History of Chapter 224 of the Acts of 2012
An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation
The Massachusetts story

- **Insurance Reforms**
  - Community Rating, Guaranteed Coverage

- **Ch. 58 Passed**
  - Health care reform

- **Ch. 305 Passed**
  - Health care transparency and e-Health

- **Ch. 288 Passed**
  - Small business health care relief

- **Ch. 224 Passed**
  - Health care cost containment

Timeline:
- 1990s
- 2006
- 2008
- 2010
- 2012
The Massachusetts story

Massachusetts now has the lowest rate of uninsurance
Percent uninsured, all ages

NOTE: The Massachusetts specific results are from a state-funded survey — the Massachusetts Health Insurance Survey (MHIS). Using a different methodology, researchers at the Urban Institute estimated that 507,000 Massachusetts residents were uninsured in 2005, or approximately 8.1 percent of the total population. Starting in 2008, the MHIS sampling methodology and survey questionnaire were enhanced. These changes may affect comparability of the 2008 and later results to prior years. The national comparison presented here utilizes a different survey methodology, the Current Population Survey, which is known to undercount Medicaid enrollment in some states.

In Massachusetts, government spending on health care crowds out other taxpayer-funded priorities

**Inflation-adjusted budgeted dollars in Fiscal Year, in billions**

![Bar chart showing government spending on various categories, with health care spending significantly higher than other categories.]

- **GIC, Mass Health & Other Health Care**: 58%
- **Mental Health & Public Health**: FY 06: $x, FY 16: $y
- **Education**: FY 06: $z, FY 16: $w
- **Human Services**: FY 06: $u, FY 16: $v
- **Infrastructure & Economic Development**: FY 06: $t, FY 16: $s
- **Law & Public Safety**: FY 06: $r, FY 16: $q
- **Local Aid**: FY 06: $p, FY 16: $n

Note: Data are CPI-adjusted. Other health care includes operations funding and the ACA coverage expansion.

Source: Massachusetts budget data obtained from massbudget.org.
Increases in health insurance premiums have outpaced income gains, consuming over 40% of family income growth since 2005

Dollars in year shown

Income increase: $16,300
Premium increase: $6,800
Ratio: $6,800/$16,300 = 42%

Note: Data are in nominal dollars. Includes cost-sharing
Source: American Community Survey (income data), Agency for Healthcare Research and Quality (premiums), and Center for Health Information and Analysis (cost-sharing)
Chapter 224 of the Acts of 2012, “An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation,” was signed into law on August 6, 2012 by Governor Patrick and became effective on November 5, 2012.
Vision for Massachusetts cost containment reform law

1. Transforming the way we deliver care
2. Reforming the way we pay for care
3. Developing a value-based health care market
4. Engaging purchasers through information and incentives

A more transparent, accountable health care system that ensures quality, affordable health care for Massachusetts residents
Massachusetts Health Policy Commission

Our structure, staff, and responsibilities.
Who we are

The Massachusetts Health Policy Commission (HPC) is an independent state agency that develops policy to reduce health care cost growth and improve the quality of patient care. The HPC’s main responsibilities include monitoring the performance of the health care system; analyzing the impact of health care market transactions on cost, quality, and access; setting the health care cost growth benchmark; and investing in community health care delivery and innovations.

Mission

The HPC’s mission is to advance a more transparent, accountable, and innovative health care system through its independent policy leadership and investment programs. The HPC’s goal is better health and better care at a lower cost across the Commonwealth.

Vision

Our vision is a transparent, accountable health care system that ensures quality, affordable, and accessible health care for the Commonwealth’s residents.
Main Statutory Responsibilities

- Monitor system transformation in the Commonwealth and cost drivers therein
- Make investments in the Commonwealth’s community hospitals to establish the foundation necessary for sustainable system transformation
- Promote an efficient, high-quality health care delivery system in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status
- Examine significant changes in the health care marketplace and their potential impact on cost, quality, access, and market competitiveness
Health care cost growth benchmark

- Sets a target for controlling the growth of total health care expenditures across all payers (public and private), and is set to the state’s long-term economic growth rate:
  - Health care cost growth benchmark for 2013 - 2017 equals **3.6%**

- If target is not met, the Health Policy Commission can require health care entities to implement Performance Improvement Plans and submit to strict monitoring

TOTAL HEALTH CARE EXPENDITURES

- **Definition**: Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources

- **Includes**:
  - All categories of medical expenses and all non-claims related payments to providers
  - All patient cost-sharing amounts, such as deductibles and copayments
  - Net cost of private health insurance
Implementing state agencies

<table>
<thead>
<tr>
<th><strong>Center for Health Information and Analysis (CHIA)</strong></th>
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<tbody>
<tr>
<td><strong>Data and analytics hub</strong></td>
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<tr>
<td>Independent state agency led by an Executive Director appointed by Governor, Auditor, and the Attorney General</td>
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<td>Duties include:</td>
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<tr>
<td>- Manages the All Payer Claims Database</td>
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<td>- Collects and reports a wide variety of provider and health plan data</td>
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<tr>
<td>- Examines trends in the commercial health care market, including changes in premiums and benefit levels</td>
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<td>- Charged with developing a consumer-facing cost transparency website</td>
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<table>
<thead>
<tr>
<th><strong>Health Policy Commission (HPC)</strong></th>
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<tr>
<td><strong>Policy development hub</strong></td>
</tr>
<tr>
<td>Independent state agency governed by an 11-member board with diverse experience in health care</td>
</tr>
<tr>
<td>Duties include:</td>
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<tr>
<td>- Sets statewide health care cost growth benchmark</td>
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<td>- Holds annual cost trend hearings and produces an annual cost trends report</td>
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<td>- Enforces performance against the benchmark</td>
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<td>- Conducts cost and market impact reviews</td>
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<td>- Certifies ACOs and PCMHs</td>
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<tr>
<td>- Supports investments in community hospitals and new innovative health care models such as telemedicine</td>
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The HPC’s Structure

Governor

Attorney General

State Auditor

Health Policy Commission Board
*Dr. Stuart Altman, Chair*

Executive Director

HPC Staff
The HPC has spent the past three years in a period of rapid staff growth. We anticipate reaching full agency staffing in FY17.

**Executive Teams**
- Office of the Chief of Staff
- Office of the General Counsel

**Policy and Program Teams**
- Accountable Care
- Strategic Investment
- Market Performance
- Research and Cost Trends

The annual operating budget in fiscal year 2017 is **$8.5 million**. Costs are annually assessed to hospitals, surgery centers, and health plans.
Main Statutory Responsibilities

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Pharmaceutical spending spiked in both the US and MA in 2014

Commercial payers’ per-enrollee annual growth rate for prescription drug spending, 2010 - 2014

Source: CMS National Health Expenditures (US commercial), CHIA data (MA commercial).
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

- 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

* 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.

Source: All-Payer Claims Database; HPC analysis
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Community hospitals provide tremendous value, but face self-reinforcing challenges that lead to more expensive and less accessible care.
The HPC’s “CHART” investment program is investing $120 million in community hospitals to support system transformation at all levels.

CHART stands for “Community Hospital Acceleration, Revitalization, and Transformation”. The overarching focus of CHART is to support achievement of the Triple Aim, including payment reform.

**Overview of CHART Investments**

- Funded by a one-time assessment on payers and select well-resourced providers
- Total amount of $120 million
- Funds are held in an off-budget trust fund to be spent over time
- Competitive proposal process to receive funds
- Strict eligibility criteria: ~25-30 eligible community hospitals
  - Non-teaching, non-profit, low relative price
- Focus to date has been on behavioral health integration and reducing unnecessary hospital utilization

Diagram:

- **Enhance health information technology**
- **Increase efficiency and coordination**
- **Allow for the secure transfer of health records across MA**
- **Demonstrate structures of accountable care**
- **Support the transition to alternative payment methods**
- **Patient-centered care through quality, safety, and affordability**
- **Building a structure for creating accountable care**

Community-based care should be efficient, high-quality, safe, and affordable.
All awardees committed to quantifiable, outcome-based “Aim Statements”

Primary aim statements are grouped into three primary categories:

1. Sixteen hospitals will reduce readmissions by a median goal of 20% for their target populations, within two years.

2. Five hospitals will reduce emergency department revisits by a median goal of 20% for their target populations, within two years.

3. Three hospitals will reduce emergency department length of stay by a median goal of 20% for their target populations, within two years.

CHART hospitals can have more than one measureable aim. Not all secondary aims are included in this slide.
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HPC is charged with developing ACO and PCMH certification programs to promote high-quality, coordinated, patient-centered accountable care

**Vision of Accountable Care**

A health care system that efficiently delivers well coordinated, patient-centered, high-quality health care, integrates behavioral and physical health, and produces optimal health outcomes and health status through the support of reformed (non-FFS) payment.

1. Create a **roadmap** for providers to work toward **care delivery transformation** – balancing the establishment of **standards** with room and assistance for **innovation**

2. Establish a **common framework** for data collection, information gathering, evaluation and dissemination of best practices to promote transparency for future learning

3. Develop standards that **align with payers’ own principles for accountable care** to further link accountability and enhance administrative simplification

4. Assure **patient engagement and protection** in their care, especially for vulnerable populations
HPC developed a unique PCMH certification program that recognizes practices with a strong commitment to behavioral health integration.

**Ongoing HPC Technical Assistance**

Practices will achieve HPC’s **PCMH PRIME** recognition by demonstrating enhanced capacity and capabilities in behavioral health integration (BHI). Practices will be initially certified on a rolling basis and must meet the HPC’s BHI criteria within a given timeline after entering the technical assistance period to maintain certification.

**Pathway to PCMH PRIME**

- 2011 Level II NCQA*
- 2011 Level III NCQA*
- 2014 NCQA

**HPC/NCQA Assessment of Behavioral Health Integration (PRIME)**

**PCMH PRIME Certification**

*Practices must convert to NCQA 2014 standards at end of their current 2011 recognition period*
Main Statutory Responsibilities

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Price, not utilization, is the primary driver of recent health care spending growth; provider prices vary extensively for the same services

Acute Hospital Composite Relative Price Percentile by Hospital Cohort (2013)
The HPC found that a substantial portion of hospital price variation is associated with market structure, and not with quality.

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

<table>
<thead>
<tr>
<th>Factors not generally associated with commercial prices (Holding all other factors equal)</th>
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</thead>
<tbody>
<tr>
<td>Quality</td>
</tr>
<tr>
<td>Mean income in the hospital’s service area</td>
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</table>
Overview of cost and market impact reviews (CMIRs)

1. Market structure and new provider changes, including consolidations and alignments, have been shown to impact health care system performance and total medical spending.

2. Chapter 224 directs the HPC to track “material change[s] to [the] operations or governance structure” of provider organizations and to engage in a more comprehensive review of transactions anticipated to have a significant impact on health care costs or market functioning.

3. CMIRs promote transparency and accountability in engaging in market changes, and encourage market participants to minimize negative impacts and enhance positive outcomes of any given material change.
The HPC tracks proposed “material changes” to the structure or operations of provider organizations and conducts “cost and market impact reviews” (CMIRs) of transactions anticipated to have a significant impact on health care costs or market functioning.

**WHAT IT IS**
- Comprehensive, multi-factor review of the provider(s) and their proposed transaction
- Following a preliminary report and opportunity for the providers to respond, the HPC issues a final report
- CMIRs promote transparency and accountability, encouraging market participants to address negative impacts and enhance positive outcomes of transactions
- Proposed changes cannot be completed until 30 days after the HPC issues its final report, which may be referred to the state Attorney General for further investigation

**WHAT IT IS NOT**
- Differs from Determination of Need reviews by Department of Public Health
- Distinct from antitrust or other law enforcement review by state or federal agencies
Process for cost and market impact reviews

**INPUTS**

- Data and documents:
  - Parties’ production
  - Publicly available information
  - Data from payers, providers, and other market stakeholders
- Support from expert consultants
- Feedback from Commissioners
- Information gathered is exempted from public records law, but the HPC may engage in a balancing test and disclose information in a CMIR report

**OUTPUTS**

- Issuance of a preliminary report with factual findings
- Feedback from parties and other market participants
- Final report issued 30 or more days after preliminary report
- Proposed change may be completed 30 or more days after issuance of final report
- Potential referral to Massachusetts Attorney General’s Office
Statutory factors for evaluating cost and market impact

- Unit prices
- Health status adjusted total medical expenses (TME)
- Provider costs and cost trends
- Provider size and market share within primary service areas and dispersed service areas
- Quality of services provided, including patient experience
- Availability and accessibility of services within primary service areas and dispersed service areas
- Impact on competing options for health care delivery, including impact on existing providers
- Methods used to attract patient volume and to recruit or acquire health care professionals or facilities
- Role in serving at-risk, underserved, and government payer populations
- Role in providing low margin or negative margin services
- Consumer concerns, such as complaints that the provider has engaged in any unfair method of competition or any unfair or deceptive act
- Other factors in the public interest
The HPC’s review is focused on cost, quality, and access and includes both quantitative and qualitative analysis

<table>
<thead>
<tr>
<th>What do we know from the terms of the transaction?</th>
<th>Costs</th>
<th>Quality</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will contractual prices change as a result of the transaction?</td>
<td>Will care shift to lower or higher priced providers?</td>
<td>What are the identified areas for quality improvement?</td>
<td>Are any changes in services identified?</td>
</tr>
<tr>
<td>Will care shift to lower or higher priced providers?</td>
<td></td>
<td>What changes do the Parties propose to address these areas?</td>
<td>How do these changes affect any shortages or oversupply of services?</td>
</tr>
<tr>
<td>How will provider and market structure change?</td>
<td>Will market share or concentration increase or decrease?</td>
<td>How are the parties aligning incentives?</td>
<td>Will the resulting organization have higher or lower government payer mix?</td>
</tr>
<tr>
<td>Will market share or concentration increase or decrease?</td>
<td>What is the anticipated impact on bargaining leverage?</td>
<td>Does the proposed structure support greater clinical integration and population care management?</td>
<td>Higher or lower mix of low/negative margin services?</td>
</tr>
<tr>
<td>Ongoing evaluation of the parties’ goals and plans</td>
<td>Continued evaluation with additional data, production, and interchange with parties and market participants.</td>
<td></td>
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</tr>
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</table>
### Types of transactions noticed

<table>
<thead>
<tr>
<th>Type of Transaction</th>
<th>Number of Transactions</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical affiliation</td>
<td>14</td>
<td>25%</td>
</tr>
<tr>
<td>Physician group merger, acquisition or network affiliation</td>
<td>12</td>
<td>21%</td>
</tr>
<tr>
<td>Acute hospital merger, acquisition or network affiliation</td>
<td>11</td>
<td>20%</td>
</tr>
<tr>
<td>Formation of a contracting entity</td>
<td>9</td>
<td>16%</td>
</tr>
<tr>
<td>Merger, acquisition or network affiliation of other provider type (e.g. post-acute)</td>
<td>5</td>
<td>9%</td>
</tr>
<tr>
<td>Change in ownership or merger of corporately affiliated entities</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>Affiliation between a provider and a carrier</td>
<td>1</td>
<td>2%</td>
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