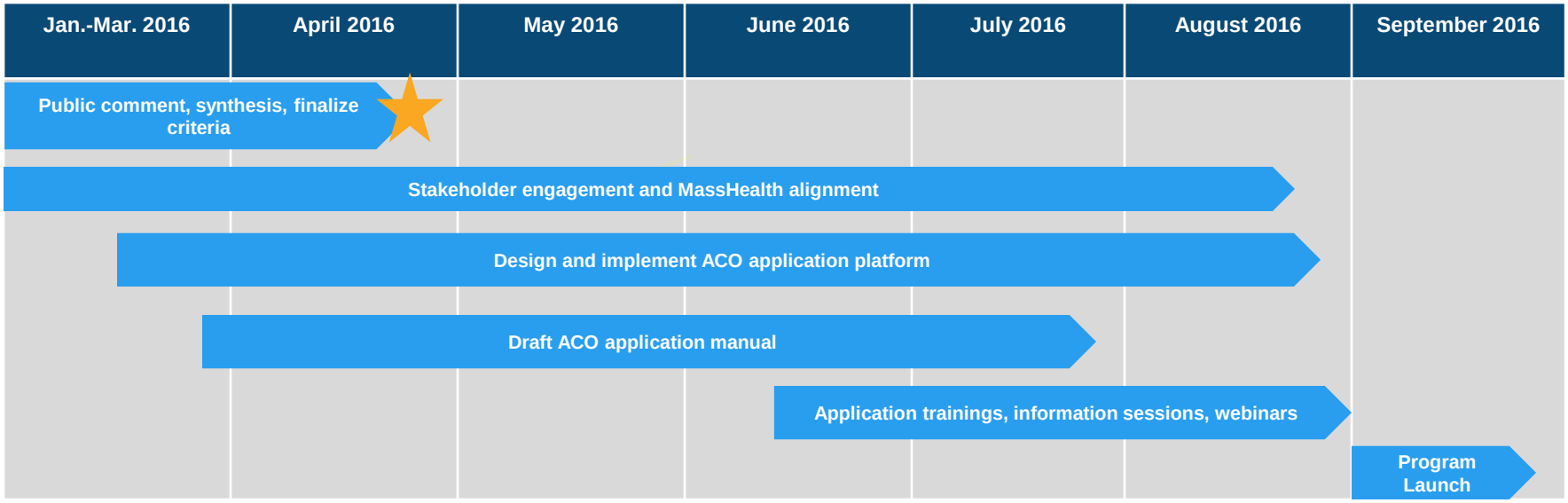
HPC seeks to minimize reporting burden for ACO certification through aligning information requests with other HPC-specific reporting programs



MCN = Material Change Notice
PCMH = Patient-centered medical home
RPO = Registered Provider Organization
PFT = Pre-Filed Testimony

Aligned provider reporting to HPC

ACO certification timeline and next steps



	Program Design	Platform Development	Program Launch
Activities	☑ Synthesize public comment ☑ Process proposed changes w/ MassHealth, stakeholders, and commissioners ☐ Finalize criteria and receive CDPST/Board approval (Apr. 27)	☑ Draft platform business requirements ☑ Engage MassIT to determine best platform option ☐ Draft application manual ☐ Build, test and finalize application platform; hold provider trainings	☐ Receive and process applications ☐ Design technical assistance opportunities
Output	• Public comment summary • Final criteria	• Submission platform • Application manual	• Certified ACOs • Technical assistance program

ACO certification program – proposed final year 1 design

Pre-requisites

4 pre-reqs.
Attestation only

- ✓ Risk-bearing provider organizations (RBPO) certificate, if applicable
- ✓ Any required Material Change Notices (MCNs) filed
- ✓ Anti-trust laws
- ✓ Patient protection

1 Assessment Criteria

6 criteria
Sample documents, narrative descriptions

- ✓ Patient-centered, accountable governance structure
- ✓ Participation in quality-based risk contracts
- ✓ Population health management programs
- ✓ Cross continuum care: coordination with BH, hospital, specialist, and long-term care services

2 Required Supplemental Information

9 criteria
Narrative or data
Not evaluated by HPC but must respond

- ✓ Supports patient-centered primary care
- ✓ Assesses needs and preferences of ACO patient population
- ✓ Develops community-based health programs
- ✓ Supports patient-centered advanced illness care
- ✓ Performs quality, financial analytics and shares with providers
- ✓ Evaluates and seeks to improve patient experiences of care
- ✓ Distributes shared savings or deficit in a transparent manner
- ✓ Commits to advanced health information technology (HIT) integration and adoption
- ✓ Commits to consumer price transparency

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ACO organization identification information

To submit an ACO certification application to HPC, ACOs will also enter basic **organization identification information**:

Field	Format
Organization legal name (and dba)	Text box
Organization Employer Identification Number (EIN)	Text box
Organization contact first name	Text box
Organization contact last name	Text box
Organization contact prefix	Drop-down box
Organization contact title	Text box
Organization contact phone number	Text box
Organization contact email	Text box
Organization street address	Text box
Organization city	Text box
Organization state	Drop-down box
Organization zip code	5 digits

Pre-requisites

ACO must attest to the following:

1. ACO has obtained, if applicable, a **risk-bearing provider organization (RBPO)** certificate or waiver from **DOI**.
2. ACO has filed all required **Material Changes Notices (MCNs)** with the **HPC**.
3. ACO is in compliance with all **federal and state antitrust laws and regulations.**
4. ACO is in compliance with the HPC's **Office of Patient Protection (OPP)** guidance regarding an **appeals process to review and address patient complaints** and provide notice to patients.

Assessment criteria

Patient-centered, accountable governance structure

1. Meaningful participation of ACO participants in the governance structure
2. Patient/consumer representation in governance structure, and Patient and Family Advisory Committee (PFAC)
3. Responsibility for assessment and improvement of the quality of and access to care

Quality-based risk contracts

4. Demonstration of quality performance in at least one risk-based contract

Population health management programs

5. Risk stratification and program implementation

Cross continuum care: coordination with BH, hospital, specialist, and post-acute services

6. Effectiveness of collaborations and test/referral tracking

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Assessment criteria #1 and #2

Domain	Criterion
Patient-centered, accountable governance structure	The ACO has an identifiable and unique governing body with authority to execute the functions of the ACO. The ACO provides **for meaningful participation in the composition and control of the governing body for its participants** or their representatives. The ACO governance structure is designed to serve the needs of its patient population, including by having at least one **patient or consumer advocate within the governance structure *and* having a Patient and Family Advisory Committee.**

Assessment criterion #3

Domain	Criterion
Patient-centered, accountable governance structure	The ACO governing body regularly **assesses the access to and quality of care** provided by the ACO, in measure domains of access, efficiency, process, outcomes, patient safety, and patient experiences of care, **for the ACO overall and for key subpopulations (i.e. medically or socially high needs individuals, vulnerable populations),** including measuring any racial or ethnic disparities in care**.** The ACO has **clear mechanisms for implementing strategies to improve its performance** and supporting provider **adherence to evidence-based guidelines**.

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Assessment criterion #4

Domain	Criterion
Participation in quality-based risk contracts	The ACO has **at least one substantive quality-based risk (up or downside) contract with a payer,** OR the ACO commits to participating in such a contract with MassHealth. ACO must report the name of each carrier, type of contract (e.g. one-sided or two-sided risk) and final performance on all quality measures associated with the contract(s) for past two performance periods.

Assessment criterion #5

Domain	Criterion
Population health management programs	The ACO routinely **stratifies** its entire patient population and uses the results to **implement programs** targeted at **improving health outcomes for its highest need patients.** At least one program addresses **behavioral health** and at least one program addresses **social determinants of health** to reduce health disparities within the ACO population.

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Assessment criterion #6

Domain	Criterion
Cross continuum care: coordination with BH, hospital, specialist, and long-term care services	To coordinate care and services across the care continuum, the ACO **collaborates** with providers outside the ACO as necessary, including: - Hospitals - Specialists, including any sub-specialties - Long-term care providers (i.e., SNFs, LTACs) - Behavioral health providers (both mental health and substance use disorder providers) The ACO assesses collaborative relationships based on protocols for **access, measurement of quality and efficiency, use of team-based care, care transition protocols and communication.** Providers and facilities within the ACO collaborate to coordinate care, including **following up on tests and referrals across care rendered within the ACO.**

Supplemental information (no assessment)

1. Supports patient-centered primary care
2. Assesses needs and preferences of ACO patient population
3. Supports community-based health programs
4. Supports patient-centered advanced illness care
5. Performs quality, financial analytics and shares with providers
6. Evaluates and seeks to improve patient experiences of care
7. Distributes shared savings or deficit in a transparent manner
8. Commits to advanced health information technology (HIT) integration and adoption
9. Commits to consumer price transparency

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Summary of revisions to ACO certification criteria in response to public comment

Eliminated criteria

- Participating providers & TINs
- Participation in MassHealth APMs
- Preferred providers
- Medication reconciliation
- Peer support programs
- APM adoption for primary care

Removed assessment component

- PCMH adoption
- Patient and family experience
- Community health

Simplified criteria:

- Separate legal entity
- Patient and consumer representative within governance structure & PFAC
- Meaningful participation within governance structure & quality committee representation
- Risk stratification & population-specific interventions
- Effectiveness of collaborations, agreements with mental health providers, & test/referral tracking
- Event notifications, EHR interoperability & Hiway
- Adherence to evidence-based guidelines

Confidentiality and transparency

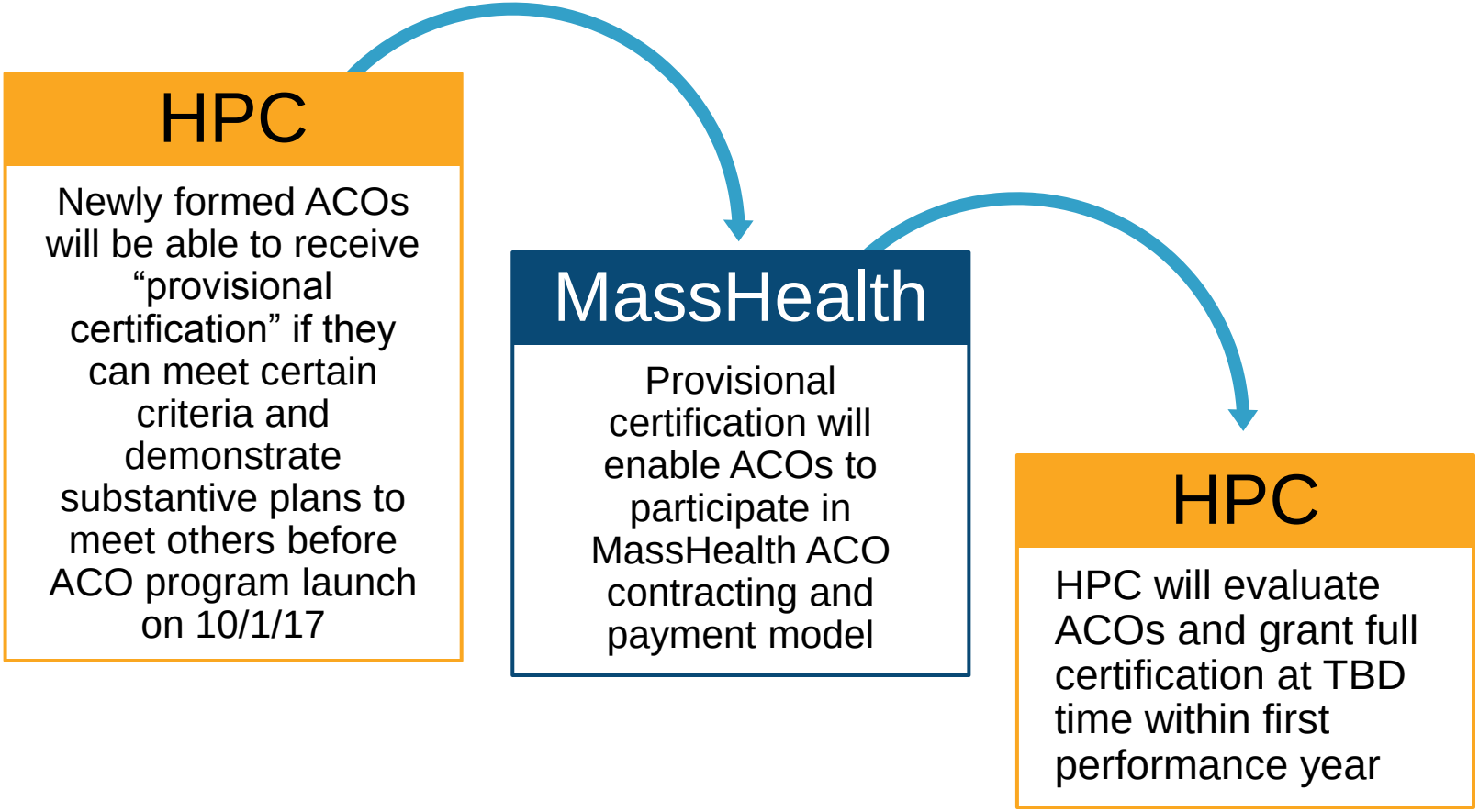
Nonpublic clinical, financial, strategic or operational documents or information submitted to the HPC in connection with ACO certification have confidentiality protections pursuant to M.G.L. c.6, sec. 2A. The HPC may make the information public in de-identified summary form, or when the commission believes that disclosure is in the public interest.

Principles for balancing ACO confidentiality with market benefits of transparency

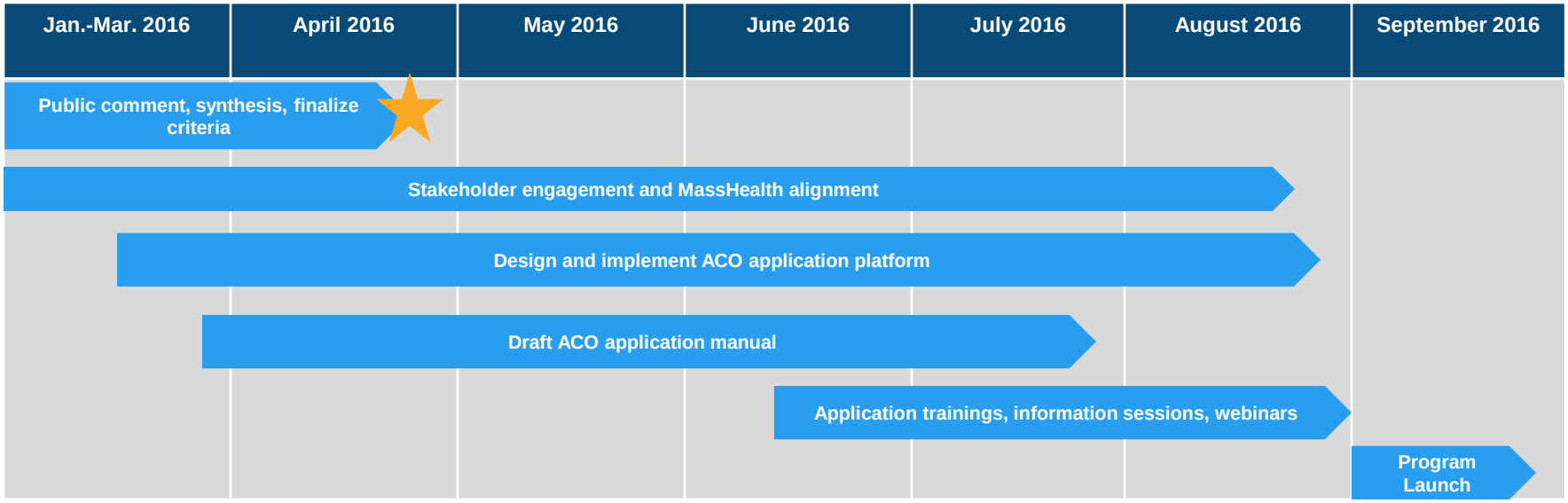
Market value:
HPC will report public information about ACOs and information submitted in the certification process that does not contain nonpublic information.

Protection for proprietary information:
For certain nonpublic information, ACOs may request confidentiality; the HPC may still report this information in aggregate or summary form.

Process for new ACOs (under development)



ACO certification timeline and next steps



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Output	• Public comment summary • Final criteria	• Submission platform • Application manual	• Certified ACOs • Technical assistance program

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VOTE: Approval of ACO Certification Criteria

MOTION: That, pursuant to section 15 of chapter 6D of the Massachusetts General Laws and as endorsed by the Care Delivery and Payment System Transformation Committee, the Commission hereby establishes the attached final certification criteria for accountable care organizations and directs the staff of the Commission to implement the accountable care organization certification program in accordance with these criteria.

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Overview of the Registration of Provider Organizations (RPO) Program

- RPO collects key information regarding the operations and structure of provider organizations, e.g. ownership, contracting and clinical relationships, facilities, and rosters of physicians.

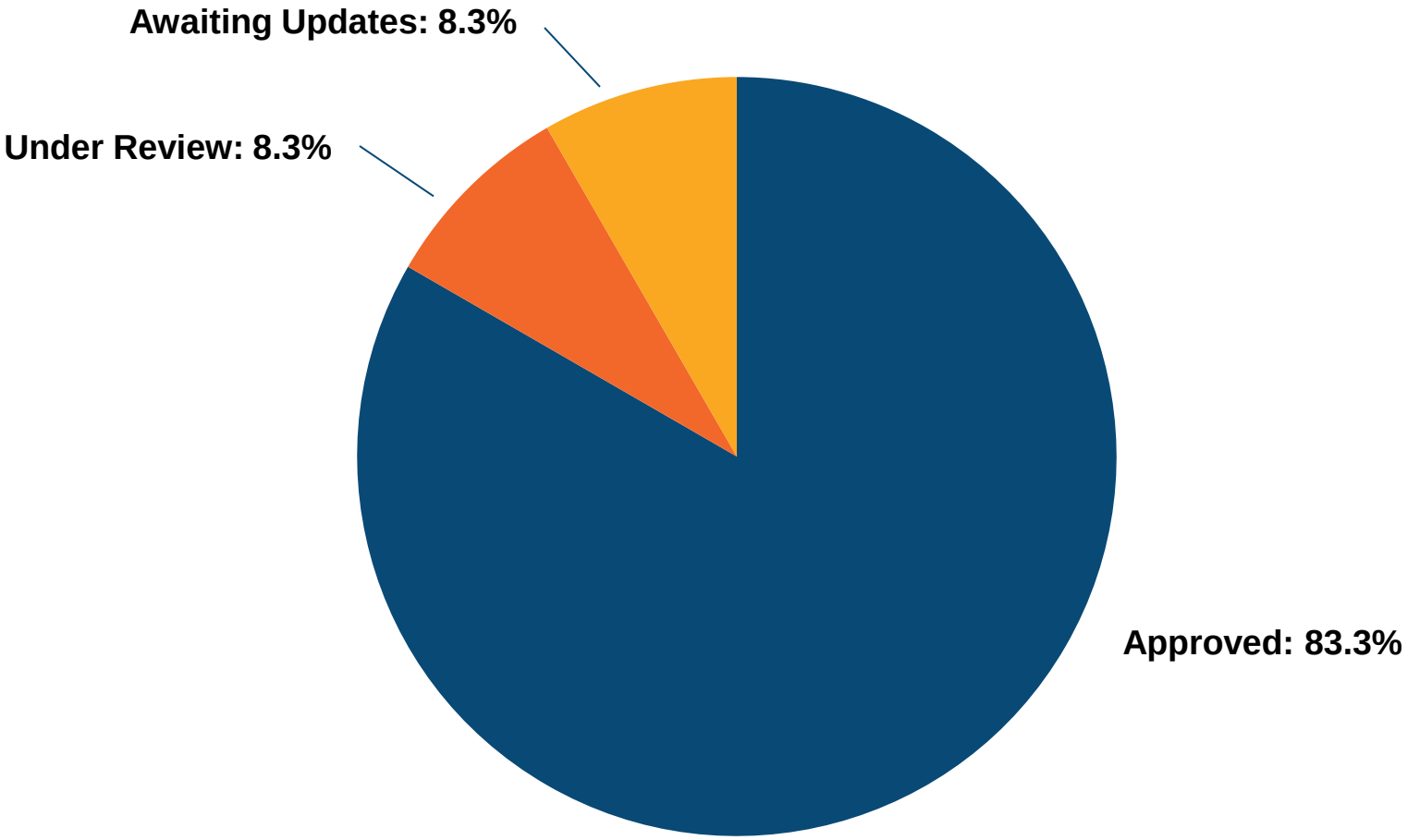
- Related annual reporting to the Center for Health Information and Analysis (CHIA) includes additional information about financial condition, organizational structure, business practices, and market share.

- RPO contributes to a foundation of information needed to support health care system monitoring and improvement. This regularly reported information on the health care delivery system supports:
  - Care delivery innovation
  - Evaluation of market changes
  - Health resource planning: assessing capacity, need, utilization
  - Tracking and analyzing system-wide and provider-specific trends

Application Status

Initial Registration: Part 2 materials were due on October 30, 2015.

As of April 22, 50 of 60 Provider Organizations have completed Initial Registration.



Stakeholder Engagement

Initial Registration: Part 2 Feedback Survey

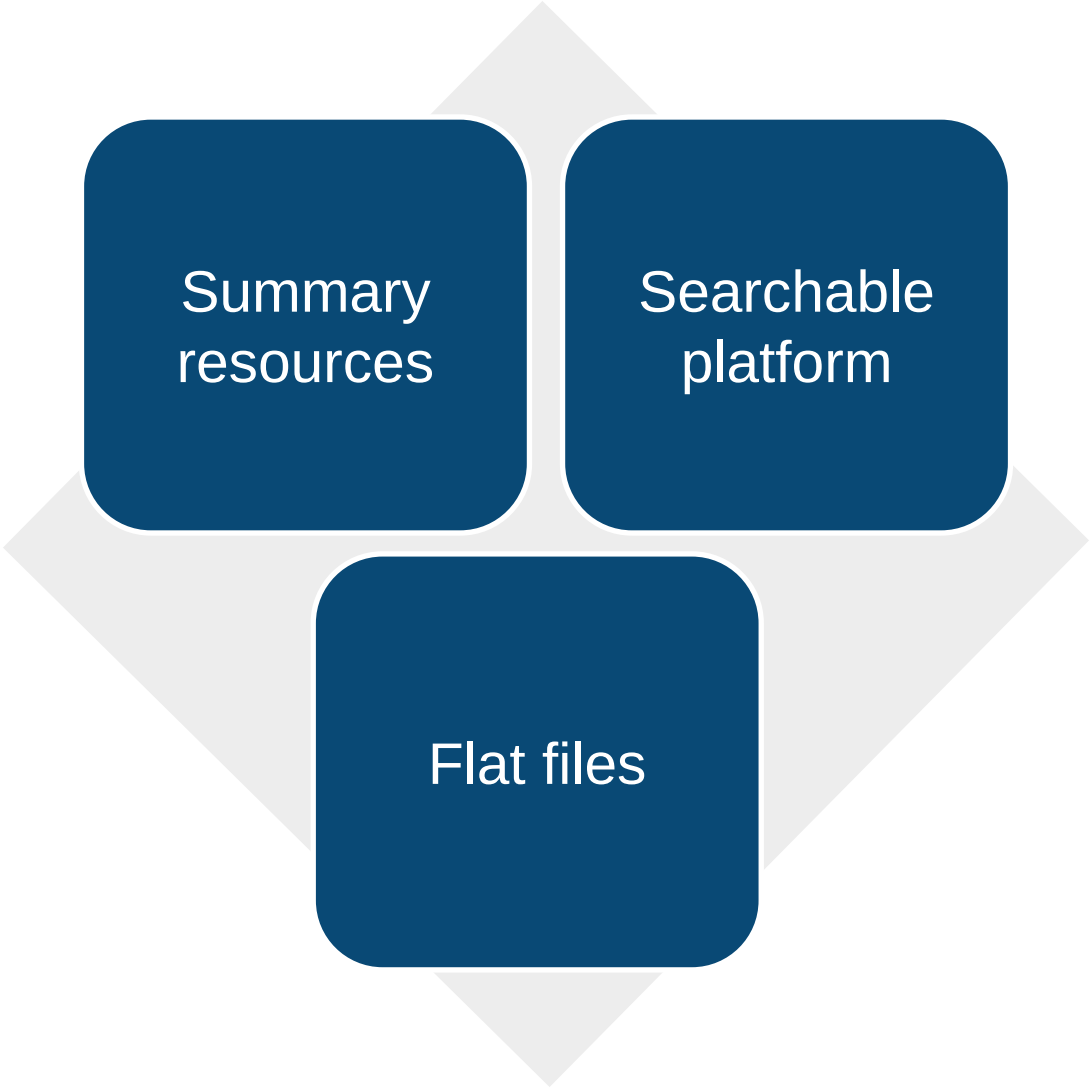
In March, the HPC conducted a survey of individuals involved in completing Part 2 materials

- Respondents felt the **amount of time to complete materials was appropriate**, but would prefer for materials to be due in the spring
- The majority of respondents indicated that the resources provided by the HPC were **clear, well-structured, and helpful**
- Nearly all respondents indicated that program **staff consistently provided timely and clear responses** to their questions
- Respondents offered **recommendations for improving the online submission platform** in future registration cycles

The HPC plans to use the information from the survey to improve future registration cycles, collaborate with CHIA on their annual filing requirement, enhance the online submission platform, and inform the data release plan.

Data Release

The HPC anticipates making data available in a variety of formats. The data release plan will reflect the needs and interests of different end-users.



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  - Update on the HPC's Stakeholder Discussions of Provider Price Variation
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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	15	25%
Physician group merger, acquisition or network affiliation	14	24%
Acute hospital merger, acquisition or network affiliation	11	19%
Formation of a contracting entity	9	15%
Merger, acquisition or network affiliation of other provider type (e.g. post-acute)	5	8%
Change in ownership or merger of corporately affiliated entities	4	7%
Affiliation between a provider and a carrier	1	2%

Update on Notices of Material Change

Notices Received Since Last Commission Meeting

- Proposed acquisition of RiverBend Medical Group, a 75-physician multi-specialty group in the Pioneer Valley, by Sisters of Providence Health System, a non-profit subsidiary of Trinity Health New England that includes Mercy Medical Center in Springfield.
- Proposed acquisition of Belmont Medical Associates, an 18-physician multi-specialty group in Cambridge, by Mount Auburn Professional Services, a 151-physician multi-specialty affiliate of Mount Auburn Hospital.
- Proposed clinical affiliation between Boston Children's Hospital and Southcoast Hospitals Group, under which Children's would begin providing Level IIA nursery services at St. Luke's Hospital in New Bedford and Charlton Memorial Hospital in Fall River, and would continue to provide pediatric services at St. Luke's Hospital and Level I nursery services at Tobey Hospital in Wareham.

Update on Notices of Material Change (cont.)

Elected Not to Proceed

- **Merger between Baystate Mary Lane and Baystate Wing under which Mary Lane would close its inpatient beds and become an outpatient satellite location of Wing.**
  - Our analysis indicated that this transaction would not likely result in substantial changes in spending, given that Wing and Mary Lane receive similar prices.
  - We did find that for those patients currently seeking inpatient care at Mary Lane, there would be a small increase in drive time to reach Wing, the next closest hospital.
  - We did not find evidence that the transaction is likely to negatively impact quality.
- **Clinical affiliation between Boston Children's Hospital, Mount Auburn Hospital, and its affiliated physicians, Mount Auburn Cambridge Independent Practice Association (jointly, MACIPA), under which Children's would become the preferred pediatric academic medical center for MACIPA patients.**
  - Children's would provide a discount on certain services provided to MACIPA risk members, and MACIPA has stated that it will share any funds received as a result of that arrangement with payers pursuant to the terms of their respective risk-sharing agreements.
  - Our analysis indicated that referral patterns for MACIPA patients were not expected to shift significantly, and thus that there was limited scope for changes to health care spending.
  - We did not find evidence suggesting negative impacts on quality or access to care.

Update on Notices of Material Change (cont.)

Elected Not to Proceed

- **Acquisition of RiverBend Medical Group by Sisters of Providence Health System.**
  - Our analysis indicated that this transaction would not likely result in substantial changes in spending, given that neither contracting practices nor referral patterns are expected to change materially.
  - We did not find evidence that the transaction is likely to negatively impact quality or access.
- **Acquisition of Belmont Medical Associates by Mount Auburn Professional Services.**
  - Our analysis indicated that this transaction would not likely result in substantial changes in spending, given that neither contracting practices nor referral patterns are expected to change.
  - We did not find evidence that the transaction is likely to negatively impact quality or access.
- **Clinical affiliation between Boston Children's Hospital and Southcoast Hospitals Group, under which Children's would provide pediatric and neonatal services at Southcoast hospitals.**
  - Our analysis indicated that referral patterns for pediatric and neonatal services are not expected to shift significantly, and thus that there is limited scope for increases to health care spending.
  - We did not find evidence that the transaction is likely to negatively impact quality or access.

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Stakeholder Discussions of Provider Price Variation

WHO	**HPC Commissioners**, HPC staff, key stakeholders including HPC Advisory Council members, expert speakers, and representatives of sister agencies (AGO, CHIA). HPC has invited legislators and legislative staff to attend. Members of the public are welcome.
WHAT	These discussions provide an opportunity for Commissioners and stakeholders to engage in a discussion regarding the potential for specific, **data-driven policy approaches to reduce unwarranted price variation** without increasing overall healthcare spending. The HPC has presented and will present further analyses and has invited expert speakers to introduce certain policy options. At the end of the process, HPC staff will present an overview of the discussions to the full Board.
WHY	As stated in the HPC's Special Report on price variation, **policy action is required** to address unwarranted price variation and its impact on overall spending and the sustainability of lower-priced providers. The goal of these meetings is to allow Commissioners and stakeholders to engage in discussions about specific policy options, informed by data-driven analyses and research.
WHEN	**Three meetings** have been scheduled to take place through the end of May 2016. The first two meetings took place on March 30, 2016 and April 13, 2016.
GOAL	The stakeholder discussions are intended to allow for discussion of policy options. At the conclusion of the process, a **Summary Report** of the discussions will be presented at a full Board meeting. The Board may take the opportunity to discuss potential policy options, make recommendations, or identify new analyses necessary to support future policy development.

Expansion and enhancement of demand-side and supply-side incentives can help address unwarranted price variation

Demand-Side Incentives

- Demand-side incentives encourage individuals and employers to make higher-value choices (e.g. tiered and limited networks, reference pricing, increased transparency)
- Demand-side incentives can result in cost savings for individuals, employers and insurers and can reduce unwarranted price variation by incentivizing higher-priced providers to lower their prices where patients are encouraged to use higher-value (e.g. lower-priced, high quality) providers
- Overall, demand-side incentives may support a more competitive, value-driven market place but likely will not fully address unwarranted price variation alone, though they may be coupled with other policy options.

Supply-Side Incentives / Alternative Payment Methods

- APMs can reduce healthcare spending by encouraging providers to reduce unnecessary utilization and refer to more efficient specialists and facilities
- APMs may reduce unwarranted price variation, to the extent that higher-priced providers seek lower price increases to control spending under their budgets and/or reduce their prices to compete for referral volume from providers under APMs.
- However, budgets based on historic spending may perpetuate unwarranted price and spending variation and threaten sustainability for some lower-paid providers.
- There are key opportunities to expand and improve APMs to reduce unwarranted price variation and support a higher quality and more efficient health care system

March 30 Discussion Summary

Tiered and Limited Networks

- HPC staff described the concept of tiered and limited networks, current levels of market take-up of these products, and considerations and limitations associated with them.
- Some stakeholders suggested that tiered products are too complicated for consumers and that tiering methods are inconsistent. There was significant concern that these products can interrupt care coordination, conflict with APMs, and place an excessive and regressive burden on consumers.
- Other stakeholders noted that tiered products warrant further development and improvement to address noted concerns.
- Stakeholders also discussed the level of incentives required to meaningfully shift consumer behavior (enrollment and using high-value care) and the importance of consumer education and transparency of tiering methods.

Office of the Attorney General Presentation on Premiums Based on Value

- The AGO described a model that would adjust insurance premiums based on the consumer's choice of primary care physician, with consumers paying less if they choose PCPs in systems with lower total medical expenses. This would not be a limited network product.
- Many stakeholders found the construct to be interesting and worthy of further consideration, and many offered thoughtful questions for such future discussion.

Reference pricing

- Stakeholders agreed that reference pricing is only appropriate for certain planned episodes of care and requires considerable consumer education and communication.

April 13 Discussion Summary

HPC Presentation

Overview on supply-side incentives, global budgets/APMs, and a look at APM take-up rates in Massachusetts. Stakeholder discussion focused on key opportunities to expand and improve APMs in Massachusetts:

- The need to move away from historic spending as the primary basis for APM financial benchmarks;
- Challenges around provider infrastructure investment and APM-related costs;
- Risk adjustment, including regarding socioeconomic factors in risk adjustment methods;
- The need for APM expansion in the PPO market;
- The importance of using appropriate quality metrics; and
- The particular challenges for lower-priced providers

Dr. Hoangmai Pham Presentation

Financial benchmarking in CMS' Next Generation Accountable Care Organizations and as proposed for the Medicare Shared Savings Program (MSSP). Stakeholder discussion focused on several key issues:

- The impact of the voluntary nature of APMs on participation and how payers can structure rates or other features to attract providers into APMs;
- How risk adjustment should be improved to better account for population variation; and
- The appropriate timeline and process for convergence in global budgets, particularly related to lower-priced providers that may need to make certain financial investments to transform care delivery

Forthcoming meeting: May 19, 2016

Meeting 3: Direct Limits on Variation

Anticipated Presenters:

HPC staff and Joshua Sharfstein, MD, former Secretary of Maryland Department of Health and Mental Hygiene, currently professor and associate dean of the Johns Hopkins University Bloomberg School of Public Health

MASSACHUSETTS
HEALTH POLICY COMMISSION

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The innovation investment procurements are open until May 13

HEALTH CARE INNOVATION INVESTMENT (HCII) PROGRAM

- $5 million available to providers and health plans
- Up to $750,000 per award

TELEMEDICINE PILOT INITIATIVE

- $1 million available to providers and health plans
- Up to $500,000 per award

NEONATAL ABSTINENCE SYNDROME (NAS) PILOT INITIATIVE

- $3.5 million available to birthing hospitals
- Award caps vary by eligibility for the CHART Investment Program

STATS

- 100 Letters of Intent received from 81 potential applicants to the HCII Program
- 4 information sessions on the application process
- 148 questions answered on topics including eligibility, partnerships, budget, and program development

UPCOMING DATES

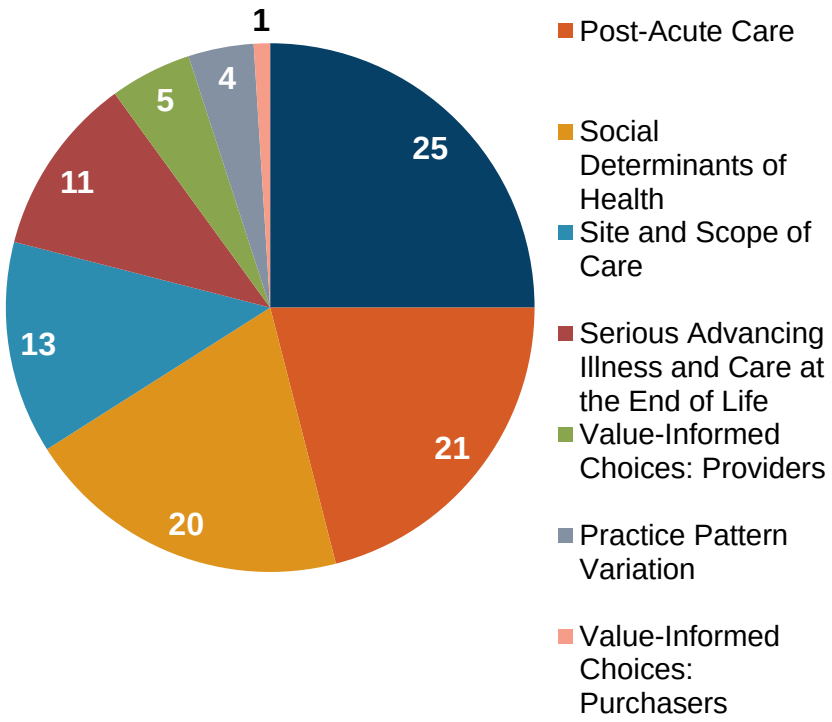
- Proposal Due Date: May 13, 2016 by 3PM
- Award Announcement: July 2016 (anticipated)
- HCII Period of Performance: October 2016 - September 2018
- Telemedicine Period of Performance: October 2016 - March 2018
- NAS Period of Performance Category A: October 2016 - December 2017
- NAS Period of Performance Category B: October 2016 - December 2018

HPC

The HPC received 100 Letters of Intent for Round 1 of the HCII Program

83 unique applicants submitted LOIs for a broad range of cost challenges and recommendations to address those challenges

Each applicant elected one cost-driving challenge area to address



Proposed initiatives include a variety of innovative service model elements

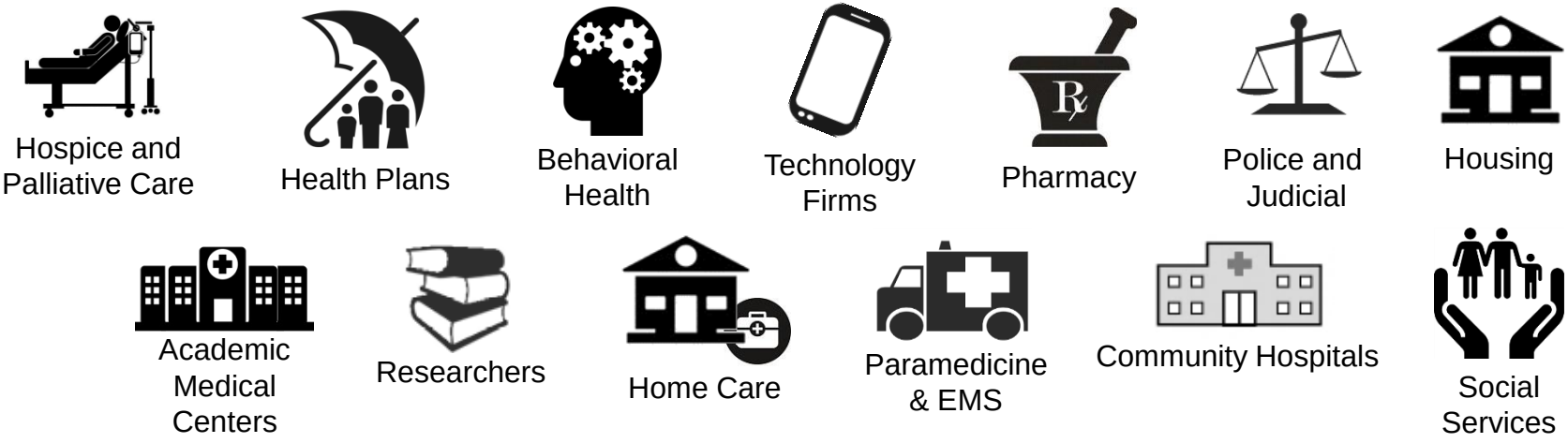
Interdisciplinary Care Planning & Coordination	Broadening care teams across disciplines and organizations to improve transitions and meet patient needs
Telemedicine & Other Technology	Deploying new technology to connect patients and providers across settings
Patient Engagement	Providing patients with the tools, information, and wraparound support to engage in their health & lifestyle decisions
Clinical Process Redesign	Using data-driven approaches to improving the cost, quality, and safety of health care

LOIs represent a total estimated funding request of **$47M-$67M**.

HPC

Applicants indicated a strong interest in cross-sector partnership

From paramedics in Berkshire County to substance use disorder treatment centers on Cape Cod, over **300 unique organizations** were named as partners in initiatives submitted from across the Commonwealth.



Additionally, **over half of applicants** utilized this opportunity to seek **additional partnership**. Notable entity types that applicants are seeking to partner with include:

- Primary Care Providers
- Elder Services
- Telemedicine Providers
- Civil Legal Services
- Emergency Responders – Police, Fire, EMS
- Social Services – Nutrition, Housing, Education, Transportation
- Pharmacy Services

The HPC reminds potential applicants and their partners that additional information is available on the HPC website

All proposals are due May 13, 2016

- Requests for proposals
- Frequently asked questions
- Information session presentations
- Eligibility guidance
- Health Care Innovation Investment LOI Summary
- Health Care Innovation Investment Challenge Descriptions

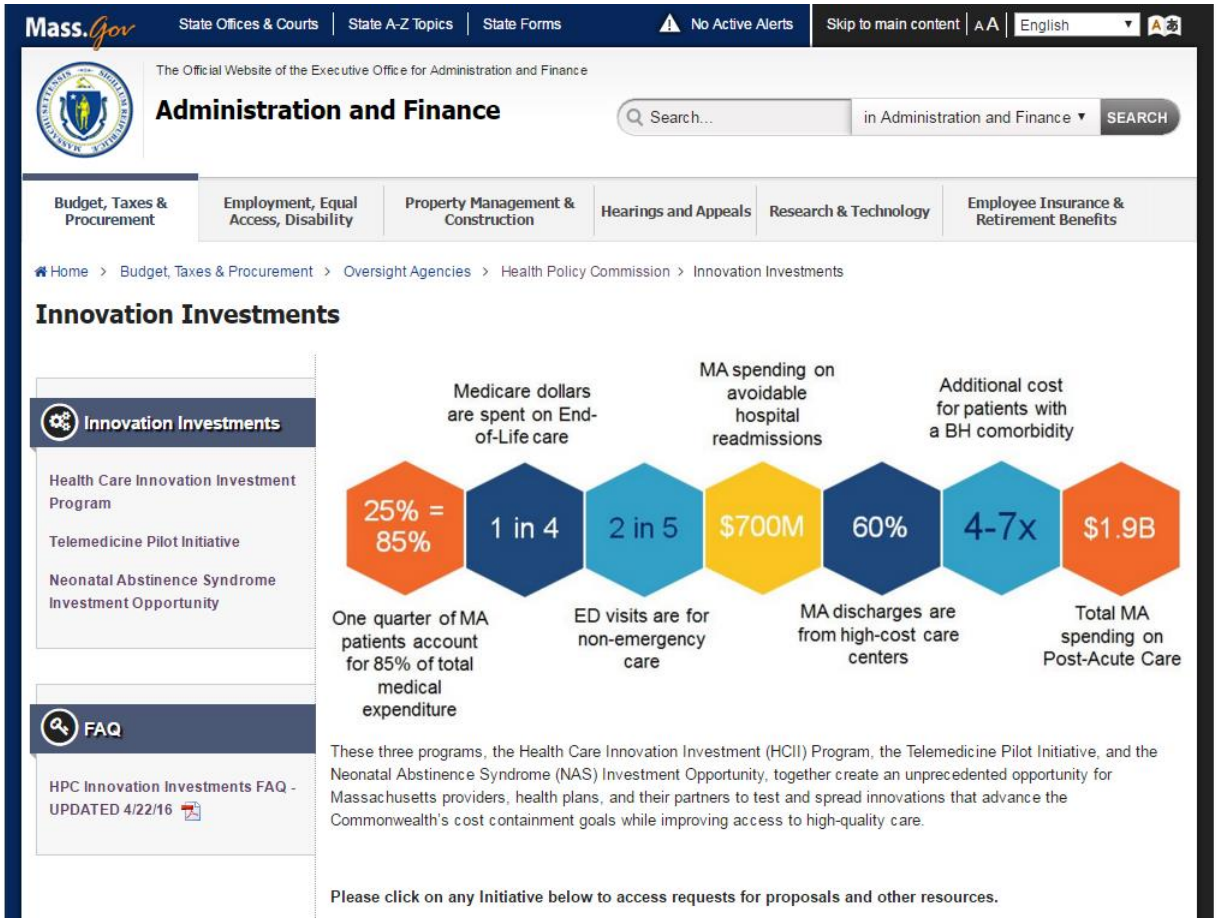


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CHART Phase 2: Progress as of April 2016

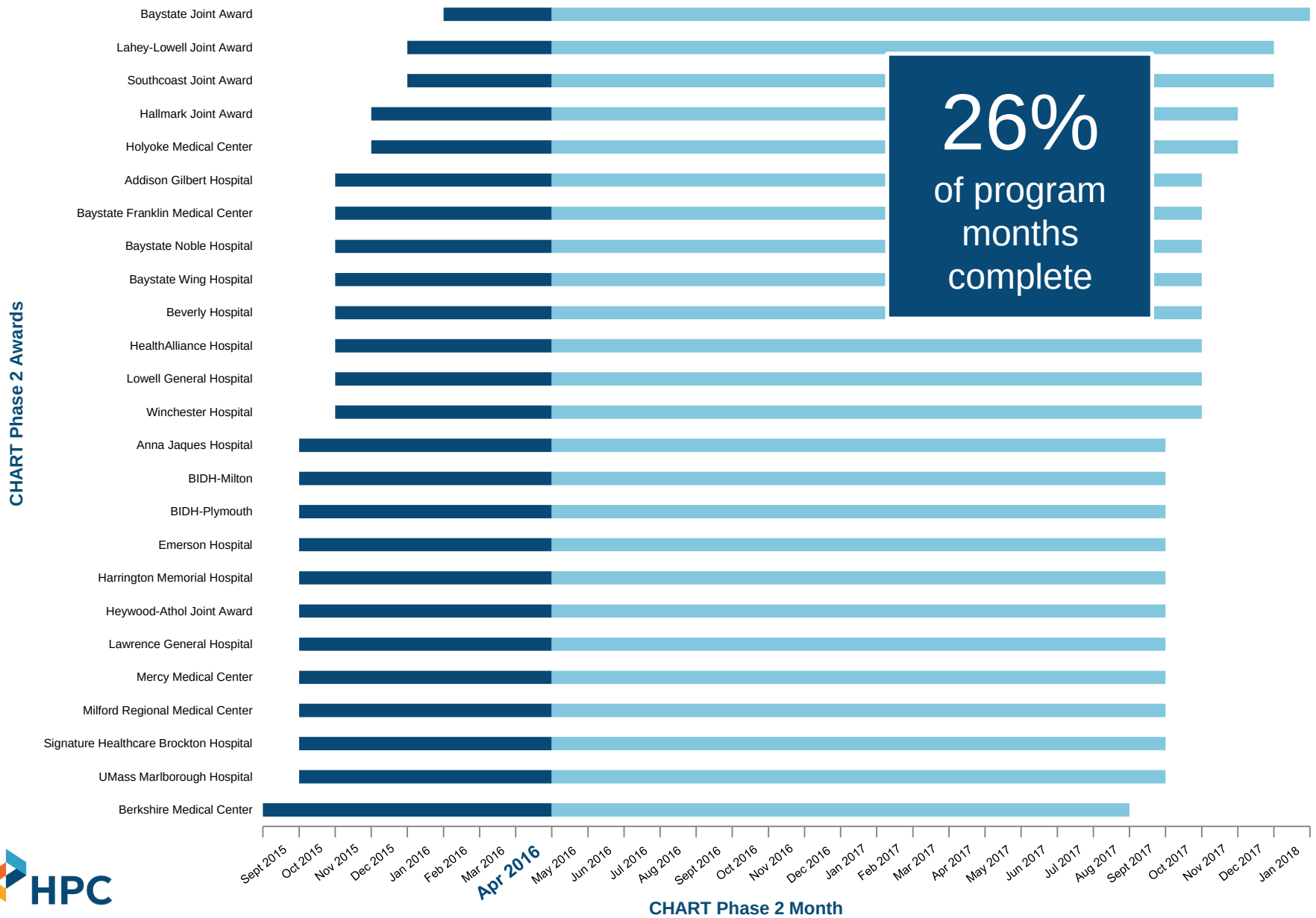

CHART Phase 2: Activities since program launch[1]

4

regional meetings[2]

with

200+

hospital and community provider attendees

63

technical assistance working meetings

250+

hours of coaching phone calls

5

CHART newsletters


March 2016

Welcome

Featured Topic

CHART Patient Story

Measure Update

CHART Evaluation Data Requirement

NE QIN-QIO

Share Your Work

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION AND TRANSFORMATION PROGRAM

MASSACHUSETTS

CHART Regional Meetings

Welcome!

Featured Topic: Notes from Community Partnerships

1,460

unique visits to the CHART hospital resource page

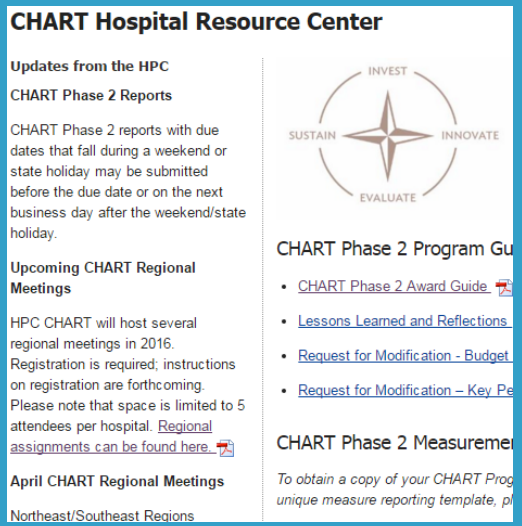
CHART Hospital Resource Center

Updates from the HPC

CHART Phase 2 Reports

CHART Phase 2 reports with due dates that fall during a weekend or state holiday may be submitted before the due date or on the next business day after the weekend/state holiday.

Upcoming CHART Regional Meetings

HPC CHART will host several regional meetings in 2016. Registration is required; instructions on registration are forthcoming. Please note that space is limited to 5 attendees per hospital. Regional assignments can be found here.

April CHART Regional Meetings

Northeast/Southeast Regions

INVEST

SUSTAIN

INNOVATE

EVALUATE

CHART Phase 2 Program Gu

- CHART Phase 2 Award Guide
- Lessons Learned and Reflections
- Request for Modification - Budget
- Request for Modification – Key Pe

CHART Phase 2 Measureme

To obtain a copy of your CHART Prog unique measure reporting template, pl

125+

data reports received

Note: Updated April 20, 2016

[1] Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015

[2] As of April 29, 2016

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HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

- Analyze and report on health care cost trends through data examination, and make recommendations for improvement in cost, quality, and access.
- Foster innovation in health care payment service delivery through competitive investment opportunities.
- Examine changes in the health care marketplace and their potential impact. In addition, the HPC is authorized to reduce health care cost growth by requiring certain health care organizations to file and implement a performance improvement plan.
- Accelerate payment system transformation and health care delivery and quality through certification programs, technical assistance, and multi-stakeholder engagement.
- Protect patient access to necessary health care services and coverage.

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Analyze and report on health care cost trends through data examination, and make recommendations for improvement in cost, quality, and access.

2015 Accomplishments

- ✓ 2015 Cost Trends Hearing
- ✓ 2015 Cost Trends Report
- ✓ 2015 Cost Trends Report: Provider Price Variation

2016 Activities

- ✓ Release of Community Hospitals at a Crossroads
- ✓ Release of Policy Briefs: Out-of-Network Billing (3/2), Oral Health (6/1)
- ▪ Research on consumer choice with the Robert Wood Johnson Foundation
- ▪ Release of Opioid Report (6/1)
- ▪ Host stakeholder discussions on Provider Price Variation
- ▪ Release of HPC Whitepaper Series
- ▪ 2016 Cost Trends Hearing
- ▪ Release of 2016 Cost Trends Report

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Foster innovation in health care payment service delivery through competitive investment opportunities.

2015 Accomplishments

- ✓ CHART Phase 1 Report and three Case Studies
- ✓ Hosting seven regional convenings for shared learning
- ✓ Implementation Planning Period for CHART Phase 2 Projects
- ✓ Launch of 22 CHART Phase 2 Projects
- ✓ Funding in the State Budget for two new pilot initiatives on telemedicine and neonatal abstinence syndrome (NAS)
- ✓ Planning for the Health Care Innovation Investment Program (HCII)

2016 Activities

- ✓ Launch of remaining CHART Phase 2 Projects
- ✓ RFP Release for NAS, Telemedicine, and HCII Investment Opportunities
- ✓ Launch of CHART Resource Page and Monthly Newsletter
- ▪ Awards for NAS, Telemedicine, and HCII Investment Opportunities
- ▪ Approval of CHART Evaluation Contract
- ▪ Ongoing technical assistance and learning dissemination
- ▪ Planning for CHART Phase 3

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Examine changes in the health care marketplace and their potential impact. In addition, the HPC is authorized to reduce health care cost growth by requiring certain health care organizations to file and implement a performance improvement plan.

2015 Accomplishments

- ✓ Partnership with NCQA for PCMH Certification
- ✓ Approval of HPC PCMH PRIME Certification Program
- ✓ Drafting of framework for ACO Certification

2016 Activities

- ✓ Launch of PCMH PRIME Certification Program (40 applications to date)
- ✓ Approval of ACO Certification Criteria
- ▪ Launch of ACO Certification Criteria Application Platform (partnership with GovNext)
- ▪ Launch of online resource databases for ACOs and PCMHs
- ▪ Approval of behavioral health technical assistance contract

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Accelerate payment system transformation and health care delivery and quality through certification programs, technical assistance, and multi-stakeholder engagement.

2015 Accomplishments

- ✓ Review of 21 Notices of Material Change
- ✓ Continued work on market metrics
- ✓ Registration of 59 RPOs in Initial Registration: Part 2
- ✓ Initiation of two Cost and Market Impact Reviews

2016 Activities

- ✓ Initiation of one Cost and Market Impact Reviews
- ✓ Approval of Interim Guidance on Performance Improvement Plans
- ▪ Release of three Cost and Market Impact Reviews
- ▪ Continued work on Notices of Material Change and Regulatory Definitions
- ▪ Creation of an online data resource for RPO Program
- ▪ Partner with CHIA for next phase of RPO data collection

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Protect patient access to necessary health care services and coverage.

2015 Accomplishments

- ✓ Approval of updates to regulations governing the Office of Patient Protection to ensure compliance with ACA and state law
- ✓ Releasing 2015 Office of Patient Protection Annual Report
- ✓ Processing 325 External Review Cases
- ✓ Answering 3,015 calls and emails from consumers seeking information on health insurance enrollment and appeals

2016 Activities

- ✓ Approval of Interim Guidance for RBPO/ACO Appeals Process
- ▪ Update to regulations governing the Office of Patient Protection
- ▪ 2016 Office of Patient Protection Annual Report
- ▪ Ongoing External Review Appeals Process
- ▪ Ongoing Health Insurance Open Enrollment Waiver Process

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Contact Information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us

MASSACHUSETTS
HEALTH POLICY COMMISSION

Appendix

April 27, 2016

Supplemental information #1

ACO criterion	Certification question
Supports patient-centered primary care	How does the ACO support patient-centered primary care transformation? Please describe plans to increase PCMH recognition rates, including any plans to achieve PCMH PRIME certification.

Supplemental information #2

ACO criterion	Certification question
Assesses needs and preferences of ACO patient population	How does the ACO assess the needs and preferences of its patient population with regard to race, ethnicity, language, culture, literacy, gender identity, sexual orientation, income, housing status, food insecurity history, and other characteristics? How does the ACO use this information to inform its operations and care delivery to patients?

Supplemental information #3

ACO criterion	Certification question
Supports community-based health policies and programs	How does the ACO use the information gathered in the criterion above to develop and support community-based policies and programs aimed at addressing social determinants of health to reduce health disparities within the ACO population?

Supplemental information #4

ACO criterion	Certification question
Promotes serious illness care	To what extent has the ACO established processes and protocols for identifying, counseling, and planning for serious illness care? To what extent has the ACO established collaborations with providers/facilities focused on serious illness care?

Supplemental information #5

ACO criterion	Certification question
Performs quality, financial analytics and shares with providers	How does the ACO conduct performance analyses, including measure domains of access, efficiency, process, outcomes, and patient safety? Does the ACO generate its own reports, collaborate with a vendor, or rely on payer reports? What process does the ACO have to disseminate reports to providers, in aggregate and at the practice level?

Supplemental information #6

ACO criterion	Certification question
Evaluates and seeks to improve patient experiences of care	Describe how the ACO evaluates patient and family experience on access, communication, and coordination. What survey tool does the ACO employ? What is the frequency of such evaluation? How does the ACO develop plans, based on evaluation results, to improve patient and family experience?

Supplemental information #7

ACO criterion	Certification question
Provides high quality care	How has the ACO's performance on quality measures improved? Report ACO-level final quality performance on the measures associated with each commercial risk contract for the last 2 performance years.

Supplemental information #8

ACO criterion	Certification question
Distributes shared savings or deficit in a transparent manner	How does the ACO distribute funds among participating providers? What is the process for making distribution and/or reinvestment decisions? Please include methodology(ies) used. How does the ACO take into consideration quality, cost, and patient experience data when developing its methodology?

Supplemental information #9

ACO criterion	Certification question
Commits to advanced health information technology (HIT) integration and adoption	What is the ACO providers' connection rate to the Mass HIway? What is the ACO's plan to increase adoption and integration rates of certified EHRs and connection rates to the Mass HIway? What are the ACO's plans and timelines to increase the current capacity for interoperability and real-time event notification between entities within and outside the ACO?

Supplemental information #10

ACO criterion	Certification question
Commits to consumer price transparency	How does the ACO encourage its participating providers to make price information available to consumers as required under state law and regulations?