MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

November 28, 2018

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- MA-RPO Filing Requirements: Request for Public Comment
- Performance Improvement Plans (PIPs): 2018 Closeout and Three-Year Recap
- 2018 Health Care Cost Trends Report
- Schedule of Next Meeting (February 27, 2019)

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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the MOAT Committee meeting held on October 3, 2018, as presented.

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Proposed 2019 MA-RPO Filing Requirements: Request for Public Comment

- The MA-RPO Program has released its **proposed updates to the 2019 filing requirements** and is **seeking comments** from Provider Organizations and other interested parties

- The proposal includes:
  - Updating an existing question to include information about **facility fees** paid by different payers;
  - Capturing information on **service availability at hospitals and clinics**
  - Requiring a **roster of employed Advanced Practice Providers**
  - Collecting **physician payer mix information**

- A memo describing the proposed updates is available on the program website: https://www.mass.gov/service-details/registration-of-provider-organizations

- Comments are due to HPC-RPO@mass.gov by **Friday, December 21, 2018 at 5:00pm**

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  - Overview of PIPs Process
  - Recap of 2016, 2017, and 2018 Processes and Key Themes
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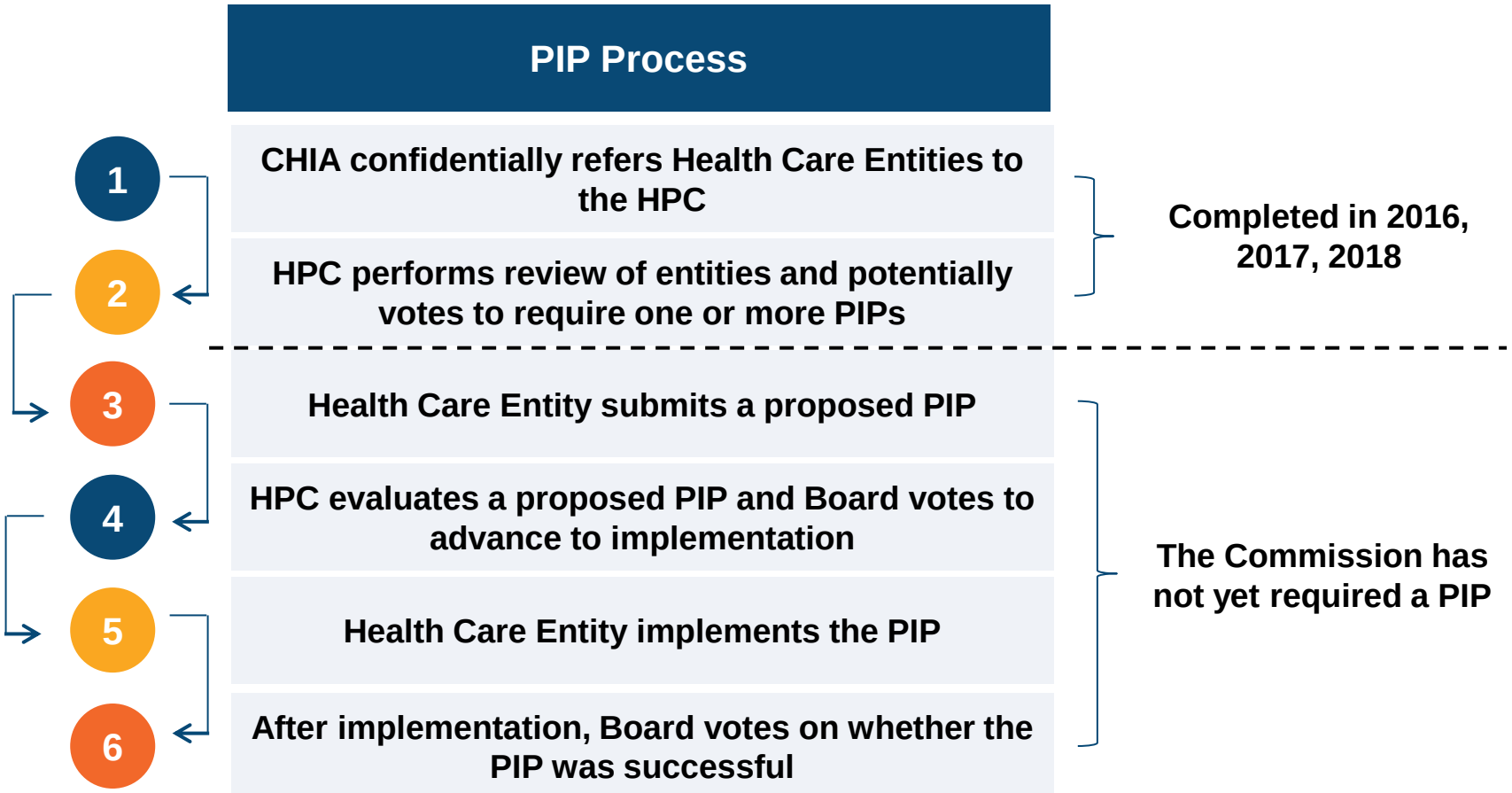
Overview of PIPs Process: Purpose

- Performance Improvement Plans (PIPs) are one of the key mechanisms by which the HPC can enforce the health care cost growth benchmark and ensure accountability *for both payers and providers* to the Commonwealth's cost containment goals.
- By statute, CHIA is required to refer to the HPC a list of payers and providers whose cost growth is "excessive" and who "threaten the benchmark."
- The HPC may require one or more of these entities to file a PIP that identifies and addresses the causes of its cost growth and includes action steps, measurable outcomes, and an implementation timetable of no more than 18 months.
- In years when the state exceeds the benchmark, the HPC may conduct a CMIR of one or more of these entities.
- Entities undergoing a PIP will provide updates to the HPC on the progress of their plan, and will have the opportunity to receive consultation and technical assistance from the HPC.

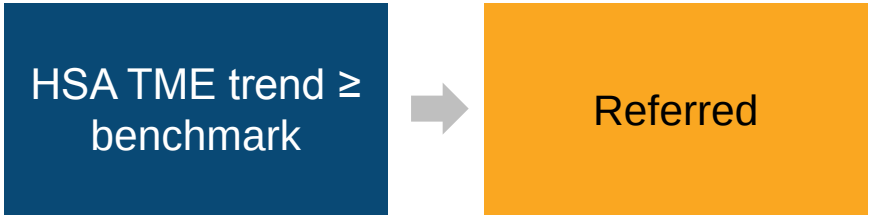
HPC

Overview of PIPs Process

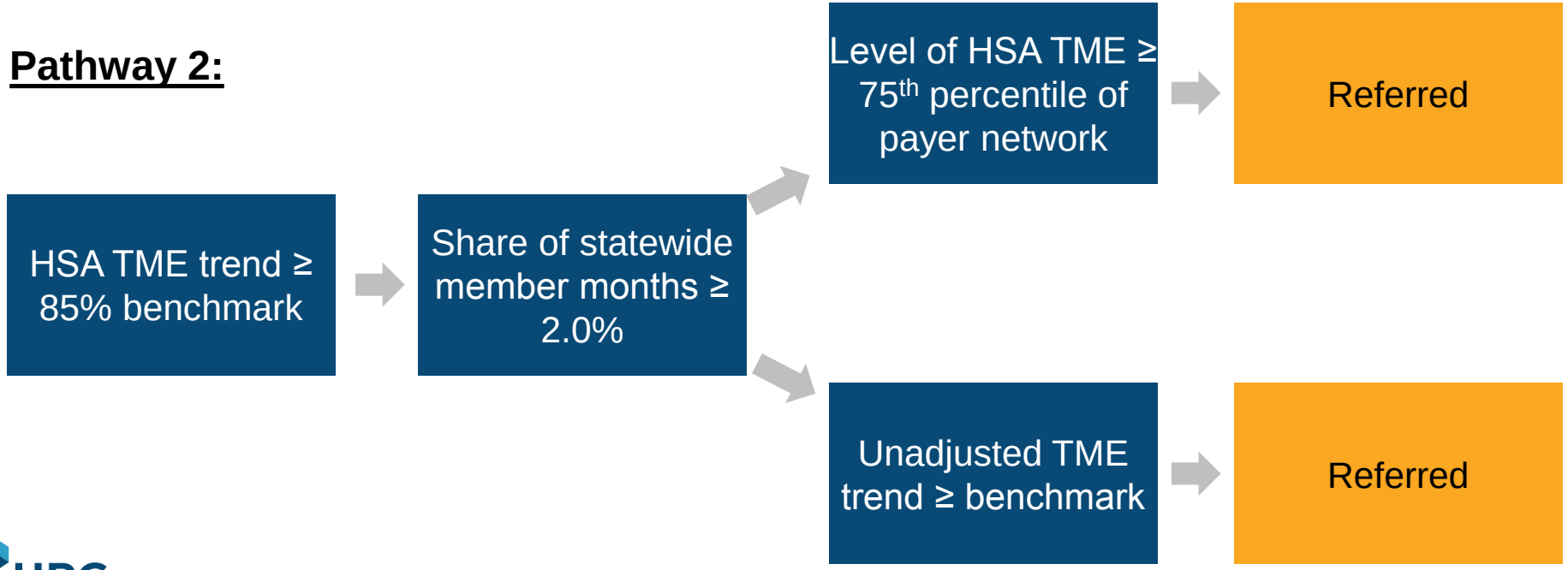


Overview of PIPs Process: CHIA's Provider Referral Methodology

Pathway 1:

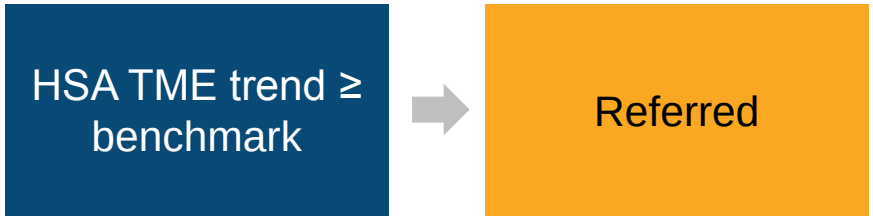


Pathway 2:



Overview of PIPs Process: CHIA's Payer Referral Methodology

Pathway 1:



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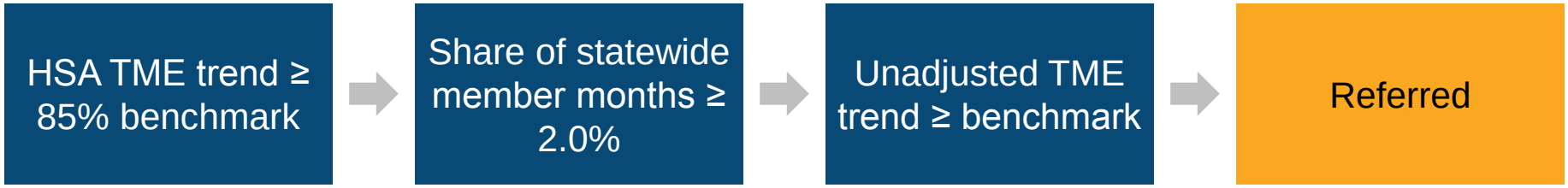

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HPC Entity Review Process

Commissioner Engagement Throughout

1 Initial Review of All Referred Entities

Examples of Factors Examined

Performance across all books of business, including those not referred by CHIA
- HSA TME
- Unadjusted TME
- Risk score

} level, growth, comparison to peers

Entity size and market share

Relative Price

Previous appearance on CHIA's list

Factors outside of entities' control

2 Board Deliberation and Vote to Follow Up with Some Entities

3 Meet with Follow Up Entities and Gather More Data

Examples of Data Requested

Entity's explanation for spending growth

Impact of care delivery and other strategies to control spending

Historical payer rate increases

Role of pharmaceutical spending

Patient population and referral patterns

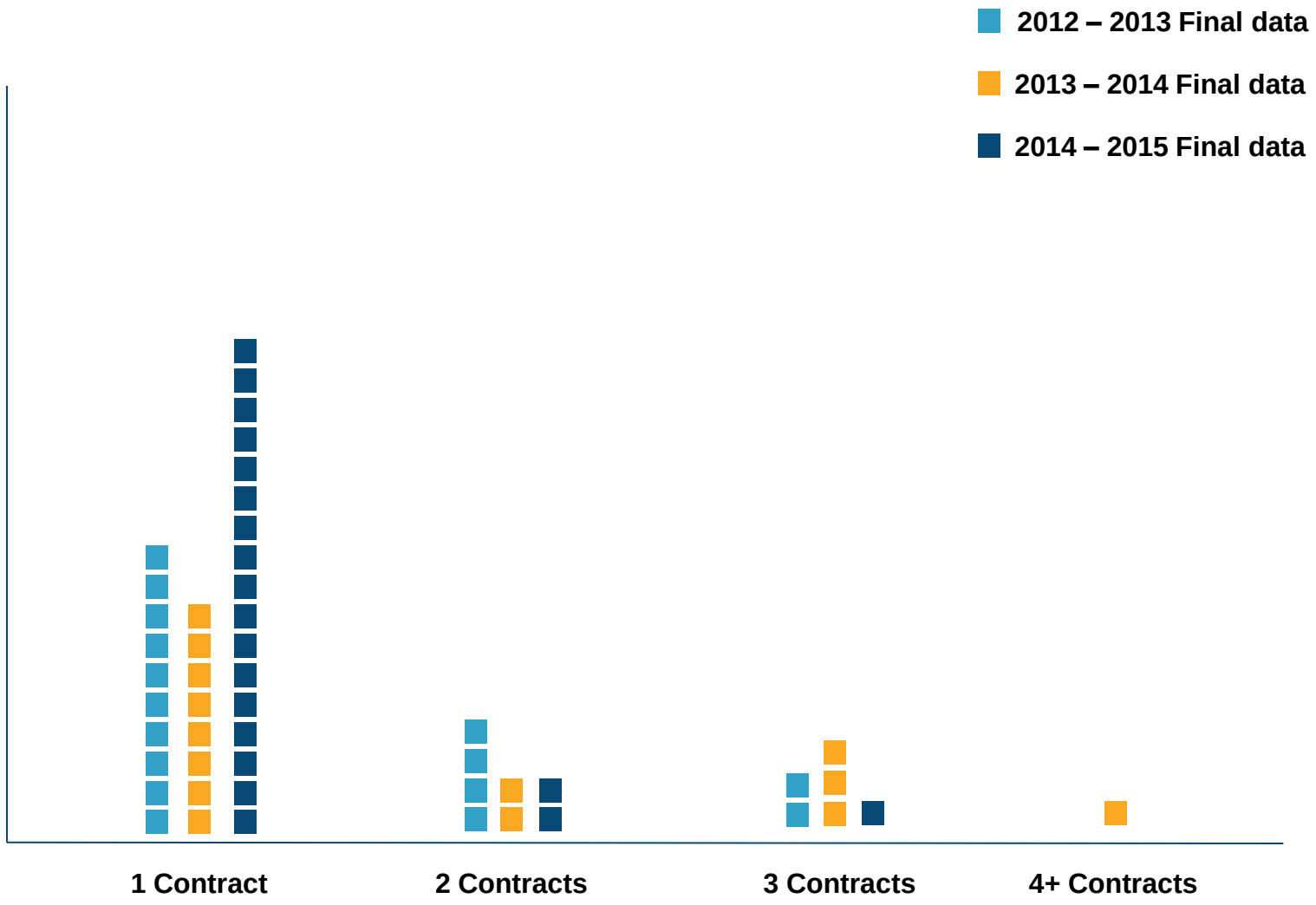
4 Board Deliberation and Vote Whether to Require PIP

HPC

Comparison of 2016, 2017 and 2018 Processes

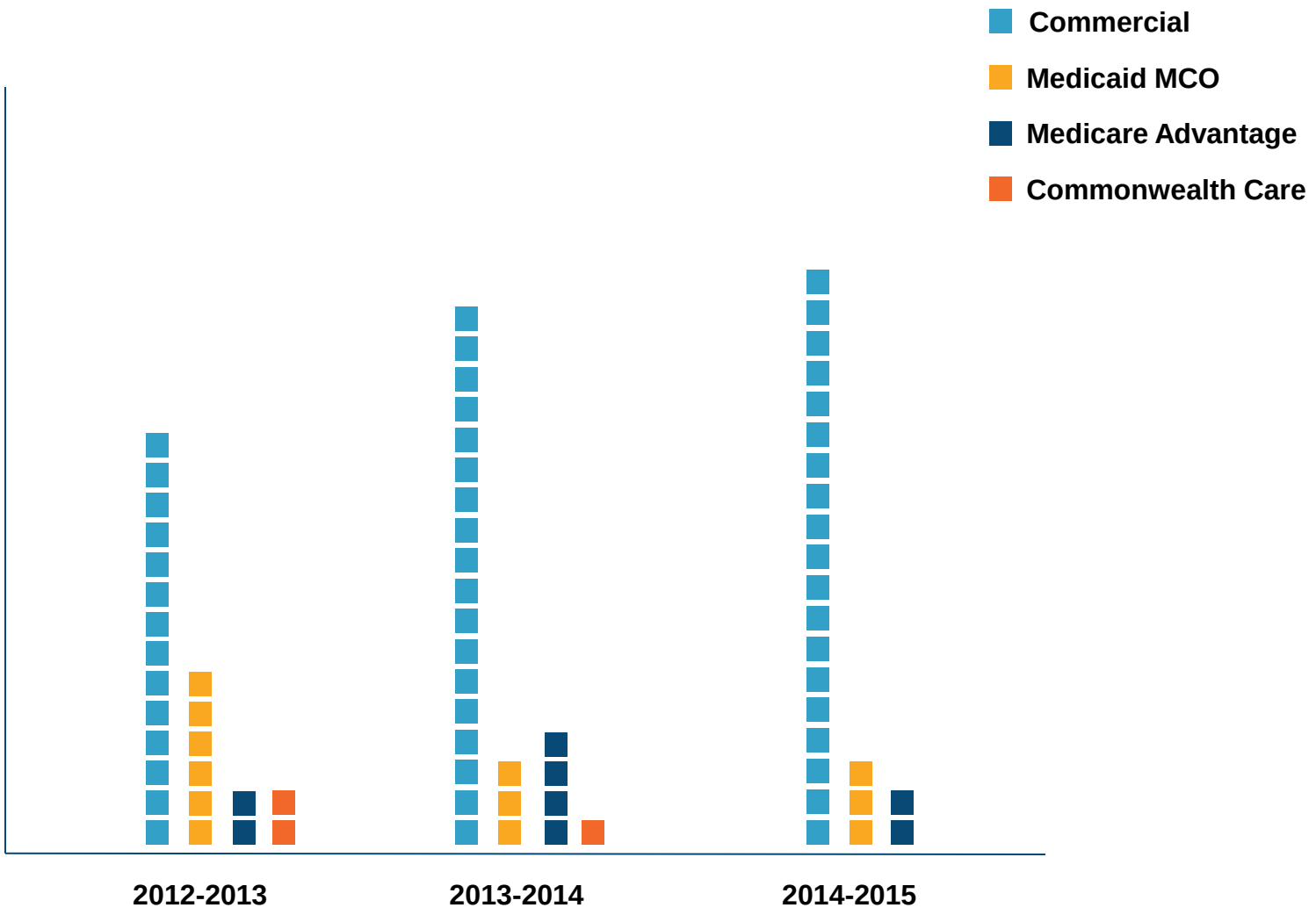
2016	2017	2018
2012 – 2013 Final Data 2013 – 2014 Prelim Data	2013 – 2014 Final Data	2014 – 2015 Final Data
Entities Referred: 33	Entities Referred: 20	Entities Referred: 26
25 providers 8 payers	14 providers 6 payers	20 providers 6 payers
↓	↓	↓
No PIP	No PIP	No PIP

The majority of providers have been referred for their performance in a single contract



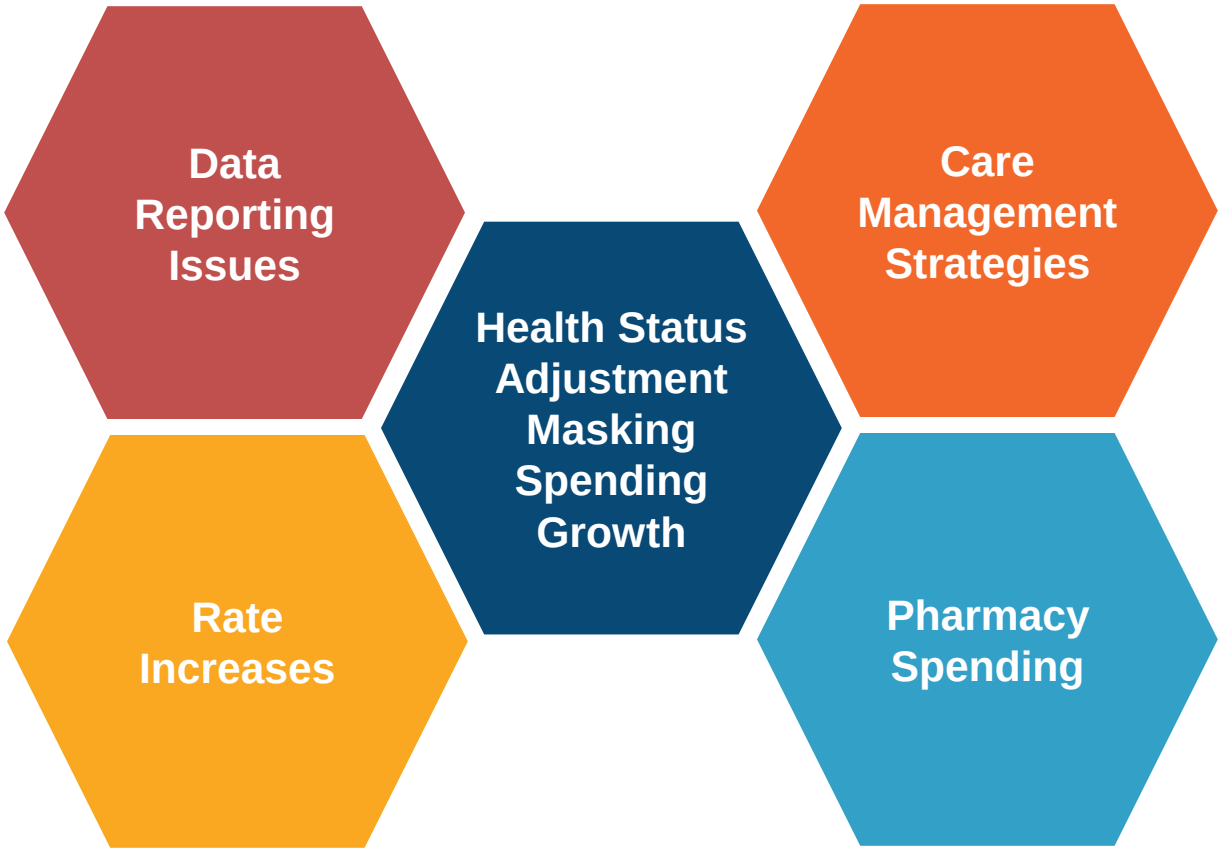
Note: To allow for a more direct comparison of identified contracts over time, we excluded providers and contracts that were identified by CHIA based on preliminary 2013-2014 data.

Most referred provider contracts have been in the commercial insurance market



Note: To allow for a more direct comparison of identified contracts over time, we excluded providers and contracts that were identified by CHIA based on preliminary 2013-2014 data.

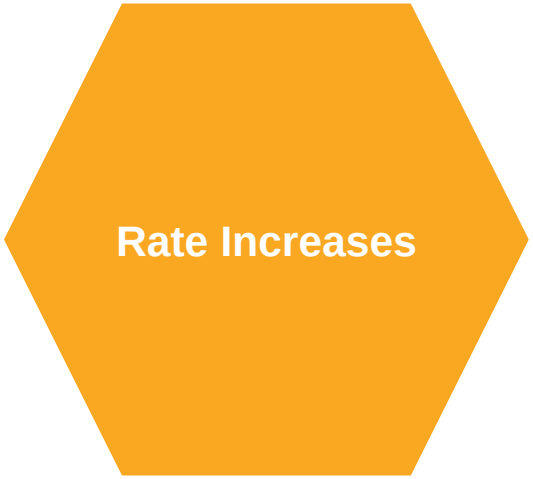
Key Themes in the 2016, 2017, and 2018 Cycles



Key Themes in the 2016, 2017, and 2018 Cycles

- The Commonwealth **requires accurately reported TME data** in order to monitor the performance of the health care market and of specific entities.
- Payer-reported TME is used to evaluate both payer and provider spending trends; payer reporting errors can lead to inaccurate referral of the payer and all of its participating providers.
- In each year, at least one payer submitted TME data that required corrections during HPC's review. A total of **four payers have been required to submit corrected data.**

Key Themes in the 2016, 2017, and 2018 Cycles



- The health care cost growth benchmark **does not act as a cap on rate increases.** The HPC has observed multiple cases of providers receiving rate increases in excess of the 3.6% benchmark.
- **Rate increases are likely a significant factor** in the growth of both payers' and providers' spending from 2012 – 2016 and may **outweigh efficiency gains** in care delivery reforms, use of APMs, ACOs, etc.
- **Entities receiving high rate increases may have difficulty staying under the benchmark** if utilization growth, service mix changes, or provider mix changes also contribute to spending growth.

Key Themes in the 2016, 2017, and 2018 Cycles

- A number of entities **have highlighted their strategies** for controlling spending growth, including:
  - Use of high-value referral partners
  - Case management, especially for high-risk patients
  - Avoidance of unnecessary ER use or hospital admissions
  - Readmission control
  - Post-acute care / SNF networks
- However, **program results have not always been closely and thoroughly tracked**, making it difficult to evaluate any savings or impact on quality of care.

Key Themes in the 2016, 2017, and 2018 Cycles

- **Pharmacy spending has been a significant driver of overall spending growth** in all three PIPs cycles to date.
- **Pharmacy spending growth can sometimes spike for a single year**, with the timing of the spike depending on:
  - The introduction of new branded drugs
  - Coverage and formulary decisions
  - Payer-provider contract renewals
  - Payer-PBM contract renewals
  - The introduction of generic equivalents or other competing drugs.
- Payers and providers **use a variety of strategies to control drug spending.**

Key Themes in the 2016, 2017, and 2018 Cycles

- The health care cost growth benchmark measures **Total Health Care Expenditures (THCE)**.
  - THCE reflects **real dollar spending**.

- CHIA's statute requires referral of payers and providers to the HPC for a potential PIP based on **Health Status Adjusted Total Medical Expense (HSA TME)**
  - HSA TME **does not reflect actual dollars spent**. It is a measure of efficiency.
  - Health status adjustment allows providers and payers with different patient populations to be fairly compared. It is also an important policy tool that discourages cherry-picking of healthy patients.

- However, an entity with **high growth in actual spending may not be referred to the HPC** if growth in its risk scores results in below-benchmark HSA TME growth.

Key Themes in the 2016, 2017, and 2018 Cycles

Sample Calculation

	Year 1	Year 2	Growth
Unadjusted TME	$450	$486	8%
Risk Score	1.45	1.54	6%
Adjustment:	$450 / 1.45	$486 / 1.54	
Health Status Adjusted TME	$310	$316	2%

← **Growth in actual dollars spent per member per month**

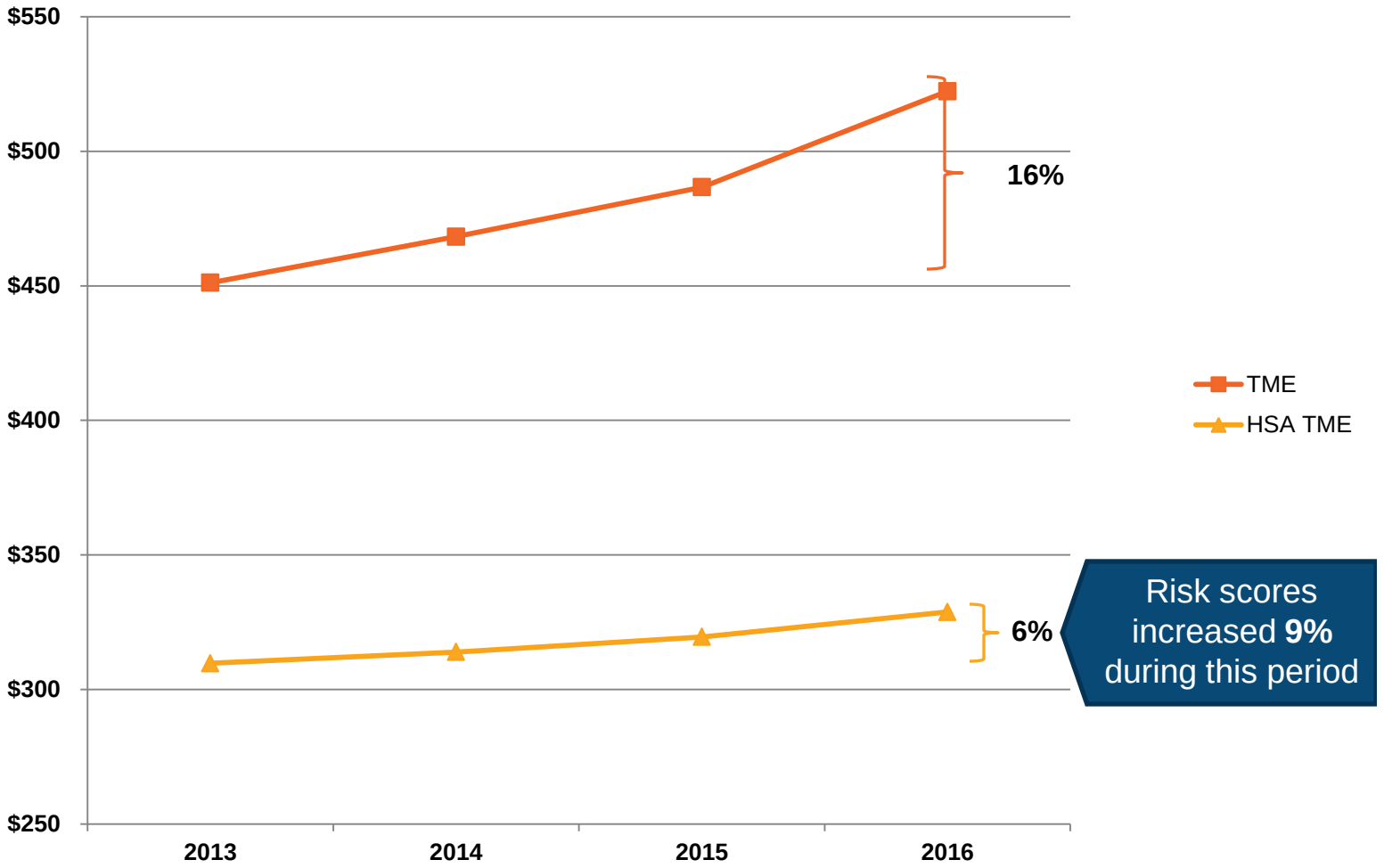
← **Basis of referral – measure of efficiency, not actual dollars spent**

Key Themes in the 2016, 2017, and 2018 Cycles

- Payer and providers may both have incentives to **fully document all patient diagnoses** in order to **maximize payment**.
- In some cases, increased risk scores may reflect factors such as **increased coding intensity rather than actual changes in patients' health status** and the expense of caring for them.
  - Many entities are investing substantial resources in medical coding and audit capabilities to more robustly document patient acuity.
  - Entities with more resources may be better able than others to make such investments and obtain higher payment as a result of increased risk scores.
- **These issues are systematic** and have a market-wide impact.

In most cases, including for the three largest commercial payers, unadjusted TME has been growing at a faster rate than HSA TME

Example commercial Book of Business Trends for 1 Large Massachusetts Payer



Many commercial payer-provider contracts have unadjusted growth above 3.6%, but are not referred due to their lower HSA TME growth rate

Each dot represents one year of change in the TME and HSA TME of one commercial payer-provider contract. For example, Payer A – Provider 1, 2013-2014. Includes data from years 2012-2016 and excludes instances when a contract's membership increased or decreased more than 10%.

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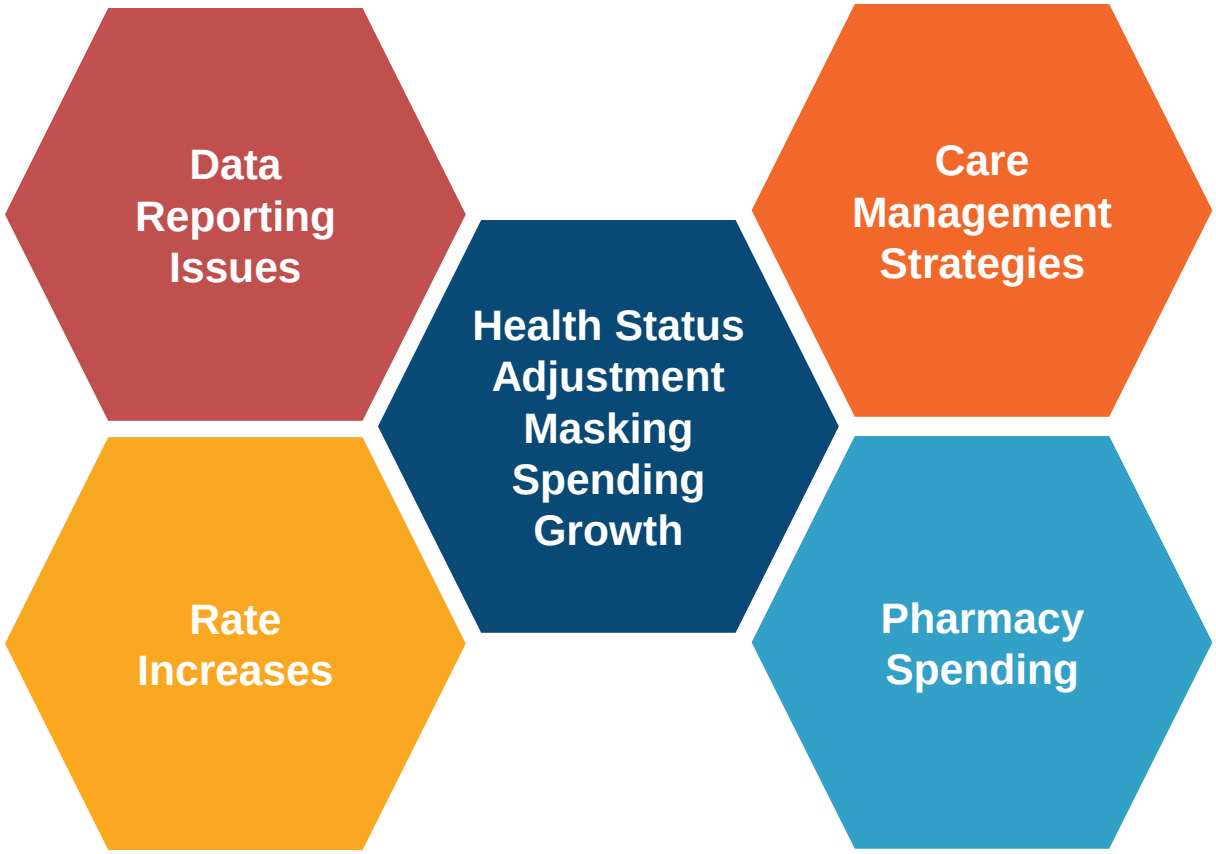
Discussion


Data Reporting Issues
Care Management Strategies
Health Status Adjustment Masking Spending Growth
Rate Increases
Pharmacy Spending

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Hospital admissions from the ED: Background

Prior HPC work has identified **Emergency Department (ED)** spending as a major driver of healthcare costs in the Commonwealth. This work has primarily focused on overall ED utilization and avoidable ED utilization.

ED visits are also the main gateway to an inpatient admission, where the decision to admit a patient is made by an ED's attending physicians and other personnel. Nationally, 11 - 20% of ED visits result in hospital admission and ~50% of inpatient stays originate in the ED (Morganti, 2013).

Research shows that there is significant variation by hospital and by condition in admission rates (Venkatesh, 2015; Sabbatini, 2018). This literature, recent controversy (see notes), as well as discussions with stakeholders indicate that this variation *may be a source of potentially avoidable health care costs*.

The cost difference between an average ED visit and an inpatient admission is significant, typically a factor of 10 or more (~$10,000-20,000 vs ~$1,000-$1,500).

By exploring inpatient admissions from the ED among Massachusetts hospitals, the HPC aims to identify variation in admission by hospital, hospital type, and condition in order to understand if there is the potential for reducing unnecessary inpatient stays.

Notes: Beginning In 2011, Health Management Associates, Inc. of Naples, FL ("HMA") was accused of using admissions quotas (15-20% overall; 50% for Medicare patients) at the hospitals they managed in order to boost their profitability. This led to a class-action suit on behalf of stock holders, a *60 Minutes* expose, as well as a DOJ investigation and eventual criminal charges. In September 2018, HMA's parent organization settled with the DOJ for more $260 million. The investigation also found that HMA had paid physicians various forms of kickbacks in exchange for medical referrals.

Many factors lead to decisions whether to admit patients from the ED

Clinical factors

- Illness severity
- Age of patient
- Multiple presentations for same complaint
- Complex past medical history
- Uncertainty about clinical trajectory

Provider- or hospital-level factors

- Risk tolerance of clinician
- PCP requests hospital
- Medicare 3-midnight rule
- Bed availability or other capacity or financial considerations
- Lack of observation unit
- On-call coverage/ service availability
- Inability to get diagnostic testing results back in a timely manner

Social factors

- Lack of reliable PCP/outpatient follow-up
- Safety of patient following discharge
- Patient/family preference
- Lack of services available over the weekend
- Lack of transportation home

HPC

Notes: These are based on discussions with clinicians and review of academic literature

Admissions from the ED: Research Design

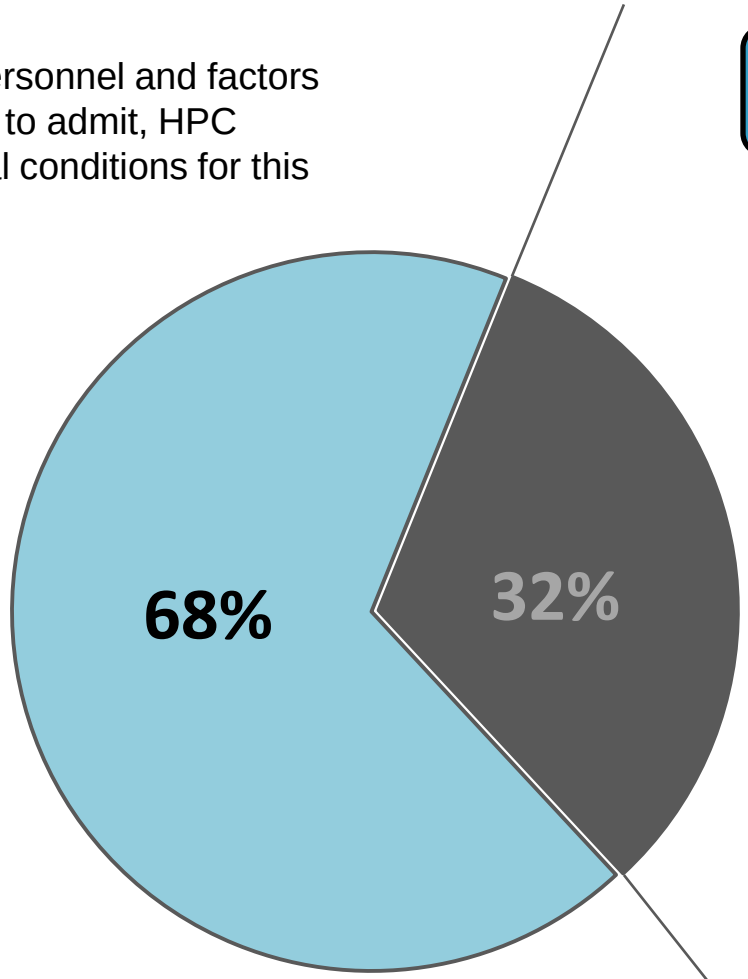
- Combined 2016 CHIA Acute Hospital discharge, emergency department visit and observation stay data sets to identify admissions to the hospital from the ED
  - Captured all ED visits discharged home, by discharge condition, by hospital
  - Identified inpatient admissions from the ED, by admitting condition, by hospital
  - Included observation stays over 48 hours
- Examined variation in admissions from the ED for the top condition categories (using CCS grouper) based on volume in admissions
  - Adjusted for patient characteristics, including age, gender, race, payer, income (based on zip code), and drive time to nearest ED (based on zip code)
- In examining admissions from the ED, the HPC sought to answer a range of questions, e.g.:
  - To what extent does ED volume drive inpatient volume at different hospitals?
  - Do admission rates vary by hospital type, location, or other characteristics?
  - Do hospitals with high admission rates of some conditions have high admission rates for other conditions?
  - Are hospitals with high admission rates admitting patients for potentially avoidable inpatient stays?
  - Are hospitals with low admission rates discharging unstable patients who end up returning to the hospital/ED?

Notes: Discharges were dropped from study if patients were <18 years old, left against medical advice, were deceased, or were discharged from a specialty hospital.

Sources: HIDD, EDD, and OOD from Case Mix databases (CHIA 2016); Clinical Classification Software (CCS; AHRQ 2017)

Identifying admissions from the ED: restricting to medical diagnoses

Due to differences in personnel and factors involved in the decision to admit, HPC focused on only medical conditions for this analysis.



Medical

1,655,325

includes disease and disorders

Maternity

44,770

Behavioral Health

210,850

(includes mental health and substance use disorder codes)

Trauma

485,443

(includes external causes and adverse effects of medical care or medications)

Residual or Unclassified

36,824

Notes: Discharges were dropped from study if patients were <18 years old, left against medical advice, were deceased, or were discharged from a specialty hospital.
Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

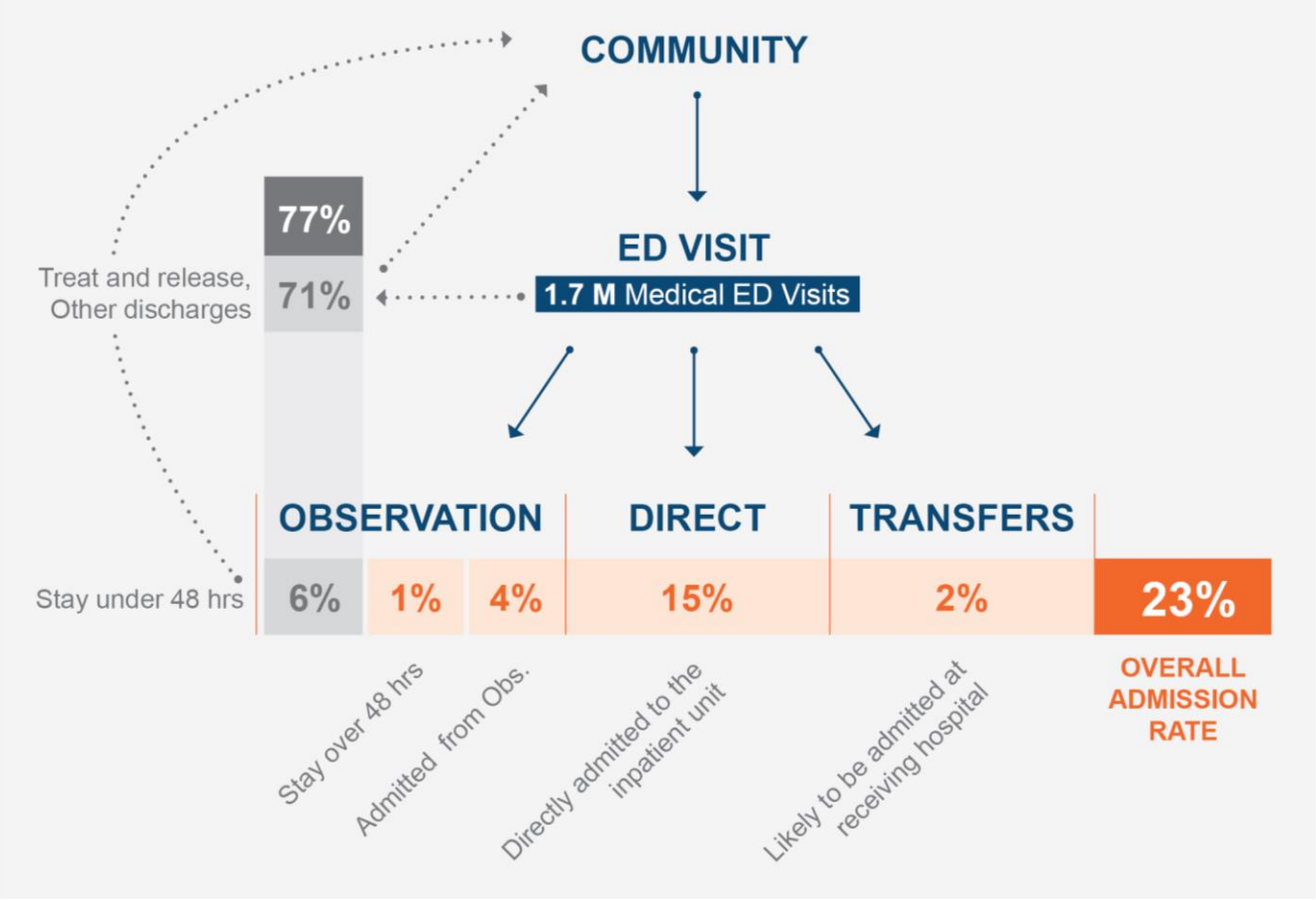
Key findings

- In 2016, **23% of all medical ED visits** in Massachusetts resulted in either a transfer, long observation stay, or inpatient admission.
- Admission rates by individual hospital varied considerably, from **13% to 32%.**
- Within certain clinical groupings, such as septicemia, there was little variation in whether a patient would be admitted.
- Other conditions, such as **chest pain and COPD**, had significant variation indicating that there may be more discretion in admitting practices or other unobserved factors.
- Hospitals with high admission rates for some conditions tended to have **high rates for other conditions**.
- Hospital variation ***does not*** appear to be driven by the type of hospital (AMC, Teaching, Community).
- Hospitals with low admission rates ***did not*** tend to see more frequent revisit rates among those patients.

Overall, 23% of medical ED visits resulted in either a transfer, long observation stay, or inpatient admission

It is important to look beyond direct inpatient admissions from the ED to understand admission rates

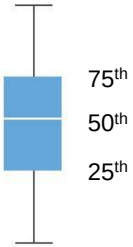
- Observation status is increasingly used in place of inpatient admissions for certain conditions, especially for Medicare patients (Overman, 2014; Sabbatini, 2018).
- Some hospitals transfer many patients from their ED to other hospitals where they are admitted

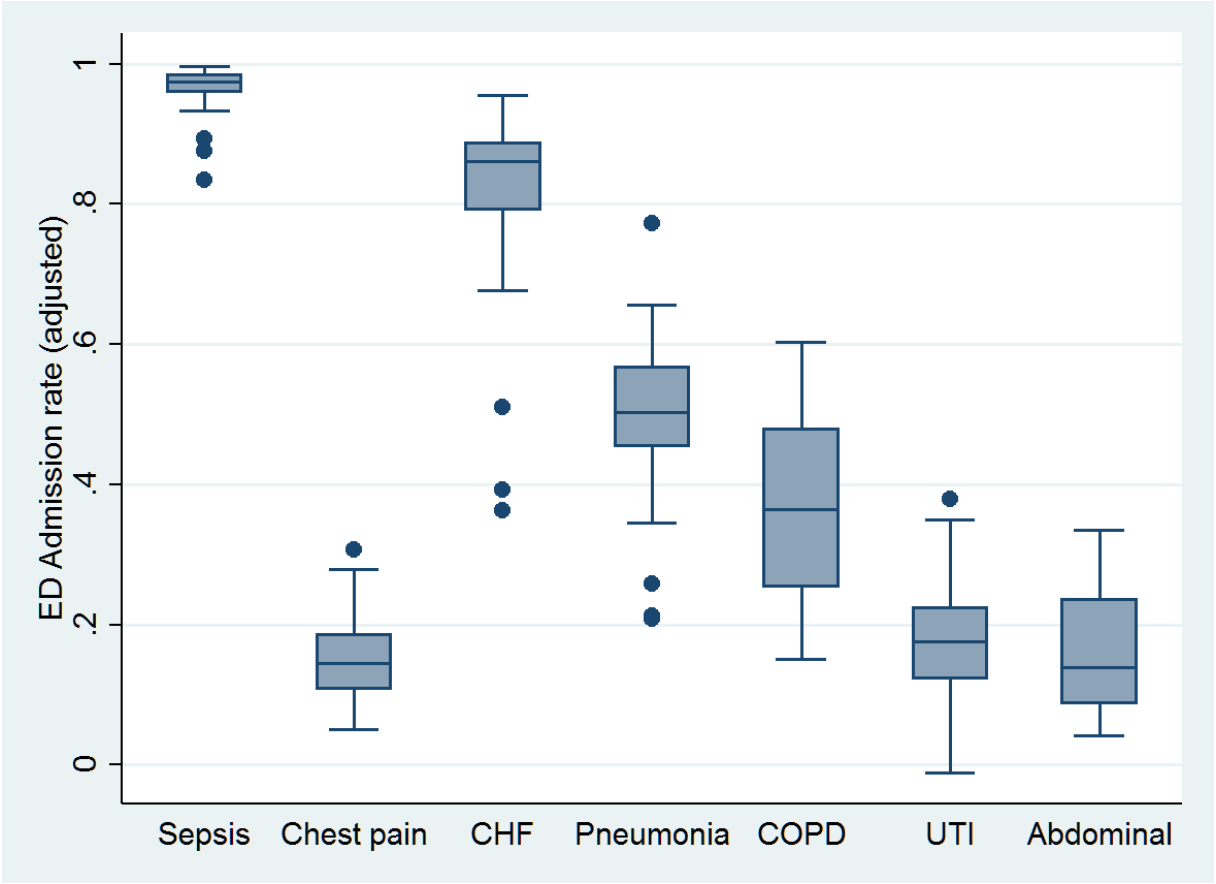


Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

The rate at which hospitals admit patients from the ED varies within and among conditions; COPD patients experienced the most significant variability in admission rates by hospital

Distribution of ED admission rates by hospital for selected conditions





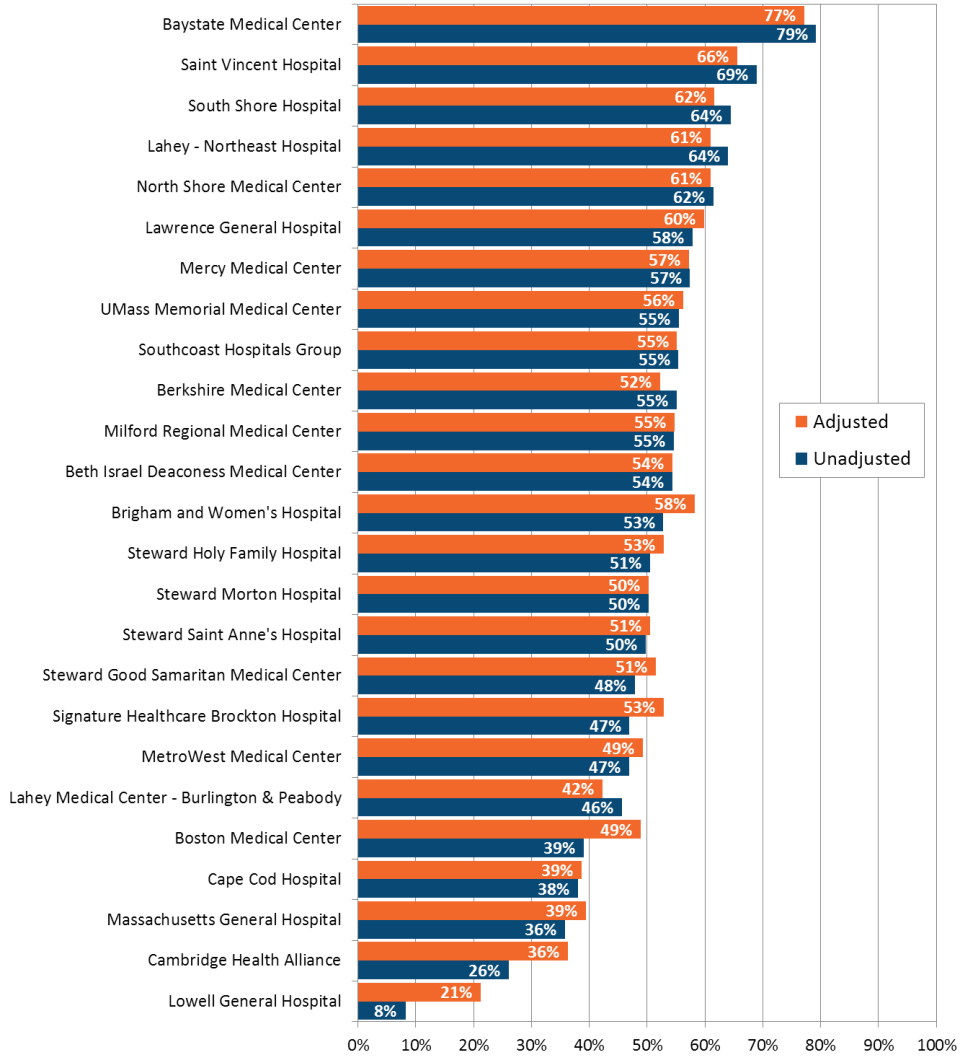
Percentage point (p.p.) difference between 75th and 25th percentile (Interquartile range)	Sepsis	Chest pain	CHF	Pneumonia	COPD	UTI	Abdominal
	2 p.p.	**8 p.p.**	**9 p.p.**	**11 p.p.**	**21 p.p.**	**9 p.p.**	**15 p.p.**

Notes: All admission rates are adjusted for patient characteristics (age, gender, race, payer, income, and drive time to nearest ED). Whiskers in the box plot are defined as the highest observed value that is within the 75th percentile plus 1.5* the interquartile range on the upper end and similar for the lower end. Dots represent outliers whose values fall outside of the whiskers.

Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

Even when adjusting for a range of patient characteristics, admission rates by hospital for pneumonia vary considerably

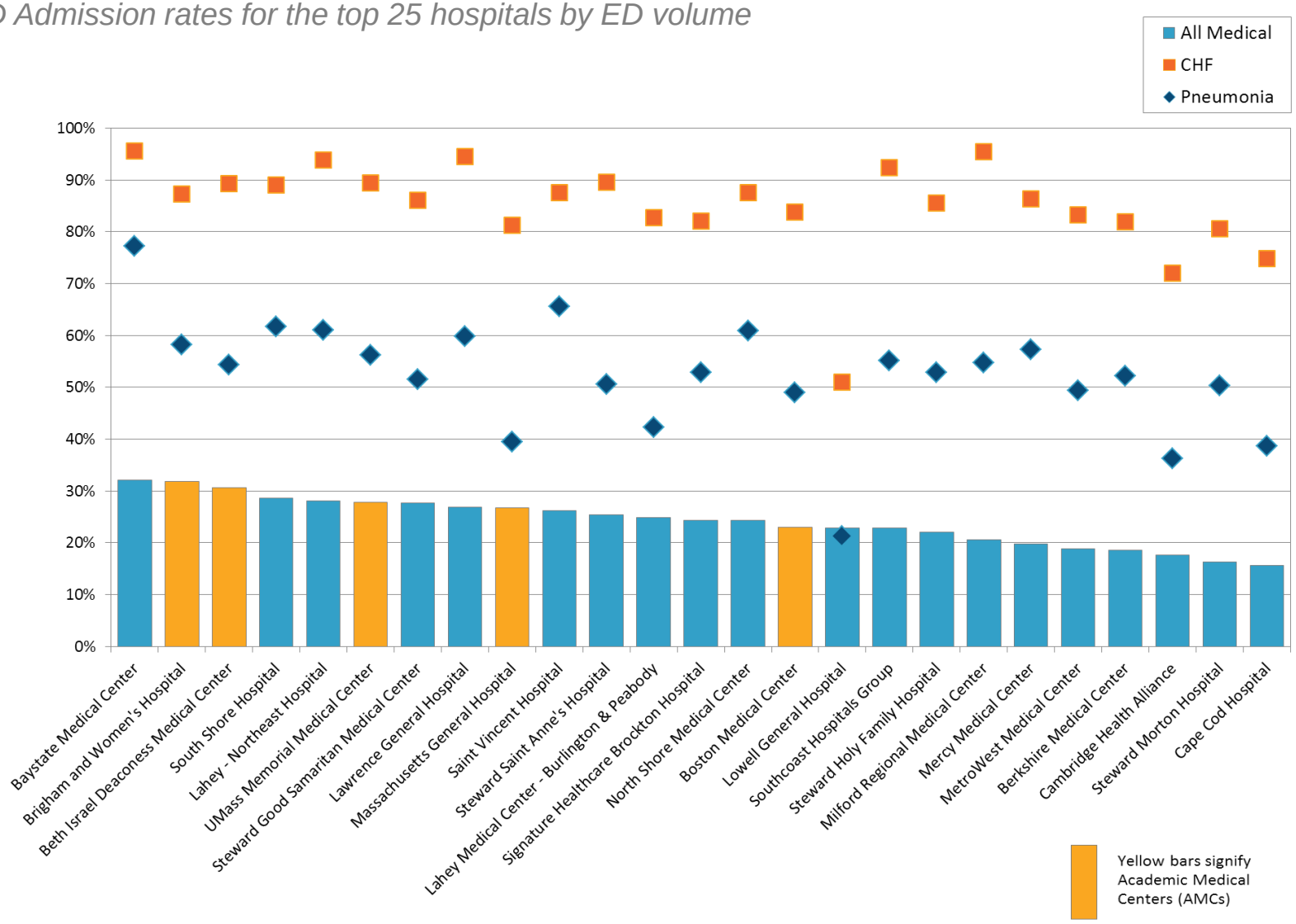
Unadjusted and adjusted ED admission rates, top 25 hospitals by ED volume, Pneumonia



Notes: Included hospitals are among the top 25 by all-medical ED volume and ordered by their unadjusted ED admission rates for Pneumonia diagnoses
Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

Hospitals with high admission rates for some conditions tend to have high rates for other conditions

ED Admission rates for the top 25 hospitals by ED volume



Notes: Hospitals are ordered by patient-adjusted ED admission rates

Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

Hospital admission rates for some conditions are strongly correlated

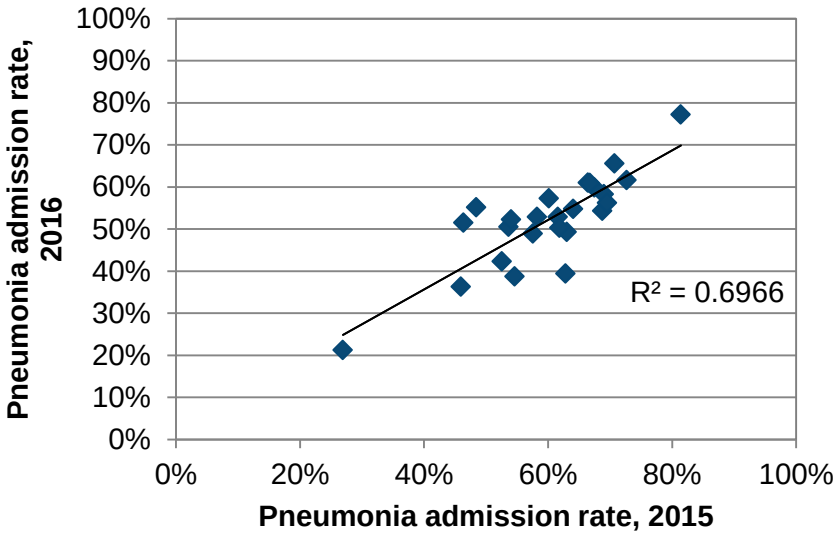
Cross-correlations of ED admission rates for selected conditions by hospital

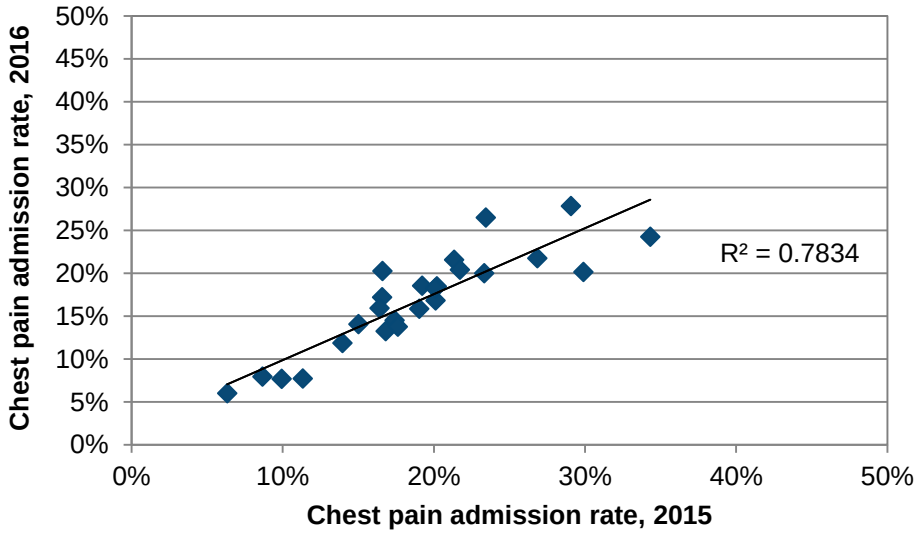
Diagnosis	Abdominal	CHF	COPD	Chest Pain	Pneumonia	Septicimia	UTI
Abdominal	1.00						
CHF	-0.17	1.00					
COPD	-0.18	0.68	1.00				
Chest pain	0.67	0.13	0.06	1.00			
Pneumonia	-0.11	0.81	0.81	0.11	1.00		
Septicemia	-0.02	0.35	0.35	-0.19	0.35	1.00	
UTI	-0.05	0.68	0.77	0.10	0.80	0.30	1.00

Notes: Correlations are based on patient-adjusted ED admission rates.
Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

Admission rates by hospital are also similar across years (2015 and 2016)

ED admission rates for top 25 hospitals by volume, Pneumonia and Chest pain, 2015 and 2016

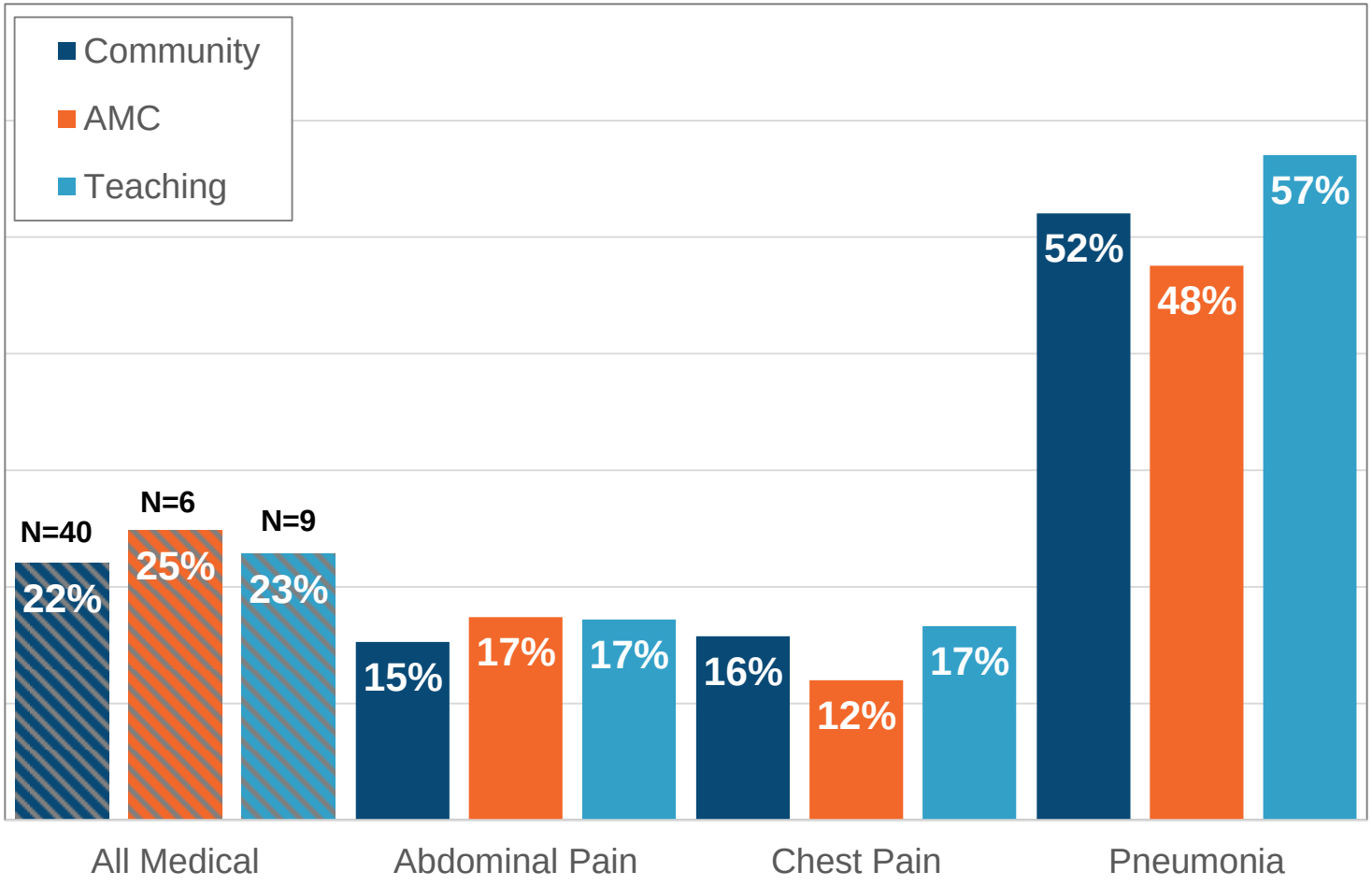




Notes: All admission rates are adjusted for patient characteristics (age, gender, race, payer, income, and drive time to nearest ED)
Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

Academic Medical Centers (AMCs) have lower admission rates for pneumonia and chest pain

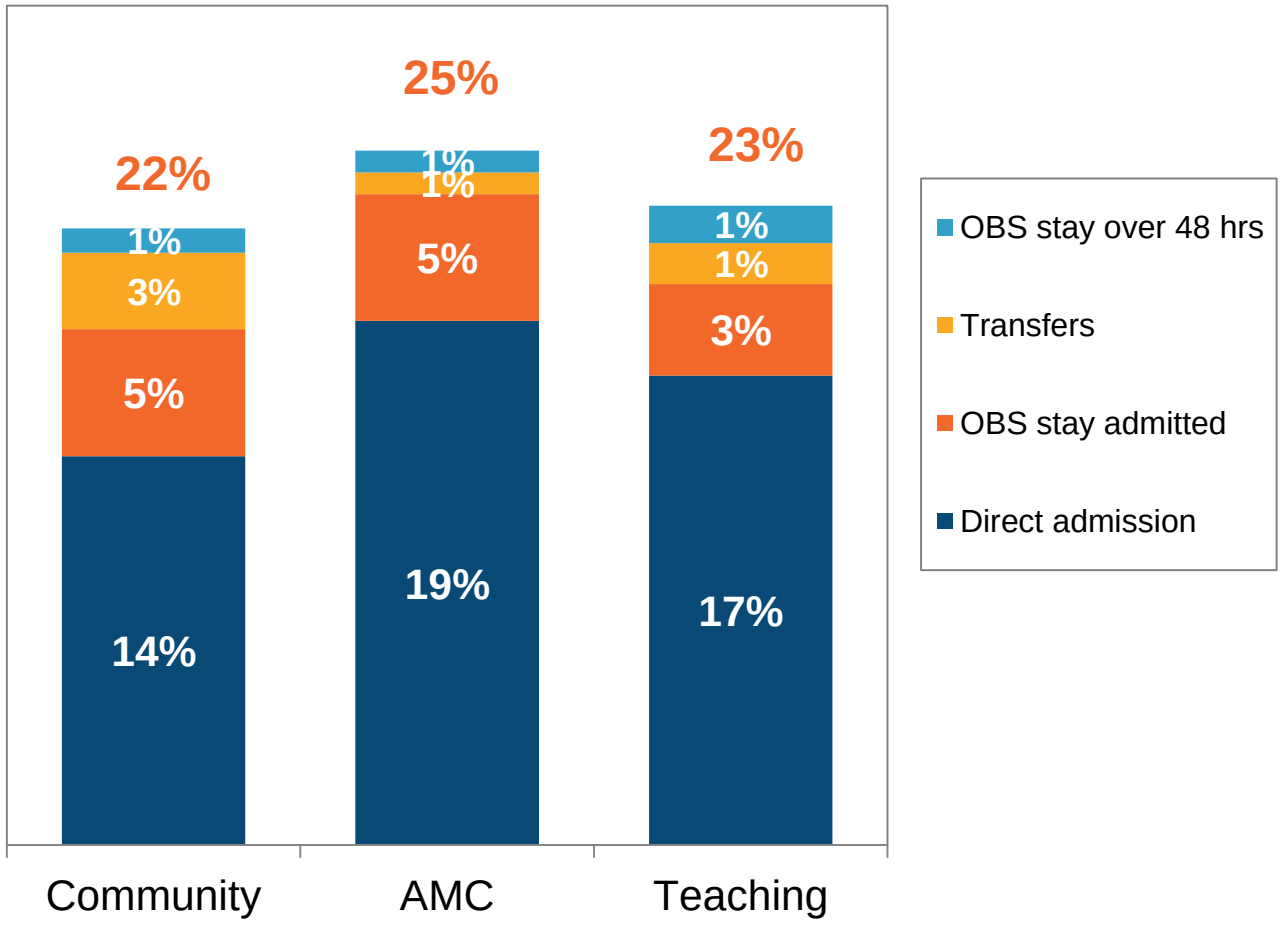
ED admission rates by hospital type, all medical and select medical conditions



Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

Community hospitals are less likely to directly admit and slightly more likely to transfer patients out to other acute care hospitals

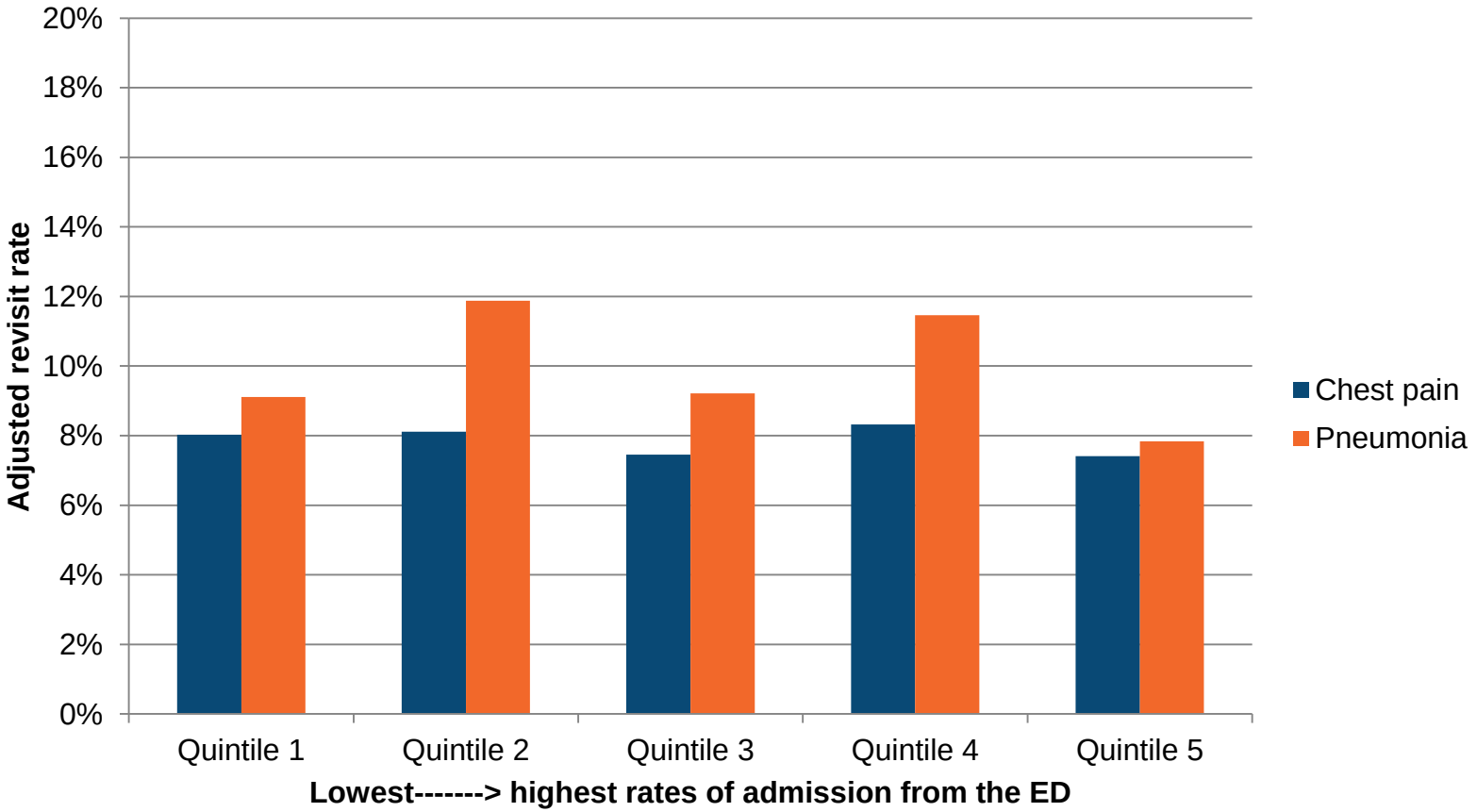
Composition of ED admissions by hospital type for all medical conditions



Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

Hospitals that admit fewer patients from the ED (Quintile 1) do not tend to see higher revisit rates among those patients

7-day adjusted revisit rate (ED, inpatient, observation) for 25 largest hospitals, grouped by admission rate from the ED for the given condition



Notes: Revisits are defined using a modification of CHIA's definition to include any ED visit, observation stay, or inpatient admission in a 7-day time period after discharge from the ED for the given condition ("Emergency Department Visits After Inpatient Discharge")

Source: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

MASSACHUSETTS
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AGENDA

- Call to Order
- Approval of Minutes
- MA-RPO Filing Requirements: Request for Public Comment
- Performance Improvement Plans (PIPs): 2018 Closeout and Three-Year Recap
- 2018 Health Care Cost Trends Report
  - Variation in Hospital Admissions from the Emergency Department
- **Schedule of Next Meeting (February 27, 2019)**

2018 Meetings and Contact Information

Board Meetings

Thursday, December 13, 2018

Committee Meetings

Wednesday, February 27, 2019

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@state.ma.us

Special Events

Massachusetts Employer Health Coalition (MEHC) Kickoff Breakfast: December 11, 2018, 8:00 AM – 10:00 AM

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Appendix

Definition of an ED admission and study population

Dataset	Population = encounters that started in the ED	"Inpatient" admission definition
EDD	Excluded DOA, eloped, died, left w/o being seen patients	Discharged as transfer to another acute care hospital
OBS	Included if admitted through ED, based on ED flags 1 & 2 or admission source	OBS with >=48 hour stay (or alternative definitions)
HDD	Included if admitted through ED, based on ED flags 1 & 2 or revenue codes	All, including those that went through observation

Common inclusion criteria for all datasets:

-Medical, non-maternity conditions (excl. trauma, psychiatric & substance abuse) based

-Adults only >=18

-General acute care hospitals (specialty and children's excluded)

References

- Morganti et al. (2014). "The Evolving Role of Emergency Departments in the United States." RAND Health.
- Sabbatini et al. (2014). "Reducing Variation In Hospital Admissions From The Emergency Department For Low-Mortality Conditions May Produce Savings." Health Affairs.
- Venkatesh et al. (2015). "Variation in US Hospital Emergency Department Admission Rates by Clinical Condition.“
- Overman et al. (2014). "Observation stays in administrative claims databases: underestimation of hospitalized cases." Pharmacoepidemiology and Drug Safety. Medical Care.
- Sabbatini et al. (2018). "The cost of observation care for commercially insured patients visiting the emergency department." American Journal of Emergency Medicine.