MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

January 31, 2018

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the January 3, 2018 Meeting
- Market Oversight and Transparency
- Care Delivery Transformation
- Executive Director’s Report
- Schedule of Next Board Meeting (March 13, 2018)
- Executive Session: Performance Improvement Plans

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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on January 3, 2018 as presented.

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  - Discussion of the Proposed Transaction including CareGroup, Lahey Health System, Seacoast Regional Health Systems, the Beth Israel Deaconess Care Organization, and Mount Auburn Cambridge Independent Practice Association
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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	21	23%
Physician group merger, acquisition, or network affiliation	19	21%
Acute hospital merger, acquisition, or network affiliation	19	21%
Formation of a contracting entity	16	18%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	9	10%
Change in ownership or merger of corporately affiliated entities	5	6%
Affiliation between a provider and a carrier	1	1%

Notices Currently Under Review

- Proposed acquisition of the non-hospital-based diagnostic laboratory business of **Cape Cod Healthcare** by **Quest Diagnostics Massachusetts,** a subsidiary of a national diagnostic testing provider.

Received Since 1/3

- Proposed joint venture among **Shields Health Care Group**, **Hallmark Health System**, and **Tufts Medical Center Physician Organization** to build and operate a freestanding ambulatory surgery center on the campus of Lawrence Memorial Hospital in Medford.

- Proposed clinical affiliation between **Shields Health Care Group** and **Tufts Medical Center** under which the parties would jointly manage MRI services at Tufts Medical Center and at Shields' MRI sites in Dorchester and Dedham.

Elected Not to Proceed

- Acquisition of all 18 **IASIS** Healthcare Corporation hospitals by **Steward Health Care**.

- Proposed joint venture between **Shields Health Care Group** and **Baystate Health** that would own and operate an urgent care clinic for patients in Baystate's geographic region.

For each of these transactions, our analysis suggested limited scope for increases to health care spending, and we did not review evidence suggesting negative impacts on quality or access.

CMIR In Progress

- CMIR initiated regarding the proposed merger of **CareGroup**, **Lahey Health System**, and **Seacoast Regional Health Systems**, the related acquisition of the **Beth Israel Deaconess Care Organization** by the merged entity, and the contracting affiliation between the merged entity and **Mount Auburn Cambridge Independent Practice Association.**

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Proposed Transaction: Creation of the "NewCo" System

Proposed **corporate affiliation** between the Beth Israel Deaconess and Lahey systems, as well as three hospitals that are currently corporately independent.

*Though corporately independent, Anna Jaques and Baptist contract through the Beth Israel Deaconess Care Organization (BIDCO). BIDMC, Mt. Auburn, and Baptist also are members of CareGroup, which jointly borrows funds and purchases services, but does not contract with payers or provide centralized operations.

Proposed Transaction: Creation of the "NewCo" System

The new system would own the parties' current contracting entities, which contract on behalf of owned and non-owned affiliates. They additionally propose a new **contracting affiliation** with the **Mount Auburn Cambridge Independent Practice Association.**

Current Contracting Entities
(would become NewCo corporate affiliates)

Beth Israel Deaconess | CARE ORGANIZATION

Lahey Health℠
- Lahey Clinical Performance Network
- Lahey Clinical Performance ACO

BIDCO Non-Owned Contracting Affiliates
(*not included in corporate merger*)

- Cambridge Health Alliance (CHA)
- Lawrence General Hospital
- MetroWest Medical Center

New Contracting Affiliate

MACIPA

HPC

Beth Israel Deaconess Medical Center (BIDMC)

Beth Israel Deaconess Medical Center

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

Beth Israel Deaconess Hospital *Needham*

Beth Israel Deaconess Hospital *Plymouth*

Beth Israel Deaconess Hospital *Milton*

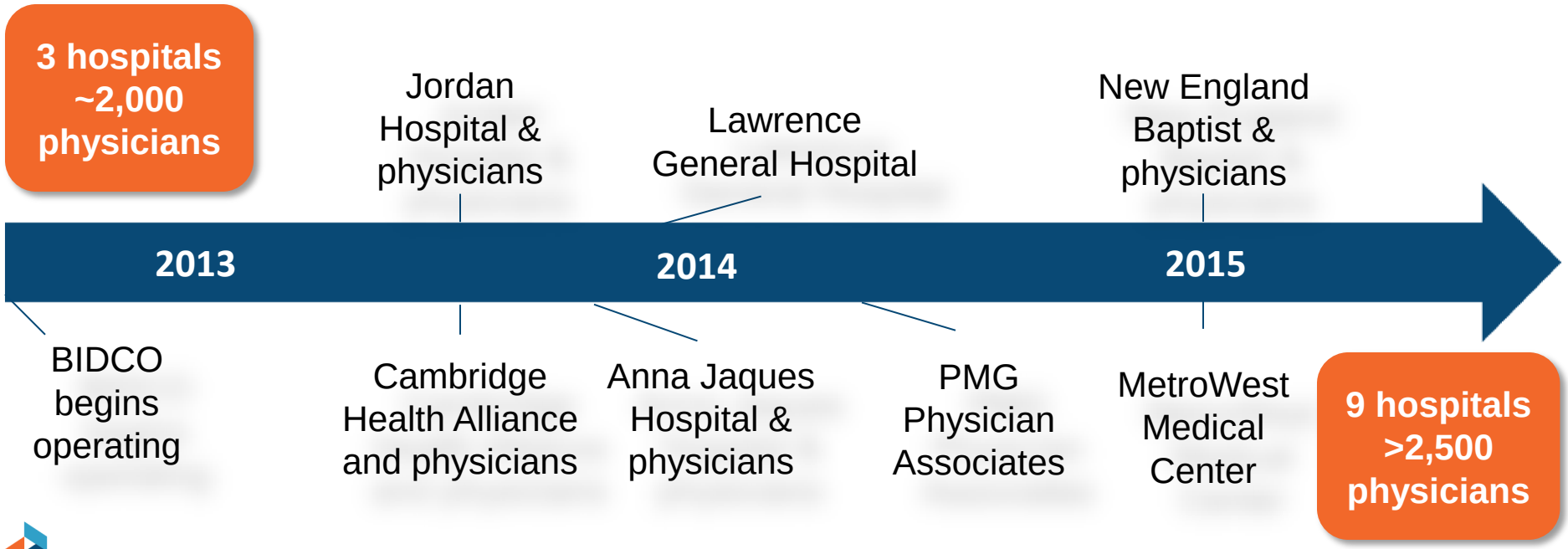
- BIDMC is a 703-bed non-profit academic medical center
- It owns three community hospitals: BID-Milton, BID-Needham, and BID-Plymouth**,** and two physician practices totaling ~417 physicians
- The BID-owned hospitals, along with New England Baptist Hospital and Mount Auburn Hospital, are part of CareGroup, which jointly borrows funds and purchases services, but does not contract with payers or provide centralized operations
- All of the BID-owned hospitals would become corporate affiliates of NewCo
- The BID-owned hospitals and physicians contract through Beth Israel Deaconess Care Organization (BIDCO)

Beth Israel Deaconess Care Organization (BIDCO)

BIDCO has grown substantially in recent years.

In addition to the BID-owned hospitals and affiliated physicians, BIDCO contracts on behalf of five contracting affiliate hospitals: **New England Baptist Hospital**, **Anna Jaques Hospital**, **Cambridge Health Alliance (CHA)**, **Lawrence General Hospital**, and **MetroWest Medical Center** as well as over 2,500 physicians.

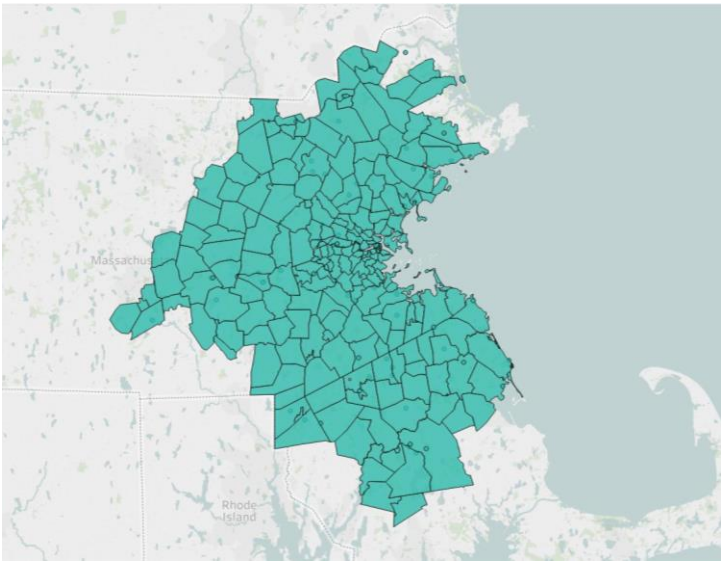
Of these, all but CHA, Lawrence General, and MetroWest would become corporate affiliates of NewCo, and BIDCO itself would become a corporate affiliate of NewCo.



Anna Jaques Hospital and Seacoast Regional Health System (SRHS)

- Seacoast Regional Health System (SRHS) would become a corporate affiliate of NewCo
- SRHS includes:
  - Anna Jaques Hospital (AJH), a 140-bed general acute care hospital located in Newburyport, MA
  - Seacoast Affiliated Group Practice, a 35-physician multi-specialty practice
- Anna Jaques Hospital and its affiliated physicians in the Whittier IPA contract through BIDCO and are clinically affiliated with BIDMC

New England Baptist Hospital (NEBH)



- New England Baptist Hospital (NEBH) is a non-profit, 95-bed orthopedic hospital in Boston, and the only specialty orthopedic hospital in Massachusetts
- It has licensed outpatient orthopedic facilities in Brookline, Chestnut Hill, and Dedham
- Its owned physician group, New England Baptist Clinical Integration Organization (NEBCIO), includes ~106 physicians (14 PCPs)
- NEBH is part of CareGroup, currently contracts through BIDCO, and is clinically affiliated with BIDMC
- NEBH would become a corporate affiliate of NewCo

BIDCO Overview: Current Size

9 Hospitals with 1,954 staffed beds

Current Hospital Members	# of Beds
BIDMC	671
BID – Milton	68
BID – Needham	31
BID – Plymouth	172
Cambridge Health Alliance	229
Anna Jaques Hospital	140
Lawrence General Hospital	230
New England Baptist	100
MetroWest Medical Center	313

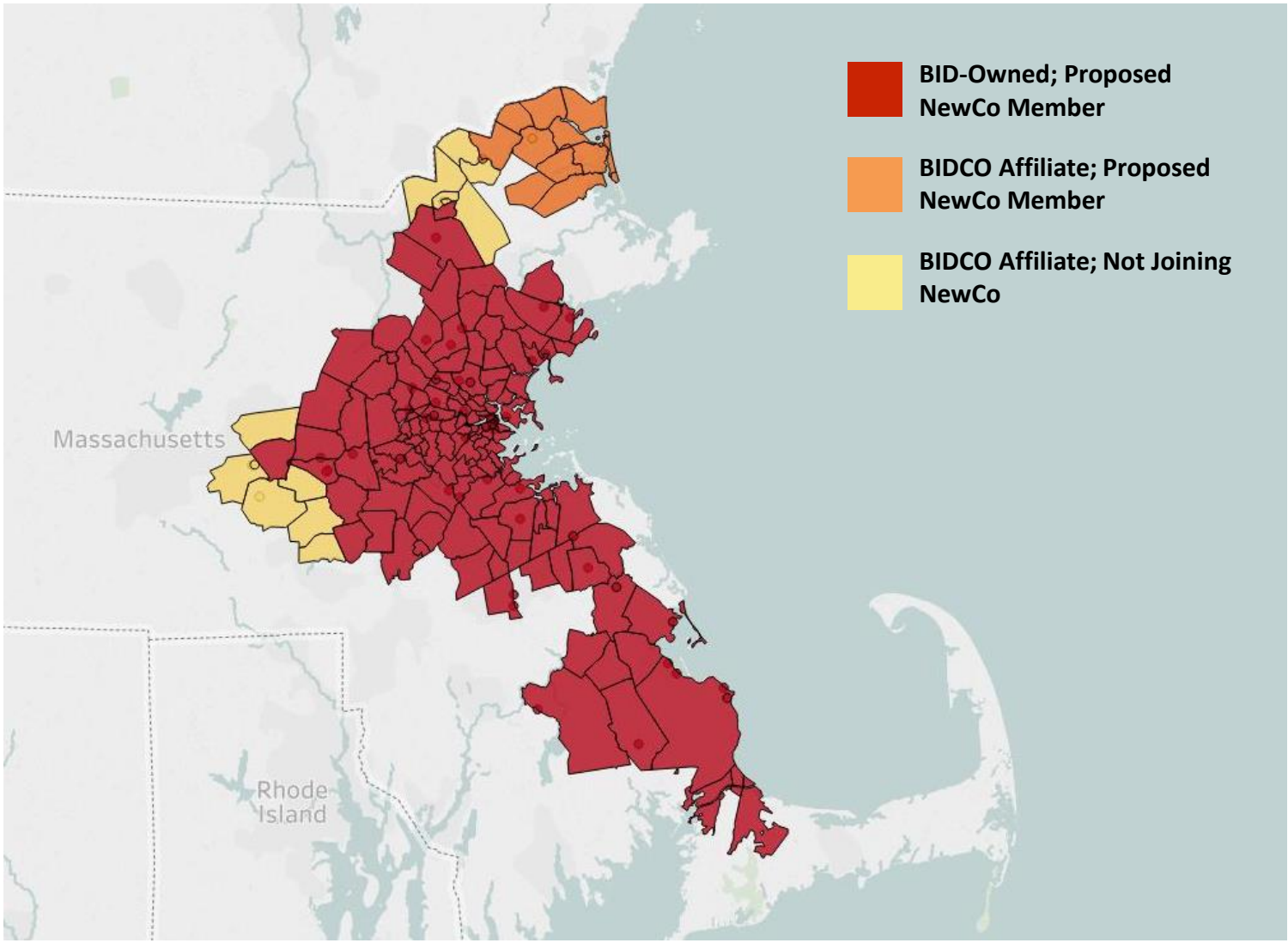
~2,500 Physicians
(~1,900 specialists; ~600 PCPs)

Current Physician Group Members
Affiliated Physicians Inc.
Harvard Medical Faculty Physicians (HMFP)
Cambridge Health Alliance Physician Organization
Jordan Physician Associates
Joslin Clinic Physicians
Lawrence General IPA
Milton PO
Whittier IPA
New England Baptist Clinical Integration Org.
Charles River Medical Associates (Pioneer ACO only)

There are also 6 CHCs, operating 14 sites staffed by BIDCO-affiliated physicians

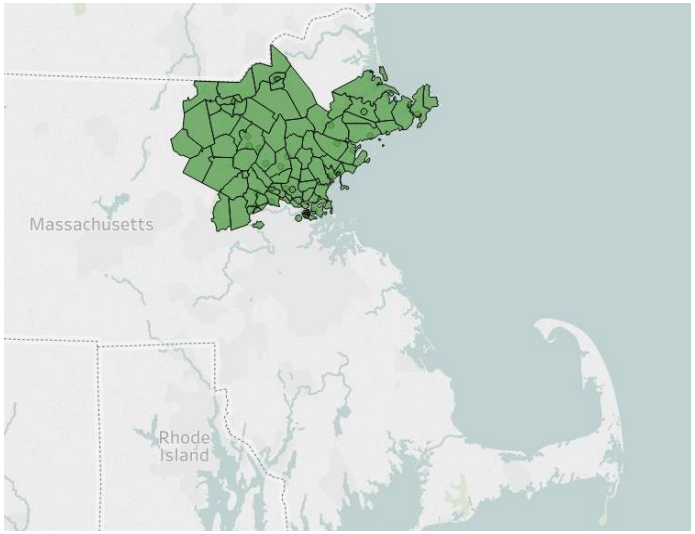
HPC

BIDCO Hospital General Acute Care Primary Service Areas



Lahey Health

Lahey Health℠



- Lahey Health System was formed in May 2012 by the merger of Northeast Health System and the Lahey Clinic Foundation. Lahey acquired Winchester Hospital in 2014.
- Lahey owns three hospitals:
  - Lahey Hospital and Medical Center (including Lahey's Peabody campus)
  - Northeast Hospital (Beverly and Addison Gilbert campuses, as well as BayRidge Hospital, which provides psychiatric services)
  - Winchester Hospital
- Lahey also owns the Lahey Clinical Performance Network (LCPN), which contracts on behalf of approximately 1,000 physicians (~200 PCPs and ~800 specialists)
- Lahey's hospitals and LCPN would become corporate affiliates of NewCo

Lahey Overview: Current Size

Lahey Health℠

Current Hospital Members	# of Beds
Lahey Hospital and Medical Center (incl. Lahey Peabody)	345
Northeast Hospital (Beverly and Addison Gilbert campuses, as well as BayRidge Hospital, which provides psychiatric services)	404
Winchester Hospital	229

Current Physician Group Members
Lahey Clinic
Northeast PHO
Winchester Physician Associates

All Lahey physicians participate in Lahey's contracting entity, the Lahey Clinical Performance Network (LCPN)

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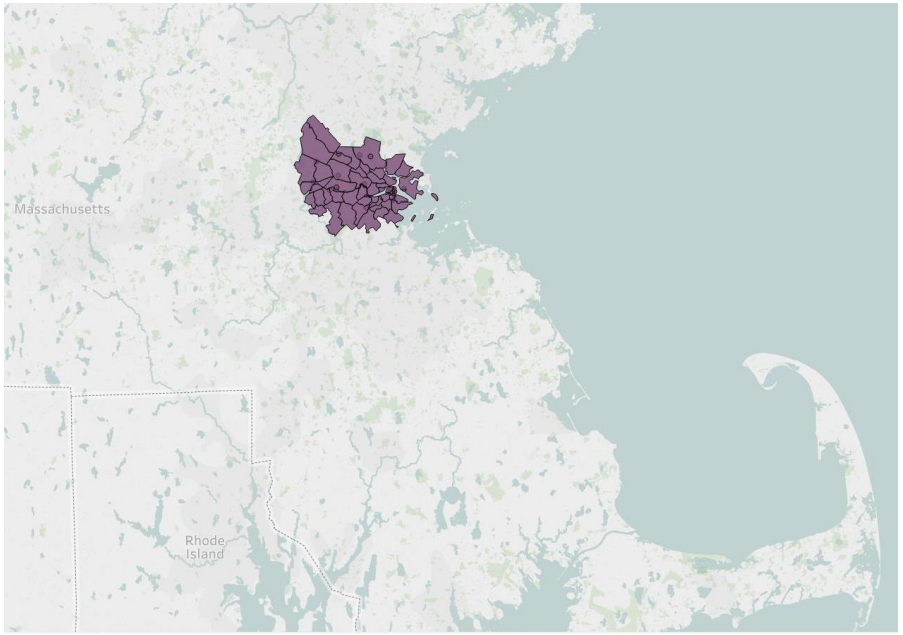
Mount Auburn Hospital and Mount Auburn Cambridge Independent Practice Association (MACIPA)

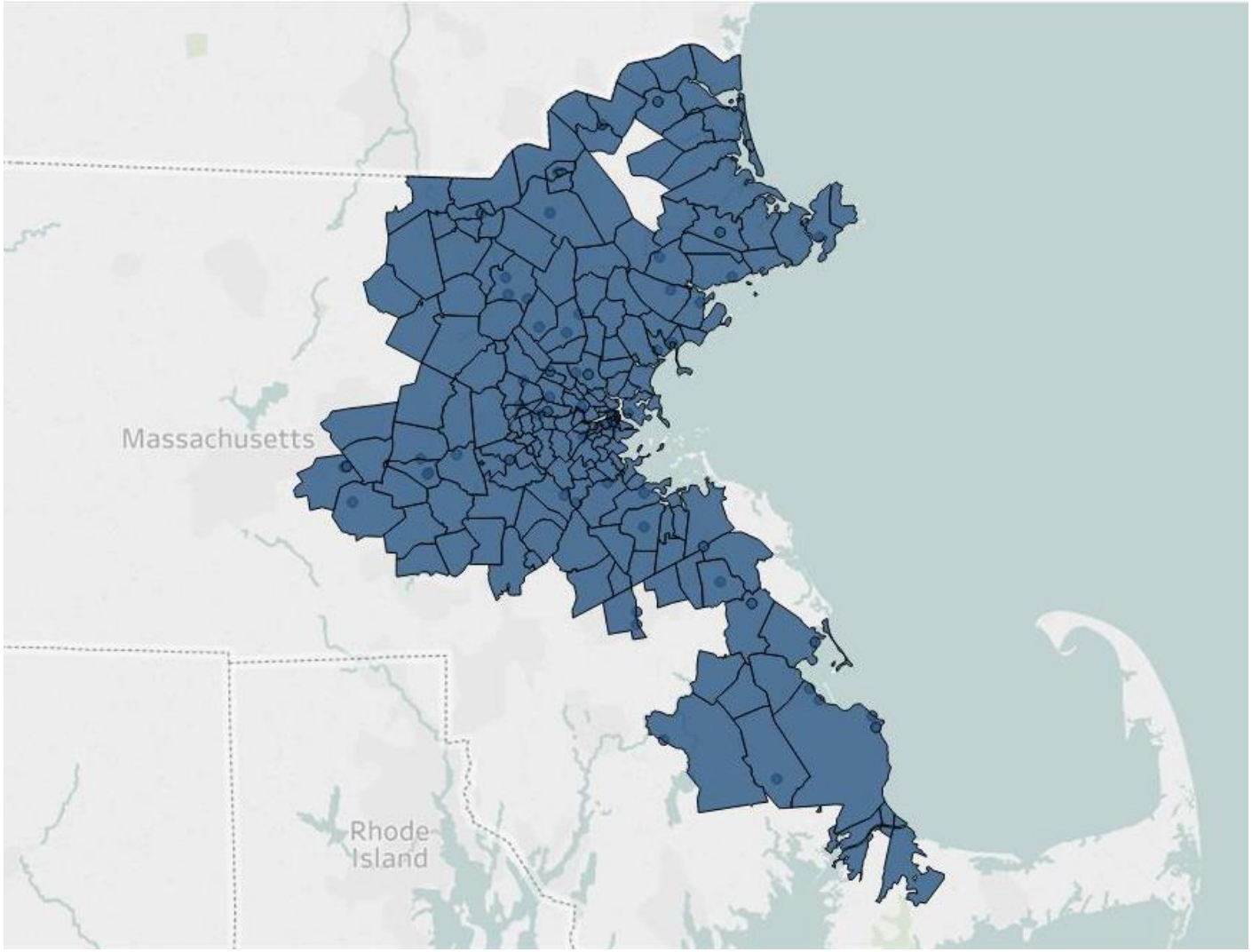
- Mount Auburn Hospital is a 227-bed teaching hospital located in Cambridge that currently contracts independently
- Mount Auburn is part of CareGroup
- Mount Auburn would become a corporate affiliate of NewCo



MACIPA

- MACIPA is an independent practice association comprised of approximately 500 physicians (~100 PCPs and ~400 specialists), including employed doctors at Mount Auburn Hospital, Cambridge Health Alliance, and small private practices
- MACIPA currently establishes physician payer contracts independently
- MACIPA would become a contracting affiliate of NewCo

NewCo Hospital General Acute Care Primary Service Areas



Transaction Claims

- NewCo would be governed by a board with fiduciary control, with some administrative functions at the system level
- Local hospital boards and management would continue to oversee day-to-day operations at the local level
- The parties expect to realize operating efficiencies over time through the consolidation of some administrative functions (e.g., supply chain and information technology); they also expect to get better debt financing rates as a unified system
    - The parties have stated they plan to invest these savings into clinical programs, and that efficiencies may eventually result in lower premiums

Transaction Claims (continued)

The parties claim that the proposed affiliation would allow NewCo to:

- Attract patients away from higher-priced provider systems, lowering total spending
- Work with insurers to create innovative insurance products, including new tiered and limited networks to incentivize consumers and employers to choose NewCo as a high-value provider network
- Keep more care in more efficient community settings
- Exert competitive pressure on more expensive providers that could result in those providers lowering their prices

Transaction Claims (continued)

The parties state that they plan to:

- Invest in systems to improve performance in APMs and assume increased responsibility for health outcomes
- Spread best practices in quality improvement and care management
- Expand access to services, including behavioral health and primary care services

The parties claim that their goals cannot be realized on a standalone basis because they require financial and other resource commitments, a large geographic footprint, a full range of services, and operational integration and alignment.

Process Update

Process to-date

- CMIR initiated on 12/14/2017
- Parties provided initial production on 1/19/2018
- Additional information is being provided by payers and other providers
- The HPC has begun analyses relevant to evaluating cost, market, quality, and access impacts
- Additional meetings with the parties are being scheduled to identify and discuss outstanding questions

Next steps

- Staff will continue to develop analytic strategies with input from expert consultants and commissioners
- Issuance of a preliminary report with factual findings
- Feedback from parties and other market participants
- Final report issued 30 or more days after preliminary report
- Potential referral to Massachusetts Attorney General's Office and/or submission to other state agencies

Factors for Review

The HPC will assess the potential impacts of the transaction based on a range of statutory factors

A. The impact of the proposed transaction, considered in light of concurrent market developments, on **costs and market functioning** in Massachusetts, including:
   - Prices (e.g., for hospitals, physicians, and other providers, including fee-for-service, capitated, and other prices)
   - Total medical expenses ("TME")
   - Patient care referral patterns
   - Competing options for care delivery
   - Quality of and access to health care services

B. **Clinician dynamics**, including any plans related to physician recruitment

C. The Parties' **size and market position**, including market shares for relevant services

D. The Parties' **role in serving at-risk, underserved, and government payer populations**

E. The Parties' **plans for patient care management** and the potential **impact of those plans on quality, costs, and market dynamics**

F. The impact of the proposed material change in light of **other prior and proposed health care transactions**

G. Other factors concerning cost and market impact as the HPC may identify

Analyses for Discussion: Potential Market Changes

- HPC staff, in consultation with our economist experts, has conducted initial reviews of the parties' service areas and market shares in hospital inpatient care, outpatient facility care, and primary care services.
- These analyses will inform continued work to analyze the potential market impacts of the transaction as we review confidential material provided by the parties.

Statewide Inpatient Market Share

Commercial inpatient market share for all discharges
2016 CHIA hospital discharge data, all commercial payers

Hospital System/Network	Statewide Share 2016
Partners	27.0%
BIDCO, Lahey, Mt. Auburn combined	**24.7% (14.0% + 8.1% + 2.7%)**
UMass	7.0%
Wellforce	6.2%
Steward	5.9%

- BIDCO and Lahey have the second- and third-largest shares of inpatient discharges of any network in the Commonwealth, respectively.
- After the transaction, their combined statewide inpatient market share would be just under that of Partners.

Statewide Outpatient Facility Market Share

Commercial outpatient facility visit market share
2014 APCD data for the three largest commercial payers

Hospital System/ Network	Statewide Share (2014)
Partners	26.7%
BIDCO, Lahey, Mt. Auburn combined	**26.0% (13.0% + 10.6% + 2.4%)**
Wellforce	6.7%
Steward	5.6%
UMass	5.4%

- BIDCO and Lahey have the second- and third-largest shares of outpatient facility visits of any network in the Commonwealth.
- After the transaction, the statewide share of the combined entity would nearly match that of Partners.

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Statewide Primary Care Market Share

Commercial primary care visit market share
2014 APCD data for the three largest commercial payers

Physician Network	Share of Statewide Primary Care Visits
Partners	15.8%
BIDCO, Lahey, MACIPA combined	**14.1% (7.2% + 5.0% + 2.0%)**
Steward	10.7%
Children's	9.8%
Wellforce	9.0%
Atrius	6.8%

- BIDCO, Lahey, and MACIPA are currently the 5th, 7th, and 11th largest providers of primary care services statewide.
- After the transaction, the parties would be the second-largest provider of these services statewide, behind Partners.

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Cost Trends Research and Reports: Revised Design Approach

Previous Approach

1 ANNUAL REPORT
- ~80-100 pages • Primarily narrative
- 10-12 fully written chapters

1-2 SUPPLEMENTAL PUBLICATIONS
Full written reports

Revised Approach

1 ANNUAL REPORT
- ~50 pages • Narrative and visual
- 3-4 fully written chapters
- 3-4 graphical chart packs
- Online interactive content utilizing data visualization tools (Tableau)

6-8 SUPPLEMENTAL PUBLICATIONS
Varying types
(Policy Briefs, Chart Packs, DataPoints)

Goal

Advance the HPC's mission to publicly report on health care system performance by producing a variety of reports and publications that are visually-appealing, engaging, and accessible to a wide range of audiences.

Presentation themes and potential areas for recommendations

Themes

Spending and the delivery system

- Spending trends
- Prescription drug spending

Opportunities to improve quality and efficiency

- Hospital outpatient
- Avoidable hospital utilization
- Post-acute care
- Provider organization performance variation

Progress in aligning incentives

- Alternative payment methods
- Demand-side incentives

Future outlook

- Future outlook

HPC

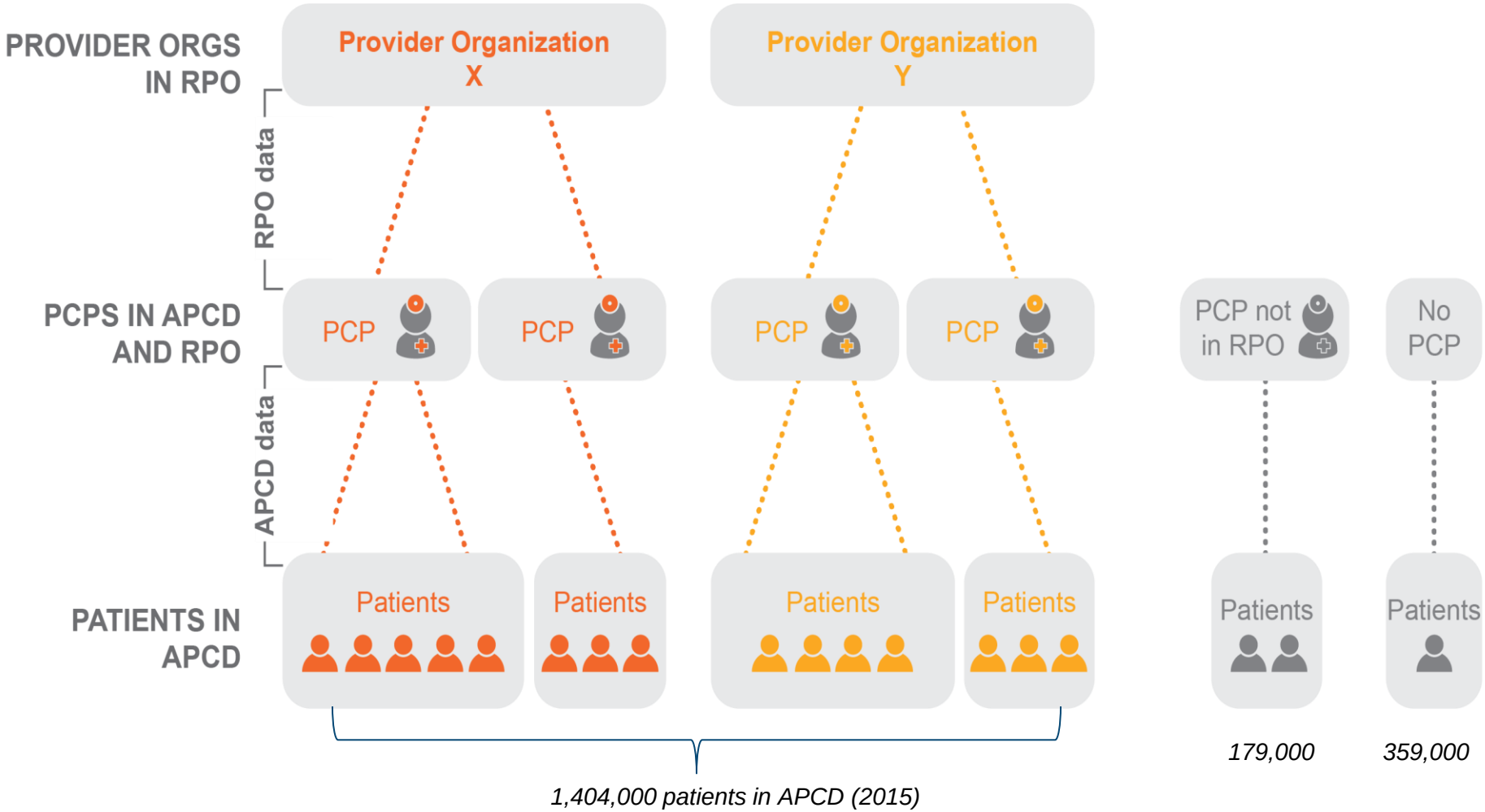
Performance Variation Among Provider Organizations: Background and Previous Work

- A chapter in the 2016 Cost Trends Report described variation in spending and provision of certain non-recommended care by provider organization.
  - This work relied on measures pre-aggregated by payers and reported to CHIA

- HPC has now linked the Massachusetts All-Payer Claims Database (APCD) and the state's Registration of Provider Organizations (RPO) database by:
  - Assigning patients observed in the data to a single primary care provider (PCP)
  - Associating PCPs with larger provider organizations using physician identifiers in both the APCD and the RPO data

- This allows examination of variation across provider groups on an unlimited number of claims-based outcomes of interest, e.g.:
  - Spending by category of service
  - Potentially avoidable utilization
  - Referral patterns

Organizations are compared by averaging spending and utilization among patients assigned or attributed to them



Notes: E.g. see McWilliams, J. Michael, et al. "Early performance of accountable care organizations in Medicare." *New England Journal of Medicine* 374.24 (2016): 2357-2366.

Patients attributed to provider organizations vary across a number of dimensions

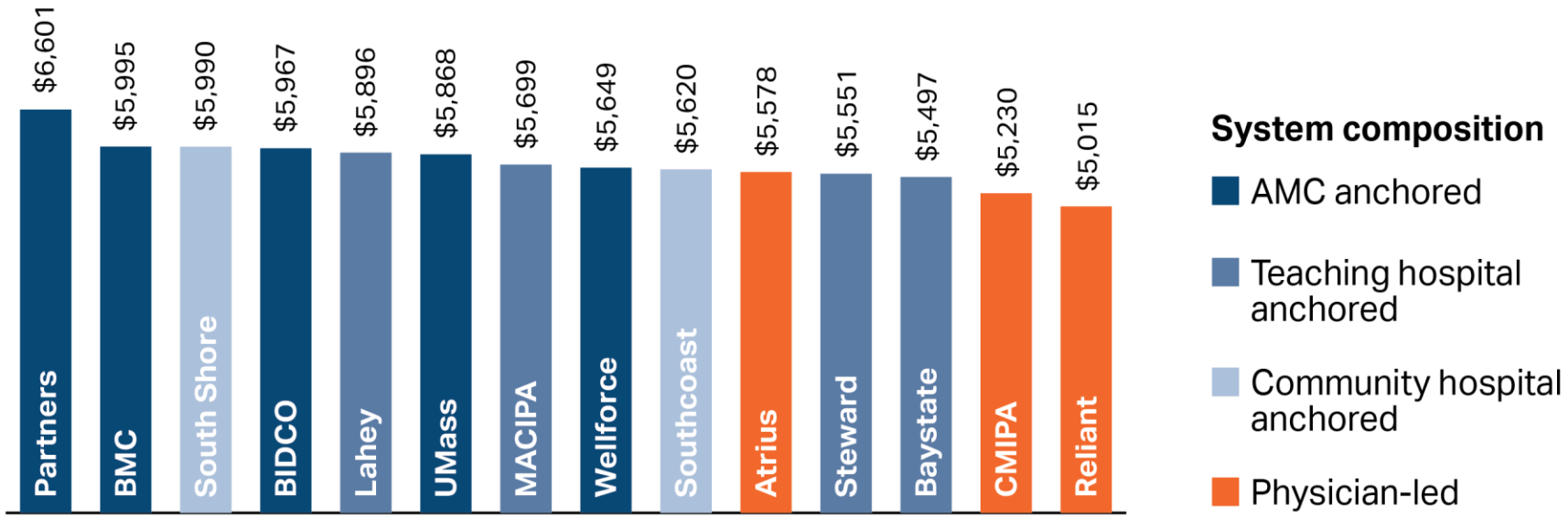
	Risk score	Zip-code income	Average deprivation index	% over 55	% self insured	% female	Number of members
Atrius	0.93	$86,091	77.0	26%	50%	56%	174,927
BMC	0.82	$65,518	88.5	19%	54%	53%	36,666
Baystate	0.95	$62,560	99.1	31%	32%	52%	49,543
BIDCO	1.00	$84,690	76.6	26%	43%	54%	145,143
CMIPA	1.00	$70,164	95.9	27%	35%	51%	13,111
Lahey	1.04	$88,455	77.8	31%	41%	52%	88,354
MACIPA	0.97	$89,359	69.8	28%	44%	53%	32,141
Partners	1.05	$88,340	76.8	29%	41%	55%	311,997
Reliant	0.91	$80,265	89.9	24%	32%	52%	42,366
South Shore	0.99	$85,507	82.5	27%	45%	56%	40,673
Southcoast	1.09	$61,679	97.6	30%	48%	51%	17,916
UMass	1.01	$74,609	93.7	30%	39%	52%	89,759
Wellforce	1.02	$82,086	84.9	28%	42%	49%	129,378
Steward	1.06	$71,796	90.3	30%	47%	52%	183,553

Note: The area deprivation index combines a number of socio-economic-related measures by census block in the U.S. (including home values and amenities, employment, poverty, and education levels) measured at the 9-digit-zip code level. It is collapsed to 5 digits in this data. Values in Massachusetts range from 120 (greatest deprivation) in parts of Boston and Springfield to -12 (least deprivation) in Weston. Risk scores are normalized to a 1.0 average.

Member spending in the highest-cost organization was 32% higher than in the lowest-cost organization

Average commercial PMPY spending, by provider organization, 2015

Risk adjusted



Notes: PMPY= per member per year, PCP= primary care provider, AMC= academic medical center. Spending adjusted using ACG risk-adjuster applied to claims data. Data includes only adults over the age of 18. Commercial payers include Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. MassHealth includes only MCO enrollees who had coverage through BMC HealthNet, Neighborhood Health Plan, or Network Health/Tufts. Members in the MassHealth Medical Security Program (MSP) were excluded. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. Average calculated using all attributed adult members in the sample, not just those with a PCP associated with one of the 14 largest provider groups.

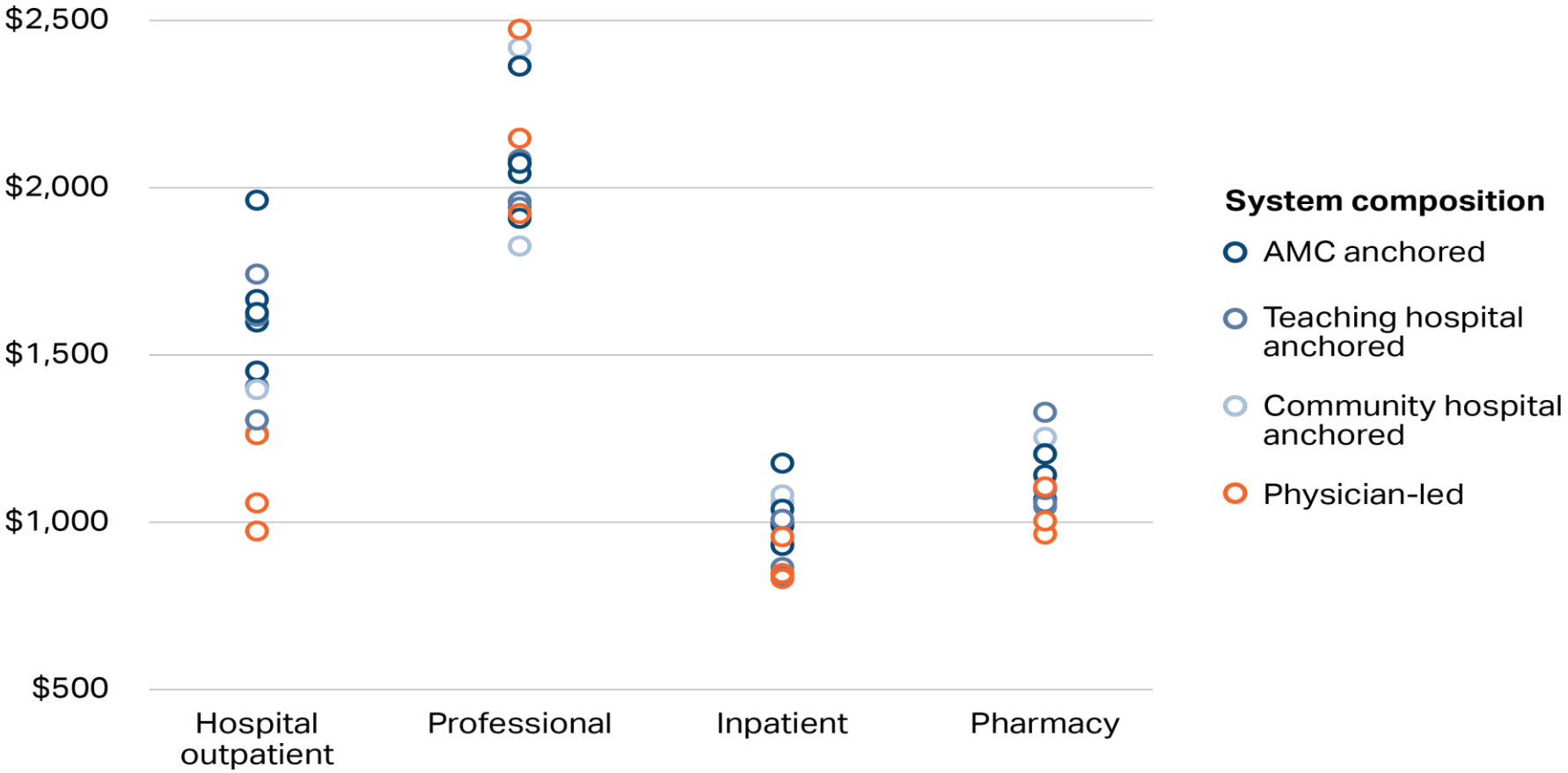
Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registry of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

HPC

Hospital outpatient spending accounted for most of the variation across provider groups

Average commercial PMPY spending, by provider organization, 2015

Risk adjusted



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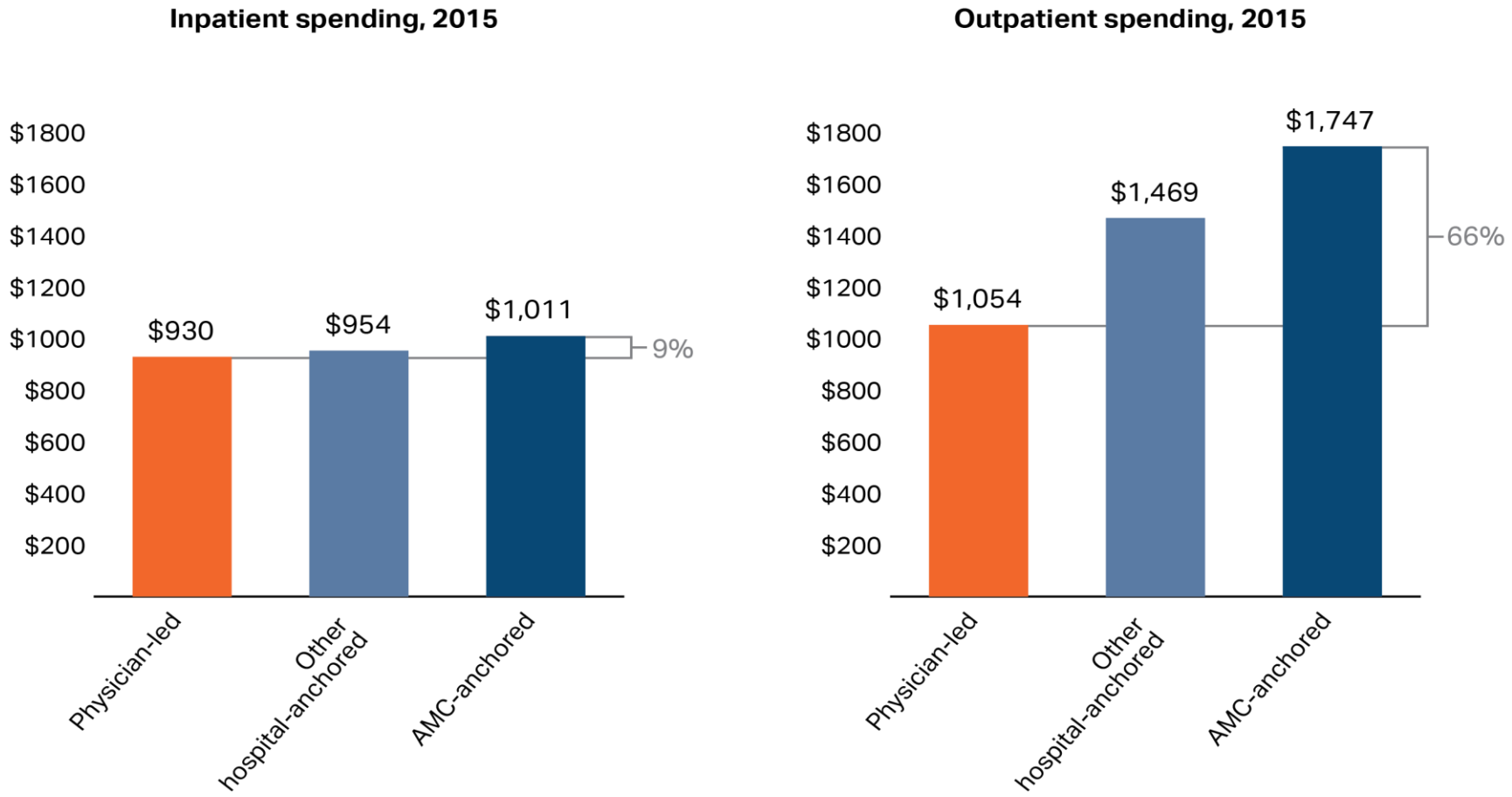
Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registry of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

HPC

Hospital outpatient spending in AMC-anchored systems was 66% higher than in physician-led systems

Average commercial PMPY hospital spending, by system composition, by category of spending, 2015

Risk adjusted



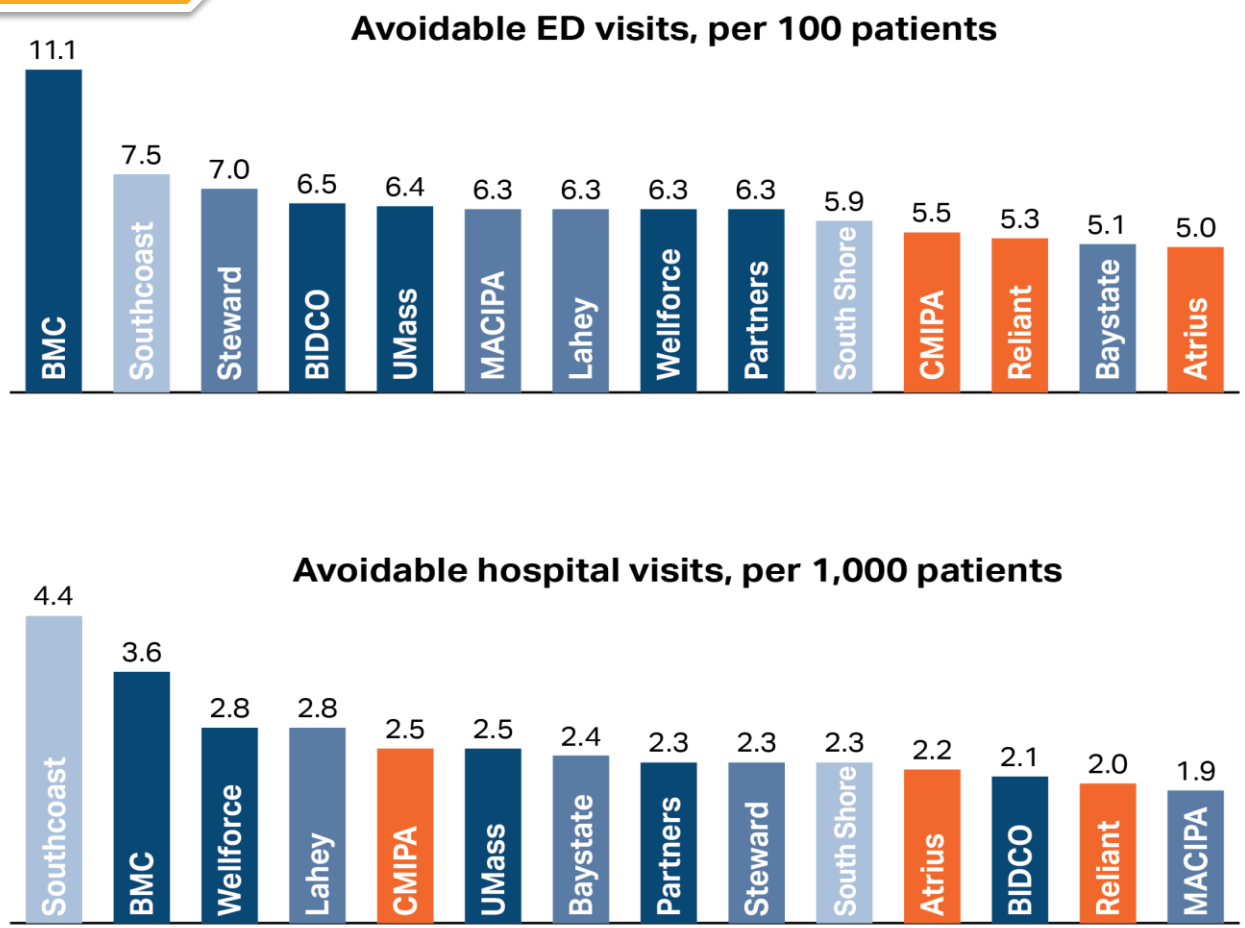
Notes: PMPY= per member per year, PCP= primary care provider, AMC= academic medical center. Other hospital-anchored includes systems anchored by either a teaching or community hospital. Spending adjusted using ACG risk-adjuster applied to claims data. Data include only privately insured adults (ages 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Only members with a PCP affiliated with one of the 14 largest PCP groups, as identified by number of patients attributed in the All-Payers Claims Database, are included here.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

Avoidable hospital and ED visits varied more than two-fold across organizations (after adjusting for patient characteristics)

ED and hospital visits that were potentially avoidable, by provider organization, 2015

Risk and demographic adjusted

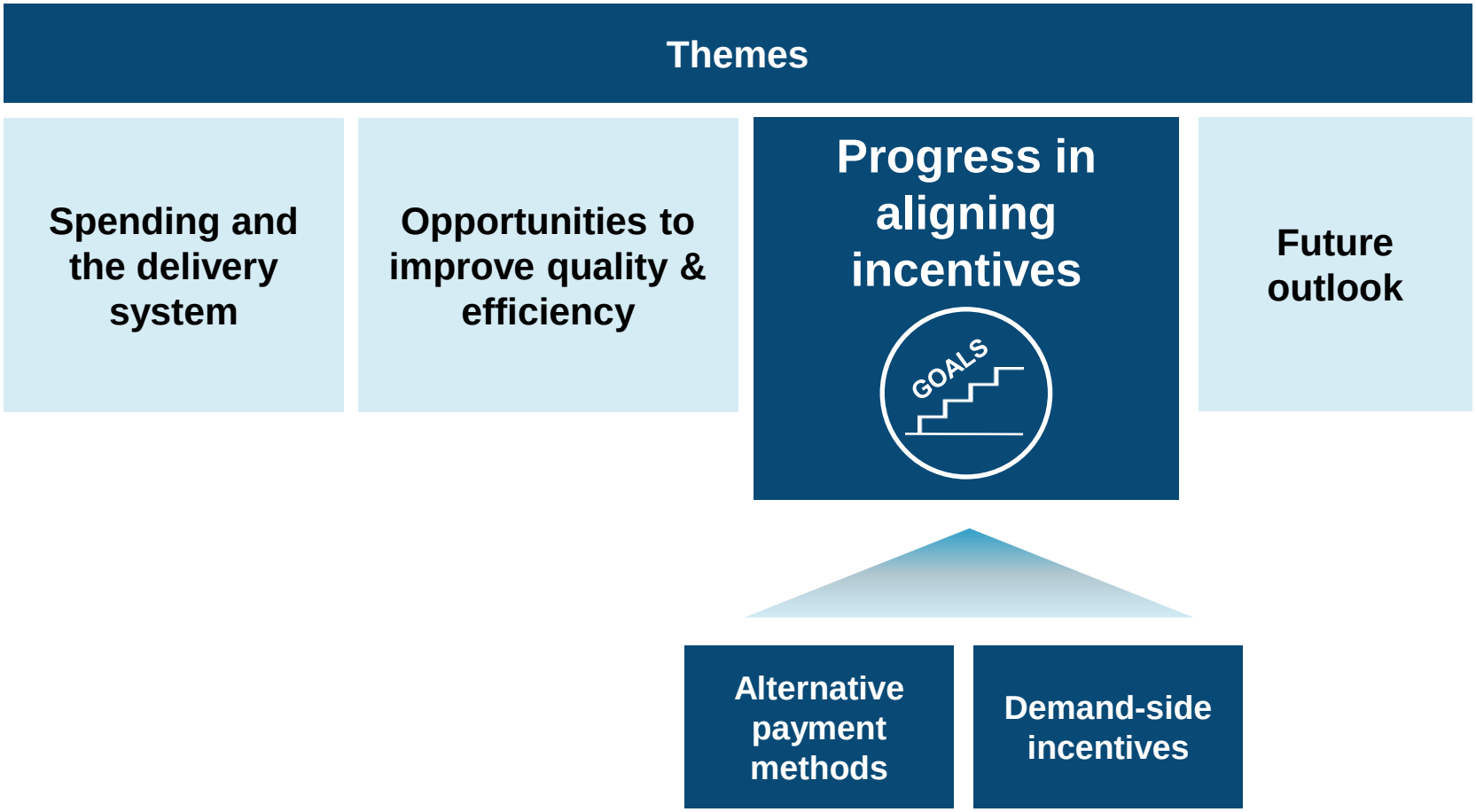


Notes: ED= emergency department; AMC= academic medical center. Adjusted avoidable ED visits by provider group were defined according to the NYU Billings Algorithm and calculated after adjusting for the following patient characteristics: risk score, median community income, area deprivation index, fully insured (commercial patients only), age, gender, and payer. Data include only privately insured adults (ages 18+) covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care and Tufts Health Plan. Shown here are the 14 largest PCP groups as identified by number of patients attributed in the All-Payers Claims Database. Avoidable hospital visits The avoidable hospital measure is based on criteria developed by the Agency for Healthcare Research and Quality's Prevention Quality Indicators to identify ambulatory care sensitive conditions – adapted for use in the APCD.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015

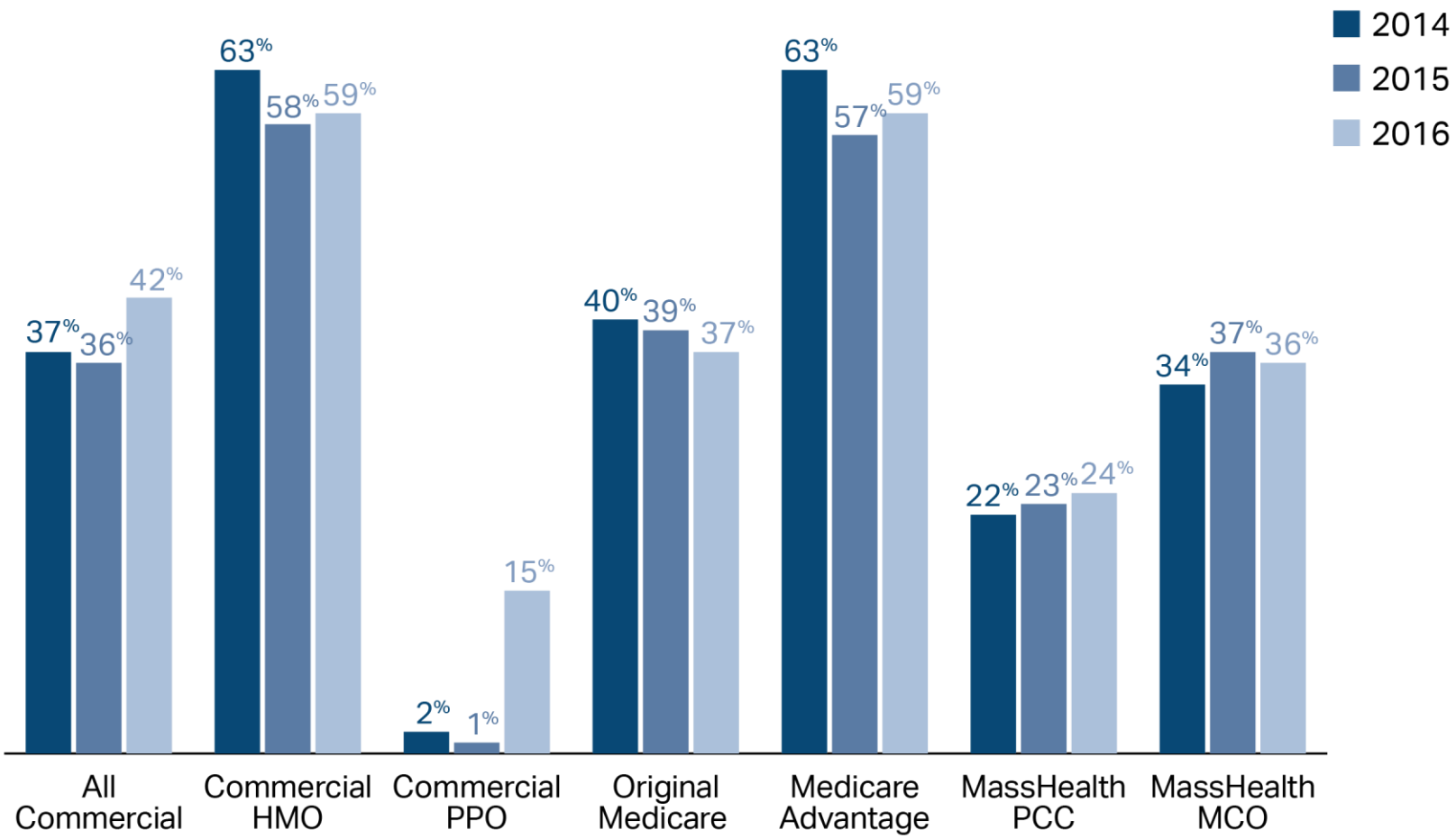
HPC

Select findings from the 2017 Cost Trends Report



Use of alternative payment methods (APMs) increased in 2016, driven by growth of APMs in commercial PPO products

Proportion of member months under APM by insurance category, 2014-2016

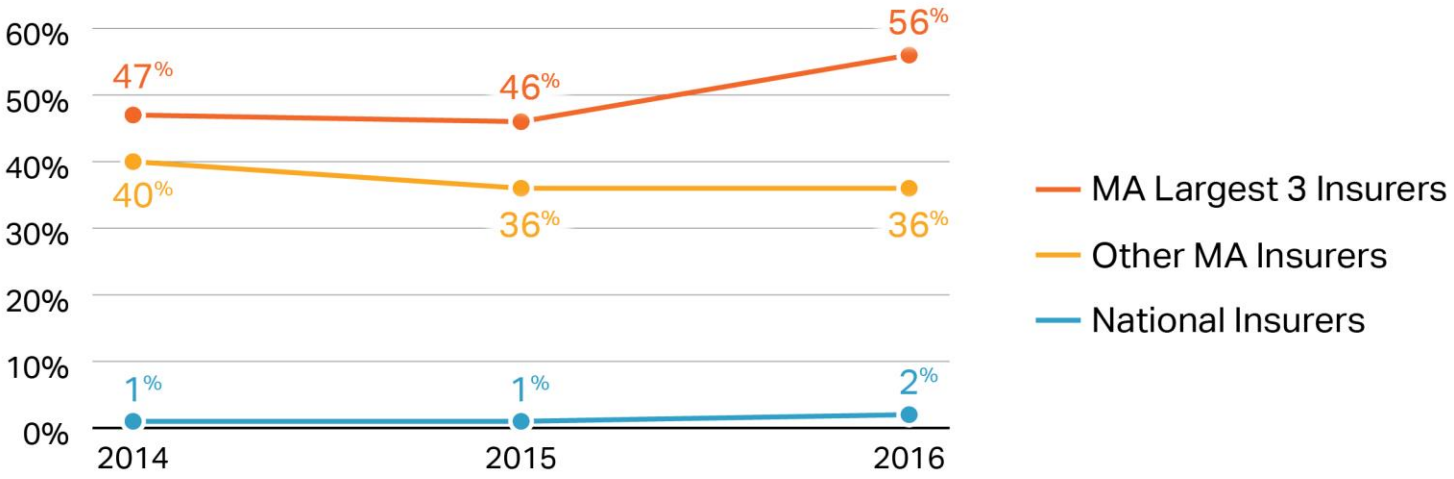


Notes: 2016 results for Original Medicare represent preliminary estimates.

Sources: HPC analysis of Center for Health Information and Analysis Annual Report APM data book, 2017; Centers for Medicare and Medicaid Services, Number of ACO Assigned Beneficiaries by County Public Use File"(2014 – 2016); "Medicare Pioneer Accountable Care Organization Model Performance Years 3- 5" (2014 - 2016); "Next Generation ACO Model Financial and Quality Results Performance Year 1" (2016).

Smaller MA insurers and national insurers have had limited growth in APMs

Proportion of commercial member months under APMs by carrier type



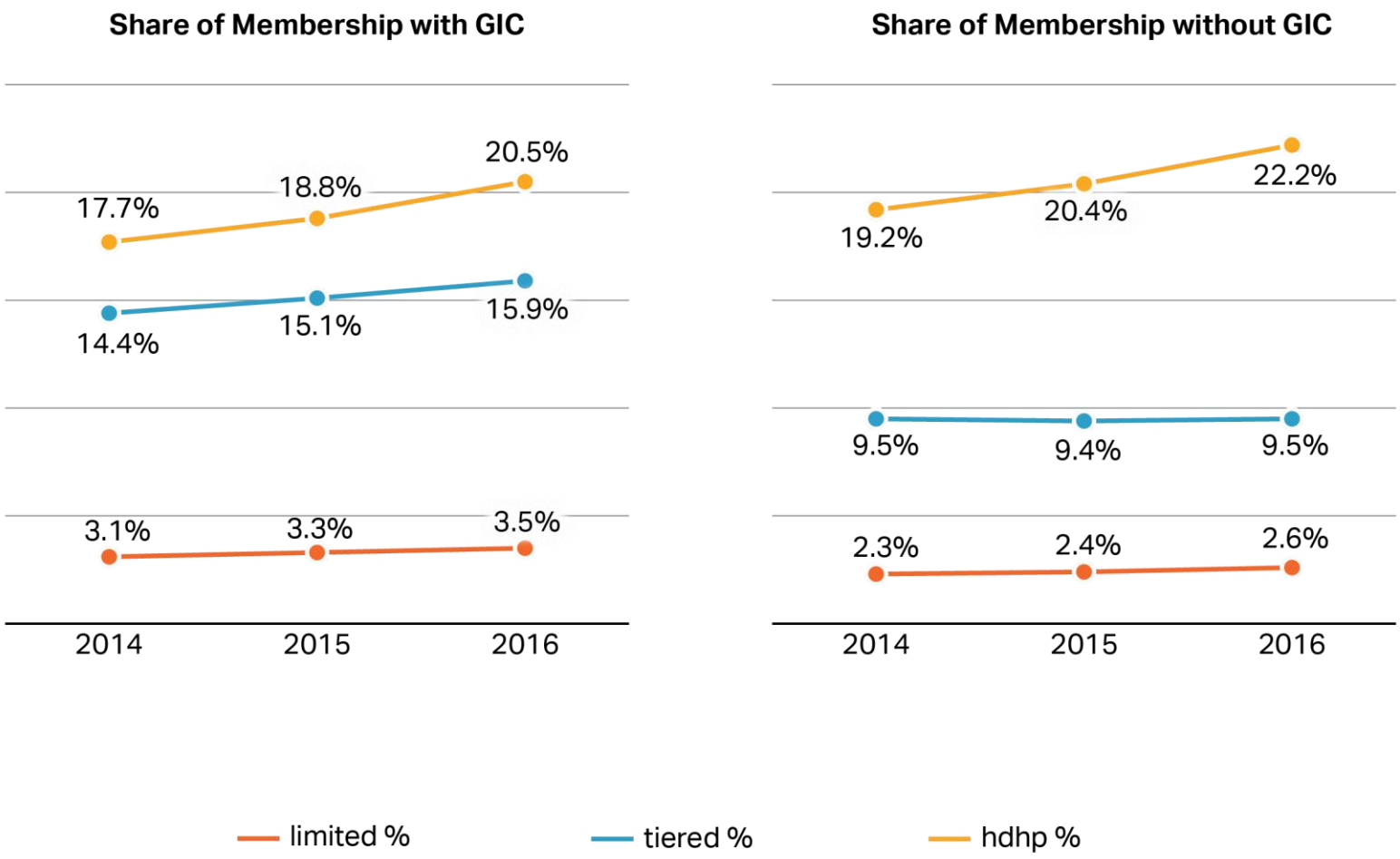
	Share of Commercial Population		
Payer Type	2014	2015	2016
MA Largest 3 Insurers	67%	65%	63%
Other MA Insurers	12%	15%	17%
National Insurers	20%	20%	20%

Notes: The three largest insurers in Massachusetts include Blue Cross Blue Shield of MA, Harvard Pilgrim Health Plan and Tufts Health Plan. Other Massachusetts plans include Network Health, BMC HealthNet Plan, Celticare Health Plan, Fallon Community Health Plan, Health New England, Health Plans, Minuteman Health, Neighborhood Health Plan, and UniCare. National insurers include Aetna, CIGNA and United Health Plans.

Sources: HPC analysis of Center for Health Information and Analysis Annual Report APM data book, 2017; Centers for Medicare and Medicaid Services, 2014 - 2016.

Uptake of tiered and limited network products grew slightly in 2016 due to the GIC

Membership by insurance product type including and excluding GIC members



Sources: HPC analysis of Center for Health Information and Analysis Annual Report [Cost and Coverage]data book, 2017

2017 Cost Trends Report: Summary of Key Findings

2017 HPC KEY FINDINGS

3.55%
Average annual rate of growth in Total Health Care Expenditures in Massachusetts from 2012-2016

$21,085
Average annual family premium plus cost-sharing for employer coverage in Massachusetts, 2016

$5.9 BILLION
Additional commercial health care spending in Massachusetts if costs had grown at the US rate from 2012-2016

X2 HIGHER
The number of routine office visits among Massachusetts Medicare beneficiaries that took place in more expensive hospital outpatient departments in 2015, compared to the U.S.

$56 MILLION
Additional spending incurred in Massachusetts due to more Medicare office visits taking place in hospital outpatient departments in 2015

31% LOWER
Premium cost for a benchmark plan on the Mass Connector in 2017, compared to those in the ACA exchanges nationwide

22%
The increase in the rate of behavioral-health ED visits among Massachusetts residents from 2011-2016

1.3%
Drop in the likelihood that a hospitalized patient is discharged to institutional post-acute care from 2014-2016

$1,586
Difference in total annual risk-adjusted spending for patients in the highest-spending organization compared to the lowest in 2015

66%
Difference in risk-adjusted hospital outpatient spending for patients in AMC-anchored provider organizations versus in physician-led organizations in 2015

Performance against targets highlights areas of success and need for improvement

Targets

Metric	Current	HPC Target	Performance
Growth of total health care expenditures per capita	2.8% (2016)	3.6% (2016)	▲
All-payer readmission rate (The rate at which patients who have been discharged are admitted again within 30 days for all payers)	15.8% (2015)	13.0% (2019)	▢
Percentage of commercial HMO patients in Alternative Payment Methods	58.6% (2016)	80.0% (2017)	▢
Percentage of commercial PPO patients in Alternative Payment Methods	14.7% (2016)	33.0% (2017)	▢
Percentage of inpatient discharges to institutional PAC	20.4% (2014)	17.1% (2020)	△

- ▲ Better performance
- △ Projected to meet target
- ● Similar performance
- ■ Worse performance
- ▢ Projected to not meet target

HPC

Board Discussion on Potential Policy Recommendations and Next Steps

1. Reflecting on the findings from the 2017 Cost Trends Report, discussion at the 2017 Cost Trends Hearing, and other work over the past five years, what issues/topics should the HPC prioritize for policy action by the Commonwealth, providers, payers, and others in 2018?

2. What issues/topics should be prioritized for HPC action in 2018?

Chapter 224 of the Acts of 2012 established the HPC and a target for reducing health care spending growth in Massachusetts.

Chapter 224 of the Acts of 2012

An Act **Improving the Quality** of Health Care and **Reducing Costs** through Increased **Transparency**, **Efficiency**, and **Innovation.**

GOAL

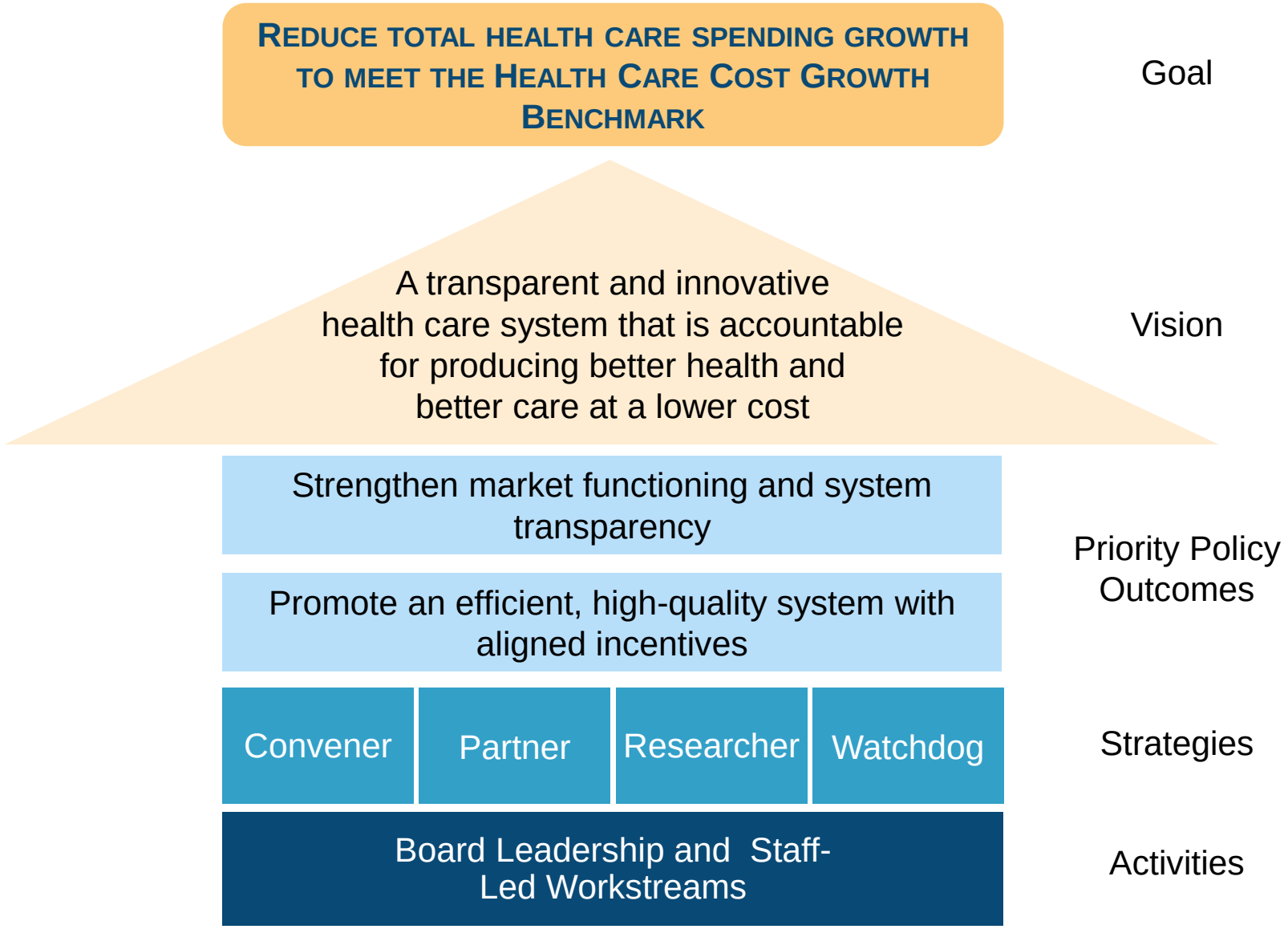
Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for the people of the Commonwealth.

HPC

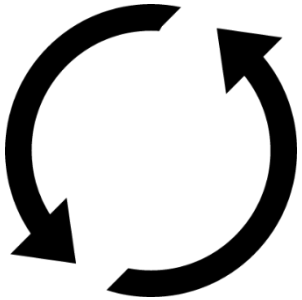
Conceptual framework for how the HPC's priority policy outcomes and strategies lead toward the vision and goal of Chapter 224.



The HPC, in collaboration with others, promotes and monitors priority policy outcomes that contribute to the goal and vision of Chapter 224.

Strengthen market functioning and system transparency

in which payers and providers openly compete, providers are supported and equitably rewarded for providing high-quality and affordable services, and health system performance is transparent in order to implement reforms and evaluate performance over time.



The two policy priorities reinforce each other toward the ultimate goal of reducing spending growth

Promoting an efficient, high-quality system with aligned incentives

that reduces spending and improves health by delivering coordinated, patient-centered and efficient health care that accounts for patients' behavioral, social, and medical needs through the support of aligned incentives between providers, employers and consumers.

Policy Priorities in the 2017 Cost Trends Report

In late 2017, the HPC restructured the policy committees of the HPC's Board to better align with its top priority policy outcomes and focus its work moving forward. The Board established two new committees, the **Market Oversight and Transparency Committee** (MOAT) and the **Care Delivery Transformation Committee** (CDT). Consistent with this strategic framework, the HPC recommends that the Commonwealth take action across the following two primary areas:

1. **Strengthen market functioning and system transparency**
2. Promoting an efficient, high-quality, health care delivery system

These include **NEW** recommendations for 2017, indicated in **orange**, and *renewed* recommendations from previous years' Cost Trends Reports, for which continued action, attention, and effort is required.

2017 Cost Trends Report: Draft Recommendations for Discussion

Strengthen market functioning and system transparency

1. Pharmaceutical Spending

The Commonwealth should take action to reduce increases in drug spending, and payers and providers should consider further opportunities to maximize value. Specific areas of focus include:

- Price transparency and accountability, including for pharmacy benefit managers (PBMs)
- NEW Maximizing value for the MassHealth program through enhanced negotiating authority
- Adding pharmaceutical and medical device manufacturers as witnesses for the cost trends hearing
- Using value-based benchmarks and contracts
- Using treatment protocols and guidelines
- Enhanced provider education and monitoring of prescribing patterns

2. Out-of-Network Billing

The Commonwealth should take action to enhance out-of-network (OON) protections for consumers. Specifically:

- Require advance patient notification
- Consumer billing protections in emergency and “surprise” billing scenarios
- Reasonable and fair reimbursement for OON services

2017 Cost Trends Report: Draft Recommendations for Discussion

Strengthen market functioning and system transparency

3. Provider Price Variation

The Commonwealth should take action to reduce unwarranted variation in provider prices. Specifically:

- Advance data-driven interventions and policies to address persistent provider price variation in the coming year

4. Facility Fees

The Commonwealth should take action to equalize payments for the same services between hospital outpatient departments and physician offices. Specifically:

- Establish limits on sites that can bill as hospital outpatient departments
- Implement site-neutral payments for select services

5. Demand-Side Incentives

The Commonwealth should encourage payers and employers to enhance strategies that empower consumers to make high-value choices. Specifically:

- Encouraging employees to choose high-value plans, and employers to purchase health insurance through the Health Connector
- Payers improving the design of tiered and limited network plans, and testing new ideas such as PCP tiering
- **NEW** Payers, employers, and employees utilizing new CompareCare website

HPC

Policy Priorities in the 2017 Cost Trends Report

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2017 Cost Trends Report: Draft Recommendations for Discussion

Promoting an efficient, high-quality, health care delivery system

6. NEW Social Determinants of Health

The Commonwealth should emphasize the importance of social determinants of health on health care access, outcomes, and costs. Building off of leadership by EOHHS and MassHealth, specific areas of focus include:

- Flexible funding to address health-related social needs
- Inclusion of social determinants in payment policies and performance measurement
- Continued evaluation of innovative interventions to build the evidence-base

7. NEW Health Care Workforce

The Commonwealth should support advancements in the health care workforce that promote top-of-license practice and new care team models. Specific areas of focus include:

- Scope of practice reform, including removing restrictions that are not evidence-based (e.g., advance practice registered nurses)
- Establishing a new level of dental practitioner for expanded oral health care access (e.g., dental therapist)
- Support for new care team models, particularly to address patient's behavioral health and health-related socials needs (e.g., community health workers, peer support specialists, recovery coaches)
- Engagement of the health care workforce in policy and delivery reform efforts

2017 Cost Trends Report: Draft Recommendations for Discussion

Promoting an efficient, high-quality, health care delivery system

8. NEW Innovation Investments

The Commonwealth should continue to support targeted investments to test, evaluate, and scale innovative care delivery models. Emerging ideas that should be considered for funding include:

- Pharmacologic treatment for substance use disorder in primary care settings
- Telehealth, particularly for clinical services with patient access challenges (e.g., behavioral health, oral health)
- Mobile integrated health, in which community paramedicine and other providers treat patients in their homes and communities

9. Unnecessary Utilization

The Commonwealth should focus on reducing unnecessary utilization and increasing the provision of care in high-value, low-cost settings, consistent with the HPC's improvement targets detailed in the health system performance dashboard. Specifically, policymakers and market participants should seek progress on:

- Avoidable ED utilization (e.g., low-acuity ED visits, BH-related ED visits)
- Avoidable hospital admissions/readmissions
- Community hospital-appropriate inpatient care at AMCs/teaching hospitals
- Institutional post-acute care

2017 Cost Trends Report: Draft Recommendations for Discussion

Promoting an efficient, high-quality, health care delivery system

10. Alignment and Improvement of APMs

The Commonwealth should continue to promote the increased adoption of alternative payment methods (APMs) and improvements in APM effectiveness. Specific areas of focus include:

- Increasing APM coverage in the commercial market, particularly for self-insured and PPO populations
- **NEW** Aligning quality measurement in APMs, based on the work of the EOHHS Quality Alignment Taskforce
- Adopting HPC ACO certification standards
- Incorporating bundled payments
- Reducing disparities in budget levels

HPC Levers to Advance Identified Policy Priorities

RESEARCH
AND FURTHER EXAMINATIONS

CONVENING
KEY STAKEHOLDERS

RECOMMENDING
TARGETED POLICY REFORMS

SUPPORTING
STATE EFFORTS

Board Discussion on Potential Policy Recommendations and Next Steps

1. Reflecting on the findings from the 2017 Cost Trends Report, discussion at the 2017 Cost Trends Hearing, and other work over the past four years, what issues/topics should the HPC prioritize for policy action by the Commonwealth, providers, payers, and others in 2018?

2. What issues/topics should be prioritized for HPC action in 2018?

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: 2017 Cost Trends Report

MOTION: That, pursuant to section 8(g) of chapter 6D of the Massachusetts General Laws, the Commission hereby authorizes the Executive Director to issue the annual report on cost trends as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the January 3, 2018 Meeting
- Market Oversight and Transparency
- **Care Delivery Transformation**
  - Program Updates
    - Investment Programs
    - Certification Programs
- Executive Director's Report
- Schedule of Next Board Meeting (March 13, 2018)
- Executive Session: Performance Improvement Plans

MASSACHUSETTS
HEALTH POLICY COMMISSION

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HEALTH POLICY COMMISSION

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CHART Phase 2: Progress as of January 2018

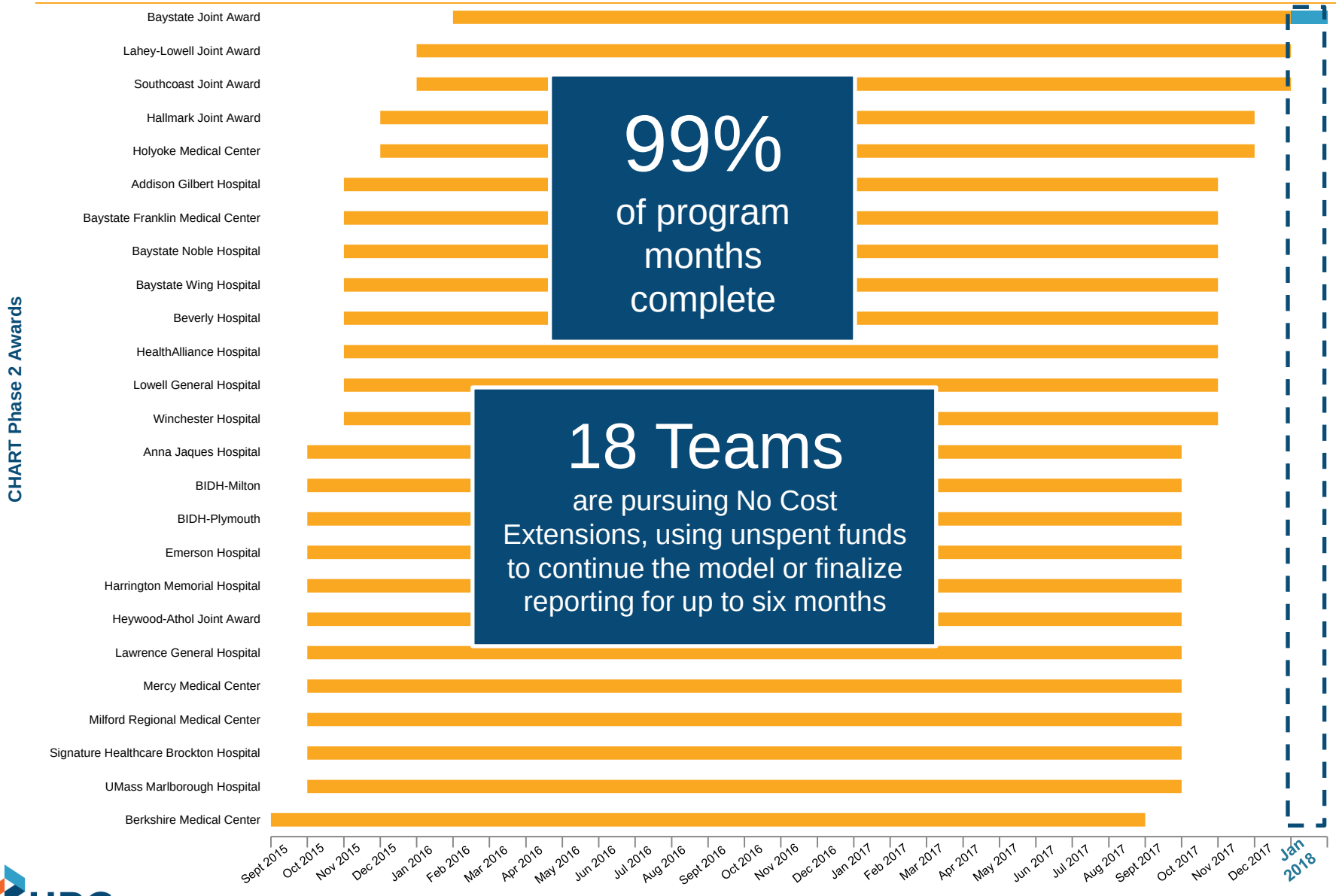


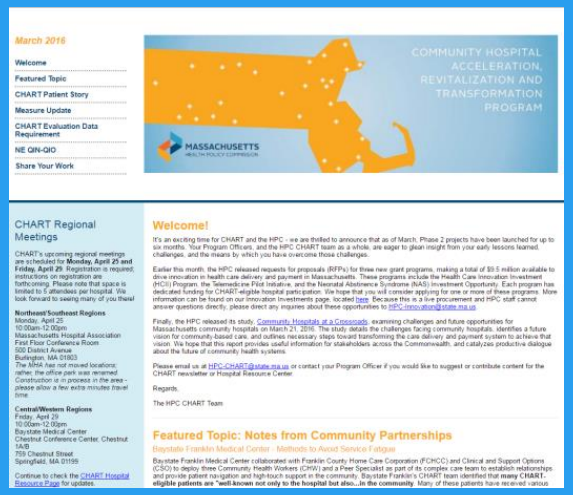
CHART Phase 2: Activities since program launch[1]

15
regional meetings
with
900+
hospital and community provider attendees

290+
technical assistance working meetings

895+
hours of coaching phone calls

25
CHART newsletters


March 2016

Welcome
Featured Topic
CHART Patient Story
Measure Update
CHART Evaluation Data Requirement
NE QIN-QIO
Share Your Work

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION AND TRANSFORMATION PROGRAM
MASSACHUSETTS

CHART Regional Meetings

Welcome!

Featured Topic: Notes from Community Partnerships

3,735 unique visits to the CHART hospital resource page

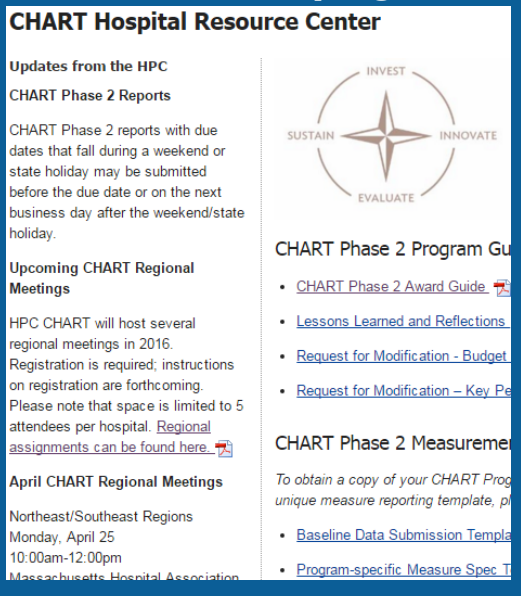


CHART Hospital Resource Center

Updates from the HPC

CHART Phase 2 Reports

CHART Phase 2 reports with due dates that fall during a weekend or state holiday may be submitted before the due date or on the next business day after the weekend/state holiday.

Upcoming CHART Regional Meetings

HPC CHART will host several regional meetings in 2016. Registration is required; instructions on registration are forthcoming. Please note that space is limited to 5 attendees per hospital. Regional assignments can be found here.

April CHART Regional Meetings

Northeast/Southeast Regions
Monday, April 25
10:00am-12:00pm
Massachusetts Hospital Association

INVEST
SUSTAIN
INNOVATE
EVALUATE

CHART Phase 2 Program Gu

- CHART Phase 2 Award Guide
- Lessons Learned and Reflections
- Request for Modification - Budget
- Request for Modification – Key Pe

CHART Phase 2 Measuremer

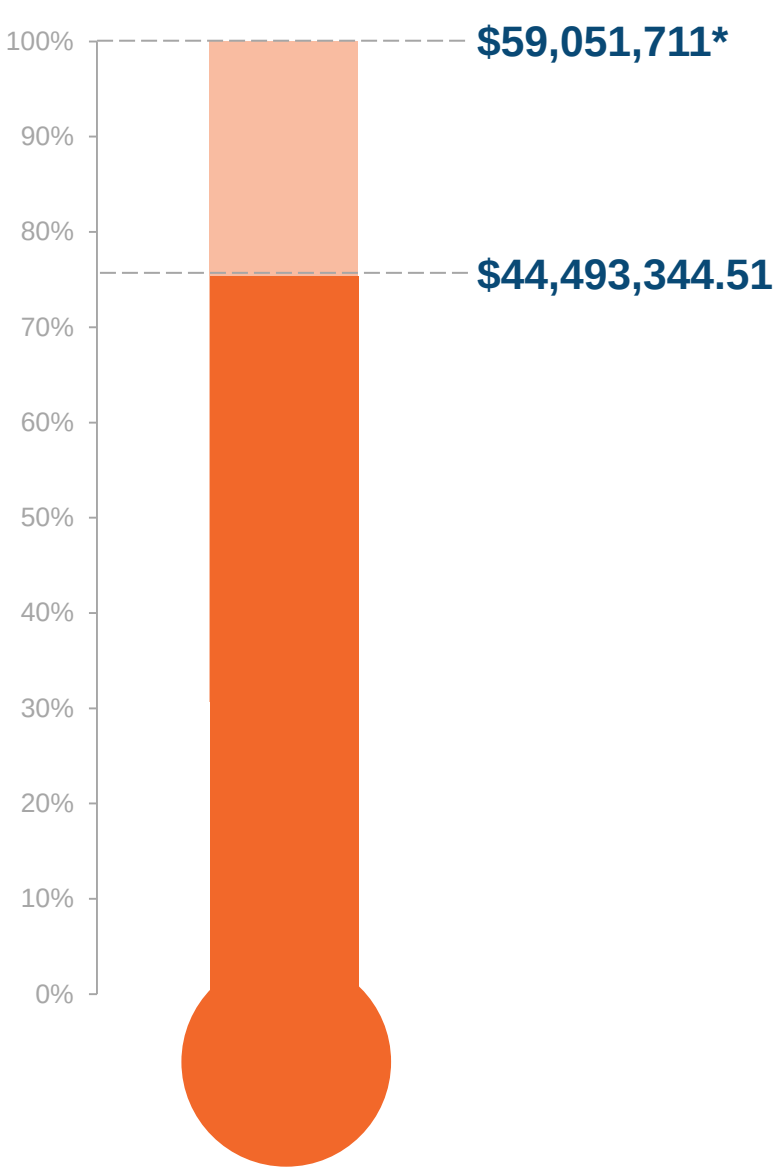
To obtain a copy of your CHART Prog unique measure reporting template, pl

- Baseline Data Submission Templa
- Program-specific Measure Spec T

570+
data reports received

[1] Updated through January 22, 2018. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015.

CHART Phase 2: The HPC has disbursed $44.5M to date



Remaining
$14,558,366.49
is inclusive of
$7,217,898
maximum outcome-based Achievement Payment opportunity

HPC

Updated January 22, 2018

* Not inclusive of Implementation Planning Period contracts. $100,000 per awardee hospital authorized March 11, 2015.

By the Numbers: Health Care Innovation Investment (HCII) Program

>100
organizations
collaborating to deliver care

48
Qualitative Reports
submitted by awardees

102 months
of Key Performance Indicators reported to the HPC; **220 measures** of patient/provider experience, quality, and outcomes

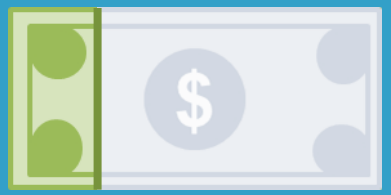
179 working meetings with HPC staff for progress reports, learning, and technical assistance

Awardees span the Commonwealth:
From the Berkshires to Boston

Initiatives deliver lower-cost care by shifting site and scope

5 HCII newsletters

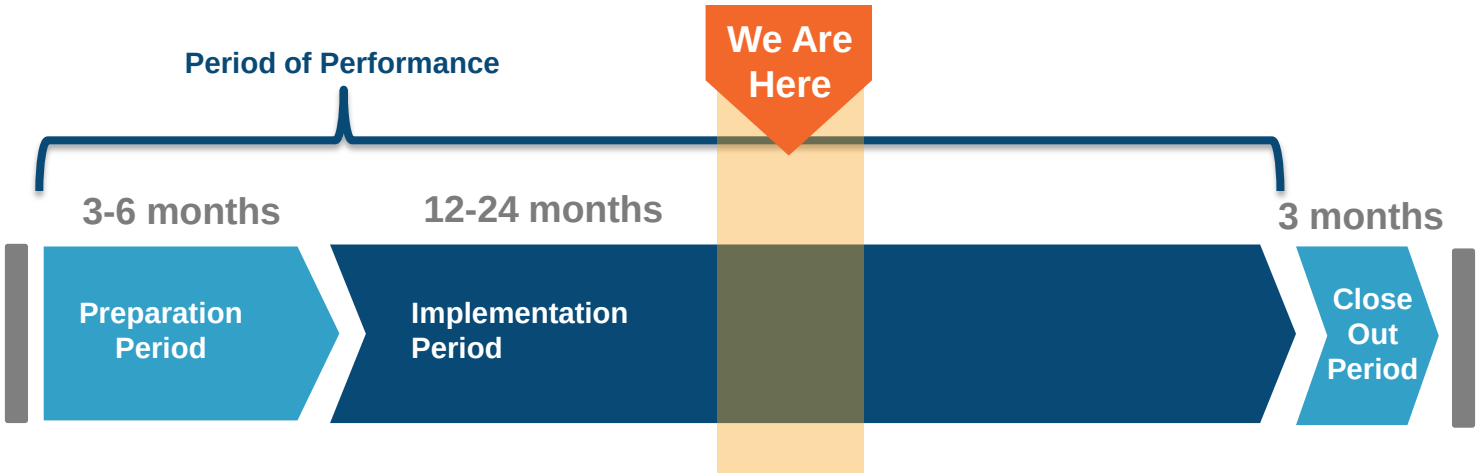
~$2M disbursed to-date



83% of funding remaining

HPC

HCII Program Timeline



Awardees are continuously enrolling patients in their target populations and delivering services, including:

- Assessing students for unmet behavioral health needs
- Engaging opioid-using mothers in evidence-based care for their Substance Exposed Newborn
- Expanding outreach on the streets to engage homeless patients
- Investigating new use cases for tele-psychiatry services
- Training physicians in holding advance care conversations with patients nearing the end of life

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Practices Participating in PCMH PRIME

Since January 1, 2016 program launch:

78 practices
are PCMH PRIME Certified

Recently certified practices include: Pleasant Lake Medical Offices, Duffy Health Center, 2 Greater New Bedford Community Health Center sites, Reading Pediatric Associates, Robert M Fishman, DO, FACP, 5 Western Mass Physician Associates sites, 3 Manet Community Health Center sites, 3 North Shore Community Health sites

36 practices
are on the **Pathway to PCMH PRIME**

114 Total Practices Participating

ACO Certification Criteria Overview

Pre-requisites

4 pre-reqs.
Attestation only

- ✓ Risk-bearing provider organizations (RBPO) certificate, if applicable
- ✓ Any required Material Change Notices (MCNs) filed
- ✓ Anti-trust laws
- ✓ Patient protection

1 Assessment Criteria

6 criteria
Sample documents, narrative descriptions

- ✓ Patient-centered, accountable governance structure
- ✓ Participation in quality-based risk contracts
- ✓ Population health management programs
- ✓ Cross-continuum care: coordination with BH, hospital, specialist, and long-term care services

2 Required Supplemental Information

9 criteria
Narrative or data
Not evaluated by HPC but must respond

- ✓ Supports patient-centered primary care
- ✓ Assesses needs and preferences of ACO patient population
- ✓ Develops community-based health programs
- ✓ Supports patient-centered advanced illness care
- ✓ Performs quality, financial analytics and shares with providers
- ✓ Evaluates and seeks to improve patient experiences of care
- ✓ Distributes shared savings or deficit in a transparent manner
- ✓ Commits to advanced health information technology (HIT) integration and adoption
- ✓ Commits to consumer price transparency

HPC

HPC ACO Certification Awarded to 17 ACOs

Certified ACOs

- Atrius Health, Inc.
- Baycare Health Partners, Inc.
- Beth Israel Deaconess Care Organization
- Boston Accountable Care Organization, Inc.
- Cambridge Health Alliance
- Children's Medical Center Corporation
- Community Care Cooperative, Inc.
- Lahey Health System, Inc.
- The Mercy Hospital, Inc.
- Partners HealthCare System, Inc.
- Reliant Medical Group, Inc.
- Signature Healthcare
- Southcoast Health System, Inc.
- Steward Health Care Network, Inc.
- Wellforce, Inc.

ACOs with Provisional Certification

- Health Collaborative of the Berkshires, LLC
- Merrimack Valley Accountable Care Organization, LLC

HPC

Timeline of Key 2018 Activities for ACO Certification Program

March 2018: Issue first in a series of briefs on ACO Certification data

April – May 2018: Spring check-in calls with ACOs

July 1 – October 1, 2018: Provisional applicants re-apply for full certification

September – November 2018: Site visits with ACO leadership

Late 2018/early 2019: Present updated Certification criteria to the Board for review and approval

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

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What is Potential Gross State Product?

Potential Gross State Product (PGSP)

Long-run average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle

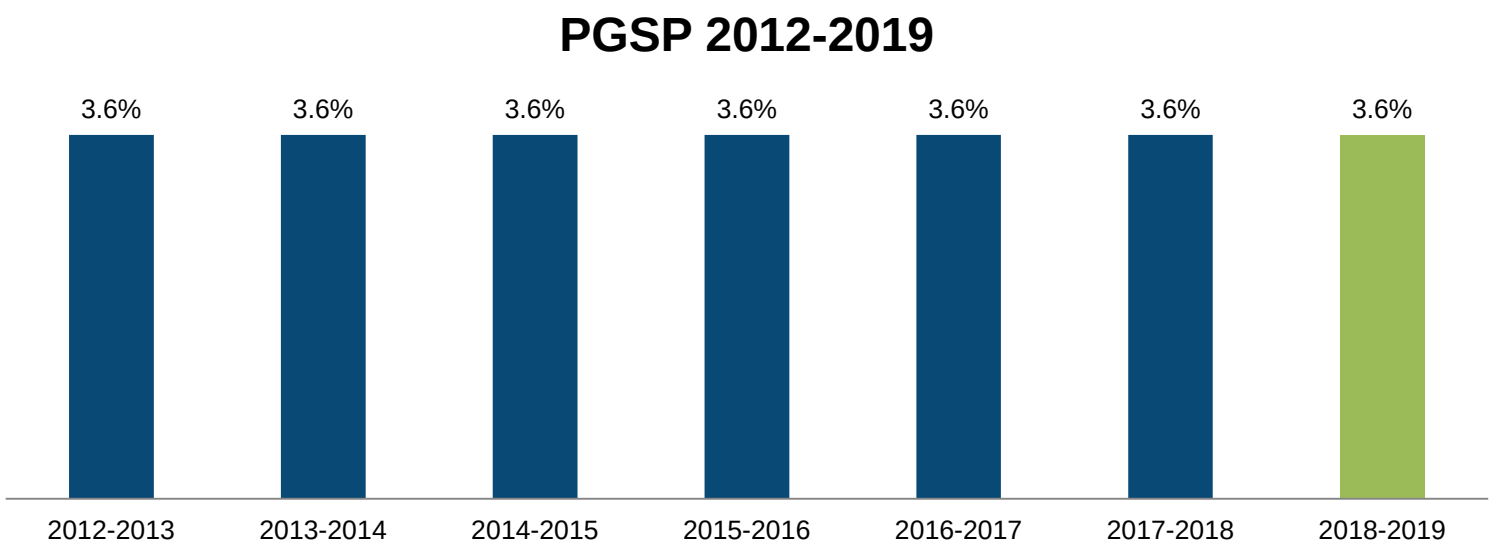
Process

- Section 7H 1/2 of Chapter 29 requires the Secretary of Administration and Finance and the House and Senate Ways and Means Committees to set a benchmark for potential gross state product (PGSP) growth
- The PGSP estimate is established as part of the state's existing consensus tax revenue forecast process and is included in a joint resolution due by January 15 of each year
- The Commonwealth's estimate of PGSP was developed with input from outside economists, in consultation with the Executive Office of Administration and Finance, the House and Senate Ways and Means Committees, the Department of Revenue Office of Tax Policy Analysis, and HPC staff

HPC

PGSP Estimate for 2018-2019

Potential Gross State Product (PGSP)
Percent growth

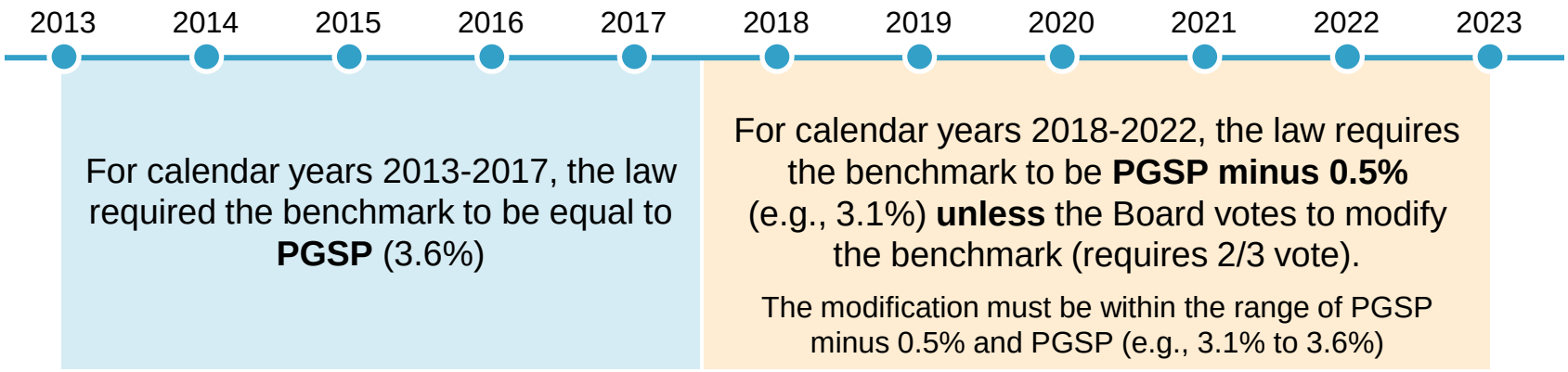


- The 2018-2019 estimate of 3.6% is within a range as discussed by experts
- Estimates were informed by standard methodologies (e.g., Congressional Budget Office) as well as legislative intent to estimate the long-run average growth rate of the Commonwealth's economy

Benchmark Modification Process Overview

- For calendar year (CY) 2019, the law requires the health care cost growth benchmark to be 3.1% (PGSP minus .5%), unless modified by the HPC Board.

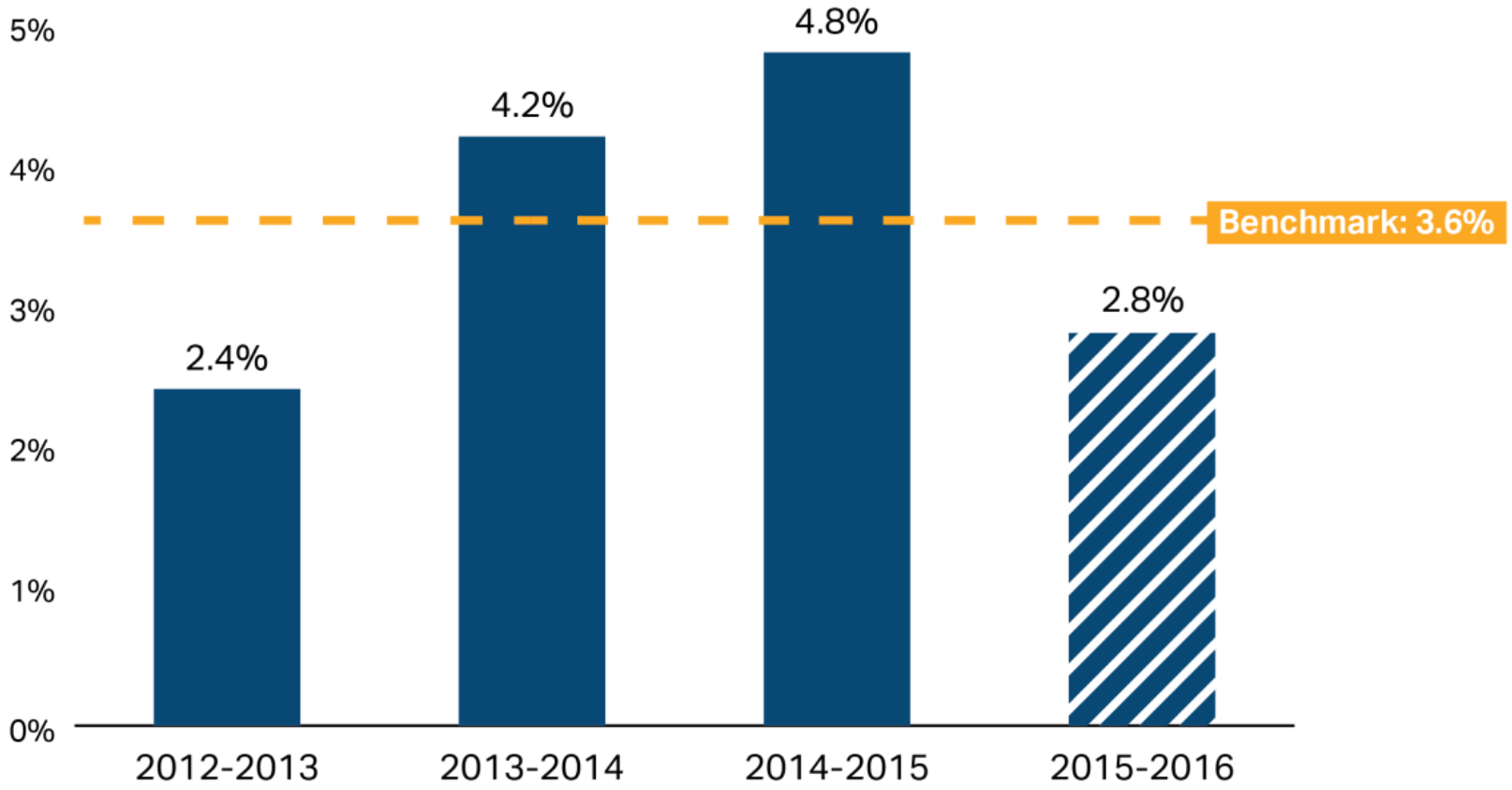
- The HPC Board sets the health care cost growth benchmark for the following calendar year annually between January (when the PGSP is established in the consensus revenue process) and April. For 2018-2019, PGSP is 3.6%.



- The HPC Board may **modify the statutory annual health care cost growth benchmark (for CY 2019)**, pursuant to a public hearing process and engagement with the Legislature.

- The law requires an extensive notice and hearing process prior to modification and gives the Legislature an opportunity to take legislative action to change the benchmark and "override" any Board action to modify the benchmark.

Performance Against the Benchmark to Date



2013-2016
Average Growth Rate: 3.55%

HPC

Public Hearing and Comment Period

Public Meeting Notice

Tuesday, March 13
12:00 PM
50 Milk Street, 8th Floor

The hearing will include testimony, information, and data on whether modification of the benchmark is appropriate.

Written testimony will also be accepted until March 30.

HPC

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HEALTH POLICY COMMISSION

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- Executive Session: Performance Improvement Plans

Meetings and Contact Information

Board Meetings

Wednesday, January 31, 2018
Tuesday, March 13, 2018
Wednesday, April 25, 2018
Wednesday, July 18, 2018
Wednesday, September 12, 2018
Thursday, December 13, 2018

Committee Meetings

Wednesday, February 14, 2018
Wednesday, June 13, 2018
Wednesday, October 3, 2018
Wednesday, November 28, 2018

Contact Us

Mass.Gov/HPC

@Mass_HPC

HPC-Info@state.ma.us

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Executive Session

MOTION: That, having first convened in open session at its January 31, 2018 board meeting and pursuant to G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with G.L. c. 6D, § 10 and its associated regulation, 958 CMR 10.00, G.L. c. 6D, § 2A, and G.L. c. 12C, § 18, in discussions about whether to require performance improvement plans by entities confidentially identified to the Commission by the Center for Health Information and Analysis.