MASSACHUSETTS
HEALTH POLICY COMMISSION

Provider Price Variation Stakeholder Discussion Series

April 13, 2016

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HEALTH POLICY COMMISSION

AGENDA

- **HPC Staff Presentation: Supply-side incentives / alternative payment methods**
- Presentation: Hoangmai Pham, MD, MPH, Chief Innovation Officer for the Center for Medicare and Medicaid Innovation
- Stakeholder Discussion
- Schedule of Next Meeting (May 19, 2016)

Supply-side incentives / alternative payment methods

- Supply-side incentives (e.g. alternative payment methods or APMs) encourage *providers* to make value-based choices in their practice and referrals
  - Chapter 224 calls for increased use of alternative payment methods
- APMs aim to change provider incentives so that providers benefit financially from
  - Keeping patients healthy
  - Providing high-quality, patient-centered care
  - Reducing unnecessary services
  - Referring to high-quality and efficient providers
- APMs have generally been used as a strategy to address *quantity* of services, but have the potential to impact *price* as well

Global budgets

- The predominant APM in Massachusetts is the global budget model. This is also the model underlying Medicare ACO APM

- The financial model or “benchmark” for global budget-based APMs generally includes
  - A requirement that patients select, or be attributed to, a primary care provider
  - A quality score that drives shared savings or deficit amounts
  - A risk adjustment methodology
  - A budget, usually based on historical spending over past 1-3 years
  - A trend component that is regionally or locally-based

Considerations for APM design and implementation and impact on price and spending variation

1. Budgets based on historic spending may perpetuate existing unwarranted variation in prices and spending and threaten sustainability for some lower-paid providers
   - For the three largest payers, risk-adjusted total medical expenditure varies by >18 percent among the 10 largest physician groups
   - Examples of risk-adjusted TME for Harvard Pilgrim Health Care
     - Partners: $335 PMPM, Atrius $287 PMPM, BMC $283 PMPM

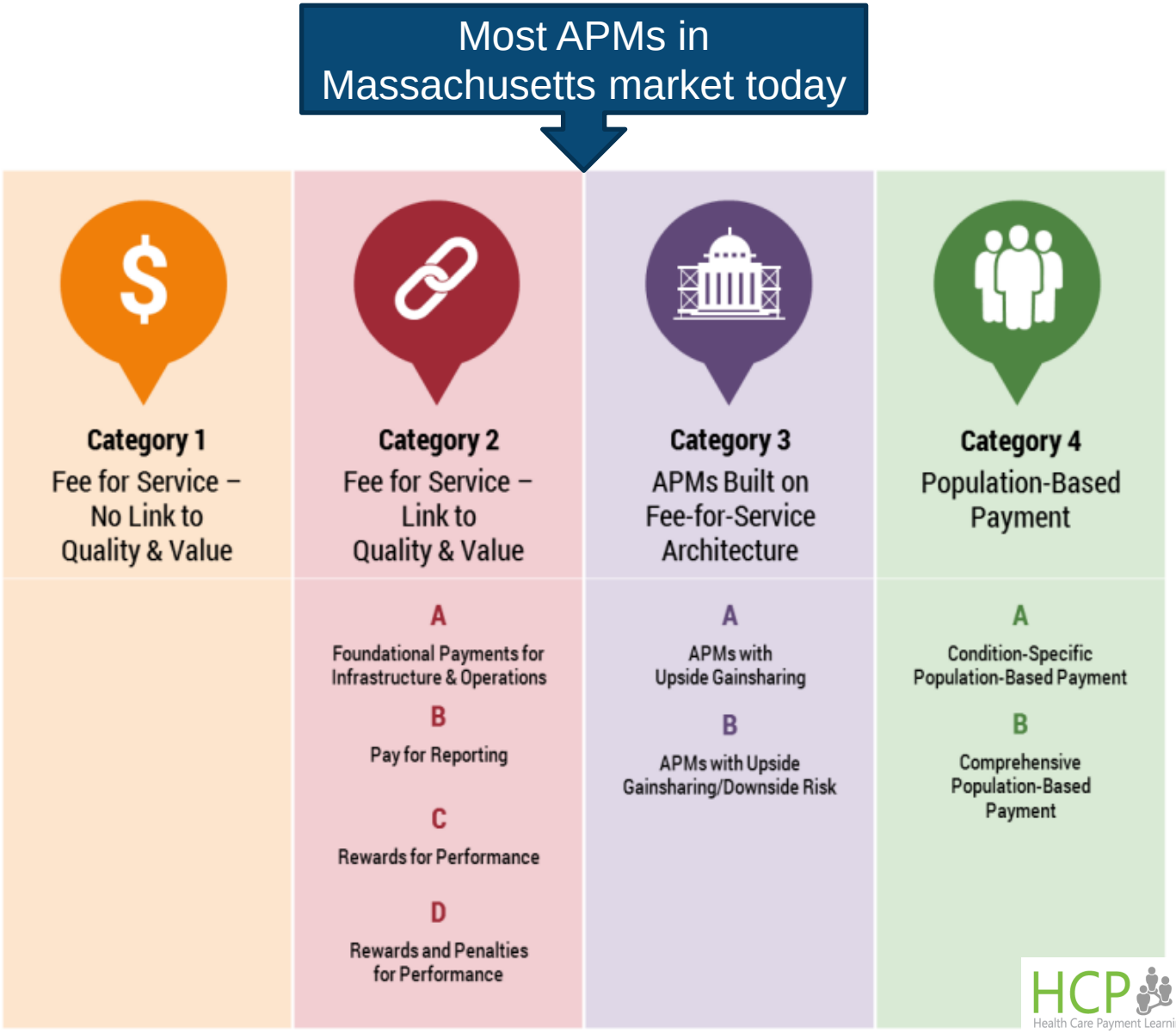
2. APMs only reduce spending relative to FFS when budgets or trend are below FFS

3. When APMs are voluntary, providers may opt out if financial model and/or contract terms are less attractive than FFS

4. Providers agree that APMs are more effective when a greater share of patients are covered and when incentives and technical elements are aligned across payers

Note: FFS: Fee-for-service payment
Source: Center for Health Information and Analysis, TME data book, 2014.

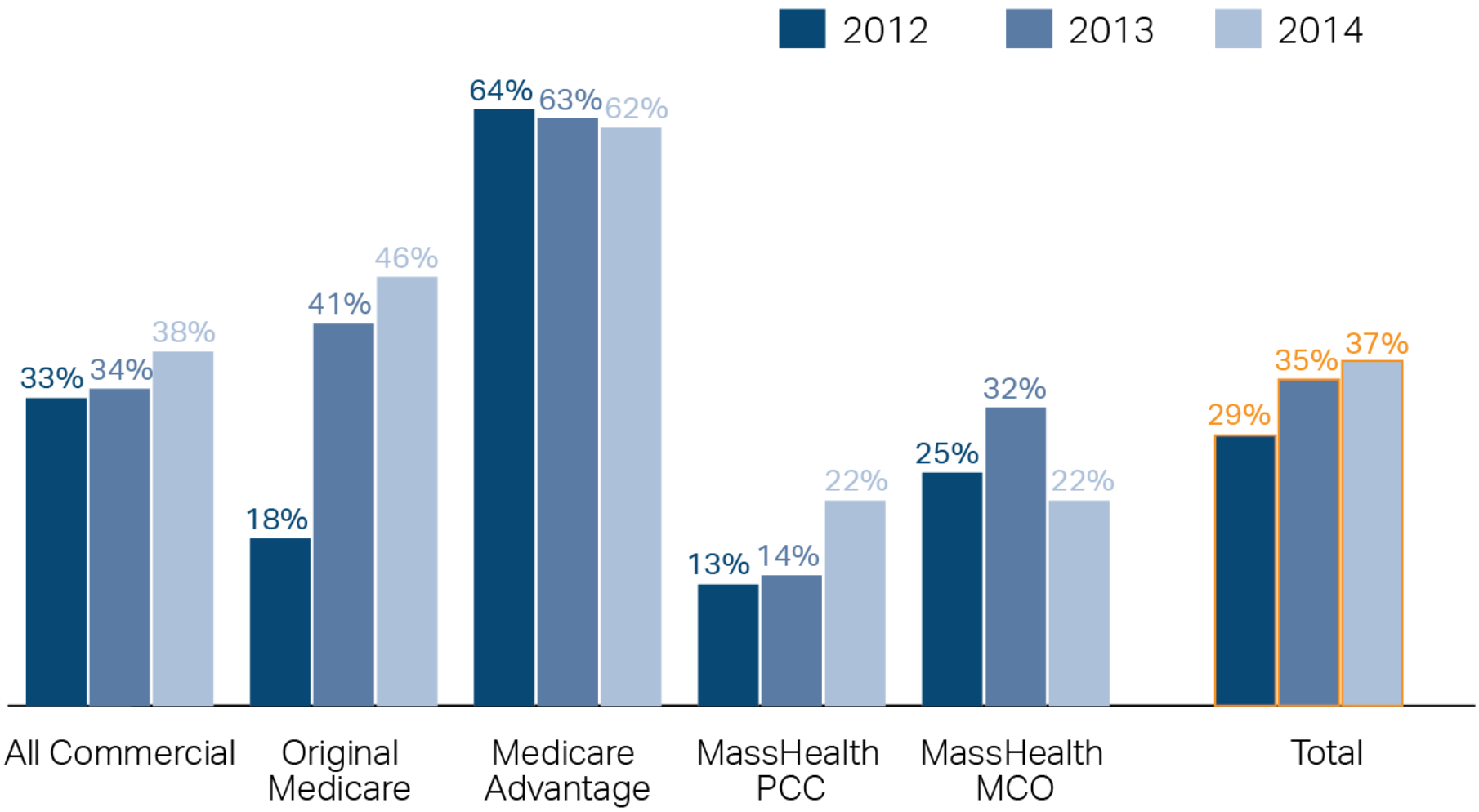
Most APMs in the MA market are based on a fee-for-service architecture



Source: CMS' Healthcare Payment Learning and Action Network

APMs cover less than half the market, and coverage varies by payer type

Percentage of covered lives in APMs across all payers



Note: See APM technical notes

Source: Center for Health Information and Analysis 2014 Annual Report Alternative Payment Methods Data Book, 2013; Center for Health Information and Analysis 2013 Alternative Payment Methods Baseline Report Data Appendix, 2012; Centers for Medicare & Medicaid Services Shared Savings Program Performance Year 1 Results; Other publicly-available Centers for Medicare & Medicaid Services data; MassHealth personal communication

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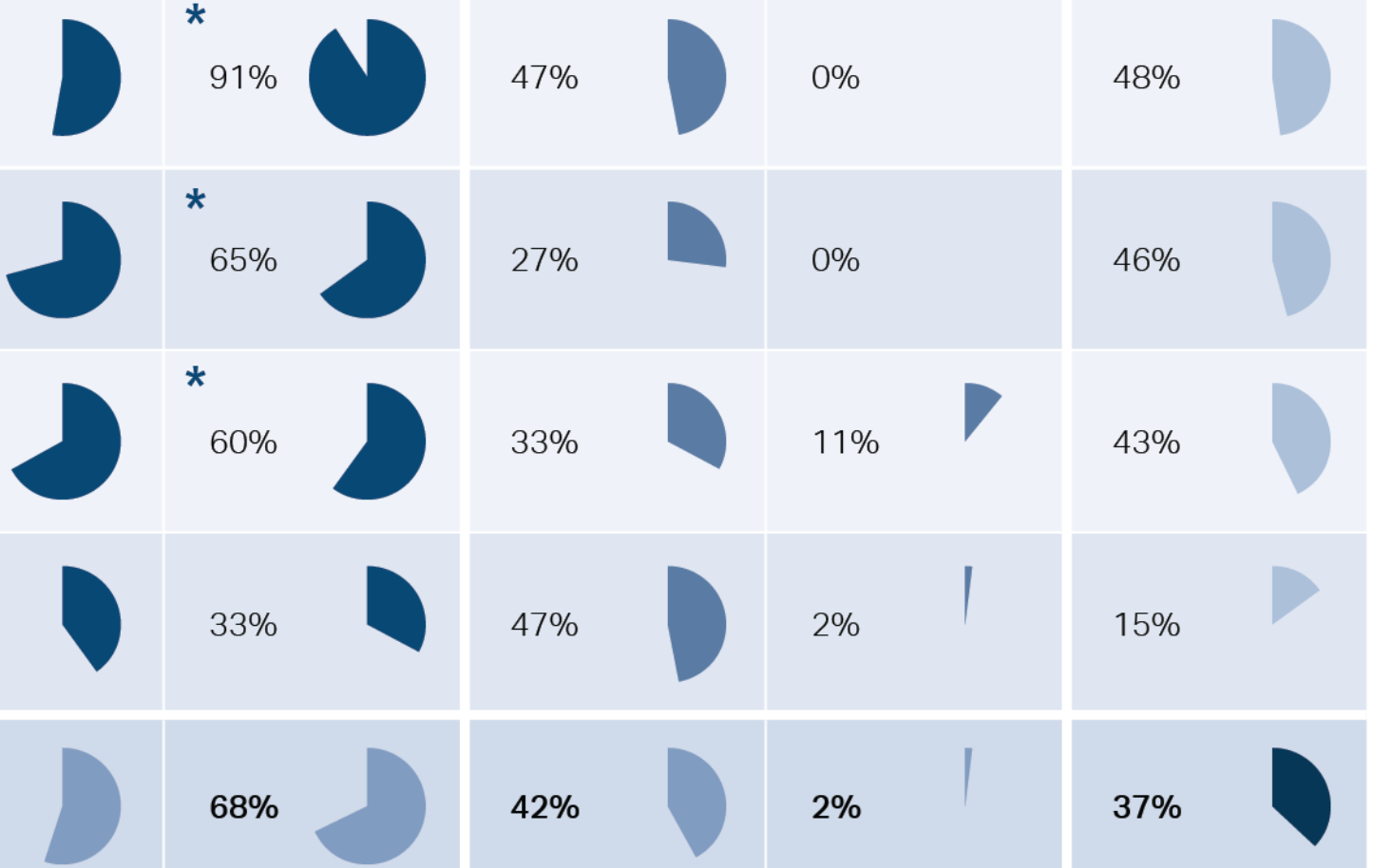
Among commercial payers, APM adoption in PPO remains low

	HMO members as percent of all members	Percent of HMO members covered by APMs	PPO members as percent of all members	Percent of PPO members covered by APMs	Percent of all members covered by APMs
BCBS	53%	* 91%	47%	0%	48%
HPHC HPI	71%	* 65%	27%	0%	46%
Tufts/ Network	67%	* 60%	33%	11%	43%
Other	40%	33%	47%	2%	15%
Total	**55%**	**68%**	**42%**	**2%**	**37%**



* Met HMO coverage goal from 2014 Cost Trends Report

Source: CHIA 2015 Annual Report, and HPC analysis of CHIA 2015 Annual Report APM data book

APM recommendations from the 2015 Cost Trends Report

9. Payers and providers should continue to focus on increasing the adoption and effectiveness of alternative payment methods (APMs):
   - APMs for commercial HMO patients – goal: 80% by 2017
   - APMs for commercial PPO patients – goal: 33% by 2017
   - Implement bundled payment in selected cases
   - Reduce disparities in payment levels
   - Include behavioral health and long-term services and supports

10. Payers and providers should seek to align technical aspects of their global budget contracts, including quality measures, risk adjustment methods, and reports to providers

Key opportunities to expand and improve APMs in Massachusetts

- Increase APMs across all insurance products, especially PPO
- Align and improve financial benchmarking
  - Transition from use of historic spending as primary basis for global budgets
  - Re-base budgets regularly
  - Consider differential budget increases based on initial spending levels (i.e., higher-spending providers receive smaller budget increases)
- Continue to move toward population-based payments
- Align and improve risk adjustment methodologies
  - Account for socioeconomic factors
  - Improve methods for pediatric populations
- Align quality metrics and attribution methodologies among all payers
- Ensure that other policies and market practices support and align with APM participation and incentives

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- HPC Staff Presentation: Supply-side incentives / alternative payment methods
- Presentation: Hoangmai Pham, MD, MPH, Chief Innovation Officer for the Center for Medicare and Medicaid Innovation
- **Stakeholder Discussion:**
  - **Expanding and improving APMs**
  - **Potential for APMs to reduce provider price and spending variation**
- Schedule of Next Meeting (May 19, 2016)

Strategies to expand and improve APMs: overview

Strategy	Examples of specific options	Considerations
Expand APMs	▪ Increase APMs for all insurance products, especially PPO ▪ Increase APMs for specialists and other provider types	▪ PPO patients don't select a PCP; providers more hesitant to take on accountability without the product-design tools to manage patient care ▪ Bundled payment extends APM incentives to additional providers and reaches additional patients ▪ Creating bundles may be operationally complex

Improve APMs	▪ Improve financial benchmarking
	▪ Align and improve risk adjustment, quality measures, and attribution
	▪ Ensure that other policies and practices reinforce APMs
		▪ Transitioning away from historic spending would mitigate historic pricing disparities
		  ▪ Transition should be phased in and coupled with other improvements (e.g. to risk adjustment)
		  ▪ Under voluntary system, APM contract terms must be more attractive to providers than FFS alternative
		▪ Providers strongly support alignment on risk adjustment, quality metrics, attribution, and financial benchmarks
		▪ Approaches to reducing price variation should complement efforts to expand and improve APMs
		▪ Some current market practices (e.g. provider-to-provider discounts) may weaken beneficial APM incentives

Contact Information

For more information about the Health Policy Commission:

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Appendices

- Supply-side incentives – additional slides
- Demand-side incentive slides which were not displayed at March 30 meeting due to time constraints
- Summary of discussion during March 30 meeting
- 2011 Special Commission on Provider Price Reform recommendations

Variance in physician group health status adjusted total medical expense (highest and lowest among 10 largest physician groups)

Health Status Adjusted TME, 2014

Blue Cross Blue Shield of Massachusetts

	Physician Group		HSA TME	% Difference
High	Partners	$	351.87	19.7%
Low	UMass	$	293.94	

Harvard Pilgrim Health Care

	Physician Group		HSA TME	% Difference
High	Partners	$	335.11	18.4%
Low	Boston Medical Center	$	283.03	

Tufts Health Plan

	Physician Group		HSA TME	% Difference
High	Partners	$	349.84	34.0%
Low	Boston Medical Center	$	261.11	

Source: 2014 CHIA TME Databook

Bundled payment

- Bundled payment = a single payment for all services associated with an episode of care
  - BP encourages the provider who manages the episode (often a specialist) to make value-based choices
  - BP potentially reaches all patients, whether or not they are covered by global payment
  - Medicare is significantly increasing its use of BP
  - BP may be operationally complex

Potential impact of bundled payment in MA

Analysis	Program modeled	Percent of spending covered	Savings to market
Rand, 2009	10 types of episodes 4 procedure, 6 chronic	31%	.1 to 5.9%
HPC, 2016 (rough calculation)	9 types of episodes used in Arkansas Medicaid BP program	15%	n/a

Note: HPC bundles were asthma, COPD, CHF, acute sinusitis, cholelithiasis, pregnancy with delivery, tonsillectomy, TJR, ADD. These represent 9/12 episodes bundled by AR Medicaid. Bundles were defined using Optum ETGs .
Source: HPC analysis of all-payer claims data base, 2012

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Key demand-side policy options

Strategy 1:

Using insurance design to encourage consumers to use high-value providers

- Tiered and limited network plans
- Reduced premiums for choosing high-value primary care providers (PCPs)
- Encouraging enrollment in value-based plans, e.g., defined employer contributions, active re-enrollment and/or premium holidays

Strategy 2:

Encouraging consumer shopping for services

- Reference pricing
- **Cash-back rebates and other consumer choice interventions**
- Price and quality transparency

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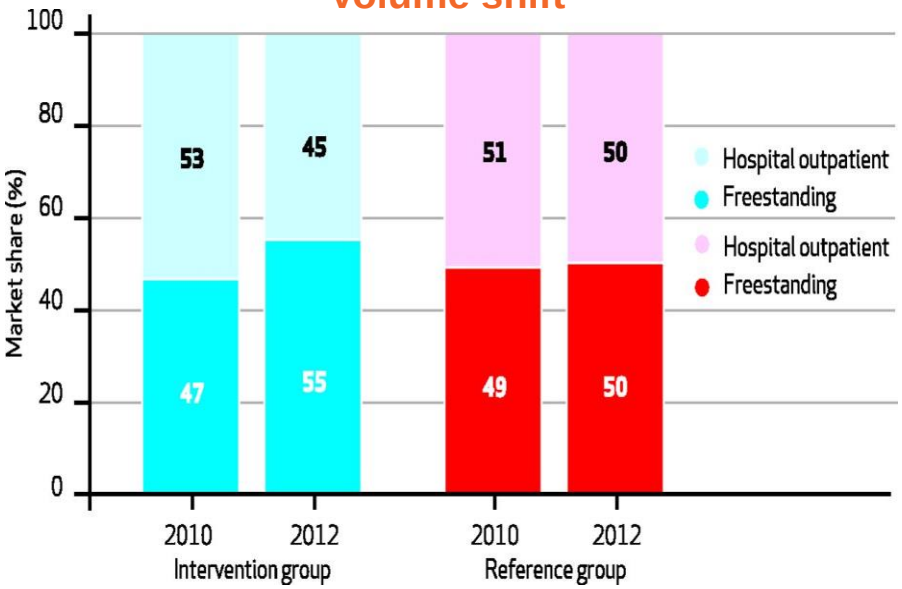
Cash-back incentives and other consumer choice interventions: Opportunities and limitations

- Cash-back rebates provide consumers with direct payments when they utilize providers designated as “high-value” providers.
  - The payer may identify specific high-value providers that consumers can choose in order to qualify for the rebate payments
  - Typically, these are used for services that are highly standardized, such as imaging services (MRI etc.) or labs
- Other interventions can also seek to steer patients to low-cost, high-quality providers
  - Simply alerting consumers to the existence of high-value providers may encourage their use, especially where consumers receive assistance in scheduling appointments with these providers
- Like reference pricing, these incentives and interventions are limited to services that consumers can shop for well in advance, and where quality is more transparent or services are more standardized

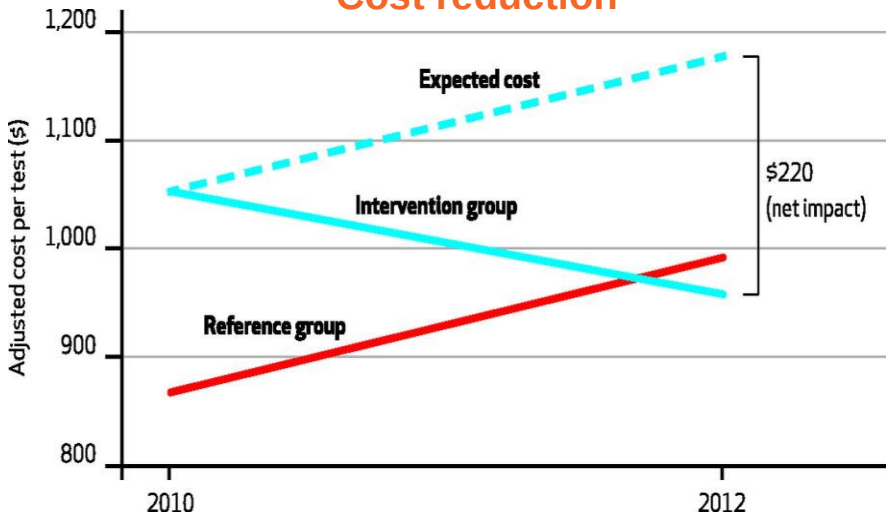
Consumer choice intervention: MRI example

- A specialty benefits management company implemented a voluntary, nationwide program
- Employees scheduled for an MRI were called by a benefits manager if there was a nearby alternative at lower cost and comparable or better quality
- The benefits manager rescheduled the appointment if the patient agreed

Volume shift



Cost reduction



Results

- Consumers who received calls spent 19% less on MRIs
- Hospital MRI prices dropped $360, freestanding site prices rose $85 (compared to controls)
- Several insurers in Massachusetts add cash-back incentives to augment this idea

Sze-jung Wu et al. Health Aff 2014;33:1391-1398. ©2014 by Project HOPE - The People-to-People Health Foundation, Inc..

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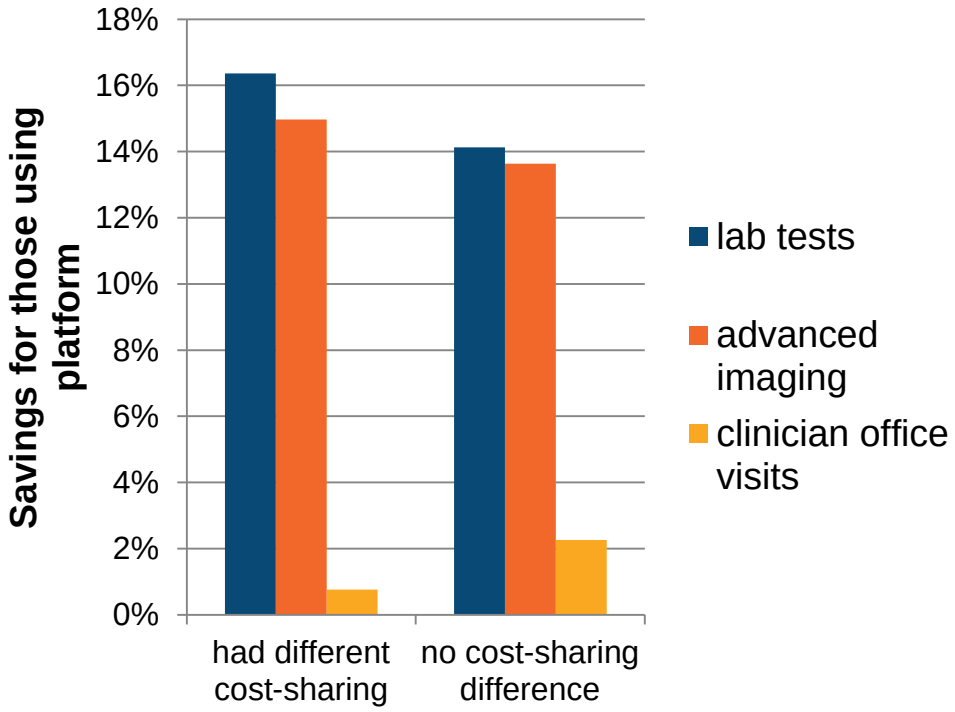
Price and quality transparency: Opportunities

- Price and quality transparency can facilitate consumer shopping:
  - Availability of price and quality information has led to lower spending among consumers who used a search tool (see next slide)
  - Clearer quality information presented alongside price information has been found to make consumers more likely to make high value choices (e.g. letting patients know if providers are rated as being responsive to patients' needs and whether providers use treatments "proven to get results.")
- Certain transparency requirements under existing Massachusetts law could consumer shopping:
  - Information on total medial expenses and relative prices for payers and providers
  - Health care providers are required give patients requested cost information within 2 business days
  - Payers are required to give patients requested cost information immediately
- Price and quality transparency are also necessary components of other demand-side incentives, such as reference pricing

Hibbard, JH, et al. (2012). An Experiment Shows That A Well-Designed Report On Costs and Quality Can Help Consumers Choose High-Value Health Care. *Health Affairs*, 31, 3: 560-568.; Whaley, C, et al. (2014). Association Between Availability of Health Services Prices and Payments for These Services. *JAMA*, 312, 16: 1670-1676; White, C, et al. (2014). Healthcare Price Transparency: Policy Approaches and Estimated Impacts on Spending. *Westhealth Policy Center: Policy Analysis.*

Price transparency example: Introduction of searchable price platform



Percent who used search tool:

Labs: 5.9%

Imaging: 6.9%

Office visits: 26.8%

- A multi-state insurer used a vendor (Castlight) to allow employees to search price and quality information for certain services
- Few used the search tool, but those who did had lower spending than those who did not
- While the existence of a cost-sharing difference between using higher- or lower-cost providers yielded larger effects, those with no cost-sharing differential also spent less

Association Between Availability of Health Service Prices and Payments for These Services. JAMA. 2014;312(16):1670-1676. doi:10.1001/jama.2014.13373

Transparency: Considerations and limitations

- The Commonwealth faces implementation challenges around current transparency laws:
  - Many providers do not currently provide price information as required
  - Payer websites may not be comprehensive, and can be difficult for consumers to navigate
  - Few consumers may use transparency sites: fewer than 50 uses per 1,000 members for 3 largest insurer websites in Massachusetts
- Price information alone, without data on quality, may lead consumers to use high-priced providers under the assumption that their quality is superior
- Transparency, like reference pricing, is only helpful in encouraging use of high-value providers for those services for which consumers can shop ahead of time

Anthony, B & Haller, S. (August 2015). Bay State Specialists and Dentists Get Mixed Reviews on Price Transparency. *Pioneer Institute, Center for Health Care Solutions: Policy Brief.* White Paper No. 135.; Anthony, B & Haller, S. (2015). Mass Hospitals Weak on Price Transparency. *Pioneer Institute, Center for Health Care Solutions: Policy Brief*; Report Card on State Price Transparency Laws; Health Care for All. (2015). Consumer Cost Transparency Report Card, *available at*: https://www.hcfama.org/updates/hcfas-2015-consumer-cost-estimation-report-card; 2015 Cost Trends Hearing Pre-Filed Testimony; See description of focus groups conducted for the HPC by Amy Lischko et al., in "Community Hospitals at a Crossroads," Health Policy Commission, March, 2016.

Demand-side incentives summary

1. Use of demand-side incentives can increase the use of efficient plan designs, shift volume to higher-value providers and reduce spending and prices through competition

2. Encouraging examples exist, but thus far, they have been somewhat limited and applied to only a subset of shoppable conditions

3. Demand-side incentives can complement other policy options

4. Overall, demand-side incentives may support a more competitive, value-driven market place but likely will not fully address unwarranted price variation alone

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March 30 Discussion Summary

- Tiered and Limited Networks
  - HPC staff described the concept of tiered and limited networks, current levels of market take-up of these products, and considerations and limitations associated with them.
  - Some stakeholders suggested that tiered products are too complicated for consumers and that tiering methods are inconsistent. There was significant concern that these products can interrupt care coordination, conflict with APMs, and place an excessive and regressive burden on consumers.
  - Other stakeholders noted that tiered products warrant further development and improvement to address noted concerns.
  - Stakeholders also discussed the level of incentives required to meaningfully shift consumer behavior (enrollment and using high-value care) and the importance of consumer education and transparency of tiering methods.
- Office of the Attorney General Presentation on Premiums Based on Value
  - The AGO described a model that would adjust insurance premiums based on the consumer's choice of primary care physician, with consumers paying less if they choose PCPs in systems with lower total medical expenses. This would not be a limited network product.
  - Many stakeholders found the construct to be interesting and worthy of further consideration, and many offered thoughtful questions for such future discussion.
- Reference pricing
  - Stakeholders agreed that reference pricing is only appropriate for certain planned episodes of care and requires considerable consumer education and communication.

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Review of the 2011 Special Commission on Provider Price Reform

- Charge from Chapter 288 of the Acts of 2010:
  - Examine policies aimed at enhancing competition, fairness and cost effectiveness in the health care market.
  - Examine provider variation in relative prices, costs, volume of care, and correlations between price and quality, patient acuity, payer mix, and the provision of unique services.
  - File a report of findings and recommendations.

- Recommendations:
  - Act upon the recommendations of the Special Commission on the Health Care Payment System to change the way we pay for and deliver health care services to improve the quality of care and reduce costs.
  - Increase transparency related to price variation.
  - Ensure competitive market behavior.
  - Evaluate the use and effect of products that increase consumer incentives to make cost-effective health care decisions.
  - Research acceptable and unacceptable factors for variation and then determine how they could be applied to reduce unacceptable variation in provider prices.
  - Establish a short-term process to ensure that higher prices more closely correlate to quality and thereby reduce costs.