MASSACHUSETTS
HEALTH POLICY COMMISSION

Joint Committee Meeting

CTMP and CHICI

July 5, 2017

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HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes
- HPC DataPoints Presentation
- 2017 Cost Trends Hearing
- Investment Spotlight: HCII Awardee – Boston Health Care for the Homeless
- Schedule of Next Meeting: September 8, 2017

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VOTE: Approving Minutes: Joint CTMP/CHICI 5/31/17

MOTION: That the joint Committee hereby approves the minutes of the joint CHICI/CTMP meeting held on May 31, 2017, as presented.

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- **HPC DataPoints Presentation**
  - Avoidable Emergency Department Use
  - Preventable Oral Health Emergency Department Visits
  - ACA's Preventative Coverage Mandate's Impact on Spending and Utilization of Contraception in Massachusetts
  - Update on Trends in Massachusetts and National Health Spending Through 2014 Based on Newly Released CMS Data
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DataPoint 2: Avoidable ED use

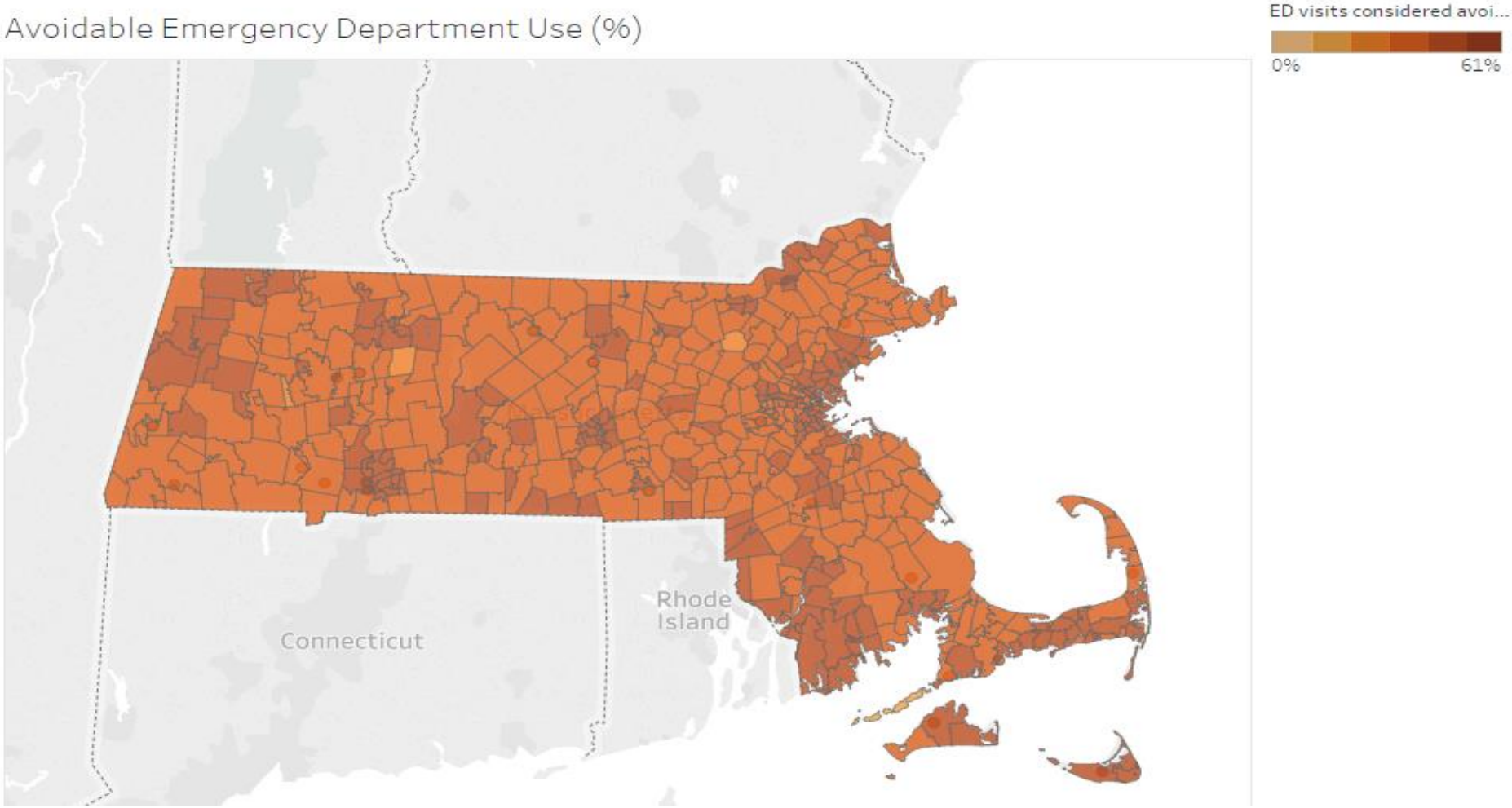
- In the 2016 Cost Trends Report, HPC reported that 42% of all ED visits in Massachusetts in 2015 were avoidable, a share that has remained constant since 2011.

- Avoidable ED visits include two types of visit categories: visits that could have been treated by a primary care provider (e.g. a visit for an ear infection) and visits that did not require any immediate medical care (e.g. a visit for a sore throat with no fever).

- The use of EDs to treat conditions that are non-emergent or amenable to primary care can be an indicator of barriers to accessing primary care. Many studies have shown that when individuals are unable to visit or speak with providers, they are more likely to use the ED.

- In this DataPoint, HPC further explored avoidable ED visits to better understand the most common types of avoidable ED visits, the time of day these visits take place, and how this differs by region within Massachusetts.

Avoidable ED visits are a state-wide concern



Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2015

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DataPoint 1: Oral health ED visits

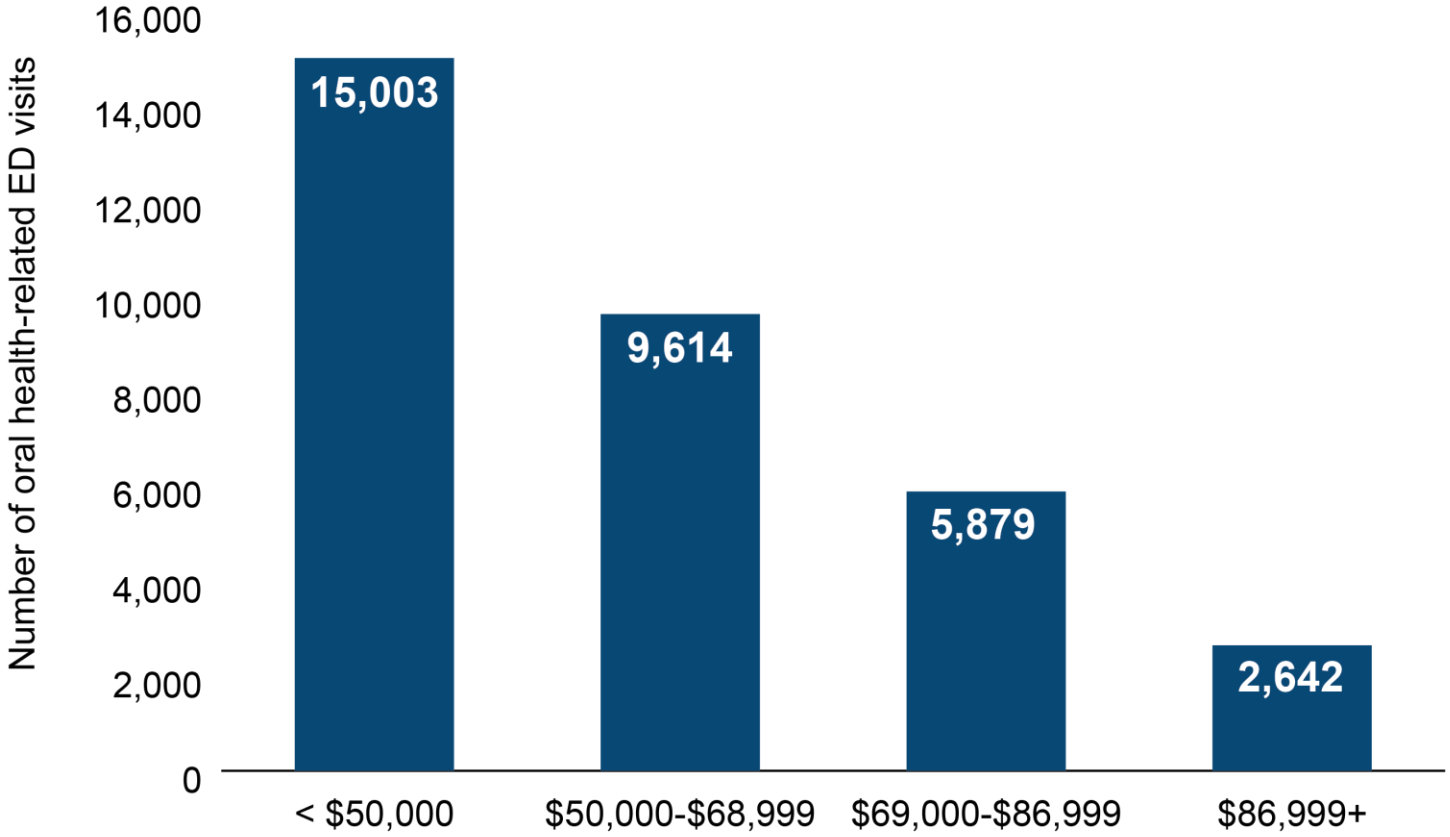
- Emergency department (ED) visits for oral health complaints represent a suboptimal use of the health system. Hospital settings are not equipped to treat the majority of dental conditions and, as a result, patients may not receive the most appropriate treatment. Treatment is also more costly in the ED, and can put pressure on overburdened ED resources throughout Massachusetts.

- Health care advocates, clinicians, and researchers consider oral health ED visits an indicator of inadequate access to oral health care.

- Last August, HPC released an Oral Health Brief that reported on the substantial number of emergency department (ED) visits in 2014 that were for preventable oral health conditions.

- This DataPoint 1 provides a brief follow-up analysis based on 33,467 ED visits for preventable oral health conditions in Massachusetts in 2015 (a slight decrease from 2014).

The 25% of Massachusetts residents residing in the lowest-income areas of the state accounted for 45% of all oral health ED visits in 2015



Factors that could contribute to higher rates of preventable oral health ED visits among lower-income patients include clinical risk factors, high out-of-pocket costs, and the fact that many dentist do not accept MassHealth patients.

Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2015

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DataPoint 3: Contraception spending and utilization

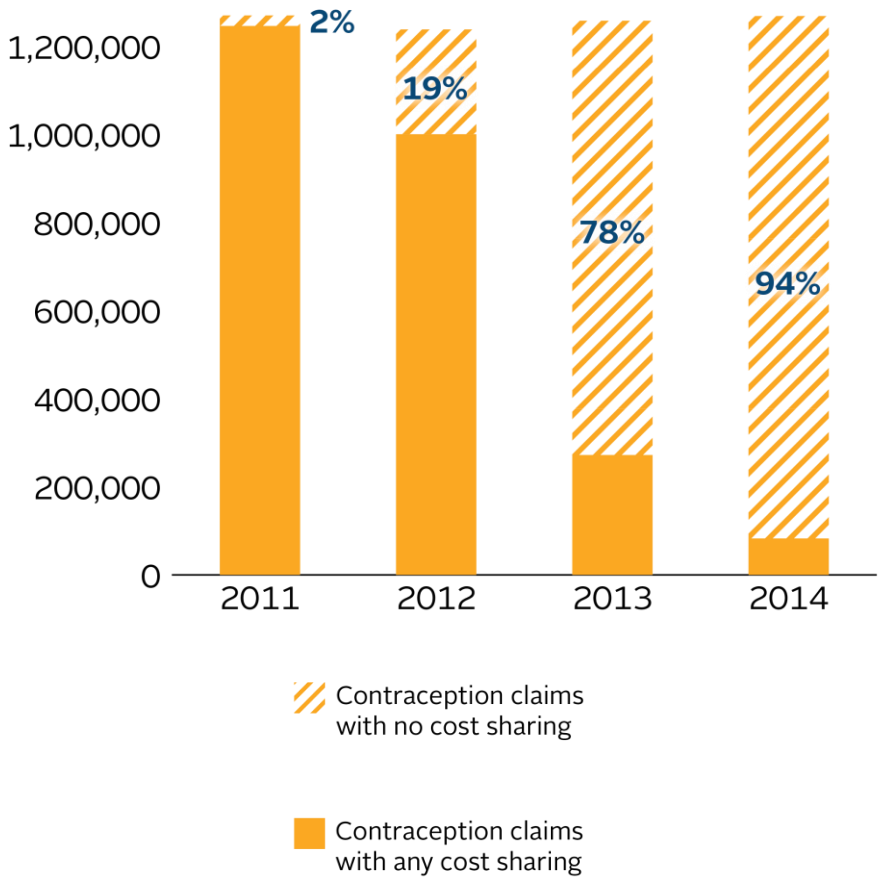
- The Patient Protection and Affordable Care Act of 2010 (ACA) established requirements for health plans to cover certain preventative services with no cost sharing.
  - These included women's health procedures, such as pre-natal care, mammography, contraceptive coverage.
  - Many of these benefits came into effect in August, 2012.

- Between 2011 and 2014, across all prescription drugs, average out-of-pocket spending per claim for women declined 14.2%, compared to 3.8% for men.
  - For women, this decline was largely due to significant decreases in patient cost sharing for contraception.

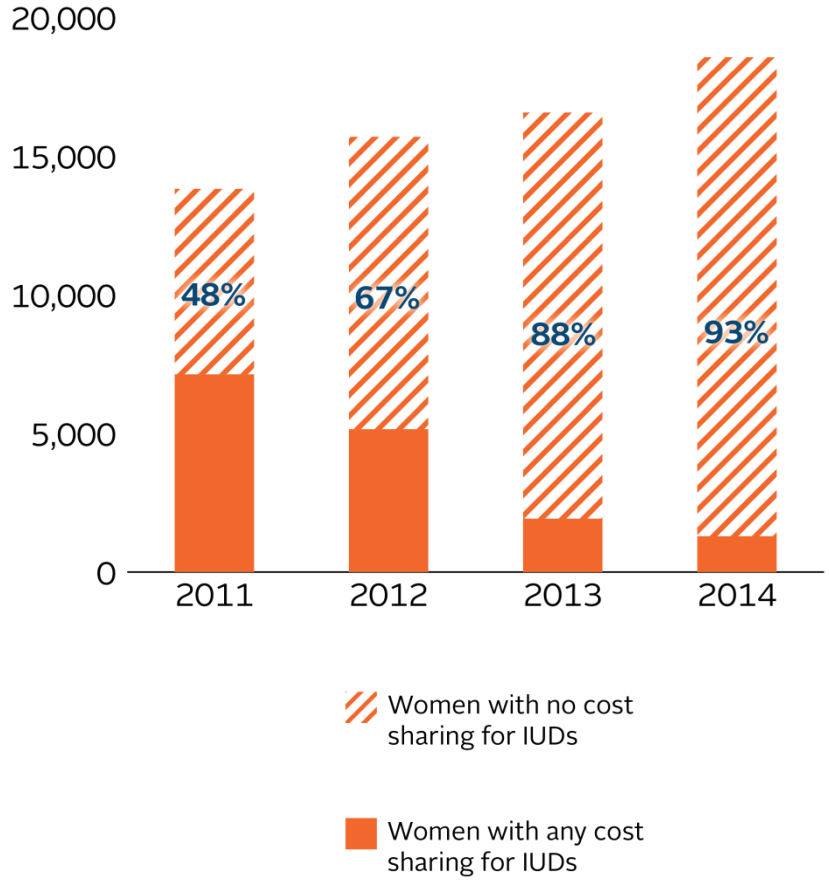
- In this DataPoint, HPC expanded prescription drug research to quantify changes in contraception spending and utilization in the Commonwealth.

Out-of-pocket spending declined for prescription contraception and IUDs as utilization of IUDs increased

Number of prescription contraception claims, by cost sharing, 2011 – 2014



Women with any IUD insertion or device claims, by annual cost sharing, 2011 – 2014



Source: HPC analysis of Massachusetts All Payer Claims Database, 2011 – 2014

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CMS State Personal HealthCare (PHC) Expenditures Data

- Data are updated every 5 years. Most recent update, 2009-2014, was released June, 2017
- Data are based primarily on provider and payer surveys as well as administrative sources
- State level data are based on state of residence of individuals
- Data are the same as CMS' Personal Health Care totals, which exclude some public health, research, and health infrastructure spending from total National Healthcare Expenditures (NHE)

- For more information, see recent Health Affairs Article, "*Health Spending By State 1991–2014: Measuring Per Capita Spending By Payers And Programs*," David Lassman, Andrea M. Sisko, Aaron Catlin, Mary Carol Barron, Joseph Benson, Gigi A. Cuckler, Micah Hartman, Anne B. Martin, and Lekha Whittle, Health Affairs Web Exclusive, 2017

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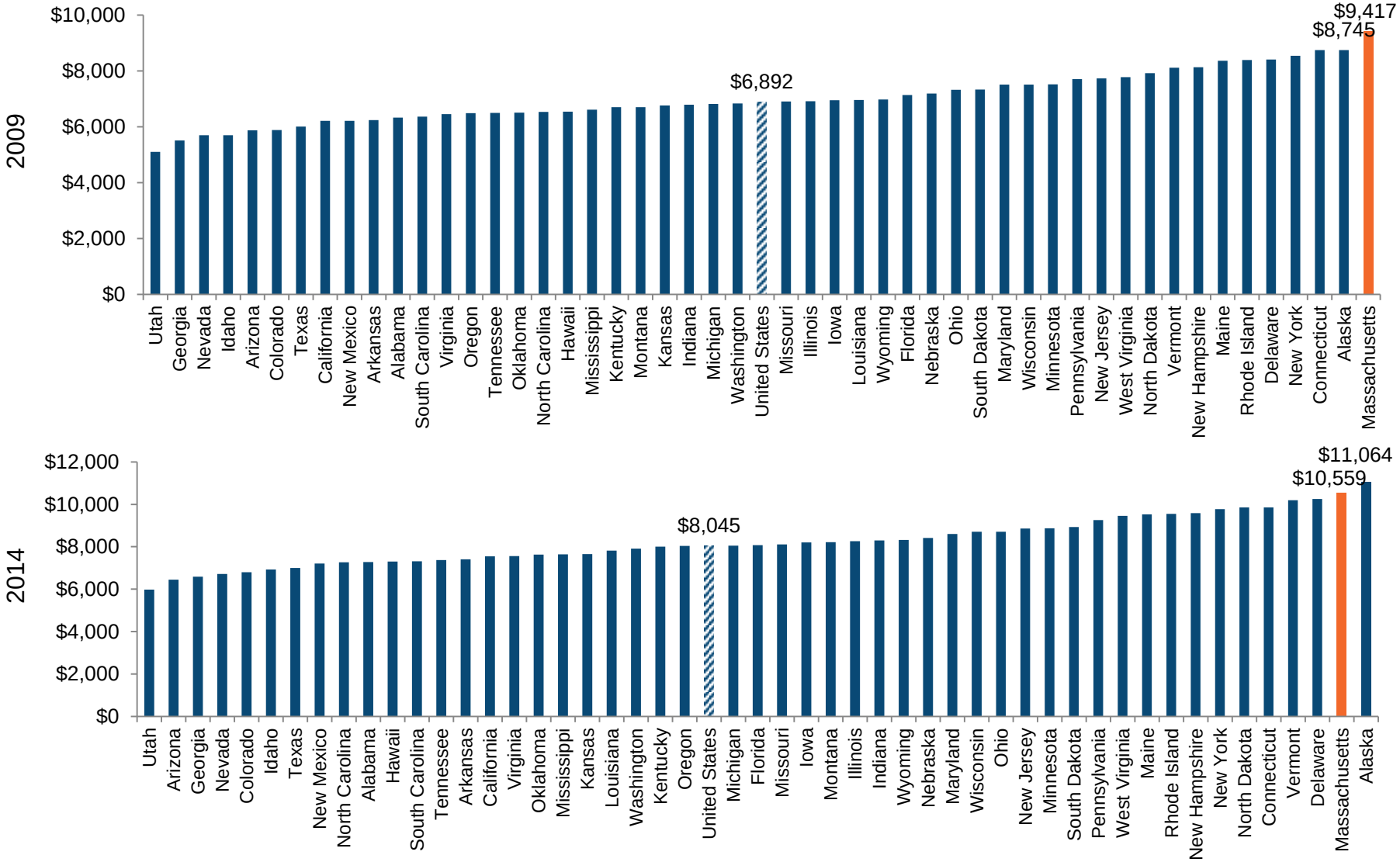
Personal health care spending, per capita, by state, 2009 and 2014



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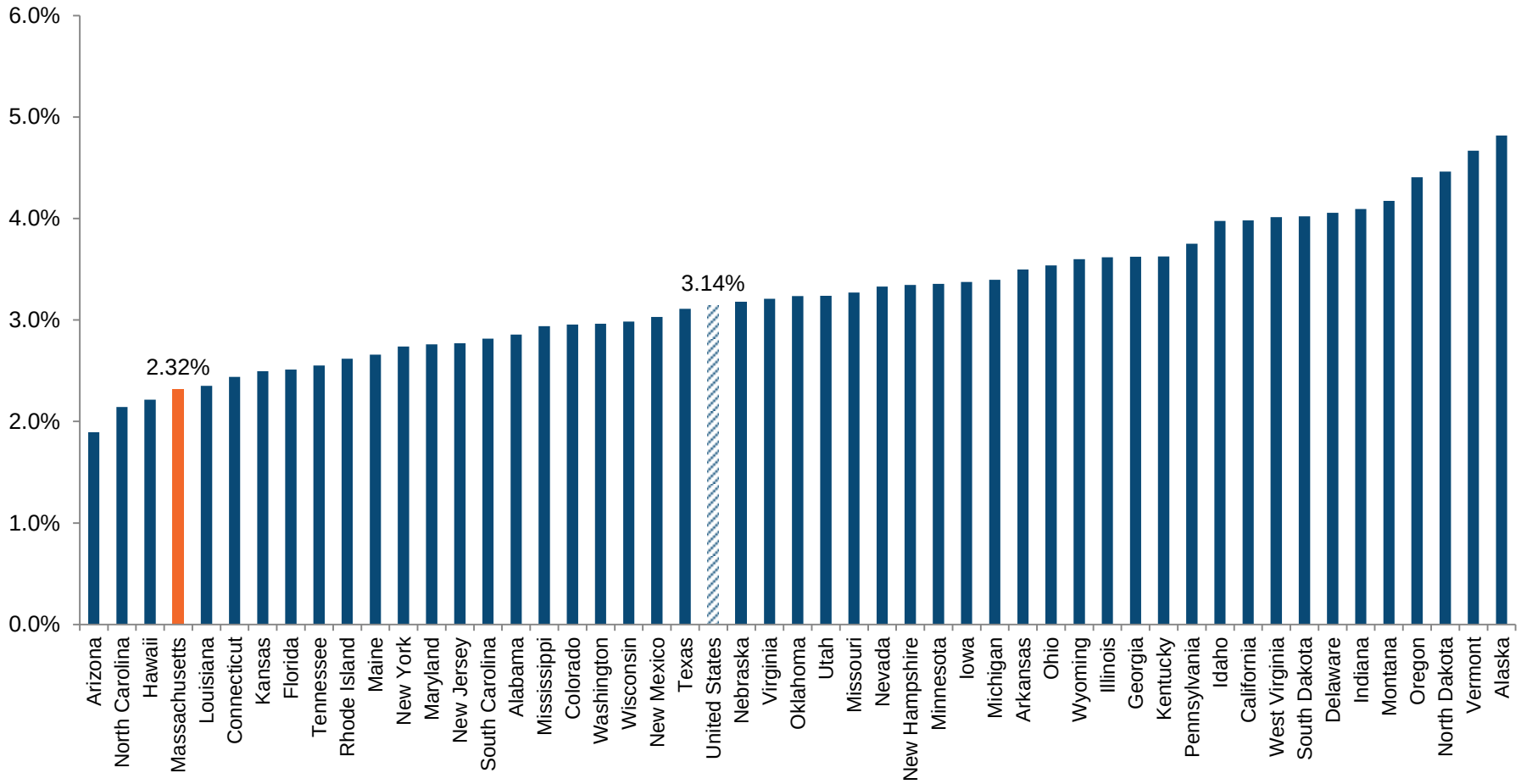
Average annual health spending growth, per capita, by state, 2009-2014



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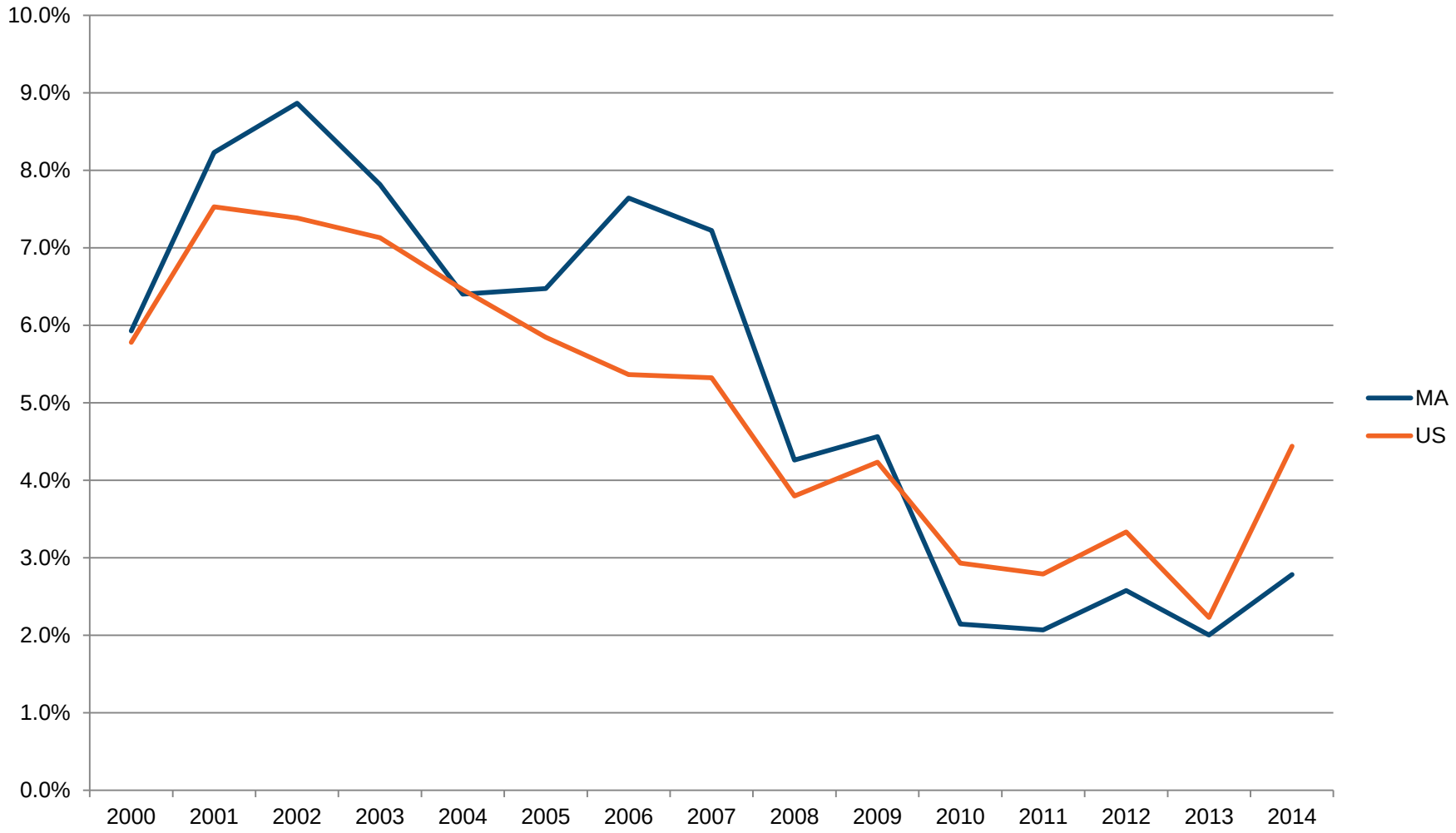
Annual health spending growth, per capita, MA vs. U.S., 2000-2014



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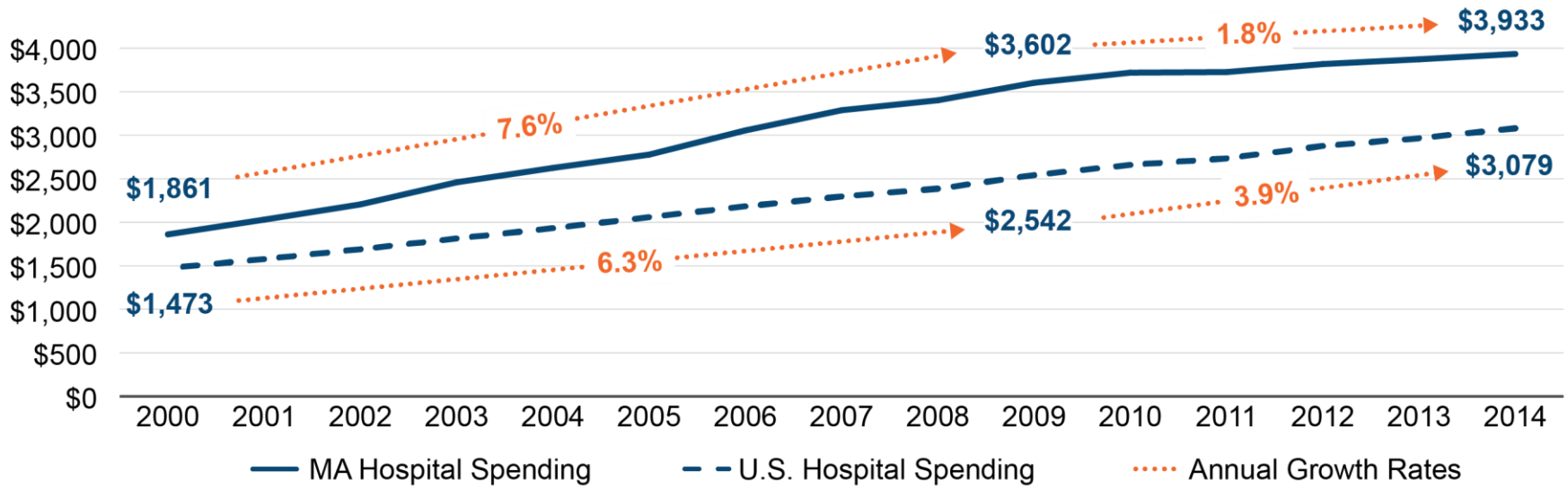
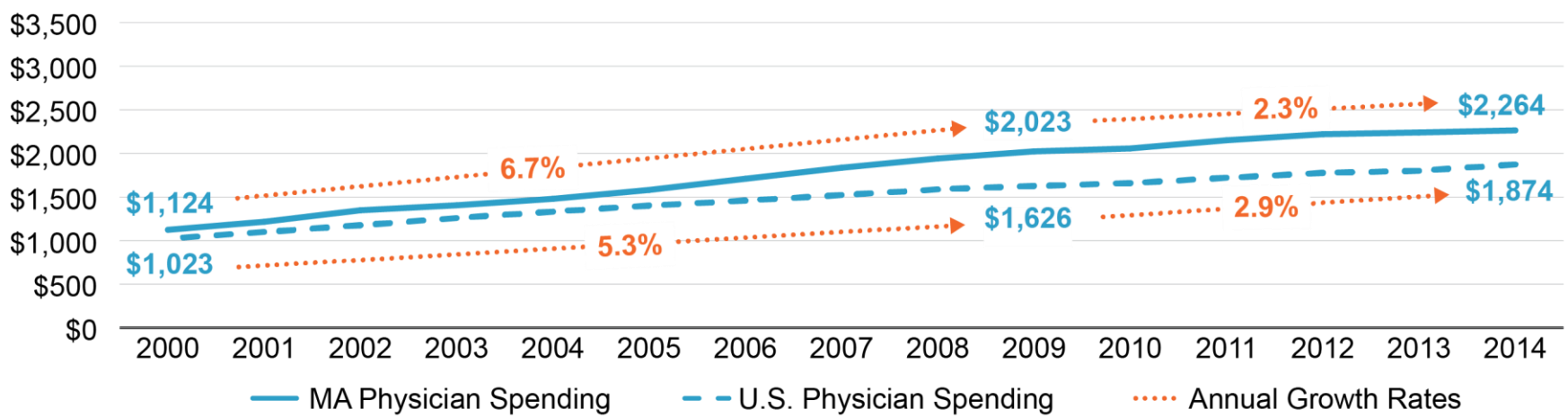
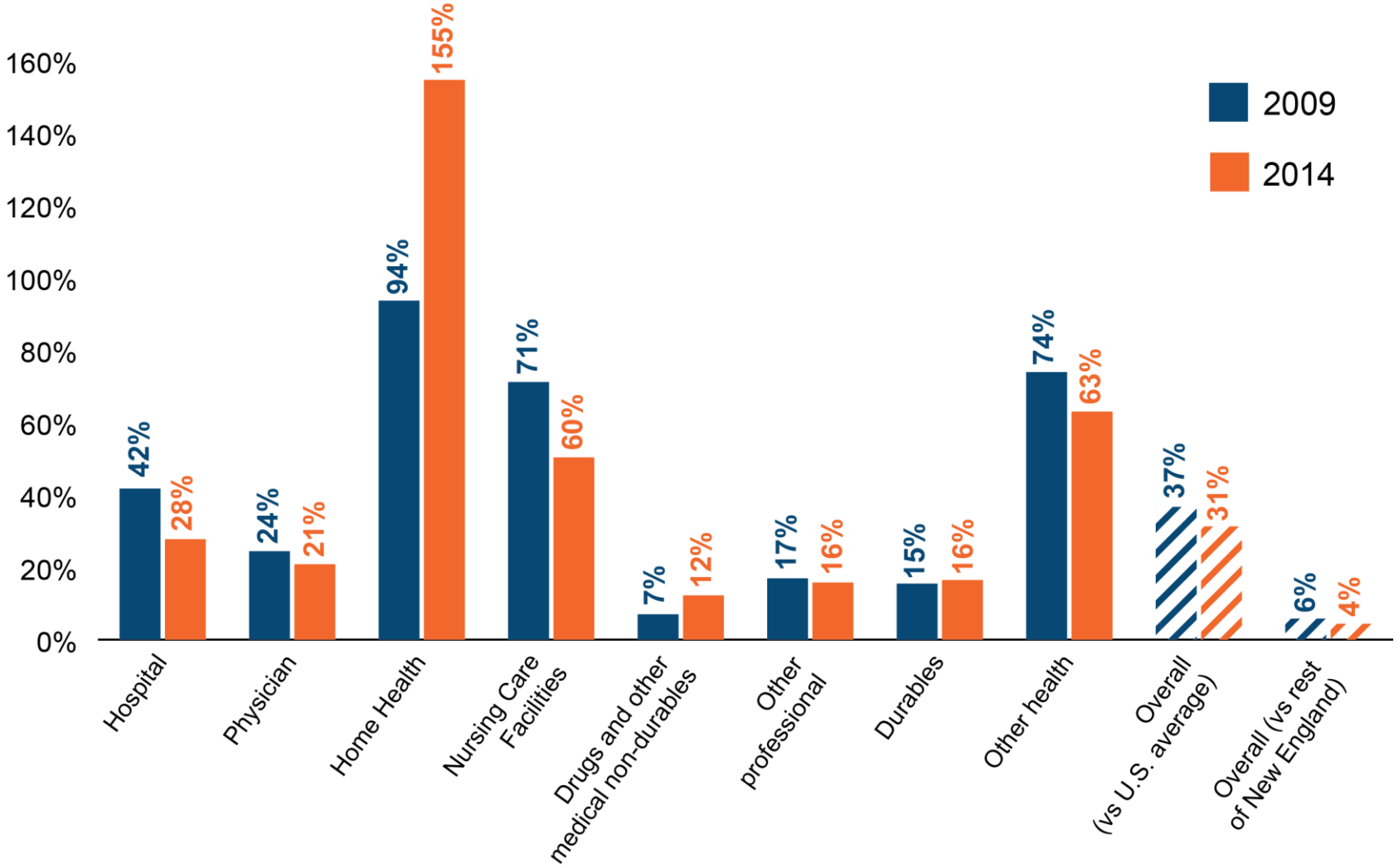
Hospital and physician spending, per capita, MA vs. U.S., 2000-2014





Note: Percents in orange are annual growth rates.

Massachusetts spending in excess of U.S. average, per capita, 2009 and 2014



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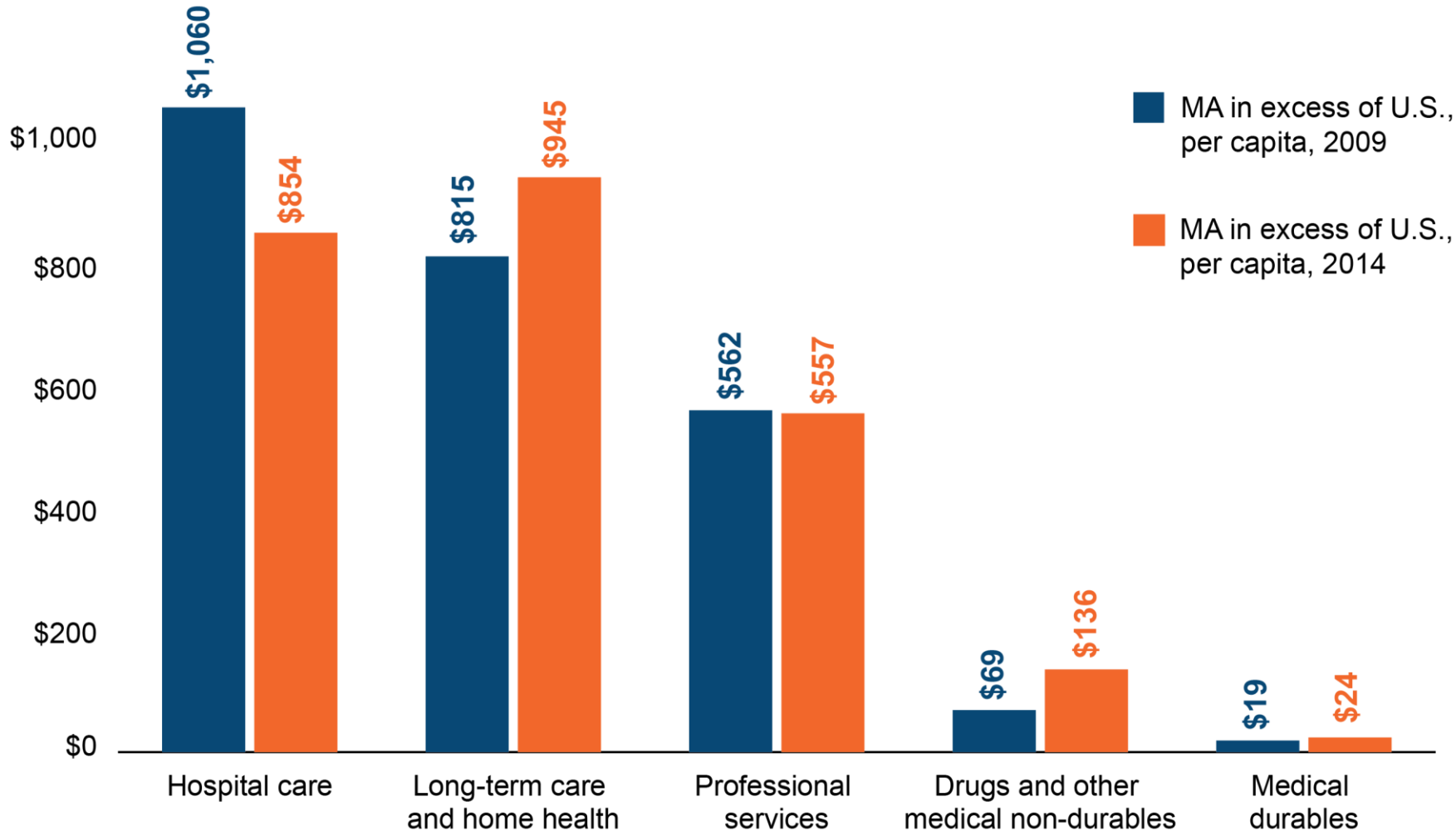
Contribution to Excess Spending in Massachusetts, 2009 and 2014



Percent of total difference	Hospital care	Long-term care and home health	Professional services	Drugs and other medical non-durables	Medical durables
	42% → 34%	32% → 38%	22% → 22%	3% → 5%	0.8% → 1.0%

Personal health care expenditures (PHC) are a subset of national health expenditures. PHC excludes administration and the net cost of private insurance, public health activity, and investment in research, structures and equipment. Includes nursing home care, home health care, and other health, residential, and professional care. Includes physician and clinical services, dental services, and other professional services. Source: Centers for Medicare & Medicaid Services; HPC analysis

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Key Findings

- In 2009, Massachusetts was the highest spending state (37% above national average). In 2014, Massachusetts was the second highest state (31% above national average), exceeded by Alaska.
- Massachusetts had the fourth lowest growth rate (2.3% per capita) in the nation between 2009 and 2014, after Hawaii, Arizona, and North Carolina
- Excess spending in Massachusetts relative to the U.S. average decreased in major health care sectors between 2009 and 2014:
  - Hospital, from 42% to 28%
  - Physician, from 24% to 21%
  - Nursing Care Facilities, from 71% to 50%
- Spending in certain sectors increased relative to the U.S. during this time:
  - Home Health, from 94% to 154%
  - Drugs, from 7% to 12%

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2017 Health Care Cost Trends Hearing – Discussion of Potential Modifications and Themes

PURPOSE

- **Enhance** the public transparency of health care spending trends
- **Engage** state government leaders, national experts, market participants, and the public to identify opportunities to reduce spending growth while improving quality
- **Evaluate** the efforts of health care market participants to meet the goals of chapter 224
- **Establish** a fact-base through written and oral testimony on the priorities and plans of health care market participants to reduce spending
- **Enable** broad public engagement in the work of the HPC

POTENTIAL MODIFICATIONS

- Streamline the Hearing to 1.5 days, with approx. 4 witness panels
- Invite one expert speaker to provide a national perspective
- Reduce the number of witnesses on each panel to allow for more in-depth examination

POTENTIAL THEMES

- Meeting the 3.1% benchmark: progress on the identified opportunities to reduce spending growth as presented at the benchmark hearing
- Reducing avoidable institutional care (e.g. avoidable ED visits, readmissions, institutional post-acute care)
- Shifting community-appropriate care from high-priced settings to high-*value* settings, including community hospitals
- Evaluating the impact of past market transactions on spending, quality and access
- Advancing value-based payment reform

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HPC's Health Care Innovation Investment Program

The Health Care Innovation Investment Program: $11.3M investing in innovative projects that further the HPC's goal of **better health and better care at a lower cost**

Health Care Innovation Investment Program Round 1 – Three Pathways

	Targeted Cost Challenge Investments (TCCI)	Telemedicine Pilots	Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions
Target Populations:	8 diverse cost challenge areas: SDH, BHI, VIC-Purchasers, VIC-Providers, Practice Pattern Variation, PAC, SAI & EOL, Site & Scope of Care	Patients from the following categories with Behavioral Health needs: 1. Children and Adolescents 2. Older Adults Aging in Place 3. Individuals with Substance Use Disorders (SUDs)	Pregnant women with Opioid Use Disorder (OUD) and substance-exposed newborns
	100% of initiatives launched	**100%** of Initiatives launched	**100%** of Initiatives Launched

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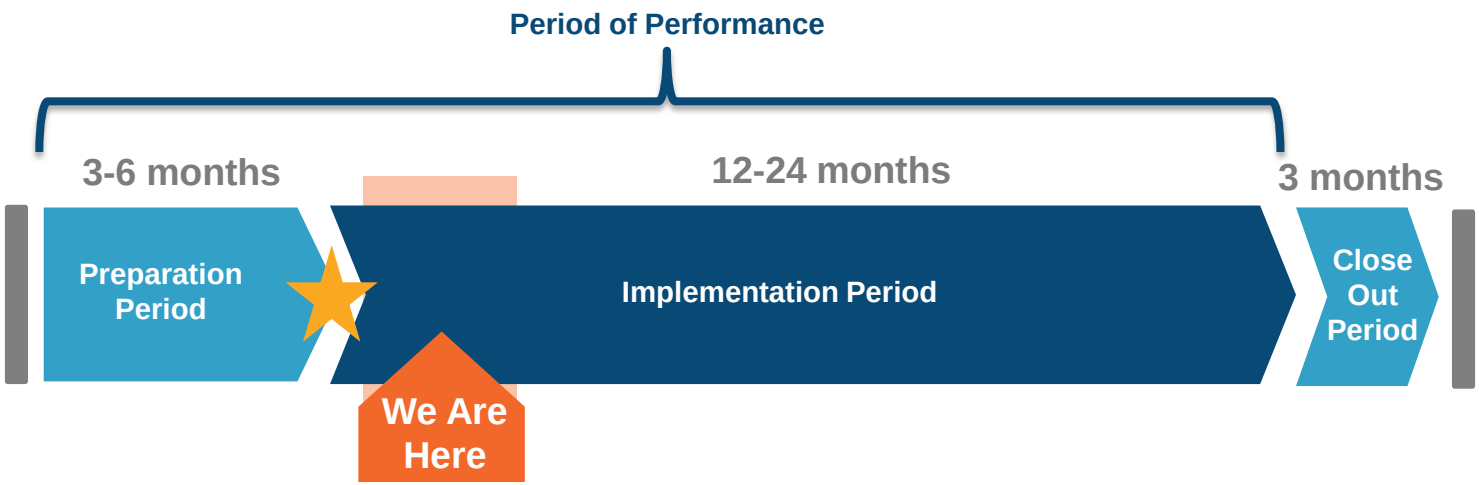
HCII Program Status Update



As of this month, all HCII Awardees are enrolling and serving their target populations, including:

- Homeless families affected by Substance Use Disorder
- Middle and high school students with behavioral health needs
- Substance exposed newborns and their mothers
- Patients with a life-limiting illness and comorbidities
- High utilizers of the ED with Social Determinants of Health needs

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Contact Information

For more information about the Health Policy Commission:

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