MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of April 24, 2013

MASSACHUSETTS HEALTH POLICY COMMISSION

THE HEALTH POLICY COMMISSION
McCormack Building
One Ashburton Place, 21st Floor
Boston, MA 02108

Docket: Wednesday, April 24, 2013, 9:30AM

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1. **Approval of the minutes from the March 12, 2013 meeting (APPROVED)**

2. **Report of the Committees**

3. **Presentation by the Attorney General's Office**

4. **HPC annual cost trends report: Approval of Timeline Process and Authorization of Executive Director to Compile Cost Trends Reports (APPROVED)**

5. **Mandatory nurse overtime guidelines (APPROVED)**

6. **Presentation by the Center for Health Information and Analysis**

7. **Process for Review of Notices of Material Change (APPROVED)**

8. **Executive Director Report: Commissioner Reimbursement Policy (APPROVED)**

Health Policy Commission
Presented below is a summary of the meeting, including time-keeping, attendance, and votes.

Date of Meeting: Wednesday, April 24, 2013
Beginning Time: 9:29AM
End Time: 12:48PM

Board Member	Attended	Item 1	Item 4	Item 5	Item 7	Item 8
		Approval of the minutes of the March 12, 2013 meeting	**HPC annual cost trends report**	**Mandatory nurse overtime guidelines**	**Process for review of notices of material change**	**Executive Director Report: Commissioner Reimbursement Policy**
Carole Allen	Yes	Yes	Yes	Yes (M)	Yes	Yes
Stuart Altman*	Yes	Yes (2nd)	Yes	Yes	Yes	Yes (M)
David Cutler	Yes	Yes	Yes	Yes	Yes	Yes
Wendy Everett	Yes	Yes (M)	Yes (2nd)	Yes	Yes	Yes
Paul Hattis	Yes	Yes	Yes (M)	Yes	Yes	Yes
Rick Lord	Yes	Yes	Yes	Yes	A	A
John Polanowicz	Yes	Yes	Yes	Yes (2nd)	A	A
Candace Reddy (Glen Shor)	Yes	Yes	Yes	Yes	A	A
Marylou Sudders	Yes	Yes	Yes	Yes	Yes (M)	Yes (2nd)
Veronica Turner	Yes	Yes	Yes	No	Yes (2nd)	Yes
Jean Yang	Yes	Yes	Yes	Yes	Yes	Yes
Summary	**11 members attended**	**Approved with 11 votes**	**Approved with 11 votes**	**Approved with 10 votes**	**Approved with 8 votes**	**Approved with 8 votes**

*Chairman
(M): Made motion; (2nd): Seconded motion; A: Absent

Proceedings
A regular meeting of the board of the Massachusetts Health Policy Commission was held on Wednesday, April 24, 2013, at the McCormack Building, One Ashburton Place, 21st Floor, Boston, MA 02108.

Commissioners present included Chair Stuart Altman; Dr. Carole Allen; Dr. David Cutler; Dr. Wendy Everett; Dr. Paul Hattis; Mr. Rick Lord; Mr. John Polanowicz; Ms. Marylou Sudders; Ms. Veronica Turner; and Ms. Jean Yang.

Ms. Candace Reddy participated in place of Mr. Glen Shor, Secretary, Executive Office of Administration and Finance.

Chair Altman called the meeting to order at 9:29AM and reviewed the agenda.

ITEM 1: Approval of the minutes from the March 12, 2013 meeting
Chair Stuart Altman initiated the meeting at 9:29AM. He solicited comments, additions, or corrections to the minutes from the March 12, 2013, Health Policy Commission meeting. Executive Director, Mr. David Seltz, noted a correction to a formatting error on page seven of the minutes. Following an observance of the correction, Chair Altman called for a motion to approve the minutes of the March 12, 2013, meeting. **Dr. Wendy Everett** made a motion to approve the minutes. After consideration, upon motion made and duly seconded by **Chair Stuart Altman**, it was voted unanimously to approve the minutes from the March 12, 2013, board meeting.

Voting in the affirmative were the 11 present commission members. There were no abstentions and no votes in opposition.

ITEM 2: Report of the Committees
Dr. David Cutler updated the Health Policy Commission on the status of the Cost Trends and Market Performance committee. He addressed two topics which were to be further discussed later in the meeting, including research topics for the cost trends report, and the process for the review of notices of material change. A third item which was in the process of being discussed by the committee, but which would not be addressed by the commission, included performance improvement plans.

Ms. Marylou Sudders updated the Health Policy Commission on the status of the Quality Improvement and Patient Protection committee. She reported that draft guidelines on mandatory nurse overtime had been created which would be reviewed and voted on later in the current commission meeting. The committee had also spent time discussing the transfer of the Office of Patient Protection from the Department of Public Health to the Health Policy Commission. Ms. Sudders noted that at the last committee meeting, the group had had discussions with the Division of Insurance (DOI) and with the Office of Medicaid and MassHealth (DMA) around the further integration of health care with behavioral health care, and that that issue would be discussed further as a central focus of the committee, with a new task force being created on the integration of physical health with behavioral health. DOI and DMA both have drafted regulations regarding this issue which have received

comments, and Ms. Sudders publicly commented that she would like to see the regulations in compliance with federal parity laws.

Dr. Carole Allen updated the Health Policy Commission on the status of the Care Delivery and Payment System Reform committee. She reported that the committee had hired Patricia Boyce as its new policy director. She then noted that the committee had held three listening sessions since the March 12, 2013, commission meeting jointly with the Division of Insurance regarding the certification process for risk-bearing organizations and the registration process for care delivery systems in an attempt to reconcile those two processes and find commonalities. Both the Massachusetts Medical Society and the Center for Health Information and Analysis (CHIA) had offered data in order to ease the process of information collection. The committee hoped to devise a registration process in a timely manner. On April 23, 2013, the committee met and discussed guidelines for Patient-Centered Medical Homes (PCMHs).

Dr. Paul Hattis updated the Health Policy Commission on the status of the Community Health Care and Consumer Involvement committee. He reported that a report on consumer-driven health plans had been published on April 1, 2013. Mr. Nikhil Sahni, Policy Director for Cost Trends and Special Projects with the Health Policy Commission, reported further on the details of the report. The report focused on the available literature where Massachusetts data was limited. It aimed to suggest areas for future research in a second report. These areas included better understanding the landscape in Massachusetts regarding these plans; comprehending the dynamics of intermediaries, including employers, payers, and brokers; and gaining further knowledge of provider organizations' considerations that are affecting consumers' decisions to switch providers based upon price. Chair Stuart Altman noted that the report had been both informative and timely. Dr. David Cutler commented that the report was balanced in reporting on high-deductible health plans. He noted that next steps could include gathering more Massachusetts-based data, and offering recommendations for the design of high-deductible health plans and under which circumstances they might be encouraged.

Dr. Paul Hattis then reported on the status of a second item, the one-time assessment on acute hospitals and surcharge payers. Mr. Nikhil Sahni reported that the commission staff had reached out and that every surcharge payer had been sent a Data Verification Form, with approximately 90-percent received at the time of the April 24, 2013, commission meeting. Data from the forms would be finalized by the week of April 28, 2013, and invoices would be sent to payers in the week of May 6, 2013. Payments would be due by June 30, 2013. For acute hospitals, Data Verification Forms were sent and 100-percent of forms were received by the commission staff by April 24, 2013. All invoices were sent to acute hospitals as of April 4, 2013. Acute hospitals would have until April 25, 2013 to submit a waiver or mitigation application, and the Community Health Care and Consumer Involvement committee would work with staff to review applications for mitigation. Staff would make recommendations regarding any applications to the commission on June 19, 2013, and payments would be due by June 30, 2013.

Dr. Paul Hattis then reported on the status of a third and final item, the Distressed Hospital Trust Fund, which would be funded by the one-time assessment on surcharge payers and acute hospitals. The Community Health Care and Consumer Involvement committee was beginning to discuss how it would use the funding, which may be up to $128 million minus mitigations, from the assessment to make grants to designated institutions, and was beginning to discuss the process it would use to grant funding to distressed hospitals as well as the purposes of the fund.

ITEM 3: Presentation by the Attorney General's Office

Mr. Chris Barry-Smith, Deputy Attorney General, initiated a presentation by staff members from the Massachusetts Attorney General's Office (AG) regarding a third cost containment report to be released in the late morning of April 24, 2013. He noted the prior release of two cost containment reports by the AG, each of which sought to illuminate market information in order to improve the functioning of the market. He discussed how the state legislature had responded to those reports and how now the information which had been released to the public in those reports was more common. The third cost containment report to be released by the AG was focused on the dynamic nature of the health care market, and on reporting market developments from the perspectives of providers, insurers, and buyers, including both employers and consumers. The report tried to identify the most imperative trends and to identify when trends are in tension, as well as to recommend ways in which the Health Policy Commission and other agencies might mitigate those tensions.

Mr. Thomas O'Brien, Assistant Attorney General, then presented regarding the cost containment report. He offered context regarding health care reform efforts in Massachusetts, beginning with health care access gains in 2006, through cost containment legislation in 2012. He discussed the AG's first two reports, noting that they identified various kinds of market dysfunction resulting in prices being paid in the commercial marketplace which are not tied to value. Due to legislative efforts since those reports, Mr. O'Brien noted that the third cost containment report did not revisit those same issues, but instead identified some positive efforts within the health care industry to promote change and to encourage rational decision making in the market. Similar to the two prior reports, the third report's methodology was based upon subpoenaed information which was confidential.

Ms. Courtney Aladro, Assistant Attorney General, continued the presentation in further detail along with Ms. Bela Gorman, Fellow of the Society of Actuaries. Ms. Aladro outlined that the AG's third report regards the activities of purchasers, health plans, and providers. In relation to purchasers, the office collected membership information and analyzed enrollment plans, finding that purchasers are increasingly moving to tiered and limited network products, and more so towards tiered network products. Purchasers have also increasingly moved towards PPO products. They are also moving away from fully insured HMO products. Simultaneously, enrollment trends are moving toward high deductible and other higher cost sharing products in exchange for lower premiums. From these findings, Ms. Aladro noted that it would be important to monitor enrollment trends and to examine

the factors that are underlying those trends as purchaser actions can significantly impact the actions of other actors in the market.

Ms. Aladro then discussed the cost containment report's findings regarding health plans, which have a very unique role in designing different health insurance products and different payment arrangements. In terms of payment arrangements, price variation persists in fee for service configurations. In addition, the report examined reimbursement under risk arrangements, and found that risk-based payments vary considerably as well. Ms. Gorman discussed comparisons of provider risk budgets made within the report, specifically focusing on the report's methodology. She highlighted the adjustments made to the budgets collected within settlement reports so that comparisons could be made across all groups. Ms. Aladro noted findings. She discussed significant variation across risk budgets, and across different payment arrangements available under risk budgets. The report also compared the medical spending of different practice groups within the same geography, which is important because provider groups located within the same geography are often located near the same secondary and tertiary centers for referrals and are often subject to the same business pressures. The report found that total medical expenditures (TME) vary across providers within specific geographic areas; vary across different geographic areas; and often vary within a system that might have local practice groups scattered throughout Massachusetts. She noted that the subject merits further analysis so that there could be more awareness regarding what TME looks like across the state.

Ms. Aladro then touched upon the report's findings on product design, which can affect purchaser enrollment and provider performance. In analyzing performance, the report examined health status, utilization rates, as well as TME. The report specifically focused on examining high cost sharing versus low cost sharing products, tiered or select networks versus broad networks; and risk versus non-risk contracts. Ms. Gorman discussed methodological processes, noting that the AG focused on cost containment strategies which insurance carriers employ to have some kind of impact on both TME and trend. She noted that the focus in examining the data was on comparing high-deductible versus low-deductible plans. Ms. Aladro further discussed findings, noting that healthier consumers were more attracted to high cost sharing products. Findings also indicated, however, that although consumers in higher cost sharing products were healthier across three major health plans, their health status adjusted TME was actually higher. This did not necessarily indicate that the products were not working as they should be as the data collected only reflected information from a single year. Rather, the AG would continue to monitor and assess the impact of different product designs on health care spending.

Ms. Aladro addressed providers, whose role in the market is to deliver care, and whose decisions are shaped by the quality of their own performance in delivering that care; by their capacity to manage the impact of broader population changes and other exogenous factors that affect care delivery, particularly under a proliferation of global risk contracts; and by their ability to obtain market share, maximize revenue, and by other business risk considerations. Between 2008 and 2012, there has been a proliferation of risk contracts, and it is important to examine how these risk contracts are adjusted to protect providers from factors outside their control. The AG's cost containment report studied adjustments to

risk budgets as well as other risk mitigation approaches. Adjustments were found to be heavily negotiated, to vary contract by contract, and to result in significant differences in dollars available to protect providers from changes in the health status of a population. Other approaches to mitigate exposure to extraordinary claims expenses are not used consistently by health plans and providers, and can affect the solvency of provider organizations. Providers are also aligning and consolidating in different ways, and these alignments must be measured and monitored.

Ms. Aladro finally addressed the last section of the AG's report, which suggests recommendations for three regulators to address some of the market tensions found in the report. The AG made recommendations for the Health Policy Commission related to the implementation of Cost and Market Impact Reviews and to the implementation of registration of provider organizations. The AG made recommendations to the Center for Health Information and Analysis (CHIA) related to reporting requirements sufficient to monitor the performance of health insurance products. And the AG made recommendations to the Department of Insurance (DOI) related to the certification of risk bearing provider organizations.

A period of questions by the commissioners to the staff of the Attorney General's Office was initiated. Dr. Paul Hattis asked if the AG does comparisons within the report between the risk side and PPO side on a per member per month basis, or between globally paid groups and fee for service paid groups. Ms. Aladro noted that the report identifies which providers are under global risk contracts and which providers are their PPOs. Mr. O'Brien added that the purpose of the report was not to highlight that unexplained variation exists in the market, but rather to highlight the complexity that providers face, whether they take global payments or not, because they're managing different streams of revenue and the purchasers are making decisions that are towards PPO and self-insurance.

Dr. David Cutler asked whether the results of the report should be read positively or negatively and what action steps are indicated by the report. Mr. O'Brien noted that the report is part of an evolving process. The report indicates a positive demand side with employers taking action. He noted that progress could be derailed if tension arises between incentives and alignments that might reduce consumer-employer options as far as how the demand side is currently operating.

Chair Stuart Altman noted that after hearing the market summary, it seemed as if the market is moving in two directions: tiered networks and high-deductible plans which are more sensitive to price versus dropping HMO coverage in favor of PPO coverage, which he identified as essentially fee for service in a modified form. He asked which weight was stronger. Ms. Aladro noted that many PPO products in Massachusetts are in fact high-deductible products. Mr. O'Brien also highlighted that the move to high-deductible plans is moving faster with risk contract populations; that there is a coupling of high deductible and HMO products; and that there are many ways to approach or examine the data which the AG collected.

Ms. Jean Yang asked if the charts presented at the meeting were also examining the differences between budget and TME such that a provider could have a high budget but good efficiency and profitability. Ms. Aladro noted that the budgets in the charts did not reflect TME.

ITEM 4: HPC annual cost trends report

Mr. Nikhil Sahni, Policy Director for Cost Trends and Special Projects with the Health Policy Commission, and Ms. Marian Wrobel, Director of Research with the Health Policy Commission, presented to the commission regarding current and ongoing activities surrounding the statutorily required annual cost trends report.

Mr. Sahni noted that Health Policy Commission staff were currently on track to meet outlined timeline goals for the cost trends report. Staff were currently developing key metrics and guiding questions for the report as per sections 1 and 2 of a structured timeline. According to the Chapter 224 statute, there are required outputs and data inputs for a cost trends report. Outputs include outlining spending trends and their underlying trends; generating recommendations for strategies to increase efficiency; and composing the legislative language necessary to implement those recommendations. Data inputs for the report would include testimonies from October 2013 hearings; registration data; data from the Center for Health Information and Analysis (CHIA); and any additional data necessarily required to fulfill the duties of reporting.

Chair Stuart Altman interjected that the primary function of AG and Health Policy Commission reports would be to make available to the public information regarding trends and movements in the health care system. The AG has completed that duty in three reports and the Health Policy Commission would add a fourth to the series. He requested that because the reports are also meant to incite change in the system, that information from prior reports would also be used as data inputs in the cost trends report. Both Mr. Sahni and Ms. Wrobel affirmed that past reports would be used in the creation of the Health Policy Commission's cost trends report.

Mr. Sahni continued his presentation, discussing the four research topics with which the commission cost trends report would engage this year. He noted that the report would first serve to establish credibility, particularly in terms of methodology, with the hope that data sets would result in expected values.

Dr. Cutler asked if it would be able to be determined if the 3.6% benchmark would be hit by the fall of 2013. Mr. Sahni responded that the best data source would be the October 2013 hearing testimonies, while Ms. Wrobel noted that CHIA would also offer forward-looking information regarding premiums in the coming year based upon what has been recently seen.

Mr. Sahni then discussed the topics of research for the 2013 cost trends report. Within the first section, "Setting baseline," topics included descriptive statistics; the decomposition of total health care expenditures, including the components of price, quality, and provider mix;

access and quality, in terms of provider access as well as geographical access; and market evolution and the current market landscape.

Ms. Marylou Sudders asked how access could be fully assessed without including an assessment of service mix. Ms. Wrobel addressed this concern by noting that the Health Policy Commission staff envisions a research agenda unfolding over multiple years that would give the ability to become more and more detailed in analysis. She said that the staff could measure the number of episodes of a particular condition, and that in terms of service mix, they would need an analytical setup in which the numbers of specific episodes, and then services within episodes, could be examined. The staff are interested in service mix and believe it will tie into payment innovation, but realistically won't be able to examine it in the 2013 cost trends report. Within the 2013 cost trends report, provider mix, quantity of services, and the prices of those services would be examined and analyzed.

Mr. Sahni then discussed research topics within the second section of the report, "Uncovering drivers." Topics included care for the costliest patients, which would employ the All Payer Claims Database (APCD) to find descriptive trends and later target recommendations; waste in the system, including both underuse and overuse as well as administrative costs within the whole system; the impact of market changes, including how material changes in the market are affecting price and other items in the system; and provider cost structure, including understanding finances and costs, the differences in these, and resultant differences in TME.

Chair Stuart Altman cautioned the staff and other commissioners about scrutinizing "waste in the system" as a topic of research too thoroughly. He noted that the terms waste, fraud, and abuse are all different, and that waste is often a subjective term. Dr. Paul Hattis then discussed his overall vision for the second section of research within the report. He hoped that the "Uncovering drivers" section would focus on care redesign as well as sustainability. Mr. Sahni then noted that the findings of this section would assist in the administration of the competitive grant program in terms of directing the targeting of resources towards meeting the cost growth benchmark and delivering higher quality care.

Ms. Wrobel commented on the issue of the term "waste," saying that in an ideal sense, the definition is the difference between optimal care and the care that is currently in place or care that is less than optimal.

Dr. Carole Allen asked if the cost trends report would focus not only on trends in the short term but also on trends in the long term. Ms. Wrobel said that having a base methodology, which was reviewed, staff would follow up with each commissioner to consult. She also noted that within the research items of quality and access, staff hoped to create space for important or special interest items.

Dr. Cutler commented that one of many other reports' categories of waste is also underuse, and that that should be taken into account by the commission. Mr. John Polanowicz asked if routine care delivered in expensive settings would also be considered as waste. Ms. Wrobel responded that in the decomposition of total health care expenditures, the staff hoped,

even in the first year's report, to do some work to cover the changing locus of care over the study period and how much that drives cost changes. She said the methodology being employed was still expanding and in process.

Mr. David Seltz made additional comments regarding the interrelated nature of the commission's activities. He noted that the cost trends report would shed light on changes in the market and on alignments and referral patterns. He also commented on the continued work of the report on consumer-driven health plans for which initial research had been completed. He also highlighted its alignment with the AG's report.

Mr. Sahni further discussed timing for three upcoming cost trends reports to be released by the end of 2014 by the Health Policy Commission. Reports would be released in December 2013 and December 2014. An additional report would be released in the summer of 2014 to update the December 2013 report once CHIA released data on total health care expenditures for 2012. Mr. Seltz and Ms. Jean Yang both expressed enthusiasm for the expected research agenda and utilization of data from the APCD. Ms. Yang also asked if there was an option to find information more updated than 2011 for the December 2013 report. Mr. Sahni said the staff was still exploring usable data sources, and that forward-looking CHIA reports might be useful.

Mr. Seltz called a vote on the question of whether to approve the proposed timeline process on the initial topics of research for the annual cost trends report as well as to authorize the Executive Director to move forward on compiling such reports as required by Chapter 224. **Dr. Paul Hattis** made a motion to approve the proposed timeline process and research agenda and to allow authorization for the Executive Director to compile the reports. After consideration, upon motion made and duly seconded by **Dr. Wendy Everett**, it was voted unanimously to approve the proposed timeline process and research agenda and to allow authorization for the Executive Director to compile the reports.

Voting in the affirmative were the 11 present commission members. There were no abstentions and no votes in opposition.

ITEM 5: Mandatory nurse overtime guidelines

Ms. Marylou Sudders opened the discussion regarding proposed guidelines for mandatory nurse overtime by announcing a public hearing for the draft guidelines to be held on Friday, April 26, 2013, at 9:00AM in Gardner Auditorium.

Ms. Sudders explained that Chapter 224 specifically abolishes mandatory nurse overtime and requires that the Health Policy Commission develop guidance on the definition of what constitutes an emergency requiring mandatory nurse overtime. In February, the Quality Improvement and Patient Protection committee held a listening session to receive feedback and comments regarding mandatory nurse overtime. The subcommittee also reached out for and received perspectives on the subject from many; researched all other states with statutes and regulations around mandatory nurse overtime; and read all existing collective bargaining agreements employing such language. The ultimate purposes of the commission's guidelines would be to ensure patient safety; to prohibit the use of mandatory

nurse overtime except in extraordinary circumstances; and to prevent mandatory nurse overtime from being used as a staffing strategy at hospitals.

Ms. Lois Johnson, General Counsel with the Health Policy Commission, then reviewed the proposed draft guidelines. Ms. Johnson began by saying the role of the Health Policy Commission with respect to mandatory nurse overtime is very specific, such that the law requires the commission to develop guidelines and procedures to determine what constitutes an emergency situation for the purposes of allowing mandatory nurse overtime. The statue prohibits mandatory nurse overtime except for in defined emergency situations.

In developing guidelines, the Health Policy Commission was required to consult with employers and employees who would be affected by such a policy and to solicit comment from those parties for a public hearing, which would occur on Friday, April 26, 2013, at 9:00AM. At a February listening session, there was significant attendance by members of labor unions, by hospital workers, and by members of community organizations. Based upon other states' statutes and collective bargaining agreements which had been reviewed, there was a consensus on the goals of the statute. These goals were that mandatory nurse overtime should not be used for staffing shortages; that consideration must be given to emergencies that are unforeseen both internal and external to a hospital; and that there would be efforts by hospitals working with nurses on staff to prevent the need for the use of mandatory nurse overtime in the first place to fill vacant shifts.

The proposed guidelines define an emergency situation for the purpose of allowing mandatory nurse overtime under Chapter 226 under the law as an unforeseen event that could not be prudently planned for or anticipated by a hospital and which affects patient safety in the hospital and where there is a: government declaration of an emergency; catastrophic event; or patient care emergency. The guidelines make clear that mandatory nurse overtime shall not be ordered in the case of an emergency situation where there is a reasonable alternative to such overtime. Where an unexpected vacancy occurs despite a hospital's implementation of a reasonable alternative, the hospital is required to exercise a good faith effort to fill the shift on a voluntary basis.

Relying on testimony received and looking at examples from other states, further definition was composed around each emergency event, both internal and external to a hospital. Additionally, the guidelines elaborate on and give examples of what constitutes a "reasonable alternative" and "good faith effort."

The statute provides that any instance of mandatory nurse overtime be reported to the Department of Public Health (DPH). The proposed guidance includes an effort by the Health Policy Commission to monitor that implementation by reviewing reports submitted to DPH of instances of mandatory nurse overtime mandated by hospitals. The Health Policy Commission may review the guidelines for mandatory nurse overtime in each annual report to determine whether changes should be made to the guidelines and procedures in accordance with the purposes of the law.

A period of questions and answers was initiated by the Health Policy Commission.

Dr. Wendy Everett asked Mr. John Polanowicz about DPH's work surrounding the reporting of mandatory nurse overtime. Mr. Polanowicz noted that DPH would be working with stakeholders to make reporting processes consistent for mandatory nurse overtime and that collection processes would be determined permanently within the context of final guidelines. Dr. Everett suggested that the commission discuss at the June 19, 2013, board meeting whether DPH reports should be reviewed more often than annually. Ms. Lois Johnson noted that because DPH reports are public record, that commissioners would be able to access them at any time once filed and posted.

Ms. Veronica Turner asked if there was a set definition under patient care emergency for determining a patient care emergency. She also noted that she would argue under existing collective bargaining agreements that the terms "reasonable alternative" and "good faith effort" are already available to hospitals. Ms. Lois Johnson noted that a patient care emergency is defined by the proposed guidelines as an unforeseen event which could not be prudently planned for and which would require continued nurse care. The determination of a patient care emergency, as defined by the guidelines, would be made by the chief executive officer or designee of a hospital, and the guidelines further define types of patient care emergencies that are and are not allowable. Ms. Johnson noted that many like guidelines and collective bargaining agreements had been reviewed which speak to the issue of how overtime and mandatory nurse overtime could be implemented in hospitals. Where those agreements are not in place this guidance seeks both reasonable alternatives to mandatory nurse overtime in the first place and to reasonable coverage if there is an emergency.

Dr. Paul Hattis asked a question regarding timing and at what point an emergency situation begins to exist. Ms. Lois Johnson noted that for the first kind of designated emergency situation, a government declaration of emergency, a government official or body would determine the existence of an emergency situation. For the second and third emergency situations, catastrophic events and patient care emergencies, respectively, a hospital's chief executive officer or designee would make the determination regarding the existence of an emergency situation. Ms. Johnson went on to say that determinations were situational and would require fact-based and reasonable determinations for each circumstance. The guidelines provide for a designation to happen, but only when patient care is in fact affected within that institution such that the situation wasn't reasonably foreseen or anticipated.

Ms. Johnson called a vote on the proposed draft guidelines for mandatory nurse overtime. **Dr. Carole Allen** made a motion to approve the proposed draft guidelines for mandatory nurse overtime. After consideration, upon motion made and duly seconded by **Mr. John Polanowicz**, it was voted to approve the proposed draft guidelines for mandatory nurse overtime.

Voting in the affirmative were ten commission members. There were no abstentions. Ms. Veronica Turner voted in opposition to the proposed draft guidelines for mandatory nurse overtime.

ITEM 6: Presentation by the Center for Health Information and Analysis
Mr. Aron Boros, Executive Director at the Center for Health Information and Analysis (CHIA), presented to the Health Policy Commission regarding the aggregate work of CHIA as well as how that work fits in the with the framework of the Health Policy Commission.

CHIA is becoming a hub for data and analytics. The Chapter 224 legislation provided for relationships between state agencies, including CHIA, the Health Policy Commission, and the Attorney General's Office. There are three significantly linked areas between CHIA and the Health Policy Commission within the Chapter 224 legislation. First, the health care cost growth benchmark, for which the commission is responsible, and the calculation of total health care expenditures, for which CHIA is responsible. Second, the annual cost trends analysis and hearings, including the December report and hearings for which the commission is responsible, and an annual report for which CHIA is responsible. And third, provider organization registration, about which CHIA has initiated discussion with HPC staff regarding administration.

CHIA is charged with calculating total health care expenditures, and will have data regarding 2011 in the late summer of 2013. This calculation is a new concept in Chapter 224, and CHIA has not determined total health care expenditures prior. The total health care expenditures calculation has three components within the statute. First, all categories of medical expenses and non-claims related payments to providers as included in the health status adjusted total medical expenses are included. CHIA has been using health status adjusted total medical expenditures for several years to calculate trends in certain subsets of the market and is now using it to calculate trends within the entire market. A second component is patient cost sharing, including deductibles and copayments. And a third component is the net cost of private health insurance. For this component, CHIA will rely upon its relationship with the Department of Insurance (DOI), using its authority in Massachusetts on the subject of the cost of health insurers.

CHIA's approach to developing a methodology for calculating total health care expenditures is twofold, employing both accuracy and credibility. In terms of accuracy, CHIA will look at data-driven models, at quality-assurance protocols, and will look towards technical support, particularly from actuaries. In terms of credibility, CHIA will strive for transparency; will seek to engage stakeholders, researchers, academics, and state agencies; and will go through a process of publishing a series of working papers to various parties through public processes with the goal of producing a methodology document by year's end.

For the methodology itself, CHIA's goals include permitting a macro-level analysis, but also promoting micro-level analysis. It is anticipated that the results of analyses will be actionable.

The data sets from which CHIA is drawing include total medical expenditures (TME) and the All Payer Claims Database (APCD). TME is a mature dataset including aggregate data and non-claims data. It is reported to CHIA at about five months once plans have a view of the

claims experience, and again at 17 months, to get a final reconciliation of both the claims and non-claims experiences.

The APCD includes very granular data as it is constructed of actual claims submitted by insurers. It allows for more specific analysis regarding access, disparities, waste, and how care is being organized. However, there is a much longer timeline for that data to become available. Data is received on a rolling basis from 120 different carriers and the target for transforming the raw information into a polished dataset is about 12 months after the close of the calendar year. Over the next 18 months to two years, CHIA hopes to transform the 12-month lag into a much shorter lag time so that the data can be used for more specific purposes.

Additional data sources include sets from Medicare, the Department of Insurance (DOI), actuarial estimates, and estimates of the uninsured.

Mr. Boros then reviewed a timeline of anticipated reports to be released by CHIA. A summer report is to be published in August 2013. The 2011 APCD data will become available in the summer and will not be included in the summer report. A December draft methodology will be released in December 2013. Between the summer and December reports, CHIA will be working with the Health Policy Commission on issue briefs around the cost trends reports and understanding how to coordinate regarding those. In September 2014, data from 2012 to 2013 will become available.

Dr. David Cutler noted that the Cost Trends and Market Performance subcommittee might need a broader process, working in tandem with the Department of Health and Human Services, because some of the data available misses the deadlines in the law. Dr. Cutler said CHIA's suggestions should be taken and that data should be examined to either see where or if it might be supplemented, or if recommendations should be made to the legislature that timelines cannot be met as listed in Chapter 224 due to missing data.

Ms. Jean Yang echoed Dr. Cutler's point, suggesting that the Health Policy Commission complete a thorough readiness assessment regarding the availability and timeliness of current data.

Mr. David Seltz commented that the Chapter 224 statute had envisioned a partnership between CHIA and the Health Policy Commission and that it is CHIA's responsibility to calculate total health care expenditures while the Health Policy Commission completes activities regarding meeting cost growth benchmark goals, such as determining performance improvement plans and creating recommendations for strategies in order to meet the benchmark over time. He highlighted the commission's shared interests with CHIA and the importance of collaborative work.

Chair Stuart Altman discussed the emphasis which many would put on meeting the health care cost growth benchmark. He also requested that in light of CHIA's unique position in the data and analytics realm that Aron and the center report back to the commission again

and continue to work with Dr. David Cutler and the Cost Trends and Market Performance committee.

ITEM 7: Process for review of notices of material change

Mr. David Seltz noted that since the last commission meeting, a notice of material change had been received by Health Policy Commission staff. The Health Policy Commission and its staff now needed to determine a process for review and for initiation of cost and market impact reviews (CMIRs). A process had been endorsed by the Cost Trends and Market Performance committee at its meeting on April 23, 2013.

Ms. Karen Tseng, Policy Director for Market Performance with the Health Policy Commission, presented on the proposed process. She noted that staff had wanted to ensure that there is a consistent process in place to review notices in a timely manner. She began by reviewing the statutory context for CMIRs.

There are three major responsibilities around understanding the provider market found in Chapter 6D, the commission's governing statute. The first major responsibility is the registration of provider organizations, a program to bring first-in-the-nation transparency to provider organizations' composition and structure in a registration process which occurs once every two years. The second responsibility is a flexible, transparent, and ideally electronic structure for receiving notices of material change. These notices would provide a real time update to the provider organization registry, as registration only occurs once every two years otherwise. The third responsibility is the initiation of CMIRs, by which a small subset of notices is more thoroughly examined.

The statute regarding CMIRs calls for a more thorough, comprehensive, and multi-factor evaluation of a proposed material change. There are three triggers for a CMIR. First, if the material change is likely to have a significant impact on the meeting of the state's cost growth benchmark. Second, if the transaction were to have a significant impact on the competitive market. Third, if there is a year in which the benchmark is exceeded and the Center for Health Information and Analysis (CHIA) identifies the activities of certain providers and payers as contributing to that excessive growth then the Health Policy Commission could initiate a CMIR on those entities. This third trigger would not apply, however, until approximately 2016. The end goal of the CMIR process is a transparent report. CMIRs are not law enforcement or antitrust. They also differ from the Department of Health's Determinations of Need. CMIRs may overlap or be parallel to those particular actions, but it is important to distinguish them as unique.

Dr. Wendy Everett asked if Ms. Tseng could discuss CHIA's role in the CMIR process, particularly in light of the fact that much of the available data is not current. Ms. Tseng responded that the measurement of total health care expenditures by CHIA would impact the third trigger and that the hope would be that the timeframe for obtaining data would be shortened in future years.

Chair Stuart Altman commented that the first two triggers noted by Ms. Tseng seemed anticipatory while the third trigger seemed retroactive. In the case of the first two triggers

for a CMIR, the Health Policy Commission would try to anticipate what the implications are of a material change in relation to competition and inflation without exact knowledge of that event. Ms. Tseng responded that a proposed transaction is not entirely unknown when a notice is provided to the commission, and that some information, including identified contractual relationships, and whose prices will be charged and in what context, would be known when a notice was filed. Those results are already measurable when a notice is given, so the decision to proceed with a CMIR is not entirely anticipatory.

Chair Stuart Altman and Dr. David Cutler commented that in the case of antitrust situations, "promises" are not accepted from organizations while CMIR might go on the word of organizations. The third trigger does require real data to determine the effects of organizations' activities, but may always be taking action retroactively. Ms. Tseng responded by saying that the third trigger trends towards examining activities that have already occurred and is in that way looking backward. In the future, CMIRs initiated based on the third trigger would be used to shed light on prior activities for public knowledge and the purposes of producing transparency, to inform how they should be handled in future should they recur.

Ms. Karen Tseng then addressed the guiding principles for the CMIR process. The proposed process involved a timely review of notices as they come in, and a process for initiating CMIRs. Notices must be reviewed in a timely manner, in no more than 30 days, in a preliminary review process. If any CMIR is to be initiated, this notice must be given to providers no more than 30 days after a provider's notice was initially filed. To be consistent with the requirements of the Open Meeting Law, the ability to timely review notices at the board level is constrained, with a recommendation that commissioners review and establish a set of criteria that staff may implement in their ongoing and timely review of notices. The review of notices would include Commissioner feedback.

Dr. Wendy Everett asked if commissioners knew of a material change for which no notice had been given, if they had an obligation to report that change. Ms. Lois Johnson said that there was no explicit statute regarding that, but that the statute asked that notice be given no later than 60 days before the close of the transaction to the commission. She also stated that commissioners were allowed to share knowledge of activities in the market with staff.

Ms. Tseng proceeded to address a proposed timeline for the CMIR process. A notice would first come in to the Health Policy Commission. Staff would post the notice to the website and transmit the notice to all commissioners. A space of time no more than 21 days would be allowed for commissioners to review and give feedback or comments regarding the notice to the commission chair and to the Cost Trends and Market Performance committee chair. Staff would review each notice according to standardized criteria.

Chair Stuart Altman asked that comments directed to the commission chair and committee chair also be made available to the Executive Director, Mr. David Seltz, so that there was a single repository for all commissioners' comments regarding any notice. He also brought up a comment regarding the initiation of CMIRs and two scenarios in which CMIRs might be neglected or proposed, respectively. Chair Altman noted that in certain cases, after staff

had reviewed the commissioners' comments, they may decide not to initiate a CMIR, 30 days would lapse without a board meeting, and the commissioners would not have an opportunity to review the notice again. He also noted that in certain cases, the staff might decide to initiate a review and propose the initiation of a CMIR to the commission at a full board meeting, in which case commissioners could overrule the staff or a minority of commissioners.

Dr. David Cutler noted that the 21-day turnaround for the review of notices by commissioners was too long within the timeline, and that there needed to be a shorter turnaround by commissioners in terms of providing feedback.

Ms. Jean Yang asked if staff would prepare short reports for commissioners regarding notices on which no action was taken because 30 days had lapsed and staff did not initiate or propose a CMIR. Ms. Tseng made a preliminary recommendation indicating that the provider organization registry is a critical component of Health Policy Commission activities in the long term and would bring market-wide notice, while CMIRs are deep-focused reviews. Depending upon how final regulations are composed, the process could function as a real time update on notices. However, there was no real guidance as of yet for staff regarding the extent of reporting back to commissioners regarding every notice.

Chair Stuart Altman urged staff to review as many notices as possible and to send notices to the commission, even if the commissioners subsequently decided not to initiate a CMIR. Otherwise, after the 30 days lapsed, the particular transaction in question would no longer be reviewable.

Mr. David Seltz responded that staff may let the 30 days lapse even with transactions that have impact on cost and market because staff members would need to focus more so on the transactions which have the most impact on those factors, not necessarily on every transaction.

Chair Stuart Altman noted that under one set of circumstances, there would be two opportunities to review the transaction, while under the other set of circumstances, there would be only one opportunity for review. He identified that some commissioners might have special interests that could be raised by particular material changes and that those interests should be honored, even if a CMIR does not go forward.

Ms. Tseng noted that the statute is clear that initiation of reviews requires significant notice back to a provider organization. The commission and staff need to be clear in laying out the basis for review, factors, and initial documentation. The proposed process was developed in close consultation with each commissioner on the Cost Trends and Market Performance committee, and she recommended that the commission and staff move forward in a balanced way.

Dr. Wendy Everett echoed Chair Stuart Altman's comment regarding his recommendations for staff reviews. She noted that at least for the first few months of receiving notices, as the staff and commissioners still learned and adjusted the process for initiating CMIRs, that

the staff trend towards more reviewing and reporting. She also suggested that rather than creating separate reports on each lapsed notice, the staff create a simple list of lapsed notices to present to commissioners at each board meeting to summarize current findings and decisions.

Chair Stuart Altman reiterated his prior comments, noting that while the staff and commissioners were still learning and adjusting the process for CMIRs, that staff lean towards review and presenting to the full board unless a clear statement is made otherwise.

Ms. Lois Johnson discussed how the statute imbues the commission with the authority to initiate a CMIR and to shut a CMIR down. She noted that initiating a CMIR entails a fairly substantial amount of work in identifying factors, documents, and information to seek from a provider organization. She indicated that she wanted to be clear that when the staff does initiate a CMIR, that they intend to conduct a very serious, thoughtful review, and only in circumstances in which a significant impact is indicated.

Chair Stuart Altman agreed that the process was not trivial and that CMIRs would not be taken on lightly, nor interventions casually. Dr. Paul Hattis asked for clarification regarding the process as to whether commissioners could turn off the process but only staff could initiate a CMIR. He then asked if there could be some kind of stipulation or amendment included in which commissioner feedback could also initiate a CMIR.

Dr. David Cutler noted that commissioners might have less of a challenge with the CMIR initiation process and more of a challenge with selecting criteria for review within a CMIR once a review has been initiated.

Ms. Tseng then continued to review the CMIR timeline. She noted that during the initial review period, substantive back and forth with any interested commissioner would occur. In some cases, the initiation of a CMIR would result from this process. At the first regularly scheduled commission meeting after that point, the Executive Director would present any proposed CMIRs. The commission would need to vote to either endorse or to not endorse the continuation of the CMIR. The commission would also need to customize the CMIR to each case. A CMIR would include the gathering of facts, the reviewing of facts, consultation with providers, and the engaging of stakeholders and other market participants. A preliminary report would then be generated and given to the provider for feedback, as well as to commissioners. Key stakeholders would also be allowed the opportunity for comment. Staff would incorporate both stakeholders' and commissioners' comments. The full commission would then receive a final report in advance of the next commission meeting, at which time the final report would be voted on.

Chair Stuart Altman shared concern that provider information be divulged too soon or in too much detail. He cautioned that staff would need space to sort through information appropriately. In response, Ms. Tseng discussed the timeframe for collecting documentation and information from providers. The statute requires that providers be allowed at least 30

days to give written feedback on the preliminary report. After comments are received by the commission staff, several weeks are budgeted for staff to incorporate comments.

Dr. Paul Hattis then requested that Mr. David Seltz review for the public audience as well as for the purposes of potential amendment the bullet points distributed to commissioners within Policy 2013-01: Process for Review of Notices of Material Change. Under "A. Process," Mr. Seltz read eight bullet points.

Mr. David Seltz recommended an amendment to the second bullet so that comments might also be submitted not only to the commission and committee chairs, but also to the executive director of the commission, as per Chair Stuart Altman's earlier comments.

Dr. Paul Hattis recommended an amendment to the third bullet point so that it include "staff analysis and input from commissioners tied to criteria."

Dr. Paul Hattis recommended an amendment to the seventh bullet point so that comments might also be submitted not only to the commission and committee chairs, but also to the executive director of the commission, as per Chair Stuart Altman's earlier comments.

Chair Stuart Altman called a vote to adopt the proposed policy on cost and market impact reviews. **Ms. Marylou Sudders** made a motion to approve the proposed policy. After consideration, upon motion made and duly seconded by **Ms. Veronica Turner**, it was voted to approve the proposed policy.

Voting in the affirmative were the eight present commission members. There were no abstentions or votes in opposition.

ITEM 8: Executive Director Report

Mr. David Seltz briefly reported on a policy to be voted on regarding reimbursements for commissioner expenses. While members of the Health Policy Commission are unpaid, the law states that they may be reimbursed for expenses incurred during Health Policy Commission-related activities. The bylaws call for commissioners to vote on a reimbursement policy. The proposed policy is similar to those policies in place for similar public agencies in that it is limited, focused, and accountable.

Chair Stuart Altman called a vote to adopt the proposed policy on reimbursement for commissioner expenses. **Chair Stuart Altman** made a motion to approve the proposed policy. After consideration, upon motion made and duly seconded by **Ms. Marylou Sudders**, it was voted to approve the proposed policy.

Voting in the affirmative were the eight present commission members. There were no abstentions and no votes in opposition.

Chair Stuart Altman adjourned the meeting at 12:48PM.

LIST OF DOCUMENTS PRESENTED AT AND POSTED AFTER THE MEETING

1. Meeting Agenda, 4/24/2013
2. Minutes of 3/12/2013 Health Policy Commission Meeting
3. Committee Presentation
4. Attorney General's Office Presentation
5. Center for Health Information and Analysis Presentation
6. Process for Review of Notices of Material Change