MASSACHUSETTS
HEALTH POLICY COMMISSION

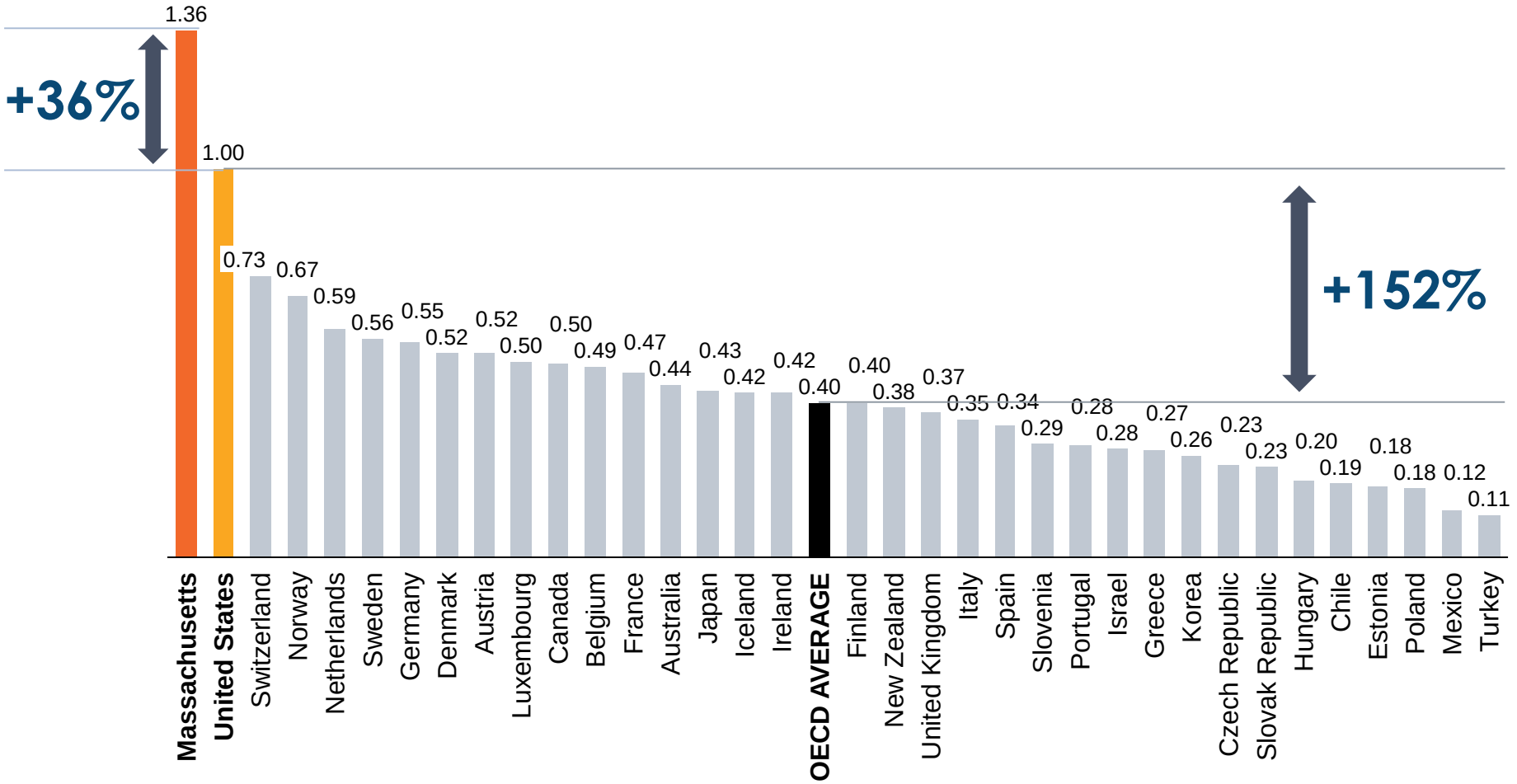
Introduction to the Health Policy Commission

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

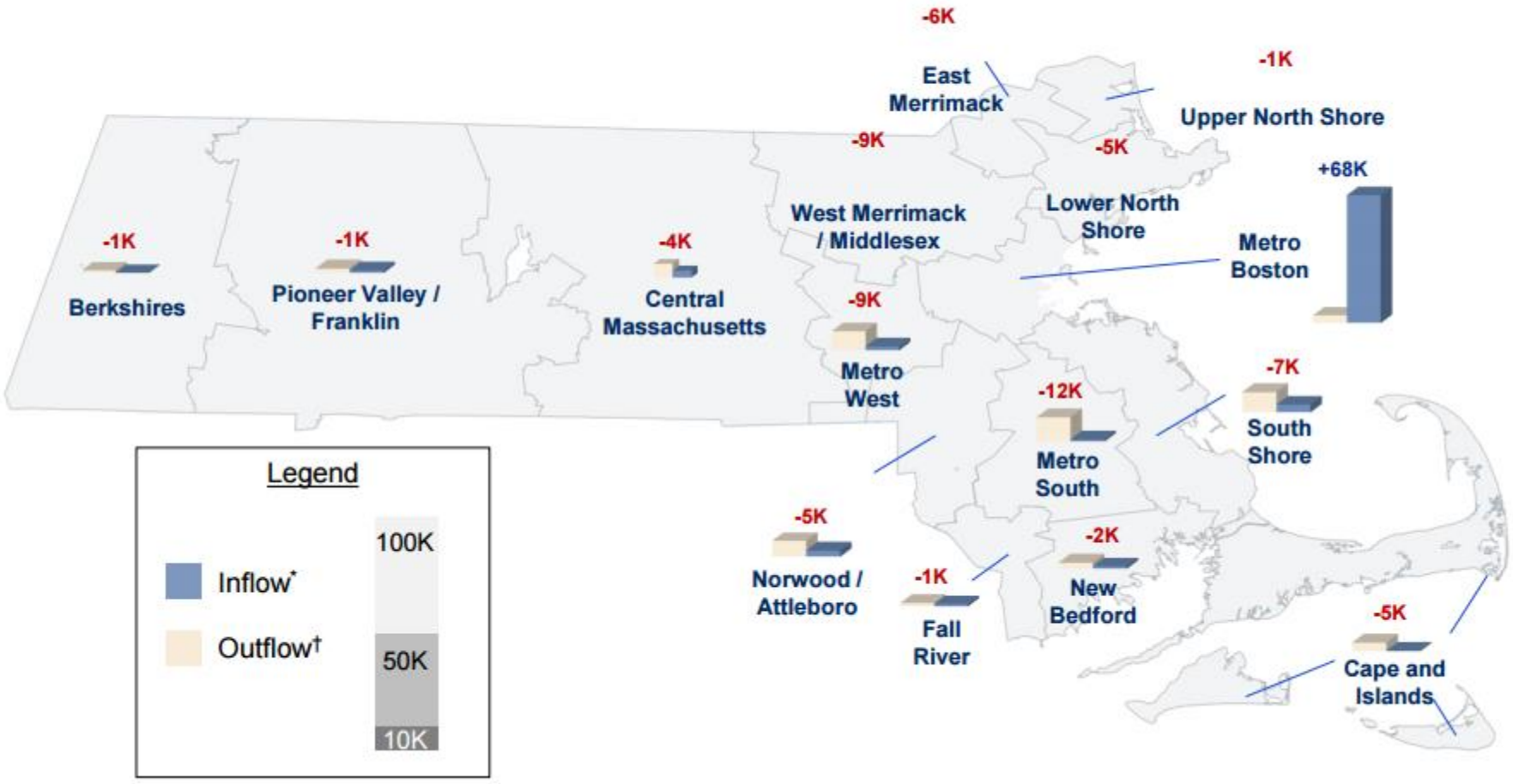


Note: OECD country wide averages indexed to US average spending 2013 (or most recent year) expenditure on health, per capita, US$ purchasing power parities (2012 is most recent year available for countries denoted by *). MA per capita spending is from Health Care Expenditures per Capita by State of Residence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

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.

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 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

Implementing State Agencies

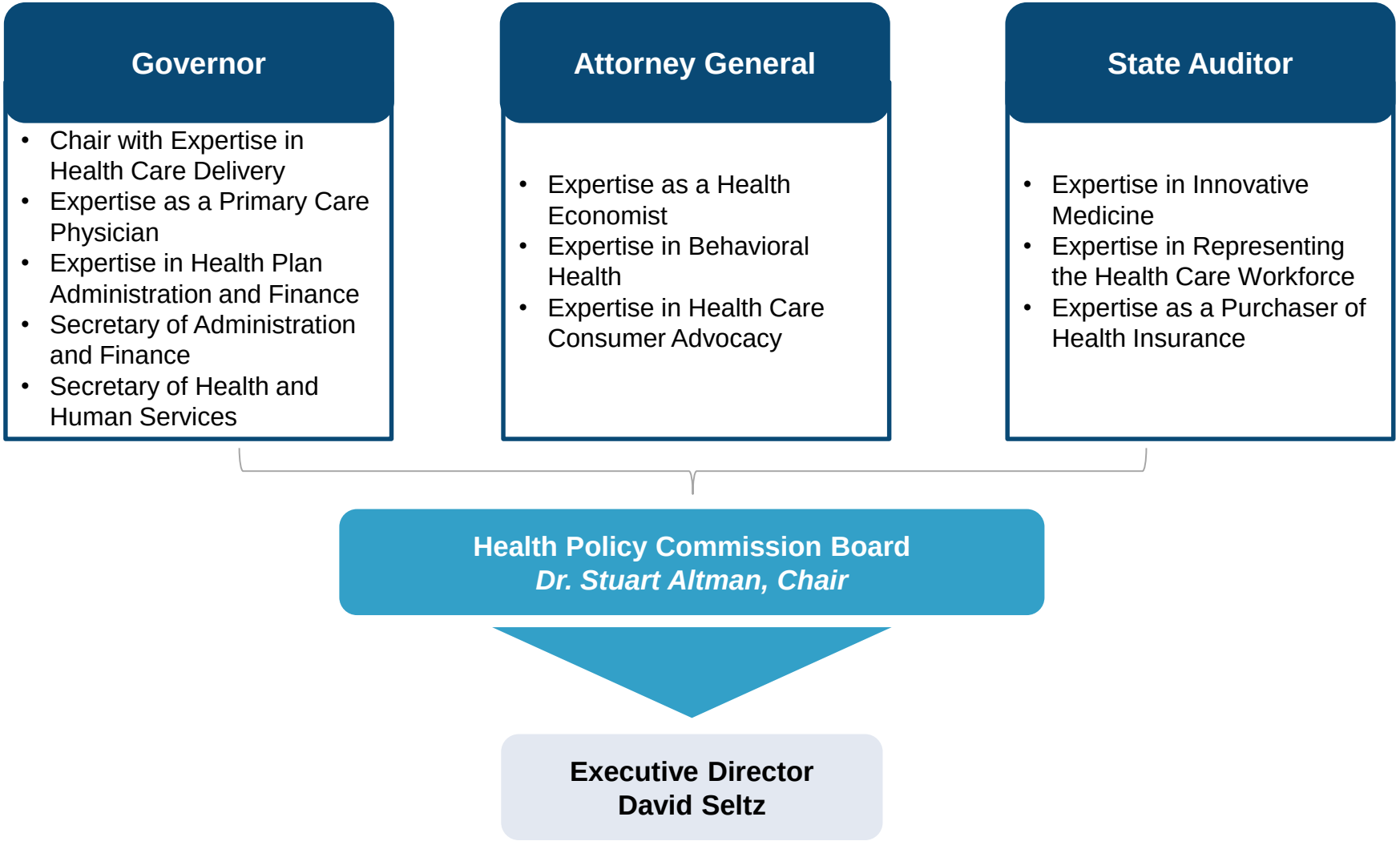
Center for Health Information and Analysis (CHIA)

- **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)

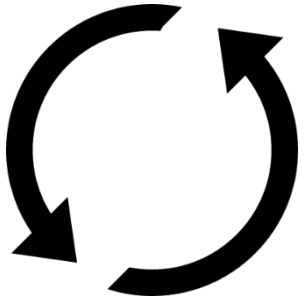
- **Policy hub**
- Duties include:
  - Sets statewide health care cost growth benchmark
  - Holds annual cost trend hearings and produces an annual cost trends report
  - Enforces performance against the benchmark
  - Conducts cost and market impact reviews
  - Certifies ACOs and PCMHs
  - Supports investments in community hospitals and new innovative health care models such as telemedicine

The HPC: Governance Structure



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

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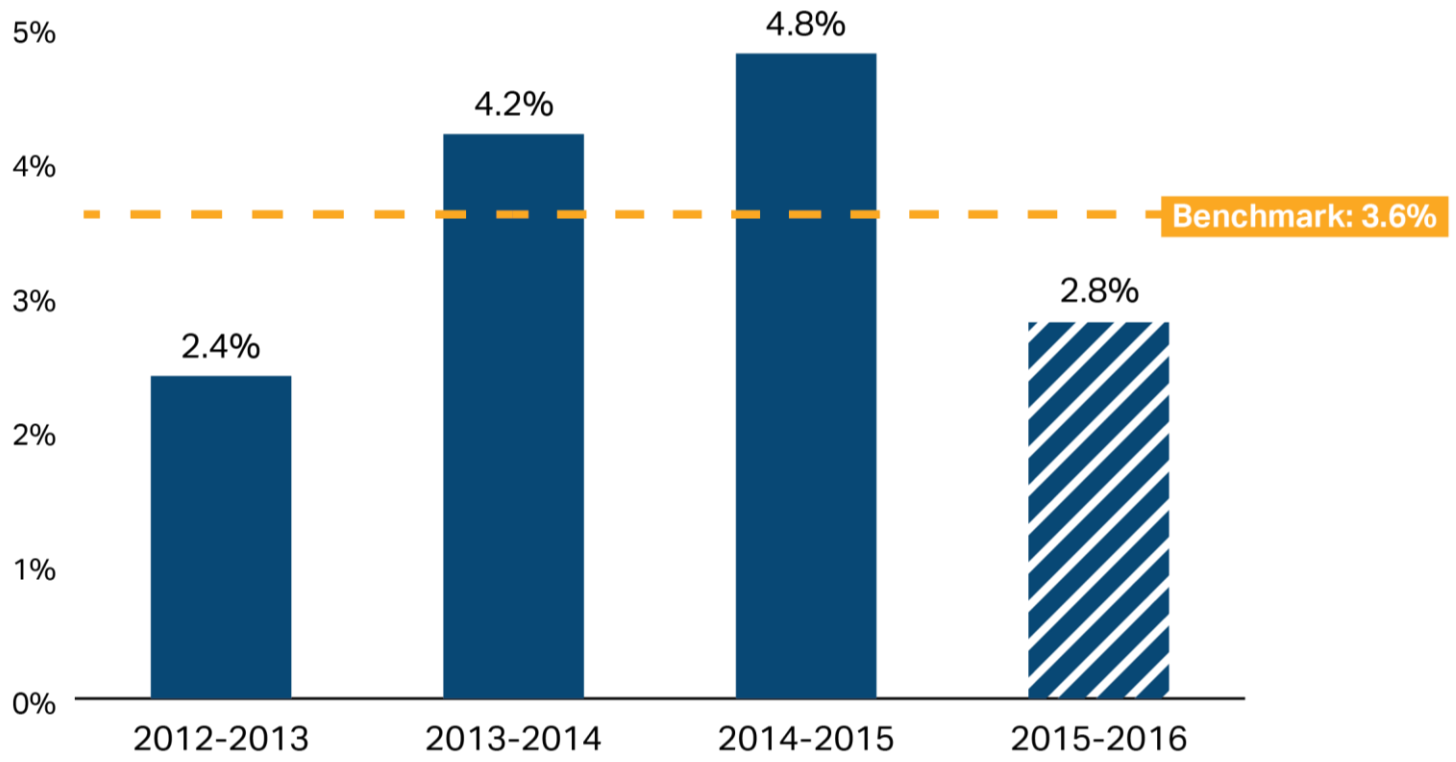
Total health care expenditures (THCE) per capita grew 2.8% in 2016, below the benchmark rate

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

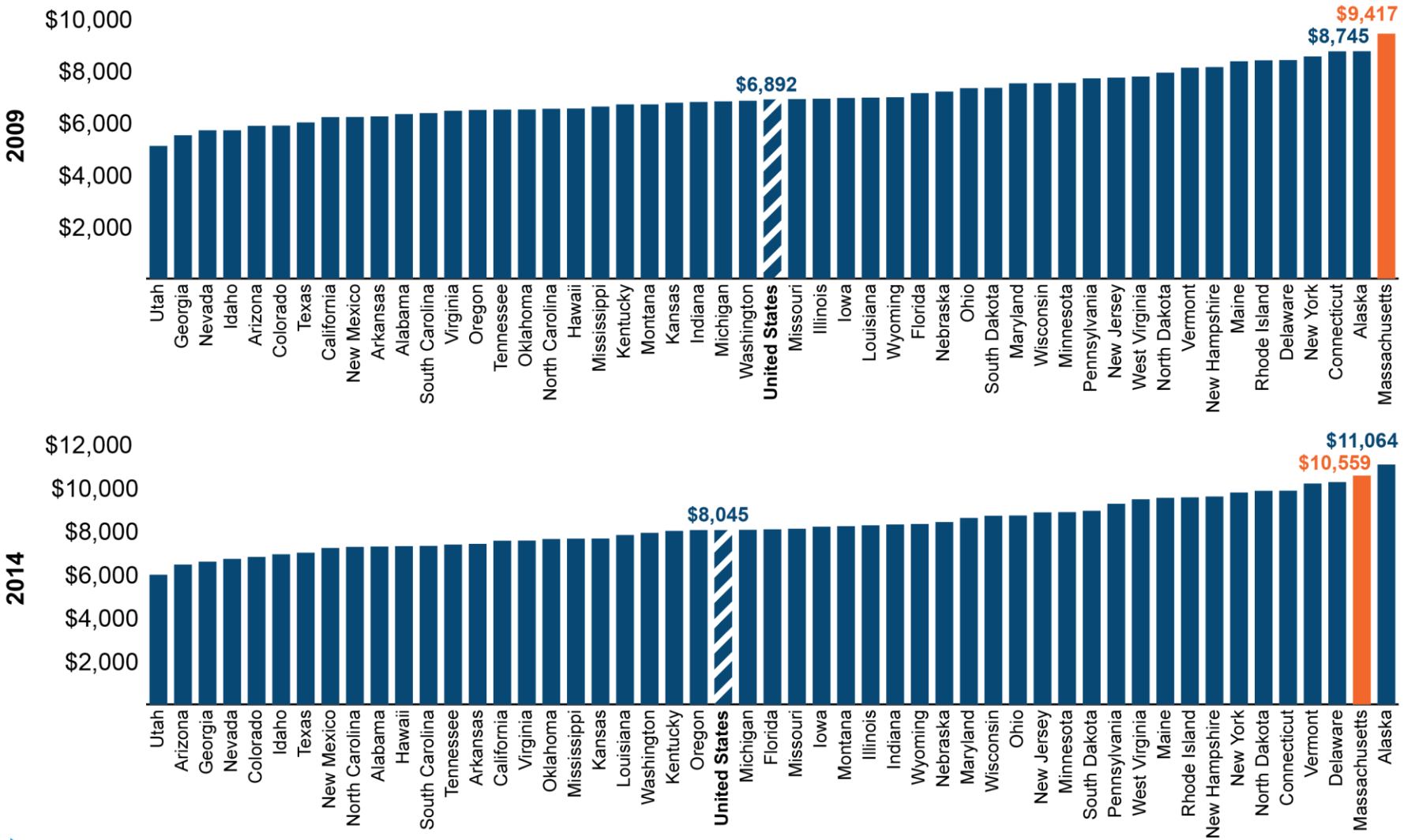


Average annual spending growth from 2012-2016: 3.55%

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)

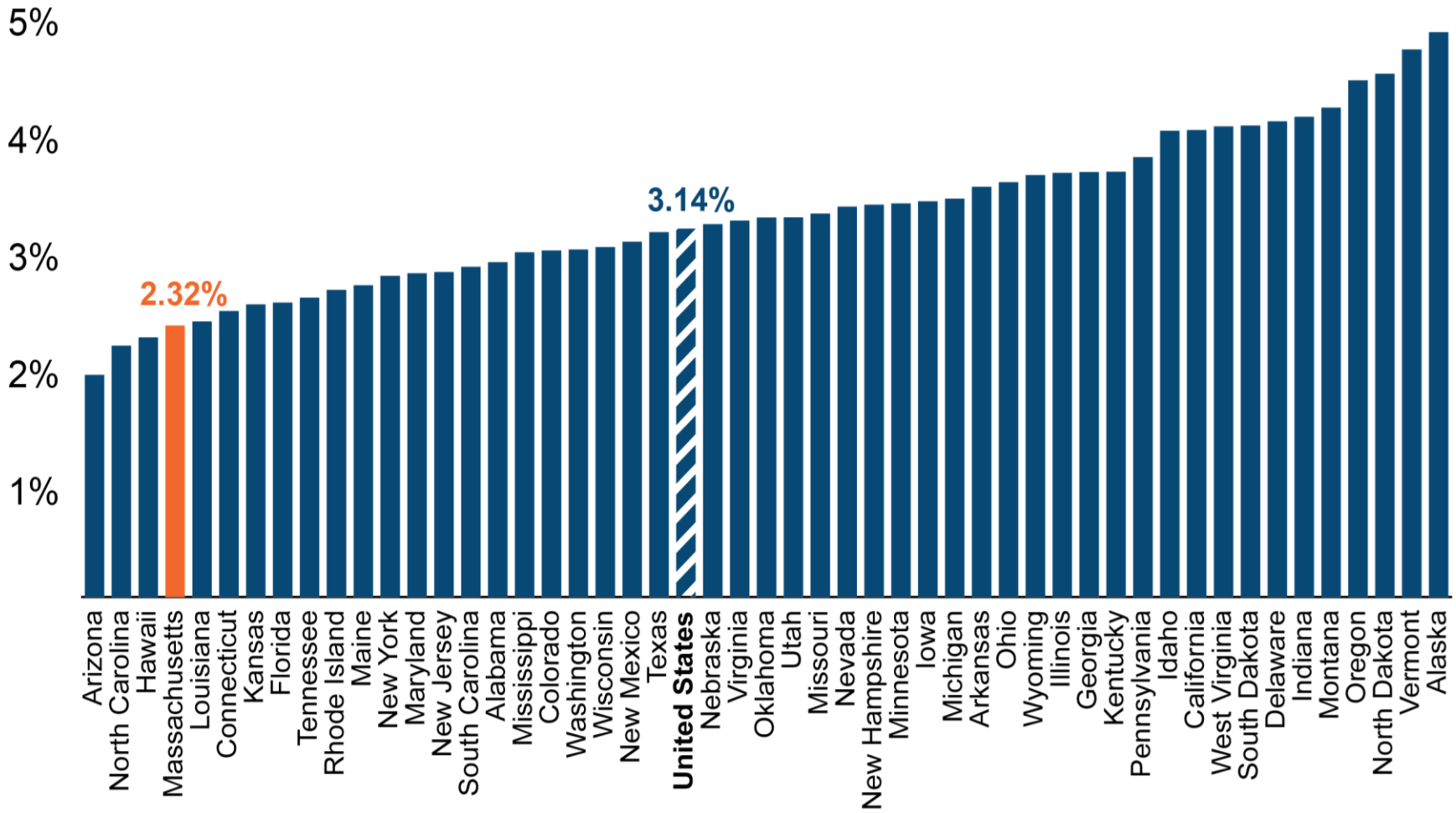
Personal health care spending, per capita, by state, 2009 and 2014



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

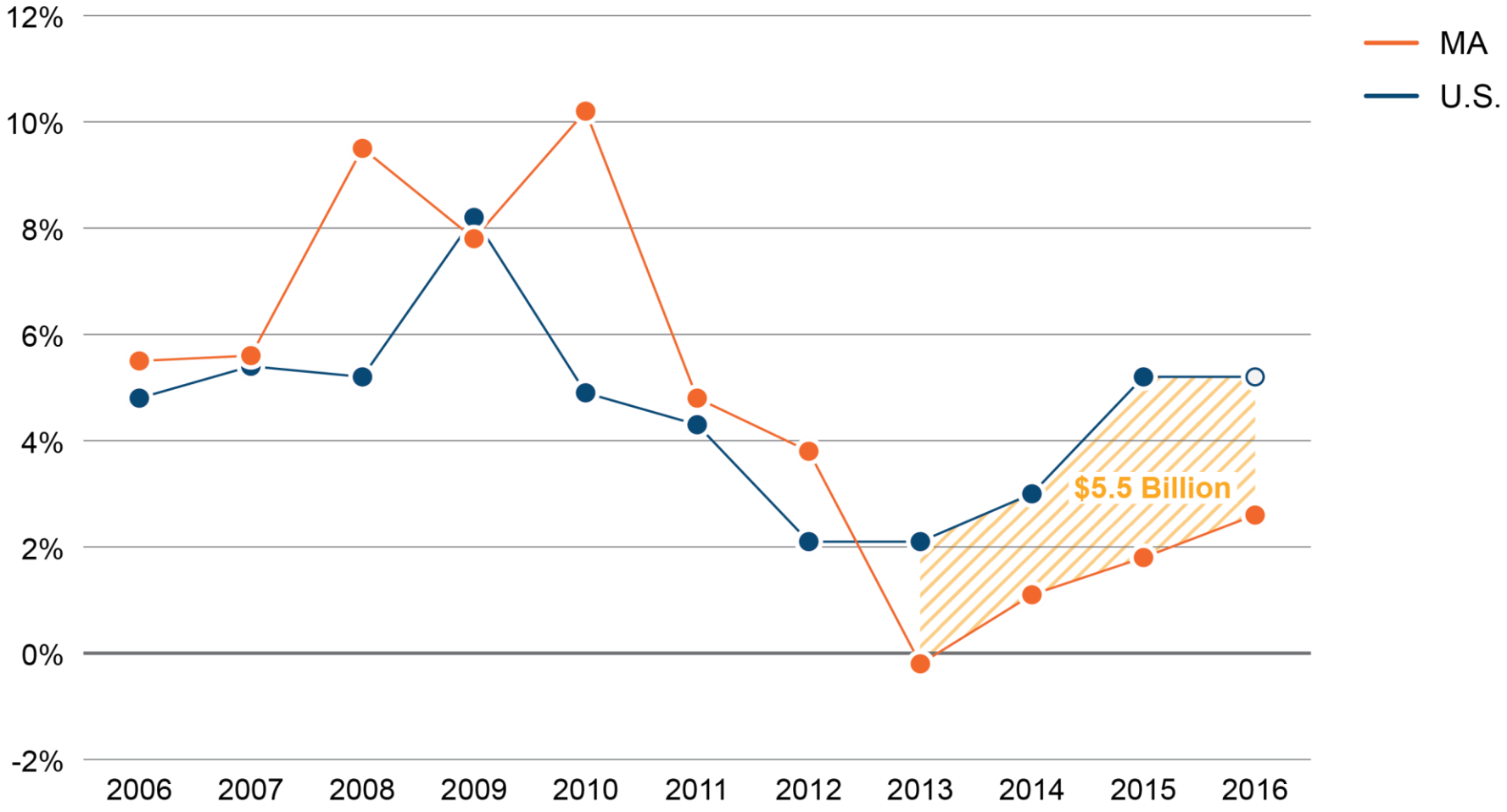
Average annual healthcare spending growth rate, per capita, 2009-2014



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)

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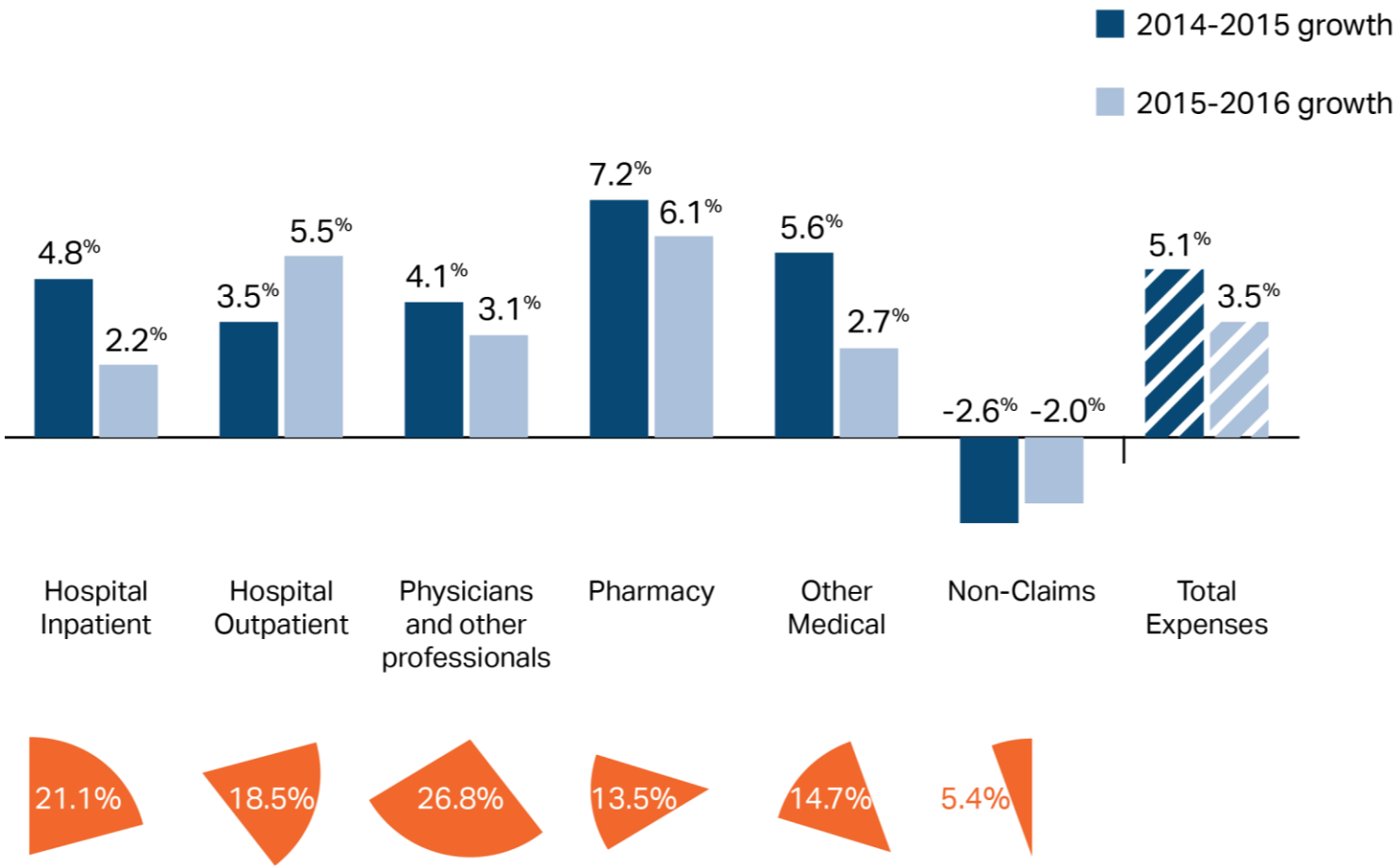
Among categories of care, pharmacy drugs and hospital outpatient spending grew the fastest in 2016

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

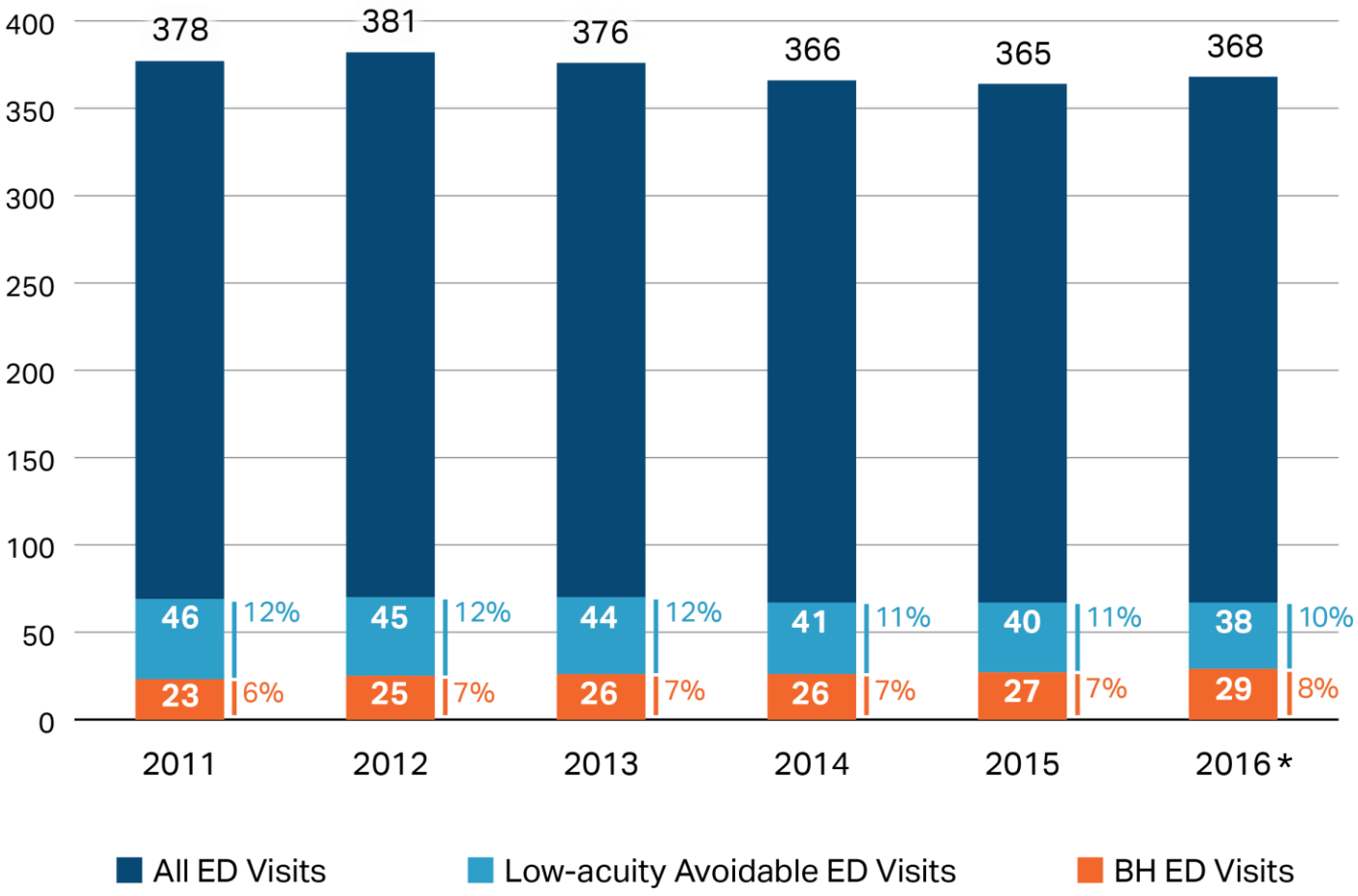


Notes: Pharmacy spending is net of rebates.

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

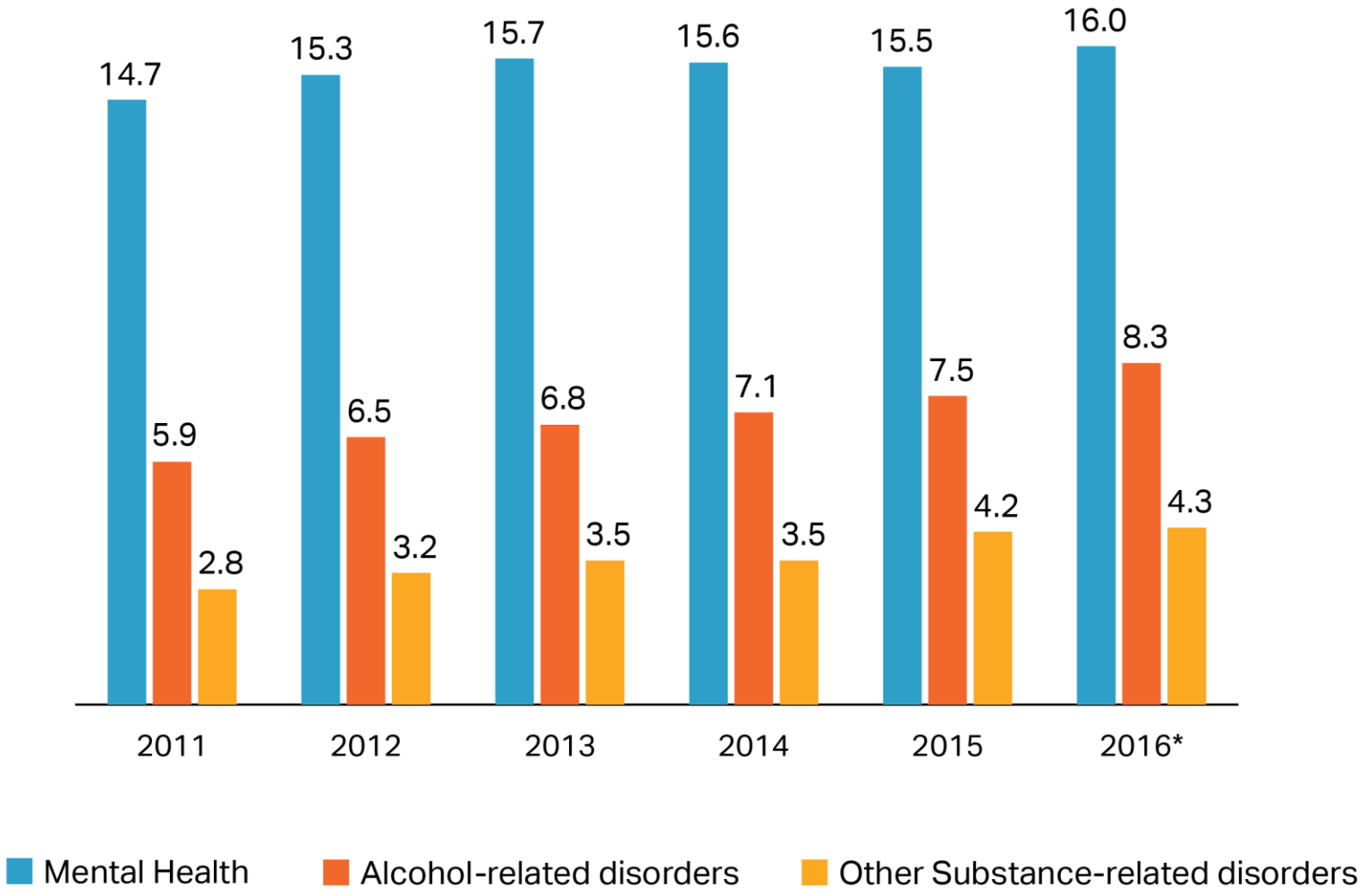


Notes: Low-acuity avoidable ED visits are based on the Medi-Cal avoidable ED visit definition, a conservative definition that may under-report avoidable ED utilization. Behavioral health ED visits were identified based on principal diagnosis using the Clinical Classifications Software (CCS) diagnostic 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



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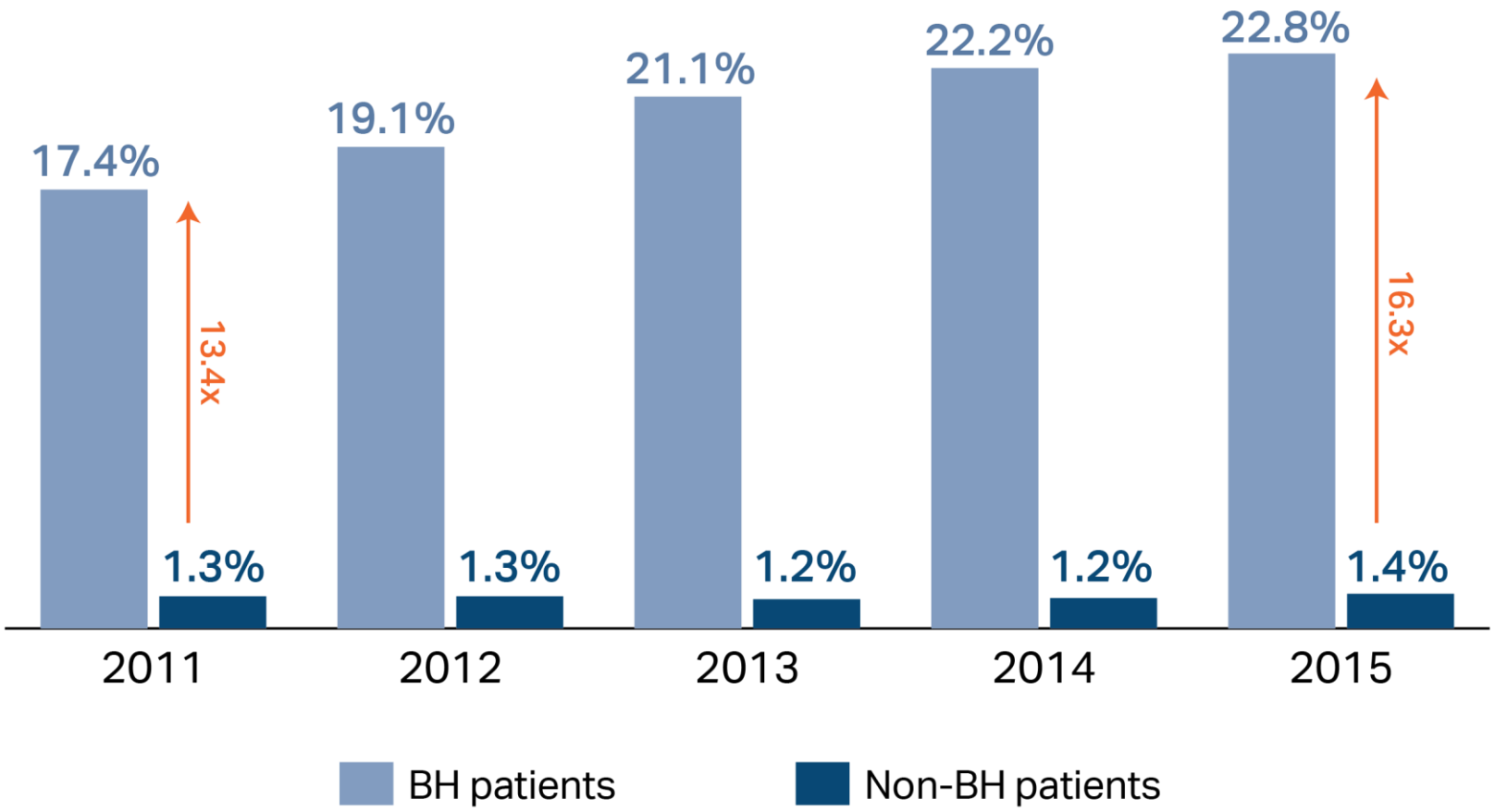
Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011- 2016

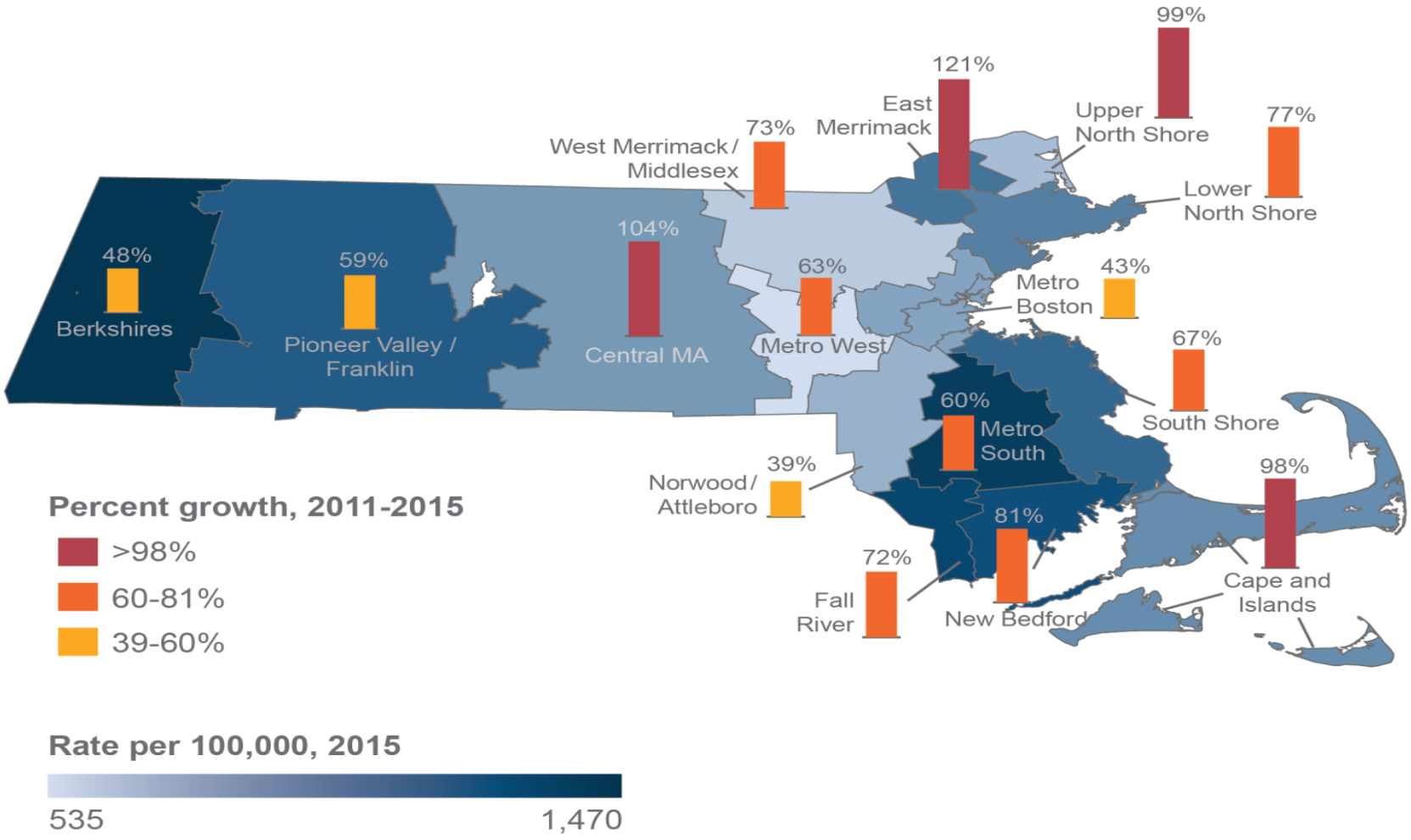
Behavioral health patients are increasingly more likely to have an extended length of stay in the ED

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

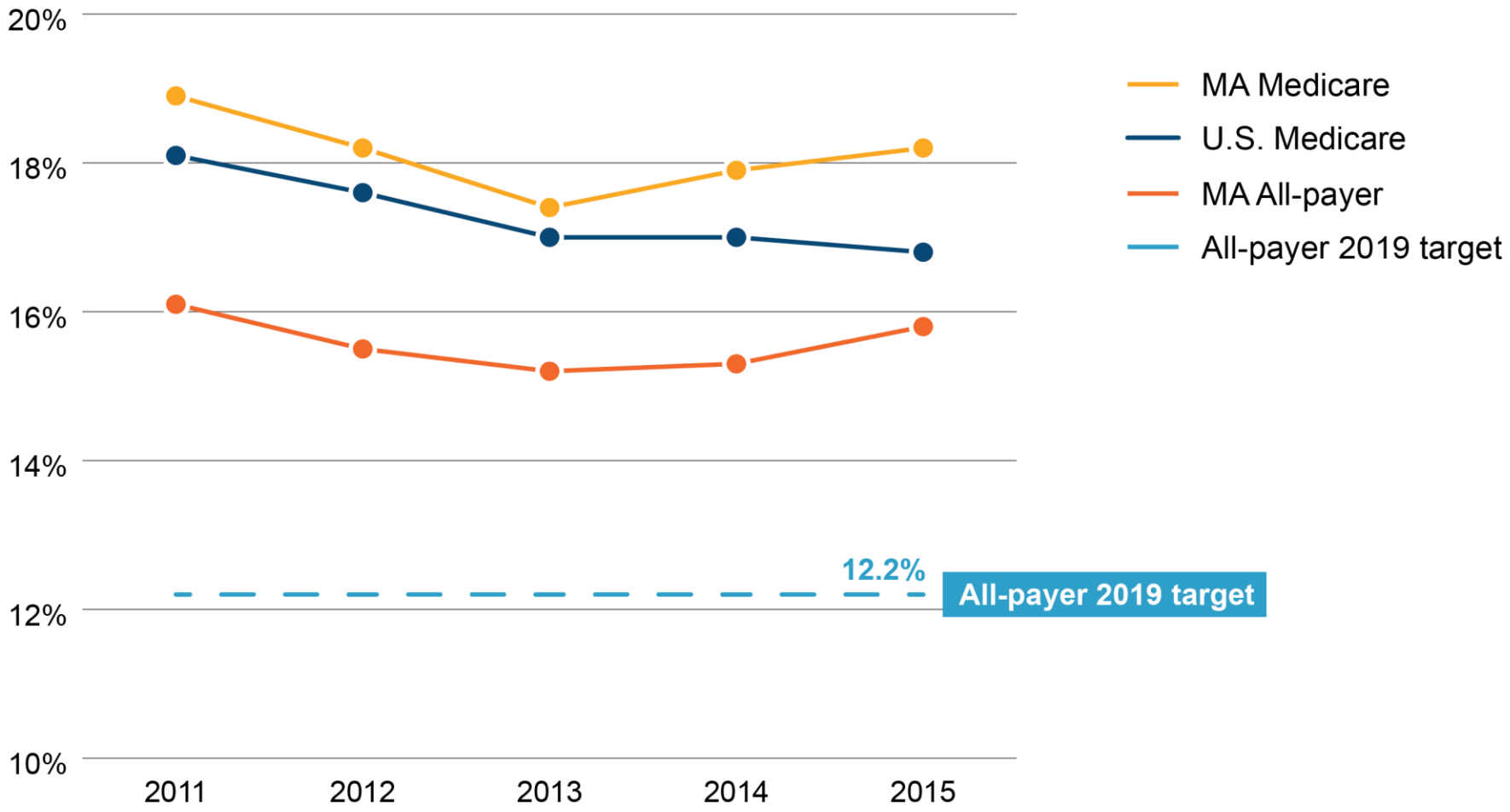
The rate of opioid-related discharges more than doubled in East Merrimack and Central Massachusetts and nearly doubled in the Upper North Shore and Cape and Island regions



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

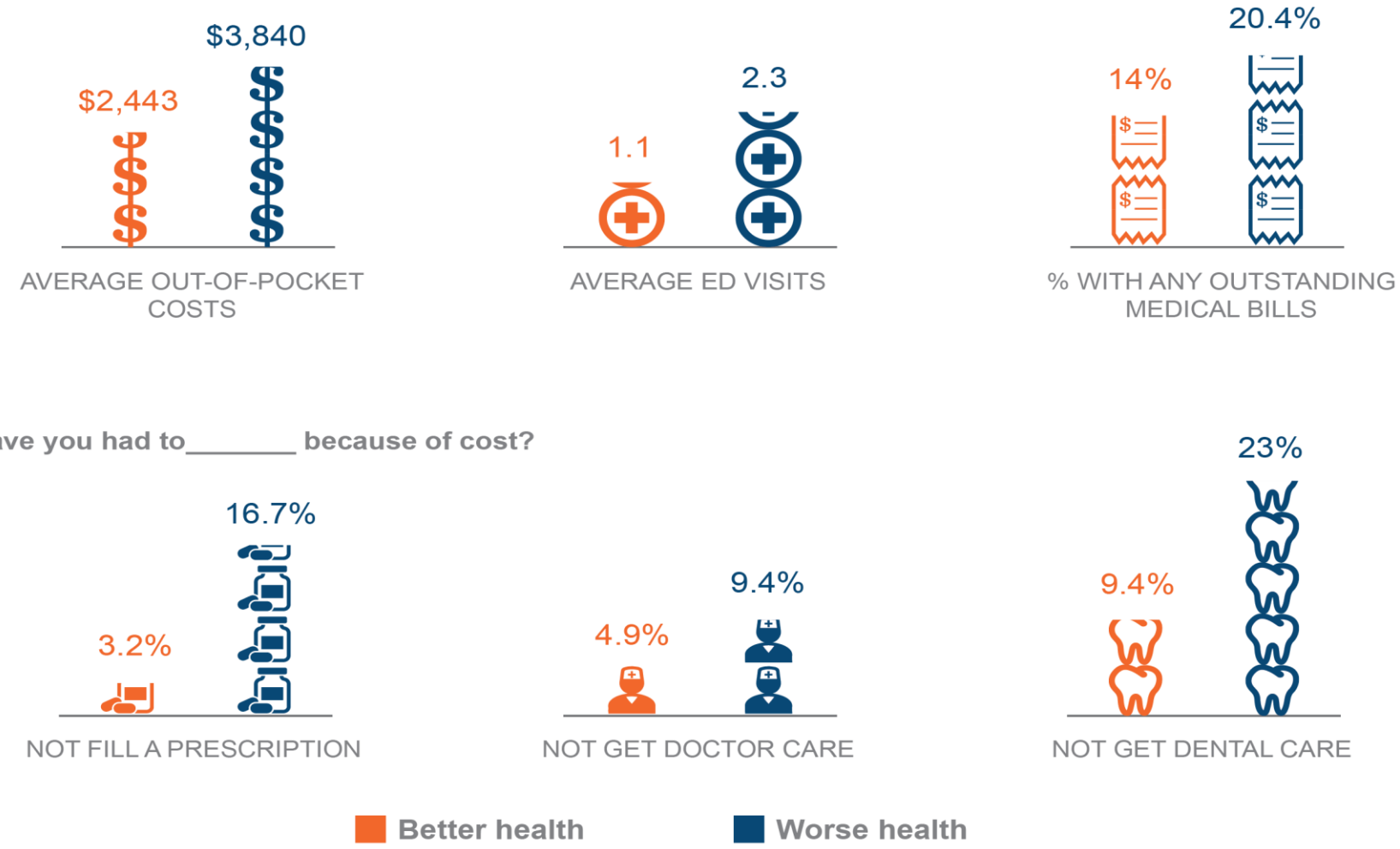
Thirty-day readmission rates, MA and the U.S., 2011-2015



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

Average responses for families divided by self-reported health status



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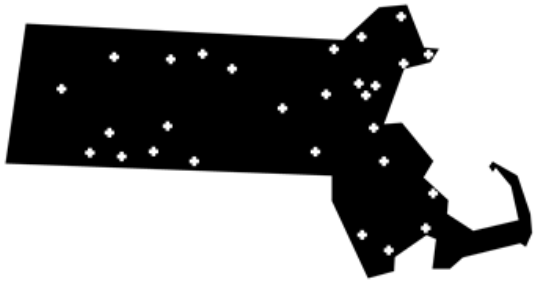
Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment Program: Phase 2 by the numbers



$60 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%*

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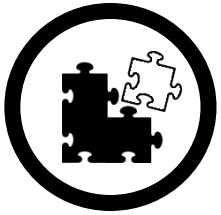
Note: These are examples only and are not an exhaustive representation of all CHART Phase 2 target populations and aim statements.

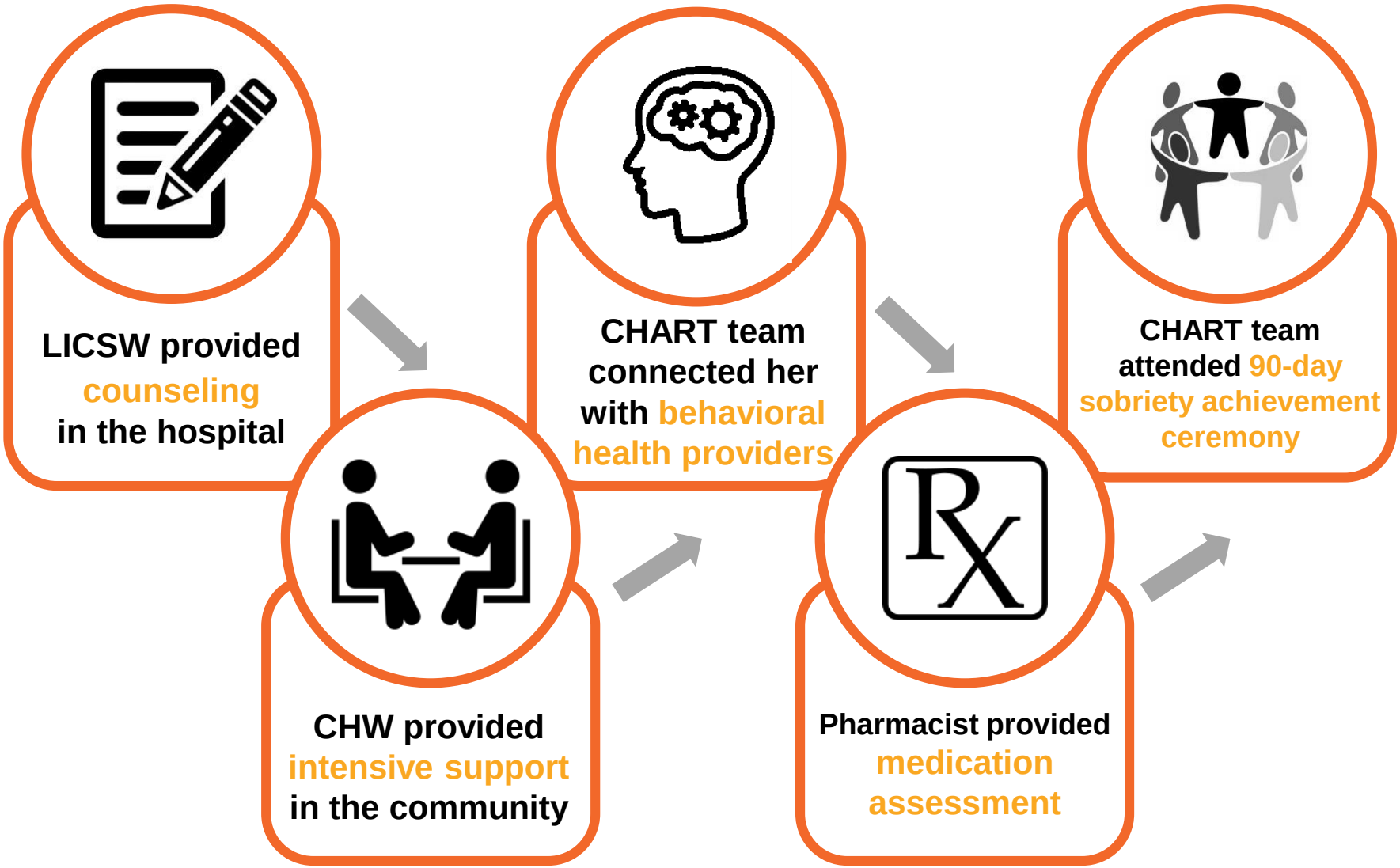
Transformation Highlights in CHART Phase 2

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



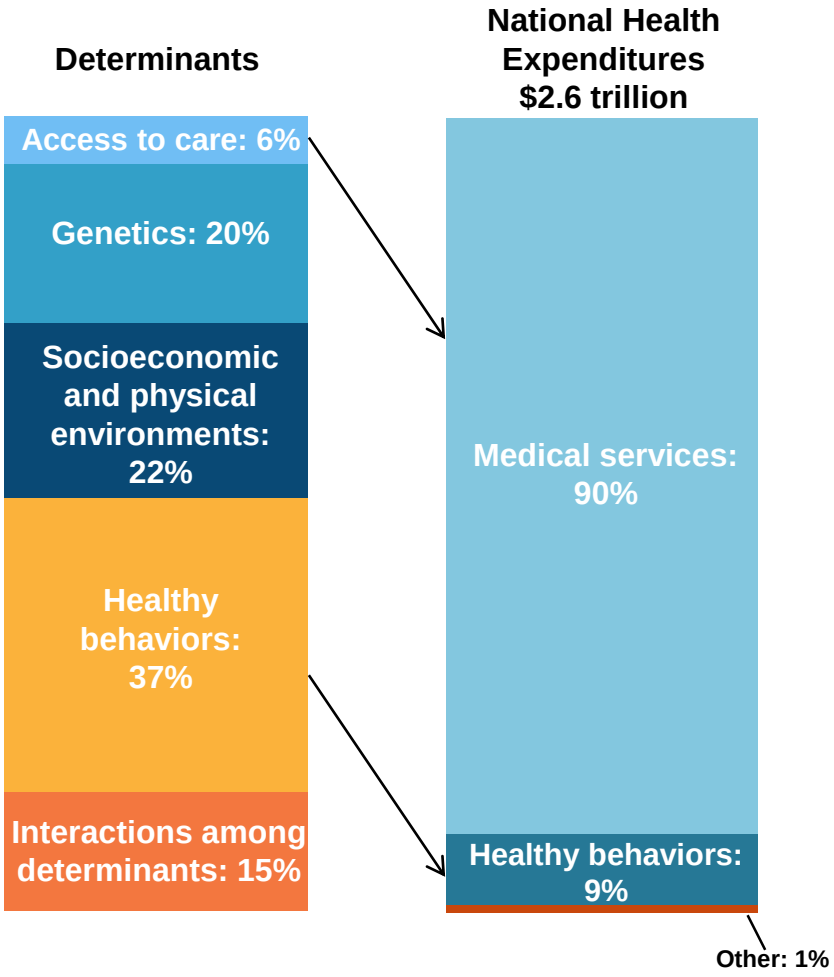
The Health Care Innovation Investment Program

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 

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.

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**

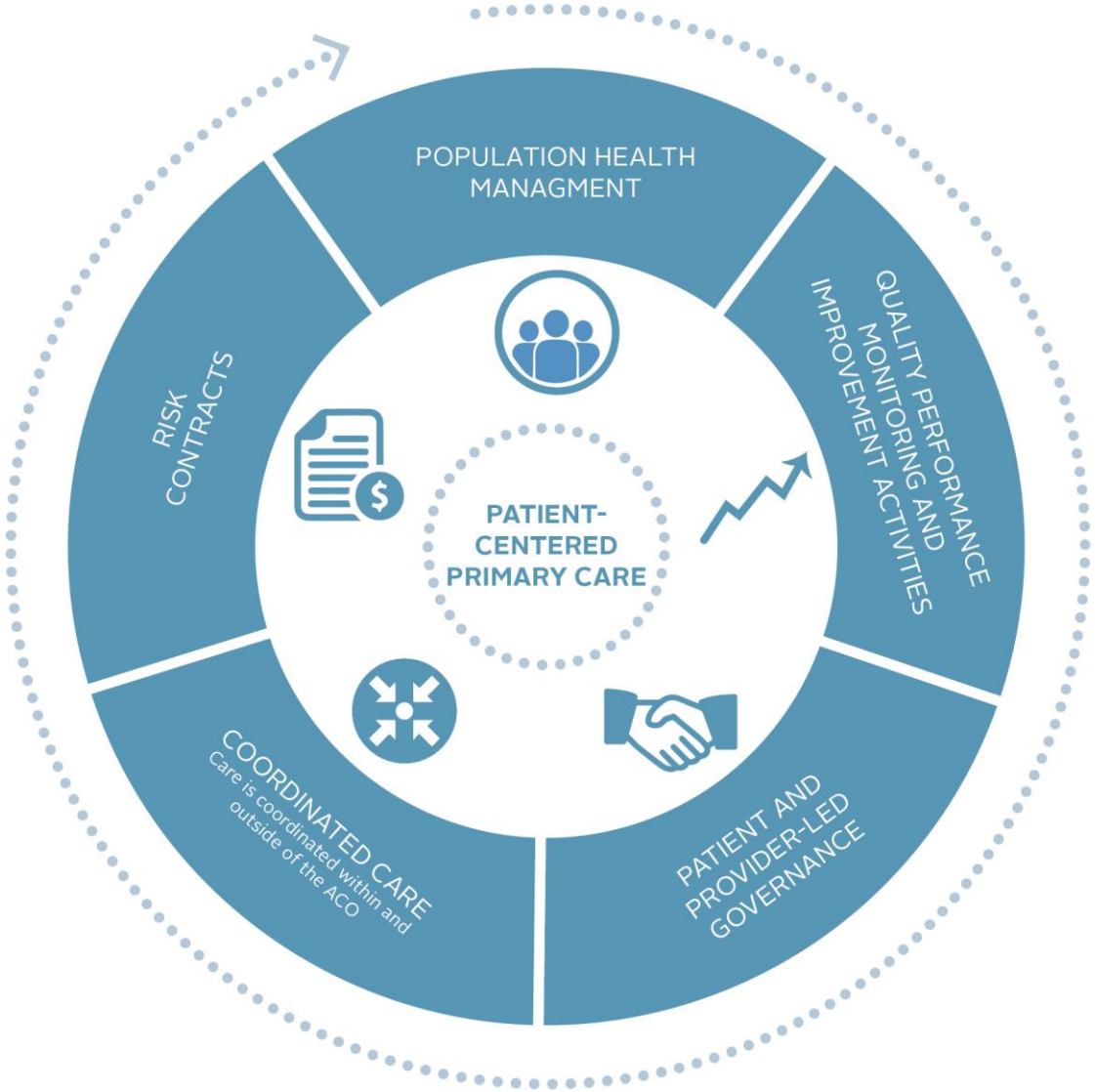
114 Total Practices Participating

HPC ACO Certification and the MassHealth ACO Program

- 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?



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.

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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

HPC

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

Material Changes Received to Date

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Clinical affiliation	21	23%
Physician group merger, acquisition or network affiliation	19	21%
Acute hospital merger, acquisition or network affiliation	19	21%
Formation of a contracting entity	16	18%
Merger, acquisition or network affiliation of other provider type (e.g., post-acute)	9	10%
Change in ownership or merger of corporately affiliated entities	5	6%
Affiliation between a provider and a carrier	1	1%

The HPC: Creating A New Government Agency