Health Policy Commission

Board Meeting

July 17, 2014

Agenda

- Approval of Minutes from July 2, 2014 Meeting
- Executive Director Report
- Cost Trends Report: July 2014 Supplement
- All-Payer Claims Database (APCD) Almanac
- Submission into Court Authorized Public Comment Period
- Schedule of Next Commission Meeting (September 3, 2014)

Agenda

- **Approval of Minutes from July 2, 2014 Meeting**
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Vote: Approving Minutes

Motion: That the Commission hereby approves the minutes of the Commission meeting held on July 2, 2014, as presented.

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Upcoming Public Meetings

August 6, 2014

9:30AM – Community Health Care Investment and Consumer Involvement

11:00AM – Cost Trends and Market Performance

August 13, 2014

9:30AM – Quality Improvement and Patient Protection

11:00AM – Care Delivery and Payment System Transformation

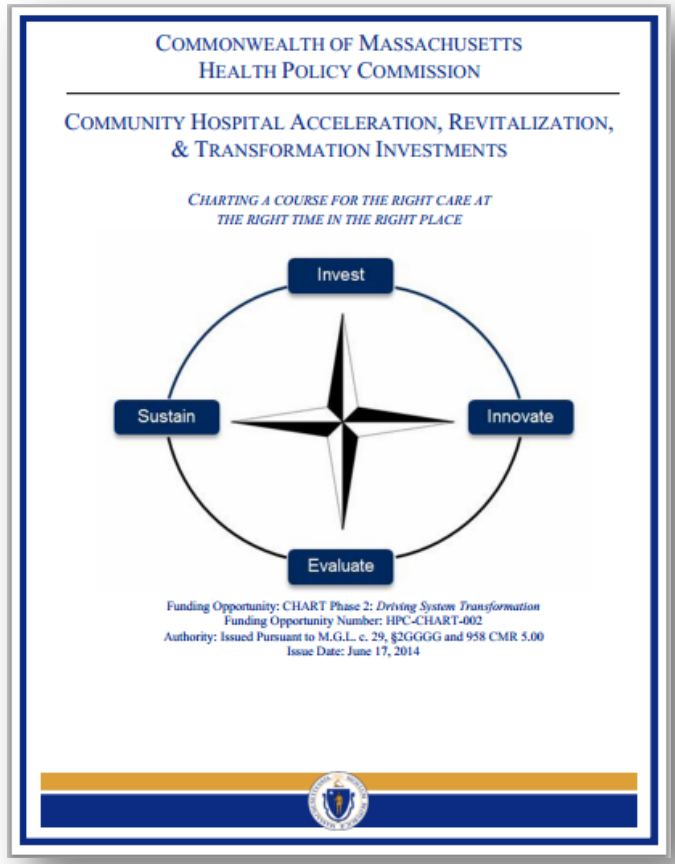
September 3, 2014

12:00PM – Board Meeting

CHART update

- The CHART Phase 2 RFP was released on June 17.
- 30 CHART-eligible hospitals can compete for up to $60M in funding in key domains specified by the Commission.
- Key dates:
  - *July 18:* Prospectuses Due
  - *September 12:* Proposals Due
  - *October:* Award recommendations to the board
- The HPC is offering a series of in depth information sessions (8+) on a variety of educational topics (e.g., behavioral health, metric selection, etc.) to support hospitals.

Phase 2 Request for Proposals


COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION, & TRANSFORMATION INVESTMENTS

CHARTING A COURSE FOR THE RIGHT CARE AT THE RIGHT TIME IN THE RIGHT PLACE

Funding Opportunity: CHART Phase 2: *Driving System Transformation*
Funding Opportunity Number: HPC-CHART-002
Authority: Issued Pursuant to M.G.L. c. 29, §2GGGG and 958 CMR 5.00
Issue Date: June 17, 2014

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Cost Trends: July 2014 supplement

Health Policy Commission

July 17, 2014

Cost Trends July 2014 supplement

- Provides further analysis related to the findings of the Commission's 2013 annual cost trends report
- These topics will likely remain key areas of interest for the Commission in its October 2014 cost trends hearing and the 2014 annual cost trends report to be released in December.

A. Spending levels and trends

- Commercial insurance trends
- MassHealth
- Long-term care and home health
- Behavioral health

B. Trends in the MA delivery system

- Mix of providers of inpatient care
- Concentration of inpatient care
- Progress in alternative payment methods

C. Disparities in quality and access

- Income-based differences in rates of preventable hospital admissions

D. Measures of spending

- Limitations of current measures of contribution to growth in health care expenditures

Later this year, CHIA will make the **first determination of Massachusetts' growth in total health care expenditures** (THCE) from 2012 to 2013, which will be the measure of performance against the health care cost growth benchmark

Topics in the July 2014 supplement

A. Spending levels and trends

B. Trends in the delivery system

C. Quality and access

D. Measures of spending

COMMERCIAL INSURANCE TRENDS, 2010-2012

Highlights from 2013 report

- Over the past decade, Massachusetts health care spending has grown much faster than the national average, driven primarily by faster growth in commercial prices

July 2014 findings

- Increases in prices paid to providers continued to be the primary driver of growth in commercial payer spending between 2010 and 2012
- Out-of-pocket spending as a proportion of total health care spending grew from 6.9% to 7.7% of total expenditures between 2010 and 2012

In recent years, the increase in prices paid has been the biggest contributor to commercial spending growth

Commercial insurance

DRIVERS OF GROWTH IN CLAIMS-BASED MEDICAL EXPENDITURES* IN MASSACHUSETTS

Percent annual growth in claims-based medical expenditures, 2010-2012

Changes in price index	×	Changes in utilization	×	Changes in health status	=	Overall spending growth
+5.2%		-2.1%		~0%		+2.9%
Increase in prices paid (may reflect unit prices and changes in provider mix)		Decrease in spending at standardized prices		No notable change in average risk scores from 2010 to 2012		Increase in per member per month claims-based medical expenditures

* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

SOURCE: HPC analysis of the All-Payer Claims Database

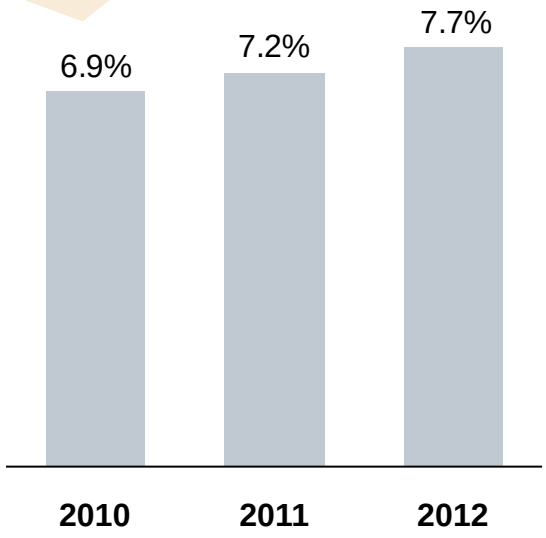
Members' out-of-pocket spending increased, as did the percentage of members paying over $500 in out-of-pocket spending

Commercial insurance

MEMBER COST SHARING, 2010 - 2012

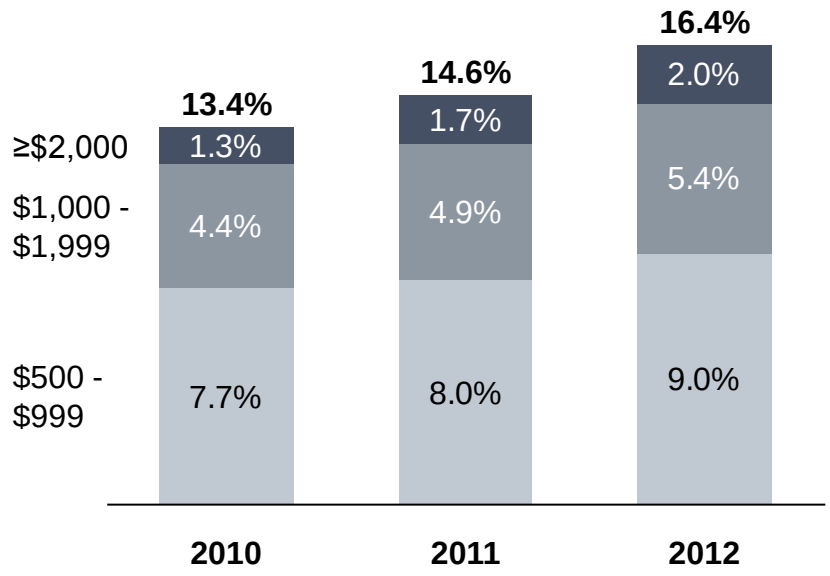
Out-of-pocket spending on cost sharing as percent of total claims-based medical expenditures†*

Includes co-pay, co-insurance, and deductible



PERCENTAGE OF MEMBERS BY AMOUNT OF OUT-OF-POCKET SPENDING* FOR MEDICAL CLAIMS

Percent of total members with cost sharing above $500, $1,000, and $2,000*



* Out-of-pocket spending includes cost sharing (co-payments, co-insurance, and deductibles) for medical services covered by commercial insurance. Pharmacy spending and services paid for outside of the insurance claims system are not included.

† Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

SOURCE: HPC analysis of the All-Payer Claims Database

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LONG-TERM CARE AND HOME HEALTH

Highlights from 2013 report

- In 2009, Massachusetts spent 72% more per capita on long-term care and home health than the U.S. average

July 2014 findings

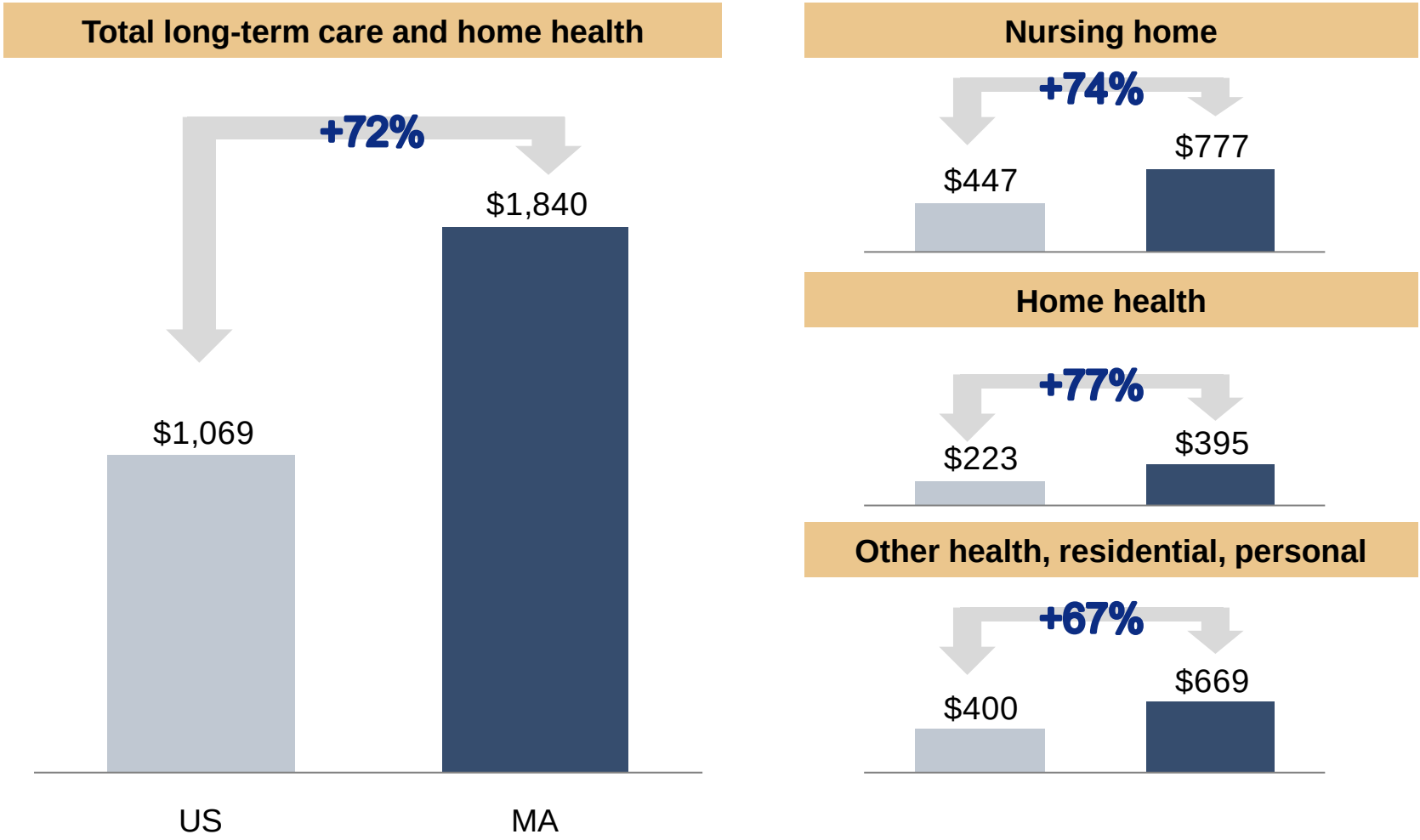
- The age of the population and Massachusetts price levels contribute to higher spending on long-term care, but there is also a large utilization difference not accounted for by demographics
- Nursing home residents covered by MassHealth have a lower average level of disability than the U.S. average for Medicaid nursing home residents
- After a hospitalization, the average Massachusetts resident is relatively more likely to be discharged to post-acute care, and rates of discharge to post-acute care vary widely across Massachusetts hospitals

Massachusetts' higher spending on long-term care and home health extends across provider types

Long-term care and home health

TOTAL SPENDING PER CAPITA ON LONG-TERM CARE AND HOME HEALTH

Dollars per capita, 2009



SOURCE: Centers for Medicare & Medicaid Services; HPC analysis

Demographics, prices, and utilization patterns all contribute to higher spending for nursing homes in Massachusetts

Long-term care and home health

FACTORS CONTRIBUTING TO HIGHER PER CAPITA SPENDING IN LONG-TERM CARE

Estimated contribution to difference in spending (figures range from 2009-2011)

Demographic differences	+	Price differences	+	Utilization differences	→	Higher spending
10-15 percentage points		**20-25** percentage points		**30-40** percentage points		**74 percent**
Higher rate of nursing facility residency expected based on age profile		Higher prices paid to nursing facilities (average across payers), in line with higher wages		Higher use of nursing facilities, adjusted for demographics – includes post-acute care and LTSS		Higher per capita spending on nursing facilities relative to U.S. average

Similar results are observed for home health

SOURCE: Centers for Medicare & Medicaid Services; American Health Care Association; Kaiser Family Foundation; Census Bureau; Genworth Financial; Bureau of Labor Statistics; Minimum Data Set; HPC analysis

For comparable DRGs, Massachusetts hospitals send a larger proportion of their patients to post-acute care

Long-term care and home health

MASSACHUSETTS ACUTE HOSPITAL DISCHARGE DISPOSITIONS RELATIVE TO U.S. AVERAGE

Hospital discharges by discharge disposition, 2011

	Rate per 10,000 discharges		
Discharge disposition	MA	U.S.	Difference
Routine	5,844	7,022	-17%
Transfer Other: includes Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Another Type of Facility	1,506	1,389	8%
Home Health Care (HHC)	1,888	1,088	74%
Transfer to short-term hospital	457	213	115%
Died	186	191	-3%
Against Medical Advice (AMA)	119	97	23%

2.1 Adjusting for patients' demographic and clinical characteristics and for the type and intensity of inpatient care delivered, we estimate that Massachusetts hospitals are **2.1 times as likely to discharge patients to either nursing facilities or home health agencies** relative to the national average.†

* Difference adjusted for case mix differences is estimated by applying the U.S. mix of DRGs to the Massachusetts rates of each discharge disposition for each DRG.

† Relative probabilities of discharge to post-acute care and of choice of post-acute care setting were estimated using a logistic regression model that adjusted for the following: age, sex, payer, income, length of stay, DRG, patient comorbidities, APR-DRG illness severity score, and APR-DRG risk of mortality score using a national inpatient sample from the Healthcare Cost and Utilization Project. Detailed results and methods are available in a technical appendix.

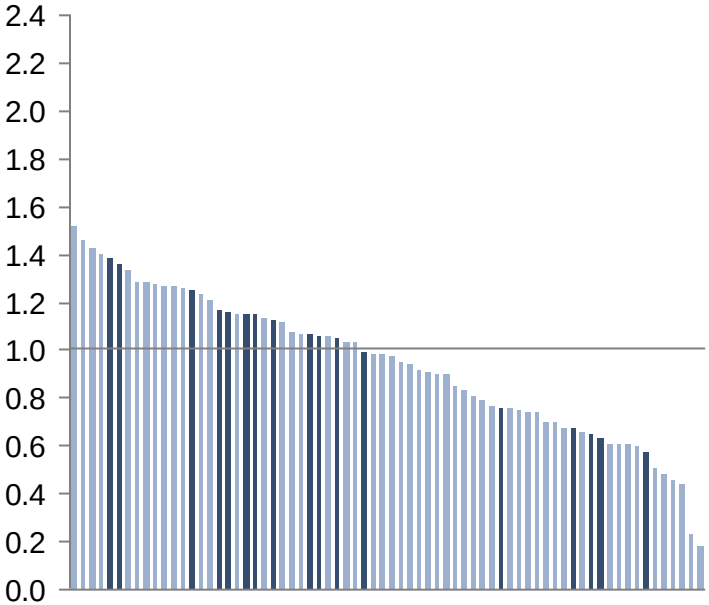
SOURCE: Healthcare Cost and Utilization Project; Census Bureau; HPC Analysis

Massachusetts hospitals vary widely in their rate of post-acute care use and in the setting selected

Long-term care and home health

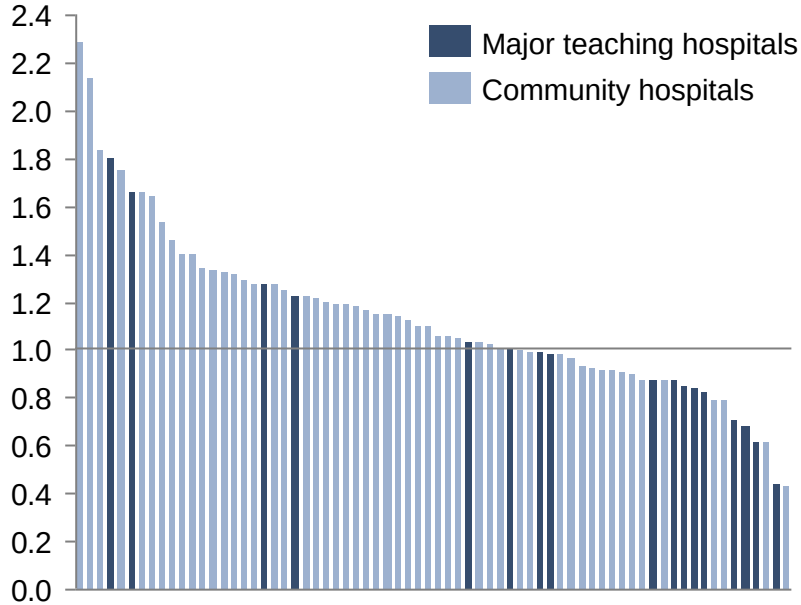
RATES OF DISCHARGE TO POST-ACUTE CARE

Adjusted rate of discharge to nursing facilities and home health, 2012*



RATES OF USE OF NURSING FACILITIES AS POST-ACUTE CARE SETTING

Adjusted rate of use of nursing facility as setting for post-acute care,†, 2012*



* Rates for each hospital were estimated using a logistic regression model that adjusted for the following: age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Our sample included patients who were at least 18 years of age and had a routine discharge, a discharge to a skilled nursing facility, or a discharge to a home healthcare provider. Specialty hospitals are excluded from figure and from displayed state average. Rates are normalized with the state average rate equal to 1.0.

† Discharge to nursing facility as a proportion of total discharges to either nursing facility or home health.

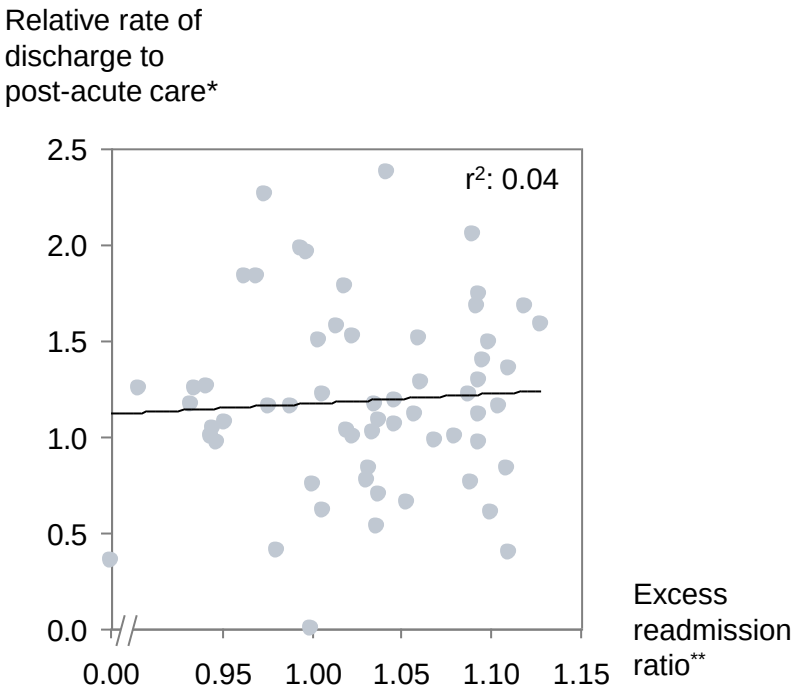
SOURCE: Center for Health Information and Analysis; HPC analysis

Massachusetts hospitals' rates of discharge to post-acute care do not correlate with their readmissions rates or average lengths of stay

Long-term care and home health

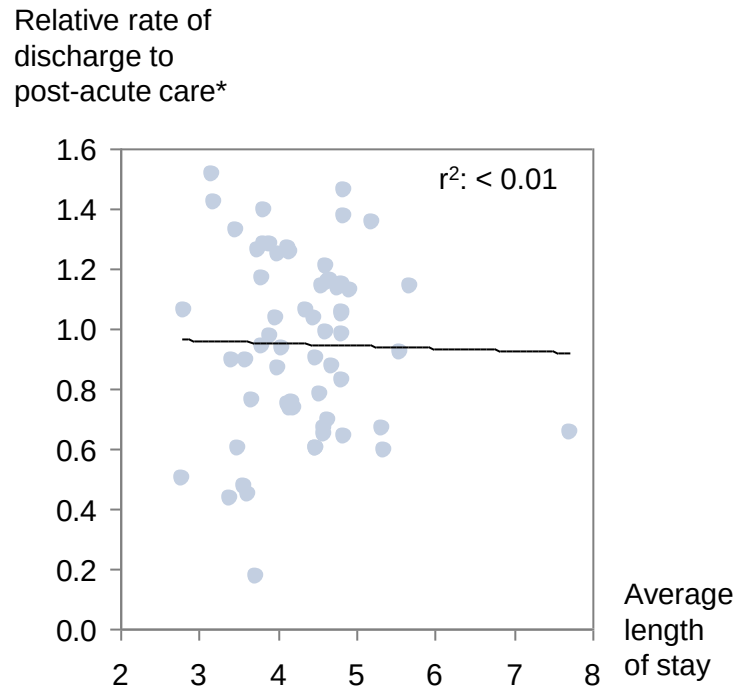
RATES OF DISCHARGE TO POST-ACUTE CARE AND EXCESS READMISSION RATIOS BY HOSPITAL

Massachusetts general acute hospitals, 2012



RATES OF DISCHARGE TO POST-ACUTE CARE AND AVERAGE LENGTHS OF STAY BY HOSPITAL

Massachusetts general acute hospitals, 2012



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† Composite of risk-standardized 30-day Medicare excess readmission ratios for acute myocardial infarction, heart failure, and pneumonia (2009-2011). The composite rate is a weighted average of the three condition-specific rates. 1.0 represents national average.

SOURCE: Center for Health Information and Analysis; Centers for Medicare & Medicaid Services; HPC analysis

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BEHAVIORAL HEALTH

Highlights from 2013 report

- Spending for patients with comorbid behavioral health and chronic medical conditions was 2.0 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition

July 2014 findings

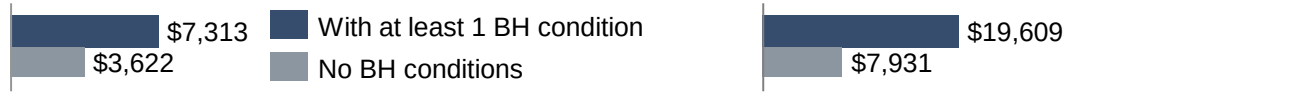
- Higher spending for patients with behavioral health conditions is concentrated in ED and inpatient care
- Patients with BH conditions spend more for other conditions, particularly if both mental health and substance use disorders are present
- Both findings suggest opportunities to improve care and reduce costs through a focus on integrated care, care management, and the use of lower-intensity settings, when possible

Higher spending for people with behavioral health conditions is concentrated in inpatient and ED spending

Behavioral health

SPENDING BY CATEGORY OF SERVICE FOR PATIENTS WITH AND WITHOUT BEHAVIORAL HEALTH CONDITIONS

Claims-based medical expenditures by category of service†, for people with and without behavioral health (BH) conditions‡, 2011*



Category of Service	Commercial: Spending per person per category	Commercial: % difference between people with and without BH conditions	Medicare: Spending per person per category	Medicare: % difference between people with and without BH conditions
ED	$291 / $122	+140%	$419 / $131	+220%
Inpatient	$2,245 / $1,000	+125%	$8,496 / $2,810	+202%
Outpatient	$926 / $515	+80%	$1,635 / $1,086	+51%
Long-Term Care and Home Health	$66 / $17	+279%	$4,715 / $1,191	+296%
Lab and X-ray	$782 / $524	+49%	$828 / $668	+24%
Professional[1]	$3,003 / $1,444	+108%	$3,516 / $2,045	+72%

* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

† For detailed definitions of categories of service, see CHIA and HPC publication, "Massachusetts Commercial Medical Care Spending: Findings from the All-Payer Claims Database." Lab/x-ray category includes professional services associated with laboratory and imaging.

‡ Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software

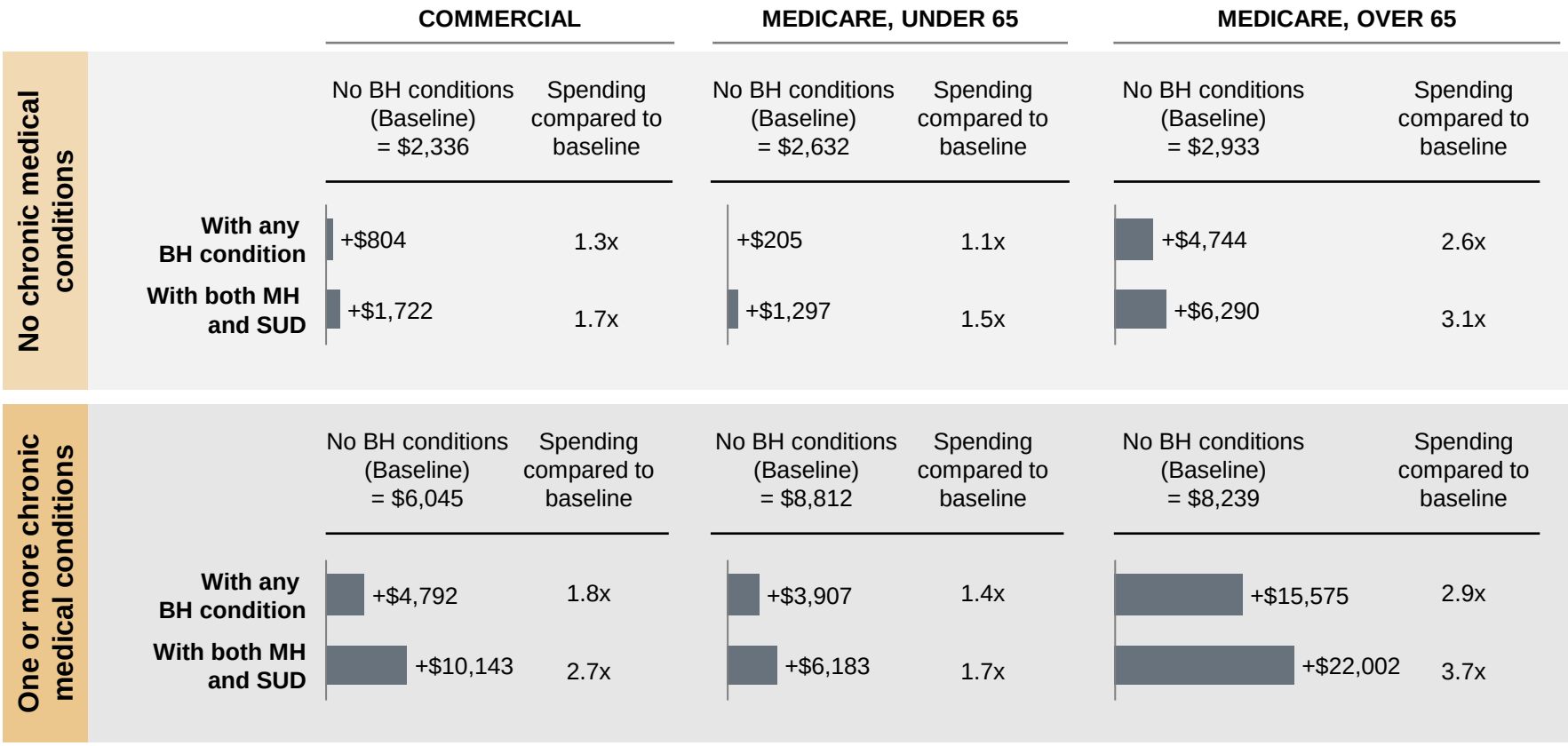
SOURCE: HPC analysis of the All-Payer Claims Database

For patients with behavioral health conditions, higher expenditures are observed for medical expenditures outside of behavioral health

Behavioral health

IMPACT OF BEHAVIORAL HEALTH COMORBIDITY ON SPENDING FOR NON-BEHAVIORAL HEALTH CONDITIONS

Per person claims-based medical expenditures on non-behavioral health conditions based on presence of behavioral health (BH) comorbidity†, 2012 (Commercial) and 2011 (Medicare)*



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† Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software. Expenditures for non-behavioral health conditions were identified using Optum ETG episode grouper. Additional detail is available in a technical appendix.

SOURCE: HPC analysis of the All-Payer Claims Database

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PROFILE OF INPATIENT CARE IN MASSACHUSETTS

Highlights from 2013 report

- Massachusetts has a 10 percent higher rate of inpatient admissions than the national average, adjusted for age differences
- 40% of Massachusetts Medicare discharges were at major teaching hospitals in 2011, compared to 16% nationwide

July 2014 findings

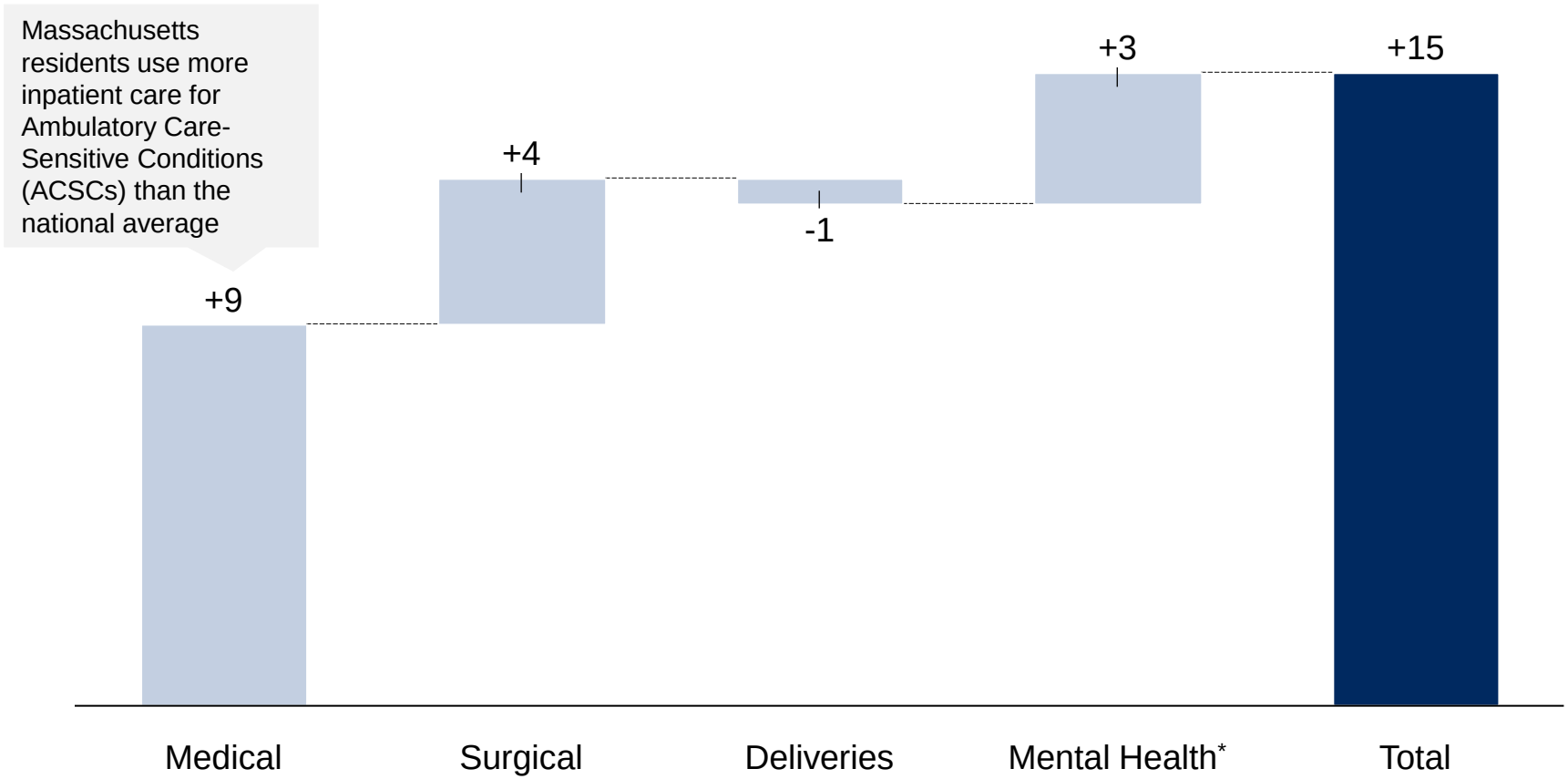
- Massachusetts' higher rate of inpatient admissions is concentrated in the medical service category, and there is room for continued improvement in reducing the rate of hospitalization for ambulatory care-sensitive conditions
- Many Massachusetts residents leave their home region to seek inpatient care in Boston, a pattern that is more pronounced among those with commercial insurance and residents of higher-income communities

Massachusetts' higher use of inpatient care is concentrated among medical discharges

Profile of inpatient care

BREAKDOWN OF DIFFERENCE IN DISCHARGES BETWEEN MASSACHUSETTS AND U.S. BY INPATIENT SERVICE CATEGORY

Inpatient discharges per 1,000 persons, 2011



* Based on discharges in general acute hospitals. Data exclude discharges in specialty psychiatric hospitals.

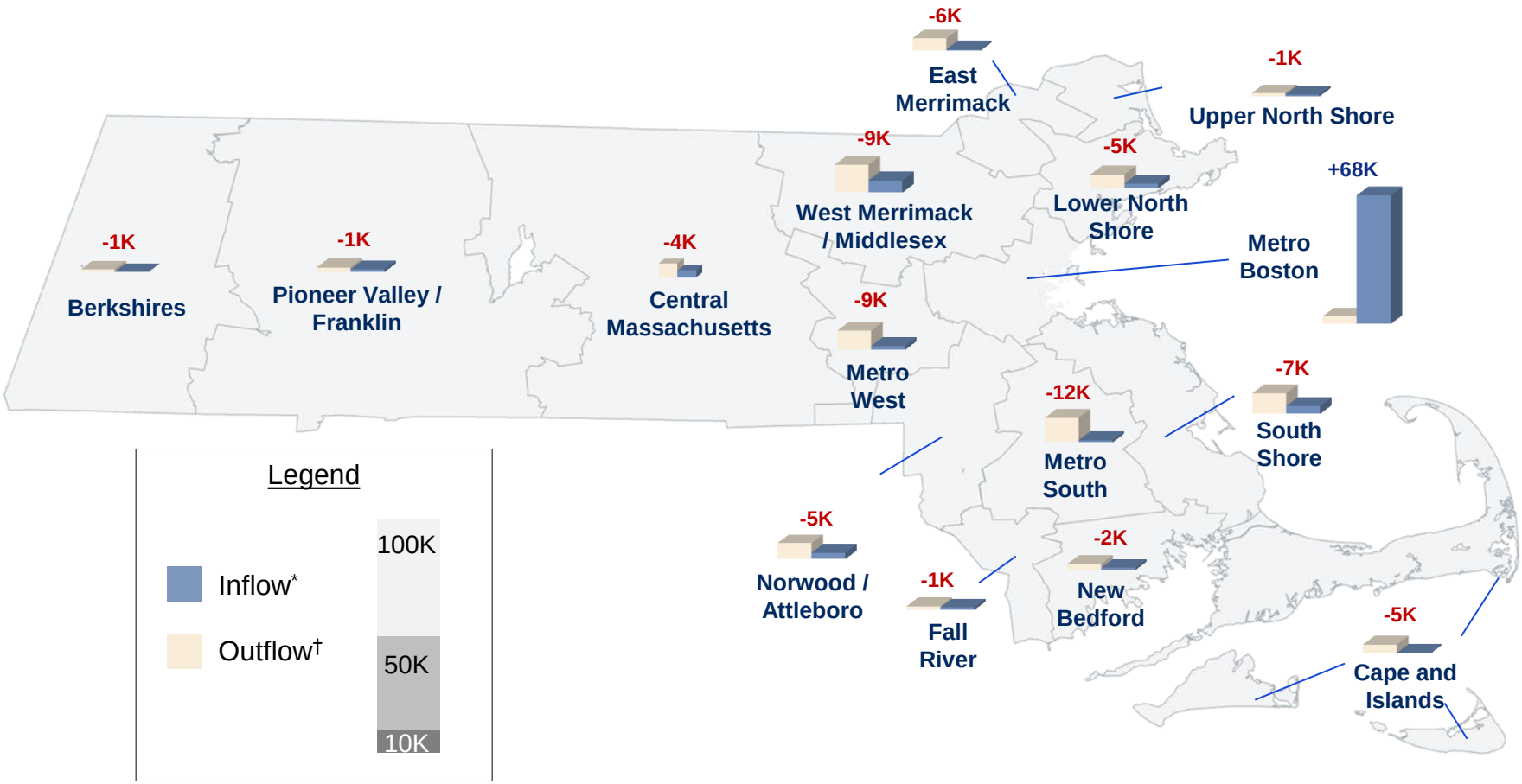
SOURCE: Agency for Healthcare Research and Quality, Kaiser Family Foundation, American Hospital Association

Most Massachusetts residents who leave their home region for inpatient care seek their care in Metro Boston

Profile of inpatient care

DISCHARGES FLOWS IN AND OUT OF MASSACHUSETTS REGIONS

Number of inpatient discharges for non-emergency, non-transfer volume, 2012



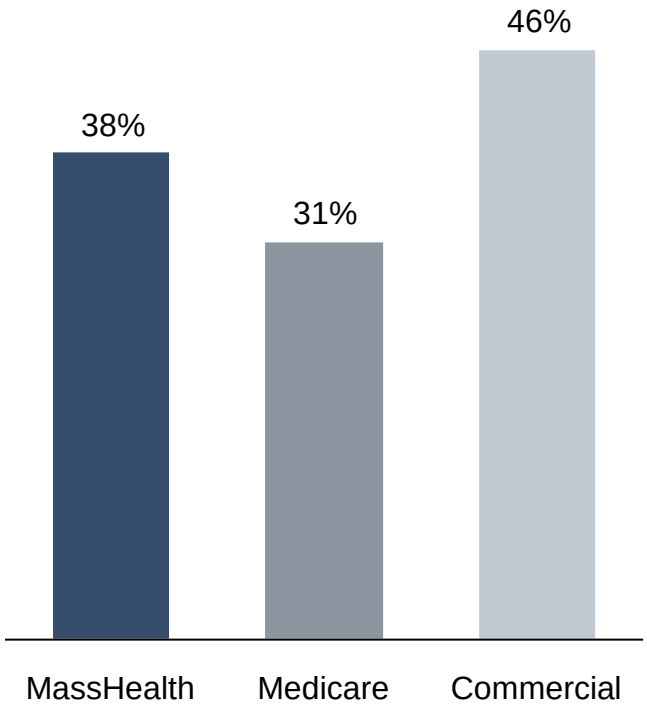
* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region
SOURCE: Center for Health Information and Analysis; HPC analysis

Commercially-insured patients and residents of higher-income communities are more likely to leave their home region for care

Profile of inpatient care

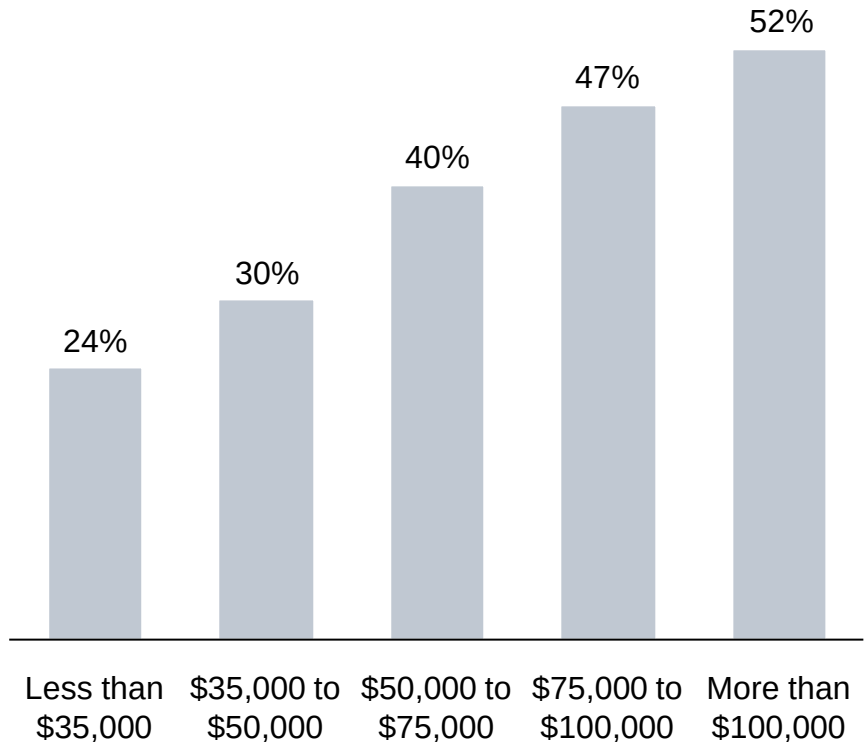
INPATIENT CARE RECEIVED OUTSIDE OF HOME REGION BY PAYER TYPE

Adjusted proportion of non-emergency, non-transfer inpatient discharges for payer type, 2012



INPATIENT CARE RECEIVED OUTSIDE OF HOME REGION BY INCOME GROUP

Percent of non-emergency, non-transfer inpatient discharges for community income group, 2012*



* Community income is estimated as the median household income for the patient's zip code

NOTE: Rates are adjusted for age, sex, payer group, distance from hospitals, distance from Metro Boston, and major diagnostic category. Analysis excluded individuals below 18 years of age, residents of Metro Boston, discharges with an ED visit in their record, and transfers from other acute hospitals.

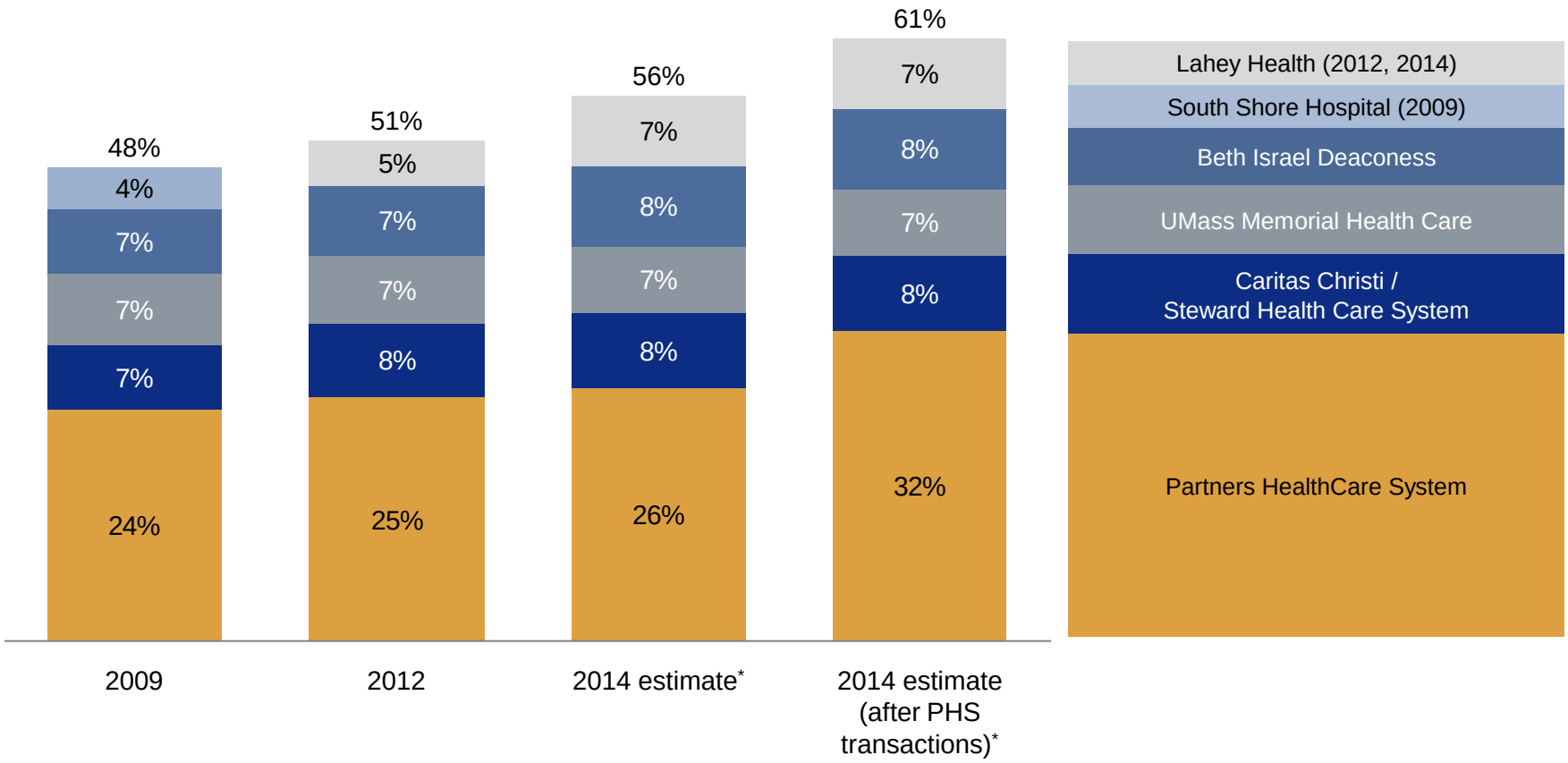
SOURCE: Center for Health Information and Analysis; HPC analysis

Commercial inpatient care in Massachusetts has grown more concentrated among large hospital systems over the past 5 years

Profile of inpatient care

CONCENTRATION OF COMMERCIAL INPATIENT CARE IN MASSACHUSETTS

Share of commercial inpatient discharges held by five highest-volume systems, 2009-2012



* 2014 data not yet available. Based on applying systems established by 2014 (including 2013 Partners HealthCare acquisition of Cooley Dickinson and 2014 Lahey Health acquisition of Winchester hospital) to 2012 inpatient discharge data

† Includes South Shore Hospital and Hallmark Health hospitals within Partners HealthCare System

SOURCE: Center for Health Information and Analysis; HPC analysis

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ALTERNATIVE PAYMENT METHODS

Highlights from 2013 report

- Medicare and commercial payers in Massachusetts have increasingly adopted alternative payment methods that establish a global budget for provider organizations

July 2014 findings

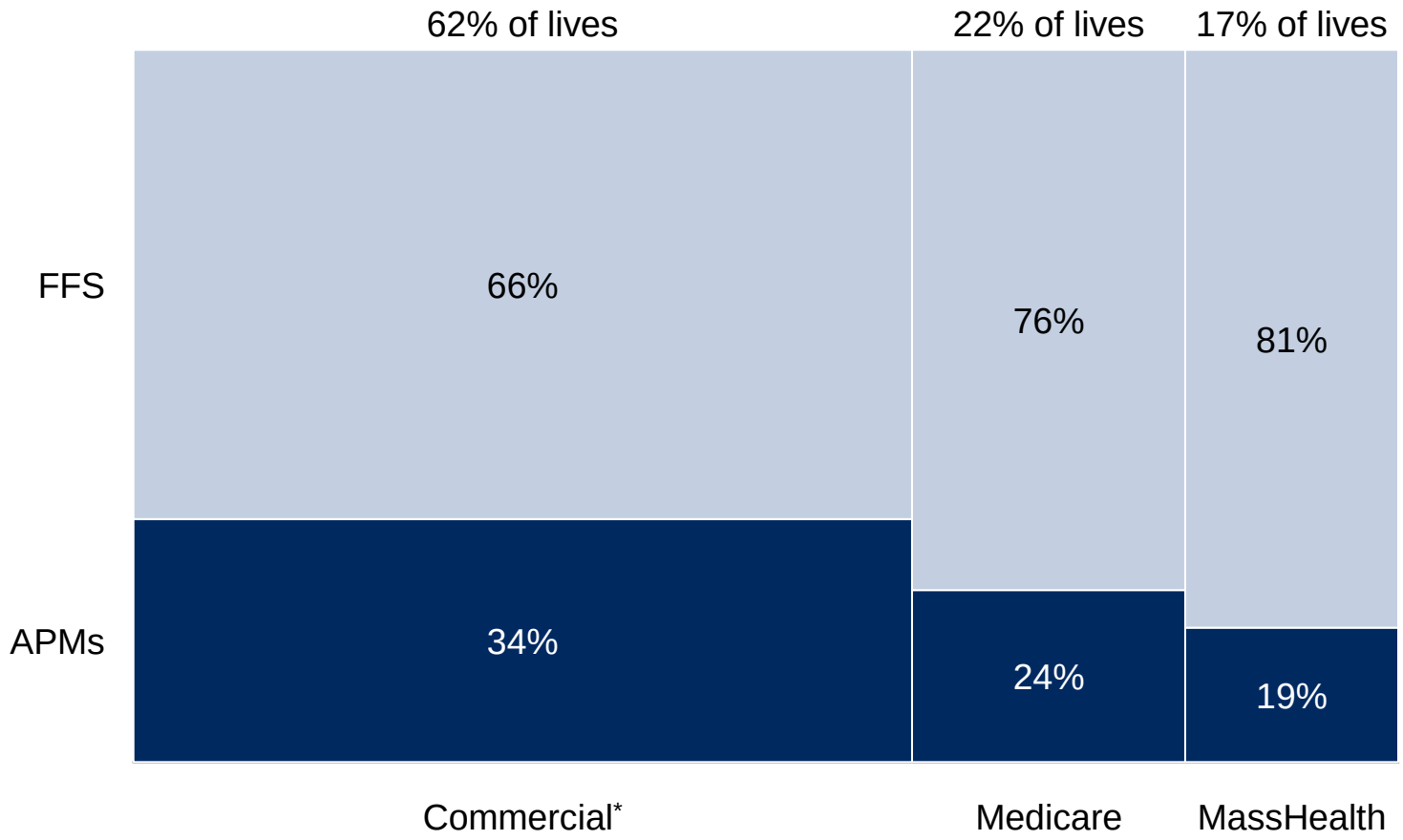
- At the end of 2012, alternative payment methods covered 29 percent of insured Massachusetts residents
- Opportunities exist to expand APM coverage and strengthen implementation

Across all payers, 29 percent of Massachusetts residents were covered by global budget APMs in 2012

Alternative payment methods

ALTERNATIVE PAYMENT METHOD COVERAGE BY PAYER TYPE

Percent of members/beneficiaries covered by global budget APMs, 2012



29%

of members were covered by APMs across commercial, Medicare, and MassHealth populations

* Includes Commonwealth Care

SOURCE: Center for Health Information and Analysis; MassHealth; Centers for Medicare & Medicaid Services; HPC analysis

Opportunities exist to expand APM coverage and strengthen implementation

Alternative payment methods

Expansion in APM coverage

Enrolling additional provider organizations	▪ Transition of commercial contracts from fee-for-service arrangements to shared savings or risk-based global budgets ▪ Growth in provider participation in Medicare demonstrations ▪ Expanded adoption of APMs for MassHealth (e.g. PCPR initiative, waiver)
Expanding commercial APMs to PPO members	▪ Review and improvement of methods for attribution of PPO members to primary care providers ▪ Examination of barriers slowing implementation of attribution methodology required for adoption of APMs for PPO members

Improvements in APM implementation

Improving global budget-based models	▪ Review and evaluation of varied approaches to payment model design and implementation (e.g. level of risk sharing, quality measures and incentives, services covered, requirements for stop-loss insurance) ▪ Identification of opportunities for increased alignment ▪ Examination of how incentives flow to individuals within provider organizations
Considering models outside of global budgets	▪ Innovation to enable care delivery organizations without aligned primary care providers - such as specialist physician groups without primary care providers – to move away from fee-for-service payment ▪ Review of models in other states (e.g., Arkansas episodes of care, Maryland total patient revenue)

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INCOME-BASED DISPARITIES IN PREVENTABLE HOSPITAL ADMISSIONS

Highlights from 2013 report

- There was an estimated $700 million in spending associated with potentially preventable hospital readmissions in 2009

July 2014 findings

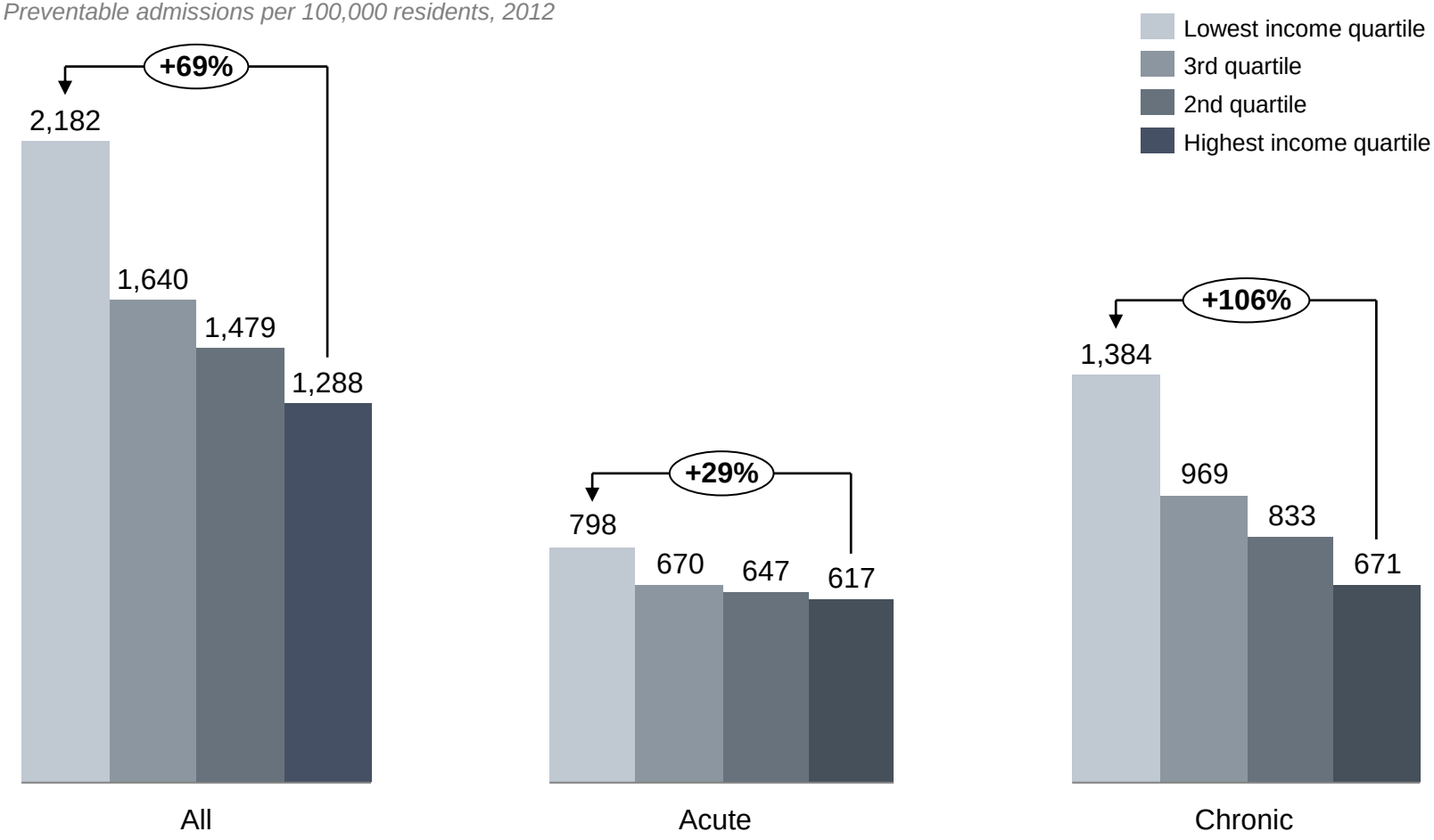
- Rates of preventable admission are much higher in lower-income communities than in higher-income communities, suggesting an opportunity to improve outcomes and reduce cost through targeted community supports and improved ambulatory care
- Income-based disparities in rates of preventable admissions are especially high for chronic conditions such as COPD, asthma, and diabetes

Rates of preventable admission are markedly higher in lower-income communities than in higher-income communities

Preventable hospitalizations

RATES OF PREVENTABLE HOSPITAL ADMISSIONS BY INCOME QUARTILE*

Preventable admissions per 100,000 residents, 2012



* Income was estimated using the median household income for the patient's zip code. Preventable hospitalizations were calculated using AHRQ's prevention quality indicator (PQI) measures. All figures are age- and sex-adjusted.

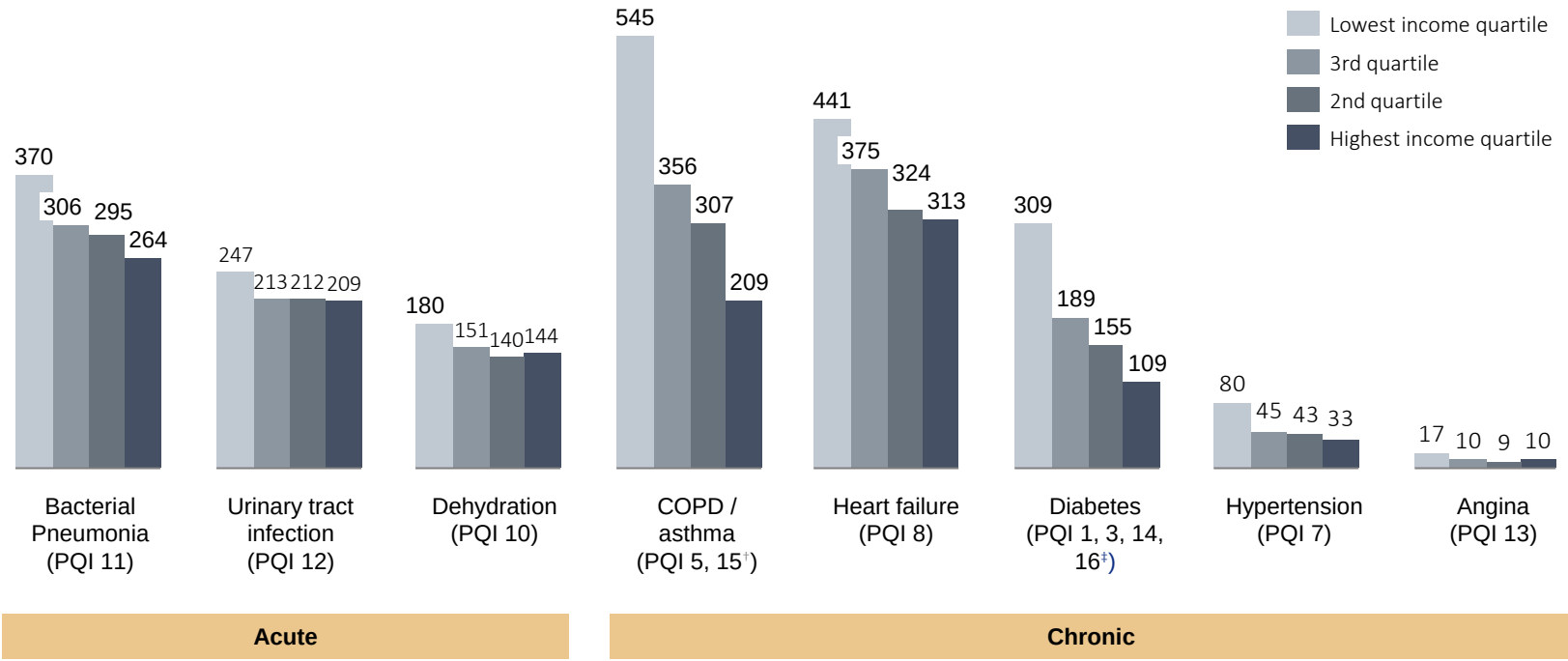
Source: Center for Health Information and Analysis; HPC analysis

Chronic conditions like COPD, asthma, and diabetes have the largest differences in rates of preventable hospital admissions by income

Preventable hospitalizations

RATES OF PREVENTABLE ADMISSIONS FOR ACUTE AND CHRONIC CONDITIONS BY INCOME QUARTILE*

Preventable admissions per 100,000 residents, 2012



* Income was estimated using the median household income for the patient's zip code. Preventable hospitalizations were calculated using AHRQ's prevention quality indicator (PQI) measures. All figures are age- and sex-adjusted.

† Composite of PQI 5 (COPD or asthma in older adults) and PQI 15 (asthma in younger adults)

‡ Composite of PQI 1 (short-term complications for diabetes), PQI 3 (long-term complications for diabetes), PQI 14 (uncontrolled diabetes), and PQI 16 (amputation among diabetes)

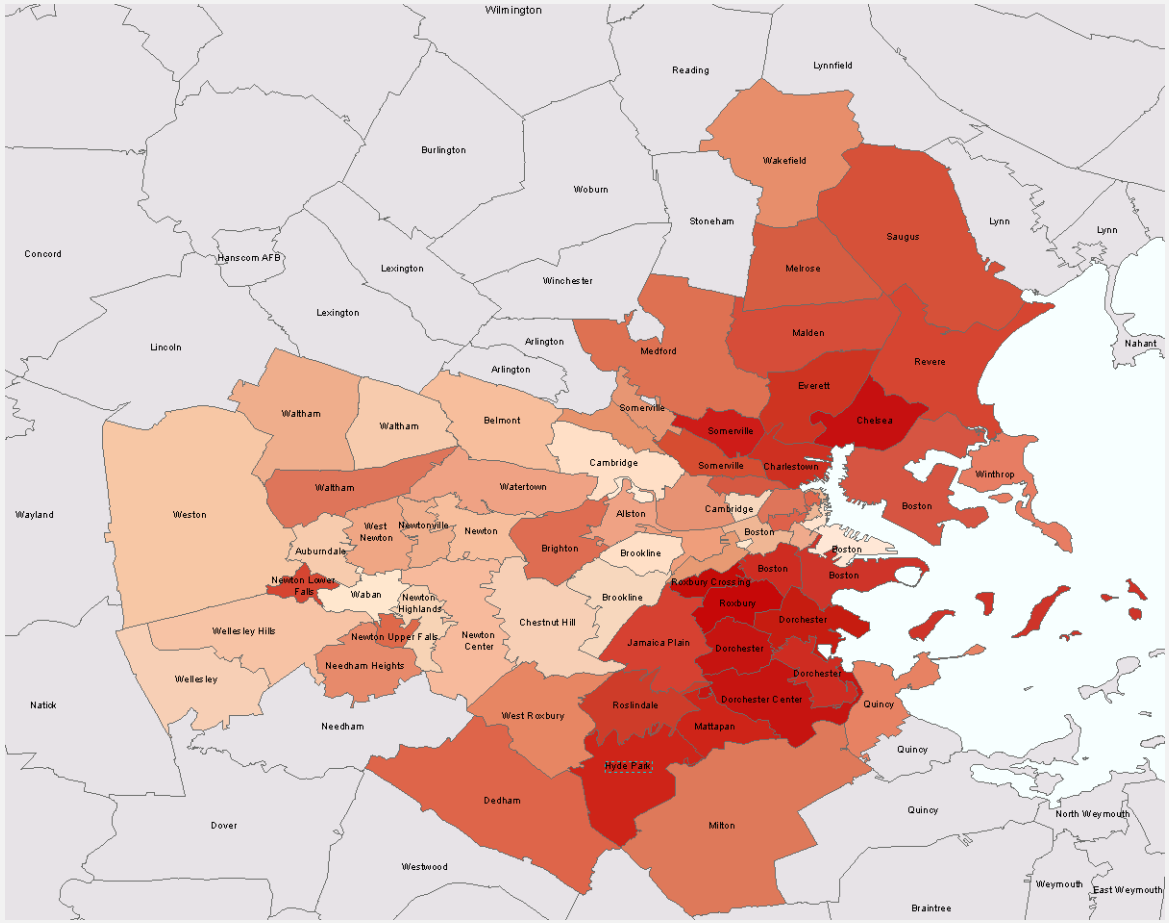
Source: Center for Health Information and Analysis; HPC analysis

Rates of preventable hospital admissions can vary dramatically between communities within a metropolitan area

Preventable hospitalizations

METRO BOSTON EXAMPLE: RATES OF PREVENTABLE ADMISSIONS BY ZIP CODE*

Preventable admissions per 100,000 residents, 2012



2,800 preventable admissions per 100,000 residents

0

* Preventable hospitalizations were calculated using AHRQ's prevention quality indicator (PQI) measures. All figures are age- and sex-adjusted.

Source: Center for Health Information and Analysis; HPC analysis

Findings from the Cost Trends July 2014 supplement

Opportunities in unit price and the mix of providers

- **Drivers of spending growth**: Increases in prices paid to providers continued to be the primary driver of growth in commercial payer spending between 2010 and 2012.
- **Mix of providers:** Many Massachusetts residents leave their home region to seek inpatient care in Boston, a pattern that is more pronounced among those with commercial insurance and residents of higher-income communities.

Opportunities for more efficient utilization

- **Preventable hospitalizations**: Massachusetts has higher rates of preventable hospital admissions than the national average, and rates are much higher in lower-income communities than in higher-income communities, particularly for chronic conditions. This suggests an opportunity to improve outcomes and reduce cost through targeted community supports and improved ambulatory care
- **Post-acute care:** After a hospitalization, the average Massachusetts resident is relatively more likely to be discharged to post-acute care, and rates of discharge to post-acute care vary widely across Massachusetts hospitals.
- **Behavioral health:** Patients with behavioral health conditions spend more for other conditions, particularly if both mental health and substance use disorders are present, and higher spending for patients with behavioral health conditions is concentrated in ED and inpatient care.

Trends in the Massachusetts delivery system

- **Concentration of inpatient care**: Commercial inpatient care in Massachusetts has grown more concentrated among large hospital systems over the past 5 years. In 2009, the five highest-volume systems accounted for 48% of commercial inpatient discharges, and in 2014 we estimate that five systems will account for 56% (61% if Partners HealthCare System completes acquisitions of South Shore Hospital and Hallmark Health).
- **Alternative payment methods**: At the end of 2012, alternative payment methods covered 29 percent of insured Massachusetts residents. Continued efforts are needed to expand APM coverage to additional providers and to PPO books of business, as well as to strengthen the design and implementation of APMs.

Findings from the Cost Trends July 2014 supplement

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Conclusions from the 2013 cost trends report

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.

Recommendations in the 2014 July cost trends supplement

Fostering a value-based market	▪ The Commission will **study the impact of new insurance products and increased cost-sharing** in commercial insurance plans on consumers' decision-making and on access to care. ▪ If health care provider systems grow, they should find ways to ensure they **deliver care to their patients in lower-cost, community settings for lower-complexity care**. ▪ The Commission will continue to **examine the flow of patients to academic medical centers for lower-complexity care** to identify and recommend policy solutions for reducing unnecessary outmigration.
Promoting an efficient, high-quality health care delivery system	▪ **Hospitals should work to optimize use of post-acute services**, including enhancing efficacy of care coordination and transitions for behavioral health patients. Where aligned with project goals, the Commission will work with community hospitals receiving CHART investments to achieve these goals. ▪ Payers and providers should continue **to increase integration of behavioral health and primary care** through use of incentives and new delivery models. ▪ The Commission will **support provision of behavioral health services in primary care settings through its PCMH and ACO certification program**s.
Advancing alternative payment methods	▪ The Commission will **study the implementation of APMs** in Massachusetts to **evaluate their effectiveness** in improving health and reducing costs**, monitor for potential adverse impacts**, and **review opportunities to increase alignment** around identified best practices. ▪ Given the variety of design choices in attribution methods and the importance to provider organizations of information on the patient populations for which they are accountable, **payers should engage in a transparent process to review and improve their attribution methods** and should align their methods to the maximum extent feasible. ▪ The Commission will work with CHIA, payers, and providers in the fall of 2014 to understand the current state of development of attribution methods and explore opportunities to **accelerate the development of aligned methods**.
Enhancing transparency and data availability	▪ CHIA should convene state agencies to **increase transparency in behavioral health** spending, quality of care, and the market for behavioral health services. ▪ To monitor and understand cost trends in the significant and growing PPO segment, CHIA should extend its reporting to include a **TME measure for PPO populations** that uses an agreed-upon attribution algorithm to identify accountable provider organizations. ▪ In 2014 and 2015, the Commission will seek to work with CHIA to design and evaluate **potential measures of contributions to health care spending growth for provider types such as hospitals, specialist physician groups, and others that do not deliver primary care**. Where feasible, these measures should be aligned with those used by other states to facilitate meaningful benchmarking.

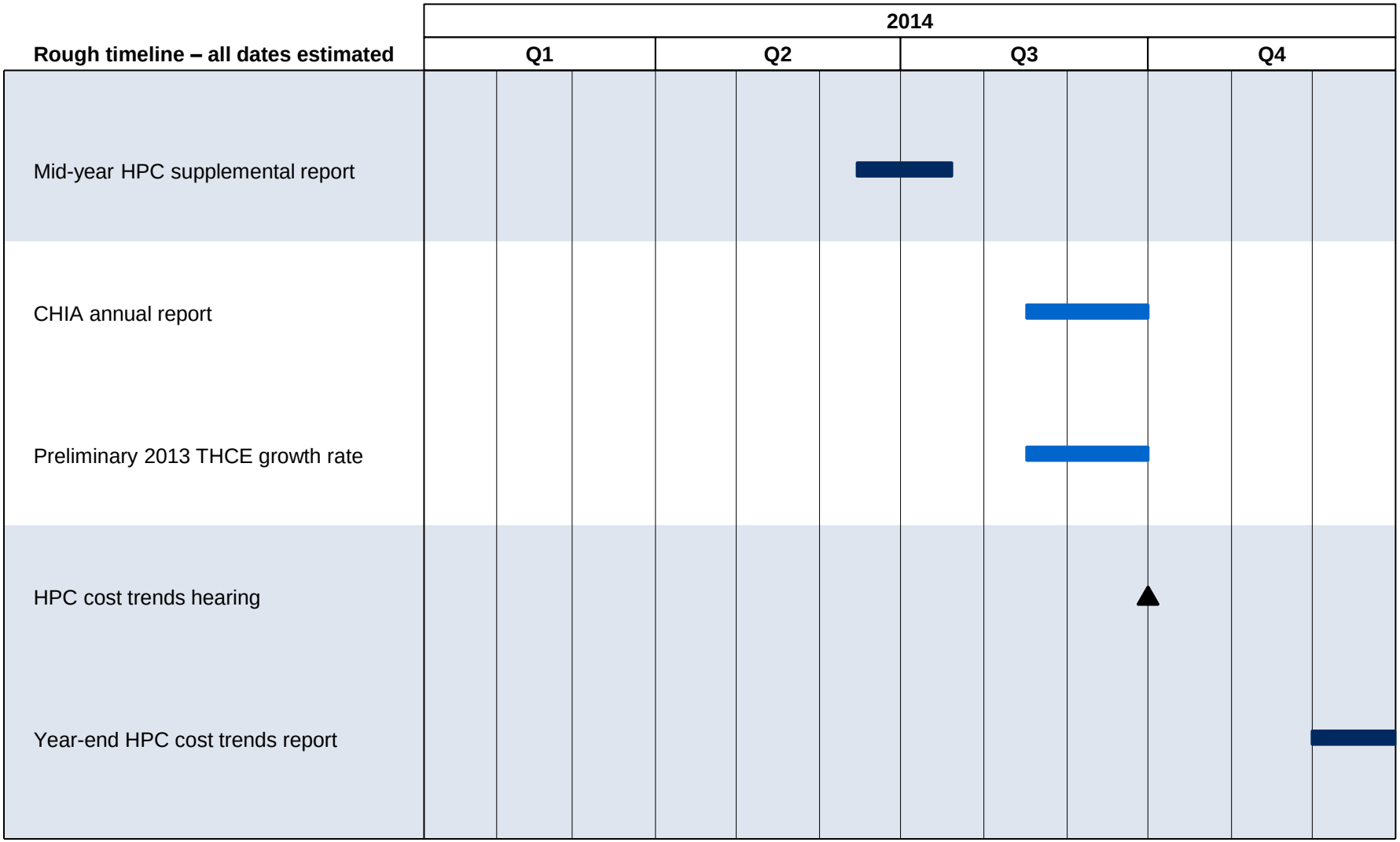
Agenda

- Approval of Minutes from July 2, 2014 Meeting
- Executive Director Report
- Cost Trends Report: July 2014 Supplement
- **All-Payer Claims Database (APCD) Almanac**
- Submission into Court Authorized Public Comment Period
- Schedule of Next Commission Meeting (September 3, 2014)

New publication on HPC website: "Massachusetts Commercial Medical Care Spending"

- Covers trends in commercial medical spending, 2010-2012
  - Data from the APCD
  - Overall spending and spending by category of service, type of episode, region
  - Chartpack highlights important trends in graphical manner
  - Databook offers additional results in a machine readable manner
- Collaborative effort between HPC and CHIA, drawing on HPC's contract with The Lewin Group
- Enhances our understanding of the Massachusetts health care market
- Reinforces our commitment to collaboration and transparency

What's next for cost trends: 2014 timeline



COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

2014 Health Care Cost Trends Hearing

An annual public examination of health care cost trends and drivers, featuring witness testimony and discussion with national experts on the challenges and opportunities within the Commonwealth's health care system.

October 6 & 7, 2014

Suffolk University Law School

120 Tremont Street, Boston, MA

The 2014 hearing will examine cost trends for public and commercial payers as well as hospitals and other providers. For the first time, the hearing will focus on the state's performance under the health care cost growth benchmark.

The HPC will hold the hearings in conjunction with the Center for Health Information and Analysis and the Office of the Attorney General.

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Commonwealth of Massachusetts v. Partners HealthCare System, Inc., South Shore Health & Educational Corp. & Hallmark Health Corp.

- On February 19 and July 2, respectively, the HPC issued its Final Report on Partners' proposed acquisition of SSH and HMA, and its Preliminary Report on Partners' proposed acquisition of HHS.
- On June 24, 2014, PHS, SSH, and HHS filed a proposed consent judgment in Suffolk Superior Court that would resolve the AGO's multiyear law enforcement investigation into Partners' market conduct and recent proposed acquisitions.
- The agreement would allow Partners to acquire SSH, Hallmark, and their related physicians, but includes provisions designed to constrain Partners' contracting practices, network growth, and prices for the next five to ten years.
- Among other provisions, the consent judgment requires the parties to confer (or allows them to petition the court) regarding mitigating any material price impacts identified by the HPC in its review of the proposed Hallmark acquisition.
- At a June 30, 2014 hearing on this matter, the court dismissed without prejudice a motion to intervene by competitor providers, and invited public comment on the proposed consent judgment through July 21, 2014.

HPC resolution to submit comment to the court

Motion: The Commission hereby directs the Executive Director to summarize key relevant findings from the Commission's final cost and market impact report regarding Partners HealthCare System's proposed acquisitions of South Shore Hospital and Harbor Medical Associates and its preliminary report regarding Hallmark Health System as well as findings from its 2013 and supplemental cost trend reports regarding market trends and delivery system dynamics and, upon approval by the Commission, to submit such summary along with the reports on or before July 21, 2014 to the Attorney General pursuant to the public comment process authorized by the court in *Commonwealth of Massachusetts v. Partners HealthCare System, Inc., South Shore Health and Educational Corporation and Hallmark Health Corporation*, Superior Court Civil Action No. 14-2033-BLS.

Overview of proposed comment

- The HPC is responsible for providing data driven analyses of factors and transactions that affect the Commonwealth's ability to meet its benchmark.

- Consistent with the HPC's view that all factors that impact total medical spending growth should be closely monitored and moderated in order to achieve the benchmark, the Comment includes findings on a range of cost and market impacts from the proposed transactions for the court and the parties' ongoing consideration of the proposed settlement.

- The evidence base for the Comment are four reports the HPC completed in the past year containing data driven analyses of the Massachusetts health care market and proposed health care transactions encompassed in this civil action:

    1) 2013 Cost Trends Annual Report (Jan. 8, 2014);

    2) 2013 Cost Trends July 2014 Supplement (July 2, 2014);

    3) Review of Partners HealthCare System's Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates: Final Report (Feb. 19, 2014); and

    4) Review of Partners HealthCare System's Proposed Acquisition of Hallmark Health Corporation: Preliminary Report (July 2, 2014).

Spending and delivery system trends

- Per capita health care spending in Massachusetts is the highest of any state, with growth in spending driven primarily by faster growth in commercial prices paid to providers:
  - Growth in the price paid per service or set of services (*unit price*), and
  - Shift toward use of higher-priced providers (*provider mix* or *site of care*).
- Care has grown increasingly concentrated in several large health care systems:
  - In 2009, the top five systems accounted for 48% of commercial discharges.
  - In 2014, we estimate the top five systems will account for 56% of commercial discharges (61% if Partners completes its acquisitions of SSH and Hallmark), with Partners' share of discharges greater than the next four systems combined.
- Many patients leave their home towns and cities and travel to receive inpatient care in Metro Boston: 81% go to major teaching hospitals and 47% go to Partners hospitals.
- Many providers are seeking to promote more patient-centered, accountable care through a variety of organizational models. These changes in provider governance and operations impact health care system performance and levels of medical spending.
- Evidence to date indicates that provider alignments and consolidations have generally resulted in net growth in spending – e.g., due to increased prices, increased bargaining leverage, and shifts in care to higher priced providers, which outpace any efficiencies from such consolidations.

Impacts of the proposed transactions

- The HPC's review of the data and evidence pertaining to Partners' proposed acquisitions of South Shore Hospital, Harbor Medical Associates, and Hallmark Health found that increases in spending are anticipated to exceed potential savings from decreased utilization through care delivery reforms and population health management:

  - For the three major commercial payers, the combined transactions are anticipated to increase total medical spending by more than $38.5 million to $49 million per year as a result of *unit price* increases and shifts in care to higher-priced Partners facilities (*provider mix*).

  - The resulting consolidated system is anticipated to have increased ability and incentives to leverage higher prices and other favorable contract terms in negotiations with payers (*bargaining leverage*), the costs of which are not included in the above projection.

  - The parties to these transactions have not provided adequate evidence of how corporate ownership is instrumental to achieving the desired care delivery reforms, and their own experience and that of other providers offer compelling alternative approaches to effectively coordinating care delivery.

Further findings relevant to the consent judgment

- *Unit Price*
  - Under the agreement, price increases from these transactions will not necessarily result in a net increase in Partners' average price growth for the life of the settlement.
  - However, Partners appears to retain certain flexibility to allocate price increases across providers to maximize revenue and market position. For example, without an individual cap, Hallmark providers may experience price growth faster than the rate of general inflation, with permanent consequences for total medical spending in an area of the state that has thus far not experienced the market impact of a local, high-priced Partners facility.
  - Without lasting change to the market structures and incentives that underlie the operation of bargaining leverage, price caps may not be effective in keeping costs down.
- *Provider Mix*
  - The material price impact of shifts in patient care to higher-priced Partners providers is not addressed by the current agreement.
  - The agreement only monitors the TME for Partners' commercial risk business, meaning increases in TME as Partners grows its non-risk books of business (about 89% of Partners' total commercial business in 2012) are unaddressed.
- *Bargaining Leverage*
  - While there may be potential for component contracting, which represents a change in current contracting practices, to promote a more competitive market, the impact of this change will depend on whether and to what extent payers vigorously pursue this option and on how the market responds.

Next steps

- Public comments due to the Attorney General by July 21, 2014.
- Attorney General to submit all comments and any response by the parties to the court by August 1, 2014.
- Following review of any written response to the Preliminary CMIR Report on the Hallmark transaction submitted by the parties by August 1, 2014, the HPC will issue a Final CMIR Report.
- Further hearing on the proposed consent judgment to be scheduled based on court order.

Vote: Issuance of HPC submission into public comment process

Motion: That the Commission hereby directs the Executive Director to submit the *Public Comment by the Massachusetts Health Policy Commission In Re Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corporation, and Hallmark Health Corporation, Superior Court Civil Action No. 14-2033-BLS*, as presented to the Commission, to the court pursuant to the process established by the court.

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Contact Information

For more information about the Health Policy Commission:

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