MASSACHUSETTS
HEALTH POLICY COMMISSION

Joint Meeting

Quality Improvement and Patient Protection

Cost Trends and Market Performance

May 18, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Quality Improvement and Patient Protection
- Public Listening Session on Out-of-Network Billing
- Cost Trends and Market Performance

MASSACHUSETTS
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AGENDA

- Quality Improvement and Patient Protection
  - **Approval of QIPP Minutes from the April 6, 2016 Meeting**
  - Discussion of Findings from HPC's Oral Health Brief
  - Update on Regulations Governing the Office of Patient Protection
- Public Listening Session on Out-of-Network Billing
- Cost Trends and Market Performance

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the Quality Improvement and Patient Protection meeting held on April 6, 2016, as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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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 adults

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

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

HPC

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 – May 18 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

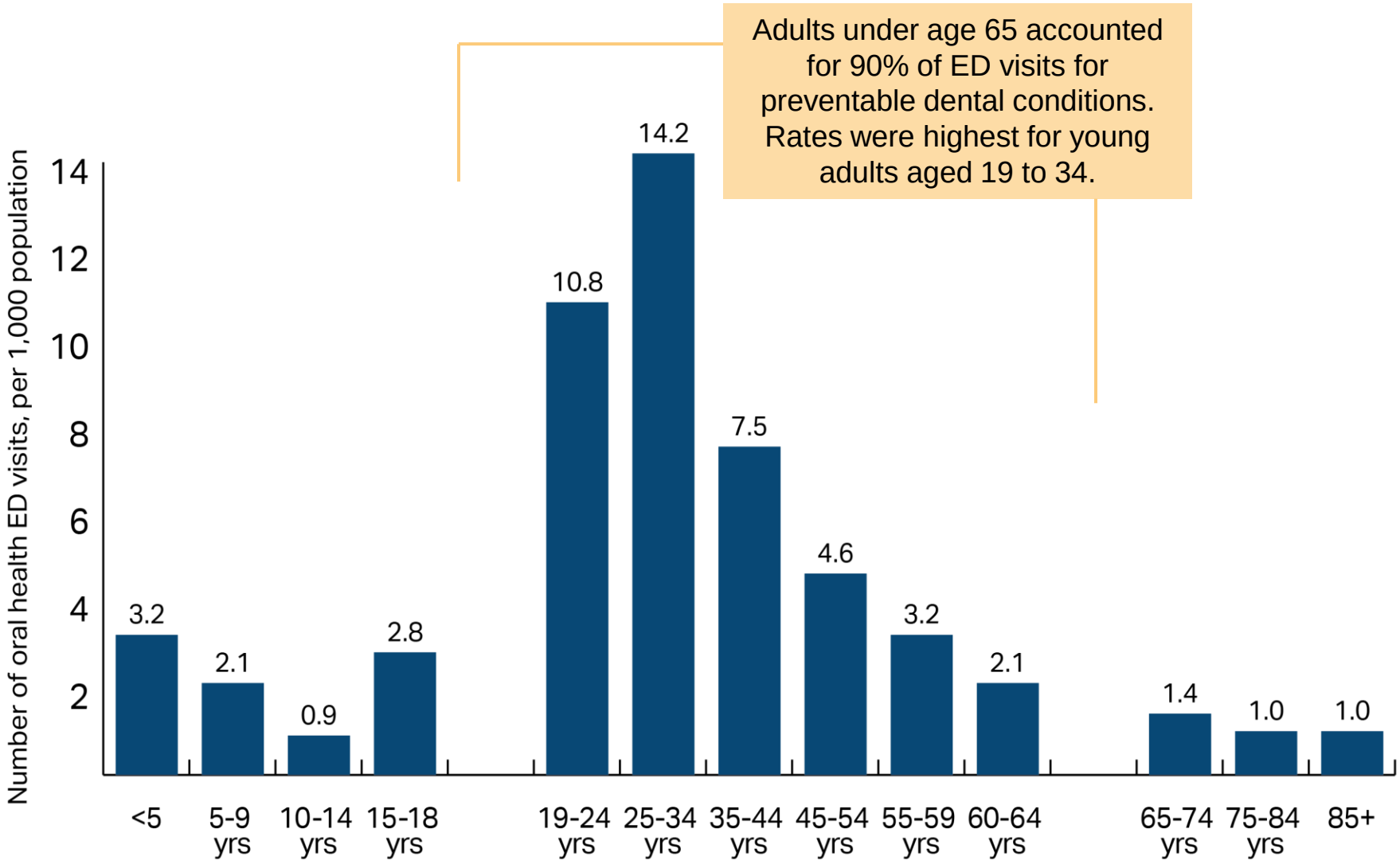
The HPC examined ED visits for preventable oral health conditions, using a method developed by the California HealthCare Foundation

- 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.

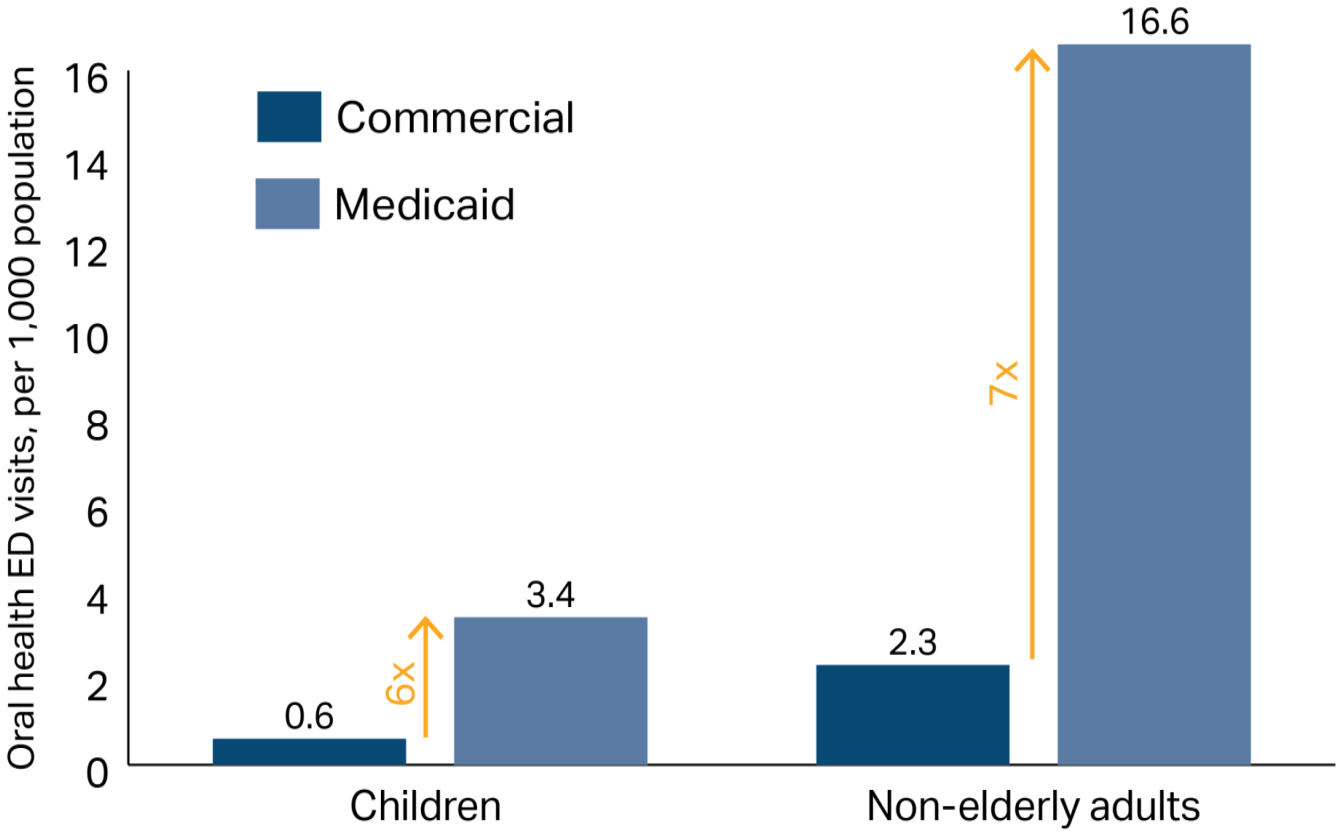
HPC Source: California HealthCare Foundation

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

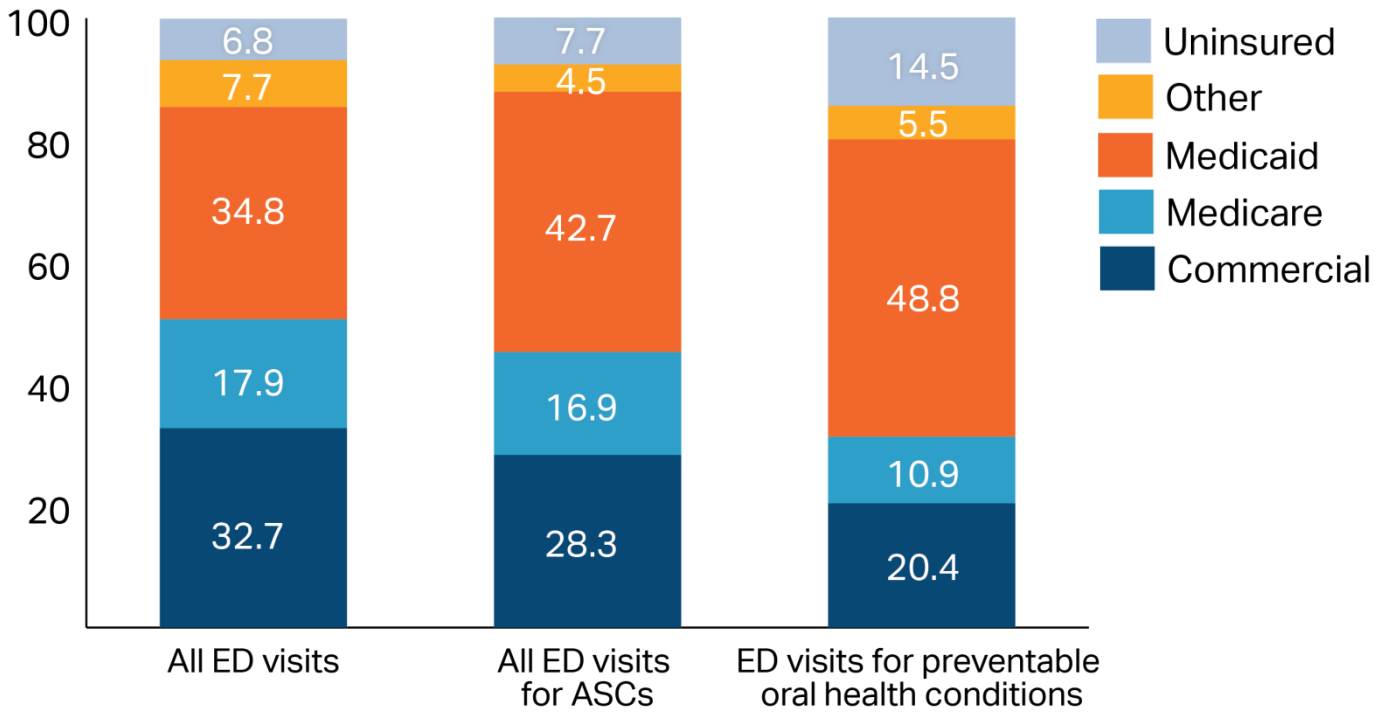
The rate of ED visits for preventable oral health conditions was higher among individuals with MassHealth



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.

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

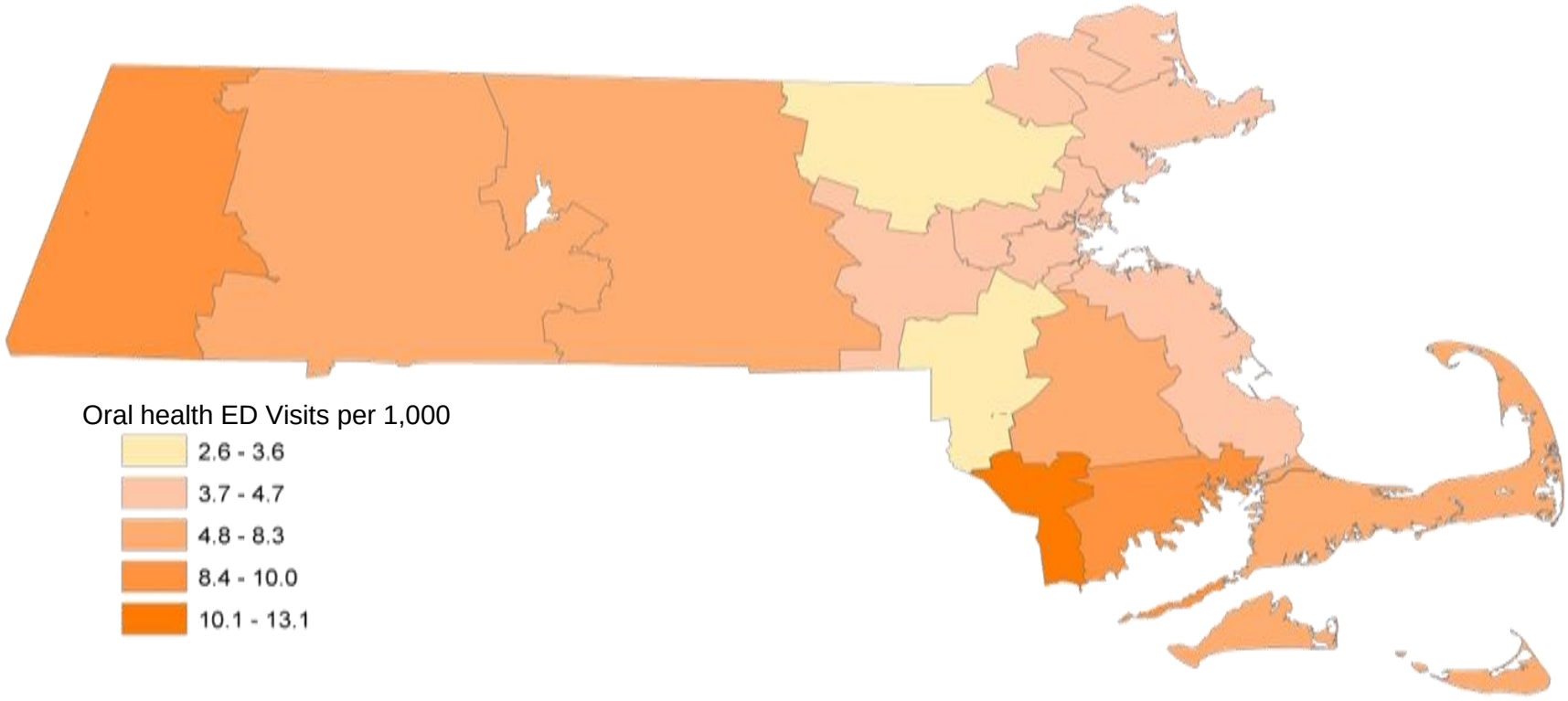
Even relative to their high ED use overall, MassHealth members make up a large share of ED visits for preventable oral health conditions



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).

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 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

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

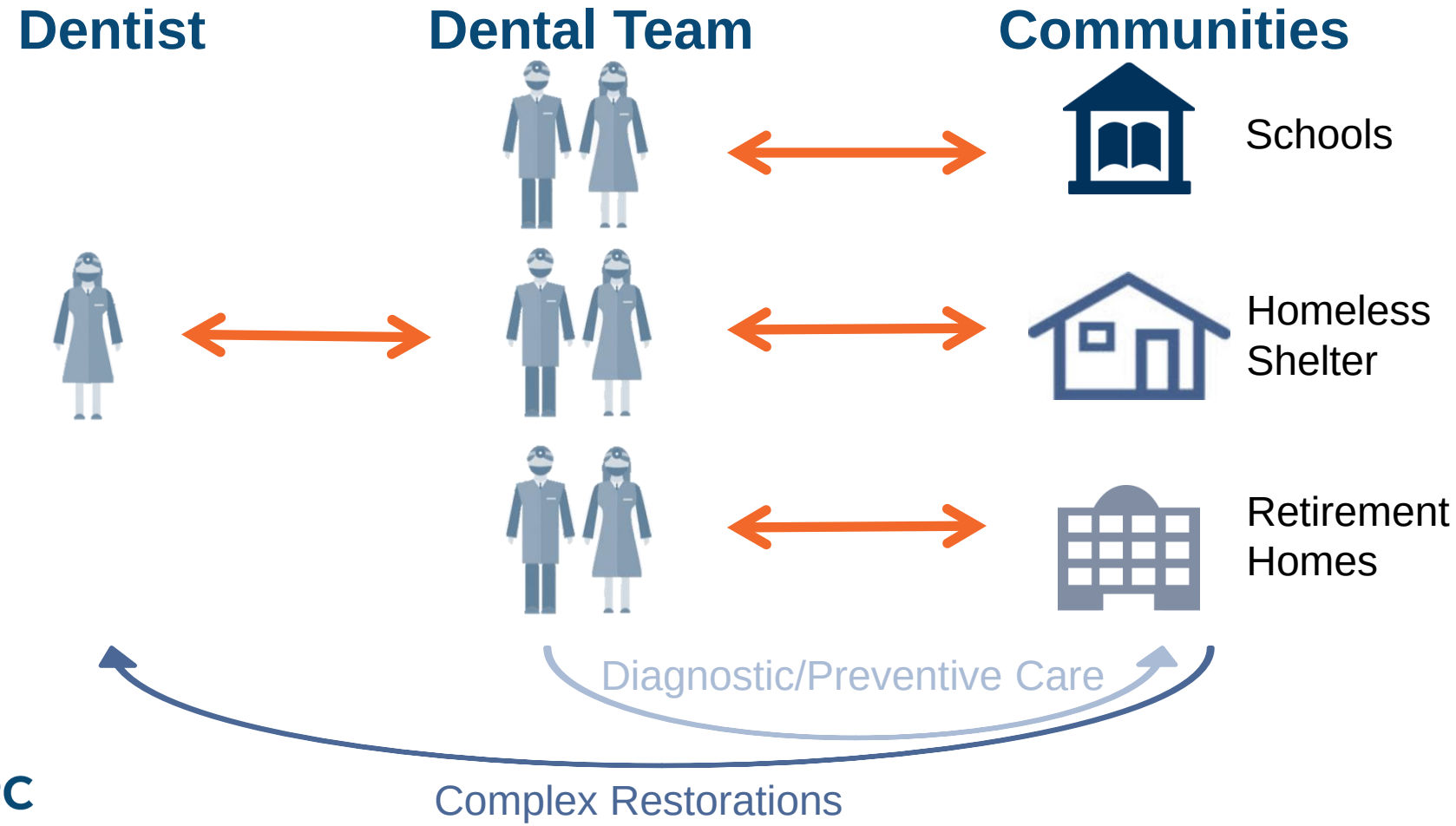
- These providers increase the capacity of dental workforce and they can make care more affordable
- Preliminary findings from Minnesota indicate that these providers have reduced ED utilization and wait times for dental appointments
- Three states currently employ mid-level dental providers and 15 other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

HPC

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



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Preview: OPP Regulatory Revision – New Carrier Reporting Requirements

Massachusetts' new opioid legislation, **Chapter 52 of the Acts of 2016**, was signed into law by Governor Baker on March 14, 2016; in part, it amends M.G.L. c. 176O, sec. 7 to add new **carrier reporting requirements on claims and claims denials** to the Office of Patient Protection (OPP) during annual reporting

> SECTION 53. Said section 7 of said chapter 176O, as so appearing, is hereby further amended by inserting after the word "age", in line 68, the following words:- ; and
>
> (5) a report detailing for the previous calendar year the total number of: (i) medical or surgical claims submitted to the carrier; (ii) medical or surgical claims denied by the carrier; (iii) mental health or substance use disorder claims submitted to the carrier; (iv) mental health or substance use disorder claims denied by the carrier; and (v) medical or surgical claims and mental health or substance use disorder claims denied by the carrier because: (A) the insured failed to obtain pre-treatment authorization or referral for services; (B) the service was not medically necessary; (C) the service was experimental or investigational; (D) the insured was not covered or eligible for benefits at the time services occurred; (E) the carrier does not cover the service or the provider under the insured's plan; (F) duplicate claims had been submitted; (G) incomplete claims had been submitted; (H) coding errors had occurred; or (I) of any other specified reason.

Accordingly, OPP's regulation ***958 CMR 3.00: Health Insurance Consumer Protection needs to be amended*** to incorporate the new statutory requirements

HPC

Considerations and Next Steps

- HPC staff are working on **developing updates to the OPP regulation** to implement the new reporting requirements
- Staff will conduct outreach with **stakeholders**, especially carriers, as well as the Division of Insurance, to get input
- In particular, staff will seek to **minimize administrative burden** for carriers to the extent possible in implementing the new requirements
- HPC staff will develop the proposed updates to 958 CMR 3.00 through the full **regulatory process**, including a public comment period and a public hearing

Proposed Timeframe to Update OPP Regulations

May 18, 2016 – Preview of regulatory revision to QIPP Committee

June 1, 2016 – Preview of regulatory revision to full Board

June 22, 2016 – QIPP Committee to review proposed regulation

July 27, 2016 – Full Board to review proposed regulation

Summer 2016 – Public hearing on proposed regulation

Summer/Fall 2016 – Deadline to submit public comments on proposed regulation

Fall 2016 – QIPP Committee to review final regulation

Fall 2016 – Commission to review final regulation

Winter 2016 – Publication of final regulation in Massachusetts Register

**Dates are subject to change.*

If the regulatory revision process is completed in accordance with the proposed timeline, carriers would report on 2017 data in their April 2018 annual reporting submission to OPP.

HPC

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- **Public Listening Session on Out-of-Network Billing**
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Review of Out-of-Network Billing Policy Solutions

- The HPC made broad recommendations to enhance current out-of-network billing protections in the 2015 Cost Trends Report, which are restated in the HPC Policy Brief on Out-of-Network Billing

- The Brief describes the categories of policy solutions implemented by states to address out-of-network billing concerns that arise as a result of unintentional or involuntary out-of-network care

1. **Disclosure and transparency initiatives** can help support the prevention of out-of-network billing concerns

2. **Hold harmless provisions and balance billing prohibitions** seek to remove the patient from the payment equation that results after receiving unintentional out-of-network care

3. **Payment to the out-of-network provider** must be determined; this involves a complex balance of interests between insurers and providers

    - **Established Payment** – set a standardized level or benchmark at which out-of-network providers are paid (e.g., a defined percentage above the median in-network rate)

    - **Dispute Resolution** – establish a forum to address resulting or remaining disagreements between insurers and providers regarding adequacy of payment

    Example: New York law incorporates both approaches; insurers must pay providers a reasonable payment amount and disclose that methodology (including how it compares to the usual and customary rates, as defined in the law); there is also an independent dispute resolution process to resolve outstanding disagreements

HPC Listening Sessions on Out-of-Network Billing

- In a joint meeting on April 6, 2016, the Cost Trends and Market Performance (CTMP) and Quality Improvement and Patient Protection (QIPP) Committees held a **listening session on out-of-network billing** 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 CTMP and QIPP Committees are hosting a **second listening session today** to provide an additional opportunity for comments

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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  - **Approval of Minutes from the April 6, 2016 Meeting**
  - Discussion of HPC Work Relative to Provider Discounts
  - Update on HPC Work Relative to Performance Improvement Plans
  - Discussion of 2016 Health Care Cost Trends Hearing
  - Schedule of Next Committee Meeting

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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 April 6, 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. • **CHIA is working with state partners on data needs and hosting a webinar with BH hospitals and Mass. Association of Behavioral Health Systems.**
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 or CTR chapter 2016.
APCD general	• APCD version 5.0 (2015 data) will be released in late June. • **CHIA intends to document the impact of the Gobeille decision in user notes.** • **CHIA and other state agencies are working with carriers to encourage self-insured employers to voluntarily submit claims to the MA APCD.**
TME for PPO	• CHIA planning new aggregate data collection. May be affected by Gobeille.
Measures of spending and spending growth for hospitals and specialists	• **APCD-based efficiency measures- CHIA has identified a preferred vendor and is finalizing a contract. HPC was on the procurement team.**
Quality data BH data	• CHIA is preparing its recommendations around reporting on behavioral health metrics for its June Oversight Council meeting.
Other new developments	• **HPC is collaborating with EOHHS, CHIA and the AGO to respond to the Supreme Court's Gobeille decision by developing an outreach plan, policy guidance, and options for legislative and regulatory changes to support APCD and other data collection going forward.**

HPC Notes: Bold text represent noteworthy developments since 4/6/2016.

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Update on Provider-to-Provider Discount Arrangements

- In December, the HPC issued Frequently Asked Questions and updated the MCN form to increase the transparency of provider-to-provider discount arrangements.
- Through such discount arrangements, providers under risk typically agree to send their risk patients to a preferred provider, and the preferred provider agrees to pay a discount back to the referring provider for services rendered to the risk patients. The discount is typically a pre-determined percentage of the preferred provider's negotiated rates.
- The changes to the MCN process have improved the HPC's ability to monitor the development of new discount arrangements.
  - In the few months since the MCN process was updated, we have already received two MCNs that have publicly disclosed that there were financial components included in clinical affiliations.
- However, Commissioners also expressed interest in understanding discount arrangements in place that pre-dated the material change notice process, or for which no material change notice was filed.

Proposal for Understanding Existing Discount Arrangements

- Per M.G.L. c. 12C § 8, CHIA shall "**require providers to report any agreements** through which provider agrees to furnish another provider with a discount, rebate or any other type of refund or remuneration in exchange for, or in any way related to, the provision of heath care services."

- The HPC has been working with CHIA to collect this information through the **Registration of Provider Organizations (RPO) Program,** which is designed to track relationships between providers.

- Given the public nature of RPO data, CHIA and the HPC agree that the providers **should report with whom** they have a discount agreement, but **not the amount of the discount**.

- Provider Organizations will have the opportunity to provide feedback on the proposed data elements **this summer**.

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CHIA Identification of Payers and Providers

CHIA is required to identify payers and providers whose cost growth, as measured by health status adjusted Total Medical Expenses (HSA TME), is considered "excessive and who threaten the benchmark" (according to Chapter 224).

- This year, CHIA has interpreted this standard as payers and providers whose HSA TME growth is above 3.6%.
- The HSA TME metric accounts for variations in health status of a payer's full-claim members. This metric allows for a more refined comparison of TME trends between payers than looking at unadjusted TME alone.
  - Payer HSA TME represents total health care spending for members' care, adjusted by health status. Payer TME is reported for each book of business for a payer.
  - Provider group HSA TME represents the total health care spending of members whose plans require the selection of a primary care physician associated with a provider group (typically HMO or POS products), adjusted for health status. Provider TME is reported for each carrier/book of business for a provider.
- This year's list is based on the trend for 2012 and 2013 final data, as well as the trend for 2013 final and 2014 preliminary data.

Performance Improvement Plans

Key Updates

1. Received final confidential list of payers and providers identified by CHIA in December
2. Released interim guidance in March
3. Conducted an initial review of all of the identified entities

Summary of Payers and Providers Identified by CHIA

Providers

- 25 Providers (Physician Groups)
- 15 physician groups were only identified for one contract, one year
- 10 physician groups were identified for more than one contract

Payers

- 8 payers
- 4 of the 8 payers were only identified for books of business in one year

Standard and Factors for Review

Standard

The HPC may require a PIP where, based on a review of factors described below,
1) the HPC identifies significant concerns about the entity's costs and
2) determines that a PIP could result in meaningful, cost-saving reforms.

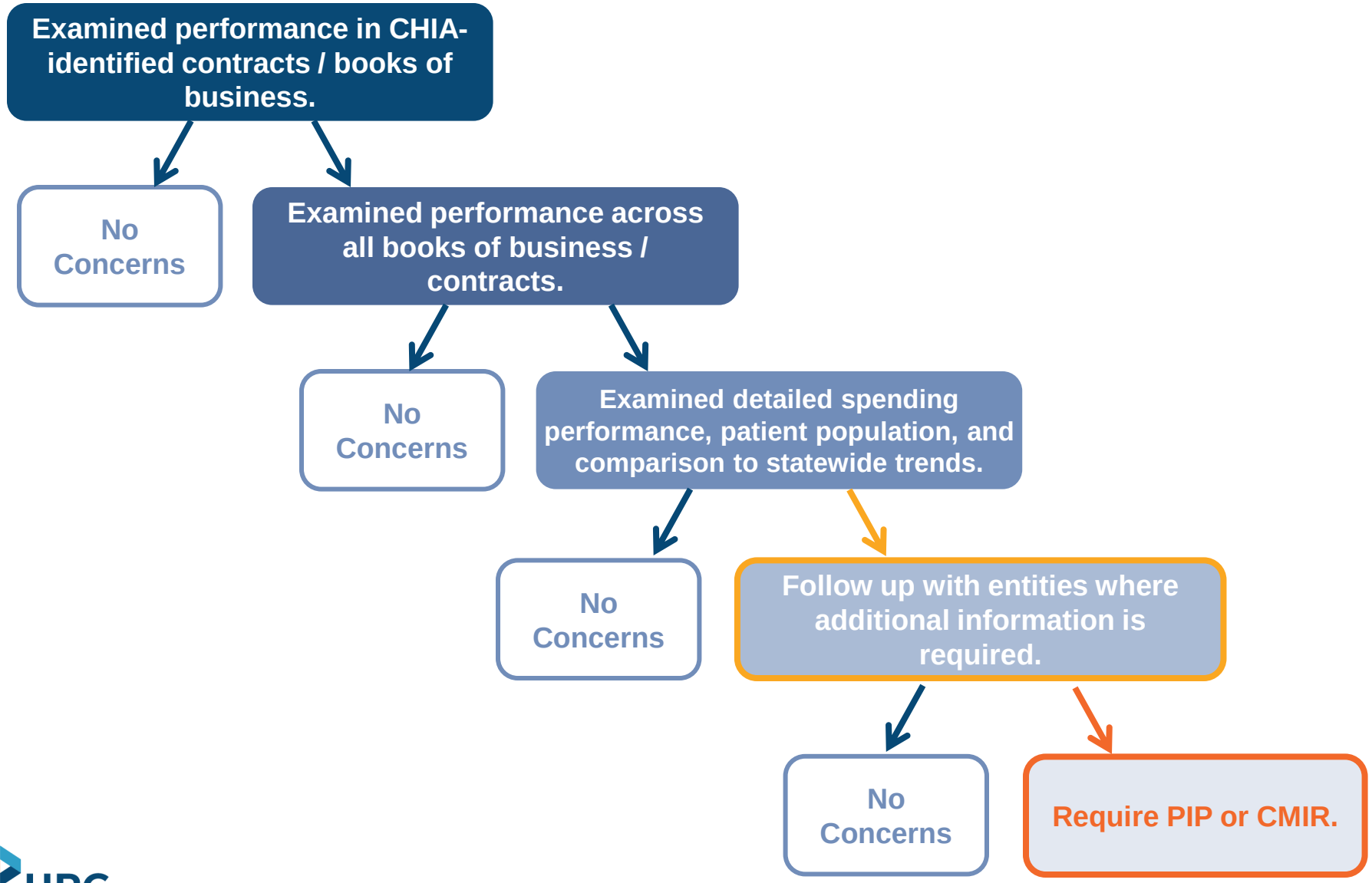
Factors for Review

Including, but are not limited to:

- Baseline spending and spending trends over time, including by service category;
- Pricing patterns and trends over time;
- Utilization patterns and trends over time;
- Population(s) served, product lines, and services provided;
- Size and market share;
- Financial condition, including administrative spending;
- Ongoing strategies or investments to improve efficiency or reduce spending growth over time; and
- Factors leading to increased costs that are outside the Health Care Entity's control.

While the same factors will be evaluated for both payers and providers, some of the underlying metrics examined may be unique to one or the other.

Overview of HPC's 2016 Initial Review Process



Overview of HPC's 2016 Initial Review Process

Notices of CHIA ID

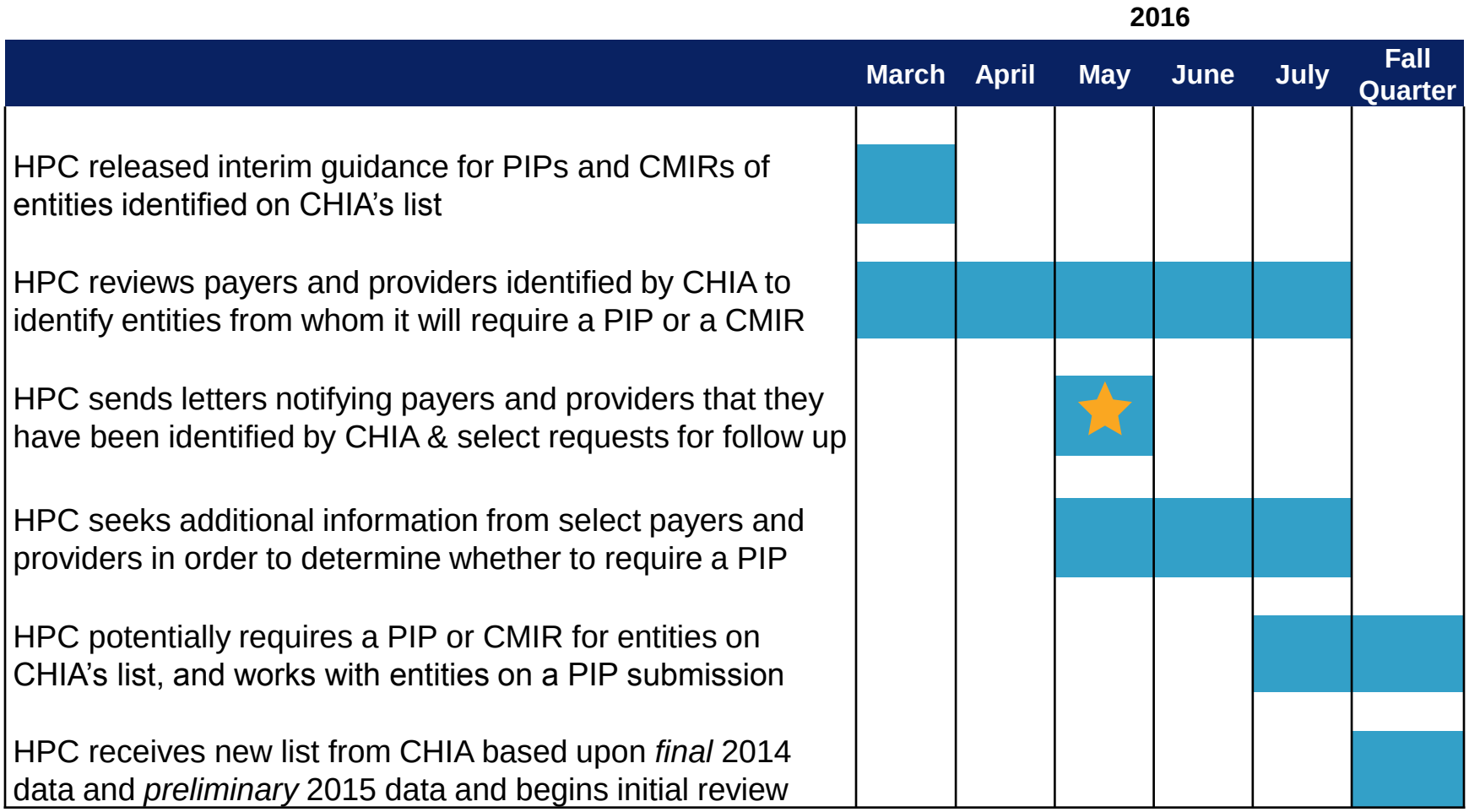
- **Notice Type #1:** No significant concerns
  - These entities will receive notices indicating no further action is necessary and they will not be required to file a PIP.
  - The HPC will continue to closely monitor the performance of these entities to the extent they continue to be identified by CHIA in future years.

- **Notice Type #2**: Additional information required
  - These entities will receive notices from the HPC requesting that the parties meet with the HPC to provide additional information explaining the identified excessive spending.
  - The HPC will continue to evaluate these entities to determine whether to recommend a PIP or Cost and Market Impact Review (CMIR).

HPC's Further Review Process of Entities of Receiving Notice Type #2

- For entities receiving notice type #2, HPC staff will conduct a more fulsome review of available data and to give the entity the opportunity to provide data and or documents to aid in that review.
- The HPC will examine the factors identified in the interim guidance for each entity, including review of any materials or information provided by the entity.
- At the conclusion of its review, the HPC may elect to require a PIP if the HPC identifies significant concerns about the entity's costs and determines that a PIP could result in meaningful, cost-saving reforms.
- The HPC may also elect to conduct a CMIR of any CHIA-identified provider organization in lieu of, or in addition to, requiring a PIP if the HPC determines that the entity's performance has significantly impacted or is likely to significantly impact market functioning or the state's ability to meet the health care cost growth benchmark.
- Any PIP or CMIR recommendations will be presented at a future Board meeting for a vote.

Next Steps and Timeline for Performance Improvement Plans



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SAVE THE DATE

2016 HEALTH CARE COST TRENDS HEARING

October 17 and 18, 2016
Suffolk University Law School
120 Tremont Street

2016 Cost Trends Hearing

Key Action Steps

1. Invite and Confirm Expert Speakers
2. Distribute and Analyze Pre-Filed Testimony
3. Select Hearing Focus Areas/Panel Topics
4. Invite Panelists

2016 Cost Trends Hearing

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Topic of Discussion Today

We plan to discuss Action Steps 1 and 4 at subsequent meetings and would appreciate any feedback you may have in these areas.

2016 Cost Trends Hearing

Key Action Steps

2 Distribute and Analyze Pre-Filed Testimony

Goals

- Fulfill statutory obligation under Ch. 224
- Build on previous pre-filed testimony to track progress over time
- Inform staff presentations at the Cost Trends Hearing
- Obtain information for policy development and the Cost Trends Report
- Add information to the public dialogue

2015 Questions

- Health Care Cost Growth Benchmark
- Alternative Payment Methodologies
- Behavioral Health Integration
- Market Performance (Provider Price Variation, Out-of-Network Billing, Facility Fees)
- Transparency

2016 Hypothesis

Due to the large number of HPC asks this fall (ACO Certification, PCMH PRIME, RPO, etc.), staff recommends:

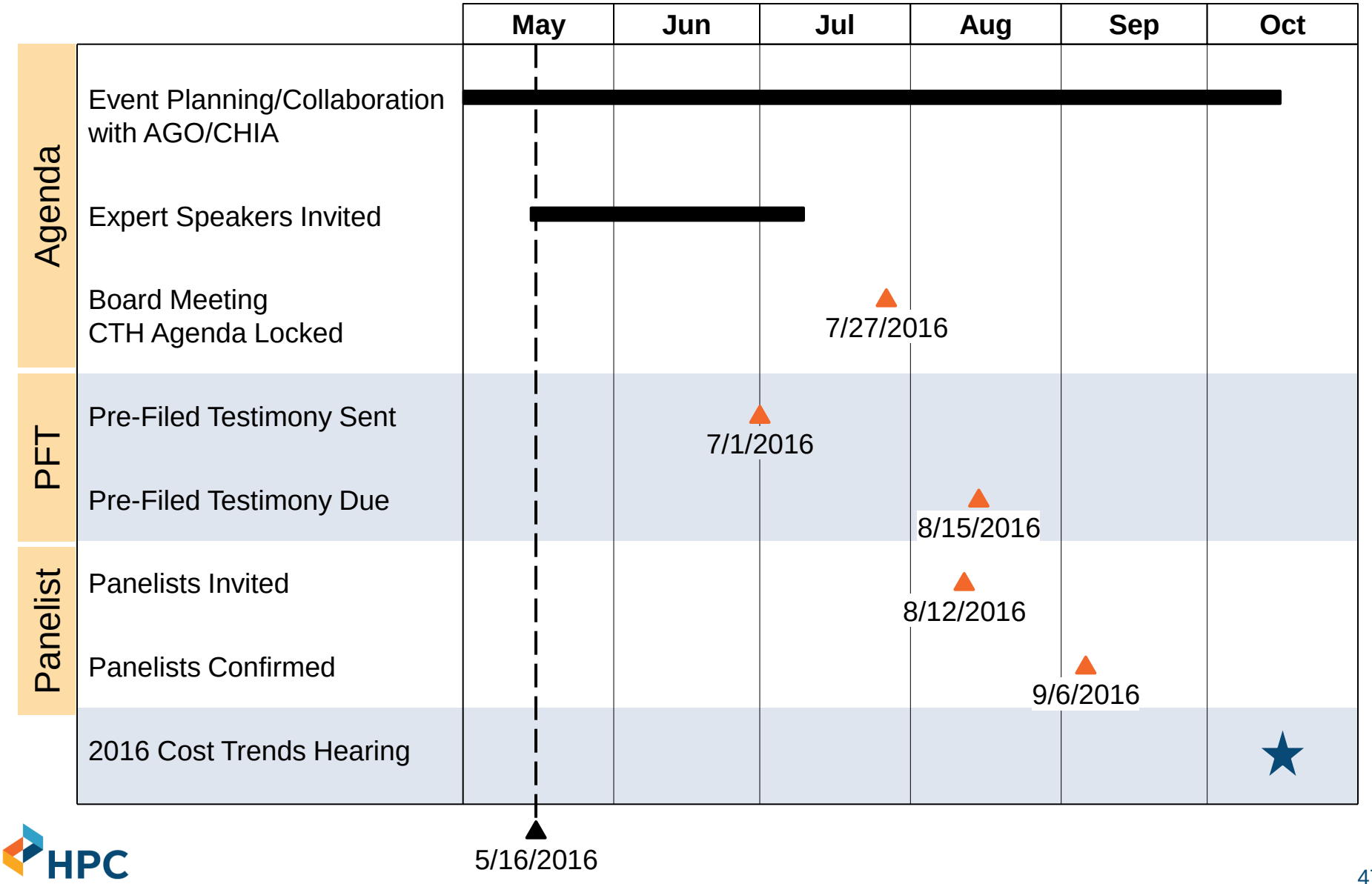
- Limited number of targeted, high-value questions
- Short answer/Check box instead of long narratives
- Pre-filed testimony released on July 1, 2016 instead of August 1.

Key Action Steps

3 Potential Hearing Focus Areas/Panel Topics – For Discussion

- Health Care Cost Growth Benchmark
- Pharmacy Spending
- Innovative Payment and Care Delivery Models
  - Discussion could include social determinants of health, behavioral health, community partners, technology
- Market Reviews/ACO Development
- Alternative Payment Methods
- Consumer Perspectives
- Serious Illness Care
- Community Hospital Study Follow-Up
- Opioid Epidemic
- Provider Price Variation

2016 Cost Trends Hearing



Contact information

For more information about the Health Policy Commission:

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