HEALTH POLICY COMMISSION
Meeting Minutes

Tuesday, December 18, 2012
12:00 PM to 2:30 PM
Suffolk University, Rosalie K. Stahl Building
73 Tremont Street, 9th Floor
Boston, MA 02108

Attendees: Stuart Altman (Chair), Carole Allen, JudyAnn Bigby, David Cutler, Wendy Everett, Paul Hattis, Rick Lord, Marylou Sudders, Veronica Turner, Jean Yang, Candace Reddy (designee).

The meeting was called to order at 12:00 PM.

I. **Welcome:** Dr. Stuart Altman greeted the board and the audience and noted that with Secretary Jay Gonzalez and Secretary JudyAnn Bigby leaving the Patrick administration, they would also be leaving the Health Policy Commission (HPC). Candace Reddy, Director of Health Care Finance for the Executive Office of Administration and Finance (ANF), represented Sec. Gonzalez at the meeting as his designee.

Given Governor Deval Patrick's recent appointments, Dr. Altman noted that Mr. Glen Shor and Mr. John Polanowicz would soon be joining the Commission.

II. **Adoption of Minutes from November 16th Board Meeting:** By unanimous vote, the board approved the minutes of the previous meeting.

III. **Executive Director:** Dr. Altman explained that as directed by Chapter 224, the full board is required to select an Executive Director. The subcommittee of Dr. Altman, Dr. Everett, Dr. Hattis, and Mr. Lord, was convened at the first meeting to collect and review applications. Dr. Altman noted that 16 applicants were fully qualified. Three applicants were interviewed of that pool.

The subcommittee agreed unanimously to recommend Mr. David Seltz to the full board, with subcommittee members Dr. Altman, Dr. Hattis, and Mr. Lord endorsing Mr. Seltz's qualifications.

By unanimous vote, the board approved the appointment of Mr. Seltz as Executive Director.

Mr. Seltz thanked the board and remarked on the mission and challenges facing the HPC and his role as Executive Director, highlighting the responsibility for the HPC to ensure access to mental health care services for all Massachusetts residents.

IV. **Adoption of HPC By-Laws:** Mr. Seltz provided an overview of the by-laws, providing further guidance around the operations of the board and commission. A draft copy of the by-laws,

modeled after the Commonwealth Connector Authority's by-laws and a number of different boards, was distributed at the previous meeting. During the overview, Mr. Seltz covered the by-laws' following components: The HPC's office and seal, location of records, and fiscal year; board membership, leadership vacancies, and designees; executive director appointment and duties; quarterly board meetings, including an annual meeting in December; formation of standing subcommittees and advisory council; indemnification of board members; and by-laws review and amendment process.

Question: With the likelihood of substantive framing of issues percolating up from the committee level, in reflecting on the advisory council process, could there be intersection with subcommittee work?

Answer: The Executive Director is charged with appointing advisory council members and plans to thoughtfully consider how best to engage with subcommittees.

By unanimous vote, the board adopted the by-laws.

V. **One-Time Surcharge Assessment Percentage for Certain Acute Care Hospitals, Hospital Systems, and Surcharge Payers:** Mr. Seltz provided an overview of Section 241 of Chapter 224, which directs the HPC to collect a one-time surcharge assessment totaling $225 million from acute hospitals, acute hospital systems, and surcharge payers. The purpose of this assessment is to provide necessary investment funding for initiatives created in Chapter 224.

Mr. Seltz outlined the surcharge assessment and its calculations: a) surcharge payer liability totaling $165 million and b) acute hospital and hospital system liability totaling $60 million. Neither surcharge payers nor acute hospitals may raise premiums or rates to offset the cost of the surcharge. Hospitals and surcharge payers have the option of paying the surcharge in one lump sum or in four annual, equal installments.

Mr. Seltz noted that hospitals may seek waivers if they demonstrate they lack access to resources by applying very specific criteria. Hospitals may also request a surcharge mitigation of up to 66% of the assessment if their net assets are proven to net less than $1.25 billion or if they receive most of their revenue from public payers.

The funding collected will be distributed as follows:

- Health Care Payment Reform Fund: 5% of assessments to support the operations of the HPC and the board ($11.2 million over four years)
- e-Health Institute Fund: $30 million
- Prevention and Wellness Trust Fund: $60 million
- Distressed Hospital Trust Fund: $128 million

Question: How will the HPC ensure that surcharge payers do not raise premiums to offset the surcharge?

Answer: DOI oversees insurers, and the law provides that the board has the ability to promulgate regulations to create an oversight mechanism for hospitals. Several other areas must be determined through the regulatory process.

Mr. Seltz informed the board that the law requires the HPC to adopt regulations by December 31. Mr. Seltz recommended the creation of draft regulations or informal guidelines by the deadline because the comment and hearing process would not be complete by December 31, 2012. Mr. Seltz was asked to list the board's three options to consider:

1) Draft and adopt emergency regulations before December 31;
2) Set a calculation before December 31 in absence of regulations and adopt regulations at the next board meeting in January that would support the calculation; or
3) Provide the unofficial guidance of a draft calculation before December 31 and formalize the process through adoption of regulations at the next board meeting.

Question: Does the process whereby hospitals and hospital systems can apply for mitigation or a waiver provide enough time after the January meeting to apply?

Answer: If we file the regulations at the January meeting, subsequent hearings will give time for public comment before the board adopts final regulations. Hearing must happen after the January meeting and the final notice to hospitals and surcharge payers would be issued directly after the final vote.

Question: Will it meet the spirit of the law to provide unofficial guidance before December 31, but not adopt emergency regulations?

Answer: Yes, and moreover, unofficial guidance would be helpful to the industry in the absence of regulations.

Question: In light of these discussions, what is the timeline for hiring HPC staff?

Answer: Mr. Seltz responded that he is seeking to hire a General Counsel and other senior staff as soon as possible.

Question: If there was a waiver or mitigation granted to a hospital, would that require a recalculation in distribution of the funds?

Answer: No, if there was a waiver or mitigation granted, it would not require a recalculation; less money would be funded to the Distressed Hospital Trust Fund.

Question: To what extent to do we have plans to collect data on employers, financials, etc., and when do we expect to be staffed up to do so?

Answer: The assessments are modeled after other assessments already in place, providing models. CHIA has committed to provide all analytics and data sets available. Hiring staff is imminent and a top priority.

Question: When Chapter 224 was going through the legislative process, the final assessment language was heavily debated and not a surprise as it was seen as a compromise among many parties. Should we only make changes with extreme hesitation?

Answer: It behooves us to proceed cautiously and make no changes or provide guidance outside the law.

Dr. Altman suggested that the board issue unofficial guidelines before the end of the year and continue work on the regulations in 2013. Mr. Seltz agreed and informed the board that the comment and hearing period would take place in January and regulations would be adopted afterwards, around February or March.

Dr. Altman moved to provide unofficial guidelines before December 31 and consider draft regulations at the January 16 meeting. The motion was unanimously approved.

VI. **Appointment of Vice Chair:** Dr. Altman recommended Dr. Wendy Everett. By unanimous vote, the board appointed Dr. Everett as Vice Chair of the commission.

VII. **Appoint of Subcommittees:** Dr. Altman outlined the four proposed subcommittees and appointed each member to two subcommittees, totaling five members on each subcommittee. The subcommittees were charged with both monitoring and operational responsibilities. Dr. Altman, as Chairperson, will serve as an ex-oficio member of all subcommittees.

The four subcommittees are:

1) Cost Trends and Market Performance. Members are David Cutler, Wendy Everett, Paul Hattis, Rick Lord, and the Secretary of Administration and Finance, ex-officio. Responsibilities are to:
   - Establish the annual health care cost growth benchmark for total health care expenditures in the Commonwealth.
   - Conduct annual cost trends hearings, in conjunction with the Center for Health Information and Analysis and the Attorney General, and issue a final report on health care trends.
   - Conduct cost and market impact reviews of providers and plans proposing significant market changes to the health care industry, considering the impact of these changes on cost, access, quality, and market competitiveness.
   - Oversee the development and implementation of performance improvement plans for certain health providers and health plans.

2) Quality Improvement and Patient Protection. Members are Carole Allen, Wendy Everett, Marylou Sudders, Veronica Turner, and Secretary of Health and Human Services, ex-officio. Responsibilities are to:
   - Examine the impact of health system changes on the quality of health care in the Commonwealth, including the impact on patient access to care, and on the providers of health care, including front-line practitioners and health care workers.
   - Establish, as appropriate, quality of health service measures in addition to the statewide quality measures, to be incorporated into the standards for certified ACOs and Patient-Centered Medical Homes.
   - Establish the role and responsibilities of the Office of Patient Protection, including the development of an external review process for the review of grievances submitted by or on behalf of patients of risk-bearing provider organizations and ACOs.

- Track the progress of efforts regarding mental health coverage parity and ensure the integration of mental health, substance use disorder and behavioral health services with physical care in the development of new care delivery and payment models.
- Develop guidance related to the prohibition of mandatory overtime for hospital nurses.
- Coordinate with the Department of Public Health and the e-Health Institute regarding investments in public health and interoperable health information technology provided in Chapter 224.

  Mr. Seltz noted that the Interdepartmental Service Agreement (ISA) with the Department of Public Health until February 4, 2013, may have to be extended, with the continuing intention that the Office of Patient Protection moves to the HPC as quickly as possible.

3) Care Delivery and Payment System Reform. Members are Carole Allen, David Cutler, Marylou Sudders, Jean Yang, and Secretary of Health and Human Services, ex-officio. Responsibilities are to:
   - Establish a provider organization registration program.
   - Develop and implement standards for a certification program of Patient-Centered Medical Homes (PCMH) and Accountable Care Organizations (ACOs) and develop model payment standards to support PCMHs.
   - Administer a competitive grant program to foster the development and evaluation of innovative health care delivery, payment models and quality of care measures.
   - Coordinate with public and private payers regarding the advancement, adoption and measurement of alternative payment methodologies.
   - Coordinate with the Division of Insurance regarding the development of regulations related to the certification of risk-bearing provider organizations.

4) Community Health Care Investment and Consumer Involvement. Members are Paul Hattis, Rick Lord, Veronica Turner, Jean Yang, and Secretary of Administration and Finance, ex-officio. Responsibilities are to:
   - Develop and administer a competitive grant program to enhance the ability of certain distressed community hospitals to meet system transformation.
   - Develop strategies for engaging with various constituencies and a communications plan for educating providers, businesses, consumers, and the general public regarding the implementation of Chapter 224.
   - Develop strategies for helping consumers navigate health care cost and quality, especially in light of additional information required under Chapter 224.
   - Conduct an investigation and make legislative recommendations relative to increased adoption of flexible spending accounts, health reimbursement arrangements, and health savings accounts, as required by April 2013.
   - Monitor and report on developments in health insurance product design regarding the impact of tiered or selective networks and high-cost sharing plans on out-of-pocket costs to individuals and families and on patient access to quality care.
   - Work with other state agencies to minimize duplicative requirements.

Dr. Altman recommended that the commission meet every other month, giving time for subcommittees to meet. He noted the possibility of meeting quarterly next year. Mr. Seltz noted that subcommittees are subject to the open meeting law.

Question: Could the board members be updated regularly on the work of each subcommittee?

Answer: Executive Director will inform members as to subcommittee schedules, agenda, and meeting minutes.

By unanimous vote, the proposed subcommittees and their responsibilities were adopted.

VIII. **Growth Rate of Potential Gross State Product for Calendar Year 2014:** Ms. Candace Reddy from ANF made a presentation on the growth rate of potential gross state product (PGSP), which is pegged to the health care cost growth benchmark. Ms. Reddy noted this will be the first year Massachusetts will be looking at the growth rate of PGSP. ANF must issue a report on PGSP prior to January 15, 2013.

Dr. Cutler added that PGSP is an agreed-upon concept among economists and budget forecasters; it underlies all the estimates the Commonwealth and the federal government use for forecasting revenue and program growth.

Ms. Turner noted industry confusion around the PGSP calculation and that some providers reported that insurers are using PGSP as a "stick" in their negotiations.

Secretary Bigby noted, as she had in the previous meeting, that PGSP is an average and that not all segments of the health care industry will grow at 3.6%, e.g., segments of the health care sector that have been under-resourced for decades must grow at more than 3.6%.

Dr. Cutler offered to share a presentation on PGSP with the board at the next meeting in January, which was encouraged.

IX. **MassHealth Patient Centered Medical Home Initiative and the Primary Care Payment Reform Initiative:** Dr. Julian Harris, Director of the Massachusetts Office of Medicaid, made a presentation on "The Transition to Alternative Payment Methods: From Patient Medical Homes to the Primary Care Payment Reform Initiative." Dr. Harris provided an overview of MassHealth's payment reform initiatives, the Patient Centered Medical Home Initiative (PCMHI) and Primary Care Payment Reform Initiative (PCPR). Dr. Harris listed the MassHealth deadlines outlined in Chapter 224: the goals are to have 25% of members participating in alternative payment methodologies by July 2013, 50% by July 2014, and 80% by July 2015.

Dr. Altman noted that the HPC and MassHealth will be working closely together.

Question: Please elaborate on the three components of the behavioral health integration model.

Answer: 1) Greater coordination of care with behavioral health providers, 2) providing onsite behavioral health services, and 3) offering a robust set of outpatient behavioral health services (e.g., community mental health centers that are also providing behavioral health services).

Question: Most Medicaid patients are children, but the majority of costs come from adults. How does this model break down between providing care for children versus adults?

Answer: The model spans programs for both children and adults and MassHealth is working to put in place quality measures that reflect both populations.

Question: What is the baseline right now for meeting the first deadline of 25% by July 2013, per the requirements of Chapter 224?

Answer: The PCMHI will make a substantial dent in meeting that benchmark, and MCOs have alternative payment contracts for which we are currently undertaking the process of assessing to make sure they meet this initiative.

Question: What steps are you taking to oversee the implementation of mental health coverage parity?

Answer: Draft regulations are being circulated now; we are working closely with the Division of Insurance (DOI) to make sure they are aligned.

X. **Schedule and Agenda for Next Board Meeting:** Dr. Altman asked Mr. Seltz to draft unofficial regulations on the surcharge assessment. Subcommittees were asked to meet by phone before the next board meeting. Dr. Altman noted that the board will try to allot time for comments and questions from the public.

Dr. Altman announced that the next meeting will be held on January 16, 2013, followed by a meeting in March. Dr. Altman thanked Secretary Bigby for her service.

The meeting was adjourned at 2:30 PM.