Cost Trends and Market Performance

Health Policy Commission

Committee Meeting

February 24, 2014

Agenda

- Approval of the minutes from the November 14, 2013 meeting
- Discussion of the projected economic growth benchmark for 2015
- Review of 2013 cost trends report and preliminary discussion of research agenda for 2014
- Discussion of statutory terms related to cost and market impact reviews (CMIR)
- Schedule of next committee meeting (April 2, 2014)

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Vote: Approving minutes

Motion: That the Cost Trends and Market Performance Committee hereby approves the minutes of the Committee meeting held on November 14, 2013, as presented.

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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

Legislation

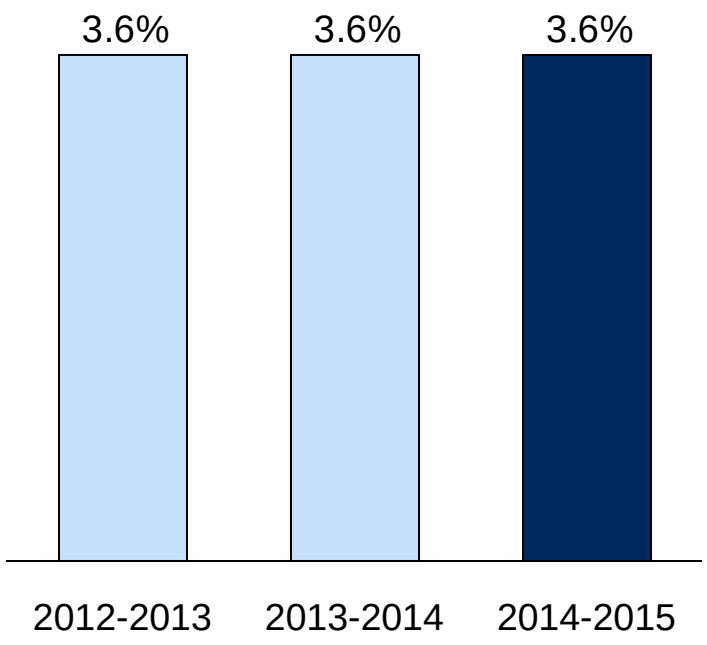
- Section 30(b) of Chapter 224 requires the Secretary of Administration and Finance and the House and Senate Ways and Means Committees to set a benchmark for potential gross state product (PGSP) growth
- The PGSP estimate is established as part of the state's existing consensus tax revenue forecast process and is to be included in a joint resolution due by January 15th of each year
- The PGSP estimate is used by the Health Policy Commission to establish the Commonwealth's health care cost growth benchmark

Process

- 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 members of the Health Policy Commission
- Consistent with existing practices:
  - Builds on Consensus Revenue process
  - Uses the same assumptions as other fiscal policy benchmarks (Long-Term Fiscal Policy Framework)
  - Developed with all stakeholders at the table

PGSP estimate for 2014-2015

Potential Gross State Product (PGSP)
Percent growth



- The 2014-2015 estimate of 3.6% is within a range of discussed by stakeholders
- Estimates were informed by standard methodologies (e.g. Congressional Budget Office) as well as legislative intent to target the long-run average growth rate of the Commonwealth's economy
- The range reflects a consensus around two key technical issues:
  - *Real growth*: How to account for under-investment in capital during the recession
  - *Inflation*: Agreement to use Fed's 2.0% target for the inflation assumption and monitor going forward

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Findings from the 2013 cost trends report (1/2)

- Per capita spending in Massachusetts is the **highest of any state** in the U.S., crowding out other priorities for consumers, businesses, and government
  - Over the past decade, Massachusetts health care spending has **grown much faster than the national average**, driven primarily by faster growth in commercial prices
  - Massachusetts residents continue to **use health care services at a higher rate** than the nation, especially in **hospital care and long-term care**, although the difference between Massachusetts and the U.S. average has been stable over the past decade

- While **spending growth in Massachusetts since 2009** has slowed in line with slower national growth, sustaining lower growth rates will **require concentrated effort**
  - Past periods of slow health care growth in Massachusetts, such as the 1990s, have been followed by **sustained periods of higher growth**
  - While observed growth rates for individual payers are low, the statewide growth rate is higher, **driven by enrollment shifts among payers** due to trends such as the aging of the population

Findings from the 2013 cost trends report (2/2)

Hospital operating expenses

- The operating expenses that hospitals incur for inpatient care **differ by thousands of dollars per discharge**, even after adjusting for regional wages and complexity of care provided
- Some hospitals deliver **high-quality care with lower operating expenses**, while many higher-expense hospitals achieve lower quality performance
- Hospitals able to negotiate **high commercial rates have high operating expenses** and cover losses they experience on public payer business with income from their higher commercial revenue, while hospitals with more limited revenue must maintain lower operating expenses

Wasteful spending

- In 2012, an estimated **$14.7 to $26.9 billion (21 to 39 percent)** of health care expenditures in Massachusetts are estimated to be wasteful, reflecting both clinical and structural opportunities
- There are **opportunities to reduce wasteful spending** in preventable hospital readmissions, unnecessary emergency department visits, health care-associated infections, early elective inductions, and unnecessary imaging for lower back pain

High-cost patients

- In 2010, five percent of patients accounted **for nearly half of all spending** among both the Medicare and commercial populations in Massachusetts
- Certain characteristics differed between high-cost patients and the rest of the population:
  - A number of **conditions occurred more often** among high-cost patients, and high-cost patients generally had more clinical conditions than the rest of the population
  - The **interaction of conditions increased spending** more than the individual condition contributions
  - There is **modest regional variation** in the concentration of high-cost patients
  - **Lower-income zip codes** have a higher concentration of high-cost patients
- Persistently high-cost patients – those who remain high-cost in consecutive years – represent **29 percent of high-cost patients** and 15 to 20 percent of total spending

2013 report conclusion and action steps

We find that there are significant opportunities in Massachusetts to enhance the value of health care, addressing cost and quality. We identify four primary areas of opportunity for improving the health care system in Massachusetts:

1. **Fostering a value-based market** in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options,
2. **Promoting an efficient, high-quality health care delivery system** in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status,
3. **Advancing alternative payment methods** that support and equitably reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases, and
4. **Enhancing transparency and data availability** necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time.

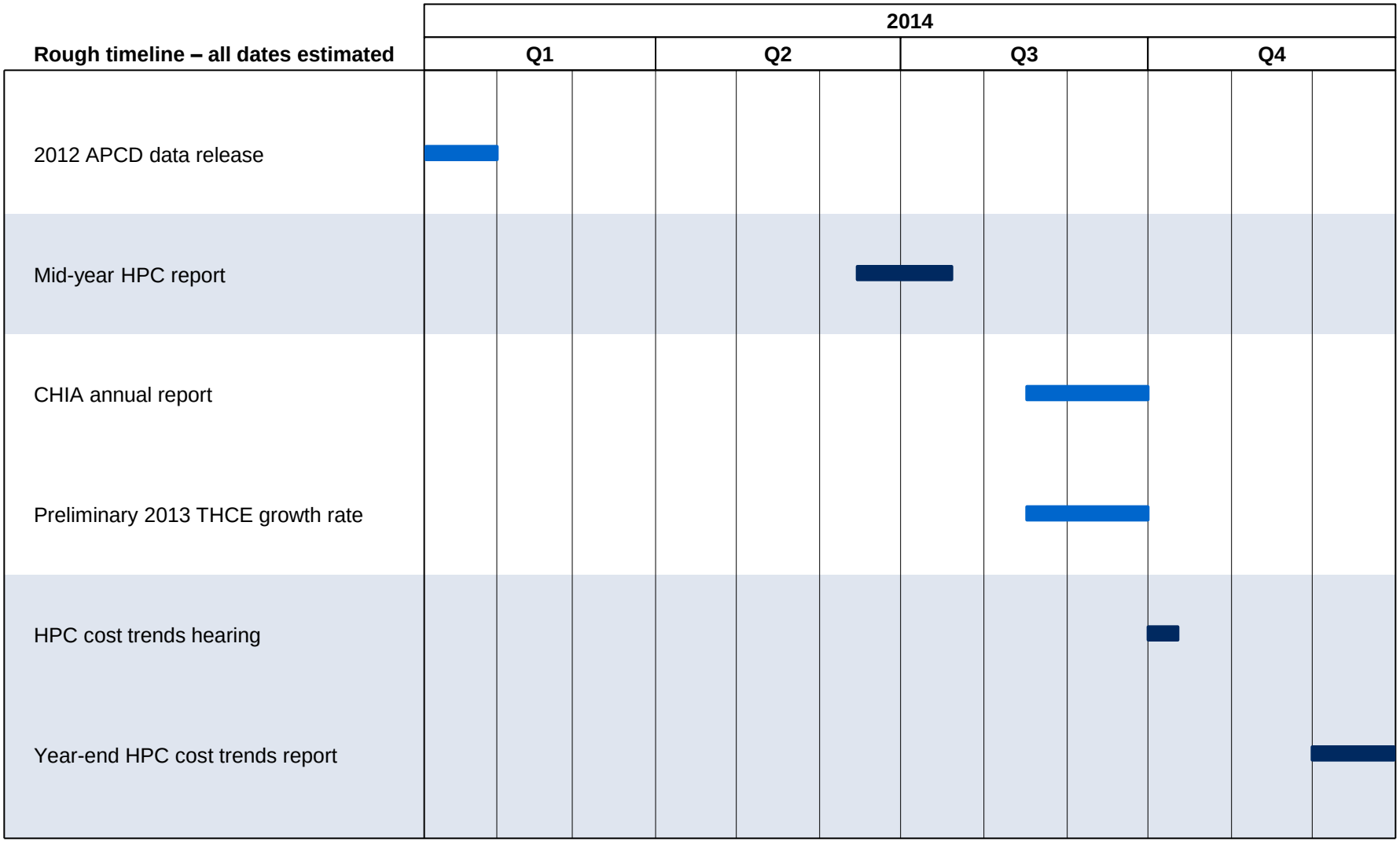
For discussion:

How can the Commonwealth follow up on these conclusions?

Preliminary 2014 research agenda extending from 2013 cost trends report

Basic profile	▪ Medicaid (payer) ▪ Long-term care and home health (service category) ▪ Behavioral health care (clinical area) ▪ Care for children (population segment) ▪ Disparities in access and care delivery ▪ Product design and trends
Hospital operating expenses	▪ Deepening analysis of particular areas of hospital expenses (e.g., capital expenses) ▪ Extending analysis to additional provider types
Wasteful spending	▪ Ongoing tracking of performance in reducing wasteful spending – Preventable readmissions – Unnecessary ED visits
High-cost patients	▪ Extending analysis to MassHealth population ▪ Identifying meaningful segments within high-cost patient population
Provider mix	▪ Profiling care provided in the Massachusetts market (discharges, episodes) ▪ Analysis of potential cost impact of provider mix changes for a common set of discharges and/or episodes

Timeline for 2014



Next steps

Goal: Support HPC's mission to develop evidence-based policy

- Solicit feedback from commissioners, committees, board, and advisory council
- Validate and analyze 2009-2012 APCD data
- Catalog other research to leverage the efforts and findings of other institutions, including:
  - Public institutions, including CHIA, MassHealth, GIC, DOI, DPH, and DMH
  - Chapter 224 commissions, including health planning council, public payer commission, and provider price variation commission
  - Private organizations, including academics, stakeholders, foundations, and research organizations

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  - Overview of Material Change Notice Regulations
  - Background and Purpose of Primary and Dispersed Service Areas
  - Primary Service Areas
  - Dispersed Service Areas
- Schedule of next committee meeting (April 2, 2014)

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Overview of Material Change Notice Regulations

- Interim Guidance issued March 12, 2013 currently governs the filing of material change notices.
- The HPC is required to define a number of terms by regulation: e.g., primary service areas, dispersed service areas, dominant market share, materially higher prices, materially higher health status adjusted total medical expenses.
- The HPC is tracking toward issuing regulations to codify these definitions and a final process for filing material change notices.

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Background and Purpose of Primary and Dispersed Service Areas

- The HPC is required to define “Primary Service Areas” and “Dispersed Service Areas” through regulation.
- “Primary Service Area” and “Dispersed Service Area” are metrics by which the HPC may evaluate Material Change Notices, and serve as the geographic area in which cost, quality, and access factors are evaluated.
- Service areas are well-vetted and established in economic literature as important tools for evaluating market effects.

Statutory Background

Section 13(d) of Chapter 6D of the General Laws

Cost and market impact reviews may examine factors including, but not limited to:

"(i) the provider or provider organization's size and market share within its ***primary service areas*** by major service category, and within its ***dispersed service areas***… (vi) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider or provider organization within its ***primary service areas*** and ***dispersed service areas***; (vii) the provider or provider organization's impact on competing options for the delivery of health care services within its ***primary service areas*** and ***dispersed service areas*** including, if applicable, the impact on existing service providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to enter a ***primary or dispersed service area*** in which it did not previously operate… (ix) the role of the provider or provider organization in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its ***primary service areas*** and ***dispersed service areas***; (x) the role of the provider or provider organization in providing low margin or negative margin services within its ***primary service areas*** and ***dispersed service areas***…"

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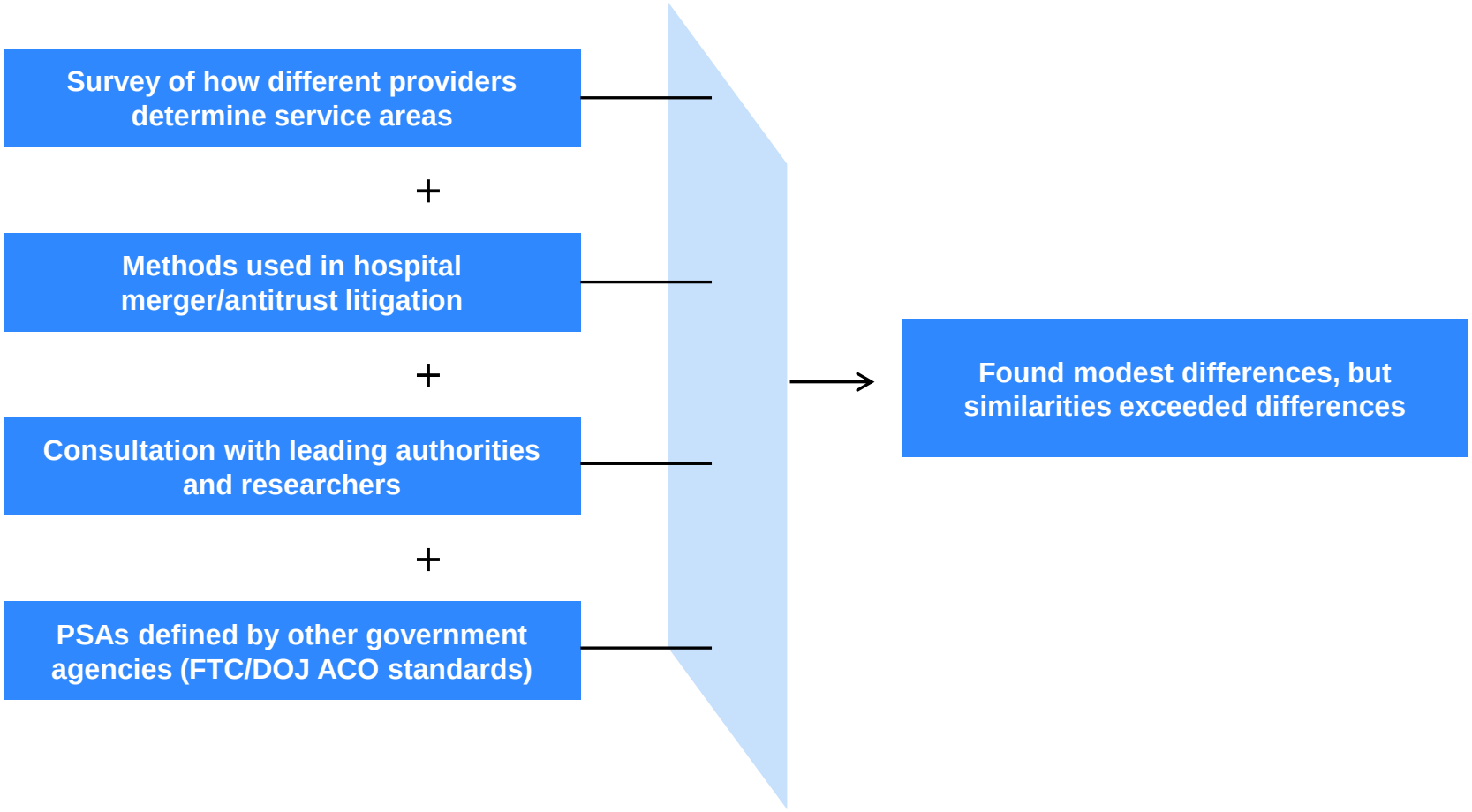
Consideration of Hospital PSA Options



Approach to Modeling Hospital PSAs in Massachusetts

PSA Common Themes

- All methods reviewed sought to identify a compact, contiguous area that is responsible for a significant proportion of the hospital's discharges.
- All methods measured the volume of discharges from zip codes or towns.
- Most methods resulted in a PSA comprising 75% of a hospital's discharges (e.g., DOJ/FTC ACO standards, methods used by market participants).
- Some methods explicitly considered geographic proximity (e.g., drive time).

Principles for an HPC PSA

- PSAs should be contiguous or nearly so.
- PSAs should primarily comprise zip codes that send a nontrivial fraction of their patients to the focal hospital.
- PSAs should account for a consistent, significant proportion of the focal hospital's patients (75%).

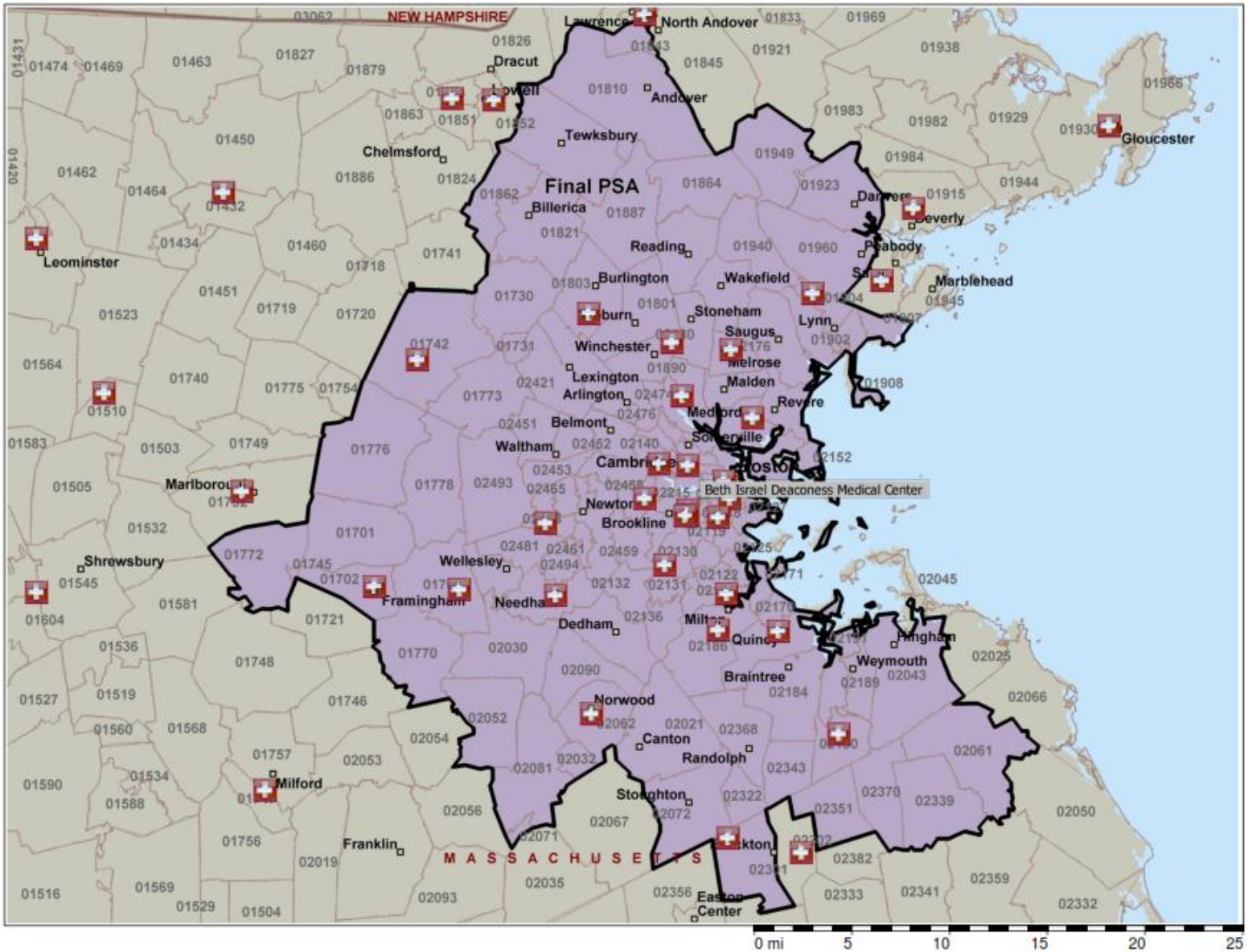
HPC Approach and Results

- Modeled multiple approaches reflecting these principles.
- Modeled across different types of hospitals (e.g., tertiary, secondary, urban, rural, high volume, low volume).
- The HPC's proposed methodology yields coherent results across different hospital types.
- The HPC's proposed methodology yields more consistently reliable results across the spectrum of Massachusetts hospitals than other methods that may be in use to define the service area of a single hospital.

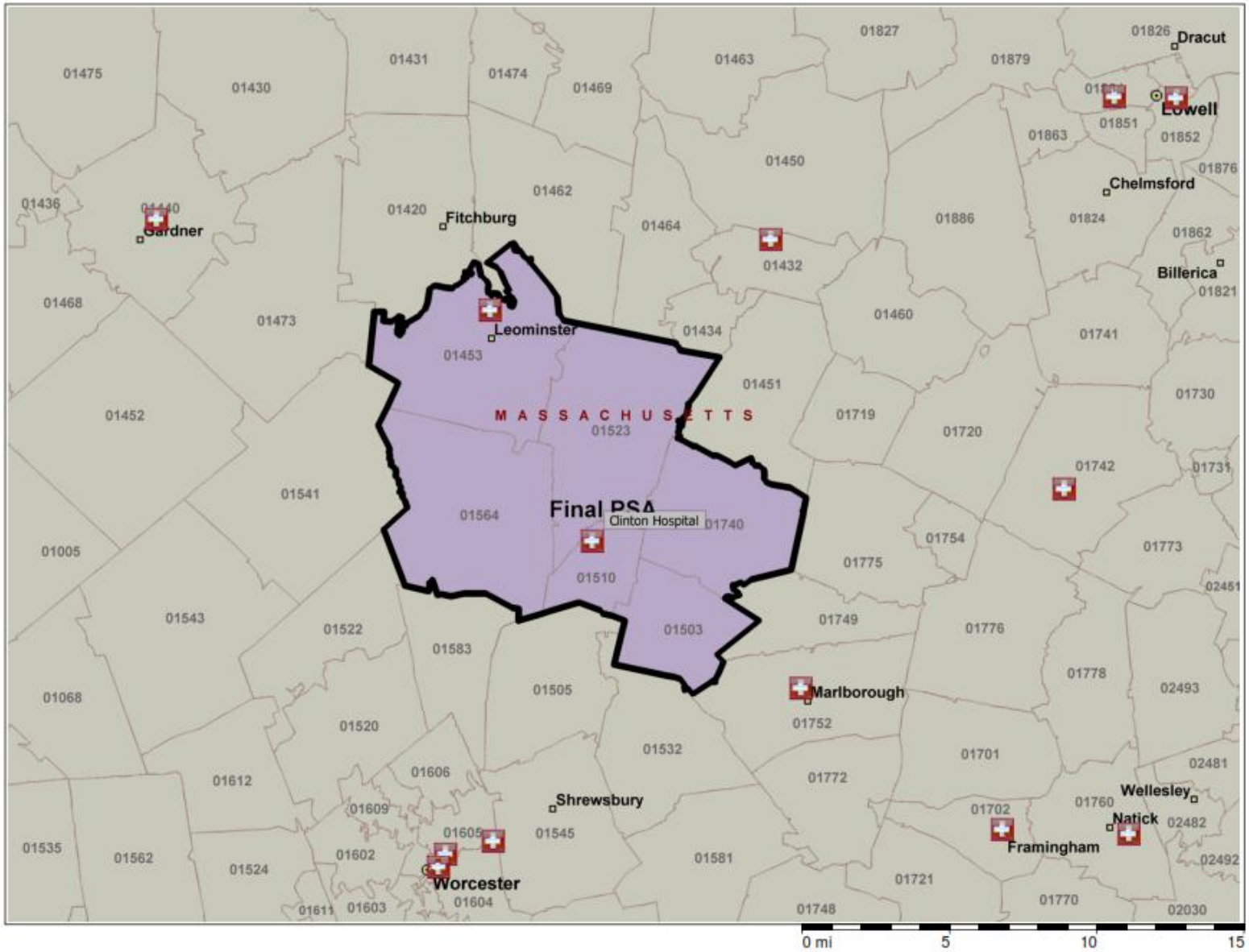
Recommended Hospital PSA Methodology

- Order zip codes based on drive time from the focal hospital.
- Starting with the closest zip codes, count the commercial discharges from each zip code until 75% of the hospital's commercial discharges are included.
- Correct for over-inclusion/under-inclusion to ensure that the PSA is a compact, contiguous area that represents an area for which the hospital is important (e.g., remove border zip codes where under 1% of the zip code's total discharges are from that hospital).
- In a full CMIR, make any necessary fact-specific adjustments to the PSA, and consider how the parties define their own primary service area.

HPC PSA Example: Urban Academic Medical Center (BIDMC)



HPC PSA Example: Lower-Volume Community Hospital (Clinton)

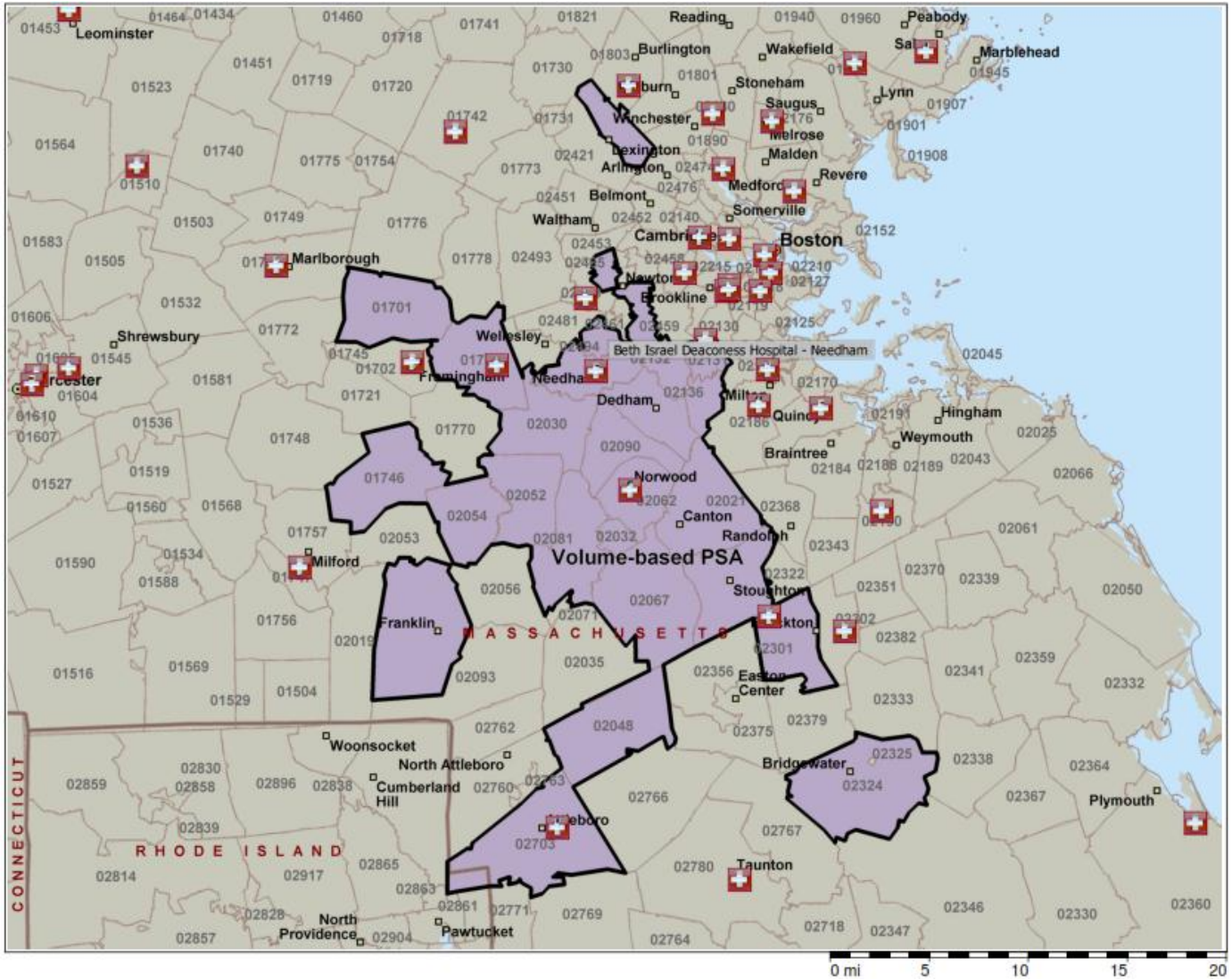


Other Approaches Do Not Work Consistently Well

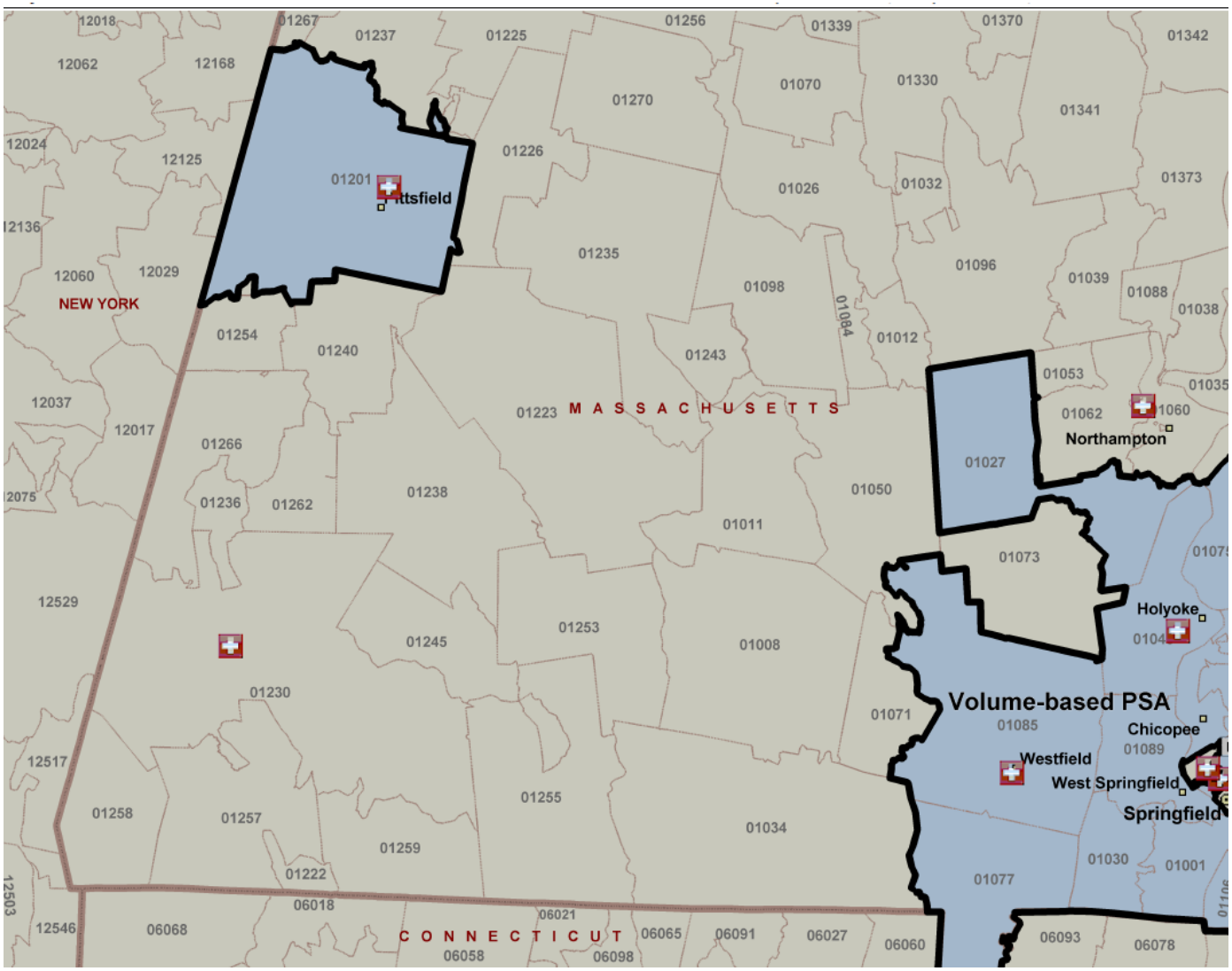
- Developing a PSA based only on volume of discharges from a zip code (and ignoring drive time) results in PSAs that are often non-contiguous.

- Developing a PSA based solely on those zip codes that contribute a certain proportion of the hospital's discharges (e.g., 1% or more) can result in a disproportionately small service area for certain hospitals.
  - For example, for high-volume hospitals, focusing only on zip codes that contribute at least 1% of the hospital's discharges can result in a PSA accounting for fewer than 30% of the hospital's discharges.

Example of Inconsistent Result: Strictly Volume-Based PSA (Needham)



Example of Inconsistent Result: Strictly % Contribution PSA (Baystate)



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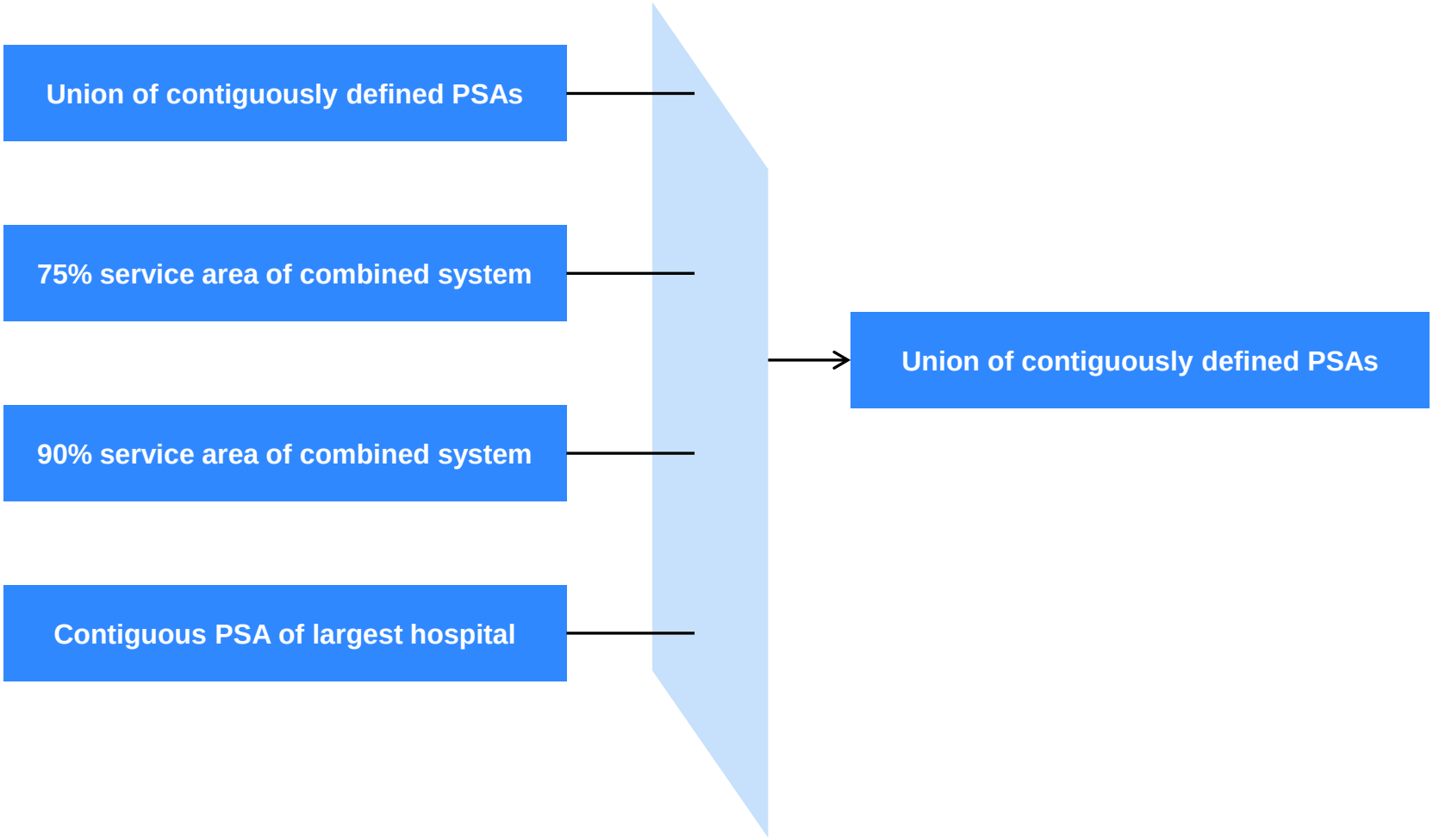
Why Do We Need Both Dispersed and Primary Service Areas?

- “Cross-market” linkages

- DSAs can provide insight into:
  - The factors purchasers/employers consider when choosing health plans
  - Health plan pricing
  - Provider mix issues

Options for DSAs for Multi-Hospital Systems

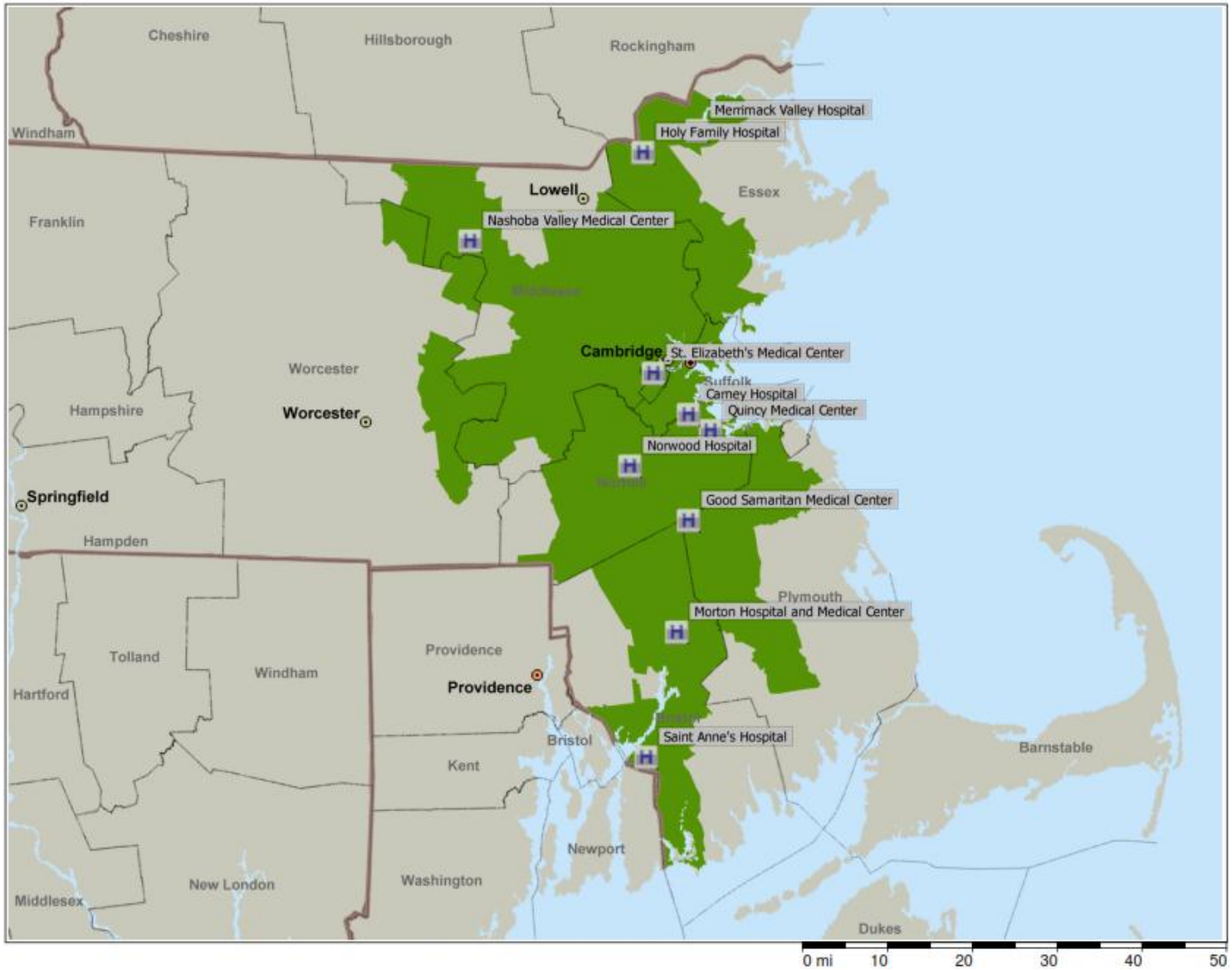


Potential Approach for Multi-Hospital System DSAs

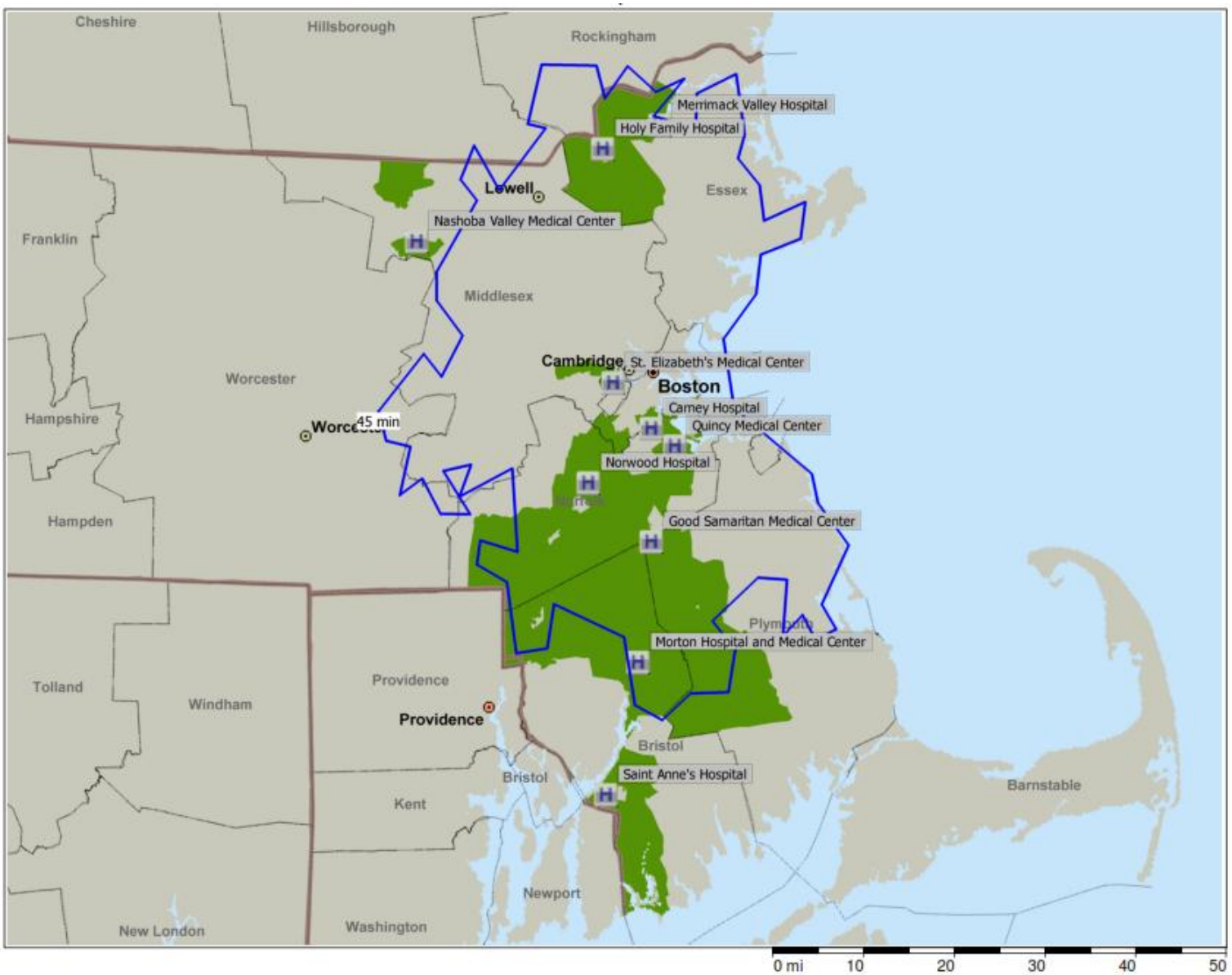
- For each hospital in the focal system, calculate a primary service area using the HPC's PSA methodology.
- Combine the resulting PSAs.*
- In a full CMIR, make any necessary fact-specific adjustments to the PSAs, and examine how the parties define the service area of their respective systems.

* Note that this will not necessarily result in a contiguous DSA.

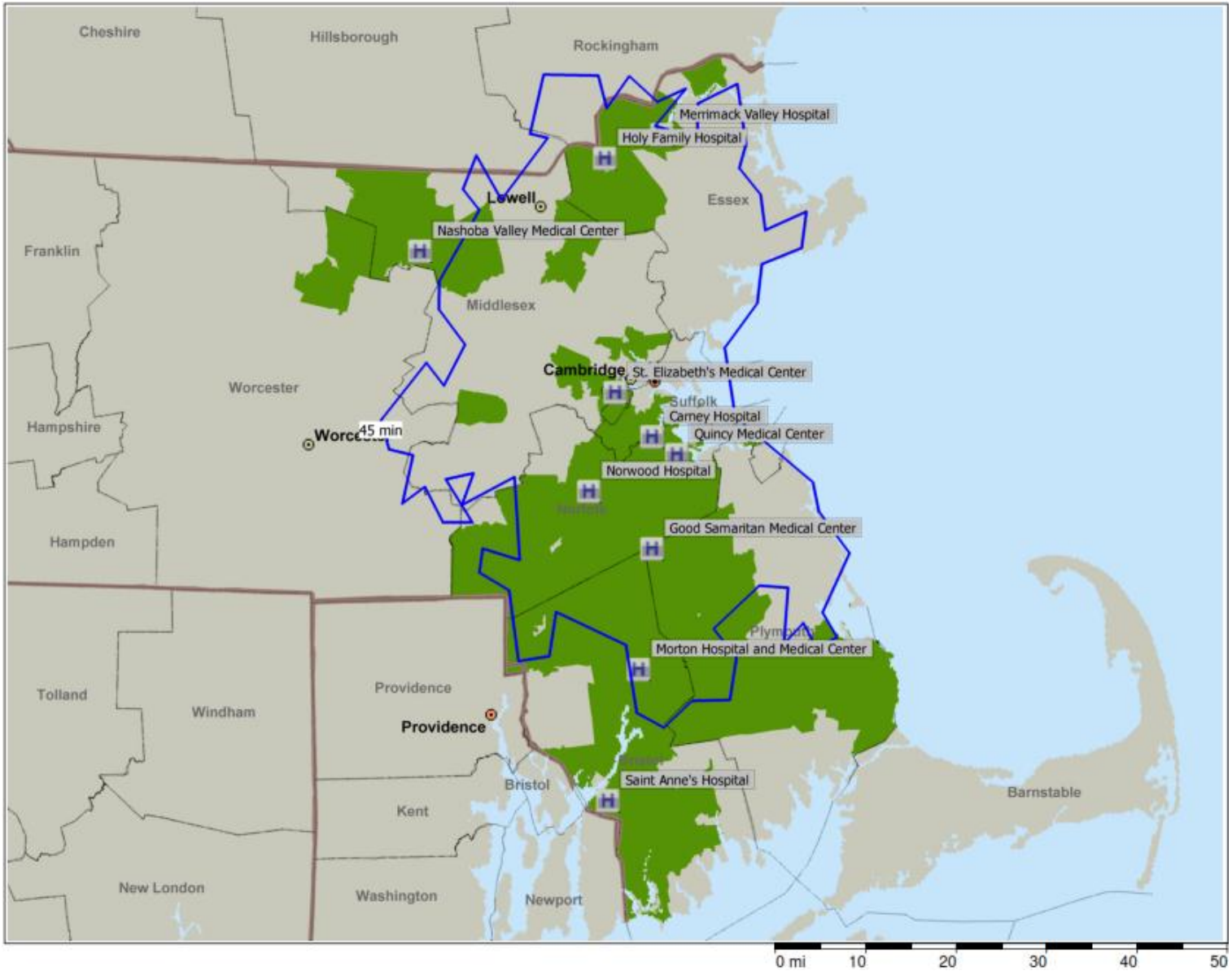
Favored DSA Approach: Union of PSAs (Steward)



Disfavored Approach: 75% System Service Area (Steward)



Disfavored Approach: 90% System Service Area (Steward)



Next Steps

- Modeling definitions for other statutory terms (materially higher price and total medical expenses, dominant market share) (Winter 2014)
- Working closely with experts and stakeholders (ongoing)
- Proposing regulations, which will be subject to the full regulatory process, including opportunities for stakeholder feedback through a public hearing and written comments (Spring - Summer 2014)

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Contact us

For more information about the Health Policy Commission:

- Visit us: http://www.mass.gov/hpc
- Follow us: @Mass_HPC
- E-mail us: HPC-Info@state.ma.us