Study of Cost Containment Models and Recommendations for Connecticut

Review of Rhode Island and Massachusetts

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March 8, 2016

bailit health

The Healthcare Cabinet
Cost Containment Study is a Partnership

Funded by a grant from the Connecticut Health Foundation

Funded by a grant from the
Universal Health Care Foundation of Connecticut

Funded by The Patrick and Catherine Weldon Donaghue Medical Research Foundation

Funding for this project was provided in part by the Foundation for community Health, Inc. The Foundation for Community Health invests in people, programs and strategies that work to improve the health of the residents of the northern Litchfield Hills and the greater Harlem Valley.

Agenda

1. Review of Rhode Island's Cost Containment Strategies and Discussion

2. Review of Massachusetts' Cost Containment Strategies and Discussion

3. Next Steps

State Cost Containment Models

Six States of Inquiry

Rhode Island

Key Statistics

	Rhode Island	Connecticut
Population	1,055,173	3,596,677
Sources of health coverage	Employer: 54% Medicaid: 18% Medicare: 13% Uninsured: 5%	Employer: 58% Medicaid: 15% Medicare: 12% Uninsured: 7%

Health Care Market Profile: Hospitals

Rhode Island: 13 hospitals

- All but one is domestically owned
- Three large hospital systems with 83% market share; largest with 48%
- Increasing hospital consolidation but relatively few PCPs are employed by hospitals

Connecticut: 28 hospitals

- Most are domestic, but some are operated by larger conglomerate health systems
- Two health systems control the majority of the statewide market (in terms of discharges)
- Market characterized by increasing consolidation

Health Care Market Profile: Primary Care

Rhode Island: ~350 PCP sites, with ~800 individual PCPs

- 1345:1 ratio of population to PCPs
- 10 FQHCs with multiple locations
- 2 large primary care groups

Connecticut: ~3000 individual PCPs

- 1385:1 ratio of population to PCPs
- ~20% of family medicine and internal medicine physicians are not accepting new patients*
- 16 FQHCs

Sources: Physician Perspectives on Care Delivery Reform: Results from a Survey of Connecticut Physicians. April 2015. UConn Health and Yale School of Public Health; and the Robert Graham Center.

Health Care Market Profile: Health Plans

Rhode Island: Two major plans:

- BCBSRI: 68% (local)
- UnitedHealth Care: 27% (national)
- Medicaid: contracts with two MCOs

Connecticut: Dominated by national plans:

- Anthem: 44%
- Cigna: 20%
- Aetna: 18%
- Medicaid: no capitated MCOs

Source for RI: OHIC, 2013
Source for CT: Division of Insurance, 2015

RI State Government's Role in Health Reform

- Office of the Health Insurance Commissioner (OHIC) has been the key agency promoting cost containment initiatives since 2008
- Governor Raimondo, who took office in 2015, wants to build on OHIC's successes and better coordinate state health care reform activities across agencies
- Rhode Island is a SIM Model Test State

Rhode Island Affordability Standards

- Creation of the Affordability Standards
- Affordability Standards Specifics
- Key Success Factors
- Key Challenges
- Next Steps for Rhode Island

OHIC's Unique Authority

- Office of the Health Insurance Commissioner (OHIC), a Cabinet-level office created by the legislature in 2004, is given three unique powers* that were embraced as legislative mandate to address affordability

Provider-oriented Responsibility	• "…encourage fair treatment of health care providers;"
Health Provider-oriented Responsibility	• "…improve the quality and efficiency of health care service delivery and outcome,"
System-oriented Responsibility	• "…view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access. • *Rhode Island PA 42-14.5-2(3),(4)and (5)

OHIC Builds Foundation for Affordability Standards

- 2007 OHIC revises process for annually filing rate factors
  - Consistent across all lines of business and insurers
  - Collected more information and made public
  - Increased public input
- 2008 OHIC required insurers to include descriptions of activities to increase affordability of coverage
  - Made public
  - Produced limited results: nonspecific lists of ongoing management activities, such as disease management, formulary management
- Commissioner saw need for a more targeted approach

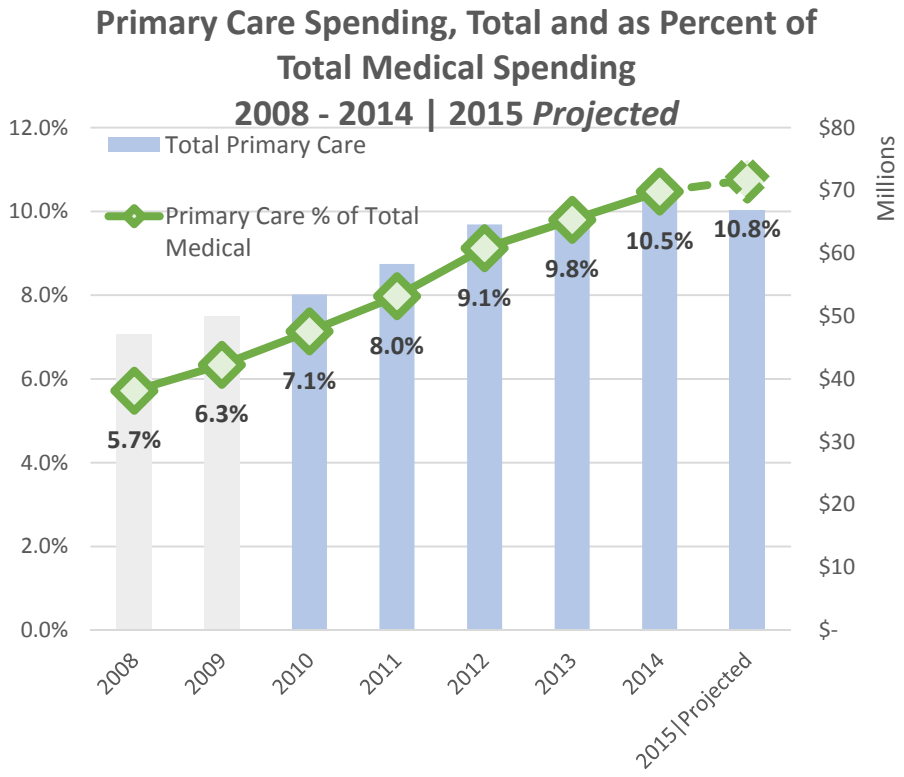
Genesis of Affordability Standards

- Goal: to identify a small number of general affordability priorities and insurer expectations
- Commissioner drove a public process, working with state staff, consultants and OHIC's Health Insurance Advisory Council to develop Affordability Standards, Version 1
- OHIC decided to target affordability efforts, in part, on primary care payment reform, without adding to the overall costs of care
  - Area where insurers can be held accountable
  - Insurers can reasonably be expected to change primary care payment models
  - Strong primary care system can lead to increased affordability

2010 Affordability Standard #1

- Increase Primary Care Spend
  - Beginning in January 2010, insurers had to increase their primary care spend by 1 percentage point annually for 5 years, compared to a 2009 baseline
  - Insurers were to emphasize innovative contracting and payment, and primary care system investment
    - OHIC adopted a broad definition of primary care spend
  - Merely increasing the PCP fee schedule was not permitted
- Insurers' plans were subject to public review and discussion

Primary Care Spending Change Since 2008

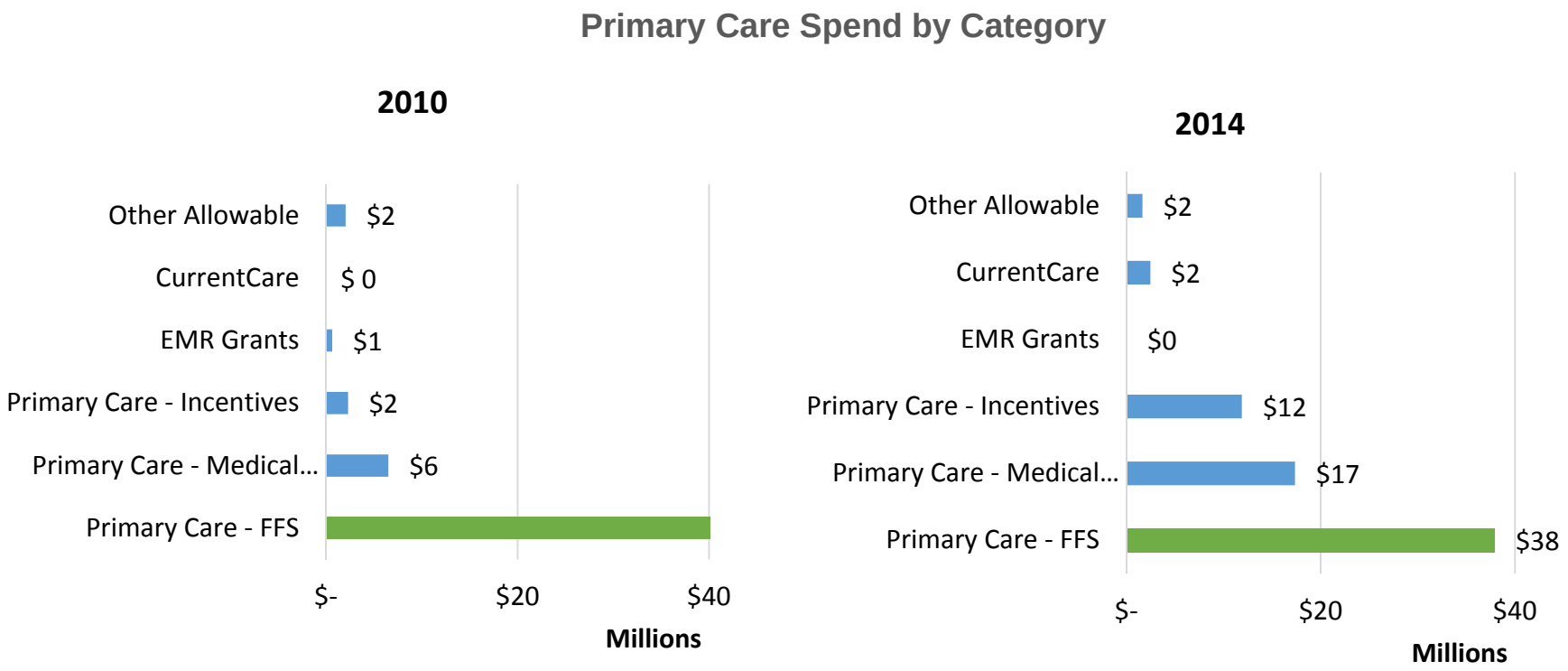


Note: Data reflect insured commercial spending for BCBSRI, United, and Tufts (which entered the market in 2009). NHP also reported through 2015 and will be added to future reports.

Key Facts

- Primary care spending increased from 5.7% to 10.5% of fully insured medical spending between 2008 and 2014.
- In aggregate, primary care spending increased from $47 million to $71 million over this period.
- Under one estimate, the primary care spend standard added an additional $61.7 million to primary care between 2010 and 2014.

Composition of Primary Care Spending: 2010 vs. 2014



In 2010 non-FFS spending equaled 21.5% of the total primary care spend; in 2014 it equaled 46.4% of the total primary care spend.

2010 Standard #2: Support PCMH Expansion

- Insurers were required to provide financial support for a multi-payer PCMH initiative previously spearheaded by OHIC through:
  - Single payment model that support practice-based care managers and infrastructure development
  - Financial support of and participation on Board of Directors of a non-profit organization implementing the initiative
- Initially started with 13 practices (32 in 2016, with potential further expansion in 2017)
- Simultaneously BCBSRI initiated its own PMCH program involving more than 75 practices
- Today approximately 54% of RI PCPs are in PCMHs

2010 Standard #3: Support HIT

- Initially focused on supporting practices to adopt EMRs.
  - Later judged to be duplicative of Meaningful Use initiatives
  - Too costly for insurers to have much impact
- OHIC subsequently revised the requirement to insurers providing financial support to Rhode Island's HIE, "CurrentCare"
  - Most providers, including hospitals, labs, providers, nursing homes participate in the HIE
  - Nearly half of all Rhode Islanders have opted in
  - Key services include: hospital alerts, view of up-to-date clinical information and telehealth alerts from VNAs

2010 Standard #4 (revised): Hospital Payment Reform

Units of Service	• Realign payment to incent efficient use of health services (DRGs, APCs)
Rate of Increase	• Limit average annual rate increase to less than or equal to external CMS PPS Hospital Input Price Index
Quality Incentives	• Allow hospitals to increase total annual revenue through use of quality incentives
Administrative Simplification	• Identify an issue that both parties agree to address during the contract period
Care Coordination	• Hospitals must participate in a Transitions-of-Care QI initiative run by the Medicare QIO
Transparency	• Hospital contracts must allow for the public release of these affordability terms

Impact of Hospital Payment Reform Requirements

Units of Service	• Moved payments to DRGs and APCs
Rate of Increase	• Shifted negotiating leverage to insurers; did not address price variation
Quality Incentives	• Changed focus from Joint Commission checklists to outcome measures; changed quality culture
Administrative Simplification	• OHIC determined issues more effectively addressed in multi-payer forum
Care Coordination	• Would be more impactful, if OHIC coordinated more closely with the implementing entity
Transparency	• Used by OHIC to publish a price variation report

Positive Impact of Affordability Standards: Evaluation of 2010 Version

1. Stakeholders viewed standards as good public policy, as they promote improved quality and reduced costs.
2. All-payer PCMH initiative viewed as a "game changer"
   - All-payer model maximized impact for practices; required stakeholders to think and talk on a system level
   - Provided practices with reliable infrastructure funding
3. Support of CurrentCare is seen as critical to its success
4. Cap on hospital rate increases and QI focus significantly changed hospital – insurer dynamics; gave insurers leverage they did not have previously to promote efficiency and quality
5. Transparency report increased public awareness of price variation

Limitations of Affordability Standards: Evaluation of 2010 Version

1. No clear evidence of reduction in costs: change takes a long time and needs to focus more broadly on alternative payment models for most services
2. Practices receiving additional financial support were concentrated on those participating in the PCMH initiative: payers did not "spread the wealth"
3. Some hospitals/insurers gamed the cap by shifting rate increases to pre-paid quality payments
   - The cap did not address price variation
4. Admin simplification now addressed on an all-payer basis
5. Standards did not address changing provider landscape – growth of ACOs

2015 Affordability Standards (Version 2)

- New standards developed after careful assessment of first version and robust public process
- Tightened definition of primary care spend
- Focused more broadly on payment reform (new Standard #4) to include ACO requirements and “payment-under- the-payment” requirements
- Worked with two advisory groups to develop standard details

Standard #1: Primary Care Spend

- Narrowed definition and refocused payments on PCPs by creating direct/indirect spend requirements
- Primary care spend must be at least 10.7% of total medical spend
  - 9.7% must be “Direct Primary Care Expenses”, which are payment to a primary care practice:
    - To provide health care services,
    - For quality payments,
    - For infrastructure payments,
    - For some shared services among PCPs
  - 1% may be for “Indirect Primary Care Expenses”, such as CurrentCare and support of the multi-payer PCMH initiative

Standard #2: PMCH Promotion

- Sets PCMH target: no later than 12/31/19, 80% of PCP practices function as a PCMH
- Care Transformation Advisory Committee to meet annually to recommend steps to meet the 80% target.
- The 2016-17 Plan includes in part:
  - Uniform PCP payment model for practices counted as PCMHs
  - 3-part definition of PCMH (beyond NCQA PCMH recognition)
  - PCMH target for 2017
  - Adoption of a uniform format for a high-risk patient list
  - Learning sessions on data use and care management
  - Pilot to monitor practice implementation of cost management strategies required of all PCMHs

Standard #3: Support CurrentCare

- Requires continued insurer support for CurrentCare
  - Considered an allowable Indirect Primary Care Payment
  - Commissioner to assess continued support for future years

Standard #4a: Payment Reform – Population-based Contracting

- Creates new ACO-oriented standards
- Establishes population-based contracting targets for shared savings, risk sharing or global capitation
  - End of 2015: 30% of insured covered lives are under population-based contracts
  - End of 2016: 45% with at least 10% covered by risk contract
  - End of 2017 and thereafter, Commissioner to set targets after considering progress to date and with stakeholder consultation
- Requires payers to assess provider organizations' operational and financial capacity to assume down-side risk

Standard #4b: Payment Reform - Alternative Payment Methodology

- Sets APM requirements to strengthen APM adoption
- Requires annual increase in nationally recognized APMs
- APM advisory committee to set annual goals and develop an annual plan
- 2016-17 plan includes:
  - Definitions of Alternative Payment Methodology
  - Sets aggregate APM target (includes FFS payments plus shared savings distributions, bundles, supplemental payments) at 40% of insured medical payments during 2017; 50% during 2018
  - Sets Non-FFS target (bundles, capitation, quality payments, shared savings distribution, supplemental payments) at 6% during 2017 and 10% during 2018

Standard #4b: Payment Reform - Alternative Payment Methodology

2016-17 APM Plan also includes:

- Specialist Engagement: Insurers must submit a plan to:
  - Align incentives between PCPs and specialists to better coordinate care and improve patient experience
  - Develop and implement APMs with high volume specialists and high volume specialty care practices.
- Consumer Safeguards
  - Risk contacts must have quality component to payment model and at last 1 measure must assess patient experience and/or access to referral services
  - Risk contracts must include a clinical risk adjustment as part of the financial model
- Meaningful Downside Risk Study
  - OHIC to conduct a study to define “meaningful downside risk”

Standard #4c: Hospital Contracts

Retains previous requirements & adds requirements that:

- Prohibit contact terms that allow pre-payment of quality incentive
- Mandates contract terms that require re-payment of any unearned quality incentive payment (going forward)
- Change cap on hospital rate increases to CPI-Urban plus 0.75% during 2016 down to 0.0% after 2018.
- Add cap on ACO budgets of CPI-Urban plus 3% in 2016 down to 1.5% after 2018
- Specify data submission requirements for payers.

Keys to Success in Rhode Island

Stakeholder Support

Leadership

Meaningful Enforcement Powers

Leadership

- Legislature supports OHIC's broad use of its powers
  - Legislation provided general direction, but not overly prescriptive
  - Legislature supports broad scope of Affordability Standards
- Strong and creative OHIC leader with vision about role of the office in pursuit of affordability
  - Saw payment reform and practice transformation as keys to promoting affordability; created "burning platform" that reform was inevitable
  - Committed to developing evidence-based standards that are clear and can be publicly assessed and enforced
  - Made it clear that insurers would be held accountable, so focused on initiatives which insurers could control

Leadership (cont'd)

- Nurtured sense of trust among payers, providers and employers and advocates
  - Sought payer and provider input at all stages of process to develop Affordability Standards and used input to make decisions
  - Used public process to present "evidence" of need for change and possible directions of change
  - Sought and used input from employers, providers and consumers via advisory council
  - Very open about acknowledging different perspectives and explaining rationale for decisions made
  - Willing to update standards, when needed, using a consensus approach

Leadership (cont'd)

- Used convener role to engage major payers and met with them quarterly to impress upon them the seriousness of OHIC intent and oversight
- Careful not to define requirements too concretely, too quickly. Guidance letters preceded regulations.
- Insurers have never formally challenged OHIC on its Affordability Standards through the legislature or Governor's Office.

Stakeholder Support

- OHIC respected payer experience and barriers they were encountering in developing Affordability Standards
- OHIC structured some Affordability Standards to align with payers' business strategies as a trade-off for their accepting other provisions. Examples…
  - OHIC helped insurers with hospital negotiations by creating rate increase cap.
  - OHIC did not allow providers to merely increase PCP FFS rates, but required payments to build PCP infrastructure.
- Payers accepted OHIC's funding assessments

Stakeholder Support (cont'd)

- Engaged providers
  - Promoted PCMH initiative that supported practice transformation and infrastructure development
  - Included providers on advisory committees to implement Affordability Standards
- Used Health Insurance Advisory Committee to present and discuss strategy options in public forum
  - Obtained provider, employer and consumer input
  - Shaped Affordability Standards based on input

Meaningful Enforcement Powers

- OHIC has a variety of enforcement powers, including:

1. **Guidance letters** to insurers laying out expectations for meeting Affordability Standards rate review requirements
   - Example: What terms are expected to be included in hospital contracts under Standard #4
2. **Monitoring** through regular data and implementation plan submissions by payers
3. **Regulations** that define Affordability Standard requirements
   - Example: Requirements to increase primary care spending by a specified amount under Standard #1
4. **Annual rate review** process
   - Ultimate power to reject a rate filing, denying the insurer the ability to sell insurance in Rhode Island

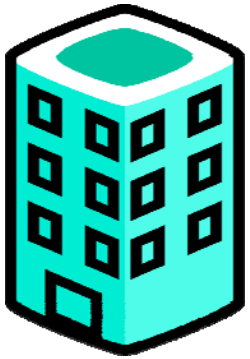
Challenges

1. Balancing promoting meaningful transformation and pushing insurers too far and prompting a political response
   - Constantly seek insurer input into development standards
   - Commissioner must be willing to make unpopular decisions

Challenges (cont'd)

2. Pursuing a primary care strategy when support for primary care initiatives by RI insurers is waning as focus on ACOs grows
   - Plans are increasingly resistant to a requirement to expand PCMH and support PMCH practices with new payment model. They want ACOs to be responsible for primary care transformation and support.

vs



Challenges (cont'd)

3. Engaging providers to implement the Affordability Standards and thereby support payer success
   - OHIC has no direct regulatory authority over providers
   - Providers are expecting to receive payments to participate in transformation initiatives; expectations about levels of payment can be unreasonable

Challenges (cont'd)

4. Having sufficient staff resources to perform non-traditional insurance regulation activities in order to implement the Affordability Standards:
   - Staff Health Insurance Advisory Committee meetings
   - Work with other advisory committees to develop standard specifics, such as definition of PCMH that goes beyond meeting NCQA PCMH recognition standards
   - Develop data collection templates; collect, analyze and distribute data; make determinations as to whether Affordability Standards requirement have been met --
   - Oversee implementation of all-payer PCMH initiative

Next Steps for Rhode Island

- Governor's proposal builds on OHIC's successes
  - Key proposal is to create an office within EOHHS to coordinate state health policy (outside budget process, using existing resources)
  - Office would work with OHIC, state health employees' plan and EOHHS agencies (including Medicaid) to coordinate policy directions. *Medicaid has already adopted OHIC's definition of PMCH and contacting targets for PCMHs and ACOs.*
  - Office would establish a total cost of care increase target
  - EOHHS would hire consultants to address data needs

Summary of Rhode Island Strategies

- OHIC uses legislatively expanded powers to develop Affordability Standards that impact costs:
  - Strengthen primary care sector funding
  - Facilitated multi-payer PCMH initiative and created PCMH contracting targets for insurers
  - Strengthened transition to APMs by setting population-based contracting and non-FFS targets
  - Mitigated cost increases by capping hospital rate increases and ACO budget increases
  - Supported development of state-wide HIE

Summary of Rhode Island Strategies (cont'd)

- OHIC utilizes a wide range of meaningful enforcement powers
  - Guidance letters
  - Monitoring insurer activities through data collection, contract reviews, payer meetings
  - Regulations
  - Rate filing approvals
- OHIC utilizes informal convening powers to build new trusting relationships among stakeholders
  - Promotes initiatives consistent with their strategic direction
  - Actively engage leaders in policy making process

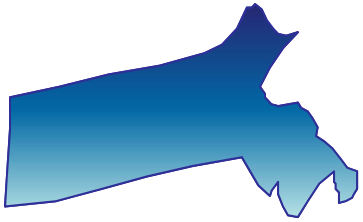
Questions and Discussion

1. Which of Rhode Islands' strategies would you like Connecticut to adopt?
2. How can the strategies be modified to overcome any possible barriers to adoption?
3. What are the facilitators to adoption?

Massachusetts

State Cost Containment Models

Six States of Inquiry



Massachusetts

Key Statistics

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Sources of health coverage	Employer: 53% Medicaid: 24% Medicare: 13% Uninsured: 4%	Employer: 58% Medicaid: 15% Medicare: 12% Uninsured: 7%

Health Care Market Profile: Hospitals

Massachusetts: 82 hospitals

- Dominated by system-affiliated hospitals
- 72% of all payments to hospitals from commercial payers went to system-affiliated hospitals
- The Partners system accounted for 31% of all acute hospital payments from leading commercial payers

Connecticut: 28 hospitals

- Most are domestic, but some are operated by larger conglomerate health systems
- Two health systems control the majority of the statewide market (in terms of discharges)
- Market characterized by extensive consolidation

Health Care Market Profile: Primary Care

Massachusetts: ~5,800 practicing PCPs

- 1,144:1 ratio of population to PCPs
- 36 FQHCs

Connecticut: ~3000 individual PCPs

- 1385:1 ratio of population to PCPs
- ~20% of family medicine and internal medicine physicians are not accepting new patients*
- 16 FQHCs

Sources: Physician Perspectives on Care Delivery Reform: Results from a Survey of Connecticut Physicians. April 2015. UConn Health and Yale School of Public Health; and the Robert Graham Center.

Health Care Market Profile: Health Plans

<u>Massachusetts</u>: Highly concentrated, but with local plans

- BCBSMA: 45% market share
- Harvard Pilgrim: 20% market share
- Tufts: 14% market share
- Medicaid: ~70% in managed care (~20% in PCCM program) ~30% in FFS

<u>Connecticut:</u> Dominated by national plans

- Anthem: 44%
- Cigna: 20%
- Aetna: 18%
- Medicaid: no capitated managed care entities

Source for MA: Center for Health Information and Analysis, 2015
Source for CT: Division of Insurance, 2015

MA State Government's Role in Health Reform

1. Legislature has been very influential in shaping health care policy
   - by passing laws that create health care policy, and create the state infrastructure to monitor the health care system
   - by tasking various state agencies to study health care problems, and then to acting upon findings
2. Several Governors have made health care reform a priority and each one has helped advance health reform in the state
   - Current Governor is a former Secretary of the agency that oversees health and human services in the state

Key Legislative Initiatives

1995 2000 2005 2010 2015 2020

1996

Non-group health insurance reforms:

- Guarantee issue
- Pre-existing condition limitations
- Standardized benefits
- Community ratings limit price variation based on demographics

2000

- Established Office of Patient Protection and DOI's Bureau of Managed Care
- Creation of Managed Care Oversight Board
- AG given authority to review the sale of nonprofit plans or providers to for-profit entities

2006

- Insurance mandate
- Exchange established
- Expanded MassHealth coverage for children
- Established the Health Care Quality and Cost Council

2008

- AG given authority to examine cost trends through subpoena power
- Special Commission on Payment Reform Created

2010

- Transparency of TME, relative prices and costs
- Requirement for plans to offer tiered/limited network products
- Reform of unfair contracting practices

2012

- Created cost growth benchmark
- Created Health Policy Comm. and CHIA
- Required Medicaid and state employees to adopt alternative payment models

2016

HB 820

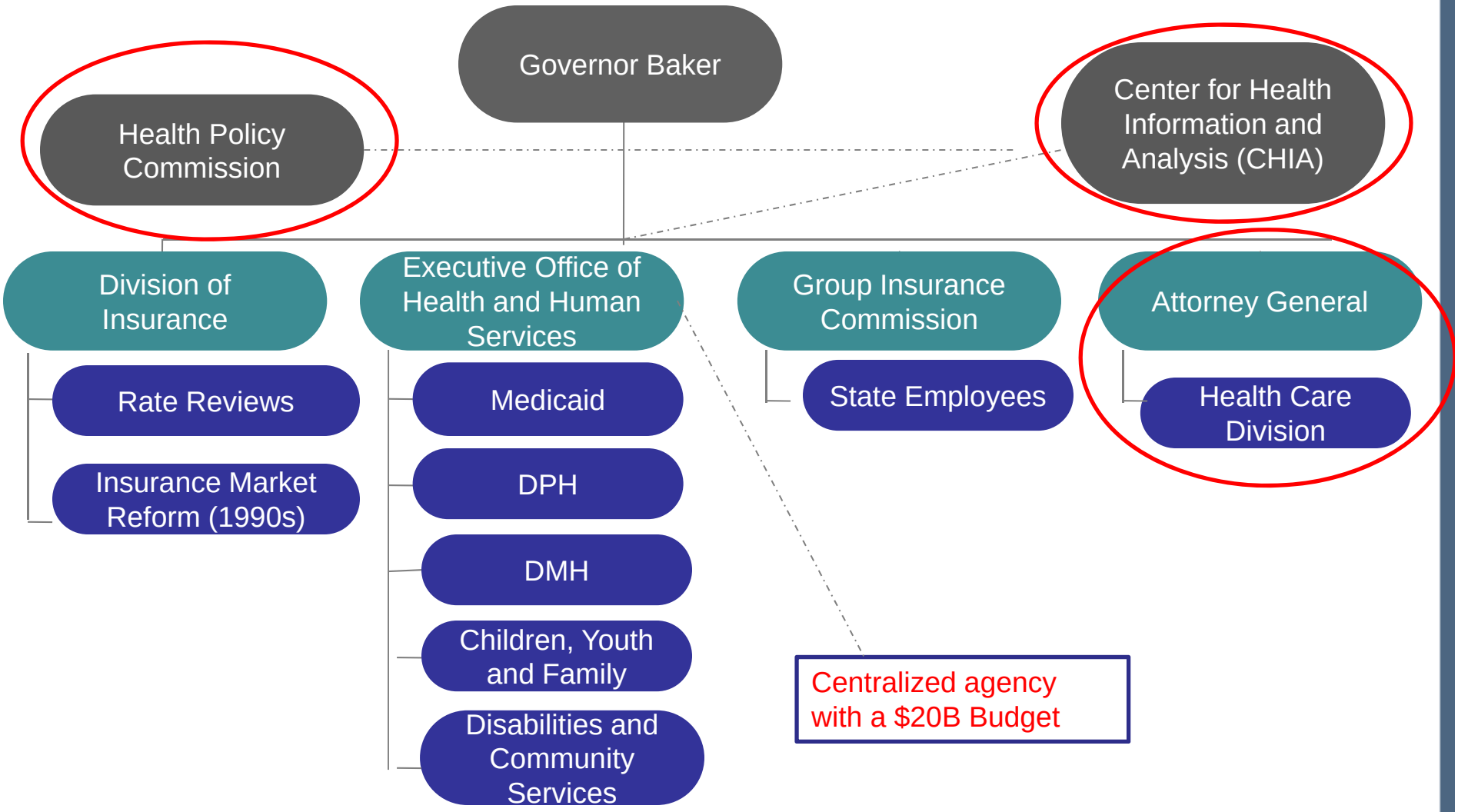
- Index cost growth benchmark based on relative price of organization

HB 3931

- Gave Health Policy Commission the ability to set caps and floors on provider prices

Sources: MA Attorney General's Office, 2016; Blue Cross and Blue Shield of MA Foundation, 2010; MA Medical Society, 2006;

MA Government Oversight of Health Reform



Note: This chart was created based on assessment of Massachusetts's organizational structure; it is not an official representation.

Massachusetts Cost Containment Strategies

1. Promotion and use of of alternative payment models

2. Transparency of fact-based information on providers and health plans.
   - Arms all market participants with LOTS of data on the market
   - Consumers are not the primary audience, though the *Boston Globe* keeps them well informed
3. "Light-touch" regulatory approach, with constant threat of a "heavy-handed" regulatory approach

2009 Special Commission on Payment Reform

- Created by the legislature in its 2008 health care reform bill *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care.*
- It defined its vision for "**fundamental reform** of the Massachusetts health care payment system that will support safe, timely, efficient, effective, equitable, patient-centered care and both **reduce per capita health care spending and significantly and sustainably slow future health care spending growth**."

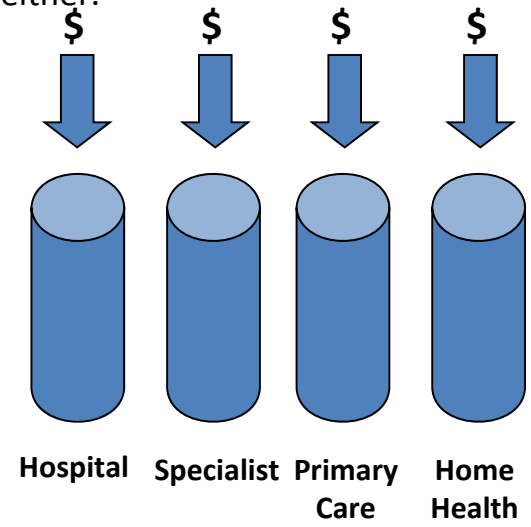
Source: Recommendations of the Massachusetts Special Commission on the Health Care Payment System, 2009

Recommendation: Make Global Payment the Predominant Payment Model by 2015

Current Fee-for-Service Payment System

The Problem

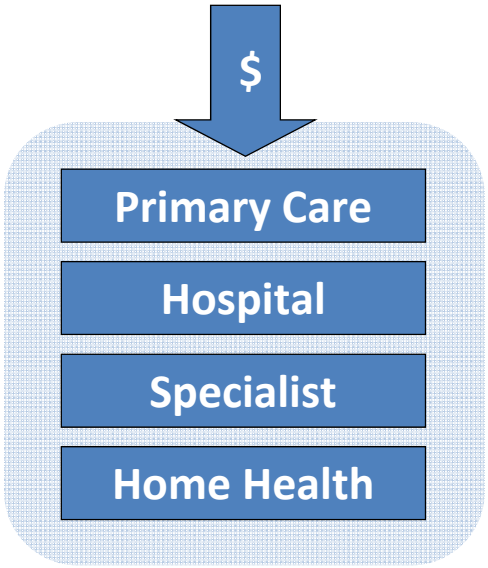
Care is fragmented instead of coordinated. Each provider is paid for doing work in isolation, and no one is responsible for coordinating care. Quality can suffer, costs rise and there is little accountability for either.



Patient-Centered Global Payment System

The Solution

Global payments made to a group of providers for all care. Providers are not rewarded for delivering *more* care, but for delivering the *right* care to meet patient's needs.



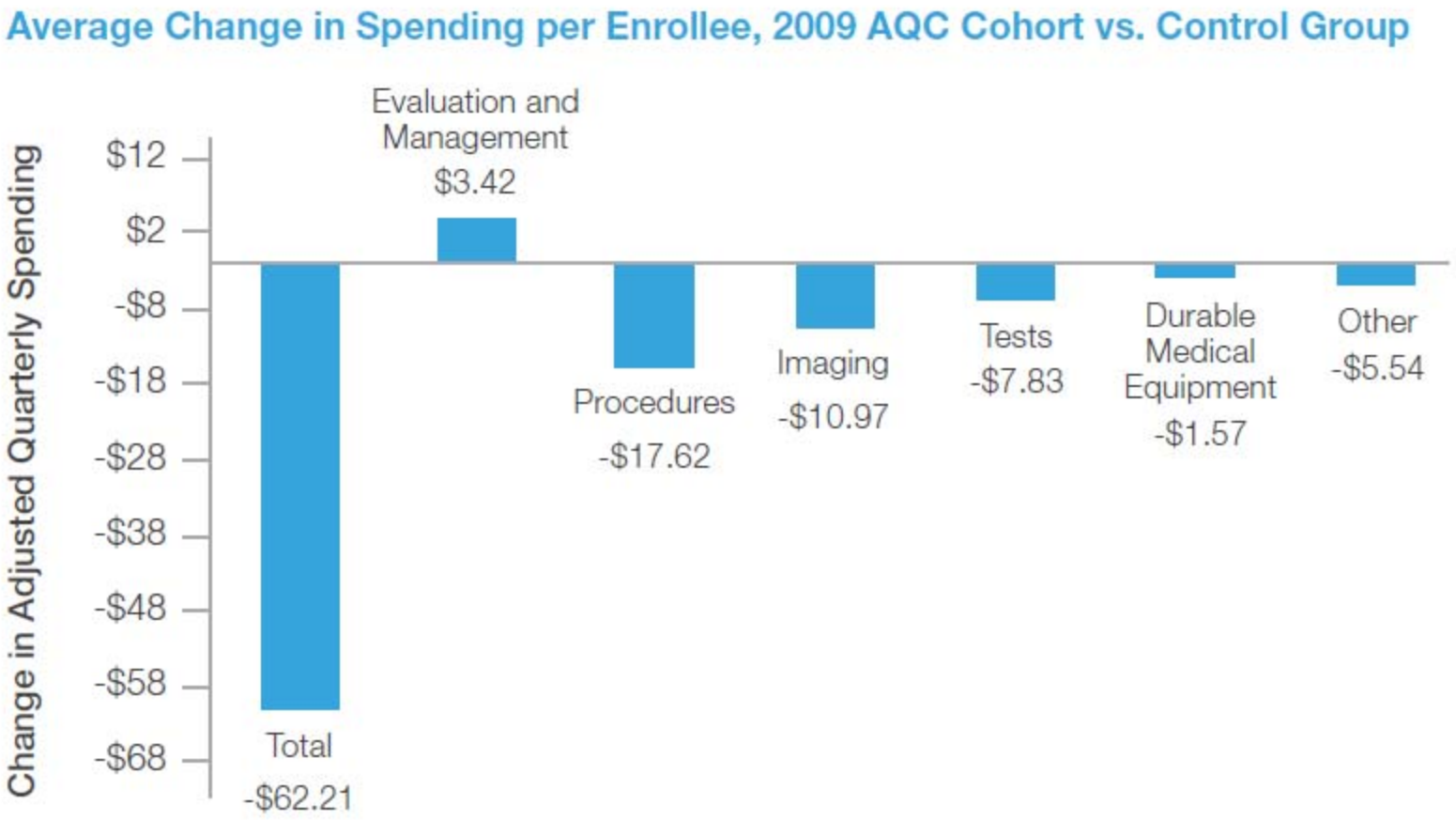
Source: Recommendations of the Massachusetts Special Commission on the Health Care Payment System, 2009

Result: The Market Responded

- We estimated in 2015 that leading commercial plans pay for between **23%-50%** of their members under a global payment reimbursement method (1)
  - In excess of 80% of network providers were participating in such arrangements in 2015.
  - **January 2016** BCBSMA introduced global payment into 1/3 its in-state PPO membership. (2)
- Much of this was led by BCBSMA's "Alternative Quality Contract" which was implemented in 2009 as a pilot program.

Sources: (1) Burns, M and Bailit, M. "Alternative Payment Models and the Case of Safety-Net Providers in Massachusetts." Blue Cross Blue Shield of Massachusetts Foundation. *March 2015.* (2) Blue Cross Blue Shield of Massachusetts Press Release October 5, 2015.

Do Global Payments Work?



Source: Song, Z., Rose, S., Safran, D. G., et al. "Changes in Health Care Spending and Quality 4 Years into Global Payment," The New England Journal of Medicine, 371(18)2014; 1704-14. Pecentages based on average post-intervention claims in the AQC cohort.

Graphic Source: Payment Reform on the Ground: Lessons from the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract. March 2015. Avalere Health, LLC

Are Global Payments Perfect?

- No….the reasons will be explained shortly.

Meanwhile, Back in State Government Payment Reform Becomes a Requirement

- In 2012, the legislature enacted a law that requires the state employee health program ("Group Insurance Commission") and Medicaid to implement alternative payment models "to the extent possible."
- As a result the state employee health program required its plans to meet specific targets for percentages of members in alternative payment models.
- MassHealth implemented its primary care-based, ACO-like Primary Care Payment Reform Program, and is actively pursuing a global payment strategy.

Recap of the Payment Reform Strategy

- The state facilitated the implementation of alternative payment models (mostly global payment) in the market by first signaling it was headed in that direction in 2009.
- The market responded (most aggressively by the dominant plan) and has continued to evolve and pursue this path with “light-touch” regulation through certification programs.
- The state continues to push this strategy through the state employee health program and Medicaid, but also through the work of CHIA and Health Policy Commission *(forthcoming discussion).*

Strategy of Transparency

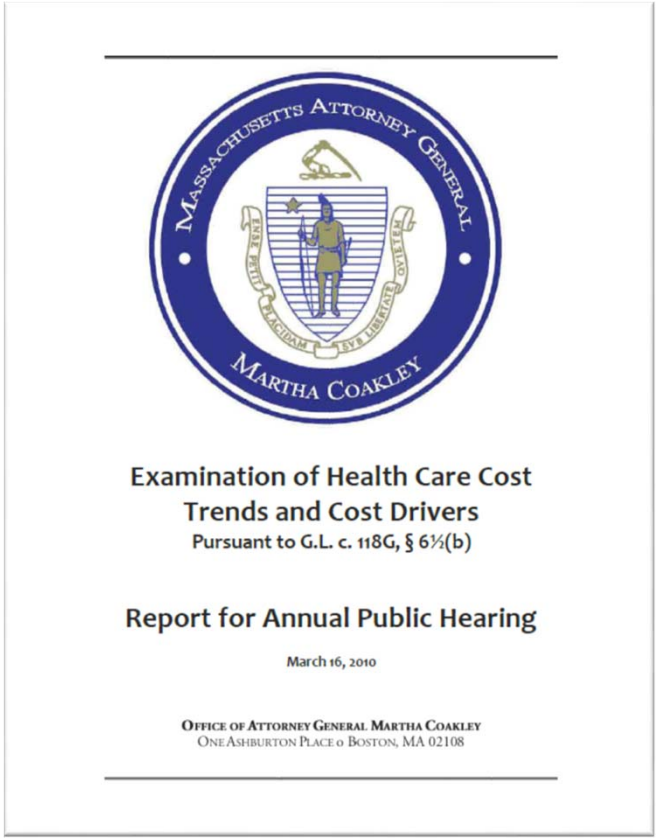
- Massachusetts has pursued transparency as a means to encourage the market to pursue cost containment.
- The Massachusetts transparency strategy is largely not focused on the consumer, but rather on policy makers, purchasers, providers and the press.
- The Attorney General, Center for Health Information and Analysis and Health Policy Commission all play a role in the strategy of transparency.

Office of the Attorney General

- The Attorney General applies the transparency strategy and helps to enforce regulation through the courts.
- In 2008, the Attorney General was given broad subpoena power to collect confidential information from plans and providers to **examine and report** on the cost trends.
- This is believed to be the first time an AG was given the authority to use subpoena power for the purposes of transparency.

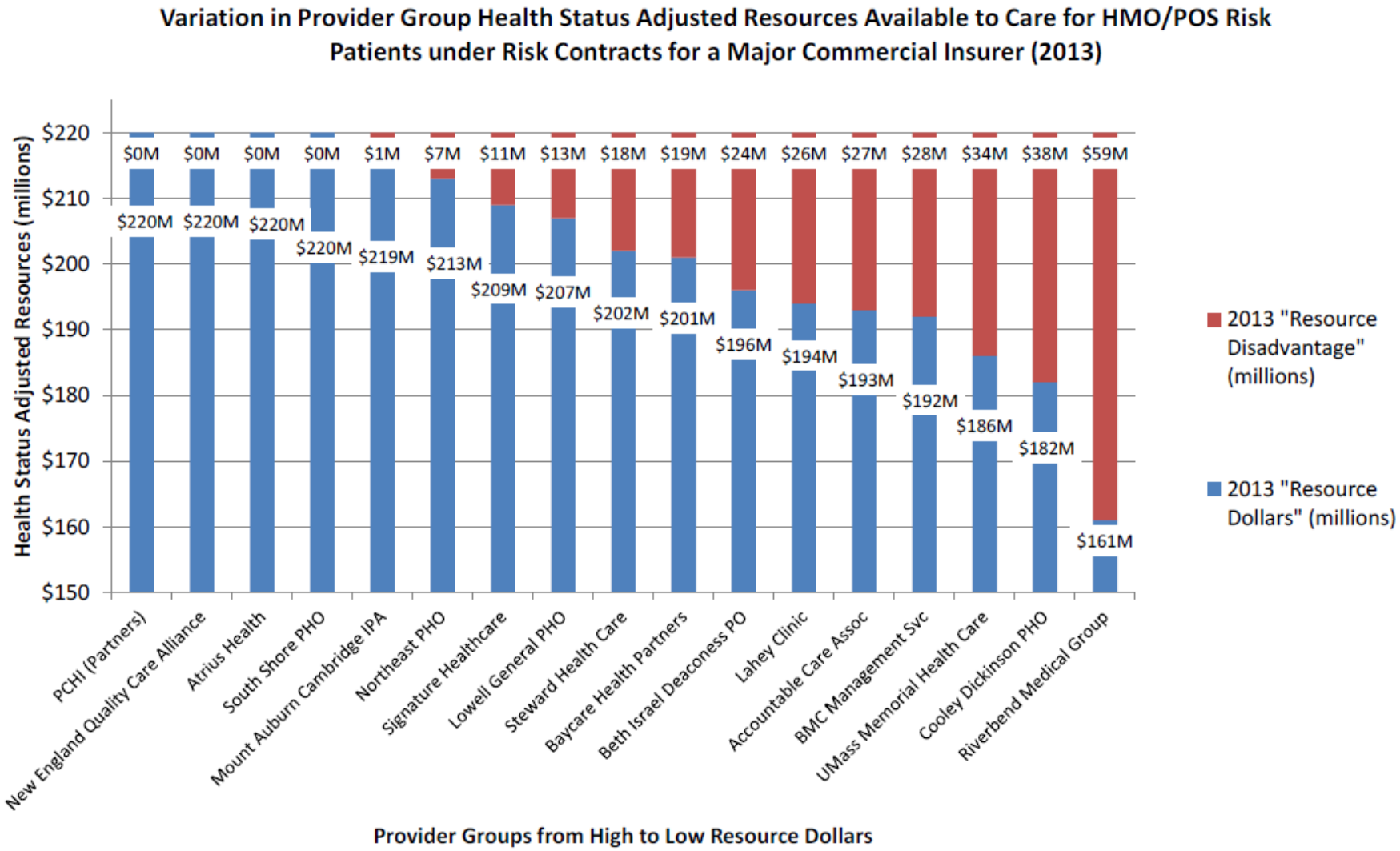
Cost Trends Reports

- As a result of the subpoena power, Cost Trends Reports were issued in 2010, 2011, 2013 and 2015.
- They have found that:
  - Prices paid to hospitals and physician groups vary significantly
  - Variation is not due to quality, patient illness or other measures of value
  - Variation is correlated to provider and insurer market leverage
  - Price increases have been the main driver of health care cost growth.
  - **Providers paid under alternative payment models (e.g., global payment) do not have lower medical spending**



Source: Tseng, Karen. Chief, Health Care Division. "National Health Policy Forum Strong Providers, Big Prices: A Look at Provider Market Power in Health Care." 2/12/16

Global Payments Don't Solve Market Power-Driven Price Variation



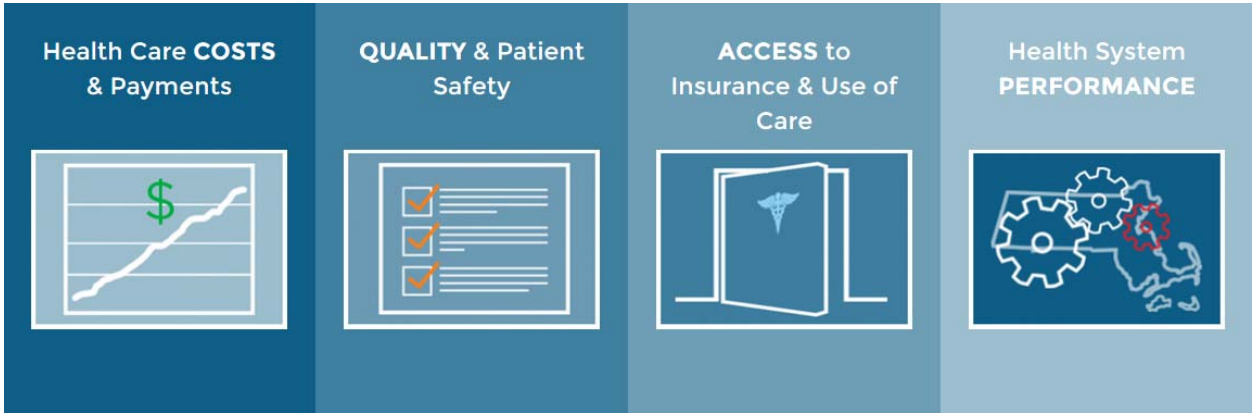
Source: Office of Attorney General Maura Healey. "Examination of Health Care Cost Trends and Cost Drivers. October 6, 2015.

Cost Trends Hearings

- In conjunction with the reports, the Attorney General Health Policy Commission and Center for Health Information Analysis hold two-day public hearings where all of the issues related to cost containment are aired.
- The executives of health plans and providers, researchers and state government leaders participate in an open conversation about the challenges and opportunities that exist within the state.

Center for Health Information Analysis: "Agency of Record"

- The public knows a lot about health care in MA due to the richness of data collected by the Center for Health Information Analysis (CHIA), and its predecessor agency.
- CHIA is an independent state agency established by law in 2012 that is "the agency of record for MA health care information." CHIA helps reinforce the state's transparency strategy. It has an budget of ~$27 million.



What Data Does CHIA Collect?

1. All-Payer Claims Database
   - Medical, pharmacy, dental claims
   - Member eligibility
   - Benefit design
   - CHIA is the single independent agency to collect data from payers
2. Acute Hospital Case Mix Database
   - Patient-level data from hospital inpatient, observation and ED visits
   - Data collected by CHIA (and its predecessor agency) for close to 20 years
   - Used to identify trends

What Data Does CHIA Collect?

3. Hospital Financial Performance
   - Annual and quarterly reports with aggregate data
   - Individual hospital fact sheets
   - DSH status

4. Long Term Care Database
   - Nursing home cost reports
   - Patient day and final rates

5. Payer Data Reporting
   - Total medical expense
   - Relative prices
   - Alternative payment methods
   - Provider payment methods

Payers are required by M.G.L.c. 12C to report this information and CHIA promulgates the regulations governing methodology and filing requirements

How are CHIA Data Used?

- State agencies use CHIA's data to make policy decisions
  - Health Connector (Exchange) uses APCD to define its risk-adjustment program
  - Health Policy Commission uses CHIA data to track total health care expenditures
- Market participants use CHIA's data for:
  - Benchmarking, strategic planning, market analysis
  - Challenging the state on its policies
  - Highlighting issues and lobbying (e.g., Massachusetts Association for Health Plans)
- Researchers access CHIA's data
  - CHIA's data is available (upon application) for research by non-governmental entities and are used by educators, foundations and others in promoting health care reform in Massachusetts

How Does CHIA Function?

- With highly specialized and skilled staff that work to ensure data integrity and completeness across payers and to normalize data to allow for cross-payer analyses.
- With oversight from a Council that guides CHIA's research and analytic priorities. Council members include key constituencies of data, including the
  - EOHHS Secretary
  - Health Policy Commission Executive Director
  - Attorney General's Office
  - Secretary of Administration and Finance.
- CHIA is funded through fees assessed to providers and payers.

Health Policy Commission (HPC)

- HPC is an independent state agency established by Chapter 224 (2012).
- It is mainly responsible for the "light-touch" regulatory strategy, through four main functions:
  1. Set the health care cost growth benchmark (*see next slide*) and hold providers responsible
  2. Change the delivery system to be more efficient
  3. Make payment support the new health care delivery models
  4. Improve market performance

1. Health Care Cost Growth Benchmark

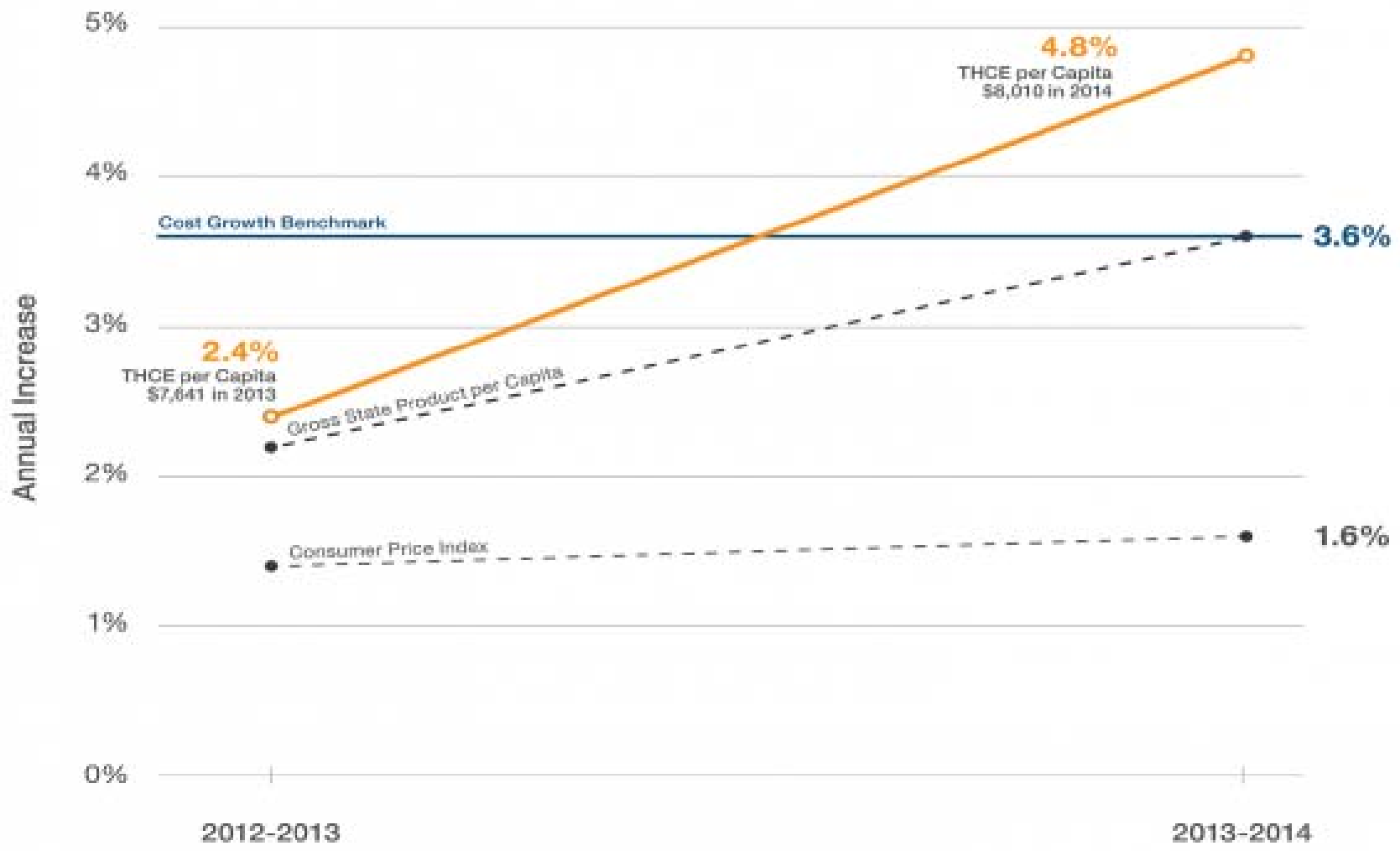
- The Health Policy Commission must set the Total Health Care Expenditure (THCE) cost growth benchmark annually, by April 15
- THCE is a per-capita measure that includes
  1. All medical expenses paid to providers by private and public payers
  2. All patient-cost sharing amounts (e.g., deductibles, co-pays)
  3. Net cost of private insurance (e.g., administrative expenses and operating margins for commercial payers)
- THCE is measured annually by CHIA

Source: Health Policy Commission

1. Health Care Cost Growth Benchmark

- For 2013-2017 the benchmark was set at the growth rate of the potential gross state product, which for 2013-2015 was **3.6%** each year.
- **So how has Massachusetts done…….?**

Mixed Results!



Source: CHIA's 2015 Annual Report on the Performance of the MA Health Care System

1. Health Care Cost Growth Benchmark

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Study of Cost Containment Models
March 8, 2016

Source: CHIA (payer-reported data) and other public sources. See technical appendix.
Notes: Percent changes are calculated based on full expenditure values. Please see databook for detailed information.
Source for slide graphic: CHIA Annual Report Chartpack, 2015

1. Health Care Cost Growth Benchmark

- The HPC does not have regulatory authority to hold providers accountable for the health care cost growth benchmark, but it has an effective "**bully pulpit**," that publicly reports performance, and holds annual Cost Trends Hearings.
- Starting in 2016, the HPC can require providers to submit and implement performance improvement plans if they are above the cost growth benchmark, and impose a $500,000 fine. *(Light-touch regulation)*

2. Improve the Delivery System's Efficiency

- The Health Policy Commission seeks to promote improvements in the health care delivery system by:
  - Creating recognition and certification programs for Patient Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs).
    - PCMH PRIME is a certification program created in collaboration with NCQA to recognize PCMH programs that have integrated behavioral health into primary care
  - Investing in 28 community hospitals and their efforts to improve the delivery system and prepare for alternative methods of reimbursement.
    - Investment is funded by a one-time assessment on "well-resourced" hospitals and plans.

3. Promote Alternative Payment Models (APMs)

- While the HPC has no regulatory authority to mandate the use of APMs by payers, it tries to promote the use of APMs through the convening of payers on quality measurement alignment (in conjunction with Medicaid), but does not have specific authority to do so.
- Provides Medicaid support in the creation of its APM programs (Medicaid is required by legislation to implement APMs).

4. Improve Market Performance

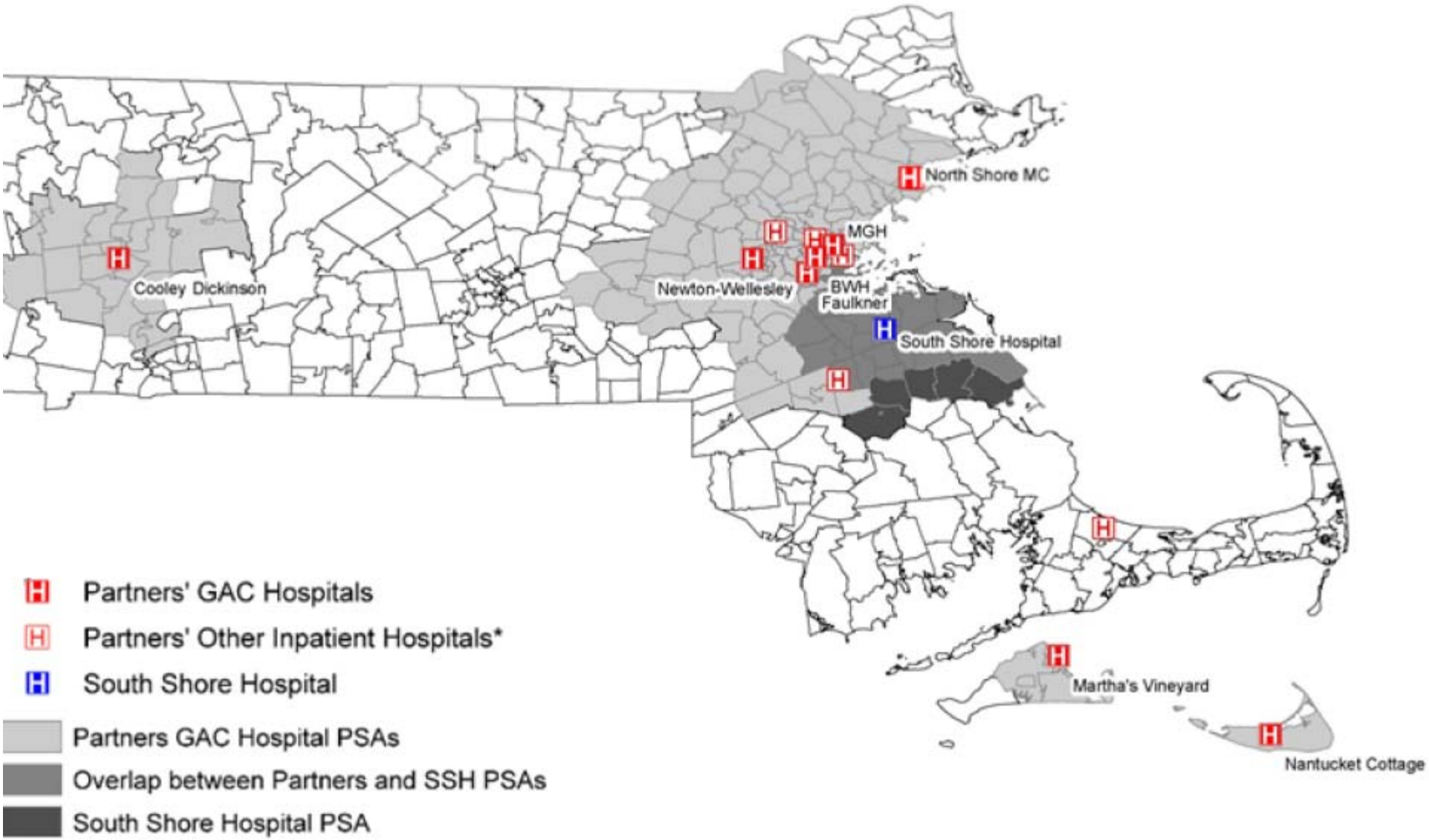
- Providers in MA must submit **Notices of Material Change** to the HPC indicating any sort of merger, affiliation, acquisition or partnership for review.
- If the HPC determines that the change might impact health care costs, quality, access or market competitiveness, the HPC can conduct a **Cost and Market Impact Review** (CMIR).
- A CMIR is a public report of the HPC's findings; a transaction cannot occur until the report is public.
- These reports also inform the Attorney General, who can then take action to block the proposed market change.

4. Improve Market Performance: Example

- **Partners HealthCare** is the largest provider in MA, with 8 hospitals and just under 3,000 inpatient beds. It also operates a psych hospital, rehabilitation network, home care agency and a network of ~6,500 MDs.
- **South Shore** is a non-profit hospital with 378 beds in Weymouth, MA, and also has about 400 employed physicians. The largest group of employed physicians is **Harbor Medical Associates.**
- Partners and South Shore hospital were negotiating a proposed acquisition that would fully integrate South Shore into the Partners system, which also included Harbor Medical Associates.

Source: Review of Partners Healthcare System's Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates. Final Report February 19, 2014.

Primary Service Areas (PSAs) of Partners' General Acute Care (GAC) Hospitals and SSH



Source: Review of Partners Healthcare System's Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates. Final Report February 19, 2014.

4. Improve Market Performance: Example

In the CMIR, the HPC found that:

1. both parties were financially strong, and garnered hospital prices higher than other hospitals in the region (or the state, in the case of Partners)

2. both parties were consistently high quality providers

3. both cared for higher proportions of commercially insured patients and lower proportions of Medicaid patients than other hospitals in the their market area

Source: Review of Partners Healthcare System's Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates. Final Report February 19, 2014.

4. Improve Market Performance: Example

In the CMIR, the HPC also found that:

4. if the transaction occurred, total medical spending would increase by $23-26 million due to increases in South Shore physician prices and increased utilization of Partners and South Shore facilities
   - This estimate did not include the potential impact that increased provider leverage would have in negotiating prices with private insurers
   - It did include the impact on price, utilization, provider mix and service mix

5. neither party adequately supported its claims that the transaction would improve care delivery or access

Source: Review of Partners Healthcare System's Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates. Final Report February 19, 2014.

4. Improve Market Performance: Example

- As a result of the CMIR, the HPC concluded that the Attorney General's Office should review the proposed acquisition.
- At the time, the Attorney General (Coakley) struck a deal that would have:
  - limited Partners' market power and allow payers to contract with Partners on a "component" basis (e.g., academic medical centers vs. community hospitals)
  - restricted joint contracting of non-owned physicians for 10 years
  - limit Partners and South Shore's price growth for 6.5 years
  - prevented further consolidation by Partners in Eastern MA (but allowed the acquisition of three hospitals (South Shore being one)

Source: AG Coakley Reaches Agreement in Principle with Partners HealthCare. May 19, 2014.

4. Improve Market Performance: Example

- In January 2015, a Superior Court judge rejected the deal stating **"permitting the acquisitions…would cement Partners' already strong position in the health care market and give it the ability, because of market muscle, to exact higher prices for insurers for the services its providers render."**
- In the Court ruling, the judge often referred to the CMIR of the Health Policy Commission.
- As a result of this public scrutiny, Partners made a decision to no longer pursue the acquisition.

Source: State House News Service. "Judge rejects Martha Coakley's deal with Partners HealthCare on MA expansion." January 29, 2015.

Challenges for Massachusetts

- Providers, and in particular safety-net providers, can be challenged by the variations in alternative payment models that exist within the market.
  - Efforts to align on key features are in process, but difficult to achieve across all segments of the market without regulation.
- Variation in provider prices continues to become a problem.
  - The state is actively making the problem more transparent through releasing detailed data (as most recently as 2/25/16)
- Coordination across state government entities is successful because of existing relationships, but the lack of formal coordination might be a missed opportunity.

The Road Ahead for Massachusetts

- It remains to be seen whether the state's health care system can limit health care cost growth to the benchmark, through the combination of promoting APMs, supporting market-based reform and market-based transparency.
- This year the legislature will debate whether the Health Policy Commission should be given the authority to regulate provider prices; and whether the cost growth benchmark should be indexed against provider prices.

Stuart Altman, Chair of the Health Policy Commission

"I wouldn't guarantee that if we hit another strong stretch of inflation that what we have in place is strong enough, but …it's worth a shot to see if we can find the ***right balance*** *between an* ***appropriate role of government*** *and* ***letting market forces have a shot*** *at trying to develop a more efficient system."*

- January 2016

Source: http://commonwealthmagazine.org/health-care/stuart-altman-health-care-watchdog/

Keys to Success in Massachusetts

Culture

Data

Transparency

Keys to Success in Massachusetts

Culture

- The state has a culture of perseverance in transforming the health care system and has taken decades to do so.
- The providers in the state are culturally attuned to payment reform.
- While there is no formal coordination between agencies, the personal relationships of those working on health care in the state are very strong and help to advance the issues forward.

Keys to Success in Massachusetts

Data

- The state has committed significant amount of financial resources to managing health care data.
- It continues to work on gathering additional data and measuring new aspects of the health care system

Keys to Success in Massachusetts

Transparency

- The state regularly publishes fact-based information to inform market participants – providers, plans, employers, and, to some extent, consumers.
- The market participants react to “public shaming.”

Summary of Strategies

1. Government-supported and insurer-led market-based payment reform strategies
2. Data-driven transparency strategy targeted to the marketplace
3. Light-tough regulation with the constant threat of the legislature taking action for greater regulation of the marketplace

Questions and Discussion

1. Which of Massachusetts's strategies would you like Connecticut to adopt?
2. How can the strategies be modified to overcome any possible barriers to adoption?
3. What are the facilitators to adoption?

Next Steps

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April 12th Meeting

- A review of Oregon and Maryland
- An initial review of stakeholder input