2018 Annual Health Care

COST TRENDS HEARING

OCTOBER 16, 2018
2018 Annual Health Care
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Up Next
Presentation on CHIA’s Annual Report
Presentation on State Perspective on Health Care Cost Trends
Presentation to the Health Policy Commission: CHIA’s Annual Report
Agenda

- Overview
- Total Health Care Expenditures
- Public Insurance Programs
- Commercial Insurance
- Questions
Overview

- CHIA’s role in establishing the metrics to evaluate the performance of the Massachusetts health care system
- Annual Report publication materials
  - 100+ page report
  - Extensive databooks
  - Technical documentation
- Acknowledgments
  - Data submitters for their role in facilitating this report through supplemental filings
  - CHIA’s staff & actuaries for their work producing the report
Total Health Care Expenditures (THCE)

$61.1B  Total Health Care Expenditures

$8,907  THCE per capita

1.6%  Growth rate per capita
Total Health Care Expenditures
Growth Rates, 2012-2017

The initial estimate of THCE per capita growth is 1.6% for 2017, the second consecutive year it fell below the Health Care Cost Growth Benchmark.
Total Health Care Expenditures
Insurance Categories, 2017

$61.1B Total Health Care Expenditures

- Commercial $22.8B +3.1% (2016-2017)
- Medicare $17.0B +1.9%
- MassHealth $17.2B -0.2%
- NCPHI $2.5B +10.2%
- Other Public $1.65B +5.3%

Total Health Care Expenditures

For more information, see page 12 of CHIA’s Annual Report

HPC Presentation | September 12, 2018
Total Health Care Expenditures
Service Categories, 2016-2017

HEALTH CARE SPENDING DECELERATED ACROSS ALL SERVICE CATEGORIES, WITH THE HIGHEST GROWTH IN PHARMACY AND OUTPATIENT SPENDING.
IN 2017, THE LARGEST INCREASE IN APM ADOPTION RATES WAS IN THE MASSHEALTH PCC PLAN.
Public Insurance Programs
MassHealth

$17.2B MassHealth Expenditures, 2017

-0.2% Expenditure Trend, 2016-2017

-2.4% Member Months, 2016-2017

For more information, see page 14 of CHIA’s Annual Report
PUBLIC INSURANCE PROGRAMS
masshealth MCO Service Categories, 2016-2017

Pharmacy spending PMPM continued to grow faster than other services, becoming the largest category in 2017.

For more information, see page 46 of CHIA’s Annual Report

HPC Presentation | September 12, 2018
Public Insurance Programs
Medicare

$17.0B Medicare Expenditures, 2017

1.9% Expenditure Trend, 2016-2017

2.4% Beneficiaries, 2016-2017

For more information, see page 15 of CHIA’s Annual Report
Public Insurance Programs
Medicare Program Spending, 2016-2017

Medicare expenditures grew at similar rates for beneficiaries covered under traditional and Medicare Advantage.

For more information, see page 15 of CHIA’s Annual Report

HPC Presentation | September 12, 2018
Commercial Insurance

$22.8B
Commercial Expenditures, 2017

3.1%
Expenditure Trend, 2016-2017

0.4%
Member Months, 2016-2017
COMMERCIAL SPENDING PMPM SLOWED ACROSS THE FOUR MAJOR SERVICE CATEGORIES IN 2017.
IN 2017, MORE THAN ONE IN FOUR (28.2%) MASSACHUSETTS CONTRACT MEMBERS WERE ENROLLED IN AN HDHP. THESE PLANS WERE MORE COMMON AMONG SMALLER EMPLOYER GROUP PURCHASERS.
Commercial Insurance
Cost-Sharing by Market Sector, 2015-2017

MEMBER COST-SHARING CONTINUED TO BE HIGHER, AND GREW FASTER, AMONG SMALLER EMPLOYER GROUPS.

For more information, see page 80 of CHIA’s Annual Report
HPC Presentation | September 12, 2018
FULLY-INSURED PREMIUMS INCREASED BY 4.9% FROM 2016 TO 2017. SMALL GROUP MEMBERS EXPERIENCED THE LARGEST PERCENTAGE INCREASE (+6.9%).

For more information, see page 72 of CHIA’s Annual Report
MEMBER COST-SHARING AND FULLY-INSURED PREMIUMS GREW FASTER THAN WAGES AND INFLATION IN 2017.

Note: Total Medical Expenses reflects commercial full-claim only.
State Perspective on Health Care Cost Trends

Dr. David Auerbach
Director of Research and Cost Trends, Massachusetts Health Policy Commission
In 2017, total healthcare spending growth in Massachusetts was well below the national rate, continuing a multi-year trend.

Annual growth in per-capita healthcare spending, MA and the U.S., 2000 – 2017

Notes: US data include MA. US and MA figures for 2017 are preliminary.
Commercial spending growth in Massachusetts has been below the national rate since 2013, generating billions in avoided spending

Annual growth in commercial spending per enrollee, MA and the U.S., 2006-2017

Notes: US data includes Massachusetts. US and MA figures for 2017 are preliminary.
Since 2013, total hospital spending growth (inpatient and outpatient) in Massachusetts has been far below national growth rates

2013 – 2017 cumulative growth in commercial spending by service category, MA and U.S.

If Massachusetts commercial spending grew at the national rate from 2013-2017, residents would have spent $1.7B more in 2017 alone ($367 per person)

Notes: US data include Massachusetts. Pharmacy spending is net of rebates.
**Unit price was the largest spending driver for the top three commercial health plans in Massachusetts between 2015 and 2017**

*Average annual growth in spending by component for top 3 payers, 2015 – 2017*

<table>
<thead>
<tr>
<th>Component</th>
<th>BCBSMA</th>
<th>THP</th>
<th>HPHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit price</td>
<td>3.0%</td>
<td>2.6%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Utilization</td>
<td>0.8%</td>
<td>1.1%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Provider and/or service mix</td>
<td>0.6%</td>
<td>-1.1%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Total</td>
<td>2.9%</td>
<td>3.0%</td>
<td>4.6%</td>
</tr>
</tbody>
</table>

Notes: Average of medical expenditure trend by year 2015-2017. BCBSMA = Blue Cross Blue Shield of Massachusetts; THP = Tufts Health Plan; HPHC = Harvard Pilgrim Health Care. Source: HPC analysis of Pre-Filed Testimony Pursuant to the 2018 Annual Cost Trends Hearing
Massachusetts inpatient hospital admission rates show little change since 2014 and continue to exceed the U.S. average

**Inpatient hospital admission rate per 1,000 residents, MA and the U.S., 2001-2017**

- **Notes:** US data include Massachusetts.
- **Sources:** Kaiser Family Foundation analysis of American Hospital Association data (U.S., 2001-2016), HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2017).
Across all inpatient discharges, the rate of discharge to institutional post-acute care continued to decline in 2017.

Note: Out-of-state residents are excluded. Rates adjusted for age, sex, and changes in DRG mix. Several hospitals were excluded (UMass, Clinton, Cape Cod, Falmouth, Marlborough) due to coding irregularities in the database.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (2010-2017).
Massachusetts readmission rates did not show any improvement in 2016

Thirty-day readmission rates, MA and the U.S., 2011-2016

Sources: Centers for Medicare and Medicaid Services (U.S. and MA Medicare 2011-2016); Center for Health Information and Analysis (MA All-payer 2011-2016).
2017 was the first year with a small increase in community hospitals’ share of community-appropriate discharges since 2012.

MA share of community appropriate discharges by hospital type, 2012-2017

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 defines community hospitals as general acute care hospitals that do not support large teaching and research programs.
Sources: HPC analysis of Center for Health Information and Analysis Hospitals Inpatient Discharge Database (2012-2017).
Overall APM adoption was relatively unchanged in 2017, but by 2018 MassHealth’s ACO program should drive statewide APM coverage toward 50%

Notes: Original Medicare data for 2017 is a preliminary estimate.
Source: Centers for Medicare and Medicaid Services (Original Medicare 2015-2017); HPC analysis of Center for Health Information and Analysis Annual Report APM Databooks (Commercial 2015-2017); additional data supplied by MassHealth (MassHealth 2018).
* Managed care eligible includes MCO and PCC Plans, including new ACO options in 2018
In 2017, Blue Cross Blue Shield of Massachusetts continued to lead the commercial market in APM adoption for PPO members.

While Massachusetts has among the highest premiums in employer markets, particularly for small employers, Connector premiums continue to rank among the lowest in state exchanges in 2018.

Annual premiums for single coverage in the employer market and average annual unsubsidized benchmark premium for a 40-year-old in the ACA Exchanges, MA and the U.S., 2013-2018

Notes: US data include Massachusetts. Employer premiums are based on the average premium according to a large sample of employers within each state. Small employers are those with less than 50 employees; large employers are those with 50 or more employees. Exchange data represent the weighted average annual premium for the second-lowest silver (Benchmark) plan based on county level data in each state. These plans have an actuarial value of 70%, compared to 85%-90% for a typical employer plan, and are thus not directly comparable to the employer plans.

Massachusetts continues to have lower deductibles than the US, although the average deductible exceeds the IRS definition for high deductible plans

Average deductible for single coverage in the employer market, MA and the U.S., 2013-2017

The increase in high deductible plans in Massachusetts may have lowered overall commercial spending growth in 2017 by roughly 0.2 percentage points*

Notes: US data include Massachusetts. Employer deductibles are based on the average deductible according to a large sample of employers within each state. Employer plans that do not have a deductible aren’t included in the average deductible calculation. Sources: US Agency for Healthcare Quality, Medical Expenditure Panel Survey (commercial premiums 2013-2017); Internal Revenue Service (for definition of high deductible plans 2013-2017).

Nearly a third of total income for lower-income, commercially insured residents is consumed by health care costs, leading to higher rates of outstanding medical debt.

Note: Figures rounded to nearest whole number. Total income represents total family income and includes employer payments, if any, toward health insurance premiums. One-person families and families with children and two adults are included in the analysis. Data are combined using survey weights which represent the population of Massachusetts. Insurance status is self-reported in the survey. "Commercial" represents insurance received through work or a union; "Health Connector" represents all private, non-group plans available through the Health Connector.

Sources: Massachusetts Health Interview Survey (CHIA), data from 2017 on 1,633 respondents from family- and single-headed households with employer-sponsored and private health insurance, representing roughly 2.9 million state residents. Other data sources include the US Agency for Healthcare Research and Quality US and state government tax and budget data.
U.S. Healthcare Spending: International Context, National Trends, and Getting to High-Value Care
Agenda

- International context: how does US spending and utilization compare with other countries?
- How did the ACA try to address our cost and quality problems? Has it worked?
- What does this mean for MA?
How does US spending compare to other countries?
Total healthcare spending, 2016

<table>
<thead>
<tr>
<th>Country</th>
<th>Spending on Health as a % of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>17.8</td>
</tr>
<tr>
<td>UK</td>
<td>9.7</td>
</tr>
<tr>
<td>DE</td>
<td>11.3</td>
</tr>
<tr>
<td>SE</td>
<td>11.9</td>
</tr>
<tr>
<td>FR</td>
<td>11.0</td>
</tr>
<tr>
<td>NL</td>
<td>10.5</td>
</tr>
<tr>
<td>CH</td>
<td>12.4</td>
</tr>
<tr>
<td>DK</td>
<td>10.8</td>
</tr>
<tr>
<td>CN</td>
<td>10.3</td>
</tr>
<tr>
<td>JP</td>
<td>10.9</td>
</tr>
<tr>
<td>AU</td>
<td>9.6</td>
</tr>
</tbody>
</table>
Why?
Hypothesis #1: Too many specialists, not enough primary care
Primary care as % of MDs

FR: 54%
CH: 48%
CN: 48%
NL: 47%
UK: 45%
DE: 45%
AU: 45%
US: 43%
Mean: 43%
JA: 43%
SE: 33%
DK: 22%
Total Spending = \textbf{Quantity} \times \textbf{Price}
Our culture of overuse
Total Spending = \textit{Quantity} \times \text{Price}
Overutilization theory #1

We are quick to go to the doctor
Doctor visits

Physician visits per capita in a given year

<table>
<thead>
<tr>
<th>Country</th>
<th>Visits per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>JA</td>
<td>12.7</td>
</tr>
<tr>
<td>DE</td>
<td>10</td>
</tr>
<tr>
<td>NL</td>
<td>8.2</td>
</tr>
<tr>
<td>CN</td>
<td>7.7</td>
</tr>
<tr>
<td>AU</td>
<td>7.6</td>
</tr>
<tr>
<td>Mean</td>
<td>6.6</td>
</tr>
<tr>
<td>FR</td>
<td>6.4</td>
</tr>
<tr>
<td>UK</td>
<td>5</td>
</tr>
<tr>
<td>DN</td>
<td>4.3</td>
</tr>
<tr>
<td>US</td>
<td>4</td>
</tr>
<tr>
<td>CH</td>
<td>3.9</td>
</tr>
<tr>
<td>SE</td>
<td>2.9</td>
</tr>
</tbody>
</table>
Overutilization theory #2

Not enough prevention and primary care leads to too many hospitalizations
Hospital discharges

We spend far fewer days in the hospital.
Overutilization theory #3

We use too many tests and procedures
MRI examinations

Examinations per 1,000 population

- DE: 131
- US: 118
- JA: 112
- FR: 105
- DN: 82
- CH: 82
- Mean: 200
- CN: 70
- UK: 156
- NL: 53
- AU: 52
- AU: 41
Total knee replacement

<table>
<thead>
<tr>
<th>Country</th>
<th>Replacement per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>226</td>
</tr>
<tr>
<td>DE</td>
<td>190</td>
</tr>
<tr>
<td>AU</td>
<td>180</td>
</tr>
<tr>
<td>CH</td>
<td>176</td>
</tr>
<tr>
<td>DN</td>
<td>168</td>
</tr>
<tr>
<td>CN</td>
<td>166</td>
</tr>
<tr>
<td>Mean</td>
<td>163</td>
</tr>
<tr>
<td>FR</td>
<td>145</td>
</tr>
<tr>
<td>UK</td>
<td>141</td>
</tr>
<tr>
<td>SE</td>
<td>124</td>
</tr>
<tr>
<td>NL</td>
<td>118</td>
</tr>
</tbody>
</table>
Total hip replacement replacement per 100,000 population:

- CH: 292
- DE: 283
- DN: 237
- FR: 236
- SE: 234
- NL: 216
- Mean: 207
- US: 204
- UK: 183
- AU: 171
- CN: 136
- JA: 90
Coronary angioplasty

Procedures per 100,000 population

- DE: 393
- US: 248
- NL: 248
- FR: 237
- Mean: 217
- SE: 205
- JA: 193
- DK: 190
- AU: 172
- CN: 157
- UK: 128
So is it utilization?

- Higher US costs not primarily about utilization
- We have fewer hospitalizations, doctor visits
- Tests and Procedures a mixed bag:
  - We do a lot more MRIs, TKRs, Angioplasties
  - We do fewer hip replacements
- Bottom line:
  - We’re above average on some things
  - We’re below average on other things
  - On average, we are pretty average
OK— so what is it?
Administrative waste
Governance, administration spending

- US: 8%
- DE: 5%
- NL: 4%
- CH: 4%
- Mean: 3%
- CN: 3%
- AU: 3%
- UK: 2%
- SE: 2%
- DN: 2%
- FR: 1%
- JA: 1%

Percentage of healthcare spending
Total Spending = Quantity \times \text{Price}
Prices
Prices of what?
Pharmaceuticals!
<table>
<thead>
<tr>
<th>Country</th>
<th>Total Pharmaceutical Spending (USD per capita)</th>
</tr>
</thead>
<tbody>
<tr>
<td>US</td>
<td>$1,443</td>
</tr>
<tr>
<td>CH</td>
<td>$939</td>
</tr>
<tr>
<td>JA</td>
<td>$837</td>
</tr>
<tr>
<td>UK</td>
<td>$779</td>
</tr>
<tr>
<td>Mean</td>
<td>$749</td>
</tr>
<tr>
<td>FR</td>
<td>$697</td>
</tr>
<tr>
<td>DN</td>
<td>$675</td>
</tr>
<tr>
<td>DE</td>
<td>$667</td>
</tr>
<tr>
<td>CN</td>
<td>$613</td>
</tr>
<tr>
<td>SE</td>
<td>$566</td>
</tr>
<tr>
<td>AU</td>
<td>$560</td>
</tr>
<tr>
<td>NL</td>
<td>$466</td>
</tr>
</tbody>
</table>
Pharma makes up about 15% of all HC spending
So that can’t be the whole story
Generalist Physician Salaries

- US: $218K
- DE: $154K
- CN: $146K
- UK: $134K
- Mean: $133K
- JA: $124K
- FR: $111K
- NL: $109K
- AU: $108K
- SE: $86K
Specialist Physician Salaries

US: $316K
AU: $202K
NL: $191K
CN: $188K
Mean: $182K
DE: $181K
UK: $171K
FR: $153K
DN: $140K
JA: $124K
SE: $98K
Nurse Salaries

- **US**: $74K
- **NL**: $65K
- **AU**: $64K
- **DN**: $58K
- **CN**: $55K
- **DE**: $53K
- **Mean**: $51K
- **UK**: $49K
- **JA**: $44K
- **FR**: $42K
So what makes US HC so expensive?
Summary

- Hypotheses unlikely to explain difference:
  - Primary care/specialist mix
  - Overutilization

- High costs driven primarily by:
  - Administrative costs
  - High prices

- We can still save money by reducing quantity
What have we largely focused on?
Total Spending = \text{Quantity} \times \text{Price}
Causes of our system dysfunction

- Fragmentation
- How we pay for care (FFS, lack of incentives)
- Inadequate transparency
- Inadequate competition
- Inadequate patient “skin in the game”
What did the ACA do to fix things?

- Change how we pay for things
  - Hospital readmissions reduction program
  - Value-based purchasing
- Hold providers accountable
  - Patient-centered medical home
  - Accountable Care Organizations
- Centrally manage innovation
  - CMMI
- Investment in Health IT
So has the ACA worked?
Value-based payment has had little effect
Readmission rates have fallen about 2.5%
- About 2/3 of that is due to coding
- Some (weak) evidence that it made mortality worse
- Impact overall quite controversial

Ibrahim et al. JAMA Internal Medicine 2017; Gupta et al. JAMA Cardiology, 2017; Jha & Pronovost, NEJM, 2015
Primary Care Initiative (CPCI)

- CPCI targeted 502 primary care practices in 7 U.S. regions
  - Spending did not decrease enough to cover care management fees
  - After 4 years, no change in overall spending growth, modest impact on quality
  - 2% lower growth in ED visits
EHR impact on mortality, 2008-2013

- Average (5.7 baseline functions, 0.6 added functions/year)
- Below Average (0 baseline functions, 0.6 added functions/year)
- Above average (5.7 baseline functions, 2 added functions/year)
Bundled Payments

- The findings are mixed
  - For medical conditions: no change in spending or quality
  - For surgical conditions: associated with decreases in spending and small quality improvements
    - 4%-20% decrease in per-episode spending for joint replacement

- Why?
  - Different spending patterns
  - Different services provided in post-acute settings
  - Different types of patients

Dummit JAMA 2016, Joynt et al NEJM 2018, Navathe JAMA 2017, Navathe Health Affairs 2018
Number of ACOs continues to grow

Center for Medicare and Medicaid Services
Impact of ACOs on Quality & Cost

How are they doing? Two alternative views:
- McWilliams et al. consistently find 2-5% savings, by cohort:
  - 2012: 4.9%
  - 2013: 3.5%
  - 2014: 1.6%

Impact on quality?
- A few positive changes in pt experience, little on outcomes

All the savings are in physician-led ACOs

McWilliams NEJM 2018
A summary of where we have been

- ACA spurred LOTS of activity
- Some of it is making a real difference
- Much of it has focused on quantity
  - Medicare led
  - Prices are fixed
  - Relative prices are not...
What’s next?

- Push towards price transparency

- Payment Reform:
  - More risk to providers
    - Bundled payments, ACOs, Capitation
  - More risk to payers (from CMS):
    - MA

- More engagement of consumers
  - Tiering coming to Medicare?

- Some efforts on prices
  - But probably not enough
What does this mean for MA?
The future of MA healthcare

- Value-based care is important
  - Promote more bundles
  - Promote more ACOs
  - Intensively study which models work and don’t – and adjust accordingly

- Value-based strategies not nearly enough

- We must deal with the 800 pound gorilla: prices
  - Price regulation versus competition
Thank you

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Twitter: @ashishkjh
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Up Next
Witness Panel 1: Meeting the Health Care Cost Growth Benchmark
Witness Panel 1

Meeting the Health Care Cost Growth Benchmark - Top Trends in Care Delivery and Payment Reform
Witness Panel 1: Meeting the Health Care Cost Growth Benchmark – Top Trends in Care Delivery and Payment Reform

Witnesses

Mr. Michael Carson, President and CEO
Mr. Normand Deschene, CEO
Dr. Mark Keroack, President and CEO
Mr. David Segal, President and CEO
Ms. Liora Stone, Owner and President

Harvard Pilgrim Health Care
Wellforce
Baystate Health
Neighborhood Health Plan
Precision Engineering, Inc., Uxbridge

Goals

This panel will discuss strategies to meet the health care cost growth benchmark in 2019 and beyond by tackling issues such as the scalability of innovations in care delivery, the lack of uptake in alternative payment methods, high levels of spending on pharmaceuticals and medical devices, and the future of the Massachusetts health care system.
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Up Next
Witness Panel 2: Innovations to Enhance Timely Access to Primary and Behavioral Health Care
Witness Panel 2

Innovations to Enhance Timely Access to Primary and Behavioral Health Care
More than a third of Massachusetts residents reported that their last ED visit was not for an emergency in 2017

Percentage reporting “most recent emergency room visit in past 12 months was for a non-emergency condition” by family income, 2017

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 139% FPL</td>
<td>40%</td>
</tr>
<tr>
<td>Between 139% and 299% FPL</td>
<td>30%</td>
</tr>
<tr>
<td>Between 300% and 399% FPL</td>
<td>43%</td>
</tr>
<tr>
<td>400% FPL or above</td>
<td>31%</td>
</tr>
<tr>
<td>Total Population</td>
<td>35%</td>
</tr>
</tbody>
</table>

Of those with a non-emergent ED visit...

57% visited because they were unable to get an appointment

68% visited because they were unable to access care after normal operating hours

Note: FPL stands for “Federal Poverty Level.”
Source: HPC’s analysis of CHIA’s Massachusetts Health Insurance Survey, 2017
The number of urgent care centers and retail clinics serving MA residents has grown strikingly since 2010, although at different rates.

Number of urgent care centers and retail clinics in Massachusetts, 2010 - 2018

Notes:
HPC defines urgent care centers as serving at least all adult patients on a walk-in (non-appointment) basis and having service hours beyond normal weekday business hours.
Sources: HPC identified urgent care centers through sources including licensure data from the Massachusetts Department of Public Health, data from the Centers for Medicare and Medicaid Services, insurers’ online directories of providers, and the websites of the clinics and their affiliated organizations. Retail clinics are identified through their licensure as limited service clinics with the Massachusetts Department of Public Health; CVS Minute Clinics are the only retail clinics operating in Massachusetts as of August 2018.
Visit costs, including patient cost sharing, vary substantially by care site

Average total spending and cost sharing per visit, all conditions vs low acuity conditions, 2015

Notes: Data does not include facility fee costs.
Sources: HPC analysis of All-Payer Claims Database, 2015
Retail clinics and urgent care centers are disproportionately located in higher income areas, although urgent care centers are more broadly distributed.

Distribution of alternative care sites by median income of clinic location zip code

Income Quintile Range
1: $15,558 - $50,108
2: $50,250 - $63,548
3: $63,625 - $77,949
4: $78,099 - $93,307
5: $93,904 - $199,519

Sources: HPC identified urgent care centers through sources including licensure data from the Massachusetts Department of Public Health, data from the Centers for Medicare and Medicaid Services, insurers’ online directories of providers, and the websites of the clinics and their affiliated organizations. Retail clinics are identified through their licensure as limited service clinics with the Massachusetts Department of Public Health.
Providers reported varied perspectives on the impact of growth in alternative care sites

<table>
<thead>
<tr>
<th>Impact on the Emergency Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertain effect on volume</td>
</tr>
</tbody>
</table>

“…it is not clear to us that the proliferation of urgent care centers in our service area has affected overall utilization of emergency departments. Instead, we **continue to see ED utilization increase**, even while urgent care encounters increase as well.”

<table>
<thead>
<tr>
<th>Impact on Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>May attract routine care versus more complex patients</td>
</tr>
</tbody>
</table>

“…we are concerned that for many patients, urgent care services are replacing comprehensive primary care due to the convenience of access to an urgent care center, resulting in **greater fragmentation of primary care**.”

<table>
<thead>
<tr>
<th>Impact on Increasing Access to Appropriate Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential for greater access at lower cost sites</td>
</tr>
</tbody>
</table>

Alternative care sites may “assist patients with having access to the appropriate level of care…. **hospitals will be able to focus on the higher levels of care** they are intended for. This focus should allow for more **timely access and higher quality outcomes for patients**… During times of physician and advanced provider shortages, they provide a **lower cost alternative than emergency services**.”
Commercial payers represent a greater share of revenue for retail clinics and urgent care centers than health care spending overall in MA.

Distribution of gross patient service revenue from alternative care sites by payer, 2017

<table>
<thead>
<tr>
<th>Payer</th>
<th>Retail Clinics</th>
<th>Urgent Care Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>49%</td>
<td>60%</td>
</tr>
<tr>
<td>Medicare</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>MassHealth</td>
<td>36%</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Number of patient visits:
- Retail Clinics: 284,545
- Urgent Care Centers: 877,283

Notes: Data weighted by respondent size, based on volume of unique patient visits. Based on responses received through pre-filed testimony, the number of unique patient visits at retail clinics totaled 284,545. The number of unique patient visits at urgent care centers totaled 1,029,034; however, only 877,283 are included in the graph. Minute Clinic was the respondent for retail clinics. Urgent care center respondents included in the graph are [see above for list]. Care Well and Berkshire Health Systems were not included because they did not provide distribution of revenue by payer.

Sources: HPC analysis of 2017 alternative care site data submitted through pre-filed testimony and 2017 Total Health Care Expenditure data from CHIA Datebooks.
Witness Panel 2: Innovations to Enhance Timely Access to Primary and Behavioral Health Care

Witnesses

Dr. Timothy Ferris, Chairman and CEO
Massachusetts General Physicians Organization
Dr. Gene Green, President and CEO
South Shore Health System
Mr. Manny Lopes, President and CEO
East Boston Neighborhood Health Center
Mr. Edward Moore, President and CEO
Harrington Healthcare System
Dr. Kristina Orio, Medical Director and Lead Physician
AFC Urgent Care

Goals

The goal of this panel is to showcase emerging models of enhancing patient access to high-quality, convenient health care, especially behavioral health care and care for vulnerable populations. Focus areas will include: the growth in urgent care centers, including urgent behavioral health care, telemedicine, digital health technology solutions, mobile-integrated health, and other strategies to engage patients in care in the community, and reduce unnecessary emergency department and hospital utilization.
2018 Annual Health Care

COST TRENDS HEARING

OCTOBER 16, 2018

Up Next
Public Testimony Opportunity
Public Testimony
Tomorrow:
Day Two of the Health Care Cost Trends Hearing

Hearing begins at 9:15 AM