MASSACHUSETTS
HEALTH POLICY COMMISSION

Introduction to the Health Policy Commission:

Better Health, Better Care, Lower Costs

January 7, 2019

In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

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

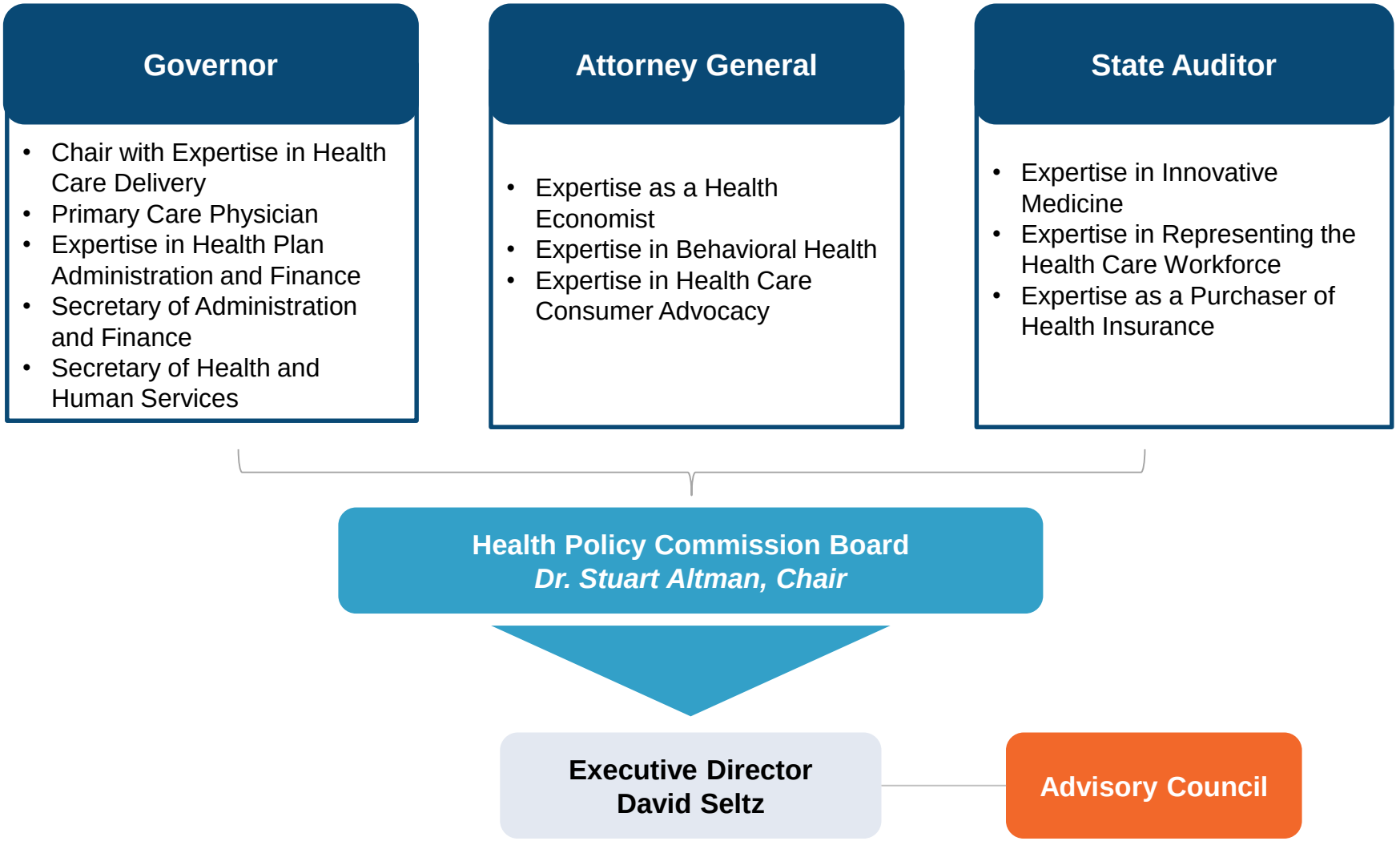
Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

VISION

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

HPC

The HPC: Governance Structure



Vision for achieving the health care growth benchmark while improving quality, access, patient engagement, and overall market functioning

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

The HPC employs four core strategies to realize its vision of better care, better health, and lower costs for all people of the Commonwealth.

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

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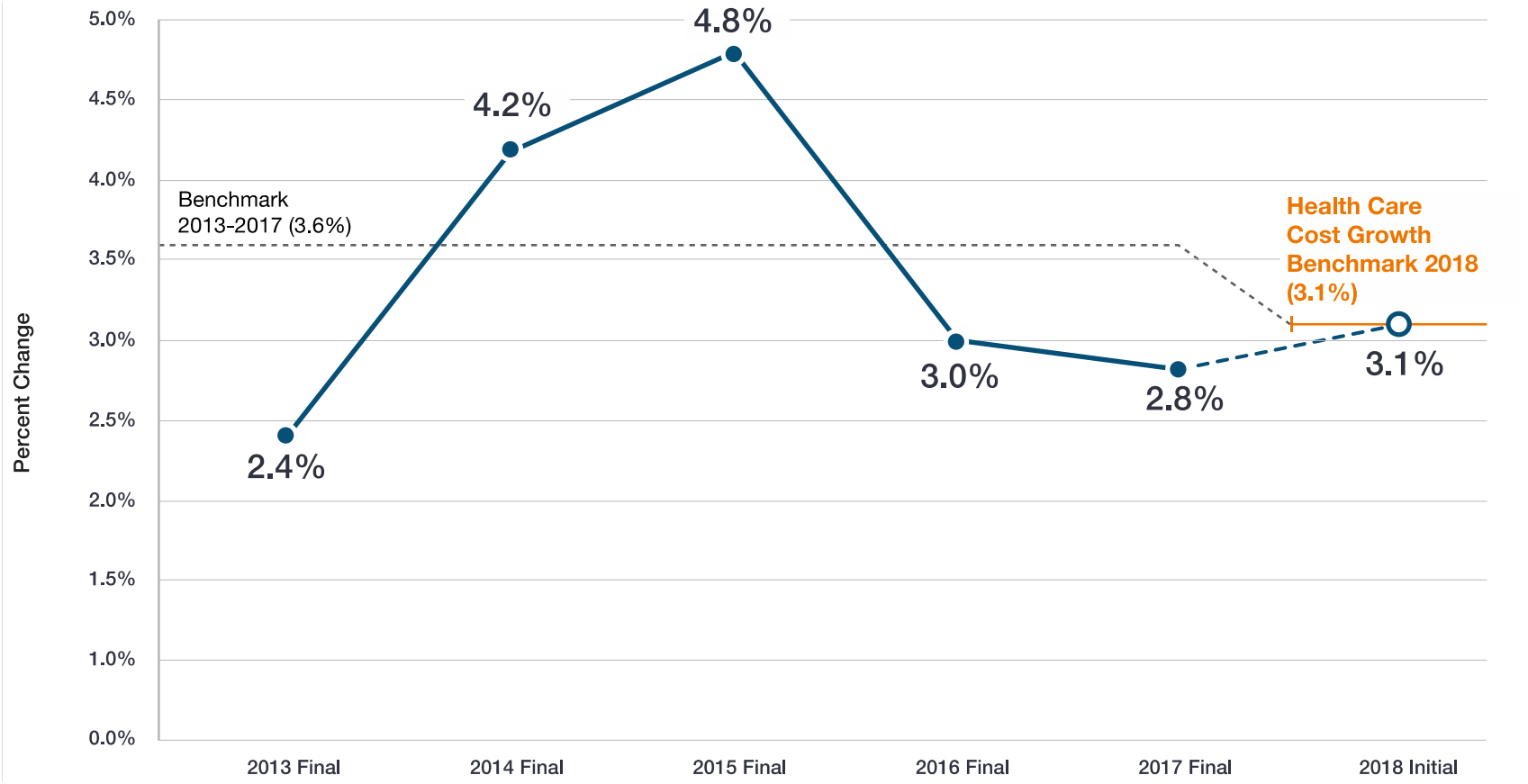
From 2012 to 2018, annual health care spending growth averaged 3.4%, below the state benchmark.



The initial estimate of THCE per capita growth for 2018 is 3.1%

This is the third consecutive year it met or fell below the health care cost growth benchmark.

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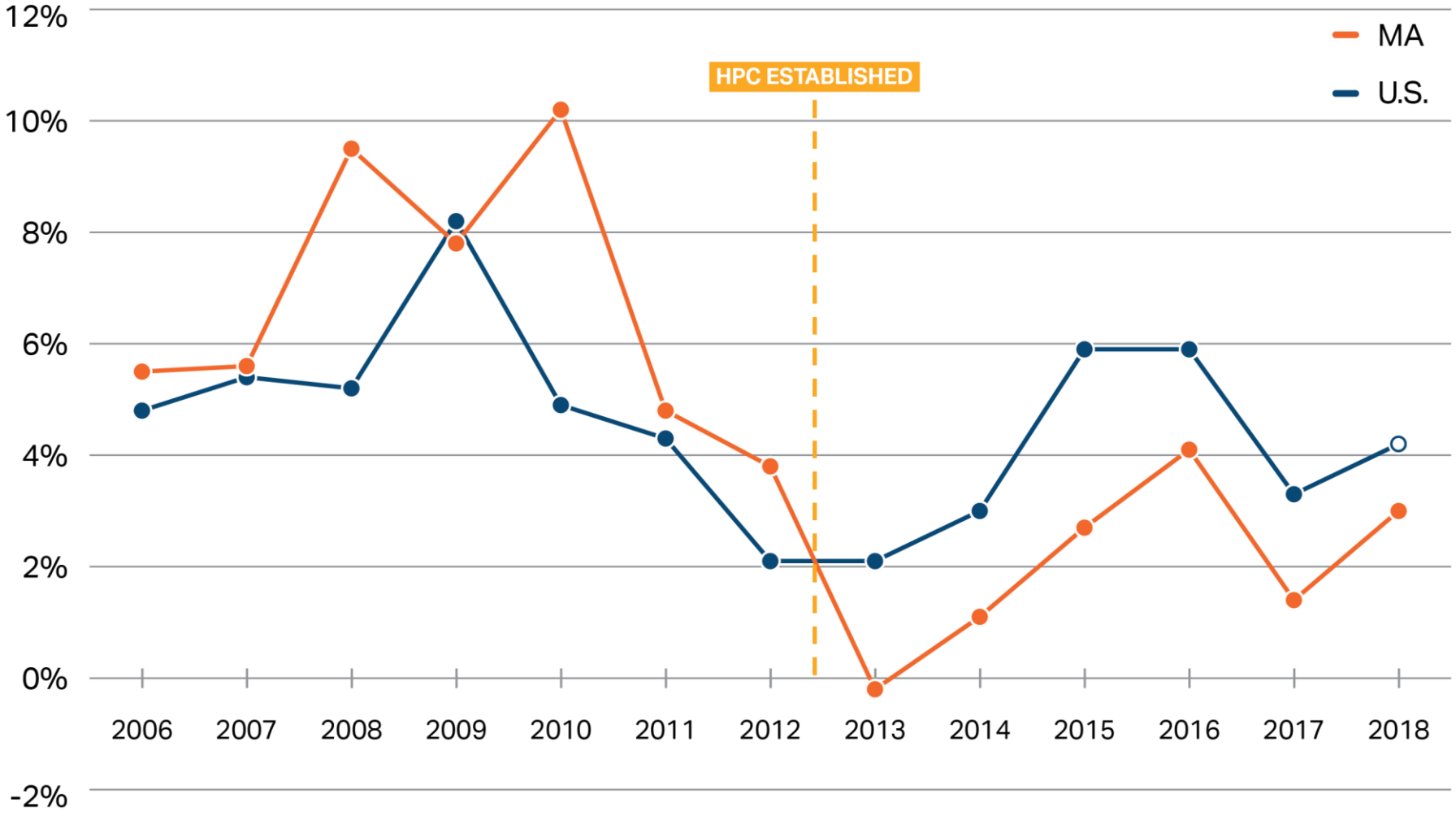
Commercial spending growth in Massachusetts has been below the national rate every year since 2013, generating billions in avoided spending.

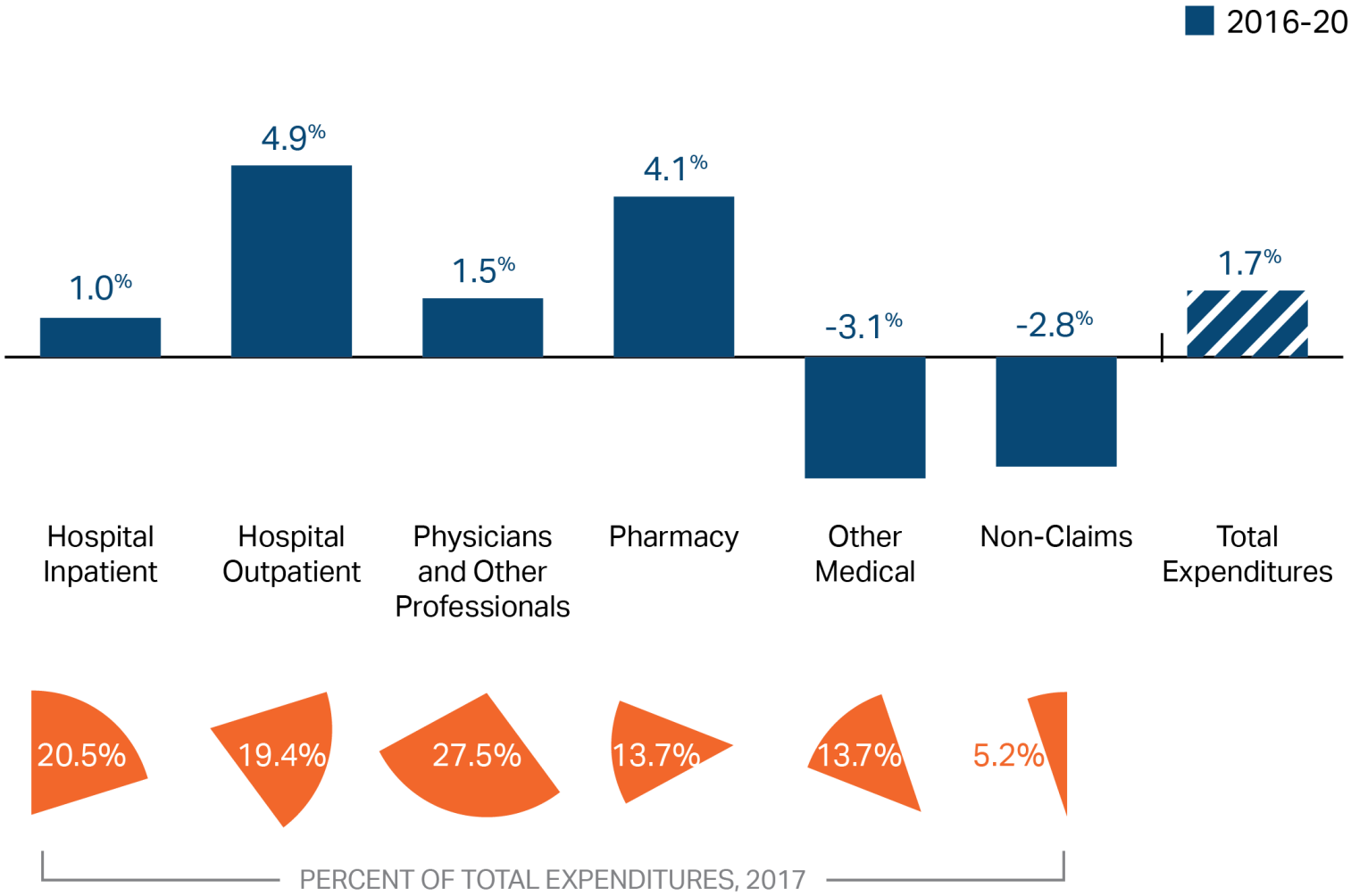
Annual growth in commercial medical spending per enrollee, Massachusetts and the U.S., 2006-2018



Notes: U.S. data includes Massachusetts. U.S. data point for 2018 is partially projected. MA data point for 2018 is preliminary.
Sources: CMS National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data (U.S. 2014-2018) ; CMS State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); CHIA Annual Report THCE Databooks (MA 2014-2018).

Hospital outpatient and pharmacy spending were the fastest-growing categories in 2017, continuing a multi-year trend of high growth

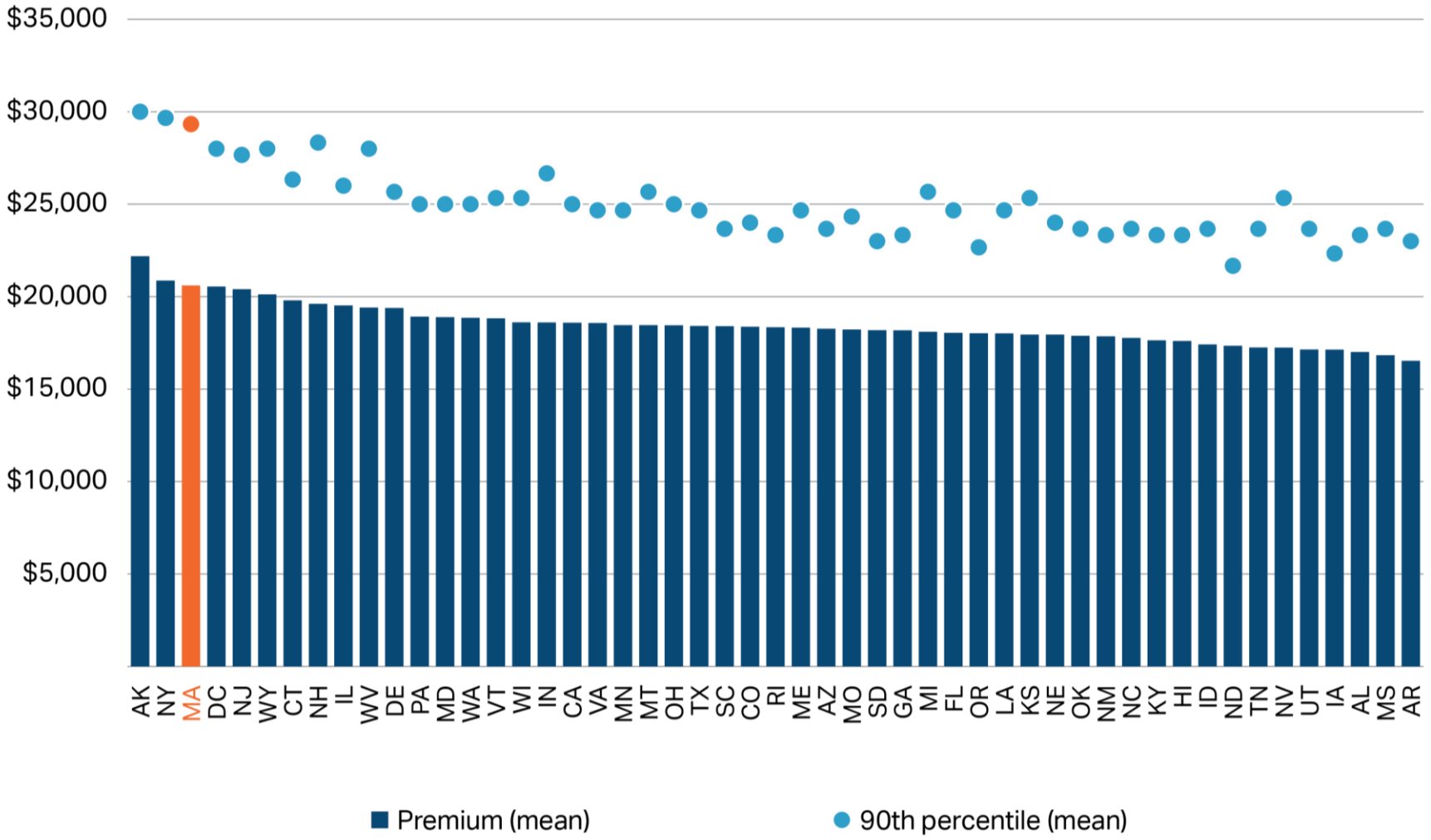
Rates of spending growth in Massachusetts in 2017 by category, all payers



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

Massachusetts has the 3rd highest average family premium in the U.S.; premiums exceed $30,000 for one in 10 Massachusetts residents.

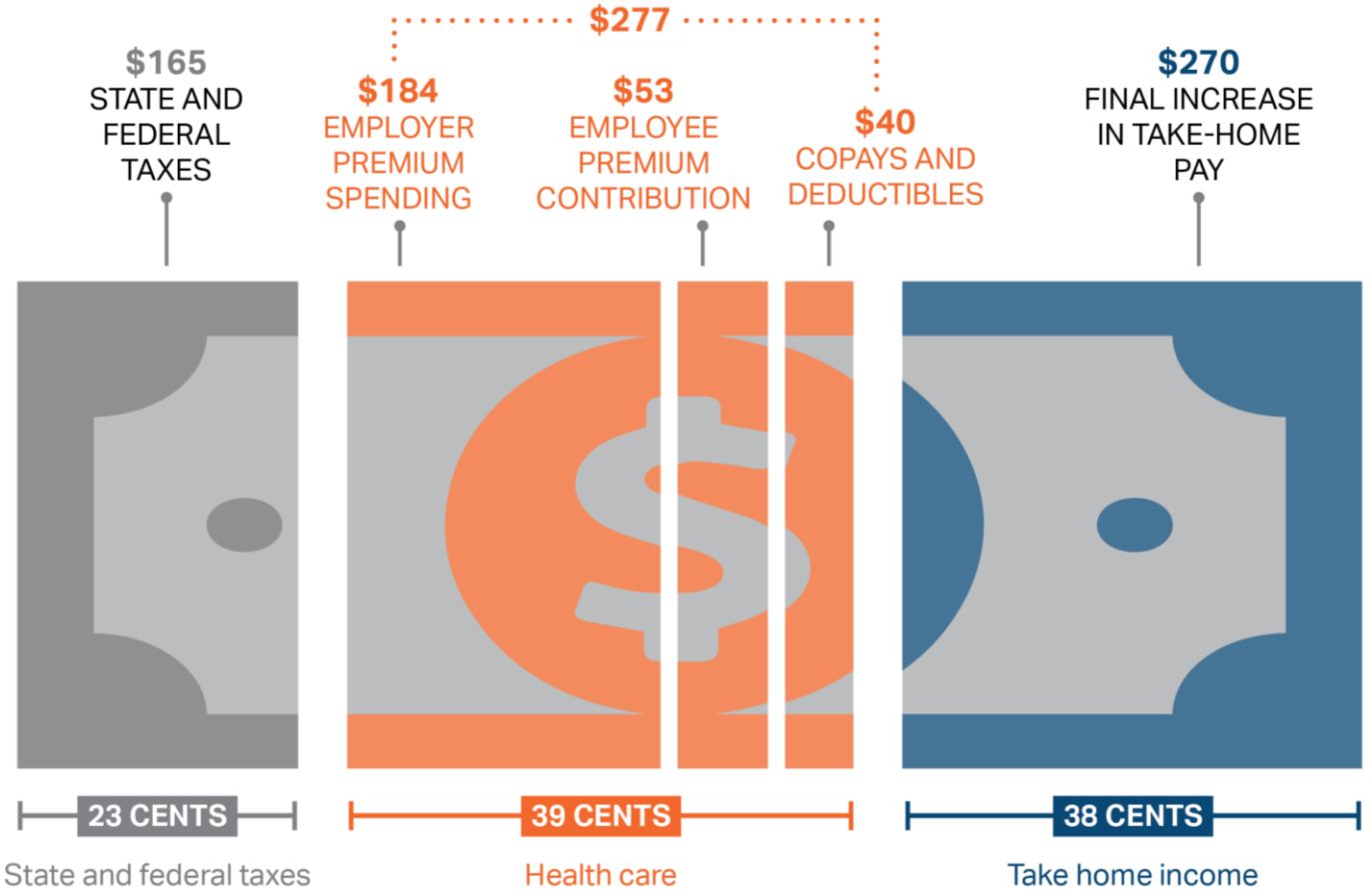
Average and 90th percentile of family premiums by state averaged across 2016-2018



Notes: Mean premiums and 90th percentile represent the three-year average from 2016 to 2018.
Source: HPC analysis of Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS), 2016-2018

Why focus on health care costs? Nearly 40 cents of every additional dollar earned by Massachusetts families between 2016 and 2018 went to health care, more than take home income.

Allocation of the increase in monthly compensation between 2016 and 2018 for a median Massachusetts family with health insurance through an employer



Notes: Data represent Massachusetts families who obtain private health insurance through an employer. Massachusetts median family income grew from $95,207 to $101,548 over the period while mean family employer-sponsored insurance premiums grew from $18,955 to $21,801. Compensation is defined as employer premium contributions plus income as recorded in the ACS and is considered earnings. All premium payments are assumed non-taxable. Tax figures include income, payroll, and state income tax.

Sources: HPC analysis of Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Insurance Component (premiums) American Community Survey (ACS) 1-year files (income), and Center for Health Information and Analysis 2019 Annual Report (cost-sharing).

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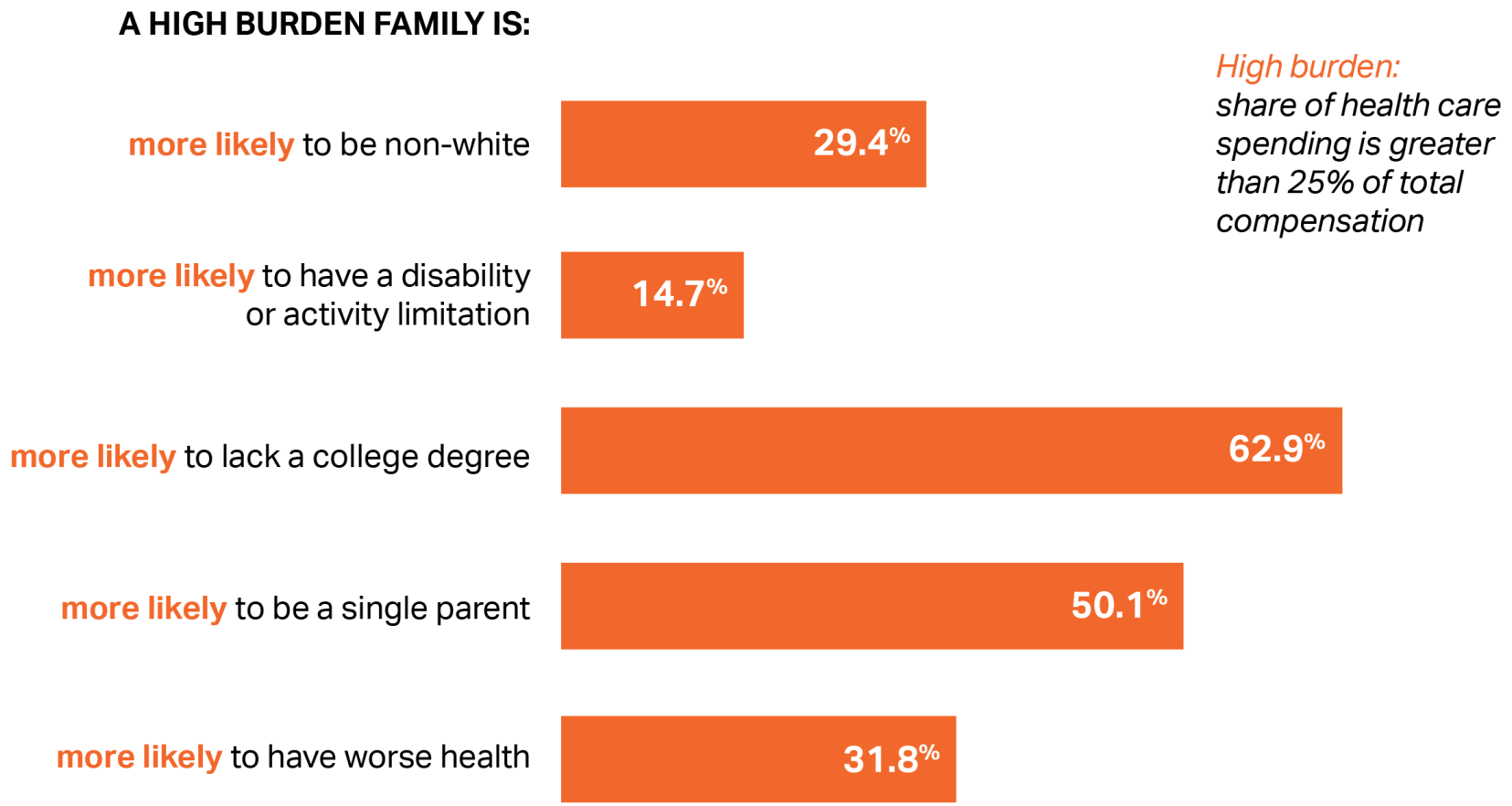
23% of Massachusetts middle-class families spend more than a quarter of all earnings on health care.

Characteristics of middle-class families with employer-sponsored health insurance that spend more than a quarter of earnings on health care (high burden families), 2016-2018 average



Notes: Estimates are a three-year average of middle class families from 2016-2018; middle class definition is based on General Social Survey (GSS) occupational prestige scores; "high burden" families are those whose total spending on healthcare (premiums, over-the-counter and other out-of-pocket spending) exceeds 25% of their total compensation. Premiums include employer and employee premium contributions and earnings (compensation) includes employer premium contribution. Disability or activity limitation was defined as difficulty walking or climbing stairs, dressing or bathing, hearing, seeing, or having a health problem or a disability which prevents work or limits the kind or amount of work they can perform. College degree was defined as having a B.A. or higher degree in the family. Single-parent families are those in families who did not report being in a married couple family (male or female reference person). Worse health was defined as those reporting a health status "poor," "fair" or "good."
Source: HPC's analysis of data from the CPS Annual Social and Economic Supplement (ASEC), 2016-8 and Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS), 2016-2018 (premiums).

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Mother and Infant-Focused NAS Interventions: Overview

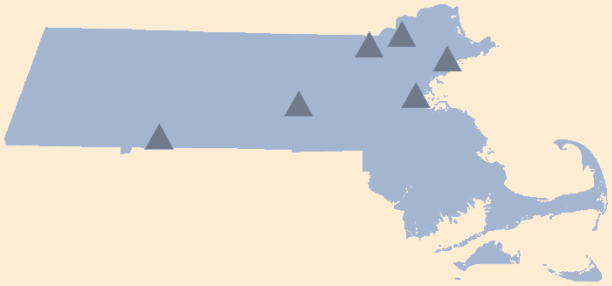
- **Goal:** To develop and/or enhance programs designed to improve care for substance-exposed newborns who may develop Neonatal Abstinence Syndrome (NAS) and for women in treatment for opioid use disorder (OUD) during and after pregnancy

6 initiatives
Funded by the HPC

$3 million
HPC funding

59 Organizations
(e.g. hospitals, primary care practices, behavioral health providers) collaborating

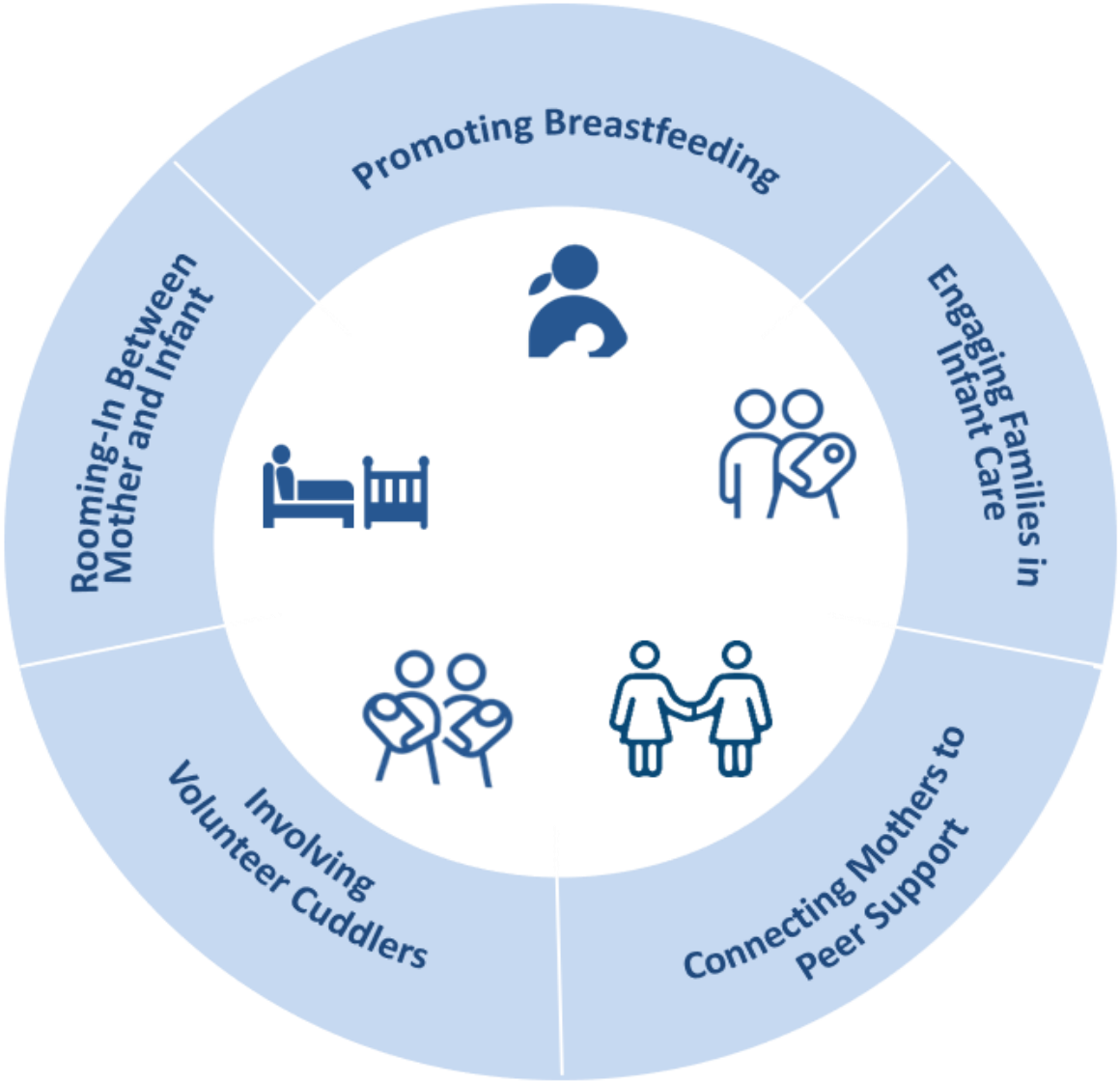
Initiatives span the Commonwealth:
From Springfield to Middlesex County



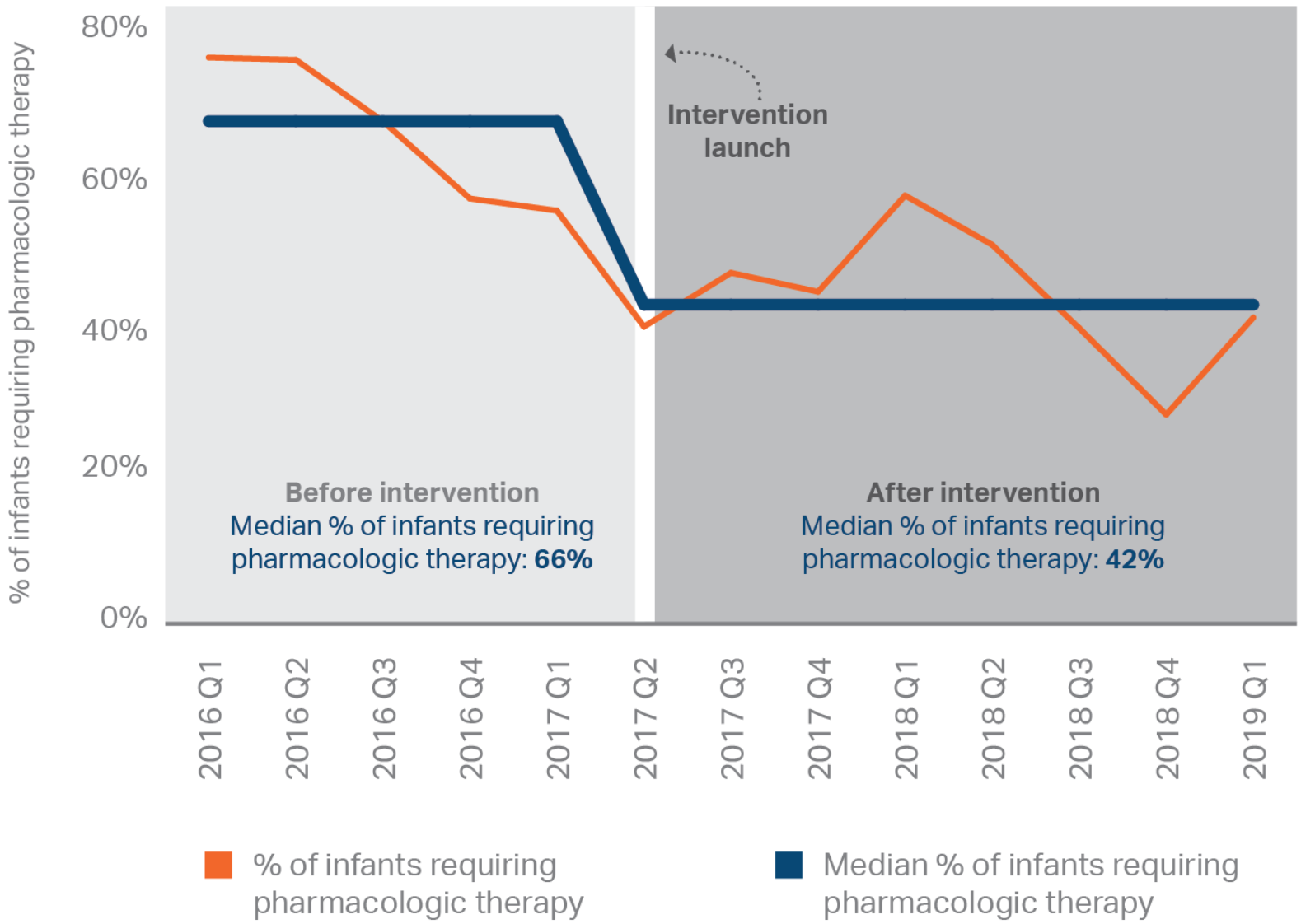
>450 infants with NAS
treated in 2015 by HPC's proposed awardees

6 initiatives

Supported by a $3 million investment from the HPC, hospitals emphasized non-pharmacologic interventions to improve care for infants with NAS.



Hospitals successfully achieved a 36% decrease in the percentage of infants requiring pharmacologic therapy.



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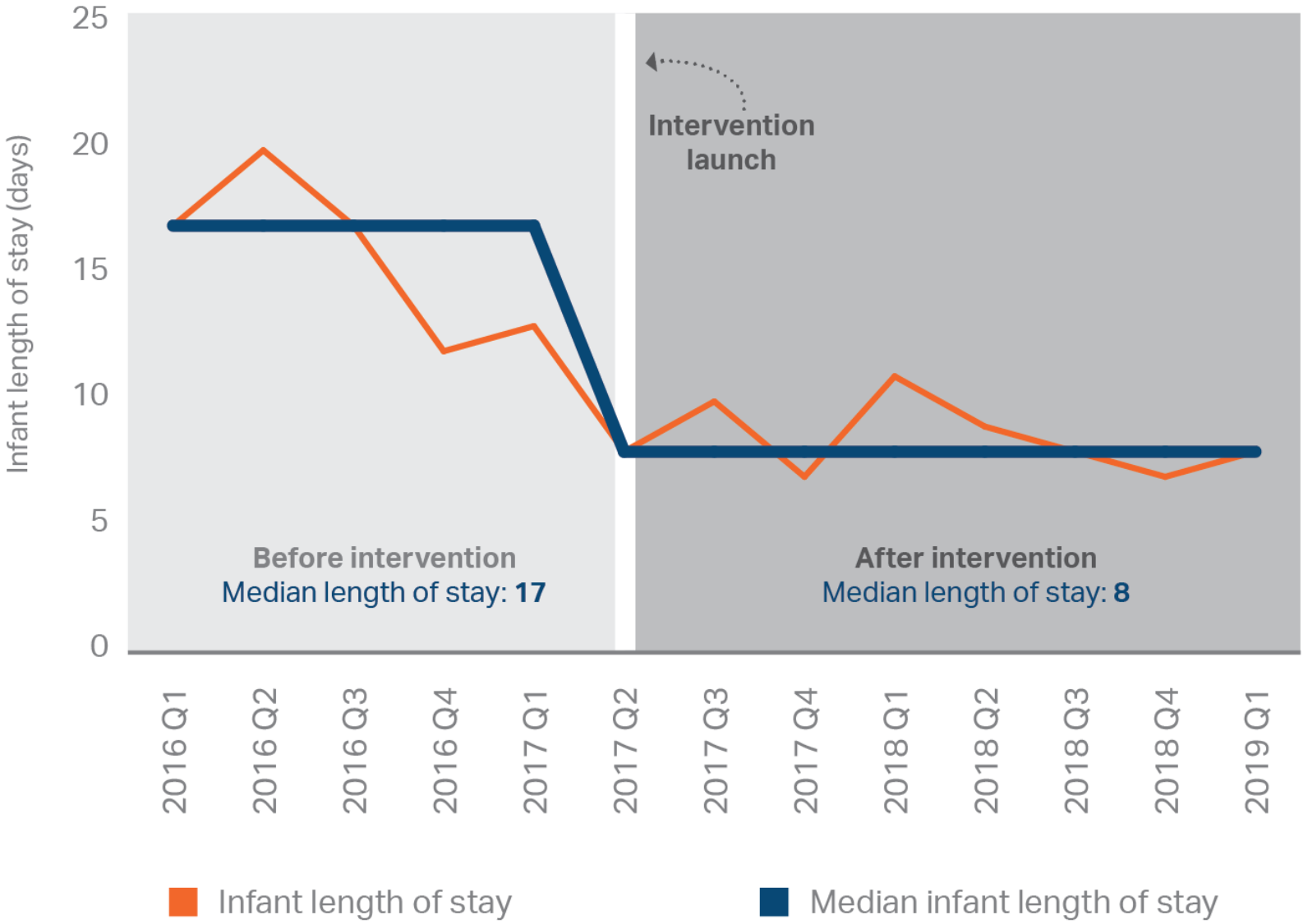
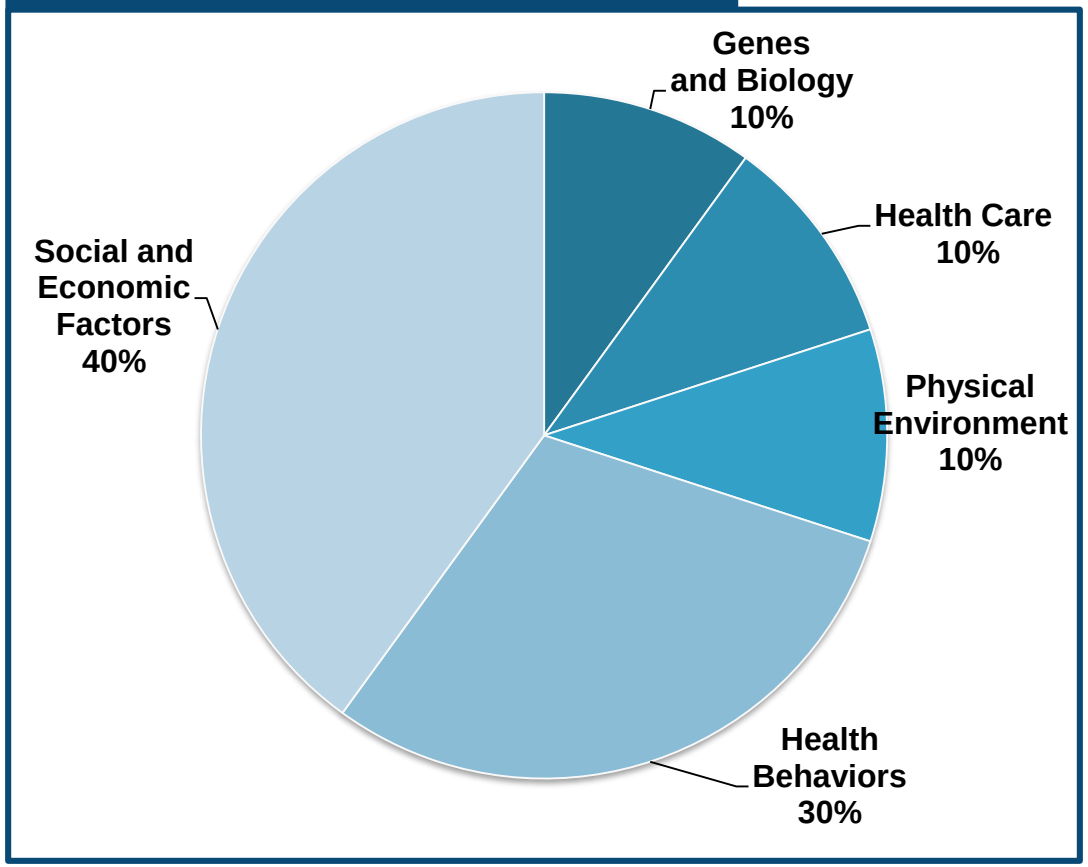
Hospitals successfully achieved a 53% reduction in hospital length of stay for infants, decreasing from 17 days to 8 days following program launch.



Addressing social determinants of health is essential to improving population health, reducing health inequities, and controlling health care costs.

Factors that Impact Health



MASSACHUSETTS HEALTH POLICY COMMISSION

2018 Annual Health Care

COST TRENDS REPORT

PROMOTING AN EFFICIENT, HIGH-QUALITY HEALTH CARE DELIVERY SYSTEM

#8. SOCIAL DETERMINANTS OF HEALTH. The Commonwealth should continue to address the impact of social determinants of health (SDH) on health care access, outcomes, and costs.

SOURCE: Tarlov, A. Public Policy Frameworks for improving population health. Annals of the New York Academy of Sciences. 1999. 896. 281-93

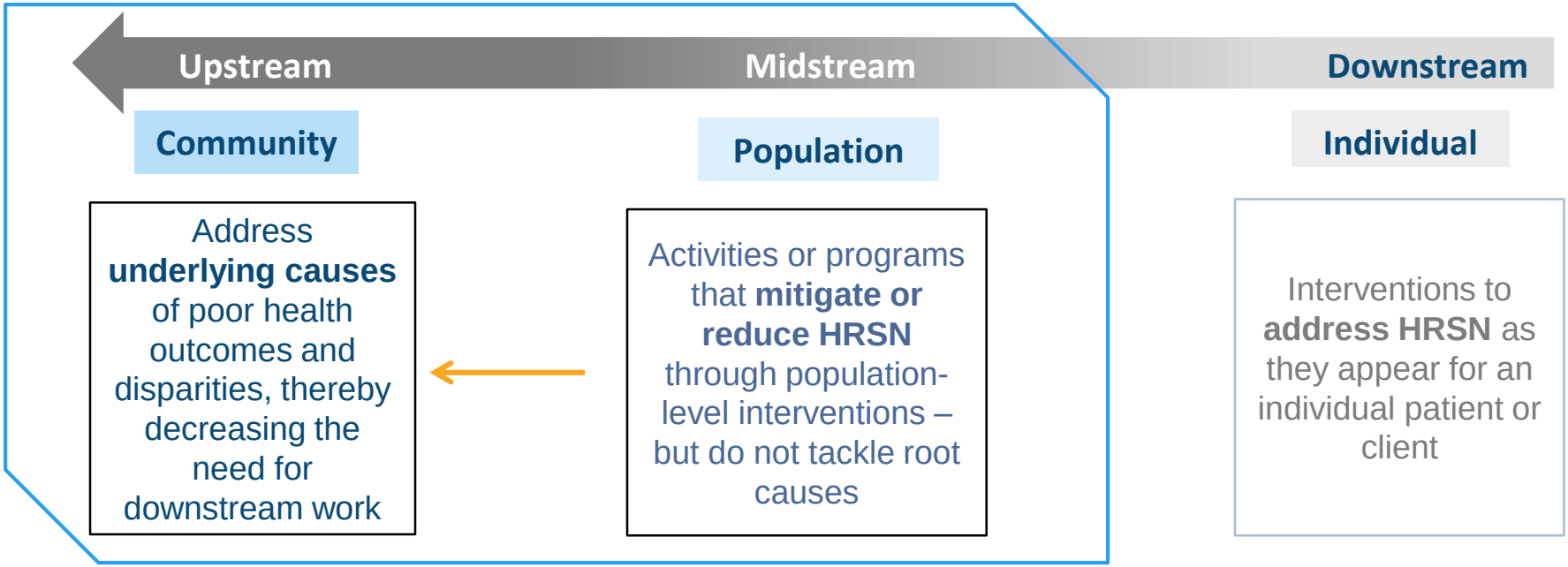
Overview of Moving Massachusetts Upstream (MassUP)

MassUP Vision:
Better health, lower costs and reduced health inequities — across communities and populations in Massachusetts — through effective partnerships between government, health care systems, and communities to address the social determinants of health.

- **A partnership across state agencies: DPH, MassHealth, AGO, EOEA, and HPC**
- Goal: to engage in **policy alignment activities** and make **investments to support health care system–community collaborations** to more effectively address the "upstream" causes of poor health outcomes and health inequity

What would it mean for health care providers and CBOs to align current work and "move upstream" through MassUP?

A shift in focus...



...and activities.

1. **Understand the local community's needs and health and health equity priorities** through CHNA data, authentic engagement, etc.
2. **Inventory current health system and community work** to identify opportunities to modify/align and move further upstream
3. **Develop upstream-oriented intervention,** including goals, strategies, and tactics

SOURCE: Downstream to upstream arrow graphic adapted from the Bay Area Regional Health Inequities Initiative framework, http://barhii.org/framework/

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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

Factors for Evaluating Cost and Market Impact of Provider Transactions

MARKET FUNCTIONING

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

Benefits of HPC's Reviews of Provider Affiliations

The Material Change Notice (MCN) and Cost and Market Impact Review (CMIR) process, in addition to increasing public awareness of provider affiliations, has produced the following benefits for consumers in Massachusetts:

Future Accountability: Requiring entities to disclose goals for a transaction allows the HPC and others to assess whether those goals have been achieved in the future.

Voluntary Commitments: Some entities have addressed concerns raised by the HPC by making certain public commitments (e.g., increasing access for Medicaid patients, not implementing facility fees at acquired physician clinics).

Support for Enforcement Actions: Findings in CMIR reports have been used by the Massachusetts Attorney General and Department of Public Health to negotiate enforceable commitments to address cost, market, quality, and access concerns.

- CMIR findings may be considered as evidence in Massachusetts antitrust or consumer protection actions, and in Determination of Need reviews.

Impacts on Transaction Plans: In some cases, entities have planned affiliations in part based on the likelihood of a CMIR, and in other cases have decided not to pursue an affiliation after the HPC raised concerns in the MCN or CMIR process.

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What's Next for the HPC?

Humble Beginnings: Creating A New Government Agency

The Boston Globe

First step for state's new Health Policy Chief: scrub the refrigerator

Contact Information

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