

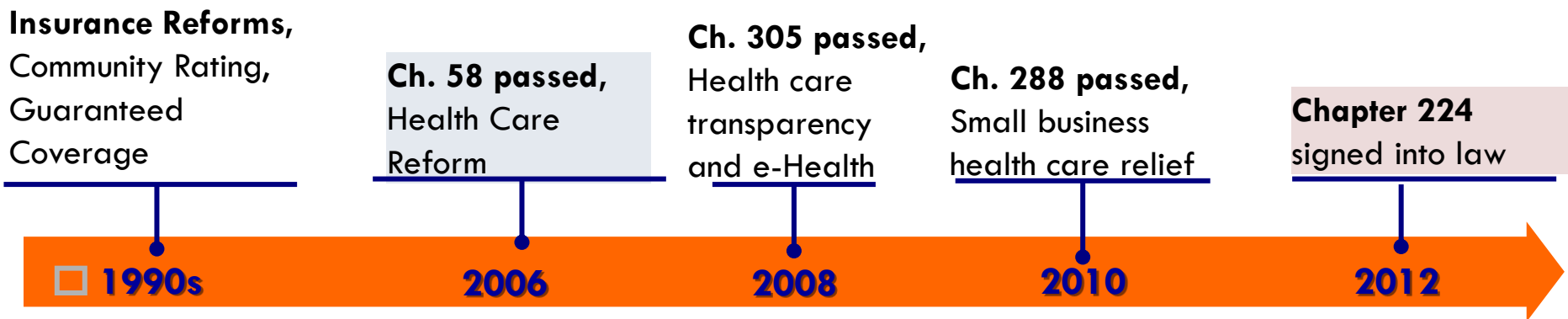
HEALTH POLICY COMMISSION

Overview of Chapter 224



Chapter 224 Overview

History of Health Care Reform Efforts in Massachusetts



Chapter 224 Overview

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 4, 2012 by Governor Patrick and is set to become effective on November 5, 2012. It represents a historic step forward for Massachusetts.



Chapter 224 Overview

Health Care Cost Growth Goal

| CALENDAR YEARS | COST GROWTH BENCHMARK |
|-----------------|---|
| 2013-2017 | Equal to the Economic Growth Rate |
| 2018-2022 | Equal to the Economic Growth Rate minus 0.5% (may be modified by the HPC) |
| 2023 and beyond | Equal to the Economic Growth Rate (may be modified by the HPC) |

Key Provisions of the Law

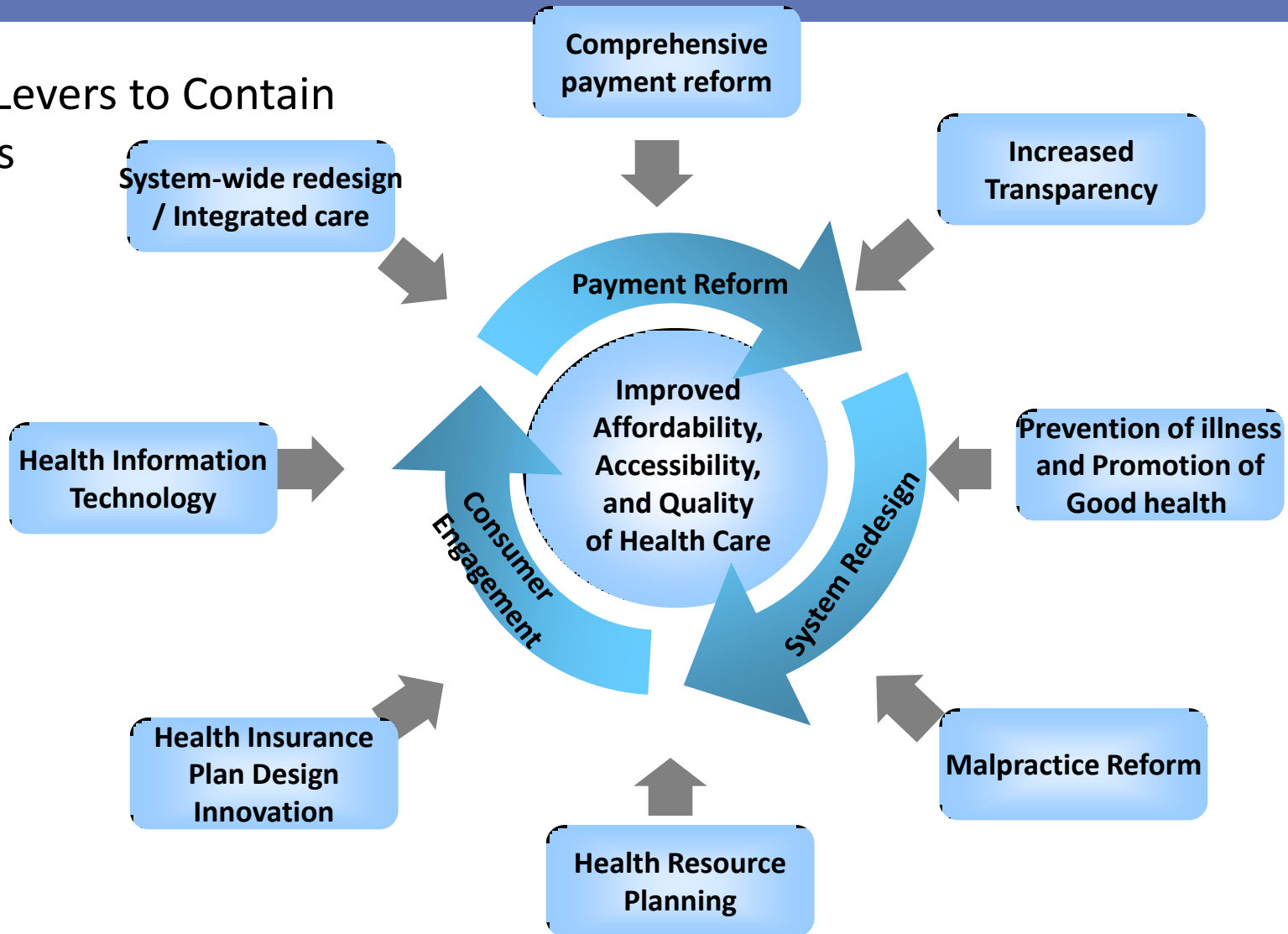
- Requires payment system reform by both public and private payers;
- Promotes delivery system reform to enhance the coordination of care for patients;
- Promotes prevention and wellness, including the expanded adoption of workplace wellness programs;
- Implements sensible malpractice reforms ;
- Increases scrutiny of health care market power and price variation;
- Continues review of health insurance rates;
- Supports expansion of the primary care workforce;
- Establishes a statewide health resource plan;

Key Provisions of the Law, continued

- Establishes standardized quality measures;
- Supports the expansion of electronic health records and the state health information exchange;
- Provides key resources for workforce development and training programs;
- Provides consumers and employers with quality and cost data to inform purchasing decisions;
- Provides necessary investments in community providers to support the transition to new care delivery and payment models;
- Promotes behavioral health care and integration;
- Restructures government agencies and functions.

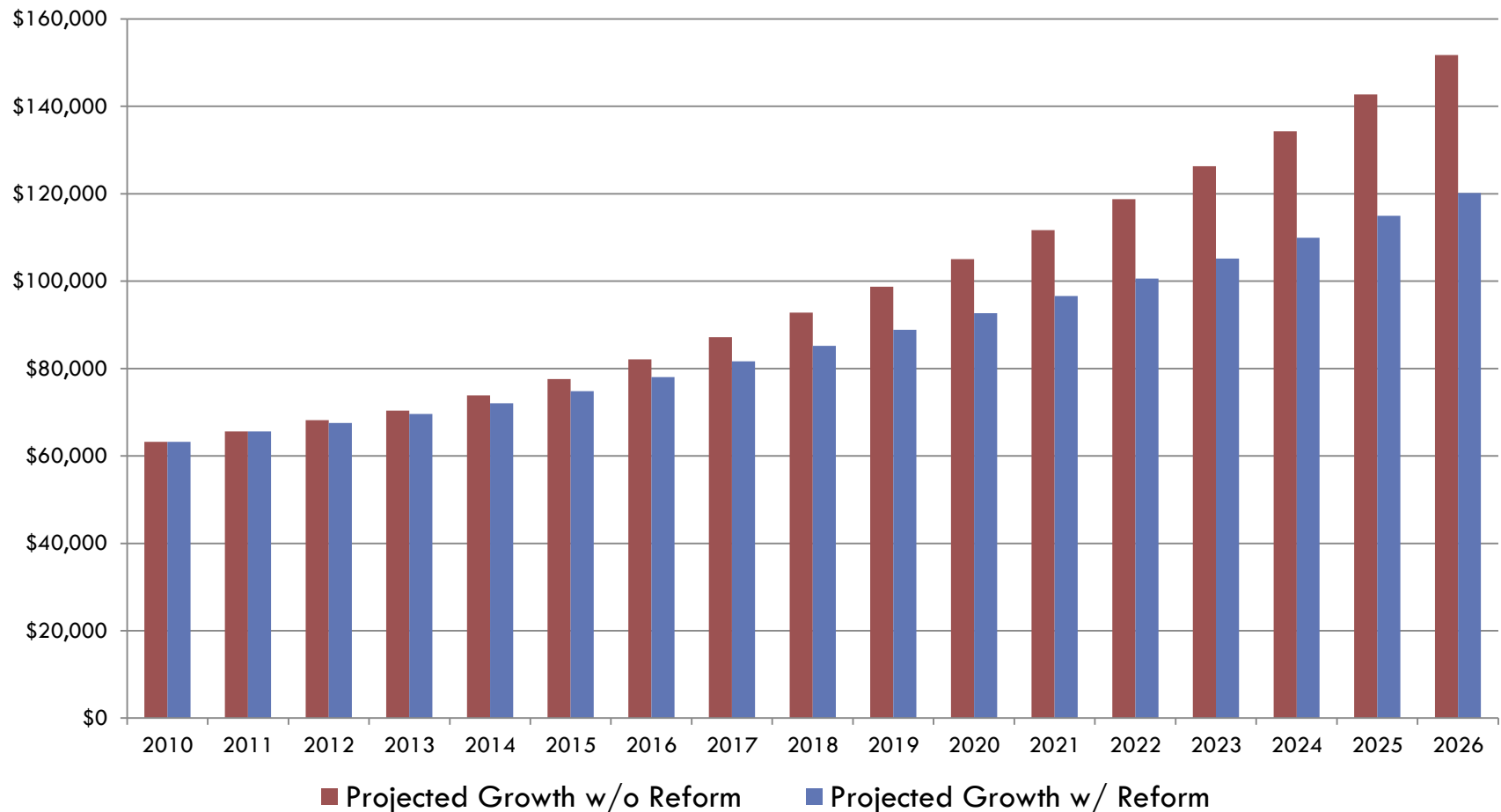
Chapter 224 Overview

Key Levers to Contain Costs



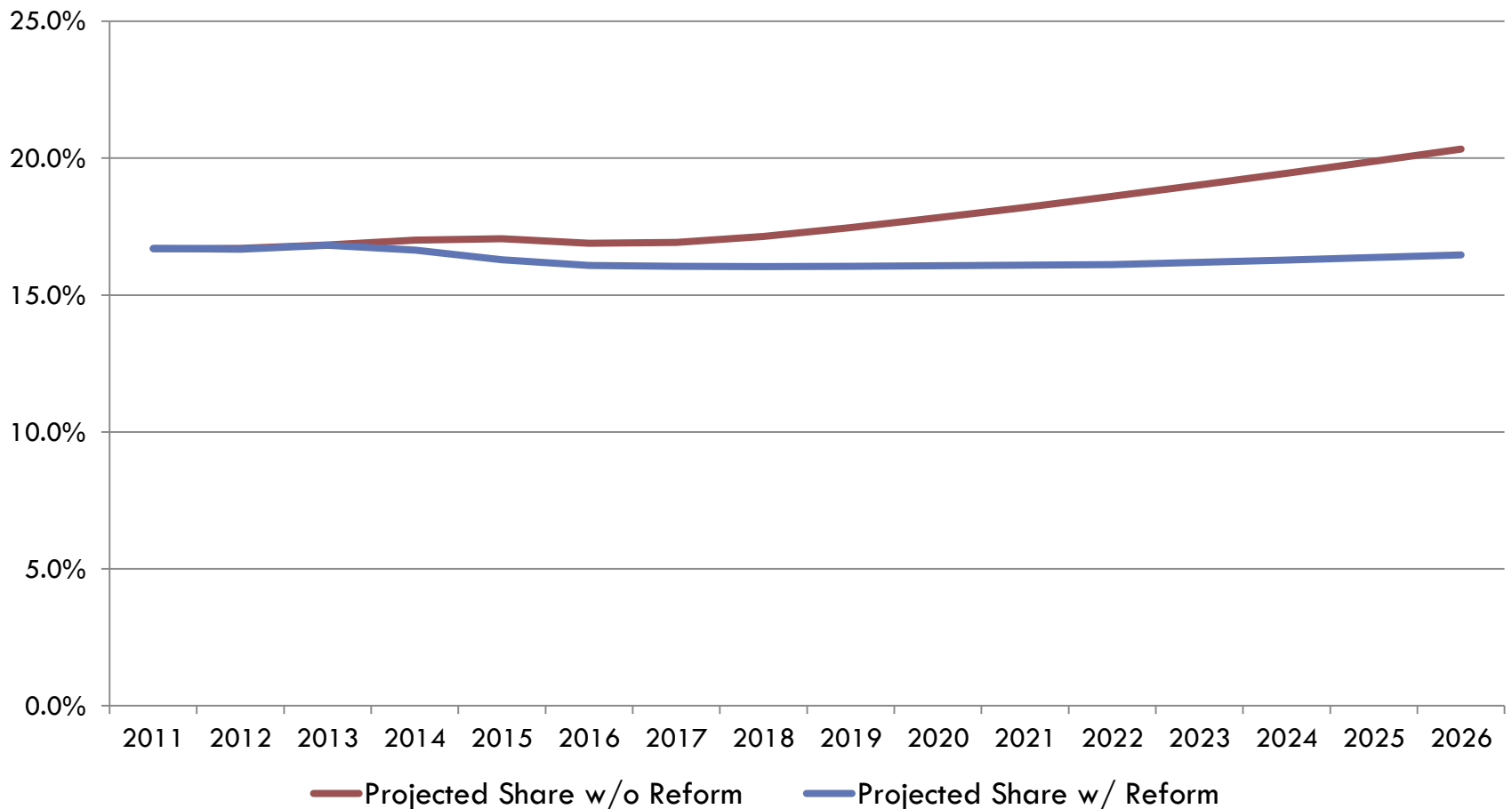
Chapter 224 Overview

PROJECTED MASSACHUSETTS TOTAL PERSONAL HEALTH CARE EXPENDITURES, 2010-2026



Chapter 224 Overview

PROJECTED MASSACHUSETTS TOTAL HEALTH CARE EXPENDITURES AS A PERCENTAGE OF GSP, 2011-2026



Chapter 224 Overview

| | |
|---|-------------------|
| Cumulative Savings over 15 Years (2012 to 2026) | ~\$200 Billion |
| Add'l Take Home Pay over 15 Years | ~\$13 Billion |
| Reduction in Avg. Family Premiums over 15 Years | ~\$40 Billion |
| Public Sector Savings over 15 Years | ~\$38 Billion |

HEALTH POLICY COMMISSION

Overview of Center for Health Information and Analysis





Center for Health Information and Analysis

Our mission is to monitor the Massachusetts health care system and to provide reliable information and meaningful analysis for those seeking to improve health care quality, affordability, access, and outcomes.

www.mass.gov/chia



Our vision is:

to be the Commonwealth's hub
and a national leader in
health care data and analytic services
and
to earn a strong reputation
as a great place to work
and build a career



HPC  CHIA

Health care **Cost Growth Benchmark**

Cost Trends analysis and hearings

Provider Organization registration and analysis



HPC CHIA

Market Impact Reviews

Quality

Performance
Improvement Plans

Access & Affordability

ACOs and PCMHs

Alternative Payment
Methods

HEALTH POLICY COMMISSION

Overview of HPC



The Health Policy Commission (HPC) is established by Chapter 224 of the Acts of 2012, titled “an act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation.” The HPC is a new independent state agency that monitors the reform of the health care delivery and payment systems in Massachusetts in order to reduce overall cost growth while improving quality.

According to the law, the HPC works to:

(i) set health care cost growth goals for the commonwealth; (ii) enhance the transparency of provider organizations; (iii) monitor the development of ACOs and patient-centered medical homes; (iv) monitor the adoption of alternative payment methodologies; (v) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care; (vi) monitor and review the impact of changes within the health care marketplace; and (vii) protect patient access to necessary health care services.

The HPC is charged with a number of specific duties necessary to carry out its mission:

- ❑ Conduct annual cost trends hearings, in coordination with the Center for Health Information and Analysis and the Attorney General, and issue final report on health care trends.
- ❑ Establish a health care cost growth benchmark for total health care expenditures in the Commonwealth.
- ❑ Oversee the implementation of performance improvement plans to improve efficiency and reduce cost growth for certain health provider and health plans.
- ❑ Establish a provider organization registration program.
- ❑ Conduct cost and market impact reviews of providers and plans.
- ❑ Develop and implement standards for a certification program of Patient-Centered Medical Homes.
- ❑ Develop and implement standards for a certification program of ACOs.
- ❑ Manage the Office of Patient Protection.
- ❑ Administer a one-time assessment on health plans and certain acute hospitals that is dispersed to the Distressed Hospital Trust Fund, the Prevention and Wellness Trust Fund, the e-Health Institute Fund, and the Health Care Payment Reform Fund.
- ❑ Administer the distribution of funds from the Distressed Hospital Trust Fund and the Health Care Payment Reform Fund.

Governance and Operations

The HPC is established within the Executive Office of Administration and Finance (ANF), but is not subject to the supervision and control of ANF or any other executive office or political subdivision. It is governed by an 11-person board, as appointed by the Governor, the Attorney General and the State Auditor.

The board is made up of a diverse mix of qualified experts with experience in health care policy and the health care industry. No member of the board may have a direct relationship with a provider of health plan in Massachusetts. The law states:

"A member of the board shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, have a financial stake in or otherwise be a representative of a health care entity while serving on the board."

Board Membership

- One member, designated as chairperson, with demonstrated expertise in health care delivery, health care management at a senior level or health care finance and administration, including payment methodologies. (Governor)
- One member with demonstrated expertise in health plan administration and finance. (Governor)
- One member who is a primary care physician. (Governor)
- One member with demonstrated expertise in health care consumer advocacy. (Attorney General)
- One member who is a health economist. (Attorney General)
- One member with demonstrated expertise in behavioral, substance use disorder, and mental health services and mental health reimbursement systems. (Attorney General)
- One member with demonstrated expertise in representing the health care workforce as a leader in a labor organization. (State Auditor)
- One member with demonstrated expertise as a purchaser of health insurance representing business management or health benefits administration. (State Auditor)
- One member with demonstrated expertise in the development and utilization of innovative medical technologies and treatments for patient care. (State Auditor)
- The secretary of health and human services. (Ex-Offico)
- The secretary of administration and finance. (Ex-Offico)

Governance and Operations

Six members of the board constitute a quorum and the affirmative vote of 6 members is necessary for any action taken by the board. Board members serve without pay, but may be reimbursed for ancillary expenses. The commission annually elects a vice-chairperson.

The Health Policy Commission is advised by an advisory council on the overall operation and policy of the Commission. The council is chosen by the executive director of the Commission and shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, educational institutions, consumer representatives, medical device manufacturers, representatives of the biotechnology industry, pharmaceutical manufacturers, providers, provider organizations, labor organizations and public and private payers.

Governance and Operations

The board must appoint an executive director to serve as the secretary of the commission. The executive director supervises the administrative affairs and general management and operations of the commission.

The executive director will, subject to board approval, prepare an annual budget for the HPC and manage administrative expenses. The administrative budget for the HPC is supported by funding from the Health Care Payment Reform Fund.

Starting in fiscal year 2017, the administrative budget for the HPC will be supported by an annual assessment on acute care hospitals, ambulatory surgery centers, and payers. The assessed amount for hospitals and ambulatory surgery centers is not less than 33% of the HPC's total budget and the assessed amount for payers is not less than 33% of the HPC's total budget. The General Court may supplement funding for the HPC through an appropriation in the state budget.

HEALTH POLICY COMMISSION

Statutory Responsibilities



Annual Cost Trends Hearings

Chapter 305 of the Acts of 2008 requires the Commonwealth to hold annual public hearings on health care cost trends and produce a final report with recommendations to increase the efficiency of the health care system. These hearings were previously conducted by the Division of Health Care Finance and Policy, in coordination with the Attorney General's Office. Under Chapter 224, this duty is transferred to the Health Policy Commission, in coordination with the Attorney General's Office.

Initial Report

- The Center for Health Information and Analysis is required to produce an annual cost trends report that examines changes in cost, price, price variation, quality, utilization, adoption of alternative payment methodologies, plan design, provider integration, and market power in the Commonwealth health care system. The report will also compare the cost trends with the health care cost growth benchmark established by the HPC. This report must be published at least 30 days before the HPC may hold its annual hearings.

Annual Hearings

- No later than October 1st of each year the HPC is required to hold public hearings on the initial report as filed by the Center. Witnesses provide testimony under oath and are subject to cross examination by the HPC, the executive director of the Center, and the Attorney General.

Final Report

- No later than December 31 of each year the HPC is required to file a final report on health care cost trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The final report is based on the findings of the initial report, along with information provided during the annual hearings, and any other information the HPC considers relevant.

The HPC is charged with annually setting a health care cost growth benchmark for the Commonwealth. The benchmark will establish the average growth in total health care expenditures for the next calendar year that the Commonwealth is seeking to achieve. This benchmark is the unifying goal that the strategies, investments, and reforms in Chapter 224 all seek to support. It is tied to the rate of projected long-term potential economic growth in Massachusetts.

No later than January 15 of every year, the Secretary of Administration and Finance will meet with the house and senate committees on ways and means and jointly develop an estimate of the state's potential economic growth for the next calendar year. The "potential growth rate" is defined as the "long-run average growth rate of the commonwealth's economy, excluding fluctuations due to the business cycle".

Chapter 224 sets the potential economic growth rate at 3.6% for calendar year 2013.

Health Care Cost Growth Benchmark

- No later than April 15 of each year the HPC will set the health care cost growth benchmark, based on the potential economic growth rate as set by the Secretary of Administration and Finance and the General Court. The law stipulates that the HPC must set the health care cost growth benchmark in accordance with these restrictions:

| CALENDAR YEARS | COST GROWTH BENCHMARK |
|-----------------|---|
| 2013-2017 | Equal to the Potential Economic Growth Rate |
| 2018-2022 | Equal to the Potential Economic Growth Rate minus 0.5% (may be modified by the HPC) |
| 2023 and beyond | Equal to the Potential Economic Growth Rate (may be modified by the HPC) |

In the event that the cost benchmark is exceeded, the HPC is charged with overseeing the implementation of performance improvement plans developed by certain health provider and health plans. The performance improvement plans are a tool to help hold providers and plans accountable for their own cost growth and to assist them in identifying and implementing strategies to improve efficiency. The solutions proposed in the performance improvement plans must originate from the health care entity, and the HPC is specifically prohibited from requiring specific elements to be included in the plan.

Identification of Health Care Entities with Excessive Cost Growth

- Beginning in 2013, the Center will identify health care payers, providers, or provider organizations whose cost increase is considered excessive and who threaten the ability of the state to meet the cost growth benchmark. The Center will confidentially provide a list of these entities to the HPC.
- The HPC will annually provide notice to any entities that have been identified by the Center and inform these entities that beginning in calendar year 2015, the HPC may require the entity to file a Performance Improvement Plan (PIP).

Performance Improvement Plan Process

- Within 45 days of receiving notice from the HPC that the cost growth benchmark has been exceeded and that the health care entity has been identified as excessively contributing to cost growth, a health care entity must either: 1.) file a PIP with the HPC, or 2.) apply to the HPC for an extension or a waiver of the requirement to file a PIP.
- The HPC cannot require specific elements in PIP - the proposed solution must originate with the health care entity.
- To enforce the compliance during the PIP process, the HPC may levy fines up to \$500,000 on any healthcare entity. The HPC is charged to work with health care entities in all aspects of the PIP process- the civil penalty is envisioned as a last resort.

The HPC is charged with developing and administering a registration program for provider organizations in Massachusetts. The purpose of the provider organization registration is to gather comprehensive data regarding all provider organizations and their operations, including location, organizational structure, finances, affiliations and partnerships. The registration must be renewed every 2 years and, to ensure compliance, only registered provider organizations can contract with health plans. Small provider organizations (less than 15,000 patients or less than \$25 million in net patient service revenue) that are not risk-bearing provider organizations are not required to register.

The specifics of the registration process are subject to the regulations of the HPC. The information collected by the provider registration process is critical for many other functions of the HPC, including: cost and market impact reviews, certification of ACOs, and the identification of entities with excessive cost growth.

The HPC is charged with reviewing significant market changes to the health care industry in Massachusetts and evaluating the impact of these changes on cost, access, quality, and market competitiveness. The purpose of the cost and market impact reviews is to provide a public examination of the impact, both positive and negative, from developments in the health care marketplace and enhance the accountability of provider organizations to engage in fair methods of competition.

The HPC may not ultimately reject or prohibit a proposed change, but information gathered under this process may be referred to the Attorney General for possible further investigation or action to protect consumers in the health care market.

Beginning January 1, 2013 all providers and provider organizations must submit notice to the HPC, the Center, and the Attorney General's Office of any "material change" in its operations or governance structure. If the HPC finds that the proposed change will result in a significant impact then the HPC may conduct a cost and market impact review.

In addition, the HPC may conduct a cost and market impact review of any provider organization identified by the Center as having excessive cost growth or contributing to the Commonwealth's exceeding the state spending benchmark.

A cost and market impact review may examine factors related to the provider's business and relative market position, as determined by the HPC.

The HPC is charged, in consultation with Masshealth, with developing and implementing standards of certification for patient-centered medical homes in the Commonwealth. The purpose of the certification process is to establish best practices and to encourage the adoption of innovative care delivery models that improve primary care, enhance care coordination, and reduce cost growth.

By January 1, 2014, the HPC, in consultation with stakeholders and in consideration of existing national standards, will develop standards for certification of patient-centered medical homes in Massachusetts. In addition, the HPC will develop a model payment system for payers to adopt that supports patient-centered care. Behavioral health providers and specialty care providers are eligible for certification.

By July 1, 2014 the HPC must establish a training program for providers to learn the best practices of the patient-centered medical home model.

The HPC is charged with developing and implementing standards for certain provider organizations to be certified as accountable care organizations (ACOs). The purpose of the ACO certification process is to encourage the development of integrated delivery care systems dedicated to reducing cost, improving quality, and protecting patients.

The HPC will develop minimum standards for certification. The law states a number of aspects that the HPC must include in the standards and a number of aspects that the HPC must *consider* for inclusion.

Certification is voluntary and is renewable every two years. The HPC will also develop a process for certain certified ACOs to be designated as “Model ACOs.” ACOs so designated as Model ACOs *may* receive a contracting preference from the state for the provision of health care services in state-funded programs.

The HPC is charged with administering the Office of Patient Protection (OPP), an office that currently resides within the Department of Public Health (DPH). The OPP was established to help consumers who are enrolled in managed care plans and have questions or problems obtaining medically necessary covered services. The OPP currently helps consumers in two ways:

- Assists consumers navigate the managed care requirements of health plans and assists in an external appeal if a health plan has denied a claim or access to services.
- Provides consumers who are seeking health insurance on their own, outside of an annual open enrollment period, with an opportunity to apply for a waiver to the open enrollment period in order to receive coverage immediately.

Chapter 224 expands these duties by requiring the establishment of both internal and external review systems for patients of certified ACOs and risk-bearing provider organizations.

The HPC is charged with administering a one-time assessment on certain acute hospitals and surcharge payers (health plans). The purpose of this assessment is to provide necessary investment funding for initiatives contained within chapter 224. These investments are critical for the building the foundation of long-term, sustainable health care cost containment and quality improvement.

By December 31, 2012 the HPC must develop the calculation and mechanism for administering a one-time \$160 million assessment on surcharge payers and a \$60 million assessment on certain acute care hospitals. Hospitals and payers may choose to pay the surcharge amount in one lump sum before June 30, 2013 or in four equal annual installments.

The HPC may mitigate or waive the assessment on acute hospitals under certain circumstances described in the law. Hospitals and payers may not increase prices or premiums to pay for this assessment.

The funding collected by the one-time assessment is distributed as follows:

- 5% of the total amount is deposited in the Health Care Payment Reform Fund. (Estimated total over 4 years: \$11.25 million)
- \$60 million is deposited in the Prevention and Wellness Trust Fund. (Minus 5% as deposited in the Health Care Payment Reform Fund. Estimated total over 4 years: \$57 million)
- \$30 million is deposited in the e-Health Institute Fund. (Minus 5% as deposited in the Health Care Payment Reform Fund. Estimated total over 4 years: \$28.5 million)
- \$135 million is deposited in the Distressed Hospital Trust Fund. (Minus 5% as deposited in the Health Care Payment Reform Fund. Estimated total over 4 years: \$128.5 million)

The HPC is charged with administering the Health Care Payment Reform Fund. The purpose of this Fund is to support the activities of the HPC and to foster innovation in health care payment and service delivery.

Upon approval of the Board, funds may be used to support the annual budget of the HPC. In addition, the HPC can award funds through a competitive grant process to develop, implement or evaluate promising models in health care payment and health care service delivery.

The HPC must coordinate expenditures from the Healthcare Payment Reform Fund with all other initiatives contained in Chapter 224 as well as any other related state or federal grant programs, such as the CMS Innovation Center.

The Fund receives revenue from the following sources:

- 5% of the one-time assessment on certain hospitals and health plans collected by the HPC pursuant to section 241. (Estimated total over 4 years: \$11.25 million)
- 23% of any licensing fees collected by the Gaming License Fund. (Min. \$19.55 million per category one gaming license)
- Funding from the Center for Health Information and Analysis (CHIA) pursuant to any interagency agreement with the HPC. (FY13-FY17 only)
- Any fees collected by CHIA from health care providers and health plans for failing to provide requested information in a timely way to CHIA.

The HPC is charged with administering the Distressed Hospital Fund. The purpose of the Fund is to improve and enhance the ability of community hospitals to improve patient care, reduce cost growth, and establish sustainable financial models.

The HPC will annually award funds to community hospitals through a competitive grant process. All expenditures must be consistent with other initiatives contained in chapter 224 and must support certain goals.

In reviewing grant applications the HPC must consider the financial health of the applicant, the anticipated return on investment, the coordination with other policy goals of the HPC, and geographic and population need. Teaching hospitals, hospitals with relatively high prices, and for-profit hospitals are not eligible to receive funds.

The Fund receives revenues from the following sources:

- Any public and private sources such as gifts, grants and donations, interest earned on such revenues and any funds provided from other sources.
- \$135 million from a one-time assessment on certain hospitals and health plans collected by the HPC pursuant to section 241, minus 5% as deposited in the Health Care Payment Reform Fund. (Estimated total over 4 years: \$128.25 million)

Guidelines Related to Mandatory Nurse Overtime

Chapter 224 prohibits mandatory overtime for hospital nurses other than in the case of “an emergency situation where the safety of the patient requires its use and when there is no other reasonable alternative.” The HPC is charged with developing guidelines and procedures to determine what constitutes an “emergency situation”. In developing those guidelines, the chapter 224 requires the HPC to consult with those employees and employers who would be affected by such a policy and to solicit comment from those same parties through a public hearing.

This provision went into effect as of November 5th, 2012.

The HPC is charged with conducting an investigation and make recommendations relative to increased adoption of flexible spending accounts, health reimbursement arrangements, and health savings accounts. The HPC must study the feasibility of such accounts for public and commercial payers and examine incentives to increase utilization of these plans.

The HPC must submit a report with its findings and recommendations by April 1, 2013.

Chapter 224 requires the HPC to work with other state agencies in the development of health care policy, including requirements to:

- ❑ Consult with the Division of Insurance on the development of a certification process for risk-bearing provider organizations;
- ❑ Provide comments to the Department of Public Health related to Determination of Need applications;
- ❑ Designate the Executive Director of the HPC to serve on the Health Information Technology Council;
- ❑ Designate the Executive Director of the HPC to serve on the Health Planning Council;
- ❑ Designate the Executive Director of the HPC to serve as a co-chair of the special commission to review variation in prices among providers.