

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

Cost Trends and
Market Performance

December 2, 2015



Agenda

- Approval of Minutes from the October 14, 2015 Meeting (VOTE)
- Update on the Material Change Notice Process as it relates to Provider-to-Provider Discount Arrangements
- Discussion of Preliminary Findings on Pharmaceutical Spending from the 2015 Cost Trends Report
- Schedule of Next Committee Meeting (January 13, 2016)



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- **Approval of Minutes from the October 14, 2015 Meeting**
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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 October 14, 2015, as presented.

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Discussion Preview: Provider-to-Provider Discount Arrangements

Agenda Topic

Provider-to-Provider Discount Arrangements and Updates to Material Change Notice (MCN) FAQs and MCN Form

Description

Staff will discuss proposed updates to the MCN FAQs and changes to the MCN form to increase transparency of a growing trend it has observed in the market: provider-to-provider discount arrangements. Staff will provide an overview of how such arrangements generally work, and why such arrangements merit further monitoring.

Key Questions for Discussion and Consideration

Commissioners will have the opportunity to ask questions regarding how such arrangements work and to provide feedback on how the HPC should be involved in monitoring these types of arrangements.

Decision Points

No votes proposed. Commissioners will be asked for their feedback on proposed updates to the MCN FAQs and MCN form.

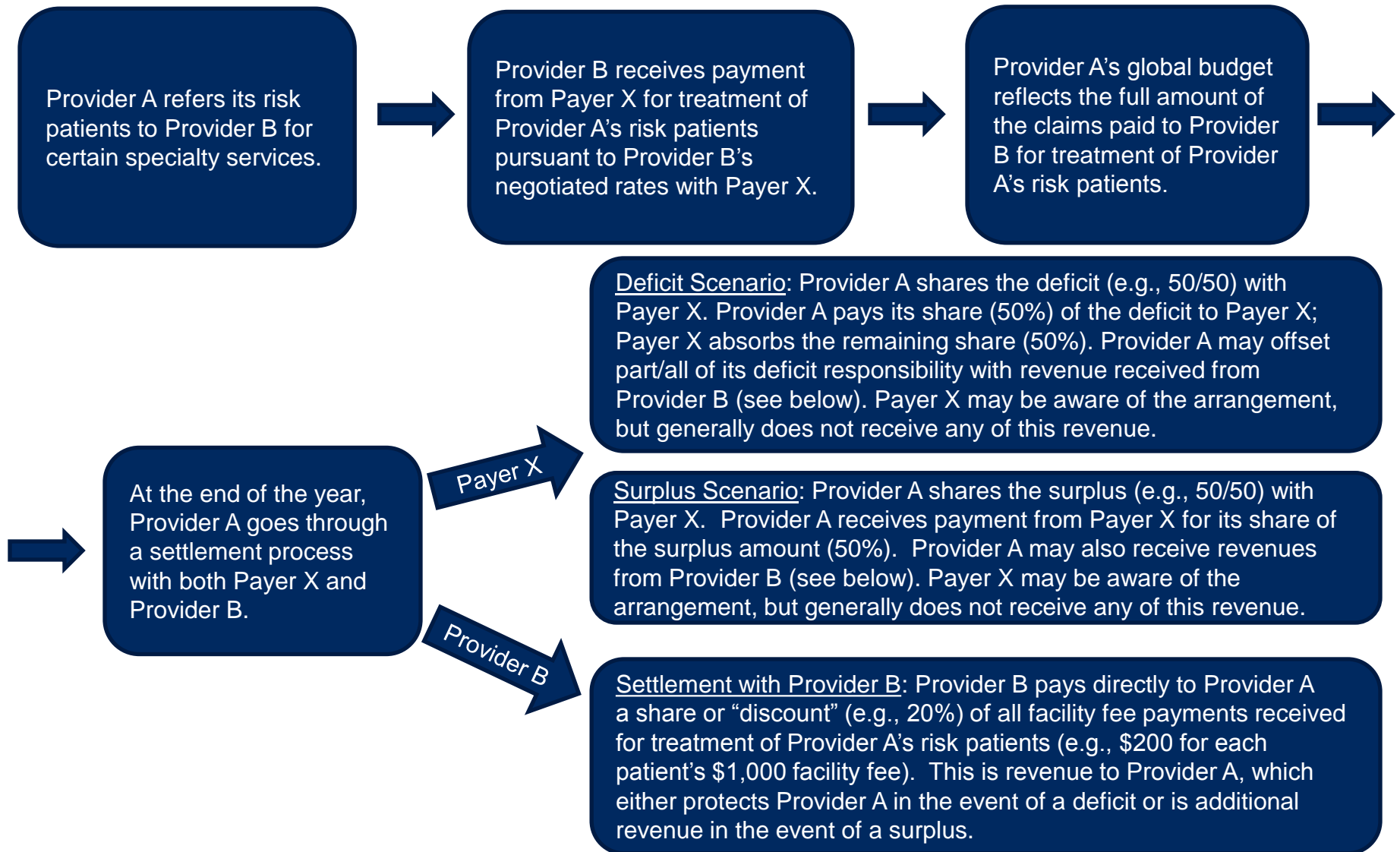
Provider-to-Provider Discount Arrangements

- Through its notice of material change process and inquiries from market participants, the HPC has become increasingly aware of a type of clinical affiliation relationship, a so-called “discount” arrangement, which is not consistently reported to the HPC as a material change.
- Through such “discount arrangements,” providers under risk typically agree to send their risk patients to a preferred provider, and the preferred provider agrees to pay a “discount” back to the referring provider for services rendered to the risk patients.
- The “discount” is typically a pre-determined percentage of the preferred provider’s negotiated rates.
- The HPC is issuing a Frequently Asked Questions document to clarify that entering into this type of relationship **is reportable** to the HPC as a material change.
- The HPC is also proposing minor edits to the material change form to increase transparency around these types of arrangements.

How Discount Arrangements Generally Work

- When the preferred provider renders treatment to the referring provider's risk patient, the preferred provider receives payment from the payer pursuant to the preferred provider's own negotiated rates with the payer.
- At the end of the year, the provider under risk would generally go through a settlement process with *both* the preferred provider and the payer(s) with which they have risk contracts. In the settlement with the preferred provider, the preferred provider transmits to the referring provider the discount amount for the risk patients they treated.
- While payers may be made aware of such arrangements, the discount is *not* generally transmitted back to the payer, reflected in the total medical spending for the risk patients, or accounted for during the global budget settlement process between the provider under risk and the payer.
- Thus, where a provider under risk has a discount arrangement in place, they may receive a sum of money that could either offset any deficit owed to the payer, or supplement any received surplus.
- As part of its ongoing market monitoring function, the HPC intends to monitor such arrangements and assess their impact on incentives for providers under risk to refer to more efficient providers.

How Discount Arrangements Generally Work



How Discount Arrangements Generally Work (Deficit Scenario)

Provider A has a global budget of \$500 PMPM for 1,000 patients with Payer X.

Provider A refers its risk patients to Provider B for certain specialty services.

100 risk patients referred

Provider B receives payment from Payer X for treatment of Provider A's risk patients pursuant to Provider B's negotiated rates with Payer X.

Provider B receives its standard rate of \$200 per claim from Payer X (\$20,000 total for the 100 risk patients)

Provider A's global budget reflects the full amount of the claims paid to Provider B for treatment of Provider A's risk patients.

Provider A's global budget reflects the \$20,000 paid in claims to Provider B

At the end of the year, Provider A goes through a settlement process with both Payer X and Provider B.

Provider A has a total DEFICIT of \$10,000 for the care of its risk patients

Payer X

Settlement with Payer X: Provider A shares the deficit 50/50 with Payer X. Provider A pays its share (50%) of the deficit to Payer X; Payer X absorbs the remaining share (50%). Provider A offsets part/all of its deficit responsibility with revenue received from Provider B (see below).

Provider A is responsible for \$5,000 of the deficit, but offsets the loss with \$4,000 from Provider B (below). Net impact is \$1,000

Payer X absorbs a \$5,000 loss; does not receive any of the \$4,000 paid by Provider B to Provider A

Provider B

Settlement with Provider B: Provider B pays directly to Provider A a share or "discount" (20%) of all payments received for treatment of Provider A's risk patients (\$40 for each patient's \$200 claim).

Provider B pays \$4,000 to Provider A (\$40 for each of the 100 Risk Patients referred by Provider A)

How Discount Arrangements Generally Work (Surplus Scenario)

Provider A has a global budget of \$500 PMPM for 1,000 patients with Payer X.

Provider A refers its risk patients to Provider B for certain specialty services.

100 risk patients referred

Provider B receives payment from Payer X for treatment of Provider A's risk patients pursuant to Provider B's negotiated rates with Payer X.

Provider B receives its standard rate of \$200 per claim from Payer X (\$20,000 total for the 100 risk patients)

Provider A's global budget reflects the full amount of the claims paid to Provider B for treatment of Provider A's risk patients.

Provider A's global budget reflects the \$20,000 paid in claims to Provider B

At the end of the year, Provider A goes through a settlement process with both Payer X and Provider B.

Provider A has a total SURPLUS of \$10,000 for the care of its risk patients

Settlement with Payer X: Provider A shares the surplus 50/50 with Payer X. Provider A receives payment from Payer X for its share of the surplus amount (50%). Provider A also receives revenue from Provider B (see below).

Provider A receives \$5,000 surplus payment from Payer X and also receives \$4,000 from Provider B (below) for a total of \$9,000

Payer X retains a \$5,000 surplus; does not receive any of the \$4,000 paid by Provider B to Provider A

Settlement with Provider B: Provider B pays directly to Provider A a share or "discount" (20%) of all payments received for treatment of Provider A's risk patients (\$40 for each patient's \$200 claim).

Provider B pays \$4,000 to Provider A (\$40 for each of the 100 Risk Patients referred by Provider A)

HPC Next Steps

- The HPC is committed to monitoring these arrangements in order to better understand and evaluate their potential impact on market functioning.
- As the existence of such arrangements has not always been public, the HPC plans to update its MCN Frequently Asked Questions to clarify that such discount arrangements constitute strategically important clinical affiliations and should, thus, be filed as notices of material change.
- The HPC will also be updating the notice of material change form to ask specifically about any financial provisions, in order to increase the transparency of these types of arrangements.
- The HPC is also updating its MCN Frequently Asked Questions to clarify that the \$25 million filing threshold applies to the corporate parent and its affiliates, not simply to the subsidiary directly involved in a transaction.

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- **Discussion of Preliminary Findings on Pharmaceutical Spending from the 2015 Cost Trends Report**
- Schedule of Next Committee Meeting (January 13, 2016)



Discussion Preview: 2015 Cost Trends Report

Agenda Topic

Select findings on pharmaceutical spending from the 2015 Cost Trends Report

Description

Staff will present research on drug spending trends in Massachusetts and the US, including the impact on the benchmark in 2014, drivers of spending growth and factors for future spending.

Key Questions for Discussion and Consideration

What are the implications of pharmaceutical spending for HPC's policy recommendations and work in 2016?

How should drugs and other high-cost innovations be considered in evaluation of state performance on spending and the benchmark?

Should the state require additional research, transparency, and / or reporting on drug pricing?

What are other opportunities at the state level to support innovation and value yet contain costs?

Decision Points

No votes proposed. Commissioners will be asked to provide input on content and policy to inform the 2015 Cost Trends Report.

2015 COST TRENDS REPORT



Massachusetts Health Policy Commission

Topics to be covered

2015 Cost Trends Report

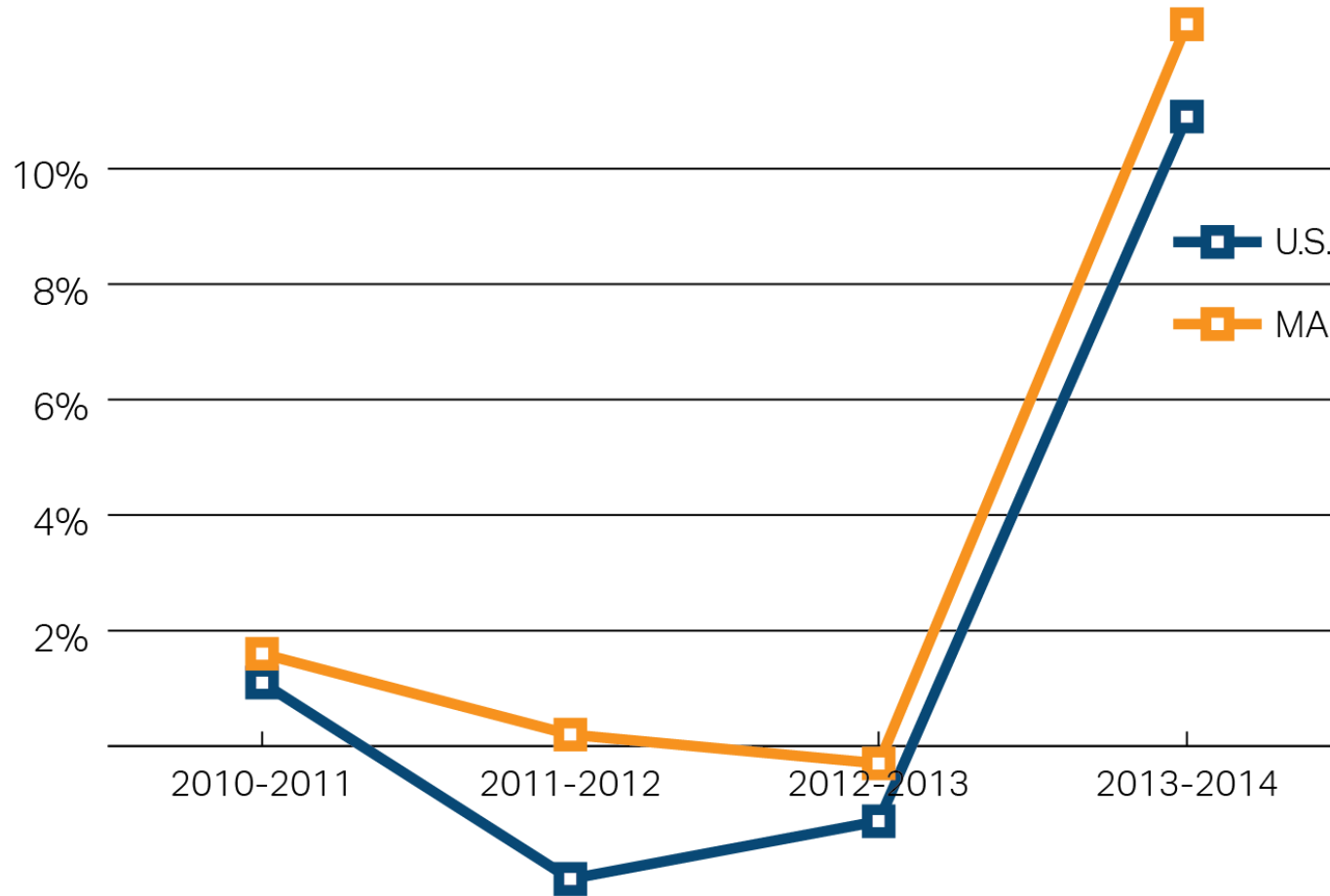
- 1 Spending trends in Massachusetts and the United States
 - Estimated 13% growth in drug spending in MA in 2014
 - Substantial growth in top drug classes, in addition to high spending for Hepatitis C drugs

- 2 Policy considerations for discussion

Pharmaceutical spending rising in both the US and MA

2015 Cost Trends Report

Commercial payers' per-enrollee annual growth rate for prescription drug spending, 2010 - 2014



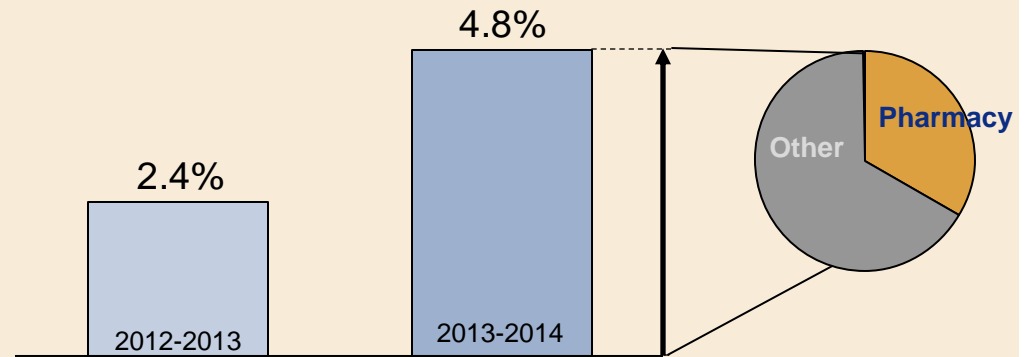
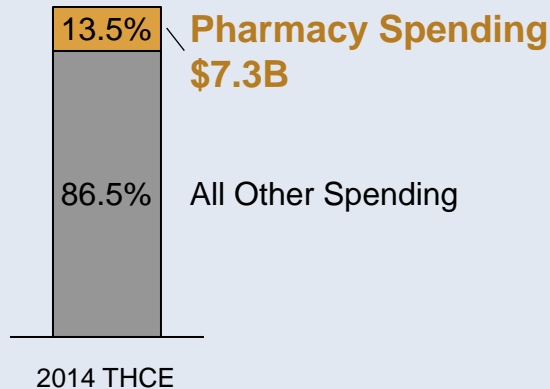
Drug spending is a pressing issue for cost containment

2015 Cost Trends Report

Spending in 2014

In Massachusetts, pharmacy spending grew 13% per capita from 2013 to 2014

Pharmacy Spending accounted for 13.5% of THCE in 2014

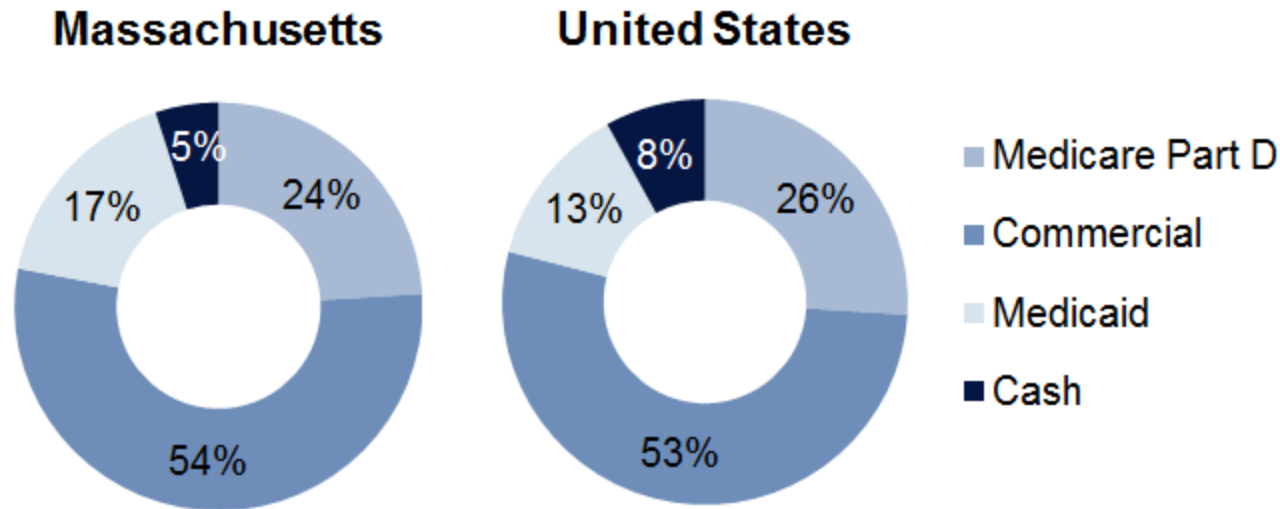


Trends in Massachusetts mirror US growth of 12 percent per capita between 2013 and 2014, after a decade of relatively low growth

Drug spending figures do not account for manufacturer rebates, which could affect both level and trend of spending

Many similar factors drive drug spending in MA as in the US overall

2015 Cost Trends Report



- National nature of drug prices
 - Drug prices for commercial insurers largely determined by negotiations between a national pharmacy benefit management company (PBM) and drug manufacturers
 - Private payers can also negotiate independently with drug manufacturers for additional rebates
 - State Medicaid agencies may negotiate individually with manufacturers or join multi-state consortiums
- Similar payer distribution for prescription drugs

Drivers of national pharmaceutical spending increase in 2014

2015 Cost Trends Report

- 1 New high-cost drugs**
Sofosbuvir (Sovaldi) and other HCV drugs entered the market late 2013 and early 2014 at extremely high prices: \$84k for 12-week treatment with Sofosbuvir
- 2 High drug price increases**
While price increases for brand drugs have greatest impact on total spending, increases for some generics also impact spending and access
- 3 Low rate of patent expirations**

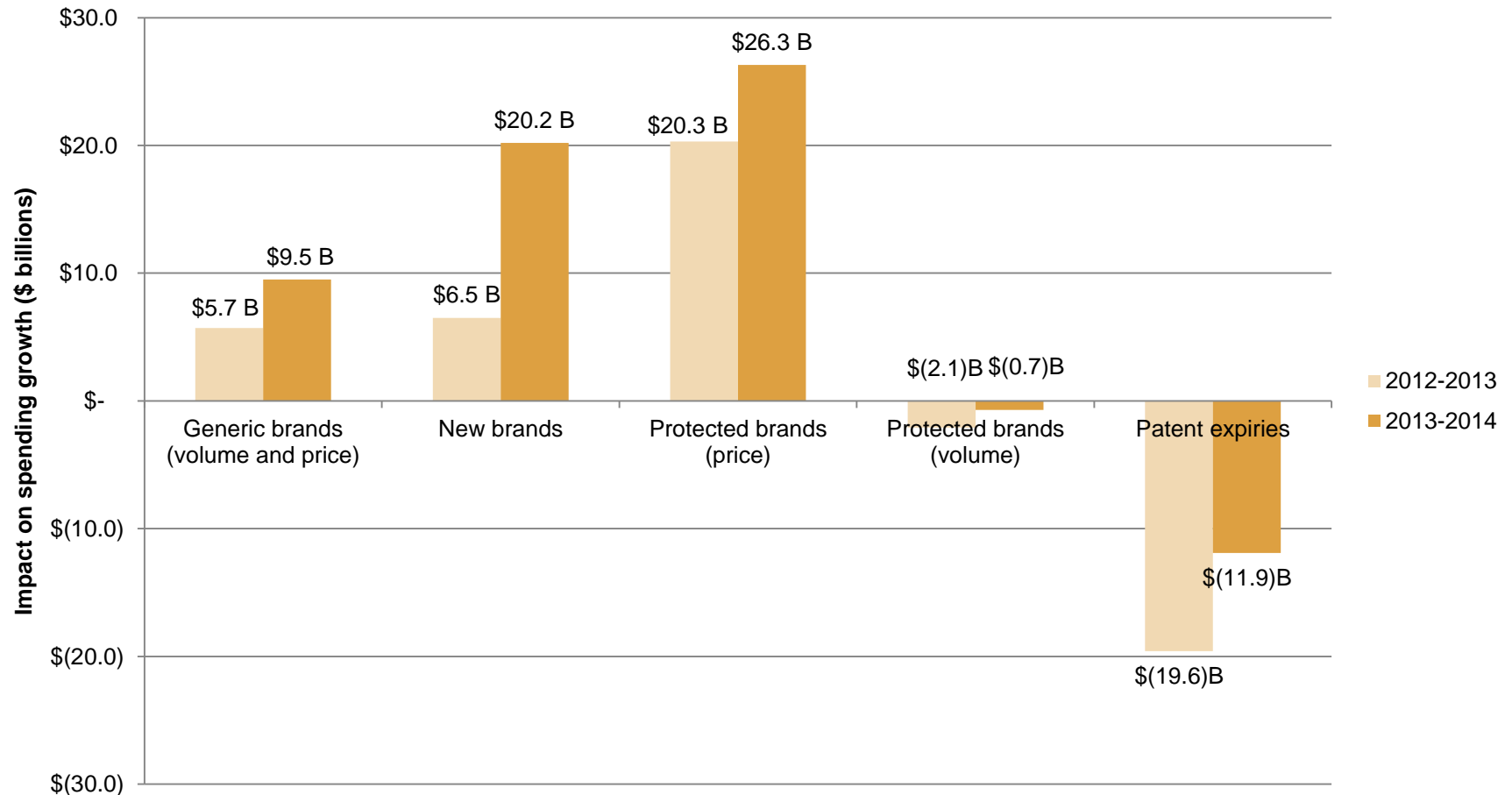
Stakeholder Impact

- Most commercial payers had financial losses due to HCV drugs
 - Sofosbuvir came to market earlier than payers expected due to FDA fast track approval
- Payers worried about meeting the health care cost growth benchmark
- Providers worried about APM budgets
- Consumers may face high cost-sharing and higher premiums

Components of drug spending growth in the US

2015 Cost Trends Report

Estimates of US spending growth for pharmacy and non-pharmacy drugs:
 +\$10.8B to \$330.5B in 2013, +\$43.4B to \$373.9B in 2014

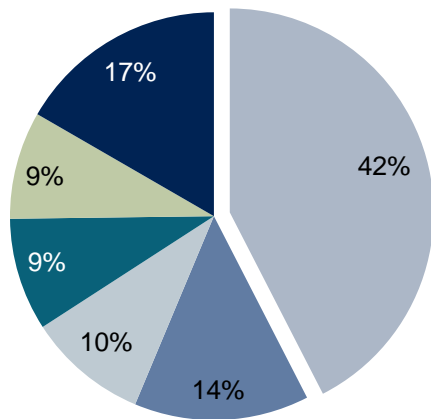


In MA, HCV drugs drove drug spending growth in 2014, but other top contributing therapy classes have had sustained high growth rates

2015 Cost Trends Report

Top therapy classes by contribution to drug spending growth in Massachusetts (dollars in millions)

Contribution to drug spending growth in 2014



- Non-HIV antivirals (mostly HCV)
- Antiarthritics, systemic
- Oncology
- Insulin
- Neurological disorders, other
- Other

	2010	2011	2012	2013	2014	2013 - 2014
1 Non-HIV Antivirals (mostly Hepatitis C)						Difference
Growth		37.7%	20.9%	-10.1%	352.3%	
Spending	\$64.4	\$88.7	\$107.2	\$96.4	\$436.0	\$339.6
2 Antiarthritics, Systemic						
Growth		15.6%	19.7%	23.5%	28.4%	
Spending	\$228.4	\$264.1	\$316.2	\$390.6	\$501.5	\$110.9
3 Oncology						
Growth		2.8%	11.2%	7.2%	12.3%	
Spending	\$506.1	\$520.3	\$578.5	\$620.0	\$696.4	\$76.4
4 Insulin						
Growth		15.0%	29.1%	33.7%	19.8%	
Spending	\$182.0	\$209.3	\$270.3	\$361.4	\$432.9	\$71.5
5 Neurological Disorders, Other						
Growth		40.2%	24.2%	27.0%	39.9%	
Spending	\$77.3	\$108.4	\$134.6	\$171.0	\$239.3	\$68.3

Overall, 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

Source: Data from IMS Health Incorporated.

Note: Spending includes drugs provided in both pharmacy (prescription) and non-pharmacy (e.g. hospital and physician office) settings. IMS estimates are not directly comparable to CHIA methodology; top contributions may represent upper bound estimates.

Many trends point towards ongoing increases in drug spending, as pharmaceutical innovation continues

2015 Cost Trends Report

National Health Expenditures estimates annual high single digit spending growth for drugs in the US over the next decade.

Drug Pricing

Sofosbuvir and other new HCV drugs have very high prices (like “orphan drugs”), but a wider market than the typical orphan drug. This pricing trend will likely continue in new products.

New costly cholesterol drugs. PCSK9 inhibitors treat high cholesterol at a cost of ~\$14k per patient per year.

- The FDA approved the first two products in summer 2015: alirocumab (Praluent) and evolocumab (Repatha)
- Approved for patients with high cholesterol resistant to traditional therapies, but off-label prescribing may capture additional populations

Specialty Drugs

Spending on specialty drugs has grown from 26% to 34% of MA pharmaceutical sales from 2010 to 2014. Such drugs are typically costly, >\$6,000 per year.

In MA, spending for specialty products grew by 67% between 2010 and 2014 compared with 16% growth for traditional products.

Biologics

Biologics are an area of innovation and growth, typically within specialty drugs. They are not amenable to typical generic competition; FDA regulations are still in flux.

- In MA, spending on biologics grew by 56% between 2010 and 2014

Public polling indicates strong support for possible solutions

2015 Cost Trends Report

86%

Favor requiring drug companies to release information to the public on how they set drug pricing⁺



84%

Favor the Medicare program negotiating with drug companies to lower the prices of prescription drugs for seniors^{*}

⁺Kaiser Family Foundation Health Tracking Poll (conducted August 6-11, 2015)

^{*} STAT/Harvard T.F. Chan School of Public Health Poll, November 2015.

Select efforts to slow price growth

2015 Cost Trends Report

Value-based benchmarks

- Third party quantifies the value of a drug, accounting for the therapy's expected clinical benefit, medical savings, and price
- Institute for Clinical and Economic Review (ICER) calculates value-based benchmark price for selected new drugs; plans to evaluate 15-20 drugs over the next two years
- Value can be used in price negotiations and potentially benefit design

Risk-based contracting

- Payers contract with manufacturers to pay less / more depending on whether drug produces expected outcomes
- Harvard Pilgrim Health Care developed a performance-based rebate model for PCSK9 evolocumab (Repatha)

Group purchasing

- Payers pool purchasing power to improve leverage with manufacturers
- Numerous models for Medicaid programs and other participants:
 - Northwest Prescription Drug Consortium: open to all OR and WA residents
 - Minnesota Multi-State Contracting Alliance for Pharmacy: includes 47 states and several cities (MA, CT, IL do not participate)

Policy considerations for discussion

2015 Cost Trends Report

- Implications for HPC's policy recommendations and work in 2016
- How should drugs and other high-cost innovations be considered in evaluation of state performance on spending and the benchmark?
- Should the state require additional research, transparency, and / or reporting on drug pricing (including the ability for the state to cap prices)?
- What are other opportunities at the state level to support innovation and value yet contain costs?

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System-wide data update

DATA NEEDS	HPC AND CHIA ACTIVITIES
Validated MassHealth data from the APCD	<ul style="list-style-type: none"> • CHIA has produced basic enrollment and spending trends for MassHealth PCC and FFS members (spending to 6/2014, enrollment to 8/2015).
MBHP data in APCD	<ul style="list-style-type: none"> • APCD 4.0 includes 2013 and 2014 data from MBHP (no substance use treatment).
APCD general	<ul style="list-style-type: none"> • HPC 2015 Cost Trends Report (CTR) will include data from 3 major commercial payers and Medicare FFS, 2011-2013. • APCD version 4.0 (2014 data) released 11/1/2015. • APCD version 5.0 (2015 data) will be released 6/2016. • HPC expects to have data through 2015v 5.0 in 2016 CTR and to do extensive research on v 4.0 in 2016.
Discharge data for psychiatric hospitals	<ul style="list-style-type: none"> • CHIA's number one priority for Case Mix data. • CHIA estimates project will take 13-18 months.
Quality data BH data	<ul style="list-style-type: none"> • CHIA soon to release their proposal vis data requests of the BH data task force. Public comment will be invited. • HPC is supporting EOHHS in developing a plan to enhance Mass Hlway for multiple purposes including clinical data exchange. .
Other new developments	<ul style="list-style-type: none"> • CHIA planning new data collection <ul style="list-style-type: none"> • Enrollment in narrow network plans • Use of APMs in PPO products, provider-level. (payer-reported)

Notes: Bold text represent noteworthy developments since 10/14/2015.

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Contact Information

For more information about the Health Policy Commission:

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

Follow us: [@Mass_HPC](#)

E-mail us: HPC-Info@state.ma.us

Appendix



Top 20 drug classes by spending

2015 Cost Trends Report

	2010	2011	2012	2013	2014
1. Oncology					
<i>Growth</i>		2.8%	11.2%	7.2%	12.3%
<i>Spending</i>	\$506.1	\$520.3	\$578.5	\$620.0	\$696.4
2. Antiarthritics, Systemic					
<i>Growth</i>		15.6%	19.7%	23.5%	28.4%
<i>Spending</i>	\$228.4	\$264.1	\$316.2	\$390.6	\$501.5
3. Non-HIV Antivirals (mostly HCV)					
<i>Growth</i>		37.7%	20.9%	-10.1%	352.3%
<i>Spending</i>	\$64.4	\$88.7	\$107.2	\$96.4	\$436.0
4. Insulin					
<i>Growth</i>		15.0%	29.1%	33.7%	19.8%
<i>Spending</i>	\$182.0	\$209.3	\$270.3	\$361.4	\$432.9
5. Antipsychotics					
<i>Growth</i>		13.5%	-28.4%	-15.6%	3.8%
<i>Spending</i>	\$499.7	\$567.1	\$405.9	\$342.5	\$355.4
6. HIV Antivirals					
<i>Growth</i>		12.5%	18.0%	9.9%	5.1%
<i>Spending</i>	\$227.0	\$255.4	\$301.4	\$331.1	\$348.0
7. Inhaled Steroids					
<i>Growth</i>		8.2%	10.8%	12.1%	0.7%
<i>Spending</i>	\$256.8	\$277.8	\$307.9	\$345.1	\$347.5
8. Immunomodulators					
<i>Growth</i>		9.5%	21.4%	20.5%	30.8%
<i>Spending</i>	\$128.9	\$141.1	\$171.3	\$206.4	\$269.9
9. GI Anti-Inflammatory					
<i>Growth</i>		12.6%	62.5%	11.6%	-23.2%
<i>Spending</i>	\$164.4	\$185.1	\$300.7	\$335.6	\$257.6
10. Analeptics					
<i>Growth</i>		16.9%	17.4%	2.1%	-1.9%
<i>Spending</i>	\$177.1	\$207.1	\$243.1	\$248.1	\$243.4

	2010	2011	2012	2013	2014
11. Neurological Disorders, Other					
<i>Growth</i>		40.2%	24.2%	27.0%	39.9%
<i>Spending</i>	\$77.3	\$108.4	\$134.6	\$171.0	\$239.3
12. Cholesterol Reducers					
<i>Growth</i>		8.8%	-22.9%	-14.0%	-1.1%
<i>Spending</i>	\$312.6	\$340.1	\$262.2	\$225.5	\$223.1
13. Bronchodilators					
<i>Growth</i>		12.5%	17.1%	0.8%	-6.3%
<i>Spending</i>	\$166.5	\$187.3	\$219.3	\$221.1	\$207.2
14. Anticoagulants					
<i>Growth</i>		-5.0%	-17.5%	-20.1%	3.8%
<i>Spending</i>	\$274.4	\$260.8	\$215.2	\$172.0	\$178.5
15. Analgesic Narcotics					
<i>Growth</i>		4.5%	8.8%	8.1%	2.9%
<i>Spending</i>	\$133.0	\$139.0	\$151.2	\$163.4	\$168.2
16. Specific Antagonists					
<i>Growth</i>		26.2%	27.8%	7.3%	4.8%
<i>Spending</i>	\$88.2	\$111.3	\$142.2	\$152.6	\$160.0
17. Antidepressants					
<i>Growth</i>		-7.6%	-13.0%	8.0%	-27.1%
<i>Spending</i>	\$249.0	\$230.0	\$200.2	\$216.3	\$157.6
18. Hematinics					
<i>Growth</i>		-15.5%	-12.3%	-2.8%	-1.7%
<i>Spending</i>	\$216.2	\$182.6	\$160.1	\$155.6	\$153.0
19. Non-Insulin Diabetes					
<i>Growth</i>		0.4%	-5.7%	-4.3%	16.9%
<i>Spending</i>	\$141.4	\$142.0	\$133.9	\$128.2	\$149.9
20. Seizure Disorders					
<i>Growth</i>		4.2%	-2.3%	18.0%	9.5%
<i>Spending</i>	\$113.2	\$118.0	\$115.3	\$136.0	\$148.9