MINUTES OF THE COST TRENDS AND MARKET PERFORMANCE COMMITTEE

Meeting of December 2, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE COST TRENDS AND MARKET PERFORMANCE COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, December 2, 2015, 9:30AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Cost Trends and Market Performance (CTMP) Committee held a meeting on Wednesday, December 2, 2015, at 50 Milk Street, 8th Floor, Boston, MA.

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

Dr. Cutler called the meeting to order at 9:30 AM.

ITEM 1: Approval of minutes

Dr. Cutler asked for a motion to approve the minutes from October 14, 2015. **Dr. Hattis** made the motion to approve the minutes. **Dr. Everett** seconded the motion. The members unanimously approved the minutes.

ITEM 2: Update on Material Change Notice Process as it relates to Provider-to-Provider Discount Arrangements

Ms. Kate Scarborough Mills, Policy Director for Market Performance, updated the committee on potential changes to the material change notice (MCN) process to address an issue that the HPC has seen in the market – provider-to-provider discounts.

Ms. Mills noted that the HPC has reviewed a number of discount arrangements through the MCN process. She stated that there are a number of these types of arrangements in the market that have not been consistently reported to the HPC through the MCN process.

Ms. Mills commented that the existence and functioning of discount arrangements has not been transparent. As such, she noted that the committee would take time to review this concept. Recognizing that these arrangements have only come up in HPC's review of confidentially material, Ms. Mills stated that she would be speaking in broad generalities.

Ms. Mills explained the HPC's understanding of discount arrangements. Providers under risk generally agree to send risk patients to a specific preferred provider. That preferred provider then agrees to return a discount, or a portion of the rate it receives from payers, back to the referring provider.

Dr. Everett asked whether the preferred provider to whom the patient is referred is also under risk. Ms. Mills stated that preferred providers may or may not be under risk. She added that they get paid pursuant to their contract.

Ms. Mills explained that payers are generally made aware of these arrangements, but do not exchange funds as a result of them. She added that the discount negotiated between the providers is not reflected in total medical spending recorded by the payer, or in the end of the year settlement process between the provider under risk and the payer.

Dr. Cutler asked whether payers have the right to prohibit these arrangements. Ms. Mills responded that staff was unsure.

Dr. Hattis asked if payers ever play a third party administrator role in the discount arrangements. Ms. Mills replied that some payers had reserved the right to administer the discounts but, to the HPC's knowledge, do not currently exercise that ability. She added that, while the HPC had seen several instances of the discount arrangement, the staff's knowledge of the arrangements is limited. This is one of the reasons that the HPC is hoping to increase transparency in this area through the MCN process.

Dr. Everett asked for clarification on the difference between the provider-to-provider discounts and kickbacks. Ms. Mills replied that discounts can raise questions about kickback agreements. She noted that the HPC had spoken with the Office of the Attorney General, which expressed an interest in learning more about these arrangements. She added that anti-kickback laws are highly complex and have a network of exceptions such that it would not be possible to apply them at the general level at which the HPC is currently exploring the discount arrangements.

Ms. Mills explained how the provider-to-provider discount arrangement work (graphs illustrating the arrangement are available in the meeting's PowerPoint presentation).

Dr. Hattis asked whether the relationship between the two providers only allowed for payments to flow at the end of the year. Ms. Mills responded that the example of funds flowing at the end of the year was a general explanation of the arrangement and one that the HPC had seen several times. She noted that it was not an exclusive explanation of the relationship.

Ms. Mills offered further explanation of a discount arrangement through an example using actual numbers being transferred between the two hypothetical providers. She started with a scenario in which Provider A and Provider B have negotiated a 20% discount on the care Provider B provides to Provider A's risk patients. She explained that if Provider A refers 100 risk patients to Provider B, and Provider B receives $200 per claim, this would equal $20,000 pursuant to its rates with the payer. Ms. Mills went on to explain that Provider A's global budget with the payer will reflect that the payer paid $20,000 to Provider B. She explained that if Provider A has overspent its global budget by $10,000 (a $10,000 deficit) and if it has a 50-50 risk sharing arrangement with the payer, the payer will be required to pay $5,000 of that, and Provider A will pay an additional $5,000.

Ms. Mills highlighted that separately, Provider A and Provider B go through a settlement and Provider B gives Provider A 20% of what it received from the payer for the treatment of the 100 referred patients (in this example, Provide B pays Provider A 20% of $20,000 or $4,000). Ms. Mills concluded the scenario by noting that Provider A will only have a $1,000 deficit after the risk agreement because they can offset that deficit with the payment from Provider B.

Ms. Mills explained how the situation would work if Provider A instead has a surplus of $10,000 at the end of the year and shares that with the payer 50-50. She noted that Provider A would get a $5,000 surplus payment from the payer, and the payer would keep the other $5,000. Provider A would also separately get that same $4,000 payment from Provider B, which will then add to their surplus, resulting in a $9,000 surplus.

Mr. David Seltz, Executive Director, commented that providers have a number of mechanisms to address risk. He stated that discount arrangements decrease incentives to participate in global budgets and reduce the money flowing back to payers.

Dr. Cutler noted that these arrangements could be exacerbating the issues surrounding high-deductible health plans in that they require consumers to pay larger deductibles without being able to reap savings.

Dr. Hattis noted that three matters stood out to him regarding the discount arrangements. The first was that the discount received by the provider could be larger than the shared savings, thus defeating the incentive to contract with value based providers and replacing it with an incentive to contract with providers with the largest discounts. Dr. Hattis explained the second point was that Provider B has an incentive to negotiate for larger payments from insurance companies since Provider B understands that it has to pass money along to Provider A via the discount. He noted that the third issue was the potential presence of swap arrangements. Dr. Hattis highlighted that he was not asserting all of these issues necessarily present in any situation but that they could be potential matters to assess.

Ms. Mills noted that staff understands that the arrangements are strategically important contracting actions by providers. To that end, she explained that the HPC is planning on releasing a frequently asked questions list directly addressing the arrangements.

Ms. Mills stated that the HPC's goal is to increase the transparency of the arrangements through its existing material change notice process. Ms. Mills explained that much of the information about discount arrangements reviewed to date has been exclusively in the exchange of confidential documents. She added that, in order to allow for effective monitoring of these types of arrangements, the HPC is proposing that discount arrangements be disclosed as part of the public filing materials.

Ms. Mills commented that this could be done by adding a requirement to note any exchange of funds between the parties (such as any arrangement to provide a discount for referred patients) to one of the existing questions in the MCN form.

Ms. Mills noted that the HPC is not expecting providers to disclose the specific amounts and terms of their discount arrangements on the public form, but rather note the existence of a discount arrangement as part of a transaction.

Dr. Everett asked how many providers and provider organizations are currently engaged in provider-to-provider discount arrangement. Ms. Mills replied that the exact number is unknown. She added that the HPC is aware that more arrangements exist than those that have come up for review.

Dr. Cutler asked whether the HPC has the right to ask providers to identify all existing discount arrangements. Ms. Mills replied that the HPC has several tools at its disposal. The current MCN process is prospective, but the agency has the ability to compel information from providers through the annual Cost Trends Hearing.

Dr. Hattis asked whether the HPC could ask for such information prior to the October 2016 Hearing. Mr. Seltz replied that it is something to consider. He noted that it is a significant amount of work for organizations to respond to the HPC's pre-file testimony requests and that the agency tries to minimize this burden. He added that reporting requirements associated with the Cost Trends Hearing are public information and, as such, may not be the best venue for this business-sensitive information.

Dr. Hattis commented that the Office of the Attorney General may be better suited to gather this information through a confidential subpoena. He emphasized the need to learn about the provider-to-provider arrangements.

Dr. Everett noted that she was aware of the burden that data reporting imposes on organizations and was sensitive to not wanting to needlessly add to this. She stated that the provider-to-provider discount arrangements represented a major policy issue. She noted that one of the Commonwealth's major goals this year is to increase the adoption of APMs and discount arrangements undermined that goal. Dr. Everett said that the data collection requirement around provider-to-provider discounts should be put in place, but as minimally invasive as possible.

Dr. Cutler commented that issues of fairness could be raised if the Commonwealth takes action only on what is currently known and not on the arrangements that are possibly unknown at this point.

Ms. Peters noted that the HPC staff might use the MCN process to determine why organizations enter into discount arrangements.

Dr. Cutler emphasized that the committee was in no way suggesting that organizations should not enter in a contract with a high cost provider. He added that it was the specific exchange of money that was at issue.

Dr. Everett asked for clarification on the incentives for preferred providers to enter the discount arrangements. She hypothesized that it had to do with increased patient volume or

the desire to be part of a larger system. Dr. Hattis added that the providers are still part of integrated delivery organizations that benefit from fee-for-service care. As such, referrals equate to more revenue for them.

Dr. Hattis pointed out that lower cost providers could also be participating in the discount arrangements. He asked the HPC for more information on the arrangements regardless of which type of provider is involved.

Dr. Cutler asked about next steps. Mr. Seltz responded that staff will carry forward with the proposed changes to the MCN process and spend time creating more options for the committee to discuss at its next meeting.

Dr. Hattis commented that payers may also have information about the arrangements and should not be left out of the discussion.

Mr. Seltz asked whether HPC's analysis has shown that payers are aware of the discount arrangements. Ms. Mills replied that staff has spoken informally with several payers and found that insurers are aware of the discounts. She added that, because of the lack of transparency in the marketplace, she could not comment on how much payers know.

Ms. Mills noted that while the HPC is proposing to issue a FAQ document on provider discount arrangements. She noted that the HPC will also update the MCN FAQ form with a minor technical clarification to address some confusion in the market about how revenue thresholds for filing a MCN apply to provider systems. She added that the HPC wants to clarify that the net patient service revenue threshold for filing an MCN refers to the revenue of the provider system engaging in a transaction, not just the specific affiliate engaged in the transaction.

ITEM 3: Discussion of Preliminary Findings on Pharmaceutical Spending from the 2015 Cost Trends Report

Dr. Marian Wrobel, Director for Research and Cost Trends, stated that the remainder of the meeting would focus on pharmacy spending findings from the 2015 Cost Trends Report (CTR). She introduced Ms. Sara Sadownik, Senior Manager for Research and Cost Trends.

Ms. Sadownik stated that drug spending was a major factor in the state surpassing the health care cost growth benchmark in 2014.

Ms. Sadownik reviewed findings that highlighted how 2014 commercial expenditures on prescription drugs increased dramatically in Massachusetts (13%) and the United States (11%). She noted that the data only includes prescription pharmacy drugs, not drugs administered to patients in the hospital.

Ms. Sadownik stated that pharmacy spending accounted for 13.5% ($7.5B) of Massachusetts total health care expenditures (THCE) in 2014. She noted that drug spending accounted for approximately one third of the growth in Massachusetts THCE in

2014. She added that these figures do not account for manufacturer rebates which could affect both the level and trend of spending.

Dr. Cutler asked the staff to further research the impact of rebates on drug spending. Commissioners briefly discussed what is known about the impact of rebates.

Dr. Cutler asked whether the HPC was overstating the growth of commercial drug spending by not including rebates. Ms. Sadownik responded that this was likely. She noted that the HPC's work on this topic is limited by data availability.

Dr. Cutler noted that the Centers for Medicaid and Medicare Services' (CMS) annual report on drug spending includes an actuarial estimate on the impact that rebates have on expenditures. Dr. Cutler asked whether Massachusetts could make a similar estimate. Dr. Everett commented that the HPC could reach out to CMS to determine whether they have a methodology that could be applied in Massachusetts.

Dr. Hattis pondered why drug companies do not release more information about their rebate practices, especially in light of recent bad press about the high cost of prescription drugs. Dr. Everett responded that there is no single price for a drug since drug companies contract with different providers and payers for different prices. She hypothesized that this competitive pricing environment is the reason that so little is known about rebates.

Ms. Sadownik highlighted that factors at the national level helped drive drug spending in Massachusetts. She explained that drug prices for commercial insurers are largely determined by negotiations between a national pharmacy benefit management company (PBM) and drug manufacturers.

Ms. Sadownik noted that there were three factors that drove 2014 drug spending: (1) new high-cost drugs, (2) high drug price increases, and (3) low rates of patent expirations. Ms. Sadownik stated that the new high-cost drugs are receiving the most attention nationally, especially Sovaldi, a hepatitis C drug. She noted that this drug is very effective with limited side effects, but costs $84,000 for a 12-week treatment.

Ms. Sadownik explained that, for the second factor, the price increase was for both brand drugs as well as some generic drugs. Ms. Sadownik noted the price increases for existing drugs were not out of line with previous years, but the third factor – the low rate of patent expirations – led to the net effect.

Ms. Sadownik reviewed the impact of high drug prices in 2014 on consumers.

Ms. Sadownik highlighted the components of national drug spending growth in 2014. She explained that the lion's share of the growth was the result of new brands of drugs entering the market place in the previous 24 months as well as price increases for brand drugs. She added that the growth in generic brands in 2014 was considerable when compared to growth in 2013, but much smaller than the other types of drugs.

Ms. Sadownik discussed which drug classes contributed most to the spending growth in Massachusetts. She noted that these data are estimates provided by IMS and use a different methodology than the data provided by CHIA. Ms. Sadownik added that the IMS numbers include both prescription drugs and drugs provided to patients in hospitals and, as such, the numbers are not directly comparable to CHIA's numbers.

Dr. Hattis asked whether the data included all payers. Ms. Sadownik replied in the affirmative.

Ms. Sadownik explained that spending on Hepatitis C drugs accounted for a significant share of the drug spending growth in Massachusetts. She noted that other drug classes (biologics and oncology) saw growth as well and often experience high growth each year. Ms. Sadownik added that, compared to the US, Massachusetts appears to have seen a particularly high rate of growth in HCV drugs. She noted that MassHealth was the least restrictive of all state Medicaid offices in its reimbursements for HCVs.

Ms. Sadownik presented data that illustrated likely future growth in drug spending, highlighting that 2014 was potentially not an anomaly but the start of a trend of higher spending in drug costs.

Dr. Everett asked for clarification on the data concerning anti-arthritic drugs. Dr. Hattis further asked if this category included injectable drugs. Ms. Sadownik replied in the affirmative.

Ms. Sadownik explained that Sovaldi and other HCV drugs came into the market priced at high levels typical of orphan drugs, or treatments for diseases with fewer than 200,000 known cases. Ms. Sadownik noted that many of these drugs are for illnesses with a much higher prevalence than 200,000.

Ms. Sadownik explained that specialty drugs, which often cost over $6,000 per year, have become more prevalent. Mr. Seltz noted that over a third of pharmaceutical sales revenue is in the specialty drug category.

Ms. Sadownik noted that public support for government intervention in drug pricing is quite high. She presented findings from Harvard School of Public Health showing that 84% of respondents favored Medicare negotiating drug prices with drug companies. She presented another survey from the Kaiser Family Foundation which found that 86% of respondents favored requiring drug companies to release information to the public on how they price drugs.

Dr. Hattis asked if the HPC tracks the average or median amount of out-of-pocket money spent by consumers on drugs. Dr. Wrobel replied that this information will eventually be available through the APCD.

Ms. Sadownik explained several efforts the HPC is exploring to slow price growth, including steps towards (1) value-based benchmarks, (2) risk-based contracting, and (3) group purchasing.

Dr. Hattis asked whether the HPC considered reference pricing or price controls as a cost growth containment policy. Mr. Seltz responded that expert testimony at the Cost Trends Hearing highlighted the potential importance of bulk purchasing and multi-state collaboratives in reigning in the cost growth of pharmaceuticals. Ms. Sadownik added that there is currently a bill in the Massachusetts legislature that would make participating in multi-state collaboratives easier.

Dr. Cutler asked if any state receives a higher rebate than Medicaid's 23.1%. Ms. Sadownik replied that some evidence suggests that states can receive higher rebates than 23.1% on branded drugs and much higher rebates on generic drugs.

Dr. Everett noted that Oregon had been successful in achieving a rebate higher than 23.1%. She added that moving forward, the HPC should keep track of instances where a state or a group of states is reducing the cost growth of drug spending. As these case studies are collected, they can help guide future actions by the HPC and Massachusetts. Dr. Wrobel commented that the national nature of the issue could offer an opportunity for the HPC to partner with other agencies.

Dr. Cutler noted that one of the biggest issues in Massachusetts is how drug spending impacts the benchmark. Dr. Everett noted that a key issue is defining how expenditures on drugs can offset costs downstream. She added that it might be helpful and necessary to partner with an organization that can identify the link between using a drug and therefore saving money on things such as readmissions and other medications in the future.

Mr. Seltz thanked the committee for their considerable feedback.

Dr. Wrobel provided her routine system-wide data update.

Dr. Cutler adjourned the meeting at 10:55.