



MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission Board Meeting

December 13, 2018



AGENDA

- Call to Order
- Approval of Minutes from September 27, 2018 Meeting
- Executive Director's Report
- Market Oversight and Transparency
- Care Delivery and Transformation
- HPC 2019 Public Meeting Calendar



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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on September 27, 2018 as presented.



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2018 Year in Review: Public Engagement

26 public meetings

(board, committee, advisory council, special events, hearings, listening sessions)



> 50
hours
of public meetings on the HPC YouTube channel



Health Care Cost Growth Benchmark Modification Hearing (March)



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



2018 Cost Trends Hearing (October)



430
unique articles about the HPC's work

33.3k

unique visits to the HPC's website



Twitter



612,200 impressions
(potential views by unique Twitter users)

26,227 profile visits

574 mentions

6th Annual
Health Care Cost
Trends Hearing

450
in-person attendees

>2,000
live stream viewers

2018 Year in Review: Market Oversight and Transparency



26 total
publications

\$4.8 billion
identified as *Opportunities for
Savings in Health Care*



56
provider
organizations
registered

5 online **DataPoints Briefs**



10
material
change
notices
reviewed

26
providers and payers reviewed
for a potential **Performance
Improvement Plan**

40
exhibits included in the *2017 Annual
Cost Trends Report* and Chartpack

329
total pages of **Cost
and Market Impact
Review** reports

2018 Year in Review: Care Delivery and Transformation



21 new practices participating in the HPC's Patient-Centered Medical Home (PCMH) program

MC MASSCHALLENGE



Strategic partner of **MassChallenge HealthTech**, working to identify promising digital health start-ups



17 HPC-Certified ACOs



\$10 million

authorized for **15 awards** in the SHIFT-Care Challenge

\$17 million

distributed among **45 grants** to support innovative care delivery models in the CHART and HCII Programs



17

ACO Profiles published

2

ACO Policy Briefs issued

Office of Patient Protection (OPP)

280

external appeals processed

826

enrollment waivers processed



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Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Clinical affiliation	22	23%
Physician group merger, acquisition or network affiliation	20	21%
Acute hospital merger, acquisition or network affiliation	19	20%
Formation of a contracting entity	17	18%
Merger, acquisition or network affiliation of other provider type (e.g., post-acute)	11	12%
Change in ownership or merger of corporately affiliated entities	5	5%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

- Proposed joint venture among **Shields Health Care Group**, **Reliant MSO**, and **ASC HoldCo**, a holding company owned by the orthopedic specialty groups Orthopedics New England and New England Hand Associates. The proposed joint venture would build and operate a freestanding ambulatory surgery center in Natick, where Reliant and ASC HoldCo physicians would provide outpatient orthopedic and general surgical services.

Received Since 9/27

- Proposed clinical affiliation between **Dana-Farber Cancer Institute (DFCI)** and **Cape Cod Healthcare**. Under the proposed affiliation, Cape Cod Hospital's cancer center would become a member of the Dana-Farber Cancer Care Collaborative, and DFCI would provide consulting, educational, and clinical support services to Cape Cod Hospital and its patients.



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2018 Cost Trends Report: Presentation Outline

Topics

Overview

- Trends in spending, affordability, and care delivery



Utilization

- Trends
- Low value care
- Admissions from the ED



Price

- Oncology drug prices
- Commercial prices compared to Medicare prices



Total Spending

- Total Medical Expenses by Provider Group
- Provider organization cohort study

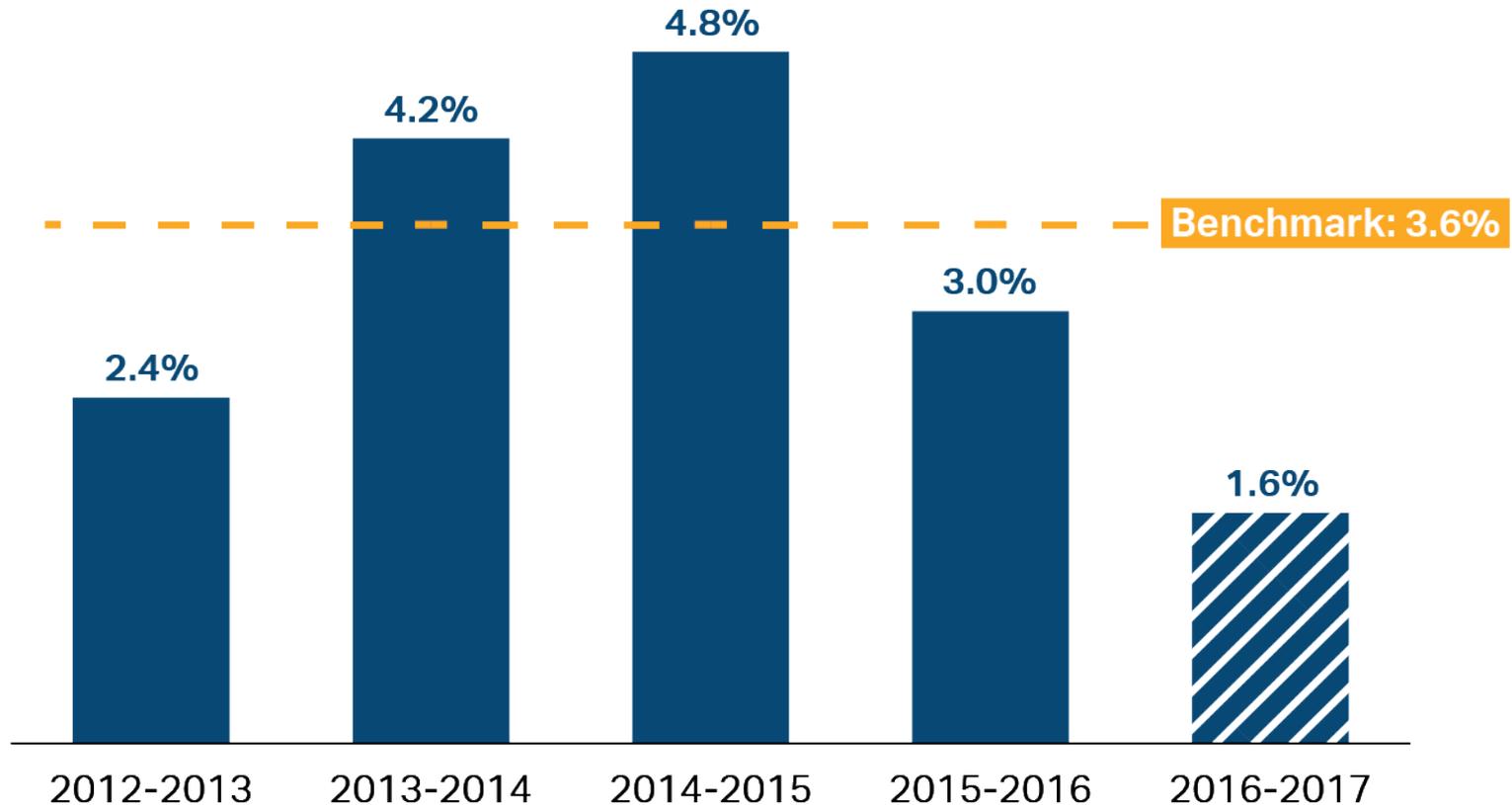


Select Findings from the 2018 Cost Trends Report



Growth in THCE per capita was 1.6% from 2016-2017, significantly below the health care cost growth benchmark

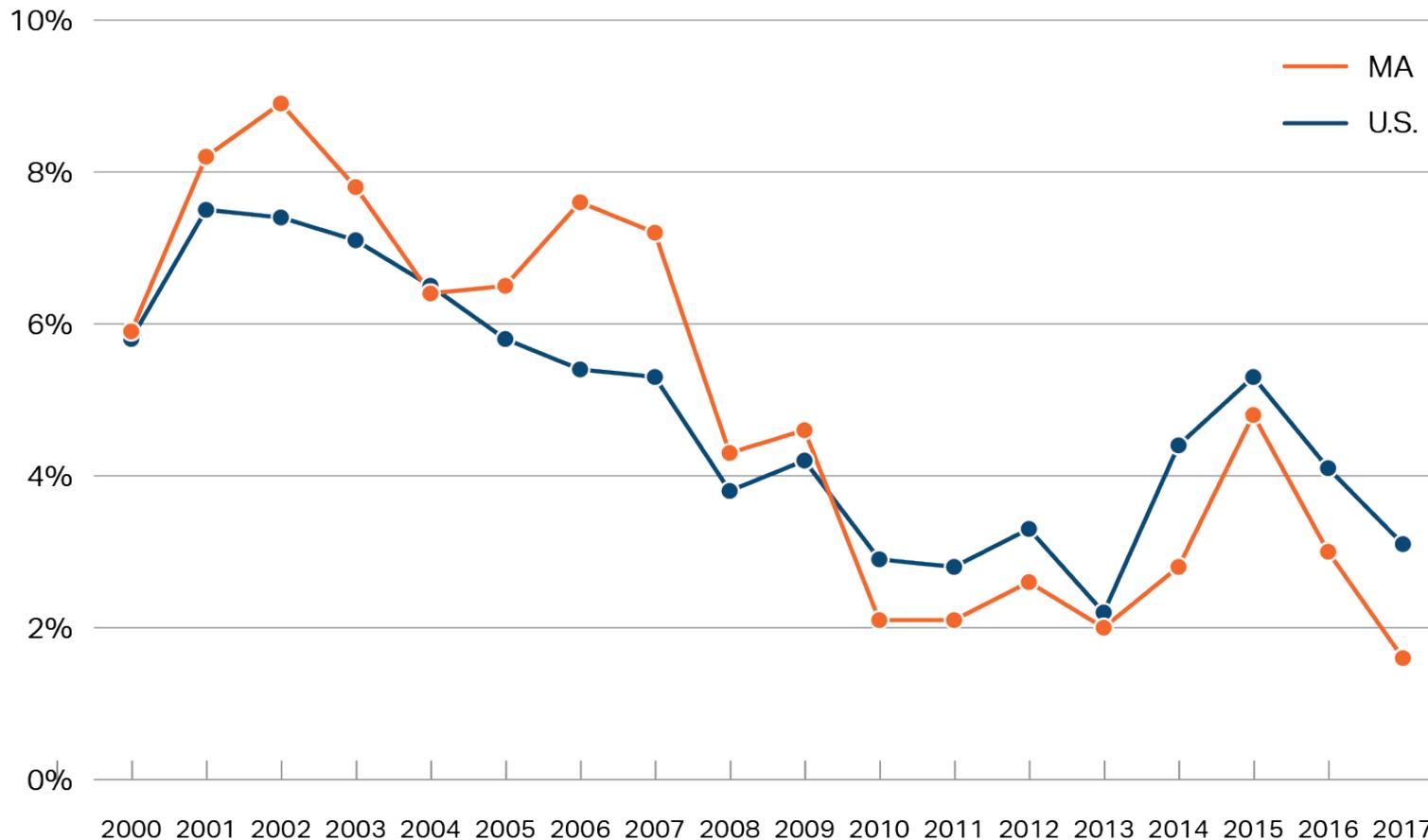
Annual growth in total health care expenditures per capita in Massachusetts



Annual growth averaged 3.2% between 2012 and 2017

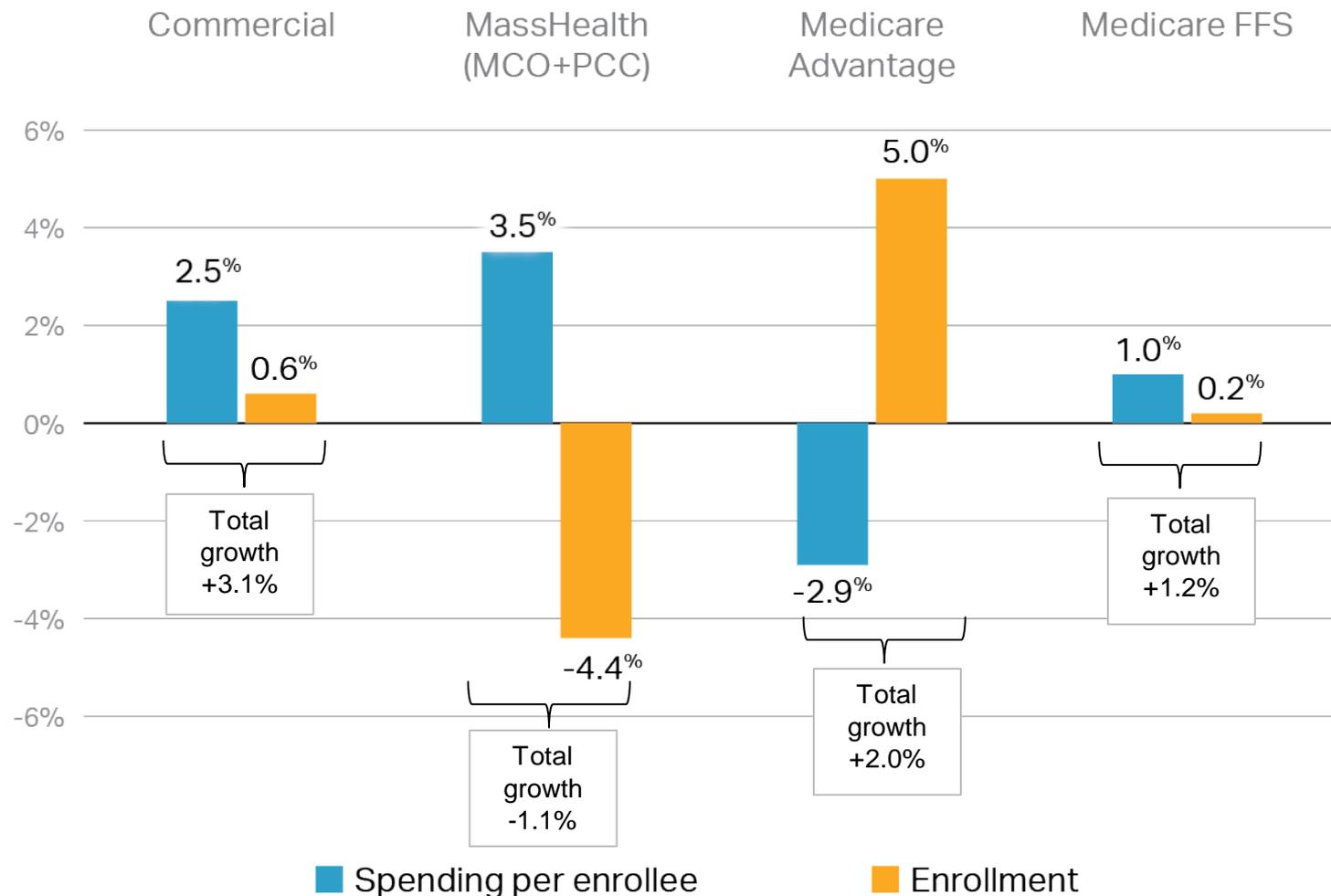
In 2017, total health care spending growth in Massachusetts was well below the national rate, continuing a multi year trend

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



Spending growth per enrollee was below the health care cost growth benchmark for each major coverage category

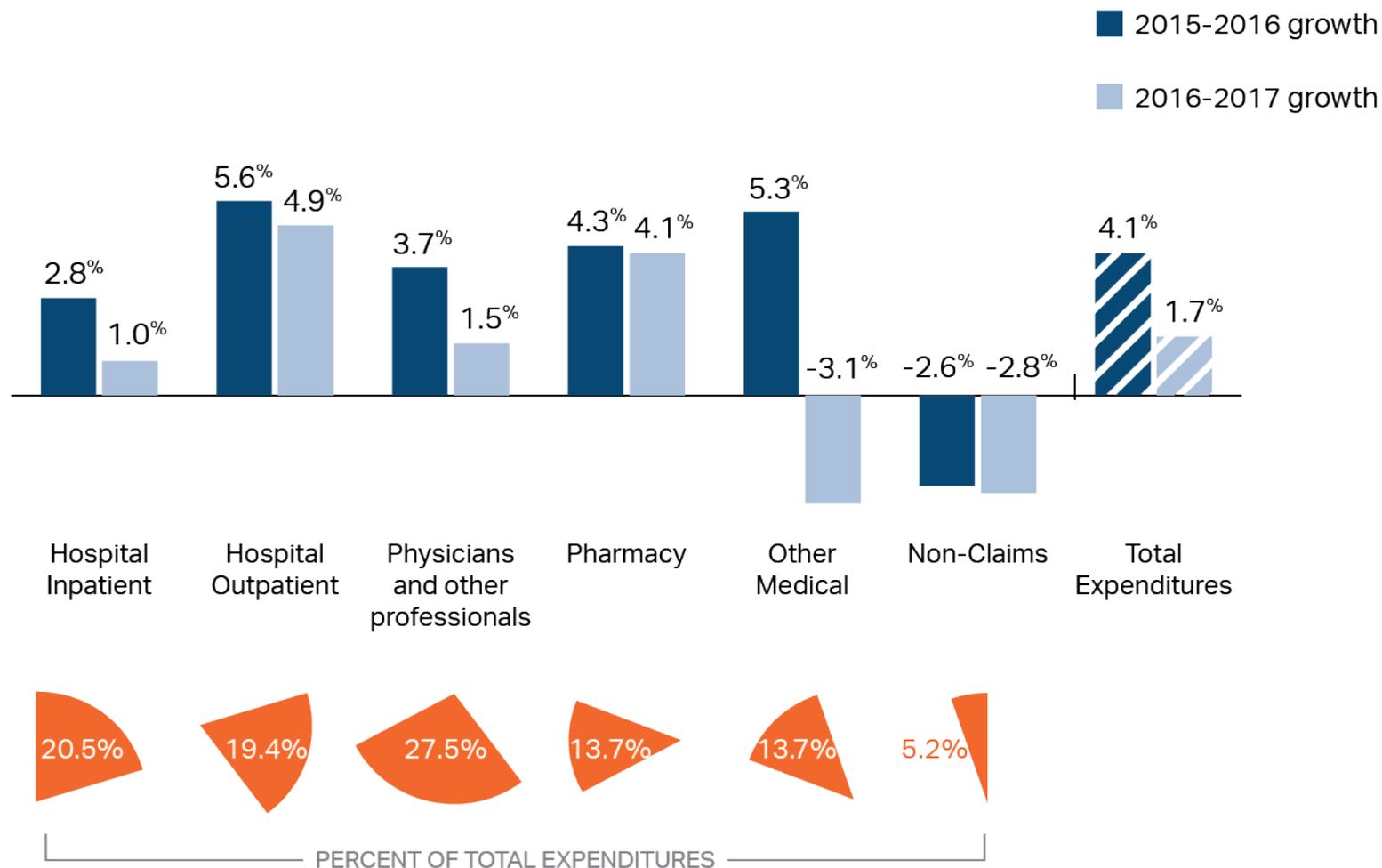
Change in enrollment and per enrollee spending by major market segment, 2016-2017



Notes: Medicare FFS spending does not include Part D prescription drug coverage. Commercial spending and enrollment growth includes enrollees with full and partial claims. MassHealth includes only full coverage enrollees in the PCC and MCO programs. Figures are not adjusted for changes in health status. Sources: Center for Health Information and Analysis Annual Report, 2018

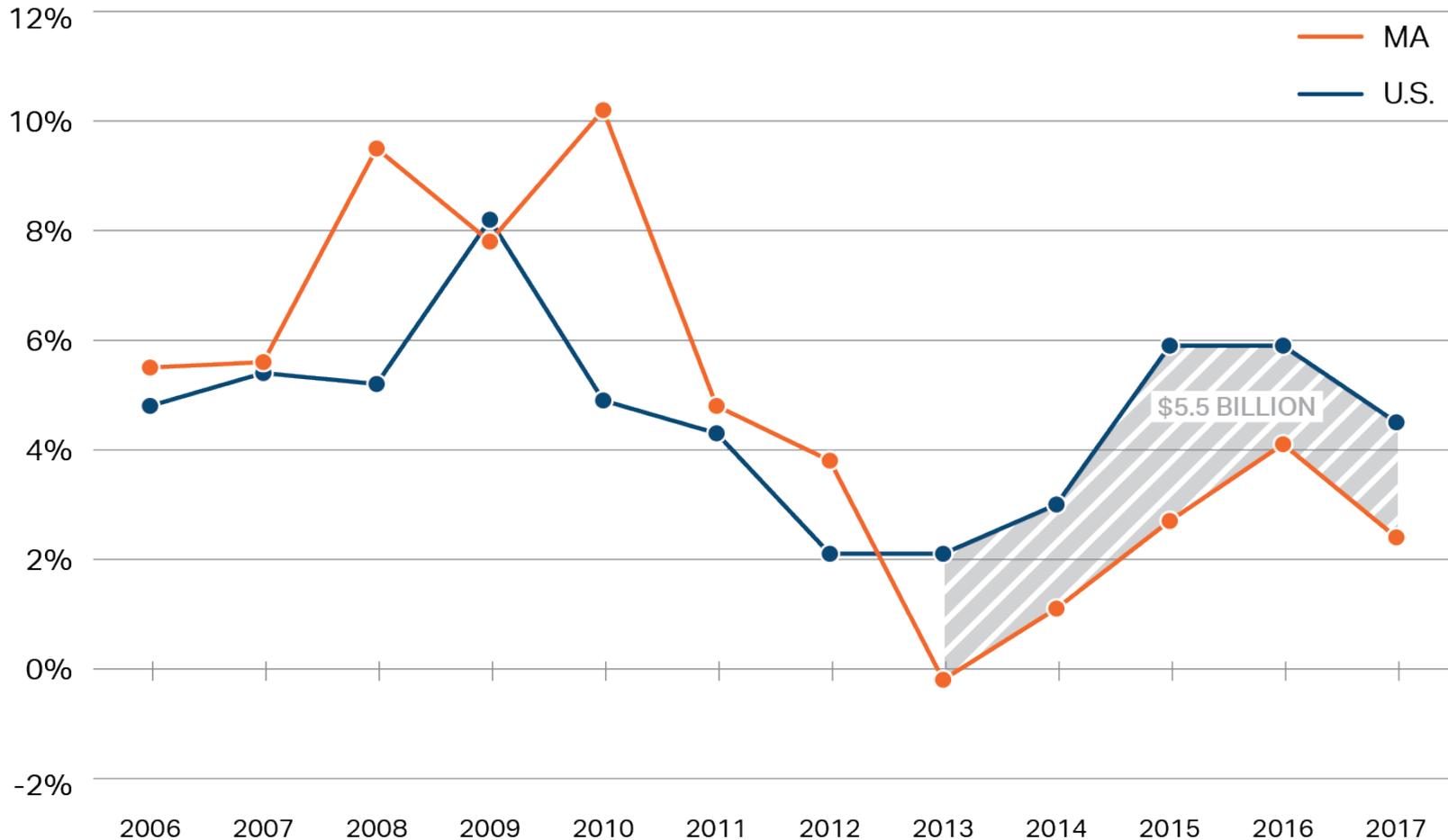
Hospital outpatient and pharmacy spending were the fastest-growing categories in 2016 and 2017

Rates of spending growth in Massachusetts in 2016 and 2017 by category, all payers



Commercial spending growth in Massachusetts has been below national trends since 2013, avoiding billions in spending

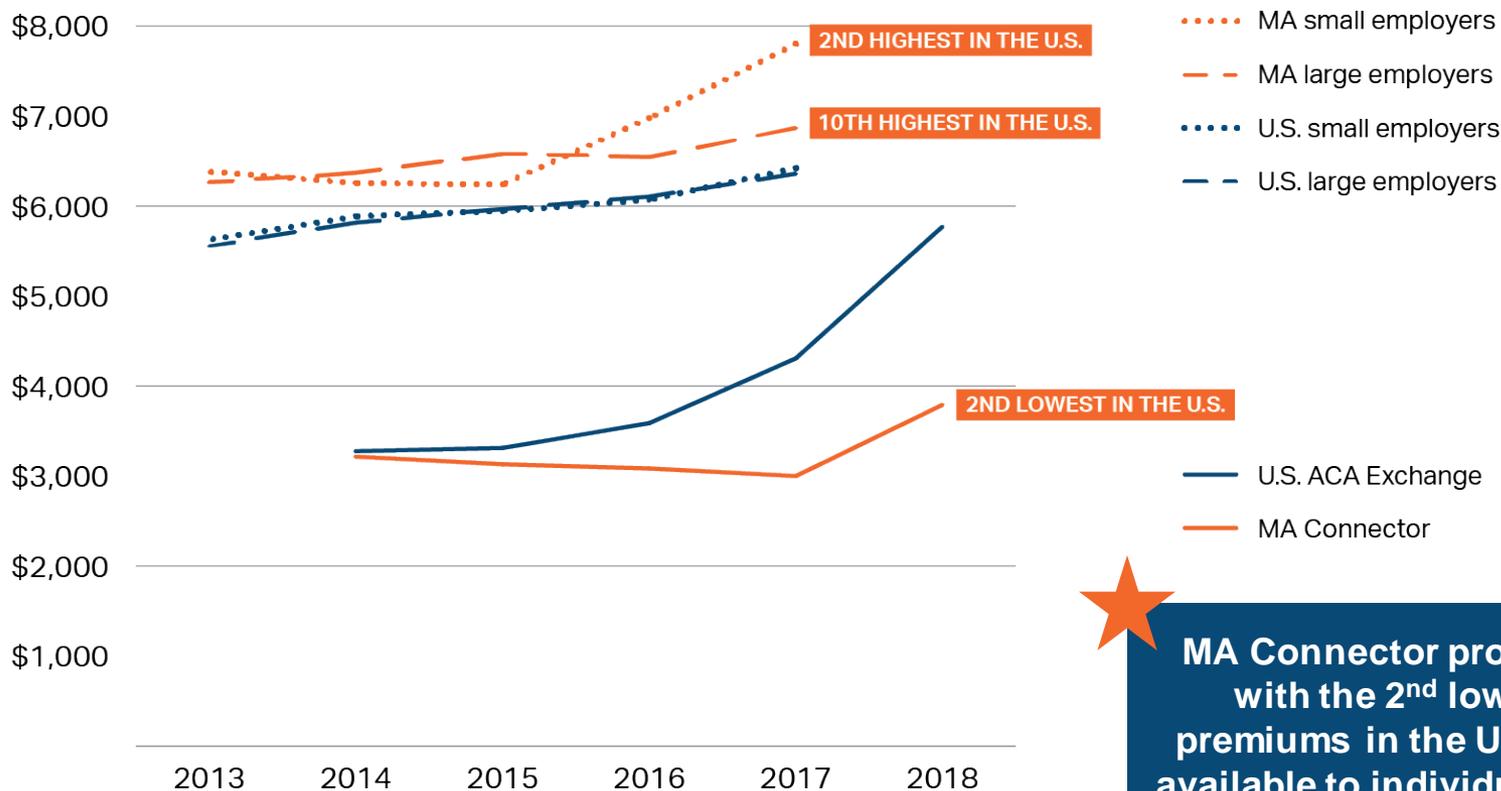
Annual growth in commercial spending per enrollee, MA and the U.S., 2006-2017



Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are based on full-claim commercial total medical expenditures (TME). Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data (U.S. 2014-2017), and State Healthcare Expenditure Accounts (U.S. 2005-2014 and MA 2005-2014); Center for Health Information and Analysis Annual Reports (MA 2014-2017)

Insurance premiums for large Massachusetts employers are 10th highest in the U.S. (down from 2nd highest in 2013), though premiums for small employers have risen recently

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



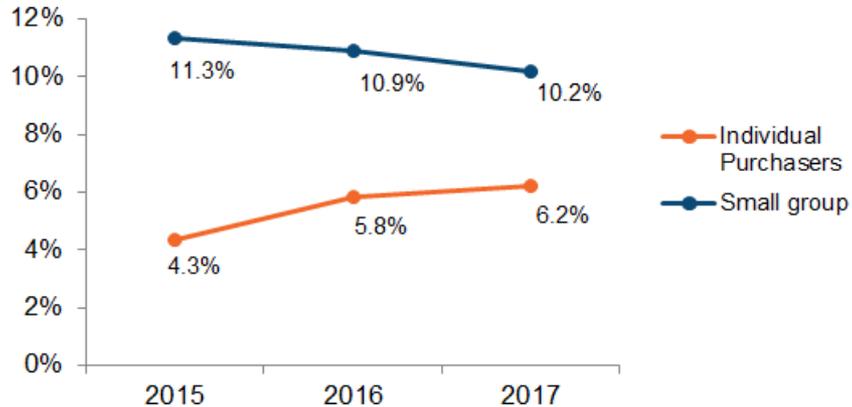
MA Connector products, with the 2nd lowest premiums in the U.S., are available to individuals and small employers

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 without adjustment.

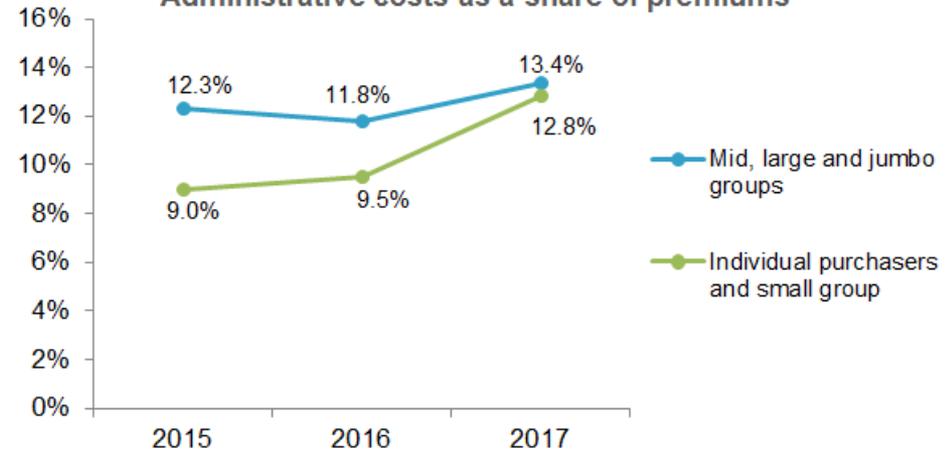
Sources: Kaiser Family Foundation analysis of premium data from healthcare.gov (marketplace premiums 2014-2018); US Agency for Healthcare Quality, Medical Expenditure Panel Survey (commercial premiums 2013-2017)

Characteristics of the Massachusetts small group insurance market: limited plan choice, rising deductibles, growing administrative costs, and declining enrollment

Small group employees and individual purchasers as a share of the MA commercial market



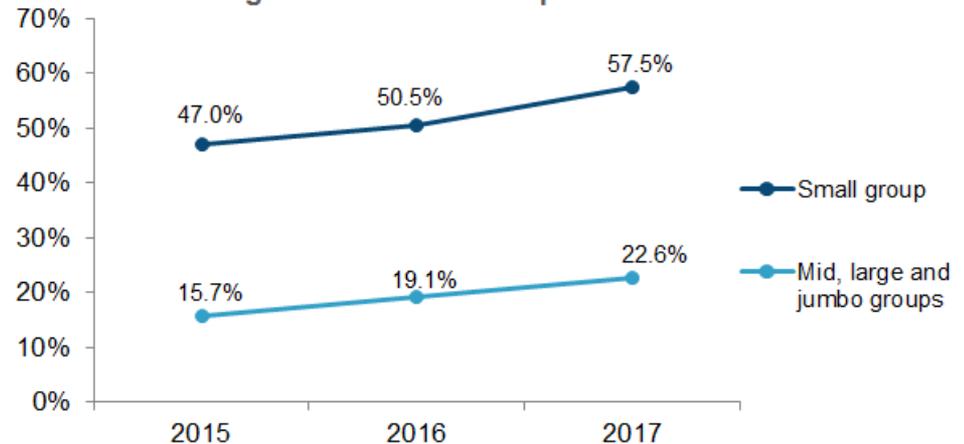
Administrative costs as a share of premiums



2015-2017 % of small employers that offered two or more plans



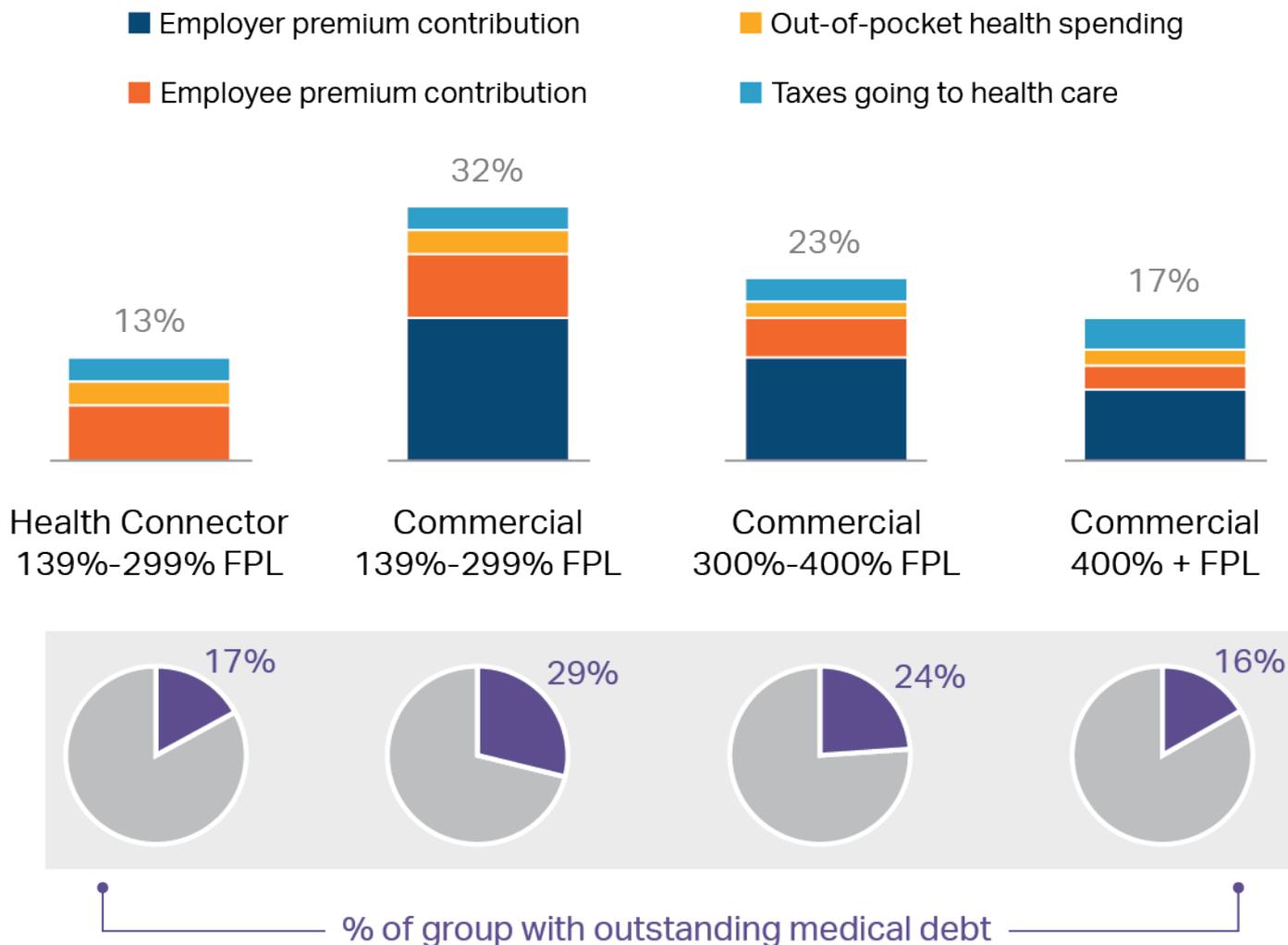
High deductible health plan enrollment in MA



Notes: Small, mid-size, large and jumbo firms are defined as those with 1- 50 employees, 51-100 employees, 101-499 employees, and 500+ employees, respectively. High deductible health plans (HDHPs) are defined as those with an individual deductible greater than or equal to \$1,300 for 2015-2017 (for the most preferred network or tier, if applicable). Premiums are pre Medical Loss Ratio rebates adjustment, as those are a component of administrative costs. Administrative costs for individual purchasers and small group are before 3R transfers. 3R transfers do not apply to larger groups.

Sources: Agency for Healthcare Research and Quality Medical Expenditure Survey (insurance offer rates 2015 - 2017); Center for Health Information and Analysis Coverage and Costs Databook 2018

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

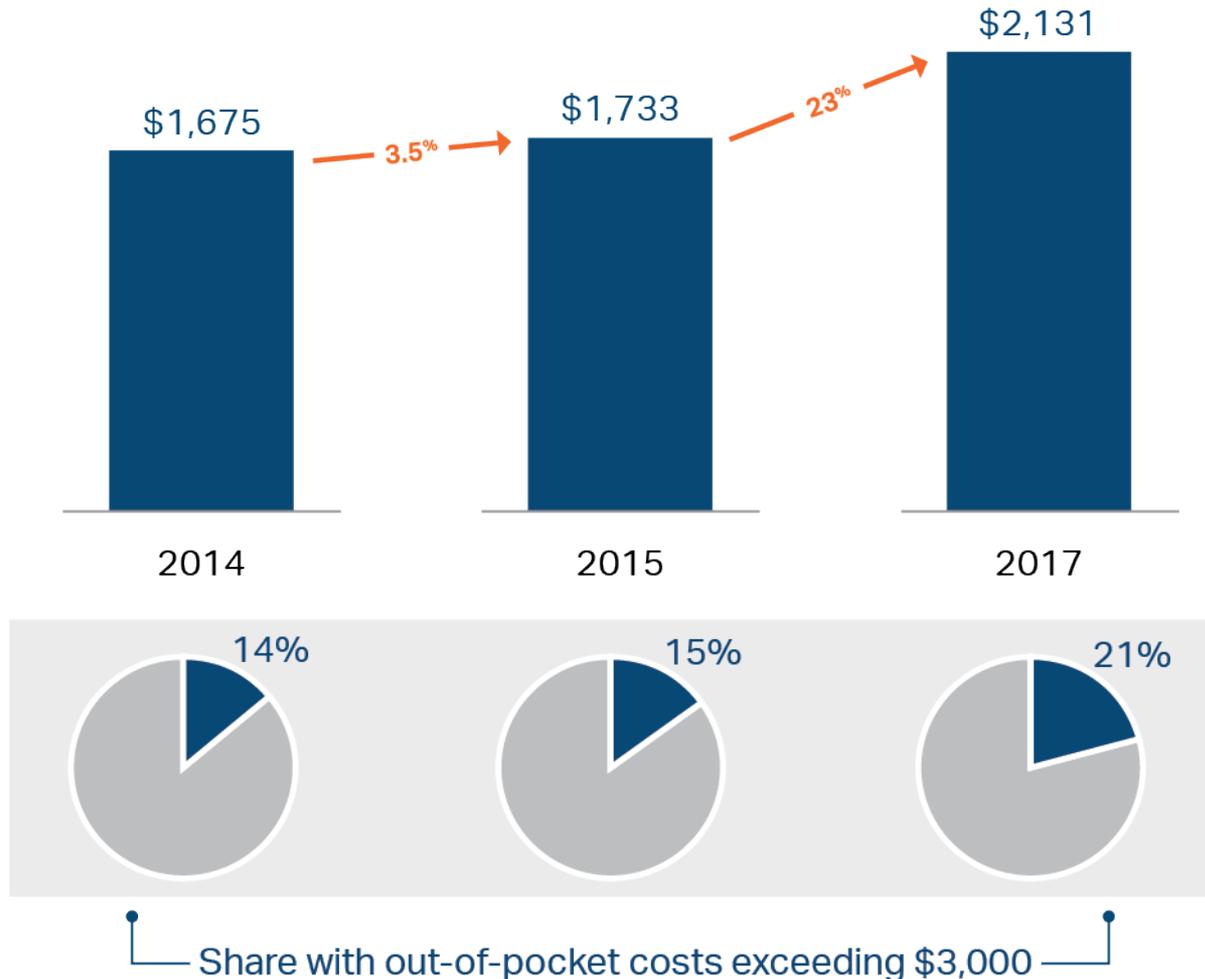


Note: Figures rounded to nearest whole number. Total income represents total family income and includes employer payments, if any, toward health insurance premiums. One-person families and families with children and two adults are included in the analysis. Data are combined using survey weights which 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.

Commercially insured residents experienced a sharp increase in out-of-pocket spending between 2015 and 2017

Out-of-pocket spending per year for enrollees with commercial insurance, 2014, 2015 and 2017

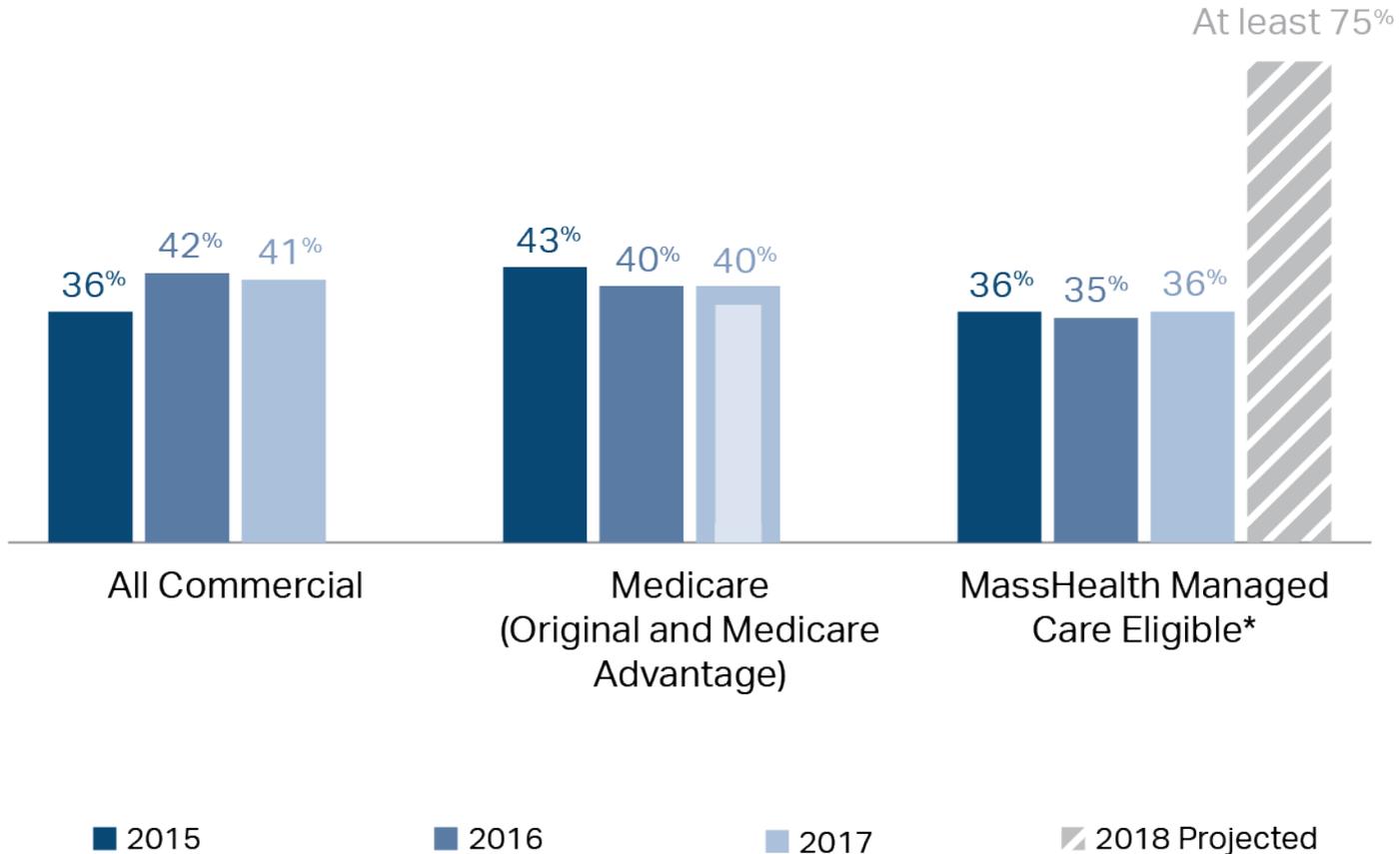


Notes: Out-of-pocket spending is defined as the amount of health care costs a respondent paid in the past 12 months, that was not covered by any insurance or special assistance they may have. Averages shown are conditional on having non-zero out of pocket spending to maintain data consistency across years of survey data.

Sources: HPC analysis of Massachusetts Health Interview Survey, 2014-2017

Overall APM adoption was relatively unchanged in 2017, but by 2018 MassHealth's ACO program will drive statewide APM coverage toward 50%

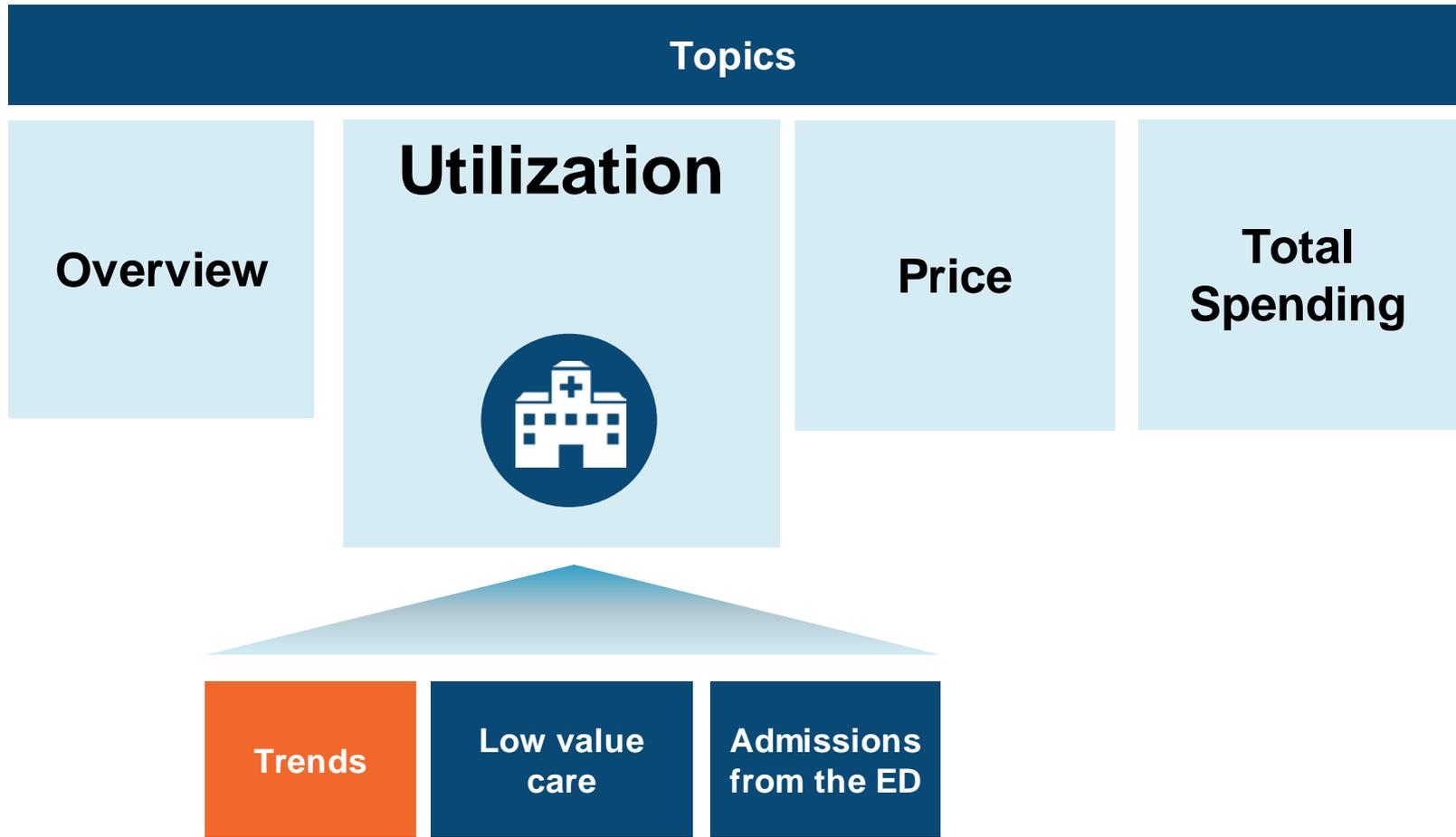
Percentage of enrollees in alternative payment methods by payer, 2015 - 2017



Notes: 2017 results for Original Medicare represent preliminary estimates.

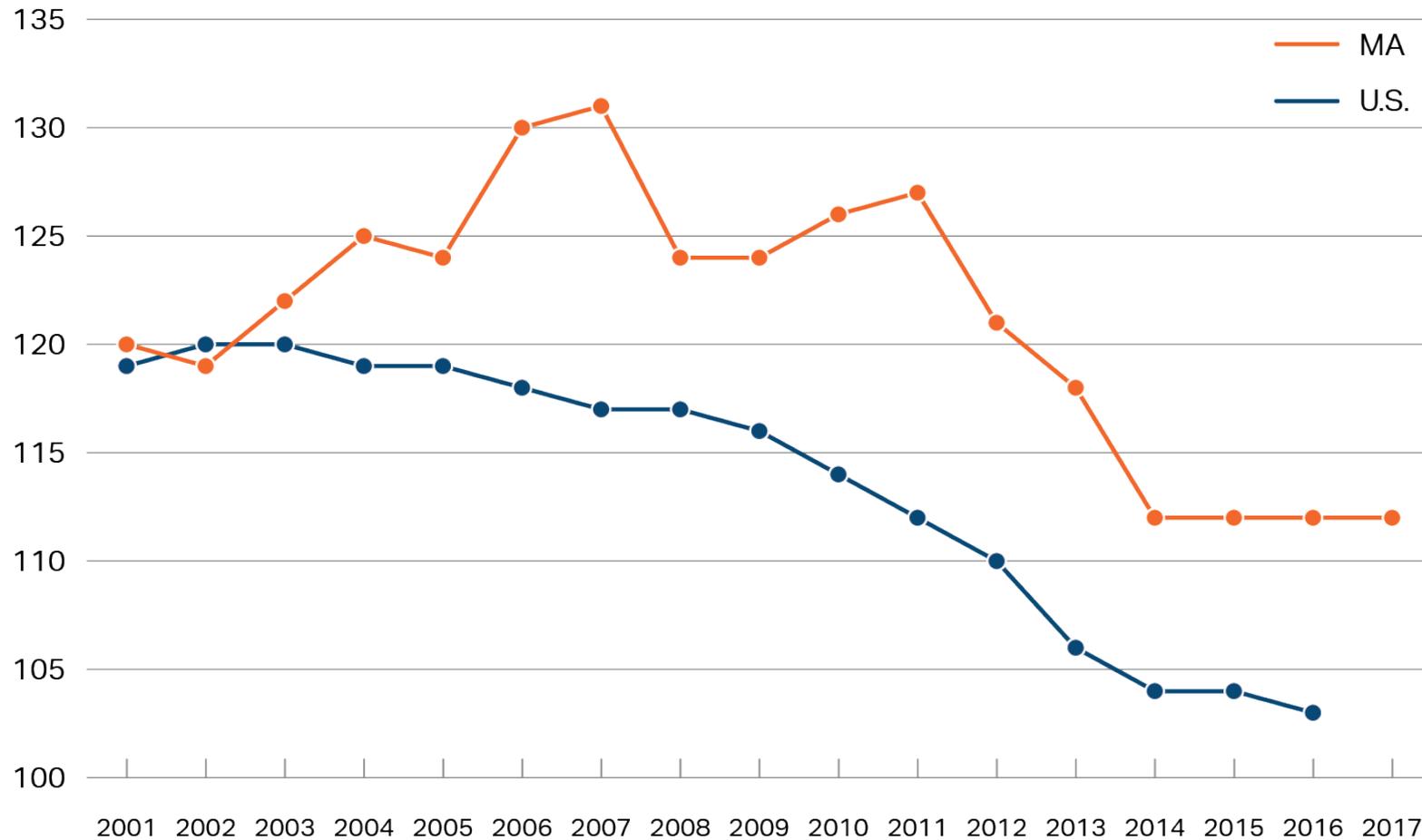
Sources: HPC analysis of Center for Health Information and Analysis Annual Report APM data book, 2018; Centers for Medicare and Medicaid Services, Number of ACO Assigned Beneficiaries by County Public Use File (2015 - 2017); "Medicare Pioneer Accountable Care Organization Model Performance Years 3- 5" (2014 - 2016); "Next Generation ACO Model Financial and Quality Results Performance Year 1" (2016, [2017 not yet available]). 2018 MassHealth Projection provided by MassHealth.

Select Findings from the 2018 Cost Trends Report



Overall Massachusetts inpatient hospital use is unchanged since 2014 and continues to exceed the U.S. average

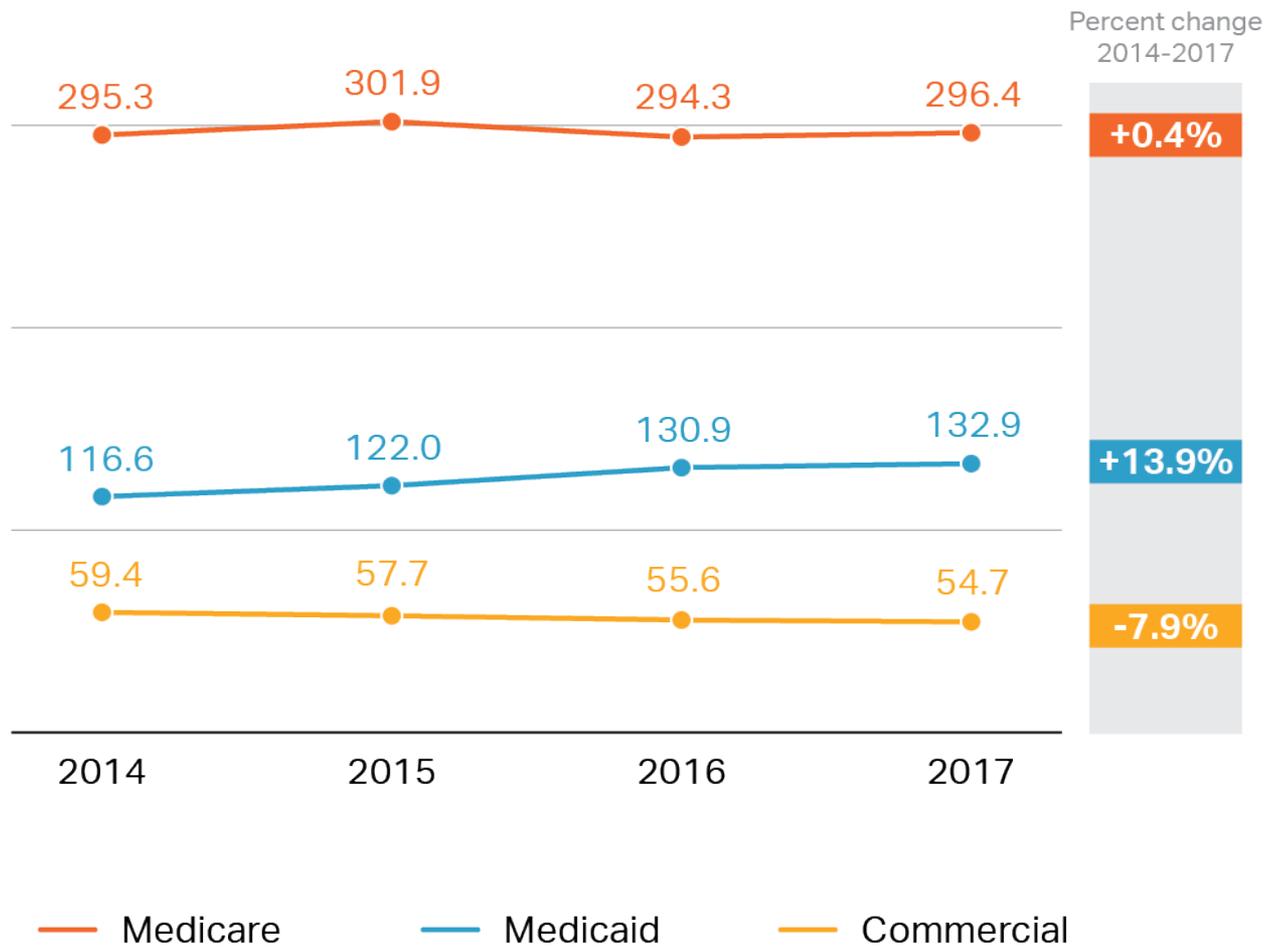
Inpatient hospital discharges per 1,000 residents, Massachusetts and the U.S., 2001-2017



Notes: US data include Massachusetts. Massachusetts' 2017 data is based on HPC's analysis of Center for Health Information and Analysis discharge data. Sources: Kaiser Family Foundation analysis of American Hospital Association data (U.S., 2001-2016), HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2017)

Inpatient hospital use has declined 8% among commercially-insured residents since 2014

Inpatient hospital discharges per 1,000 enrollees by payer, 2014 - 2017

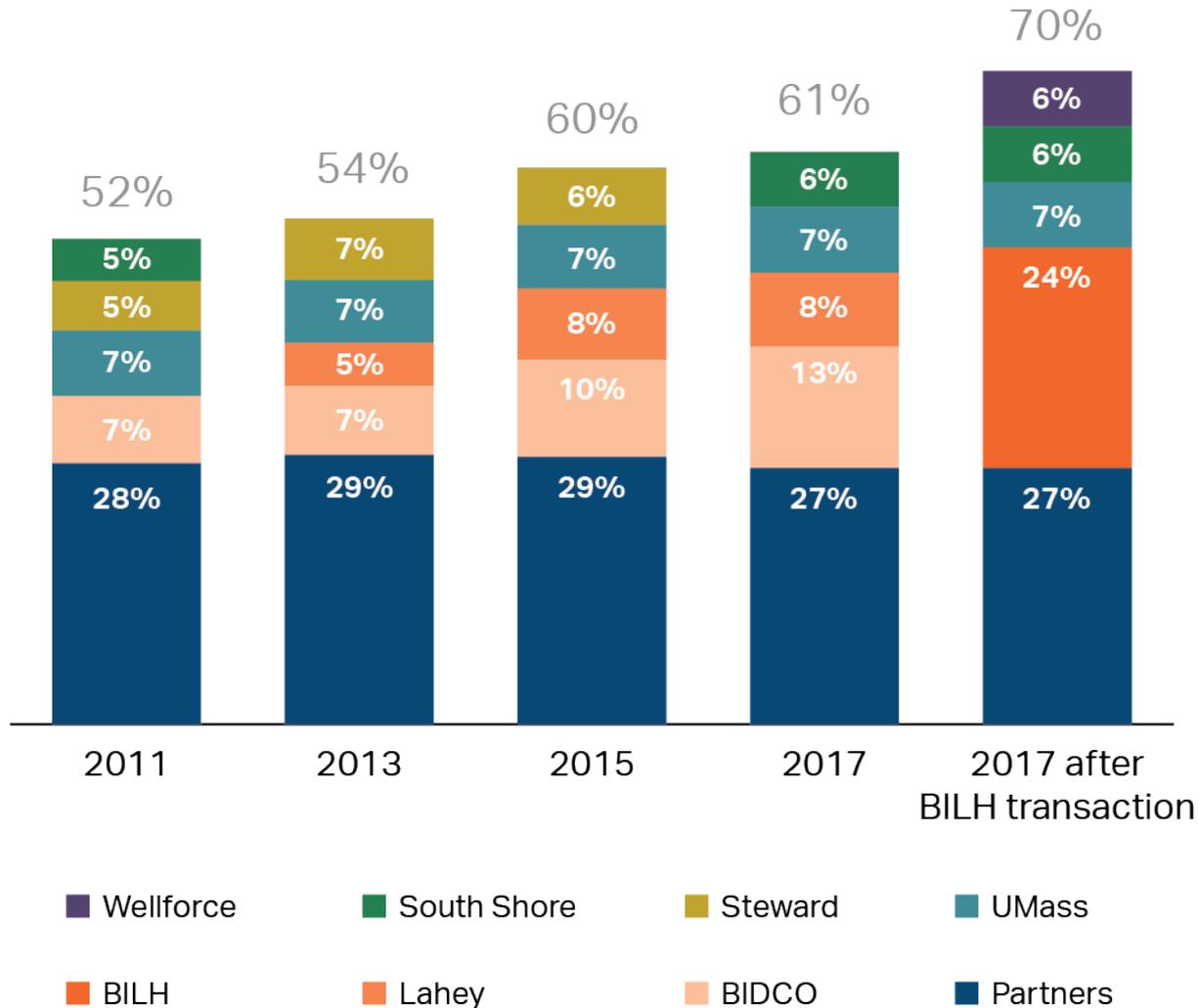


Notes: Out of state residents are excluded from the analysis.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (2014 - 2017). Center for Health Information and Analysis Enrollment Databook 2018.

After the formation of Beth Israel Lahey Health, the top five health systems will account for 70% of all commercial inpatient stays statewide, continuing a multi year trend of increasing concentration

Share of commercial inpatient discharges in the five largest hospital systems in each year, 2011 - 2017

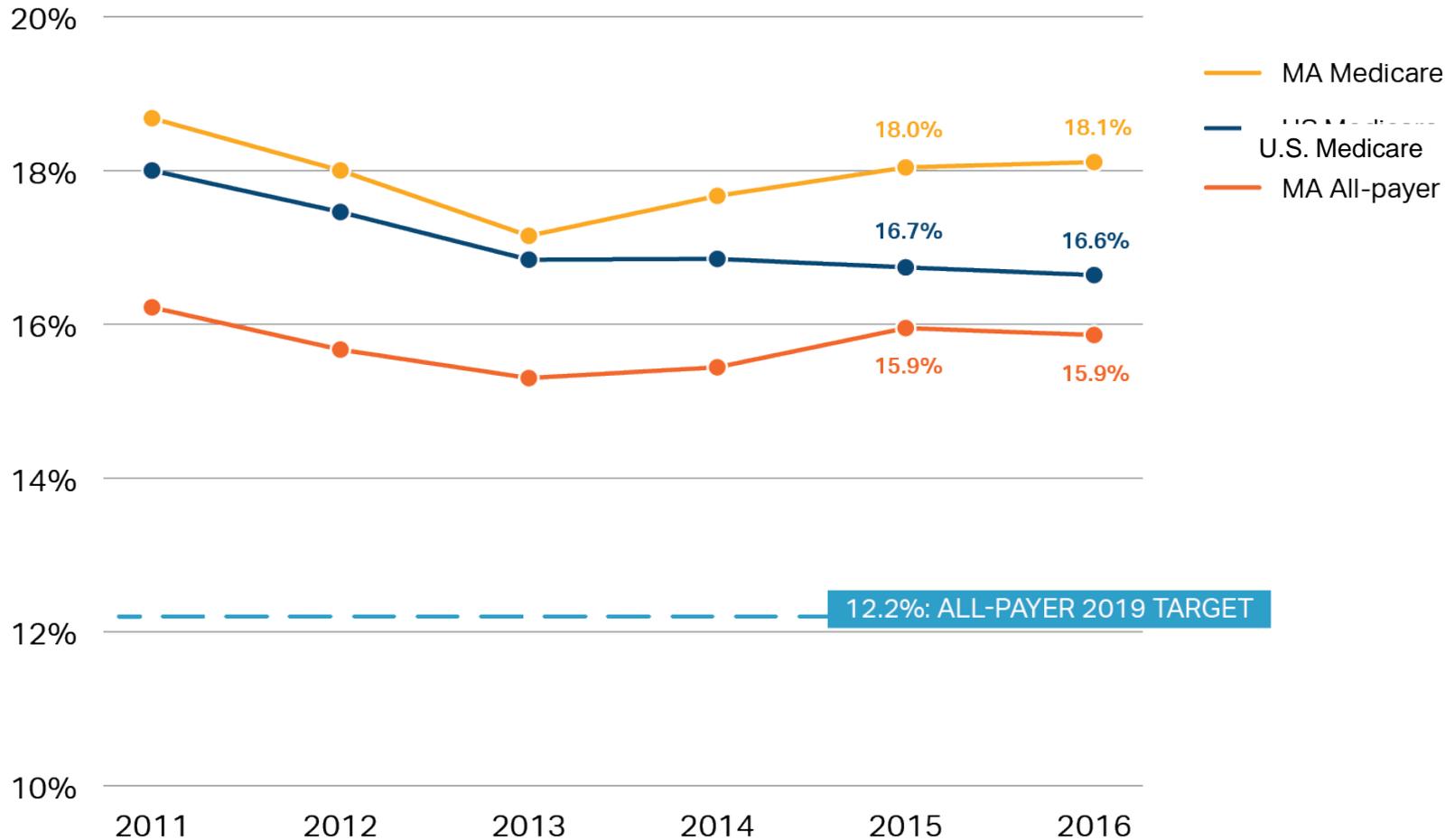


Notes: Percentages represent each system's share of commercial inpatient hospital discharges provided in Massachusetts for general acute care services. Discharges for normal newborns, non-acute services, and out-of-state patients are excluded.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (2011-2017)

Massachusetts readmission rates showed no improvement in 2016

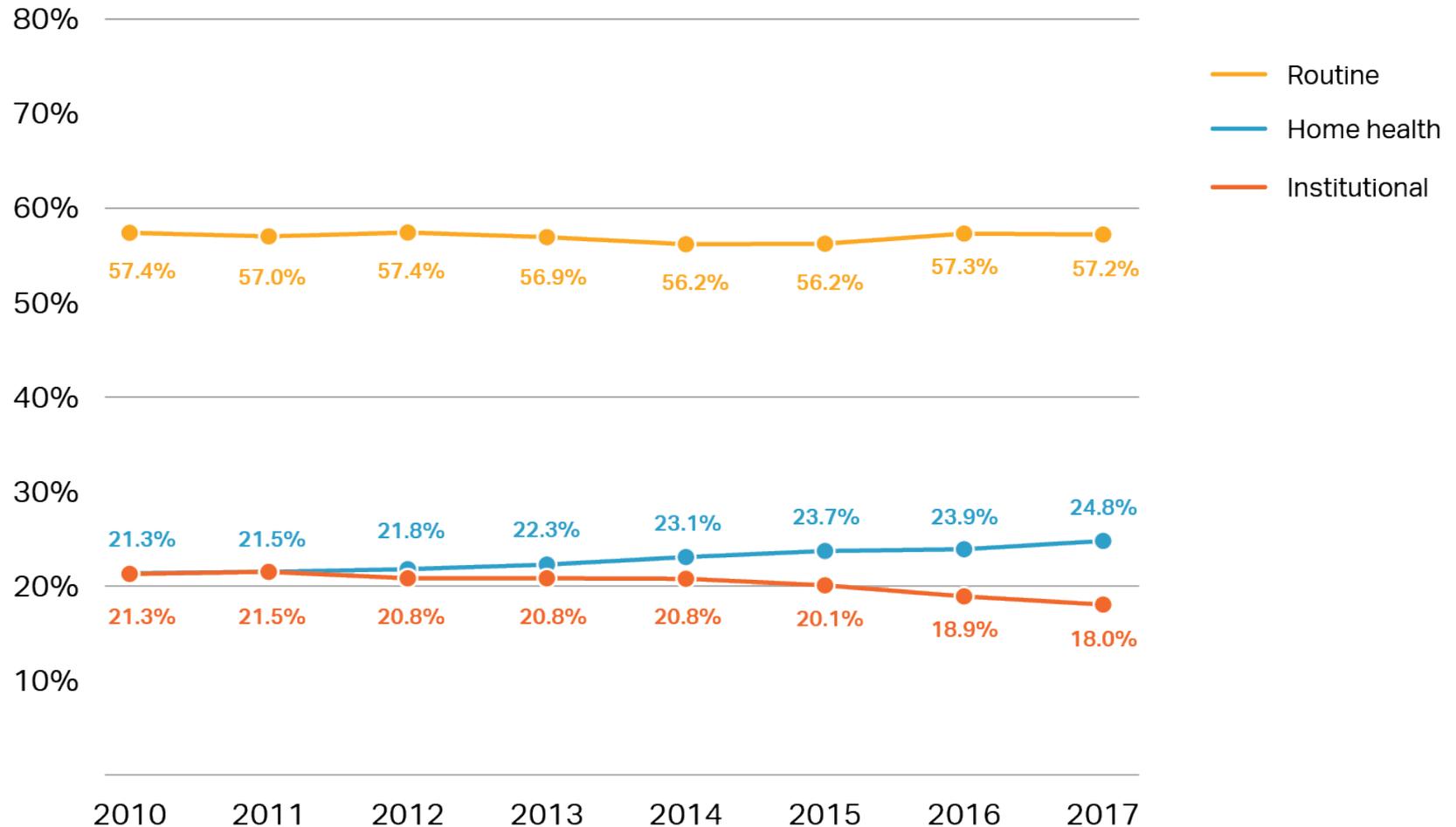
Thirty-day readmission rates, Massachusetts and the U.S., 2011-2016



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).

The percentage of Massachusetts hospital patients discharged to institutional post-acute care continued to decrease in 2017

Discharge destination following hospitalization for Massachusetts residents, 2010-2017

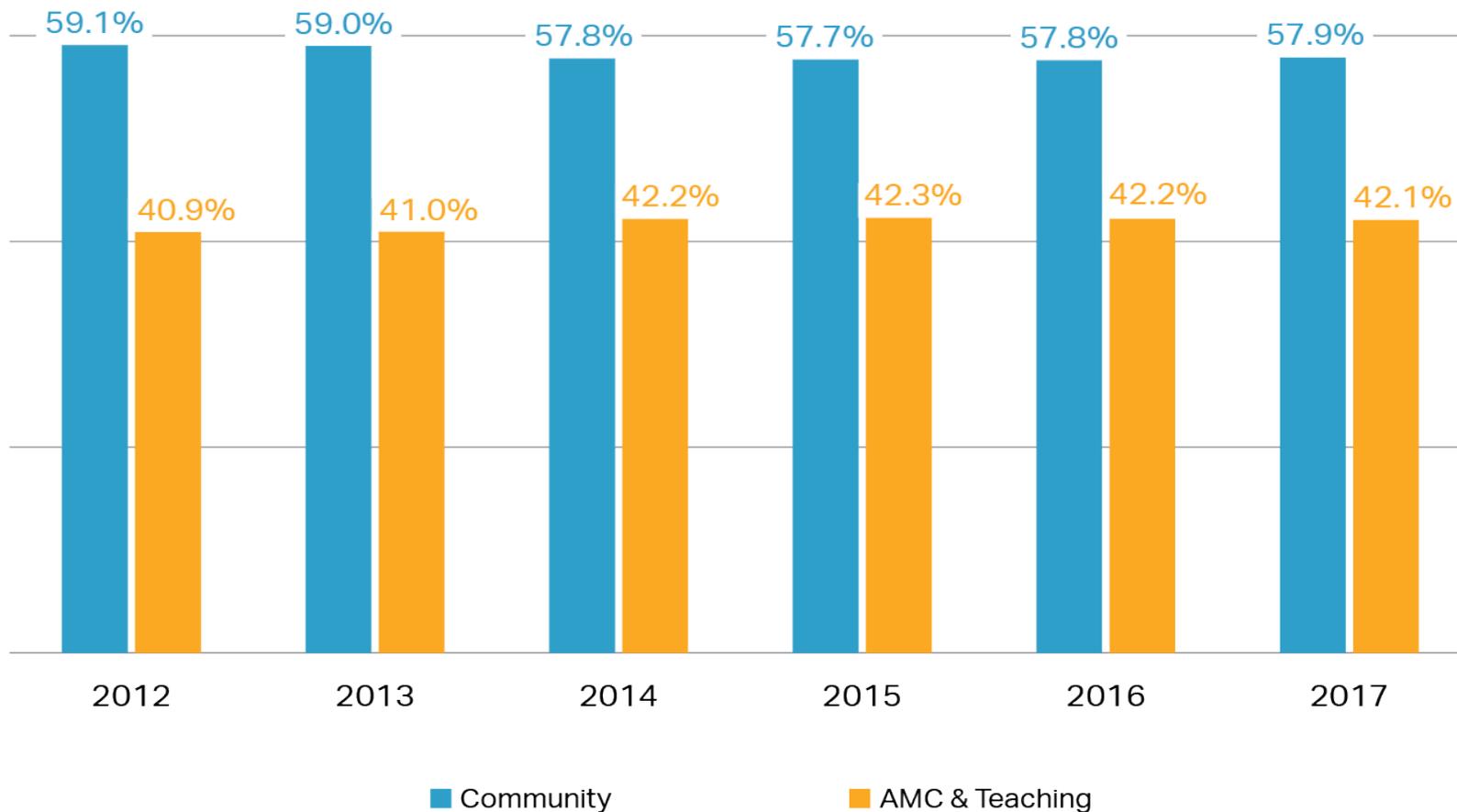


Notes: Out of state residents are excluded. Institutional post-acute care settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Rates adjusted using ordinary least squares (OLS) regression to control for age, sex, and changes in the mix of diagnosis-related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

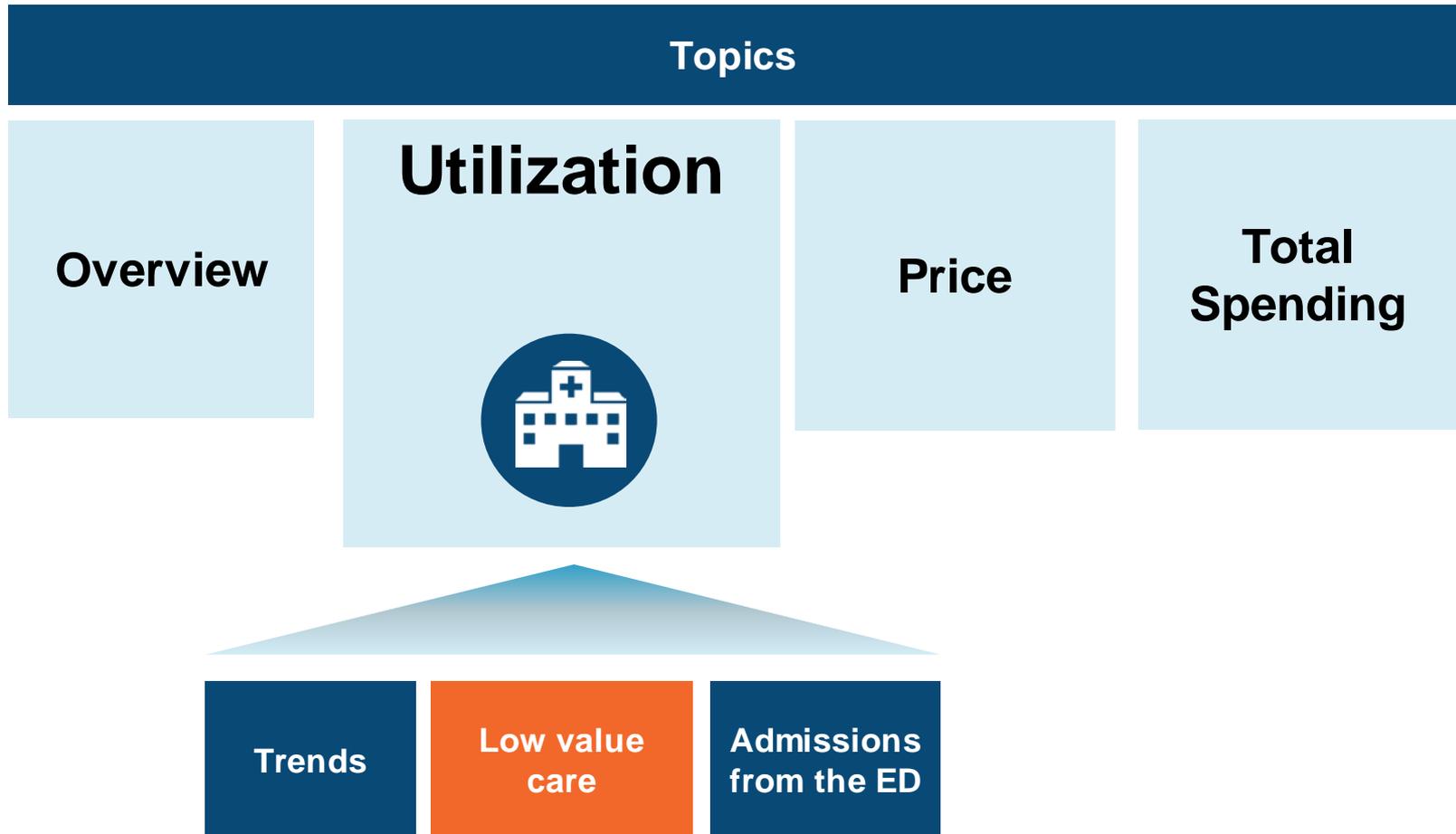
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2010-2017

The share of community-appropriate inpatient care treated at community hospitals has stabilized

Share of community appropriate discharges in Massachusetts by hospital type, 2012-2017



Select Findings from the 2018 Cost Trends Report



Low Value Care (LVC) in the Commonwealth: Background

- **Background:** Choosing Wisely, an initiative of the American Board of Internal Medicine (ABIM) Foundation, convened specialist organizations in 2012 to select procedures in their fields that had little to no value to patients
- **Aim:**
 - Identify instances of provision of certain low-value care services in the Massachusetts APCD
 - Quantify the extent of these services, overall and by provider group

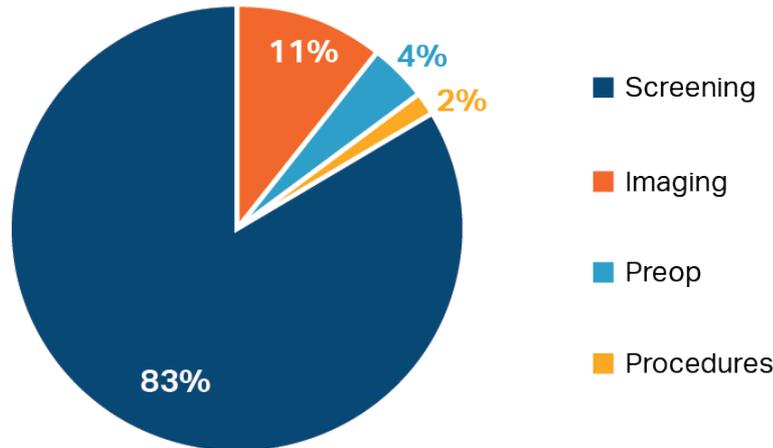
Unnecessary screening tests	Unnecessary Imaging
Vitamin D deficiency screening	Head imaging for uncomplicated headache
Homocysteine screening	Back imaging for patients with non-specific low back pain
Carotid artery disease screening for those at low-risk	Head imaging in the evaluation of syncope
Pap smears for women under 21	Electroencephalogram (EEG) for uncomplicated headache
Unnecessary pre-operative testing	Imaging for diagnosis of plantar fasciitis/heel pain
Cardiac stress test before low-risk, non-cardiac surgery	Neuroimaging in children with simple febrile seizure
Pulmonary function test (PFT) for low and intermediate risk surgery	Sinus CT for simple sinusitis
Unnecessary procedures	Abdominal CT with and without contrast
Spinal injections for low-back pain	Thorax CT with and without contrast
Arthroscopic surgery for knee osteoarthritis	Inappropriate prescribing
IVC Filters	Inappropriate antibiotics for sinusitis, pharyngitis, suppurative otitis media, and bronchitis

Low Value Care: Key Findings

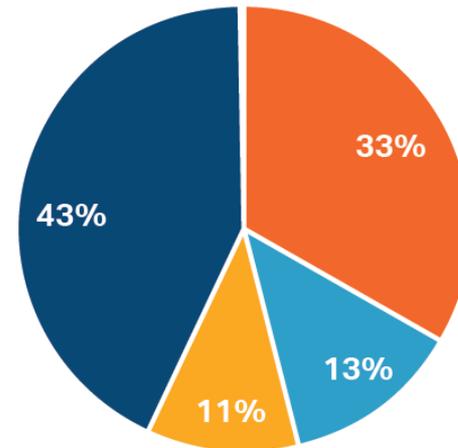
Among the three major commercial health plans in the Commonwealth:

- **485,377** of 2.36 million members (**20.5%**) received at least one low value care service in a 2-year time period
- All 19 low value care procedures accounted for **\$80.0 million (\$12.2 million out of pocket)** in health care spending in the 2 year period between 2013-2015*

Total LVC encounters for 19 measures, commercial APCD 2013-15¹



Total LVC spending for 19 measures, commercial APCD 2013-15¹



¹n=626,015 encounters

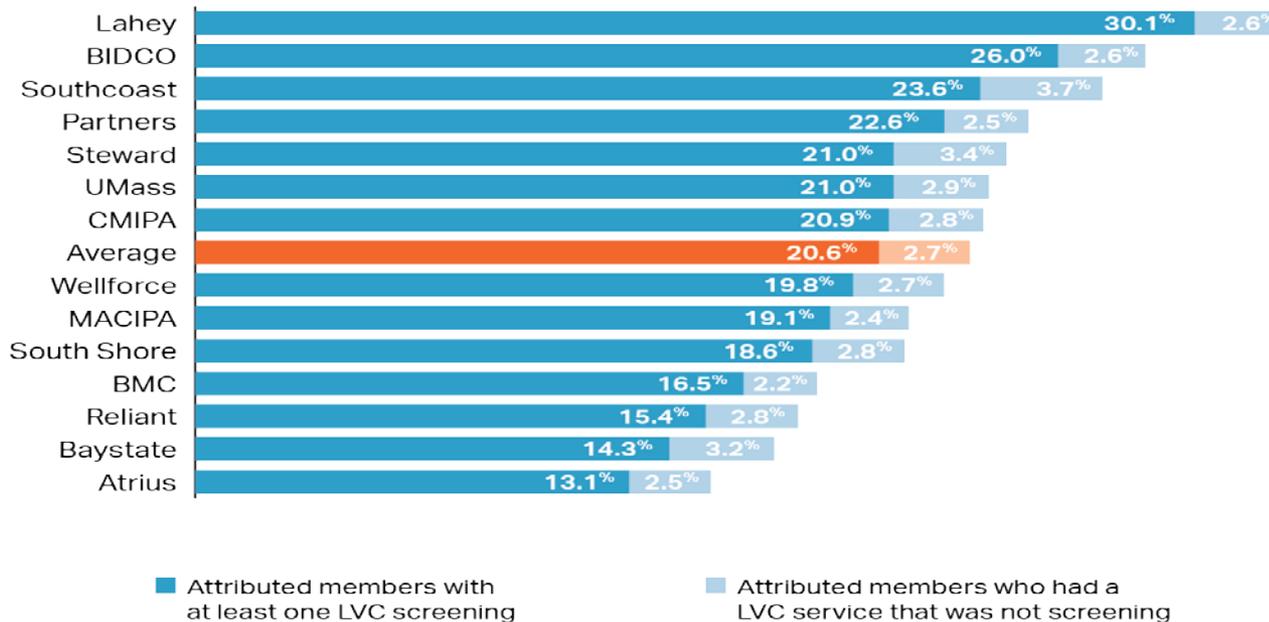
Notes: This timeframe was selected because much of the literature is based on ICD-9 diagnoses and several measures required a “look-back” period. *For thorax and abdomen CT with and without contrast, only the marginal cost of the procedure was counted that was in excess of either with or without contrast.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2013-2015

Variation in rates of low value care by provider organization are driven primarily by low value screening

- 1.6 million members were attributed to one of the top 14 largest provider organizations based on their primary care provider
- Members experiencing at least one low value care service by attributed provider organization varied from 15.5% (Atrius) to 32.7% (Lahey)
- If low value screening is excluded, member rates of receiving low value care ranged from 2.2% (BMC) to 3.7% (Southcoast)

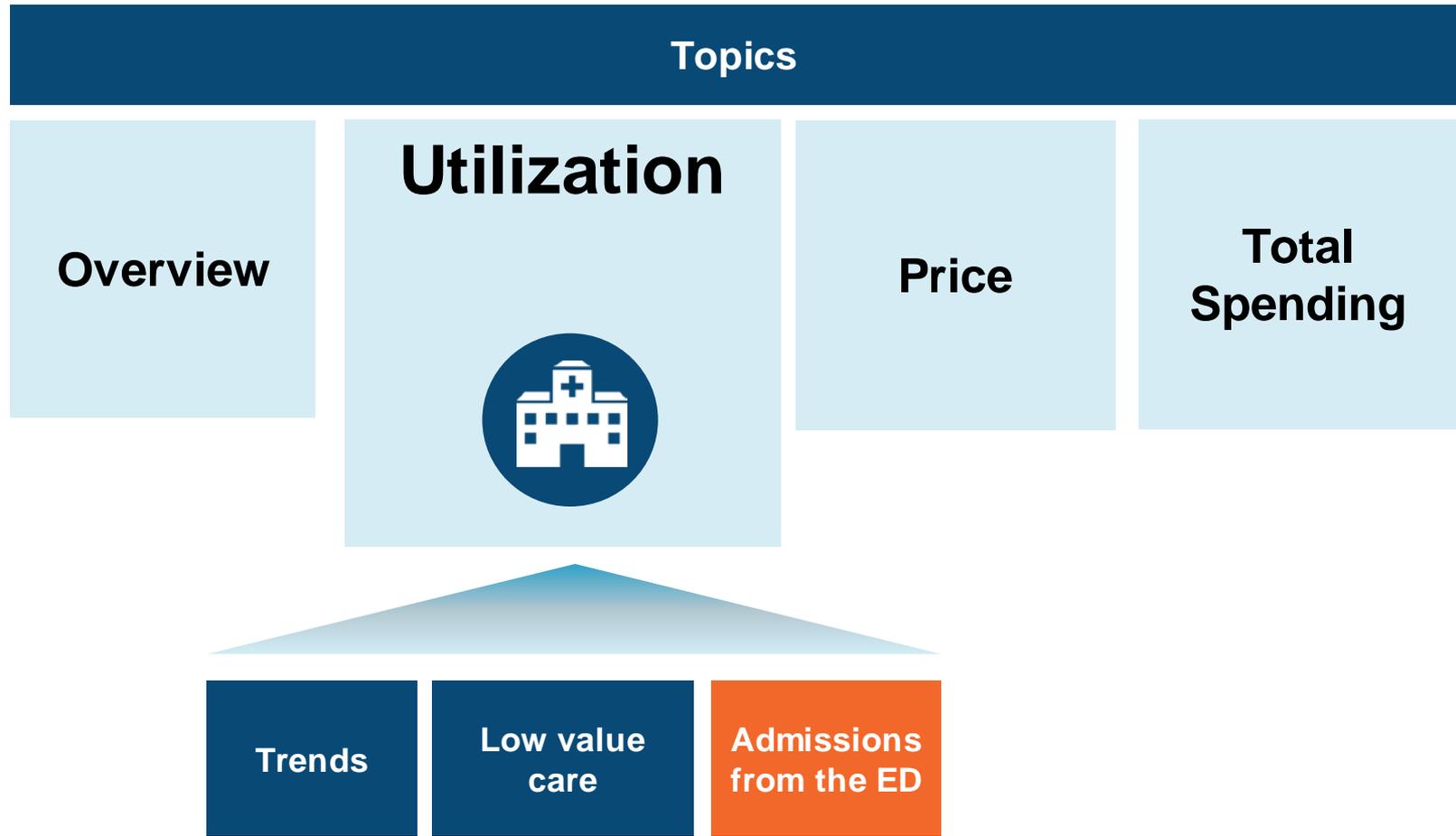
Attributed members with at least one low value care service by provider organization



Notes: Analysis uses HPC provider attribution methodology to assign patients to a provider organization. A total of 1.6 million members were attributed to 1 of the 14 top provider organizations. See CTR 2017 for more information on this methodology.

Sources: Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2013-2015

Select Findings from the 2018 Cost Trends Report



Hospital Admissions from the Emergency Department (ED): Background

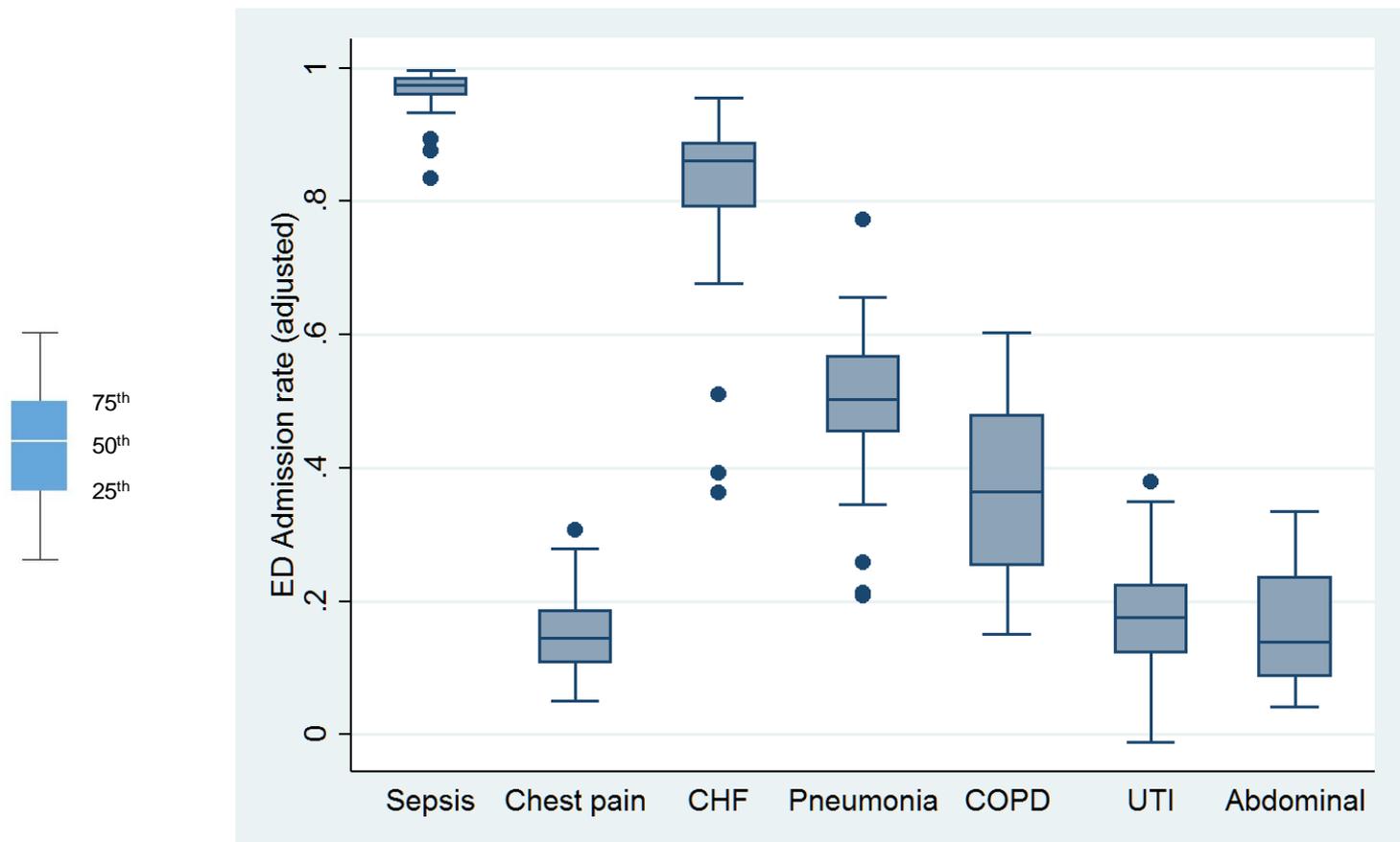
- ED visits are the main gateway to an inpatient admission, where the decision to admit a patient is made by an ED's attending physicians and other personnel and can be influenced by social and administrative as well as clinical factors. Nationally, ~50% of inpatient stays originate in the ED.
- Research shows that there is significant variation by hospital and by condition in admission rates. 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.

Whether hospitals admit ED patients for inpatient stays varies widely by medical condition

Distribution of ED admission rates by hospital for selected conditions, 2016



Percentage point (p.p.) difference between 75th and 25th percentile (Interquartile range)

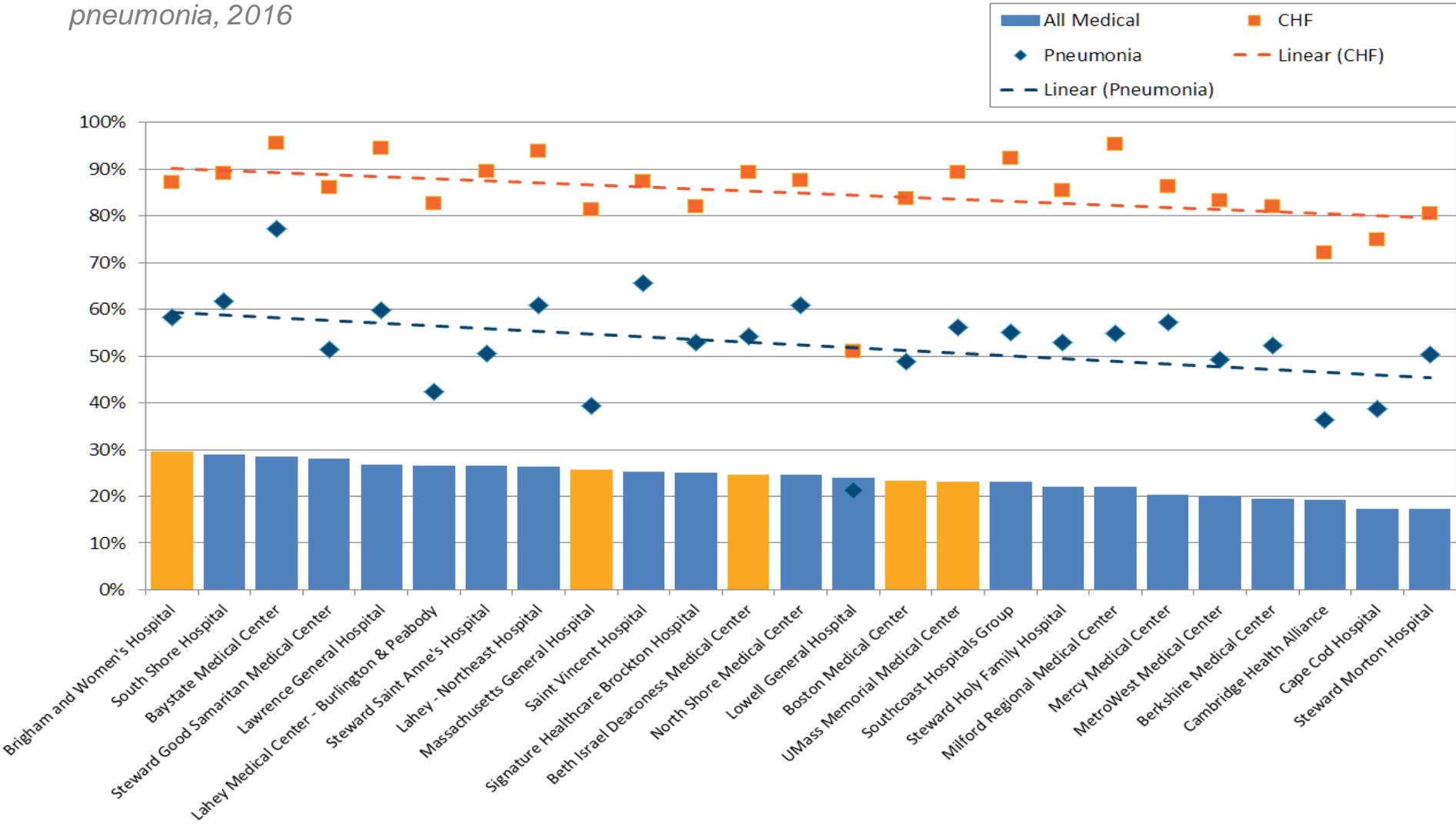
2 p.p. **8 p.p.** **9 p.p.** **11 p.p.** **21 p.p.** **9 p.p.** **15 p.p.**



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. Admission rates include transfers to other hospitals and observation stays greater than 48 hours. Sources: HPC analysis of Center for Health Information and Analysis discharge data (HIDD, EDD, OOD, 2016)

Some hospitals systematically admit a higher proportion of patients from the ED

ED admission rates for the top 25 hospitals by ED volume: all medical conditions, CHF, and pneumonia, 2016



Notes: Hospitals are ordered by patient-adjusted ED admission rates. Admission rates include transfers to other hospitals and observation stays greater than 48 hours. Rates are adjusted for age, gender, race, payer, income, and drive time to nearest ED and for "All Medical" for patient mix of conditions (CCS) at each hospital. Trendlines shown are based on OLS.

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

Hospital Admissions from the ED: 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 hospital varied considerably - from **12% to 30%**
- 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 Chronic Obstructive Pulmonary Disease (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**
- Hospitals with low admission rates **did not** tend to have more frequent revisit rates among those patients

Select Findings from the 2018 Cost Trends Report

Topics

Overview

Utilization

Price



Total Spending

Oncology drug prices

Commercial compared to Medicare

Oncology Drug Prices: Background

Oncology Drug Costs

- Oncology drugs represent the highest drug expenditure by therapeutic class in both Massachusetts and the U.S.
 - \$700 million in Massachusetts in 2014, up 12% from 2013
- Spending is expected to increase as hundreds of late phase oncology therapies are currently in the global pipeline

Injection Chemotherapy Drug Pricing

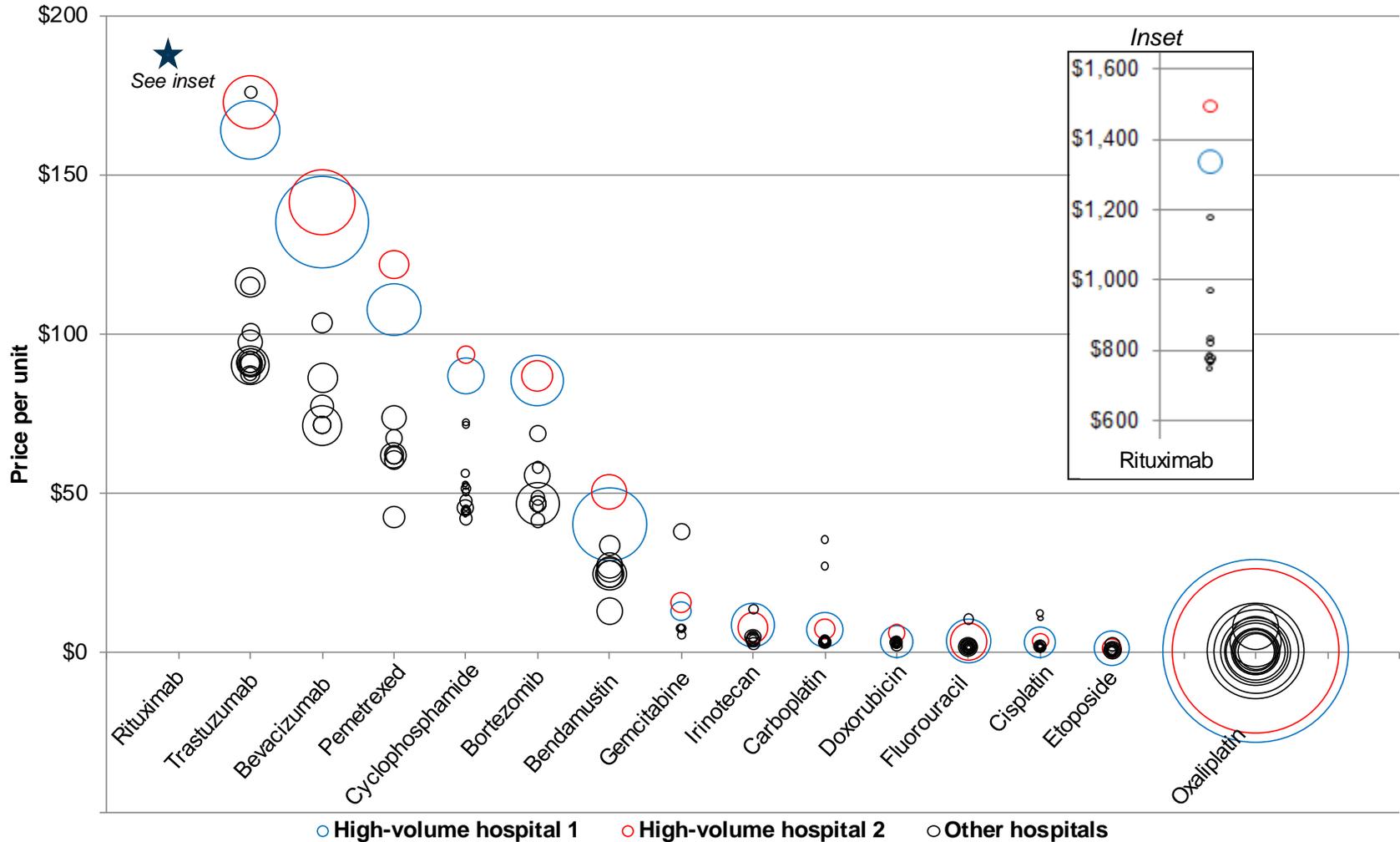
- Chemotherapy drugs are typically administered by injection and thus, are typically covered under a patient's medical benefit, rather than the pharmacy benefit
- The provider purchases a stock of the drug from the manufacturer or wholesaler and administers the drug to the patient in a hospital or physician office. The payer reimburses the provider for both the acquisition and administration of the drug.
 - Prices are negotiated between the provider and the payer

Oncology Drug Prices: Approach

- The HPC examined variation in prices and utilization of injectable chemotherapy drugs
- The HPC analyzed hospital drug prices and utilization for the highest volume injectable chemotherapy drugs in 2016, defined as drugs for which there were more than 10 claims in at least 10 hospitals in 2016, among two of the state's largest commercial payers, Blue Cross Blue Shield of Massachusetts and Tufts Health Plan
 - Harvard Pilgrim Health Care was excluded due to data anomalies
 - This definition resulted in set of 15 injectable chemotherapy drugs

Prices vary substantially for the most common chemotherapy drugs, with volume concentrated in the highest priced hospitals

Variation by hospital in drug unit prices and volume for commonly used chemotherapy drugs, 2016



Oncology Drug Prices: Key Findings

- For 14 of the 15 drugs examined, the price per unit at the highest-priced hospital was more than **double the price** per unit at the lowest-priced hospital
- Volume was skewed towards the highest priced hospitals
 - 40% of units administered were priced more than 50% above the median price per drug
 - The two hospitals that billed the largest volume of these drugs consistently received the highest prices. For the 15 drugs examined, these two hospitals billed 55% of total units and 54% of total claims
 - On average, these two hospitals had prices per unit that were **71% and 92% higher** than the median drug price, respectively

Select Findings from the 2018 Cost Trends Report

Topics

Overview

Utilization

Price



**Total
Spending**

**Oncology drug
prices**

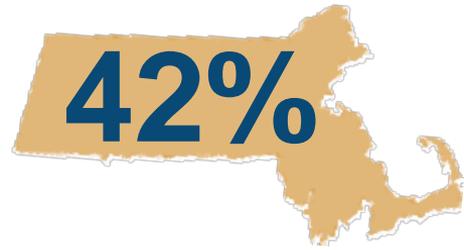
**Commercial
compared to
Medicare**

Commercial Prices: Background and Approach

- **Background:** Medicare prices serve as an important anchor in price comparisons, negotiations and in some cases, out of network prices. Commercial prices relative to Medicare prices facilitate comparisons with the rest of the US. Commercial price **growth** is a key factor in premium growth and meeting the state's benchmark
- **Aim:** Understand differences in commercial prices relative to Medicare prices in the Commonwealth, both at a point in time, and trends over time
- **Approach:** Compare prices for common services in the Massachusetts APCD (2014-2016 data) to Medicare payments for the same services
- **Data:** 2014-2016 APCD data from Blue Cross, Tufts, and Harvard Pilgrim compared to Medicare administered prices. Data were adjusted for outlier payments and outlier claims or those with invalid prices were excluded

By comparing commercial prices to Medicare using the APCD, the HPC aims to quantify the sometimes significant differences in payment for comparable services. By identifying commercial price growth over time, the HPC aims to highlight the impact of price growth on total spending.

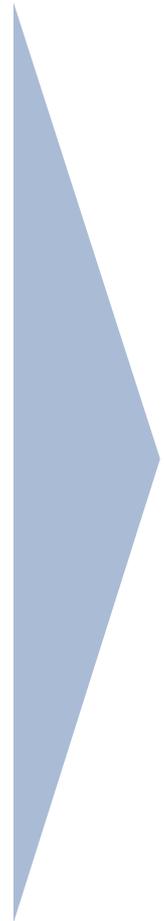
MA has much higher utilization of teaching hospitals, contributing to average Medicare hospital prices that are among the highest in the country



of Medicare discharges in Massachusetts were in major teaching hospitals in 2016



of Medicare discharges in the U.S. were in major teaching hospitals in 2016

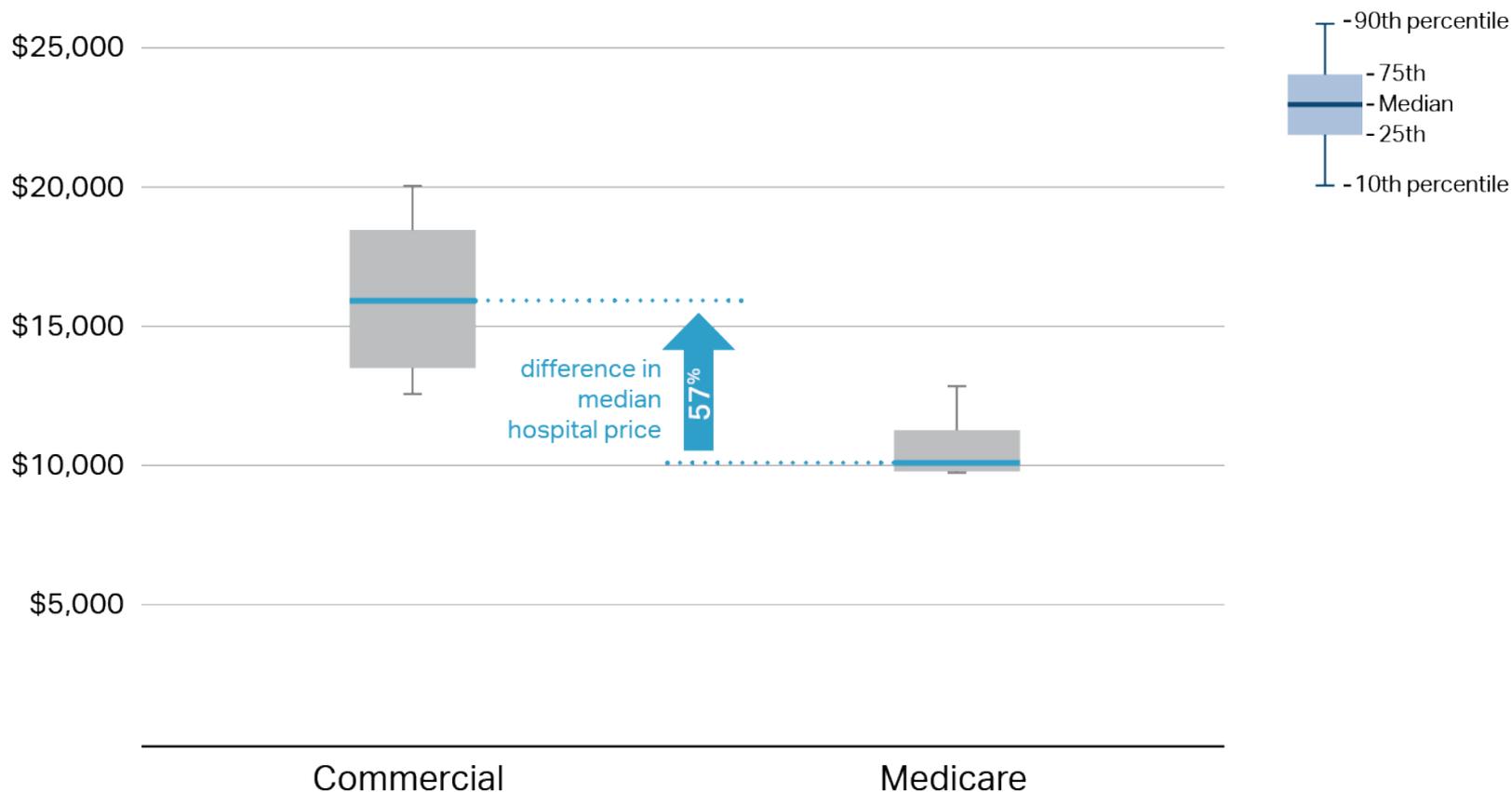


Massachusetts has the **6th** highest average Medicare inpatient prices of all states, **21%** above the U.S. average

Massachusetts has the **4th** highest average Medicare outpatient prices, **12%** above the U.S. average

Inpatient prices: Average commercial prices for inpatient care are substantially higher than Medicare and vary more

Distribution of average hospital facility payments per discharge, commercial and Medicare, 2016

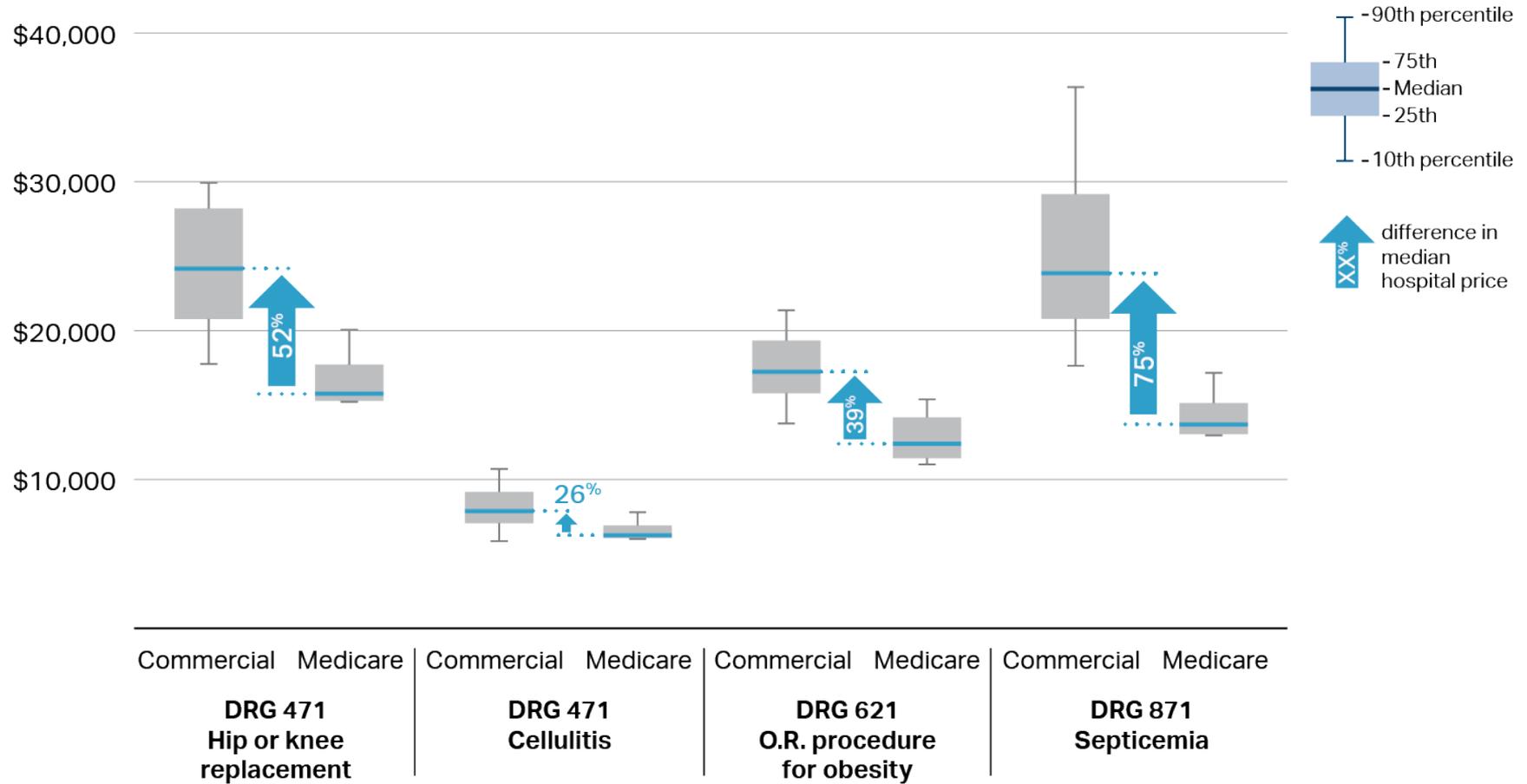


Notes: Analysis includes facility payments only, excluding professional services. Analysis excludes claims with invalid payment codes and excludes outlier claims at each hospital. Excludes some maternity claims for which discharge of mother and newborn cannot be distinguished. Commercial average payment per discharge is adjusted for case weight across hospitals; Medicare averages are calculated according to Medicare payment rules, including DSH and teaching hospital adjustments, and assume the same acuity and patient distribution as commercial discharges. Excludes hospitals not paid under Medicare's Inpatient Prospective Payment System, including Critical Access Hospitals and certain specialty hospitals.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; Medicare Impact File 2016 and FY 2016 Final Rules Tables, Table 1A-1E.

Inpatient services: Variation between commercial and Medicare payments for inpatient care is greater for certain services

Distribution of average hospital facility payments per discharge, commercial and Medicare, select diagnoses, 2016

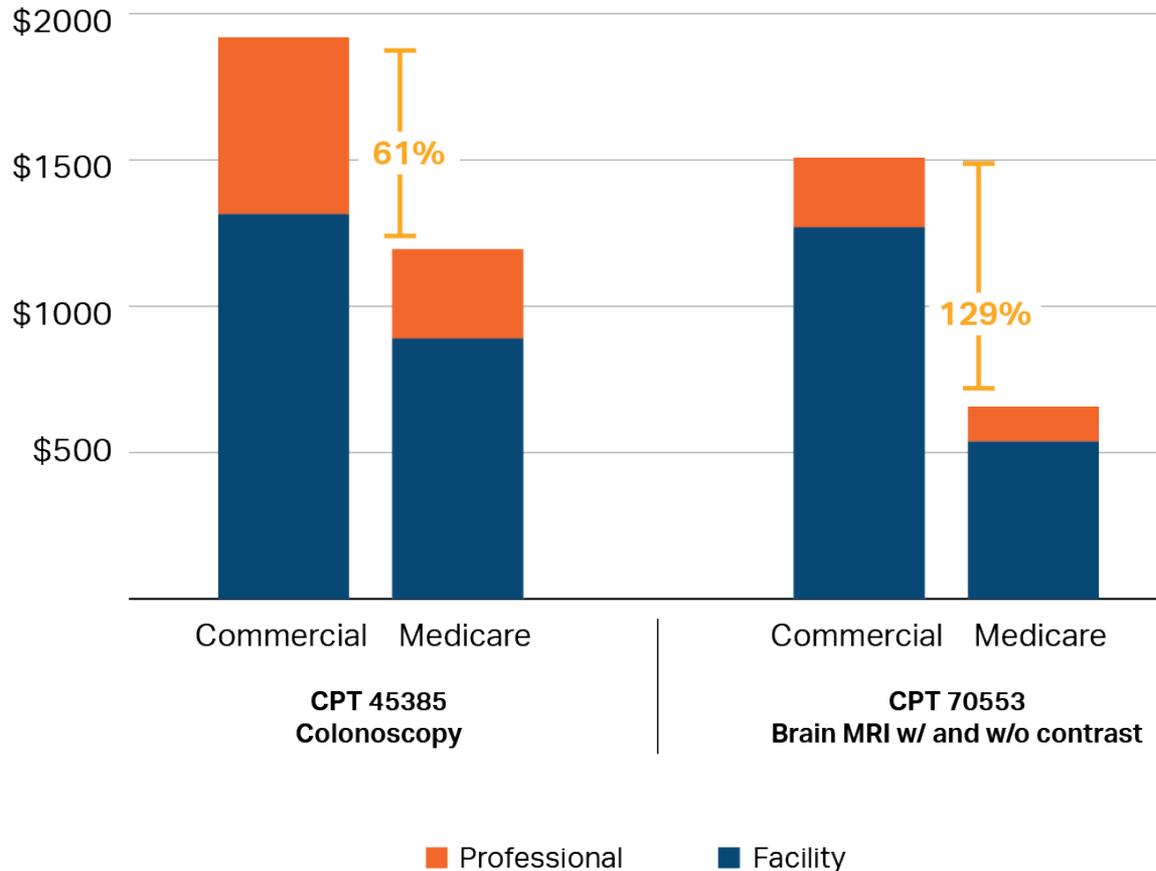


Notes: Analysis includes facility payments only, excluding professional services. Analysis excludes claims with invalid payment codes and excludes outlier claims at each hospital. Commercial average payment per discharge is adjusted for case weight across hospitals; Medicare averages are calculated according to Medicare payment rules, including DSH and teaching hospital adjustments, and assume the same acuity and patient distribution as commercial discharges. Excludes hospitals not paid under Medicare's Inpatient Prospective Payment System, including Critical Access Hospitals and certain specialty hospitals.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; Medicare Impact File 2016 and FY 2016 Final Rules Tables, Table 1A-1E.

Hospital Outpatient: Average commercial prices for comparable outpatient services are substantially higher than Medicare

Average payment per hospital outpatient department visit, commercial and Medicare, for colonoscopy and brain MRI, 2016

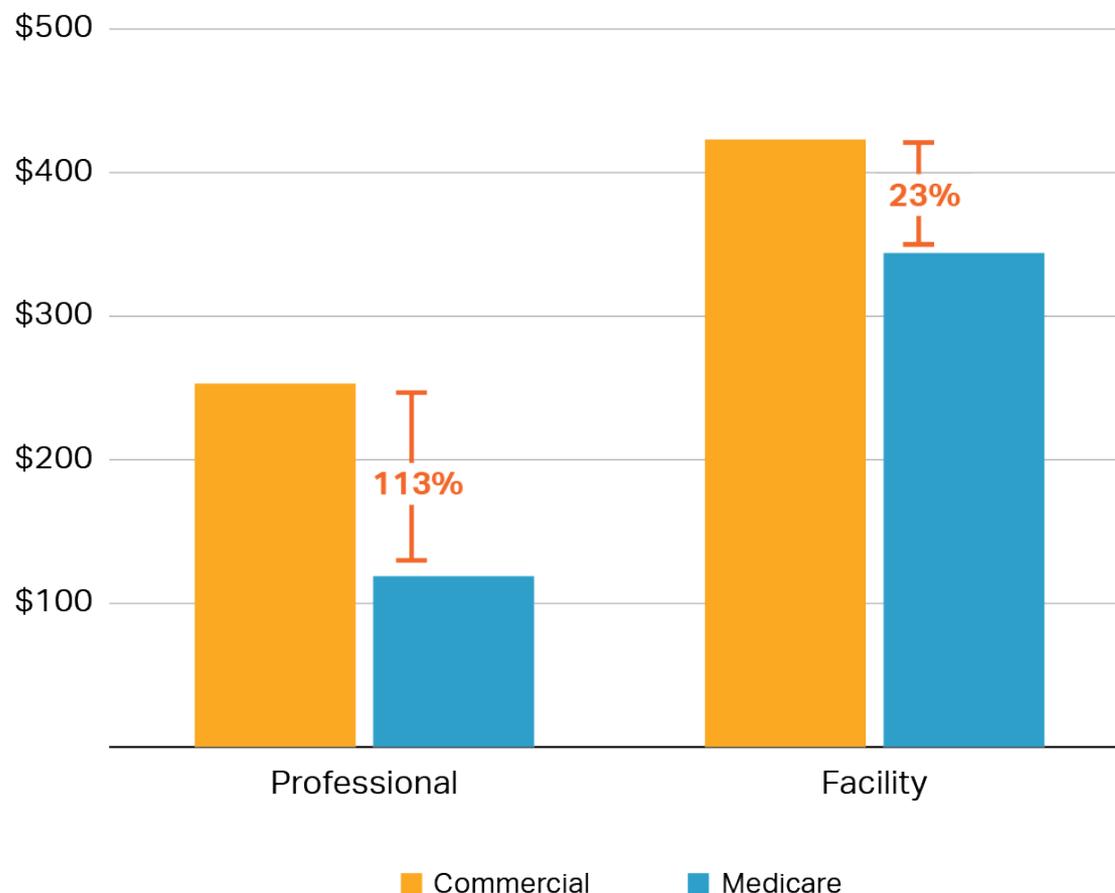


Notes: Commercial averages weighted by hospital volume, and exclude claims with invalid payment codes and outlier claims at each hospital. Medicare professional averages are based on statewide average payments for these services; Medicare facility averages are calculated according to Medicare payment rules, including DSH and teaching hospital adjustments, and assume the same patient distribution as commercial visits. Facility amounts exclude hospitals not paid under Medicare's Outpatient Prospective Payment System, including Critical Access Hospitals and certain specialty hospitals.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; Medicare Impact File 2016; Medicare Outpatient Prospective Payment Addendum B 2016.

Emergency Department: Commercial prices are also higher for ED visits, particularly for the professional portion of the visit

Average payment per hospital emergency department visit (evaluation and management portion only), commercial and Medicare

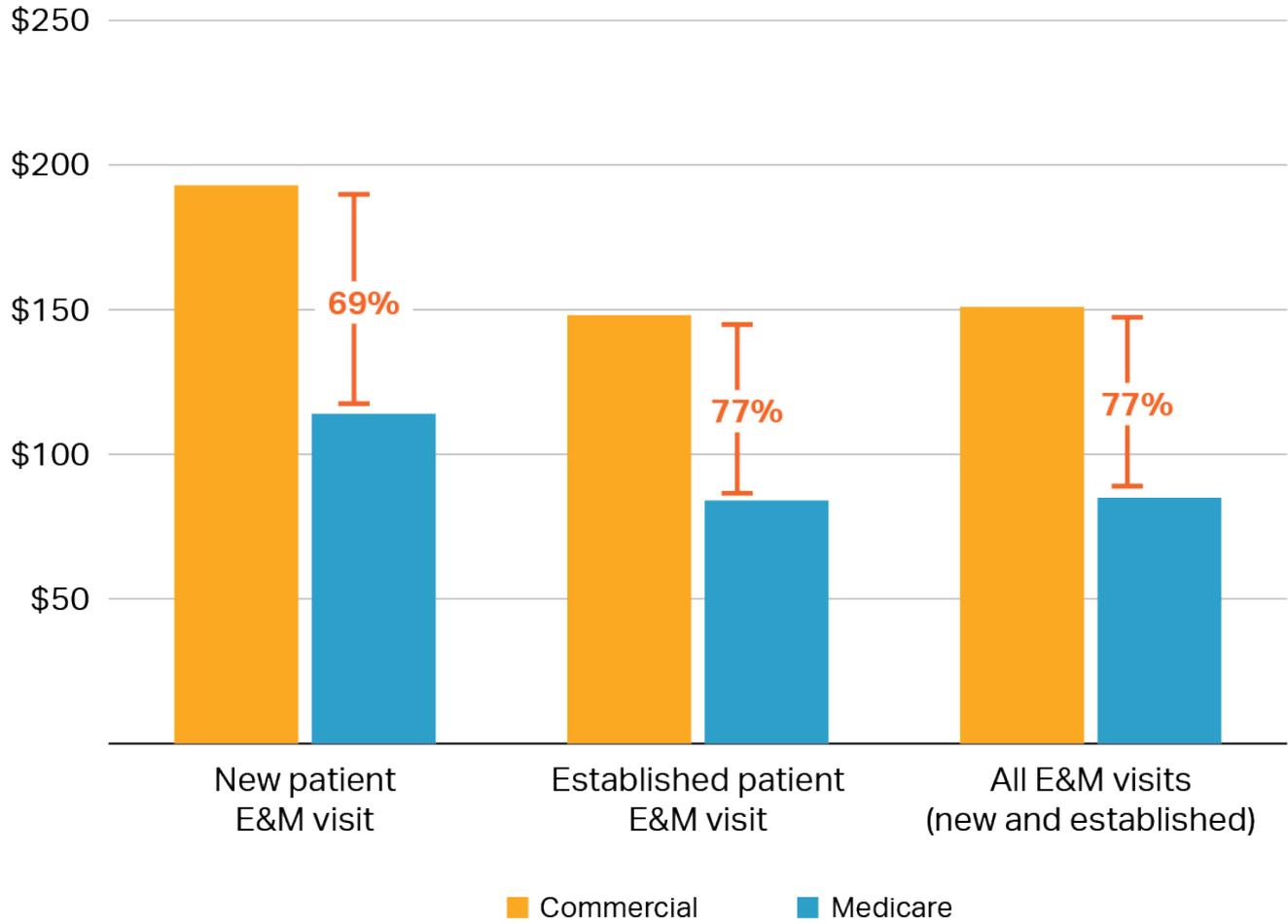


Notes: Commercial professional average includes all commercial claims for E&M codes billed in hospital emergency departments with valid payment amounts; Medicare professional average based on statewide average payments for E&M codes, weighted by volume of commercial codes at each hospital. Commercial facility average excludes claims with invalid payment codes; Medicare facility average calculated according to Medicare payment rules, including DSH and teaching hospital adjustments, and assume the same patient distribution and mix of procedure codes as commercial visits. Facility amounts exclude hospitals not paid under Medicare's Outpatient Prospective Payment System, including Critical Access Hospitals and certain specialty hospitals.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; Medicare Impact File 2016; Medicare Outpatient Prospective Payment Addendum B 2016.

Primary Care: Average commercial prices are also substantially higher than Medicare prices for routine primary care office visits

Average payment per primary care office visit, commercial and Medicare, evaluation and management portion only

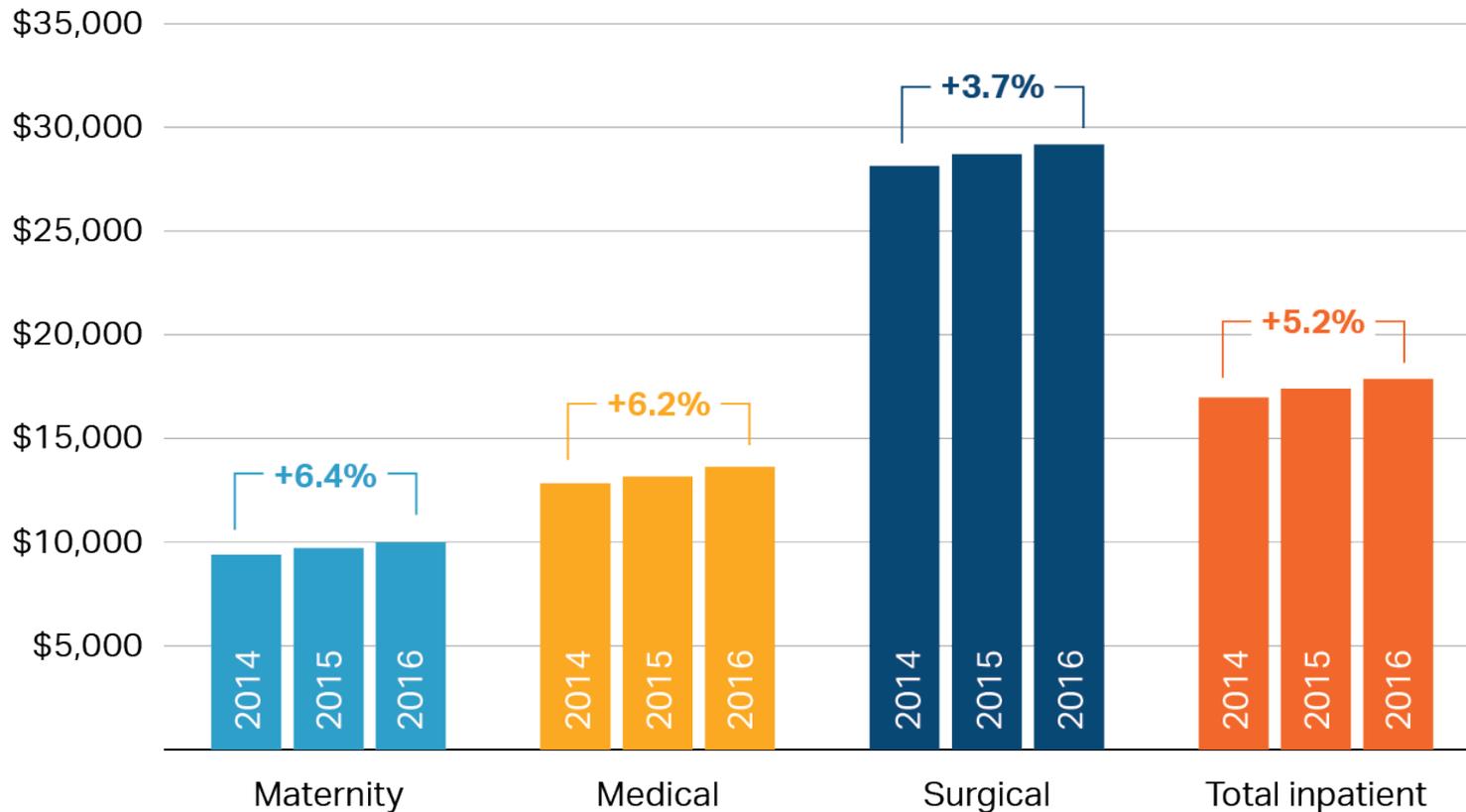


Notes: Analysis includes only claims for adult patients receiving care from primary care providers, and excludes outlier claims. Medicare averages are calculated according to Medicare payment rules, and assume the same patient distribution and mix of procedure codes as commercial visits.
Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; primary care providers identified using HPC Registration of Provider Organizations filings and SK&A provider database; Medicare State HCPCS Aggregate Summary Table CY2016

Commercial prices for inpatient care increased 5.2% from 2014 to 2016, with faster growth for maternity and medical discharges

Growth in average commercial hospital payment per discharge overall and by service category (adjusted for changes in acuity and provider mix), 2014-2016

2014-2016 Medicare inpatient price growth: 3.3%

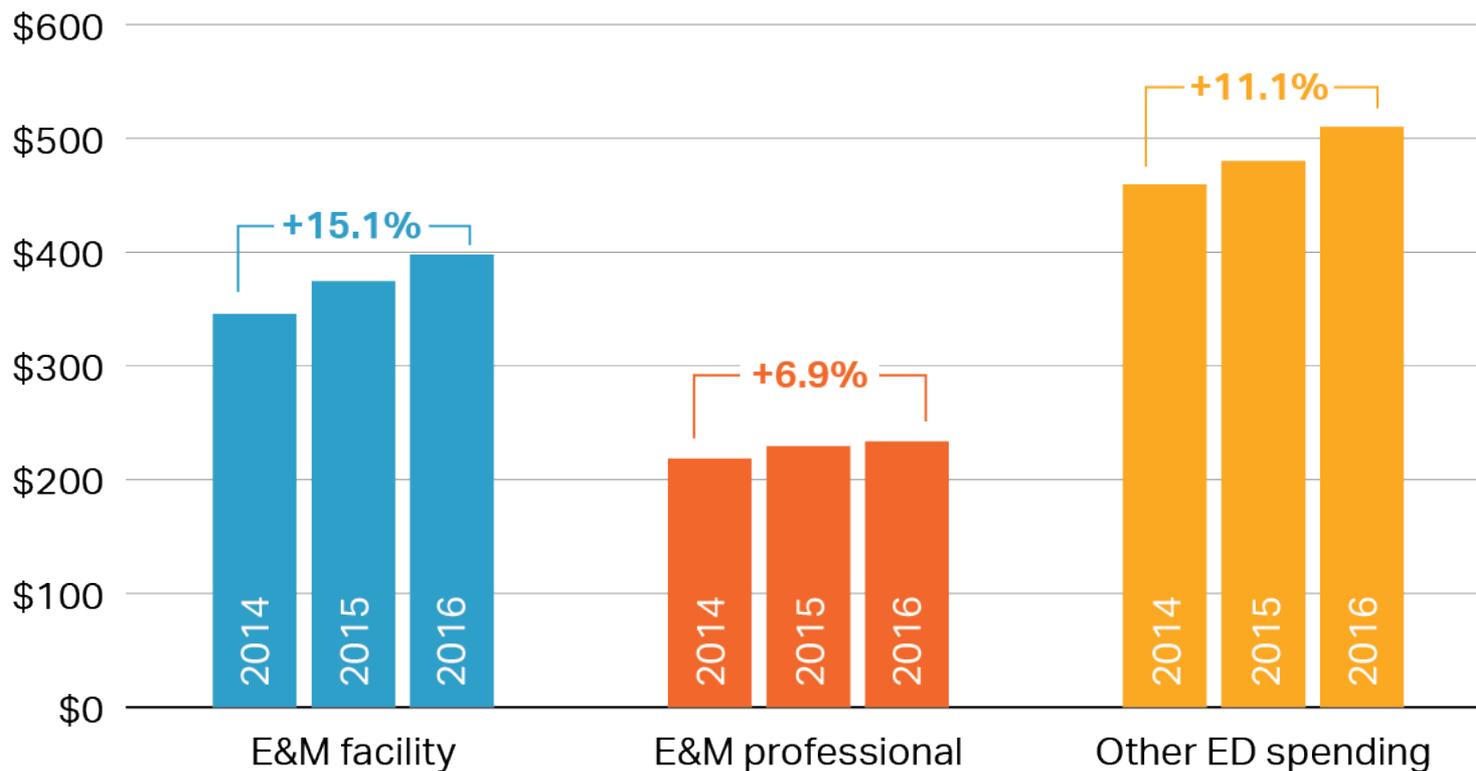


Notes: Analysis includes facility portion of claims only, excluding professional claims and claims with invalid payment codes and outlier claims at each hospital. Excludes some maternity claims for which discharge of mother and newborn cannot be distinguished. Allowed amounts in each service category are adjusted for acuity using Medicare DRG case weights, and adjusted for changes in provider mix over time by holding distribution of hospital volume constant at 2014 levels. Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2016; Medicare FFS trends 2014-2016

Commercial payments for ED visits increased 12% from 2014 to 2016

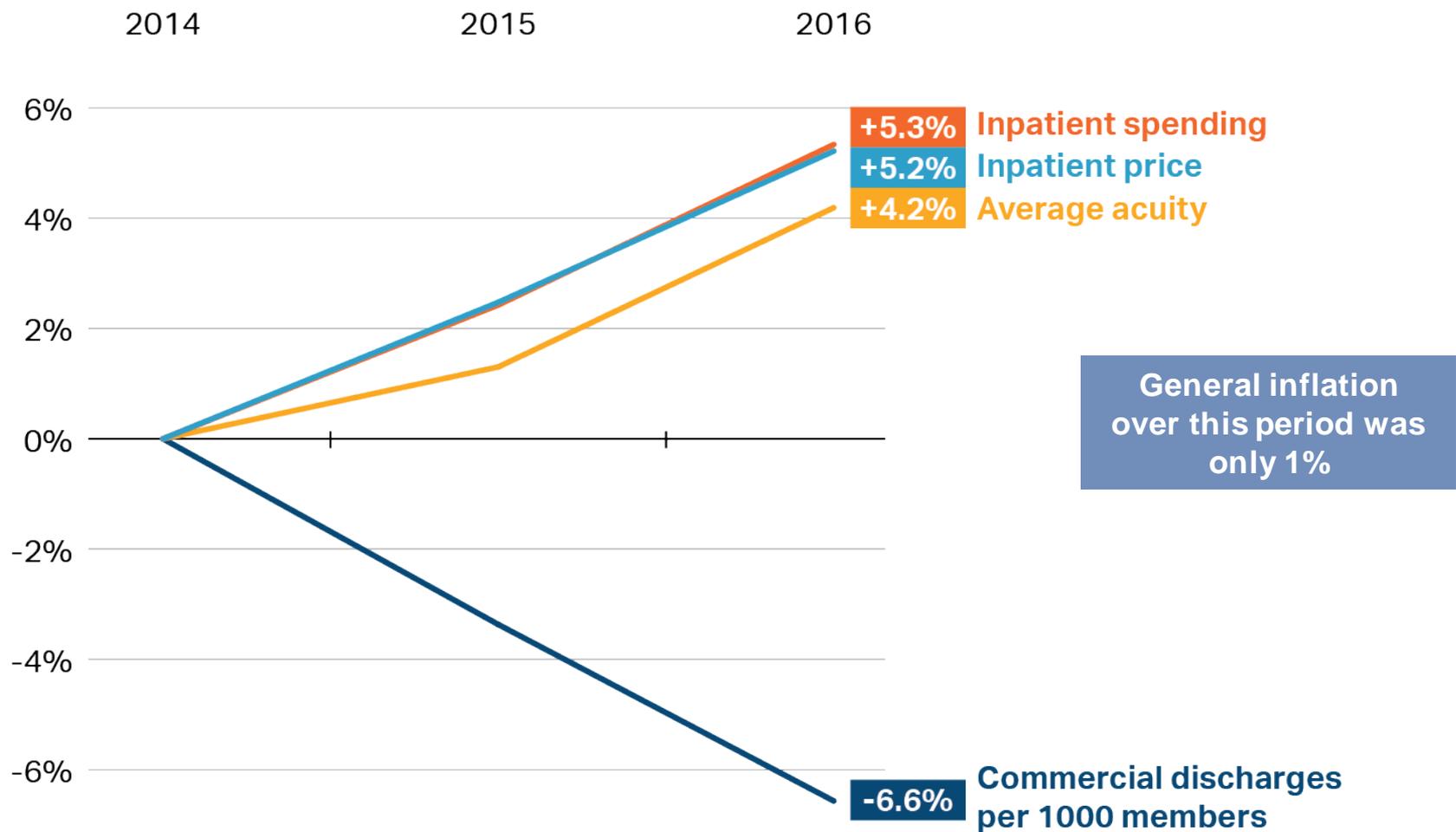
Growth in average payment per commercial emergency department visit, 2014-2016

Average total spending for an ED visit rose 12% from 2014 to 2016 (\$1,024 to \$1,142)



Although commercial inpatient utilization has declined, inpatient spending has continued to increase, driven by increasing prices and average acuity

Change in average commercial inpatient prices, utilization, acuity, and spending, 2014-2016



Notes: Price analysis includes facility portion only, adjusted for changes in acuity and provider mix over time, and excludes claims with invalid payment codes, outlier claims at each hospital, and some maternity claims for which discharge of mother and newborn cannot be distinguished. Commercial TME trend represents facility payments to the three largest commercial payers in MA, acuity trend was calculated for all commercial discharges using Medicare DRG case weights, and discharge trend is per 1000 commercial members for all commercial payers.
 Sources: HPC analysis of All-Payer Claims Database, 2016; CHIA hospital discharge data sets for 2014-2016; CHIA Total Medical Expense files.

Commercial Prices: Key Findings

- In 2016, Massachusetts commercial prices were far above Medicare prices for comparable services across a variety of service lines and settings
 - Commercial price for inpatient care was **57% higher** than Medicare
 - Commercial price for a hip or knee replacement was **52% higher** than Medicare
 - Commercial price for a routine office visit was **77% higher** than Medicare
 - Commercial price for a brain MRI was **129% higher** than Medicare
- Variation in commercial prices across providers is substantially greater than variation in Medicare prices for comparable services
- Between 2014 and 2016, Massachusetts commercial prices for **inpatient care grew 5.2%**. This commercial price growth outpaced:
 - **General inflation (1%)**
 - **Medicare price growth (3.3%)**
- During the same time period, the average payment for an Emergency Department (ED) visit **increased 12%**
- Commercial price increases are a key driver in overall health care spending, preventing the Commonwealth from realizing net savings as a result of declining inpatient utilization

Select Findings from the 2018 Cost Trends Report

Topics

Overview

Utilization

Price

**Total
Spending**

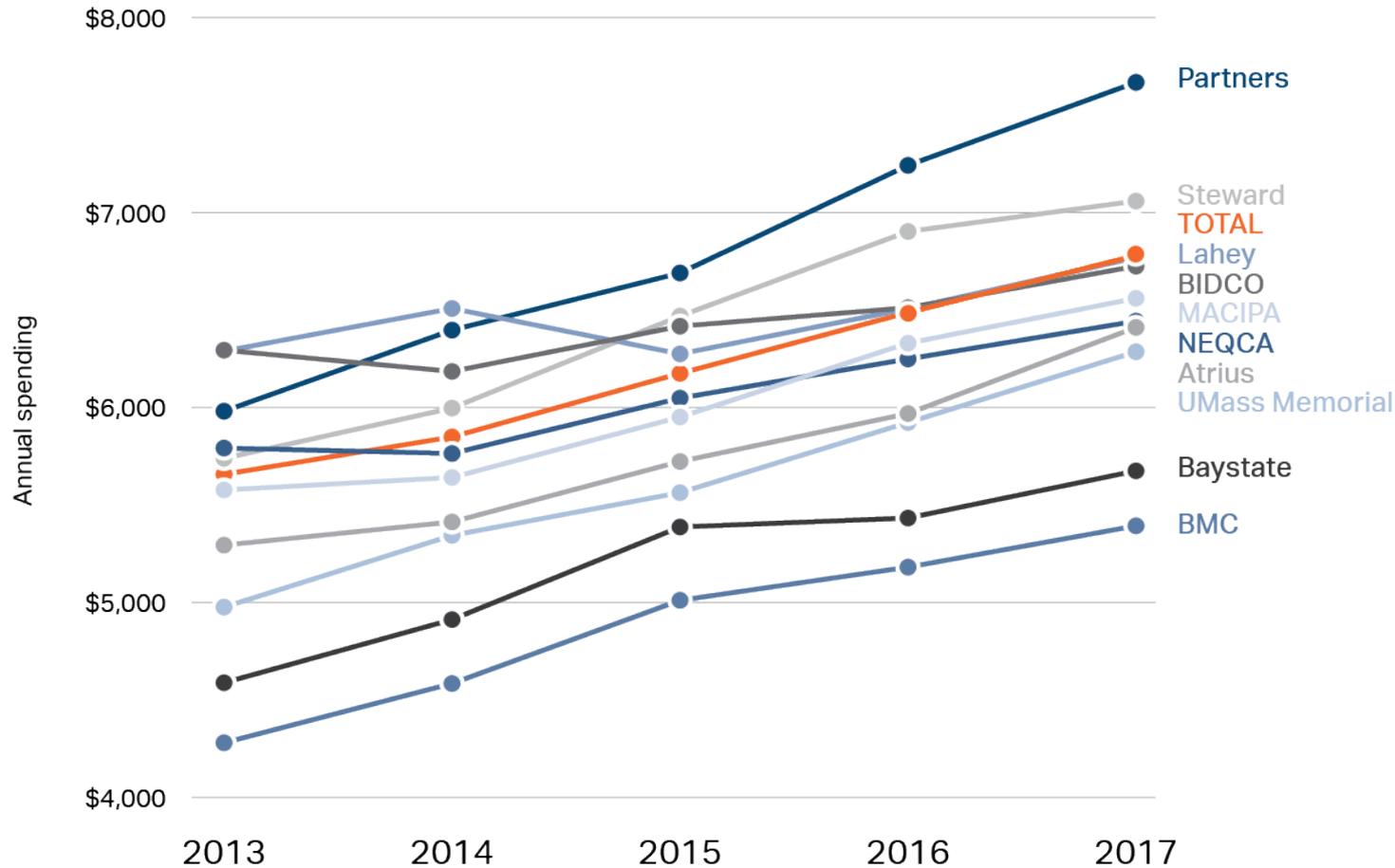


TME by
Provider
Group

Provider
organization
cohort study

Annual per member total medical expenses (TME) varies more than \$2k by attributed primary care provider group, and is diverging over time

Annual total spending per attributed member insured with either BCBS, THP, or HPHC

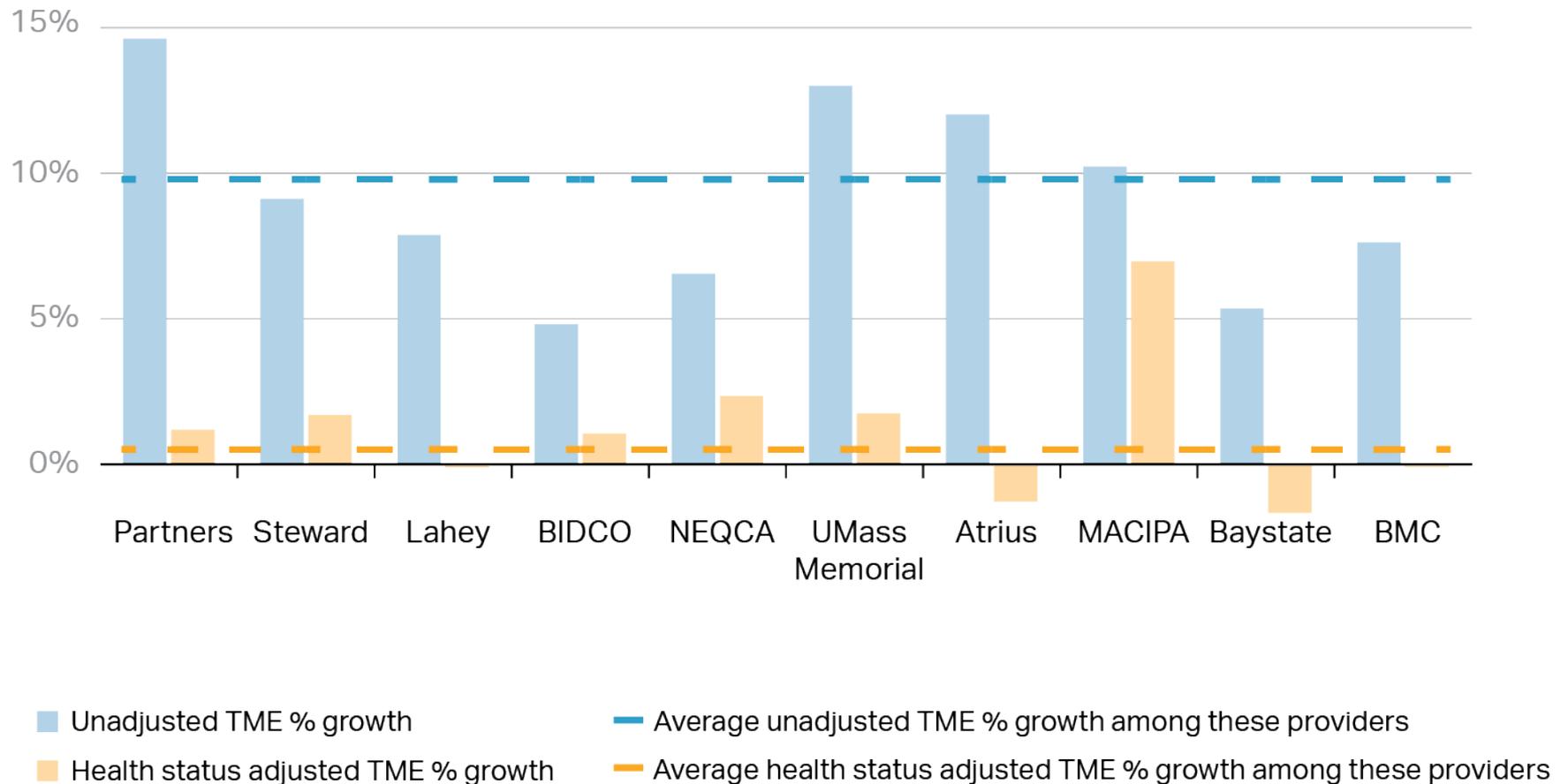


Notes: TME = total medical expenses; PCP = primary care provider. For members insured with either BlueCrossBlueShield of Massachusetts, Tufts Health Plan, or Harvard Pilgrim Health Plan, analysis includes 10 largest PCP groups as identified by the Center for Health Information and Analysis in terms of 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 Independent Physician Association (MACIPA); UMass Memorial Medical Group (UMass Memorial); Boston Medical Center Management Services (BMC); Baystate Health Partners (Baystate).

Sources: HPC analysis of Center for Health Information and Analysis 2016, 2017, and 2018 Annual Report TME Databook

Unadjusted TME grew 10% between 2015 and 2017 yet health-status adjusted TME grew just 0.5%; risk scores grew 9.5%

Total growth in TME from 2015 to 2017 per attributed commercial member with BCBS, THP, or HPHC



Notes: Analysis includes the ten largest PCP groups and three large payers as identified by CHIA in terms of member months and noted on the previous slide. Health-status adjusted TME uses risk scores as reported by the payers for each provider group as described in previous HPC reports.

Sources: HPC analysis of Center for Health Information and Analysis 2018 Annual Report TME Databook

Select Findings from the 2018 Cost Trends Report

Topics

Overview

Utilization

Price

**Total
Spending**



TME by
Provider
Group

Provider
organization
cohort study

Provider Organization Performance Variation (POPV): Background

- In the 2017 Cost Trends Report, the HPC attributed 1.4 million patients in the Massachusetts APCD to provider organizations in order to compare spending and utilization across organizations
- Members with PCPs in AMC-anchored organizations tended to have **higher spending** than those with PCPs in physician-led groups
 - This finding is consistent with a growing body of research finding better performance of ACOs that do not include hospitals¹
 - *Hospital outpatient* spending accounted for most of the variation

Provider Organization Cohort Study: Approach

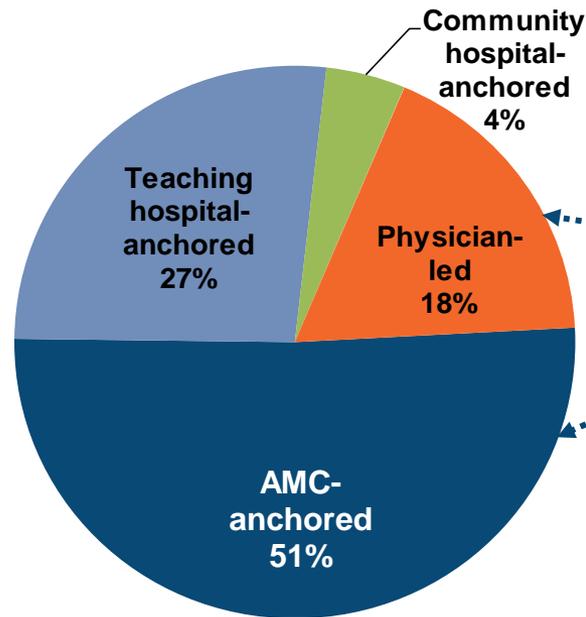
- **Aim:** Develop further understanding of why spending differs

- **Approach:** Identify **clinically similar** groups of patients ('cohorts') to better isolate the impact of provider organizations' practice and pricing patterns
 - Decompose spending difference across organizations into price, site of service, and utilization
 - Compare quality of care among settings

- **Data:** 2015 APCD including commercially-insured members of Blue Cross Blue Shield, Tufts Health Plan, and Harvard Pilgrim Health Care attributed to provider organizations

Approach: Identify clinically similar patient subgroups ('cohorts') and provider organization groupings

Healthy Cohort n = 500,098	Cardiometabolic Cohort n = 158,970	Diabetes Cohort n = 10,403
Members have no major chronic diseases, and risk score < 2	Members have only cardiovascular disease, hypertension, and/or diabetes	Members have diabetes and no other major chronic diseases



Compare patients attributed to **physician-led** and **AMC-anchored** groups, which are distinguished by major differences in structure

Notes: Cohorts based on Johns Hopkins DRG grouper and are not mutually exclusive with the exception of the Healthy Cohort which has none of the 12 chronic conditions identified in HPC's APCD Analytic Files, and has been further restricted to individuals with ACG risk scores <2.0. The Diabetes Cohort and cardiometabolic cohorts are restricted to individuals with risk scores less than 5.0 to remove potential high cost outliers.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2015

Constructing clinically similar cohorts with more comparable patients between provider groups nonetheless shows significant spending differences

Cohort study

Characteristics of patients attributed to physician-led groups and AMC-led groups

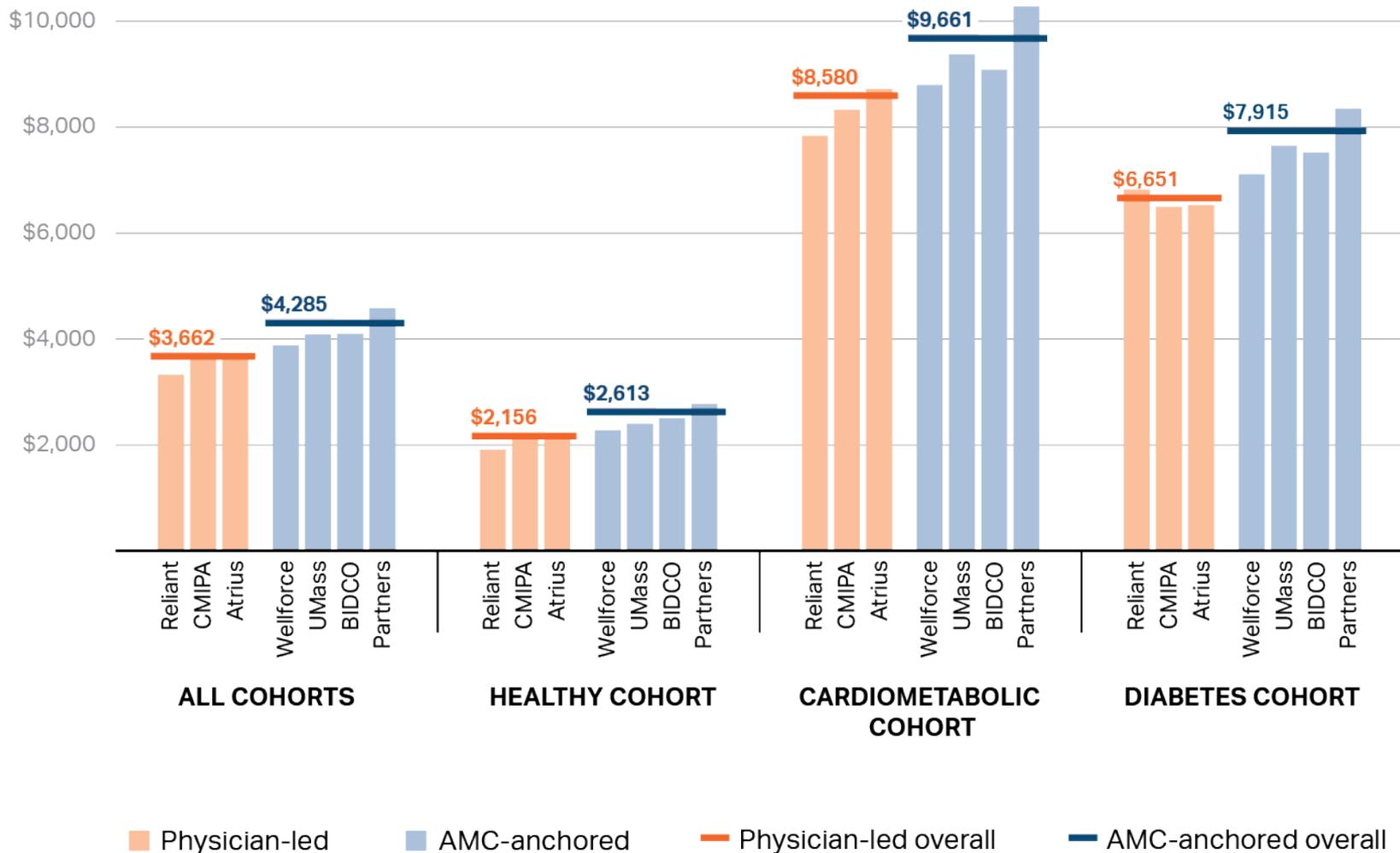
	Members (N)	Risk Score	Average Age	% Female	% HMO/POS	Total Spend	% Difference in Spending
Overall							
AMC-anchored	488,662	0.90	44.1	51.1%	65.8%	\$4,398	23.3%
Physician-led	170,406	0.85	42.7	52.5%	70.6%	\$3,566	
Healthy Cohort							
AMC-anchored	368,104	0.59	41.4	52.0%	67.1%	\$2,659	25.6%
Physician-led	131,994	0.57	40.1	53.4%	71.6%	\$2,118	
Cardio Metabolic Cohort							
AMC-anchored	120,558	1.81	52.2	48.5%	61.7%	\$9,706	13.7%
Physician-led	38,412	1.80	51.8	49.2%	67.3%	\$8,540	
Diabetes Cohort							
AMC-anchored	7,633	1.35	51.7	41.6%	62.5%	\$7,926	19.3%
Physician-led	2,770	1.35	51.2	42.3%	66.6%	\$6,642	

Notes: HMO is health maintenance organization. POS is point of service plan. AMC-anchored includes BIDCO, Partners, UMass, Wellforce; Physician-led includes Atrius, CMIPA, and Reliant. BMC was not included in the AMC category due to data abnormalities and its role as a high-public-payer hospital. Individuals included in the study population were able to be attributed to a provider organization, had at least 1 year of continuous enrollment, an ACG risk score <5, and ages 18+. Individuals were excluded from study if sex was undetermined based on the member eligibility file. Percent difference is the percentage by which spending for patients attributed to AMC-anchored groups exceeds that of patients attributed to physician-led groups.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2015

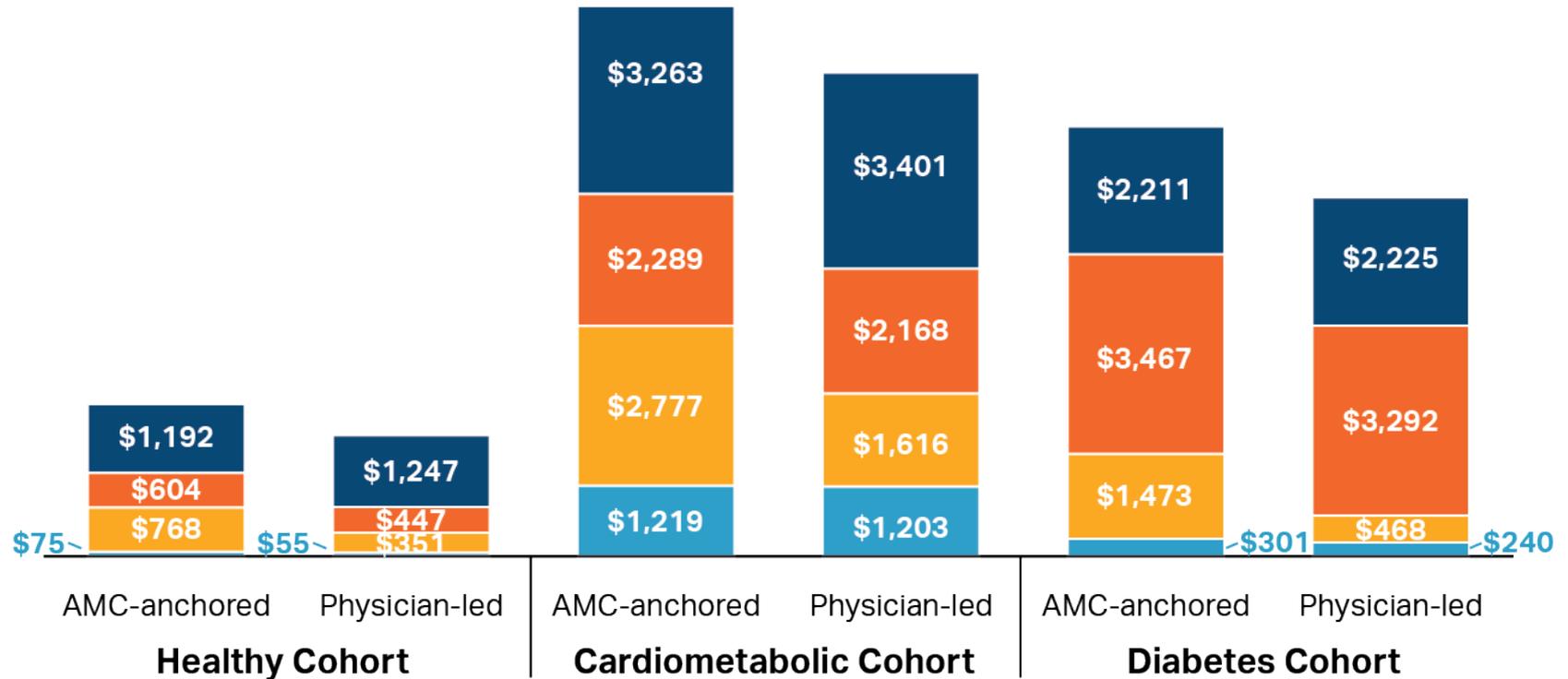
Spending is higher in AMC-anchored provider organizations compared to those in physician-led organizations for all cohorts

Per member per year (PMPY) risk-adjusted overall spending, 2015



Hospital outpatient spending is the largest driver of spending differences

Per member per year (PMPY) spending by category, 2015

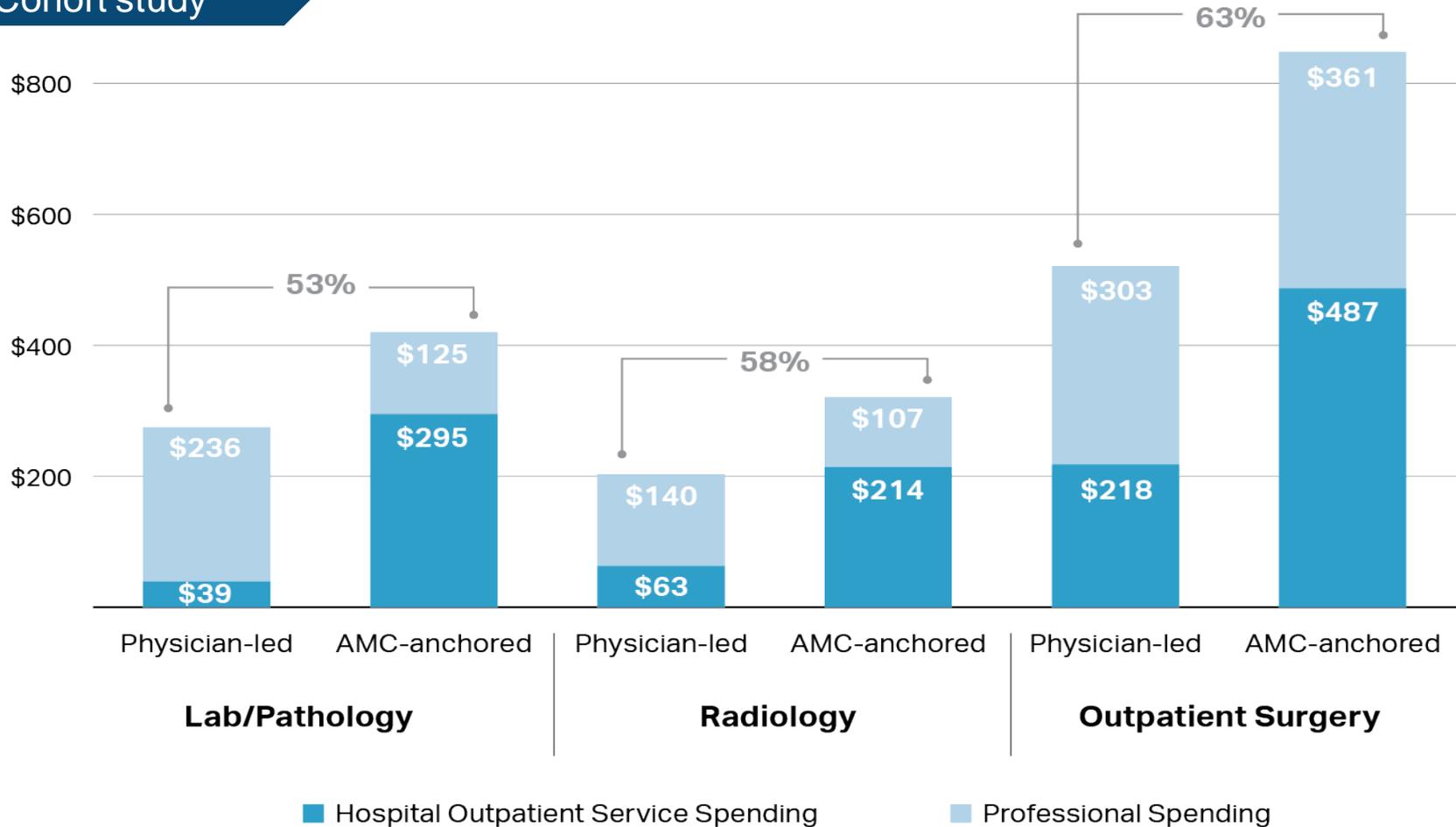


- Inpatient Spending
- Hospital Outpatient Spending
- Prescription Spending
- Professional Spending

Spending is 50-60% higher for patients in AMC-anchored groups for major categories of hospital outpatient spending, even after accounting for differences in professional spending

Diabetes Cohort: Hospital outpatient and professional spending, PMPY, for select services, 2015

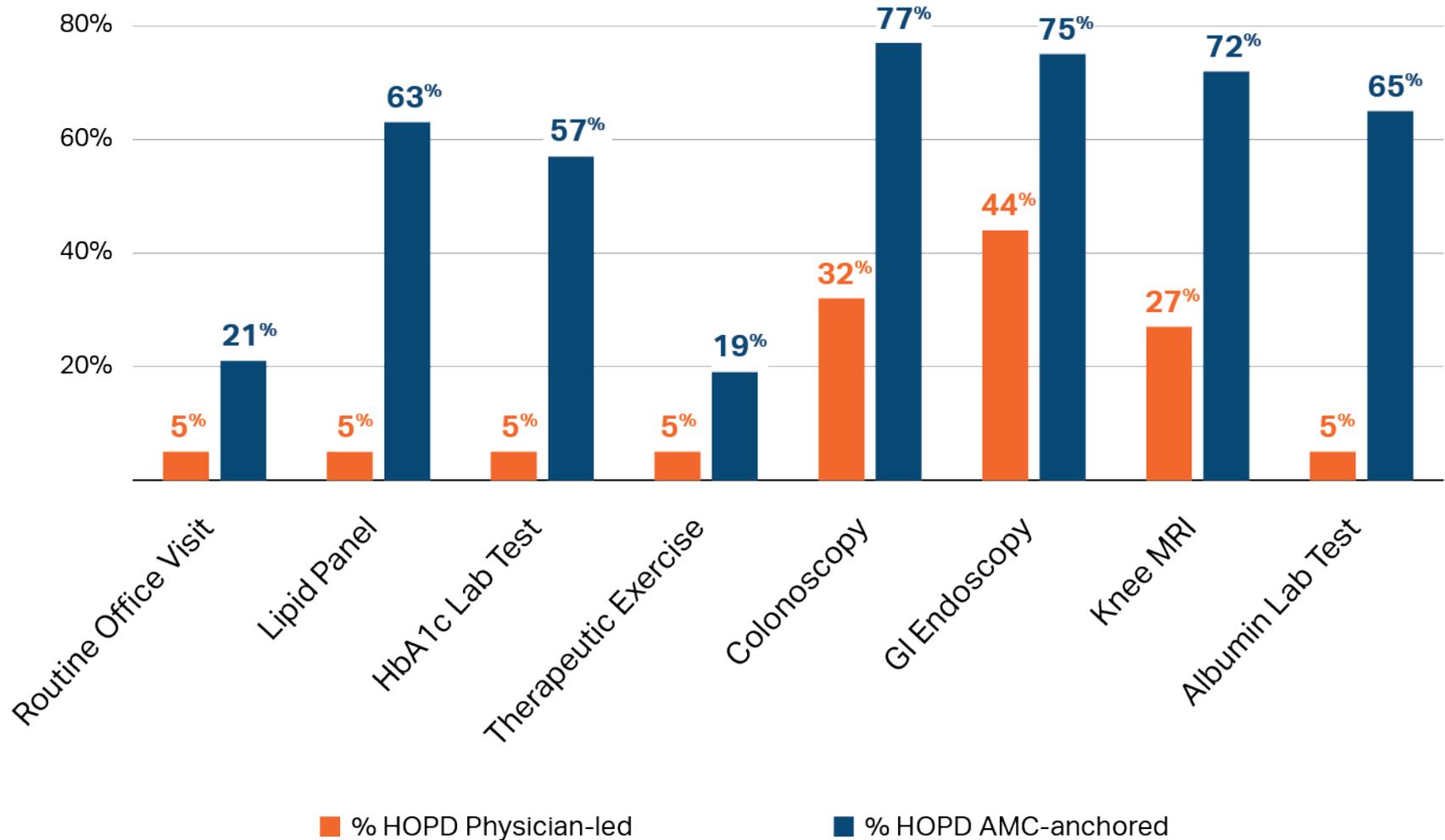
Cohort study



Notes: Analysis uses HCCI categories that had a comparable outpatient and professional categories. Outpatient spending and professional spending designation were based on claim type (outpatient dollars are tied to facility fees only). AMC-anchored: n=7,633 members. Physician-led: n=2,770 members
 Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2015

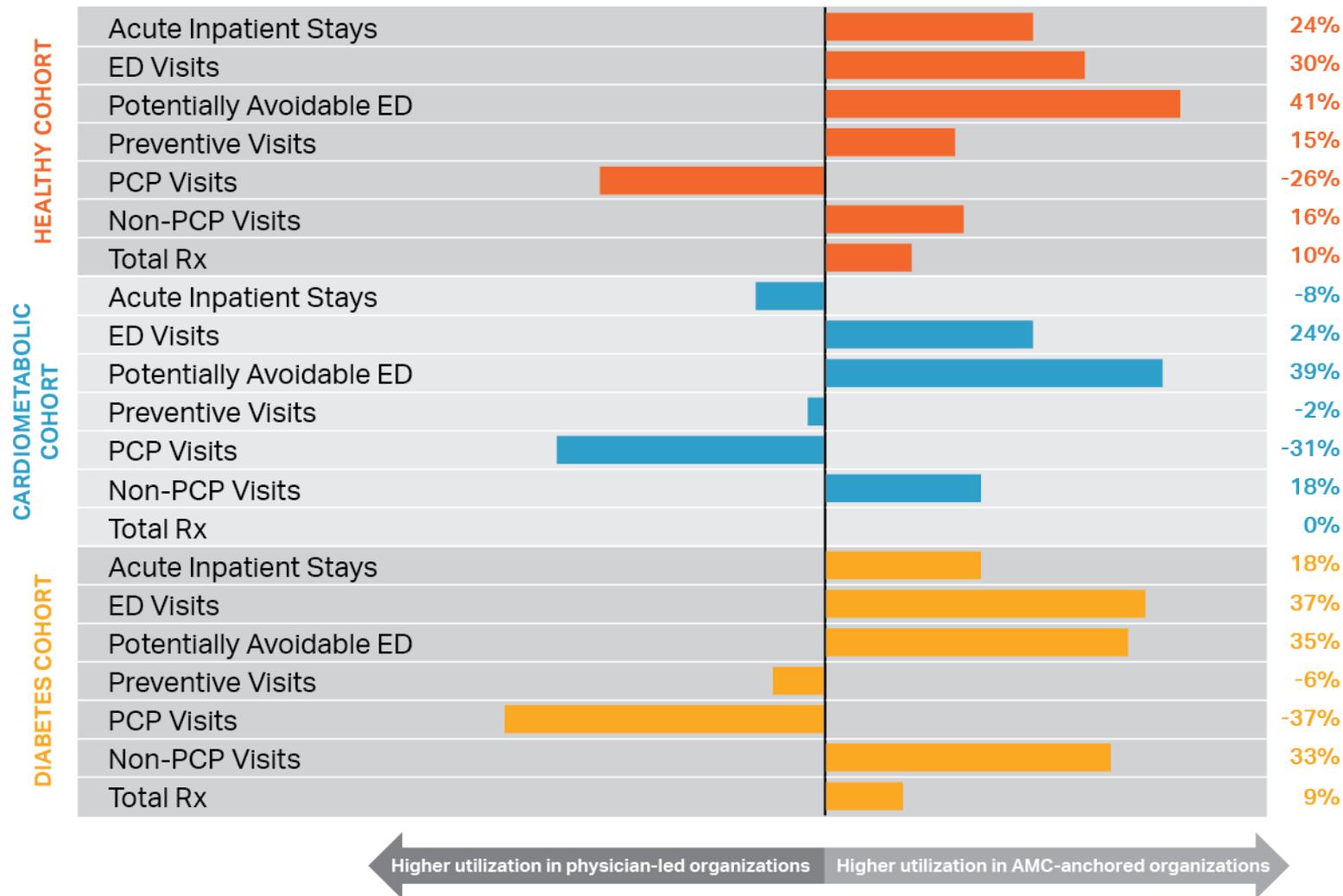
Common ambulatory services are much more likely to be provided in hospital outpatient departments in AMC-anchored groups

Diabetes Cohort: Percentage of services delivered in a hospital outpatient department (HOPD) setting



Utilization is generally higher in AMC-anchored organizations, with the exception of PCP visits and preventive visits

Comparison of AMC-anchored utilization with physician-led utilization by cohort

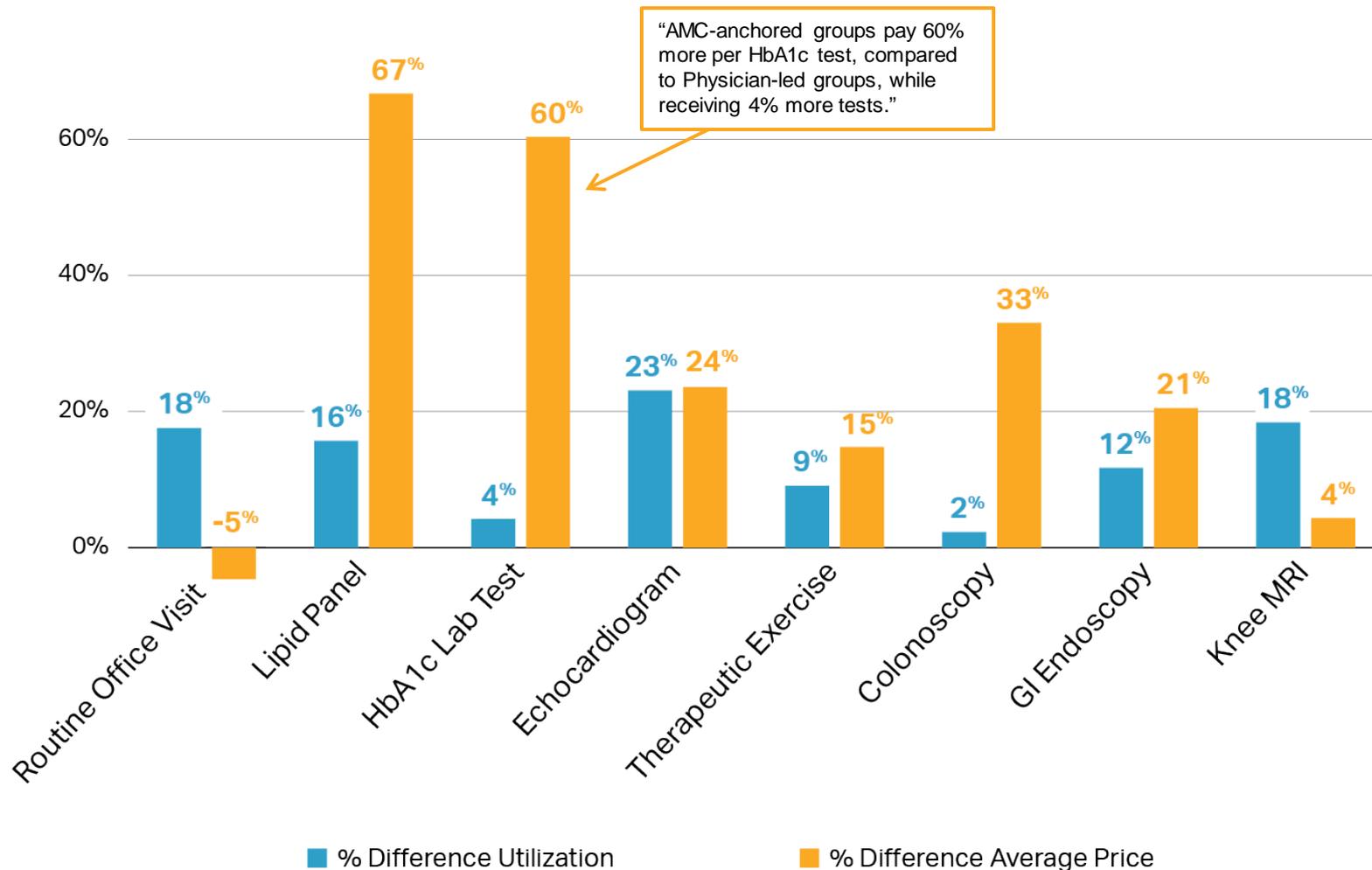


Notes: "Non-PCP visits" are any visits with a physician or other licensed care provider that have not been identified as primary care. This could include physician specialists as well as other providers such as occupational therapists. "PCP Visits" are not mutually exclusive from the "Preventive Visits" category. "Preventive Visits" include s CPT codes 99381-99387, 99391-99397, 99401-99404, 99429, G0402.

Sources: HPC analysis of Massachusetts All-Payer Claims Database, 2015

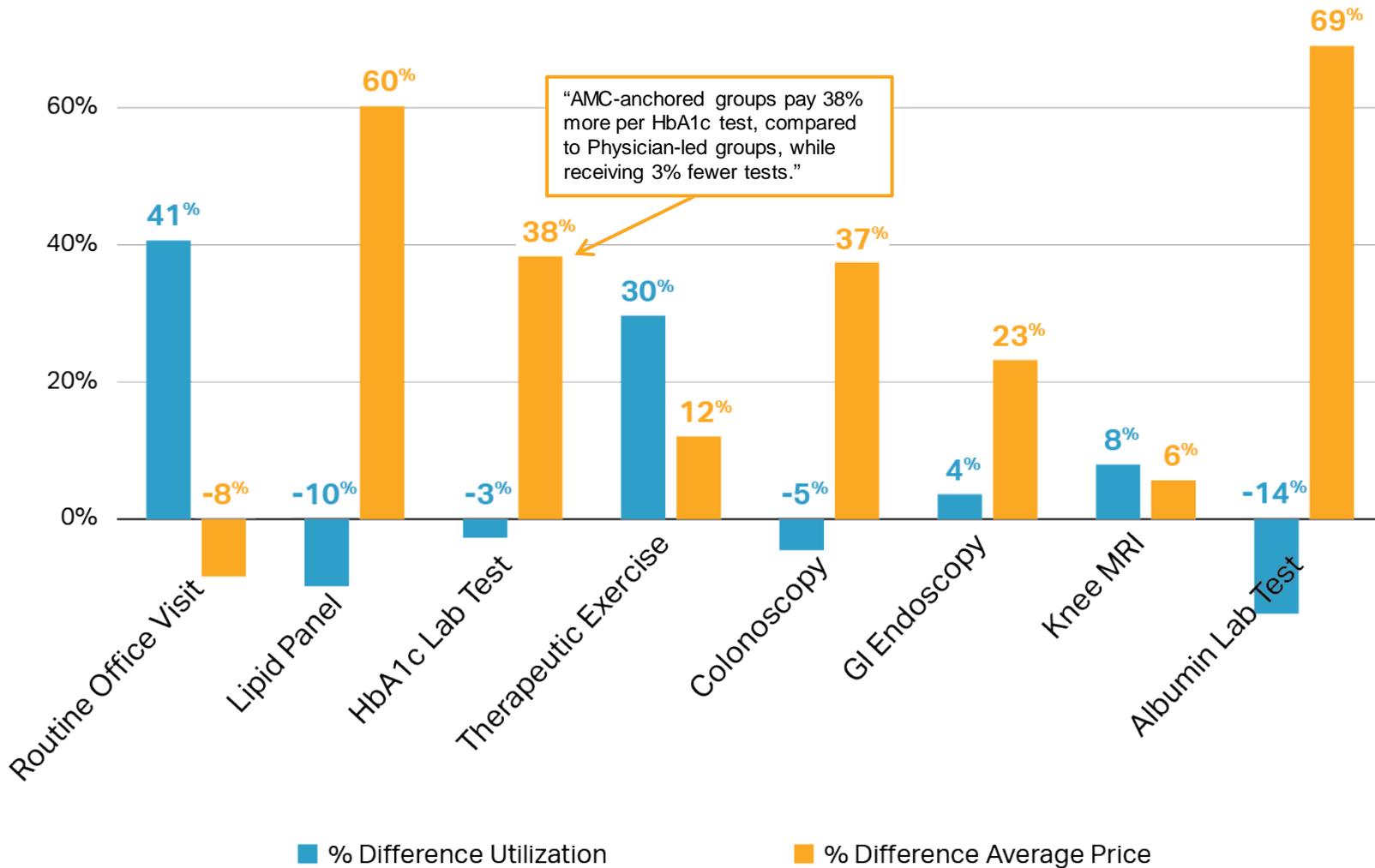
Healthy Cohort: Spending differences by provider group are driven more by price than utilization

Percentage difference in average price and utilization rates of the Healthy Cohort (n=500,098)
 Positive numbers indicate higher rates or prices in the AMC-led group



Diabetes Cohort: Spending differences by provider group are driven more by price than utilization

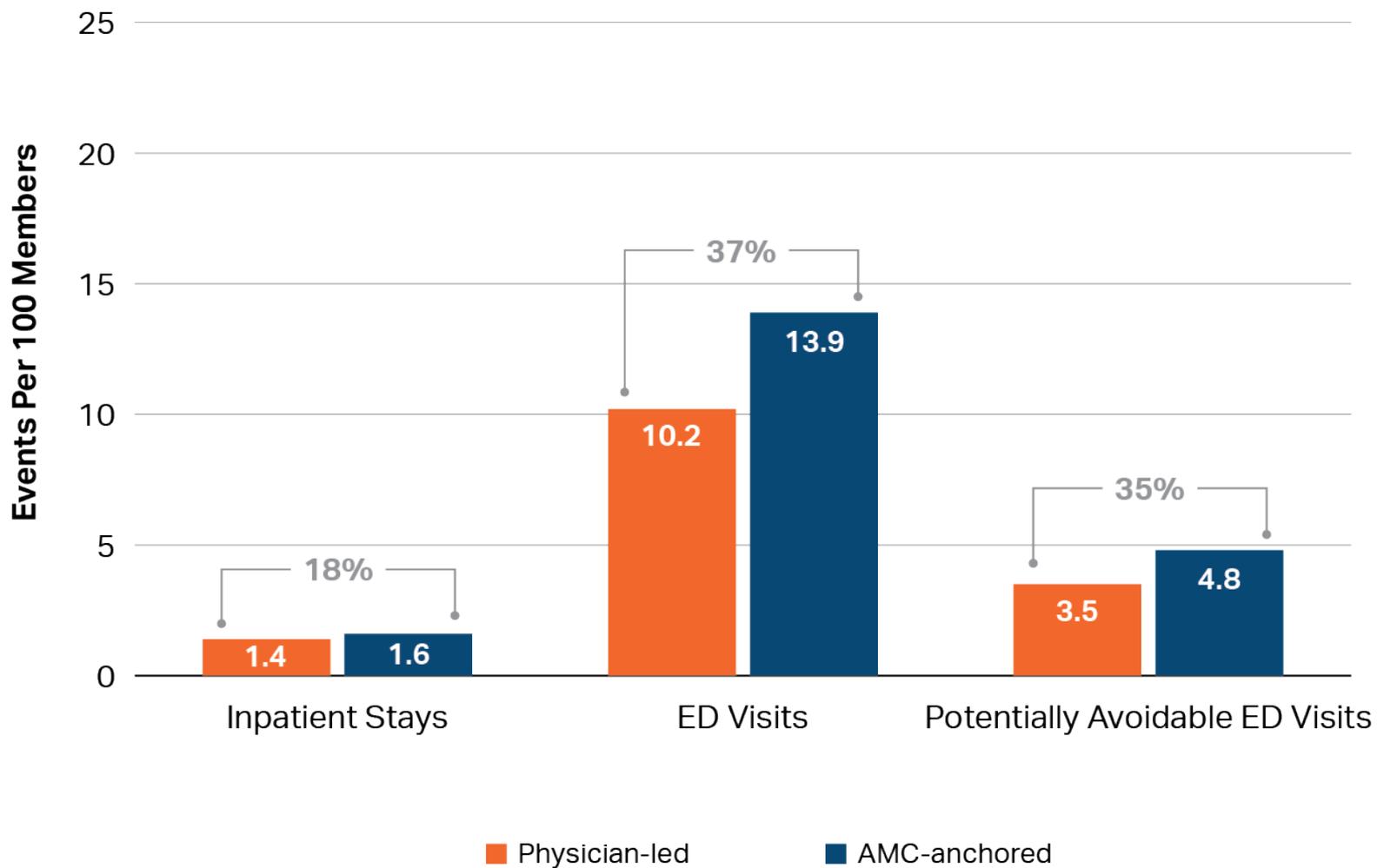
Percentage difference in average price and utilization rates of the Diabetes Cohort (n=10,403). Positive numbers indicate higher rates or prices in the AMC-led group



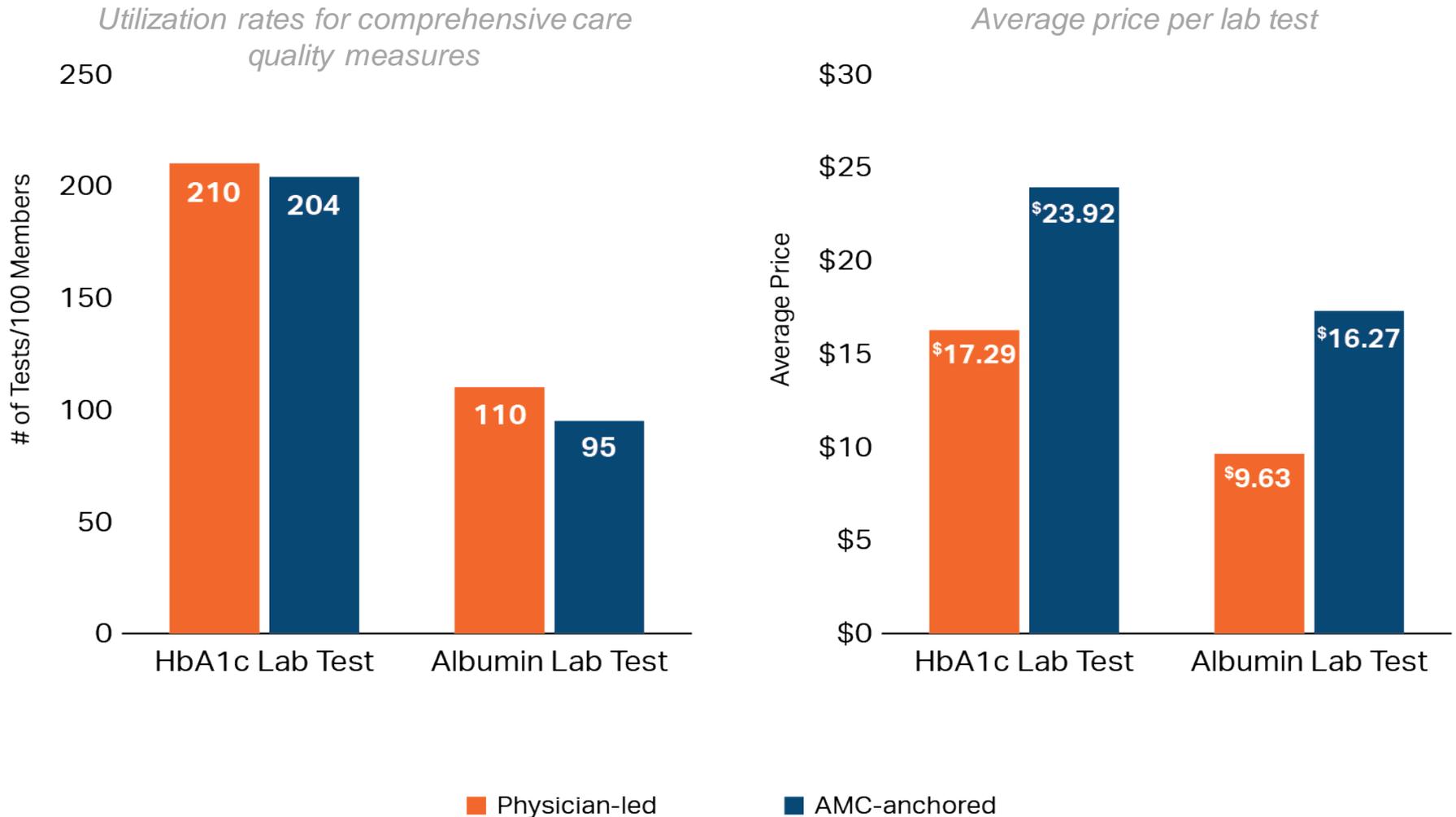
"AMC-anchored groups pay 38% more per HbA1c test, compared to Physician-led groups, while receiving 3% fewer tests."

Diabetes Cohort: Physician-led groups have lower inpatient, overall ED, and potentially avoidable ED use

Events per 100 members in AMC-anchored and physician-led groups, 2015



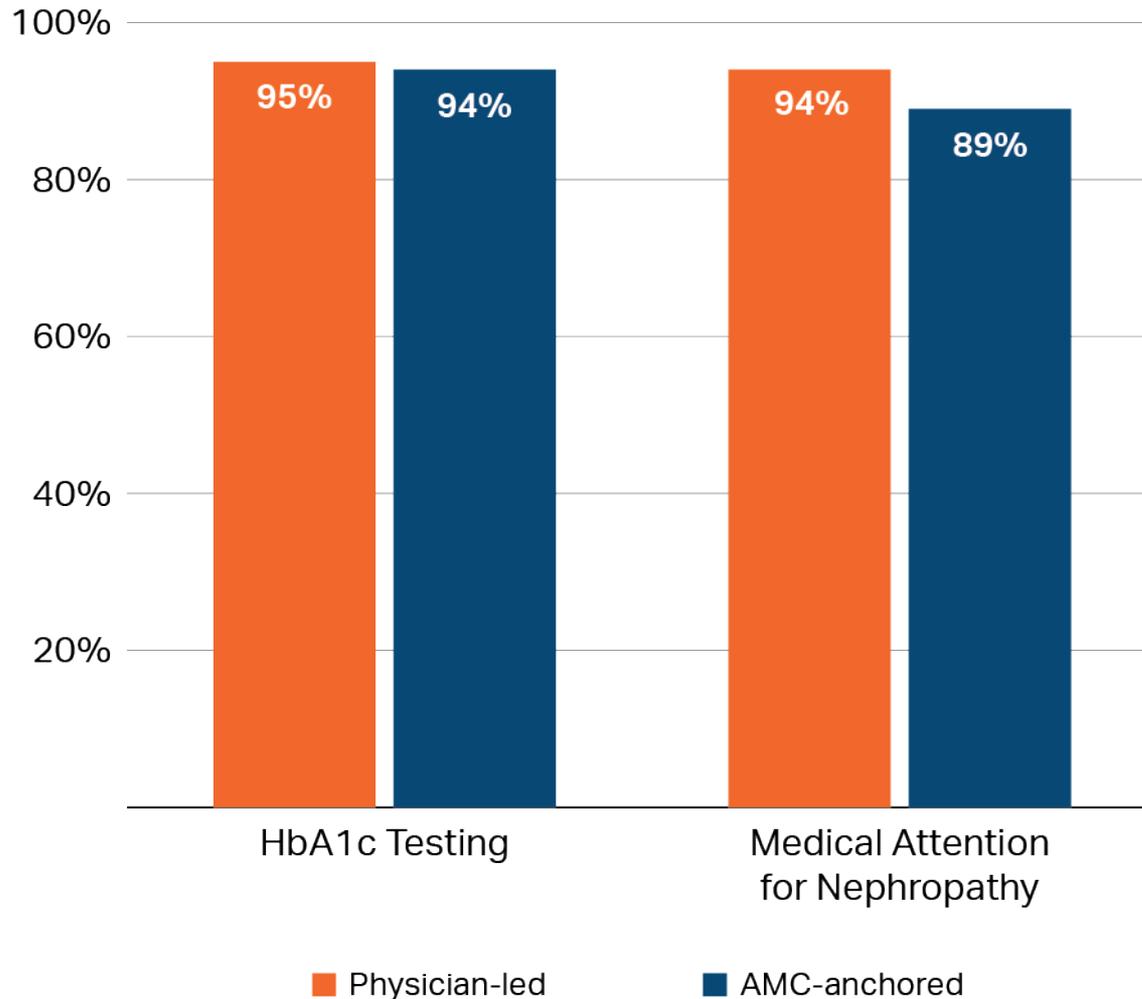
Diabetes Cohort: Patients receive similar rates of recommended monitoring tests, but spending is 38% and 69% more for AMC-anchored groups



Quality guidelines indicate that individuals with diabetes should receive (2) HbA1c tests per year (CPT 83036), and medical attention for nephropathy for at least once per year (CPT 82043): Parceró, A. F., Yaeger, T., & Bienkowski, R. S. (2011). Frequency of Monitoring Hemoglobin A1C and Achieving Diabetes Control. *Journal of Primary Care & Community Health*, 205–208. <https://doi.org/10.1177/2150131911403932>; Handelsman, Yehuda, et al. "American Association of Clinical Endocrinologists and American College of Endocrinology—clinical practice guidelines for developing a diabetes mellitus comprehensive care plan—2015." *Endocrine Practice* 21.s1 (2015): 1-87.

Diabetes Cohort: AMC-led providers do not score better on two measures of quality diabetes care

Diabetes-related quality metrics for AMC-anchored and physician-led organizations, 2014



Provider Organization Cohort Study: Key Findings

- Once we isolated to similar groups of patients, spending was still ~**20% higher** for patients attributed to AMC-anchored organizations vs. those attributed to physician-led organizations
 - **Hospital outpatient spending** continued to be a key driver, with **more than 50%** higher spending for patients in AMC-anchored groups for outpatient surgery, labs and pathology, and radiology
 - **Site of service:** Patients in AMC-anchored groups typically received routine services (such as labs, tests, procedures) in more expensive hospital outpatient departments; patients in physician-led groups received them in physician offices
 - **Price:** Patients in AMC-anchored groups often paid 30-60% more for the same services
 - **Utilization:** Patients in AMC-anchored groups had more ED visits and more office visits to non-PCPs. They had **fewer** visits to PCPs.
 - **Quality and provision of recommended care** was not superior at AMC-anchored groups for diabetes patients

Presentation Topics and potential areas for recommendations

Topics

Overview	Utilization	Price	Total Spending
<ul style="list-style-type: none">Trends in spending, affordability, and care delivery 	<ul style="list-style-type: none">TrendsLow value careAdmissions from the ED 	<ul style="list-style-type: none">Oncology drug pricesCommercial prices compared to Medicare prices 	<ul style="list-style-type: none">TME by provider groupProvider organization cohort study 

Themes from the 2018 Cost Trends Hearing and Policy Recommendations

Key Themes of the 2018 Cost Trends Hearing

1.6%

2017 Total Health Care
Expenditures Growth
Rate per capita

- Variation and complexity in health care payment systems increases **administrative burden** and impedes transparency
- **Health care cost savings are not being passed to consumers** in the form of more affordable insurance products
- **Price is a primary driver** of health care spending
- **Inpatient readmissions** rates remain high
- **Rising pharmaceutical costs** are a driving factor of cost growth
- **Telehealth and interoperable electronic medical records** can increase access to high-quality behavioral health care
- The **future of the health care workforce** is uncertain, but there are efforts to develop new roles and focus on patient-centered care
- There has been limited adoption and alignment of **alternative payment methodologies**
- Spending to address **social determinants of health** will improve upstream intervention and health care quality

Board Discussion on Potential Policy Recommendations for the 2018 Cost Trends Report and 2019 Priorities

Reflecting on the findings presented today from the 2018 Cost Trends Report, discussion at the 2018 Cost Trends Hearing, and other work over the past year, what other topics should the HPC consider for inclusion in this year's policy recommendations and/or prioritize for further examination in 2019?



AGENDA

- Call to Order
- Approval of Minutes from September 27, 2018 Meeting
- Executive Director's Report
- Market Oversight and Transparency
- **Care Delivery Transformation**
 - SHIFT-Care Challenge: Proposed Evaluation Vendor for MAT in the ED Initiatives
- HPC 2019 Public Meeting Calendar



AGENDA

- Call to Order
- Approval of Minutes from September 27, 2018 Meeting
- Executive Director's Report
- Market Oversight and Transparency
- Care Delivery Transformation
 - **SHIFT-Care Challenge: Proposed Evaluation Vendor for MAT in the ED Initiatives**
- HPC 2019 Public Meeting Calendar

Management of the HPC's investment programs and the role of evaluation



Program + Relationship Mgmt

Interface with awardees to manage performance and identify improvement opportunities, serving as trusted advisor and key point of contact

Administration + Operations

Administer investment programs by overseeing investment contracts, tracking and approving deliverables, issuing payments, and managing data

Technical Assistance

Coach or assist an entity or cohort to succeed in a given initiative

Evaluation

Codesigned with the program, understand how an initiative was implemented, whether it succeeded in its aim(s), and whether it is sustainable

Learning + Dissemination

Communicate lessons learned and broaden the adoption of promising practices identified within HPC programs

Evaluation for select SHIFT-Care awards

Nine awards enhancing opioid use disorder (OUD) treatment

- The HPC identified value in conducting a centralized evaluation for the OUD treatment cohort, allowing for the opportunity to make important contributions to the evidence base for OUD treatment.
- Evaluation will address implementation of innovative treatment models at the individual hospital sites and cohort overall, and will assess ED utilization, initiation and engagement in treatment, and patient and provider experience.



Value of a centralized evaluation for the OUD treatment cohort

While these Awards' care models are based on the Yale New Haven Hospital pilot, a few new features create opportunities for important contributions to the evidence base for OUD treatment:

- **Diversity of provider types, geographies, and partnership models** including academic medical centers, community hospitals, community based outpatient providers, primary care, and first responders/municipalities allows for **evaluation relevant to a wide range of settings**.
- While patients in the intervention group of the original pilot were referred to on-site care, SHIFT-Care awardees have **more varied arrangements with partners in the community** for patients to continue to receive OUD treatment.
- The nine sites have tailored specifics of the care model, but will report the same metrics, creating an opportunity to **evaluate sites individually, and as a cohort**.
- The **18-month duration** of the SHIFT-Care awards allows for measurement of treatment engagement over time, testing **how long the benefits of the ED-based model last**.
- All awards will track **patient experience**, a measure that the pilot model did not explore.
- **Patient interviews** will add depth and strengthen validity

Process for selecting an external evaluator

Process

- HPC staff engaged with stakeholders and Subject Matter Experts (SMEs) to design the proposed evaluation for the SHIFT 2b cohort
- HPC issued an RFR on 10/4/2018 and requested bids be submitted by 11/9/2018
- HPC received seven bids for the evaluation
- Staff convened a Procurement Management Team (PMT) to review and score proposals and engaged SMEs to provide additional feedback.
- The PMT scheduled in-person interviews with two vendors

Scoring Criteria

- Overall responsiveness, comprehensiveness, and quality of the proposed approach
- Qualifications of the team
- Demonstrated ability to execute the project
- Value
- Supplier diversity program

Procurement Overview and Timeline

Scope

Finalize design with HPC to conduct a mixed-methods evaluation of nine SHIFT-Care initiatives that promote timely access to behavioral health care by supporting care models that make pharmacologic treatment for opioid use disorder (OUD) and referral to outpatient services available through the emergency department (ED).

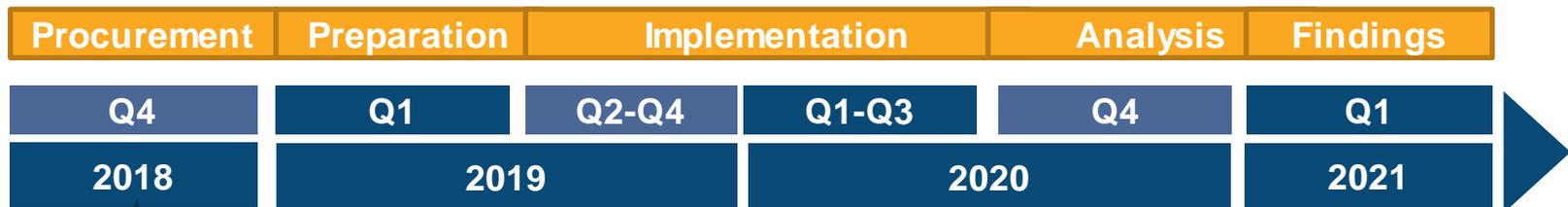
Award Cap

\$600,000

Recommended Evaluator

Brandeis University

Timing



12/13 Board vote

Recommended Evaluator: Brandeis University

Quantitative Approach

Measurement and analysis, by site and cohort, of:

- Initiation of Opioid Use Disorder (OUD) treatment
- Engagement in Opioid Use Disorder (OUD) treatment
- ED visits and 30-day revisits
- All cause mortality
- Lethal and non-lethal overdose
- Patient experience

Qualitative Approach

- Key informant interviews of hospital program staff and MAT partner providers
- Patient interviews

Key Strengths

- Strong quantitative approach to data collection and measurement
- Substantial experience in measurement, especially in measures related to Initiation and Engagement in Substance Use Disorder (SUD) treatment
- Demonstrated expertise in qualitative data gathering and analysis
- Advisory group with strong clinical experience



VOTE: Proposed Evaluation Vendor for SHIFT-Care Challenge MAT in the ED Initiatives

Motion: That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws, the Commission hereby authorizes the Executive Director to enter into a contract with the Brandeis University Schneider Institutes for Health Policy for professional services to conduct an evaluation of nine HPC Sustainable Healthcare Innovations Fostering Transformation (SHIFT-Care) initiatives that make pharmacologic treatment for opioid use disorder (OUD) and referral to outpatient services available through the emergency department (ED), with a contract term of December 17, 2018 through June 30, 2021 and for a total contract amount up to no more than \$600,000, subject to further agreement on terms deemed advisable by the Executive Director.



AGENDA

- Call to Order
- Approval of Minutes from September 27, 2018 Meeting
- Executive Director's Report
- Market Oversight and Transparency
- Care Delivery Transformation
- **HPC 2019 Public Meeting Calendar**

2019 Public Meeting Calendar

Board Meetings^Δ

- Wednesday, February 13
- Wednesday, March 13 – Benchmark Hearing
- Wednesday, May 1 (1:00 PM)
- Wednesday, July 24
- Wednesday, September 11
- Wednesday, December 11

2019 Cost Trends Hearing

Day One: Tuesday, October 22

Day Two: Wednesday, October 23

Committee Meetings[†]

- Wednesday, February 27
- Wednesday, June 5
- Wednesday, October 2
- Wednesday, November 20

^Δ Board meetings begin at 12:00 PM, unless otherwise noted.

[†] Market Oversight and Transparency (MOAT) Committee meets at 9:30 AM and Care Delivery and Transformation (CDT) Committee meets at 11:00 AM, unless otherwise noted.

APPENDIX

Strengthen market functioning and system transparency

1. **Pharmaceutical Spending**

The Commonwealth should take action to reduce increases in drug spending, and payers and providers should consider further opportunities to maximize value.

Specific areas of focus include:

- Price transparency and accountability, including for pharmacy benefit managers (PBMs)
- Maximizing value for the MassHealth program through enhanced negotiating authority
- Adding pharmaceutical and medical device manufacturers as witnesses for the cost trends hearing
- Using value-based benchmarks and contracts
- Using treatment protocols and guidelines
- Enhanced provider education and monitoring of prescribing patterns

2. **Out-of-Network Billing**

The Commonwealth should take action to enhance out-of-network (OON) protections for consumers. Specifically:

- Require advance patient notification
- Consumer billing protections in emergency and “surprise” billing scenarios
- Reasonable and fair reimbursement for OON services

Strengthen market functioning and system transparency

3. Provider Price Variation

The Commonwealth should take action to reduce unwarranted variation in provider prices. Specifically:

- Advance data-driven interventions and policies to address persistent provider price variation in the coming year

4. Facility Fees

The Commonwealth should take action to equalize payments for the same services between hospital outpatient departments and physician offices. Specifically:

- Establish limits on sites that can bill as hospital outpatient departments
- Implement site-neutral payments for select services

5. Demand-Side Incentives

The Commonwealth should encourage payers and employers to enhance strategies that empower consumers to make high-value choices. Specifically:

- Encouraging employees to choose high-value plans, and employers to purchase health insurance through the Health Connector
- Payers improving the design of tiered and limited network plans, and testing new ideas such as PCP tiering
- Payers, employers, and employees utilizing new CompareCare website

Promoting an efficient, high-quality, health care delivery system

6. Social Determinants of Health

The Commonwealth should emphasize the importance of social determinants of health on health care access, outcomes, and costs. Building off of leadership by EOHHS and MassHealth, specific areas of focus include:

- Flexible funding to address health-related social needs
- Inclusion of social determinants in payment policies and performance measurement
- Continued evaluation of innovative interventions to build the evidence-base

7. Health Care Workforce

The Commonwealth should support advancements in the health care workforce that promote top-of-license practice and new care team models. Specific areas of focus include:

- Scope of practice reform, including removing restrictions that are not evidence-based (e.g., advance practice registered nurses)
- Establishing a new level of dental practitioner for expanded oral health care access (e.g., dental therapist)
- Support for new care team models, particularly to address patient's behavioral health and health-related social needs (e.g., community health workers, peer support specialists, recovery coaches)
- Engagement of the health care workforce in policy and delivery reform efforts

Promoting an efficient, high-quality, health care delivery system

8. Innovation Investments

The Commonwealth should continue to support targeted investments to test, evaluate, and scale innovative care delivery models. Emerging ideas that should be considered for funding include:

- Pharmacologic treatment for substance use disorder in primary care settings
- Telehealth, particularly for clinical services with patient access challenges (e.g., behavioral health, oral health)
- Mobile integrated health, in which community paramedicine and other providers treat patients in their homes and communities

9. Unnecessary Utilization

The Commonwealth should focus on reducing unnecessary utilization and increasing the provision of care in high-value, low-cost settings, consistent with the HPC's improvement targets detailed in the health system performance dashboard.

Specifically, policymakers and market participants should seek progress on:

- Avoidable ED utilization (e.g., low-acuity ED visits, BH-related ED visits)
- Avoidable hospital admissions/readmissions
- Community hospital-appropriate inpatient care at AMCs/teaching hospitals
- Institutional post-acute care

Promoting an efficient, high-quality, health care delivery system

10. Alignment and Improvement of APMs

The Commonwealth should continue to promote the increased adoption of alternative payment methods (APMs) and improvements in APM effectiveness. Specific areas of focus include:

- Increasing APM coverage in the commercial market, particularly for self-insured and PPO populations
- Aligning quality measurement in APMs, based on the work of the EOHHS Quality Alignment Taskforce
- Adopting HPC ACO certification standards
- Incorporating bundled payments
- Reducing disparities in budget levels