MASSACHUSETTS
HEALTH POLICY COMMISSION

Board Meeting

March 2, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from the January 20, 2016 Meeting (VOTE)
- Executive Director's Report
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
- Administration and Finance
- Schedule of Next Meeting (April 27, 2016)

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on January 20, 2016, as presented.

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PCMH and ACO certification programs update

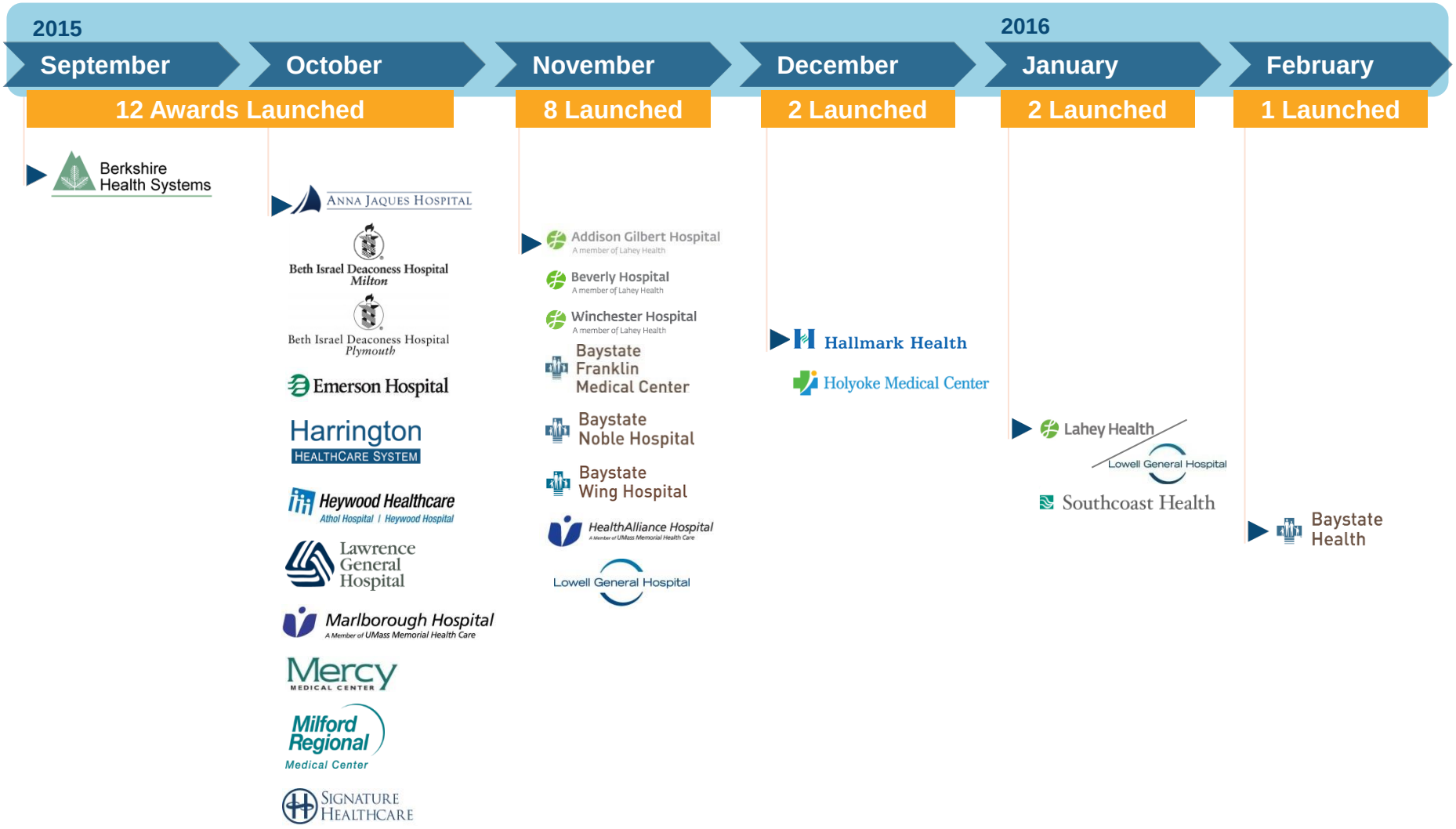
PCMH PRIME Certification

- Launched January 1, 2016
- With NCQA, implemented multi-pronged communications plan, including
  - Dedicated website
  - One-page flyer and FAQ documents
  - Emails to current NCQA PCMH Recognized practices; post cards to other Massachusetts practices
  - Press release
- *4 practices/health centers have applied to participate as of March 1, 2016*
- Training webinar scheduled for March 22

ACO Certification

- Public comment closed January 29; 52 comment letters submitted
- Staff are analyzing public comment and meeting with key stakeholders on potential program design changes
  - 5 provider meetings, 1 roundtable convening hospitals (as of March 1, 2016)
  - 3 additional provider meetings scheduled in coming weeks
- Continuing to develop technical platform specifications and implementation strategy
- Revised program design will be presented for discussion at CDPST meeting March 23 and April 27 board meeting

CHART Phase 2: Launch update



HPC seeks applications for $9.5M in innovation investments from Massachusetts payers and providers and their partnering organizations

HEALTH CARE INNOVATION INVESTMENT (HCII) PROGRAM

- $5 million available to providers and health plans
- Up to $750,000 per award

TELEMEDICINE PILOT INITIATIVE

- $1 million available to providers and health plans
- Up to $500,000 per award

NEONATAL ABSTINENCE SYNDROME (NAS) PILOT INITIATIVE

- $3.5 million available to birthing hospitals
- Award caps vary by eligibility for the CHART Investment Program

KEY DATES

- Requests for Proposals for all three programs released 3/2
- Proposals due on 5/13
- Information sessions to be held on 3/16 in-person at the HPC and on 3/25 via webinar
- Awardees to be announced in July

Anticipated Votes

1. 2017 Health Care Cost Growth Benchmark
2. Interim Guidance on Performance Improvement Plans
3. Cost and Market Impact Review
4. Community Hospital Study
5. Contract Extension

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What is Potential Gross State Product?

Potential Gross State Product (PGSP)

Long-run average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle

Process

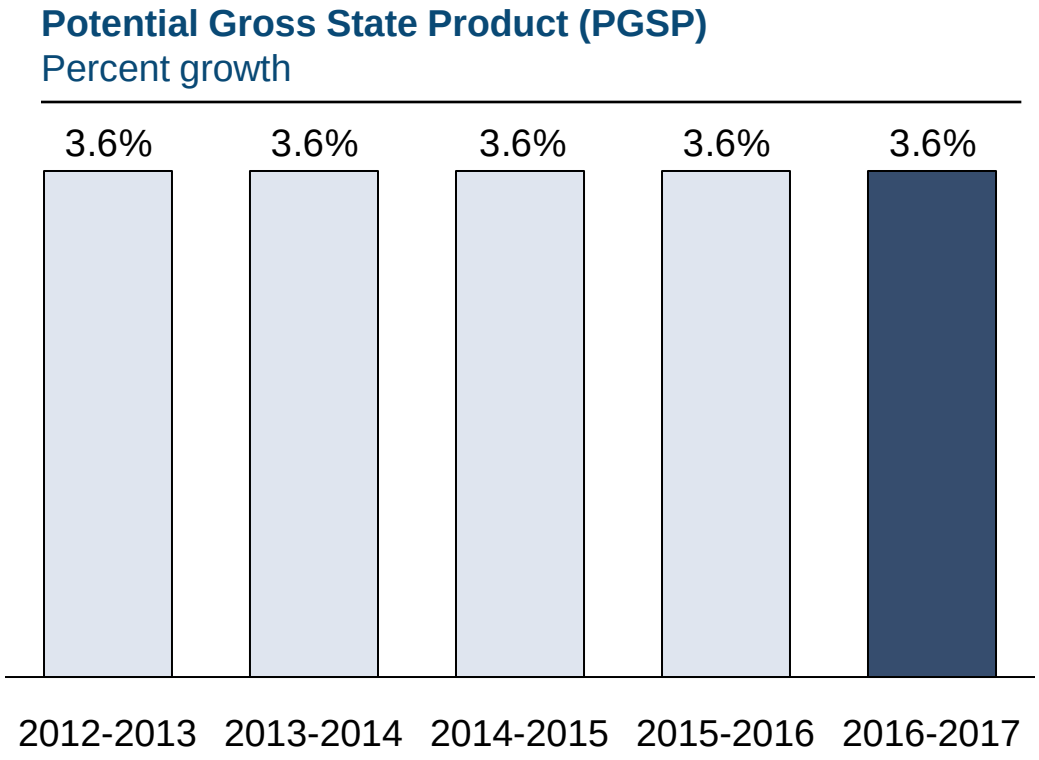
- Section 7H 1/2 of Chapter 29 requires the Secretary of Administration and Finance and the House and Senate Ways and Means Committees to set a benchmark for potential gross state product (PGSP) growth
- The PGSP estimate is established as part of the state's existing consensus tax revenue forecast process and is included in a joint resolution due by January 15th of each year
- The Commonwealth's estimate of PGSP was developed with input from outside economists, in consultation with Administration and Finance, the House and Senate Ways and Means Committees, the Department of Revenue Office of Tax Policy Analysis, and Health Policy Commission staff

HPC's Role

- The PGSP estimate is used by the Health Policy Commission to establish the Commonwealth's health care cost growth benchmark
- For CY2013-2017, the benchmark must be equal to PGSP
- For CY2018-2022, the Commission may modify the benchmark at an amount equal to PGSP to minus 0.5 percent

HPC

PGSP Estimate for 2016-2017



- The 2016-2017 estimate of 3.6% is within a range as discussed by experts
- Estimates were informed by standard methodologies (e.g., Congressional Budget Office) as well as legislative intent to estimate the long-run average growth rate of the Commonwealth's economy

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: APPROVING THE 2017 BENCHMARK

MOTION: That, pursuant to by G.L. c. 6D, § 9, as determined jointly by the Secretary of Administration and Finance and the House and Senate Ways and Means Committees, and endorsed by the Cost Trends and Market Performance committee, the Commission hereby establishes the health care cost benchmark for calendar year 2017 as 3.6%.

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Discussion Preview: Out-of-Network Billing

Agenda Topic

HPC briefing on out-of-network billing.

Description

In connection with recommendations made in the HPC's 2015 Cost Trends Report and the Special Report on Provider Price Variation, staff will present a review of out-of-network billing. The presentation will cover background information on out-of-network billing and highlight policy solutions implemented by other states. HPC staff have prepared a policy brief on out-of-network billing that will be available on the HPC's website.

Key Questions for Discussion and Consideration

Commissioners will have the opportunity to discuss out-of-network billing (e.g., potential solutions to further address out-of-network billing in Massachusetts and/or future research directions).

Decision Points

No votes proposed.

In-Network and Out-of-Network Care

- Most insurance plans involve a **provider network** (i.e., a group of hospitals, physicians, and other providers) that contracts with the insurer to provide services to patients
    - Provider networks generally vary between insurers and among insurance products, as do the terms of the plan and levels of patient cost-sharing (e.g., coinsurance, copayment) for in-network and out-of-network care
- When a provider joins an insurer's network (i.e. becomes an **in-network provider**), that provider agrees to receive negotiated prices for services rendered, which are typically lower than the provider's full list price or charges
- When a provider is **out-of-network**, there may not be a contract between the insurer and provider that obligates the provider to accept a lower, negotiated price
    - The out-of-network provider can then charge full price (**charges**) for services rendered and the insurer can decide how much it is willing to pay against those charges
    - Patients who obtain out-of-network care may be required to pay the full cost of services or for more of the cost-sharing than they would for in-network care, depending on the terms of their plan (which can vary considerably)
- Establishing provider networks is an important way for insurers to provide value to patients, and differential cost-sharing is a key component of many insurance plan designs, including limited and tiered networks.

Out-of-Network Billing Concerns

- Patients may seek out-of-network care in a variety of circumstances (e.g., a patient has the option to see an in-network provider but knowingly elects out-of-network care, understanding any cost implications according to their specific insurance plan)

- Concerns arise when patients receive out-of-network care that they *did not or could not intentionally choose to receive*, which predominantly occurs in two key scenarios:

  - **Emergency care:** A patient receives emergency care at an out-of-network hospital; because of the emergency circumstances, the patient is not able to choose care at an in-network facility

  - **Out-of-network care at an in-network facility:** A patient seeks care at an in-network facility, but during the course of treatment the patient is unexpectedly treated by an out-of-network provider (e.g., an out-of-network emergency room physician, radiologist, anesthesiologist, or pathologist)

- These out-of-network care scenarios can give to rise to:

  - **Balance billing:** A patient is billed for the difference between the out-of-network provider's charge for services rendered and the insurer's payment to the provider

  - **Surprise billing:** A patient receives an unexpected bill from an out-of-network provider after seeking and receiving care at an in-network facility; the consumer may not know that he or she received care from an out-of-network provider until the patient receives a "surprise bill" for services rendered

Out-of-Network Billing Concerns in Massachusetts

- Certain laws in Massachusetts aim to address these out-of-network billing scenarios:
  - **Emergency care**: HMOs and PPOs must pay a reasonable amount to providers for out-of-network emergency services
    - However, balance billing is not prohibited (i.e., out-of-network providers may bill patients for the difference between their charges and what the insurer paid)
    - Insurers may sometimes elect to pay the full provider charges to prevent balance billing of the patient, but this can result in increased health care spending
  - **Out-of-network care at an in-network facility**: Insurers are required to cover services from out-of-network providers practicing inside in-network facilities with no greater cost-sharing to the patient, where the patient did not have a "reasonable opportunity" to choose to have the service performed by a network provider. However, there is not a standardized process for patients to receive this protection, and patients may have to contest a bill after it is received.
- Data on the frequency and extent to which out-of-network billing adversely impacts patients in Massachusetts is difficult to obtain. However, the HPC understands that both balance billing for emergency services and "surprise billing" occur in Massachusetts.

Out-of-Network Billing Concerns in Massachusetts, continued

Lack of Patient Notice	Even in non-emergency scenarios, it is not always easy for patients to have timely, reliable, and accessible information to determine: ▪ Which providers will be part of their care and whether they are in-network or out-of-network ▪ How much any out-of-network care may cost; and ▪ How much their insurer may be reasonably expected to cover for any out-of-network care
Financial Burden for Patients	Out-of-network bills can be substantial, unexpected, and can result in significant financial burden for patients
Administrative Burden for Patients	The resolution of out-of-network billing issues can be complicated and administratively burdensome for patients: ▪ There is no standardized insurer approach to addressing out-of-network billing issues (e.g., some insurers will pay out-of-network provider full charges, or a negotiated amount, to prevent balance billing of the patient for emergency services); and ▪ Patients may have to be aware of their rights and affirmatively contest surprise billing issues
Market Implications	The absence of balance billing prohibitions and limitations on out-of-network charges for emergency care may affect insurer-provider negotiations and ultimately lead to overall increases in spending

State Policies to Address Out-of-Network Billing Concerns

Several states have adopted a variety of **policy solutions** to address out-of-network billing concerns; New York's law is the most comprehensive approach to out-of-network billing to date

- **Disclosure and Transparency**

New York: There are extensive disclosure and transparency requirements for insurers, hospitals, and physicians with the goal of patients having the information to determine network status and resulting cost implications. For example, hospitals are required to post on their website the insurance plans in which they are a participating provider.

Connecticut: There are disclosure and transparency requirements for insurers and providers. For example, prior to any scheduled admission, procedure or service, for nonemergency care, providers must determine whether the patient is insured; if the patient is determined to be uninsured or the provider is out-of-network, the provider must notify the patient in writing (including but not limited to the charges for the service).

- **Hold Harmless Provisions and Balance Billing Prohibitions**

New Jersey: Patients are held harmless for emergency and other out-of-network care services (liability is limited to in-network cost sharing amounts and balance billing prohibited). Insurers must pay the billed out-of-network provider charges (or litigate charges).

New York: Patients are held harmless for emergency services. Patients are further protected from balance billing in surprise billing circumstances if the patient assigns the provider's claim to the insurer (i.e., patient transfers the right of payment to the out-of-network provider, who can then directly seek payment from and be paid by the insurer).

State Policies to Address Out-of-Network Billing Concerns

- **Determination of Provider Payment**
  - **California**
    - Insurers must pay out-of-network emergency providers a “reasonable and customary” payment rate that must be based on “statistically credible information that is updated at least annually” and must take into account certain factors (e.g., the provider’s training and experience, and the nature of services provided).
    - The state also has a voluntary, non-binding independent dispute resolution process for out-of-network providers to contest payment adequacy.

  - **New York**
    - Insurers must establish a reasonable payment amount and disclose their methodology for determining that amount and how it compares to usual and customary rates (as defined in the law).
    - If the out-of-network provider is not satisfied with the payment, the provider may utilize the state’s independent dispute resolution process, which is binding.

  - **Connecticut**
    - For emergency care, out-of-network providers may bill the insurer directly and the insurer must reimburse out-of-network providers the greatest of (1) the amount the plan would pay for emergency services if rendered by an in-network provider; (2) the usual, customary and reasonable rate (as defined in the law) or (3) the amount Medicare would reimburse for such services.
    - For surprise billing situations, insurers must reimburse the out-of-network provider or insured, as applicable, for services rendered at the in-network rate as payment in full unless the insurer and provider agree otherwise.

Out-of-Network Billing Recommendations for Massachusetts

- As set forth in the HPC's 2015 Cost Trends Report and the Special Report on Price Variation, Massachusetts should draw on models from other states (like New York) to **build upon the existing out-of-network billing protections** by:

    1. Requiring providers to **disclose network status** prior to the delivery of services
    2. Requiring insurers to **hold members harmless** for out-of-network emergency services (i.e., prohibit balance billing for patients)
    3. Enhancing patient **awareness of "surprise billing"** protections
    4. Establishing a **maximum reasonable price** for out-of-network services

- There are a number of bills pending in the Legislature that address out-of-network billing in some manner

- HPC staff have prepared a policy brief on out-of-network billing that will be available on the HPC's website

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Discussion Preview: Performance Improvement Plans

Agenda Topic

Performance Improvement Plans: Proposed Process and Interim Guidance

Description

Staff will provide an update on the development of the process for Performance Improvement Plans, and will present proposed interim guidance, as endorsed by the CTMP committee, for discussion and vote by the full Board. Staff will detail the HPC's recommended process for evaluating payers and providers, including discussion of the standard and factors to be reviewed. Staff will also discuss the HPC's authority to conduct cost and market impact reviews of CHIA-identified provider organizations.

Key Questions for Discussion and Consideration

Commissioners will have the opportunity to provide feedback on the process and guidance for performance improvement plans.

Decision Points

Commissioners will be asked to vote on the release of the proposed interim guidance.

Overview of Performance Improvement Plans

Performance Improvement Plans (PIPs) are a mechanism for the HPC to monitor and assist payers and providers whose cost growth may threaten the state benchmark.

- CHIA is required to provide to the HPC a confidential list of payers and providers whose cost growth, as measured by health status adjusted Total Medical Expenses (HSA TME), is considered excessive and who threaten the benchmark.
- The HPC is required to provide notice to all such payers and providers informing them that they have been identified by CHIA.
- The HPC may require some of the identified payers and providers to file a PIP where, after comprehensive analysis and review, the HPC has identified significant concerns about the entity's cost growth and found that the PIP process could result in meaningful, cost reducing reforms.
    - The HPC also has the option to conduct a cost and market impact review (CMIR) of any of the provider organizations identified by CHIA *if the state's total health care expenditures exceed the cost growth benchmark*.

Recommendation for Interim Guidance and Purpose

- Pending the adoption of final regulations, the HPC proposes to issue interim guidance to provide clarity for market participants about the PIPs process this year.
- The interim guidance provides direction with respect to the process for identifying payers and providers subject to PIPs, and for the submission, approval, and amendment of PIPs.
- The interim guidance closely tracks statutory requirements, but fills in key details (e.g. where the Board must vote, confidentiality protections), and clarifies certain statutory provisions.
- The development of the interim guidance has been informed by discussions with Commissioners, other state agencies, market participants, and subject matter experts.
- The regulatory process will provide further opportunity for public comment. The Commission's final regulations will supersede the requirements of the interim guidance and, accordingly, may differ.

CHIA Identification of Payers and Providers

CHIA is required to identify payers and providers whose cost growth, as measured by health status adjusted Total Medical Expenses (HSA TME), is considered excessive and who threaten the benchmark.

- This year, CHIA has chosen to identify payers and providers whose HSA TME growth is above 3.6%.
- The HSA TME metric accounts for variations in health status of a payer's full-claim members. This metric allows for a more refined comparison of TME trends between payers than looking at unadjusted TME alone.
    - Payer HSA TME represents total health care spending for members' care, adjusted by health status. Payer TME is reported for each book of business for a payer.
    - Provider group HSA TME represents the total health care spending of members whose plans require the selection of a primary care physician associated with a provider group (typically HMO or POS products), adjusted for health status. Provider TME is reported for each carrier/book of business for a provider.
- This year's list is based on the trend for 2012 and 2013 final data, as well as the trend for 2013 final and 2014 preliminary data.

Confidentiality and Commissioner Votes

Identification by CHIA and HPC Review Process: By statute, the list of identified payers and providers is confidential.

- The notices that will be sent to all identified entities will be confidential.
- The list, as well HPC staff findings and recommendations, will be shared confidentially with commissioners.
- The identity of any entity for which the HPC recommends a PIP would become public at the point of a Board meeting and vote on that PIP recommendation
- Any entity required to file a PIP will be identified on the HPC's website.

Information Provided to the HPC by Payers and Providers: The HPC will not disclose confidential information or documents provided in connection with PIP activities without the entity's consent, except in summary form in evaluative reports (e.g., public reporting in summary form when Board vote required) or where the HPC believes that such disclosure should be made in the public interest after weighing privacy, trade secret or anticompetitive considerations.

Commission vote required: (would include a public, staff presentation prior to vote)

- ❑ To require a PIP and/or CMIR from any entity
- ❑ To approve/disapprove any requests for waiver from the requirement to file a PIP
- ❑ To approve/disapprove a proposed PIP from a payer/provider
- ❑ To approve/disapprove any significant proposed amendments during implementation
- ❑ To determine whether the PIP was successful and, if unsuccessful, to extend implementation, amend the PIP, or require a new PIP filing.
- ❑ To require a penalty if the entity fails to file or implement a PIP in good faith

Recommended Standard and Factors for Review

Standard: The HPC may require a PIP where, based on a review of factors described below,

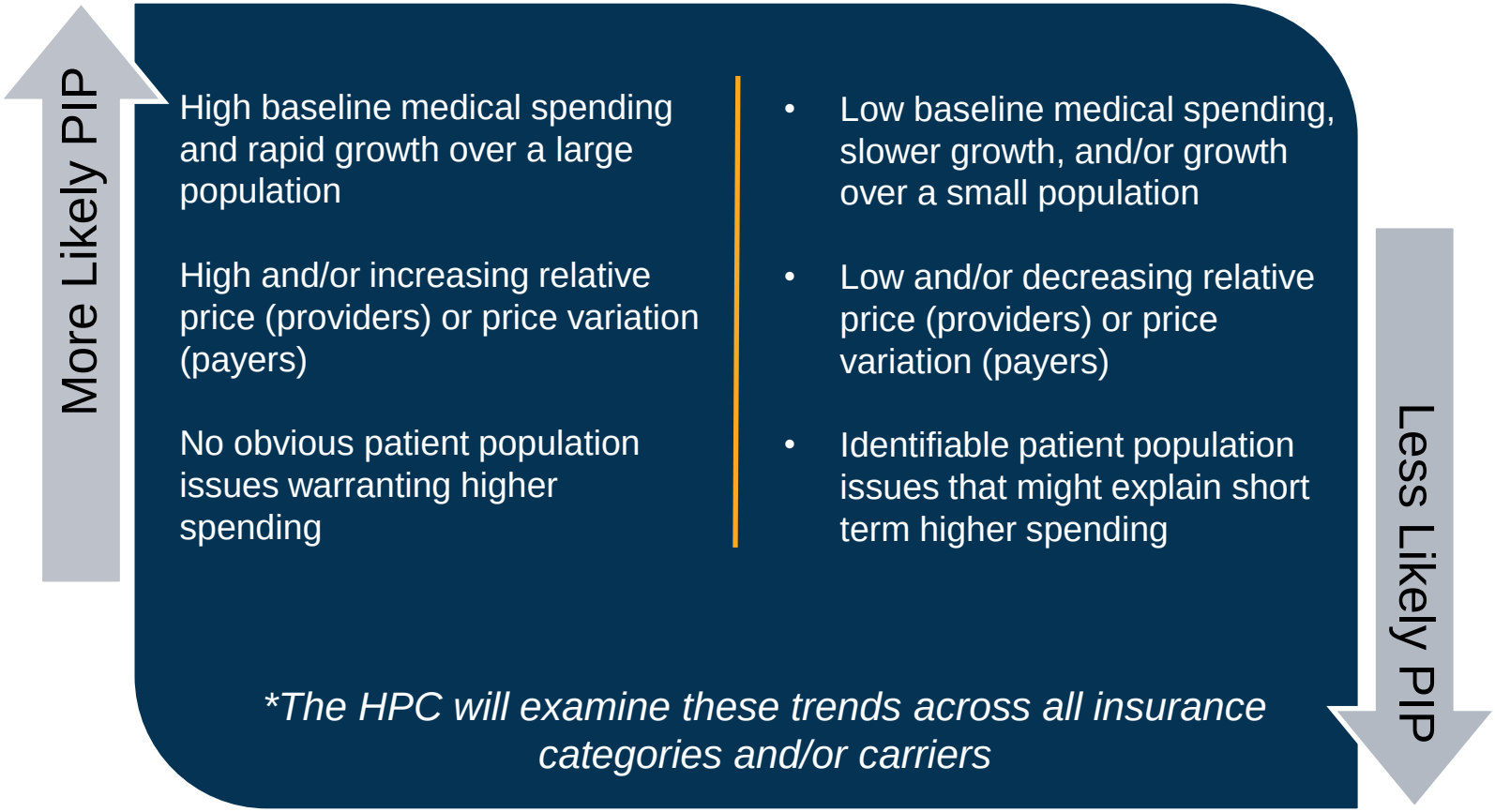
1) the HPC identifies significant concerns about the entity's costs and
2) determines that a PIP could result in meaningful, cost-saving reforms.

Factors for review include, but are not limited to:

- Baseline spending and spending trends over time, including by service category;
- Pricing patterns and trends over time;
- Utilization patterns and trends over time;
- Population(s) served, product lines, and services provided;
- Size and market share;
- Financial condition, including administrative spending;
- Ongoing strategies or investments to improve efficiency or reduce spending growth over time; and
- Factors leading to increased costs that are outside the Health Care Entity's control.

While the same factors will be evaluated for both payers and providers, some of the underlying metrics examined may be unique to one or the other.

Payer and Provider Example Analysis



Other Key Elements: PIP Proposals; Approval/Disapproval Process

PIP Proposals: The proposed PIP must be developed by the entity.

- It must include, but need not be limited to:
  - Identification of the cause(s) of the entity's cost growth, with supporting analytic materials as applicable;
  - Specific strategies, adjustments, and action steps the entity proposes to implement to improve health care spending performance;
  - Specific identifiable and measurable expected outcomes, with a timetable for measurement, achievement, and reporting of such outcomes;
  - Any requests by the entity for implementation assistance from the Commission;
  - A timetable for implementation of 18 months or less; and
  - Any documentation necessary to support any claims or assertions contained in the proposal.

- The HPC may publicly report in summary form upon the proposed PIP.

Approval or Disapproval of a Proposed PIP

- The HPC will approve a proposed PIP if it meets the criteria listed above, and if the HPC determines that the proposed PIP is reasonably likely to successfully address the underlying cause(s) of the entity's cost growth.

- If the HPC finds the proposed PIP unacceptable, it will provide up to 30 days for resubmission and will encourage the entity to consult with the HPC on the criteria that have not been met.

- Approval of a proposed PIP will require an affirmative vote of six members of the Commission.

Other Key Elements: Conclusion of a PIP; Penalties

Conclusion of a PIP

- Entities will be required to report on the outcome of the PIP, and the HPC may publicly report on the outcome in summary form.
- The HPC will determine, via affirmative vote by six members of the Commission, whether the PIP was successful.
- If the PIP is found unsuccessful, the HPC may extend the implementation timetable, request and/or approve amendments, or require the entity to submit a new PIP.

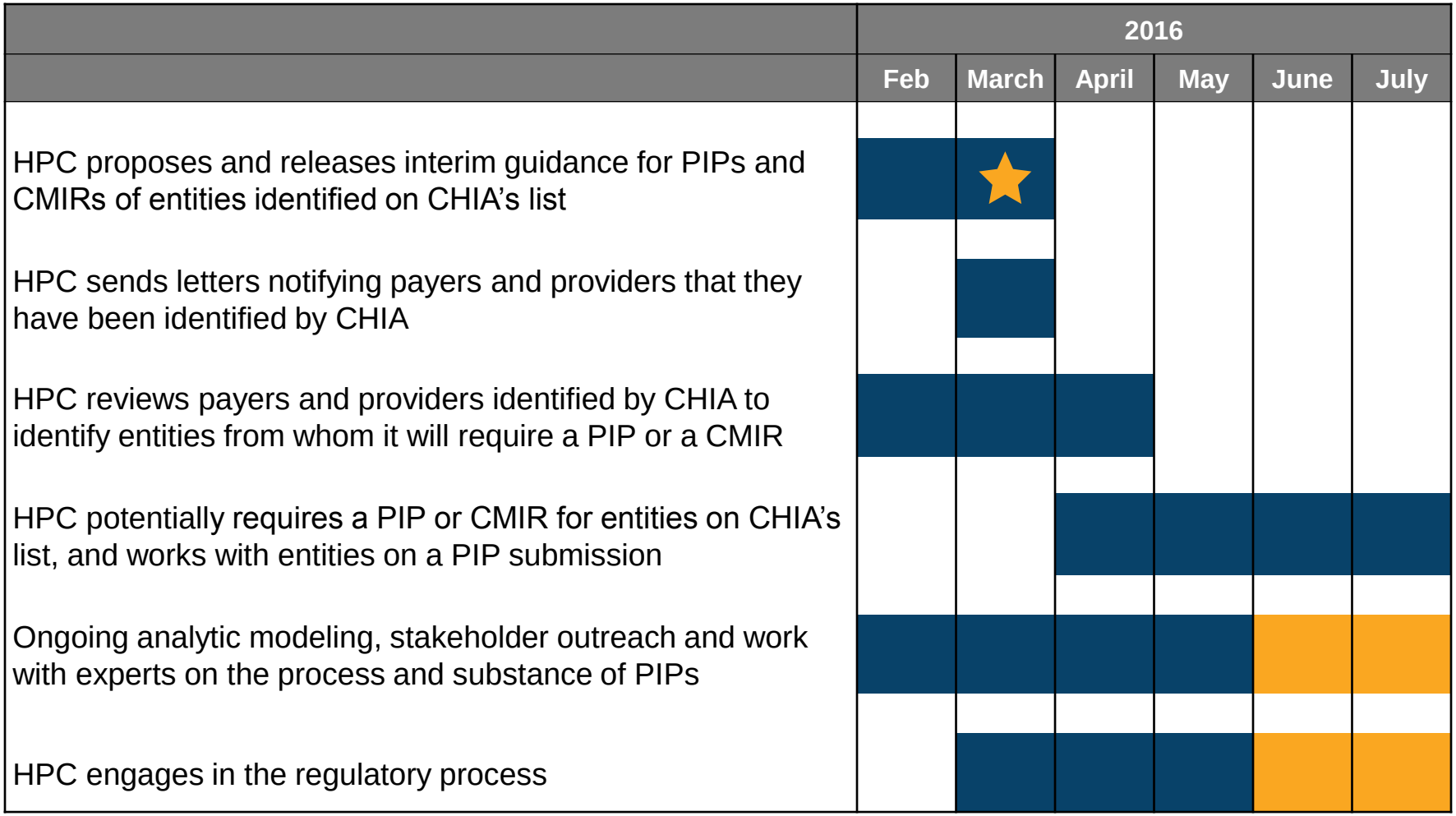
Penalties

- The HPC may assess a civil penalty of no more than $500,000 if an entity
  1) willfully neglects to timely file a PIP,
  2) fails to file an acceptable PIP in good faith,
  3) fails to implement a PIP in good faith, or
  4) knowingly fails to provide information to the HPC required by PIP statute.
- The Commission shall determine whether to assess a penalty by affirmative vote of six members.
- The HPC will provide written notice to any entity that is assessed a penalty of the amount of the penalty, the reason(s) for assessing the penalty, and the right to request a hearing.

Proposed Interim Guidance: Outline

1. Notice of Identification by CHIA
2. Standard for Requiring a PIP
3. Notice of Requirement to File a PIP
4. Timing for Responding to PIP Notice
5. Requests for Extension of Time
6. Requests for Waiver
7. PIP Proposals
8. Approval or Disapproval of a Proposed PIP
9. Implementation: Monitoring, Reporting, Amendments
10. Conclusion of Implementation Period
11. Confidentiality
12. Penalties
13. CMIR Process for CHIA-Identified Provider Organizations

Next Steps and Timeline for Performance Improvement Plans



MASSACHUSETTS
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Vote: Issuing Interim Guidance

MOTION: That, pursuant to sections 10 and 13 of chapter 6D of the Massachusetts General Laws, and endorsed by the Cost Trends and Market Performance committee, the Commission hereby issues the attached interim guidance for payers, providers, and provider organizations relative to performance improvement plans and cost and market impact reviews.

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Discussion Preview: Update on Material Changes and Continuation of Cost and Market Impact Review

Agenda Topic

Update on material change notices and continuation of cost and market impact review of the proposed clinical affiliation between Beth Israel Deaconess Medical Center (BIDMC), Harvard Medical Faculty Physicians at BIDMC (HMFP), and MetroWest Medical Center (MetroWest).

Description

Staff will provide an update on material change notices and present findings from its 30-day MCN review of the proposed clinical affiliation between BIDMC, HMFP and MetroWest, under which the parties would expand MetroWest service offerings and direct MetroWest patients to BIDMC for tertiary/quaternary care.

Key Questions for Discussion and Consideration

Commissioners will have the opportunity to provide feedback on the staff's findings and to ask any clarifying questions.

Decision Points

Commissioners will be asked to vote to continue the cost and market impact review of the proposed BIDMC-HMFP-MetroWest clinical affiliation.

Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	14	25%
Physician group merger, acquisition or network affiliation	12	21%
Acute hospital merger, acquisition or network affiliation	11	20%
Formation of a contracting entity	9	16%
Merger, acquisition or network affiliation of other provider type (e.g. post-acute)	5	9%
Change in ownership or merger of corporately affiliated entities	4	7%
Affiliation between a provider and a carrier	1	2%

Update on Notices of Material Change

Notices Received Since Last Commission Meeting

- Proposed merger of Baystate Wing Hospital (Wing) and Baystate Mary Lane Hospital (Mary Lane), whereby Wing would be the surviving entity, and Mary Lane would become a satellite location. All inpatient medical and surgical care would be provided at Wing.

Elected Not to Proceed

- Proposed joint venture between Shields Health Care Group and Cooley Dickinson Hospital to operate a PET/CT diagnostic imaging clinic.
  - Our analysis indicated that this transaction would not likely result in substantial changes in prices for PET/CT services at Cooley Dickinson Hospital, and therefore there was limited scope for increases to health care spending.
  - We did not find evidence suggesting negative impacts on quality or access to care.

Elected to Proceed with Cost and Market Impact Review (CMIR)

- Clinical affiliation between Beth Israel Deaconess Medical Center (BIDMC), Harvard Medical Faculty Physicians at BIDMC, and MetroWest Medical Center (MetroWest), under which the parties would expand MetroWest service offerings and direct MetroWest patients to BIDMC for tertiary/quaternary care.

Continuation of Cost and Market Impact Review: Background on the Parties

BIDMC is an academic medical center

- Non-profit academic medical center with 672 beds in Boston
- Owns three non-profit community hospitals in Milton, Needham, and Plymouth
- Major teaching hospital for Harvard Medical School
- BIDCO member; CEO is co-chair of the Beth Israel Deaconess Care Organization (BIDCO) board

HMFP is a physician group exclusively affiliated with BIDMC

- Non-profit corporation that employs approximately 800 physicians
- Physicians are members of the medical staff at BIDMC and faculty at Harvard Medical School
- BIDCO member; President is co-chair of the BIDCO board

MetroWest is a general acute care community hospital

- For-profit community hospital with 284 beds at 2 campuses (Framingham and Natick)
- Owned by Tenet Healthcare (purchased in 2013 along with St. Vincent Hospital)
- Currently a clinical affiliate of Tufts Medical Center for tertiary services and Floating Hospital for pediatrics
- Proposed contracting affiliation with BIDCO is the subject of a current cost and market impact review

Basis and Goals for Review

- The proposed clinical affiliation is closely related to the contracting affiliation between BIDCO and MetroWest, which is currently the subject of a cost and market impact review.
- The parties to the proposed clinical affiliation state that MetroWest's participation in BIDCO is "an important component of the organizations' overall relationship."
- Many elements of the clinical affiliation would effectuate the goals of the contracting affiliation between MetroWest and BIDCO, including:
  - MetroWest referring its patients to BIDMC instead of Tufts for tertiary/quaternary care
  - Integration and linking of BIDMC, HMFP, and MetroWest through participation in BIDCO
  - Collaboration in quality initiatives and health information technology
- Other significant elements of the clinical affiliation include:
  - Expansion of primary care in MetroWest's service area
  - Expansion of surgical services at MetroWest
  - Development of a joint cancer center
  - Potential co-recruitment of specialists
  - Potential collaboration in OB/GYN services

Basis and Goals for Review (cont.)

- Our initial review of the clinical affiliation found significant scope for potential cost impacts, including:
  - Potential for spending increases due to changes in referral patterns
  - Potential for spending increases due to recruitment of primary care and specialty physicians from lower-priced systems into BIDCO
  - Potential for increased market concentration in BIDCO's market share due to physician recruitment and service line expansions at MetroWest
- At the same time, the parties have stated that the goal of the affiliation is to improve care for their patients through clinical alignment, which will allow them to provide high-quality, cost-effective care and keep more care in the community.
- Conducting this CMIR will enable us to objectively examine all aspects of the proposed transaction in order to better understand any potential negative impacts as well as any potential care delivery and quality improvements.
- Due to the close interrelationship between the BIDMC-HMFP-MetroWest clinical affiliation and the BIDCO-MetroWest contracting affiliation, staff plan to coordinate reviews of these transactions.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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 Beth Israel Deaconess Medical Center, Harvard Medical Faculty Physicians, and MetroWest Medical Center, pursuant to section 13 of chapter 6D of the Massachusetts General Laws and 958 CMR 7.00 et seq.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from the January 20, 2016 Meeting
- Executive Director's Report
- Cost Trends and Market Performance
  - Approval of 2017 Health Care Cost Growth Benchmark
  - Discussion of Out-of-Network Billing
  - Update on Performance Improvement Plans
  - Update on Material Change Notices and Continuation of Cost and Market Impact Review
  - **Discussion of Public Process for Provider Price Variation**
- Community Health Care Investment and Consumer Involvement
- Administration and Finance
- Schedule of Next Meeting (April 27, 2016)

Discussion Preview: Stakeholder Discussions of Provider Price Variation

Agenda Topic

Stakeholder discussions of provider price variation

Description

Staff will present a proposed plan for a series of stakeholder discussions of provider price variation. These meetings, hosted by the Commission, provide an opportunity for discussion regarding potential data-driven policy approaches for reducing unwarranted price variation. The meetings will be open to the public and key stakeholders, including HPC Advisory Council members, sister agencies and expert speakers, will be invited to participate. Following the meetings, staff will present to the Commission a summary of the discussions, and the Commission may choose to make policy recommendations, which may be informed by these stakeholder discussions.

Key Questions for Discussion and Consideration

Commissioners will have the opportunity to provide feedback on the proposed plan for stakeholder discussions on provider price variation.

Decision Points

No votes proposed.

Stakeholder Discussions of Provider Price Variation

WHO	**HPC Commissioners**, HPC staff, key stakeholders including HPC Advisory Council members, expert speakers, and representatives of sister agencies (AGO, CHIA). HPC will invite legislators and legislative staff to attend. Members of the public are welcome.
WHAT	These discussions provide an opportunity for Commissioners and stakeholders to engage in a discussion regarding the potential for specific, **data-driven policy approaches to reduce unwarranted price variation** without increasing overall healthcare spending. The HPC anticipates presenting analyses and inviting expert speakers to introduce certain policy options. At the end of the process, HPC staff will present an overview of the discussions to the full Board.
WHY	As stated in the HPC's Special Report on price variation, **policy action is required** to address unwarranted price variation and its impact on overall spending and the sustainability of lower-priced providers. The goal of these meetings is to allow Commissioners and stakeholders to engage in discussions about specific policy options, informed by data-driven analyses and research.
WHEN	**Three to four meetings** will be scheduled to take place through the end of May 2016. Each meeting is expected to last two hours. The first meeting will take place on March 30, 2016, during the previously scheduled HPC Advisory Council Meeting.
GOAL	The stakeholder discussions are intended to allow for discussion of policy options. At the conclusion of the process, a **Summary Report** of the discussions will be presented at a full Board meeting. The Board may take the opportunity to discuss potential policy options, make recommendations, or identify new analyses necessary to support future policy development.

Proposed Meetings

Meeting #1: March 30

Topic: Potential Demand-Side Policy Options: Value-based product design, Reference Pricing, and Transparency

Description: Discussion of proposed policies to produce design and market transparency to encourage consumers to use high-value providers for their care

Presenter(s): HPC staff and expert speakers TBD

Meeting #2: Mid-April

Topic: Potential Supply-Side Policy Options: Enhancements to Alternative Payment Methodologies

Description: Discussion of proposed transition away from use of providers' historic spending as the basis for global budgets and other proposed enhancements to APMs, including greater use of bundled payments

Presenter(s): HPC staff and expert speakers TBD

Meeting #3: Mid-May

Topic: Direct Limits on Variation

Description: Discussion of proposed direct limits on the extent of variation, the types of factors upon which prices may vary and other policies designed directly change the methods by which provider prices are set.

Presenter(s): HPC staff and expert speakers TBD

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from the January 20, 2016 Meeting
- Executive Director's Report
- Cost Trends and Market Performance
- **Community Health Care Investment and Consumer Involvement**
  - Discussion of Community Hospital Study
- Administration and Finance
- Schedule of Next Meeting (April 27, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from the January 20, 2016 Meeting
- Executive Director's Report
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
  - **Discussion of Community Hospital Study**
- Administration and Finance
- Schedule of Next Meeting (April 27, 2016)

Discussion Preview: Community Hospitals at a Crossroads

Agenda Topic

Community Hospitals at a Crossroads: Review of Findings and Release of Report

Description

Staff will present key findings from a new report on the state of community hospitals in the Commonwealth. The report is the product of more than a year of research, analysis, and interviews with providers, payers, elected officials, and expert partners to document the contributions of community hospitals to the health care landscape, identify challenges that require changes to the traditional community hospital operational model, and identify a future vision of community-based care.

Key Questions for Discussion and Consideration

Commissioners will have the opportunity to discuss findings in the report and identify priorities for further research and discussion with stakeholders.

Decision Points

Commissioners will be asked to vote on a motion to approve the release of the report.

Background of the report: building a path to a thriving, community-based health care system

The need for the report

- Hospitals and health systems across the country are facing **unprecedented impetus to adapt** to new care delivery approaches and value-based payments
- Community hospitals are under particular pressure to change and are uniquely challenged **by current market and utilization trends,** as evidenced by a number of recent consolidations, closures, and conversions in Massachusetts
- The state is pursuing sweeping delivery system transformation to achieve shared cost containment goals, and effective, **action-oriented planning is necessary**

Objectives of the report

- To understand and describe the **current state of and challenges facing community hospitals**
- To examine the implications of **market dynamics** that can lead to elimination or reduction of community hospital services
- **To identify challenges to and opportunities for transformation** in community hospitals
- To **encourage proactive planning** to ensure sustainable access to high-quality and efficient care and catalyze a **multi-stakeholder dialogue** about the future of community health systems

*"I don't see any future for community hospitals…I think there's a **fantastic future for community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don't see much of a future for that. But I see a **phenomenal future** for health systems with a strong community hospital that breaks the mold [of patient care]."*

COMMUNITY HOSPITAL CEO

HPC

Key themes of the report

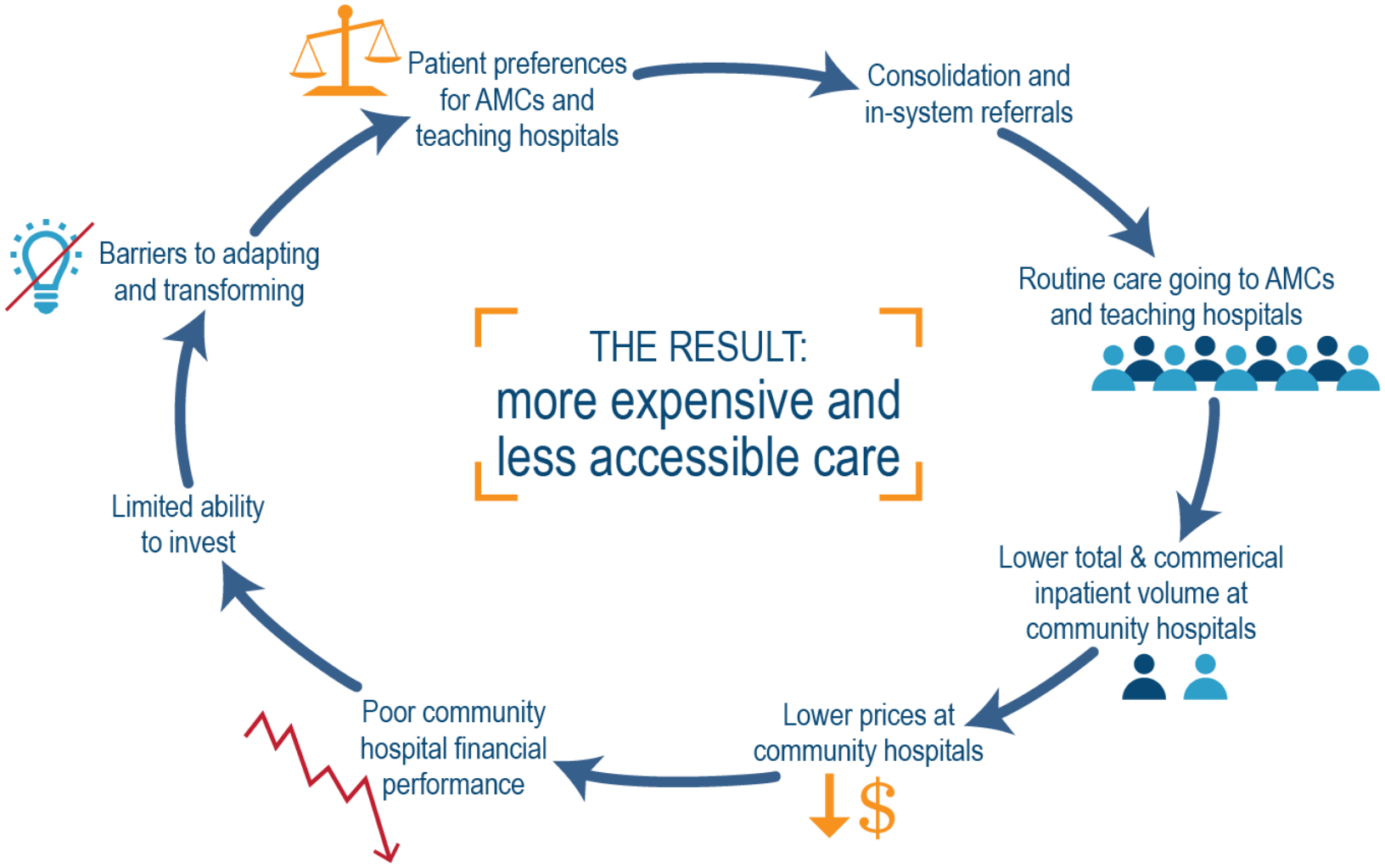
Community hospitals provide a unique value to the Massachusetts health care system

- While individual characteristics vary, as a cohort community hospitals play a critical role in care for publicly insured patients; providing local, community-based access; and, in particular, meeting behavioral health needs
- Community hospitals provide more than half of all inpatient discharges and more than 2/3 of all ED visits statewide
- Community hospitals generally provide high-quality health care at a low-cost, providing a direct benefit to the consumers and employers who ultimately bear the costs of the health care system

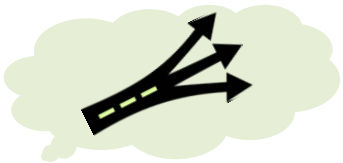
The traditional role and operational model for many community hospitals faces tremendous challenges

- Community hospitals generally have worse financial status, older facilities, and lower average occupancy rates than AMCs and teaching hospitals
- Many hospitals face barriers to transformation:
  - Consolidation of acute and physicians services into major health systems
  - Routine care going to AMCs and teaching hospitals
  - Lower commercial volume and prices leading to lack of resources for reinvestment
  - Difficulty participating in current alternative payment models

Community hospitals face self-reinforcing challenges that lead to more expensive and less accessible care



Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System



Overview | **Value** | **Challenges** | **Path Forward**

- An **overview** of community hospitals in Massachusetts
- The **value** of community hospitals to the health care system
- **Challenges** facing community hospitals
- The **path** to a thriving community-based health care system

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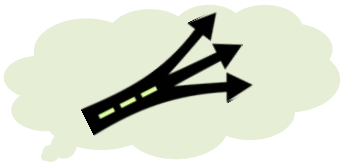
Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System



Overview | **Value** | **Challenges** | **Path Forward**

- Key distinguishing features of community hospitals (geographic distribution, patient populations, services, financial condition)
- Key community hospital trends (transitions, consolidation and closure)

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Community hospitals at a glance

43 Community Hospitals

27 DSH

18 non-DSH

Older age of plant

Community hospitals generally have older physical plants than AMCs or teaching hospitals

52%

more than half of beds statewide

(19 beds – 556 beds per hospital)

low occupancy rate

(29% – 74%)

64% community hospitals vs. **84%** AMCs

low case mix index

(0.60 – 0.93)

0.8 community hospitals

1.33 AMCs

5.8M | 42%

outpatient visits

1.9M | 65%

2/3 of ED visits

(10,329 – 155,236)

Higher public payer mix

Community hospitals generally have disproportionately high shares of Medicaid and Medicare patients

51.3% **more than half of discharges statewide**

(556 discharges – 40,303 discharges)

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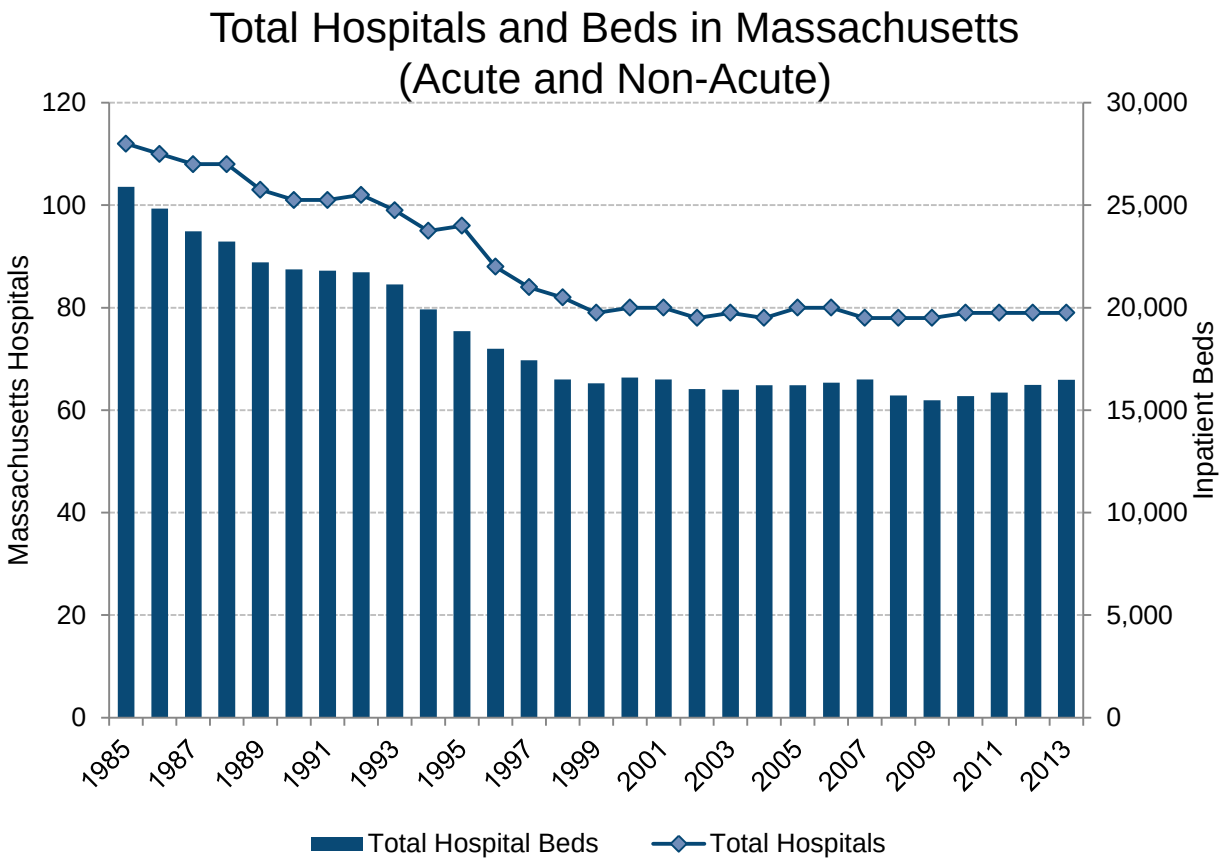
Consolidations and closures over the last 30 years have contributed to a dynamic hospital market in Massachusetts



Source: American Hospital Association

Recent Conversions in Massachusetts Have Had Varied Impact

North Adams Regional Hospital

Steward Quincy Medical Center

Two Conversions Are Being Currently Contemplated

Baystate Mary Lane Hospital

Partners North Shore Medical Center – Union Hospital

Hospital-related Material Change Notices since 2013

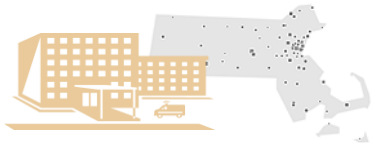
11
mergers or acquisitions of one hospital by another

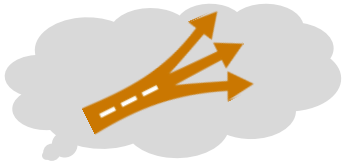
16
new contracting or clinical relationships between hospitals

5
hospitals acquiring physician groups

HPC

The value of community hospitals to the health care system





Overview | **Value** | Challenges | Path Forward

Community-based care and access

- Care close to home / drive time analyses
- Patient populations / payer mix

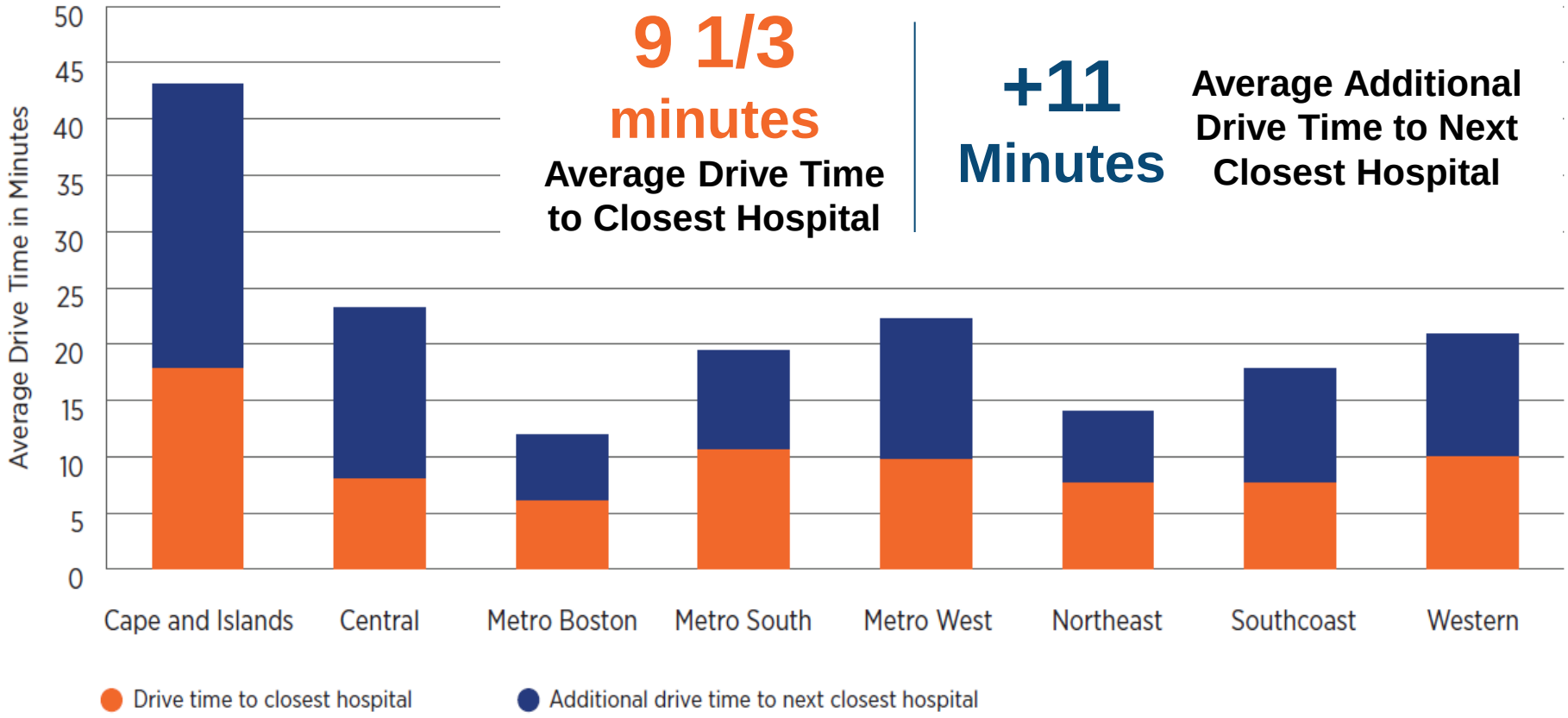
Quality and Efficiency

- Examination of quality performance by community hospitals and patient perception of quality and value
- Variation in spending and costs for community-appropriate care at community vs other hospitals

Community hospitals provide local access for local patients

Average Drive Times for Patients Using Their Local Community Hospital

Analysis of patients who use their closest community hospital as a usual site of care



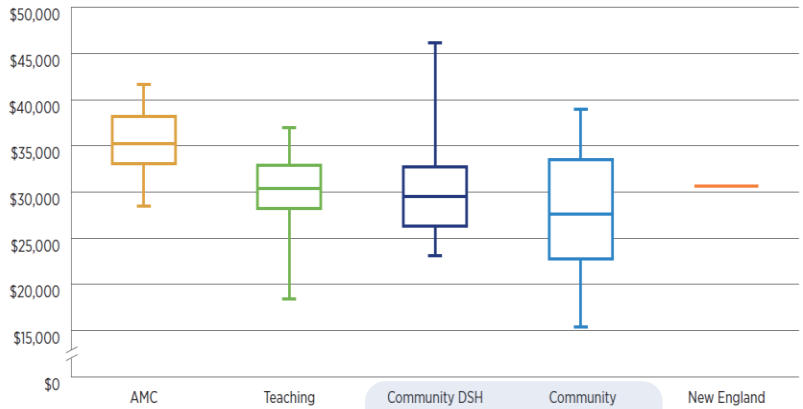
Source: HPC analysis of MHDC 2013 discharge data.
Notes: Drive times may underrepresent travel time and travel time differentials for populations relying on public modes of transportation. The Cape and Islands region includes only Falmouth and Cape Cod Hospital for the purposes of this analysis, since measuring drive times for Hospitals on Nantucket and Martha's Vineyard islands would not be meaningful.

Spending at community hospitals is generally lower for low-acuity orthopedic and maternity care and is not associated with any difference in quality

Orthopedics

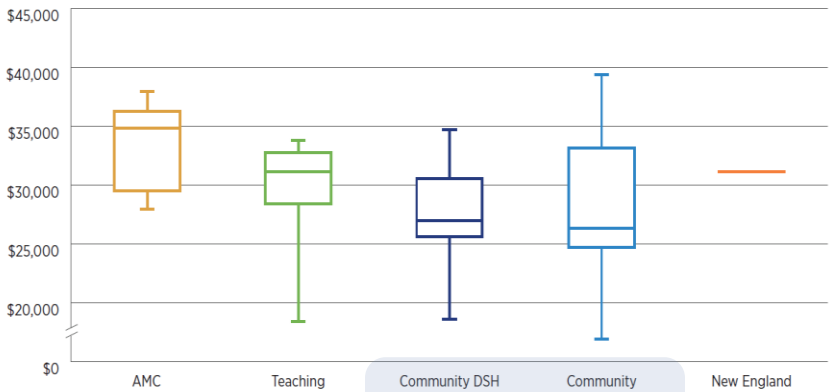
Deliveries

Hip Replacement



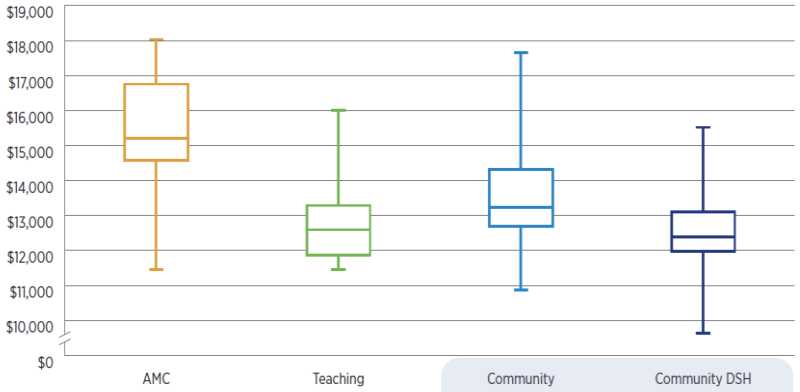
$6,750
less than AMCs

Knee Replacement



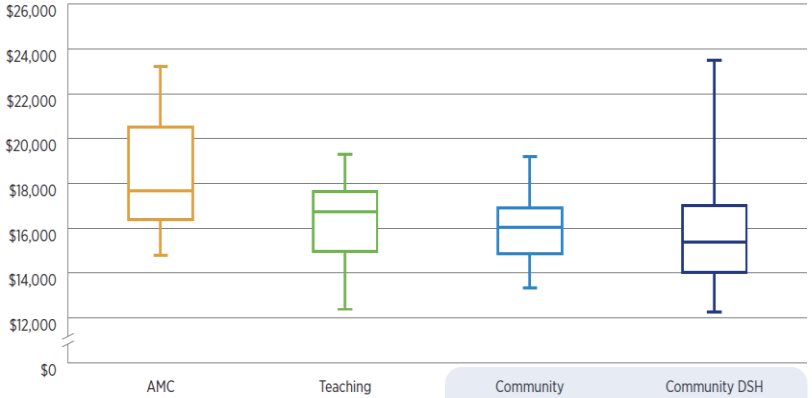
$8,200
less than AMCs

Pregnancy - Vaginal Delivery



$2,200
less than AMCs

Pregnancy - Caesarian Delivery



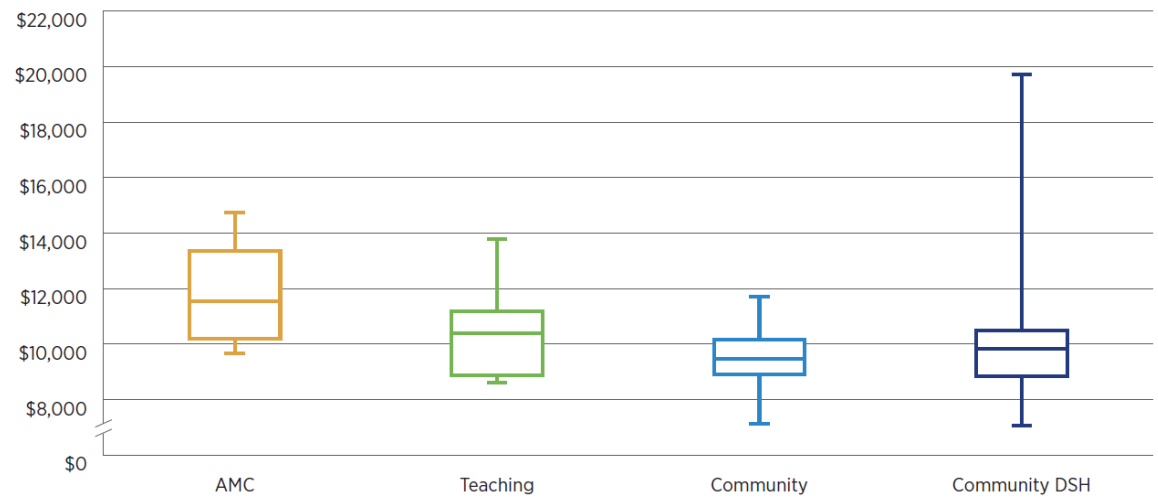
$2,100
less than AMCs

Source: HPC analysis of 2011 and 2012 APCD data for Blue Cross Blue Shield, Tufts Health Plan, and Harvard Pilgrim Health Plan patients

We found no correlation between hospital cost and quality. Each group of hospitals has higher and lower quality performers but no cohort outperforms any other overall.

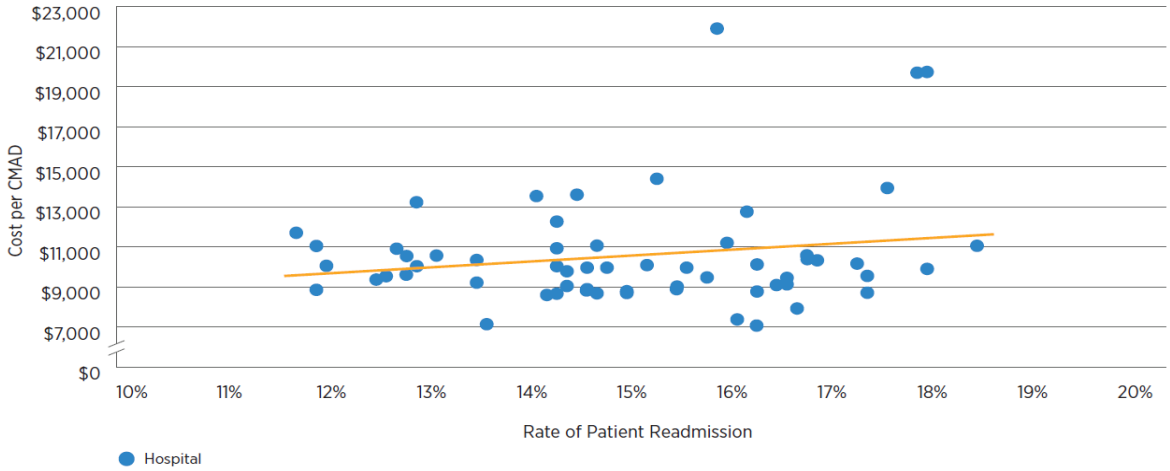
Most community hospitals provide care at a lower cost per discharge, without significant differences in quality

Hospital costs per case mix adjusted discharge, by cohort



Source: HPC analysis of CHIA Hosp. Profiles, 2013

Costs per CMAD are not correlated with lower quality
(risk-standardized readmission rates)



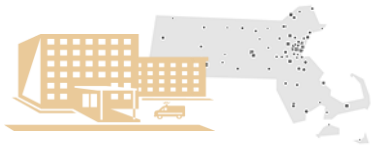
Source: HPC analysis of CHIA Hosp. Profiles, 2013; CHIA Focus on Provider Quality Databook, Jan 2015

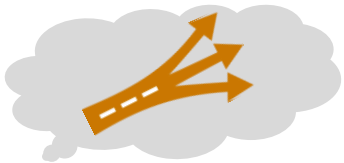
On average, **community hospital costs are nearly $1,500 less per inpatient stay** as compared to AMCs, although there is some variation among the hospitals in each group

Although costs per discharge for community hospitals have grown at a slightly higher rate than those for AMCs, the gap between AMC and community hospital costs has not substantially changed

Reasons for differences in efficiency likely vary, and may include service offerings, support for teaching programs, and, particularly for community hospitals, the pressure of tight operating margins

Challenges facing community hospitals





Overview | Value | **Challenges** | Path Forward

- Referral patterns and consumer perceptions
- Consolidation of hospitals and primary care providers with large systems
- Decreasing inpatient volume and misalignment of supply and demand for hospital services (current and future)
- Payer mix, service mix, and variation in prices
- Competition from non-traditional market entrants
- Implications if current trends continue

Driven by referrals and perceived quality, many patients are choosing AMCs and teaching hospitals over community hospitals for routine care

HPC commissioned qualitative analyses (8 focus groups in four regions of the state) by Tufts University to better understand what drives consumer choices of hospitals

> *"I guess it might be something in your psyche because I like brand-name products. So maybe that's what drives me to Boston."*
>
> *FOCUS GROUP PARTICIPANT*

- Patients often mentioned that **they did not feel that they had a choice** of hospitals because their primary care provider or insurance plan determined where they could go for care
- **Two in three Massachusetts adults** have **never sought information** about the safety or quality of medical care, instead valuing the experiences of peers and recommendations of their primary care physicians.
- Many patients stated that they felt that **AMCs and teaching hospitals were better** because they had the best physicians, including doctors who had graduated from medical schools they considered prestigious. Many patients indicated that they **believed AMCs and teaching hospitals had developed reputable brands**
- Some patients stated that the **higher costs of AMCs and teaching hospitals must mean that they provided better quality**, regardless of what quality data showed. Many also said they wanted to "get their money's worth" from the health care system after investing heavily in health insurance coverage. Others reported that **cost is not a factor when it comes to health**

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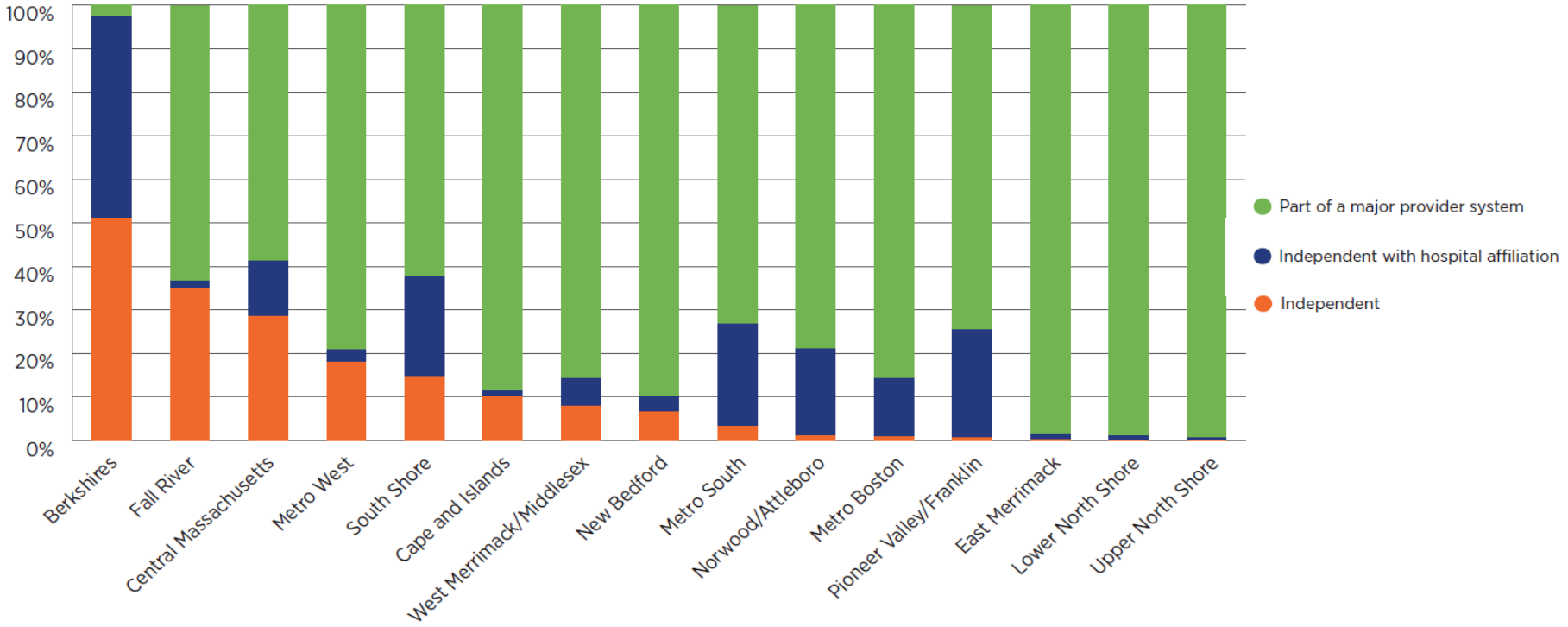
Most primary care services are now delivered by physicians affiliated with major provider systems

Percentage of Primary Care Services Delivered by Independent versus Affiliated Physicians by Region, 2012



"Retaining primary care staff and specialists, 'the gatekeepers to volume' is challenging. Providers continue to leave for big-name systems and AMCs – and patients follow"

Synthesis of
MASSACHUSETTS PROVIDER INTERVIEWS

Source: HPC analysis of 2012 APCD claims for BCBS and HPHC ; 2012 MHQP Master Provider Database.
Note: For the purposes of this analysis, major provider systems include Atrius Health, Baycare Health Partners, Beth Israel Deaconess Care Organization, Lahey Health System, New England Quality Alliance, Partners Community Health Care, Steward Health Care Network, and UMass Memorial Health Care. PCPs affiliated with multiple systems are counted as being part of a major provider system.

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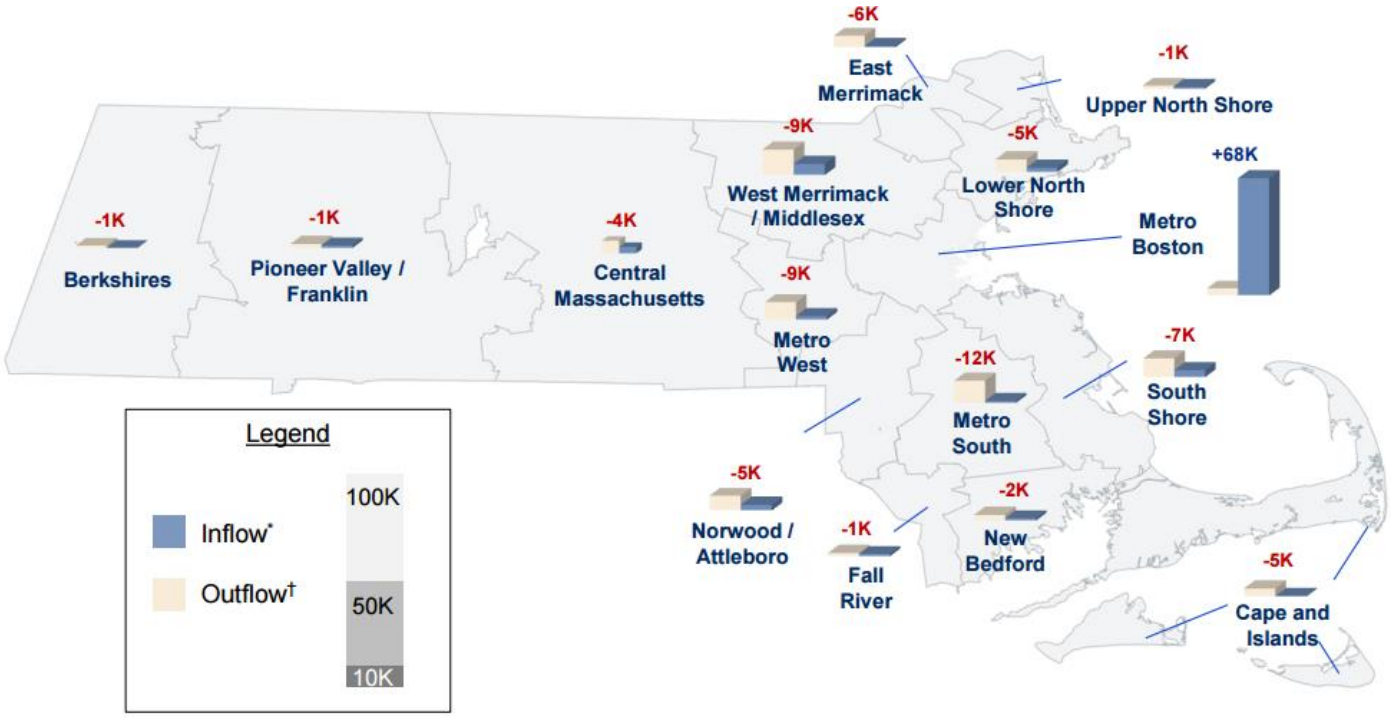
Most Massachusetts residents who leave their home region for inpatient care seek care in Metro Boston at higher-priced hospitals



Commercially insured patients are most likely to outmigrate to Boston

Patients from higher income regions are more likely to outmigrate to Boston

Trends hold across a variety of service lines, including deliveries

* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region
Source: HPC Cost Trends Report, July 2014 Supplement

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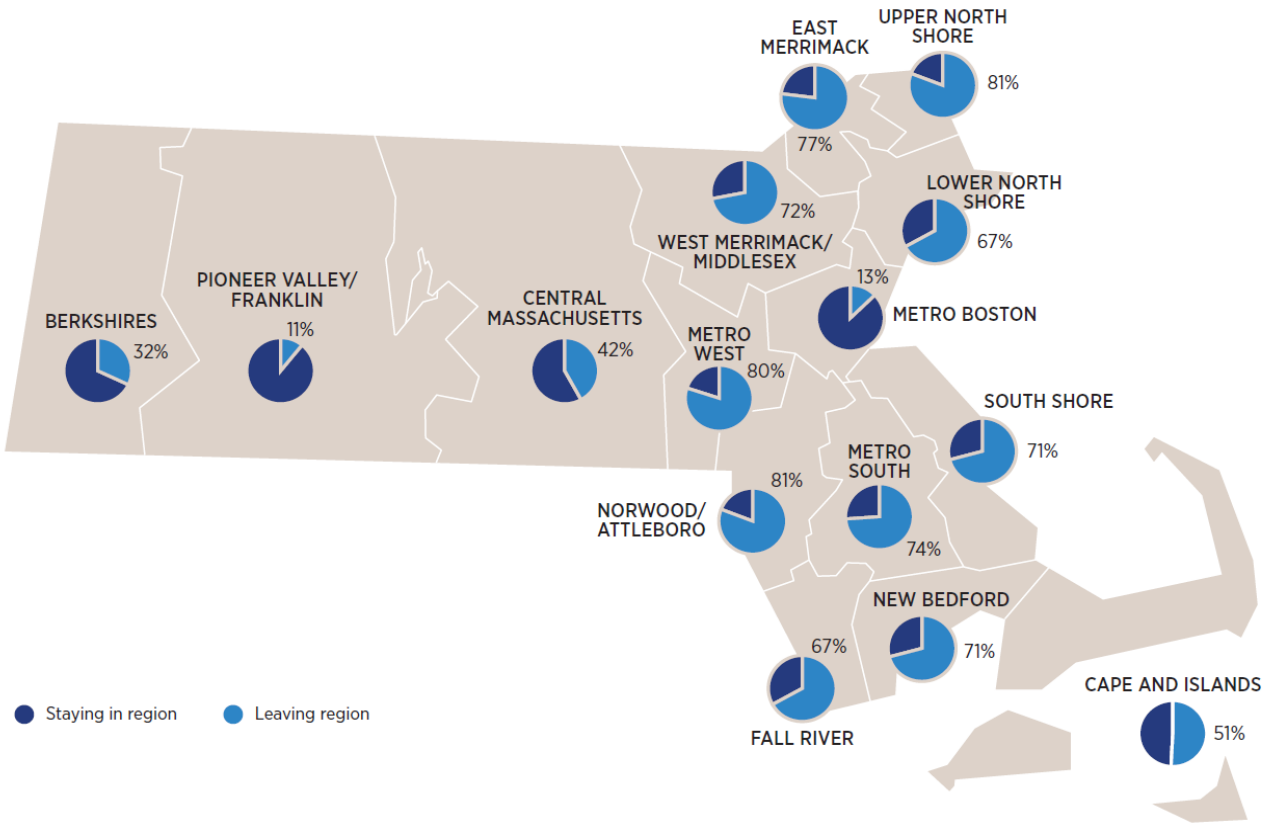
Large proportions of patients leave their home regions for deliveries

Percentage of Patients Leaving their Home Regions for Community-Appropriate Deliveries, 2013



74%→50%

change in proportion of all births in community hospitals from 1992 – 2012[1]

[1]Healthcare Equality and Affordability League, *Healthcare Inequality in Massachusetts: Breaking the Vicious Cycle*

6 hospitals saw **53%**

of low risk births in 2011-2012. 5 of these hospitals had above average delivery costs.

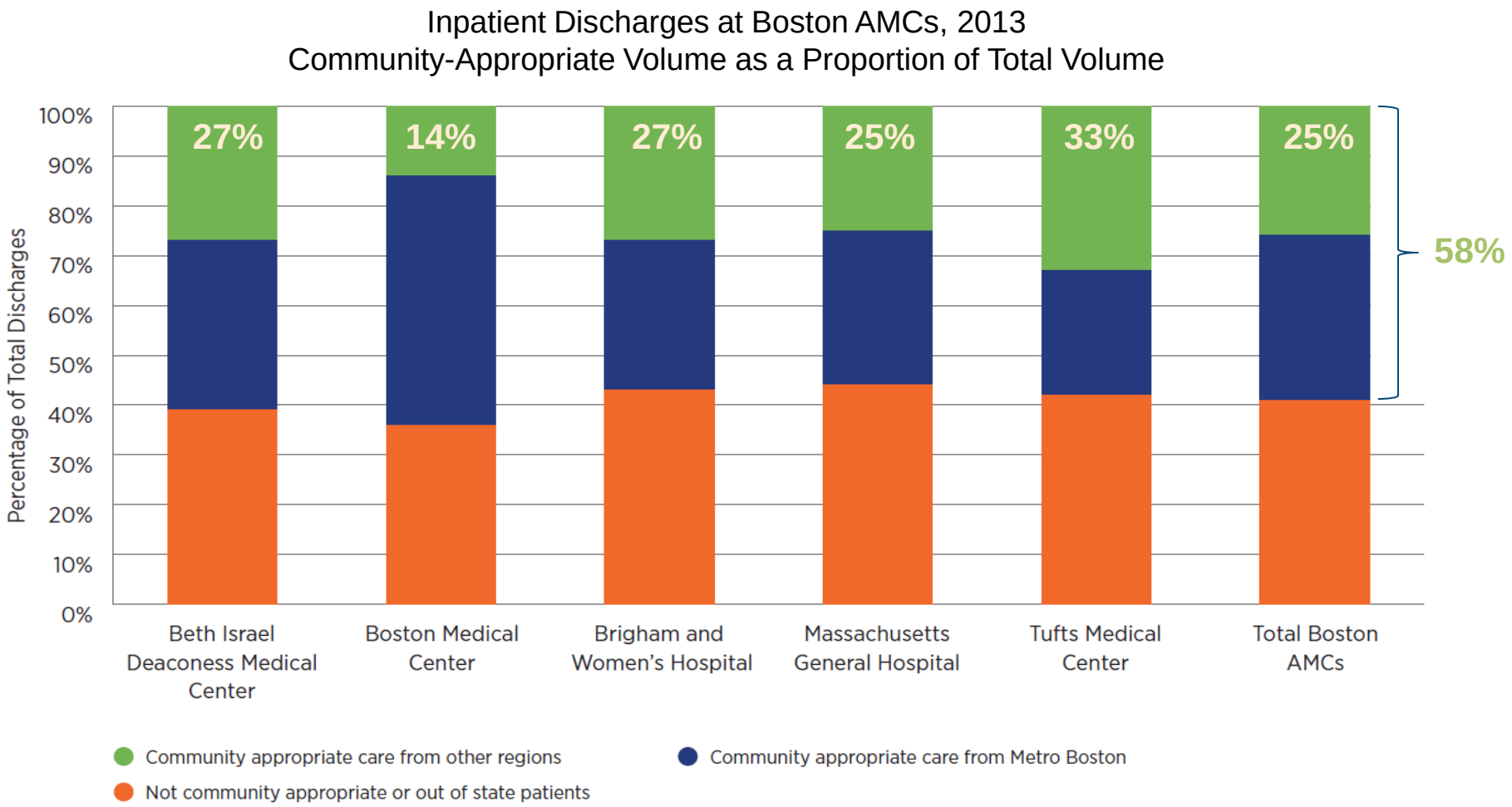
Massachusetts General Hospital and Brigham and Women's Hospital have highest costs statewide for maternity care and saw

20%

of all low-risk births in the state

Source: HPC analysis of MHDC discharge data.

A significant portion of the care provided at Boston AMCs could be appropriately provided in a community hospital setting



Source: HPC analysis of MHDC 2013 discharge data.
Note: Figure shows proportion of volume at each hospital, and does not reflect differences in total volume amongst the hospitals shown. Estimates of the volume of community appropriate care provide at AMCs are conservative as community appropriate care is defined to exclude cases which some community hospitals could effectively handle but that many community hospitals could not.

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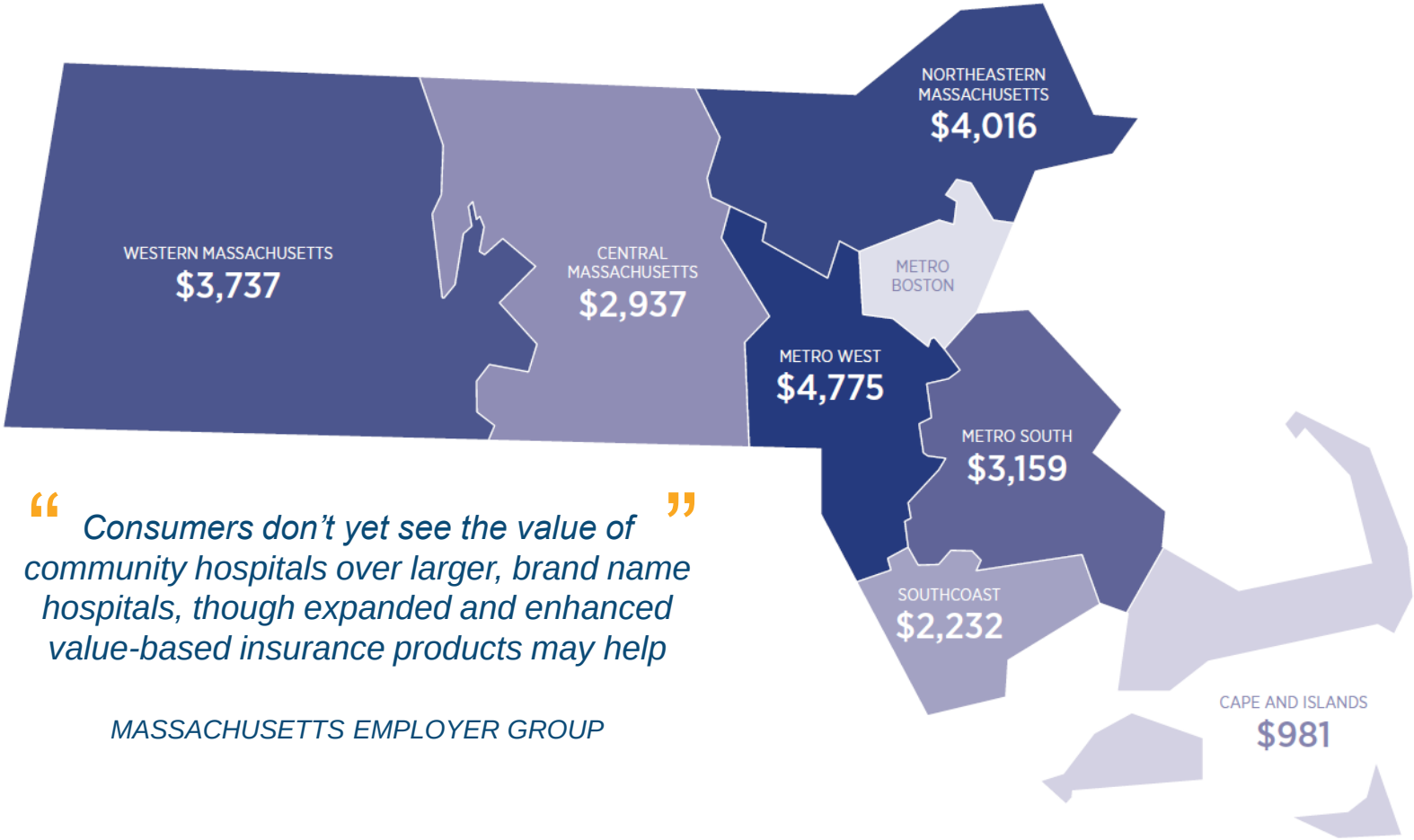
Patient migration to Boston increases health care spending

Average Additional Case-Mix Adjusted Cost for Each Commercial Discharge at a Boston Hospital Rather Than a Local Hospital, by Region of Patient Origin

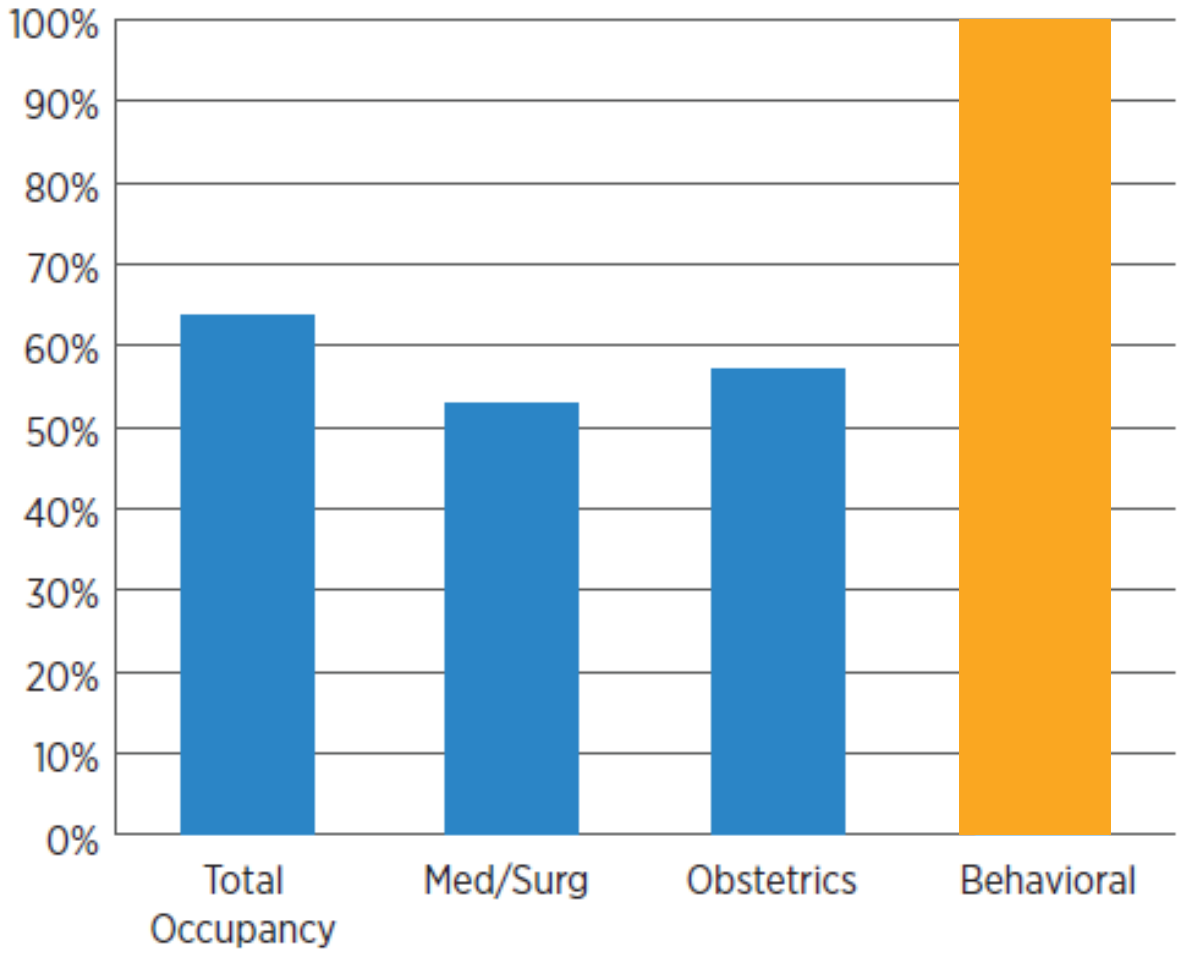


> *"Consumers don't yet see the value of community hospitals over larger, brand name hospitals, though expanded and enhanced value-based insurance products may help"*
>
> *MASSACHUSETTS EMPLOYER GROUP*

Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.
Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

In addition to lowering volume, migration results in community hospitals seeing larger proportions of government payer patients and those seeking behavioral health services

Community Hospital Staffed Bed Occupancy Rate by Admission Type



Boarding of behavioral health patients in emergency departments increased by

40%

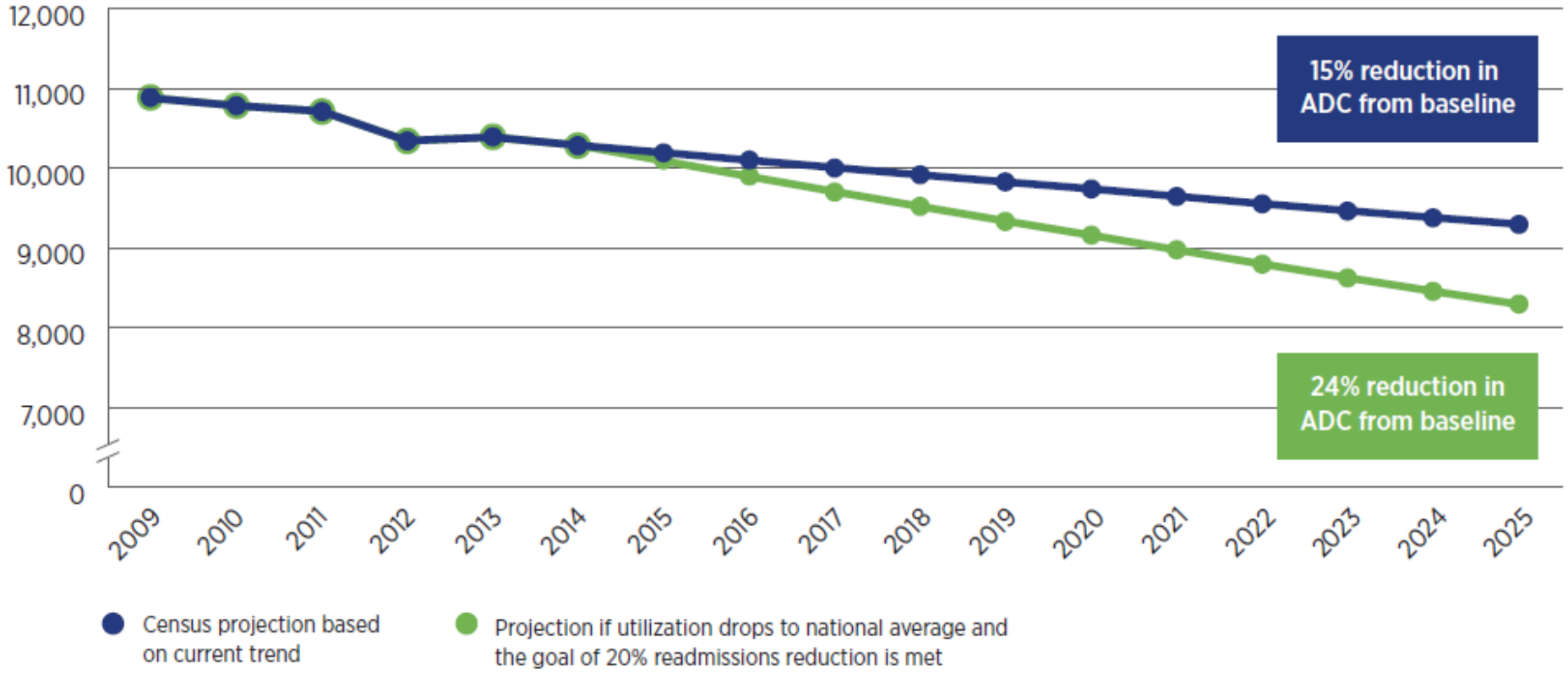
from 2012 - 2014

Source: HPC analysis of Department of Public Health data

Source: HPC analysis of MHDC 2013 discharge data and CHIA hospital 403 reports.

Declining inpatient utilization poses a structural challenge to the traditional community hospital model

Total Average Daily Census Projections for all Massachusetts Hospitals, 2009 - 2025



Sources: HPC analysis of MHDC discharge data, CHIA hospital 403 reports, AHA Hospital Statistics, and population data from the University of Massachusetts Donahue Institute.
Notes: Projection based on current trend assumes a continuation of recent utilization trends in major service categories, but does not take into account numerous other factors impacting utilization, e.g. the movement of more types of care from inpatient to outpatient settings. The alternate projection assumes a 10.2% reduction that would bring Massachusetts in line with national hospital utilization, and a 20% reduction in readmissions, reflecting goals of reducing unnecessary readmissions.

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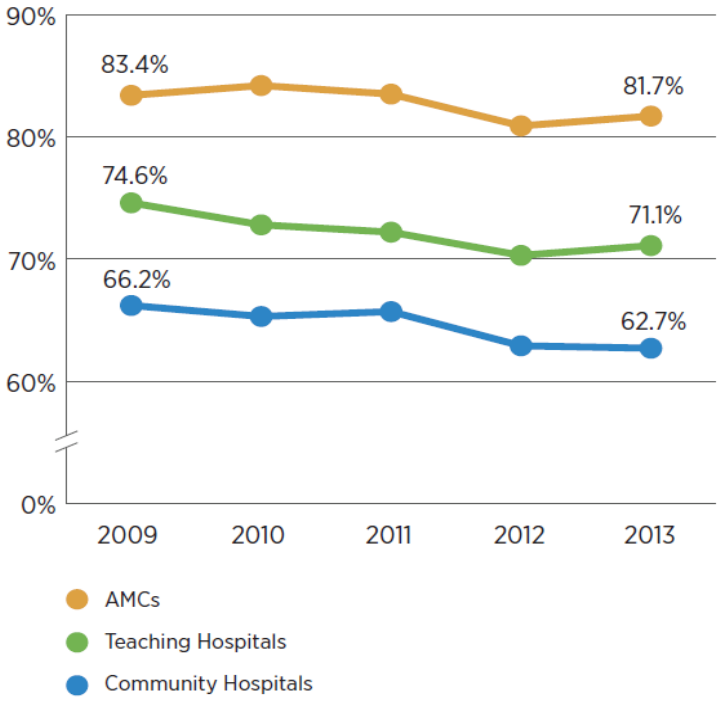
Community hospitals have lower average occupancy, and declining hospital utilization has further impacted occupancy rates

Total Inpatient Occupancy by Hospital Cohort, 2009 – 2013



Sources: HPC analysis of MHDC discharge data and CHIA hospital 403 reports.
Notes: Based on assessment of discharges and average patient length of stay compared to bed counts. Bed counts as of 2013. Bed types included are medical/surgical (including ICU), obstetrics, behavioral, and neonatology (normal newborn bassinets are excluded).

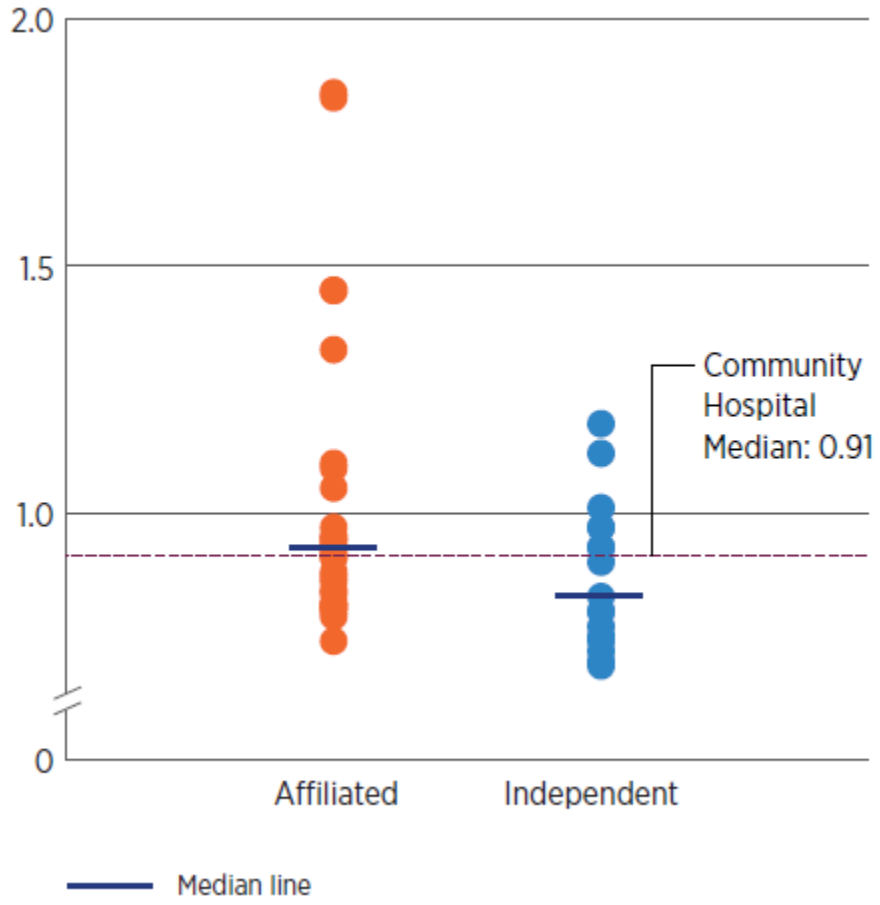
If current trend continues, community hospitals could face average occupancy rates of less than

50% within

10 years

Community hospitals affiliated with systems tend to have higher relative prices

Community Hospital Relative Prices and Affiliation Status, BCBS FY13



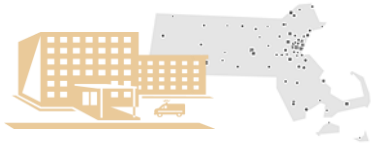
Source: HPC analysis of CHIA 2013 RP Databook
Note: While this graph shows relative prices for only one major commercial payer, price and affiliation status are similarly correlated for the other two major commercial payers.

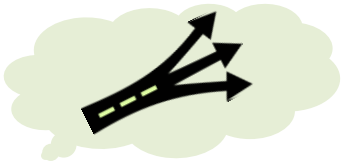
Hospitals with higher public payer mix tend to have lower relative prices, compounding financial stresses; cross-subsidization of higher public payer mix with higher commercial prices is not observed

Hospital Commercial RP and Percent of Revenue from Public Payers by Cohort, BCBS FY13

Source: HPC analysis of CHIA 2013 RP Databook and CHIA Hosp. Profiles, 2013

The path to a thriving community-based health care system





Overview | Value | Challenges | **Path Forward**

- Most patients should get most care in an efficient and high-quality setting close to home
- Providers must adapt to make this possible, and incentives and policies should align to support them
- Call to develop an Action Plan in concert with market participants

Building a path to a thriving community-based health care system

Vision of Community-based Health

A health care system in which patients in Massachusetts are able to get most of their health care in a local, convenient, cost-effective, high-quality setting.

- **The traditional role and operational model for many community hospitals faces tremendous challenges:**
  - evolution in the health care delivery and payment system
  - persistent market dysfunction → resource inequities and overreliance on higher cost care settings

- **A re-envisioning of the role of community hospitals will require:**
  - development of a roadmap for care delivery transformation focused around the community
  - planning and investment for better alignment of providers with community needs

- **Multi-sector dialogue** is necessary to build consensus and identify a series of targeted actions to be taken by providers, payers, consumers, and government

> *"We need to **stop playing defense and start playing offense**. This [challenge of supporting community hospitals] is one of the most complex health policy issues we have, but we cannot keep just relying on short term fixes. These hospitals are the backbones of our communities — we owe it to our communities to come together to develop a plan for their future"*
>
> *MASSACHUSETTS STATE LEGISLATOR*

Fostering dialogue and developing an Action Plan

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Authorizing the Release of Community Hospitals at a Crossroads

MOTION: That the Commission hereby approves the attached special report on community hospitals in the Commonwealth.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from the January 20, 2016 Meeting
- Executive Director's Report
- Cost Trends and Market Performance
- Community Health Care Investment and Consumer Involvement
- Administration and Finance
  - **Contract Extension**
- Schedule of Next Meeting (April 27, 2016)

Accountable Care Project Management Contract Extension

Description

The Executive Director is seeking the Committee's endorsement of a proposed amendment to the Commission's contract with **Accenture, LLP** for an additional amount of up to $100,000 through June 30, 2016.

Since October 2015, Accenture consultants have been supporting the PCMH and ACO certification programs with project management activities, including developing detailed implementation plans, process maps, and business requirements (for an ACO submission platform).

Over the next three months, Accenture's specific tasks will include expanding the ACO project plan to include new workstreams such as technical assistance; assisting with the identification or procurement of a technical platform for ACO submissions; and providing training to HPC staff to assume project management activities at the end of their engagement.

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Authorizing Contract Extension

MOTION: That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws, the Executive Director is hereby authorized to amend the Commission's contract with Accenture, LLP, for an additional amount of up to $100,000 through June 30, 2016, as endorsed by the Administration and Finance Committee, for project management support for the PCMH and ACO certification programs, subject to further agreement on terms deemed advisable by the Executive Director.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from the January 20, 2016 Meeting (VOTE)
- Executive Director's Report
- Cost Trends and Market Performance
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- Administration and Finance
- **Schedule of Next Meeting (April 27, 2016)**

Contact Information

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