Massachusetts and its Approach To Health Care Cost Containment Since Its Passage of its 2012 Law—Chapter 224

Prepared for the California Assembly Health Committee

December 11, 2017

Paul A. Hattis MD, JD, MPH

Tufts University Medical School

Why did MA pass a 2012 Cost Containment Law?

- When we passed our access bill in 2006 (Romneycare), there was an explicit policy decision that stakeholders accepted: Defer dealing with cost and quality through state policy in favor of an access effort to cover as many as possible
- Massachusetts though for many years had been *the most* expensive state for health care on a per capita basis (now No. 2)
- A number of reasons for that—but importantly in Massachusetts—a rather rich benefits package for insurance, plus care more often provided by more expensive hospitals, (significant use of AMCs), with the problem exaggerated by health care mergers and acquisitions giving market leverage to some systems or a few specialty hospitals with 'name brand pricing power' affecting both hospital and physician pricing
- So—by 2012 with health care spending having grown faster in MA than the country overall for a good part of the previous decade—legislature and Governor Patrick decided to pass Chapter 224 as an effort to begin to take on the spending challenge
- Structurally—new law created 2 new *independent* state agencies to help provide oversight and guidance to the state's effort

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

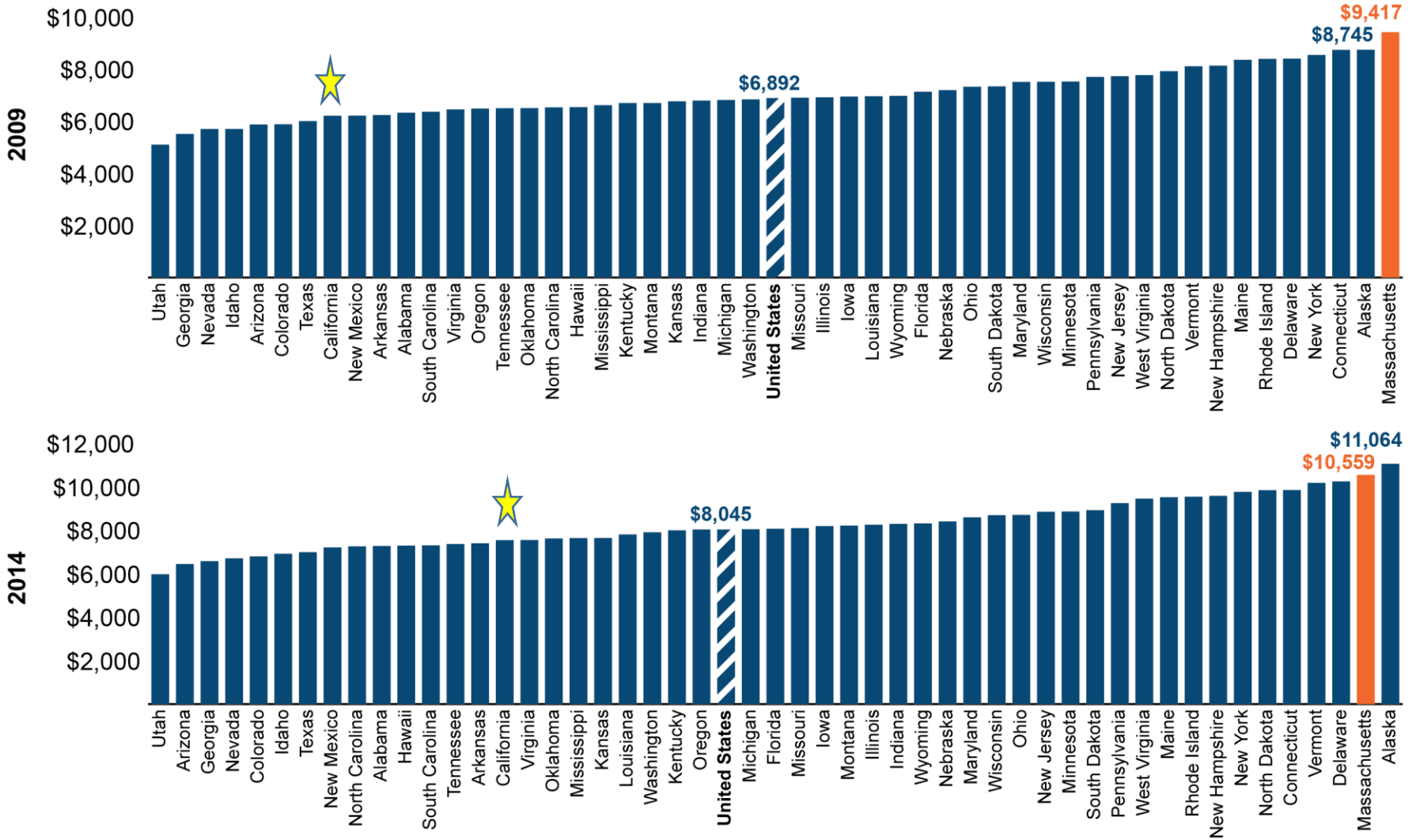
..In case I lose you in the detail—key take home points

- Massachusetts historically expensive in care delivery under commercial insurance
- History of rate regulation in late 1980s through early 1990s when Governor Weld was elected. In 1996, state passed law with guaranteed issue and limited medical underwriting—but not without consequences in terms of impact on raising premiums.
- By 2012, MA had seen for much of previous decade, health care spending growth greater than the national average and above growth of economy
- Since passage of Chapter 224 in 2012—have seen moderating spending growth (due to 2012 law?, 2008 Recession? other factors?)
- Continuing challenges: Provider price variation, mergers and consolidations in provider space, out-of-network care costs, facility fee growth, pharma price challenges, plus all of the other causes of waste (estimated to be 25-35% of all health care spending)
- To date—Massachusetts has held on to the notion of trying to make the 'market work'….Nov. 2017 Senate bill just passed calls for a study of 'single payer'

Per Capita Spending

Massachusetts went from first to second highest in state health care spending by 2014; California well below the median—but has risen slightly over the 2009 to 2014 period

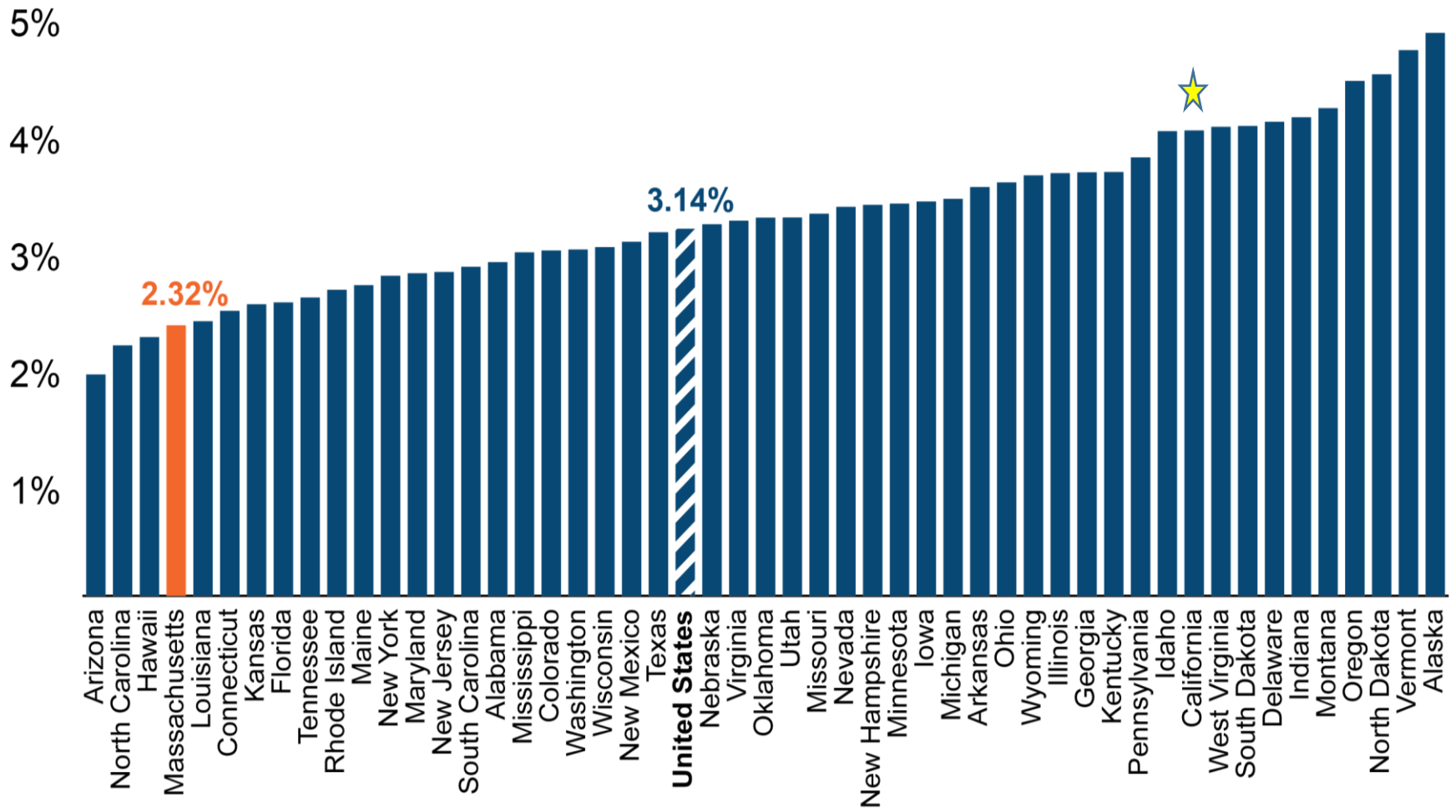
Personal health care spending, per capita, by state, 2009 and 2014



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

Massachusetts healthcare spending grew at the 4th lowest rate in the US from 2009-2014

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



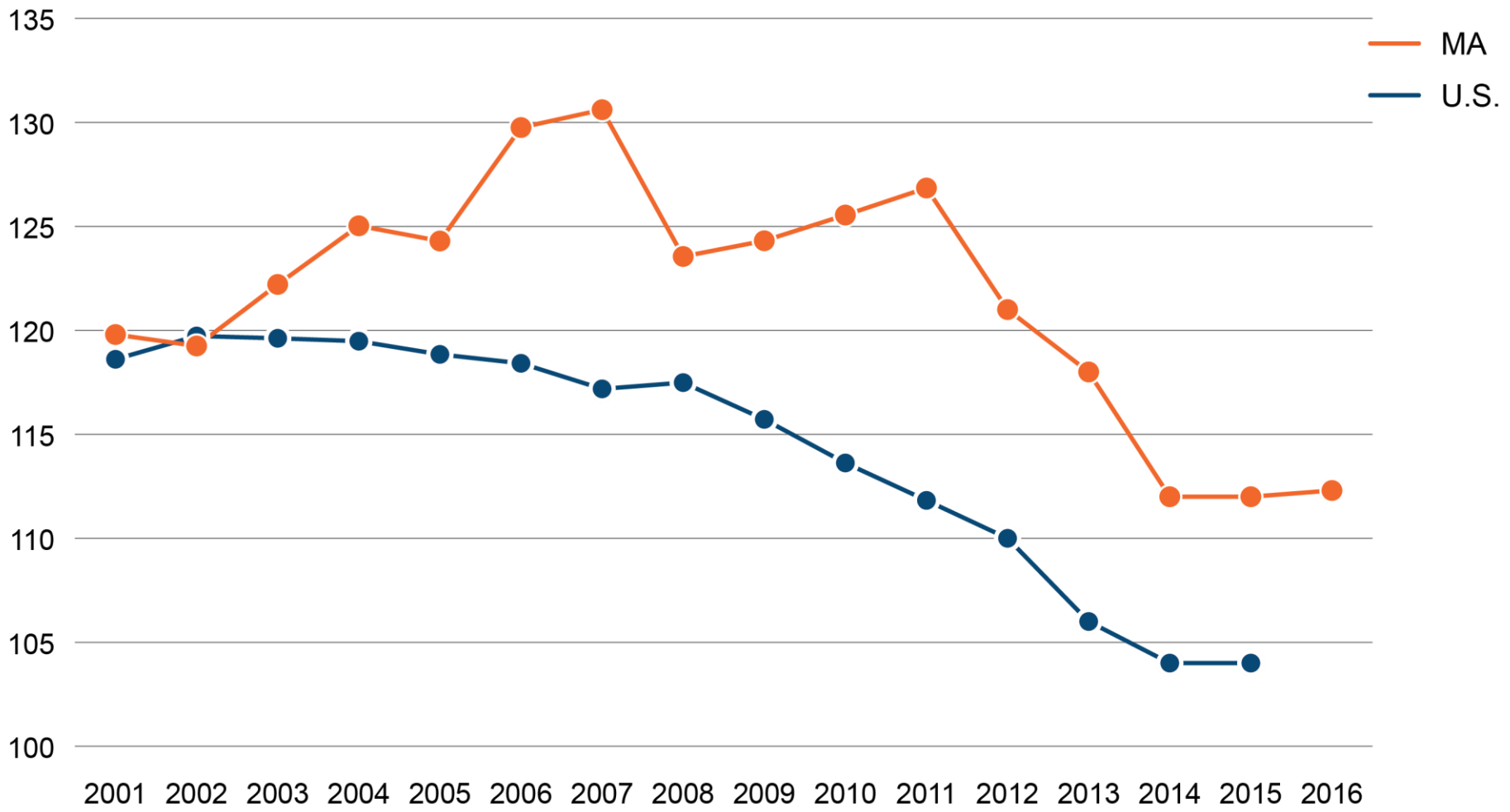
Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

So how is Massachusetts Different than the rest of the country:

- We spend more on hospitals and long term (particularly nursing home) care
- For our hospital care, we use Academic Medical Centers more overall, including for routine care (i.e. 40% of Medicare discharges in Major Teaching Hospitals versus 16% nationally)
- 80% of care is delivered by higher priced providers (hospitals and physicians)
- We have provider markets with more commercial price variation than most states

Hospital inpatient admissions rate in Massachusetts is above the rest of the US

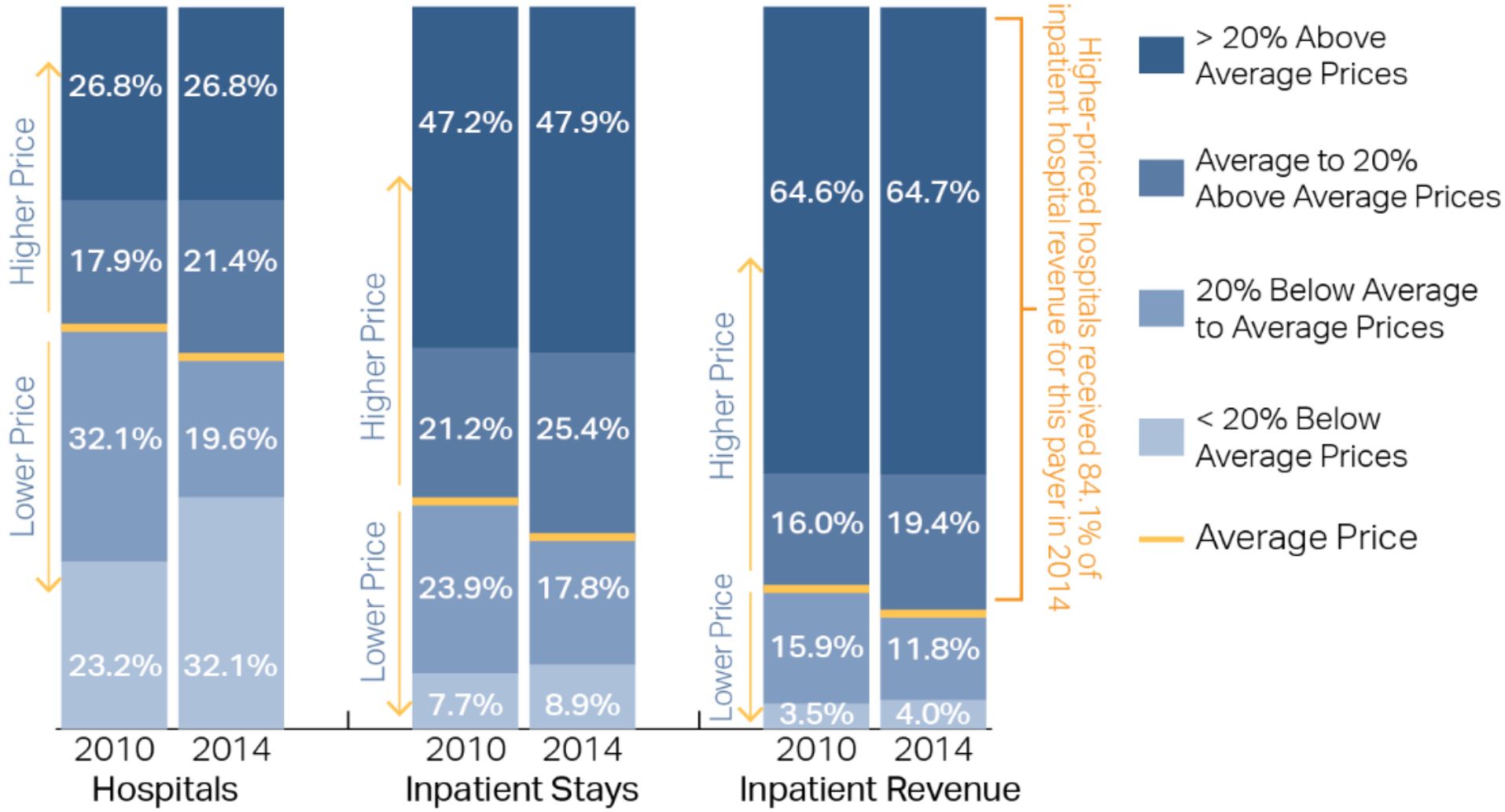
Inpatient hospital admissions per 1,000 residents, MA and the U.S., 2001-2016



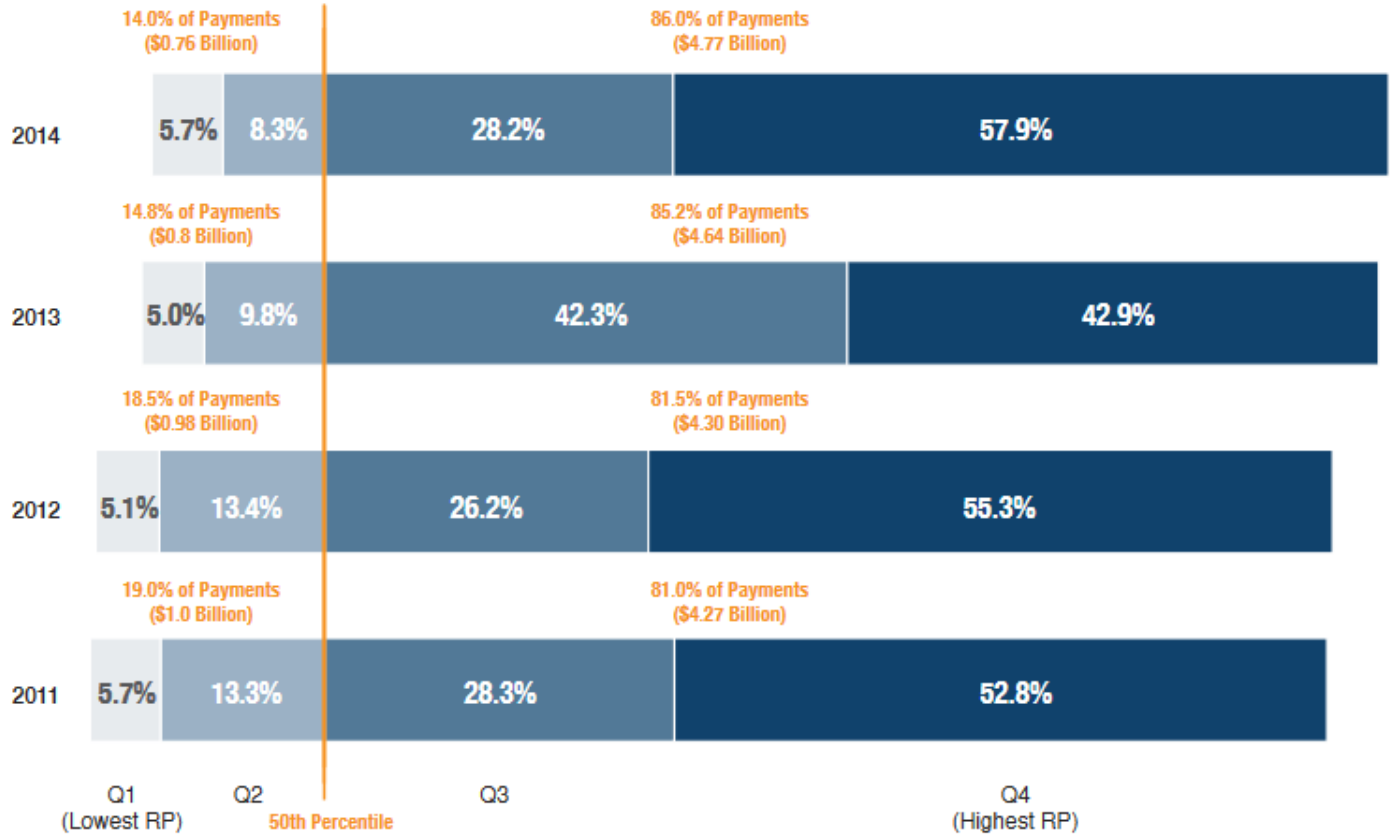
Source: Kaiser Family Foundation analysis of American Hospital Association data (2001-2015); HPC analysis of Center for Health Information and Analysis Hospital Inpatient Database (MA 2016)

Higher health care spending is driven by both the higher prices some providers receive and the large volume at these higher-priced providers.

Distribution of Inpatient Volume and Revenue at Higher and Lower Priced Providers



Distribution of Physician Group Commercial Payments by RP Quartile, 2011-2014

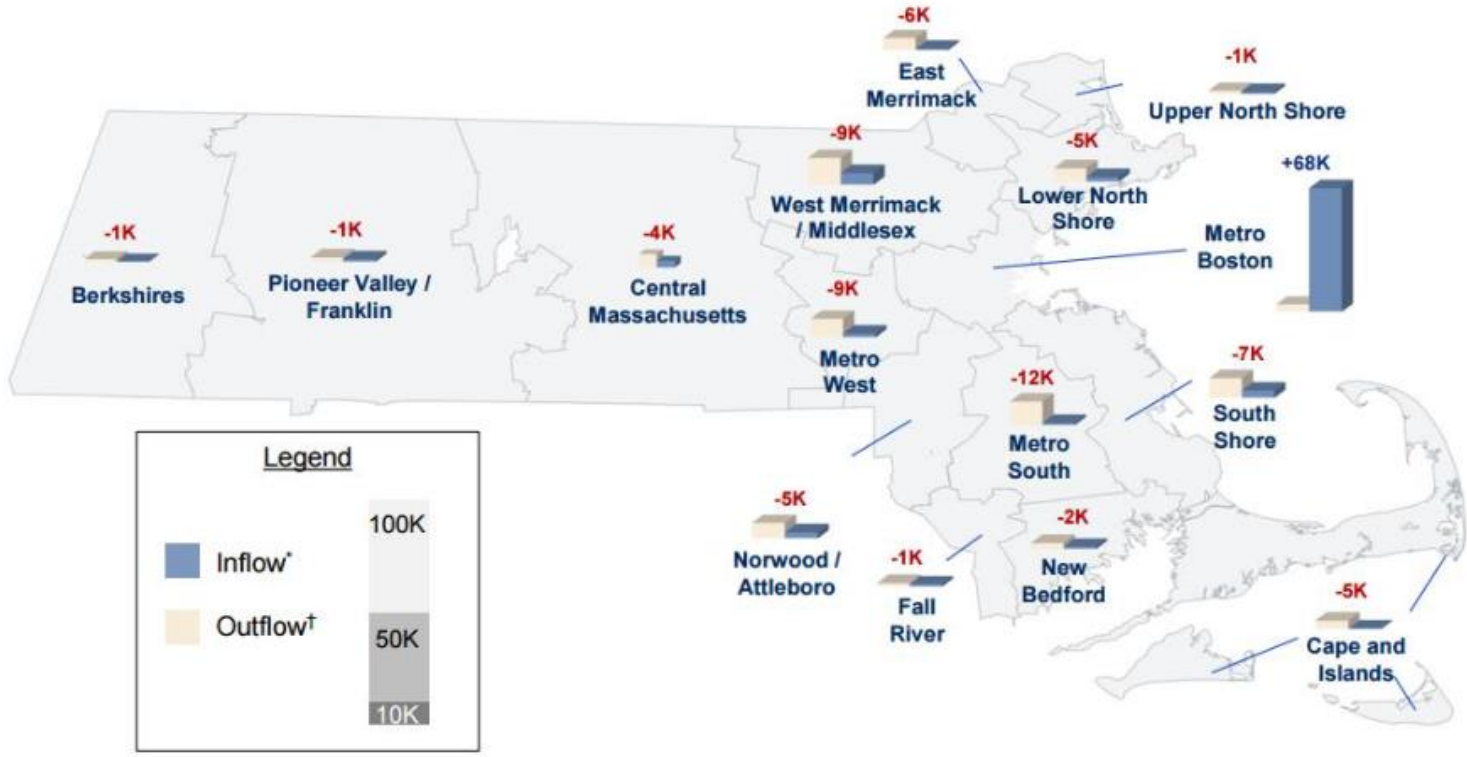


Source: Payer reported data to CHIA

Notes: Within each payer's network, physician groups are ordered by relative price, and grouped into quartiles such that each quartile contains an equal (or as close to equal as possible) number of providers. For each payer, the first quartile (Q1) contains physician groups with the lowest RP values while Q4 contains those with the highest RP values in the network. Payments to physician groups assigned to Q1 are then summed across all payers to calculate total Q1 payments. Note that a specific provider may be assigned to different quartiles in different payer networks. This figure includes only payments made to physician groups that were included in the relative price calculation after payment thresholds were applied, accounting for 99% of Commercial total payments to physician groups.

Statewide: A net movement of hospital care into Boston teaching hospitals

Most Massachusetts residents who leave their home region for inpatient care seek care in Metro Boston at higher-priced hospitals



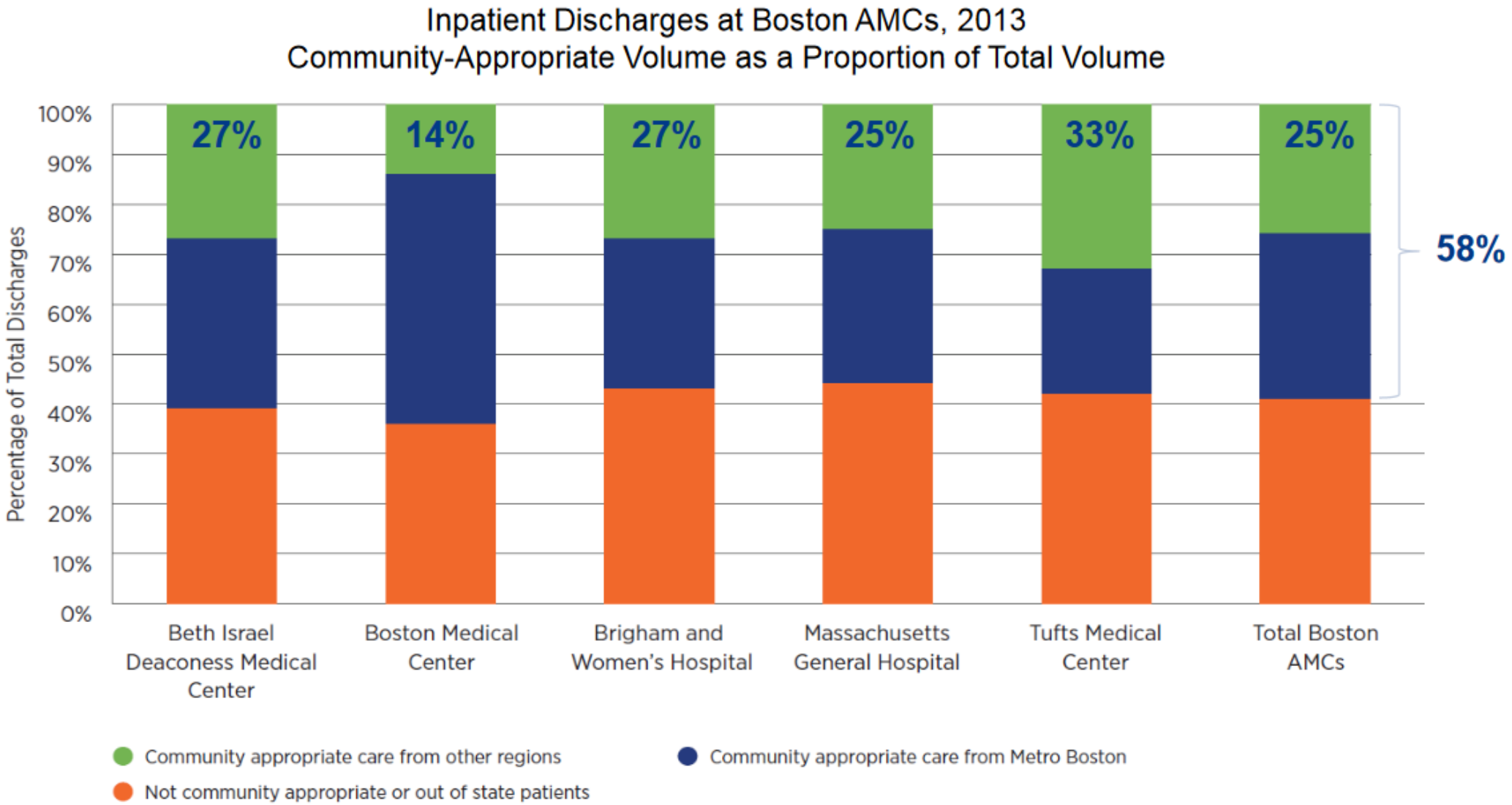
Commercially insured patients are most likely to outmigrate to Boston

Patients from higher income regions are more likely to outmigrate to Boston

Trends hold across a variety of service lines, including deliveries

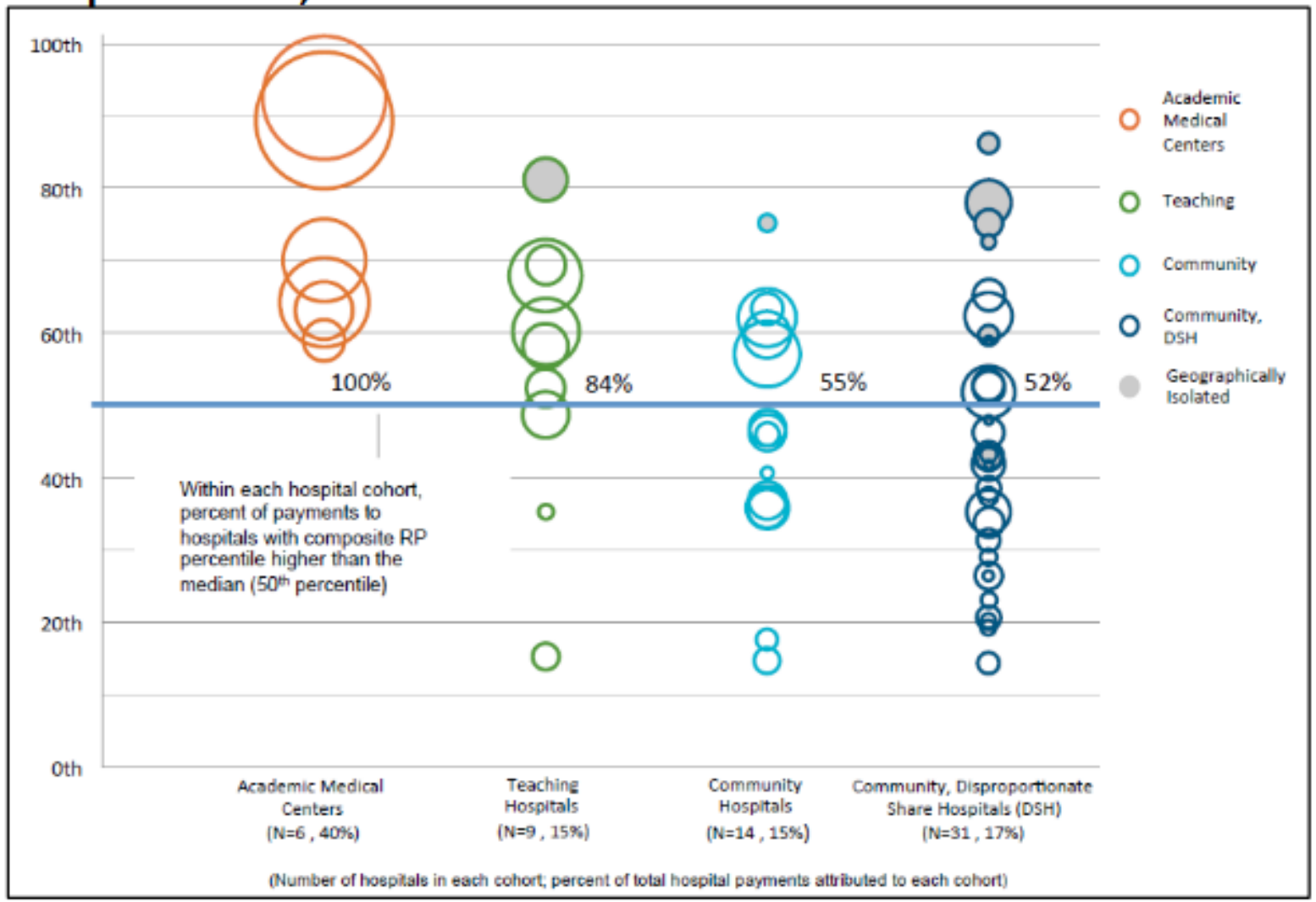
* Discharges at hospitals in region for patients who reside outside of region

A significant portion of the care provided at Boston AMCs could be appropriately provided in a community hospital setting



Provider Prices for Commercial Insurance and Medicare/Medicaid Managed Care are linked to Size and Market Power from Consolidations

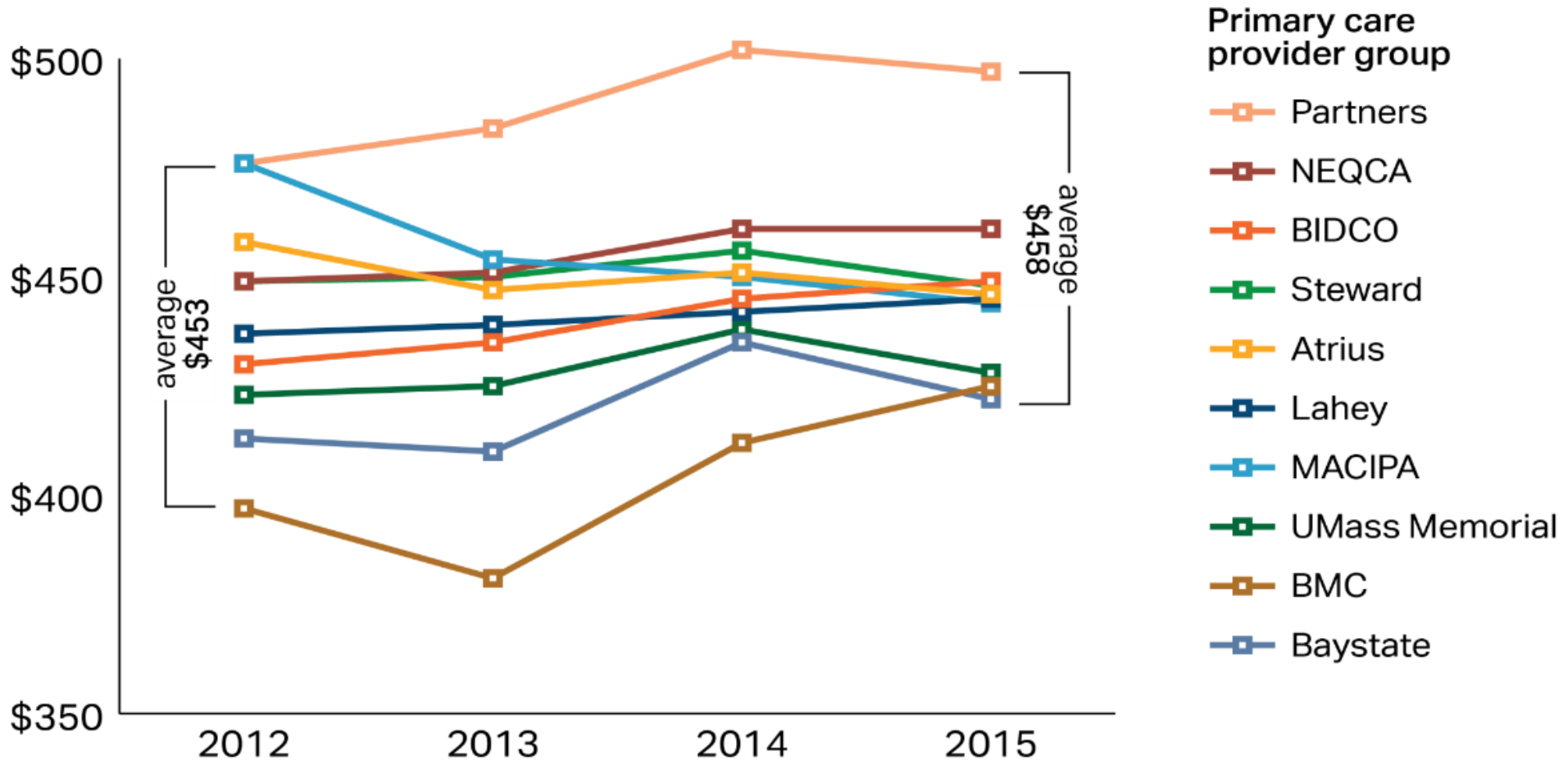
Acute Hospital Composite Blended Relative Price Percentile, by Hospital Cohort, 2014



Reference: CHIA Annual Report Series. Relative Price: Health Care Provider Price Variation in the Massachusetts Commercial Market. February 2016. Available at: http://www.chiamass.gov/assets/docs/r/pubs/16/relative-price-chartbook-2014.pdf.

TME by PCP group has converged somewhat over time, with the exception of Partners

Blended health status adjusted TME, per member per month, 2012-2015

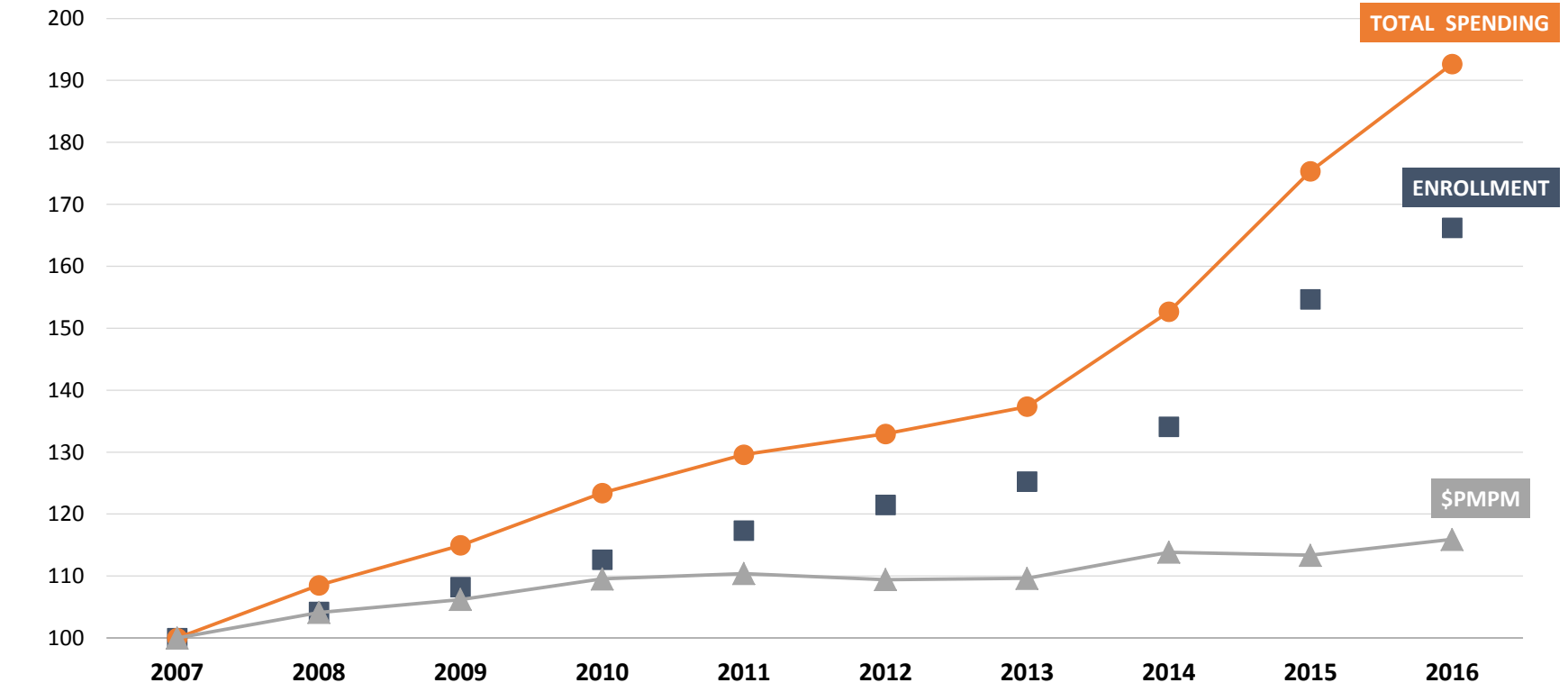


Notes: TME= total medical expenses, Blended TME is the combined normalized health status adjusted TME weighted across the three largest commercial payers (see Technical Appendix for details). Analysis includes the 10 largest primary care groups as identified by the Center for Health Information and Analysis (CHIA) in terms of member-months: Partners Community Physicians Organization (Partners); New England Quality Care Alliance (NEQCA), a corporate affiliate of Wellforce; Beth Israel Deaconess Care Organization (BIDCO); Steward Health Care Network (Steward); Atrius Health (Atrius); Lahey Clinical Performance Network (Lahey); Mount Auburn Cambridge IPA (MACIPA); UMass Memorial Medical Group (UMass Memorial); Boston Medical Center Management Services (BMC); and Baycare Health Partners (Baycare).

Burden on State Spending from Health Care

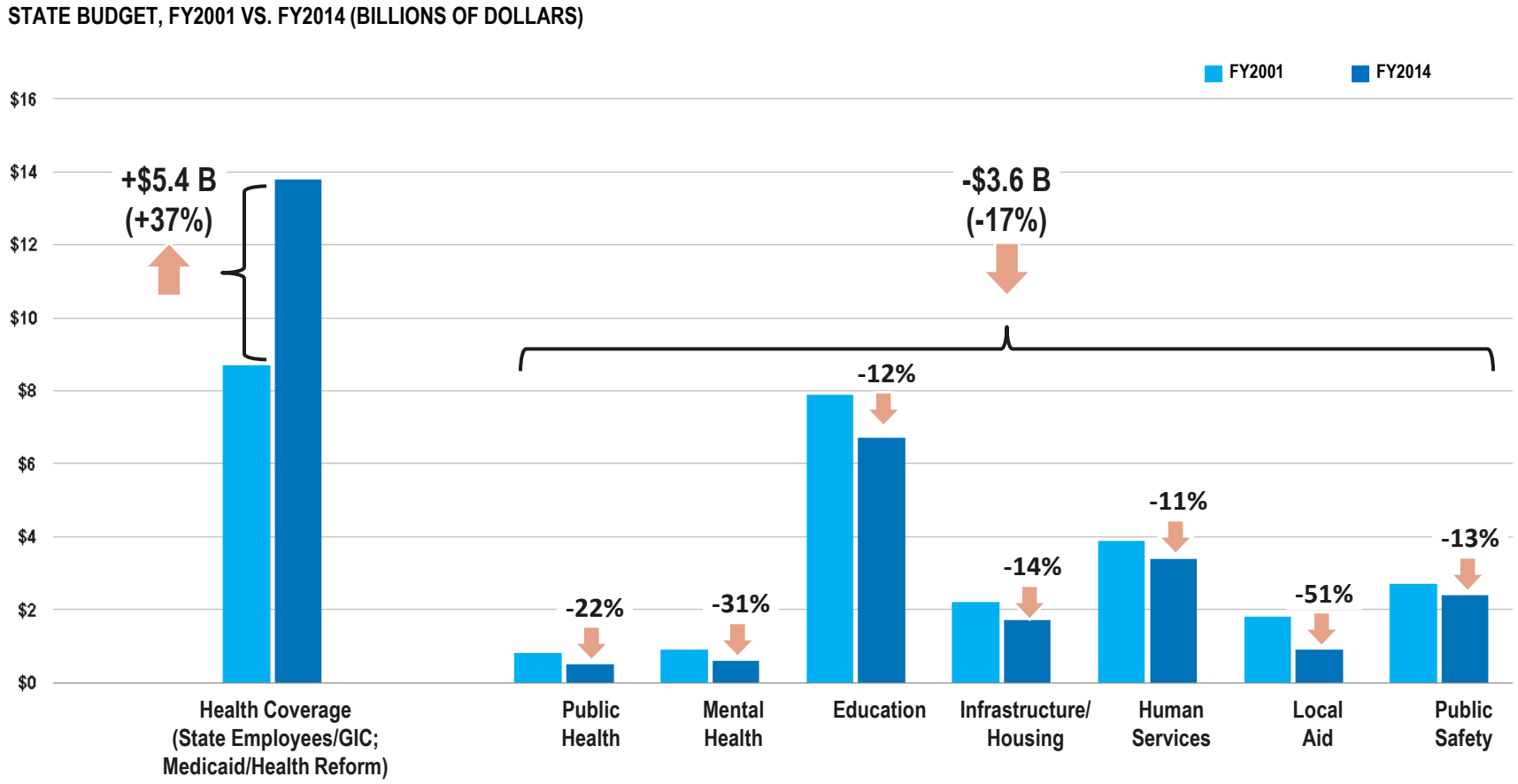
ENROLLMENT, MORE THAN PER MEMBER COST, HAS DRIVEN GROWTH IN MASSHEALTH SPENDING

GROWTH IN MASSHEALTH TOTAL SPENDING, ENROLLMENT AND PER MEMBER PER MONTH (PMPM) COSTS
(YEAR 2007 = 100)



SOURCE: MassHealth Budget Office (total date of service spending and enrollment) and authors' calculations. Excludes spending and enrollment for "Temporary Medicaid" category.

The increasing cost of health care in MA compared to other public spending priorities



Source: Health Policy Commission, 2013 Cost Trends Report, data from the Massachusetts Budget and Policy Center

How We Got Here: Massachusetts Health Care Reform (Part 2 in 2012)

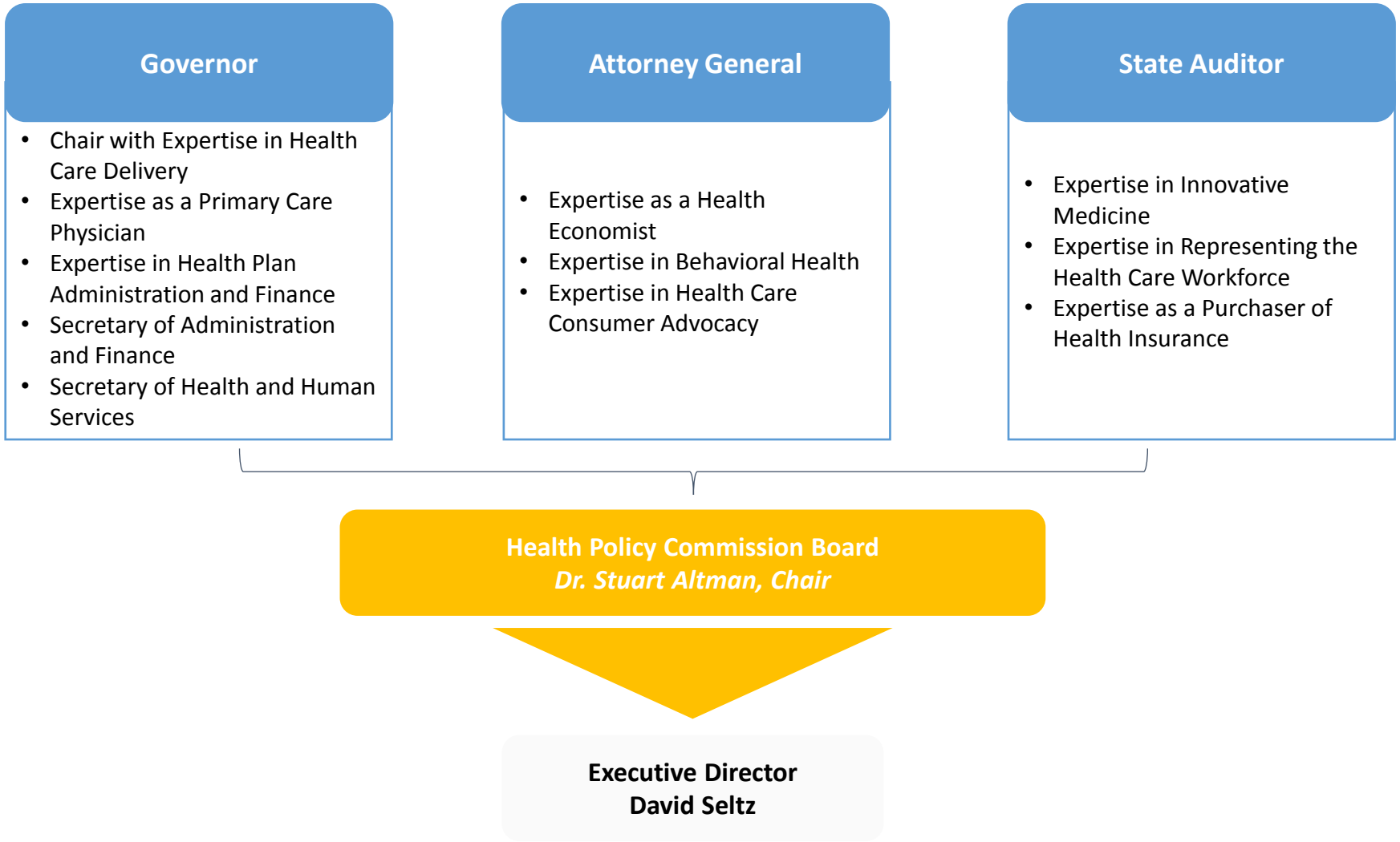
Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation," was signed into law on August 6, 2012 by Governor Patrick and became effective on November 5, 2012. *Bill signing at the Massachusetts State House, Boston.*

Vision for Massachusetts cost containment reform law: Chapter 224 of the Acts of 2012

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 Health Policy Commission: Governance Structure



MASSACHUSETTS
HEALTH POLICY COMMISSION

Main Responsibilities

- Monitor system transformation in the Commonwealth and cost drivers therein
- Make investments in the Commonwealth's community hospitals to establish the foundation necessary for sustainable 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

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

HPC

In summary: MA Cost Control effort since 2012: The G.P.S. Approach

In 2012, Massachusetts decided to navigate to reduce growth in health care spending through using the "G.P.S." formula

G: **G**lobal Payments (alternatives to fee-for-service) and Getting Care to stay Local

P: Increase **P**rovider Price Transparency, and **P**erforming Cost and Market Impact Reviews, require Performance Improvement Plans (though none yet asked for since this HPC power to mandate these started in 2016)

S: **S**pending Growth Targets for All Medical Care

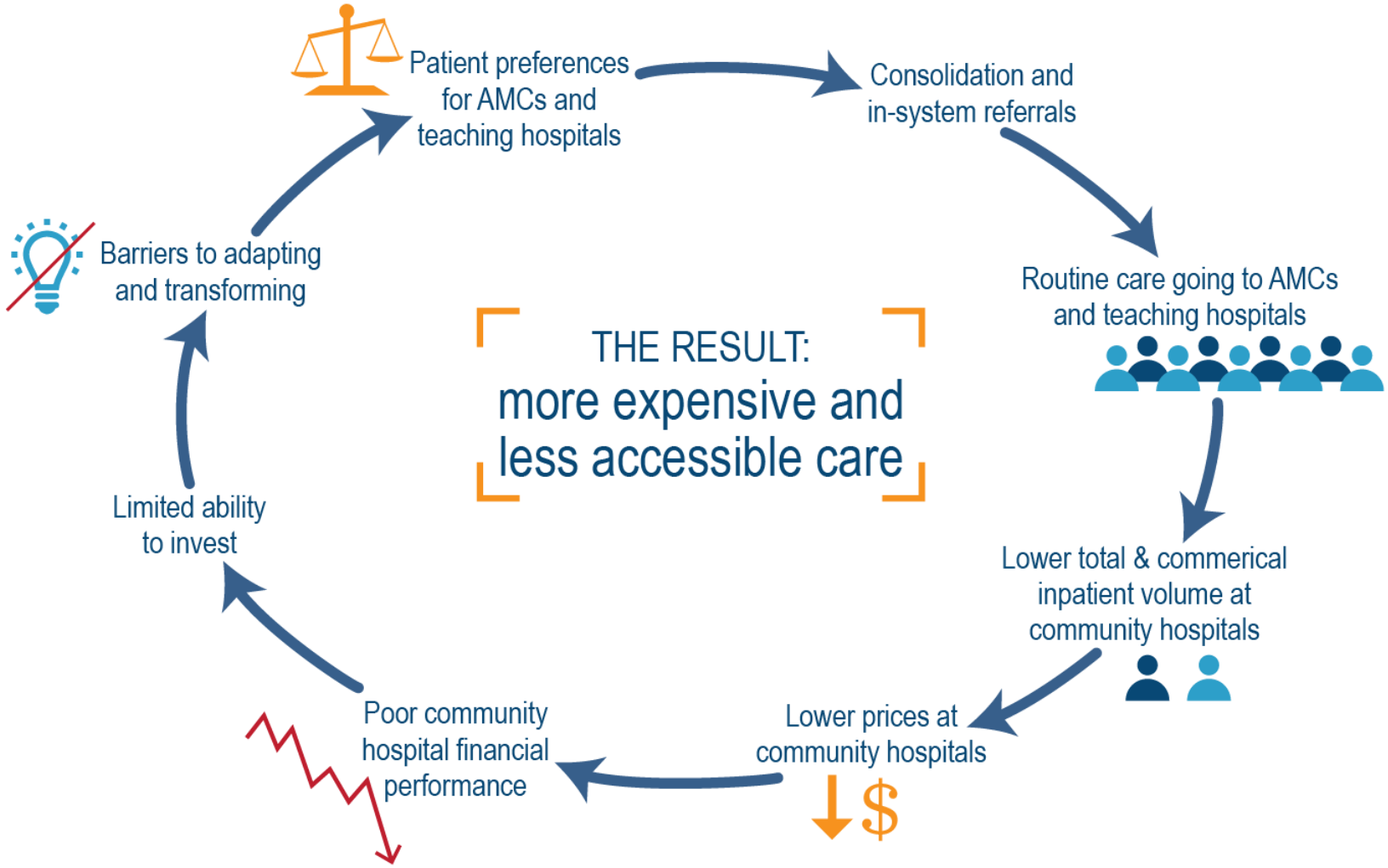
Global Payment: HPC is charged with developing ACO and PCMH certification programs to both promote high-quality, coordinated, patient-centered accountable care and move toward Global Payment and away from 'naked fee-for-service'

Vision of Accountable Care

A health care system that efficiently delivers well coordinated, patient-centered, high-quality health care, integrates behavioral and physical health, and produces optimal health outcomes and health status through the support of reformed (non-FFS) payment.

1. Create a roadmap for providers to work toward **care delivery transformation – balancing** the establishment of **standards** with room and assistance for **innovation**
2. Establish a common framework for data collection, information gathering, evaluation and dissemination of best practices to promote transparency for future learning
3. Develop standards that align with payers' **own principles for accountable care** to further link accountability and enhance administrative simplification
4. Assure patient engagement and protection in their care, especially for vulnerable populations

Get Care to Stay Local: Massachusetts community hospitals provide tremendous value, but face self-reinforcing challenges that lead to more expensive and less accessible care—so state gave $120 million for ‘transformation’ grants under 2012 law



Price Related Issues and Performing Transaction Reviews

Consumer Price Transparency: Effort in 2012 law to increase price transparency information for consumers in MA (…But not much success—like a group in this national study)

RESEARCH LETTER | HEALTH CARE REFORM

Consumer Behaviors Among Individuals Enrolled in High-Deductible Health Plans in the United States

Jeffrey T. Kullgren, MD, MS, MPH[1,2,3,4]; Elizabeth Q. Cliff, MS[5]; Christopher Krenz, BA[4]; Brady T. West, PhD[3,6]; Helen Levy, PhD[3,5,6]; A. Mark Fendrick, MD[2,3,5]; Angela Fagerlin, PhD[7,8]

JAMA Intern Med. Published online November 27, 2017. doi:10.1001/jamainternmed.2017.6622.

Table 1. Engagement in Consumer Behaviors Among Individuals Enrolled in HDHPs in the United States

	Proportion of Individuals (%)[a]				
Measure	Saved for Future Services	Compared Prices for a Service	Compared Quality Ratings for a Service	Discussed Cost for a Service With Clinician	Tried to Negotiate a Price for a Service
Engaged in behavior in past 12 mo	685/1637 (40)	248/1637 (14)	204/1637 (14)	445/1637 (25)	98/1637 (6)

Discussion

We found that few individuals enrolled in HDHPs in the United States are engaging in consumer behaviors, and those that are could be realizing more benefits.

Peforming 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

Through November 2017, Summary of kinds of transaction notices—to date 8 advanced to a full Cost and Market Impact Review

Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	20	23%
Physician group merger, acquisition, or network affiliation	19	22%
Acute hospital merger, acquisition, or network affiliation	19	22%
Formation of a contracting entity	15	17%
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%

What is a cost and market impact review?

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 either or both the Department of Public Health's Public Health Council for use in the Determination of Need Process, or the state Attorney General for further investigation for violation of any laws

WHAT IT IS NOT

- Differs from Determination of Need (DON) reviews by Department of Public Health—though HPC has the power to choose to study large capital projects and offer comments into the DON process
- Distinct from antitrust or other law enforcement review by state or federal agencies
- ***HPC does not on its own have ultimate power to stop any transaction***

Effect of Performing Cost and Market Impact Reviews

- Of the 8 proposed transactions that went to a full Cost and Market Impact Review, to date, 7 have been completed
- Of the 7, 4 were not found to be of market share or spending consequence such that the HPC recommended any referral to the State Attorney General for further consideration
- Three of the transactions were referred to the State Attorney General. They involved the proposed purchase by Partners Healthcare, of South Shore Hospital (SSH), 2 hospitals part of Hallmark Health (HH) and Harbor Medical Associates (physician group connected to South Shore Hospital.)
- The then Attorney General reached a settlement agreement with Partners for the hospital related acquisition proposals that contained some time limited conduct remedies, but would have allowed the purchase of SS and HH to go forward. However, the settlement was ultimately rejected by a MA judge who found that the conduct remedies were not sufficient to mitigate the harms that the HPC projected and so was a settlement agreement deemed 'not in the public interest.' In the fact of this decision, Partners decided to drop the proposed purchase of these three hospitals.
- Ultimately, only the Harbor Medical (physician group) purchase went forward when our Attorney General send she did not believe she had the legal power to stop it—even though she was not in favor of it and publicly asked Partners not to close the deal.
- One additional CMIR, currently before the HPC, results from Partners proposing to acquire the Mass Eye and Ear Infirmary. HPC Preliminary report found the possibility of substantial increased health care spending. Parties to the transaction submitted a rebuttal to that estimate, and the final HPC report is currently pending.

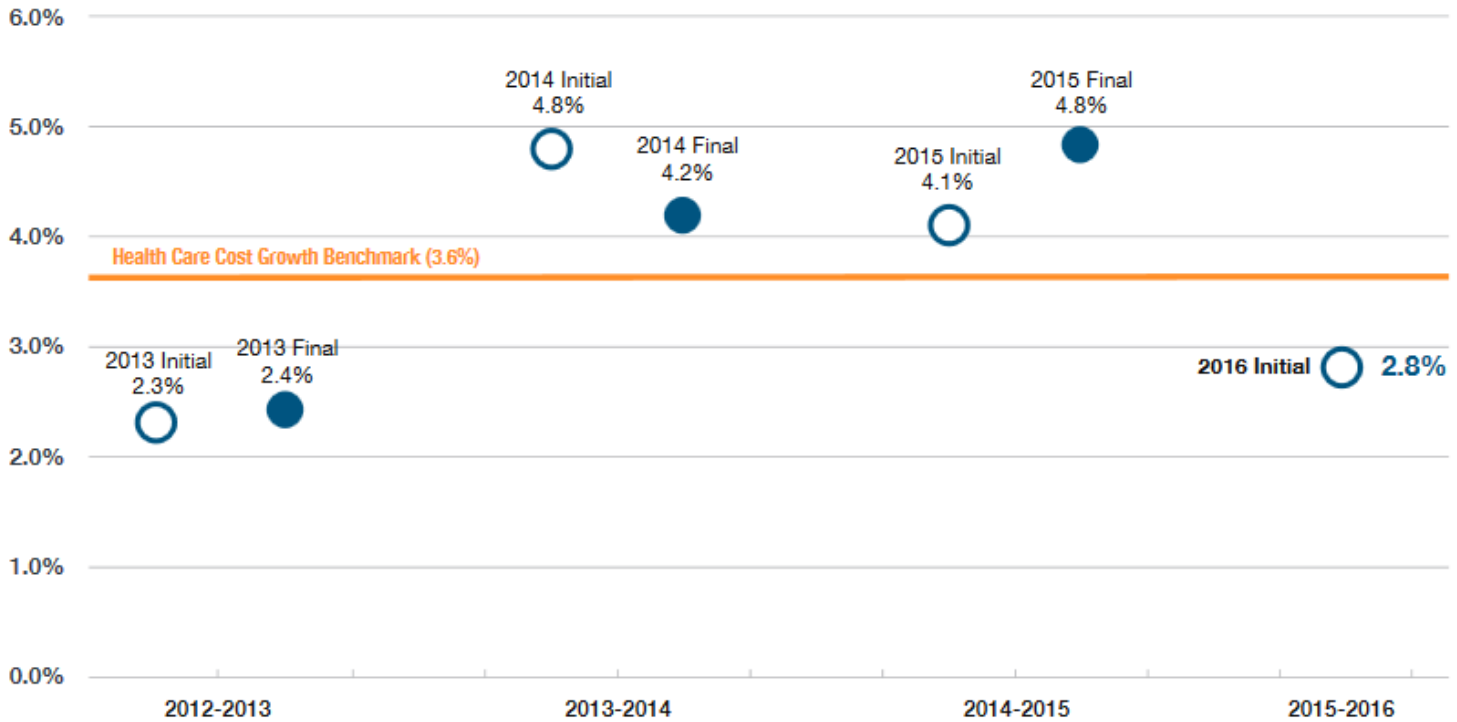
The Spending Target for Total Health Care Expenditures

- **Definition of THCE**: 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

- Sets a target for controlling the growth of total health care expenditures across all payers (public and private), which is set to the state's long-term economic growth rate:
  - Health care cost growth benchmark for 2013 - 2017 equals **3.6%**
  - For 5 years, starting in 2018, set spending target at Predicted Growth of the Economy *less 0.5%* (Now set for **3.1%** for 2018)
- If target is not met, the Health Policy Commission can require health care entities whose growth exceeds the benchmark to implement Performance Improvement Plans and submit to strict monitoring

Per Capita Total Health Care Expenditures Growth, 2012-2016



THE INITIAL ASSESSMENT OF TOTAL HEALTH CARE EXPENDITURES PER CAPITA GROWTH IS 2.8% FOR 2016, BELOW THE HEALTH CARE COST GROWTH BENCHMARK.

Source: Total Health Care Expenditures from payer-reported data to CHIA and other public sources. Inflation from the U.S. Bureau of Labor Statistics: Consumer Price Index 12-Month Percent Change. Gross State Product from U.S. Bureau of Economic Analysis: GDP by State in Current Dollars.

In summary: MA Cost Control effort since 2012: The G.P.S. Approach

In 2012, Massachusetts decided to navigate to reduce growth in health care spending through using the "G.P.S." formula

G: **G**lobal Payments (alternatives to fee-for-service) and Getting Care to stay Local

P: Increase **P**rovider Price Transparency, and **P**erforming Cost and Market Impact Reviews, require Performance Improvement Plans (though none yet asked for since this HPC power to mandate these started in 2016)

S: **S**pending Growth Targets for All Medical Care