COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Cost Trends and Market Performance

October 14, 2015

Agenda

- Approval of Minutes from the July 15, 2015 Meeting (VOTE)
- Discussion of the 2015 Health Care Cost Trends Hearing
- Discussion of the 2015 Cost Trends Report
- Discussion of HPC Performance Improvement Plans
- Schedule of Next Committee Meeting (December 2, 2015)

Fall/Winter 2015 HPC Meetings

October 21 full commissioner meeting has been rescheduled to November 18.

Wednesday, October 14

9:30AM CTMP

11:00AM CHICI

Thursday, November 12

9:30AM CDPST

11:00AM QIPP

Wednesday, November 18

11:00AM Advisory Council

12:00PM Full Commission

Wednesday, December 2

9:30AM CTMP

11:00AM CHICI

Wednesday, December 9

9:30AM CDPST

11:00AM QIPP

Wednesday, December 16

12:00PM Full Commission

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Vote: Approving Minutes

Motion: That the Cost Trends and Market Performance Committee hereby approves the minutes of the Committee meeting held on July 15, 2015, as presented.

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2015 Health Care Cost Trends Hearing: Selected Takeaways

2015 Health Care Cost Trends Hearing: Selected Takeaways

Panel 1

Challenges to the Benchmark

"There is no substitute for paying less or doing less." (Chandra)

Rising drug spending, especially from high-priced drugs, drove one-third of spending growth between 2013 and 2014.

- Strategies to address drug spending should consider drug value.
- Payers want aligned coverage guidelines and pricing anchor points.

Some stakeholders argue that payment disparities are at root of market consolidation and ongoing shift of care to Boston/high-priced providers.

Panel 6

Meeting the Benchmark in 2015 and Beyond

Some payers seek a statewide standard for risk-adjustment.

Ultimately, doctors strongly influence patients' use of care and choice of specialists and hospitals.

Providers challenged on the efficacy of population health management and the pace of transformation

2015 Health Care Cost Trends Hearing: Selected Takeaways

Panel 2 **Care Delivery Transformation**	Relative to other states, Massachusetts restricts nurse practitioners' scope of practice. Urgent care clinics and retail clinics meet patients' demand for convenience, but must coordinate with other providers to avoid fragmentation of care. Behavioral health integration remains critical, and underpayment remains a widely-cited issue. • Crisis stabilization beds are needed. Hospitals should not be the care giver of last resort. Primary care access and intermediate levels of care are needed. Payment policies should support innovation in care delivery, including tele-health. Hospital systems need statewide benchmarks for high-risk populations to evaluate their care delivery.
Panel 3 **Value-Based Payment Reform**	Stakeholders voiced broad support for APMs as a foundation for coordination, integration, and transformation. BCBS plans to expand AQC to PPO with four major providers starting in 2016. Stakeholders call for payers to move away from historical rates when forming global budgets and other APM targets For both APMs and purchaser incentives, stakeholders call for simplification and standardization of quality measures and for measures that are more relevant to patients. • Including clinical outcome measures and patient experience measures (e.g. how well doctors communicate) Many providers expressed interest in global budgets, mixed views on bundled payment.

2015 Health Care Cost Trends Hearing: Selected Takeaways

Panel 4

Market Structure to Promote Value

Hospital mergers raise prices even when two hospitals do not compete directly in one market. (Dafny)

While major systems promise to shift care back to communities, progress is not yet evident in data.

- Providers and consumers are not necessarily rewarded for this shift – vertical integration could help.

Smaller providers believe consolidation is needed to achieve efficiencies and remain competitive.

Some stakeholders call for providers to guarantee outcomes following a merger. Guarantees should be enforceable with consequences for violation.

Panel 5

Transparency and Purchaser Incentives

Payers' price transparency tools now offer information on cost and quality, but take-up is low and there is room for improvement. (HCFA)

High-deductible health plans are increasingly prevalent, but cause consumers to scale back care indiscriminately, especially low-income consumers.

- Tiering providers or services on value may be preferable and payment differentials among tiers increase.

Value-based insurance should also focus on upstream decision points: consider financial incentives for consumers to choose PCPs affiliated with high-value systems or ACOs. (AGO)

Consumers in rural areas may not have choices among competing providers.

Some interest in a single state agency to oversee price transparency.

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Draft outline for 2015 Cost Trends Report

Trends in spending and delivery

- Benchmark– spending trends in MA and US
- Components of spending growth within MA
- Trends in provider markets
- Employer premium trends
- Access – financial and geographic
- Quality of care

Progress in aligning incentives

- Payment Reform – trends in MA and US
  - ACOs, global payment, shared savings, P4Q
  - Bundled payments
  - Multi-payer alignment on APMs
  - Providers' needs for data and alignment
- Demand-side incentives
  - Network design, cost-sharing, reference pricing
  - Price transparency

Opportunities to increase quality and efficiency

- *Price variation and site of care delivery*
- *Opportunities to improve acute care use*
  - Preventable admissions, readmissions, ED use
- *Opportunities for improvement across non-acute needs*
  - Serious illness and end of life care
  - Post-acute care
  - Medicaid and long-term care

Recommendations

- Dashboard (summary of current performance and areas for improvement)
- Recommendations from new and previously reported topic areas

System-wide data update

DATA NEEDS	HPC AND CHIA ACTIVITIES
Validated MassHealth data from the APCD	• CHIA is producing basic enrollment and spending trends for MassHealth PCC and FFS members, using APCD data (2011-2013). • HPC is examining enrollment and claims data from APCD for MassHealth MCO plans. • If these data appear valid for the purpose of analyzing cost trends, then HPC will include selected results in 2015 Cost Trends Report.
MBHP data in APCD	• CHIA plans to include 2013 and 2014 data in APCD version 4.0 • CHIA and HPC to discuss including data from prior years
Discharge data that includes free-standing psychiatric hospitals	• **CHIA has completed survey of BH hospitals re operational aspects of data collection.** • **Results to be presented Oct 20.**
Quality data, especially for BH	• **Hearings emphasized the importance of quality data to support APMs, price transparency, and demand-side incentives. Clinical outcomes and patient experience especially relevant.**
BH data, including clinical data exchange, research data, quality and expenditure measures	• **HPC is supporting EOHHS in developing a plan to enhance Mass Hlway for multiple purposes including clinical data exchange.** • **CHART investing in clinical data exchange.** • **SQAC identified BH as a quality measurement priority area.** • **HPC working with EOHHS to select quality measures, including BH measures, for payment reform program.** • **HPC will consider research on measuring BH expenditures in 2016.**

Notes: Bold text represent noteworthy developments since 7/8/2015.

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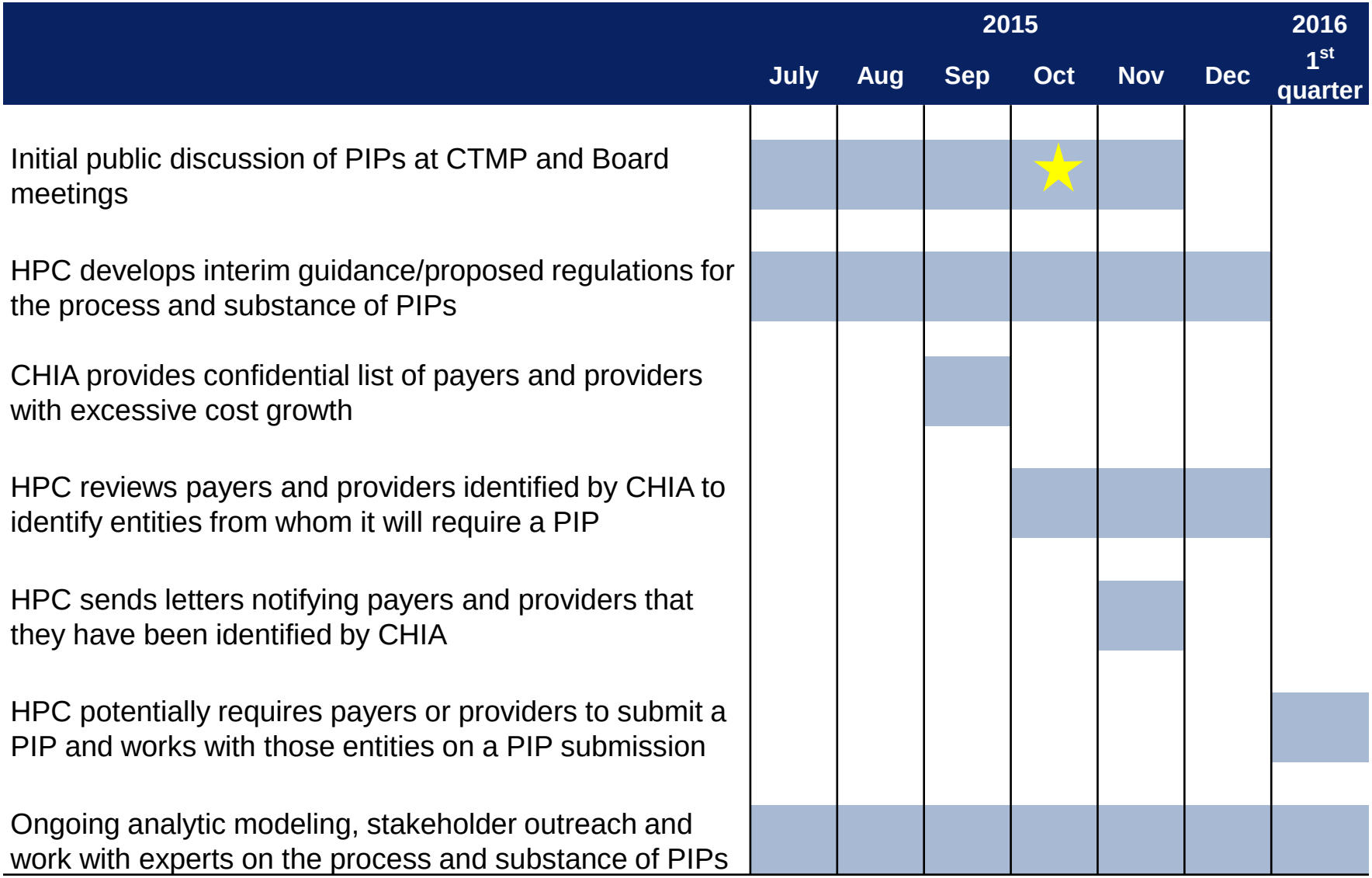
Payer and Provider Performance Improvement Plans

Performance Improvement Plans (PIPs) are a mechanism for the HPC to monitor and assist payers and providers whose cost growth may threaten the state health care cost growth benchmark.

- CHIA is required to provide annually to the HPC a confidential list of payers and providers whose cost growth, as measured by health status adjusted Total Medical Expenses (TME), is **considered excessive and who threaten the benchmark**.
- The HPC is required to **provide notice** to all such payers and providers informing them that they have been identified by CHIA.
- The HPC may require some of the identified payers and providers to file a **PIP** where, after comprehensive analysis and review, the HPC has confirmed concerns about the entity's cost growth and found that the PIP process could result in meaningful, cost reducing reforms.
- The payer or provider must develop the PIP. It must identify and address the causes of its cost growth and include action steps, measurable outcomes, and an implementation timetable of no more than 18 months. The PIP must be **reasonably expected to succeed** and to address the underlying causes of the entity's cost growth.
- Implementation will involve reporting, monitoring, and assistance from the HPC.

Anticipated Timeline for Performance Improvement Plans



All dates are approximate.

Proposed HPC Process for Identifying Payers and/or Providers Required to File a Performance Improvement Plan

Once the HPC receives the confidential list of payers and providers from CHIA, the HPC will validate the list and confidentially provide it to Commissioners.

The HPC will send notices to the identified payers and providers informing them that they have been identified by CHIA.

The HPC will perform a rigorous review of all identified entities by examining a range of factors (outlined on the following slides) to comprehensively understand the entity, its cost growth, and any identifiable causes for such growth.

The HPC will engage with those payers and providers for which the HPC identifies concerns, and may request additional information.

HPC staff will brief Commissioners on the results of this review, including analysis of those payers or providers for which staff recommends a PIP.

HPC staff will present an overview of its analysis and PIP recommendations at a public Board Meeting. **PIPs will require a Board vote**. The HPC will send notices to any entities required to file a PIP.

Any entity required to file a PIP may file a request for extension or waiver with the HPC. **Waivers will require a Board vote**.

This process will be further detailed in interim guidance/proposed regulations.

Potential Payer Factors for Review

- Baseline spending and spending trends over time, including by service category
- Pricing patterns and trends over time, including price variation across the payer's network
- Utilization patterns and trends over time
- Population(s) served and product lines (e.g., patient risk profile, membership changes)
- Size and market share
- Payer financial condition and costs, including non-medical/administrative spending
- Ongoing strategies or investments to improve efficiency and reduce spending growth over time (e.g., adoption of APMs)
- Factors leading to increased costs that may be outside the payer's control

Potential Payer Factors for Review: Example Questions (Slide 1 of 2)

Baseline spending and spending trends over time, including by service category

- What is the payer's baseline spending compared to other payers?
- Has the payer had consistently high spending growth over a number of years or is this year unusual?
- Is the spending growth driven by unusually high spending in a particular service category (e.g., pharmaceutical spending)?
- How has spending growth impacted premiums?

Pricing patterns and trends over time, including variation across the payer's network

- Is there significant variation in price over the payer's network?
- Has the degree of variation been increasing or decreasing over time?

Utilization patterns and trends over time

- Are there changes in the utilization of high-priced providers that may be affecting spending growth?

Population(s) served and product lines (e.g., patient risk profile, membership changes)

- Have there been significant changes in the payer's membership composition that may be affecting spending growth (e.g., changes in the number of high-risk patients)?

Potential Payer Factors for Review: Example Questions (Slide 2 of 2)

Size and market share

- Is the high spending growth across a large population?
- Is the high spending growth across a significant portion of the payer's overall business?

Payer financial condition and costs, including non-medical/administrative spending

- What is the payer's medical loss ratio as compared to other payers, and what has been the trend over time?
- What is the payer's non-medical spending as compared to other payers, and what has been the trend over time?

Ongoing strategies or investments to improve efficiency and reduce spending growth over time

- Is the payer implementing alternative payment methods that have or may be anticipated to affect spending growth in the long term?
- Is the payer implementing value-based insurance designs that have or may be anticipated to affect spending growth in the long term?

Factors leading to increased costs that may be outside the payer's control

- Are there external factors that may be leading to increased utilization or costs across the payer's membership (e.g., introduction of new high-cost pharmaceuticals)?

Potential Provider Factors for Review

- Baseline spending and spending trends over time, including by service category
- Provider price and trends over time
- Utilization patterns and trends over time, including referral patterns
- Population served and services provided (e.g., high-risk patients, public payer patients, low margin services)
- Size and market share
- Financial condition and costs
- Ongoing strategies or investments to improve efficiency and reduce spending growth over time
- Factors leading to increased costs that may be outside the provider's control

Potential Provider Factors for Review: Example Questions (Slide 1 of 2)

Baseline spending and spending trends over time, including by service category

- What is the provider's baseline spending compared to other providers?
- Has the provider had consistently high spending growth over a number of years or is this year unusual?
- Is the spending growth driven by unusually high spending in a particular service category (e.g., pharmaceutical spending)?

Provider price and trends over time

- How do the provider's relative prices compare to other providers in the payer's network, and how have those prices changed over time?

Utilization patterns and trends over time, including referral patterns

- Have there been changes in referrals to high-priced providers that are affecting spending?

Population served and services provided (e.g., high-risk patients, public payer patients, low margin services)

- What is the composition of the population served by the provider group (e.g., number of high-risk patients, public payer patients) and has it changed over time?
- What is the mix of services provided (e.g., high-margin or low-margin services) and has it changed over time?

Potential Provider Factors for Review: Example Questions (Slide 2 of 2)

Size and market share

- Is the high spending growth across a large population?
- What is the provider's market share and is it increasing or decreasing?

Financial condition and costs

- What are the provider's baseline costs per discharge or costs per episode of care and what has been the trend over time?
- What is the provider's financial condition and has it shifted over time?

Ongoing strategies or investments to improve efficiency and reduce spending growth over time

- Are there current investments (e.g., quality improvement initiatives) that have or may be anticipated to affect spending growth in the long term?

Factors leading to increased costs that may be outside the provider's control

- Are there external factors that may be leading to increased utilization or costs across the population served by the provider (e.g., introduction of new high-cost pharmaceuticals)?

Next Steps for the HPC

1. The HPC has received CHIA's confidential list of payers and providers and is performing initial validation and review of identified entities.

2. The HPC anticipates sending notices to entities identified by CHIA in November.

3. The HPC will continue performing analysis and review of identified entities, and will develop its recommendations for PIPs in the coming months.

4. The HPC anticipates releasing interim guidance/proposed regulations on filing and implementing PIPs in winter 2015.

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Contact Information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

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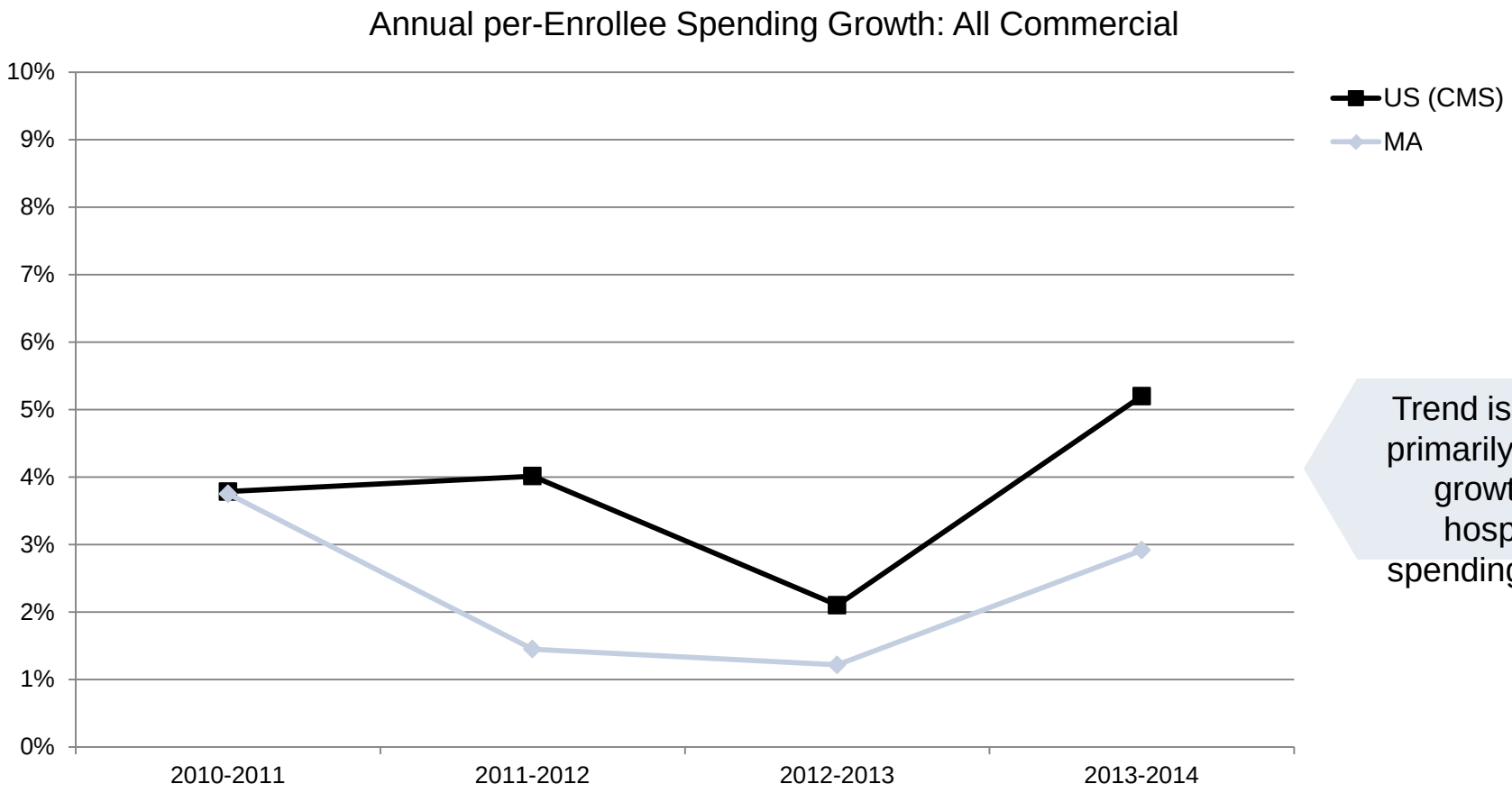
Appendix:
HPC Selected Findings from Cost Trends Report

HPC Selected Findings:

Between 2013 and 2014, commercial per-person spending grew at 2.9 percent in MA, well below the growth rate in the nation as whole

Panel One

Percentage growth in per member per year spending for commercial enrollees in Massachusetts and in the U.S., 2010 - 2013



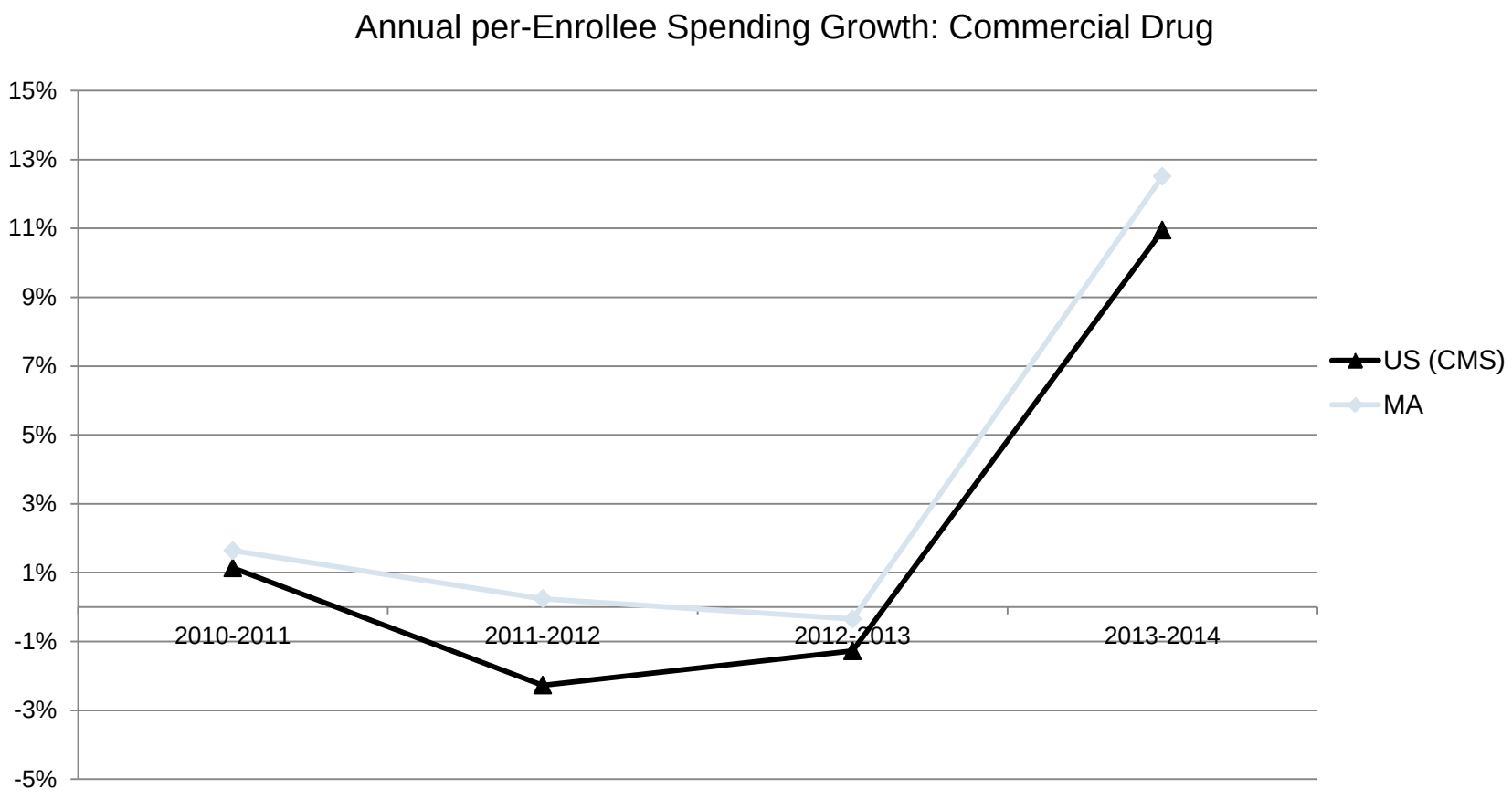
Trend is driven primarily by low growth in hospital spending in MA

Massachusetts data are Total Medical Expenditures for commercial enrollees for which full claims data are available as reported by CHIA. US data are from the Private Health Insurance totals within the National Health Accounts series produced by the Center for Medicare and Medicaid Services (CMS).

HPC Selected Findings:

Massachusetts commercial spending on prescription drugs spending grew significantly in 2014, consistent with the national trend

Panel One



Massachusetts data are Total totals Medical Expenditures for commercial enrollees for which full claims data are available as reported by CHIA. US data are from the Private Health Insurance within the National Health Accounts series produced by the Center for Medicare and Medicaid Services (CMS).

HPC Selected Findings:

Oncology remained MA's top therapy class in 2014 with non-HIV antivirals leading growth due to new Hepatitis C products

Panel One

Top therapy classes by adjusted spending (millions) in Massachusetts

Many top drug classes have substantial annual spending growth, although total spending in earlier years was offset by decreases in other drug classes, due to factors including generic entry

		2010	2011	2012	2013	2014
1	**Oncology**					
	Growth		2.8%	11.2%	7.2%	12.3%
	Spending	$506.1	$520.3	$578.5	$620.0	$696.4
2	**Antiarthritics, Systemic**					
	Growth		15.6%	19.7%	23.5%	28.4%
	Spending	$228.4	$264.1	$316.2	$390.6	$501.5
3	**Non-HIV Antivirals (mostly Hepatitis C)**					
	Growth		37.7%	20.9%	-10.1%	352.3%
	Spending	$64.4	$88.7	$107.2	$96.4	$436.0
4	**Insulin**					
	Growth		15.0%	29.1%	33.7%	19.8%
	Spending	$182.0	$209.3	$270.3	$361.4	$432.9
5	**Antipsychotics**					
	Growth		13.5%	-28.4%	-15.6%	3.8%
	Spending	$499.7	$567.1	$405.9	$342.5	$355.4

Source: Data from IMS Health Incorporated