COMMONWEALTH OF MASSACHUSETTS

# HEALTH POLICY COMMISSION

# Cost Trends and Market Performance

January 13, 2016

# Agenda

- Approval of Minutes from the December 2, 2015 Meeting (VOTE)
- Discussion of Provider Discounts
- Discussion of 2015 Cost Trends Report: System Performance Dashboard
- Discussion of 2016 Research Agenda
- Schedule of Next Committee Meeting (February 24, 2016)

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# Vote: Approving Minutes

**Motion**: That the Committee hereby approves the minutes of the Cost Trends and Market Performance Committee meeting held on December 2, 2015, as presented.

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# Discussion Preview: Provider-to-Provider Discount Arrangements

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## Agenda Topic

Provider-to-Provider Discount Arrangements: Continued Discussion

## Description

Following up from December's CTMP meeting, staff will provide a brief overview of potential options for monitoring these provider arrangements outside of the material change notice process.

## Key Questions for Discussion and Consideration

Commissioners will have the opportunity to provide feedback as to how to proceed in understanding these types of arrangements.

## Decision Points

No votes proposed. Commissioners will be asked for their feedback on the potential options for understanding these types of arrangements.

# Provider-to-Provider Discount Arrangements

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- As discussed previously, through its notice of material change process and inquiries from market participants, the HPC has become increasingly aware of a type of clinical affiliation relationship involving a provider-to-provider discount arrangement that has not been consistently reported to the HPC as a material change.

- Through such discount arrangements, providers under risk typically agree to send their risk patients to a preferred provider, and the preferred provider agrees to pay a discount back to the referring provider for services rendered to the risk patients. The discount is typically a pre-determined percentage of the preferred provider's negotiated rates.

- Last month, the HPC updated its MCN Frequently Asked Questions to clarify that such discount arrangements constitute strategically important clinical affiliations and should, thus, be filed as notices of material change.

- The HPC also updated the notice of material change form to ask specifically about any financial provisions, in order to increase the transparency of these types of arrangements.

# HPC Steps to Increase Understanding of Discount Arrangements

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- The changes to the MCN process will improve the HPC's ability to monitor the development of new discount arrangements. However, Commissioners also expressed interest in understanding discount arrangements in place that pre-dated the material change notice process, or for which no material change notice was filed.

- HPC staff have explored options to increase transparency of these discount arrangements, including examining the HPC's authority to collect such information, as well as the potential authority of other state agencies.

- HPC staff have also heard from provider stakeholders about this issue since the last committee meeting.
  - Several providers have indicated to the HPC that they view such discount arrangements as a critical tool for being successful under risk contracts, often allowing them to extract discounts from high-priced providers where the payer has not.
  - Providers also expressed that they sometimes use the revenue received through such discounts to fund various care coordination and improvement activities that are traditionally not reimbursed by payers.

# Options to Increase Understanding of Discounts Arrangements

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- **<u>Potential CHIA Role</u>: CHIA is authorized under its statute to require providers to report provider-to-provider discounts arrangements.**
  - **MGL Ch. 12C, Section 8(a):** "[CHIA] shall also promulgate regulations to require providers to report any agreements through which *provider agrees to furnish another provider with a discount, rebate or any other type of refund or remuneration in exchange for, or in any way related to, the provision of health care services*" (emphasis added).
  - **CHIA could explore regulations to require reporting.**
    - Specific reporting requirements would be developed through regulatory process; allows for stakeholder input on the appropriate level of detail to be collected and consideration of administrative burden.
- **<u>Continued outreach</u> with providers to understand the role of such arrangements in risk contracting.**

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# Background: HPC's dashboard of key metrics

## 2014 Cost Trends Report recommendation

> "The importance of transparency and availability of data surfaces throughout our discussions of spending trends, care delivery, APMs, and demand-side incentives. Data are essential to all aspects of system transformation, including setting priorities, strengthening care delivery, designing and succeeding in new payment models, harnessing the power of consumer choice, and monitoring progress."

## HPC's method to advance the goal

The HPC will develop a set of **measures** to track health system performance. In 2015, the HPC will develop a set of health system performance measures, or "**dashboard**," to enable the HPC to set **concrete goals** for advancement. This dashboard will be publicly available, updated regularly, and will include metrics in the HPC's key areas of interest.

# HPC's dashboard of key metrics – objectives and principles

## Objectives for creating an HPC dashboard

- Develop a concise set of measures to track Massachusetts health system **performance** across areas identified by HPC as priorities for ongoing attention and improvement
- Create **accountability** over the long term
    - Measure performance against targets and include in each annual Cost Trends Report to track progress
- Align measures with the areas of **focus** identified in previous Cost Trends Reports: benchmark and spending; efficient, high-quality care delivery; APMs; value-based markets; and transparency and data availability

## Principles for measure inclusion

1. Measures that are linked to HPC's policy agenda and crucial to health system performance
2. Measures that have a valid, regular, and up-to-date data source
3. Measures that build upon previous and ongoing HPC research and analysis

# Dashboard – benchmark & spending

| Measure | MA time trend | | Direction of change | US comparison | MA relative to US |
|---|---|---|---|---|---|
| 1. Growth of THCE per capita (performance assessed relative to 3.6% benchmark) | 2.4% (2012-2013) | 4.8% (2013 - 2014) | ■ | 4.2% (2013-2014) | ■ |
| 2. Growth in premiums | Family:1.7% Single:2.8% (2012-2013) | Family: 1.6% Single: 0.9% (2013-2014) | ▲ | Family: 3.9% Single: 4.7% (2013-2014) | ▲ |
| 2a. Level of premiums | Family:$17,424 Single:$6,290 (2013) | Family: $17,702 Single: $6,348 (2014) | N/A | Family: $16,655 Single: $5,832 (2014) | ■ |
| 3. Individuals with high out-of-pocket spending relative to income | N/A | 11% (2013 and 2014 average) | ▲ | MA ranked 2nd out of 51 (US = 15%) (2013 and 2014 average) | ▲ |

▲ Performed Better

● Performed Similar

■ Performed Worse

Sources: Centers for Health Information and Analysis (measure 1-MA), Agency for Healthcare Research and Quality (Measures 2,2a), Commonwealth Fund (Measure 3) Centers for Medicare and Medicaid Services (measure 1-US)

# Dashboard – efficient, high-quality care delivery

| Measure | MA time trend | | Direction of change | US comparison | MA relative to US |
|---|---|---|---|---|---|
| 4. Readmission rate (Medicare) | 19.4% (2010) | 17.4% (2013) | ▲ | MA ranked 39 out of 51 (US = 17.0%) (2013) | ■ |
| 4a. Readmission rate (All payer) | 15.9% (2011) | 15.0% (2013) | ▲ | N/A | N/A |
| 5. ED utilization (per 1,000 beneficiaries) | 361 (2010) | 349 (2014) | ▲ | MA ranked 35 out of 51 (2013) | ■ |
| 5a. Behavioral health ED utilization (per 1,000 persons) | 21 (2010) | 25 (2014) | ■ | N/A | N/A |
| 6. Percentage of inpatient cases discharged to institutional PAC | 20.6% (2013) | 20.8% (2014) | ● | MA = 20.4% US = 16.7% (2012) | ■ |
| 7. At-risk adults without a doctor visit | 7% (2013) | 7% (2014) | ● | 13% (2014) | ▲ |
| 8. Number of primary care physicians practicing in certified PCMHs | 1,512 19% of all PCPs (2014) | 2,006 25% of all PCPs (2015) | ▲ | 15% of all PCPs (2015) | ▲ |

Sources: Institute of Medicine (measure 4), Center for Health Information and Analysis (measure 4a), Center for Health Information and Analysis, HPC analysis (measures 5 and 5a-MA, measure 6-MA), Commonwealth Fund (measure 7), National Commission on Quality Assurance and American Association of Medical Colleges, HPC analysis (measure 8), Kaiser Family Foundation (measure 5-U.S.), Agency for Healthcare Research and Quality (measure 6-US).

# Dashboard – APMs and value-based markets

| Measure | MA time trend | | Direction of change | US comparison | MA relative to US |
|---|---|---|---|---|---|
| **APMs** | | | | | |
| 9. Percentage of beneficiaries in Original Medicare covered by APMs | 41% (2013) | 46% (2014) | ▲ | 16% (2014) | ▲ |
| 10. Percentage of commercial HMO patients in APMs | 61% (2013) | 68% (2014) | ▲ | N/A | N/A |
| 11. Percentage of commercial PPO patients in APMs | ~1% (2013) | 2% (2014) | ● | N/A | N/A |
| 12. Percentage of MassHealth members in APMs | PCC: 14% (2013)<br>MCO: 32% (2013) | PCC: 22% (2014)<br>MCO: 22% (2014) | ● | N/A | N/A |
| **Value-based market** | | | | | |
| 13. Enrollment in tiered network products | Tiered: 14.5% (2013) | Tiered: 16.0% (2014) | ● | N/A | N/A |
| 14. Percentage of discharges in top 5 systems | 51% (2012) | 56% (2014) | ■ | N/A | N/A |
| 15. Percentage of discharges from hospitals with relative price of 1.0 or above | 68% (2012) | 73% (2014) | ■ | N/A | N/A |

Sources: Centers for Medicare and Medicaid Services, HPC analysis (measure 9), Center for Health Information and Analysis (measures 10, 11, 13), MassHealth – private communication (measure 12),Center for Health Information and Analysis, HPC analysis (measures 14-15).

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# Key statistics from the 2015 Cost Trends Report

## 2015 HPC Key Findings

**$19,300**
annual health insurance premium plus cost-sharing for typical family

**1.0%**
rate of growth of commercial spending on physician and hospital services

**4.8%** rate of growth of THCE

**1.6%** percentage points due to drug spending

**3.2%** percentage points due to MassHealth (2.5 excluding drugs)

**74%**
percent of PCPs affiliated with one of the 8 largest provider systems

**$6,300**
difference in spending between Mass General and Mt. Auburn for a low-risk pregnancy

**56%**
difference in price of colonoscopy between hospital outpatient department and community setting

**~0**
change in statewide rate of discharge to institutional post-acute care, 2010-2014

**24%** statewide growth in ED visits with a primary behavioral health diagnosis, 2010-2014

**~50%** growth in behavioral health ED visits in New Bedford and Fall River

**68%**
share of HMO lives covered by alternative payment models, 2014

**2%**
share of PPO lives covered by alternative payment models, 2014

**49/57**
number of hospitals that decreased their rate of discharge to institutional post-acute care after joint replacement surgery, 2010-2014

# Potential policy research topics for 2016 – for discussion

**Value-Based Market**

- Market consolidation and effects on prices, spending, practice patterns, billing practices

**Efficient Care Delivery**

- Avoidable use of hospital and post-acute care
- Behavioral health spending and use, including trends in provider markets
- After-hours care (retail clinics/urgent care centers); growth, access and impact on ED use and hospitals
- End-of-life care

**APMs**

- APM uptake, especially in PPO

**Demand-Side Incentives**

- Uptake of tiered network products/markets for employer-based health insurance/public and private exchanges
- Consumer choice (funded by RWJF)

**Cross Cutting**

- MassHealth enrollment, utilization, and spending, including LTSS
- Drug spending
- Health information technology (ENS, telehealth)

# System-wide data update

| Data needs | HPC and CHIA activities |
|---|---|
| Discharge data for psychiatric hospitals | • CHIA's number one priority for Case Mix data.<br>• CHIA estimates project will take 13-18 months. |
| Validated MassHealth data from the APCD | • **HPC and CHIA discussing joint project for 2016** |
| APCD general | • APCD version 4.0 (2014 data) released 11/1/2015.<br>• APCD version 5.0 (2015 data) will be released 6/2016. |
| TME for PPO | • CHIA planning new aggregate data collection |
| **Measures of spending growth for hospitals and specialist physician groups** | • **CHIA and HPC have had preliminary conversations.** |
| Quality data<br>BH data | • CHIA posted the BH Task Force Dashboard reporting plan for a public comment period, which ended December 27.<br>• **CHIA is currently preparing a summary of the stakeholder comments received.** |
| Other new developments | |

Notes: Bold text represent noteworthy developments since 12/2/2015.

# Potential HPC recommendation:
# Data for transformation and accountability

**To support transformation and accountability, CHIA should continue to improve and document its data resources and develop key spending measures, including:**

a. *Discharge data from freestanding psychiatric and substance use disorder hospital*

b. *Data on drug rebates*

c. *The All-Payer Claims Data Base (APCD)*

   i. Master provider index, in connection with the HPC registration of provider organization programs

   ii. MassHealth enrollment, spending and other essential measures

   iii. Attribute patients to providers and develop additional measures of spending

d. *Total medical expenditures for PPO populations*

   i. Use consensus attribution algorithm to identify ACOs in APCD

   ii. Collect aggregate data on TME for PPO populations (interim step)

e. *Provider-level measures of spending growth for hospitals and specialist physician groups*

f. *Relative prices – refine to allow cross-payer comparison*

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# Contact information

For more information about the Health Policy Commission:

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