



MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission Board Meeting

June 1, 2016



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)



AGENDA

- **Approval of Minutes from the April 27, 2016 Meeting**
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)



VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on April 27, 2016, as presented.



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- **Cost Trends and Market Performance**
 - Update on Notice of Material Change
 - Update on HPC's Stakeholder Discussions on Provider Price Variation
 - Presentation on Performance Improvement Plans
 - 2016 Cost Trends Hearing
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
 - **Update on Notice of Material Change**
 - Update on HPC's Stakeholder Discussions on Provider Price Variation
 - Presentation on Performance Improvement Plans
 - 2016 Cost Trends Hearing
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	16	26%
Physician group merger, acquisition or network affiliation	14	23%
Acute hospital merger, acquisition or network affiliation	11	18%
Formation of a contracting entity	9	15%
Merger, acquisition or network affiliation of other provider type (e.g., post-acute)	6	10%
Change in ownership or merger of corporately affiliated entities	4	7%
Affiliation between a provider and a carrier	1	2%

Update on Notices of Material Change

Notices Received Since Last Board Meeting

- Proposed clinical affiliation between **Atrius Health** (Atrius), a 750-physician multi-specialty group, and **Winchester Hospital** (Winchester), a 189-bed general acute care hospital, under which Winchester would become a preferred hospital for Atrius patients. The agreement includes remuneration related to the improvement of patient care quality and reduction of total medical expense.
- Proposed acquisition of three long term care hospitals owned by **Kindred Healthcare** (Kindred), a national health care services company, by **Curahealth Massachusetts** (Curahealth), a new organization established to own and manage long term care hospitals. Under the proposed acquisition, Curahealth would acquire:
 - Kindred Hospital-Boston North Shore, a 50-bed long term care facility in Peabody;
 - Kindred Hospital-Boston, a 59-bed long term care facility in Brighton; and
 - Kindred Hospital Northeast-Stoughton, a dually licensed long term care and inpatient psychiatric facility in Stoughton with 198 beds (110 currently out of service).



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
 - Update on Notice of Material Change
 - **Update on HPC's Stakeholder Discussions on Provider Price Variation**
 - Presentation on Performance Improvement Plans
 - 2016 Cost Trends Hearing
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

Recap: Provider price variation stakeholder discussions

Following the 2015 Cost Trends Report on Provider Price Variation, the HPC provided additional research and analyses and convened stakeholders to present and discuss specific policy options to reduce unwarranted price variation, including:

March

Policies to enhance healthcare market transparency and encourage consumers to use high-value providers for their care;

April

Transitioning away from use of historic spending for setting global budgets; and

May

Options to directly limit price variation



**A more sustainable
and value-based
health care system**

The stakeholder discussions allowed for robust discussion of policy options. All materials and video of the discussions are available on our website.

Staff has also prepared a **Summary Report** of the discussions to be released in the coming weeks to help **inform policymakers as they seek to address this critical issue**

Unwarranted price variation can also be addressed through direct limits on variation

- Policies that directly limit price variation are potentially a more direct, faster and more targeted approach to addressing unwarranted price variation
 - Different policies and implementation options will differ in the extent to which they can achieve certain outcomes, e.g.:
 - Controlling total health care spending over time, in addition to price variation
 - Creating a more value-driven health care marketplace
 - Promoting the financial health of low-cost providers
 - Complementing demand-side and supply-side incentives, including by applying to both fee-for-service rates and global budgets
 - Aligning incentives across the provider market, including for lower-priced providers
 - Applying across health care market, e.g. to hospitals, primary care and specialist physicians, insurance markets
 - ...and the challenges they may create:
 - Resources necessary for greater government oversight
 - Technical complexity of defining appropriate target levels of variation, timing for rate convergence, and/or adjustment levels for appropriate variation
 - Potential for unintended consequences for providers, payers, and/or consumers
-

May 19 Discussion Summary

HPC Presentation

Overview of direct limit policy options, including rate banding, differential rate growth, and limiting variation to acceptable factors, as well as brief summaries of policies in other states. Stakeholder discussion focused on several key themes:

- Considering how the specifics of a rate banding policy (e.g., where the bands are set, which providers are included) would greatly affect its impact;
- The importance of avoiding sudden, major revenue reductions for any provider, to avoid destabilizing the market;
- The urgency of addressing market dysfunction and need for some action, even in the form of small steps; stakeholders expressed support for the goal of limiting variation to acceptable factors, as identified by either an expert or stakeholder group.

Dr. Joshua Sharfstein Presentation

Dr. Joshua Sharfstein presented a description of Maryland's current system of hospital global budgets, and how this new approach, under an all-payer system, has encouraged hospitals to work to reduce their volume. Stakeholder discussion focused on the following issues:

- The importance of the system's credibility and perceptions of fairness;
- The value of a strong statewide health information exchange; and
- The challenge of alignment between hospitals and physicians

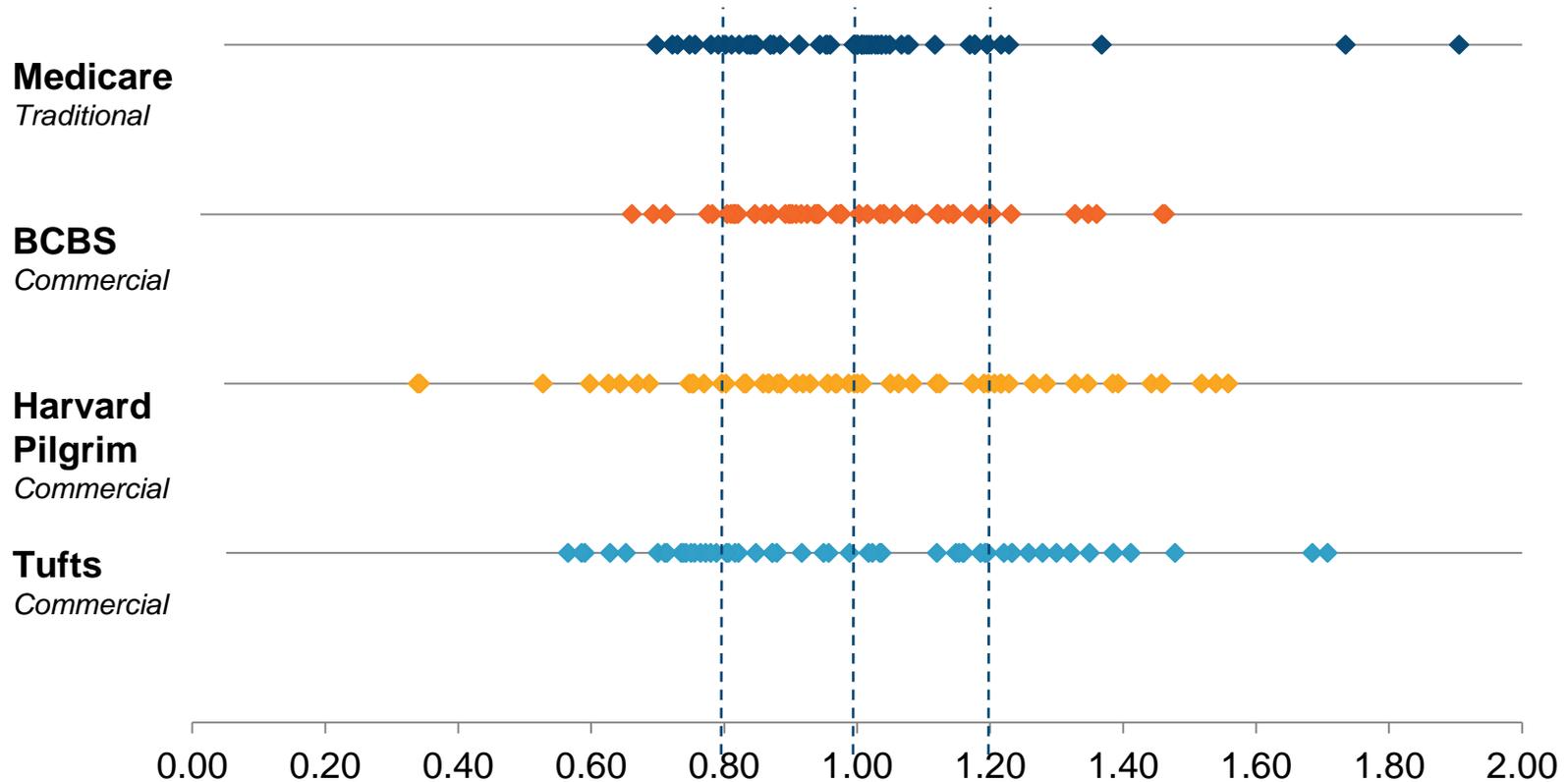
Overview of policy options to directly limit price variation discussed on May 19

Strategy	Examples of specific options	Considerations
Rate banding	Prohibiting prices from varying from average/median by more than a given amount	<ul style="list-style-type: none"> ▪ Timeline for implementation; How much variation is permitted ▪ Applicability (by cohort or across all providers; non-hospital providers; exclusions) ▪ Risks associated with significant revenue reductions ▪ Uncertainty of possible volume/utilization responses over time
Differential rate increases	Allowing lower-priced or more efficient providers greater increases in prices or global budgets	<ul style="list-style-type: none"> ▪ Applicability (to price and/or global budget; to which providers) ▪ Target for how much variation would be allowed to remain ▪ How much growth is permitted for different providers ▪ Convergence could take many years
Limiting variation to acceptable factors	Limiting price variation (FFS or global budgets) to value-based factors that provide benefit to the Commonwealth	<ul style="list-style-type: none"> ▪ Potential to enhance value in health care market ▪ Requires selection of value-based factors, and possibly amount of variation allowed for each, by government and/or by market; common nexus of factors deemed valuable in payment systems ▪ Many implementation options, e.g., requirement to justify all variation (or variation beyond certain levels); administered pricing ▪ May be more complex to implement and enforce compliance
Other options	All-payer global budgets for hospitals (Maryland)	<ul style="list-style-type: none"> ▪ Encourages hospitals to reduce unnecessary volume, focus on population/ public health ▪ Relies on past rate-setting system to ensure payment equity ▪ Requires sophisticated adjustments to account for exogenous volume changes

Limiting variation to acceptable factors; extent of price variation under Medicare's administered pricing

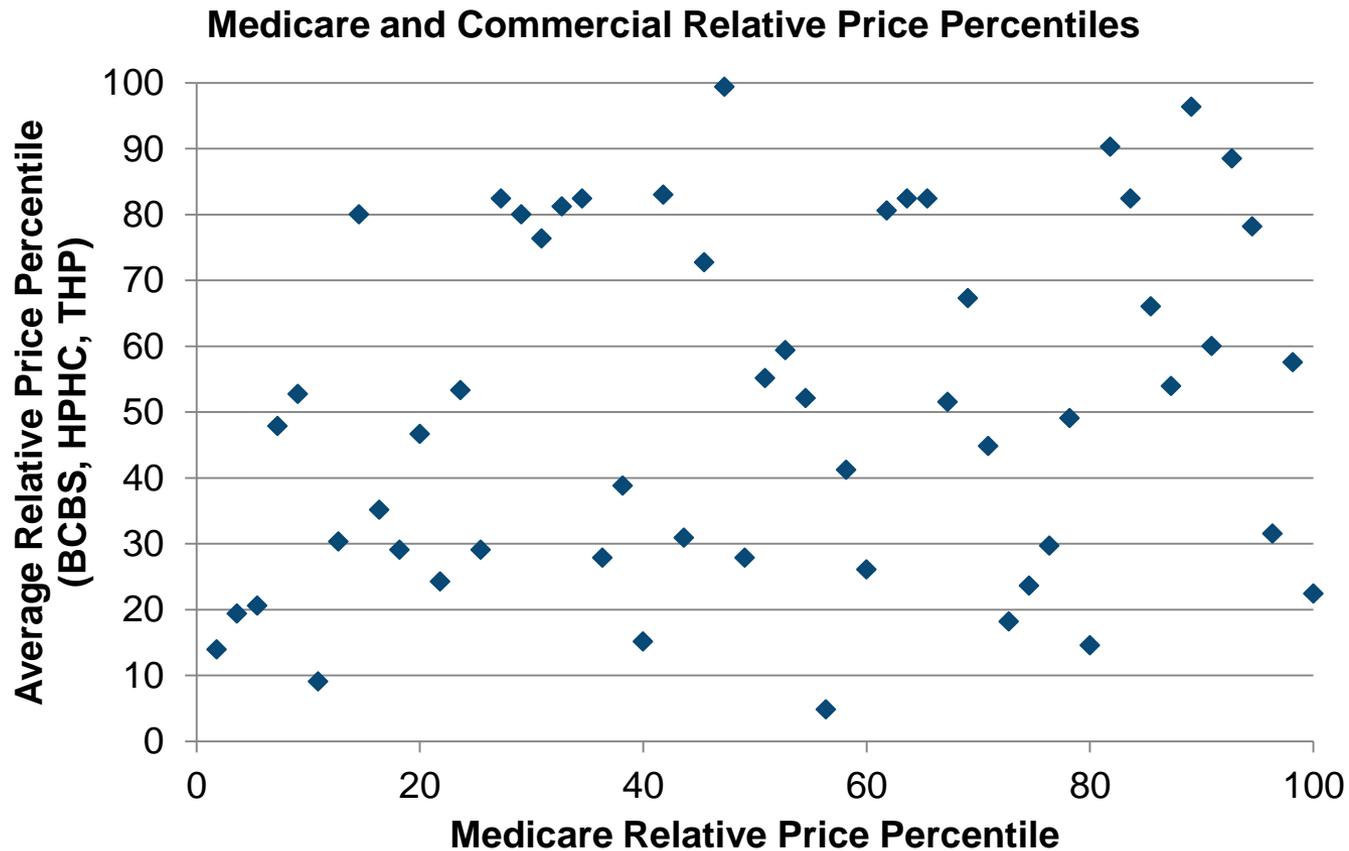
Medicare prices do vary, but the variation is based on certain factors that are defined by that system as acceptable, and prices are similar for most providers

Distribution of Inpatient Relative Price by Payer, 2014



Limiting variation to acceptable factors; Medicare and commercial prices have little correlation

In Medicare, where prices are allowed to vary based on certain acceptable factors, the price levels of different providers have little relationship with commercial price levels.

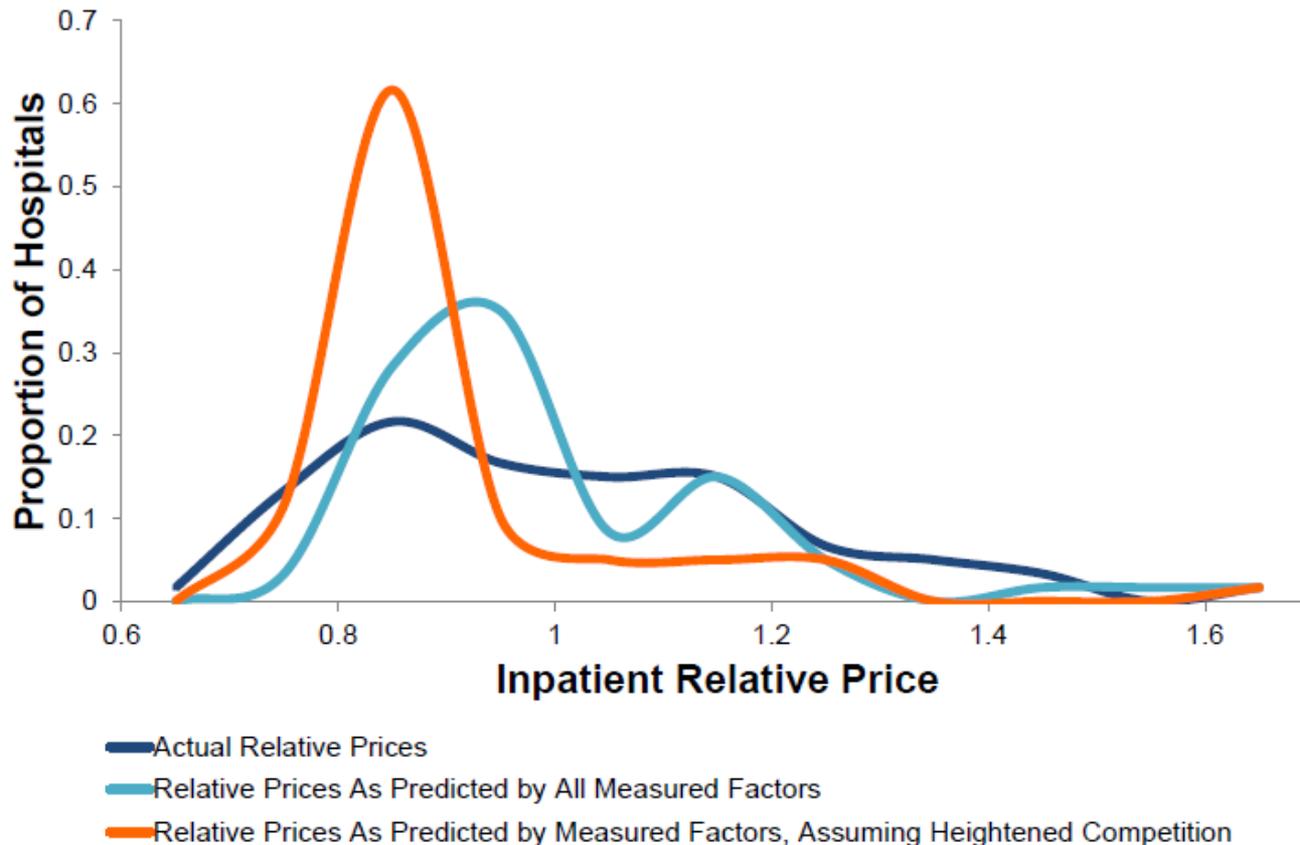


Note: Acute hospitals not paid under Medicare IPPS are excluded to provide more appropriate comparisons.
Source: Based on analysis performed by CHIA at HPC's request

Limiting variation to acceptable factors; holding certain competition factors constant reduces variation

Holding certain competitive factors constant at levels that indicate increased competition among hospitals results in reduced price variation (orange line).

Distribution of Inpatient Relative Prices
Blue Cross Blue Shield



Update on new provider price variation legislation

MassHealth Delivery System Reform Trust Fund

- New \$275 million annual hospital assessment, to be distributed to hospitals by the Secretary of Health and Human Services.
- Of this amount, \$250 million had been proposed previously and \$15 million is newly proposed in this legislation.

Community Hospital Reinvestment Trust Fund

- CHIA will transfer \$5 million to the Fund this year and \$10 million per year for four additional years, for a total of \$45 million over five years.
- To be eligible, acute hospitals must have relative price below 120% of statewide median.
- The Secretary of Health and Human Services will administer the fund, allocating payments based on hospitals' relative size, as measured by gross patient service revenue, adjusted to allocate greater payments to hospitals with lower prices.

Special Commission to Review Variation in Prices Among Providers

- Co-chaired by the Senate and House chairs of the Joint Committee on Health Care Financing
- Charged with:
 - Identifying the acceptable and unacceptable factors contributing to price variation
 - Comparing price variation in MA and in other states
 - Reviewing contracting practices for multi-location providers
 - Recommending steps to reduce variation and recommend the maximum reasonable adjustment to a commercial payer's median rate for each acceptable factor.
- CHIA and the HPC shall provide data and analysis necessary for the evaluation.
- The Commission shall meet by September 15, 2016 and release recommendations by March 15, 2017.

Next Steps

Feedback and discussion with commissioners



Issue price variation summary report



Support price variation commission in creating a more sustainable and value-based health care system



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
 - Update on Notice of Material Change
 - Update on HPC’s Stakeholder Discussions on Provider Price Variation
 - **Presentation on Performance Improvement Plans**
 - 2016 Cost Trends Hearing
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

CHIA Identification of Payers and Providers

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

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

Performance Improvement Plans

Key Updates

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

Summary of Payers and Providers Identified by CHIA

Providers

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

Payers

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

Standard and Factors for Review

Standard

The HPC may require a PIP where, based on a review of factors described below,

- 1) the HPC identifies significant concerns about the entity's costs and
- 2) determines that a PIP could result in meaningful, cost-saving reforms.

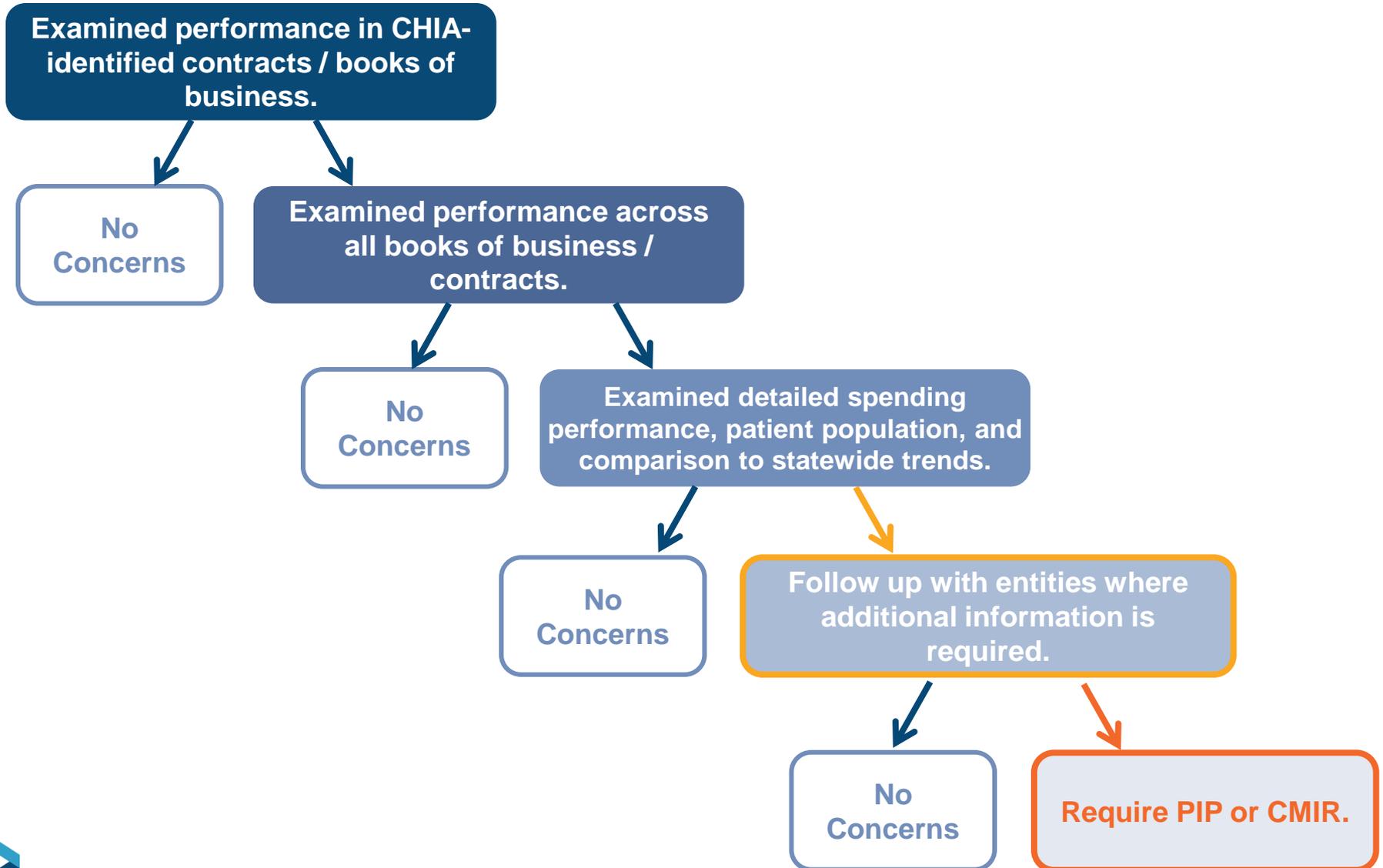
Factors for Review

Including, but are not limited to:

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

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

Overview of HPC's 2016 Initial Review Process



Overview of HPC's 2016 Initial Review Process

Notices of Identification

■ **Notice Type #1:** No significant concerns

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

■ **Notice Type #2:** Additional information required

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

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

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

Next Steps and Timeline for Performance Improvement Plans

	2016					
	March	April	May	June	July	Fall Quarter
HPC released interim guidance for PIPs and CMIRs of entities identified on CHIA's list	■					
HPC reviews payers and providers identified by CHIA to identify entities from whom it will require a PIP or a CMIR	■	■	■	■	■	
HPC sends letters notifying payers and providers that they have been identified by CHIA & select requests for follow up				★		
HPC seeks additional information from select payers and providers in order to determine whether to require a PIP				■	■	
HPC potentially requires a PIP or CMIR for entities on CHIA's list, and works with entities on a PIP submission					■	■
HPC receives new list from CHIA based upon <i>final</i> 2014 data and <i>preliminary</i> 2015 data and begins initial review						■



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
 - Update on Notice of Material Change
 - Update on HPC’s Stakeholder Discussions on Provider Price Variation
 - Presentation on Performance Improvement Plans
 - **2016 Cost Trends Hearing**
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

SAVE THE DATE

2016 HEALTH CARE COST TRENDS HEARING

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



2016 Cost Trends Hearing

Key Action Steps

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

2016 Cost Trends Hearing

Key Action Steps

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

Topic of
Discussion Today

2016 Cost Trends Hearing

Key Action Steps

2 Distribute and Analyze Pre-Filed Testimony

Goals

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

2015 Questions

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

2016 Hypothesis

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

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

Key Action Steps

3 Potential Hearing Focus Areas/Panel Topics – For Discussion

Framed around core HPC values of **Accountability, Transparency** and **Innovation**

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

Dashboard – benchmark & spending

Measure	MA time trend		Direction of change	US comparison	MA relative to US
1. Growth of THCE per capita (performance assessed relative to 3.6% benchmark)	2.4% (2012-2013)	4.8% (2013 - 2014)		4.2% (2013-2014)	
2. Growth in premiums	Family:1.7% Single:2.8% (2012-2013)	Family: 1.6% Single: 0.9% (2013-2014)		Family: 3.9% Single: 4.7% (2013-2014)	
2a. Level of premiums	Family:\$17,424 Single:\$6,290 (2013)	Family: \$17,702 Single: \$6,348 (2014)	N/A	Family: \$16,655 Single: \$5,832 (2014)	
3. Individuals with high out-of-pocket spending relative to income	N/A	11% (2013 and 2014 average)	N/A	MA ranked 2nd out of 51 (US = 15%) (2013 and 2014 average)	

-  Performed Better
-  Performed Similar
-  Performed Worse

Dashboard – efficient, high-quality care delivery

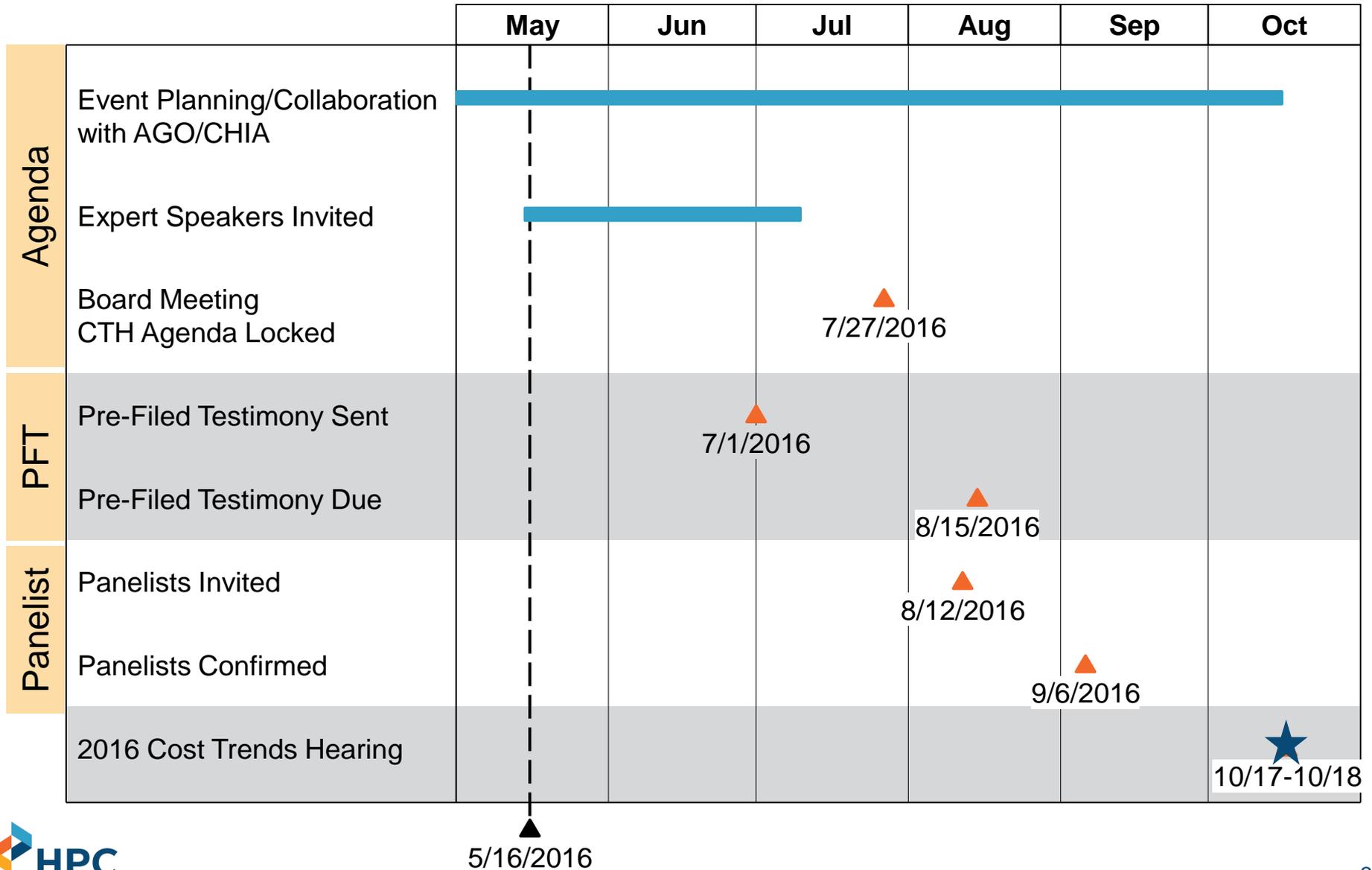
Measure	MA time trend		Direction of change	US comparison	MA relative to US
4. Readmission rate (Medicare 65+)	19.4% (2010) 18.2% (2012)	17.4% (2013)		MA ranked 39 out of 51 (US = 17.0%) (2013)	
4a. Readmission rate (All payer)	15.9% (2011)	15.0% (2013)		N/A	N/A
5. ED utilization (per 1,000 persons)	361 (2010) 357 (2013)	349 (2014)		MA ranked 35 out of 51 (2013)	
5a. Behavioral health ED utilization (per 1,000 persons)	21 (2010) 24 (2013)	25 (2014)		N/A	N/A
6. Percentage of inpatient cases discharged to institutional PAC	20.6% (2013)	20.8% (2014)		MA = 20.4% (2012) US = 16.7% (2012)	
7. At-risk adults without a doctor visit	7% (2013)	7% (2014)		13% (2014)	
8. Percentage of primary care physicians practicing in certified PCHMs	1,580 20.3% of all PCPs (2014)	2,024 25.3% of all PCPs (2015)		15.2% of all PCPs (2015)	

Sources: Institute of Medicine (measure 4), Center for Health Information and Analysis (measure 4a), Center for Health Information and Analysis, HPC analysis (measures 5 and 5a-MA, measure 6-MA), Commonwealth Fund (measure 7), National Commission on Quality Assurance and American Association of Medical Colleges, HPC analysis (measure 8), Kaiser Family Foundation (measure 5-U.S.), Agency for Healthcare Research and Quality (measure 6-US).

Dashboard – APMs and value-based markets

Measure	MA time trend		Direction of change	US comparison	MA relative to US
APMs					
9. Percentage of Original Medicare members in APMs	41% (2013)	46% (2014)		16% (2014)	
10. Percentage of commercial HMO members in APMs	61% (2013)	68% (2014)		N/A	N/A
11. Percentage of commercial PPO members in APMs	~1% (2013)	2% (2014)		N/A	N/A
12. Percentage of MassHealth members in APMs	PCC: 14% (2013) MCO: 32% (2013)	PCC: 22% (2014) MCO: 22% (2014)		N/A	N/A
Value-based market					
13. Enrollment in tiered network products	Tiered: 14.5% (2013)	Tiered: 16.0% (2014)		N/A	N/A
14. Percentage of discharges in top 5 systems	51% (2012) 53% (2013)	56% (2014)		N/A	N/A
15. Percentage of discharges from hospitals with relative price of 1.0 or above	68% (2012) 72% (2013)	73% (2014)		N/A	N/A

2016 Cost Trends Hearing





AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- **Care Delivery and Payment System Transformation**
 - Update on HPC Certification Programs
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
 - **Update on HPC Certification Programs**
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

Practices participating in PCMH PRIME

1 practice
is PCMH PRIME Certified
Fenway South End

1 practice
has an application under review for PCMH
PRIME Certification

39 practices
are on the **Pathway to PCMH PRIME**

2 practices
are working toward NCQA PCMH
Recognition and PCMH PRIME Certification
concurrently



Outreach and training for practices

COMPLETED

April 28, 2016

Webinar: Introduction to PCMH PRIME

54 participants

May 23-24, 2016

In-person Seminar: Introduction to PCMH
and PCMH PRIME

41 participants

UPCOMING

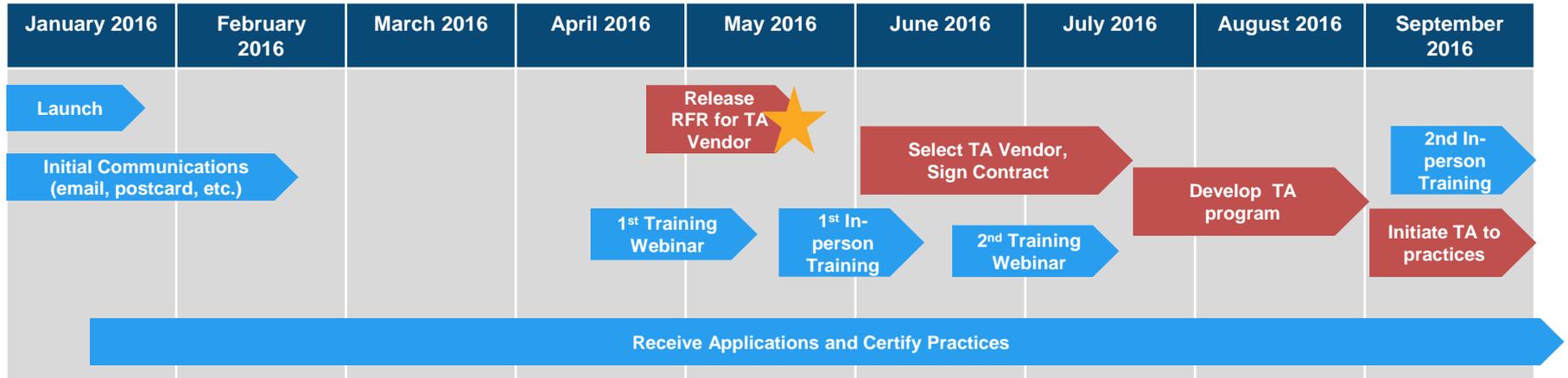
June 28, 2016

Webinar: Introduction to PCMH PRIME

September 2016 (date TBD)

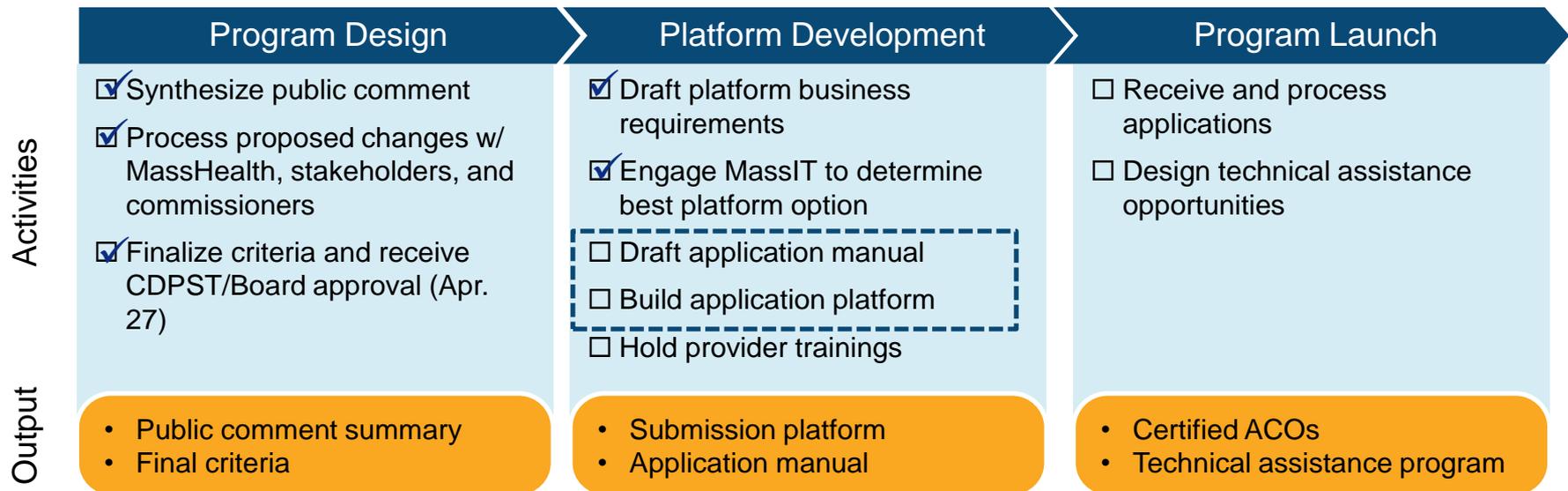
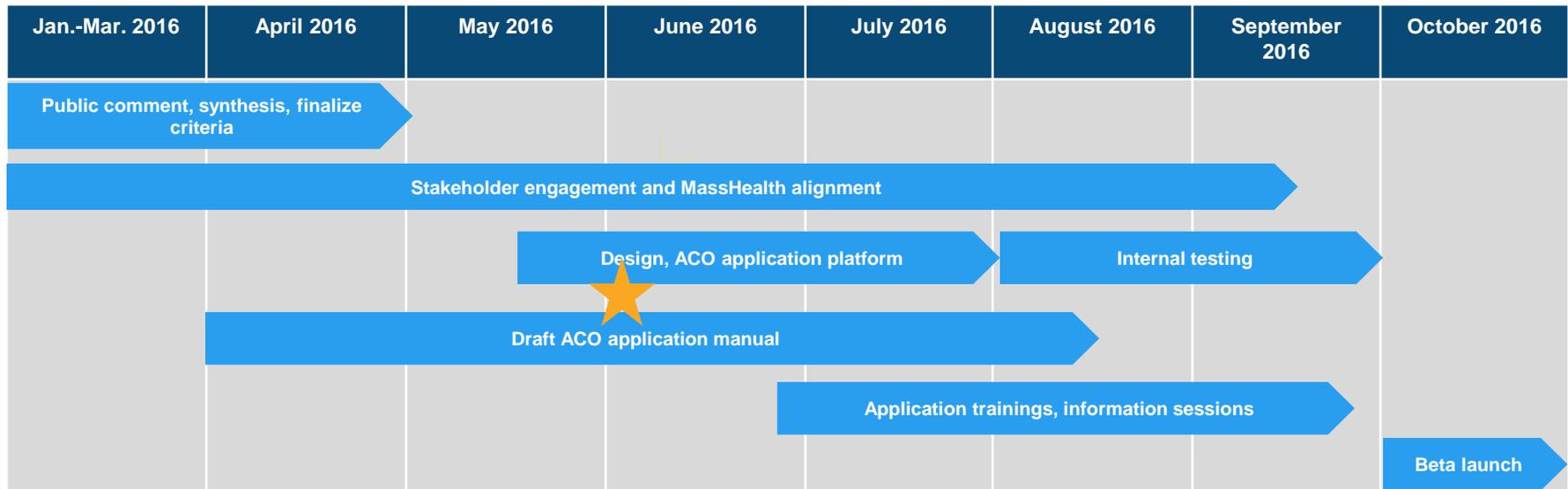
In-person Seminar:
Introduction to PCMH and PCMH PRIME

PCMH PRIME timeline and next steps



	Launch and Communications	Training	Technical Assistance
Activities	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Load PCMH PRIME criteria into NCQA technical platform <input checked="" type="checkbox"/> Notify practices via email, postcard, web, etc. <input checked="" type="checkbox"/> Begin receiving applications to HPC <input type="checkbox"/> Continue communications outreach 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Develop training program and schedule <input checked="" type="checkbox"/> Hold 1st in-person training (May 23-24) <input type="checkbox"/> Hold 2nd webinar training (June 28) 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Develop TA framework and draft RFR <input checked="" type="checkbox"/> Release RFR – bids due May 31 <input type="checkbox"/> Select and contract with vendor <input type="checkbox"/> Work with vendor to design program <input type="checkbox"/> Begin providing TA
Output	<ul style="list-style-type: none"> • Application system • Communications plan 	<ul style="list-style-type: none"> • Training plan and materials 	<ul style="list-style-type: none"> • Vendor selection • TA program design

ACO certification timeline and next steps





AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- **Quality Improvement and Patient Protection**
 - Presentation on Oral Health Brief
 - Update on Regulations Governing OPP
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
 - **Presentation on Oral Health Brief**
 - Update on Regulations Governing OPP
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

The HPC has identified ED visits and avoidable ED visits as an area of ongoing focus

Measure	MA time trend		Direction of change	US comparison	MA relative to US
	2010	2014			
5. ED utilization (per 1,000 beneficiaries)	361 (2010)	349 (2014)		MA ranked 35 out of 51 (2013)	

- While emergency departments are essential to the delivery system, some ED visits may be avoidable - either because the condition was preventable with earlier treatment or because the condition could be treated in an alternate setting
- ED use in MA is high relative to the US, although it dropped between 2013 and 2014
- HPC has conducted several studies of ED use and avoidable ED use
 - Avoidable ED use and growth in behavioral health-related ED visits – 2015 Cost Trends Report
 - Opioid-related hospital visits (including ED) – March 23 QIPP Meeting
 - ED visits for preventable oral health conditions – May 18 CTMP/QIPP Meeting
- Past work on ED use has highlighted regional variation, relationship to income and other patient characteristics, and relationship to provider supply

Summary of Key Findings

4-7X

More expensive to visit the ED for an oral health condition instead of a dental office

6x

rate of children covered by MassHealth visited the ED for preventable oral health conditions compared to the rate of commercially insured children

7x

rate of adults covered by MassHealth visited the ED for preventable oral health conditions compared to the rate of commercially insured adults

48.8

percent of all preventable ED oral health visits paid for by MassHealth

1/10th

of MA population lives in a federally designated dental health professional shortage area

53%
low-income children

56%
low-income adults

saw a dentist in 2014

Young adults had the highest rates

of ED visits for preventable oral health conditions

~25

percent of the population covered by MassHealth

five-fold regional variation

in the number of oral health ED visits per population, high: 13.1 visits per 1,000, Fall River
low: 2.6 visits per 1,000, West Merrimack/Middlesex

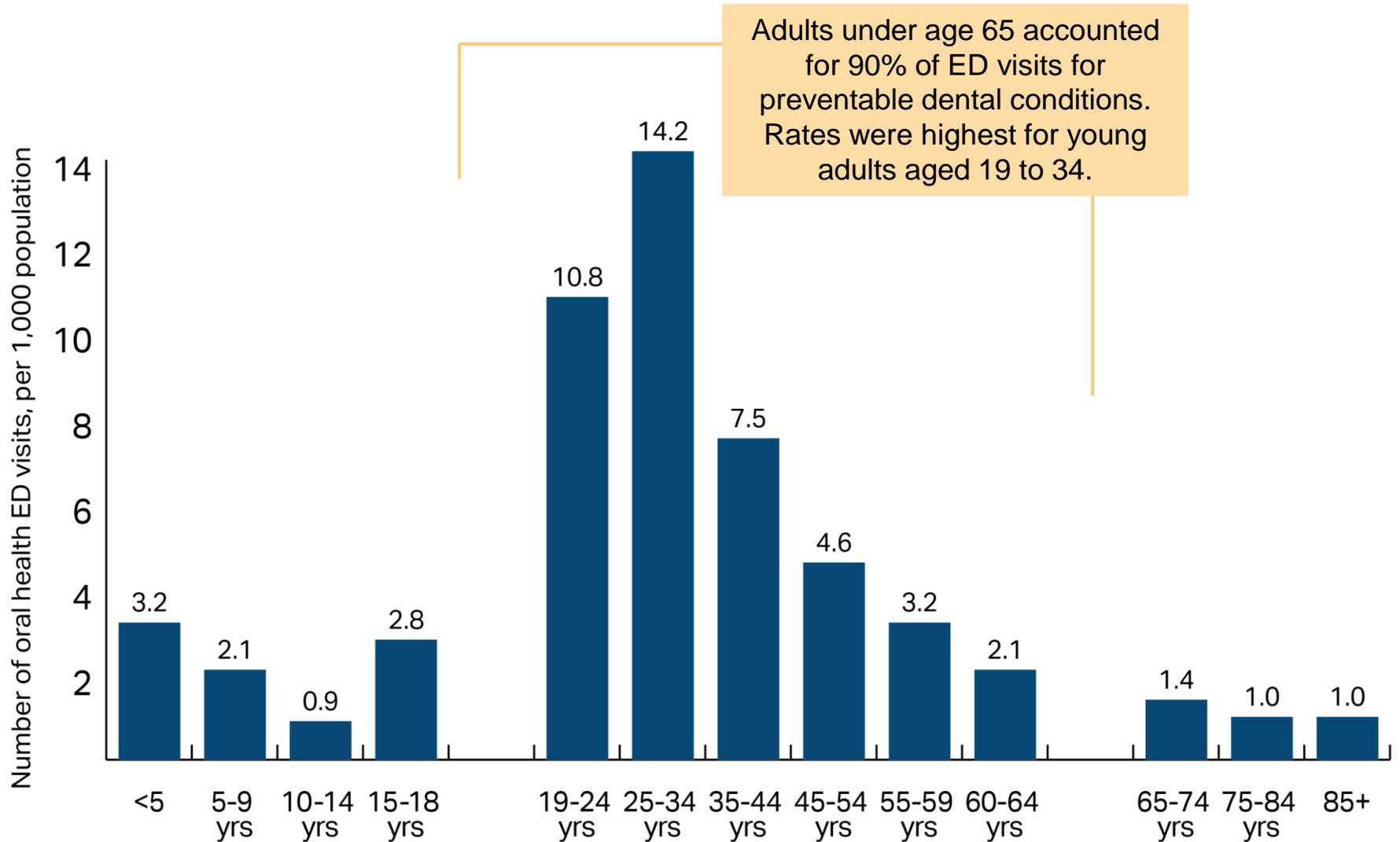
26%

of dentists billed at least \$10,000 to MassHealth in 2014

Highlighted interventions include

- (1) Mid-level dental providers
- (2) Teledentistry

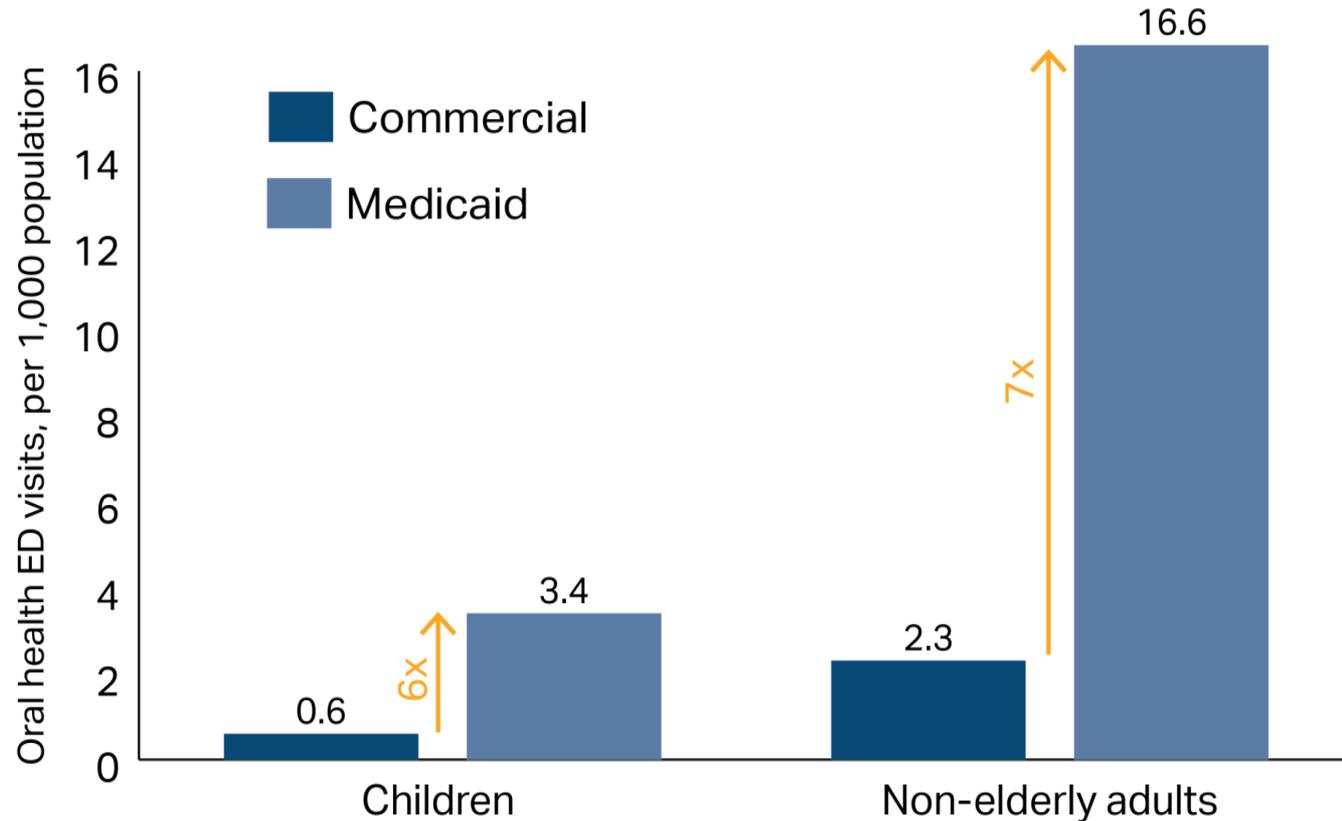
Young adults had the highest rates of ED visits for preventable oral health conditions



Notes: Figure reports dental conditions defined based on ICD-9 primary diagnostic codes designated by the California HealthCare Foundation. These include ICD-9: 521, 522, 523, 525, and 528.

Source: HPC analysis of Center for Health Information and Analysis, Emergency Department Database, 2014; population counts from the Kaiser Family Foundation

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

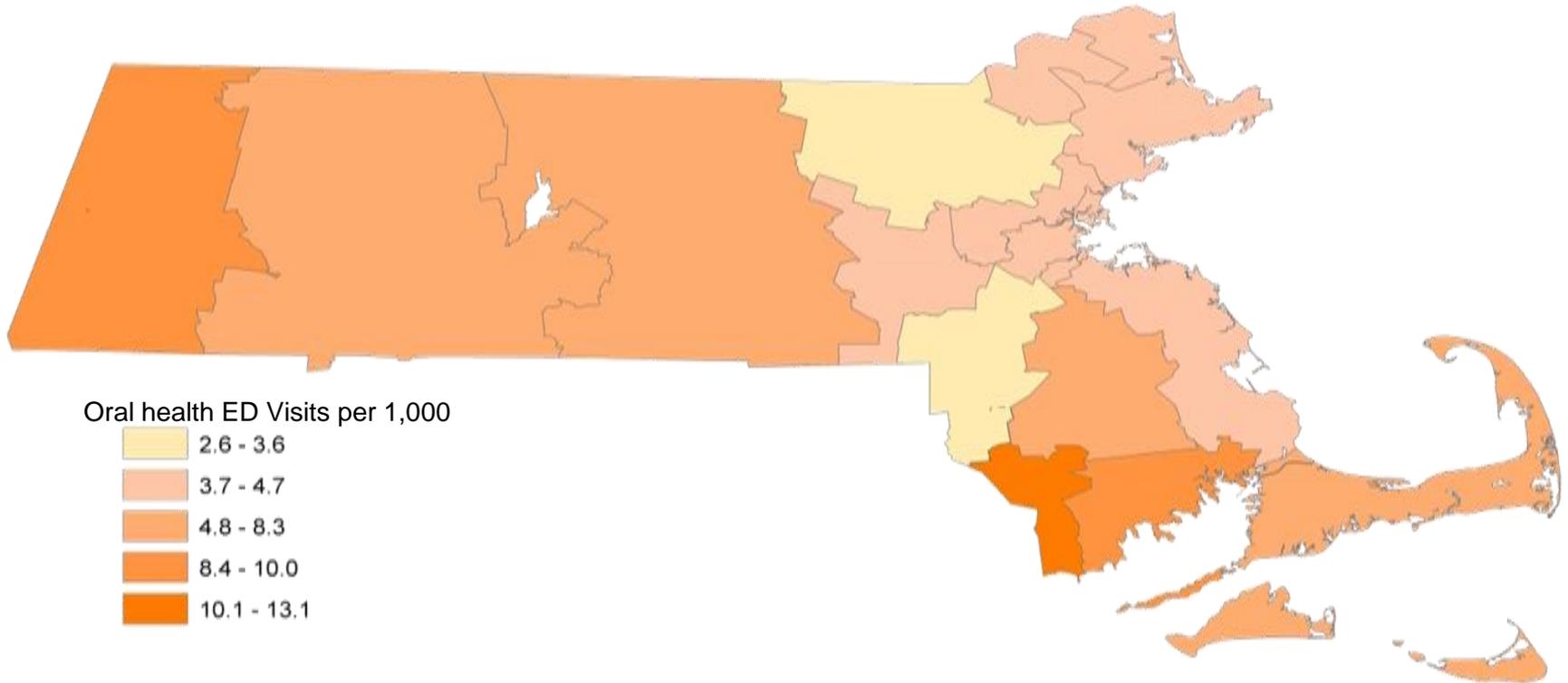


There could be many reasons for higher rates of preventable oral health ED visits among MassHealth enrollees, but likely contributing factors include: clinical risk factors, a low number of dentists accepting MassHealth patients, and patients' costs.

Notes: Figure reports dental conditions defined based on ICD-9 primary diagnostic codes designated by the California HealthCare Foundation. These include ICD-9: 521, 522, 523, 525, and 528.

Source: HPC analysis of Center for Health Information and Analysis, Emergency Department Database, 2014; population counts from the Kaiser Family Foundation

The rate of ED visits for preventable oral health conditions varied by region, with the highest rate in Fall River, followed by the Berkshires and New Bedford



Areas with more ED visits had lower median incomes and fewer full-time dentists relative to the population*

*The correlation coefficient was -.6 in both cases.

Notes: Figure reports dental conditions defined based on ICD-9 primary diagnostic codes designated by the California HealthCare Foundation. These include ICD-9: 521, 522, 523, 525, and 528.

Source: HPC analysis of Center for Health Information and Analysis, Emergency Department Database, 2014; population counts from the Kaiser Family Foundation

Exemplar oral health interventions

- The use of EDs for preventable oral health conditions suggests a clear opportunity to strengthen the Commonwealth's dental safety net and expand access to routine oral health care
- Exemplar oral health interventions to consider include:
 - Augmenting the oral health workforce
 - Supporting teledentistry initiatives
- Impact evaluations of these models show that they can increase access to oral health care by expanding the capacity of dental care teams and utilizing technology to extend the reach of the dental workforce
 - In both cases, the interventions can be focused on vulnerable populations

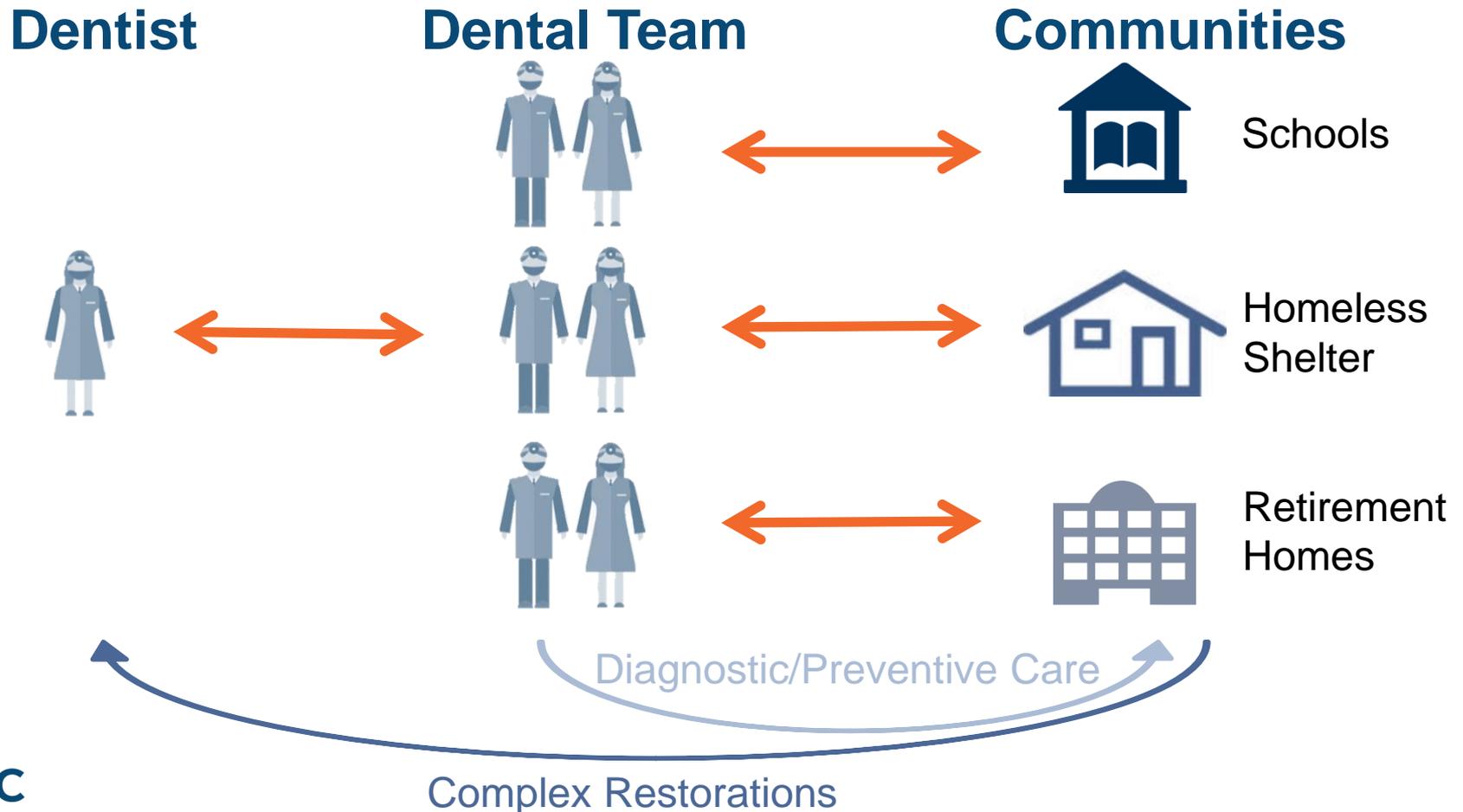
Augmenting the oral health workforce by licensing mid-level dental providers

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

State	Type of provider	Education/Training	Services provided
AK	Dental health aide therapist	18-to 24-months at a community college/ technical school program	Preventive, restorative (fillings and extractions) under standing orders and remote supervision by a dentist
MN	Dental therapist; advanced dental therapist	DT: bachelor's degree in dental therapy ADT: Master's degree in advanced dental therapy	DT: preventive services, some restorative (fillings/extractions), supervision of a dentist required for some procedures ADT: treatment plans, oral evaluations, extraction of permanent teeth. Some procedures require collaborative management agreement with dentist
ME	Dental hygiene therapist	Bachelor's degree in dental hygiene	Preventive, oral health assessments, simple extractions, prepare and replace crowns, referrals, local anesthesia under supervision of a dentist

Supporting teledentistry initiatives

- Teledentistry enables dentists to remotely supervise staff through the use of mobile technology
- Allows dental hygienists to provide care in schools, nursing homes, homeless shelters, prisons, and other community settings
- Removes financial and logistical barriers that vulnerable populations face



Update on Oral Health Provision in Senate Budget Bill

- On May 25, 2016, the **Senate unanimously adopted an amendment** to the State Budget filed by Senate Majority Leader Harriette Chandler (No. 479, as redrafted) authorizing a model to expand oral health access by establishing new mid-level dental professionals
- The new mid-level dental practitioners, **dental hygiene practitioners (DHPs)**, which are similar to medical physician assistants, would increase dental access for vulnerable populations and make health care spending more efficient
- DHPs are dental hygienists authorized to **provide oral health care services to patients**, including preventive, oral evaluation and assessment, educational, palliative, therapeutic and restorative services
- Similar models have been adopted successfully in **other states** (e.g., Minnesota, Alaska) and other states are attempting to do the same (e.g., Vermont, Maine)
- The model has been **approved by the Commission on Dental Accreditation**, which sets national standards for dental providers

Highlights from Dental Hygiene Practitioner Provision

Requirements

DHPs will be required to (1) undergo additional education and training requirements and (2) enter into a written collaborative management agreement with a licensed dentist that outlines the procedures, services, responsibilities, and limitations of the DHP

Scope of Practice

DHPs will be authorized to perform certain services and procedures without the supervision or direction of a dentist (e.g., interpreting radiographs); however, DHPs will be able to perform certain additional services and procedures only with the authorization of the collaborating dentist

Reimbursement

DHPs shall be reimbursed for services covered by Medicaid and other third-party payers

Collaborative Management Agreements

Supervising dentists may have collaborative management agreements with no more than 4 DHPs at the same time

Evaluation

The Board of Registration in Dentistry, in consultation with EOHHS, will perform a 5-year evaluation of the impact of the new mid-level practitioners on patient safety, cost-effectiveness and access to dental services; a report must be submitted no later than July 1, 2021 to multiple legislative committees



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
 - Presentation on Oral Health Brief
 - **Update on Regulations Governing OPP**
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

Preview: OPP Regulatory Revision – New Carrier Reporting Requirements

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

SECTION 53. Said section 7 of said chapter 176O, as so appearing, is hereby further amended by inserting after the word "age", in line 68, the following words:- ; and

(5) a report detailing for the previous calendar year the total number of: (i) medical or surgical claims submitted to the carrier; (ii) medical or surgical claims denied by the carrier; (iii) mental health or substance use disorder claims submitted to the carrier; (iv) mental health or substance use disorder claims denied by the carrier; and (v) medical or surgical claims and mental health or substance use disorder claims denied by the carrier because: (A) the insured failed to obtain pre-treatment authorization or referral for services; (B) the service was not medically necessary; (C) the service was experimental or investigational; (D) the insured was not covered or eligible for benefits at the time services occurred; (E) the carrier does not cover the service or the provider under the insured's plan; (F) duplicate claims had been submitted; (G) incomplete claims had been submitted; (H) coding errors had occurred; or (I) of any other specified reason.

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

Considerations and Next Steps

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

Proposed Timeframe to Update OPP Regulations

May 18, 2016 – Previewed regulatory revision with the QIPP Committee

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

September 14, 2016 – QIPP Committee to review proposed regulation

November 9, 2016 – Full Board to review proposed regulation

Fall 2016 – Public hearing on proposed regulation

Fall 2016 – Deadline to submit public comments on proposed regulation

November 2016 – QIPP Committee to review final regulation

December 2016 – Commission to review final regulation

**Dates are subject to change.*

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



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- **Community Health Care Investment and Consumer Improvement**
 - Update on HPC Innovation Investments
 - Update on CHART Investment Program
 - Approval of CHART Evaluation Contract
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
 - **Update on HPC Innovation Investments**
 - Update on CHART Investment Program
 - Approval of CHART Evaluation Contract
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

The HPC's Innovation Investment Opportunities have entered an extremely competitive review and selection phase

HEALTH CARE INNOVATION INVESTMENT (HCII) PROGRAM

- \$5 million available to providers and health plans
- Up to \$750,000 per award
- Total anticipated awards: 7-10
- **58 Proposals**

TELEMEDICINE PILOT INITIATIVE

- \$1 million available to providers and health plans
- Up to \$500,000 per award
- Total anticipated awards: 2
- **11 Proposals**

NEONATAL ABSTINENCE SYNDROME (NAS) PILOT INITIATIVE

- \$3.5 million available to birthing hospitals
- Award caps vary by eligibility for the CHART Investment Program
- Total anticipated awards: 4
- **6 Category A Proposals**
- **7 Category B Proposals**

UPCOMING DATES

- Award Announcement: July 2016 (anticipated)
- HCII Period of Performance: October 2016 - September 2018
- Telemedicine Period of Performance: October 2016 - March 2018
- NAS Period of Performance Category A: October 2016 - December 2017
- NAS Period of Performance Category B: October 2016 - December 2018

Innovation Investment Opportunities procurement by the numbers



Initial scans of proposals suggest a competitive field of applicants

- Applicants demonstrated understanding of each program's goals and a commitment to **achieving bold improvement targets** for patients receiving care in Massachusetts
- Proposals describe **diverse approaches to innovation** in terms of proposed engagement of technology, mid-level practitioners, partners and patients
- To meet patients where they are, applicants **intend to partner** with community-based organizations such as supportive housing, police, community-based addiction treatment providers, and WIC programs
- Several initiatives were described by applicants as advancing long-term **population health management strategies** for improving care at lower cost under risk-based payment

Next Steps for Review and Selection

- 
- Staff has completed a technical review of all proposals to determine which have met the programs' minimum requirements
 - Eligible proposals are currently in review with HPC Commissioners, program staff, interagency representatives and expert advisors who will assess proposals against the program selection criteria
 - Substantive review will culminate in deliberation meetings among reviewers to discuss the relative merits of proposal
 - Staff will bring award recommendations to the Board for discussion and the Board's endorsement on July 27



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
 - Update on HPC Innovation Investments
 - **Update on CHART Investment Program**
 - Approval of CHART Evaluation Contract
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

CHART Phase 2: Progress as of May 2016

CHART Phase 2 Awards

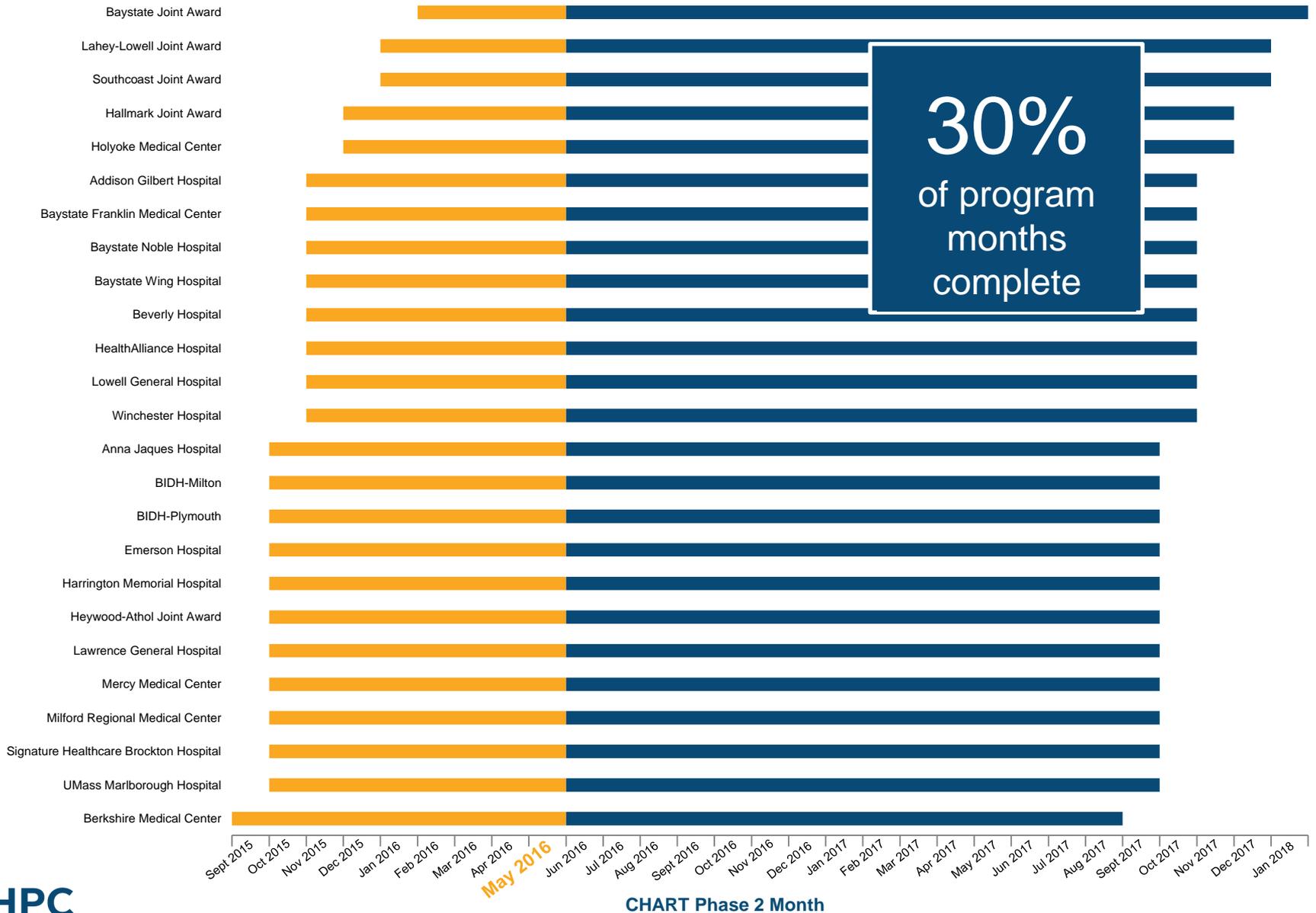
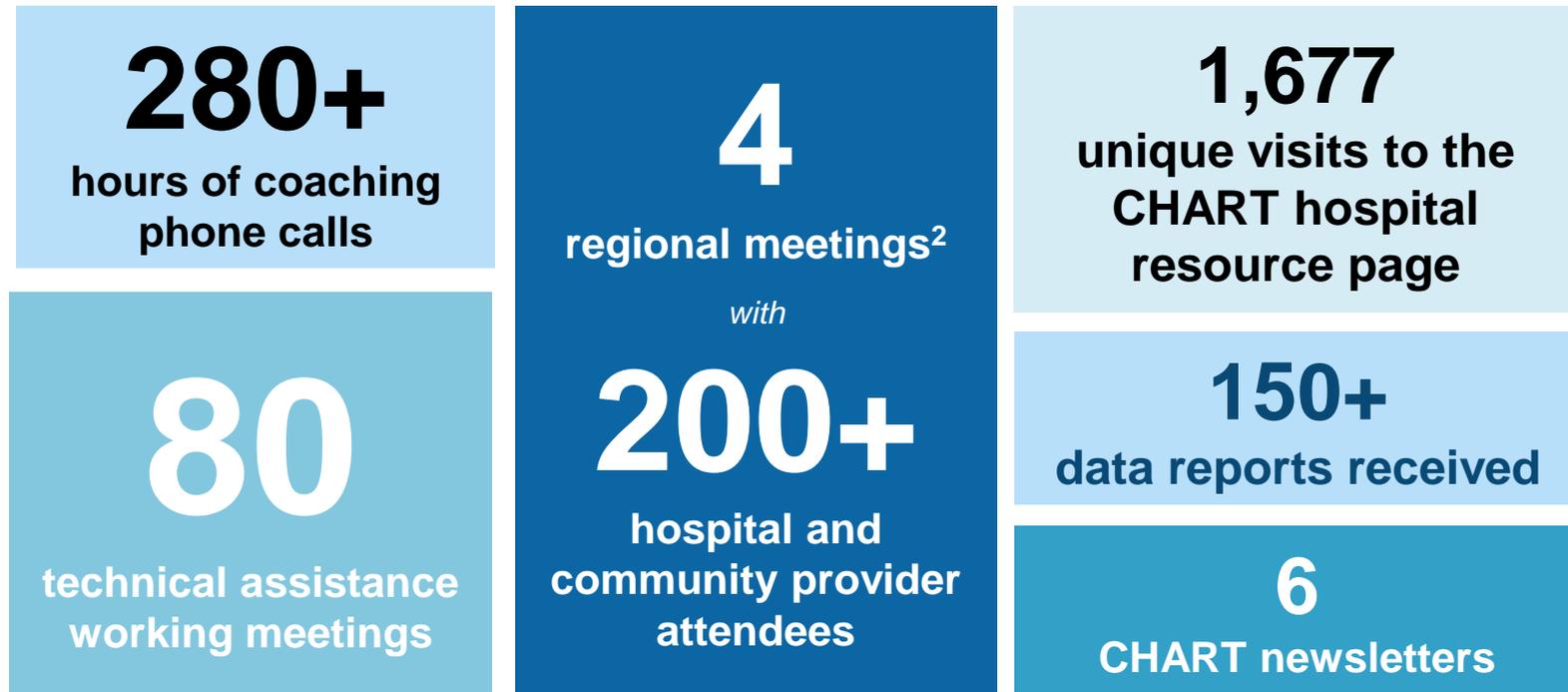


CHART Phase 2: Activities since program launch¹



Note: Updated May 26, 2016

¹ Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015

² Next regional meetings scheduled for 6/20/16 and 6/21/16



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting (VOTE)
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
 - Update on HPC Innovation Investments
 - Update on CHART Investment Program
 - **Approval of CHART Evaluation Contract (VOTE)**
- Administration and Finance
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

CHART evaluation background

CHART Phase 2

- Phase 2 of the CHART Investment Program awards over \$60 million to 28 community hospitals across the Commonwealth. Launched in late 2015 after implementation planning, the program is approximately 30% complete. At this point, the HPC anticipates that the Phase 2 projects will be complete in early 2018.
- Chapter 224 requires the HPC to conduct an evaluation of Phase 2 of the CHART Investment Program. The value and goals of the evaluation were discussed with CHICI in April 2015.
- In order to generate an independent, rigorous, and insightful evaluation, the HPC proposes to hire an outside evaluator with the necessary expertise and resources.

CHART Evaluation Design Process

- In May of 2015, the HPC released an Request for Proposal (RFP) to hire a consultant to assist with the development of an evaluation design for the CHART Program. At that time, the HPC engaged with **Abt Associates**.
- Working with Abt, the HPC finalized an evaluation design and presented it at CHICI meetings in October 2015 and February 2016. The evaluation design includes a plan for mixed-methods summative evaluation with performance feedback to hospitals, descriptions of data collection and analysis to be conducted, as well as reports and other deliverables, and a timeline that calls for baseline and interim reports to be available during the program period. The final report is to be delivered by the end of 2018.
- With a thorough evaluation design formulated, the HPC procured for a vendor for implementation.

Building insight into care delivery and hospital transformation

Goals	<p><u>TO ASSESS EFFICACY</u> of CHART Phase 2 in achieving its quantitative and qualitative goals, including the ROI, sustainability, and scalability of hospital projects</p>	<p><u>TO ADVANCE KNOWLEDGE</u> regarding opportunities, challenges, and best practices for health care organizations that seek to transform care delivery</p>	<p><u>TO ENHANCE CAPABILITY</u> of participating hospitals and of the HPC for measurement, continuous improvement, and accountability</p>
--------------	---	--	--

Value	During CHART Phase 2	After Period of Performance Ends
	Improve technical assistance to awardees	Report to HPC’s Board and the Legislature on results
	Provide feedback to hospitals	Disseminate findings on program effectiveness and best practices
	Identify challenges and create learning opportunities	Guide future HPC investments
	Identify questions that need further study	Make policy recommendations

Assessing performance of a forward-looking investment



	Was the intervention fully deployed?	Did the intervention work as designed?	Did the intervention produce lasting changes?
Research questions	Did each hospital carry out the activities described in the implementation plan?	Was avoidable hospitalization reduced?	Did CHART hospitals move towards effective participation in accountable care?
	Was the CHART program as a whole implemented effectively?	Was patient-centered, integrated care delivery expanded?	Did CHART hospitals increase their capability for continuous improvement?
Methods	Qualitative Site visits, Document review	Qualitative Site visits, Document review, Patient perspective study	Qualitative Site visits, Organization Survey
		Quantitative Pre-Post Analysis Difference-in-difference	Quantitative Return on Investment

Selecting an external evaluator

The HPC sought to partner with an experienced team capable of implementing the full-scope of the evaluation on time and as designed and of delivering high-quality results.

Process

- Staff finalized the Evaluation Design Report with input from hospitals and accountable care team
- HPC issued an RFR on 3/11/2016 requesting bids to carry out the plan described in the EDR
- HPC received two bids for the evaluation as designed
- Staff interviewed both vendors in person and scored proposals on merit

Scoring Criteria

- Experience with health care delivery evaluation
- Experience in mixed-methods synthesis
- Experience in iterative performance improvement
- Expertise in community hospitals and MA provider landscape
- Track record of effective project management and timely deliverables

Selecting an external evaluator

Recommendation

Boston University School of Public Health

Factors

- Depth and breadth of expertise in subject matter
- Fluency in quantitative and qualitative methods
- Experience in mixed-methods synthesis
- Detailed plan for collaborative process leading to on-time deliverables
- Higher value, lower cost
- Additionally, BUSPH responded to an optional component to study patient perceptions of CHART care

Budget

\$1,300,000 total cost

Includes Patient Perspective Study

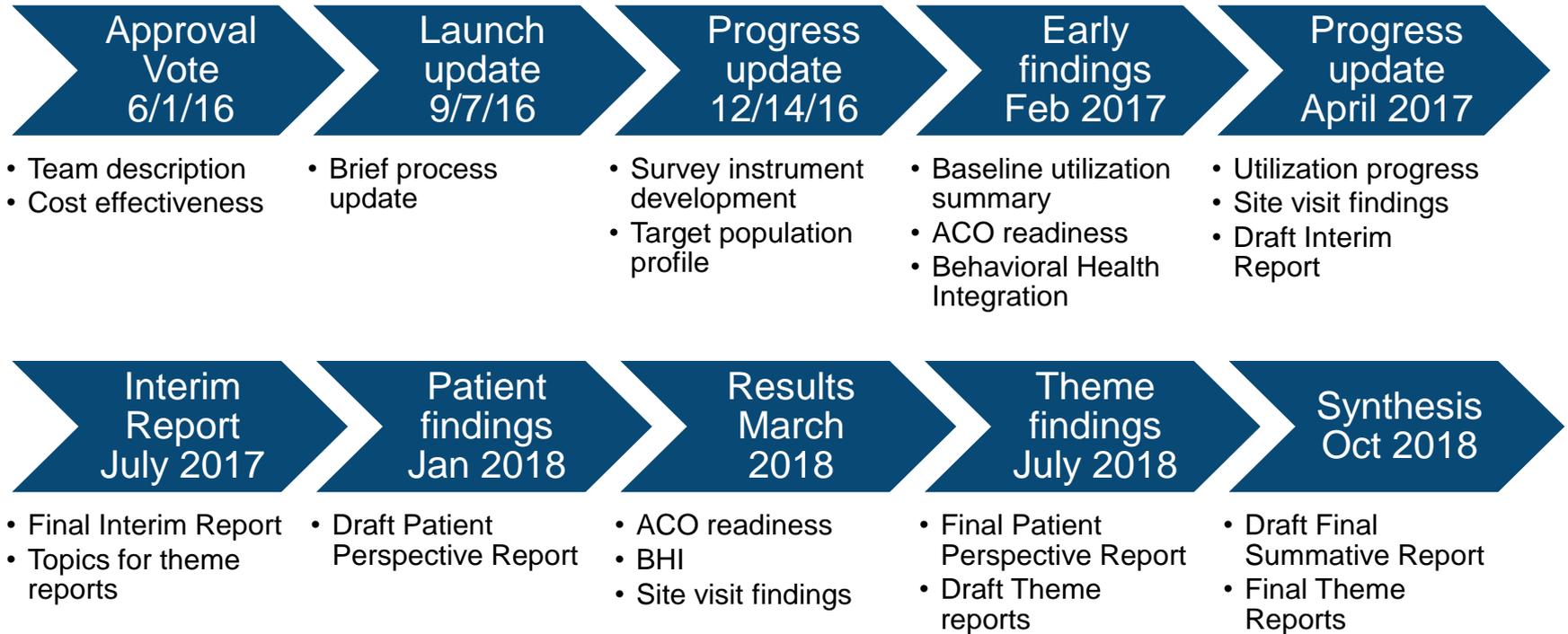
Period of Performance June 2016 – December 2018

Approx. \$600K cost for FY17

Supported by the Distressed Hospital Trust Fund

Delivering findings

Between waves of results, updates are planned for alternate board meetings.



Final Summative Report Jan 2019



Vote: Approval of CHART Evaluation Contract

Motion: That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws, and as endorsed by the Administration and Finance committee, the commission hereby authorizes the Executive Director to enter into a contract with the Boston University School of Public Health for professional services to conduct an evaluation of the projects funded by the Community Hospital Acceleration, Revitalization, and Transformation Investment Program (Phase 2), as required by G.L c.29, 2GGGG, through December 31, 2018, for total contract amount up to no more than \$1,300,000, subject to further agreement on terms deemed advisable by the Executive Director.



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- **Administration and Finance**
 - Approval of Draft Regulations on HPC Operating Assessment
 - HPC Budget Extension
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
 - **Approval of Draft Regulations on HPC Operating Assessment**
 - HPC Budget Extension
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

Proposed Regulation for the HPC's Annual Assessment: Background

2013 - Present

HPC operations have been partially supported by a portion of the One-Time Assessment on certain hospitals and surcharge payors and a portion of gaming license fees, as authorized in Chapter 224. A significant portion of these funds (43% or \$22 million) have been diverted from the HPC to support other state budgetary priorities.

Pursuant to 958 CMR 2.00, the HPC collected the funds from the One-Time Assessment over the past four years.

- *Assessed hospitals and payors elected to pay in a single payment or in four equal annual installments.*

FY16 is the last year of receipt of funds under the One-Time Assessment. In addition, the Massachusetts Gaming Commission has declined to award any additional commercial gaming licenses at this time.

FY2017

Chapter 224 directs the HPC to collect an annual assessment from acute hospitals, ambulatory surgical centers and surcharge payors to fund HPC operations and programs.

- The statute provides that the assessed amount for hospitals and ambulatory surgical centers be *at least* 33% of the amount appropriated by the General Court in the state budget, and the assessed amount for surcharge payors to also be *at least* 33% of the appropriated amount.

The statutory language authorizing the HPC's industry assessment (*MGL. c. 6D, Section 6*) mirrors the statute governing CHIA's annual assessment (*MGL. c. 12C, s. 7*).

Development of HPC's Proposed Annual Assessment Regulation

Advisory Council Administration and Finance Committee

- January 25, 2016
- April 18, 2016

Center for Health Information and Analysis

- Consulted with CHIA on the process used for operationalizing and collecting its annual assessment

Administration and Finance Committee Meeting

- March 2, 2016
- June 1, 2016 (**ENDORSED PROPOSED REGULATION**)

Advisory Council ANF Committee Members
Association for Behavioral Healthcare
Blue Cross Blue Shield of Massachusetts
Conference of Boston Teaching Hospitals
Massachusetts Hospital Association
Massachusetts Association of Health Plans
Massachusetts Council of Community Hospitals

Proposed Regulation 958 CMR 9.00: Assessment on Certain Health Care Providers and Surcharge Payors

958 CMR: HEALTH POLICY COMMISSION

958 CMR 9.00: ASSESSMENT ON CERTAIN HEALTH CARE PROVIDERS AND SURCHARGE PAYORS

Section

- 9.01: General Provisions
- 9.02: Definitions
- 9.03: Acute Hospital and Ambulatory Surgical Center Assessment
- 9.04: Surcharge Payor Assessment
- 9.05: Special Provisions

Next steps in the regulatory process



- June 1, 2016** HPC Board vote to issue proposed regulation
- July 2016** Public Hearing on proposed regulation at ANF committee
- July 27, 2016** HPC Board approval of final regulations
- August 12, 2016** Regulation effective date
- October 1, 2016** Preliminary payments due to HPC



Vote: Proposed Regulation on Annual Assessment

Motion: That the Commission hereby authorizes the issuance of the PROPOSED regulation on the annual assessment, pursuant to MGL c. 6D, Section 6, and directs the Administration and Finance Committee to conduct a public hearing and comment period on the regulation pursuant to Chapter 30A of the General Laws.



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
 - Approval of Draft Regulations on HPC Operating Assessment
 - **HPC Budget Extension**
- Report from the Executive Director
- Schedule of Next Meeting (July 27, 2016)

HPC line-item FY17 budget proposals

All FY17 budget proposals propose identical funding levels for the HPC's operating budget. This figure is set at level-funding to the FY16 Board-approved budget.

Governor's FY17 Budget Proposal

1450-1200: *For the operation of the Health Policy Commission...* \$8,479,800

House FY17 Budget Proposal

1450-1200: *For the operation of the Health Policy Commission...* \$8,479,800

Senate FY17 Budget Proposal

1450-1200: *For the operation of the Health Policy Commission...* \$8,479,800

Vote: HPC Budget Extension

Motion: That the Commission hereby authorizes the Executive Director to continue spending funds to support the ongoing operations of the agency at the level of funding approved by the Commission for fiscal year 2016, until the Commission approves the operating budget for fiscal year 2017 at its next meeting.



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting (VOTE)
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- **Report from the Executive Director**
- Schedule of Next Meeting (July 27, 2016)

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

- Analyze and report on health care cost trends through data examination, and make recommendations for improvement in cost, quality, and access.
- Foster innovation in health care payment service delivery through competitive investment opportunities.
- Examine changes in the health care marketplace and their potential impact. In addition, the HPC is authorized to reduce health care cost growth by requiring certain health care organizations to file and implement a performance improvement plan.
- Accelerate payment system transformation and health care delivery and quality through certification programs, technical assistance, and multi-stakeholder engagement.
- Protect patient access to necessary health care services and coverage.

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Analyze and report on health care cost trends through data examination, and make recommendations for improvement in cost, quality, and access.

2015 Accomplishments

- ✓ 2015 Cost Trends Hearing
- ✓ 2015 Cost Trends Report
- ✓ 2015 Cost Trends Report: Provider Price Variation

2016 Activities

- ✓ Release of Community Hospitals at a Crossroads
- ✓ Release of Policy Briefs: Out-of-Network (OON) Billing (3/2); multiple stakeholder listening sessions on OON issues
- ✓ Host stakeholder discussions on Provider Price Variation (Spring)
 - Release Oral Health Policy Brief (June)
 - Release of Opioid Report (July)
 - Research on consumer choice with the Robert Wood Johnson Foundation
 - Release of HPC Whitepaper Series (Ongoing)
 - 2016 Cost Trends Hearing (October)
 - Release of 2016 Cost Trends Report (December)

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Foster innovation in health care payment service delivery through competitive investment opportunities.

2015 Accomplishments

- ✓ CHART Phase 1 Report and three Case Studies
- ✓ Hosting seven regional convenings for shared learning
- ✓ Implementation Planning Period for CHART Phase 2 Projects
- ✓ Launch of 22 CHART Phase 2 Projects
- ✓ Funding in the State Budget for two new pilot initiatives on telemedicine and neonatal abstinence syndrome (NAS)
- ✓ Planning for the Health Care Innovation Investment Program (HCII)

2016 Activities

- ✓ Launch of remaining CHART Phase 2 Projects
- ✓ RFP Release for NAS, Telemedicine, and HCII Investment Opportunities
- ✓ Launch of CHART Resource Page and Monthly Newsletter
- ✓ Approval of CHART Evaluation Contract
 - Awards for NAS, Telemedicine, and HCII Investment Opportunities
 - Ongoing technical assistance and learning dissemination
 - Planning for CHART Phase 3

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Accelerate payment system transformation and health care delivery and quality through certification programs, technical assistance, and multi-stakeholder engagement.

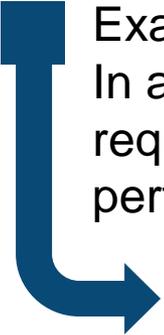
2015 Accomplishments

- ✓ Partnership with NCQA for PCMH Certification
- ✓ Approval of HPC PCMH PRIME Certification Program
- ✓ Drafting of framework for ACO Certification

2016 Activities

- ✓ Launch of PCMH PRIME Certification Program (40 applications to date)
- ✓ Approval of ACO Certification Criteria
 - Approval of behavioral health technical assistance contract
 - Launch of ACO Certification Criteria Application Platform (partnership with GovNext)
 - Launch of online resource databases for ACOs and PCMHs
 - Approval of ACO technical assistance contract

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]



Examine changes in the health care marketplace and their potential impact. In addition, the HPC is authorized to reduce health care cost growth by requiring certain health care organizations to file and implement a performance improvement plan.

2015 Accomplishments

- ✓ Review of 21 Notices of Material Change
- ✓ Continued work on market metrics
- ✓ Registration of 59 RPOs in Initial Registration: Part 2
- ✓ Initiation of two Cost and Market Impact Reviews

2016 Activities

- ✓ Initiation of three Cost and Market Impact Reviews
- ✓ Approval of Interim Guidance on Performance Improvement Plans
 - Partner with CHIA for next phase of RPO data collection
 - Release of three Cost and Market Impact Reviews
 - Continued work on Notices of Material Change and Regulatory Definitions
 - Creation of an online data resource for RPO Program

HPC Organizing Activities [Originated in Chapter 224 of the Acts of 2012]

Protect patient access to necessary health care services and coverage.



2015 Accomplishments

- ✓ Approval of updates to regulations governing the Office of Patient Protection to ensure compliance with ACA and state law
- ✓ Releasing 2015 Office of Patient Protection Annual Report
- ✓ Processing 325 External Review Cases
- ✓ Answering 3,015 calls and emails from consumers seeking information on health insurance enrollment and appeals

2016 Activities

- ✓ Approval of Interim Guidance for RBPO/ACO Appeals Process
 - Update to regulations governing the Office of Patient Protection
 - 2016 Office of Patient Protection Annual Report
 - Ongoing External Review Appeals Process
 - Ongoing Health Insurance Open Enrollment Waiver Process



AGENDA

- Approval of Minutes from the April 27, 2016 Meeting (VOTE)
- Cost Trends and Market Performance
- Care Delivery and Payment System Transformation
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Improvement
- Administration and Finance
- Report from the Executive Director
- **Schedule of Next Meeting (July 27, 2016)**

Contact Information

For more information about the Health Policy Commission:

Visit us: <http://www.mass.gov/hpc>

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us

Appendix A: Provider Price Variation Stakeholder Process

Recap: Key findings from HPC examination of provider price variation

- Provider prices vary extensively for the same sets of services.
- Provider price variation has not diminished over time.
- Market leverage continues to be a significant driver of higher prices; higher hospital prices are not generally associated with higher quality or other value-based factors that provide benefit to the Commonwealth.
- While some variation in prices may be warranted to support activities that provide value to the Commonwealth (e.g. physician training), unwarranted variation in prices combined with the large share of volume at higher-priced providers results in increased health care spending and creates inequities in the distribution of health care resources.
- Other states have also found unwarranted variation in provider prices; however, in one state that limits hospital price variation to value-based factors, hospital prices for specific services vary less than in Massachusetts.
- Unwarranted price variation is unlikely to diminish over time absent policy action to address the issue.

Expansion and enhancement of demand-side and supply-side incentives can help address unwarranted price variation

Demand-Side Incentives

- Demand-side incentives encourage individuals and employers to make higher-value choices (e.g. tiered and limited networks, reference pricing, increased transparency)
- Demand-side incentives can result in cost savings for individuals, employers and insurers and can reduce unwarranted price variation by incentivizing higher-priced providers to lower their prices where patients are encouraged to use higher-value (e.g. lower-priced, high quality) providers
- Overall, demand-side incentives may support a more competitive, value-driven market place but likely will not fully address unwarranted price variation alone, though they may be coupled with other policy options.

Supply-Side Incentives / Alternative Payment Methods

- APMs can reduce healthcare spending by encouraging providers to reduce unnecessary utilization and refer to more efficient specialists and facilities
- APMs may reduce unwarranted price variation, to the extent that higher-priced providers seek lower price increases to control spending under their budgets and/or reduce their prices to compete for referral volume from providers under APMs.
- However, budgets based on historic spending may perpetuate unwarranted price and spending variation and threaten sustainability for some lower-paid providers.
- There are key opportunities to expand and improve APMs to reduce unwarranted price variation and support a higher quality and more efficient health care system

March 30 Discussion Summary

Tiered and Limited Networks

- HPC staff described the concept of tiered and limited networks, current levels of market take-up of these products, and considerations and limitations associated with them.
- Some stakeholders suggested that tiered products are too complicated for consumers and that tiering methods are inconsistent. There was significant concern that these products can interrupt care coordination, conflict with APMs, and place an excessive and regressive burden on consumers.
- Other stakeholders noted that tiered products warrant further development and improvement to address noted concerns.
- Stakeholders also discussed the level of incentives required to meaningfully shift consumer behavior (enrollment and using high-value care) and the importance of consumer education and transparency of tiering methods.

Office of the Attorney General Presentation on Premiums Based on Value

- The AGO described a model that would adjust insurance premiums based on the consumer's choice of primary care physician, with consumers paying less if they choose PCPs in systems with lower total medical expenses. This would not be a limited network product.
- Many stakeholders found the construct to be interesting and worthy of further consideration, and many offered thoughtful questions for such future discussion.

Reference pricing

- Stakeholders agreed that reference pricing is only appropriate for certain planned episodes of care and requires considerable consumer education and communication.

April 13 Discussion Summary

HPC Presentation

Overview on supply-side incentives, global budgets/APMs, and a look at APM take-up rates in Massachusetts. Stakeholder discussion focused on key opportunities to expand and improve APMs in Massachusetts:

- The need to move away from historic spending as the primary basis for APM financial benchmarks;
 - Challenges around provider infrastructure investment and APM-related costs;
 - Risk adjustment, including regarding socioeconomic factors in risk adjustment methods;
 - The need for APM expansion in the PPO market;
 - The importance of using appropriate quality metrics; and
 - The particular challenges for lower-priced providers
-

Dr. Hoangmai Pham Presentation

Financial benchmarking in CMS' Next Generation Accountable Care Organizations and as proposed for the Medicare Shared Savings Program (MSSP). Stakeholder discussion focused on several key issues:

- The impact of the voluntary nature of APMs on participation and how payers can structure rates or other features to attract providers into APMs;
- How risk adjustment should be improved to better account for population variation; and
- The appropriate timeline and process for convergence in global budgets, particularly related to lower-priced providers that may need to make certain financial investments to transform care delivery



Appendix B: Supplementary Information on the HPC Oral Health Brief

Oral health care in Massachusetts

- Oral health is a key component of overall health, yet many residents of the Commonwealth go without dental care each year
 - Forgoing routine care often leads to more severe, advanced forms of oral health disease at a later date
- One key reason underlying this missed opportunity is an insufficient access to dental care, particularly among low-income residents
 - There are 61 federally designated dental care health professional shortage areas in Massachusetts
 - In 2014, 35% of dentists treated a MassHealth patient and only 26% billed at least \$10,000 to the program
 - In a 2015 survey, 82% of high-income adults reported seeing a dentist in past year, compared to only 56% of low-income adults
- When access to dental care is limited, patients may seek care for preventable oral health conditions in EDs

Key definitions and methods

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

- Preventable oral health conditions, also described as “ambulatory care-sensitive” dental conditions, were those for which “good outpatient care could potentially prevent the need for hospitalization or ... early intervention could prevent complications or more severe disease”

Preventable oral health conditions

Diseases of the hard tissues of teeth

Tooth decay (ex: cavities, abrasion of teeth)

Diseases of pulp and periapical tissues

Inflammation of the dental pulp (blood vessels and nerves inside the tooth); often caused by bacterial invasion from tooth decay or, less commonly, cracked teeth

Gingival and periodontal diseases

Inflammation of the gums (caused by bacterial infection)

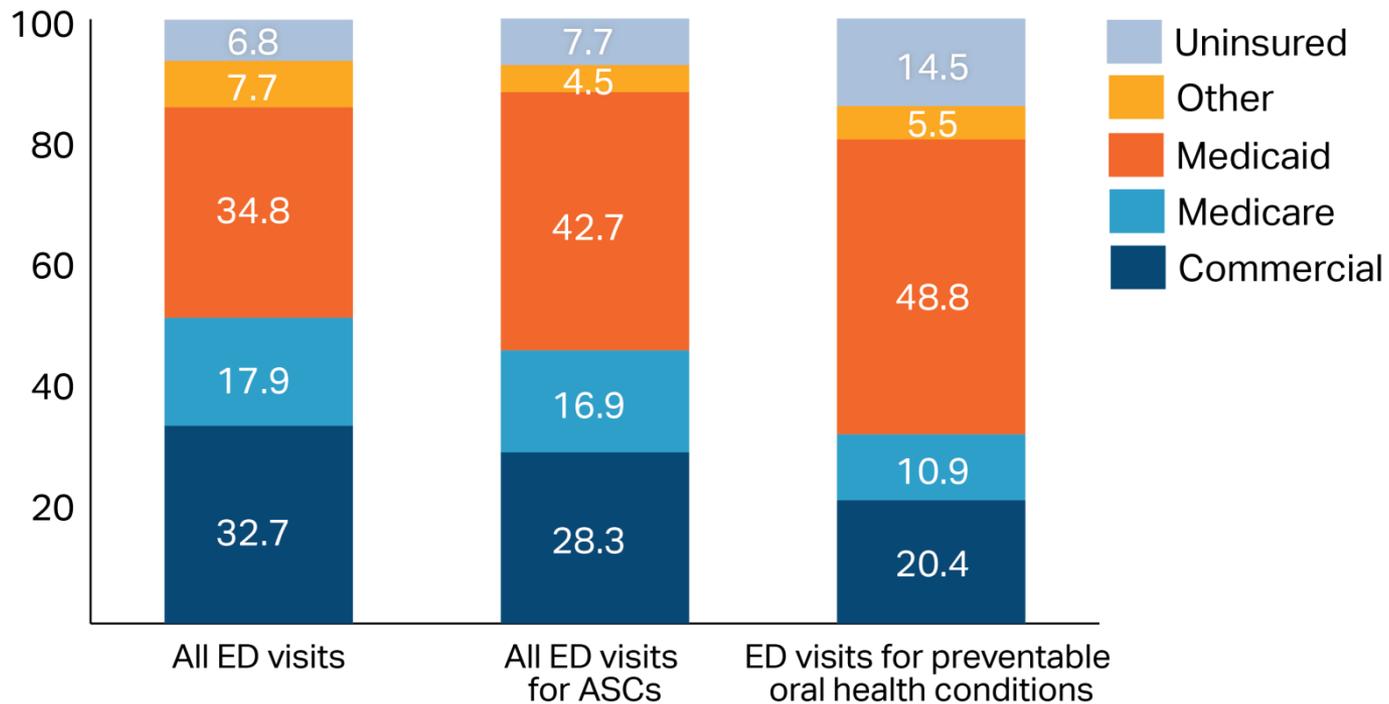
Other diseases and conditions of the teeth and supporting structures

Includes loss of teeth, complete or partial absence of teeth, and poor fillings. The loss of teeth due to trauma was not included in this analysis.

Diseases of the oral soft tissues, excluding lesions specific for gingiva and tongue

Including inflammation of the linings of the cheeks, lips, and tongue.

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



MassHealth paid for a third of all ED visits, but almost half of all preventable oral health ED visits (despite only covering roughly a quarter of the state's residents).



Appendix C: Supplementary Information on Proposed
Regulation 958 CMR 902

Proposed Regulation 958 CMR 902: Definitions

Acute Hospital

The teaching hospital of the University of Massachusetts Medical School and any hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

Ambulatory Surgical Center

Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the U.S. Centers for Medicare and Medicaid (CMS) requirements for participation in the Medicare program.

Surcharge Payor

A Surcharge Payor is an individual or entity that pays for or arranges for the purchase of health care services provided by provided by Acute Hospitals and Ambulatory Surgical Centers, including a managed care organization; provided, however, that the term “Surcharge Payor” shall not include (1) Title XVIII and Title XIX programs and their beneficiaries or recipients; and (2) other governmental programs of public assistance and their beneficiaries or recipients; and (3) the workers’ compensation program established pursuant to M.G.L. c. 152.

GPSR

The total dollar amount of an Acute Hospital’s or an Ambulatory Surgical Center’s charges for services rendered in a Fiscal Year.

Proposed Regulation 958 CMR 9.03: Assessment

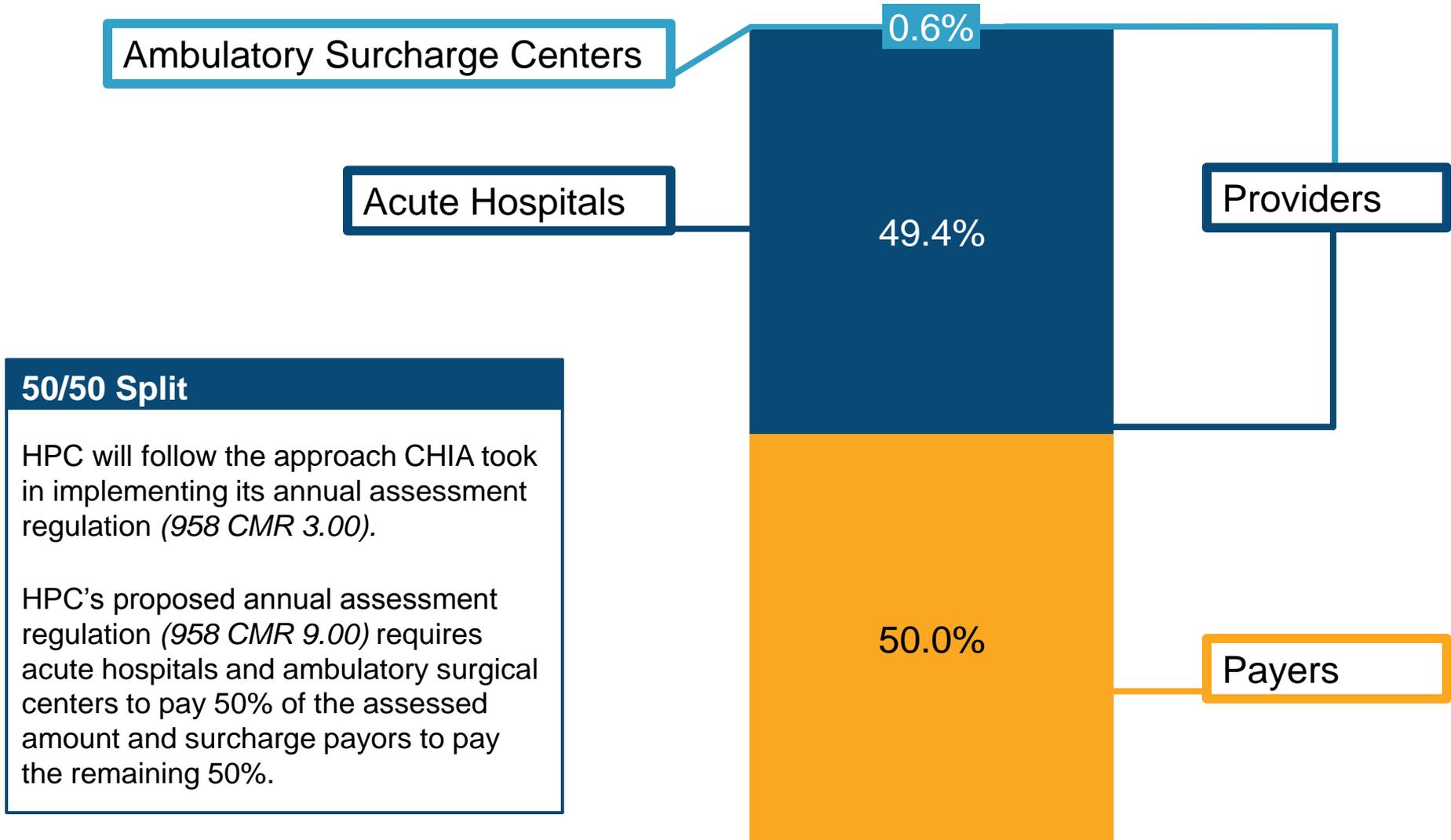
Acute Hospital and Ambulatory Surgical Center Assessment Calculation

- The assessment percentage for each hospital and ambulatory surgical center is calculated by dividing each entity's individual gross patient service revenue (GPSR) for the most recent fiscal year for which complete data was reported to CHIA, by the total of all such GPSR reported by all acute hospitals and ambulatory surgical centers.
- The assessment liability for each acute hospital and ambulatory surgical center is the product of the assessment percentage and one-half of commission expenses.
 - *This methodology relies on data already collected by CHIA (pursuant to 957 CMR 3.05) and is identical to the one used currently by CHIA.*
- 958 CMR 9.03 does not apply to any state institution or to any acute hospital which is operated by a city or town.

Surcharge Payor Assessment Calculation

- Qualifying Surcharge Payor:
 - Payments that are made by surcharge payors to acute hospitals and ambulatory surgical centers pursuant to MGL c. 118E, s. 68 (Health Safety Net Trust Fund) are subject to assessment if those payments were at least \$1 million during the last 12 month period for which complete data was received by CHIA.
- The assessment percentage for each surcharge payor is calculated by dividing an individual surcharge payor's payments subject to assessment during the last fiscal year for which complete data was received by CHIA by the total of all such payments by all qualifying surcharge payors.
- The assessment liability for each qualifying surcharge payor is the product of the surcharge payor's assessment percentage, and one-half of commission expenses.
 - *This methodology relies on data already collected by CHIA (pursuant to 957 CMR 3.05) and is identical to the one used currently for the One-Time Assessment and by CHIA.*

Proposed Annual Assessment Regulation: Amount of the Assessment (Based on FY16 CHIA assessment – for illustrative purposes only)



50/50 Split

HPC will follow the approach CHIA took in implementing its annual assessment regulation (958 CMR 3.00).

HPC's proposed annual assessment regulation (958 CMR 9.00) requires acute hospitals and ambulatory surgical centers to pay 50% of the assessed amount and surcharge payors to pay the remaining 50%.

Proposed Regulation 958 CMR 9.03(4) and 9.04(6): Payment Process

Collection of Annual Assessment

- The HPC will collect preliminary payments on October 1 of each year in an amount equal to one-half of the previous year's total assessment.
 - *The balance will be collected after providing notice to the entities.*
- The commission shall adjust the assessment to account for any variation in actual commission expenses.
 - *Commission expenses shall include the cost of fringe benefits and indirect expenses as established by the Comptroller (MGL. c. 29, s. 5D).*
- The commission shall also adjust the assessment to account for any changes in acute hospital and or ambulatory surgical center GPSR.