Health Policy Commission

Advisory Council Meeting

July 16, 2014

Agenda

- Executive Director’s Report
- Cost Trends Report: July 2014 Supplement
- Community Hospital Study
- Discussion
- Schedule of Next Advisory Council Meeting (November 19, 2014)

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- **Executive Director's Report**
  - CHART Investment Program
  - Market Performance Reviews
- Cost Trends Report: July 2014 Supplement
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Legislative Update

The final FY15 budget includes $2 million for a behavioral health integration initiative, administered by the HPC. This one-time reserve money is appropriated for the acceleration and support of behavioral health integration within patient-centered medical homes.

This investment could support:

- Technical assistance staff and faculty expertise assigned to practice sites
- Capacity mapping for behavioral health resources in selected communities
- Assistance with developing/strengthening patient referral and tracking systems for successful integrated care delivery
- Regional learning events
- Virtual coaching assistance to participating practices
- Distillation of implementation strategies for successful BH integration
- Evaluation of cost and quality impact

Chapter 155 of the Acts of 2014, signed by the Governor on June 30, 2014, establishes nurse staffing ratios in intensive care units. The law:

- Sets up ratios of one nurse to one patient, or one nurse to two patients, depending on the stability of the patients being treated, as assessed by an “acuity tool” that each hospital is required to develop.
- Charges the HPC with promulgating regulations governing the implementation of the bill including:
  - The formulation of the “acuity tool”,
  - The method of reporting staff compliance, and
  - The identification of patient safety quality indicators.

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CHART Phase 1: Update

- All CHART Phase 1 hospitals are making progress on key goals and deliverables.
- Safe & Reliable is currently conducting site visits in all hospitals; HPC staff have completed site visits in 26 of 27 CHART Phase 1 hospitals.
- Harvard Business School is currently implementing the World Management Survey in participating hospitals. Early reports are that the opportunity has been well received.
- HPC, in coordination with the Mass. Council on Community Hospitals, is hosting a learning collaborative on care coordination and management of complex patients in early July.
- The CHART Leadership Academy will occur in September.

Leadership Academy

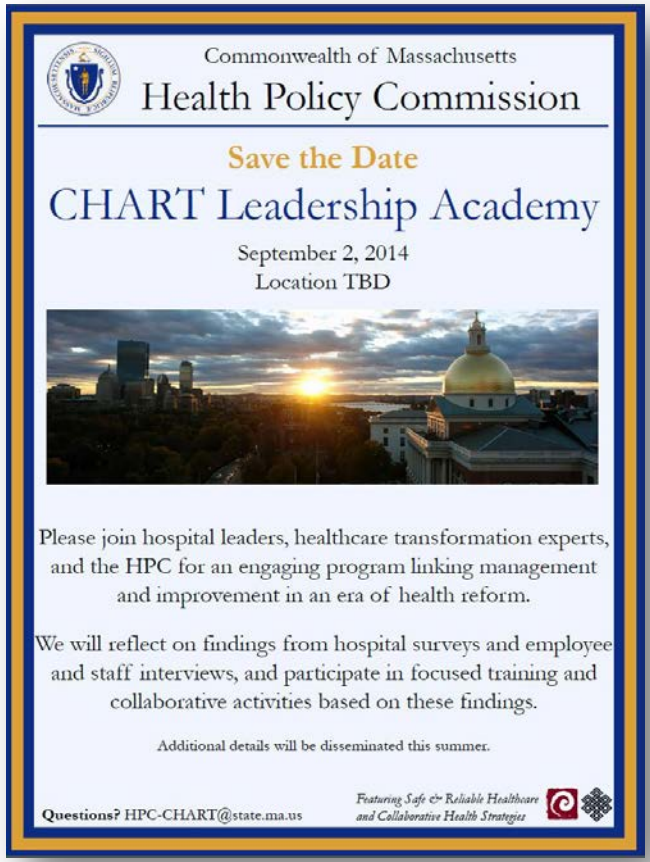
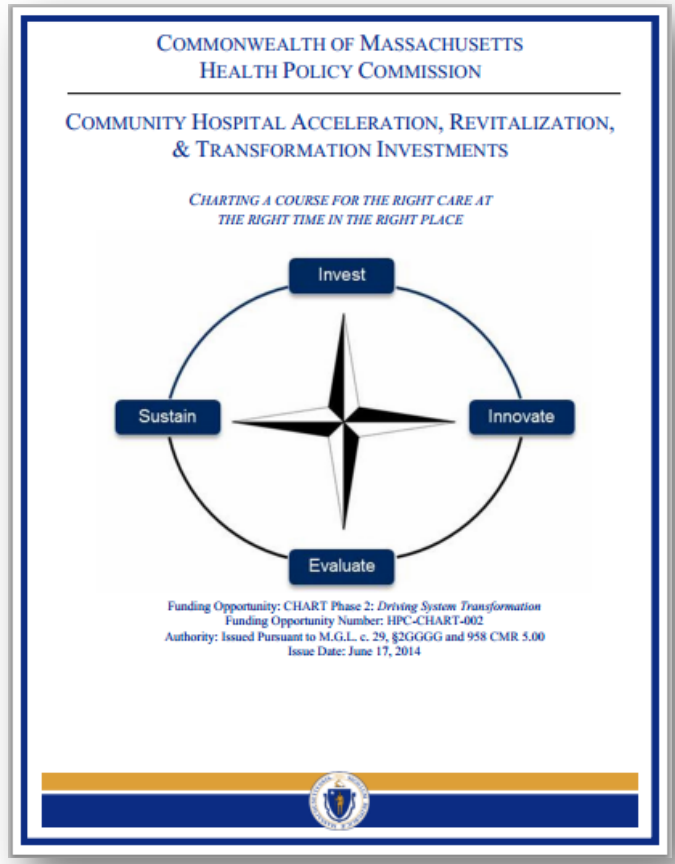


CHART Phase 2: Update

- The CHART Phase 2 RFP was released on June 17.
- 30 CHART-eligible hospitals can compete for up to $60M in funding in key domains specified by the Commission.
- Key dates:
  - *July 18:* Prospectuses Due
  - *September 12:* Proposals Due
  - *October:* Award recommendations to the board
- The HPC is offering a series of in depth information sessions (8+) on a variety of educational topics (e.g., behavioral health, metric selection, etc.) to support hospitals.

Phase 2 Request for Proposals



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Material Change Notices: Types of Transactions

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group affiliation or acquisition	8	32%
Acute hospital acquisition	6	24%
Clinical affiliation	4	16%
Change in ownership or merger of owned entities	3	12%
Acquisition of post-acute provider	2	8%
Formation of contracting entity	2	8%

Cost and Market Impact Reviews: Reports

Completed and Pending Reviews

Partners HealthCare System's Proposed Acquisition of South Shore Hospital

Partners HealthCare System's Proposed Acquisition of Harbor Medical Association

Lahey Health System's Proposed Acquisition of Winchester Hospital and Affiliates

Partners HealthCare System's Proposed Acquisition of Hallmark Health Corporation

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Cost Trends: July 2014 supplement

Health Policy Commission

July 16, 2014

Cost Trends July 2014 supplement

- Provides further analysis related to the findings of the Commission's 2013 annual cost trends report
- These topics will likely remain key areas of interest for the Commission in its October 2014 cost trends hearing and the 2014 annual cost trends report to be released in December.

A. Spending levels and trends

- Commercial insurance trends
- MassHealth
- Long-term care and home health
- Behavioral health

B. Trends in the MA delivery system

- Mix of providers of inpatient care
- Concentration of inpatient care
- Progress in alternative payment methods

C. Disparities in quality and access

- Income-based differences in rates of preventable hospital admissions

D. Measures of spending

- Limitations of current measures of contribution to growth in health care expenditures

Later this year, CHIA will make the **first determination of Massachusetts' growth in total health care expenditures** (THCE) from 2012 to 2013, which will be the measure of performance against the health care cost growth benchmark

Findings from the Cost Trends July 2014 supplement

Opportunities in unit price and the mix of providers

- **Drivers of spending growth**: Increases in prices paid to providers continued to be the primary driver of growth in commercial payer spending between 2010 and 2012.
- **Mix of providers:** Many Massachusetts residents leave their home region to seek inpatient care in Boston, a pattern that is more pronounced among those with commercial insurance and residents of higher-income communities.

Opportunities for more efficient utilization

- **Preventable hospitalizations**: Massachusetts has higher rates of preventable hospital admissions than the national average, and rates are much higher in lower-income communities than in higher-income communities, particularly for chronic conditions. This suggests an opportunity to improve outcomes and reduce cost through targeted community supports and improved ambulatory care
- **Post-acute care:** After a hospitalization, the average Massachusetts resident is relatively more likely to be discharged to post-acute care, and rates of discharge to post-acute care vary widely across Massachusetts hospitals.
- **Behavioral health:** Patients with behavioral health conditions spend more for other conditions, particularly if both mental health and substance use disorders are present, and higher spending for patients with behavioral health conditions is concentrated in ED and inpatient care.

Trends in the Massachusetts delivery system

- **Concentration of inpatient care**: Commercial inpatient care in Massachusetts has grown more concentrated among large hospital systems over the past 5 years. In 2009, the five highest-volume systems accounted for 48% of commercial inpatient discharges, and in 2014 we estimate that five systems will account for 56% (61% if Partners HealthCare System completes acquisitions of South Shore Hospital and Hallmark Health).
- **Alternative payment methods**: At the end of 2012, alternative payment methods covered 29 percent of insured Massachusetts residents. Continued efforts are needed to expand APM coverage to additional providers and to PPO books of business, as well as to strengthen the design and implementation of APMs.

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In recent years, the increase in prices paid has been the biggest contributor to commercial spending growth

Commercial insurance

DRIVERS OF GROWTH IN CLAIMS-BASED MEDICAL EXPENDITURES* IN MASSACHUSETTS

Percent annual growth in claims-based medical expenditures, 2010-2012

Changes in price index	×	Changes in utilization	×	Changes in health status	=	Overall spending growth
+5.2%		-2.1%		~0%		+2.9%
Increase in prices paid (may reflect unit prices and changes in provider mix)		Decrease in spending at standardized prices		No notable change in average risk scores from 2010 to 2012		Increase in per member per month claims-based medical expenditures

* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

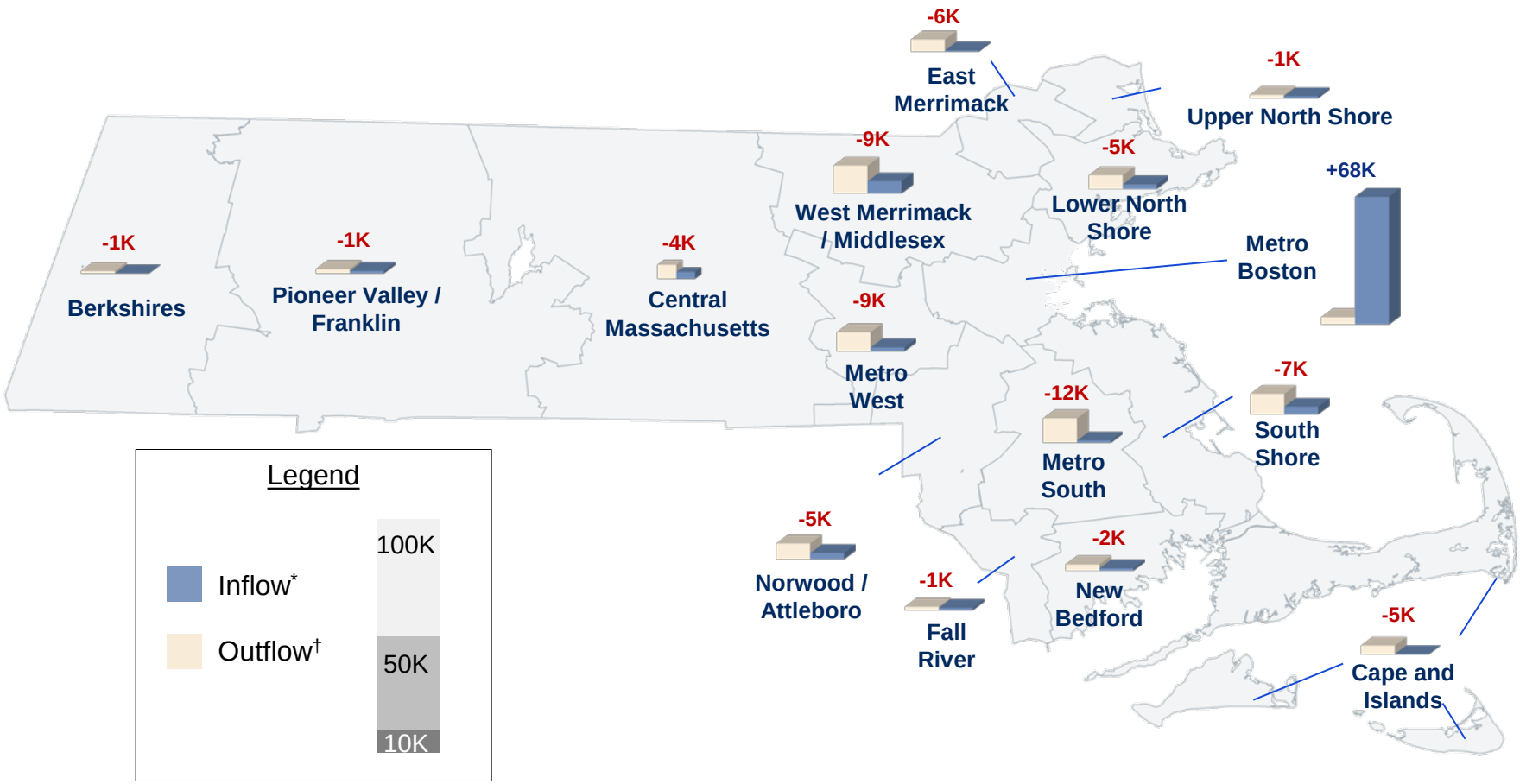
SOURCE: HPC analysis of the All-Payer Claims Database

Most Massachusetts residents who leave their home region for inpatient care seek their care in Metro Boston

Profile of inpatient care

DISCHARGES FLOWS IN AND OUT OF MASSACHUSETTS REGIONS

Number of inpatient discharges for non-emergency, non-transfer volume, 2012



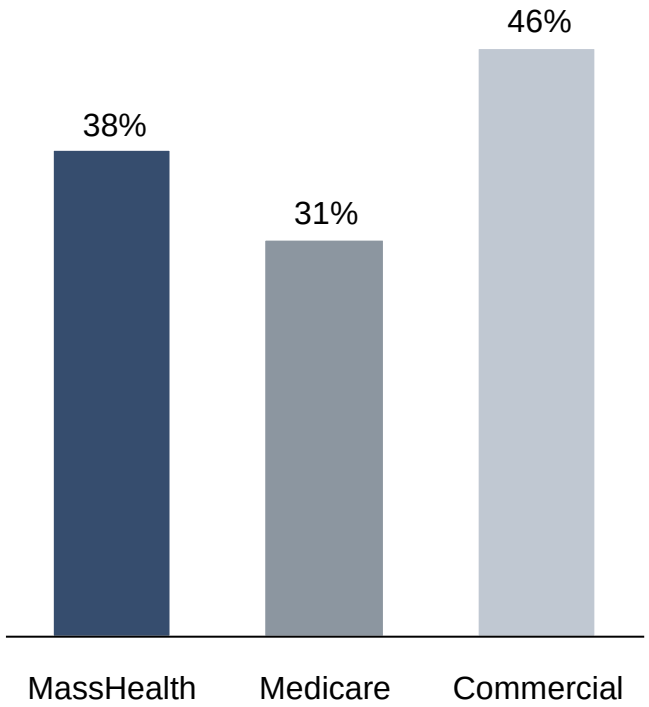
* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region
SOURCE: Center for Health Information and Analysis; HPC analysis

Commercially-insured patients and residents of higher-income communities are more likely to leave their home region for care

Profile of inpatient care

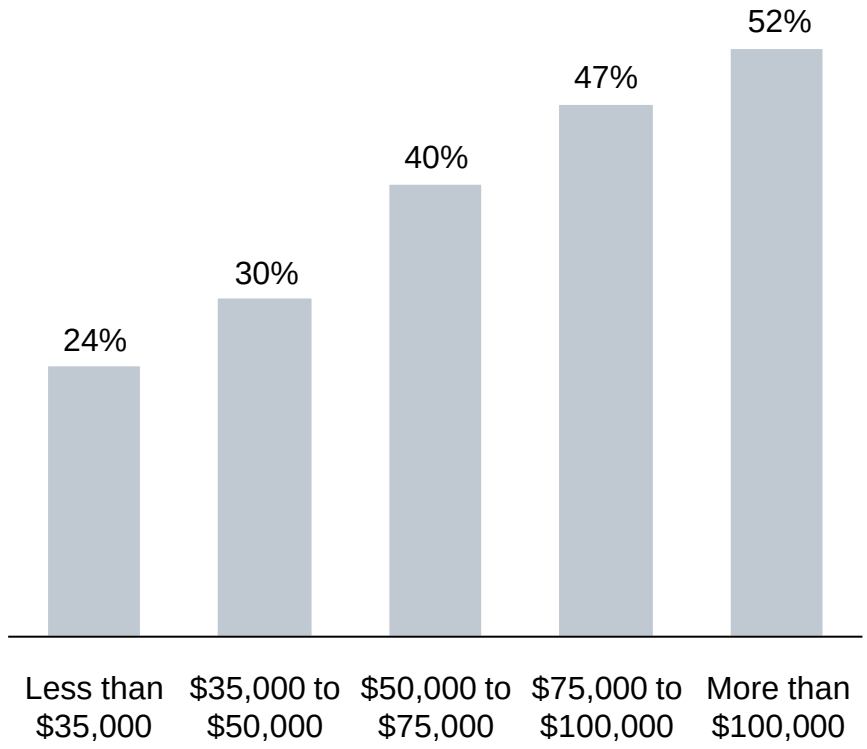
INPATIENT CARE RECEIVED OUTSIDE OF HOME REGION BY PAYER TYPE

Adjusted proportion of non-emergency, non-transfer inpatient discharges for payer type, 2012



INPATIENT CARE RECEIVED OUTSIDE OF HOME REGION BY INCOME GROUP

Percent of non-emergency, non-transfer inpatient discharges for community income group, 2012*



* Community income is estimated as the median household income for the patient's zip code

NOTE: Rates are adjusted for age, sex, payer group, distance from hospitals, distance from Metro Boston, and major diagnostic category. Analysis excluded individuals below 18 years of age, residents of Metro Boston, discharges with an ED visit in their record, and transfers from other acute hospitals.

SOURCE: Center for Health Information and Analysis; HPC analysis

Findings from the Cost Trends July 2014 supplement

Opportunities in unit price and the mix of providers

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Opportunities for more efficient utilization

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Trends in the Massachusetts delivery system

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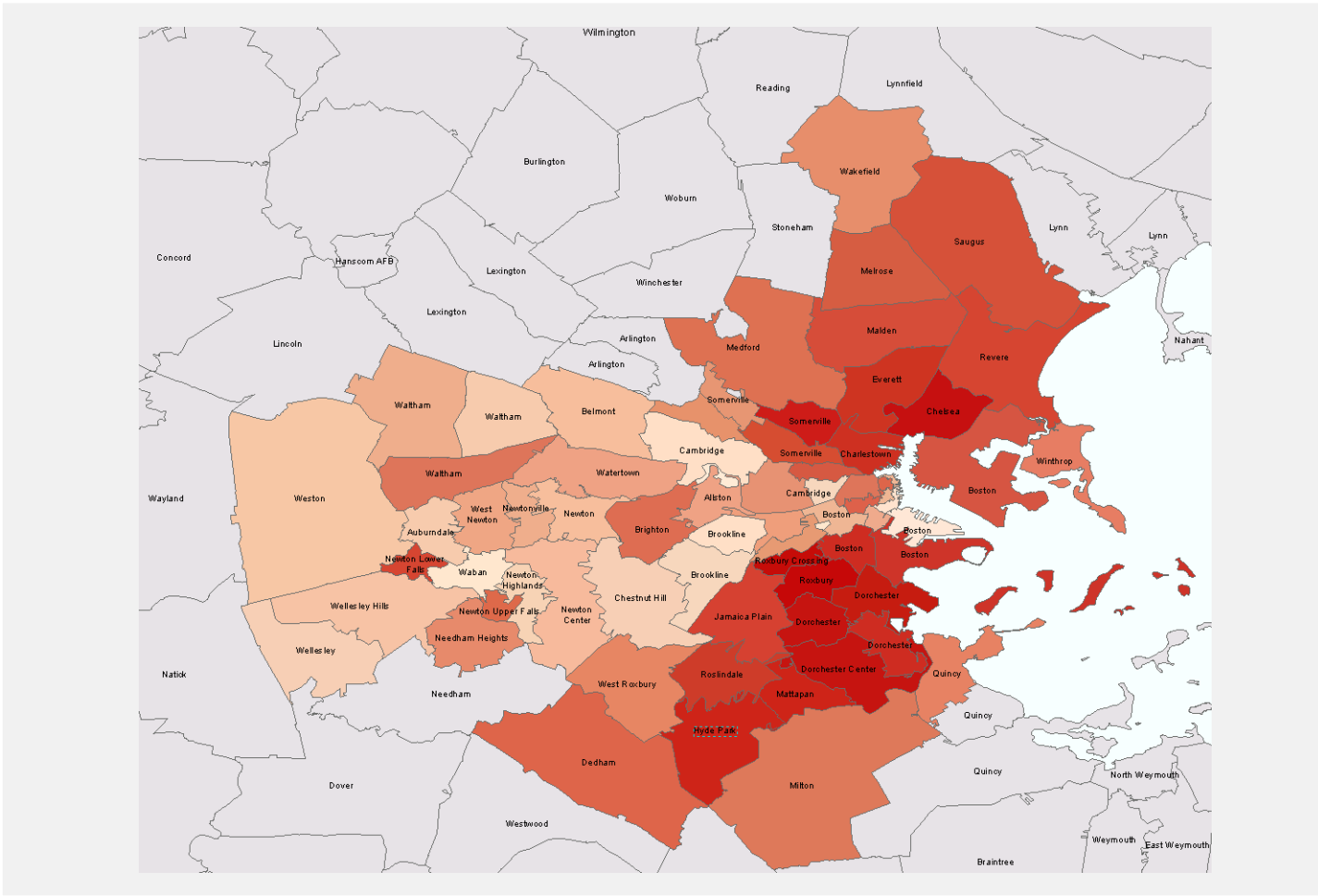
Rates of preventable hospital admissions can vary dramatically between communities within a metropolitan area

Preventable hospitalizations

METRO BOSTON EXAMPLE: RATES OF PREVENTABLE ADMISSIONS BY ZIP CODE*

Preventable admissions per 100,000 residents, 2012



2,800 preventable admissions per 100,000 residents

0

* Preventable hospitalizations were calculated using AHRQ's prevention quality indicator (PQI) measures. All figures are age- and sex-adjusted.

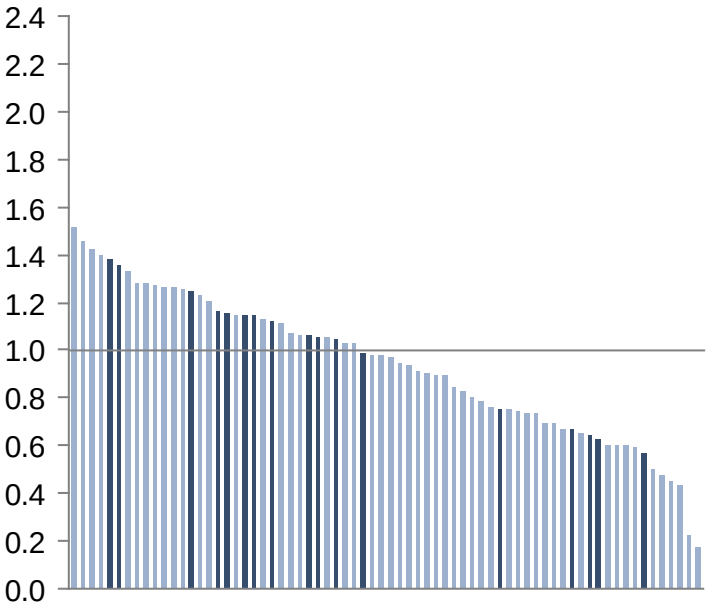
Source: Center for Health Information and Analysis; HPC analysis

Massachusetts hospitals vary widely in their rate of post-acute care use and in the setting selected

Long-term care and home health

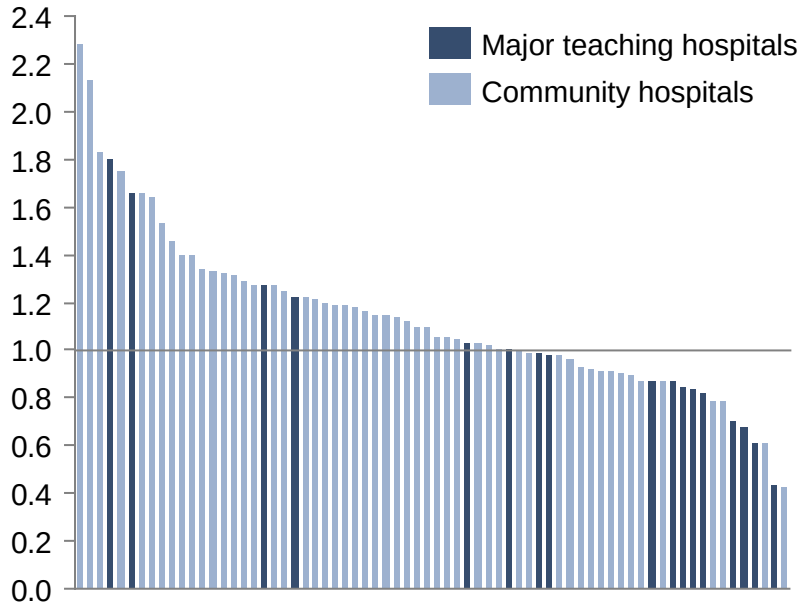
RATES OF DISCHARGE TO POST-ACUTE CARE

Adjusted rate of discharge to nursing facilities and home health, 2012*



RATES OF USE OF NURSING FACILITIES AS POST-ACUTE CARE SETTING

Adjusted rate of use of nursing facility as setting for post-acute care,†, 2012*



2.1 Adjusting for patients' demographic and clinical characteristics and for the type and intensity of inpatient care delivered, we estimate that Massachusetts hospitals are **2.1 times as likely to discharge patients to either nursing facilities or home health agencies** relative to the national average.†

* Rates for each hospital were estimated using a logistic regression model that adjusted for the following: age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Our sample included patients who were at least 18 years of age and had a routine discharge, a discharge to a skilled nursing facility, or a discharge to a home healthcare provider. Specialty hospitals are excluded from figure and from displayed state average. Rates are normalized with the state average rate equal to 1.0.

† Discharge to nursing facility as a proportion of total discharges to either nursing facility or home health.

‡ Relative probabilities of discharge to post-acute care and of choice of post-acute care setting were estimated using a logistic regression model that adjusted for the following: age, sex, payer, income, length of stay, DRG, patient comorbidities, APR-DRG illness severity score, and APR-DRG risk of mortality score using a national inpatient sample from the Healthcare Cost and Utilization Project. Detailed results and methods are available in a technical appendix.

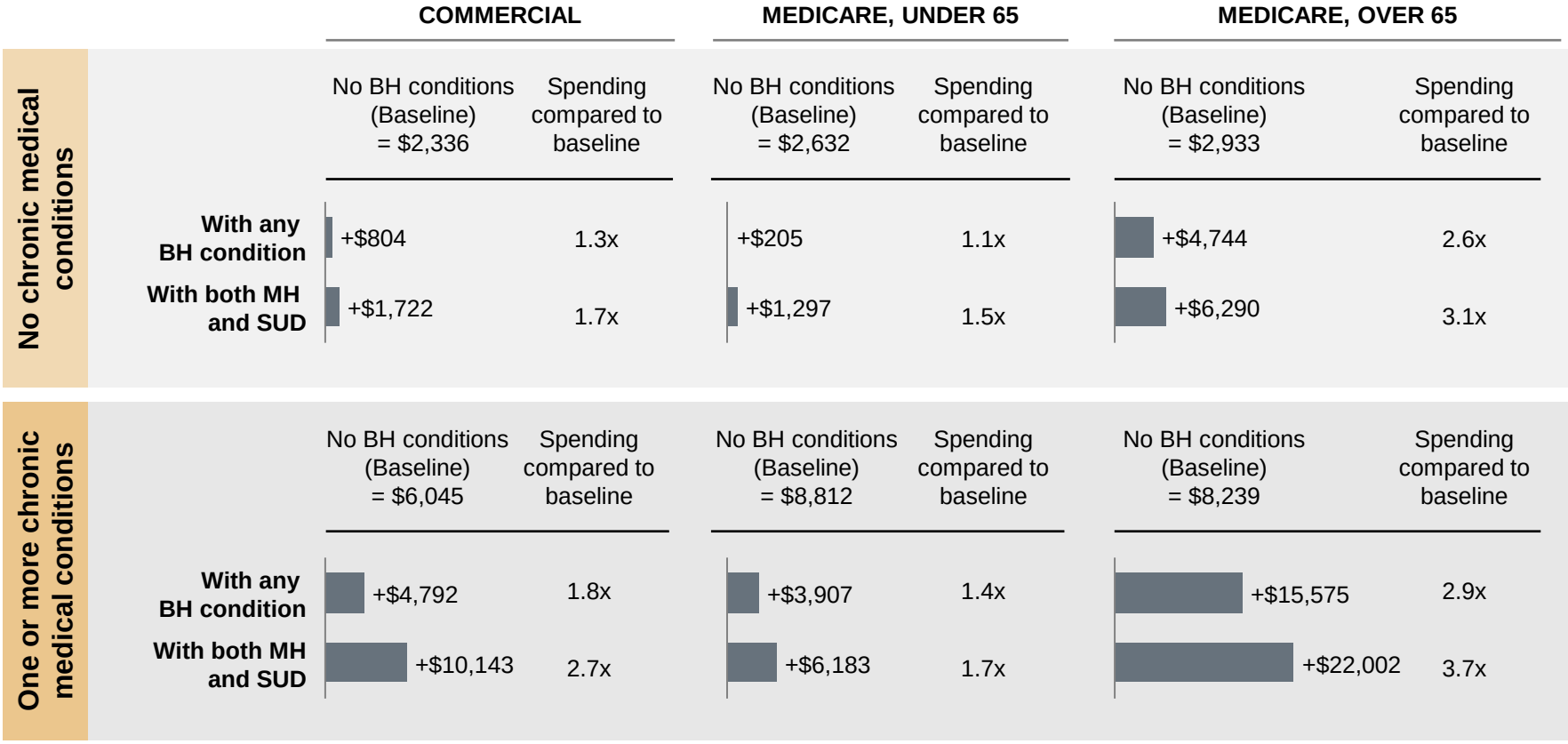
SOURCE: Center for Health Information and Analysis; HPC analysis

For patients with behavioral health conditions, higher expenditures are observed for medical expenditures outside of behavioral health

Behavioral health

IMPACT OF BEHAVIORAL HEALTH COMORBIDITY ON SPENDING FOR NON-BEHAVIORAL HEALTH CONDITIONS

Per person claims-based medical expenditures on non-behavioral health conditions based on presence of behavioral health (BH) comorbidity†, 2011*



* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

† Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software. Expenditures for non-behavioral health conditions were identified using Optum ETG episode grouper. Additional detail is available in a technical appendix.

SOURCE: All-Payer Claims Database; HPC analysis

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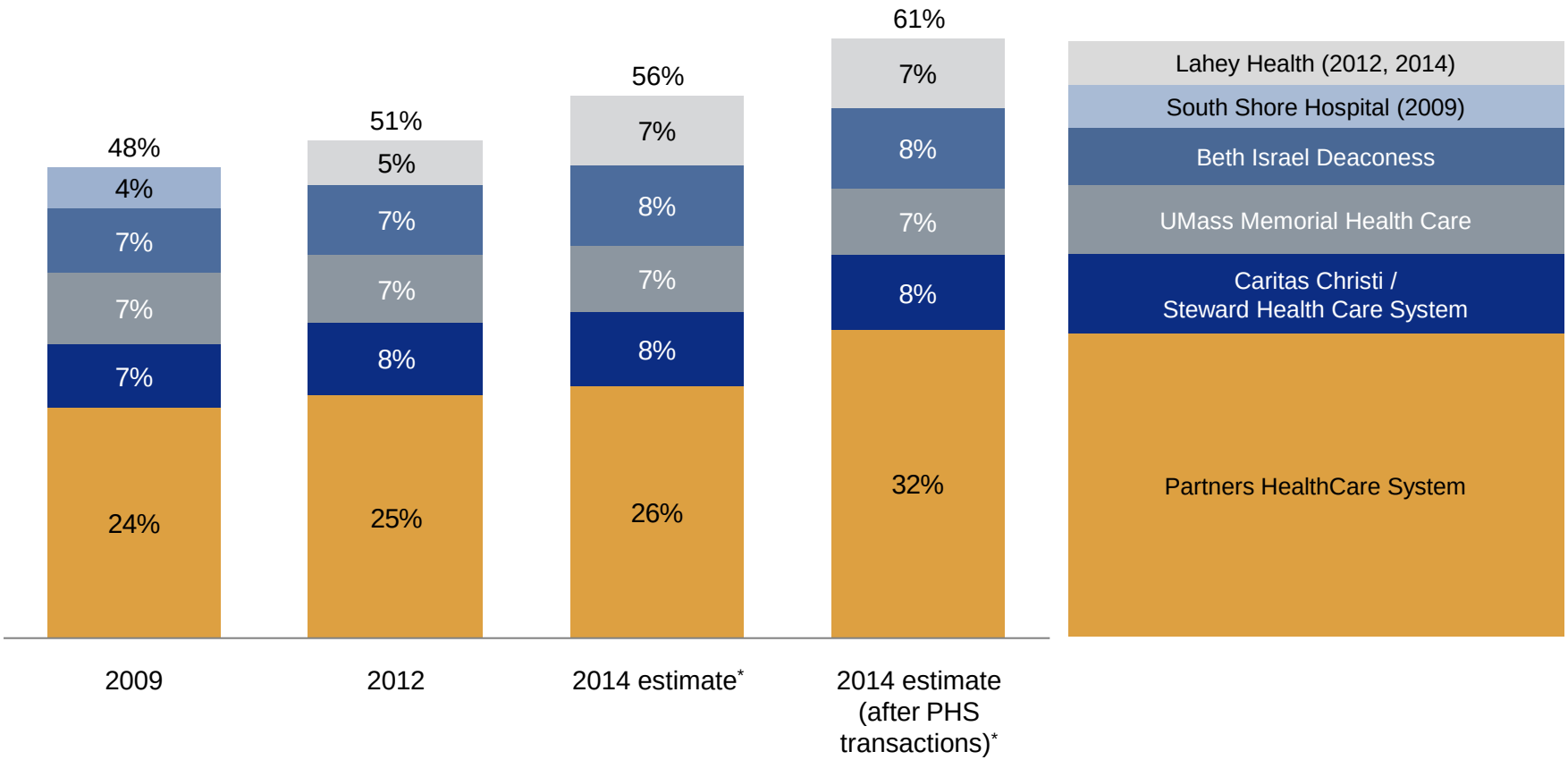
Commercial inpatient care in Massachusetts has grown more concentrated among large hospital systems over the past 5 years

Profile of inpatient care

CONCENTRATION OF COMMERCIAL INPATIENT CARE IN MASSACHUSETTS

Share of commercial inpatient discharges held by five highest-volume systems, 2009-2012



* 2014 data not yet available. Based on applying systems established by 2014 (including 2013 Partners HealthCare acquisition of Cooley Dickinson and 2014 Lahey Health acquisition of Winchester hospital) to 2012 inpatient discharge data

† Includes South Shore Hospital and Hallmark Health hospitals within Partners HealthCare System

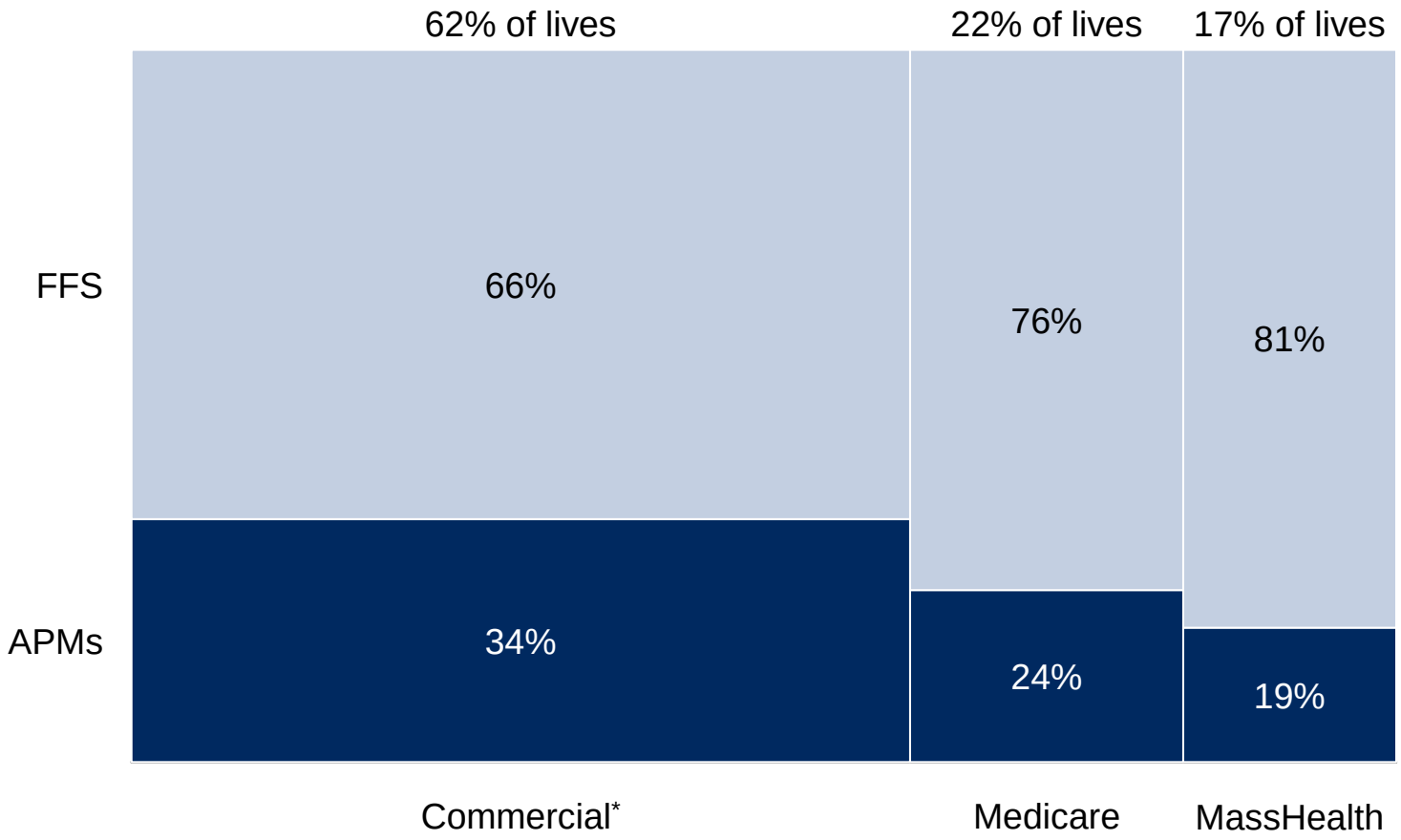
SOURCE: Center for Health Information and Analysis; HPC analysis

Across all payers, 29 percent of Massachusetts residents were covered by global budget APMs in 2012

Alternative payment methods

ALTERNATIVE PAYMENT METHOD COVERAGE BY PAYER TYPE

Percent of members/beneficiaries covered by global budget APMs, 2012



29%

of members were covered by APMs across commercial, Medicare, and MassHealth populations

* Includes Commonwealth Care

SOURCE: Center for Health Information and Analysis; MassHealth; Centers for Medicare & Medicaid Services; HPC analysis

Opportunities exist to expand APM coverage and strengthen implementation

Alternative payment methods

Expansion in APM coverage

Enrolling additional provider organizations	▪ Transition of commercial contracts from fee-for-service arrangements to shared savings or risk-based global budgets ▪ Growth in provider participation in Medicare demonstrations ▪ Expanded adoption of APMs for MassHealth (e.g. PCPR initiative, waiver)
Expanding commercial APMs to PPO members	▪ Review and improvement of methods for attribution of PPO members to primary care providers ▪ Examination of barriers slowing implementation of attribution methodology required for adoption of APMs for PPO members

Improvements in APM implementation

Improving global budget-based models	▪ Review and evaluation of varied approaches to payment model design and implementation (e.g. level of risk sharing, quality measures and incentives, services covered, requirements for stop-loss insurance) ▪ Identification of opportunities for increased alignment ▪ Examination of how incentives flow to individuals within provider organizations
Considering models outside of global budgets	▪ Innovation to enable care delivery organizations without aligned primary care providers - such as specialist physician groups without primary care providers – to move away from fee-for-service payment ▪ Review of models in other states (e.g., Arkansas episodes of care, Maryland total patient revenue)

Conclusions from the 2013 cost trends report

We find that there are significant opportunities in Massachusetts to enhance the value of health care, addressing cost and quality. We identify four primary areas of opportunity for improving the health care system in Massachusetts:

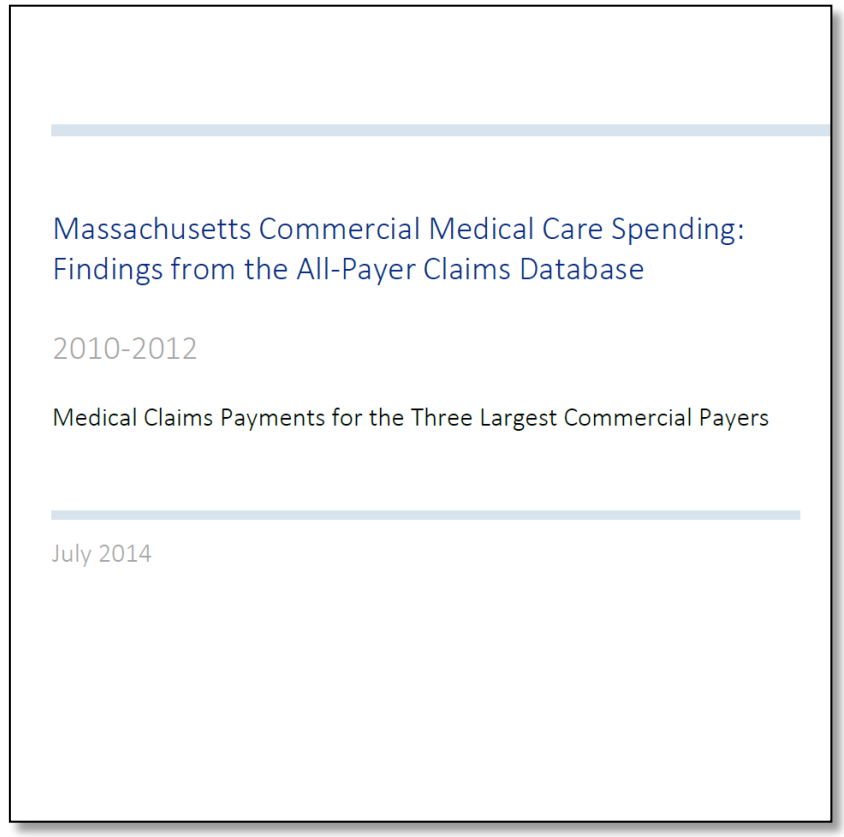
1. **Fostering a value-based market** in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options,
2. **Promoting an efficient, high-quality health care delivery system** in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status,
3. **Advancing alternative payment methods** that support and equitably reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases, and
4. **Enhancing transparency and data availability** necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time.

Recommendations in the 2014 July cost trends supplement

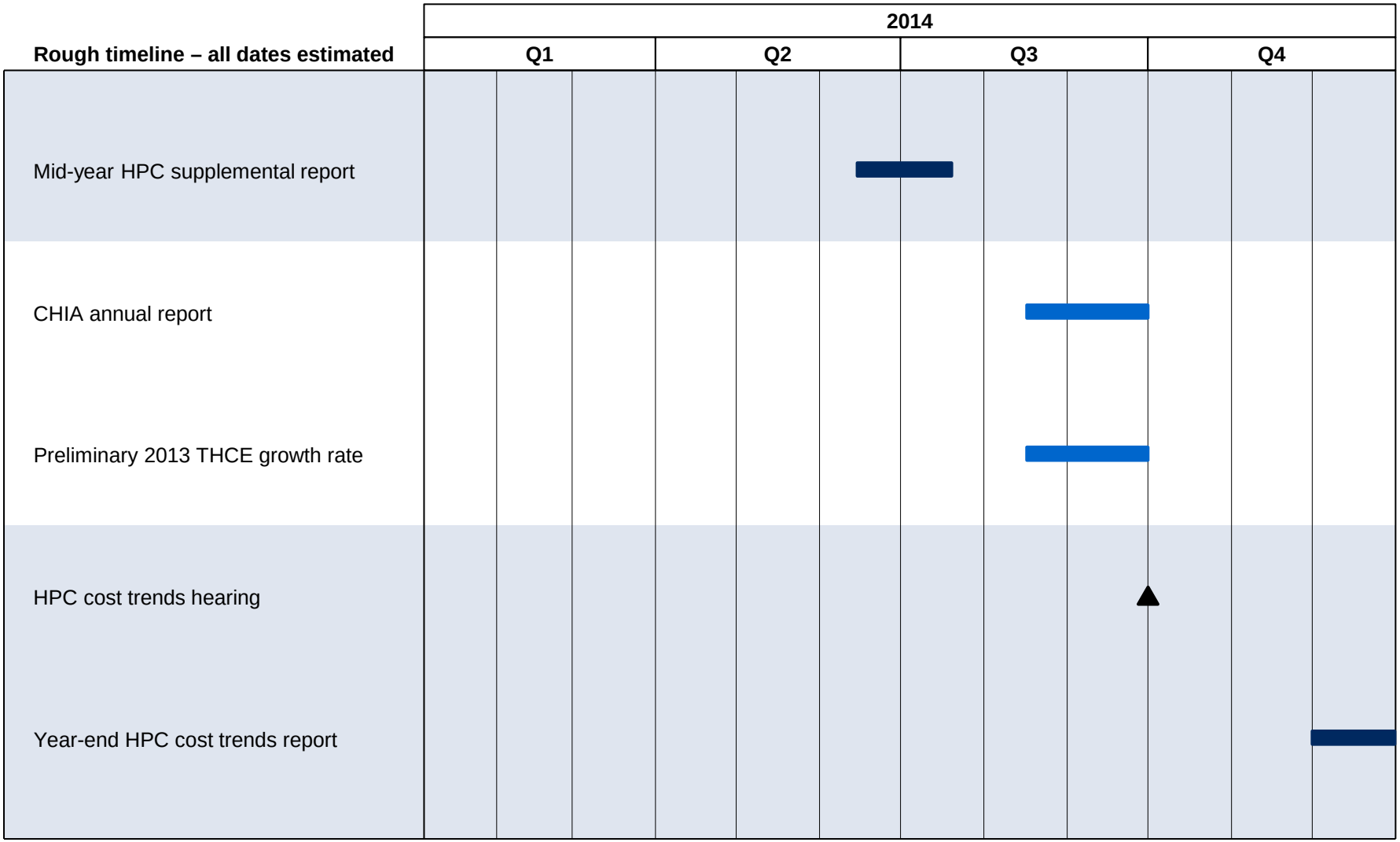
Fostering a value-based market	▪ The Commission will **study the impact of new insurance products and increased cost-sharing** in commercial insurance plans on consumers' decision-making and on access to care. ▪ If health care provider systems grow, they should find ways to ensure they **deliver care to their patients in lower-cost, community settings for lower-complexity care**. ▪ The Commission will continue to **examine the flow of patients to academic medical centers for lower-complexity care** to identify and recommend policy solutions for reducing unnecessary outmigration.
Promoting an efficient, high-quality health care delivery system	▪ **Hospitals should work to optimize use of post-acute services**, including enhancing efficacy of care coordination and transitions for behavioral health patients. Where aligned with project goals, the Commission will work with community hospitals receiving CHART investments to achieve these goals. ▪ Payers and providers should continue **to increase integration of behavioral health and primary care** through use of incentives and new delivery models. ▪ The Commission will **support provision of behavioral health services in primary care settings through its PCMH and ACO certification program**s.
Advancing alternative payment methods	▪ The Commission will **study the implementation of APMs** in Massachusetts to **evaluate their effectiveness** in improving health and reducing costs**, monitor for potential adverse impacts**, and **review opportunities to increase alignment** around identified best practices. ▪ Given the variety of design choices in attribution methods and the importance to provider organizations of information on the patient populations for which they are accountable, **payers should engage in a transparent process to review and improve their attribution methods** and should align their methods to the maximum extent feasible. ▪ The Commission will work with CHIA, payers, and providers in the fall of 2014 to understand the current state of development of attribution methods and explore opportunities to **accelerate the development of aligned methods**.
Enhancing transparency and data availability	▪ CHIA should convene state agencies to **increase transparency in behavioral health** spending, quality of care, and the market for behavioral health services. ▪ To monitor and understand cost trends in the significant and growing PPO segment, CHIA should extend its reporting to include a **TME measure for PPO populations** that uses an agreed-upon attribution algorithm to identify accountable provider organizations. ▪ In 2014 and 2015, the Commission will seek to work with CHIA to design and evaluate **potential measures of contributions to health care spending growth for provider types such as hospitals, specialist physician groups, and others that do not deliver primary care**. Where feasible, these measures should be aligned with those used by other states to facilitate meaningful benchmarking.

New publication on HPC website: "Massachusetts Commercial Medical Care Spending"

- Covers trends in commercial medical spending, 2010-2012
  - Data from the APCD
  - Overall spending and spending by category of service, type of episode, region
  - Chartpack highlights important trends in graphical manner
  - Databook offers additional results in a machine readable manner
- Collaborative effort between HPC and CHIA, drawing on HPC's contract with The Lewin Group
- Enhances our understanding of the Massachusetts health care market
- Reinforces our commitment to collaboration and transparency



What's next for cost trends: 2014 timeline



COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

2014 Health Care Cost Trends Hearing

An annual public examination of health care cost trends and drivers, featuring witness testimony and discussion with national experts on the challenges and opportunities within the Commonwealth's health care system.

October 6 & 7, 2014

Suffolk University Law School

120 Tremont Street, Boston, MA

The 2014 hearing will examine cost trends for public and commercial payers as well as hospitals and other providers. For the first time, the hearing will focus on the state's performance under the health care cost growth benchmark.

The HPC will hold the hearings in conjunction with the Center for Health Information and Analysis and the Office of the Attorney General.

Discussion Questions: Cost Trends Reports and Hearing

- What are your general reactions to the findings from the cost trends supplement?
- How should the HPC follow up on the findings highlighted, and which additional lines of research would be helpful this year in our December report?
- What is your organization doing to address the findings highlighted in the cost trends report?
- What topics are of most interest for the October hearing this year?

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- Discussion
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A Call to Action for Understanding the State of Community Hospitals

- Hospitals and health systems in Massachusetts are facing an unprecedented impetus to transform care delivery structures and approaches
  - Shifts in reimbursement models and funding pressures
  - Shifting demographics of Commonwealth's residents
  - General trend from inpatient to outpatient care
- No comprehensive set of vetted approaches exists to guide hospital transformation
- Community hospitals, as small organizations, can be particularly sensitive to such change
- Massachusetts is at the cusp of delivery system transformation, and effective, action-oriented planning is necessary to ensure that hospital resources are distributed to meet current and future community need
- Many stakeholders, including the HPC Advisory Council, have emphasized the importance and timeliness of a study of community hospital use, capacity and need as well as barriers and opportunities for change

Study Goals

- To develop an **action-oriented report on the future of community hospitals** in Massachusetts, including analysis of baseline status, community need, and toolkits to support overcoming common barriers to community hospital transformation
- To identify **challenges to and opportunities for transformation** in community hospitals
- To examine the experience of key stakeholders to inform solutions to these challenges and identify innovations that can work in the Commonwealth to help the **CHART Investment Program** drive transformation in an eligible community hospital
- To support **HPC funding prioritization** and hospital proposals for future phases of CHART
- To conduct an analysis of acute care supply and to identify opportunities to meet community needs

Analytic Approach *(draft for discussion)*

Aim 1
Analysis of acute care supply & identification of opportunities to align capacity with community need

- Total capacity and need
- Current distribution of resources in select community-essential service lines
- Forecasting the impact of changing demographics and other drivers of changing need
- Recommendations to support *hospital decisions* regarding potential reconfiguration of services that mitigate excess capacity or address unmet community need

To support health systems' alignment of services with community needs

To support public and private sector health resource planning and investment

Aim 2
Identifying and Addressing Barriers to Structural Transformation in Massachusetts Community Hospitals

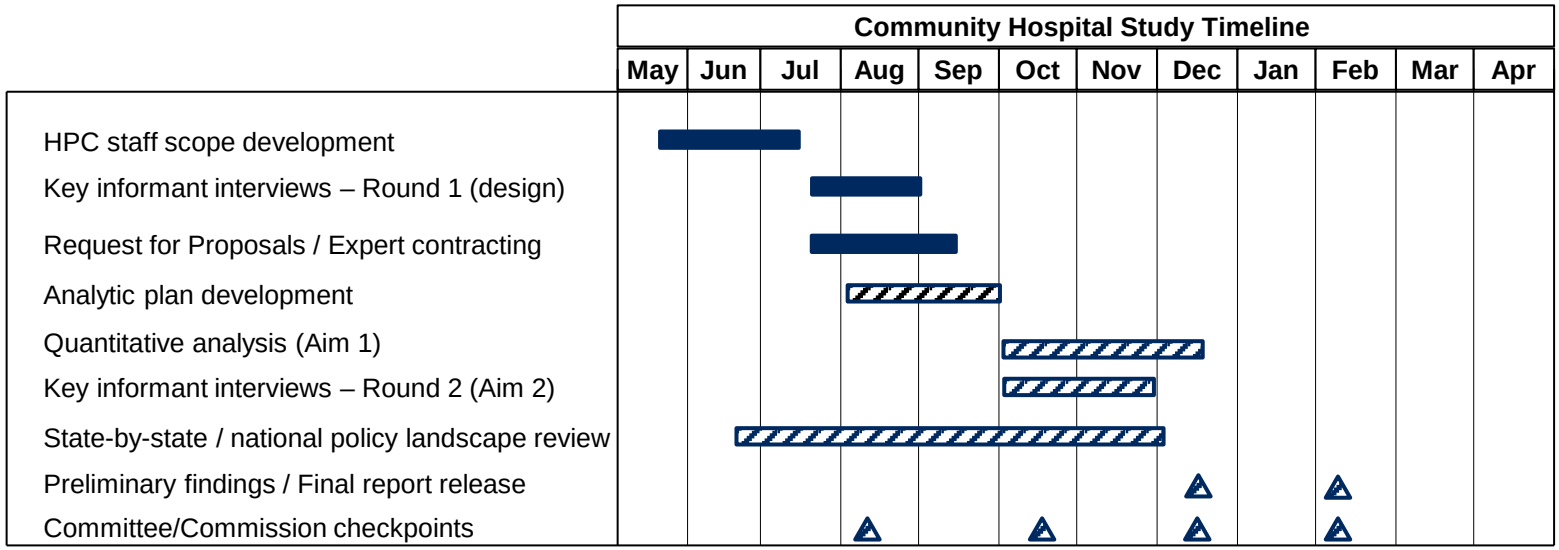
- Engagement of key leaders in Massachusetts and other states with experience in related efforts
- Examination of federal and state regulatory frameworks governing the operations of acute hospitals, with a focus on potential barriers to structural change and a comparative analysis of policy approaches adopted nationally
- Identification of innovations consistent with the Commonwealth's policies

To inform policy initiatives that address challenges to transformation

To support hospital strategic planning and engagement in transformation

Process and Timeline

- To meet the goal of releasing a community hospital report in Quarter 1, 2015, an aggressive timeline for scope development and project implementation is necessary
- This timeline includes regular touch-points to engage the CHICI Committee and Commission, with ongoing engagement with other state agencies and key stakeholders including the Advisory Council
- Staff anticipate returning to the CHICI Committee this summer and the Advisory Council this fall for an update and detailed discussion of the analytic scope
- The study team will reach out to many of you with invitations to participate as key informants to the study



Discussion Questions: Community Hospital Study

- In designing a study of the current landscape for community hospitals, what topics do you think are the most important for the HPC to include?
  - Those currently under consideration include: capacity assessment, needs assessment, hospital debt financing, shifting payment models, demographics, patient referral patterns, geography, and comparison to other States' experiences.
- What primary barriers to successful transformation of care do you believe hospitals face today? In the next five years?
- How should the HPC use findings from a study like this one to promote best practices and community hospital transformation in Massachusetts?

Agenda

- Executive Director’s Report
- Cost Trends Report: July 2014 Supplement
- Community Hospital Study
- **Discussion**
- Schedule of Next Advisory Council Meeting (November 19, 2014)

Discussion Questions: General HPC Questions

- What strategies would you recommend the HPC employ to enhance its engagement with various constituencies including providers, businesses, consumers, and the general public?
- What role do you think the Advisory Council should play in collaborating with the HPC on public engagement efforts? What are some specific opportunities for collaboration outreach and education efforts?
- What information or incentives do believe would be most helpful to consumers and employers in assisting them to make “high-value” choices for their care and coverage options?

Agenda

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Contact Information

For more information about the Health Policy Commission:

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