MASSACHUSETTS
HEALTH POLICY COMMISSION

Annual Health Care
COST TRENDS HEARING

OCTOBER 2 & 3, 2017

Executive Summary

December 1, 2017

MASSACHUSETTS HEALTH POLICY COMMISSION

2017 Cost Trends Hearing
October 2-3
Suffolk University Law School – Boston, MA

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2017 Health Care Cost Trends Hearing

MONDAY, OCTOBER 2

Welcome and Remarks **9:00am**

Dr. Stuart Altman, Chair, and Mr. David Seltz, Executive Director, Health Policy Commission
The Honorable Charles Baker, Governor
The Honorable Stanley Rosenberg, President of the Senate

State Perspective: Health Care Spending Trends and Impact on Affordability **9:45am**

Mr. Ray Campbell, Executive Director, Center for Health Information and Analysis
Dr. David Auerbach, Director, Research and Cost Trends, Health Policy Commission

National Perspective: Health Care Costs and Readmissions **10:30am**

Dr. Karen Joynt Maddox, MD, MPH, Assistant Professor, Washington University School of Medicine and Brown School of Social Work

Witness Panel 1: Reducing Unnecessary Hospital Use **11:15am**

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.

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

Lunch Break **12:30pm**

Presentation from the Office of the State Auditor **1:15 pm**

Ms. Pamela E. Lomax, Deputy Auditor for Administration and Finance

Witness Panel 2: Evaluating the Impact of Recent Provider Transactions **1:30pm**

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.

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

Presentation from the Office of the Attorney General **2:45pm**

Ms. Sandra Wolitzky, Assistant Attorney General, Health Care Division

Public Testimony Opportunity **3:00pm**

Adjournment **4:00pm**

2017 Health Care Cost Trends Hearing

TUESDAY, OCTOBER 3

Welcome and Remarks **9:00am**

Dr. Stuart Altman, Chair, and Mr. David Seltz, Executive Director, Health Policy Commission
The Honorable Maura Healey, Attorney General
The Honorable Robert DeLeo, Speaker of the House

Witness Panel 3: Promoting High-Value Care Through Payment Reform and Purchaser Innovations **10:00am**

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.

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

Break **11:15am**

Witness Panel 4: Achieving the Health Care Cost Growth Benchmark in 2018 and Beyond **11:30am**

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.

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

Closing Discussion **12:45pm**

Board of Commissioners, Health Policy Commission

Adjournment **1:30pm**

INTRODUCTION

On October 2 and 3, 2017, the Massachusetts Health Policy Commission (HPC) convened its fifth annual Health Care Cost Trends Hearing (CTH) at Suffolk University Law School in Boston, Massachusetts.

The annual health care cost trends hearing is a public event at which policymakers and researchers convene to address challenges and discuss opportunities for improving care and reducing costs in the Commonwealth's health care sector. The prominent, two-day hearing features live testimony from top health care executives, industry leaders, and government officials. Questions are posed from Massachusetts and national health care experts about the state's performance under the Health Care Cost Growth Benchmark, the drivers of health care costs, and other health care reform efforts.

In addition to presentations by a leading researcher and keynote remarks from the Governor and Attorney General, the 2017 hearing featured four witness panels. These panels provided the audience with thoughts, concerns, and policy suggestions for upcoming research and initiatives. Panels addressed the following issues:

- Reducing Unnecessary Hospital Use
- Evaluating the Impact of Recent Provider Transactions
- Promoting High-Value Care Through Payment Reform and Purchaser Innovations
- Achieving the Health Care Cost Growth Benchmark in 2018 and Beyond

This Executive Summary is intended to summarize the major themes raised by CTH participants. The assertions, conclusions, and recommendations described do not necessarily reflect the position of the HPC or its commissioners. To watch a full recording of the Hearing, please visit the HPC's website.

VISIBILITY AND REACH

Nearly 450 people attended the 2017 CTH, with an additional 2,500 individuals watching via the online live stream. The 2017 CTH also drew an international audience, with viewers from the U.S., India, Sweden, the Philippines, the United Kingdom, Malaysia, and China.

AUDIENCE

- Nearly 450 individuals in-person
- Over 2,500 individuals watching online
- International viewers came from India, Sweden, Philippines, UK, Pakistan, Malaysia and China

WEBSITE

- 5,595 unique website visits
- 15.7% of all traffic to the Mass.Gov website
- The majority of people navigated to the Cost Trends Hearing agenda and materials

MEDIA

- 20 unique articles
- 18 major news outlets

TWITTER

- 125 Official HPC Tweets
- 53,600 impressions (potential views by unique Twitter users)
- 202 Retweets → 168 Likes → 20 Replies

Overview of Panels

PANEL OVERVIEW

REDUCING UNNECESSARY HOSPITAL USE

Avoidable hospital use is a prominent driver of health care costs. Massachusetts continues to significantly higher rates of hospital readmissions than other states have. The purpose of Panel 1 was to discuss different providers' efforts to reduce avoidable hospital readmissions and the challenges in addressing patients' behavioral health (BH) and social needs to reduce boarding in and unnecessary visits to the emergency department.

WITNESSES

I. Baystate Franklin Medical Center
II. Emerson Hospital
III. Hilltown Community Health Center
IV. Tufts Medical Center
V. Tufts Public Health Plan

MAIN TAKEAWAYS FROM THE PANEL

- Technological barriers are a significant challenge for providers in rural areas
  Panelists discussed their positive experiences with technological advances such as secure remote communication with patients and IBM Watson for population health management. Hilltown Community Health Center (CHC), however, noted that its patients have particularly poor access to behavioral health (especially psychiatry) and long term supports and services. These geographic and workforce-related access barriers are compounded by a lack of high speed internet and reliable cellular service. Hilltown CHC is interested in building capacity for telemedicine, but lower-tech methods of coordinating care will be necessary without adequate infrastructure investments.

- Hospital discharges should activate team-based resources in primary care to reduce future acute care utilization
  At Tufts Medical Center, primary care providers take a proactive approach to reducing readmissions by identifying patients who are in decline or at risk of readmission, then adjusting their care plans accordingly. Patient-centered medical home and other team-based health care models facilitate care management across the care delivery continuum into the community and social determinants of health (e.g., stable housing, food security, education). Some providers have also trained primary care physicians (PCPs) to start conversations on palliative and hospice care with patients for whom these are appropriate.

- The opioid epidemic has illuminated the shortcomings of post-discharge care in recent years
  The epidemic of opioid use disorder is contributing to the Commonwealth's high readmissions rate. Providers often lack infrastructure for follow-up after detoxification discharge. Without access to local and appropriate follow-up care, care management, and social services, patients often cycle through relapse, overdose, hospitalization, detoxification, and recovery. The burden of the opioid epidemic is also driving clinician burnout. MassHealth's Section 1115 Demonstration includes provisions that address gaps in the delivery system for BH care access, including for opioid use disorder.

- Short-term, grant-based funding for CHWs and CHART-style programs are working, but sustainable reform requires long-term investment and partnership
  Community Hospital Acceleration and Revitalization (CHART) awardees stated that the program has been a collaborative and positive experience: Baystate Franklin Medical Center's community health workers engage patients immediately after emergency department discharge to identify their needs, drive them to

appointments, and serve as a resource patients can reach by secure text in real time. Emerson will sustain its CHART initiatives even after funding ends. Tufts Medical Center stated that while accountable care organization (ACO) transformation initiatives help align incentives with those of readmissions interventions, community hospital providers are less willing to take on risk since they already receive low reimbursement relative to their patients' disproportionately complex social and medical care. Movement to an ACO model presents some threat to community hospitals' economic viability unless academic medical centers (AMCs) treat them as partners in care delivery, instead of as "feeders" or solely referral sources.

- Panelists expressed reservations about hospital readmissions as a metric
  Panelists noted that readmissions are expected for patients who are receiving end-of-life care and patients with catastrophic illness. Hospital readmission metrics fail to adequately risk-adjust for socioeconomic factors and therefore punish providers who have higher shares of sick patients and/or serve disadvantaged communities. The metric also focuses only on a single level of care without considering coordination between different levels of care in readmissions calculations.

- Providers predicted that efforts to reduce readmissions will take 10 years to pay off
  Risk-based contracting and global payments would create a strong financial incentive for providers to reduce acute care use. Emerson Hospital has chosen to invest in health and wellness centers with over 100 health promotion and education programs even though it anticipates it will take 10 years before it can realize savings. Other panelists concurred with expectations of late but long-term return on investment.

EVALUATING THE IMPACT OF RECENT PROVIDER MARKET TRANSACTIONS

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

WITNESSES

I. Lahey Health
II. Lawrence General Hospital
III. Massachusetts General Hospital
IV. Steward Health Care

MAIN TAKEAWAYS FROM THE PANEL

- Keeping care in the community is an important goal for the Commonwealth
  Panelists emphasized their commitment to directing appropriate care to community hospitals rather than teaching hospitals and AMCs.

- Shifting care to community hospitals is a long-term project
  Panelists stated that it takes time to make the changes needed to encourage patients and physicians to use community hospitals instead of teaching hospitals and AMCs. Accordingly, they said we should not assume that the absence of encouraging evidence thus far means that no progress is being made, and should continue to monitor trends.

- Investment in community hospitals is necessary for efforts to keep care in these institutions
  Panelists described the need to invest in improvements to community hospitals, including facility improvements, specialist recruitment, and implementation of new technology, in order to attract more patients.

- Price variation, proximity to teaching hospitals, and patient preference are challenges that health systems are facing
  Panelists cited price variation, and especially underpayment of some community hospitals, as one factor making it more difficult to invest in these institutions. They also observed that hospitals closer to downtown Boston may have a more difficult time encouraging patients not to go to a downtown AMC, and that patients may not realize that they can receive high-quality care in a community setting. Patient education and more significant financial incentives to choose a community hospital (e.g., through tiered health plans) may help.

- Financial incentives for hospitals may not encourage keeping care in the community, but more engagement with alternative APMs is changing this
  Health systems generally achieve higher margins if they deliver care in teaching hospitals and AMCs, and panelists explained that they often lose money when they redirect care to community hospitals. However, greater participation in risk contracts changes the incentive because health systems can share in the savings they achieve by keeping care at community hospitals.

PANEL OVERVIEW

PROMOTING HIGH-VALUE CARE THROUGH PAYMENT REFORM AND PURCHASER INNOVATIONS

The panel focused on the adoption and improvement of APMs and innovations to promote the use of high-value providers. The panel also examined purchaser strategies to promote efficient care and innovative care delivery models.

WITNESSES

I. Atrius Health
II. Blue Cross Blue Shield of Massachusetts
III. Group Insurance Commission
IV. New England Baptist Hospital

MAIN TAKEAWAYS FROM THE PANEL

- Adoption of APMs is increasing, but significant barriers remain
  One major payer has extended APMs to some of its preferred provider organization (PPO) population through attribution methods, but ultimately, many providers are unwilling to accept risk for PPO patients and the payer has little leverage to convince them to do so. They also note difficulty enrolling members in APMs whose employers are headquartered out of state. One large provider system notes that larger employers are increasingly choosing national insurers as third party administrators (TPAs) who do not tend to employ APMs to a significant degree. Employers need to be convinced of the value of APMs.

- Other payment policies can supplement APMs to help drive high-value care, and could be expanded in Massachusetts
  For example, one payer sometimes includes readmissions within a short time frame (such as less than two weeks) as part of the same hospitalization and does not pay for an additional admission. A panelist noted that some national insurers have implemented non-payment for hospital-based MRI, for example. Massachusetts payers have considered site-neutral payment for these and other procedures, and could expand them further, though they do not want to interfere with the incentives inherent in global-payment and ACOs. One provider notes it is ready and willing to bundle inpatient and post-acute care, but they do not find a market willingness to pay that way in a large scale yet. Use of telehealth for BH services is expanding.

- Tiered networks and alignment
  A payer noted that allowing providers to opt out of tiered networks can erode half of the potential savings of a tiered network plan. Quality measures are used currently in tiering, but claims-based quality measures are limited and should be supplemented with additional types of measures such as patient-reported outcomes.

- Use of expanded set of provider types could help with BH access
  Provider groups noted that use of expanded types of providers and roles could help reduce readmissions rates, improve access to BH services, and reduce costs. APMs are better suited to use of expanded provider types.

PANEL OVERVIEW

ACHIEVING THE HEALTH CARE COST GROWTH BENCHMARK IN 2018 AND BEYOND

The panelists discussed 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 alternative payment, pharmaceutical and medical device spending, and the future of the Massachusetts delivery system.

WITNESSES

I. AstraZeneca
II. Beth Israel Deaconess Medical Center (BIDMC)
III. Harvard Pilgrim Health Care (HPHC)
IV. Iora Health

MAIN TAKEAWAYS FROM THE PANEL

- Stalled use of APMs limits benefits of risk contracting
  Despite consensus that providers need a substantial proportion of their business in risk arrangements to see the benefit of care management programs, expanded use of APMs has stalled in Massachusetts. Panelists cited the administrative complexity of different APMs models, that substantial business is still fee-for-service, and that risk models are still on fee-for-service "chassis" as significant challenges for scale and effectiveness of APMs. Panelists noted that national payers and self-insured employers to date have not seen the value of APMs and the difficulty of convincing providers to take risk on PPO patients. Iora Health challenged panelists to change the business model and double down on primary care and risk. While acknowledging the effectiveness of Iora's disruptive model, some raised questions about whether such an approach is scalable, particularly for legacy, hospital-based organizations.

- Concerns about growth in pharmaceutical costs persist and spur efforts to demonstrate value
  Despite a lower growth rate last year, panelists expressed persistent concerns about pharmaceutical spending, particularly as they anticipate new drugs coming on line, like gene therapies. Manufacturer Astra-Zeneca underscored the need to reconcile the life-saving/life-prolonging benefits of pharmaceuticals with cost and value. Panelists identified the need to pursue strategies to focus on value in pharmaceutical pricing, such as increased transparency, comparative clinical effectiveness, and value-based contracting.

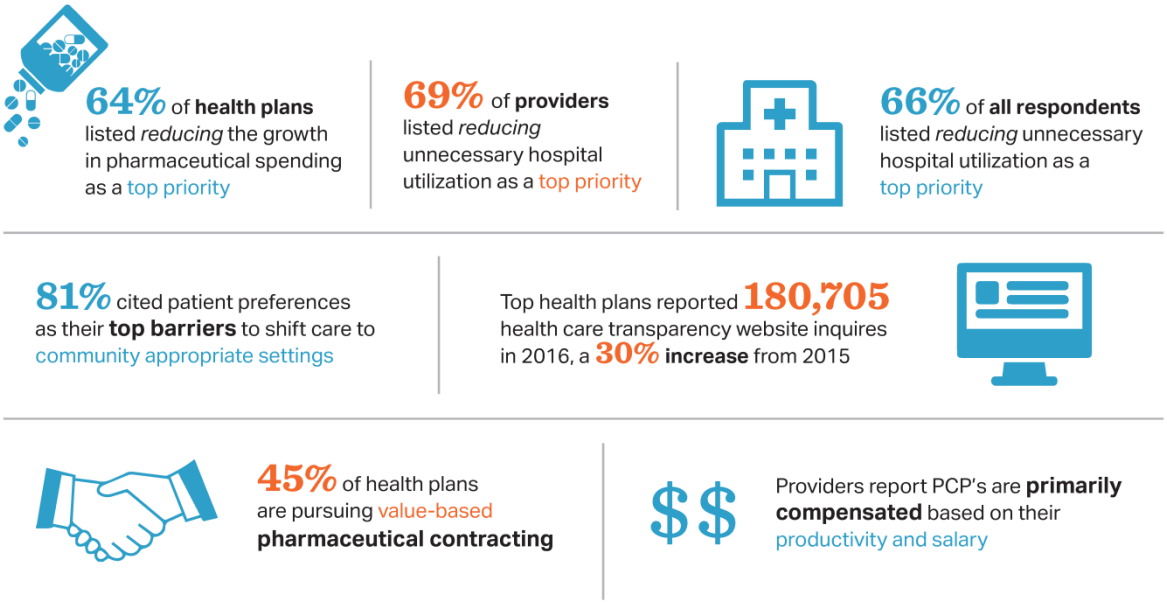
- Providers and payers recognize impact of social determinants on health care spending but strategies vary
  Panelists universally recognized the need to address social determinants of health while acknowledging that widespread interventions and results are limited. Iora Health provided the most concrete examples of the practical (and low-cost) interventions it uses to promote access and adherence to treatment (e.g., Uber, iPod). Other efforts underway include prevention-based approaches and the use of data to target high-cost patients, such as HPHC's work with Benevera, but results must be demonstrated.

- Persistent, unwarranted variation in provider prices should be addressed
  Panelists debated whether the higher margins paid for AMCs and teaching hospitals are warranted by the need to subsidize medical education and research; most agreed that higher hospital prices are largely driven by brand and lack of transparency in provider quality. Panelists acknowledged the challenges of keeping care out of expensive hospitals and moving patients to lower costs sites of care.

BIDMC cited some evidence of success and acknowledged the importance of having lower cost sites of care to send patients to.

- Increased transparency and scrutiny is necessary across the health care market
  Panelists agreed that increased transparency on health care cost and quality was critical to continued progress, including enhancing comparative information available to consumers. Providers and HPHC specifically called for greater transparency of pharmaceutical pricing. HPHC also called for increased scrutiny of provider coding patterns.

SUMMARY OF PRE-FILED TESTIMONY



Responses to Questions on Meeting the Cost Growth Benchmark

Top Priority for Meeting the Benchmark:

Payers: 64% listed reducing the growth in pharmaceutical spending as their top priority.
Providers: 58% listed shifting care from high cost settings as their top priority.
Hospitals: 79% listed reducing unnecessary hospital utilization as a top priority.

Top Barriers to Meeting the Benchmark:

Payers: Lack of transparency on pharmaceutical spending, market consolidation.
Providers: Fee-for-service payment models that do not fit the health care system.
Hospitals: Payment methodologies and rates.

"One key issue is the significant increase in pharmacy costs. As government and private payers are faced with these costs, we need to collectively analyze the impact of new and breakthrough therapies, technologies and drugs that hold so much promise for people with serious medical conditions. In addition to the increased costs associated with prescription drugs generally, we must specifically consider the high costs associated with specialty drugs and personalized medicine." – BLUE CROSS BLUE SHIELD MA

Responses to Questions on Community Appropriate Care

#1 Barrier to Shifting towards Community Appropriate Care: Patient Perceptions and Preferences

Providers: 77% of responding providers noted patient perception of quality and patient preferences as major barriers to the shift towards community appropriate care.
Hospitals: 86% of responding hospitals cited patient preferences and 79% cited patient perception as major barriers to the shift towards community appropriate care.

Top Strategies to Shift towards Community Appropriate Care:

Providers: Expansion of interoperable EHRs and data sharing capabilities; Education programs to train providers and patients on the importance of high-quality low-cost referrals.
Hospitals: Development of programs to limit patient leakage, standardization around referral process, and education programs to train providers and staff to refer effectively to high-quality, low-cost community providers.

Responses to Questions on Pharmaceutical Spending

Pursuit of Value-Based Drug Contracting:

45% of responding payers are pursuing value-based drug contracting. Of these, two are partnering with pharmacy benefit managers (PBMs). None of these payers currently have data to indicate whether these contracts have resulted in meaningful cost savings.

#1 Barrier to Pursuing Value-Based Drug Contracting: Administrative/Operational Implementation Costs

83% of payers not pursuing value-based drug contracting indicate that administrative/operational implementation costs are a barrier to doing so. 67% indicated the lack of appropriate quality measures as a barrier.

Responses to Questions on Strategies to Support Innovative Care Delivery through Payment Policies

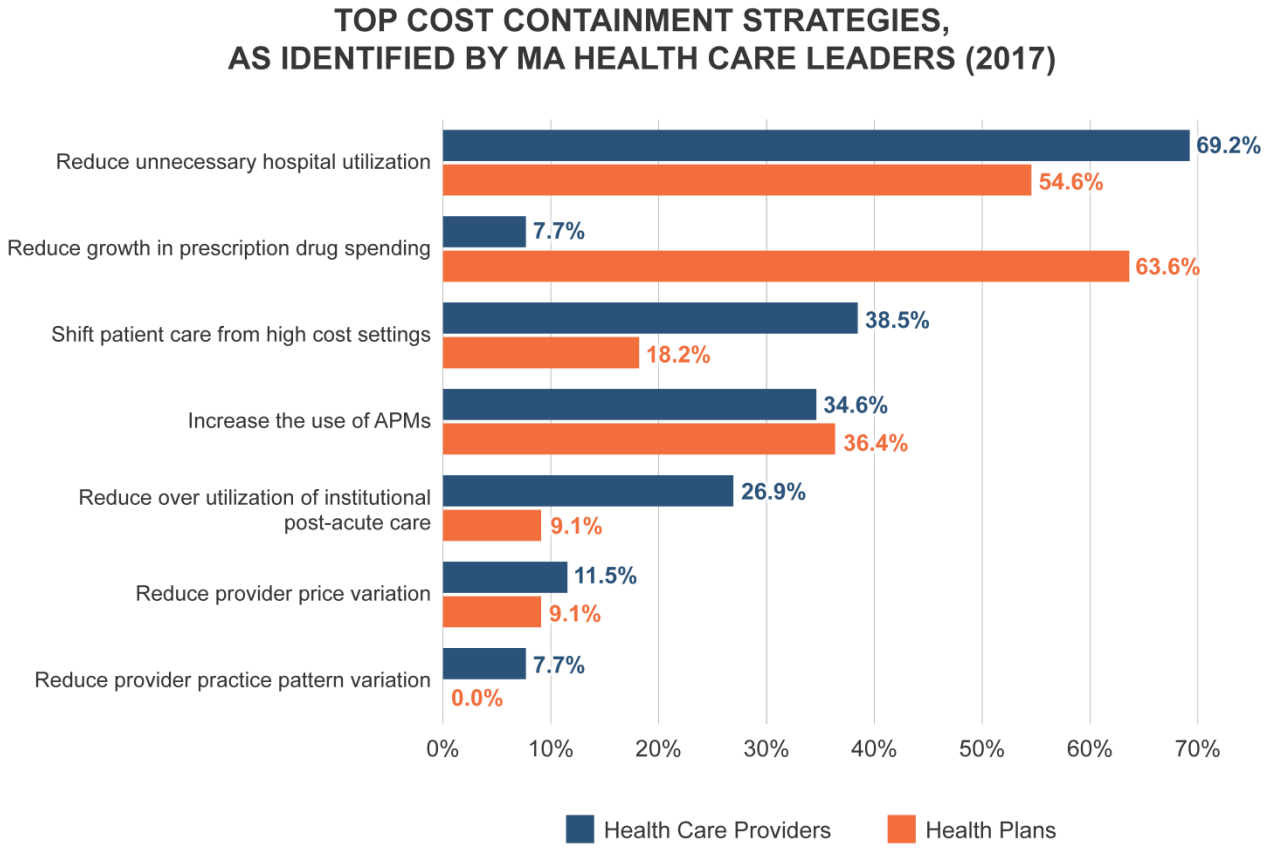
Payers continue to adopt payment policies related to key areas outlined by the HPC.

100% of responding payers report having new payment policies related to **readmissions.**
82% of responding payers report having new payment policies related to **telehealth.**

Responses to Questions on Physician Compensation Models

Compensation models can have a variety of drivers, such as productivity, salary, panel size, or performance measures. While most providers note having no plans to change their compensation models in the future, about 50% of hospitals note upcoming changes to move toward a system based on performance metrics.

- **PCPs:** Compensation primarily driven by salary and productivity for providers and hospitals
- **Specialists:** Compensation primarily driven by salary and productivity for providers and hospitals



2017 COST TRENDS HEARING RESOURCES

All resources listed below are available on the HPC's website.

- Agenda
- Program Booklet
- Testimony
- Videos: 2017 Cost Trends Hearing
- Presentation (Day One & Two)
- CHIA Presentation – Day One
- HPC Presentation – Day One
- Dr. Karen Joynt Maddox Presentation – Day One
- AGO Presentation – Day One

HPC PUBLICATIONS

All publications listed below are available on the HPC's website.

- **2016 Cost Trends Report**
  - 2016 Cost Trends Report
  - Executive Summary: 2016 CTR
- **HPC Reports**
  - Behavioral Health-Related Emergency Department Boarding
  - Opioid Use Disorder Report
  - Opioid Chart Pack
  - Community Hospitals at a Crosswords
- **HPC Briefs**
  - Policy Brief: Oral Health
  - Research Brief: Serious Illness and End of Life Care in the Commonwealth
  - Research Brief: Behavioral Health Compendium

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