MASSACHUSETTS
HEALTH POLICY COMMISSION

October 2, 2017

Annual Health Care

COST TRENDS HEARING

OCTOBER 2 & 3, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Presentation by CHIA
and the HPC

Annual Health Care

COST TRENDS HEARING

OCTOBER 2 & 3, 2017

CENTER FOR HEALTH INFORMATION AND ANALYSIS

PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

ANNUAL REPORT
SEPTEMBER 2017

CHIA.

2016
THCE
Growth

Cost Drivers

MAJOR TOPICS

APM Adoption

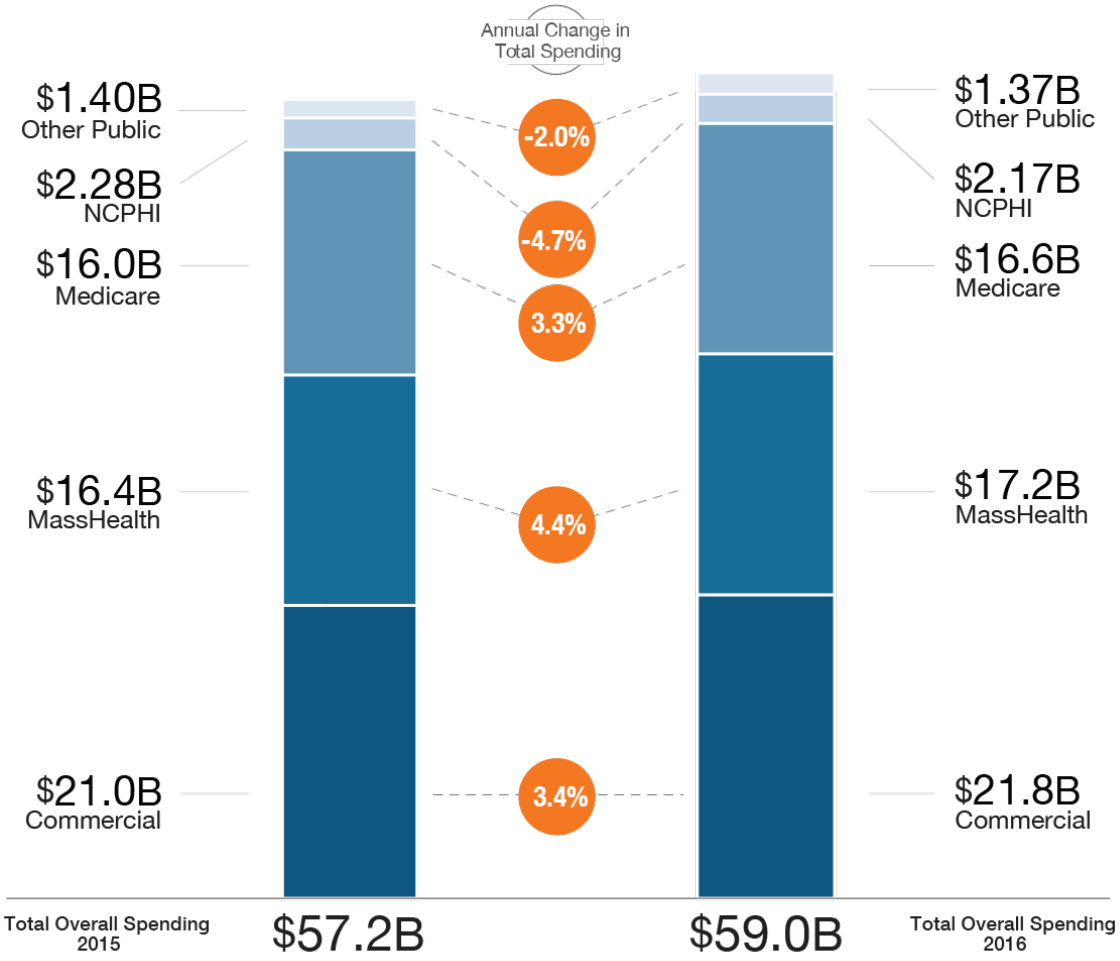
Cost of Coverage

Member
Cost-Sharing

Hospital
Readmits

CHIA.

Components of Total Health Care Expenditures by Insurance Category, 2015-2016



2016 THCE Growth

2.8%

Percent Change per capita from 2015-2016

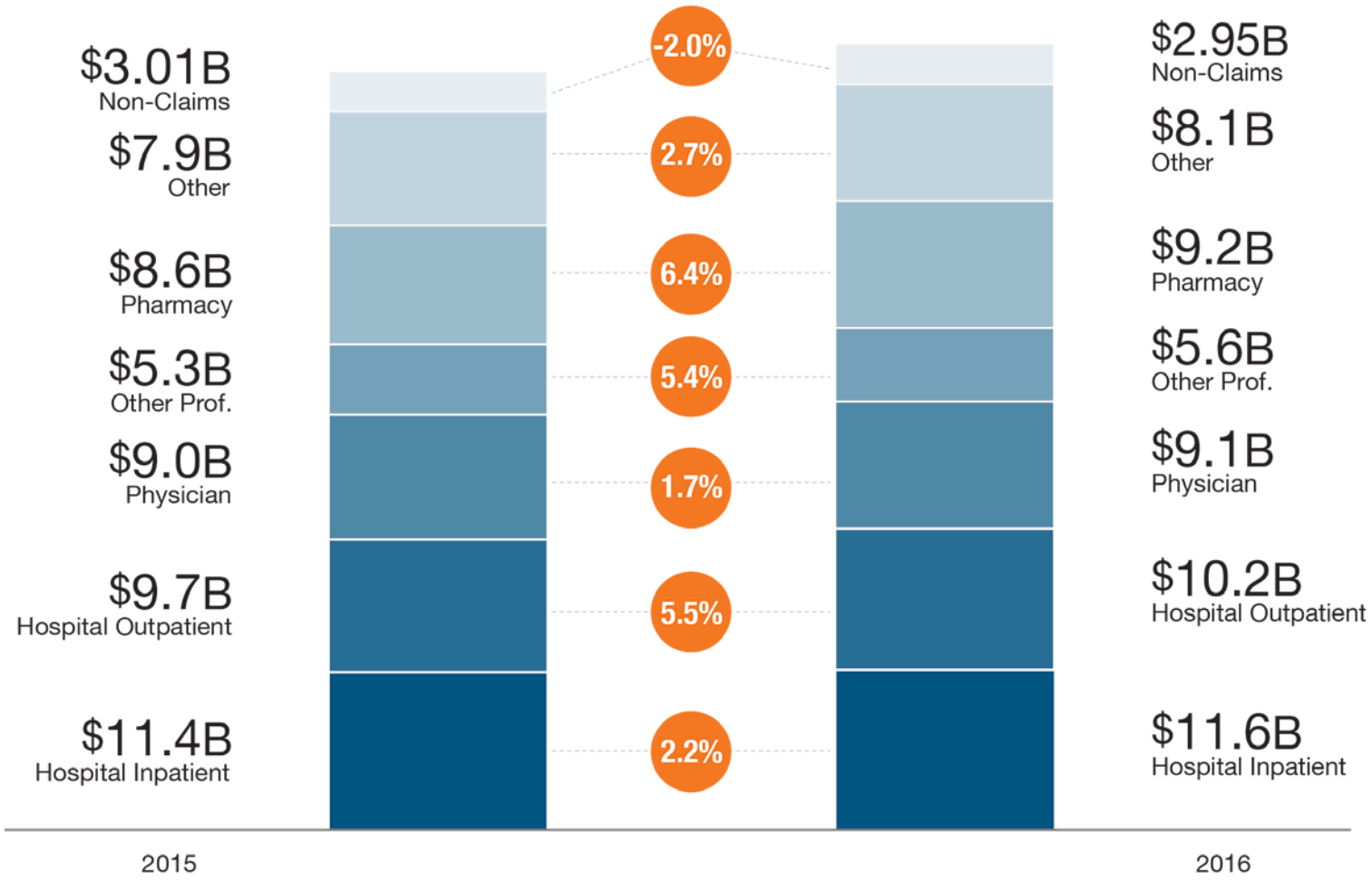
$8,663

THCE per capita

OVERALL SPENDING INCREASED ACROSS ALL MAJOR INSURANCE CATEGORIES, BUT DECLINED FOR THE NET COST OF PRIVATE HEALTH INSURANCE.

CHIA.

Health Care Expenditures by Service Category, 2015-2016

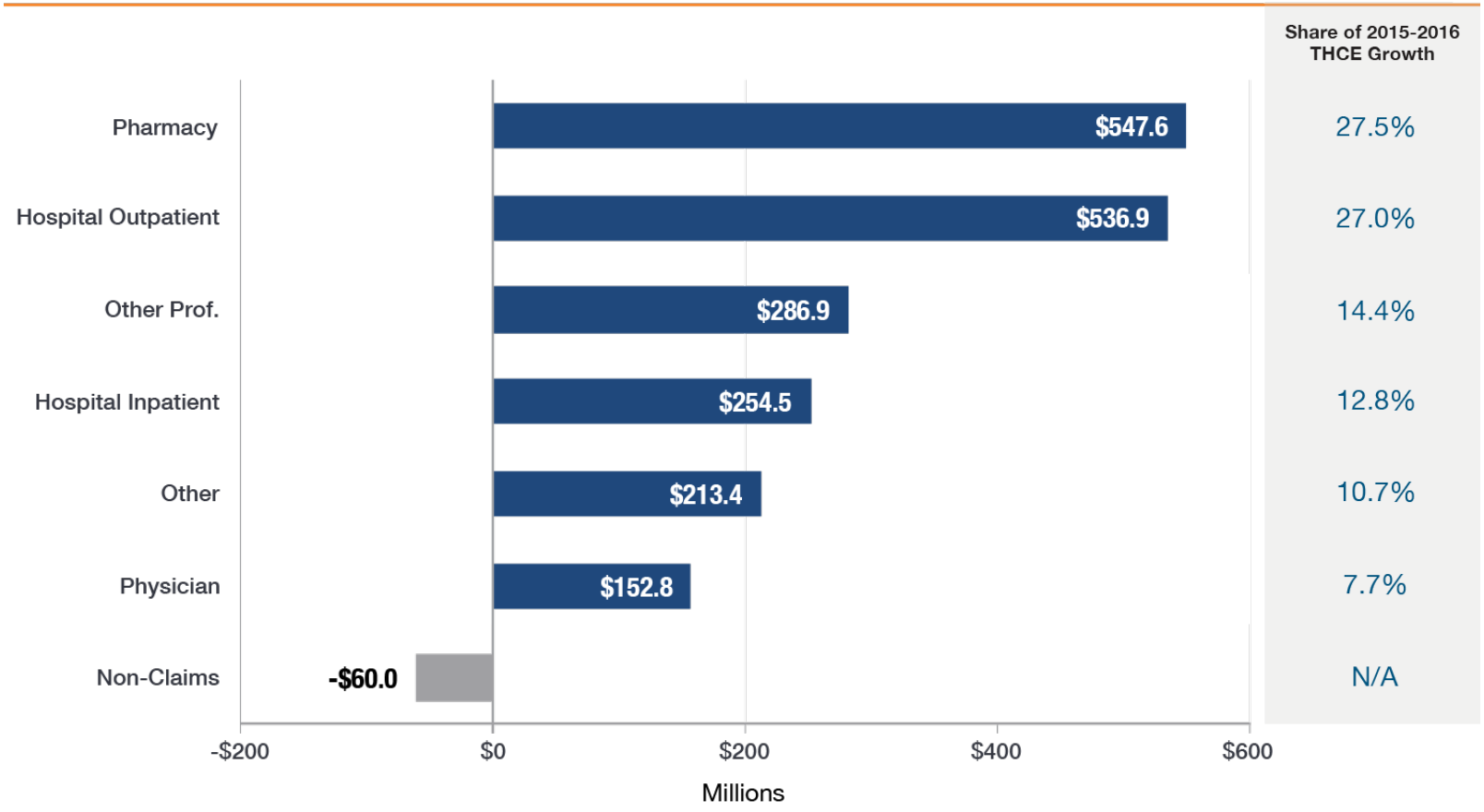


2016 THCE Growth

HEALTH CARE SPENDING INCREASED IN ALL CLAIMS-BASED SERVICE CATEGORIES, WITH PHARMACY BEING THE LARGEST AT 6.4%.

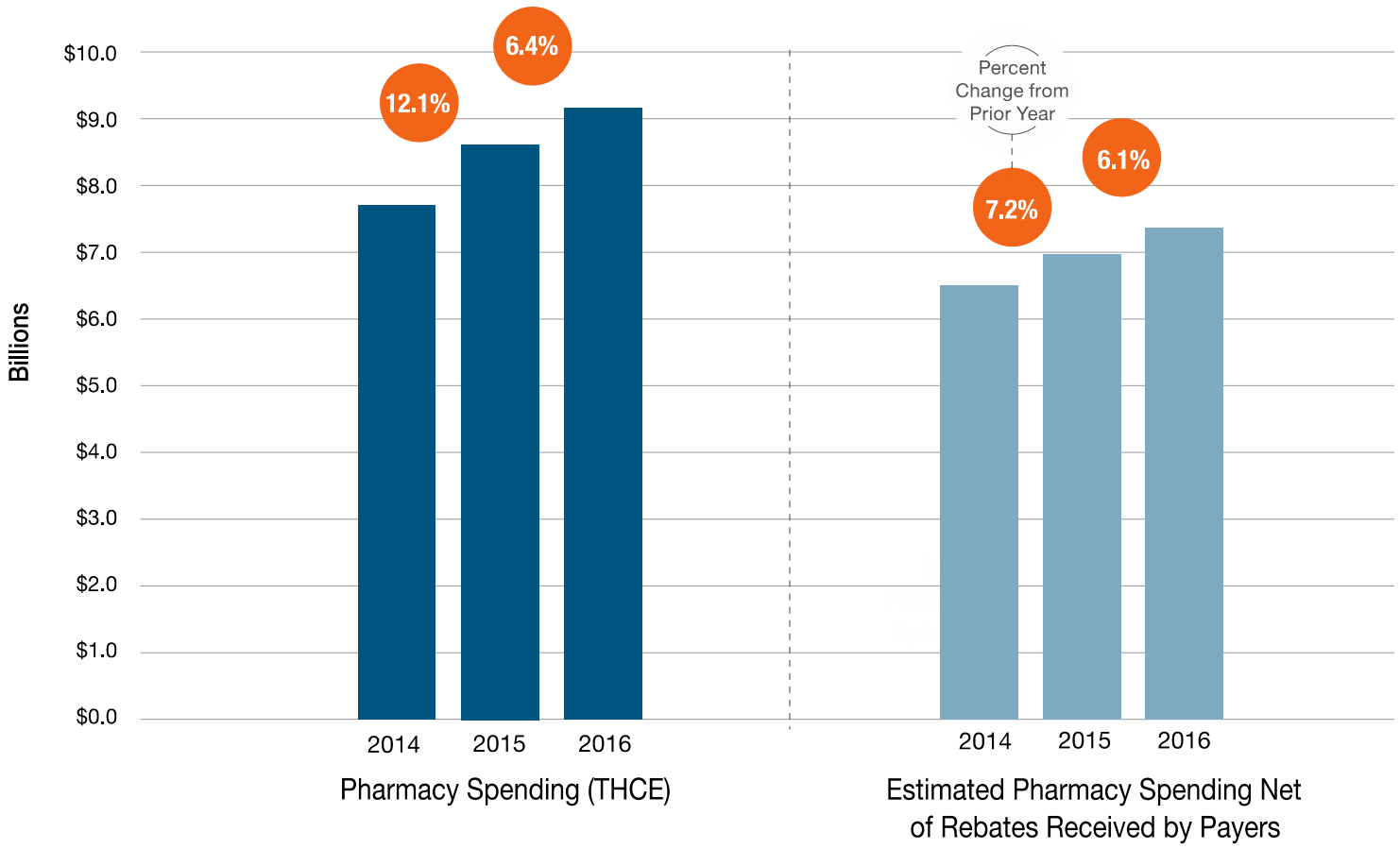
CHIA.

Change in Health Care Expenditures by Service Category, 2015-2016



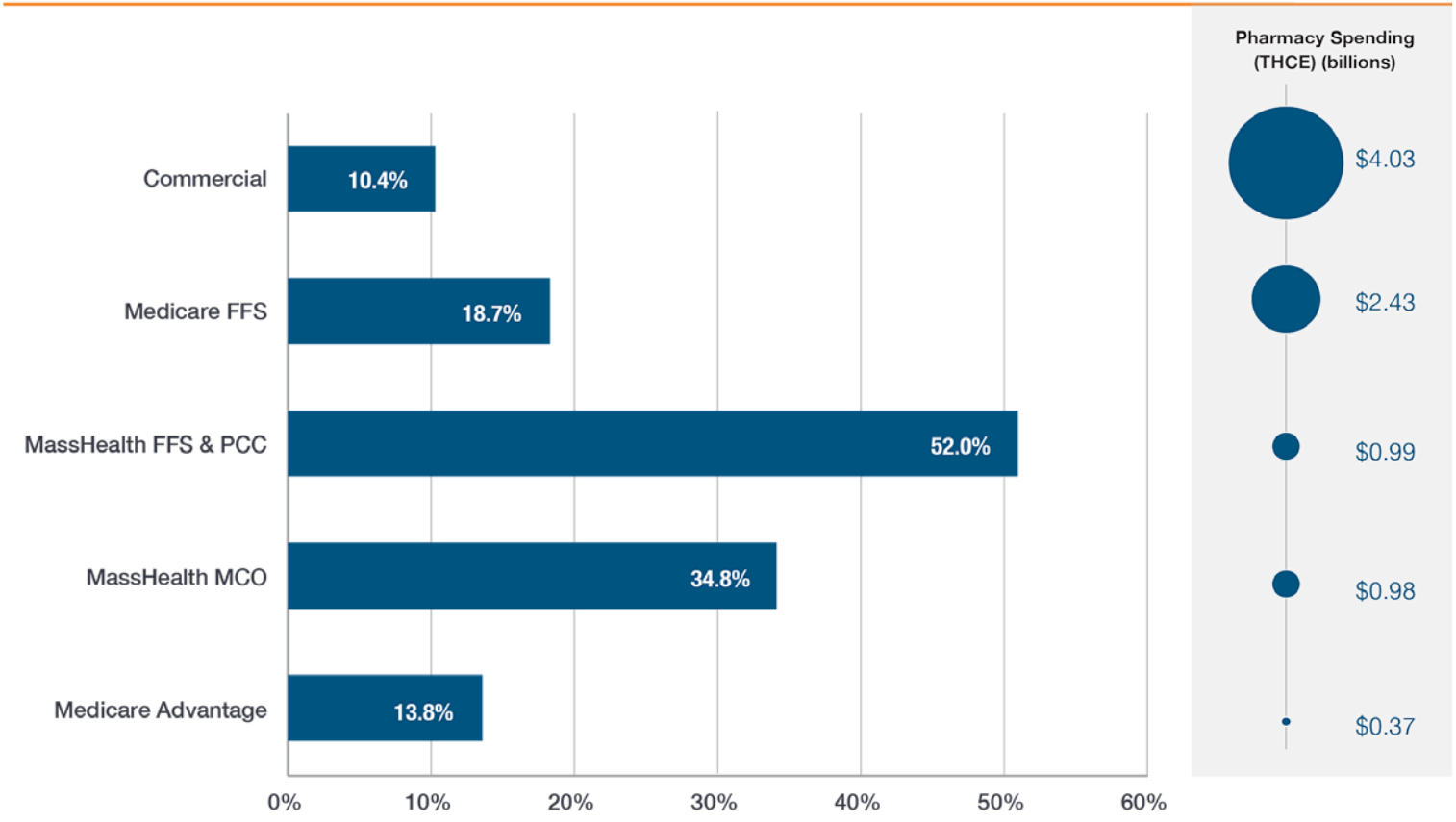
INCREASES IN PHARMACY AND HOSPITAL OUTPATIENT SPENDING WERE THE LARGEST DRIVERS OF THCE GROWTH BETWEEN 2015 AND 2016.

Estimated Impact of Rebates on Pharmacy Spending and Growth, 2014-2016



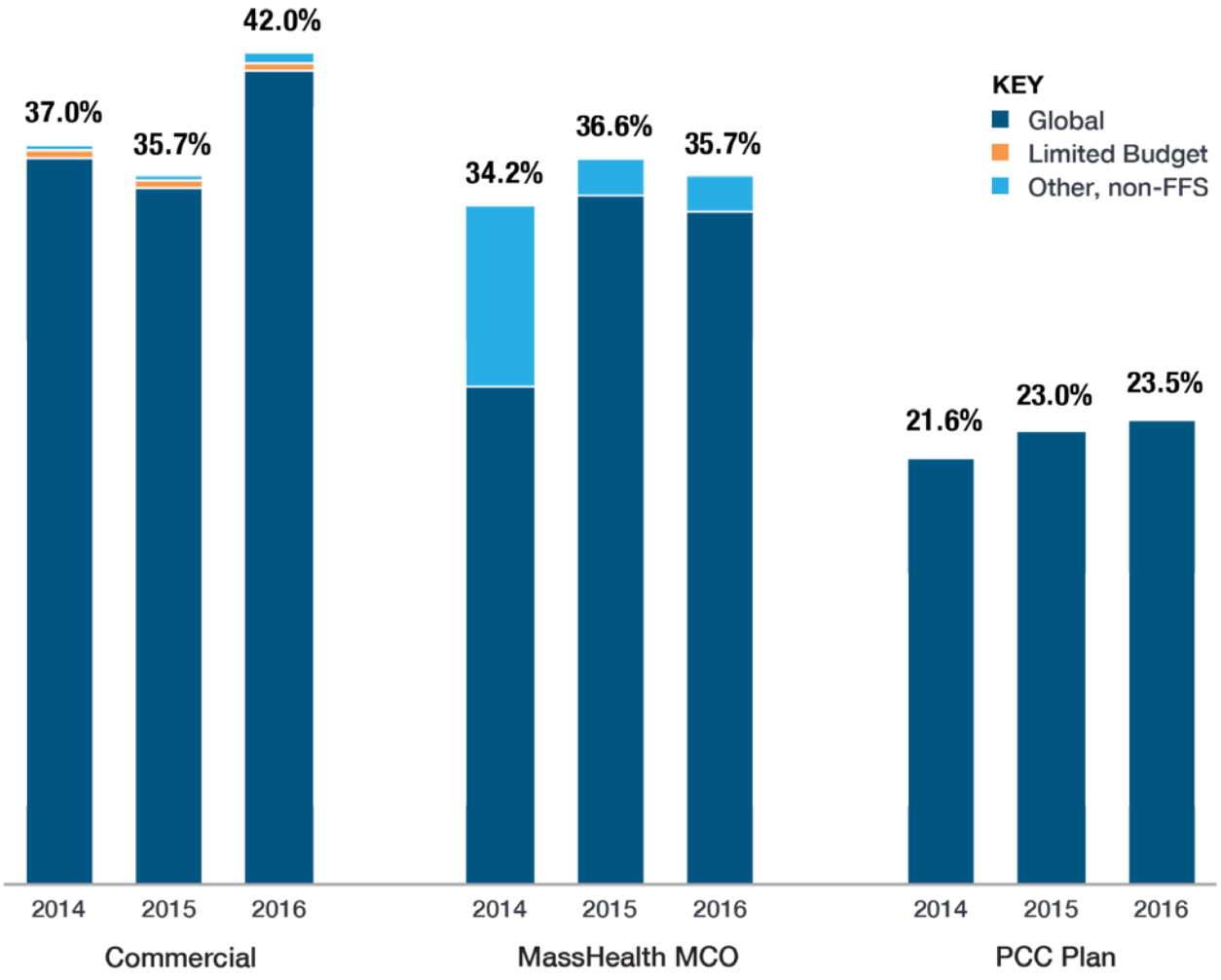
FROM 2015 TO 2016, PAYER PAYMENTS FOR PRESCRIPTION DRUGS GREW BY 6.4% IN THCE. ESTIMATED REBATES TO PAYERS WOULD REDUCE THIS RATE TO 6.1%.

Estimated Drug Rebate Proportion of Pharmacy Spending by Insurance Category, 2016



PHARMACY REBATES VARIED ACROSS INSURANCE CATEGORIES, FROM 10.4% IN THE COMMERCIAL MARKET TO 52.0% IN MEDICAID FFS AND PCC.

Adoption of Alternative Payment Methods by Insurance Category, 2014-2016

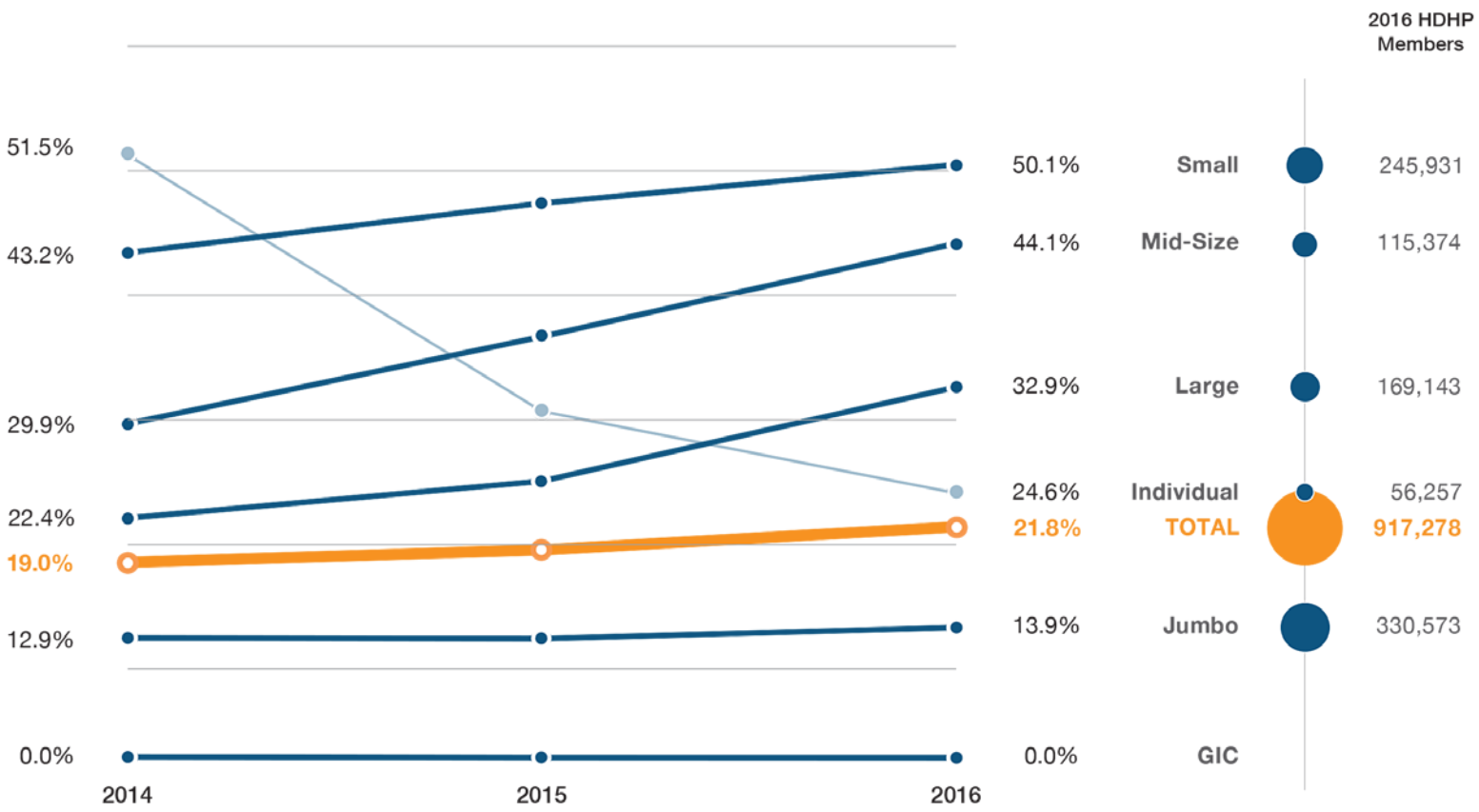


ADOPTION OF APMS INCREASED BY 6.3 PERCENTAGE POINTS IN THE COMMERCIAL MARKET IN 2016.

Fully-Insured Premiums by Employer Size, 2016

INDIVIDUAL PURCHASERS WERE THE ONLY GROUP TO SEE THEIR PREMIUMS DECLINE IN 2016, DUE LARGELY TO MEMBERSHIP SHIFTS TOWARD CONNECTORCARE PLANS.

High Deductible Health Plan Prevalence by Employer Size, 2014-2016

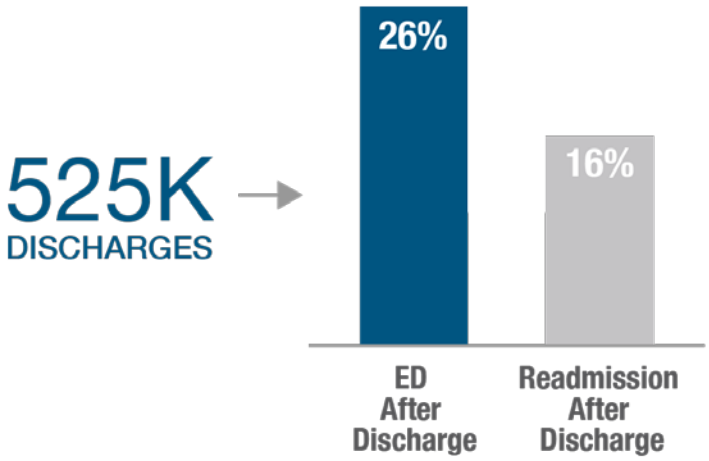


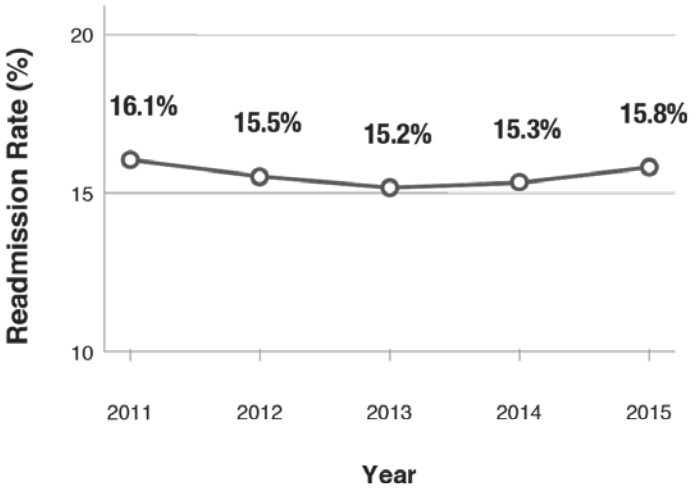
HIGH DEDUCTIBLE PLANS WERE MOST PREVALENT AMONG SMALL AND MID-SIZE EMPLOYERS, IN TERMS OF BOTH THE ABSOLUTE NUMBER AND PERCENTAGE OF MEMBERS.

Cost-Sharing by Employer Size, 2016

MEMBER COST-SHARING CONTINUED TO BE HIGHER AMONG SMALLER EMPLOYERS IN 2016. SUBSIDIES HELPED DECREASE COST-SHARING FOR INDIVIDUAL PURCHASERS.

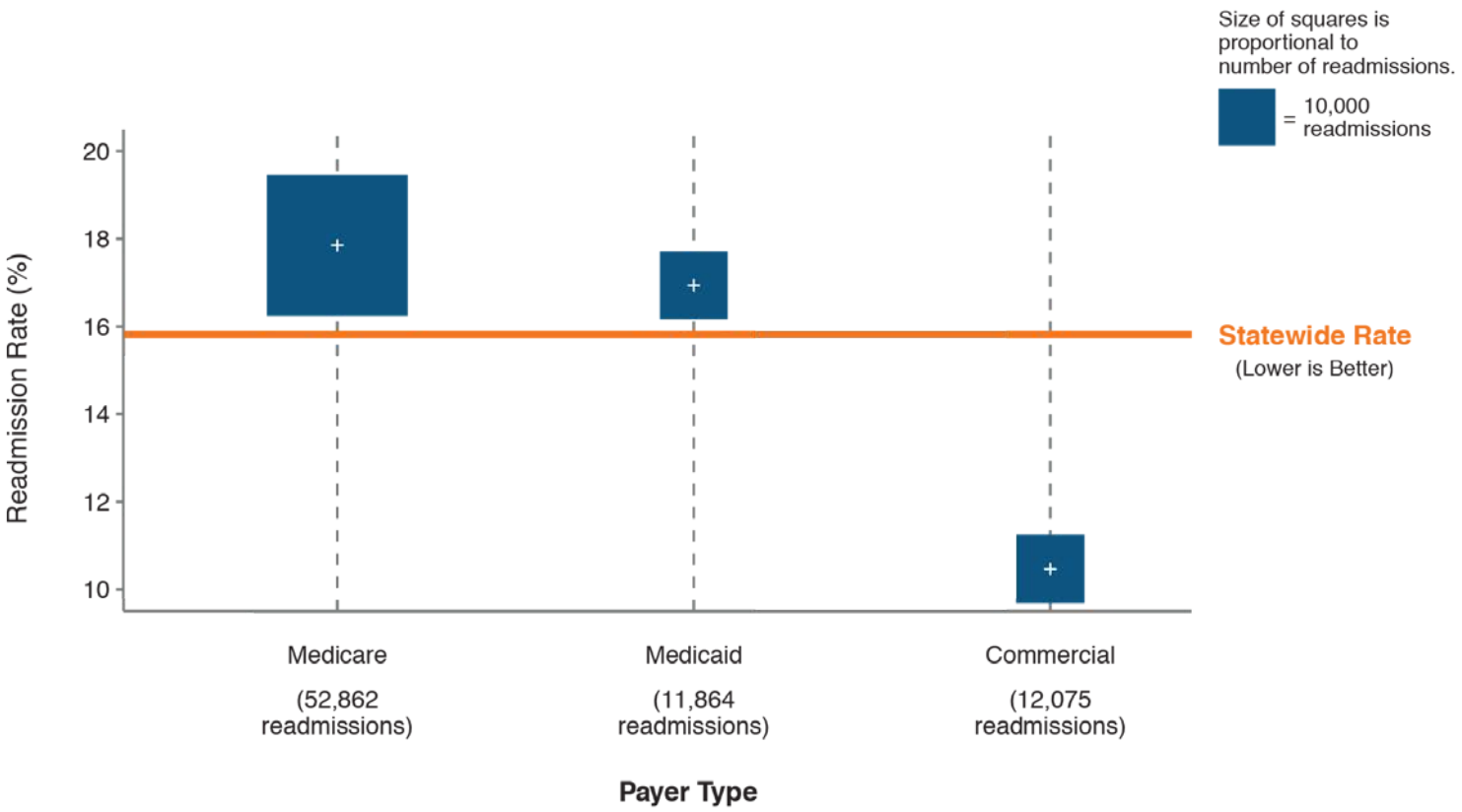
All-payer 30-day Revisits and Readmissions, SFY15





IN SFY15, 26% OF DISCHARGES ENDED UP BACK IN THE ED WITHIN 30 DAYS. 16% WERE READMITTED TO THE HOSPITAL; AN INCREASE AFTER SEVERAL YEARS OF DECLINES.

All-Payer Readmissions by Payer Type, SFY15



READMISSION RATES FOR MEDICARE (18%) AND MEDICAID (17%) WERE SUBSTANTIALLY HIGHER THAN FOR COMMERCIAL PAYERS (11%).

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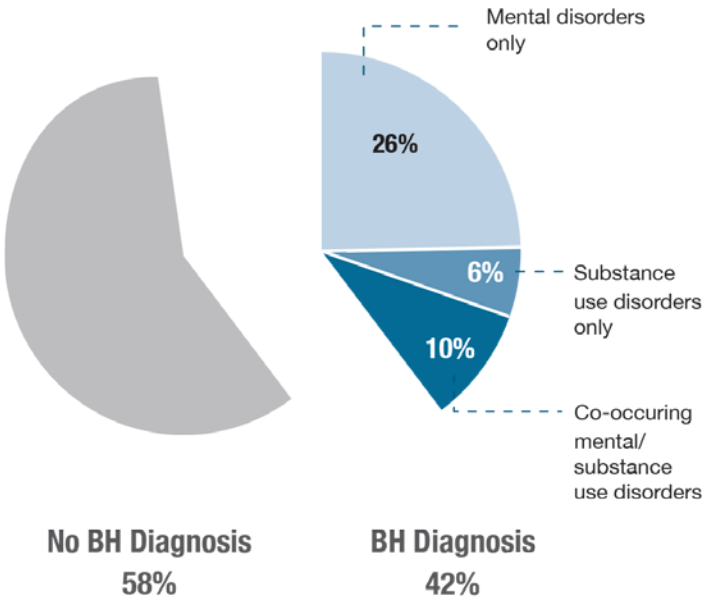
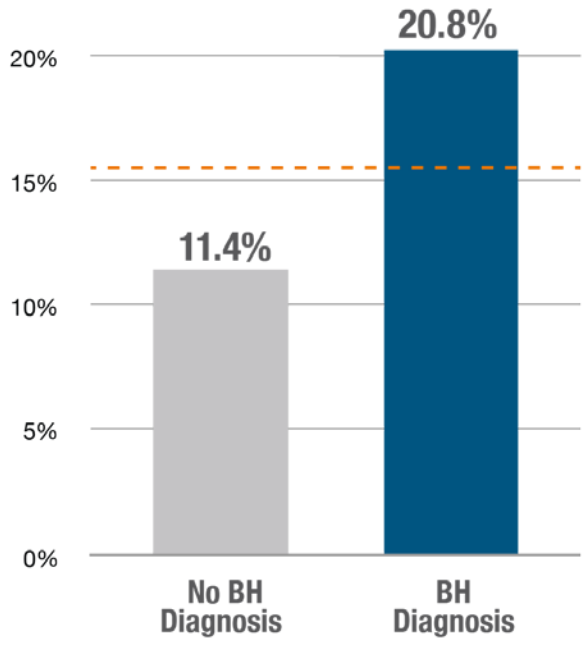
Behavioral Health Comorbidities and Readmissions, SFY15



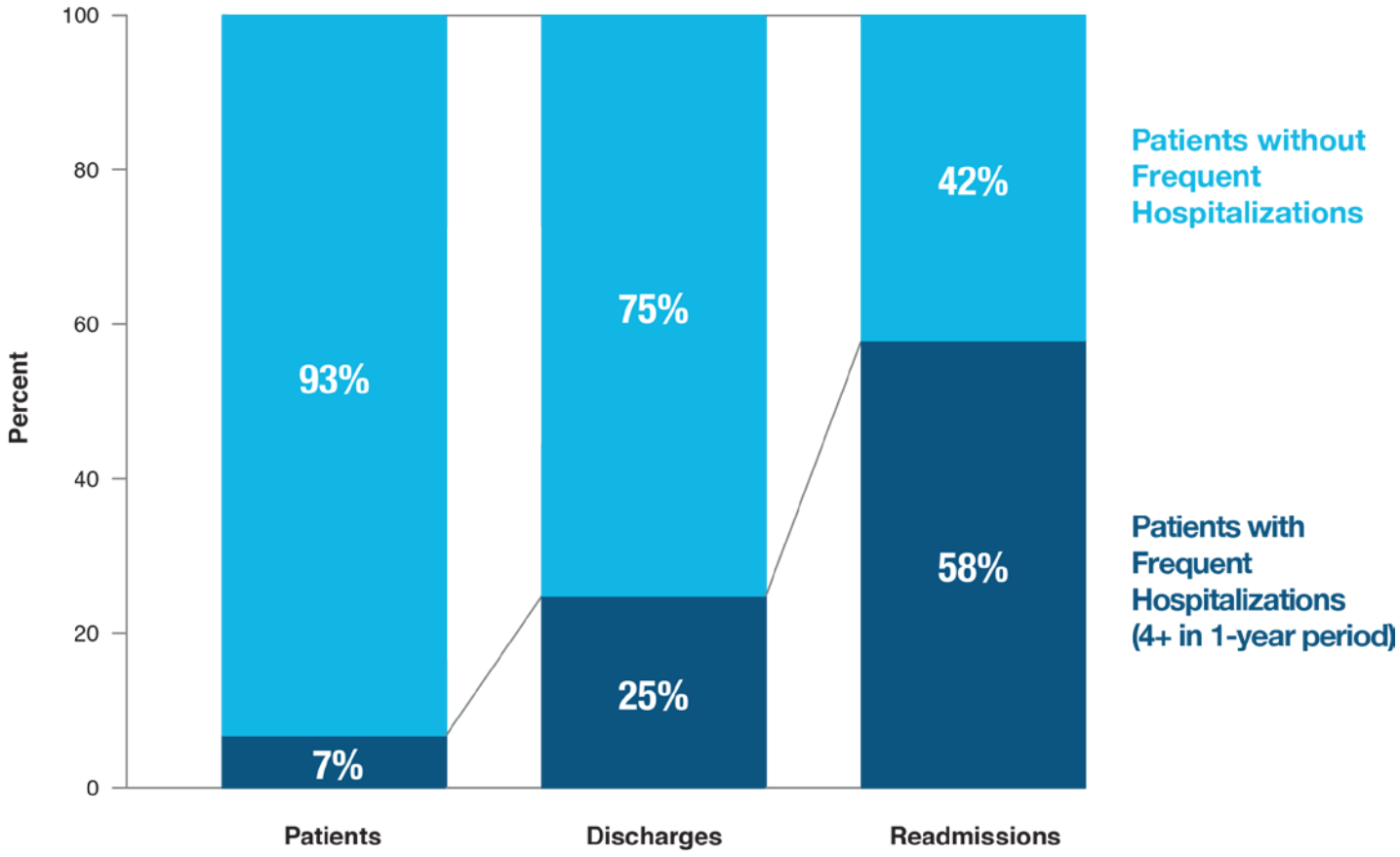
Percent of Patients



Percent of Readmissions

THE 42% OF PATIENTS WITH A BEHAVIORAL HEALTH COMORBIDITY HAD A READMISSION RATE OF 20.8%, ALMOST TWICE THAT OF THOSE WITHOUT A BEHAVIORAL HEALTH DIAGNOSIS.

All-Payer Readmissions among Frequently Hospitalized Patients, SFY 2013-2015



THE 7% OF PATIENTS WITH FREQUENT HOSPITALIZATIONS ACCOUNTED FOR 25% OF DISCHARGES AND 58% OF READMISSIONS.

CHIA.

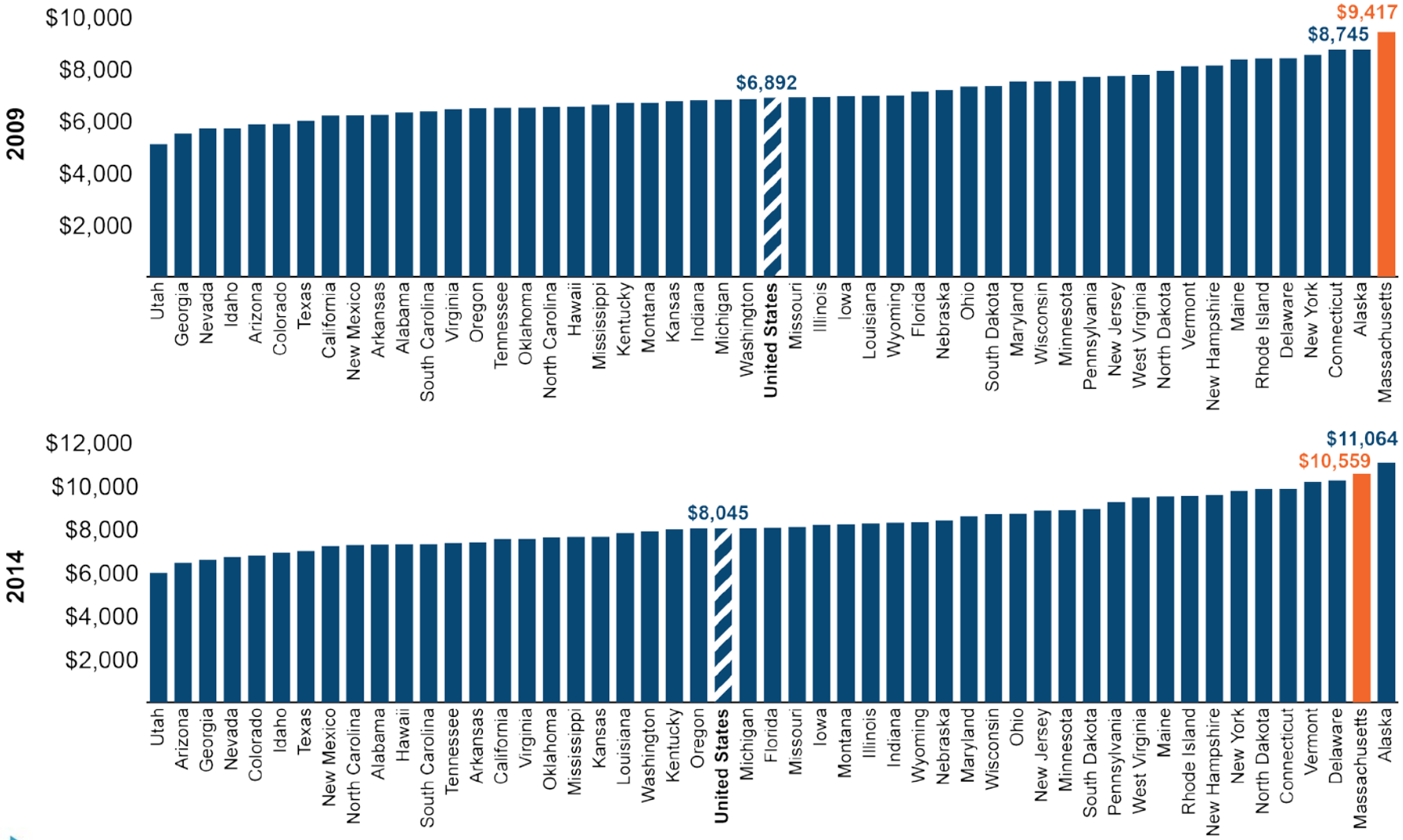
MASSACHUSETTS
HEALTH POLICY COMMISSION

Massachusetts health care cost trends in a national context

David Auerbach, PhD
Director of Research
Massachusetts Health Policy Commission
October 2, 2017

Massachusetts no longer spends the most on health care

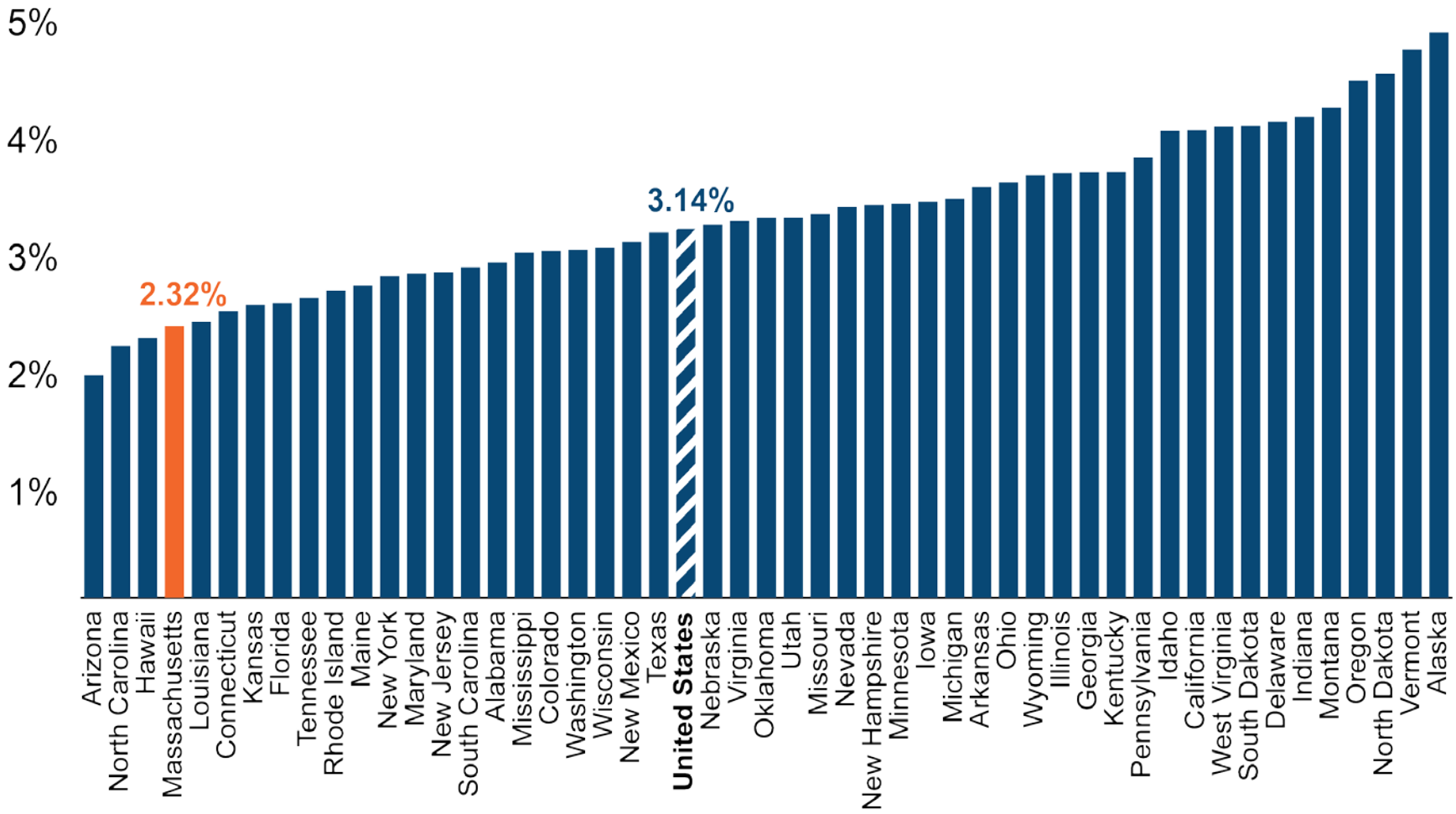
Personal health care spending, per capita, by state, 2009 and 2014



Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

Massachusetts healthcare spending grew at the 4th lowest rate in the US from 2009-2014

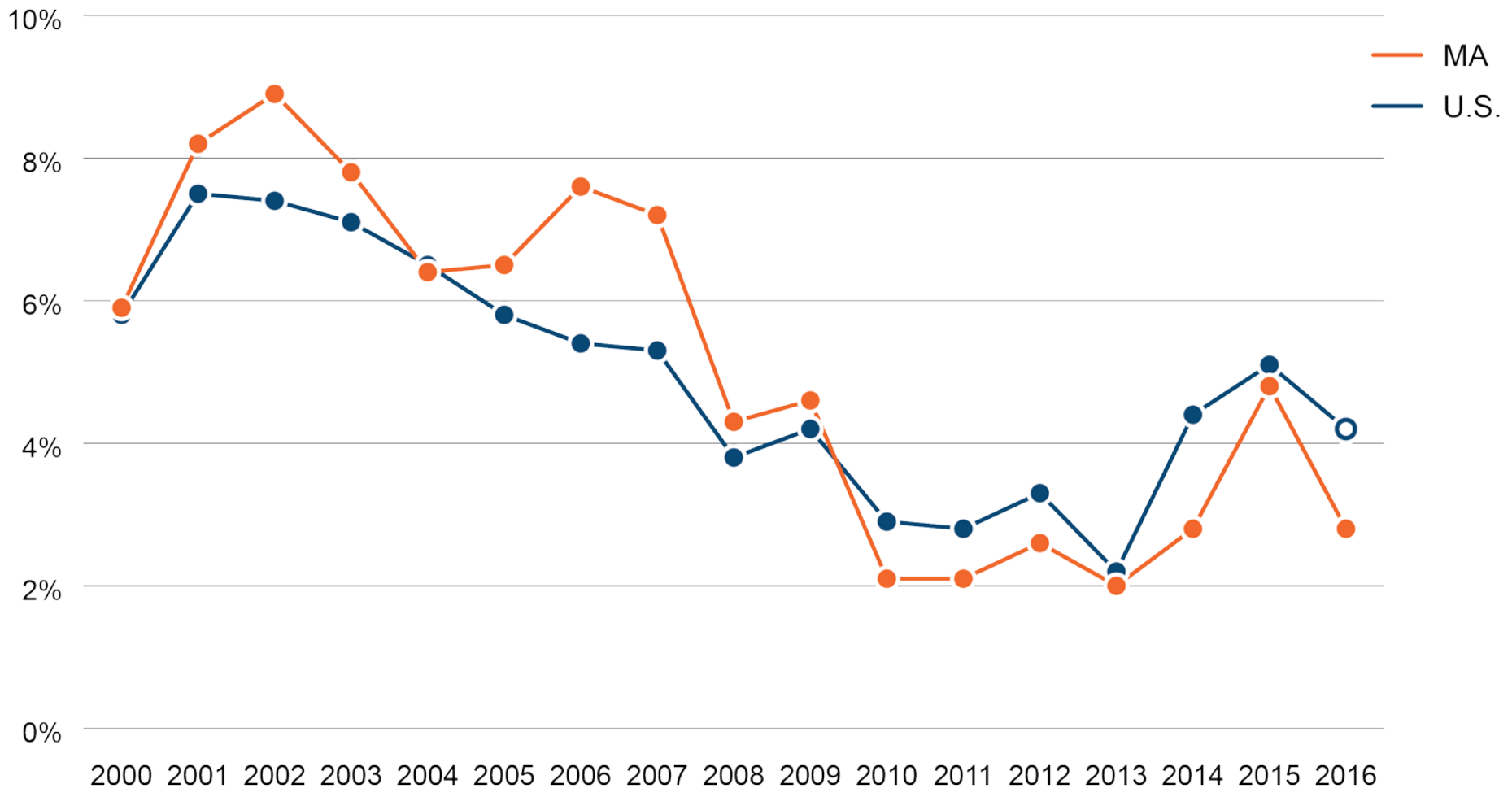
Average annual healthcare spending growth rate, per capita, 2009-2014



Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

Healthcare spending growth continued to be below the U.S. average in 2015 and 2016

Annual growth in per capita healthcare spending, MA and the U.S., 2000-2016

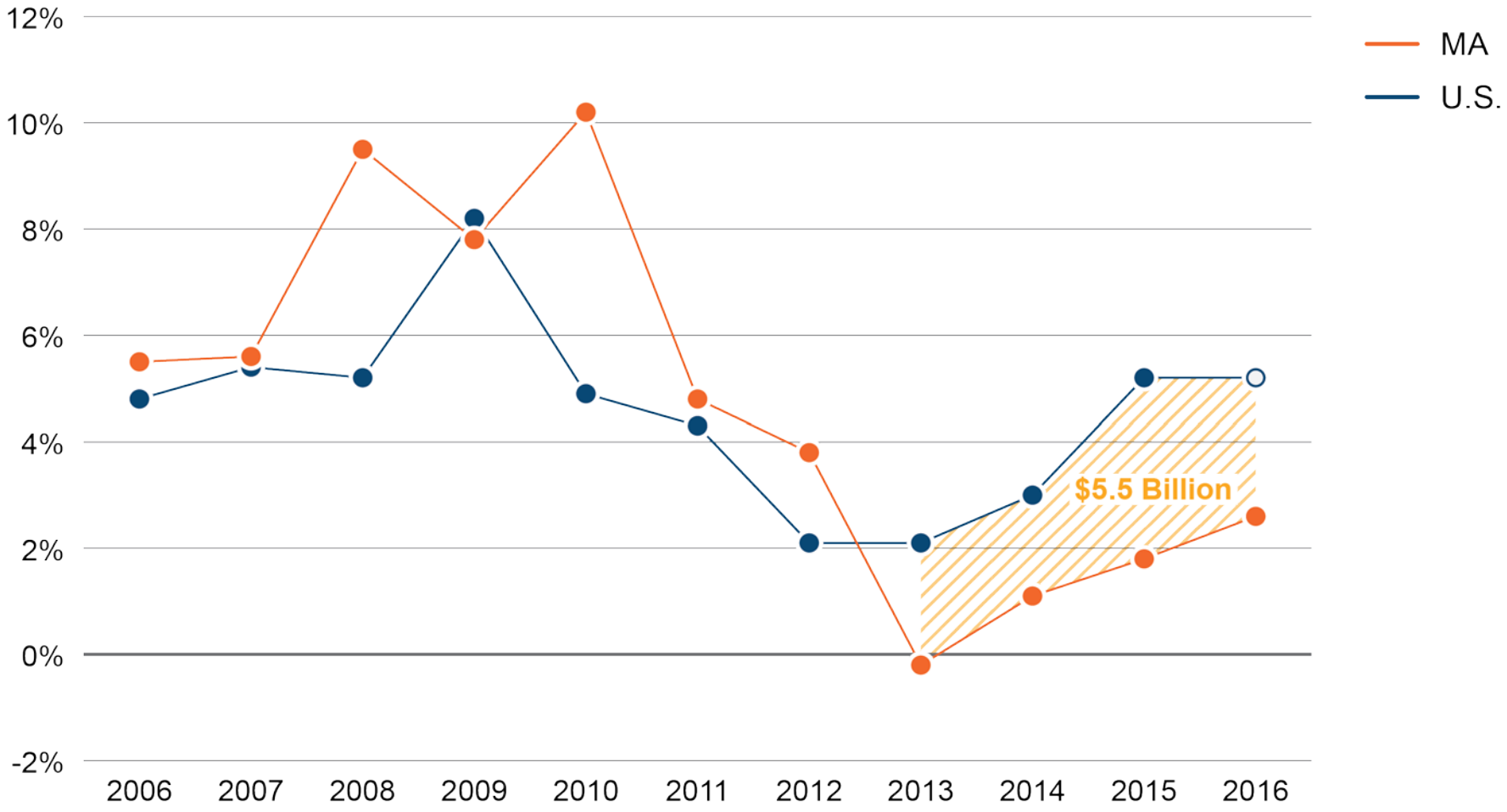


Note: U.S. figure for 2016 is partially projected.

Sources: Centers for Medicare and Medicaid Services, National Health Expenditure Accounts Personal Health Care Expenditures (U.S. 2015-2016) and State Health Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); Center for Health Information and Analysis Annual Report THCE Databook (MA 2015-2016)

In recent years, growth in spending on private health insurance in Massachusetts has been consistently lower than national rates

Annual growth in commercial health insurance premium spending from previous year, per enrollee, MA and the U.S.

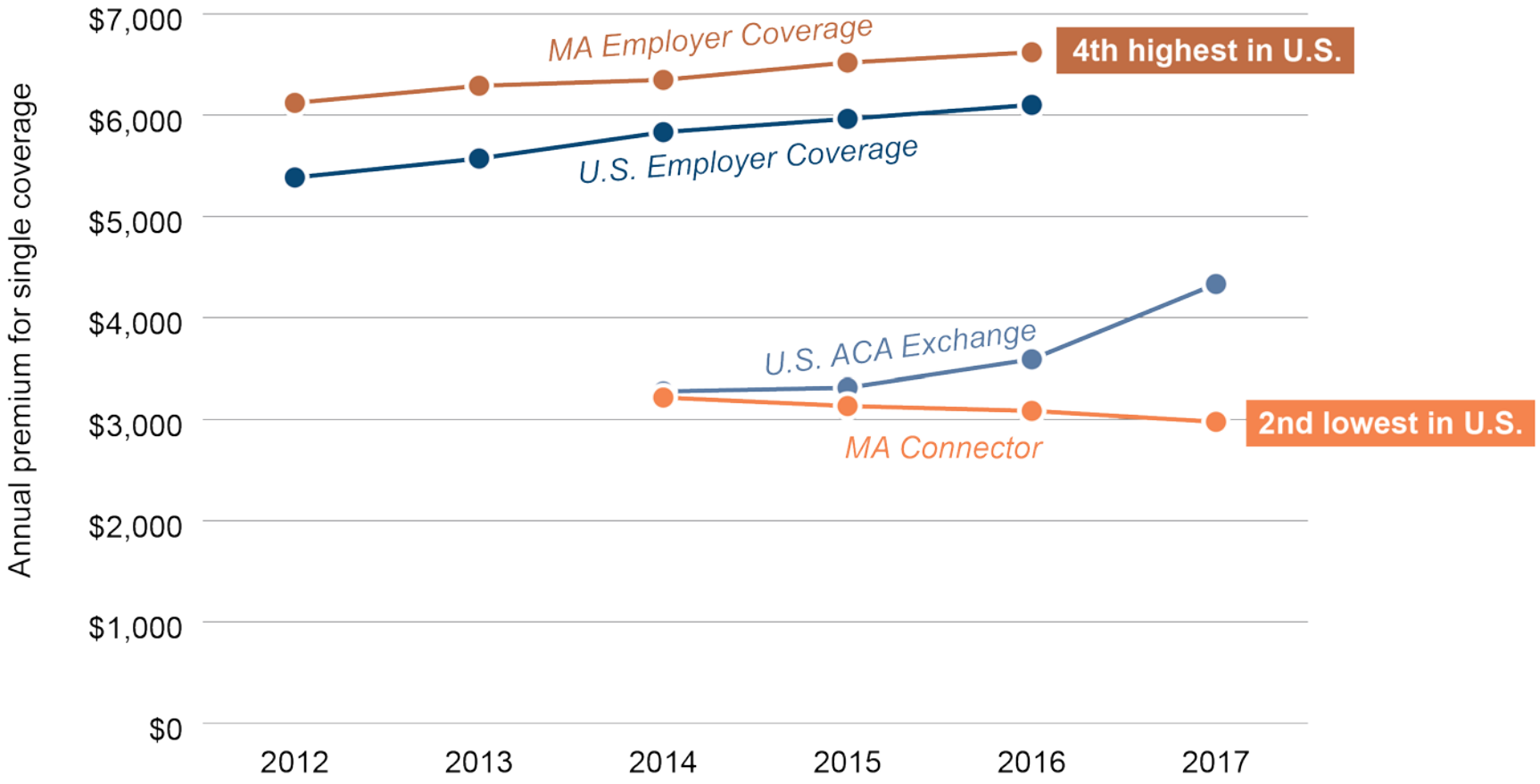


Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only. U.S. data for 2016 is partially projected.

Source: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts and Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005-2014); Center for Health Information and Analysis Annual Reports (MA 2015-2016)

Low growth in commercial spending has been driven in part by MA Connector's 2nd lowest premiums in the U.S.

Average annual premium for single coverage in the employer-sponsored market and average annual unsubsidized benchmark premium for a 40-year old in the ACA Exchanges, MA and the U.S.



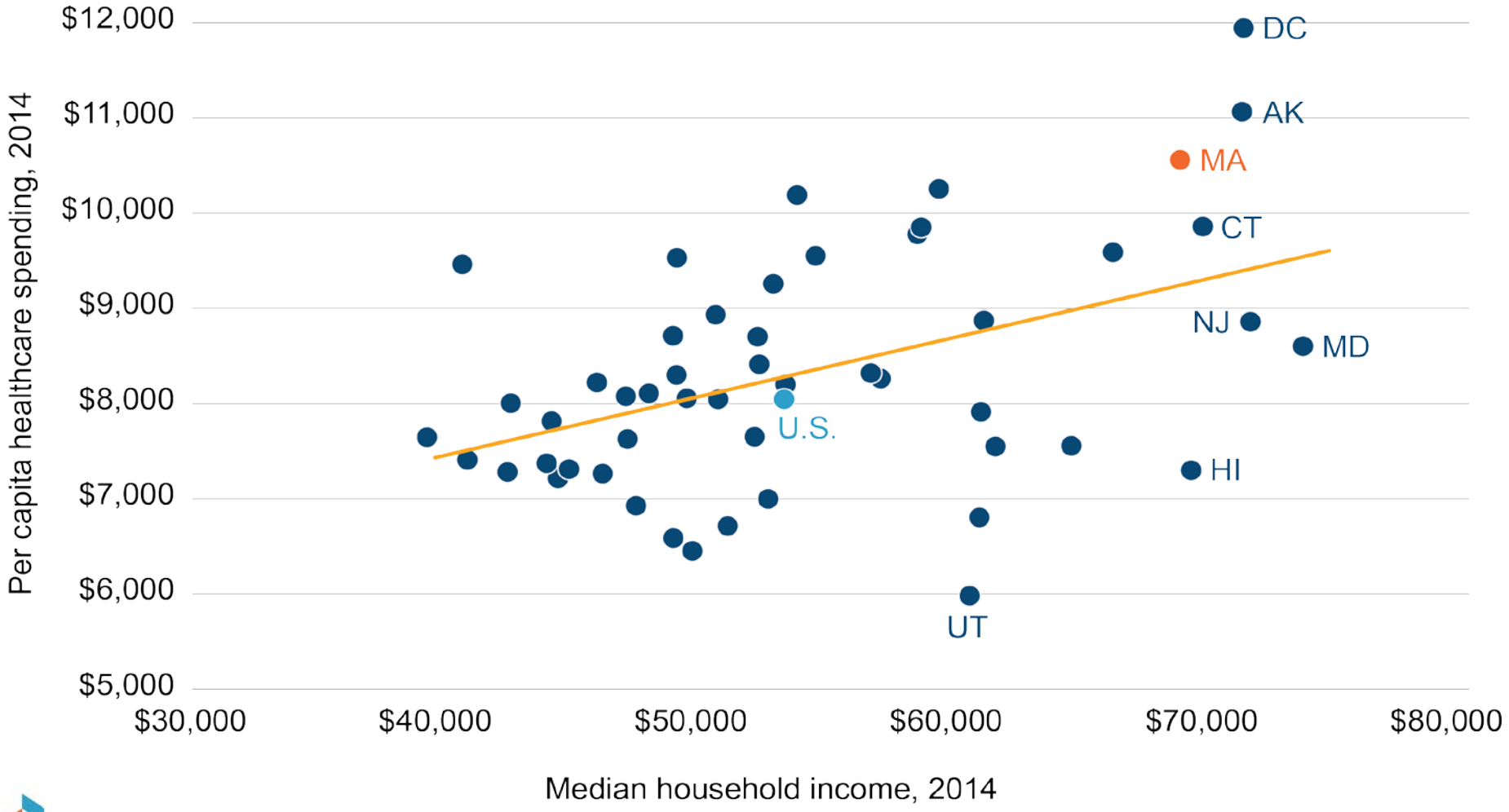
Notes: Exchange data represents the weighted average annual premium for second-lowest silver (Benchmark) plan based on country level data in each state. Premiums do not include any subsidies. Employer premiums are based on the average premiums according to a large sample of employers within each state.

Sources: Kaiser Family Foundation analysis of premium data from healthcare.gov; US Agency for Healthcare Quality, Medical Expenditure Panel Survey (insurance component), 2012-2016

HPC

Healthcare spending Massachusetts remains high, even accounting for higher levels of income

Healthcare spending per capita and median household income, by state, 2014

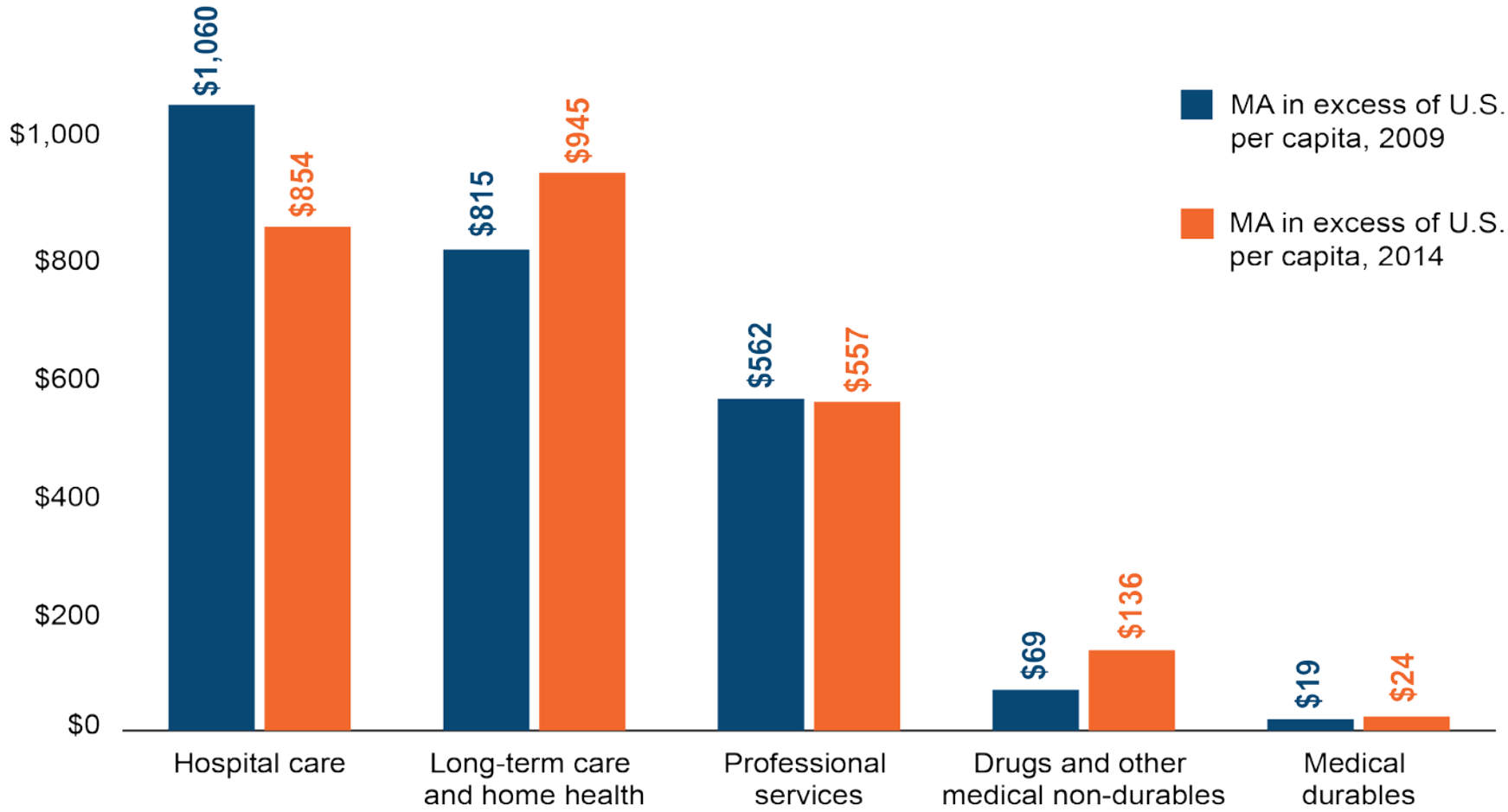


Note: Income data reported in 2014 dollars.

Sources: American Community Survey (income data); Center for Medicare and Medicaid Services (per capita health spending)

Hospital care and long-term care are the biggest contributors to excess spending in Massachusetts

Spending per person in MA in excess of the U.S. average, 2009 and 2014



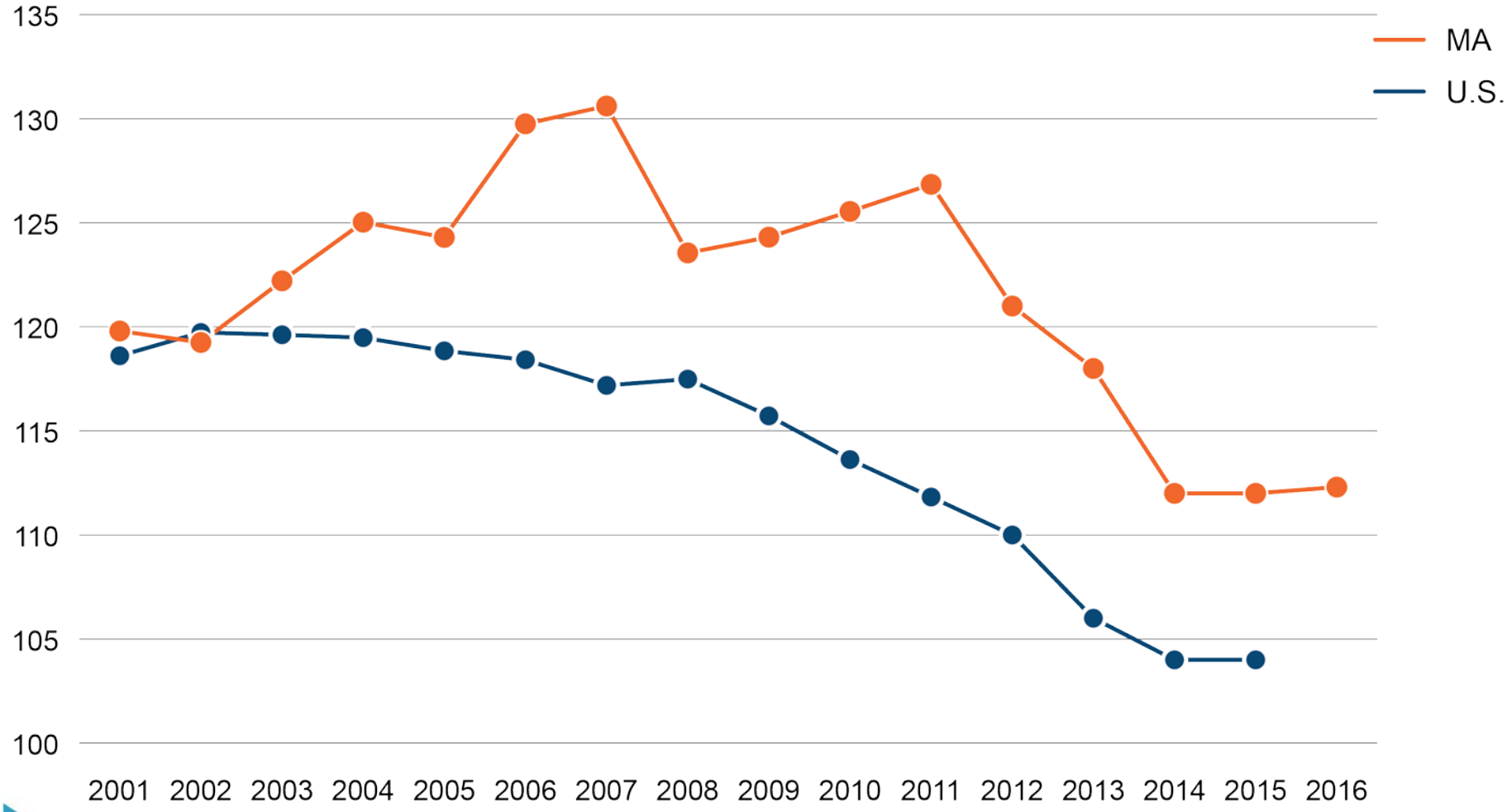
Percent of total difference	Hospital care	Long-term care and home health	Professional services	Drugs and other medical non-durables	Medical durables
	42% → 34%	32% → 38%	22% → 22%	3% → 5%	0.8% → 1.0%

Note: Hospital care includes both inpatient and outpatient care, as well as hospital-based nursing home care. Long term care and home health includes spending in freestanding nursing facilities, home health agencies, and other residential and personal care taking place in community and facility settings.

Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

After years of steady decline, the inpatient admissions rate in Massachusetts has started to increase and is now 8% above the U.S. rate

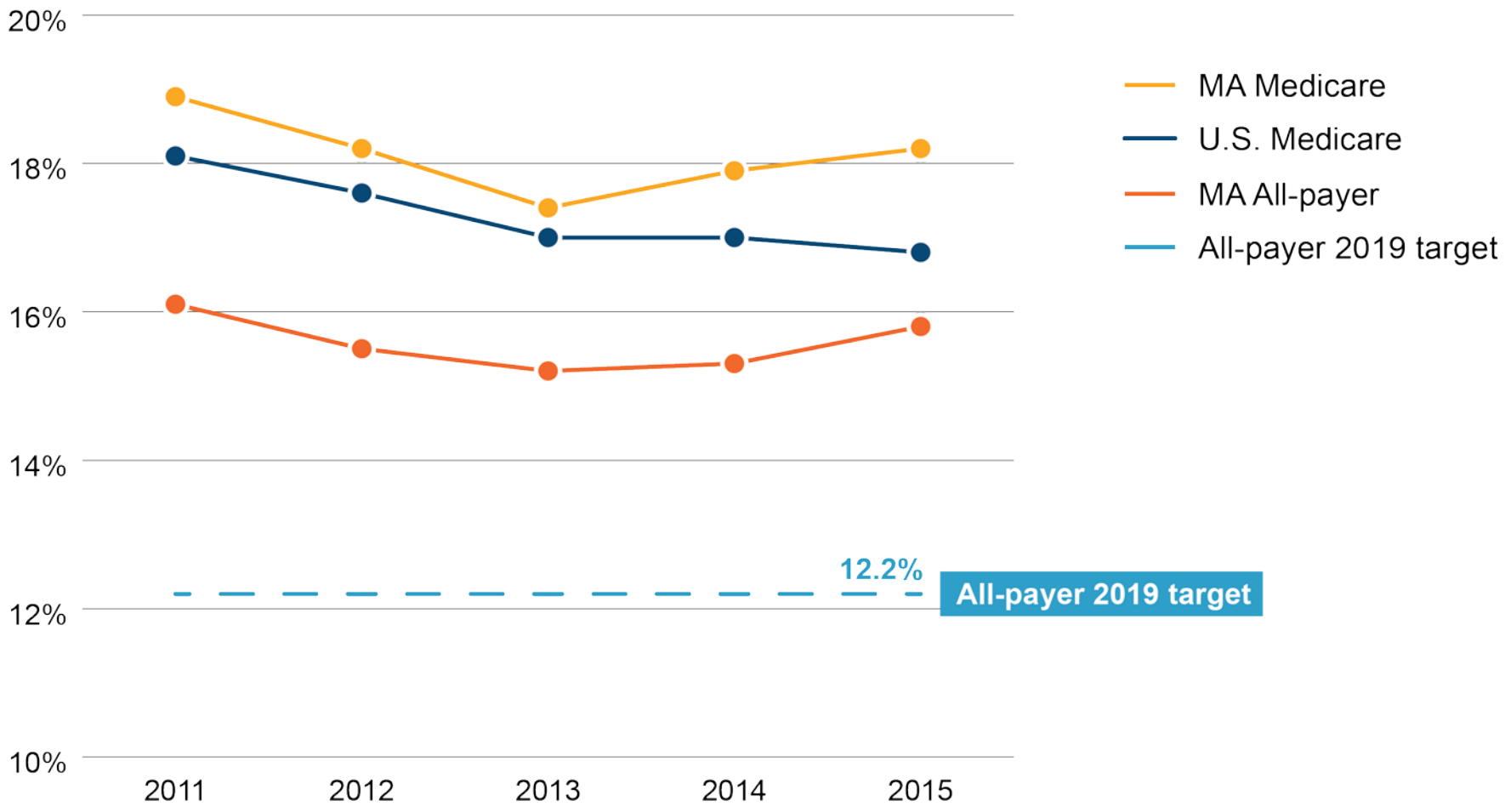
Inpatient hospital admissions per 1,000 residents, MA and the U.S., 2001-2016



Source: Kaiser Family Foundation analysis of American Hospital Association data (2001-2015); HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2016)

Readmission rates are increasing in Massachusetts while falling elsewhere

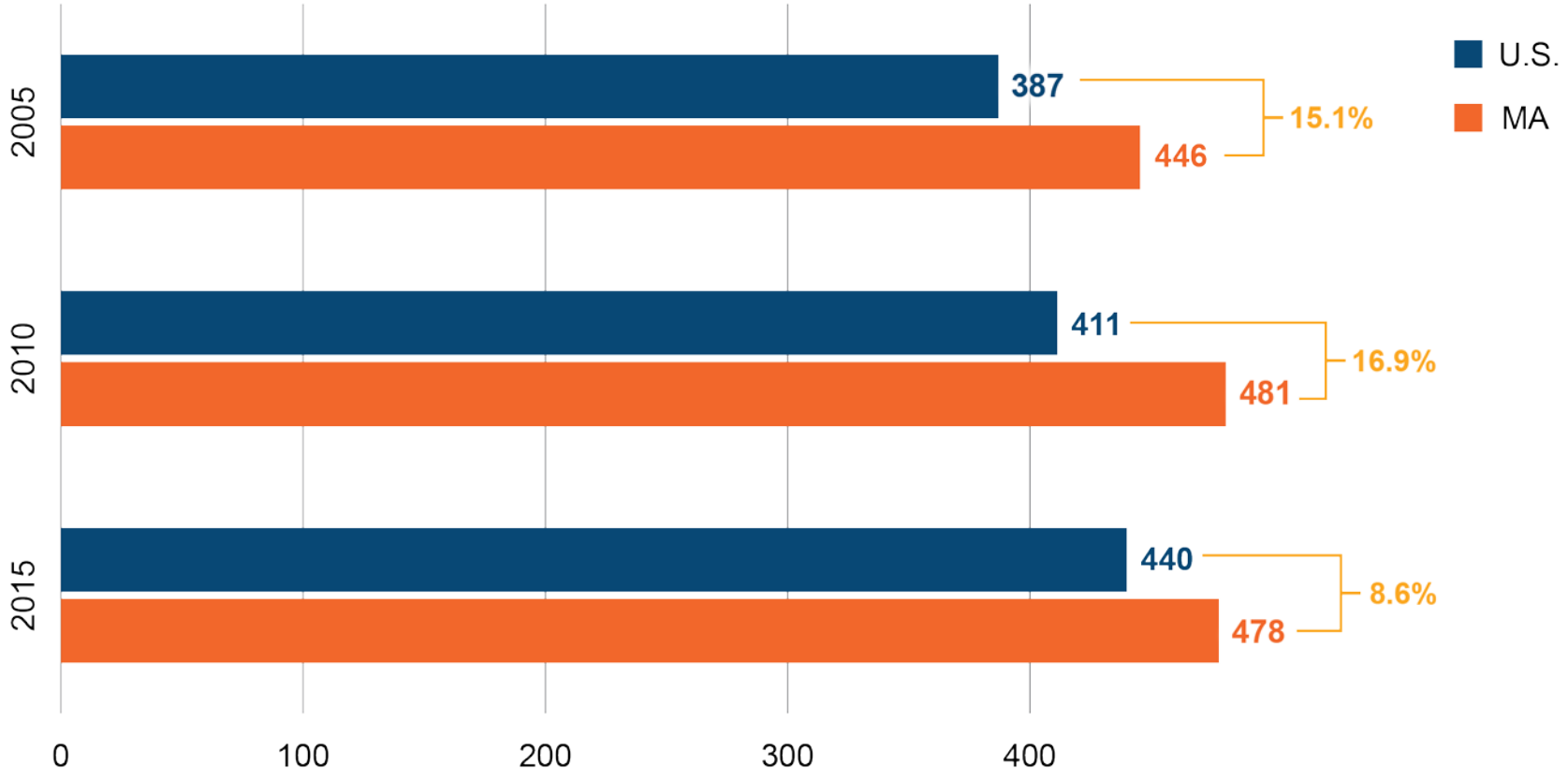
Thirty-day readmission rates, MA and the U.S., 2011-2015



Source: Centers for Medicare and Medicaid Services (U.S. and MA Medicare), 2011-2015; Center for Health Information and Analysis (all-payer MA), 2011-2015

The rate of emergency department visits has improved, but remains 9% higher than the U.S.

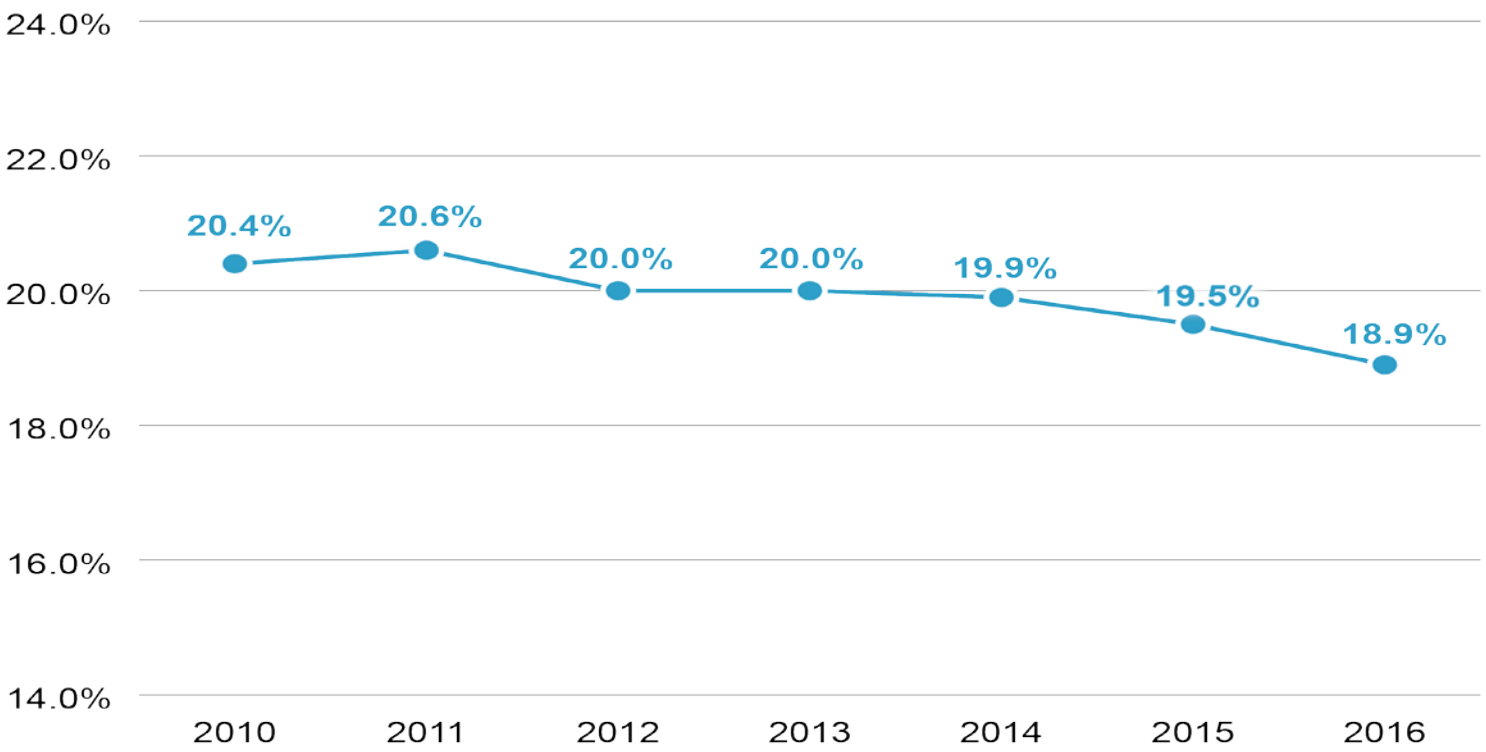
Emergency department visits, per 1,000 residents, MA and the U.S., 2005, 2010, and 2015



Source: Kaiser Family Foundation analysis of American Hospital Association data, 2005, 2010 and 2015

The rate of discharge to institutional post-acute care continues to decline

Percent of patients discharged to institutional post-acute care following an inpatient admission, 2010-2016

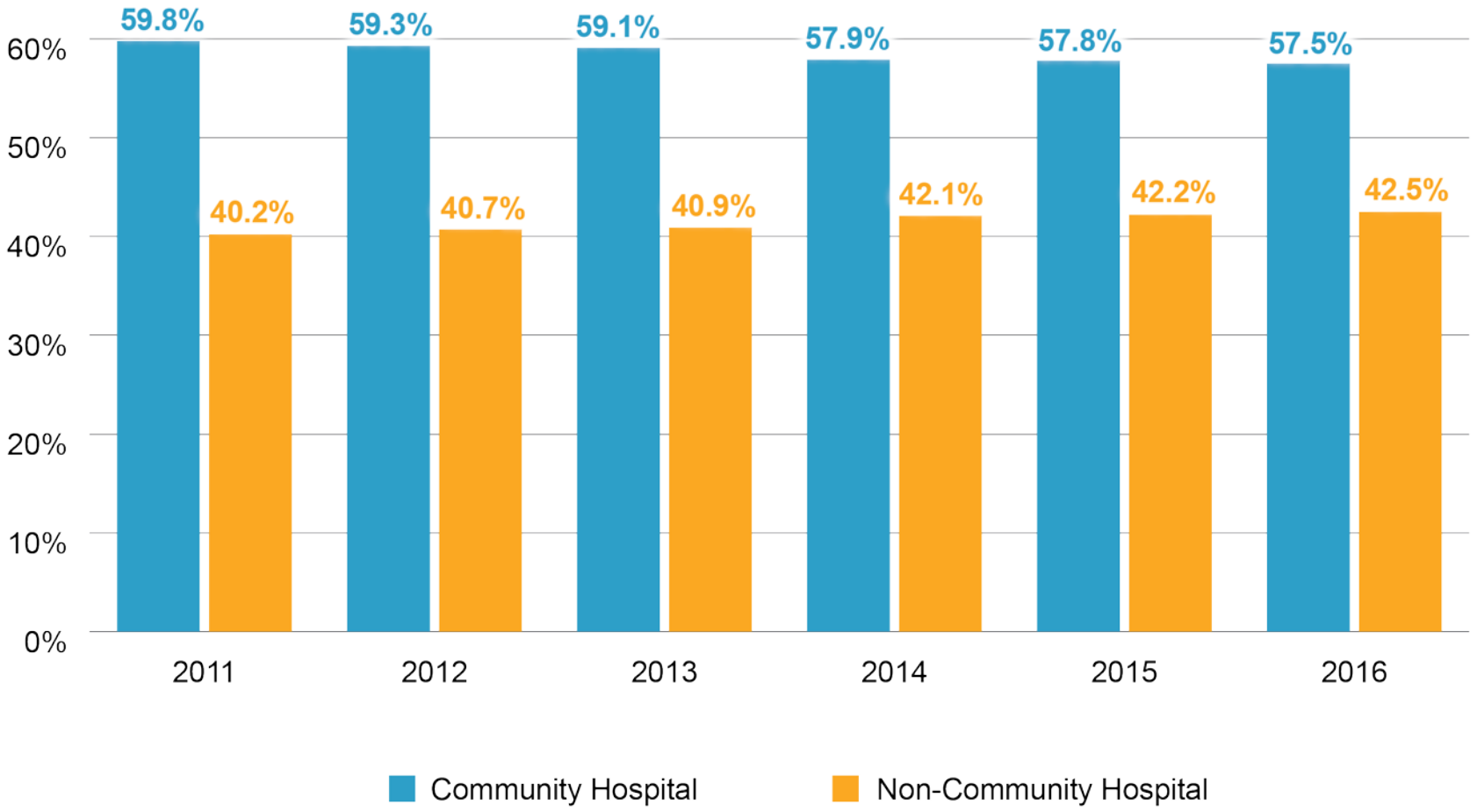


Notes: Institutional post-acute care settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Rates adjusted using ordinary least squares (OLS) regression to control for age, sex, and changes in the mix of mix of diagnosis-related groups (DRGs) over time. Discharges from hospitals that closed and specialty hospitals, except New England Baptist, were excluded. Several hospitals (UMass Memorial Medical Center, Clinton Hospital, Cape Cod Hospital, Falmouth Hospital, Marlborough Hospital) were excluded due to coding irregularities in the database.

Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2010-2016

The share of community-appropriate discharges taking place at community hospitals continues to decline

Share of community appropriate discharges, by hospital type, 2011-2016

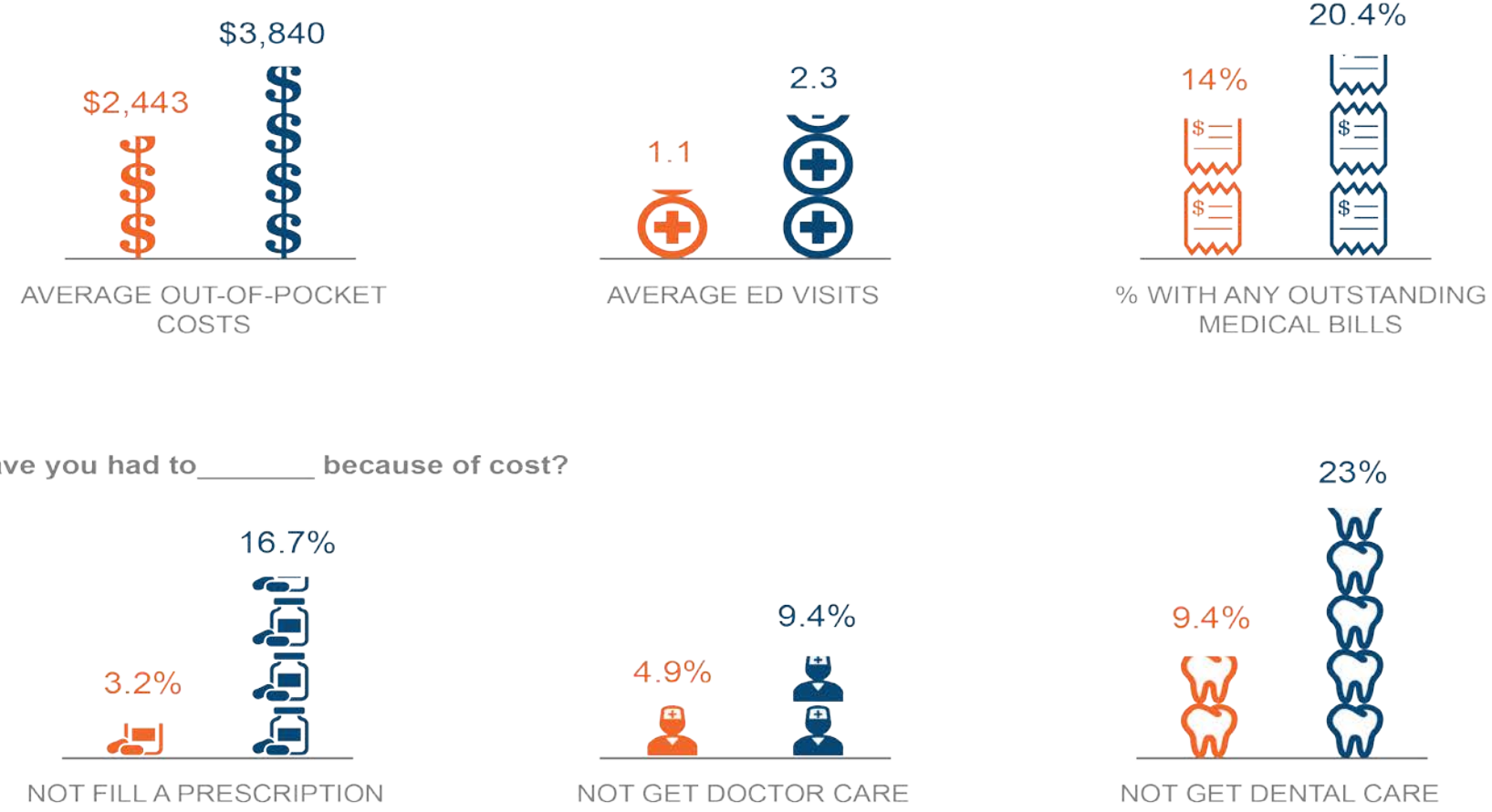


Notes: Discharges that could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs). The Center for Health Information and Analysis defines community hospitals as general acute care hospitals that do not support large teaching and research programs.

Source: HPC analysis of Center for Health Information and Analysis, Hospital Inpatient Discharge data, 2011-2016

Access and affordability challenges remain in Massachusetts, especially for families with self-reported health problems

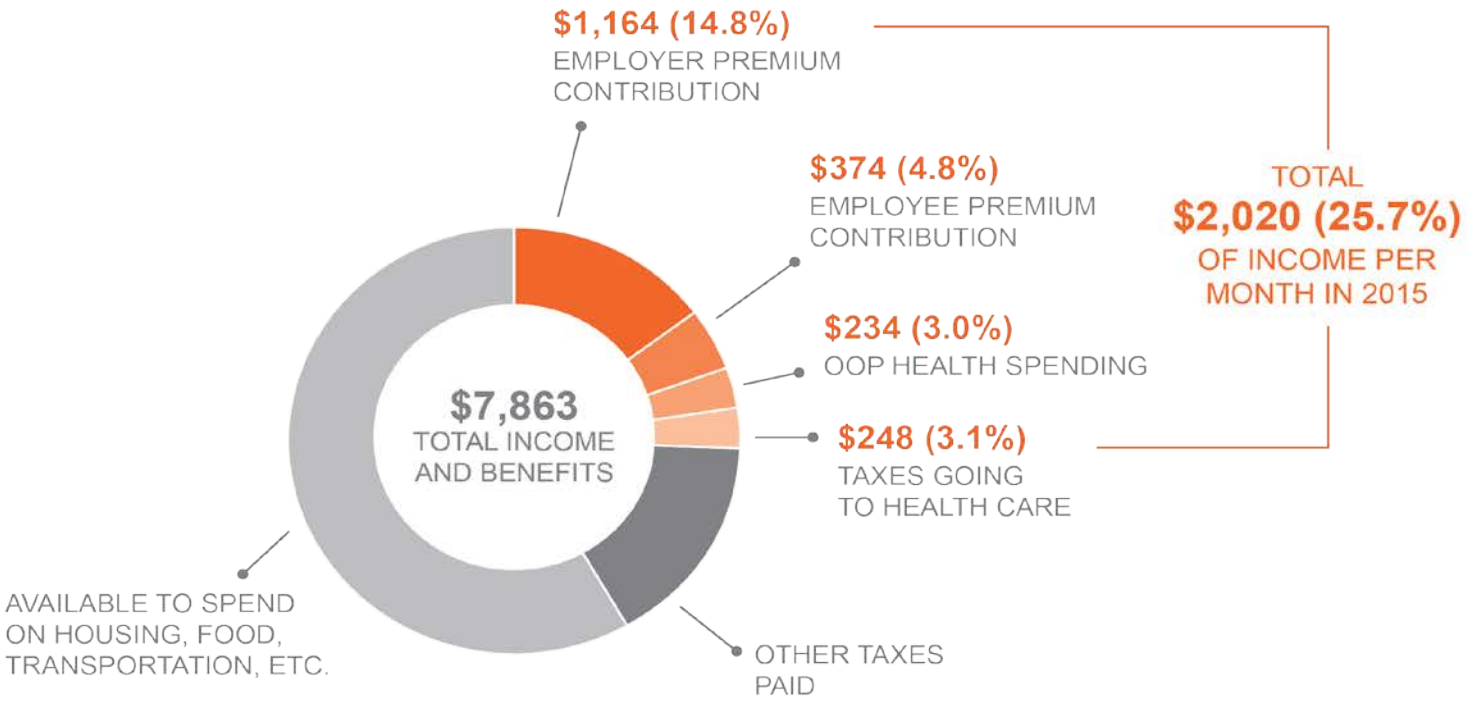
Averages for middle-income families, grouped by self-reported health status



Notes: Analysis is based on 843 families with employer-sponsored health insurance between 200% and 500% of the federal poverty level, representing 1.5 million state residents (across two years). All differences are statistically significant at the 10% level (p<.10) or less and all but two (outstanding medical bills and doctor care) are statistically significant at the 5% level (p<.05). Better health is defined as those reporting their health is 'excellent' or 'very good'. Worse Health is 'good', 'fair' and 'poor'.
Source: HPC analysis of Center for Health Information and Analysis Massachusetts Health Insurance Survey, data from 2014 and 2015

Health care costs represent a high burden on all Massachusetts families, leaving less for other priorities

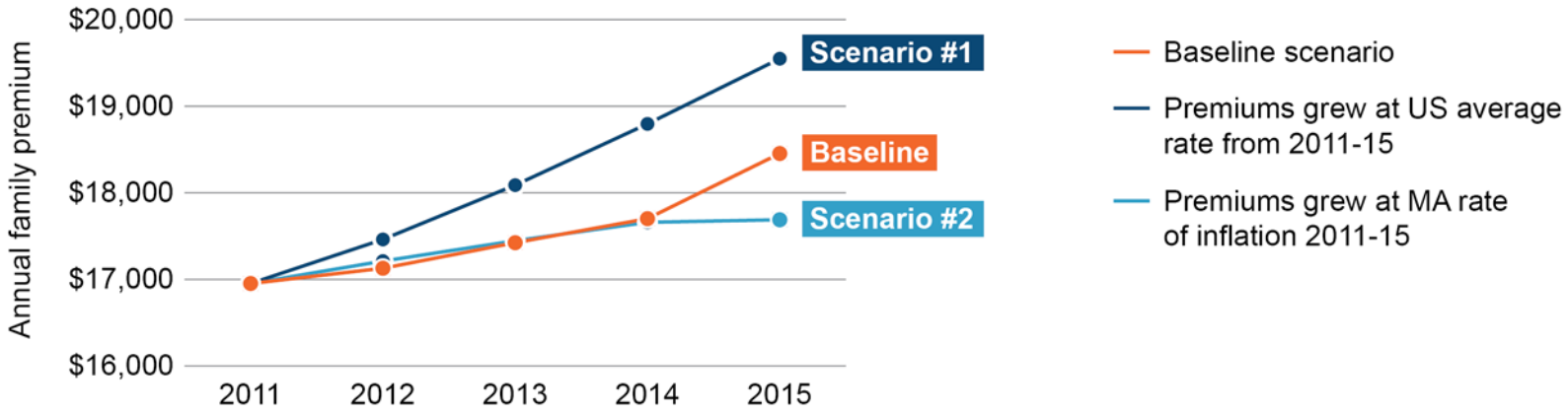
- *Monthly budget for an average Massachusetts family of four with median income ($75,000) that obtains health insurance from a family policy through an employer.*
- *Data are for 2015.*
- *The family's total monthly compensation received from the employer is $7,863*



Note: Compensation paid by employers not counted in income includes the employer health insurance premium contribution and employer share of payroll taxes. Share of taxes devoted to health care include spending on Medicare, Medicaid and other federal health programs.

Data sources: Massachusetts Health Interview Survey (CHIA), data from 2014-5 on 843 families with employer-sponsored health insurance between 200% and 500% of the FPL, representing roughly 1.5 million state residents across two years. Other data sources include US and state government budget data and data from the US Agency for Healthcare Research and Quality

How does healthcare spending growth affect family and state budgets?



	Baseline	Scenario #1		Scenario #2	
	Baseline data	If premiums grew at US average rate from 2011-15	Change in 2015	If premiums grew at MA rate of inflation 2011-15	Change in 2015
State: Health Insurance spending ($Billion)	$23.6	$25.0	$1.4B	$22.6	-$1.0B
State: Income Tax revenue collected ($Million)	$14,374	$14,025	-$349M	$14,618	$244M
Family: Annual raise	2.0%	1.0%	-1.0%	2.7%	0.7%
Family: Annual take-home pay after taxes and health care costs	$54,785	$54,050	-$734	$55,298	$513

Notes: Projections assume a full tradeoff between health insurance premium spending and salaries. See Emanuel, Ezekiel J., and Victor R. Fuchs. "Who Really Pays for Health Care?: The Myth of "Shared Responsibility"." *Jama* 299.9 (2008): 1057-1059

Data sources: Family health insurance premiums are obtained from the US Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, Insurance component. Other data sources are detailed on the previous slide.

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MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

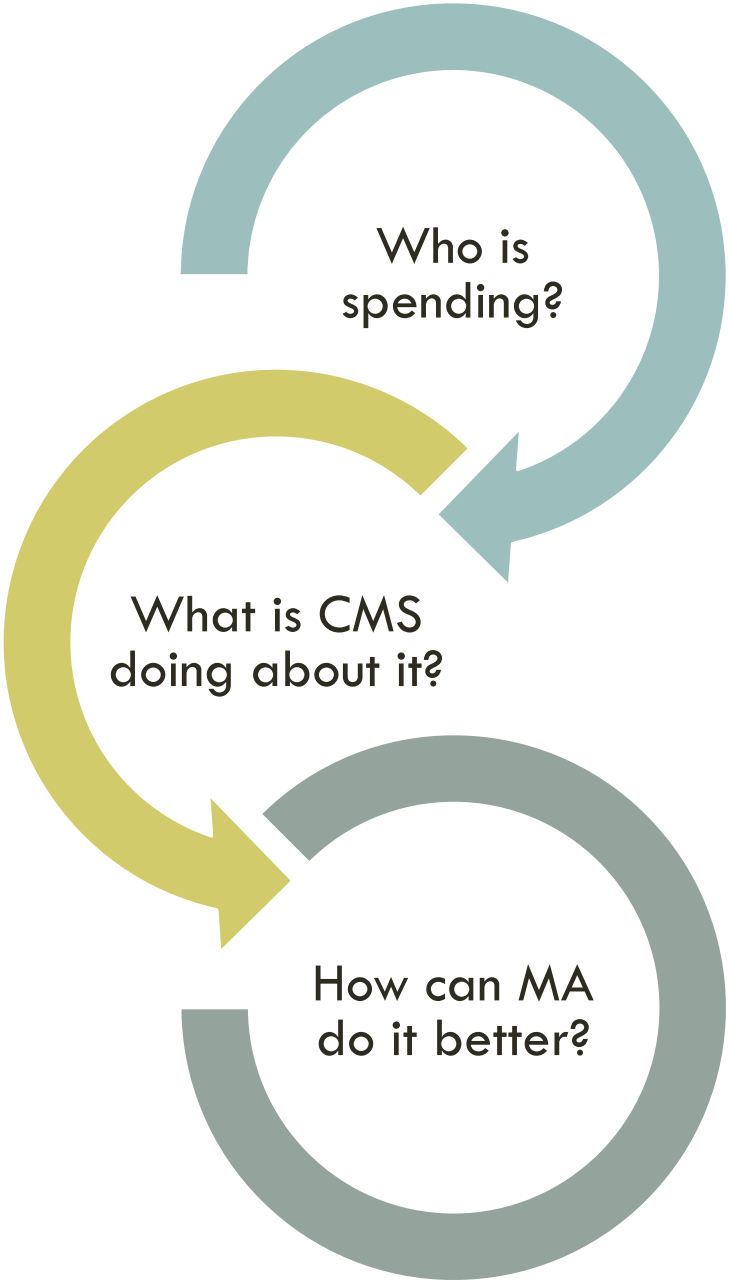
Presentation by Dr. Karen Joynt Maddox

NATIONAL PERSPECTIVE: HEALTH CARE COSTS AND READMISSIONS

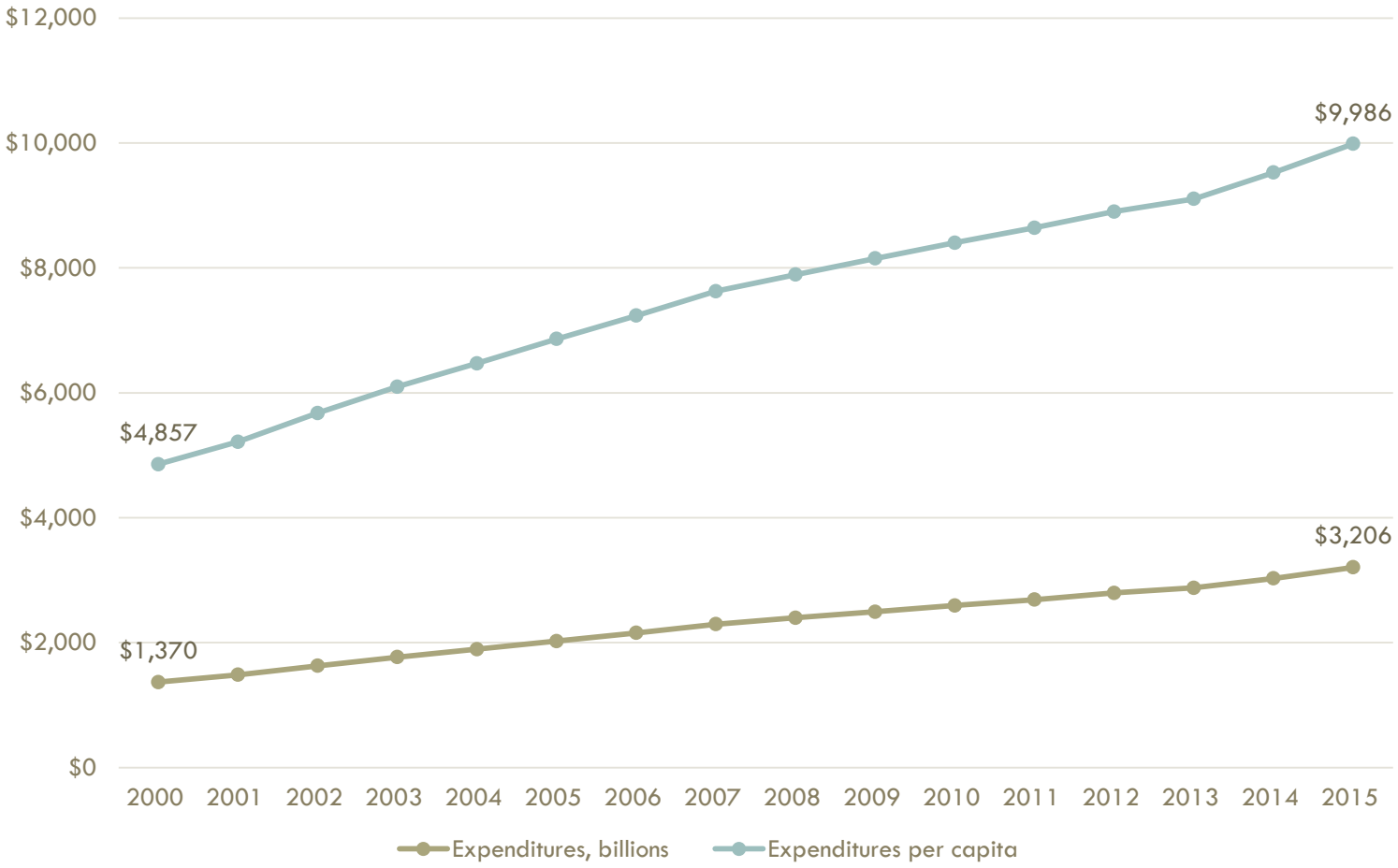
Cost Trends Hearing

Karen Joynt Maddox, MD MPH

October 2, 2017

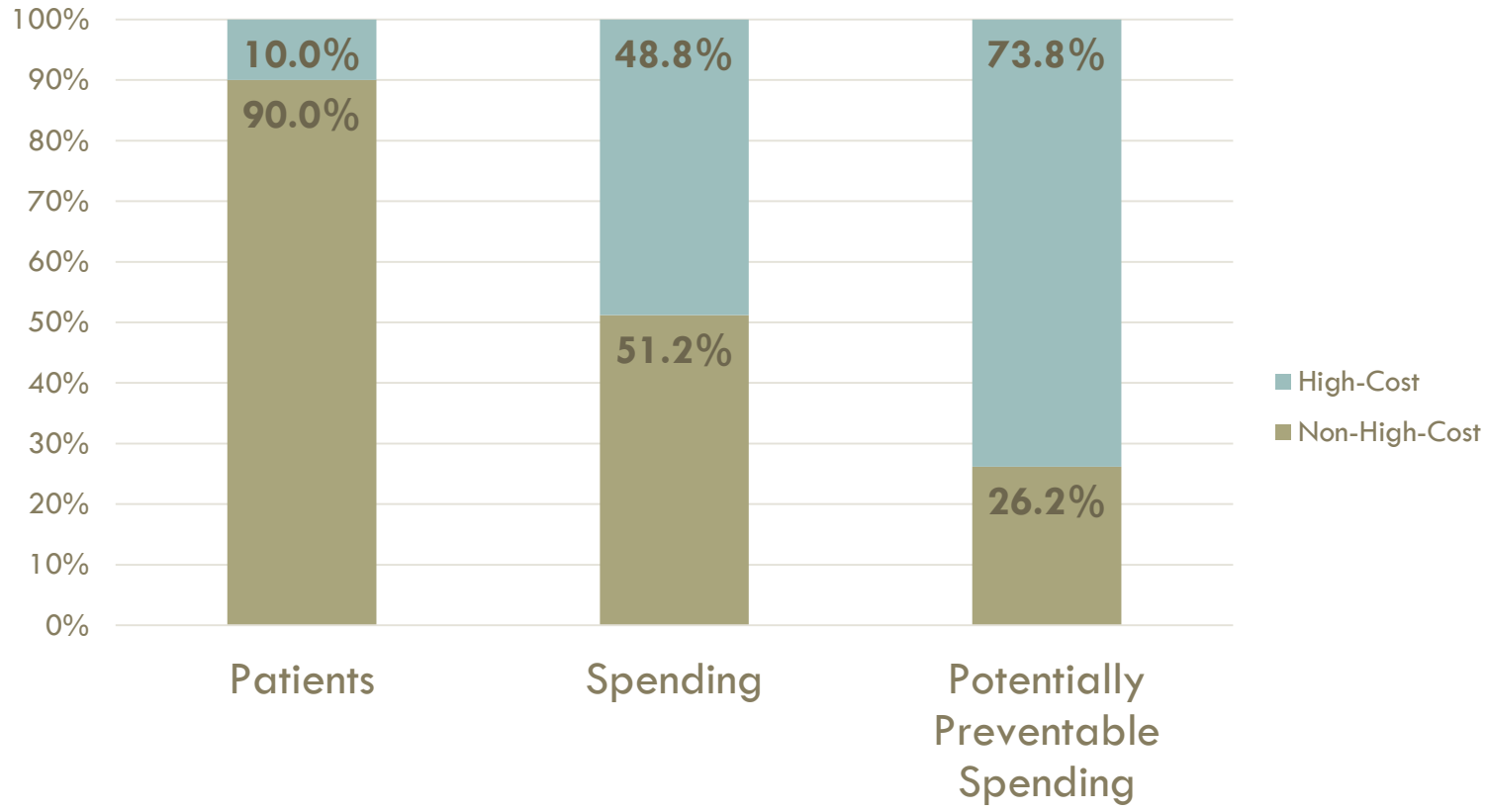

Who is spending?
What is CMS doing about it?
How can MA do it better?

NATIONAL HEALTH EXPENDITURES



https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

WHO IS SPENDING?



Joynt et al, Healthcare 2016

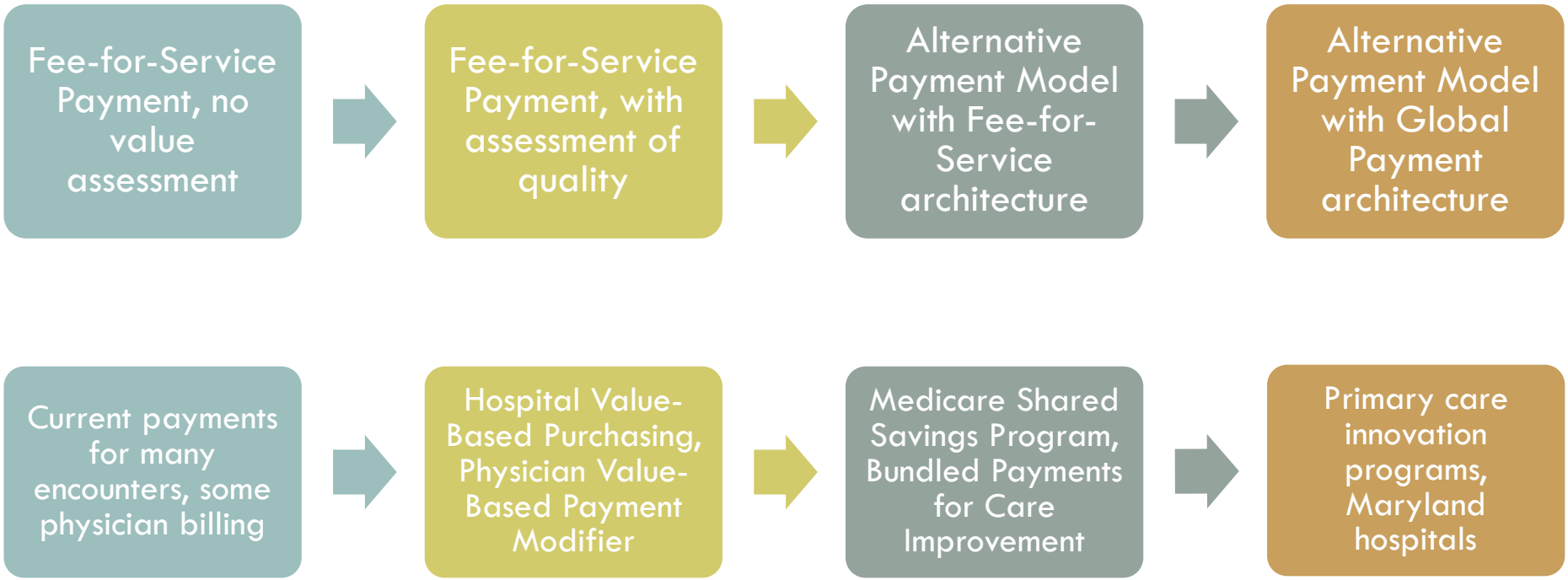
WHO ARE THESE HIGH-COST PATIENTS?

	High-Cost	Non-High-Cost
Median Age	73	72
Non-white	24%	19%
Dually eligible	37%	18%
Qualified based on disability	37%	24%
Mental health diagnosis	16%	6%
Number of chronic conditions	11	6
2 or more frailty indicators	40%	5%

Joynt et al, Healthcare 2016

NATIONAL EFFORTS TO REDUCE COSTS

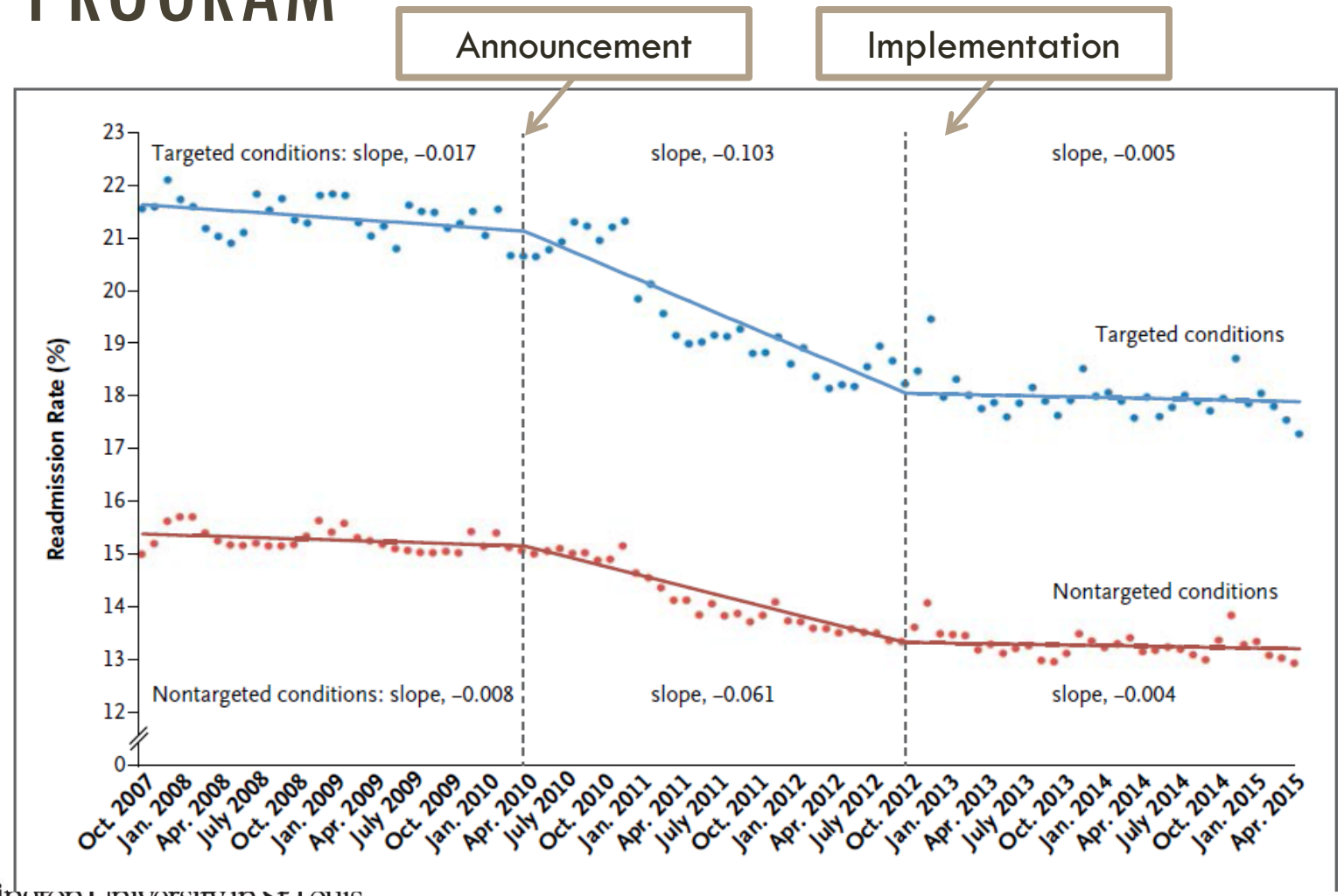
PAYMENT REFORM



HOSPITAL READMISSIONS REDUCTION PROGRAM

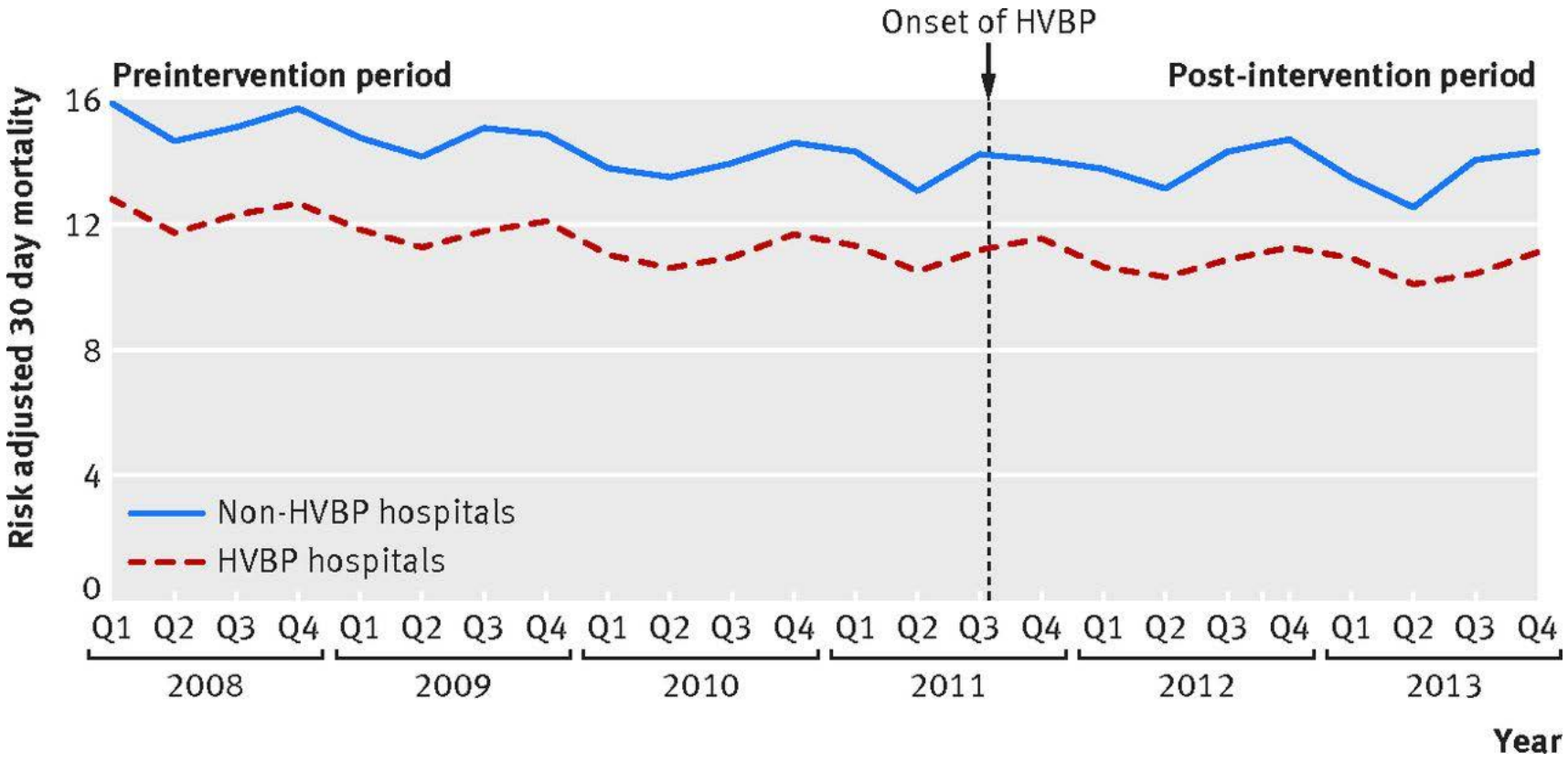
STATE	HOSPITALS PENALIZED	HOSPITALS NOT PENALIZED	% PENALIZED
Delaware	6	0	100%
West Virginia	29	0	100%
Arkansas	42	2	95%
New Jersey	61	3	95%
Connecticut	28	2	93%
New York	139	11	93%
Florida	155	13	92%
Virginia	68	6	92%
Kentucky	59	6	91%
Massachusetts	**52**	**5**	**91%**

HOSPITAL READMISSIONS REDUCTION PROGRAM



Zuckerman et al, NEJM 2016

HOSPITAL VALUE-BASED PURCHASING



Figueroa et al, BMJ 2016

POLICY EVALUATION: 2 PARTS

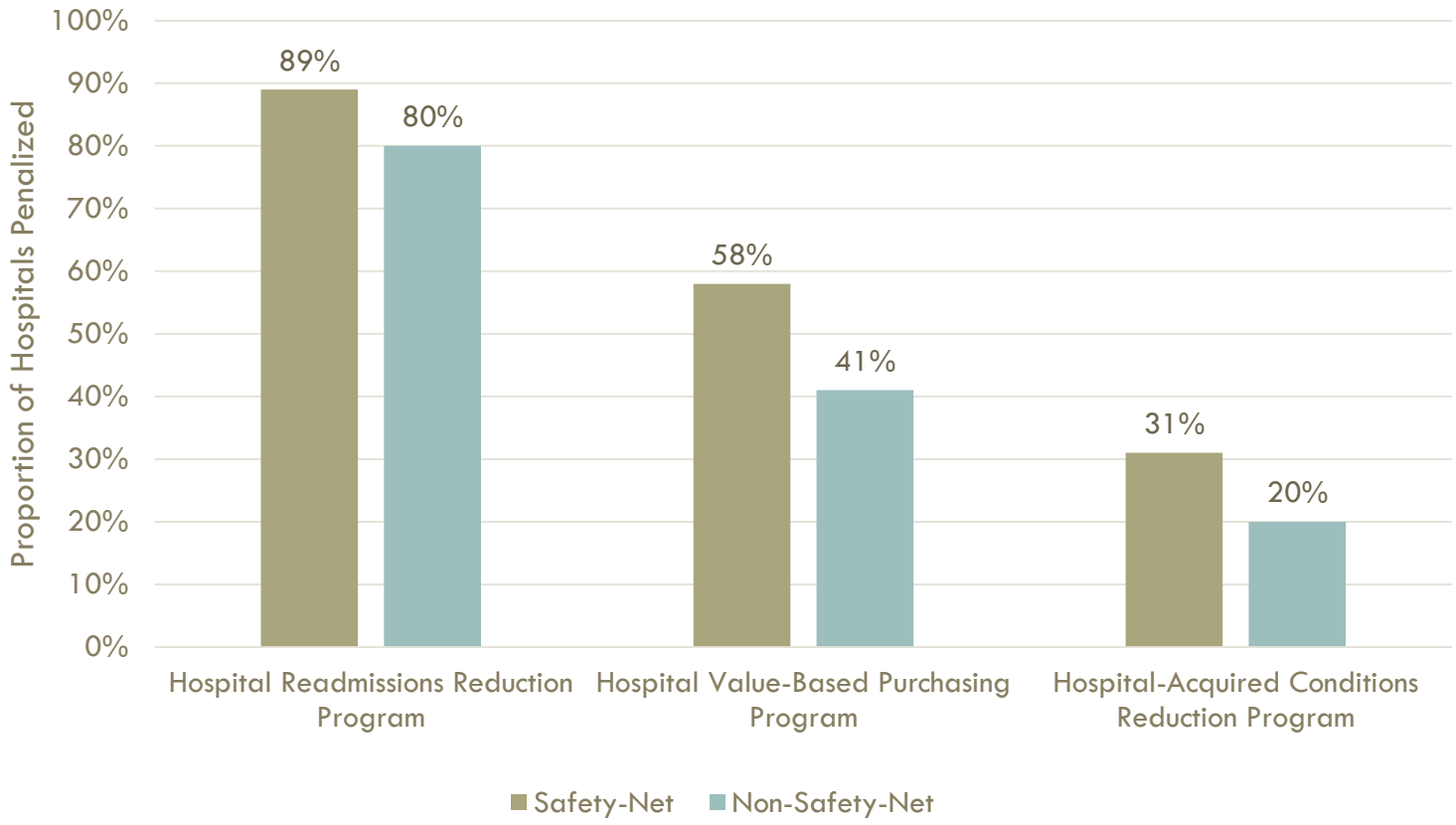
Prove efficacy

- Like the treatment effect in a clinical trial
  - Size and consistency of effect

Evaluate for unintended consequences

- Like the safety effect in a clinical trial
- What is "safety" in health policy?
  - Risk aversion
  - Gaming
  - Penalizing vulnerable hospitals
  - Exclusion of vulnerable populations

HOSPITAL-BASED PAYMENT REFORM: IMPACT ON THE SAFETY NET



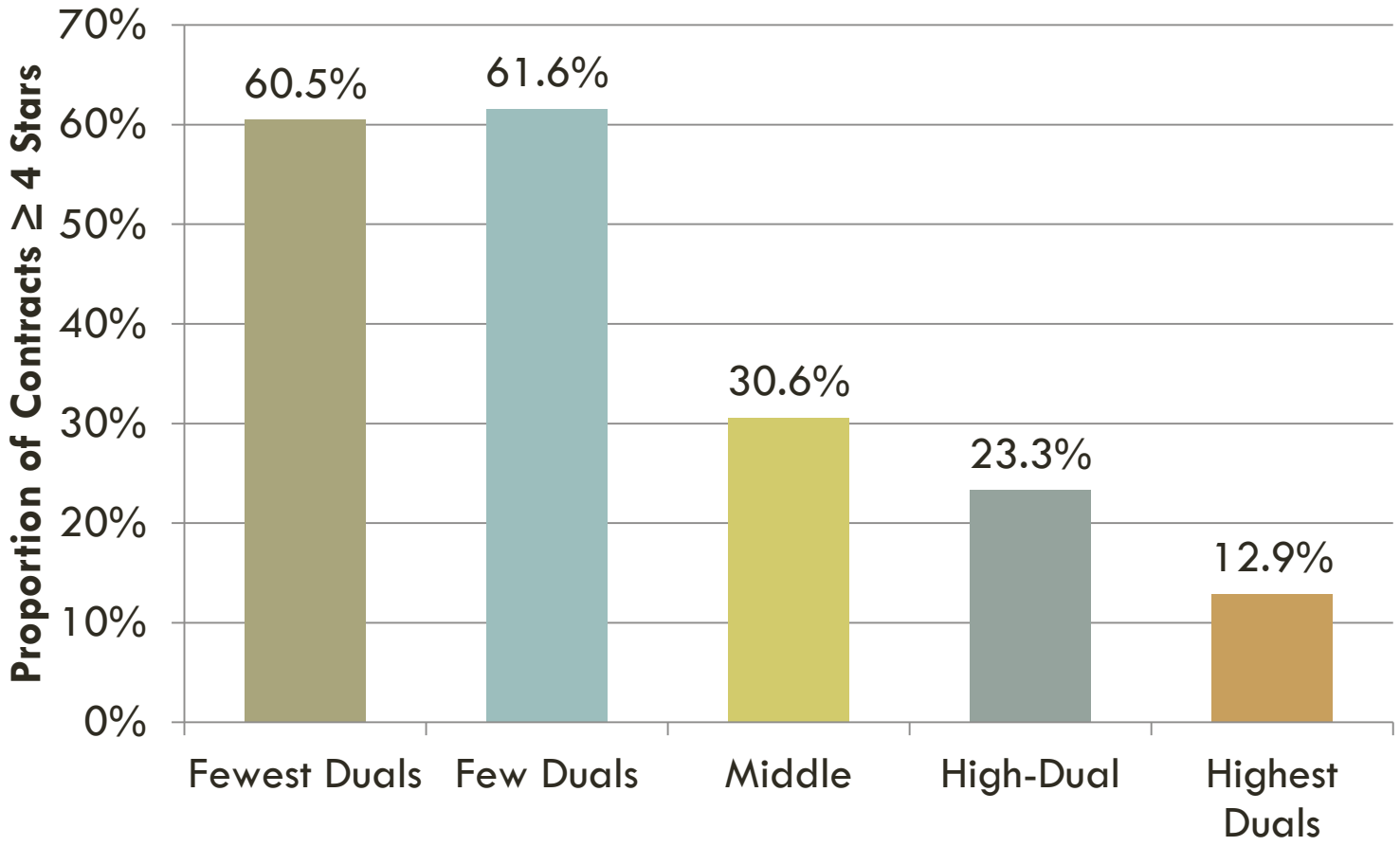
ASPE Office of Health Policy, 2016

SOCIAL RISK AND READMISSIONS

	Dual Enrollment Alone	Dual Enrollment, Adjusting for Comorbidities
Acute MI	1.45	1.14
Heart Failure	1.24	1.13
Pneumonia	1.26	1.10
Hip/knee replacement	1.67	1.31
Chronic obstructive pulmonary disease	1.44	1.15

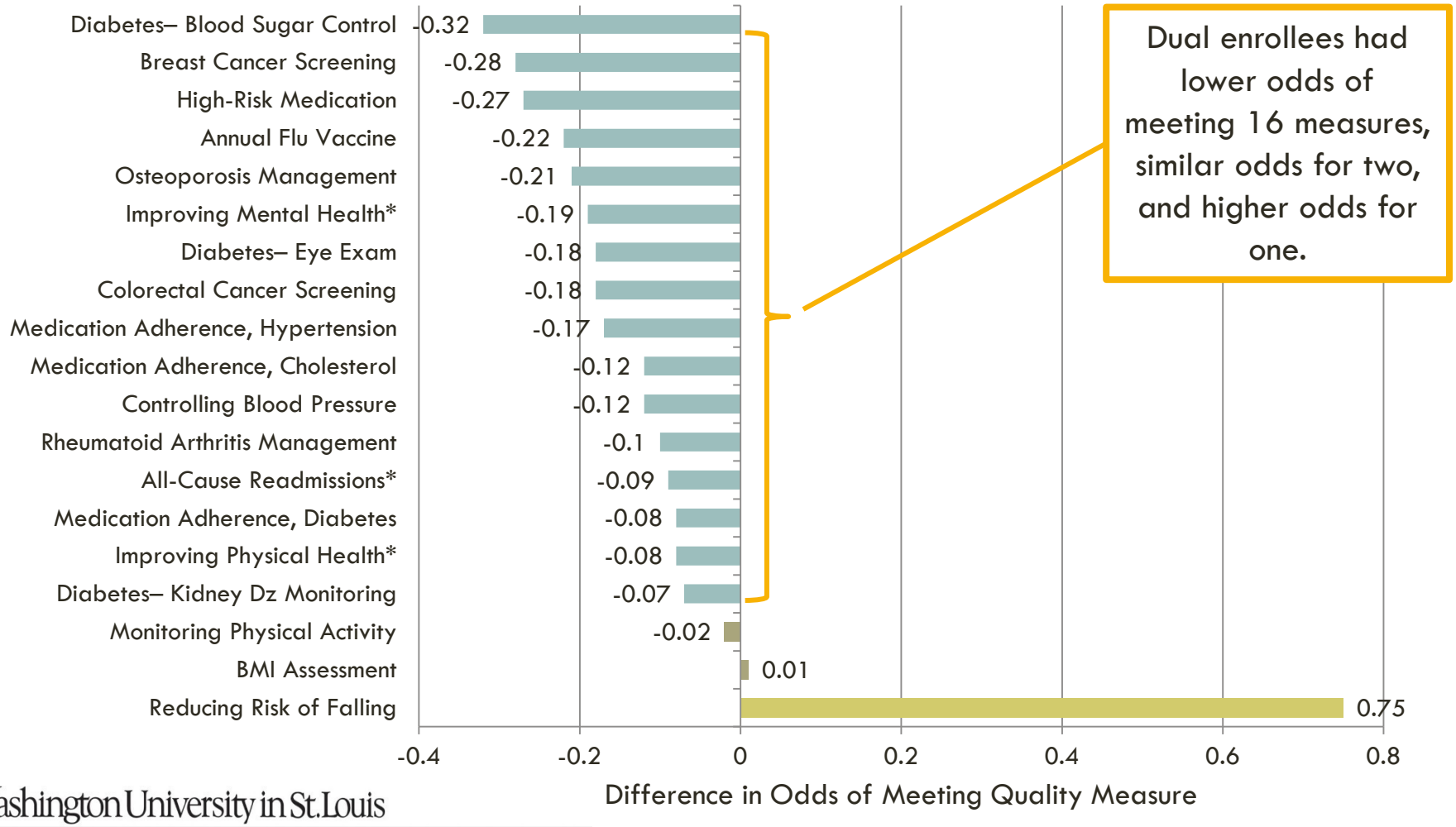
ASPE Office of Health Policy, 2016

MEDICARE ADVANTAGE PAYMENT REFORM: IMPACT ON THE SAFETY NET



ASPE Office of Health Policy, 2016

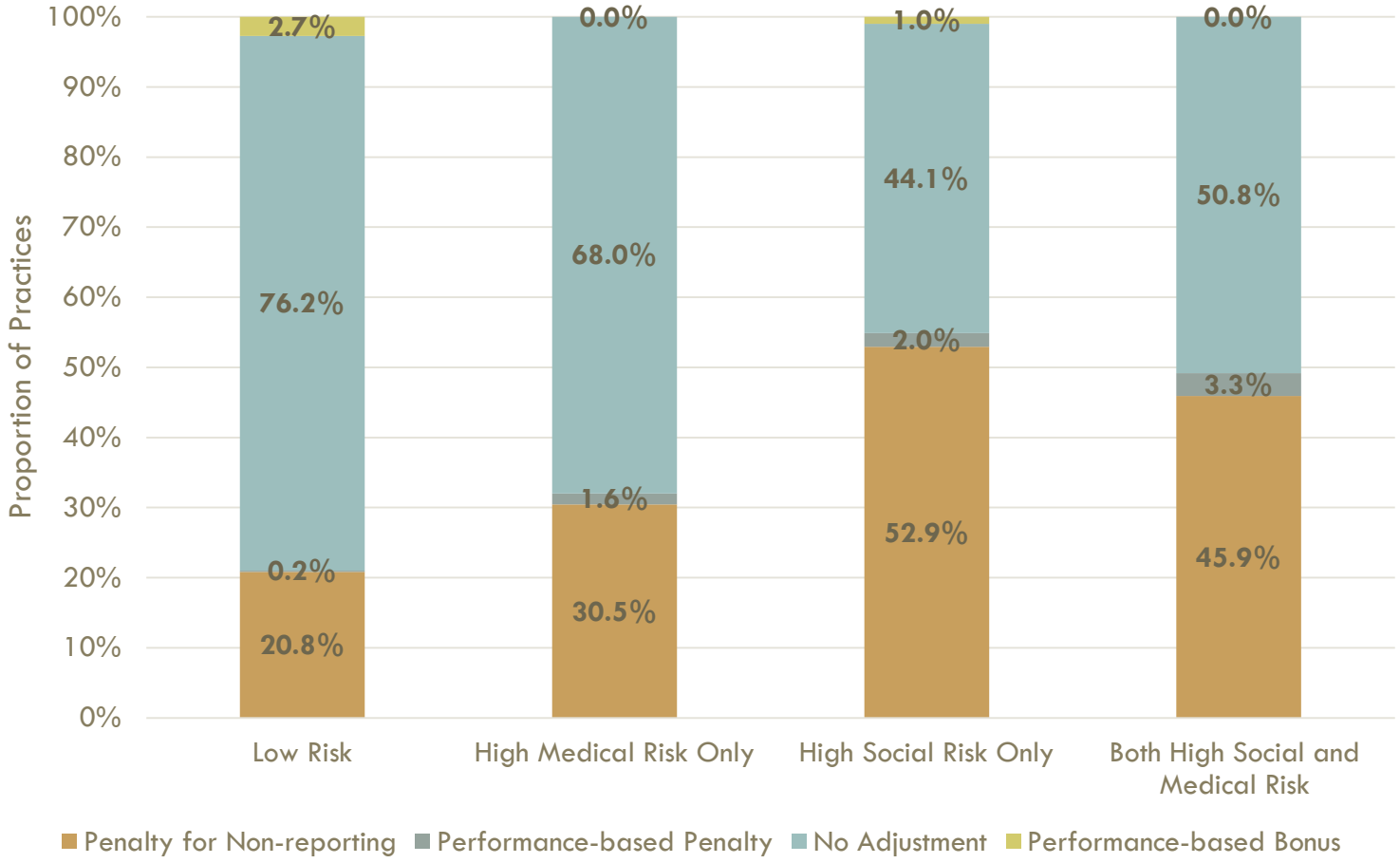
SOCIAL RISK AND QUALITY METRICS



Washington University in St. Louis
School of Medicine

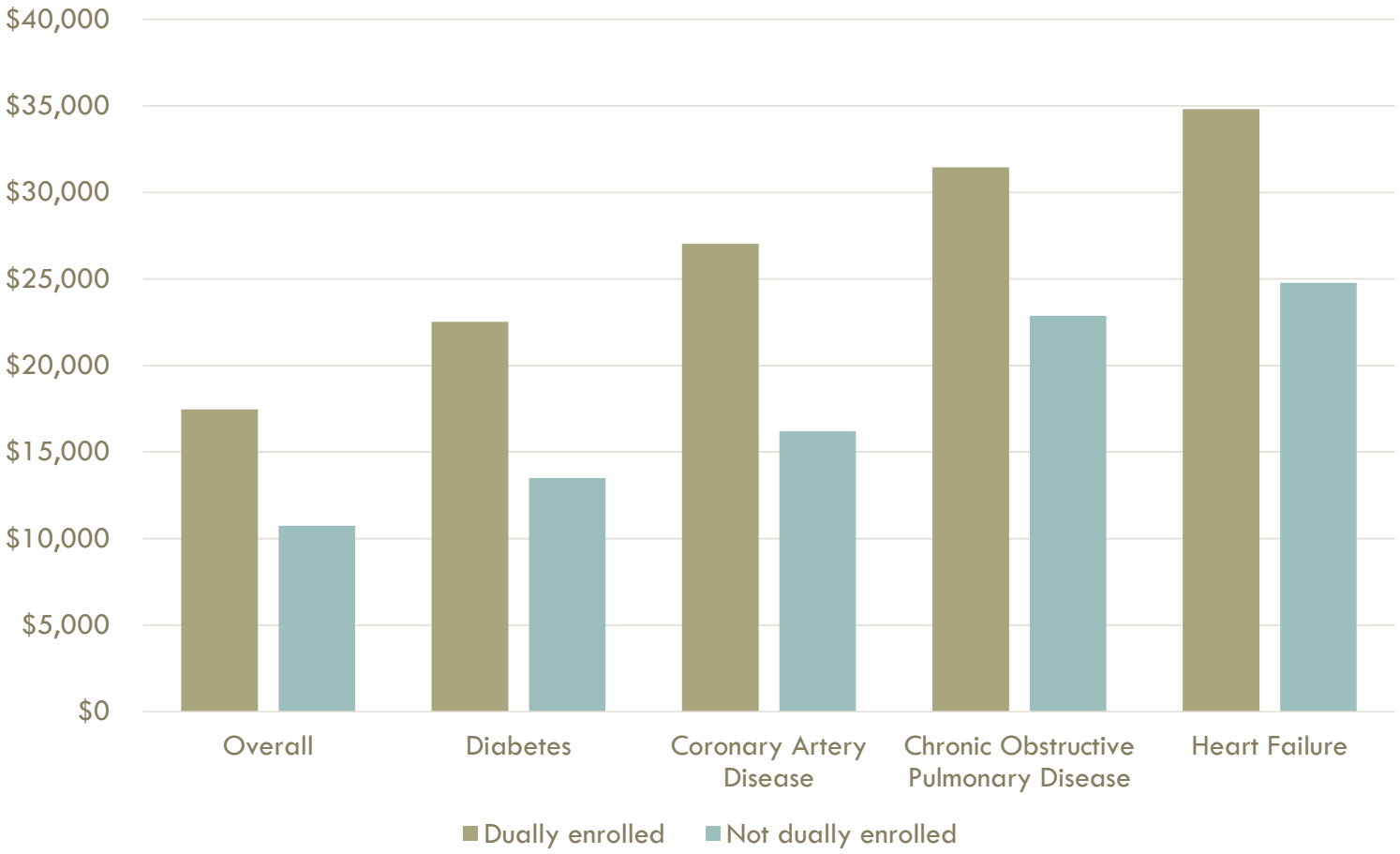
ASPE Office of Health Policy, 2016

PHYSICIAN-FOCUSED PAYMENT REFORM: IMPACT ON THE SAFETY NET



Chen et al, JAMA 2017

SOCIAL RISK AND COSTS OF CARE



ASPE Office of Health Policy, 2016

SO WHERE ARE WE WITH FEDERAL PAYMENT REFORM?

- Suboptimal efficacy
- High likelihood of unintended consequences

- What can we learn?

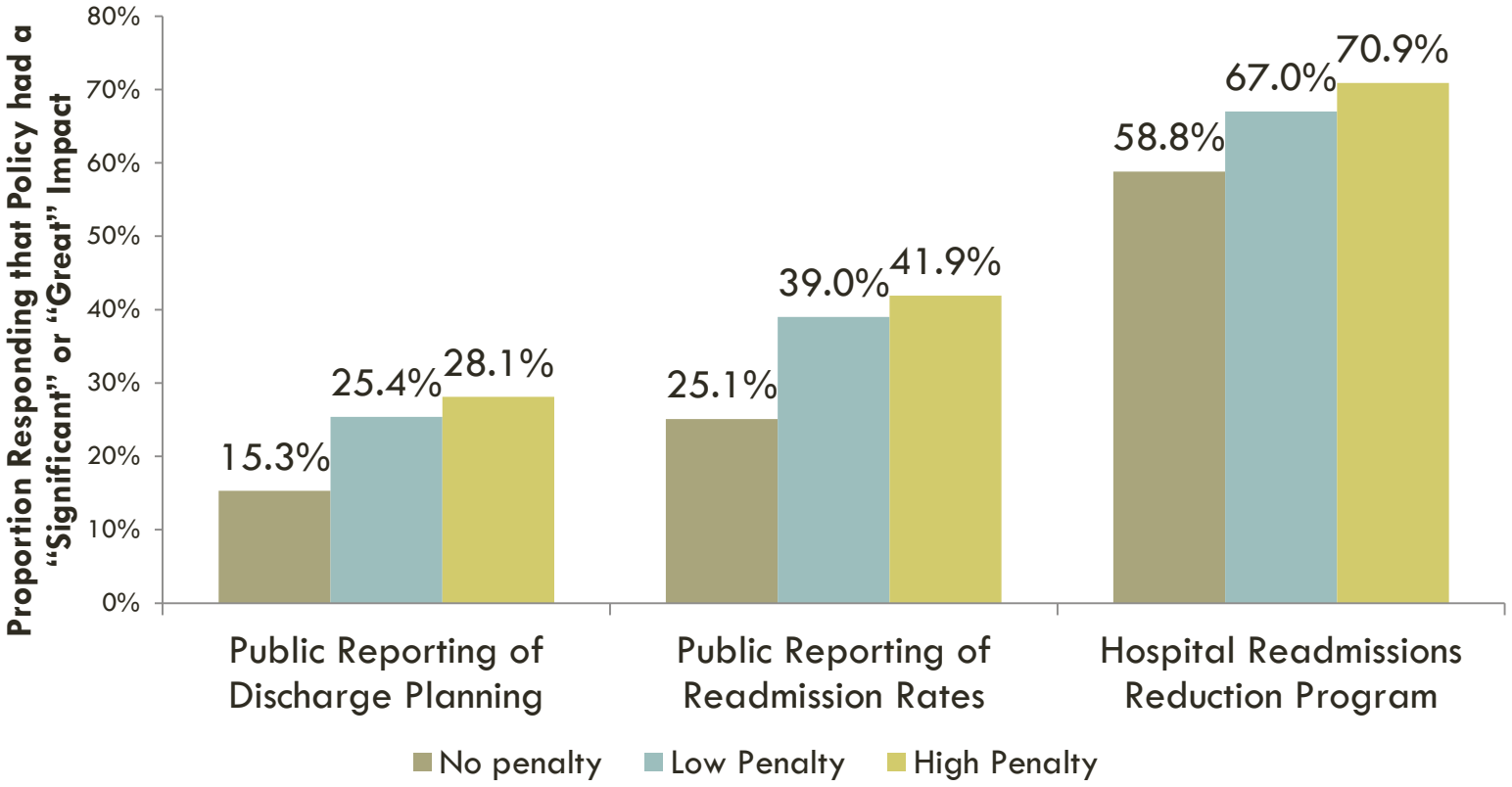
STRATEGIES TO IMPROVE EFFICACY

- Match program design to goals
  - Narrow or broad focus?
    - Readmissions program more efficacious than value-based purchasing
    - Data from the UK suggests erosion of gains over time, so rotation might be needed
  - Penalties or bonuses?
    - Standard of care might respond to penalties
    - Innovation might better be driven by bonuses
      - Harness clinicians' drive to do good and do well
- Ensure adequate incentives
  - Unclear what this is for hospitals, clinics, etc.
- Focus on addressing the actual problems…

Joynt Maddox et al, JGIM 2017

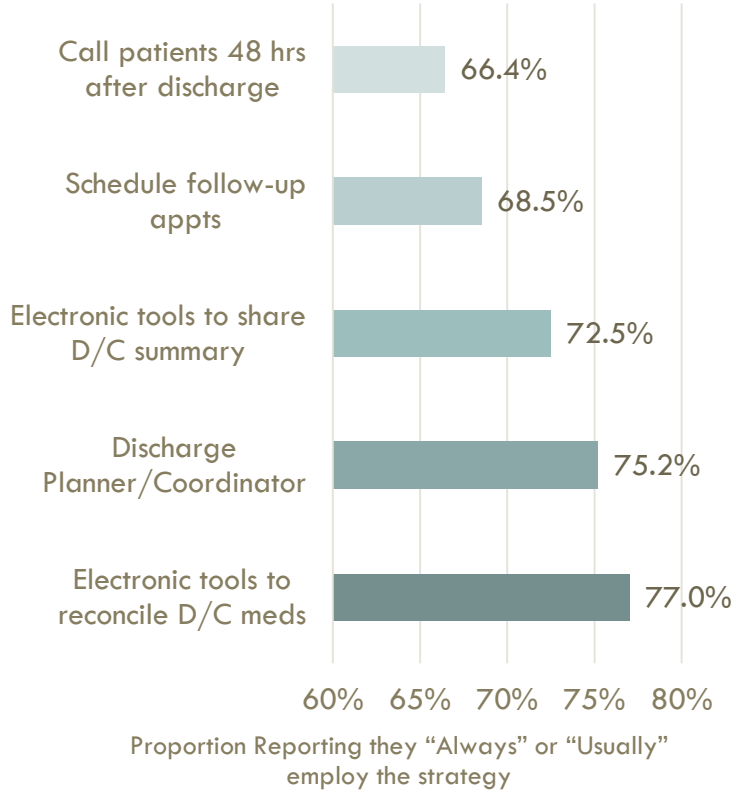
EVIDENCE FOR FINANCIAL INCENTIVES

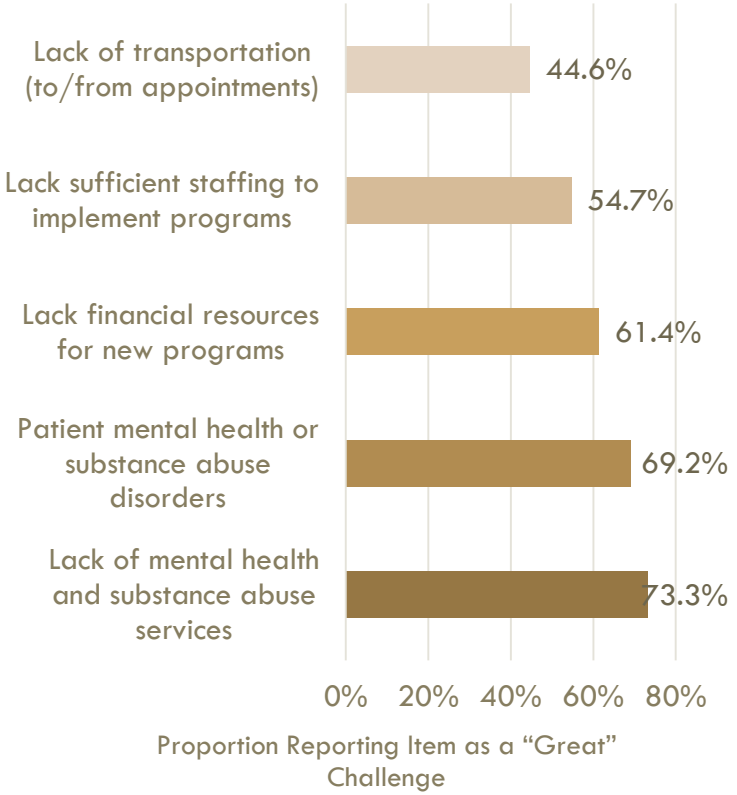
Did the policy have a large impact on your institution's efforts to reduce readmissions?



Joynt et al, AJMC 2016

EVIDENCE FOR FOCUSING ON SOCIAL RISK





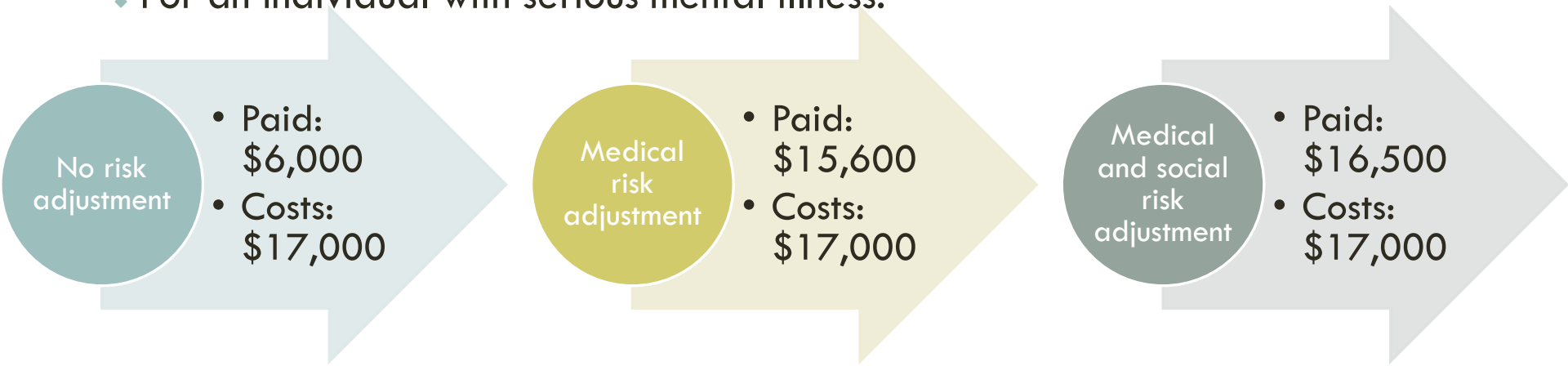
Figueroa et al, Med Care 2017

STRATEGIES TO REDUCE UNINTENDED CONSEQUENCES

- Account for social and medical risk in performance evaluation, where appropriate
  - Risk adjustment – including functional status
- Reward improvement
  - Helps baseline poor performers enter and succeed
- Consider targeted bonuses
  - Rewards only available to clinicians serving vulnerable populations

IMPACT OF MEDICAL AND SOCIAL RISK ADJUSTMENT

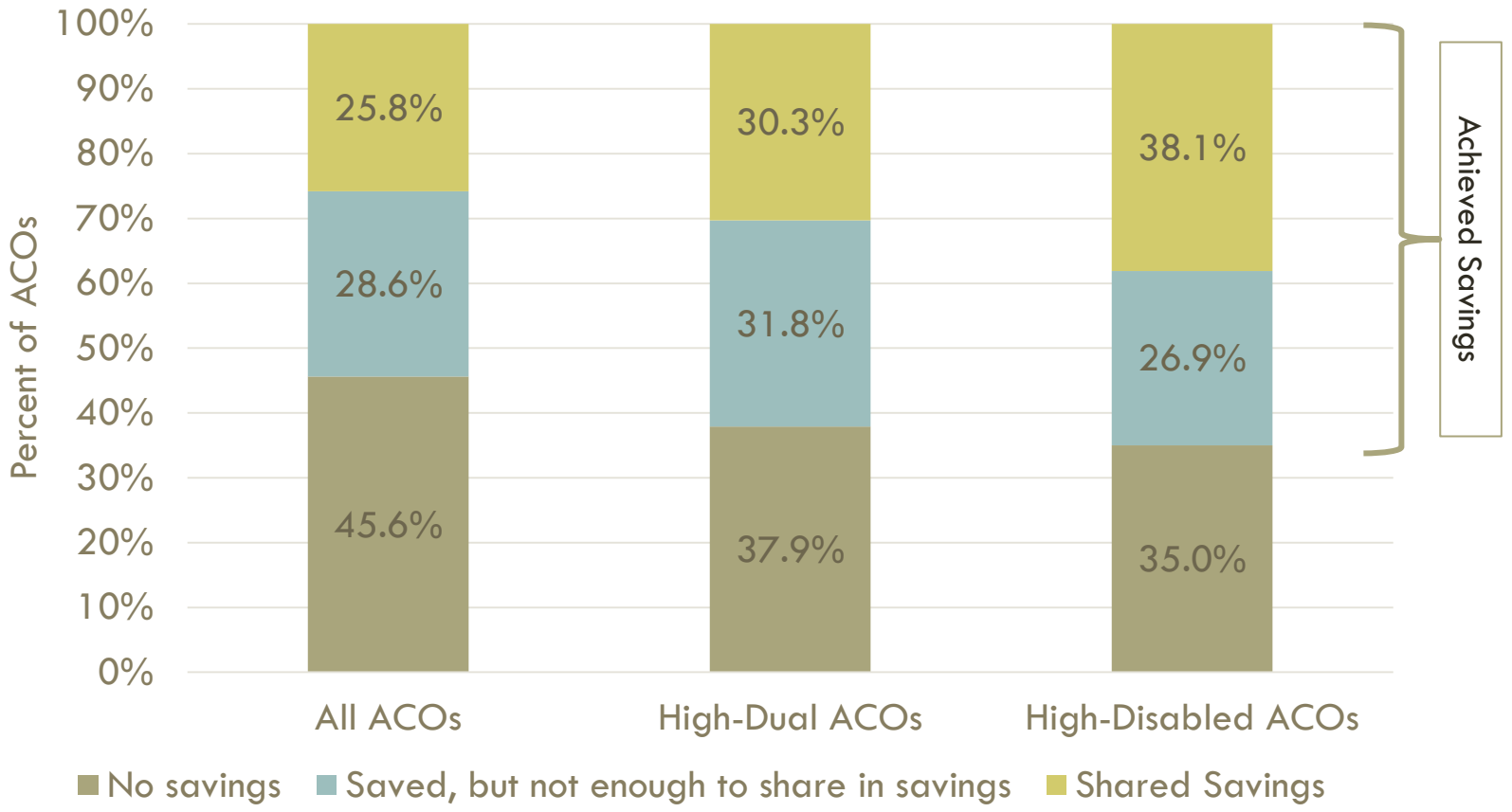
- For an individual with serious mental illness:



- For a Department of Mental Health client:

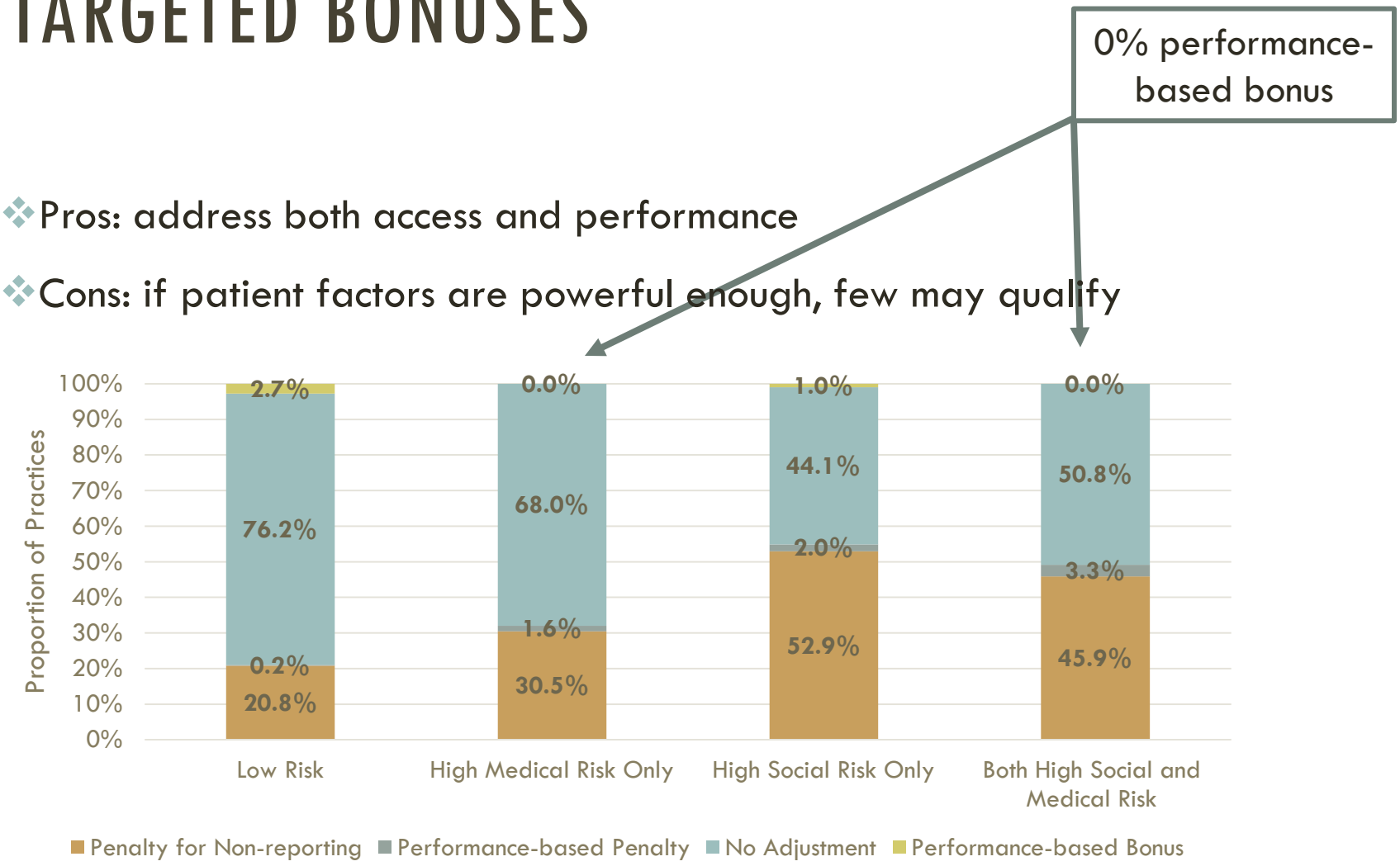
Ash et al, JAMA IM 2017

ACCOUNTABLE CARE COST TARGETS ARE AN IMPROVEMENT MEASURE



TARGETED BONUSES

- Pros: address both access and performance
- Cons: if patient factors are powerful enough, few may qualify



Chen et al, JAMA 2017

SUMMARY AND CONCLUSIONS

- Healthcare spending is high, rising, and concentrated in complex, vulnerable patients
- Payment reform has potential, but efficacy thus far has been modest
- Must be done with caution, or could hurt the most vulnerable

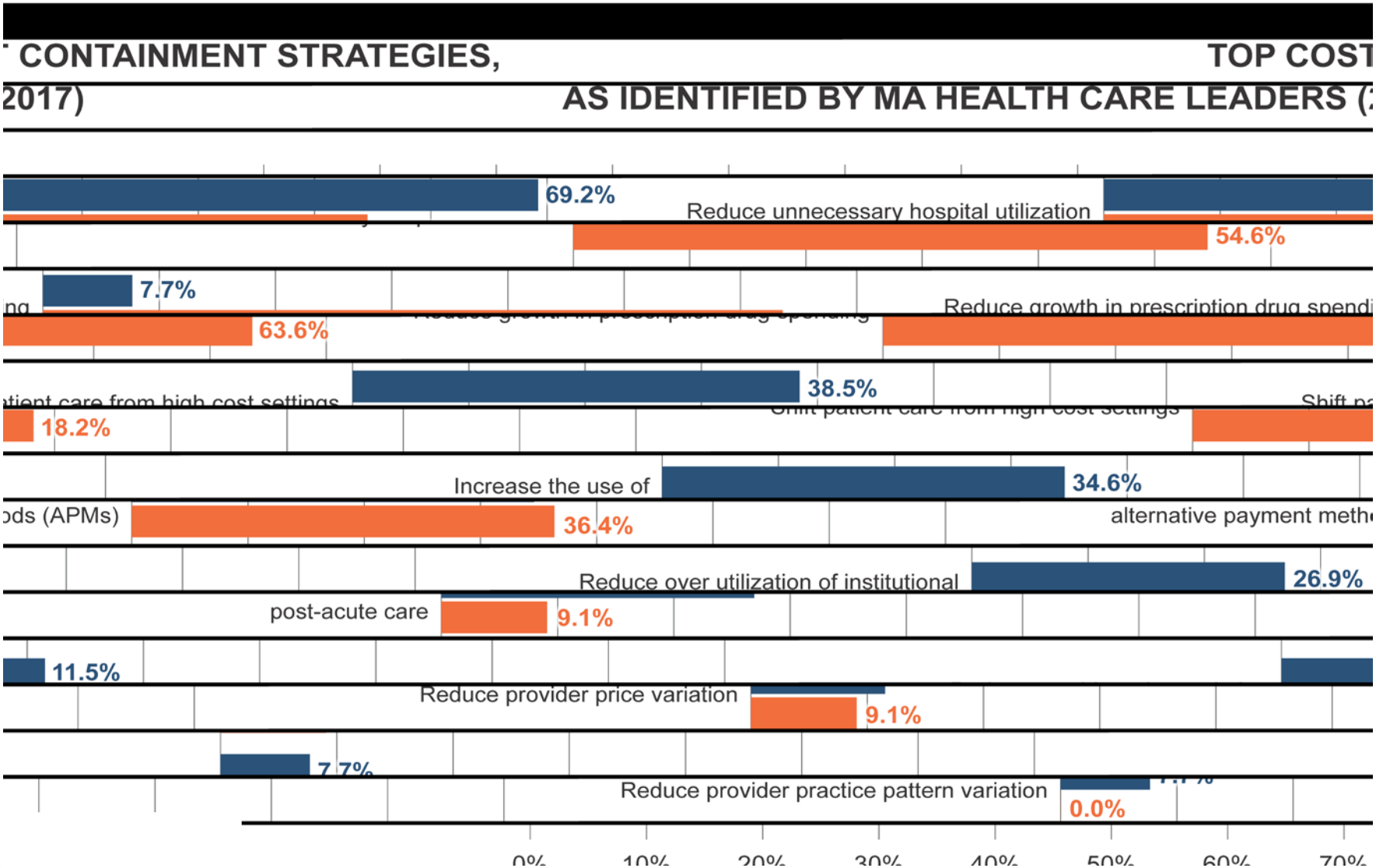
QUESTIONS / DISCUSSION

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Panel 1: Reducing Unnecessary Hospital Use

Reducing Unnecessary Hospital Utilization is a Top Priority for Providers and Health Plans in Massachusetts



Source: HPC 2017 Pre-Filed Testimony. All responses may be found at: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/annual-cost-trends-hearing/testimony.html

Reducing Unnecessary Hospital Utilization: Readmissions By the Numbers

All-payer, all-cause readmissions increased from 15.2% in 2013 to

15.8%

in 2015*

Readmission rate for patients with a behavioral health diagnosis:

20.2%*

Reducing readmissions by 20% would yield

$245 M

in annual savings**

Emerson risk-adjusted readmission rate:

14.9%*

Baystate Franklin risk-adjusted readmission rate:

15.9%*

Tufts Medical Center risk-adjusted readmission rate:

17.4%*

# of hospitals working to reduce readmissions through the CHART Program:

15

* CHIA Hospital-Wide Adult All Payer Readmissions in Massachusetts, December 2016: http://www.chiamass.gov/assets/docs/r/pubs/16/Readmissions-Report-2016-12.pdf

** HPC Benchmark Hearing, March 8, 2017, slide 29: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/testimony-regarding-modification-of-the-benchmark.html

Panel 1: Reducing Unnecessary Hospital Use

Witnesses

Baystate Franklin Medical Center	Ms. Cheryl Pascucci, Family Nurse Practitioner
Emerson Hospital	Ms. Christine Schuster, President and CEO
Hilltown Community Health Center	Ms. Eliza Lake, Chief Executive Officer
Tufts Health Plan	Mr. Christopher “Kit” Gorton, President, Public Plans
Tufts Medical Center	Dr. Michael Wagner, President and CEO

Goals

This panel will focus on efforts to reduce avoidable hospital readmissions and other forms of unnecessary hospital utilization. The panel will also discuss addressing the behavioral health and social needs of patients to avoid emergency department visits and boarding.

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HEALTH POLICY COMMISSION

Up Next

Presentation by the Office of the State Auditor

Panel 2: Evaluating the Impact of Recent Provider Transactions

MASSACHUSETTS
HEALTH POLICY COMMISSION

Presentation by the Office of the State Auditor

Annual Health Care

COST TRENDS HEARING

OCTOBER 2 & 3, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Panel 2: Evaluating the Impact of Recent Provider Transactions

Review of Past Hospital Acquisitions and Contracting Affiliations

- The HPC has continued to monitor the performance of providers post-transaction to understand the ongoing impacts on health care costs, quality, and access.
- Today, the HPC is reporting on one such metric – changes in site of care – for community hospitals that were recently acquired by, or which affiliated with, larger provider organizations.
- All of these hospitals and provider organizations cited “keeping care in the community” as a goal of the affiliation.
- Monitoring changes in site of care is important as one of the drivers of health care spending growth in Massachusetts is the increasing share of community-appropriate care provided by academic medical centers and teaching hospitals.
- Yet, providers have cited a range of barriers to keeping more care in the community.

Top Provider-Reported Barriers to Keeping Care in the Community

Patient Preference and Perception of Quality

Physician Preference

Geographic Proximity of More Expensive Setting

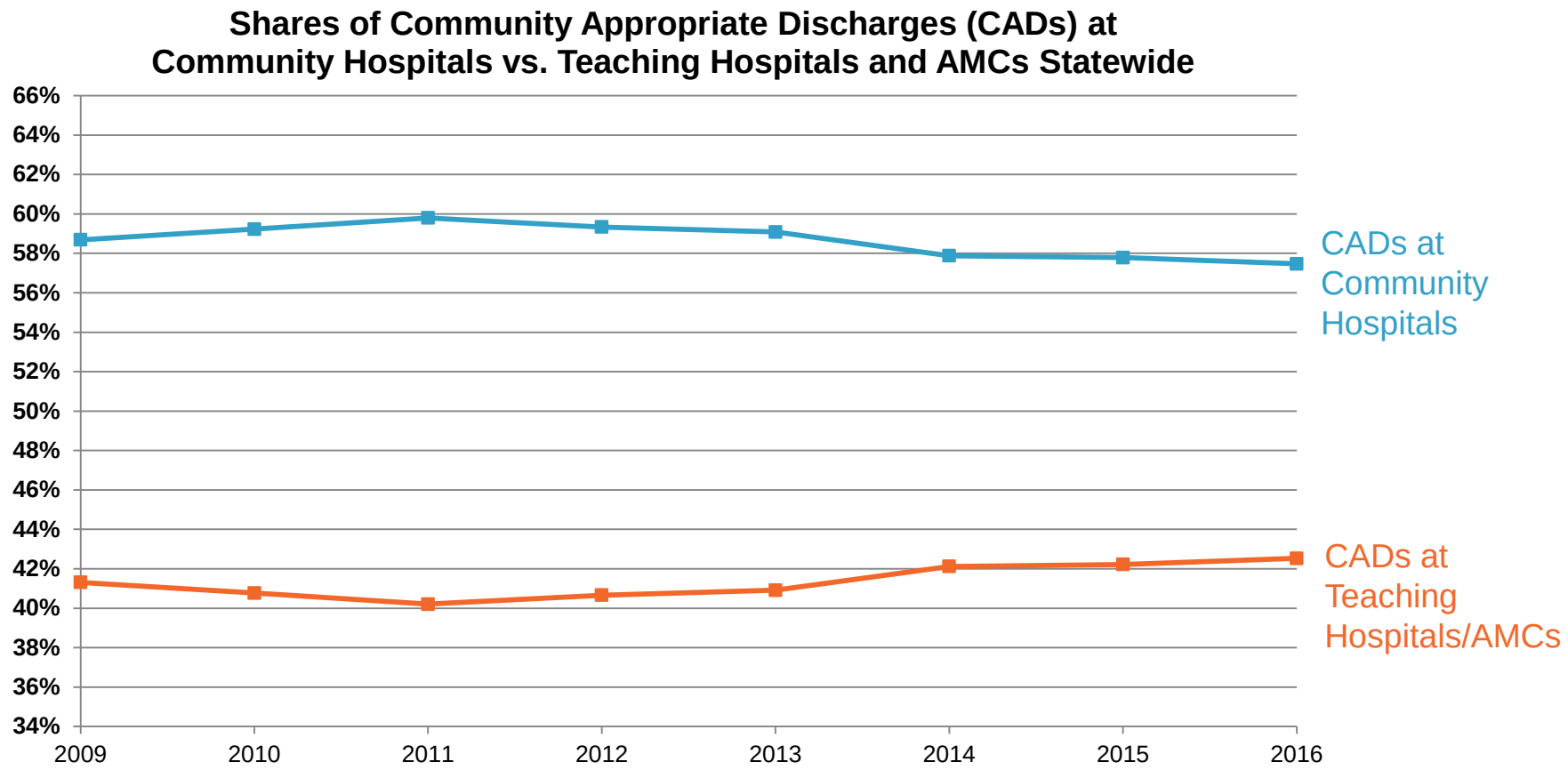
Insufficient Cost-Sharing Incentives

Site of Care Changes after Hospital Acquisitions and Affiliations: Overview

- The HPC examined 14 hospitals that were acquired by a provider organization or began a new contracting affiliation between 2011 and 2015.
- To examine the effects of hospital acquisitions and affiliations on whether community-appropriate care remained in the community, the HPC analyzed:
  - the share of local patients receiving community-appropriate care at the focal hospital, before and after the transaction, and
  - the share of local patients receiving community-appropriate care at other hospitals, including academic medical centers (AMCs) and teaching hospitals, before and after the transaction.
- Note that short time periods following transactions may prevent us from seeing the full impact of these affiliations, and observed trends may also be impacted by factors not related to the transactions.

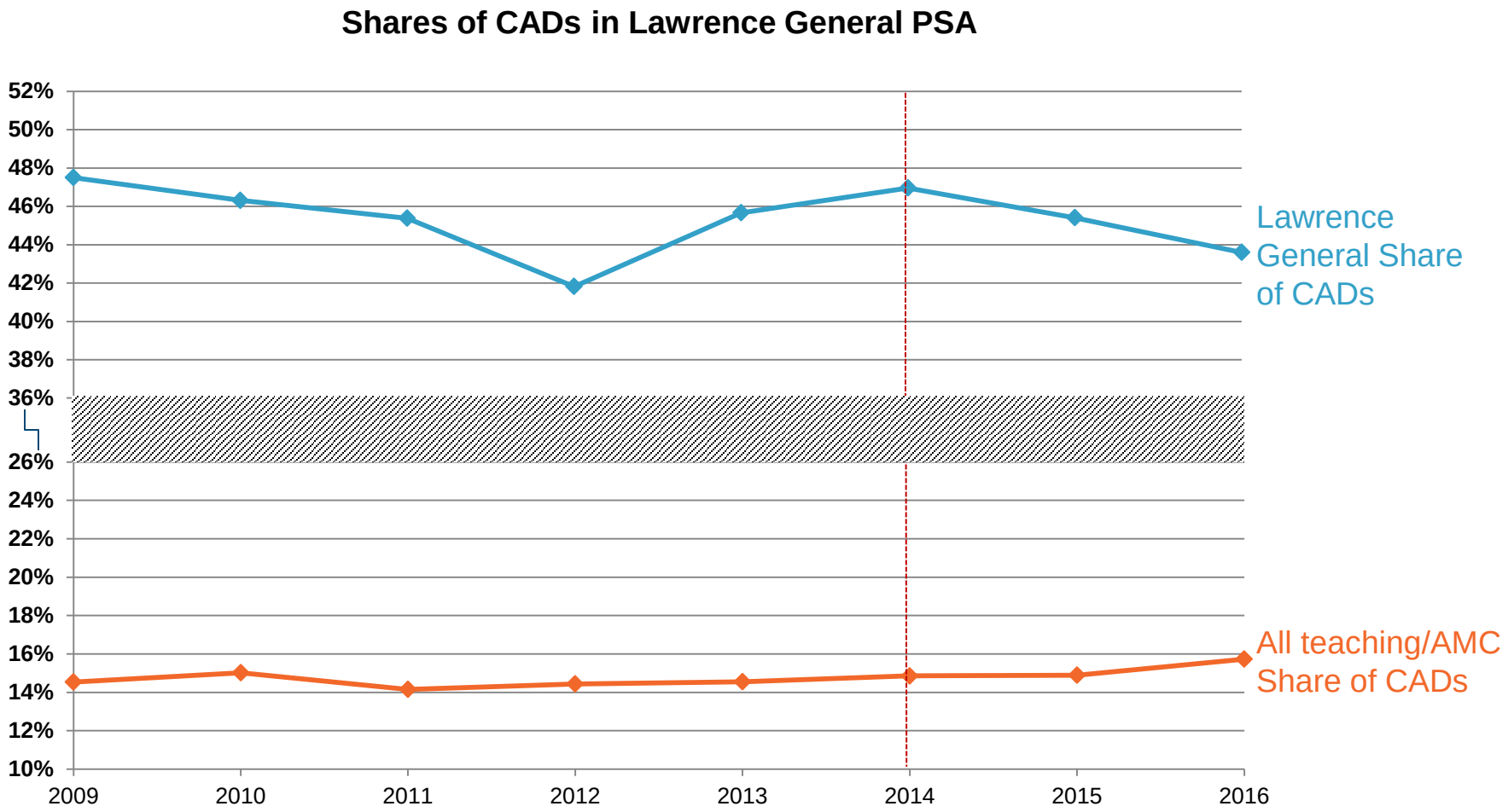
Notes: "Community-appropriate discharges" do not include intensive or specialized procedures, complications, or comorbidities and are clinically appropriate for nearly all community hospitals. "Local patients" were defined as those residing within the primary service area (PSA) of the focal hospital, as defined in the HPC's Technical Bulletin for 958 CMR 7.00: Notices of Material Change and Cost and Market Impact Reviews, available at http://www.mass.gov/anf/docs/hpc/regs-and-notices/technical-bulletin-circ.pdf
Source: 2009 to 2016 CHIA hospital discharge data.

Community-appropriate inpatient care is increasingly being provided by teaching hospitals and AMCs.



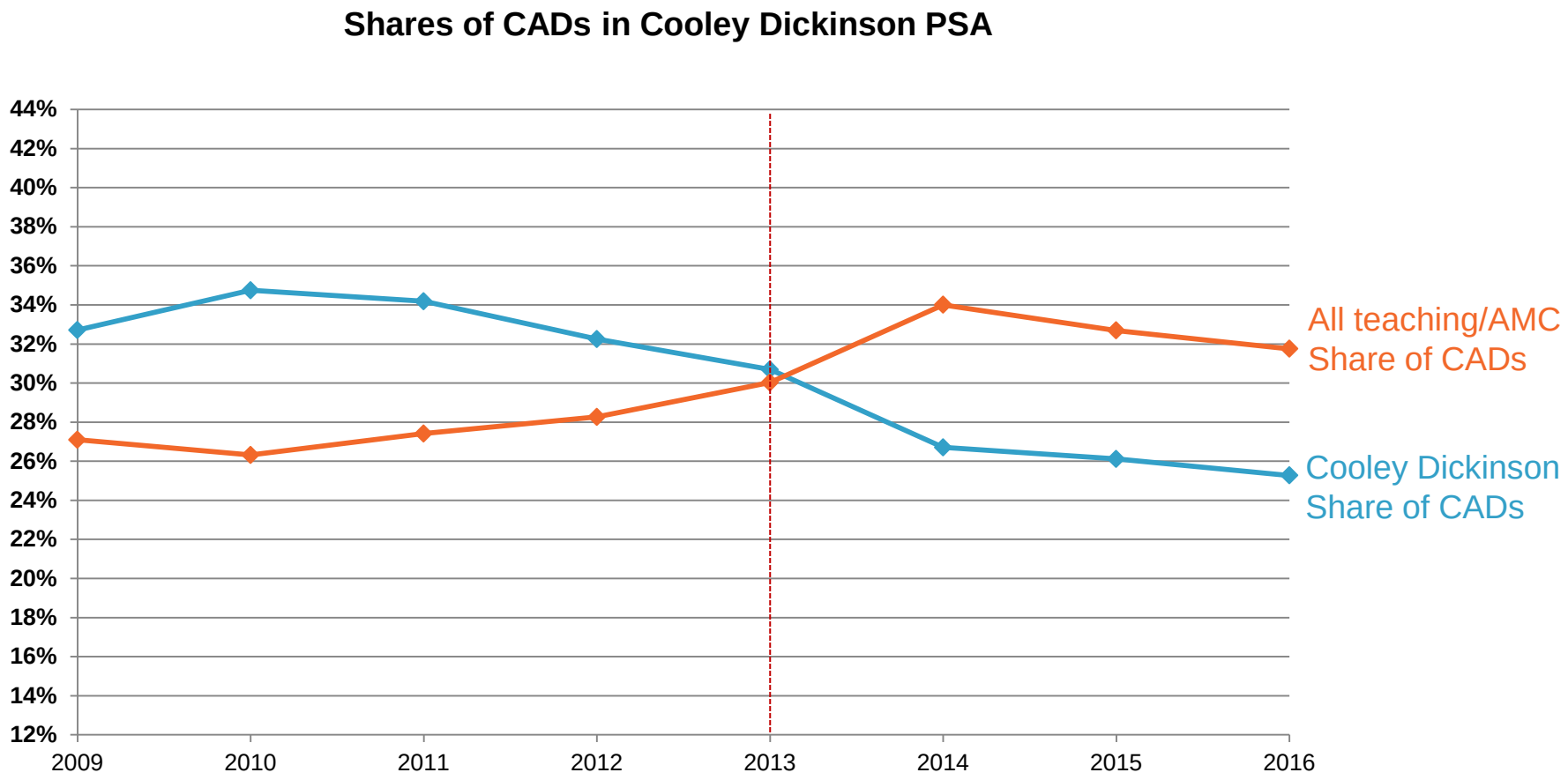
- Few hospitals that were acquired or formed contracting affiliations appear to have reversed this trend.

Lawrence General's share of local community-appropriate discharges declined faster than the statewide trend after it affiliated with BIDCO.

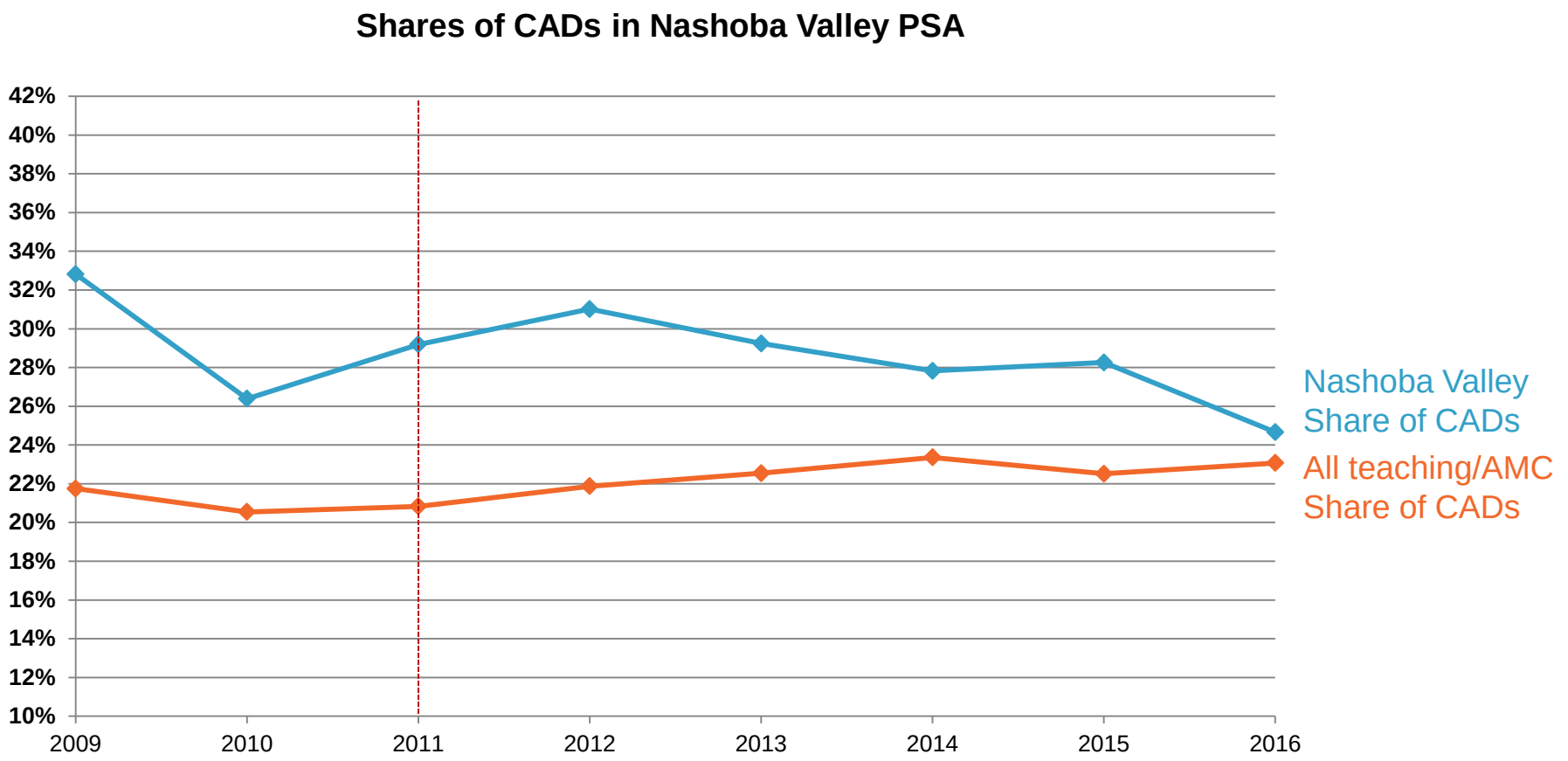


- Anna Jaques and Cambridge Health Alliance also saw their shares of CADs in their local areas decrease at a rate faster than the statewide trend after affiliating with BIDCO, with AMCs and teaching hospitals gaining shares at a rate faster than the statewide trend.

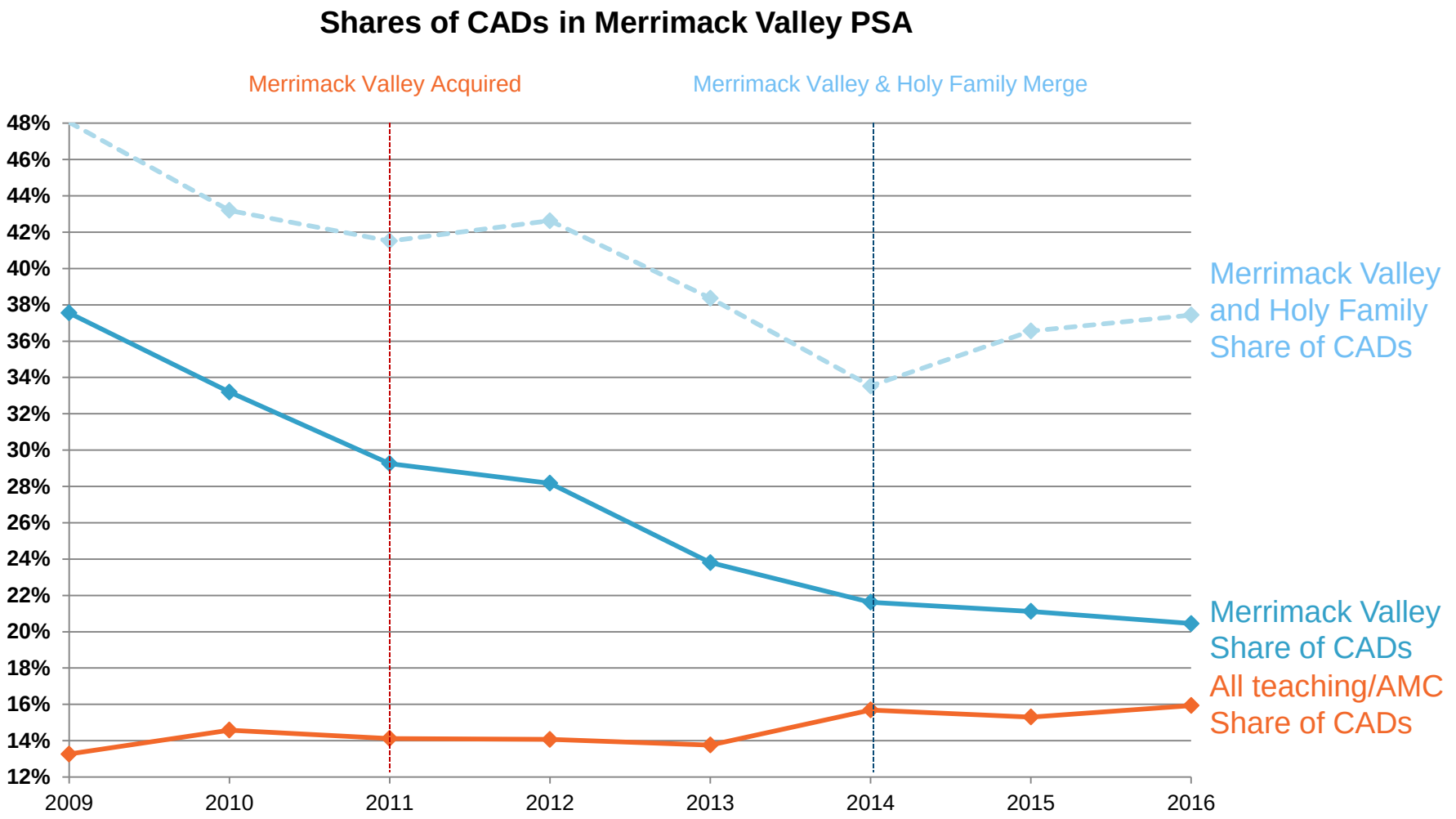
Cooley Dickinson's share of local community-appropriate discharges also decreased faster than the statewide trend after it was acquired by Partners.



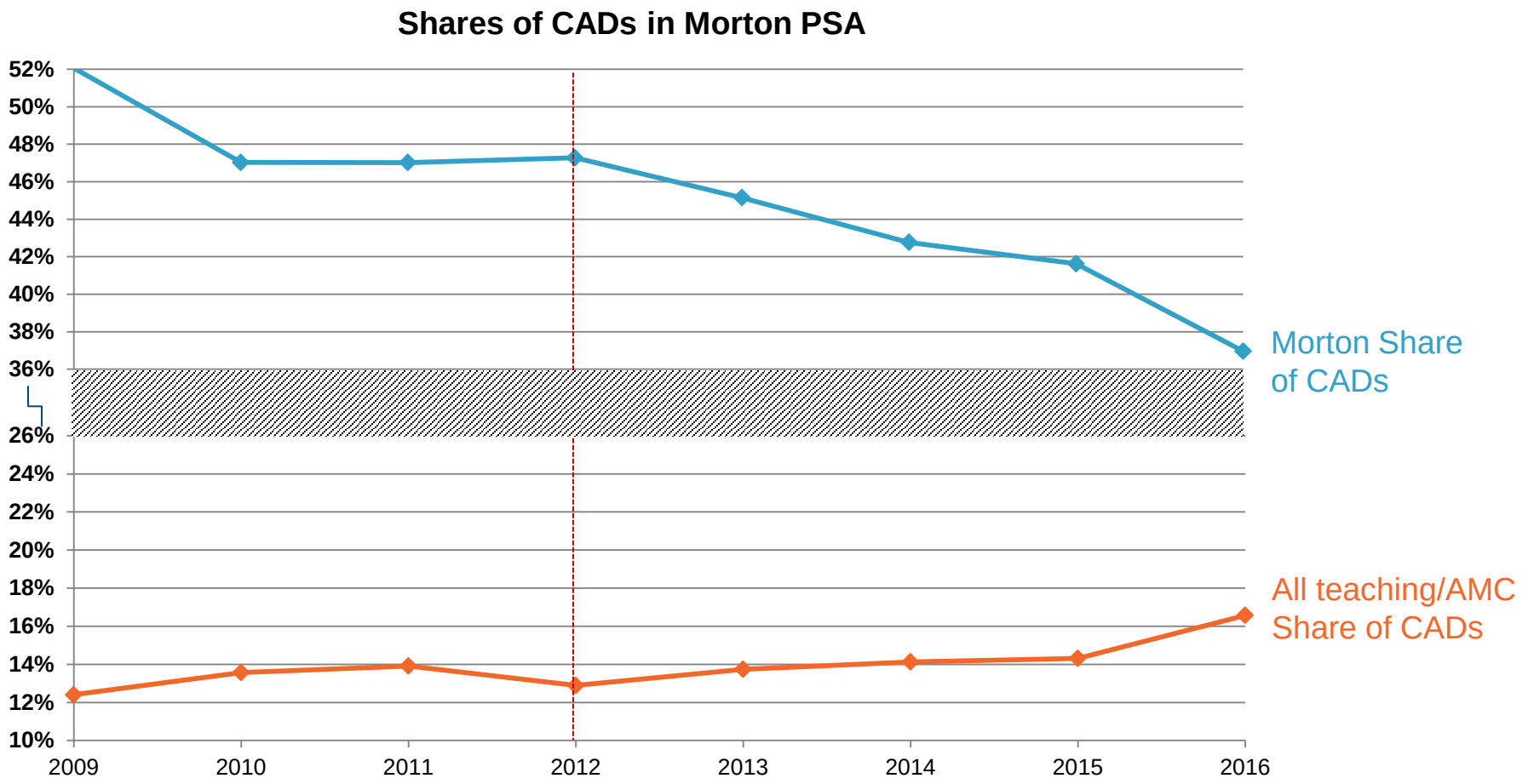
Nashoba Valley also lost shares of community-appropriate discharges in its local area after it was acquired by Steward.



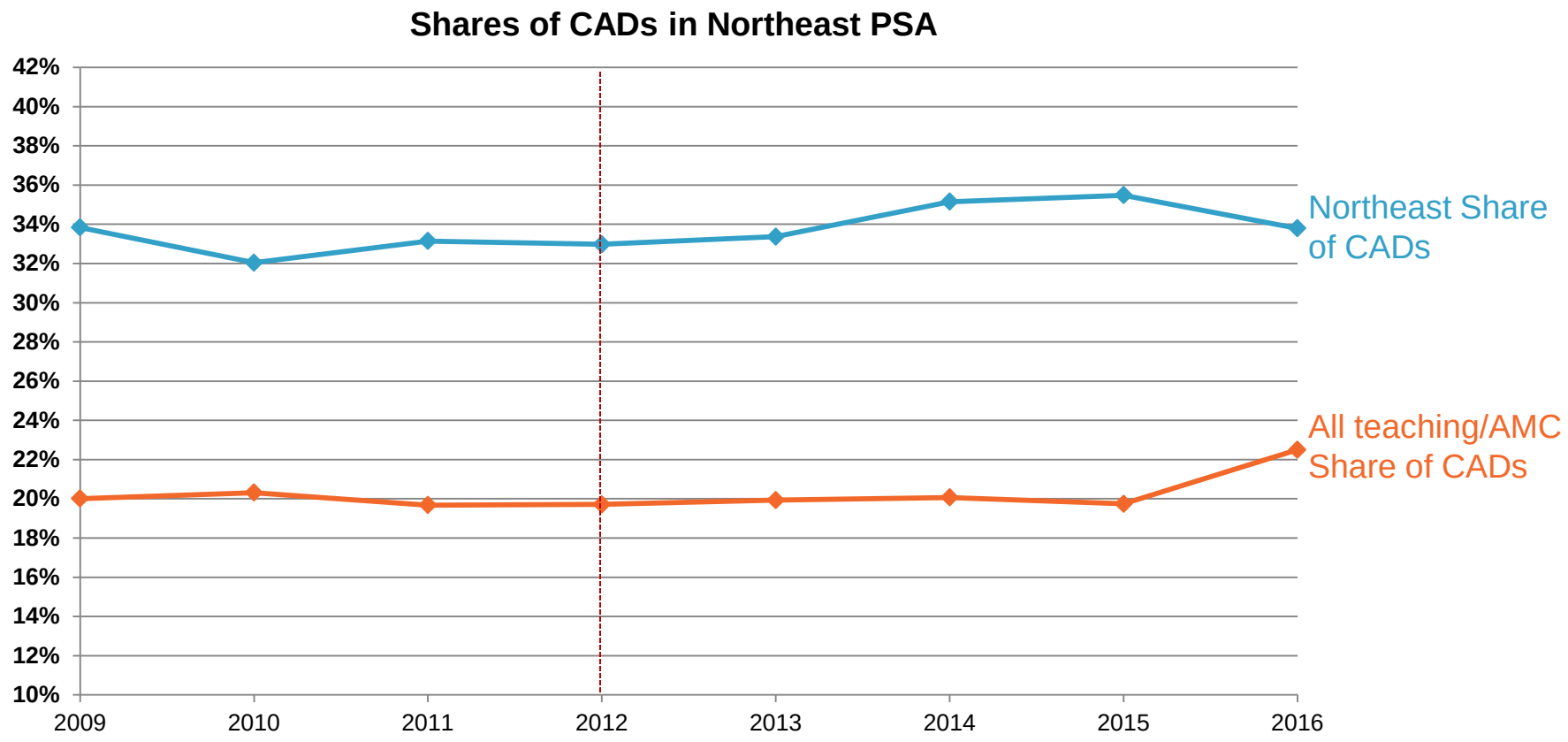
Merrimack Valley also lost shares of community-appropriate discharges in its local area after it was acquired by Steward.



Morton Hospital lost a significant share of community-appropriate discharges in its local area after it was acquired by Steward.

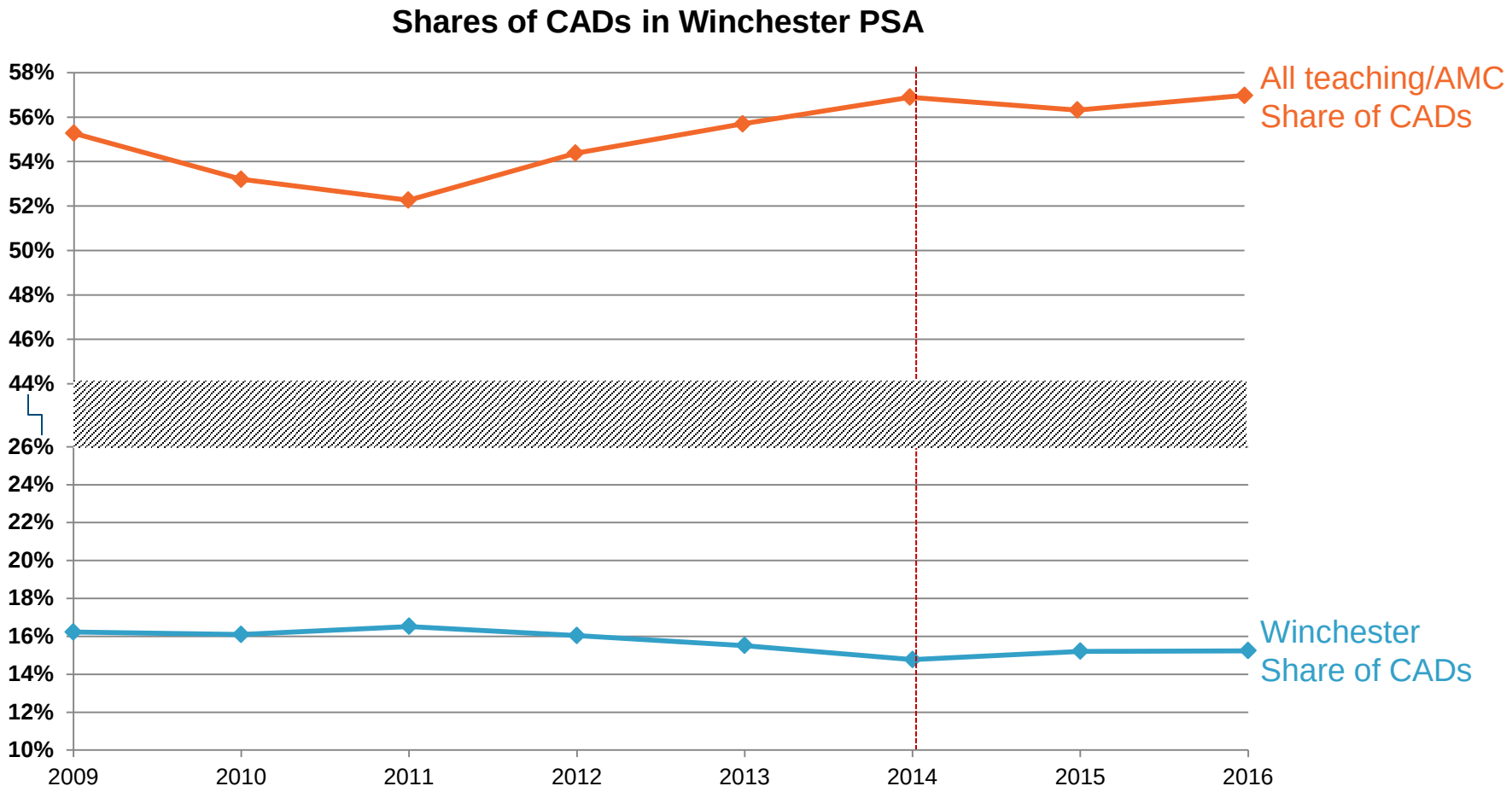


In contrast, Northeast Hospital did not experience the same decline in its share of community-appropriate discharges after acquisition by Lahey.



- The share of community-appropriate discharges at Northeast Hospital (Beverly Hospital and Addison-Gilbert) has **slightly increased** following acquisition by Lahey.
- Until 2016, the share of community-appropriate discharges at teaching hospitals and AMCs was also relatively stable.

Similarly, Winchester Hospital did not have a decline in its share of community-appropriate discharges after it was acquired by Lahey.



- Winchester Hospital's share of community-appropriate discharges was decreasing before its acquisition by Lahey, but its share appears to have now stabilized and slightly increased.
- While AMCs and teaching hospitals gained a slightly larger share of CADs in this service area following Winchester's acquisition, it has also been slower than the statewide trend.

The HPC is monitoring a range of other performance metrics for those providers that have formed new corporate or contracting affiliations.

The HPC is continuing to monitor a range of metrics for providers that have new affiliations such as:

- Relative price and composite relative price percentile;
- Inpatient net patient service revenue per case mix adjusted discharge;
- Inpatient costs per case mix adjusted discharge;
- Case mix index;
- Occupancy rate;
- Payer mix;
- Nationally-recognized quality metrics;
- Total Medical Expenses for patients residing in the providers' primary service areas; and
- Total Medical Expenses by provider organization.

We look forward to reporting information about these and other performance metrics in the future.

Panel 2: Evaluating the Impact of Recent Provider Transactions

Witnesses

Lahey Health	Dr. Howard Grant, President and CEO
Lawrence General Hospital	Ms. Dianne Anderson, President and CEO
Massachusetts General Hospital	Dr. Peter Slavin, President
Steward Health Care System	Mr. John Polanowicz, Executive Vice President

Goals

This panel will examine trends in keeping community-appropriate care in the community, before and after recent hospital acquisitions and affiliations. The panel will also discuss how broader changes in the provider market are impacting care delivery as well as cost, quality, and access.

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Presentation by the Office of the Attorney General

Annual Health Care

COST TRENDS HEARING

OCTOBER 2 & 3, 2017

AGO Presentation for 2017 Cost Trends Hearing

October 2, 2017

OFFICE OF ATTORNEY GENERAL
MAURA HEALEY
ONE ASHBURTON PLACE
BOSTON, MA 02108

Presentation Topics

I. Aligning AGO Community Benefits Guidelines with Broader Population Health Initiatives

II. A Related Question of Proportional Care for Underserved Communities

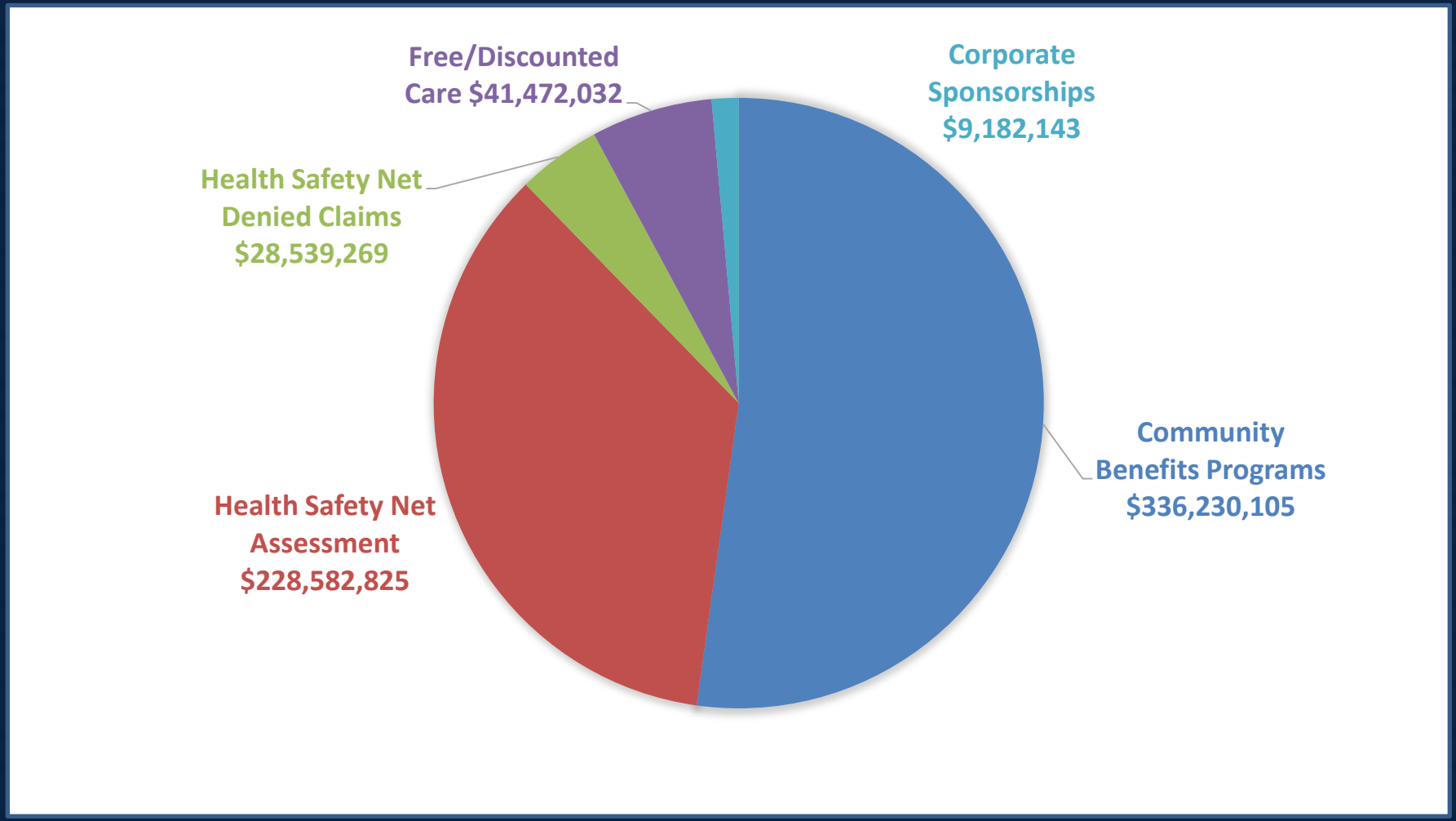
What Are Community Benefits?

- Hospitals have long been recognized for their charity care and efforts to improve the health of the communities they serve.
- Community Benefits are investments by hospitals and HMOs that further their charitable mission of addressing their communities' health and social needs.
- Community Benefits reporting programs have developed in many states, as well as federally through reporting to the IRS, as a way of formalizing the provision of these benefits and quantifying their community health impact.

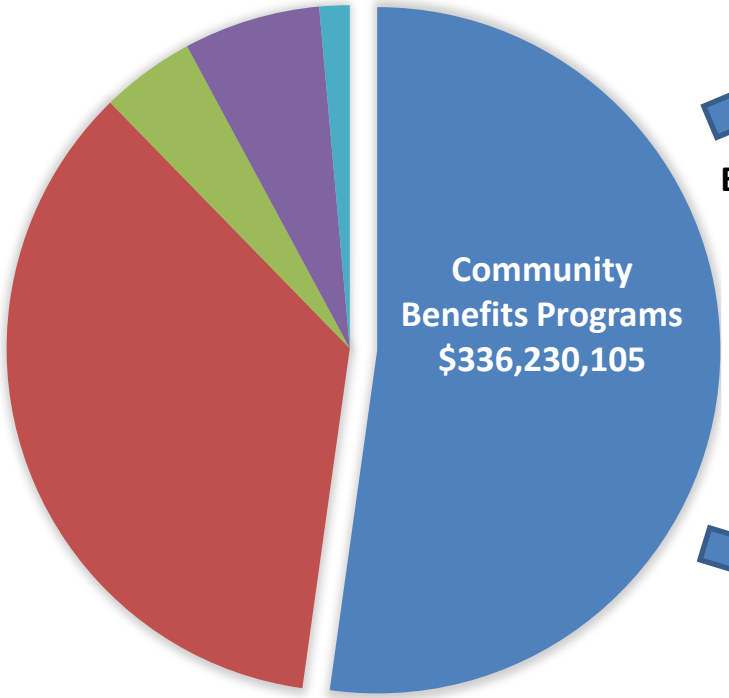
Goals for Updated Community Benefits Guidelines

- Align AGO Guidelines with IRS and DPH standards to decrease administrative burden on participants and harmonize resources for building long-term capacity to improve health outcomes and reduce disparities
- Improve coordination among participants and within regions, and enhance transparency around community engagement throughout the planning and implementation process
- Develop approaches to improving program assessment and transparency (e.g., by enhancing reporting on Community Benefits expenditures)

Breakdown of 2016 Hospital Community Benefits Spending



Opportunity for Increased Transparency into Substantial Community Health Investments



E.g., Investment Type

- Community Health Education
- Direct Clinical Services
- Access/Coverage Supports
- Investments in Social Determinants
- Grants/Donations

E.g., EOHHS/DPH Focus Issues

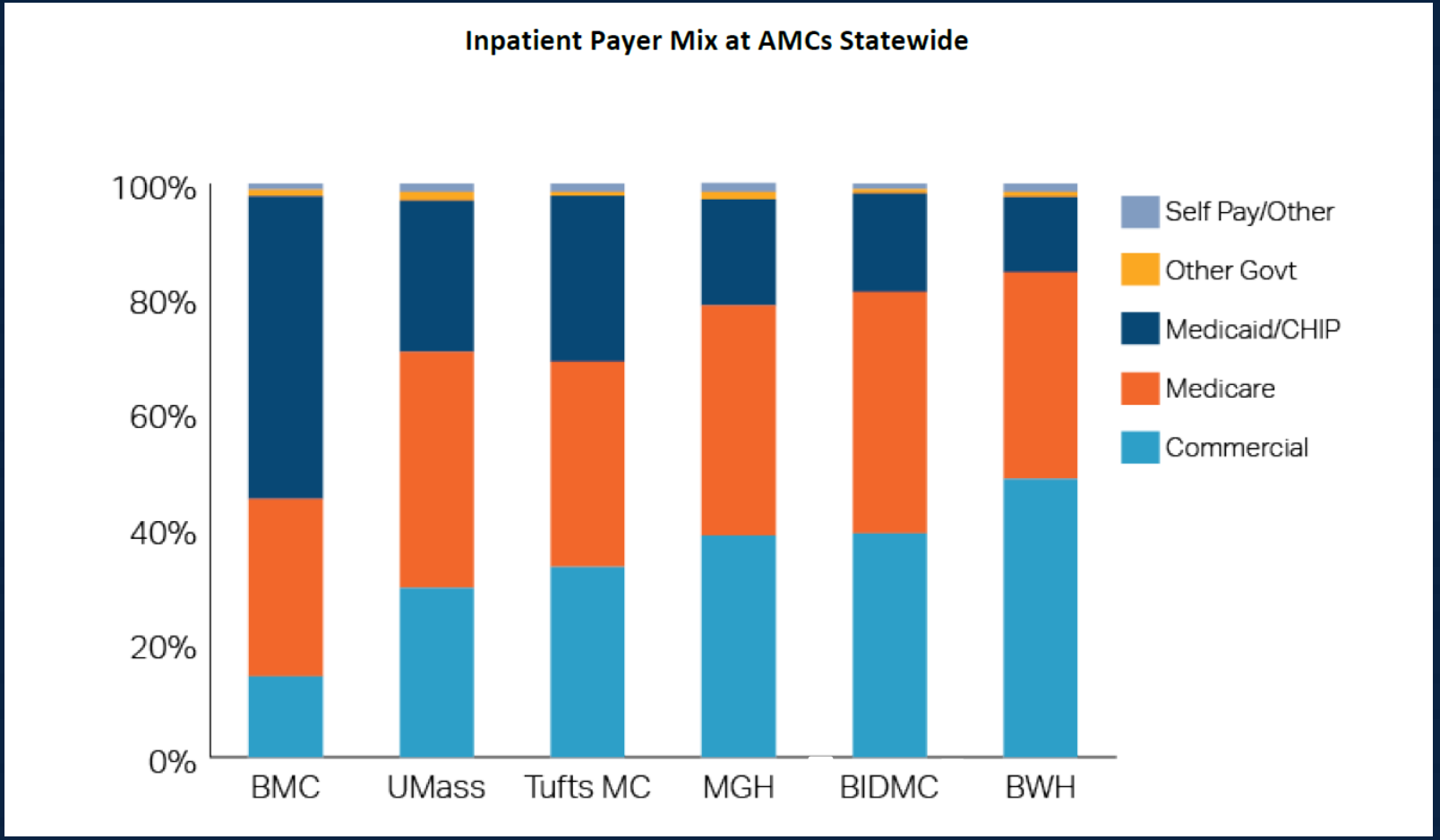
- Substance Use Disorder
- Housing Stability/Homelessness
- Mental Illness / Mental Health
- Chronic Disease
- Other Health Needs Identified by Community

Presentation Topics

I. Aligning AGO Community Benefits Guidelines with Broader Population Health Initiatives

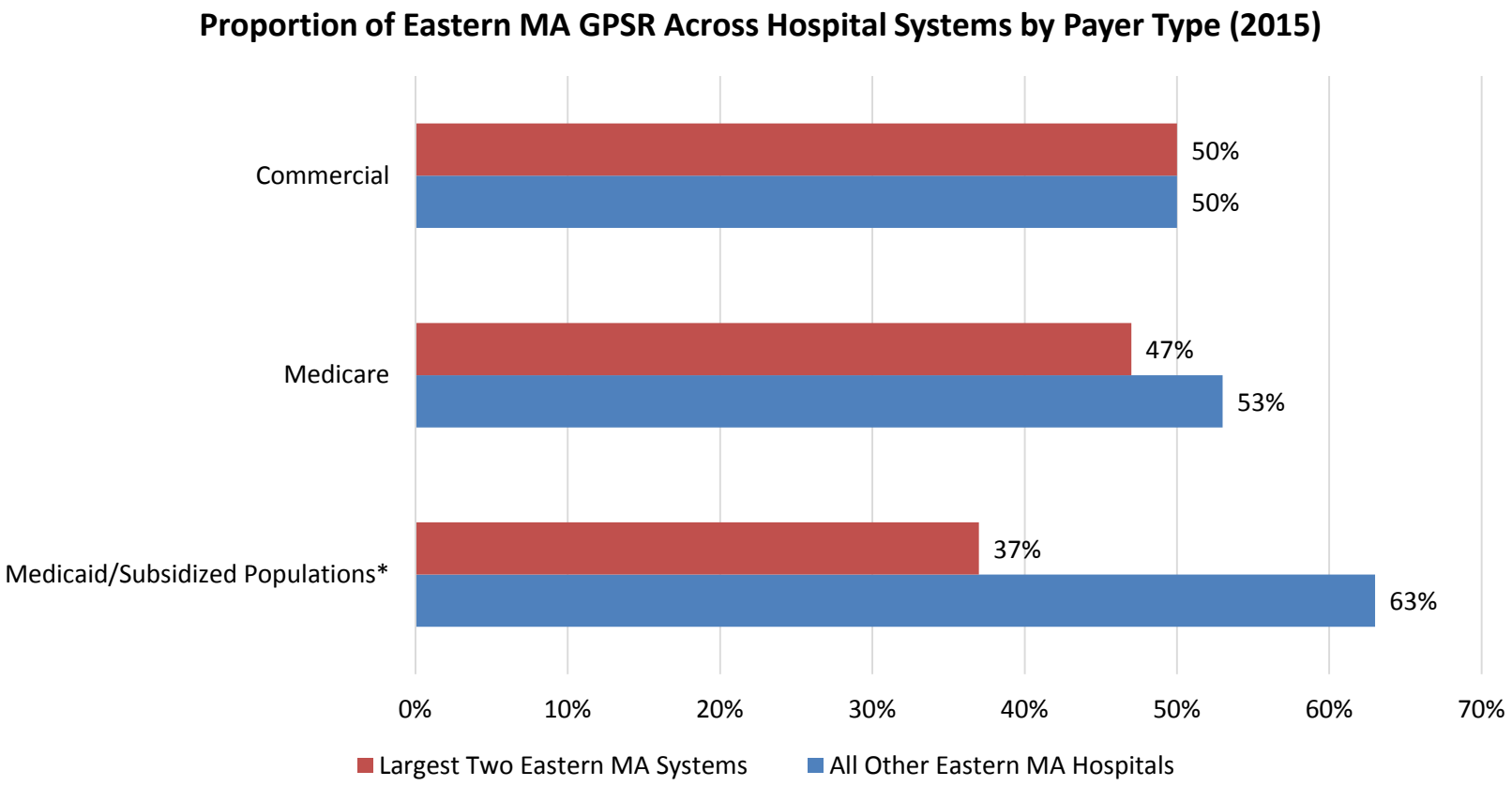
II. A Related Question of Proportional Care for Underserved Communities

Significant Variation in Payer Populations Served by Providers Is Well Documented by the HPC



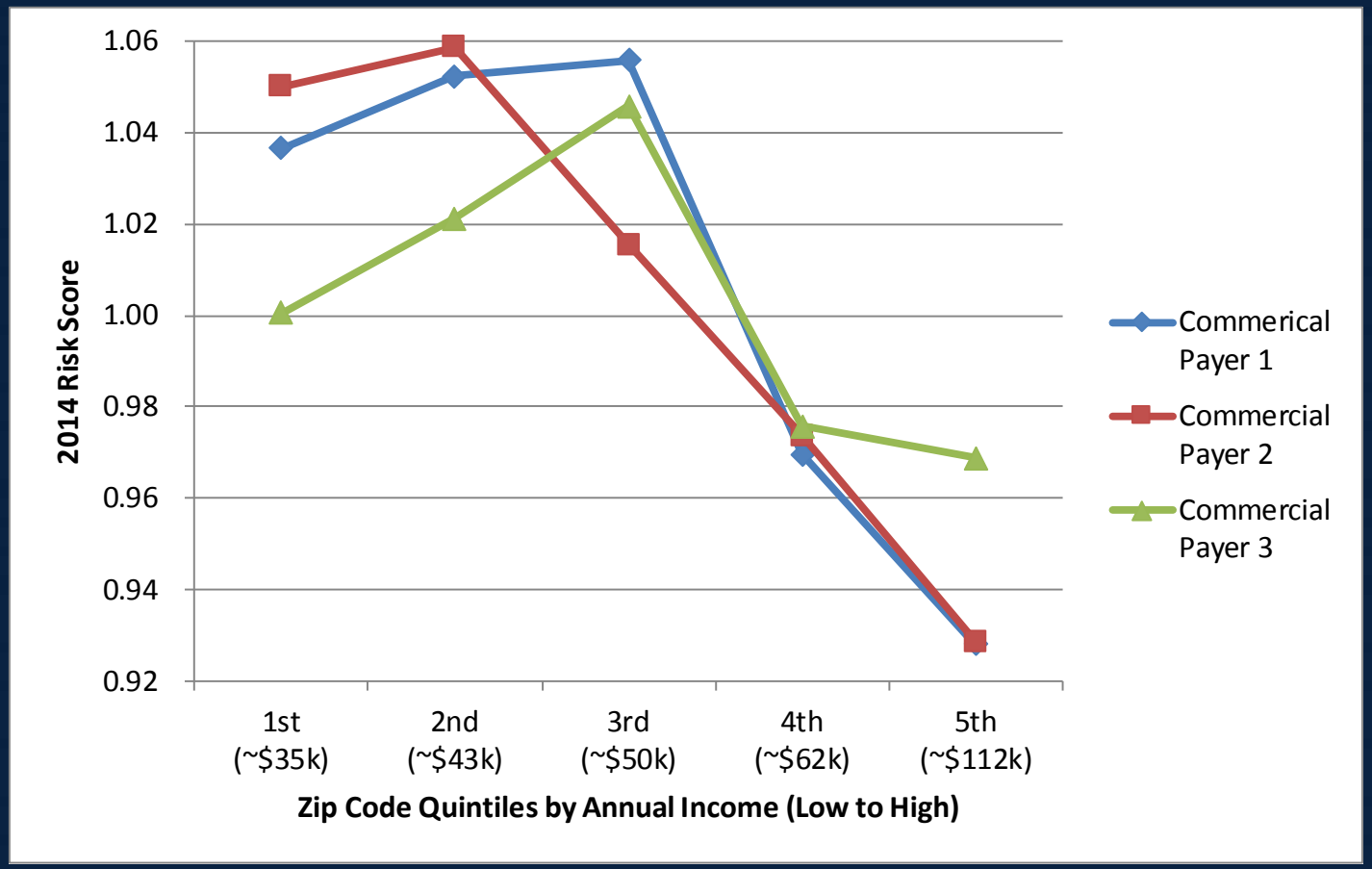
Source: Health Policy Commission CMIR (Sept. 7, 2016) at 57; based upon 2015 CHIA hospital discharge data.

Largest Provider Systems Tend to Have Higher Commercial Mix Than Government Mix

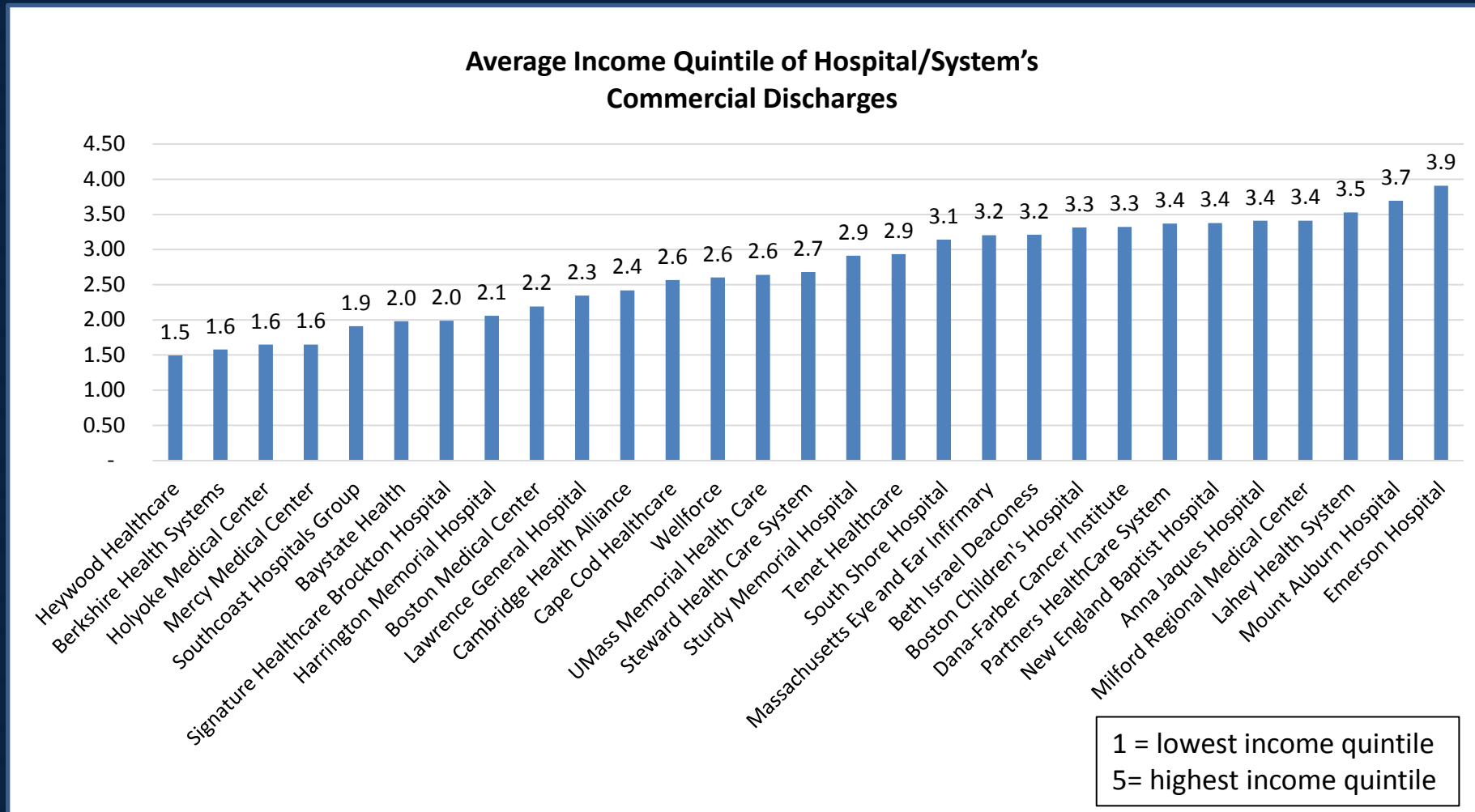


*Medicaid/Subsidized Populations includes MassHealth, Health Safety Net, and ConnectorCare.

Prior AGO Analysis Showed That Higher Income Communities Are Generally Healthier



Even Among Commercial Discharges, Hospitals Serve Different Proportions of Low-Income Patients



Opportunities for Coordinated Oversight of Access Questions

- Department of Public Health – e.g., Determination of Need Regulations
- Health Policy Commission – e.g., CMIRs, Performance Improvement Plans
- Attorney General's Office – e.g., Health Care Market Oversight, Community Benefits

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Public Testimony

Annual Health Care

COST TRENDS HEARING

OCTOBER 2 & 3, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

Public Testimony

Annual Health Care

COST TRENDS HEARING

OCTOBER 2 & 3, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

October 3, 2017

Annual Health Care

COST TRENDS HEARING

OCTOBER 2 & 3, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Panel 3: Promoting High-Value Care Through Payment Reform and Purchaser Innovations

Promoting High-Value Care Through Payment Reform and Purchaser Innovations

Top Health Plan APM Expansion Strategies

- **Expand APM adoption in public programs**, such as MassHealth and Medicare Advantage
- **Expand adoption beyond primary care** to include other provider types, such as specialists

Health Plan Payment Policy Innovations

- **100%** have policies related to **readmissions**
- **82%** have policies related to **telemedicine**
- **45%** have policies related to **behavioral health integration** into primary care
- **18%** have policies related to services to remove/protect **patients from violence**

Top Provider APM Expansion Barriers

- **Lack of alignment on APM models**, including quality measurement, with limited resources to invest in necessary infrastructure
- Most APMs are still based on a **fee-for-service chassis**

Quality Measures

Payers require provider reporting on **106** different quality measures for APMs

Health Care Website Transparency Inquiries

The top health plans reported **180,705** inquiries in 2016, a **30%** increase from 2015

HPC

Source: HPC 2017 Pre-Filed Testimony. All responses may be found at: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/annual-cost-trends-hearing/testimony.html

Panel 3: Promoting High-Value Care Through Payment Reform and Purchaser Innovations

Witnesses

Atrius Health	Dr. Steven Strongwater, President and CEO
Blue Cross Blue Shield of Massachusetts	Ms. Deborah Devaux, Chief Operating Officer
Group Insurance Commission	Dr. Roberta Herman, Executive Director
New England Baptist Hospital	Ms. Trish Hannon, President and CEO

Goals

This panel will focus on the adoption and improvement of alternative payment models (APMs) and innovations to promote the use of high-value providers. The panel will also examine purchaser strategies to promote efficient care and innovative care delivery models.

MASSACHUSETTS
HEALTH POLICY COMMISSION

Up Next

Panel 4: Achieving the Health Care Cost Growth Benchmark in 2018 and Beyond

Key “Forward-Looking” Policies and Strategies Discussed During the Hearing

- Strengthen and support primary care, behavioral health, and team-based models of coordinated care that address “whole person” needs of patients to better reduce avoidable hospital use (e.g. readmissions, ED visits)
- Account for socio-economic factors in payment policies
- Address underlying price disparities
- Continue to monitor community appropriate discharges in Massachusetts, and investigate other measures of success for the aligned goal of providing the “right care, at the right price, at the right time”
- Improve alternative payment methodologies to reward providers for providing high-value care and move away from an underlying FFS architecture
- Improve financial incentives to reward consumers who choose high-value health insurance products and providers

Panel 4: Achieving the Health Care Cost Growth Benchmark in 2018 and Beyond

Witnesses

AstraZeneca	Mr. Richard Buckley, Vice President, Global Corporate Affairs
Beth Israel Deaconess Medical Center	Dr. Kevin Tabb, President and CEO
Harvard Pilgrim Health Care	Mr. Eric Schultz, President and CEO
Iora Health	Dr. Rushika Fernandopulle, Co-Founder and CEO

Goals

This panel will discuss strategies to meet the health care cost growth benchmark in 2018 and beyond by tackling issues such as the scalability of innovations in care delivery and payment, spending on pharmaceuticals and medical devices, and the future of the Massachusetts health care system.

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Concluding Discussion

Annual Health Care

COST TRENDS HEARING

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