MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of December 13, 2018

MASSACHUSETTS HEALTH POLICY COMMISSION

Date of Meeting: December 13, 2018

Start Time: 12:02 PM

End Time: 1:57 PM

	Present?	ITEM 1: Approval of Minutes	ITEM 2: SHIFT-Care Challenge Evaluation
Stuart Altman*	X	X	ab
Don Berwick	X	X	X
Martin Cohen	X	X	2nd
David Cutler	X	X	X
Wendy Everett	X	M	M
Timothy Foley	X	X	X
Chris Kryder	X	X	X
Rick Lord	X	X	X
Ron Mastrogiovanni	X	X	X
Sec. Marylou Sudders	X	2nd	X
Sec. Michael Heffernan	A	A	A
Summary	**10 Members Attended**	**Approved with 10 votes in the affirmative**	**Approved with 9 votes in the affirmative**

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.

*Chairman

(M): Made motion; (2nd): Seconded motion; (ab): Abstained from Vote; (A): Absent from Meeting

Proceedings

A regular meeting of the Health Policy Commission (HPC) was held on December 13, 2018, at 12:00 PM. A recording of the meeting is available here. Meeting materials are available on the Board meetings page here.

Commissioners present included Dr. Stuart Altman (Chair); Dr. Wendy Everett (Vice Chair); Dr. Donald Berwick; Mr. Martin Cohen; Dr. David Cutler; Mr. Timothy Foley; Dr. John Christian "Chris" Kryder; Mr. Richard Lord; Mr. Ron Mastrogiovanni; and Undersecretary Lauren Peters, designee for Secretary Marylou Sudders, Executive Office of Health and Human Services.

Dr. Altman called the meeting to order at 12:02 PM and welcomed those present. He noted that this meeting would be Dr. Everett's last and thanked her for her work during her tenure as the HPC's Vice Chair.

ITEM 1: Approval of Minutes from December 13, 2018

Dr. Altman provided a brief overview of the day's meeting. Dr. Altman called for a motion to approve the minutes from December 13, 2018. Dr. Everett made the motion to approve the minutes. Undersecretary Peters seconded. The motion was unanimously approved.

ITEM 2: Executive Director's Report

Dr. Altman introduced Mr. David Seltz, Executive Director, and Ms. Coleen Elstermeyer, Deputy Executive Director, who provided a summary of the HPC's activities in 2018. For more information, see slides 7-9.

Mr. Seltz provided an overview of the meeting agenda.

ITEM 3: Market Oversight and Transparency

Item 3a: Update on Notices of Material Change

Mr. Seltz provided an update on notices of material change received since the last Board meeting. For more information, see slides 12-13.

Mr. Seltz asked whether there were any questions.

Dr. Cutler noted that since the last Board meeting the Attorney General's Office (AGO) had come to an agreement with the parties to the proposed Beth Israel Lahey Health (BILH) transaction on conditions for the transaction to proceed. He asked whether these conditions had any implication for the HPC's role in the process. Dr. Altman suggested that it would be helpful for the Board to get a more in-depth presentation on the final set of decisions by the AGO and Department of Public Health (DPH) on the BILH transaction. Regarding Dr. Cutler's question, Mr. Seltz said that the HPC would need to consider carefully what its role was moving forward. He agreed with Dr. Altman that a deeper dive into this topic at the next Board meeting would be useful.

Item 3b: 2018 Cost Trends Report – Key Findings

Mr. Seltz introduced the next presentation on key findings from the 2018 Cost Trends Report. Dr. Altman encouraged Board members to ask questions and provide feedback during the presentation. Mr. Seltz noted that the full report would be an opportunity to provide additional context and nuance. He asked Commissioners to suggest where additional details would be useful.

Mr. Seltz turned the presentation over to Dr. David Auerbach, Director, and Ms. Sara Sadownik, Deputy Director, Research and Cost Trends, who presented on key findings from the 2018 Health Care Cost Trends Report. For more information, see slides 15-67.

Dr. Berwick said that the data regarding health care spending growth over time was very helpful. He asked if there was a way that over the next year the HPC could look at changes in the percentage of the state budget going to health care spending. Dr. Auerbach said that the percentage of the budget going to health care was growing. He noted that staff had included this data in the past and could do so in the future. Dr. Cutler said that the growth would be due to additional people rather than additional spending as the total health care expenditure (THCE) growth rate had been below the growth rate of the state economy over the same period. He said that he agreed with Dr. Berwick that it would be useful to show this trend.

Regarding slide 22, Mr. Lord asked what accounted for the stark difference in premiums between the small group market and the Massachusetts Health Connector. Dr. Auerbach said that studies had shown that the structure of the Connector was designed to be very pro-competitive. He said that plans compete to be the lowest cost plan because many enrollees are automatically put into low cost plans. He added that many of these plans are different than those seen the broader market and may employ cost saving measures such as the use of narrow networks that exclude higher-priced providers. Undersecretary Peters added that the premiums in the individual market were available to small businesses with under 50 employees and that the Connector allowed employees to select from a variety of plans with lower premiums. Mr. Lord asked if, when using the Connector, employers would select a level and then employees would shop for individual plans from a selection of options. Undersecretary Peters confirmed that that was the case. She said that employers could choose a "horizontal shelf," offering employees a series of options in the same actuarial tier, or a "vertical shelf," offering employees a series of options at different premium levels. Mr. Foley asked how many small businesses participated in the Connector. Undersecretary Peters said that approximately six thousand lives were covered by the Connector through the small business option. She said that there were efforts to expand this. Dr. Cutler asked whether the Connector allowed for a defined contribution strategy on the part of employers. Undersecretary Peters said that the Connector was currently examining the potential implications of allowing for that. Mr. Seltz added that the Connector's vertical option does include some elements of a defined contribution strategy. Dr. Berwick asked whether an employee of a small business that moved onto the Connector would be getting the same level of coverage as those in the small group market. Dr. Auerbach said the Connector left it up to the individual and that it was more a tradeoff between provider choices than benefit structure.

Dr. Altman noted that the chart on slide 23 suggested that there were higher administrative costs for large group purchasers than individuals and small groups. He asked what accounted for this as he assumed that the opposite would be the case. Dr. Auerbach said that he understood Dr. Altman's intuition regarding this relationship to be correct but suggested focusing more on the change over time in the graph. He said that before the Affordable Care Act (ACA), the administrative cost on individual and small group plans had been enormous. He suggested that that cost might not be captured in this data given the way in which the Connector operates.

Dr. Everett asked whether there was any sense of why there was such a dramatic increase in administrative costs from 2016 to 2017. Dr. Auerbach said that it could be that insurers had lost money in 2016 and had to make up the shortfall in 2017. He noted there is a cycle to underwriting and that these numbers tend to go up and down but that beyond those factors he was unsure. He said there was more to understand in this picture. Dr. Altman said that he looked forward to a deeper dive into this topic.

Dr. Berwick said that it would be helpful to link the data on slide 24 to whether there were trends in people's overall spending behavior based on their out-of-pocket health care costs. Dr. Auerbach agreed and said there was extensive data on this topic, including the Center for Health Information and Analysis' (CHIA) health insurance survey.

Regarding the graph on slide 24, Undersecretary Peters asked whether the percentages were based on the assumption that employees would be otherwise receiving the employer premium contribution as income. Dr. Auerbach confirmed that that was the assumption used in the analysis. Dr. Altman said that if that was the case this amount should be added to the employees' compensation. Dr. Auerbach confirmed that it was and said that this amount was included in both the numerator and denominator in the analysis. Mr. Seltz said that, according to the CHIA survey, 25.6 percent of Massachusetts residents reported they had unmet health care needs due to the cost. He added that two thirds of these individuals had health insurance. Dr. Berwick said that it would be useful to track this year-over-year.

Dr. Kryder said that it would be helpful to display the gross dollar amounts along with the graphs on slide 26. Dr. Auerbach asked if Dr. Kryder was referring to the dollars at risk. Dr. Kryder clarified that he was referring to the actual transfer amounts and said that he believed that payers were required to report this information. Dr. Auerbach said that staff were able to see non-claims payments but that there had been struggles trying to track the true amount of risk that providers were holding under these agreements. Mr. Seltz said that a goal for 2019 was to have more detailed information about these contracts including how many actually had downside risk. He said that not every alternative payment model (APM) looks the same and how APMs are actually structured could impact the incentives involved. Dr. Kryder said that unless this information could be framed in terms of how the payers were selectively contracting in gross dollars, it would be difficult have a clear insight into what was actually happening. Dr. Auerbach said that he agreed.

Dr. Berwick noted that slide 19 showed a 4.4 percent drop in enrollment in MassHealth. He asked whether this represented a change in acuity that might account for the drop in

hospitalizations shown on slide 28. Dr. Auerbach said that that enrollment drop was only from 2016 to 2017 and that staff could not be sure whether there was a relationship between those numbers and the change in hospitalization rate. He said that drop in enrollment was due to eligibility changes in the program. Undersecretary Peters clarified that the drop was due to program integrity and not eligibility requirements. Dr. Berwick asked where this population ended up. Undersecretary Peters said that there is often a good deal of churn between the Massachusetts Health Connector and MassHealth and that income fluctuations might cause an individual to jump between the two. Dr. Kryder said that the number of individuals who shifted from MassHealth to the Connector and vice-versa over a given period would also be useful to have.

Regarding slide 31, Dr. Altman noted that there was some push back on the issue of readmissions in that the metric did not account for the socio-economic condition of the patients. Mr. Seltz added that CHIA had engaged a multi-agency working group to reevaluate how readmissions were being measured in Massachusetts and their report would be released in the coming weeks. He said that there was an opportunity as a state to rethink how some of these factors were being measured. He noted that at the Cost Trends Hearing, Dr. Ashish Jha had raised the possibility of examining the total cost of care for a patient 90 days after treatment rather than just whether or not the patient was readmitted. Dr. Auerbach added that adjusting for social determinants of health (SDH) does make a difference when comparing the readmission rate hospital to hospital but, looking statewide and being a relatively healthy state overall, he did not believe that Massachusetts' numbers suffered from the lack of adjustment. He noted that preliminary results from CHIA seemed to indicate that the state had continued to perform poorly by this metric in 2017.

Dr. Altman noted that the $80 million in low value care (LVC) procedures listed on slide 36 was a small percentage of overall health care spending, but that the fact that $12.2 million of this amount was paid out-of-pocket was significant. He said that one option for insurance companies could be to provide patients with a card listing LVC procedures so that patients could be better informed. Dr. Auerbach said that this was a great point and noted that some insurers had stopped covering some of these procedures leaving patients to eat the cost. Mr. Seltz noted that part of the Choosing Wisely Campaign involved educating patients to ask the right questions of their providers before having a procedure. He also noted the numbers on slide 36 were fairly conservative and, due to the data lag, were several years old. With more Massachusetts residents in high-deductible plans in 2018, Mr. Seltz said that these numbers were likely considerably higher. Dr. Berwick added that the 19 procedures captured in this data was also not inclusive of all LVC procedures. Dr. Kryder agreed that in addition to the unnecessary diagnostic procedures listed, there were also unnecessary therapeutics not captured in this analysis. Dr. Auerbach said that staff were working with other researchers in an effort to expand this list of LVC procedures. Mr. Cohen asked if there were other tools beyond publishing this list that the HPC could use to work with providers. Dr. Auerbach said that some providers had tools that the HPC tried to encourage other providers to adopt. Mr. Mastrogiovanni said that tools like this would be very helpful for consumers.

Dr. Cutler noted that there were two ways to look at the variation in emergency department (ED) admissions shown on slide 40 as well as variation in other metrics throughout the presentation. He said that one way is to assume that all organizations want to improve in these metrics and would look to adopt best practices from organizations that were performing better. He said experience seemed to indicate that this was not the case in practice. The other way to view these metrics was as a pretext to use negative incentives against underperforming organizations. He said that this might lead the HPC to think about what kinds of things were being incentivized by the APMs. Mr. Seltz said that this was an open question for the Board and that it would be useful to think about the HPC's role and whether the focus should be on changing the incentive structures or singling out underperforming organizations. Dr. Kryder noted that on slide 37, Atrius and Mount Auburn Cambridge Independent Physicians Association (MACIPA) stood out from the pack and a conversation with representatives from both organizations might be useful. He added that Atrius was doing innovative things to reduce unnecessary ED use.

Regarding slide 46, Dr. Cutler asked if high volume hospitals were likely to acquire chemotherapy drugs at a lower price than other hospitals. Ms. Sadownik said that staff did not have that information as the acquisition costs were not publicly known. Dr. Everett asked why Dr. Cutler assumed that the high volume hospitals would pay a lower price. Dr. Cutler said that because these hospitals were larger, they likely had greater negotiating leverage with drug manufacturers or wholesalers.

Dr. Berwick asked what the definition of a unit of was on the y-axis of the graph on slide 46. Ms. Sadownik clarified that this referred to the smallest volume in which the drug could be purchased. She noted that this could vary among different drugs. Dr. Berwick asked if this unit was the same for all hospitals in the graph. Ms. Sadownik said yes. Mr. Seltz said that the typical administration of a given drug could be many individual units.

Dr. Berwick said that the oncology section of the presentation was extremely important and he hoped that staff considered a journal submission on this topic.

Referring to slide 50, Dr. Altman said that the issue was how the differential between the commercial and Medicare rates in Massachusetts compared to the average differential for the rest of the country because of its implications for the commercial market. Dr. Everett asked whether Massachusetts' higher average Medicare prices were mostly due to the higher concentration of teaching hospitals. Dr. Auerbach noted that the concentration of teaching hospitals impacted both the commercial and Medicare prices. Dr. Berwick said that hospitals justify this as a necessary cross-subsidy to make up for the lower Medicare and Medicaid rates. He asked if there was any data that could shed light on this claim. Dr. Cutler said that this was a complicated question. He said that the overall profit margin for hospitals in the Commonwealth was somewhere in the range of three percent, comparable to the national average. The question, he said, was whether high-cost, unnecessary procedures could be reduced which could lower costs while not impacting profits.

Undersecretary Peters asked whether, in the commercial prices portion of the presentation, the commercial price referred to the actual price that was paid to the provider. Dr. Auerbach said that

that was correct. Undersecretary Peters asked if staff had looked at reimbursement arrangements to get this data. Dr. Auerbach said that this analysis was careful to compare like-to-like services from commercial to Medicare.

Dr. Auerbach turned the presentation over to Ms. Hannah James, Research Associate, Research and Cost Trends, who presented on a cohort study examining spending of clinically similar patient subgroups. For more information, see slides 68 – 78.

Dr. Everett asked why academic medical centers (AMCs) were paying so much more for tests than physician led groups. Dr. Everett said that given their size she would assume that AMCs would have more bargaining leverage. Mr. Seltz clarified that the figures on slides 73 and 74 represented the prices being paid by insurance companies to these facilities rather than what the facilities themselves were paying.

Dr. Altman noted that on slide 70 the amount of money going to professional services in AMC-anchored organizations was actually lower than physician-led organizations in a number of instances. He said that it would be useful to look into the cost structure and the margins of these facilities to better understand the situation.

Dr. Everett thanked the staff for the presentation on the key findings of the Cost Trends Report. She congratulated the team.

Mr. Seltz reviewed the next steps in the process of releasing the Cost Trends Report. He asked if there were additional questions or feedback.

Dr. Kryder thanked the staff and said that studying the employment model in the health care system might be instructive. He added that there were questions as to how the workforce would respond to an economic downturn.

Mr. Seltz thanked the Board for their questions and feedback.

ITEM 4: Care Delivery Transformation

Item 3a: SHIFT-Care Challenge – Proposed Evaluation Vendor for SHIFT-Care Investment Program

Mr. Seltz presented on the proposed vendor to conduct an evaluation of the SHIFT-Care Investment Program. For more information, see slides 84-89.

Dr. Altman announced that he would be recusing himself from the vote.

Mr. Cohen said that he believed the Brandeis team was well-suited to conduct this evaluation.

Mr. Foley asked the reasoning behind the timeframe for the evaluation. Mr. Seltz said that the plan was to bring the evaluator in earlier to be along for the lifespan of the program.

Dr. Everett made the motion to approve the proposed evaluation vendor. Mr. Cohen seconded. The motion was approved with nine votes in the affirmative. Dr. Altman abstained.

Dr. Altman thanked the Board and the staff. The meeting was adjourned at 1:57 PM.