MEETING MINUTES:

MARKET OVERSIGHT AND TRANSPARENCY COMMITTEE

Meeting of November 28, 2018

MASSACHUSETTS HEALTH POLICY COMMISSION

Market Oversight and Transparency Committee
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, November 28, 2018, 9:30 AM

PROCEEDINGS
The Massachusetts Health Policy Commission's (HPC) Market Oversight and Transparency (MOAT) Committee held a meeting on Wednesday, November 28, 2018, at the HPC's offices, 50 Milk Street, 8th Floor, Boston, MA.

Members present included Dr. David Cutler (Chair); Mr. Richard Lord; and Mr. Ron Mastrogiovanni. Ms. Elizabeth Denniston, designee for Secretary of Administration and Finance Michael Heffernan, participated over the phone. Dr. Stuart Altman, HPC Chair, was also in attendance.

The meeting notice and agenda can be found here.
The presentation from the meeting can be found here.
A video of the meeting can be seen here.

Dr. Cutler called the meeting to order at 9:34 AM. He welcomed members of the public to the meeting.

ITEM 1: APPROVAL OF MINUTES FROM JUNE 13, 2018 MEETING
Dr. Cutler asked for a motion to approve the minutes from the MOAT Committee meeting held on June 13, 2018. Mr. Lord motioned to approve the minutes. Mr. Mastrogiovanni seconded. The minutes were approved unanimously, as presented.

Dr. Cutler outlined the day's agenda. Mr. David Seltz, Executive Director, said that the cost trends report presentation at today's meeting would serve as a preview of a more in-depth presentation at the full Board meeting on December 13.

ITEM 2: MA-RPO FILING REQUIREMENTS
Ms. Katherine Mills, Policy Director, Market Performance, and Ms. Kara Vidal, Senior Manager, Market Performance, presented on the 2019 Registration of Provider Organizations (RPO) filing requirements and request for public comment. For more information, see slide 7.

Dr. Cutler asked how much additional work the new requirements placed on filers. Ms. Vidal said that it depended on the specific question. She said that the hope was that the first two questions would take fairly minimal effort to answer particularly as HPC staff would be pre-populating the service availability portion based on Department of Public Health (DPH) data. She said that the advanced practice provider (APP) section would be more work, but stressed that this was a section that the end-users of the data had highlighted as particularly important. She added that the physician-payer mix section would fall somewhere in between these other examples in terms of difficultly. Ms. Mills added that some of the most helpful feedback that staff had received in the past was regarding the wording of specific questions as well as the timeframe.

Mr. Lord asked what the level of provider compliance was and what the consequences of non-compliance were. Ms. Vidal said that compliance had been very high so far. She said that providers who

did not comply would be statutorily forbidden from contracting with payers which provided a very effective incentive for organizations to submit data.

ITEM 3: PERFORMANCE IMPROVEMENT PLANS

Ms. Mills and Ms. Vidal presented on the 2018 closeout and three-year recap of the performance improvement plan (PIP) process. For more information, see slides 10-30.

Referring to slide 17, Dr. Cutler noted that many of the contracts for which organizations had been referred by the Center for Health Information and Analysis (CHIA) were fairly small. Ms. Vidal confirmed that this was the case.

Mr. Lord noted that there was a significant lag in the PIPs data. He asked whether it would ever be possible to bridge the gap and have entities being looked at for much more recent performance data. Ms. Vidal said she did not know whether this gap would be closed. She said that the process could hypothetically look at one-year more recent data but that this data would be preliminary and would still lag by multiple years. She said that CHIA could also potentially change their reporting requirement dates, but that this system was currently designed so that the data was available ahead of the cost trends hearing annually. Mr. Ramsay Hoguet, Senior Policy Associate, Market Performance, noted that the data does shift from the preliminary to the final. Ms. Mills added that in the first year of the process, CHIA had used the preliminary data but had moved to using the final based on feedback that the preliminary data was not reliable enough as a basis for referral. Ms. Vidal noted that staff do look at the preliminary data and use it as an opportunity to request additional information from entities. Dr. Cutler agreed with Mr. Lord that the time lag was an issue but that he was unsure how best to deal with it. Dr. Altman noted that while the data lag was an issue, during the review entities provided more recent data. He said that it was important that people understand that the PIPs process is not entirely based on older data. Ms. Mills said that Dr. Altman's point was a good one. She noted that the initial referral was just a first step in a very robust review process.

Dr. Altman asked whether CHIA is required by statute to use the health status adjusted (HSA) total medical expenditure (TME) metric outlined on slide 25. Ms. Vidal confirmed this is the case. Ms. Mills concurred and said that the law stated that CHIA should broadly be using HSA TME in its analysis. Dr. Altman asked if CHIA also provided the HPC with unadjusted spending numbers. Ms. Mills confirmed that CHIA did. Dr. Altman asked if the HPC could use the unadjusted spending numbers in its determination. Ms. Mills said yes but added that the HPC was not able to require a PIP from an organization that had not been referred by CHIA. Dr. Altman said that he understood that. He added that with a referred entity, however, the HPC could consider the unadjusted spending numbers. Ms. Mills noted that the example on slide 25 was of an organization that would not be referred to the HPC because its HSA TME was below growth was below the benchmark.

Mr. Mastrogiovanni asked how stringent the policies were regarding the algorithm used to calculate risk score. Ms. Mills clarified that the payers calculate their own risk scores; CHIA does not prescribe a method. Ms. Vidal said that she was not aware of what guardrails may be in place regarding these calculations and suggested it might be a useful area to look into. Mr. Mastrogiovanni asked what role the provider played in calculating the risk score. Ms. Vidal said that typically the provider was not calculating the risk score. Mr. Mastrogiovanni said that the provider would be documenting the diagnostic and demographic data from which the risk score would be calculated. Ms. Vidal confirmed that this was the case. Mr. Mastrogiovanni said that a higher risk score would benefit providers. Ms. Vidal said that generally this was the case but that payers could also benefit from higher risk scores

particularly post-Affordable Care Act (ACA). Dr. Cutler noted that the process of determining risk scores was actually quite expensive as people were employed to ensure the maximum risk scores were being determined across a patient population. Ms. Vidal said Dr. Cutler was correct. She noted that entities with more resources could invest more in auditing and capturing this data more accurately. She said that HPC staff did not have a way to determine whether a higher risk score was indicative of an older, sicker population, or a greater investment in coding. Dr. Altman said that this kind of waste in the system was a major issue and something that the HPC had to work around.

Dr. Cutler asked if there was anything about the HPC's process of conducting the PIPs review that the agency should consider revisiting. Ms. Vidal said that staff revisited their process following the conclusion of each year's PIPs review but that most of the issues raised were related to staff workflow. She said that, in her view, the decision to do a comprehensive review up front and only ask questions of a limited set of entities had worked well. She said that since the process had now been conducted several times, staff were looking for ways to standardize how some of the questions were asked. Ms. Mills said that she felt the conversations with organizations that took place during the review process were extremely helpful. She said that many of the challenges had already been highlighted in the day's discussion including: the timeliness of data, and limited tracking data from organizations on their own care delivery improvements.

Ms. Mills asked if any commissioners had feedback on the PIPs review process. Dr. Cutler agreed with Ms. Mills' point that conversations with the organizations under review had been extremely helpful and that the organizations had identified these conversations as helpful as well. He said that he might recommend changes to the law to allow for more referrals to the HPC and that a conversation with CHIA about how rapidly the data could be processed would also be useful. Mr. Mastrogiovanni said that he had great faith in the process. He said that examining how to deal with the issues surrounding risk scores was something that the HPC needed to consider moving forward. Mr. Lord said that the process was very thorough and complimented the staff for the work. Dr. Altman said that the PIPs review process was a crucial part of allowing Chapter 224 to function as intended. He echoed Mr. Lord's thanks to the staff. Ms. Denniston said that there was flexibility in the law currently and suggested that more analysis might be appropriate before determining whether legislative change was necessary. She suggested that information from organizations about the number and types of employees doing the billing and coding work would be useful to have. Dr. Cutler asked staff to draft recommendations for the next MOAT meeting on some of the issues raised in this discussion.

ITEM 4: 2018 HEALTH CARE COST TRENDS REPORT

Dr. Cutler introduced Dr. Laura Nasuti, Senior Researcher, Research and Cost Trends, and Mr. Lyden Marcellot, Research Associate, who presented on findings on variation in hospital admissions from the emergency department in the 2018 Cost Trends Report. For more information, see slides 33-46.

Referencing the second bullet on slide 37, Mr. Mastrogiovanni asked whether staff had seen a difference in readmission rates between community hospitals and academic medical centers (AMCs). Dr. Nasuti said that this variation did not appear to be driven by hospital type. She said that hospitals with high readmission rates for some conditions had high readmissions for other conditions.

Dr. Altman noted that the medical conditions listed on slide 39 may influence where a patient might choose to seek care and therefore influence the ED admission rate. He suggested there may be additional information in the exhibit worth analyzing. Mr. Marcellot noted that the data did show

patterns related to specific hospitals. Dr. Altman suggested that there might be an opportunity for public education around this. Mr. Seltz noted that this was the first time an analysis like this had been done in Massachusetts and that it was an opportunity to engage in conversations around this issue. He said there were opportunities to learn from hospitals and ED physicians about how some of the decisions captured in the data were made.

Dr. Cutler said that engaging the stakeholders on this research was extremely valuable. He said that it would be a useful tool in giving hospitals a better picture of the relative acuity of the patients they admit.

Dr. Altman said that this was a fascinating line of research. He noted that the ED is often used as an extension of the outpatient system and that the capacity and technology of different EDs varies tremendously. He said that this was the beginning of a very interesting study and that there was much more to learn in this area. Mr. Seltz added that ED physicians had communicated to staff in conversations that they do not have control over the patients coming to the ED, but do feel like they have some agency in determining whether patients are admitted by providing high-quality care in the ED to discharge patients to home. He said that the ED physicians had largely agreed that there were areas for improvements. He noted that the HPC had heard from some Community Hospital Acceleration, Revitalization, and Transformation (CHART) awardees that the CHART teams had given ED physicians confidence to discharge certain patients who would continue to have support and monitoring once back in the community. He noted that this was a complex issue and that staff were excited to engage with other experts moving forward.

ITEM 5: ADJOURNMENT

Dr. Cutler thanked the Committee and the staff. The meeting adjourned at 10:58 AM.