Introduction to the Health Policy Commission

Massachusetts Health Policy Forum
April 6, 2018
In 2009, Massachusetts had the highest per capita spending on health care of any state 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.

A large amount of patients traveled to the Metro Boston area to receive care

Number of inpatient discharges for non-transfer, non-emergency volume, 2012

* Discharges at hospitals in region for patients who reside outside of region
† Discharges at hospitals outside of region for patients who reside in region

SOURCE: Center for Health Information and Analysis; HPC analysis
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.
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 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
Implementing State Agencies

Center for Health Information and Analysis (CHIA)

- **Data hub**
  - 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 hub**
  - 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: Governance Structure

**Governor**
- Chair with Expertise in Health Care Delivery
- Expertise as a Primary Care Physician
- Expertise in Health Plan Administration and Finance
- Secretary of Administration and Finance
- Secretary of Health and Human Services

**Attorney General**
- Expertise as a Health Economist
- Expertise in Behavioral Health
- Expertise in Health Care Consumer Advocacy

**State Auditor**
- Expertise in Innovative Medicine
- Expertise in Representing the Health Care Workforce
- Expertise as a Purchaser of Health Insurance

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

Executive Director
*David Seltz*
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

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

The two policy priorities reinforce each other toward the ultimate goal of reducing spending growth.
The HPC employs four core strategies to advance its mission.

- **RESEARCH AND REPORT**
  Investigate, analyze, and report trends and insights.

- **WATCHDOG**
  Monitor and intervene when necessary to assure market performance.

- **CONVENE**
  Bring together stakeholder community to influence their actions on a topic or problem.

- **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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Total health care expenditures (THCE) per capita grew 2.8% in 2016, below the benchmark rate.

Annual per-capita total health care expenditure growth in Massachusetts, 2012-2016

Average annual spending growth from 2012-2016: 3.55%

Notes: 2015-2016 growth is preliminary. All other years represent final data.
Sources: Center for Health Information and Analysis, Total Health Care Expenditures
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
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
In recent years, growth in spending on private health insurance in Massachusetts has been consistently lower than national rates

Annual growth in commercial health insurance premium spending from previous year, per enrollee, MA and the U.S.

Notes: U.S. data includes Massachusetts. Center for Health Information and Analysis data are for the fully-insured market only. U.S. data for 2016 is partially projected.

Source: Centers for Medicare and Medicaid Services, State and National Healthcare Expenditure Accounts and Private Health Insurance Expenditures and Enrollment (U.S. and MA 2005-2014); Center for Health Information and Analysis Annual Reports (MA 2015-2016)
Among categories of care, pharmacy drugs and hospital outpatient spending grew the fastest in 2016

Change in all-payer spending 2014-2015 and 2015-2016 by category of care

Notes: Pharmacy spending is net of rebates.

Source: Payer reported TME data to CHIA and other public sources; appears in Center for Health Information and Analysis Annual Report, 2017.
Behavioral-health related ED visits have steadily increased since 2011 even as total ED visits have remained steady

All ED visits, avoidable ED and behavioral health ED visits per 1,000 residents, 2011-2016

Notes: Low-acuity avoidable ED visits are based on the Medi-Cal avoidable ED visit definition, a conservative definition that may under-report avoidable ED utilization. Behavioral health ED visits were identified based on principal diagnosis using the Clinical Classifications Software (CCS) diagnostic classifications. 2016 BH ED visits were identified using Beta-CCS diagnostic classifications, based on ICD-10 codes. Some discontinuity in trends by diagnosis may attributed to the change in diagnostic coding from ICD-9 to ICD-10 in October 2016.

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2016
Since 2011, behavioral health ED visits involving alcohol and SUD diagnoses increased 40% and 54% respectively.

Behavioral health-related ED visits per 1000 residents, 2011 - 2016

Notes: Behavioral health ED visits were identified based on principal diagnosis using the Clinical Classifications Software (CCS) diagnostic classifications. 2016 BH ED visits were identified using Beta-CCS diagnostic classifications, based on ICD-10 codes. Some discontinuity in trends by diagnosis may attributed to the change in diagnostic coding from ICD-9 to ICD-10 in October 2016. Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011 - 2016
Behavioral health patients are increasingly more likely to have an extended length of stay in the ED

Percent of ED visits with a length of stay of more than 12 hours, by primary diagnosis type, 2011-2015

Notes: ED= emergency department; BH=behavioral health. BH ED visits identified using NYU Billings algorithm and include any discharge with a primary mental health, substance abuse, or alcohol-related diagnosis code. Length of stay is calculated as the difference between the point of registration and the point of admission or discharge.

Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2015
The rate of opioid-related discharges more than doubled in East Merrimack and Central Massachusetts and nearly doubled in the Upper North Shore and Cape and Island regions.

Source: HPC analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and Emergency Department Databases, 2011 and 2015
Readmission rates are increasing in Massachusetts while falling elsewhere

Thirty-day readmission rates, MA and the U.S., 2011-2015

Source: Centers for Medicare and Medicaid Services (U.S. and MA Medicare), 2011-2015; Center for Health Information and Analysis (all-payer MA ), 2011-2015
Affordability and access challenges remain in Massachusetts, especially for families with self-reported health problems

Source: HPC analysis of Center for Health Information and Analysis Massachusetts Health Insurance Survey, 2016. All differences are statistically significant at the 10% level (p<.10) or less and all but two (outstanding medical bills and doctor care) are statistically significant at the p<.05 level.
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Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment Program: Phase 2 by the numbers

$60\text{ million} \mid 24\text{ 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*: $\geq 4$ inpatient admissions or $\geq 6$ 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 $10\%$

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
Patient Story 1: Before CHART Engagement

A middle-aged woman with a long and complicated history of substance abuse presented to the ED on a monthly basis. On one occasion, when she arrived to the ED seeking detox treatment, no available bed could be found, and she was released. Days later, she overdosed and was revived at an unaffiliated ED.
Patient Story 1: CHART Intervention

LICSW provided counseling in the hospital

CHART team connected her with behavioral health providers

CHW provided intensive support in the community

Pharmacist provided medication assessment

CHART team attended 90-day sobriety achievement ceremony
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**

<table>
<thead>
<tr>
<th>Targeted Cost Challenge Investments (TCCI)</th>
<th>Telemedicine Pilots</th>
<th>Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target Populations:</strong> 8 diverse cost challenge areas:</td>
<td>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)</td>
<td>Pregnant women with Opioid Use Disorder (OUD) and substance-exposed newborns</td>
</tr>
</tbody>
</table>
Social determinants account for a significant proportion of health determinants, yet health spending does not match this reality.


**Determinants**
- Access to care: 6%
- Genetics: 20%
- Socioeconomic and physical environments: 22%
- Healthy behaviors: 37%
- Interactions among determinants: 15%

**National Health Expenditures**
- Medical services: 90%
- Other: 1%
- Healthy behaviors: 9%
- Interactions among determinants: 15%

**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

Access to care: 6%
Genetics: 20%
Socioeconomic and physical environments: 22%
Healthy behaviors: 37%
Interactions among determinants: 15%
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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Practices Participating in PCMH PRIME

Since January 1, 2016 program launch:

- **78 practices** are PCMH PRIME Certified
- **36 practices** are on the **Pathway to PCMH PRIME**
- **114 Total Practices Participating**
ACOs seeking to participate in the MassHealth ACO program were required by MassHealth to obtain HPC certification by 1/1/2018.

Newly formed ACOs seeking to participate in the MassHealth ACO program were eligible for “Provisional Certification” if they were able to meet certain criteria and demonstrate substantive plans to meet others before ACO program launch.

HPC has collaborated extensively with MassHealth to align components of the certification and bid processes in order to reduce administrative burden.

Alignment without unnecessary duplication
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.
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Examine significant changes in the health care marketplace and their potential impact on cost, quality, access, and market competitiveness
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>
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<tbody>
<tr>
<td>Less competition</td>
</tr>
<tr>
<td>Larger hospital size (above a certain size)</td>
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<tr>
<td>Corporate affiliations with certain systems</td>
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<tr>
<td>Provision of higher-intensity (tertiary) services</td>
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<td>Status as a teaching hospital</td>
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<th>Factors associated with lower commercial prices (Holding all other factors equal)</th>
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<tbody>
<tr>
<td>More Medicare patients</td>
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<tr>
<td>More Medicaid patients</td>
</tr>
<tr>
<td>Corporate affiliations with certain systems</td>
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<tr>
<th>Factors not generally associated with commercial prices (Holding all other factors equal)</th>
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<tbody>
<tr>
<td>Quality</td>
</tr>
<tr>
<td>Median income in the hospital’s service area</td>
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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.

<table>
<thead>
<tr>
<th>WHAT IT IS</th>
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<tbody>
<tr>
<td>▪ Comprehensive, multi-factor review of the provider(s) and their proposed transaction</td>
</tr>
<tr>
<td>▪ Following a preliminary report and opportunity for the providers to respond, the HPC issues a final report</td>
</tr>
<tr>
<td>▪ CMIRs promote transparency and accountability, encouraging market participants to address negative impacts and enhance positive outcomes of transactions</td>
</tr>
<tr>
<td>▪ 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</td>
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<thead>
<tr>
<th>WHAT IT IS NOT</th>
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<tbody>
<tr>
<td>▪ Differs from Determination of Need reviews by Department of Public Health</td>
</tr>
<tr>
<td>▪ Distinct from antitrust or other law enforcement review by state or federal agencies</td>
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## Material Changes Received to Date

<table>
<thead>
<tr>
<th>TYPE OF TRANSACTION</th>
<th>NUMBER</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical affiliation</td>
<td>21</td>
<td>23%</td>
</tr>
<tr>
<td>Physician group merger, acquisition or network affiliation</td>
<td>19</td>
<td>21%</td>
</tr>
<tr>
<td>Acute hospital merger, acquisition or network affiliation</td>
<td>19</td>
<td>21%</td>
</tr>
<tr>
<td>Formation of a contracting entity</td>
<td>16</td>
<td>18%</td>
</tr>
<tr>
<td>Merger, acquisition or network affiliation of other provider type (e.g., post-acute)</td>
<td>9</td>
<td>10%</td>
</tr>
<tr>
<td>Change in ownership or merger of corporately affiliated entities</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>Affiliation between a provider and a carrier</td>
<td>1</td>
<td>1%</td>
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The HPC: Creating A New Government Agency