MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

June 2, 2021

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes from February 10, 2021 **(VOTE)**
- Registration of Provider Organizations (RPO)
- 2020 Health Care Cost Trends Report: Chartpack Highlights
- Schedule of Next Meeting (October 6, 2021)

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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **February 10, 2021** as presented.

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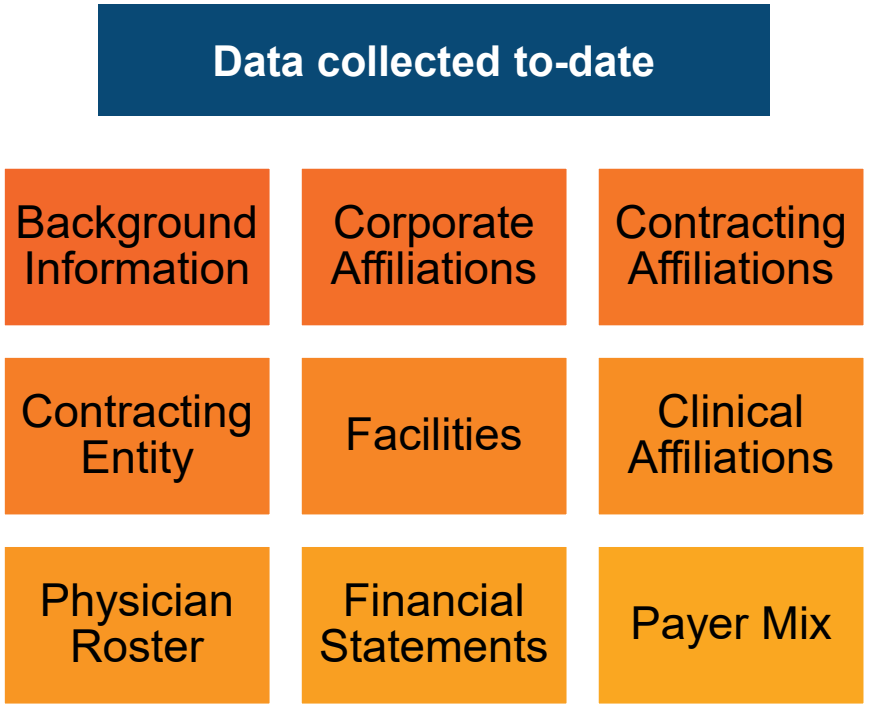
Overview of the MA-RPO Program

- The MA-RPO Program is a **first-in-the-nation** initiative for collecting public, standardized information on Massachusetts' largest health care providers annually.
- The data contribute to a foundation of information needed to support **health care system transparency and improvement.**
- This regularly reported information on the health care delivery system supports many functions including: care delivery innovation, evaluation of market changes, health resource planning, and tracking and analyzing system-wide and provider-specific trends.



HPC

Value to Users

RESEARCHERS
Ariadne Labs
BU, Harvard, UC Berkeley
NBER
RAND
MARKET PARTICIPANTS
Providers
Payers
Trade Organizations
Unions
GOVERNMENT
HPC
EOHHS
CHIA
AGO
US Dept. of Labor
Federal Trade Commission

The MA-RPO program makes data about the structure of the Massachusetts provider market available in a standardized, accessible format.

- The HPC uses MA-RPO data as a major input into several ongoing workstreams:
  - **Provider Organization Performance Variation**
  - **Cost and Market Impact Reviews**
  - **Performance Improvement Plan assessments**
- Teams across the agency regularly use the data to answer specific questions

Available Data from 2015-2019 Filings

Master File and Individual Provider Organization Files

- A single Excel file for each Provider Organization and a master Excel file that combines data for all Provider Organizations.
- Includes relevant file attachments (e.g., organizational charts).

Physician Roster

- Includes each physician participating in at least one contract negotiated by a registering Provider Organization as of Jan. 1 of the filing year.
- Contains physician name, NPI, license number, specialty, practice sites and medical groups.

Provider Contracting Relationships and Contract Types

- Identifies corporate entities within a Provider Organization that negotiate payer contracts, corporate and contracting affiliates that participate in the contracts, the payers (e.g., BCBS, Medicare) with which that entity contracts, and the types of contracts (e.g., FFS, global budget) negotiated.

Other Resources

- Data release notes on each filing are provided to assist users in interpreting and using the MA-RPO dataset.

2020 Filing

- Recognizing the unprecedented challenges to the health care system from the COVID-19 pandemic, the MA-RPO program did not require Provider Organizations to submit a 2020 filing.
- The **only 2020 filing requirement** for the MA-RPO program is an **updated physician roster**.
  - The 2020 Physician Roster file template is **available on the program website**.
- Provider Organizations may submit their 2020 Physician Roster either as a file attachment in the online submission platform as part of their 2021 filing or via email to HPC-RPO@mass.gov any time prior to the 2021 filing.

2021 Filing Updates: Process

- The Data Submission Manual (DSM), containing the data elements and filing requirements for the 2021 MA-RPO filing, will be posted on the program website in the coming weeks.
- The MA-RPO program anticipates that the online submission platform, the site Provider Organizations use to submit their filings, will be open in early July and prepopulated with data from the 2019 filing.
- Provider organizations will be notified via email when the DSM has been posted and the online submission platform is open.
- The 2021 MA-RPO filing will be due on **September 30, 2021**.
- Program staff are preparing pre-filing checklists for each organization. Pre-filing checklists provide guidance on how to complete the 2021 filing based on an organization's previous filing.
- Program staff are available for one-on-one meetings to discuss any questions on how the filing requirements apply to specific organizations.

2021 Filing Updates: Content

The MA-RPO program made two substantive updates for the 2021 filing:

Financial Statements

In order to better understand how federal and state COVID-19 relief funds impacted the financial situations of Provider Organizations and physician practices, and to align with comparable updates made by CHIA to their financial reporting requirements, the MA-RPO Program has:

- Added two new data elements to the Financial Statements file: RPO-175A: Other Operating Revenue: Federal COVID-19 Relief Funds, and RPO-175B: Other Operating Revenue: State & Other COVID-19 Relief Funds
- Added a new schedule to the Financial Statements file to collect more detailed information on federal and state COVID-19 relief funds received.

As a reminder, Provider Organizations that have submitted annual standardized financial statements for the most recent fiscal year to CHIA are not required to submit the information separately to the MA-RPO Program if those financial statements are available from CHIA.

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2021 Annual Cost Trends Report – Outline and Public Presentation Dates

- **Chapter #1: Massachusetts Spending Performance** (Key findings presented at the Annual Hearing on the Potential Modification of the Health Care Cost Growth Benchmark held 3/25/21)

- **Chapter #2: Patterns in Health Care Spending, Access and Affordability by Income** (Key findings presented at the HPC Board meeting on 5/19/21)

- **Five Chartpacks** (Key findings today, 6/2/21)
  - Hospital Utilization and Post-Acute Care
  - Post-Acute Care
  - Alternative Payment Methods
  - Provider Organization Performance Variation
  - Price Trends and Variation **(new!)**

- **Performance Dashboard** (Preview today, 6/2/21)

- **Recommendations** (To be discussed at the HPC Board meeting on 7/24/21)

Commonwealth of Massachusetts Office of the Attorney General Examination of Health Care Cost Trends and Cost Drivers, Oct 13, 2016
Arlene Ash., et al. "Social determinants of health in managed care payment formulas." JAMA internal medicine 177.10 (2017): 1424-1430
Sherman, Bruce W., et al. "Health care use and spending patterns vary by wage level in employer-sponsored plans." Health Affairs 36.2 (2017): 250-257.

HPC Chartpacks

BACKGROUND

- Data is generally through either 2019 (CHIA inpatient and ED discharge data) or 2018 (All-Payer Claims Database)
  - APCD data includes HPHC, Tufts, BCBSMA, Anthem and NHP (AllWays).
  - Some 2020 discharge data has been presented earlier as part of the preliminary COVID-19 study
- For next year's Cost Trends Report, we expect to have 2020 discharge **and** APCD

Commonwealth of Massachusetts Office of the Attorney General Examination of Health Care Cost Trends and Cost Drivers, Oct 13, 2016
Arlene Ash., et al. "Social determinants of health in managed care payment formulas." JAMA internal medicine 177.10 (2017): 1424-1430
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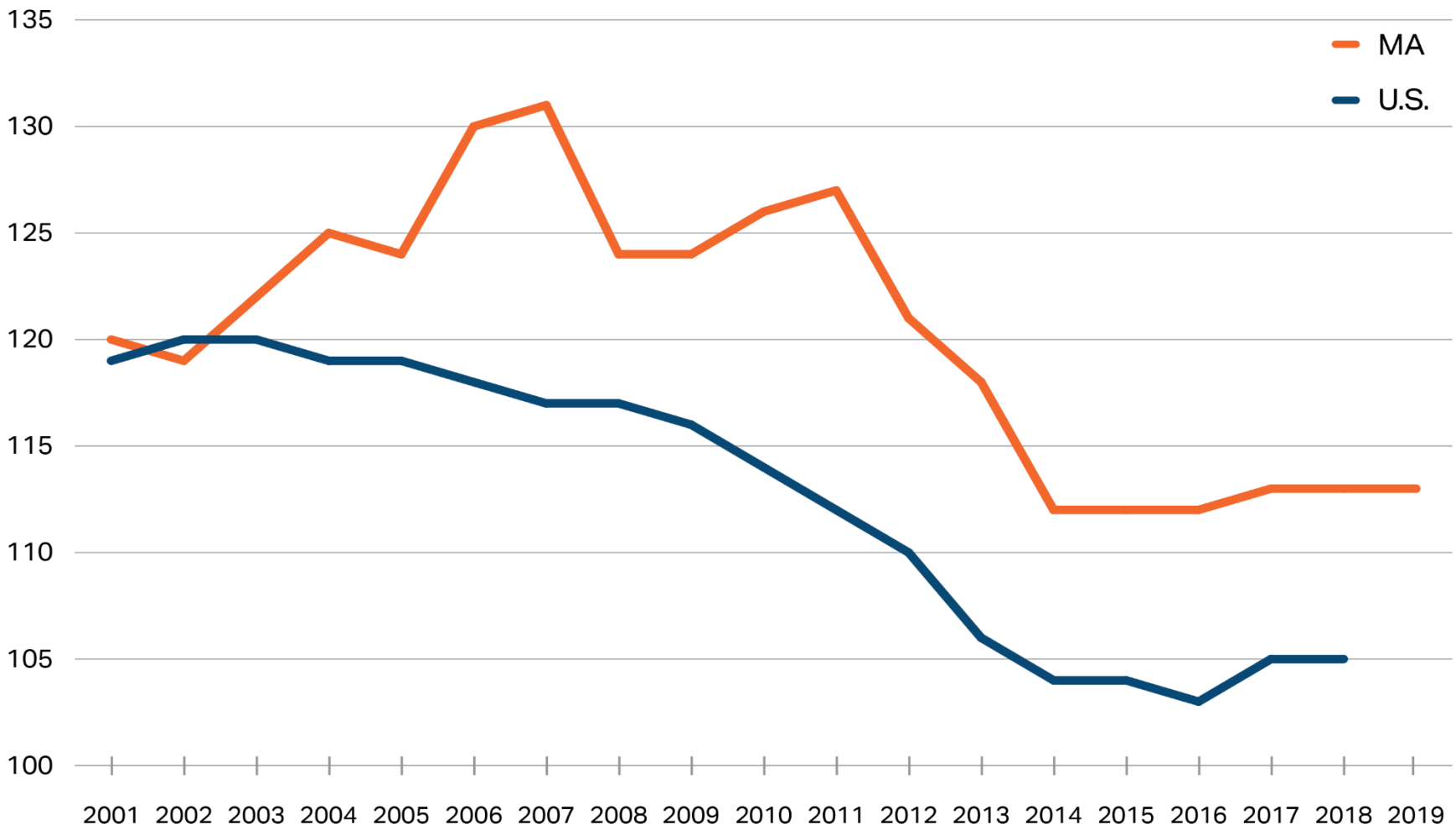
Per-capita hospitalizations in Massachusetts remained around 8% above the U.S. average in 2018.

Inpatient hospital discharges per 1,000 residents in Massachusetts and the U.S., 2001-2019

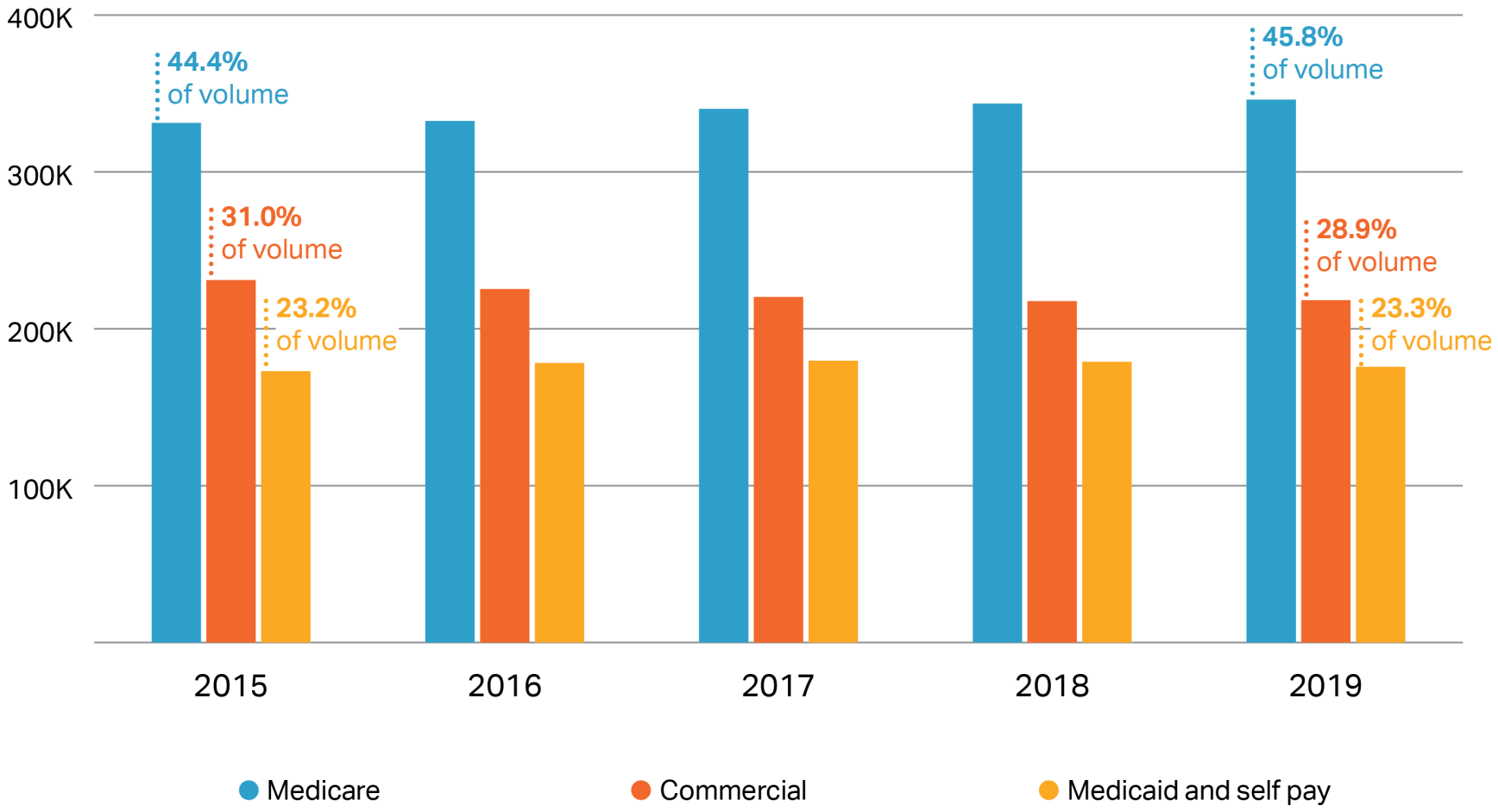


Notes: U.S. data include Massachusetts. Massachusetts' 2019 data is based on HPC's analysis of Center for Health Information and Analysis discharge data.

Sources: Kaiser Family Foundation analysis of American Hospital Association data (U.S., 2001-2018), HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2019)

29% of inpatient hospital stays were paid by commercial insurance in 2019.

Total inpatient hospital discharges by payer, 2015-2019



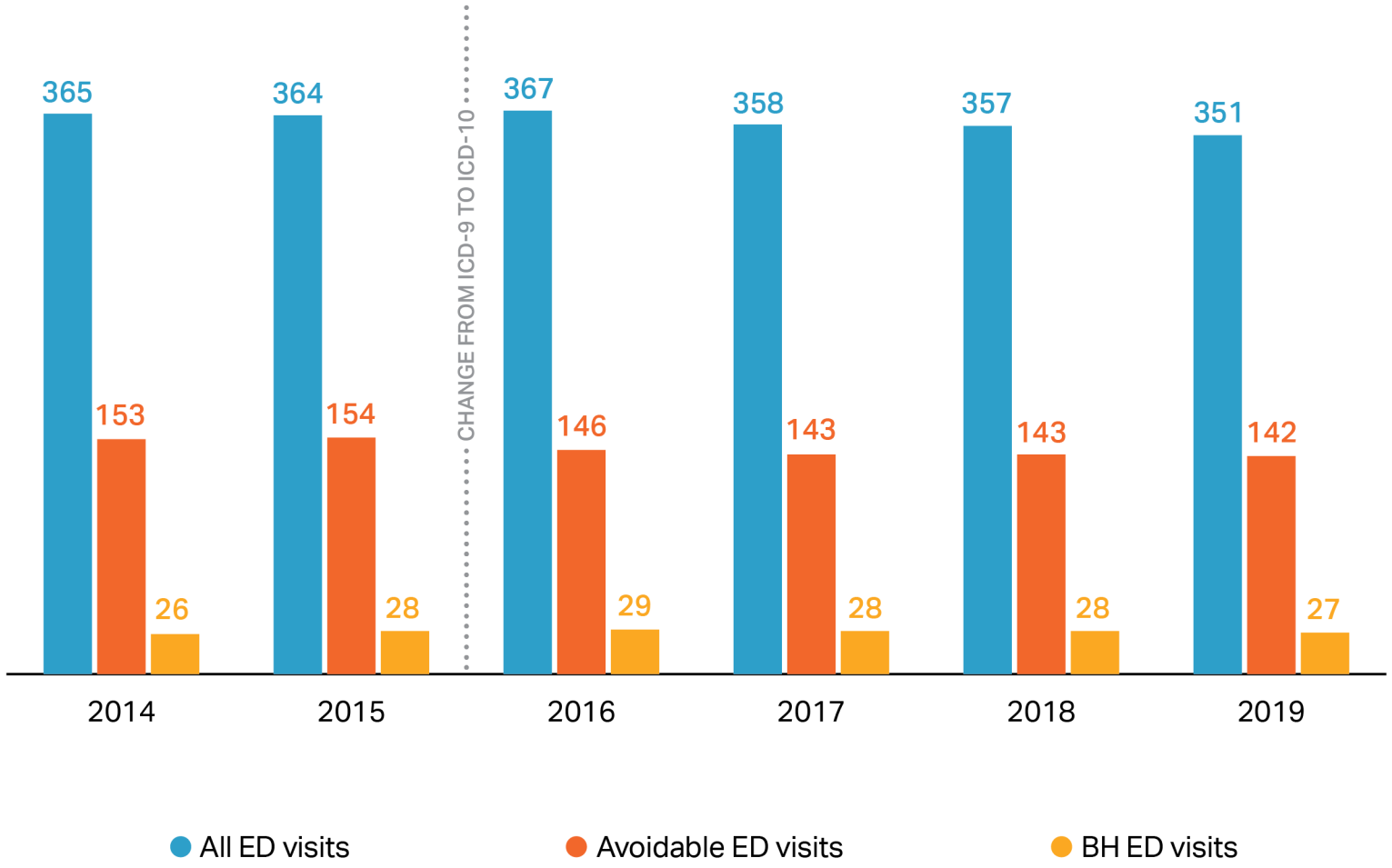
Notes: Out of state residents (~5% of discharges) are excluded from this analysis. Medicaid and self pay category includes free care, health safety net, and CommonwealthCare/ConnectorCare plans. All other payers (including other government) are not illustrated, but accounted for in percentage calculations. The number of inpatient hospital discharges coded with self pay as the primary payer has increased nearly three-fold between 2015 and 2019, from 0.6% to 2.2%. Based on provider input, the HPC and CHIA believe that many Medicaid discharges were incorrectly coded as self pay. To address this inconsistency, the HPC grouped self pay with Medicaid for this analysis.

Sources: HPC analysis of Center for Health Information and Analysis Inpatient Discharge Database, 2015-2019

HPC

Emergency department (ED) visits continued to decline slightly in 2019.

All ED visits, potentially avoidable ED visits, and behavioral health ED visits per 1,000 residents, 2014-2019



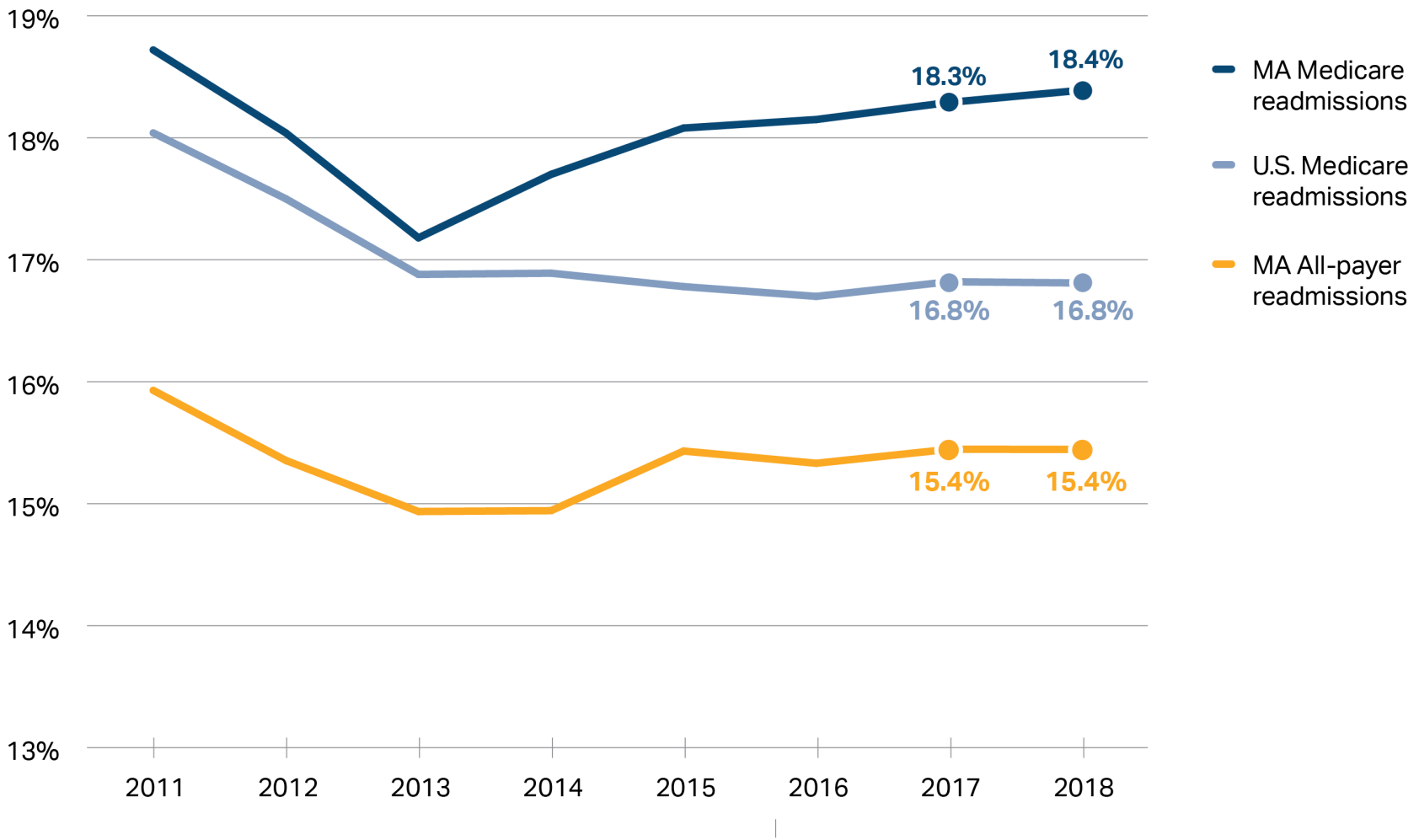
'Notes: Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into the following categories: Emergent - ED care needed and not avoidable; Emergent - ED care needed but avoidable; Emergent - primary care treatable; and Non-emergent - primary care treatable. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent - primary care treatable. Behavioral health ED visits were identified based on a principal diagnosis related to mental health and/or substance use disorder using the Clinical Classifications Software (CCS) diagnostic classifications. To improve classification rate, diagnosis codes unclassified by the Billings algorithm were truncated and shortened codes were re-classified. Please see the technical appendix for additional details.

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2014 - 2019

HPC

Thirty-day readmission rates increased slightly in Massachusetts while holding steady in the rest of the U.S.

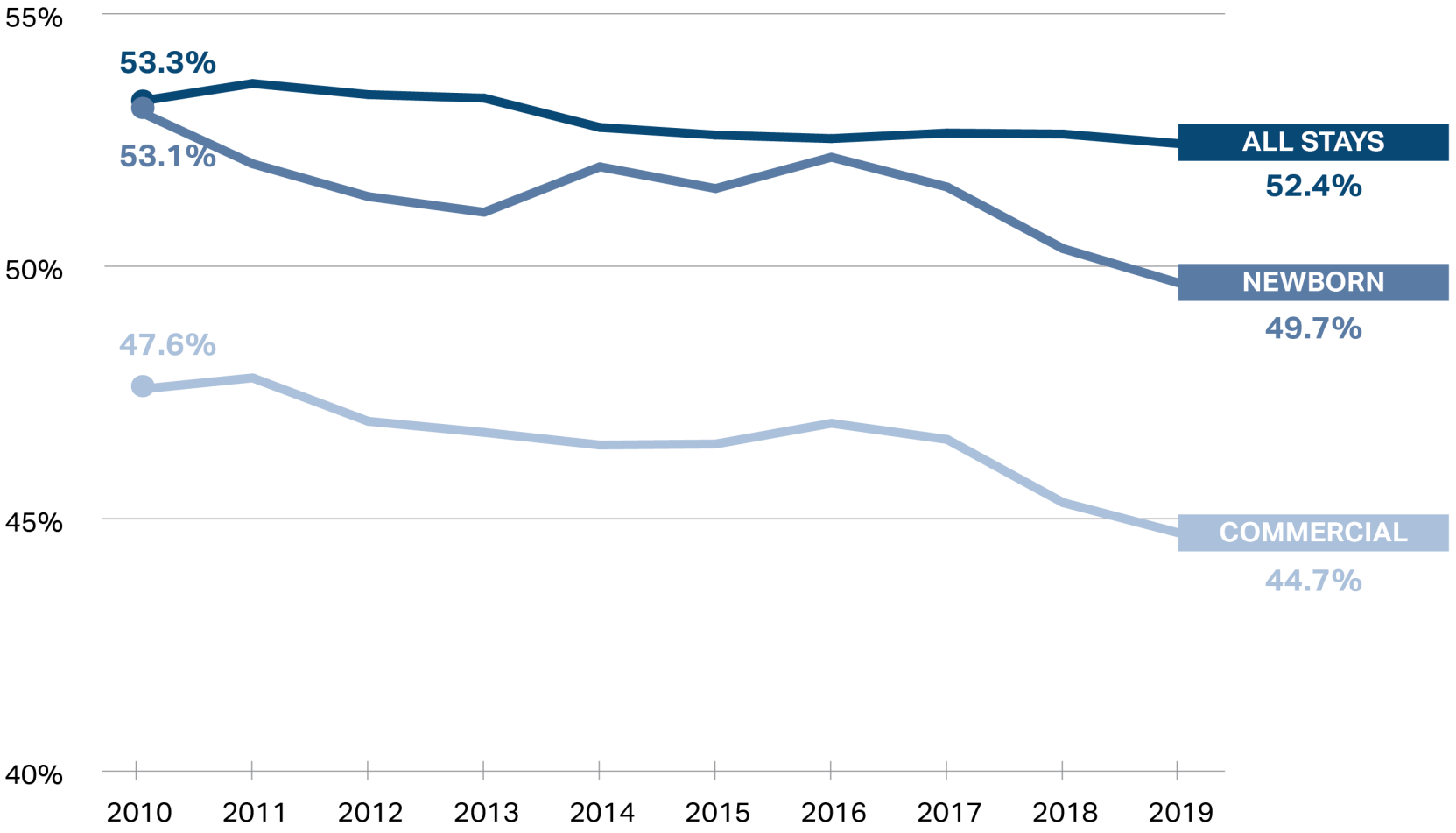
Thirty-day readmission rates, Massachusetts and the U.S., 2011-2018



Sources: Centers for Medicare and Medicaid Services (U.S. and MA Medicare), 2011-2018; Center for Health Information and Analysis (all-payer MA), 2011-2018

The proportion of newborn and commercial stays taking place in community hospitals continued to decline in 2019.

Percentage of inpatient stays occurring in community hospitals, by discharge type, 2010-2019

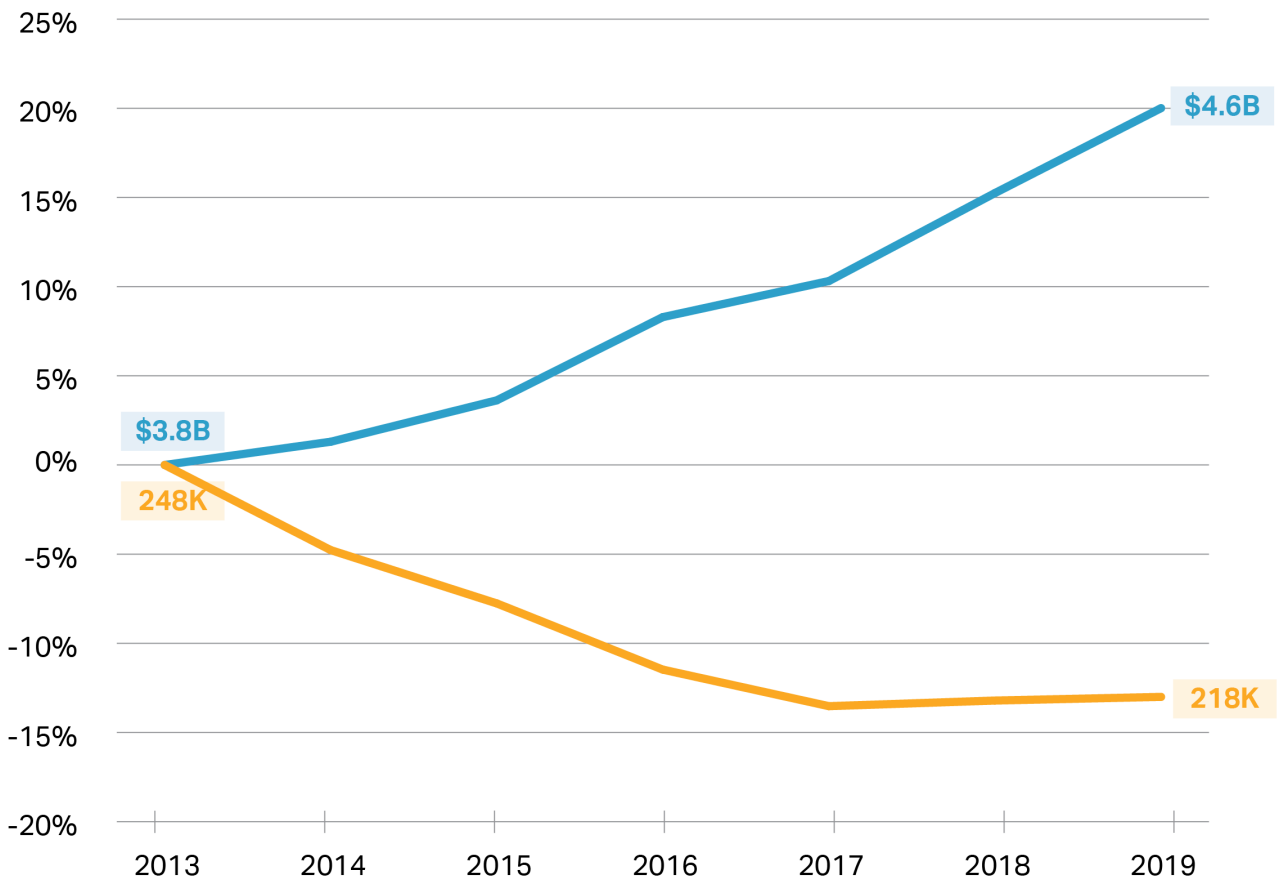


Notes: The Center for Health Information and Analysis defines community hospitals as general acute care hospitals that do not support large teaching and research programs.

Sources: HPC analysis of Center for Health Information and Analysis Hospitals Inpatient Discharge Database, 2010-2019

Commercial inpatient spending on hospital stays grew 20% even as volume declined 13% from 2013 to 2019.

Cumulative change in commercial inpatient hospital volume and spending per-enrollee (percentages) and absolute, 2013 – 2019



Spending per commercial discharge grew **38%** (5.5% annually), from **$15,100 to $20,900,** from 2013 to 2019

5.5% growth in price per discharge has been divided roughly evenly between **price increases** and **acuity increases**

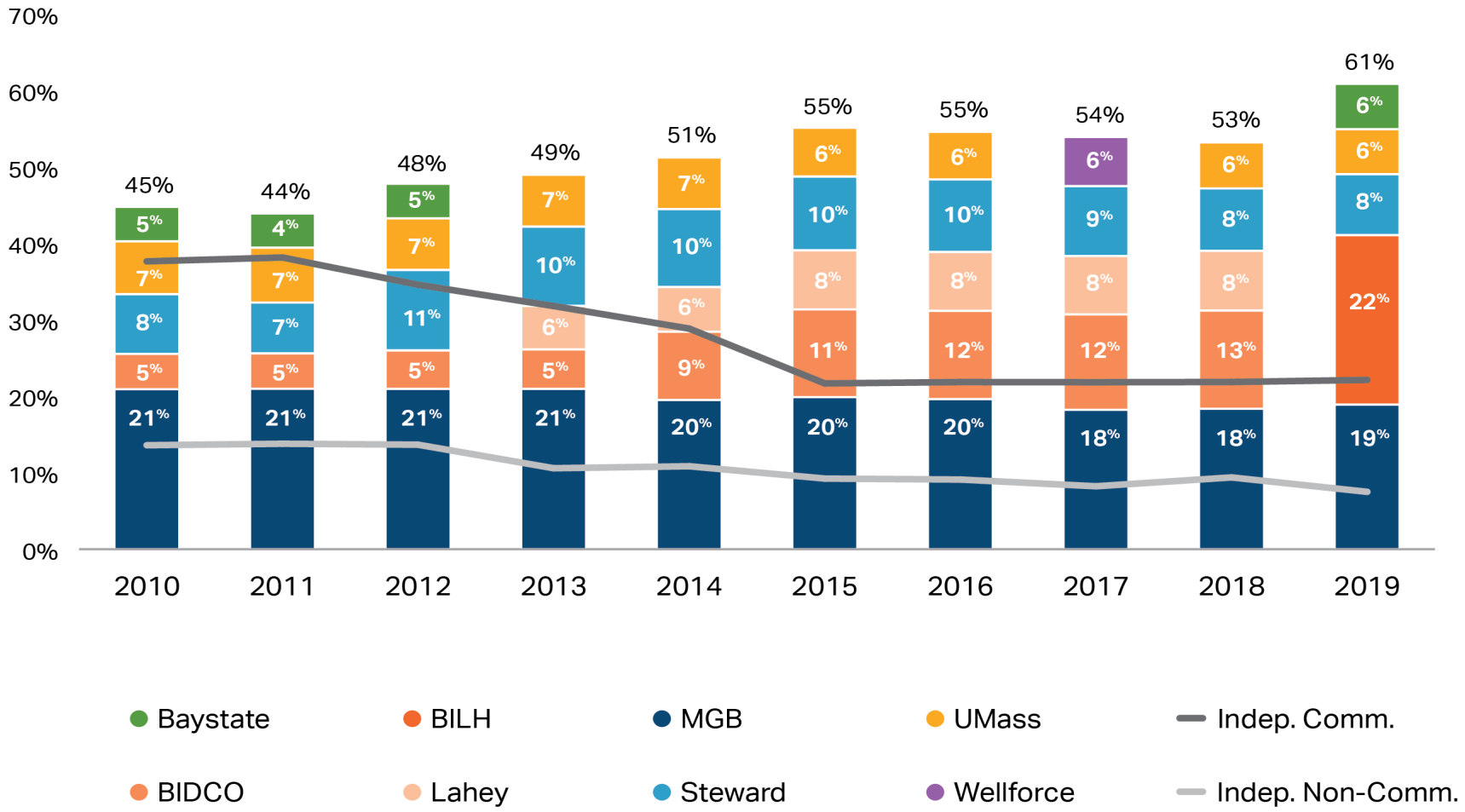
Notes: Data points indicate % growth from previous year (2013=0). Volume data correspond to fiscal years while spending data are calendar years.

Sources: CHIA Hospital Inpatient Discharge Data, 2013-2018. Commercial full-claims TME from CHIA Annual Report TME Databooks. 2019 Annual report (for 2017-8 growth and 2016-7 growth), 2018 Annual Report (for 2015-6), 2017 annual report (for 2014-2015) and 2016 Annual Report (for 2013-4 growth).

HPC

In 2019, the proportion of statewide hospital care (inpatient and outpatient) occurring in the five largest hospital systems exceeded 60%.

Share of inpatient and outpatient care in the five largest hospital systems and independent hospitals, 2010 – 2019

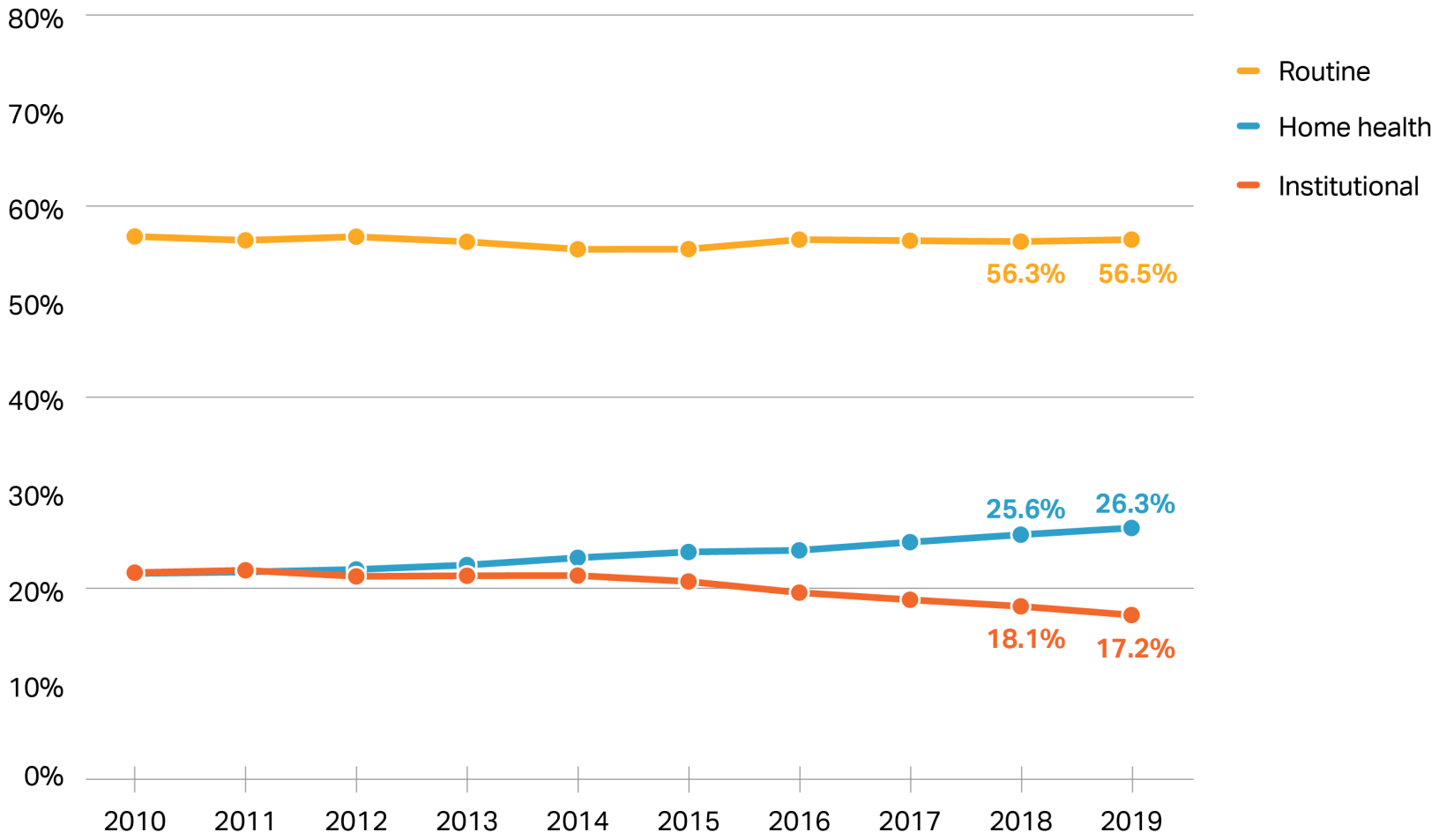


Notes: Partners HealthCare changed its name to Mass General Brigham (MGB) in 2019. Inpatient care is measured in hospital discharges for general acute care services. Hospital outpatient care is measured in outpatient discharge equivalents, the quantity of outpatient services expressed in inpatient stay equivalents. See technical appendix for details.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Cost Reports, 2010-2019

Hospital discharges to institutional post-acute settings continued to decline in favor of discharges to home health care.

Use of post-acute care in Massachusetts following hospital discharge, all DRGs, 2010 - 2019



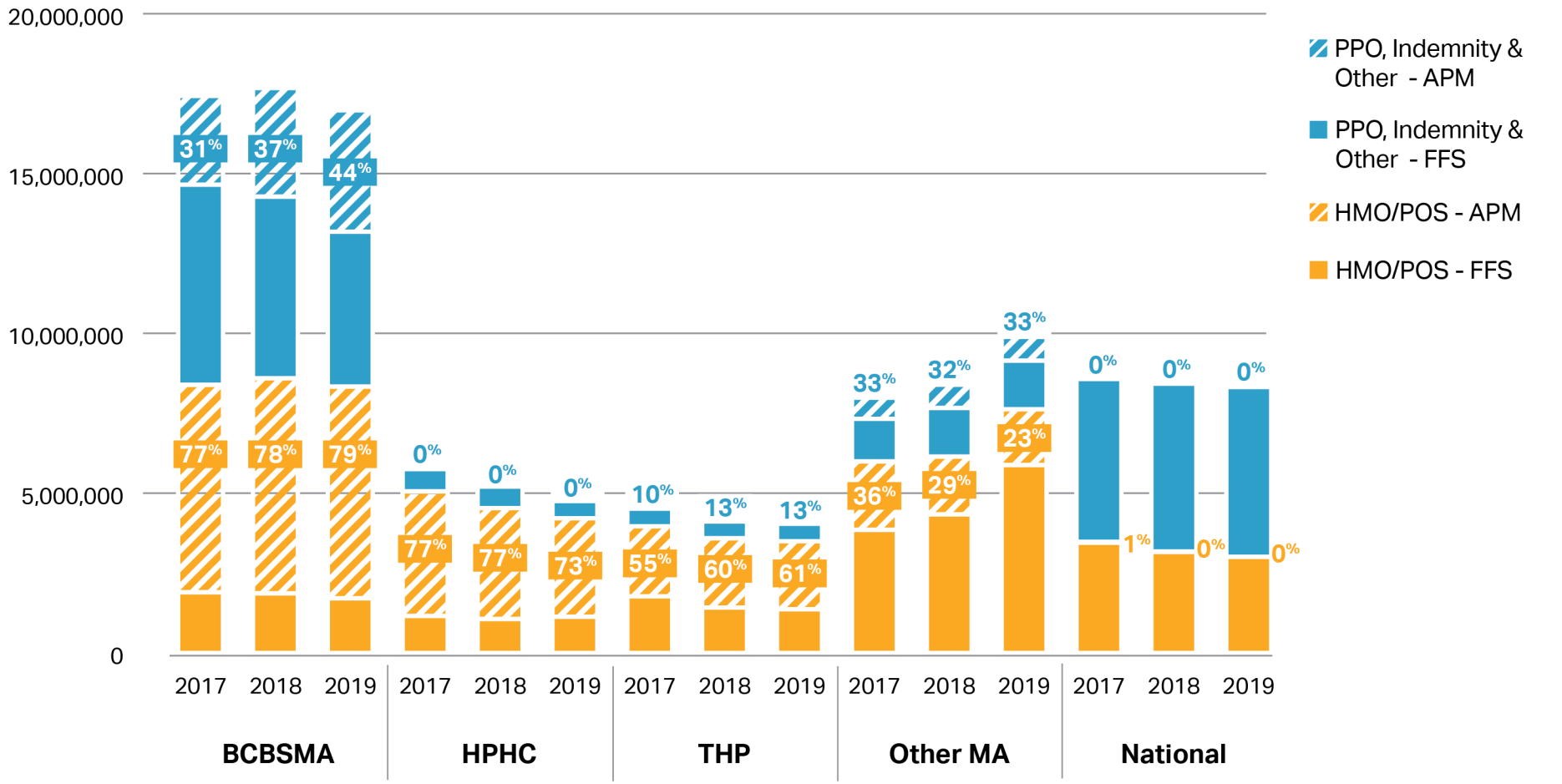
Notes: Out of state residents and those under 18 are excluded. Institutional post-acute care settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Rates adjusted using ordinary least squares (OLS) regression to control for age, sex, and changes in the mix of diagnosis-related groups (DRGs) over time. Discharges from hospitals that closed and specialty hospitals, except New England Baptist, were excluded. Several hospitals (UMass Memorial Medical Center, Clinton Hospital, Cape Cod Hospital, Falmouth Hospital, Marlborough Hospital) were excluded due to coding irregularities in the database. Routine = discharge to home with no formal post-acute care.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2010-2019

HPC

Commercially-insured member-months under alternative payment models in Massachusetts were flat or dropped from 2017-2019.

Commercially-insured member-months under APMs in Massachusetts (Massachusetts-based and national insurers), 2017-2019



Notes: The three largest insurers in Massachusetts include Blue Cross Blue Shield of MA (BCBSMA), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP), including Tufts HMO. Other MA payers include AllWays, BMC HealthNet Plan, Fallon Community Health Plan, Health New England, Health Plans Inc., Tufts Health Public Plans, and Unicare (Anthem). National payers include Cigna and United. *Aetna was excluded due to data irregularities.

Sources: HPC analysis of Center for Health Information and Analysis Annual Report APM data set, 2020. Analysis includes full and partial claims for commercial.

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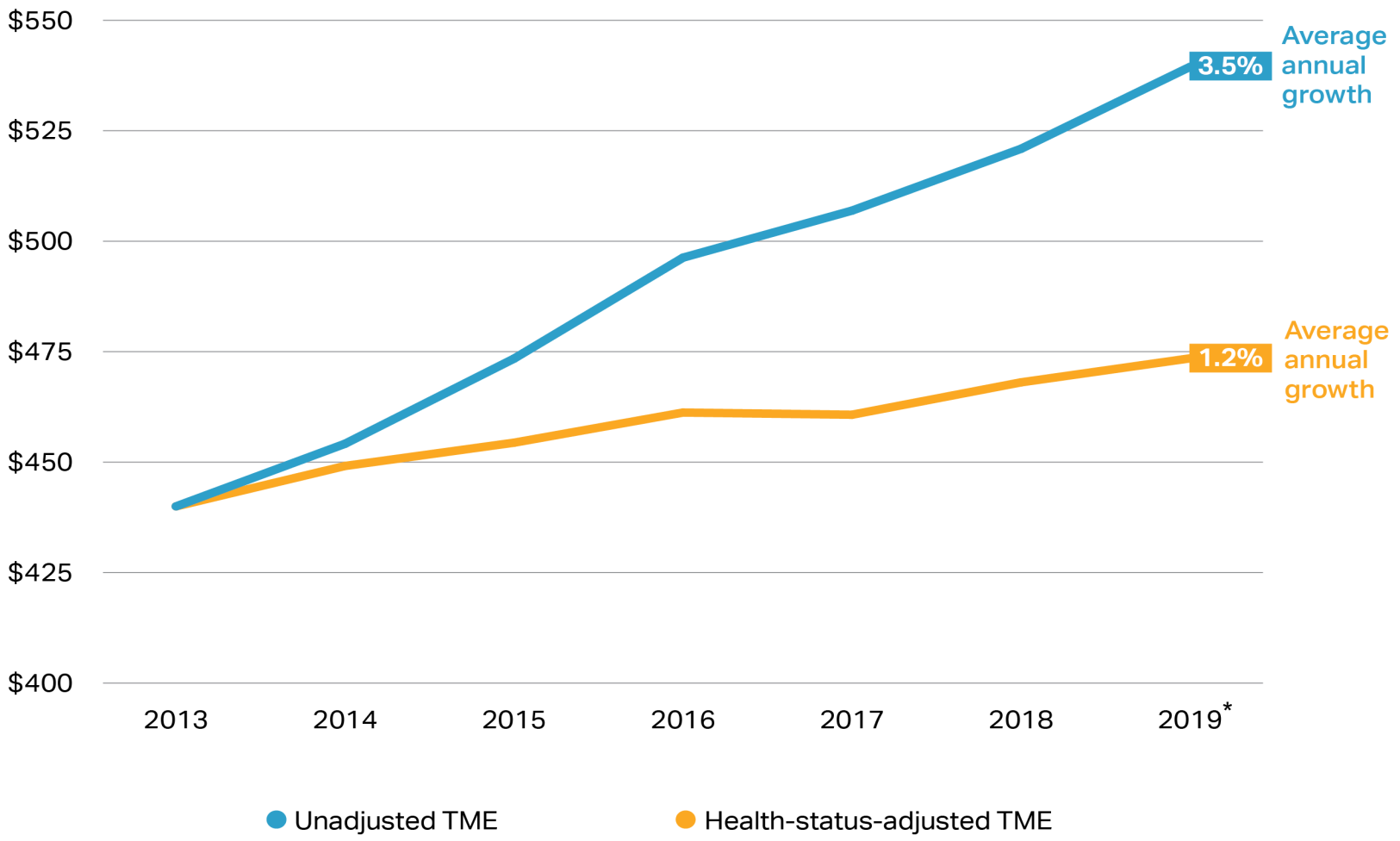
Unadjusted total medical expenditures (TME) grew 3.5% per year from 2013 to 2019, triple the growth of health-status adjusted TME (1.2%).

Growth in unadjusted TME and health-status adjusted TME from 2013, cumulative; 2013 risk scores = 1.0



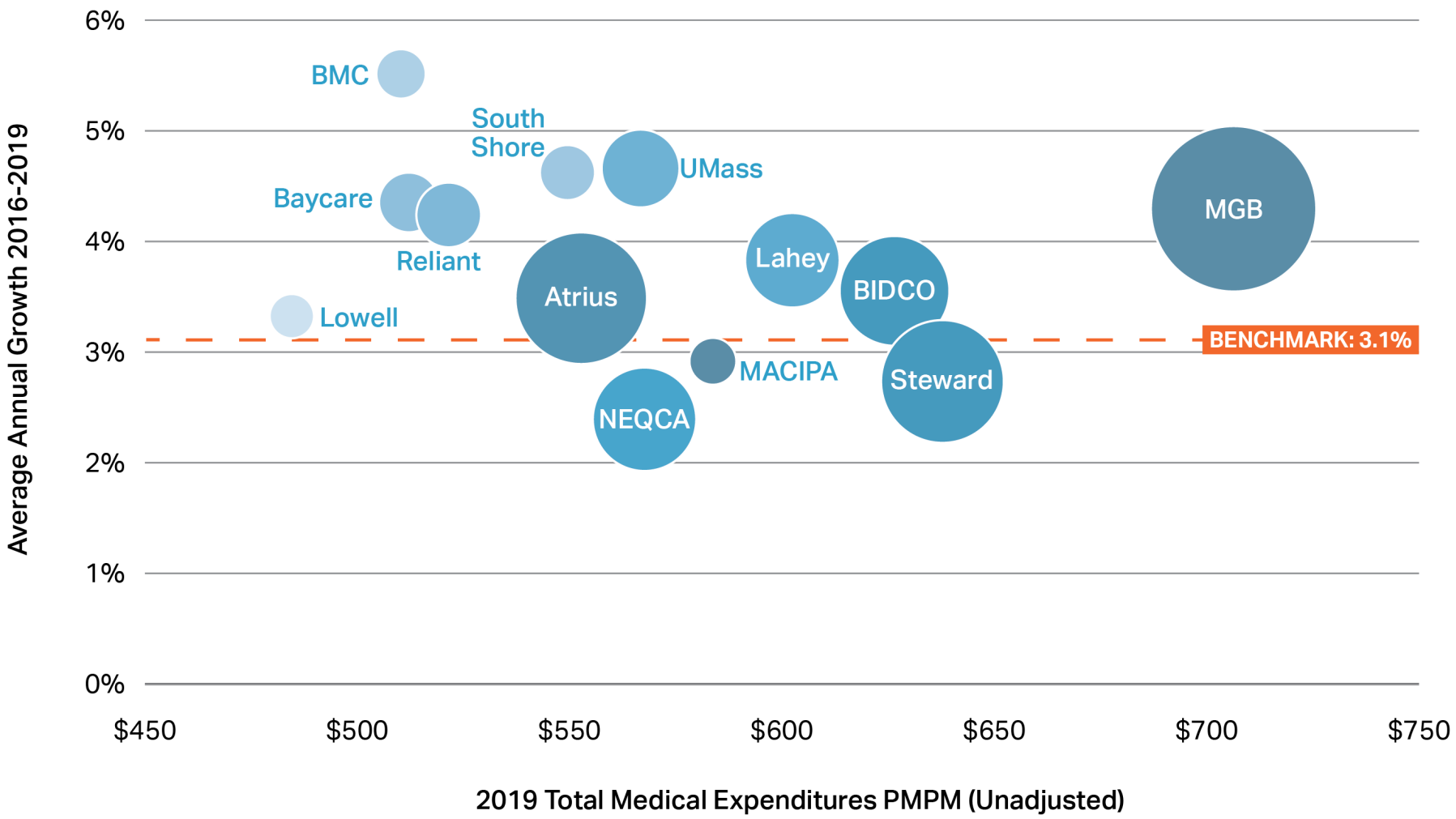
Data are compiled from successive CHIA annual reports as follows: 2020 annual report (2017-9); 2019 annual report (2016-7 growth); 2018 annual report (2015-6 growth); 2017 annual report (2014-5 growth); 2016 annual report (2013-4 growth). Data represent commercial full claims only and the following payers: Aetna, BCBS, THP, HPHC, HNE, Fallon. Other payers' data had anomalies in at least some years.

*2019 data is preliminary.

HPC

Most provider groups had unadjusted TME growth over the benchmark from 2016-2019. During this time period, MGB had high average annual unadjusted TME growth and had the highest TME level in 2019.

Provider group unadjusted TME per member per month in 2019 and 2016-2019 average annual growth in unadjusted TME

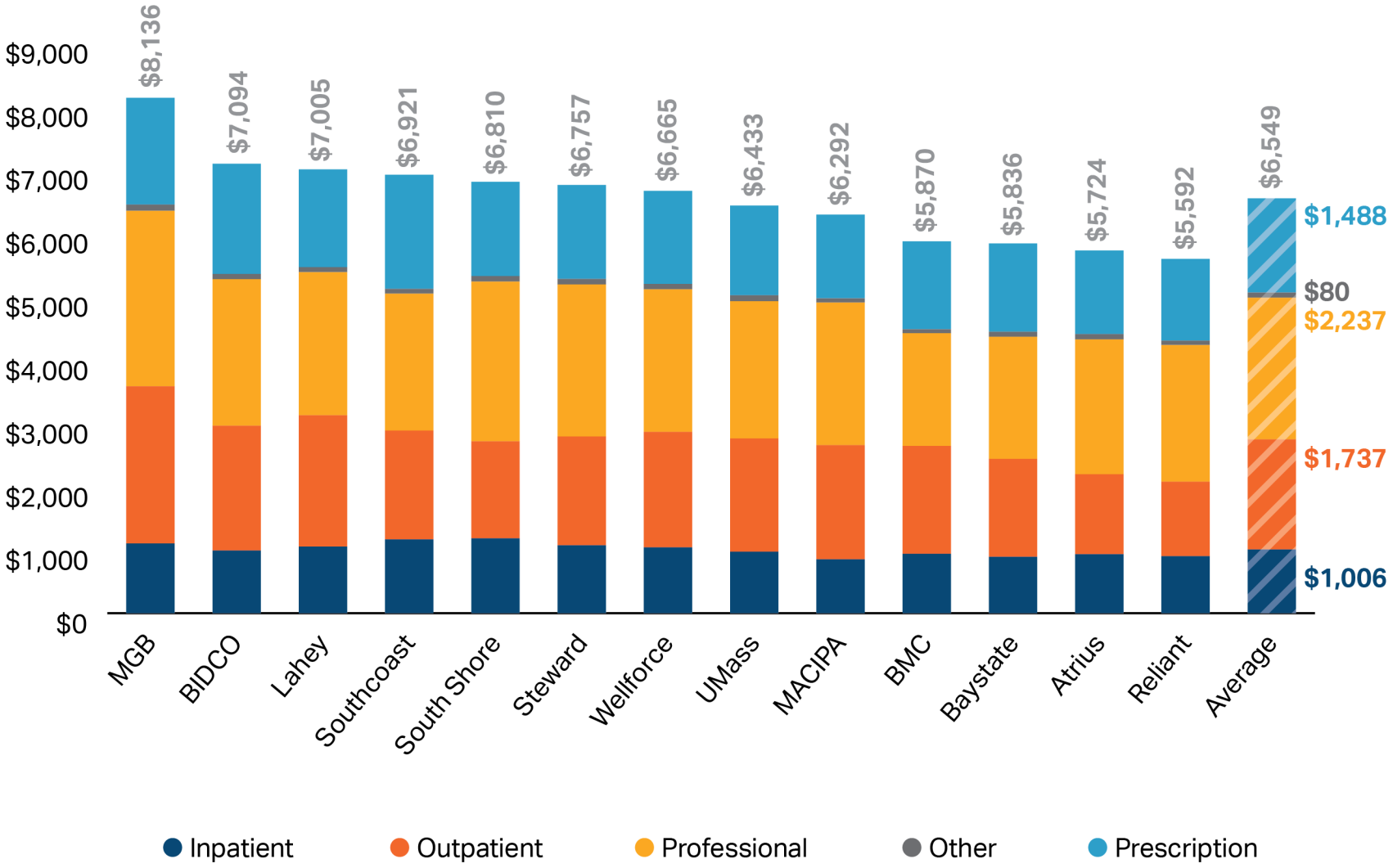


Notes: Bubble size reflect total member months. Only providers with at least 100,000 member months in each year are included. Spending data are for BCBSMA, HPHC and THP only and include PPO plans in addition to HMO and POS. 2019 data is preliminary

Sources: HPC analysis of Center for Health Information and Analysis 2020 and 2019 annual reports; TME databooks.

Unadjusted spending was 45% higher for patients with MGB primary care physicians than for patients with Reliant physicians. Hospital outpatient spending for MGB's patients was more than double that of Reliant.

Unadjusted medical spending per member per year by category and provider organization, 2018

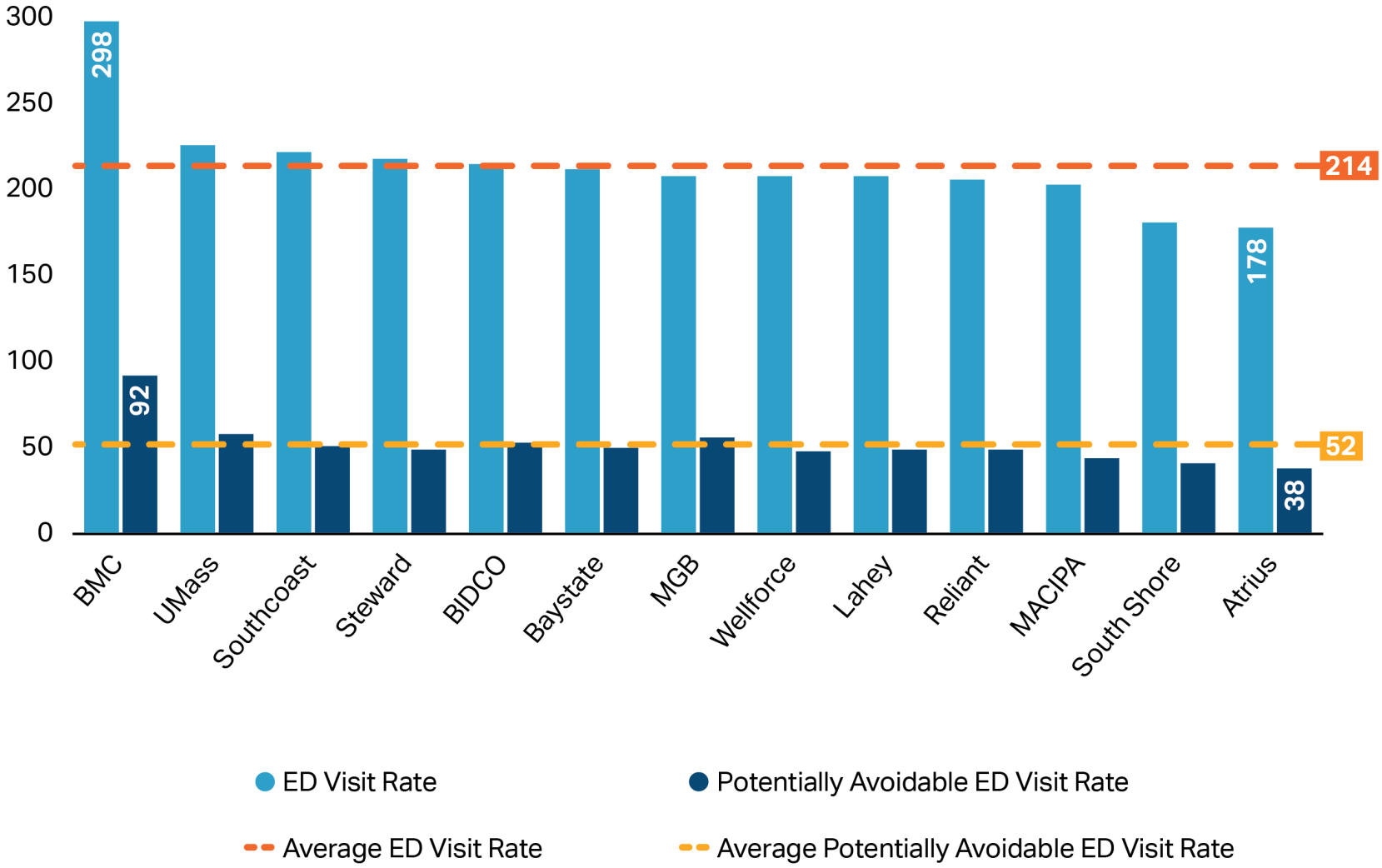


Notes: PMPY: Per member per year. Individuals without 12 months of prescription drug insurance coverage were excluded. Spending results are for commercial attributed adults (N=689,304). See technical appendix for more details.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2018

Patients with Atrius primary care physicians had the lowest rate of ED and potentially avoidable ED visits in 2018.

Adjusted total and potentially avoidable ED visits per 1,000 attributed commercial patients, 2018



Notes: Potentially avoidable ED visits are based on the Billings algorithm. Results reflect commercial attributed adults, at least 18 years of age (N=877,946). Results are adjusted for differences in age, sex, health status, and community-level variables related to education and socioeconomic status. See technical appendix for details.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2018

Over 80,000 commercially-insured Massachusetts residents received at least one of seven low-value care services in 2018 based on APCD analysis.

LOW VALUE SERVICES STUDIED
Screening
T3 (Thyroid) screening for patients with hypothyroidism
Cardiac stress testing for patients with an established diagnosis of ischemic heart disease or angina
Vitamin D screening for patients without chronic conditions
Pre-operative testing
Baseline labs in patients without significant systemic disease undergoing low-risk surgery
Chest radiograph for patients undergoing noncardiothoracic low-risk surgery
Procedures
Spinal injections for lower back pain
Coronary stent for patients with an established diagnosis of ischemic heart disease or angina

80,168

Total # of patients with at least 1 LVC service

137,226

Total # of LVC services identified

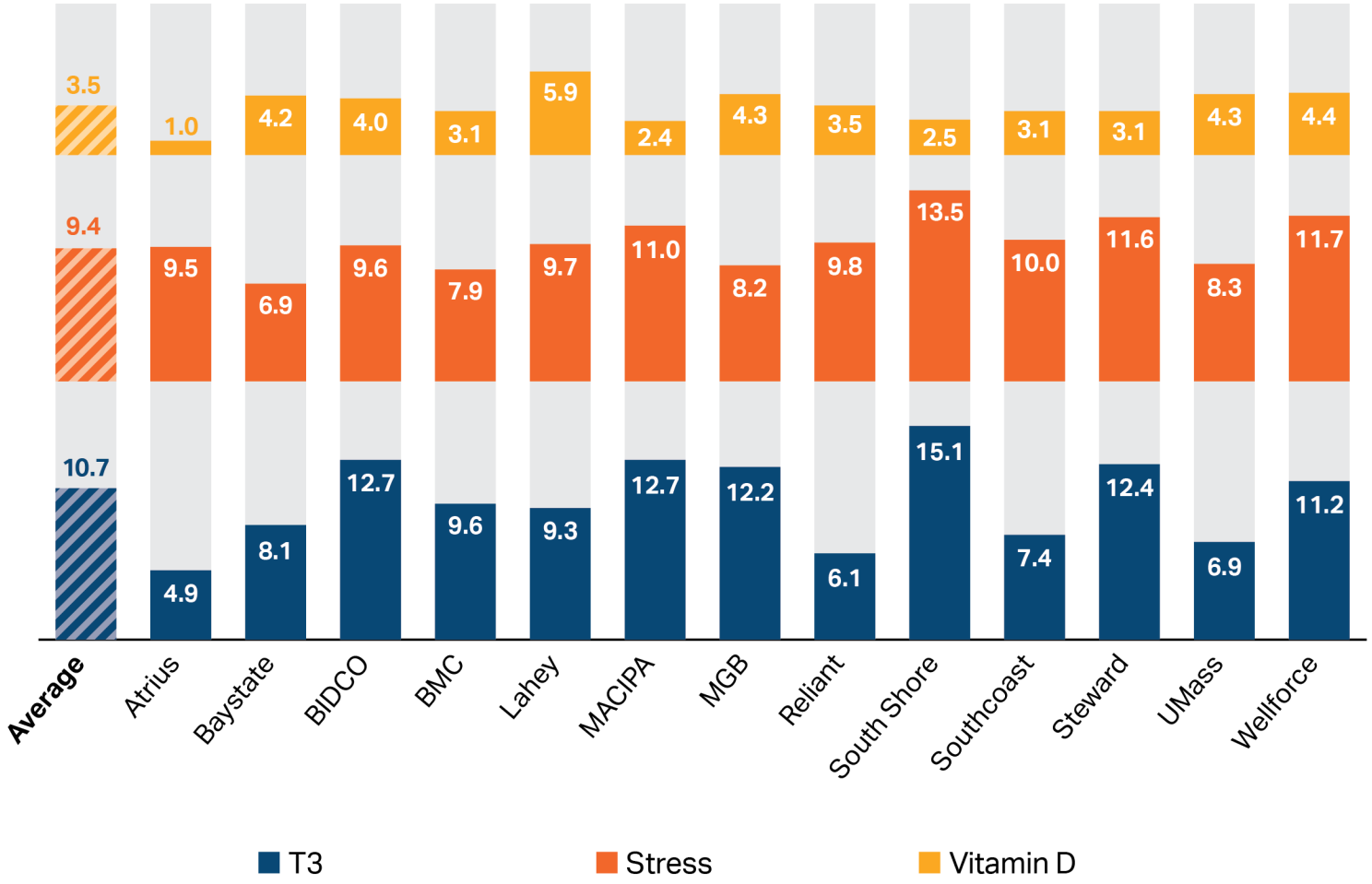
2:1

Variation in LVC spending per 100 eligible members across provider organizations

HPC

Physicians at South Shore performed twice as many low-value screenings as Atrius physicians in 2018.

Low value screenings per 100 eligible commercial patients, 2018



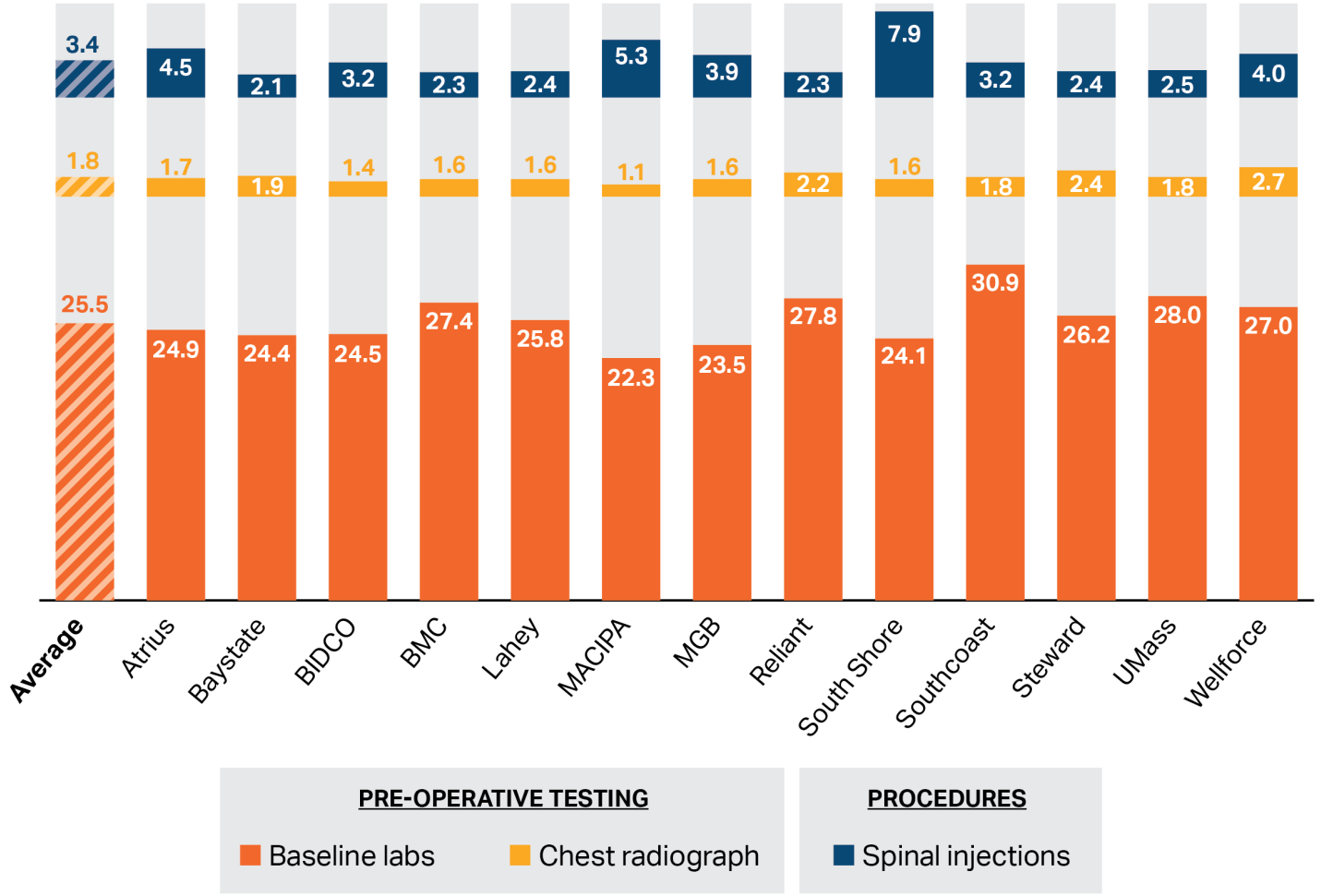
Notes: T3 = Total or free T3 level measurement in a patient with a hypothyroidism diagnosis during the year; Stress = Stress testing for patients with an established diagnosis of ischemic heart disease or angina at least 6 month before the stress test, and thus not done for screening purposes; Vitamin D = Population based screening for 25-OH-Vitamin D deficiency. Based on a patient's medical history and inclusion criteria for each low value measure, a patient could be counted in multiple measures. Average reflects rate for all commercial patients, including patients not attributed to a listed provider organization. See technical appendix for details.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2018

HPC

About one in four patients received pre-operative baseline lab tests that provide no benefit.

Low value pre-operative tests and procedures per 100 eligible commercial patients, 2018



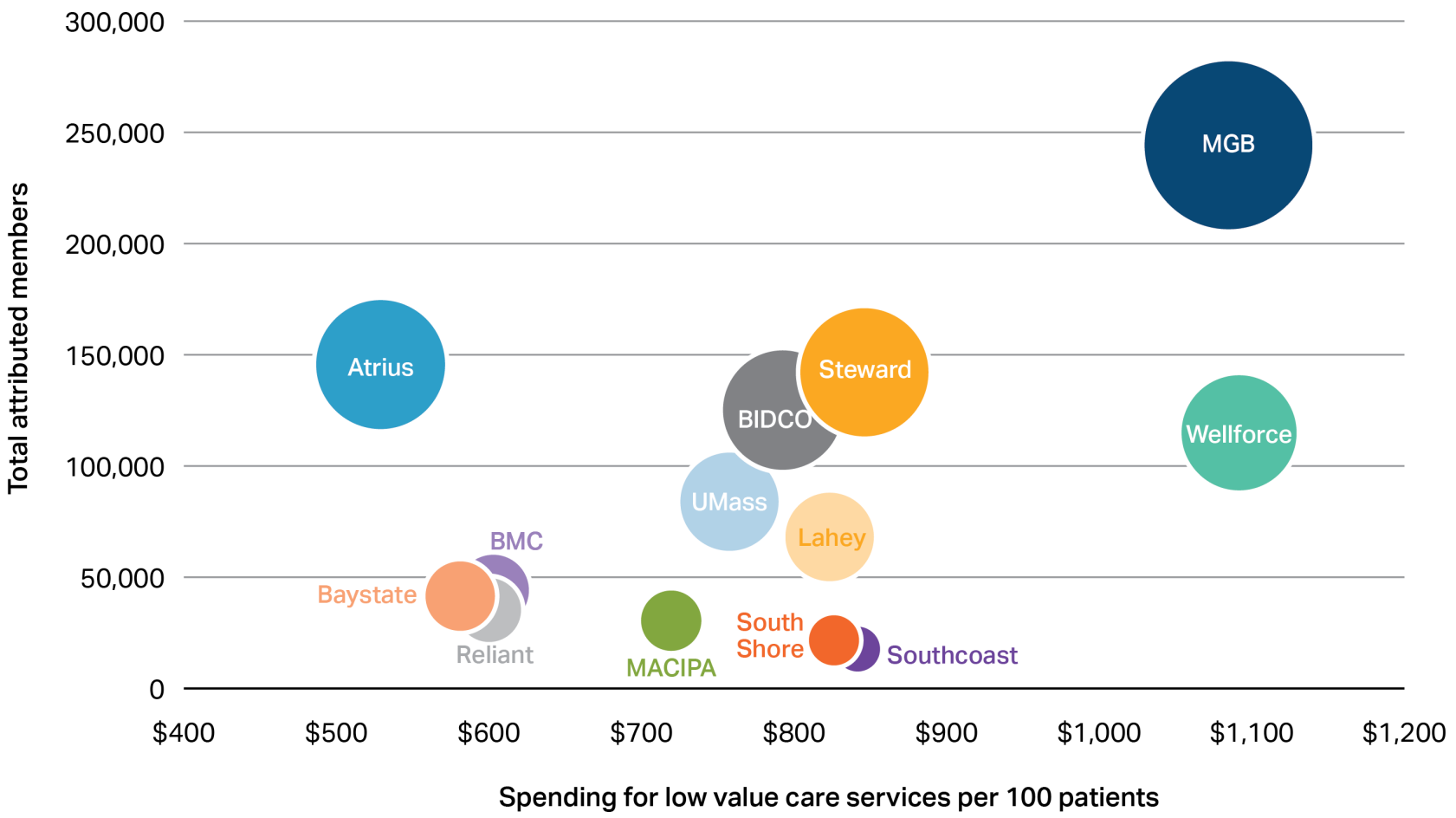
Notes: Baseline labs = Baseline labs in patients without significant systemic disease undergoing low-risk surgery; Chest radiograph = Chest radiographs occurring less than 30 days before a low or intermediate risk non-cardiothoracic surgical procedure (not associated with inpatient or emergency care). Based on a patient's medical history and inclusion criteria for each low value measure, a patient could be counted in multiple measures. Average reflects rate for all commercial patients, including patients not attributed to a listed provider organization. See technical appendix for details.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2018 and Berlin, Nicholas L., et al. "Patterns and Determinants of Low-Value Preoperative Testing in Michigan." JAMA Internal Medicine (2021).

HPC

Spending for seven low-value services per 100 patients varied by a factor of two across provider organizations in 2018.

Spending for seven low value services per 100 patients and total attributed patients by provider organization, 2018



Notes: Low value spending across all seven measures was summed by provided organization and then divided by the total number of commercial adult attributed patients, and reported as a rate per 100 patients. Results for the low value stent procedure are not presented by provider organization due to small numbers at some organizations in the two previous charts, but are included here in overall spending. Patients included in this population were not restricted to 12 months of continual coverage, N=1,117,933.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2018

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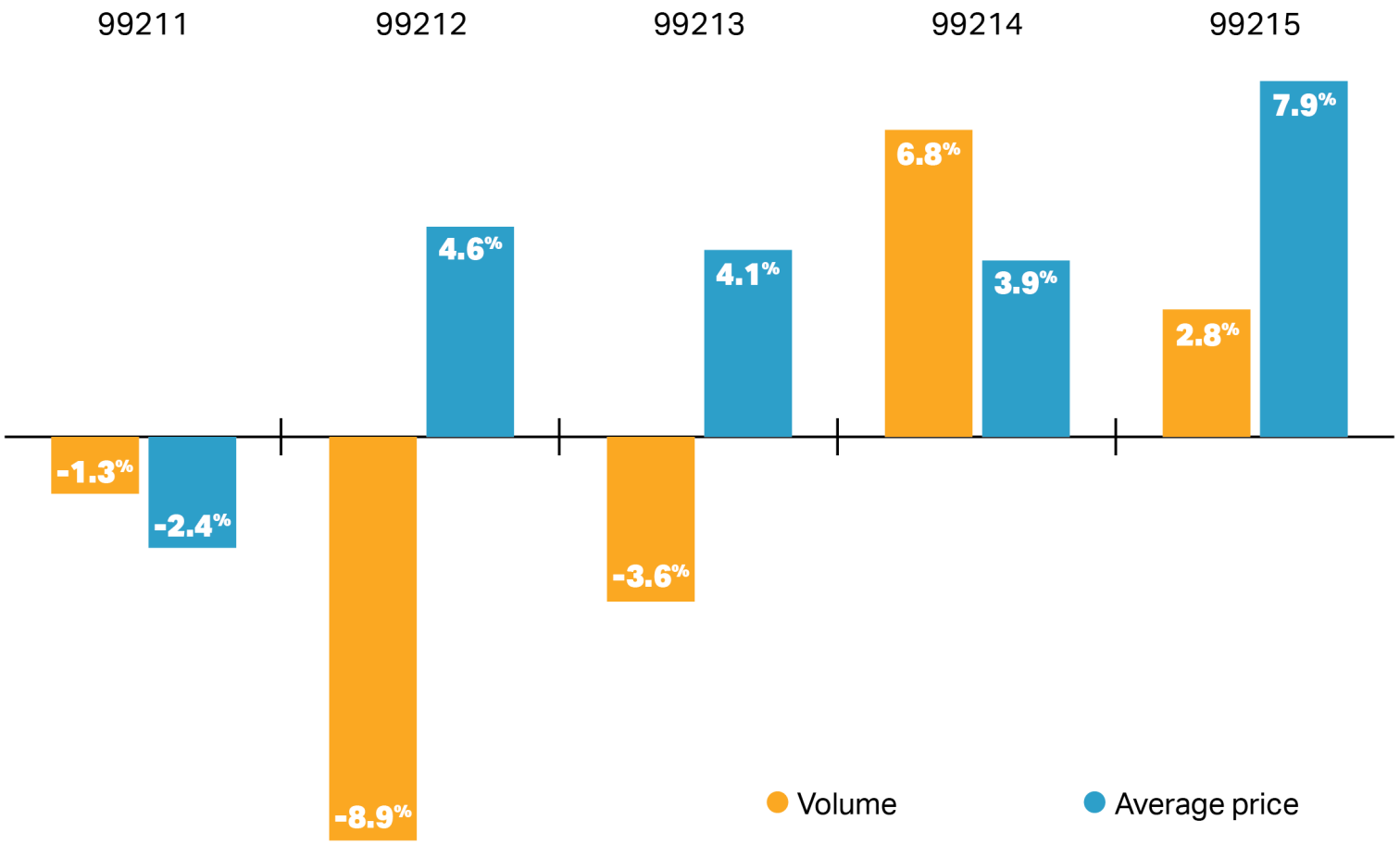
From 2016 to 2018, average physician prices grew for more complex E&M visits while volume also shifted toward these visits.

Established patient evaluation and management visits: change in volume and price, 2016-2018

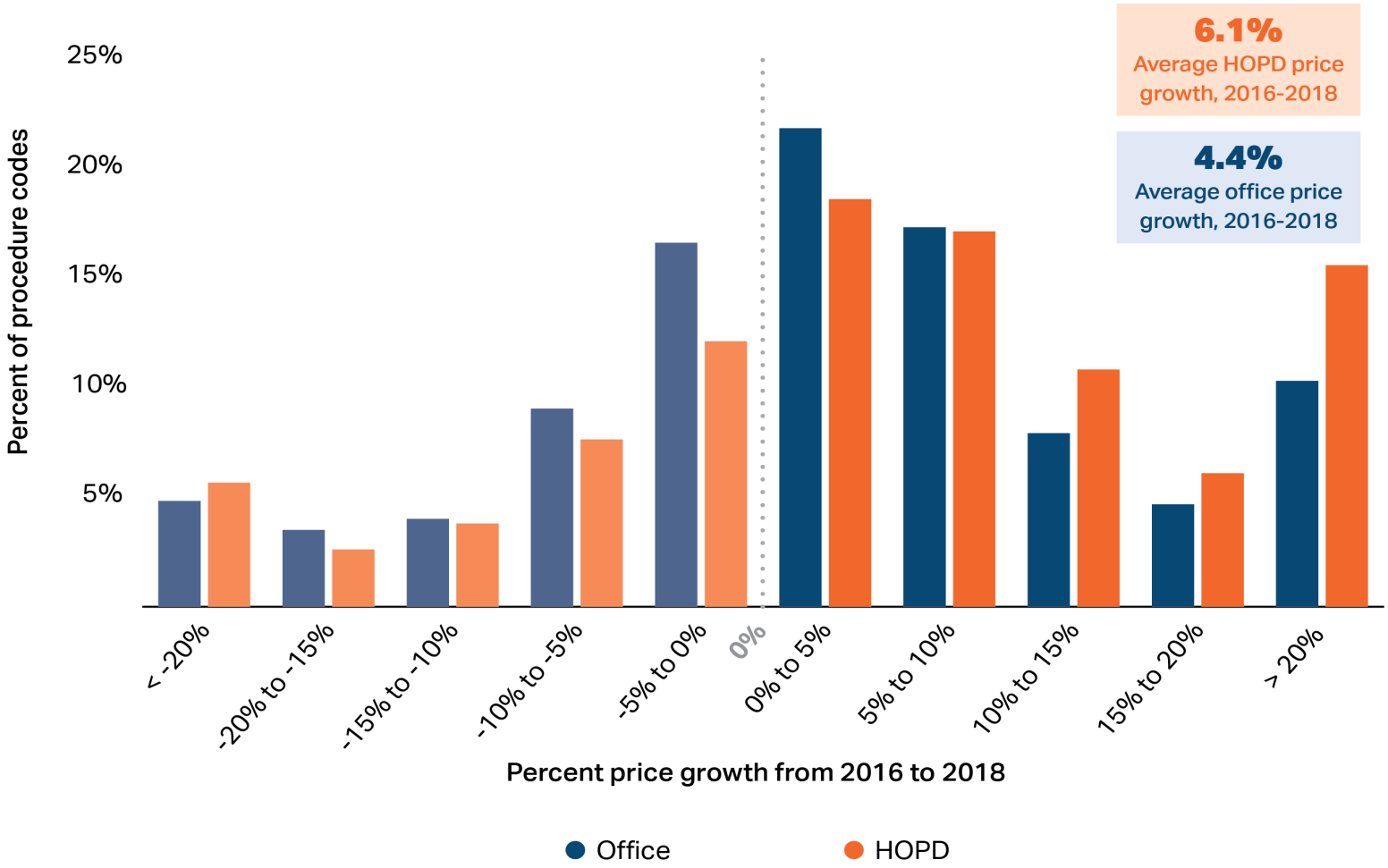


Notes: Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day for the same encounter. Evaluation and management visits are billed by a variety of provider types (advanced practice nurses, primary care providers, specialists, etc.) and these figures include services across all provider types billed in office and hospital outpatient department care settings. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

Prices increased by more than 10% for one in three hospital outpatient department (HOPD) procedures from 2016 to 2018. Average HOPD prices grew 6.1%, versus 4.4% for office procedures.

Percentage of procedure codes occurring in either office or HOPD settings with price changes in the specified range, 2016-2018



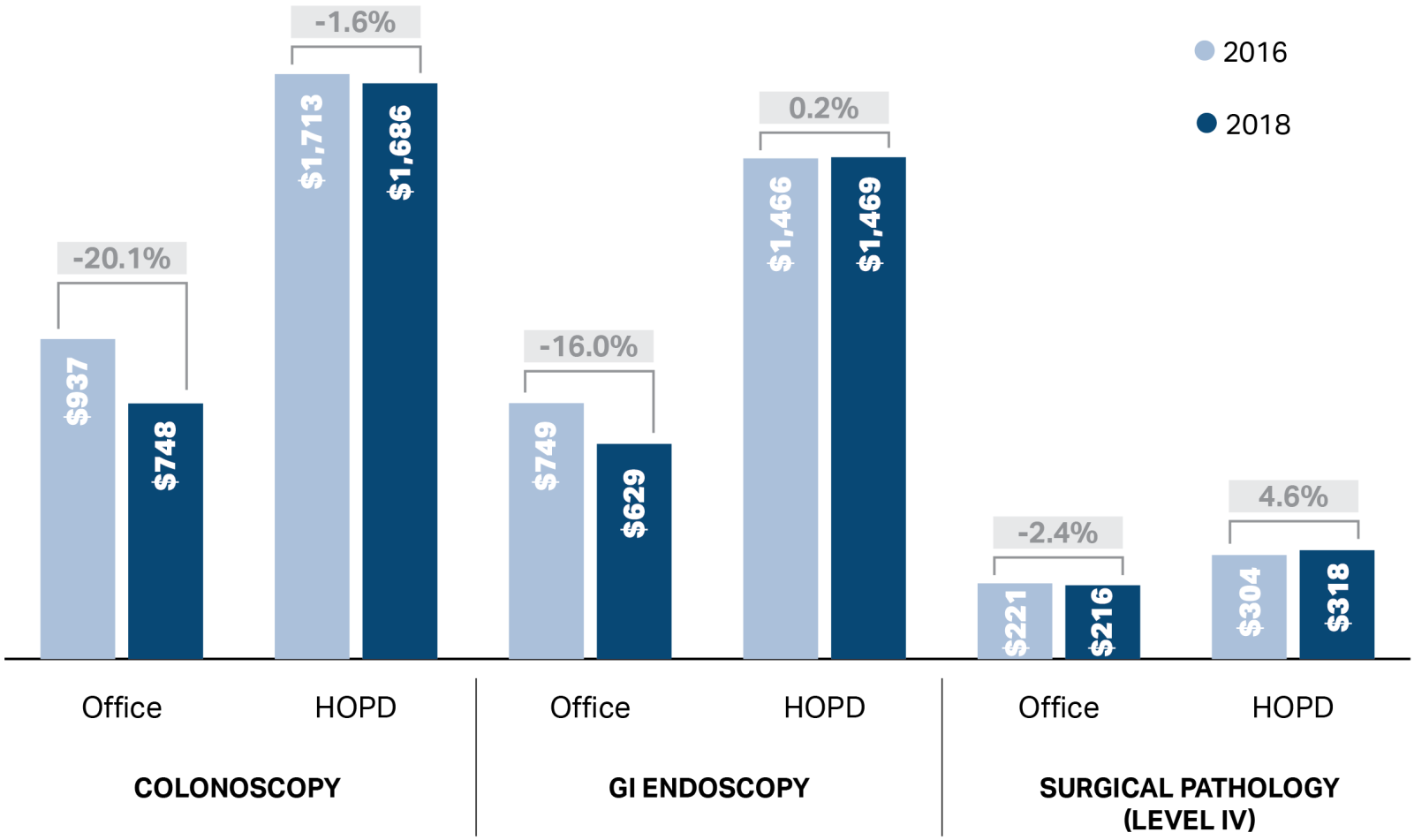
Notes: Price growth is computed at the level of the procedure code encounter. Encounters are defined as the same person, same date of service, same procedure code to capture the potential for both facility and professional claims billed on the same day for the same service based on the setting. Procedure codes are consistent between 2016 and 2018, and procedures codes with < 20 services or < $1,000 in aggregate spending in 2018 were excluded. Overall percent price growth for Office and HOPD was weighted by 2018 aggregate spending for the procedure code in the respective setting.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

HPC

Spending for three common procedures is double if performed in a HOPD versus an office setting in 2018.

Average spending and spending growth for common procedures occurring in both Office and HOPD settings, 2016-2018



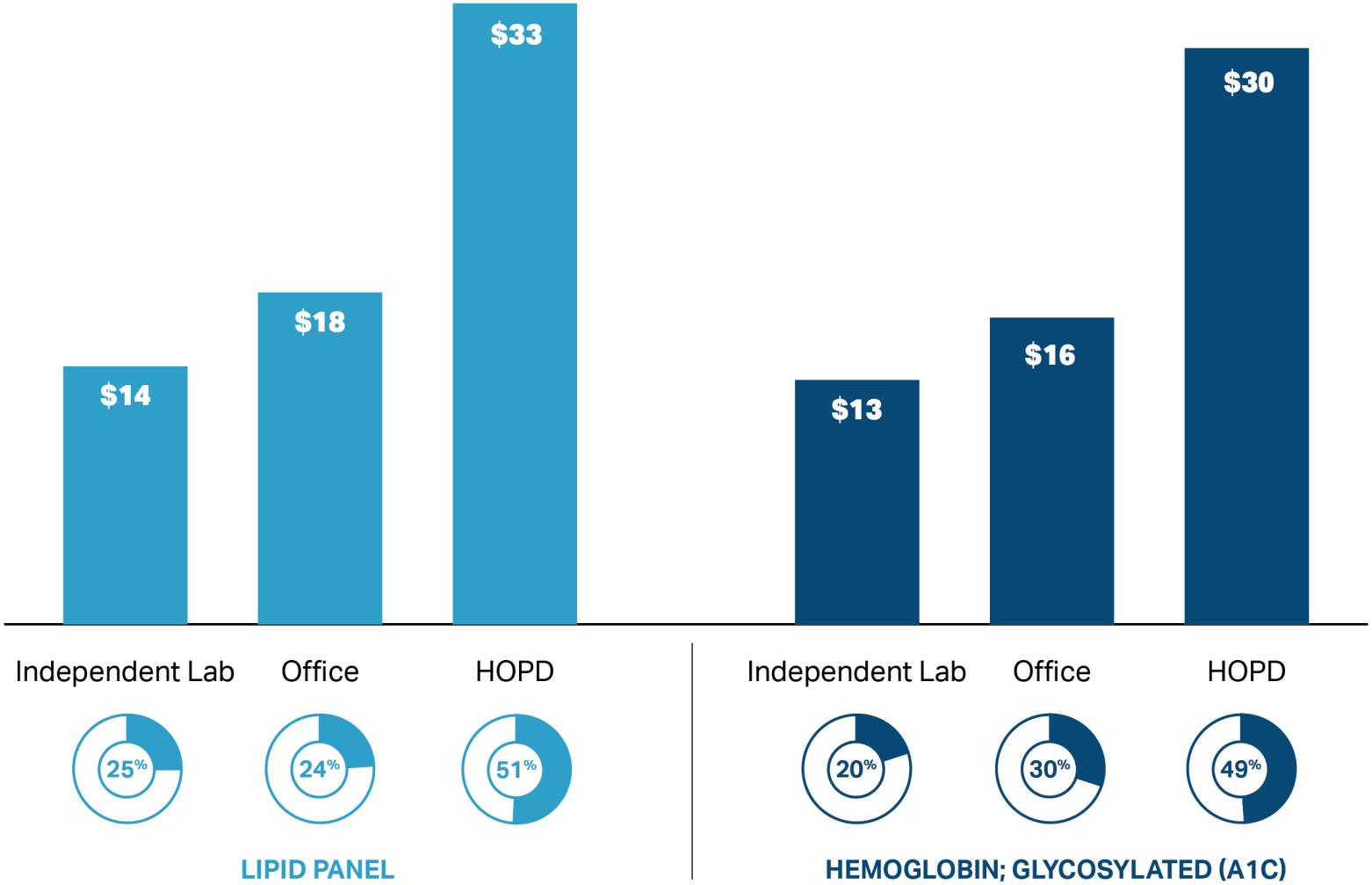
Notes: Services displayed had the highest aggregate HOPD spending in 2018 (colonoscopy: $22.9M; pathology: $20M; endoscopy: $15.6M) and were also billed in 2016. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Colonoscopy (CPT 45380, 'Colonoscopy, flexible; with biopsy, single or multiple'); GI endoscopy (CPT 43239, 'Esophagogastroduodenoscopy'); Surgical pathology (CPT 88305, 'Level IV Surgical pathology, gross and microscopic examination').

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

HPC

Half of all common lab tests were performed in a HOPD where prices were double the price of the same labs performed in offices or independent labs.

Average prices for lab services among Independent Lab, Office, and HOPD settings, with volume share, 2018



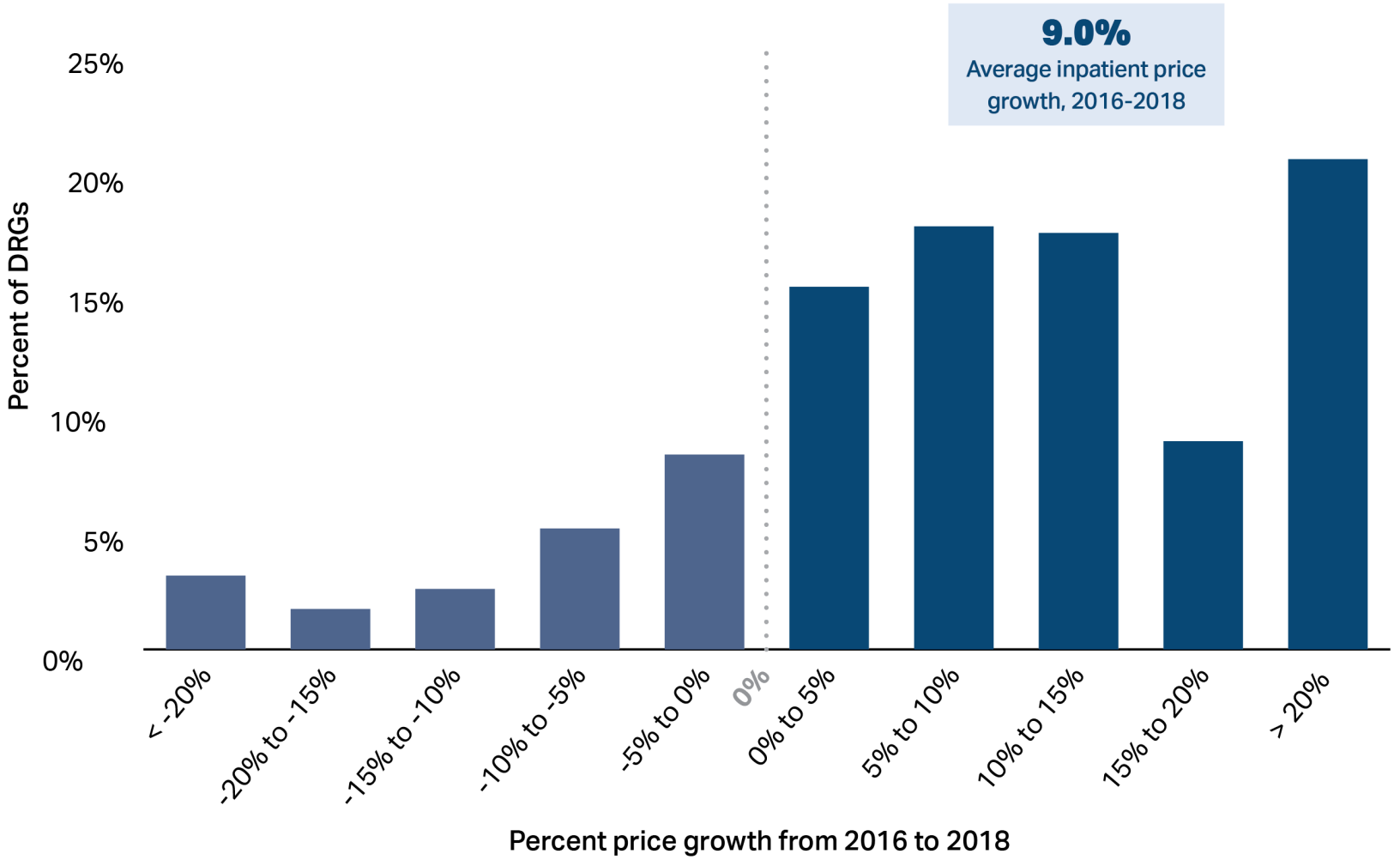
Notes: Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price. Lipid panel (CPT 80061, 'Lipid panel'); Hemoglobin glycosylated (A1c) (CPT 83036, 'HbA1c'). Share of volume for all ambulatory lab services is listed as a percent under the x-axis; some values may not add up to 100% due to rounding.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

HPC

Payments per stay increased by over 10% for nearly half of inpatient stay DRGs from 2016 to 2018.

Percentage of DRGs with average price changes in the category as shown, 2016-2018



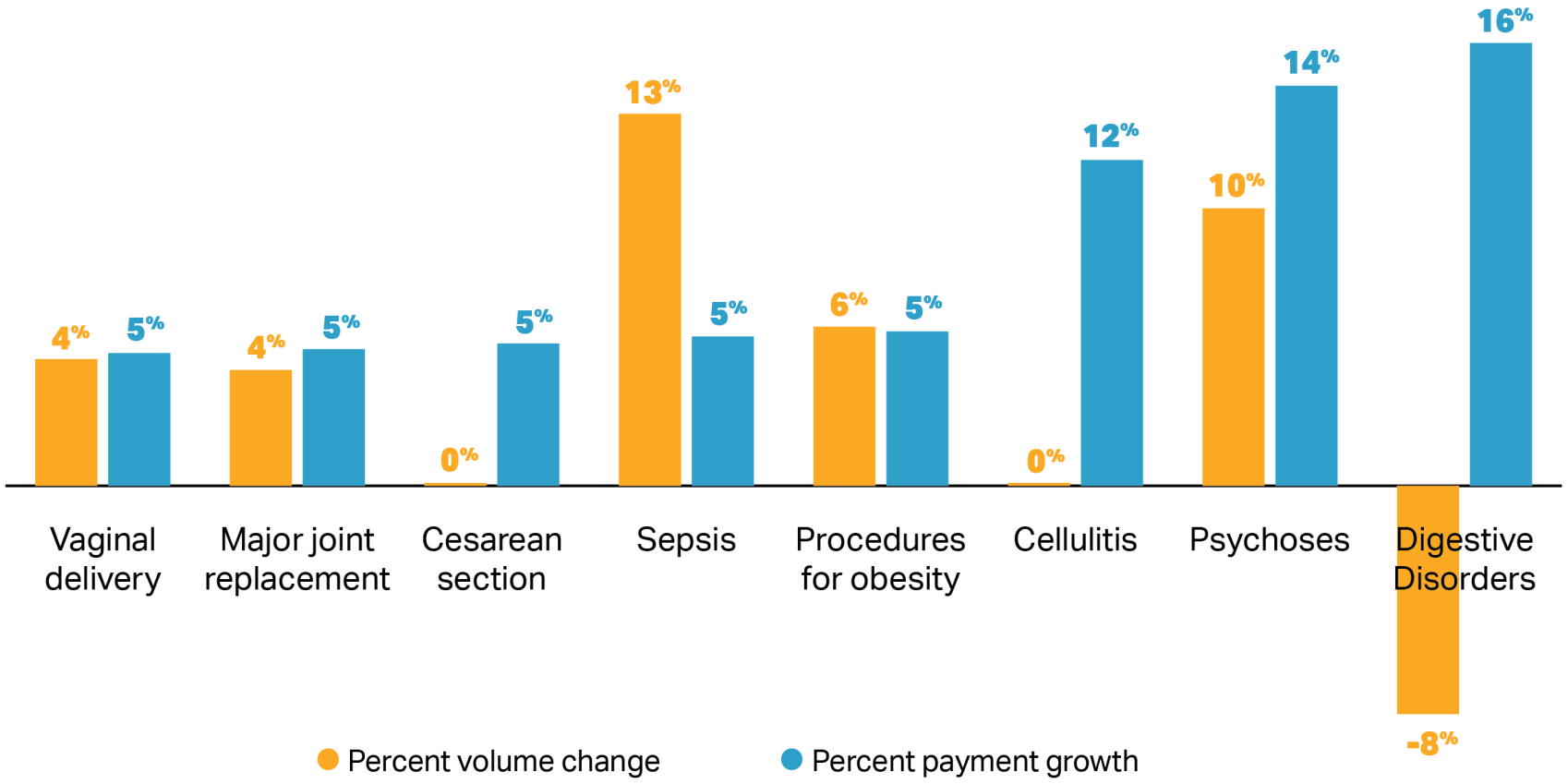
Notes: Average payment growth includes both facility and professional claims for an inpatient stays. Inpatient stays were all identified by an MS-DRG (DRG-stays). Of stays, 356 MS-DRGs out 739 identified in the 2018 APCD were included in this analysis. In order to be included there needed to be at least 20 inpatient stays with a particular DRG and at least $10,000 in 2018 aggregate spending in order to be included. Average inpatient price growth weighted to 2018 total spending.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, v8 2016-2018

HPC

Payments per stay grew significantly for the most common inpatient stay categories. The volume of inpatient stays coded as sepsis increased.

Percent change in payment and volume for high-volume categories of inpatient stays, 2016-2018



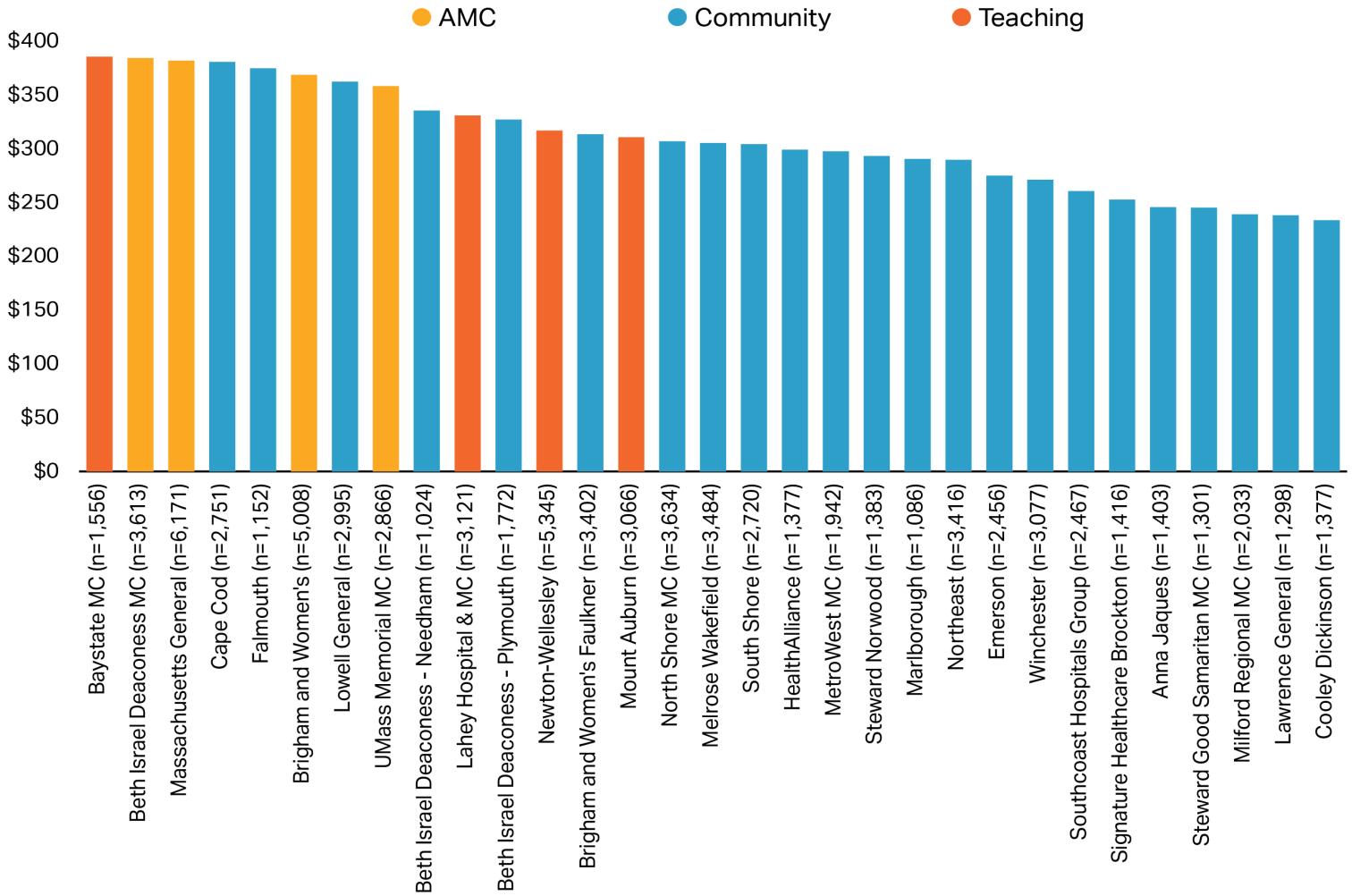
Notes: Average payment shown includes both facility and professional claims for an inpatient stay collapsed across severity levels for a DRG-stay (eg, with and without major complexity or comorbidity). Vaginal delivery includes MS-DRGs 774 and 775. Major joint replacement includes MS-DRG 469 & 470. Cesaerean includes 765 and 766. Sepsis includes MS-DRG 871 and 872, but not 871 (with mechanical ventilation). Obesity procedures includes MS-DRGs 619-621. Cellulitis includes MS-DRGs 602 and 602. Psychoses only includes MS-DRG 885. Digestive disorders includes MS-DRGs 391 and 392). Volume is adjusted for total member months in each year.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, v8 2016-2018

HPC

In 2018, the hospital with the highest-average mammography price was 65% higher ($152) than the lowest cost hospital.

Average mammography prices among high volume hospital outpatient departments, 2018



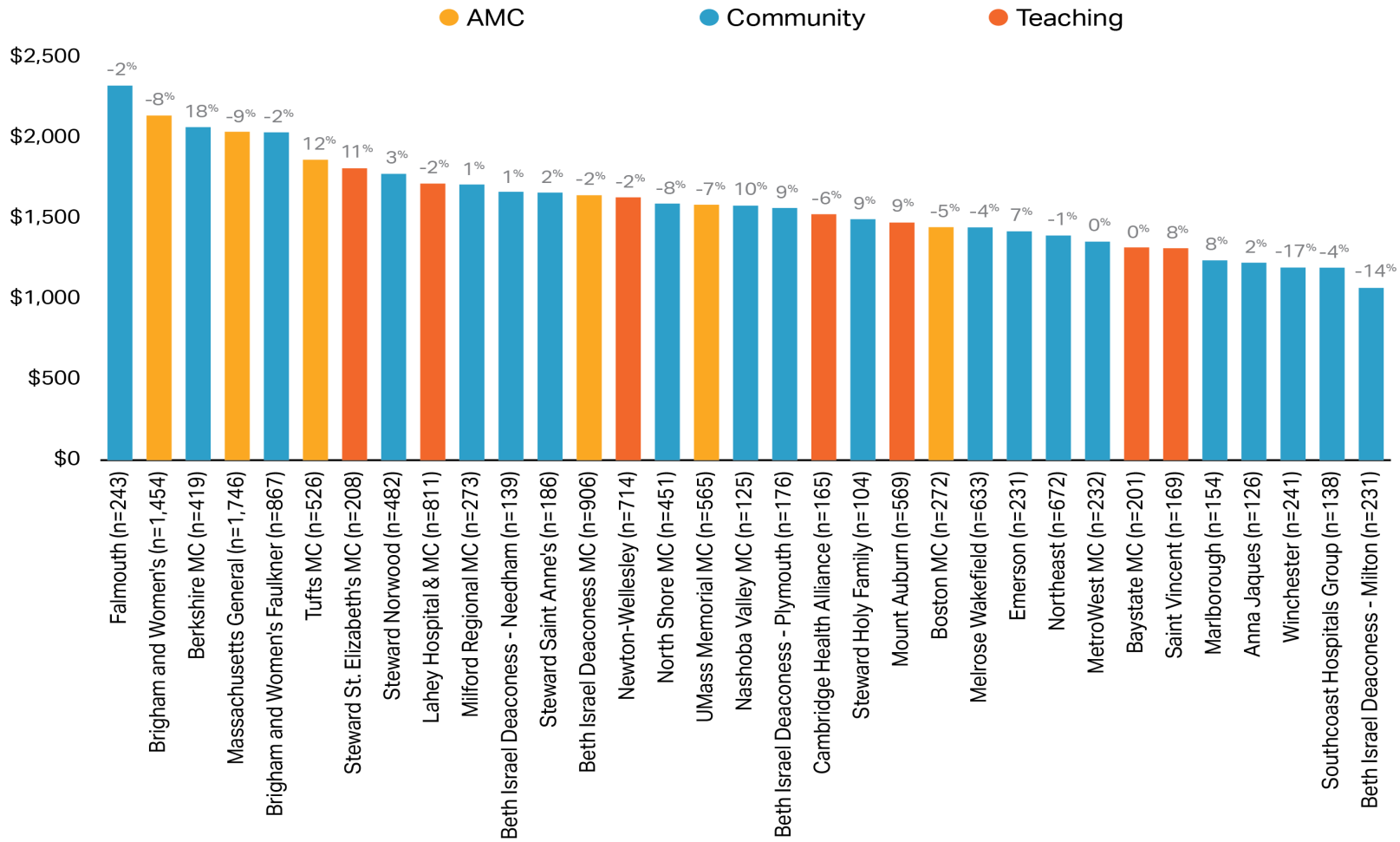
Notes: Facilities listed are limited to those with at least 1,000 commercial encounters delivered in 2018. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price. Mammography (CPT 77067, 'Screening mammography, bilateral, including computer-aided detection (CAD) when performed').

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

HPC

In 2018, the hospital with the highest-average colonoscopy price had an average price 117% higher ($1,256) than the lowest cost hospital.

Average colonoscopy prices (2018) among high volume hospital outpatient departments with percent growth in price, 2016- 2018



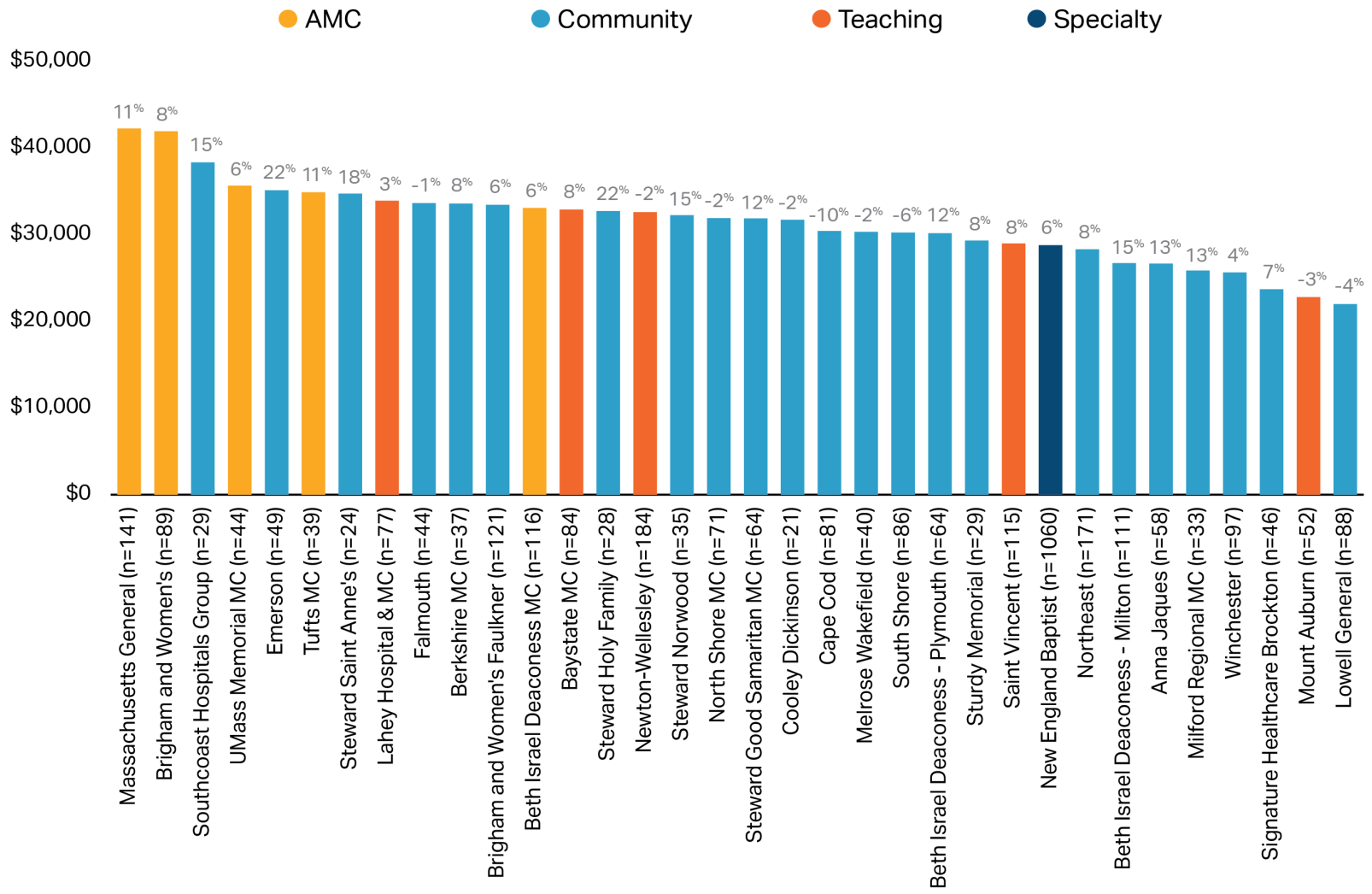
Notes: Facilities listed are limited to those with at least 100 commercial encounters delivered in 2018. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price. Colonoscopy (CPT 45380, 'Colonoscopy, flexible; with biopsy, single or multiple')

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

HPC

The average payment for a major joint replacement stay varied from $42,000 (MGH) to $22,000 (Lowell General) in 2018.

2018 average major joint replacement payment with percent growth in average payment by hospital, 2016-2018

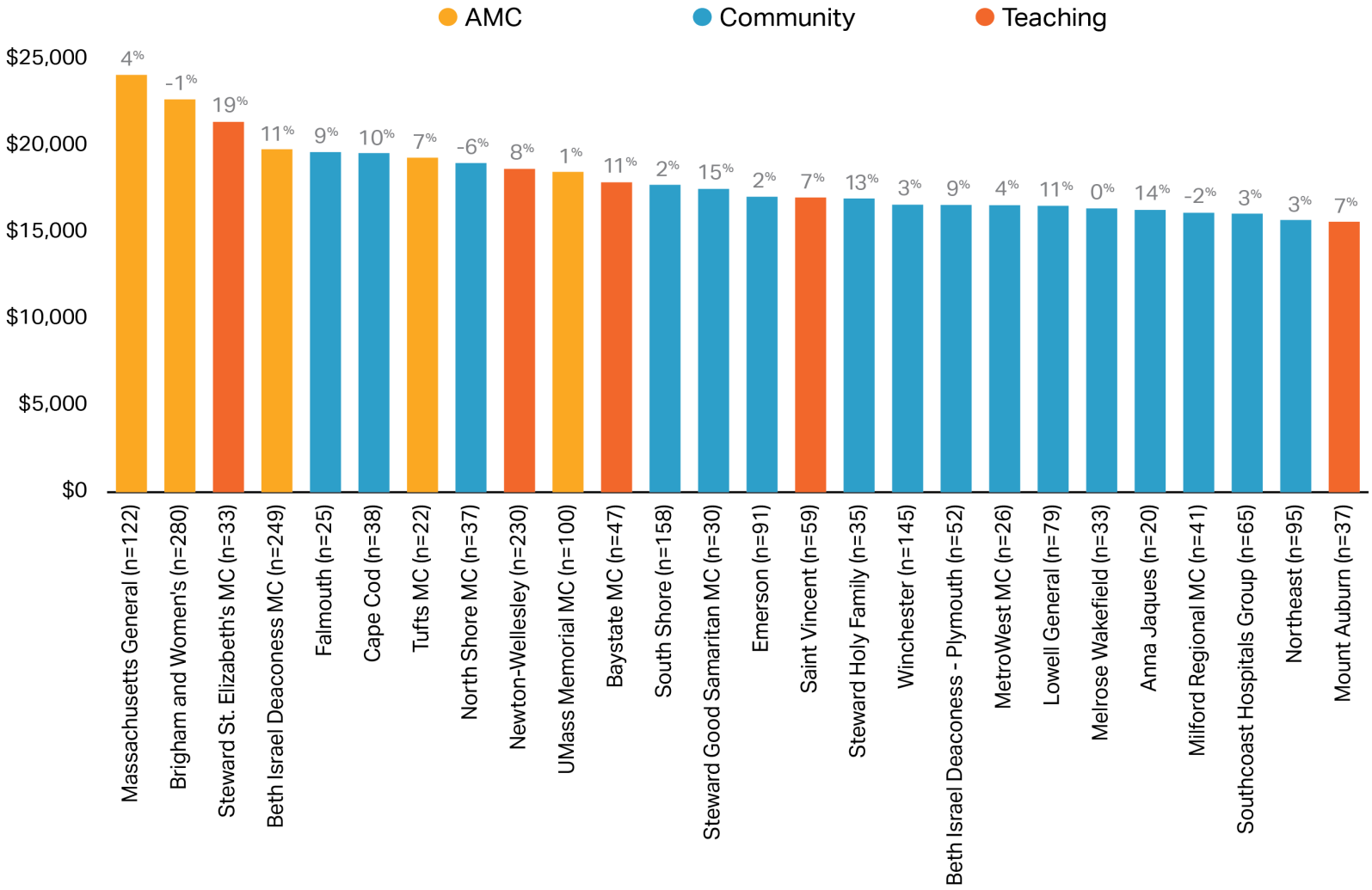


Notes: Average payment shown includes both facility and professional claims for an inpatient stay labelled with DRG 470 (major joint replacement without major complication or comorbidity). Only hospitals with at least 20 inpatient stays for 2016 and 2018 were included in the analysis.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, v8 2016-2018

The average commercial payment for a c-section delivery varied from $24,000 at Mass General to $15,600 at Mount Auburn hospital in 2018.

2018 average cesarean delivery payment with percent growth in average payment by hospital, 2016-2018



Notes: Average payment shown includes both facility and professional claims for an inpatient stay labelled with DRG 766 (cesarean section without major complication or comorbidity). Only hospitals with at least 20 inpatient stays for 2016 and 2018 were included in the analysis.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, v8 2016-2018

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from February 10, 2021 **(VOTE)**
- Registration of Provider Organizations (RPO)
- 2020 Health Care Cost Trends Report: Chartpack Highlights
  - Hospital Utilization and Post-Acute Care
  - Provider Organization Performance Variation
  - Price Variation and Trends
  - **Dashboard Preview**
- Schedule of Next Meeting (October 6, 2021)

Dashboard Sections and Examples

Health Equity

Alternative Payment Methods

Efficient, High-Quality Care Delivery

Benchmark and Spending

Value-Based Markets

HPC

Select Health Equity Measures from the Dashboard

STATE INCOME DISPARITY DATA

	Data year	All	State rank	Low income	High income	Disparity (ppt)	Disparity State rank
Individuals under age 65 with high out-of-pocket spending relative to income	2017-2018	6.1%	4	20.0%	0.07%	-19.3	31
Adults age 18 and older who went without care because of cost in the past year	2018	9%	5	18%	5%	-13	12
Fair or poor health status (adult)	2018	13%	8	23%	6%	-17	4

STATE RACE / ETHNICITY DISPARITY DATA

	Data year	Overall	State rank	White	Black	Disparity (ppt)	Hispanic	Disparity (ppt)	Other	Disparity (ppt)
Mortality amenable to health care (deaths per 100,000 population)	2016-2017	57.4	2	56.6	87.3	-30.7	54.2	2.4	31.9	24.7
Infant mortality (per 1,000 live births)	2017	3.7	1	2.7	7.4	-7.2	4.6	-4.4	--	--

HPC

Sources: Radley DC, Collins SR, Baumgartner JC. 2020 Scorecard on state health system performance. The Commonwealth Fund. September 2020.

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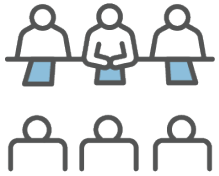
Upcoming 2021 Meetings and Contact Information

BOARD MEETINGS

July 14

September 15

November 17



COMMITTEE MEETINGS

October 6

December 15

ADVISORY COUNCIL

September 29

December 8

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@Mass_HPC

HPC-info@mass.gov

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