MASSACHUSETTS
HEALTH POLICY COMMISSION

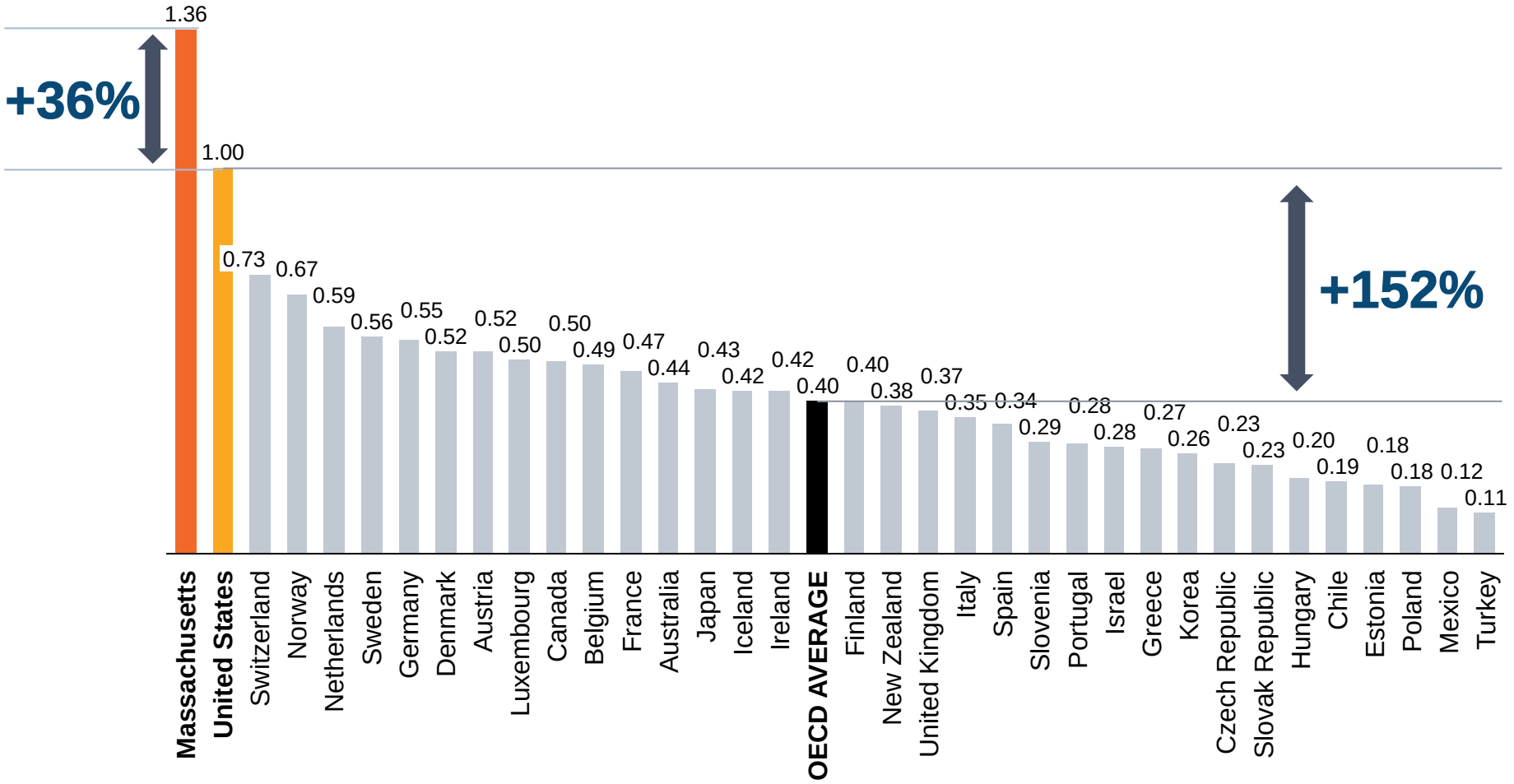
Introduction to the Health Policy Commission

Massachusetts Health Policy Forum's Student Forum

January 11, 2019

In 2009, Massachusetts had the highest per capita spending on health care of any state in the U.S. and the U.S. spends the most per capita of any OECD country

Per capita health care expenditures, indexed to U.S. average



Note: OECD country wide averages indexed to US average spending 2013 (or most recent year) expenditure on health, per capita, US$ purchasing power parities (2012 is most recent year available for countries denoted by *). MA per capita spending is from Health Care Expenditures per Capita by State of Residence from 2009 and indexed to US Health Care Expenditures per Capita by State of Residence from 2009.

Source: OECD Health Statistics 2014 - Frequently Requested Data; KFF, "Health Care Expenditures per Capita by State of Residence", 2009

Chapter 224 of the Acts of 2012 established the HPC and a target for reducing health care spending growth in Massachusetts.

Chapter 224 of the Acts of 2012

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

GOAL

Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

A **transparent** and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for the people of the Commonwealth.

HPC

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%**
  - Health care cost growth benchmark for 2018-2020 equals **3.1%**

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

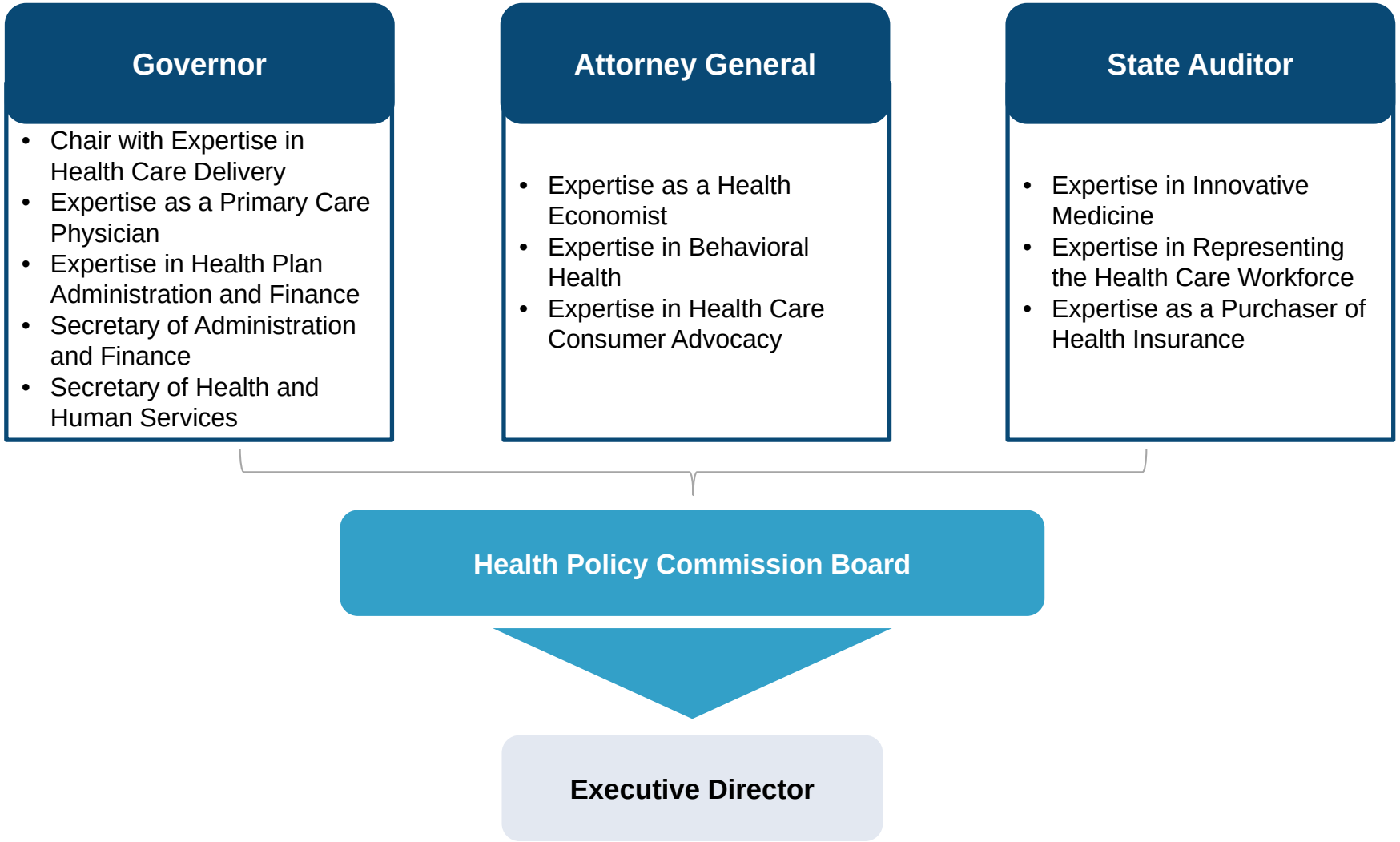
TOTAL HEALTH CARE EXPENDITURES

- **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

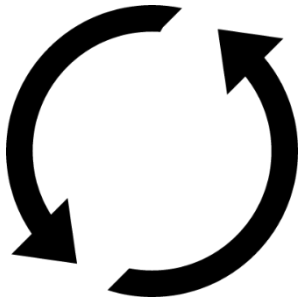
HPC

The HPC: Governance Structure



The HPC promotes two priority policy outcomes that contribute to reducing health care spending, improving quality, and enhancing access to care.

Strengthen market functioning and system transparency



The two policy priorities reinforce each other toward the ultimate goal of reducing spending growth

Promoting an efficient, high-quality delivery system with aligned incentives

HPC

The HPC employs four core strategies to advance its mission.

RESEARCH AND REPORT

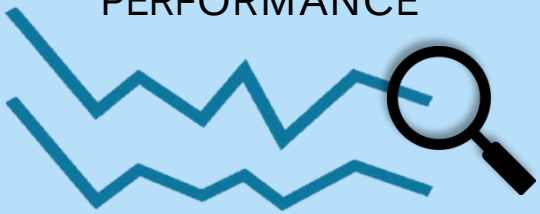
INVESTIGATE, ANALYZE, AND REPORT TRENDS AND INSIGHTS

CONVENE

BRING TOGETHER STAKEHOLDER COMMUNITY TO INFLUENCE THEIR ACTIONS ON A TOPIC OR PROBLEM

WATCHDOG

MONITOR AND INTERVENE WHEN NECESSARY TO ASSURE MARKET PERFORMANCE



PARTNER

ENGAGE WITH INDIVIDUALS, GROUPS, AND ORGANIZATIONS TO ACHIEVE MUTUAL GOALS

The HPC: Main Responsibilities

- Monitor system transformation in the Commonwealth and cost drivers therein
- Make investments in innovative care delivery models that address the whole-person needs of patients and accelerate health 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

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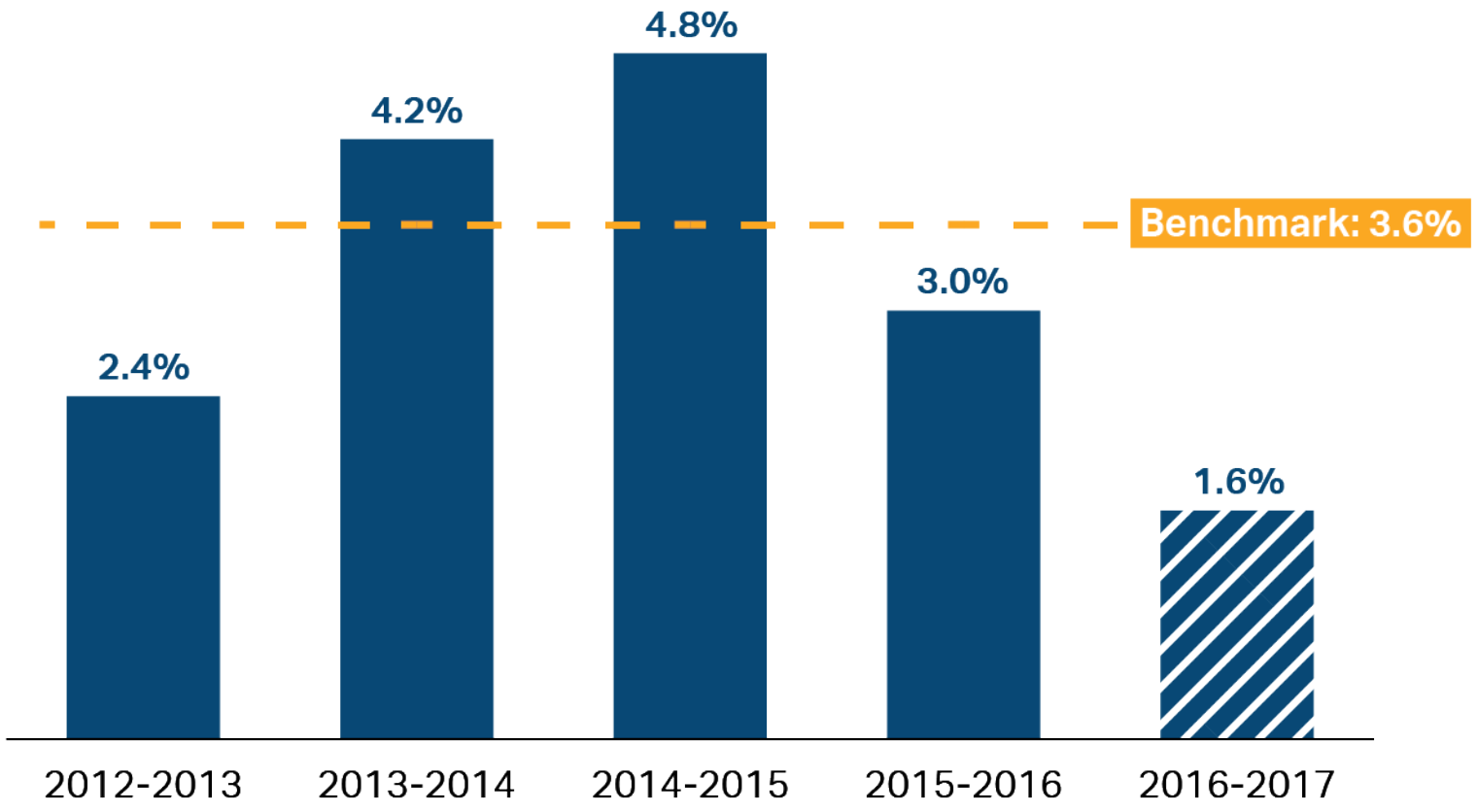
Growth in total health care spending was 1.6% from 2016-2017, significantly below the health care cost growth benchmark

Annual growth in total health care expenditures per capita in Massachusetts

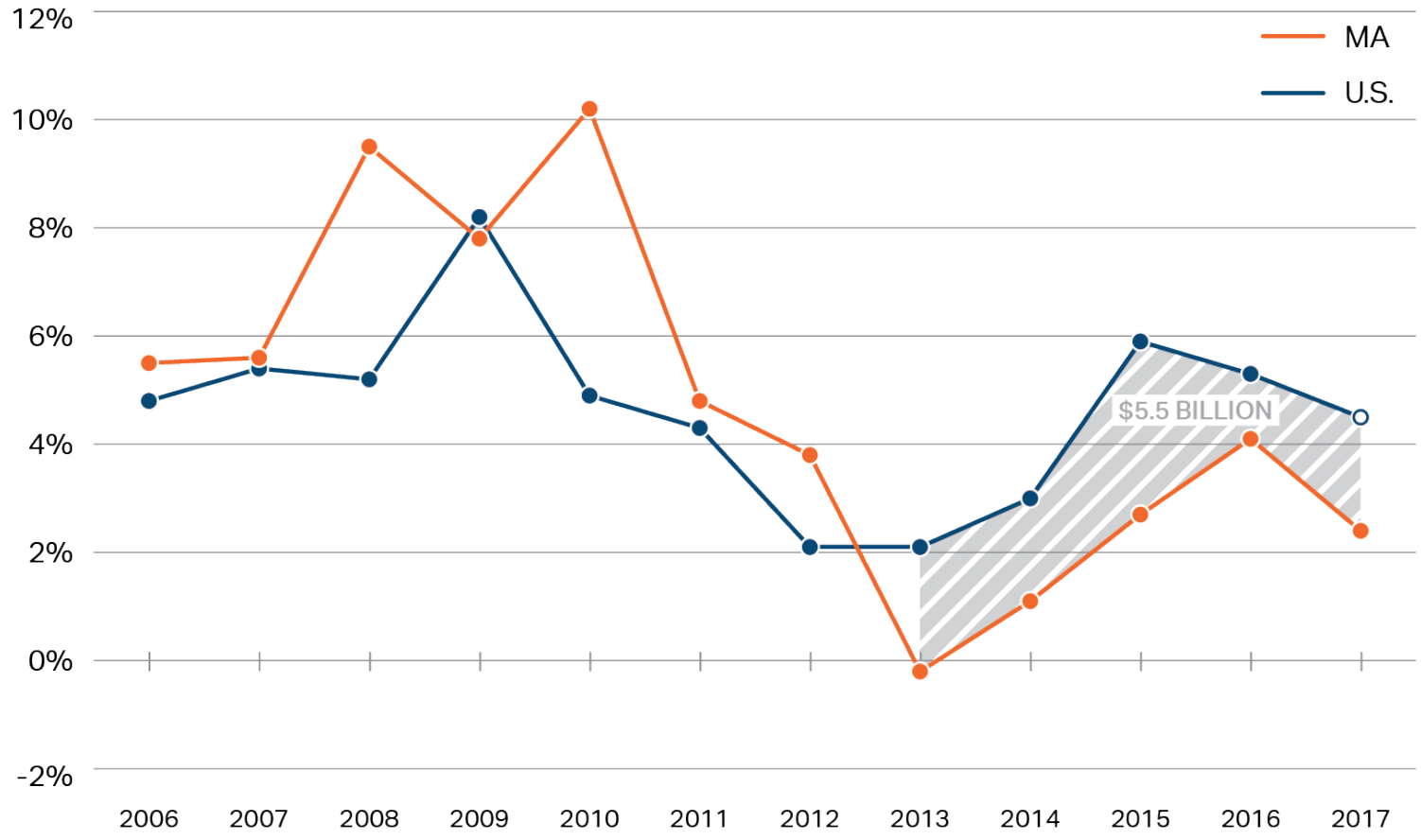


Annual growth averaged 3.2% between 2012 and 2017

Notes: 2016-2017 spending growth is preliminary.
Sources: Center for Health Information and Analysis Annual Report, 2018

Commercial spending growth in Massachusetts has been below the national rate since 2013, generating billions in avoided spending

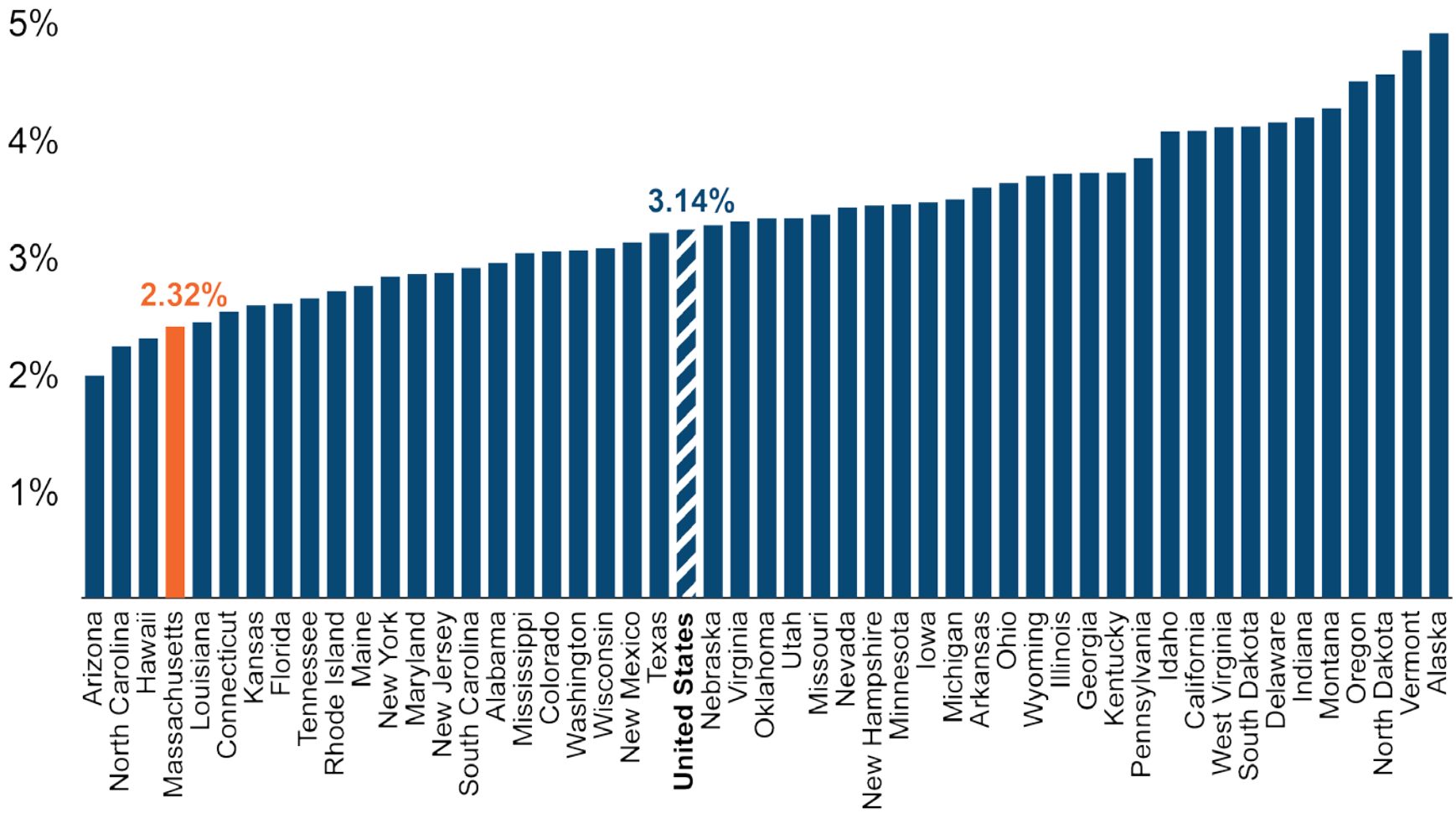
Annual growth in commercial spending per enrollee, MA and the U.S., 2006-2017



Notes: US data includes Massachusetts. US and MA figures for 2017 are preliminary.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data (U.S. 2014-2017) and State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); Center for Health Information and Analysis Annual Report TME Databooks (MA 2014-2017).

MA healthcare spending grew at the 4th lowest rate in the U.S. from 2009-2014

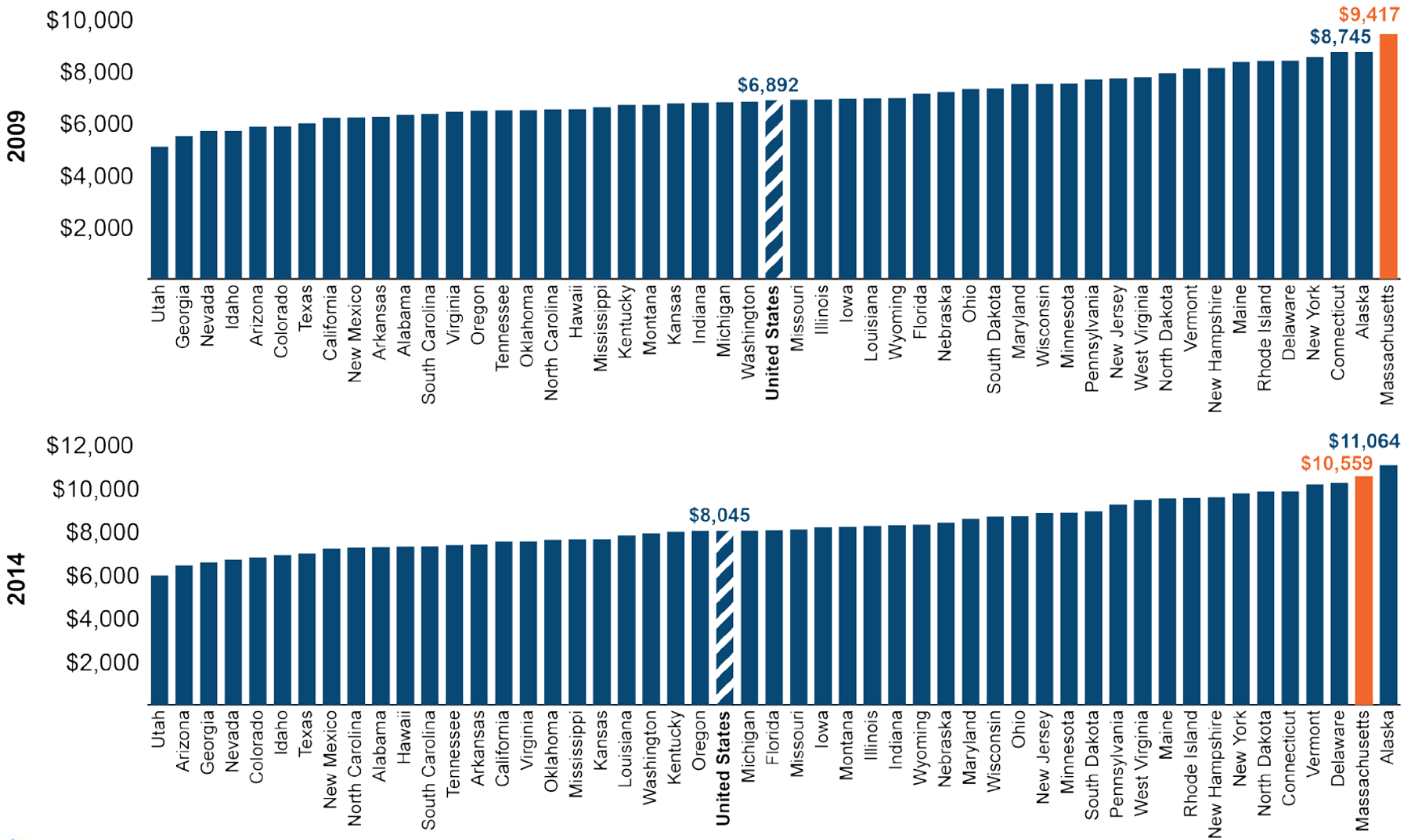
Average annual healthcare spending growth rate, per capita, 2009-2014



Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

Massachusetts no longer spends the most on health care! (We're #2)

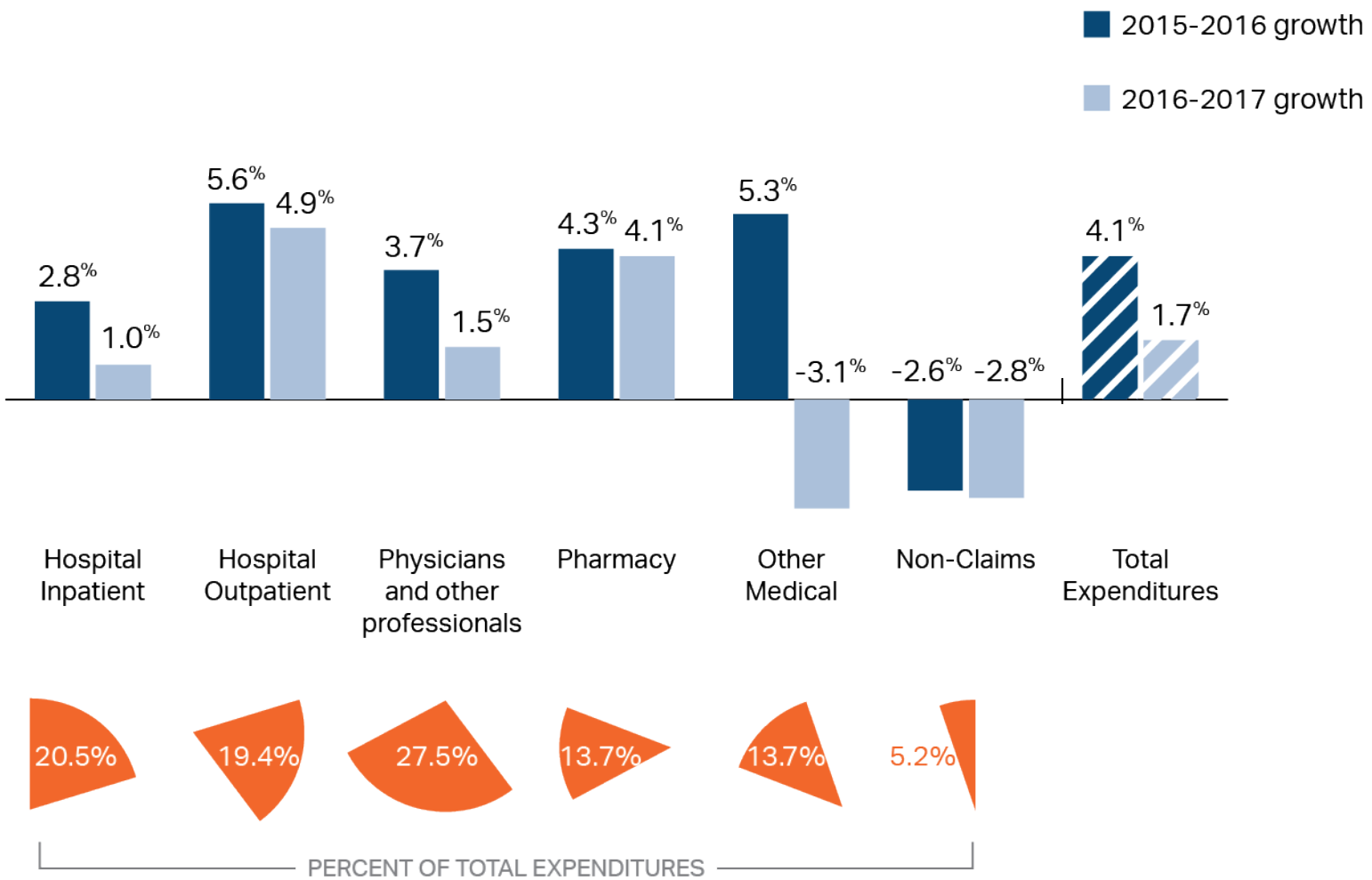
Personal health care spending, per capita, by state, 2009 and 2014



Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

Hospital outpatient and pharmacy spending were the fastest-growing categories in 2016 and 2017

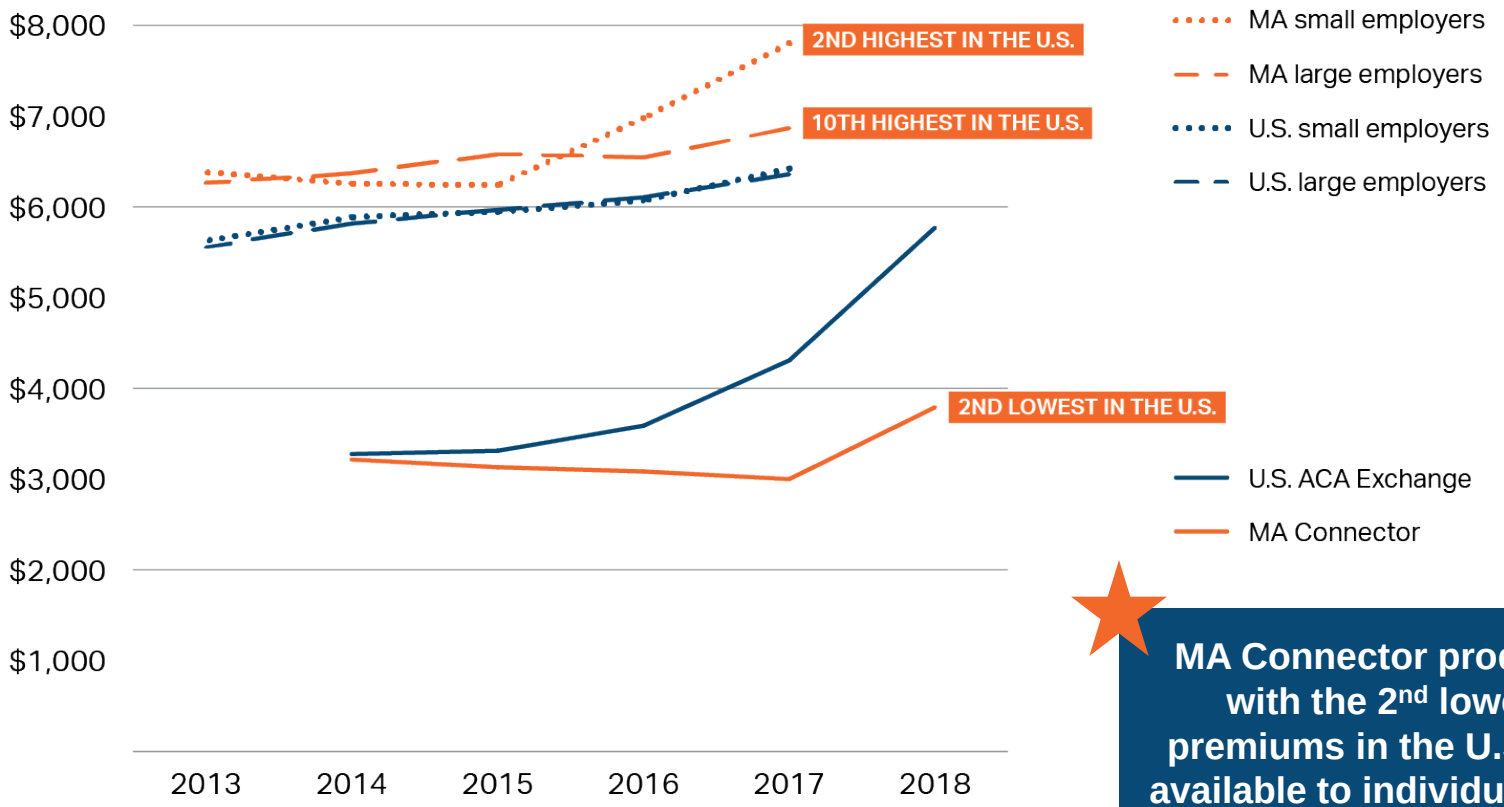
Rates of spending growth in Massachusetts in 2016 and 2017 by category, all payers



Notes: Total expenditures exclude net cost of private health insurance, VA and Health Safety Net. Pharmacy spending is net of rebates. Other medical category includes long-term care, dental and home health and community health. Non-claims spending represents capitation-based payments.
Source: Payer reported TME data to CHIA and other public sources; appears in Center for Health Information and Analysis Annual Report, 2018

Insurance premiums for large Massachusetts employers are 10th highest in the U.S. (down from 2nd highest in 2013), though premiums for small employers have risen recently

Annual premiums for single coverage in the employer market and average annual unsubsidized benchmark premium for a 40-year-old in the ACA Exchanges, MA and the U.S., 2013-2018



MA Connector products, with the 2nd lowest premiums in the U.S., are available to individuals and small employers

Notes: US data include Massachusetts. Employer premiums are based on the average premium according to a large sample of employers within each state. Small employers are those with less than 50 employees; large employers are those with 50 or more employees. Exchange data represent the weighted average annual premium for the second-lowest silver (Benchmark) plan based on county level data in each state. These plans have an actuarial value of 70%, compared to 85%-90% for a typical employer plan, and are thus not directly comparable to the employer plans without adjustment.
Sources: Kaiser Family Foundation analysis of premium data from healthcare.gov (marketplace premiums 2014-2018); US Agency for Healthcare Quality, Medical Expenditure Panel Survey (commercial premiums 2013-2017)

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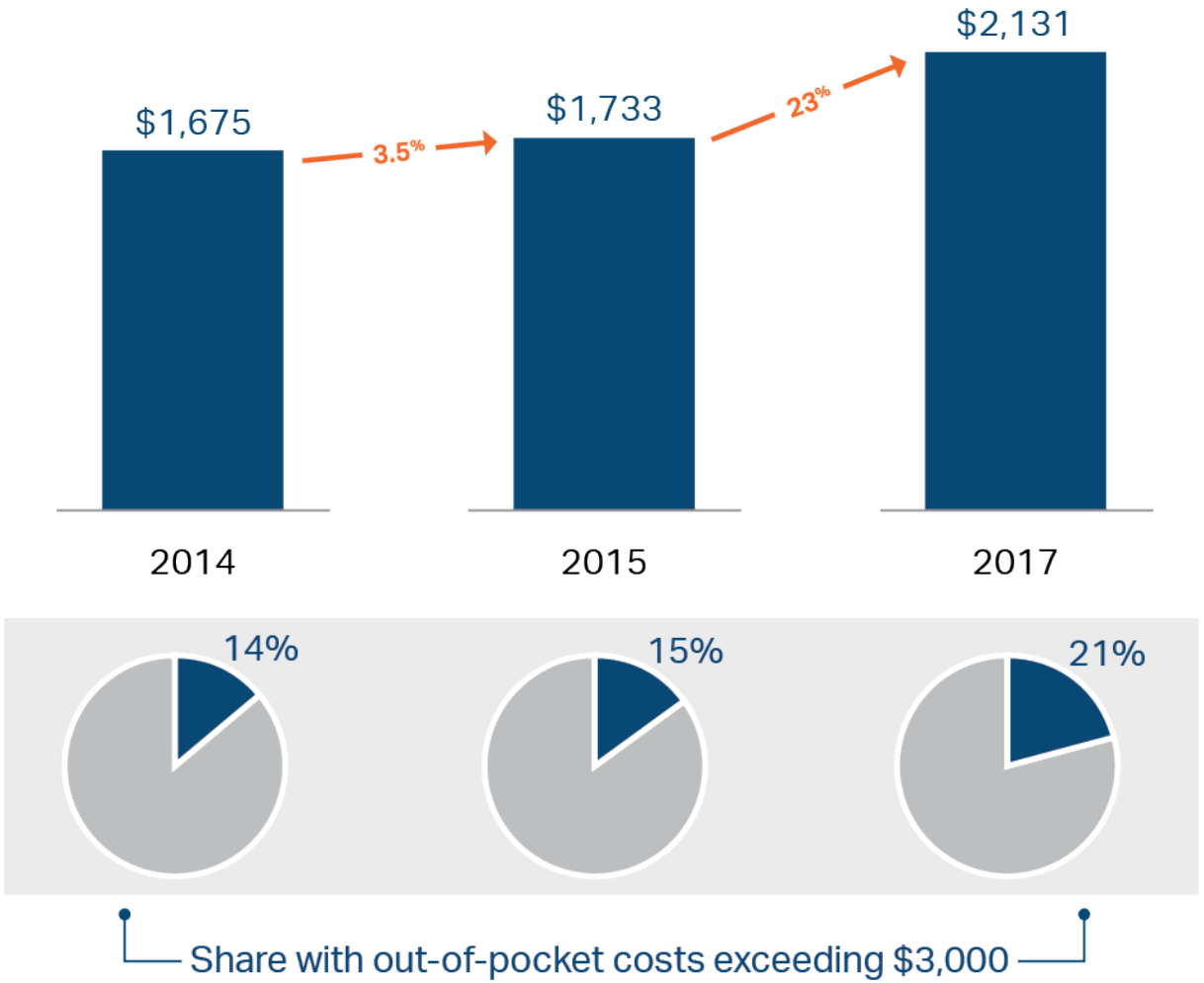
Commercially insured residents experienced a sharp increase in out-of-pocket spending between 2015 and 2017

Out-of-pocket spending per year for enrollees with commercial insurance, 2014, 2015 and 2017

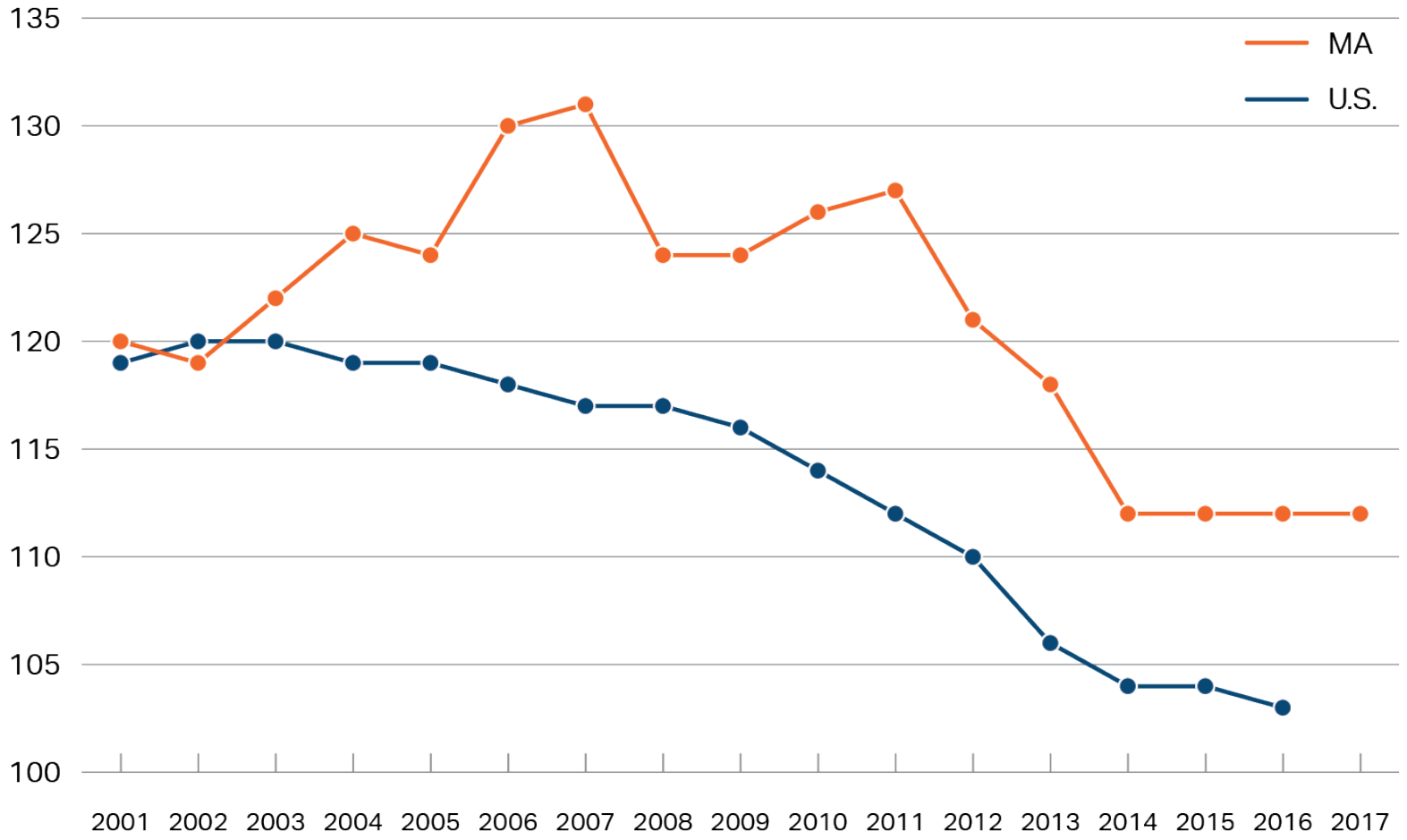


Notes: Out-of-pocket spending is defined as the amount of health care costs a respondent paid in the past 12 months, that was not covered by any insurance or special assistance they may have. Averages shown are conditional on having non-zero out of pocket spending to maintain data consistency across years of survey data.

Sources: HPC analysis of Massachusetts Health Interview Survey, 2014-2017

Overall Massachusetts inpatient hospital use is unchanged since 2014 and continues to exceed the U.S. average

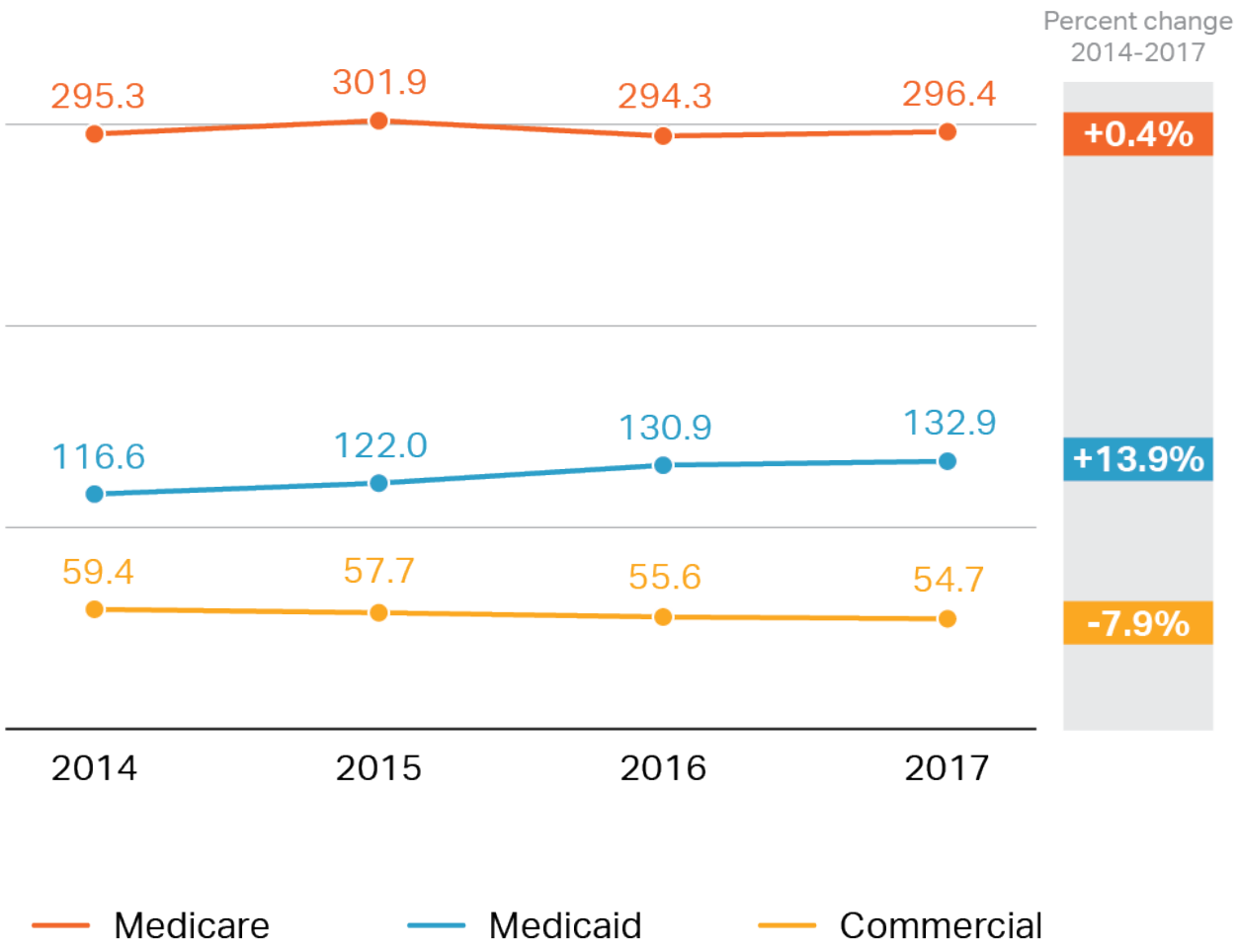
Inpatient hospital discharges per 1,000 residents, Massachusetts and the U.S., 2001-2017



Notes: US data include Massachusetts. Massachusetts' 2017 data is based on HPC's analysis of Center for Health Information and Analysis discharge data.
Sources: Kaiser Family Foundation analysis of American Hospital Association data (U.S., 2001-2016), HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2017)

Inpatient hospital use has declined 8% among commercially-insured residents since 2014

Inpatient hospital discharges per 1,000 enrollees by payer, 2014 - 2017

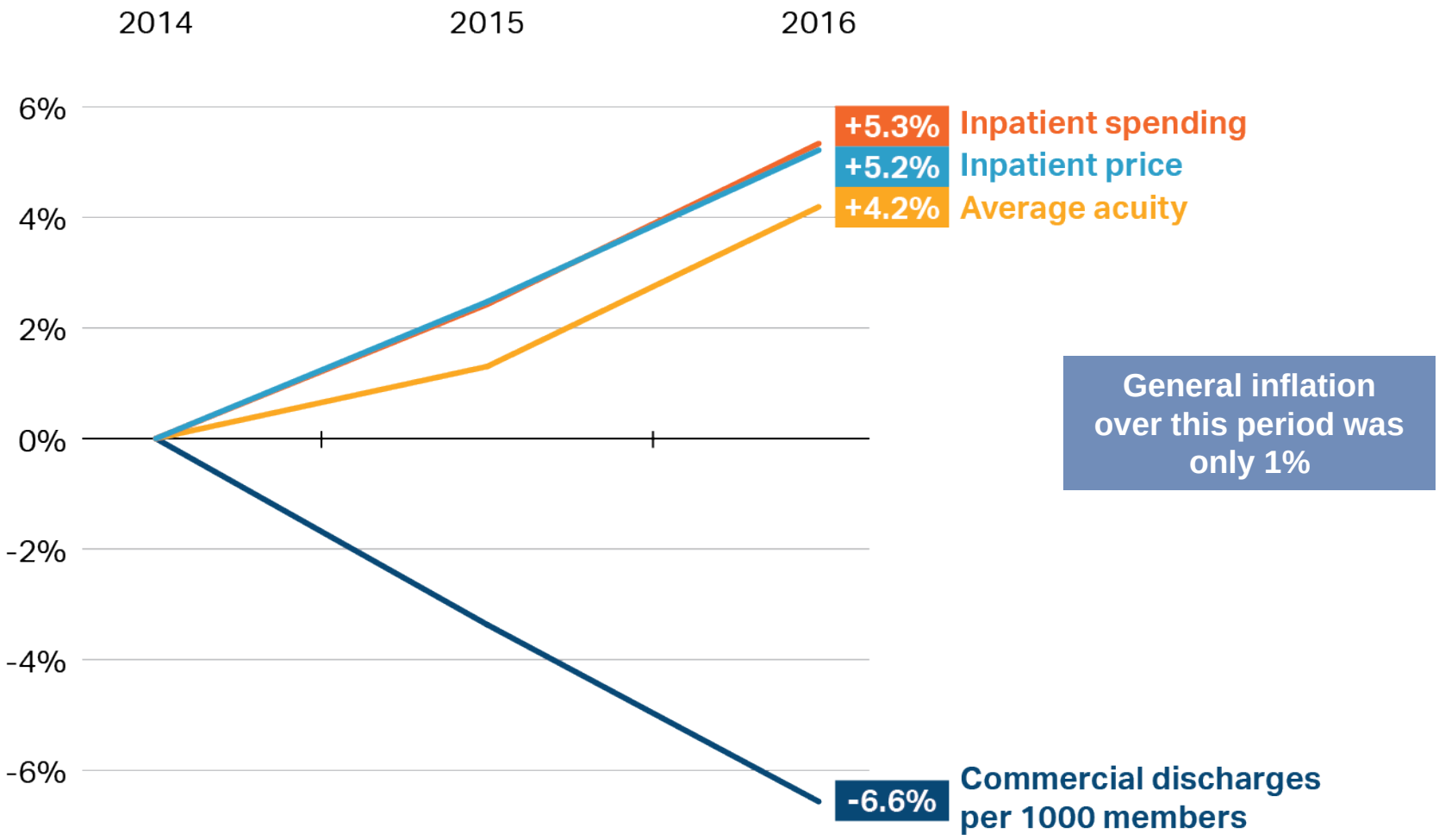


Notes: Out of state residents are excluded from the analysis.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (2014 - 2017). Center for Health Information and Analysis Enrollment Databook 2018.

Although commercial inpatient utilization has declined, inpatient spending has continued to increase, driven by increasing prices and average acuity

Change in average commercial inpatient prices, utilization, acuity, and spending, 2014-2016

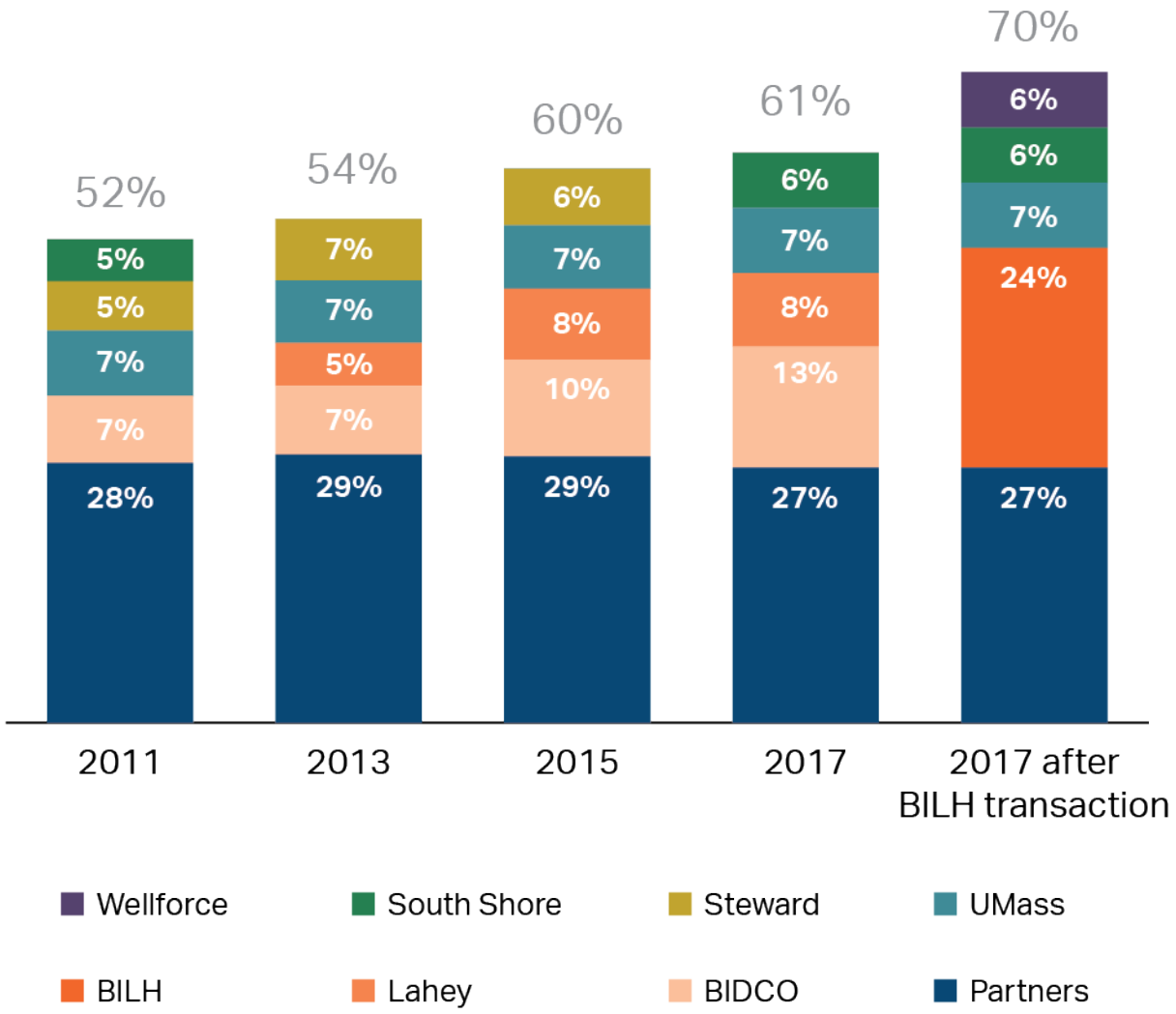


Notes: Price analysis includes facility portion only, adjusted for changes in acuity and provider mix over time, and excludes claims with invalid payment codes, outlier claims at each hospital, and some maternity claims for which discharge of mother and newborn cannot be distinguished. Commercial TME trend represents facility payments to the three larges commercial payers in MA, acuity trend was calculated for all commercial discharges using Medicare DRG case weights, and discharge trend is per 1000 commercial members for all commercial payers.

Sources: HPC analysis of All-Payer Claims Database, 2016; CHIA hospital discharge data sets for 2014-2016; CHIA Total Medical Expense files.

After the formation of Beth Israel Lahey Health, the top five health systems will account for 70% of all commercial inpatient stays statewide, continuing a multi-year trend of increasing concentration

Share of commercial inpatient discharges in the five largest hospital systems in each year, 2011 - 2017



Notes: Percentages represent each system's share of commercial inpatient hospital discharges provided in Massachusetts for general acute care services. Discharges for normal newborns, non-acute services, and out-of-state patients are excluded.
Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database (2011-2017)

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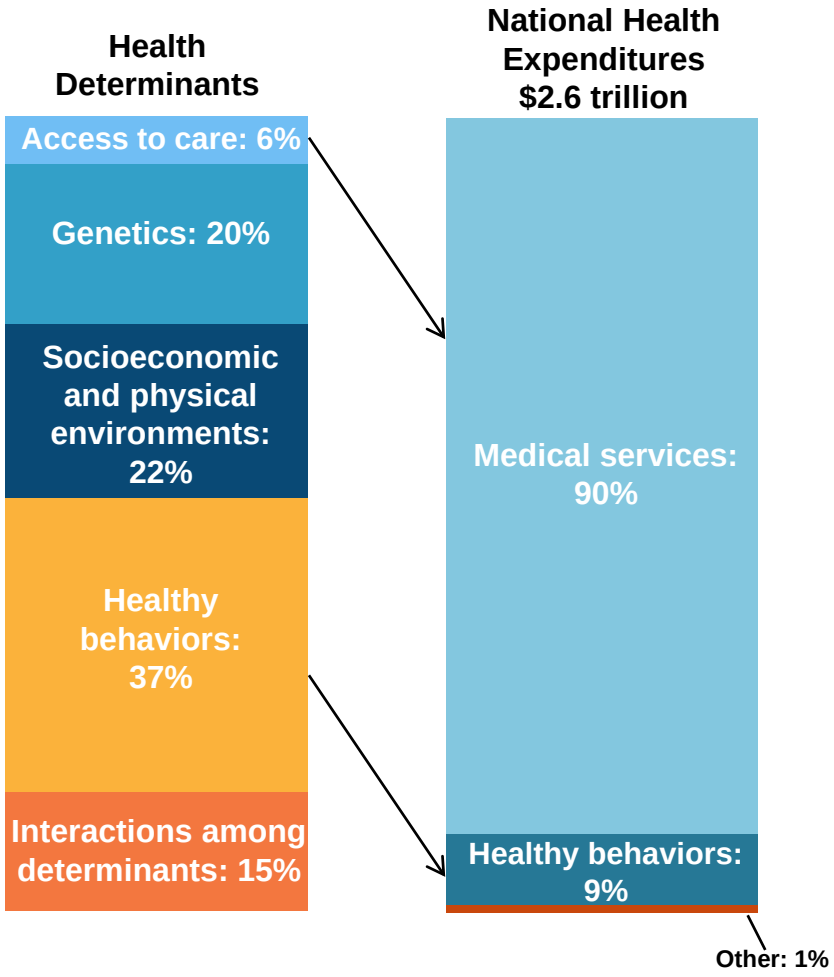
Social determinants account for a significant proportion of health determinants, yet health spending does not match this reality



Patients with high utilization have:

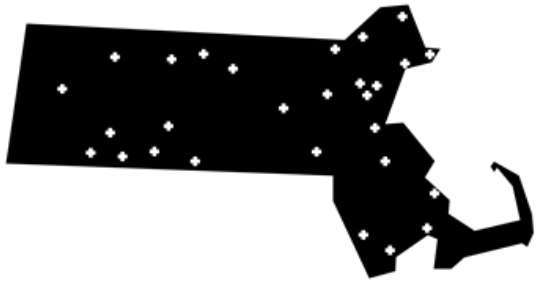
- **Lower socioeconomic status**
- **Higher rates of Medicaid coverage**
- **One or more chronic diseases, including behavioral health conditions**

To better address high utilization in the ED and hospital, care delivery models can address the social determinants of health:

- **Economic stability**
- **Housing**
- **Nutrition**
- **Education**
- **Community supports**

Sources: NEHI and University of California, San Francisco, 2013; Johnson et al. (2015). For many patients who use large amounts of health care services, the need is intense yet temporary. *Health Affairs*, *34*(8), 1312-1319; Schroeder, S. (2007). We can do better—improving the health of the American people. *New England Journal of Medicine* 357(12),1221-1228; Vinton et al. (2014). Frequent users of US emergency departments: characteristics and opportunities for intervention. *Emergency Medicine Journal*, *31*(7), 526-532.

Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment Program: Phase 2 by the numbers



$60 million | **24 months**

27 hospitals implementing

25 projects

Phase 2 awardees serve patient populations that include, e.g.:

- Patients with high utilization of the hospital and/or ED
  - ***example:*** *≥ 4 inpatient admissions or ≥ 6 ED visits in the last 12 months*
- Patients with a behavioral health diagnosis
  - ***example:*** *primary or secondary behavioral health diagnosis, including substance use disorder*

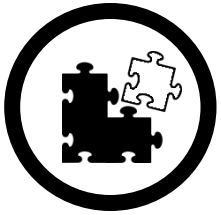
With the goal of achieving primary aims that include, e.g.:

- Reducing unnecessary hospital utilization
  - ***example:*** *reduce 30-day readmissions by 20%*
- Reducing avoidable ED utilization
  - ***example:*** *reduce 30-day ED revisits by 10%*
  - ***example:*** *reduce ED length of stay by 10%*

HPC

Note: These are examples only and are not an exhaustive representation of all CHART Phase 2 target populations and aim statements.

Transformation highlights in CHART Phase 2

Traditional care	vs.	Transformed care through CHART
Hospital-centric, medical model		Whole-person continuum of care
Focus on in-hospital care		Sustained community engagement
Specialization in silos		Collaboration extends beyond silos
Data use limited		Enabling technology investment

The Health Care Innovation Investment Program

The Health Care Innovation Investment Program: $11.3M investing in innovative projects that further the HPC's goal of **better health and better care at a lower cost**

Health Care Innovation Investment Program
Round 1 – Three Pathways

	Targeted Cost Challenge Investments (TCCI)	Telemedicine Pilots	Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions
Target Populations:	8 diverse cost challenge areas: 	Patients from the following categories with Behavioral Health needs: 1. Children and Adolescents 2. Older Adults Aging in Place 3. Individuals with Substance Use Disorders (SUDs)	Pregnant women with Opioid Use Disorder (OUD) and substance-exposed newborns 

SHIFT-Care: Two funding tracks to reduce avoidable acute care use

FUNDING TRACK 1: Addressing health-related social needs

- Support for innovative models that **address health-related social needs** (i.e., social determinants of health) of complex patients in order to prevent a future acute care hospital visit or stay (e.g., respite care for patients experiencing housing instability at time of discharge)

FUNDING TRACK 2: Addressing behavioral health needs

- Support for innovative models that **address the behavioral health care needs** of complex patients in order to prevent a future acute care hospital visit or stay (e.g. expand access to timely behavioral health services using innovative strategies such as telemedicine and/or community paramedicine)

OUD FOCUS: Enhancing opioid use disorder (OUD) treatment

- Support for innovative models that enhance opioid use disorder treatment by **initiating pharmacologic treatment in the ED** and connecting patients to community based BH services (Section 178 of ch. 133 of the Acts of 2016 directed the HPC to invest not more than $3 million in this focus area)

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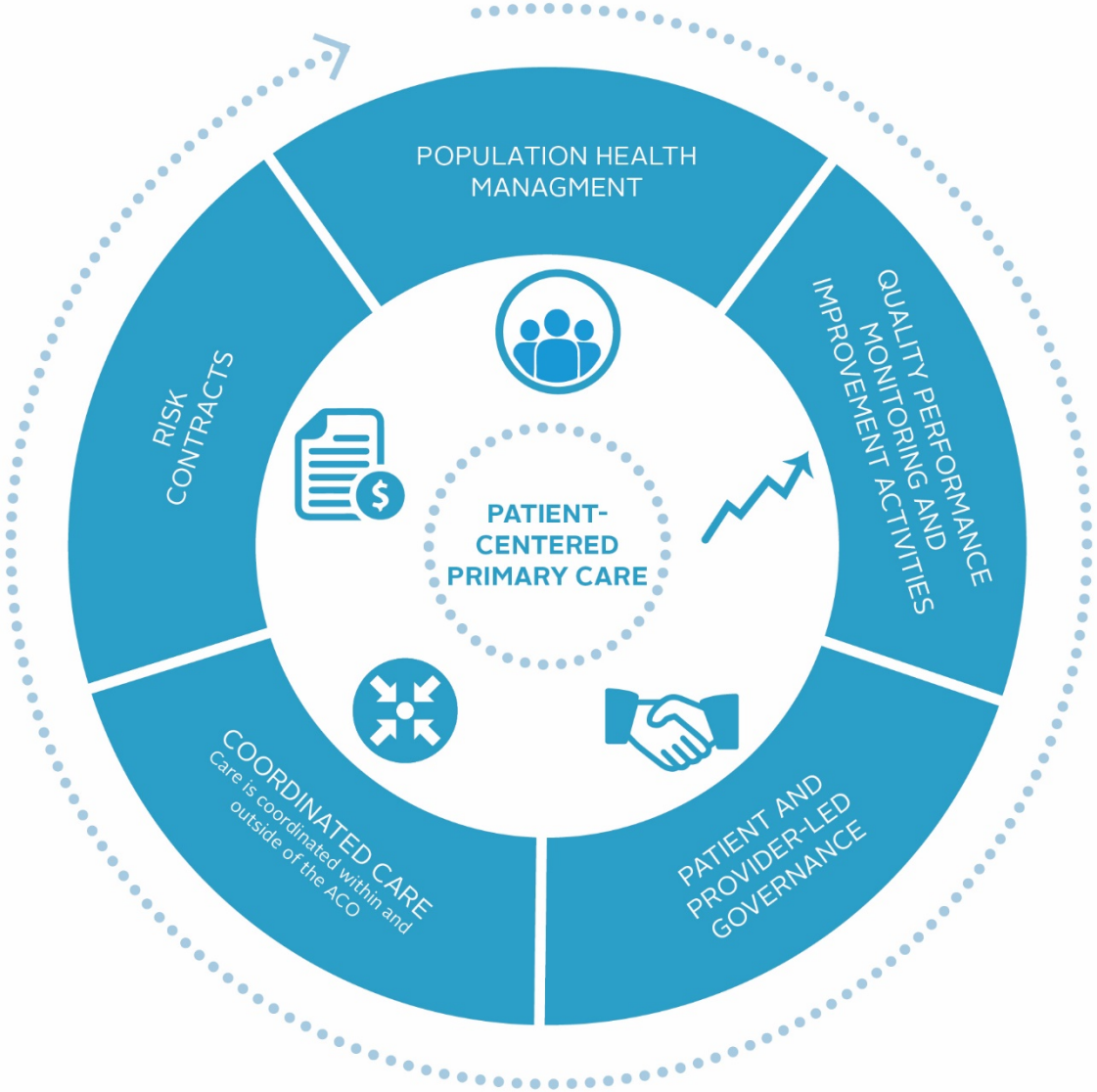
Health Policy Commission Care Delivery Vision

The vision of the HPC's care delivery transformation is that providers and payers are patient-centered and accountable for high-value care across a patient's medical, behavioral, and health-related social needs.

ACO Certification Program Values

- Support the HPC's **care delivery vision** through certification standards-setting
- Encourage ACOs to **work with non-medical providers** in the community as needed to support the full spectrum of patient needs
- Commit to regular **assessment of the program** to ensure continuous improvement and market value
- Increase **public transparency** while balancing administrative burden for providers in Massachusetts

What is an HPC-Certified ACO?



HEALTH POLICY COMMISSION
ACO
CERTIFIED
– 2017 –

What is an HPC-Certified ACO?

An HPC-Certified ACO is a group of healthcare providers that meets certain care delivery standards designed to promote patient-centered care. ACOs contract with payers to assume responsibility for the delivery of care and outcomes for their patients, typically in alternative or value-based payment models that encourage ACO providers to work together in innovative ways to meet quality improvement and efficiency goals.

ACO Certification aims to promote ongoing transformation and improvement over time

Current market

- Multiple ACO programs in the market
  - Medicare ACOs (i.e., MSSP, Next Gen)
  - Commercial programs (e.g., BCBSMA's AQC)
  - MassHealth ACOs
- Evidence on the relationship between ACO capabilities and outcomes is still developing

Initial focus of HPC ACO Certification

- Create a set of **multi-payer standards** for ACOs to enable care delivery transformation and payment reform
- Build **knowledge and transparency** about ACO approaches
- Facilitate **learning** across the care delivery system
- Align with and complement **other standards and requirements** in the market, including MassHealth, Connector, and Dept of Public Health (DPH) requirements

Vision for Future Certification

- Develop the **evidence base** on how ACOs achieve improvements in quality, cost and patient experience
- Move certification standards from structural/process requirements to **quality outcomes and cost performance requirements**
- Encourage additional payers and purchasers to adopt certification standards

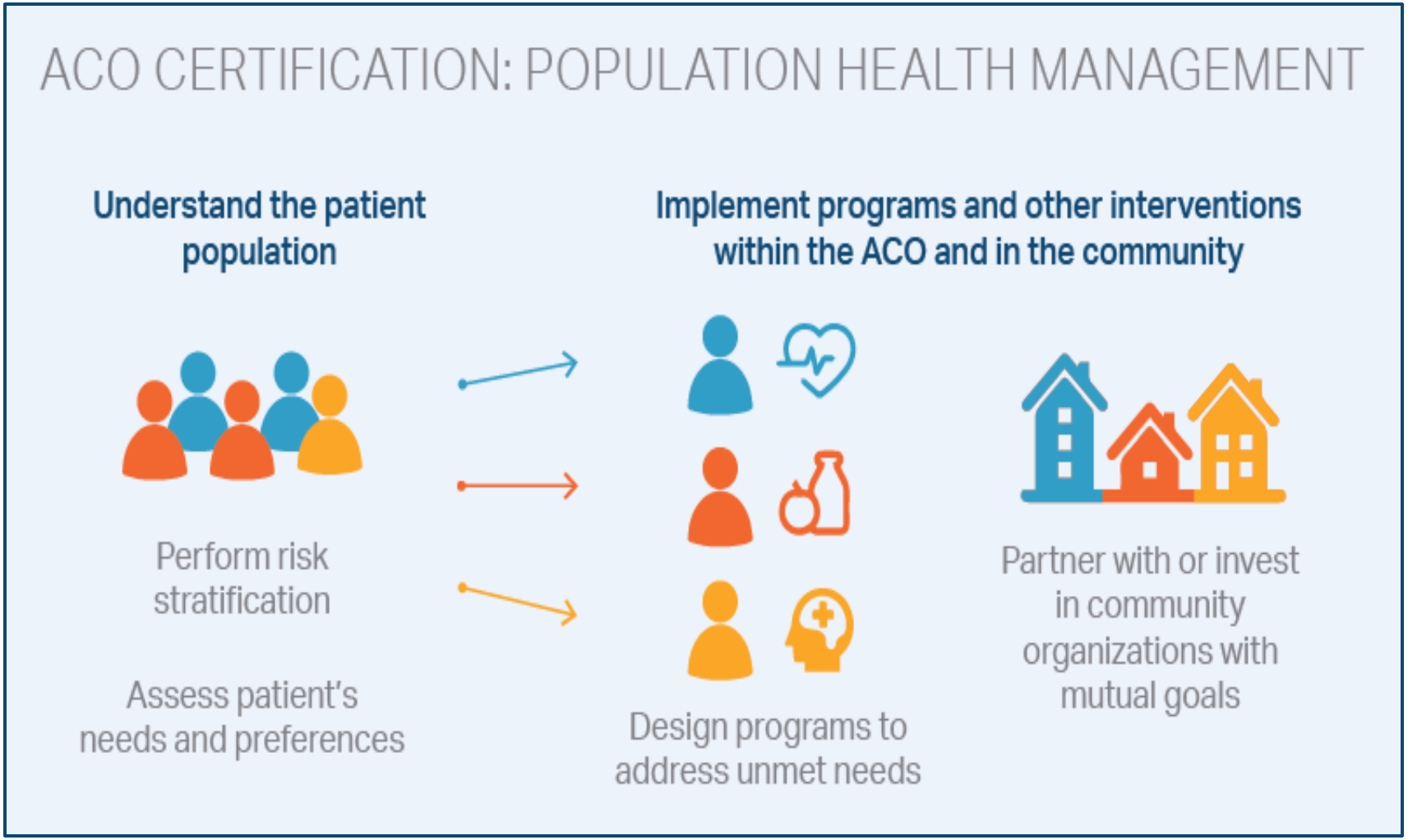
HPC

The HPC has certified 18 ACOs

Certified ACOs

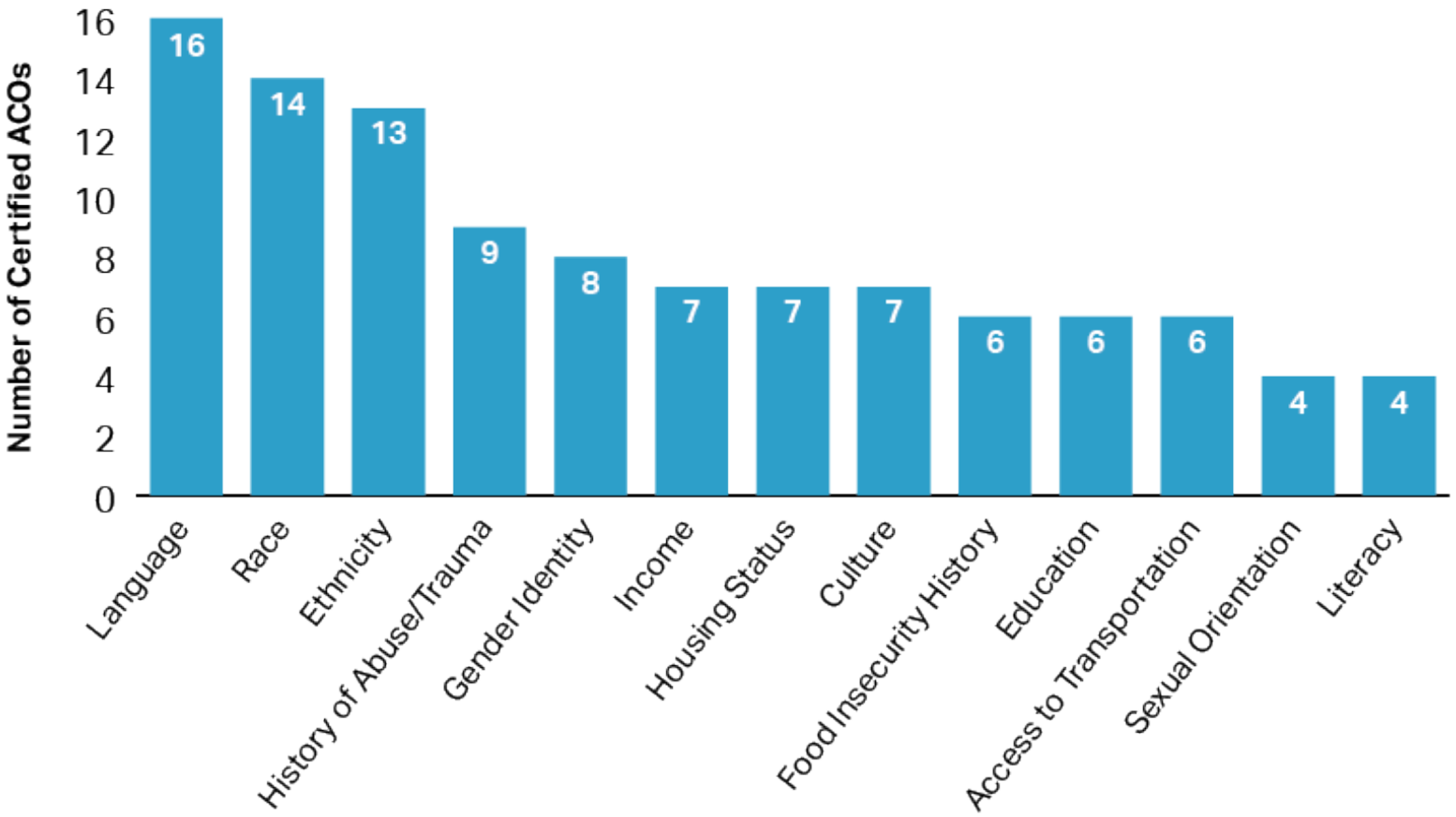
- Atrius Health, Inc.
- Baycare Health Partners, Inc.
- Beth Israel Deaconess Care Organization
- Boston Accountable Care Organization, Inc.
- Cambridge Health Alliance
- Children's Medical Center Corporation
- Community Care Cooperative, Inc.
- Health Collaborative of the Berkshires, LLC
- Lahey Health System, Inc.
- The Mercy Hospital, Inc.
- Merrimack Valley Accountable Care Organization, LLC
- Mount Auburn Independent Practice Association
- Partners HealthCare System, Inc.
- Reliant Medical Group, Inc.
- Signature Healthcare
- Southcoast Health System, Inc.
- Steward Health Care Network, Inc.
- Wellforce, Inc.

Key Findings from "How ACOs in MA Manage their Population Health"



Key Findings from “How ACOs in MA Manage their Population Health”

Patient Population Factors Assessed by HPC-certified ACOs



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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 hospital 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
Median 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 (CMIRs)

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

Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Clinical affiliation	22	23%
Physician group merger, acquisition or network affiliation	20	21%
Acute hospital merger, acquisition or network affiliation	19	20%
Formation of a contracting entity	17	18%
Merger, acquisition or network affiliation of other provider type (e.g., post-acute)	11	12%
Change in ownership or merger of corporately affiliated entities	5	5%
Affiliation between a provider and a carrier	1	1%

Contact Information

For more information about the Health Policy Commission

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