JOINT MEETING MINUTES:
COST TRENDS AND MARKET PERFORMANCE & COMMUNITY HEALTH CARE INVESTMENT AND CONSUMER INVOLVEMENT COMMITTEES

Meeting of February 24, 2016

MASSACHUSETTS HEALTH POLICY COMMISSION

JOINT MEETING: COST TRENDS AND MARKET PERFORMANCE & COMMUNITY HEALTH CARE INVESTMENT AND CONSUMER INVOLVEMENT COMMITTEES OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
HEALTH POLICY COMMISSION
50 MILK STREET, 8TH FLOOR
BOSTON, MA 02114

Docket: Wednesday, February 24, 2016 9:30-12:30 AM

PROCEEDINGS

The Massachusetts Health Policy Commission's Cost Trends and Market Performance (CTMP) Committee and Community Health Care Investment and Consumer Involvement (CHICI) Committee held a joint meeting on Wednesday, February 24, 2016 at the Health Policy Commission, 50 Milk Street, 8th Floor, Boston, MA 02114.

Committee members present included Dr. David Cutler (Chair, CTMP), Mr. Rick Lord (Acting Chair, CHICI), Dr. Wendy Everett; Mr. Martin Cohen; Mr. Ron Mastrogiovanni; Ms. Veronica Turner; and Ms. Lauren Peters, designee for Ms. Kristen Lepore, Secretary of Administration and Finance.

The presentation slides for the day's meeting can be found here.

Dr. Cutler reviewed the meeting's agenda. He noted that the first hour would be dedicated to CTMP business and the second CHICI hour would cover the HPC's study of community hospitals.

ITEM 1: Approval of CTMP minutes

Dr. Cutler asked for a motion to approve the minutes from January 13, 2016. **Mr. Lord** motioned to approve the minutes. **Mr. Cohen** seconded the motion. The members voted unanimously to approve the minutes.

Dr. Cutler emphasized the significant work that HPC staff put into all of the agenda items for the day's committee meeting.

Item 2: Discussion of 2017 Health Care Cost Growth Benchmark

Mr. David Seltz, Executive Director, reviewed the statutory background of the Commonwealth's health care cost growth benchmark.

Mr. Seltz noted that the HPC is required to set the benchmark at the potential gross state product (PGSP) until 2017. Mr. Seltz explained that the PGSP has remained consistently at 3.6 percent since 2012.

Dr. Cutler commented that the process of basing the benchmark off of the PGSP has worked well in recent years.

Mr. Lord asked for clarification on whether the PGSP was expected to remain constant for so many years in a row. Mr. Seltz replied that the PGSP is generally intended to be a stable measure over time.

Dr. Cutler called for a motion to endorse the health care cost growth benchmark at 3.6 percent and advance the issue to a vote at the next full Board meeting. Ms. Peters made the motion. Mr. Lord seconded the motion. The committee voted unanimously to endorse and advance the benchmark.

Item 3: Update on Interim Guidance on Performance Improvement Plans

Mr. Seltz provided background on the HPC's work to date on performance improvement plans (PIPs). He noted that Chapter 224 envisioned PIPs as a means of benchmark accountability. Mr. Seltz added that 2016 is the first year in which the HPC is statutorily able to conduct a PIP.

Mr. Seltz explained that the proposed interim guidance on PIPs is part of an effort to help stakeholders understand the PIP process and the method through which the HPC is going to determine which organizations must potentially undergo a PIP.

Ms. Katherine Scarborough Mills, Policy Director for Market Performance, reviewed the underlying concepts and processes involved in a PIP. For more information, see slide 12.

Ms. Mills explained the role that the Center for Health Information Analysis (CHIA) has in the PIP process. For more information, see slide 13. Ms. Mills noted that CHIA will identify entities which exceed a health-status adjusted total medical expenditure (TME) of 3.6 percent growth, or the benchmark for the year.

Dr. Cutler noted the HPC could work with CHIA to broaden the definition of TME to include other insurance products.

Ms. Mills highlighted the reasoning behind issuing interim guidance on PIPs and explained how such guidance could be useful to affected parties (see presentation slide 14).

Ms. Mills noted that there are three areas in particular that the staff aimed to focus on in the interim guidance: (1) confidentiality (see presentation slide 15), (2) the role of the Board (see presentation slide 16), and (3) the exact standard that would be used in requiring a PIP (see presentation slide 17).

Mr. Lord asked whether Chapter 224 gives the HPC the authority to deny public record requests relating to information gathered by HPC staff from an entity taking part in the PIP process. Mr. Seltz responded in the affirmative, noting that confidential information

received by the HPC in connection with a PIP would be protected from public record requests.

Dr. Everett asked for clarification on the timeline of the PIP process. Ms. Mills replied that PIPs have an 18 month implementation.

Commissioner Mastrogiovanni asked for clarification on the factors that would contribute to determining if a PIP is necessary. Ms. Mills responded that the factors are essentially the same for payers and providers, noting that the metrics might vary.

Dr. Cutler asked how price variation intersects with the HPC's work on PIPs. Ms. Mills replied that the review process for PIPs includes a comparison of performance across entities, as well as an examination of the trend of that particular entity (e.g., is variation increasing?). She noted that a key part of the review is looking for outliers.

Mr. Seltz added that the specific type of variation examined in a PIP is that which leads to increased spending.

Ms. Mills explained the process for PIPs laid out in the interim guidance. She stated that it aligns very closely with the statute. For more information, see slides 19-27.

Ms. Peters asked if the request for a waiver from the PIP process will be public or confidential. Ms. Mills responded that the request would be public given a Board vote would be required. She added that information regarding the request would be presented at a high level to maintain confidentiality.

Dr. Everett asked whether MassHealth would be considered a payer on the list generated by CHIA. Ms. Mills replied that the list that the HPC receives from CHIA only includes Medicaid MCOs, not FFS or PCC. Mr. Seltz added that this was the same for Medicare plans; the list from CHIA would include Medicare Advantage plans by the named insurance providers but not FFS.

Commissioner Mastrogiovanni noted that Medicare Advantage is not as popular among consumers as other supplemental policies. He asked why then is Medicare Advantage being used rather than other policies to look at spending. Mr. Seltz replied that it is a result of how CHIA calculates TME. Insurers are only required to report certain books of business to CHIA.

Ms. Mills provided an overview of the next steps and timeline for the PIP process. For more information, see slide 28.

Dr. Cutler asked for a motion to endorse the proposed interim guidance and move it to a vote by the full Board. Mr. Lord made the motion. Dr. Everett seconded. The committee voted unanimously in favor of endorsing the proposed interim guidance.

Item 4: Presentation on Findings from the Community Hospital Study

Mr. Seltz introduced the HPC's study on community hospitals: *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System*.

Dr. Cutler commented that the day's discussion would be focused on key findings from the report. He noted that additional policy conversations would occur over the next few weeks.

Mr. Iyah Romm, Policy Director for Care Delivery Innovation and Investment, provided an overview of the report. He noted that, over the past two years, conversations around investing in community hospitals have coincided with the closure of several such entities. He added that the objective of the study was to catalogue the state of community hospitals in the Commonwealth.

Mr. Romm explained the self-reinforcing challenges that community hospitals face. For more information, see slide 36.

Dr. Cutler noted that there has been a downward trend in the need for inpatient care which, in turn, means that fewer inpatient beds are necessary.

Mr. Romm reviewed the geographic spread of community hospitals around the state and the diversity of entities within the community hospital cohort. For more information, see slides 39-40.

Mr. Romm highlighted the number of consolidations among hospitals over the last 30 years and the associated decrease in the number of hospitals beds. He added that, while consolidation activity slowed for a period of time, the state has seen activity increase in the last half decade.

Commissioner Lord asked if the graph on slide 41 accurately reflected that there had in fact been an increase in beds in the most recent years of data. Mr. Romm replied that there is some slight variation. He added that the metric measures staffed beds, not necessarily *actual* beds added.

Sasha Hayes-Rusnov, Project Manager for Market Performance, overviewed the value to the Massachusetts health care system by community hospitals. He explained that many community hospitals provide critical access to services and that, in some areas of the state, they are the closest providers of low cost and generally high quality care.

Mr. Hayes-Rusnov described an analysis which found that patients who use their local community hospitals would, on average, face more than a doubling of their drive time to the next closest hospital if the community hospital they currently utilize were to close (see presentation slide 43).

Dr. Everett asked for clarification and further information on who was included in the analysis of local access and travel times. Mr. Hayes-Rusnov explained that the population included patients who live closer to a community hospital than any other hospital and chose

to utilize that hospital. He added that additional time calculated in the analysis was the additional time the patient would have to drive to get to their next closest hospital – community hospital or otherwise.

Commissioner Turner asked if by "traveled" it was meant traveled by car specifically. Mr. Hayes-Rusnov confirmed this and noted that the time increase did not take into account the likely additional time involved in utilizing public transportation.

Mr. Hayes-Rusnov explained how community hospitals tend to serve higher proportions of public payer patients (see presentation slide 44).

Mr. Hayes-Rusnov discussed examples illustrating that community hospitals provide low-acuity services at lower costs and generally high quality (see slide presentation slides 45 and 46).

Dr. Everett asked what sources the staff used for the quality data cited in the study. Mr. Hayes-Rusnov replied that a range of quality measures were used, including CMS hospital comparison measures. He noted that there is widely understood to be variation among hospitals in terms of quality and that generally Massachusetts' hospitals perform well in most measures compared to national benchmarks. Mr. Hayes-Rusnov added that there was no relationship between what type of hospital an entity was and its quality scores. Ms. Mills noted that there was also no relationship between cost and quality found in the study.

Mr. Hayes-Rusnov explained that if a community hospital were to close, in most cases, total expenditures on patient care would increase by under $4 million but, in some cases, spending would increase by over $5 million (see presentation slide 47).

Dr. Cutler asked how much of the cost difference related to the older plants of many community hospitals, which in turn could lead to less debt service for the hospital. He noted that if this was a significant factor, then modernizing the facilities might lead to higher costs for the hospitals. Mr. Hayes-Rusnov replied that this is a factor that could play into the internal cost structure per discharge at community hospitals. He clarified that the savings cited in relation to hospital closures stemmed only from hospital revenues received from hospital discharges.

Commissioner Mastrogiovanni commented that the HPC should help community hospitals transform to keep up with contemporary patient needs to protect themselves from going out of business. Mr. Romm responded that the goal of the CHS and the CHART investment program.

Commissioner Lord asked for clarification on the methodology of the hospital closure analysis and where it was assumed patients would go if their closest community hospital was no longer an option. Mr. Hayes-Rusnov replied that the HPC worked in collaboration with economists to understand the preferences and behaviors of community hospital patients and ran several multivariate regressions. He noted that they compared patients

who use community hospitals to similar patients who utilize similar care settings to analyze where certain populations go to seek care.

Commissioner Turner noted that many patients who are on public payer plans would not have the ability or financial capacity to travel to a type of hospital other than a community hospital. Ms. Mills commented that this is accurate and was incorporated into the econometric model the staff used.

Mr. Romm explained the qualitative patient survey via focus groups commissioned by the HPC to assess the patient perspective on community hospitals versus academic medical centers and teaching hospitals (see presentation slide 49). Mr. Romm highlighted important takeaways from the survey such as the issue of perceived higher quality at AMCs and teaching hospitals over community hospitals and that most patients seek care where their doctor refers them, rather than based on their own research. He added that there is a common belief that higher costs equate to higher quality and that since health insurance is paying for much, if not all, of the care, that it doesn't matter to the patient to try and seek less expensive options.

Dr. Cutler noted that the state's quality assessment system has not kept pace with the perceptions of consumers and patients' understanding of quality. He added that this will be a major part of future work done at the HPC.

Commissioner Turner asked for clarification on who was included in the focus groups. Mr. Romm replied that the HPC collaborated with researchers at Tufts University who created panels of recent patients who had had an inpatient hospital experience in the previous 12 months. He noted that panels were created for each of four geographic areas of the state and that the panels purposefully oversampled so as to be able to identify variation among important subgroups.

Commissioner Mastrogiovanni noted that health care should be no different from any other industry in that providers should make their costs publically accessible and consumers should be informed of how to access this information.

Mr. Romm explained how provider consolidation in recent years has led to a shift in referral patterns among PCPs (see presentation slide 50). He added that the larger providers are accounting for more and more referrals within their affiliated networks.

Dr. Everett noted that costs for non-physician employees are relatively consistent between community hospitals and AMCs/teaching hospitals, but that physicians see much more variation in their associated costs.

Mr. Romm highlighted the large number of consumers who leave their home regions for certain types of care, such as deliveries (see presentations slide 53). He further explained how a significant proportion of care at Boston-area AMCs could readily and appropriately be handled in a community hospital (see presentation slide 54). Mr. Romm discussed the

potential savings that could be realized if patients sought care at an appropriate local hospital (see presentation slide 55).

Commissioner Turner asked if the numbers included out-patient treatments as well. Mr. Romm replied that the analysis only looked at inpatient data as out-patient data was not as robust. He added that including more robust out-patient data was a focus of future research.

Dr. Everett noted that there is a disparity in skill level among physicians in ED departments which hampers the ability of community hospitals to keep certain patients in their facility and forces them to transfer the patient to an AMC or teaching hospital. She added that addressing this would help secure the financial bottom lines of some community hospitals and also impact other policy endeavors such as telemedicine. Mr. Romm replied that while some AMCs and teaching hospitals send physicians out to community hospitals to train local staff in specialty areas, emergency medicine training is often done in city hospitals. He added that, anecdotally, this further engrains the referral patterns which see doctors sending patients to the AMCs and teaching hospitals.

Mr. Romm reviewed trends in occupancy and inpatient at community hospitals compared to AMCs and teaching hospitals (see presentation slides 59-62). He added that community hospitals receive lower commercial prices than compared to AMCs and teaching hospitals, further straining community hospital finances (see presentation slide 63).

Mr. Romm noted the barriers community hospitals face in transforming to more financially stable operations based on qualitative data collection (see presentation slide (66).

Mr. Romm discussed possible next steps to continue the conversation around improving community hospitals' ability to transform and innovate. He noted that the HPC is planning a program, Community Hospitals at a Crossroads: A Conversation to Foster a Sustainable Community Health System, for the end of March.

Commissioner Lord asked for more information regarding the community hospital event and the role of the commissioners. Mr. Seltz replied that, while some details were still being worked on, the goal was to facilitate a conversation with stakeholders and that commissioners would play a role in that. Dr. Everett agreed with this and commented that the commissioners could help further the conversation and help inform where the HPC has already done some work.

Dr. Everett adjourned the CTMP meeting and turned the chairmanship to Commissioner Lord to chair the CHICI committee meeting.

Item 5: Approval of CHICI minutes

Commissioner Lord asked for a motion to approve the minutes from the January 6 CHICI meeting. **Commissioner Mastrogiovanni** made the motion. **Dr. Everett** seconded the motion. The committee voted unanimously to approve the minutes.

Item 6: Update on CHART Phase 2

Mr. Seltz updated that all 25 Phase 2 awards have been launched and that the agency is in the process of providing various types of assistance to the hospitals. He added that regional convenings have started to take place to gather direct input from the CHART participants.

Mr. Seltz discussed the amount of funds disbursed to date in Phase 2 funding. Commissioner Lord asked for a clarification of outcome based dollars in the CHART awards. Mr. Seltz explained that a portion of each hospital's award was set aside as a performance based incentive to be distributed only if the hospital succeeds in meeting its outcome based aim.

Item 7: Discussion of the Evaluation Plan for CHART Phase 2

Cecilia Gerard, Director of Strategic Initiatives, updated the committee on why evaluation of CHART Phase 2 is necessary and what the outcomes of the evaluation would be used for.

Dr. Jessica Lang, Senior Manager for Care Delivery Evaluation, explained the goals and anticipated outputs of the evaluation (see presentation slide 77). She added that the purpose of the evaluation of Phase 2 is not to assess whether hospitals are "good" or "bad" but rather what the hospitals and the HPC have learned from CHART.

Dr. Lang discussed that the evaluation would focus on each of the 25 interventions but also on the one singular CHART program and that the evaluation would test a distinct hypothesis for each setting (see presentation slide 78).

Dr. Lang overviewed the evaluation method that would be used with its focus on implementation, impact, and sustainability (see presentation slide 79).

Dr. Lang noted that there is a range of evaluation methods that could be used, from descriptive to experimental. She noted that Phase 2 evaluation would use a mixed-methods approach (see presentation slide 81). Dr. Lang explained that this approach would include a pre/post for each intervention to assess impact and, where feasible, a difference-in-difference test.

Dr. Lang explained that there will be different levels of metrics used to assess impact both at the hospital level and across hospitals (see presentation slide 82). She also noted that part of the sustainability domain would be to calculate a return on investment (ROI) for the program (see presentation slide 83).

Commissioner Mastrogiovanni asked if there would be future ROI projections beyond the initial ones from the current planned evaluation. Dr. Lang replied that there are ongoing discussions about where and when these could occur. Dr. Everett noted that it might be worthwhile to look at the ROI of hospitals that all pursued similar investment strategies to see if any one approach resulted in a better or worse ROI.

Dr. Lang noted that much of the evaluation's qualitative effort would focus on getting feedback directly from the hospitals (see presentation slide 84). She noted that all findings would be documented in reports during and after the evaluation (see presentation slide 85).

Dr. Lang noted that the HPC is currently planning a competitive procurement for a vendor to perform the evaluation.

Item 8: Presentation from the Center for Health Information and Analysis on Hospital Readmissions Data

Zi Zhang from CHIA presented on the Center's findings from the Hospital-Wide Adult All-Payer Readmissions in Massachusetts: 2011 – 2014 report. The report may be found here.

Item 8: Adjournment

Following the presentation, Commissioner Lord adjourned the meeting.