

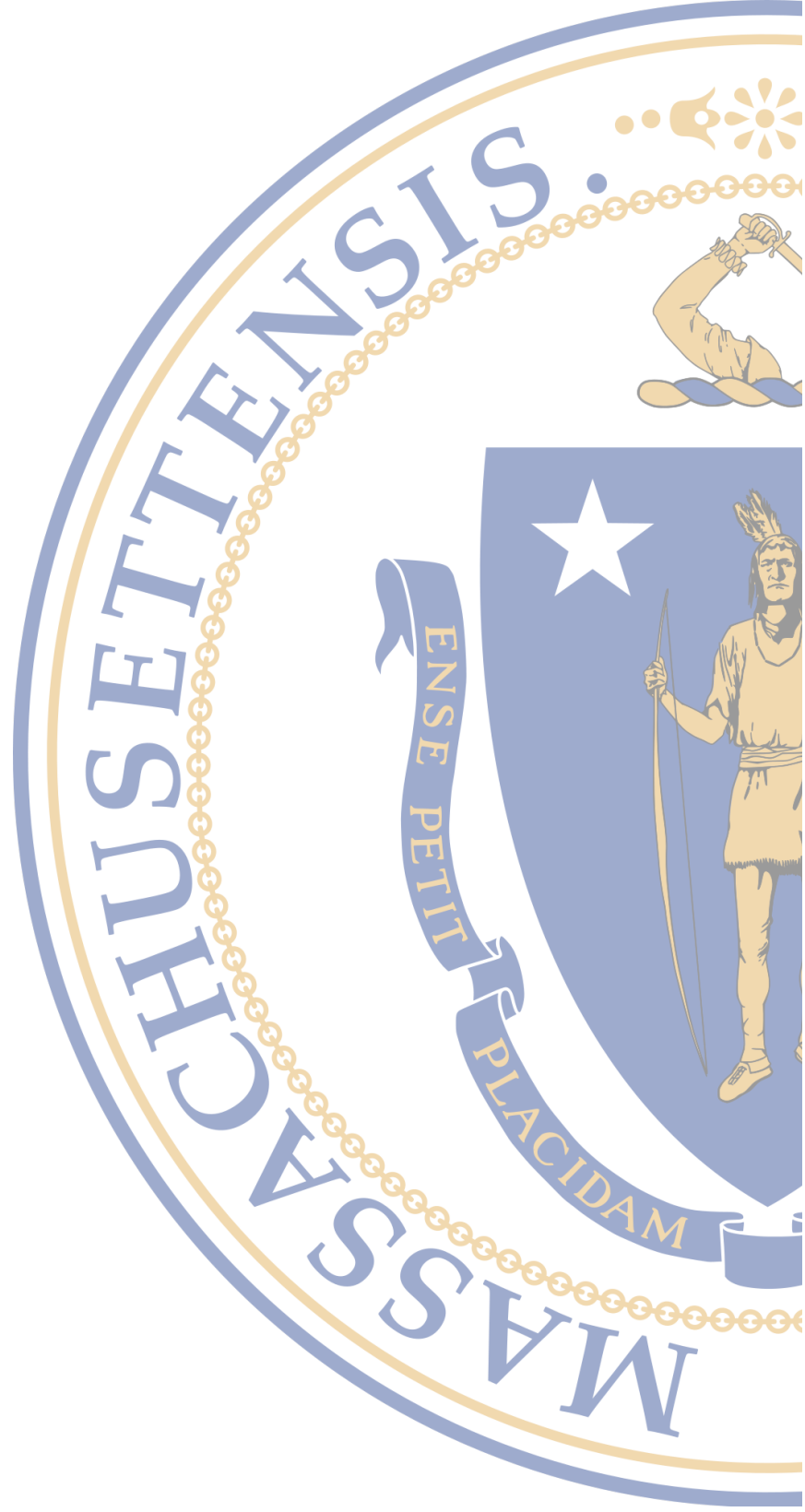
Special Commission on PROVIDER PRICE VARIATION REPORT

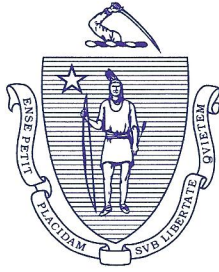
March 15, 2017

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House Chair of the Joint Committee
on Health Care Financing

Senator James T. Welch, Co-Chair
Senate Chair of the Joint Committee
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March 15, 2017

I write to acknowledge the hard work, leadership, and collaboration that members of the Special Commission on Provider Price Variation displayed throughout its operation.

As a Chairman of the Commission, I had the pleasure of helping to guide this important conversation about provider price variation in Massachusetts, but it was our Commission members who gave that conversation life and led it to bear fruit. I extend my gratitude to the subcommittee chairs, Deborah Devaux, Connie Englert, and Kate Walsh, for their commitment. The breadth of the Commission report and the strength of its recommendations speak to the full Commission's efforts more than I could hope to do here.

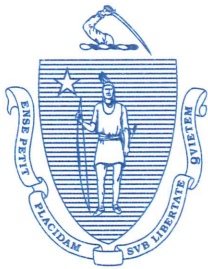
I would also like to thank my legislative director and counsel, Michael Cannella, for his work throughout the process.

Our work on provider price variation does not end with this report and its recommendations. The recommendations offer a guiding light on our journey to improve the financing and delivery of healthcare in Massachusetts. I look forward to continuing that journey.

Sincerely,

A handwritten signature in blue ink that reads "James T. Welch".

James T. Welch
Hampden District



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March 15, 2017

The Special Commission on Provider Price Variation spent the last six months tackling complex issues in healthcare, including the payer-provider contracting relationship, the impact of healthcare market forces, how transparency can be implemented meaningfully, and a potential role for the state in reviewing provider rates. The conversation was engaging and informative, but at times challenging.

Given the complexity of the issues at hand and the short time frame, we created a process to allow all members to engage in a respectful dialogue and tackle the breadth of this issue. I did not want to revisit old reports and analyses and rehash old debates. Instead, I wanted to foster objective, focused discussions and hopefully find some points of agreement. Although the Commission's mandate was specific in some areas, it was also quite broad. Therefore, the Commission's work was informed by systemic concerns, such as continued increases in healthcare costs and how to support community providers.

Considering the size of the Commission, as well as the time frame, we created three subcommittees to allow Commission members to continue conversations between meetings and draft initial recommendations in their respective topic areas to bring back to the full Commission. In addition, to facilitate thoughtful and in-depth conversations, the Commission invited nationally-recognized industry experts to each meeting, where they presented on their areas of expertise. Once the Commission drafted its recommendations, we assembled a final panel of experts to challenge and expand our thinking. To engage members of the public and stakeholders not represented on the Commission, we held a public listening session. These issues impact all residents of the Commonwealth so we wanted to provide an opportunity for people to address the Commission.

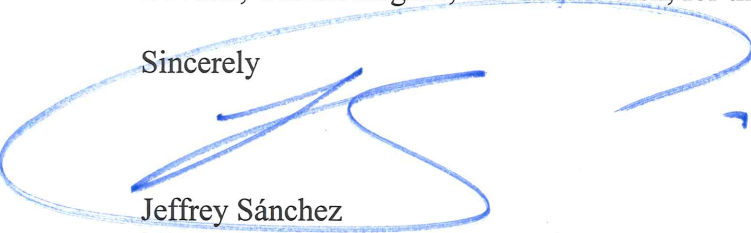
From the beginning, in my role as Chair of the Commission, my goal was for all stakeholders to come together, discuss action-oriented ideas that address the challenges in our healthcare market, and see if Commission members could reach consensus. It was not easy work, but over the course of nine meetings, all of which were open to the public, and almost a dozen subcommittee meetings, a few common themes emerged. Commission members agreed that higher payments

are justified for high-quality providers and providers that care for sicker or high-cost patients. The Commission also agreed that patients receiving emergency services or those cared for without their knowledge by an out-of-network provider should not be subject to a surprise bill. Members emphasized the fact that small businesses face unique hurdles when they purchase health insurance and may need additional resources. There was also recognition that it is essential to design innovative insurance products that appeal to consumers and employers. There was broad agreement that patients need more accessible, actionable, and understandable information, both when they choose their plans and when they access care. Finally, Commission members agreed that all stakeholders must work to ensure the sustainability of providers across the Commonwealth. The Commission also recognized that any proposed actions should not increase total healthcare spending in the Commonwealth or increase the financial burden on patients and employers.

Our discussions and these recommendations are merely the beginning of a conversation. There is a lot of uncertainty at the federal level as we wait and see how Congress and the Trump Administration is going to act regarding the future of healthcare. Massachusetts is a leader in healthcare innovation and policy reform and I look forward to continuing the conversation.

Finally, I'd like to thank my staff for all their work on this effort, specifically, Sarah Sabshon (Chief of Staff), Timothy O'Neill (Committee Director), Erin Liang (Committee Counsel) and Sharone Assa (Research Analyst). I'd also like to thank the subcommittee chairs, Deborah Devaux, Connie Englert, and Kate Walsh, for their hard work throughout this process.

Sincerely



Jeffrey Sánchez
Massachusetts State Representative
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LIST OF ACRONYMS & ABBREVIATIONS

ACA	Affordable Care Act
ACO	Accountable Care Organization
AGO	Office of the Attorney General
AIM	Associated Industries of Massachusetts
AMC	Academic Medical Center
APAD	Adjudicated Payment Amount per Discharge
APC	Ambulatory Payment Classification
APEC	Adjudicated Payment per Episode of Care
APM	Alternative Payment Method
AQC	Alternative Quality Contract
ASC	Ambulatory Surgical Center
BCBS	Blue Cross Blue Shield of Massachusetts
BMC	Boston Medical Center
CHIA	Center for Health Information and Analysis
CMIR	Cost and Market Impact Review
CMMI	Centers for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
Connector	Commonwealth Health Insurance Connector Authority
DHHS	U.S. Department of Health & Human Services
DME	Direct Medical Education
DMH	Department of Mental Health
DOI	Division of Insurance
DPH	Department of Public Health
DRG	Diagnosis-Related Group
DSH	Disproportionate Share Hospital
ED	Emergency Department
EOHHS	Executive Office of Health & Human Services
FFS	Fee-For-Service
FTC	Federal Trade Commission
GIC	Group Insurance Commission
GMCB	Green Mountain Care Board
GME	Graduate Medical Education
GPC	Group Purchasing Cooperative
HDHP	High Deductible Health Plan
HMO	Health Maintenance Organization
HPC	Massachusetts Health Policy Commission
HPHC	Harvard Pilgrim Health Care
IME	Indirect Medical Education

IPPS	Inpatient Prospective Payment System
LNP	Limited-Network Plan
LTNP	Limited- and Tiered-Network Plan
MACRA	Medicare Access and CHIP Reauthorization Act
MAHP	Massachusetts Association of Health Plans
MCN	Notice of Material Change
MCO	Managed Care Organization
MedPAC	Medicare Payment Advisory Commission
MHA	Massachusetts Health & Hospital Association
MIPS	Merit-Based Incentive Payment System
NIH	National Institutes of Health
OHIC	Rhode Island Office of the Health Insurance Commissioner
OPPS	Outpatient Prospective Payment System
PACE	Program for All-Inclusive Care for the Elderly
PAPE	Payment Amount Per Episode
PCC	Primary Care Clinician Plan
PCP	Primary Care Provider
PIP	Performance Improvement Plan
PMPM	Per-Member-Per-Month
PPO	Preferred Provider Organization
RP	Relative Price
RPO	Registration of Provider Organizations
SCH	Sole Community Hospital
SCO	Senior Care Options
THP	Tufts Health Plan
TME	Total Medical Expense
TNP	Tiered-Network Plan

EXECUTIVE SUMMARY

In May 2016, the Massachusetts Legislature passed Chapter 115 of the Acts of 2016 to address health system viability and provider price variation, or differences in prices paid to providers for the same set of services. The Act establishes the Special Commission on Provider Price Variation, a twenty three-member group consisting of legislators, insurers, providers, employers, and other stakeholders. The Act directs the Commission to identify acceptable and unacceptable factors contributing to price variation, examine price variation in other states, and review certain payer-provider contracting practices.

Commission members addressed these and related topics over the course of nine meetings. Members also participated in one of three subcommittees – market forces, state monitoring, and transparency – to examine in greater detail various proposals raised at full Commission meetings. Subcommittees drafted recommendations, which the Commission considered at subsequent meetings. This report is the result of this comprehensive process. It builds off the work of state agencies, considers the extent of price variation in Massachusetts and nationally, and explores reasons for and steps to address price variation. The Commission did not examine whether overall price levels are too high or too low, as this was not part of its statutory charge.

Per the Commission's charge, the report concludes with recommendations to reduce unwarranted provider price variation. These recommendations seek to balance appropriate payments to providers and ensure stability in the market, while keeping in mind the impact on premiums and total healthcare costs in the Commonwealth. It is important to note that not all Commission members agree with each recommendation. The full report details member conversations including places of disagreement.

RECOMMENDATIONS

MARKET FORCES

Warranted & Unwarranted Factors for Price Variation

The Special Commission on Provider Price Variation recommends the following factors be considered warranted or unwarranted reasons for provider price variation in Massachusetts. This list is intended to apply to both acute-care hospitals and other provider types (e.g., physicians), although the methods for measuring the factors would likely vary between hospitals, physicians, and other provider types. Also, it should be noted that this list does not consider the methodology or weight that such factors could or should be given in determining pricing.

This recommendation should be considered a policy document that serves as a guide for transparency and deliberation during price negotiations between providers and payers. The feasibility and effectiveness of this recommendation, with respect to

preventing unwarranted factors from influencing rates, could be evaluated and monitored through a transparent, objective, and accountable process with ongoing oversight by the appropriate state agency, such as the Health Policy Commission (HPC) or the Division of Insurance (DOI).

Addressing provider price variation must keep in mind the dual goals of making healthcare more affordable for employers and consumers and addressing unwarranted differences in prices paid to providers. The influence of factors is complex and varied. In the current payment environment, every hospital is paid at a different level for the same services by different payers, and some types of services are reimbursed at rates higher than others.

WARRANTED FACTORS:

Warranted factors should be clearly defined and measureable and not used as proxies for unwarranted factors:

Patient acuity

Prices should reflect whether providers generally care for sicker or more complex patients (e.g., provide tertiary or quaternary care). For inpatient care, the case-mix index may be the most appropriate measure of patient acuity, but further research may be needed to identify the most accurate case-mix adjuster for ambulatory outpatient hospital services. Patient acuity measures should be further reviewed and evaluated with reference to socio-economic factors and in conjunction with evolving scientific and medical developments.

High-cost outliers

Although most payers offer some type of cost-based reimbursement for high-cost outliers, it may also be appropriate for pricing levels to be higher for providers who care for high-cost outliers. For example, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital MS-DRG payments. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The provider is paid 80% of costs above the fixed-loss threshold. Since outlier cases are unpredictable and outlier payments may not cover the full cost of care, it may be appropriate for pricing levels to be higher for providers who care for a substantial number of high-cost outliers, provided that there is transparency on providers' cost structures. It is important to ensure that this factor is not already incorporated into another factor, such as patient acuity, to avoid the potential for multiple counting of the same elements.

Quality

Providers offering higher quality of care, particularly as measured by clinical outcomes and including measures that capture patient experience/satisfaction, such as willingness to recommend, may receive higher prices to reward this higher value. There may be additional payments or reductions in payments based on performance on a set of quality measures, which should also take into consideration contracts that already provide financial incentives or penalties based on quality. There is agreement

that outcome and patient experience measures should be improved and expanded over time.

FACTORS REQUIRING ADDITIONAL ANALYSIS:

Analysis either by the Health Policy Commission and/or the Center for Health Information to Determine their Impact on Overall Healthcare Costs and Validity as Warranted Measures

Area wages

To the extent providers have different labor costs, driven by labor costs in the region from which they draw employees, prices should reflect those differences. Medicare adjusts its payment amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital, compared to the national average hospital wage level. The Medicare wage index is revised each year and is based on wage data reported in hospital cost reports, which are publicly available. To avoid circularity, the Medicare wage index uses the average hospital wage levels for all hospitals in a given geographic area or labor market using Core-Based Statistical Areas (CBSAs), as defined by the Office of Management and Budget. There should be greater transparency surrounding providers' cost structures, including the cost of labor, to understand how wages vary among providers, particularly providers in the same geographic region. This information should be available as part of the contract negotiation between payers and providers to justify the influence of this factor in pricing determinations.

Low/no-margin services

Higher prices may also be warranted for providers that provide a higher proportion of services that yield little or no margin but that are demonstrably needed by the community. Margin data for hospitals, however, is not uniform, may be unreliable, and is impacted by allocation decisions at the provider level. Better insight into underlying provider costs is needed to determine whether a service is truly low- or no-margin. A uniform, definitive approach into underlying provider costs is necessary and needs more research by the HPC and the Center for Health Information and Analysis (CHIA) before being considered as a factor.

Teaching

Teaching payments reflect the higher costs providers incur in maintaining a medical education program, beyond the costs accounted for through acuity and outlier adjustments. With any decrease in federal funding provided to Massachusetts by the federal government, shortfalls in federal funding should not be automatically borne by the commercial market. There should be recognition that this is a societal good with benefit for the Commonwealth, and that there needs to be a sustainable appropriate funding mechanism aside from commercial and government payers. CHIA and the HPC should examine the extent of graduate medical education funding in other states as well as whether and to what extent there is an appropriate role for a commercial health plan and/or state government to fund these activities. Further, greater transparency is needed to understand the costs associated with teaching in relation to underlying costs, including lower labor costs associated with residents providing care. Similar to other factors, if teaching is to be considered a

justifiable factor, other factors, such as acuity and outliers, would need to be taken into account, so that there is no duplication in payment factors.

Stand-by capacity

Some hospitals maintain 24/7 stand-by capacity for unique, specialized services that meet recognized community need. Acuity adjustments and outlier payments reimburse providers when a service is utilized by a patient. Standby capacity, on the other hand, is the cost of ensuring that a service is available when needed, regardless of whether it is utilized sufficiently to cover fixed costs. It may be appropriate for prices to reflect the costs of maintaining stand-by capacity for unique and specialized services. It is important, however, to document those services for which costs are not covered and to examine the extent to which the costs of maintaining this capacity are not already reimbursed through higher payments associated with higher patient acuity and/or high-cost outliers. It is also important to note that demand for stand-by care in rural areas may be more variable and therefore justified as a cost of serving the community.

Socioeconomic status of patient population

The resources needed to meet the needs of low-income populations are different than for other commercial sub-populations. Work to date has identified that healthcare costs vary for higher-income populations compared to lower-income populations. Research shows that lower socioeconomic status is associated with higher costs. Additional investigation is needed to determine whether costs relating to socioeconomic status are accounted for in commercial reimbursement rates. If changes are warranted, then work is needed to identify appropriate payment adjustments.

UNWARRANTED FACTORS:

Market power or bargaining clout, brand, and geographic isolation do not warrant price variation and do not provide societal benefits. Potential government payment shortfalls and research do not warrant price variation in commercial rates but do have a societal impact that needs to be recognized.

Factors with no societal impact

Market Power

In this context, market power refers primarily to the negotiating leverage conferred by size or relative market position, compared to payers and other provider organizations. Patient experience/willingness to recommend and provider referral preferences, which are factors that warrant variation, may contribute to a provider's size and brand. Size and brand alone, however, should not be considered a differentiating factor for price variation.

Brand

State reports have found that brand does not correlate to with high performance on a wide variety of quality measures. Although patient satisfaction and provider referral

relationships may contribute to a provider's brand, brand alone should not be considered a differentiating factor for price variation.

Geographic Isolation

Health plan's networks must reflect local geography and demographics to ensure that members have sufficient access to necessary care. However, geographic isolation alone is not a valid factor for price variation. Further, DOI monitors and reviews health plan networks to determine whether members have reasonable and timely access to a broad range of providers and services. In some cases, however, geographically-isolated providers may merit higher prices, if they are the sole provider of low-margin services in their area. This factor, however, should be examined in the context of whether this is already covered by higher payments for wages, standby costs, and other factors referenced above.

Factors with societal impact

Government payment shortfalls

There is a persistent dynamic among governments, providers, and commercial payers (including employers) concerning what constitutes sustainable, appropriate government funding by Medicare, Medicaid, and the Group Insurance Commission. Providers are concerned about possible future reductions in government funding, and have used commercial payments to some degree to balance any difference between payment and the cost of providing care. Payers and employers on the Commission, however, noted that it is not viable to expect commercial payers to automatically make up the difference in any potential government shortfalls. There should be recognition that serving those insured by public payers is a societal need that requires a sustainable government funding mechanism.

Research

Currently, research costs are covered by public funding (e.g. National Institutes of Health), philanthropy, and other private sources. There are differing opinions among Commission members about whether research costs should be included in commercial payment rates. To the extent that maintaining academic research programs may result in costs not covered, and given the economic importance of medical research to the Commonwealth and to patient care, if the current funding model changes, some on the Commission feel a that sustainable and appropriate broad-based funding mechanism is essential. Other Commission members do not believe that commercial health plans and employers should be expected to fund these efforts.

Address "Surprise Billing" and Out-of-Network Issues to Protect Consumers and Support Network Participation

As a key part of an overall strategy to address provider price variation through market mechanisms, the Special Commission on Provider Price Variation applauds the increased use of limited- and tiered-product designs. These products, designed appropriately, can be an important tool to enable patients and consumers to have the benefit of lower-cost coverage options, promote high-value providers, and help address price variation.

Certain issues concerning these types of plans, however, merit a strong recommendation for legislative action. These issues occur when patients receive care out-of-network and then receive what is sometimes called a surprise bill. There are two situations in which this occurs. First, the patient is cared for by a non-participating provider in an emergency. Second, the patient is cared for without his or her knowledge by a non-participating provider at an in-network facility. For example, a patient is scheduled for surgery with a participating surgeon but receives services from a non-participating anesthesiologist, pathologist, or radiologist. In this situation, the patient did not know or make a decision to see the non-participating provider. Out-of-network billing must be addressed so that patients are protected and payers are able to develop innovative plans.

The following issues must be addressed and resolved together as a package, since the absence of any one solution will lead to inappropriate results.

1. Consumer awareness of “surprise billing” scenarios,
2. Patient protections to prevent balance-billing, and
3. A maximum reasonable provider reimbursements for out-of-network services.

1) CONSUMER AWARENESS

Health plans educate patients on the benefits of in-network care and the risks of receiving care out-of-network. Toll-free member service lines, Explanation of Benefits guidance, and cost estimation tools are all used to demonstrate that no network is all-inclusive. Planned out-of-network care or inadvertent leakage can lead to additional costs for the consumer and the healthcare system.

Massachusetts should adopt additional member protections – similar to measures adopted by California, Connecticut, and New York – that define specific surprise bill and non-surprise bill scenarios, including a reminder that patients can be billed when they knowingly choose to receive services from a provider that is not participating in their health plan. Providers should inform patients when the patient is going to be cared for by a non-participating provider. Likewise, health plans should assist their members in determining which physicians and hospitals are in- or out-of-network.

2) PROTECTING PATIENTS FROM BALANCE BILLING

Effective balance-billing prohibitions are necessary to protect patients. Massachusetts should enact into law prohibitions on patients being billed by providers for the portion of their care not covered by their insurance plan. This patient protection should only apply when a patient receives emergency services (emergency room and any associated admission or care) or a non-participating provider provides care in a participating hospital or facility. If a member decides to seek care out-of-network, no protection should be implemented, since patients should appropriately bear the risk of a planned decision.

One possible model for adoption in Massachusetts is the National Association of Insurance Commissioners (NAIC) model act. It has comprehensive requirements on

network adequacy and would give DOI sufficient authority to determine whether a network is adequate, by providing quantitative standards.

3) ESTABLISHING AN OUT-OF-NETWORK PAYMENT RATE

There was consensus among Commission members that establishing a default rate of payment for services rendered out-of-network is a critical part of any recommendation. This protection is particularly important for incenting the creation of robust networks necessary for novel insurance product designs that can help address provider price variation.

In setting a maximum reasonable price for out-of-network services, the state should adhere to the following key principles. First, the overall impact should result in cost savings to consumers and employers and have minimal additional administrative expense to both providers and payers. Second, there should be a reasonable, transparent, and simple approach to applying a rate, not a cumbersome metric that is non-transparent or easily administered. Finally, any rate should ensure that current in-network participation levels by providers are improved upon. The set rate must not inadvertently be at such a high level as to entice providers to leave a network, or at such a low level as to make a health plan indifferent as to whether the provider is in- or out-of-network.

Commission members examined the following two scenarios in detail:

1. The patient receives emergency care from a provider participating in a health plan's broad network but that provider has either opted out of or not been selected for participation in a tiered- or limited network product; or
2. The patient receives care in a contracted facility from a physician that is not contracted with the health plan (e.g. Emergency, Radiology, Anesthesia, and Pathology [ERAP]).

Scenario 1: A provider's payment for emergency out-of-network services, as described above, should be set at its currently-contracted rate with that health plan or at a level slightly above that rate (e.g., 10%). The rate should be set by statute to ensure both easy administrative processing and regulatory certainty in the marketplace. The HPC, or other appropriate state entity, should convene a workgroup of interested parties for the specific and time-sensitive purpose of drafting recommendations on this rate, to be filed with the legislature. A statutorily set rate should incent robust network development, as well as significantly lower the cost of care.

Scenario 2: Where a provider does not have a contract with the health plan, the default rate should be at a level significantly below charges but not below Medicare. The appropriate entity should convene a workgroup of interested parties for the specific and time-sensitive purpose of advising the HPC so that it can draft recommendations on this rate, to be filed with the legislature. Like the prior scenario, this rate should be codified in statute in such a manner as to incent robust network development, as well as significantly lower the cost of care.

Tiering Transparency and Participation

The Special Commission on Provider Price Variation endorses the need for improved transparency regarding the provider tiering by health plans. Health plans and providers should collaborate to facilitate further offerings of tiered- and limited-network products as an important option for consumers and employers.

TIERING DISPLAY

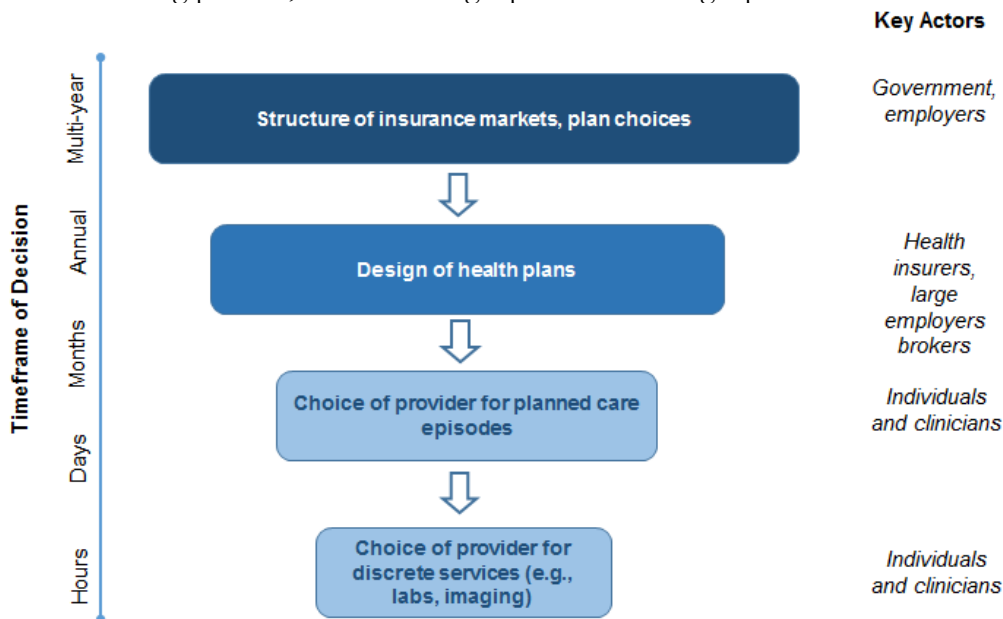
Health plans should develop a uniform method for displaying a hospital's assigned benefit tier so that information on how the hospital performed on cost and quality benchmarks is presented in a consumer-friendly format for patients and providers.

TIERING TRANSPARENCY

Upon request by a hospital, health plans should provide the methodology used for a hospital's tier placement, including the criteria, measures, and data sources, as well as hospital-specific information used in determining the hospital's quality score, how the hospital's quality performance compares to other hospitals, and the data used in calculating the hospital's cost-efficiency.

TRANSPARENCY

These recommendations are designed to improve transparency at each point in the decision-making process, from selecting a plan to choosing a provider.



¹ This chart is based off a visual created by the Health Policy Commission presented by David Auerbach at a meeting of the Special Commission on December 13, 2017.

These recommendations were guided by the following principles:

1. The definition of transparency is broader than price comparisons at the point-of-service, because efforts to implement transparency solely at this point in the decision-making process have been met with limited success.
2. The opportunity and challenge of improving transparency should affect each sector of the industry and occur at each decision-point along the continuum, recognizing differences within sectors (e.g. small- and large-group insurance market; large and small employers; specialty hospitals/surgical centers and academic medical centers).
3. Efforts to improve transparency should not add to the administrative and financial burden on small businesses in the Commonwealth.
4. Transparency for transparency's sake is not the goal. Tools must be developed that educate and inform insurers, employers, providers, and patients about the fiscal and clinical implications of product design, network access, out-of-pocket expenses, and other considerations.
5. Wherever possible, these recommendations seek to further explore, support, and enhance existing legislative and regulatory mechanisms to improve transparency.
6. Elements of successful transparency efforts in other states (e.g., New Hampshire website) should be adopted.
7. Effective transparency tools must include quality as well as cost information. The quality data should be as granular as possible where it exists and should reflect developments in quality measurements. Standard quality metrics should be developed to provide consistency and support improved quality.
8. Transparency tools need to adapt continually to be relevant.

Transparency Website

As mandated by Chapter 224 of the Acts of 2012, CHIA will establish a consumer website. The development of this website will be informed by a thorough stakeholder process and the principles articulated above and take into account the following recommendations.

- CHIA will release a beta site by July 1, 2017, with a focus on supporting consumers and small business owners.
- CHIA will create an educational platform to provide information along the decision point continuum, including publishing a multi-payer weighted average price for a market basket of “shoppable” services. This will likely require payers to provide pricing information.
 - Full transparency includes specific information about access to behavioral and substance abuse services, drug formularies, and other costs, which can be opaque to employers and employees when selecting plans.
- There shall be a strong partnership between CHIA, the Commonwealth Connector Authority (Health Connector), the HPC, and the Group Insurance Commission to leverage work already complete or underway and to ensure consistent methodology and analytics.

- When consumers seek information on out-of-pocket costs, the website will direct consumers to their insurer's website, wherever possible.
 - Interactive decision-tree tools should be developed to inform consumers and employers about the ramifications of their plan choice; for example, how choosing a tiered network impacts the patient's choice of hospital.

Support for Small Employers

Small businesses should be additionally supported through the following actions:

1. When considering the user requirements for its website, CHIA should place specific emphasis on interactive decision tools and educational materials to support consumers and small business owners who may not have access to data or expertise.
2. DOI should prioritize implementation of the Ch. 224 mandate to create standardized, understandable, and timely explanation of benefits forms that includes information about lower-cost alternatives.
3. The Commonwealth should pursue opportunities to improve the purchasing power of smaller businesses and consider Professional Employer Organizations (PEOs), as allowed.
4. Insurers and small employers should work together to develop tools for employers to understand trends within their insured population, while protecting the privacy of individuals.

STATE MONITORING

These recommendations were guided by the following principles:

1. Unwarranted provider price variation is a problem in Massachusetts.
2. There are providers that are being greatly underpaid due to unwarranted factors, just as there are providers being overpaid based on unwarranted factors. Underpayment and overpayment are both signs of market failure and are equally problematic.
3. Ensuring access to efficient and affordable healthcare in the community requires that providers are fairly paid according to warranted factors.
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 Commission recognizes the importance of innovation that drives patients to high-quality, low-cost providers.

Compression of Provider Rates

The Special Commission recommends a direct, multi-component proposal with a date-certain implementation and a mechanism for periodic review to address unwarranted price variation. The proposal aims to promote price compression in Massachusetts for providers in both single- and multi-year contracts. The

components authorize a state entity to disapprove payer-provider contracts and/or allow for differential growth rates for hospitals whose prices are subject to the influence of unwarranted factors, and ensure that hospitals subject to the most significant levels of underpayment get immediate relief. This proposal aims to hold both payers and providers accountable for ensuring the compression of provider rates. The Commission recommends that Part 1 & Part 2 be implemented together to address disparities in payment.

PART 1: REGULATE GROWTH IN RATES

The Special Commission recommends, in order to control overall healthcare costs, to compress overall provider prices, and enable the establishment of a minimum or floor as described in Part 2, that the state implement one or both of the following. The Commission recognizes that these two actions taken together would make the most meaningful impact on provider price variation.

- An enhanced role for the appropriate state entity, such as DOI or the HPC, to review and approve insurance contracts using unwarranted and warranted factors in provider payments, such as those found in Recommendation #1. Payer-provider contracts may be reviewed, and keeping in mind the administrative burden on all stakeholders, the appropriate entity will more closely examine those contracts where providers receive relatively high or low rates (outlier contracts), as defined by the legislature. Contracts with rates based on unwarranted factors will be subject to disapproval. The state entity should utilize these factors to close the gap between high-cost outliers and more efficient, lower-reimbursed, high-value providers, and ensure that plan designs are promoting high-value providers and helping to control the growth in statewide healthcare costs.
- Overall, growth in provider rates in Massachusetts would be consistent with the statewide benchmark on total spending growth. The rate of growth in prices for individual providers or groups of providers would be designed such that providers with low commercial prices would be able to increase their rates more rapidly than providers with high prices due to unwarranted factors.

The implementing state entity shall take measures to protect consumers and address any potential for disruptions in care. The appropriate state entity shall ensure that any savings above those needed to implement Part 1 and Part 2 is returned to employers and consumers through premium relief, while also re-allocating some savings to high-value/efficient providers in an effort to achieve the goal of compressing price variation while also lowering overall TME.

PART 2: RATE MINIMUM OR FLOOR FOR COMMUNITY HOSPITALS

In order to correct for apparent underpayment, the Commission recommends a minimum rate or floor for hospitals in Massachusetts. This floor should take into account the limits set in Part 1, ensuring premiums do not increase for consumers and employers, and warranted and unwarranted factors for price variation. The formula should be determined by the legislature in conjunction with appropriate state entities.

Monitoring Patterns of Utilization

The HPC shall 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 patient 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.

Meaningful Consumer Incentives

The HPC, DOI, and other appropriate state entities should take measures to encourage the use of more meaningful consumer incentives to promote high-value choices including, but not limited to, contribution policy, increasing price differentials among tiers, increasing the premiums between limited- and tiered-network plans and broader commercial plans, tiering plans based on primary care provider, and other efforts to enhance consumer choice through innovative product design. Current insurance constraints on limited- and tiered-network plans should be revisited and possibly relaxed, to encourage uptake and adoption.

Total Medical Expense (TME)

The Commonwealth shall continue to refine its methodology to measure TME in order to better capture the healthcare market.

INTRODUCTION

The *Massachusetts Fair Health Care Pricing Act*, an initiative filed in 2016 but not included on the ballot, would have set a floor and ceiling on commercial payments to certain healthcare providers.¹ In May 2016, the Massachusetts Legislature passed *An Act Relative to Equitable Health Care Pricing* to further explore the issues of healthcare pricing and rising healthcare costs.² In addition to creating a \$45 million fund to be distributed to lower-priced hospitals over five years,³ the Act establishes a Special Commission on Provider Price Variation.⁴ The Commission, a twenty three-member group consisting of legislators, insurers, providers, employers, and other stakeholders, must identify acceptable and unacceptable factors contributing to price variation, examine price variation in other states, and review certain payer-provider contracting practices.⁵ The Act requires the Commission to release a final report, including steps to address unwarranted price disparities, by March 15, 2017.

The Commission focused its work according to the following 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 its discussions.

The Special Commission held nine public meetings between September 2016 and March 2017. Each meeting focused on a specific topic, informed by the Special Commission's statutory charge.⁶ After establishing a work plan in the first meeting,

¹ The language of the ballot initiative was also filed as legislation in 2015 by Senator Benjamin B. Downing. See S.574, 2015-2016 Sess. (Mass. 2015), "An Act relative to Equitable Health Care Pricing."

² H.4348, 2015-2016 Sess. (Mass. 2016).

³ 2016 Mass. Acts 115, § 4 (2016).

⁴ The Massachusetts Legislature previously authorized a commission on provider price reform under Chapter 288 of the Acts of 2010. See 2010 Mass. Acts 288, §67. The Commission published its report on November 9, 2011. Another commission was created under Chapter 224 of the Acts of 2012 but was never convened. See 2012 Mass. Acts 224, § 279.

⁵ 2016 Mass. Acts 115, § 9.

⁶ Id.

members spent the second and third meetings discussing acceptable and unacceptable factors for commercial rate variation. Members examined these factors in the context of Medicaid and Medicare, to understand how programs with uniform payment schemes take into account the characteristics of different providers. Joseph Newhouse, the John D. MacArthur Professor of Health Policy and Management at Harvard University, gave an overview of Medicare's reimbursement methodology. Matthew Klitus, the Chief Financial and Strategy Officer at MassHealth, spoke to members about MassHealth's payment system.

In the following four meetings, the Special Commission engaged in action-oriented discussions about payer-provider contracting and market forces, plan design and consumer incentives, price transparency, and state monitoring. At the fourth meeting, Professor Gwendolyn Majette, Associate Professor at the Cleveland-Marshall College of Law, spoke about payer-provider contract negotiations, provider competition, and the impact of market forces on price variation. At the fifth meeting, the Special Commission discussed plan design and other levers to incentivize consumers to make high-value choices. David Auerbach, the Director for Research and Cost Trends at the Massachusetts Health Policy Commission, described how these demand-side incentives may indirectly reduce price variation.

At the sixth meeting, Katherine Baicker, the C. Boyden Gray Professor of Health Economics at the Harvard T.H. Chan School of Public Health, presented on price transparency and price variation, including how patients respond to price transparency initiatives. In the seventh meeting, Special Commission members heard from Kathleen Hittner, the Health Insurance Commissioner for the state of Rhode Island. Commissioner Hittner discussed regulations in Rhode Island that aim to reduce price variation, address rising healthcare costs, and foster delivery system innovation. Professor Majette, Robert Berenson, Institute Fellow at the Urban Institute, and Paul Ginsburg, the Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution, attended the eighth meeting to engage with members regarding the final recommendations. In the ninth meeting, members reviewed a draft report and made final comments.

To facilitate the work of the Special Commission, the Chairs, Representative Jeffrey Sánchez and Senator James Welch⁷, created three subcommittees: Market Forces, State Monitoring, and Transparency. The subcommittees enabled Commission members to both continue the dialogue between meetings and advance conversations about provider price variation at subsequent Commission meetings. Led by subcommittee chairs, each subcommittee met a minimum of three times. In these public meetings, subcommittee members delved into their respective topics and drafted preliminary recommendations.

Chairman Sánchez and Chairman Welch recognized that the work of the Special Commission on Provider Price Variation affects all citizens in the Commonwealth,

⁷ Representative Jeffrey Sánchez and Senator James Welch are the House and Senate chairs of the Joint Committee on Health Care Financing.

including Massachusetts residents concerned with rising healthcare costs. Therefore, in addition to the Commission and subcommittee meetings, the Chairs held a public listening session. This session allowed members of the public and stakeholders not represented on the Commission to share their perspectives. The session was well attended and many that testified submitted written testimony (See Appendix E).

This comprehensive report on provider price variation in Massachusetts is the product of these efforts. The report builds upon analyses of price variation by the Office of the Attorney General, the Health Policy Commission, and the Center for Health Information and Analysis. It takes into account feedback from all stakeholders, including Commission members and those testifying at the public hearing.

Chapter 1 provides a background on price variation in Massachusetts and nationally. Chapter 2 examines a variety of warranted and unwarranted reasons for price variation, in the context of Medicare, MassHealth, and state rate-setting systems. Chapter 3 examines payer-provider contracting practices and healthcare market forces. Chapter 4 defines and explores demand-side incentives, including where and when demand-side incentives can be used to encourage consumers and employers to make high-value choices. Chapter 5 discusses the role of price transparency. Chapter 6 analyzes the potential for state monitoring and intervention to address provider price variation.

This report is published at a challenging time for Massachusetts, given the uncertainty over the future of Medicaid and the Affordable Care Act. Even in this ambiguous federal policy environment, the Chairmen and all members of the Special Commission on Provider Price Variation are pleased to present these recommendations, and are optimistic that this report will further state efforts to address healthcare costs, quality, and access.

CHAPTER 1 – PROVIDER PRICE VARIATION IN MASSACHUSETTS AND NATIONALLY

INTRODUCTION

Massachusetts is a health policy innovator and a national leader in ensuring access to affordable care. As part of this commitment, three state entities collect and report on a wealth of data from payers and providers, including healthcare claims, costs, relative prices, medical expenses, and other relevant data.¹ This information, which forms the basis of this report, enables the Commonwealth to analyze trends in the healthcare sector, including provider price variation.

Section I of this chapter provides background on price variation metrics and reporting in Massachusetts. Section II analyzes trends in price variation from 2008 to the present. Section II also identifies hospital characteristics that correlate with high prices. Section III examines the direct and indirect effects of price variation in Massachusetts. Finally, Section IV compares price variation in Massachusetts with price variation in other states in the region and across the United States, including variation in prices paid for specific services.

SECTION I: PRICE VARIATION METRICS AND REPORTING IN MASSACHUSETTS

The Center for Health Information and Analysis (CHIA) collects information² from payers to generate two metrics on healthcare sector performance: provider relative price (RP) and total medical expense (TME).³ Relative price is an aggregate measure of all prices paid to a provider,⁴ in relation to the average price paid to all providers in that payer's network. Hospital inpatient and outpatient relative prices may be calculated separately or as one "blended" relative price, the overall price level for that hospital. By definition, a payer's average RP is 1.0. This means that a provider with an inpatient RP of 1.2, for example, is paid on average 120% of that payer's average price for inpatient services. Because an RP of 1.0 represents a different dollar amount for each payer, relative price values are not comparable across payers.⁵ Relative price considers the full range of prices, so in some circumstances it is also helpful to consider variation between .8 and 1.2 RP. For some payers, the majority of hospitals are within this range; for other payers, there is a wider spread (See Figure 1.1).

¹ MASS. GEN. LAW ch. 12C, § 16 (2016).

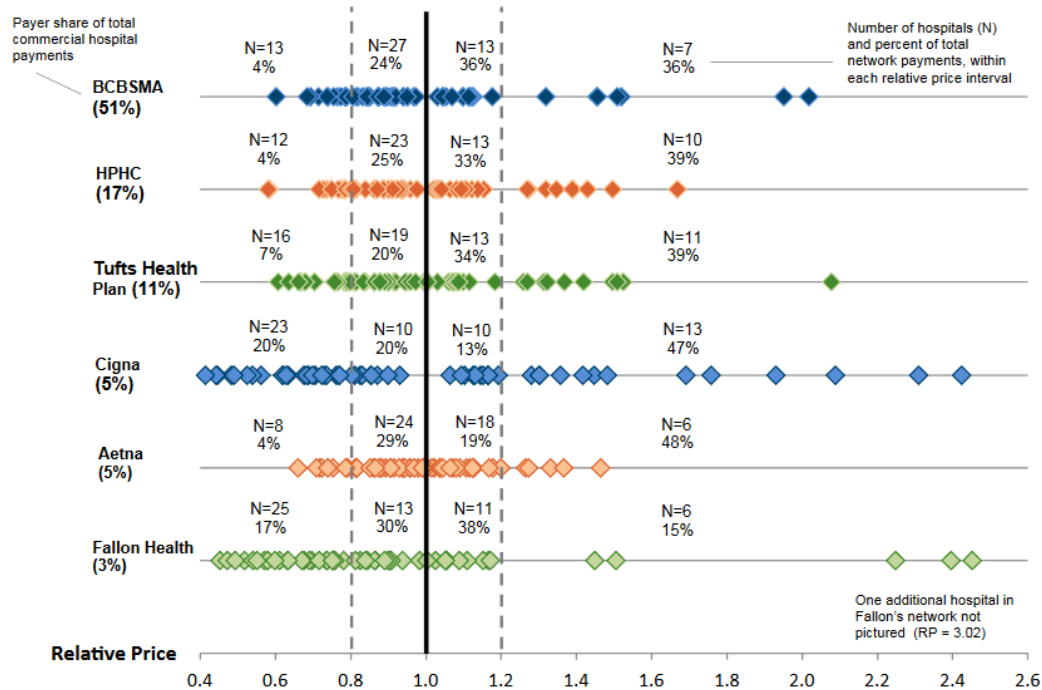
² This information includes provider claims, member cost-sharing payments to providers, and all non-claims related payments to providers, such as those made under alternative payment methodologies.

³ These measures are the basis for price variation analyses and are referred to throughout this report.

⁴ Providers are compared by category: hospitals, physicians, other groups.

⁵ Center for Health Information and Analysis, *Methodology Paper: Relative Price* (Boston, MA, September 2016).

Figure 1.1: Distribution of Acute Hospital Blended Relative Price by Payer, 2014⁶

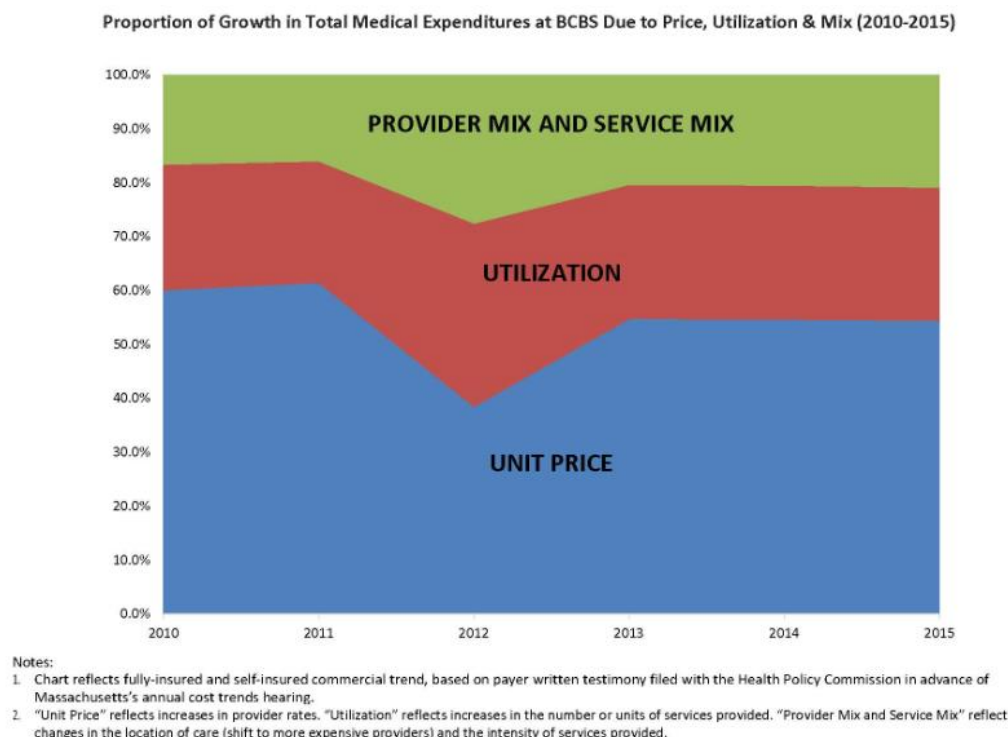


CHIA recently finalized its methodology for calculating a statewide RP value for acute care hospitals.⁷ This allows for a comparison of RP across payers. Collecting information on prices is important because approximately 50% of spending growth in Massachusetts is typically explained by growth in unit prices (See Figure 1.2).

⁶ Center for Health Information and Analysis, *Relative Price: Health Care Provider Price Variation in the Massachusetts Commercial Market* (Boston, MA, February 2015), slide 6. The graph includes the top six commercial payers ranked by share of total payments.

⁷ MASS. GEN. LAW ch. 29, § 27TTT (2016); Center for Health Information and Analysis, *Methodology for the Calculation of Statewide Relative Prices* (Boston, MA, January 2017).

Figure 1.2: Proportion of Growth in Total Medical Expenditures at Blue Cross Blue Shield, 2010-2015⁸



While RP tracks prices, TME tracks prices and utilization: the total amount paid to providers, both by patients and insurers, for all services. This measure is reported on a per-member-per-month (PMPM) basis. For providers, TME is currently only calculated for primary care provider (PCP) groups.⁹ It represents all spending for all healthcare providers that a patient uses, which is then attributed back to that patient's PCP group.¹⁰ CHIA standardizes and adjusts RP and TME to account for differences among providers in the quantity and types of services provided, the types of insurance products offered by the payer to the provider, patient case mix/health status, and any other unique factors that apply to a given provider's payment history.¹¹

In addition to CHIA, two other state entities monitor healthcare market trends, including provider price variation. The Office of the Attorney General (AGO) uses

⁸ Updated graphic provided to Health Care Financing staff by the Office of the Attorney General, November 7, 2016.

⁹ There is no TME figure for other types of providers, like hospitals or specialist physicians. In other words, a patient's spending on hospital care is included in the TME for that patient's PCP group, regardless of whether the hospital is affiliated with the PCP group.

¹⁰ Center for Health Information and Analysis, *Annual Report on the Massachusetts Health Care System, Supplement 5: Managing Physician Group Total Medical Expenses and Quality* (Boston, MA, September 2014).

¹¹ Id.; Center for Health Information and Analysis, *Methodology Paper*, supra note 5.

its authority to interview relevant stakeholders and subpoena information from payers and providers, including contract documents and cost data. The AGO relies on this information, along with CHIA data, to publish reports examining cost trends and drivers.¹² The Health Policy Commission (HPC) is an independent agency that monitors the Commonwealth's healthcare payment and delivery systems.¹³ The HPC holds annual public hearings and requires testimony under oath on cost and price trends, including factors that contribute to cost growth.¹⁴ The HPC uses this testimony, CHIA data, and data from other sources to annually report on healthcare cost trends and the drivers of healthcare spending.¹⁵ The data in this report are taken from these and other applicable sources.

SECTION II: MASSACHUSETTS TRENDS IN PRICE VARIATION

Beginning with the AGO's 2010 examination on cost trends and drivers, successive reports by the AGO, the HPC, and CHIA conclude that price variation exists in Massachusetts. The 2010 report examines commercial health plan payments to health care providers.¹⁶ The AGO collected data from five major Massachusetts payers and 15 providers, including academic medical centers (AMCs), teaching hospitals, community hospitals, disproportionate share hospitals (DSH), physician groups, and one ancillary service provider.¹⁷ The report documents that in 2008, the differences in relative payments to hospitals¹⁸ within the networks of the three largest Massachusetts insurers, Blue Cross Blue Shield (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP), were approximately 0.75 – 1.4, 0.4 – 1.6, and 0.6 – 2.0, respectively. This means that the differences in payments made by those insurers to the lowest-paid versus the highest-paid hospitals were 90%, 300%, and 240%, respectively.¹⁹ The report also finds wide variation in physician prices: 224% for BCBS and approximately 130% for both HPHC and THP.²⁰ The report concludes that there is significant variation in payments made to hospitals and

¹² MASS. GEN. LAW ch. 12, § 11N (2016).

¹³ MASS. GEN. LAW ch. 6D, § 5 (2016).

¹⁴ § 8.

¹⁵ Id. In its 2015 Cost Trends Report, the HPC also did an original multivariate analysis of the factors correlated with higher relative prices and issued a standalone report on provider price variation. See Health Policy Commission, *2015 Cost Trends Report: Provider Price Variation* (Boston, MA, 2016).

¹⁶ Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers: Report for Annual Public Hearing* (Boston, MA, March 16, 2010), 6 [hereinafter Office of the Attorney General, *Examination 2010*].

¹⁷ Id. at 6. CHIA defines academic medical centers as principal teaching hospitals with case mix intensity greater than 5% above statewide average, extensive research programs, and extensive resources for tertiary and quaternary care. Teaching hospitals are non-AMC hospitals that report at least 25 full-time equivalent medical school residents per 100 inpatient beds. Community hospitals are non-teaching hospitals with a public-payer mix of less than 63%. DSH hospitals are teaching or community hospitals with a public-payer mix of 63% or more. Health Policy Commission, *Provider Price Variation*, supra note 15, at 4.

¹⁸ Prior to the passage of Chapter 224, there was no standardized methodology for relative price. The AGO's 2010 report calculates "payment relativity"; this metric that is comparable to relative price. Office of the Attorney General, *Examination 2010*, supra note 16, at General Appendix, 1.

¹⁹ Id. at 10-12.

²⁰ Id. at 12-15.

physician groups that are providing the same services within the same geographic area. The report finds further that hospital and physician variation was relatively stable between 2004 and 2008.²¹

Recent reports by the AGO, the HPC, and CHIA²² reinforce these original findings. The reports have consistently documented that “the extent of variation and the distribution of hospital prices have been generally consistent since 2010, and that variation in physician prices has increased somewhat since 2009.”²³ For example, between 2010 and 2014, BCBS consistently paid the highest-priced hospitals 2.5 to 3.4 times more than the lowest-priced hospitals for the same set of services. The same pattern was true for HPHC and THP.²⁴ This stable trend in hospital price variation has also persisted for prices paid to physician groups between 2009 and 2013. HPHC paid its highest-priced groups 2.26 to 3.32 more than the lowest-priced groups, with similar trends for BCBS and THP.²⁵ Mirroring the trend in relative price, there is also persistent variation in physician organization budgets. For example, for one large commercial carrier in 2013, health-status adjusted PMPM payments ranged from approximately \$370 to \$515. Incentive payments varied as well.²⁶

These reports identify additional key characteristics of provider price variation in Massachusetts. First, there is little change in each provider’s relative price year over year.²⁷ This means that the same providers consistently receive higher payments. Second, there is significant variation in both fee-for-service rates and global budgets.²⁸ Third, hospital prices vary significantly within hospital cohorts (See Figure 1.3).²⁹ Finally, there tends to be higher price variation within the networks of smaller payers; therefore, the reports may underestimate the full extent of variation.³⁰

²¹ Id. at 15-16.

²² See Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA, September 18, 2015) [hereinafter Office of the Attorney General, *Examination 2015*]; Health Policy Commission, *Provider Price Variation*, supra note 15; Center for Health Information and Analysis, *Health Care Provider Price Variation*, supra note 6.

²³ Health Policy Commission, *Provider Price Variation*, supra note 15, at 2.

²⁴ Id. at 6-7.

²⁵ Id. at 8.

²⁶ AGO, *Examination 2015*, supra note 22, at 18. This percentage is derived from data listed in the report.

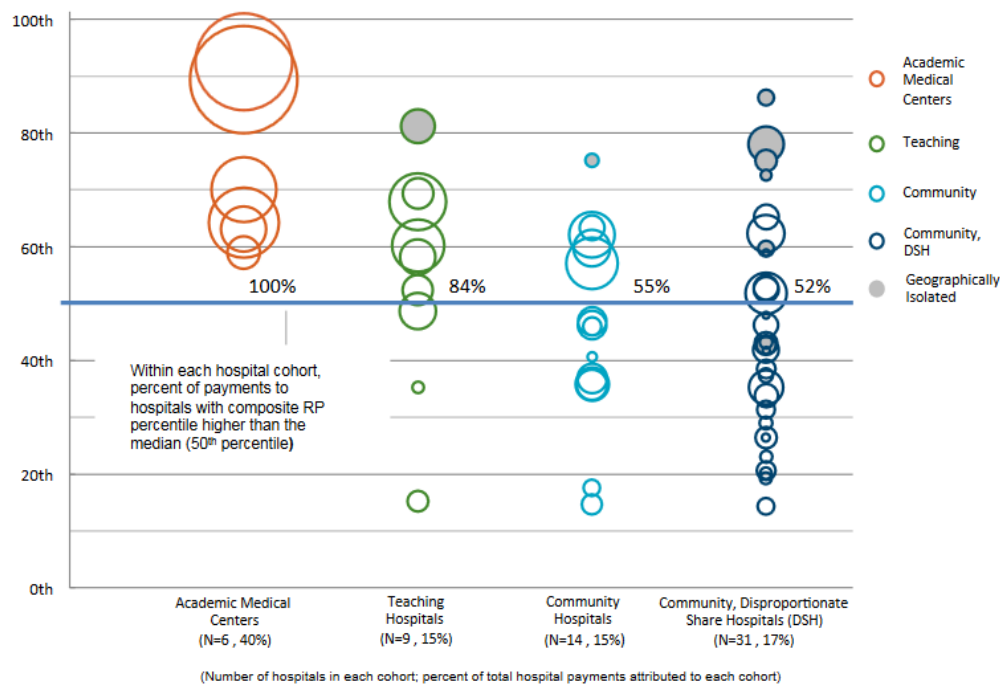
²⁷ Id. at 19; Health Policy Commission, *Provider Price Variation*, supra note 15, at 6-8.

²⁸ Health Policy Commission, *Provider Price Variation*, supra note 15, at 5. Data indicate that fee-for-service rate differentials have been baked in to global budgets. Id.

²⁹ Id. at 4.

³⁰ Id.

Figure 1.3: Acute Hospital Blended Relative Price by Cohort, 2014³¹



The AGO, CHIA, and the HPC have also examined provider characteristics that correlate with higher prices. The AGO’s 2010 report was the first to outline which factors do *not* correlate with or adequately explain high hospital prices. These factors include high input costs, patient acuity, and quality performance, as determined by process of care, outcomes, efficiency, and patient experience metrics.³² Instead, this and successive reports conclude that high prices correlate with market power or market leverage, defined broadly by the AGO as “the ability [of a provider] to influence the other side during negotiation.”³³ Provider leverage impacts the market significantly when an insurer cannot credibly threaten to exclude a provider from its network.³⁴ When the insurer cannot “walk away from the table,” the provider has greater leverage to demand higher prices. This is why higher prices are also correlated with the size of the hospital system, the level of hospital competition, whether or not the hospital provides certain specialized services, and the identity of

³¹ Center for Health Information and Analysis, *Relative Price*, supra note 6. Composite RP percentile for each hospital is equal to the simple average of all payers’ blended RP percentiles for that hospital. “Blended” denotes that inpatient and outpatient RP results are combined. Circles are sized according to hospitals’ shares of total hospital commercial payments. Grey color denotes geographically isolated hospitals, where the provider is the sole acute hospital within a 20-mile radius. Six hospitals were omitted because they deliver care to specific patient populations, based either on age or type of medical condition. These specialty hospitals are not considered comparable with other cohorts. Hospitals shown accounted for 87% of total hospital payments in 2014. For the RP for all acute hospitals in Massachusetts, see Appendix B.

³² AGO, *Examination 2010*, supra note 16, at 16-28.

³³ Id. at 28.

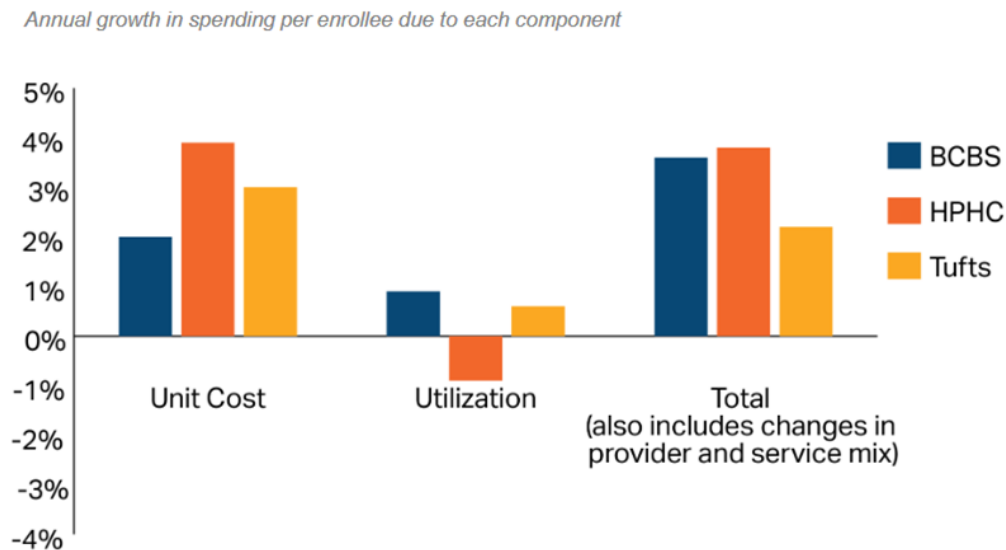
³⁴ Health Policy Commission, *Provider Price Variation*, supra note 15, at 1.

the affiliated hospital system (reflecting brand as well as other characteristics).³⁵ Hospitals that treat a greater percentage of Medicare and Medicaid patients (and, as a result, have a smaller proportion of commercial patients) also tend to receive relatively lower commercial rates.³⁶ Chapter 3, *Contracting and Market Forces*, further explores the relationship between lack of competition and higher relative prices.

SECTION III: DIRECT AND INDIRECT EFFECTS OF PRICE VARIATION IN MASSACHUSETTS

Healthcare spending is a function of price (how much reimbursement a provider receives for a given service) and utilization (how many units of that service are provided). The AGO and the HPC have determined that increases in prices, not utilization, primarily drive growth in total healthcare spending.³⁷ For this reason, the direct result of provider price variation is an increase in total healthcare costs (See Figure 1.4; see also Figure 1.2).³⁸

Figure 1.4: Unit Price Drives Spending Increases, 2014-2015³⁹



An indirect but related effect of price variation is its impact on hospital service mix. According to an HPC survey, many patients believe that brand and higher cost

³⁵ Id. at 11-14. As used here, “brand” refers to affiliation with certain health systems and/or good reputation independent of high performance on quality metrics.

³⁶ Id. at 11.

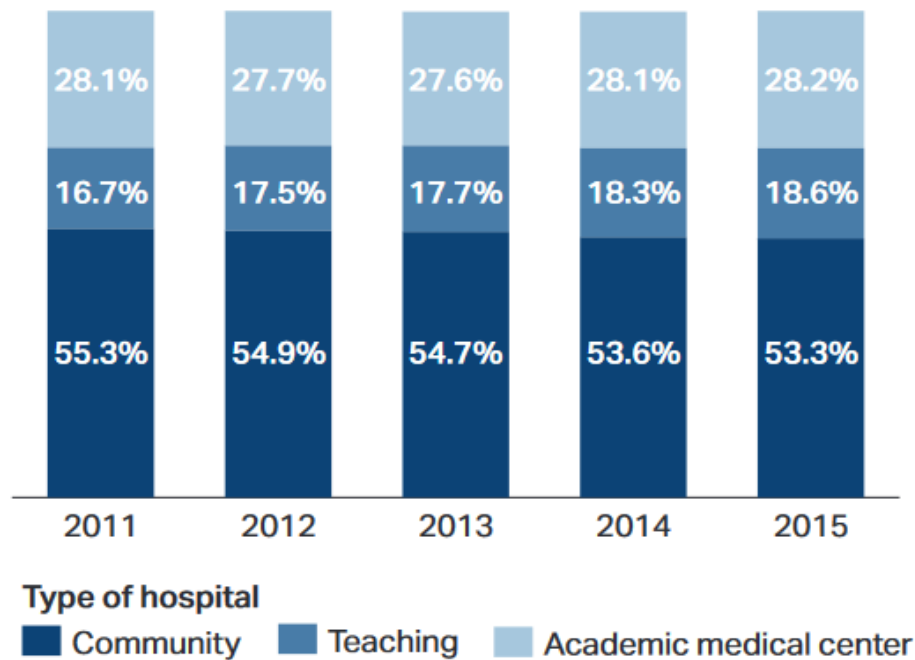
³⁷ AGO, *Examination 2010*, supra note 16, at 35-38; Zach Cooper, et. al., *The Price Ain’t Right? Hospital Prices and Health Spending on the Privately Insured* (Health Care Cost Institute, May 2015), 2-3.

³⁸ Health Policy Commission, *Provider Price Variation*, supra note 15, at 9. This assumes that any decrease in growth rates for non-dominant providers does not fully offset the increase in total cost growth caused by high payments to dominant providers.

³⁹ Health Policy Commission, *Annual Health Care Cost Trends Hearing* (Boston, MA, October 17, 2016), slide 15, available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2016/cth16-presentation.pdf>.

indicate quality.⁴⁰ Therefore, patients may gravitate toward seeking care at higher-priced institutions, leading to higher total costs.⁴¹ Figure 1.5 illustrates this trend: year over year, Massachusetts AMCs continue to provide nearly 30% of community-appropriate care (See Figure 1.5).⁴²

Figure 1.5: Share of Community Appropriate Discharges by Hospital Type, 2011-2015⁴³



Note: Discharges which could be appropriately treated in community hospitals were determined based on expert clinician assessment of the acuity of care provided, as reflected by the cases' diagnosis-related groups (DRGs).

Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2011-2015

Furthermore, this shift in volume enables higher-paid hospital systems to invest in capital improvements. New services and improvements improve quality in some circumstances; in others they tack on “bells and whistles,” further shifting patient

⁴⁰ Health Policy Commission, *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System* (Boston, MA, 2016), 40.

⁴¹ Further discussions of patient behavior can be found in Chapters 4, *Demand-Side Incentives*, and Chapter 5, *Transparency*.

⁴² Health Policy Commission, *2016 Cost Trends Report* (Boston, MA, February 2017), 49. Community-appropriate care is care that can be safely and effectively delivered in a community hospital, as opposed to a teaching hospital or AMC. All AMCs have relative prices that exceed the network median across all payers. See Figure 1.3.

⁴³ Id.

volume without improving patient care.⁴⁴ Even absent price increases, shifts in volume to higher-priced institutions increase spending.

In addition to increasing total costs, shifts in volume may threaten the financial stability of non-dominant hospitals. The HPC's report on community hospitals notes that any further shifts in commercial patient volume may lead to community hospital closures. When a lower-priced community hospital closes, the patients that sought care at that hospital might be forced to visit a higher-priced hospital. This increases total spending.⁴⁵ It is important to acknowledge, however, that increases in commercial prices alone may not shore up certain hospitals, particularly those that treat a relatively small proportion of commercially-insured patients. Reducing price variation, however, would to some extent improve the financial position of these hospitals.⁴⁶ In addition, it should be noted that for many residents in the Commonwealth, including those living in Boston, Worcester and Springfield, an AMC or teaching hospital is their community hospital. For these residents, care delivered at these hospitals might be considered appropriate.

SECTION IV: PRICE VARIATION IN OTHER STATES AND NATIONALLY

Provider price variation is not unique to Massachusetts.⁴⁷ New York, Rhode Island, Vermont, and New Hampshire have all published reports on the causes and extent of provider price variation within their borders.⁴⁸ All reports conclude or assume that high prices are correlated with a provider's position within the healthcare market, which the reports define in terms of size, competitive position, and/or brand. Although these studies were designed differently and use slightly different methodologies, the results are informative.⁴⁹ The New York report concludes that depending on region, in 2014 the highest-priced hospitals were paid blended prices 150% to 270% more than the lowest-priced hospitals.⁵⁰ The Rhode Island report determines that in 2010 its highest-paid hospital received rates that were 210% more for inpatient care and 73% more for outpatient care.⁵¹ The Vermont report finds that in 2012 its highest-paid hospital was paid 180% more for inpatient care.⁵² Finally, the New Hampshire report finds that in 2009 its highest-paid hospital was paid 217%

⁴⁴ AGO, *Examination 2015*, supra note 22, at 21-22.

⁴⁵ Health Policy Commission, *Community Hospitals*, supra note 40, at 32-33.

⁴⁶ Id. at 4, 7.

⁴⁷ "National Chartbook of Health Care Prices – 2015," Health Care Cost Institute, last accessed February 27, 2017, www.healthcostinstitute.org/report/national-chartbook-health-care-prices-2015.

⁴⁸ New York State Health Foundation, *Why Are Hospital Prices Different? An Examination of New York Hospital Reimbursement* (December 2016); Xerox, *Variation in Payment for Hospital Care in Rhode Island: Prepared for the Rhode Island Office of the Health Insurance Commissioner and the Rhode Island Executive Office of Health and Human Services* (December 2012); Wakely Consulting Group, *Price Variation Analysis: Prepared for the Green Mountain Care Board* (August 2014); Katharine London, et. al., *Analysis of Price Variation In New Hampshire Hospitals: Prepared for the New Hampshire Insurance Division* (April 2012).

⁴⁹ All results are adjusted for case mix/complexity of service provided.

⁵⁰ New York State Health Foundation, *Hospital Prices*, supra note 48, at 41.

⁵¹ Xerox, *Rhode Island*, supra note 48, at 14-16.

⁵² Wakely Consulting Group, *Price Variation*, supra note 48, at 21.

more than the lowest-paid hospital for inpatient discharges and 213% for outpatient episodes.⁵³ In comparison, in Massachusetts the highest priced hospitals are paid 250% to 340% as much as the lower-priced hospitals.⁵⁴

Provider price variation exists not just within states but across and within hospital referral regions (HRRs).⁵⁵ The Health Care Pricing Project recently published the most comprehensive study to date on price variation. The report uses data collected by the Health Care Cost Institute, comprising four years of insurance claims data for three major insurers that collectively insure 27.6% of individuals with employer-sponsored insurance.⁵⁶

The report examines price variation across 306 HRRs for seven common, uncomplicated procedures delivered in the hospital setting. After adjusting for extraneous variables like case mix, the study finds that inpatient prices in the highest-spending HRR, averaged over three years, are more than 400% higher than those in least expensive HRR.⁵⁷ The price ratio⁵⁸ of the most-expensive to the least-expensive hospitals ranges from 6.13 (percutaneous transluminal coronary angioplasty) to 11.99 (MRI). This study examined HRRs in Massachusetts but only reported on the 25 most populated HRRs. The raw data on wage-adjusted hospital inpatient prices from 2008-2011, however, finds that HRRs in Massachusetts are in the lowest-priced quintile (\$6,548-10,474).⁵⁹ This means after adjusting for income, average prices in Massachusetts HRRs are less than in many other areas of the country. On the other hand, the HPC has found that maternity episode spending in Massachusetts for low-risk pregnancies varies from approximately \$9,722 to \$18,475 (190%).⁶⁰ It is also important to note that Boston's AMCs are near the bottom in terms of rates, when compared to similar institutions across the country (See Figure 1.6).

⁵³ Katharine London, *Analysis of Price Variation*, supra note 48, at 4 (percentage calculated from reported data).

⁵⁴ Health Policy Commission, *Provider Price Variation*, supra note 15, at 6.

⁵⁵ Hospital Referral Regions are regional healthcare markets for tertiary medical services. Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery. "The Dartmouth Atlas of Health Care," Dartmouth Atlas Project, accessed February 1, 2017, <http://www.dartmouthatlas.org/tools/faq/researchmethods.aspx>.

⁵⁶ Zach Cooper, et. al., *The Price Ain't Right?*, supra note 37.

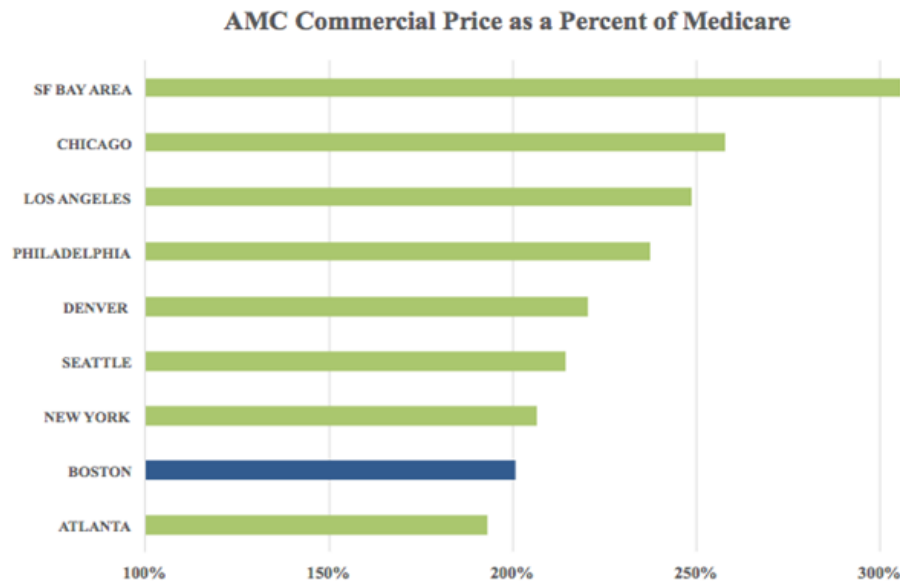
⁵⁷ Id. at 19.

⁵⁸ Id. at 10-12. Price ratio measures how many times more expensive the highest-cost service is, compared to the lowest-cost service.

⁵⁹ Id. at 52.

⁶⁰ Health Policy Commission, *Provider Price Variation*, supra note 15, at 5.

Figure 1.6: Academic Medical Center Commercial Price Comparisons, 2014⁶¹



SECTION V: EFFECT OF PRICE VARIATION ON MASSACHUSETTS RESIDENTS

Even though there is significant price variation in Massachusetts, since 2012 growth in commercial premium spending has been consistently below the national trend⁶² (see Figure 1.7), and income-adjusted premiums in certain markets are lower than average.⁶³

Figure 1.7: Growth in Insurance Premium Spending Per Enrollee, 2005-2015⁶⁴



⁶¹ Chancellor Consulting Group, Inc., *Analysis of Truven Claims Data (2014) and Medicare 100% (2014)*.

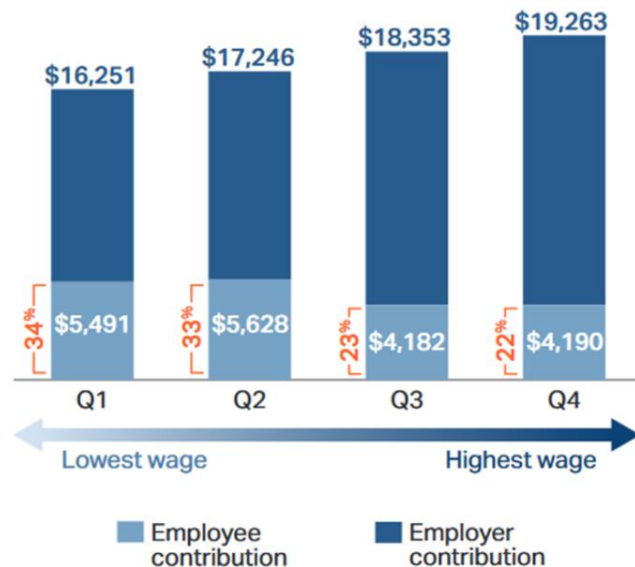
⁶² Health Policy Commission, *2016 Cost Trends Report*, supra note 42, at 14.

⁶³ Sara R. Collins, et. al., *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch* (Commonwealth Fund, October 2016).

⁶⁴ Health Policy Commission, *2016 Cost Trends Report*, supra note 42, at 14.

The cost of healthcare, however, is still burdensome for some residents (See Figure 1.8). Although Massachusetts has a higher than average median income, it ranks seventh highest among states in degree of income inequality.⁶⁵ In Massachusetts, 39% of residents are low- to middle-income (See Figure 1.9).

Figure 1.8: Average Annual Family Premium & Employer Contributions by Wage Quartile, 2015⁶⁶



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2015

“Despite the suggestion that Massachusetts’ health care costs are affordable, continued increases in the cost of health care are a serious threat to small businesses, so it’s important to provide a complete picture on health care spending on the Commonwealth.” – Jon Hurst, President of the Massachusetts Retailers Association, testimony to the Special Commission

In addition, although out-of-pocket spending is relatively similar across income brackets, low-wage employees spend a greater share of their paycheck on health insurance premiums.⁶⁷ Massachusetts employee healthcare costs also continue to grow.⁶⁸ Despite several years of low premium growth, the Massachusetts Division of

⁶⁵ United States Census Bureau, *American Community Survey Briefs: Household Income 2015*, by Kirby G. Posey (Washington, D.C., September 2016).

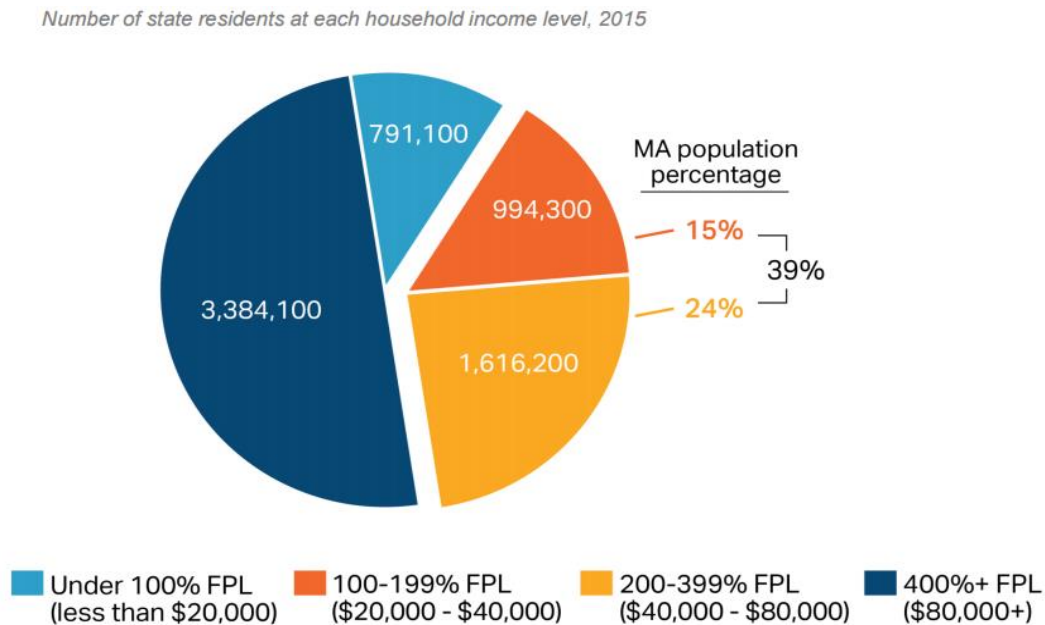
⁶⁶ Id. at 19.

⁶⁷ Health Policy Commission, *2016 Cost Trends Report*, supra note 42, at 19.

⁶⁸ Collins, *Slowdown in Employer Insurance*, supra note 63.

Insurance has reported base rate increases in the small group and individual markets between 5.4% and 8.3% from the end of 2015 through the first quarter of 2017.⁶⁹ Anecdotally, this burden may fall disproportionately on those that live in geographically-isolated or rural areas.

Figure 1.9: Massachusetts Residents by Income, 2015⁷⁰



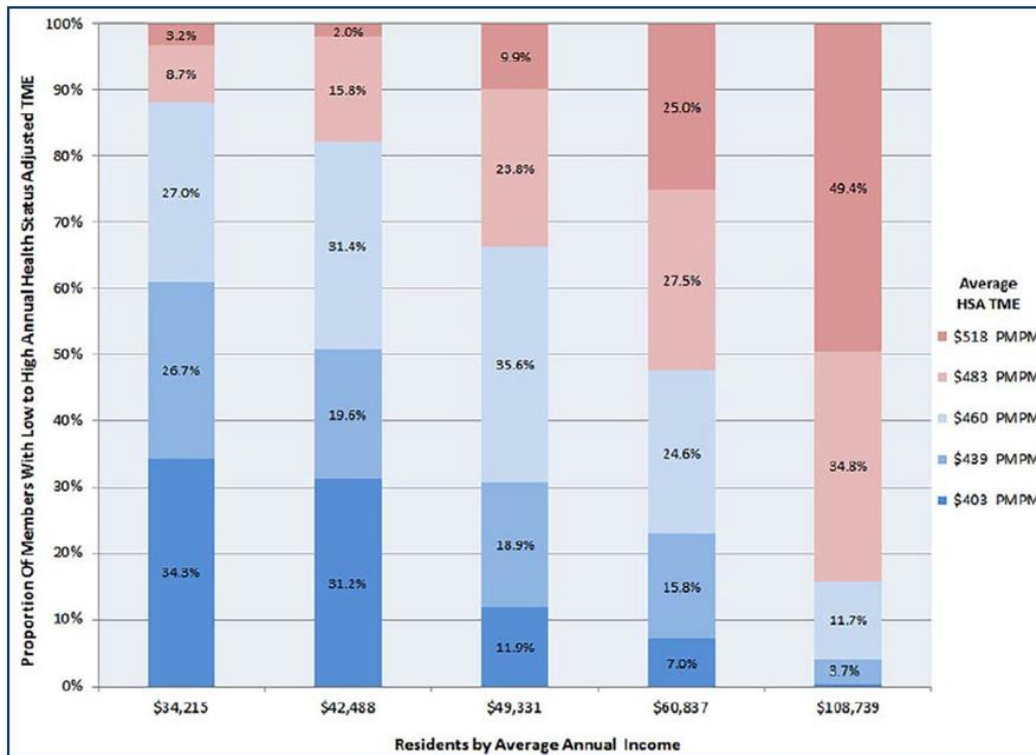
Furthermore, although premium growth has slowed, Massachusetts premiums are still the fifth-highest in the country.⁷¹ Finally, an analysis by the AGO concludes that, on average, there is higher commercial medical spending on higher-income residents. (See Figure 1.10).

⁶⁹ Health Policy Commission, *2016 Cost Trends Report*, supra note 42, at 41.

⁷⁰ Health Policy Commission, *Select Findings: 2016 Cost Trends Report* (Boston, MA, January 11, 2017), slide 11.

⁷¹ Health Policy Commission, *Massachusetts Health Care Spending*, supra note 39, at slide 6.

Figure 1.10: Distribution of Risk-Adjusted Medical Spending by Average Annual Income for One Major Massachusetts Payer's Members, 2014⁷²



⁷² Graphic provided to Health Care Financing staff by the Office of the Attorney General, November 7, 2016. Chart reflects per-member-per-month (PMPM) 2014 health status-adjusted TME for one major payer's commercial members (HMO, POS, PPO, and indemnity), reported by Massachusetts zip code. Income data is from the IRS Statistics on Income Division. It reflects 2013 adjusted gross income for one major payer's 2014 commercial membership, reported by Massachusetts zip code.

CHAPTER 2 – RATE ADJUSTMENT & FACTORS INFLUENCING PRICE VARIATION

INTRODUCTION

As part of its statutory charge, the Special Commission on Provider Price Variation must examine whether the following factors are acceptable reasons for price variation:¹

- Location
- Quality
- Costs
- Medical education
- Services provided by disproportionate share hospitals and other providers serving underserved or unique populations
- Use and continued advancement of medical technology and pharmacology
- Research
- Stand-by service capacity
- Emergency service capacity
- Market share of individual providers and affiliated providers
- Provider size
- Advertising
- Care coordination between/among medical and allied health professionals

Section I of this chapter provides background on commercial contracting and rate-setting systems, including Medicare, Medicaid, and systems in Maryland and Vermont. Section II more closely examines Medicare and Medicaid, as these public programs served as the starting point for the Special Commission’s discussion about acceptable and unacceptable factors for price variation. Section III details each factor in the Special Commission’s charge, including discussion highlights. Section IV discusses global budgets and all-payer rate setting in Maryland and Vermont.

SECTION I: COMMERCIAL CONTRACTING & RATE SETTING SYSTEMS

In the commercial market, insurers and providers negotiate how much providers are paid for medical goods and services. Like any negotiation, provider payments reflect the parties’ respective bargaining positions. For example, if an insurer covers a large percentage of the patient population, it is able to steer a large amount of business to the “in-network” providers with which it contracts. Providers may agree to accept relatively lower rates from the insurer in order to access this patient volume and capture this source of revenue. On the other hand, if a provider has a good

¹ 2016 Mass. Acts 115, §9.

reputation or strong brand name, offers specialty services, or is the largest or only provider in the area, it may have the leverage to demand higher prices. This is because insurers compete among themselves to offer the most attractive plans to consumers and employers. If insurers cannot guarantee access to a variety of providers, they are at a competitive disadvantage.² It is important to note, of course, that greater health plan leverage does not benefit consumers or decrease total spending, unless adequate regulation and/or competition among health plans causes insurers to pass through savings to purchasers.

In contrast, Medicare, Medicaid, and the states of Maryland and Vermont regulate the rates that providers receive. Under these rate-setting systems, the federal or state government establishes how much providers are paid for medical goods and services. For Medicaid and Medicare, the government sets and periodically updates a detailed list of provider payments.³ Maryland sets a global budget for hospitals, under which hospitals are paid a fixed annual amount for inpatient and outpatient services. This is an all-payer system, meaning that Medicare, Medicaid, and commercial payments are set in the same manner.⁴ In 2017, Vermont began implementing a voluntary all-payer system, under which accountable care organizations (ACOs) comprised of different types of providers are paid under a global budget.⁵ These systems are prospective, meaning that rates are set in advance and reflect the costs that the typical efficient provider is expected to incur.

Regardless of how a provider is reimbursed, all of these payment systems allow for variation in reimbursement rates. There are many reasons why some providers receive higher payments than others. For example, average wages are higher in many big cities, so payments must reflect those higher operational costs. The Special Commission on Provider Price Variation was convened to discuss these acceptable reasons for price variation.

SECTION II: MEDICARE & MEDICAID

MEDICARE

Medicare is a federal health insurance program for people ages 65 and over and people under 65 with permanent disabilities and certain diseases. It covers

² Health Policy Commission, *2015 Cost Trends Report: Provider Price Variation* (Boston, MA, 2015); Anna Sommers, Chapin White, and Paul Ginsburg, *Addressing Hospital Pricing Leverage Through Regulation: State Rate Setting* (National Institute for Healthcare Reform: May 2012).

³ MedPAC, *Hospital Acute Inpatient Services Payment System* (Washington, D.C., October 2016); MedPAC, *Outpatient Hospital Services Payment System* (Washington, D.C., October 2015); MASS. GEN. LAWS Ch. 118E, §§13C, 13D (2016).

⁴ National Conference of State Legislatures, *Equalizing Health Provider Rates: All-Payer Rate Setting* (Denver, CO: June 2010).

⁵ Shannon Muchmore, “Vermont’s All-Payer ACO Will Begin in January,” *Modern Healthcare*, October 26, 2016, <http://www.modernhealthcare.com/article/20161026/NEWS/161029930>; Centers for Medicare and Medicaid Services, Letter to Hal Cohen (Washington, DC, October 24, 2016), available at <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf>.

approximately 55 million people⁶ in the United States and pays for a wide variety of medical services, including inpatient and outpatient procedures, physician visits, and nursing care. It is funded primarily through payroll taxes, general revenue, and beneficiary premiums.⁷

Medicare pays facilities for most episodes of care through two payment systems, one for inpatient services and one for outpatient. Under the Inpatient Prospective Payment System (IPPS), once the hospital discharges a patient, it reports to Medicare the patient's diagnoses, procedures, and other information. Medicare uses this information to assign the case to one of 757⁸ diagnosis-related groups (DRGs). Each DRG reflects the patient's principal diagnosis, procedure(s) provided, complications or comorbidities, and certain other characteristics. The DRG has a corresponding payment weight, which reflects the average level of resources needed to treat a typical Medicare patient in that DRG, relative to the average level of resources needed to treat all Medicare patients. More complex and costly conditions are assigned higher weights. For example, in Fiscal Year 2017 the DRG weight for one type of concussion treatment is 1.48, while the DRG weight for a certain type of heart transplant is 27.10.⁹ In this way, hospitals can expect to receive higher payments for episodes of care that, on average, are relatively more costly to provide.¹⁰

After the case is assigned a DRG, the weighted DRG is multiplied by standardized base payment rates.¹¹ Base payment rates are designed to cover the operating and capital costs that an efficient healthcare facility can be expected to incur. These rates are adjusted to account for geographic factors. The resulting adjusted base payment rate reflects both the cost of care provided and location-adjusted internal costs. The actual payment the hospital receives takes into account additional factors (See Figure 2.1), such as the hospital's performance on quality measures and payments for

⁶ "Total Number of Medicare Beneficiaries," Kaiser Family Foundation, last modified March 2016, <http://kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D>.

⁷ "Issue Brief: An Overview of Medicare," Kaiser Family Foundation, last modified April 2016, <http://kff.org/medicare/issue-brief/an-overview-of-medicare>.

⁸ The number of DRGs can change each year. The 2017 IPPS Final Rule specifies 575 DRGs. See <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-NPRM-Table-5.zip>; "FY 2017 IPPS Final Rule Homepage," Centers for Medicare and Medicaid Services, last modified August 15, 2016, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page.html>.

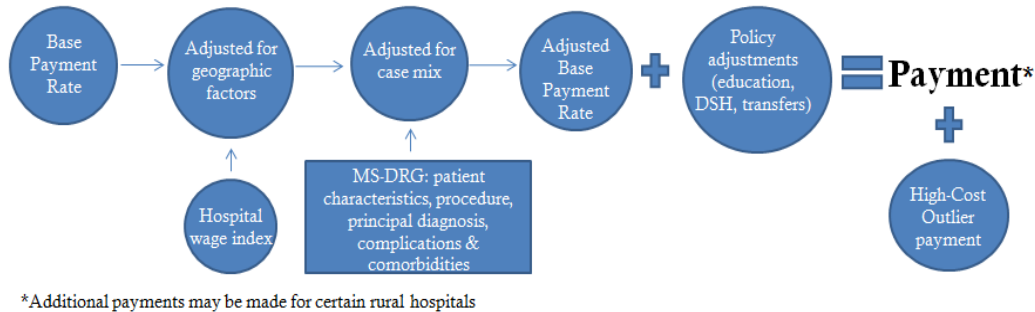
⁹ "FY 2017 Final Rule and Correction Notice Tables," Centers for Medicare & Medicaid Services, accessed December 15, 2016. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html> (Click on Table 5).

¹⁰ MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Acute Care Hospital Inpatient Prospective Payment System* (Washington, D.C., February 2016).

¹¹ MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Inpatient*, supra note 10.

graduate medical education.¹² Approximately 15% of acute care hospitals are exempted from the IPPS. These hospitals are mostly specialized or small and rural.¹³

Figure 2.1: Medicare Inpatient Prospective Payment System



Commission member Stuart Altman, appointed by Senate President Rosenberg, was consulted by Congress when it was creating the DRG system. Dr. Altman provided the Commission with his perspective on the IPPS. He said that Congress grappled with how to establish a uniform base or unadjusted payment rate, since the actual cost of providing the same service varies from hospital to hospital. Dr. Altman added that another consideration is that hospitals that are paid more tend to be less efficient. In other words, the more an institution is paid, the higher its costs will be, because additional money will be spent in inefficient ways. To solve this problem, Congress and the Administration decided that each DRG should reflect the average cost to all hospitals of providing that service. Congress then determined how much to adjust each rate to reflect legitimate cost differences like teaching and wages. Political concerns also played a role in arriving at that final number.

The Outpatient Prospective Payment System (OPPS) is similar to the IPPS (See Figure 2.2), in that Medicare pays hospitals a fixed amount for providing the service. Each case is assigned to an ambulatory payment classification (APC), which is analogous to a DRG. In a similar manner, the APC is then adjusted to reflect provider characteristics. As the figures below illustrate, the APC is also the basis for payments to ambulatory surgical centers (ASCs), although the methodology for determining ASC payments is different (See Figure 2.3).¹⁴

¹² MedPAC, *Inpatient*, supra note 3.

¹³ Stuart Altman (statement to the Special Commission on Provider Price Variation, October 11, 2016).

¹⁴ MedPAC, *Outpatient*, supra note 3; Medicare Learning Network, *Hospital Outpatient Prospective Payment System* (Washington, D.C., January 2016).

Figure 2.2: Medicare Outpatient Prospective Payment System

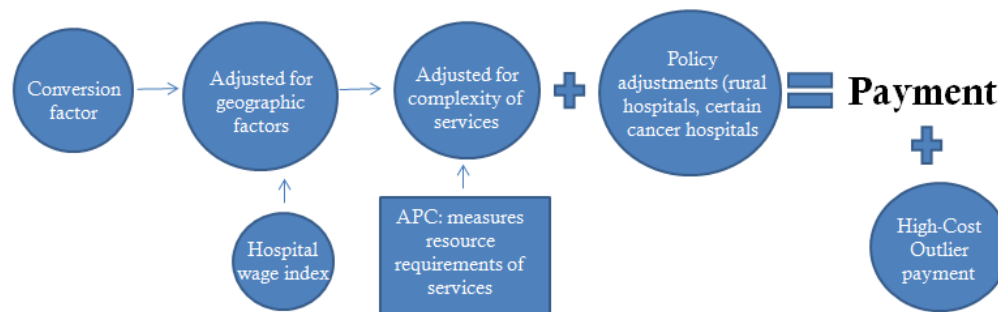
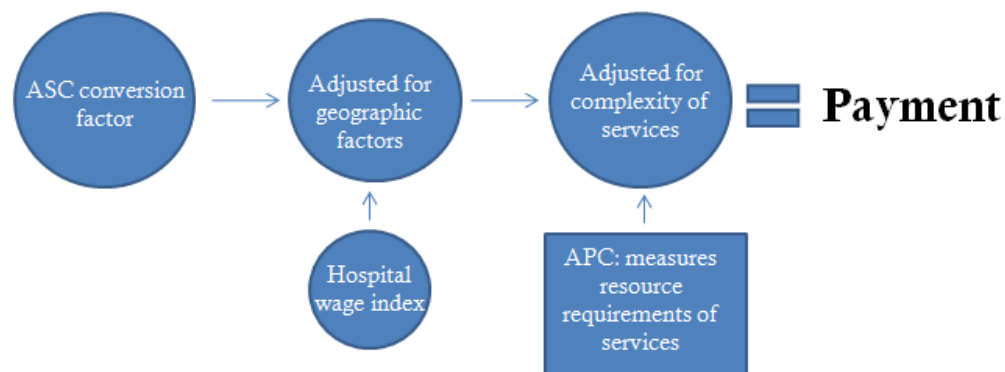


Figure 2.3: Medicare Ambulatory Surgical Center Payments



The Department of Health and Human Services annually updates DRG and APC groupings, payment rates, and the types and amounts of rate adjustments. Among other factors, updates reflect changes in technology, practice patterns, and inflation. DRGs and APCs do not include the costs of physician and other professional services and certain goods and services, which are reimbursed according to a fee schedule.¹⁵

MEDICAID (MASSHEALTH)

MassHealth, a joint federal- and state-funded program, is the public payer for medical care for the state's low- and middle-income residents.¹⁶ Covering one in four Massachusetts residents, or 1.8 million patients, MassHealth is the second-largest

¹⁵ Medicare Learning Network, *Inpatient*, supra note 10; Medicare Learning Network, *Outpatient*, supra note 14; Uwe E. Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs* 25 (2006): 57-69.

¹⁶ For more information on MassHealth eligibility, see MassHealth & Massachusetts Health Connector, *Member Booklet 2016 for Health and Dental Coverage and Help Paying Costs* (Boston, MA, October 2016).

healthcare payer in Massachusetts. MassHealth spending accounts for approximately 37% of the state's budget each year.¹⁷ The federal government, however, reimburses Massachusetts for more than half of this amount.¹⁸ The MassHealth population is made up of 32% non-disabled children, 14% adults with disabilities, 43% non-disabled adults, and 8% adults over the age of 65.¹⁹

MassHealth itself is comprised of several different programs, which vary in methods of payment and patient populations served (See Figure 2.4). MassHealth pays for care in two ways – fee-for-service (FFS) and capitation. FFS payments reimburse providers for each individual service provided. Capitation payments, often used in the context of managed care, reimburse providers a flat amount, usually per month for each individual enrolled. In addition, some services are covered by MassHealth but are not included in the capitation rate. These “wrap” services are paid through FFS.

MassHealth FFS is a traditional insurance program, under which providers are paid for each billable service rendered. Members enrolled in MassHealth FFS are generally people under the age of 65 who are not enrolled in another MassHealth program, individuals with other primary insurance coverage, and patients who live in an institutional setting, such as a nursing home. Approximately 31% of MassHealth patients are enrolled in the FFS program.²⁰ Similar to the FFS program, the Primary Care Clinician Plan (PCC) reimburses providers for medical services on a FFS basis. Primary care providers (PCPs) are directly paid an additional fee, however, to coordinate the patient's medical care. Behavioral health services under the PCC plan are not paid through FFS and are instead covered by a separate behavioral health plan under a capitated payment arrangement. Dental and long-term care benefits are included and paid through FFS. As of January 2016, approximately 21% of MassHealth patients are enrolled in the PCC plan.²¹

MassHealth has several managed care programs, including the Managed Care Organizations (MCOs), Senior Care Options (SCO), Program for All-Inclusive Care for the Elderly (PACE), One Care, and CarePlus. Participating providers in these programs are paid a capitated fee to manage patient benefits and provide services. SCO and PACE focus on coordinating care for MassHealth's older members. One Care coordinates long-term services and supports, physical healthcare services, and behavioral health services for members who are dually-eligible for MassHealth and Medicare. SCO, One Care, and PACE serve approximately 3% of MassHealth consumers.²² CarePlus was created as part of the Medicaid expansion under the

¹⁷ This percentage represents gross state spending, prior to any federal reimbursement.

¹⁸ “MassHealth: The Basics,” Blue Cross Blue Shield Foundation of Massachusetts, last updated June 2016, http://bluecrossfoundation.org/sites/default/files/download/publication/MassHealthBasics_Chartpack_FY2015_FINAL_1.pdf.

¹⁹ Id.

²⁰ Id.

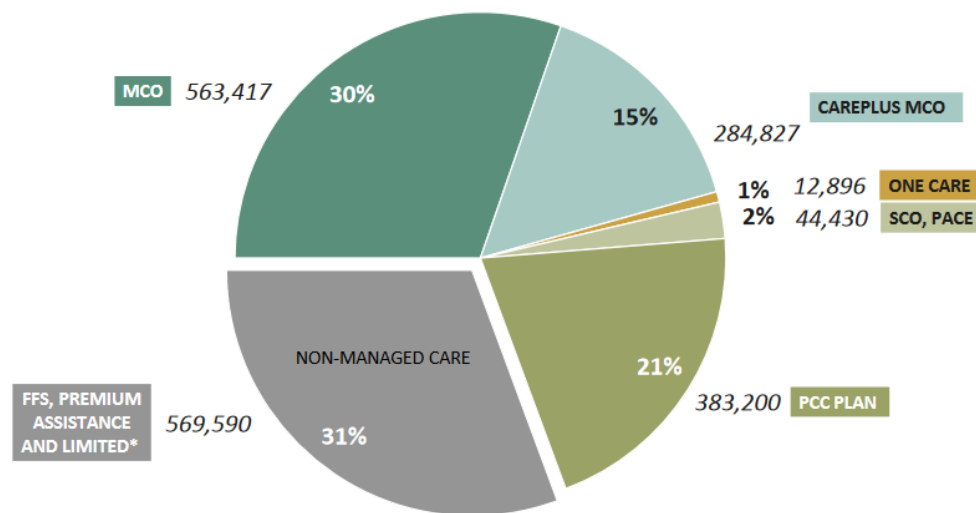
²¹ Id.

²² Id.

Affordable Care Act. The program is for residents ages 21 to 64 that are not eligible for MassHealth Standard²³ and have an income below 133% of the federal poverty level.

Figure 2.4: MassHealth Enrollment by Payer Type, 2016²⁴

MASSHEALTH ENROLLMENT BY PAYER TYPE, JANUARY 2016



*MassHealth Limited provides coverage for emergency medical services for 136,000 undocumented non-citizens.
SOURCE: MassHealth, January 2016 Snapshot Report.

Similar to Medicare, MassHealth FFS pays for episodes of care. MassHealth establishes a state-wide base rate and then adjusts the rate for patient acuity, area wage index, and outlier payments, with a possible penalty for excessive readmissions. For inpatient services, MassHealth reimburses providers an Adjudicated Payment Amount per Discharge (APAD).²⁵ This payment covers the member's entire acute inpatient stay, from admission to discharge. There are some exceptions to the APAD payment system; for example, psychiatric and rehabilitation services are paid separately.

Through December 2016, MassHealth paid a Payment Amount Per Episode (PAPE) for hospital outpatient services.²⁶ The PAPE covered all acute outpatient hospital services delivered to a member on a single calendar day. Certain services,

²³ MassHealth & Massachusetts Health Connector, *Member Booklet*, supra note 16. MassHealth Standard covers many different population groups, including pregnant women, adults living with children younger than age 19, and adults with disabilities. Income eligibility varies for each group. *Id.*

²⁴ "MassHealth: The Basics," supra note 18.

²⁵ MassHealth, *Notice of Proposed Agency Action: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services*, effective October 1, 2015, (Boston, MA, 2015).

²⁶ *Id.*

like laboratory services, were not included. In December 2016, MassHealth moved from the PAPE to the Adjudicated Payment per Episode of Care system (APEC). The APEC is similar to the PAPE in that it pays one rate per encounter; however, the methodology is prospective instead of retrospective and better accounts for the actual cost and complexity of services provided. Similar to Medicare's episode-based payment systems, APADs and APECs do not cover physician and other professional fees.

MassHealth sets rates by regulation for twenty-seven different categories of ambulatory services provided in various provider settings. For example, the Medicine Regulation includes rates for all services performed by physicians, including professional fees. Other regulations cover payments for diagnostics, laboratory tests, and medical services.²⁷ A regulation can contain thousands of codes with corresponding payment rates. MassHealth reviews its regulations and promulgates new rates in three year cycles. The Center for Health Information and Analysis (CHIA) provides MassHealth with essential data, including data published in the annual hospital cost reports, and performs necessary analytic work. A single rate is set for a given service, which is the same for all non-hospital based providers participating in MassHealth.²⁸ Rates for inpatient and outpatient hospital services are set by contract each year via the Acute Hospital Request for Applications process.

SECTION III: FACTOR DISCUSSION

Medicare and/or MassHealth payment systems adjust for several of the factors that are part of the Commission's charge. By discussing the factors in the context of public programs, members were able to get a sense of how uniform payment systems account for differences among providers. The Commission began by discussing factors for which Medicare and MassHealth adjust reimbursement rates. At a second meeting, the Commission discussed factors that are not adjusted for by these systems. At several points during these discussions, hospital representatives noted the effect on commercial prices of relatively lower MassHealth payments. Some hospitals are able to shift unreimbursed costs to commercial payers; many others do not have that leverage.

LOCATION

According to provider representatives on the Commission, salaries and wages account for almost 70% of total hospital expenses. Since labor costs vary based on location, both Medicare and MassHealth adjust payments for expected labor costs. Medicare's IPPS adjusts rates using the hospital area wage index, which compares the average hourly wage for hospital staff in a given area to the national average. Hospitals operating in higher-cost areas receive a 69.6% adjustment to the operating base payment rate. Hospitals in lower-cost areas receive a 62% adjustment.²⁹

²⁷ Matthew Klitus, "MassHealth" (presentation to the Special Commission on Provider Price Variation, Boston, MA, November 1, 2016).

²⁸ *Id.*

²⁹ Medicare Learning Network, *Inpatient*, *supra* note 10.

Medicare's OPPS uses the same area wage index. In Massachusetts, the difference in payment due to geographic variation or differences in wage area is 30%.³⁰ Beginning in October 2016, differences in payments based on geographic variation increased due to an adjustment to the rural floor.³¹ MassHealth uses the same Centers for Medicare & Medicaid Services (CMS) wage area indices as Medicare but a slightly different methodology.³² Medicare and MassHealth also adjust physician fees to account for geographic variations in the cost of practicing medicine. Medicare physician reimbursement rates are 9% higher in metro Boston than in other parts of Massachusetts.³³ MassHealth uses a methodology based on Medicare's payment system.

Commission members expressed reservations about using location and/or wages as an acceptable reason for provider price variation. Health plans and hospital representatives commented on the unintended consequences of Medicare's "rural floor" payment rule, under which Medicare must reimburse a state's urban hospitals for employee wages at least as much as it reimburses its rural hospitals.³⁴ Massachusetts' only rural hospital is Nantucket Cottage Hospital, a nineteen-bed hospital with relatively high wages, due to its remote location and the high cost of living in that area. Although it may make sense to consider commercial costs by region, one member expressed concern about using Medicare's methodology as a baseline metric. Another member was concerned about the effect of adjusting rates for location in the context of tiered-network plans. These plans steer members to high-value providers, but when a geographically-isolated hospitals is placed in a higher tier, this can drive patients out of their community.

³⁰ "Details for Title: FY 2017 Final Rule and Correction Notice Table," Centers for Medicare & Medicaid Services, last accessed March 8, 2017, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending> (click on "Tables 2 and 3"). This calculation does not include the rural floor budget neutrality adjustment; see next paragraph for a discussion of the rural floor. If the rural floor adjustment is included, the range of difference in payment is approximately 12%. Only certain areas are subject to the rural floor. Cambridge-Newton-Framingham, MA, Pittsfield, MA, Providence-Warwick, RI-MA, Springfield, MA and Worcester, MA-CT are subject to the rural floor. Rural Massachusetts, as defined by CMS, Barnstable Town, MA and Boston, MA are not.

³¹ "FY 2017 Final Rule and Correction Notice Tables," Centers for Medicare & Medicaid Services, accessed January 25, 2017, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Tables.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>. See the following paragraph for a discussion of the rural floor.

³² Material provided by MassHealth to the Joint Committee on Health Care Financing staff, August 2, 2016 and January 12, 2017. For example, a fifteen minute evaluation and management visit in 2016 reimburses physicians \$79 in metro Boston and \$75 in the rest of the Commonwealth. Health Policy Commission, *Provider Price Variation*, supra note 30.

³³ Health Policy Commission, *Provider Price Variation*, supra note 30.

³⁴ Balanced Budget Act of 1997, § 4410. See also Liz Kowalsky, "How a Tiny Hospital Has Imperiled Mass. Medicare Funds," *Boston Globe*, May 2, 2016, <https://www.bostonglobe.com/lifestyle/health-wellness/2016/05/01/partners-healthcare-errors-costs-all-mass-hospitals/17ZloAaDKzTFst9kmbBuwM/story.html>.

As part of its price variation working group, the Massachusetts Health & Hospital Association (MHA) discussed using a hospital's provision of low- and no-margin services³⁵ as a better justification for higher rates. MHA members agreed that geographic isolation in of itself does not warrant higher rates. During the Commission's discussion, it was suggested that any system using location as a basis for rates must consider employee migration patterns, as many healthcare professionals in Massachusetts commute to higher-wage settings.

QUALITY

Medicare and MassHealth adjust payments, both positively and negatively, to incentivize high performance on quality measures. Medicare's IPPS makes three quality adjustments. The Hospital Value-Based Purchasing Program rewards performance on measures like patient experience, clinical care outcomes, and cost reduction. To fund the program, Medicare reduces hospital base payments, meaning that lower-performing hospitals experience a net loss. Two other penalty programs, the Hospital Acquired Condition and Hospital Readmissions Reduction Programs, reduce base rates for hospitals with a high incidence of hospital-acquired conditions³⁶ or excessive readmissions for certain medical conditions. Overall, roughly 2% of base payments are redistributed based on performance and quality measures. Under both the IPPS and the OPDS, providers must also report certain quality metrics to receive full payments.³⁷

MassHealth provides incentives for high-quality performance and penalties for readmissions. Under MassHealth's Pay for Performance Program, inpatient hospitals can earn payments in addition to their base rates, depending on their performance on pre-selected quality measures. The slate of measures evolves from year to year. Hospitals are scored on selected measures, and those scores are compared with those of other hospitals that provide similar services. Poor performance results in no additional payment. In recent years, the total payment to all hospitals has ranged from \$25 to \$40 million a year.³⁸ In addition, to encourage hospitals to limit readmissions, MassHealth penalizes providers for preventable readmissions. The penalty is a reduction of up to 4% in the hospital's per-discharge base payment rate for the upcoming year.³⁹ MassHealth also denies payments for serious reportable

³⁵ The Massachusetts Health & Hospital Association's Price Variation Workgroup Report includes examples of low- and no-margin services: inpatient psychiatry, obstetrics and newborn nursery services, dialysis, pulmonary function. Massachusetts Health & Hospital Association, *Report of the Massachusetts Health & Hospital Association Price Variation Workgroup* (Boston, MA: September 2016).

³⁶ A Hospital Acquired Condition is a medical condition or complication that a patient develops during a hospital stay, which was not present at admission. "Quality Definitions and Methodology," American Hospital Directory, last modified May 14, 2015, https://www.ahd.com/definitions/hqi_acq_cond_measures.html.

³⁷ Medicare Learning Network, *Inpatient*, supra note 10; Medicare Learning Network, *Outpatient*, supra note 14; Joseph Newhouse, "Medicare" (presentation to the Special Commission on Provider Price Variation, October 11, 2016).

³⁸ Material proved by MassHealth to the Joint Committee on Health Care Financing staff, August 2, 2016.

³⁹ Id.

events, like care ordered by a person impersonating a physician or a wrong-side surgery. These events are rare and must also be reported to the Massachusetts Department of Public Health (DPH).⁴⁰

In addition to facility payments, Medicare adjusts physician rates to reflect quality. Physicians must report certain quality measures in order to receive full Medicare payments. Further, through 2018, Medicare will phase in a value-based payment modifier, which adjusts physician payments upwards or downwards based on the quality of care provided in relation to its cost. Beginning in 2019, Medicare will begin implementing provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This legislation fundamentally changes the way physician fees are set and annually updated.

Under MACRA, physicians choose one of two payment tracks, both of which reward or penalize physicians based on quality. The Merit-Based Incentive Payment System (MIPS) will grade physicians on quality of care, resource use, clinical practice improvement activities, and meaningful use of electronic health records. Based on those scores, Medicare will adjust physician rates upwards or downwards by an increasing percentage, from 4% in 2019 to 9% after 2022. Under the Alternative Payment Model (APM) track, physicians will join a practice, such as an ACO, that is paid to deliver coordinated care and assume financial risk for a group of patients. Under this track, the practice must meet a set of quality measures, comparable to measures under MIPS, to receive full payment.⁴¹

Most Commission members agreed that although the quality of a provider's performance justifies price variation, there are challenges to measuring and reporting quality. Roberta Herman, representing the Group Insurance Commission, informed the Commission that she spent a large portion of her early career on quality measurement. She commented on the risk of deciding on behalf of patients which measures are important, since different patients value different measures. She also questioned whether quality metrics can provide a degree of differentiation sufficient to justify price variation. Karen Tseng, representing the Office of the Attorney General, reminded Commission members that surveys suggest that quality is a reason why residents of the Commonwealth would be willing pay more for healthcare services. She agreed that it can be difficult to measure quality, but if quality is not a basis for deciding where to direct healthcare dollars, then "what is the alternative?"

⁴⁰ Id.

⁴¹ "MACRA: Delivery System Reform, Medicare Payment Reform," Centers for Medicare & Medicaid Services, accessed December 30, 2016, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html>; "The Medicare Access & CHIP Reauthorization Act of 2015: The Path to Value," Centers for Medicare & Medicaid Services, accessed January 2, 2017, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf>; "Medicare Access and CHIP Reauthorization Act (MACRA) Quality Payment Program Final Rule: AMA Summary," American Medical Association, last Modified October 19, 2016, <https://www.ama-assn.org/sites/default/files/media-browser/public/physicians/macra/macra-qpp-summary.pdf>.

Quality and case mix could be tools to better align payments. David Torchiana, representing Partners Healthcare, clarified that quality measures may encompass reputation. This is a justified factor that includes measures such as willingness to recommend, which appears on the CMS quality survey.

Hospital representatives on the Commission stated that quality measures must be standardized, in order to make “apples to apples” comparisons among providers. They pointed out that for some quality measures, there is little differentiation among providers. Therefore, the Commission must consider which measures have the most impact, as the Commonwealth encourages providers to invest in population health and value-based care and providers across the state embrace “paying for value” initiatives. Several members noted that lower-paid organizations are at a disadvantage, however, because they do not have sufficient funding to invest in new programs.

HIGH-COST OUTLIERS

Where actual treatment costs greatly exceed the reimbursement rate, both Medicare and MassHealth make additional high-cost outlier payments. For Medicare patients, cases are identified by comparing the estimated cost of providing that service to a DRG-specific “fixed loss” threshold. Under both the IPPS and the OPPIs, if actual costs exceed a fixed amount, the hospital is paid some percentage of the amount above that threshold. For most inpatient procedures, for example, Medicare pays 80% of the amount above the threshold. The threshold is updated annually. High-cost outlier payments account for 5% of base payments and are financed by reducing base rates, so that payments do not increase total Medicare spending.⁴²

MassHealth also makes high-cost outlier payments. On the inpatient side, these payments apply to admissions exceeding \$25,000. Hospitals are reimbursed for 80% of actual costs above this threshold.⁴³ Outlier payments are built into the APAD and APEC rates and typically represent 5-10% of the total value of payments. MassHealth recently began reimbursing outpatient cases for high-cost outliers. Outpatient service costs of \$2,000 or more are eligible. Just as on the inpatient side, MassHealth pays 80% of the difference between the reimbursement rate and the actual cost of care.⁴⁴ MassHealth reviews the outlier threshold each year and updates it where appropriate. Because these payments do not cover the full cost of care, hospitals are still incentivized to increase efficiency.

Dr. Altman provided members with some background on outlier payments. These payments were established at the same time as the DRG system. Congress wanted to pay hospitals a greater amount for serving sicker patients, so that hospitals would not have a financial incentive to avoid high-cost patients. Congress arbitrarily came up with a threshold of 5-6% above the average rate. Dr. Altman said this percentage,

⁴² MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Outpatient*, supra note 14; Newhouse, “Medicare,” supra note 37.

⁴³ Klitus, “MassHealth,” supra note 27.

⁴⁴ *Id.*

however, is not actually related to costs. Were the Commission to consider a methodology, he advised it not to rely on Medicare's system.

Commission members, including hospitals and health plan representatives, agreed that payments for high-cost patients are appropriate and important. Dr. Torchiana highlighted the high number of transfer patients that Massachusetts General Hospital and Brigham and Women's Hospital receive. Dr. Torchiana noted that the cost of caring for those patients is 80% higher than the average case, and those patients represent 40% of hospital mortality.

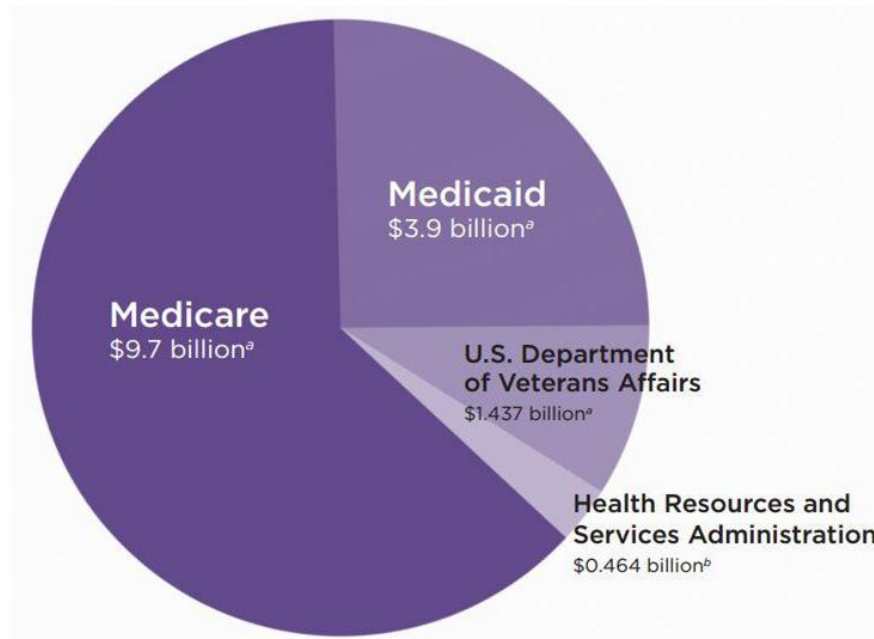
GRADUATE MEDICAL EDUCATION

Graduate Medical Education (GME) trains future physicians in clinical- and hospital-based settings. Medical school graduates and resident physicians participate in training programs for three to seven years, depending on medical specialty, and are supervised directly by faculty members. Although 2% of United States residents live in Massachusetts, Massachusetts teaching hospitals train 5% of all medical residents.⁴⁵ Funding for GME comes from multiple sources (See Figure 2.5). The largest source is Medicare, which contributes almost \$10 billion annually.⁴⁶

⁴⁵ Amy Nordrum, "The High Cost of Healthcare: America's \$15B Program To Pay Hospitals For Medical Resident Training Is Deeply Flawed," *International Business Times*, August 13, 2015, <http://www.ibtimes.com/high-cost-healthcare-americas-15b-program-pay-hospitals-medical-resident-training-2040623>.

⁴⁶ Jay Greene, "Hospitals Say They Subsidize Graduate Medical Education, but Cost-Benefit Unknown," *Crain's Detroit Business*, July 19, 2015, <http://www.modernhealthcare.com/article/20150719/NEWS/307199999>.

Figure 2.5: Graduate Medical Education Payments in United States⁴⁷



a. Data from 2012

b. Data from 2011 and 2013

Medicare funding is distributed through two mechanisms, direct and indirect payments. Direct medical education (DME) payments cover the costs required to run a training program, such as resident stipends, faculty salaries, and hospital administrative costs. These payments are made separately from the IPPS.⁴⁸ Indirect medical education (IME) payments cover the higher patient care costs associated with training new residents, such as costs due to longer inpatient stays and more frequent testing. These payments are adjusted for in the base rate.⁴⁹ Both payments are formula-driven, meaning they do not reflect the actual financial impact of operating residency programs.⁵⁰ The number of residents a hospital can claim for its Medicare reimbursement is capped, but almost all Massachusetts hospitals meet or are above their cap (See Figure 2.6).⁵¹

⁴⁷ Jill Eden, Donald Berwick and Gail Wilensky, *Graduate Medical Education That Meets the Nation's Health Needs* (Washington, D.C.: National Academies Press, 2014).

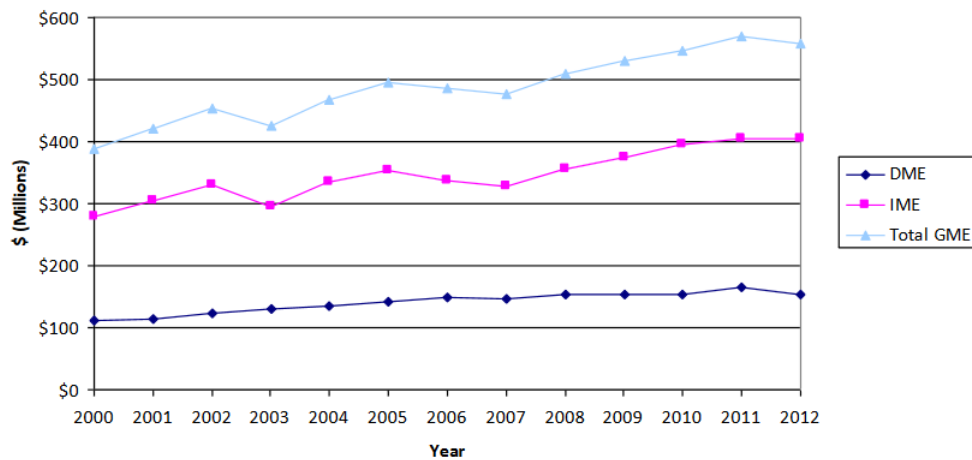
⁴⁸ "Medicare Direct Graduate Medical Education (DGME) Payments," Association of American Medical Colleges, accessed December 30, 2016, https://www.aamc.org/advocacy/gme/71152/gme_gme0001.html.

⁴⁹ "Medicare Indirect Medical Education (IME) Payments," Association of American Medical Colleges, accessed December 30, 2016, https://www.aamc.org/advocacy/gme/71150/gme_gme0002.html.

⁵⁰ Barbara Wynn, Robert Smalley, and Kristina M. Cordasco, *Does it Cost More to Train Residents or to Replace Them? A Look at the Costs and Benefits of Operating Graduate Medical Education Programs* (RAND Corporation, 2013).

⁵¹ MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Inpatient*, supra note 10; Executive Office of Health & Human Services, *Report of the Special Commission on Graduate Medical Education* (Boston, MA, 2013).

Figure: 2.6: Medicare Funding for Graduate Medical Education in Massachusetts, 2000-2012⁵²



In addition to Medicare, other federal programs, private industry, and physician organizations fund graduate medical education.⁵³ While most states also use Medicaid funding to support GME, Massachusetts does not.⁵⁴ The Massachusetts Department of Mental Health (DMH), however, does provide \$5 million annually to psychology residents through its Residency Training Grants. Instead of tying the funding to an exact number of residents, the money pays a portion of the residency program's costs. In return, DMH provides input on the curriculum and residents participate in DMH training opportunities.⁵⁵

Although training residents is an important aspect of the healthcare system, it is unclear how hospitals distribute Medicare payments or how much it actually costs a hospital to train a resident. For years, teaching hospitals across the country have maintained that they lose money training residents, and have pressed for higher reimbursements rates. On the other hand, senior residents have the same duties as licensed physicians, but are paid less than a fifth of that physician's salary.⁵⁶ The Medicare Payment Advisory Commission once estimated that teaching hospitals do incur an extra 2.7% in expenses for each patient they treat, compared to non-teaching hospitals. GME payments, however, are partially based on a formula that covers 5.5% of each Medicare bill.⁵⁷ There seems to be interest among healthcare stakeholders in taking a closer look at GME funding. There have been proposals to decrease funding, increase transparency around how GME dollars are spent, and

⁵² Executive Office of Health & Human Services, *Graduate Medical Education*, supra note 51.

⁵³ Id.; Department of Mental Health, email message to Joint Committee on Health Care Financing staff, December 28, 2016.

⁵⁴ Tim Henderson, *Medicaid Graduate Medical Education Payments: A 50-State Survey* (Washington, D.C.: Association of American Medical Colleges, 2013).

⁵⁵ Executive Office of Health & Human Services, *Graduate Medical Education*, supra note 51.

⁵⁶ Nordrum, "High Cost of Healthcare," supra note 45.

⁵⁷ Id.; Lane Koenig, et al., "Estimating the Mission-Related Costs of Teaching Hospitals," *Health Affairs* 22 (2003): 112-122.

reward hospitals for training more PCPs.⁵⁸ The Medicare Payment Advisory Commission has suggested a new performance-based GME program.⁵⁹

Commission members agreed on the importance of teaching activity and acknowledged the challenges around determining the correct payment level. At the same time, most members agreed that teaching status on its own is not a justifiable reason for price variation. John Fernandez, representing the Conference of Boston Teaching Hospitals, however, did emphasize that GME payments do not fully cover teaching costs. Dr. Altman pointed out that Medicare has made cuts to the teaching adjustments over the years; however, some analysts believe that the adjustments are still too large. He noted also that commercial payers indirectly pay for teaching, because hospitals may make up for GME payment shortfalls by charging higher rates.

DISPROPORTIONATE SHARE HOSPITALS & SERVICES PROVIDED TO UNIQUE AND/OR UNDERSERVED POPULATIONS (DSH)

Although eligibility criteria differ, both Medicare and MassHealth provide additional payments to hospitals that serve a higher percentage of patients insured through public programs. Under the IPPS, hospitals that serve a high percentage of Medicare and Medicaid patients are eligible for disproportionate share hospital (DSH) payments. The original rationale for DSH payments was to compensate hospitals for the higher operating costs associated with treating a larger share of low-income Medicare patients. The reasoning was that these patients tend to be more costly, so DRG payments, which are based on the cost of an average patient, are inadequate. Over time, there became a second and broader justification for DSH payments: preserving access to care for all low-income patients by supporting the hospitals that they tend to use.⁶⁰

Medicare formulas for determining DSH payments are complex and take into account the hospital's percentage of low-income patients, location, size, and level of charity care provided. Large urban hospitals, as defined by Medicare,⁶¹ are also eligible for DSH payments if they have 100 or more beds and receive 30% of total inpatient revenue from state and local governments for uncompensated or charity care. Medicare's IPPS also makes special payments to certain rural hospitals that, because of location and patient mix, tend to be less financially stable. For example, hospitals located at least 35 miles from another hospital and hospitals that meet

⁵⁸ Nordrum, "High Cost of Healthcare," supra note 45.

⁵⁹ MedPAC, *Report to the Congress: Aligning Incentives in Medicare* (Washington, D.C., June 2010).

⁶⁰ "Medicare Disproportionate Share (DSH) Payments," Association of American Medical Colleges, accessed December 18, 2016, <https://www.aamc.org/advocacy/medicare/155102/dsh.html>; Sarah Mutinsky, "Medicaid and Medicare DSH: Current Rules and Future Challenges," *American Essential Hospitals*, June 26, 2015, https://essentialhospitals.org/wp-content/uploads/2015/07/Mutinsky_MedicaidMedicareDSH_062415_vF.pdf.

⁶¹ Medicare calls these hospitals "Pickle Hospitals." See Section 1886(d)(5)(F)(i)(II) of the Social Security Act.

other location requirements are eligible for sole community hospital (SCH) payments.⁶²

Medicare's OPPS makes budget-neutral adjustments for two categories of hospitals. Most services provided at SCHs are eligible for a 7.1% payment increase. In addition, cancer and children's hospitals have permanent "hold harmless" statuses, meaning that if the OPPS methodology changes and payments to these hospitals are lower than what they would have received under the previous policy, the hospitals receive additional payments to make up the difference. Cancer hospitals, which are more likely to care for high-cost patients, also receive adjustments so that their ratio of payments to costs is comparable to other hospitals.⁶³

The Executive Office of Health and Human Services (EOHHS), which comprises MassHealth and other agencies, compensates hospitals that provide a disproportionate amount of care to underserved populations, through several supplemental payment programs (See Figure 2.7). This population is medically complex and often requires a greater amount of hospital resources. Medicaid payments are often lower than Medicare and commercial payments, so supplemental payments support these hospitals' ability to serve MassHealth members and uninsured populations and transition to risk-based delivery systems.⁶⁴ In fiscal year 2016, MassHealth supplemental payments totaled \$900 million.⁶⁵ Several members of the Commission noted that even with supplemental payments, certain hospitals are not fully compensated for the cost of providing care to MassHealth members and the uninsured.

⁶² MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Inpatient*, supra note 10; Newhouse, "Medicare," supra note 37. In Massachusetts, Cape Cod Hospital is the only designated SCH. See "FY 2017 Final Rule and Correction Notice Data Files," Centers for Medicare & Medicaid Services, accessed January 25, 2017, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Final-Rule-Home-Page-Items/FY2017-IPPS-Final-Rule-Data-Files.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending>.

⁶³ Medicare Learning Network, *Outpatient*, supra note 14; MedPAC, *Outpatient*, supra note 3.

⁶⁴ Massachusetts Executive Office of Health and Human Services, *MassHealth Medicaid Section 1115 Demonstration* (Boston, MA, 2016).

⁶⁵ Klitus, "MassHealth," supra note 27.

Figure 2.7: MassHealth Supplemental Payments, FY2016⁶⁶

Program	Recipients	Qualifications	FY16 Value (\$M)
Delivery System Transf. Initiative (DSTI)	7 Hospitals	Hospitals with Medicaid volume >1 SD <u>above</u> statewide mean + commercial volume >1SD <u>below</u> statewide mean (Boston Medical Center, Cambridge Health Alliance, Holyoke Hospital, Lawrence General Hospital, Mercy Medical Center, Signature Brockton Hospital, Carney Hospital)	200.0
Public Service Hospital	2 Hospitals	Authorized in 1115 Waiver specifically for CHA and BMC	140.0
Public Hospital Transf. Initiative (PHTII)	1 Hospital	Authorized in 1115 Waiver specifically for CHA	220.0
MassHealth Essential	5 Hospitals	Non-profit teaching hospitals affiliated with state-owned medical school or public acute hospital with Medicaid patient days ≥ 7% (Cambridge Health Alliance, UMass Memorial Hospital, Clinton Hospital, Health Alliance Hospital, Marlborough Hospital)	213.0
High Medicaid Discharge Hospitals	12 Hospitals	Hospitals with > 2.7% of statewide Medicaid discharges (Baystate Hospital, Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham And Women's Hospital, Cambridge Health Alliance, Lawrence General Hospital, Lowell General Hospital, Massachusetts General Hospital, Mercey Hospital, Southcoast Hospital, Tufts Medical Center, UMass Memorial Hospital)	115.0
High Public payor	35 Hospitals	Hospitals whose Medicaid + Medicaid volume >= 63% (Boston Medical Center, Steward Carney Hospital, Inc. Holyoke Hospital, Cambridge Health Alliance, Mercy Hospital, Lawrence General Hospital, Southcoast Health Systems, Signature Healthcare Brockton Hospital, Athol Memorial Hospital, North Shore Medical Center, Berkshire Medical Center, Wing Memorial Hospital, Clinton Hospital, Steward Saint Anne's Hospital, Baystate Franklin Medical Center, Falmouth Hospital, Steward Holy Family Hospital (combined), Baystate Medical Center, Morton Hospital Cape Cod Hospital, Steward Good Samaritan Medical Center, HealthAlliance Hospitals, Inc., Noble Hospital, Fairview Hospital, Harrington Memorial Hospital, Martha's Vineyard Hospital, Saint Vincent Hospital, Steward St. Elizabeth's Medical Center, Sturdy Memorial Hospital, Heywood Hospital, Lowell General Hospital, UMMC, Steward Norwood Hospital, Marlborough Hospital, Nashoba Valley Medical Center, Beth Israel Deaconess Hospital - Plymouth)	24.0
High Complexity pediatric	4 Hospitals	Pediatric Hospitals that treat high complexity children (Boston Childrens Hospital, Tufts Floating Hospital, Shriners Hospital for Children, Shriners Burn Hospital)	15.0
Total			927.0

Under Massachusetts' new 1115 Medicaid Waiver, approved in November of 2016, many of these supplemental payments will be restructured. Some will be linked to MassHealth ACO participation and will include performance-based accountability

⁶⁶ Id. High public payer and pediatric payments were appropriated in FY2017 GAA Budget and were eliminated in December 2016 under the Governor's 9C authority. DSTI and PHTII are risk-based transformation incentive payments, not payments for Medicaid services. Funding totals for DSTI, Public Service Hospitals, PHTII, and MassHealth Essential include intergovernmental transfer funds from providers that serve as the means to get federal matching dollars. See Massachusetts Executive Office of Health and Human Services, *MassHealth*, supra note 64.

requirements, under which a portion of the payments are at risk and linked to performance measures.⁶⁷

Commission members were divided as to whether hospitals that serve a larger number of low-income patients should receive higher commercial rates; in other words, whether commercial payers should subsidize perceived shortfalls in Medicaid reimbursements. The health plans and employer representatives pointed to the already high cost of insurance for consumers and employers. They asked the Commission to focus on commercial disparities among providers, not public-payer shortfalls. Several members noted that providers with higher public-payer mixes receive relatively lower commercial rates.⁶⁸

“We must level the playing field in our hospital payment system and ensure our community and safety net hospitals have the resources we need to provide the quality care our patients deserve. Our private insurance rates shouldn’t suffer just because the majority of our patients are MassHealth beneficiaries.” – Sheilah Belin, Medical Assistant at Boston Medical Center, member of 1199 Service Employees International Union, testimony to the Special Commission

Other members felt that there is a community-wide obligation to pay for the care for low-income residents. When the MHA workgroup discussed DSH payments, there was a sense that commercial rates should recognize provider DSH status, because funding care for those populations is a societal responsibility.

Another hospital representative agreed that there should be a shared responsibility to care for low-income people, but the Commission should instead recommend that “innovator providers,”⁶⁹ such as retail and unaffiliated urgent care clinics competing with community hospitals, accept MassHealth patients.

Several Commission members stated that aside from current adjustments and supplemental payments, payment systems should take into account the social determinants of health or the socioeconomic factors that influence health. Kate Walsh, representing Boston Medical Center, commented that although supplemental

⁶⁷ Centers for Medicare & Medicaid Services, *MassHealth Medicaid Section 1115 Demonstration*, 11-W-00030/1, (November 4, 2016).

⁶⁸ Health Policy Commission, *2015 Cost Trends Report*, supra note 2.

⁶⁹ These providers do not have to accept Medicaid and are not subject to Department of Public Health Determination of Need Process and the Health Policy Commission Cost and Market Impact Reviews. See 105 Mass. Code Regs 100 (2017); MASS. GEN. LAWS ch. 6D § 13 (2016). They are also not included in ACO certification requirements. See Health Policy Commission, *Final Accountable Care Certification Standards For Certification Year 1* (Boston, MA, April, 2016); Executive Office of Health and Human Services, *Section 1115 Demonstration Project Amendment and Extension Request* (Boston, MA, July 22, 2016). Ambulatory surgical centers began accepting MassHealth in January 2015. See 130 CMR 423.000 (2015).

payments help address the cost of caring for complex patients, they do not address health disparities.⁷⁰

NEW TECHNOLOGIES, DEVICES, AND PHARMACEUTICALS

There can be a time lag between when a costly therapy becomes available and when a DRG is updated to reflect that cost. For this reason, Medicare provides temporary add-on payments to hospitals for up to three years, for both inpatient and outpatient care, to offset the costs of new technologies, drugs, biologics, and devices that result in better patient outcomes. CMS evaluates applications by manufacturers, technology firms, and others and considers newness, cost, and the potential for substantial clinical improvement over existing technology. The payment amount is based on the cost to the hospital of using the new technology. Between the beginning of this program in 2001 and 2015, CMS approved 19 of 53 applications for new inpatient therapies.⁷¹

Health plans and hospital representatives agreed that providing new technology does not in of itself justify significant differences in reimbursement rates. Dr. Torchiana commented that speaking as a physician who practiced in a technologically-dense field, he believes that not all new technology represents a clinical advance. Therefore, it is important to maintain a cap on the number of new technologies that qualify for this payment, since incremental advances are often modest or nonexistent. He acknowledged that some new discoveries, such as Sovaldi,⁷² are stunning advancements in medicine, but these advances come with a monumental price tag. Figuring out how to pay for these technologies is a difficult problem. Ms. Walsh added that the struggle to pay for new technologies is something that all healthcare providers face, and is therefore not justifiable reason for price variation.

STAND-BY SERVICES

Stand-by services are services that a hospital unit provides on a 24-hour basis. These units must be staffed at all times. In addition, the care provided tends to be episodic and high-intensity, requiring specially-trained staff, specialized equipment, and dedicated space. For these reasons, stand-by units tend to have relatively higher overhead costs. Stand-by units include trauma centers, burn centers, and psychiatric units.

Trauma and Burn Centers

Level I trauma centers provide comprehensive care for patients with severe or life-threatening physical injuries. There are nine Level I trauma centers in Massachusetts,

⁷⁰ Several Commission members and providers in other public forums have stated that MassHealth payments do not reimburse the full cost of the episode of care.

⁷¹ MedPAC, *Inpatient*, supra note 3; Medicare Learning Network, *Inpatient*, supra note 10; Newhouse, “Medicare,” supra note 37; John Hernandez, et al., “US Hospital Payment Adjustments for Innovative Technology Lag Behind Those In Germany, France, And Japan,” *Health Affairs* 34 (2015): 266.

⁷² Sovaldi treats chronic Hepatitis C. It is considered a breakthrough drug, but in the United States is among the most expensive.

seven in the greater Boston area, one in Worcester, and one in Springfield.⁷³ These centers must be certified by DPH and verified by the American College of Surgeons.⁷⁴ Burn units are specialized units that treat patients with severe burns. There are five burn units in Massachusetts, four in Boston, and one in Worcester.⁷⁵

A number of factors determine whether trauma and burn centers are profitable. Unprofitable trauma centers treat a higher percentage of Medicaid patients and are generally located in low-income urban areas. In contrast, trauma centers may be profitable if they are located in wealthy or suburban areas, treat a greater percentage of commercially-insured patients, and/or receive relatively higher payments from commercial insurers.⁷⁶ There is little research on the profitability of burn centers; most analyses take for granted that burn centers are unprofitable because of high fixed costs that are not fully reimbursed.

The majority of Commission members agreed that although the provision of these services is important and the costs to provide them are not shared equally, stand-by capacity is not a justifiable reason for price variation. Many thought it was outside the scope of the discussion. Hospital representatives informed Commission members that several hospital service lines, including burn centers, lose money. These lines are cross-subsidized by more profitable service lines, an inherent part of how hospitals ensure overall financial stability. In contract negotiations, parties do not discuss stand-by services. The provider's rates depend on its relative leverage; burn and trauma costs are built into base rates and are part of the cost of doing business. Hospitals make the strategic decision to offer these services, based on community need or as a business decision. One hospital representative said that unless an entity can demonstrate that it is particularly expensive to maintain a stand-by service, the Commission should not focus on this topic.

Psychiatric Units and Twenty Four-Hour Behavioral Health Services

Members agreed, and independent research confirms,⁷⁷ that unique issues surround the provision of behavioral health services in the Commonwealth. As of October

⁷³ Baystate Medical Center, UMass Memorial Medical Center, Beth Israel Deaconess Medical Center, Boston Medical Center, Boston Children's Hospital (pediatric), Massachusetts General Hospital, Tufts Floating Hospital for Children (pediatric), Tufts Medical Center.

⁷⁴ 105 CMR 130 (2016).

⁷⁵ Brigham & Women's Hospital, Shriner's Hospital, Massachusetts General Hospital, Boston Medical Center, and UMass Memorial Medical Center.

⁷⁶ "Trauma Drama: Patients for Profits?," *Emergency Medicine News* 36 (March 2014) 22-23; Yu-Chu Shen, Renee Y. Hsia and Kristen Kuzma, "Understanding the Risk Factors for Trauma Center Closures," *Medical Care* 47 (2009) 968-978; Samir M Fakhry, et al., "Trauma Center Finances and Length of Stay: Identifying a Profitability Inflection Point," *Journal of the American College of Surgeons* 210 (2010) 817-821; Emily Friedman, "The Roller-Coaster Supply of Burn and Trauma Care," *Hospital & Health Networks Magazine*, April 7, 2015, <http://www.hhnmag.com/articles/3589-the-roller-coaster-supply-of-burn-and-trauma-care>.

⁷⁷ "Behavioral Health Compendium," Health Policy Commission, accessed January 3, 2017, <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/key-findings-bh-compendium.pdf>; Margaret Hoy and Michael Bailit, *Barriers to Behavioral and Physical Health Integration in Massachusetts* (Boston, MA: Blue Cross Blue Shield Foundation of Massachusetts, June 2015); Center for Health Information and Analysis, *Behavioral* (footnote continued)

2016, Massachusetts had 2,662 DMH licensed inpatient beds at 55 hospitals and five Intensive Residential Treatment Programs.⁷⁸ Psychiatric units tend to treat a higher percentage of Medicaid patients, for whom providers are reimbursed relatively less. This means that organizations serving many behavioral health patients may struggle financially. This leads to “ED boarding,” in which these patients remain in the emergency department (ED) even after they are ready for discharge. ED boarding may be due in part to insufficient locations to transfer psychiatric patients. In addition to affecting quality of care, ED boarding can be costly. In Massachusetts, community hospitals serve a higher proportion of behavioral health patients than academic medical centers (AMCs) and teaching hospitals, so they experience more ED boarding.⁷⁹ On the other hand, new payment methods, such as global budgets, have incentivized some Massachusetts providers to expand behavioral health services, since providing more psychiatric care may prevent future hospitalizations and save money in the long run.⁸⁰

Several members asserted that reimbursement by payers for psychiatric services is low. Others argued that profitability per case can vary substantially, depending on the payer. Ms. Walsh stated that payments for geriatric psychiatric care are relatively strong compared to Medicaid and even some commercial payments. Marylou Sudders, Secretary of the Executive Office of Health and Human Services, agreed, stating that there has been growth in certain psychiatric service lines, such as geriatric services, because Medicare is the payer and it pays well. Average profits may also differ for services provided in free-standing psychiatric units. For this reason, it was suggested that any conversation about psychiatric reimbursement should not lump all beds together. Steven Walsh, representing the Massachusetts Council of Community Hospitals, explained that the issue of behavioral health underpayment goes back to a number of causes; for example, Medicare’s usual and customary charges, developed in the 1960s, the traditional separation of behavioral and physical healthcare, and economic disparities. He asked the Commission to focus on price variation in the commercial market and not on underpayments by public payers.⁸¹

Lynn Nicholas, representing the Massachusetts Health & Hospital Association, noted that during a discussion with her members regarding low- or no-margin

Health & Readmissions in Massachusetts Acute Care Hospitals (Boston, MA, August 2016); Center for Health Information and Analysis, *Access to Substance Use Disorder Treatment in Massachusetts* (Boston, MA, April 2015); Center for Health Information and Analysis, *Task Force on Behavioral Health Data Policies and Long Term Stays* (Boston, MA, June 2015).

⁷⁸ Department of Mental Health, email to Joint Committee on Health Care Financing staff, October 24, 2016.

⁷⁹ Health Policy Commission, *2015 Cost Trends Report*, supra note 2.

⁸⁰ Massachusetts Health & Hospital Association, *Price Variation Workgroup*, supra note 35; Robert Preidt, “Psychiatric Patients Face Longer Waits in ER,” *HealthDay*, September 13, 2016, <http://health.usnews.com/health-care/articles/2016-09-13/psychiatric-patients-face-longer-waits-in-er>; Liz Kowalczyk, “Steward Healthcare Expanding Psychiatric Facilities,” *Boston Globe*, August 7, 2014, <https://www.bostonglobe.com/metro/2014/08/06/hospitals-expanding-psychiatric-units/FCKNHUP5thhG93ncAUaYeM/story.html>.

⁸¹ 2016 Mass. Acts 115, §9.

services, hospitals placed psychiatric services at the top of the list.⁸² They agreed that behavioral healthcare is not provided equally in all communities. Hospitals that do offer complex and costly services should get increased payments, possibly at the expense of other hospitals. Not all beds and services are alike, and payments should reflect the cost of providing certain types of complex care. For example, forensic capabilities and services for dual-diagnosis and/or violent patients are more costly to offer than substance use disorder services for commercially-insured patients.

ADVERTISING

Before 1980, the American Medical Association considered advertising for services unethical. Today, the Federal Trade Commission regulates advertisements for healthcare services, which are treated no differently than advertisements for other services.⁸³ Since the ban was reversed in 1980,⁸⁴ healthcare entities have steadily increased the amount and type of advertising that they produce. National spending on advertising in the healthcare industry increased almost 20% from 2011 to 2014.⁸⁵ Advertising costs, however, still make up less than 1% of a typical hospital's budget.⁸⁶

Hospitals advertise on billboards, in magazines, and online. In addition, social media and digital marketing strategies have made it easier for hospitals to reach their target audience.⁸⁷ Patient advocates and even some healthcare practitioners, however, view advertising as wasteful since it is designed to increase market share, not direct patients towards needed services.⁸⁸ In fact, advertising may encourage patients to seek inappropriate care. These stakeholders argue that advertisements provide little usable information to patients and instead focus on emotional appeal.⁸⁹ Advertising for healthcare services relates to the issue of price transparency and brand name. In many markets, consumers have the incentive and tools to shop for bargains. In the healthcare market, however, insurance coverage shields patients from the direct costs of their care. In addition, costs are often not disclosed until after the service has been provided. Even if patients want to obtain information on cost or quality prior to the service, it may be very difficult to do so. At the same time,

⁸² Massachusetts Health & Hospital Association, *Price Variation Workgroup*, supra note 35.

⁸³ Yael Schenker, Robert Arnold and Alex John London, "The Ethics of Advertising for Healthcare Services," *The American Journal of Bioethics* 14 (2014): 34-43.

⁸⁴ Am. Med. Ass'n v. Fed. Trade Comm'n, 638 F.2d 443 (1980).

⁸⁵ Elizabeth Rosenthal, "Ask Your Doctor if This Ad is Right for You," *New York Times*, February 27, 2016, http://www.nytimes.com/2016/02/28/sunday-review/ask-your-doctor-if-this-ad-is-right-for-you.html?_r=0.

⁸⁶ Amanda Erikson, "The Average Marketing Budget for a US Hospital," *AZCentral*, accessed November 18, 2016, <http://yourbusiness.azcentral.com/average-marketing-budget-hospital-17444.html>.

⁸⁷ Jan Greene, "Healthcare Marketers Reshape Ad Strategies," *Modern Healthcare*, October 30, 2015, <http://www.modernhealthcare.com/article/20151030/MAGAZINE/310309995>.

⁸⁸ "Editorial: Hospitals Spend Millions Luring Patients Away from Each Other," *Des Moines Register*, December 19, 2016, <http://www.desmoinesregister.com/story/opinion/editorials/2016/12/18/editorial-hospitals-spend-millions-luring-patients-away-each-other/95517504>.

⁸⁹ Schenker, "Ethics of Advertising," supra note 83, at 38-39.

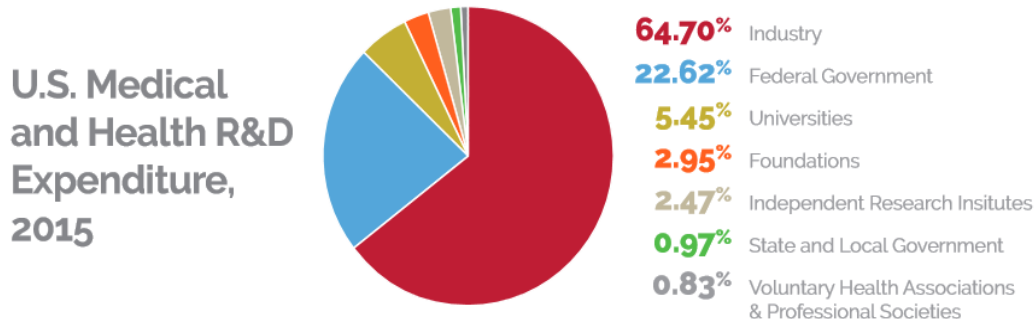
patients are becoming more active decision-makers regarding where they receive care. In the absence of other signals, brand name and advertising may be influential.

Commission members agreed that advertising is part of the cost of doing business, not a justifiable reason for provider price variation. They distinguished advertising from constructive efforts to provide unbiased cost and quality information to consumers. Mr. Walsh noted, for example, that there is a role for publicly-subsidized advertising to promote the use of community hospitals, almost all of which do not have a sizeable advertising budget. Over time, this could lower total healthcare spending in the state.⁹⁰ Several Commission members commented on the power of brand name and the fact that many patients make their decisions based on brand. Mr. Walsh stated that advertising may be necessary to fight the power of brand and move patient volume to high-value, low-cost providers.

RESEARCH

In 2015, the nation spent \$158.7 billion on medical and health research and development (See Figure 2.8).⁹¹ The main sources of funding are the government and industry stakeholders. The majority of government funding comes from the National Institutes of Health (NIH), which is part of the U.S. Department of Health and Human Services. The NIH is the primary government agency responsible for medical research, investing approximately \$32 billion each year.⁹²

Figure 2.8: United States Medical and Health R&D Expenditure, 2015⁹³



Massachusetts has one of the highest concentrations of life science researchers in the United States.⁹⁴ Because of its large number of AMCs and strong biotechnology

⁹⁰ Massachusetts Fiscal Year 2017 budget appropriated money for a community hospital marketing campaign. 2016 Mass. Acts 133, § 179.

⁹¹ Research America, *US Investments in Medical and Health Research and Development* (Arlington, VA: 2016), available at https://www.researchamerica.org/sites/default/files/2016US_Invest_R%26D_report.pdf.

⁹² "Budget," National Institutes of Health," last modified April 4, 2016, <https://www.nih.gov/about-nih/what-we-do/budget>.

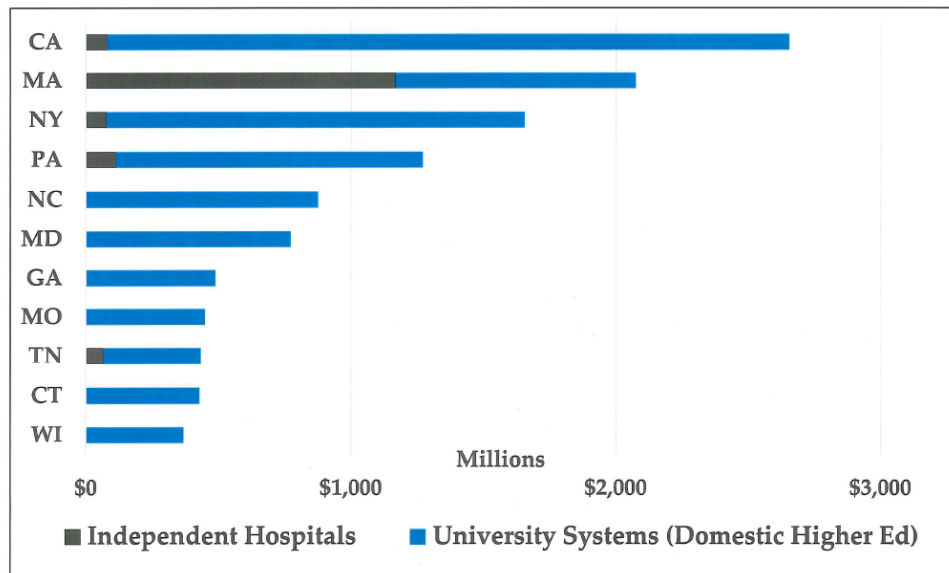
⁹³ Research America, *US Investments*, supra note 91.

⁹⁴ Beethika Khan and Jaqueline C. Falkenheim, *Regional Concentration of Scientists and Engineers in the United States* (Arlington, VA: National Science Foundation, 2013).

presence, Massachusetts receives more NIH funding per capita than almost any other state.⁹⁵ In 2016, Massachusetts received approximately \$2.5 billion.⁹⁶ Unlike in many other states, Massachusetts hospitals and not universities attract the majority of NIH dollars, because of how certain Massachusetts hospitals are structured (See Figure 2.9).

Figure 2.9: NIH Funding for Hospitals Compared to Universities, 2015⁹⁷

**NIH Funding Received by Hospitals vs. Universities –
State Comparison**



Commission members agreed that research is both a societal good and integral to the Commonwealth’s economy. Members disagreed, however, as to whether spending on research is a justifiable reason for commercial price variation. Dr. Torchiana stated that Partners Healthcare receives the most NIH funding in Massachusetts. In addition, every dollar Partners receives is matched by a foundation, philanthropic source, or industry partner. Therefore, Partners’ total research budget is \$1.4 billion dollars (twice the amount indicated in Figure 2.10). Nonetheless, industry and government funding do not fully cover direct and indirect research costs. Research in the clinical setting requires investment in staff, technology, and physical space. Research institutions must comply with rigorous methodological research standards, as well as governing laws and regulations. In addition, the process of applying for

⁹⁵ “Connect With Partners, Price Variation and Research: 3 Facts to Consider,” Partners Healthcare, October 31, 2016, <http://www.connectwithpartners.org/2016/10/31/price-variation-and-research-3-facts-to-consider>.

⁹⁶ “NIH Awards by Location and Organization,” National Institutes of Health, accessed December 19, 2016, <https://report.nih.gov/award/index.cfm>. For a breakdown of 2016 NIH funding by state, see Appendix A.

⁹⁷ Material provided by Partners Healthcare System to the Joint Committee on Health Care Financing staff, November 1 2016.

grants is very expensive. Funding from patents and clinical revenue offset these costs. Medical research also significantly contributes to the Massachusetts economy.

Figure 2.10: NIH Funding by Hospital System in Massachusetts, 2016

<u>Hospital</u>	<u>NIH Funding</u>
Partners (System)	\$690M
Boston Children's Hospital	\$140M
Beth Israel Deaconess	\$123M
Dana-Farber	\$128M
Boston Medical Center	\$27M
Massachusetts Eye & Ear	\$20M
Tufts Medical Center	\$19M

Dr. Altman noted that aside from patient care, AMCs spend the most money on research. This is an issue at both the state and federal levels. He said that commercial payers already indirectly subsidize research because hospitals funnel hundreds of millions of dollars of commercial payments into research. In addition, Medicare indirectly pays for research, because rates to teaching hospitals are higher than necessary. Dr. Altman noted further that in a market-based system, research should not be funded through patient care dollars but at the community, state, and/or federal levels.

Community hospital representatives noted that research capacity and spending do not drive provider price variation. The majority of hospitals across the state do not conduct research, yet price variation persists among those organizations. The issue is reimbursement variation, which can be addressed while still maintaining the billions of dollars that Massachusetts receives in research funding each year. Other hospital representatives encouraged the Commission to be cautious when discussing research funding. Ms. Nicholas highlighted the fact that at one point, most medical research and innovation came out of Europe. As European countries switched to single-payer systems, however, they by and large stopped paying for research through healthcare dollars. Ms. Nicholas stated that this led to the demise of superior research in those countries. Ms. Nicholas suggested that perhaps AMCs should get paid more on a relative basis than community hospitals that do not conduct research. There should not, however, be a big dollar differential. In her working group, MHA members decided that research is not a reason for significant price variation.

CARE COORDINATION BETWEEN/AMONG MEDICAL AND ALLIED HEALTH PROFESSIONALS

Many patients in the Commonwealth have healthcare needs that require more than traditional medical or pharmaceutical services. Care coordination is a concerted effort by a group of healthcare professionals and others to facilitate and manage the

appropriate delivery of services to a patient.⁹⁸ Care coordination encompasses a variety of practices, such as assigning a care coordinator to answer patients' questions and handle logistics, sending an advanced practice nurse to check in on a high-risk patient at home, and managing a patient's transition from one type of provider to another. Both providers and payers implement care coordination initiatives, which may include many types of healthcare professionals, including allied health professionals.⁹⁹

Care coordination services can benefit patients but may necessitate additional staff and information technology, which can lead to increased costs. There are many different mechanisms to pay for care coordination services, including monthly payments for staff and infrastructure, upfront payments for initial costs, designated funding, agreements with payers to employ case managers, and quality bonuses. The shift towards APMs and accountable care models has given providers greater flexibility to use resources for care management, since global budgets can be used to pay for nonclinical services.¹⁰⁰ It is important to note that the goal of care coordination is to enhance the patient's experience and improve outcomes, not necessarily produce savings.¹⁰¹ There have been many pilot programs within Medicare and state Medicaid programs; evaluations of those pilots show minimal, if any, consistent savings to date.¹⁰²

Commission members stated that care coordination is not a justifiable reason for price variation. Several members noted that as providers in the Commonwealth are increasingly reimbursed through APMs, with a focus on total medical expenditure, they will make the right investments to coordinate patient care.

SECTION IV: GLOBAL BUDGETS

As explained in Section I, a global budget is a payment mechanism under which a single payment covers all healthcare costs for a patient over a given period of time. Under the most advanced type of global budget arrangement, if a provider meets certain quality measures and stays within its budget, it earns a net profit. If a provider exceeds the budget, there is a net loss. As the Massachusetts healthcare market moves towards increased adoption of APMs, discussions of warranted and unwarranted factors for price variation become less important. Global budgets

⁹⁸ "What is Care Coordination," Agency for Healthcare Research and Quality, last reviewed June 2014, <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/index.html>.

⁹⁹ Allied health professionals (for example, occupational therapists, speech pathologists, and social workers) do not directly work in medicine or pharmacy, but support these functions through diagnostics, therapy, rehabilitation, and other services.

¹⁰⁰ Melanie Evans, "Demand Grows for Care Coordinators," *Modern Healthcare*, March 28, 2015, <http://www.modernhealthcare.com/article/20150328/MAGAZINE/303289980>.

¹⁰¹ J. Michael McWilliams, "Cost Containment and the Tale of Care Coordination," *New England Journal of Medicine* 375 (2016): 2218-2220.

¹⁰² Deborah Peikes, Arnold Chen, and Jennifer Schore, "Effects of Care Coordination on Hospitalizations, Quality of Care, and Healthcare Expenditures among Medicare Beneficiaries: 15 Randomized Trials," *Journal of the American Medical Association* 301 (2009): 603-618.

incentivize providers to reduce unnecessary care and focus on disease prevention and population health, since profits increase when utilization decreases. Global budgets also provide a source of fixed revenue, which allows providers to make investments and plan for future improvements.

Medicare has several global budget pilots, including the Next Generation ACO Model. Participants in the Next Generation Model receive an all-inclusive per-beneficiary-per-month payment for each member attributed to the ACO. This program is built upon Medicare's Shared Savings Program and Pioneer ACO Models, but it allows providers to take on higher levels of financial risk and offers greater opportunities to coordinate care.¹⁰³ There are 18 Next Generation ACO Models in the United States and two in Massachusetts: the Pioneer Valley ACO in Springfield and the Steward Integrated Care Network in Boston.¹⁰⁴ To date, the results of demonstration projects across the country have been mixed.¹⁰⁵ There is no conclusive evidence that ACOs save money, and it has been challenging to incentivize providers to take on risk. CMS, however, has stated that patients receive better care through ACOs and that it will continue to change and refine the program.

In the commercial market, Blue Cross Blue Shield created the Alternative Quality Contract (AQC) in 2008 to reduce healthcare costs and improve quality. The AQC gives participating providers an annual budget to meet the healthcare needs of their patients. It also requires providers to achieve certain quality targets. Providers share in any savings generated and must absorb any costs exceeding the budget.¹⁰⁶ A *New England Journal of Medicine* article concludes that in the four years following implementation, AQC enrollees had lower medical spending growth and improved quality, compared to similar populations in other states.¹⁰⁷

Maryland is the only state in which commercial insurers and providers do not negotiate payment rates. Instead, since 1971 Maryland has operated an all-payer hospital rate-setting system, under which an independent state agency determines and annually updates hospital payments. The linchpin of this system is a federal waiver, under which providers receive equal rates from Medicare, Medicaid, and commercial insurers. Prior to 2014, hospitals were paid a set amount per inpatient case and per outpatient visit. This is similar to how Medicare pays providers. In addition, during most of the waiver time period, Maryland had volume controls in

¹⁰³ "Next Generation ACO Model," Centers for Medicare & Medicaid Services, accessed December 19, 2016, <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model>.

¹⁰⁴ Id.

¹⁰⁵ Jordan Rau and Jenny Gold, "Medicare Yet to Save Money Through Heralded Medical Payment Model," *Kaiser Health News*, September 14, 2015, <http://khn.org/news/medicare-yet-to-save-money-through-heralded-medical-payment-model>; "Experts Debate: Have ACO Models Been Successful?," *Advisory Board Company*, August 19, 2016, <https://www.advisory.com/daily-briefing/2016/08/19/have-aco-models-been-successful>.

¹⁰⁶ Josh Seidman, et al., "Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract," *Avalere Health LLC*, March 2015, <https://www.bluecrossma.com/visitor/pdf/avalere-lessons-from-aqc.pdf>.

¹⁰⁷ Zirui Song, et al. "Changes in Healthcare Spending and Quality 4 Years into Global Payment," *New England Journal of Medicine* 371 (2014): 1704-1714.

place, under which a hospital with excessive admissions received proportionately lower rates. This reduced hospitals' incentive to increase the amount of services provided.¹⁰⁸

In 2014, Maryland re-negotiated its federal Medicare waiver. Instead of payments per visit or per episode, hospitals are now paid through a global budget. Maryland annually updates each hospital's budget to reflect the characteristics of the hospital and its service area. Among other factors, updates reflect changes in the cost of wages, service area demographics, and the hospital's market share. Annual adjustments are also made for performance on quality metrics. The objective is to create a budget that incentivizes quality improvement and reflects the expected costs of operating that hospital efficiently.¹⁰⁹ This is a five-year demonstration, under which Maryland must meet savings, spending, and quality targets. By 2019, Maryland will transition to a global budget model for all providers, not just hospitals. Preliminary analyses indicate that Maryland is meeting most of its Medicare requirements and is on track to fulfilling the terms of the waiver.¹¹⁰

In October 2016, Vermont obtained permission from CMS to set up an All-Payer ACO Model that reimburses providers through a global budget. Similar to the payment system in Maryland, a group of providers will receive a fixed amount of money to care for a group of patients. Global budgets will be similar across all payers and rates will be adjusted to account for differences among providers. As in Maryland, participating providers will have to meet spending and quality targets.

Vermont's system is first of its kind in several respects. First, money will be funneled through an ACO. The state will offer providers the opportunity to participate in existing Medicare ACOs, and it will provide start-up investments to spur the development of ACOs operated by Medicaid, commercial payers, and self-insured plans. Second, provider and payer participation is voluntary. Vermont will incentivize participation; for example, by offering providers predictable payments, facilitating care coordination, and providing data analytics. In addition, participating providers will automatically be in compliance with MACRA. Vermont's goal is to cover 70% of insured residents and 90% of Medicare beneficiaries under an ACO model by 2022. At the time of this report's publication, implementation is in its early stages, so it is

¹⁰⁸ Robert Murray, et al., *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* (Washington, D.C.: Urban Institute, November 2015); Centers for Medicare & Medicaid Services, "Maryland All-Payer Model to Delivery Better Care and Lower Costs," accessed December 9, 2016, <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model>.

¹⁰⁹ Robert Murray, *Hospital Rate Setting*, supra note 108; Maryland Health Services Cost Review Commission, *Agreement Between the Health Services Cost Review Commission and Anne Arundel Medical Center, Inc. Regarding Global Budget Revenue and Non-Global Budget Revenue* (MD, 2015).

¹¹⁰ Ankit Patel, et al., "Maryland's Global Hospital Budgets – Preliminary Results from an All-Payer Model," *New England Journal of Medicine* 373 (2015) 1899-1901; "Monitoring of Maryland's New All-Payer Model: Biannual Report," Health Services Cost Review Commission, April 2016, <http://www.hsrc.maryland.gov/documents/legal-legislative/reports/HSCRC-Biannual-Report-on-All-Payer-Model-April-2016.pdf>.

too soon to determine the ACO Model's effect on spending, quality, and health outcomes.¹¹¹

During a brief Commission discussion about global payment models, Ms. Nicholas acknowledged that community hospitals have fewer resources and weaker infrastructure, and therefore struggle with global budgets. Mr. Walsh, however, noted that community hospitals are still excited about the promise of global payments. Many hospitals have been providing wrap-around services to the community for a long time, but under a FFS structure they are not being paid to do so. Several members cautioned that since global budgets are based on existing FFS rates, rate disparities are “locked in.” Moving forward, it will be important to re-base community hospital rates to adequately reimburse hospitals for the services that they provide.

¹¹¹ Green Mountain Care Board, *Draft Vermont All-Payer Accountable Care Organization Model Agreement*, (VT, 2016), available at http://gmcboard.vermont.gov/sites/gmcb/files/documents/payment-reform/DRAFT_APM_Agreement_UNDER_LEGAL_REVIEW.pdf; “Vermont All-Payer ACO Model,” Centers for Medicare & Medicaid Services, last accessed January 3, 2016, <https://innovation.cms.gov/initiatives/vermont-all-payer-aco-model>; Virgil Dickson, “Vermont Gets Preliminary OK to Move Towards All-Payer System,” *Modern Healthcare*, September 28, 2016, <http://www.modernhealthcare.com/article/20160928/NEWS/160929874>; Mattie Quinn, “Vermont Takes a Health Risk That Many States Abandoned,” *Governing*, December 6, 2016, <http://www.governing.com/topics/health-human-services/gov-vermont-all-payer-health-care-maryland.html>; Vera Gruessner, “VT All-Payer Model Aligns Costs for Public, Private Insurers,” *Health Payer Intelligence*, October 11, 2016, <http://healthpayerintelligence.com/news/vt-all-payer-model-aligns-costs-for-public-private-insurers>.

CHAPTER 3 – HEALTHCARE CONTRACTING AND MARKET FORCES

INTRODUCTION

As part of its mandate, the Special Commission must review certain healthcare contracting practices. First, the Commission must examine contracts that require payers to pay the same or similar prices to all provider locations for a multi-location healthcare provider, where geographic differences in the provider's site do not support charging the same or similar prices. During its discussion of rate adjustment, the Commission discussed factors that correlate with higher prices for facilities within a health system, regardless of location. These factors include affiliation with certain healthcare systems and provider size. Second, the Commission must examine the feasibility of requiring insurers to contract separately with all provider locations within a healthcare system, as opposed to contracting with the healthcare organization as a unit.¹ This practice is known as separate or component contracting.²

The Commission expanded its directive and considered additional market forces solutions to address provider price variation. Market forces solutions aim to correct distortions and inefficiencies in the marketplace by increasing competition, so that differences in prices reflect so-called warranted reasons for price variation. It is important to foster competition among healthcare providers and insurers in light of increasing consolidation in healthcare markets, both in Massachusetts and nationally.³

Section I of this chapter summarizes previous efforts in Massachusetts to increase competition in the healthcare market, including proposals to require component contracting. Section II explores the theory and history of component contracting and the Commission's feedback on this solution. Sections III, IV, and V detail additional contracting and market forces solutions discussed by the Commission.

Many Commissioners have noted that market forces solutions, although necessary, are part of a menu of options to reduce price variation. Further chapters explore additional solutions, including consumer-targeted initiatives and state regulation.

¹ Act Relative to Equitable Health Care Pricing, 2016 Mass. Acts 115.

² Gwendolyn Majette, "Healthcare Contracting & Market Forces" (presentation to the Special Commission on Provider Price Variation, Boston, MA, November 29, 2016).

³ Bara Vaida and Alexander Wess, *Health Care Consolidation* (Washington, D.C.: Alliance for Health Reform, 2015); Robert Weisman, "Hospital Mergers May Drive Up Costs," *Boston Globe*, October 3, 2013, <https://www.bostonglobe.com/business/2013/10/02/health-care-leaders-warn-that-hospital-consolidation-could-drive-costs/ZAg3Wy0tomHOPK3UNiHw0J/story.html>.

SECTION I: LEGISLATIVE & LEGAL EFFORTS TO BOLSTER COMPETITION IN THE MASSACHUSETTS HEALTHCARE MARKET & NATIONALLY

CHAPTER 288 AND CHAPTER 224

In 2006, Massachusetts passed its landmark health reform law, which extended coverage to all residents.⁴ Chapter 58 achieved near-universal healthcare coverage, increased access to care, and improved health outcomes.⁵ In the ten years since Chapter 58, the Massachusetts Legislature has continued to prioritize healthcare reform and innovation. These important gains in access, however, have contributed to the trend of rapidly increasing healthcare costs. The Legislature responded to this problem in 2010 with the passage of Chapter 288 and again in 2012 with the passage of Chapter 224.

Chapter 288, an *Act to Promote Cost Containment, Transparency, and Efficiency in Health Insurance for Individuals and Small Businesses*,⁶ prohibits a number of practices that the Office of the Attorney General (AGO) and others had identified as anti-competitive. To bolster the development of limited- and tiered-network products (LTNPs), the law prohibits guaranteed participation clauses, under which an insurer is required to include a provider in an LTNP. The law also prohibits clauses that require all facilities within a healthcare system to be placed in the same tier within a tiered-network plan. For limited-network products, the law prohibits all-or-nothing clauses, under which an insurer is required to include in its network all provider members of a healthcare system.⁷ The law also prohibits most favored nation clauses, under which a dominant insurer/provider demands the lowest/highest price and precludes the other party from offering similar or better terms to its competitors.⁸ Additionally, Chapter 288 granted providers the right to opt-out of the new LTNP 60 days before the new plan is submitted to the Commissioner of the Division of Insurance for approval. Finally, Chapter 288 requires providers to make price and quality information available to the state and the public.⁹ These provisions are designed to “level the playing field” among providers with varying degrees of market leverage.

Chapter 224, *An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation*,¹⁰ did not directly address insurer/provider contracting but did create oversight mechanisms to track and review proposed provider ownership and affiliation agreements. First, in order to contract with payers, providers are required to register with the Health Policy Commission (HPC). Providers must submit details about their ownership, governance, operational structure, affiliates, employed and affiliated professionals,

⁴ Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 58.

⁵ Kelly Love and Robert Seifert, *10 Years of Impact: A Literature Review of Chapter 58 of the Acts of 2006* (Boston, MA: Blue Cross Blue Shield Foundation of Massachusetts, 2016).

⁶ 2010 Mass. Acts 288.

⁷ MASS. GEN. LAWS ch.176O, § 9A (2016).

⁸ MASS. GEN. LAWS ch.176D, §§ 3, 3A (2016).

⁹ MASS. GEN. LAWS ch.176O, §§ 7, 9A (2016).

¹⁰ 2012 Mass. Acts 224.

licensed facilities, and other pertinent information.¹¹ The purpose of the Registration of Provider Organizations process is to give the HPC necessary information to monitor provider transactions in the market. Chapter 224 also creates the Material Change Notice (MCN) and Cost and Market Impact Review (CMIR) processes. Under the MCN process, providers must notify the HPC when they wish to make certain acquisitions, mergers, and affiliations (See Figure 3.1). If the HPC reviews the filed information and determines that the proposed material change may reduce competition or increase total spending, it can conduct a more detailed CMIR and refer the matter to the AGO for further investigation.¹²

Figure 3.1: Notices of Material Change, 2013-2016¹³

April 2013 to Present		
Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	18	24%
Physician group merger, acquisition, or network affiliation	18	24%
Acute hospital merger, acquisition, or network affiliation	15	20%
Formation of a contracting entity	13	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	6	8%
Change in ownership or merger of corporately affiliated entities	5	7%
Affiliation between a provider and a carrier	1	1%

Other states, the federal government, and private parties have addressed provider consolidation and anti-competitive contracting practices. In 2016, the California Legislature introduced a bill that prohibits several provisions, including all-or-nothing and price secrecy clauses. In addition, the bill would limit out-of-network rates for emergency services.¹⁴ The Department of Justice and the Federal Trade Commission (FTC),¹⁵ the two agencies that monitor competition in the healthcare marketplace, have addressed the market clout that may result from the movement

¹¹ MASS. GEN. LAWS ch. 6D, § 11 (2016).

¹² § 13. The regulations state that HPC must refer the report under certain circumstances, and may refer any report “as appropriate.” 958 Mass. Code Regs 7.14 (2015).

¹³ Information provided by the Health Policy Commission to the Joint Committee on Health Care Financing staff.

¹⁴ S.B. 932, 2016 Leg., Reg. Sess. (Cal. 2016).

¹⁵ The Federal Trade Commission is a federal agency that oversees healthcare provider mergers and acquisitions.

toward Accountable Care Organizations (ACOs).¹⁶ The agencies released a policy statement encouraging providers to form ACOs but identifying conduct by dominant ACOs that may be anti-competitive. For example, contracts should not contain guaranteed and most favored nation clauses and should not require providers to work exclusively within an ACO.¹⁷ Recent lawsuits by private parties have also alleged anti-competitive practices by providers. In California, for example, a union and a group of self-insured employers jointly sued the largest provider in northern California. The complaint alleges that certain clauses are anti-competitive. One clause states that the health plan must encourage its members to receive all of their care from that provider system.¹⁸ As healthcare costs continue to rise, we can expect further actions by governments and private parties to address anti-competitive practices.

SECTION II: COMPONENT CONTRACTING

As discussed in Chapter 1, a provider's market leverage refers to whether an insurer can credibly exclude that provider from its network. This is why mergers and acquisitions correlate with higher prices.¹⁹ After a consolidation, providers that had formerly competed against one another are able to bargain as a unit. If these providers collectively serve a large portion of the market, it becomes difficult for an insurer to exclude these providers from its network. If the insurer is unable to refuse to negotiate with the provider unit, the provider's bargaining power is enhanced and the provider can command higher prices.²⁰

¹⁶ For background on federal healthcare antitrust enforcement, see Department of Justice, *The Role of Antitrust Enforcement in Health Care Markets*, by Bill Baer (Washington, D.C., November 13, 2015), available at <https://www.justice.gov/opa/file/794051/download>; "Health Care," United States Department of Justice, last modified Sept. 29, 2016, <https://www.justice.gov/atr/health-care>; "Health Care Competition," Federal Trade Commission, accessed Jan. 11, 2017, <https://www.ftc.gov/news-events/media-resources/mergers-competition/health-care-competition>.

¹⁷ Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Oct. 28, 2011).

¹⁸ Complaint, *UFCW v. Sutter Health*, No. 14-538451 (Apr. 7, 2014). For another example of a recent lawsuit alleging anti-competitive practices, see Complaint, *United States v. Carolinas Healthcare Sys.*, 3:16-cv-00311 (June 9, 2016). The complaint alleges that a dominant provider required anti-competitive steering provisions in contracts with payers. On a side note, it is important to recognize, that lawsuits can be imperfect vehicles for increasing competition: they may be costly and burdensome, and their results are unpredictable.

¹⁹ Asher Schechter, "The True Price of Reduced Competition: Hospital Monopolies Drastically Drive Up Prices," *Pro-Market*, March 14, 2016, <https://promarket.org/the-true-price-of-reduced-competition-in-health-care-hospital-monopolies-drastically-drive-up-prices>; David Cutler and Fiona Morton, "Hospitals, Market Share, and Consolidation," *Journal of the American Medical Association* 301 (2013): 1964-1970.

²⁰ Office of the Attorney General, *Examination of Healthcare Cost Trends and Cost Drivers, Report for Annual Public Hearing* (Boston, MA, 2010), available at <http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf>; Health Policy Commission, *2015 Cost Trends Report: Provider Price Variation* (Boston, MA, 2015), available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf>; Eric Roberts, Michael Chernew and J. Michael Williams, "Market Share Matters: Evidence Of Insurers and Provider Bargaining Over Prices," *Health Affairs* 36 (2017): 141-148, available at <http://content.healthaffairs.org/content/36/1/141.full.pdf+html>.

The theory behind component contracting is that one can simulate the competition among providers that existed before they consolidated by requiring each provider within a system to negotiate with insurers separately and independently. Implementing component contracting requires policies and procedures to ensure each provider does in fact negotiate as a separate entity. For example, each provider location needs its own negotiating team, which would be prohibited from sharing confidential information with other teams. In theory, the insurer would be able to negotiate lower rates, because providers would compete on price to maximize their chances of getting the insurer's business. In a way, component contracting is an extension of the prohibition on all-or-nothing contracting. Whereas all-or-nothing prohibitions allow an insurer to select which provider locations to include in its network, component contracting also enables the insurer to negotiate directly with each location.²¹

Massachusetts has a history of exploring component contracting as a solution to high provider prices. Several bills introduced during recent legislative sessions, including the House version of Chapter 224,²² would have required certain or all providers within a healthcare system to negotiate separately.²³ The 2011 Special Commission on Provider Price Reform also suggested prohibiting system-based contracting.²⁴ The idea gained wider attention in 2014, however, when prohibitions on all-or-nothing contracting were included in a proposed consent judgment between the Commonwealth of Massachusetts and Partners Healthcare.²⁵ Under this agreement, the Commonwealth would have allowed Partners, an already dominant healthcare system, to acquire South Shore Hospital and two hospitals within Hallmark Health Systems under certain conditions. The agreement, which did not include a component contracting remedy, would have settled claims related to the acquisition that the Commonwealth might otherwise have challenged on antitrust grounds.

The consent judgment was rejected by the Superior Court, in part because of testimony questioning the feasibility and efficacy of component contracting.²⁶

²¹ Majette, "Contracting & Market Forces," supra note 2; Gautam Gowrisankaran, Aviv Nevo and Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," *American Economic Review* 105 (2015): 172-203; Leemore Dafny et al., Letters from Economists to Judge Sanders, (Boston, MA, 2014); Tasneem Chitty, *Expert Testimony, Review of Partners Healthcare System's Proposed Acquisitions of Hallmark Health Corporation* (Boston, MA, Health Policy Commission, September 3, 2014).

²² H.B. 4155 § 66, 2011-2012 Leg., Reg. Sess. (Mass. 2012).

²³ Id.; H1916, 2015-2016 Leg., Reg. Sess. (Mass. 2015); H0602, 2011-2012 Leg., Reg. Sess. (Mass. 2011); H1471, 2011-2012 Leg., Reg. Sess. (Mass. 2011).

²⁴ Executive Office of Administration and Finance and the Division of Health Care Finance and Policy, *Recommendations of the Special Commission on Provider Price Reform* (Boston, MA, 2011), available at <http://www.chiamass.gov/assets/docs/g/special-comm-ppr-report.pdf>.

²⁵ Final Judgement by Consent, Commonwealth v. Partners HealthCare System, SUCV2014-02033-BLS (June 24, 2014).

²⁶ Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgment by Consent, Commonwealth v. Partners HealthCare System, SUCV2014-02033-BLS2 (Jan. 29, 2015); Dafny, Letters from Economists, supra note 21; Health Policy Commission, *Review of Partners Healthcare System's Proposed Acquisitions of Hallmark Health Corporation* (Boston, MA, 2014). The proposed consent judgment prohibited all-or-nothing contracting, not component contracting. Much of the
(footnote continued)

Moreover, additional analyses, models, and a high-profile real-world example²⁷ support the conclusion that component contracting would not restore competition or lower prices. First, component contracting rests on the assumption that rival providers do not want to lose business to one another. This holds true for actual competitors but is unlikely where providers are part of the same system. For example, suppose that Hospitals A and B operate in the same area and are part of the same organization. Even if the hospitals are forced to negotiate separately, revenues generated by each hospital flow to the same parent organization. In this case, it does not really matter which hospital a patient visits. Neither Hospital A nor Hospital B has an incentive to lower its prices, since the insurer's only threat is to take its business to the other hospital in the same system. A paper modeling the effects of component contracting supports this reasoning.²⁸ It determines that component contracting results in the same or slightly higher prices than those negotiated by the single entity.²⁹

There may be additional drawbacks to component contracting. It increases administrative costs, because providers must maintain firewalls between teams, and because both providers and insurers must execute a greater number of contracts.³⁰ Component contracting requires state monitoring and regulation to ensure compliance. Finally, component contracting addresses the lack of competition among providers that, but for the merger or acquisition, would have been competitors. If all facilities within that health system were independent, however, it does not necessarily follow that they would compete for the same business. Health systems are typically comprised of diverse groups of providers that provide specific services to specific regions; only some of these markets overlap. It would be inefficient to require these facilities to contract separately. In this case, component contracting would also not lower prices, since each facility would retain its unique monopoly over a particular market.

There is only one real-world example of component contracting, and it did not lower prices. In the early 2000s, the FTC began to review previously-approved hospital mergers, to examine their effects on prices. In 2004, the FTC filed a complaint against Evanston Northwestern Healthcare alleging that the health system's acquisition of rival Highland Park Hospital enabled it to raise its prices.³¹ In 2007, the FTC ruled that the merger was anti-competitive.³² At that point, however, the

testimony to Judge Sanders analyzed the related issue of component contracting, including the requirement for separate negotiating teams.

²⁷ See below for an analysis of the efficacy of the FTC's *Evanston Northwest Healthcare Corporation* decision, which ordered component contracting.

²⁸ Gowrisankaran, "Prices Are Negotiated," supra note 21.

²⁹ Majette, "Contracting & Market Forces," supra note 2; Gowrisankaran, "Prices Are Negotiated," supra note 21; Dafny, Letter from Economists, supra note 21; Chipty, *Expert Testimony*, supra note 21.

³⁰ Commission members (statements to the Special Commission on Provider Price Variation, Boston, MA, Nov. 29, 2016).

³¹ *Evanston Northwest Healthcare Corp.*, Docket No. 9315 (Fed'l Trade Comm'n Feb. 10, 2004) (complaint).

³² *In re Evanston Northwest Healthcare Corp.*, Docket No. 9315 (Fed'l Trade Comm'n Aug. 6, 2007) (opinion).

hospitals had been integrated for several years and had created joint service lines and training programs. The standard antitrust remedy to a merger or acquisition is to block the consolidation. Where a consolidation has already taken place, antitrust agencies typically favor a structural remedy – breaking apart or divesting the entities.³³ In this case, however, the FTC was concerned that breaking apart the hospitals would negatively affect patient care. Instead, it imposed a component contracting remedy. The health system was allowed to remain as is, but the hospitals were required to contract separately for ten years.

The effects of the remedy have not lived up to expectations. Notably, no insurer has chosen to contract separately, despite the theoretical pro-competitive benefits of doing so. Perhaps independent negotiations would have been administratively difficult, or perhaps insurers realized that the hospitals did not have a true incentive to bargain down their prices. In any case, component contracting did not lower prices, and the FTC has since distanced itself from this remedy.³⁴

Gwendolyn Majette, Associate Professor at the Cleveland-Marshall College of Law, briefed Commission members on component contracting and the Evanston case. The majority of members agreed that component contracting would not reduce provider price variation and could have negative unintended consequences. According to Lynn Nicholas, representing the Massachusetts Health & Hospital Association (MHA), the MHA workgroup decided that component contracting would inhibit the formation of ACOs, since it is not feasible for facilities within an integrated system to contract separately. Other provider representatives agreed that health systems often rearrange service lines among facilities. For example, a system might centralize cardiac care in one hospital. Component contracting does not work in this situation.

Payer representatives agreed that component contracting would probably not lower prices and could cause drastic and unintended consequences. For example, a provider system could evade the separate contracting requirement by restructuring its components. In addition, component contracting would create administrative complexity, which could be destabilizing to both payers and providers. Several Commission members, however, thought that there might be value in examining all-or-nothing clauses in insurer/provider contracts. Lora Pellegrini, representing the Massachusetts Association of Health Plans, pointed out that some ACOs are not truly clinically integrated. In that case, all-or-nothing contracting could be prohibited. Karen Tseng, representing the AGO, stated that prohibiting all-or-nothing clauses is simpler in principle than requiring component contracting, especially since these clauses are already prohibited in LTNP contracts. She agreed that coordination and clinical integration are important but do not necessarily justify all-or-nothing contracting.

³³ Ryan D. DeMotte and Andrea M. Ferrari, *Lessons from Evanston: FTC Orders Novel Remedy in Hospital Merger Case* (Delaware: K&L Gates, 2007).

³⁴ Gowrisankaran, “Prices Are Negotiated,” *supra* note 21; Dafny, Letter from Economists, *supra* note 21; Chipty, *Expert Testimony*, *supra* note 21; DeMotte, *Lessons from Evanston*, *supra* note 33.

One assumption underlying separate contracting is that when a lower-priced provider joins a higher-priced system, its rates increase. Ms. Nicholas stated this did not happen when some hospitals joined the higher-priced Beth Israel Deaconess system. The newly-acquired providers received referrals and access to specialists but not rate increases. She stated that conversations about market leverage generally assume that health systems negotiate as a unit and that rates increase as a result. Ms. Nicholas wondered if this was actually true. Payer representatives answered that health systems do not necessarily contract as a unit. There is no immediate and direct correlation between joining a provider system and automatically receiving higher rates, although rates may increase over time. According to one payer, however, system-wide contracting is the norm.

SECTION III: OUT-OF-NETWORK BILLING IN SUPPORT OF PROMOTING LIMITED/TIERED NETWORK PRODUCTS

Although the Commission was not enthusiastic about component contracting, there was interest in other policies to reduce price variation and increase provider competition. Many members felt that out-of-network billing practices warrant closer scrutiny. Out-of-network bills are charges that arise when a patient receives services from a provider outside of the patient's insurance network. These bills raise public policy concerns when the patient did not have prior knowledge that those services would be performed by an out-of-network provider.

This can occur in two situations. First, the patient may have been taken to an out-of-network emergency facility. In this case, the patient was unable to request, and it would have been medically inadvisable to transport the patient to, an in-network hospital. Second, healthcare professionals do not necessarily belong to the same networks as the facilities in which they work. This means that a patient may unknowingly receive care from an out-of-network doctor at an in-network facility. The resulting charge to the patient is known as a surprise bill.³⁵ In both cases, the out-of-network provider may, at his or her discretion, bill full charges, since there is no contractual relationship between the patient's insurer and the provider.

Massachusetts has several out-of-network billing protections. Health maintenance organizations and preferred provider organizations must pay out-of-network emergency facilities a "reasonable amount," which is less than full charges.³⁶ In addition, two health insurance laws protect consumers from surprise bills. First, when an insured patient visits an in-network facility, the patient is not responsible for out-of-network charges for services performed by an out-of-network provider, unless the patient had a "reasonable opportunity" to choose to have the service performed by an in-network provider.³⁷ Theoretically, this means that a patient is not

³⁵ Health Policy Commission, *Policy Brief on Out-of-Network Billing* (Boston, MA, 2015), <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-out-of-network.pdf>.

³⁶ MASS. GEN. LAWS ch. 176G, § 5(f) (2016); MASS. GEN. LAWS ch. 176I, § 3 (2016).

³⁷ MASS. GEN. LAWS ch. 176O, § 6 (2016).

responsible for a surprise bill unless he or she affirmatively consented to receive care from an out-of-network provider. Second, health plans must establish a phone number and website that allow consumers to request their estimated or maximum out-of-pocket costs for a proposed admission, procedure, or service. The patient cannot be required to pay more than the disclosed amounts for the covered healthcare benefits that were provided, absent unforeseen circumstances.³⁸

In addition, several Massachusetts laws address price transparency and consumer notice of out-of-network billing practices. In addition to binding out-of-pocket cost estimates for medical services, Evidence of Coverage documents must explain what out-of-network charges are and the circumstances in which a consumer may receive an out-of-network bill.³⁹ Prior to any admission, procedure, or service and upon request, providers must disclose allowed charges or the estimated maximum allowed charge. In addition, upon request the provider must provide the patient with sufficient information to obtain out-of-pocket cost estimates from the patient's health plan.⁴⁰ Finally, several laws allow consumers to obtain quality, price, and out-of-pocket cost information from providers, insurers, and a state website.⁴¹

“We agree that patients should be taken out of the middle and held harmless when there is a “surprise lack of coverage” resulting in balancing billing. There should be more transparency around the insurers’ network of providers so patients can make informed choices when they have the ability to predict medical needs.” – Massachusetts College of Emergency Physician, testimony to the Special Commission

Although these laws, on paper, provide consumers with information and protect them from unexpected bills, there are still several ways in which a consumer might end up paying an out-of-network bill. First, although insurers must pay out-of-network emergency facilities a “reasonable amount,” the law does not explicitly

prohibit these facilities from balance-billing the patient. Balance billing is the practice of sending a bill to the patient for the difference between the amount reimbursed by the insurer and the out-of-network charge.

Second, there is no streamlined or standardized way for a consumer to take advantage of existing protections. This means that a consumer may unknowingly pay an out-of-network bill for which the consumer is not responsible.⁴² In fact, the surprise billing protection does not explicitly prevent providers from sending

³⁸ § 23; *see also* MASS. GEN. LAWS ch. 32A, § 27 (2016).

³⁹ Ch. 176O, § 6.

⁴⁰ MASS. GEN. LAWS ch. 111, § 228 (2016).

⁴¹ For example, Chapter 224 requires providers to report quality measures to CHIA. CHIA must make quality information available to consumers on its website. Health insurance consumer protections require payers to make available provider quality information upon member enrollment or request. MASS. GEN. LAWS ch. 12C, § 20 (2016); Ch. 176O, § 7; Ch. 176O, § 9A.

⁴² Health Policy Commission, *Out-of-Network Billing*, *supra* note 35.

surprise bills. Rather, it is part of a health insurance consumer-protection law that specifies the content of Evidence of Coverage documents.⁴³ In addition, studies indicate that current protections may not provide adequate notice and price transparency. For example, a Health Care For All analysis determined that three insurers' websites were not consumer-friendly, and the Pioneer Institute concluded that many hospitals were unable to comply in a timely fashion with cost-disclosure requirements.⁴⁴

Finally, current laws do not establish a mechanism for resolving payment disputes between payers and providers. Although out-of-network billing is generally considered a consumer protection issue, there are implications for provider price variation. Insurers may decide to shield their members from out-of-network bills by paying some or all of the complete charge. This is known as holding the patient harmless. Certain providers, however, receive roughly the same amount of business whether they are in- or out-of-network. These providers include high-volume emergency facilities and in-demand hospital-based specialists. These providers may leverage this dynamic to receive higher rates, or in some cases, may decide not to contract at all.⁴⁵ In addition, insurers are only able to offer premium discounts on LTNPs because the providers participating in those products are lower-cost. It is difficult to develop, market, and realize savings from LTNPs if a smaller network results in a greater number of higher-cost out-of-network bills that are paid by the insurer or the patient.

Comprehensive out-of-network billing laws require a three-pronged approach. First, there must be a fair default rate for out-of-network services. Second, there must be consumer education, notice to patients, and provider price transparency, so that consumers only receive out-of-network bills when they affirmatively choose to visit an out-of-network provider. Third, where the health plan pays the provider the appropriate default rate, that provider must be prohibited from balance-billing the patient.

Commission members agreed that regulating out-of-network billing practices could protect patients, address increasing healthcare costs, and encourage innovative health plan designs such as refinements to LTNPs. Stuart Altman, appointed by Senate President Rosenberg, commented that this issue cuts across several areas of Commission discussion, including making markets work, transparency, and the role of government. There was some disagreement, however, regarding the breadth of the regulations. Several members cautioned against applying these protections too broadly: if a provider could leave the negotiation and still receive a high rate, this would negate the ability of insurers to create leverage. Ms. Nicholas suggested that

⁴³ Ch. 176O, § 6.

⁴⁴ Barbara Anthony and Scott Haller, *Mass Hospitals Weak on Price Transparency* (Boston, MA: Pioneer Institute, 2016); Health Care for All, *Consumer Cost Transparency Report Card* (Boston, MA, 2015). Note: The Pioneer studies collected information by cold-calling hospitals. The prices provided were hospital charges and not the negotiated reimbursement between the provider and the contracting plans. See Chapter 5 for more information on transparency.

⁴⁵ Health Policy Commission, *Out-of-Network Billing*, supra note 35.

the Commission focus on emergency facilities and ERAP (emergency, radiology, anesthesiology, pathology) hospital-based physicians. It is important to note that Ms. Pellegrini disagreed with the Commission's final recommendation, which could allow for a default rate of slightly above the provider's contracted rate (See Recommendations).

SECTION IV: MATERIAL CHANGE NOTICES & COST AND MARKET IMPACT REVIEWS

As previously noted, when a provider above a certain revenue threshold wishes to make a material change to its governance or operations, it must submit a MCN to the HPC. The HPC reviews data regarding the parties' performance and the parties' plans and stated goals for the material change to determine how and when the material change could impact health care spending and market functioning, including whether it could result in efficiencies and care delivery improvements. The HPC may then conduct a CMIR – a comprehensive analysis of the parties' business and relative market position as well as the impact of the transaction on health care costs, quality and access – for particular material changes anticipated to have a significant impact on healthcare costs or market functioning. Throughout the CMIR process, the HPC solicits data and documents from the parties and other market participants, including relevant payers. The HPC releases a preliminary report, gives the parties an opportunity to respond to the report, and then releases a final CMIR report.

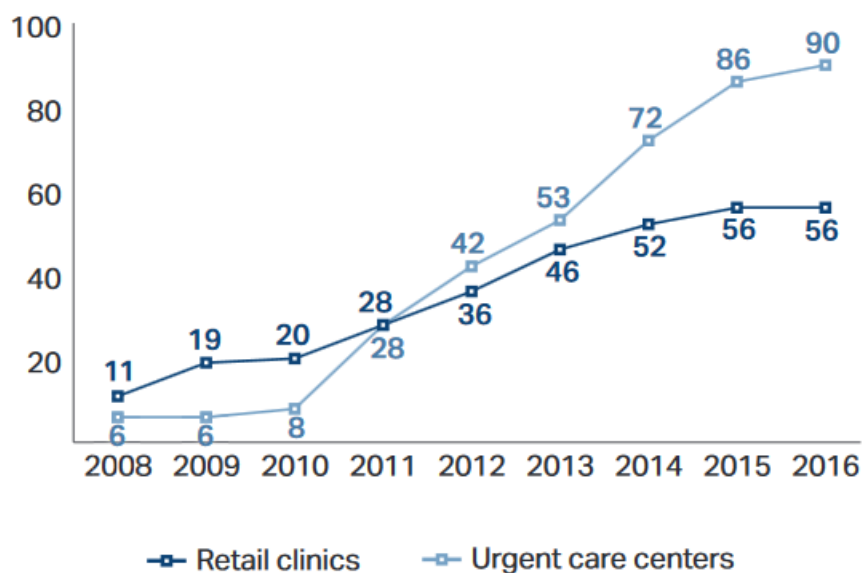
The HPC must refer the final report to the AGO where the provider has a dominant market share and significantly higher prices and total medical spending than other providers. The HPC may refer any other report at its discretion. The AGO may choose to investigate the provider for engaging in unfair methods of competition or anti-competitive behavior, and may file an action in court to temporarily or permanently halt the material change.⁴⁶ Therefore, the MCN/CMIR process operates as a pre-transaction review that gives the public and relevant parties an opportunity to assess the impacts of proposed transactions, encourage positive outcomes, and avert or minimize negative impacts on the market before they occur.

Several Commission members stated that the MCN/CMIR process is accomplishing its goals and that the HPC has been successful in its role. Speaking as Chairman of HPC's Board, Dr. Altman reminded Commission members that the HPC is not interested in conducting CMIRs for most material changes. The HPC focuses on changes that are likely to have a major impact on prices and competition. It issues a report to help stakeholder groups understand the possible effects of the material change, not to express an opinion for or against the change. The HPC's role is simply to make information available to the AGO, the Department of Public Health, and other agencies. Several members agreed that shining a light on these transactions is important.

⁴⁶ MASS. GEN. LAWS ch. 6D, § 13; 958 Mass. Code Regs 7 (2015); MASS. GEN. LAWS ch. 12, § 11N; MASS. GEN. LAWS ch. 93A, § 4.

Other members felt that the MCN/CMIR process could be modified or strengthened. Ms. Pellegrini suggested giving the HPC authority to reject proposed material changes if certain conditions could not be proven. Howard Grant, representing Lahey Health, suggested that the HPC scrutinize more closely the effect of physician employment transitions from lower- to higher-cost organizations, because the cumulative impact of these changes could raise healthcare costs significantly. Steve Walsh, representing the Massachusetts Council of Community Hospitals, suggested that the HPC could take on a strategic role. It could use the statewide health plan to direct resources to high-value community hospitals, maintaining access to services for patients and allowing them to receive care close to home. This would benefit the long-term health of community hospitals. Several Commission members also felt that certain “innovative” providers, such as limited-service clinics and urgent care centers, are expanding their market imprint and should help fund the HPC and CHIA (See Figure 3.2).

Figure 3.2: Retail Clinics and Urgent Care Centers in Massachusetts, 2008-2016⁴⁷



Sources: HPC analysis of data provided by CVS MinuteClinic (retail clinics) and HPC analysis of data from HIPPA Space.com (urgent care centers), 2016

SECTION V: ACQUISITIONS & MERGERS OF PHYSICIAN ORGANIZATIONS

The Evanston case challenged the merger of competitors. This so-called horizontal integration limits the number of providers offering the same service in a given area. This type of consolidation may increase a health system’s bargaining power, which

⁴⁷ Health Policy Commission, *2016 Cost Trends Report* (Boston, MA, February 2017), 31.

may lead to higher prices. Another concern raised by the AGO and other stakeholders is vertical integration, which occurs when hospitals/hospital systems and physicians/physician organizations enter into contractual, ownership, or employment relationships. These entities are not competitors, but they do provide complementary services. Vertical integration may increase a hospital or healthcare system's market clout in several ways. The hospital may be able to lock up a pool of referring physicians, either because an integrated clinical care arrangement naturally facilitates this patient flow or because physicians agree to refer patients to that hospital. Vertical integration also enables all-or-nothing contracting between the hospital/physician group and the health plan. Finally, vertical integration can bolster a health system's brand name, making it harder for an insurer to exclude that health system from its network.⁴⁸ In recent years, there has been an increase in vertical integration in Massachusetts, and some stakeholders are concerned that the state does not adequately monitor or regulate these arrangements.⁴⁹

Commission members discussed two reasons why vertical integration may lead to higher prices. First, a hospital or health system might make the strategic decision to employ an in-demand physician. In order to lure the physician away from competitors, the hospital would have to offer higher rates than the physician would otherwise receive. Rates are not the only thing, however, that may make joining a hospital system appealing to physicians. Hospitals can make health information technology investments, reduce revenue uncertainty, and provide access to cutting edge technology. Although this practice often increases payments to physicians, it does not increase total spending or the rates paid by insurers and consumers. Rather, employing physicians is an internal business decision that hospitals make for a number of reasons. For example, the organization may seek to better integrate care or standardize best practices.

Members agreed that the Commission should not focus on hospital payments to physicians, which reflect strategic choices made by the hospital. Ms. Nicholas noted, however, that there could be a more standardized approach to reporting information about physician cost and payments to the state. This would enhance our understanding about the effect of physician payments, referral patterns, and prices, contributing to a more complete picture of hospital financial performance. The HPC or CHIA could also make this information transparent to stakeholders and consumers. Kate Walsh, representing Boston Medical Center (BMC), emphasized that although transparency is important, health systems must have the autonomy to

⁴⁸ Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA, 2013), available at <http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf>; Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending," *Health Affairs* 33 (2014): 759-763, available at <http://content.healthaffairs.org/content/33/5/756.full.pdf+html>; Robert Kocher and Nikhil Sahni, "Hospitals' Race to Employ Physicians – The Logic Behind a Money-Losing Proposition," *New England Journal of Medicine* 364 (2011): 1790-1793, available at <http://www.nejm.org/doi/full/10.1056/NEJMp1101959#t=article>.

⁴⁹ Office of the Attorney General, *Cost Trends*, supra note 48. The FTC addresses the impact of vertical integration in its guidance on the formation of ACOs. See 76 Fed. Reg. 67026.

make internal business decisions. As an example, she discussed BMC's labor floor costs. BMC pays \$1 million more than similar organizations each year to cover the labor floor. Staff include midwives, obstetricians, obstetrical trainees, maternal-fetal medical specialists, family medicine residents, and attending physicians. BMC staffs the labor floor this way because it views training family physicians as an obligation to the community.

There is another way, however, in which vertical integration may lead to higher prices. As discussed above, a hospital or health system may acquire or employ physicians as a way to increase its bargaining leverage with insurers. Several members stated that the Commission should examine this cause of price variation, since greater health system bargaining power ultimately leads to higher hospital and physician rates. Furthermore, a hospital that wishes to compete with a dominant provider for physicians must match the higher rates that the dominant provider offers. If that hospital has less market leverage, and thus receives relatively lower rates from insurers, it could be forced to take money out of its coffers. This puts the lower-priced hospital at an even greater competitive disadvantage.

Provider representatives, however, stated that a hospital does not automatically increase its bargaining power with insurers when it employs or acquires physicians. Several members noted that many types of hospitals are acquiring and employing physicians, because physicians are eager to enter into these arrangements. There are many reasons for this shift, including reduced administrative burdens, access to state of the art technology, and increased operational efficiencies. One member noted that this trend is the reality of today's healthcare market and does not just benefit dominant health systems.

Commission members briefly discussed another area of concern, facility fees. If a hospital acquires a physician practice or outpatient clinic, it may be able to charge a facility fee – a separate bill for the facility, on top of the bill for physician services. Dr. Altman explained that facility fees were established in the early 1980's, when the DRG payment system was created. Hospitals argued that they provided services to more complex patients, and that they needed to charge facility fees to make up the cost difference. According to Dr. Altman, there is some truth to this argument. Medicare did not anticipate, however, that the healthcare outpatient delivery system would change drastically. Today institutions linked to hospitals provide a greater volume of basic care, meaning that facility fees apply to a greater number of cases. These patients are not necessarily more complex or costly than those treated in independent practices. Facility fees, which generate billions of dollars in annual revenue, affect commercial rates as well because hospitals that bill Medicare this way must do so for all commercial insurers.⁵⁰ Despite its effect on healthcare costs,

⁵⁰ Sandra G. Boodman, "Facility fees' are Surprise Cost for Many Patients," *Kaiser Health News*, October 6, 2009, <http://khn.org/news/fees>; Kelly Gooch, "6 Things to Know About Facility Fees," *Becker's Hospital Review*, March 22, 2016, <http://www.beckershospitalreview.com/finance/6-things-to-know-about-facility-fees.html>.

however, most Commissioners decided that issue was too off-topic, given the Commission's charge.

Most Commission members felt that exploring the nuances of hospital affiliations with physician organizations and other forms of vertical integration should not be a Commission priority. Members expressed strong support, however, for increased transparency and reporting of prices that result from these transactions.

CHAPTER 4 – DEMAND-SIDE INCENTIVES IN HEALTHCARE

INTRODUCTION

Demand-side incentives are strategies or mechanisms to encourage consumers, employers, and employees to make high-value choices. For consumers, this can reduce out-of-pocket costs and lower premiums. Demand-side incentives can also reduce overall system spending, which is beneficial for all stakeholders. In addition, these incentives can reduce unwarranted price variation. If enough consumers visit high-quality, low-cost providers, this can incentivize higher-priced providers to reduce their prices to capture greater patient volume.

The Special Commission discussed how to leverage demand-side incentives to reduce price variation. Section I outlines the circumstances in which demand-side incentives can be used. It also summarizes pre-requisites for and the limitations of demand-side incentives. Section II considers the role of health insurance market structures. Section III examines how plan design can promote high-value choices. Section IV discusses how shopping tools can incentivize the use of lower-cost providers and services.

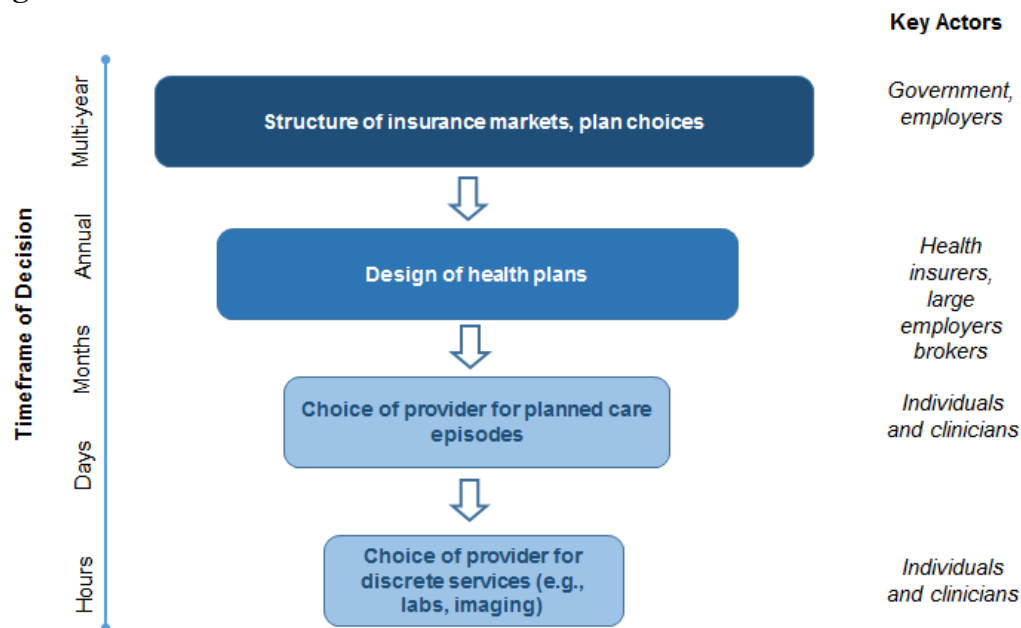
SECTION I: DEMAND-SIDE INCENTIVES IN HEALTHCARE

David Auerbach, Director of Research and Cost Trends at the Massachusetts Health Policy Commission (HPC), presented to the Commission on demand-side incentives. Dr. Auerbach explained that demand-side incentives have the potential to increase the use of efficient health plan designs, shift volume to higher-value providers, and reduce spending and prices through competition.¹ There are several points along the healthcare continuum in which demand-side incentives operate (See Figure 4.1). The highest level is through plan selection and the structure of insurance markets. Here large employers and government actors can take steps to offer and incentivize the uptake of high-value plans. For example, the Group Insurance Commission (GIC) offered all members a three-month “premium holiday” if they enrolled in a limited-network plan.² At the next level, health insurers can design and market high-value plans, which affect choices made by providers and consumers. Finally, patients and clinicians can identify and choose high-value providers for planned episodes of care and discrete services.

¹ David Auerbach, “Demand-Side Incentives to Address Provider Price Variation” (presentation to the Special Commission on Provider Price Variation, Boston, MA, Dec. 13, 2016).

² Auerbach, “Demand-Side Incentives,” *supra* note 1.

Figure 4.1: Demand-Side Incentives in Healthcare



As this chapter discusses, at each of these levels there are barriers and disincentives to choosing high-value providers. For this reason, the Special Commission agreed that demand-side incentives alone will not solve the problem of unwarranted provider price variation. Nonetheless, in a variety of circumstances demand-side incentives can lower costs and shift patient volume to high-value providers.³ Commission members agreed that influencing consumer demand is a key component of making markets work.

SECTION II: STRUCTURE OF HEALTHCARE MARKETS

At the highest level, government agencies and employers can promote high-value choices when they select which plan designs and benefits to make available to consumers. This can influence uptake of products that are cost-effective and reward choice of high-value providers. For example, health insurance exchanges can foster competition among payers seeking to offer the most attractive plans to consumers and small businesses. Exchanges can facilitate competition in a number of ways, with the goal of steering shoppers to plans that reward high-value providers.⁴

The Massachusetts state exchange is the Commonwealth Health Insurance Connector Authority (Connector). For consumers eligible for state subsidies, the Connector pays a fixed amount, regardless of plan choice. Consumers that choose higher-cost plans pay larger premiums, which may shift preferences to lower-cost

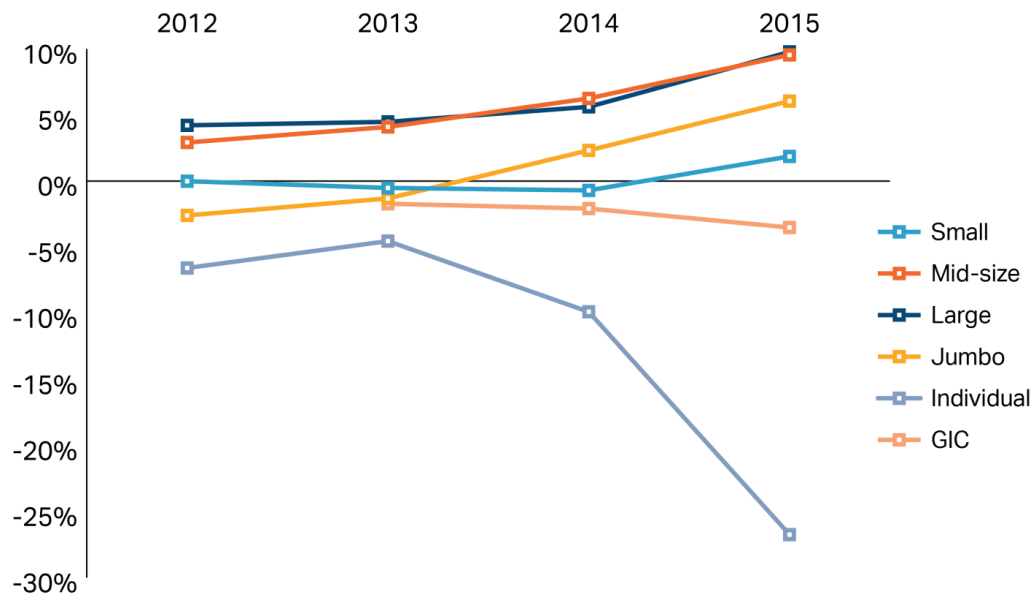
³ Id.

⁴ As a prerequisite, there must be a sufficient number of participating insurers. Studies show that when competition among carriers decreases, insurance premiums increase. Leemore Dafny, *Evaluating the Impact of Health Insurance Consolidation: Learning From Experience* (New York, NY: Commonwealth Fund, 2015).

products. The Connector is also an active purchaser. It limits the number of plans to five per region, requiring carriers to compete on price. Active purchasing incentivizes carriers to offer low-premium products, including limited- and tiered-network plans (LTNPs).⁵ Finally, the Connector facilitates lower-priced offerings by standardizing coverage documents, which allows consumers to easily compare plans.

Large employers, such as the GIC, are in the best position to reproduce these conditions and facilitate the adoption of high-value plans, because they purchase insurance for a large number of consumers.⁶ The pro-competitive features of the Connector and the GIC contribute to lower premiums in those markets, compared to other segments of the commercial insurance market (See Figure 4.2).

Figure 4.2: Premiums by Group Size Relative to 2012 Small-Group Premiums, 2012-2015⁷



Smaller employers are not as capable of replicating these competitive conditions. 69% of small Massachusetts businesses (50 or fewer employees)⁸ and 40% of mid-size businesses (50-99 employees) offer only one choice of plan (See Figure 4.3).⁹ In response to an HPC survey, small- and mid-sized businesses stated they do not have enough employees and/or they find it too complicated to offer multiple plans.¹⁰ These businesses are more likely to offer a broad-network plan to accommodate the

⁵ Auerbach, “Demand-Side Incentives,” *supra* note 1.

⁶ The Group Insurance Commission provides health insurance options for all state employees as well as a number of municipalities that have chosen to participate.

⁷ *Id.* Note that the individual coverage line represents both subsidized and unsubsidized coverage.

⁸ Health Policy Commission, *2016 Cost Trends Report* (Boston, MA, February 2017), 69.

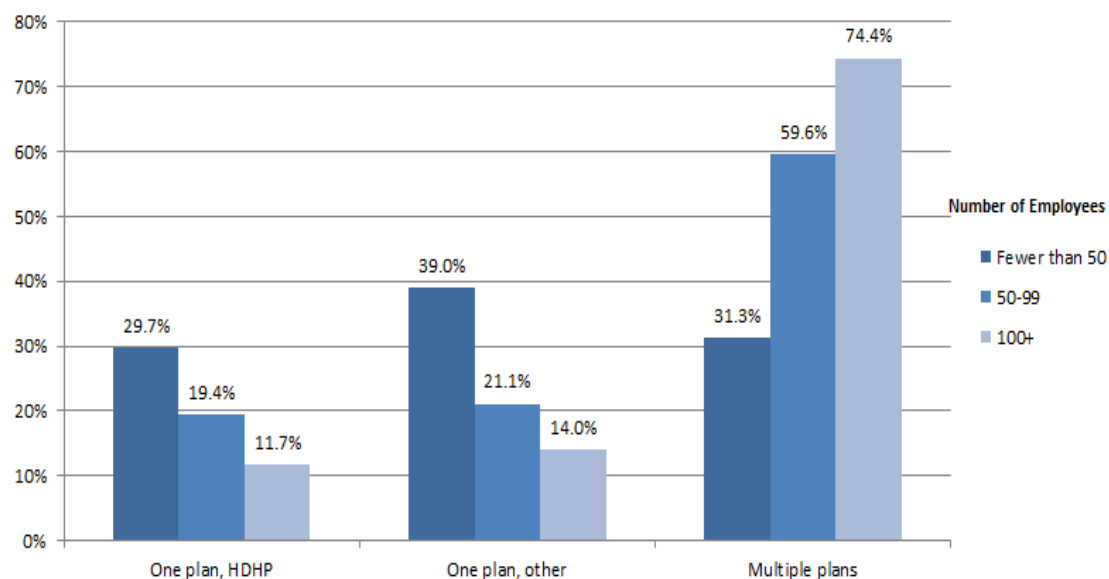
⁹ *Id.*

¹⁰ *Id.*

health needs of all employees.¹¹ Furthermore, many eligible businesses do not take advantage of the Connector to purchase insurance for their employees. A recent report by the Associated Industries of Massachusetts (AIM) found that less than 1% of businesses use the Connector. 90% of employers have either “not considered using the Massachusetts Connector” or are “not really sure what the Massachusetts Connector is.”¹²

Even when employers offer more than one plan, few offer products like LTNPs that reward high-value providers. Approximately 8% of the non-GIC commercial market¹³ is in a tiered-network plan, and commercial enrollment in limited-network plans is approximately 3%.¹⁴ These factors collectively point to the need for a significant amount of education and outreach to smaller employers by the state, brokers, and other actors.

Figure 4.3: Employer Size and Plan Options, 2014¹⁵



Several times members discussed how small business health insurance purchasing cooperatives (co-ops) could reproduce the pro-competitive features of the large-group and self-insured markets. Under this model, small businesses (those with up to

¹¹ For example, a business owner needing to provide LGBTQ-related services many only have one choice of plan, as many LGBTQ health services are only provided by out-of-state or non-network providers.

¹² Associated Industries of Massachusetts, *Trends and Practices Among Massachusetts Employers: 2016 Report* (Boston, MA: 2016).

¹³ Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA, June 30, 2015).

¹⁴ Center for Health Information and Analysis, *Massachusetts Tiered Network Membership* (Boston, MA 2016).

¹⁵ Health Policy Commission, *2016 Cost Trends Report*, supra note 7, at 69.

50 and in some cases 100 employees) join together to form a larger purchasing pool. This allows co-ops to negotiate with insurers for lower premium rates and broader benefit packages. A number of states established co-ops in the mid-1990s. By 2009, 28 states operated some version of a co-op.¹⁶ Massachusetts administers the Group Purchasing Cooperative (GPC) program, under which groups of eligible small businesses can seek approval from the Division of Insurance (DOI) to form purchasing associations.¹⁷ Up to six GPCs can operate at a time;¹⁸ since 2010, the DOI has certified five.¹⁹ The Transparency Subcommittee recommended that the Commonwealth explore opportunities to improve the purchasing power of smaller businesses (See Recommendations).

SECTION III: HEALTH PLAN DESIGNS THAT REWARD HIGH-VALUE PROVIDERS

LTNPs have the potential to steer consumers to high-value providers in different ways. In contrast to Preferred Provider Organizations (PPOs), limited-network plans (LNPs) include a narrow set of high-value providers. In most circumstances, consumers must pay out-of-network rates when they visit providers outside this network. Tiered-network plans (TNPs), on the other hand, may be as broad as PPOs. They steer consumers to lower-cost/higher-quality providers by placing providers in different cost-sharing “tiers.” Higher-cost/lower-quality providers are placed in less favorable tiers, according to the carrier’s tiering methodology. In most circumstances consumers pay greater co-pays or coinsurance amounts to visit these providers. Some plans, such as the plan offered by Polar Beverages, also require higher deductibles for services provided at unfavorably-tiered hospitals. (See Feature: Polar Beverages Tiered Health Plans). Most products have two or three tiers. Both LNPs and TNPs are designed to have lower premiums.²⁰ Together these plans make up approximately 20% of the commercial market (See Figure 4.4).

¹⁶ “Health Insurance Purchasing Cooperatives: State and Federal Roles,” National Conference of State Legislatures, accessed February 6, 2017, <http://www.ncsl.org/research/health/purchasing-coops-and-alliances-for-health.aspx>.

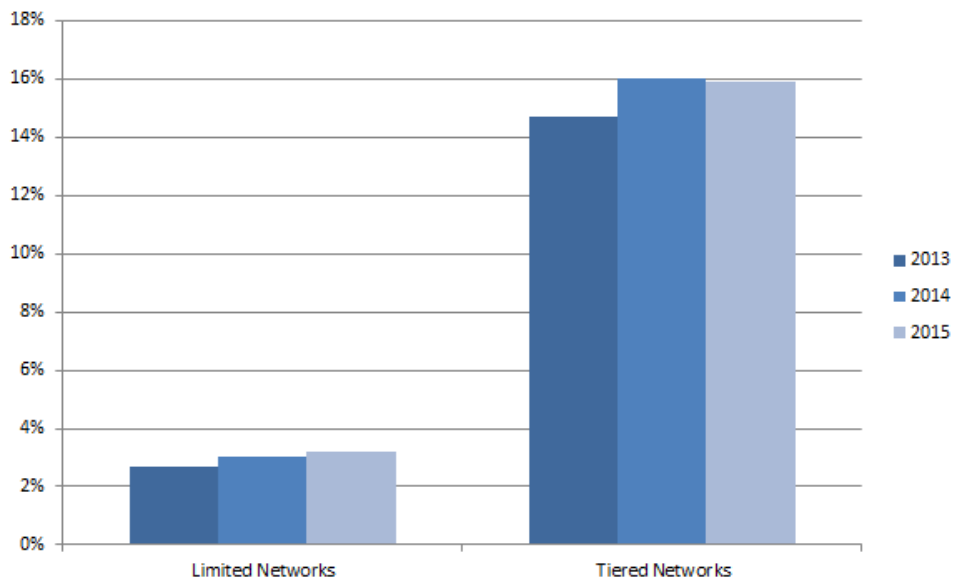
¹⁷ MASS. GEN. LAWS ch. 176J, §12 (2016).

¹⁸ Id. at (b). Note: The Affordable Care Act places limitations on acceptable rating factors, prohibiting state-specific rating factors. The state’s Group Purchasing Cooperative rating factor will be phased out entirely on January 1, 2018. See Kevin Connihan, Letter to Louis Gutierrez (Washington, D.C., June 16, 2015).

¹⁹ These GPCs are the Associated Subcontractors of Massachusetts, Massachusetts Association of Chamber of Commerce Executives, Massachusetts Society of Certified Public Accountants, Retailers Association of Massachusetts, and Spring Healthcare Cooperative. Massachusetts Division of Insurance, *Certified Group Purchasing Cooperatives* (Boston, MA, April 30, 2015), available at <http://www.mass.gov/ocabr/docs/doi/2012-group-purchasing-coop.pdf>.

²⁰ Massachusetts carriers that serve more than 5,000 members must offer an LTNP with a base premium at least 14% lower than the base premium for the carrier’s most actuarially-similar non-LTNP plan. MASS. GEN. LAWS ch. 176J, §11.

Figure 4.4: Commercial Enrollment in Limited and Tiered Network Plans, 2013-2015²¹



It is unclear how many additional consumers would select an LTNP if their employer offered one. Dr. Auerbach and Commission members, however, noted a number of barriers to the uptake of LTNPs. Consumers prefer and are used to a wide choice of providers. Karen Tseng, representing the Office of the Attorney General (AGO), explained that tiered plans without enough brand-name providers begin to look like LTNPs, which constrains their popularity. In addition, networks must be robust, so that patients have access to comprehensive and accessible coverage. Steven Walsh, representing the Massachusetts Council of Community Hospitals, noted that people who live in geographically-isolated areas or whose plans exclude higher-priced providers may have to seek out-of-network care or travel longer distances to access care. Consumers may also be concerned that switching to an LTNP could disrupt their care. Furthermore, Dr. Auerbach pointed out that consumers may view LTNPs as an insurance company scheme to make more money. This is especially true where consumers equate provider cost and quality.²² Finally, consumers may be wary of plans that require them to second-guess their physician’s decisions; for example, as to where the patient seeks specialist care. For these reasons, Commission members agreed that making LTNPs work requires additional consumer education. These plans can be difficult to explain to members, and patients need to understand their choices both at the point of enrollment and the point of service.

²¹ Auerbach, “Demand-Side Incentives,” supra note 1.

²² Health Policy Commission, *Community Hospitals at a Crossroads: Findings from an Examination of the Massachusetts Health Care System* (Boston, MA, March 2016), 40.

In some cases, LTNP may not even have lower premiums. In that case, the consumer has little incentive to purchase the product. The AIM report found that on average, surveyed employees contribute the same or a greater premium amount to a TNP as they do to a PPO plan.²³ Payer representatives have explained a number of reasons why LTNP premiums are not always significantly lower; for example, limitations to risk adjustment methodologies. Premium subsidies, although an important way to make plans affordable, also blunt the effect of premium differentials.

Polar Beverages Tiered Health Plan

Five years ago, Polar Beverages, a self-insured employer based in Massachusetts, switched its Massachusetts employees to a tiered health plan. The plan has three tiers – Enhanced, Standard, and Basic. The Enhanced tier contains the highest-quality, lowest-cost providers. Employees that visit these providers have little or no cost-sharing. Employees are still free to visit any covered provider, but they must pay higher deductibles and higher cost-sharing amounts to visit non-Enhanced providers.

Steve Carey, the Vice President of Human Resources for Polar Beverages, represents large employers on the Special Commission on Provider Price Variation. He explained that for Polar, the most important and challenging aspect of moving to a tiered-network plan was employee education. Polar undertook an extensive education process, including mandatory annual meetings with all employees. It created a patient portal, on which employees can look up pricing and quality information. Polar also established a healthcare concierge service to help employees with questions about hospitals and specialists, costs of services, and other matters. When the concierge service began, it was provided through an outreach program run by St. Vincent's Hospital. Later, Polar brought a dedicated concierge professional in-house. Mr. Carey and two of his colleagues also keep themselves available to answer employee questions.

More than 90% of Polar employees receive services from providers in the Enhanced tier. The majority of employees are satisfied with the plan, and premiums have increased at a lower rate since Polar began offering this plan. Mr. Carey explained that without extensive education, however, the plan would not have been as successful in keeping down premium costs.

Despite these limitations, the right set of incentives can increase LTNP uptake, produce savings, and potentially reduce price variation. For example, as noted above, in 2012 the GIC offered its members no premiums for three months if they switched to an LNP. 10% of its membership switched plans, resulting in 36% lower spending per person compared to the broad-network plan. LNPs produced savings because of decreased use of high-cost providers and hospital and specialist care, with no reduction in quality or member health. Both healthier and sicker members reduced spending. In addition, although a greater number of healthier members joined an LNP, the differential was not large enough to separate the risk pools. Spending on primary care did increase, but the spending was more than offset by the decrease in specialist visits. Overall, GIC spending fell by 4.2%. Although some consumers were

²³ Associated Industries of Massachusetts, *Trends and Practices*, supra note 11, at 16.

confused or dissatisfied with their plans,²⁴ the majority of people who switched plans remained in LNPs in subsequent years.²⁵

As Figure 4.4 indicates, consumers tend to prefer TNPs, because they are less restrictive than LNPs. TNPs have been shown to change patient preferences and indirectly reduce price variation. A study in the *American Journal of Managed Care* found that when selecting a new provider, certain populations tend to choose favorably-tiered providers. This changed the marketplace – physicians in the worst tier experienced a 10-15% decrease in market share.²⁶ Another study examined a Blue Cross Blue Shield Massachusetts hospital TNP that has large cost-sharing differentials among tiers. For example, the co-pay at preferred hospitals is \$150, compared to \$1,000 at non-preferred hospitals. Based on claims data, the authors concluded that if all members switched to a TNP, scheduled admissions to non-preferred hospitals would drop 7.6%, and admissions to middle and preferred hospital would increase by .9% and 6.6%, respectively.²⁷ In addition, there is anecdotal evidence that some providers reduce their prices so that they can be placed in a preferred tier.²⁸

Although TNPs encourage the use of high-value providers, in certain circumstances they do not change patient choices. Several Commission members noted that cost-sharing differences among tiers become less relevant once the consumer reaches his or her deductible. Cost-sharing differences become irrelevant once the consumer reaches the out-of-pocket maximum. Ms. Tseng explained that 75% of medical spending is by people who exceed the out-of-pocket maximum on an annual basis. Out-of-pocket maximums should not be removed – they are important consumer protections. They must be paired, however, with additional incentives.²⁹

Furthermore, Dr. Auerbach explained that consumers often prioritize perceived provider value over cost. Consumers may choose a brand-name provider, even if unfavorably tiered, if they equate cost with quality. Similarly, in a stressful situation, patients may become indifferent to out-of-pocket costs and choose a provider without regard to tier. As noted above, consumers may also associate cost and quality. Provider representatives noted that this is a major reason why they are frustrated by perceived lack of transparency in tiered products. The primary factors that determine tier placement are cost and quality so when high-quality providers are

²⁴ In the Commission meeting, Ms. Pellegrini noted that the GIC needed to create a separate re-enrollment period for a small number of members who were unhappy with their LNP.

²⁵ Jonathan Gruber and Robin McKnight, “Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees” (Cambridge, MA: National Bureau of Economic Research, September 2014); Auerbach, “Demand-Side Incentives,” *supra* note 1.

²⁶ Anna Sinaiko, “Variations in Response to Tiered Physician Networks,” *American Journal of Managed Care* 22 (2016): 420-425.

²⁷ Matthew B. Frank, et. al., “The Impact of a Tiered Network on Hospital Choice,” *Health Services Research* 5 (Oct. 2015):1628-48.

²⁸ Dolores Mitchell, testimony to the Health Policy Commission, 2015; statement by Lora Pellegrini to Special Commission members.

²⁹ For example consumers could receive a cash rebate for choosing a high-value provider. See Section IV.

placed in an unfavorable tier, consumers may view them as low-quality. Improved transparency would help consumers understand what they are purchasing when they choose a physician or hospital.

The Commission discussed ways to increase uptake of TNPs by changing the provider “opt-out” provision, increasing the cost differentials among tiers, and improving transparency in health plans’ tiering methodology. Lora Pellegrini, representing the Massachusetts Association of Health Plans, emphasized that the opt-out provision, which allows providers that otherwise contract with a payer to opt-out of participating in a TNP,³⁰ is a significant barrier to creating robust TNPs. She said that providers should be required to participate in TNPs if they participate in broader-network plans. Deborah Devaux, representing Blue Cross Blue Shield of Massachusetts, added that at the very least, providers that opt out of TNPs should be required to participate when delivering emergency services. Lynn Nicholas, representing the Massachusetts Health & Hospital Association (MHA), disagreed. She stated that the MHA believes that the opt-out provision should remain in place, and that providers should not be required to participate in a given tiered product. She added, however, that the MHA work group discussed how greater differentials among tiers could really affect patient decision-making. David Torchiana, representing Partners Healthcare, added that TNP innovations require a consistent tiering methodology among carriers.

Some members noted that it is difficult to create TNPs in regions with few hospitals or consolidated health systems. For example, Steven Carey, representing Polar Beverages, said that Baystate Medical Center acquired several favorably-tiered hospitals and then raised those hospitals’ rates. This pushed the hospitals out of the most-favorable tiers. As a result, his employees have fewer lower-cost options. In addition, employees that had been receiving care at the smaller hospitals found themselves facing higher out-of-pocket costs. Mr. Walsh added that tiering cannot move the market if price variation causes lower-cost providers go out of business. Mark Goldstein, representing Anna Jaques Hospital, pointed out that some community hospitals are so under-reimbursed that they lose money with each patient. In this case, additional patient volume hurts, not helps. He expressed concern that tiering does not directly impact price disparities for these hospitals.

The Market Forces Subcommittee presented two recommendations to the Commission on health plan tiering and methodology. First, health plans should develop a uniform method for displaying a hospital’s assigned benefit tier. Information on how the hospital performed on cost and quality benchmarks should be presented in a consumer-friendly format for both providers and patients. Second, upon request, health plans should provide the methodology used for a hospital’s tier placement, including criteria, measures, and data sources. Health plans should also provide the hospital-specific information used to determine the hospital’s quality score, how the hospital’s performance compares to other hospitals, and the data used in calculating the hospital’s cost-efficiency (See Recommendations).

³⁰ MASS. GEN. LAWS ch. 176O, § 9A (2016).

Ms. Devaux noted an additional and major barrier to LTNP uptake: out-of-network providers can bill full charges, even when the patient has no choice of provider. As explained in Chapter 3, patients in emergency situations do not choose which emergency room to visit. Patients may also receive care from a non-contracted provider in a contracted facility. Ms. Devaux explained that after factoring in just the costs of out-of-network emergency care, LTNPs do not realize a significant portion of their potential cost savings. She recommended setting a rate for out-of-network services when they are provided to patients that do not have a choice of provider.

New Tiering Policy at the Group Insurance Commission

The Group Insurance Commission (GIC) is enhancing its tiering program for two large products (Tufts Navigator and Harvard Pilgrim Independence). Tiering will be based on provider group value instead of individual performance and is being extended to include primary care physicians, in addition to specialists and hospitals. Since primary care physicians are usually the source of downstream referrals to specialists and hospitals, the GIC expects this approach to be more effective in steering members to higher value practitioners across the care spectrum. Members will pay lower copays for providers and facilities in lower tiers. For example, patients may select a primary care provider and pay \$10, \$20, or \$40 for Tier 1, 2, or 3 respectively. A patient can be referred to a specialist in the same tier or a different tier. Co-pays for specialists are \$30, \$60, and \$90.

The Commission also discussed an innovative health plan design proposed by the AGO. Under this plan, the consumer would choose a primary care provider (PCP) at the point of enrollment. The consumer's premium would reflect the efficiency of the health system with which the PCP is aligned. The assumption is that through referrals and recommendations, the PCP, where appropriate, would keep the patient's care within that higher-quality, lower-cost facility.³¹ Ms. Tseng explained that this product could shift patient volume to high-value systems and keep appropriate care in the community. These products are also fairer to consumers, because patient premiums directly reflect the efficiency of the providers they choose. In addition, these products are in harmony with payment reforms that require provider systems to take on risk and coordinate care within the system.

Ms. Tseng stressed that this idea is at the concept level and would be part of a menu of options to lower costs. There are important questions that still need to be answered, such as how to avoid adverse risk selection and how to price premiums in relation to broader-network plan. In addition, there must be effective actuarial modeling to anticipate spending based on PCP choice. Payer representatives stated that this type of plan might be worthwhile, but success would hinge on provider participation. One payer cautioned that given the uncertainty around the future of the Affordable Care Act, developing these products will probably not be a priority in the near future. Howard Grant, representing Lahey Health, stated that he was

³¹ For more information, see Office of the Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Boston, MA, Oct. 13, 2016).

impressed with this idea, because it encourages both physicians and consumers to make value-based decisions. Currently there are few financial implications for physicians that join or contract with high-cost networks. Ms. Nicholas stated that she discussed this idea with the MHA work group. Although the group had some concerns about the details of implementation, it was interested in exploring a pilot program. Finally, several Commission members noted that the success of this product depends on employer buy-in.

SECTION IV: SHOPPING FOR HEALTHCARE SERVICES

In recent years there has been a movement both nationally and in Massachusetts to make price and quality information available to consumers so they can shop for services. As healthcare costs continue to rise, patients are being asked to pay a greater share of costs and be more active decision-makers. Increased access to price and quality information can help patients choose high-value, low-cost providers, leading to lower out-of-pocket costs. Shopping based on value can also reduce price variation by encouraging providers to compete on price and quality.³²

“Consumers must be able to translate cost and quality transparency data into healthcare decisions. This means explicitly showing consumers their options, and supplying decision aids to teach how to navigate through data, and how to use cost and quality information to reach an informed decision about treatment.” – Health Care For All, testimony to the Special Commission

Although consumer shopping can lower costs and reduce price variation for certain services, it has limitations. Only certain healthcare services or procedures are “shoppable.” A healthcare service is shoppable if it can be planned in advance and is

offered by more than one provider. In addition, sufficient information on quality and price must be available.³³ The information must be combined with easy-to-use shopping tools, and there must be immediate and significant savings.³⁴ Furthermore, as the market moves towards models like ACOs and as healthcare systems take on more risk, shopping could negatively impact care coordination. In addition, quality measures may confuse patients. Patients may be confronted with too many, too few,

³² Health Care Cost Institute, *Spending on Shoppable Services in Health Care*, (Washington, D.C., Mar. 2016).

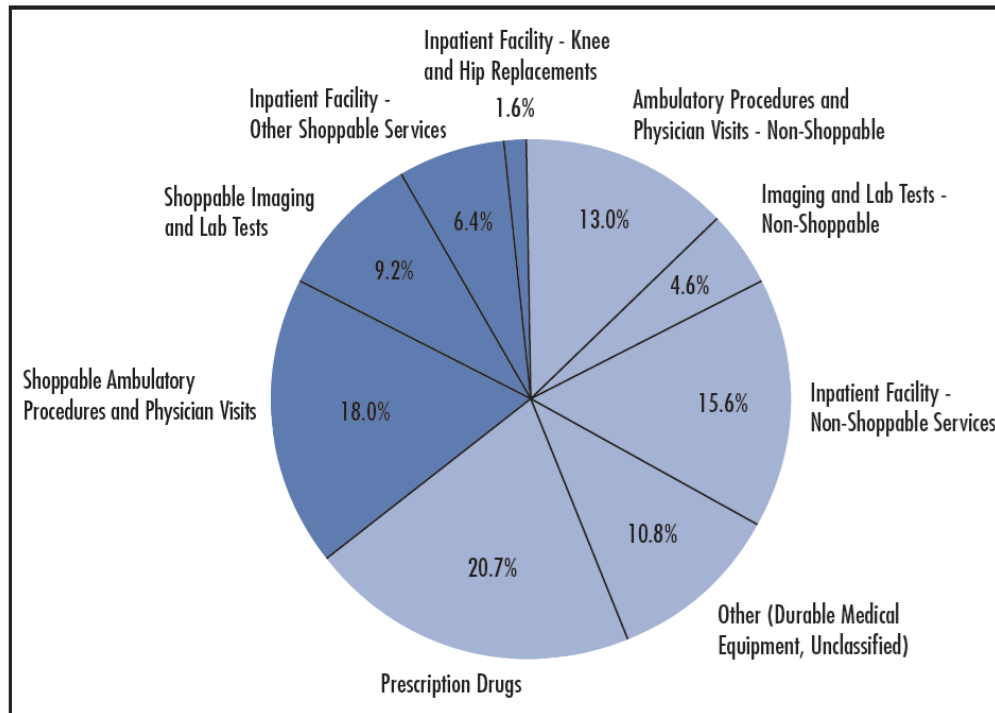
³³ Id.; Auerbach, “Demand-Side Incentives,” *supra* note 1.

³⁴ Jon Gabel et al., *Price Transparency Tool Attracts Users But Does Not Lead to Use of Lower-Priced Services* (NJ: Robert Wood Johnson Foundation, September 2016); Judith Hibbard, et. al., “An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care,” *Health Affairs*, 31 (2012) 560-568; Auerbach, “Demand-Side Incentives,” *supra* note 1.

or the wrong measures.³⁵ Finally, spending on shoppable services only accounts for a third of total spending, so there are limits to its potential to reduce total costs.³⁶

Figure 4.5 Shoppable Services in Healthcare³⁷

Figure 1
Shoppable Services Account for One-Third of Total Spending



Note: Shoppable services were identified in claims data based on the diagnosis-related group for inpatient facility stays or the Healthcare Common Procedure Coding System and Current Procedural Terminology codes for outpatient facility and professional services.

Source: Authors' calculations using 2011 claims data from nonelderly privately insured autoworkers and dependents

The Commission discussed cash-back programs, an example of a demand-side incentive used to promote consumer shopping. These programs provide cash rebates to consumers when they make high-value choices. Consumers use a website to search for services and view price information, quality scores, and even reviews from other patients. If the patient chooses a low-cost provider, the patient gets a refund check in the mail. Insurers typically use a vendor for these services, such as Vitals or Castlight.³⁸ There is some evidence that these programs promote competition in the

³⁵ David Newman and Amanda Frost, "Reimagining the Consumer Role in Improving Value," *Health Affairs Blog*, June 10, 2016, <http://healthaffairs.org/blog/2016/06/10/reimagining-the-consumer-role-in-improving-value>.

³⁶ Chapin White and Megan Eguchi, *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle* (Washington, D.C.: National Institute for Health Care Reform, 2014).

³⁷ Id.

³⁸ See, e.g., <https://www.vitalssmartshopper.com> and www.castlighthealth.com. See also Priyanka Dayal McCluskey, "Employers Reward Workers who Shop Around for Health Care," *Boston Globe*, (footnote continued)

market and result in savings.³⁹ Roberta Herman, representing the GIC, praised the concept of cash-back rebates. She informed Commission members that each GIC plan has some variation of a shopping program for a finite number of services. She noted, however, that its impact on costs is modest and it requires proactive outreach to encourage use.

Commission members agreed that consumers should be encouraged to shop for value and that shopping tools can reduce healthcare spending and encourage consumers to seek high-value care. Ms. Nicholas, however, noted, that although shopping tools produce short-term benefits, the MHA working group was concerned about longer-term implications. For example, cash-back rebates can encourage patients to seek care outside their network, which negatively impacts care coordination. Hospitals might also lose revenue from profitable service lines that cross-subsidize low- and no-margin services. This could hurt certain hospitals in the long run, especially those that are smaller and do not have brand power. This is mostly a concern, however, for ambulatory care services; shopping on the inpatient side could drive patients to lower-cost hospitals. John Fernandez, representing the Conference of Boston Teaching Hospitals, cautioned that these tools could be a “cherry picking mechanism,” driving healthy, insured, non-complex cases to surgery centers.

Commission members talked briefly about reference pricing, under which the insurer pays a fixed amount for a procedure (the reference price) and the patient pays all costs above that amount. In 2011, CalPERS⁴⁰ implemented a reference pricing program. The program sets a maximum contribution for knee and hip replacement surgeries, cataract removal surgeries, colonoscopies, and several other elective procedures. The program resulted in a shift in patient volume to designated facilities, as well as decreases in hospital prices.⁴¹ Stuart Altman, appointed by Senate President Rosenberg, commented that when California implemented CalPERS, prices for procedures at several institutions were above the reference price. The hospitals lowered their prices so attract patients. Just like cash-back programs, however, reference pricing only works for a limited number of services.

November 28, 2016, <https://www.bostonglobe.com/business/2016/11/27/employers-rewarding-workers-who-shop-around-for-health-care/JKkmu5BI7q6fNEgbZzyZmN/story.html>.

³⁹ Auerbach, “Demand-Side Incentives,” *supra* note 1; Ha Tu and Rebecca Gourevitch, *Moving Markets: Lessons from New Hampshire’s Price Transparency Experiment*, (Robert Wood Johnson Foundation and California Healthcare Foundation, April 2014); Paul Bennett, “Vitals Aims to be the Priceline of American Healthcare,” *Forbes*, July 23, 2015, <http://www.forbes.com/sites/teconomy/2015/07/09/vitals-aims-to-be-the-priceline-of-american-healthcare/#51fea2127674>.

⁴⁰ The California Public Employees’ Retirement System is the largest employer and healthcare purchaser in the state.

⁴¹ White, *Reference Pricing*, *supra* note 36; James Robinson and Timothy Brown, “Increases in Consumer Cost Sharing Redirect Patient Volume and Reduce Hospital Prices for Orthopedic Surgery,” *Health Affairs* 32 (2013): 1392-1397.

CHAPTER 5 – PRICE TRANSPARENCY

INTRODUCTION

Chapter 4 discusses demand-side incentives, or ways to encourage patients to make high-value choices. These mechanisms rely on the availability of meaningful information, such as the cost difference between visiting one provider over another, to guide decision-making. Which information is available and how it is shared with the target audience are key questions facing those that seek to use price transparency to reduce provider price variation. Solutions to these questions involve multiple actors – providers, payers, employers, patient advocates, and the state – at various points in time and across the continuum of care.¹ Each of these stakeholders plays a role in making critical information available and understandable so that patients and employers can make high-value choices.²

At the Commission meeting, all members agreed that transparency is essential to lowering consumer out-of-pocket costs and decreasing the total cost of care. Research at the national level, however, concludes that patients may not have optimal access to the right information.³ Although the Massachusetts Legislature has passed several laws to increase transparency, many Commission members stated that employers and consumers need additional information and better transparency tools.

This chapter explores the potential of transparency initiatives to improve the healthcare system's efficiency. Commission members also analyzed transparency tools and strategies they felt could best address provider price variation. Section I discusses the role of price transparency in healthcare, including challenges around the use of available information. Section II summarizes Massachusetts price transparency legislation. Section III encapsulates members' feedback on price transparency initiatives, including a website currently in development by the Center for Health Information and Analysis (CHIA).

¹ Anna D. Sinatko and Meredith B. Rosenthal, "Increased Price Transparency in Health Care – Challenges and Potential Effects," *New England Journal of Medicine* 364 (2011): 891-894.

² Maura Calsyn, *Shining Light on Health Care Prices* (Washington, D.C.: Center for American Progress, 2014).

³ Bruce Jaspen, "Health Care Prices Remain a Secret in Most States," *Forbes*, July 8, 2015, <http://www.forbes.com/sites/brucejaspen/2015/07/08/health-care-price-information-still-elusive-in-most-states/#6f936fb1616a>; "Medical Price Transparency Law Rolls Out: Physician Must Help Patients Estimate Costs," Massachusetts Medical Society, January 3, 2014, <http://blog.massmed.org/index.php/2014/01/mass-medical-price-transparency-law-rolls-out-physicians-must-be-able-to-estimate-costs-for-patients>.

SECTION I: PRICE TRANSPARENCY IN HEALTHCARE

Unlike most consumer-driven industries, healthcare is an anomaly, in that prices are generally not disclosed before the consumer purchases the product.⁴ Without readily-available, useful, and understandable ways to shop for services, consumers lack the tools to choose high-value care, and are trapped in a system that encourages cost-blind treatment.⁵ Employers too need mechanisms to help them understand and shop for health insurance, since they are in the best position to select high-value plans and give employees the information they need to choose among those plans.

Price transparency is particularly important given the trend towards employer-sponsored high-deductible health plans (HDHPs).⁶ Employees with HDHPs have lower premiums but must pay higher annual deductibles before the insurer covers a portion of the costs.⁷ Employers view these plans as a tool to contain costs while still

“As costs continue to rise, it is increasingly difficult for many consumers to not only afford the health care services they need, but to navigate and understand why price varies so widely among hospitals and providers. These high costs are reflected in increased premiums, and in higher deductibles and other cost sharing.” – Health Care For All, testimony to the Special Commission

offering competitive healthcare coverage. In 2014, 45% of Massachusetts employers offered HDHPs, a 12% increase over three years and more than double the national percentage.⁸ The highest uptake in HDHPs in Massachusetts is in the small-group market, in which 47% of members have a HDHP.⁹ This trend is caused in part by year-over-year increases in small-group market premiums.¹⁰

⁴ Amanda Frost and David Newman, *Spending on Shoppable Services in Health Care* (Washington, D.C.: Health Care Cost Institute, March 2016).

⁵ Megan Collado and Andrea Ducas, “Patients, Physicians, And Price Transparency: If You Build It, Will They Come?” *Health Affairs Blog*, August 31, 2016, <http://healthaffairs.org/blog/2016/08/31/patients-physicians-and-price-transparency-if-you-build-it-will-they-come>.

⁶ *Health Policy Brief: High-Deductible Health Plans* (Health Affairs, February 4, 2016), available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_152.pdf.

⁷ In calendar year 2016 the minimum deductible was \$1,300 for an individual and \$2,600 for a family. “IRS Provides Guidance on Calendar Year 2016 High Deductible Health Plans, Out-of-Pocket Maximum Deductible Levels, and Health Savings Account Contribution Limitations,” Blue Cross Blue Shield Office of National Health Reform, August 3, 2015, <http://www.bcbsm.com/health-care-reform/reform-alerts/irs-provides-guidance-2016-deductibles-out-of-pocket-max-hsa.html>.

⁸ Center for Health Information and Analysis, *Massachusetts Employer Survey: 2014 Summary of Results* (Boston, MA, October 2014).

⁹ Center for Health Information and Analysis, *Performance of the Massachusetts Health Care System: Annual Report* (Boston, MA, September 2016).

¹⁰ Between 2012 and 2014, small-group market premium increases were modest. See Commonwealth Connector Authority, *Request for a State Innovation Waiver Under Section 1332 of the Affordable Care Act* (Boston, MA, February 2, 2016), 11. Small-group market premiums, however, increased by an average of 6.1% in 2015 and 6.7% in the first half of 2016. See Office of the Attorney General, *Examination of* (footnote continued)

According to a Health Policy Commission (HPC) survey, many employees, particularly those working for small businesses, are only offered a HDHP.¹¹ Since individuals enrolled in HDHPs pay more out-of-pocket, the onus rests on them to control their healthcare costs. This can be especially challenging for fixed- and lower-income patients, as they must pay their deductible first before the plan covers a portion of out-of-pocket costs. This can discourage people from seeking needed medical treatment.¹²

Proponents of HDHPs, however, argue that these plans encourage consumers to use higher-value care. To make efficient choices, though, consumers need access to information about both cost and quality. In the absence of actionable information, HDHPs may simply increase out-of-pocket costs.¹³ Katherine Baicker, the C. Boyden Gray Professor of Health Economics at the Harvard T.H. Chan School of Public Health, presented to the Commission on price transparency in the context of price variation. Dr. Baicker noted that out-of-pocket prices are sometimes more salient to patients than their medical symptoms. This may lead patients to avoid seeking care, which may increase costs in the future and lead to poorer health outcomes.

Despite their importance, however, there are limitations to the capacity for price transparency tools to change consumer behavior and reduce price variation. Several studies determine that even where these tools are available, there is low consumer utilization.¹⁴ For example, New Hampshire launched a state-run transparency website in 2007; in the following three years, only 1% of the state's residents used the site.¹⁵ Patients may also be unaware of the resource; there is room here for employers, payers, and others to encourage uptake. In addition, for some services patients only pay a small portion of the actual cost of care, leaving little incentive to choose a low-cost provider. Further, patients often associate quality and cost, and assume that higher-priced providers are of higher quality.¹⁶ If the incentive leads to the "wrong" choice, the incentive is ineffective or even counter effective. Several Commission members identified this as a major disadvantage of price transparency initiatives.

Health Care Cost Trends and Cost Drivers: Report for Annual Public Hearing (Boston, MA, October 13, 2016), 1.

¹¹ An HPC survey determined that 29.7% of employees in businesses with fewer than 50 employees are offered only a HDHP. The percentages are 19.4% for businesses with 50-99 employees and 11.7% for businesses with more than 100 employees, respectively. Health Policy Commission, *Select Findings: 2016 Cost Trends Report* (Boston, MA, January 11, 2017), slide 48.

¹² Sarah Kliff, "This Study is Forcing Economists to Re-Think High Deductible Health Plans," *Vox*, October 14, 2015, <http://www.vox.com/2015/10/14/9528441/high-deductible-insurance-kolstad>.

¹³ Ifrad Islam, "Trouble Ahead for High Deductible Health Plans?," *Health Affairs Blog*, October 7, 2015, <http://healthaffairs.org/blog/2015/10/07/trouble-ahead-for-high-deductible-health-plans>.

¹⁴ Kevin G. Vlopp, "Price Transparency: Not a Panacea for High Health Care Costs," *Journal of the American Medical Association* 315 (2016): 1842-1843; Ateev Mehtotra, Tyler Brannen, and Anna Sinaiko, "Use Patterns of a State Health Care Price Transparency Web Site: What Do Patients Shop For?," *Inquiry: Journal of Health Care Organization, Provision and Financing* 1 (2014) 1-3.

¹⁵ Mehtotra, "Use Patterns," *supra* note 14.

¹⁶ Sinaiko, "Increased Price Transparency," *supra* note 1, at 892.

Finally, consumers are generally unaccustomed to having access to cost and quality information, and transparency websites are not always easy to navigate. Dr. Baicker pointed out several ways to maximize the user's experience. For example, consumers should be able to compare prices side-by-side in a way that conveys that the options are of the same quality. In addition, there must be a reasonable number of providers; too many choices may simply confuse the consumer.¹⁷

SECTION II: MASSACHUSETTS PRICE TRANSPARENCY LAWS

Massachusetts and 37 other states have passed some form of price transparency legislation.¹⁸ The breadth and effectiveness of this legislation varies widely. As explained in Chapter 3, a variety of Massachusetts laws require payers and providers to make price information available to consumers. Payers must establish a toll-free number and website that gives consumers real-time out-of-pocket cost estimates, including facility fees.¹⁹ Payers must also disclose in- and out-of-network cost-sharing policies and utilization review criteria.²⁰ Similar requirements apply to providers. Within two business days, a provider must disclose the allowed amount or charge of a service, including any facility fees. Upon request, the provider must provide the patient with sufficient information to obtain out-of-pocket cost estimates from the patient's health plan. If the provider cannot predict the treatment or diagnostic code, the provider must disclose the estimated maximum allowed amount or charge.²¹

Aside from these requirements, payers, at their discretion, may help patients obtain cost estimates based on procedure codes. In this case, the payer, with the patient's permission, obtains the procedure code from the provider.²² To make this process easier for patients, providers, and payers, Mass Collaborative²³ developed a form that assists patients in getting specific information from providers to bring to their payer for a reliable estimate.²⁴ Massachusetts health plans, including Blue Cross Blue

¹⁷ Katherine Baicker, "Patient Choice, Price Transparency, and High-Value Care" (presentation to the Special Commission on Provider Price Variation, Boston, MA, January 10, 2017).

¹⁸ Francois de Brantes and Suzanne Delblanco, *Report Card on State Price Transparency Laws* (Newtown, CT: Catalyst for Payment Reform, July 2016).

¹⁹ Absent unforeseen circumstances, the consumer is not required to pay more than this disclosed amount. See MASS. GEN. LAWS ch. 176O, § 23 (2016); MASS. GEN. LAWS ch. 32A, § 27 (2016).

²⁰ Ch. 176O, § 6.

²¹ MASS. GEN. LAWS ch. 111, § 228 (2016).

²² "Bulletin 2013-10, Carrier Compliance with Transparency With Respect to the Estimated or Maximum Allowed Charge for a Service and Insureds' Out-of-Pocket Health Care Costs," Massachusetts Consumer Affairs and Business Regulation, December 13, 2016, <http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2013-doi-bulletins/bulletin-2013-10.html>.

²³ Mass Collaborative is a "voluntary, open organization of more than 35 payers, providers, and trade associations dedicated to reducing complex and cumbersome healthcare administrative processes in Massachusetts." "Who We Are," Mass Collaborative, accessed March 3, 2017, <http://www.masscollaborative.org>.

²⁴ Mass Collaborative, *Massachusetts Medical Price Transparency Law and Cost Estimate Worksheet* (Boston, MA, January 2015), available at <http://www.masscollaborative.org/downloads/Cost-Estimate-Worksheet.pdf>.

Shield, have also invested in state-of-the-art cost estimation tools, to help patients identify both the price of the service as well as their out-of-pocket cost.²⁵

Despite these laws, two recent studies conclude that it may still be challenging for Massachusetts consumers to obtain price information. In 2015, Health Care For All reviewed three major Massachusetts insurers' price transparency websites, and created a "report card" to determine how helpful, accessible, and comprehensive each website was. It found numerous flaws. For example, some insurers did not offer information about the costs of inpatient procedures and others reported the total cost of a service but did not specify the patient's out-of-pocket costs.²⁶ To receive an "A," the insurer's website had to meet all criteria, including allowing the user to compare costs of multiple providers on one screen, clearly differentiating between total and out-of-pocket costs, and earning a high overall usability score. Across all measures, no plan received a mark higher than "B-." The report did note, however, that each insurer told Health Care For All that it planned to improve its website in the following months.²⁷

"Price transparency in healthcare requires nothing short of cultural change in the way consumers/patients and employers, aided by payers, providers and the state, consider healthcare options." – Pioneer Institute, testimony submitted to the Special Commission

A 2016 study by the Pioneer Institute highlights gaps in consumer access to provider information. Although surveyed providers eventually provided the price information requested, few providers had systems in place to provide timely and fully accurate information when first contacted.²⁸ Overall, most

hospitals were unable to answer questions about costs within two business days, as required.²⁹ The survey also found that 60% of Massachusetts residents were unaware of price transparency requirements, and the minority that were aware described accessing the information as a frustrating and complex process.³⁰

These studies offer evidence that initial efforts to promote the availability and use of healthcare price information have not had the desired effect. This suggests that there

²⁵ Blue Cross Blue Shield, for example, launched new online "Find a Doctor" and "Estimate Costs" tools in December 2015. See Blue Cross Blue Shield of Massachusetts, *Profile Testimony, Health Policy Commission 2016 Cost Trends Hearing* (Boston, MA: September 2, 2016).

²⁶ Felice J. Freyer, "Insurers Asked to Improve Health Cost Websites," *Boston Globe*, July 14, 2015, <https://www.bostonglobe.com/metro/2015/07/13/group-gives-health-insurers-low-grades-for-price-information-tools/nXjVsj4m0qXVNPz8ISS1CO/story.html>.

²⁷ Health Care for All, *Consumer Cost Transparency Report Card* (Boston, MA: 2015), 1-2, 6.

²⁸ Barbara Anthony and Scott Haller, *Mass Hospitals Weak on Price Transparency* (Boston, MA: Pioneer Institute, 2016).

²⁹ Id. at 2.

³⁰ Id. at 1.

is a significant need for additional price transparency initiatives in Massachusetts, especially in the internet realm, the most utilized consumer platform.

SECTION III: PRICE TRANSPARENCY INITIATIVES

Price transparency tools can direct consumers to high-value providers, fostering competition and decreasing the market clout of certain providers. Consumer decisions, however, are affected by their perception of the party providing the information. Insurance companies tend to have the most information, since they pay or process member claims and they have access to cost and utilization data and patterns. The issue is that consumers may not trust insurers to steer them towards high-quality care.³¹ Dr. Baicker explained that the most trusted sources of information are physicians and social connections. Therefore, it is important that physicians have some interest in containing the total cost of care (for example, by participating in a global budget arrangement), so that they are incentivized to recommend high-value providers. Dr. Baicker also noted that even information that comes from a trusted source needs to be presented in a digestible way to the target audience.³²

The Commission discussed whether existing transparency laws should be amended or strengthened, to address the fact that consumers may still find it difficult to get price estimates. Commission members agreed that current price transparency laws are important. Nonetheless, Karen Tseng, representing the Office of the Attorney General, clarified that the laws do not explicitly designate an enforcement agency.³³ Majority Leader Ronald Mariano, appointed by House Speaker DeLeo, and Steven Walsh, representing the Massachusetts Council of Community Hospitals, served in the Legislature when the transparency laws were passed. They explained that the Legislature intentionally chose not to delegate these responsibilities to an agency. This was part of a compromise between legislators and payers/providers, who agreed in good faith to comply. Mr. Walsh and other members stated that compliance has improved and that the Commission should focus on whether additional laws should be passed.

³¹ Baicker, “Patient Choice,” *supra* note 17.

³² Id. See also Katherine Baicker, et al. “Behavioral Hazard in Health Insurance,” *Quarterly Journal of Economics* (2015): 1623- 1667, available at <http://people.hbs.edu/jschwartzstein/BehavioralHazard.pdf>.

³³ Some state entities, however, provide guidance and monitor parties using existing processes. In December 2013, for example, the Division of Insurance released a bulletin outlining requirements for payers regarding estimated or maximum allowed charges. See “Bulletin 2013-10,” *supra* note 22. In addition, as part of its annual Cost Trends Hearings, the Health Policy Commission collects testimony on efforts by payers to increase consumer access to health care information. See MASS. GEN. LAWS ch. 6DA, § 8 (2012). As part of their 2016 Cost Trends Hearings pre-filed testimony, payers were asked to submit data regarding the number of individuals that ask for an estimated or maximum allowed amount or charge for a proposed admission or procedure. See Health Policy Commission, “Testimony,” accessed February 27, 2017, <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2016/testimony.html>.

HEALTH CONNECTOR SMALL BUSINESS FEATURE

Through a unique partnership, Massachusetts will work with the District of Columbia's group market exchange¹ to implement an employee choice model for small businesses in the Commonwealth. Many small business employees are only offered one plan choice. Therefore, small business owners have the greatest need for a platform that enables them to offer a range of products to their employees. The Massachusetts Health Connector currently hosts a small business platform, but only a relatively small number of employers have taken advantage of it. As of 2016, approximately 6,000 small business employees and their dependents enrolled in a Health Connector product. The low uptake could be due to lack of awareness of the option. Employers may also find it more convenient to use a single vendor for both health insurance and other benefits, such as long-term and disability insurance. In addition, the website currently lacks several features that allow for greater employer choice and flexibility.

In contrast to the current website, through which the employer selects one plan or one carrier for all employees, employee choice will give employees access to multiple plans. Employers may have the option of choosing a carrier and allowing their employees to select their preferred plan from among the carrier's plans at different actuarial value levels, or the employer can select a given actuarial value for a plan, and allow employees to choose among carriers. Employers are then able to set a fixed-contribution for a reference plan the employer selects. Based on the employee choice model the employer selects, employees can choose to purchase a plan that is more expensive or less expensive than the reference plan to meet their needs. Depending on the plan the employee selects, employees can save up to 30% of an average small group plan for comparable benefits.

The Health Connector anticipates that new employee choice options may prove attractive to smaller employers, such as those with fewer than five employees. A wider selection of plans means that employees can pick the plan that best fits their needs. Employee choice also gives employers greater financial predictability and promotes competition among payers in the small-group market. The Health Connector recognizes that carrier availability and the ability to work within the new platform are key, and anticipates a pilot program for October 2017 coverage and full launch for January 2018 coverage.

David Torchiana, representing Partners Healthcare, emphasized the importance of ensuring that information is understandable to patients. Information should be publicly available, but medical literacy is a barrier to presenting complex information. This is one reason why many consumers do not use price transparency websites, even where available. He said that as electronic health records become more universal and patient portals become more popular, patient-reported outcomes will be easier to gather and report. That information is very valuable to patients. Dr. Torchiana stated that gathering and presenting data at the appropriate medical literacy level is an area in which the state could focus its efforts. Leader Mariano agreed that the state has a role to play in this area. Richard Frank, a healthcare economist appointed by Governor Baker, underscored that any effort needs to factor in how consumers process information.

Commission members also discussed a state-run transparency website currently under development by the CHIA. The website will enable patients to compare prices for common shoppable services, using data from the Massachusetts All-Payer Claims Database.³⁴ Roberta Herman, representing the Group Insurance Commission, and Lynn Nicholas, representing the Massachusetts Health & Hospital Association, stated that CHIA should consider focusing on high-volume, shoppable conditions. Ray Campbell, Executive Director of CHIA, attended the meeting. He explained that CHIA is studying other websites and working to overcome design challenges to create a flexible, accessible site.

³⁴ The All-Payer Claims Database is a compilation of medical, pharmacy, and dental claims submitted by commercial insurers and public programs. Center for Health Information and Analysis, *Overview of the Massachusetts All-Payer Claims Database* (Boston, MA, March 2014). Third-party administrators may elect to but are not required to submit claims. Gina Stephan, “Are All-Payer Claims Databases now ‘Some Payer Claims Databases’ after Gobeille v. Liberty Mutual?” *Wolters Kluwer*, May 15, 2016, <https://www.wolterskluwerfs.com/article/are-all-payer-claims-databases-now-some-payer-claims-databases-after-gobeille-v-liberty-mutual.aspx>.

CHAPTER 6 – STATE MONITORING OF THE HEALTHCARE MARKET

INTRODUCTION

After discussing the impact on provider price variation of market forces, demand-side incentives, and increased transparency, the Special Commission turned its attention to the potential role for the state in monitoring the healthcare market. State monitoring policies involve a variety of stakeholders and encompass a range of activities, from approval of payer/provider contracts to tracking costs throughout the healthcare system. In its more targeted forms, state monitoring includes provider rate-setting and caps on growth in rates. Over the course of its meeting on this topic, Commission members discussed possible roles for the state in addressing provider price variation.

Section I of this chapter summarizes Massachusetts laws that monitor the healthcare marketplace. Section II examines two states, Maryland and Vermont, that have established all-payer controls on provider rates. Section III discusses the state of Rhode Island, which monitors provider rates, payment methodologies, and quality as part of its annual insurance rate review. This section includes information presented by Dr. Kathleen Hittner, Health Insurance Commissioner for the state of Rhode Island, along with Commission feedback and questions. Section IV outlines state monitoring solutions discussed by the Commission.

SECTION I: MONITORING THE HEALTHCARE MARKET IN MASSACHUSETTS

Chapter 224¹ establishes the Health Policy Commission (HPC), an agency charged with the broad task of “monitor[ing] the reform of the health care delivery and payment system.”² This includes setting healthcare cost growth goals, enhancing the transparency of provider organizations, monitoring and reviewing the impact of changes in the healthcare marketplace, monitoring the development of alternative payment methodologies and new care delivery models, and fostering innovations in delivery and payment.³

In accordance with statute, the HPC sets an annual cost growth benchmark. The benchmark is the maximum growth rate for total per-capita medical spending in the Commonwealth across all sectors. Through December 2017, the benchmark is equal to growth in potential gross state product (3.6%). After 2017 the benchmark is pegged to potential gross state product minus 0.5% (3.1%), but may be modified by

¹ Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation, 2012 Mass. Acts 224.

² MASS. GEN. LAW ch. 6D, § 5 (2016).

³ Id.

the HPC to fall between 3.6% and 3.1%.⁴ The HPC also conducts annual public hearings to investigate the causes of growth in total healthcare expenditures in relation to the benchmark. These hearings explore systemic trends like utilization patterns, price transparency efforts, and innovations in benefit design. The focus, however, is on “factors that contribute to cost growth,” including provider price variation. The Office of the Attorney General (AGO) may intervene in the hearings, and providers and payers are required to provide testimony under oath to the HPC, the Center for Health Information and Analysis (CHIA), and the AGO. Testimony may include information about price variation within and across payer networks, along with variation in global budgets and total medical expenses.⁵ In addition to informing the HPC’s future work on this topic, the hearings are a way to shine light on the healthcare system and make the performance of the healthcare sector more transparent.

In addition to annual hearings, the HPC also tracks cost growth for payers and providers. CHIA annually provides the HPC with a list of all providers and payers whose cost growth, based on health status-adjusted total medical expense (TME),⁶ is excessive and who threaten the ability of the state to meet the healthcare cost growth benchmark.⁷ The HPC reviews factors such as the entity’s prices, market share, financial condition, and any current strategies to reduce spending growth. In 2016, the HPC may require certain entities to file and implement a performance improvement plan (PIP) where it identifies “significant concerns” about that entity’s costs and determines that a PIP could result in meaningful, cost-saving reforms.⁸ The PIP is a plan created by the healthcare entity and approved by the HPC. It identifies the causes of and implements specific strategies to reduce cost growth. The entity carries out the PIP over the course of eighteen months, after which the HPC evaluates its success. The HPC may require additional actions to lower costs, and can fine an entity up to \$500,000 for failure to file, implement, or report on its PIP. The HPC has the further option to conduct a Cost and Market Impact Review (CMIR)⁹ of provider organizations identified by CHIA in years where total health care expenditures exceeded the healthcare cost growth benchmark.¹⁰

Another function of the HPC is to enhance the transparency of provider organizations. Through the Registration of Provider Organizations (RPO) program, the HPC and CHIA collect data on provider organizations in the Commonwealth. In order to contract with payers, providers¹¹ need to register with the HPC, and must

⁴ § 9(d).

⁵ § 8.

⁶ Providers on this list are only primary care provider groups. Health status-adjusted TME does not exist for other types of providers, such as specialists and hospitals.

⁷ MASS. GEN. LAW ch. 12C, § 18 (2016).

⁸ MASS. GEN. LAW ch. 6D, § 10 (2016); Health Policy Commission, *Bulletin 2016-01: Interim Guidance for Payers, Providers, and Provider Organizations Relative to Performance Improvement Plans and Cost and Market Impact Reviews* (Boston, MA, March 13, 2016).

⁹ See Chapter 3 for a discussion of Cost and Market Impact Reviews.

¹⁰ § 10; Health Policy Commission, *Bulletin 2016-01*, supra note 8.

¹¹ Small and lower-revenue providers do not need to register. See § 1.

submit details to the RPO program about their ownership, governance, operational structure, affiliates, employed and affiliated professionals, licensed facilities, and other pertinent information.¹² This publicly-available data is vital to understanding the current structure of and trends in the healthcare marketplace. It is helpful to policymakers and researchers as well as market participants. Finally, the HPC is required to certify accountable care organizations (ACOs) and patient-centered medical homes.¹³

In addition to the HPC, CHIA and the AGO monitor cost trends. As explained in Chapter 1, CHIA collects and publishes healthcare data, including provider relative prices and market share.¹⁴ The AGO has the authority to compel information from payers and providers, including contract documents and cost data, and interview relevant stakeholders. It uses this information and CHIA data to publish an annual report examining cost trends and drivers.¹⁵

SECTION II: ALL-PAYER RATE SETTING IN MARYLAND AND VERMONT

As discussed in Chapter 2, Maryland has operated an all-payer hospital rate-setting system since 1971. Unlike rate-setting systems in other states, this model has survived in some form until the present.¹⁶ This is primarily due to a Maryland-specific Medicare waiver, enacted into federal law, which allows Maryland's rate-review commission to set Medicare reimbursement rates.¹⁷ The original waiver required that growth in Medicare payments per case remain less than the national average. Hospitals were paid itemized rates for a given service; Maryland also established maximum payments per case and volume controls on total services provided. These limits incentivized hospitals to reduce costs, avoidable readmissions, and unnecessary care, since in most cases providing additional or more intense services would not increase reimbursement.¹⁸

In 2008, Maryland's costs per admission were below the national average and there was a narrow and stable distribution of hospital earnings. As the health system evolved, however, the rate-setting methodology inadvertently contributed to rapid increases in Medicare charges per case. Maryland worried that it would not continue

¹² § 11.

¹³ §§ 14, 15.

¹⁴ MASS. GEN. LAW ch. 12C, § 16 (2016).

¹⁵ MASS. GEN. LAW ch. 12C, § 11N (2016).

¹⁶ Between the late 1960s and 1997, at least twenty-seven states had some rate-review or rate-setting system. Massachusetts had a rate-setting system in some form from 1974 until 1991. Robert Murray, et. al., *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* (Washington, D.C., Urban Institute, November 2015).

¹⁷ Id. at 43-44.

¹⁸ Id. at 45-46; "Maryland All-Payer Model to Delivery Better Care and Lower Costs," Centers for Medicare & Medicaid Services, accessed December 9, 2016, <https://innovation.cms.gov/initiatives/Maryland-All-Payer-Model>. See also Rahul Rajkumar, et. al., "Maryland's All-Payer Approach to Delivery-System Reform," *New England Journal of Medicine* 370 (2014) 493-495.

to meet the terms of its Medicare waiver. In 2014, Maryland received approval from the Centers for Medicare & Medicaid Innovation (CMMI) to build off existing global payment pilots and establish a system of global budgets for all hospitals.¹⁹ Under this system, revenue earned throughout the year cannot exceed a set amount. Other provisions in the waiver limit growth in revenue and spending per capita.²⁰ As Chapter 2 discusses, Maryland's performance to date has been mixed but reports indicate some positive results: growth has stayed below the limit and Maryland has almost fully implemented global budgeting for hospitals, without hurting hospital margins. Maryland anticipates extending rate-setting to the entire spectrum of care by 2019.²¹

Vermont has also collaborated with the federal government to facilitate system transformation and address provider price variation. In 2011, Vermont established the Green Mountain Care Board (GMCB), an independent agency tasked with overseeing the creation, implementation, and efficacy of healthcare payment and delivery reforms.²² Consistent with this role, the GMCB has extensive approval authority over provider and insurer rates, hospital and ACO budgets, and Vermont's certificate of need process.²³ The GMCB also manages Vermont's all-payer claims database.²⁴

The GMCB started Vermont on the path to healthcare reform in 2013. Vermont created a multi-payer ACO model, under which providers that stayed under budget were able to keep a portion of the savings.²⁵ These shared-savings programs were

¹⁹ 42 U.S.C. § 1315a (2016). The Affordable Care Act created CMMI "to test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care." "About the CMS Innovation Center," Centers for Medicare & Medicaid Services, accessed February 28, 2017, <https://innovation.cms.gov/About>.

²⁰ Murray, *Hospital Rate Setting Revisited*, supra note 16, at 52-55; Centers for Medicare & Medicaid Services, "Maryland's All-Payer," supra note 18; See also Maryland Health Services Cost Review Commission, *Agreement Between the Health Services Cost Review Commission and Anne Arundel Medical Center, Inc. Regarding Global Budget Revenue and Non-Global Budget Revenue* (2015).

²¹ Ankit Patel, et al., "Maryland's Global Hospital Budgets – Preliminary Results from an All-Payer Model," *New England Journal of Medicine* 373 (2015) 1899-1901; "Monitoring of Maryland's New All-Payer Model: Biannual Report," Health Services Cost Review Commission, April 2016, <http://www.hscrc.maryland.gov/documents/legal-legislative/reports/HSCRC-Biannual-Report-on-All-Payer-Model-April-2016.pdf>; Rajkumar, "Maryland's All-Payer Approach," supra note 18; Advisory Board Company, *Maryland's All-Payer Global Budget Cap Model and its Implications for Providers* (Washington, D.C.: May 23, 2016).

²² VT. STAT. ANN. tit. 18 § 9375(b) (2016). Parallel authority was also given to the Secretary of Administration to support the efforts of the GMCB. 3 V.S.A § 2222a(c)(9) (2016).

²³ VT. STAT. ANN. tit. 18 § 9375(b) (2016). The GMCB even has the authority to approve provider workforce plans and health information technology implementation strategies of health sector participants. *Id.*

²⁴ VT. STAT. ANN. tit. 18 § 9410 (2016).

²⁵ Agency of Administration, *Vermont Health Care Innovation Project Quarterly* (Montpelier, VT, February 23, 2016), 2, available at <http://legislature.vermont.gov/assets/Legislative-Reports/VHCIP-Report-to-the-Legislature-February-2016.pdf>. The State Innovation Model grant program provides federal funds to "advance multi-payer health care payment and delivery system reform models . . . to achieve better quality of care, lower costs, and improved health for the population of the participating states or territory." "State Innovation Models Initiative: General Information," Centers for Medicare & Medicaid Services, accessed February 28, 2017, <https://www.cms.gov/innovationcenter/stateinnovationmodels>.
(footnote continued)

based on Medicare's upside risk only ACOs, and the results were mixed. The Medicaid ACO saved \$15.7 million; commercial and Medicare ACOs did not achieve savings but did improve upon certain quality metrics.²⁶ Based on these outcomes, in 2015 the Vermont Legislature authorized the GMCB and Vermont's Secretary of Administration to explore with CMMI the feasibility of an all-payer model. The goal of this model was to transition payments for all providers from fee-for-service (FFS) to alternative payment methodologies (APMs).²⁷ After a year-long stakeholder engagement process, the state entities brought their proposal back to the Legislature, which granted them the formal authority to apply for an 1115 Waiver from the Centers for Medicare & Medicaid Services.²⁸ Vermont received permission in late 2016 to establish the all-payer model.²⁹

There are several notable features of Vermont's all-payer model. Payers must adhere to a 3.5% aggregate per-capita cost growth cap target for the five year period of the active demonstration. In addition, the GMCB will annually recommend Medicaid reimbursement increases, to bring payments more in line with Medicare FFS rates. The model also incorporates investments in population health, with corresponding performance targets. Finally, the agreement extends the GMCB's regulatory authority to Medicare ACOs, allowing the GMBC to direct investments in infrastructure and care delivery models.³⁰ The agreement provides that the all-payer model will operate over a period of six years, with the first year serving as a preparatory period (See

Medicaid Services, accessed February 28, 2017, <https://innovation.cms.gov/initiatives/state-innovations>.

²⁶ Vermont Health Care Innovation Project, *Vermont's Year 2 Medicaid and Commercial ACO Shared Savings Program Results* (Montpelier, VT, October 2016), available at http://healthcareinnovation.vermont.gov/sites/vhcip/files/documents/VHCIP%20Webinar%202015%20SSP%20Results_10-28-16%20FINAL.pdf.

²⁷ 2015 Vt. Acts and Resolves No. 54, Sec. 1.

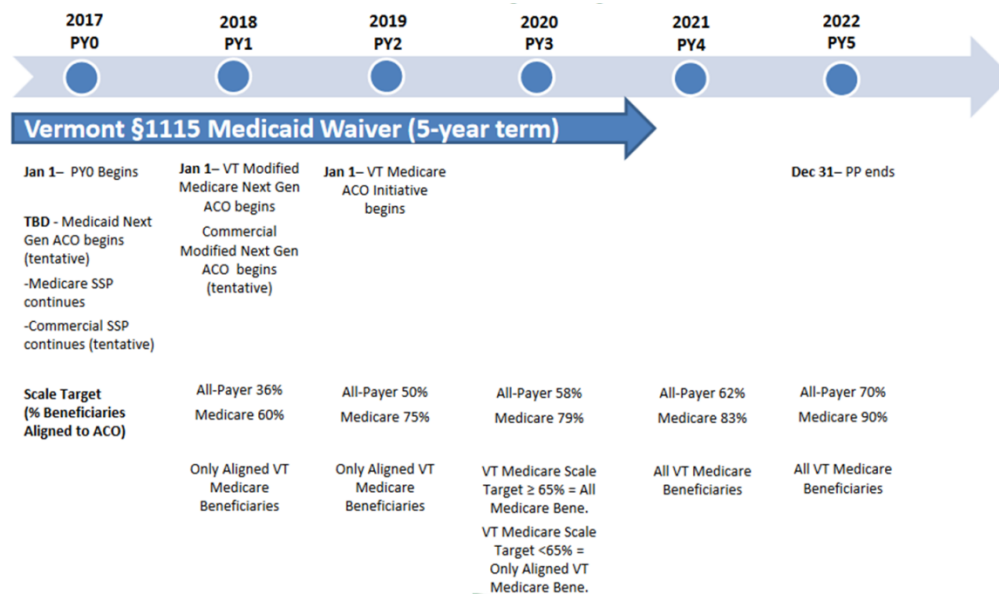
²⁸ 1115 Waivers allow states to use Medicaid funds in ways not otherwise permitted by law. This provides states with a way to test innovative delivery and payment reform systems. Social Security Section § 1115, 42 U.S.C. 1315 (2014). The arrangement needs to create a value-based, all-payer payment model that “provides direct payments from Medicare to providers or ACOs without state involvement; maximizes alignment between payers; strengthens investments in primary care; incorporates social determinants of health; integrates mental health, substance abuse treatment and community-based providers into the overall health care system; prioritizes local and regional health care provider collaborations; allows providers to choose whether to participate in an ACO; evaluates access to care, quality of care, patient outcomes and social determinants of health; protects patient rights and includes processes and protocols for shared decision-making while taking into account an individual's needs, preferences, values and priorities; and ensures a robust grievance and appeals process through their [Office of the Health Care Advocate].” Green Mountain Care Board, *In re: Vermont All-Payer Accountable Care Organization Model Agreement* (Vermont, October 31, 2016), 4, available at <http://gmcboard.vermont.gov/sites/gmcb/files/documents/APM-FINAL-Justification.pdf>.

²⁹ Vikki Wachino, Letter to Hal Cohen, Secretary, Vermont Agency of Human Services, October 24, 2016, available at <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf>. See also Centers for Medicare & Medicaid Services, *Vermont All-Payer Accountable Care Organization Model Agreement* (October 27, 2016), available at <http://gmcboard.vermont.gov/sites/gmcb/files/documents/10-27-16-vermont-all-payer-accountable-care-organization-model-agreement.pdf>.

³⁰ Green Mountain Care Board, *In re: Vermont*, supra note 28, at 10. See also Centers for Medicare & Medicaid Services, *Vermont All-Payer*, supra note 29.

Figure 6.1).³¹ This lead-up time may prove necessary for Vermont to meet the year-over-year Medicare and all-payer member ACO attribution goals.³² Additional operational and structural details have yet to be developed.

Figure 6.1: Vermont All-Payer ACO Model Agreement Timeline³³



SECTION III: EFFORTS TO CURB SPENDING GROWTH IN RHODE ISLAND

Rhode Island is the only state in the country with a dedicated Office of the Health Insurance Commissioner (OHIC). The Rhode Island Legislature created OHIC in 2004 and gave it broad authority to improve the quality, accessibility, and affordability of healthcare in Rhode Island.³⁴ OHIC’s duties go beyond those of other state divisions of insurance. OHIC not only ensures health insurer solvency and consumer protections but also requires insurers to improve the quality and efficiency of care delivery.³⁵ One of the unique functions of OHIC is its ability to regulate growth in provider rates through its annual review of insurer premium rate filings.

³¹ Green Mountain Care Board, *In re: Vermont*, supra note 28, at 8.

³² Centers for Medicare & Medicaid Services, *Vermont All-Payer*, supra note 29, at 9. The goal is that by 2022, 70% of all insured residents and 90% of Medicare beneficiaries will be attributed to an ACO. Id.

³³ Green Mountain Care Board, *All-Payer Accountable Care Organization Model Update*, by Pat Jones and Melissa Miles (Montpelier, VT, January 12, 2017), slide 11, available at <http://gmcboard.vermont.gov/sites/gmcb/files/documents/Implementing%20the%20All-Payer%20Model%202017-01-12FINAL.pdf>.

³⁴ R.I. Gen. Laws §42-14.5-2 (2014).

³⁵ “About OHIC,” Office of the Health Insurance Commissioner for the State of Rhode Island, accessed February 8, 2017, <http://www.ohic.ri.gov/ohic-about.php>.

When reviewing insurer rates, OHIC focuses on three goals: cost growth containment, payment reform, and care transformation. OHIC assesses whether the insurer has met affordability standards, including whether the insurer has adhered to rate growth ceilings in its contracts with providers.³⁶ Commercial hospital inpatient and outpatient rates cannot grow by more than the federal consumer price index-urban³⁷ (CPI-Urban) plus 1%.³⁸ OHIC requires that half the rate increase be earned through quality performance. ACOs have been given a bit more flexibility, since they are newer and less-established entities. Their rate limits are CPI-Urban plus 3% in 2016, but will be gradually reduced to 1.5% by 2019.³⁹ Even though OHIC only oversees the fully-insured market, growth limits influence costs in the self-insured market.⁴⁰

Rate growth limits have been in place for five years. In her presentation to the Commission, Dr. Kathleen Hittner, the Health Insurance Commissioner for the state of Rhode Island, stated that the limits have been very effective. She acknowledged that when Rhode Island first established growth caps, some insurers argued that it would be more difficult to negotiate with hospitals. Hospitals too were skeptical, worrying that the limits would affect operating margins. OHIC, however, does have a waiver option and is open to reconsidering growth limits that might inhibit innovation. Dr. Hittner said that she encourages insurers and providers to speak to her about this process. She informed Commission members that OHIC also has the ability to attach stipulations to its approval of rate increases. These stipulations typically involve provider price transparency.⁴¹ David Torchiana, representing Partners Healthcare, asked about Rhode Island's statewide medical cost and premium trends. Dr. Hittner responded that premium rates have been reasonable compared to other states. It is not unusual for there to be 0% premium increases on Rhode Island's state health exchange. Rhode Island has seen increases in total medical expense between 3% and 3.5% over the past several years.⁴²

OHIC review also fosters payment reform and care transformation. Currently, approximately 30% of healthcare payments in Rhode Island are through APMs. The goal is to achieve 50% APM uptake by the end of 2018. OHIC has an Alternative Payment Methodology Committee that defines which APMs qualify and sets the

³⁶ R.I. Code R. §32-1-2:1 (2015). These affordability standards were written into regulation in 2010.

³⁷ OHIC uses the National Consumer Price Index for All Urban Consumers: All Items Less Food and Energy.

³⁸ Regulations adopted in February 2015 required the 1% additive factor to decrease by 0.25% each year until 2019. Rhode Island hospitals sought relief from this provision in 2016. OHIC's revised regulations, effective January 2017, hold the growth cap for hospital inpatient and outpatient services at +1%. Information provided by OHIC to Joint Committee on Health Care Financing staff, February 21, 2017.

³⁹ Kathleen Hittner, "Provider Price Variation & the Cost of Healthcare in Rhode Island" (Presentation to the Special Commission on Provider Price Variation, January 31, 2017).

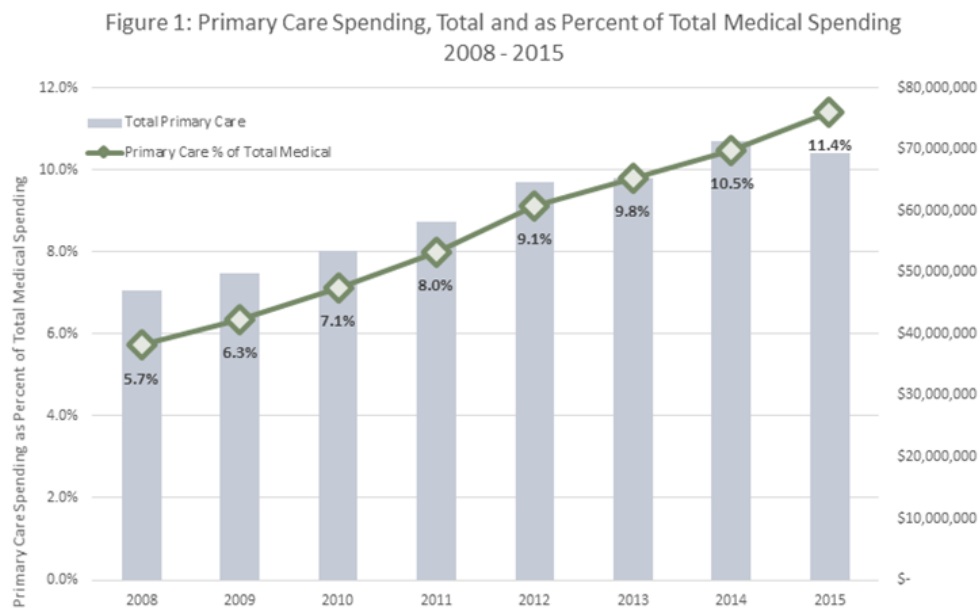
⁴⁰ Id. Payers and providers sometimes execute a single contract for all plans; thus, OHIC's review process may indirectly limit the rates paid by self-insured plans.

⁴¹ Hittner, "Provider Price Variation," *supra* note 39.

⁴² Hittner, "Provider Price Variation," *supra* note 39. Note: This is an average across the small-group, large-group and individual markets.

annual targets.⁴³ In addition, OHIC's Care Transformation Collaborative is working to improve the efficiency and quality of care through innovations in primary care. At present, 50% of primary care practices have transitioned to patient-centered medical homes.⁴⁴ The goal is to increase that number to 80% in the near future. Dr. Hittner acknowledged that achieving this target will be challenging. Most of these practices are smaller and do not have electronic medical records, making measurements for shared savings and risk management difficult.⁴⁵ Rhode Island's health insurance affordability standards also mandate that commercial insurers increase payments to primary care providers by 1% each year, without increasing total spending. In 2010, spending on primary care was 7.1% of total medical spending. By 2015, it had increased to 11.4% (See Figure 6.2).

Figure 6.2: Primary Care Spending in Rhode Island, 2008-2015⁴⁶



Lynn Nicholas, representing the Massachusetts Health & Hospital Association, asked Dr. Hittner about the financial health of Rhode Island's insurers and providers. Dr. Hittner acknowledged that her response might not be popular but suggested that some hospitals are not necessary and certain facilities may need to close. She referenced a study from several years ago showing that Rhode Island has two hundred excess hospital beds. This number may be even higher today, given that care is increasingly provided in outpatient settings. She clarified that specialties like behavioral health may not have excess beds, so one strategy is to repurpose beds.

⁴³ Hittner, "Provider Price Variation," supra note 39.

⁴⁴ Patient-centered medical homes are delivery systems through which a patient's primary care provider coordinates specialist visits and oversees continuity of care. Office of Legislative Research, *Rhode Island's Health Insurance Affordability Standards*, by Alex Reger (Hartford, CT, August 22, 2016), available at <https://www.cga.ct.gov/2016/rpt/2016-R-0146.htm>.

⁴⁵ Hittner, "Provider Price Variation," supra note 39.

⁴⁶ Hittner, "Provider Price Variation," supra note 39, at slide 15.

Cory King, a member of Dr. Hittner’s staff, explained that the financial strain certain hospitals experience may also be due to lower public-payer rates. Dr. Hittner added that she does not believe that employers and consumers should be forced to pay the difference when public-payer rates decrease. OHIC’s rate growth limits prevent this cost-shift.

Roberta Herman, representing the Group Insurance Commission, asked what the product suite is like in Rhode Island’s market. Dr. Hittner responded that there are quite a variety of plans in Rhode Island and OHIC reviews each plan to ensure network adequacy. She noted, however, that high deductibles in certain plans are placing a strain on employers. OHIC is working on this issue, but this is also a national problem.

SECTION IV: ADDITIONAL STATE MONITORING IN MASSACHUSETTS

Commission members discussed options for additional monitoring in Massachusetts, including rate compression, which involves reducing the variation in rates between the lowest- and highest-paid hospitals, which can include setting a minimum rate or floor for lower-paid hospitals. Members also discussed encouraging the use of more meaningful consumer incentives for high-value choices, including the promotion of tiered-network plans (TNPs). Finally, members considered state monitoring of utilization patterns among different types of hospitals (See Recommendations).

“We should all admit the reality that our very expensive healthcare system in Massachusetts has a number of root causes, many of them not only Massachusetts in origin as there are many systemic challenges in healthcare delivery and financing across the US.” – Paul Hattis, Professor at Tufts University School of Medicine and member of Greater Boston Interfaith Organization’s Strategy Team, testimony to the Special Commission

The Commission discussed a two-part rate compression proposal. The proposal establishes a rate minimum or floor to provide immediate relief to the lowest-paid hospitals and recommends implementing one or both of the following mechanisms. First, a state entity should be authorized to reject payer/provider contracts if it determined

that payments were based on unwarranted factors for price variation. In addition, or in the alternative, the state entity should establish and ensure compliance with differential limits on growth in reimbursement rates. Rates paid to lower-paid providers should be allowed to increase more rapidly than rates paid to higher-paid providers. Taken together, this proposal increases payments to providers at the bottom and either directly or over time reduces rates paid to providers at the top. This would compress price variation while also lowering TME (See Recommendations).

Steven Walsh, representing the Massachusetts Council of Community Hospitals, explained that State Monitoring Subcommittee members did not discuss at length

which agency would be best suited to regulate growth in provider rates. It chose the Division of Insurance (DOI) because the agency currently approves payer contracts. In addition, the Subcommittee did not agree on whether the entity should review payer/provider contracts for unwarranted factors, to monitor growth in rates, or both. Karen Tseng, representing the AGO, explained that two pricing factors contribute to increases in TME in the Commonwealth. First, TME increases when rates increase, both in FFS and risk contracts. Second, even if rate growth is frozen, TME increases when the market share of higher-priced providers grows and patient volume shifts to more expensive providers. She said that at a concept level, this proposal addresses both of these problems. Richard Frank, a healthcare economist appointed by Governor Baker, added that the proposal's intent is not to shock the system, but to create a "glide path" towards price compression or narrower price differences. He stated that limiting rate growth, in particular, accomplishes this goal. Dr. Torchiana did not support the Commission's recommendation regarding compression. He stated that taking funding from higher-priced institutions will harm hospitals in Massachusetts who are already competing with their international peers. He emphasized that the unemployment rate is very low, premium growth is low, and placing a cap on hospital prices is not an answer to the healthcare challenges in the Commonwealth.

"Hospitals like Lawrence General Hospital are part of the solution for cost savings to the Commonwealth and every person who seeks healthcare in Massachusetts. Every time someone chooses my hospital they save the system. We are part of the solution for unsustainable health care costs – but only if we are sustainable!" –
Dianne Anderson, CEO of Lawrence General Hospital, testimony to the Special Commission

Commission members supported increasing rates for the lowest-paid providers, but also agreed that it is important to keep total costs down. Several members expressed concern about the funding source for the immediate lift. Mr. Walsh explained that there are several options to fund the rate increase, including using funds appropriated by

Chapter 115 of the Acts of 2016, which created the Special Commission. Chapter 115 establishes the Community Hospital Reinvestment Trust Fund and designates \$45 million to be distributed to hospitals with relative price levels under 1.2.⁴⁷ Funding could also come from the process itself. For example, if a state entity rejected a contract based on unwarranted factors, the payer and provider would have to negotiate lower rates. The resulting contract would yield savings that could be used to fund those providers at the bottom. Mr. Walsh emphasized that it would take a very small amount of money to increase payments to these providers to some minimum threshold.

Several members suggested a more detailed approach to setting the minimum rate floor. Dr. Torchiana asserted that as the nuances of rate-setting pile up, it becomes

⁴⁷MASS. GEN. LAWS. ch. 12C, § 23.

clear that regulating a little bit is not necessarily realistic. Each hospital has a different commercial payer mix. Therefore, the impact of a lift would be different for each institution. Dr. Torchiana suggested that the threshold take this into account, to ensure that providers receive approximately the same financial benefit. Ms. Nicholas suggested using an additional filter, such as warranted and unwarranted factors for variation, to determine how the money is distributed. Lora Pellegrini, representing the Massachusetts Association of Health Plans, stated that payments to community hospitals should take into account the fact that not all community hospitals are losing money. Robert Berenson, Institute Fellow at the Urban Institute, served as an expert panelist at the Commission meeting. He suggested that the members look at West Virginia's approach to setting a rate floor, which bases the floor on hospital input costs.

Commission members also discussed which state entity could implement the rate compression proposal. All members acknowledged that new legislation would be necessary to grant the implementing entity the statutory power to regulate. Dr. Frank suggested using DOI's existing power to approve rates, since the new responsibility could be layered on to the existing rate-review process. Gwendolyn Majette, Associate Professor at the Cleveland-Marshall College of Law, serving as an expert panelist at the Commission meeting, agreed. She noted that the proposal would give payers greater power at the negotiating table: they would have the leverage to refuse certain provider demands, by pointing to the fact that the contract might not be approved.

Ms. Pellegrini, however, added that DOI only regulates the payers, so additional measures are necessary to hold providers accountable. She made it clear that this language was necessary in order for her to support the recommendation. She emphasized that her smaller plans feel that there is a great risk that dominant providers would simply refuse to do business with them. Since plans that do not include certain providers are unappealing to consumers, fewer consumers would choose these products. This would threaten the plans' market position and financial stability and disrupt patient care. Ms. Pellegrini suggested granting authority to the HPC. Ms. Nicholas responded that her members would be extremely opposed to granting the HPC this authority, since there is no hospital experience represented on the HPC Board. She added that expanding DOI's role makes sense because it would give DOI greater capacity to comprehensively regulate health insurance. Finally, Ms. Nicholas stated that no business entity should be forced to deal or contract with another entity. House Majority Leader Ronald Mariano, appointed by House Speaker DeLeo, initially expressed his support for granting the authority to the HPC but ultimately suggested that the legislature determine the appropriate entity.

To address Ms. Pellegrini's concerns, Professor Majette suggested that the Commission consider building off the HPC's Performance Improvement Plan (PIP) process. PIPs could be used to hold providers and not just payers accountable to rate compression requirements. Professor Majette emphasized that the PIP process is already in place and could be adapted to this application. Secretary Marylou Sudders, representing the Executive Office of Health and Human Services, noted that PIPs

have an important role, but DOI needs to maintain its statutory authority over plans. She suggested placing regulatory authority with DOI and using the HPC's PIP process as a "bully pulpit." Mr. Walsh noted that neither entity is perfectly suited to the role, since DOI regulates payers and the HPC primarily monitors providers. Commission members ultimately agreed to leave the decision to the Legislature in the event that legislation is filed. Members agreed also that any enabling legislation should include robust provisions to protect consumers from disruptions in care. Speaking to the overall work of the Commission, Professor Majette added that any legislation should minimize additional regulatory burdens on payers or plans as complex federal and state regulatory systems are already in place.

In addition to rate compression, Commission members briefly discussed a proposal to incentivize consumers to make high-value choices. Ms. Pellegrini raised a concern with TNP "opt-out" provisions. As discussed in Chapter 3, Chapter 288 of the Acts of 2010 prohibits payer/provider contracts that contain certain anti-competitive clauses; for example, that a limited-network product include all providers in a health system.⁴⁸ Chapter 288, however, also grants participating providers 60 days to opt out of a new TNP.⁴⁹ Ms. Pellegrini stated that if a payer attempts to increase the price differentials among tiers, DOI could treat this as a new product, which triggers the 60-day provider opt-out window. This is a barrier to creating innovative TNPs, since TNPs that do not include a variety of providers may be unpopular with employers and consumers.

Ms. Pellegrini suggested that if there is no new contract for that product, then the opt-out provision should not apply. Ms. Tseng stated that this recommendation is intended to study these sorts of unintended consequences of cost-control laws. Rick Lord, representing the Associated Industries of Massachusetts, commented that meaningful consumer incentives are key to increasing competition and lowering costs. He noted that TNPs are not the solution but are an important part of it. He said that DOI needs tools to make TNPs more attractive, so that consumers and employers who have not embraced TNPs to date can make high-value choices. The Commission recommended that current insurance constraints on LTNP should be revisited and possibly relaxed, to encourage adoption and consumer uptake.

Finally, Commission members agreed with a State Monitoring Subcommittee recommendation to track patient movement among providers, to assess the impact on statewide cost and quality (e.g., patient leakage or migration from community hospitals to academic medical centers). Paul Ginsburg, the Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution, served as an expert panelist at the Commission meeting. He noted that Massachusetts is somewhat atypical compared to other states, because Massachusetts academic medical centers play a larger role in the delivery of non-tertiary care.

⁴⁸ Act to Promote Cost Containment, Transparency and Efficiency in the Provision of Quality Health Insurance for Individuals and Small Business, 2010 Mass. Acts 288.

⁴⁹ MASS. GEN. LAWS ch. 176O, § 9A (2016).

SPECIAL COMMISSION ON PROVIDER PRICE VARIATION

RECOMMENDATIONS

MARKET FORCES RECOMMENDATIONS

Warranted & Unwarranted Factors for Price Variation

The Special Commission on Provider Price Variation recommends the following factors be considered warranted or unwarranted reasons for provider price variation in Massachusetts. This list is intended to apply to both acute-care hospitals and other provider types (e.g., physicians), although the methods for measuring the factors would likely vary between hospitals, physicians, and other provider types. Also, it should be noted that this list does not consider the methodology or weight that such factors could or should be given in determining pricing.

This recommendation should be considered a policy document that serves as a guide for transparency and deliberation during price negotiations between providers and payers. The feasibility and effectiveness of this recommendation, with respect to preventing unwarranted factors from influencing rates, could be evaluated and monitored through a transparent, objective, and accountable process with ongoing oversight by the appropriate state agency, such as the Health Policy Commission (HPC) or the Division of Insurance (DOI).

Addressing provider price variation must keep in mind the dual goals of making healthcare more affordable for employers and consumers and addressing unwarranted differences in prices paid to providers. The influence of factors is complex and varied. In the current payment environment, every hospital is paid at a different level for the same services by different payers, and some types of services are reimbursed at rates higher than others.

WARRANTED FACTORS:

Warranted factors should be clearly defined and measureable and not used as proxies for unwarranted factors:

Patient acuity

Prices should reflect whether providers generally care for sicker or more complex patients (e.g., provide tertiary or quaternary care). For inpatient care, the case-mix index may be the most appropriate measure of patient acuity, but further research may be needed to identify the most accurate case-mix adjuster for ambulatory outpatient hospital services. Patient acuity measures should be further reviewed and evaluated with reference to socio-economic factors and in conjunction with evolving scientific and medical developments.

High-cost outliers

Although most payers offer some type of cost-based reimbursement for high-cost outliers, it may also be appropriate for pricing levels to be higher for providers who care for high-cost outliers. For example, Medicare makes extra payments for these so-called outlier cases, in addition to the usual operating and capital MS-DRG payments. To qualify for outlier payments, a case must have costs above a fixed-loss cost threshold amount. The provider is paid 80% of costs above the fixed-loss threshold. Since outlier cases are unpredictable and outlier payments may not cover the full cost of care, it may be appropriate for pricing levels to be higher for providers who care for a substantial number of high-cost outliers, provided that there is transparency on providers' cost structures. It is important to ensure that this factor is not already incorporated into another factor, such as patient acuity, to avoid the potential for multiple counting of the same elements.

Quality

Providers offering higher quality of care, particularly as measured by clinical outcomes and including measures that capture patient experience/satisfaction, such as willingness to recommend, may receive higher prices to reward this higher value. There may be additional payments or reductions in payments based on performance on a set of quality measures, which should also take into consideration contracts that already provide financial incentives or penalties based on quality. There is agreement that outcome and patient experience measures should be improved and expanded over time.

FACTORS REQUIRING ADDITIONAL ANALYSIS:

Analysis either by the Health Policy Commission and/or the Center for Health Information to Determine their Impact on Overall Healthcare Costs and Validity as Warranted Measures

Area wages

To the extent providers have different labor costs, driven by labor costs in the region from which they draw employees, prices should reflect those differences. Medicare adjusts its payment amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital, compared to the national average hospital wage level. The Medicare wage index is revised each year and is based on wage data reported in hospital cost reports, which are publicly available. To avoid circularity, the Medicare wage index uses the average hospital wage levels for all hospitals in a given geographic area or labor market using Core-Based Statistical Areas (CBSA's), as defined by the Office of Management and Budget. There should be greater transparency surrounding providers' cost structures, including the cost of labor, to understand how wages vary among providers, particularly providers in the same geographic region. This information should be available as part of the contract negotiation between payers and providers. to justify the influence of this factor in pricing determinations.

Low/no-margin services

Higher prices may also be warranted for providers that provide a higher proportion of services that yield little or no margin but that are demonstrably needed by the community. Margin data for hospitals, however, is not uniform, may be unreliable,

and is impacted by allocation decisions at the provider level. Better insight into underlying provider costs is needed to determine whether a service is truly low- or no-margin. A uniform, definitive approach into underlying provider costs is necessary and needs more research by the HPC and the Center for Health Information and Analysis (CHIA) before being considered as a factor.

Teaching

Teaching payments reflect the higher costs providers incur in maintaining a medical education program, beyond the costs accounted for through acuity and outlier adjustments. With any decrease in federal funding provided to Massachusetts by the federal government, shortfalls in federal funding should not be automatically borne by the commercial market. There should be recognition that this is a societal good with benefit for the Commonwealth, and that there needs to be a sustainable appropriate funding mechanism aside from commercial and government payers. CHIA and the HPC should examine the extent of GME funding in other states as well as whether and to what extent there is an appropriate role for a commercial health plan and/or state government to fund these activities. Further, greater transparency is needed to understand the costs associated with teaching in relation to underlying costs, including lower labor costs associated with residents providing care. Similar to other factors, if teaching is to be considered a justifiable factor, other factors, such as acuity and outliers, would need to be taken into account, so that there is no duplication in payment factors.

Stand-by capacity

Some hospitals maintain 24/7 stand-by capacity for unique, specialized services that meet recognized community need. Acuity adjustments and outlier payments reimburse providers when a service is utilized by a patient. Standby capacity, on the other hand, is the cost of ensuring that a service is available when needed, regardless of whether it is utilized sufficiently to cover fixed costs. It may be appropriate for prices to reflect the costs of maintaining stand-by capacity for unique and specialized services. It is important, however, to document those services for which costs are not covered and to examine the extent to which the costs of maintaining this capacity are not already reimbursed through higher payments associated with higher patient acuity and/or high-cost outliers. It is also important to note that demand for stand-by care in rural areas may be more variable and therefore justified as a cost of serving the community.

Socioeconomic status of patient population

The resources needed to meet the needs of low-income populations are different than for other commercial sub-populations. Work to date has identified that healthcare costs vary for higher-income populations compared to lower-income populations. Research shows that lower socioeconomic status is associated with higher costs. Additional investigation is needed to determine whether costs relating to socioeconomic status are accounted for in commercial reimbursement rates. If changes are warranted, then work is needed to identify appropriate payment adjustments.

UNWARRANTED FACTORS:

Market power or bargaining clout, brand, and geographic isolation do not warrant price variation and do not provide societal benefits. Potential government payment shortfalls and research do not warrant price variation in commercial rates but do have a societal impact that needs to be recognized.

Factors with no societal impact

Market Power

In this context, market power refers primarily to the negotiating leverage conferred by size or relative market position, compared to payers and other provider organizations. Patient experience/willingness to recommend and provider referral preferences, which are factors that warrant variation, may contribute to a provider's size and brand. Size and brand alone, however, should not be considered a differentiating factor for price variation.

Brand

State reports have found that brand does not correlate to with high performance on a wide variety of quality measures. Although patient satisfaction and provider referral relationships may contribute to a provider's brand, brand alone should not be considered a differentiating factor for price variation.

Geographic Isolation

Health plan's networks must reflect local geography and demographics to ensure that members have sufficient access to necessary care. However, geographic isolation alone is not a valid factor for price variation. Further, DOI monitors and reviews health plan networks to determine whether members have reasonable and timely access to a broad range of providers and services. In some cases, however, geographically-isolated providers may merit higher prices, if they are the sole provider of low-margin services in their area. This factor, however, should be examined in the context of whether this is already covered by higher payments for wages, standby costs, and other factors referenced above.

Factors with societal impact

Government payment shortfalls

There is a persistent dynamic among governments, providers, and commercial payers (including employers) concerning what constitutes sustainable, appropriate government funding by Medicare, Medicaid, and the Group Insurance Commission. Providers are concerned about possible future reductions in government funding, and have used commercial payments to some degree to balance any difference between payment and the cost of providing care. Payers and employers on the Commission, however, noted that it is not viable to expect commercial payers to automatically make up the difference in any potential government shortfalls. There should be recognition that serving those insured by public payers is a societal need that requires a sustainable government funding mechanism.

Research

Currently, research costs are covered by public funding (e.g. National Institutes of Health), philanthropy, and other private sources. There are differing opinions among Commission members about whether research costs should be included in commercial payment rates. To the extent that maintaining academic research programs may result in costs not covered, and given the economic importance of medical research to the Commonwealth and to patient care, if the current funding model changes, some on the Commission feel a that sustainable and appropriate broad-based funding mechanism is essential. Other Commission members do not believe that commercial health plans and employers should be expected to fund these efforts.

Address “Surprise Billing” and Out-of-Network Issues to Protect Consumers and Support Network Participation

As a key part of an overall strategy to address provider price variation through market mechanisms, the Special Commission on Provider Price Variation applauds the increased use of limited- and tiered-product designs. These products, designed appropriately, can be an important tool to enable patients and consumers to have the benefit of lower-cost coverage options, promote high-value providers, and help address price variation.

Certain issues concerning these types of plans, however, merit a strong recommendation for legislative action. These issues occur when patients receive care out-of-network and then receive what is sometimes called a surprise bill. There are two situations in which this occurs. First, the patient is cared for by a non-participating provider in an emergency. Second, the patient is cared for without his or her knowledge by a non-participating provider at an in-network facility. For example, a patient is scheduled for surgery with a participating surgeon but receives services from a non-participating anesthesiologist, pathologist, or radiologist. In this situation, the patient did not know or make a decision to see the non-participating provider. Out-of-network billing must be addressed so that patients are protected and payers are able to develop innovative plans.

The following issues must be addressed and resolved together as a package, since the absence of any one solution will lead to inappropriate results.

1. Consumer awareness of “surprise billing” scenarios,
2. Patient protections to prevent balance-billing, and
3. A maximum reasonable provider reimbursements for out-of-network services.

1) CONSUMER AWARENESS

Health plans educate patients on the benefits of in-network care and the risks of receiving care out-of-network. Toll-free member service lines, Explanation of Benefits guidance, and cost estimation tools are all used to demonstrate that no network is all-inclusive. Planned out-of-network care or inadvertent leakage can lead to additional costs for the consumer and the healthcare system.

Massachusetts should adopt additional member protections – similar to measures adopted by California, Connecticut, and New York – that define specific surprise bill and non-surprise bill scenarios, including a reminder that patients can be billed when they knowingly choose to receive services from a provider that is not participating in their health plan. Providers should inform patients when the patient is going to be cared for by a non-participating provider. Likewise, health plans should assist their members in determining which physicians and hospitals are in- or out-of-network.

2) PROTECTING PATIENTS FROM BALANCE BILLING

Effective balance-billing prohibitions are necessary to protect patients. Massachusetts should enact into law prohibitions on patients being billed by providers for the portion of their care not covered by their insurance plan. This patient protection should only apply when a patient receives emergency services (emergency room and any associated admission or care) or a non-participating provider provides care in a participating hospital or facility. If a member decides to seek care out-of-network, no protection should be implemented, since patients should appropriately bear the risk of a planned decision.

One possible model for adoption in Massachusetts is the National Association of Insurance Commissioners (NAIC) model act. It has comprehensive requirements on network adequacy and would give DOI sufficient authority to determine whether a network is adequate, by providing quantitative standards.

3) ESTABLISHING AN OUT-OF-NETWORK PAYMENT RATE

There was consensus among Commission members that establishing a default rate of payment for services rendered out-of-network is a critical part of any recommendation. This protection is particularly important for incenting the creation of robust networks necessary for novel insurance product designs that can help address provider price variation.

In setting a maximum reasonable price for out-of-network services, the state should adhere to the following key principles. First, the overall impact should result in cost savings to consumers and employers and have minimal additional administrative expense to both providers and payers. Second, there should be a reasonable, transparent, and simple approach to applying a rate, not a cumbersome metric that is non-transparent or easily administered. Finally, any rate should ensure that current in-network participation levels by providers are improved upon. The set rate must not inadvertently be at such a high level as to entice providers to leave a network, or at such a low level as to make a health plan indifferent as to whether the provider is in- or out-of-network.

Commission members examined the following two scenarios in detail:

1. The patient receives emergency care from a provider participating in a health plan's broad network but that provider has either opted out of or not been selected for participation in a tiered- or limited network product; or

2. The patient receives care in a contracted facility from a physician that is not contracted with the health plan (e.g. Emergency, Radiology, Anesthesia, and Pathology [ERAP]).

Scenario 1: A provider's payment for emergency out-of-network services, as described above, should be set at its currently-contracted rate with that health plan or at a level slightly above that rate (e.g., 10%). The rate should be set by statute to ensure both easy administrative processing and regulatory certainty in the marketplace. The HPC, or other appropriate state entity, should convene a workgroup of interested parties for the specific and time-sensitive purpose of drafting recommendations on this rate, to be filed with the legislature. A statutorily set rate should incent robust network development, as well as significantly lower the cost of care.

Scenario 2: Where a provider does not have a contract with the health plan, the default rate should be at a level significantly below charges but not below Medicare. The appropriate entity should convene a workgroup of interested parties for the specific and time-sensitive purpose of advising the HPC so that it can draft recommendations on this rate, to be filed with the legislature. Like the prior scenario, this rate should be codified in statute in such a manner as to incent robust network development, as well as significantly lower the cost of care.

Tiering Transparency and Participation

The Special Commission on Provider Price Variation endorses the need for improved transparency regarding the provider tiering by health plans. Health plans and providers should collaborate to facilitate further offerings of tiered- and limited-network products as an important option for consumers and employers.

TIERING DISPLAY

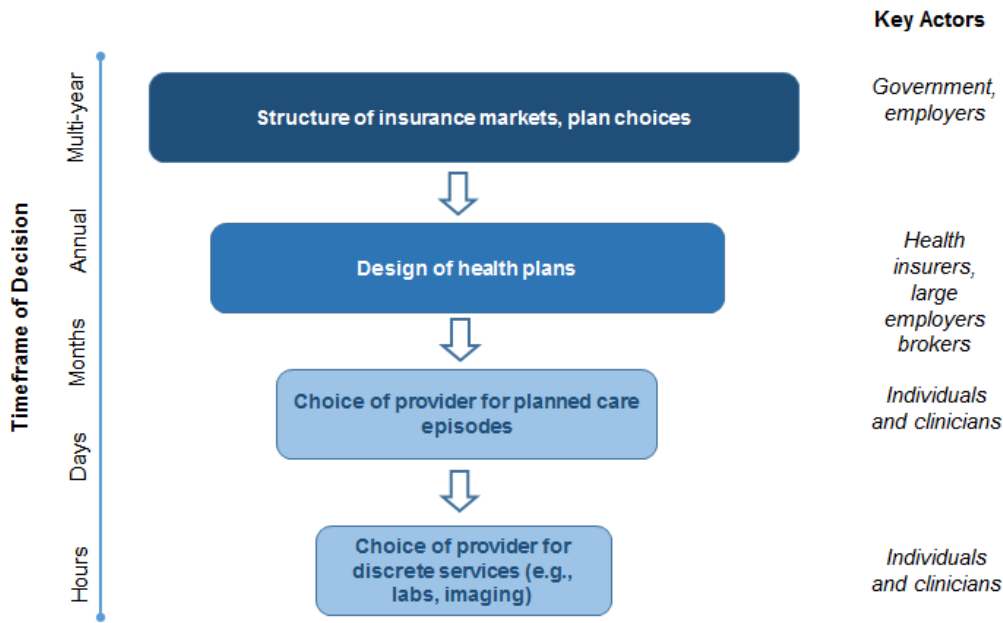
Health plans should develop a uniform method for displaying a hospital's assigned benefit tier so that information on how the hospital performed on cost and quality benchmarks is presented in a consumer-friendly format for patients and providers.

TIERING TRANSPARENCY

Upon request by a hospital, health plans should provide the methodology used for a hospital's tier placement, including the criteria, measures, and data sources, as well as hospital-specific information used in determining the hospital's quality score, how the hospital's quality performance compares to other hospitals, and the data used in calculating the hospital's cost-efficiency.

TRANSPARENCY RECOMMENDATIONS

These recommendations are designed to improve transparency at each point in the decision-making process, from selecting a plan to choosing a provider.



1

These recommendations were guided by the following principles:

1. The definition of transparency is broader than price comparisons at the point-of-service, because efforts to implement transparency solely at this point in the decision-making process have been met with limited success.
2. The opportunity and challenge of improving transparency should affect each sector of the industry and occur at each decision-point along the continuum, recognizing differences within sectors (e.g. small- and large-group insurance market; large and small employers; specialty hospitals/surgical centers and academic medical centers).
3. Efforts to improve transparency should not add to the administrative and financial burden on small businesses in the Commonwealth.
4. Transparency for transparency's sake is not the goal. Tools must be developed that educate and inform insurers, employers, providers, and patients about the fiscal and clinical implications of product design, network access, out-of-pocket expenses, and other considerations.
5. Wherever possible, these recommendations seek to further explore, support, and enhance existing legislative and regulatory mechanisms to improve transparency.
6. Elements of successful transparency efforts in other states (e.g., New Hampshire website) should be adopted.
7. Effective transparency tools must include quality as well as cost information. The quality data should be as granular as possible where it exists and should reflect developments in quality measurements. Standard quality metrics should be developed to provide consistency and support improved quality.
8. Transparency tools need to adapt continually to be relevant.

¹ This chart is based off a visual created by the Health Policy Commission presented by David Auerbach at a meeting of the Special Commission on December 13, 2017.

Transparency Website

As mandated by Chapter 224 of the Acts of 2012, CHIA will establish a consumer website. The development of this website will be informed by a thorough stakeholder process and the principles articulated above and take into account the following recommendations.

- CHIA will release a beta site by July 1, 2017, with a focus on supporting consumers and small business owners.
- CHIA will create an educational platform to provide information along the decision point continuum, including publishing a multi-payer weighted average price for a market basket of “shoppable” services. This will likely require payers to provide pricing information.
 - Full transparency includes specific information about access to behavioral and substance abuse services, drug formularies, and other costs, which can be opaque to employers and employees when selecting plans.
- There shall be a strong partnership between CHIA, the Commonwealth Connector Authority (Health Connector), the HPC, and the Group Insurance Commission to leverage work already complete or underway and to ensure consistent methodology and analytics.
- When consumers seek information on out-of-pocket costs, the website will direct consumers to their insurer’s website, wherever possible.
 - Interactive decision-tree tools should be developed to inform consumers and employers about the ramifications of their plan choice; for example, how choosing a tiered network impacts the patient’s choice of hospital.

Support for Small Employers

Small businesses should be additionally supported through the following actions:

1. When considering the user requirements for its website, CHIA should place specific emphasis on interactive decision tools and educational materials to support consumers and small business owners who may not have access to data or expertise.
2. DOI should prioritize implementation of the Ch. 224 mandate to create standardized, understandable, and timely explanation of benefits forms that includes information about lower-cost alternatives.
3. The Commonwealth should pursue opportunities to improve the purchasing power of smaller businesses and consider Professional Employer Organizations (PEOs), as allowed.
4. Insurers and small employers should work together to develop tools for employers to understand trends within their insured population, while protecting the privacy of individuals.

STATE MONITORING RECOMMENDATIONS

These recommendations were guided by the following principles:

1. Unwarranted provider price variation is a problem in Massachusetts.
2. There are providers that are being greatly underpaid due to unwarranted factors, just as there are providers being overpaid based on unwarranted factors. Underpayment and overpayment are both signs of market failure and are equally problematic.
3. Ensuring access to efficient and affordable healthcare in the community requires that providers are fairly paid according to warranted factors.
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 Commission recognizes the importance of innovation that drives patients to high-quality, low-cost providers.

Compression of Provider Rates

The Special Commission recommends a direct, multi-component proposal with a date-certain implementation and a mechanism for periodic review to address unwarranted price variation. The proposal aims to promote price compression in Massachusetts for providers in both single- and multi-year contracts. The components authorize a state entity to disapprove payer-provider contracts and/or allow for differential growth rates for hospitals whose prices are subject to the influence of unwarranted factors, and ensure that hospitals subject to the most significant levels of underpayment get immediate relief. This proposal aims to hold both payers and providers accountable for ensuring the compression of provider rates. The Commission recommends that Part 1 & Part 2 be implemented together to address disparities in payment.

PART 1: REGULATE GROWTH IN RATES

The Special Commission recommends, in order to control overall healthcare costs, to compress overall provider prices, and enable the establishment of a minimum or floor as described in Part 2, that the state implement one or both of the following. The Commission recognizes that these two actions taken together would make the most meaningful impact on provider price variation.

- An enhanced role for the appropriate state entity, such as DOI or the HPC, to review and approve insurance contracts using unwarranted and warranted factors in provider payments, such as those found in Recommendation #1. Payer-provider contracts may be reviewed, and keeping in mind the administrative burden on all stakeholders, the appropriate entity will more closely examine those contracts where providers receive relatively high or low rates (outlier contracts), as defined by the legislature. Contracts with rates based on unwarranted factors will be subject to disapproval. The state entity should utilize these factors to close the gap between high-cost outliers and more efficient, lower-reimbursed, high-value providers, and ensure that plan designs are

promoting high-value providers and helping to control the growth in statewide healthcare costs.

- Overall, growth in provider rates in Massachusetts would be consistent with the statewide benchmark on total spending growth. The rate of growth in prices for individual providers or groups of providers would be designed such that providers with low commercial prices would be able to increase their rates more rapidly than providers with high prices due to unwarranted factors.

The implementing state entity shall take measures to protect consumers and address any potential for disruptions in care. The appropriate state entity shall ensure that any savings above those needed to implement Part 1 and Part 2 is returned to employers and consumers through premium relief, while also re-allocating some savings to high-value/efficient providers in an effort to achieve the goal of compressing price variation while also lowering overall TME.

PART 2: RATE MINIMUM OR FLOOR FOR COMMUNITY HOSPITALS

In order to correct for apparent underpayment, the Commission recommends a minimum rate or floor for hospitals in Massachusetts. This floor should take into account the limits set in Part 1, ensuring premiums do not increase for consumers and employers, and warranted and unwarranted factors for price variation. The formula should be determined by the legislature in conjunction with appropriate state entities.

Monitoring Patterns of Utilization

The HPC shall 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 patient 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.

Meaningful Consumer Incentives

The HPC, DOI, and other appropriate state entities should take measures to encourage the use of more meaningful consumer incentives to promote high-value choices including, but not limited to, contribution policy, increasing price differentials among tiers, increasing the premiums between limited- and tiered-network plans and broader commercial plans, tiering plans based on primary care provider, and other efforts to enhance consumer choice through innovative product design. Current insurance constraints on limited- and tiered-network plans should be revisited and possibly relaxed, to encourage uptake and adoption.

Total Medical Expense (TME)

The Commonwealth shall continue to refine its methodology to measure TME in order to better capture the healthcare market.

GLOSSARY

Academic Medical Center (AMC): For the purpose of this report, unless otherwise noted, an AMC is a major adult hospital that 1) has extensive research and teaching programs; 2) is a principal teaching hospital for a medical school; 3) allocates extensive resources for tertiary and quaternary care; and 4) is a full-service hospital with a Case Mix Index intensity that is more than 5% above the state average.

Accountable Care Organization (ACO): A network of health professionals that share responsibility for providing coordinated care to a group of patients.

Acuity: A measurement that characterizes the health status or relative sickness of a patient population.

All-payer rate-setting: A system under which payment rates that are the same for all patients who receive the same service or treatment from the same provider. “All payers” include private health insurance plans, Medicaid, and Medicare (under an approved waiver from the federal government).

Case Mix Index (CMI): The average of the DRG relative case weights for all of a hospital’s volume.

Centers for Medicare & Medicaid Services (CMS): The federal agency responsible for administering the Medicare and Medicaid programs.

Charge: The dollar amount the hospital bills for a service. This is generally more than the amount paid to the hospital by insurers.

Cost and Market Impact Review (CMIR): A comprehensive analysis of the parties’ business and relative market position, as well as the impact of the proposed material change on health care costs, quality and access, for particular proposed material changes anticipated to have a significant impact on healthcare costs or market functioning.

Cost growth benchmark: The maximum annual growth rate for total per-capita medical spending in the Commonwealth across all sectors.

Diagnosis Related Group (DRG): A method used by Medicare to reimburse for hospital inpatient cases by classifying different types of admissions into one of approximately 575 codes (DRGs).

Deductible: The amount a member pays for covered healthcare services before the insurance plan starts to pay all or some charges.

Disproportionate Share Hospital (DSH): A community hospital that is disproportionately reliant upon public revenues by virtue of having a public-payer

mix of 63% or greater. Public payers include Medicare, MassHealth, and other government payers, including Connector Care and the Health Safety Net.

Fee schedule: An insurer's list of prices for each good or service provided. Most insurers have a "base" or "standard" fee schedule. Insurers and providers negotiate "multipliers" or "enhancements" to the base fee schedule; for example, a provider with a 1.2 multiplier for radiology services would be paid 120% of the standard fee schedule rate for covered radiology services.

Global budget: A fixed amount of funding for a fixed period of time (typically one year) paid to a provider to care for a specified population, as opposed to fixed payments for individual services or cases.

Health Maintenance Organization (HMO): A HMO is a plan that has a closed network of providers, outside of which coverage is not provided, except in emergencies. These plans generally require members to coordinate care through a primary care physician.

High-Deductible Health Plan (HDHP): A plan with a higher deductible than a traditional insurance plan. In calendar year 2016, the minimum deductible was set at \$1,300 for an individual and \$2,600 for a family.

Horizontal integration: The combining of market participants that offer goods and services in the same segment of the market (e.g., tertiary hospital care).

Limited-Network Plan (LNP): A plan that includes a narrow set of providers, compared to the carrier's general network.

Managed care: A healthcare delivery system organized to manage cost, utilization, and quality. Managed care provides for the delivery of health benefits and additional services through contracted arrangements with managed care organizations (MCOs) that accept a set payment for those services.

Material Change: A proposed transaction involving a provider or provider organization, such as a merger with or an acquisition of or by a hospital or hospital system, as defined by 958 CMR 7.02.

Material Change Notice (MCN): Notification to the Health Policy Commission by a provider or provider organization prior to making a material change to its operations or governance structure.

Medical Loss Ratio (MLR): The sum of a payer's incurred medical expenses, expenses for improving healthcare quality, and expenses for deductible fraud, abuse detection, and recovery services, divided by the difference of premiums minus taxes and assessments. The term is used to indicate the proportion of premium dollars spent on clinical services and quality improvement.

Network: The universe of providers, including acute hospitals and subacute facilities, physicians, and ancillary providers, with which an insurer contracts to provide medical services to its members.

Out-of-network bill: Charges that arise when a patient receives services from a provider outside of the patient's insurance network.

Payer: An insurer or health plan that provides some form of healthcare coverage to patients.

Payment method: The structure that an insurer uses to reimburse healthcare providers. A variety of payment methodologies exists, such as fee-for-service, per-diem, and capitation.

Performance Improvement Plan (PIP): A plan created by a healthcare entity and approved by the Health Policy Commission that identifies the causes of and implements specific strategies to reduce cost growth.

Preferred Provider Organization (PPO): A health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Members pay less if they use providers that belong to the plan's network.

Price: The contractually-negotiated amount (reimbursement rate) that an insurer agrees to pay a particular hospital, physician, or other healthcare provider for a given healthcare service.

Primary Care Provider (PCP): A health professional qualified to provide general medical care for common healthcare problems, who supervises, coordinates, prescribes, or otherwise provides or proposes healthcare services, initiates referrals for specialist care, and maintains continuity of care within the scope of his/her practice.

Provider: A physician, other health professional, or hospital that provides medical services to patients.

Provider system or provider network: A group of physicians, health professionals, and/or hospitals that jointly contract with health insurers.

Relative price: A calculated, aggregate measure that compares a provider's prices within a payer's network for a standard mix of insurance products (e.g., HMO, PPO and Indemnity) to the average of all providers' prices in that network. The relative price method standardizes the calculation of provider prices, while accounting for differences in the quantity and types of services delivered by providers and for differences in the types of insurance products offered by payers.

Risk-sharing contract: A contract between a health insurer and a provider that puts the provider at risk for some or all of the costs associated with the provision of medical care to a particular population. There are various types of risk-based

contracts, such as capitated or global contracts and withhold arrangements, under which the return of withheld amounts depends on keeping total medical expense below a certain level.

Teaching hospital: A hospital that reports at least 25 full-time equivalent medical school residents per 100 inpatient beds in accordance with Medicare Payment Advisory Commission standards and which does not meet the criteria to be classified as an academic medical center.

Tiered-Network Plan (TNP): A plan that steers consumers to certain providers by placing providers in different cost-sharing “tiers.” In most circumstances members have higher out-of-pocket costs if they visit a provider that is unfavorably tiered.

Total Medical Expenses (TME): The total cost of care for the patient population that is associated with a group of primary care providers, usually expressed as a dollar amount per patient (or member) per month. TME includes all of the medical expenses incurred by those member patients, regardless of where care is incurred (i.e., it includes physician visits as well as all hospital, laboratory, imaging, pharmacy costs, and other services, wherever those services occur). TME reflects both the price of those services and their frequency of use (i.e., utilization).

Utilization: The amount or number of medical services or units of service used by a given population over a period of time.

Vertical Integration: The combination of market participants that offer complementary goods and services in different segments of the market (e.g., tertiary hospital care and primary care).

APPENDICES

[Appendix A: NIH Funding by State, 2016](#)

[Appendix B: Relative Price & Payer Mix of all Acute Care Hospitals in Massachusetts](#)

[Appendix C: Special Commission Slides](#)

[Appendix D: Presentations to the Special Commission](#)

[Appendix E: Testimony from the Special Commission's Listening Session](#)

ACKNOWLEDGMENTS

Guest Speakers

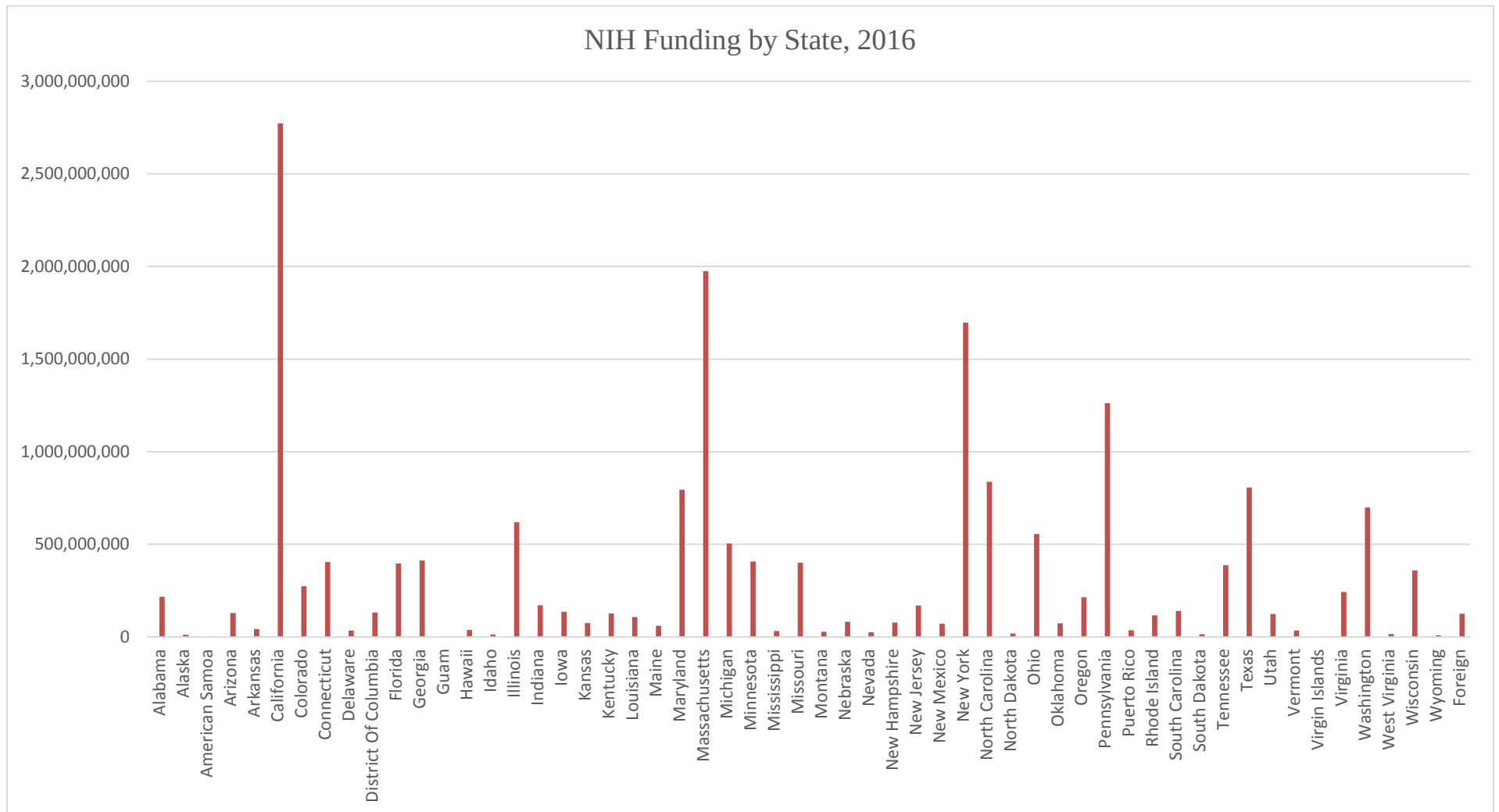
Joseph Newhouse	John D. MacArthur professor of Health Policy and Management at Harvard University
Matthew Klitus	Chief Financial and Strategy Officer at MassHealth
Gwendolyn Majette	Associate Professor at the Cleveland-Marshall College of Law
David Auerbach	Director for Research and Cost Trends at the Massachusetts Health Policy Commission
Katherine Baicker	C. Boyden Gray Professor of Health Economics at the Harvard T.H. Chan School of Public Health
Kathleen Hittner	Health Insurance Commissioner for the state of Rhode Island
Robert Berenson	Institute Fellow at the Urban Institute
Paul Ginsburg	Leonard D. Schaeffer Chair in Health Policy Studies at the Brookings Institution

The Special Commission on Provider Price Variation would like to thank our statutory partners in this work, the Massachusetts Health Policy Commission and the Center for Health Information and Analysis. Executive Directors David Seltz and Ray Campbell, respectively, and their staff assisted the Commission with data requests and drafting support. The Office of the Attorney General, the Commonwealth Health Insurance Connector Authority and specifically Executive Director Louis Gutierrez, MassHealth, and the Group Insurance Commission also assisted in this work. The Special Commission thanks the Massachusetts State House Legislative Information Services for assisting Commission staff offsite and Metro Catering for providing refreshments.

The Special Commission also thanks all the industry experts with whom we connected throughout this process. We'd also like to thank our guest speakers for their presentations to the members and their thoughtful comments. Many of our guest speakers traveled from other states and we appreciate their time.

Finally, we thank the staff of all Special Commission members for providing such timely feedback.

Appendix A



National Institutes of Health, Research Portfolio Online Reporting Tools, accessed August 2016 <https://report.nih.gov/award>

Appendix B

Massachusetts Hospital Relative Price & Payer Mix Center for Health Information & Analysis, 2016

#	Hospital	CHIA Payer Mix		Relative price
		Public	Comm	
1	Baystate Noble Hospital	65.6%	34.4%	0.681
2	Holyoke Hospital	76.2%	23.8%	0.722
3	Baystate Wing Hospital	69.6%	30.4%	0.749
4	Heywood Hospital	64.5%	35.5%	0.752
5	Lawrence General Hospital	73.5%	26.5%	0.754
6	Anna Jaques Hospital	59.1%	40.9%	0.756
7	Beth Israel Deaconess Hospital - Milton	60.0%	40.0%	0.760
8	HealthAlliance Hospitals, Inc.	67.9%	32.1%	0.781
9	Signature Healthcare Brockton Hospital	72.0%	28.0%	0.785
10	Cambridge Health Alliance	74.7%	25.3%	0.797
11	Mercy Hospital	74.2%	25.8%	0.806
12	Lowell General Hospital	64.3%	35.7%	0.822
13	Massachusetts Eye & Ear Infirmary	45.2%	54.8%	0.833
14	Saint Vincent Hospital	65.6%	34.4%	0.836
15	Milford-Whittinsville Regional Hospital	51.9%	48.1%	0.840
16	Emerson Hospital	44.9%	55.1%	0.846
17	Marlborough Hospital	63.6%	36.4%	0.849
18	Morton Hospital	68.4%	31.6%	0.855
19	MetroWest Medical Center	61.5%	38.5%	0.856
20	Steward Holy Family Hospital	67.2%	32.8%	0.859
21	Beth Israel Deaconess Hospital - Plymouth	63.1%	36.9%	0.861
22	Northeast Hospital	61.9%	38.1%	0.867
23	Winchester Hospital & Family Medical Center	44.1%	55.9%	0.892
24	Steward Carney Hospital, Inc.	76.5%	23.5%	0.895
25	Steward Norwood Hospital	63.9%	36.1%	0.897
26	Harrington Memorial Hospital	66.1%	33.9%	0.905
27	Steward Good Samaritan Medical Center	68.2%	31.8%	0.907
28	Southcoast Health Systems	72.6%	27.4%	0.908
29	Shriners Hospitals for Children Springfield		100.0%	0.909
30	Hallmark Health Systems	61.8%	38.2%	0.910
31	Shriners Hospitals for Children Boston		100.0%	0.925
32	Steward Saint Anne's Hospital	69.4%	30.6%	0.934
33	New England Baptist Hospital	44.2%	55.8%	0.935
34	Mount Auburn Hospital	53.8%	46.2%	0.938
35	Clinton Hospital	69.5%	30.5%	0.942
36	Athol Memorial Hospital	70.8%	29.2%	0.950
37	Beth Israel Deaconess Hospital - Needham	51.8%	48.2%	0.983

38	Baystate Franklin Medical Center	69.4%	30.6%	0.985
39	Nashoba Valley Medical Center	63.3%	36.7%	0.991
40	Baystate Mary Lane Hospital	62.3%	37.7%	1.001
41	Cooley Dickinson Hospital	58.7%	41.3%	1.005
42	North Shore Medical Center	70.5%	29.5%	1.005
43	Baystate Medical Center	68.5%	31.5%	1.010
44	Boston Medical Center	77.8%	22.2%	1.011
45	Lahey Clinic Hospital	85.2%	14.8%	1.011
46	Newton-Wellesley Hospital	40.3%	59.7%	1.014
47	Brigham and Women's Faulkner Hospital	55.7%	44.3%	1.046
48	Tufts Medical Center	60.0%	40.0%	1.050
49	Sturdy Memorial Hospital	65.0%	35.0%	1.051
50	Beth Israel Deaconess Medical Center	56.5%	43.5%	1.064
51	UMMC	64.3%	35.7%	1.066
52	Steward Saint Elizabeth's Medical Center	65.4%	34.6%	1.079
53	South Shore Hospital	57.5%	42.5%	1.108
54	Berkshire Medical Center	70.0%	30.0%	1.130
55	Cape Cod Hospital	68.3%	31.7%	1.311
56	Fairview Hospital	66.2%	33.8%	1.324
57	Massachusetts General Hospital	56.2%	43.8%	1.405
58	Brigham and Women's Hospital	51.4%	48.6%	1.409
59	Dana-Farber Cancer Institute	43.8%	56.2%	1.503
60	Boston Children's Hospital	35.7%	64.3%	1.514
61	Falmouth Hospital	69.1%	30.9%	1.519
62	Martha's Vineyard Hospital	65.9%	34.1%	1.932
63	Nantucket Cottage Hospital	44.1%	55.9%	1.960

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

3

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

► 5

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.

► 6

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.

▶ 7

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.

▶ 8

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.

▶ 9

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

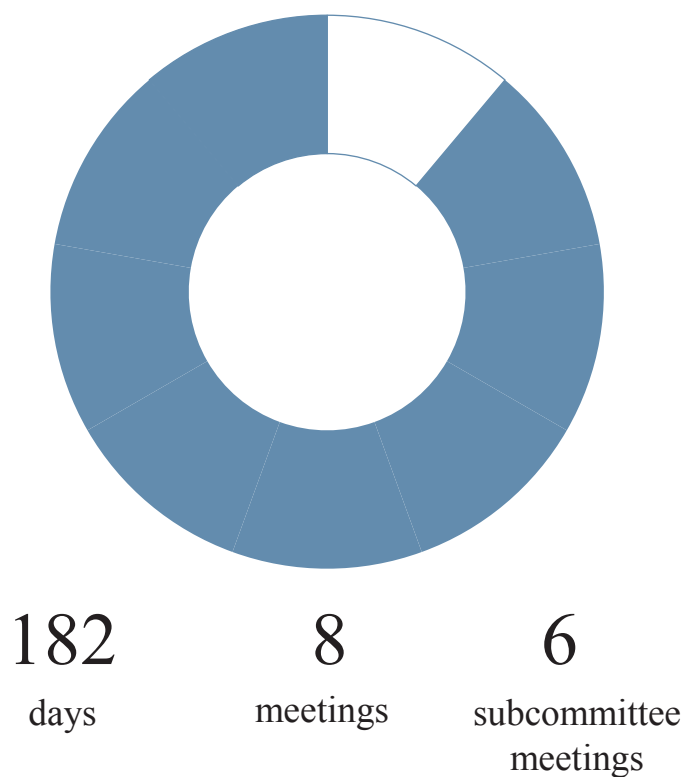
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Next Steps

- ▶ 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”

▶ 11

The Commission’s Report is due in...



▶ 12

Special Commission on Provider Price Variation

October 11, 2016

I

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

▶ 4

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

► 5

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.

► 6

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.

▶ 7

Discussion of Payment Factors

▶ 8

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



▶ 9

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

▶ 10

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.

▶ 11

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.

▶ 12

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.

▶ 13

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.

▶ 14

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 DHCFP-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.

▶ 15

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

▶ 16

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

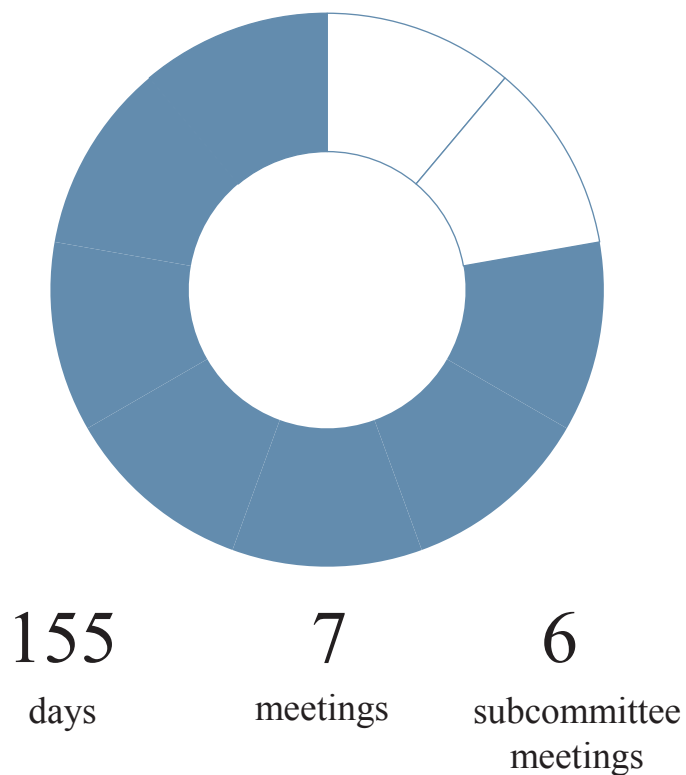
- Stand-by Services
- ED Services
- Advertising
- Research
- Care Coordination & Community Benefits by Allied Health Professionals

Next Steps

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

▶ 19

The Commission's Report is due in...



▶ 20

Special Commission on Provider Price Variation

November 1, 2016

I

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.

▶ 3

Presentation MassHealth Payment Systems

Matthew Klitus
Chief Financial & Strategy Officer
MassHealth

▶ 4

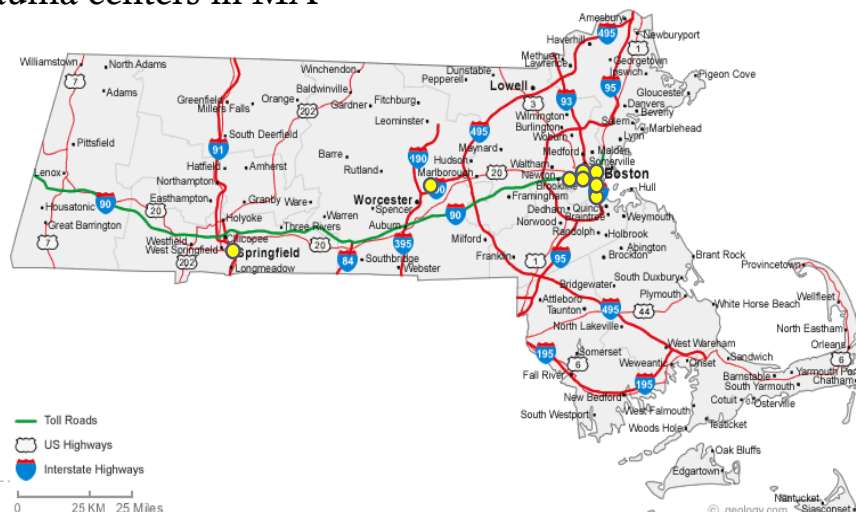
Stand-By Service Capacity

- ▶ 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.

▶ 5

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



▶ 6

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



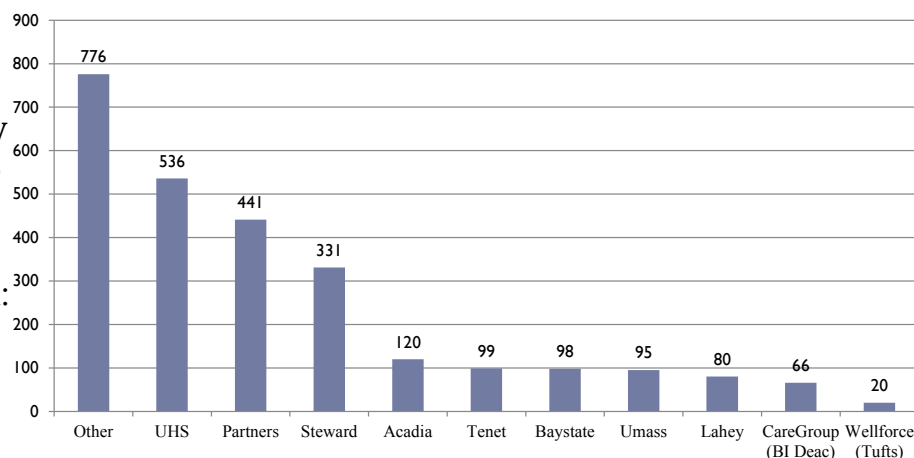
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Stand-By Service Capacity: Psych Units

- ▶ 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



▶ 8

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).

▶ 9

Advertising

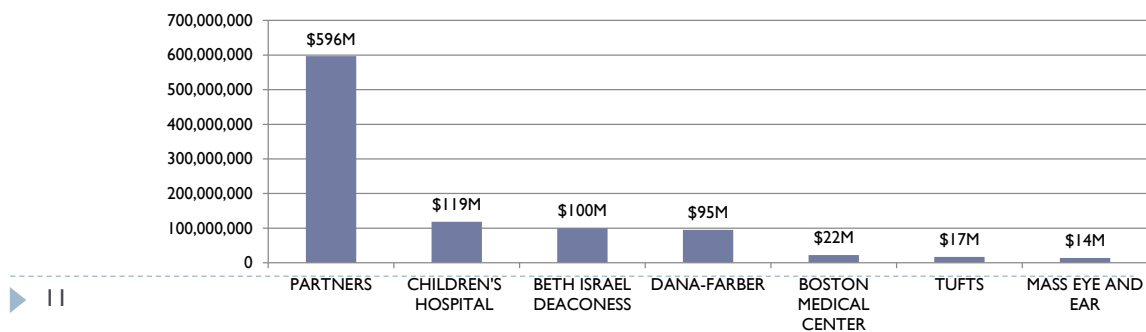
- ▶ The average advertising budget is less than 1% of total budget.
- ▶ Health care facilities are increasing their advertising and marketing budgets. Possibly due to:
 - ▶ Mounting pressure to increase revenue
 - ▶ More active decision-making by patients
- ▶ Advertising can add value to the healthcare 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.

▶ 10

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



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)

▶ 13

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)	

▶ 14

Next Steps

▶ Upcoming Commission Meeting

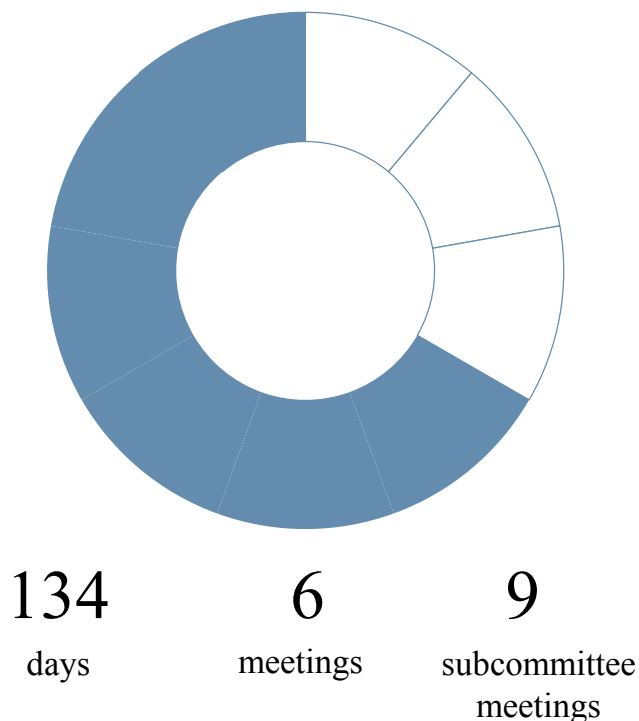
- ▶ November 29, 2016
 - ▶ 11:00am – 2:00pm at 50 Milk Street, 8th floor (Health Policy Commission)

▶ 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

▶ 15

The Commission's Report is due in...



▶ 16

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.

▶ 4

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.

▶ 5

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.

▶ 8

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).

▶ 9

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

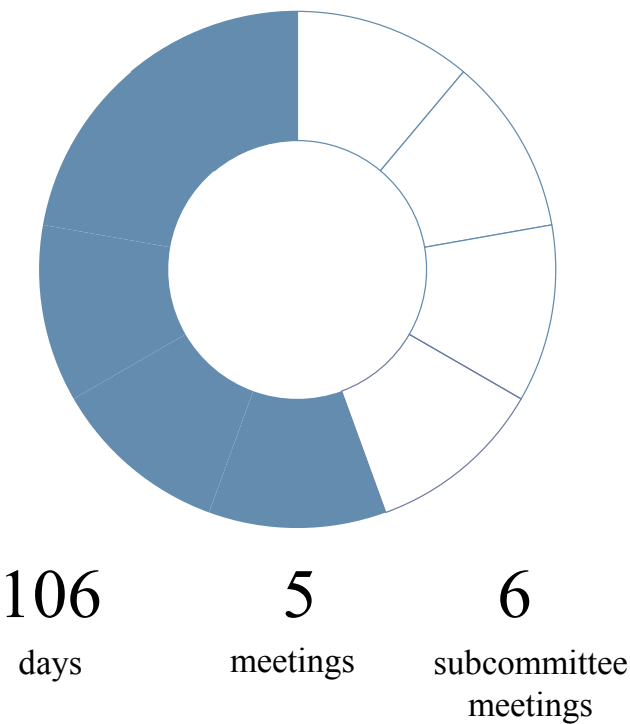
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Next Steps

- ▶ 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.
- ▶ 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
 - ▶ 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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► 6

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

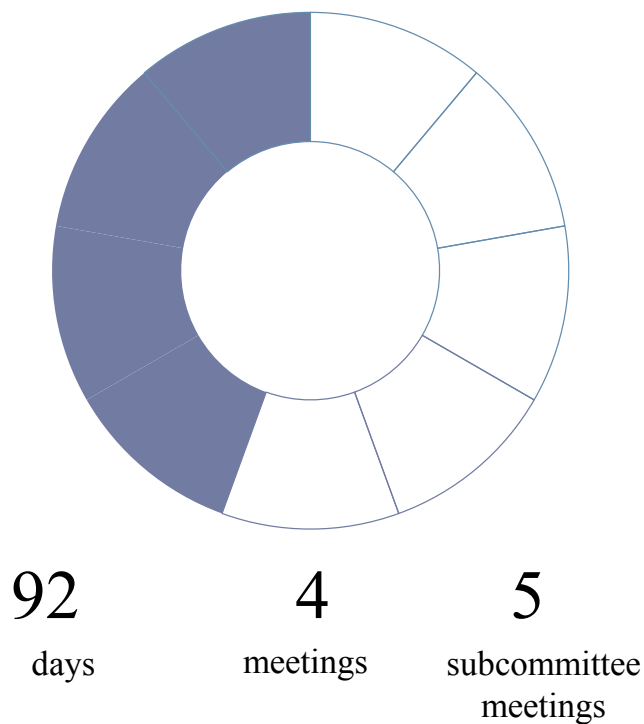
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Next Steps

- ▶ 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

▶ 9

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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Deductible amount			
Maximum out-of-pocket (MOOP) amount			
Is dental coverage included?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is there co-insurance for any services you may need?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
■ If yes, how much is the co-pay for the prescriptions you need?			

▶ 7

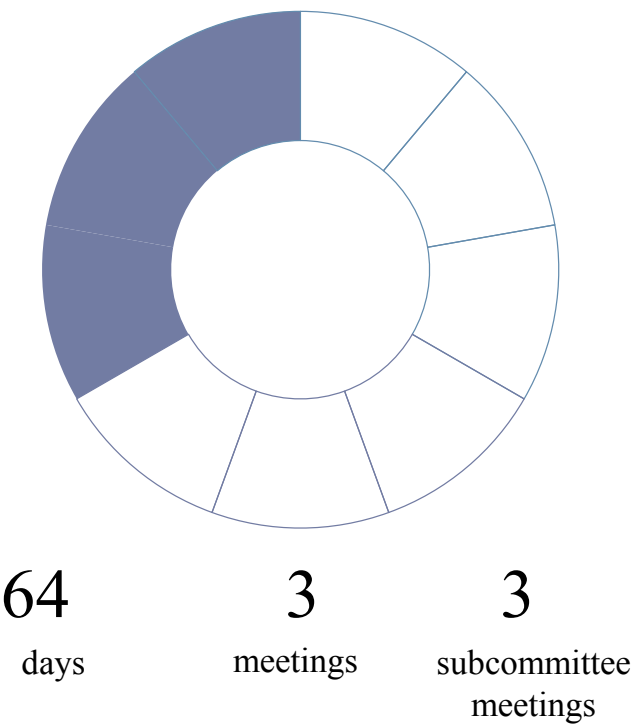
Health Connector, Health Plan Shopping Guide 2017, Individuals and Families.

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

► 3

Data Presentation
Dr. David Torchiana

► 4

State Monitoring Subcommittee Update

► 5

Transparency Subcommittee Recommendations

► 6

Market Forces Subcommittee Recommendations

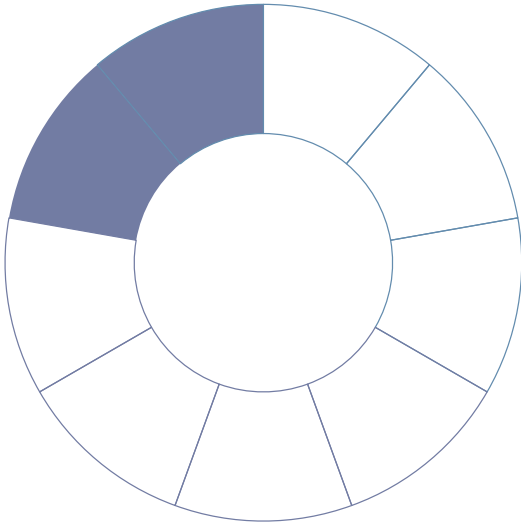
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Next Steps

- ▶ 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...



43

days

2

meetings

1

subcommittee
meetings

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

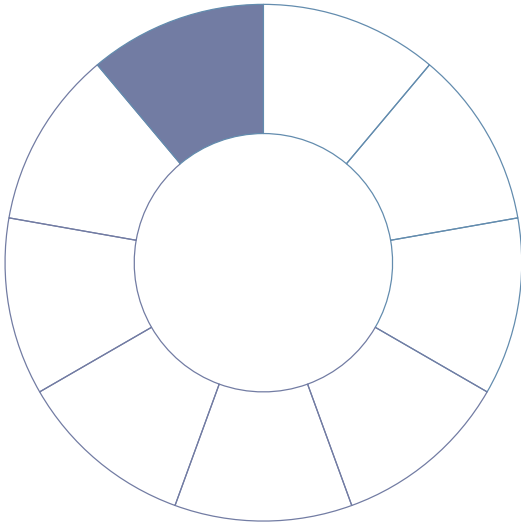
▶ II

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

Medicare Payment Systems

Joseph P. Newhouse

October 11, 2016

Disclosure and a Caveat

- I am a director of Aetna
- Medicare's reimbursement systems are complex; I will leave out many details and try to focus on the main ideas

The Inpatient Prospective Payment System (IPPS)

- Since 1983 Medicare has used the IPPS to pay most hospitals, \$147 billion (2014)
- It's a take-it-or-leave-it price, no negotiation
- Starts with a per stay (per admission) base payment and makes some adjustments
 - ◆ Physician services are excluded from the IPPS
 - ◆ A detail: There are separate systems for operating and capital expenses, but they function similarly

The IPPS: The Base Payment

- All admissions are classified into one of 751 groups defined by the principal diagnosis, whether there are additional diagnoses and how severe the diagnosis is (“complication or comorbidity” or “major complication or comorbidity”), and whether certain procedures were done
 - ◆ The groups are called MS-DRG's

The Base Payment, cont.

- Each group has a weight that corresponds to Medicare's estimate of its relative cost
 - ◆ For example, the weight for a bone marrow transplant is 4.37 and for a prostatectomy is 1.0, so, other things equal, the hospital is paid 4.37 times as much for the bone marrow transplant*
- Each year Congress sets a “conversion factor,” which says how many dollars will be paid for a weight of 1.0; future conversion factors were reduced to pay for the ACA

*These are the weights with no complicating conditions. If there are complicating conditions, the weights are higher.

The Wage Adjustment

- Each hospital is classified into a labor market area and hospitals are paid more or less according to how high wages are in that area
 - ◆ Massachusetts has had an exception for the wage index for the past few years, although it will lose that for 2017 through an error
 - Massachusetts hospitals will lose \$160 million*

*Boston Globe, May 2, 2016; CMS denied Massachusetts' appeal to rectify the error on August 2.

Other Adjustments

- The IPPS also has hospital-specific payments: Graduate Medical Education (GME) \$ and Disproportionate Share Hospital (DSH) \$
 - ◆ GME's intent is to reimburse the higher costs of teaching hospitals; it multiplies the base amount by a multiple of the number of residents/bed and also reimburses a percentage of resident salaries
 - ◆ DSH's intent is to help pay for uncompensated care; it pays hospitals with high numbers of Medicaid patients more
 - It is being reduced as the uninsured rate comes down

Other Adjustments, cont.

- Outliers: 5% of base payments go to pay for individuals with very costly stays; these payments are budget neutral
- Technology: Certain expensive new technologies get add-on payments since the base weight does not account for them
- Bad debt: Medicare reimburses for 65% of Medicare bad debt

Other Adjustments, cont.

- Quality/Value-Based Purchasing:
 - ◆ Penalties for excessive readmissions: Imposed on 78% of hospitals nationally in 2016; but only 15% of hospitals lost 1% or more of Medicare revenue and only a few lost the maximum 3%
 - ◆ Around 2% of base payments were redistributed according to quality measures, including infection rates

*Numbers are national numbers; I don't know the Massachusetts number.

Incentives of the IPPS

- Per stay payment $\Rightarrow$ incentive for *efficiency*
 - ◆ Major reduction in length of stay
- Within-MS-DRG variation $\Rightarrow$ incentive for *selection*
 - ◆ Early evidence* of modest “dumping” (selecting against high cost cases) to safety net hospitals (generally public hospitals) and also to exempt** hospitals which continued on cost reimbursement up to a limit; those studies have not been repeated

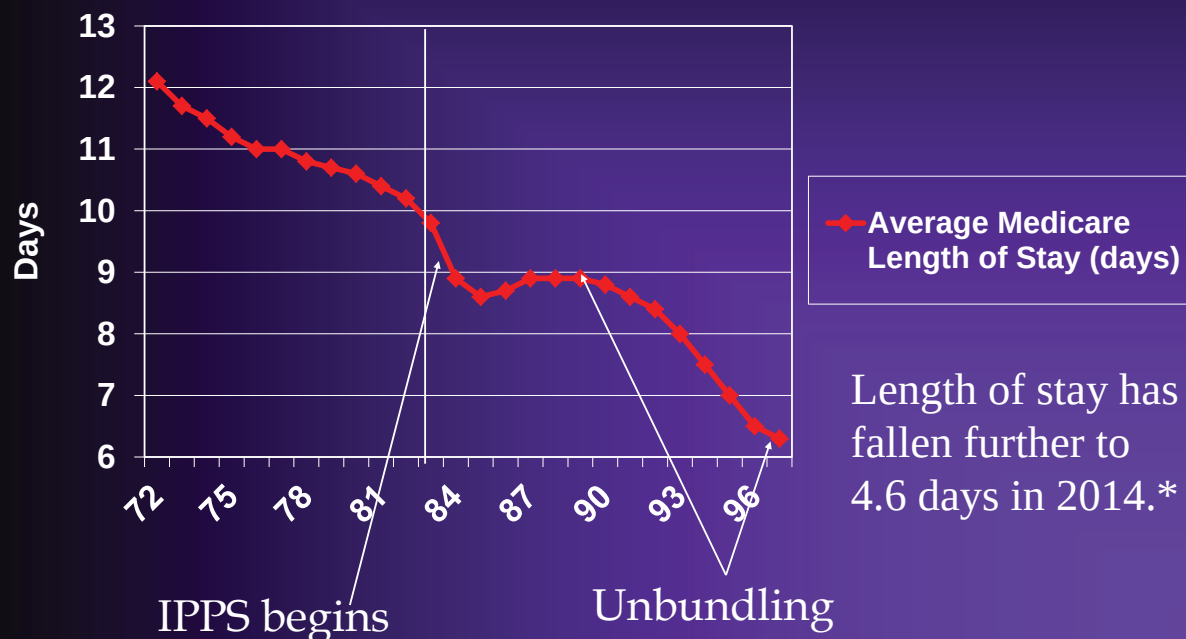
*Dumping to last resort: Newhouse, HCFR, 1989; to exempt hospitals: Newhouse and Byrne, JHE 1988.

**Psychiatric, rehabilitation, and long-term hospitals were initially exempt from the IPPS.

Incentives of the IPPS, cont.

- Marginal Revenue = 0 $\Rightarrow$ incentive to *unbundle* and possibly *stint*
 - ◆ Growth of post-acute and outpatient services since the 1980's from unbundling (shifting last days of stay out of inpatient to post-acute)

Fall in Hospital Length of Stay*



*Sources: HCFA Statistical Supplement, 1999, p. 130 and MedPAC Data Book 2016, Chart 6-9.

The Outpatient Prospective Payment System (OPPS)

- System used for hospital outpatient departments (OPD's) excluding MD's; \$53 billion (2014)
- Introduced in 2000, same principle as IPPS
- Uses Ambulatory Payment Classification (APC's), similar to MS-DRG's, 700 groups
- Adjustments: Wage index, new technology

Physician Payment: The Medicare Fee Schedule (MFS)

- For decades Medicare paid fee-for-service, some change lately; \$69 billion in 2014*
- CMS specifies relative fees for 7,000-8,000 procedures and services; Congress sets a conversion factor
- Also adjusted by an input price index
- Separate components for “work” (take-home), practice expense, malpractice cost

*Includes payments to allied health personnel such as psychologists and chiropractors, but the great bulk is to physicians.

Incentives of the MFS

- To cover fixed cost (e.g., rent) fees must exceed marginal cost, so an MD paid this way can always earn more by doing more
- How to handle “practice costs” for the same service across different sites has been a problem

Site-of-Service Differentials

- Medicare reimbursement for facility costs *for the same procedure* differs by site: OPDs; MD offices; ASCs;* inpatient hospitals
 - ◆ These are “practice expenses” in MD offices; APC amounts include these costs in ASC weights, as do MS-DRG weights in hospitals
 - ◆ Because the three** payment systems differ, payment for same patient getting the same procedure differs by site

*ASC = Ambulatory Surgery Center. Procedures commonly done in ASC's include cataract removal and colonoscopy.

**3 systems: MD office, OPD's and ASC's, inpatient hospital.

A Site-of-Service Differential*

**TABLE
2-1**

Medicare and beneficiaries pay more for a 15-minute E&M office visit provided in an OPD than in a freestanding physician's office, 2013

	Service provided in freestanding physician practice*	Service provided in OPD		
		Physician facility rate*	OPPS rate	Total, OPD rate
Program payment	\$58.00	\$39.76	\$58.94	\$98.70
Beneficiary cost sharing	14.50	9.94	14.74	24.68
Total payment	72.50	49.70	73.68	123.38

Note: E&M (evaluation and management), OPD (hospital outpatient department), OPPS (outpatient prospective payment system). The Current Procedural Terminology code for this visit is 99213.

*Paid under the Medicare physician fee schedule.

Source: MedPAC analysis of payment rates in the 2013 physician fee schedule and OPPS.

Medicare paid 70% more ($=123.38/72.50$) for a 15 minute physician visit in the hospital OPD than for the same 15 minute visit in an office.

*Source: MedPAC, June 2013.

Another Site-of-Service Differential*

Reimbursement was almost double (\$738/\$389) in the OPD

Table 2. Payment rates to physicians and OPDs for laser eye procedures, 2012

	Payment amount	Calculation
Current payment rates		
<i>Service in physician office</i>		
Payment to physician	\$389.01	Work/PLI (\$171.53) + Non-Facility PE (\$217.49)
<i>Service in OPD</i>		
Payment to physician	359.51	Work/PLI (\$171.53) + Facility PE (\$187.98)
Payment to hospital	378.93	Hospital outpatient department rate (\$378.93)
Total payment	738.44	
Policy that aligns rates across settings- Service in OPD		
Payment to physician	359.51	Work/PLI (\$171.53) + Facility PE (\$217.49)
Payment to hospital	29.51	Non-Facility PE (\$217.49) - Facility PE (\$187.98)
Total payment	389.01	

Note: OPD (hospital outpatient department), PLI (professional liability insurance) PE (practice expense). Payments include both program spending and beneficiary cost sharing.

Source: MedPAC analysis of payment rates in the 2010 physician fee schedule and outpatient prospective payment system.

*Source: MedPAC staff presentation, October 2012.

Why Are Many Cardiologists Becoming Hospital Employees?

- Medicare has, seemingly unwittingly, been driving a major change in the organization of US medical care; MD's historically were self-employed in small scale practices; increasingly they are becoming employees of large practices

Payment for Echocardiograms in the OPD Is 2.5X the Office!

**TABLE
2-3**

Differences in payment rates for level II echocardiogram without contrast provided in physician's office and OPD, 2013

	Payment amount	Calculation
Current payment rates		
<i>Service in physician's office</i>		
Payment to physician	\$188.31	Work (\$) + PI (\$) + nonfacility PE (\$)
<i>Service in OPD</i>		
Payment to physician	\$62.40	Work (\$) + PI (\$) + facility PE (\$)
Payment to hospital	\$390.49	OPPS rate (\$)
Total payment	\$452.89	

If the cardiologist is a hospital employee, the hospital can share the difference in reimbursement with the cardiologist.

The Consequences

Table 9. E&M office visits and cardiac imaging services are migrating from freestanding offices to HOPDs, where payment rates are higher

Type of service	Share of ambulatory services performed in HOPDs, 2012	Per beneficiary volume growth, 2010-2012	
		Freestanding office	HOPD
E&M office visits (CPT codes 99201-99215)	10.7%	-2.3%	17.9%
Echocardiograms without contrast (APCs 269, 270, 697)	34.6	-9.9	33.3
Nuclear cardiology (APCs 377, 398)	39.0	-16.8	24.3

Note: E&M (evaluation and management), HOPD (hospital outpatient department), CPT (Current Procedural Terminology), APC (ambulatory payment classification).

Source: MedPAC analysis of Standard Analytic Claims Files from 2010, 2011, and 2012.

HOPD = Hospital Outpatient Department. See notes to slide for other acronyms.

Source: MedPAC, unpublished. MedPAC has also computed data for 2013-2014 changes for echocardiograms (-5.7% in the office, +7.0% in the HOPD) and nuclear cardiology (-9.6% in the office, +1.1% in the HOPD).

A Bow in the Direction of a Fix

- The Bipartisan Budget Act of 2015 allowed the site-of-service differentials for existing hospitals to remain in place, but restricted new ones
 - ◆ My take: The horse is out of the barn

Health Policy Has Recently Seen Two 800 Pound Gorillas



The ACA



MACRA

MACRA: In 2019 Medicare Physician Payment Changes

- Starting in 2019, almost all MD's will be paid under one of two new payment models, the Merit Based Incentive Payment System (MIPS) or Advanced Alternative Payment Models (APM's); CMS estimates 90% will be paid under the MIPS, and I will focus on the MIPS

The New Payment Methods

- ◆ CMS issued a proposed rule in April 2016 (900+ pages)
- ◆ MIPS: Payments to an individual MD can go up or down 4% in 2019, 5% in 2020, 7% in 2021, and 9% after that based on quality, use of EHR's, clinical practice improvement, and cost*
 - The actual adjustments for any individual MD will depend on the distribution of scores to in order achieve budget neutrality

*Plus there is an extra 10% bonus for "exceptional" performance that is not subject to the budget neutrality adjustment, \$500 million in total.

MIPS, cont.

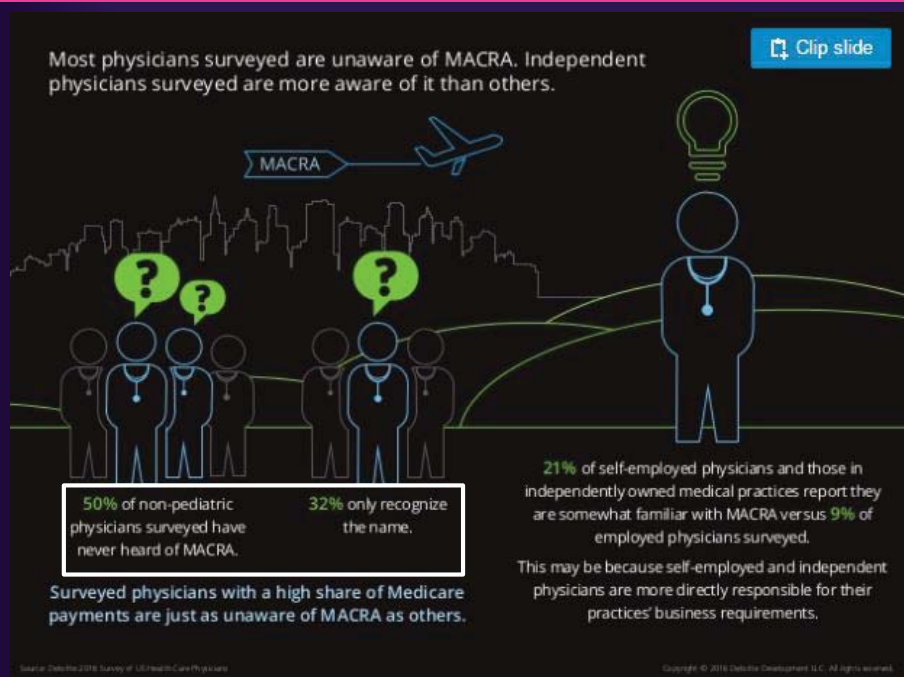
- Although the payment adjustments ($\pm 4\%$ in 2019 for incentive payments, going up to $\pm 9\%$ in 2022) don't start until 2019, **they are based on performance in 2017** and then the adjustment is applied to Traditional Medicare billings in 2019, so from an MD's point of view the new system starts in a few months

The Politics of MACRA

- MACRA was enacted with substantial bipartisan support so although the details may be modified, it is likely to remain policy irrespective of the election results*
 - ◆ The many Republican bills in the House to repeal the ACA exempted its delivery system reforms, which was the heart of the changes in MACRA

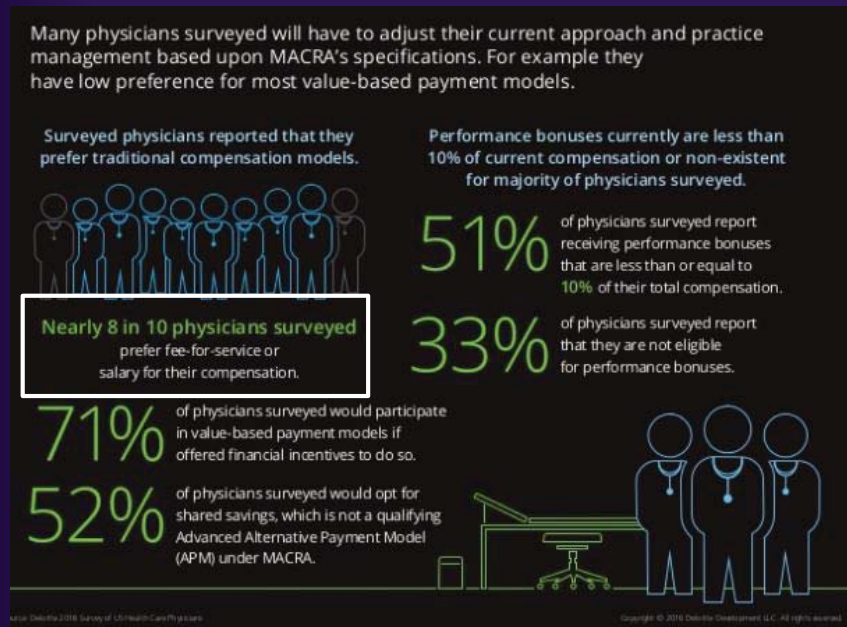
*I expect the Final Rule to be issued in November.

Despite MACRA's Importance Most MD's Don't Know of It*



*Source: <http://www.slideshare.net/DeloitteUS/2016-survey-of-us-physicians-physician-awareness-perspectives-and-readiness-for-macra>

And MD's Like FFS Reimbursement or Salary*



*Source: Same as prior slide.

And a Month Ago CMS Took Its Foot Off the Gas Pedal

- September 8, 2016: CMS says it will effectively allow a physician to push implementation off a year; all he or she has to do to avoid a negative adjustment is to report some (as yet unspecified) data
- Or the physician can report for part of the year and get a positive adjustment
- Or he or she can participate in the MIPS or the APN as originally specified

My Take on Future Physician Payment

- Moving from the fee-for-service system is going to be a slow process
- Even if an organization like an Accountable Care Organization takes some financial risk, individual physicians may have a large part of their compensation paid under fee-for-service

Conclusions

- Running administered price systems like Medicare's is difficult; prices that are misaligned with cost induce distortions, which may be under- or overprovision of various services or shifts to employed physicians
 - ◆ New products and gains in productivity from experience are hard to account for

Supplemental Slides

The Merit Incentive Payment System (MIPS)

Box. The 4 Components of the Composite Performance Score of the Merit-Based Incentive Payment System

Quality (50% Decreasing to 30% in 2021)

Physicians must report on at least 6 quality measures, including 1 outcome measure if available, from an annually updated inventory (example outcome measures include functional improvement following surgery and depression remission).

Resource Use (10% Increasing to 30% in 2021)

These measures will be calculated by CMS using claims, including 2 general measures that assess the total cost of care for beneficiaries during a year or surrounding a hospitalization, as well as 40 clinical episode measures, as a basis for rewarding efficient physicians.

Advancing Care Information (25%)

This category replaces meaningful use measures on health information technology with fewer and more flexible reporting requirements intended to promote interoperability and data flow relevant to a physician's practice, rather than electronic health record capabilities per se.

Clinical Practice Improvement Activity (15%)

Clinicians must attest to several of a wide range of practice-level activities, such as delivery of telehealth services, participation in registries, and provision of 24/7 access.

Fee-for-service remains; these are adjustments up or down to a physician's payments under TM; more in class 15. CMS estimates ~90% of MD's will be in MIPS in 2019.*

*<https://www.aamc.org/advocacy/washhigh/highlights2016/459692/042916cmsreleasesproposedruleformacraphysicianpaymentsystem.html>

MACRA Pushes MD's Toward Risk-Based Entities*

Provisions Related to Advanced Alternative Payment Models

For clinicians who take a further step towards care transformation, the law creates another path. Clinicians who participate to a sufficient extent in Advanced APMs would qualify for incentive payments.

Importantly, the law does not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Standards for Advanced Alternative Payment Models (APMs)

Under the law, Advanced APMs are those in which clinicians accept risk for providing coordinated, high-quality care. As proposed, to be an Advanced APM, models must be a CMS Innovation Center model or a statutorily required demonstration and must generally:

- 1. Require participants to bear a certain amount of financial risk.** Under our proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures.

*Source: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf>.

APM's

- 5% bonus on TM payments for being in an APM; APM's may be Patient Centered Medical Homes or risk-bearing entities like an Accountable Care Organizations, but they have to save money to qualify for a bonus and the amount of financial risk necessary to qualify rises over time*
- Starting in 2026 physicians in APM's are to get 0.75 pct pt updates vs 0.25 for others**

*See slide above; the proposed rule also pushes delivery systems or physician groups toward risk-based contracting in commercial insurance, since commercial contracts count starting in 2021. **This compounds over time.



MassHealth Presentation to the Special Commission on Provider Price Variation

Executive Office of Health & Human
Services

Discussion document
November 1, 2016

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Agenda

- MassHealth FY16 summary
- Ambulatory payment methodology
- Hospital payment methodology
- Supplemental payments summary
- Questions

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MassHealth: FY16 Overview

 Focus of today's discussion

- 1.9 million members, 28% of Massachusetts population
- \$15.7 billion in FY 2016 program + supplemental spending spend:
 - \$6.8 billion on managed care capitation payments
 - \$3.9 billion on direct payments to LTSS providers (e.g., Nursing facilities, Home Health agencies, PCAs)
 - **\$4.0 billion on direct payments to medical providers**
 - **\$1.9 billion rate payments to ambulatory medical providers**
 - **\$1.2 billion rate payments to hospitals**
 - **\$0.9 billion supplemental payments to hospitals**
 - \$1.0 billion on Medicare premiums and other payments

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Payment Methodology: Ambulatory medical providers

- \$1.9 billion FY16 spending on ambulatory medical providers, e.g.:
 - Physicians
 - Community Health Centers
 - Clinical Labs
- Rate-setting process:
 - 27 Rates set by regulation M.G.L 118E Sec. 13C, 13D, in accordance with state law
 - Multi-step process to develop + promulgate rates:
 - CHIA analysis
 - Stakeholder engagement
 - Public hearings
 - Final adoption
- Payment methodology:
 - Class rates (i.e., same for any participating provider) for each procedure code
 - Procedure codes billed reflect unique services provided to each member
 - E.g. Office visit, knee replacement

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Payment Methodology: Acute Care Hospitals

- \$1.2 billion FY16 hospital rate payments (inpatient + outpatient)
- Bundled rates for inpatient + outpatient hospitals set annually in single hospital contract (“RFA”)
- Inpatient payments cover all hospital services provided during a **single admission**
 - State-wide base rate established by RFA
 - RY 17 base rate = \$10,207
 - Base rates adjusted for:
 - Acuity (calculated using 3M APR-DRG discharge grouper), e.g.:
 - Chest Pain= 0.3808 x base rate
 - Liver Transplant: 11.0454 x base rate
 - Area wage index (+/- 0.1%)
 - Outlier payment add-on for admissions with costs > \$25,000
 - Readmission penalty – Hospitals are evaluated based on their ability to limit readmissions. The base rate penalty reduction ranges from 0% - 4.4%

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Payment Methodology: Acute Care Hospitals (continued)

- Outpatient payments cover all hospital services provided during a **24-hour episode**
 - State-wide base rate established by RFA
 - RY 17 base rate = \$252.00
 - Outpatient base rates adjusted for:
 - Acuity (calculated using 3M EAPG ambulatory grouper), e.g.:
 - Skin Repair (i.e., stitches) = 0.6899 x base rate
 - Arthroplasty = 14.10 x base rate
 - Outlier payment adjustment for episodes with costs > \$2,100
 - Prior to Dec 1 2016, hospitals receive a fixed Payment Amount Per Episode (“PAPE”) that reflects the hospitals’ historical acuity + outlier cost.
 - After Dec 1 2016, rates will be adjusted for acuity and outlier costs in real time (APEC)
- Pay for Performance Program – In addition to rate payments, hospitals can earn additional payment for delivering high quality care.
 - \$20 million in RY16 paid on the basis of performance against prescribed measures

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Summary of Supplemental Payments

In addition to hospital rate payments, MassHealth makes approximately \$0.9 billion in supplemental payments not tied directly to hospital admissions/episodes

Program	Recipients	Qualifications	FY16 Value (\$M)
Delivery System Transf. Initiative (DSTI)	7 Hospitals	Hospitals with Medicaid volume >1 SD <u>above</u> statewide mean + commercial volume >1SD <u>below</u> statewide mean	200.0
Pubic Service Hospital	2 Hospitals	Authorized in 1115 Waiver specifically for CHA and BMC	140.0
Public Hospital Transf. Initiative (PHTII)	1 Hospital	Authorized in 1115 Waiver specifically for CHA	220.0
MassHealth Essential	5 Hospitals	Non-profit teaching hospitals affiliated with state-owned medical school or public acute hospital with Medicaid patient days ≥ 7%	213.0
High Medicaid Discharge Hospitals	12 Hospitals	Hospitals with > 2.7% of statewide Medicaid discharges	115.0
High Public payor	35 Hospitals	Hospitals whose Medicaid + Medicaid volume ≥ 63%	24.0
High Complexity pediatric	4 Hospitals	Pediatric Hospitals that treat high complexity children	15.0
Total			927.0

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Questions?

Health Care Contracting & Market Forces

Special Commission on Provider Price Variation
November 29, 2016

Professor Gwendolyn Roberts Majette
The Center for Health Law and Policy
Cleveland-Marshall College of Law

[1]

Agenda

- Introduction
- Challenges in the Massachusetts Health Care Market
- History of Health Care Contracting
- Health Care Contract Provisions
- Recent Cases & Initiatives
- Market & Regulatory Solutions: Reducing Price Variation
- Component Contracting
- Key Take-Aways

[2]

Challenges in the Massachusetts Health Care Market

- Fragmented care
- High volume in a primarily fee-for-service payment system
- Increasing consolidation in the market
- Increasing health care costs

[3]

History of Health Care Contracting

- Managed Care Revolution (mid-1990s)
 - Selective contracting – i.e. plans are looking for specific providers to adhere to cost containment principles and accept their payment methodology
 - Growth of hospital systems
- Consolidation & Integration (mid-1990s - 2004, post Affordable Care Act)
 - Cost-containment initiatives – i.e. risk-based contracting
 - Large health care systems & large health insurance companies

[4]

Health Care Contract Provisions

- All-or-Nothing*
 - Clause requiring the purchase/use of unwanted goods/services as a condition to obtain the desired good/service.
 - In MA, all-or-nothing language in limited- and tiered-network plans is prohibited under Ch. 176O Section 9A(a)(3) (2010).
- Anti-Incentive/Anti-Steering
 - Clause prohibiting a payer from steering consumers to high-value, low-cost providers.

[5]

*This is different from tying in the anti-trust context, which is linking goods or services across different markets.

Health Care Contract Provisions

- Price Secrecy
 - Clause prohibiting a payer from sharing the price/cost of a good or service.
 - In MA, Ch. 176O Section 9A(d),(e) (2010) and Ch. 224 prohibit price secrecy and require providers and payers to share price and cost-sharing information with consumers.
- Quality/Performance Secrecy
 - Clause prohibiting a payer from sharing quality, efficiency, or performance data.
 - In MA,
 - Ch. 224 requires providers to report quality measures to the Center for Health Information and Analysis (CHIA). CHIA must make quality information available to consumers on its website.
 - Ch. 176O Section 7 (2010) requires payers to make available provider quality information (CHIA – Standard Quality Measure Set) upon member enrollment or request.

[6]

Health Care Contract Provisions

- Most Favored Nation
 - Clause under which a dominant plan/provider demands the best price and precludes the other party from offering similar terms to its competitors.
 - In MA, these clauses are banned under Ch. 176D Sections 3 & 3A (2010).
- Out of Network Billing
 - An out-of-network bill arises when an insured individual inadvertently receives care from an out-of-network provider.
 - Examples:
 - Individual taken to an out-of-network emergency room
 - Service provided by an out-of-network provider within an in-network facility. This occurs most often with emergency, radiology, anesthesiology, and pathology services (ERAP).
 - Under Ch. 224, a consumer is not responsible for out-of-network charges if he/she did not have a “reasonable opportunity” to choose to have the service performed by an in-network provider.

[7]

Recent Cases & Initiatives

- CA Senate Bill 932 (Apr 2016)
 - Prohibits all-or-nothing language (tying), anti-tiering/steering, and price secrecy.
 - Limits rates for emergency room out-of-network providers.
- Federal Trade Commission (FTC) ACO Policy (Oct 2011)
 - Identifies four types of conduct that raise competitive concerns when exercised by ACOs with market power.
 - Anti-tiering/steering, guaranteed inclusion, and most favored nation clauses
 - All or nothing language (tying)
 - Mandating exclusive contracting with providers
 - Price, quality, performance secrecy
- UFCW & Employers Benefit Trust v. Sutter Health (2014)
 - Union and self-insured employer vs. Northern California provider
 - Alleges that certain contract provisions are anti-competitive: all or nothing language (tying), anti-incentive, exclusive dealing, price secrecy.
- US/NC v. Carolinas Healthcare System (2016)
 - US Dept of Justice and North Carolina vs. major North Carolina hospital system
 - Alleges that several contract provisions (no tiering/narrow networks and price/quality confidentiality) violate the Sherman Anti-Trust Act by unreasonably interfering with competition.

[8]

Market & Regulatory Solutions: Reducing Price Variation

- Market Solutions
 - Prohibit anti-competitive* contract provisions
 - Encourage transparency – price and quality information
 - Incentivize use of high-value providers
 - Ex: Tiered- and Limited-Network Products
- Regulation
 - All-payer rate setting (Maryland)
 - Rate caps

*Anti-competitive practices are “unfair business practices that are likely to reduce competition and lead to higher prices, reduced quality or levels of service, or less innovation.” Federal Trade Commission, *Anticompetitive Practices*, <https://www.ftc.gov/enforcement/anticompetitive-practices> (last visited Nov. 10, 2016).

[9]

Component Contracting

- Evanston FTC Order (2007)
 - Two Illinois hospitals merged in 2000.
 - The FTC retroactively reviewed the impact of the merger and found that prices had increased.
 - The FTC imposed a conduct remedy requiring separate contracting for 10 years. Payers, however, did not take advantage of this option.
 - Each hospital was required to create separate negotiating teams and establish firewalls.

[10]

Component Contracting (cont.)

- Benefits of Component Contracting
 - May reduce rates paid to certain providers.
- Disadvantages of Component Contracting
 - Increased administrative costs
 - Difficult to monitor/regulate
 - Duration
 - Changing dynamic in the health care market
- The FTC has not ordered a component contracting remedy since Evanston.
- The reviewing court heavily criticized the component contracting requirement that was part of the proposed anti-trust settlement between Partners HealthCare and the Commonwealth of Massachusetts, when Partners' proposed mergers with South Shore and Hallmark Hospitals.

[11]

Key Take-Aways

- Provider price variation exists across the country.
- Health care contracts are a product of dynamics in the health care market and have a role in price variation.
- Solution is likely a combination of both market and regulatory actions.
- Any solution will need to be phased in over time.

[12]

QUESTIONS

Demand-side incentives to address provider price variation

December 13, 2016

AGENDA

- **Overview**
- Key policy strategies
 - Insurance Design
 - Consumer Engagement and Shopping
 - Fostering Choice and Competition
- Q&A

Demand-side incentives can improve health care value

- Demand-side incentives in health care encourage purchasers of coverage and services (i.e. individuals and employers) to make higher-value choices
- Demand-side incentives can result in cost savings
 - Lower out of pocket spending and lower premiums
- Demand-side incentives can reduce price variation
 - By encouraging patients to use higher-value (e.g. lower-priced, high quality) providers, demand-side incentives can incentivize higher-priced providers to reduce prices



3

Limitations of demand-side incentives

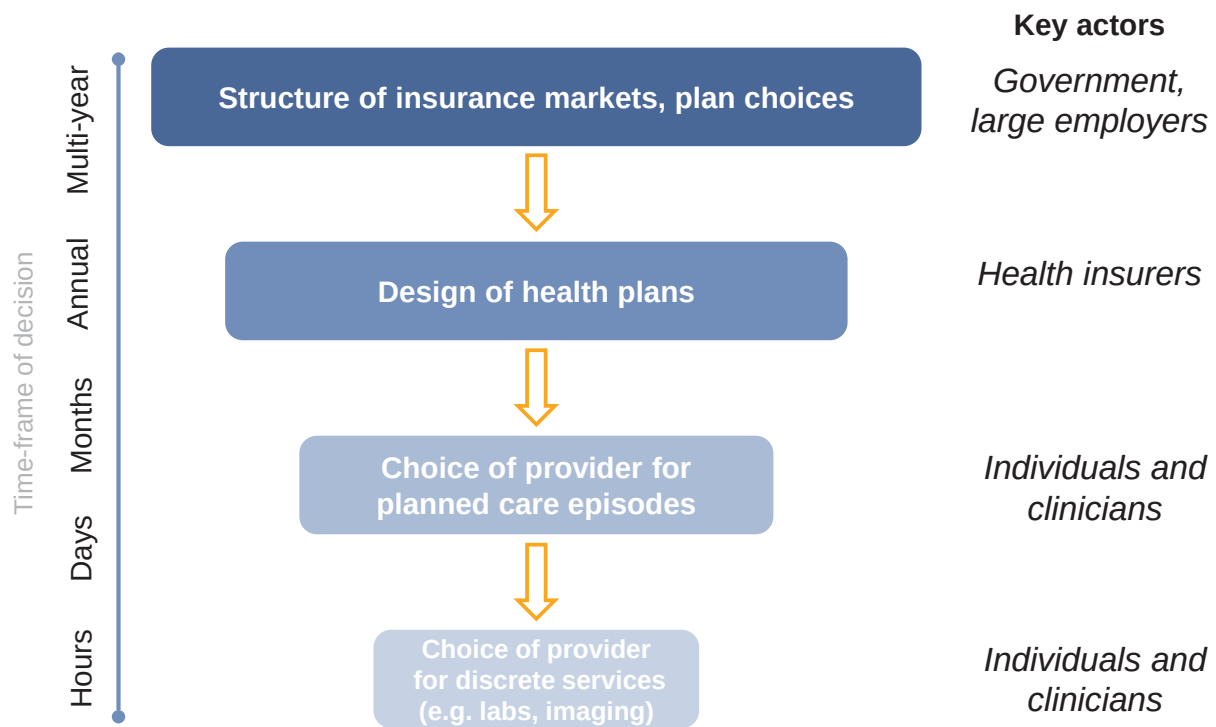
- Demand-side incentives tend to play a smaller role in health care
 - Consumers often prioritize health over cost
 - Insurance and subsidies limit exposure to the cost of care
 - Consumers don't know what health care services they need - and depend on providers to make care decisions
 - Quality is hard to judge; consumers sometimes assume higher prices mean with higher quality*
- Demand-side incentives may not work for all types of care. They tend to work best for:
 - Planned episodes of care
 - Situations where quality is transparent or doesn't vary much
- Demand-side incentives may create financial burdens for some consumers



* These findings are partly informed by a series of focus groups conducted for the HPC by Amy Lischko et al, as described in "Community Hospitals at a Crossroads," Health Policy Commission, March, 2016

4

Where can demand-side incentives be applied in health care?



5



AGENDA

- Overview
- Key policy strategies
 - **Insurance Design**
 - Consumer Engagement and Shopping
 - Fostering Choice and Competition
- Q&A

Tiered and limited network plans: Evidence of savings in Massachusetts

Limited network plans exclude higher priced/lower value providers from network

- The GIC used a premium holiday in 2012 to encourage employees to switch to limited network plans
- Those who switched had 36% lower spending with no reduction in quality of care (Gruber and McKnight, 2016)
 - Savings resulted from reduction in both prices and quantities of hospital and specialist care used; spending increased on primary care

Tiered network plans assign higher cost-sharing to higher priced/lower value providers

- BCBS of MA introduced tiered network plans in 2007, enhanced in 2009
 - \$150 copay for preferred hospitals vs \$1,000 (with \$2,000 deductible) for non-preferred
 - Radiology: \$75/250; Outpatient surgery: \$150/\$500
- The design shifted ~7% of hospital admissions from non-preferred to preferred hospitals (Frank, Chernew et al, 2015)
 - There were also impacts on radiology, outpatient, and total spending...study forthcoming

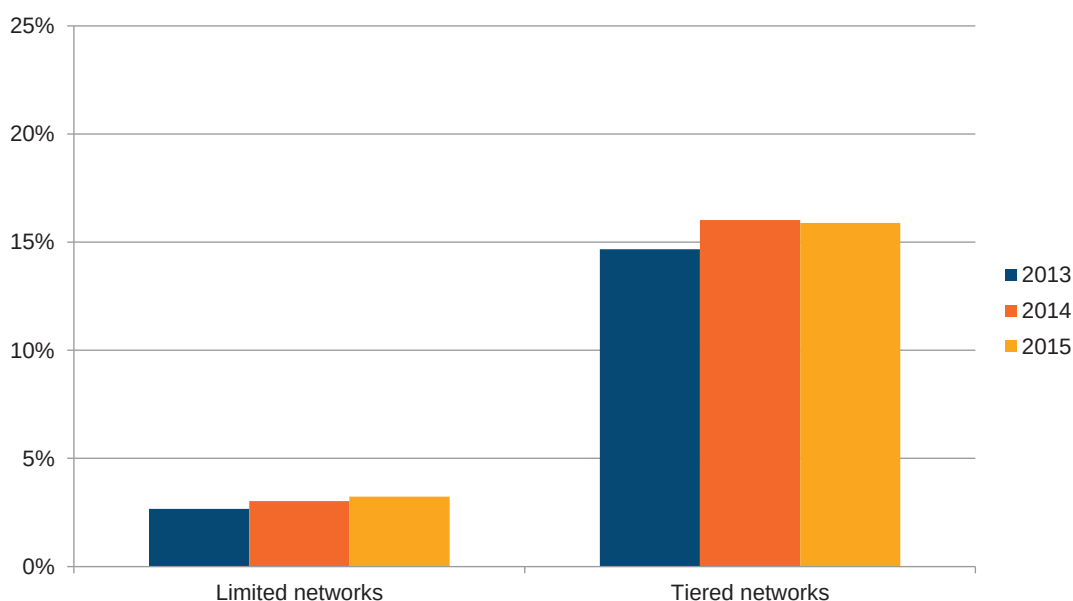


Frank, Matthew B., et al. "The impact of a tiered network on hospital choice." *Health services research* 50.5 (2015): 1628-1648
Gruber, Jonathan, and Robin McKnight. *Controlling health care costs through limited network insurance plans: Evidence from Massachusetts state employees*. No. w20462. National Bureau of Economic Research, 2014.

7

Enrollment in tiered and limited network plans in Massachusetts, 2013-2015

Percent of commercial members enrolled in each plan type



- Tiered and limited network plans change provider choice and reduce spending
- There is anecdotal evidence that some providers seek to reduce prices to be in a preferred tier
- However,
 - Consumers do not like having limited provider choices
 - *Especially if they don't feel they directly benefit from the savings*
 - These plans can be complex for employers to explain and for consumers to understand
 - These plans may work in tension with ACOs and care coordination
 - Cost-sharing differences aren't relevant if consumers are over out of pocket maximum



Testimony of Delores Mitchell, GIC director, Health Policy Commission Annual Cost Trends Hearing, 2015

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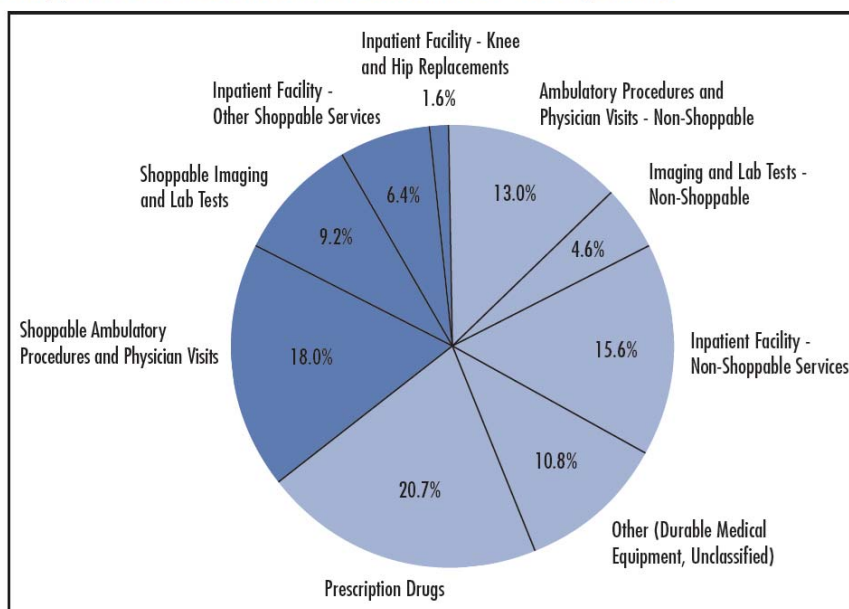


AGENDA

- Overview
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About 30-40 percent of health spending is 'shoppable' (dark blue)

Figure 1
Shoppable Services Account for One-Third of Total Spending



Note: Shoppable services were identified in claims data based on the diagnosis-related group for inpatient facility stays or the Healthcare Common Procedure Coding System and Current Procedural Terminology codes for outpatient facility and professional services.

Source: Authors' calculations using 2011 claims data from nonelderly privately insured autoworkers and dependents

Shoppable Services
Planned in advance
Choice of providers
Quality and price information are potentially available



White, Chapin, and Megan Eguchi. *Reference Pricing: A Small Piece of the Health Care Price and Quality Puzzle*. Research brief #18. Mathematica Policy Research, 2014. Health Care Cost Institute, *Spending on Shoppable Services in Health Care*, 2016

11

Getting consumers to shop

- Price and quality information, by themselves, do not tend to lead to comparison shopping and reduced spending (Gabel, 2016; Desai et al, 2016)
- But, they are a necessary ingredient for successful programs that combine price and quality information with:
 - easy-to-use programs/interventions
 - Immediate and significant savings
- Examples: reference pricing, redirection for imaging services, cash-back programs

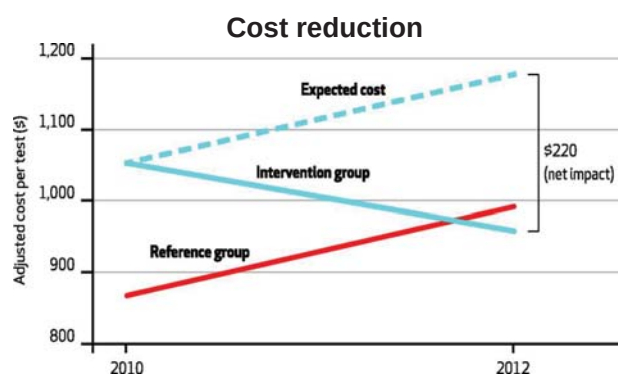
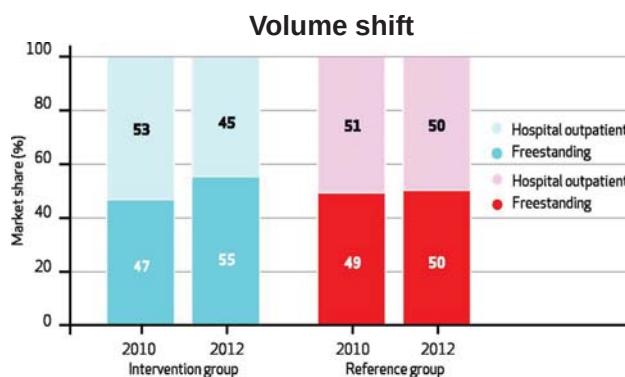


Jon Gabel et al., "Price Transparency Tool Attracts Users But Does Not Lead to Use of Lower-Priced Services," *Changes in Health Care Financing & Organization*, Issue Brief, September 2016.
Desai, Sunita, et al. "Association Between Availability of a Price Transparency Tool and Outpatient Spending." *JAMA* 315.17 (2016): 1874-1881.

12

Consumer choice intervention: patient redirection for MRI services

- A specialty benefits management company implemented a voluntary, nationwide program taken up by some employers under BCBS but not others
- 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
- Consumers who received calls from benefits manager saved 19% on MRI spending
- The program also appeared to spur competition: Unit prices dropped \$360 for hospital MRIs, and rose \$85 for freestanding (compared to controls)



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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Cash-back programs

Cash-back programs are similar to the previous example, but across a wide set of services, and with immediate cash savings to the consumer

- Insurers typically use an add-on vendor such as Vitals Smartshopper™
- Member uses website to search for services and prices
- If member chooses low-cost provider via website and fulfills service, gets a refund check, e.g. colonoscopy (max savings: \$250), MRI (\$150), gastric bypass surgery (\$500), blood draw (\$25), physical therapy (\$150), hysterectomy (\$500)

Some self-insured employers set up similar programs along these lines

Anecdotal evidence of competition-induced changes in provider market

Fallon, HPHC and now Unicare offer these programs in the GIC

New Hampshire state employees program claims \$1.7m savings in 9 months (though not a rigorous evaluation)



From New Hampshire's program for state employees using SmartShopper via Anthem Blue Cross
<https://das.nh.gov/hr/documents/VitalsSmartShopperIncentiveList.pdf>; Employers Reward Workers who shop around for health care, Boston Globe, November 28, 2016: <https://www.bostonglobe.com/business/2016/11/27/employers-rewarding-workers-who-shop-around-for-health-care/JKkmu5BI7q6fNFgbZzyZmN/story.html>

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AGENDA

- Overview
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Competitive insurance market structure

- Market structure can foster take up of efficient plans (e.g. a narrow network plan that excludes high-cost providers).
- Optimally, these conditions would be met:
 - Plans must be available to employees (i.e. choice of plans)
 - Plans must be understandable and ideally, comparable or standardized
 - Employees must realize significant savings from choosing these plans
 - Defined contribution
 - Premium holidays (GIC) or other incentives to choose low-cost plans
- The Massachusetts Connector and the GIC are good examples, though private exchanges and large firms can also create these conditions

Pro-competitive features of the Mass Connector

Standardized plans support apples-to-apples comparisons

Fixed-dollar subsidies require enrollees to pay the full difference in premiums between plans, increasing competition based on price

The Connector is an active purchaser, allowing no more than 5 plans per region – which combined with the large market volume (200,000 enrollees), gives it leverage to only accept the most competitive plans into the market

The ConnectorCare program prioritizes carriers that have experience serving Medicaid populations to facilitate transitions between the two programs. But this prioritization also empowers Medicaid MCO carriers to offer commercial plans that leverage the greater scale of Medicaid membership in the negotiation of provider contracts

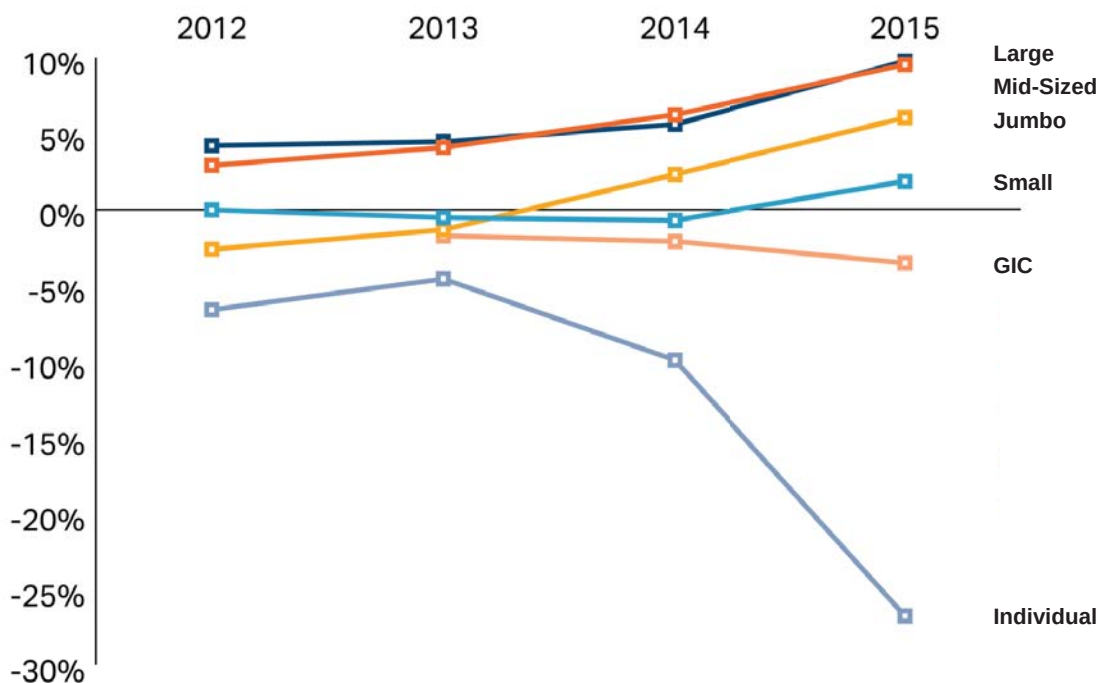
Individuals purchasing their own insurance are more likely to choose plans with a more selective and competitively-priced provider network, while employers that can only offer one or two choices tend to purchase broader-network plans to meet the needs of all members of the group



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GIC and the individual market have competitive structures and the lowest premiums

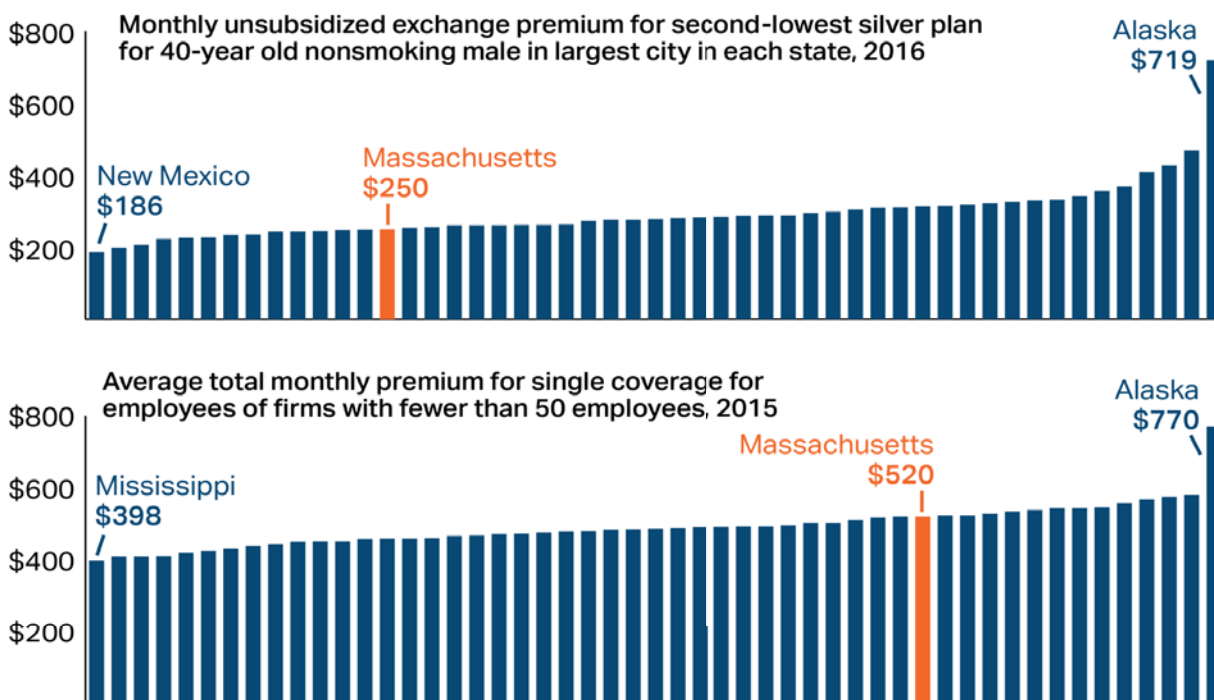
Premiums by group size relative to 2012 small group premiums, 2012-15



Source: Data from the Center for Health Information and Analysis and Oliver Wyman Consulting. Premiums are adjusted for enrollees' age, gender and actuarial value of the plan.

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Mass Connector premiums are also low by national standards

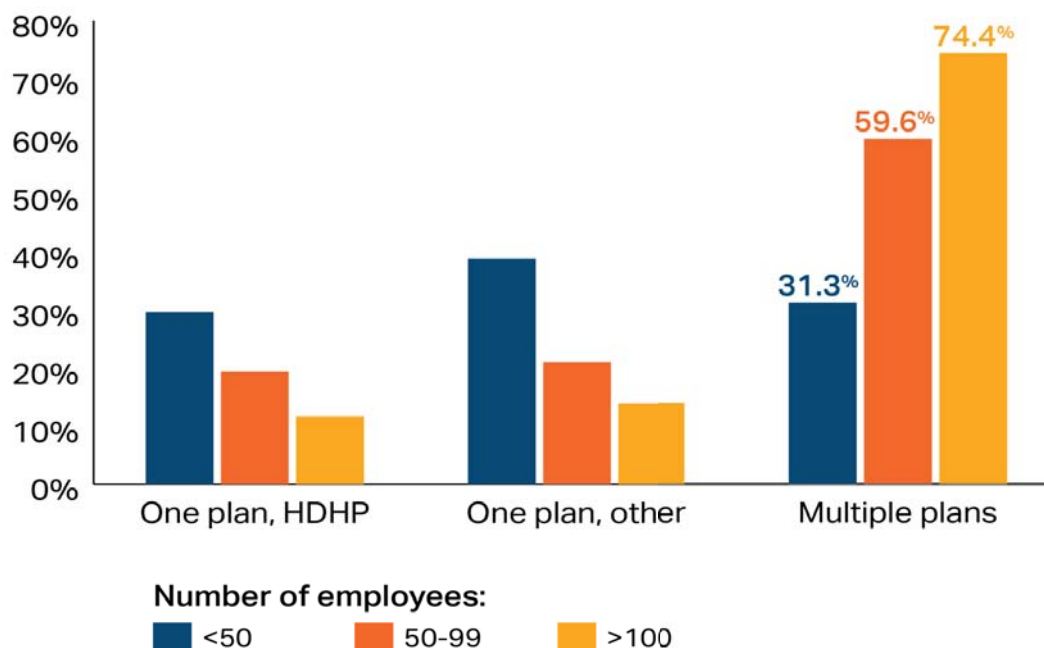


Top: Kaiser Family Foundation, State Health Facts, 2016
Bottom: AHRQ, 2015, Medical Expenditure Panel Survey

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On the other hand, most smaller businesses in Massachusetts struggle to even offer employees a choice of plans

Among employees offered coverage by their firms, percent with plan choice by company size, Massachusetts, 2014

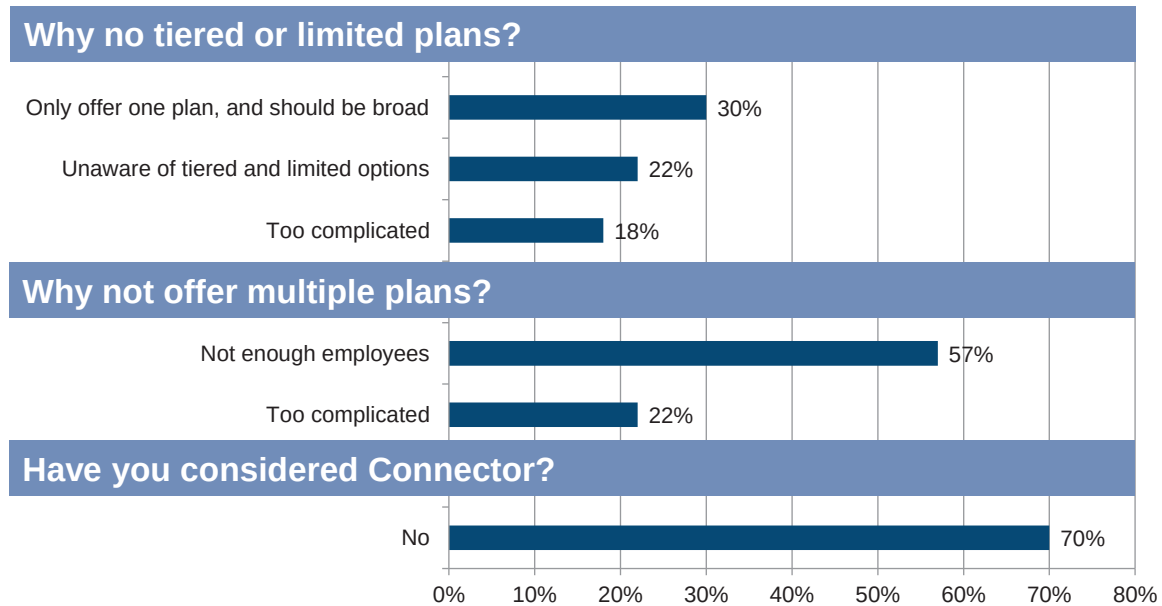


Source: CHIA Massachusetts Employer Survey, 2014

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Small and mid-sized businesses noted challenges in creating a competitive insurance marketplace

Percent of firm representatives answering yes. Multiple affirmative responses allowed



HPC/AIM survey of 188 employers, 2015

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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 and innovations exist, but thus far, use has not been widespread enough to drive market-wide changes by themselves
- 3 Fostering a competitive environment through market structure and price and quality information can spur innovation and efficiency



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Contact Information

For more information about the Health Policy Commission:

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

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



Patient Choice, Price Transparency, and High-Value Care

Katherine Baicker

C. Boyden Gray Professor of Health Economics

Harvard T.H. Chan School of Public Health

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Agenda

- Context for deploying transparency tools
- Evidence on patient responses to cost-sharing
 - Effects on utilization, value, and health
 - Interaction with payment policy
- Complementing transparency
 - Addressing behavioral factors

Patient Prices Matter . . .

- Decades of evidence that patients respond to prices
 - Demand slopes down!
 - Transparency is necessary
- Prices patients face now hamper some efforts to improve value
 - Medicare FFS
 - ACOs

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5

. . . But Not Exactly as Economics Alone Would Predict

Study	Price Change	Change in Use	
		<i>High Value</i>	<i>Lower Value</i>
Chandra (2010)	\$7 increase in drug copay (from ~\$1 to ~\$8)	Elasticity of around .15 for acute care and chronic care Rx	Elasticity of around .15 for "lifestyle" Rx
Goldman (2006)	\$10 increase in copay (from \$10 to \$20)	Compliance with cholesterol meds among high risk drops from 62% to 53%	Compliance with cholesterol meds among low risk drops from 52% to 46%; medium drops from 59% to 49%
Selby (1996)	Introduction of \$25-\$35 ER copay	9.6% reduction in visits for emergency conditions	21% reduction in visits for non-emergency conditions
Johnson (1997)	Increase from 50% coinsurance with \$25 max to 70% coinsurance with \$30 max	40% reduction in use of antiasthmatics; 61% reduction in thyroid hormones	40% reduction in non-opiate analgesics; 22% reduction in topical anti-inflammatories
Lohr (1986)	Cost-sharing vs. none in RAND	21% reduction in use of highly effective care; 40% reduction in beta blockers, 44% reduction in insulin	26% reduction in less effective care; 6% reduction in hayfever treatment, 40% reduction in cold remedies, 31% reduction in antacids
Tamblyn (2001)	Introduction of 25% coinsurance, \$100 deductible, \$200 max for Rx	9.1% reduction in essential drugs	15.1% reduction in non-essential drugs

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Importance of Behavioral Factors

- Traditional problem: “moral hazard”
 - Insurance provides valuable risk protection, but drives higher use
 - Affects insurers’ plan design and individual choices
 - Cost-sharing should balance effects on use and financial protection
- “Behavioral hazard”: Choice errors change that calculus
 - People may not respond “rationally” to prices
 - Copays should balance effects on health care use and health outcomes

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7

Small Price Changes Can Matter a Lot

Study	Price Change	Use Change	Health Value
Chandra (2010)	\$7 ↑ in drug copay	Elasticities: -.15 to -.23 for essential drugs, asthma, depression meds	6% ↑ hospitalization
Chernew (2008)	Drug copays ↓ from \$5 to 0 for generics; from \$25 to \$12.50 for name brands	Elasticities: -.12 ACE inhibitors; -.11 beta blockers; -.14 diabetes drugs	Beta blockers post heart-attack ↓ mortality by 20-30%
Hsu (2006)	Imposition of \$1000 annual cap	Adherence to antihypertensives, statins, diabetes drugs ↓ 30%	13% ↑ nonelective hospital use; 9% ↑ high cholesterol; 16% ↓ glycemic control
Goldman (2006)	\$10 ↑ in copay	10 percentage point ↓ in statin adherence	Statins ↓ risk of major coronary event by 25%
Lohr (1986)	Cost-sharing vs. none in RAND	↓ in use of insulin of 44%, beta blockers 40%, antidepressants 36%	Diabetes meds can reduce hospitalization risk by 7 ppt
Selby (1996)	Introduction of \$25-\$35 ER copay	9.6% ↓ in visits for emergency conditions	Conditions including heart attack, appendicitis, respiratory failure, etc.
Landsman (2005)	Addition of third drug tier (moving top payment from \$10 or \$20 to \$35 or \$40)	Elasticities: -.16 for ACE inhibitors; -.10 for statins; -1.15 for antidepressants	70% ↑ relapse of depression when meds discontinued

Source: Baicker, Mullainathan, and Schwartzstein, *Quarterly Journal of Economics*

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So How Can Prices Help?

- Prices are a powerful tool – but must be deployed with nuance
 - Transparency is necessary – but far from sufficient
- How, when, and by whom info presented is key
 - Trusted source
 - Quality vs. price
- “Nudges” can augment price and transparency levers

Using Nudges to Complement Transparency

- Info about costs vs. benefits
 - Misperception of risks
 - Salience of symptoms, benefits, cost
 - Delay of benefits vs. payments
- Cognitive overload and complexity
- Reference dependence
 - Framing as gain vs. loss
- Benchmarks
 - Social comparisons

Principles Apply More Broadly

- Many stakeholders – all people!
 - Transparency and framing key at many junctures
 - Patients/enrollees
 - Health care: utilization, compliance
 - Insurance: take-up and enrollment, choice of plans
 - Health behaviors: smoking, obesity
 - Insurers and Payers
 - Plans offerings, how to price/subsidize, recruitment tools
 - Providers
 - Intensity of treatment, compliance with best practices
 - Choice architecture matters a lot here
 - Transparency and framing
-

PROVIDER PRICE VARIATION & THE COST OF HEALTHCARE IN RHODE ISLAND

Presentation to the Massachusetts Special Commission on Provider Price Variation

January 31, 2017

Dr. Kathleen C. Hittner, Health Insurance Commissioner

Agenda

- Background on OHIC
 - OHIC Theory of Action
- Why OHIC Cares About Price Variation
- OHIC Efforts to Curb Spending Growth
 - Price Transparency
 - Innovative Regulation

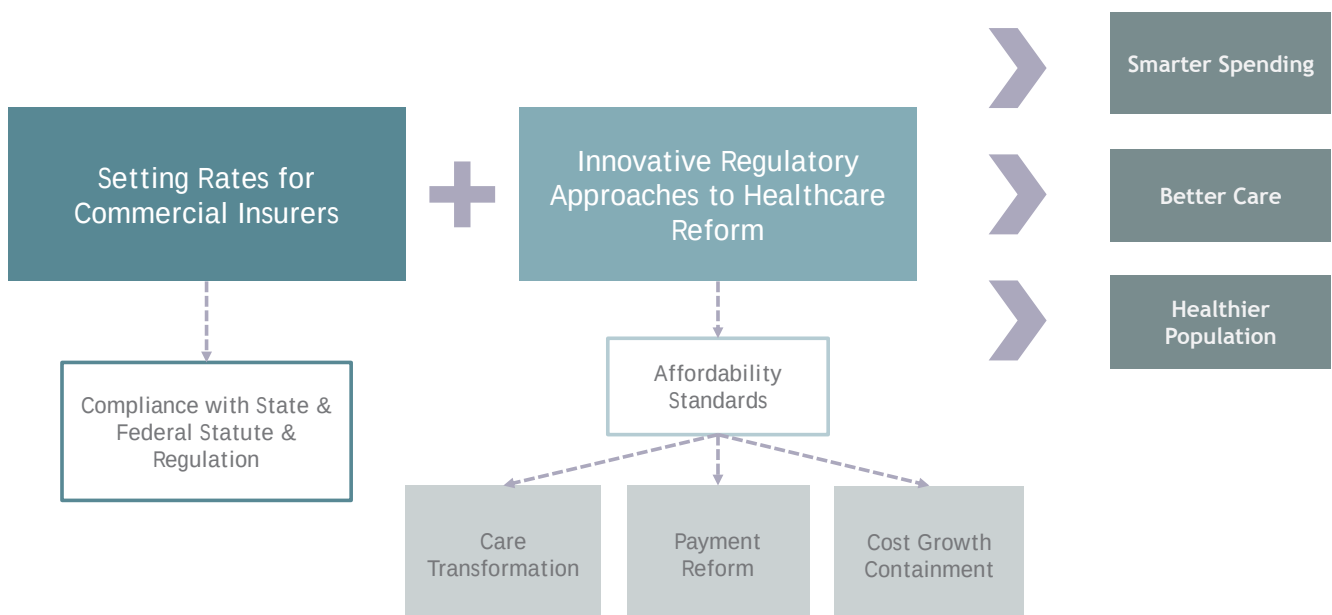
OHIC's Legislative Charge



“View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access”

R.I. Gen. Laws § 42-14.5-2

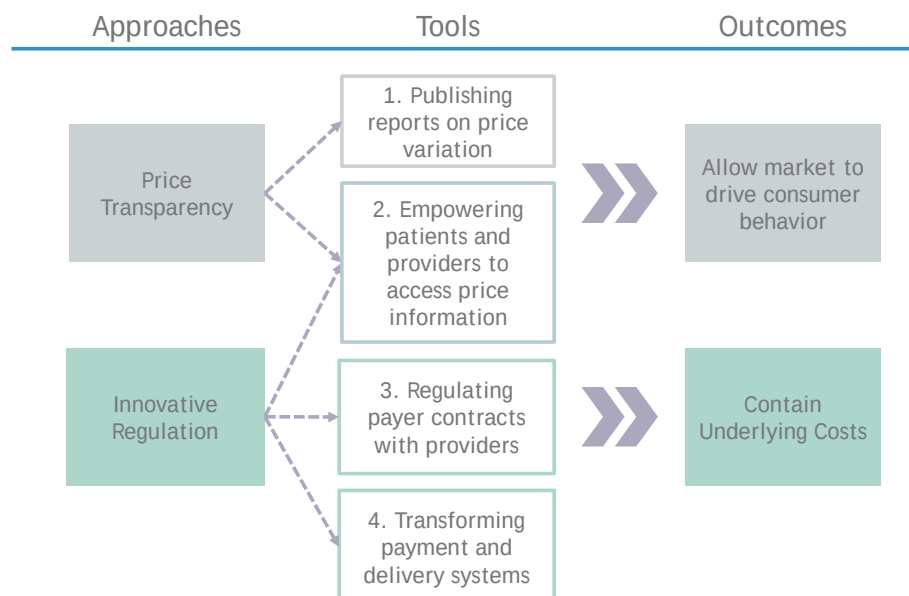
OHIC Theory of Action



Why does OHIC care about Price Variation?

- The price of healthcare services is a significant factor in the level and growth of healthcare expenditures, which impacts premiums.
- Variation in prices paid by different payers translates into a differential cost burden borne by different healthcare purchasers.
- There is no apparent link between payment rates and quality of care.
- State efforts to curb excessive healthcare spending growth should focus on price variation, among other factors, including price inflation rates, unnecessary utilization of services, etc.
- OHIC's efforts to curb health expenditure growth encompass several mechanisms that drive our delivery system toward value-based, efficient, and high-quality care.

OHIC Efforts to Curb Spending Growth



1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: A 2012 Study

- In 2012, OHIC and EOHHS commissioned a study on hospital payment variation
- The study used a dataset of 2010 inpatient and outpatient claims from public and private payers in RI, spanning 11 general hospitals and 2 psychiatric hospitals.
- Payments were casemix adjusted to allow for apples-to-apples comparison

1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: Key Findings

- Considerable variation in payments for similar services
- Commercial plans paid the most
- Medicaid FFS ranked relatively high as a payer

Examples of Variation in Payment for Specific Services							
	Medicare FFS	Medicare Mgd Care	Medicaid FFS	Medicaid Mgd Care	Commercial Plans		
Service	Overall	Overall	Overall	Overall	Overall	Lowest-Paid Hospital	Highest-Paid Hospital
Inpatient Care							
Pneumonia, severity 3 (APR-DRG 139-3)	\$8,518	\$9,217	\$10,374	\$11,401	\$12,566	N/A	N/A
COPD, severity 2 (APR-DRG 140-2)	\$6,496	\$6,761	\$5,615	\$9,163	\$12,627	N/A	N/A
Knee joint replacement, severity 1 (APR-DRG 302)	\$15,147	\$13,667	N/A	N/A	\$22,405	\$22,911	\$26,758
Vaginal delivery, severity 1 (APR-DRG 560-1)	N/A	N/A	\$3,386	\$3,716	\$7,043	\$5,413	\$7,693
Outpatient Care							
Colonoscopy, including related services	N/A	\$745	N/A	\$954	\$1,440	\$802	\$2,343
Evaluation of chest pain (note 1)	N/A	\$888	\$813	\$508	\$918	\$480	\$2,035
Typical ER evaluation (note 2)	\$231	\$365	\$206	\$188	\$638	\$482	\$1,214
Typical advanced imaging service (note 2)	\$398	\$413	\$321	\$395	\$486	\$376	\$808

Notes:

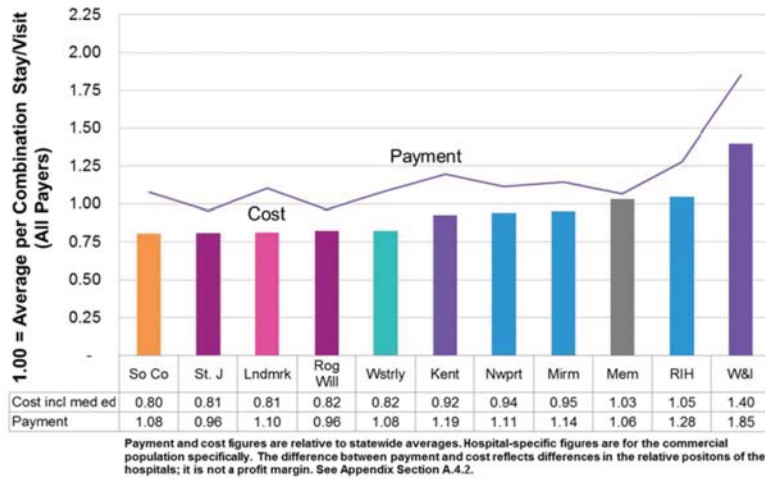
- 1) Evaluation of chest pain refers to the total payment for a patient seen in the ER for evaluation of chest pain, including related services. Patients who were admitted to inpatient care or who underwent cardiac catheterization were excluded from this definition. See Appendix Section B.6.4.
- 2) "Typical" ER evaluation and advanced imaging services refer to a weighted average index of procedure codes, e.g., 99281-99285 for ER evaluation. These figures refer to the specific procedure codes only; related services are excluded. See Appendix Section B.6.5.
- 3) Data are shown only for services where the hospital performed at least 50 services for a specific payer in 2010. Other cells are shown as N/A.
- 4) Examples shown are for purposes of illustration. Overall analysis of variation in cost and payment was done using all stays and visits, typically using APR-DRGs for casemix adjustment of inpatient care and EAPGs for service mix adjustment of outpatient care.
- 5) Detailed Medicare FFS data for outpatient claims were not available, so the cells for colonoscopy and evaluation of chest pain are shown as N/A. Medicare FFS payment figures for the ER evaluation and advanced imaging service indexes were calculated using APC fees applicable in Rhode Island.

1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: Key Findings

Chart 4.2.3

Commercial Payment Compared with Total Cost
Cost includes medical education



- Commercial plans tended to pay more to Lifespan and Care New England than to other hospitals
- Considerable variation in costliness across hospitals
- Higher cost hospitals tended to be paid more

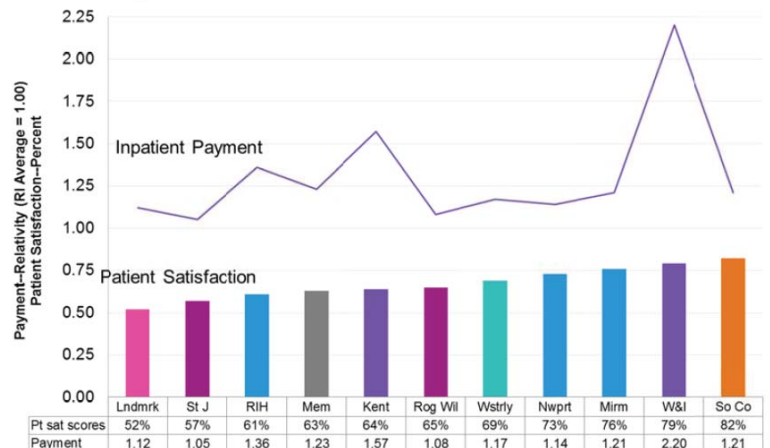
1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: Key Findings

- While quality data were limited, no link between quality and payment was found

Chart 4.3.1

Commercial Payment and Patient Satisfaction



Hospitals are ranked in increasing order of the quality measure. Payment = commercial payment, casemix-adjusted using APR-DRGs.

1. Publishing Reports on Price Variation

Variation in Payment for Hospital Care in Rhode Island: Key Findings

Price variation for hospital services is a problem everywhere, and if payments vary less in Rhode Island, it may be because of our smaller, more tightly regulated provider and insurer markets.

Table 3.5.1

Variation in Inpatient Payment by Private Plans for Specific Inpatient Services

APR-DRG			Median Hospital		Difference from Lowest-paid Hospital to Highest-paid Hospital	
	RI Low Hospital	RI High Hospital	RI	MA	RI	MA
139-3 Pneumonia, severity 3	\$9,330	\$12,538	\$11,967	\$12,420	30%	1350%
140-2 COPD, severity 2	\$7,207	\$21,291	\$10,691	\$7,455	200%	520%
302-1 Knee joint replacement, Sev 1	\$18,041	\$26,758	\$21,882	\$21,241	50%	980%
540-1 Cesarean delivery, Severity 1	\$6,334	\$12,405	\$7,935	\$7,598	100%	490%

Notes:

- 1) The source for the Massachusetts data is Massachusetts Executive Office of Health and Human Services, Division of Healthcare Finance and Policy, *Massachusetts Healthcare Cost Trends: Price Variation in Healthcare Services* (Boston: DHCFF, June 2011), p.9.
- 2) In 2010, Rhode Island had 11 general hospitals while Massachusetts had 79. Rhode Island figures are for hospitals with at least five stays for each DRG, while the Massachusetts figures are for hospitals with at least 30 stays for each DRG. Rhode Island data are for 2010 while Massachusetts data are for 2009.

2. Empowering Patients and Providers to Access Price Information

Regulation 2, Section 12: Price Disclosure

- OHIC's Price Transparency requirements are written into Regulation with the intention to empower consumers and providers to make cost-effective healthcare decisions within the realm of the insurer's network. The two key requirements are:

Disclosure of Price Information to Providers

Insurers must disclose price information to designated providers (upon request) for the purposes of:

- Making cost-effective referrals
- Engaging in care coordination
- Making treatment decisions

Submission of a Comprehensive Price Transparency Plan

Insurers created comprehensive Price Transparency Plans that include:

- An Implementation Timeline
- Services, products, and supplies subject to price disclosure
- Appropriate limitations on disclosure
- FFS and APM price information

Innovative Regulation: OHIC Affordability Standards

The Affordability Standards were written into regulation in 2010 to influence the affordability of healthcare by focusing on three key strategies:



Care Transformation

Improving the efficiency and quality of care by transforming primary care practices



Payment Reform

Moving from volume to value by increasing the amount of payments that are tied to quality and cost efficiency



Cost Growth Containment

Slowing the rate of rising healthcare costs by limiting the rate increases of hospital based services and ACO total cost of care budgets

3. Regulating payer contracts with providers

Containing Medical Cost Growth

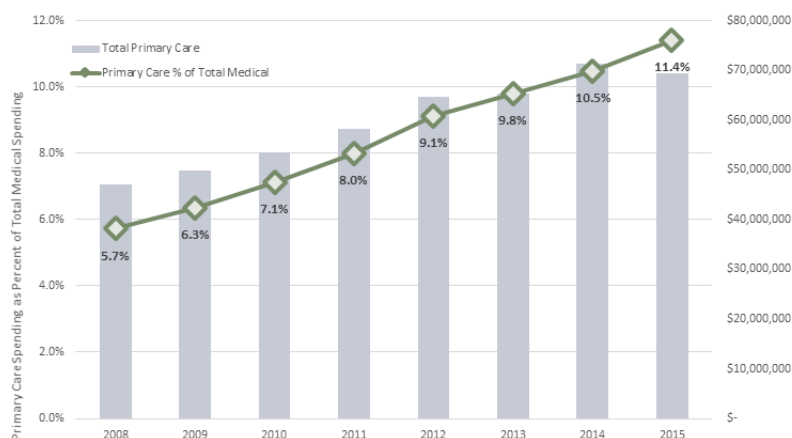
- Recognizing that health insurance rate increases are driven not only by fee-for-service payment structures, but also by systemic medical expense trends, the Affordability Standards include requirements that limit the annual rate increase of medical services.

	Hospital Contracting Requirements	ACO Contracting Requirements
Annual Rates for:	Inpatient and outpatient services	Total cost of care for services
Affordability Standards Requirement:	Average rate increases shall not exceed the CPI-Urban percentage increase plus 1%	Increase in the total cost of care shall not exceed the CPI-Urban plus 3.0% in 2016, plus 2.5% in 2017, plus 2.0% in 2018, and plus 1.5% in 2019.

4. Transforming Payment and Delivery Systems

Increasing Investments in Primary Care

Figure 1: Primary Care Spending, Total and as Percent of Total Medical Spending 2008 - 2015



The Affordability Standards ensure the financial support of primary care

- Between 2010 and 2014, insurers were required to increase primary care spending by 1 percentage point (of total medical spend) each year
- Now, primary care expenses must comprise at least 10.7% of total medical spend
- Investments in primary care reinforce ongoing care transformation work

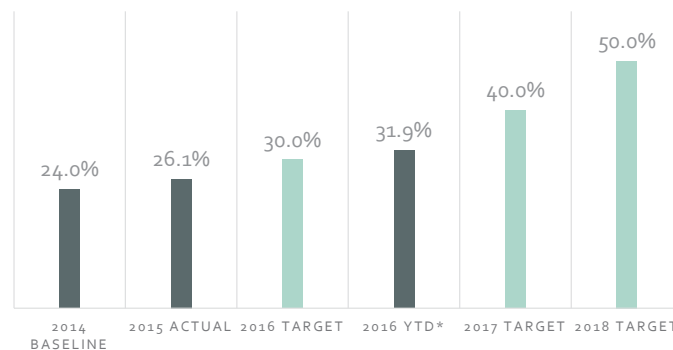
4. Transforming Payment and Delivery Systems

Reforming Payment Models

The Affordability Standards call for significant reductions in the use of fee-for-service payment as a payment methodology by commercial insurers

- Target:** 50% of an insurer's annual commercial insured medical spend will be in the form of APM payments by 2018
- OHIC's Alternative Payment Methodology (APM) Committee establishes annual targets for commercial insurers

AGGREGATE ALTERNATIVE PAYMENT MODEL TARGETS



*2016 YTD figures include data up to the end of May 2016

THANK YOU

Any Questions?

Appendix E



Massachusetts College of Emergency Physicians

860 Winter Street Waltham, MA 02451, Telephone (781) 890-4407, Fax (781) 890-4109, www.macep.org

February 11, 2017

Representative Jeffrey Sanchez
House Chair, Price Variation Commission
State House, Room 236
Boston, MA 02133

Senator James Welch
Senate Chair, Price Variation Commission
State House, Room 309
Boston, MA 02133

Dear Representative Sanchez and Senator Welch,

As you know, the issue of Out of Network (OON) billing is of paramount importance to the Massachusetts College of Emergency Physicians (MACEP). Emergency physicians are EMTALA providers, and Emergency Medicine is the only specialty that can never turn away or refuse to see any patient, regardless of insurance status or ability to pay for services. This distinction separates Emergency Medicine from all other specialties in terms of negotiating with health insurers.

MACEP supports the Price Variation Commission's recommendations around patient protections. We agree that patients should be taken out of the middle and held harmless when there is a "surprise lack of coverage" resulting in balance billing. There should be more transparency around the insurers' network of providers so patients can make informed choices when they have the ability to predict medical needs.

We have concerns about the Commission's recommendation to tie the reimbursement of OON providers to "contracted rates" or to some percentage of Medicare. Emergency physicians support implementing the Connecticut model, which requires the use of an independent and transparent charge database, such as the Fair Health Database (www.fairhealth.org) to determine usual, customary and reasonable rates, and which would eliminate high charge outliers by setting the rate at the 80th percentile.

The problem with using a percentage of Medicare rates as a determinant of reimbursement is that they were never intended to become the foundation for "fair" reimbursement. Medicare rates have no relationship to fair market value or the cost of care and are based on federal budgetary considerations

rather than on what physicians have been customarily paid. To implement Medicare reimbursement, or even a system based on a modicum reimbursement factor above Medicare rates, would bankrupt many emergency practices and departments across Massachusetts. A Rand study released in late 2016 concluded that the safety net in New Jersey – including critical access hospitals – would be in serious jeopardy if reimbursement were capped at 250% of Medicare. Such a system in Massachusetts would have equally damaging consequences, far beyond emergency departments. It would hurt community and critical access hospitals, which would be forced to either subsidize their emergency departments or close them.

A problem with using contracted rates is that the process is not transparent and will inevitably create ongoing disputes among insurance companies, hospitals and sadly, patients; while wasting valuable healthcare resources. Insurance companies must be transparent about how they calculate payments and provide fair coverage for patients. Payments for emergency visits must be based on a reasonable portion/percentage of charges, rather than arbitrary rates or contracted rates that may not even cover the costs of care.

Another issue with trying to use contracted rates as a determinant of fair reimbursement is the absence of a “ones-size-fits-all” rate. Contracted rates from insurance companies differ significantly according to size of the hospital, market share, patient population, geographic location, physician specialty, etc. An appropriate contracted rate for one emergency group/department may not be sufficient for others and could be exorbitant in another area of the state. Requiring all physicians – not just emergency physicians - to accept insurers’ contracted rates would remove negotiating power from physicians and place it all in the hands of insurers. Allowing insurers to unilaterally determine what they deem to be appropriate reimbursement will eventually drive down all contracted rates and threaten the viability of all hospitals: critical access, community, academic, tertiary-care and trauma centers alike.

The attached American College of Emergency Physicians 2016 Fair Coverage Fact Sheet details the creation of the FAIR Health Database. By way of background, the State of New York successfully sued United Health Care for fraudulently calculating rates and significantly underpaying doctors for out-of-network medical services. The database United Healthcare used, Ingenix, forced patients to overpay up to 30 percent for out-of-network doctors. United paid a \$350 million settlement to the State of New York and the American Medical Association, and agreed to the creation of FAIR Health, which, among other objectives, established an independent database of healthcare charge information with the support of academic experts.

Attached is a comparison of three different databases: Ingenix, Fair Health, and Health Care Cost Institute (HCCI). It is clear from this comparison that Fair Health is the most robust, transparent, independent database available for determinations of fair and reasonable reimbursement rates. It can be easily searched by physician specialty and zip code, and is the best mechanism available to ensure transparency and prevent miscalculation of payments.

The question of how often OON billing occurs here in Mass has not yet been determined. However, several studies from other states (attached) are noteworthy and provide excellent information from which we can extrapolate. For example, the Washington State Insurance Commissioner received insurance industry data (18 million claims) and issued a report regarding OON billing. The data had some limitations due to some high outlier charges but is overall supportive of MACEP’s position. Importantly, as mentioned above, the dataset involved 18 million claims and *was provided by the health insurance*

plans themselves, supporting its validity and the underlying conclusions that the magnitude of ED OON billing is small. Their conclusions include the following:

- OON Emergency physician billing is infrequent at 3%: Only 3% of Emergency physician and ED services were out of network. We are well aware of a recent NEJM article, whose authors were funded by grants from the insurance industry, and which presented an inaccurate picture of the scope of OON billing. The Washington State report demonstrates that the frequency of OON ED billing is actually very small. In fact, approximately half of the Washington State ED visits were excluded from the data that were analyzed, including Medicare and Medicaid. Once those visits are factored in only about 1.5% of ED services were provided by an out of network provider.
- High ED charges are rare: Only 3% of the OON bills were larger than \$1,500.
- ED services are not responsible for the majority of OON bills: The vast majority of OON claims were clinic/outpatient-based. Addressing ED claims alone will not fix the OON billing "problem."

I have also attached a study showing that out-of-network emergency billing in the state of Florida is rare. According to the data, which represented 10 percent of all emergency department visits in Florida, the average patient payment was just \$49 – hardly the thousands of dollars that the insurance companies would like you to believe.

I would welcome the opportunity to meet with you to further discuss the importance of fair and reasonable out of network billing recommendations for emergency physicians. I will contact your office in hopes of scheduling a meeting at your earliest convenience.

Thank you



Jeffrey Hopkins, MD, FACEP
President

Modern Healthcare

What New Jersey's proposed out-of-network cap would do to hospital margins

By [Shelby Livingston](#) | November 22, 2016

New Jersey legislation to cap the amount hospitals can charge for involuntary out-of-network services would lead to operating losses at hospitals across the state and could cause some to take on severe cost-saving measures, including staff layoffs or mergers with competitors, according to a study commissioned by a for-profit hospital system.

In an emergency, patients often don't get to choose where an ambulance takes them. Some inevitably end up at an out-of-network hospital and rack up a massive medical bill.

Under New Jersey law, patients who involuntarily receive emergency care from a hospital outside of their health plan's network are responsible for paying only the portion of costs they would have been charged for similar in-network care. The rest of the bill is footed by that patient's health plan.

Insurers argue that because the state doesn't regulate how much hospitals can charge for out-of-network care, insurers are forced to pay whatever the hospital demands, even if excessive.

[Legislation](#) being debated in the New Jersey Assembly, known as the Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act, or A1952, seeks to cap what hospitals can charge for involuntary out-of-network care between a range of 90% to 200% of the price that Medicare pays for the same service.

According to a study conducted by RAND Corp., hospitals rely heavily on the payments from involuntary out-of-network services, which are about double the rate of in-network services. While such involuntary charges account for less than 20% of hospitals' total commercial revenue, they make up almost 40% of hospital profits for treating commercially insured patients.

The study, which was commissioned by for-profit New Jersey health system CarePoint Health, estimates that implementing the legislation would reduce New Jersey hospital payments from commercial health plans by 6% to 10%. That would lead to an operating loss at 48% to 70% of hospitals, depending on how high the cap is set, researchers found.

If the cap on out-of-network charges is limited to 90% of Medicare rates—the lowest

end of the range—less than a third of hospitals in the state would remain profitable, the study estimated.

“Hospitals live off the margins from these out-of-network payments,” said Soeren Mattke, senior scientist at RAND and lead author of the study. “If you take them away as the law proposed, you put a good chunk of them in an operating loss.”

The legislation would also weaken the hospital's power to negotiate with insurers over rates for in-network services, researchers said. Without the looming threat of high out-of-network charges, health insurers are likely to seek lower in-network rates.

If the cap is implemented, “It's possible that some (hospitals) may have to close,” Mattke said, though he added it's difficult to predict how providers will react. Most will have to find ways to cut costs, such as layoffs or closing the community clinic, he said.

Surprise out-of-network medical bills have gained attention from lawmakers nationwide, and there's [a growing trend among states](#) to limit what hospitals and doctors can charge for out-of-network bills incurred voluntarily. Several states, including California, Connecticut, Florida and New York, have passed legislation to protect patients from surprise bills and require health plans and hospitals to set up an arbitration process to work out any payment issues.

“Different states have solved that problem in different ways, and some have put more of an onus on providers and more on health plans or split the difference,” said Mark Hall, a senior fellow at the Brookings Institution. New Jersey's proposal of arbitration and payment caps, he said, is “a thoughtful approach.”

The bill has been highly contentious. It was [the second-most lobbied piece](#) of legislation in the state in the first half of 2016, following only behind the state budget bill, according to the New Jersey Election Law Enforcement Commission.

The New Jersey Hospital Association argues the legislation unfairly favors health insurers.

“We cannot yield on a bill that props up insurance companies to the detriment of the hospitals and physicians that care for the people of New Jersey,” Betsy Ryan, president and CEO of the New Jersey Hospital Association, said in an Oct. 27 statement about the legislation.

A spokesman for CarePoint Health, which paid for the RAND study, declined to comment on the bill but said “it was important to commission an unbiased study” to study “out-of-network legislation and its impact on the well-being of community healthcare in New Jersey.”



Florida Data Suggest Balance Billing is Rare in Emergency Medicine

Dec 16, 2016

BALANCE BILLING AND HOW IT WILL IMPACT FLORIDA

HB 221: Health Insurance Coverage for Emergency Services

GENERAL BILL by Trujillo; (CO-INTRODUCERS) Stark

SB 1442: Out-of-Network Health Insurance Coverage (similar to HB 221)

GENERAL BILL by Garcia

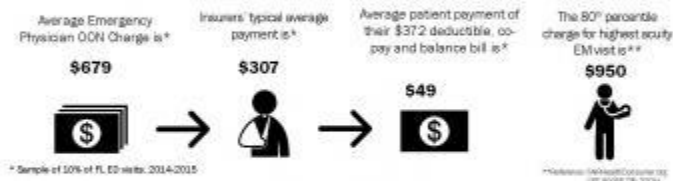
The proposed legislation impacts physician reimbursement in emergency departments, limiting the amount a physician can collect to the amount arbitrarily reimbursed by insurance companies. Though coined as a ban on "balance billing," the legislation has a chilling effect in a state with a debunk provider dispute program and no third party claims data base for payment transparency.

Setting the Facts Straight

Emergency physicians are the **ONLY** specialists who see every patient, regardless of insurance status or ability to pay -- 24 hours a day, 7 days a week and 365 days per year.

The emergency physician sees an **average of \$138,000 per physician in uncompensated care yearly** and is the Safety Net for all Florida citizens, including vulnerable uninsured, Medicare, Medicaid, and Pediatric patients.

EMERGENCY PHYSICIAN OUT-OF-NETWORK (OON) CHARGES



BALANCE BILLING RESULTS FROM THE UNWILLINGNESS OF INSURERS TO CONTRACT FOR ADEQUATE PAYMENT FOR PROVIDERS, WHICH OCCURS FOR ONLY ABOUT 12% OF INSURED FLORIDIANS.

Insurers are cutting their costs by paying providers less and raising deductibles on patients, increasing the burden on consumers but raising insurers' profits.

Customary Reimbursement of Emergency Provider Services

Physicians set charges based on the cost of recruiting and retaining qualified providers, providing for uncompensated and undercompensated care, standby costs for surge capacity, medical malpractice insurance costs, among other factors. Physicians may allow for some discounts to preferred contracted insurers. National and state databases, such as RVR Health, show aggregate and median charges per zip code for billions of provider charges.

Insurers vary widely in how they reimburse OON charges. The range of reimbursement varies from zero to a low percentage of Medicare allowances to full charges.

In a PPO, the consumer does not have indemnity coverage (as they would in a HMO or Medicare), but an arrangement that allows insurer to pay their own determination of the "Maximum Allowable Charge" or a percentage thereof.

- Consumers are buying a **flexed product** and **narrow network** makes this worse.
- Insurers are selling "in-network" hospitals, while often **NOT** negotiating with physicians who staff those hospitals.
- Allowing insurers to unilaterally determine "allowable" reimbursement lacks transparency, encourages manipulation and is not based on the costs of providing care by the physicians.
- This will lead to **downward market forces** that will hinder EM physicians from negotiating fair in-network rates, which they do now **80%** of the time.

FLORIDA COLLEGE OF EMERGENCY PHYSICIANS

EMERGENCY MEDICINE DAYS 2016

Florida Balanced Billing Fact Sheet

WASHINGTON, Dec. 16, 2016 /**PRNewswire-USNewswire**/ -- With the support of the American College of Emergency Physicians (ACEP), the Florida College of Emergency Physicians (FCEP) today urged state and national policymakers to investigate the

reimbursement practices of insurance companies, especially when patients go out of network for emergency medical care.

"We are urging Senator Bill Nelson to investigate fully what is happening in his own state before calling for an inquiry into 'surprise bills' by emergency physicians," said Jay Falk, MD, FACEP, president of FCEP. "Our report shows that less than 4 percent of privately insured patients in Florida actually received balance bills. We are calling for an examination of what insurers are offering their patients under high-deductible plans. Many insurers pay a percentage of what they call 'usual and customary allowables' which is typically well below actual charges, or usual and customary charges listed by the Fair Health™, a national independent database of insurance claims. They must be held accountable under the newly passed legislation in Florida addressing 'surprise bills.' The fair payment provisions of the law must be enforced."

FCEP conducted an analysis of billing data provided by Martin Gottlieb & Associates, a medical billing company. Of all Floridians, about 26 percent had private insurance (the rest were either uninsured or had Medicare or Medicaid). Of privately insured emergency patients, 88 percent were treated by in-network emergency physicians. Among the 12 percent of patients who were treated by emergency physicians who were out of their insurer's network, the average emergency physician out-of-network charge was \$679. The average insurer's payment was \$307 and the average patient payment was just \$49.

"More national data are needed, but it's reasonable to say the Florida data, which represent 10 percent of all Florida emergency department visits, could be extrapolated to other states as well as nationally," said ACEP's president Rebecca Parker, MD, FACEP. "Recent focus by the media on a select group of theoretical balance bills from emergency physicians severely distorts what is really happening and distracts policymakers from what is in the best interests of patients and the health care system. The few balance bills that exist in Florida result from unwillingness by insurers to contract for fair and reasonable payment to medical providers, such as emergency physicians."

The Fair Health claims database (www.fairhealth.org) was developed after United Healthcare was successfully sued by the State of New York for fraudulently calculating and significantly underpaying doctors for out-of-network medical services (using Ingenix database). The formula they used forced patients to overpay up to 30 percent for out-of-network doctors. Four out of five big insurers have been sued for illegally manipulating what is deemed "usual and customary" medical charges.

"The Florida Legislature agreed a "surprise bill" should not occur when care is provided in a scenario where a patient does not have a choice of providers, and clearly defined what should be paid for out-of-network care, both for HMO and PPO patients," said Dr. Falk.

"With payment now stipulated at the provider's usual and customary charge, insurers will be paying their fair share and shifting costs less to patients. Prior to the law change, insurers were underpaying for care, which was unfair to both patients and physicians. Florida's new law, if enforced, will prevent this practice."

"ACEP is committed to getting patients out of the middle and proposing solutions to escalating health care costs," said Dr. Parker. "But bullying tactics by the insurance industry and their surrogates are creating a lot of confusion for our patients who want what emergency physicians are advocating for: fair coverage for emergency care."

ACEP is the national medical specialty society representing emergency medicine. ACEP is committed to advancing emergency care through continuing education, research and public education. Headquartered in Dallas, Texas, ACEP has 53 chapters representing each state, as well as Puerto Rico and the District of Columbia. A Government Services Chapter represents emergency physicians employed by military branches and other government agencies.

SOURCE American College of Emergency Physicians (ACEP)

For further information: Mike Baldyga, 202-370-9288, mbaldyga@acep.org,
<http://newsroom.acep.org>

Patients increasingly are facing higher premiums for health insurance but getting less coverage. They are paying more out-of-pocket costs and have higher deductibles and co-insurance. Health insurance companies are offering plans with low premiums, and people are not aware of how little coverage they actually have. Nearly all emergency physicians across the country responding to a recent poll (96 percent) said that patients don't understand what their policies cover. What's more, 8 in 10 emergency physicians said they are seeing patients with health insurance who had delayed medical care because of high out-of-pocket expenses, deductibles and co-insurance. (This is more than a 10-percent increase over 6 months ago when emergency physicians were asked the same question.) To learn more about how insurance companies are squeezing emergency patients, go to www.FairCoverage.org.

- **Health insurance companies are misleading patients by offering “affordable” premiums for policies that cover very little.**
 - No insurance plan is affordable if it abandons you in an emergency.
 - *Nine in 10 emergency physicians polled say health insurance companies mislead patients by offering “affordable” premiums for policies that cover very little.¹*
 - Insurance companies shift the costs of medical care onto patients and medical providers, while enriching themselves.
 - *Nearly 80 percent of emergency physicians polled with knowledge of reimbursement issues said that insurance companies have reduced the amount they reimburse for emergency care.*
- **Patients can't choose where and when they will need emergency care and should not be punished financially for having emergencies.**
 - Insurance companies exploit federal law to reduce payments for emergency care. They know that hospital emergency departments have a federal mandate to care for all patients, regardless of ability to pay (EMTALA).
 - In a medical emergency, many insurance companies do better jobs of protecting themselves than protecting you.
- **Each day, emergency physicians see patients who have paid significant co-pays, up to \$400 or more, for emergency care.**
 - For many, it's too much of a financial burden and we'll deter them from seeking emergency care.
 - *87 percent of emergency physicians believe insurance companies should pay the in-network rate if an emergency patient has no access to an in-network facility or physician.*
 - *Nearly two-thirds (61 percent) say most health insurance companies provide less than adequate coverage for emergency care visits to their customers.*
- **Just because you have health insurance coverage does not mean you have access to medical care.**
 - Insurance companies are creating narrow networks to save money, making it more likely that patients will see out-of-network doctors and be responsible for additional costs.
 - Insurance companies are forcing physicians out of network by reducing reimbursements to the point they do not cover costs. The vast majority of emergency physicians and their groups prefer to be “in network.”
 - *More than 60 percent of emergency physicians polled had difficulty in the past year finding in-network specialists to care for patients with a quarter of them saying it happens daily.*
- **Health insurance companies have created this situation. Balance billing would not exist if insurance companies paid what is considered reasonable in the insurance industry and what's known to everyone as “fair” payment.**

- When insurance companies do not pay fairly, physicians must choose between billing patients for the difference or going unpaid for their services (similar to how a dentist bills). The solution is to return responsibility for those bills back to insurance companies where they belong.
- When insurance reimbursements do not cover the costs of providing services, physicians drop out of networks.
- **Insurance companies must be transparent about how they calculate payments and provide FAIR coverage for emergency patients.**
 - Payments for emergency visits must be based on a reasonable portion/percentage of charges, rather than arbitrary rates that don't even cover costs of care.
 - Health plans have a long history of not paying for emergency care. United Healthcare was successfully sued by the State of New York for fraudulently calculating and significantly underpaying doctors for out-of-network medical services (using Ingenix database — NOTE: the former CEO of Ingenix is the current, acting head of CMS — Andy Slavitt). The formula they used forced patients to overpay up to 30 percent for out-of-network doctors. The company paid the largest settlement to the state of New York and the American Medical Association. Part of the settlement created the Fair Health database.
 - o *79 percent of emergency physicians say the Fair Health database is the best mechanism available to ensure transparency and to make sure insurance companies don't miscalculate payments. (www.fairhealth.org)*
- **State and federal policymakers need to ensure that health plans provide fair payment for emergency services or emergency patients will suffer.**
 - States that seek to ban balance billing without ensuring fair coverage of emergency care will create huge benefits for health insurance companies while endangering patients and the medical safety net.
- **Patients and physicians must work together to combat these harmful practices by health insurance companies.** (Contact your state legislators.)
- **A federal regulation by CMS does not require health insurance companies to use a fair and transparent database, such as Fair Health to calculate in out-of-network payments, opening the door to reimbursements that do not even cover the costs of care.**
 - This regulation represents a failure to implement the “patient protections” promised in the Patient Protection and Affordable Care Act. It is a clear victory for health insurers at the expense of patients and physicians.
 - The health insurance industry no longer has any incentive to negotiate fairly.
 - This regulation benefits insurance companies at the expense of patients.
 - ACEP advocated for an objective standard in which benefits would be transparently determined, enforceable, reasonable, and market driven.
 - ACEP submitted claims evidence, showing how insurers were shifting hundreds of millions of dollars in out-of-pocket expenses onto patients. The evidence shows how insurance companies would use their own proprietary data to reduce payments to physicians and to shift financial liability to beneficiaries.
 - o *91 percent of emergency physicians polled say this new CMS rule will make finding specialists and follow up care for patients more difficult.*

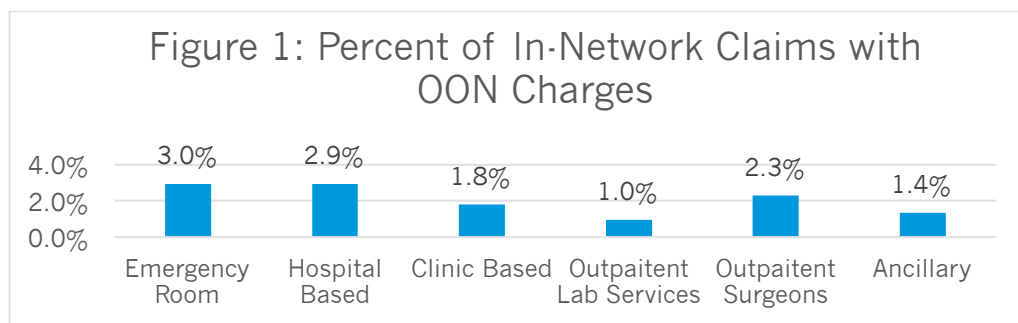
ⁱ An emergency physician survey was conducted online in the United States by Marketing General Incorporated on behalf of the American College of Emergency Physicians between April 4-11, 2016, among 1,924 emergency physicians, providing a response rate of 7 percent and a margin of error of 2.2 percent.

Report on HB 1117 (Surprise Billing)

In 2016 the Washington Office of the Insurance Commissioner put out a call for data relating to the issue of surprise billing to all the major health insurers in the state of Washington. This data request focused on fully insured individuals who were under 65 years old and were insured in the state of Washington.

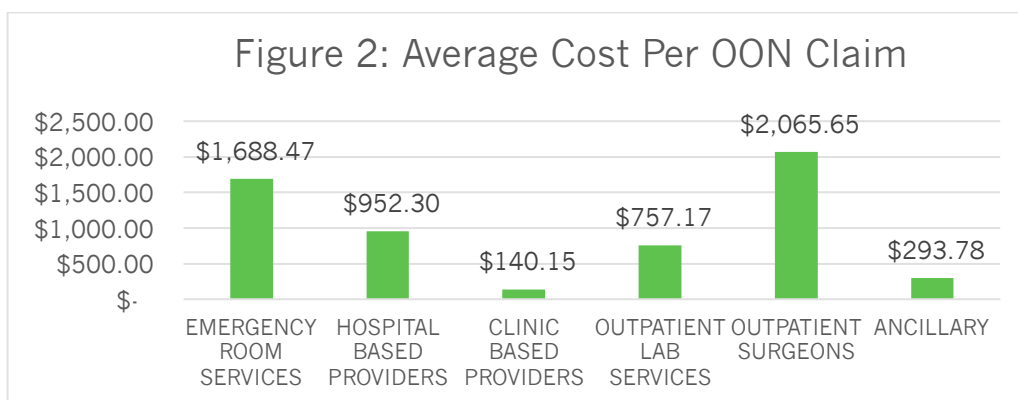
For the 2015 calendar year, 13 insurers reported receiving 18,472,855 health insurance claims. Of these, 4.8% (881,694) were described as “Out-of-Network” (OON) claims which were to be paid by the insured rather than the insurer. This includes 293,834 OON billings that resulted from in-network facility visits. These claims occur when an insured individual visits an in-network facility, such as an emergency room, hospital, clinic, outpatient lab, outpatient surgeon, or ancillary service provider facility, but receives un-covered services.

Of all the claims submitted to health insurers in 2015, the vast majority were from clinic based providers (11,780,471 claims). Clinic based providers also billed the greatest number of OON claims from in-network facilities (212,831). However, clinic based providers were less likely than average to bill OON on a per claim basis. As shown in Figure 1, emergency room services were 63.3% more likely than clinic based providers to submit an OON claim (3.0% of their claims) than clinic based providers (1.8% of claims).

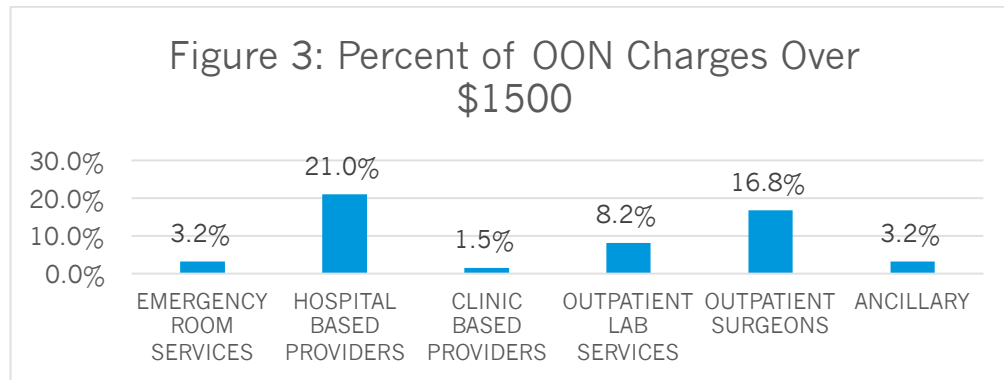


While the relative frequency of

OON billing was relatively small across most provider categories, the per-occurrence cost of OON charges was relatively high. Figure 2 shows that for both outpatient surgeons and emergency room services, the average billing rate for OON charges was \$2,066 and \$1,688 compared to an overall average OON charge rate of \$264.



However, OON charges are not evenly distributed within each provider category. While emergency room services average a relatively large cost of \$1,688.47 per charge, much of this cost is explained by a small number of large charges with only 3.2% of emergency room OON charges exceeding \$1500. Conversely, outpatient surgeon services are relatively expensive per claim (\$2,065.65 on average) with 16.8% of individuals receiving an OON bill above \$1,500. As illustrated in Figure 3, insured customers were more than twice as likely to receive an OON bill over \$1,500 from a visit to a hospital based provider or outpatient surgeon than any of the remaining four provider categories.



While the OIC is unaware of any studies that causally link the cost of surprise billing to any particular source, some authors have suggested that the large cost per claim exhibited by emergency room services and outpatient surgeons is related to how hospitals contract with insurers. While hospitals may hold billing agreements with several insurers not all providers agree to the same pricing level that insurers reimburse, resulting in denied payments or short-pays where the insured are responsible to pay balances. In cases such as emergency room visits, the insured may not have the ability to shop for in-network doctors or services when options are presented as a package deal. This results in charges from anesthesiologists, who are often not affiliated with the primary care doctor and may hold different billing agreements, being cited as one of the most costly OON billings.

Conversely, ancillary charges frequently are not covered by insurers, thus incentivizing individuals to “shop around” for pricing or forego expensive procedures. The most costly of these OON charges are frequently cited to be dental procedures by carriers. These are often covered by a separate policy and not considered to be part of full coverage and may be covered by a company not included in this data. Further, these charges tend to be relatively small with 81% of OON ancillary bills being between \$0 and \$300.

Given the rate at which OON charges above \$1500 occur in each provider category, the OIC estimates that some 11,930 cases of surprise billing for OON services at an in-network facility will be reported annually. OIC staff believes that under HB 1117, most insurers and providers will resolve disputes with values under \$1500 through arbitration. The remaining disputes are more likely to require direct intervention by OIC through a notice or fine.

Ingenix Inc., FAIR HEALTH, Inc. AND HEALTH CARE COST INSTITUTE (HCCI)

Comparison/Contrast

Organizations and Data

	Optum360, f/k/a OptumInsight Inc. and f/k/a Ingenix Inc.	FAIR Health, Inc.	HCCI
Organization	Optum360 Optum360 was formed in Oct 2013 by the merger of Dignity Health and OptumInsight. Optum is the Health Services platform of UnitedHealth Group UnitedHealth Group also owns UnitedHealthcare – started myHealthcare Cost Estimator UnitedHealth Group trades on NYSE under UNH. In 2010, the <u>AMA v. United Healthcare</u> lawsuit settlement of \$350 million was approved by a NY federal judge regarding the Ingenix Inc. database. The AMA with several prominent state medical societies alleged that UNH's subsidiary Ingenix had engaged in RICO conspiracies and Unfair and Deceptive Trade Practices to undervalue the "usual and customary" (U&C) charges for providers and that the U&C data underpaid out of network providers. The AMA in turn filed lawsuits against several health plans that utilized the Ingenix Inc. database including Aetna, CIGNA and WellPoint and successfully settled these cases in federal court.	FAIR Health, Inc. NY 2009. Unaffiliated with any insurer or other stakeholder Conflict-free, uncompensated board of directors. Fair Health Inc. was created in 2009 after the NY Attorney General's settlement with United Healthcare over the Ingenix Inc. database (see previous notes under Optum360) Independent Not-for-Profit, tax-exempt under § 501(c)(3): created as part of legal settlement to establish transparent and accurate source of healthcare cost information for consumers, researchers, policymakers and healthcare industry. Incorporated in statutes, regs and programs: NY, NH, IN, AK, KY, ND, AZ, WI., CT, MN, NJ, PA, MD, MS, and U.S. federal departments and agencies: HHS, GAO, AHRQ, and was recommended by CMS' CCIIO contractor,	Health Care Cost Institute, Inc., DC 2011. Tax-exempt nonprofit research corporation formed initially by four insurance companies, (three continue to participate, to provide virtual data access to researchers for selected projects.) IRS Form 990 from 2014 shows the following: Schedule B, Schedule of Contributors to HCCI: 1. UnitedHealth Group: \$3.59 Million 2. Aetna Inc.: \$2.72 Million; 3. Humana Inc.: \$1.65 Million; 4. Kaiser Permanente: \$350,000 Schedule O: Compensation to the Five Highest Paid Contractors: 1. Optum Global Solutions: \$1.050 Million, consulting; 2. Modern Climate: \$607,000, website design; 3. Upton Hill, LLC: \$538,000, data analysis; Significance of the capital contributions: HCCI is likely barred from

	Ingenix Inc. was then merged into and the name was changed to OptumInsight in June 2011 after the AMA settlement. Fair Health Inc. was created in 2009 after the NY Attorney General's settlement with United Healthcare over the Ingenix Inc. database. www.lexisnexis.com/legalnewsroom/insurance/b/medicalinsurance/archive/2010/09/21/final-approval-granted-in-350-million-settlement-with-united-in-reimbursement-dispute.aspx?Redirected=true	IMPAQ, as a transparent database. Honors/recognitions include White House, AHRQ, URAC, eHealthcare, AppPicker.	being the charges database for the Connecticut minimum benefit standard (the MBS); by statute, the MBS cannot be "affiliated" with a health plan. Also, because of its significant business dealings with United Healthcare, HCCI may be barred under the Ingenix settlement agreement from serving as a "charges data base" or MBS for states such as CT, FL or NY.
Organization Website	www.optum.com	www.fairhealth.org	www.healthcostinstitute.org
Data Contributors	Real-life claims from FAIR Health database of over one billion current charge records	Over 60 contributors nationwide - insurers and TPAs.	Three insurers (two of them also contribute to the FAIR Health repository) – Currently Aetna, UHC and Humana
Period of Data Represented	Annual-current	2002 -Present Widely available in standard products and customized datasets; research subject to security capacity but no substantive or topical restriction/qualification	Available in five-year increments: 2008-2012 or 2009-2013 upon application and approval of project by HCCI
Type of Claims		All types of private insurance – fully-insured, self-insured, group, individual, etc. [Also Medicare – 4+Billion]	Individual-, group-insured and Medicare Advantage. HCCI is believed to have both contracted and non-contracted claim data combined.

Number of Claims in Database		19+ Billion	N/A
Number of Individuals Covered		151 million	Research: 50 million (vs. 40 million for consumer website; see below)
Regions		All US - 493 Geozips Florida – 23 Geozips	N/A
Consumer Tools		English and Spanish	English
Consumer Website		Medical and Dental www.fairhealthconsumer.org www.consumidor.fairhealth.org	Medical www.guroo.com N/A
Consumer Mobile APP		FH® Cost Lookup (English) FH ®CC Salud (Spanish)	40 million covered lives
Data Supporting Site		151 million covered lives, updated 2X/year	78 bundled medical treatments/services
Consumer Cost Information	Benchmark to 50 th , 75 th and 90 th percentile then use geographic conversion factor, 2017 release has seven reference points	Search by common name and/or standard billing codes and zip code All 10,000 medical procedures, 3700 HCPCS services/medical equipment and all dental services by standard code and common name with “prompt” to add common related services (e.g., colonoscopy + ane + pathology) Benchmarks: 50 th (median), 60 th , 70 th , 80 th and 90 th percentile charge values based on actual market (OON) charges Allowed amount benchmarks in development to be added to site in 2016 Out-of-pocket costs &	Per Guroo, costs estimates are based on in-network costs reported as “Averages” based on a combination of means and medians (not an arithmetic mean) http://www.guroo.com/#!/terms-and-conditions/averages

		insurance reimbursement estimates for both percentage of UCR and percentage of Medicare plans	
Operations		All In-House Holds all actual claims data Conducts auditing and validation on all collected data Creates standard and custom data sets for distribution to entire healthcare sector pursuant to Data Licensing Agreements	NORC holds data; virtual access
Staff		Est. 65	Est. 8
			HCCI Information based on HCCI and GUROO websites

Credits: Florida College of Emergency Physicians (FCEP) Dr. Andrea Brault, member of the ACEP Reimbursement Committee and ACEP/EDPMA Joint Task Force (JTF) on Reimbursement Issues and Ed Gaines, Chair of the JTF.



Massachusetts College of Emergency Physicians

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December 14, 2016

Representative Jeffrey Sanchez
Chair, Health Care Financing Committee
State House, Room 130
Boston, MA 02133

Senator James Welch
Chair, Health Care Financing Committee
State House, Room 309
Boston, MA 02133

Dear Chairman Sanchez and Chairman Welch,

It is our understanding that the Price Variation Commission is investigating the issue of out-of-network (OON) services. As you know, the Health Policy Commission held a Listening Session on May 18, 2016 on this issue. The Massachusetts College of Emergency Medicine Physicians ("MACEP") presented oral comments at that hearing and followed up in writing on May 31st. We are attaching those comments for your reference.

Emergency physicians have a unique voice in the discussion of OON services in that, as EMTALA providers, we are mandated to provide care to anyone who believes they are having a medical emergency, regardless of insurance status. Emergency care is an "essential benefit" which is "covered" whether it is provided by in-network or out-of-network physicians. If a patient receives a larger than expected bill for emergency care, they often mistakenly assume the bill is a reflection of the doctor's charges over and above fair reimbursement from the insurance company. Yet, in most instances, it is simply a reflection of the patient's out of pocket costs related to their deductible, co-insurance or copayment responsibilities, which can be quite high. And the emergency physician is neither aware of these insurance gaps nor in control of limiting them. However, we strongly support, and share your interest, in protecting patients from inadequate coverage for emergency services.

As we expressed during the HPC listening session, and in our follow up comments, we would welcome the opportunity to participate in a meaningful discussion with the Price Variation Commission, or one of

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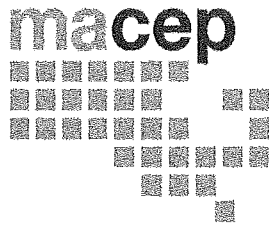
its subcommittees on this important issue. Please let us know if there are certain times and dates over the next several weeks when we could meet with you directly. We will reach out to you, and the HPC, to follow up on this request.

Sincerely,



Jeffrey Hopkins, MD
MACEP President

Cc: David Seltz
HPC Executive Director



Massachusetts College of Emergency Physicians

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**Massachusetts Health Policy Commission
Cost Trends and Market Performance and
Quality Improvement Patient Protection Sub-Committees**

**Testimony Regarding Out-Of-Network Concerns – Emergency Department
Physician Perspective**

**Greg Brodek, Partner, Duane Morris LLP
on behalf the Massachusetts College of Emergency Physicians**

Chairman, Vice Chair, and Board Members:

On behalf of the Massachusetts College of Emergency Physicians (“MACEP”), I thank you for allowing us to offer written testimony to the Massachusetts Health Policy Commission (“HPC”) and its Sub-committees concerning out-of network (“OON”) issues concerning emergency medicine services. MACEP represents a membership of 1,000 emergency medicine physicians in Massachusetts and has first-hand knowledge of issues associated with the provision of OON services by its members albeit, as noted below, these concerns appear to be limited in the Commonwealth. The issue associated with the rendering of OON services is very complicated, and we applaud the HPC for accepting testimony and scheduling hearings to investigate the scope of the problem, hear the perspectives of consumers and other stakeholders, and begin to explore possible solutions.

In its 2015 Policy Brief, the HPC enumerated its “OON Billing Concerns” as lack of patient notice, and the financial and administrative burdens its places on consumers.¹ As an initial matter, we believe the focus simply on “OON billing” is far too limiting and inaccurately identifies the cause(s) giving rise to, and the scope

¹ The Health Policy Brief is available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-out-of-network.pdf>

of, the varied underlying concerns. We believe the complex issues associated with OON services provided in an emergency medicine context include: the extent services are covered under the patient's plan; patient education of what is, and is not, included, and at what rates or reimbursement are services covered; the legal obligation of emergency medicine providers to render care in an emergency department; the cost associated with rendering that emergency care; and the fair payment that must be made to compensate the emergency medicine providers for that care. As a result, we do not believe a myopic focus on the billing of the underlying services appropriately captures the fact that OON concerns involve the relationship of three inextricably, interrelated parties, the provider, the payer, and the patient. Therefore, we will globally refer to the issues and concerns stemming from a patient receiving OON services from an emergency medicine provider, as "OON Concerns."

Turning back to HPC's Policy Brief, HPC noted that its concerns regarding OON billing were particularly heightened for emergency medicine services due to the fact that patients, as a result of the emergent nature of their injuries, rarely have an opportunity/choice to select an in-network provider. As an initial matter, MACEP is unaware of any data that supports the position that OON Concerns for emergency medicine services is a wholesale, or systemic, problem for patients in Massachusetts, or that OON Concerns are increasing costs to consumers. Indeed, HCP conceded in its Policy Brief that there was no comprehensive data on the frequency or extent of OON Concerns in Massachusetts. Policy Brief p.3. In fact, it is our understanding that OON Concerns originated with Massachusetts health care plans and not consumers. While MACEP recognizes that patients should not be caught in the middle of reimbursement disputes between payers and physicians, particularly when the patient had little choice in who provided their care, the OON Concerns largely result from payers failing to pay the fair market value for reasonable and necessary emergency medical services.

Framework of existing laws/challenges

The move to investigate OON Concerns brings into focus the complex reimbursement regimen at the heart of the U.S. and Massachusetts health care systems. Historically, payers have established limited networks of providers to leverage more favorable payment rates for health care services. Today, there are an ever increasing myriad of insurance product designs that complicate the reimbursement landscape, such as high deductible plans, and tiered and narrow

networks that involve higher out-of-pocket costs for consumers if they see providers that are considered a less preferred tier or out-of-network. This can result in increased deductibles and/or copays for consumers. Unfortunately, consumers buying these high deductible plans because they are attracted to their lower premiums, often lack the financial means to meet their “patient responsibility” particularly with regard to unexpected emergency services.

Within this complex regime, emergency medicine physicians are unique because they are required to treat any patient presenting at a hospital with an emergency medical condition, regardless of ability the patient to pay, under the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA). Due to the volume of uninsured and underinsured patients that emergency medicine physicians encounter, and their role as a 24/7 safety net provider, emergency medicine physicians must receive fair payment from insurance companies for the services they render. Additionally, emergency physicians cannot close their doors, and as a result have unique and significant structural cost challenges compared with other specialties. Emergency physicians provide uncompensated safety net services to payer members and the general public during low volume hours, such as in the middle of the night, when they stand ready to provide high quality care for strokes, heart attacks and other injuries and illnesses.

Further exacerbating these concerns is the situation described by Commissioner Cutler during the listening session on May 18, 2016, where the patient is treated at a hospital that is in-network, but where the emergency department physicians are out-of-network. In recognition of this unique scenario, federal and state laws have been enacted with the stated goal of protecting consumers from “surprise bills.” As noted during the listening session, we believe this characterization of an alleged patient “surprise bill” is a payer derived concept that misses the mark. If there is truly any “surprise,” it lies in the patient’s realization that he/she paid for insurance that only covers the rendering of services in certain hospitals, and if rendered outside of these facilities he/she may personally be responsible for paying a disproportionately large amount of the total bill (i.e. “surprise lack of coverage”).

The federal and state protections that have been passed, generally require insurance plans to pay OON providers, including emergency medicine providers, a reasonable rate for their services in an effort to minimize the cost of OON services to patients. Although a laudable goal, these laws have largely been “gamed” by the payers, resulting in greater patient uncertainty, and invariably, greater patient responsibility.

For example, the Patient Protection and Affordable Care Act (“PPACA”) mandated that payers pay emergency service providers the greater of three rates: the Medicare rate, the “usual and customary” rate for the area, or the payer’s median in-network rate for the service. There is no question that the intent of this law was to prevent payers from imposing greater financial burdens upon consumers, by paying an artificially low amount to OON providers. This, however, has not been the reality of how this law has played out. It is MACEP’s understanding that emergency providers are charging reasonable charges and payers are by and large reimbursing providers for those charges.

We believe that it is the payers’ use of liberal discretion in calculating the “usual, customary, and reasonable” fees that is the principal root cause of the OON Concerns, and the most important problem to be addressed. The “usual and customary” rate for emergency services has some inherent limitations, including the lack of provider involvement and transparency in setting rates. Massachusetts law has been interpreted to require an HMO to pay OON emergency services at “reasonable charges.”² As discussed below, we believe this law may provide a viable option for the consideration in addressing any true OON Concerns. Moreover, under Massachusetts law a payer must pay the OON emergency services provider “at least 80% of the Benefit Levels for the same covered Health Care Services rendered by Preferred [i.e. in-network] Providers.”³ “Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a Usual and Customary Charge, and not a percentage of the amount paid to Preferred Providers.” However, “Usual and Customary Charge” is defined as “the fees identified by a carrier as the usual fees charged by similar Health Care Providers in the same geographic area.”⁴ Accordingly, both under Federal and Massachusetts law, payers are permitted to use their alleged independent “databases” to determine the usual and customary rate for the service, or “reasonable charges,” with no input from providers, and no oversight from any regulatory body. Not surprisingly, this unfettered discretion will inevitably result in OON emergency services providers

² 176 Mass Code Reg. 5.

³ 211 Mass Code Reg. § 51.05. “The 80% requirement shall be met if the coinsurance percentage for Health Care Services rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same Health Care Services rendered by a Preferred Provider, excluding reasonable deductibles and copayments.”

⁴ 211 Mass Code Reg. § 51.02.

often being paid well below fair market value for their services requiring emergency service providers to seek compensation from the patients.⁵

Lessons Learned and Potential Solutions

If the HPC decides to support legislation to determine the fair value to be paid for OON services, its decision should ensure that all the stakeholders' interests and concerns are addressed.⁶ We believe that five guiding principles should frame these deliberations: (1) payments for OON services should constitute the reasonable value for the services rendered, (2) the payment rates should be established using an unbiased methodology that sets the reasonable value for the services, (3) the overall methodology should be administratively efficient so as not to waste healthcare delivery dollars or create the need for cumbersome regulatory oversight, (4) provider-patient interactions should focus on patient care, and (5) providers need to have input into, and access to the methodology used, to ensure payments for OON services are fair and transparent. There is no perfect solution to this issue, but we believe we can learn from actions taken in other states, as well as from the existing law in the Commonwealth.

Many states, such as New York and Connecticut, have adopted various regulatory schemes that attempt to minimize the OON Concerns. Inevitably, these laws attempt to identify certain rates that are "reasonable," limit the provider's ability to seek compensation in excess of these rates, and provide a dispute mechanism that can be used by the payer, provider, and in certain rare instances, the patient. As noted at the listening session, we believe many aspects of New York's model to be overly complicated, administratively burdensome, and confusing. Significantly, a frequent misconception is that New York's model prohibits balance billing. As written, there is confusion over whether the law prohibits all balance billing of emergency medical services, or only those that are subject to "Independent Dispute Review." Moreover, the take-it-or-leave-it, baseball style discretion given to payors in determining what "reasonable" payment is, has spawned a number of disputed cases. Finally, the reliance on yet another payer populated black box pricing index,

⁵ Further complicating this process is that certain fraud and abuse laws prohibit the routine waiver of consumer's cost-sharing amounts unless there is a documented financial need to do so.

<http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html>.

⁶ HPC should note that any legislation proposed by HPC to address the perceived balance billing concerns would only apply to state regulated insurance plans, and would not include ERISA based plans, which account for ___ number of plans/covered lives in the state. This could result in a disparity among consumers regarding payment obligations for OON balance billing.

Fair Health, is equally problematic. Although carrying several of the same infirmities as New York, Connecticut's legislation seems more promising to strike a balance with all of the relevant stakeholders.

With the five guiding principles in mind, we offer the following concepts for your consideration:

- Expansion of the Commonwealth's current HMO law to all products. We believe that most providers are requesting reasonable charges, and for those outliers that are not, we believe those disputes should remain disputes between the payer and provider. MACEP has not been provided any data that substantiates the OON Concerns are widespread and is in need of extensive regulatory correction.
- If further definition of "reasonable" payment is necessary, we propose that it be tied to a reasonable current, fixed amount that is adjusted yearly based upon medical inflationary index. We are not in favor of the use of a pricing database, such as Fair Health that is populated only by payors, lacks transparency as to the claims being populated by the payors, and lacks any meaningful ability to have provider input into, or even monitor, the data.
- If it is desired that there be the ability to address the "reasonableness" of the payment being made, we propose an independent, binding dispute resolution process (IDRP) which:
 - a. Allows either a provider or payer to access the IDRP. Patients should be removed from the process;
 - b. Provides for resolution on a per CPT code basis, and not on a per visit or per encounter basis;
 - c. Uses CPT definitions for all coding disputes;
 - d. Concludes its findings within a reasonable period of time given the number and nature of the claims in dispute, but not to exceed 12 months of receiving the dispute (if adjudication takes additional time, there should be a mechanism for the provider to file for interim payment subject to a true-up based on the IDRP findings);
 - e. Allows aggregation, on both a group and claims basis, for claims with common issues of fact and/or law to be bundled together and adjudicated into one IDRP;

- f. Includes on the IDRP panel licensed medical providers in the same or similar specialty as the provider subject to the review, and individuals with healthcare claims experience including training and experience in CPT coding;
- g. Assigns a single person to each matter that is below a designated claim threshold, and a panel of three people for matters over that threshold;
- Payers must accept patient's assignment of benefits to the OON provider. The failure to recognize assignment of benefits, needlessly and inappropriately, thrusts patients into the payer/provider dispute.
- As mentioned at the listening session, we believe providers should be removed from their status of debt collector, and require that the payers pay OON providers the patient's cost-sharing obligation, and in turn bear the risk of collecting that amount from the patient. To address a concern raised in the HPC Policy Briefing, this requirement could be supported by a provision requiring payers to hold patients harmless from paying these sums to the providers. Payers, the only party that is engaged in the business of insurance, should be required to bear this financial burden, not the provider.

In sum, MACEP appreciates the opportunity to continue its dialogue with the HPC to create a fair, efficient, transparent system that ensures payment of reasonable and fair compensation that alleviates any documented OON Concerns.



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**Testimony Submitted to:
Price Variation Commission
January 17, 2017**

Chairman Sanchez, Chairman Welch, and Committee Members, thank you for the opportunity to speak with you today at the Price Variation Commission hearing to discuss concerns related to out-of-network emergency services. This is an incredibly important issue that has a direct impact on our patients, providers, and the overall healthcare system in Massachusetts.

Much has been made of the ever increasing out-of-pocket expenses that our patients have been stuck with at the hands of the insurance industry, and rightfully so. With the rise of high deductible plans, large co-pays and co-insurance, patients are increasingly responsible for paying much more than their monthly premiums when it comes to healthcare. Patients are understandably confused and frustrated when they receive bills from multiple providers, as they assume that the health insurance they purchased will cover them, especially when it comes to emergencies. Nobody can predict or choose when or where they will need emergency care and patients should not be punished financially for seeking emergency care. The insurance industry would like for you to believe that the cost shifting and higher out-of-pocket expenses are due to providers who are charging above and beyond what is fair and appropriate for services rendered. This misperception is often tied to “out-of-network” providers who have been blamed for causing excessive out-of-pocket expenses, when much of the cost is simply a reflection of cost-shifting by insurers and increasing patient responsibility. It is the insurance industry itself who has created this situation, with inadequate, narrow networks and so-called “affordable” policies that actually cover very little, leaving patients to foot the bill and providers to collect payments. This is exactly the type of position that neither patients, nor providers, should be forced into – it’s a losing formula for everyone except the insurers. It is our firm belief that patients need to be taken out of the middle. Physicians should focus on practicing medicine and insurers should be responsible for collecting payments.

As we discuss healthcare costs and insurance coverage, it’s important to consider the unique position of emergency medicine and the care that is provided to over 3 million patients per year in Massachusetts emergency departments. I am a practicing emergency physician in the Hallmark Health System, and Chair of the Massachusetts College of Emergency Physicians (MACEP) reimbursement committee, and a Past President of MACEP, which represents over 1000 emergency physicians, we are first and foremost about our patients and their ability to access the highest quality emergency care, 24/7/365. Emergency



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departments are the only setting in all of healthcare where patients can be treated without an appointment by highly trained physicians for any condition, at any time of the day, without consideration for the ability to pay. This is an important distinction from all other specialties and places of service and is unique to emergency medicine, where all of the care we provide is subject to EMTALA. As many of you know, EMTALA is an unfunded federal mandate, passed in 1986, that requires all patients presenting to an emergency facility to be seen and stabilized, regardless of payment or insurance status. As emergency providers, we are proud to wear the EMTALA badge and care for anyone with anything at any time. However, this federal law also places a huge financial burden on emergency departments, who see a disproportionate share of uninsured and underinsured patients. Each emergency physician provides an average of \$130,000 of unreimbursed care annually, more than any other specialty. With an increasing volume of more complex, higher acuity patients arriving at our doorsteps each day, it is more important than ever to ensure fair payment by insurers in order to support and preserve the emergency medicine safety net.

With this background information, I'd like to address the out-of-network emergency services issue. Just as patients cannot choose when they have an emergency, emergency providers cannot choose which patients they will or will not see. Insurers offer in-network rates, at below-market value, in exchange for driving patients toward a particular system or provider. There is no incentive for payers to offer fair and reasonable rates to those of us who provide emergency care, as we are bound by our EMTALA obligation. Insurers can game the system by setting high deductibles and offering unfairly low in-network reimbursement rates for emergency care. If emergency providers are forced to accept unreasonable rates that do not cover the cost of delivering 24/7/365 care, then the safety net will fall apart. Our emergency departments will not be able to appropriately staff and serve our patients and many will be forced to close altogether. The only recourse that emergency providers currently have to protect fair payment is our ability to go out-of-network. Without that option, we would be setting ourselves up for a public health emergency and abandoning our patients at the time of greatest need.

So what solutions can we suggest to preserve the safety net for patients and prevent surprises in "lack-of-coverage" as it relates to emergency services? The answer is transparency, taking the patient out of the middle and ensuring fair and reasonable payment. Health plans have a long history of undervaluing emergency care and sticking patients with balance bills, as evidenced by the multi-million dollar settlement that United Healthcare was forced to pay in New York State as a result of systemic underpayment for services using the Ingenix database. We recommend the use of an independent, unbiased, transparent UCR database based on charges to determine fair reimbursement rates.

Protecting patients: Furthermore, we recommend that patients be taken out of the middle, and that copays, coinsurance and deductibles should not apply to the professional component of emergency department care. Cost sharing would still apply to the facility component. This removes any confusion about bills coming from multiple different sources and streamlines and simplifies the overall process. This would remove the misperception that patients are receiving multi-thousand dollar balance bills from emergency physicians in Massachusetts. Finally, emergency physicians would be willing to consider a cap on professional charges related to any single ED visit, which would completely remove the possibility of

patients receiving excessive, multi-thousand dollar bills from their emergency provider. This proposed solution would protect patients, reduce waste (by removing payment disputes, arbitration, and administrative costs), and preserve fair payment to maintain the emergency safety net.

Thank you for consideration of our comments and for the opportunity to speak with you today. We look forward to continued collaboration as we work to protect the interests of our patients and preserve the ability to provide the highest quality emergency care in Massachusetts.

Sincerely,

Elijah Berg, MD, FACEP
Massachusetts College of Emergency Physicians

Special Commission on Provider Price Variation - January 17, 2017 Hearing

Good afternoon, I'm Dan Keenan and I serve as the Senior Vice President of Government and Community Relations for Mercy Medical Center. Chairman Welch, Chairman Sanchez and all the members of the commission, thank you for the opportunity to testify. I appreciate the work and time you have dedicated to examining provider price variation in the commercial market and for your efforts to put forth initiatives that will have a positive impact.

Mercy Medical Center is a 182-bed community hospital located in Springfield that provides nearly 80,000 ED visits annually. Mercy includes Weldon Rehabilitation Hospital, our 30-bed rehabilitation center located on the Mercy campus, and Providence Behavioral Health Hospital, our 125-bed behavioral health campus of Mercy, located in Holyoke. Providence is one of the largest providers of acute behavioral health care in the Commonwealth, providing inpatient and outpatient psychiatric care for children and adults, inpatient substance abuse treatment, as well as outpatient Methadone and Suboxone treatment.

Mercy serves one of the more financially challenged regions in the Commonwealth and has a payer mix that reflects our community at approximately 75% public payer, including 30% Medicaid and only 25% commercial.

Consequently, Mercy has one of the lowest relative prices paid from commercial payers at less than 80% of the statewide average.

I know that the Commission is examining a range of factors that affect provider payment rates that are both warranted and unwarranted. And, that you are investigating factors that could impact unwarranted price variation, including transparency, competition, and state monitoring.

I am here today to encourage action by the Commission in all these areas, but with a special focus on a regulatory approach that will have positive impact on providers with the lowest relative commercial rates.

Current relative price disparities for the same quality and service levels threaten the availability of affordable local healthcare. As I mentioned earlier, Mercy is one of the largest providers of inpatient behavioral health services in the Commonwealth. We lost nearly \$10M on behavioral health services in our most recently closed fiscal year and are budgeted to lose \$8M this year.

Commercial rate disparity is a contributing factor to these losses. Commercial rate disparity also impacts our ability to make needed investments in people, to build infrastructure, to recruit physicians and ultimately, in our ability to continue to provide negative margin services.

Attorney General Martha Coakley released her report, Examination of Health Care Cost Drivers in March of 2010. That report, among other findings, concluded that:

- Prices paid by health insurers to hospitals within the same geographic region vary significantly for similar services.
- These price variations were not correlated to quality of care or the cost to provide the care.
- These price variations were correlated to market share within geographic regions.
- The 2010 Report also concluded that higher priced hospitals were gaining market share at the expense of lower priced hospitals.

With the continued work of the Administration, Legislature, Attorney General, Health Policy Commission and CHIA, much has changed since 2010. Much has changed in terms of the sophistication of analysis of price disparity in the commercial market.

We have the data, now is the time to act.

I commend the commission and policy makers in Massachusetts for the continued efforts to have an impact on unwarranted price variation in the commercial market and I am hopeful that this commission will play a role in rectifying this challenging commercial payment scheme.

There is no warranted reason for Mercy's commercial rates to be so low. Transparency and market forces continue to have an impact on negotiations with the payers. Mercy will continue to do its part as high quality provider and attempt to negotiate fair rates.

We need help from the Commission to assure that we are paid at a comparable level to other like community hospitals. A commercial rate floor of .90 on the relative price index is an option worth significant consideration.

I encourage your action. Hospitals like Mercy, who are at the bottom of the relative price index distribution, need your help. We need this Commission to take action and establish a relative price floor of .90.

Thank you for the opportunity to testify.



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

January 20, 2017

The Honorable James T. Welch
Senate Chair, Joint Committee on Health Care Financing
State House, Room 309
Boston, MA 02133

The Honorable Jeffrey Sánchez
House Chair, Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

Re: Provider Price Variation Commission

Dear Chairmen Welch and Sánchez and members of the Special Commission on Provider Price Variation:

Thank you for the opportunity to provide comment to the Provider Price Variation Commission. Despite lacking an appointment to this commission, we have attended the meetings and followed your work with interest, particularly as the focus of many conversations at the commission meetings have shifted toward physician matters, including tiered insurance plan design and out of network billing.

While it is critical to engage in conversations about alternative insurance plan designs such as tiered network and the issue of out-of-network billing, we hope that they will ultimately take place in a venue that allows for full participation of relevant stakeholders, and we urge that specific recommendations related to these issues be developed when such an inclusive venue presents itself. We further note that there is plenty of work to still be done per the original charge of the commission, which is in part to identify “the acceptable and unacceptable factors contributing to price variation in physician, hospital, diagnostic testing and ancillary services.” There appear to be many other charges to the commission that have evaded substantial discussion, as well.

I would like to highlight two general considerations that the physician community would like to convey to the Commission.

First, the issue of tiering has been raised many times in the course of this Commission- in fact; many conversations have referenced “tiering on steroids” as a possible solution to addressing price variation. The Medical Society wishes to highlight some perspectives regarding tiering which have largely evaded conversation of the Commission thus far.

- 1) Doubling down on tiering is not a panacea, as the jury is still out on the effectiveness of these plans to promote lower cost care. In their 2015 Report on Health Care Cost Trends and Cost Drivers, the Attorney General’s office said, “We found that membership in tiered products has grown, but the presence of these products has not resulted in an overall shift in patient volume away from hospitals that insurers have identified as lower value.” We urge continued study of these and other alternative payment designs to ensure focus on strategies with the strongest evidence base.

- 2) The same Attorney General's report indicated substantial inconsistencies among tiering products, some of which lead to high price hospitals being included in the best available tier (without quality-based explanations) Tiering needs substantial fixing before it should be affirmed or even amplified in the market.
- 3) Lastly, tiering methodologies are shrouded in opacity. The above finding of the AG's report allude to a tension between the findings of their study of tiering and the Ch. 288 mandate to tier providers based on standardized and transparent cost and quality measures. Combining these concerns with longstanding issues such as variability and inconsistency of deductibles and co-payments, and still imperfect attribution methodologies, and tiering suddenly may not be the solution that should be put on steroids. For example, a study published in 2016 found that "the current methods for profiling physicians on quality may produce misleading results."ⁱ Therefore, we hope these perspectives are considered by the commission as a whole.

We have also been particularly interested in the many conversation of this Price Variation Commission around the issue of out-of-network billing.

First, the Medical Society remains committed to finding a solution to out-of-network billing that takes the patient out of the middle of all surprise bills- held harmless, with a prohibition on their receiving a balance bill. Patients seeking care at in-network facilities should not be subject to surprise bills.

That is why we are pleased to let you know that the Medical Society is finalizing legislation to address this issue- to prohibit patients from receiving "surprise bills" and providing a sustainable reimbursement strategy moving forward. The Medical Society's leadership and Committee on Legislation are currently reviewing this legislation that we hope will offer a thoughtful solution to the issue that has been the subject of so much conversation at your commission. The legislation is modeled after successful legislative solutions put forward by other states- strategies highlighted by the Health Policy Commission in its 2015 Cost Trends Report. We look forward to discussing and engaging on this issue through your roles as legislative chairs of the Joint Committee.

And second, while we don't have the data to know the exact nature of the issue, it will be critically important moving forward to ensure that patients have access to adequate networks. While we're all concerned about cost of health care, cost savings are only as good as are the ability of the underlying strategies to assure access to the care. We urge you to keep this issue in the forefront of all conversations moving forward.

Again, as the discussions of out-of-network billing have come solely from the limited membership of the Commission, I'm joined by Dr. Alex Hannenberg from the Massachusetts Association of Anesthesiologists. Dr. Hannenberg has long been closely involved in billing matters for his practice, and is here to highlight some considerations and reactions to many of the conversations of the Commission on this topic.

Sincerely,

Brendan Abel, Esq.
Legislative & Regulatory Affairs Counsel

ⁱ Adams JL & Paddock SM. 2016. Misclassification risk of tier-based physician quality performance systems. *Health Services Research*.



Massachusetts Society of Anesthesiologists

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Comments of the Massachusetts Society of Anesthesiologists

Presented to the Special Commission on Provider Price Variation Public Hearing

Officers

Public Hearing

January 17, 2017

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Good morning, my name is Alexander Hannenberg, M.D., and I am an anesthesiologist very recently retired from clinical practice at Newton-Wellesley Hospital. During my 26 year tenure at Newton-Wellesley, I was principally responsible for contracting and billing operations in our practice. Currently, I am leading payment reform work for the American Society of Anesthesiologists (ASA). I am a past president of the ASA, and Chairman of the Economics Committee of the Massachusetts Society of Anesthesiologists (MSA), and I am here today on behalf of the MSA, which represents over 1,000 physician anesthesiologists practicing in the Commonwealth.

MSA appreciates the opportunity to provide comments regarding out of network (OON) billing, and in particular "surprise billing" in which a patient may receive a bill for medical services provided at an in network hospital by an out of network clinician.

We understand this issue has become a subject of discussion within the Commission on Provider Price Variation, particularly in reference to discussions of tiered and limited networks. This is a complex issue that will become all the more complex as limited networks, which by definition limit provider participation, become more common. As this issue is explored, it is helpful to note that the Health Policy Commission (HPC) in its report on OON Surprise Billing acknowledges that comprehensive data on the frequency and extent to which OON billing occurs in Massachusetts is difficult to obtain or quantify.

In conjunction with the Massachusetts Medical Society, I have been asked to discuss out of network billing for services by hospital based physicians and highlight some considerations regarding the issue.

Out of Network Hospital Based Physicians

At my hospital, Newton-Wellesley, the anesthesia group participates in all major local and regional insurance plans that have contracts with the hospital. I believe that is the case at most hospitals in the Commonwealth. However, there may be hospitals in which anesthesia groups are out of network for some payers. In the case of a low-volume national commercial plan my experience is that these plans demonstrate little interest in pursuing a participation agreement with the practice.

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Out of Network Surprise Billing

In Massachusetts, hospital based physicians typically provide 24/7 services pursuant to a contract with the hospital. We have a powerful incentive to maintain a solid relationship with the hospital, and at my hospital, we work hard to keep patients, surgeons and the hospital happy. Our hospital contract is at stake. In my 26 years at the hospital, it has not had a single patient complaint relating to anesthesia OON billing, and this has been validated to me by our hospital administration. Frankly, we would benefit in some ways from agreements with some of the national insurance carriers I have mentioned previously, but our efforts to execute an agreement were stymied by indifference on the part of the insurers, or an unwillingness to stipulate to basic terms of an anesthesia agreement. In the absence of a participating agreement, the patient is out of network, and my practice walks the patient through the appeal process with their insurer and we write off a lot of the balance---thus the absence of complaints. I believe, our handling of OON billing is how most anesthesia practices in the state deal with the issue.

Limited Networks

At last week's Commission meeting, I understand BCBS made a presentation about tiered and limited network plans. As you know, those plans limit members to a limited network of hospitals and clinicians. By design they achieve discounts or lower fees from the limited network providers by assuring patient volume.

BCBS implied that cost savings expected from a limited network are greatly at risk due to limited network members receiving services, including emergency services, at out of network providers, who are paid their charges. That is not the case.

If you are a participating provider with BCBS, as are most anesthesia practices in the state, you agree to treat BCBS patients per your BCBS contract and at your contracted fee. We may not be a participating provider in a BCBS limited network (typically excluded from that network), but if a BCBS limited network member receives services at my hospital, as an emergency or otherwise, the group would receive our contracted BCBS fee; **NOT** our usual and customary charge. Moreover, as a participating BCBS provider, we cannot bill the patient except for the co-pay and deductible. Alternatively, the plan may refuse to cover the service we have provided despite our participation agreement – in this case the insurer is manufacturing an OON situation. We have negotiated in good faith a contract with BCBS to treat their patients at an agreed upon fee schedule. It would be totally unfair if BCBS can throw aside its contract with us and impose a limited network fee schedule on OON providers, who are unable to participate in the limited network, in the event a limited network patient seeks care at an OON hospital.

Solutions

While there does not appear to be comprehensive data regarding the extent of OON surprise billing in Massachusetts, MSA would welcome the opportunity to engage in discussions to find a reasonable solution that would remove the patient from the middle of a billing issue. Possible solution should include:

- Transparency...Up to date information for patients and referring physicians to ascertain whether hospital based providers are in network or not. This will allow patients to make a choice as to where to receive non-emergency care. Consider that by the time I encounter a patient, they have nearly always been through a facility registration process which represents the earliest and best opportunity to inform the patient. This is an activity that, in my opinion, should not occur at the bedside.
- Surprise OON billing for services that are an emergency...the patient should be held harmless except for co-pays and deductibles, and a process for determining a reasonable rate for the OON provider be established that is based on an independently recognized data base, similar to the NY law. Considering the unfortunate history of the Ingenix database, we are very concerned about the accuracy of the benchmarks that are created.
- In establishing a reasonable rate, a balance must be struck such that there are no incentives for participating providers to go OON, nor should it be so low that insurers will not contract with providers and pay an OON rate.

Caution on Using Medicare Fees as a Benchmark

MSA would caution against using Medicare fees as a benchmark in any solution. We would note that for medical services other than anesthesia, Medicare payments are 80% of the average commercial payment rates. For anesthesia services, which is on a different type of payment system, the Medicare payments are 33% of the average commercial insurance payment rates. These comparisons have been established by federal agencies. The use of Medicare as a benchmark would

be devastating to anesthesia and, if implemented, would affect our ability in Massachusetts to recruit and retain anesthesiologists.

MSA supports the Medical Society's solution to OON surprise billing that will be filed for the current legislative session. We would welcome the opportunity to engage in discussions with the Commission and other stakeholders, and work with the Legislature to find a reasonable solution that takes the patient out of the middle of surprise out of network billing.



Testimony to Special Commission on Provider Price Variation

January 17, 2017

Paul Hattis MD, JD, MPH
Tufts University Medical School

Chairpersons Welch and Sanchez:

With no consumer representatives on this Commission—I appreciate today’s hearing so that there is some opportunity for consumers to raise our voices of concern. I am Paul Hattis, faculty member at Tufts University Medical School and a member of the GBIO’s Health Care team—a social justice organization that has been working to achieve a quality, affordable health care system in our state.

Special Commissioners—I remind you that your name is the Special Commission on Provider Price Variation. And so I, like so many consumers across the state worried about health care affordability, are truly depending on you to make robust recommendations to the legislature on the issue of: reducing unwarranted commercial price variation. But I would be remiss—if I did not also say to you that I think you also have responsibilities in some way that as you craft some recommendations tied to the price variation issue, you should do so with some due consideration for taking a bigger picture look at the entire functioning of the market system for health care—particularly in the area of hospital services in our state.

From the outset, let me say that there are some very serious issues of concern with respect to those hospitals that are most underpaid in our commercial pricing scheme. When you combine that underpayment challenge with the reality that their payer mix is highly tilted towards care of government funded patients, no surprise that you can create survival challenges for some of these institutions. While today, I focus more on the issues of the overpaid, I do want to suggest that it may be wise to think about policy solutions that go beyond just raising prices for those at the bottom—to consider more a Maryland style guarantee of a total revenue flow for an ‘essential’ subset of our challenged community hospitals in order to assure their viability in the world to come.

As I now turn to the challenge of confronting the burdens placed on all of us as a result of there being a select group of hospitals that are overpaid under our state’s commercial insurance scheme, let me note that with great support, I have been able to catch a few of your meetings where you have discussed the issue of ‘Out of Network’ care pricing in all of its forms and settings. Seems to me that it is low hanging fruit for your Special Commission to make

credible recommendations that can mitigate the incredible waste of resources that flow to some physicians, hospitals, labs, ambulance companies etc. as a result of there not being subject to a payment level under an insurance contract for services they deliver to patients. (If I heard the Blue Cross VP's testimony correctly last week—15% of commercial insurance spending is for such out of network care—at the margin, some good savings can be accrued here.) At present, Massachusetts is behind a good number of other states that have already passed legislation to reign in this set of intolerable billing practices.

But as important as it is to address this issue, to stop there would really be letting Massachusetts consumers down in terms of your charge and state policy needs.

We should all admit the reality that our very expensive health care system in Massachusetts has a number of root causes, many of them not only Massachusetts in origin as there are many systemic challenges in health care delivery and financing across the US. And commercial price variation exists as well across many markets in this country. But as stated in the testimony today of John Freedman—variation in provider pricing in our market places here in Massachusetts is some of the widest in the country. And when you deal with the reality that 80% of care happens in our most expensive settings-- the TME spending and affordability challenges for people really add up when you allow such price gouging to take place.

Boston Children's Hospital and its physicians are the most extreme offenders in receiving high commercial prices in the state relative to their competitors. But with a relatively higher Medicaid patient payer mix, they pose some specific specialty referral hospital challenges that have not really been fully explored by the Special Commission; so I leave discussion of some targeted policy solutions about them to another day. But come your report in March, I don't think you can ignore them in your thinking and recommendations as BCH's specific pricing and affordability challenges cause consumers and businesses a lot of pain. And it's only going to get worse—so says the HPC about their proposed bed expansion likely to result in increased MA commercial market share and related spending.

Today, however, I wish to focus primarily on what has become the poster child for leading us down a path of high premiums and out of pocket payments in Massachusetts: Partners Healthcare.

Certainly, their existence and behavior has created a good deal of the market dysfunction that exists in health care markets in our state.

Let me say that I don't think that Partners and their providers are evil organizations or bad people. On the contrary—I think they are from a mission perspective—very well intended in so many ways. I don't come to criticize their aims, or for that matter, the substantive activities that make-up the teaching, research, patient care, and community benefit activities that they carry out every day. I praise the fact that they are national leaders in a number of these areas and should be proud of that reality. Though in each of these mission areas—the strengths that they often bring to the table can be uneven and do not exist across all of their facilities or

manifest in all of the people that come to work under the Partners banner. Even at the MGH and BWH—you can sometimes get bad care. And overall, based on the indicators that are currently used in quality measurement, their overall patient care quality compared to others does not stand out.

But to get to the heart of my concern: my biggest beef with them is that they are overpaid for the patient care that they do for commercially insured Massachusetts patients. And as I understand at least some of the historic data, that overpayment concern should also be applied to Medicare Advantage and Medicaid MCO patients they price negotiate for as well.

Their overpayment stems from Partners creation: when MGH and BWH and their doctors came together for the primary purpose of avoiding price competition with each other. Period. This allows them to negotiate prices as a total enterprise and to do so with extreme negotiating leverage.

So what should you do?

Without delving into all of the specifics of the policy ideas noted in the Freedman testimony today as well as approaches taken in Maryland—let me focus you on what could come from a definitive recommendation leading to legislative action. It relates to an idea expressed by Dr. Torchiana in a December 2015 Boston Globe interview where he acknowledged that the thought of breaking up Partners was something that “has crossed my mind.” His idea is important and one that I picked up on last June in a Commonwealth Magazine blog.

The Special Commission could make a set of recommendations, looking to legislation aimed at placing some sort of administered pricing and payment schemes such as capping payment levels, writing rules for a defined formula for a rate ‘build-up’, or perhaps suggesting a creative, ‘common carrier’ pricing scheme outlined by Longman and Hewitt in a 2014 Washington Monthly article. The key thing is that the net effect of such an approach is that commercial payments made to Mass General and Brigham and Women’s and their doctors would not only be definitively constrained, but if done correctly, could also lead these institutions and their leaders to conclude that it would be in their own best self-interest to divorce each other.

Why could such a change in the pricing or payment scheme lead to that decision?

First, ever since Partners’ creation, Mass General and Brigham and Women’s and their doctors have remained fiercely competitive with each other; manifesting minimal interest in working together as part of an integrated care system. Both hospitals and their doctors likely feel the “waste” of having to support Partners overhead without getting much in return.

Second, with the creation of the HPC and the firm line it took in its reports that convinced Judge Sanders that Partners’ planned hospital expansions in this state would only heighten our spending and market dysfunction challenges, the net effect is that today, Partners is left facing

the reality—that at least for Eastern Massachusetts, and quite possibly the whole state—further hospital acquisitions seem legally doomed so long as the system remains intact at its current level of market share.

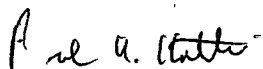
So with these two realities already at play, imagine for a moment that the Legislature enacts a law which contains a scheme that effectively reduces the allowed commercial price differential paid to Partners providers as compared with others. And then imagine further that under such a price-constrained system, Mass General and Brigham and Women's and their doctors and affiliates would get the *same prices if they were separated into two competing systems as they would receive if they remain together under the Partners umbrella*. (You could even sweeten the divorce incentive initially, and for a limited time agree to pay each hospital system separately more than if they remain as Partners.)

Put it all together and you soon come to the conclusion that MGH, its doctors and community hospital and physician affiliates and a corresponding group at BWH with their affiliates would be better off navigating the health care delivery world in their own separate integrated delivery systems. These two competitive systems would also have the possibility of growth though some new acquisitions or affiliations--if net societal value can be demonstrated for any future proposed transactions to the HPC.

If you believe in a market competition system, what a better way to try to obtain that in our state from such a break-up of Partners Healthcare. It can all start from the right sort of recommendations coming out of this Special Commission.

Thanks for the opportunity to testify today.

Respectfully Submitted,

A handwritten signature in dark ink, appearing to read "Paul A. Hattis". The signature is written in a cursive, slightly stylized font.

Paul A. Hattis MD, JD, MPH



PIONEER INSTITUTE

185 Devonshire St, Suite 1101, Boston, MA 02110

Honorable Jeffrey Sanchez
Honorable Steve Welch
President Kate Walsh
Special Commission on Provider Price Variation
Commonwealth of Massachusetts

January 31st, 2017

Recommendations of Pioneer Institute to the Transparency Subcommittee of the Special Commission on Provider Price Variation

Dear Representative Sanchez, Senator Welch and President Walsh:

Introduction

Thank you for the opportunity to submit the views and some recommendations of Pioneer Institute to your Commission, and in particular to the Subcommittee on Transparency in Health Care. The Commission meetings have been interesting to attend, and staff have been very professional to work with for both the Commission and the Pioneer Working Group on Healthcare Price Transparency.

While there are many dimensions to transparency in healthcare, our current system is largely defined by one fundamental fact: **Patients and consumers have little idea of the cost of the procedures they and/or their employers are asked to pay for.** While this is especially important for consumers with high deductible health plans, it is also relevant to those with low deductibles who could be incented to make high-value low-cost provider decisions. This lack of information impedes synergistic opportunities among employees, employers and payers who can use their purchasing decisions to actually drive down the cost of medical care and reduce unwarranted price variation.

Price transparency is also extremely important to the healthcare system as a whole. There seems to be no acceptable rationale not to shine sunlight on the price of healthcare procedures and services among providers in Massachusetts. There is no question that our healthcare market is a hybrid of market forces and government regulation. Under these circumstances, suppressing price information from consumers'/employers' view leads to the inevitable result that healthcare dollars are misallocated because the price of healthcare services is not available to help guide the decision-making process of consumers and employers.

Although we have state laws requiring cost estimator tools from insurers and the disclosure of price information by providers, surveys by Pioneer,¹ **submitted with this**

letter, show that obtaining prices from providers upon request is still a daunting task for prospective patients. There is little or no information on provider websites to inform consumers that they have a right to know the price of even common procedures, and telephoning most types of providers ends up as a futile exercise for consumers. Consumers do not even know they have the right to this information. For consumers with high deductible plans who are paying the first dollar of their health care costs, this is not the hallmark of a progressive, consumer-friendly system.

As for the cost-estimator tools of Massachusetts payers, they vary in quality. Some contain a limited number of procedures, others contain hundreds. Some are easy to navigate, some more difficult. The uptake by members has been slow, but is growing. However, it appears that there is not a lot of promotion, marketing or change in plan design, for sustained periods, to incent and teach employers and employees about using these tools or offering greater incentives to do so.

The result is predictable. There is little awareness among consumers that they can shop for planned procedures, from MRIs to joint replacement (some studies show that almost 40% of procedures fall into a shoppable category). For the fearless who try to obtain such information, the experience is often not successful. Skeptics of consumer price transparency claim a lack of interest among consumers and employers for healthcare price transparency information based on low transparency tool usage rates. If consumers don't want a particular product, perhaps the product needs changing to make it attractive and more consumer friendly.

Price transparency in healthcare requires nothing short of a cultural change in the way consumers/patients and employers, aided by payers, providers and the state, consider healthcare options. There is no one-shot silver bullet, a bold multi-pronged strategy among and aimed at all stakeholders is needed.

We know that consumer behavior can be positively impacted through programs of education and incentives implemented over a sustained period. Consider smoking cessation campaigns and consciousness around healthy food. Price transparency in healthcare requires a similarly sustained effort. **From this Commission's work, we see promising models of mandatory, sustained employee education and targeted outreach by Polar Beverages and the new GIC Vitals SmartShopper program.**

Pioneer rejects the notion that consumers/patients are not medically literate enough to take advantage of price transparency for non-emergent care. In no other market is the burden placed on consumers to prove that they can handle price information. **A March 2015 national survey funded by the Robert Wood Johnson, performed by the respected Public Agenda think tank in New York, showed categorically that consumers with high deductible plans (over \$3,000) said they tried to find price information before obtaining care.²** See, "How Much Will It Cost", Public Agenda, March 9, 2015, attached to this letter.

But consumer/patients need help and reinforcement in order to change behavior and redirect healthcare dollars more wisely.

This is where this Commission can play a key role by providing a blueprint for action to stimulate initiatives and innovations to propel price transparency forward and benefit Massachusetts consumers/patients. Most importantly, this Commission is in a position to lay to rest the myth that consumers don't want this information, while simultaneously affirming that providing useful price information to patients is connected to fixing unwarranted difference in health care prices. See, *"Panel Pegs Challenge: Easily Understandable Health Care Pricing Info,"* State House News, Katie Lannan, Jan 10, 2017.³

Pioneer recommends that the Price Variation Commission calls for the following actions:

1. **State Wide Education Campaign:** The initiation of a two-year state-wide campaign pulling together state, payer, provider and employer resources to lead and educate Massachusetts consumers/patients and employers on the benefits of (a) knowing the cost of healthcare services and procedures, and (b) how utilizing various strategies such as cash/non-cash incentives (tiering, reference pricing, etc.) can erode unwarranted price variation and save healthcare dollars. This campaign can be coordinated by the executive branch of state government. A low cost but sustained social media/transit advertising campaign augmented by radio and TV media exposure over a sustained period of time can raise awareness and receptivity. This should be accompanied by an educational campaign aimed at, and utilizing, employers and workers through the chambers of commerce, business and trade groups and major employers, and should include every region of the state.
2. **CHIA Data Release:** Set the stage, and lead off the campaign, by releasing, on a regular basis going forward, cost data from the Center for Health Information and Analysis (CHIA) on up to 40 of the most popular procedures, de-identified by patient, but identified by provider and region. Medicare transparency has set in place a precedent to follow. This does not have to wait until a new website is developed, it simply involves posting the relevant price/provider information. It would begin to raise awareness among consumers and employers that there are real differences in prices and that directing dollars towards certain high-value low-cost providers could save millions of dollars.
3. **Use Existing State Authority:** There is a great deal more that can be done under existing state law to encourage and motivate payers and providers to more fully embrace and promote existing price transparency statutes. Payers and providers have had since 2102 to prepare robust, consumer-friendly, transparency initiatives for patients and consumers. But even today, over 4 years later, most consumers are not even aware that healthcare price transparency is their right. As stated above, Pioneer's surveys of providers, with a new

installment about to be issued this month, shows rather dismal performance even if a consumer is savvy enough to seek out price from a hospital or doctor for a procedure or service. Further, there is little marketing to employers by health plans about ways in which they can save on health costs by the addition of internal health navigators or basic education to employees on what they can do. Programs that are available to employers increase the costs of premiums, impeding their spread.

The executive branch, working through its Department of Public Health, the Division of Insurance, the Boards of Medicine, Dentistry and any other licensed entity covered by the transparency provisions of Chapter 224, can use its regulatory authority to spur much faster advancements in the area of price transparency. **We are attaching two articles on the power of the state to use its existing authority in this area.** One is an opinion piece from Pioneer in *Mass Lawyers Weekly*,⁴ and the other is a Pioneer blog⁵ that outlines how each agency can use its existing regulatory authority to spur a greater embrace of price transparency by both payers and providers.

We at Pioneer have also found a disconnect between what some providers have described to the Health Policy Commission in answers to questions posed by the Attorney General about their consumer facing transparency efforts and the experience Pioneer researchers have encountered. It would seem there is enough non-compliance to warrant the attention of appropriate state offices.

4. **Reward Patients in the Small Business and Individual Market for Being Smart Shoppers:** Given the regulatory regime in the merged market, patients are rarely rewarded for making smart healthcare decisions. As a first step, the state should ask insurers to grant these patients a share of the savings when they seek out a high-value provider within their plan design that is below the mean cost for that procedure or service in their area. These rewards can help offset the high deductible costs that many enrollees face, and keeps those with chronic conditions engaged in saving money even after they have blown through their deductible. An article in Forbes Magazine on the success of one such program is attached.⁶
5. **Give Small Businesses Access to Health Claim Information:** Through contracting arrangements, smaller companies, unlike their larger counterparts, are often prohibited from accessing health claims from their insurer. The state should level the playing field by allowing companies of all sizes access to their own claims information, with appropriate privacy around patient medical information, so they can serve employees more effectively, and understand and control healthcare costs.
6. **Use GIC To Encourage Greater Transparency:** Support and encourage, perhaps through Executive Order, the state Group Insurance Commission in its efforts to use its market clout to drive down healthcare costs. The Commission

could recommend that the GIC require that its third party administrators (TPAs) demonstrate proof of robust compliance with state transparency laws and that the TPAs in turn require the same from the providers with whom they contract on behalf of the GIC.

In addition, this Commission should look at other states' employee insurance markets, such as CalPERS in California, to recommend other ways the GIC can use its clout as a way to drive costs down and as examples to other employers and payers.

For example, CalPERS, and indeed other large employers, use reference pricing for certain shoppable procedures. CalPERS, long a leader in value-based purchasing, has recently initiated reference pricing and claims that reference pricing has resulted in price reductions, not merely slowdowns in the rate of growth. While there have to be sensible limits to reference pricing, the argument that providers will merely cross-subsidize to make up differences has to be evaluated in the context that other large employers and indeed large payers with clout are in the same position to use reference pricing or clinical centers of excellence to extricate themselves from unwarranted price variations. See, attached, "Appropriate Use of Reference Pricing Can Increase Value," Health Affairs Blog, July 7, 2015.⁷ At some point, prices have to decline.

7. **Transparency Awards:** A Commonwealth Healthcare Transparency Award(s) could be initiated as a challenge to businesses to develop innovative transparency/financial incentive programs to reduce health care costs. These initiatives could include reference pricing models, financial/material incentive award programs, educational modules, working with payers or directly with providers to provide easy access for employees to find value-based healthcare and earn rewards. A more careful look at the Mass Challenge Awards programs may be helpful for deciding how to structure such an initiative.

The key here is that the Commission should encourage innovative programs such as reference pricing, providing employees financial rewards for choosing high-value low-cost providers, making transparency easy to navigate, and sharing savings with employees who choose low-price high-value providers. And, very importantly, all such programs have to be accompanied by long term educational efforts to employers and employees about access to price transparency in health care services.

Thank you for the opportunity to present these recommendations.

Sincerely,



James Stergios

Executive Director, Pioneer Institute

¹ [“Massachusetts Hospitals Weak on Price Transparency”](#) Pioneer Institute. Anthony, Barbara; Haller, Scott. June 24, 2015.

[“Bay State Specialists and Dentists Get Mixed Reviews on Price Transparency”](#) Pioneer Institute. Anthony, Barbara; Haller, Scott. August 11, 2015.

[“Healthcare Prices for Common Procedures Are Hard for Consumers to Obtain”](#) Pioneer Institute. Anthony, Barbara; Haller, Scott. February 21, 2016.

[“Transparency in Retail Drug Prices: Easy to Obtain but Accuracy May Be Doubtful”](#) Pioneer Institute. Anthony, Barbara; Haller, Scott. October 13, 2016.

² [“How Much Will it Cost?”](#) Public Agenda. March 9, 2015.

³ [“Panel Pegs Challenge: Easily Understandable Health Care Pricing Info”](#) State House News Service. Lannan, Katie. January 10, 2017.

⁴ [“Transparency in Health Care Prices Calls for State Action”](#) Massachusetts Lawyers Weekly. Anthony, Barbara; Idelson, Sarah. December 10, 2015.

⁵ [“How To Tell If the Price Is Right: Fostering Transparency in Healthcare Prices for Massachusetts Consumers”](#) Pioneer Institute. Anthony, Barbara; Idelson, Sarah. October 5, 2015.

⁶ [“Right To Shop: The Next Big Thing In Health Care”](#) Forbes Magazine. Archambault, Josh. August 5, 2016.

⁷ [“Appropriate Use Of Reference Pricing Can Increase Value”](#) Health Affairs. Boynton, Ann; Robinson, James C. July 7, 2015.



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January 17, 2017

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State House, Room 236
Boston, MA 02133

Re: Provider Price Variation Commission

Dear Chairmen Welch and Sánchez and members of the Special Commission on Provider Price Variation:

I am writing on behalf of Atrius Health to provide an independent physician group perspective as the Special Commission continues its deliberations on Provider Price Variation. We believe it is important for members of the Special Commission to hear directly from physician practices, particularly those like Atrius Health who have an advanced care model, as we have a unique perspective on the health care market in Massachusetts.

Atrius Health, an innovative nonprofit healthcare leader, delivers an effective system of connected care for more than 675,000 adult and pediatric patients in eastern and central Massachusetts. Atrius Health's 29 medical practices, with more than 35 specialties and 750 physicians, work together with the home health and hospice services of its VNA Care subsidiary and in close collaboration with hospital partners, community specialists and skilled nursing facilities. Atrius Health provides high-quality, patient-centered, coordinated care to every patient it serves. By establishing a solid foundation of knowledge, understanding and trust with each of its patients, Atrius Health enriches their health and enhances their lives.

Atrius Health has been a leader in the state in the adoption of alternative payment contracts, advanced patient-centered medical homes, and population health management. Everything we do is focused on improving patients' lives and health outcomes, and ensuring value by reducing overall Total Medical Expenses (TME). We are unique in our decades-long experience with global payments, which currently represent about 80% of our total revenues. We take financial risk across the continuum of care, including specialty providers, hospitals, rehabilitation, home health, hospice, and pharmacy, so we are highly aligned with the Commonwealth in seeking innovative ways to reduce costs by keeping patients healthy and providing the right site of care – particularly at home instead of in a facility. Our goal wherever possible is to reduce duplication of services, enhance coordination of care and to ensure that our patients receive care in the community wherever possible.

Atrius Health believes the Commission's focus on unwarranted price variation should be on hospital prices, rather than physician prices (particularly primary care) for two reasons. First, hospital prices drive the largest portion of controllable expenses within the total cost of care. For example, about 68% of TME lies outside of Atrius Health's direct control (e.g. hospital inpatient, hospital facility outpatient care, and emergency department care and prescription drug costs). Hospital costs are generally increasing despite our many efforts to reduce costs by referring patients to high quality lower cost hospitals and through creating innovative (typically not reimbursed or subsidized) programs to care for patients in their homes, and by offering extended urgent care and phone hours. Second, within healthcare systems the hospitals often subsidize their referring physician groups. With this as a "hidden" source of revenue for the physician groups, it would be very complicated to find any solution that would be equitable for independent groups like Atrius Health which are not subsidized in any way.

Below are additional comments and recommendations for your consideration:

- Right Site of Care - We are supportive efforts to **promote the right site of care**. Clinical needs should be matched to the right resources which would also support community hospitals. HPC could measure and publish the percentage of care for each healthcare system provided in their academic medical center for procedures that could be treated in community settings and continue to trend referral patterns of care.
- Risk adjustment methodology - We believe that a **better risk adjustment methodology** (e.g. inclusive of socio-economic factors) is needed which should be applied consistently across all payers to ensure that TME is truly comparable. Even when they use the same tool (e.g. DXcG), payers are applying it differently today.
- Site Neutral Payments - We support efforts by the state to **equalize payments for the same services provided by hospital outpatient departments and physician offices** and believe such payments will level out the market for the same type of services which is currently not the case in Massachusetts. Medicare is leading the way in this area.
- PPO Attribution - TME is only compared today on plans where there is a patient requirement to select a primary care physician. Comparison needs to be done on a larger percentage of the patients to be meaningful. PPO attribution methodology was developed and agreed to by many of the larger health plans and provider organizations in Massachusetts several years ago. If CHIA asks the health plans to use this methodology and provide CHIA with the attributed medical group for each patient, then **CHIA can compare TME for PPO products** as well as HMO products. Furthermore, the state should enforce the requirement in Chapter 224 that the health plans attribute PPO patients to primary care providers (or physician groups) and **share the claims data** with that primary care provider or physician group. This would enable the physicians to do the same kind of risk assessment we do on our HMO patients so that we can proactively provide services to keep patients out of the hospital, thereby improving health and reducing TME. We feel strongly this should include sharing behavioral health data so that we can include behavioral risk in assessing overall risk for these patients.
- Reference Pricing - We suggest that the state's **Group Insurance Commission (GIC) be a leader in reference pricing** for standard procedures as a way to re-align the market and address provider price variation. The California Public Employees Retirement System (CalPERS), which purchases coverage for 1.3 million employees and their families, and has long been recognized as a leader in value based purchasing, implemented reference pricing as a consumer-oriented incentive designed to increase in health care through higher quality and lower cost care. It has been reported that a change by CalPERS to reference pricing resulted in changes in consumer choices that in turn resulted in reductions in prices and payments as certain high-priced providers reportedly reduced their prices in order to address the potential loss of patient volume. We believe that adoption of reference pricing by GIC (and other employers) has the potential to reduce health care costs and reduce provider price variation and warrants further examination by this Commission or the Health Policy Commission (HPC).

- End of Life Care – As was reported by the HPC in its report dated November 2, 2016, “Serious Illness and End of Life Care in the Commonwealth” there need to be significant improvements made in the quality of care at the end of life. As the report (which studied Medicare patients) points out, **spending in the last six months of life is concentrated in inpatient acute-care hospitals** which in most cases is nearly three times more expensive than in other settings. We believe that significant opportunity exists in the state to reduce health care costs for patients at the end of life and that additional analysis and policy recommendations should be considered. For example, MassHealth might find that reimbursing for hospice care could be less expensive than paying for hospital or skilled nursing home care at end of life.
- Tiering – We support the **creation of tiered products** with tiering methodology for hospitals and providers that is consistent across the plans and transparent to both providers and patients. Such products should be structured to provide more meaningful differential between higher and lower co-pays and to include key quality measures such as readmission rates.
- Telemedicine - The administration, legislators and the HPC should help foster reforms on both the state and federal level that lead to reimbursement for innovative technologies such as **telemedicine that can drive down TME**. Expanding such reimbursement would encourage more efficient operations by allowing patients to be cared for in the home, rather than by ambulance to the emergency departments, when transportation, mobility issues or other factors might limit a patient’s ability to come for an office visit. Payment should be assessed on time required, not simply at parity to in-person services, to enable telemedicine to bring down total TME. Some consideration should also be given to the site where telemedicine is received; it should not be possible to increase revenue simply by moving the telemedicine provider to a different site with a higher reimbursement rate.
- Limited Network Plans – Patients have not historically understood what they have purchased when buying a limited network product. This is frustrating to patients and creates difficulty for referring providers who may be linked with hospitals and specialists not in the network. However, we can support the development of additional offerings of **limited network products** as part of a multi-pronged approach if the limited network is created around the ACOs rather than by the payer.
- Contracts – Hospitals within a system should have separate **rates as appropriate** to account for various factors such as teaching, acuity levels of patients, and geography, but not separate contracts or separate negotiations which just add administrative work without adding value.

Thank you again for the opportunity to provide input to members of the Commission with our thoughts on provider price variation. We would welcome the opportunity to discuss any of the above-mentioned items with you at your convenience. Please feel free to contact me at (617) 559-8042 or Kathy Keough, Director of Government Relations at (617) 559-8561.

Sincerely,



Steven Strongwater, MD
President & CEO, Atrius Health

Cambridge Health Alliance

Draft Testimony: Provider Price Variation Commission – January 17, 2017

Chairmen Sanchez and Walsh and Commission Members:

Thank you for the opportunity to testify today. My name is Jill Batty, Senior Vice President and Chief Financial Officer, of Cambridge Health Alliance (CHA).

We join together with other hospital colleagues you will hear from today in urging the Commission to recommend systemic actions now to address unwarranted price variation faced by underpaid hospitals.

Despite the high quality and high value services we provide, our hospitals are among the lowest paid hospitals by private insurance with a relative price of less than 0.8 compared to an average commercial rate of 1.

On behalf of our patients and communities, urgent action is needed to generate a systemic fix and meaningful progress toward a private insurance rate floor of no less than 0.9 of the average commercial rate.

The longer we wait for action, the challenges are compounded.

The Health Policy Commission's 2015 report found that unwarranted price variation "perpetuates inequities in the distribution of healthcare resources that threaten the viability of lower-priced, high quality providers."

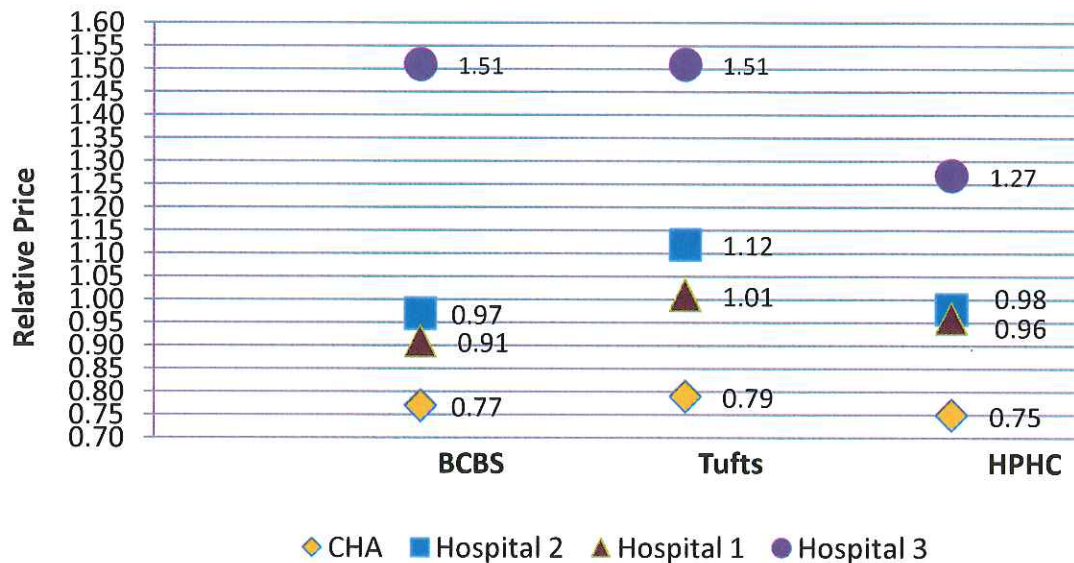
The past 7 years of transparency reporting in Massachusetts has validated that unwarranted price variation by private insurance:

- occurs extensively across the same sets and quality of services,
- contributes to higher healthcare spending due to higher prices and volume shifts to higher-priced providers,
- has not and will not diminish over time -- absent policy action.

The market will not fix this problem on its own. Over the past five years, CHA has actively pursued negotiating and contracting strategies to address this inequality. Yet, its position has stubbornly and consistently remained among one of the lowest paid in the Commonwealth.

According to the most recent publicly available data from the Center for Health Information and Analytics in the 2014 Relative Prices data book, within the 2 mile radius of our service area, the commercial insurance rate for the state's largest payer varies by about 100%, from a low of 0.77 for CHA, two hospitals between 0.91 and 0.97, and another hospital at 1.51. The chart contained in our submitted written testimony demonstrates this discrepancy exists across the state's three major commercial insurers. Contracts negotiated since 2014 have resulted in minimal increases as insurance companies cite the overall statewide growth target as a limitation in their ability to implement meaningful strategies to equitably compensate providers who are locked into low rates.

2014 Hospital Relative Prices by Major Private Insurer in Cambridge Health Alliance Service Area



Source: Center for Health Information & Analysis 2014 Relative Prices by Payer

These data clearly show why we respectfully urge this Commission to fulfill its charge by adopting a payment floor of not less than 0.9 of the average hospital commercial rate.

Chapter 115 calls for the Commission to undertake a “rigorous, evidence-based analysis... [of] the acceptable and unacceptable factors contributing to price variation” and make corresponding recommendations.

We urge the Commission to include in its report clear findings and recommendations which acknowledge and address the important role providers paid on the low-end of the private insurance spectrum play in maintaining access to high quality and low-cost patient and community-centered care.

- It is simply not warranted and not acceptable for providers to be paid vastly less for the same services despite the same quality of care.
- It is not acceptable to perpetuate a market system which deprives communities and patient populations of adequate payment rates to their local health care provider solely based on unwarranted factors such as:
 - freezing in place low payment rates,
 - lack of a significant commercial payer mix or market clout, and
 - greater services to poor, low-income, and government payer dependent populations.

These examples are just a few documented factors in multiple state reports contributing to private insurance underpayments.

The annual financial impact of the difference between our current payment rates and payment at the market average is in the range of \$20 million according to our internal analysis. As a way of example, I'd like to review three specific implications of the inequity to the communities and patients CHA

serves. CHA is a community-based safety net system which offers care to approximately 150,000 unique patients annually.

- Under-investment in local care delivery: CHA, as a result of the mix of services it provides, payment rates, and the patient population it serves, annually faces the challenge to reliably budget for a positive bottom line. Consequently, our capital investments in facilities and programs to deliver services in existing locations close to patients and within the local community have been severely limited.
- Threats to provider/staff recruitment and retention: Our providers and staff are mission-driven and demonstrate their commitment to the patients and communities we serve. Yet, like other underpaid providers, we experience continuing threats to physician and staff recruitment and retention from more highly resourced organizations.
- Concentration of service mix: Commercial price disparities - which can be 2 – 3 times greater rates for the same services - enable higher paid providers to invest and attract patients to higher margin services, leaving vulnerable the essential access we provide. As with all providers, CHA relies on payments from higher margin services to continue to provide access to essential lower margin services such as behavioral health, substance use treatment, and primary care services. The fact that our payment rates are far below market rates limits the scope of our investment and, consequently, access to wellness-oriented care which is correlated to lower health costs in the long run. Addressing the commercial rate disparity for lower paid providers is also crucial to our ability to maintain our regional mental health and substance use disorder services which reach beyond our service area to the entire Commonwealth.

These three consequences of continued payment inequities are significant. Over time, they have the effect of exacerbating the inability of the Commonwealth and its partners in the healthcare industry to offer the residents access to high quality, lower-cost care, close to home. They further concentrate market power and, ultimately the delivery of services, in high cost providers which, in turn, prevents businesses and consumers from having access to reasonably priced insurance products.

CHA can speak from experience that payment reforms like global payments, tiered or limited networks, or the transition to Accountable Care Organizations do not serve to address the underlying underpayment problem. We are successful participants in all of these, but they all start from a flawed, inequitable base.

Now more than ever with federal health policy uncertainty in Washington and ongoing pressure to government programs, like Medicare and Medicaid, it is critical that a level of private insurance rate equity be achieved for underpaid hospitals.

As high value health care systems (quality and price), if our private insurance rates are lifted toward the hospital average, we are collectively poised to be a greater part of the solution and serve more patients cost-effectively in community settings. As you develop your report and recommendations, we ask that a minimum payment floor of 0.9 be established to address a portion of that underpayment.

For the reasons above, policy action to lift up the private insurance rates to a minimum payment floor for underpaid providers – is an essential part of the equation to support the availability and viability of an affordable health care system across the state.

In closing, thank you again for this opportunity to testify. We are available to answer questions and serve as a resource in the Commission's work ahead.

***Testimony of Dianne Anderson, President & CEO, Lawrence General Hospital
January 17, 2017 Price Variation Commission Listening Session***

I'm Dianne Anderson, the President of Lawrence General Hospital. Thank you Chairman Sanchez, Chairman Welch and the entire commission for the work and time you have dedicated to examining unwarranted provider price variation and solutions. This is a critical issue that impacts the sustainability of community hospitals and the affordability and access of health care. LGH is a Regional Medical Center serving the city of Lawrence and the entire Merrimack Valley. With 70,000 ED visits/year, we are one of the busiest trauma centers in the State. We are a disproportionate share hospital, with 35% Medicaid. We provide vital, high quality care to a large socioeconomically challenged area, including advanced surgery, pediatrics and neonatal care. Many of these patients would be able to access to comprehensive clinical care without us. In addition, we are the largest employer in Lawrence.

I am here today because Lawrence General is perpetually among the bottom TEN lowest paid hospitals in the Commonwealth. Our commercial rates are significantly lower than other community hospitals a few miles down the road- for the same procedures, the same diagnoses and the same- or greater acuity levels.

Eight years ago, in my very first month as the CEO of Lawrence General, I was invited to testify on rate variation among hospitals. Back then it was the Attorney General's office that organized and called for hearings, following the seminal AG report on unwarranted price – or rate- variation . I shared my vision of working to keep more care local, to position Lawrence General to provide greater access to clinical specialties, to invest in infrastructure needed. In fact, we are about to open a new surgical suite to replace the 50 yr old ORs. I focused on the high value we offered, the great quality of care and how we were part of the solution for keeping health care cost growth down. We have kept our bargain and succeeded in expanding clinical services and work hard to keep care within our high value

system of care. Our strategy is working- surgeries are up 9%, transfers to Boston down by 50% and great improvement in preventing out of network care at more expensive facilities. However, the constant Government payer cuts and our unwarranted low commercial rates are threatening our ability to preserve key clinical programs.

Naively, in retrospect, I hoped that thoughtful policy makers would find a way to turn this new transparency on hospital rates into a resolution, a commitment, and take action to improve the rates for those that we learned were paid so poorly.

More recently, when the Health Policy Commission came out with their Community Hospital Report in 2015 I thought WOWFINALLY, the State is showcasing how important it is that we have a vital community hospital segment because it's community hospitals that offer the most value. It is community hospitals that are the keys to containing costs. If more patients go to community hospitals for community-appropriate care it creates cost savings for the entire health system.

Chairman Sanchez and Welch, members of this Commission – Hospitals like Lawrence General Hospital are part of the SOLUTION for cost savings to the Commonwealth and every person who seeks health care in Massachusetts. Every time someone chooses my hospital they save the system. We are part of the solution for unsustainable health care costs- but only if we are sustainable!!

There is no warranted reason for our commercial rates to be so low. Market forces have not changed this dynamic- and neither do negotiations with the payers. LGH must be reimbursed at a comparable level to other like community hospitals. That is the difference between being in the red and being able to make a margin to reinvest in clinical programs and staff to benefit the region- and provide easy access to high quality high value care.

However, nothing has changed in the past 8 years since my original testimony on the AG report. . Actually, one thing has changed, there are TWO COMMUNITY HOSPITALS THAT WERE PAID AT THE BOTTOM, that have CLOSED.

My colleagues and I who lead hospitals that are paid in the bottom 10 need a permanent systemic fix, and we need it urgently. We need this Commission to take action and establish a floor of .90.

The future of some community hospitals and our capacity to reduce overall health care costs in the Commonwealth, by keeping care in high value community hospitals, hangs in the balance.

I urge you to find a way to adopt a permanent fix that ends the practice of unwarranted price variation before it is too late.



**Embargoed Until 12:01 a.m.
Tuesday, January 17, 2017**

**CONTACT: Eric Linzer
617-338-2244**

New Health Care Pricing Analysis: MA Among Nation's Highest *Review Questions Affordability Assumptions in Commonwealth*

Boston, MA – Massachusetts health care costs are among the most expensive in the United States and provider price variation is more extreme in the Commonwealth than nearly all other markets in the nation, a new analysis of state and national reports reveals. The review, conducted by Freedman HealthCare, shows how market-based efforts have failed to improve affordability and that short-term regulatory efforts may be necessary to improve the functioning of the health care market.

"While the AIM board has not endorsed regulatory intervention as recommended in this report, rising health care costs are the number one issue facing AIM members. The Freedman analysis is important to help us all better understand how Massachusetts health care costs impact employers and consumers, and his analysis that the market has failed to correct this variation requires us to provide health plans with the necessary tools to rein in costs and to continue to monitor the market to see if more robust product designs can drive employers and consumers to lower cost, more efficient providers," said Rick Lord, President and Chief Executive Officer of Associated Industries of Massachusetts.

With health care spending exceeding the state's cost benchmark the last two years, the analysis outlines the challenges high health care costs create for residents and employers. Among them:

- Employee health care costs as a percentage of income continues to grow;
- Massachusetts businesses competing nationally are disadvantaged by higher premiums; and
- Rising health care costs force crowding out of household and government spending.

"Despite the suggestion that Massachusetts' health care costs are affordable, continued increases in the cost of health care are a serious threat to small businesses, so it's important to provide a complete picture on health care spending in the Commonwealth," said Retailers Association of Massachusetts President, Jon Hurst.

The analysis also found that provider price variation in Massachusetts is much wider than nearly all other markets across the U.S. For example, the state's highest-priced hospitals were 2.5 to 3.4 times more expensive than the lowest-priced hospitals, a significantly higher spread than the range among hospitals in neighboring states. Further, the analysis noted that price variation has contributed to increases in health care spending and that disparities will continue to grow as providers consolidate and volume shifts to higher cost providers.

"Rising health care costs are the number one issue facing small businesses and the people who work for them. While it is important to address provider price variation, it is essential that any solution results in lower health care costs for Massachusetts employers," said Bill Vernon, Massachusetts State Director for the National Federation of Independent Business.

Despite efforts to address provider price variation through "market-based" reforms, such as tiered and narrow network plans and the use of alternative payment methods, the analysis concludes that these measures have had no discernible effect on price variation or market dysfunction.

– more –

Moreover, as suggested in reports from the Health Policy Commission and the Office of the Attorney General, further market based intervention are unlikely to help and short-term regulatory action is warranted. The analysis outlines a series of potential options to address price variation, including:

- Expanding authority under the Performance Improvement Plans;
- Driving price convergence through "guardrails" on contracted prices;
- Capping payments at a percentage of Medicare;
- Addressing overcharges in surprise bills; and
- Considering longer-term regulation such as Maryland-type rate setting

"Multiple state reports have shown that the price of services that doctors and hospitals charge is the main reason for increasing health care costs and the gap between the highest-priced and lower-priced providers is widening," said Lora Pellegrini, President and Chief Executive Officer of the Massachusetts Association of Health Plans. "As premiums reflect the cost of care, addressing unwarranted differences in provider prices must result in making health care more affordable for employers and consumers."

The analysis, conducted for the Massachusetts Association of Health Plans (MAHP), the National Federation of Independent Business (NFIB), and the Retailers Association of Massachusetts (RAM), examined the more than two dozen Massachusetts state reports on health care costs, as well as national data for all states on health care spending and prices, including information from the U.S. Department of Commerce, Centers for Medicare and Medicaid Services, and the Commonwealth Fund.

"Despite years of effort, four health care reform laws, and more than two dozen state reports, limited progress has been made in addressing high health care costs with no improvement in price variation. Given the impact of rising health care costs on employers and consumers, short-term regulatory action could address health care spending and price variation in a way that market-based solutions have not," said John Freedman, MD, MBA, President of Freedman HealthCare.

About AIM

Established in 1915, Associated Industries of Massachusetts is the largest nonprofit, nonpartisan association of Massachusetts employers. With nearly 4500 member companies employing more than 600,000 people in Massachusetts, AIM's mission is to promote the well-being and prosperity of the Commonwealth by reducing business costs, shaping state and federal business regulation, and ensuring a skilled and highly educated work force. For further information, visit www.aimnet.org.

About RAM

The Retailers Association of Massachusetts is a statewide trade association of 4,000 retailers and restaurants of all types and sizes. The retail sector in Massachusetts employs 600,000 residents, or 17% of all jobs, and has total sales of over \$100 billion annually.

About NFIB

The National Federation of Independent Business is the leading small business association representing small and independent businesses nationwide. Its mission is to promote and protect the right of its members to own, operate and grow their businesses. A non-profit, nonpartisan organization founded in 1943, NFIB represents the consensus views of its members in Washington and all 50 state capitals.

About MAHP

The Massachusetts Association of Health Plans represents 17 health plans covering more than 2.6 million Massachusetts residents. It is dedicated to improving health for all in Massachusetts by promoting affordable, safe and coordinated health care.

About Freedman HealthCare

Established in 2005, Freedman HealthCare is a leader in performance measurement, health care reform, and the data needed to guide change. Through Freedman HealthCare's work with state health organizations, healthcare providers, payers and policymakers, the firm assists diverse stakeholder groups in adopting policies and programmatic changes that drive quality improvement and cost containment.

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Good morning and thank you for the opportunity to share with you some interesting information about provider price variation in Massachusetts. My name is John Freedman, and I am a physician and consultant. In the past, I have held clinical appointments at Boston Medical Center, Beth Israel Deaconess Medical Center and the Massachusetts General Hospital. Later, I was responsible for quality and medical management at Tufts Health Plan. More recently, I have advised many states on health care markets and reform, including numerous Massachusetts state agencies.

Today, I would like to address three major points with you. First, I will demonstrate the huge magnitude of provider price variation in Massachusetts as it compares to other markets around the United States. After all, this is the Commission on Provider Price Variation in Massachusetts, and it seems fitting that you consider these comparative data as part of your deliberations. Frankly, regardless of whether our market has more variation than others, the evidence presented to you has already made it clear that it's a problem here. Yet the data I will share will further demonstrate that Massachusetts not only has a high degree of variation but that it has a higher degree of variation than nearly every other market in the country. Second, I will reiterate what others have shown: that health care costs in Massachusetts indeed are expensive and are expensive despite the fact that Massachusetts is wealthier on average than other states. Further, I will show that due to those high costs, health care spending has been crowding out spending on other priorities, in both our public expenditures and our private household expenditures. Massachusetts, because it is devoting more resources to healthcare is devoting fewer resources elsewhere. My third point is that thus far, the market-based solutions that we have pursued have failed to address health care costs sufficiently and have failed to address provider price variation at all.

Provider Price Variation. Let me begin with provider price variation in Massachusetts. Multiple state reports have documented the degree of variation in Massachusetts, which has persisted at about 2.5-3.4 fold, and I would like to discuss six reports that have looked at variation in other states, so that we can compare. First is the work of the Health Policy Commission which compared Massachusetts to Maryland, finding that Massachusetts has greater variation for the large majority of services. Studies in Rhode Island, Vermont and New York all found less variation in hospital prices. In Rhode Island, no more than 2-fold, Vermont 1.8-fold, and New York—across three different markets within that state—ranges from 1.5-2.7-fold. These 4 studies all find lower variation in other states than in Massachusetts.

Looking further, for comparisons across all states, I will turn to two good studies. One is from the BCBSA and the other from researchers at Yale. Each uses multiple years' of data across the entire country, for different procedures. And although each uses different payers' data (Blue Cross payers in one and a number of large national payers in the other), and uses somewhat different definitions for health care markets (one using census areas and the other hospital referral regions), the results could not be more similar or more striking. On average, our market is at the 83rd percentile of all markets in its degree of price variation. In fact, looking at how our market stacks up against the 120 markets in the Yale study, our average variation puts us in the top 10 of those 120. Although my

good friends at the hospital association have called this finding “entirely erroneous,” I invite you—and them—to consider these data, with the understanding that wide provider price variation causes higher health care costs, causes volume shifts away from lower-cost hospitals to higher-cost ones, and exacerbates the Reverse Robin Hood effect that we have here—where residents of poorer neighborhoods perversely pay for the higher cost care of residents of wealthy neighborhoods.

As for health care costs, it is gratifying that Massachusetts has fallen from #1 in the country to #3 or #5, depending upon which figures you use. Yet, health care is hardly affordable here. Just last week, the Health Policy Commission showed the impact of high costs on a wide swath of Massachusetts residents, essentially all but the most wealthy. Lauren Taylor and others have shown the crowding out of public expenditures on everything from mental health, education and public safety due to the increase in health spending.

The Commonwealth Fund has shown that health premiums as a percentage of income have risen steadily from 15 to 19% over the past decade. According to Commerce Department data, this pressure has squeezed out other household expenditures. From 2006 to 2014, as a fraction of household spending, health care costs have grown 11.3%, the largest of any category. At the same time, spending on household furnishings has fallen 19.8%, clothing 12.3%, housing and utilities 6.4%, recreational goods by 5.7%, and non-durable good by 1.8%.

Massachusetts has been a leader in innovative and market-based approaches to health care. After 4 reform laws, 2 dozen state reports and lots of innovation, provider price variation is no better, and health costs continue to consume an increasing share of our public and private spending. Health care is a market like no other—it really is not much of a market at all in some ways. Therefore, let us consider our innovation in context. Thus far, we have failed to substantially change the dynamics in our market. If we wish to continue with market based solutions, some radical redesign is needed. In fact, supplementing market-based solutions with targeted, temporary, regulatory action may be needed.

What could those actions be? As possibilities, please consider expanding the authority of the Performance Improvement Plan (PIP) program, so that the HPC can enforce corrective action. Or adding pricing “guardrails” that payers would follow to drive toward rate convergence. Commercial payments could be capped at some rate, which might be most needed as part of a solution to the surprise billing problems we face. It is my hope that a vigorous framework of market and regulation can get us to where we need to go. Other options such as Maryland-type rate setting could also be effective and perhaps using short term regulatory action could make that unnecessary.

Thank you for your time and consideration, and for the work of the Commission.

Provider Price Variation and Health Costs in MA—an Analysis of State and National Data

Presentation to Provider Price Variation Commission
January 17, 2017



Freedman HealthCare on behalf of the Associated Industries of Massachusetts, the Massachusetts Association of Health Plans, the National Federation of Independent Business, and the Retailers Association of Massachusetts



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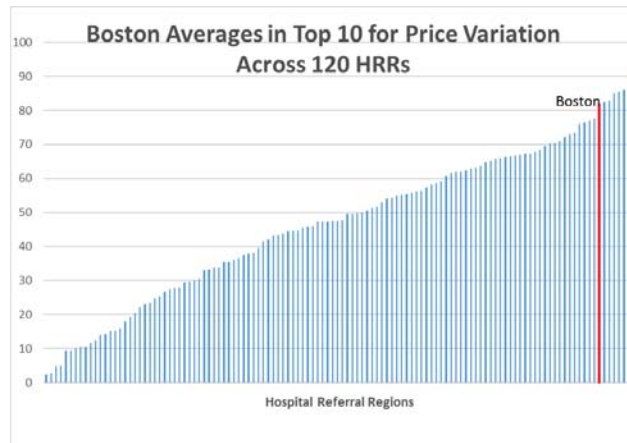
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- ▣ Background on provider price variation in Massachusetts
- ▣ Regional and national perspectives on health care spending, utilization, and price variation
- ▣ Harmful effects of provider price variation in Massachusetts
- ▣ Existing and potential market-based interventions in Massachusetts
- ▣ Challenges of health care as a market
- ▣ Options for short-term regulatory action

Executive Summary

- ▶ Provider price variation in MA is more extreme than nearly all other U.S. markets
- ▶ Disparities grow as providers consolidate and volume shifts to higher cost providers
 - This results in higher health care costs and significantly impacts individuals and employers
- ▶ Policy action and short-term intervention would help to address this issue
 - Market-based interventions have not solved this problem to date



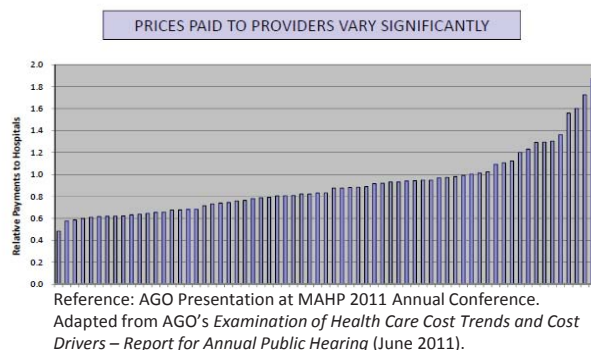
Reference: FHC analysis of 2008-2011 data from HCCI, available through the Health Care Pricing Project¹⁵

Understanding provider price variation in Massachusetts

OVERVIEW

Understanding Provider Price Variation in MA

- ▶ The MA Attorney General's Office (AGO) first identified provider price variation in the health care market in 2010¹
 - Higher-priced hospitals received payments up to 3 to 4 times higher than those received by lower-priced hospitals in 2008¹
- ▶ Provider price variation
 - Not due to differences in quality^{2,3} or patient severity¹
 - Seen in both fee-for-service and global payment arrangements^{2,3}
 - Seen among both hospitals and physician groups^{2,4}
 - Driven by market share (both providers' and payers')^{4,5}
 - Hospitals persist as higher- or lower-priced year after year^{2,3}

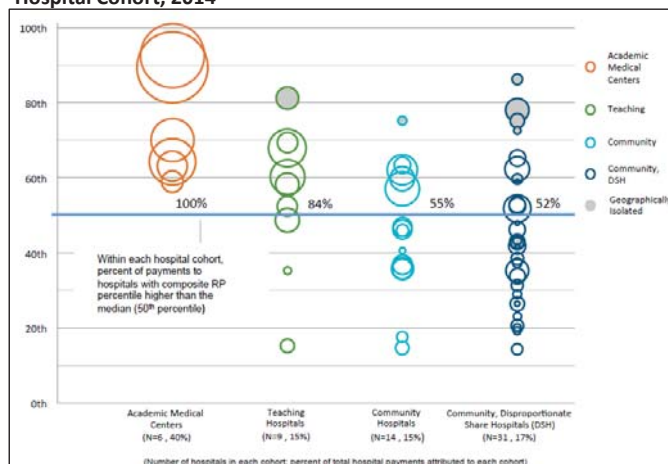


Understanding Provider Price Variation in MA

Among acute hospitals in 2014⁵:

- ▶ Price variation appears among all hospital cohorts
- ▶ Academic medical centers (AMCs) were consistently priced above the network average
- ▶ AMCs had the largest share of total hospital payments

Acute Hospital Composite Blended Relative Price Percentile, by Hospital Cohort, 2014



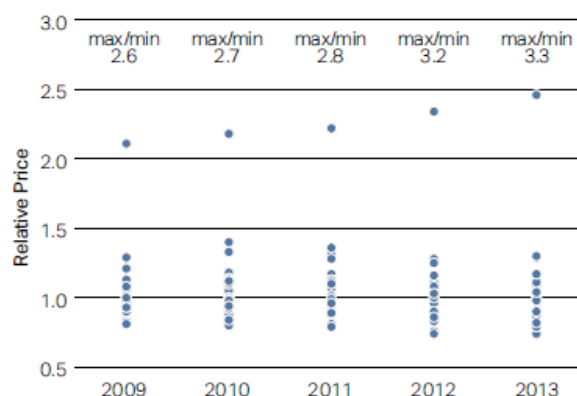
Reference: CHIA Annual Report Series. Relative Price: Health Care Provider Price Variation in the Massachusetts Commercial Market. February 2016. Available at: <http://www.chiamass.gov/assets/docs/r/pubs/16/relative-price-chartbook-2014.pdf>.

Understanding Provider Price Variation in MA

- ▶ Since 2010, price variation has not improved, and evidence suggests that the price gap is growing wider^{2,3,6}

- From 2010-2014, highest-priced hospitals have consistently been 2.5 to 3.4 times more expensive than lowest-priced hospitals²
- Price variation worsened among physician groups from 2009-2013²

Distribution of Physician Group Relative Prices, 2009-2013



Reference: Health Policy Commission. 2015 Cost Trends Report: Provider Price Variation. Exhibit 9. Available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf>. Data Source: CHIA Relative Price Databooks (2012-2015).

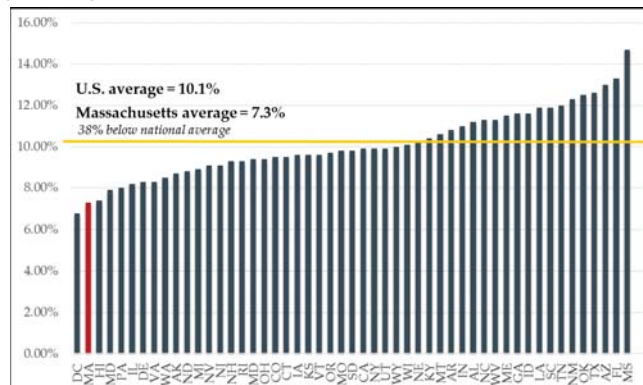
- ▶ HPC and AGO have called for regulatory action to address price disparities^{2,3,6}

Understanding Provider Price Variation in MA

- ▶ Some argue that Massachusetts' high health care costs are affordable

- Employee health care costs as a percentage of median household income are the second lowest in the nation⁷
- Hospital prices, adjusted for wages, are low (bottom 20%)⁸
- MA ranks highly in terms of overall quality and health system performance⁹
- High-priced providers, such as AMCs, are driving the local economy through medical research and innovations
- High commercial payments offset low public reimbursement rates

Average employee health care costs (premium and deductible) as a percentage of median household income, 2015

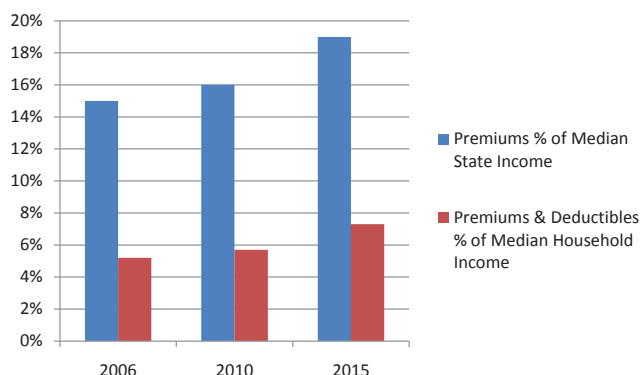


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Understanding Provider Price Variation in MA

- ▶ Yet Massachusetts' high health care costs are harmful to residents and businesses
 - Employee health care costs as a percentage of income keep growing⁷
 - MA employee premiums are 3rd most expensive (for both family and individual plans) in U.S.¹⁰
 - MA businesses competing nationally are disadvantaged by MA's higher premiums
 - MA failed to meet cost benchmark for 2014 & 2015
- ▶ Price level arguments ignore the problems of large, persistent provider price variation

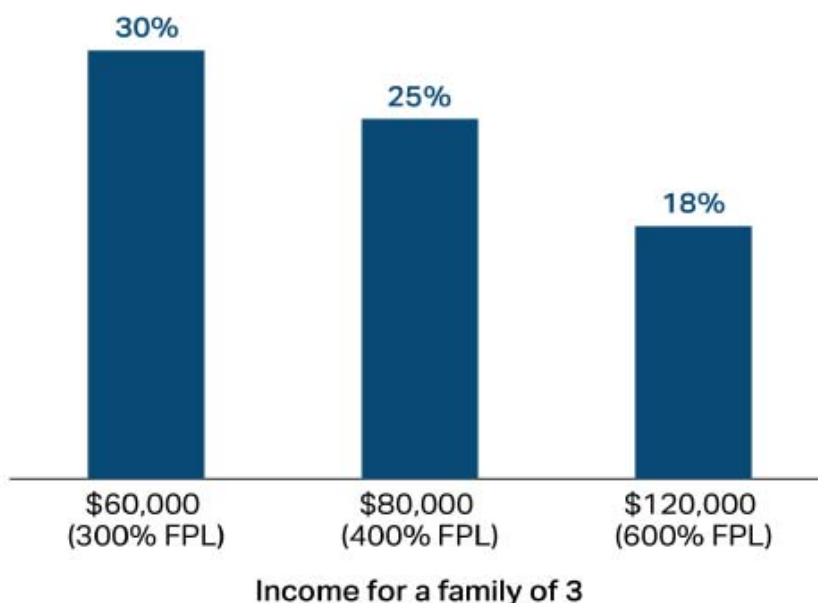
MA employee health costs as a percentage of income keep growing



Reference: Adapted from: S. R. Collins, D. C. Radley, M. Z. Gunja, and S. Beutel. *The Slowdown in Employer Insurance Cost Growth: Why Many Workers Still Feel the Pinch*. The Commonwealth Fund (October 2016). Available at: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2016/oct/1910_collins_slowdown_employer_ins_cost_growth_ib.pdf.

Health care costs have a higher impact on individuals of low to middle incomes

Total healthcare spending relative to income for a family with employer-based coverage, 2015



"What these slides show is that for a significant amount of our population, it is a real problem and we can't mask it over by the fact that some of us earn significantly above the national average and can afford it."

Stuart Altman, Chairman
Health Policy Commission
Commonwealth Magazine
January 11, 2017

Reference: Health Policy Commission. "Select Findings: 2016 Cost Trends Report." Presentation for January 11, 2017 HPC Board Meeting. Data sources: Agency for Healthcare Research and Quality, 2015 Medical Expenditure Panel Survey (MEPS); 2015 Executive Office of Labor and Workforce Development, Massachusetts Workforce and Labor Area Review. Available at <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/20170111-commission-document-ctr-presentation.pdf>.

Comparing Massachusetts to other health care markets

PROVIDER PRICE VARIATION: WORSE IN MASSACHUSETTS THAN ELSEWHERE

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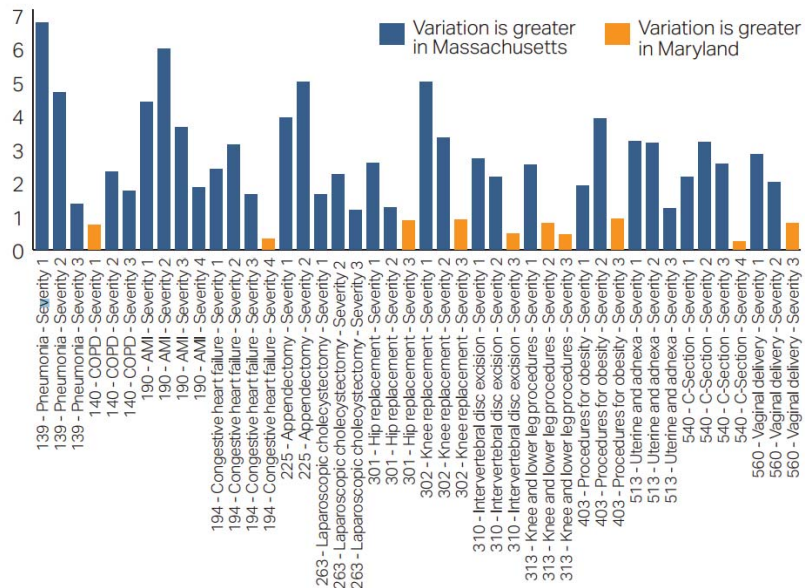
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High Provider Price Variation in MA

- ▶ The highest-priced hospitals in MA have been **2.5-3.4x** more expensive than the lowest-priced hospitals from 2010-2014²
- ▶ This price variation is wider than that in neighboring states
 - New York: Commercial prices were 1.5-2.7x higher in some hospitals than in others within the same region (CY 2014 data)¹¹
 - Rhode Island: Commercial payments to hospitals are up to 2x more in some hospitals than in others (CY 2010 data)¹²
 - Vermont: Commercial price for most expensive hospital was 1.8x higher than for least expensive hospital (CY 2012 data)¹³

High Provider Price Variation in MA

- For 77% of services, Massachusetts had greater variation in price than Maryland

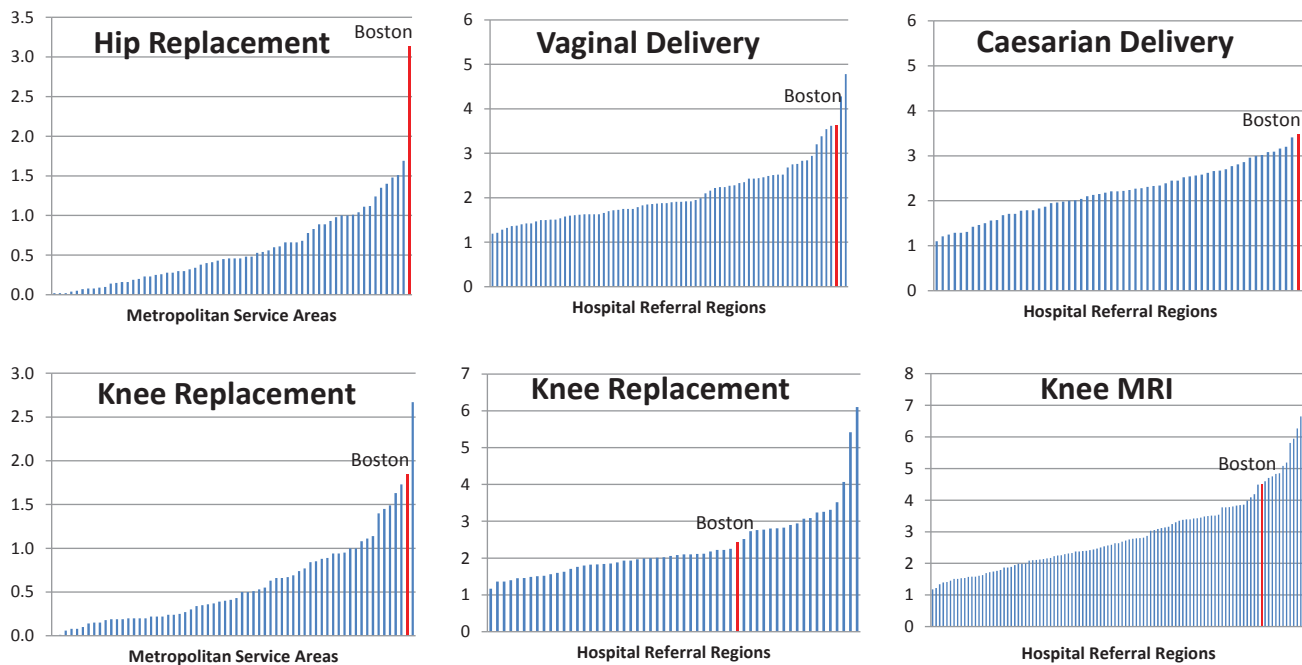


Reference: Health Policy Commission. 2015 Cost Trends Report: Provider Price Variation. Exhibit 12: Ratio of Massachusetts Variation to Maryland Variation. Data sources: DHCFP 2011 Report; Maryland Health Services Cost Review Commission.

High Provider Price Variation in MA

- MA has more price variation than other US markets
 - BCBS study on hip and knee replacements¹⁴
 - Among 64 Metropolitan Service Areas (MSAs), examined 2010-2013 payments by BCBSA plans for hip and knee replacement procedures.
 - Yale study on various common procedures¹⁵
 - Compared between 56 and 105 Hospital Referral Regions (HRRs), examining 2008-2011 payments by Health Care Cost Institute payers for caesarean and vaginal deliveries, lower limb MRI, colonoscopy, and knee replacement.

Extreme Variation – Boston Averages the 83rd Percentile Nationwide



Hip & knee replacement by MSA. Adapted from Blue Cross Blue Shield (January 2015) study using 2010-2013 data from Blue Health Intelligence.¹⁴

Vaginal & caesarian deliveries, knee replacement, knee MRI & colonoscopy (not shown) by HRR. Adapted from Health Care Pricing Project using 2008-2011 data from HCCI.¹⁵

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High Provider Price Variation in MA

- ▶ In addition to high health care costs, provider price variation in MA is more extreme than nearly all other markets across the US
- ▶ Disparities grow as providers consolidate and volume shifts to higher cost providers

Comparing Massachusetts to other health care markets

HEALTH CARE SPENDING: REGIONAL AND NATIONAL PERSPECTIVES

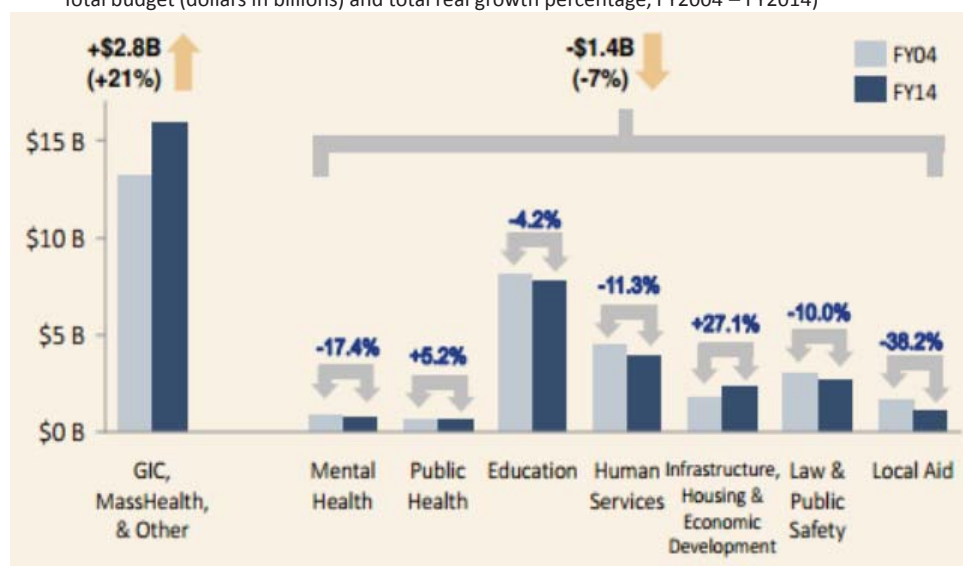
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Health Care Spending in MA is High

Health care costs crowd out other priorities

State Budgets for Health Care Coverage and Other Priorities, FY2004-FY2014¹⁶
Total budget (dollars in billions) and total real growth percentage, FY2004 – FY2014)



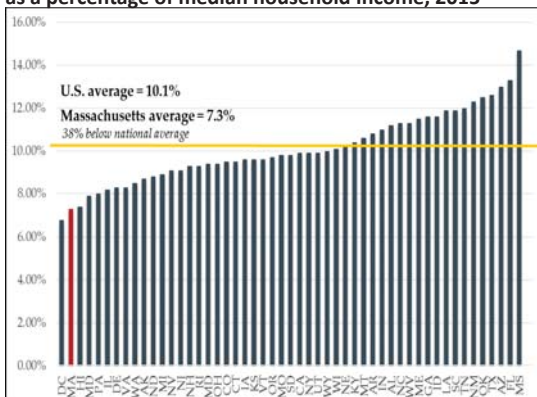
Reference: L.A. Taylor. "Social Determinants of Health: Opportunities and Challenges." Presentation to MA Annual Cost Trends Hearing, October 18, 2016. Data source: Massachusetts Budget and Policy Center. Note: Figures adjusted for GDP growth.

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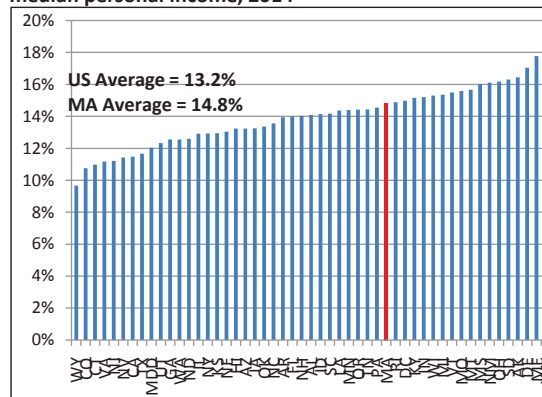
Health Care Spending

Average employee health care costs (premium and deductible) as a percentage of median household income, 2015



Data source: Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey – Insurance Component, 2015. Health care costs include premiums and deductibles. Reference: Meeting materials for Special Commission on Provider Price Variation Market Forces Subcommittee (December 6, 2016). Adapted from The Commonwealth Fund (October 2016).⁷

Personal Health Care Expenditures as a percentage of median personal income, 2014



Data source: FHC analysis of Per capita personal consumption expenditures by state for selected categories, 2014. Bureau of Economic Analysis, US Department of Commerce.¹⁷ Personal health care expenditures include spending on outpatient services and hospital and nursing home services. Outpatient services consist of physician services, dental services, and paramedical services. Adjusted for 2014 median personal income using data from the Bureau of Economic Analysis, US Department of Commerce.¹⁸

- Adjusted spending in MA is relatively lower than gross spending, though it appears above US average
- Rising health care costs force crowding out of household and government spending

Health Care Spending

- MA is a wealthy state, and its income-adjusted spending is comparatively lower across many spending categories – not just health. Yet personal spending on health is among the highest in MA

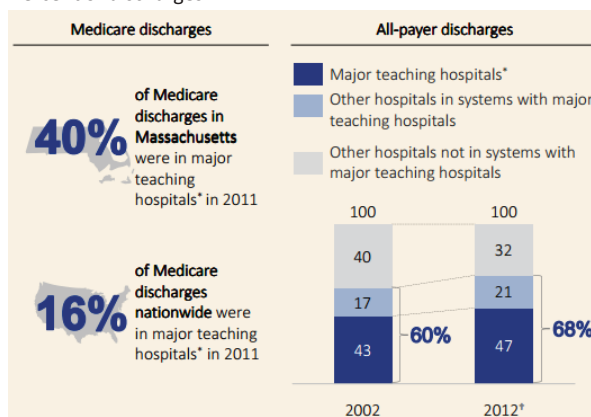
Public Expenses*	MA Rank	Private Expenses*	MA Rank
Public health	50	Motor vehicles	46
Transportation	50	Durable household equipment	44
Government administration	46	Gasoline & energy	44
Education	44	Groceries	40
Public safety	40	Restaurants	28
Social service & income maintenance	33	Housing & utilities	23
Environment & housing	27	Health care	18
Utilities	21	Recreation services	18
Interest on debt	11	Transportation services	15
Total Expenditures	36	Total Personal Consumption	29

*MA ranked out of 50 states plus District of Columbia. Adjusted for per capita income. Data sources: FHC analysis of 2014 public expenditures data from the US Census Bureau,¹⁹ adjusted for population and median income using data from the Bureau of Economic Analysis.¹⁸ FHC analysis of 2014 per capita personal consumption expenditures data from the Bureau of Economic Analysis,¹⁷ adjusted for median income using data from the Bureau of Economic Analysis.¹⁸

Health Care Utilization

- ▶ MA AMCs have higher prices, higher payments, and higher volume than other hospitals.^{5,20,21,22}
- ▶ MA residents use AMCs more than the national average
 - MA major teaching hospitals (including AMCs) represented 40% of Medicare discharges, compared to national average of 16%²³
 - In just 2 years, MA's 5 largest health systems (3 of which have AMCs) increased commercial inpatient share from 51% to 56%²⁴
- ▶ MA has 4x more major teaching hospitals than average
 - In 2011, major teaching hospitals (including AMCs) represented 23% of acute hospitals in MA, compared to 5% of acute hospitals nationwide²³

Discharges in Massachusetts hospital systems, 2002-2012
Percent of discharges



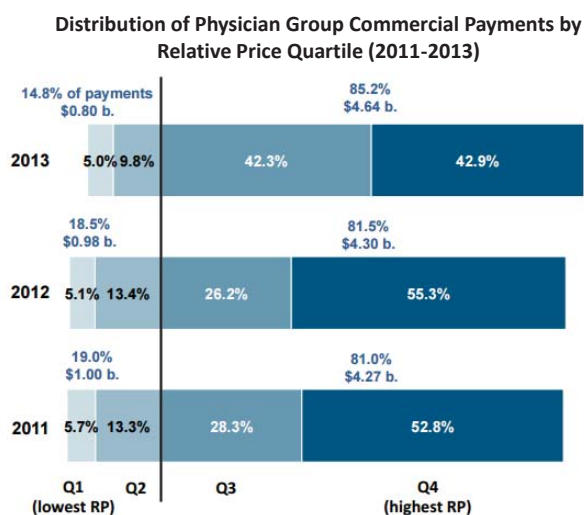
Reference: Health Policy Commission, 2013 Cost Trends Report. Figure 1.7. Available at: <http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-full-report.pdf>. Data source: CHIA; Medicare Payment Advisory Commission; HPC analysis. Major teaching hospitals are defined as those with at least 25 residents per 100 beds.

HARMFUL EFFECTS OF PROVIDER PRICE VARIATION IN MASSACHUSETTS

Harmful Effects of Provider Price Variation in MA

▣ Volume shifts to higher-priced providers

- Higher-priced hospitals have high and growing shares of inpatient stays, outpatient visits, and revenue²
- In 2014, 80.3% of commercial payments for acute hospitals went to higher-priced hospitals⁵
- Higher-priced AMCs consistently hold the major share of total hospital payments (2010-2014)^{4,5,21}
- From 2011-2013, more than 80% of total physician group payments went to physician groups above the average relative price⁵
- Since 2009, three acute hospitals have closed or converted to other health care uses due to financial strain^{25,26,27,28}



Reference: CHIA. Annual Report Series. Relative Price: Health Care Provider Price Variation in the Massachusetts Commercial Market (February 2016). Available at: <http://www.chiamass.gov/assets/docs/r/pubs/16/relative-price-chartbook-2014.pdf>.

Harmful Effects of Provider Price Variation in MA

- ▣ Price variation has contributed to increased health care spending²
- ▣ The recent proposed expansion of a major AMC (one of the highest-priced hospitals in the state) is likely to result in increased health care spending, due to predicted shifts in utilization away from lower-priced facilities and reduced market competition, according to the HPC²⁹
- ▣ Low-income neighborhoods pay for people's health care in high-income neighborhoods³⁰
- ▣ Premiums are not adjusted to reflect whether a consumer chooses between high- or low-priced providers – which may reduce consumers' incentives to make value-based health care decisions³⁰
- ▣ Price variation has persisted despite years of reform efforts
- ▣ If current conditions remain as they are, provider price variation will most likely continue in the future^{2,3,6}

Payment Disparities Expected to Persist

Effect of Increased Pharmacy Trend and Illustrative Provider Contractual Increases on "Allowed"
Commercial Unit Price Trend for All Other Providers and Services under State Cost Growth
Benchmark

	Estimated % Commercial TME in 2014	Estimated Commercial Expenses in 2014	Total Assumptions for 2015		Benchmarked Commercial Expenses in 2015
			Utilization	Unit Price	
Prescription Drug Expenses	16.7%	\$3.2 billion	12.5%		\$3.6 billion
All Other Expenses	83.3%	\$15.8 billion	1.0%	0.8%	\$16.1 billion
Total Medical Expenses	100.0%	\$18.9 billion	3.6% Benchmark		\$19.6 billion

Source: MA AGO, Examination of Health Care Cost Trends and Cost Drivers, September 2015.

"In its current form the benchmark is being used as a tool to further entrench the current healthcare pricing disparities."

Tufts Medical Center pre-filed testimony for HPC's 2016 Cost Trends Hearing³¹

Payment Disparities Expected to Persist

- ▶ The cost growth benchmark may inadvertently widen the provider price gap
 - In order to maintain moderate price increases for higher-priced providers and still meet the benchmark, commercial payers must reduce their reimbursement rates to already low-priced providers.
- ▶ Updated for 2016's projected national pharmacy growth of 6.7%,³² the effect is smaller than in 2015, but still the same: the gap between the higher- and lower-paid providers will worsen
- ▶ If higher-paid providers representing one-third of the market get price increases of as little as 2%, then lower-priced providers must fall further behind

Overall, Hospitals are Faring Better Financially than Health Plans

- On the whole, MA hospitals were profitable in 2015, with 80% reporting positive total margins³³

- Statewide median total margin across 65 hospitals in 2015 was 3.7%
- Five out of six AMCs had positive margins
- DSH hospitals had the highest median margins of any hospital cohort in 2015

Financial Performance of Acute Hospitals: Median Total Margin Trend by Cohort, FY2013 – FY2015

	FY13	FY14	FY15
Statewide Median	4.1%	4.2%	3.7%
AMC	4.6%	4.7%	2.4%
Teaching	7.6%	8.2%	4.2%
Community	3.6%	2.9%	3.0%
Community-DSH	3.7%	5.3%	5.4%

Reference: Adapted from Center for Health Information and Analysis. *Massachusetts Acute Hospital Financial Performance, Fiscal Year 2015* (August 2016). Available at: <http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/HFY15-Acute-Financial-Report.pdf>.

- Conversely, many MA health plans are struggling financially

- Median total margin across 10 health plans in 2015 was -0.05%, down from 0.67% in 2013

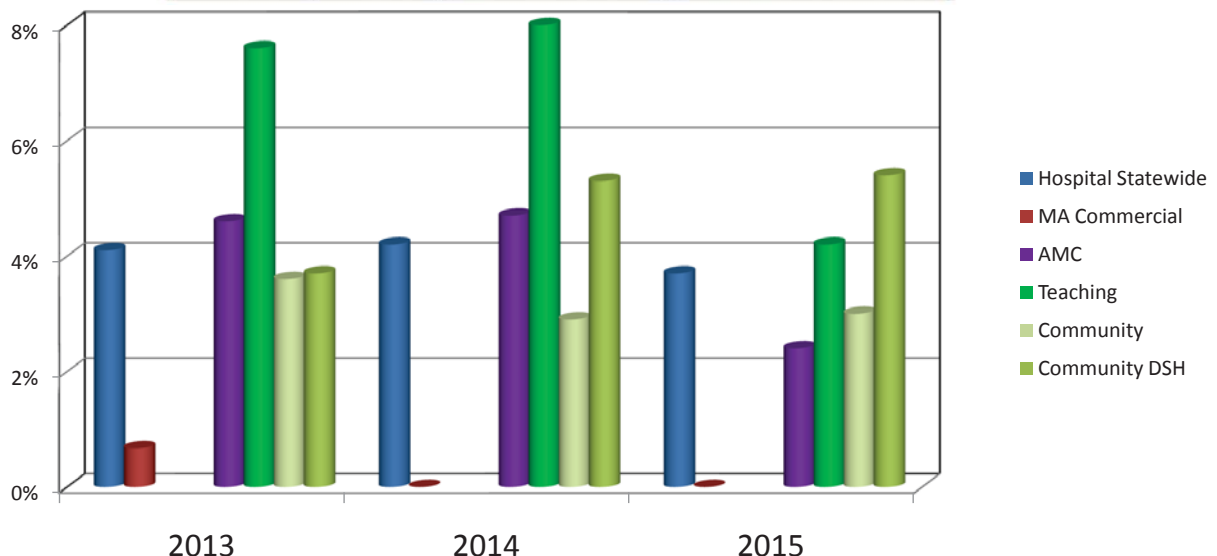
Financial Performance of MA Commercial Health Plans: Median Total Margin Trend, FY2013 – FY2015

	FY13	FY14	FY15
Median Total Margin for MA Health Plans	0.67%	-0.11%	-0.05%

Reference: FHC analysis of statements filed with the MA Division of Insurance for MA commercial plans.

Overall, Hospitals are Faring Better Financially than Health Plans

Median/Average Total Margins: 2013-2015



Hospital Reference: Adapted from Center for Health Information and Analysis. *Massachusetts Acute Hospital Financial Performance, Fiscal Year 2015* (August 2016). Available at: <http://www.chiamass.gov/assets/Uploads/mass-hospital-financials/HFY15-Acute-Financial-Report.pdf>.

Health Plan Reference: FHC analysis of statements filed with the MA Division of Insurance for MA commercial plans.

Summary of Analysis

- ▶ Health care costs continue to exceed state benchmark, and to consume larger shares of public and personal spending
- ▶ Massachusetts has extremely high price variation compared to other states and markets
- ▶ Health care utilization and spending is concentrated among high-priced providers such as AMCs and dominant, high-paid community hospitals
- ▶ Price variation has not improved for hospitals and has worsened for physicians
- ▶ Projected pharmacy spending and moderate price increases for high-priced providers virtually ensures price variation will persist or worsen under the cost growth benchmark

Existing and potential approaches for addressing provider price variation in Massachusetts

INTERVENTION OPTIONS TO ADDRESS COSTS AND PRICE VARIATION

Interventions Implemented in MA Since the 2000s

▶ Demand-side interventions implemented over past decade

- High-deductible health plans
- Tiered networks
- Narrow networks

▶ Supply-side interventions

- Accountable Care Organizations (ACOs)
- Alternative payment methodologies (APMs)

APM growth has stalled



Reference: Adapted from Center for Health Information and Analysis. *Performance of the Massachusetts Health Care System: Annual Report* (September 2016). Figure 5. Available at: <http://www.chiamass.gov/assets/2016-annual-report/2016-Annual-Report.pdf>.

Ineffectiveness of Market-Based Interventions in MA

- ▶ Four MA health care reform laws between 2006-2012
- ▶ MA recognized as national leader in both supply- and demand-side efforts
- ▶ Supply- and demand-side reforms have not managed to meet the cost benchmark, reduce provider price variation, or support lower-priced providers
- ▶ Residents across income spectrum continue to struggle with health costs³⁴

Why Have Our Market-Based Efforts Failed?

- ▶ Attempted interventions assume that we are in a neo-classical economic market³⁵
- ▶ Health care is a market like no other
 - Few services are truly “shoppable”
 - Majority of cost paid for persons who have exceeded their out of pocket maxima
 - Buyers usually have incomplete information to make informed purchasing decisions
 - Decisions about health care are often emotional and often urgent
- ▶ Supplementing market-based solutions with targeted regulatory action may be a needed catalyst for curbing health care costs and disparities

Potential Regulatory Solutions

- ▶ Short-term regulatory action could be successful in addressing health care spending in a way that market-based solutions have not
- ▶ Potential solutions include:
 - Expanded Performance Improvement Plan (PIP) authority
 - Pricing “guardrails” to bring rate convergence
 - Capping commercial payments at percentage of Medicare
 - Preventing inflationary behaviors, such as surprise billing by capping rates for out-of-network providers at network facilities
- ▶ These options are moderate alternatives to further regulation such as Maryland-type rate setting

Conclusion

- ▶ Despite years of effort, 4 reform laws, and more than 20 state reports, we have made limited progress in addressing high health care costs, no improvement of price variation, and have largely failed to remedy the market dynamics observed in Massachusetts
- ▶ We have missed the cost benchmark in 2014 and 2015, and anticipate missing the 2016 benchmark as well
- ▶ Market-driven solutions have limited ability to address prices, price variation and the volume shift to higher priced providers
- ▶ Short-term regulatory solutions would help catalyze improvements

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January 20, 2017

The Honorable Jeffrey Sánchez
House Chair, Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133

The Honorable James T. Welch
Senate Chair, Joint Committee on Health Care Financing
State House, Room 309
Boston, MA 02133

Re: Special Commission to Review Variation in Prices among Providers

Dear Representative Sánchez and Senator Welch:

On behalf of Health Care For All (HCFA), thank you for the opportunity to submit testimony on the on the issue of provider price variation in Massachusetts. HCFA works in support of policies that advance a patient-centered health care system that is affordable, accessible, and high quality, and we are particularly concerned about the most vulnerable residents of Massachusetts.

Health care costs are one of the most significant issues facing Massachusetts residents, and the wide variation in hospital prices is a major driver of health cost growth in the Commonwealth. The Center for Health Information and Analysis (CHIA) has been documenting this problem for years. Their latest chart book, which came out in February 2016, demonstrates a wide variation in prices, with a majority of payments going to the most expensive quartile of acute hospitals.¹ Reports of the Office of the Attorney General have also documented provider price variation in MA over time,² and the Health Policy Commission (HPC) conducted a rigorous analysis of the issue in a report issued in 2015.³

¹ Relative Price: Provider Price Variation in the MA Commercial Market, Center for Health Information and Analysis (February 2016), available at: <http://www.chiamass.gov/assets/docs/r/pubs/16/relative-price-chartbook-2014.pdf>

² Examination of Health Care Cost Trends Cost Drivers, Office of the Attorney General (September 2015), available at: <http://www.mass.gov/ago/docs/healthcare/cctcd5.pdf>

³ 2015 Cost Trends Report: Provider Price Variation, Health Policy Commission, available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2015-ctr-ppv.pdf>

These reports confirm a number of troubling trends. First, as previously stated, rising provider prices are one of the main drivers of the growth in health care spending in Massachusetts. Second, among hospitals, prices vary dramatically between higher-priced and lower-cost institutions. According to the CHIA data, on average, looking at all their payers on an apples-to-apples basis, our most expensive hospitals have prices two to four times higher than the least-expensive hospitals. Furthermore, the wide variation in hospital prices has not been improving over the past few years. Third, this variation in price is harmful to our health care system. The higher-priced hospitals do not produce better quality care or better health outcomes. Higher prices are not associated with higher value, but with more market leverage. This is despite the fact most consumers are more likely to equate high cost with high quality. As a result, more and more patients are going to the higher-priced hospitals, leading to increasing costs for health care overall. The conclusions of multiple reports over a number of years from the Attorney General, CHIA, the HPC and others, are clear: state action is needed to address the issue of unwarranted price variation.

We represent patients and consumers who are paying the price for high-cost health care. As costs continue to rise, it is increasingly difficult for many consumers to not only afford the health care services they need, but to navigate and understand why price varies so widely among hospitals and providers. These high costs are reflected in increased premiums, and in higher deductibles and other cost sharing. Division of Insurance rate filings show that for individuals and small business, rates are going up by double digit percentages for some insurers.⁴

Increasing co-pays and deductibles have become an obstacle to good health care in MA. According to the most recent CHIA Annual Report on the Performance of the Massachusetts Health Care System, Massachusetts continues to see increased enrollment in high deductible health plans – which are now 19% of the commercial market – and increased consumer cost-sharing, which rose by 4.4% from 2014-15, while benefit levels remained constant. The 2015 Massachusetts Health Reform Survey (MHRS) found that nearly one in five fully-year insured adults reported problems paying family medical bills in the past year, and more than one in five reported having medical bills they are paying off over time (i.e., medical debt). More than 43% of insured adults reported that health care costs had caused problems for them and their families over the last year and 19.3% reported that they went without needed care because of health care costs.

People who have low incomes and those who are in poor health or have chronic conditions needing regular care or medication experience even greater difficulties with the high cost of health care. Studies show that for vulnerable populations, increased cost-sharing is associated with adverse health outcomes.⁵ Recent HPC findings confirm that MA residents with low to middle incomes face a higher

⁴ “Health insurance rates rising faster for small businesses.” *The Boston Globe* (August 17, 2016), available at: <https://www.bostonglobe.com/business/2016/08/17/mass-small-business-health-insurance-rates-rising-average-percent/sHRgbzo98ztwhkA81y8IdM/story.html>; “Premiums soar 21 percent for popular health plan.” *The Boston Globe* (September 9, 2016), available at: <https://www.bostonglobe.com/metro/2016/09/08/premiums-soar-for-popular-health-plan/xAcJy1ye9lcLGGJznLLZKP/story.html>

⁵ Swartz, K. Cost-Sharing: Effects on Spending and Outcomes, Robert Wood Johnson Foundation (December 2010), available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1

burden of health care costs relative to income.⁶ The 2016 AGO Examination of Health Care Cost Trends and Cost Drivers found that in the Massachusetts commercial insurance market, health care spending relative to health burden continues to be higher for patients from higher income communities than for patients from lower income communities.⁷ In other words, while members in lower income communities are less healthy than members in higher income communities, we are spending less health care dollars on those members with the highest health needs.

HCFA strongly agrees that provider price variation among hospitals should be examined and addressed, and we would strongly encourage the Committee to do so in a way that moves our health care system toward rewarding high quality care first and foremost. This testimony will focus on a number of issues that have come before the Special Commission that directly impact consumers, including “demand side incentives” such as price and quality transparency, tiered network and high deductible health plans; value-based insurance design; and the issue of surprise out-of-network billing.

Price and quality transparency

Transparency around health care cost and quality is critically important to the state’s efforts to reduce the growth in health care costs, yet effectively implementing this “demand side incentive” also presents a number of challenges and limitations.

First and foremost, consumers often equate cost with quality, and in the absence of other usable signals of quality, consumers will rely on cost as a proxy. For example, in focus groups commissioned by the HPC as part of the *Community Hospitals at a Crossroads* report,⁸ patients indicated that they generally did not perceive that community hospitals provide high-quality care, and that Boston academic medical centers (AMCs) and teaching hospitals provide better quality of care. Few patients were familiar with validated clinical quality scores, and quality performance information was not a significant factor in directing where patients choose to go to for care. In fact, patients valued the experience of peers over quality measures when choosing where to access care.

In addition, the focus groups showed that consumers feel they have little choice in where to get hospital care. Many patients indicated that provider referrals dictated what hospitals they used. Furthermore, only a small percentage of health care is shoppable, since patients generally only choose the location for non-emergency care that can be scheduled in advance.

While solutions for increased transparency are difficult, we offer the following six core principles to make cost and quality data most relevant for consumers:

⁶ Health Policy Commission Board Meeting Presentation, Slide 25 (January 11, 2017), available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/public-meetings/board-meetings/20170111-commission-document-presentation.pdf>

⁷ Examination of Health Care Cost Trends and Cost Drivers, Office of the Attorney General (October 2016), available at: <http://www.mass.gov/ago/docs/healthcare/cc-market-101316.pdf>

⁸ Community Hospitals at a Crossroads, Health Policy Commission (March 2016), available at: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/community-hospitals-at-a-crossroads.pdf>

1. *Data must be meaningful for patients:* Consumers need to have easy-to-interpret quality information alongside cost information, and highlighting high-value options. Quality data must go beyond the basic process measures, and include a mix of patient experience, access, and outcomes measures.
2. *Data must be accessible:* Consumers need to be aware that the information exists and should be able to access data when they need it. This means having displays of information available in a number of ways and formats, expanding or contracting to fit the differing needs of consumers.
3. *Data must be understandable:* Information presented should be easy to read, use, and navigate. This is especially important for populations that have difficulty in using basic health information, including those with low health literacy skills, limited numeracy skills, and Limited English Proficiency. Simplifying information for consumers through appropriate language and reading level empowers all consumers to make cost-effective healthcare choices.
4. *Data must inspire action:* Consumers must be able to translate cost and quality transparency data into health care decisions. This means explicitly showing consumers their options, and supplying decision aids to teach how to navigate through data, and how to use cost and quality information to reach an informed decision about treatment.
5. *Data must be presented with consumers in mind:* Clear and organized data presentation, along with a practical design, will guide consumers through the decision-making process from start to finish. This means making transparency data engaging and easy-to-use, providing consumers information in a “one-stop shop,” and incorporating their feedback on the material to help improve any online tools, setting an expectation of continuous improvement.
6. *Consumers must be made aware of cost and quality, and their importance, through targeted promotion efforts:* Once transparency data is made publicly available, carriers, providers and state agencies should consistently promote the data and tools. Transparency efforts must also strengthen the capacity of providers, staff and insurance company personnel to discuss prices

For the last few years, state agencies have begun to comply with and support transparency initiatives, but the efforts are diffuse, duplicative, lack a unified vision, are of varying quality and do not meet core principles of consumer education. For example, Massachusetts insurers’ cost estimation tools are in need of improvement: in 2015 HCFA’s ”Report Card” gave major insurers a C+ on basic consumer education principles.⁹ HCFA’s more recent review of the cost estimation tools show that the tools still vary widely in their use of comparative quality information, the number and type of searchable services, and consumer accessibility.

Massachusetts should also look to other states who are further along in transparency efforts, such as New Hampshire, Maine and California. New Hampshire has a website run by the state insurance department allowing people to compare the cost and quality of specific medical procedures, dental procedures and prescription drugs. The website lets consumers see how much they would have to pay based on the price their insurer negotiated with each provider, and also shows the price uninsured people must pay. The latest version of NHHealthCost.Org features 31 additional medical procedures, including physical therapy, behavioral health and chiropractic care. Cost estimates for 16 dental

⁹ Health Care For All Consumer Cost Transparency Report Card (July 2015), available at: https://www.hcfama.org/sites/default/files/consumer_cost_estimation_report_card.pdf

procedures are now available, as well as new information on the retail price of 65 brand-name and generic drugs. Maine allows consumers to compare cost and quality information via a publicly accessible website (<http://www.comparemaine.org/>). California released an expanded version of its quality report cards on 154 large physician groups. The report cards, which already assessed clinical quality and patient experiences, now also summarize the total cost of medical services run up by the average patient of each group.

Tiered network plans

Health insurers using a tiered-network model classify doctors and hospitals based on a combination of cost and quality measures. Patients, in turn, are required to pay higher copays and/or deductibles for utilizing providers in a high-cost tier. In theory, tiered network plans create incentives for health care providers to deliver high quality, cost efficient care, and for consumers to select these high-value providers. However, tiered networks have proven to be opaque and confusing for both patients and providers, making it difficult for patients to make informed choices about where to seek care based on cost and quality data. We have concerns with recent recommendations for “strengthening” tiered networks to increase the difference in consumer cost sharing differentials between tiers until the below concerns have been addressed.

Tiered network plans, in their present form, are not transparent or consumer-friendly. Carriers do not use uniform or standardized cost or quality criteria to classify providers into tiers, resulting in inconsistent determinations of a provider’s tier level from one health plan to another. Based on what we hear from consumers, people are often totally unaware of how these tiered plans work, and are frustrated when they discover they owe higher copays for their regular provider. Tiering cannot promote behavioral change if consumers do not fully understand how their tiered plans work or lack other basic information, such as which providers are tiered separately and at what level, as well as understanding the tiering levels when there are multiple providers for a single episode of treatment.

Tiered networks may disrupt continuity of care in existing treatment plans and patient-physician relationships. When carriers move providers from a lower-cost tier to a higher-cost tier, patients may face a disruption in care if they cannot afford the additional out of pocket expenses to continue seeing their usual providers. Patients may also face such disruptions in care if their employer switches to a tiered network plan, forcing them to choose between seeing a longtime provider placed in a higher-cost tier or forming a new relationship with a lower-tier provider. These choices are especially difficult for patients who have long-standing relationships with particular caregivers, such as mental health providers, or those receiving care for serious or chronic conditions.

For example, one consumer who contacted Health Care For All faced a potential disruption in care when her employer switched to a tiered network plan. Under the plan, she had the option of paying a \$25 copay per visit to stay with her current PCP, or traveling 45 minutes to see a new PCP for a copay of \$15 per visit. Since she has a chronic illness, she felt that continuity of care was essential. Between her health condition, the cost (both in time and money) of transportation, and her trust in her longtime PCP of over 10 years, she chose to stay with her current provider. However decision this came at a

significant expense. She paid over \$1,000 more in copays over the course of a year. If her copays increase again, she will be forced to stop seeing her longtime physician.

Tiered network plans do not take into other limitations on provider choice. As mentioned previously, factors other than cost can be fundamental to a consumer's choice of provider. For example, geography and available transportation limit the ability of many consumers to access lower-cost care in tiered plans. Patients who live in communities not conveniently located to low-tiered providers are left with higher copays or an unmanageably long commute to seek care. For individuals in certain regions of the state, such as Cape Cod and the Berkshires, choosing a provider in a low-cost tier may not be an option at all when the only providers in their area are classified as high-tier. As a result, some may forgo needed care altogether. In addition, consumers in need of urgent care are in no position to "shop around" or research which provider is in the tier most appropriate for their health care needs.

Finally, tiered network plans may discourage coordinated care if providers within the same facility or organization are placed in different level tiers. Incentives for consumers to choose providers based on quality and efficiency under tiered network plans may conflict with provider incentives under contracts that require them to manage patient care under a global budget. Consumers who would prefer to obtain care in one location or from one organization may be unable to do so where its providers are differentially tiered. Therefore, we recommend that all providers affiliated with an Accountable Care Organization or in a Patient Centered Medical Home should be assigned to the same tier.

Given that continuity of care, quality of care, and accessibility of care may all be threatened under the current framework of tiered network plans, we urge the Special Commission to address these concerns along alongside any recommendation to "strengthen" tiered network products.

High deductible plans

According to CHIA, 52% of individual health insurance purchasers and 43% of those receiving coverage through small employers (50 or fewer employees) were enrolled in a high deductible health plan (HDHP) by 2014.¹⁰ Multiple studies show that high deductibles don't make patients into better shoppers for their care. Instead, higher deductibles mean that patients forgo needed care. Preventive care is reduced and the sickest people are those who are most likely to reduce their use of care while still under the deductible, even though this is the group that needs the most care.

Increased cost-sharing has the potential to slow the growth of health spending *only if*: (1) there is a reduction in use of low-value or medically unnecessary care; (2) any utilization reduction is not offset by the use of more expensive services; *and* (3) reductions in service use do not result in adverse outcomes that may be more expensive to treat. However, patients are often not able to discern between appropriate and inappropriate care in response to increased cost-sharing. Studies of patients with high deductibles show that patients reduce use of both high-value and low-value care. Furthermore, for

¹⁰ Annual Report, Massachusetts High Deductible Health Plan Membership, Center for Health Information and Analysis (November 12, 2015), available at: <http://www.chiamass.gov/assets/docs/r/pubs/15/High-Deductible-Health-Plans-Brief.pdf>

vulnerable populations, increased cost-sharing is more likely to reduce use of high-value care, resulting in adverse health outcomes.¹¹ We therefore urge the Special Commission against recommending HDHPs as an effective demand side incentive until we have more information on how these plans are impacting consumer cost-sharing and utilization for Massachusetts consumers.

Value-based insurance design

One strategy proven effective at addressing rising out-of-pocket costs for consumers is called “value-based insurance design” (VBID), which aligns patients’ out-of-pocket costs with the value of health services. As out-of-pocket costs rise, patients may be less likely to access care or follow prescribed treatments and medications, especially patients with low incomes or chronic conditions who need multiple medications and services. When patients delay or forgo obtaining necessary health care, this can in turn lead to more intensive and expensive care. As cited above, a review of the literature documents that increased cost-sharing increases the underuse of needed treatments and medications, particularly for individuals with chronic conditions.

Cost-effective treatments, however, help avoid the need for expensive acute care. Research shows that certain medications and services for chronic conditions such as hypertension, high cholesterol, diabetes, asthma, depression, and HIV/AIDS are considered “high value,” because they provide large health benefits with comparatively low costs. The health system should therefore encourage patients to use these treatments, instead of imposing high co-pays and deductibles that discourage their use.

Removing barriers to essential, high-value health services through VBID results in significant increases in patient compliance with recommended treatments, while also being cost-neutral, and even potentially cost-saving in the long term. The Health Connector has introduced some VBID elements in their 2017 requirements for Qualified Health Plans, directing insurers to eliminate all out-of-pocket costs for medication-assisted addiction treatment, including drugs such as methadone or Suboxone, along with counseling. HCFA has proposed comprehensive legislation using the VBID framework to eliminate co-pays, deductibles, and co-insurance for high value cost-effective prescription medications and treatments in order to increase adherence and help patients avoid further complications and hospitalizations. We encourage the Special Commission to highlight VBID as a strategy to encourage choice of high value care.

Out-of-network surprise billing

Out-of-network billing occurs when patients receive out-of-network care that they did not or could not intentionally choose to receive, and are subsequently faced with unaffordable medical bills. This predominantly occurs in two key scenarios: 1) the patient receives emergency care at an out-of-network facility but because of the circumstances, the patient was not able to choose care at an in-network facility; or 2) the patient seeks care at an in-network facility, but during the course of treatment the patient is unexpectedly treated by an out-of-network provider. HCFA has heard from patients, for

¹¹ Swartz, K. Cost-Sharing: Effects on Spending and Outcomes, Robert Wood Johnson Foundation (December 2010), available at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1

example, who go to a hospital that is in their network, choose a surgeon that is in their network, and then find out after the fact that the anesthesiologist was out of their network.

These scenarios can result in balance billing, where the patient is billed for the difference between the out-of-network provider's charge for services and the insurer's in-network payment rate to the provider. They can also result in surprise bills, where a patient receives an unexpected bill from an out-of-network provider after seeking and receiving care at an in-network facility. In the latter case, the consumer may not know that she received care from an out-of-network provider until she receives a surprise bill for the services. As cited at a recent HPC Board meeting, a 2016 study showed that of emergency department visits at in-network hospitals in Massachusetts, 22% involved out-of-network physicians.¹² In these cases, out-of-network emergency physicians charged an average of 798% of Medicare rates, and these costs are borne by both patients and insurers.

We recommend that the Special Commission consider recommending real protections to consumers in these cases of surprise billing, and propose the following in order to enhance out-of-network billing protections in Massachusetts. These protections can draw on New York¹³ and Connecticut¹⁴ laws, which implement consumer-friendly safeguards that would be effective in Massachusetts.

First, providers should be required to furnish accurate, up-to-date information to consumers with respect to whether they are in or out-of-network. For example, in New York hospitals are required to post on their website the insurance plans in which they are a participating provider, the contact information of physicians groups the hospital has contracted with to provide services (including anesthesiology, pathology, or radiology) and instructions how to contact the groups to determine which plans those physicians participate in, and information about physicians employed by the hospital and the plans in which they participate. In Connecticut, providers must determine whether a patient is insured prior to any scheduled admission, procedure, or service for nonemergency care. If the patient is uninsured or the provider is out-of-network, the provider must provide written notification to the patient about the charges for the upcoming treatment, the fact that the patient may be charged and is responsible for unforeseen service that may arise out of the proposed care, and that any out-of-network rates under the patient's health plan may apply.

Second, insurers should be required to keep provider directories and online tools updated and accurate, subject to auditing and ramifications for non-compliance. Accurate and comprehensive provider directories are necessary because health plan enrollees need accurate information about which providers and facilities they can use in-network. In New York, insurers must provide examples of out-of-pocket costs for frequently billed out-of-network services, written information (including on the insurer's

¹² Zack Cooper & Fiona Scott Morton, *Out-of-Network Emergency-Physician Bills – An Unwelcome Surprise*, New England Journal of Medicine 375, 1915-18 (2016).

¹³ 23 NYCRR 400; *see also* New York Department of Financial Services, Protection from Surprise Bills and Emergency Services, available at <http://www.dfs.ny.gov/consumer/hprotection.htm>

¹⁴ An Act Concerning Hospitals, Insurers and Health Care Consumers, Pub. Act No. 15-146 (Reg. Sess.), available at <https://www.cga.ct.gov/2015/act/pa/pdf/2015PA-00146-R00SB-00811-PA.pdf> (to be codified at Conn. Gen. Stat. §§ 19a-904a, 38a-477e, 38a-477aa, 38a-591b, 20-7f, and 38a-193, respectively).

website) that reasonably permits a patient to estimate anticipated out-of-pocket costs for out-of-network services, and upon request, insurers must disclose the approximate dollar amount that the insurer will pay for a specific out-of-network service (though the approximation is not binding). In Connecticut, insurers must also maintain a website and toll-free phone number that enables consumers to request and obtain information on network status, including information on out-of-network costs for inpatient admissions, health care procedures and services.

Third, providers should be prohibited from balance billing consumers, and insurers should be required to hold members harmless, in emergency situations and in other situations where a consumer unknowingly sought care from an out-of-network provider. In these situations, consumers would still be responsible for their usual in-network cost-sharing. In New York, balance billing by out-of-network providers for emergency care is prohibited. Surprise billing for non-emergency out-of-network services is also prohibited if the patient assigns the provider's claim to the insurer. New York utilizes a "Member Assignment of Benefits Form," which clearly informs the consumer what constitutes a surprise bill and explains the consumer's ability under the law to assign these rights to their insurer so that the provider cannot seek payment from the consumer beyond any cost-sharing which would have been owed had the provider been in-network.

Fourth, the protections should include a well-defined process for determining payment of surprise out-of-network bills or setting a standardized level at which out-of-network providers are paid. Under New York law, insurers must pay providers at a reasonable payment amount. The methodology for determining reasonable payment amounts must be disclosed, including how the calculation compares to the usual and customary rates, which are defined as the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area. Under Connecticut law, insurers must reimburse out-of-network providers the greater of the following: (1) the amount the plan would pay for emergency services if rendered by an in-network provider; (2) the usual, customary, and reasonable rate; or (3) the amount Medicare would reimburse for such services.

Finally, another option to consider is including an arbitration process between providers and insurers, which would shield patients from becoming involved in payment negotiations and provide additional financial protection. Under New York law, if a provider is not satisfied with the amount paid, the provider may pursue an Independent Dispute Resolution (IDR) process, which includes a binding arbitration utilizing a reviewing physician in active practice in the same or similar specialty as the doctor providing the service and a reviewer with training and experience in billing, reimbursement and usual and customary charges. Reviewers can choose either the provider's original billed charge or the plan's original payment – as opposed to any amount in the middle. In making a decision, the IDR must consider the patient's characteristics, the doctor's training and experience, and the usual and customary rate.

These provisions, as a whole, directly address the problems that consumers face and represent a balanced compromise between the competing concerns of providers, insurers and consumers.

We urge the Special Commission to take into account these issues and the direct impact on cost for consumers as it formulates recommendations to address the problem of unwarranted provider price variation in the Commonwealth. Please don't hesitate to contact us with any questions at avangeli@hcfama.org or 617-275-2922.

Sincerely,

A handwritten signature in black ink, appearing to read "Alyssa Vangeli".

Alyssa R. Vangeli, Esq., MPH
Associate Director, Policy and Government Relations
Health Care For All

cc: Members, Special Commission to Review Variation in Prices among Providers

Submission of the Massachusetts Society of Pathologists
To the Massachusetts Special Commission on Provider Price Variation
January 19, 2017

The Massachusetts Society of Pathologists (MSP) welcomes the opportunity to comment on the issue of out-of-network balance billing. The nature and extent of the problem of out-of-network balance billing has not been established in Massachusetts. It should be noted that the national Blue Cross/ Blue Shield Executive Director recently stated (October 13, 2016) at a Brookings forum on this issue that “there is a dearth of evidence” and “the problem at least as I see from the evidence cited to date has yet be explicated very rigorously or comprehensively.” This is one area where we concur with Blue Cross/Blue Shield in that more information and analysis is needed to determine both the scope of the problem and appropriate solutions. Consequently, we respectfully suggest that the Commission’s recommendations not address the issue, and, instead, we ask that the matter be referred to the legislature’s Joint Committee on Health Care Financing, which will have at least one bill on this topic in the 2017-2018 session.

Intuitively, we know there is a fundamental correlation between out of network balance billing and health plan network adequacy. When regulators approve health plans that do not have hospital based physicians under contract, patients of these facilities are likely to have out of network charges. It is logical that enrollees with health insurance plans providing robust network adequacy, including hospital based physicians, have fewer bills for out of network services. Thus, the problem of out of network billing will only be exacerbated by the failure of regulators and health plans to ensure physician networks at in-network hospitals and facilities. Another factor exacerbating patient reliance on out-of-network (OON) physicians at in-network facilities is the deliberate narrowing of insurance networks by health plan payers.

“Second, under existing market forces, provider networks are becoming narrower, creating more situations where patients encounter a mix of network and non-network providers. This is particularly the case in the non-group (individual) market, where narrow networks are especially pronounced as a result of competition on premiums for cost-conscious consumers (Cousart 2016; Bauman 2015; Polsky 2015), though network narrowing is also seen to some extent in the group market (Kaiser Family Foundation 2015).”¹

Current American Medical Association (AMA) Policy on Network Adequacy (H-285.908.11) states: “Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties, (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.”

Accordingly, health insurance plans should be scrutinized by state insurance regulators, prior to approval, to ensure that such plans are capable of providing their enrollees with

¹ [“Solving Surprise Medical Bills,”](#) Center for Health Policy at Brookings, A Brookings Institution-USC Schaffer Center Partnership, Mark Hall, Paul Ginsberg, Steven Lieberman, Loren Adler, Caitlin, Caitlin Brandt, Margaret Darling, October 2016

reasonable and timely access to in-network physician specialties at in-network hospitals and facilities.

When health plan enrollees purchase health insurance products that list in-network hospitals and facilities, but such plans have failed to contract with certain essential hospital based physician specialties at these locations, the health plan has deceived the enrollee into purchasing an insurance product that is fundamentally deficient. Such deceptive trade practices should be subject to state sanction.

Of related concern regarding the conduct of health insurance plans, some payers construe any physician waiver of co-payments, co-insurance, or deductibles whether occurring up front at the time of medical services or after receipt of payment by the plan, on any patient claim, regardless of the patient's economic status, as a potentially fraudulent activity by the physician. It has been noted in the legal community that "...the practice of out-of-network providers waiving copayments and deductibles has continued and is occurring with such frequency in the market that one national insurer in particular has resolved to commence a major legal campaign to curtail the billing practice."² Furthermore:

A provider may receive significant legal protection similarly by including a statement on its insurance claim that it will waive the copayment or deductible, or that it reserves the right not pursue the patient for these amounts. This disclosure, however, could result in the insurer's denial of the claim, and if the insurer does not agree to the statement, a provider risks displaying the requisite intent for being accused of insurance fraud.³

Nevertheless, according to a recent national survey, approximately 22% of individuals who used OON providers negotiated an OON bill with the insurer or provider, and 58% were successful in reducing their costs for at least one of the bills.⁴

Health insurance plan efforts to legally assail physician authority to waive charges, on a case-by-case basis, based upon a patient's economic condition, creates a hostile legal atmosphere that is designed to deter such benevolent financial actions by physicians for their patients. Accordingly, physicians should have an explicit legal safe harbor in state law to conduct such waivers on out-of-network charges on a case by case basis so as to financially benefit economically distressed patients.

The issue of out-of-network balance billing is multi-dimensional. Simplistic solutions that favor health insurance plans with governmental price setting for out-of-network physician services would, and should, raise questions about the fundamental purpose and need for health insurance plans if they have no financial incentive, nor legal obligations, to contract for physician services.

² "Out of Network Referrals and Waiver of Patient Copayments and Deductibles: The Battle Between Payors and Providers Endures and Intensifies," The Health Lawyer, Charles C Dunham, Esq. O'Connell & Assoc. Albany, NY., Volume 25, Number 5, June 2013.

³ Ibid.

⁴ "Patient's Success in Negotiating Out-of-Network Bills," The American Journal of Managed Care, Kelly A. Kyanko, MD, MHS, Susan H. Busch, PhD, Vol, 22, No 10, October 2016.

The non-partisan National Association of Insurance Commissioners (NAIC) in its annotations on this issue (MDL 74-22) noted that states should consider a payment formula such as: “a) some percentage of a public, independent database of charges for the same or similar services in the same geographic area, or b) some percentage of usual, customary and reasonable (UCR) charges in the state, if defined in state law or regulation.” Importantly, the NAIC notes the imperative need for states to recognize the need for payment equilibrium in the market:

“In setting a benchmark or benchmarks state should carefully consider the impact on the market. Setting a rate too high or too low may negatively impact the ability of facility based providers and health carriers to agree on a contract.”

It is the position of the Massachusetts Society of Pathologists, and the College of American Pathologists, that patients are best served by insurance products that provide in-network services through the continuum of care that an enrollee is likely to need and receive in the hospital setting. Health policy measures that do not compel health plans to contract for the provision of such services for their enrollees alter the public policy rationale for participating provider (PPO) insurance products and should raise fundamental questions about the role of insurance in the value chain of health care delivery.

Thank you for your consideration.

Provider Price Variation Commission Public Listening Session

Filaine Deronnette; 1199SEIU Vice President of BMC/Community Hospitals

January 17, 2017

Good afternoon.

My name is Filaine Deronnette and I am the 1199SEIU Vice President of Community Hospitals and Health Systems.

Thank-you Chairman Sanchez and Chairman Welch - and the other members of this Commission - for this opportunity. I'm pleased to offer these brief remarks on behalf of the 56,000 Massachusetts members of 1199.

As many of you know, this Commission was formed early last summer under a comprehensive settlement and agreement that 1199 would withdraw our "Fair Care" ballot initiative. A ballot initiative that would have established several new laws and regulations designed to reduced provider price variation.

We're very happy, therefore, to have seen the Commission taking its job so seriously for the past several months.

And to see so many policy experts and advocates joining us here at today's Listening Session and in search of a comprehensive solution to this persistent problem.

Since at least 2010, multiple state agencies have documented significant and "unwarranted" variation in provider prices. Variation that's not tied to measurable differences in quality, complexity of care, or other common measures of value.

Meanwhile, provider price variation seems unlikely to decrease absent significant policy reform. And comparatively low reimbursement has meant that many of our community and safety net hospitals are struggling to remain financially viable.

A successful approach to reducing provider price variation in the commercial market must include solutions that are consistent with our policy priorities.

To be specific, it is essential that the work of this Commission, its final report, and any recommended reforms ensure the following:

- That, at least in the short term, the state is ensuring that we have adequate public payer rates and the other supplemental support needed to ensure the financial viability of community hospitals;
- Second, that we avoid placing too much of the burden of reform on either healthcare consumers or the low-wage healthcare workforce;
- Third, that addressing provider price variation is part of a comprehensive approach to controlling statewide health care costs;
- And, finally, that the proper incentives are in place to guarantee affordable, accessible and high-quality health care for all.

We urge the Commission to issue a strong final report and recommendations that offer comprehensive solutions to this persistent problem. It is very important to reach consensus on “warranted” and “unwarranted factors for price variation, including the appropriateness of efforts to mitigate existing socio-economic health disparities.

In addition, at a very minimum, our community and safety net hospitals need immediate financial relief. The newly created Community Hospital Revitalization Trust Fund is well-designed to support supplemental payments to hospitals receiving lower relative commercial payments. But the funding of just \$45 million over 5 years is insufficient. In the short term and as we allow market-based reforms and additional state oversight to work, this Commission should also ensure that there’s adequate support to guarantee the financial viability of the lowest-paid tier of community and safety-net hospitals.

To wrap-up, we look forward to continuing our work within the Commission. In the end, we remain open to supply-side, demand-side and direct regulatory solutions that are consistent with the priorities laid out above. And we understand that all may be needed to fully address the issue.

Thank you again for the opportunity to offer these remarks. Now I hope you’ll appreciate hearing from the community hospital worker members of our panel.

[Introduce first member: Name, Employer, Job Title]

Provider Price Variation Commission Public Listening Session

James Farren; St. Elizabeth's Hospital; January 17, 2017

Good afternoon members of the commission. My name is Jim Farren and I am a Patient Access Representative in the Steward Healthcare System, which is made up of many community and DSH hospitals. I am an original 10 signer of the ballot initiative that helped bring us here today.

I want to thank the Commission for undertaking the task in front of us. As a leader of 1199 and a healthcare worker at a community hospital it is vital that industry leaders from across the state come together around real solutions to support accessible, quality care across Massachusetts that protects our most vulnerable community hospitals.

I feel very proud of the fact that I have a good, union job in the community where I am from. We are a diverse mix of ages and most of the patients that we see depend on Medicaid or Medicare. This is reflective of who our community is made up of in this part of the city.

Working at St. Elizabeth's, I know I'm making a difference for the residents that depend on us most. Because I am the first stop for a lot of our patients, I hear countless stories of people who feel like St. Elizabeth's is their hospital—they truly feel ownership of it and regardless of where they may go, they end up back at St. Elizabeth's for care.

Clearly, the importance of our hospital for our patients and residents cannot be understated and we are here today to come together around solutions that at their core protect and preserve hospitals like these.

When I became an original signer of this initiative petition, I was excited to have the opportunity to make more of a difference for community hospitals. I still feel optimistic that this commission will take this charge to heart. Please remember the voices of healthcare workers as you work towards a real policy solution. If we cannot come to agreement on more complex policy solutions, at a minimum we must maintain the consensus we have heard over the past two years--community hospitals must be given the support they need to remain affordable, community providers.

We need to stand up for access to quality care, and to ensure the economic engines of our gateway cities operate under a more level playing field. I believe in affecting change and I believe we must do more for our community providers. I'm here today because I want to ensure my hospital is still here 10 years from now. Thank you.

Provider Price Variation Commission Public Listening Session

Sheilah Belin ; Boston Medical Center; January 17, 2017

Good morning. My name is Sheilah Belin, I am a Medical Assistant at Boston Medical Center and a proud member of 1199SEIU. Thank you for the opportunity to testify at this important hearing.

I am here today to stand up for safety net hospitals like mine that are on the front lines of caring for vulnerable and diverse communities. From dealing with mental illnesses, tackling substance abuse addictions, to providing primary and preventive care and saving lives in our world-class trauma center, we treat not only the ailments that afflict our patients, but also help break down barriers that prevent them from being healthy.

The patients we see every day come from all across the city, often taking several modes of transportation just to get their medications. They are children, seniors, people with disabilities and low-income families. And these folks are not just our patients - they're our friends, families and neighbors too.

I am proud to be part of the BMC healthcare team that provides "exceptional care without exception" to every patient who walks through our doors. Regardless of you are, where you're from, or your ability to pay.

Eventually, however, someone has to bear the burden of those costs. And it often falls on safety net hospitals to make up the difference. But with this inequity in payment, how can we compete with other providers that admit only patients with the financial means to afford private insurance? How can my hospital continue to keep its doors open to the people who need us?

We must level the playing field in our hospital payment system and ensure our community and safety net hospitals have the resources we need to provide the quality care our patients deserve. Our private insurance rate shouldn't suffer just because the majority of our patients are MassHealth beneficiaries. We need better Medicaid reimbursement rates as well as fairer private insurance rates that take into consideration socioeconomic factors like the demographics and income of our patients.

I join my 1199SEIU brothers and sisters here today in thanking the Commission for the critical work you are all doing.

Your task is not an easy one, and I am sure you have many different opinions about how best to address the unfair way Massachusetts hospitals currently are reimbursed for care. But I hope we all can agree on one thing - if we want to reduce healthcare costs and ensure quality care for all, community and safety net hospitals must continue to thrive and survive.

February 10, 2017

Dear Commission Member:

The physician community has watched with interest as the *Special Commission to Review Variation in Prices among Providers* has met and deliberated on important issues related to provider price variation. The legislature tasked your commission with the difficult goal of “conducting a rigorous, evidence-based analysis to identify the acceptable and unacceptable factors contributing to price variation in physician, hospital, diagnostic testing and ancillary services.” We have watched as recommendations about this primary charge and other tangential issues have been developed among the various subcommittees. The twenty physician organizations undersigned here write to comment on and share concerns regarding one particular recommendation discussed at the January 31st meeting.

Out-of-network billing has increasingly been a topic of conversation in multiple health policy forums in Massachusetts over the past year. The Medical Society and many medical specialty societies undersigned here have also been engaged on this issue as it relates to out-of-network physicians at in-network facilities. We have pledged for some time our commitment to finding a solution to this issue. The Medical Society has proposed legislation that will do just that: remove patients from the middle of the situation by holding them harmless from any unavoidable out of network bill. **To that end, the physician community supports three high-level principles related to out-of-network billing: 1) greater education of patients by plans and providers, 2) provision of strong patient protections by holding patients harmless for unavoidable out-of-network bills, and 3) a process by which all affected parties, including physicians, can participate in the establishment of a payment formula for out-of-network providers.**

We write to share our strong opposition to the use of this Commission to provide detailed recommendations on a default rate of reimbursement for Out-of-Network providers. Details regarding a formula for reimbursement are far afield from the charge of the Commission, and discussions of them should take place in a venue that is inclusive of the primary party affected by this issue.

As discussed at the public hearing of your Commission, the undersigned physician organizations believe that many important perspectives of the issue of Out-of-Network billing have evaded consideration as a result of the limited membership of the Commission. This is not a repudiation of the Commission—again many important discussions about price variation will lead to improved health care delivery in the Commonwealth—but rather, an urging that the Commission to return to its focus on those larger issues. Continuing to move forward with detailed recommendations about a default out-of-network reimbursement rate without inviting the parties most affected by the reimbursement formula to join in the discussion could have unintended, harmful consequences for patient care and the delivery of medical care.

We offer a sampling of the concerns of the physician community regarding the details of the Out-of-Network default reimbursement rate recommendations.

References to Medicare as a Benchmark for Default Commercial Payment Are Problematic

The physician community opposes references to Medicare fee schedules in these conversations about default out-of-network physician reimbursement. Medicare is not currently and was never intended to be a broadly applicable index for commercial physician payment. Medicare rates are not established to represent a valuation of professional services provided; instead, they function as a distribution of an already limited budget of this social service program. Further, Medicare rates differ widely across specialties as evidenced by a study published recently in *JAMA Internal Medicine* that found significant

variation in the relative price of services across specialty billing Medicare. A driving factor of this variation is that the denominator—the rate of Medicare payment—varies significantly across specialties. For example, a GAO report highlighted, “Medicare payments were lower than private payments [for anesthesia] by an average of 67%.” While other specialties may not have such wide variation, this example underscores why tying any payment formula to Medicare is not appropriate and will have incredibly negative impacts for certain specialties which could ultimately impede patient’s access to good quality medical care.

References to “Significantly Below Charges” is also Problematic

The undersigned physician organizations oppose the inclusion of this level of vague detail in any recommendations put forward by the Commission. The Medical Society has put forward a legislative proposal to solve the out of network billing issue that puts forth a nuanced reimbursement formula that includes one option that defines the usual and customary rate based on a percentile of charges in the geographic area, as determined by a neutral third-party non-profit organization, such as Fair Health. This formula was recently adopted by the legislatures of the states of New York and Connecticut, states that are both good models for Massachusetts as they are similar geographically, population, etc.

The details of Reimbursement for providers “in broad network” are Problematic

While we are not privy to the working documents of the Commission that detail some of these recommendations, we have strong concerns about the language requiring those contracted to a broad network to accept the contracted rate. While our initial interpretation was that a “Physician Group A” who is contracted with “Insurer B” for many plans, but not of patient’s “Narrow Network Plan C” offered by Insurer B would receive the physician’s contracted rate per their broader contract with Insurer B, this language could also be interpreted as to reimburse the physician at the rate of Narrow Network Plan C.

This latter interpretation would be unacceptable and have significant detrimental unintended consequences by imposing a potentially inadequate rate of reimbursement on a physician organization that is not a party to the contract. The valuation of physician services includes many warranted factors for price variation, as highlighted by the Commission at its last meeting. These factors include patient acuity, high cost outliers, and quality. The Commission indicated that several more factors could likely be added to that list upon further discussion, including area wages, teaching, stand-by capacity, and lower or no margin services. **A narrow network rate contracted between an insurer and one physician organization may be acceptable for one physician organization but not sustainable for another physician organization based on factors for price variation recognized by your Commission as entirely warranted.** The imposition of one privately contracted reimbursement rate on another physician practice could have serious effects on the sustainability of physician practices, jeopardizing access to care for patients. It could also allow insurers to take advantage of inadequate networks by relying upon this law to prevent patients from receiving bills while forcing inadequate rates on physicians not a party to the narrow network contract.

The Medical Community is Concerned with the Consequences of Unsustainable Reimbursement

The physician community again urges discussion of the reimbursement formula in a more inclusive venue as the failure to establish a sustainable reimbursement formula could have substantial implications on broader contracting dynamics, and could extend well beyond physician groups and affect low-margin hospitals.

An unsustainable default reimbursement formula recommended by this Commission could have broad implications beyond just the narrow sliver of reimbursement presently attributed to unavoidable out-of-

network care. If a default rate is set that is substantially below market value, insurers would have little incentive to negotiate in good faith with physician practices, knowing that any resulting out-of-network scenario would be reimbursed at a low rate. This would significantly jeopardize the sustainability of many physician practices, threatening access to care for patients across the Commonwealth. This also has the potential for disincentivizing physicians from practicing in Massachusetts, making recruiting and retaining physicians increasingly difficult.

We point out that many in the physician community are concerned about the impact that insufficient reimbursement formulas could have on hospitals and patients. Hospitals rely upon these physician groups for the very heart of their mission- emergency physicians, anesthesiologists, radiologists, and pathologists, among others, are the lifeblood of the hospital. If these physician groups cannot remain solvent due to lower reimbursements and unfair negotiating dynamics, hospitals will be forced to find ways to retain these services, often through subsidization of the physician practice. If these levels of subsidization increase, many hospitals with low operating margins—often those that provide critical access in geographically isolated locations often to low-income patients in need—the very sustainability of the hospitals and access to care for thousands of patients could be in jeopardy.

Network Adequacy Needs to be Properly Considered

The physician community supports strategies to promote the sustainable delivery of health care in Massachusetts, and will welcome policies that protect our patients from rising premiums and out-of-pocket expenses.

But, costs reductions are only as good as the good care that they continue to facilitate. Unfortunately, an unintended consequence of narrowing networks to reduce cost is that networks may become so narrow that they can jeopardize consumers' access to care, potentially driving up the costs they were designed to reduce while negatively impacting quality of care and health outcomes. Specifically, narrow networks may lack an adequate mix of provider specialties or not provide enough physicians to care for patients, essentially giving consumers no choice but to obtain out-of-network care. For example, researchers at Harvard found that approximately 15 percent of health plans offered on the 2015 Federal Marketplace lacked in-network physicians for one or more specialties. Without adequate transparency and education by insurers, narrow networks can be confusing and frustrating for consumers. In fact, the Commonwealth Fund found that as many as one in four Marketplace enrollees were unaware that the plans they were choosing from had different networks, and McKinsey and Company found 40 percent of newly enrolled consumers were unaware of the network configuration of the Marketplace plan they chose. Therefore, we urge further examination and monitoring of network adequacy as conversations continue about increasing these narrow network plans.

The medical community reiterates its commitment to working with members of the Provider Price Variation Commission, patient advocacy groups, and others to see the adoption of public policy to address out of network billing. We write to support that work by highlighting many of the perspectives that have not been included in meetings of the Commission, largely due to the lack of physician representation. We urge that broad principles regarding out of network billing as outlined at the outset of this letter be adopted, but that all references to a specific default reimbursement formula should be left for a venue inclusive of physicians, patients, and all other affected parties. As laid forth in this letter, the implications of recommending factors that will lead to an unsustainable reimbursement rate are too great for the patient and physician communities.

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Massachusetts Medical Society

Ira Skolnik, MD, PhD, President
Massachusetts Academy of Dermatology

Jordan Scott MD, President
Massachusetts Allergy and Asthma Society

Mitchell Bamberger, MD, President
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DeWayne Pursley, M.D., MPH, President
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Anne Campbell Larkin, MD, FACS, President
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Deborah Levine, MD, FACR, President
Massachusetts Radiological Society

Maryanne Bombaugh, MD, FACOG, President
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Mary Ann Vann, MD, President
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Claire Fung, MD
Massachusetts Society of Clinical Oncologists

John Mandeville, MD, PhD, President
Massachusetts Society of Eye Physicians & Surgeons

Michael Medlock, MD, President
Massachusetts Society of Neurosurgeons

Robert Patz, MD, President
Massachusetts Orthopedic Association

Jeffrey Brown, MD, President
Massachusetts Society of Otolaryngology

William D. Kasimer, MD, President
Massachusetts Society of Pathologists

Special Commission on Provider Price Variation
Public Hearing on January 17, 2017
Summary of Oral Testimony with No Written Submission

Jon Hurst

President of the Retailers Association of Massachusetts

- Represents 4,000 employers in the retail and restaurant sphere
- The goal of RomneyCare was to increase coverage and lower the cost of insurance.
 - While more people are insured, premiums have increased especially for small businesses.
 - Surveyed members every year since the passage of RomneyCare and found that the average increase for small businesses, of 15 employees and under, per year is about 12%, which he noted is well above the 3.6% target and above the 4.2% mark.
 - Premium increases are a contributing factor to the closing of small businesses.
 - Need for action, not the creation of new committees or research.
 - The average inflation from the passage of Romney Care through the recession was about 0 to 2%, yet there has been significant increases in premiums for small businesses and their employees.
 - The law is unfair and it has created an unequal market place depending on the size/type of the business you work because providing and paying for insurance and healthcare largely varies based on where you work.
 - In the years since RomneyCare, 26 mandates and/or assessments have been passed which have been paid for by the consumer through higher health insurance premiums and are often avoided by large self-insurers who make up 60% of the marketplace.
 - This has created a marketplace that really discriminates based on where you work because if you work for a small business you cannot escape those mandates.
 - Those mandates help the provider groups who lobbied for them because it increases their utilization and their reimbursements which results in increased medical inflation in the state, and makes insurance less and less affordable for small businesses.
 - A DOI survey of third party administrators found that 9-10 state mandates are not covered by 90% of self-insured businesses. This is an unfair playing field created by the government.
 - Proposed a rate cap to deal with high cost providers and believes that high cost providers are expensive because their expenses are too high.
 - Providers failed to address their high expenses because they have an endless amount of money coming in through insurance premiums and taxes, and therefore they have no incentive to lower their expenses. Instead they “pass the bill” to small businesses.
 - Lower cost facilities don’t need to be brought up and paid at higher rates. Instead, more consumers should be pushed towards low cost providers.
 - This can be accomplished by utilizing tiered and limited networks but to have them capped off at a 14% differential does not make any sense because it does not create an incentive to buy them and it does not give high cost providers a reason to bring down their costs.
 - Need real incentives for consumers to buy a tiered network product meaning that premiums should reflect in-network vs. out of network providers.
 - State agencies, maybe the DOI, should look into the expenses of these providers that are driving premiums up because someone needs to be looking out for the consumers on that expense growth.
 - It was a mistake to merge the individual and small business insurance marketplace because employees of small businesses now have a hidden “tax” in their premiums that works to subsidize the healthcare of an individual.
 - MA is the only state that does this, ACA did not do this
 - This does not affect self-insurers.

- Proposed separation of risk pools and re-implementation of some rating factors to ensure that insurance premiums are fair because while insurance is about subsidization, subsidies should be fair. Right now they are not.
- Urged government to give small businesses a break when it comes to state mandates since the majority of self-insured businesses do not cover them. Give small businesses the ability to opt-in or opt-out of state mandates.
- The 3.6% benchmark needs to be revisited because it is too high. It is far higher than the economy and even still we are exceeding it. Not everyone was at 4.2% last year if you look at the different risk pools, and it needs to be transparent to consumers.
- Asked why very large, nonprofit healthcare providers are exempt from sales tax, it would bring in more tax revenue and help these providers look at their expenses more thoughtfully.

Spiros Hatiras

CEO of Holyoke Medical Center

- The purpose of the Commission is to figure out if “somebody can get something for nothing.”
- The question is: As a state, can we say it is okay for somebody to get something for nothing? Is it okay to cheat, or should we have equal pay for equal work?
- It is not the responsibility of this commission to come up with a solution.
- Holyoke is a 3-year running experiment and worked to fix its own issues when they were losing patients to other hospitals in 2013. They created and executed a plan to let their community know about all of the great work they were doing.
 - In those three years between 2013 and 2016, Holyoke received the top safety hospital award 2 out of 3 three years which is given to about 50-60 hospitals in the country, they have the best admissions rates, best care, best numbers in stroke care, they were voted by our patients one of the top 3 cleanest hospitals in our state, and have had no central line infections in two years.
 - At the end of 2016, they closed with \$140 million in revenue but their expenses increased by \$20.1 million, so there was no net gain. That is a result of being paid less than the cost of care.
- Acknowledged that with Ch. 224 the legislature set a ceiling, but did not think about creating a safety floor. This has allowed insurance companies to pay lower and lower commercial rates.
- There needs to be a safety floor, especially for those 11 hospitals on the bottom (referenced a chart with CHIA relative price data) that are receiving rates so low it is not sustainable for those hospitals to remain open.
 - Bring all hospitals up to at least 0.9 on relative price.
- Price caps and tiered networks won't work because even if more business was brought to Holyoke, it would increase their expenses and therefore their bottom line would not improve, which is what happened between 2013 and 2016.
- Reminded legislators that they will be held accountable by the people of the Commonwealth, specifically the employees of those 11 worst paid hospitals even though it was the insurance companies, not Partners, that created this issue.