MINUTES OF THE COST TRENDS AND MARKET PERFORMANCE COMMITTEE

Meeting of May 20, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE COST TRENDS AND MARKET PERFORMANCE COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
CONFERENCE CENTER
50 MILK STREET, 8th FLOOR
BOSTON, MA 02109

Docket: Wednesday, May 20, 2015, 9:30 AM – 11:00 AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Cost Trends and Market Performance (CTMP) Committee held a meeting on Wednesday, May 20, 2015 in the HPC's Conference Center, located at 50 Milk Street, 8th Floor, Boston, MA

Members present were Dr. David Cutler (Chair), Dr. Wendy Everett, Dr. Paul Hattis, Mr. Rick Lord, and Ms. Lauren Peters, designee for Secretary Kristen Lepore, Administration and Finance.

Dr. Cutler called the meeting to order at 9:35 AM.

ITEM 1: Approval of minutes

Dr. Cutler asked for any amendments to the minutes from April 1, 2015.

Dr. Hattis clarified a point he had made at the April 1 meeting. He reiterated that the role that the HPC should play to address health care cost containment, emphasizing a focus on quality, and not just quantity, of care. Mr. David Seltz, Executive Director, agreed and noted the HPC's ongoing discussions in this area with the Department of Public Health (DPH). Mr. Seltz offered to update the committee on this progress at future committee meetings.

Dr. Hattis made a motion to approve the minutes from April 1, 2015, Mr. Lord seconded. Members voted unanimously to approve the minutes.

ITEM 2: Update on Market Metrics for Specialty Hospitals and Primary Care Services

Ms. Katherine Scarborough Mills, Acting Policy Director for Market Performance, and Ms. Megan Wulff, Senior Manager for Market Performance, joined the committee to discuss the development of market metrics.

Dr. Cutler stated that the goal of the discussion was to provide guidance on the HPC's determination of market areas in the context of material changes involving specialty hospitals or primary care services. Dr. Cutler emphasized that the HPC would like to provide as much guidance as possible on how it will evaluate the impact of material changes.

Ms. Mills reminded the committee that the HPC issued a regulation on notices of material change and cost and market impact reviews and an accompanying technical bulletin that took effect on January 2, 2015. She stated that the HPC intends to update the technical bulletin later this year as they finalize new market metrics, and noted that the HPC may also refine certain market definitions based on feedback from market participants. In particular, Ms. Mills described plans to update the committee about refined guidance on clinical affiliations reportable as material changes in the near future.

Ms. Wulff then presented on the HPC's current work modeling service areas for specialty hospital and primary care services. Ms. Wulff noted that the HPC is required to define service areas by statute, and uses service areas to examine potential cost, quality, and access impacts of provider transactions. To put the current work in context, Ms. Wulff explained that the HPC initially modeled service areas for inpatient general acute care services; is now refining its methodology for inpatient hospital services to cover services provided at specialty hospitals, as well as beginning to model service areas for primary care services; and plans to expand into outpatient and post-acute services as data and time allow.

Ms. Wulff then reviewed the current PSA methodology for inpatient general acute care services, which includes contiguous zip codes by drive time that comprise 75% of the hospital's commercial discharges, and is consistent with methodologies used in antitrust litigation, by the market, and by other agencies such as the FTC and DOJ.

In refining that methodology for specialty services, Ms. Wulff emphasized that specialty hospitals pose unique considerations. For example, specialty hospitals provide only a subset of all general acute care services, and commonly treat more out-of-state patients than general acute care hospitals. However, despite these differences, Ms. Wulff reported that the HPC's approach for defining a PSA for general acute care hospitals works well for specialty hospitals in Massachusetts that provide significant inpatient services, with only one important change: focusing analyses on the subset of services that reflect the core services that each specialty hospital provides.

Mr. Lord asked for clarification on the number of specialty hospitals in Massachusetts. Ms. Wulff responded that there are four specialty acute-care hospitals: Dana Farber Cancer Institute, New England Baptist Hospital, Boston Children's Hospital, and Massachusetts Eye and Ear Institute.

Mr. Seltz asked for an example of core services provided by specialty hospitals. Ms. Wulff responded that each specialty hospital is different, but that the HPC considers the core services of Children's Hospital, for example, to be the services it provides to patients under the age of 18. The HPC would then compare the services Children's Hospital provides to patients under 18 to the same services provided by general acute care hospitals within Children's PSA.

Dr. Everett noted that large, self-insured companies can send their employees across state lines to receive care at centers of excellence, regardless of location. She inquired as to

whether this concept of centers of excellence had entered into the HPC's planning. Ms. Wulff responded that, because hospital PSAs are contiguous, any state that does not border Massachusetts would not show up in a hospital's PSA. She noted that it would be interesting to understand which, if any, large national employers are sending their Massachusetts employees out of state to receive specialty care.

Ms. Mills acknowledged that specialty hospitals see a higher number of out-of-state patients. The HPC modeled PSAs both including and excluding these patients, and found that there was little difference between the two PSAs.

Dr. Hattis noted that, in terms of cost containment, the HPC should focus its research on Massachusetts residents. He emphasized that the way in which the HPC views a specialty hospital's market share may depend on whether the specialty hospital provides primarily high acuity care, or is competing for a significant amount of lower acuity care as well. Ms. Wulff responded that the HPC is examining market shares of specialty hospitals by patient severity to better understand this very issue, and will also be modeling service areas and shares for similar specialty hospitals in other states.

Mr. Seltz asked for clarification on the size of specialty hospital PSAs. Ms. Wulff replied that specialty hospitals have somewhat larger PSAs than many of their general acute care counterparts, closer to the size of an academic medical center's PSA. The PSAs can span somewhere between one third to one half of the state.

Dr. Hattis asked if staff were thinking about the reach these specialty hospitals have in the community as well, noting that a specialty hospital's physicians often provide care at other locations through clinical affiliations. He asked if this would impact the assessment of whether a specialty hospital has a dominant market share in a PSA since the claims for the physicians' services would not be attributed to the specialty hospital. Ms. Wulff responded that the All-Payers Claims Database (APCD) separately tracks claims billed by hospitals and by physicians, mitigating the concern that services provided outside a specialty hospital by its physicians could not be attributed to the specialty hospital's market share.

Dr. Cutler noted that the Health and Human Services Department in Washington, D.C. convened a meeting on health care consolidation around the country and the experts who spoke cited Massachusetts as prime example of how to track such transactions. He stated that he believed the metrics the HPC is using are the right ones.

Dr. Everett inquired as to whether Dana Farber's use of Brigham and Women's for its inpatient care was being factored into attributing such care to Dana Farber. Ms. Wulff responded that the team had not yet delved into referrals from specialty hospitals to other institutions, but that it is something they are looking into.

Dr. Everett further inquired if contractual relationships or clinical affiliations between specialty hospitals and other providers could be tracked. Ms. Mills responded that such scenarios are the impetus behind the HPC's push to refine the definition of reportable clinical affiliations. Understanding those relationships is crucial to understanding the care

delivery patterns that underlie not only health care costs but also quality and access concerns. Ms. Wulff expressed optimism that the Registration of Provider Organizations will provide a much-needed map of significant clinical affiliations in the market.

Ms. Wulff next explained that the HPC has begun to examine service areas of non-hospital-based services, beginning with primary care. She described considerations particular to primary care provider (PCP) services. For example, PCPs are harder to identify, they include non-physician clinicians, and they can practice in multiple locations. With these considerations in mind, the HPC is currently developing a methodology for a primary care PSA that will work for large and small physician groups alike, in all regions of the state.

Ms. Wulff described a number of working principles for primary care PSAs, including that, unlike hospital PSAs, primary care PSAs may not be contiguous, and should take into account nearby hospitals where the provider group refers its primary care patients.

Dr. Hattis asked why we should take into account nearby hospitals when calculating a primary care PSA. Ms. Wulff responded that much of the reason that the HPC cares about affiliations between hospitals and physician groups is that primary care physicians have a lot of control over where their patients go for care. Thus, the HPC may want to think about primary care service areas in relation to where patients living in their service areas receive hospital care. She added that the HPC's work defining PSAs for physician groups is still in the preliminary stages, and that further substantial modeling will be necessary, given that provider groups vary so much.

The committee heard public comment from Ms. Stacy Ober, Massachusetts Coalition of Nurse Practitioners, and Dr. Judith Steinberg, University of Massachusetts Medical School.

Ms. Wulff concluded by stating that the HPC is planning to continue modeling service areas and market shares for a wide range of services, and is hoping to develop a TME-like metric for hospitals that incorporates both inpatient and outpatient care.

ITEM 3: Update on System-Wide Data

Dr. Marian Wrobel, Director for Research and Cost Trends, joined the committee to provide an update on system-wide data.

Dr. Wrobel updated the committee on several topics. She noted that CHIA has received additional enrollment and eligibility data from MassHealth to supplement the MassHealth data in the APCD. This additional data is essential for the HPC and other users be able to analyze enrollment and costs for MassHealth. It will be released to HPC and other users as part of APCD version 4.0 (data through 2014, release date 12/2015). Mr. Seltz reiterated that Massachusetts Behavioral Health Plan (MBPH) data for the MassHealth population will also be included in APCD version 4.0 (data for 2013 and 2014).

Dr. Wrobel stated that HPC staff is working with CHIA to obtain basic enrollment and cost statistics for the MassHealth PCC population, derived from the APCD, for HPC's 2015 Cost Trends Report. Like other APCD data, these statistics would cover the time period 2011-2013.

Dr. Wrobel continued that CHIA and the HPC are also discussing including free-standing psychiatric hospitals in CHIA's existing effort to collect hospital discharge data. Mr. Seltz acknowledged that such data collection will unavoidably cause some administrative burden on the hospitals that are newly included.

Dr. Cutler requested one page updates for future committee meetings about the progress that has been made on data collection.

Dr. Cutler asked about the HPC's plans for a "dashboard" summarizing key statistics. Dr. Wrobel replied that in the short term, the dashboard will rely on measures that are established and well-understood. In the long term, the dashboard can be expanded to include new measures.

ITEM 4: Adjournment

Dr. Cutler adjourned the meeting at 10:38 AM.