MASSACHUSETTS
HEALTH POLICY COMMISSION

Joint Meeting

Quality Improvement and Patient Protection

Cost Trends and Market Performance

April 6, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of QIPP Minutes from the March 23, 2016 Meeting
- Approval of CTMP Minutes from February 24, 2016 Meeting
- Public Listening Session on Out-of-Network Billing
- Discussion of Preliminary Findings from Oral Health Brief
- Schedule of Next Meeting (May 18, 2016)

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MASSACHUSETTS
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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the Quality Improvement and Patient Protection meeting held on March 23, 2016, as presented.

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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the Cost Trends and Market Performance meeting held on February 24, 2016, as presented.

System-wide data update

Data needs	HPC and CHIA activities
Discharge data for psychiatric hospitals	• CHIA estimates project will take 13-18 months.
Validated MassHealth data from the APCD	• CHIA has developed extensive tables related to enrollment and spending. • Tables will be foundation for joint CHIA/HPC project in 2016.
APCD general	• APCD version 5.0 (2015 data) will be released 6/2016 (3 months run-out).
TME for PPO	• CHIA planning new aggregate data collection
Measures of spending and spending growth for hospitals and specialists	**Medicare revenue per CMAD – CHIA collaborating with HPC to support provider price variation work.** • APCD-based efficiency measures- CHIA has is soliciting a vendor to evaluate and recommend measures. HPC is working with CHIA to evaluate proposals.
Quality data BH data	• CHIA is preparing its recommendations around reporting on behavioral health metrics for its June Oversight Council meeting. • CHIA plans to refine its data collection re percentage of market covered by global APMs that include BH .
Other new developments	• **HPC and others are working to understand impact of Supreme Court's Gobeille decision on APCD, TME, and other key data sources.** • CHIA assessing feasibility of collecting and using data on drug rebates – per HPC request. • HPC and CHIA discussing potential technical refinements to THCE calculation. • **Data on provider discounts: CHIA and HPC discussing reporting framework.**

Notes: Bold text represent noteworthy developments since 2/24/2016.

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Out-of-Network Billing

- In connection with the 2015 Cost Trends Report series, the HPC recently released a Policy Brief on Out-of-Network Billing that provides more detailed information on out-of-network billing, including related concerns and policy approaches in other states to address such concerns

- Today's joint Quality Improvement and Patient Protection (QIPP) and Cost Trends and Market Performance (CTMP) Committee meeting provides an **opportunity for stakeholders and members of the public to provide comments to the HPC** regarding out-of-network billing

- Following today's meeting, HPC staff will update the Commission on information received to date, and staff will continue to gather information on out-of-network billing concerns in Massachusetts

Health Policy Commission 2015 Cost Trends Report

POLICY BRIEF ON OUT-OF-NETWORK BILLING

As recently outlined in the Health Policy Commission's (HPC) 2015 Cost Trends Report, the HPC has identified out-of-network billing as an area of policy interest.[1] In connection with the HPC's 2015 Cost Trends Report series, this Policy Brief provides more detailed information on out-of-network billing and related concerns and highlights policy approaches taken by several other states to address these issues. While Massachusetts has already adopted certain protections to address the complicated matters of out-of-network billing, there is no current industry standard to address out-of-network billing concerns, and patients may have to be aware of their rights and affirmatively contest their medical bills to resolve unwarranted bills. This can result in difficulties for patients and may also have implications for the functioning of the health care market as a whole. The Policy Brief reiterates recommendations previously issued by the HPC for Massachusetts to build upon existing protections to more comprehensively address out-of-network billing issues.

I. BACKGROUND ON OUT-OF-NETWORK BILLING

In-Network And Out-Of-Network Providers. Most health insurance plans involve a **provider network**, which is a group of hospitals, physicians, and other providers with whom the insurer contracts (often called **in-network, preferred, or participating providers**). Provider networks generally vary between different insurers and insurance plans, as do the terms and **cost-sharing** amounts for in-network and out-of-network care. When a patient seeks care from a provider who is in the network for the patient's insurance plan, the patient typically pays a lower cost-sharing amount than what the patient would pay for care from a provider who is not in his or her insurance plan's network (an **out-of-network provider**).

KEY TERMS:

A **provider network** is a group of providers with which an insurer contracts to provide services at negotiated prices. Providers that are part of a network for a particular insurance product may be called "in-network," "preferred," or "participating" providers.

Charges are the provider's full or total price for services. Charges are typically higher than negotiated in-network rates.

Cost-sharing is the amount a patient has to pay for an item or service under the terms of a particular health plan (e.g., deductible, copayment, coinsurance).

Provider networks are an important way for insurers to control costs while providing benefit and value to patients. When a provider joins an insurer's network, it agrees to receive negotiated prices for services (or an **allowed amount**), which are often substantially lower than a provider's full list price or **charges** for a service. After a patient receives care from an in-network provider, the patient pays a cost-sharing amount pursuant to the terms of the health insurance plan, and the insurer pays the provider the negotiated price for services rendered.

However, when a patient seeks care from an out-of-network provider, there may not be a lower, negotiated price between the insurer and the out-of-network provider. As a result, a patient may be required to pay significantly greater cost-sharing than he or she would ordinarily pay for in-network care, and he or she could be required to pay cost-sharing that is based on the full list price or charges for the service. The patient's responsibility varies considerably based on the specific terms of the health insurance plan.

MASSACHUSETTS HEALTH POLICY COMMISSION

Summary: Policy Brief on Out-of-Network Billing

Summary

1. Patients may receive care from out-of-network providers for a variety of reasons; concerns arise when patients do not or cannot intentionally choose the out-of-network provider (either for emergency care, or when care is rendered by an out-of-network provider at an in-network facility), which may result in **balance billing** or "**surprise billing**" for patients

2. There are **current laws** in Massachusetts that aim to protect patients in these circumstances but may not provide full protection

3. Comprehensive **data** on the extent to which out-of-network billing concerns occur in Massachusetts is difficult to obtain or quantify

Summary: Policy Brief on Out-of-Network Billing, continued

Summary

4. Certain concerns may need to be **further addressed** (e.g., lack of patient notice and administrative burden for patients); out-of-network billing concerns can also have implications for the health care system as a whole

5. **Other states** have taken a variety of approaches to address out-of-network billing concerns; New York's law is the most comprehensive approach

6. The HPC made **recommendations** in the 2015 Cost Trends Report to enhance current out-of-network billing protections, including a recommendation that the Legislature should establish a maximum reasonable price for out-of-network services to improve market functioning and ensure that out-of-network billing protections do not result in increased overall spending or have other unintended consequences

Stakeholder Comments on Out-of-Network Billing

General Questions

- Do you have any data or information regarding the extent to which consumers/patients/members in Massachusetts have problems with bills resulting from out-of-network care that they did not intentionally or knowingly choose (whether for emergency services or care by out-of-network providers at an in-network facility)?
- From your perspective, what are the biggest challenges with respect to these types of out-of-network billing scenarios?
- What suggestions do you have for enhancing out-of-network billing protections in Massachusetts?

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Summary of Key Findings

4-7X
More expensive to visit the ED for an oral health condition instead of a dental office

6x rate of children covered by MassHealth visited the ED for preventable oral health conditions compared to the rate of commercially insured children

7X rate of adults covered by MassHealth visited the ED for preventable oral health conditions compared to the rate of commercially insured children

48.8
percent of all preventable ED oral health visits paid for by MassHealth

~25
percent of the population covered by MassHealth

1/10th
of MA population lives in a federally designated dental health professional shortage area

53% low-income children saw a dentist in 2014

56% low-income adults saw a dentist in 2014

Young adults had the **highest rates** of ED visits for preventable oral health conditions

five-fold regional variation
in the number of oral health ED visits per population,
high: 13.1 visits per 1,000, Fall River
low: 2.6 visits per 1,000, West Merrimack/Middlesex

26%
of dentists billed at least $10,000 to MassHealth in 2014

Highlighted interventions include
(1) Mid-level dental providers
(2) Teledentistry

The HPC has identified ED visits and avoidable ED visits as an area of ongoing focus

Measure	MA time trend		Direction of change	US comparison	MA relative to US
5. ED utilization (per 1,000 beneficiaries)	361 (2010)	349 (2014)		MA ranked 35 out of 51 (2013)	

- While emergency departments are essential to the delivery system, some ED visits may be avoidable - either because the condition was preventable with earlier treatment or because the condition could be treated in an alternate setting
- ED use in MA is high relative to the US, although it dropped between 2013 and 2014
- HPC has conducted several studies of ED use and avoidable ED use
  - Avoidable ED use and growth in behavioral health-related ED visits – 2015 Cost Trends Report
  - Opioid-related hospital visits (including ED) – March 23 QIPP Meeting
  - **ED visits for preventable oral health conditions – April 6 CTMP/QIPP Meeting**
- Past work on ED use has highlighted regional variation, relationship to income and other patient characteristics, and relationship to provider supply

HPC

Oral health care in the U.S. and Massachusetts

- Oral health is a key component of overall health
  - Studies have identified oral infections as a risk factor for heart and lung disease, osteoporosis, low-birthweight, and diabetes
  - Regular dental care has also been shown to decrease medical expenses and hospitalizations for some systemic conditions, such as rheumatoid arthritis
- Key elements of access to oral health care include: geographic availability of providers, insurance coverage, and affordability
- In Massachusetts the supply of dentists varies considerably by region
  - One tenth of the population lives in a federally-designated dental health professional shortage area
- While MassHealth covers some dental care, not all dentists accept MassHealth
  - In 2014, 35% of dentists treated a MassHealth patient and only 26% billed at least $10,000 to the program
- Access to dental care varies with income
  - In a 2015 survey, 82% of high-income adults reported seeing a dentist in past year, compared to only 56% of low-income adults

Sources: Oral health in America: A report of the Surgeon General. U.S. Department of Health and Human Services; Jeffcoat M. et al. Impact of periodontal therapy on general health: evidence from insurance data for five systemic conditions. American journal of preventive medicine. 2014; Better Oral Health for Massachusetts Coalition. Oral health plan for Massachusetts: 2010-2015, 2010; A path to expanded dental access in Massachusetts: Closing persistent gaps in care. The Pew Charitable Trusts 2015; Center for Health Information and Analysis. Massachusetts Health Insurance Survey Boston (MA) 2015.

ED use for preventable oral health conditions in the U.S.

- When access to dental care is limited, patients may seek care for preventable oral health conditions in EDs
- A visit to the ED for an oral health condition can range from $400 to $1,500 per visit, which is four to seven times more than a dental office visit, which average between $90 and $200 per visit
- Most EDs are not equipped to provide comprehensive dental care
  - One study found that, of children who used the ED for preventable oral health conditions, 80% subsequently had to go to a dentist for treatment

Sources: ER utilization action for dental health. American Dental Association, 2013; Allareddy V, Nalliah RP, Haque M, Johnson H, Rampa SB, Lee MK. Hospital-based emergency department visits with dental conditions among children in the United States: Nationwide epidemiological data. Pediatric dentistry. 2014; 36:393-9.

Key definitions and methods

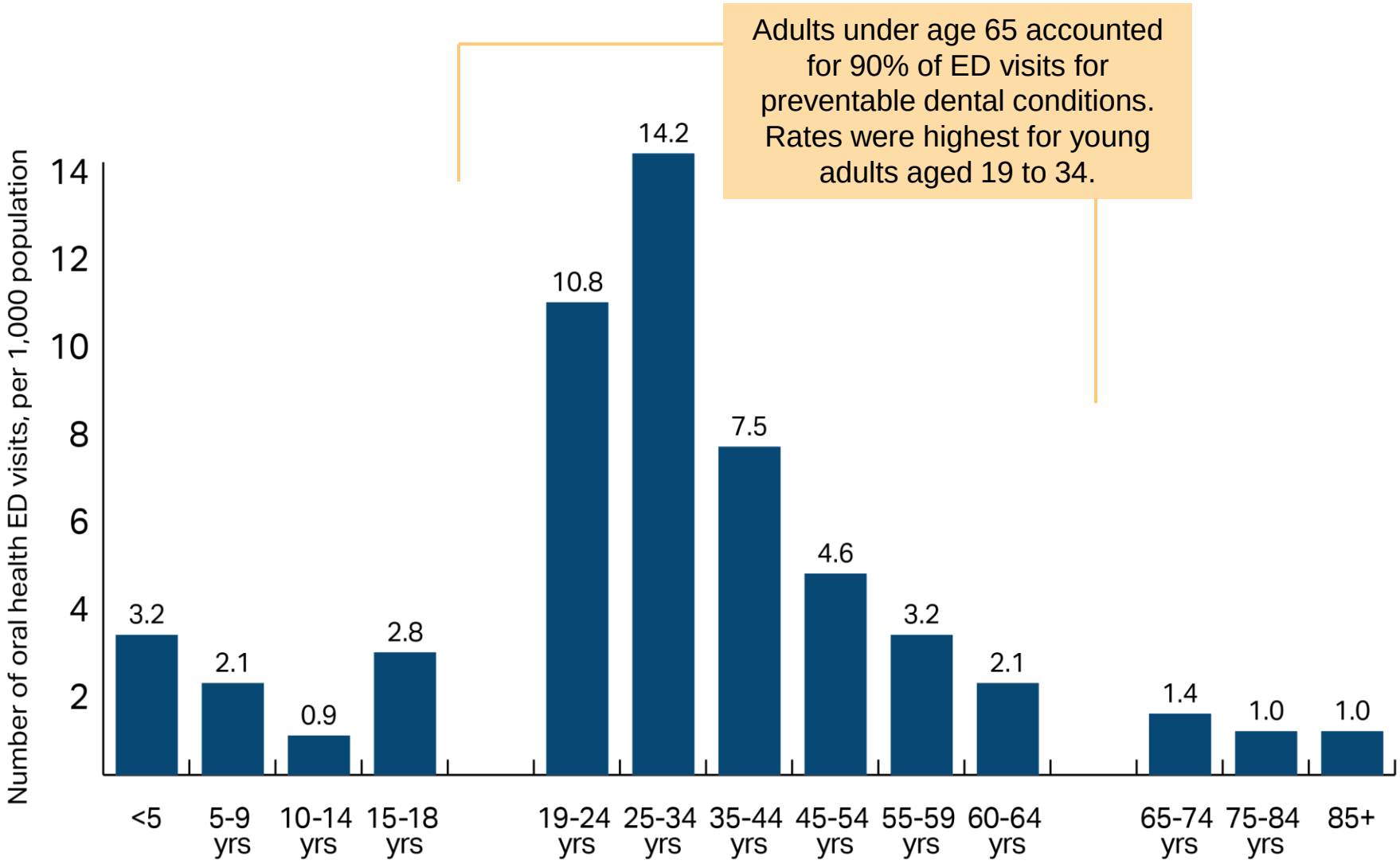
The HPC examined ED visits for preventable oral health conditions, using a method developed by the California HealthCare Foundation

- Preventable oral health conditions, also described as “ambulatory care-sensitive” dental conditions, were those for which “good outpatient care could potentially prevent the need for hospitalization or … early intervention could prevent complications or more severe disease”

Preventable oral health conditions	
Diseases of the hard tissues of teeth	Tooth decay (ex: cavities, abrasion of teeth)
Diseases of pulp and periapical tissues	Inflammation of the dental pulp (blood vessels and nerves inside the tooth); often caused by bacterial invasion from tooth decay or, less commonly, cracked teeth
Gingival and periodontal diseases	Inflammation of the gums (caused by bacterial infection)
Other diseases and conditions of the teeth and supporting structures	Includes loss of teeth, complete or partial absence of teeth, and poor fillings. The loss of teeth due to trauma was not included in this analysis.
Diseases of the oral soft tissues, excluding lesions specific for gingiva and tongue	Including inflammation of the linings of the cheeks, lips, and tongue.

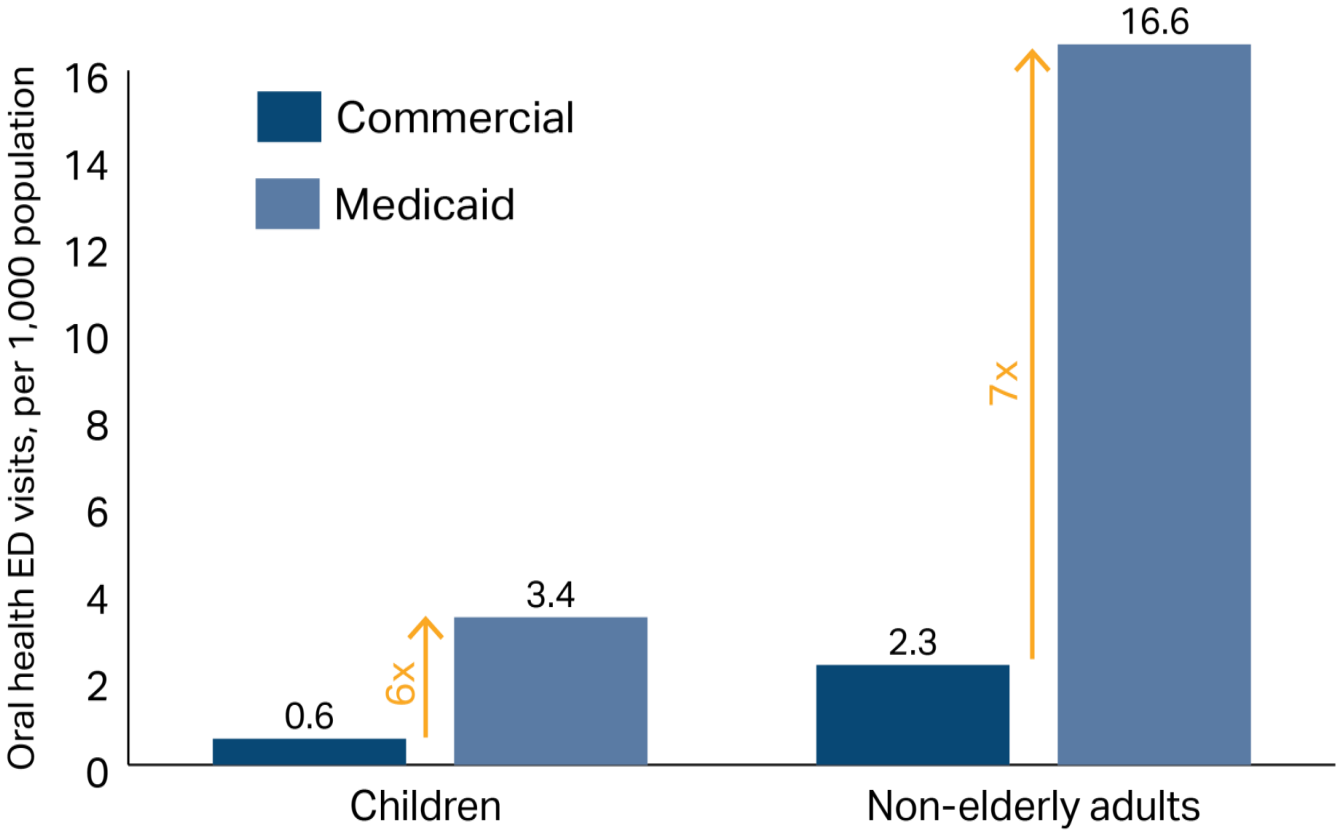
HPC Source: California HealthCare Foundation

Young adults had the highest rates of ED visits for preventable oral health conditions



Notes: Figure reports dental conditions defined based on ICD-9 primary diagnostic codes designated by the California HealthCare Foundation. These include ICD-9: 521, 522, 523, 525, and 528.
Source: HPC analysis of Center for Health Information and Analysis, Emergency Department Database, 2014; population counts from the Kaiser Family Foundation

The rate of ED visits for preventable oral health conditions was higher among individuals with MassHealth



There could be many reasons for higher rates of preventable oral health ED visits among MassHealth enrollees, but likely contributing factors include: clinical risk factors, a low number of dentists accepting MassHealth patients, and patients' costs.

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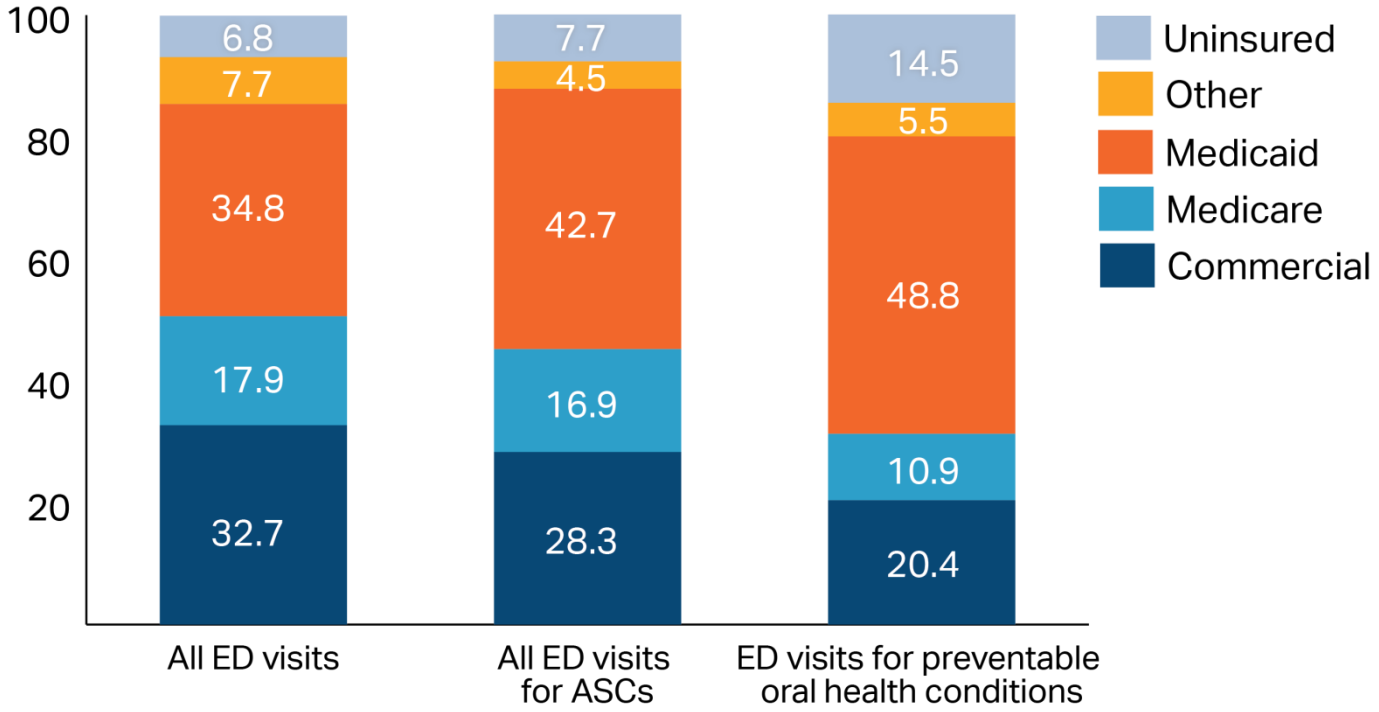
Source: HPC analysis of Center for Health Information and Analysis, Emergency Department Database, 2014; population counts from the Kaiser Family Foundation

Even relative to their high ED use overall, MassHealth members make up a large share of ED visits for preventable oral health conditions



MassHealth paid for a third of all ED visits, but almost half of all preventable oral health ED visits (despite only covering roughly a quarter of the state's residents).

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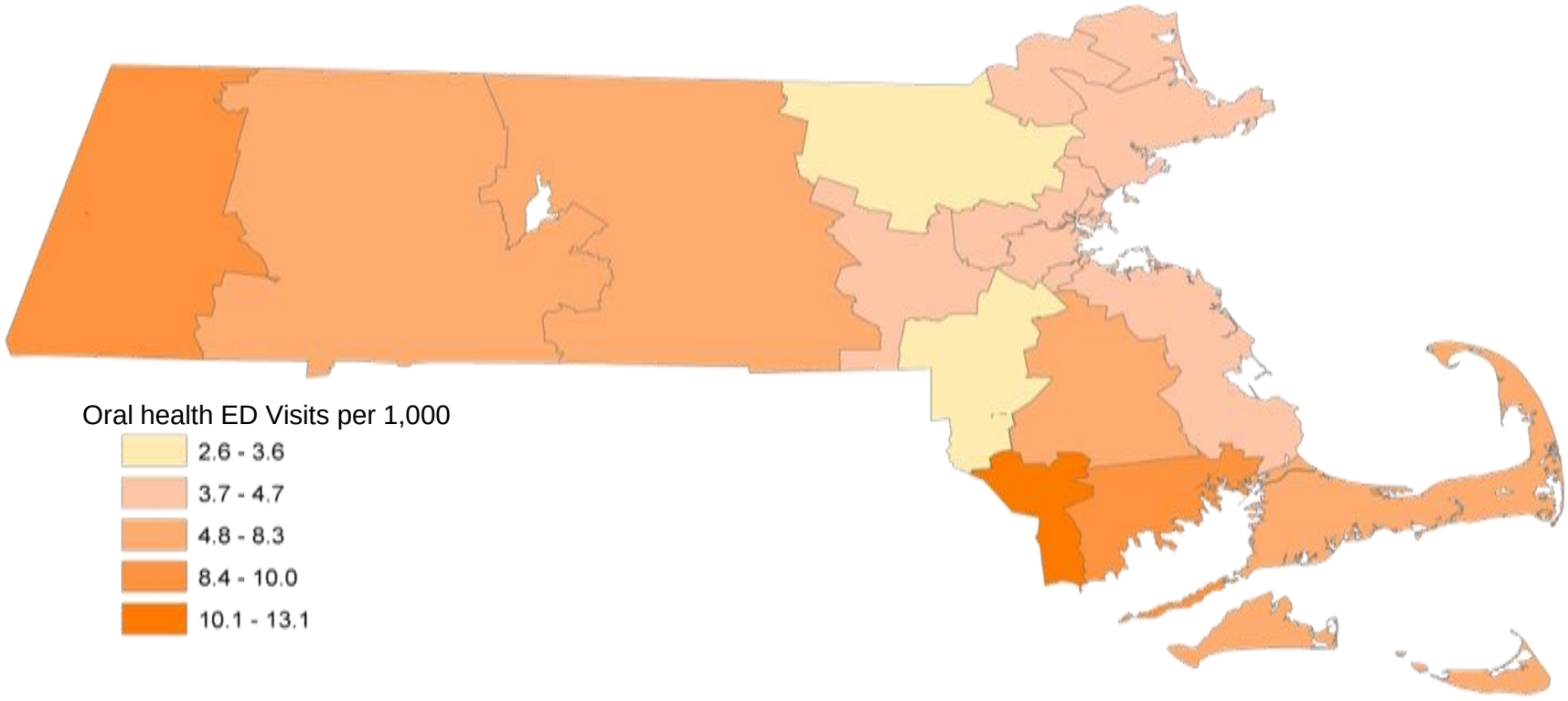
Source: HPC analysis of Center for Health Information and Analysis, Emergency Department Database, 2014; population counts from the Kaiser Family Foundation

The rate of ED visits for preventable oral health conditions varied by region, with the highest rate in Fall River, followed by the Berkshires and New Bedford



Areas with more ED visits had lower median incomes and fewer full-time dentists relative to the population*

*The correlation coefficient was -.6 in both cases.
Notes: Figure reports dental conditions defined based on ICD-9 primary diagnostic codes designated by the California HealthCare Foundation. These include ICD-9: 521, 522, 523, 525, and 528.
Source: HPC analysis of Center for Health Information and Analysis, Emergency Department Database, 2014; population counts from the Kaiser Family Foundation

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Exemplar oral health interventions

- The use of EDs for preventable oral health conditions suggests a clear opportunity to strengthen the Commonwealth's dental safety net and expand access to routine oral health care

- Exemplar oral health interventions to consider include:
  - Augmenting the oral health workforce by licensing mid-level dental providers
  - Supporting teledentistry initiatives

- Impact evaluations of these models show that they can increase access to oral health care by expanding the capacity of dental care teams and utilizing technology to extend the reach of the dental workforce
  - In both cases, the interventions can be focused on vulnerable populations

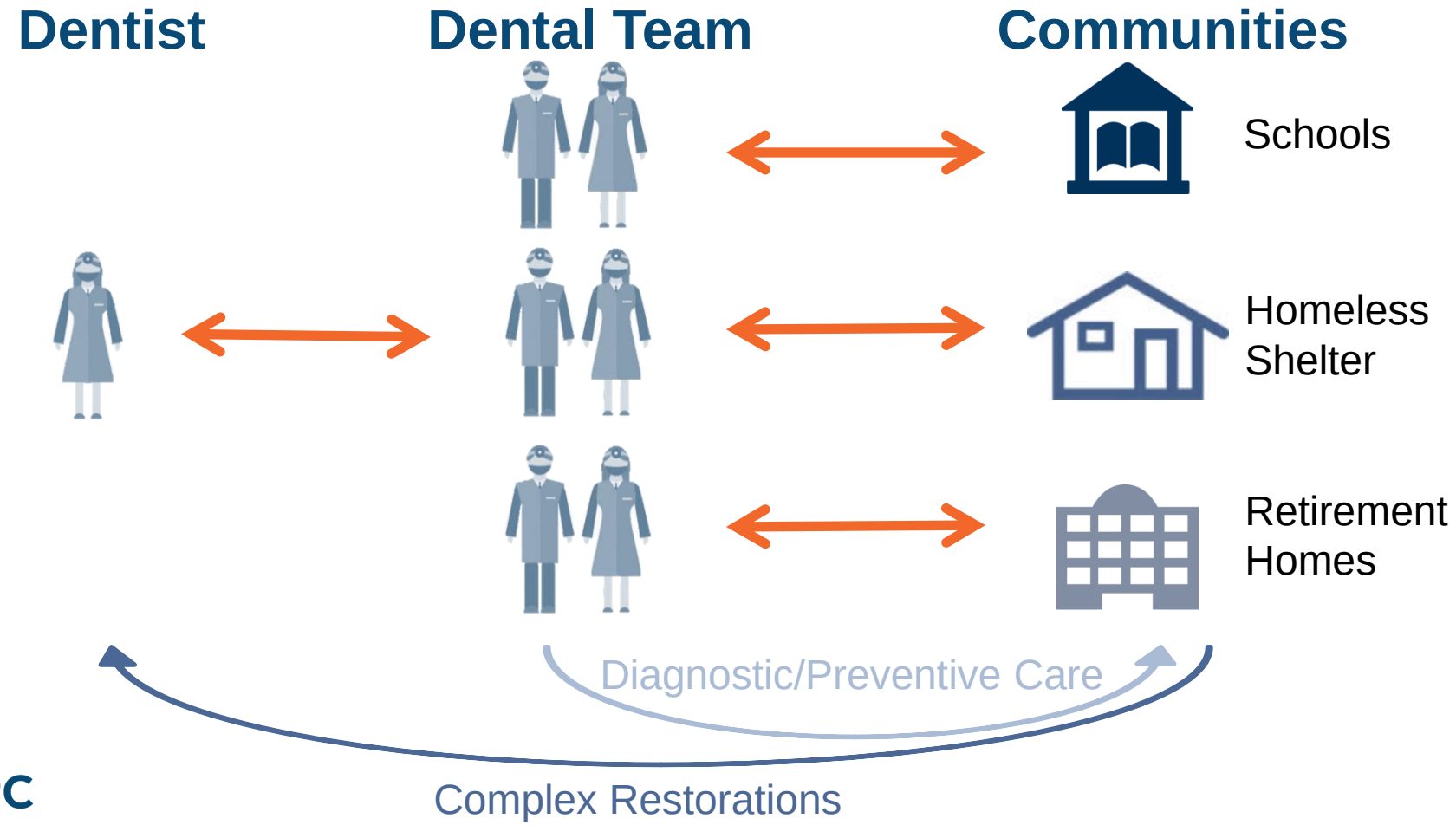
Augmenting the oral health workforce by licensing mid-level dental providers

- These providers increase the capacity of dental workforce and they can make care more affordable
- Preliminary findings from Minnesota indicate that these providers have reduced ED utilization and wait times for dental appointments
- Three states currently employ mid-level dental providers and 15 other states, including Massachusetts, are considering similar legislation

State	Type of provider	Education/Training	Services provided
AK	Dental health aide therapist	18-to 24-months at a community college/ technical school program	Preventive, restorative (fillings and extractions) under standing orders and remote supervision by a dentist
MN	Dental therapist; advanced dental therapist	DT: bachelor's degree in dental therapy ADT: Master's degree in advanced dental therapy	DT: preventive services, some restorative (fillings/extractions), supervision of a dentist required for some procedures ADT: treatment plans, oral evaluations, extraction of permanent teeth. Some procedures require collaborative management agreement with dentist
ME	Dental hygiene therapist	Bachelor's degree in dental hygiene	Preventive, oral health assessments, simple extractions, prepare and replace crowns, referrals, local anesthesia under supervision of a dentist

Supporting teledentistry initiatives

- Teledentistry enables dentists to remotely supervise staff through the use of mobile technology
  - Allows dental hygienists to provide care in schools, nursing homes, homeless shelters, prisons, and other community settings
  - Removes financial and logistical barriers that vulnerable populations face
- California and Colorado recently passed legislation authorizing state Medicaid programs to reimburse for teledentistry services



Contact information

For more information about the Health Policy Commission:

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