MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of July 25, 2013

MASSACHUSETTS HEALTH POLICY COMMISSION

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

Docket: Thursday, July 25, 2013, 9:30AM

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1. **Approval of the Minutes from June 19, 2013 Meeting – (APPROVED)**

2. **Executive Director Report**

3. **Community Health Care Investment and Consumer Involvement Update**
    a. **Approval of Proposed Regulation for the CHART Grant Program – (APPROVED)**
    b. **Discussion of Framework for CHART Grant Program**

4. **Care Delivery and Payment System Reform Update**
    a. **Update on Health Planning Council**

5. **Quality Improvement and Patient Protection Update**
    a. **Update on Office of Patient Protection Listening Sessions**

6. **Cost Trends and Market Performance Update**
    a. **Update on Material Change Notices**
    b. **Update on Cost Trends Hearing (October)**
    c. **Approval of Contractor for Cost Trends Analysis in the All-Payer Claims Database (APCD) – (APPROVED)**

7. **Public Comment**

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

Date of Meeting: Thursday, July 25, 2013
Beginning Time: 9:35AM
End Time: 12:19PM

Board Member	Attended	ITEM 1	ITEM 3a	ITEM 6c
		Approval of Minutes from June 19, 2013	**Approval of Proposed Regulation for the CHART Grant Program**	**Approval of Contractor for Cost Trends Analysis in the All-Payer Claims Database (APCD)**
Carole Allen	Yes	Yes (2nd)	Yes	Yes
Stuart Altman*	Yes	Yes (M)	Yes (M)	Yes
David Cutler	Yes	Yes	Yes	Yes (M)
Wendy Everett	Yes	Yes	Yes	Yes
Paul Hattis	Yes	Yes	Yes (2nd)	Yes
Rick Lord	Yes	Yes	Yes	Yes (2nd)
John Polanowicz	Yes	Yes	Yes	Yes
Glen Shor	Yes	A	Yes	Yes
Marylou Sudders	Yes	Yes	(ab)	Yes
Veronica Turner	Yes	Yes	Yes	Yes
Jean Yang	Yes	Yes	Yes	Yes
Summary	**11 members attended**	**Approved with 10 votes**	**Approved with 10 votes (1 vote in abstention)**	**Approved with 11 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 Thursday, July 25, 2013, at the McCormack Building, One Ashburton Place, 21st Floor, Boston, MA 02108.

Commissioners present included Chair Stuart Altman; Dr. Carole Allen; Dr. David Cutler; Dr. Wendy Everett; Dr. Paul Hattis; Mr. Rick Lord; Mr. John Polanowicz, Secretary, Executive Office of Health and Human Services; Mr. Glen Shor, Secretary, Executive Office of Administration and Finance; Ms. Marylou Sudders; Ms. Veronica Turner; and Ms. Jean Yang.

Chair Altman called the meeting to order at 9:35AM and reviewed the agenda.

ITEM 1: Approval of the Minutes from the June 19, 2013 Meeting

Chair Stuart Altman initiated the meeting at 9:35AM. He solicited comments, additions, or corrections to the minutes from the June 19, 2013, Health Policy Commission meeting. **Chair Altman** then called for a motion to approve the minutes of the June 19, 2013, meeting. After consideration, upon motion made and duly seconded by **Dr. Carole Allen**, it was voted unanimously to approve the minutes from the June 19, 2013, board meeting.

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

ITEM 2: Executive Director Report

Mr. David Seltz, Executive Director for the Health Policy Commission, presented a report regarding the status of the commission.

Mr. Seltz updated commissioners on the HPC's 2013 implementation timeline.

Mr. Seltz then reported to the commission and audience regarding the annual cost trends hearing, to be held on Tuesday, October 1, 2013, and Wednesday, October 2, 2013, at the University of Massachusetts Boston Campus Center.

Mr. Seltz concluded by referencing the two upcoming votes which had been included within the July 25, 2013, commission meeting agenda: the first in ITEM 3a: Approval of the Proposed Regulation for the CHART Grant Program, and ITEM 6c: Approval of Contractor for Cost Trends Analysis in the All-Payer Claims Database (APCD).

ITEM 3: Community Health Care Investment and Consumer Involvement Update

Dr. Paul Hattis, chair of the Community Health Care Investment and Consumer Involvement (CHICI) Committee introduced a discussion of committee updates. Mr. David Seltz commenced this update, focusing the discussion on a summary of the one-time assessment for fiscal year 2013 and fiscal year 2014.

Mr. Seltz explained that the first installment of the one-time assessment on certain hospitals and payers was expected to generate approximately $74.2 million. The amount deposited into the Distressed Hospital Trust Fund from this assessment would be $39.9 million, or approximately one-third of the four-year total for the assessment, as many of the surcharge payers had selected a "lump sum" payment option. This amount would be available for distribution until June 30, 2014, or the second year of assessment collection. The collection amounts in years two through four of the assessment would be $26.3 million, annually. Mr. Seltz noted funds not expended could be put through to the next year and would not revert to the General Fund.

Mr. Seltz next reviewed the statute which had established the Distressed Hospital Trust Fund as well as the purposes of the fund. The Distressed Hospital Trust Fund was established by Section 2GGGG of M.G.L. Chapter 29 and is funded by a one-time industry assessment in the total amount of $119.08 million over four years. That amount of collection included the initially calculated $128.25 million, less a $9.17 million mitigation that had been provided to certain qualifying acute hospitals. A competitive grant process was being established to distribute the Distressed Hospital Trust Fund for which there would be statutory eligibility criteria.

In outlining the purposes of the Distressed Hospital Trust Fund, Mr. Seltz first noted that the fund was intended to partner with qualifying community hospitals, and not as a "bailout." Distributed funds would seek to improve and enhance the ability of community hospitals to serve populations efficiently and effectively, as well as to advance the adoption of health information technology. Funds would be targeted at accelerating the ability to electronically exchange information between grantees and other providers in the community to ensure the continuity of care for patients, and would attempt to support the infrastructure investments necessary for transitions to alternative payment methodologies. Distributed resources would also be focused towards aiding in the development of care practices and the operational standards necessary for ACO certification, and would be intended to improve both the affordability and quality of care.

ITEM 3a: Approval of the Proposed Regulation for the CHART Investment Program

ITEM 3b: Discussion of Framework for the CHART Investment Program

Mr. Iyah Romm, HPC's Director for System Performance and Strategic Investment, introduced Item 3a of the agenda, initial approval of the proposed Community Hospital Acceleration and Revitalization Transformation (CHART) Investment Program proposed regulation, 958 CMR 5.00. Mr. Romm outlined that 958 CMR 5.00 establishes key definitions which particularly define "eligibility criteria," based upon statute. Additionally, 958 CMR 5.00 establishes grant application requirements as well as a process for the development of Requests for Proposals (RFPs).

Mr. Romm next reviewed in detail the proposed regulation's establishment of the grant program's operating structure and process. First, the commission would develop a program framework, followed by the development and release of RFPs. Eligibility lists for applicants would be developed and released at the time of RFP issuance. Applications would then be received and reviewed for their completeness, and comprehensive applications from qualifying applicants would be directed to a staff review committee.

Mr. Romm added that applications would be reviewed by staff against criteria that would be established in regulation and in RFP(s). The executive director would next recommend grant recipients for approval to the full commission, and would execute contracts with selected awardees pending approval by the full commission. An award period would be initiated.

During a phase of monitoring and evaluating award recipients, commission staff would oversee contractual compliance and could make arrangements to amend or terminate the contracts if warranted. The Health Policy Commission would also provide an evaluation framework, and would manage an assessment process for distributed funds.

To supplement the three-phase program framework outlined, Mr. Romm also presented a timeline which assigned proposed dates for each action by the commission and commission staff between May 2013 and the end of calendar year 2013, beginning with the development of a work plan for implementing the CHART Investment Program, and ending with project launches for initial grantees.

Finally, Mr. Romm outlined the definition of a qualified acute care hospital, which included four key factors: that the hospital be a non-teaching hospital, as defined by the Center for Health Information and Analysis (CHIA); that the hospital have non-profit status, as confirmed through Massachusetts Department of Public Health (MDPH) licensure; that hospitals with relative prices determined by the commission to be above the statewide median relative price be excluded; and that, in consultation with CHIA, an eligible applicant would be considered at the time of issuance of an RFP to be a qualified acute care hospital. Mr. Romm concluded by reviewing a listing of eligible hospitals which had been inventoried as of July 10, 2013.

Ms. Marylou Sudders raised a concern that the proposed regulation, 958 CMR 5.00, too narrowly aligned with statute, and should instead further define the commission's expectations as to how the funds should be used in terms of lowering costs and increasing quality.

Dr. Paul Hattis requested that Mr. David Seltz read the motion regarding a vote to approve the proposed regulation for the CHART Investment Program. Mr. Seltz read the motion: that the commission hereby approves and issues the attached PROPOSED regulation on the administration of the distressed hospital trust fund, developed pursuant to section 2GGGG of Chapter 29 of the General Laws by the commission's, and directs the Committee on Community Health Care Investment and Consumer Involvement to conduct a public hearing and comment period pursuant to Chapter 30a of the General Laws. After consideration,

upon motion made by **Chair Stuart Altman** and duly seconded by **Dr. Paul Hattis**, it was voted to approve the proposed regulation for the CHART Grant Program.

Voting in the affirmative were ten present commission members. **Ms. Marylou Sudders** abstained from voting. There were no votes in opposition.

ITEM 4: Care Delivery and Payment System Reform Update

Dr. Carole Allen, chair of the Care Delivery and Payment System Reform (CDPSR) Committee, updated the full commission on committee activities. She noted that the committee had not met since the last full commission meeting on June 19, 2013, but that the committee would be holding a meeting immediately following the July 25, 2013, Health Policy Commission meeting at 1:00PM on the ground floor of the McCormack Building. She introduced Madeleine Biondolillo, MD, Director of the Bureau of Health Care Safety and Quality to give a presentation regarding the Health Planning Council.

ITEM 4a: Update on Health Planning Council

Dr. Biondolillo provided an introduction to the Health Planning Council for the members of the Health Policy Commission. She noted that in Chapter 224 of the Acts of 2012, Section 14 had established a Health Planning Council within the Executive Office of Health and Human Services and the requirement that this council develop a state health plan related to the location, distribution, and nature of health care resources in the Commonwealth. The plan would also establish and maintain on a current basis an inventory of those health care resources with other reasonably pertinent information.

Dr. Biondolillo detailed specific information regarding the state health plan, including that the plan should identify the needs of the Commonwealth in terms of health care services, providers, programs, and facilities; should create prioritization for those needs; and should make recommendations for the appropriate supply and distribution of resources, programs, capacities, technologies, and services. The health plan is due to the legislature on January 1, 2014.

To effect this plan, the Health Planning Council, between April 2013 and June 2013, oversaw a planning approach, the delineation of services in the statute, and the scoping of the first year of the initiative. The council examined health plans established in other states, solicited input, and also examined geographic areas for analysis. Dr. Biondolillo next reviewed the three levels of analysis that the council had developed.

Dr. Biondolillo noted that the work of the Health Planning Council in generating a state health plan would not only be short-term proposal development, but would serve as the development of an infrastructure for data warehousing, analytics, and the creation of subsequent plans for the Commonwealth.

Chair Stuart Altman asked Dr. Biondolillo if the council would balance examination of areas of need with areas of overuse in the system. Dr. Biondolillo responded that the Health

Planning Council has been clear in generating a focus within the greater context of Chapter 224 in which balance is a primary concern. As a result, overutilization of resources would be examined in addition to resource deprivation.

Chair Stuart Altman then asked how reallocation might actually be put into action once the Health Planning Council has completed its analyses. Dr. Biondolillo responded that the intent of Chapter 224 was system change and that from the council's perspective, there is clarity in terms of its guiding principles and role in promoting better health for the citizens of Massachusetts and for identified populations through its work. These principles will remain a guide as choices are made regarding resource allocation.

Dr. Wendy Everett asked Dr. Biondolillo how available and reliable the current data to which the Health Planning Council has access. Dr. Biondolillo responded that although the council does have data, its comprehensiveness remained a concern. Mr. David Seltz noted that when concerns regarding "data gaps" arise in the context of state government, it is vital to examine currently available data within state systems as well as data which is in need of collection, and to coordinate between state agencies in order to avoid overlap or administrative redundancies, either for government or for the health care industry.

Dr. David Cutler asked Dr. Biondolillo how much she anticipated the data collected by the Health Planning Council would facilitate the Health Policy Commission and its work. She reiterated Mr. Seltz's comments regarding the necessity of avoiding redundancies in data collection, and indicated that the Health Planning Council would be inventorying and using current state data resources in order to limit duplication while identifying gaps in data. In response to Dr. Cutler's question, she said that she expected the plan could be used by state agencies in a variety of ways and that the council would be prioritizing areas where its services in data collection and information analysis might be requested.

Mr. David Seltz added that the Health Policy Commission had been aware of the Health Planning Council and its work, and had requested the presentation with Dr. Cutler's question in mind, recognizing the importance of the Health Planning Council's work and the potential assistance which it could provide the Health Policy Commission.

Ms. Marylou Sudders noted that she anticipated that the Health Planning Council's work and information would assist with Department of Public Health hearings regarding essential services, particularly around behavioral health.

Ms. Jean Yang asked Dr. Biondolillo to reflect on how resource reallocation might affect market functioning. Dr. Biondolillo responded that the goal for data collection in the short term was to at least produce a description of health care resources which might support thinking and decision making surrounding resource allocation.

Dr. Stuart Altman noted that although descriptive data regarding resources is important, it is only a starting point. He requested that the Health Planning Council not only reference resources from external state governments and the US Federal Government, but also from European nations.

Dr. Carole Allen asked Dr. Biondolillo how the Health Planning Council would be collecting data regarding the social determinants of health in addition to areas in which health care disparities might exist. Dr. Biondolillo responded that the council was investigating every avenue of information and data and offered the example of leveraging Department of Public Health data collected with investment in a state health improvement plan.

Dr. Paul Hattis asked if the scope of the Health Planning Council's work would include the examination of long term care. Dr. Biondolillo responded that long term care was included under the investigative category of "post-acute care" and did include nursing home care.

ITEM 5: Quality Improvement and Patient Protection Update

Ms. Marylou Sudders, chair of the Quality Improvement and Patient Protection (QIPP) Committee, updated the full board regarding the activities of that committee. She noted that the committee met on July 24, 2013, and that the focus of the committee remained strengthening consumer protections and ensuring that behavioral health would receive equal focus during health care system transformations.

At the July 24, 2013, meeting, Ms. Jennifer Bosco, Director of the Office of Patient Protection (OPP), presented regarding updates and clarifications surrounding the office since its transfer from the Department of Public Health to the Health Policy Commission.

ITEM 5a: Update on Office of Patient Protection Listening Sessions

Ms. Jen Bosco presented a summary of the July 24, 2013, meeting of the Quality Improvement and Patient Protection Committee.

Chapter 224 of the Acts of 2012 legislated that the OPP be moved from the Department of Public Health to the Health Policy Commission in April 2013. Ms. Bosco discussed the main responsibilities of OPP and outlined the review process for internal and external reviews. She also reviewed the issues not covered by OPP and spoke about the referral process to other agencies.

Ms. Bosco discussed the effect of the Affordable Care Act (ACA) on OPP regulations. She noted that, following Chapter 25 of the Acts of 2013, OPP is nearly completely compliant with the ACA requirements.

Ms. Bosco shared data regarding appeals to the OPP: for calendar year 2012, 12,780 internal insurance appeals had been filed regarding various issues of medical necessity. Forty-percent of those internal appeals had been overturned to the benefit of the consumer involved. Almost 300 external appeals had been filed to the OPP. Thirty-five-percent of those appeals were overturned to the benefit of the consumer involved. She emphasized that since the inception of the OPP, the primary area of medical necessity for appeals had been behavior health.

Ms. Sudders closed her committee report by noting that she had received the Behavioral Health Task Force report after the committee meeting, a report which would most likely be discussed further at the September 2013 meeting of the Quality Improvement and Patient Protection Committee.

ITEM 6: Cost Trends and Market Performance Update

Dr. David Cutler, chair of the Cost Trends and Market Performance (CTMP) Committee, updated the full board regarding the activities of that committee. He noted three updates to be discussed during his committee's report to the commission: an update regarding the status of filed material change notices; a review of the upcoming cost trends hearing scheduled for October, 2013; and a vote on approval of an external contractor to assist with analyses for the cost trends report.

ITEM 6a: Update on Material Change Notices

Mr. David Seltz presented several slides to summarize the status of material change notices which had been submitted to the Health Policy Commission and reviewed by staff. He exhibited in aggregate the material change notices received, and then displayed the notices in three categories: those notices on which no action had been taken; those notices on which action was pending; and those notices on which a review had been initiated. He then elaborated in greater detail about reviews which had been initiated and about reviews which were pending both as of the June 19, 2013, commission meeting and as of the July 25, 2013, meeting. He noted the current transaction that the commission was reviewing: the acquisition of South Shore Hospital by Partners Health Care System. Mr. Seltz noted that there had already been positive interactions with the parties, that documents and data were being collected, and that analyses had been initiated.

ITEM 6b: Update on Cost Trends Hearing (October)

Mr. Seltz reviewed the history and current context of the upcoming cost trends hearing scheduled for October 1, and October 2, 2013. Mr. Seltz noted that the annual cost trends hearing was established in Chapter 305 of the Acts of 2008 in order to provide an annual public examination of the factors driving cost trends in the Commonwealth. The hearing would act as a platform for market participants, experts, and witnesses to discuss challenges to meeting cost trends goals, and would serve to identify opportunities to contain costs and improve quality. The Division of Health Care Finance and Policy (DHCFP) was formerly the host of the hearing, and the Center for Health Information and Analysis (CHIA) was a subsequent host. Chapter 224 of the Acts of 2012 transferred that responsibility to the Health Policy Commission.

Chapter 224 followed past practice by outlining witnesses to be called and topics to be addressed during the two-day hearing. A past practice had been to collect information through a combined gathering of advance written testimony as well as oral testimony from a subset of witnesses at the hearing. Feedback would be collected from stakeholders regarding identifying in-person witnesses.

Mr. Seltz emphasized that the intent for the upcoming hearing would be to have a discussion with stakeholders about their performance against the cost growth target outlined by Chapter 224. Although the first benchmark measurement will not occur until 2014, the Health Policy Commission seeks to engage with industry members to understand reactions and experiences regarding overall and specific statutes, particularly in relation to the cost growth benchmark.

Mr. Seltz noted that in addition to engaging industry leaders as witnesses, experts would be called as well so that their authority and research work within their respective fields could be utilized by the commission and other agencies.

At the hearing, the commission would also be asking participants to react to the annual cost trends report from CHIA, and hear testimony to build on findings within that report. Those collective findings would then offer context and support for the Health Policy Commission's own cost trends report, due at the end of calendar year 2013.

As of July 25, 2013, HPC staff had finalized a location and date for the hearing, and had put forth a preliminary theme and agenda. The Attorney General's Office (OAG) and the CHIA would be acting as partners with the Health Policy Commission in the annual cost trends hearing, and would also have the opportunity to ask witnesses questions in written and oral formats. HPC staff would be in close communication with both agencies. Additionally, Mr. Seltz noted that staff was in the process of reaching out to commissioners in order to receive guidance regarding witness selection and modifications to themes and topics.

CHIA was scheduled to release its initial cost trends report by September 1, 2013. Mr. Seltz anticipated that the cost trends hearing would again be an agenda item at the September 11, 2013 Health Policy Commission meeting so that the commission might further flesh out agenda items and witness selections.

Mr. Nikhil Sahni, HPC's Policy Director for Cost Trends and Special Projects, presented to the commission regarding the proposed agenda for the October cost trends hearing, which consists of four panels with four different topics. The second day would also include a presentation by the Attorney General.

Commissioners initiated a period of discussion regarding the proposed agenda for the annual cost trend hearing.

Secretary John Polanowicz referenced a slide within Mr. Seltz's presentation that displayed listings of witnesses and topics mandated by statute for the cost trends hearing. Secretary Polanowicz asked how the large listing of topics and witnesses would be categorized or divided in order to make their selection meaningful, and requested that Mr. Seltz explain what the commission's selection process would be. Mr. Seltz responded that he hoped to engage commissioners in examining a list of witnesses requested. He would be asking commissioners which broad groups would be most appropriate for each thematic panel, and

noted that he recognized it would not be feasible to call all witnesses or witness groups on the two days allotted for the hearing.

Mr. Rick Lord asked Mr. Seltz what the timetable would be for identifying witnesses. Mr. Seltz responded that an initial group of witnesses would most likely be identified by mid-August. He emphasized that staff would be working on selecting witnesses during the three to four weeks following the July 25, 2013, commission meeting.

Mr. Lord then asked Mr. Seltz how specific the HPC would be in terms of the questions they would be asking witnesses. Mr. Seltz responded that the commission would be asking witnesses specific questions.

ITEM 6c: Approval of Contractor for Cost Trends Analysis in the All-Payer Claims Database (APCD)

Mr. Nikhil Sahni next presented to the commission regarding a proposed contract for cost trends analysis in the All-Payer Claims Database (APCD). He noted that the purpose of the contract would be to analyze the APCD for the Health Policy Commission's annual cost trends report. The contractor would be doing validation of the ACPD to make sure that the data is complete and thorough, and would prepare files for the Health Policy Commission to conduct the annual cost trends report. Additionally, the work within the contract would serve to mature the APCD as a data set so that data could in turn be shared with CHIA.

Mr. Sahni noted that the contract would be foundational, such that it would establish the groundwork that would allow the Health Policy Commission to continue working with the APCD in an effective, efficient, and more extensive manner in future years.

Mr. Sahni next reviewed the scope of the proposed contract. There would be three phases to the contract, and he emphasized that the contract could be stopped at any given phase. Work could also be revised during the duration of the contract.

Mr. Sahni described the procurement process the Health Policy Commission used to find a contractor. A notice of intent to procure was posted on April 26, 2013. An RFR was posted and bids were solicited. Questions were submitted and the Health Policy Commission responded the following day. Responses were submitted on June 28, 2013. Three finalists were interviewed by phone on July 2, 2013. Staff recommendations were presented for endorsement to the CTMP Committee on July 10, 2013. At the current July 25, 2013, Health Policy Commission meeting, staff sought endorsement of the contract with the Lewin Group. Mr. Sahni also outlined scoring and evaluation criteria that were used to select the vendor.

Mr. Sahni noted that the Lewin Group had previously worked with the APCD and CHIA. As such, this contractor had been able to articulate approaches to deal with issues unique to the APCD, such as risk adjustment in a multi-payer database.

Ms. Marylou Sudders asked if the scores for the bidders were a consensus document. Mr. Sahni responded that the scores were the result of consensus among the three members of the procurement management team, having reviewed the materials for bidders together.

Dr. David Cutler read the motion: that, pursuant to Section 6.2 of the Health Policy Commission's By-Laws, the commission hereby authorizes the executive director to sign a contract with The Lewin Group, Inc. to analyze cost trends using the all-payer claims database maintained by the Commonwealth's Center for Health Information and Analysis, for an amount up to no more than $537,781 through December 31, 2014, with an option to renew for up to three years, subject to further agreement on terms deemed advisable by the executive director.

After consideration, upon motion made by **Dr. David Cutler** and duly seconded by **Mr. Rick Lord**, it was voted unanimously to approve of the contractor for cost trends analysis in the all-payer claims database (APCD).

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

ITEM 7: Public Comment

Ms. Peggy O'Malley, a registered nurse from Gloucester, Massachusetts, asked two questions of the Health Policy Commission. She first noted that she heard at the meeting much mention of cost and quality issues, but wondered if the commission would be addressing the factor of access to care. She then noted that she had heard many stakeholders discussed at the meeting that day, but would have liked to hear patients themselves acknowledged as vital stakeholders in the health care system. She asked if patient stakeholders would be represented at the October cost trends hearing.

Chair Stuart Altman responded that access was being addressed by the commission and offered the Health Planning Council's discussion of resource development and allocation as an example of that focus. He then noted that Ms. O'Malley's second set of comments regarding patient stakeholders was important, and that commission staff would take those comments into account. He said that patients, families, and communities are affected by decision making in health care and that those groups should be acknowledged when evaluating system changes or costs.

Dr. Ron Dunlap, President-Elect of the Massachusetts Medical Society, commented on the commission's discussion of the CHART Investment Program, noting that it would be important to fully examine the potential impact of those grant funds; to target those funds; and to comprehensively examine the communities into which those funds could be placed, from investigating hospital management in those communities to analyzing socioeconomic factors. Chair Stuart Altman responded in agreement, noting that the Health Policy Commission would be examining many factors, including hospital administration and the capacity of hospitals to manage funding when reviewing applications. He also noted that a

community's capacity to receive funding would be an important factor in distributing funding appropriately.

After soliciting further public comment, Chair Stuart Altman adjourned the meeting of the Health Policy Commission at 12:19PM.

LIST OF DOCUMENTS PRESENTED AND POSTED AFTER THE MEETING

1. Meeting Agenda, 7/25/2013
2. Minutes of the 6/19/2013 Health Policy Commission Meeting
3. Committee Presentation, 7/25/2013