MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

November 1, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the September 13, 2017 Meeting
- Chairman's Report
- Market Performance
- Research Presentation
- Investment and Certification Programs
- Schedule of Next Board Meeting (December 12, 2017)

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on September 13, 2017 as presented.

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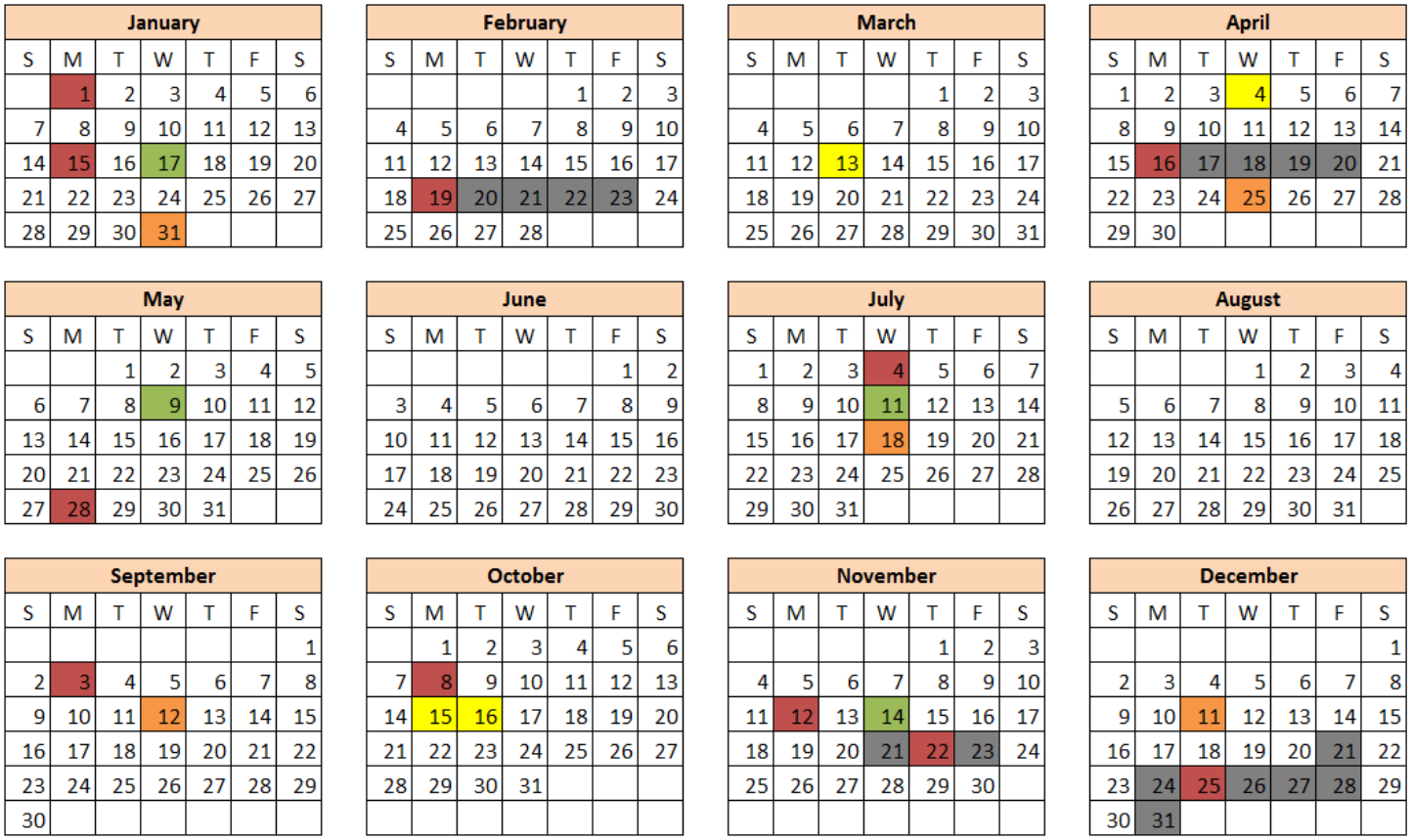
2018 Health Policy Commission Calendar



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Bank Holiday
School Holiday

Board Meeting
Special Event
Advisory Council

Board Meetings
January 31, 2018
April 25, 2018
July 18, 2018
September 12, 2018
December 11, 2018

Special Events
March 13, 2018 - Hearing on the Potential Modification of the 2019 Benchmark
April 4, 2018 - Spring Special Event (TBA)
October 15 and 16, 2018 - 2018 Health Care Cost Trends Hearing

Advisory Council
January 17, 2018
May 9, 2018
July 11, 2018
November 14, 2018

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

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- **Market Performance**
  - Notices of Material Change
  - Preliminary Cost and Market Impact Review: Partners HealthCare and Massachusetts Eye and Ear Infirmary (VOTE)
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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	20	23%
Physician group merger, acquisition, or network affiliation	19	22%
Acute hospital merger, acquisition, or network affiliation	19	22%
Formation of a contracting entity	15	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	9	10%
Change in ownership or merger of corporately affiliated entities	5	6%
Affiliation between a provider and a carrier	1	1%

Notices Currently Under Review

- Proposed acquisition of the non-hospital-based diagnostic laboratory business of **Cape Cod Healthcare** by **Quest Diagnostics Massachusetts,** a subsidiary of a national diagnostic testing provider.

- Proposed acquisition of the non-clinical assets of **Reliant Medical Group** by the **OptumCare business of Collaborative Care Holdings**, a subsidiary of UnitedHealth Group.

- Proposed merger of **CareGroup**, **Lahey Health System**, and **Seacoast Regional Health Systems**, the related acquisition of the **Beth Israel Deaconess Care Organization** by the merged entity, and the contracting affiliation between the merged entity and **Mount Auburn Cambridge Independent Practice Association**.

Received Since 9/13

- Acquisition of eight **Community Health Systems** hospitals in Ohio, Pennsylvania, and Florida by **Steward Health Care**.

- Acquisition of all 18 **IASIS Healthcare Corporation** hospitals by **Steward Health Care**.

Notices Currently Under Review

Received Since 9/13

- Proposed joint venture between **Shields Health Care Group** and **Baystate Health** that would own and operate an urgent care clinic for patients in Baystate's geographic region.

- Proposed clinical affiliation between **Harrington Memorial Hospital** (Harrington), its affiliated physician group, **Harrington Physician Services** (HPS), and **UMass Memorial Health Care** under which several HPS OB/GYN physicians would apply for staff membership and privileges at UMass Memorial Medical Center.

- Proposed acquisition of **AdCare Hospital of Worcester**, a for-profit hospital that provides inpatient and outpatient substance use disorder treatment services throughout Massachusetts and Rhode Island, by the **AAC Healthcare Network**, a national for-profit provider of substance use disorder treatment services.

Elected Not to Proceed

- Proposed acquisition of **Community Health Care d/b/a Health Care Resources Center**, a for-profit provider of opioid dependency treatment services throughout Massachusetts, by **BayMark Health Services**, a national for-profit provider of opioid dependency treatment services.
  - Our analysis suggested little potential for changes in prices or shifts in referral patterns.
  - The parties stated that they do not anticipate any changes to the services CHC provides or the clinical management of CHC.
  - We did not find any evidence suggesting negative impacts on quality or access.

CMIR In Progress

- Proposed acquisition of the Foundation of the Massachusetts Eye and Ear Infirmary and its subsidiaries, including the **Massachusetts Eye and Ear Infirmary** and **Massachusetts Eye and Ear Associates**, by **Partners HealthCare System**.

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Overview of Cost and Market Impact Reviews

The HPC conducts **cost and market impact reviews (CMIRs)** of transactions anticipated to have a significant impact on health care costs or market functioning.

CMIR INPUTS

- Publicly available data and documents
- Confidential data and documents from parties, payers and other providers
- Support from expert consultants, including actuaries, accountants, economists and care delivery experts
- Feedback from Commissioners

CMIR OUTPUTS

- Preliminary report
- Feedback from parties and other market participants
- Final report; transaction may close 30 days later
- Potential referral to Massachusetts Attorney General's Office and/or submission to Department of Public Health Determination of Need Program

About the Transaction

Partners HealthCare proposes to acquire the Foundation for the Massachusetts Eye and Ear Infirmary (MEE), including:

- Its anchor hospital, the Massachusetts Eye and Ear Infirmary (MEEI), and its hospital and clinic satellite locations
- Its physician group, Massachusetts Eye and Ear Associates (MEEA)

The proposed acquisition is also under review by the Department of Public Health's Determination of Need Program.

The parties have identified several goals of this acquisition:

- For MEE to become the system-wide ophthalmology and otolaryngology resource for Partners.
- For MEE to utilize existing Partners facilities to provide its services in more locations with substantially less capital investment than would be required to invest in its own new facilities.
- For MEE to achieve operating cost savings by utilizing Partners corporate services.
- The parties have also stated that they expect to achieve "market competitive rates" for MEEI and MEEA physicians in contracts not already negotiated by Partners.

Background on the Parties: Partners HealthCare System

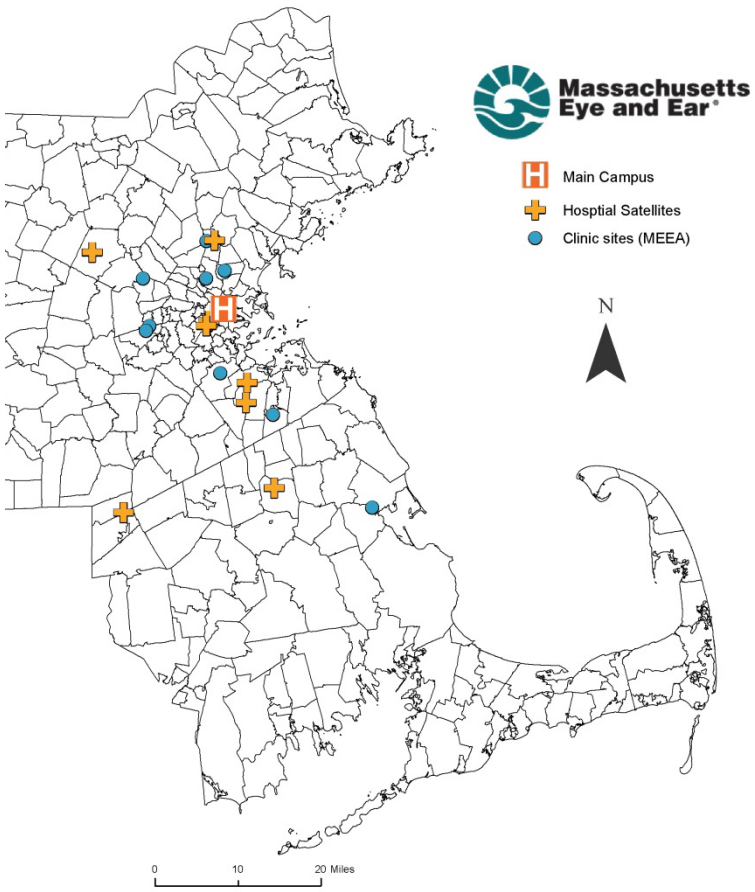
- Largest health system in Massachusetts, with $11.7B in operating revenue in FY15
- Includes:
  - 8 general acute care hospitals in Mass. with 2,928 staffed beds in FY15
  - A specialty psychiatric hospital (McLean)
  - A rehabilitation network (Spaulding)
  - A home health agency
  - An insurance carrier
  - A physician group, PCPO, contracting on behalf of more than 6,700 physicians
- Partners' hospitals and physician groups are among the highest priced in the Commonwealth
- Partners hospitals do not participate in a number of limited network products and Medicaid MCO networks, and are often in the highest-priced tier of tiered network products

Background on the Parties: Mass. Eye and Ear

Massachusetts Eye and Ear®
sense life. experience life.

- Acute care hospital specializing in ophthalmology and otolaryngology
- 18 locations in Massachusetts, including the main campus in Boston with 41 beds (21 adult, 20 pediatric), and 8 hospital satellites
- Approximately $163M in net patient service revenue; 90% of patient revenue is from outpatient services
- Medical group, Mass. Eye and Ear Associates (MEEA), includes approximately 200 employed specialists who already contract through the Partners network with the three largest commercial payers
- MEEA physicians have dual appointments at MEEI and MGH and serve as MGH's ophthalmology and otolaryngology departments

MEE Hospital and Physician Practice Sites



HPC

Review Structure

Costs and Market Functioning → **Care Delivery and Quality** → **Access**

The HPC evaluated the **Baseline Performance** and current trends for each of the parties across these areas.

Then, we evaluated the **Impact of the Transaction** across these areas.

Cost and Market Baseline: Key Findings

- Partners is the largest health care system in the state, with high inpatient, outpatient, and physician market shares.
- MEEI provides more outpatient otolaryngology and ophthalmology services than any other provider in its service area, but a relatively small share of inpatient services. Partners provides some overlapping services, particularly outpatient otolaryngology.
- Partners' hospitals and physicians garner some of the highest prices in the state, and its primary care patients have among the highest health status adjusted medical spending.
- MEE has substantially lower prices than Partners, and is frequently treated by payers as a more efficient provider than Partners providers in tiered and limited network products.

Partners is the largest healthcare system in the state.

Commercial inpatient and outpatient market share statewide

2016 CHIA hospital discharge data and 2014 APCD data for the three largest payers

Hospital System/Network	Share of Inpatient Discharges	Share of Outpatient Facility Visits
Partners	27.0%	26.7%
BIDCO	14.0%	13.0%
Lahey	8.1%	10.6%
UMass	7.0%	5.4%
Wellforce	6.2%	6.5%
Steward	5.9%	5.6%
All Other	31.9%	32.2%

Commercial primary care market share statewide

2014 APCD data for the three largest payers

Physician Network	Share of Primary Care Physician Visits
Partners	15.8%
Steward	10.7%
Children's	9.8%
Wellforce	9.0%
All Other	54.4%

MEE provides more outpatient otolaryngology and ophthalmology services than other providers in its service area.

Shares of commercial outpatient facility visits in MEEI's PSA

2014 APCD data for the three largest payers

Hospital System/Network	Share of Otolaryngology Visits
MEEI	26.5%
Partners	18.7%
Children's	16.0%
Lahey	7.1%
HealthSouth	6.2%
All Other Combined	25.5%

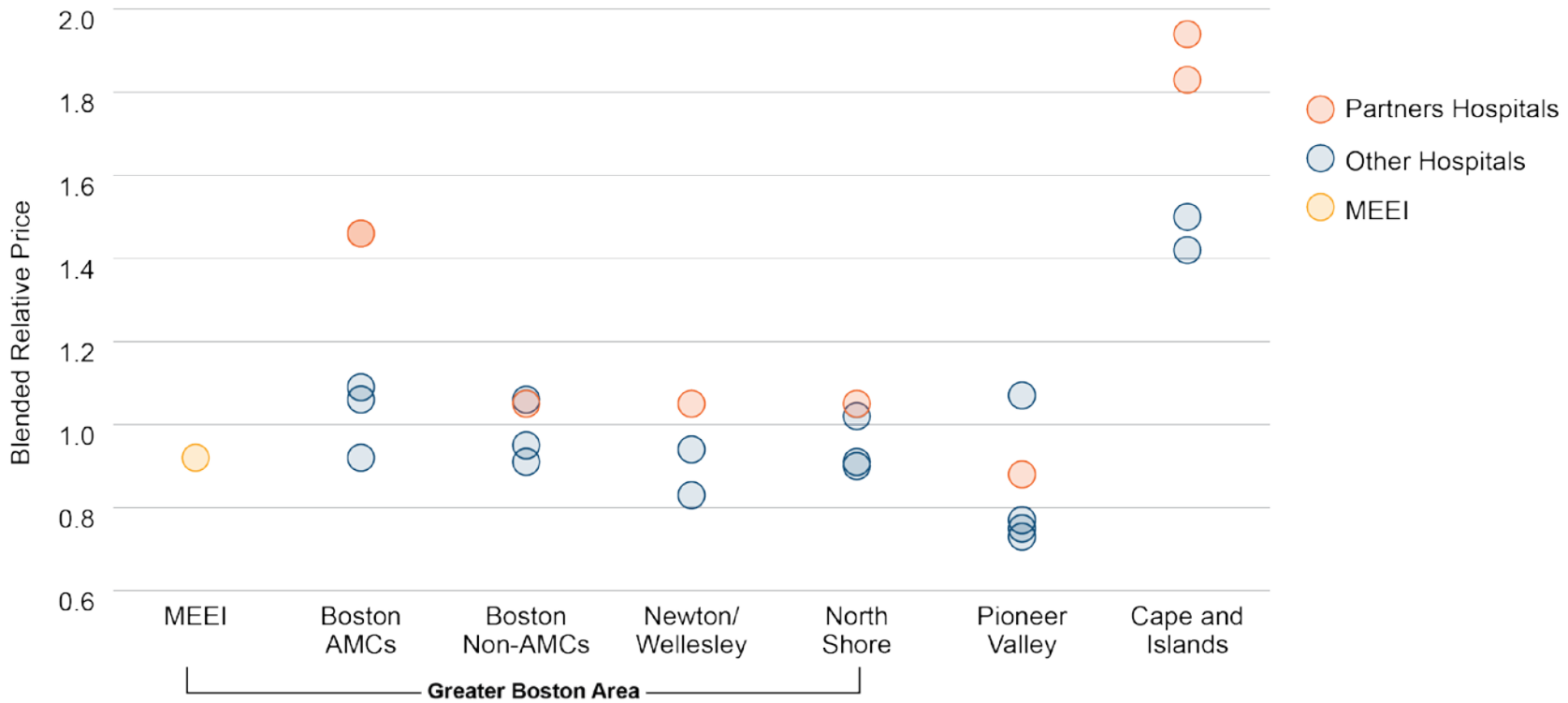
Hospital System/Network	Share of Ophthalmology Visits
MEEI	34.6%
Wellforce	16.1%
Lahey	11.5%
BMC	8.9%
Partners*	1.0%
All Other Combined	27.9%

Note: Although other providers have higher ophthalmology shares, Partners' share is shown for reference

- MEEI facilities do not provide a substantial share of inpatient or all outpatient services.
- Partners facilities provide some services that overlap with MEE, particularly outpatient otolaryngology. Partners physicians also provide a substantial share of ophthalmology services in non-facility settings and in non-Partners facilities.

Partners hospitals and physicians receive some of the highest prices in the state; its community hospitals and AMCs are higher priced than MEEI.

Inpatient and Outpatient Blended Relative Price for Partners Community Hospitals and AMCs, MEEI, and Local Comparators - BCBS 2015



Local Comparators: **Boston AMCs:** BWH, MGH, Beth Israel Deaconess MC, Boston MC, Tufts MC; **Boston Non-AMCs:** BWH-Faulkner, Carney Hospital, Norwood Hospital, St. Elizabeth's MC; **Newton/Wellesley:** Newton-Wellesley Hospital, BID-Needham, Mt. Auburn Hospital; **North Shore:** NSMC, Hallmark Health, Lahey Hospital and Medical Center, Northeast Hospital; **Pioneer Valley:** Cooley Dickinson, Baystate MC, Holyoke MC, Mercy Hospital, Noble Hospital; **Cape and Islands:** Martha's Vineyard, Nantucket, Cape Cod Hospital, Falmouth Hospital

MEE has substantially lower prices than Partners, and is frequently treated by payers as an efficient provider in tiered and limited networks.

- For the three largest payers, Partners' inpatient hospital prices are approximately 11.5% higher (for some of its community hospitals) to 34.6% higher (for MGH) than MEEI's prices.
- For the three largest payers, Partners' outpatient hospital prices are approximately 6% - 52% higher (for some of its community hospitals) to 58% - 105% higher (for MGH) than MEEI's prices.
- MEEA physicians have low to mid-range prices for those payers for which they don't already contract through Partners. Partners' physician prices are higher.
- Reflecting its relative efficiency, MEEI is frequently included in limited network products and placed in the most efficient tier of tiered network products.

Quality Baseline: Key Findings

- Partners is generally a high-quality provider system, performing equal to or above the state average on most of the measures we examined.
- Fewer standard measures are applicable to MEE, as a specialty provider, but MEEI generally performs well on applicable quality measures.
- Partners and MEE both demonstrate notable commitment to high quality care through their internal quality measurement and reporting systems.

Access Baseline: Key Findings

- MEEI is the principal provider of a small number of uncommon specialty services in its service area.
- MEEI participates in more limited network insurance products and Medicaid MCO networks than Partners hospitals, and is generally in more favorable cost sharing tiers in tiered network products.
- MEEI and most Partners hospitals have higher commercial payer mix and lower Medicaid payer mix relative to comparator hospitals.

MEEI participates in more limited network products than Partners and is in more efficient tiers than Partners for tiered network products.

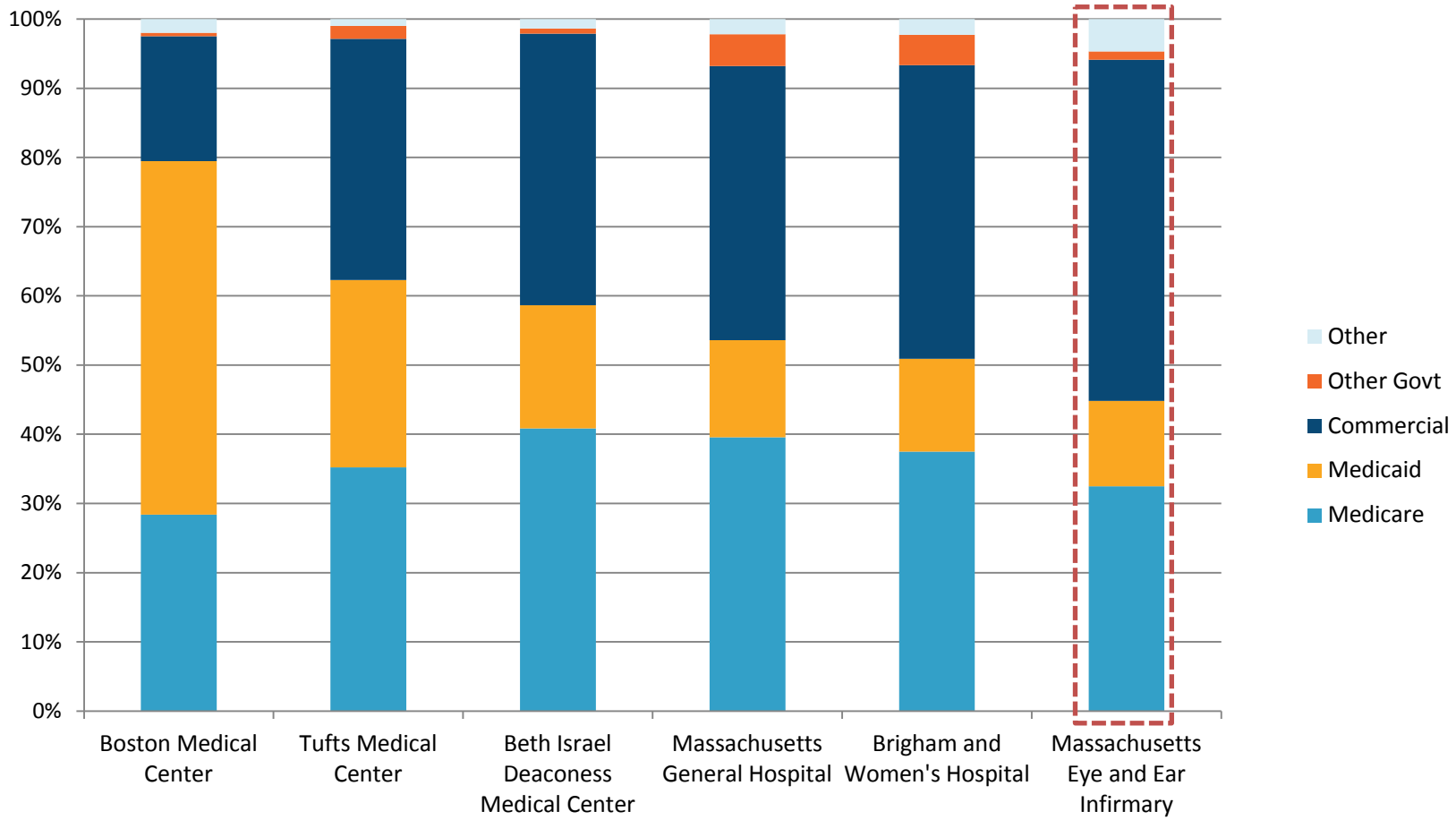
Hospital	Tiered and Limited Networks for the Three Largest Commercial Payers					
	BCBS		HPHC		THP	
	Limited Network	Tiered Networks	Limited Network	Tiered Networks	Limited Network	Tiered Networks*
MEEI	In Network	Most Efficient	In Network	Most Efficient	Out of Network	Most Efficient
BWH	Out of Network	Least Efficient	Out of Network	Least Efficient	Out of Network	Least Efficient
MGH	Out of Network	Least Efficient	Out of Network	Least Efficient	Out of Network	Least Efficient
BWH Faulkner	Out of Network	Most Efficient	Out of Network	Middle	Out of Network	Least Efficient
Newton-Wellesley	Out of Network	Most Efficient	Out of Network	Middle	Out of Network	Least Efficient
NSMC	Out of Network	Most Efficient	Out of Network	Middle	Out of Network	Least Efficient

MEEI participates in more Medicaid Managed Care Organization products than Partners.

Hospital	Medicaid Managed Care Organization Payer			
	BMC HealthNet Plan	CeltiCare Health Plan	Neighborhood Health Plan	Tufts Health Public Plan
MEEI	In Network	Out of Network	In Network	In Network
BWH	Out of Network	Out of Network	In Network	Out of Network
MGH	Out of Network	Out of Network	In Network	Out of Network
BWH Faulkner	Out of Network	Out of Network	In Network	Out of Network
Newton-Wellesley	Out of Network	Out of Network	In Network	Out of Network
NSMC	In Network	Out of Network	In Network	Out of Network

MEEI and most Partners hospitals have higher commercial payer mix and lower Medicaid mix than comparator hospitals.

Combined Inpatient and Outpatient Payer Mix for MEEI and Boston-area AMCs- 2016 GPSR



Note: Graph is in descending order of government payer patients, which is the sum of the yellow (Medicare), dark blue (Medicaid/CHIP) and orange (Other Government) bars.
Source: CHIA *Hospital Cost Report Data Access Tool* (FY 2016 data).

Cost and Market Impact: Key Findings

- The transaction is not anticipated to substantially increase Partners' overall hospital inpatient or outpatient market share. However, the transaction would substantially increase its share of outpatient otolaryngology and ophthalmology services.

- Partners would likely seek substantial hospital rate increases for MEEI's main campus and hospital-licensed outpatient sites after an acquisition.

- Over time, we estimate that health care spending would increase by **$14.9 million to $55.3 million annually** if Partners achieves parity between MEEI's rates and those of Partners' other hospitals, consistent with Partners' past practice.

- As the MEEA physicians join Partners contracts for all commercial payers, changes in MEEA's physician rates would additionally increase total medical spending in Massachusetts by approximately **$5.9 million annually**.

- The parties claim that the transaction would yield operational efficiencies and allow MEEI to avoid capital expenditures. However, they have not committed to using any resulting savings to reduce prices or otherwise reduce spending for payers or consumers.

Impact on Specialty Inpatient and Outpatient Services

Shares of commercial inpatient discharges in MEEI's PSA

2016 CHIA hospital discharge data

Hospital System/ Network	Share of MEEI Core Service Discharges Post-Acquisition
Partners + MEE	37.6% (34.0% + 3.5%)
BIDCO	12.7%
Lahey	12.1%
Wellforce	8.0%
Children's	7.9%
All Other Combined	21.7%

Shares of commercial outpatient facility visits in MEEI's PSA

2014 APCD data for the three largest payers

Hospital System/ Network	Share of Otolaryngology Visits Post-Acquisition
MEEI + Partners	45.2% (26.5% + 18.7%)
Children's	16.0%
Lahey	7.1%
HealthSouth	6.2%
All Other	25.5%

Hospital System/ Network	Share of Ophthalmology Visits Post-Acquisition
MEEI + Partners	35.6% (34.6% + 1.0%)
Wellforce	16.1%
Lahey	11.5%
BMC	8.9%
All Other	27.9%

HPC

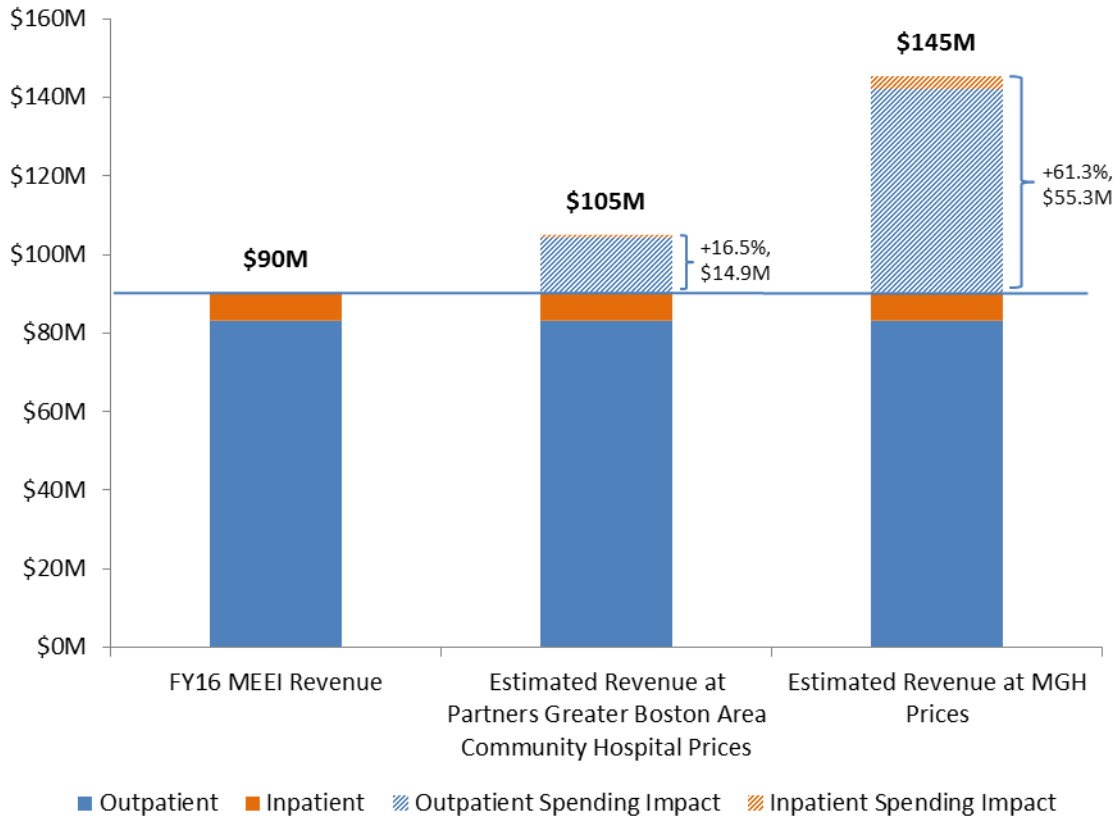
Overview of Spending Impacts

Our analysis suggests that the proposed transaction would likely increase health care spending for commercial payers due to rate increases in three areas:

	Spending Included in Category
Hospital inpatient rates	Facility billing for hospital inpatient services if MEEI's rates increase to be comparable to other Partners hospitals
Hospital outpatient rates	Facility billing for hospital outpatient services (both at MEEI's main campus and at hospital-licensed outpatient sites) if MEEI's rates increase to be comparable to other Partners hospitals
MEEA physician rates	Professional billing for physician services in hospital inpatient, hospital outpatient, and clinic settings as MEEA physicians join Partners contracts with the remaining payers

There would be a substantial increase to hospital spending over time if Partners achieves parity in prices between MEEI and its existing hospitals.

The proposed transaction could increase commercial health care spending by **$14.9 million to $55.3 million annually** if Partners achieves parity between MEEI rates and those of its other hospitals, which would be consistent with past practice.



There would be an immediate increase to physician spending if MEEA physicians join all Partners' commercial payer contracts.

- The proposed transaction would increase commercial health care spending by **$5.9 million** if MEEA physicians join Partners contracts for the payers for which MEEA currently negotiates independently.
- Unlike for hospital price changes, which would require contract renegotiation, price changes for MEEA physicians may occur immediately as these physicians join existing Partners contracts.

*In total, the proposed transaction is projected to increase commercial health care spending by **$20.8 million** to **$61 million annually** from hospital and physician rate increases combined.*

The parties have not committed to using any savings from operational efficiencies to reduce prices or otherwise reduce spending.

The parties claim that the transaction would yield operational efficiencies and allow MEEI to avoid capital expenditures:

- MEEI anticipates a need for new additional operating rooms due to increasing demands for its services. By utilizing available operating room capacity at Partners sites, MEEI expects to avoid capital expenditures.

- In addition, the parties have identified several areas where they expect to achieve operational efficiencies. These include integration of administrative and information technology functions, sharing the costs of research infrastructure, and improved borrowing rates for MEE.

Despite the parties' expectation that these efficiencies would improve MEE's margins and support its clinical and research activities, they have not committed to using the resulting savings to reduce prices or otherwise reduce spending for payers or consumers.

Quality Impact: Key Findings

The parties have stated that the proposed transaction would improve quality by:

- Integrating MEE into the Partners ACO model and integrating the parties' quality data and measurement programs.
- Removing current HIPAA restrictions on sharing protected health information that prevents clinicians from having "complete" access to a patient's medical record.

- It is unclear to what extent additional integration into Partners' data infrastructure would meaningfully alter MEE's already-strong quality performance.
- The parties have not described how the transaction would change ACO participation and incentives for MEEA physicians, who already participate in Partners contracts with the top three commercial payers.
- While changes in the parties' shared EHR system may result in administrative efficiencies, the potential impact on overall clinical quality is uncertain.
- The parties have not provided sufficient information for HPC to assess the appropriateness of the quality improvement measures they have proposed.

Access Impact: Key Findings

The parties have stated that the proposed transaction would improve patient access to care by:

- Making MEEI the Partners system-wide resource for ophthalmology and otolaryngology services,
- Meeting a growing need for ophthalmology and otolaryngology services by enabling MEE to provide services at Partners community facilities, and
- Ensuring that MEE can remain viable as a provider of specialty services in a market shifting to ACO structures.

- It is unclear why the proposed merger is necessary for MEE to be the Partners system-wide resource.
- Without details on where MEE may offer new or expanded services, the HPC cannot evaluate to what extent MEE's already broad geographic presence would expand.
- Patient volume at MEE has increased substantially in recent years, despite its status as an independent provider.
- If MEE were to adopt Partners contracting patterns, patients in limited and tiered plans may face barriers to accessing MEE's services, potentially creating barriers to access for the specialized services MEE provides.

Next Steps

- Per M.G.L. c. 6D, § 13, the HPC issues a preliminary report
- The parties will have the opportunity to respond, and the Commission will issue a final report thereafter
- The parties may not close the transactions until at least 30 days following the issuance of the final report

MASSACHUSETTS
HEALTH POLICY COMMISSION

Vote: Issuance of a Preliminary CMIR Report

Motion: That, pursuant to section 13 of chapter 6D of the Massachusetts General Laws, the Commission hereby authorizes the issuance of the attached preliminary report on the cost and market impact review of Partners HealthCare System's proposed acquisition of the Foundation of the Massachusetts Eye and Ear Infirmary.

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Executive Summary and Key Findings

Goal of the study

- Building off past HPC reports[1], this study analyzes a sample of commercial health insurance claims to better understand the characteristics of out-of-network billing in Massachusetts.
- This analysis is intended to inform the discussion of policies to address out-of-network billing in order to protect consumers, improve market functioning, enhance the viability of limited network products, and reduce costs.

Key findings

- The HPC examined 70,000 distinct out-of-network claims in two of the largest commercial payer networks in 2014, representing over 30,000 members.
- Across a range of identical services, the average spending on out-of-network claims far exceeded the average spending on in-network claims
- In almost 2/3 of the cases, the insurer paid the full charge amount of an out-of-network claim; in other cases, the patient may have been liable for partial or full payment
- Ambulance and ERAP providers (emergency, radiology, anesthesiology, or pathology) accounted for over 90% of out-of-network claims
- Average out-of-network payment rates for common ambulance services exceeded in-network rates by 22% to more than 200%
- For non-emergency ambulance transportation services, average out-of-network payment rates exceeded $1,100, compared to an in-network average payment rate of approximately $340
- Average out-of-network payment rates for common ED visits were around 70% higher than in-network rates

1 HPC 2016 Annual Cost Trends Report; HPC 2015 Annual Cost Trends Report; HPC 2015 Policy Brief on Out-of-Network Billing

Background on Out-of-Network Billing

- Out-of-network billing occurs when patients receive services from providers that do not have a negotiated rate with the patient's insurer
  - Sometimes patients see out-of-network providers knowingly
  - But, often, it is outside of the patients' control, e.g.
    - a third party firm staffing an **Emergency Department** (ED) at an in-network hospital; or
    - an **out-of-network physician** participating in a surgery without the patient's knowledge; or
    - an **ambulance company** serving a geographic region.
- With no negotiated rate, payment to providers is typically based on a price that providers set for their services
  - Payers may pay some or all of these charges, but they typically pay a higher rate for these out-of-network services than they would pay in-network.

Out-of-Network Billing Implications for Payers, Consumers, and Overall Market Functioning

- When payers pay higher rates to out-of-network providers:
  - Those costs are passed along through **higher premiums**; and
  - The costs of out-of-network payments may **diminish or even surpass any savings** the payer may be able to achieve through **limited network products**.
- If a payer does not pay the full amount charged by an out-of-network provider, the patient can be "**balance billed**" and expected to pay the difference, sometimes totaling thousands of dollars.
  - This can occur even where the patient did not knowingly choose to see an out-of-network provider (e.g. through a "surprise bill").

Because of the cost of out-of-network billing, some payers seek to bring as many providers in-network as possible, even at higher negotiated rates.

Looking at *frequency* of out-of-network billing, particularly for the largest/broadest payer networks, therefore understates the impact of out-of-network billing on total health care spending.

National Research and Data on Out-of-Network Billing

- Using data from one of the largest national insurers, Cooper and Morton (2016) found that **22%** of ED visits nationally involved an out-of-network ED physician[1]

- In a follow-up study (2017) using data from the same payer they found[2]
  - **50%** of hospitals nationally have rates of out-of-network billing below **5%**; **15%** have a rate of out-of-network billing above **80%**
  - Rates of out-of-network billing are substantially higher at for-profit hospitals
  - Outsourcing emergency staffing is a lead contributor to out-of-network billing
    - **2/3** of hospitals nationally outsource ED staffing (for comparison, **1/3** of Massachusetts hospitals substantially outsource ED staffing[3])

1 Cooper Z, Morton FS. Out-of-Network Emergency Physician Bills—An Unwelcome Surprise. Health Affairs; 2016 Nov 17.

2 Cooper Z, Morton FS, Shekita N. Surprise! Out-of-Network Billing for Emergency Care in the United States. National Bureau of Economic Research; 2017 Jul 20.

3 Registration of Provider Organizations, hospitals fall into this category if they report that an outside provider group provides "complete or substantial staffing" of their ED

HPC Study of Out-of-Network Claims

- Out-of-network billing was identified by the HPC as an area of policy interest in the 2015 and 2016 Annual Cost Trends reports. Building off of past analyses, the HPC sought to better understand the characteristics of out-of-network billing in Massachusetts using the all-payer claims database (APCD).

- We used 2014 claims from **two** large MA commercial payers that together represent **over 50%** of the Massachusetts commercial market
  - We identified out-of-network claims by using the 'in network' designation submitted by these payers
  - Claims are from MA residents under 65 who received care in Massachusetts
  - Professional claims only (excludes facility claims)

- Sample is limited to sites of service that could have involved multiple providers or resulted in a surprise out-of-network bill:
  - Emergency department
  - Ambulance
  - Hospital inpatient
  - Hospital outpatient
  - Ambulatory surgical centers
  - Urgent care

All acute care hospitals in Massachusetts are in both payers' networks.

Important Context and Caveats

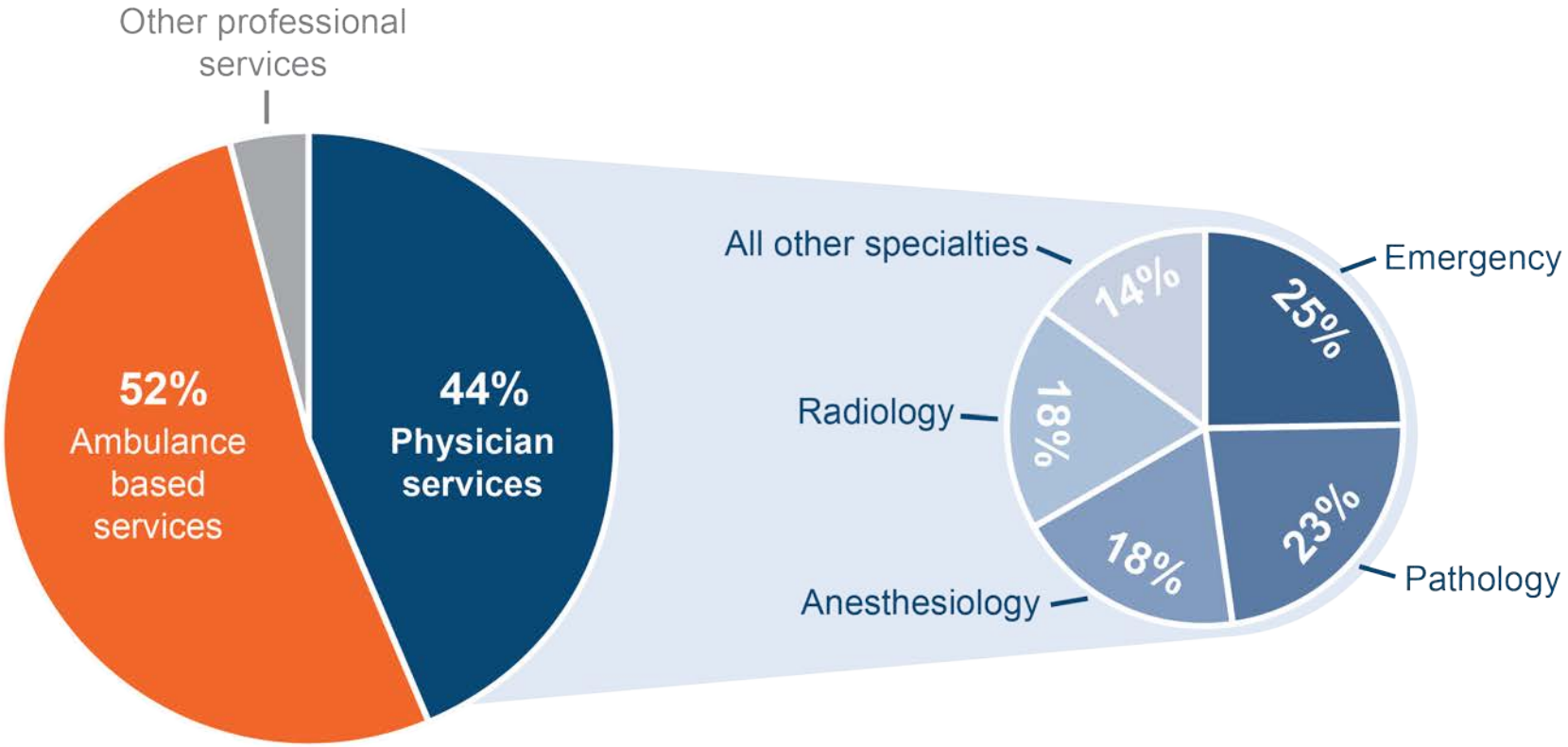
- Our estimates apply only to the portion of the Massachusetts commercial market covered by the two payers in our sample
- Estimates about the frequency and scale of out-of-network billing based on these two payers **are likely to be conservative**:
  - These are two of the largest payers in Massachusetts with the broadest networks
  - The broader a payer's network, the less likely it is that its members will encounter out-of-network providers
  - Insurers that are dominant in a particular market have more leverage to bring local providers into their networks.
  - Even between the two payers in this sample, the one with the larger market share has a lower rate of out-of-network billing
  - Estimates of out-of-network billing for payers with a national presence are much higher[1]

HPC

1 The four largest national payers made up 24% of the MA commercial market in March 2017 (CHIA Enrollment Trends, 2017)

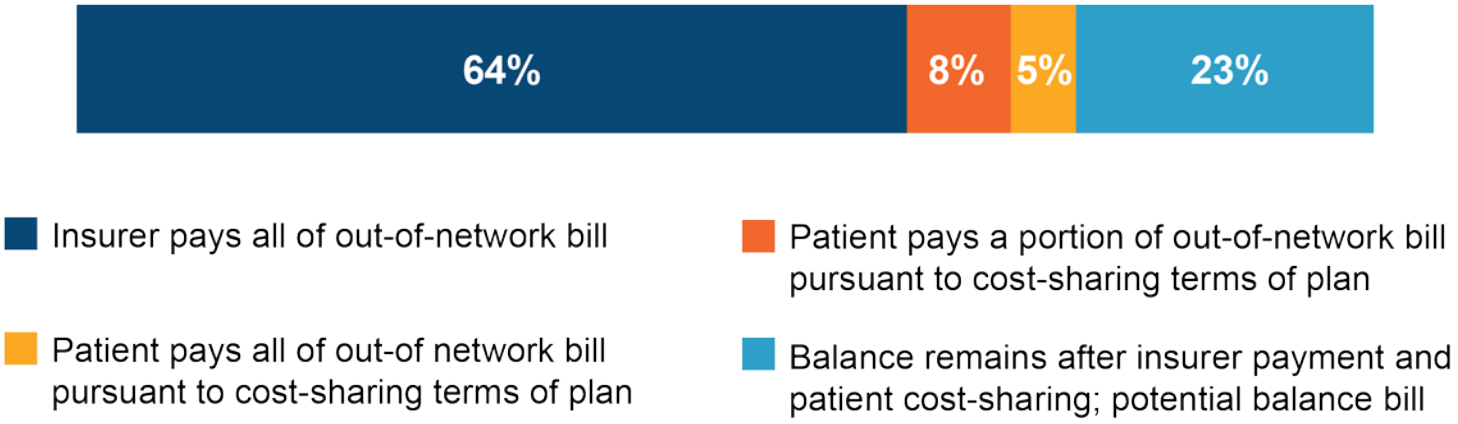
By service/provider type, ambulance and ERAP providers account for 90% of out-of-network claims

- The HPC identified **70,107** out-of-network professional claims for services provided to **30,538** individuals
- Claims for ambulance-based services are the largest share of out-of-network claims for professional services
- Out of all out-of-network physician service claims, **85%** were for emergency, radiology, anesthesiology, or pathology (ERAP) providers



How are out-of-network claims paid?

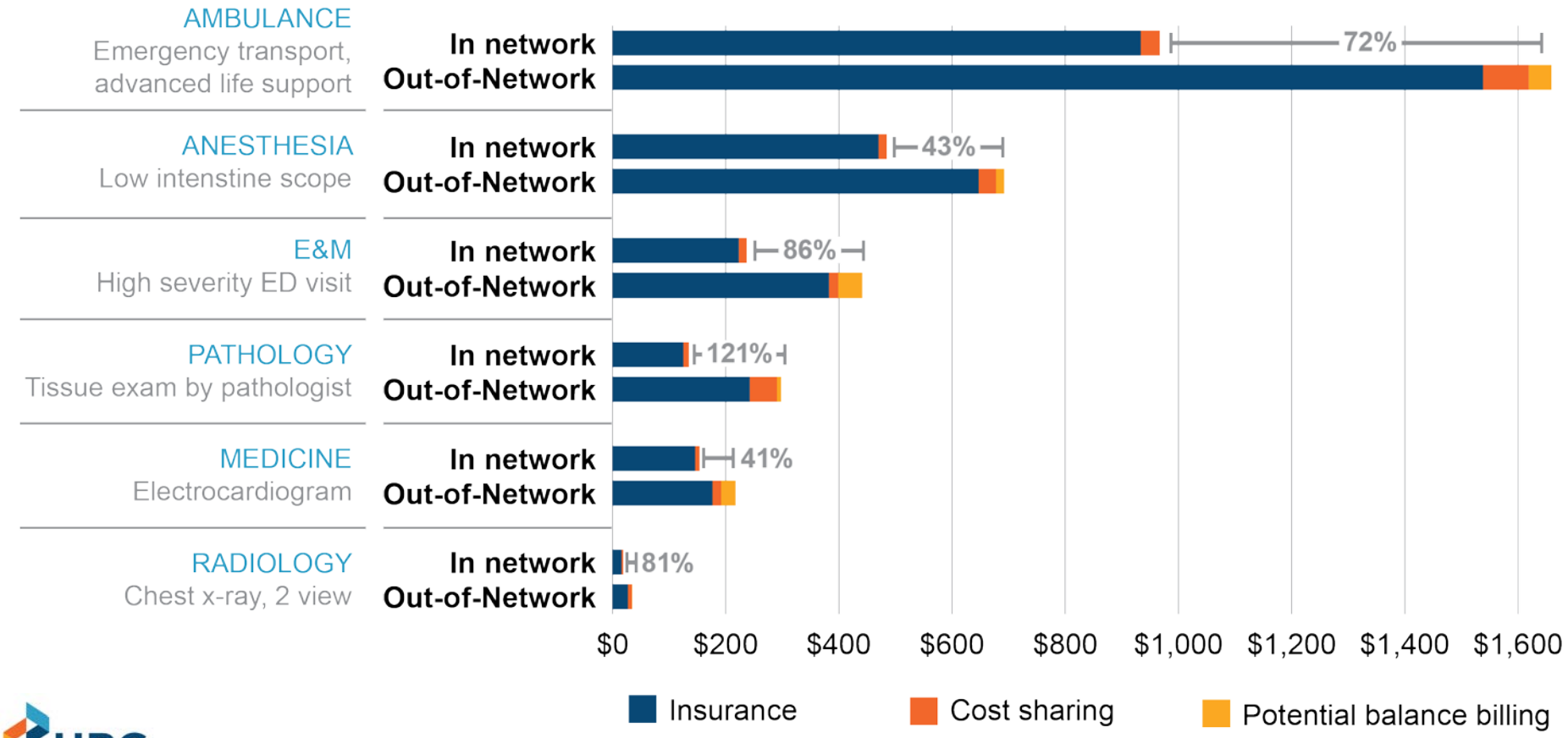
- In almost **2/3** of cases, the insurer paid the full charge amount on an out-of-network claim
- Nearly **1/4** of network claims in this sample may have resulted in a balance bill
  - **9,668** Massachusetts residents in this sample could have received balance bills
  - Average potential balance bill per member with any outstanding balance: **$355**



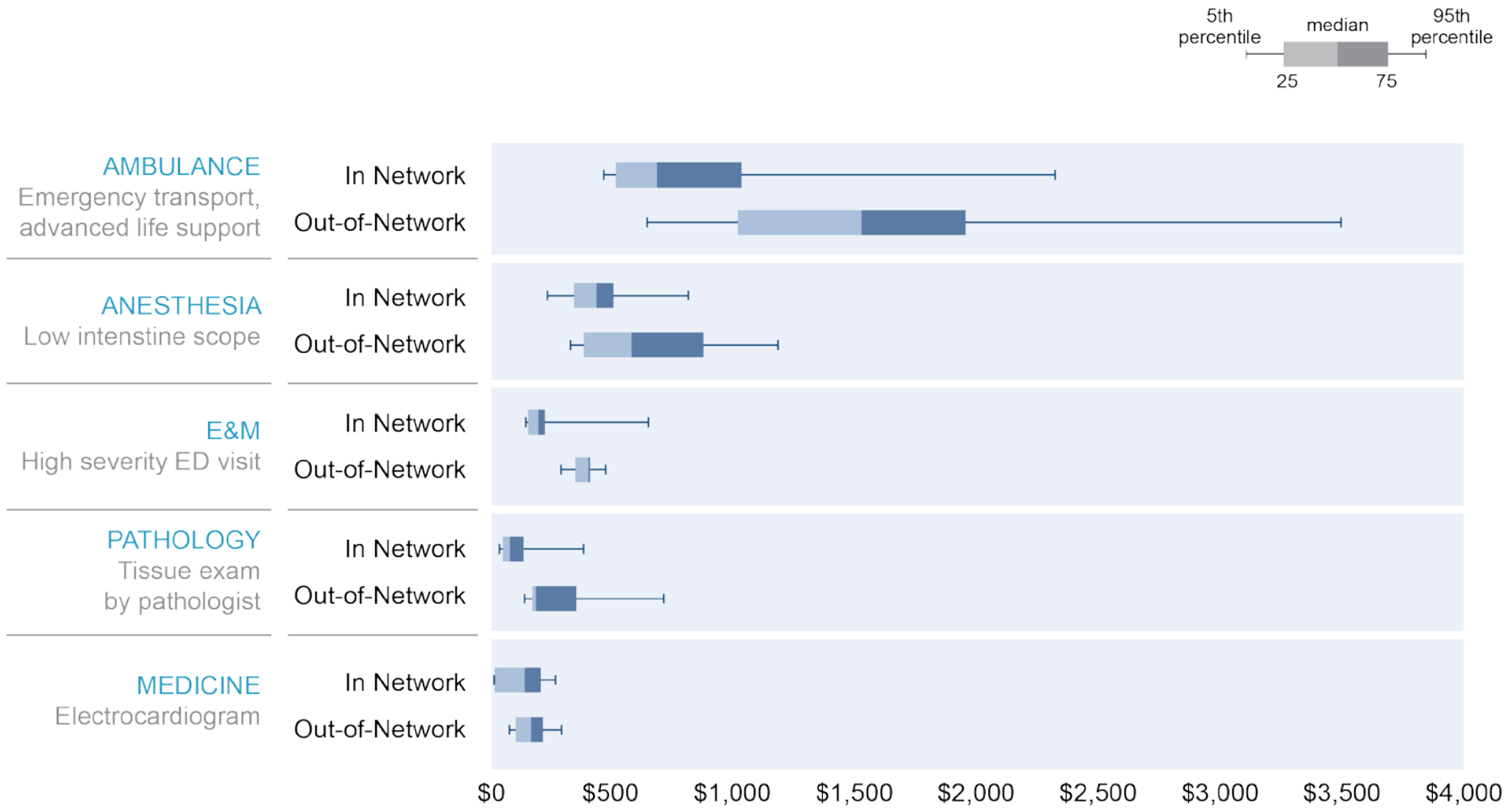
Potential balance bill: An out-of-network claim where the combined amount paid by the insurer and the member (through deductible, copay, and coinsurance) is less than the charge amount on the claim

Across a range of services, the average spending on out-of-network claims far exceeds the average spending on in-network claims

- Combined spending on out-of-network professional claims for both payers in the sample totaled **$28.7 million** in 2014.
  - **$27.0 million** paid by insurers
  - **$2.2 million** that might have been balance billed to patients



For the same services, the range of spending on out-of-network claims is often larger than for in-network claims



Out-of-network payment rates for common ambulance services exceed in-network rates by 22% to more than 200%, on average

Ambulance ground mileage
- In network: **$214**
- Out-of-network: **$261**

22%

47% of all ambulance claims

Emergency transport with advanced life support
- In network: **$967**
- Out-of-network: **$1619**

67%

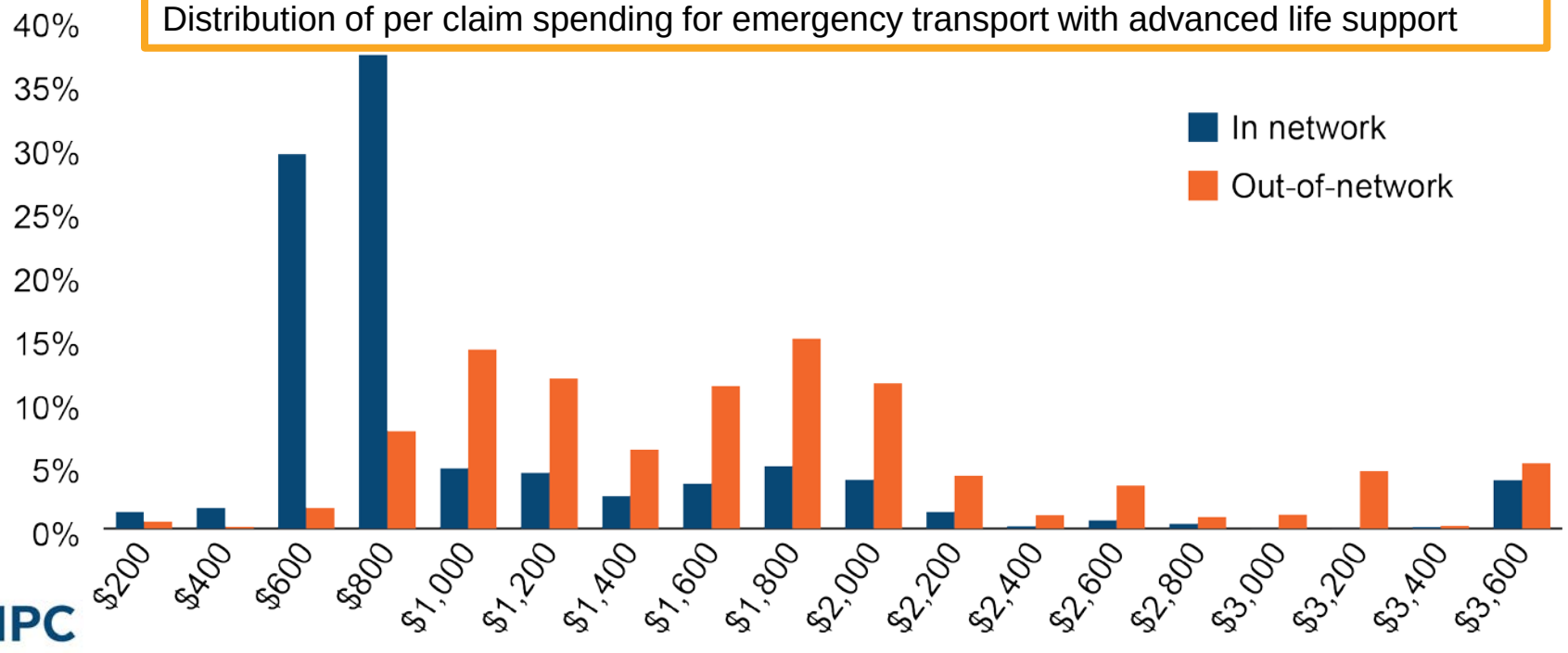
19% of all ambulance claims

Non-emergency transport with basic life support
- In network: **$338**
- Out-of-network: **$1107**

227%

9% of all ambulance claims

Distribution of per claim spending for emergency transport with advanced life support



Out-of-network payment rates for common ED visit types exceed in-network rates by 68% to 81%, on average

ED visit moderate severity (99283)
- In network: **$143**
- Out-of-network: **$248**

73%

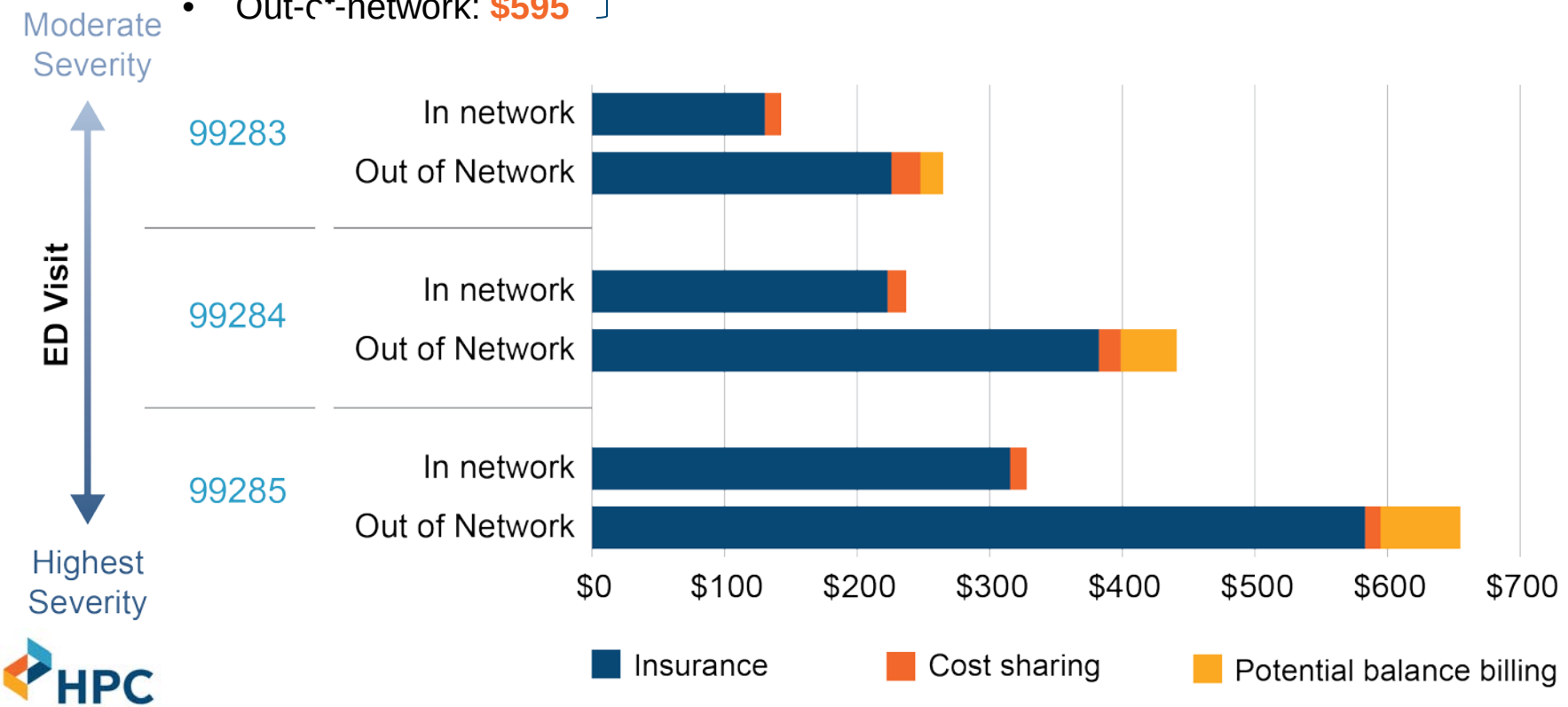
ED visit high severity (99284)
- In network: **$237**
- Out-of-network: **$399**

68%

ED visit highest severity (99285)
- In network: **$328**
- Out-of-network: **$595**

81%

These three E & M codes for moderate to very severe ED visits make up **46%** of in-network ED claims and **71%** of out-of-network ED claims



State Policies to Address Out-of-Network Billing

- Some states have taken effective approaches to protecting patients from out-of-network emergency care and surprise billing
- A handful of states have banned balance billing and established guidelines for provider reimbursement (CA, NY, CT, FL, NJ)
- In addition, these states have introduced some novel policies to address out-of-network billing:
  - New York (2014) resolves payment disputes about out-of-network claims through a binding third party arbitration process
    - Cooper et al. found that the NY law lowered the incidence of out-of-network billing by **one third**
  - California (2016) allows patient cost-sharing to count toward patient's annual maximum out-of-pocket allowance and requires out-of-network providers to refund with interest any cost-sharing in excess of in-network rates
  - Connecticut (2015) requires surprise bills issued to a patient to be marked with "this is not a bill" and prohibits their referral to a collection agency if the patient doesn't pay
- Note that state policies that address out-of-network billing may not affect self-funded plans, which are federally regulated under ERISA (**60%** of the Massachusetts commercial market)

MASSACHUSETTS
HEALTH POLICY COMMISSION

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- Research Presentation
- **Investment and Certification Programs**
  - Care Delivery Certification Programs
  - Strategic Investment Programs
  - Future Care Delivery Investments
- Schedule of Next Board Meeting (December 12, 2017)

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Practices Participating in PCMH PRIME

Since January 1, 2016 program launch:

42 practices
are PCMH PRIME Certified

64 practices
are on the **Pathway to PCMH PRIME**

1 practice
is working toward NCQA PCMH Recognition and PCMH PRIME Certification concurrently

107 Total Practices Participating

ACO Certification Program: Application Submission and Timeline

Beta Launch Certified ACOs

Community Care Cooperative (C3)
Boston Accountable Care Organization (BACO)

Full Launch

15 additional applications now under review

Timeline and Next Steps

October 1, 2017 – ACOs submit certification applications

By January 1, 2018 – HPC issues certification decisions

Full certification decisions are valid until December 31, 2019

2018 – HPC analyzes and reports on information received, re-opens application system as needed, Applicants with provisional certification submit for full certification, etc.

HPC

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CHART Phase 2 Statewide Convening: October 16, 2017

> 250

attendees representing CHART hospitals, state government, payers, and providers

4 panels

Panel 1: ***Reducing readmissions for high risk patients***

Panel 2: ***Slowing the cycle of high utilization for multi-visit patients***

Panel 3: ***Improving care for behavioral health patients in the ED***

Panel 4: ***Lessons learned, capabilities developed, and the future***

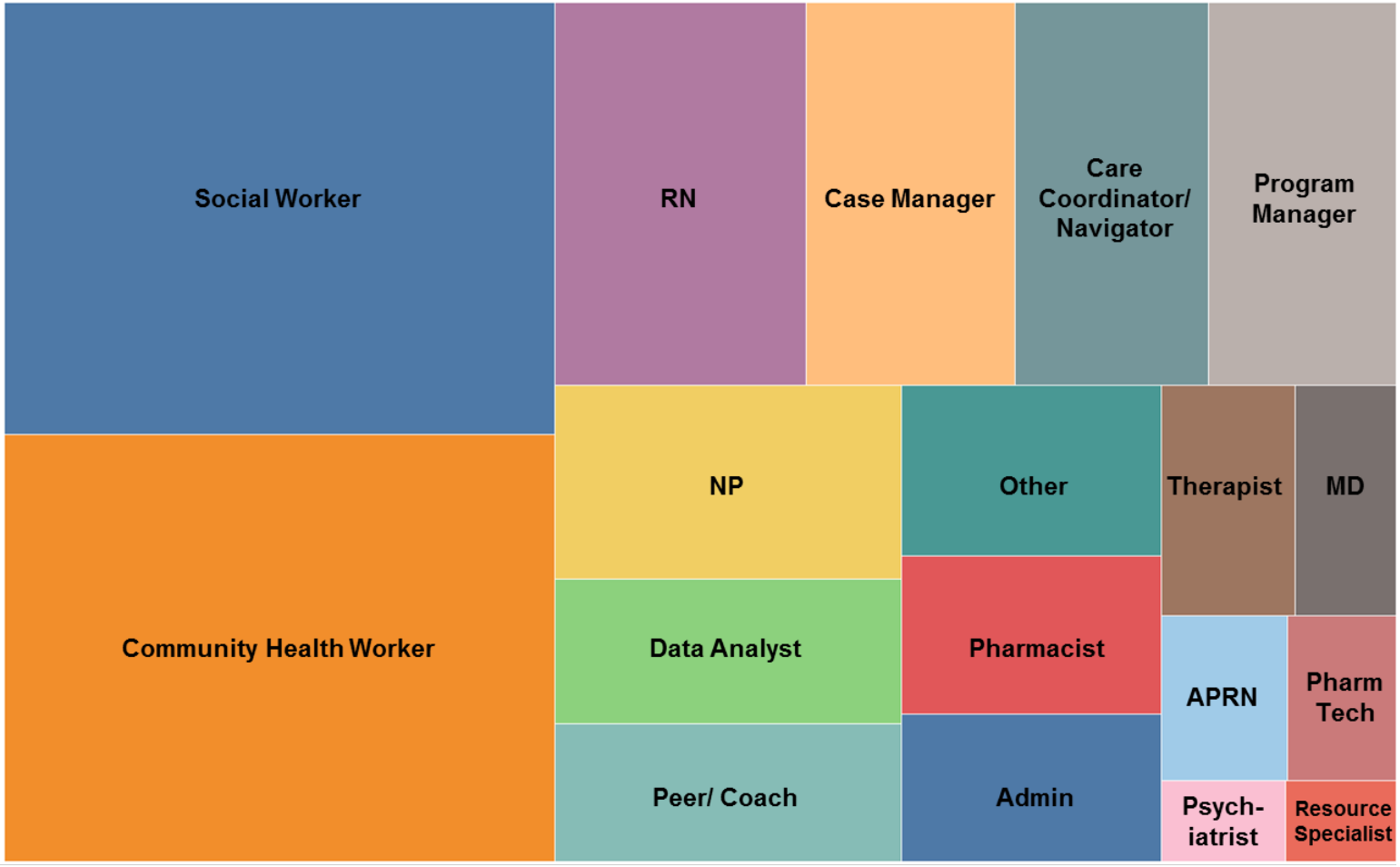
8

breakout sessions

CHART Phase 2 workforce: multidisciplinary and committed

CHART Phase 2

250 full-time equivalents engaging approximately 180,000 CHART-eligible acute encounters.[1]



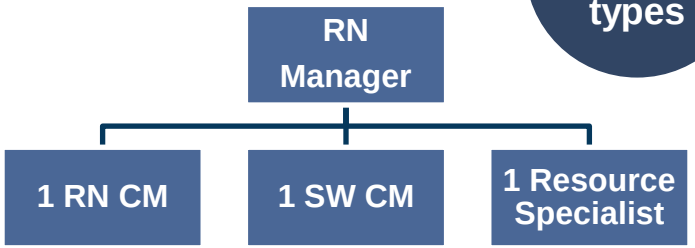
[1]Based on reports received from CHART Phase 2 awardees through September 2017.

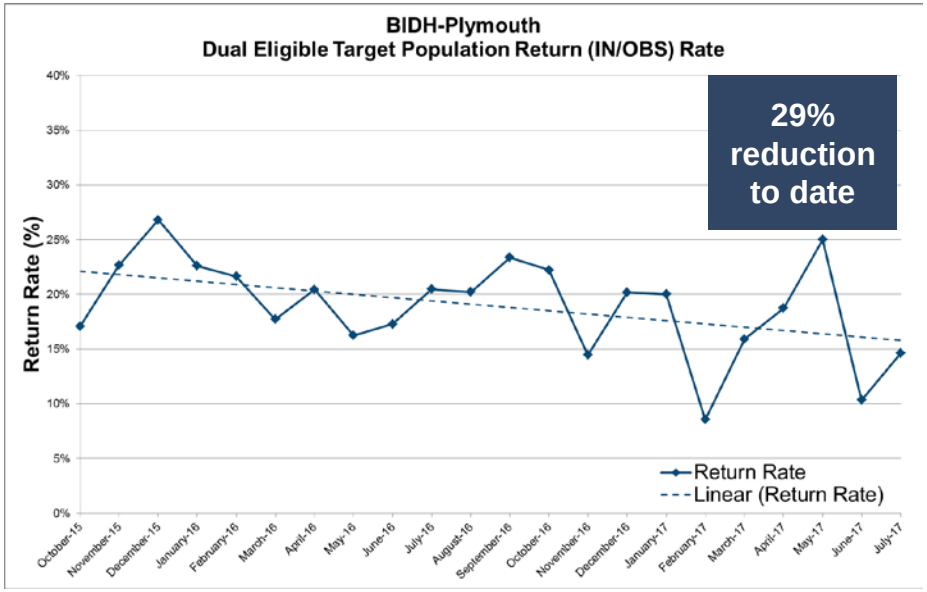
Example panel slide: BID – Plymouth
Reducing returns for high risk patients

Beth Israel Deaconess Hospital Plymouth

Team

4 FTEs
4 role types





Average volume

85
Discharges/ month

70 (82%)
Discharges served/ month

125 patients/ month

Success factors

- ✓ Transition from telephone to community outreach
- ✓ Co-management of patients
- ✓ Leverage Resource Specialist's skills
- ✓ Engage patients while hospitalized

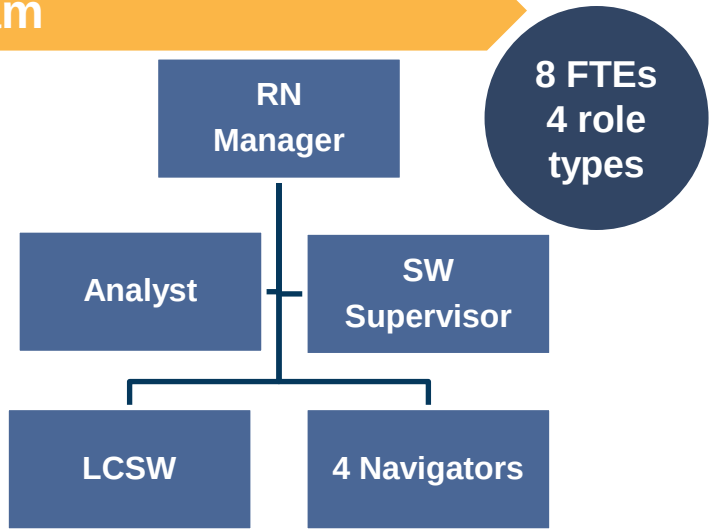
HPC

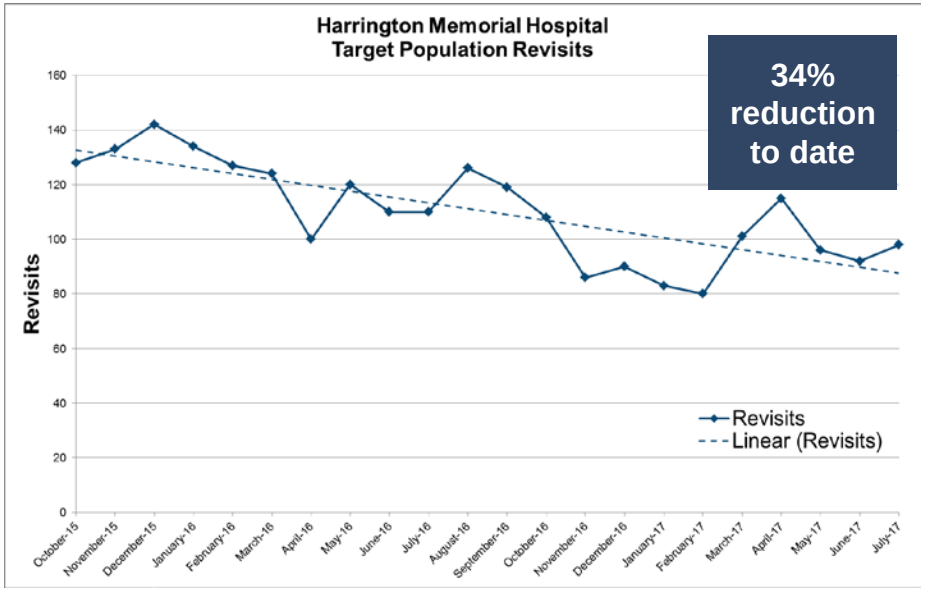
CHART Phase 2 teams developed content for these slides for the purposes of the October 2017 Statewide Convening that reflects their hands-on experience, self-reported data analysis, and key findings.

Example panel slide: Harrington Memorial Hospital
Improving care for behavioral health ED patients

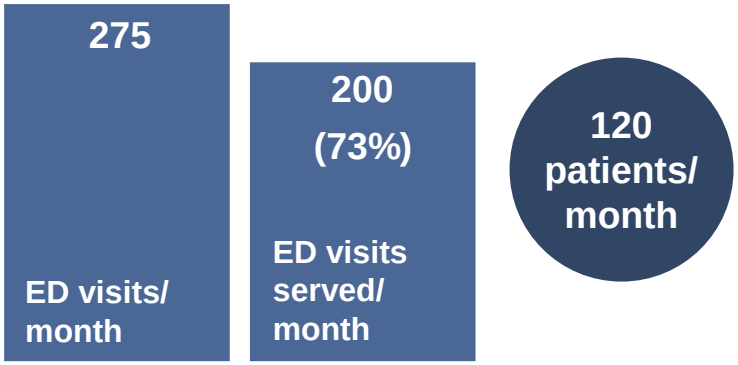
Harrington HEALTHCARE SYSTEM

Team





Average volume



Success factors

- ✓ **Address patients' basic needs first**
- ✓ **Creatively leverage community resources**
- ✓ **Effective engagement tactics, frequent contact**
- ✓ **Adapt care model to achieve outcomes**
- ✓ **Drill down on data to understand impact**

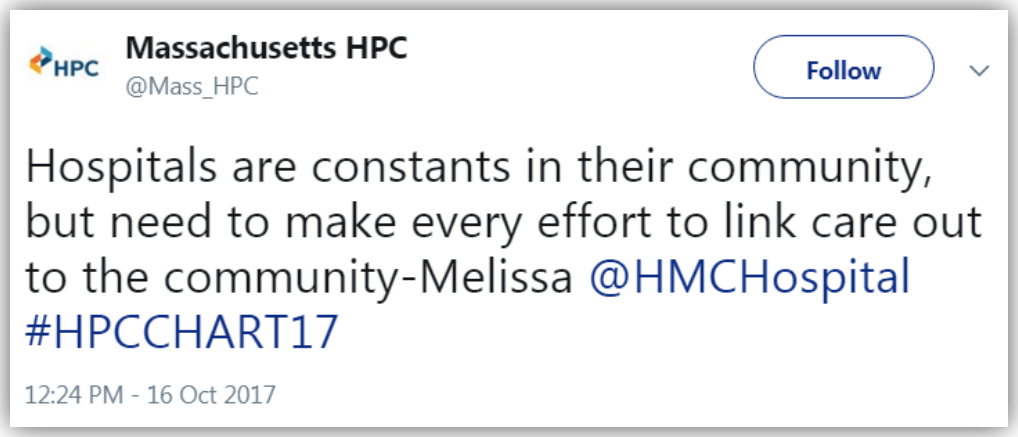
HPC

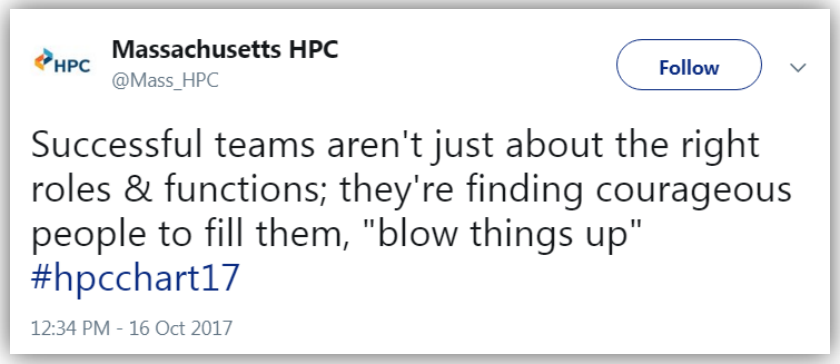
CHART Phase 2 teams developed content for these slides for the purposes of the October 2017 Statewide Convening that reflects their hands-on experience, self-reported data analysis, and key findings.

CHART Phase 2 teams are passionate about their work and eager to share their lessons learned with a broad group of stakeholders

"CHART allowed us to shift the paradigm from 'talk and tell' to "listen and ask."

Mary Beth Strauss, Winchester Hospital





"The CHW role is so important for the 'hand-holding' – we're all in this room because we have someone to hold our hands; our patients do not."

Lisa Brown, Lowell General Hospital

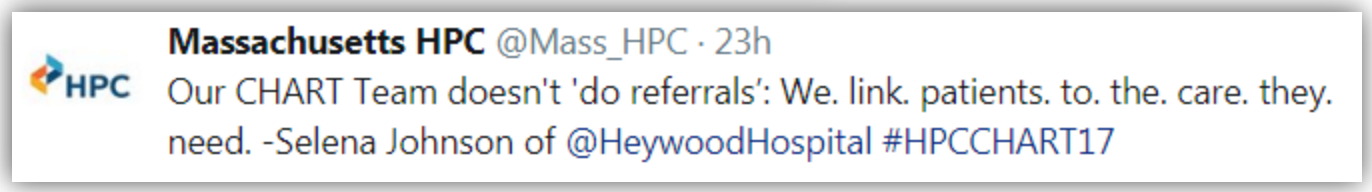


CHART Phase 2: Progress as of October 2017

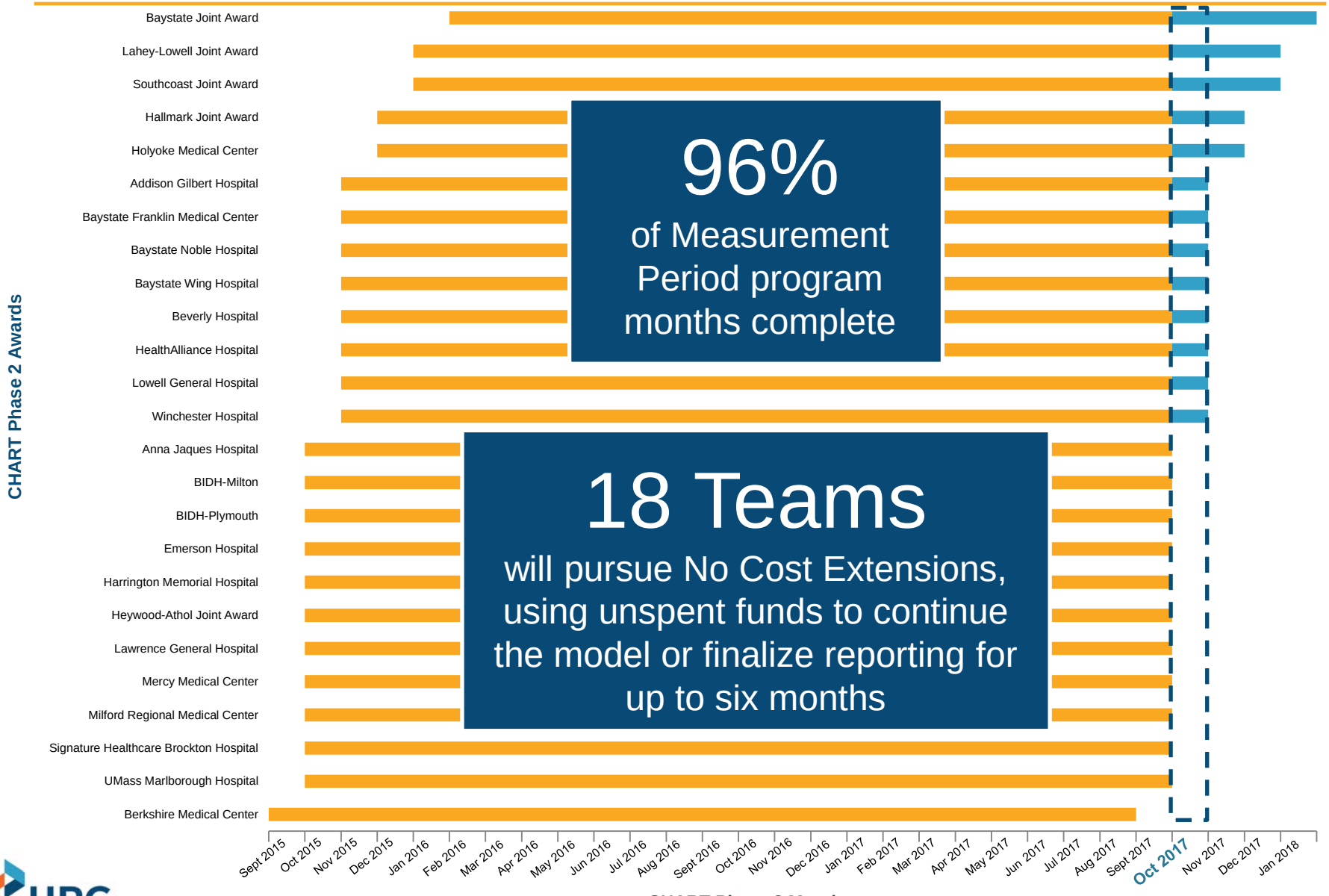


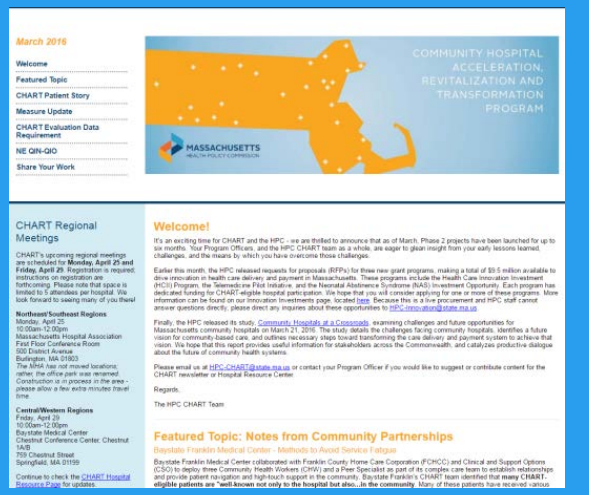
CHART Phase 2: Activities since program launch[1]

15
regional meetings
with
900+
hospital and community provider attendees

290+
technical assistance working meetings

865+
hours of coaching phone calls

21
CHART newsletters


March 2016

Welcome
Featured Topic
CHART Patient Story
Measure Update
CHART Evaluation Data Requirement
NE QIN-QIO
Share Your Work

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION AND TRANSFORMATION PROGRAM
MASSACHUSETTS

CHART Regional Meetings

Welcome!

Featured Topic: Notes from Community Partnerships

3,523 unique visits to the CHART hospital resource page


CHART Hospital Resource Center

Updates from the HPC

CHART Phase 2 Reports

CHART Phase 2 reports with due dates that fall during a weekend or state holiday may be submitted before the due date or on the next business day after the weekend/state holiday.

Upcoming CHART Regional Meetings

HPC CHART will host several regional meetings in 2016. Registration is required; instructions on registration are forthcoming. Please note that space is limited to 5 attendees per hospital. Regional assignments can be found here.

April CHART Regional Meetings

Northeast/Southeast Regions
Monday, April 25
10:00am-12:00pm
Massachusetts Hospital Association

INVEST
SUSTAIN
INNOVATE
EVALUATE

CHART Phase 2 Program Gu

- CHART Phase 2 Award Guide
- Lessons Learned and Reflections
- Request for Modification - Budget
- Request for Modification – Key Pe

CHART Phase 2 Measuremer

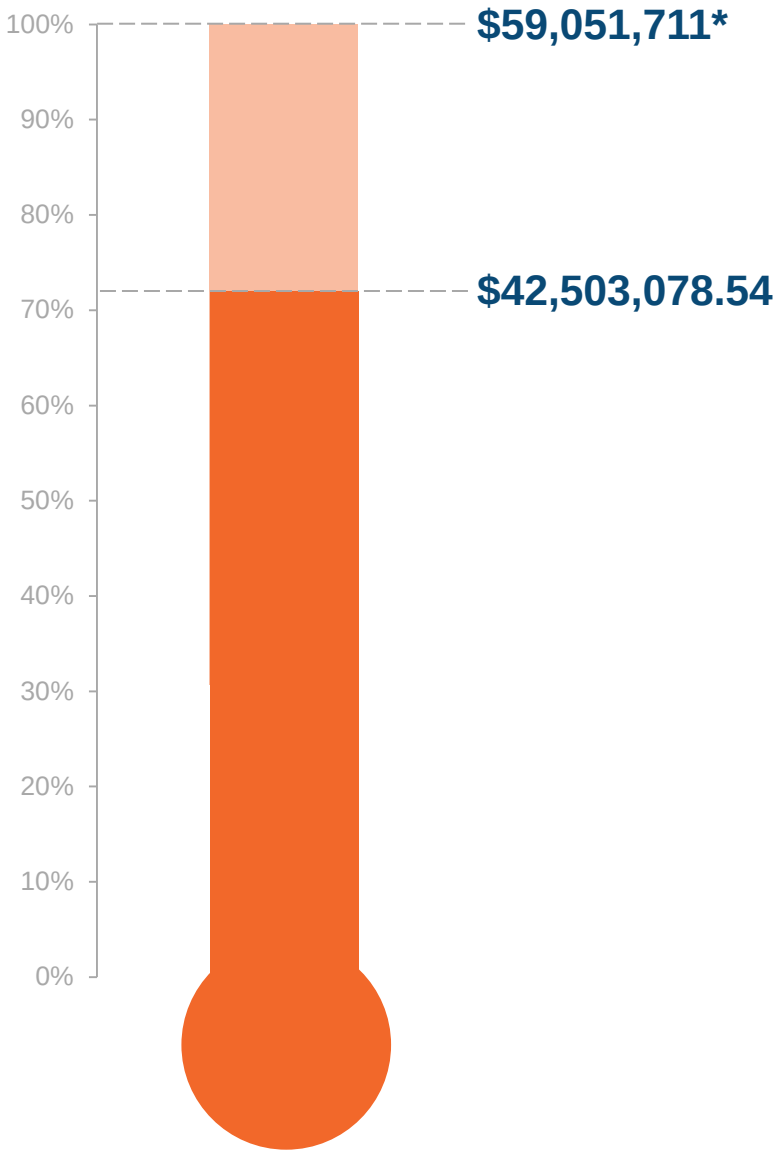
To obtain a copy of your CHART Prog unique measure reporting template, pl

- Baseline Data Submission Templa
- Program-specific Measure Spec T

550+
data reports received

[1] Updated through October 17, 2017. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015.

CHART Phase 2: The HPC has disbursed $M to date



Remaining
$16,548,632.46
is inclusive of
$7,217,898
maximum outcome-based Achievement Payment opportunity

HPC

Updated October 12, 2017

* Not inclusive of Implementation Planning Period contracts. $100,000 per awardee hospital authorized March 11, 2015.

By the Numbers: Health Care Innovation Investment (HCII) Program

All 20 initiatives
funded by the HPC have launched

>100 organizations
collaborating to deliver care

220 initiative-specific measures
recording patient experience, provider experience, quality, process, and outcomes

~6,500 patients
will be served, including patients with SUD, chronic homelessness, and comorbid conditions

Awardees span the Commonwealth:
From the Berkshires to Boston

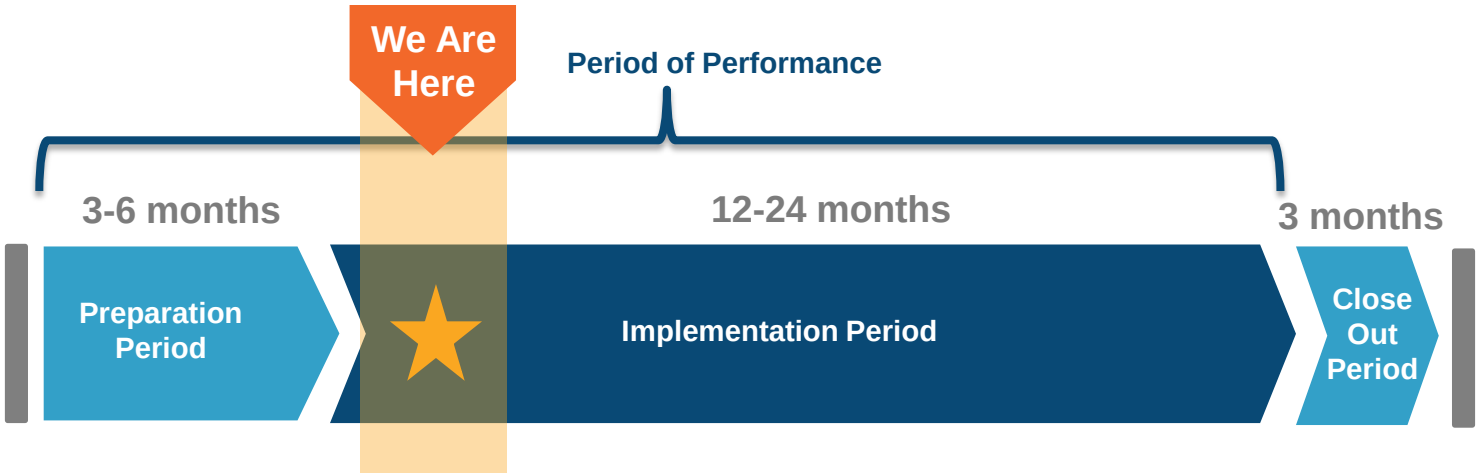
3 HCII newsletters

$40M
in estimated health care cost savings

Initiatives will deliver lower-cost care by shifting site and scope

HPC

HCII Program Timeline and Next Steps



Awardees are continuously enrolling patients in their target populations and delivering services, including:

- Assessing students for unmet behavioral health needs
- Expanding outreach on the streets to engage homeless patients
- Investigating new use cases for tele-psychiatry services
- Training physicians in holding advance care conversations with patients nearing the end of life

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Goals and principles of HPC's care delivery investments

Vision for Care Delivery Transformation

A health care system that efficiently delivers on the triple aim of better care for individuals, better health for populations, and lower cost through continual improvement and the support of alternative payment.

Goals of investments

- To **accelerate transformation** of care **for people, families and communities**
- Support successful achievement of **target aims (e.g., readmissions, ED use)**
- Promote **state policy priorities** (e.g., addressing the opioid epidemic, integrating behavioral health)

Principles of investments

- **Meet providers where they are**
- Promote a **system of learning** and **continuous improvement**
- **Align** HPC and state activities for care delivery transformation (e.g., MassHealth DSRIP TA)
- **Minimize** administrative burden to and reporting by providers
- **Encourage partnership** and collaboration with community partners

HPC

Proposal: Dedicate approximately $10 million from the HPC Trust Funds for the next round of investment

Health Care Payment Reform Trust Fund

- Primary Purposes:
  - Grants to providers and their partners to foster innovation in health care payment and service delivery through a competitive grant program (“Health Care Innovation Investment Program”)
  - Technical assistance and provider supports related to the PCMH/ACO certification programs

Distressed Hospital Trust Fund

- Primary Purpose:
  - Grants to low-priced community hospitals and their partners to reduce unnecessary hospital utilization and enhance behavioral health through the Community Hospital Acceleration, Revitalization, and Transformation Investment Program (CHART)

All investment programs are carefully designed to further the Commonwealth’s goal of better health and better care at a lower cost

Proposal: Ground design proposal in lessons learned from CHART and HCII

Proposed design components are informed by HPC's experience with **$80M of awards**, spread **over 75 awards**

CHART Phases I and II

HCII

Performance measures	Maximize value by focusing on a **parsimonious set of core measures**, but allow applicants to propose additional initiative-specific measures
Award size	**Awards of all sizes were successful** in transforming care delivery, serving vulnerable patients, and achieving measurable results in CHART Phase 2
Financial support & sustainability	**Alignment with organizational strategy** and requiring **in-kind contributions** and **strong sustainability plans** can maximize long term impact of investment
Prep period	Awardees and program staff **valued having a preparation period** before performance period began to hit the ground on day 1
Building the evidence base	There is utility in using investments to continue to build the evidence base/ return on investment case for innovative care **models that integrate medical, behavioral, and social needs**.

HPC

The 2017 Cost Trends Hearings reinforced that avoidable acute care utilization is driving costs and poor quality in the Commonwealth

Growth in health care expenditures is concentrated in complex patients vulnerable to social risks.[2,3]

69.2% of providers and

54.6% of payers submitted pre-filed testimony attesting that reducing unnecessary hospital utilization is a critical cost containment strategy.

Community appropriate inpatient care is increasingly being provided by teaching hospitals and AMCs.

The readmission rate for patients with a behavioral health diagnosis was

20.2%

in 2015[1]

1 CHIA Hospital-Wide Adult All Payer Readmissions in Massachusetts, December 2016: http://www.chiamass.gov/assets/docs/r/pubs/16/Readmissions-Report-2016-12.pdf
2 United States Department of Health and Human Services: Office of the Assistant Secretary for Planning and Evaluation. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Purchasing Programs A Report Required by the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014. December 2016.
3 Presentation by Karen Joynt Maddox.

HPC

Proposal: Next round of funding should focus on reducing avoidable acute care utilization

Next round of funding should focus on promoting an **efficient, high-quality healthcare delivery system** by investing in innovative ways to **reduce avoidable ED visits and inpatient readmissions**

ED visits

26%
of inpatient discharges were followed by a return to the ED within 30 days in SFY 2015*

42%
of all first ED revisits that occurred within 30 days of inpatient discharge occurred within 7 days of discharge*

Opioid-related ED utilization increased by
87%
from 2011-2015**

Patients with a primary BH diagnosis were
16.3 times
more likely to board than other patients in 2015**

Readmissions

41%
of commercial spending growth in 2015 was attributable to hospital care**

MA all payer unplanned readmissions has stayed at around
16%
for the past 5 years, while the national rate has declined***

In 2016, HPC recommended a reduction in all-cause all-payer 30-day readmissions to
<13%
by 2019**

Reducing readmissions to 13% would yield
$245 M
in savings****

* CHIA Emergency Department Visits After Inpatient Discharge in Massachusetts , July 2017: http://www.chiamass.gov/assets/docs/r/pubs/17/ed-visits-after-inpatient-report-2017.pdf
** HPC Annual Health Care Cost Trends Report 2016: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf
*** CHIA Performance of the Massachusetts Health Care System: Annual Report, September 2017: http://www.chiamass.gov/assets/2017-annual-report/2017-Annual-Report.pdf
**** HPC Benchmark Hearing, March 8, 2017, slide 29: http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/testimony-regarding-modification-of-the-benchmark.html

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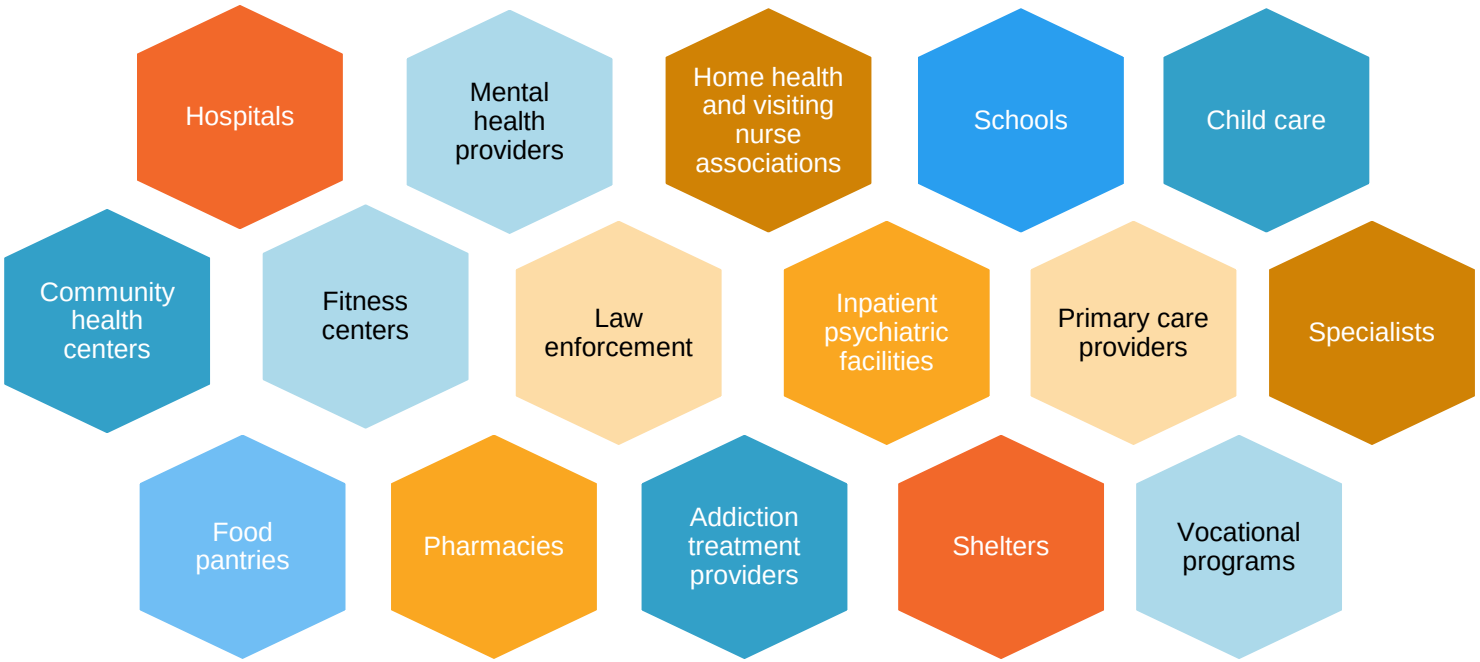
Proposal: Next round of funding should promote community based health care systems

*"I don't see any future for community hospitals…I think there's a fantastic future for **community health systems**. If small stand-alone hospitals are only doing what hospitals have done historically, I don't see much of a future for that. But I see a **phenomenal future for health systems with a strong community hospital that breaks the mold** [of patient care]."*

- COMMUNITY HOSPITAL CEO



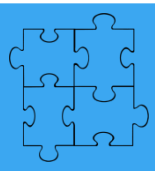
Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data.
Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.

Proposed design components

1. Tracks

2. Award size and duration

3. Financial support and sustainability



4. Competitive factors

Proposal: Two funding tracks to reduce avoidable acute care use

Funding Track 1: Reduce avoidable acute care use through addressing social determinants of health

- Support for innovative models that **address social determinants of health** after an acute care visit or stay in order to prevent a future visit or stay (e.g., respite care for patients experiencing housing instability at time of discharge)
- **Partnership** with **social service providers / community based organizations required**

Funding Track 2: Reduce avoidable acute care use through increasing immediate access to behavioral health care

- Support innovative care models to **increase immediate access to real time behavioral health services**, (e.g. plans to **expand access** to 24/7 psychiatric assessment and short term prescribing, using **telemedicine** and/or **mobile integrated health**, and/or **other innovative strategies)**
- **Partnership** with **outpatient behavioral health providers required,** if applicant is a BH provider, partnership with medical care provider required

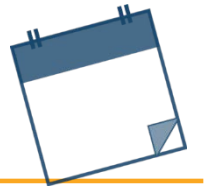
→ **focus on opioid use disorder treatment**

  - Section 178 of ch. 133 of the Acts of 2016 directed the HPC to invest not more than $3M from the DHTF to support hospitals in further testing **ED initiated pharmacologic treatment for SUD**, with the goals of increasing rates of engagement and retention in evidence-based treatment
  - **Eligible entities** would include hospitals with EDs; **partnership** with **outpatient providers required**

Eligible entities include HPC certified ACOs* and their participants and/or CHART eligible hospitals

***including provisionally certified ACOs**

Proposal: Award size and duration



Total funding

Up to $10,000,000

Individual awards*

Up to $750,000

Duration

18 – 24 months

*Any given awardee will receive maximum of one award (may apply for multiple tracks)

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Proposal: Financial support and sustainability

- Require **in-kind contributions**
- For every eligible expense in the award, the **awardee will be reimbursed at 75%** (i.e., awardee is responsible for 25%)

Require **sustainability plans** to ensure continuation beyond grant cycle (no separate sustainability plan award)

Proposal: Four key domains of competitive factors

Competitive factors

Care Model and Impact

- Collaborative **multi-disciplinary team approach** to care delivery
- Strength of **evidence-base**
- **Projected impact** and logic model (e.g. 5% reduction in readmissions)
- Strength and role of **relationship with community partner, including pass through of award dollars**

Leadership and Organization

- Alignment of project with **organizational strategy** (e.g. population health management approach or community health needs assessment)
- **Financial health** of organization and demonstration of **financial need**
- **Past performance** in HPC awards
- Organizational leadership and project **leadership engagement** (e.g. % of time spent on the project)

Sustainability and Scalability

- Solid **sustainability plan,** including **in-kind funds** and anticipated utilization reduction
- Alignment with organization's DSRIP plan, if applicable

Evaluation

- Strength of **evaluation plan** to determine impact of model

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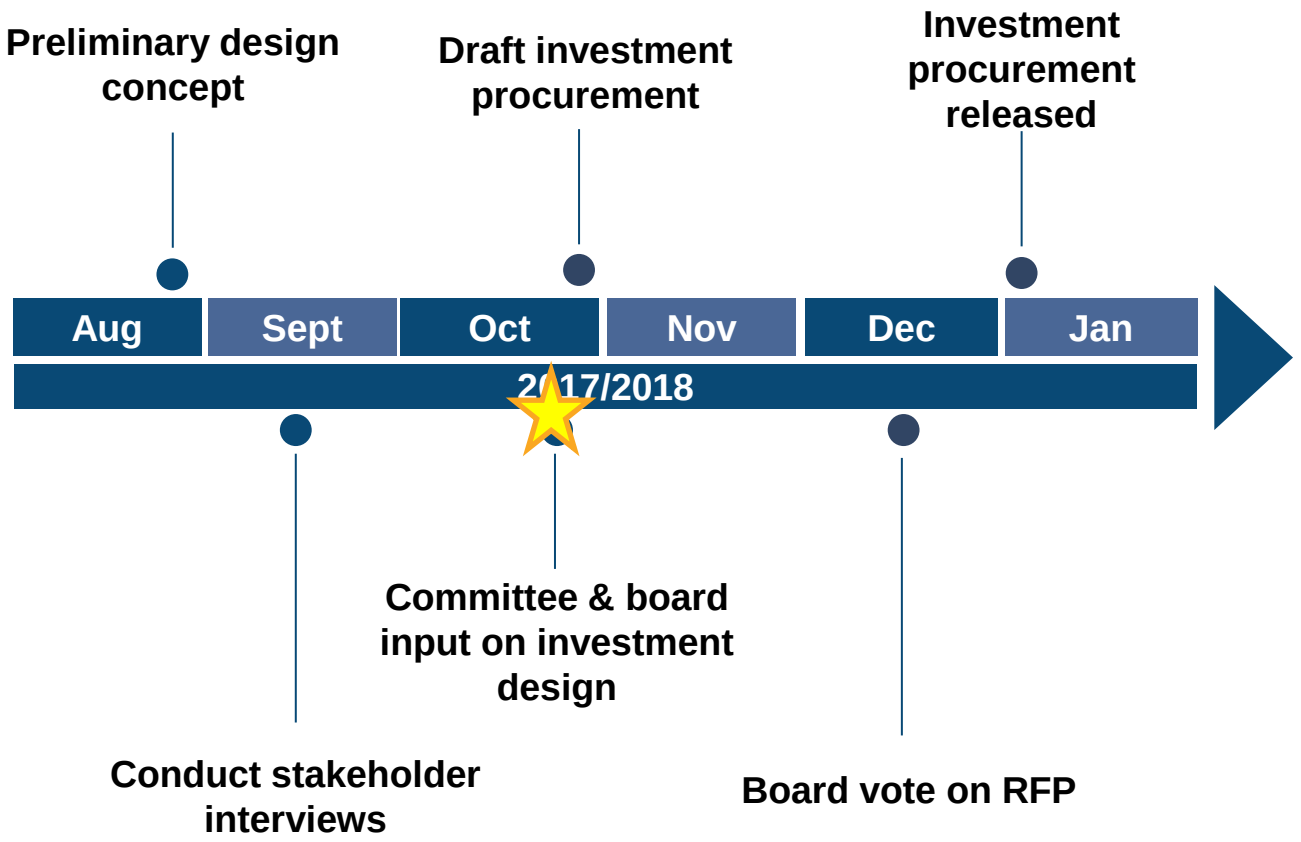
See appendix for definition of community partners

Summary of new investment proposal

THEME	Enhancing and ensuring sustainability of community-based, collaborative approaches to care delivery transformation that drive reductions in avoidable acute care utilization
FUNDING	Proposed total funding of up to $10M
COMPETITIVE FACTORS	▪ Care model and impact ▪ Organizational leadership, strategy and demographics ▪ Evaluation ▪ Sustainability and scalability
OUTCOMES	Address one or more of the HPC's key target areas for reducing avoidable acute care utilization and improving quality: ▪ Reduce all-cause 30-day hospital readmissions ▪ Reduce 30-day ED revisits ▪ Increase initiation of and engagement in OUD treatment

Next steps


Preliminary design concept
Draft investment procurement
Investment procurement released
Aug
Sept
Oct
Nov
Dec
Jan
2017/2018
Committee & board input on investment design
Conduct stakeholder interviews
Board vote on RFP

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes from the September 13, 2017 Meeting (VOTE)
- Chairman's Report
- Market Performance
- Research Presentation
- Investment and Certification Programs
- **Schedule of Next Board Meeting (December 12, 2017)**

Contact Information

For more information about the Health Policy Commission:

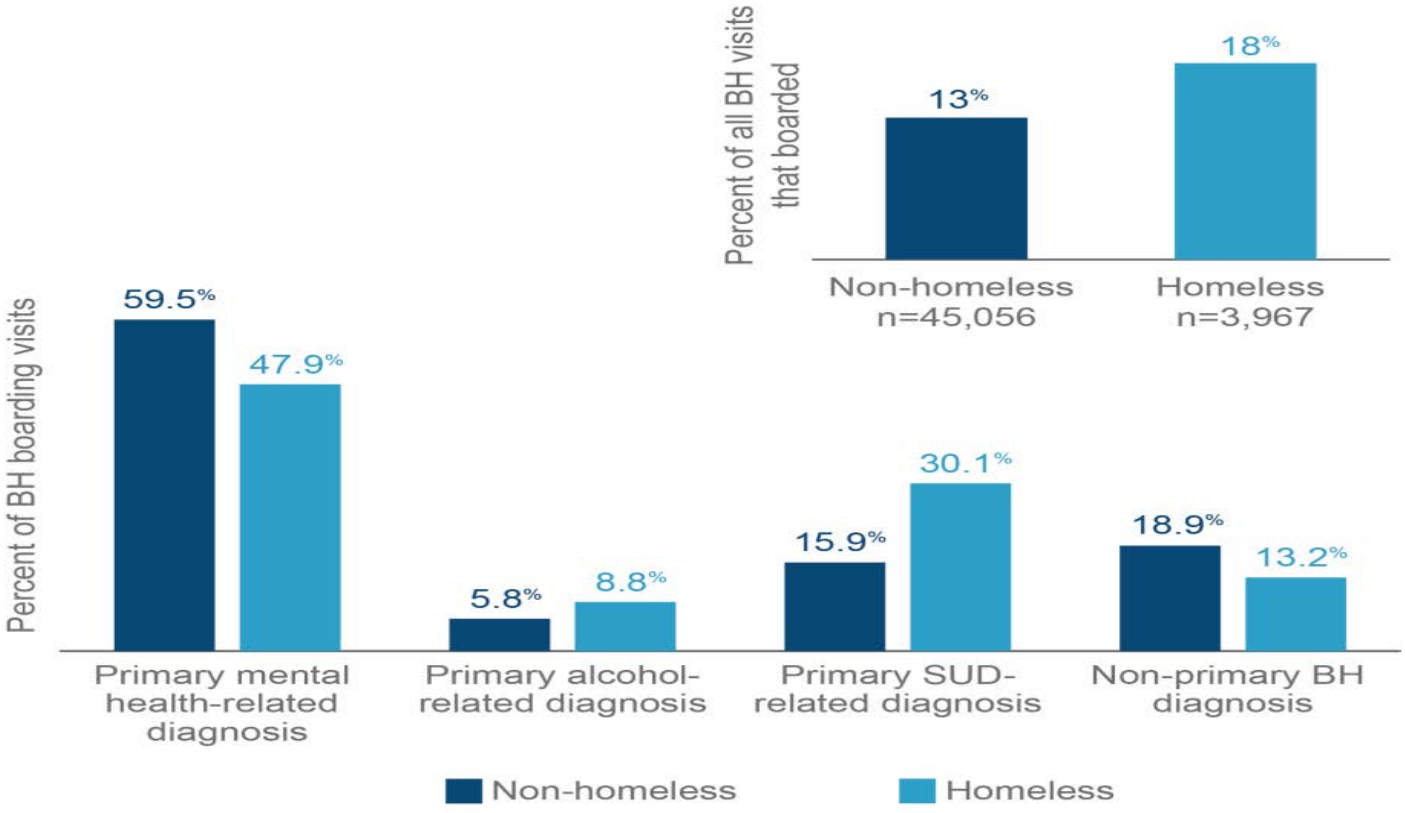
Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

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

Appendix

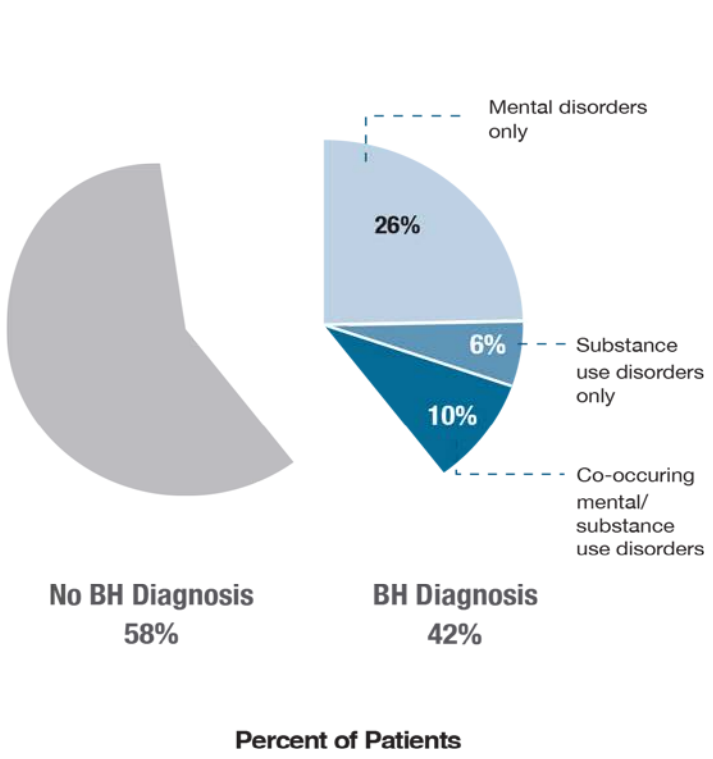
Evidence: Patients with unaddressed social complexities such as homelessness are more likely to utilize high cost and inefficient acute care treatment

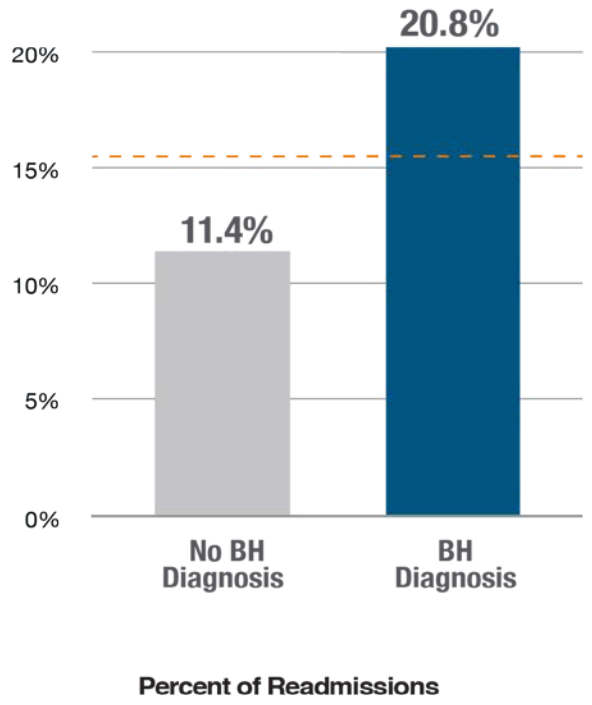


See appendix for additional data supporting rationale for track 1

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2015
Note: Emergency department (ED) boarding is definied as patients who had an ED stay of 12 or more hours from their time of arrival to their time of departure. BH ED visits identified using NYU Billings algorithm and include any discharge with a mental health, substance abuse, or alcohol-related diagnosis code.

Evidence: Patients with comorbid behavioral health diagnoses are more likely to be readmitted





In 2015, patients with a behavioral health comorbidity had a readmission rate of 20.8%, nearly twice that of those without a behavioral health diagnosis

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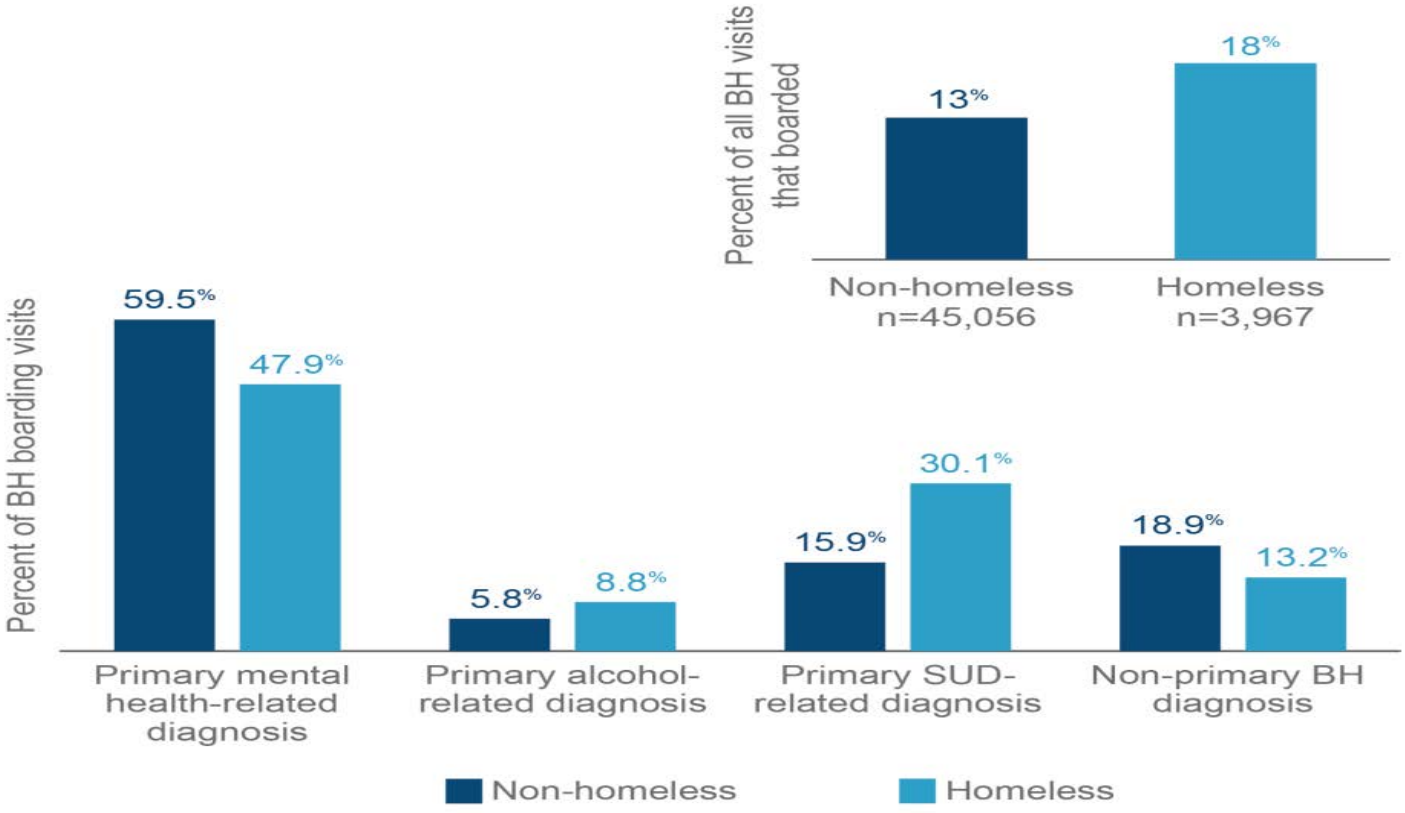
Graph and analyses created by the Center for Health Information and Analysis, using FY15 data (2017).

Evidence: Patients with unaddressed social complexities such as homelessness are more likely to utilize high cost and inefficient acute care treatment



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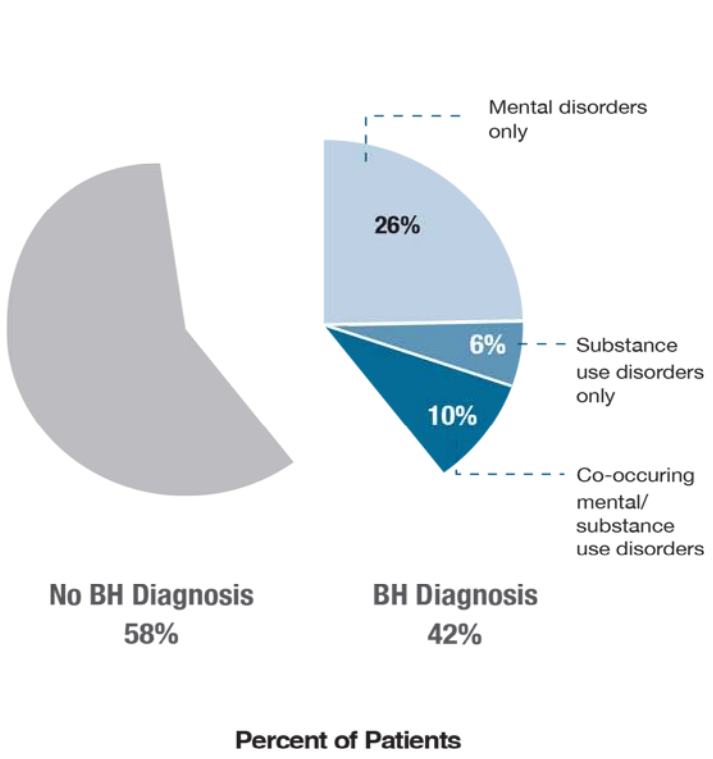

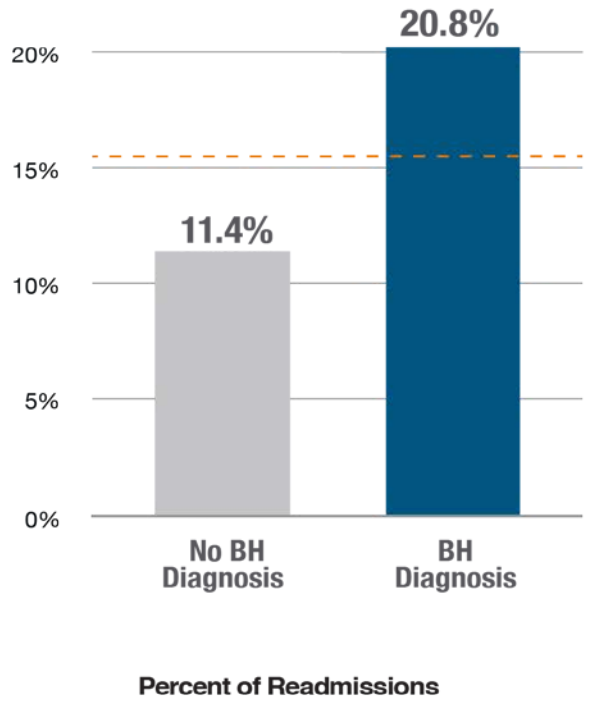

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