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.
The HPC: Governance Structure

Governor
- Chair with Expertise in Health Care Delivery
- 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*

Advisory Council
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.

**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.
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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.
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.
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

<table>
<thead>
<tr>
<th>Category</th>
<th>2016-2017 Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>1.0%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>4.9%</td>
</tr>
<tr>
<td>Physicians and Other</td>
<td>1.5%</td>
</tr>
<tr>
<td>Professionals</td>
<td>-3.1%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>4.1%</td>
</tr>
<tr>
<td>Other Medical</td>
<td>-2.8%</td>
</tr>
<tr>
<td>Non-Claims</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td></td>
</tr>
</tbody>
</table>

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).
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

A HIGH BURDEN FAMILY IS:

- **more likely** to be non-white: 29.4%
- **more likely** to have a disability or activity limitation: 14.7%
- **more likely** to lack a college degree: 62.9%
- **more likely** to be a single parent: 50.1%
- **more likely** to have worse health: 31.8%

**High burden:** share of health care spending is greater than 25% of total compensation.

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.”

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

Before intervention
Median length of stay: **17**

After intervention
Median length of stay: **8**
Addressing social determinants of health is essential to improving population health, reducing health inequities, and controlling health care costs.

**Factors that Impact Health**

- **Genes and Biology**: 10%
- **Health Care**: 10%
- **Physical Environment**: 10%
- **Health Behaviors**: 30%
- **Social and Economic Factors**: 40%

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, EOA, 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...

Upstream

Community

Address underlying causes of poor health outcomes and disparities, thereby decreasing the need for downstream work

Midstream

Population

Activities or programs that mitigate or reduce HRSN through population-level interventions – but do not tackle root causes

Downstream

Individual

Interventions to address HRSN as they appear for an individual patient or client

…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

- 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.
What’s Next for the HPC?

Top 2020 Priorities

- Reducing Health System Administrative Complexity without Value
- Enhancing Transparency of the Pharmaceutical Industry and Supply Chain
- Reviewing the Price and Value of Certain Drugs as Referred by MassHealth
- Enabling Upstream Interventions to Address Social Determinants of Health
- Investing in Improvements for Child and Maternal Health
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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