




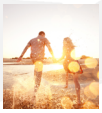

2014

COST TRENDS REPORT

HEALTH POLICY COMMISSION

Executive Summary

Consistent with the statutory mandate of the Health Policy Commission (HPC), this 2014 Cost Trends Report presents an overview of healthcare spending and delivery in Massachusetts, opportunities to improve quality and efficiency, and progress in key areas and contains recommendations for strategies to increase quality and efficiency in the Commonwealth.

Past HPC reports have identified four areas of opportunity: fostering a value-based market; promoting an efficient, high-quality healthcare delivery system; advancing alternative payment methods (APMs); and advancing transparency and data availability. The HPC continues to emphasize these four areas in its analysis and recommendations.

This Executive Summary presents a concise overview of our findings and recommendations, which are described more fully in the chapters of the report.

Trends in spending and care delivery

- In September 2014 the Center for Health Information and Analysis (CHIA) formally measured for the first time the growth of total healthcare expenditures in Massachusetts relative to the state's cost containment benchmark. Between 2012 and 2013, total healthcare expenditures grew at a rate of 2.3 percent per capita, a rate that is lower than the statutory benchmark of 3.6 percent, a significant development. Growth was below the benchmark in all sectors (commercial, Medicare, MassHealth); among commercial payers, growth was driven more by prices than utilization.
- 2013 does not appear to be an aberration. Spending growth for Medicare and Medicaid in Massachusetts over the last few years is comparable to or lower than the rest of the U.S., while growth in the commercial sector has been slower since 2011, particularly for hospital spending.
- The amount and percentage of out-of-pocket spending by commercially-insured individuals was stable from 2012 to 2013, after growing steadily in 2010 and 2011. At the same time, based on 2013 survey data, the percentage of adults paying off medical bills over time or with trouble paying medical bills was at its highest level since 2006. As a percentage of total spending, out-of-pocket spending was relatively high for behavioral health conditions and total out-of-pocket spending may reach high levels for patients with chronic conditions.
- The Massachusetts market is characterized by a high share of discharges from academic medical centers (AMCs) and a growing concentration of inpatient care. Five hospital systems accounted for 51 percent of commercial discharges in 2012 but 56 percent in 2014. That figure could rise to 61 percent if the Partners/South Shore/Hallmark merger was completed. The share of discharges from community hospitals without AMC affiliations dropped between 2009 and 2012.
- Massachusetts performs well relative to the rest of the U.S. on most measures of quality and access to care and had the highest rate in the nation of insurance coverage in 2013. However, rates of ambulatory-care-sensitive hospital admissions are higher than average, and considerable opportunities remain to further improve quality and access as well as population health.
- The Center for Medicare and Medicaid Services (CMS) projects higher growth rates in healthcare spending (>5%) in 2014 and beyond, based on population aging, economic recovery, and additional utilization among the newly covered under the Affordable Care Act (ACA). Massachusetts may be on a lower spending growth trajectory than the nation,

however, and will not face increased spending from the ACA coverage expansion.

- Future spending trends in Massachusetts will be affected by a number of factors. Some factors, such as demographic trends, cannot be controlled. However, policy and action can have a significant impact on other important drivers of healthcare spending, including market consolidation, the dissemination of alternative payment methods (APMs), and consumer incentives to make efficient care choices.

Opportunities to improve quality and efficiency

- Hospitals vary widely in prices charged for an episode of care with similar quality outcomes. For hip and knee replacements, AMCs are 23 and 15 percent more expensive than New England Baptist, respectively, without substantial differences in quality outcomes measured. For percutaneous coronary intervention (PCI), AMCs are 11 percent more expensive than teaching hospitals, without differences in quality outcomes measured.
- In Massachusetts, 39 percent of patients receive post-acute care following a hospital discharge, compared to 27 percent nationwide, and there is wide variation in discharge practice patterns among Massachusetts hospitals. For hip and knee replacements, most hospitals discharge patients to institutional care more frequently than New England Baptist, a recognized orthopedic specialty hospital. Use of standardized discharge planning tools, sharing of best practices, and development and use of better data among hospitals and PAC providers, as well as aligned financial incentives, could help hospitals optimize care for patients following discharge.
- Rates of hospital readmissions and visits to emergency departments (EDs) highlight areas for improvement in care delivery throughout the system. The state's readmission rates are higher than the national average, and CMS will penalize approximately 80 percent of all hospitals in Massachusetts for higher-than-expected Medicare readmission rates in fiscal year 2015. Almost half of ED visits were avoidable in 2012, and rates of overall ED use varied by a factor of two across regions of the state. Collaborations between providers, community-based services and other local partners represent a particularly important strategy for reducing avoidable ED use.
- The HPC's new work highlights key conditions that characterize patients with persistently high costs within the commercial and Medicare population and reinforces the need for continued focus on behavioral health and managing chronic conditions, as well as efficient care, prevention, and innovation, including for catastrophic conditions.
- Effective treatment for behavioral health is a critical factor in the Commonwealth's strategy to promote population health and contain costs. Our work indicates that the spending differential between patients with and without behavioral health conditions is pronounced for many medical conditions. State agencies should develop a coordinated behavioral health strategy, and improving behavioral health data will be critical to support this strategy.

Progress in aligning incentives

- While fee-for-service (FFS) payment creates perverse financial incentives that reinforce health system tendencies towards waste and fragmentation, well-designed APMs offer incentives that support value and patient-centered care.
- Between 2012 and 2013, APM coverage in Massachusetts did not increase substantially in the commercial sector, but did grow substantially in Medicare due to participation in the Medicare Shared Savings Program (MSSP). APM coverage also increased in the commercial managed care organizations (MCOs) that serve MassHealth members.
- In order to expand APMs in the commercial sector, a coalition of payers and providers has agreed on a set of shared principles for attributing preferred provider organization (PPO) enrollees to physicians, a necessary condition for assigning accountability and global budgets.
- MassHealth has been engaged in an intensive stakeholder input process to design a proposed Accountable Care Organization (ACO) model in early 2015 and aims to launch in early 2016.
- Bundled payments for discrete episodes or procedures offer the potential to further extend the incentives of APMs to hospitals and specialists, whether or not a patient is covered by an APM for care they receive from their primary care provider (PCP).
- Coverage by comprehensive APMs (defined as APMs designed to affect the full spectrum of a pa-

tient's care) could grow by 7 percentage points if all commercial payers increased APM coverage in their health maintenance organization (HMO) population to close two-thirds of the gap between their 2013 coverage rate and 90 percent; by 11 percentage points if all commercial payers achieved half the APM coverage rate in their PPO population that is projected in their HMO population; and by 2 percentage points if MassHealth closed one-third of the gap between their 2014 coverage rate and 100 percent. Taken together, progress in these three areas could increase the statewide coverage rate from 35 percent in 2013 to 55 percent in 2016.

- Well-designed insurance products offer incentives to employers and consumers to support value and patient-centered care. For demand-side incentives to be successful, consumers must receive adequate information on their network limits and cost-sharing requirements ahead of time. If used to support other efforts toward efficiency such as increasing APMs, the impact of demand-side incentives could be felt throughout the delivery system.
- In the individual insurance market, consumers are able to reduce premiums substantially— about 20 percent— by selecting a limited network plan.
- Take-up of high-deductible health plans and tiered and limited network plans has remained relatively low, but the enrollment patterns in some markets (Group Insurance Commission, the Connector) suggest that consumers do choose low-cost plans when presented with choice, incentives, and comparative information. The greatest near-term opportunity for demand-driven cost containment may reside in enhancing the availability and take-up of value-oriented products in the employer market.

Transparency and data availability

- The importance of transparency and data availability surface throughout the discussions of spending trends, care delivery, APMs, and demand-side incentives.
- Improved data is especially important for behavioral health, given the diversity of providers and services involved across the care continuum. Better behavioral health data capabilities will be necessary for any state strategy to successfully improve care.
- APMs are most effective when providers have the data needed to manage care, including real-time data for care coordination and regular reports on spending and utilization, and when the methods used in reporting and payment are transparent.
- Chapter 224 requires payers to make available consumer-oriented, web-based pricing tools that display out-of-pocket costs for particular services from specific providers or pre-set treatment pathways. These tools are in their early stages and, together with the mandate that providers make their prices transparent, have the potential to encourage consumers to make value-based choices.

Recommendations

In light of these findings, as well as our other analytic and policy work throughout the year, the HPC makes the following recommendations and commitments to promote the goals of Chapter 224:

Recommendations to foster a value-based market

1. Massachusetts should lead the nation in direct-to-consumer transparency, enabling access to detailed information on the prospective cost and quality of services.
2. Payers should continue to develop and promote value-oriented products and enhance information provided to employers.
3. Employers, including the state, should offer their employees plan choices that include value-oriented products, or embed value-based concepts into their chosen plan offering.
4. Providers should present measurable indicators of how proposed material changes, such as mergers, acquisitions, or other contracting or clinical alignments, are likely to result in improved performance and demonstrate that benefits outweigh potential detriments to the Commonwealth.
5. The HPC will examine past transactions to assess their impacts.

Recommendations to promote an efficient, high-quality care delivery system

1. Providers should adopt appropriate tools and share best practices to improve quality and efficiency in specific priority areas, namely:
   - addressing variation among providers in spend-

ing per episode and use of post-acute care
  - reducing readmission rates and ED utilization
  - coordinating care and advancing clinical integration across settings
  - identifying and managing high-cost patients
  - caring for patients in community settings
  - treating behavioral health conditions, especially via integrated models.

  In particular, hospitals and PAC providers should improve discharge planning and the collection and use of assessment data.
2. To support providers and complement efforts elsewhere in the market, the HPC will convene providers and offer technical assistance in these priority areas and will emphasize these areas in our investment programs and model payment approaches.
3. The Commonwealth should develop a coordinated behavioral health strategy that is aligned across agencies. The Center for Health Information and Analysis (CHIA) should begin collecting data in priority areas.

Recommendations to advance alternative payment methods

1. Payers and providers should continue to focus on increasing adoption of APMs and on increasing the effectiveness of APMs in promoting high quality, efficient care. In 2016, all payers should use APMs for 60 percent of HMO lives and 33 percent of PPO lives.
2. The state should prioritize efforts to define a standard set of provider quality measures to be used for purposes of public and private payer contracts, provider tiering, and establishing goals for statewide improvement.
3. The HPC will convene stakeholders to explore episode-based payment models.
4. MassHealth should continue progress towards developing and launching an ACO.

Recommendations to enhance transparency and data availability

1. The HPC will develop a set of measures to track health system performance.
2. CHIA should improve All-Payer Claims Database (APCD) capabilities and transparency and develop key spending measures.
3. Government agencies should coordinate on APM data collection and continue health resource planning.

In the coming year, the HPC will pursue the activities noted above and work collaboratively with the Baker/Polito Administration, the Massachusetts health care industry, employers, consumers, and other stakeholders on advancing the goals of a more affordable, effective, accountable, and transparent healthcare system in Massachusetts.

Recommendations

The HPC is required by law to publish an annual report tracking the healthcare industry's efforts to meet the statewide growth benchmark while identifying opportunities for improvement in cost, quality, and access. In light of the findings presented in this 2014 Annual Report, as well as our other analytic and policy work throughout the year, the HPC has developed recommendations for market participants and other government agencies. In addition, the HPC is committing to certain activities in 2015 to advance these recommendations and to foster innovative healthcare delivery and payment models, consistent with our statutory mission. This concluding section presents those recommendations and commitments.

The recommendations and commitments are organized into four primary areas of opportunity for improving the healthcare system in Massachusetts:

1. **Fostering a value-based market** in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options
2. **Promoting an efficient, high-quality healthcare 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
3. **Advancing alternative payment methods** that support and equitably reward providers for delivering high-quality care while holding them accountable for slowing future healthcare spending increases
4. **Enhancing transparency and data availability** necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time

Fostering a value-based market

Over the past few years, consumers have seen the growth of insurance products that encourage them to make value-based choices about their care. While take-up of tiered and limited network plans has been limited, the enrollment patterns in some market segments (Group Insurance Commission [GIC], the Connector) suggest that consumers do choose these plans when presented with choice, incentives, and comparative information. Similarly, in order to empower patients as informed consumers of healthcare services, they must have access to meaningful information on provider prices and quality.

These demand-side incentives rely on a competitive health care market that offers high-value provider options. As documented by the HPC, Massachusetts provider organizations are increasingly consolidating and forming new contracting and clinical alignments. These types of changes have been shown to impact healthcare market functioning, and thus the performance of our healthcare system.

To advance the goal of a more value-based market 2015, the HPC recommends:

1. **Massachusetts should lead the nation in direct-to-consumer transparency, enabling access to detailed information on the prospective cost and quality of services.** Payers should enhance price transparency tools by incorporating up-to-date contracted prices and meaningful measures of quality. Providers should make prices and performance information for common procedures and episodes of care publicly available. Prices for follow-on services (such as labs, tests and referrals to other healthcare professionals) should also be available and considered at the time providers recommend such care to their patients. Price query capabilities should be built into electronic health records.

2. **Payers should continue to develop and promote value-oriented products and enhance information provided to employers.** Payers should develop and promote products that reward consumers financially for making efficient choices, incorporating tools like aligned cost sharing, narrower networks products (potentially tied to accountable care organizations [ACOs]) and reference pricing. Payers and employers should continue to promote products that require or encourage members to select a primary care provider (PCP). Payers should also provide summary health claims reports and other actionable information to employers to enable employers to select products and benefits designs that will optimally incentivize employees to make value-based decisions, to inform employee wellness programs, and to address inappropriate utilization trends among employees such as avoidable emergency department (ED) use.
3. **Employers, including the state, should offer their employees plan choices that include value-oriented products, or embed value-based concepts into their chosen plan offerings.** Specifically, employers should consider insurance products or add-on services that offer cash benefits or "shared savings" for employees that choose providers that are lower cost or are paid using APMs. As the state's largest purchaser, the GIC should continue its innovative efforts to engage state employees in value-based decision-making by establishing incentives for employees to choose lower-cost/high-performing plans and providers, and to encourage enrollment in products that require members to select a PCP. The GIC should consider piloting other value-based benefit design elements such as reference pricing for certain elective low-risk procedures such as hip and knee replacements.
4. **Providers should present measurable indicators of how proposed material changes, such as mergers, acquisitions, or other contracting or clinical alignments, are likely to result in improved performance and demonstrate that benefits outweigh potential detriments to the Commonwealth.** Providers proposing material changes—particularly changes not already subject to law enforcement action but which may negatively impact the healthcare system—should demonstrate to the HPC how such changes will generate specific, measurable improvements that will be passed along to payers and purchasers, in areas such as in total medical expenses (TME) and quality. Providers should demonstrate that those measureable benefits outweigh potential detriments to the Commonwealth and commit to a process and targets for ongoing measurement and evaluation of progress.
5. **The HPC will examine past transactions to assess their impacts.** As part of its ongoing research and analyses, the HPC will examine past transactions to assess the extent to which commitments made by parties engaging in significant changes have been fulfilled, such as commitments for improved efficiency, quality, or access. The HPC will consider whether additional legislative authority is necessary for it to ensure that such commitments have been fulfilled.

Promoting an efficient, high-quality care delivery system

The HPC's research has highlighted variation among providers in spending for selected episodes of care and use of post-acute care (PAC) and opportunities to reduce readmission rates and ED utilization. Moreover, we have identified additional opportunities to improve quality and efficiency in the areas of care coordination and clinical integration across settings, identifying and managing high-cost patients (HCPs), caring for patients in community settings, and screening and treatment of behavioral health conditions, especially through integrated behavioral health models. The increased adoption of effective APMs will align incentives around quality and efficiency in care delivery. To this end, specific recommendations to increase the use and effectiveness of APMs are detailed in the next section.

Ongoing progress in the care delivery system will contribute to meeting the statewide cost growth benchmark, improve patient care, and enable providers to succeed under new forms of payment. To advance the goal of an efficient, high-quality care delivery system in 2015, the HPC recommends:

1. **Providers should adopt appropriate tools and share best practices to improve quality and efficiency in the specific priority areas noted above,** drawing from their own experience, the work of other organizations, and the HPC in these efforts. In addition to work in all these priority areas, in response to the state's relatively high use of PAC, the following specific actions are recommended:

a. *Acute hospitals should develop and adopt standard approaches to discharge planning to inform PAC site of care, and to optimize patient outcomes, patient experience, and value of care.* Acute hospitals should engage across the care continuum with PAC providers and PCPs to determine optimal approaches to managing site of care selection with the goal of reducing inappropriate and costly practice pattern variation.

b. *PAC providers should collect standardized patient assessment and quality information.* PAC providers should accelerate implementation of federally standardized approaches for collection of patient assessment data and quality measures and use this information for care delivery improvement activities, including facilitating improvement in discharge planning by hospitals.

2. **To support providers and complement efforts elsewhere in the market, the HPC will convene providers and offer technical assistance in these priority areas and will emphasize these areas in our investment programs and model payment approaches.** In 2015, the HPC will convene providers for the identification, dissemination, and evaluation of best practices in the priority areas and will also seek to provide direct technical assistance to provider organizations, through the CHART investment program, the innovation investment program, and through the PCMH and ACO certification programs. Technical-assistance efforts will be coordinated with other state, federal, and private sector organizations engaged in similar work.

3. **The Commonwealth should develop a coordinated behavioral health strategy that is aligned across agencies.** In 2015, the Commonwealth should develop a coordinated behavioral health payment, care delivery, and data strategy. Specifically:

   a. *Behavioral Health Data Task Force activities.* Given the importance of increasing data capabilities to improving access, quality, efficiency, parity, and integration in behavioral health care, in 2015, the Center for Health information and Analysis (CHIA), should begin collecting data in priority areas including:

      - Incorporating Massachusetts Behavioral Health Partnership and commercial managed behavioral health organizations claims into the All-Payer Claims Database (APCD)
      - Collecting discharge data from freestanding psychiatric and substance use disorder hospitals
      - In collaboration with HPC, the Department of Public Health (DPH), and the Department of Mental Health (DMH), enhancing the availability of behavioral health quality data and promoting behavioral health outcome measure development.

      Through the Behavioral Health Data Task Force, CHIA should identify any additional data gaps and develop a plan for closing such gaps over the next year.

   b. *DPH, DMH, MassHealth and HPC should coordinate to adapt policies to promote behavioral health integration efforts.* DPH, DMH, MassHealth and HPC should coordinate policies and efforts to promote behavioral health integration, including review of state licensure regulations and payment policies to reduce barriers, especially to co-location of medical and behavioral health care services.

Advancing Alternative Payment Methodologies

Effective APMs offer incentives that support value and patient-centered care, but between 2012 and 2013, expansion of APM coverage stalled in the commercial sector. In addition, global budgets alone may not be sufficient to alter the incentives facing many hospitals and specialists, sectors which are essential to health system transformation and cost containment. To advance the goal of expanded adoption of effective APMs in 2015, the HPC recommends:

1. **Payers and providers should continue to focus on increasing adoption of APMs and on increasing the effectiveness of APMs in promoting high quality, efficient care.**

   Market participants should advance the following:

   a. *APMs for HMO patients*. All commercial payers should increase the use of global APMs to pay for at least 60 percent of their HMO-covered lives in 2016.

   b. *APMs for PPO patients.* The coalition of payers and providers that developed consensus

guidelines for PPO attribution should seek to involve other market participants in the coalition, and all members of this expanded coalition should begin introducing APMs for PPO covered lives in 2016 with the goal of reaching at least one-third of their PPO lives that year.

c. *Behavioral health in APM budgets*. Exclusion of behavioral health spending from APM budgets may further fragment an already fragmented system for patients with mental health and substance use disorder needs. Payers and providers should evaluate how best to include behavioral health spending in APM budgets to support integrated, whole-person care and should work to adopt such arrangements starting in 2015.

d. *Market-wide alignment on risk-adjustment.* In 2015, payers and providers should agree on a common methodology for risk-adjustment to be used across all payer contracts in Massachusetts beginning in 2016. Payers and providers should assess the potential gains from incorporating socio-economic measures in the risk-adjustment methodology.

2. **The state should prioritize efforts to define a standard set of provider quality measures to be used for purposes of public and private payer contracts, provider tiering, and establishing goals for statewide improvement.** The current process for developing the Standard Quality Measure Set should be strengthened and the Statewide Quality Advisory Committee (SQAC) focused so that, in addition to ensuring that the measures are statistically valid and clinically relevant, the process results in a standard quality measure set with a limited number of priority measures that payers, providers and the Commonwealth use for the purposes listed above. CHIA should collect and publish the Standard Quality Measure Set, and should also report on all-payer patient experience data and pilot patient-reported outcome measures.

3. **The HPC will convene stakeholders to explore episode-based payment models.** In 2015 and 2016, the HPC will convene stakeholders, including payers, providers, purchasers and researchers, to explore opportunities to extend episode-based payment models across payers in Massachusetts, including both stand-alone episode-based payment and episode-based payment used in conjunction with global budgets. The HPC will conceptualize, design and describe opportunities to implement episode-based payment models for relevant conditions and specialties.

4. **MassHealth should continue progress towards developing and launching an ACO.** MassHealth should maintain its effort to develop an ACO program with goals of developing a proposed model in early 2015 and launch in early 2016. The HPC and MassHealth should work together to ensure alignment between the MassHealth ACO and the HPC ACO certification program. MassHealth should continue to invest in the necessary data analytics and infrastructure necessary to offer support to providers in taking on risk for patients, including through reports in the following domains:
   - raw claims data
   - regular reporting on budget and quality performance compared to benchmarks
   - real-time information regarding admissions, transfers and discharges

Enhancing transparency and data availability

The importance of transparency and availability of data surfaces throughout our discussions of spending trends, care delivery, APMs, and demand-side incentives. Data are essential to all aspects of system transformation, including setting priorities, strengthening care delivery, designing and succeeding in new payment models, harnessing the power of consumer choice, and monitoring progress. To advance the goal of greater transparency and data availability, the HPC recommends:

1. **The HPC will develop a set of measures to track health system performance.** In 2015, the HPC will develop a set of health system performance measures, or "dashboard," to enable the Commonwealth to set concrete goals for advancement. This dashboard will be publicly available, updated regularly, and will include metrics regarding the level and rate of growth of total spending, provider-level spending and prices as well as APM coverage, prevalence of ACOs and other indicators of payment and care delivery reform. It will also include measures of waste, inefficiency, and quality—such as hospital readmissions, avoidable ED and testing use, medical harm, and areas of practice-pattern variation, such as PAC.

2. **CHIA should improve APCD capabilities and transparency and develop key spending measures.** In addition to the work to improve behavioral health data noted above, CHIA should accelerate the full implementation of several key functions described in Chapter 224 to support market participants in achieving transformation goals and work to develop additional spending measures critical to the goals of that legislation:
    a. *APCD is a critical tool for evaluating and monitoring system performance.* By the end of 2015, CHIA should:
        i. Expedite processing of requests from other state agencies, researchers and policymakers for access to APCD so that such requests are filled within one month
        ii. Work with payers to improve the usefulness and quality of the data by requiring aligned field specifications, especially for key services and fields
        iii. Implement a master provider index in collaboration with the HPC's registered provider organization (RPO) program to allow analysis of individual providers across systems
        iv. Expedite release of APCD updates to maximize timeliness of data
        v. Work with MassHealth to establish and publish a credible method to use APCD data to calculate enrollment, spending and other essential measures for the MassHealth population as a whole and for key segments within it.
    b. *Total Medical Expenditures for PPO populations (recommendation repeated from July 2014 supplement)*. To monitor and understand cost trends in the significant and growing PPO segment, CHIA should extend its reporting to include a TME measure for PPO populations that uses the consensus attribution algorithm to identify accountable provider organizations.
    c. *Provider-level measures of spending growth (recommendation repeated from July 2014 supplement)*. In 2015, CHIA should work with the HPC and other stakeholders to design and examine measures for evaluating contribution to health care spending growth for provider types such as hospitals, specialist physician groups, and others not captured by the TME measure. Where feasible, these measures should be aligned with those used by other states to facilitate meaningful benchmarking.
3. **Government agencies should coordinate on APM data collection and continue health resource planning.**
    a. *APM data collection.* CHIA, the Attorney General's Office, the Department of Insurance, the HPC, and other state agencies should coordinate the collection of APM data in order to reduce the burden on payers and better enable the health policy community to track progress towards greater adoption of meaningful APMs. This approach should provide the necessary level of detail both on the extent of risk associated with each APM and on the use of episode-based payment or other complementary approaches in conjunction with global payment.
    b. *Health resource planning.* The HPC and other agencies should collaborate to develop a plan to strengthen the work of the Health Resource Planning Council to develop a robust, sustainable State Health Plan that drives prioritization of health care resources and informs public and private investments. The HPC will work with agency partners to assess and ensure sufficient access to essential health services in the commonwealth.

In the coming year, the HPC will pursue the activities noted above and work collaboratively with the Baker/Polito Administration, the Massachusetts health care industry, employers, consumers, and other stakeholders on advancing the goals of a more affordable, effective, accountable, and transparent healthcare system in Massachusetts.

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