MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of January 11, 2017

MASSACHUSETTS HEALTH POLICY COMMISSION

Date of Meeting: Wednesday, January 11, 2017
Start Time: 9:30 AM
End Time: 12:30 PM

	Present?	ITEM 1: Approval of Minutes	ITEM 2: Process for Setting 2018 Benchmark	ITEM 3: Office of Patient Protection Regulation
Carole Allen	X	X	X	X
Stuart Altman*	X	X	X	X
Don Berwick	X	X	X	X
Martin Cohen	A	A	A	A
David Cutler	X	2nd	2nd	X
Wendy Everett	X	M	M	X
Rick Lord	A	A	A	A
Ron Mastrogiovanni	X	X	X	2nd
Marylou Sudders	X	X	X	X
Kristen Lepore	X	X	X	X
Timothy Foley	X	X	X	X
Summary	**9 Members Attended**	**Approved with 9 votes in the affirmative**	**Approved with 9 votes in the affirmative**	**Approved with 9 votes in the affirmative**

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.
*Chairman
(M): Made motion; (2nd): Seconded motion; (ab): Abstained from Vote; (A): Absent from Meeting

Proceedings

A regular meeting of the Massachusetts Health Policy Commission was held on Wednesday, January 11, 2017.

Commissioners present included Dr. Stuart Altman (Chair); Dr. Wendy Everett (Vice Chair); Dr. Carole Allen; Dr. Don Berwick; Dr. David Cutler; Mr. Ron Mastrogiovanni; Mr. Timothy Foley; Ms. Lauren Peters, designee for Secretary Kristen Lepore, Executive Office of Administration and Finance; and Undersecretary Alice Moore, designee for Secretary Marylou Sudders, Executive Office of Health and Human Services.

Dr. Altman called the meeting to order at 9:30 AM and welcomed those present.

ITEM 1: Approval of Minutes from November 9, 2016

Dr. Altman solicited comments on the minutes from November 9, 2016. Seeing none, he called for a motion to approve the minutes, as presented. **Dr. Everett** made a motion to approve the minutes. **Dr. Cutler** seconded. The minutes were unanimously approved.

ITEM 2: Cost Trends and Market Performance

Dr. Cutler provided an overview of the topics to be covered during the update from the Cost Trends and Market Performance Committee.

ITEM 2a: Update on Notices of Material Change

Dr. Cutler introduced Ms. Megan Wulff, Deputy Director for Market Performance, who provided an update on new Material Change Notices (MCN) received by the HPC since the last Board meeting. For more information, see slides 8-11.

ITEM 2b: 2016 Cost Trends Report, Preliminary Findings

Dr. Cutler provided a brief introduction to the preliminary findings from the 2016 Cost Trends Report (CTR). He said that his goal was to facilitate a discussion among the Board members about the findings and potential policy recommendations. He introduced Dr. David Auerbach, Director, Research and Cost Trends.

Dr. Auerbach provided an overview of the spending trends and affordability of care sections of the CTR. For more information, see slides 13-26.

Dr. Allen asked, regarding the table on slide 18, whether the growth in long term services and supports (LTSS) spending for MassHealth was due to more services being provided or an increase in the prices of existing services. Dr. Auerbach responded that it was difficult to parse the data in a way that could show definitively which was the driving force behind this trend as MassHealth spending is spread across so many different sources.

Noting the growth in Medicare enrollment, Dr. Altman said that the health care cost growth benchmark was intended to be a flat number that was unresponsive to shifting demographics. He stated that the HPC should investigate the potential of creating a more sophisticated version that would shift in accordance with demographic trends, such as the age of the population.

Dr. Auerbach noted that the HPC could complete a more in-depth analysis on exactly how much the aging population contributed to cost growth.

Dr. Cutler asked for clarification on the relative growth of Medicare spending in the Commonwealth and the nation. Dr. Auerbach said that Medicare spending would be similar to the commercial spending trends in the report. Dr. Everett asked whether these charts were only showing premiums. Dr. Auerbach responded in the affirmative.

Dr. Cutler said that premiums are likely reflective of spending given administrative shares. Dr. Auerbach agreed with Dr. Cutler and noted that an examination of total medical expenditure (TME) would show similar trends.

Dr. Cutler said that spending growth in Massachusetts has been similar to national growth because the Commonwealth's additional spend on MassHealth, much of which is in the form of LTSS, was not growing as rapidly in other states. Mr. David Seltz, Executive Director, said that the HPC had not completed a comparison of Medicaid spending across states. He noted that such an analysis would be difficult due to demographic and coverage differences between states.

Dr. Cutler noted that, as a matter of arithmetic, if the commercial growth was lower and Medicare growth was the same, then the residual growth would have to be attributed to Medicaid. Dr. Auerbach said that this was correct, but noted that last year saw significant enrollment in MassHealth.

Dr. Altman noted that several variables were playing out in the commercial spending chart on slide 20. He asked if the graph took into account all sources or solely premiums. He asked specifically if the data included out-of-pocket expenses. Dr. Auerbach said that, while out-of-pocket expenses were not included on the graph, the same trend held if out-of-pocket expenses were included.

Dr. Altman said that for a long time Massachusetts had lower deductibles and cost-sharing relative to the nation. Dr. Auerbach stated that Massachusetts still tends to have lower deductibles. He said overall spending growth in Massachusetts was still lower than the rest of the nation. He noted that this analysis would be included in the full report.

Dr. Altman asked how Massachusetts compared to the nation in terms of other benefits, such as health savings accounts (HSA) or high-deductible plans. He added that the Commonwealth used to be significantly under the national average on these benefits. Dr. Auerbach responded that the Commonwealth's benefits were slightly higher over the rest of the country but that there was no way to compare these state-to-state.

Dr. Berwick asked whether this data indicated anything about what to expect in terms of premium growth in 2016. Dr. Auerbach said that he did not think that it will be a radically different story in 2016.

Mr. Mastrogiovanni asked whether out-of-pocket expenses were a substantially smaller component of spending for retirees in Massachusetts. He said he understood this to be the case nationally. Dr. Auerbach said that staff had not broken down out-of-pocket expenses in that way. He said this was a good question for future research.

Mr. Mastrogiovanni asked if the original Medicare numbers presented on slide 21 were just parts A and B. Dr. Auerbach responded that the data included Part D, as well.

Mr. Foley asked how the numbers on slide 21 looked on the home care side of spending as it is such a large component of Medicaid spending. Dr. Everett asked whether those numbers were included in the post-acute care figure. Dr. Auerbach said that the numbers were included in the post-acute figure in the table on slide 21. He said that Massachusetts is 15 to 20 percent higher on the home care spending than the rest of the country.

Dr. Cutler noted that the chart on slide 21 shows areas on which the HPC should focus, such as post-acute services.

Dr. Altman stated that Massachusetts hospital spending is significantly higher than the rest of the country while physician spending is somewhat lower. He said that it would be worthwhile looking into what this divide means and why it exists.

Dr. Cutler noted that likely the largest part of the post-acute care costs would be on the institutional side, as well. Dr. Altman agreed and said that Massachusetts tends to be institutionally focused. Dr. Auerbach stated that readmission rates were related to this issue.

Mr. Seltz added that there may be a relationship between the lower physician spending and higher, out-patient hospital spending due to the consolidation of physicians into large, hospital-based systems.

Dr. Berwick asked for clarification on whether, as physicians are acquired by hospitals, spending becomes a component of the outpatient hospital spending. Dr. Auerbach said that this was the case.

Dr. Cutler noted that the payment for the doctor ends up in the physician component while the facility fee ends up being counted towards the hospital spending.

Dr. Everett said that there are still some instances in m and a's in which the doctors become salaried employees. She asked whether, in this case, spending would not go into the physician category but into the inpatient facility category. Dr. Altman said that this question was worth examining.

Dr. Berwick asked to clarify whether or not the chart on slide 21 dealt with growth. Dr. Auerbach responded that it dealt with overall level of spending and not growth.

Dr. Berwick noted that the chart on slide 23 showed that lower-income employees were not only paying for a higher percentage of their health care, but that they were paying a higher absolute dollar amount.

Dr. Berwick asked whether the chart on slide 25 included employer contribution to the premiums. Dr. Auerbach said that it did.

Dr. Altman said the burden on lower income residents of the Commonwealth was a very important topic as some have suggested that the cost of healthcare in Massachusetts is commensurate with the state's higher incomes relative to the rest of the country. He said the data in the report shows that, for a significant portion of the population, healthcare spending is a serious problem.

Regarding the finding that 30 percent of income for lower earners goes to health care, Dr. Berwick asked what portion of that was covered by the employer's contribution. Dr. Auerbach referenced the chart on slide 23. He stated that, with the approximately $5,500 contributed by the employee, a little over $10,000 is covered by the employer.

Mr. Mastrogiovanni asked if this included out-of-pocket. Dr. Auerbach said that this chart showed all costs. He said that it did not include out-of-network costs, such as non-reimbursed, out-of-network mental health care.

Mr. Foley asked how the percentages presented on slide 25 compare to the national levels. Dr. Auerbach responded that a fixed individual or family would spend more in Massachusetts than in any other state because of higher premiums.

Dr. Cutler asked if it would be possible to go into more detail on the data from the map on slide 26 and determine which institutions were most responsible for the high out-of-network billing. Dr. Auerbach stated that the staff could do such an examination with the All Payer Claims Database (APCD).

Dr. Berwick noted that the national map on slide 26 seemed to indicate that out-of-network charges were high in the Berkshires as well as the eastern part of the state. Dr. Auerbach said that was correct and added that charges were low in Central Massachusetts.

Ms. Peters asked if the data on slide 25 accounted for self-insured employers. Dr. Auerbach said that yes, that slide did take into account the self-insured.

Dr. Auerbach then turned the discussion over to Ms. Sara Sadownik, Deputy Director, Research and Cost Trends, who provided an overview of the prescription drug spending section of the CTR. For more information, see slides 27-33.

Dr. Berwick asked where post-acute numbers were captured in the chart on slide 28. Ms. Sadownik said that they fell into the "other" category. Dr. Auerbach added that the chart only captured the commercial space.

Referring to slide 30, Dr. Altman said that the shift from branded drugs to generic had decreased. He noted that the report should capture that the reliance on branded drugs drives costs. Ms. Sadownik noted that staff had examined this shift and found that the share of all claims for generics had been increasing over time.

Dr. Berwick asked whether the population captured on slide 30 was commercially insured only or also included public payers. Ms. Sadownik responded that it was commercial only.

Mr. Seltz added regarding slide 32 that one of the policy goals of the Affordable Care Act (ACA) was to promote gender equity in terms of healthcare spending. He said that HPC data shows that women had paid a greater share of these costs prior to the ACA.

Dr. Cutler said that the presentation so far showed that the burden of health spending is still very high despite the fact that the state was performing better by some measures, particularly in the commercial space. He added that there are still opportunities to improve.

Dr. Berwick agreed with Dr. Cutler and pointed out how regressive the financing trends outlined in the report were. Dr. Everett agreed and said that the data from the charts on slides 22 and 25, showing how much more is paid by the 40 percent of employees in relative poverty, represents one of the most important takeaways from the report.

Dr. Berwick added that this group ran right up into the lower-middle class and re-emphasized the regressive nature of this financing.

Mr. Mastrogiovanni said that this information underscored the need to address the potential repeal of the affordable care act (ACA).

Dr. Allen pointed out that the HPC is able to make recommendations. She asked whether it might be worth recommending sliding-scale premiums so that employers might charge lower-paid employees less for health coverage. She added that those employees would then have more money to put back into the economy.

Dr. Auerbach pointed out that the structure in the exchanges closely mirrored this model but that this did not necessarily exist in the employer market.

Mr. Mastrogiovanni added that he did not believe that employers were allowed to offer sliding-scale premiums in this manner. Mr. Foley said that in union contracts it was possible to negotiate sliding-scale premiums whereby lower-income individuals paid less for health costs.

Ms. Natasha Reese-McLaughlin, Research Associate, Research and Cost Trends, provided an overview of the avoidable hospital utilization section of the report. For more information, see slides 34-42.

Dr. Everett asked whether opioid use related emergency department (ED) visits were captured in the "emergency" or in the "behavioral health" (BH)-related sections of the data shown on slide 37. Ms. Reese-McLaughlin said that they were mutually exclusive based on the primary diagnosis. She said that this suggests that the chart on slide 37 likely underestimates the level of BH visits to the ED. She provided an example of a patient who was dealing with respiratory issues due to opioid use, saying that this case would appear in the emergency data.

Dr. Everett asked if cases in which the primary diagnosis was opioid overdose were categorized as BH. Ms. Reese-McLaughlin responded in the affirmative.

Dr. Cutler asked whether the inpatient numbers on the graph on slide 39 included post-acute care. Ms. Reese-McLaughlin responded that they only included hospital care.

Dr. Altman asked if the data on slide 39 was age-adjusted. Ms. Reese-McLaughlin responded in the affirmative.

Dr. Auerbach clarified that the data showed an age band. Dr. Altman acknowledged that this was a bit of an age adjustment. He asked for clarification that the under-65 population numbers continued to decline. Ms. Reese-McLaughlin said that this was correct.

Dr. Cutler asked whether for the final report the readmission data on slide 40 could be separated into BH and non-BH. Ms. Reese-McLaughlin said that staff could certainly try to do that.

Dr. Cutler asked for clarification on how much of the readmission numbers were BH-related. Ms. Reese-McLaughlin said that in 2014, 60 percent of the all-payer, all-cause readmission rate was due to patients with BH comorbidity.

Dr. Everett said that, in these cases, the patients had a BH comorbidity but that staff could not know whether that was the primary cause of the readmission. Ms. Reese-McLaughlin said that this was correct.

Dr. Everett added that, for the 65 and older population in particular, the readmission rate very well may not be related to BH issues.

Dr. Berwick asked if the category of "community appropriate discharges" used in the chart on slide 41 was a nationally accepted standard. Ms. Reese-McLaughlin said that the HPC had devised this standard for the *Community Hospitals at a Crossroads* report.

Dr. Berwick said that it was important to validate the community appropriate discharge metric and suggested getting an outside, independent party to look at it.

Mr. Foley asked whether staff had looked at community appropriate discharges in terms of the insurance product the individual was in for their discharge. Dr. Auerbach said that this was a good question. He added that there was external research that showed that tiered networks do redirect care to community hospital settings.

Dr. Altman asked whether it would be possible to replicate the graph on slide 42 for other big systems that had acquired community hospitals. Ms. Reese-McLaughlin responded that staff was already in the process of doing this.

Mr. Seltz added that the findings on slide 42 were important as they represented a new area in which the HPC is working. He said that staff will examine some past market transactions and use data from the cost to market impact review (CMIR) process to validate and understand how the transactions met some of the goals presented to the HPC.

Mr. Seltz noted that this was one year of data so it was important not to overstate the impact of the findings but that the data was trending in the right direction. He said that staff intended to continue to do this kind of work.

Dr. Cutler suggested looking at charts for all of the approved transactions at a future Board meeting.

Ms. Reese-McLaughlin turned the discussion over to Ms. Sadownik who provided an overview of the preliminary findings of the CTR on post-acute care. For more information, see slides 43-45.

Regarding the map on slide 45, Mr. Mastrogiovanni asked whether staff had examined whether the greater amount of time in hospitals and skilled nursing facilities was due to the long-term insurance products available in the Massachusetts market. Ms. Sadownik responded that long-term insurance products did not really apply to this map as the map referred to Medicare covered benefits exclusively.

Mr. Mastrogiovanni asked if it might have something to do with usage of Medigap policies in Massachusetts, particularly the highest level F category, and whether Massachusetts residents utilized this option more than residents from other states. Ms. Sadownik said that this was a good question for follow-up.

Ms. Sadownik turned the discussion over the Dr. Auerbach who provided an overview of the variation in spending by primary care provider (PCP) groups. For more information, see slides 46-53.

Mr. Seltz pointed out that the analysis presented on slide 48 had not been presented in the Commonwealth before. He said that staff had been able to blend the rate being provided by the PCPs across different health plans to show the trend over time.

Dr. Berwick asked what patient population was being looked at on slide 48. Dr. Auerbach said that the data included everyone in an HMO or a POS product.

Dr. Berwick asked whether this was in the realm of 11 percent of the market. Dr. Auerbach said it was actually closer to about half the commercial market.

Dr. Berwick asked what risk adjustment staff had used on this data. Dr. Auerbach said that the data was from Tufts, Blue Cross, and Harvard Pilgrim, which all use similar risk adjusters.

Dr. Altman said that it was important for everyone to understand that the data on slide 48 represented a combination of price and utilization differences.

Dr. Berwick asked what impact coding changes might be having on these numbers. Dr. Auerbach said that this was an excellent question. He said that CHIA was looking into this question more closely .

Dr. Berwick asked if the horizontal axis in the graph on slide 49 represented the percentage of members in APMs for the payer. Dr. Auerbach said that it was for the provider group.

Dr. Berwick asked whether each dot was a provider group. Dr. Auerbach confirmed that this was the case.

Dr. Berwick asked what the numerator and denominator were for the data on slide 52. Dr. Auerbach said that each of the measures were different but that essentially the number represented the percentage of patients who received a non-recommended service when it was unwarranted.

Dr. Berwick asked whether staff then adjusted the denominator for every single measure. Dr. Auerbach replied in the affirmative and noted that staff then normalized the data to 1.0.

Mr. Seltz noted that the data on non-recommended care on slide 52 was a new area for the HPC. He said that the data highlighted room for potential improvement in some areas but also an opportunity to share best practices.

Mr. Seltz added that staff hoped that providing this data and facilitating conversation around it would help to accelerate improvements in these areas.

Dr. Everett added that it would be interesting to look at more recent data. She added that tracking this data year-to-year could paint an interesting picture. Dr. Auerbach agreed and said that staff hoped to take advantage of new data from the APCD this spring.

Dr. Altman said that, for the screening category of non-recommended care, many would argue that these are positive and help prevent further care. He said that unnecessary screenings and unnecessary surgeries are not comparable given the expense and risk disparity between the two.

Dr. Everett said that, in this example, the surgeries presented were fairly limited in scope.

Dr. Berwick said that for the work of the HPC, enhancing understanding of what was happening at the clinical level, such as with the data on slide 52, and understanding exactly what tests and procedures were taking place, would be extremely valuable.

Dr. Allen said that there was an item in a Dartmouth study on different treatments that showed often even in adjacent towns there were vastly different treatment trends. Dr. Auerbach agreed that the data seemed to support that generally.

Ms. Sadownik provided an overview of the APM section of the report. For more information, see slides 54-56.

Mr. Auerbach provided an overview of the demand-side incentives section of the report. For more information, see slides 57-68.

Dr. Berwick asked if the plan outlined in the graph on slide 62 was a bronze or silver plan. Dr. Auerbach clarified that it was the second-lowest cost silver plan.

Dr. Altman suggested adding to the "promising developments" section on slide 63 the fact that small group coverage in Massachusetts is now lower than several other states whereas in the past the Commonwealth had been the highest.

Dr. Cutler asked if there were questions before moving on to the next agenda item.

Dr. Altman said that he would like to see further investigation into pricing patterns relative to Medicare and how Massachusetts compared, even on a selective basis, to other parts of the country. Dr. Auerbach said that this was a huge focus and an area in which staff planned to do more work.

Dr. Everett added that it would be helpful for the Board to go through slide 63's challenging developments section and determine which the HPC should try to tackle. She said that it was phenomenal to have this data and analysis and that the question was now what the Board did with these findings.

Dr. Cutler followed up on Dr. Everett's comment saying that for the next discussion of the report, it might be helpful not to see a large number of recommendations but instead see a list of key headlines from the data and have Board members discuss or react to those. Dr. Cutler added that this would help Board members to think about these issues more conceptually.

Dr. Berwick asked for clarification on the timeline of the report. Mr. Seltz responded that the report would be released after the February 8 Board meeting.

Mr. Foley said that a potential "challenging development" bullet point could be the percentage of income that low-income residents are paying for health insurance. Dr. Auerbach agreed that this was something that should be added to that section.

Dr. Cutler thanked the staff for their presentation.

ITEM 2c: Process for Setting the 2018 Health Care Cost Growth Benchmark (VOTE)

Mr. Seltz provided a brief introduction to the process for setting the 2018 health care cost growth benchmark. He introduced Ms. Lois Johnson, General Counsel, who provided an overview of the process for setting the benchmark. For more information, see slides 70-73.

Dr. Berwick asked if it was correct that if there were no vote to modify the benchmark, then no public hearing was required. Ms. Johnson said that that was correct.

Dr. Altman said that he believed that the Board should make a decision regarding the benchmark based on data. He added that, before voting to raise the benchmark, the Board should examine some forward-looking data projections.

Dr. Altman added that it might make sense to speak with people who are experts at a national level to see how Massachusetts compares with the rest of the country.

Mr. Seltz said that the vote here was regarding whether to hold a public hearing on the benchmark. He noted that the initiation of the public hearing process does not presuppose a modification by the Board.

Mr. Seltz added that the benchmark is the driving principle of Chapter 224. He recommended that the HPC enter the process fully considering how important it is to 224 and that the Board make an informed decision.

Mr. Seltz pointed out that any decision to modify does require a two-thirds vote in favor from the Board.

Dr. Altman supported Mr. Seltz's comment saying that it made sense to organize the public hearing and begin moving forward on it immediately unless there were objections. He added that it might make sense to tailor the public hearing to the data.

Dr. Berwick asked for confirmation that in deciding to launch the public hearing process, the Board was not committing to going through the modification process. Dr. Altman said that it was not and that the hearing process represented an effort to better understand the issue. He added that the Board did not have the authority to raise the benchmark past 3.6 percent and said that the national projections show that inflation is beginning to heat up.

Undersecretary Moore said that the public hearing was important as it represented what the HPC does best in applying data to a public discussion.

Dr. Cutler suggested that a more in-depth presentation on February 8 examine what factors would influence any decision to modify the benchmark.

Dr. Everett suggested that a benchmark discussion be the main agenda item on February 8.

Dr. Altman called for a motion to initiate the process for setting the 2018 health care cost growth benchmark. **Dr. Everett** made a motion to approve the minutes. **Dr. Cutler** seconded. The motion passed unanimously.

ITEM 3: Quality Improvement and Patient Protection

Mr. Seltz provided a brief introduction to the Quality Improvement and Patient Protection (QIPP) section of the meeting.

ITEM 3a: Regulation Governing the Office of Patient Protection (VOTE)

Mr. Seltz turned the discussion over to Ms. Johnson who provided an overview of the background and key considerations regarding the regulation governing the Office of Patient Protection (OPP). For more information, see slides 77-78.

Ms. Johnson turned the discussion over to Mr. Steven Belec, Director, OPP, who provided an overview of the regulatory development process and next steps. For more information, see slides 79-81.

Dr. Altman called for a motion to approve the regulation governing the OPP. **Dr. Everett** made the motion. **Mr. Mastrogiovanni** seconded. The motion passed unanimously.

ITEM 4: Community Health Care Investment and Consumer Involvement

Mr. Seltz provided a brief introduction to the Community Health Care Investment and Consumer Involvement Presentation.

ITEM 4a: Presentations from CHART Investment Program Participants

Mr. Seltz turned the discussion over to Ms. Kathleen Connolly, Director, Strategic Investments, who introduced the CHART hospital presenters.

Representatives from the CHART hospitals provided presentations on their programs. For more information, see slides 89-113.

Dr. Altman thanked the CHART presenters.

ITEM 5: Schedule of Next Meeting

Dr. Altman adjourned the meeting 12:30 PM. The next Board meeting is scheduled for February 8, 2017.