MINUTES OF THE COST TRENDS AND MARKET PERFORMANCE COMMITTEE

Meeting of February 24, 2014

MASSACHUSETTS HEALTH POLICY COMMISSION

THE COST TRENDS AND MARKET PERFORMANCE COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
Center for Health Information and Analysis
Daley Room, Two Boylston Street, 5th Floor
Boston, MA 02116

Docket: Monday, February 24, 2014, 9:30 AM – 11:00 AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Cost Trends and Market Performance Committee held a meeting on Monday, February 24, 2014 in the Daley Room at the Center for Health Information and Analysis located at Two Boylston Street, 5th Floor, Boston, MA 02116.

Members present were Dr. David Cutler (Chair), Dr. Paul Hattis, and Mr. Rick Lord, and Ms. Kimberly Haddad, representative for Mr. Glen Shor, Secretary for Administration and Finance.

Dr. Wendy Everett was absent from the meeting.

Chair Cutler called the meeting to order at 9:33 AM.

ITEM 1: Approval of minutes

Chair Cutler made no changes to the minutes and asked for a motion to accept the minutes. Mr. Lord made the motion and Dr. Hattis seconded. Members voted unanimously to approve the minutes.

Dr. Cutler provided an overview of the day's agenda.

ITEM 2: Discussion of the projected economic growth benchmark for 2015

Dr. Cutler noted that this year, 2014, is the second year of the economic growth benchmark. He asked whether the Committee would be approving the cost growth benchmark for 2015. Mr. Seltz responded that the Committee was simply acknowledging the benchmark for 2015 as established by law, and that the HPC would have more flexibility adjusting the benchmark in future years. Dr. Hattis stated that the HPC will be able to adjust the number beginning in 2018.

Dr. Cutler explained that Chapter 224 states that the Executive Office of Administration and Finance establishes an estimate of growth in potential gross state product (PGSP), which is approved by the House and Senate Ways and Means and then ratified by the Health Policy Commission. The health care cost growth benchmark is linked to the PGSP growth

estimate. Dr. Cutler stated that the Executive Office of Administration and Finance invited 25 experts to discuss the data and potential changes to the PGSP growth estimate. Dr. Cutler noted that he was part of the discussion and that it was extremely well done.

Mr. Lord asked who else was involved in this discussion. Ms. Haddad responded that it was a combination of economists, tax payer associations, and government officials, including Mr. Seltz. Dr. Cutler stated that the discussion had as much information as he could imagine.

Dr. Cutler stated that the convened body decided to maintain the PGSP growth estimate at 3.6% for 2015. Mr. Seltz added that the first year of the benchmark, which was set at 3.6% by law, applied to the growth from 2012-2013 and will be reported on by CHIA in the coming year. He stated that the benchmark projects a year forward, while the evaluation always looks a year backward.

Dr. Hattis noted that the PGSP growth rate was an estimate of the potential growth of the economy. He asked what would occur if the potential, which is based on current economic conditions, greatly differed from the actual numbers. Dr. Cutler responded that the estimate is not a forecast of growth in a particular year. Rather, the body would only know over an extended period of time whether the estimate of long-run average growth was off or not. To get at this number, Dr. Cutler stated that the convened body had to ask questions such as, "Will Massachusetts' economy grow faster than US because of a higher educated workforce?"

Mr. Nikhil Sahni, HPC's Policy Director for Cost Trends, reviewed the calculation for Gross State Product, noting that it was the sum of the real growth and inflation in the state. He stated that the end result of this calculation was a tightly clustered group of numbers around 3.6%. As such, the House and Senate Ways and Means Committees approved 3.6%. Dr. Cutler added that he was very comfortable with this number.

Mr. Seltz stated that the staff would update the full board on the 2015 economic growth benchmark at the March 5, 2014 board meeting.

Dr. Cutler asked for any questions. Seeing none, he moved to the next agenda item.

ITEM 3: Review of 2013 cost trends report and preliminary discussion of research agenda for 2014

Dr. Cutler introduced the next agenda item. He noted that this was a time for the Committee to discuss anything that was not fully understood from the 2013 cost trends report. He also charged the Committee with brainstorming next steps stemming from the report.

Mr. Sahni briefly reviewed the findings from the 2013 cost trends report that were initially presented at the December 16, 2013 and January 8, 2014 board meetings. He then summarized the report's conclusions and potential action steps. Mr. Sahni noted that there

were four main areas of opportunity for improvement: (1) fostering a value based market; (2) promoting an efficient, high-quality health care delivery system; (3) advancing alternative payment methods; and (4) enhancing transparency and data availability.

Dr. Cutler asked where the Commonwealth currently stood on these issues.

Mr. Sahni responded that the 2013 report linked up well with the 2013 cost trends hearing. He stated that there is movement in the industry to make improvements in these areas, but that there is still a ways to go to meet these goals.

Dr. Cutler stated that work towards fostering a value-based market could involve analyzing the use of price and quality tools. He stated that there are no reports on how frequently these tools are used and on what experience people are having with them.

Dr. Hattis stated that providers were supposed to give more transparent information beginning this past year. He noted that it is important for individuals to understand what information is available to them prior to making choices. Dr. Hattis also pointed to an important structural issue that underlies this need for transparent information. He stated that if the savings from a proven choice do not accrue to the individual, but rather only to health plan, consumers may not think that it matters to select the lower cost option.

Dr. Hattis next spoke on the consequences of an evolving system with few numbers of choices for providers. He asked whether the Commonwealth was getting any better value from integration. Dr. Cutler stated that Dr. Stuart Altman, Chair of the HPC, expressly asked the Cost Trends and Market Performance Committee to investigate who receives the benefits from cost savings.

Mr. Lord stressed the need for appropriately timed consumer education about the health care tools.

Dr. Cutler stated that the other areas of improvement could be addressed by various HPC projects, such as the Patient-Centered Medical Home Certification Program and the CHART Investment Program.

Mr. Lord asked whether there is a role for the HPC to address wasteful spending in a meaningful way or if the Commission was just making the data available. Mr. Sahni noted that this question would be answered in the remainder of the presentation.

Mr. Seltz stated that the four areas of improvement align with the goals of Chapter 224. He stated that it is useful to think of these in terms of what the HPC can do, what other state agencies can do, and what the industry can do. He noted that reducing wasteful spending is an area where all three of these bodies can work together around one idea and drive it forward.

Mr. Sahni reviewed the preliminary 2014 research agenda and next steps for the Committee.

Dr. Cutler asked for any questions. Seeing none, he moved to the next agenda item.

ITEM 4: Discussion of statutory terms related to review of material changes

Dr. Cutler introduced the next agenda item. He encouraged commissioners to think about a generic cost and market impact review (CMIR) during the discussion.

Ms. Karen Tseng, HPC's Policy Director for Market Performance, updated the Committee on the HPC's work on statutory definitions relevant to assessing material change notices (MCN). She noted that the HPC's development of statutory definitions and MCN regulations have been valuably informed by the HPC's experience evaluating MCNs over the past year.

At this point, Ms. Tseng introduced Mr. Cory Capps, an expert from Bates White, who joined the meeting via conference call. Ms. Tseng stated that staff would now present two definitions of geographic areas: primary service areas (PSA) and dispersed service areas (DSA).

Ms. Tseng provided the statutory background for the definitions of PSA and DSA, noting that they are metrics by which market effects are measured. She stated that while PSAs are well established in literature and research, DSAs are a newer concept. She stated that she asked Bates White to join the meeting so that HPC experts could speak directly on dispersed service areas.

Ms. Kate Scarborough, Project Manager for Cost and Market Impact Reviews, provided a summary of the process for defining PSAs. She stated that the HPC started with a survey of how providers define their own service areas and examined the methods used by other government agencies, leading researchers, and national experts. Staff found modest differences in definition of PSAs, but similarities far outweighed differences.

Ms. Scarborough reviewed the HPC's approach to modeling hospital PSAs in Massachusetts. She stated that most of the methods reviewed made a PSA that served 75% of the hospital's patients. She confirmed that this approach yields coherent results across a full range of different types of Massachusetts hospitals, and is the definition the HPC is pursuing.

Ms. Scarborough noted that the HPC aims to be completely transparent regarding definitions to allow market participants to understand how the HPC is evaluating MCNs. This will allow providers, if they choose, to adjust their conduct accordingly.

Dr. Cutler asked whether the staff could release the zip codes for the PSAs of all hospitals in Massachusetts. Ms. Scarborough confirmed this would be the recommended approach because the HPC intends to be completely transparent about the service area for a given hospital.

Ms. Scarborough provided multiple maps to demonstrate the modeling of primary service areas. These maps included visualizations of why certain less effective approaches would

not be recommended (e.g., those that do not filter for drive time or proximity and can result in services areas that are non-contiguous).

Dr. Hattis asked if all zip codes in Massachusetts would be included in a primary service area if PSAs were defined for all providers. Ms. Tseng responded that the primary service areas capture the vast majority of zip codes.

Dr. Cutler asked which consultants the staff consulted when defining primary service areas. Ms. Tseng responded that the process was well developed, researched, and documented. She stated that the primary consultant was Bates White. The HPC also used other leading authorities.

Ms. Tseng noted that for policy purposes there is a balancing between flexibility/precision and transparency. She stated that the HPC seeks to provide the utmost possible level of transparency in the MCN and CMIR process.

Dr. Hattis noted that the statute requires the HPC to define market and market concentration. He asked how much variability there would be in a market concentration analysis if staff used another approach to defining PSA. Ms. Tseng responded that this is less a question of degree and more a question of a different topology altogether. She stated that it is not coherent to evaluate a concentration analysis when there is not a cohesive service area.

Mr. Seltz stated that, in the Partners HealthCare System/South Shore Hospital CMIR, the staff evaluated market concentration by both the HPC approach to PSAs and South Shore Hospital's approach to PSAs. Both of these analyses yielded a similar result.

Ms. Tseng next introduced Mr. Capps to discuss dispersed service areas, an area of concrete data development that is not as far along as PSAs.

Mr. Capps went into detail on the definition of a DSA, the approach used for modeling DSAs, and the methodological differences between PSAs and DSAs.

Dr. Cutler stated that the HPC must define a dominant market share once it has a solid definition of service areas.

Mr. Capps next reviewed why the HPC would look at both PSA and DSA. He stated that the reason was trifold. First, the HPC must look at both by statute. Second, it should look at DSAs because they are an important area of developing research. Finally, he stated that the HPC should look at DSAs in recognizing that the customers of payer networks are companies that have employees located over dispersed geographic areas. He stated that this means that if you eliminate preferred hospitals that don't directly compete in a single geographic area, you can still impair the payer network so as to make it less valuable to employees.

Ms. Tseng stated that there is no one set approach for DSAs for multi-hospital systems.

She reviewed potential approaches for multi-hospital system DSAs and provided multiple maps as visual examples.

Ms. Tseng reviewed the next steps for the Market Performance team. She stated that the staff would continue to model the definitions of statutory terms and solicit input from stakeholders, with the goal of proposing regulations during summer 2014.

Mr. Seltz emphasized that the Committee would not be asked to vote or endorse the definitions today. Rather, he stated that these are complex concepts that will be the subject of ongoing conversation with commissioners and stakeholders.

Dr. Cutler asked how the Committee can solicit feedback from the market. Ms. Tseng responded that this has occurred through written and oral engagement and comments received on an ad hoc basis. She stated there would also be a formal comment period and public hearing following the release of the proposed regulations.

Dr. Hattis asked Ms. Tseng to summarize the applications of service areas in CMIRs. Ms. Tseng responded that defining and analyzing service areas demonstrates the potential consequences for market share and concentration following a transaction.

Dr. Cutler asked anyone with comments to email HPC-Info@state.ma.us.

ITEM 5: Public Comment

An audience member asked if the HPC was only looking at inpatient services or at the specialty groups in the hospitals. Ms. Tseng responded that data is most robust on inpatient care so the HPC started its analysis in this area. Ultimately, the statute provides for the HPC's scope of authority to look at all service lines.

ITEM 6: Adjournment

Chair Cutler announced the next meeting of the Cost Trends and Market Performance Committee (April 29, 2014) and adjourned the meeting at 11:12 AM.