AGENDA

- Call to Order
- Approval of Minutes from the January 31, 2018 Meeting
- Commissioner Updates
- Market Oversight and Transparency
- Executive Director’s Report
- Public Hearing on the Potential Modification of the 2019 Health Care Cost Growth Benchmark
- Schedule of Next Board Meeting (April 25, 2018)
Call to Order

Approval of Minutes from the January 31, 2018 Meeting
Commissioner Updates
Market Oversight and Transparency
Executive Director’s Report
Public Hearing on the Potential Modification of the 2019 Health Care Cost Growth Benchmark
Schedule of Next Board Meeting (April 25, 2018)
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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on January 31, 2018 as presented.
Benchmark Hearing Agenda

12:00PM
• Brief meeting of the HPC Board

12:30PM
• Introduction, Dr. Stuart Altman
  • Opening Remarks, Vice Chairman Jeffrey Roy and Chairman James Welch

12:40PM
• Statutory Process and Factors for Consideration, David Seltz

12:45PM
• Overview of MA Spending Performance and Opportunities for Savings, Dr. David Auerbach

1:15PM
• Board Discussion
  • Questions from the Board and members of the Joint Committee on Health Care Financing

1:25PM
• Public Testimony
  • Questions from the HPC Board and members of the Joint Committee on Health Care Financing
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- Call to Order
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  - Vice Chair Appointment
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VOTE: Vice Chair Appointment

MOTION: That, pursuant to Section 2.3 of the By-Laws, the Commission hereby appoints __________ to serve a one-year term as Vice Chairperson of the Health Policy Commission.
AGENDA

- Call to Order
- Approval of Minutes from the January 31, 2018 Meeting
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  - 2017 Health Care Cost Trends Report
  - Executive Director’s Report
  - Public Hearing on the Potential Modification of the 2019 Health Care Cost Growth Benchmark
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- Call to Order
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  - 2017 Health Care Cost Trends Report
    - Executive Director’s Report
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- Schedule of Next Board Meeting (April 25, 2018)
The 2017 report includes material in two publications, a narrative written report and a graphical chartpack.

Written Report Focus Areas:
- Trends in Spending and Care Delivery
- Hospital Outpatient Department Spending
- Provider Organization Performance Variation
- Policy Recommendations

Chartpack Focus Areas:
- Hospital Utilization
- Post-Acute Care
- Alternative Payment Methods
- Demand-Side Incentives
VOTE: 2017 Cost Trends Report

MOTION: That, pursuant to section 8(g) of chapter 6D of the Massachusetts General Laws, the Commission hereby authorizes the Executive Director to issue the annual report on cost trends as presented.
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CHART Phase 2: Activities since program launch

15 regional meetings with 900+ hospital and community provider attendees

900+ hours of coaching phone calls

3,794 unique visits to the CHART hospital resource page

27 CHART newsletter features

290+ technical assistance working meetings

575+ data reports received

18 teams are pursuing No Cost Extensions, using unspent funds to continue the model or finalize reporting for up to six months

1 Updated through March 5, 2018. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015.
CHART Phase 2: The HPC has disbursed $47M to date

- $59,451,629.75*
- $47,483,233.58

Remaining
$11,968,396.17
is inclusive of
$7,217,898
maximum
outcome-based
Achievement Payment opportunity

Updated March 22, 2018
*This reflects the most recent, up-to-date accounting of CHART Phase 2 contract maximum obligations
* Not inclusive of Implementation Planning Period contracts. $100,000 per awardee hospital authorized March 11, 2015.
By the Numbers: Health Care Innovation Investment (HCII) Program

>100 organizations collaborating to deliver care

54 Qualitative Reports submitted by awardees

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

Awardees span the Commonwealth: From the Berkshires to Boston

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

Initiatives deliver lower-cost care by shifting site and scope of care

~$2.8M disbursed to-date

7 HCII newsletter features

75% of funding remaining
Awardees are continuously enrolling patients in their target populations and delivering services, including:

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

Since January 1, 2016 program launch:

79 practices are PCMH PRIME Certified

21 practices are on the Pathway to PCMH PRIME

100 Total Practices Participating
HPC SPECIAL EVENT

Partnering to Address the Social Determinants of Health: What Works?

Join the HPC for a special event to explore how partnerships between health care providers and community stakeholders work to address health-related social needs. The morning will feature nationally-recognized experts and panels of Massachusetts health care leaders focused on the practical and policy approaches for supporting such partnerships. Coffee and a light breakfast will be provided. Register now (link below) and visit the HPC’s website (www.mass.gov/HPC) for more information.

Reserve your seat: tinyurl.com/HPCAddressingSDH
Call to Order

Approval of Minutes from the January 31, 2018 Meeting

Commissioner Updates

Market Oversight and Transparency

Executive Director’s Report

Public Hearing on the Potential Modification of the 2019 Health Care Cost Growth Benchmark

Schedule of Next Board Meeting (April 25, 2018)
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**Schedule of Next Board Meeting (April 25, 2018)**
HEARING ON THE POTENTIAL MODIFICATION OF THE HEALTH CARE COST GROWTH BENCHMARK

March 28, 2018
Health Care Cost Growth Benchmark

Sets a target for controlling the growth of total health care expenditures across all payers (public and private), and is set to the state’s long-term economic growth rate:

- Health care cost growth benchmark for 2013 - 2017 equals 3.6%
- Health care cost growth benchmark for 2017 - 2018 equals 3.1%

If target is not met, the Health Policy Commission can require health care entities to implement Performance Improvement Plans and submit to strict monitoring.

TOTAL HEALTH CARE EXPENDITURES

Definition: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

Includes:
- All categories of medical expenses and all non-claims related payments to providers
- All patient cost-sharing amounts, such as deductibles and copayments
- Net cost of private health insurance
What is Potential Gross State Product?

Potential Gross State Product (PGSP)

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

Process

- Every year the Secretary of Administration and Finance and the House and Senate Ways and Means Committees meet to develop and estimate of potential gross state product (PGSP) growth
- The PGSP estimate is established as part of the state’s existing consensus tax revenue forecast process and is included in a joint resolution by January 15th of each year
- The Commonwealth’s estimate of PGSP is developed with input from outside economists
- The PGSP estimate is used by the Health Policy Commission to establish the Commonwealth’s health care cost growth benchmark
Beginning in 2017, the HPC Board may **modify the statutory annual health care cost growth benchmark (for the following calendar year)**, 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.

For calendar years 2013-2017, the law required the benchmark to be equal to **PGSP (3.6%)**

For calendar years 2018-2022, the law requires the benchmark to be **PGSP minus 0.5%** (e.g., 3.1%) **unless** the Board votes to modify the benchmark (requires 2/3 vote).

The modification must be within the range of PGSP minus 0.5% and PGSP (e.g. 3.1% to 3.6%)

“For calendar years 2018 through 2022, if the commission determines that an adjustment in the health care cost growth benchmark is **reasonably warranted**...the board of the commission may modify the health care cost growth benchmark...” between -0.5 and PGSP.
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 of intent to modify.
- 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.
Factors to consider in determining whether an adjustment is reasonably warranted

1. Massachusetts’ health system performance to date
2. Impact of enrollment and demographic changes on performance
3. Opportunities for and barriers to additional savings in Massachusetts
4. Financial impact of modifying the benchmark
5. Significant changes to the state or federal health care landscape
6. Role of the benchmark in the HPC’s statutory responsibilities
7. Feedback from market participants and interested parties
Total health care expenditures (THCE) per capita grew 2.8% in 2016, below the benchmark rate.

Annual per-capita total health care expenditure growth in Massachusetts, 2012-2016

Average Annual Growth 2012-2016

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts Health Care Spending</td>
<td>3.55%</td>
</tr>
<tr>
<td>National Health Care Spending</td>
<td>3.8%</td>
</tr>
<tr>
<td>Consumer Price Inflation (Boston)</td>
<td>1.3%</td>
</tr>
<tr>
<td>Wages and Salaries (Boston)</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

Notes: 2015-2016 growth is preliminary. All other years represent final data.
Sources: Center for Health Information and Analysis, Total Health Care Expenditures
Health care spending in Massachusetts grew slower than the nation again in 2016

Annual growth in per capita health care spending, MA and the U.S., 2000-2016

Sources: Centers for Medicare and Medicaid Services, National Health Expenditure Accounts Personal Health Care Expenditures (U.S. 2014-2016) and State Health Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); Center for Health Information and Analysis, Total Health Care Expenditures
Among categories of care, pharmacy drugs and hospital outpatient spending grew the fastest in 2016.

Notes: Pharmacy spending is net of rebates.
Source: Payer reported TME data to CHIA and other public sources; appears in Center for Health Information and Analysis Annual Report, 2017.
In recent years, growth in spending on private health insurance in Massachusetts has been consistently lower than national rates

Annual growth in commercial health insurance spending from previous year, per enrollee, MA and the U.S.

Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only. U.S. data for 2016 is partially projected.

Sources: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts and Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005-2014); Center for Health Information and Analysis Annual Reports (2015-2016)
For both families and individuals, the difference between MA and U.S. premiums narrowed between 2012 and 2016

Annual employer sponsored health insurance premiums, single and family coverage

Family premiums in Massachusetts averaged $19,000 in 2016, $21,085 including typical cost-sharing; as high as $29,000 for 10% of residents

Sources: HPC analysis of Medical Expenditures Panel Survey data, 2012 - 2016
Employees working for low-wage firms contribute considerably more for family coverage

Average annual employer sponsored health insurance family coverage premium by firm wage quartile

Note: Q1 represents firms with average wages in the lower 25th percentile among all surveyed Massachusetts firms

Source: HPC analysis of Medical Expenditures Panel Survey data, 2016
As of 2015, readmission rates in Massachusetts increased, diverging from national trends

*Thirty-day readmission rates, Massachusetts and the U.S., 2011-2015*

Based on pre-filed testimony, payers are starting to adopt a range of strategies to reduce readmissions, including non-payment for avoidable readmissions.

Sources: Centers for Medicare and Medicaid Services 2011-2015 (U.S. and MA Medicare); Center for Health Information and Analysis (MA All-payer), 2011-2015
From 2011 to 2016, the share of community appropriate hospital stays in community hospitals has steadily declined.

Inpatient hospital discharges by hospital type, 2011-2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Community</th>
<th>Non-Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>59.8%</td>
<td>40.2%</td>
</tr>
<tr>
<td>2012</td>
<td>59.3%</td>
<td>40.7%</td>
</tr>
<tr>
<td>2013</td>
<td>59.1%</td>
<td>40.9%</td>
</tr>
<tr>
<td>2014</td>
<td>57.9%</td>
<td>42.1%</td>
</tr>
<tr>
<td>2015</td>
<td>57.8%</td>
<td>42.2%</td>
</tr>
<tr>
<td>2016</td>
<td>57.7%</td>
<td>42.3%</td>
</tr>
</tbody>
</table>

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2014; Registration of Provider Organizations, 2016; SK&A Office and Hospital Based Physicians Databases, December, 2015
Uptake of alternative payment methods (APMs) increased in 2016, driven by growth in commercial PPO products

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

Notes: 2016 results for Original Medicare represent preliminary estimates.
Sources: HPC analysis of Center for Health Information and Analysis Annual Report APM data book, 2017; Centers for Medicare and Medicaid Services, Number of ACO Assigned Beneficiaries by County Public Use File"(2014 – 2016); "Medicare Pioneer Accountable Care Organization Model Performance Years 3- 5" (2014 - 2016); "Next Generation ACO Model Financial and Quality Results Performance Year 1" (2016).
Aging of the population in Massachusetts contributes to health care spending growth

- The Massachusetts population is aging

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2015</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age</td>
<td>38.8 years</td>
<td>39.4 years</td>
<td>40.2 years</td>
</tr>
<tr>
<td>% of state residents 65+</td>
<td>13.9%</td>
<td>15.4%</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

- Older residents have higher spending

<table>
<thead>
<tr>
<th>Age</th>
<th>0-18</th>
<th>19-44</th>
<th>45-64</th>
<th>65-84</th>
<th>85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average PMPY spending</td>
<td>$3,394</td>
<td>$4,260</td>
<td>$9,091</td>
<td>$16,123</td>
<td>$30,972</td>
</tr>
</tbody>
</table>

- Relative population aging contributes consistently to notable TME growth

<table>
<thead>
<tr>
<th>TME growth per year due to relative aging</th>
<th>2012-2015</th>
<th>2016-2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>+0.5%</td>
<td>+0.6%</td>
</tr>
</tbody>
</table>

Notes: Resident spending by age bracket are national CMS estimates.
National health care spending growth has averaged 4-5% from 2014 to 2017, driven by both prices and utilization.

- Price growth over this period has been historically low (1-2%), with the exception of:
  - Commercial sector hospital prices (~3% per year)
  - Prescription drug prices (~4% per year)

National health care spending is projected to increase 5 percent annually from 2017 to 2026

- Higher expected growth driven by population aging, prices, and specialty prescription drugs
Price increases are projected to be the primary driver of national health care spending growth moving forward.

- Price growth has been relatively low from 2014-7 but is expected to increase.

HEARING ON THE POTENTIAL MODIFICATION OF THE HEALTH CARE COST GROWTH BENCHMARK

Opportunities for Cost Savings

March 28, 2018
In order to inform the consideration of whether to modify the health care cost growth benchmark, the HPC identified a set of specific opportunities for improvement and modeled potential health care spending reduction estimates for each one.

The limited set of seven scenarios is based on specific policy recommendations and targets described in the 2017 Cost Trends Report. This should not be considered an exhaustive list of potential areas for reducing health care spending.

These illustrative, “what-if” scenarios are intended to provide the HPC’s Board, the Legislature, market participants, and the public with a greater understanding of the scope and scale of different savings opportunities.

This year, the model includes five-year estimates from 2018 to 2022 and separate estimates for commercial spending, Medicare, and MassHealth, where applicable.
List of 2018 Spending Reduction Scenarios

1. Reduce Hospital Readmissions
2. Reduce Institutional Post-Acute Care
3. Reduce Avoidable Emergency Department Use
4. Shift Community-Appropriate Inpatient Care to Community Hospitals
5. Implement Site-Neutral Payment for Hospital Outpatient Services
6. Reduce Prescription Drug Price Growth
7. Increase Adoption of Alternative Payment Methods
**BACKGROUND**

- Massachusetts all-payer hospital readmissions rates *increased* in 2014 and 2015 while the national average has been falling
  - Massachusetts’ Medicare readmission rate was 10th highest in the US in 2015 at 18.2% versus 16.8% in the rest of the nation

**ESTIMATE TARGET AND SCOPE**

- *Reduce all-payer readmissions gradually such that the 2022 readmissions rate is 20% below the 2015 rate*
- Scope: All discharges

**KEY ASSUMPTIONS**

- Baseline: readmission rates hold steady for all payers from 2015 onward
- Assume that rates for Medicare, Commercial, and MassHealth each drop by 20% from their 2015 levels
Reducing hospital readmissions by 20% would save $1.04 billion over five years

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$66,041,768</td>
</tr>
<tr>
<td>2019</td>
<td>$134,704,966</td>
</tr>
<tr>
<td>2020</td>
<td>$206,070,783</td>
</tr>
<tr>
<td>2021</td>
<td>$280,222,749</td>
</tr>
<tr>
<td>2022</td>
<td>$357,246,803</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,044,287,069</strong></td>
</tr>
</tbody>
</table>

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Baseline spending

Target spending
Post-Acute Care

**BACKGROUND**

- Massachusetts residents are more likely to be discharged from hospitals to institutional post-acute care (PAC) settings than residents of other states (20.4% versus 17.1%).
  - Of 36 states with available data, Massachusetts had the *highest* rate of institutional PAC discharges; 13 states had a discharge rate to institutional PAC below 15%.
- All institutional PAC settings (SNFs, IRFs, LTCHs) are markedly more costly, on average, than routine discharges or home health care.

**ESTIMATE TARGET AND SCOPE**

- *Gradually reduce the rate of discharge to institutional PAC to 15% by 2022 without increasing home health use*
- Scope: All discharges

**KEY ASSUMPTIONS**

- **Baseline**: rate of discharges to PAC settings remains at 2016 levels
- Use Medicare payment amounts for all payers; Medicare makes up 80% of PAC discharges
Reducing institutional post-acute care by 25% would save $1.37 billion over five years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$88,690,518</td>
</tr>
<tr>
<td>2019</td>
<td>$178,626,287</td>
</tr>
<tr>
<td>2020</td>
<td>$270,946,831</td>
</tr>
<tr>
<td>2021</td>
<td>$365,700,683</td>
</tr>
<tr>
<td>2022</td>
<td>$462,937,279</td>
</tr>
</tbody>
</table>

**Total**  $1,366,901,599
Avoidable Emergency Department Use

**BACKGROUND**

- Emergency departments often serve patients with non-emergency conditions (~20% of visits) or conditions that could be safely treated in a primary care setting (~20% of visits)
- Massachusetts has a higher rate of Emergency Department visits and avoidable ED visits than the nation as a whole

**ESTIMATE TARGET AND SCOPE**

- By 2022, gradually shift:
  - 20% of visits for emergent primary care treatable conditions to primary care settings
  - 33% of visits for non-emergency conditions to a lower-intensity setting (urgent care center, retail clinic, or primary care office), and
- Gradually eliminate 33% of visits for non-emergency conditions
- Scope: MassHealth and Commercial ED visits

**KEY ASSUMPTIONS**

- Baseline: the number of ED visits per year remains constant
- Shifts are in the same proportions for Commercial and MassHealth patients
Reducing non-emergent ED visits by 66%, including a 33% shift to other settings, would save $260 million over five years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$16,683,137</td>
</tr>
<tr>
<td>2019</td>
<td>$33,866,769</td>
</tr>
<tr>
<td>2020</td>
<td>$51,562,155</td>
</tr>
<tr>
<td>2021</td>
<td>$69,780,783</td>
</tr>
<tr>
<td>2022</td>
<td>$88,534,369</td>
</tr>
<tr>
<td>Total</td>
<td>$260,427,213</td>
</tr>
</tbody>
</table>
Shifting 20% of emergent primary care treatable ED visits to other settings would save $91 million over five years

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Savings</td>
<td>$5,479,069</td>
<td>$12,634,813</td>
<td>$18,402,271</td>
<td>$24,339,909</td>
<td>$30,451,537</td>
<td>$91,307,599</td>
</tr>
</tbody>
</table>

- **Primary care: baseline spending**
- **Primary care: target spending**
- **ED: baseline spending**
- **ED: target spending**

*Commercial + MassHealth*
“Community appropriate” inpatient care can be safely delivered to patients at most hospitals in the Commonwealth

- As much as possible, this care should be provided at high-value community hospitals

The percentage of such care provided by community hospitals has steadily fallen from 59.8% in 2011 to 57.7% in 2016

Gradually shift 25% of Commercial and Medicare community appropriate care from teaching hospitals to community hospitals by 2022

Scope: Commercial and Medicare discharges

Baseline: The number of community appropriate discharges remains constant from 2016 onward
Shifting 25% of community appropriate inpatient discharges from teaching hospitals to community hospitals would save $211 million over five years.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$13,477,918</td>
</tr>
<tr>
<td>2019</td>
<td>$27,409,461</td>
</tr>
<tr>
<td>2020</td>
<td>$41,806,221</td>
</tr>
<tr>
<td>2021</td>
<td>$56,680,058</td>
</tr>
<tr>
<td>2022</td>
<td>$72,043,103</td>
</tr>
<tr>
<td>Total</td>
<td>$211,416,761</td>
</tr>
</tbody>
</table>
In 2016, hospital outpatient spending represented the fastest-growing category of commercial spending at 5.5% per member

- It was also the largest source of variation in spending by provider organization

Many services performed in hospital outpatient departments (HOPDs) can be performed in alternative settings, including less expensive physicians’ offices and freestanding imaging centers

Reimburse select outpatient procedures at a site-neutral rate, starting in 2018

Scope: 19 selected high-volume, ‘shoppable’ outpatient procedures*

Baseline: Assume constant utilization rates of selected procedures from 2015 to 2022

Apply site-neutral payments, based on the price of performing these procedures in non-HOPD settings, for patients attributed to the 14 largest provider organizations in Massachusetts.


The commercial estimate uses 19 procedures including Imaging (Brain MRI – 70553, Joint MRI – 73721, Chest x-ray – 71020), Upper GI endoscopy (43239), Colonoscopy (45378), Surgical pathology (88305), Echocardiogram (93306), E&M visit (99212)
Implementing site-neutral outpatient reimbursement for certain high-volume, “shoppable” conditions would save over $1 billion over five years.
**Background**

- Prescription drug spending represented the fastest growing category of care in 2015 and 2016 (7.2% and 6.1% net of rebates, respectively)

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**Estimate Target and Scope**

- In order to achieve overall growth consistent with the benchmark, *cap annual growth in the price of existing prescription drugs at 1.6%*
- This allows up for up to 1.5% spending growth due to utilization and introduction of new therapies/products
- Scope: Commercial market; prescription drugs that rank high in total spending - comprising the top 50% of all drug spend

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**Key Assumptions**

- **Baseline:** 2018-2022 drug prices grow in accordance with 2015-2017 national trends

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1Health Sector Economic Indicators, Altarum Center for Value in Health Care [https://altarum.org/sites/default/files/uploaded-related-files/SHSS-Price-Brief_February_2018_0.pdf](https://altarum.org/sites/default/files/uploaded-related-files/SHSS-Price-Brief_February_2018_0.pdf)
Limiting prescription drug price growth to 1.6% would save $230 million over five years

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Savings</td>
<td>$43,366,003</td>
<td>$44,517,093</td>
<td>$46,037,453</td>
<td>$47,357,490</td>
<td>$49,233,591</td>
<td>$230,511,630</td>
</tr>
</tbody>
</table>

[Diagram showing baseline and target spending for years 2015 to 2022, with a total savings of $230 million highlighted.]
BACKGROUND

- Massachusetts APM adoption in the commercial market increased from 37% to 42% between 2014 and 2016, which is still below the rate needed for APMs to provide sufficient incentives to reduce health care costs.

ESTIMATE TARGET AND SCOPE

- Increase APM adoption in the commercial market to 68% among HMO plans and 40% among PPO plans by 2022 (see graph)
- Scope: Commercial market

KEY ASSUMPTIONS

- Baseline: APM rates hold steady from 2016 onward; spending grows 3.1% per year
- APMs reduce spending growth by 1-2%, but the effect is twice as large once a critical mass (63%) of patients is under APMs for a given provider organization
Expanding use of alternative payment methods would save $494 million over five years

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$3,877,163</td>
</tr>
<tr>
<td>2019</td>
<td>$30,889,395</td>
</tr>
<tr>
<td>2020</td>
<td>$74,780,093</td>
</tr>
<tr>
<td>2021</td>
<td>$150,444,441</td>
</tr>
<tr>
<td>2022</td>
<td>$234,635,036</td>
</tr>
<tr>
<td>Total</td>
<td>$494,626,098</td>
</tr>
</tbody>
</table>

- Commercial HMO/POS APM target
- Commercial HMO/POS APM baseline
- Commercial PPO APM target
- Commercial PPO APM baseline
Total savings over five years exceeds $4.7 billion

<table>
<thead>
<tr>
<th>Measure</th>
<th>2018 savings</th>
<th>2019 savings</th>
<th>2020 savings</th>
<th>2021 savings</th>
<th>2022 savings</th>
<th>5 year savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmissions</td>
<td>$66.0m</td>
<td>$134.7m</td>
<td>$206.1m</td>
<td>$280.2m</td>
<td>$357.2m</td>
<td>$1.04b</td>
</tr>
<tr>
<td>PAC</td>
<td>$88.7m</td>
<td>$178.6m</td>
<td>$270.9m</td>
<td>$365.7m</td>
<td>$462.9m</td>
<td>$1.37b</td>
</tr>
<tr>
<td>Avoidable ED</td>
<td>$22.2m</td>
<td>$46.5m</td>
<td>$70.0m</td>
<td>$94.1m</td>
<td>$119.0m</td>
<td>$351.7m</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$195.1m</td>
<td>$202.8m</td>
<td>$210.8m</td>
<td>$219.1m</td>
<td>$227.7m</td>
<td>$1.06b</td>
</tr>
<tr>
<td>CADs</td>
<td>$13.5m</td>
<td>$27.4m</td>
<td>$41.8m</td>
<td>$56.7m</td>
<td>$72.0m</td>
<td>$211.4m</td>
</tr>
<tr>
<td>Drugs</td>
<td>$43.4m</td>
<td>$44.5m</td>
<td>$46.0m</td>
<td>$47.4m</td>
<td>$49.2m</td>
<td>$230.5m</td>
</tr>
<tr>
<td>APMs</td>
<td>$3.9m</td>
<td>$30.9m</td>
<td>$74.8m</td>
<td>$150.4m</td>
<td>$234.6m</td>
<td>$494.6m</td>
</tr>
<tr>
<td>Net savings</td>
<td>$432.7m</td>
<td>$665.5m</td>
<td>$920.4m</td>
<td>$1.21b</td>
<td>$1.52b</td>
<td>$4.76b</td>
</tr>
<tr>
<td>Commercial savings</td>
<td>$291.6m</td>
<td>$379.5m</td>
<td>$484.8m</td>
<td>$623.6m</td>
<td>$773.3m</td>
<td>$2.55b</td>
</tr>
</tbody>
</table>

Note: Savings by measure and year may not add to the total savings due to rounding.
Compared to recent performance, achieving the combined savings would reduce THCE by $1.5 billion (2.1%) in 2022.
2018 Meetings and Contact Information

Board Meetings

Wednesday, April 25, 2018
Wednesday, July 18, 2018
Wednesday, September 12, 2018
Thursday, December 13, 2018

Committee Meetings

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

Contact Us

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

Special Events

Thursday, May 17, 2018: Partnering to Address the Social Determinants of Health: What Works?
Monday and Tuesday, October 15 and 16, 2018: Cost Trends Hearing