2019 HEALTH CARE COST TRENDS HEARING

OCTOBER 23

MASSACHUSETTS
HEALTH POLICY COMMISSION

#CTH19

2019 HEALTH CARE COST TRENDS HEARING

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Up Next

The Office of the Attorney General

Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 12C, § 17

October 23, 2019

OFFICE OF ATTORNEY GENERAL
MAURA HEALEY
ONE ASHBURTON PLACE
BOSTON, MA 02108

AGO Cost Trends Examinations

- Authority to conduct examinations:
  - G.L. c. 12, § 11N to monitor trends in the health care market.
  - G.L. c. 12C, § 17 to issue subpoenas for documents, interrogatory responses, and testimony under oath related to health care costs and cost trends.
- Findings and reports issued since 2010.
- This examination focused on two key cost containment initiatives that aim to encourage patients and providers to choose higher-value care.

Questions Presented

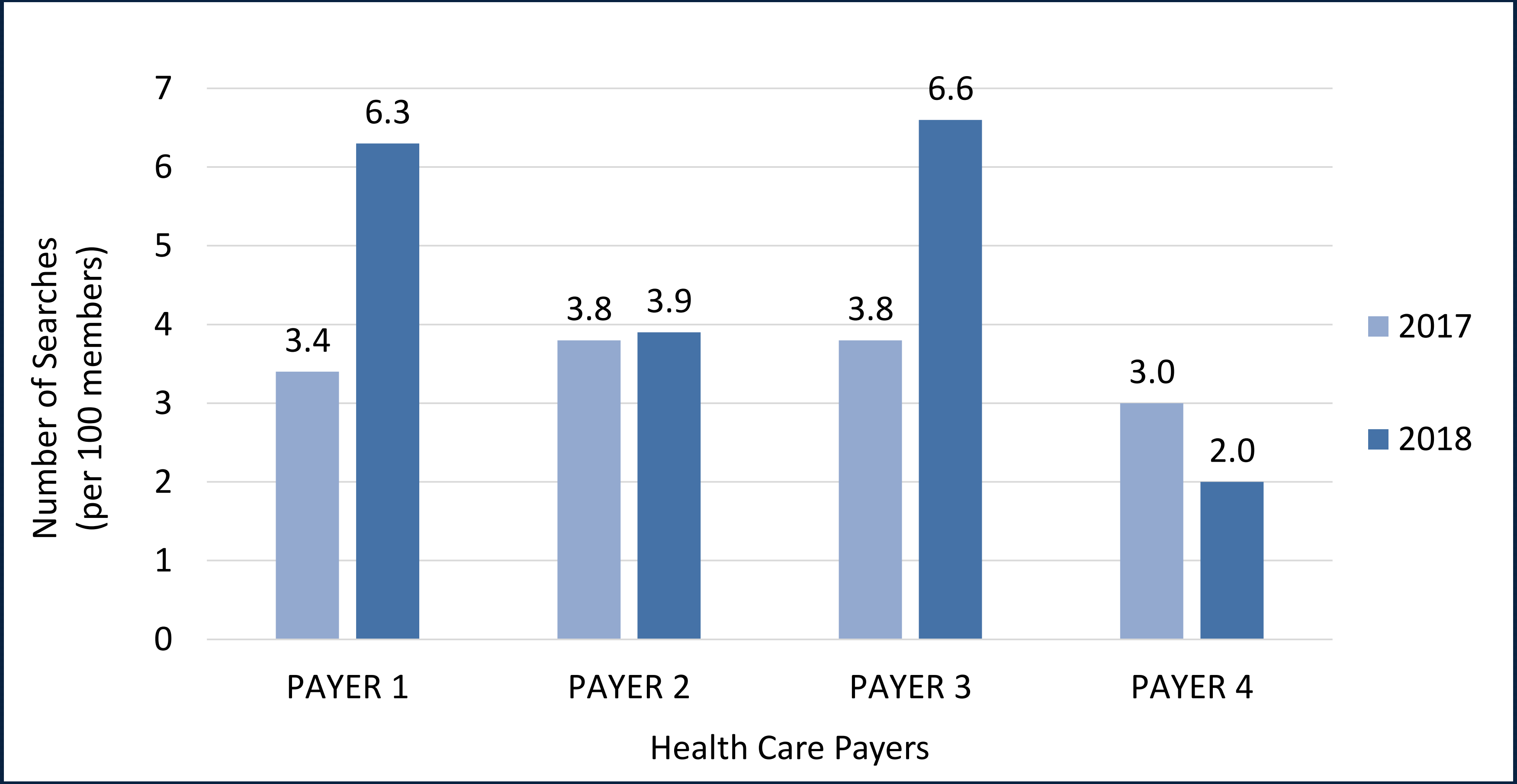
I. Are consumer-facing cost estimator tools influencing patients to select lower-priced care options?

II. How do patient movement across health plans and administrative complexity impact provider incentives in APMs?

III. Have patient expenditures shifted towards lower-priced hospitals in recent years?

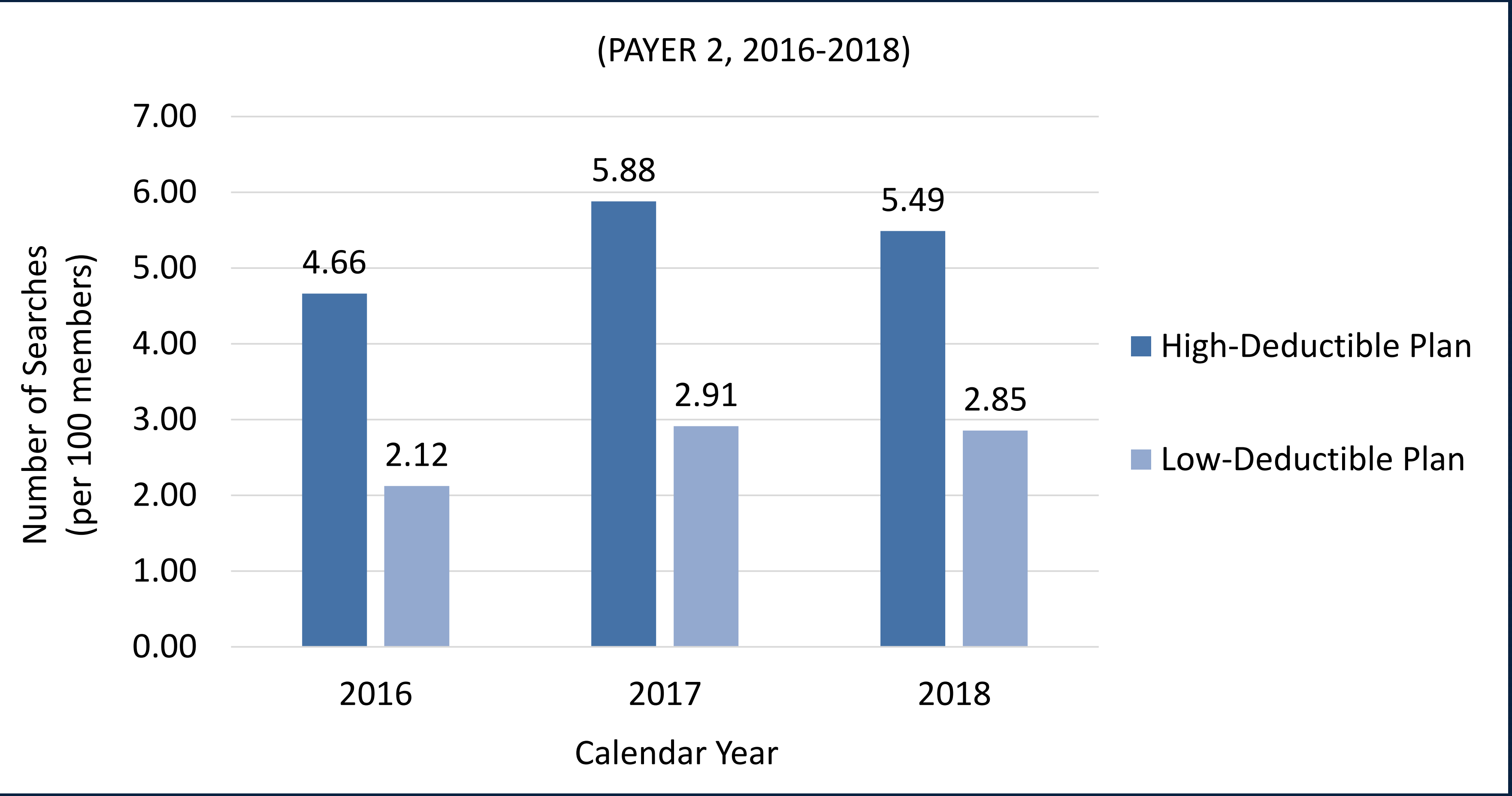
Few Patients Use Payers' Online Cost Estimator Tools

The Number of Searches Per 100 Members Ranged From 2.0 to 6.6 in 2017-18



Consumers in High-Deductible Plans Are More Likely to Use Cost Estimators

The Opportunity to Reduce Spending Among Consumers with High-Deductibles is Limited



Consumer "Shopping" Patterns Highlight Opportunities for Tool Enhancement

The Total Number of Searchable Services and Top Searched Services in 2018

	PAYER 1 (245 services)	PAYER 2 (1625 services)	PAYER 3 (105 services)	PAYER 4 (800 services)	PAYER 5 (770 services)	PAYER 6 (302 services)
1	Imaging (MRI, Mammography)	Physician Office Visits	Imaging (MRI, X-Ray)	Imaging (MRI, Ultrasound)	Imaging (MRI, X-Ray)	Imaging (MRI, X-Ray)
2	Colonoscopy	Imaging (MRI, X-Ray)	Clinical Pathology	Specialist Office Visits	Clinical Pathology	Pregnancy & Childbirth
3	Physician Office Visits	Behavioral Health	Colonoscopy	Physician Office Visits	Pregnancy & Childbirth	Colonoscopy
4	Elective Surgery (Orthopedic)	Pregnancy & Childbirth	Elective Surgery (Bariatric)	Colonoscopy	Elective Surgery (Gastrointestinal)	Physician Office Visits
5	Pregnancy & Childbirth	Chiropractic Visits	Pregnancy & Childbirth	Behavioral Health	Preventive Care	Elective Surgery (Bariatric)

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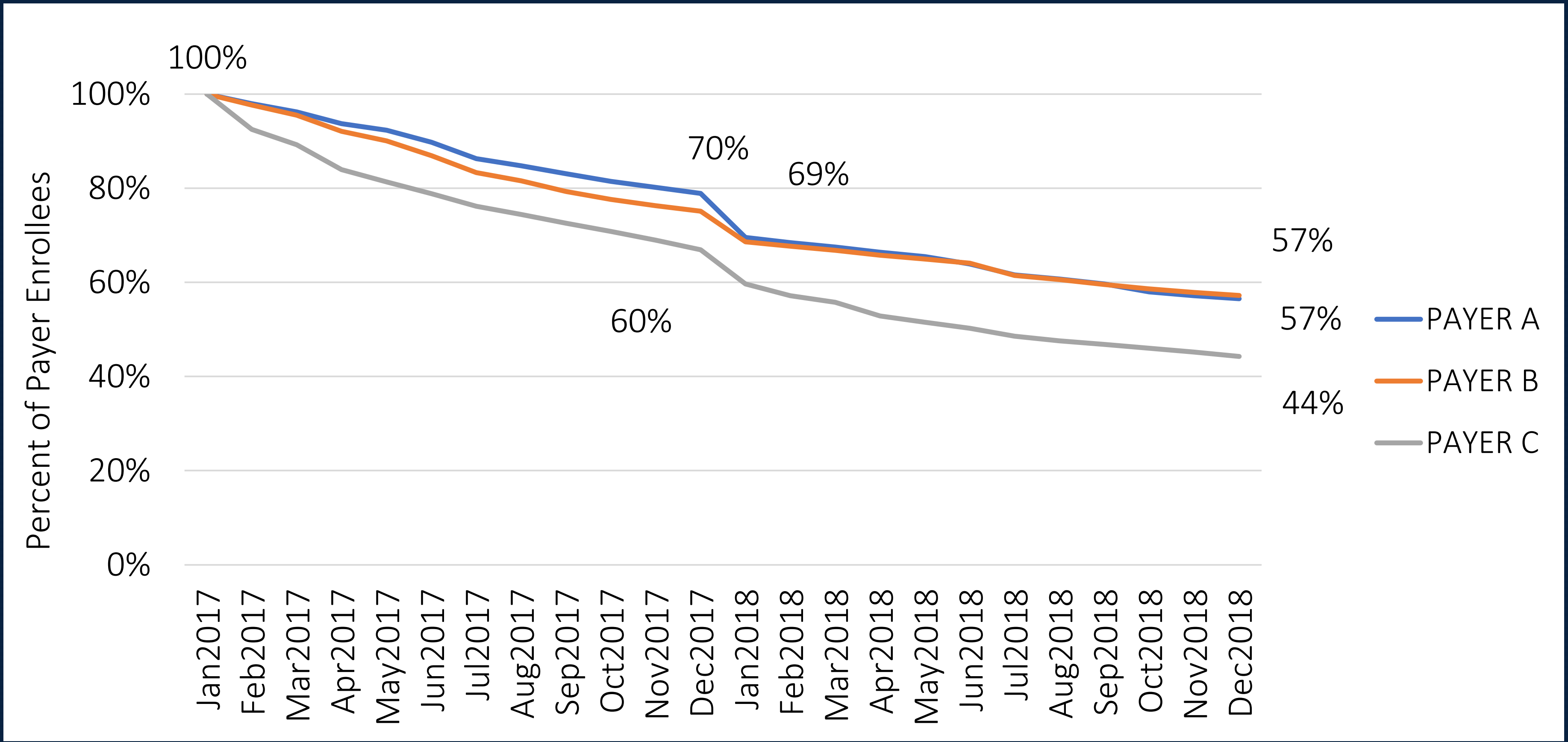
I. Are consumer-facing cost estimator tools influencing patients to select lower-priced care options?

II. How do patient movement across health plans and administrative complexity impact provider incentives in APMs?

III. Have patient expenditures shifted towards lower-priced hospitals in recent years?

Patient Movement Across Payers Makes it Difficult to Measure APM Performance

Only Half of Patients Enrolled in a Payer or Product Remained Over a Two-Year Period
(Jan. 2017 - Dec. 2018)



Complex APM Attribution Methods May Add Costs and Hinder Incentives

Attribution Methods Varied Across Three Payers in 2018

	PAYER A	PAYER B	PAYER C
Providers Eligible for Attribution	• Primary Care Physicians • Specialty Care Physicians	• PCPs • Double-Boarded Physicians (i.e. PCP/SCP combination)	• PCPs • Nurse Practitioners (“NPs”) • Physician Assistants (“PAs”)
Attribution Lookback Period	18-27 months	24 months	24 months
Attribution Criteria and Methodology	• Member selection of PCP • Well-visit in previous 24 mos. • Evaluation and Management visit (“E&M”) in previous 24 mos. • Prescription (“Rx”) from a PCP in previous 24 mos. • Well-visit with certain SCPs in previous 24 mos. • E&M visit with certain SCPs in previous 24 mos. • Rx from certain SCPs in previous 24 mos.	• PCP visit in previous 24 mos. • Rx in previous 24 mos.	• Member selection of PCP, NP, PA • At least 1 well-visit in previous 12-24 mos. (if multiple, most recent visit) • At least 1 E&M visit in 12-24 mos. (if multiple, most recent visit) • 3 or more Rx from a PCP in previous 12-24 mos. (if multiple, most prescriptions; if tied, most recent)
Attribution Limitations		• All IP, OP and Behavioral Health claims are excluded	• Patient must be MA Resident • OP claims must be in MA

Questions Presented

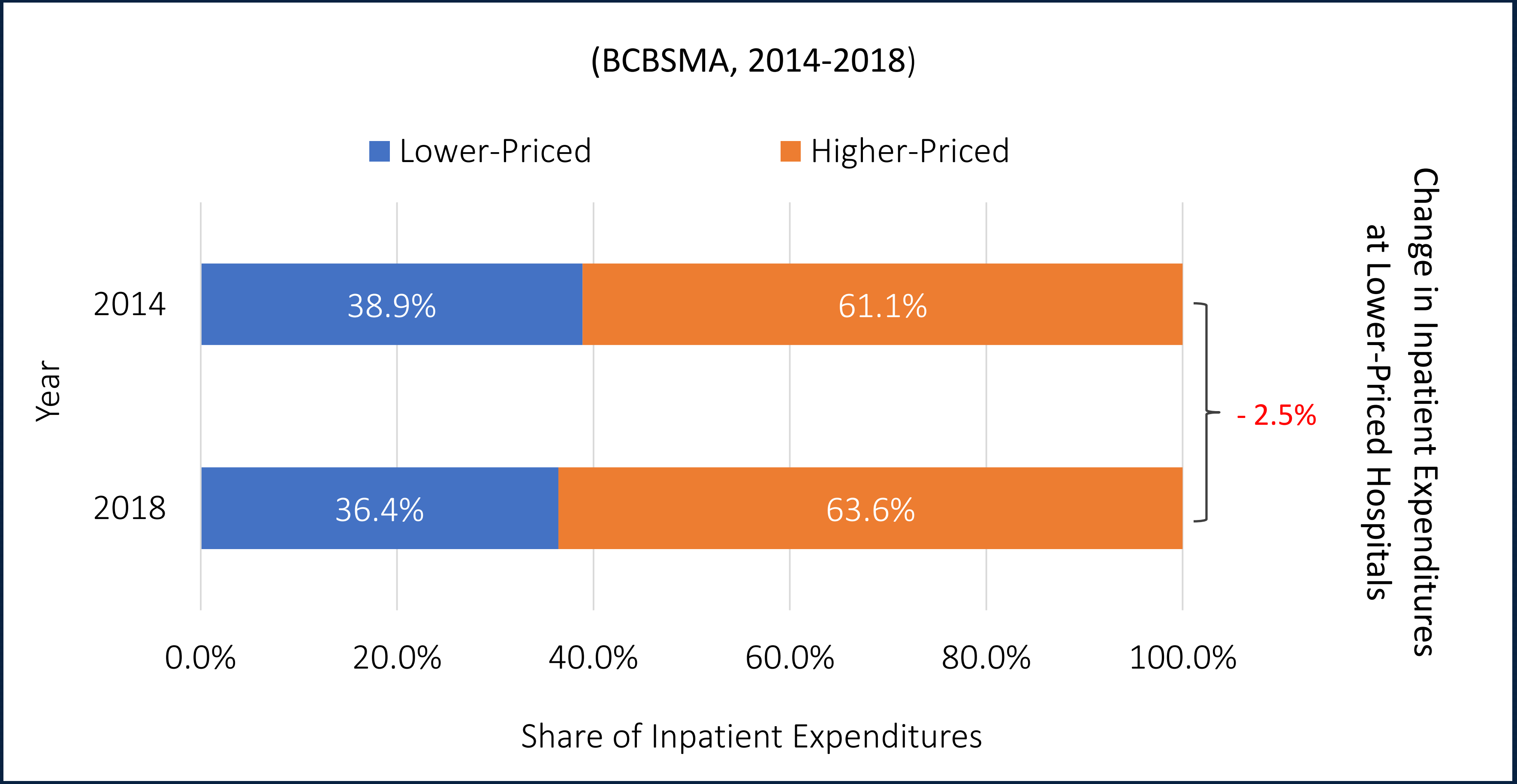
I. Are consumer-facing cost estimator tools influencing patients to select lower-priced care options?

II. How do patient movement across health plans and administrative complexity impact provider incentives in APMs?

III. Have patient expenditures shifted towards lower-priced hospitals in recent years?

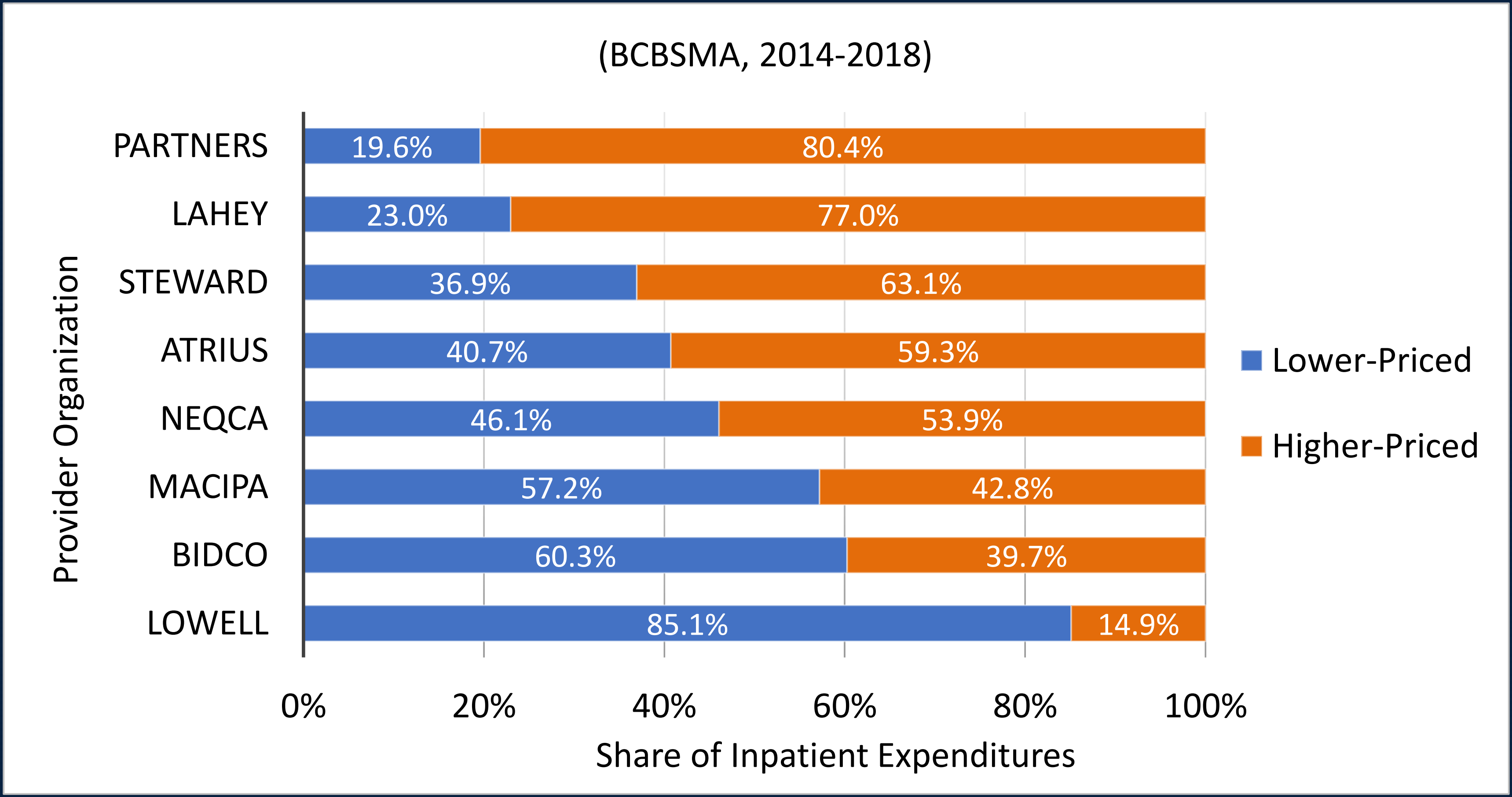
Expenditures at Lower-Priced Hospitals Have Decreased Since 2014

The Share of Inpatient Expenditures at Higher-Priced Hospitals Increased by 2.5%



Expenditures at Lower-Priced Hospitals Varied Significantly Across Providers

System Composition May Influence Patient Use of Lower and Higher-Priced Hospitals



Recommendations

1. Temper expectations that consumer-driven price transparency tools will reduce health care cost growth.
   - Design transparency tools that help consumers choose PCPs affiliated with high-quality, lower-cost systems.
   - Enhance cost estimator tools to focus on shoppable services, expand access for non-English speakers, and integrate pharmacy, behavioral health services.
2. Closely review incentives for providers to direct patients to lower-cost settings.
3. Recognize that providers' APM incentives are hampered by frequent patient movement across payers.
4. Standardize APM attribution methods.

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Up Next

Presentation: State Policy Options to Increase Investment in Primary Care

Dr. Marie Ganim, Health Insurance Commissioner, Rhode Island

Mr. Chris Koller, President, Milbank Memorial Fund

INVESTING IN PRIMARY CARE

A RHODE ISLAND CASE STUDY

Marie Ganim, PhD.
Health Insurance Commissioner
State of Rhode Island

The Office of the Health Insurance Commissioner (OHIC) was created by the Rhode Island General Assembly in 2004.

OHIC'S KEY PRIORITIES

- Protecting the interest of consumers
- Guarding the solvency of health insurers
- Encouraging policies and developments that improve the quality and efficiency of health care service delivery and outcomes
- Viewing the health care system as a comprehensive entity and encouraging and directing insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

AGENDA

- Primary Care Investment in Rhode Island
- Considerations for Policy Design
- Tracking Investment and Accountability
- Next Steps in the Evolution of Primary Care Investment
- Integrated Behavioral Health in Rhode Island
- Primary Care Payment Reform

PRIMARY CARE INVESTMENT IN RHODE ISLAND

- In 2010 OHIC required commercial insurers to increase the percentage of their overall medical spending dedicated to primary care by 1 percentage point per year for five years.
- The primary care spending requirement was one of several *Affordability Standards* established by OHIC.

CORRECT UNDERINVESTMENT IN RHODE ISLAND COMPARED TO HIGH PERFORMING SYSTEMS.

POLICY LEVER TO DRIVE TRANSFORMATION OF PRIMARY CARE.

OPPORTUNITY TO IMPROVE SYSTEM PERFORMANCE ON COST, QUALITY AND ACCESS.

RHODE ISLAND'S RATIONALE FOR PRIMARY CARE INVESTMENT

CONSIDERATIONS FOR POLICY DESIGN

- What constitutes spending on primary care?
- What is your baseline and how does it compare to external benchmarks?
- What outcomes do you want to achieve?
- Once you decide to increase investments, what specific investments should be encouraged?

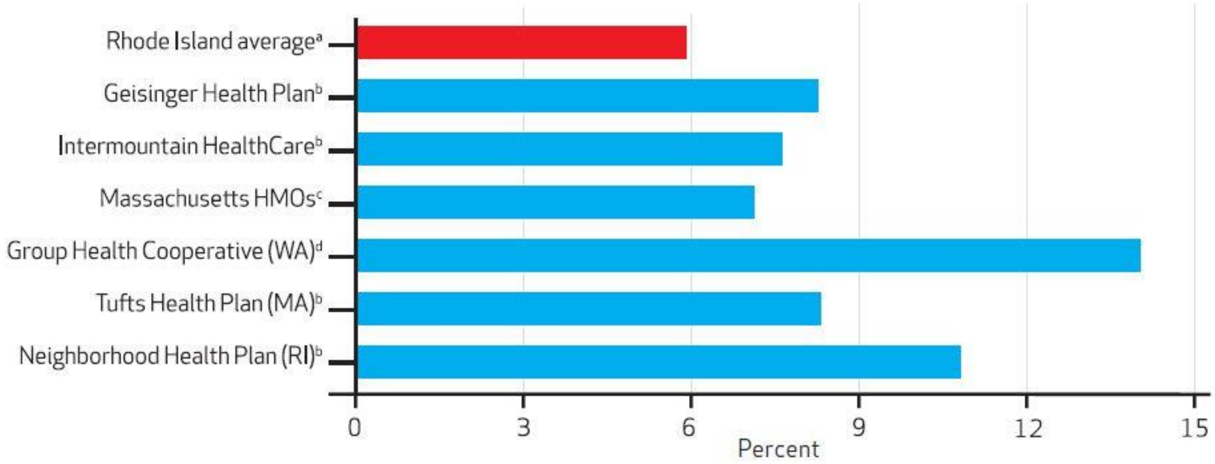
PRIMARY CARE INVESTMENT AS A POLICY LEVER

- Rhode Island used mandatory investment in primary care as a catalyst for practice transformation and payment reform.
- Rhode Island convened a multi-payer PCMH project and encouraged investment in PCMHs.
- Investments through non-FFS payments were specifically encouraged.

RHODE ISLAND'S BASELINE MEASUREMENT

EXHIBIT 1

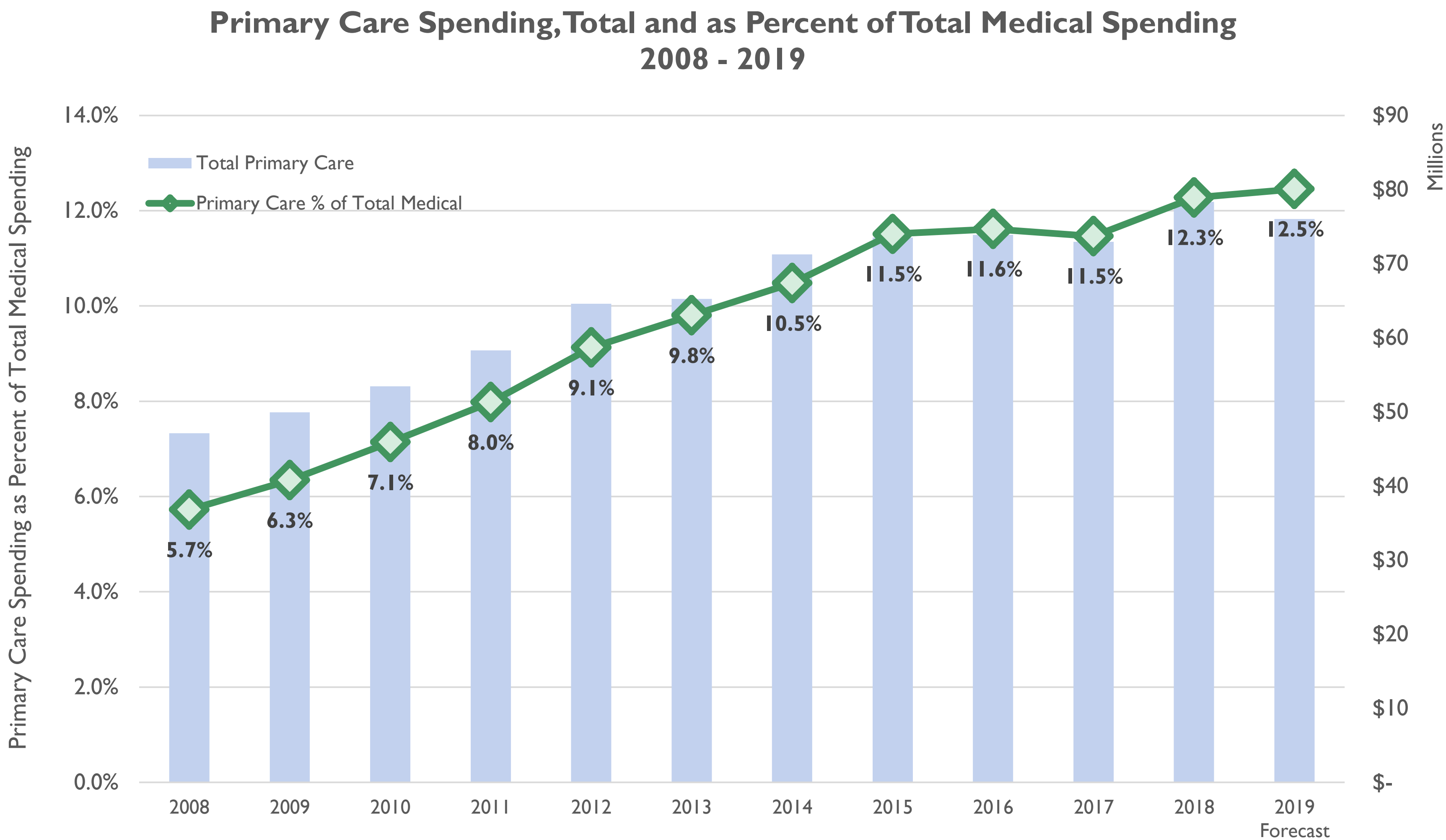
Primary Care Spending As A Percentage Of Total Medical Spending, Rhode Island Average (Baseline) And Benchmarks From Six Large Insurers



SOURCES Office of the Health Insurance Commissioner, Rhode Island; and various other sources (see below). **NOTES** The Rhode Island average is the mathematical average of the two largest commercial insurers in the state, Blue Cross Blue Shield of Rhode Island and UnitedHealthcare of New England. The Rhode Island target is 10.9 percent, which is the current rate plus five percentage points, as set in affordability standards. [a]Plan-specific spending rates are greatly influenced by membership mix. [b]Source: Self-reported by insurers. [c]Source: Oliver Wyman Study, 2008 Sep, based on commercial, fully insured health maintenance organizations (HMOs) only. Primary care includes obstetrics/gynecology; excludes pay-for-performance. [d]Source: Wagner EH, director of the MacColl Institute for Health-care Innovation, Center for Health Studies, Group Health Cooperative. Group Health Cooperative is a group-model HMO with owned facilities, like Kaiser Permanente.

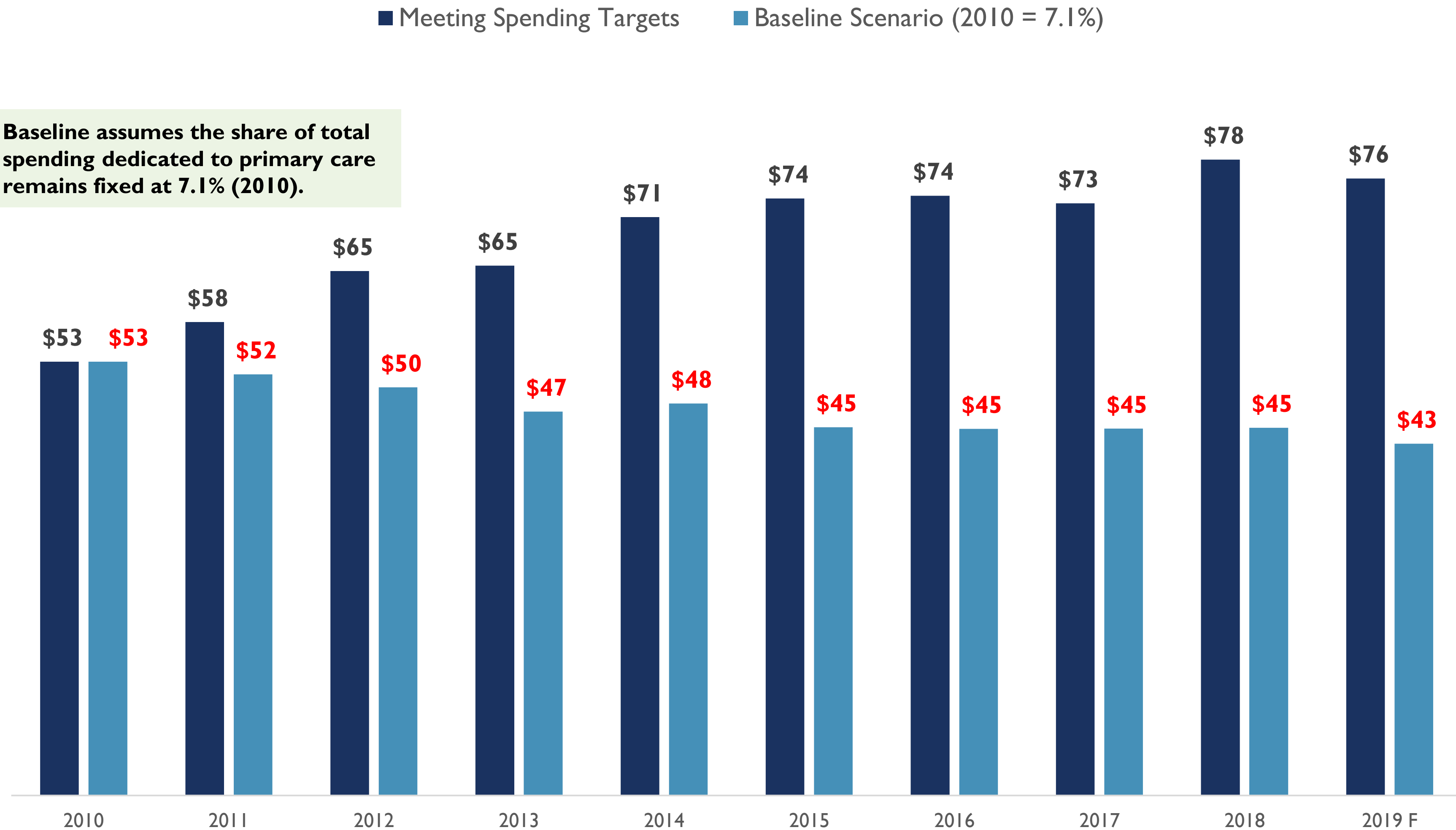
Koller, C. F., Brennan, T. A., & Bailit, M. H. (2010). Rhode Island's Novel Experiment To Rebuild Primary Care From the Insurance Side. *Health Affairs, 29*(5), 941-947.

TRACKING INVESTMENT & ACCOUNTABILITY

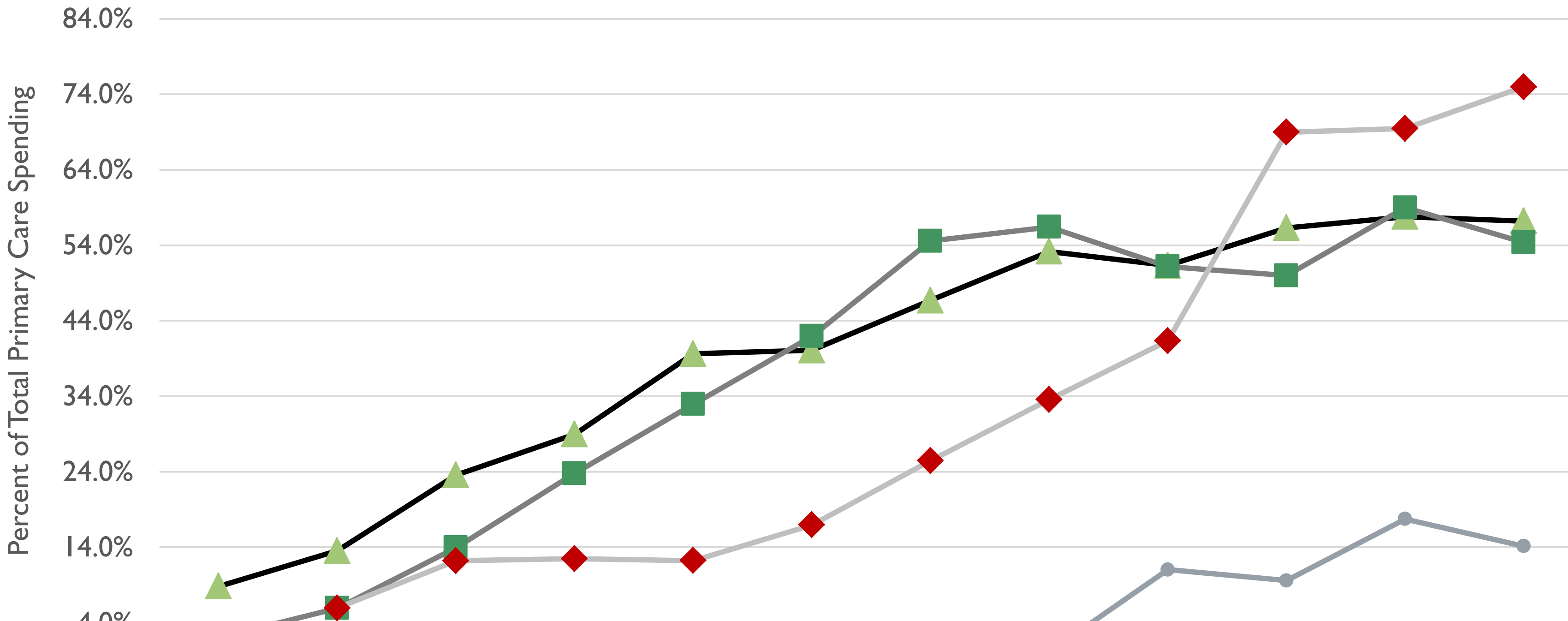

Primary Care Spending, Total and as Percent of Total Medical Spending
2008 - 2019
Primary Care Spending as Percent of Total Medical Spending
Millions
Total Primary Care
Primary Care % of Total Medical
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
$90
$80
$70
$60
$50
$40
$30
$20
$10
$-
5.7%
6.3%
7.1%
8.0%
9.1%
9.8%
10.5%
11.5%
11.6%
11.5%
12.3%
12.5%
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
Forecast

Total Primary Care Spending (in Millions) Actual vs. Baseline Scenario

Baseline assumes the share of total spending dedicated to primary care remains fixed at 7.1% (2010).



Percent of Primary Care Spending Dedicated to Non-FFS Investments by Insurer 2008 - 2019



	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 Forecast
BCBSRI	8.8%	13.5%	23.6%	29.0%	39.6%	40.1%	46.7%	53.2%	51.3%	56.3%	57.8%	57.2%
UHC	2.0%	5.9%	13.9%	23.8%	33.0%	42.0%	54.6%	56.4%	51.2%	50.0%	59.0%	54.4%
THP		6.0%	12.2%	12.5%	12.2%	17.0%	25.5%	33.6%	41.3%	69.0%	69.5%	75.0%
NHP								0.1%	11.0%	9.6%	17.7%	14.2%

RHODE ISLAND NAMED MOST IMPROVED STATE BY THE COMMONWEALTH FUND

- The Commonwealth Fund assesses and ranks each state on 47 measures of health care access, quality, efficiency, health outcomes, and disparities. This year, Rhode Island was ranked as the number one most improved state in the country.
- Rhode Island has improved nine ranks over other states – making Rhode Island the seventh highest ranking state in the country. In the past year Rhode Island has improved on access and affordability, prevention and treatment, disparity, healthy lives, and uninsured adults.

RI Ranking Highlights	2019 Ranking	Change from Baseline*
Overall Ranking	7	+9
Access and Affordability	3	+10
Prevention and Treatment	5	+15
Avoidable Hospital Use and Cost	26	-3
Healthy Lives	11	+14
Disparity	13	+7

*The baseline year varied depending on each measure - it ranged from 2011 - 2016.

The Commonwealth Fund

NEXT STEPS IN THE EVOLUTION OF PRIMARY CARE INVESTMENT

INTEGRATED BEHAVIORAL HEALTH

- OHIC has prioritized the integration of behavioral health into the primary care setting as a cost-effective way of increasing access to behavioral health services.
- A 2019 analysis of the CTC-RI's Community Health Teams work shows significant reductions in patient health risk, depression, and anxiety after less than 5 months in care.
- Among other successes, the CTC-RI Integrated Behavioral Health program has also reduced emergency department visits.
- OHIC is committed to the expansion of the IBH model in primary care by:
  - Removing administrative barriers to IBH.
  - Promoting provider payment models which enable and sustain IBH.

PRIMARY CARE PAYMENT REFORM

- OHIC is encouraging the adoption of APMs for primary care.
- APMs, such as capitation, may encourage transformations in the delivery of primary care that are not possible under fee-for-service payment.
- OHIC has aligned quality measures for primary care.
  - For 2020 there are 8 core measures and 14 menu measures.
  - The measure sets are updated annually.

LINKS FOR MORE INFORMATION

- OHIC website: ohic.ri.gov
- Affordability Standards Regulations: http://www.ohic.ri.gov/documents/2016-OHIC-Regulation-2-amendments-2016-12-12-Effective-2017-1-1.pdf

Milbank Memorial Fund

Using evidence to improve population health.

The Case for a Primary Care–Oriented Delivery System

Massachusetts Health Policy Commission

October 23, 2019

Christopher Koller

What Is Primary Care?

Barbara Starfield's 4 characteristics of effective primary care

- First Contact
- Comprehensive
- Coordinated
- Continuous

From the Patient-Centered Primary Care Collaborative:

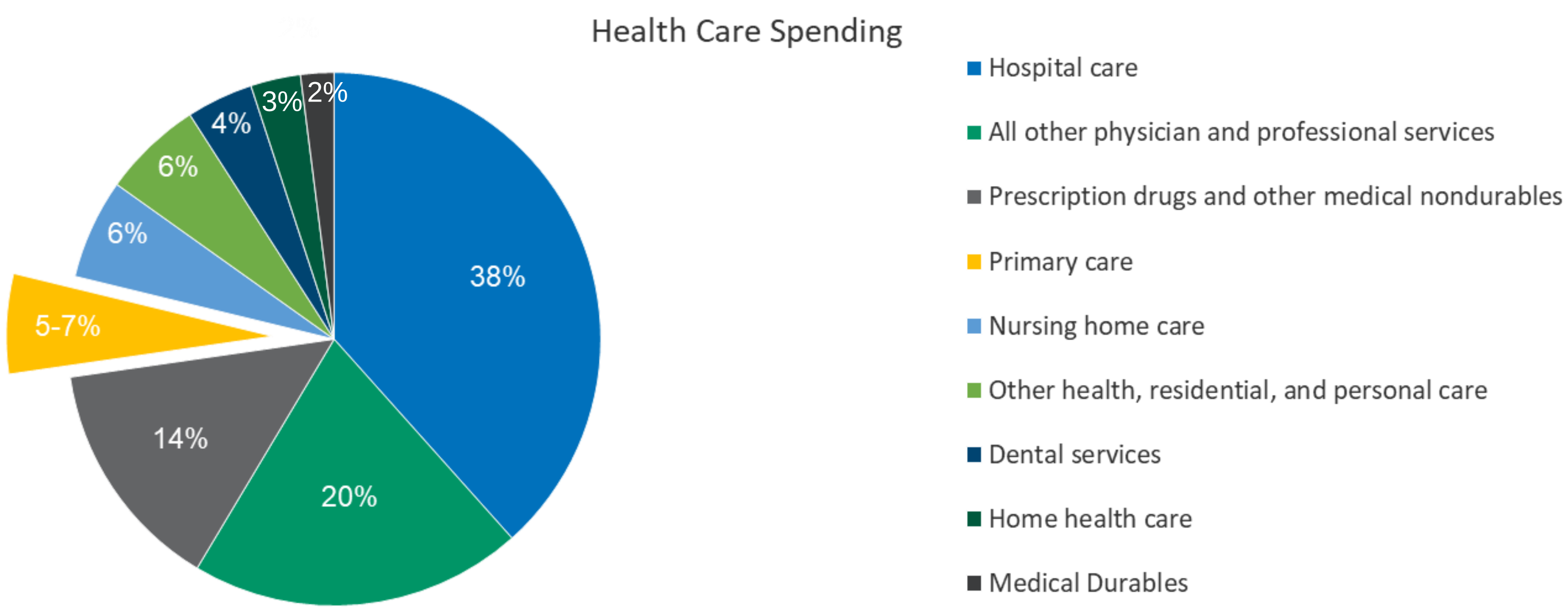
Why Should an Entity Accountable for Population Health Outcomes Be "Primary Care Oriented"?

- "Primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of primary care, or the receipt of important features of primary care. "
- "Primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations"

—Starfield, Shi, Macinko (*Milbank Quarterly*, 2005)

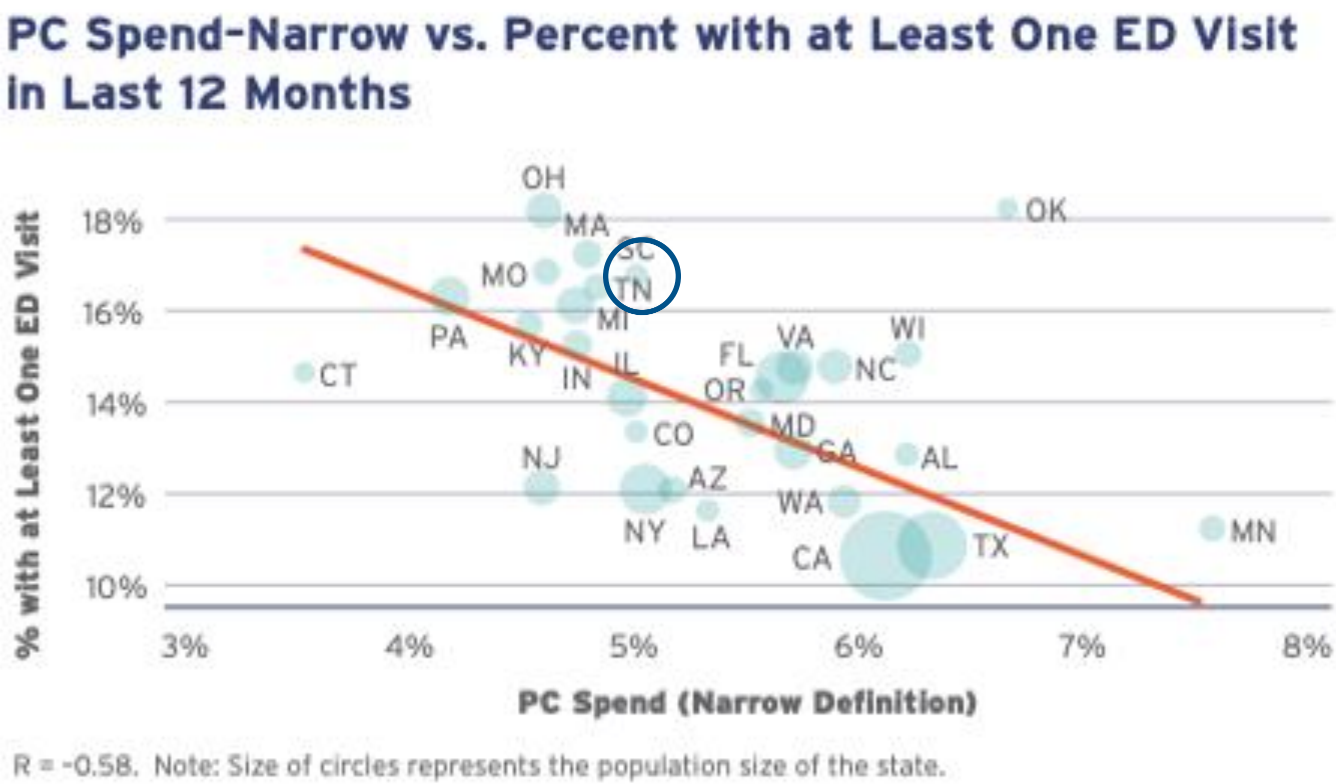
Primary Care Spending Is a Way to Evaluate an Entity's Primary Care Orientation

- Easily understood by many people
- Focuses on dollars
- Distinguishes low percentage of primary care spending relative to other health spending and other countries



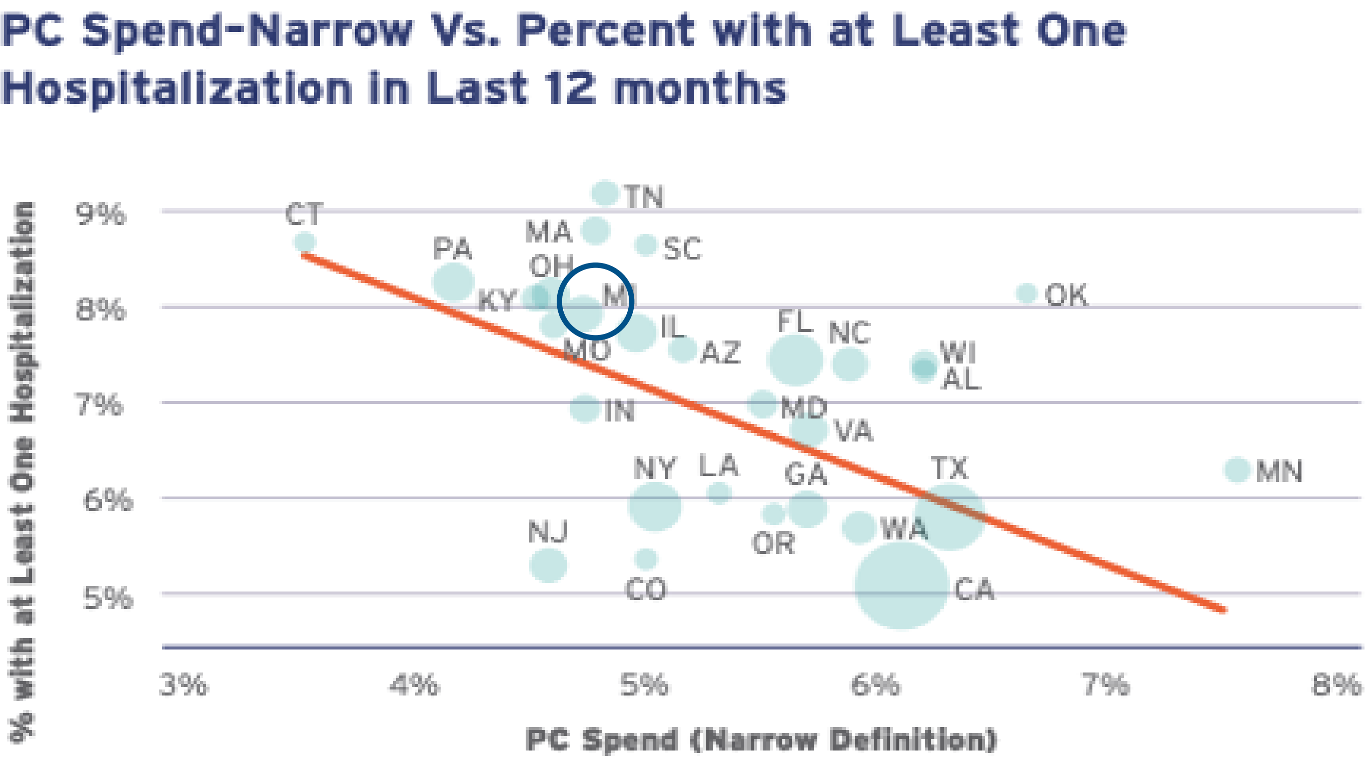
Source: Patient-Centered Primary Care Collaborative – Investing in Primary Care, 2019

It is Significant: As Primary Care Spending Increases, ED Visits Decrease…



Source: PCPCC 2019 Evidence Report, "Investing in Primary Care: A State-Level Analysis, July 17, 2019. Commercial and Medicare spend combined. .

...and Hospitalizations Decrease



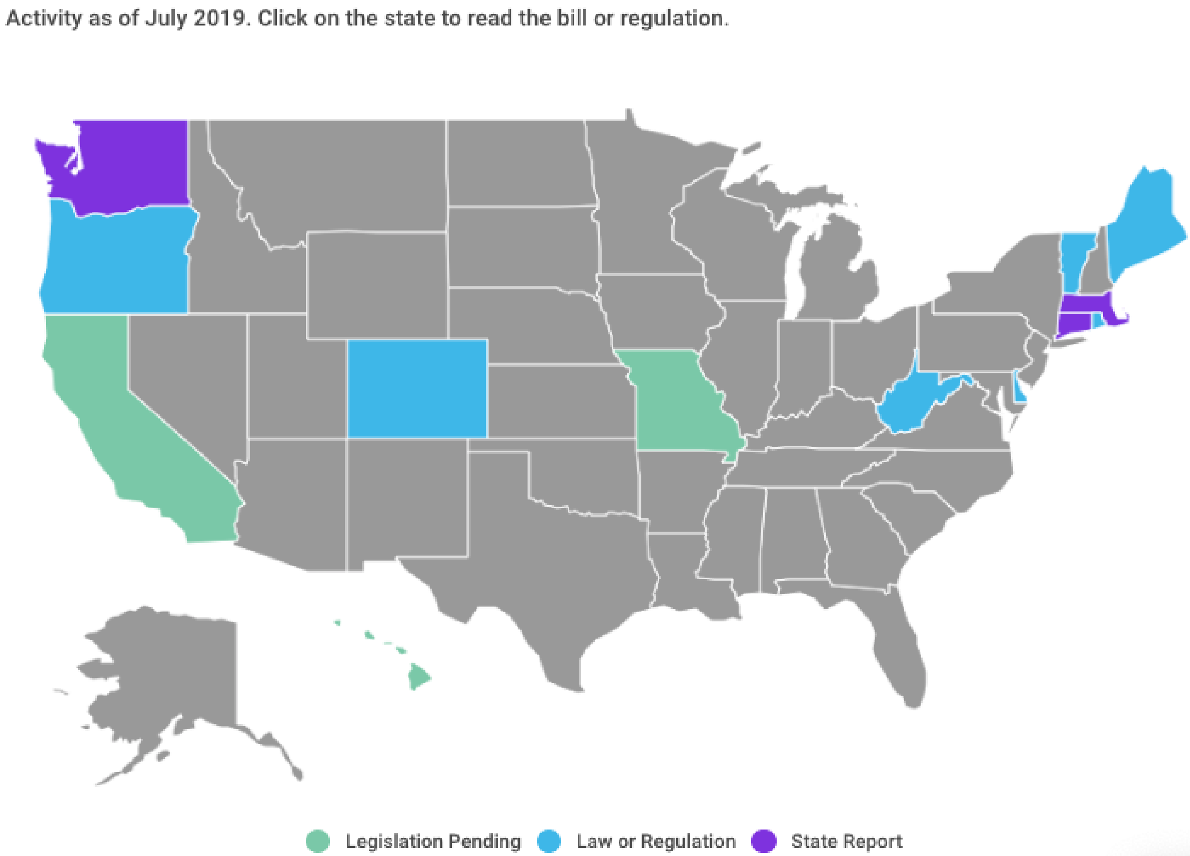
R = -0.58. Note: Size of circles represents the population size of the state.

Source: PCPCC 2019 Evidence Report, "Investing in Primary Care: A State-Level Analysis, July 17, 2019 Commercial and Medicare spend combined.

Alternate Payment Mechanisms alone will not promote a Primary Care-Oriented Delivery System

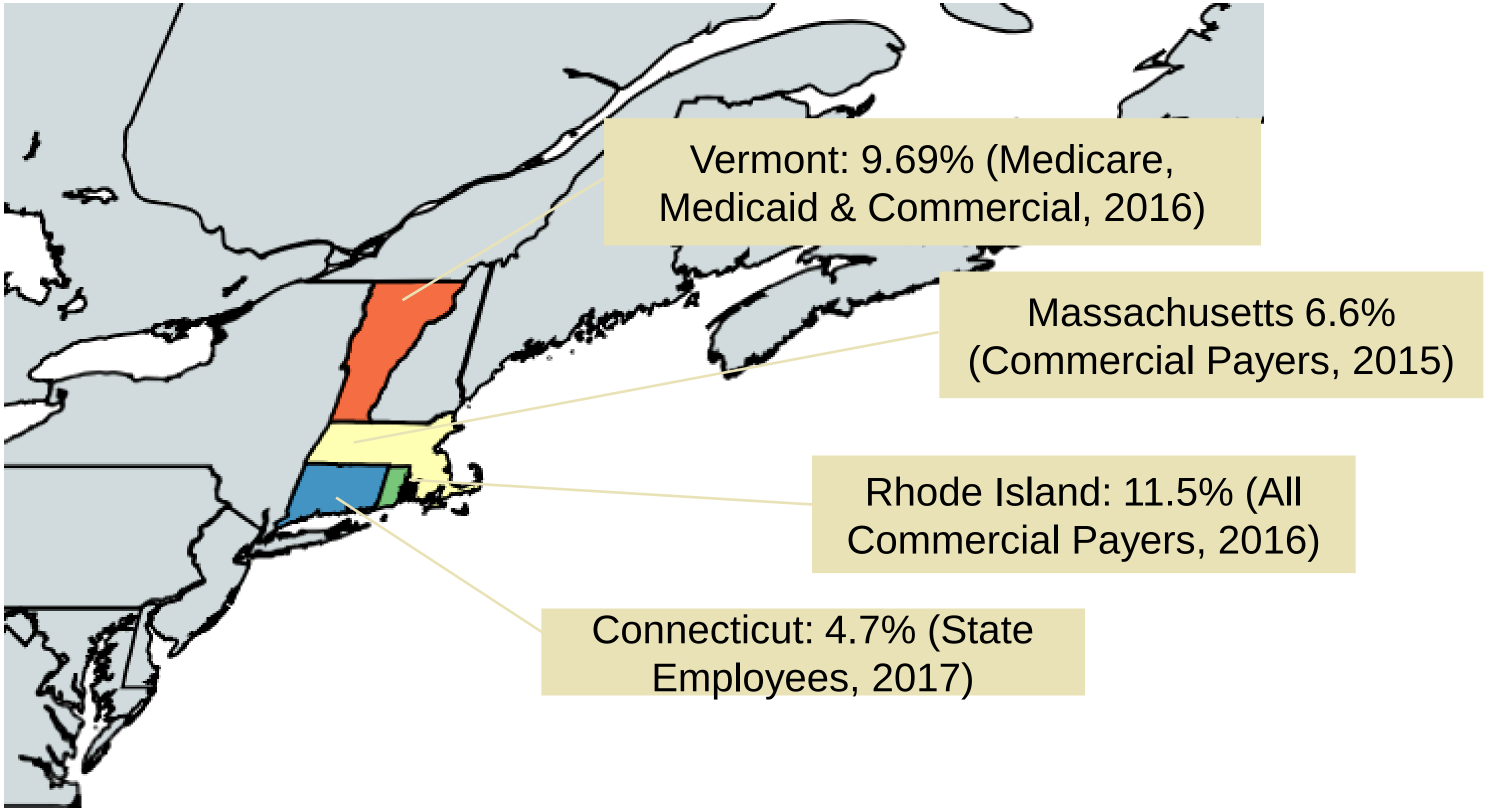
- Yes - Primary Care–based Accountable Care Organizations do better than hospital- or specialty- based ACOs.
- But health care does not not follow rules of market.
- Addressing the economics is not enough- must address the politics as well
- Intent behind state-level action on Primary Care Spending
- Consistent with a "market-oversight" state health policy

States Are Taking Action to Promote More Primary Care Spending



- Reporting
- Formal Measurement and Study
- Increase and Maintain (OR and RI)

Collaborative Activity in New England on Measuring Primary Care Spending Rates



Health Policy Commission staff have played an integral role in the Primary Care Workgroup established by New England States Consortium Systems Organization. The workgroup generated these primary care spend estimates for states that had data available.

Biggest Lesson from Other States: Must Not Only Measure but Have Ongoing Public Discussion

- Oregon – Commission, ongoing legislation
- Rhode Island – Health Insurance Advisory Council
- Other states have created primary care collaboratives, which are designed to bring stakeholder input into state policy decisions on primary care investment
- Need to create a public discussion that prioritizes primary care.
- Sometimes tied to multi payer work on primary care transformation

What's in?
How to Calculate Primary Care Spending

- The numerator can be defined in a narrow or broad way

Primary Care Specialties	Primary Care Only Service Codes	Primary Care Providers – All Service Codes
Internal Medicine, Family Practice, Pediatrics		
Internal Medicine Family Practice, Pediatrics, and Other Specialties		

States are not waiting for a national definition – some are going quite broad.

Other Lessons

- The perfect vs the good
  - Is the policy goal a greater emphasis on primary care or more high-quality primary care?
- What is the accountable entity?
  - State, payer type (Medicare, Medicaid, commercial), health plan, accountable delivery system
- What is an adequate level?
  - Depends on population
  - Depends on numerator
  - We won't know until we start to measure.
- Target or Standard?

More Lessons

- Accounting for non-fee-for-service spending, such as:
  - Salaried providers; Bonus payments; Capitated payments
  - Payments to accountable delivery systems – is there a public interest?
- Where do increases go?
  - How directive to be?
- Relationship to broader delivery system reform (value-based payments, consolidation, etc.)
- Answers to these technical questions have policy implications
  - Need a public table for ongoing conversations

Manage Expectations: A Primary Care Orientation Is Necessary but Not Sufficient for a High-Performing Health System

Four challenges for the United States, based on international comparisons:

1. Lack of access to health care. (Affordable and comprehensive insurance coverage is fundamental.)
2. Relative underinvestment in primary care
3. Administrative inefficiency
4. Pervasiveness of disparities in the delivery of care

Source: "From Last to First – Could the U.S. Health Care System Become the Best in the World?" *N Engl J Med* 2017; 377:901-903

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Up Next

Witness Panel 3: Strengthening Primary and Behavioral Health Care

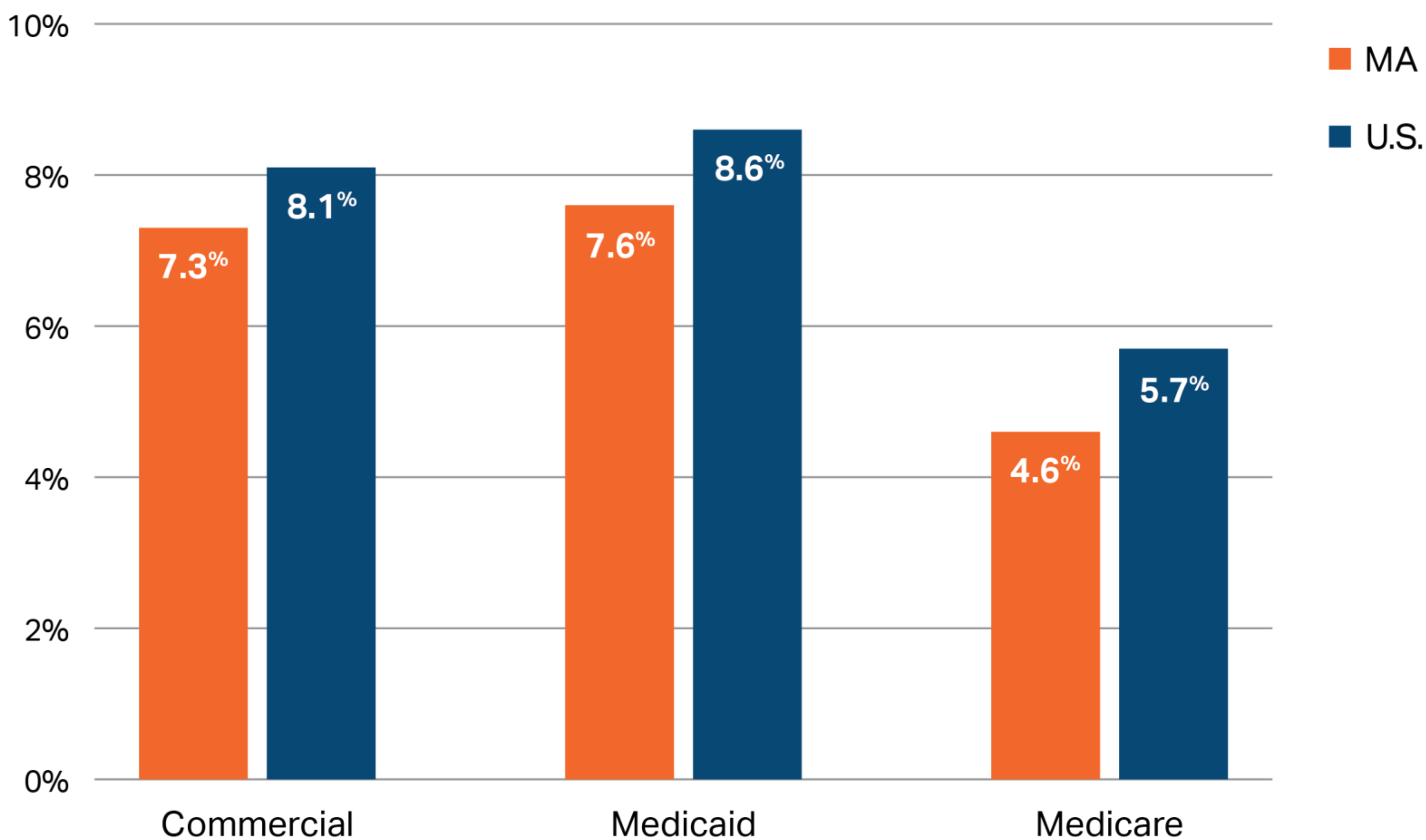
Witness Panel 3

Strengthening Primary and Behavioral Health Care

MASSACHUSETTS HEALTH POLICY COMMISSION

A lower share of Massachusetts health care spending goes to primary care, compared to other states.

Percent of all health care spending devoted to primary care, 2011-2016 combined



Notes: Data represent an average of the "narrow" and "broad" definitions of primary care spending as reported in noted source. Narrow definition includes primary cares services provided by primary care physicians (family medicine, general practice, geriatrics, general internal medicine, and general pediatrics). Broad definition also includes NPs, PAs, OB/GYNs, and behavioral health care providers. Data do not include non-claims based spending.

Source: Patient-centered Primary Care Collaborative, "Investing in primary care a state-level analysis." July, 2019. Data based on the Medical Expenditure Panel Survey.

HPC

Strategies to Support and Increase Investment in Primary and Behavioral Health Care

Primary Care

- Higher **reimbursement** for primary care services
- Eliminating **scope of practice** restrictions
- **Greater collaboration** between PCPs and other providers, and improved **care coordination**
- Utilizing **care navigators or Community Health Workers**

Behavioral Health Care

- Co-locating **behavioral health clinicians in primary care**
- Increasing access to **outpatient care**, emergency **behavioral health beds**, and **telemedicine**
- Improving use of **behavioral health screenings** across the care continuum
- Utilizing **multidisciplinary teams** with knowledge in behavioral health
- Increasing **care management resources** that include behavioral health

Source: HPC analysis of pre-filed testimony pursuant to the 2019 Annual Health Care Cost Trends Hearing. Available at https://www.mass.gov/info-details/testimony-for-the-2019-health-care-cost-trends-hearing

Witness Panel 3: Strengthening Primary and Behavioral Health Care

Witnesses

Dr. Joseph Frolkis, President and CEO	New England Quality Care Alliance
Dr. Jeffrey Greenberg, Co-Founder and COO	Firefly Health
Richard Lynch, COO	Blue Cross Blue Shield of Massachusetts
Dr. Nancy Norman, Medical Director of Integration	Massachusetts Behavioral Health Partnership
Christina Severin, President and CEO	Community Care Cooperative (C3)

Goal

This panel will focus on strategies to enhance primary and behavioral health care in the Commonwealth through direct investment, expanding workforce, behavioral health integration, and other capacity building.

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Witness Panel 4: Provider Market Trends and Cost Drivers

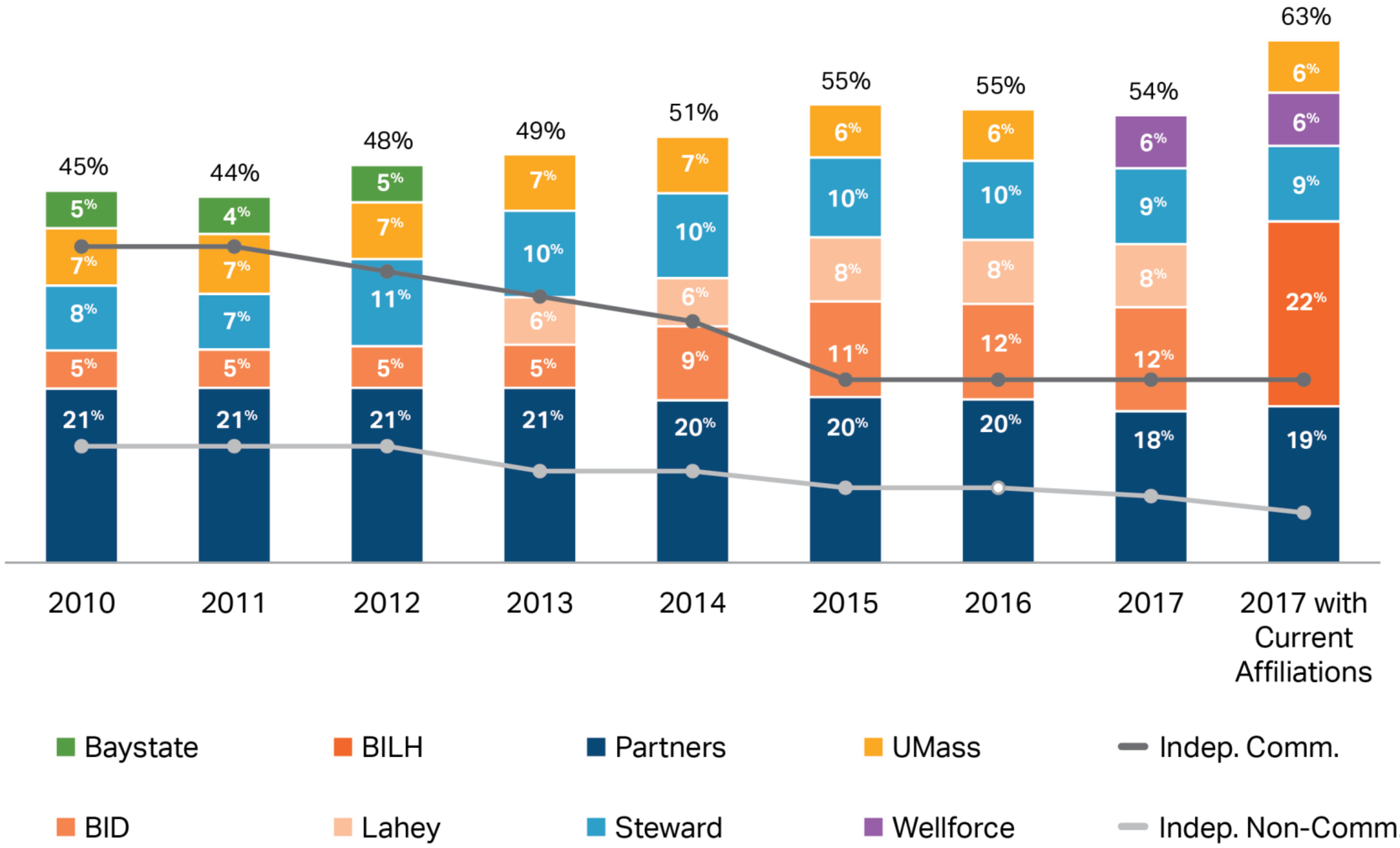
Witness Panel 4

Provider Market Trends and Cost Drivers

MASSACHUSETTS
HEALTH POLICY COMMISSION

Hospitals continue to consolidate and care is increasingly concentrated in the largest health systems.

The share of volume in the **top five systems increased 18 percentage points** from 2010 to 2017 (accounting for current affiliations). The share of volume in **independent community hospitals declined 16 percentage points**.

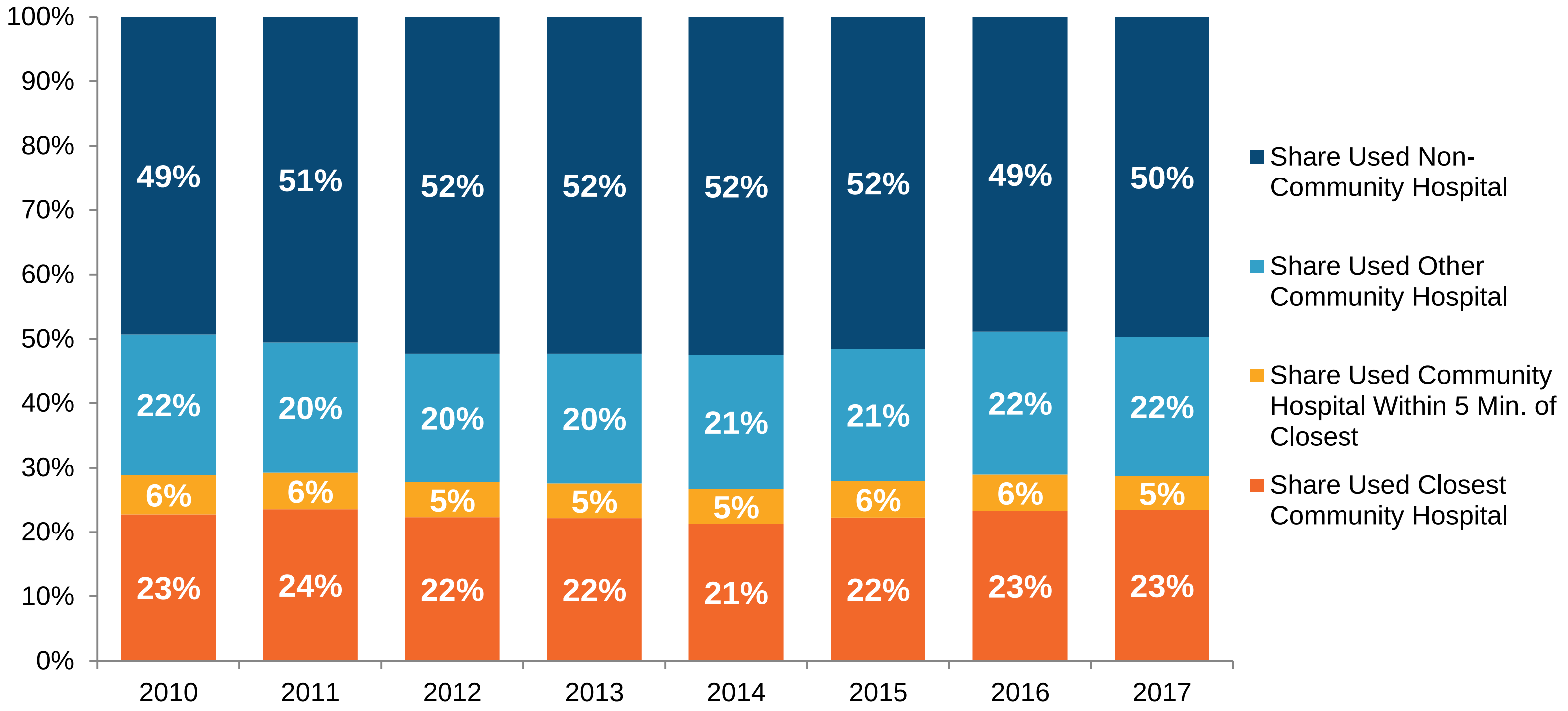


HPC

AMCs and teaching hospitals still provide half of the scheduled community-appropriate care for patients who live near community hospitals.

- A community hospital was the closest option for 80% of commercial patients who received scheduled, community-appropriate care.
- From 2010 to 2017, **approximately half of patients** whose closest hospital was a community hospital **traveled to a non-community hospital** for scheduled, non-maternity, community-appropriate care.

Site of Care for Adult Patients Receiving Scheduled, Non-Maternity Community-Appropriate Services Whose Closest Hospital is a Community Hospital (2010 – 2017, Commercial)



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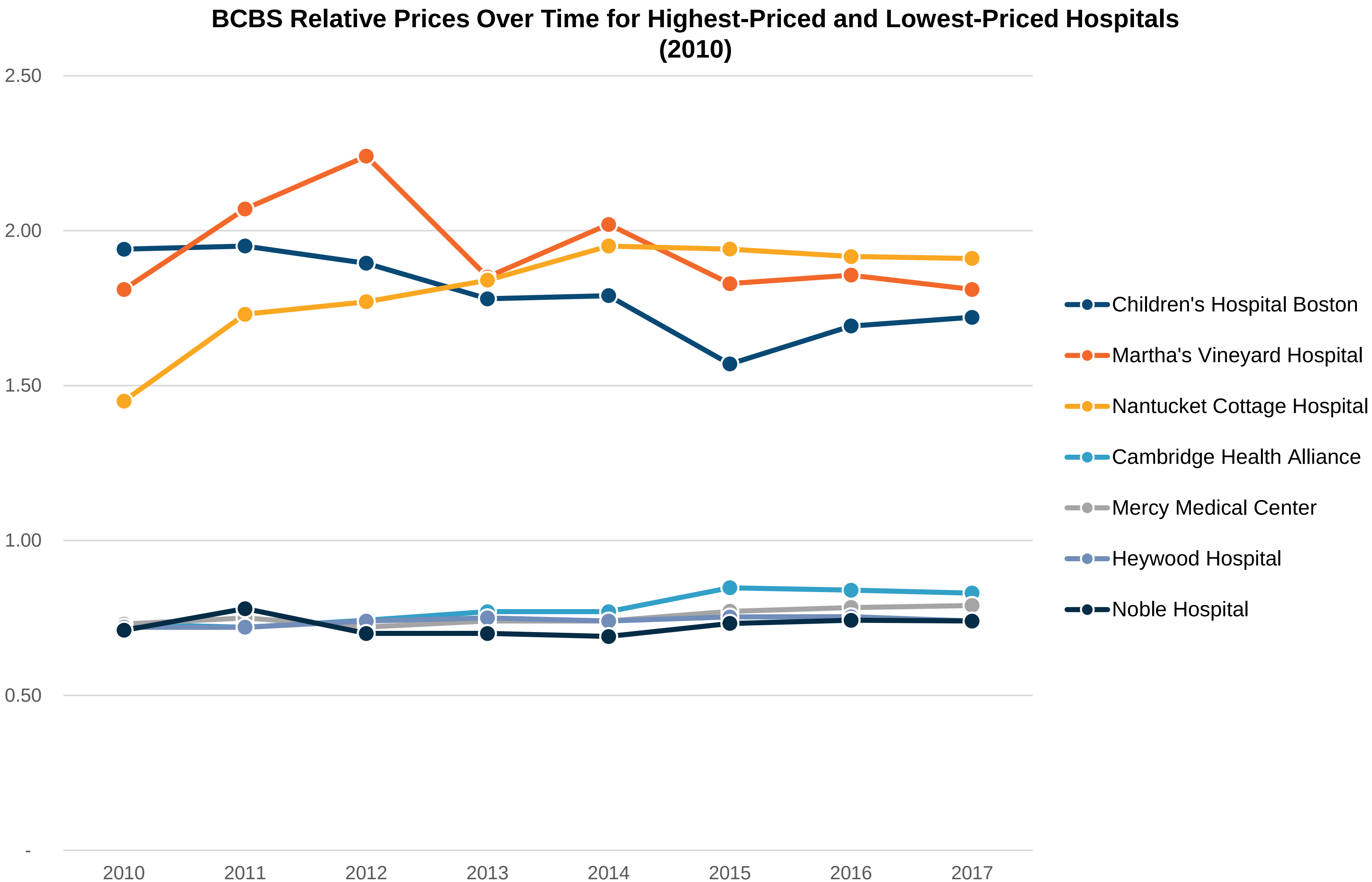
Notes: Community-appropriate discharges represent a narrow set of inpatient services that could likely be performed effectively in any hospital setting.

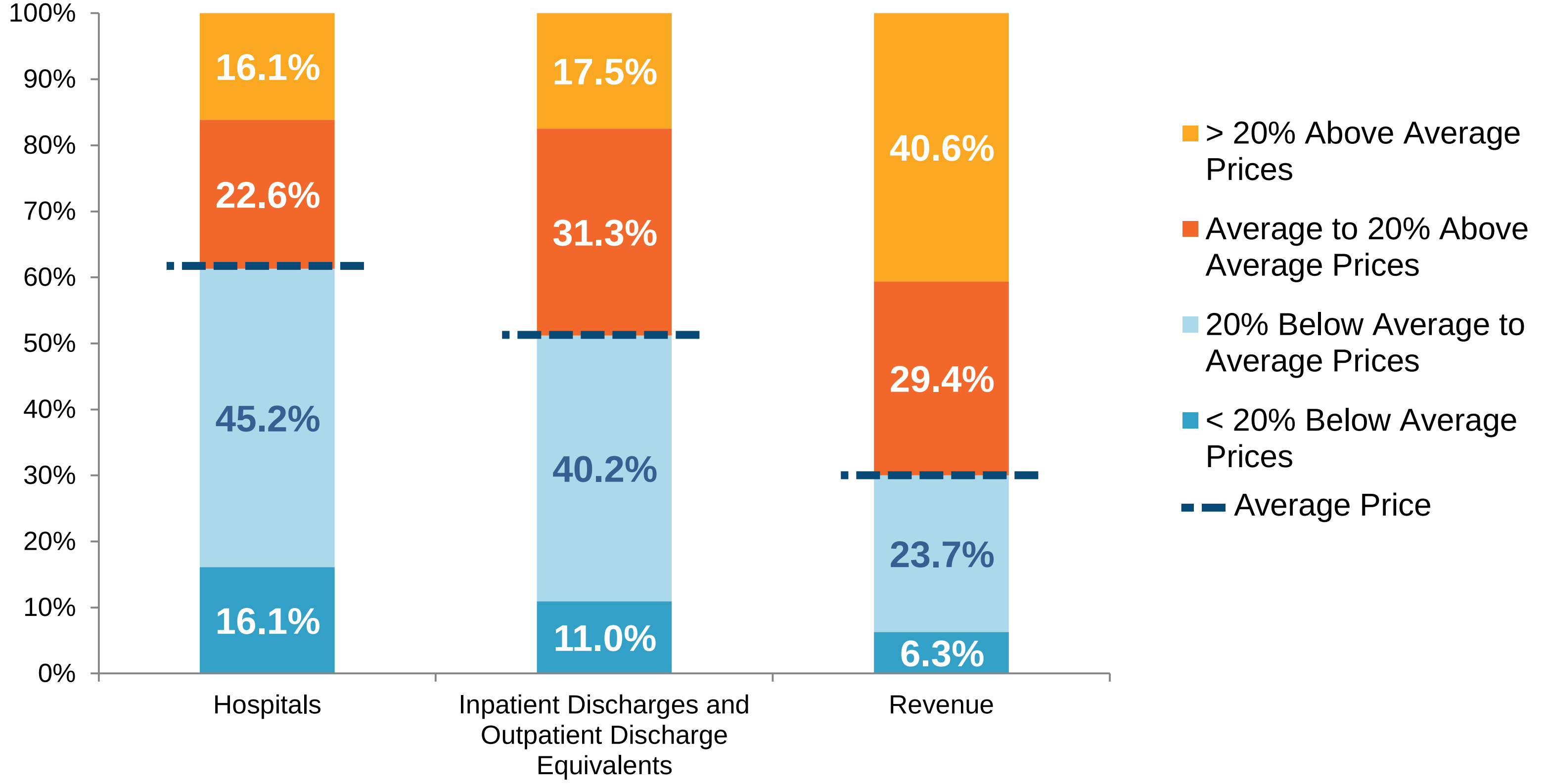
Price variation persists without significant improvement over time.



HPC

Higher health care spending is driven by both higher prices and higher volume at higher-priced providers.

Distribution of Commercial Volume and Revenue and Higher and Lower-Priced Providers (2017)



In 2017, **38.7%** of hospitals had above-average statewide relative price. These hospitals received **48.8%** of inpatient and outpatient volume, and captured **70%** of commercial hospital revenue.

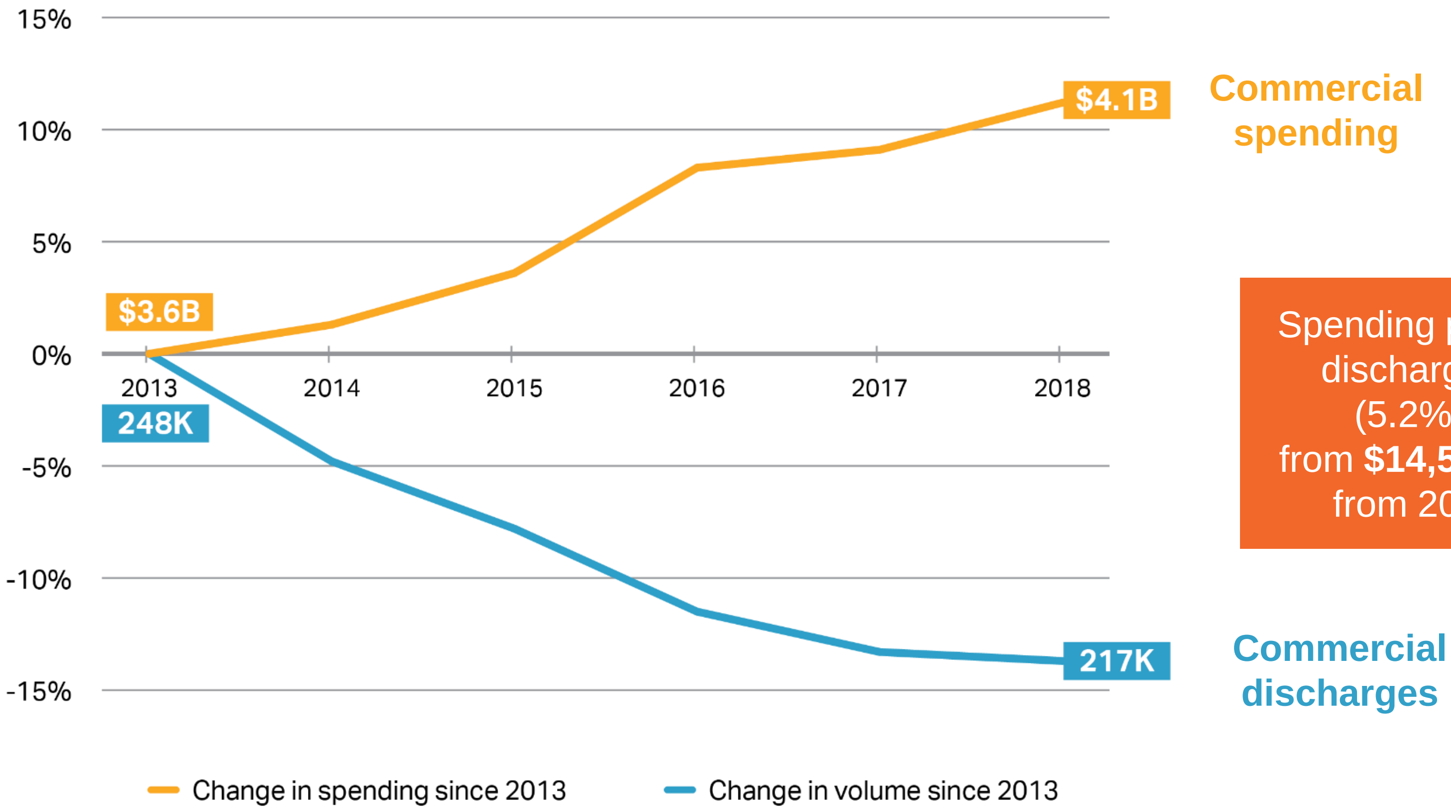
Price and share of statewide commercial revenue data source: [2017 Statewide Relative Price] (see tab A). Data reported by payers to CHIA.
Inpatient Discharges and Outpatient Discharge Equivalents data source: 2017 Hospital Cost Reports. Data reported by hospitals to CHIA.

The HPC's 2016 *Community Hospitals at a Crossroads* report identified challenges for community hospital sustainability and a need for action.

Many of these challenges persist.

Commercial inpatient spending grew 11% even as volume fell 14% between 2013 and 2018.

Cumulative change in commercial inpatient hospital volume and spending per enrollee (percentages) and absolute, 2013-2018



Spending per commercial discharge grew **29%** (5.2% annually**)**, from **$14,500 to $18,700,** from 2013 to 2018.

Inpatient prices in Massachusetts are both high and growing.
A recent RAND study found that Massachusetts has the **fourth-highest inpatient commercial prices** compared to Medicare out of 25 states.

Notes: Data points indicate % growth from previous year (2013=0). Volume data correspond to fiscal years while spending data are calendar years.

Sources: CHIA Hospital Inpatient Discharge Data, 2013-2018. Commercial full-claims TME from CHIA Annual Report TME Databooks. 2019 Annual report (for 2017-8 growth and 2016-7 growth), 2018 Annual Report (for 2015-6), 2017 annual report (for 2014-2015) and 2016 Annual Report (for 2013-4 growth).

Strategies to Address Health Care Spending Growth

Strategic Priorities

Payers:
Expansion or prioritization of APMs or value-based models

Providers:
Shifting care to lower-cost settings

Recommended Policy Actions

- Expansion of **telemedicine**
- Increased **reimbursements** for community-based providers
- Addressing **pharmaceutical costs**
- **Transparency** around pharmaceutical prices
- Addressing **provider price variation** and hospital consolidation
- Addressing **out-of-network** or **“surprise” billing**

Source: HPC analysis of pre-filed testimony pursuant to the 2019 Annual Health Care Cost Trends Hearing. Available at https://www.mass.gov/info-details/testimony-for-the-2019-health-care-cost-trends-hearing

Witness Panel 4: Provider Market Trends and Cost Drivers

Witnesses

Thomas Croswell, President and CEO	Tufts Health Plan
Sandra Fenwick, CEO	Boston Children's Hospital
Kim Hollon, President and CEO	Signature Healthcare
Dr. Anne Klibanski, President and CEO	Partners HealthCare
Dr. Steven Strongwater, President and CEO	Atrius Health
Dr. Kevin Tabb, President and CEO	Beth Israel Lahey Health

Goal

This panel will examine how changes in the provider market continue to impact spending as well as quality of and access to care. The panel will include discussion of trends in the appropriate use of lower-cost sites of care, the impacts of continued market consolidation, and the role and future of community-based providers.

2019 HEALTH CARE COST TRENDS HEARING

#CTH19

Up Next
Concluding Discussion

Thank You!

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