

Appendix C

Special Commission on Provider Price Variation

September 13, 2016

I

Agenda

- ▶ Introductions
- ▶ Ethics
- ▶ Background on Provider Price Variation
- ▶ Subcommittee Discussion
- ▶ Proposed Commission Work Plan
- ▶ Next Steps

Membership of Commission

Representative Jeffrey Sánchez	Representative, Massachusetts House of Representatives (co-chair)
Senator James T. Welch	Senator, Massachusetts State Senate (co-chair)
Karen Tseng, Health Care Division Chief	Massachusetts Attorney General
Secretary Kristen Lepore	Administration & Finance
Secretary Marylou Sudders	Health & Human Services
Dr. Roberta Herman, Executive Director, Group Insurance Commission	Group Insurance Commission
Steve Walsh, President & CEO, Massachusetts Council of Community Hospitals	Massachusetts Council of Community Hospitals
Lora Pellegrini, President & CEO, Massachusetts Association of Health Plans	Massachusetts Association of Health Plans
Deborah Devaux, Chief Operating Officer, Blue Cross Blue Shield of Massachusetts	Blue Cross Blue Shield of Massachusetts
Lynn Nicholas, President & CEO, Massachusetts Hospital Association	Massachusetts Hospital Association
John Fernandez, President & CEO, Massachusetts Eye & Ear	Conference of Boston Teaching Hospitals
Legislative Appointments	
Dr. Stuart Altman, Brandeis University	Appointee of the Senate President
Rick Lord, President & CEO, Associated Industries of Massachusetts	Appointee of the Speaker of the House
Dr. Howard Grant, President & CEO, Lahey Health	Appointee of the Minority Leader of the Senate
Majority Leader Ronald Mariano, House of Representatives	Appointee of the Minority Leader of the House
Gubernatorial Appointments	
Dr. Richard Frank, Harvard Medical School Department of Health Care Policy	Health Economist
Kate Walsh, President & CEO, Boston Medical Center	Representative of a High-Medicaid & Low-Income Public Payer DSH
Mark Goldstein, President & CEO, Anna Jaques Hospital	Representative of a Hospital with 200 Beds or Less
Dr. David Torchiana, President & CEO, Partners Healthcare	Representative of a Hospital with 800 Staffed Beds or More
Tyrek Lee, Executive Vice President, SEIU 1199	Person with Expertise in Representing Health Care Workforce, Labor Leader
Steve Carey, Vice President of Human Resources, Polar Beverages	Representative of Employer with More than 50 Employees
Connie Englert, Principal & Managing Director, TrueNorth Transit Group, LLC	Representative of Employer with Less than 50 Employees
Greg P. DeConciliis, President, MA Association Ambulatory Surgical Centers	Representative of an Ambulatory Surgical Center

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State Ethics

- ▶ For the duration of this Commission, members are considered state employees for the purpose of the state's Conflict of Interest laws.
- ▶ Please review the handout we have provided.
- ▶ If you have any questions, please reach out to the State Ethics Commission at 617-371-9500.
- ▶ Additionally, this Commission is not subject to Open Meeting Law or Public Records Law.

Background on Provider Price Variation

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Commission Mission Statement

The purpose of this Commission is to substantially advance the dialogue on provider price variation in Massachusetts and to make recommendations to address unwarranted price variation, where appropriate. Commission members have been chosen because of their unique perspectives, backgrounds, and expertise. Over the course of several meetings, the Commission shall examine a range of factors that affect provider payment rates and shall discuss both unwarranted and warranted variation. In addition, the Commission shall investigate transparency initiatives, explore possibilities to foster greater competition in the market, and discuss ideas related to state monitoring that could alleviate unwarranted price variation. The Commission shall report on the results of their discussions.

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Commission Subcommittees

- ▶ There will be 3 subcommittees.
 - ▶ Transparency Subcommittee
 - ▶ Market Forces Subcommittee
 - ▶ State Monitoring Subcommittee
- ▶ Subcommittee agendas will be based on discussions in full commission meetings with a specific focus on solutions and action-oriented policy ideas.
- ▶ Meeting summaries from each subcommittee will be provided to all Commission members prior to the next full Commission meeting.
- ▶ Staff will be on hand to support these meetings.

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Subcommittee Descriptions

- ▶ Transparency
 - ▶ This committee will explore solutions related to transparency in relation to price variation.
- ▶ Market Forces
 - ▶ This committee will explore ideas that seek to increase competition in the health care market.
- ▶ State Monitoring
 - ▶ This committee will examine the current and potential role of the state.

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Subcommittee Assignment

- ▶ Each Commission member will select one subcommittee.
- ▶ Subcommittee selection will be first come, first serve at a predetermined date and time using an electronic survey tool.
- ▶ You will be able to sign up for subcommittees on **Tuesday, September 20th at 9:00am.**
- ▶ Chairs of the Commission, Representative Sánchez & Senator Welch, will select one member of each subcommittee to chair that subcommittee.

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Commission Work Plan

- ▶ Timeline
 - ▶ September 13, 2016 – March 15, 2017
- ▶ Guest/Expert Speakers
- ▶ Engagement of Subcommittees & Stakeholders
 - ▶ Subcommittee meetings
 - ▶ Tuesdays or Thursdays at 11:00am
 - ▶ Public hearing on January 17th, 2017
- ▶ Written Report due March 15, 2017

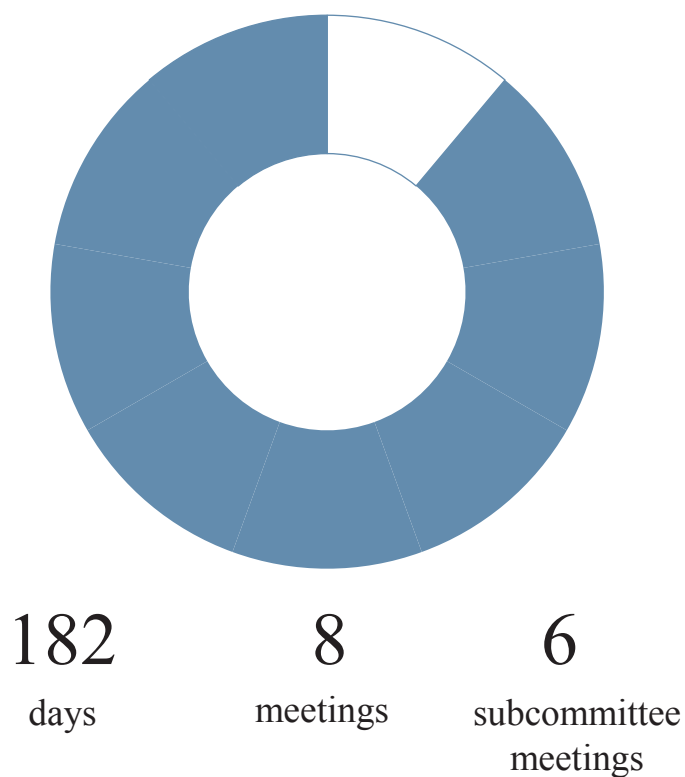
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Next Steps

- ▶ You will be able to sign up for subcommittees on Tuesday, September 20th at 9:00am.
- ▶ Upcoming Commission Meetings:
 - ▶ October 11, 2016
 - ▶ 11:00am – 2:00pm at 1 Ashburton Place, 21st Floor
 - ▶ November 1, 2016
 - ▶ 11:00am – 2:00pm at 1 Ashburton Place, 21st Floor
- ▶ Information about upcoming meetings can be found on the Joint Committee on Health Care Financing website.
 - ▶ Click on the tab labeled “Documents”

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The Commission’s Report is due in...



▶ 12

Special Commission on Provider Price Variation

October 11, 2016

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Agenda

- ▶ Welcome & Updates
- ▶ Presentation: Medicare Payment Systems
- ▶ Discussion of Payment Factors

Subcommittee Assignments

- ▶ **Market Forces**
 - ▶ **Deborah Devaux**
 - ▶ House Majority Leader Ronald Mariano
 - ▶ Dr. Stuart Altman
 - ▶ Lora Pellegrini
 - ▶ Dr. Howard Grant
 - ▶ Lynn Nicholas
 - ▶ Dr. David Torchiana
- ▶ **State Monitoring**
 - ▶ **Connie Englert**
 - ▶ Karen Tseng
 - ▶ Mark Goldstein
 - ▶ Dr. Richard Frank
 - ▶ Steve Walsh
 - ▶ Roberta Herman
 - ▶ Tyrek Lee
- ▶ **Transparency**
 - ▶ **Kate Walsh**
 - ▶ Lauren Peters
 - ▶ Rick Lord
 - ▶ Secretary Sudders
 - ▶ John Fernandez
 - ▶ Greg DeConciliis
 - ▶ Steve Carey

Subcommittee Chairs are in bold.

▶ 3

Presentation
Professor Joseph Newhouse, PhD
Harvard University
Medicare Payment Systems

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Medicare Payment Systems Summary

Payment System	Setting	Unit of Payment
Inpatient Prospective Payment System	Hospital inpatient	Per discharge
Outpatient Prospective Payment System	Hospital outpatient	Per service, with moderate packaging of some items
Physician Fee Schedule	All settings with different practice expense amounts for services furnished in facility vs. office settings	Per service, with limited packaging
Ambulatory Surgical Center Payment System	Ambulatory surgical centers	Per service, with moderate packaging of some items

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MassHealth Payment System Summary

- MassHealth, Massachusetts's Medicaid program, pays for care differently depending on the program.
- Certain hospitals may be eligible for supplemental reimbursements.
- MassHealth pays physicians according to a fee schedule.
- Contracts with Ambulatory Surgical Centers (ASCs)
 - Freestanding ASC rates are set statewide through regulation
 - Hospital-based ASC rates are set by contract
- MassHealth is in the process of moving to ACO-like models of care.

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Ambulatory Surgical Centers (ASCs)

- ▶ Ambulatory surgical centers (ASCs) are distinct entities that provide outpatient surgical services to patients.
 - ▶ Can be independent or affiliated with a hospital.
- ▶ Physicians refer patients to ASCs for certain outpatient procedures.
- ▶ Commercial ASC rates are set annually and contracts can be formed
 - ▶ Jointly among MA Association of ASC members with Blue Cross Blue Shield, Tufts & Harvard Pilgrim, and/or
 - ▶ Individually between ASCs and payers.

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Discussion of Payment Factors

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The HPC found that a substantial portion of hospital price variation is associated with market structure, and not with quality

Factors associated with <u>higher</u> commercial prices (Holding all other factors equal)	Factors associated with <u>lower</u> commercial prices (Holding all other factors equal)
Less competition	More Medicare patients
Larger system size (above a certain size)	More Medicaid patients
Corporate affiliations with certain systems	Corporate affiliations with certain systems
Provision of higher-intensity (tertiary) services	
Status as a teaching hospital	

Factors not generally associated with commercial prices (Holding all other factors equal)
Quality
Mean income in the hospital's service area



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Quality

- ▶ Medicare and MassHealth use payment incentives to improve quality.
- ▶ Payments can be:
 - ▶ Built into rates
 - ▶ Bonus payments/payment reductions (penalties)
- ▶ Examples
 - ▶ Value-based purchasing
 - ▶ Pay-for-Reporting
 - ▶ Reductions for excess readmissions and hospital-acquired conditions
 - ▶ Pay-for-Performance

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Provision of Services to Unique & Underserved Populations

- ▶ Medicare and MassHealth provide additional funding for hospitals serving low-income, rural or other underserved populations.
- ▶ Medicare adjusts payments for both inpatient and outpatient services.
- ▶ MassHealth
 - ▶ Supplemental payments are given to hospitals serving unique and/or underserved populations.
 - ▶ Cancer hospitals are paid using a unique outpatient base rate.

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Location

- ▶ Medicare and MassHealth adjust payments based on location.
- ▶ Medicare adjusts payments for geographic differences in wages for all states & cost of living in AK & HI only.
 - ▶ 3% adjustment in MA for FY 2016
- ▶ MassHealth uses the CMS wage area assignments.

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Physician Fees

- ▶ Medicare reimburses physicians and other health professionals based on a fee schedule.
 - ▶ Physician fees only adjusted for location
 - ▶ Fees 9% higher in metro Boston than in other parts of the state.
- ▶ Medicare physicians must report specific quality metrics to receive full payment.
- ▶ MassHealth has a fee schedule based on Medicare's methodology.

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Costs

- ▶ Medicare and MassHealth provide high-cost outlier payments when actual treatment costs greatly exceed the fixed reimbursement rate.
- ▶ Medicare (inpatient & outpatient)
 - ▶ Ex: If inpatient cost exceeds a fixed amount, hospital is paid 80% of amount above the threshold (90% for burn cases).
- ▶ MassHealth (inpatient)
 - ▶ MassHealth pays an extra 7-10% for high cost outliers
 - ▶ Outpatient high cost outlier payments beginning December 2016
- ▶ MassHealth & Medicare adjust payments for case-mix.

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Medical Education

- ▶ Medicare adjusts hospital base rates to account for additional costs associated with teaching activity.
 - ▶ Indirect medical education (IME) payment compensates facilities for higher patient care costs caused by the “inefficiencies” associated with teaching residents.
 - ▶ Direct medical education (DME) payment compensates facilities for the cost of teaching residents.

Number of Interns, Residents, Fellows - 2014

Partners	1,754
Children’s Hospital	708
CareGroup	687
UMass	535
Boston Medical Center	486
Wellforce	420
Baystate	323
Steward	208
Tenet	154
Cambridge Health Alliance	145
Lahey	135
Berkshire	77

Note: Partners data does not include McLean or Spaulding.

Data from Massachusetts 403 Cost Reports - Acute and non-acute hospitals submit DHCFF-403 cost reports to CHIA on an annual basis. These filings contain a wide range of detailed information about each hospital's component costs, revenues and statistics for business and facility operations.

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Medical Technology & Pharmacology

- ▶ Medicare adjusts rates for use of new and costly technologies, and new drugs, biologics and devices, that result in better patient outcomes.
- ▶ Manufacturer submits application to CMS.
- ▶ Payments limited to 3 years after FDA approval & commercialization.
- ▶ Between 2001, when this payment program began, and 2015, CMS approved 19 of 53 applications for an inpatient add-on payment.
 - ▶ 15 devices and 4 drugs

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Review

Factor	Medicare	MassHealth
Quality	✓	✓
Medical Education	✓	
Stand-by Service Capacity		
Emergency Service Capacity		
Special Services by DSH to Unique Populations	✓	✓
Market Share		
Provider Size		
Advertising		
Location	✓	✓
Research		
Cost	✓ (for high-cost outlier cases)	✓ (for high-cost outlier cases)
Care Coordination		
Community Based Services by Allied Health Professionals		
Use/Advancement of Medical Technology & Pharmacology	✓ (small # of specific technologies)	

- ▶ 17 Committee on Health Care Financing staff review.

Factors for Discussion in Meeting 3

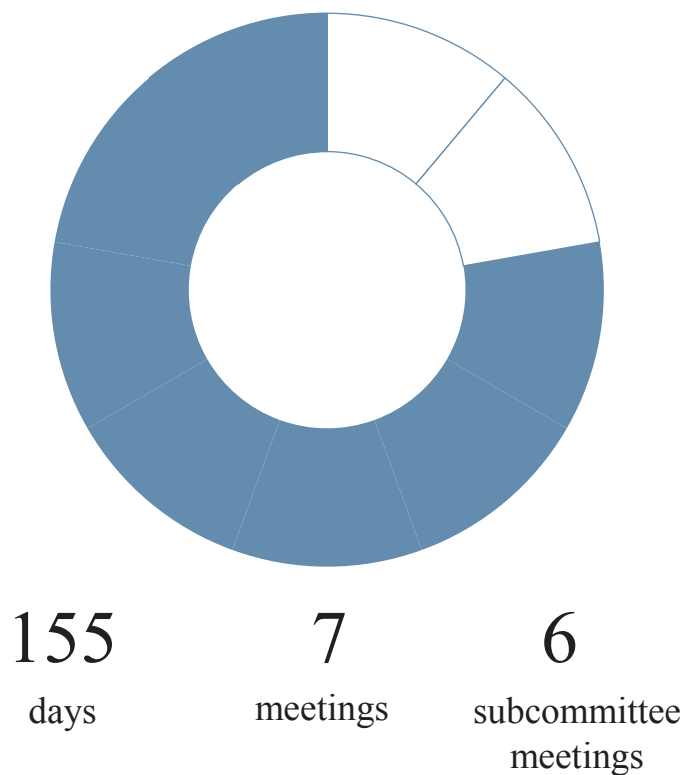
- ▶ Stand-by Services
- ▶ ED Services
- ▶ Advertising
- ▶ Research
- ▶ Care Coordination & Community Benefits by Allied Health Professionals

Next Steps

- ▶ Upcoming Commission Meeting:
 - ▶ November 1, 2016
 - ▶ 11:00am – 2:00pm at 1 Ashburton Place, 21st Floor
- ▶ Subcommittee Meeting Schedule

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The Commission's Report is due in...



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Special Commission on Provider Price Variation

November 1, 2016

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Agenda

- ▶ Welcome & Updates
- ▶ Presentation: MassHealth Payment System
- ▶ Discussion of Payment Factors

Review: October 11th Commission Meeting

- ▶ Medicare and MassHealth adjust payment rates or give additional payments for:
 - ▶ Location
 - ▶ Cost
 - ▶ Quality
 - ▶ Services provided to unique or underserved populations
- ▶ Medicare provides additional payments for graduate medical education.
- ▶ Medicare adjusts rates for a small number of new technologies and gives temporary add-on payments for certain innovative devices, drugs and biologics, which it reviews on a case-by-case basis.

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Presentation MassHealth Payment Systems

Matthew Klitus
Chief Financial & Strategy Officer
MassHealth

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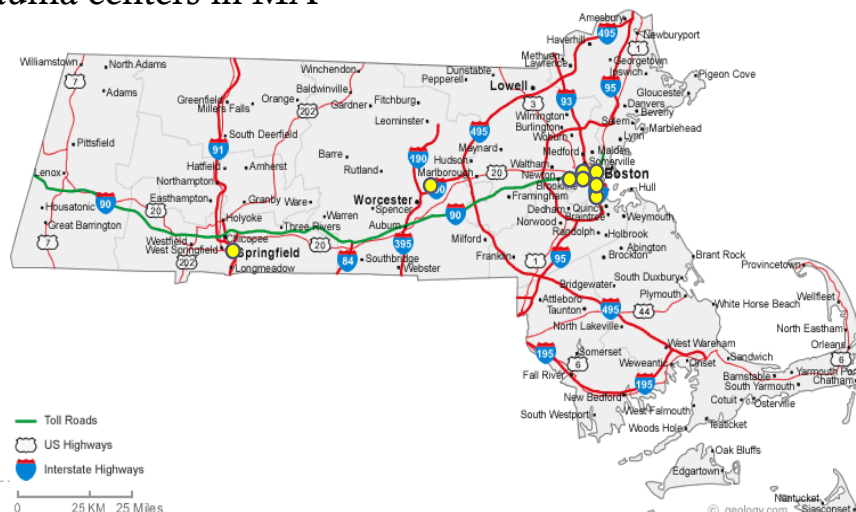
Stand-By Service Capacity

- ▶ These are hospital units that deliver care on a twenty-four hour basis.
- ▶ Tend to have higher overhead costs than other units as they must be staffed 24/7.
- ▶ Examples: burn centers, trauma centers, psychiatric units & emergency departments
- ▶ Maintaining stand by services requires the support of:
 - ▶ Sufficiently trained staff
 - ▶ Facilities responsive to general population needs, and
 - ▶ Specialized facilities responsive to unique cases or events.

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Stand-By Service Capacity: Trauma Centers

- ▶ Trauma centers treat patients with severe or life-threatening physical injuries.
- ▶ Must be certified by DPH and verified by the American College of Surgeons.
- ▶ 9 Level One trauma centers in MA
 - ▶ Baystate
 - ▶ UMass
 - ▶ BID
 - ▶ BMC
 - ▶ Brigham
 - ▶ BCH
 - ▶ MGH
 - ▶ Tufts
 - ▶ Tufts Floating



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Stand-By Service Capacity: Burn Centers

- ▶ Treat burn patients, require specialized resources and staff.
- ▶ Anecdotal evidence is that burn centers have very high fixed costs and that revenue from these services may not cover costs.
- ▶ 5 burn centers in MA
 - ▶ Brigham & Women's
 - ▶ Shriners's
 - ▶ MGH
 - ▶ BMC
 - ▶ UMass



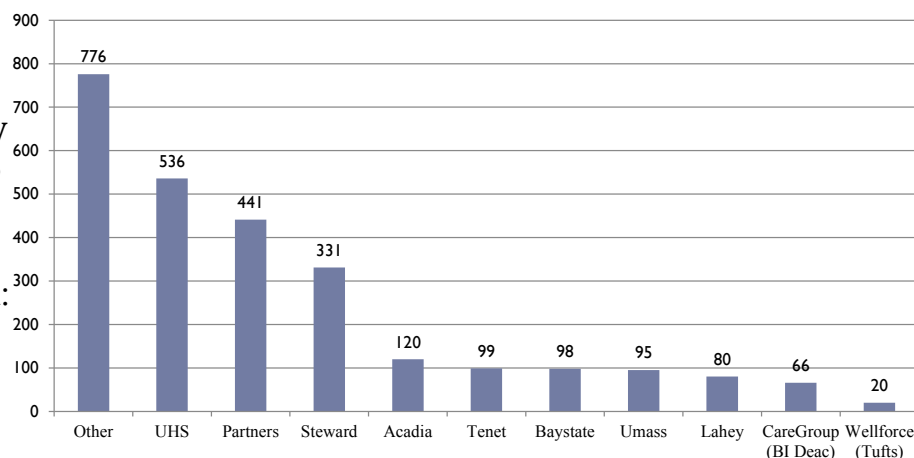
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Stand-By Service Capacity: Psych Units

- ▶ Anecdotal evidence suggests that inpatient hospital psychiatric units are costly to operate.
- ▶ Some Massachusetts hospitals/health systems have cut services; others have built or expanded psychiatric units.

Dept. of Mental Health Licensed Inpatient Beds, by System Oct. 2016

Total beds in MA: 2,662



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Universal Health Services (UHS) includes Arbour Hospital (Jamaica Plain and Quincy sites), Arbour HRI, Arbour Fuller, Westwood Lodge/ Lowell Treatment Center/ Pembroke Hospital, Acadia is Southcoast Behavioral Health

Stand By Service Capacity: Emergency Service Capacity

- ▶ Emergency departments (ED) are valuable to communities.
- ▶ Many factors influence the ability of an ED to support itself.
 - ▶ % of commercially-insured patients
 - ▶ Relative price of the hospital
 - ▶ # of admissions from ED to hospital
- ▶ Inpatient admissions from the ED may generate additional net income or losses, depending on payer mix (commercial vs. Medicare vs. Medicaid).

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Advertising

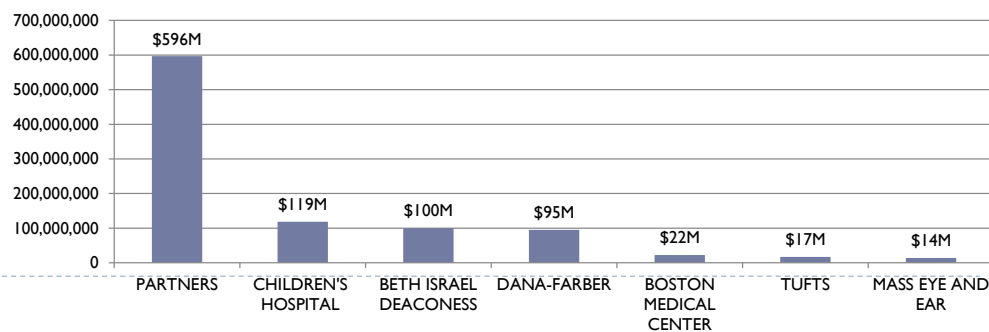
- ▶ The average advertising budget is less than 1% of total budget.
- ▶ Health care facilities are increasing their advertising and marketing budgets. Possibly due to:
 - ▶ Mounting pressure to increase revenue
 - ▶ More active decision-making by patients
- ▶ Advertising can add value to the healthcare system to the extent that it better informs patients and drives the appropriate use of services, not just higher utilization.
- ▶ Brand name is very influential on patient decision making.

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Research

- ▶ Top source of research funding is government, both state and federal dollars.
- ▶ Supporting research in the clinical setting requires investment in staff, technology, and physical space to comply with rigorous methodological research standards as well as governing laws and regulations.
 - ▶ Ex: clinical trial management, contract review and/or protocol development
- ▶ Massachusetts is second only to California in the amount of funding received from the National Institutes of Health for 2016.
 - ▶ MA awarded \$1.9B

NIH Funding by Hospital System, 2016



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Care Coordination Among Providers & Allied Health Professionals

- ▶ Care coordination is the commitment to and development of systems to enhance patient care management.
- ▶ Allied health professionals are professionals that do not directly work in medicine or pharmacy but support these functions through diagnostics, therapy, rehabilitation, and other services.
- ▶ There are different mechanisms to pay for care coordination services.

Global budgets

- ▶ Global budget: a single payment covers all the health care for a patient over a given period of time.
- ▶ Medicare has several global budget pilots including the NextGen ACO model.
- ▶ MassHealth's OneCare program, jointly administered with Medicare, serves patients ages 21-64 who are dually eligible for Medicare and Medicaid.
- ▶ State demonstrations:
 - ▶ Maryland has an all-payer rate setting system.
 - ▶ Vermont recently received permission from CMS to set up an all-payer model.
- ▶ Blue Cross Blue Shield Alternative Quality Contract (AQC)

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Factors Discussed

Factor	Medicare	MassHealth
Quality	✓	✓
Medical Education	✓	
Stand-by Service Capacity		
Emergency Service Capacity		
Special Services by DSH to Unique Populations	✓	✓
Market Share		
Provider Size		
Advertising		
Location	✓	✓
Research		
Cost	✓ (for high-cost outlier cases)	✓ (for high-cost outlier cases)
Care Coordination		
Community Based Services by Allied Health Professionals		
Use/Advancement of Medical Technology & Pharmacology	✓ (small # of specific technologies)	

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Next Steps

▶ Upcoming Commission Meeting

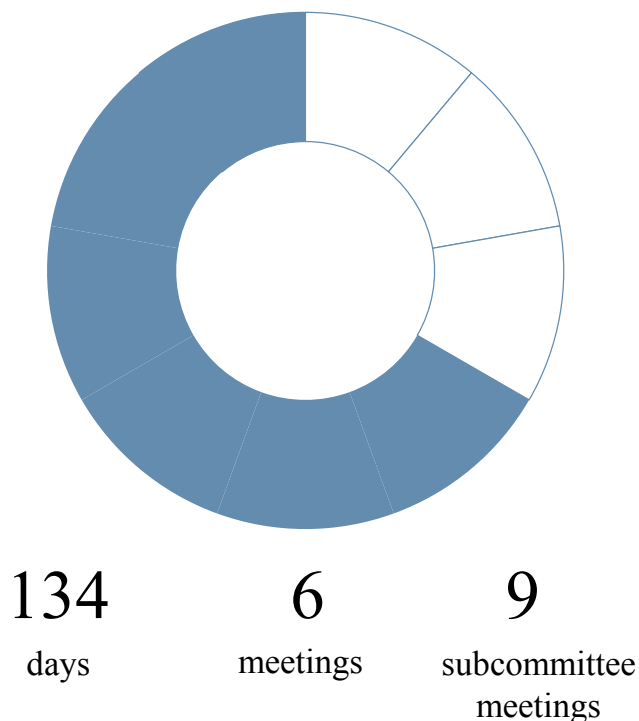
- ▶ November 29, 2016
 - ▶ 11:00am – 2:00pm at 50 Milk Street, 8th floor (Health Policy Commission)

▶ Upcoming Subcommittee Meeting

- ▶ State Monitoring Subcommittee
 - ▶ November 10th at 11:00am, House Members Lounge
- ▶ Market Forces Subcommittee
 - ▶ November 16th at 11:00am, House Members Lounge
- ▶ Transparency Subcommittee
 - ▶ November 17th at 11:00am, Room 350

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The Commission's Report is due in...



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Special Commission on Provider Price Variation

November 29, 2016

I

Agenda

- ▶ Welcome
- ▶ Subcommittee Updates
- ▶ Presentation: Professor Gwendolyn Roberts Majette
- ▶ Discussion
- ▶ Next Steps

Presentation

Health Care Contracting & Market Forces

Gwendolyn Roberts Majette, JD, LLM
Associate Professor
Cleveland-Marshall College of Law
Center for Health Law & Policy

▶ 3

Review of Payer/Provider Contracts

- ▶ **Division of Insurance***
 - ▶ If a carrier intends to pay “similarly situated” providers different rates, the carrier must provide a detailed description of the bases for the different rates, with reference to 1) quality of care delivered; 2) mix of patients; 3) geographic location at which care is provided; and 4) intensity of services provided.” (211 CMR 66.09(3)(1)) [Small Group Health Insurance]
- ▶ **Office of the Attorney General**
 - ▶ The attorney general may require a provider to produce documents, answer interrogatories, and provide testimony under oath about health care costs and cost trends in the Commonwealth. (M.G.L. Ch. 12 Section 11N)

*The Division of Insurance also regulates premiums, plan surplus, network adequacy and ensures plans are financially stable.

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Separate (“Component”) Contracting

- ▶ Separate (component) contracting: Provider locations within a multi-location health care system negotiate with insurers individually and independently.
- ▶ Elements required for separate contracting:
 - ▶ Separate provider negotiating teams: Each provider location has its own team to negotiate contracts with insurers.
 - ▶ Firewalls: Negotiating teams cannot share confidential information among themselves (i.e., terms and conditions of individual contracts).
 - ▶ Insurer chooses in-network provider location(s): Insurer contracts with any or all provider locations within the health system.

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Component Contracting - Considerations

- ▶ Operational/administrative
 - ▶ Some providers have indicated that it would be administratively burdensome to establish separate contracting teams.
- ▶ Rules and regulations
 - ▶ Which entity(ies) would enforce the law and how?
- ▶ Clinical and financial integration
 - ▶ Consider definitions of components (i.e. hospitals, ACOs).
 - ▶ Should there be an exception for a tightly-integrated group of providers?

▶ 6

Out-of-Network Billing

- ▶ Out-of-network bill: Charge arising when an insured individual receives care from an out-of-network provider.*
- ▶ Regulating out-of-network billing may:
 - ▶ Reduce impact on payers who have full or partial hold-harmless policies
 - ▶ Facilitate the creation and uptake of limited- and tiered-network products
- ▶ BCBS and others suggest a three-pronged solution:
 - ▶ Default rate for out-of-network services
 - ▶ Consumer notice and price transparency
 - ▶ Protection from balance-billing

*Kaiser Family Foundation, *Surprise Medical Bills* (Mar. 2016).

▶ 7

Review of Current & Proposed Provider/Provider Contracts

- ▶ In Massachusetts, several entities review current and proposed provider/provider contracts.
- ▶ Health Policy Commission
 - ▶ Registration of Provider Organizations
 - ▶ Material Change Notice & Cost and Market Impact Review
- ▶ Office of the Attorney General
 - ▶ May investigate providers referred to it by the Health Policy Commission, following a Cost and Market Impact Review.

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Enhance the Material Change Notice/Cost and Market Impact Review Process

- ▶ Under current law, a provider/provider organization must submit a **notice of material change (MCN)** to the Health Policy Commission (HPC).
- ▶ HPC may choose to conduct a **cost and market impact review (CMIR)**.
- ▶ HPC may refer the final CMIR report to the Attorney General's Office (AGO).

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MCN/CMIR Process (cont.)

Stakeholders have suggested various ways to enhance the MCN/CMIR process. For example:

- ▶ Apply the law to additional providers/provider organizations
- ▶ Additional/more stringent standards regarding how HPC approves the material change and conducts the CMIR
- ▶ Additional/more stringent standards regarding CMIR referrals and legal proceedings
 - ▶ Ex: Additional criteria under which HPC *must* refer a CMIR
 - ▶ Ex: CMIR must be given evidentiary weight in an action to halt the material change.
 - ▶ Ex: The proposed material change cannot move forward while legal action is pending.
- ▶ State monitoring, following approval of the material change

▶ 10

Acquisitions & Mergers of/by Physician Organizations

- ▶ There has been an increase in physician organization (PO) consolidations.
- ▶ There is concern that the state does not adequately monitor or regulate PO acquisitions and mergers.
- ▶ Proposed solutions include:
 - ▶ Regulating physician rates and/or regulating growth in physician rates, following PO acquisition by a higher-priced provider
 - ▶ Reporting to the state
 - ▶ Ex: MCN/CMIR process for lower-revenue PO mergers
 - ▶ Prohibiting certain facility fees

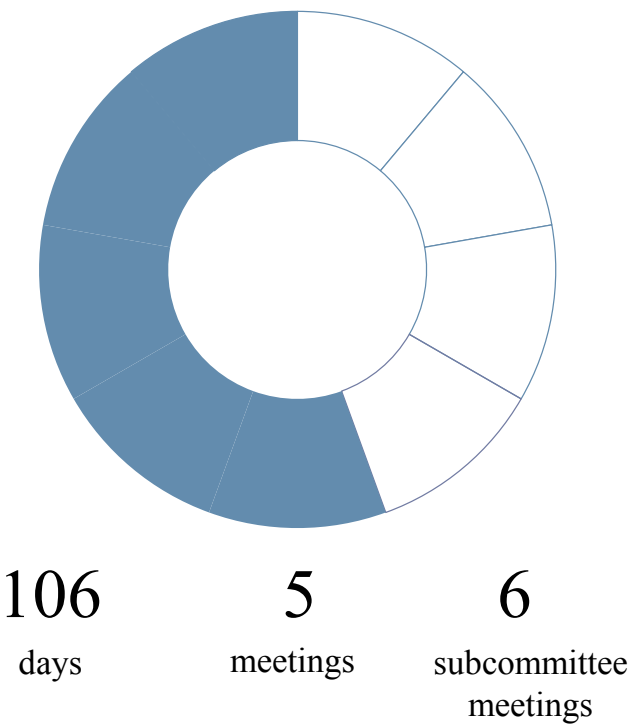
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Next Steps

- ▶ Upcoming Commission Meeting
 - ▶ December 13, 2016
 - ▶ 11:00am – 2:00pm at State House, Room 428
- ▶ Upcoming Subcommittee Meetings
 - ▶ Market Forces Subcommittee
 - ▶ December 6, 2016
 - ▶ 11:00am, location TBD
 - ▶ Transparency Subcommittee
 - ▶ December 15, 2016
 - ▶ 11:00am, location TBD
 - ▶ Market Forces Subcommittee
 - ▶ January 5, 2017
 - ▶ 11:00am, location TBD

▶ 12

The Commission’s Report is due in...



Special Commission on Provider Price Variation

December 13, 2016

I

Agenda

- ▶ Welcome
- ▶ Subcommittee Updates
- ▶ Market Forces Discussion (cont.)
- ▶ Presentation: David Auerbach, Health Policy Commission
- ▶ Discussion
- ▶ Next Steps

Subcommittee Updates

- ▶ State Monitoring Subcommittee

- ▶ Met on November 29, 2016

- ▶ Market Forces Subcommittee

- ▶ Met on December 6, 2016

▶ 3

Acquisitions & Mergers of/by Physician Organizations

- ▶ There has been an increase in physician organization (PO) consolidations.
- ▶ There is concern that the state does not adequately monitor or regulate PO acquisitions and mergers.
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 - ▶ Regulating physician rates and/or regulating growth in physician rates, following PO acquisition by a higher-priced provider
 - ▶ Reporting to the state
 - ▶ Prohibiting certain facility fees

▶ 4


Presentation

Plan Design & Consumer Incentives

David Auerbach, PhD
Health Policy Commission
Director of Research & Cost Trends

► 5

Premiums Based on Value



What Would Premiums Look Like If They Reflected Provider Efficiency?			
Differentiating Premiums Based on Patient's Choice of PCP Group (Not a Limited Network Product) While Continuing to Socialize Health Risk			
	Provider Relative Efficiency	Traditional Monthly Premium	Differentiated Monthly Premium
Provider A	0.88	\$584	\$514
Provider B	0.92	\$584	\$537
Provider C	0.96	\$584	\$561
Provider D	0.97	\$584	\$566
Provider E	1.00	\$584	\$584
Provider F	1.00	\$584	\$584
Provider G	1.01	\$584	\$590
Provider H	1.06	\$584	\$619

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Promote Limited- & Tiered-Network Products (LTNPs)

Possible strategies to make LTNPs more popular and effective:

- ▶ Greater premium differences among products and among tiers
- ▶ Greater consumer education
 - ▶ At point of enrollment
 - ▶ At point of service
- ▶ Address data and methodology concerns
 - ▶ Common quality measures
 - ▶ Common quality/price methodology
 - ▶ Timely reporting to providers

▶ 7

Point-of-Service Shopping & Consumer Incentives

- ▶ Possible strategies to enhance the effectiveness of these tools
 - ▶ Provide healthcare professionals more information to guide value-based patient decision-making
 - ▶ Increase consumer education about:
 - ▶ Potential savings
 - ▶ Relationship between price and quality
 - ▶ Facilitate access to consumer-friendly price information
 - ▶ Role of payers, providers, employers, and the Commonwealth

▶ 8

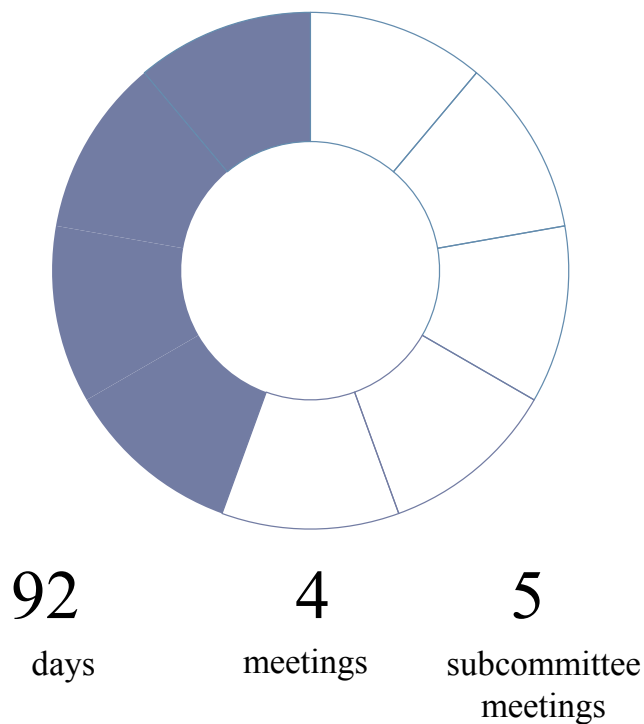
Next Steps

- ▶ **Upcoming Commission Meeting**
 - ▶ January 10, 2016
 - ▶ 11:00am – 2:00pm at State House, Room 428

- ▶ **Upcoming Subcommittee Meetings**
 - ▶ **Transparency Subcommittee**
 - ▶ December 15, 2016
 - ▶ 11:00am, House Members Lounge
 - ▶ **Market Forces Subcommittee**
 - ▶ January 5, 2017
 - ▶ 11:00am, Room 350

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The Commission's Report is due in...



▶ 10

Special Commission on Provider Price Variation

January 10, 2017

I

Agenda

- ▶ Welcome
- ▶ Subcommittee Updates
 - ▶ Transparency
 - ▶ Market Forces
 - ▶ BCBSMA presentation on out-of-network costs and levers for tiered and limited network plans
- ▶ Presentation: Katherine Baicker, PhD on Patient Choice, Price Transparency & High-Value Care
- ▶ Discussion
- ▶ Next Steps

Subcommittee Updates

- ▶ Transparency Subcommittee

- ▶ Met on December 15, 2016

- ▶ Market Forces Subcommittee

- ▶ Met on January 5, 2017

▶ 3

Presentation Patient Choice, Price Transparency, & High-Value Care

Katherine Baicker, PhD
Harvard T.H. Chan School of
Public Health

▶ 4

Enforce or Amend Current Laws

Examples of strategies:

- ▶ Agency-directed process to ensure compliance with provider/insurer price disclosure requirements
- ▶ Additional education for patients about consumer-protection laws
- ▶ Create user-friendly standards for insurer websites and distributed material
- ▶ Expand the role of providers in facilitating access to information, for example: out-of-pocket costs

▶ 5

Transparency Website

- ▶ CHIA Healthcare Website*
 - ▶ CHIA's website will enable patients to compare prices for common shoppable services.
 - ▶ It will obtain necessary information from the APCD.
 - ▶ Currently under development.
- ▶ How can the state create a website that ensures patient access to timely, accurate price and quality information?

*Ch. 12C, § 20

▶ 6

Assistance to Purchasers

- ▶ Standardized “report cards” created by health plans to help
 - ▶ employers choose plans, and
 - ▶ employees to compare plans.

Plans A, B & C are offered by different insurance companies

	Plan A	Plan B	Plan C
Name of plan			
Monthly premium			
Are the providers and hospitals you want in the plan network?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deductible amount			
Maximum out-of-pocket (MOOP) amount			
Is dental coverage included?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there co-insurance for any services you may need?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
■ If you answered “Yes” above, how much is the co-insurance?			
How much are co-pays for visits to a Primary Care Physician (PCP)?			
How much are co-pays for visits to specialists?			
Are the prescription medications you take covered by this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
■ If yes, how much is the co-pay for the prescriptions you need?			

▶ 7

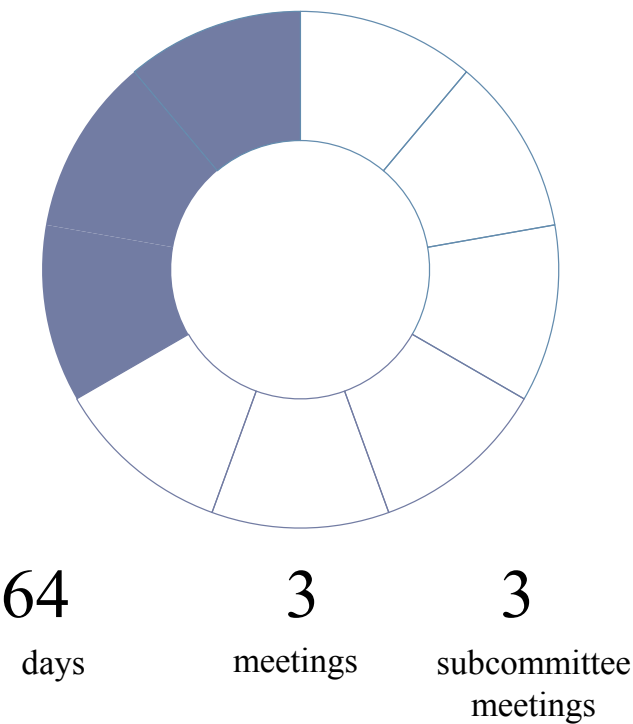
Health Connector, Health Plan Shopping Guide 2017, Individuals and Families.

Next Steps

- ▶ Upcoming Commission Meeting
 - ▶ January 31, 2017
 - ▶ 11:00am – 2:00pm at One Ashburton Place, 21st Floor
- ▶ Public Listening Session
 - ▶ January 17, 2017
 - ▶ 11:00am – State House, Room B-1
- ▶ Upcoming Subcommittee Meetings
 - ▶ State Monitoring Subcommittee
 - ▶ January 19, 2017
 - ▶ 11:00am, State House, Room 350
 - ▶ Transparency Subcommittee
 - ▶ January 26, 2017
 - ▶ 11:00am, State House, Room 350

▶ 8

The Commission’s Report is due in...



Special Commission on Provider Price Variation

January 31, 2017

I

Agenda

- ▶ Welcome
- ▶ Presentation: Dr. Kathleen Hittner, Health Insurance Commissioner for the State of Rhode Island
- ▶ Data Presentation by Dr. David Torchiana
- ▶ Subcommittee Updates
 - ▶ State Monitoring
 - ▶ Transparency
 - ▶ Market Forces
- ▶ Next Steps

Presentation

Dr. Kathleen Hittner
Health Insurance Commissioner for the
State of Rhode Island

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Data Presentation
Dr. David Torchiana

► 4

State Monitoring Subcommittee Update

► 5

Transparency Subcommittee Recommendations

► 6

Market Forces Subcommittee Recommendations

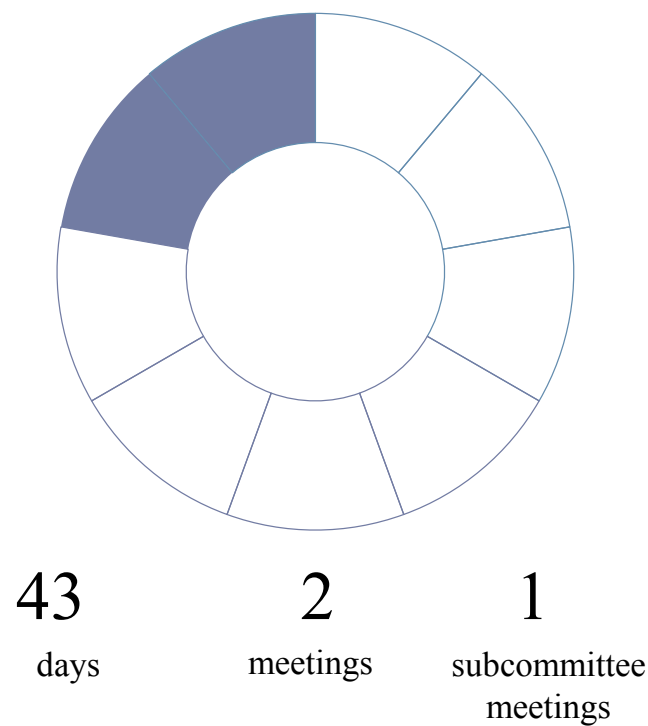
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Next Steps

- ▶ Upcoming Commission Meeting
 - ▶ February 14th, 2017
 - ▶ 11:00am – 2:00pm at One Ashburton Place, 21st Floor
- ▶ Upcoming Subcommittee Meetings
 - ▶ State Monitoring Subcommittee
 - ▶ February 7th, 2017
 - ▶ 11:00am, State House, Room 350

▶ 8

The Commission’s Report is due in...



Special Commission on Provider Price Variation

February 14, 2017

I

Agenda

- ▶ Welcome
- ▶ State Monitoring Recommendations
- ▶ Market Forces Recommendations – Updates
- ▶ Discussion
- ▶ Next Steps

Guest Panelists:

Dr. Robert Berenson

Dr. Paul Ginsburg

Professor Gwendolyn Majette

► 3

State Monitoring Subcommittee Recommendations

► 4

State Monitoring Subcommittee Principles

1. Unwarranted provider price variation is a problem in Massachusetts.
2. There are providers that are being greatly underpaid stemming from unwarranted factors just as there are hospitals being overpaid based on unwarranted factors. Underpayment and overpayment are both signs of market failure and equally problematic.
3. Ensuring access to efficient and affordable healthcare in the community requires that providers are fairly paid according to warranted factors.

► 5

State Monitoring Subcommittee Principles

4. Short term differential (preferential) investments may be required.
5. Policies to address unwarranted variation in prices should not increase total healthcare spending in the Commonwealth.
6. The Subcommittee recognizes the importance of innovation that drives patients to high-quality, low-cost providers.

► 6

State Monitoring: Recommendation #1

Compression of Provider Rates

▶ Part 1: Regulate Growth in Rates

- ▶ The Subcommittee recommends, in order to control overall healthcare costs and to enable the establishment of a minimum or floor as described in Part 2, that the state implement one or both of the following. The Subcommittee recognizes that these two actions taken together would make the most meaningful impact on provider price variation.
 - ▶ Enhanced role for the Division of Insurance
 - ▶ Rate of growth in provider rates differentially indexed

▶ Part 2: Rate Minimum or Floor for Community Hospitals

▶ 7

State Monitoring: Recommendation #2

Monitoring Patterns of Utilization

- ▶ The Health Policy Commission (HPC) should track patient movement across various providers in the state and assess the impact of that movement on statewide cost and quality (e.g. leakage or migration between community hospitals and academic medical centers).
- ▶ This information will help
 - ▶ Evaluate the impact of tiering,
 - ▶ Better inform the HPC's review of mergers and acquisitions in the Commonwealth, and
 - ▶ Potentially assist in driving appropriate care to community hospitals.

▶ 8

State Monitoring: Recommendation #3

Meaningful Consumer Incentives

- ▶ The Health Policy Commission, the Division of Insurance, and other appropriate state entities, should take measures to encourage the use of more meaningful consumer incentives to make high-value choices including, but not limited to,
 - ▶ The ability to increase the differentials among tiers and between limited- and tiered-network plans (LTNPs) and broader commercial plans,
 - ▶ Tiering plans based on primary care provider, and
 - ▶ Other efforts to enhance consumer choice through innovative product design.
- ▶ Current DOI constraints on tiered and limited network products should be revisited and, possibly relaxed, to encourage uptake and adoption.

▶ 9

Market Forces Recommendations Update

▶ 10

Discussion

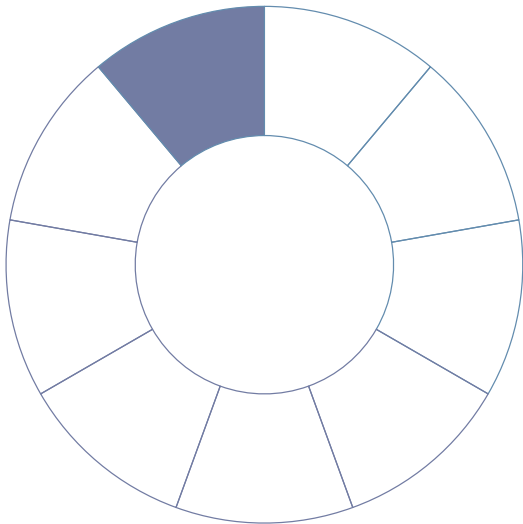
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Next Steps

- ▶ Upcoming Commission Meeting
 - ▶ March 7th, 2017
 - ▶ 11:00am – 2:00pm at One Ashburton Place, 21st Floor

▶ I2

The Commission’s Report is due in...



30

days

1

meetings

0

subcommittee
meetings

Special Commission on Provider Price Variation

March 7, 2017

I

Agenda

- ▶ Welcome
- ▶ Discussion
- ▶ Next Steps

Discussion

▶ 3

Next Steps

- ▶ Report is due on March 15, 2017

▶ 4