



MASSACHUSETTS
HEALTH POLICY COMMISSION

Improving Healthcare Quality and Controlling Costs: Lessons from Massachusetts

California Legislature
March 16, 2016

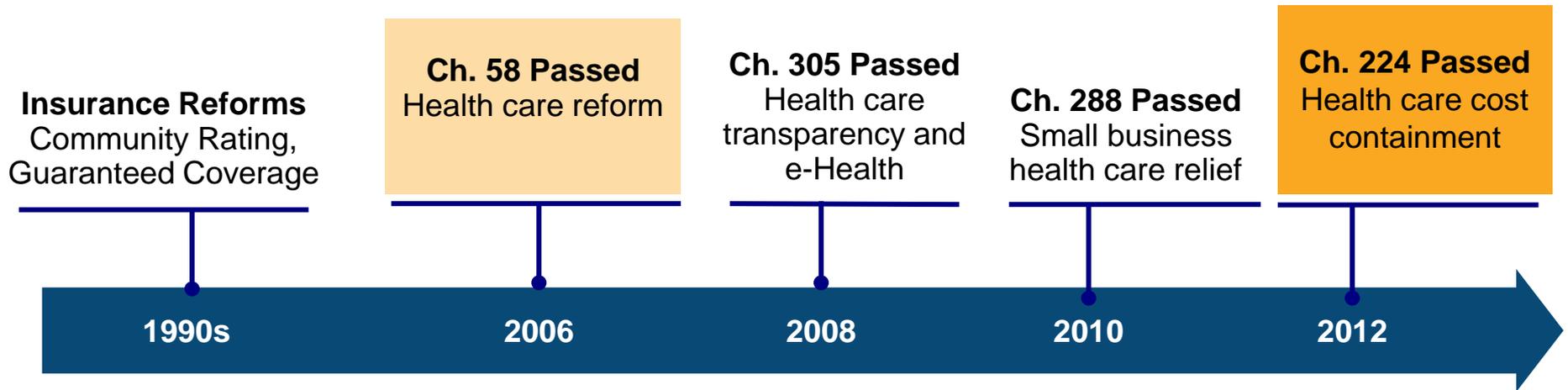


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History of Chapter 224 of the Acts of 2012

An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation

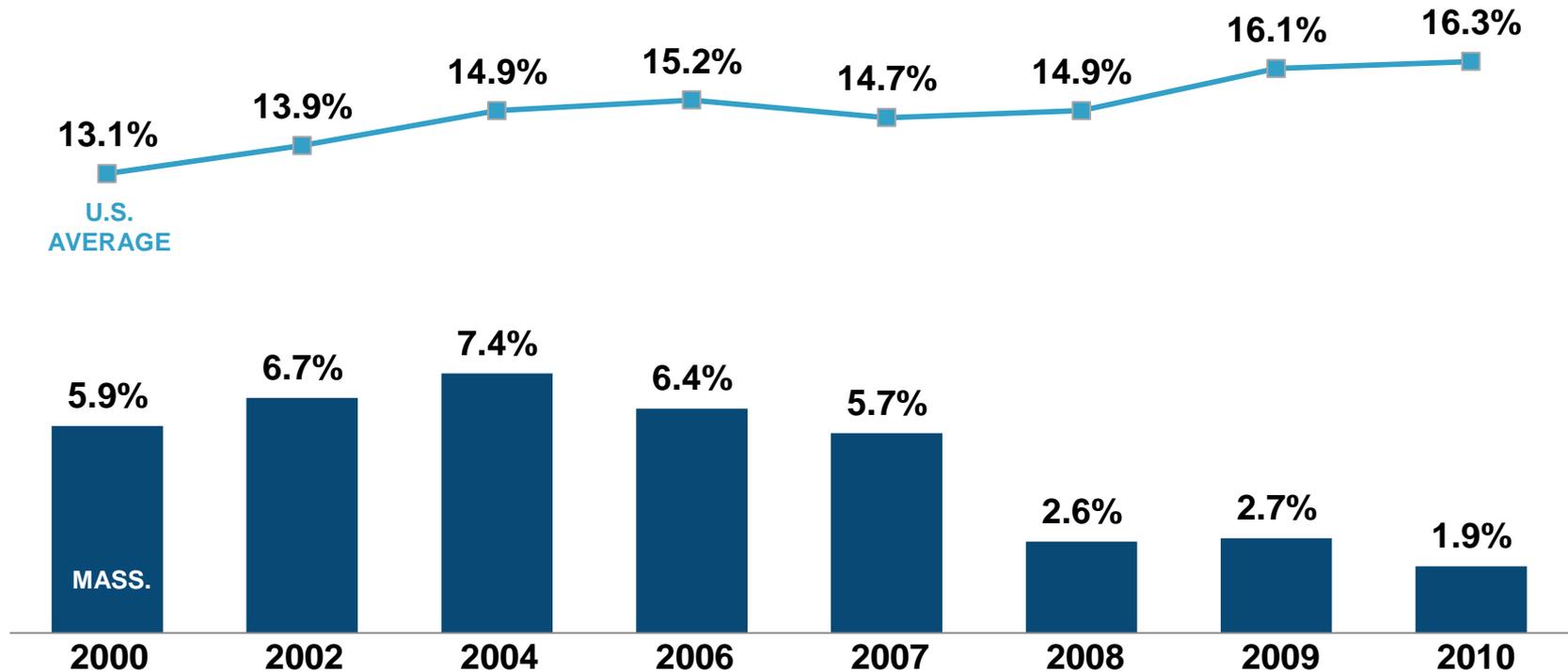
The Massachusetts story



The Massachusetts story

Massachusetts now has the lowest rate of uninsurance

Percent uninsured, all ages

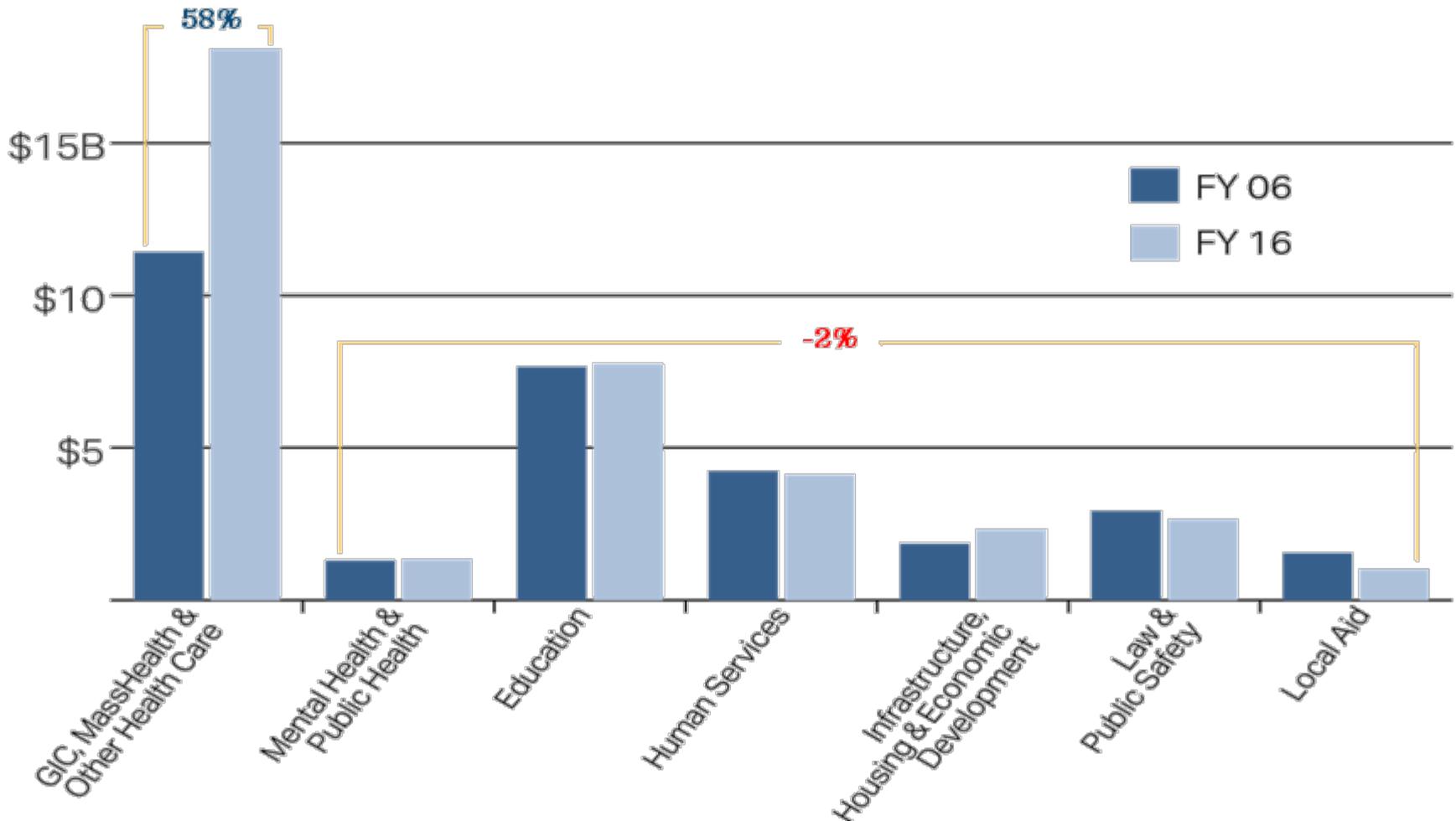


NOTE: The Massachusetts specific results are from a state-funded survey — the Massachusetts Health Insurance Survey (MHIS). Using a different methodology, researchers at the Urban Institute estimated that 507,000 Massachusetts residents were uninsured in 2005, or approximately 8.1 percent of the total 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.

SOURCES: Urban Institute, Health Insurance Coverage and the Uninsured in Massachusetts: An Update Based on 2005 Current Population Survey Data In Massachusetts, 2007; Massachusetts Division of Health Care Finance and Policy, Massachusetts Health Insurance Survey 2000, 2002, 2004, 2006, 2007, 2008, 2009, 2010; U.S. Census Bureau, Current Population Survey 2010.

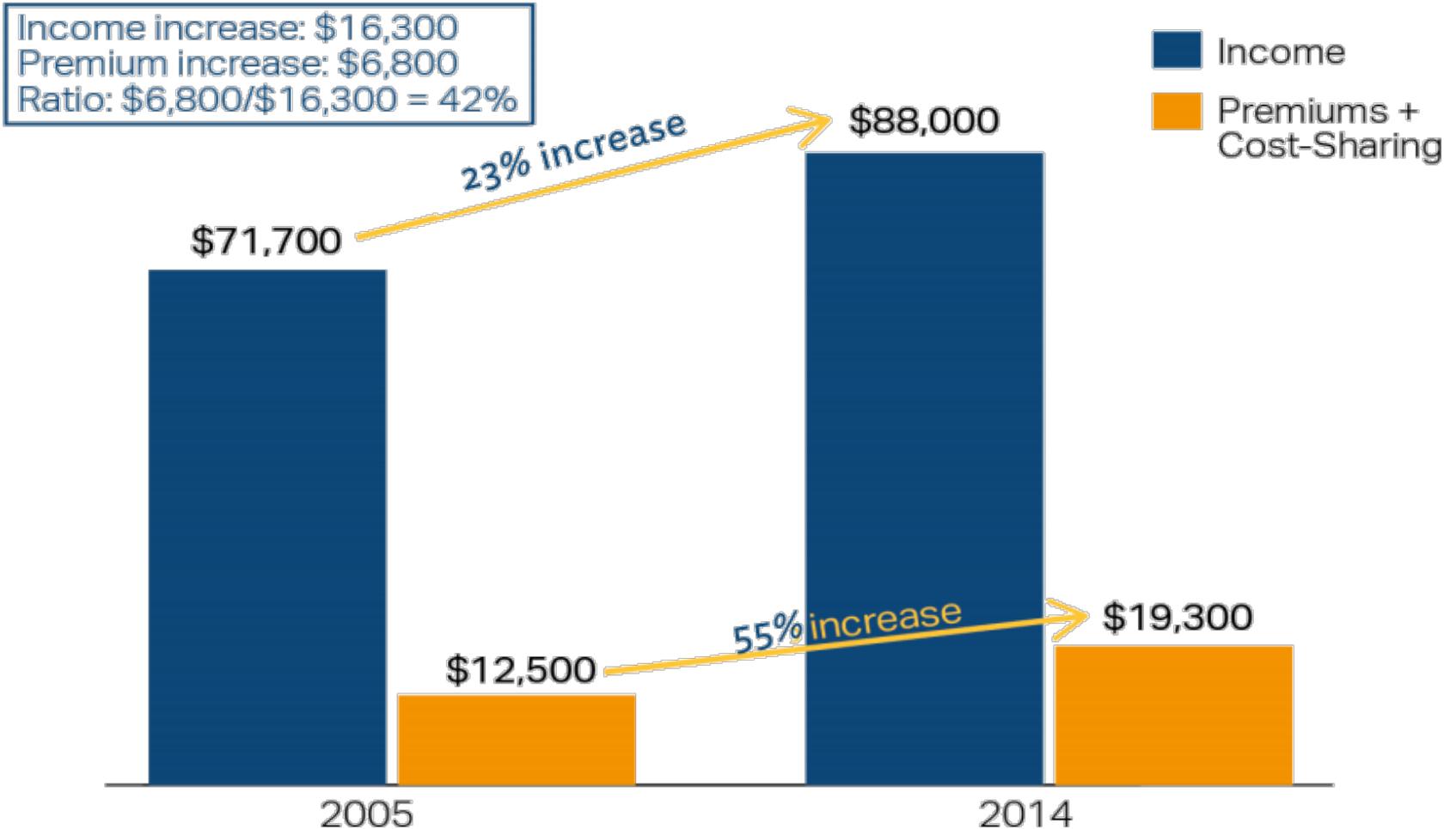
In Massachusetts, government spending on health care crowds out other taxpayer-funded priorities

Inflation-adjusted budgeted dollars in Fiscal Year, in billions



Increases in health insurance premiums have outpaced income gains, consuming over 40% of family income growth since 2005

Dollars in year shown



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)

How We Got Here: Health Care Reform (Part 2)



Bill signing at the Massachusetts State House, Boston.

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

Massachusetts Health Policy Commission

Our structure, staff, and responsibilities.

The HPC: At a Glance

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

CHIA HPC

Center for Health Information and Analysis (CHIA)

- **Data and analytics hub**
- Independent state agency led by an Executive Director appointed by Governor, Auditor, and the Attorney General
- Duties include:
 - Manages the All Payer Claims Database
 - Collects and reports a wide variety of provider and health plan data
 - Examines trends in the commercial health care market, including changes in premiums and benefit levels
 - Charged with developing a consumer-facing cost transparency website

Health Policy Commission (HPC)

- **Policy development hub**
- Independent state agency governed by an 11-member board with diverse experience in health care
- Duties include:
 - Sets statewide health care cost growth benchmark
 - Holds annual cost trend hearings and produces an annual cost trends report
 - Enforces performance against the benchmark
 - Conducts cost and market impact reviews
 - Certifies ACOs and PCMHs
 - Supports investments in community hospitals and new innovative health care models such as telemedicine

The HPC's Structure

Governor

Attorney General

State Auditor

Health Policy Commission Board
Dr. Stuart Altman, Chair

Executive Director

HPC
Staff

The HPC's Teams

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

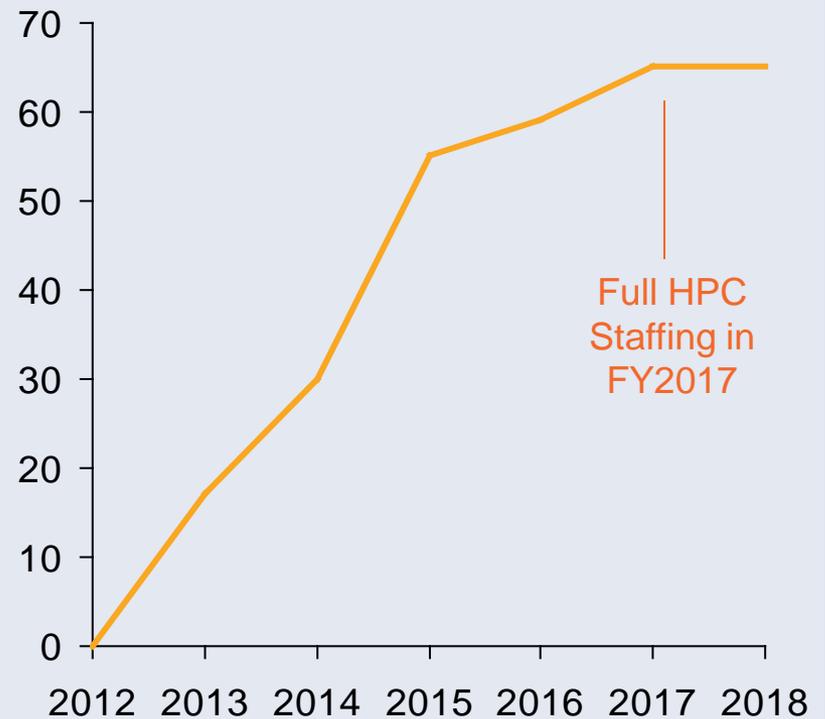
- Office of the Chief of Staff
- Office of the General Counsel

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.

HPC Staff Growth, 2012 - 2018

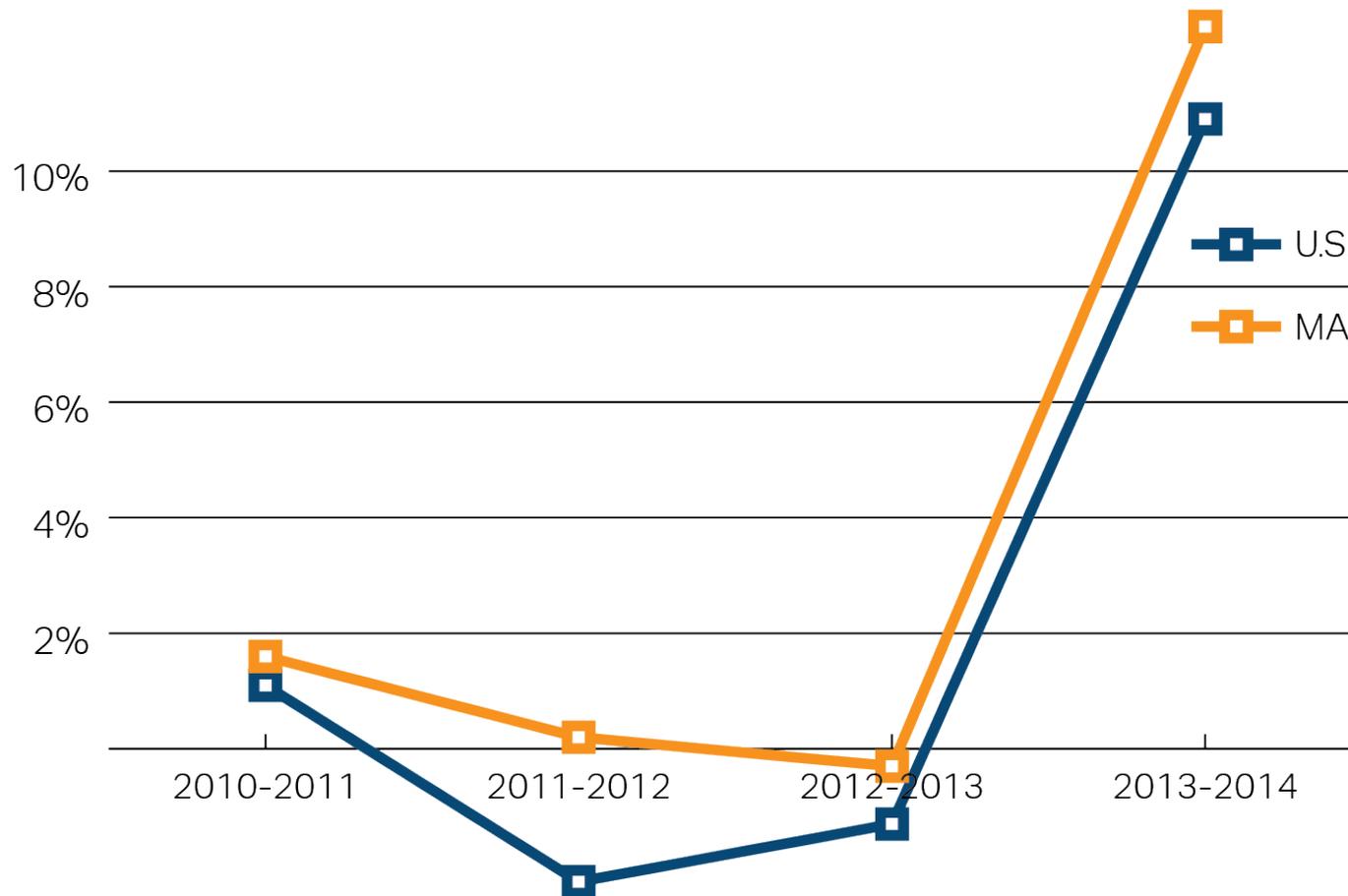


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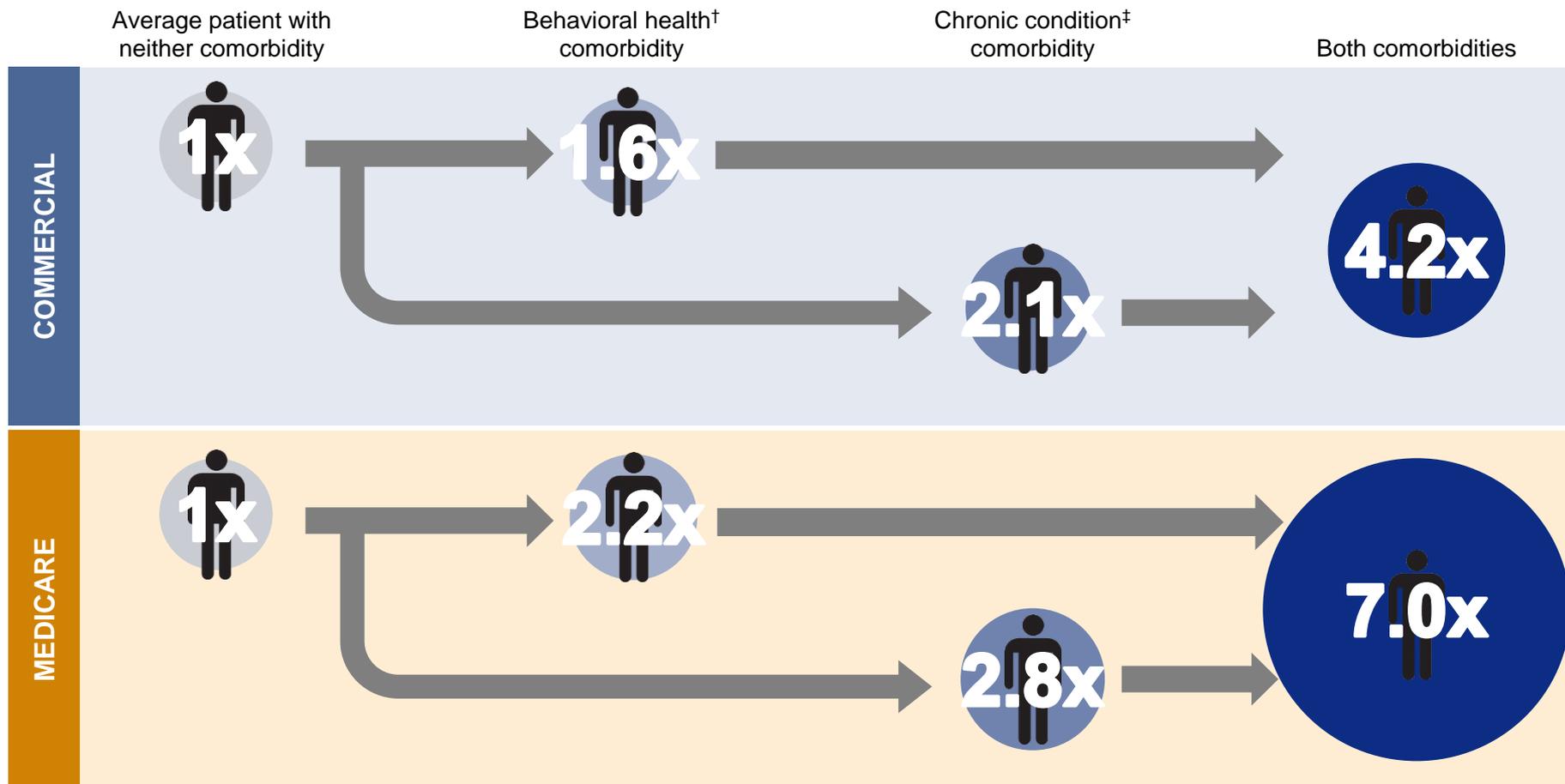
Pharmaceutical spending spiked in both the US and MA in 2014

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



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



* 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

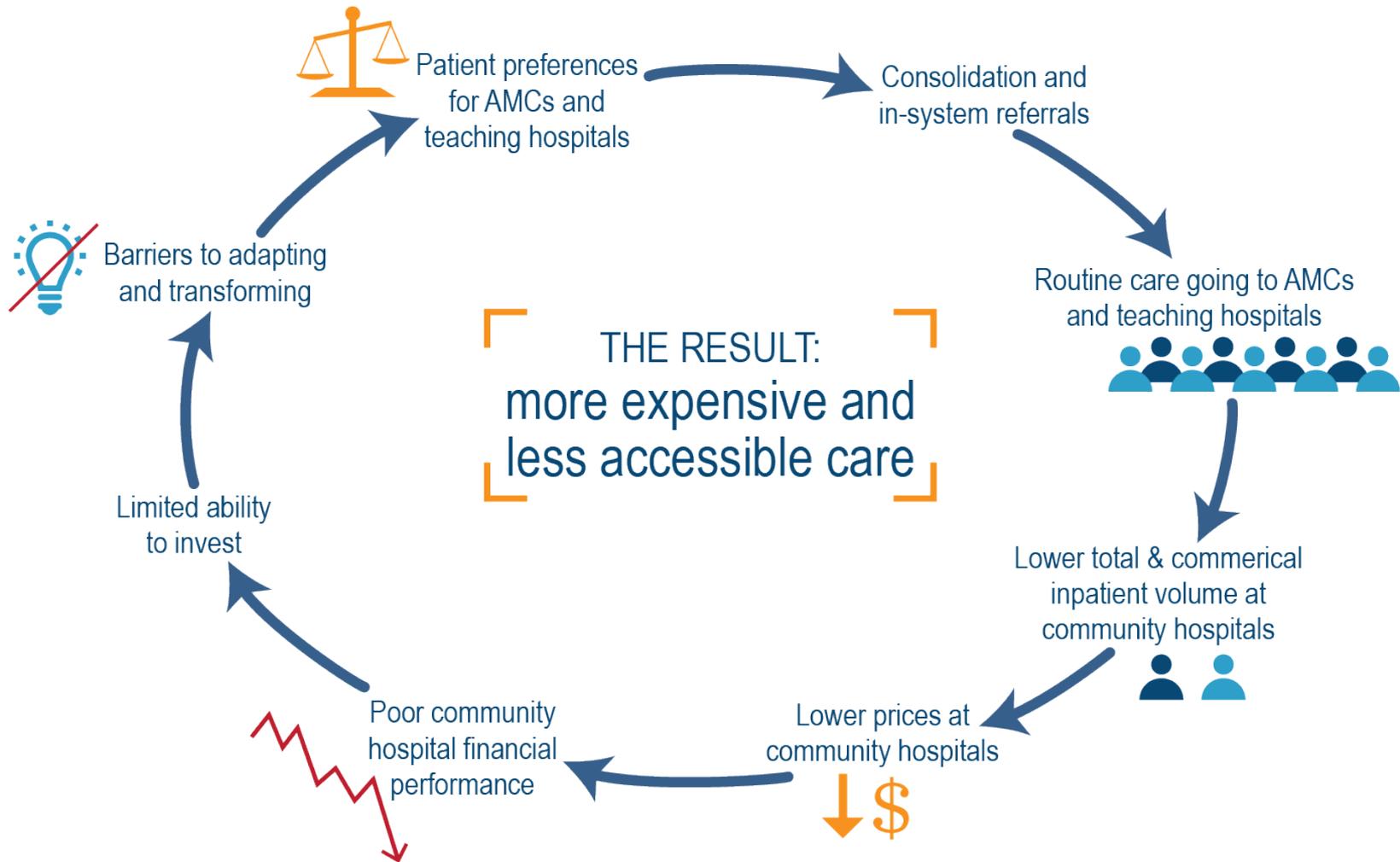
[‡] Chronic condition includes arthritis, epilepsy, glaucoma, hemophilia, sickle-cell anemia, heart disease, HIV/AIDS, hyperlipidemia, hypertension, multiple sclerosis, renal, asthma, and diabetes

Source: All-Payer Claims Database; HPC analysis

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Community hospitals provide tremendous value, but face self-reinforcing challenges that lead to more expensive and less accessible care

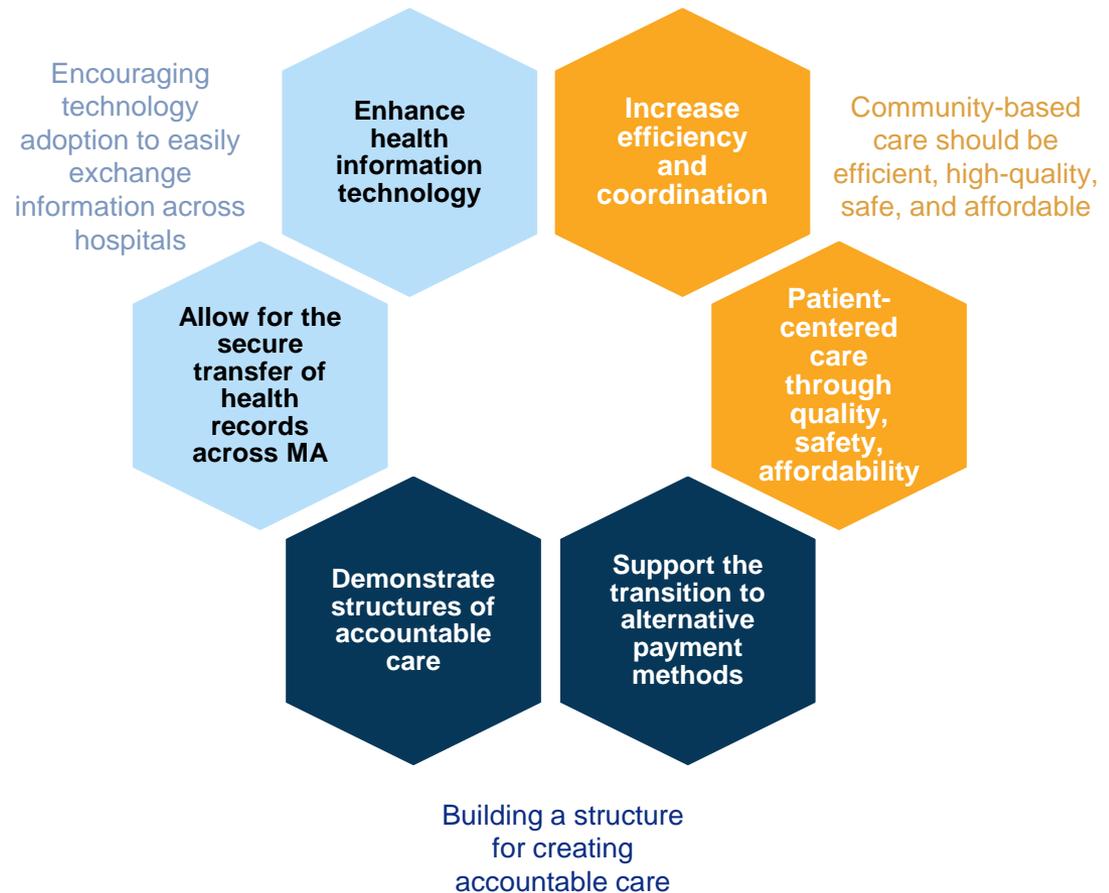


The HPC's "CHART" investment program is investing \$120 million in community hospitals to support system transformation at all levels

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



All awardees committed to quantifiable, outcome-based “Aim Statements”

Primary aim statements are grouped in to 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

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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

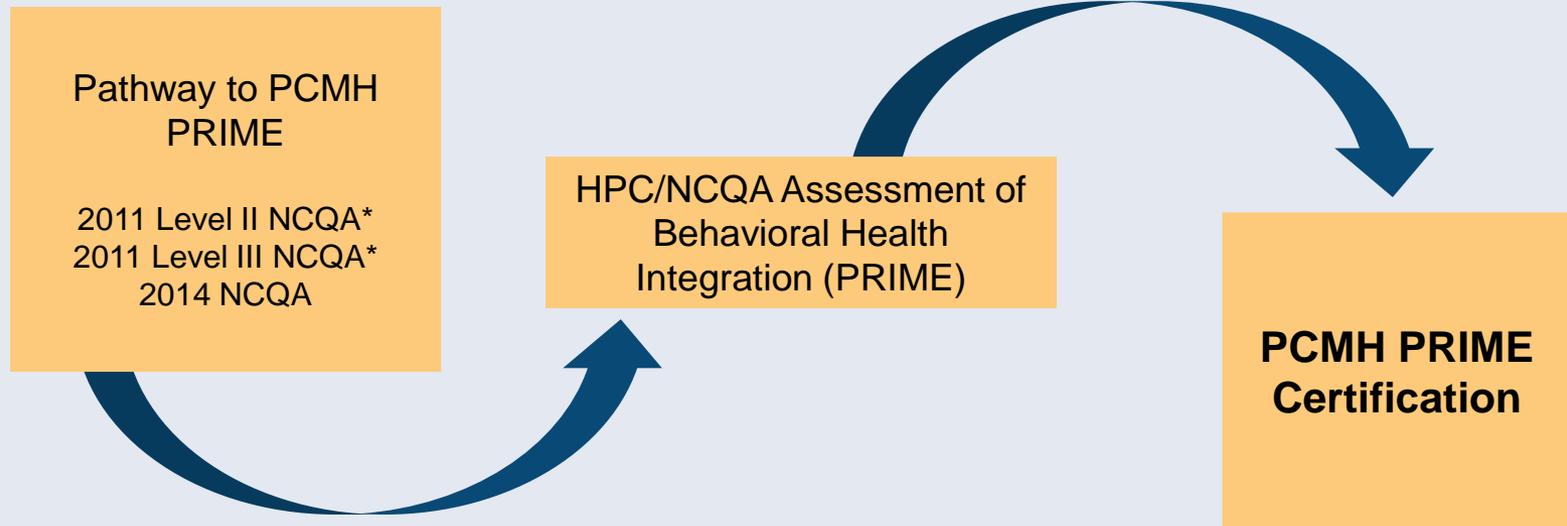
A health care system that efficiently delivers well coordinated, patient-centered, high-quality health care, integrates behavioral and physical health, and produces optimal health outcomes and health status through the support of reformed (non-FFS) payment.

- 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.



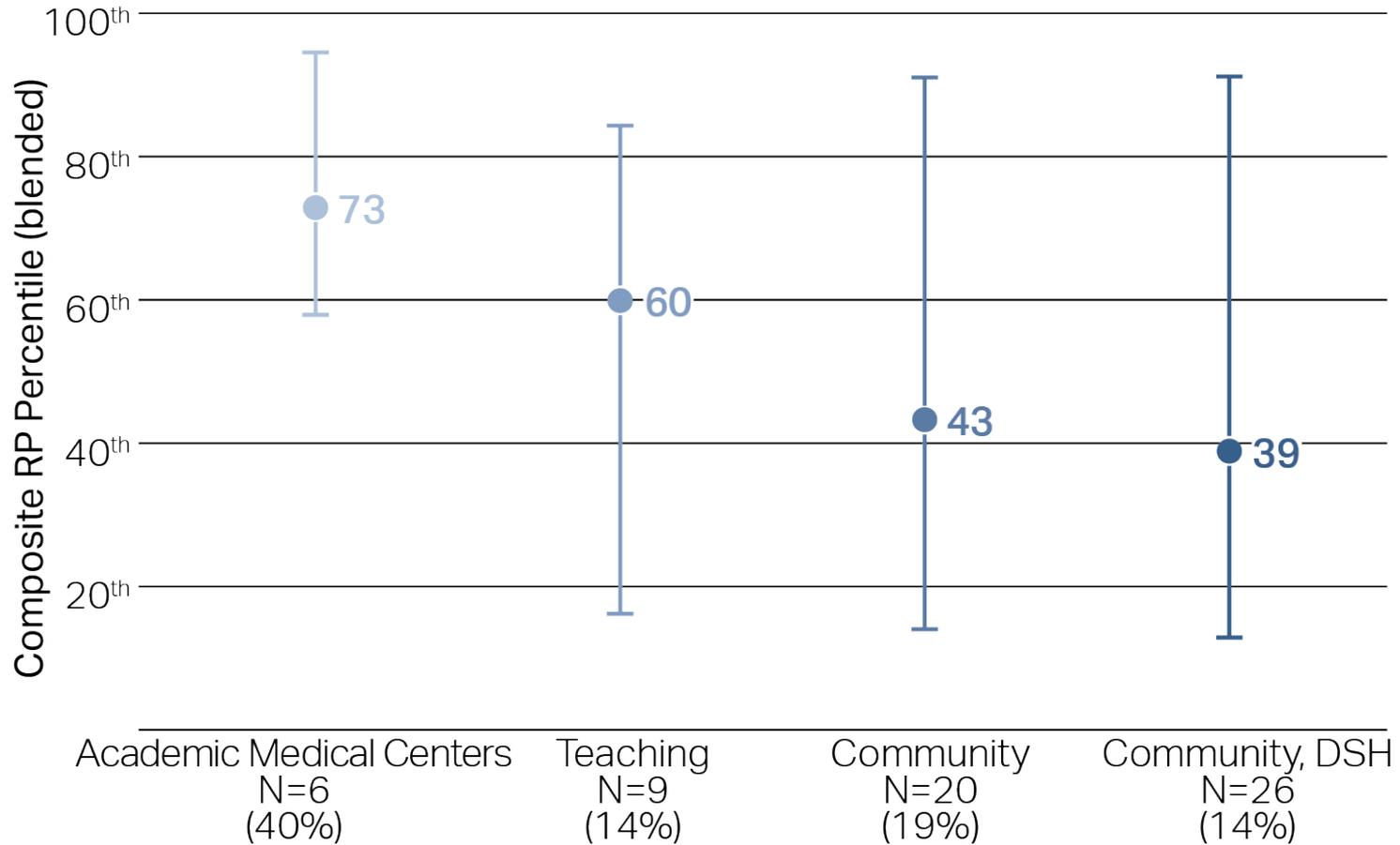


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Price, not utilization, is the primary driver of recent health care spending growth; provider prices vary extensively for the same services

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

Factors associated with higher commercial prices

(Holding all other factors equal)

Less competition

Larger system size (above a certain size)

Corporate affiliations with certain systems

Provision of higher-intensity (tertiary) services

Status as a teaching hospital

Factors associated with lower commercial prices

(Holding all other factors equal)

More Medicare patients

More Medicaid patients

Corporate affiliations with certain systems

Factors not generally associated with commercial prices

(Holding all other factors equal)

Quality

Mean income in the hospital's service area

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

Overview of cost and market impact reviews

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

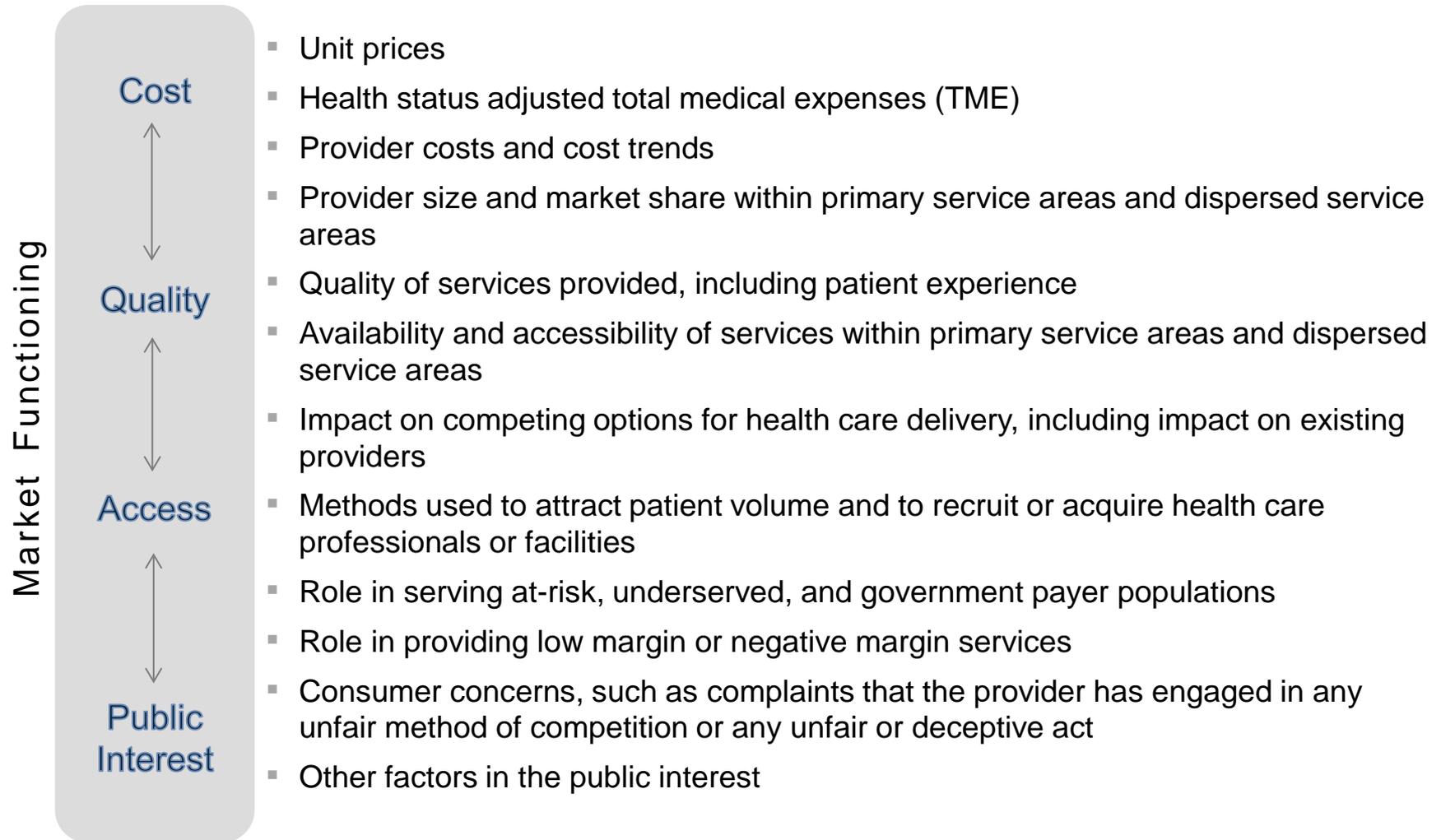
INPUTS

- 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



The HPC's review is focused on cost, quality, and access and includes both quantitative and qualitative analysis

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

Types of transactions noticed

April 2013 to Present

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

Contact Information

**For more information about the
Massachusetts Health Policy Commission:**

Contact Us:

Executive Director David Seltz

david.seltz@state.ma.us

Chief of Staff Coleen Elstermeyer

coleen.elstermeyer@state.ma.us

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