North Shore Chamber of Commerce
Health Care Breakfast

Howard Grant, JD, MD
February 1, 2017
Health Care Reform

Ch. 58 AN ACT PROVIDING ACCESS TO AFFORDABLE, QUALITY, ACCOUNTABLE HEALTH CARE. - 2006

Ch. 224 AN ACT IMPROVING THE QUALITY OF HEALTH CARE AND REDUCING COSTS THROUGH INCREASED TRANSPARENCY, EFFICIENCY AND INNOVATION. - 2012

The PATIENT PROTECTION AND AFFORDABLE CARE ACT - 2010
Health Care is a Priority in 2017

- ACA Repeal & Replace?
- Medicaid Reform?
- Medicare Reform?
- Prescription Drugs Price Controls?

Lahey Health
Health Care is a Priority in 2017

- Medicaid Transformation
- Cost Containment
- Payment Reform
- Provider Price Caps?
- Prescription Drug Purchasing?
Massachusetts Challenges

- Affordability is a growing challenge for consumers, employers and government
- Annual family premium plus cost-sharing is $20,400
- An increasing number of high-value community hospitals are facing financial jeopardy
- Health care is crowding out essential state services
Massachusetts Spending vs. US

Massachusetts per capita health care expenditures are greater than the rest of the country, even after adjusting for factors like age, coverage/access and input costs.

** 36%**

16% Estimated contribution of certain factors

20% Remaining difference in spending between MA and U.S.

** Difference in per capita spending between MA and U.S.**

**FACTORS**

- Age
- Coverage and access
- Input costs†

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**Personal health care expenditures are a subset of national health expenditures; PHC excludes administration and the net cost of private insurance, public health activity and investment in research, structures and equipment.**

† Based on the Medicare Geographic Adjustment Factor (GAF), which adjusts for wages, office rents, supplies and medical malpractice insurance premiums.

Sources: Centers for Medicare & Medicaid Services Medical Expenditure Panel Survey; Smith S. Newhouse JP, Freeland MS, Health Affairs, Bureau of Economic Analysis; Center for Health Information and Analysis; MassHealth; Census Bureau; HPC Analysis
Figure 1.1: State budgets for health care coverage and other priorities, FY2004- FY2014

Total budget (dollars in billions) and total real growth percentage, FY2004 – FY2014

- **$2.8B** (+21%)
- **-1.4B** (-7%)

**GIC, MassHealth, & Other**

- **$15 B**

**Mental Health**

- **-17.4%**

**Public Health**

- **+6.2%**

**Education**

- **-4.2%**

**Human Services**

- **-11.3%**

**Infrastructure, Housing & Economic Development**

- **+27.1%**

**Law & Public Safety**

- **-10.0%**

**Local Aid**

- **-38.2%**

**Source:** Massachusetts Budget and Policy Center

**Note:** Figures all adjusted for Gross Domestic Product (GDP) growth; GIC = Group Insurance Commission.
Market Situation
Major Teaching Hospital Utilization

The Massachusetts delivery system uses major teaching hospitals for far more of its inpatient care than the rest of the nation.

40% of Medicare discharges in Massachusetts are in major teaching hospitals

16% of Medicare discharges nationwide are in major teaching hospitals
Unwarranted Price Variation

• Prices vary extensively for the same sets of services.

• Higher hospital prices are not associated with higher quality or other common measures of value; market leverage continues to be a significant driver of higher prices.

• The disparity has not diminished over time and is particularly damaging to lower cost, high quality community hospitals.

• Contributes to higher health care spending due both to the prices and to the large share of volume at higher-priced providers.
Self-Reinforcing Challenges Facing Community Hospitals

HPC Report
Community Hospitals at a Crossroads, p. 36, March 2016
Patient migration to Boston increases health care spending

Average Additional Case-Mix Adjusted Cost for Each Commercial Discharge at a Boston Hospital Rather Than a Local Hospital, by Region of Patient Origin

Source: HPC analysis of MHDC 2013 discharge data and raw CHIA relative price data. Note: Figures shown are differences in average commercial revenue per CMAD for hospitals in each region compared to those in Metro Boston, adjusted for payer mix.
Inpatient care that could safely and effectively be provided in community hospitals is increasingly being provided by teaching hospitals

**Share of community appropriate discharges, by hospital type, 2011-2015**

<table>
<thead>
<tr>
<th>Year</th>
<th>Community</th>
<th>Teaching</th>
<th>Academic medical center</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>55.3%</td>
<td>16.7%</td>
<td>28.1%</td>
</tr>
<tr>
<td>2012</td>
<td>54.9%</td>
<td>17.5%</td>
<td>27.7%</td>
</tr>
<tr>
<td>2013</td>
<td>54.7%</td>
<td>17.7%</td>
<td>27.6%</td>
</tr>
<tr>
<td>2014</td>
<td>53.6%</td>
<td>18.3%</td>
<td>28.1%</td>
</tr>
<tr>
<td>2015</td>
<td>53.3%</td>
<td>18.6%</td>
<td>28.2%</td>
</tr>
</tbody>
</table>

Notes: Discharges that 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). The Center for Health Information and Analysis (CHIA) defines community hospitals as general acute care hospitals that do not support large teaching and research programs. Teaching hospitals are defined as hospitals that report at least 25 full-time equivalent medical school residents per one hundred inpatient beds in accordance with Medicare Payment Advisory Commission (MedPAC) guidelines. Academic medical centers are a subset of teaching hospitals characterized by (1) extensive research and teaching programs, (2) extensive resources for tertiary and quaternary care, (3) principal teaching hospitals for their respective medical schools, and (4) full service hospitals with case mix intensity greater than 5 percent above the statewide average. Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2011-2015
What Can Be Done
The Commonwealth has taken important steps to slow the growth of healthcare costs – but is constrained in its ability to create market-based solutions that drive innovations to migrate care from higher-cost to lower-cost providers.

**Chapter 224**

- Created a statewide target for healthcare spending growth
- Increased transparency of healthcare spending
- Expanded oversight of provider market changes
- Emerging focus on provider price variation

The Heath Care Cost Growth Benchmark is set at 3.6%* per year; actual cost growth was 4.2% from 2013-2014 and 4.1% from 2014-2015

*Represents cumulative impact of both rates and utilization increases on total healthcare expense*
Special Commission on Price Variation

• Advance dialogue and make recommendations to address unwarranted price variation
• Examine factors that affect provider payment rates
• Investigate transparency initiatives
• Explore possibilities to foster greater competition
• Discuss ideas related to state monitoring that could alleviate unwarranted price variation
• Report due March 15, 2017
# Forward Thinking Care @ Lahey Health

## Acute Care
- Addison Gilbert Hospital
- Beverly Hospital
- Lahey Hospital & Medical Center
- Lahey Medical Center Peabody
- Winchester Hospital

## Behavioral Health
- BayRidge Hospital

## Outpatient Centers
- Danvers
- Lexington
- Medford
- Wilmington
- Winchester
- Woburn
Lahey Health Vision: Keeping Care Local

• One of the founding principles of Lahey Health is delivering the right care in the right place at the right time

• Patients treated in the lowest cost setting appropriate for their care, always subject to patient choice

• More accessible, closer to home

• PCP centered, inclusive of employed and independent practitioners

• Lower cost to payers, consumers, and the Commonwealth

Cost + Quality + Access = Value
Redistributing lower acuity patients from Lahey’s tertiary hospital ED to our community hospitals for inpatient care.
However, following Lahey’s acquisition of Winchester (a community hospital) in 2014, community appropriate discharges increased at Winchester and decreased at Lahey Medical Center (a teaching hospital).

Notes: Discharges that 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). All other discharges are classified as “higher acuity” for the purposes of this analysis.

Source: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database, 2012-2015
Movement of Patients from Higher Cost to Lower Cost, High Quality Care
Keeping Care Local
Growth in Admissions Since Affiliation with Lahey

During this same period, admissions declined 1.35% in the Eastern MA market.

Affiliation May 2012
Chronic Conditions and Behavioral Health Impact

Patients with behavioral health and chronic conditions have significantly higher medical expenditures.

**Medical expenditures per patient (excludes drug spending)**
- Relative to average patient with no behavioral health or chronic comorbidity in 2010

- **Average patient with neither comorbidity**
- **Behavioral health** comorbidity
- **Chronic condition** comorbidity
- **Both comorbidities**

**Commercial**
- 1x
- 1.6x
- 2.1x
- 4.2x

**Medicare**
- 1x
- 2.2x
- 2.8x
- 7.0x

*The sample for analysis was limited to patients who had continuous enrollment from 1/1/2010 – 12/31/2011 and costs of at least $1 in each year. Figures do not capture pharmacy costs, payments outside the claims system, Medicare cost-sharing, or end-of-life care for patients who died in 2010 or 2011.

† Behavioral health comorbidity includes child psychology, severe and persistent mental illness; mental health; psychiatry; and substance abuse.

§ Chronic condition includes arthritis, epilepsy, glaucoma, hemophilia, sickle-cell anemia, heart disease, HIV/AIDS, hyperlipidemia, hypertension, multiple sclerosis, renal, asthma, and diabetes.

Source: All-Payer Claims Database, HPC analysis

Health Policy Commission
High Integrated Care with a Community Focus

- Low cost/high quality under new models of payment
- Moving towards population health
- Successful clinical program development
- One electronic health record
- Well poised to send care to the community
- Shared governance
- A nonprofit community asset
Lahey Value

• Lahey Outperformed comparable providers in meeting cost growth and benchmark as measured by total medical expense. (data 2013 – 2014)

• Proportion of members whose care was paid for using alternative payment methods in commercial market increased 4% (34% to 38%)

• LHMC ranked #2 in physician group relative price at 0.8 (lower is better; 1.0 avg.)

• NEPHO ranked #5 in physician group relative price at 0.89
Conclusion
Conclusion

• Bending the curve is possible, but complicated.

• It requires providers, insurers, employers and elected officials to work together:
  • Employers should develop products that discourage use of inappropriately high cost care, while rewarding quality and access.
  • Health systems need to create value by keeping high quality care in the lowest possible setting.
  • The State must oversee a transparent, objective and fair process to ensure insurers and providers are accountable for not paying or receiving rates that reflect unjustifiable factors.
Let’s Work Together To Lower Health Care Costs

• Employers
• Consumers
• Providers
• Insurers
• Brokers
• Government