MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

January 11, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the November 9, 2016 Meeting
- Cost Trends and Market Performance
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Involvement
- Executive Director Update
- Public Comment
- Schedule of Next Board Meeting

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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on November 9, 2016, as presented.

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- **Cost Trends and Market Performance**
  - Update on Notices of Material Change
  - 2016 Cost Trends Report, Preliminary Findings
  - Process for Setting the 2018 Health Care Cost Growth Benchmark (VOTE)
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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	18	24%
Physician group merger, acquisition, or network affiliation	17	23%
Acute hospital merger, acquisition, or network affiliation	15	20%
Formation of a contracting entity	12	16%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	6	8%
Change in ownership or merger of corporately affiliated entities	5	7%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

- Proposed merger of two general acute care hospitals that are part of the UMass Memorial Health Care system, **HealthAlliance Hospital (HAH)** and **Clinton Hospital (Clinton)**, under which Clinton would merge with HAH and become a satellite location under HAH's hospital license.
  - Merger would allow the locations to share physicians more efficiently and alleviate inpatient capacity concerns at Clinton, especially with respect to over-capacity geriatric medical-psychiatry beds.
  - Our analysis indicated that this transaction would not likely result in substantial changes in spending, given that both hospitals are already part of UMass.
  - Merger has the potential to increase access to certain services for area residents.
  - We did not find evidence suggesting negative impacts on quality.
- Proposed acquisition of **Central Massachusetts Independent Physician Association (CMIPA)**, a 200-physician independent practice association in Worcester County and Springfield, by **Steward Health Care Network (Steward)**, under which Steward would purchase substantially all assets of CMIPA and take over certain CMIPA contracts.
  - Our analysis suggested that there is limited potential for increased bargaining leverage as a result of the transaction and that any change to commercial rates is likely to have a relatively limited impact on health care spending.
  - Evidence we reviewed also suggested that referral patterns are unlikely to change significantly.
  - We did not find evidence suggesting negative impacts on quality or access.

Notices Still Under Review

Received Since 11/9

- Proposed formation of a joint venture between **UMass Memorial Health Ventures**, a subsidiary of UMass Memorial Health Care, and **ATI Physical Therapy (ATI).** ATI is a multistate provider of physical therapy, occupational therapy, workers' compensation, and sports medicine services with approximately 30 locations in Massachusetts. The joint venture would provide non-hospital outpatient physical and occupational therapy services in Central Massachusetts.

- Proposed formation of a joint venture between **Shields Health Care Group (Shields)** and **Berkshire Medical Center (Berkshire)**. Shields is an independent provider of diagnostic imaging, radiation therapy, and outpatient management services that operates primarily through joint ventures with hospitals and other provider systems. The joint venture would operate a mobile PET/CT diagnostic imaging clinic at Berkshire's Hillcrest Campus in Pittsfield, MA.

- Clinical affiliation between **Lahey Hospital & Medical Center (Lahey)** and **New England Life Flight, d/b/a Boston MedFlight (MedFlight)**. MedFlight is a non-profit corporation that provides rapid aircraft and ground transportation and healthcare services for critically ill and injured patients. Under the proposed affiliation, Lahey would become an affiliate member of MedFlight and would contribute financially to support MedFlight's continued operations.

Notices Still Under Review

Received Since 11/9

- Proposed acquisition of First Psychiatric Planners d/b/a **Bournewood Hospital (Bournewood Hospital)**, a for-profit psychiatric hospital located in Brookline, by **Alita Care,** a for-profit Delaware company that owns and operates residential and outpatient behavioral health treatment facilities in eight states, including Massachusetts. Under the proposed acquisition, Alita Care would acquire 100% of the stock of Bournewood Hospital.

- Proposed clinical affiliation between **UMass Memorial Health Care** and **Dana-Farber Cancer Institute (DFCI)**. Under the proposed affiliation, UMass Memorial Medical Center (UMass) would become a member of the Dana-Farber Cancer Care Collaborative, through which DFCI would provide certain consulting, educational, and clinical support services to UMass and its patients.

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Key statistics from the 2016 Cost Trends Report

2016 HPC Key Findings

$20,400

annual health insurance premium plus cost-sharing for typical family in MA

6.0%

commercial health care spending per person in MA in excess of national average

44.7%

portion of income a typical family of 3 at twice the federal poverty level pays for health insurance premiums, copayments, and deductibles

31%

portion of employees at small firms who have a choice of insurance plan

8.8%

per capita growth in commercial prescription drug spending, not factoring rebates

2 percentage point

impact of rebates and discounts on commercial pharmacy spending trends as reported by the AGO

21%

approximate percent of commercial health care spending attributable to prescription and medical drugs combined

24.4%

rate of non-recommended imaging for lower back pain per 100 eligible cases

22.8%

portion of behavioral health related emergency department visits with a length of stay of more than 12 hours

4X

growth in percent of prescriptions with no cost sharing among women between 2012 and 2014 (3.2% to 13.4%)

+11,000

change in the number of inpatient admissions in Massachusetts in 2015 after 3 years of declines of over 20,000 per year

HPC

Statutory mandate for HPC's annual Cost Trends Report

Section 8g of Chapter 224 of the Acts of 2012

The commission shall compile an **annual report concerning spending trends and underlying factors**, along with any **recommendations for strategies to increase the efficiency of the health care system**. The report shall be based on the commission's analysis of information provided at the **hearings** by providers, provider organizations and insurers, **registration data** collected under section 11, **data collected by the Center for Health Information and Analysis** under sections 8, 9 and 10 of chapter 12C and **any other information the commission considers necessary to fulfill its duties under this section**, as further defined in regulations promulgated by the commission. The report shall be submitted to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include **any legislative language necessary to implement the recommendations**.

Data inputs

- **Hearings**
- **Registration data**
- **CHIA data**
- **Any other information necessary to fulfill duties**

Required outputs

- **Annual report concerning spending trends and underlying factors**
- **Recommendations for strategies to increase efficiency**
- **Legislative language necessary to implement recommendations**

HPC

Presentation themes and potential areas for recommendations

Themes

Spending and the delivery system

- Spending trends
- Affordability of care
- Prescription drug spending

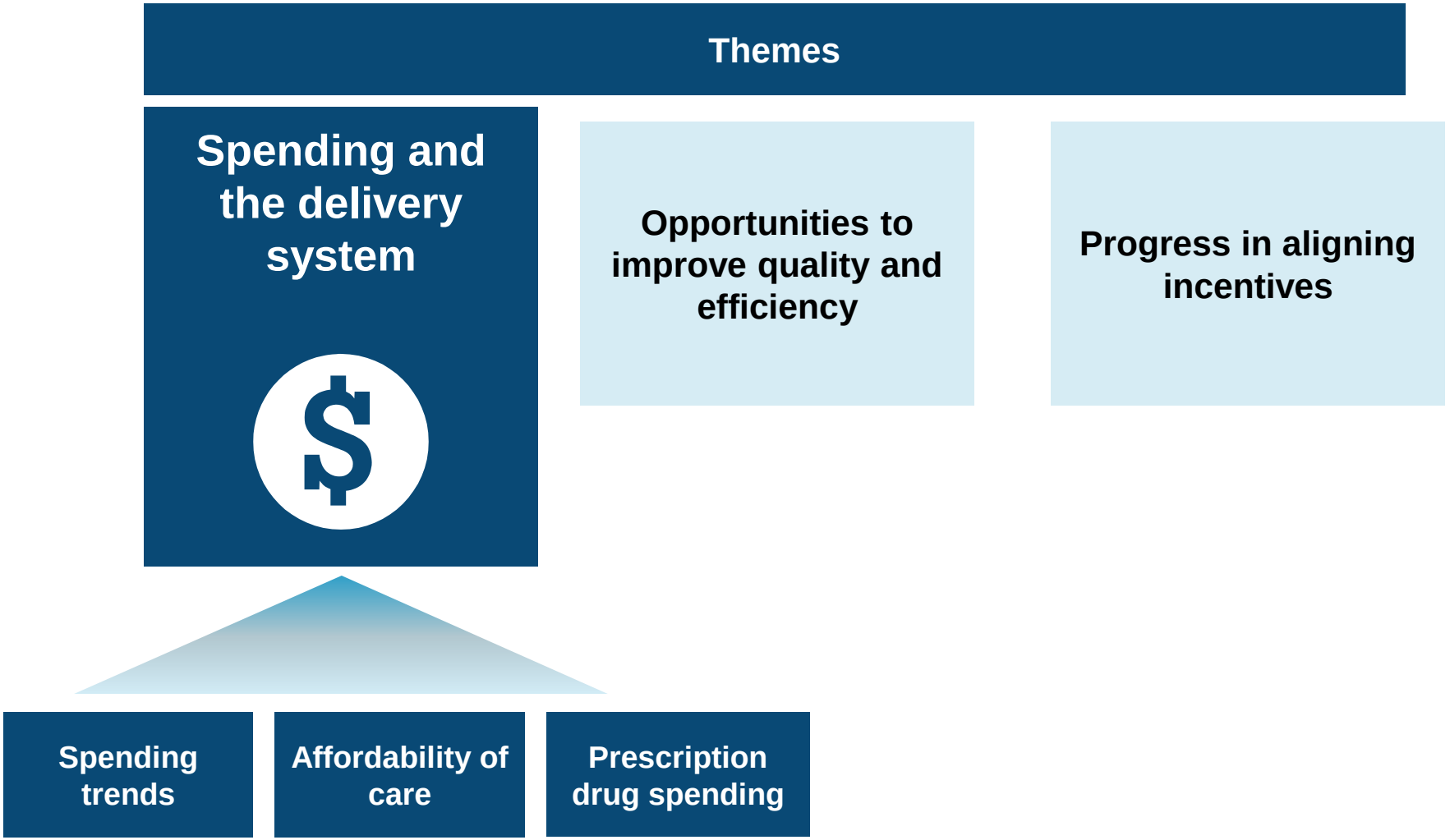
Opportunities to improve quality and efficiency

- Avoidable hospital utilization
- Post-acute care
- Variation in spending by primary care provider group

Progress in aligning incentives

- Alternative payment methods
- Demand-side incentives

Select findings from the 2016 Cost Trends Report



Massachusetts healthcare spending growth

Background

- After years of high growth in annual healthcare spending throughout the 2000s, Massachusetts spent more than any other state on health care per person in 2009
  - Medicare spending per capita was **9%** higher
  - Commercial premiums were **13%** higher

- Since 2012, the state (through the HPC) annually establishes a health care cost growth benchmark, as measured by growth in total health care expenditures (THCE) per capita. This target is based on projections of the state's long-term economic growth and has been set at **3.6%** annual growth through 2017

- Since 2012, the actual growth rates in THCE were:
  - 2012-2013: **2.4%**
  - 2013-2014: **4.2%**
  - 2014-2015 preliminary: **4.1%**

- Overall, between 2012-2015, the average growth rate in TCHE was **3.57%**

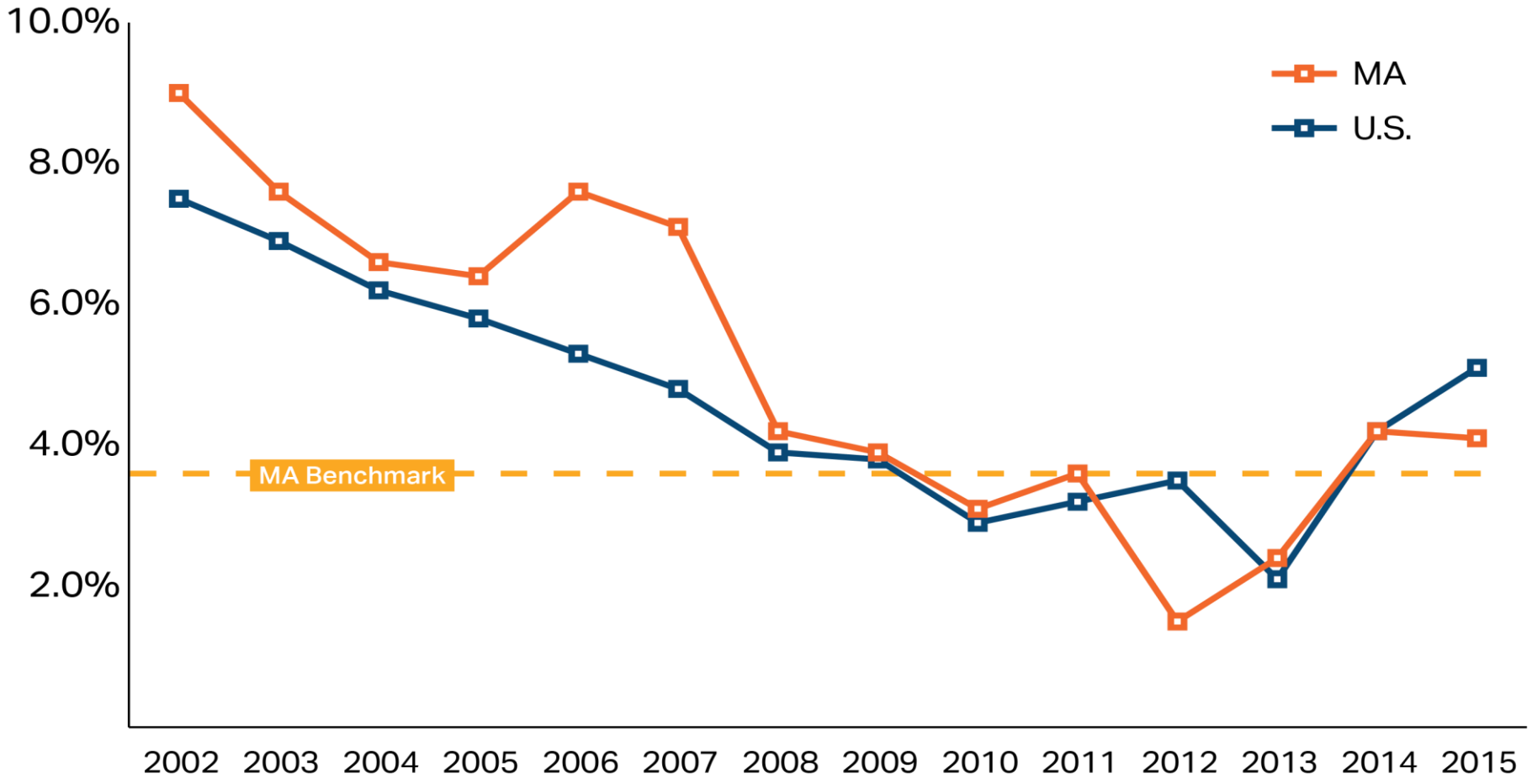
Growth in prescription drug spending, among other factors, contributed to exceeding the benchmark in 2015

Sector/spending category	Drivers of growth beyond benchmark rate, 2014-2015
Commercial	• Prescription drugs (**8.9%** growth, not factoring rebates)
Medicare (FFS)	• Prescription drugs (**10.9%** growth, not factoring rebates) • Home health care (**6.6%** growth)
MassHealth	• Prescription drugs (**9.1%** growth, not factoring rebates) • Long term services and supports (LTSS), particularly spending on home and community-based services
Other	• Medicare enrollment growth (Original Medicare, One Care and Senior Care Options) • Net cost of private health insurance

Note: Prescription drug figures under MassHealth include MCO, PCC and FFS spending only and exclude PACE, SCO and One Care. Prescription drug figures exclude impact of rebates. Growth figures provided are per member or per enrollee (Medicare drug spending is per Part D enrollee)
Sources: HPC analysis of Center for Health Information and Analysis 2016 Annual Report and July 2016 Enrollment Trends Report

Since 2009, total healthcare spending growth in Massachusetts has been near or below national growth

Annual growth in per capita healthcare spending, MA and the U.S., 2002-2015

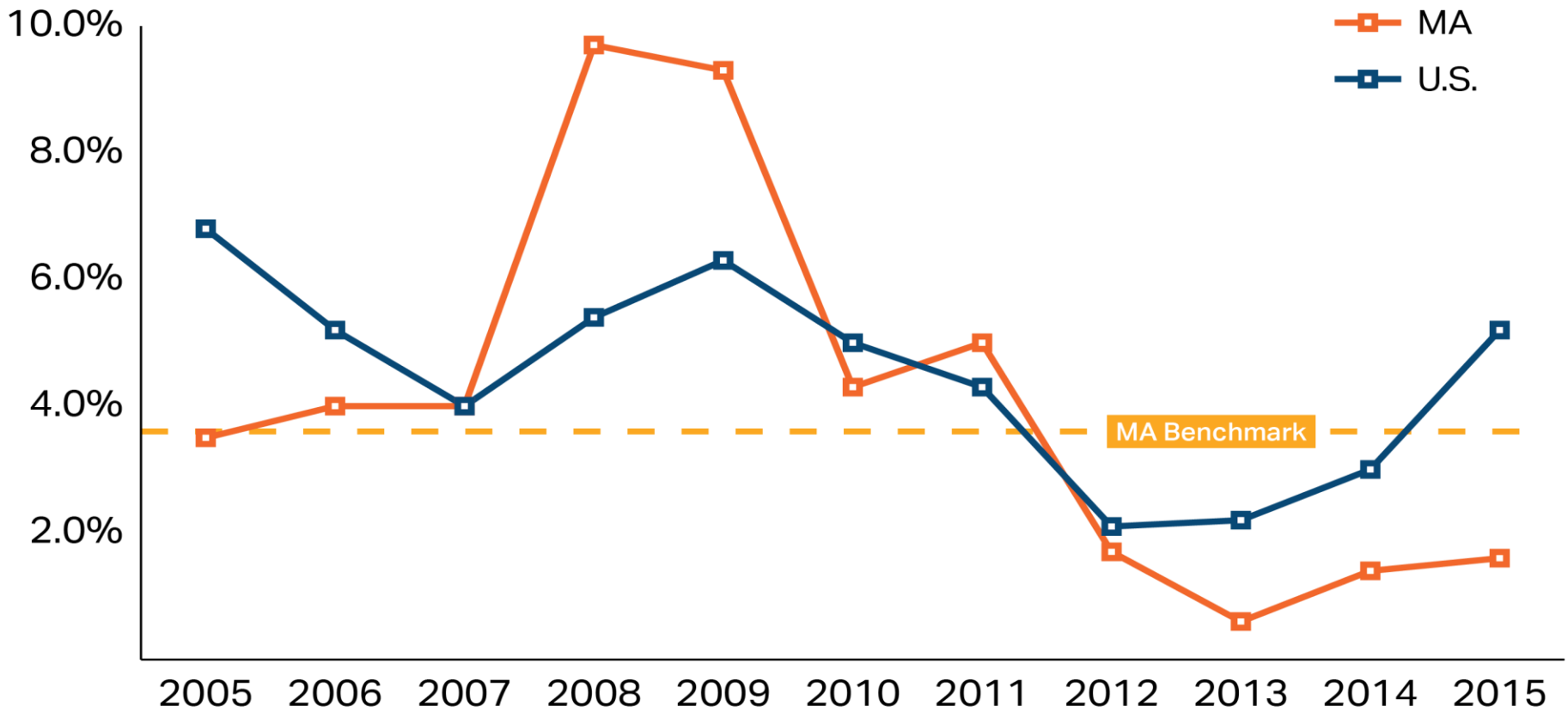


Note: U.S. data includes Massachusetts.

Sources: Centers for Medicare and Medicaid Services National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data, and State Healthcare Expenditure Accounts (U.S. 2002-2015 and MA 2002-2009); Center for Health Information and Analysis Annual Report THCE Databook (MA 2009-2015)

In recent years, commercial spending growth in Massachusetts has been consistently lower than national growth

Annual growth in commercial health insurance premium spending from previous year, per enrollee



Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only.
Sources: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts, Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005-2009); Center for Health Information and Analysis Annual Reports (MA 2009-2015)

Despite recent lower growth, spending per person in Massachusetts remains 6-7% higher than U.S. averages

Massachusetts per person spending in excess of U.S. averages, 2014 and 2015

	Overall	Inpatient hospital	Outpatient hospital	Physician	Post-acute care	Prescription drugs
Original Medicare (FFS)	6%	19%	24%	-9%	18%	1%

Commercial

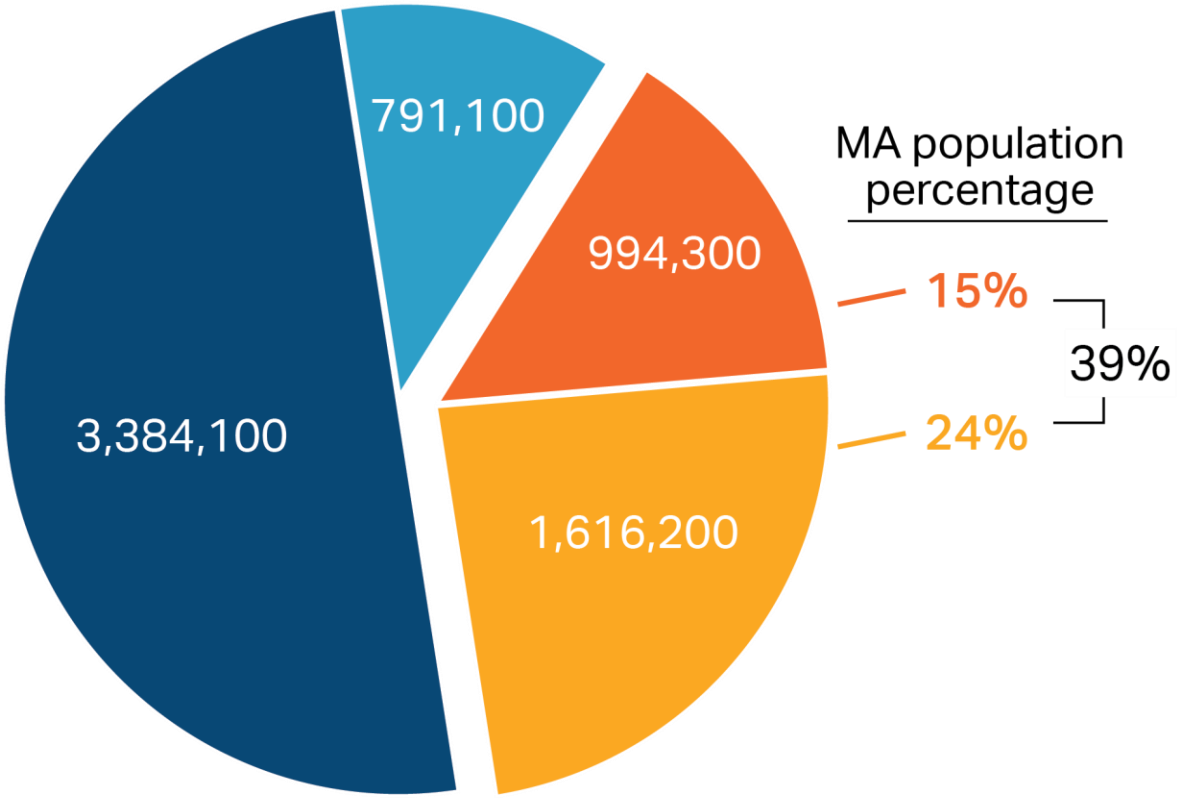
- Milliman, Inc. (claims-based), 2014
  - **6%** overall (statewide)
    - **9%** Boston-area
- U.S. Agency for Healthcare Research and Quality (survey of employers), 2015
  - **6.5%** family premiums
  - **9.3%** single premiums

HPC

Sources: Centers for Medicare and Medicaid Services 2016 (Medicare); Milliman, Inc., 2014 and Agency for Healthcare Research and Quality Medical Expenditure Panel Survey, 2015 (commercial)

Massachusetts has a considerable portion of residents at low to middle income levels

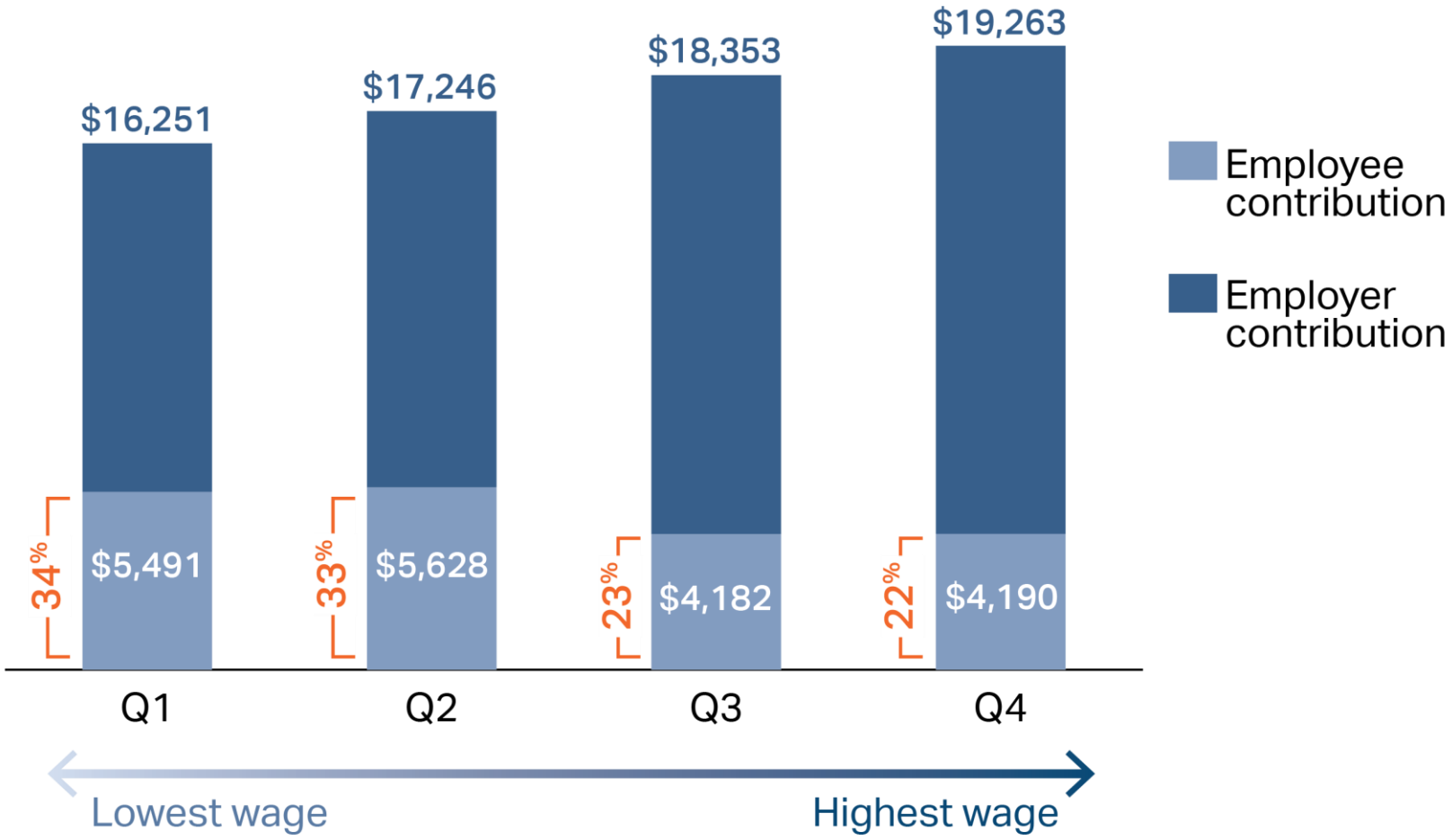
Number of state residents at each household income level, 2015



Note: Dollar values are for a family of two adults and one child.
Source: Current Population Survey as reported by Kaiser Family Foundation

On average, health insurance premiums in Massachusetts are relatively similar for low- and high-wage employers, but the employee share is greater among lower-wage employers

Average family premiums and employee contributions, by wage quartile, 2015

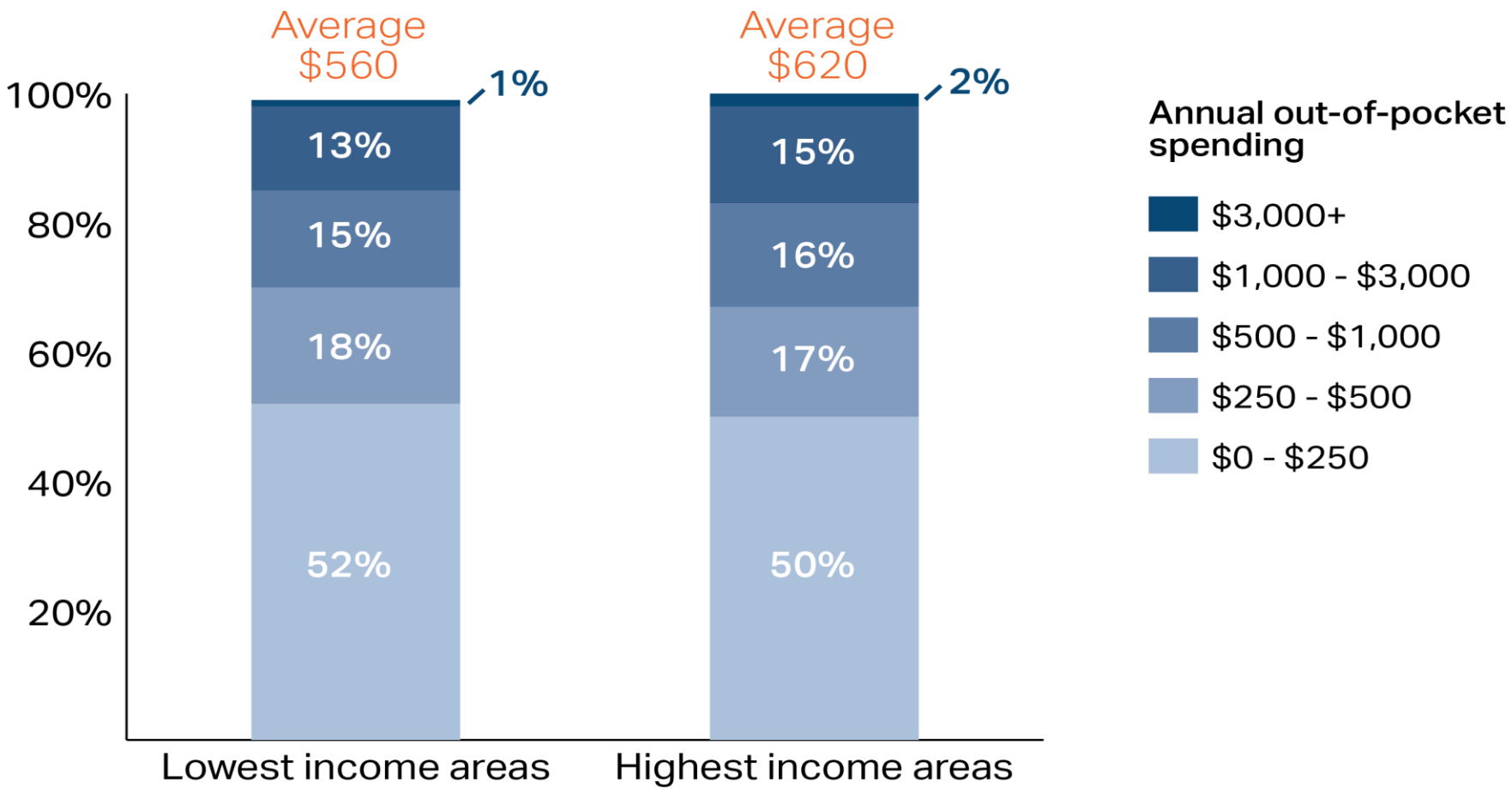


Average premium plus typical cost sharing was **$20,400** in 2015 while the average wage was **$64,116**

Source: Agency for Healthcare Research and Quality Medical Expenditure Panel Survey, 2015; Executive Office of Labor and Workforce Development 2015 Massachusetts Workforce and Labor Area Review

Out-of-pocket healthcare spending is relatively similar for residents in low and high income areas

Percent of residents, by annual out-of-pocket spending, 2014

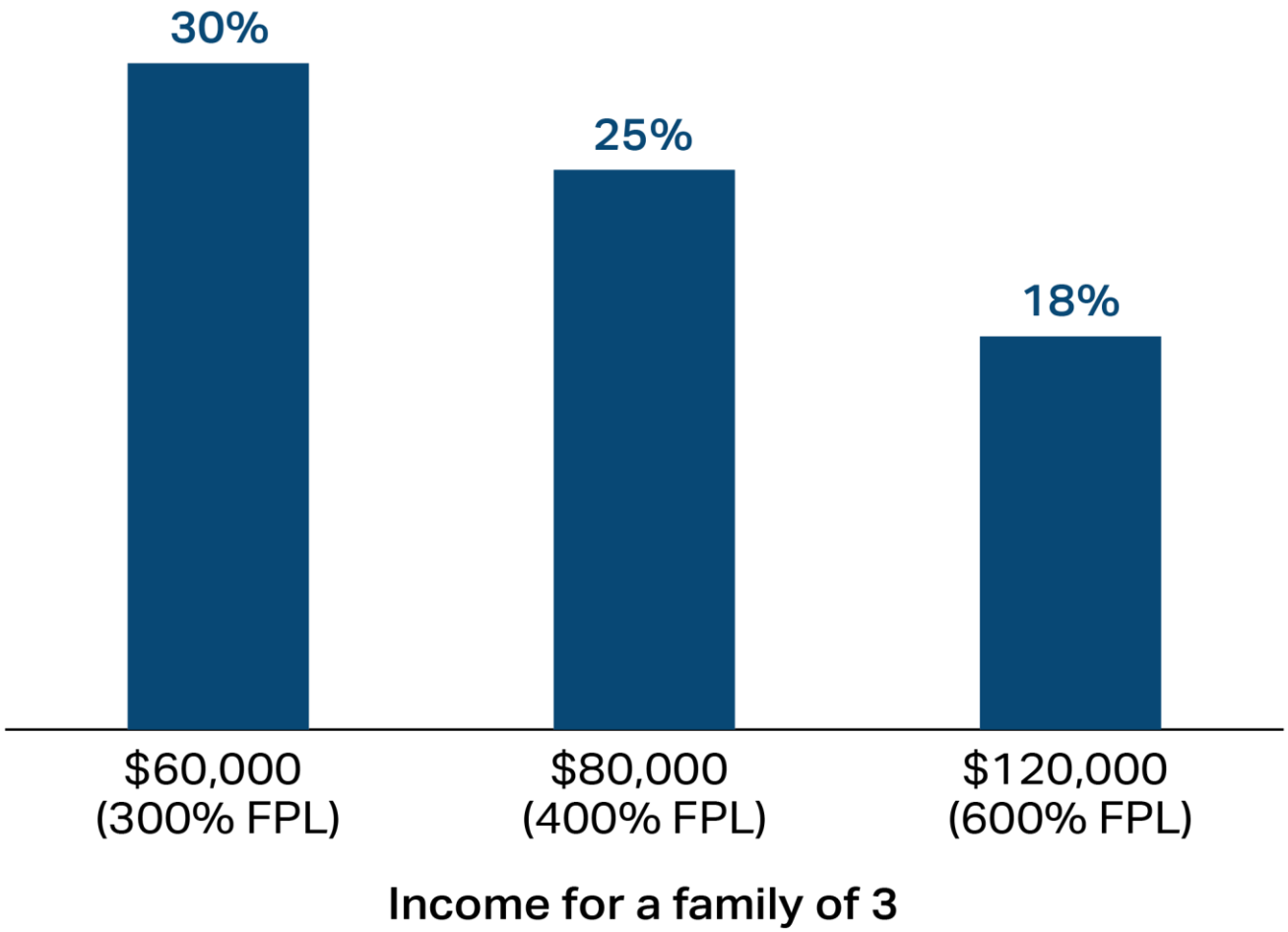


Notes: Spending includes only out-of-pocket spending within insurance benefits (e.g. copays and deductibles) and is conditional on having non-zero spending. Lowest income areas represent the quartile of zip codes in the state with the lowest household median income. Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care. Data do not include spending outside of health insurance such as dental care, over-the-counter medications, or privately-paid mental health visits.
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2014

HPC

Massachusetts residents with low to middle incomes face a high burden of healthcare costs relative to income

Total healthcare spending relative to income for a family with employer-based coverage, 2015

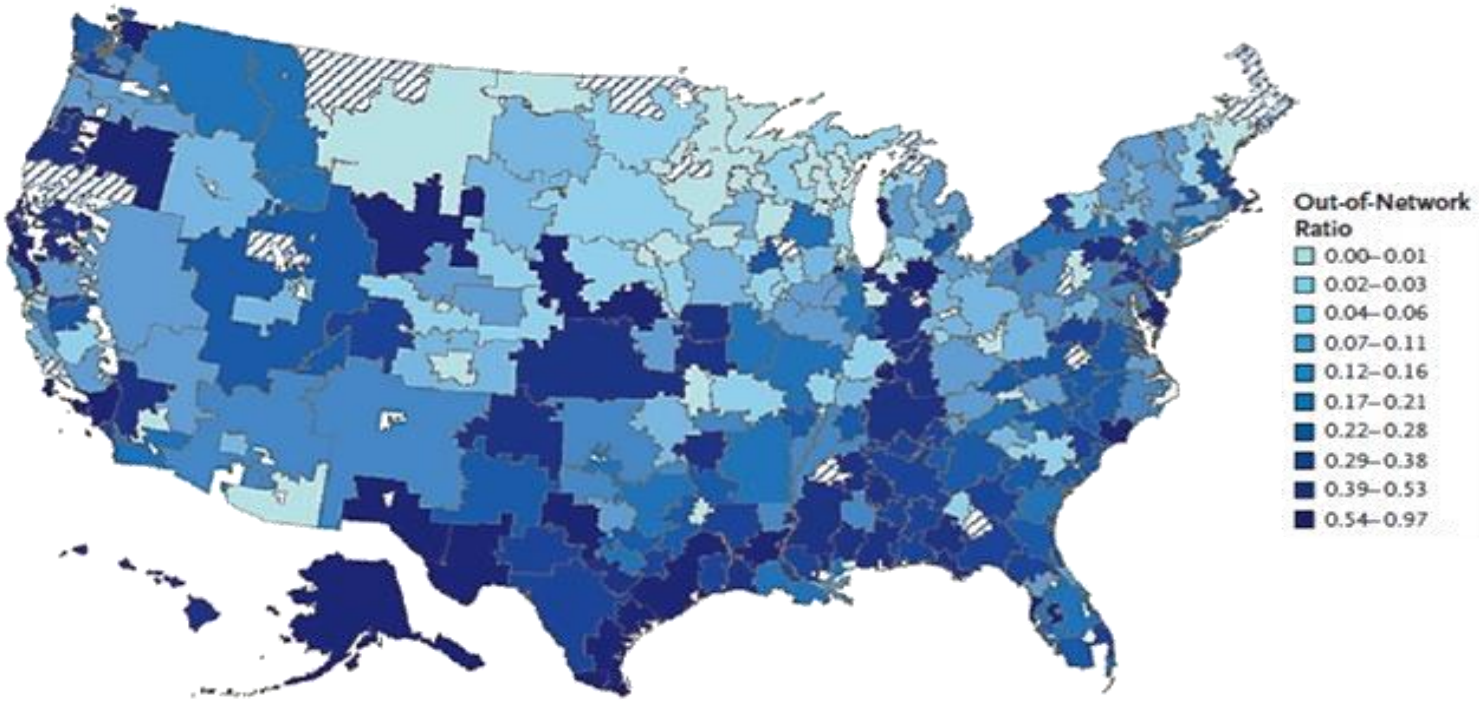


Note: FPL= federal poverty level. Calculation assigns premium (including employer and employee contribution) for lowest-wage quartile employers (from private health insurance premium slide) to the 200% FPL family, the second highest-quartile to the 400% FPL family and the highest-quartile premium to the 600% FPL family. Cost sharing is assigned as a fixed proportion of the total premium using total cost sharing as reported by the Center for Health Information and Analysis. Calculations do not account for tax deductibility of employer-sponsored health insurance premiums or spending on health care outside of covered benefits.
Source: HPC analysis of Agency for Healthcare Research and Quality Medical Expenditure Panel Survey, 2015

HPC

Out-of-network charges can also burden patients and impact spending

Proportion of ED visits at in-network facilities that involved out-of-network physicians



- A 2016 study published in the *New England Journal of Medicine* showed that of ED visits at in-network hospitals, **22%** involved out-of-network physicians
  - Eastern MA was above the national average while the Worcester area was below
- Out-of-network emergency physicians charged an average of **798%** of Medicare rates
- These costs are borne by both patients and insurers
- Massachusetts policy makers are exploring the topic of out-of-network billing

Notes: ED= emergency department. A recent MassHealth policy change caps Managed Care Organization (MCO) reimbursements for out-of-network non-emergency services at 100% of MassHealth fee-for-service rates. The Special Commission on Provider Price Variation is considering out-of-network billing issues in the scope of its ongoing work, which could result in policy action.

Source: Zack Cooper & Fiona Scott Morton, Out-of-Network Emergency-Physician Bills – An Unwelcome Surprise, New England Journal of Medicine 375, 1915-18 (2016)

Prescription drug spending

Background

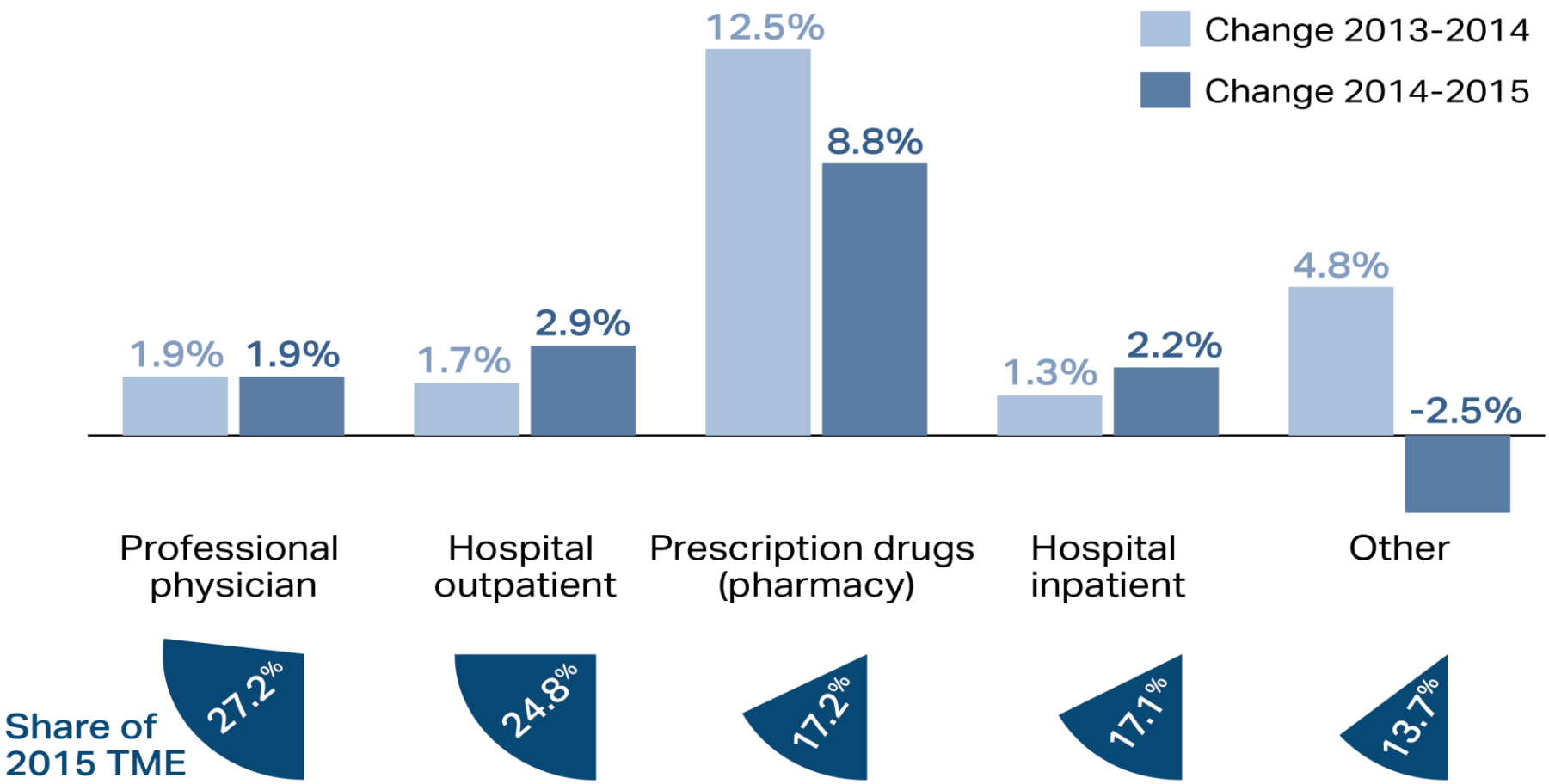
- For the second year in a row, prescription drug spending in Massachusetts exceeded historical growth rates (**10.2%** in 2015 and **13.5%** in 2014)
  - This growth is consistent with national trends
  - The entry of new high-cost drugs, price growth for existing drugs, and a low level of patent expirations remained the largest contributors to drug spending growth in 2015
- Commercial prescription drug spending grew **8.8%** per capita in 2015, down from **12.5%** in 2014
- The estimates above do not factor rebates, which affect both level and trend
  - AGO reports that commercial* per capita prescription drug spending growth in 2015 was two percentage points lower net of rebates: from **8.2%** to **6.1%**
- Even including rebates, growth in prescription drug spending exceeded spending growth in all other commercial categories of service

*Note: Analysis only includes five Massachusetts health plans.

Source: Office of the Attorney General. Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 12C, § 17. Boston (MA) : Office of the Attorney General; 2016 October 7

Among major spending categories, prescription drugs have the highest growth rate

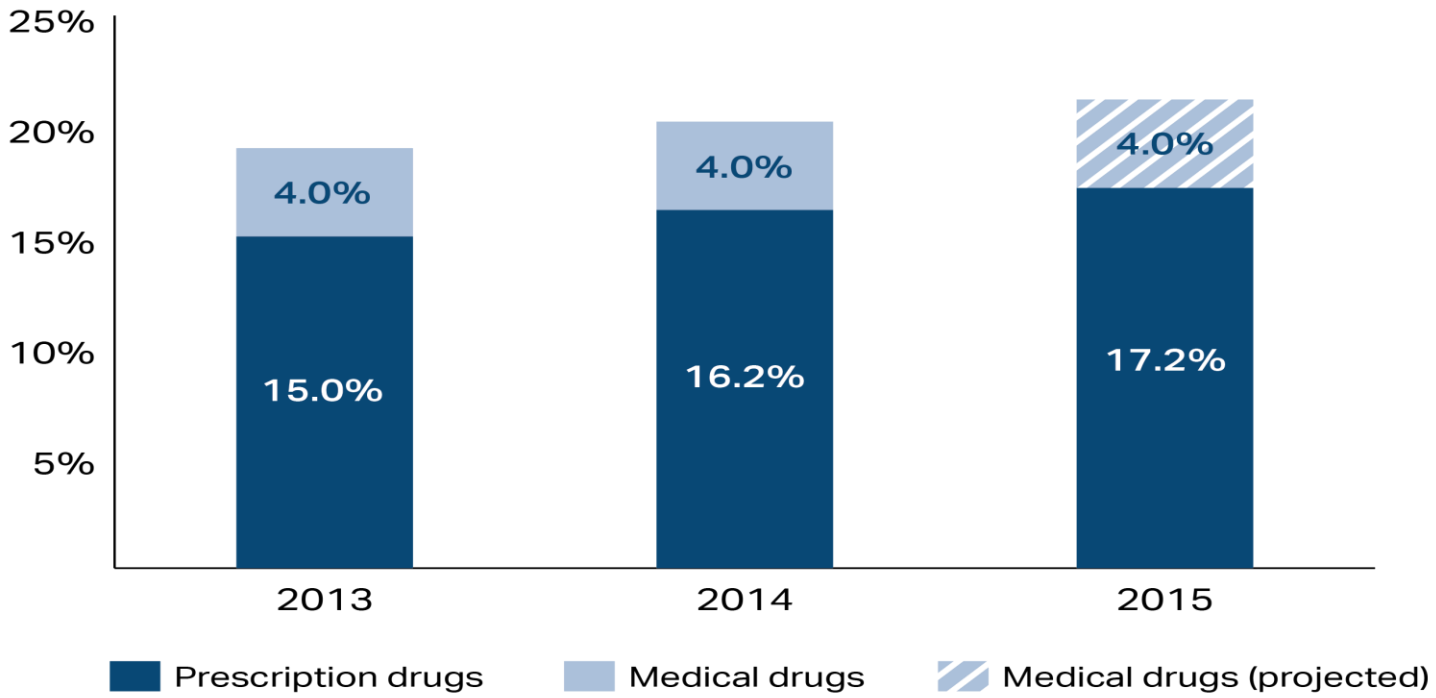
Growth in commercial spending categories and proportion of total TME, 2013-2015



Note: TME= total medical expenses. Prescription drug figures exclude impact of rebates.
Source: HPC analysis of Center for Health Information and Analysis 2016 Annual Report TME Databook

Medical and prescription drug spending combined comprise over 20% of commercial health spending in Massachusetts

Percent of commercial healthcare spending, by drug benefit type, 2013-2015



- Medical drugs are administered by providers (e.g. chemotherapeutic agents, flu vaccine)
- Medical drug spending grew **4%** per capita from 2013 to 2014, with ~ **6%** annual per capita growth from 2011 to 2014
- Combined medical and prescription drug spending represents a growing share of total health spending

Note: 2015 medical drug spending data is estimated based on 2013 and 2014 share of spending. Figures exclude impact of rebates.

Source: HPC analysis of Massachusetts All-Payer Claims Database, 2012-2014 (medical drug spending) and Center for Health Information and Analysis Annual Report TME Databooks (prescription drug spending)

From 2012-2014, total drug spending increased while average cost sharing declined

Average spending and cost sharing for generic and branded drugs, per member per year, 2012-2014

	Generic dugs		Branded drugs	
	Average spending (PMPY)	Average cost sharing (PMPY)	Average spending (PMPY)	Average cost sharing (PMPY)
2012	$349	$126	$829	$93
	+10%	-6%	+23%	-13%
2013	$353	$118	$853	$85
2014	$384	$117	$1,018	$81

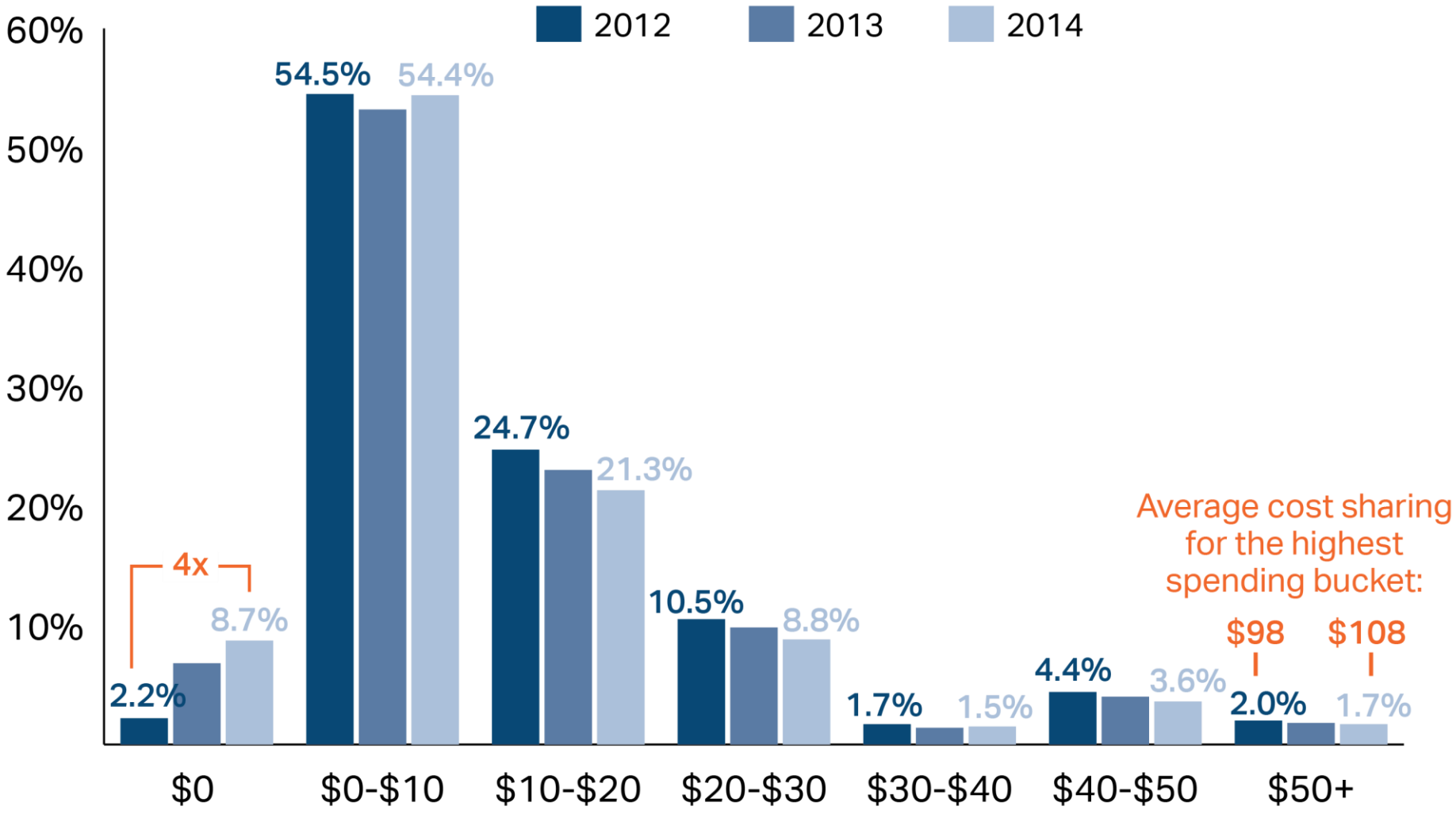
During this time period, the Affordable Care Act (ACA) prohibited payers from imposing patient cost sharing – copayments or coinsurance – on many preventative drugs

Notes: PMPY= per member per year. Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care who use the prescription drug benefit at least once in the calendar year. Figures exclude impact of rebates.

Source: HPC analysis of Massachusetts All-Payer Claims Database, 2012-2014

From 2012-2014, the proportion of drugs with no cost sharing increased

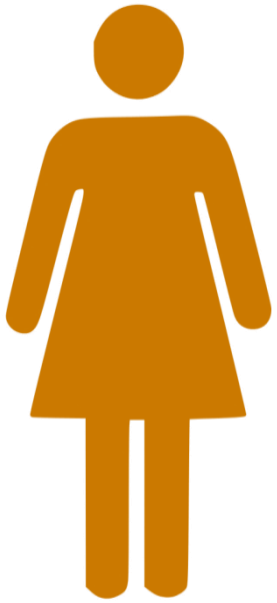
Percent of claims, by cost sharing amount, 2012-2014



Notes: Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care. Includes only commercial users of the pharmacy drug benefit. Figures exclude impact of rebates.

Source: HPC analysis of Massachusetts All-Payer Claims Database, 2012-2014

From 2012-2014, cost sharing on prescription drugs decreased substantially for women, due in large part due to the ACA



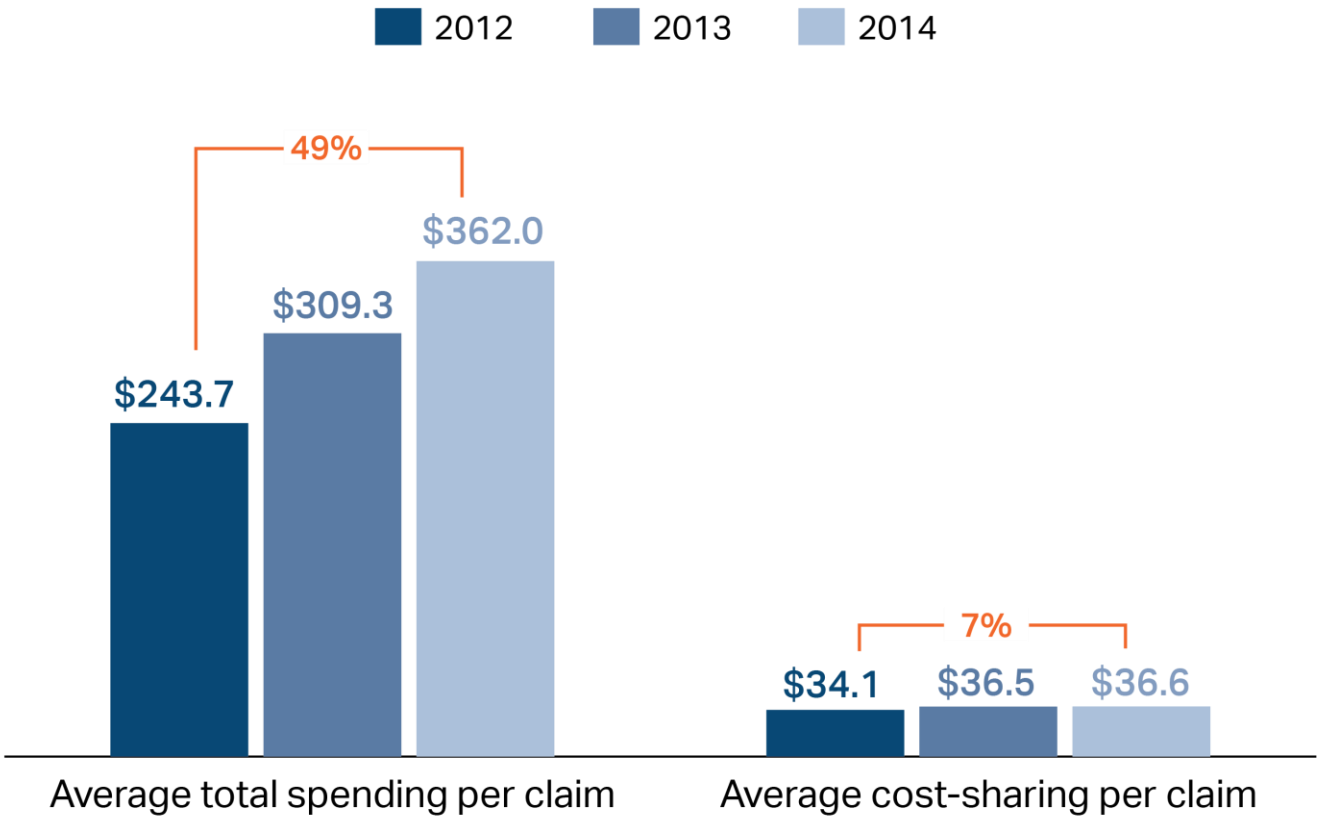
Year	Women	Men
	Percent of claims with $0 cost sharing	Percent of claims with $0 cost sharing
2012	3.2%	0.9%
2013	10.7%	1.6%
2014	13.4%	2.4%

- Many contraceptive methods are included under the ACA's mandatory coverage
- Average annual cost sharing particularly dropped for women from 2012 to 2014 – a **14%** decline ($205 to $176) versus a **4%** decline for men ($202 to $193)

Notes: PMPY= per member per year. Data include privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care who use the prescription drug benefit at least once in the calendar year. Figures exclude impact of rebates.
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2012-2014

From 2012-2014, EpiPen prices increased rapidly, though generally without an impact on cost sharing

Average spending and cost sharing on Mylan's EpiPen, per claim, 2012-2014



However, in 2014 a small portion of the Massachusetts commercial population paid most or all of EpiPen's cost out-of-pocket – **2.9%** paid more than $100 and **1.3%** paid more than $300

Notes: Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care who use the prescription drug benefit at least once in the calendar year. Figures exclude impact of rebates.

Source: HPC analysis of Massachusetts All-Payer Claims Database, 2012-2014

Select findings from the 2016 Cost Trends Report

Themes

Spending and the delivery system

Opportunities to improve quality & efficiency

Progress in aligning incentives

Avoidable hospital utilization

Post-acute care

Variation in spending by PCP group

HPC

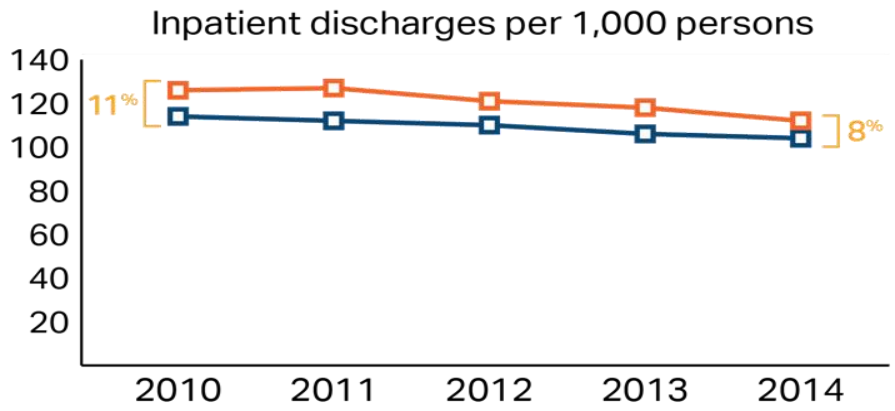
Background

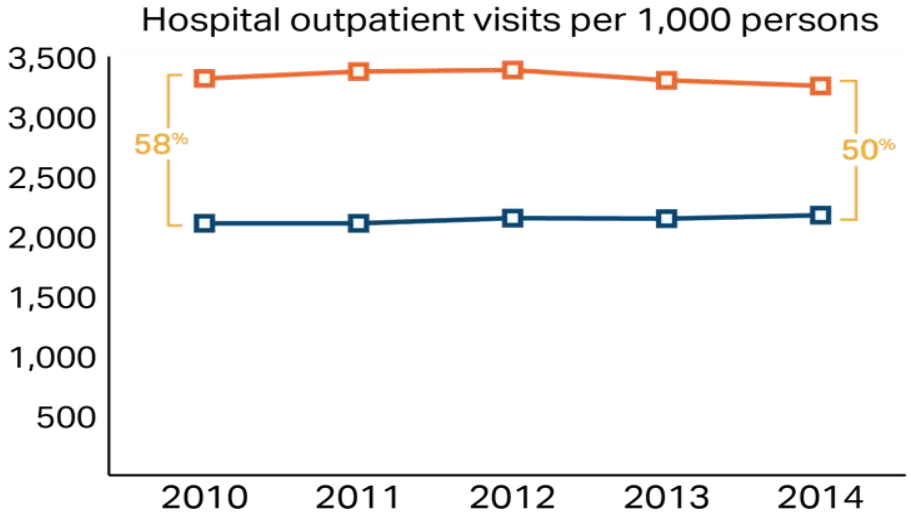
- Hospital and PAC use in Massachusetts continues be higher than the nation overall
- Compared to the U.S. average, in 2015 Medicare spent **19%** more on inpatient hospital services, **24%** more on outpatient hospital services, and **18%** more on PAC* for Massachusetts enrollees
- The HPC has previously identified opportunities to improve quality and enhance efficiency in this category (e.g. reducing readmissions, avoidable ED visits)

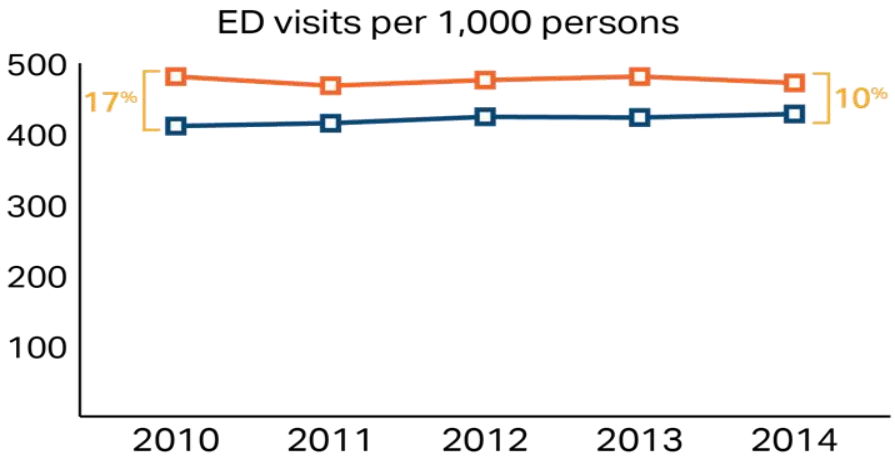
*Note: Includes home health and skilled nursing facilities.

Hospital use in Massachusetts remains higher than national averages

Hospital use in MA and U.S., per 1,000 population, 2010-2014



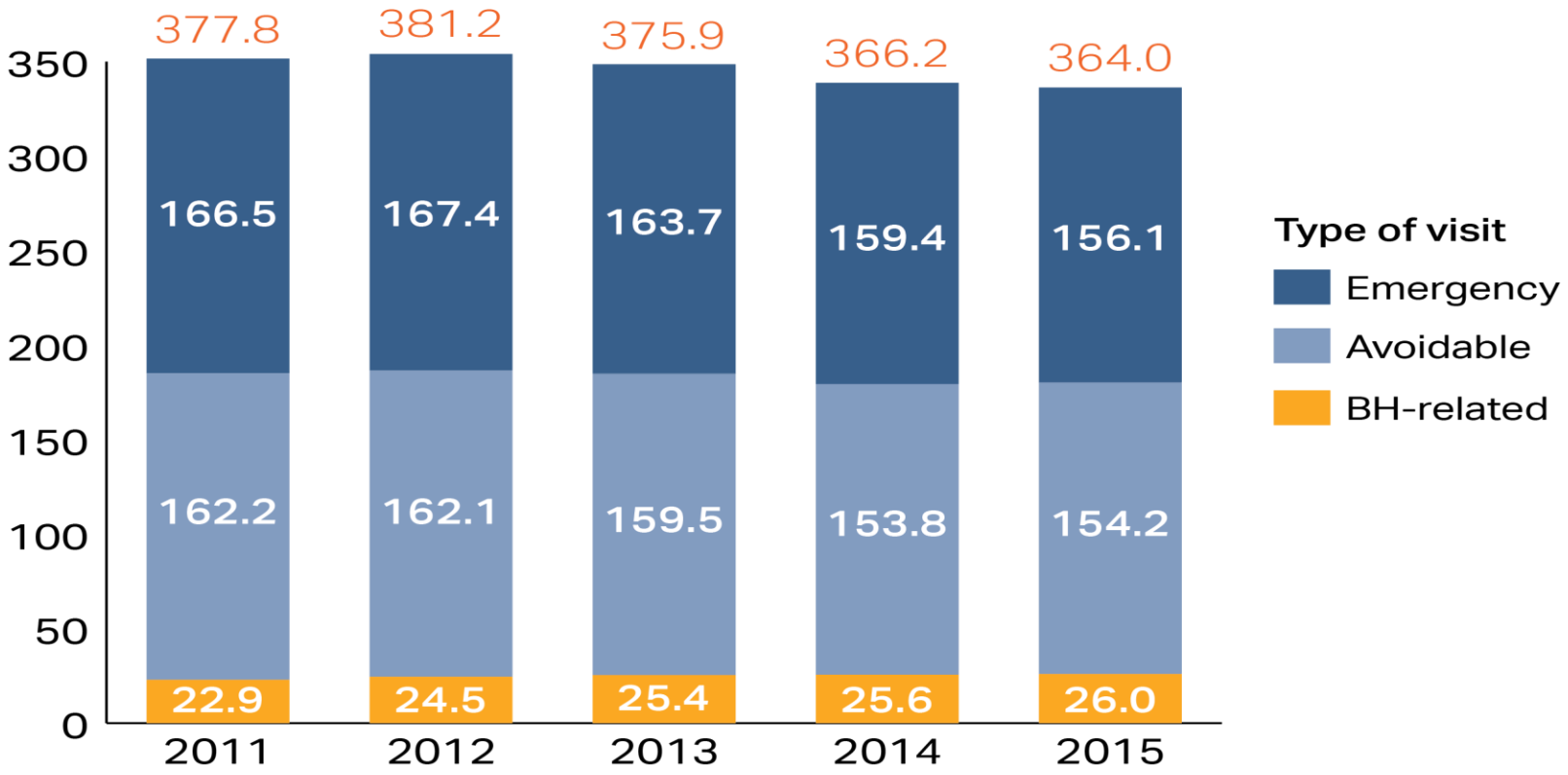




Note: ED= emergency department.
Source: Kaiser Family Foundation analysis of American Hospital Association data, 2010-2014

While ED visits have declined overall, behavioral health-related visits have increased steadily

ED visits by category, per 1,000 population, 2011-2015



The growth in BH-related ED visits was in part due to increases in opioid-related ED visits, which grew **87%** from 2011 to 2015

Notes: ED= emergency department; BH= behavioral health. Definition of ED categories based on NYU Billings Algorithm categorization of a patient's primary diagnosis and are mutually exclusive. BH ED visits includes any discharge with a primary mental health, substance use disorder, or alcohol-related diagnosis code. Emergency visits include the Billings categories of emergency and emergent, ED care preventable; avoidable visits include the Billings categories of non-emergent and emergent, primary care treatable. One category, unclassified visits, also grew during this time period, but is not shown here. Some non-Massachusetts residents are included in the number of ED visits. In 2015, 4% of all ED visits in Massachusetts were made by non-Massachusetts residents.
Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2015

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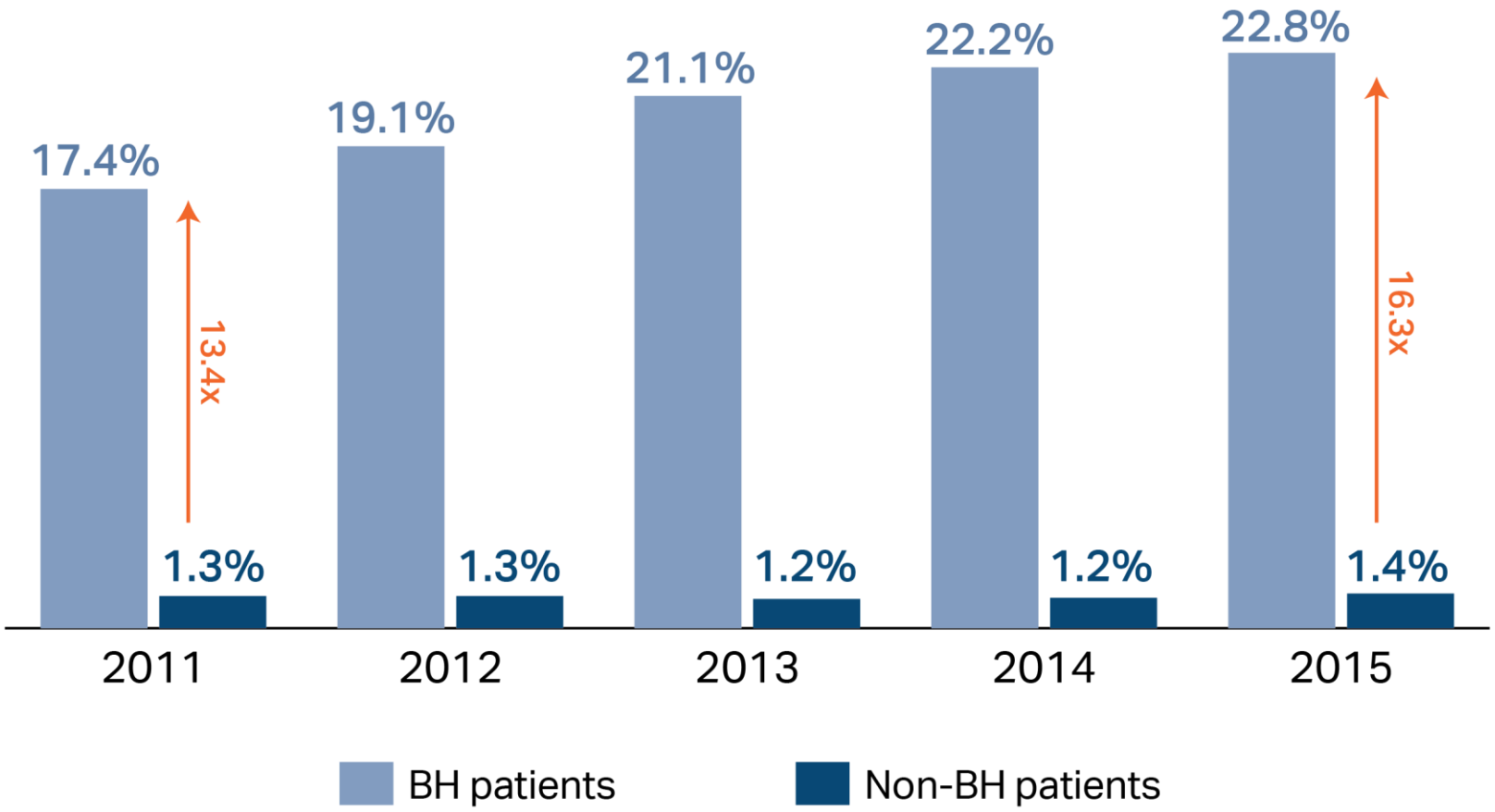
Behavioral health patients are increasingly more likely to have an extended length of stay in the ED

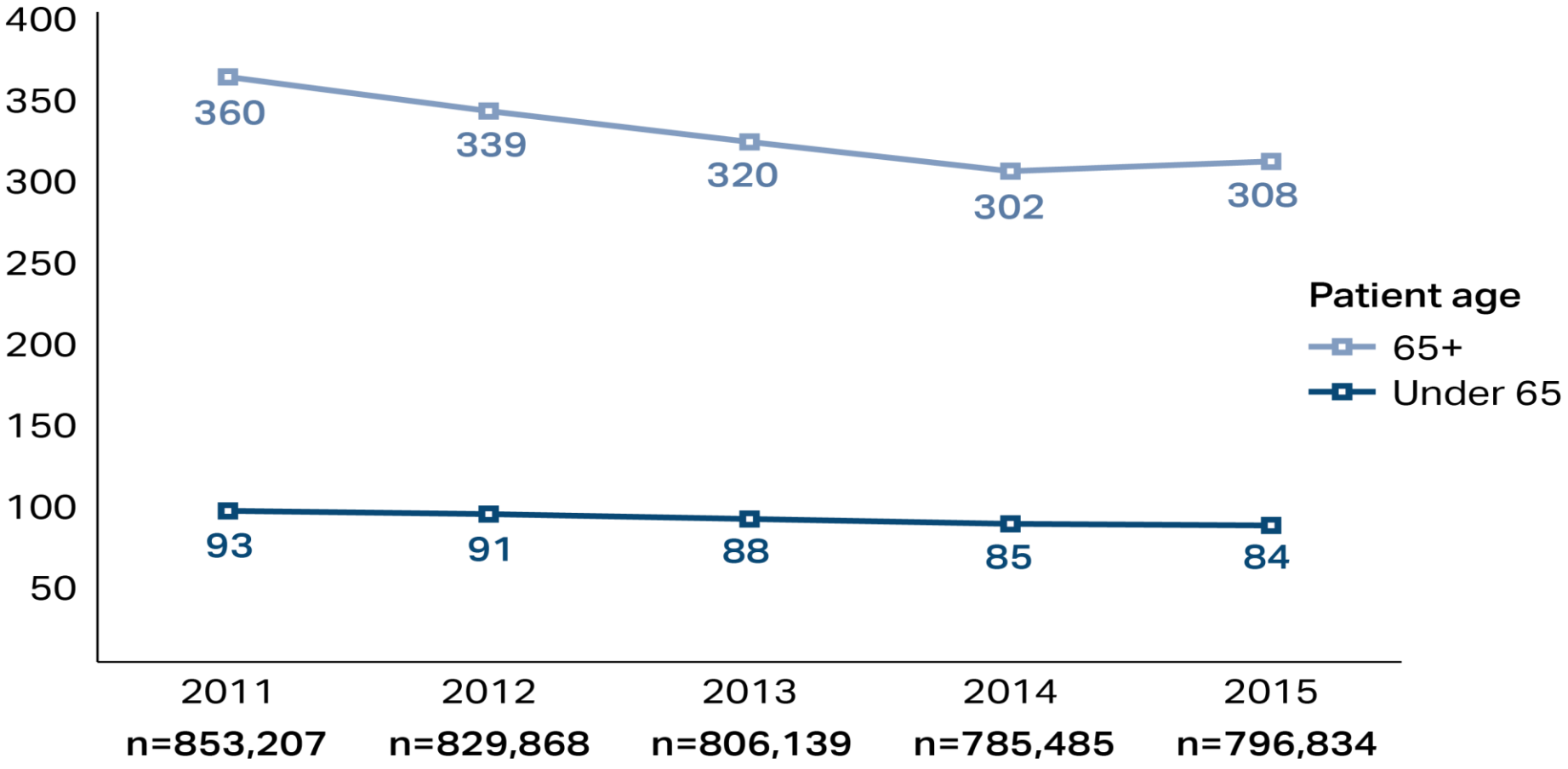
Percent of ED visits with a length of stay of more than 12 hours, by primary diagnosis type, 2011-2015



Notes: ED= emergency department; BH=behavioral health. BH ED visits identified using NYU Billings algorithm and include any discharge with a primary mental health, substance abuse, or alcohol-related diagnosis code. Length of stay is calculated as the difference between the point of registration and the point of admission or discharge.
Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2015

After three years of annual declines of over 20,000, inpatient admissions increased in 2015, driven by patients 65 and over

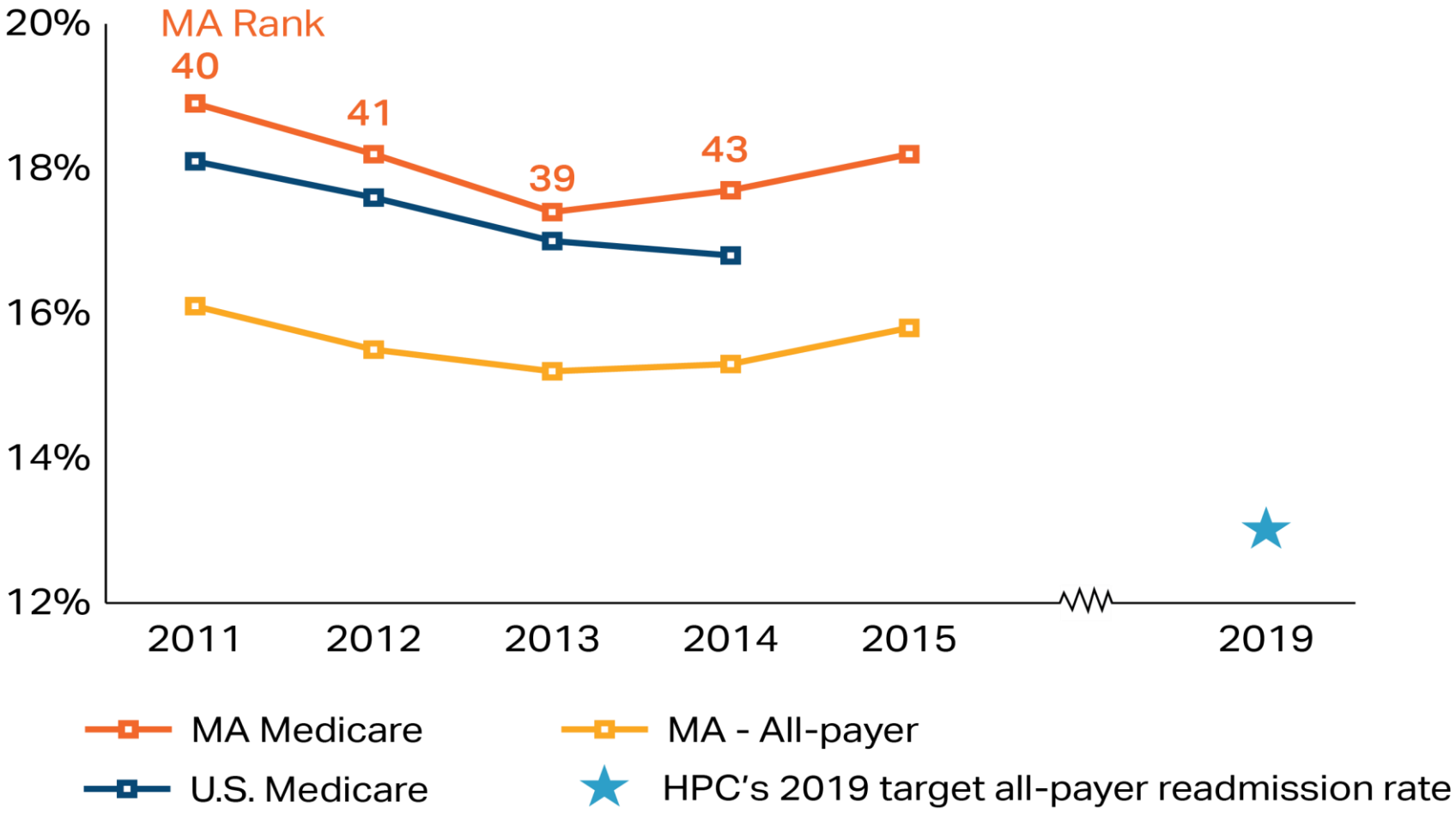
Inpatient admissions per 1,000 population, by age category, 2011-2015



Notes: Some non-Massachusetts residents are captured in the Massachusetts admissions. In 2015, non-Massachusetts residents represented 5% of all inpatient admissions.
Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2011-2015

Massachusetts hospital readmissions began increasing in 2014 after a sustained decline

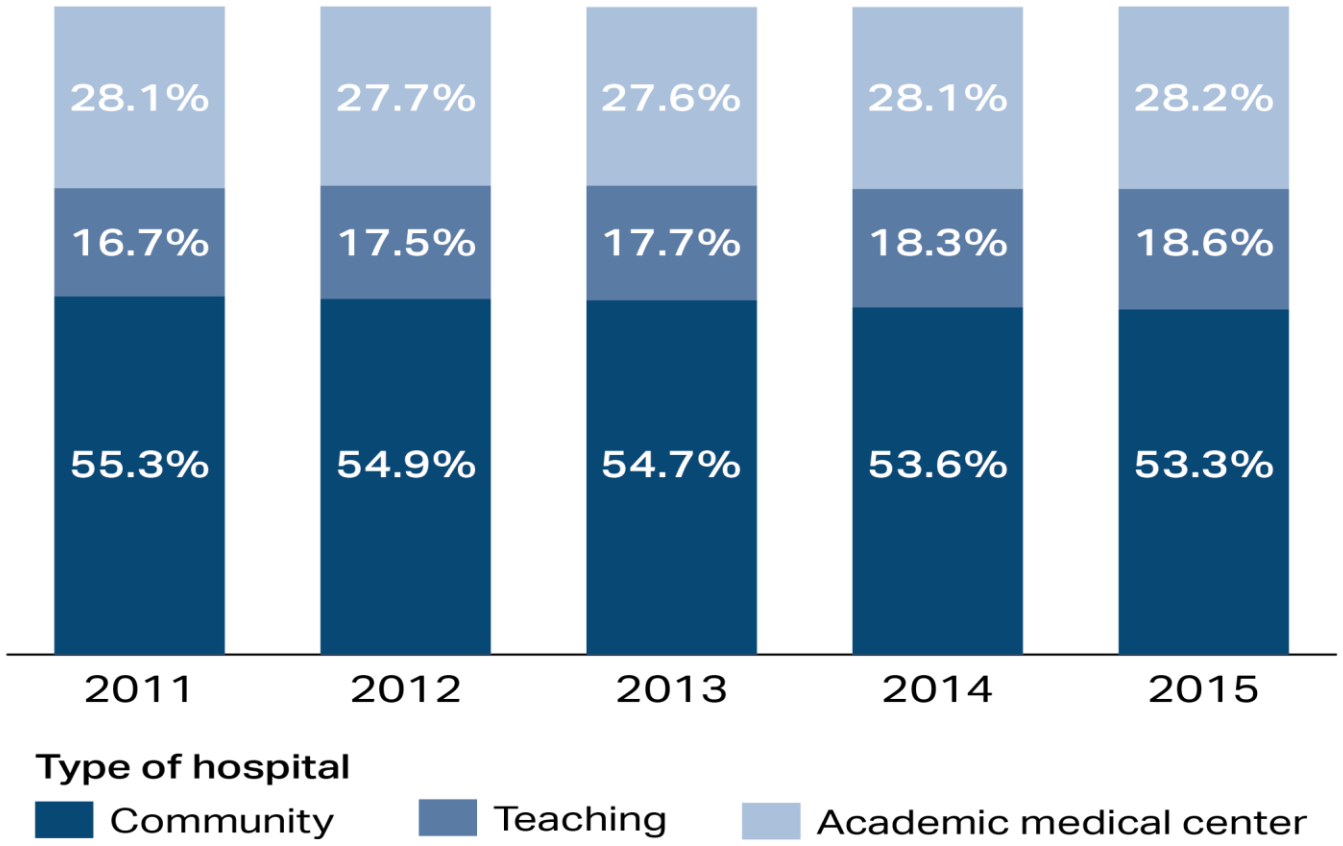
Thirty-day readmission rate, by payer, MA and the U.S., 2011-2014



Sources: Centers for Medicare and Medicaid Services (U.S. Medicare and MA Medicare 2011-2013); Center for Health Information and Analysis (all-payer and MA Medicare 2014-2015)

Inpatient care that could safely and effectively be provided in community hospitals is increasingly being provided by teaching hospitals

Share of community appropriate discharges, by hospital type, 2011-2015



Notes: Discharges that could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs). The Center for Health Information and Analysis (CHIA) defines community hospitals as general acute care hospitals that do not support large teaching and research programs. Teaching hospitals are defined as hospitals that report at least 25 full-time equivalent medical school residents per one hundred inpatient beds in accordance with Medicare Payment Advisory Commission (MedPAC) guidelines. Academic medical centers are a subset of teaching hospitals characterized by (1) extensive research and teaching programs, (2) extensive resources for tertiary and quaternary care, (3) principal teaching hospitals for their respective medical schools, and (4) full service hospitals with case mix intensity greater than 5 percent above the statewide average.
Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2011-2015

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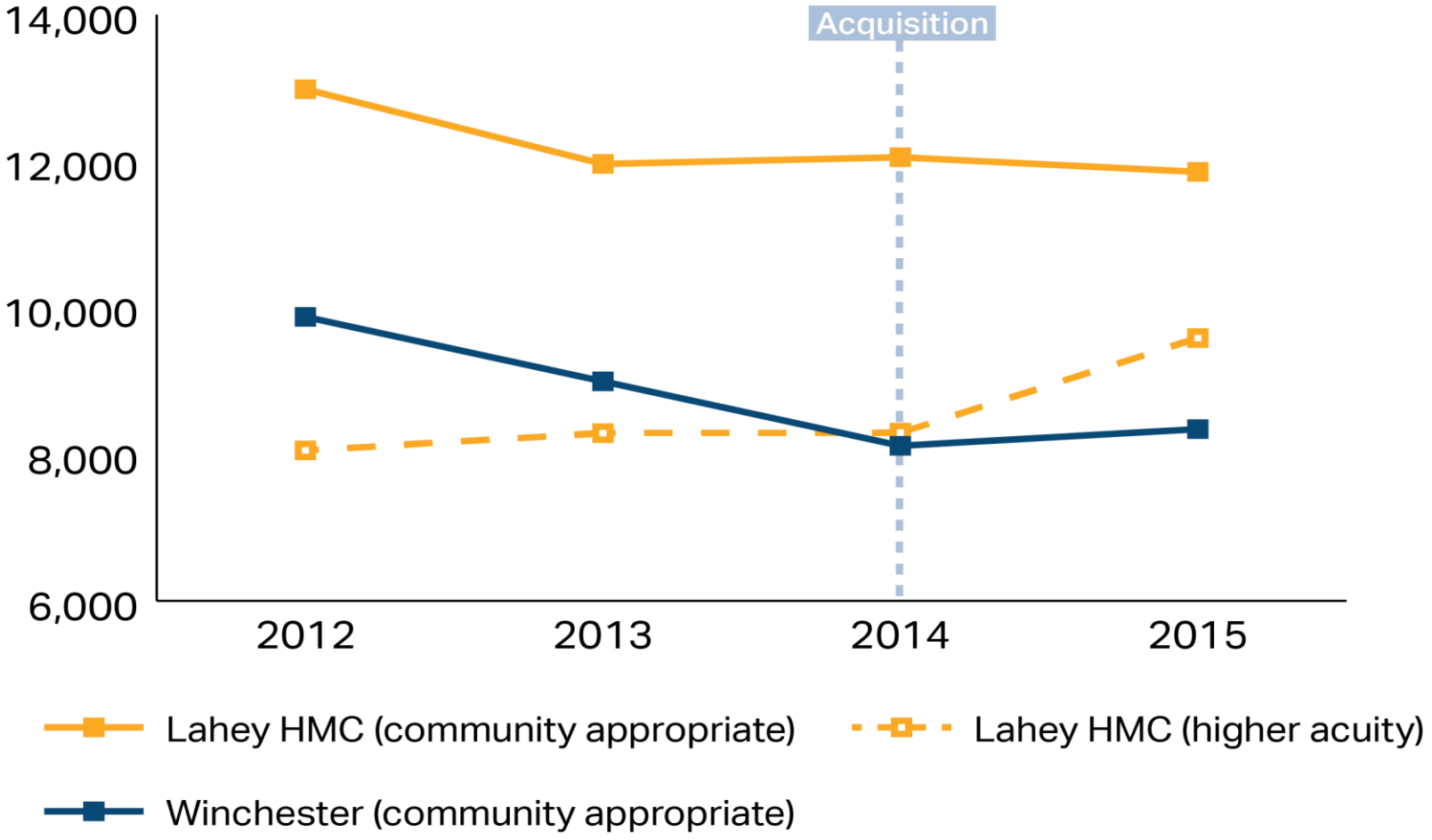
However, following Lahey's acquisition of Winchester (a community hospital) in 2014, community appropriate discharges increased at Winchester and decreased at Lahey Medical Center (a teaching hospital)

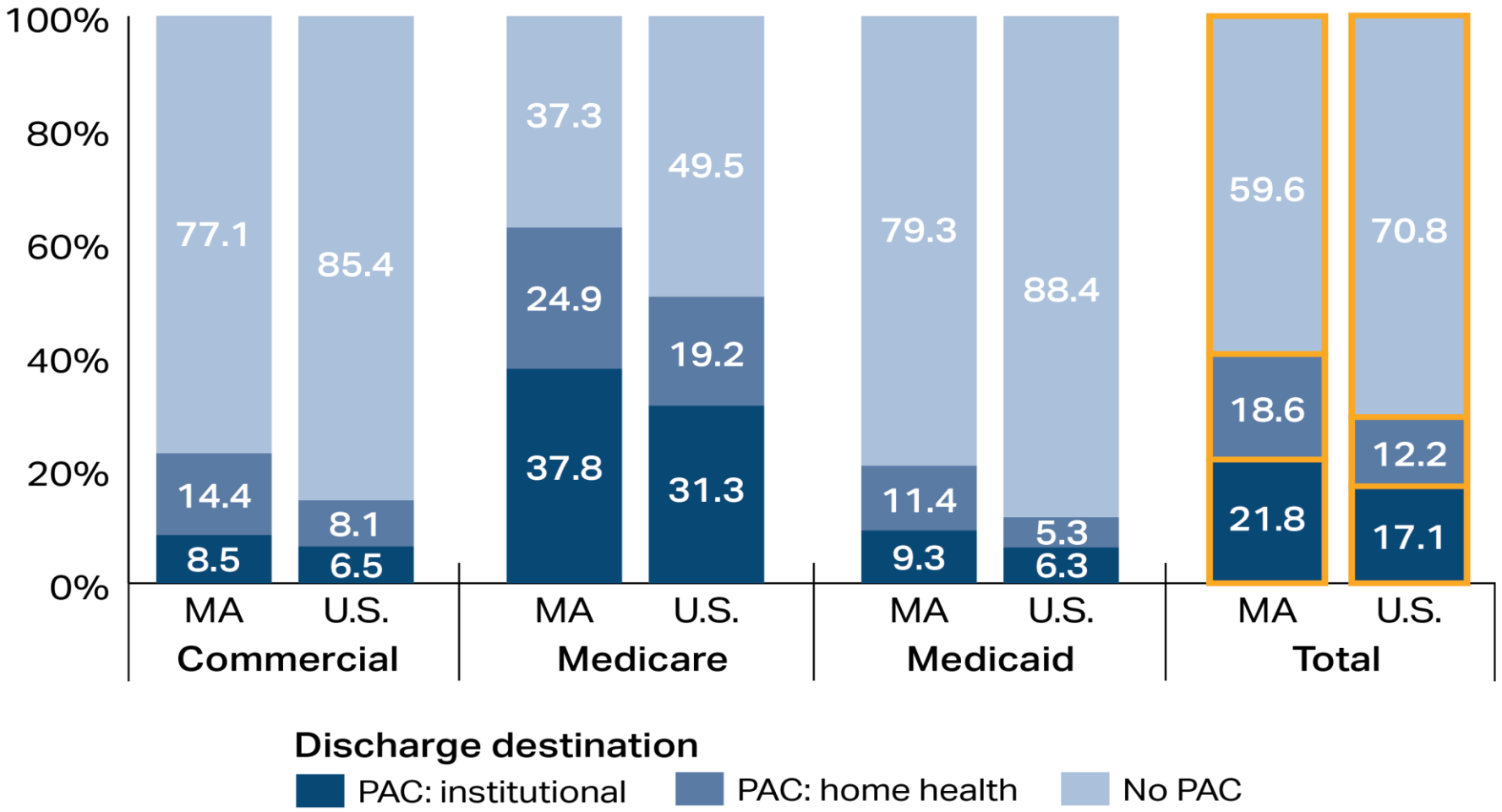
Discharges at Lahey and Winchester hospitals, by type, 2012-2015



Notes: Discharges that could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs). All other discharges are classified as "higher acuity" for the purposes of this analysis.
Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2012-2015

Massachusetts has a higher rate of discharge to institutional PAC than the U.S. average

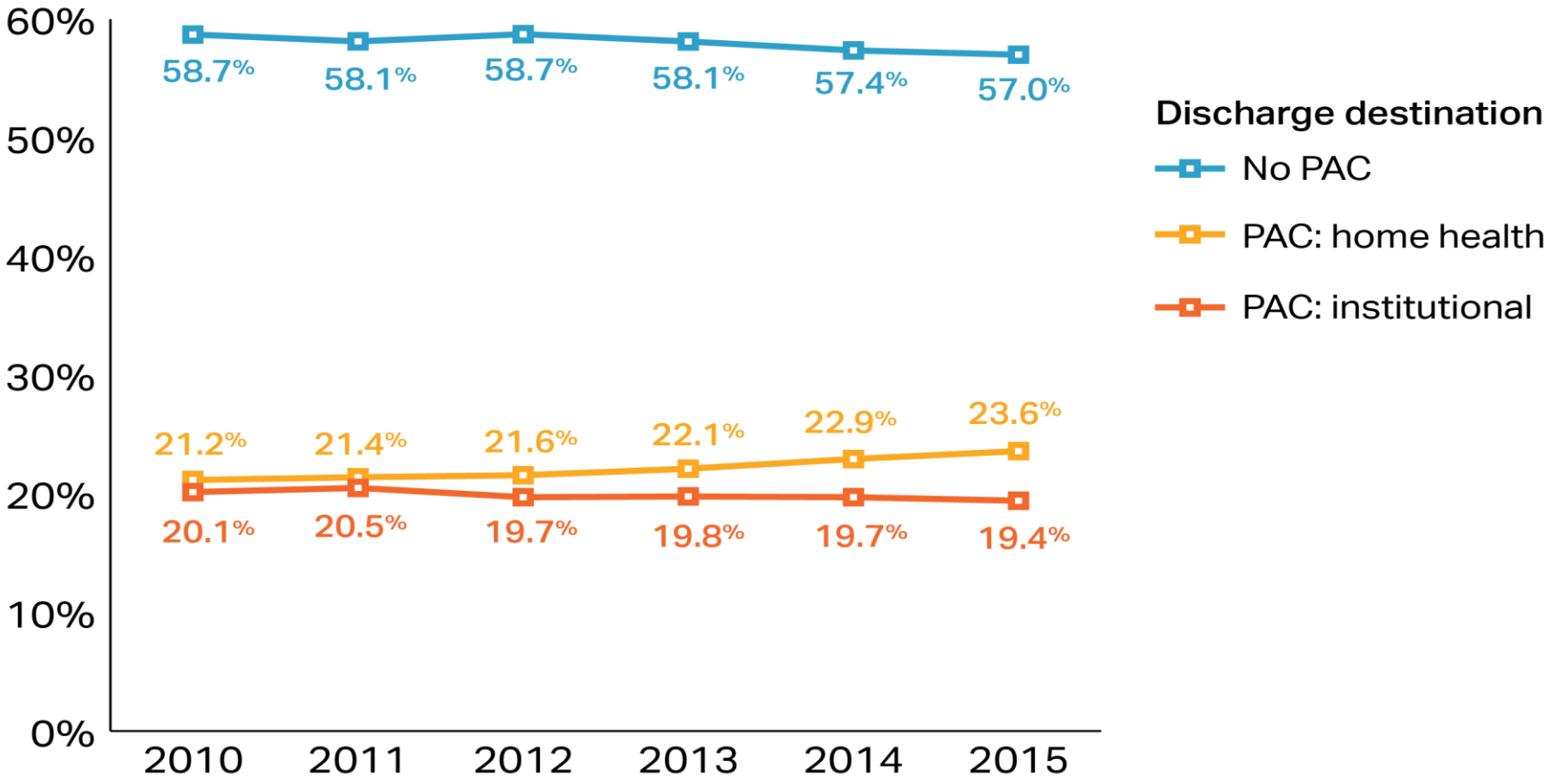
Discharge destination following an inpatient admission, by payer, 2013



Notes: PAC=post-acute care. Institutional includes skilled nursing facilities, short-term hospitals, intermediate care facilities (ICF), and another type of facility.
Sources: HPC analysis of Healthcare Cost and Utilization Project (HCUP) Massachusetts State Inpatient Database & Nationwide Inpatient Sample Survey, 2013

Since 2010, home health PAC use is increasing, while institutional PAC use remains fairly constant

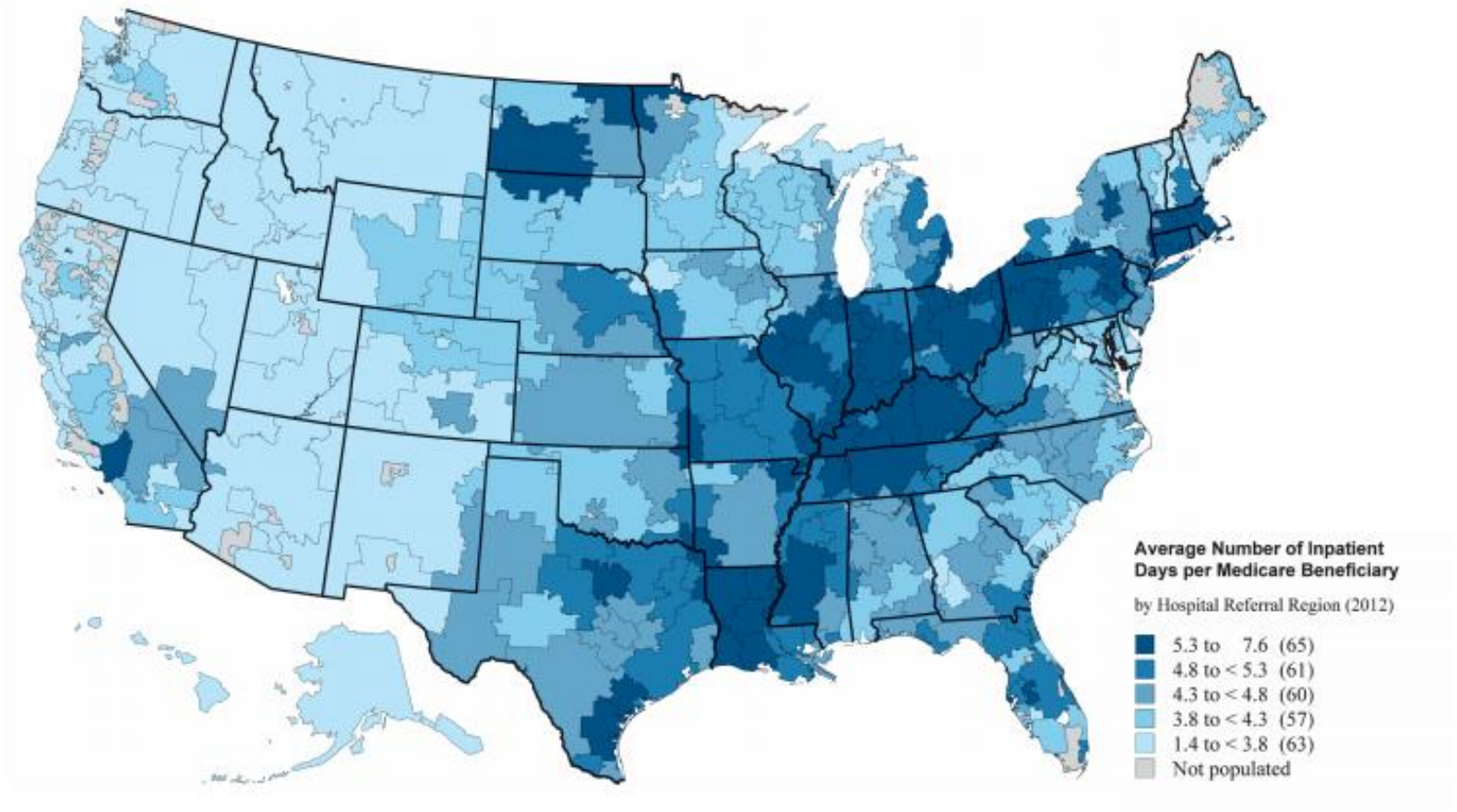
Discharge destination following an inpatient admission, adjusted for DRG mix, 2010-2015



Notes: PAC= post-acute care. Data include adult patients who were discharged to routine care or some form of PAC. Discharges from hospitals that closed and specialty hospitals, except New England Baptist, were excluded. Discharges from UMass Memorial, Cape Cod, Marlborough, Clinton and Falmouth hospitals were excluded due to coding irregularities in the database. Institutional PAC settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Adjusted using ordinary least squares (OLS) regression to control for changes in mix of diagnosis-related groups (DRGs) over time.
Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2010-2015

Medicare beneficiaries in Massachusetts spend more time in hospitals and skilled nursing facilities (SNFs) than in most regions of the country

Combined inpatient hospital and SNF days, per Medicare beneficiary, 2012



Notes: SNF= skilled nursing facility. Inpatient days= SNF days + hospital inpatient days.
Source: Dartmouth Atlas, 2012

Variation in spending by primary care provider (PCP) group

Background

- Massachusetts has higher commercial spending per enrollee compared to the U.S. average, particularly on physician services and outpatient care[1]
- HPC assessed two measures of spending by primary care provider (PCP) group: total medical expenses (TME) and non-recommended care

Total medical expenses

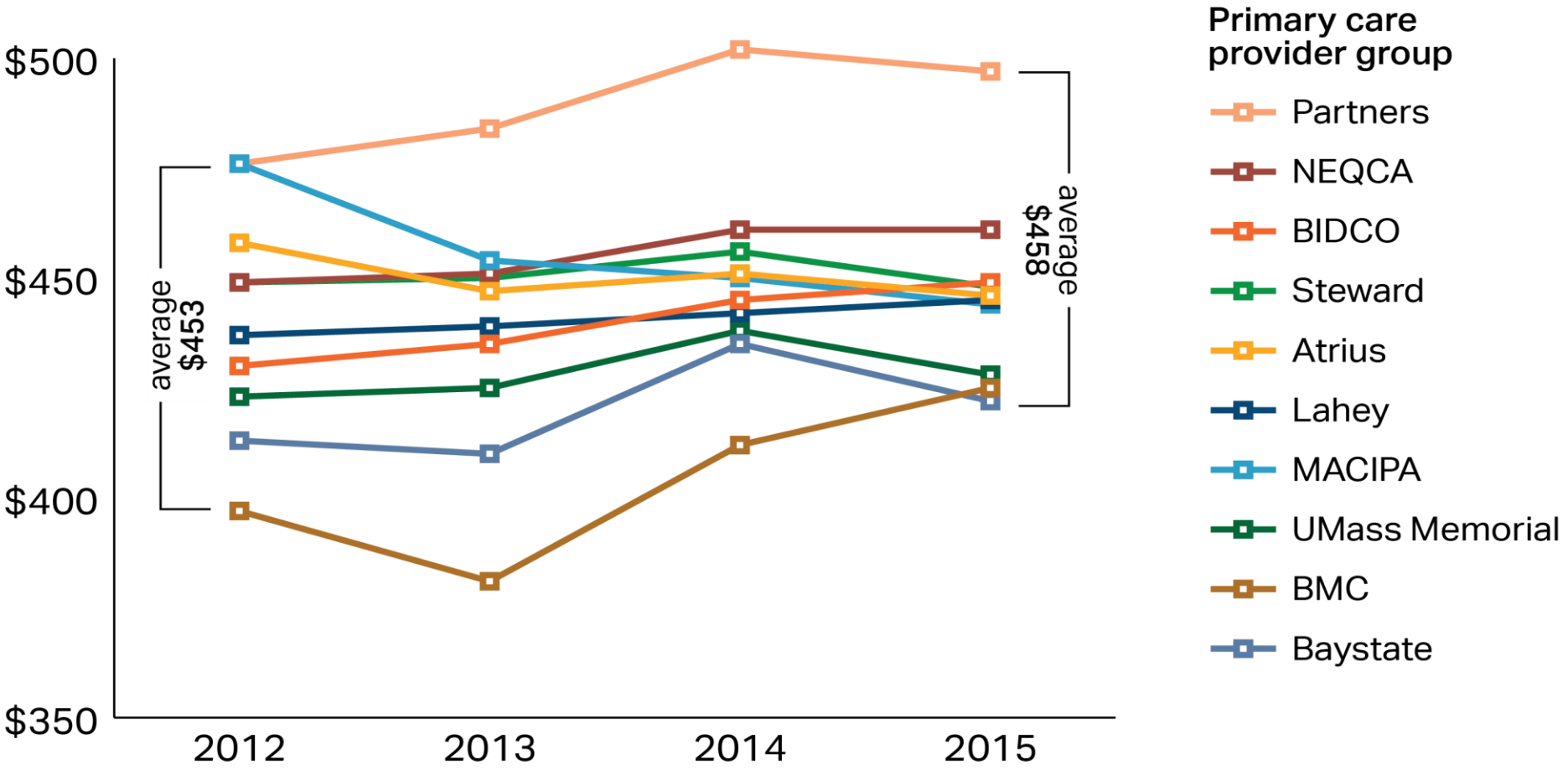
- TME includes all medical care spending for patients with an assigned PCP for enrollees in HMO and POS products
- Comparing TME across provider groups allows for comparison of resources used to care for comparable (health status adjusted) patients and reflects differences in both practice patterns and prices
- Comparisons can help inform supply-side (e.g. APMs) and demand-side (e.g. premium differentials by PCP group) incentives that are based on TME

Notes: Includes TME only for members of Blue Cross Blue Shield of MA, Tufts Health Plan and Harvard Pilgrim Health Care. HMO= health maintenance organization, POS= point of service, APM= alternative payment methods

Source: [1]Milliman, Inc., 2014

TME by PCP group has converged somewhat over time, with the exception of Partners

Blended health status adjusted TME, per member per month, 2012-2015

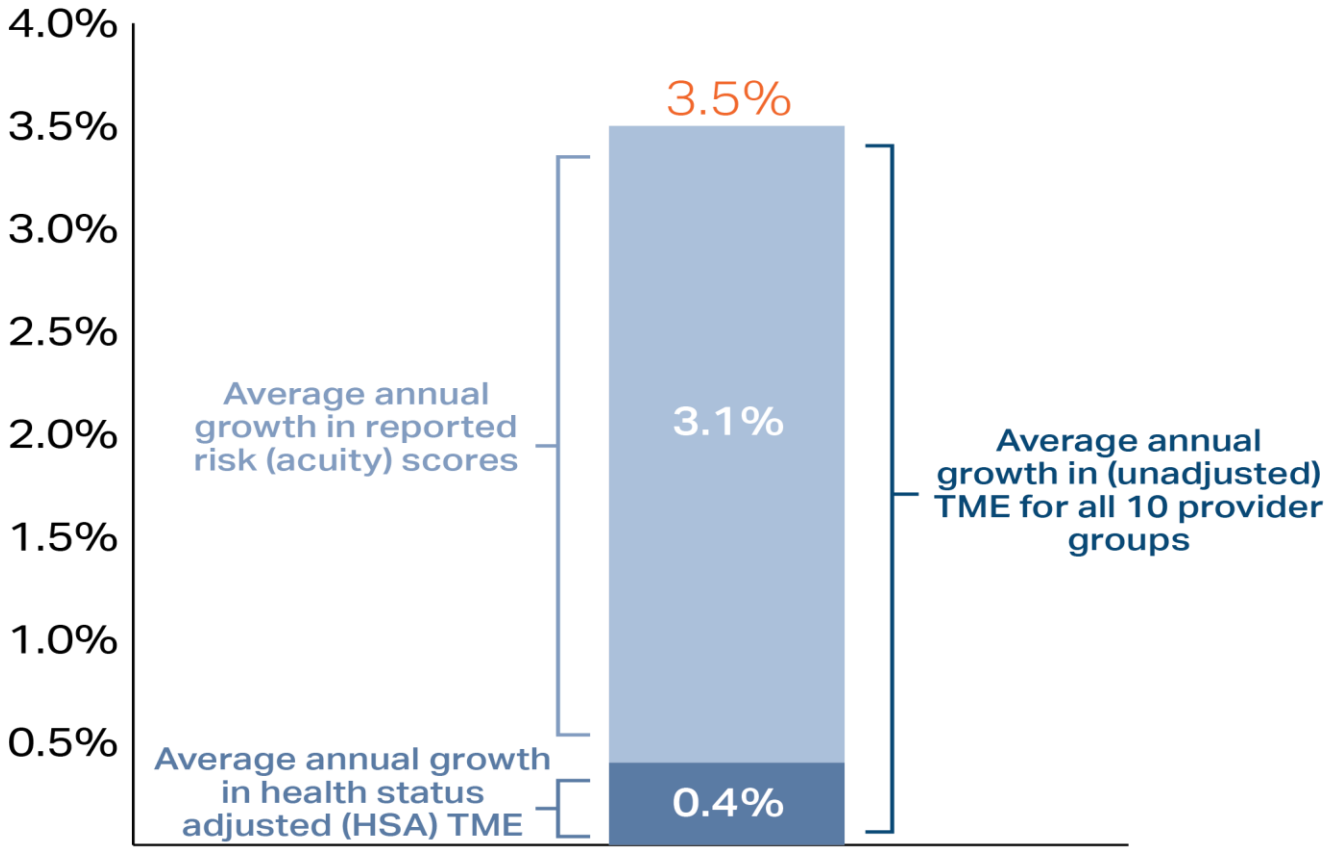


Notes: TME= total medical expenses, Blended TME is the combined normalized health status adjusted TME weighted across the three largest commercial payers (see Technical Appendix for details). Analysis includes the 10 largest primary care groups as identified by the Center for Health Information and Analysis (CHIA) in terms of member-months: Partners Community Physicians Organization (Partners); New England Quality Care Alliance (NEQCA), a corporate affiliate of Wellforce; Beth Israel Deaconess Care Organization (BIDCO); Steward Health Care Network (Steward); Atrius Health (Atrius); Lahey Clinical Performance Network (Lahey); Mount Auburn Cambridge IPA (MACIPA); UMass Memorial Medical Group (UMass Memorial); Boston Medical Center Management Services (BMC); and Baycare Health Partners (Baycare).

Source: HPC analysis of Center for Health Information and Analysis 2016 Annual Report TME Databook

Reported patient acuity has increased 3% per year; as a result, unadjusted TME growth is substantially higher than health status adjusted TME growth

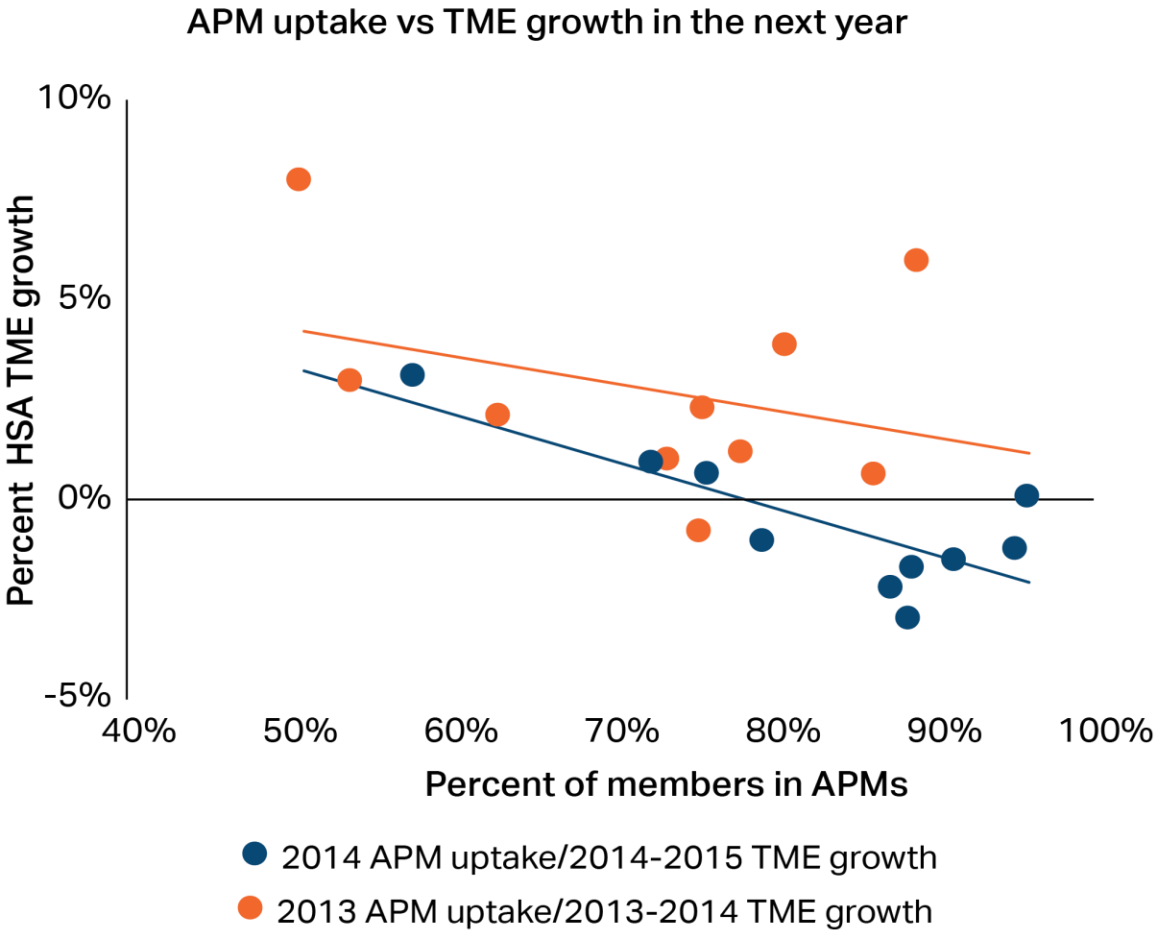
Growth in blended TME, 2012-2015

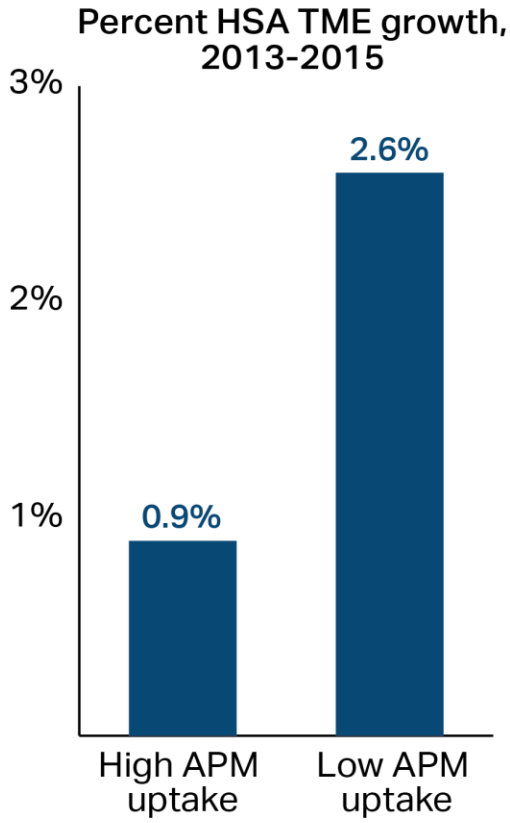


Notes: Blended TME is the combined normalized health status adjusted TME weighted across the three largest commercial payers (see Technical Appendix for details). Analysis includes the 10 largest primary care groups: Partners Community Physicians Organization (Partners); New England Quality Care Alliance (NEQCA), a corporate affiliate of Wellforce; Beth Israel Deaconess Care Organization (BIDCO); Steward Health Care Network (Steward); Atrius Health (Atrius); Lahey Clinical Performance Network (Lahey); Mount Auburn Cambridge IPA (MACIPA); UMass Memorial Medical Group (UMass Memorial); Boston Medical Center Management Services (BMC); and Baycare Health Partners (Baycare).

Source: HPC analysis of Center for Health Information and Analysis 2016 Annual Report TME Databook

High APM uptake has been followed by lower TME growth in the next year





Notes: APM= alternative payment methods. High APM uptake defined as providers with more than 74 percent of their members under APMs. Blended TME is the combined normalized health status adjusted TME weighted across the three largest commercial payers (see Technical Appendix for details). Analysis includes the 10 largest primary care groups: Partners Community Physicians Organization (Partners); New England Quality Care Alliance (NEQCA), a corporate affiliate of Wellforce; Beth Israel Deaconess Care Organization (BIDCO); Steward Health Care Network (Steward); Atrius Health (Atrius); Lahey Clinical Performance Network (Lahey); Mount Auburn Cambridge IPA (MACIPA); UMass Memorial Medical Group (UMass Memorial); Boston Medical Center Management Services (BMC); and Baycare Health Partners (Baycare).

Source: HPC analysis of Center for Health Information and Analysis 2016 Annual Report APM and TME Databooks

Examining non-recommended care as an opportunity for improvement

- This analysis was informed by the Choosing Wisely campaign, in which physician specialty groups defined wasteful or unnecessary screenings, procedures, and tests within their own specialty. Non-recommended care is alternatively referred to as "**low-value care**"

- Previous work has examined practice pattern variation by region and payer, while HPC's analysis also examines measures of utilization by primary care provider group
  - Through combination of the Massachusetts All-Payer Claims Database with the Registry of Provider Organizations dataset

- Methods to measure non-recommended care are based on previous studies care:
  - Rosenthal et. Al, "Choosing Wisely: prevalence and correlates of low-value health care services in the United States", *Journal of General Internal Medicine* (2015)
  - Schwartz et. Al, "Measuring low-value care in Medicare", *Journal of American Medical Association* (2016)

Measures of non-recommended care analyzed by HPC

Measures and number of instances in MA, 2013-2014

Screenings	Surgeries and invasive procedures	Imaging and lab tests
Cervical cancer screening for women under 21 (n=12,261)	Arthoscopic surgery for knee osteroarthritis (n=1,010)	Neuroimaging for child febrile seizure (n=122)
HPV testing in women under 30 (n=24,493)	Inferior vena cava filters for pulmonary embolism (n=480)	Homocysteine testing for cardiovascular disease (n=175,813)
Echography for adnexal cysts (n=7,459)	Renal artery stenting (n=100)	CT for appendicitis (n=98)
	Spinal injection for lower back pain (n=7,451)	Head imaging for syncope (n=4,830)
	Vertebroplasty for osteoporotic vertebral fractures (n=110)	Imaging for diagnosis of plantar fasciitis (n=20,024)
		EEG for uncomplicated headache (n=1,683)
		Head imaging for uncomplicated headache (n=27,250)
		Back imaging for non-specific low back pain (n=89,999)

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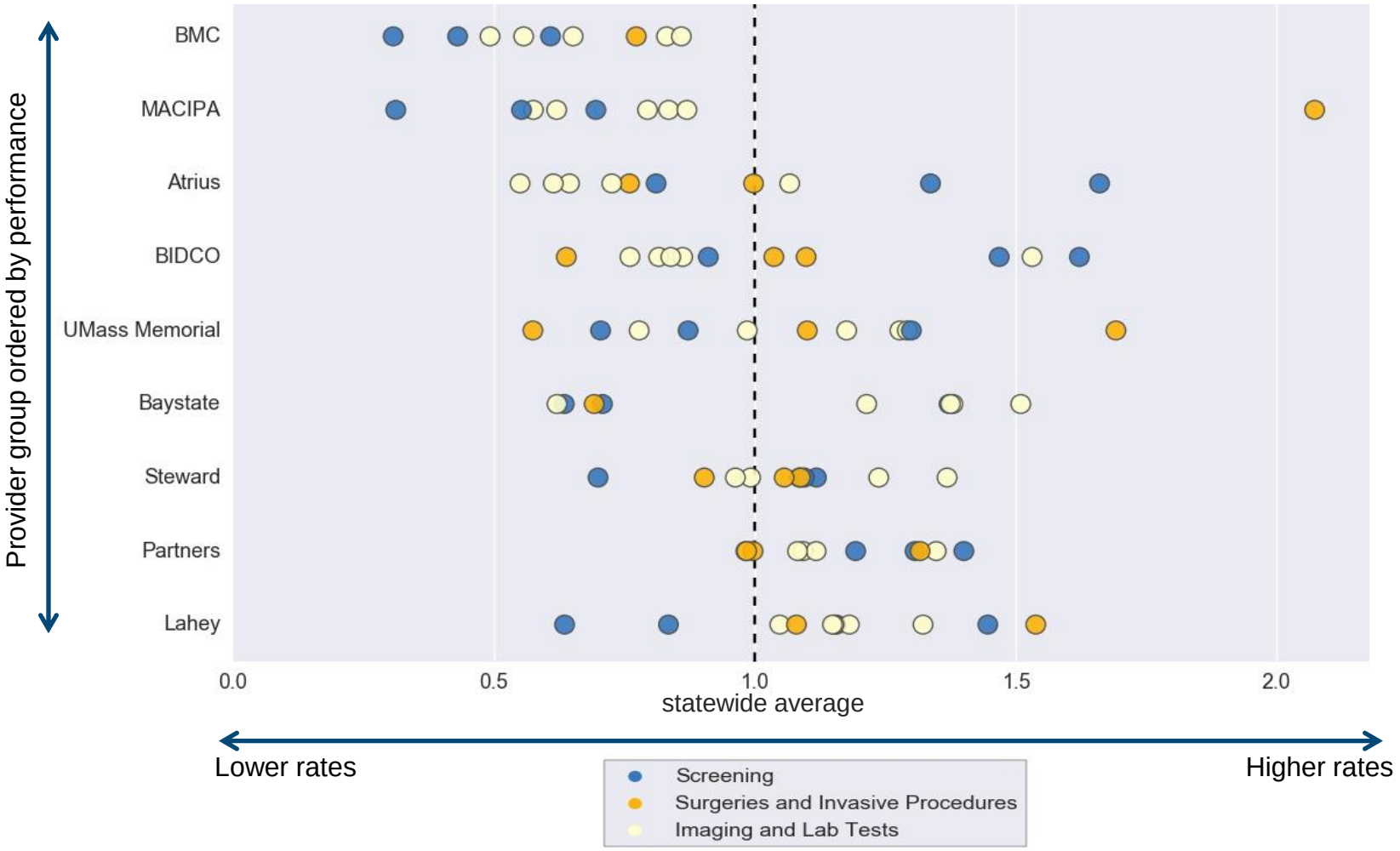
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2013 and 2014

Some provider groups had consistently low or high rates of non-recommended care across measures

Rates of non-recommended care, by provider group relative to the statewide average (indexed to 1.0 for each measure), 2013

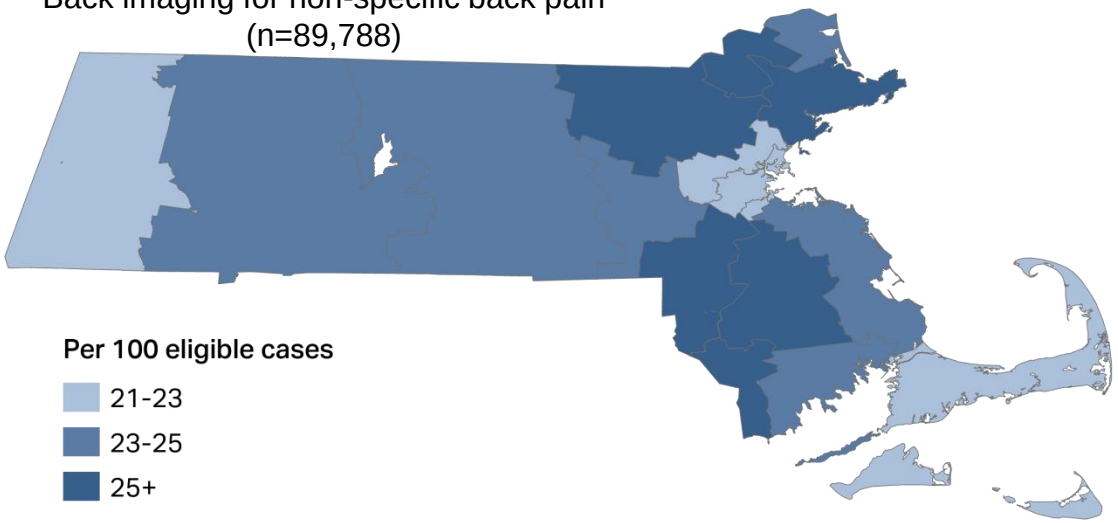


Notes: Analysis includes the same provider groups in the Total Medical Expenses (TME) analysis with the exception of NEQCA. Some measures are not reported for some organizations due to cell size limitations. Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care.

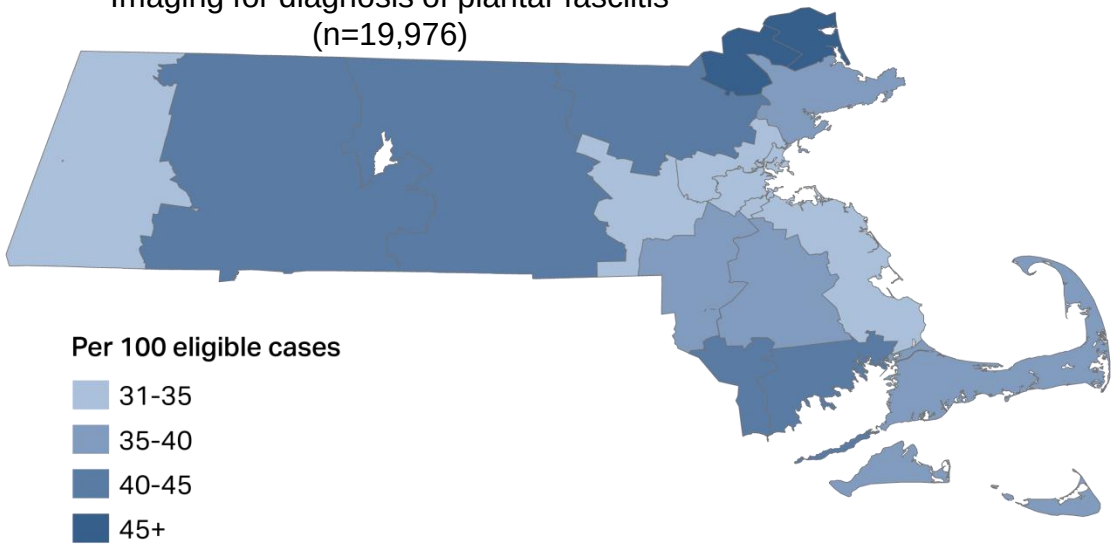
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2013 and Registry of Provider Organizations, 2016

Rates of non-recommended imaging vary by region

Back imaging for non-specific back pain
(n=89,788)



Imaging for diagnosis of plantar fasciitis
(n=19,976)



Notes: Data include only privately insured individuals covered by Tufts Health Plan, Blue Cross Blue Shield of MA, and Harvard Pilgrim Health Care.
Source: HPC analysis of Massachusetts All-Payer Claims Database, 2013 and 2014

Select findings from the 2016 Cost Trends Report

Themes

Spending and the delivery system

Opportunities to improve quality & efficiency

Progress in aligning incentives

Alternative payment methods

Demand-side incentives

HPC

Alternative payment methods (APMs)

Background

- APMs align financial incentives with care delivery goals
- In 2015, HPC set targets for APM adoption in the Commonwealth:
  - *APMs for HMO patients*: All commercial payers should increase the use of APMs, with the goal of having **80%** of the state HMO population in APMs by **2017**
  - *APMs for PPO patients*: Commercial payers should seek to increase the use of APMs for members enrolled in PPO plans, with the initial goal of having **one-third** of the state PPO population in APMs by **2017**

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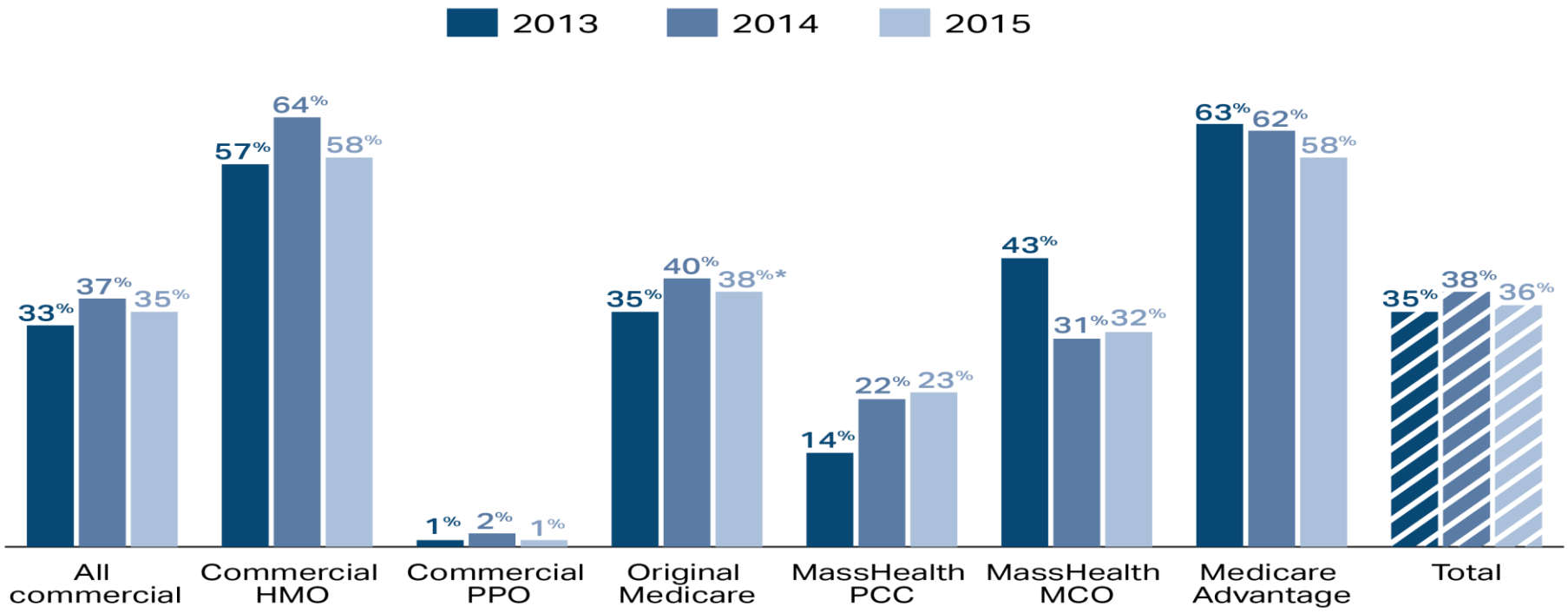
Notes: HMO= health maintenance organization, PPO= preferred provider organization.

While progress on APMs stalled in 2015, there are several promising developments for 2016 and beyond

Proportion of member months under APMs, by insurance category, CY 2013-2015



- Commercial: Developments in expanding APMs into PPO products, including one major commercial payer which is extending its APM to PPO members served by several large providers systems
- Medicare: Implementation of MACRA to link quality to physician payments, adoption of the Next Generation ACO program, and introduction of new bundled payment initiatives
- MassHealth: Implementation of MassHealth ACO program, as supported the Delivery System Reform Incentive Program (DSRIP) and the amended 1115 waiver

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Notes: * denotes that 2015 results based on preliminary estimates. Original Medicare= fee-for-service, APM= alternative payment method, CY= calendar year, PPO= preferred provider organization, MACRA= Medicare Access and CHIA Reauthorization Act of 2015, ACO= accountable care organization.

Sources: Centers for Medicare and Medicaid Services, 2013-2015; Center for Health Information and Analysis 2016 Annual Report APM Databook

Demand-side incentives (DSI)

Background

- DSIs reduce healthcare spending and improve market functioning by encouraging individuals and employers to make value-based choices, including:
  - Tiered and limited network plans
  - Cash-back incentives and price transparency programs
  - Reference pricing products

- These mechanisms are enabled and fostered by:
  - Informed and activated employers and employees
  - Price and quality transparency
  - Competitive insurance markets such as exchanges

Some incremental progress on DSI

- Mechanisms include:
  - Cash-back incentives
    - Unicare adds cash-back option for GIC members (2016)
  - Tiered and limited network products
    - Limited network products increased from **3.0%** to **3.2%** of commercial market in 2015 while tiered networks decreased from **16.0%** to **15.9%**

- Enabling forces include:
  - Price transparency
    - Several insurers, notably Blue Cross Blue Shield of MA and Harvard Pilgrim Health Care, reported increase in website hits from 2015 to 2016
    - The Center for Health Information and Analysis is planning to launch a statewide price and quality website in 2017
  - Market structure
    - The HPC has conducted an analysis on small and mid-size employers to understand if 1) their employees served well by the health insurance market, and 2) these employers able to enable and foster high-value insurance choices

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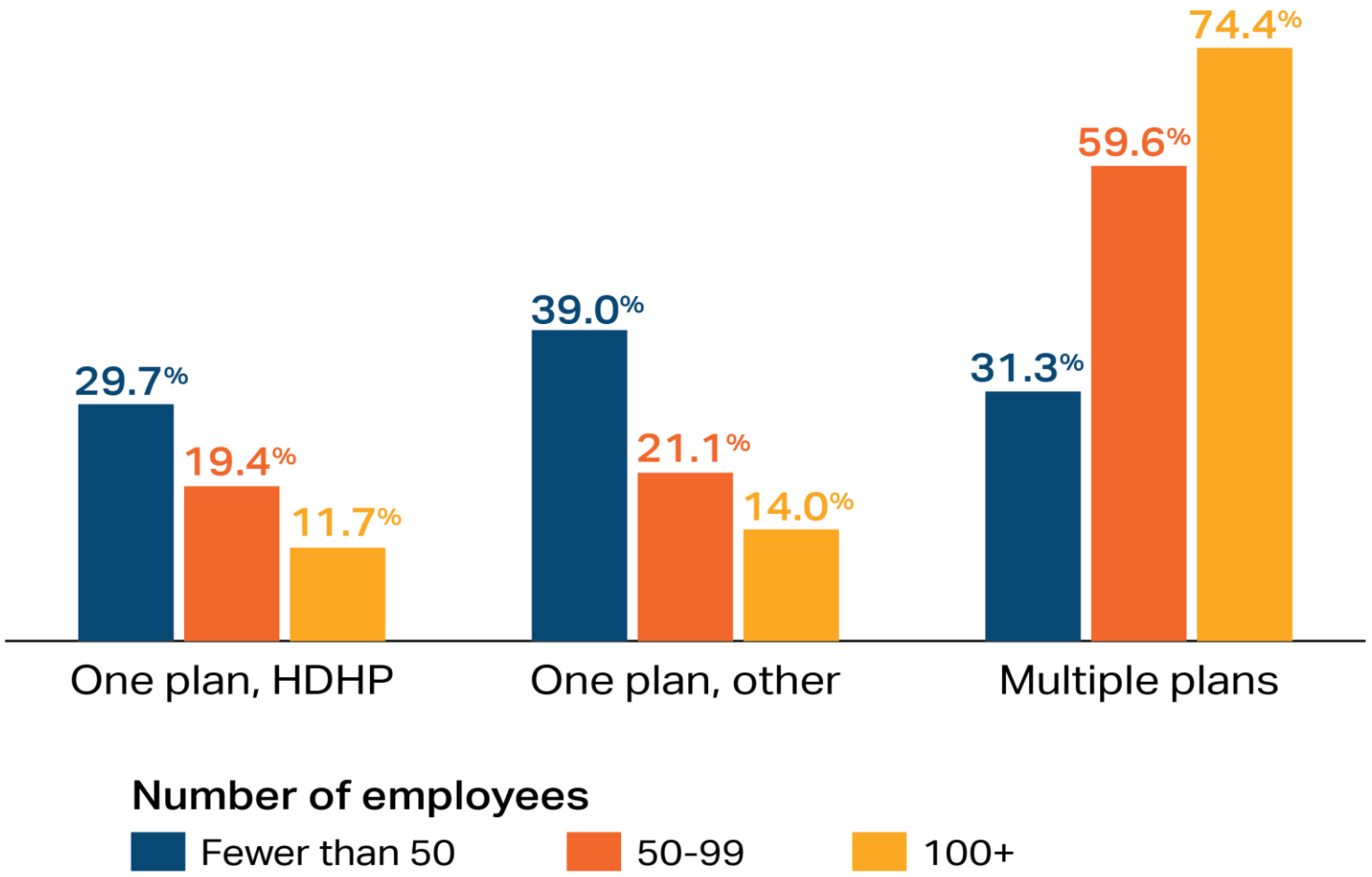
Source: ???

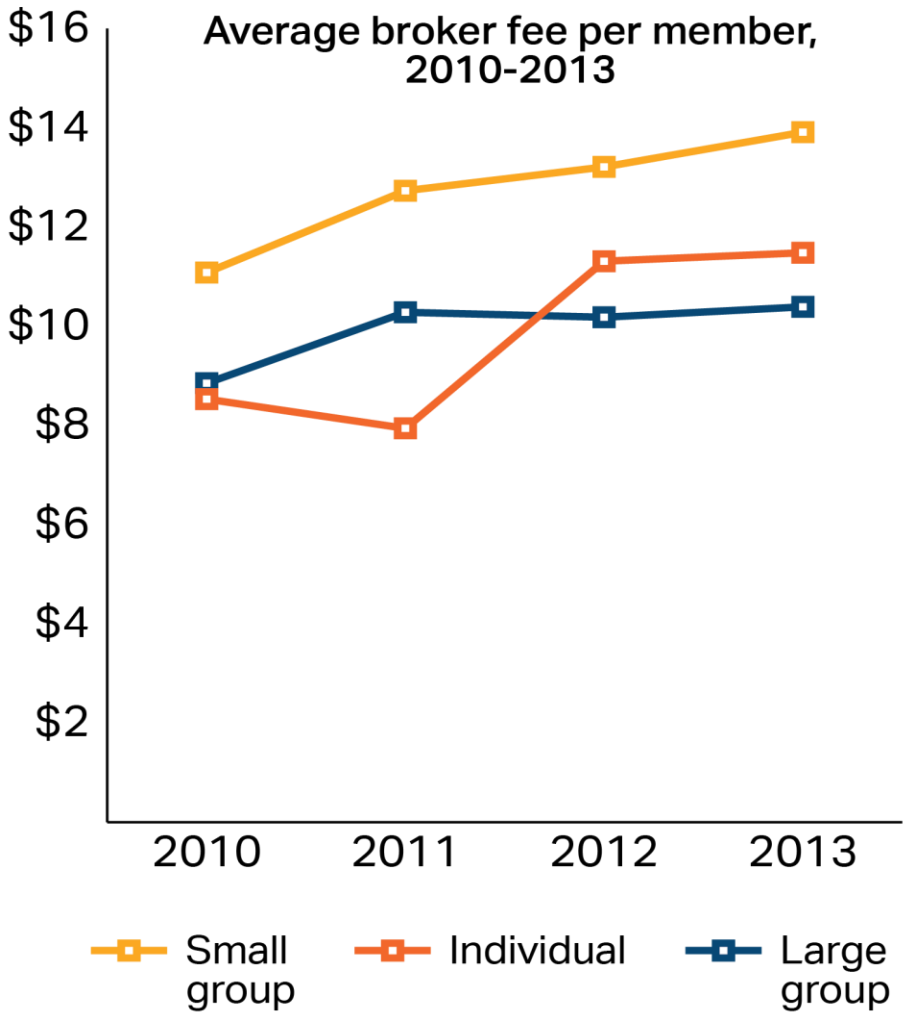
Most small group employees do not have a choice of plans

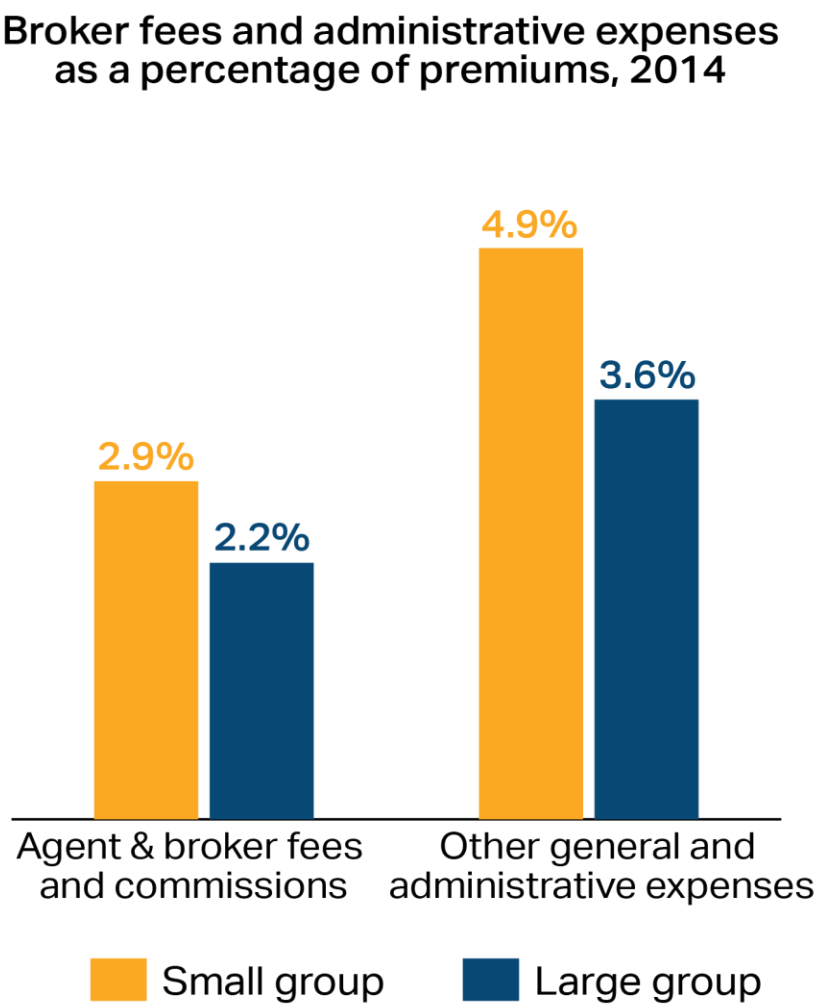
Among employees offered coverage by their firms, percent with plan choice by company size, 2014



Note: HDHP= high-deductible health plan.
Source: HPC analysis of Center for Health Information and Analysis Massachusetts Employer Survey, 2014

Small group employers pay more in broker fees and other insurance administrative costs



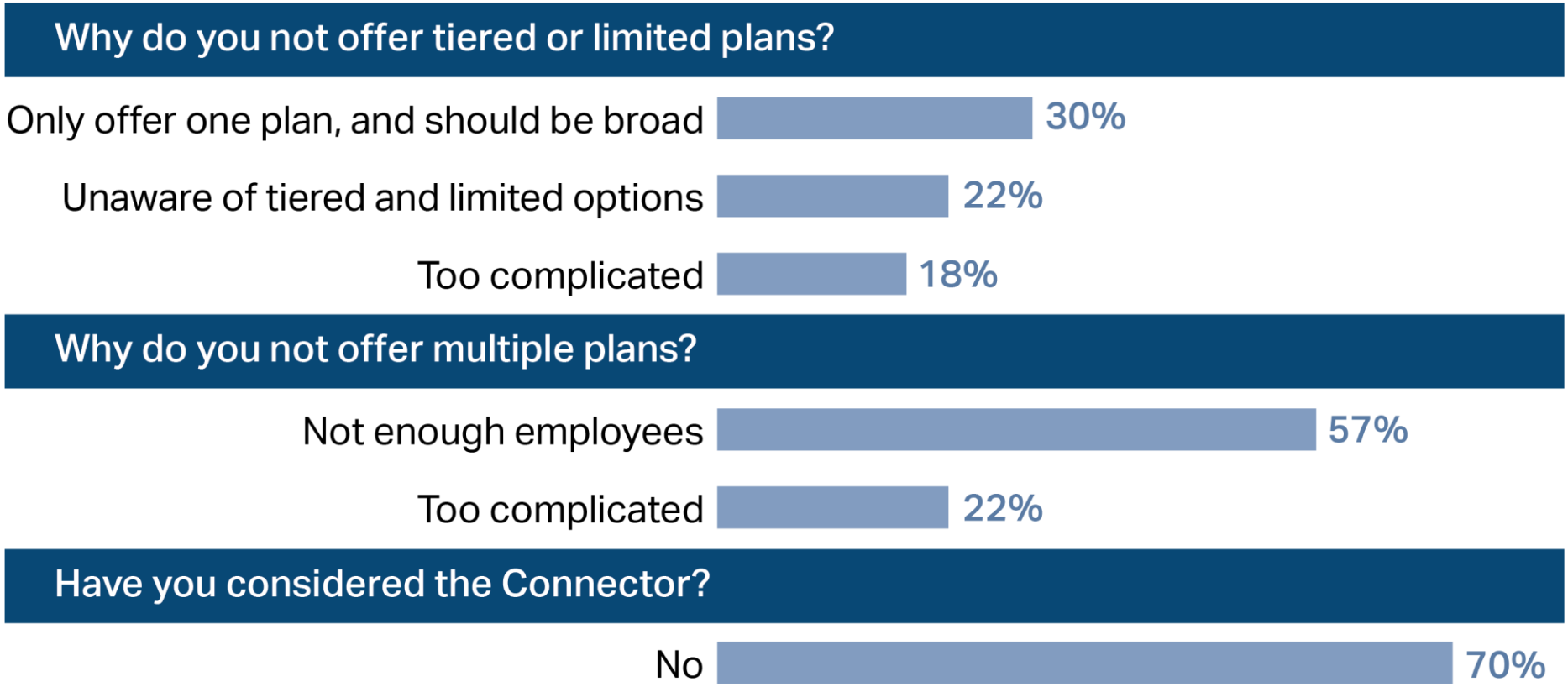


Notes: Graph on left defines small employers as those with fewer than 100 employees; graph on right defines small employers as those with fewer than 50 employees. In 2015, the vast majority (75%) of employees at firms with fewer than 100 employees were in firms with fewer than 50 employees.

Source: Kaiser Family Foundation analysis of data from Mark Farrah Associates, 2010-2013

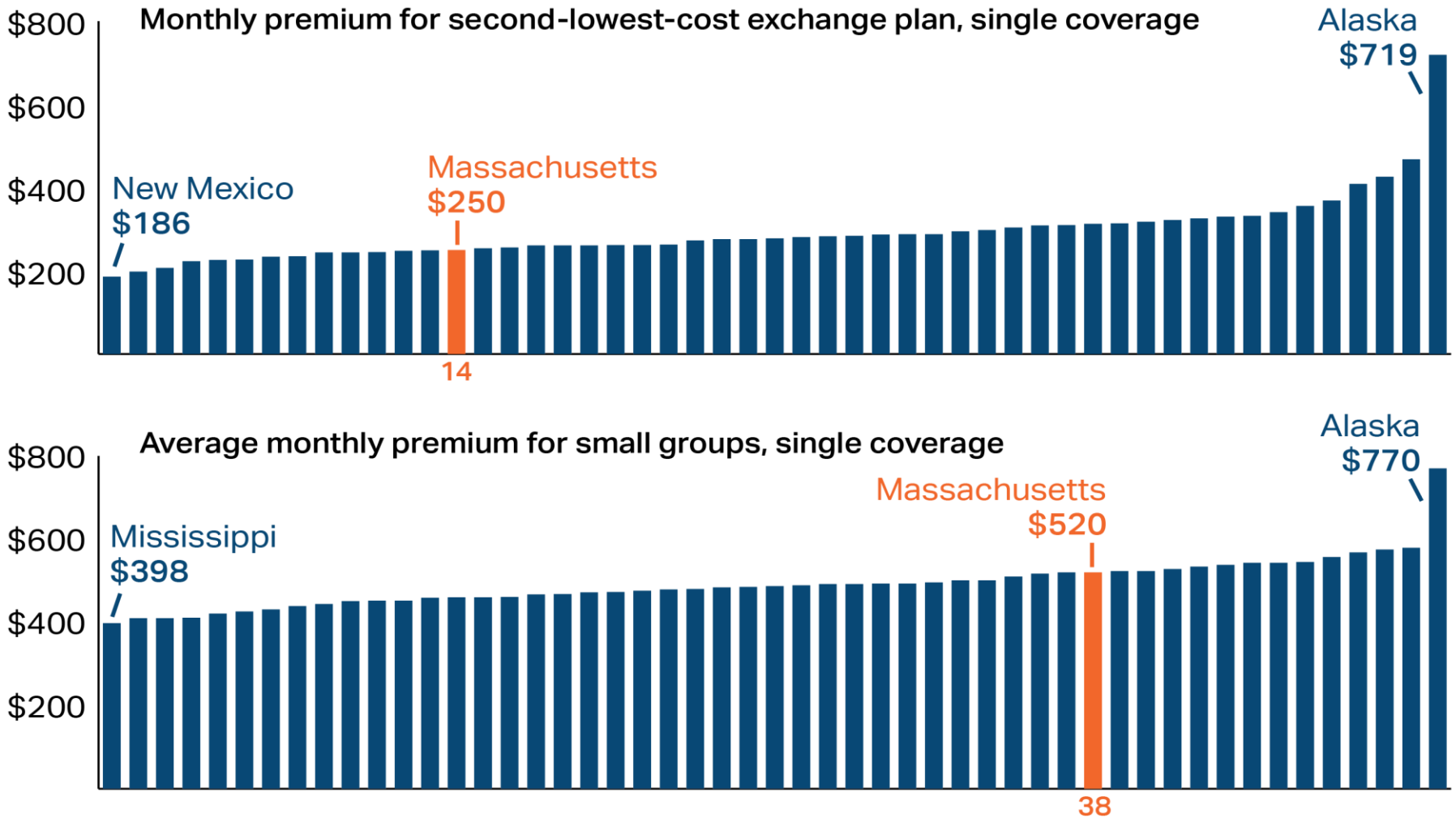
Small and mid-size employers noted challenges in offering competitive insurance options

Percent of firm representatives answering yes (multiple affirmative responses allowed), 2015



Source: HPC and Associated Industries of Massachusetts (AIM) survey of 188 Massachusetts employers, 2015

Massachusetts Health Connector premiums are below the national average, but employer based small-group premiums are higher



Notes: Top graph shows the average for the second-lowest silver plan premium for a 40 year old non-smoker earning $30,000 per year in the largest city in each state; bottom graph reflects the average monthly single premium for a private sector firm with fewer than 50 employees.

Sources: Kaiser Family Foundation, 2016 (top); Agency for Healthcare Research and Quality, 2015 (bottom)

2016 Cost Trends Report: summary of preliminary findings

Promising Developments

- Recent spending growth per person in Massachusetts continues to be below national rates; Massachusetts now spends about **6-7%** more on health care than other states, down from about **9-13%** more in 2009
- Overall, Massachusetts residents benefitted from lower prescription drug cost sharing from 2012-2014, due in large part to protections in the Affordable Care Act
- Early directional evidence suggests adoption of Alternative Payment Methods (APMs) may contribute to moderated spending growth for certain primary care provider groups
- Premiums for individual coverage offered through the Massachusetts Health Connector are below the U.S. average, unlike employer-based coverage

Challenging Developments

- Hospital utilization and readmissions increased in 2015 after years of decline
- Community appropriate care is continuing to increase at teaching hospitals
- While moderating somewhat in 2015, prescription drug spending in Massachusetts continues to grow more rapidly than any other category of service
- Rates of behavioral health-related ED use and ED boarding are increasing
- Post-acute care spending and utilization – particularly use of institutional care – remains high
- Growth in APM coverage stalled in 2015, though there are promising signs for 2016 and beyond
- Most small employers do not offer employees choice of insurance plan and pay higher broker/administrative fees

Dashboard: Benchmark and spending

Key area	Measure	MA time trend		Comparison	
				U.S.	Target
Benchmark and spending	1. Growth of THCE per capita (performance assessed relative to 3.6% benchmark)	4.2% (2013-2014)	4.1% (2014-2015)	5.1% (2014-2015)	< 3.6%
	2. Growth in commercial premiums	1.4% (2013-2014)	1.6% (2014-2015)	5.2% (2014-2015)	
	2a. Level of commercial premiums	Family: $17,702 Single: $6,348 (2014)	Family: $18,454 Single: $6,519 (2015)	Family: $17,322 Single: $5,963 (2015)	
	3. Individuals with high out-of-pocket spending relative to income	11% (2013-2014)	11% (2014-2015)	14% (2014-2015)	

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Better performance | Similar performance | Worse performance | Projected performance

Dashboard: Efficient, high-quality care delivery

Key area	Measure	MA time trend		Comparison	
				U.S.	Target
Efficient, high-quality care delivery	4. Readmission rate (Medicare)	17.7% (2014)	18.2% (2015)	MA ranked 43rd out of 51 (U.S. = 16.8%) (2014)	
	4a. Readmission rate (All payer)	15.3% (2014)	15.8% (2015)	N/A	< 13% by 2019
	5. ED utilization (per 1,000 persons)	366 (2014)	364 (2015)	MA ranked 32nd out of 51 (2014)	
	5a. BH-related ED utilization (per 1,000 persons)	25.6 (2014)	26.0 (2015)	MA = 25.4 U.S. = 17.8 (2013)	
	6. Percentage of inpatient discharges to institutional PAC	19.7% (2014)	19.4% (2015)	MA = 21.8% U.S. = 17.1% (2013)	
	7. At-risk adults without a doctor visit	7% (2014)	7% (2015)	13% (2015)	
	8. Number of primary care physicians practicing in certified PCMHs	2,024 25.3% of all PCPs (2015)	2,347 28.6% of all PCPs (2016)	16.3% of all PCPs (2016)	33% by 2017; 20% in Prime practice by 2017
	9. Hospital inpatient days in last 6 months of life (Medicare 65+)	N/A	8.5 (2012)	8.7 (2012)	
	10. Of decedents who used hospice, percent who used hospice for 7 days or less	N/A	30.9% (2012) (Medicare 65+)	35.5% (2012) (All decedents)	

HPC

Better performance | Similar performance | Worse performance | Projected performance

Dashboard: Alternative payment methods (APMs)

Key area	Measure	MA time trend		Comparison	
				U.S.	Target
APMs	11. Percentage of beneficiaries in Original Medicare covered by APMs	40% (2014)	38% (2015)	20% (2015)	
	12. Percentage of commercial HMO patients in APMs	64% (2014)	58% (2015)	N/A	80% by 2017
	13. Percentage of commercial PPO patients in APMs	2% (2014)	1% (2015)	N/A	33% by 2017
	14. Percentage of MassHealth members in APMs	PCC: 22% MCO: 31% (2014)	PCC: 23% MCO: 32% (2015)	N/A	

HPC

Better performance | Similar performance | Worse performance | Projected performance

Dashboard: Value-based markets

Key area	Measure	MA time trend		Comparison	
				U.S.	Target
Value-based markets	15. Enrollment in tiered and limited network products	19.1% (2014)	19.1% (2015)	N/A	
	16. Percentage of discharges in top 5 systems	60.9% (2014)	59.9% (2015)	N/A	
	17. Percentage of community appropriate discharges from community hospitals	53.6% (2014)	53.3% (2015)	N/A	

HPC

Better performance | Similar performance | Worse performance | Projected performance

Key statistics from the 2016 Cost Trends Report

2016 HPC Key Findings

$20,400
annual health insurance premium plus cost-sharing for typical family in MA

6.0%
commercial health care spending per person in MA in excess of national average

44.7%
portion of income a typical family of 3 at twice the federal poverty level pays for health insurance premiums, copayments, and deductibles

31%
portion of employees at small firms who have a choice of insurance plan

8.8%
per capita growth in commercial prescription drug spending, not factoring rebates

2 percentage point
impact of rebates and discounts on commercial pharmacy spending trends as reported by the AGO

21%
approximate percent of commercial health care spending attributable to prescription and medical drugs combined

24.4%
rate of non-recommended imaging for lower back pain per 100 eligible cases

22.8%
portion of behavioral health related emergency department visits with a length of stay of more than 12 hours

4X
growth in percent of prescriptions with no cost sharing among women between 2012 and 2014 (3.2% to 13.4%)

+11,000
change in the number of inpatient admissions in Massachusetts in 2015 after 3 years of declines of over 20,000 per year

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

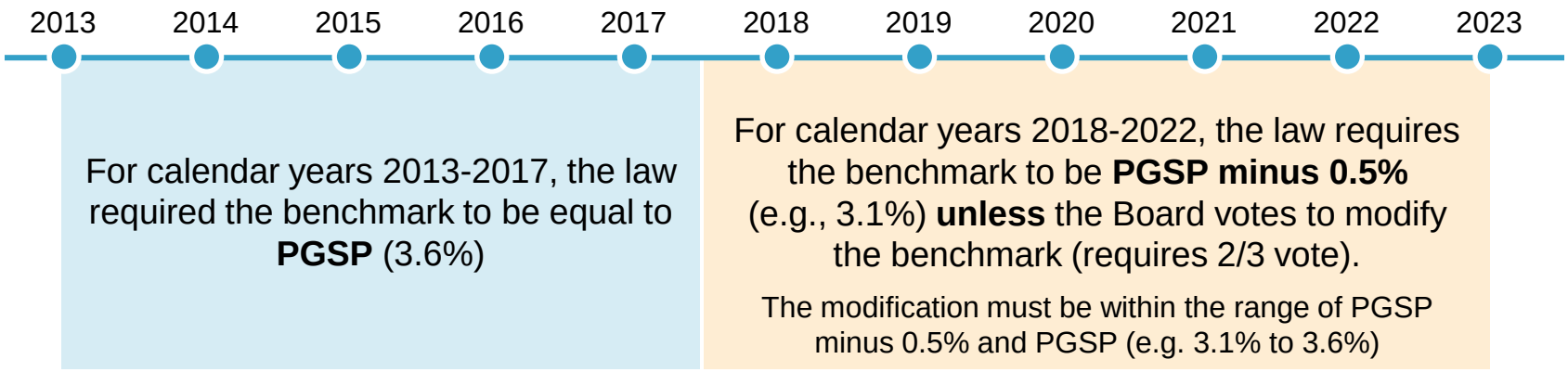
AGENDA

- Call to Order
- Approval of Minutes from the November 9, 2017 Meeting
- Cost Trends and Market Performance
  - Update on Notices of Material Change
  - 2016 Cost Trends Report, Preliminary Findings
  - **Process for Setting the 2018 Health Care Cost Growth Benchmark (VOTE)**
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Involvement
- Executive Director Update
- Public Comment
- Schedule of Next Board Meeting

Benchmark Modification Process Overview

- For the first time, in 2017, the HPC Board may **modify the statutory annual health care cost growth benchmark (for calendar year 2018)**, pursuant to a public hearing process and engagement with the Legislature.

- The HPC Board sets the health care cost growth benchmark for the following calendar year annually between January 15 (when the PGSP is established in the consensus revenue process) and April 15.



- 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.

Benchmark Modification Process – Key Steps

HPC Role

- HPC Board must hold a **public hearing** prior to making any modification of the benchmark
- Hearing must consider testimony, information, and data on whether modification of the benchmark is appropriate:
  - **Data**: CHIA annual report, other CHIA data, or other data considered by the Board
  - **Information**: "health care provider, provider organization, and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system"
  - **Testimony**: representative sample of providers, provider organizations, payers and other parties determined by HPC
  - The Joint Committee on Health Care Financing may participate in the hearing
- Following a potential vote to modify, the HPC Board **must submit notice** of its intent to modify the benchmark to the Joint Committee

Legislative Process

- Joint Committee must hold a public hearing within 30 days of notice
- Joint Committee must submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of hearing
- General Court must act within 45 days of public hearing or the HPC Board's modification of the benchmark takes effect

Benchmark Modification Process - *Proposed Timeline*

January 11, 2017

Board discusses process for potential modification of benchmark for calendar year 2018 which by operation of law will be PGSP minus 0.5% unless the board votes to modify; Board authorizes ED to submit notice of hearing on *potential* modification of benchmark to Joint Committee on Health Care Financing and schedule a hearing, providing 45 days notice to Joint Committee

January 15, 2017

Benchmark established in consensus revenue process

February 8, 2017

Board discussion of hearing, factors to be considered in potential modification

March 1, 2017

Board hearing on potential modification of benchmark

March 28, 2017

Board votes whether to modify benchmark; if Board votes to modify, submit notice of intent to modify to Joint Committee on Health Care Financing

April 15, 2017

Statutory deadline for Board to set benchmark

April 2017

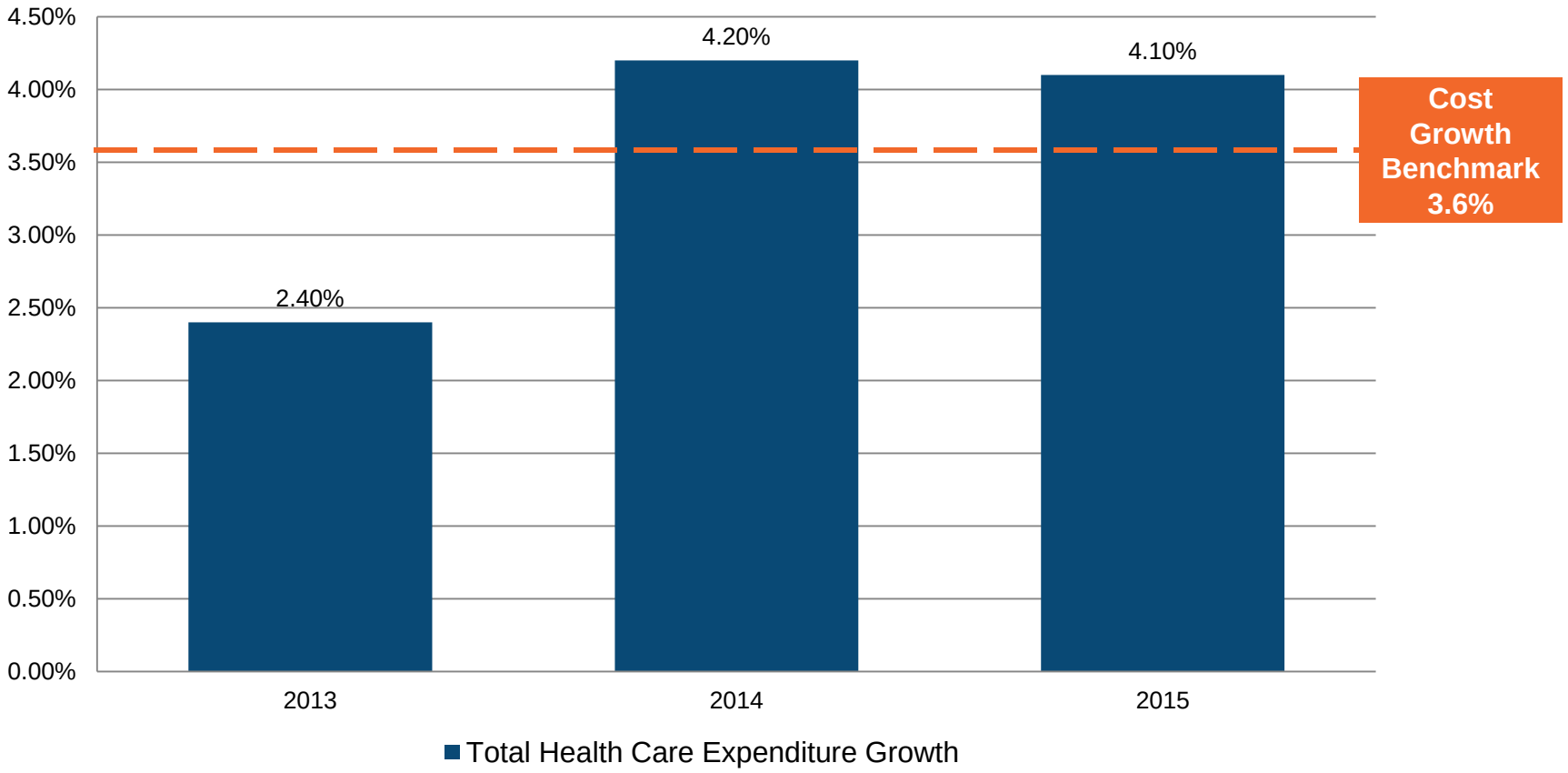
Joint Committee holds a hearing within 30 days of notice (between March 29 and April 29)

May 2017

Joint Committee reports findings and recommended legislation to General Court within 30 days of hearing; legislature has 45 days from hearing to enact legislation which may establish benchmark; if not legislation, then Board vote to modify takes effect

HPC

Performance Against the Benchmark to Date



2013-2015
Average Growth Rate: 3.57%

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Process for Setting the 2017 Health Care Cost Growth Benchmark

MOTION: That the Board hereby authorizes the Executive Director to schedule a public hearing, on a date no sooner than 45 days from January 11, 2017, to consider whether modification of the benchmark for calendar year is appropriate and to provide notice of said hearing to the Joint Committee on Health Care Finance, pursuant to section 9 of chapter 6D of the General Laws.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
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- Cost Trends and Market Performance
- **Quality Improvement and Patient Protection**
  - Regulation Governing the Office of Patient Protection (VOTE)
- Community Health Care Investment and Consumer Involvement
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MASSACHUSETTS
HEALTH POLICY COMMISSION

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Background on Final OPP Regulation 958 CMR 3.000

- Massachusetts' 2016 opioid law included a provision to add new **carrier reporting requirements detailing aggregate data on claims and claims denials** submitted annually to OPP *(Chapter 52 of the Acts of 2016 & M.G.L. c. 176O, sec. 7)*
  - OPP's regulation 958 CMR 3.000, *Health Insurance Consumer Protection*, must be **amended** to incorporate the new statutory requirements
- The new reporting requirements:
  - **Provide** greater transparency regarding the total "universe" of fully insured claims/requests for services submitted and denied
  - **Broaden** the data currently reported to OPP
  - **Supplement** information submitted to DOI pursuant to DOI's mental health parity authority
  - **Capture** post-service denials and claims regarding treatments/services that do not require prior authorization (e.g., out-of-network provider, service not covered, administrative denials)

Regulatory Development: Key Considerations

- HPC staff have been working closely with the **Division of Insurance** (DOI), given DOI's authority regarding parity certification and the related reporting requirements

- HPC staff are developing a proposed **reporting template** to guide submissions, a draft of which has been shared with carriers; HPC and DOI staff are planning to hold joint meetings with carriers in early 2017 to obtain additional feedback on the reporting template

- The new required information would be **first reported to OPP in 2018** (reporting on 2017 data)

Development of the Regulation

May 18, 2016 – Previewed regulatory revision with the QIPP Committee

June 1, 2016 – Previewed regulatory revision to full Board

November 2, 2016 – QIPP Committee voted to advance proposed regulation

November 9, 2016 – Full Board reviewed and voted to release proposed regulation

Mid-late November 2016 – Draft reporting template shared with carriers for comment

November 30, 2016 – Public hearing on proposed regulation; deadline to submit comments

January 11, 2017 – QIPP Committee voted to advance final regulation to the Board

HPC

Public Comments Received

Organization	Comment	HPC Recommendation
Blue Cross Blue Shield (BCBS)	BCBS supports the revised regulation; supports the concurrent submission of new reporting requirements with carrier submission to DOI for mental health parity certification (in July).	No change recommended.
Health Law Advocates (HLA) / Health Care For All (HCFA)	HLA/HCFA supports the new reporting requirements for providing more comprehensive reporting and greater transparency regarding claims and requests for services, with further specificity about reasons for claims denials. Recommended clarifying that the new requirements are submitted to OPP; proposed regulation could be misinterpreted to allow a carrier to submit only to DOI.	Clarified that the new reporting elements are required to be submitted to OPP concurrent with carrier submission to DOI for parity certification.
Massachusetts Association of Health Plans (MAHP)	MAHP expressed concerns about carrier burden and administrative simplification, as the new reporting requirements will constitute a separate report to OPP from that currently submitted to DOI for parity. With respect to any future reports, MAHP requested that OPP work closely with DOI in developing any explanatory materials to avoid possible misinterpretation of the data.	No change recommended. The HPC is directed by statute to collect the new information. OPP will continue to work closely with DOI and carriers to implement in a manner so as to streamline and align reports.

HPC staff recommend two minor clarifications in the final regulation: the first fixes an existing citation error in the regulation, and the second addresses HLA/HCFA's suggestion above.

Next Steps

***May 18, 2016** – Previewed regulatory revision with the QIPP Committee*

***June 1, 2016 –** Previewed regulatory revision to full Board*

***November 2, 2016** – QIPP Committee voted to advance proposed regulation*

***November 9, 2016 –** Full Board reviewed and voted to release proposed regulation*

***November 30, 2016** – Public hearing on proposed regulation; deadline to submit comments*

***January 11, 2017** – QIPP Committee voted to advance final regulation to the Board*

January 11, 2017 – Full Board votes to issue final regulation

January 27, 2017 – Anticipated effective date of regulation

Early 2017 – HPC and DOI plan to hold joint meetings with carriers to refine reporting template

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

Vote: Office of Patient Protection Regulation

Motion: That the Commission hereby approves and issues the attached FINAL regulation on health insurance consumer protection, pursuant to M.G.L. c. 6D, sec. 16 and M.G.L. c. 176O.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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    - Beth Israel Deaconess – Milton
    - Mercy Medical Center
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HEALTH POLICY COMMISSION

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CHART Phase 2: Progress as of January 2017

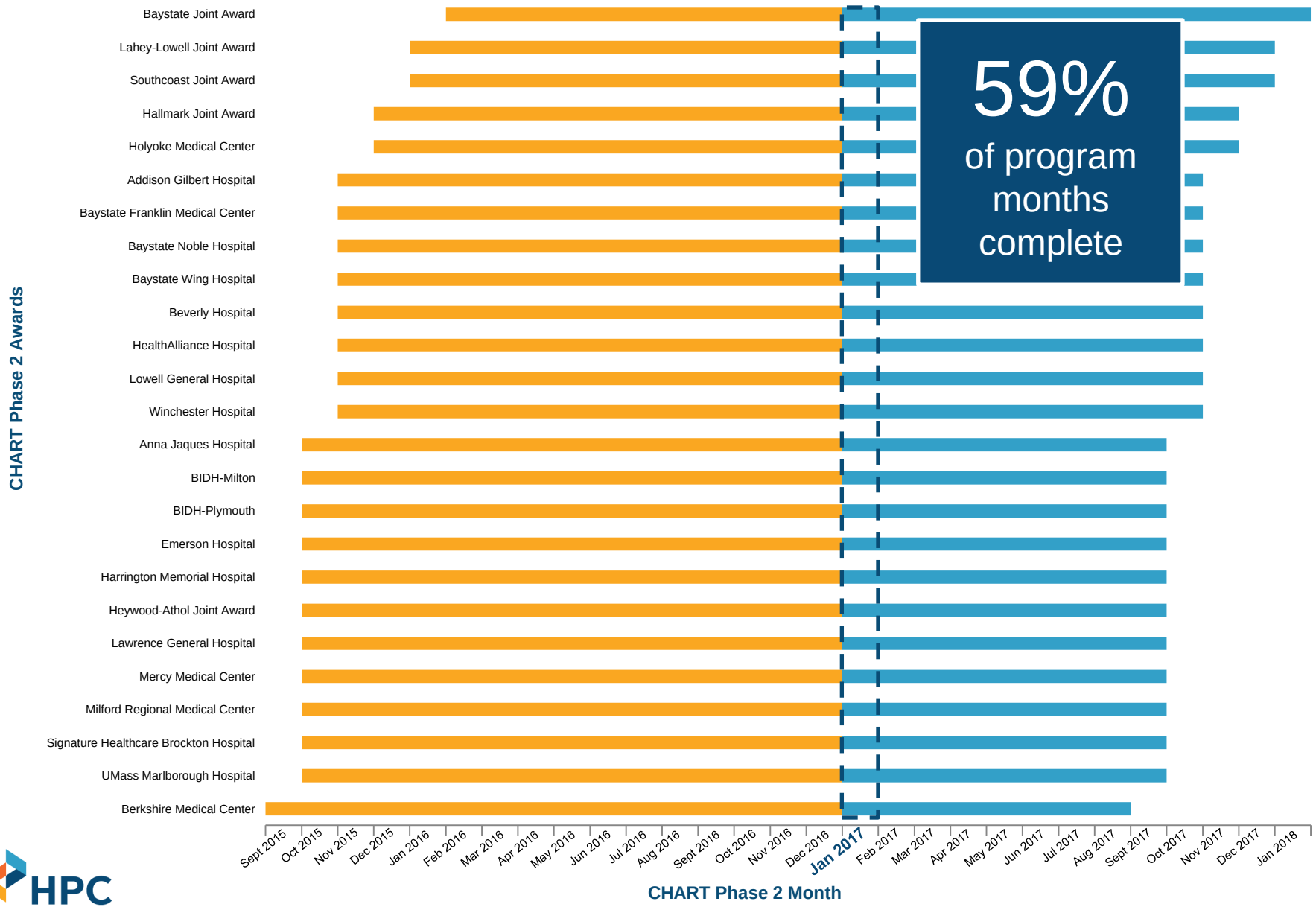


CHART Phase 2: Activities since program launch[1]

9

regional meetings

with

500+

hospital and community provider attendees

165+

technical assistance working meetings

530+

hours of coaching phone calls

13

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

2,722 unique visits to the CHART hospital resource page

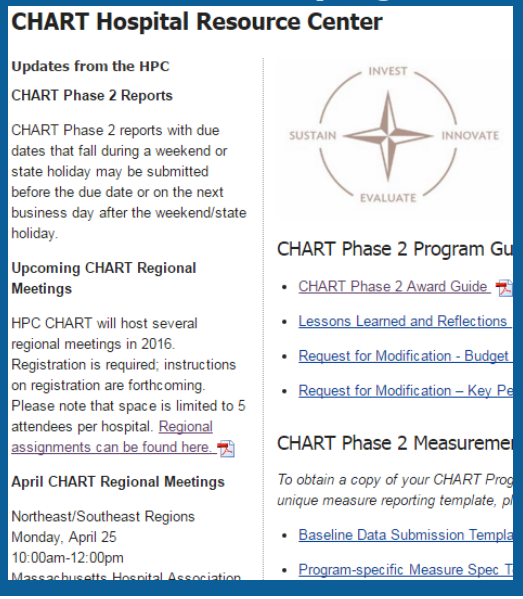


CHART Hospital Resource Center

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

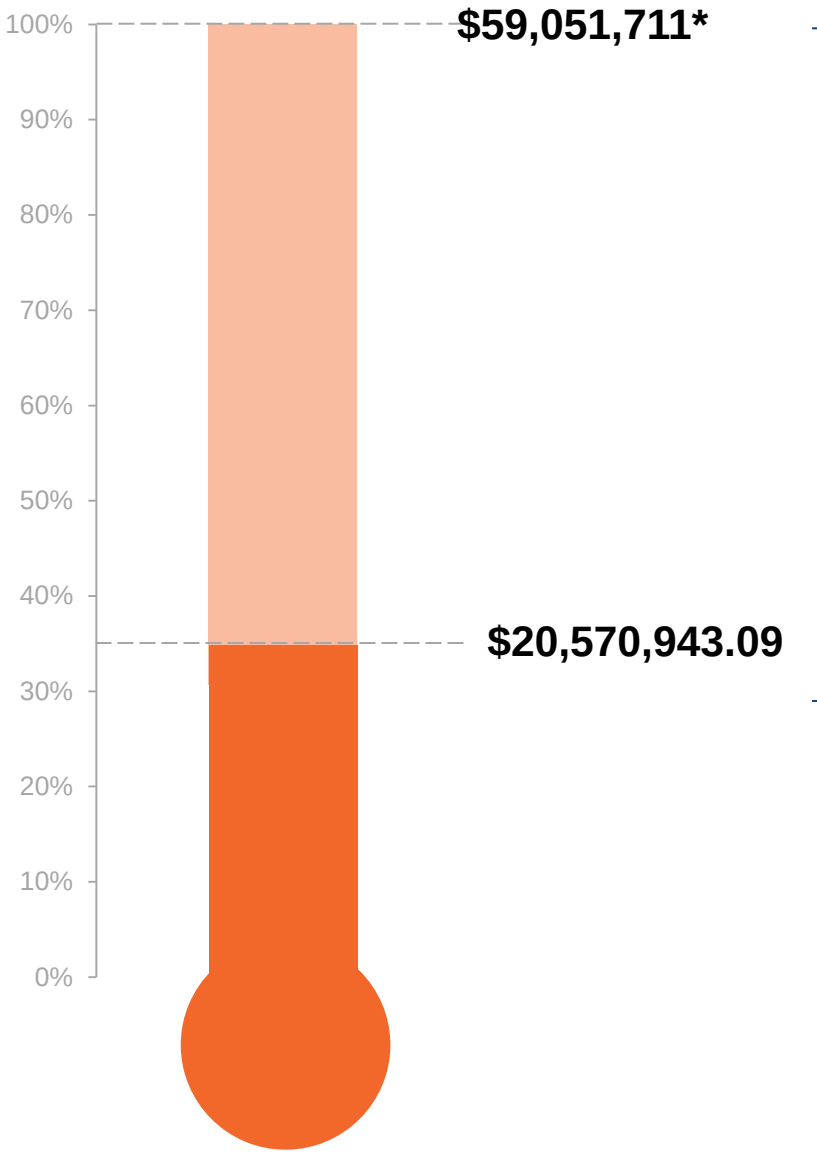
- Baseline Data Submission Templa
- Program-specific Measure Spec T

325+

data reports received

[1] Updated through December 31, 2016. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015.

CHART Phase 2: The HPC has disbursed $20.6M to date



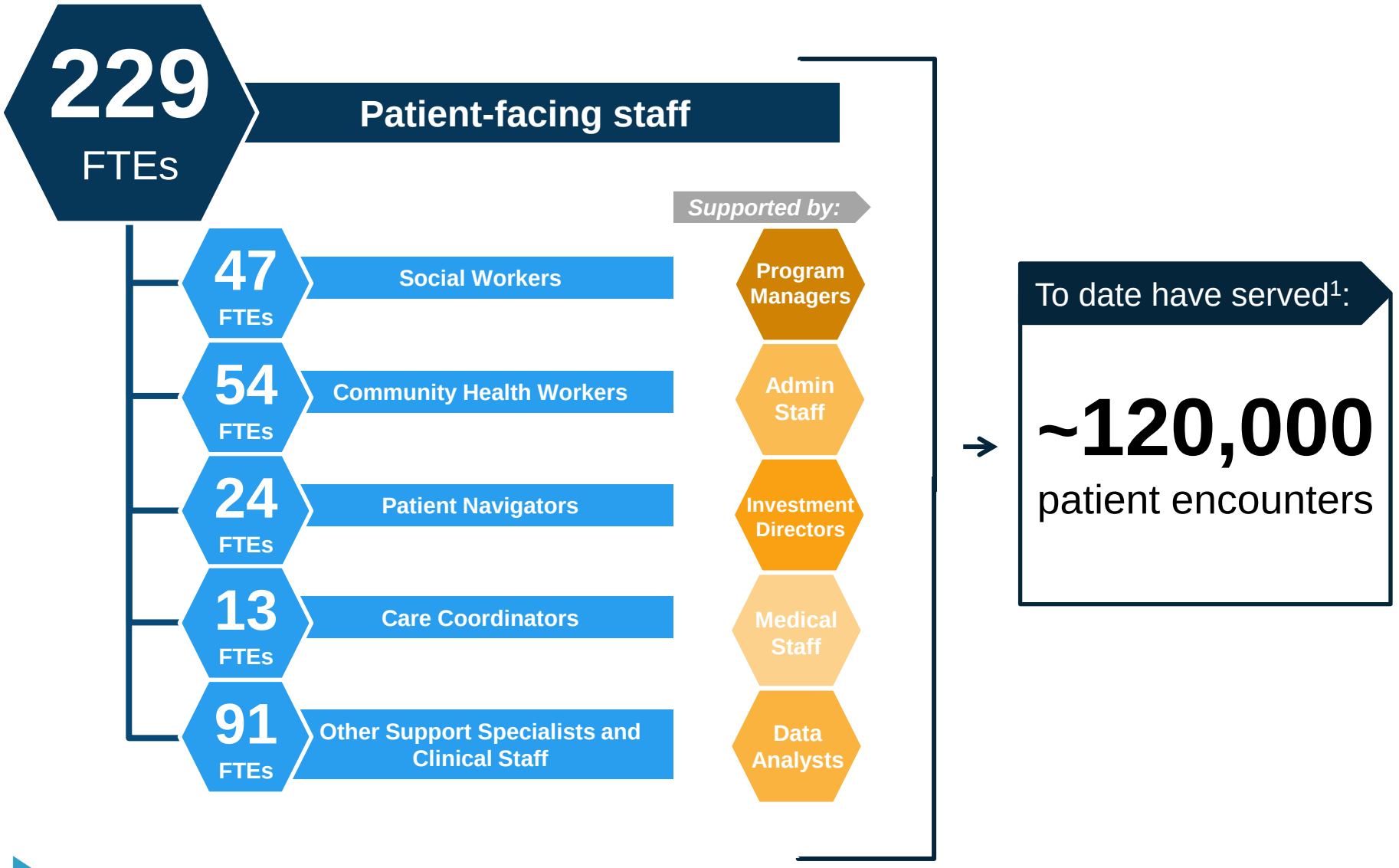
Remaining
$38,480,767.91
is inclusive of
$7,217,898
maximum outcome-based Achievement Payment opportunity

HPC

Updated January 3, 2017

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

HPC CHART Phase 2 funded staff and patients served



[1] According to data reported by CHART Phase 2 awardee hospitals

Presentations from CHART Investment Program Participants

- Beth Israel Deaconess - Milton
- Mercy Medical Center
- Milford Regional Medical Center
- Signature Healthcare Brockton Hospital

CHART Phase 2 teams developed content for the following slides for the purposes of the January 2017 HPC Board Meeting. This data reflects their hands-on experiences, data analysis, and key findings thus far.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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CHART program overview

Beth Israel Deaconess Hospital Milton

Target Population	Patients in the Emergency Department (ED) with a length of stay >8 hours who are referred to South Shore Mental Health (SSMH) for a behavioral health (BH) crisis evaluation ED BH population = 149 visits/month BH visits with SSMH evaluation = 31/month
Aim	Reduce length of stay for long-stay BH boarders in the ED
Team	**Patient-facing**: 1 SW, 0.5 Navigator, 0.2 Peer, 0.2 Music, 1 Therapist, 0.2 Pharmacist, 0.1 Chaplain, 1 Director of Care Integration, Security (24 hours/day)
	Administrative: 0.2 RN/MD ED Champion, 1 Program Manager, 1 Data/IT Analyst

HPC

Program activities

Beth Israel Deaconess Hospital Milton

Identify
- MD order for South Shore Mental Health (SSMH) crisis evaluation
- RN/ SSMH notified

Engage
- SSMH co-located during business hours and weekends

Assess
- Present to ED in serious psychiatric distress

Serve
- Crisis evaluation, level of care determination, therapeutic intervention initiated, crisis stabilization, family intervention

Manage
- ED care plan, therapeutic maintenance/ crisis stabilization, post-discharge care plan, warm hand-off, ED return plan

HPC

Success stories

Beth Israel Deaconess Hospital Milton

Patient Story

A male patient in his early 30s with hemophilia and a complex psychiatric presentation had multiple ED visits in early summer.

The BIDH-Milton CHART team:

- Coordinated cross-agency/ system care planning meetings
- Created a cross-agency/ system “acute care plan”
- Implemented a non-narcotics pain management plan

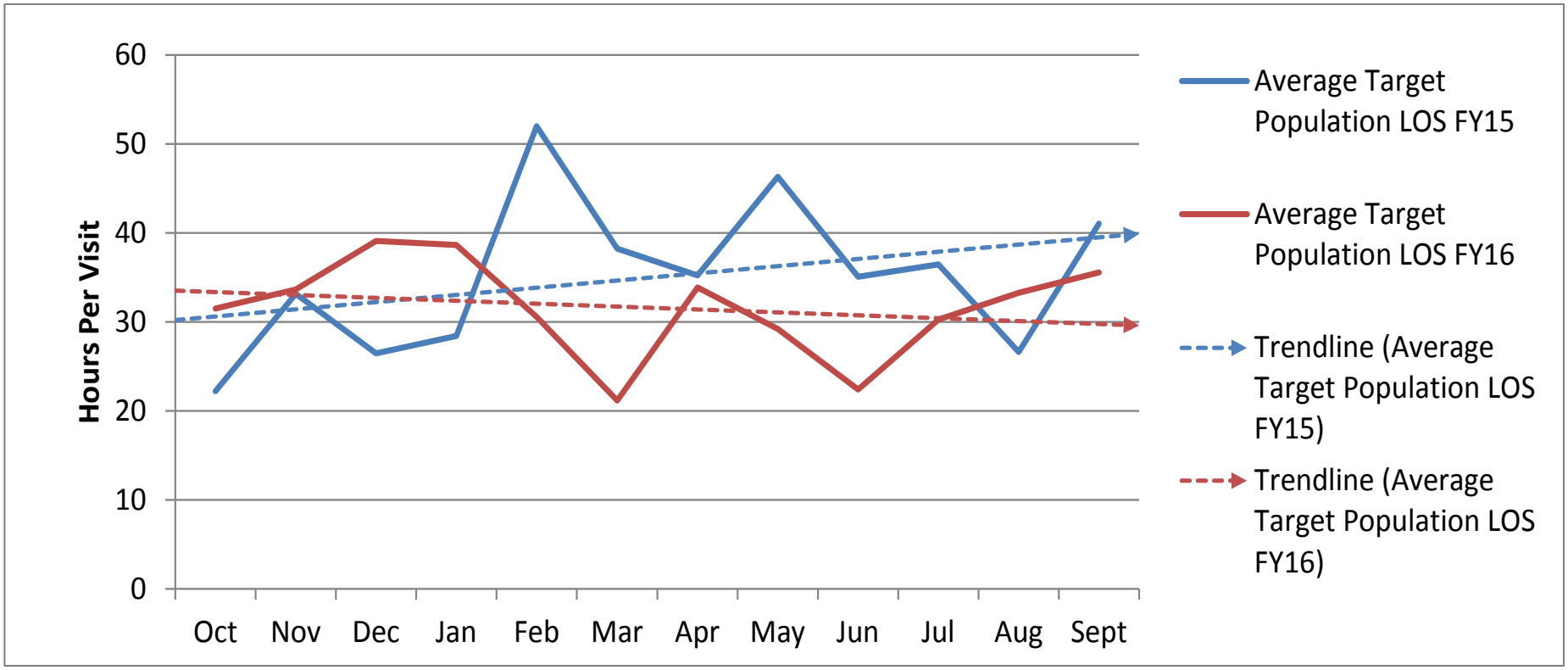
Operational Successes

- Co-location
- Warm hand-offs
- Navigator and Peer Specialist follow-up in community

Results to date

Beth Israel Deaconess Hospital Milton

Average Length of Stay for ED BH Boarders - Target Population FY15 vs. FY16



HPC

Summary

Beth Israel Deaconess Hospital Milton

Successes

- Reduced length of stay and revisits
- Focus on patient management for patients with a BH diagnosis
- Embedded SSMH clinicians in ED and educated staff on BH patient management
- Reduced stigma

Challenges

- Off-hours coverage
- Patient volume
- Patients with multiple complex needs
- Lack of alignment

Next Steps

- Hardwire successful operations
- Expand work to patients in inpatient units

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

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CHART program overview

Target Population	Emergency Department (ED) patients with a primary behavioral health (BH) diagnosis
Aim	Reduce ED revisits by 20%
Team	**Patient-facing**: 5 CHWs, 4.2 BH-trained RNs **Administrative**: Project Manager, Complex Care Coordinator, Supervision for CHWs

Program activities

Identify
- CHWs review the ED tracker and patients' medical records.
- ED-based CHW refers patients to CHWs via texting, email, and phone.

Engage
- First contact: "Good news! CHART program can help you to get back on your feet." Automatic enrollment. Client can always decline CHART CHW services. Most clients welcome CHART services.

Assess
- 1) "What brought you to the ED?"
- 2) "What can we do now to help you to feel better and safer?"
- 3) "What are some of your goals that would help you feel better?"

Serve
- Group 1: Less intervention. Mostly referrals by phone.
- Group 2: More intervention. Face-to-face, hands-on support and advocacy.

Manage
- Set up appointments with 48-hour phone contacts.
- Focus first on long-term goals that must be completed in 60 days.

Success stories

Patient Story

A female patient in her 40s visits the ED frequently for anxiety.

The Mercy CHART team:

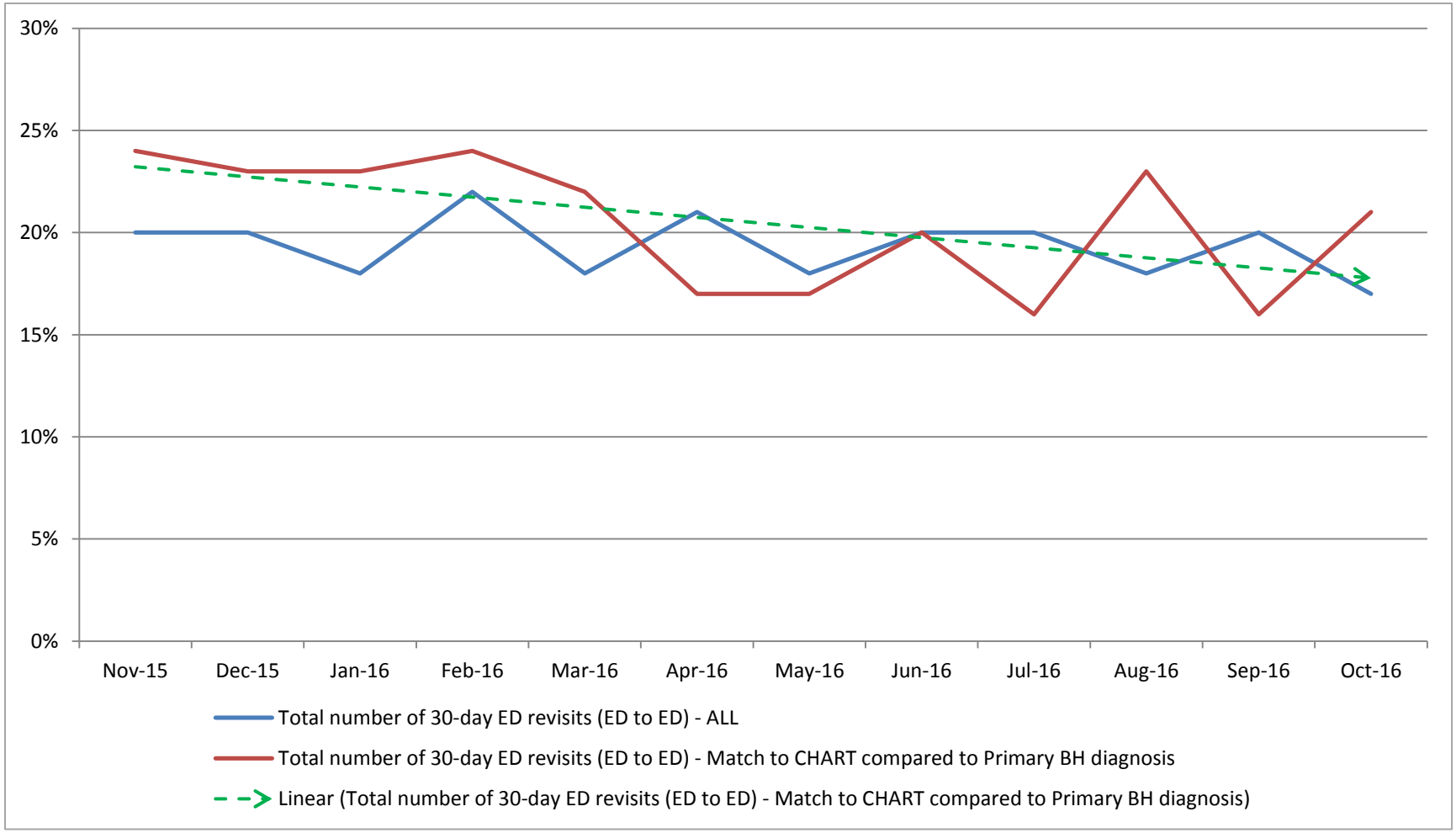
- Established a trusting working relationship and conducted home visits
- Assisted in finding therapy and community social support options
- Set up a payment plan arrangement with landlord to keep housing

Operational Successes

- 67% 48-hour timely follow-up for Group 1 population
- ED revisit rate down to 16% for target population
- ED average length of stay (in minutes) down by 20% for target population even with an increase in volume

Results to date

30-day ED Revisit Rates for ALL vs. Target Population By Month: November 2015 – October 2016



Summary

Successes	• CHW engagement in the community
Challenges	• Information sharing with other programs • Sustainability of staffing model
Next Steps	• Continue to hardwire what is working well • Journal publication(s)

MASSACHUSETTS
HEALTH POLICY COMMISSION

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CHART program overview

Target Population	Patients with 3 or more hospitalizations in the last 12 months ~352 patients to date	
Aim	Reduce 30-day readmissions by 25%	
Team	**Patient-facing**	1 Palliative Care PA, 1 RNCM, 1 Pharmacist, 1 Social Worker
	Administrative	Hospitalist, ED Physician, Intensivist, CNO, CM Coordinator, Informatics, Directors CM/SW and Quality

Program activities

Identify
- Patients are flagged by a daily “high utilization” report
- Report is auto-generated to the team daily at 6:00 am

Engage
- High Risk Mobile Team (HRMT) triage initiates introduction to team

Assess
- Weekly readmit meeting and chart review to identify key issues

Serve
- Services are determined by key driver

Manage
- Follow-up within 48 hours of discharge to home or skilled nursing facility
- Follow-up visits determined by patient need. Face-to-face vs phone contact

Success stories

Milford Regional Medical Center

Patient Story

An elderly female patient with anemia was repeatedly admitted to receive transfusions.

The Milford CHART team:

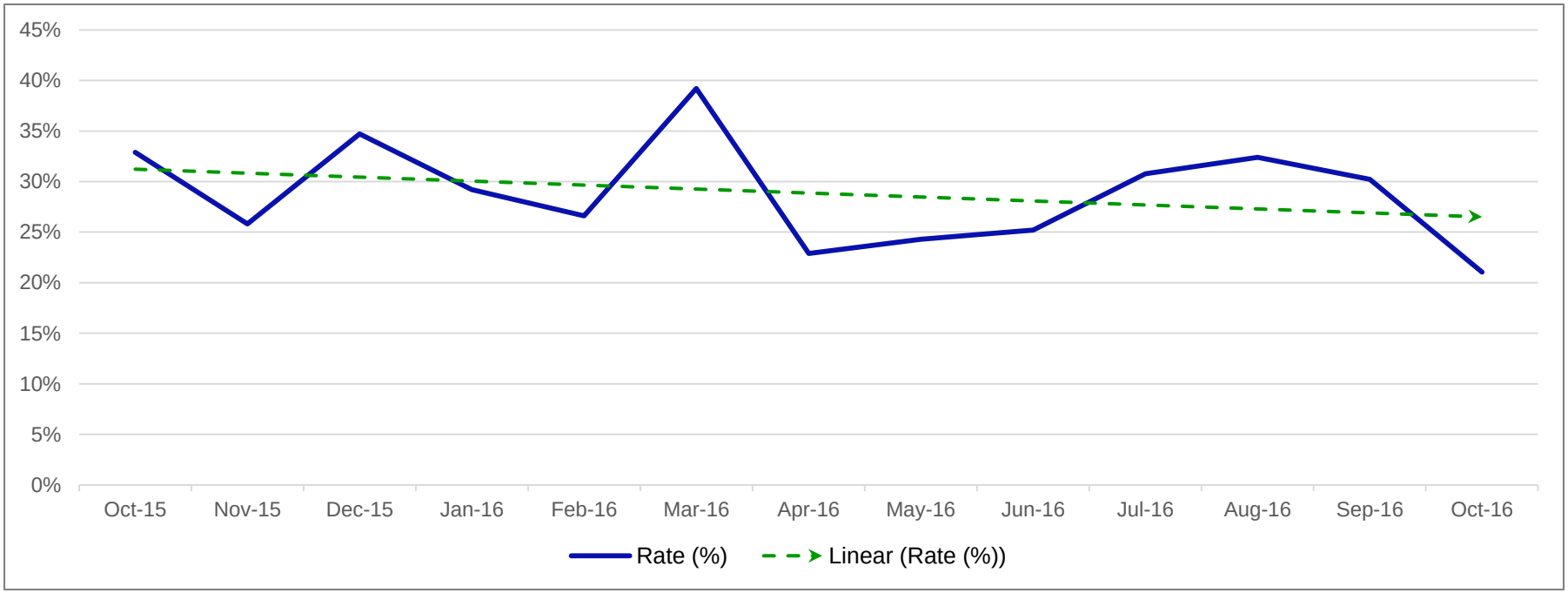
- Developed and communicated a care plan with PCP, mobile lab, infusion suite, and the patient and her family.

Operational Successes

High Risk Mobile Team changed its workflow in order to maximize out-of-hospital visits: on a rotating basis, one member of the team triages in the hospital while the others are out in the community engaging with patients (e.g., at home, at SNFs, at PCPs, etc.).

Results to date

30-day Readmission Rates for Target Population By Month: October 2015 – October 2016



Summary

Successes	• Reaching patients in their homes allows the HRMT to visualize and explore other factors that may contribute to readmissions • Automatic Palliative Care Consults • Reduction in target population readmissions
Challenges	• Ensuring post-discharge visits with PCP within 3 days. Barriers include: transportation, availability of caregiver, and scheduling appointments • Medication adjustments create financial burden • Influx of “new” patients with high utilization
Next Steps	• Adapt HRMT workflow in the Emergency Department to triage patients with high utilization

MASSACHUSETTS
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CHART program overview

Target Population	Patients at high risk of readmission: • ≥ 10 ED visits/ year or ≥ 4 admits/year; • Congestive heart failure (CHF) or chronic obstructive pulmonary disease (COPD); • ≥ 65 years old + ≥ 10 medications 1,778 patients to date (served 1,122)
Aim	Reduce readmissions by 20%
Team	**Patient-facing**: 3 RN Care Managers, 1 CHW, 1 LICSW, 1 Palliative Care RN, 1 NP, 2 Pharmacists, 1 Pharmacy Tech **Administrative**: Program Coordinator; 4 Team Leaders

Program activities

Identify
- Automatic identification through EMR upon registration
- Customized database sends alerts via email to all staff

Engage
- Staff introduce themselves as part of hospital care team during hospitalization and/ or post discharge
- Staff call and/ or visit patients within 48 hours post-discharge, if possible

Assess
- Assign lead team member based on patient needs or qualifiers
- Develop patient-centered care plan with patient to prioritize services and/or assistance needed

Serve
- Direct assistance with obtaining public and community-based services; direct support in home by team; accompany patients to appointments; assist with medications in home; monitor biometrics via telehealth; advocate for services

Manage
- Patients participate in program for as long as necessary or desired; staff work with them to transition to community-based providers but remain available in background for ongoing support

Success stories

Patient Story

A male patient frequently presented to the ED.

The Signature Brockton CHART team:

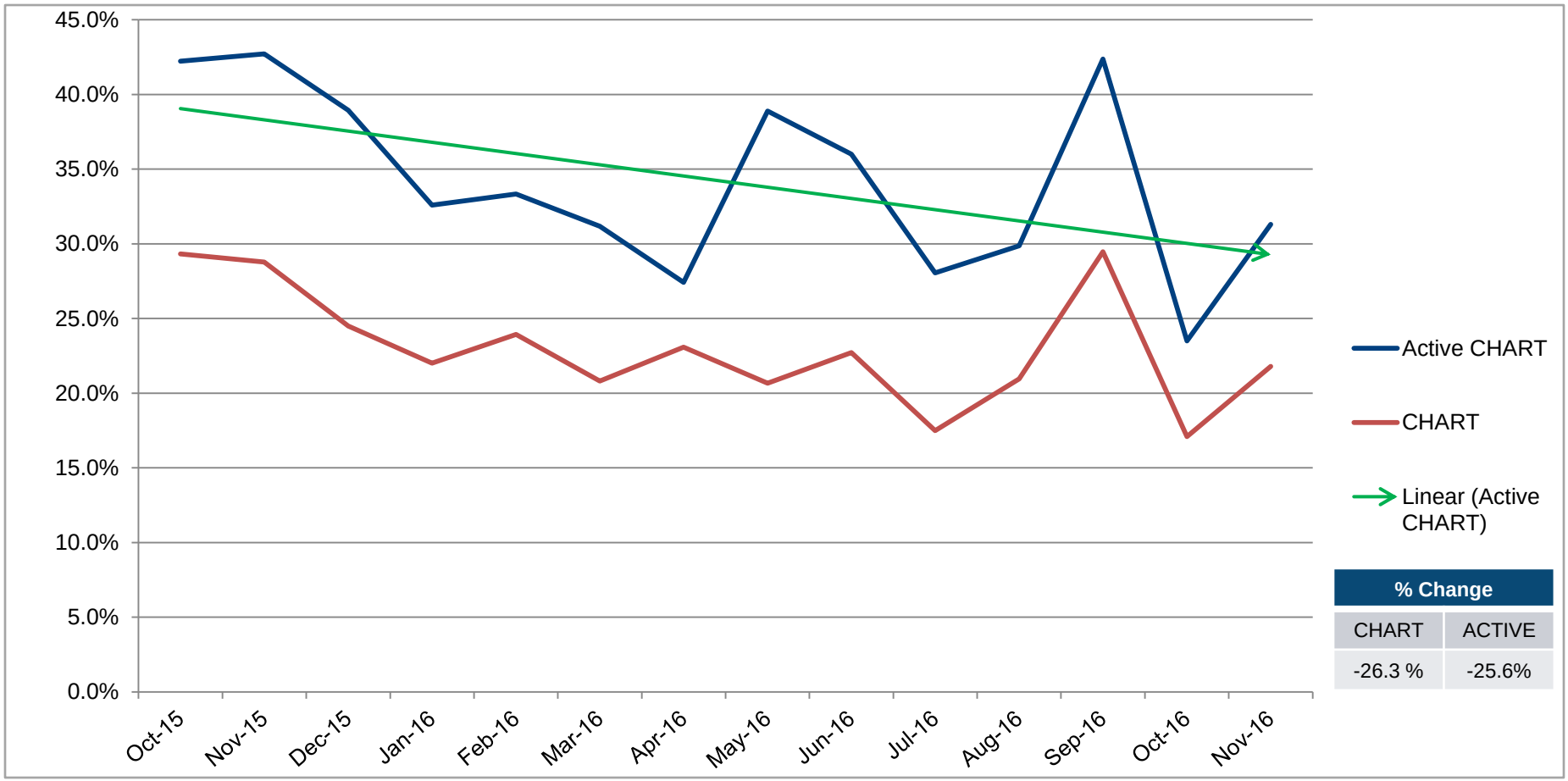
- Collaborated to obtain patient prescriptions for free or at a lower cost
- Connected him to elder services, the Commission of the Blind, visiting nurse services, and medication delivery
- Installed oxygen equipment at patient home
- Maintain weekly phone contact

Operational Successes

The team configured a flag in the EHR to alert all staff that a patient is receiving CHART services and who their lead contact is. This notification enables a higher level of collaboration on discharge plans, a deeper level of teamwork across departments, and a greater awareness of the complex needs of patients.

Results to date

30-day Readmission Rates for All Eligible vs. Active CHART Patients By Month: October 2015 – November 2016



% Change	
CHART	ACTIVE
-26.3 %	-25.6%

Summary

Successes	• Reduced readmission rates and ED visits • Established weekly interdisciplinary team meetings with community partners to coordinate services for patients • Patients call us!
Challenges	• Demand for services exceeds capacity • Traditional model of hospital course and discharge planning contradicts innovative approaches • Lack of services in community for substance use disorders and behavioral health
Next Steps	• Continue to build connections with community partners • Continue to track outcomes

MASSACHUSETTS
HEALTH POLICY COMMISSION

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HPC by the Numbers: The First Four Years

166 public board meetings

634 HPC articles

1,403,272 unique **twitter** impressions

$46 million distributed in grants to **27** community hospitals

686,323 unique **website** hits

900,000,000 lines of **claims** analyzed in the APCD

1,000,000 lines of **code** written

71 MCNs reviewed

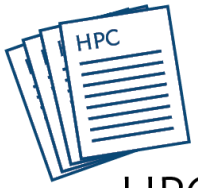
2,551 tweets

27 publications

HPC

HPC by the Numbers: Public Engagement in 2016

206,809
unique **website** hits



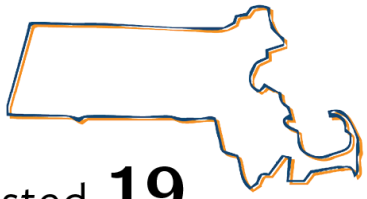
260
HPC articles

39
public meetings

2,120
attendees at **public meetings** throughout 2016

650+
meetings with over **200** different stakeholders

211
pages of minutes



hosted **19** **external meetings** for MA state agencies

21
newsletters

890
tweets

HPC

HPC by the Numbers: 2016 Policy Work

19
MCNs Reviewed

12
Reports Released

2
Regulations Approved

4
Investment Programs

60
Registering Provider Organizations

26
PCMH PRIME Certified Practices

8
unique data sets in 2016 Cost Trends Findings

HPC by the Numbers: Consumer and Patient Support in 2016

In 2016, the Office of Patient Protection processed

1241

calls and emails from consumers seeking information on health insurance enrollment and appeals

330

External Review Cases filed by consumers seeking a determination of medically necessary

HPC by the Numbers: 2016 Cost Trends Hearing

AUDIENCE

- Nearly 400 individuals in-person
- Over 2,700 individuals watching online
- Viewers came from the US, Germany, the Philippines, the UK, and Australia

WEBSITE

- 5,330 unique website visits
- 6.6% of all traffic to the Mass.Gov website
- The majority of people navigated to the Cost Trends Hearing agenda and materials

TWITTER

- 143 Official HPC Tweets
- 69,800 impressions (potential views by unique Twitter users)
- 32% outside of Massachusetts with 4% outside of the US
- 304 Retweets ⟶ 175 Likes ⟶ 50 Replies

MEDIA

- 25 unique articles across 14 major news outlets

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the November 9, 2017 Meeting
- Cost Trends and Market Performance
- Quality Improvement and Patient Protection
- Community Health Care Investment and Consumer Involvement
- Executive Director Update
- **Public Comment**
- Schedule of Next Board Meeting

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HEALTH POLICY COMMISSION

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- **Schedule of Next Board Meeting (February 8, 2017)**

Contact Information

For more information about the Health Policy Commission:

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