Health Policy Commission

Board Meeting

November 20, 2013

Agenda

- Approval of Minutes from October 16, 2013 Meeting
- Executive Director Report
- Care Delivery and Payment System Reform
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Involvement
- Cost Trends and Market Performance
- Public Comment
- Schedule of Next Commission Meeting

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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on October 16, 2013, as presented.

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Upcoming Meetings

Monday, December 16, 2013
Quality Improvement and Patient Protection Committee Meeting:
Hearing on Proposed Office of Patient Protection (OPP) Regulations
9:00AM – 10:30AM
Daley Room, Two Boylston Street, 6th Floor, Boston, MA

Care Delivery and Payment System Reform Committee Meeting
10:30AM – 11:30AM
Daley Room, Two Boylston Street, 6th Floor, Boston, MA

Wednesday, December 18, 2013
Health Policy Commission (HPC) Board Meeting:
Annual Meeting
11:00AM – 2:00PM
Gardner Auditorium, State House, Boston, MA

Wednesday, January 8, 2014
Health Policy Commission (HPC) Board Meeting
12:00PM – 3:00PM
1 Ashburton Place, 21st Floor, Boston, MA

Key Upcoming Activities

- Release executive summary of cost trends hearing
- Issue cost and market impact review report on Partners-South Shore Hospital
- Release annual cost trends report by December 31, 2013
- Release Phase 1 funds in response to the competitive CHART grant program request for proposals (RFP)
- Propose regulations on the registration of provider organizations
- Finalize program design and evaluation plan for phased implementation of PCMH certification
- Update material change notice guidance and forms
- Propose regulations on the cost and market impact review process
- Develop program for certification of accountable care organizations

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  - Patient-Centered Medical Homes Certification (PCMH) Program
  - Registered Provider Organizations (RPO) Program
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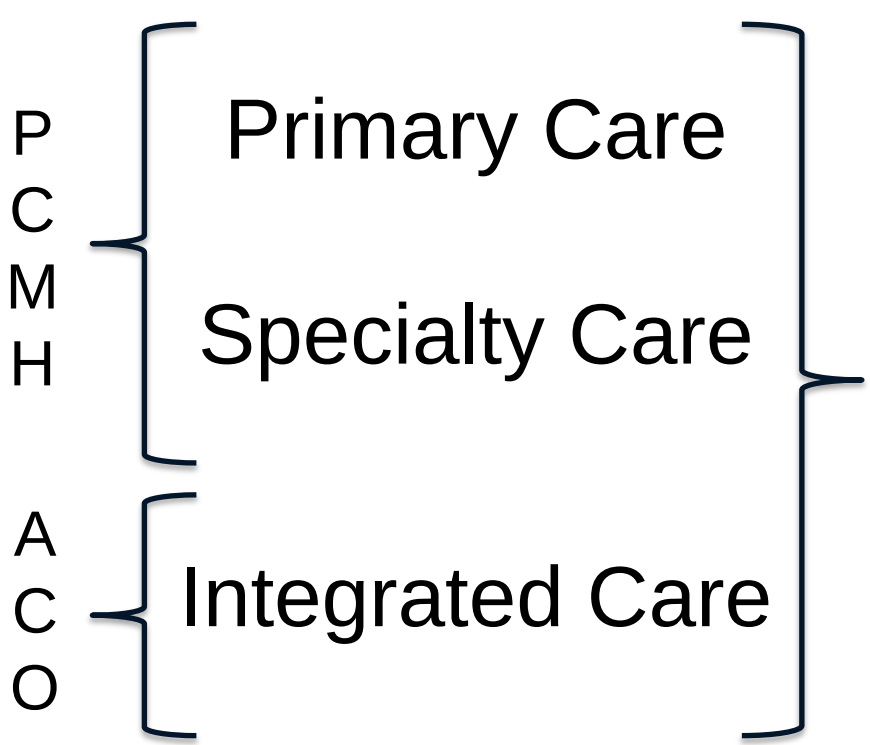
HPC Care Delivery Programs: Focus on *Patient-Centered* Accountable Care



Accountable Care Certification (ACC)

ACC = reduced cost + improved quality

A unified framework for promoting, validating and monitoring the adoption and impact of accountable care in the Commonwealth

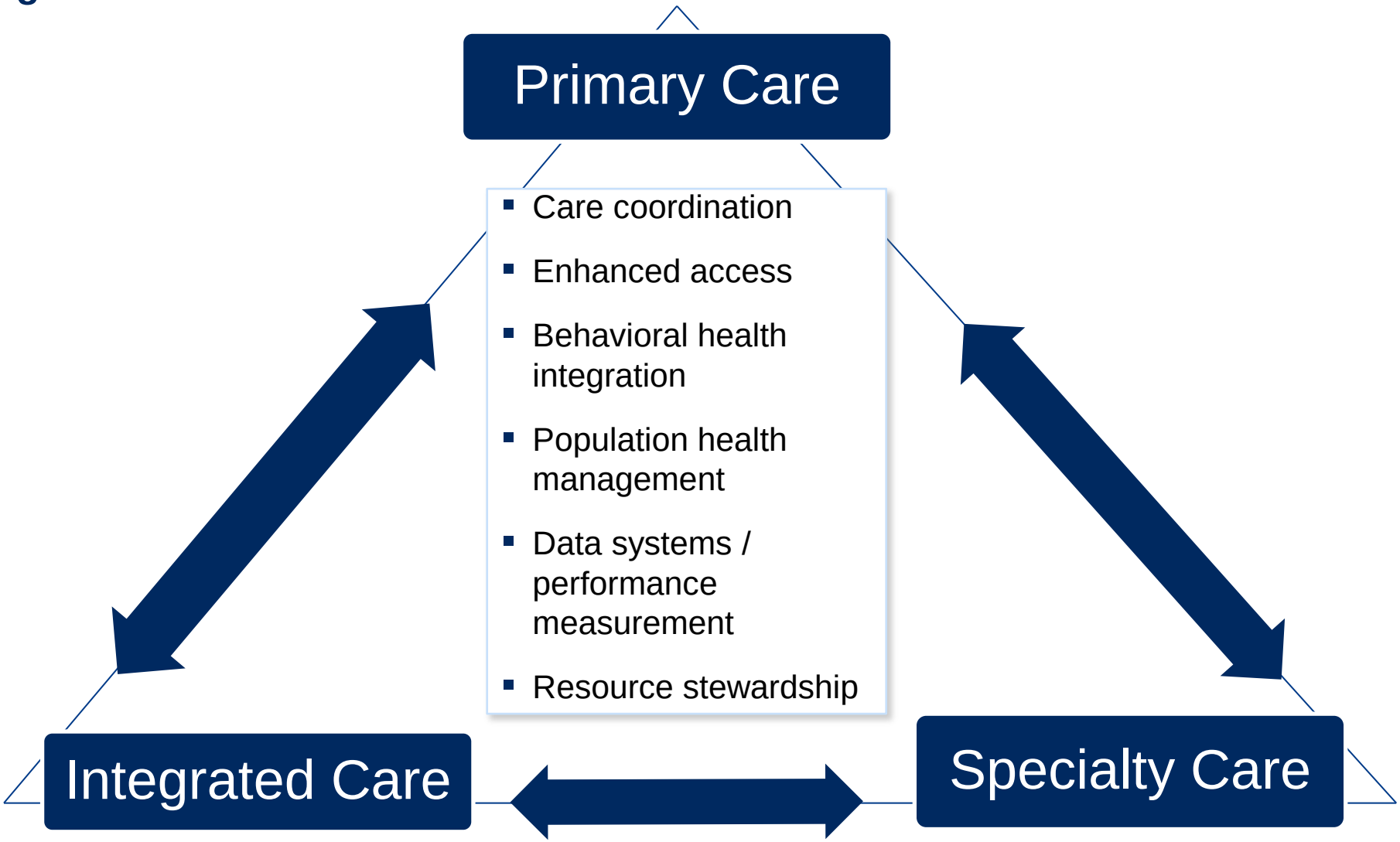
Defining Accountable Care

Value-based, data-driven, patient-centered care that rewards quality over quantity

Principles:

- Control costs through appropriate access to care and utilization of services
- Improve the health of a population of patients
- Focus on proactive and preventive care
- Monitor structures, outcomes & systems of accountable care
- Leverage the value of primary care

High Value Elements of Patient-Centered Accountable Care



High value: demonstrated impact on quality, cost and patient experience

Stakeholder Engagement: Responses to Date

- Positive response on HPC framework and focus on high-value elements of accountable care
- General consensus on certification pathway and proposed elements, pending additional refinement to criteria
- Accrediting bodies open to review and support alignment of high-value elements with national standards
- Opportunities for continued engagement with payers, purchasers, and providers

Next Steps: Key Deliverables for HPC Certification Programs

Q3-Q4 2013	Q1-Q2 2014	Q3-Q4 2014
▪ PCMH standards and criteria ▪ Payer engagement ▪ Payment model design ▪ Reporting and monitoring methods ▪ PCMH pilot and evaluation design	▪ Practice engagement ▪ Training and technical assistance resources ▪ PCMH pilot launch	▪ ACO standards and measures ▪ ACO program design ▪ Implement PCMH pilot ▪ PCMH Pilot evaluation (Phase I)

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Registered Provider Organizations – Three Key Aims

1. RPO **enhances transparency** of the health care marketplace in the Commonwealth by gathering information on the **composition, structure and relationships** among and within Massachusetts health care providers.

2. RPO **maps the provider delivery system**, including clinical affiliations, capacity, and market share, and monitors changes over time.

3. RPO creates a **centralized resource** for the Commonwealth and other stakeholders by compiling information about the provider market. RPO supports such functions as health resource planning, determinations of need, cost and market impact reviews, evaluation of health care cost trends, health system investments, and certification programs.

What does the HPC process look like?

Who must register?

- Any provider[1] or provider organization[2] that is a risk-bearing provider organization (as defined by DOI)
- Any provider or provider organization
  - with a patient panel greater than 15,000 and
  - which represents providers who collectively receive $25,000,000 or more in annual net patient service revenue from carriers or third-party administrators

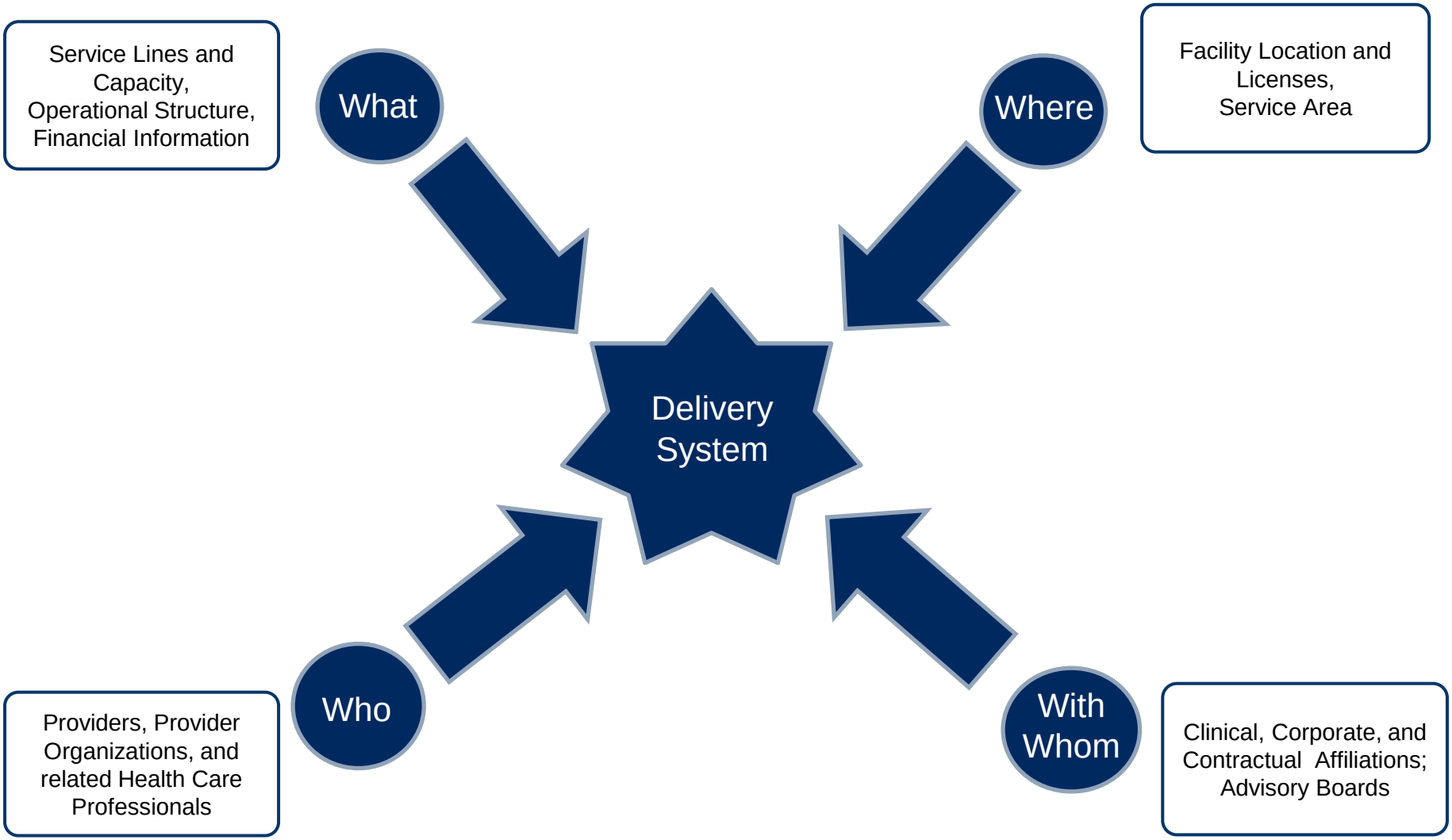
Identifying RPOs

- DOI to provide list of RBPOs. All RBPOs to receive notification
- Any provider/provider organization determined to meet the NPSR threshold to receive notification
  - Including, e.g., hospitals, IPAs, PHOs, SNFs, CHCs
- Notified provider/provider organization is presumed to have a patient panel greater than 15,000
  - "Patient panel" defined to account for those facilities where a traditional patient panel is inapplicable
- Notified provider/provider organization registers as an RPO *or* provides compelling evidence of non-applicability

1 "Provider" is any person, corporation, partnership, governmental unit, state institution or any other entity qualified under the laws of the commonwealth to perform or provide health care services

2 "Provider organization" is any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of heath care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services

RPO Data


Service Lines and Capacity, Operational Structure, Financial Information
What
Where
Facility Location and Licenses, Service Area
Delivery System
Who
With Whom
Providers, Provider Organizations, and related Health Care Professionals
Clinical, Corporate, and Contractual Affiliations; Advisory Boards

Regulation Development: Work to Date

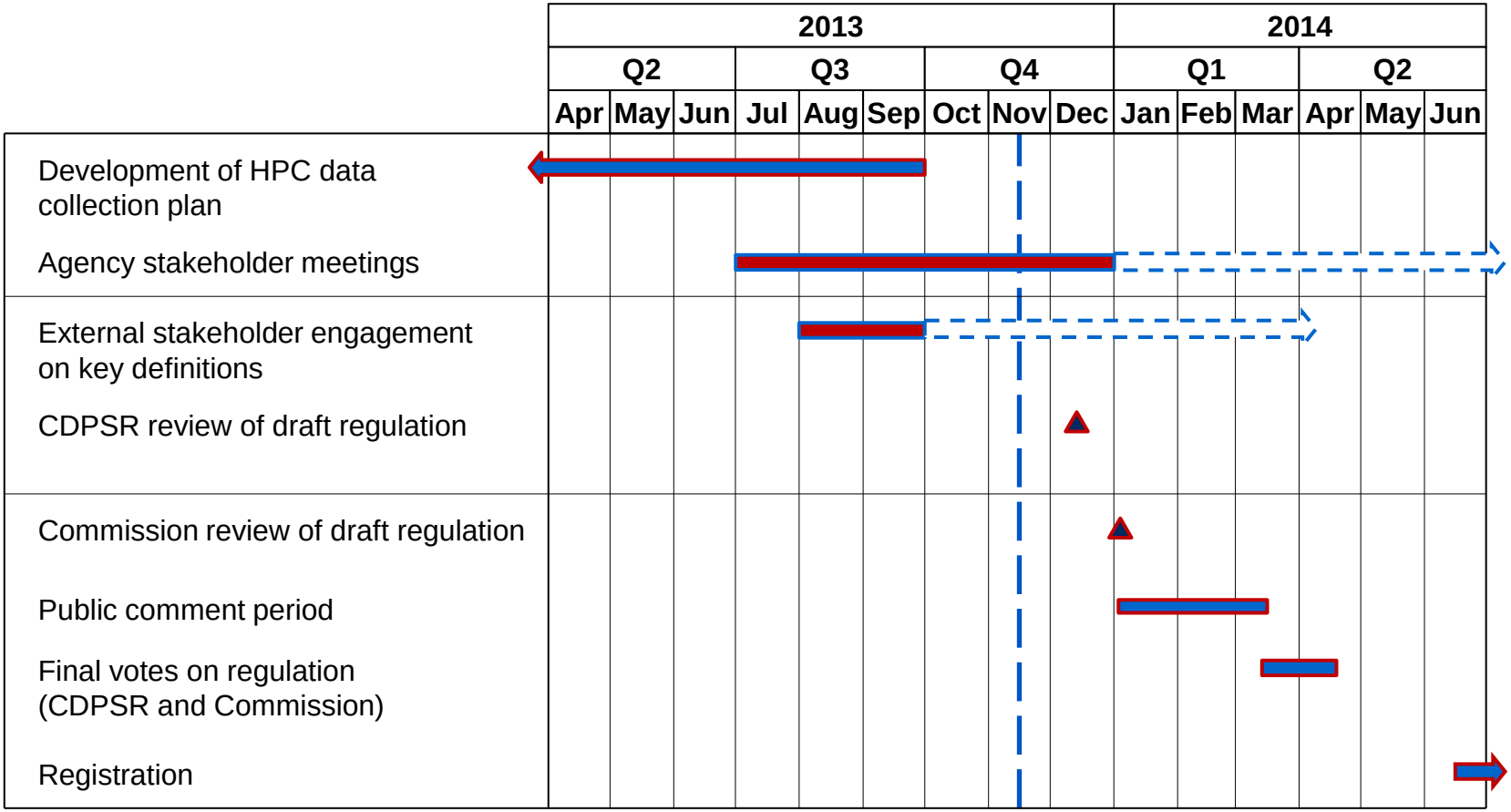
Principles

- Avoid duplication and promote administrative simplification through cross-agency collaboration and provider engagement while focusing on high-value reporting requirements
- Support DOI's Risk-bearing Provider Organization certification process
- Support cross-agency data needs, including e.g. health planning, material change notices, key research questions
- Coordinate with other agencies/entities
  - Center for Health Information and Analysis
  - Division of Insurance
  - Executive Office of Health and Human Services
    - Department of Public Health and MassHealth
  - Attorney General's Office
  - Boards of Registration for health care providers
  - MeHI

Work to date

- Joint DOI-HPC Listening Sessions and Feedback Received
  - Different types of provider organizational structures, relationships with affiliated physicians
  - Nature of information ordinarily developed in the course of business, or reported to other agencies or health plans
- Ongoing collaboration with DOI and CHIA
  - Developing streamlined reporting mechanisms and ensuring consistency in definitions
  - Developing single point of entry to CHIA and HPC for RPOs
- Developing approach to regulation and data specification that ensures deep provider engagement, and allows for flexibility in reporting while standardizing data to ensure analytic value

Draft RPO Timeline



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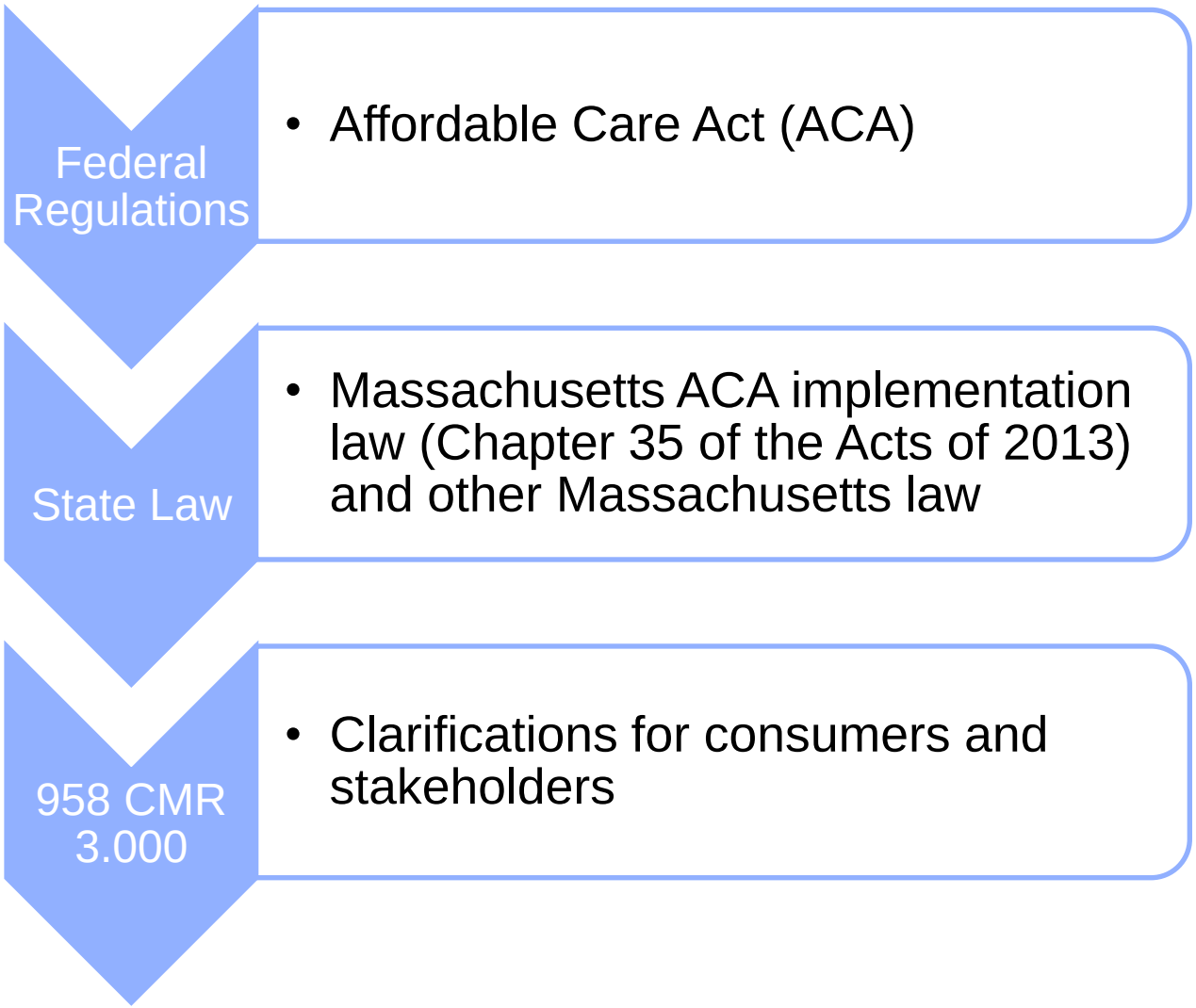
Foundations of Proposed Changes



Changes Required by Massachusetts ACA Compliance Law (Chapter 35 of the Acts of 2013)

- **Clarify grounds for filing grievances.**
  - Rescission of coverage
  - Determination that a requested service is experimental or investigational
- **Faster resolution of internal grievances and external reviews.**
  - Expedited member grievances and expedited external reviews must be resolved within 72 hours (decrease from current four days).
  - Non-expedited external review decisions to be issued by the external review agency within 45 days (decrease from current 60 days).
- **Simultaneous review**. Certain patients with urgent medical needs will be able to file an expedited member grievance and an expedited external review request at the same time.
- **Consumer-friendly fee changes**. The $25 external review fee will be refunded to consumers who win their external reviews. Additionally, caps total consumer fees for external reviews at $75 per year.

Changes Required by ACA Regulations

- **Internal Review Changes**
  - One level of internal review
  - Option for waiver of internal review by the insurance carrier
  - Improvements to consumer notices
  - Sharing new information with consumers
  - Removing option to extend carrier's deadline for making a decision on the internal grievance
- **External Review Changes**
  - Clarifies standard for obtaining expedited review of an internal grievance
  - Clarifies that external review agencies must be accredited by a national accrediting organization and free from conflict of interest
  - No minimum financial threshold for external review requests
  - Clarifies consumer right to submit additional medical information to support the request for external review
  - Rules regarding a carrier's responsibilities to provide notices in non-English languages

Changes Required by Ch. 224 and other Massachusetts Laws

- Changes to the definition of “material professional affiliation” to refer to a “health care professional” instead of a physician, to match the language used in G.L. c. 176O.
- Access to utilization review and medical necessity criteria. New section to incorporate rights added by Ch. 224.
- Changes “business days” to calendar days to remain consistent with the language in the statute, clarifies eligibility for external review, and changes the term “physician or nurse practitioner” to the current statutory term “provider.”

Other Clarifications for Consumers and Stakeholders

Additional amendments promoting consistency and transparency, including:

- Clarification that the regulations do not prevent voluntary conferences.
- Further guidance about the types of requests which are not eligible for external review.
- Enhanced carrier reporting requirements, to include data on internal grievances and reconsiderations of internal grievances.
- Electronic submission of carrier reports.

Public Hearing on Proposed Regulations

A public hearing on these proposed regulations is scheduled for:

Monday, December 16, 2013
9:00 AM

Daley Conference Room
Two Boylston Street, 5th Floor
Boston, MA 02116

Vote: Approving Office of Patient Protection (OPP) Proposed Regulations

Motion: That the Commission hereby approves and issues the attached PROPOSED regulation on consumer protection in health insurance, pursuant to section 16 of chapter 6D of the General Laws and directs the Committee on Quality Improvement and Patient Protection to conduct a public hearing and comment period pursuant to Chapter 30A of the General Laws

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  - CHART Investment Program
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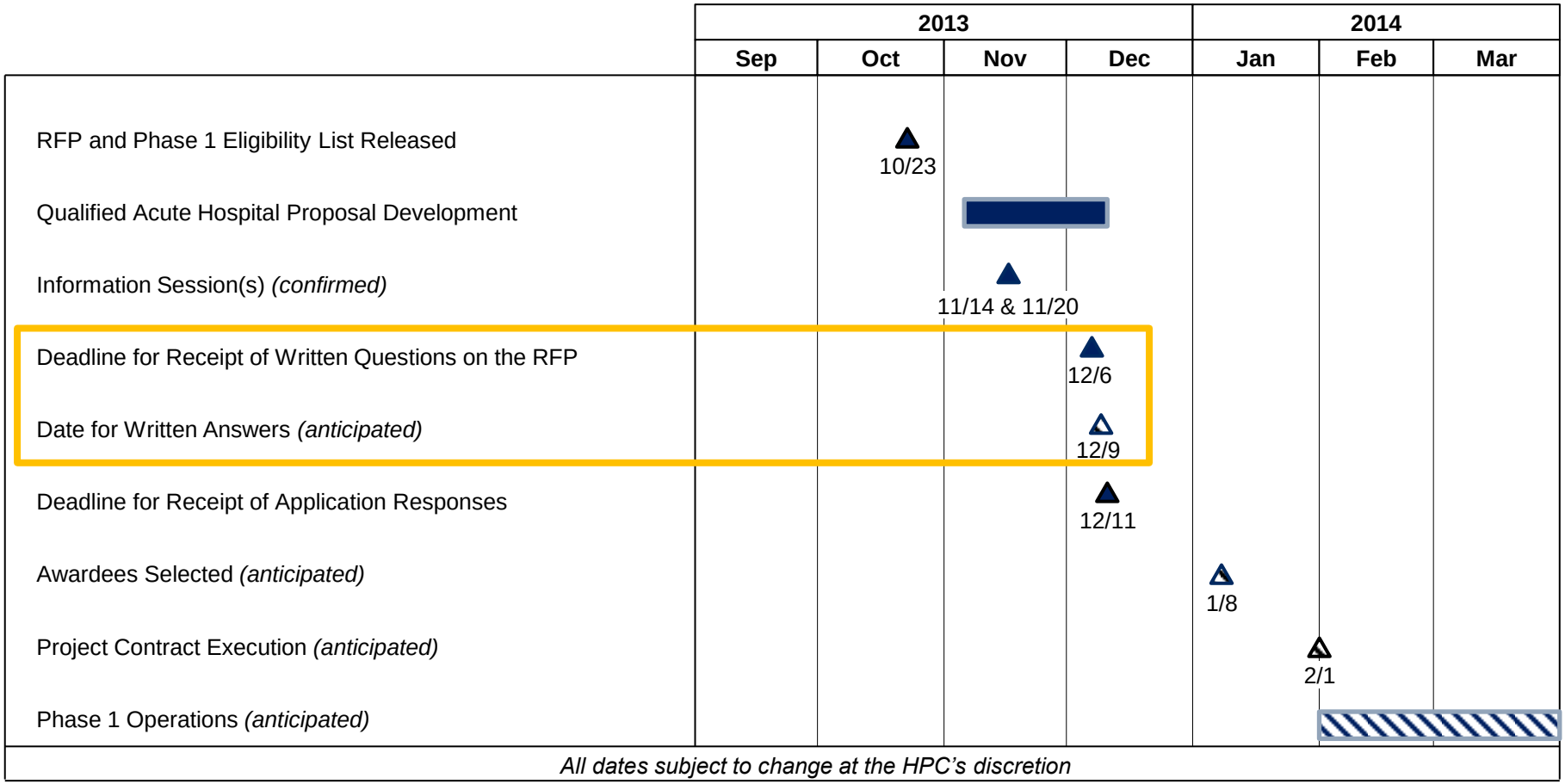
CHART Phase 1 Anticipated Timeline



Denotes change

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Update on APCD Analysis

Purpose: To support our annual cost trends report and create a foundation for our future work and the work of other APCD users

Time period	▪ Years: 2009-2011
Payers and products	▪ Three major commercial carriers and Medicare FFS ▪ (MassHealth probably postponed to Spring 2014)
Spending included	▪ Claims-based medical spending only ▪ No drug spending ▪ No other payments (shared savings, P4P, infrastructure, etc.)
Level of aggregation	▪ Results for three major commercial carriers presented collectively ▪ No analysis by provider or provider system
Potential analyses for Dec. report	▪ Total expenditures – focus on PMPMs ▪ Analysis of episodes (number by type, price paid, trend) ▪ Analysis of most costly patients
Longer term analysis options	▪ Conduct targeted analysis of trends in access, quality, utilization, and spending ▪ Explore variation among regions and providers ▪ Evaluate innovations in care delivery, payment, and insurance product design ▪ And more

Topics of Research for 2013 Cost Trends Report

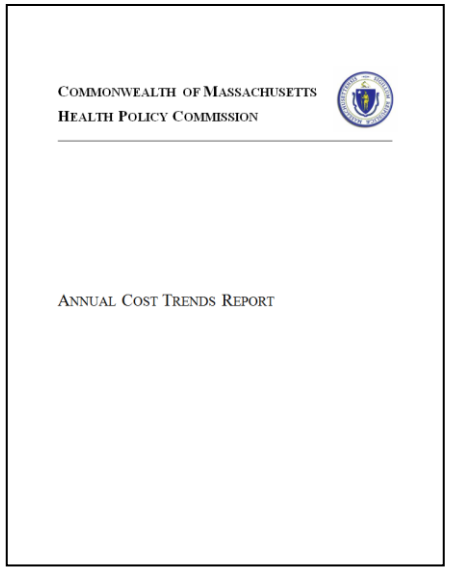
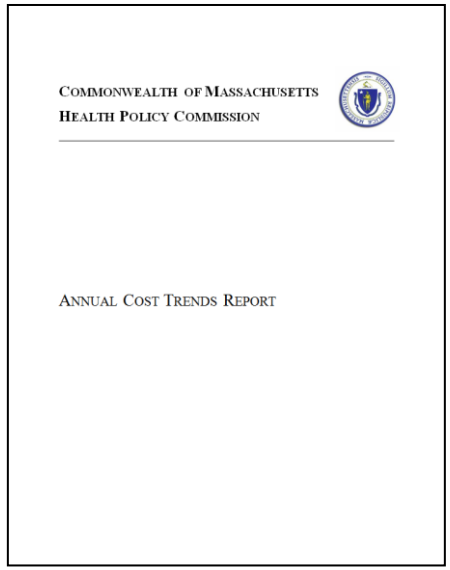
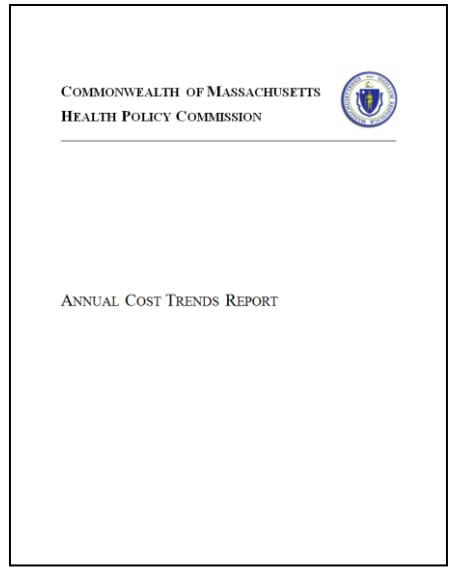
Section 1: Profile of MA

- Health care spending levels
- Growth in health care spending
- Delivery system and access
- Health care outcomes

Section 2: Deep-dives into cost drivers

- Provider mix
- Provider cost structure
- Care of costliest patients
- Wasteful spending

Publication Expectations Through End of 2014

	December 2013	Early Summer 2014	December 2014
			
Total Health Expenditures	2012	2012	**2013**
APCD	2011 (claims files released by CHIA on ~Jun 30 2013)	**2012** (claims files released by CHIA on ~Dec 30 2013)	**2012** (claims files released by CHIA on ~Dec 30 2014)

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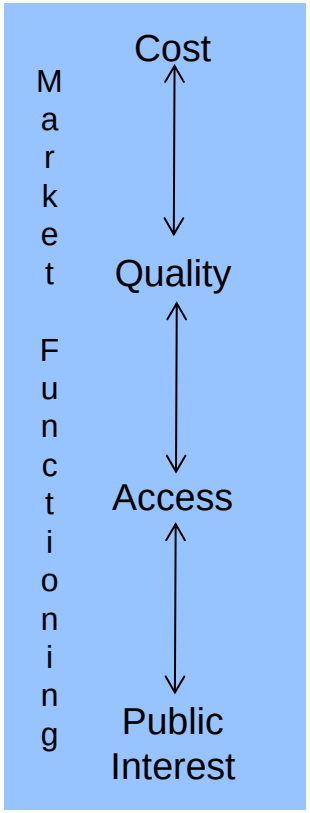
Statutory Factors for Review of Material Changes

Statutory standard

Factors should evaluate whether the material change is likely to result in a significant impact
- "on the Commonwealth's ability to meet the health care cost growth benchmark" or
- "on the competitive market"



- Unit prices, including whether prices are ***materially higher*** than other providers
- Health status adjusted TME, including whether TME is ***materially higher*** than other providers
- Provider costs and cost trends, including compared to statewide trends
- Provider size and market share within ***primary service areas*** and ***dispersed service areas***, including whether the provider has ***dominant market share***
- Quality, including patient experience and level of coordinated, population-based care
- Availability and accessibility of services similar to those proposed to be provided
- Impact on competing options for health care delivery, including the impact on existing providers
- Methods used to attract patient volume and to recruit or acquire health care professionals or facilities
- Role in serving at-risk, underserved, and government payer populations, including those with behavioral and substance use disorders or mental health conditions
- Role in providing low margin or negative margin services
- Consumer concerns, such as complaints that the provider has engaged in any unfair method of competition, or any unfair or deceptive act
- Other factors in the public interest

Focused list of factors for 30-day review

Categories of Impact Review

Combine historic performance with details of the transaction and the parties' goals and plans to project the impact of the transaction

MCN ↕ CMIR

	Costs	Quality	Access
What do we know from the terms of the transaction?			
How will provider and market structure change?			
Ongoing evaluation of the parties' goals and plans			

Questions for Impact Review

	Costs	Quality	Access
What do we know from the terms of the transaction?	▪ Will contractual prices change as a result of the transaction? ▪ Will care shift to lower or higher priced providers?	▪ What are the identified areas for quality improvement? ▪ What changes do the Parties propose to address these areas?	▪ Are any changes in services identified? ▪ How do these changes affect any shortages or oversupply of services?
How will provider and market structure change?	▪ Will market share or concentration increase or decrease? ▪ What is the anticipated impact on bargaining leverage?	▪ How are the parties aligning incentives? ▪ Does the proposed structure support greater clinical integration and population care management?	▪ Will the resulting organization have higher or lower government payer mix? ▪ Higher or lower mix of low/negative margin services?
Ongoing evaluation of the parties' goals and plans	Continued evaluation with additional data, production, and interchange with parties and market participants. E.g., ▪ Are the parties' plans internally consistent and/or supported by historic results? ▪ Are proposed changes both necessary and sufficient to improve cost, quality, and access? ▪ Are cost savings likely to be passed on to purchasers (employers and consumers)?		

Modeling Quantitative Analysis: Example for Discussion

Unlikely CMIR		Likely CMIR
Decrease in price	⟸ ═ ═ ═ ═ ═ ⟹	Increase in price, especially if a "material" increase
Modest to no change in market share or concentration	⟸ ═ ═ ═ ═ ═ ⟹	Significant change in market share or concentration
Increase in proportion of care for underserved populations/low margin services	⟸ ═ ═ ═ ═ ═ ⟹	Decrease in proportion of care for underserved populations/low margin services

Next Steps

- Modeling definitions of materially higher price and total medical expenses, primary service area, dispersed service area, dominant market share, and other statutorily identified terms (Dec 2013 - Jan 2014)
- Modeling ranges for these definitions (Dec 2013 - Jan 2014)
- Recommending updates to the Interim Guidance and Form for submitting material change notices (Jan - Feb 2014)
- Proposing regulations (Q1 2014)

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Types of Transactions Noticed

2013 YTD

Type of Transaction	Frequency
Physician group affiliation or acquisition	30%
Acute hospital acquisition	25%
Acquisition of post-acute provider	15%
Clinical affiliation	15%
Change in ownership	10%
Formation of contracting entity	5%

Timeframe for Pending Notices

Pending decision	
Description	**Deadline to initiate any CMIR**
Acquisition of Winchester Hospital by Lahey Health System	Nov 29
Acquisition of Hallmark Health Corporation by Partners HealthCare System	Dec 12
Acquisition of Emerald Physician Services by Medical Affiliates of Cape Cod	Dec 18

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Update on Partners-South Shore Cost and Market Impact Review

- Received most of the data and documents requested of the Parties and other market participants
- In the final stages of our review and analysis of information provided
- Continuing to meet with Parties and market participants to discuss our work
- On track to complete a preliminary report by the end of the year
- Received formal notice of an important physician component within the broader Partners-South Shore alignment

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Partners' Acquisition of Harbor Medical Associates: Basis for Review

Description of transaction

- Partners proposes acquiring Harbor Medical Associates, a 65 physician multispecialty group that is currently part of South Shore Physician Hospital Organization.
- The parties have described their objectives as improving population health, expanding access across the care continuum, providing more patient-centered health care services, and moderating the rate growth of health expenditures in southeastern MA.

Basis for review

- This transaction is an important element of the broader alignment between Partners and South Shore Hospital (SSH") currently under HPC review. Partners and SSH have stated "tighter integration" and "alignment" of physicians with SSH and the Partners hospitals is "a key component to successful implementation" of population health management and Partners' acquisition of SSH.
- Other factors reinforce the cost and market significance of the proposed acquisition, e.g.:
  - Partners' physician prices are significantly higher than Harbor's. Total medical spending will be impacted by whether and when Harbor physicians may begin receiving Partners' higher prices.
  - Partners and SSH are among the highest-priced providers in their regions. Total medical spending will be impacted by a proposal to redirect care to these high-priced settings.

Factors for Review

A. The impact of the proposed acquisition on **cost, quality, and access**, including
   - Prices
   - Total medical expenses
   - Patient care referral patterns
   - Competing options for care delivery
   - Quality of and access to care

B. **Physician dynamics**, including the Parties' plans for physician recruitment, compensation and management

C. The Parties' **size and market position in the geographies they serve**

D. The Parties' **role in serving at-risk, underserved, and government payer populations**, and in **providing low or negative margin services**

E. The Parties' **plans for population care management**, including the proposed integration of the Parties' governance, clinical, and business operations, and the projected **impact of those plans on quality, costs, and market dynamics**

F. The cost and market impact of this proposed material change in light of other proposed transactions involving the Parties including, but not limited to, Partners' proposed acquisition of **Hallmark Health System**

G. Other factors concerning cost and market impact as the HPC may identify

Vote: Authorizing the Continuation of Cost and Market Impact Review

Motion: That the Commission hereby authorizes the continuation of the cost and market impact review of the proposed material change to Partners HealthCare System, Inc. and Harbor Medical Associates, P.C., pursuant to section 13 of chapter 6D of the Massachusetts General Laws and the Commission's Policy 2013-01 (Process for Review of Notices of Material Change).

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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