Executive Summary

Per capita health care spending in Massachusetts is the highest of any state in the United States, with higher spending than the national average across all payer types. Massachusetts devoted 16.6 percent of its economy to personal health care expenditures in 2012, compared with 15.1 percent for the nation. Higher spending results from higher utilization and higher prices, and is concentrated in two categories of service: hospital care and long-term care and home health.

Over the past decade, Massachusetts health care spending has grown much faster than the national average, driven primarily by faster growth in commercial prices. While spending growth in Massachusetts since 2009 has slowed in line with slower national growth, sustaining lower growth rates will require concerted effort. Past periods of slow health care growth in Massachusetts and the United States, such as the 1990s, have been followed by sustained periods of higher growth.

Massachusetts has better overall health care quality performance and offers better access to care than many other states. However, considerable opportunities remain to further improve quality and access as well as population health.

Significant trends are occurring in the provider and payer market. For providers, the delivery system is growing increasingly concentrated in several large systems, with a larger proportion of discharges occurring from major teaching hospitals and hospitals in their systems. Further, many provider organizations seek to re-orient care delivery around patient-centered, accountable care models, though significant challenges such as misaligned payment incentives, persistent barriers to behavioral health integration, and limited data and resources remain.

In the payer market, insurance companies are offering and purchasers are increasingly selecting products intended to involve consumers in making higher-value decisions, such as choosing high-quality, lower-priced providers and avoiding unnecessary services. With these changes, the proportion of costs covered by insurance benefits has declined.

In addition, public and commercial payers are increasingly developing alternative payment methods that aim to alter supply-side incentives. However, there are significant challenges in implementation, including wide variation in these types of contracts covering Massachusetts providers, both within and across payers, as budget levels, risk adjustments, and other terms are negotiated. In addition, behavioral health services are often excluded from global budgets. Finally, an increasing shift in the commercial market to PPO products, which currently do not support alternative payment methods, presents an obstacle to the continued adoption and potential effectiveness of these payment methods.

To identify potential opportunities for savings in Massachusetts, we reviewed three cost drivers in depth: hospital operating expenses, wasteful spending, and high-cost patients.

Hospital operating expenses

There are major opportunities to improve operating efficiency in Massachusetts hospitals. The operating expenses that hospitals incur for inpatient care differ by thousands of dollars per discharge, even after adjusting for regional wages and the complexity of care provided. Some hospitals deliver high-quality care with lower operating expenses, while many higher-expense hospitals achieve lower quality performance.

Operating expenses are driven in part by market dynamics. Hospitals that are able to negotiate high commercial rates have high operating expenses and cover losses they may experience on public payer business with income from their higher commercial revenue, while hospitals with more limited revenue must maintain lower expenses. Hospitals can follow various strategies to reduce operating expenses, such as adopting "lean" management principles and improving their procurement and supply-chain management processes.

Wasteful spending

An estimated 21 to 39 percent ($14.7 to $26.9 billion in 2012) of health care expenditures in Massachusetts could be considered wasteful. There are specific examples of wasteful spending that payers and providers can address, either in the current fee-for-service system or under alternative payment methods. Large opportunities across care settings include $700 million in preventable acute hospital readmissions and $550 million in unnecessary emergency department visits. Hospitals could reduce health care-associated infections, estimated at $10 to $18 million. Finally, there are a number of opportunities addressable by individual physicians and patients, such as early elective inductions ($3 to $8 million) and inappropriate imaging for lower back pain ($1 to $2 million).

High-cost patients

Five percent of patients account for nearly half of all spending among the Medicare and commercial populations in Massachusetts. Significant savings can be captured by focusing on a subset of the population with identifiable and predictable characteristics. Certain clinical conditions, regions of residence, and demographic characteristics differ between high-cost patients and the rest of the population. A number of conditions occurred more often among high-cost patients, and high-cost patients generally had more clinical conditions than the rest of the population. The presence of multiple conditions, such as behavioral health and chronic medical conditions, increased spending more than the combined effects of individual conditions, illustrating the complexity of managing multiple conditions simultaneously. There was modest regional variation in the concentration of high-cost patients. Socioeconomic factors were also important, as lower zip code income correlated with being high-cost among the commercial population.

Persistently high-cost patients – those who remain high-cost over multiple years – are easier to identify for care improvement and better health outcomes. These patients represent 29 percent of high-cost patients and make up 15 to 20 percent of Medicare and commercial spending in Massachusetts. Interventions that have been shown to improve the efficiency of care for high-cost patients include: prevention of conditions that often lead to expensive health crises; process and operational improvements that reduce the cost of episodes that are common among high-cost patients; and care management resources to support patients to manage their care more effectively and better coordinate care for patients across multiple provider settings.

Conclusion

This report highlights key challenges and opportunities as the Commonwealth seeks to reduce the growth of health care spending. Although Massachusetts has seen a recent slowdown in per capita health care spending growth similar to national trends, maintaining this slower rate of growth will require a sustained commitment by all stakeholders to continue necessary reforms of the health care payment and delivery systems. Through our cost trends hearings and examination, the Commission supports this effort by reviewing significant drivers of spending growth, identifying areas of opportunity, and recommending evidence-based interventions, innovations, and policies. Our first annual cost trends report builds on prior work and has important implications for our ability to meet the goals of Chapter 224.

In summary, 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.

Our findings and recommendations are summarized below:

Meeting the benchmark

Understanding the complex factors that drive health care spending trends is important if Massachusetts is to meet its cost growth benchmark. Health care spending is a function of the amount and type of services provided (utilization) and the prices paid for health care services (price), which includes both the price per service (unit price), and the setting in which those services are provided (provider mix). We find:

- Per capita personal health care services spending in Massachusetts is the highest of any state in the U.S., crowding out other priorities for households, businesses, and government. This higher per capita spending is consistent across all payer types. Massachusetts residents use more services, especially hospital care and long-term care and home health, and are more likely to receive care at more expensive major teaching hospitals. Prices paid for health care services are higher in Massachusetts than the U.S. average.
- Over the past decade, growth in health care spending in Massachusetts exceeded the U.S. average and is driven primarily by growth in commercial prices, including both higher unit prices and a shift of patients to higher-priced providers. Commercial prices vary significantly in Massachusetts and are associated with the relative market position of the provider, not the quality of care provided.
- Massachusetts has better overall health care quality performance and offers better access to care than many other states. However, considerable opportunities remain to further improve quality and access as well as population health.

Fostering a value-based market

There is an opportunity in Massachusetts to improve health care market functioning by promoting value-based competition, increasing cost and quality transparency,

and encouraging both demand-side and supply-side approaches to drive health care value. We find:

- The provider market in Massachusetts is rapidly changing with many provider organizations exploring a range of potential affiliations, from corporate to contractual to clinical. These changes can significantly impact market functioning. It is important to balance potential cost and quality benefits of such transactions with potentially negative effects on patient access to care, prices and total spending, and the ability of payers to develop viable alternative network products. The Commission will continue to monitor these developments through its statutory authority to review provider material changes and conduct cost and market impact reviews.
- Payers have developed, and employers and consumers have increasingly selected, high-deductible and tiered or limited network products that provide greater financial incentives for consumers to make value-based health care decisions such as choosing high-quality, lower-priced providers and avoiding unnecessary services. While payers should continue to develop value-based products, it is important to monitor the impact of such products to ensure that specific product designs do not inhibit or otherwise discourage consumers from seeking necessary care.
- As required by Chapter 224, payers and providers are taking steps to make health care price information transparent and available to consumers. In order to further support value-based decisions, these transparency efforts should include comparable information on provider quality performance and patient experience.

Promoting an efficient, high-quality health care delivery system

There is an opportunity in Massachusetts for providers to more efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status. We find:

- Consistent with national findings, an estimated 21 to 39 percent ($14.7 to $26.9 billion in 2012) of annual health care spending in Massachusetts does not return value and in some cases causes preventable harm to patients. This "wasteful spending" includes spending on preventable ED visits, hospitalizations for ambulatory care-sensitive conditions, and unnecessary hospital readmissions, among other areas. Spending in these areas could be reduced by interventions such as more effective care coordination, adherence to evidence-based guidelines, and clinical process standardization. The Commission will continue to work with payers, providers and other stakeholders to identify and address these and other areas of wasteful spending.
- Consistent with national findings, a small number of patients account for a significant proportion of the Commonwealth's overall health care expenditures. In part due to ineffective coordination across a fragmented care delivery system, the interaction of multiple conditions can lead to even higher spending. There are opportunities to better identify and target interventions to improve health outcomes and reduce overall expenditures, especially for patients who are persistently "high-cost" or who have multiple conditions such as behavioral health and chronic medical conditions.
- Operating efficiency varies greatly from one hospital to another. Certain hospitals are able to achieve high levels of quality with lower operating expenses than other hospitals. Hospitals performing at lower efficiency should critically examine their cost structures and adopt best practices designed to improve their efficiency in delivering high-quality care.

Advancing alternative payment methods

All major payers in Massachusetts are implementing forms of alternative payment methods, such as global payments, which, in contrast to fee-for-service payments, are designed to support and financially reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases. We find:

- There is wide variation in the types of alternative payment contracts covering Massachusetts providers, both within and across payers, as budget levels, risk adjustments and other contract terms are negotiated. In addition, behavioral health services are often excluded from global budgets. As a result, underlying payment disparities persist, and providers face challenges managing patients' care under different incentive structures. The Commission will continue to evaluate the impact of alternative payment methods and encourage, where appropriate, the standardiza-

tion of such payment methods that responsibly foster high-quality care and the efficient use of resources.

- Commercial alternative payment contracts currently apply primarily to patients in HMO products. However, employers and consumers in Massachusetts are increasingly selecting PPO product offerings, which currently do not feature alternative payment contracts. Payers should accelerate the development of methodologies and address other barriers so that alternative payment methods can be extended to PPO products as well. The Commission will continue to monitor effective ways to coordinate patient care and incentives across multiple forms of product design.

Enhancing transparency and data availability

Readily available data are necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time. We find:

- To effectively coordinate and manage care delivery, including better identifying needs of high-cost patients, providers need access to patient data, even when care is delivered by another provider or within a different health system. These data needs include both current patient data and retrospective information on relative performance. Payers should support providers by making this data more readily accessible for all patients in all product types. The Commission supports the continued development of a health information exchange and an accessible all-payer claims database as important efforts to enhance data accessibility.
- Analysis of hospital operating expenses is limited by variation in hospital cost reporting. There is a need for improved cost accounting at hospitals and increased standardization in the allocation of administrative costs and public reporting of all patient care expenses. An improved set of data should be collected by the Commonwealth, including through the current CHIA reporting process.
- As payers and providers achieve efficiencies through these reforms, the Commission will monitor the impact of these efforts to ensure that employers and consumers share in the savings in the form of lower growth in premiums and consumer out-of-pocket spending.

In the coming months we intend to update many of the analyses contained in this report with claims data from 2012, including Medicaid information. In addition, through our ongoing analysis of the APCD and other data sources, we intend to continue our analysis of issues that are critical to the success of the Commonwealth's cost containment and quality improvement efforts. We look forward to working with the Massachusetts health care industry, stakeholders, businesses, and consumers on advancing the goal of a more affordable, effective and accountable health care system in Massachusetts.