



*Healthy Living. Healthy Massachusetts.*



**MassSenate**



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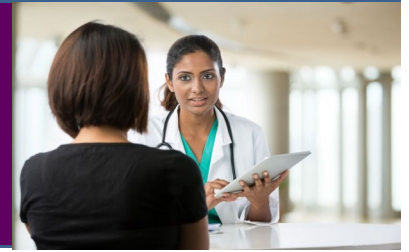
Working Together to Improve Our Health. Right Care, Right Place, Fair Price



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# Acknowledgements

Working Together to Improve Our Health. Right Care, Right Place, Fair Price



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The Working Group is grateful for the input from all the stakeholders who engaged in this process, both here in Massachusetts and across the country. We want to sincerely thank all of the stakeholders in the states researched by the Working Group for their time and expertise.

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Additionally, the Working Group is grateful to the Massachusetts stakeholders who participated in the series of roundtables for the instructive conversations.

**Massachusetts Roundtable Participants (August 2017)**

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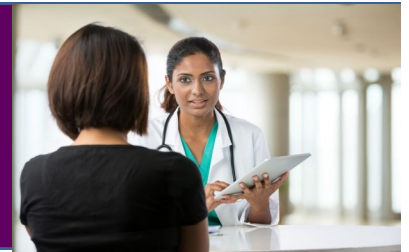
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Finally, this project would not have been possible without the hard work and support from the staff that assisted the Working Group. In particular, the Working Group wishes to thank Michael Cannella, Legislative Director & Counsel, Office of Senator James T. Welch, Joint Committee on Health Care Finance; Martha Kwasnik, Health Policy Director and Associate Counsel, Senate Committee on Ways & Means; Will Poff-Webster, Fiscal Policy Analyst, Senate Committee on Ways & Means; Bryan Barash, Chief of Staff, Office of Majority Leader Harriette Chandler; Dennis Burke, Legislative Director and General Counsel, Office of Senator Jason Lewis; Alejandro Alves, Chief of Staff, Office of Senator John F. Keenan; Daria Afshar, Legislative Director, Office of Senator Patrick O'Connor; Mark Dailey, Policy Advisor, Office of Senate President Stan Rosenberg; Anna Freedman, Fiscal Policy Advisor, Office of Senate President Stan Rosenberg; and, the Office of the Senate Counsel.

# Letter from Working Group

Working Together to Improve Our Health: Right Care, Right Place, Fair Price



Massachusetts has consistently been a national leader on improving health care access and working to address high health care costs. As the first state in the nation to provide near universal insurance coverage through health care reform legislation passed in 2006, we continue to seek solutions to drive costs down, such as those proposed in our landmark legislation passed in 2012. We continue to lead the nation in health insurance coverage with an uninsured rate of only 2.8 percent. However, there is still work to do to address the cost of health care.

Senate President Stan Rosenberg convened the Senate Working Group on Health Care Cost Containment and Reform in the fall of 2016. The purpose of the Working Group was to explore best practice strategies used by other states to control health care costs while improving health outcomes and to identify approaches that Massachusetts should consider adopting.

The Working Group heard loud and clear from local stakeholders that Massachusetts can do more to reduce costs for families, businesses, and the state budget, while improving health outcomes for residents and strengthening the functionality of the health care market overall. Policy experts and stakeholders in other states and Massachusetts articulated a need for ensuring a health care system that provides *the right care at the right place for a fair price*. This portends a system that increases access to high-quality, lower cost preventative health care, reduces unnecessary emergency department and hospital utilization, protects consumers from excessive and surprise out-of-pocket costs, rewards consumers for making high-value choices, and supports innovative care delivery and payment models to increase efficiencies and improve care management.

The Working Group took a comprehensive, system-wide approach to evaluating proposals in order to identify meaningful reforms. The Working Group prioritized a consumer protection focus and worked to ensure that policy solutions do not reduce access or benefits, especially to our Commonwealth's most vulnerable. Additionally, priority was given to proposals that don't require substantial upfront investment and have short-and long-term savings.

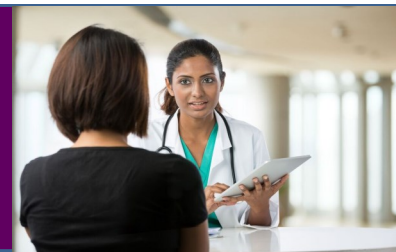
The Working Group is deeply grateful to the many individuals and organizations that made time to meet to share their expertise and experience and look forward to continuing the collaborative discussions on these issues. It is our hope that legislation to enact these reforms will be adopted this session.

While the Working Group did not reach unanimous agreement on every issue, the overwhelming majority is recommending legislation with the following goals:

- **Reducing hospital readmissions**
  - **Reducing prescription drug costs**
  - **Reducing the use of post-acute institutional care and improving integration of long-term services and supports (LTSS)**
  - **Reducing unnecessary emergency department use**
  - **Addressing provider price variation**
  - **Improving access to behavioral health**
  - **Commercial market reforms to reduce cost growth and reward high-quality decisions**
  - **Medicaid reforms to ensure maximum efficiency throughout the program**
- Short-and long-term cost savings**

# Executive Summary

Working Together to Improve Our Health: Right Care, Right Place, Fair Price



In the fall of 2016 Senate President Stan Rosenberg convened a working group of senators, in partnership with the Milbank Memorial Fund, to explore best practice strategies used by other states to control health care costs while improving health outcomes. Along with Senate President Rosenberg, the senators participating in the working group are: Senate Majority Leader Harriette Chandler, Senator Karen Spilka (Chair, Senate Committee on Ways & Means), Senator Jason Lewis (Chair, Joint Committee on Public Health), Senator John Keenan (Vice Chair, Joint Committee on Mental Health and Substance Use, and Vice Chair, Special Senate Committee on Addiction Prevention, Treatment and Recovery Options) and Chair, Senate Committee on Bonding, Capital Expenditures and State Assets), Senator Patrick O'Connor (Member, Special Senate Committee on Addiction Prevention, Treatment and Recovery Options), and Senator Jim Welch (Chair, Joint Committee on Health Care Finance), who led the effort. The working group also engaged with health care policy representatives from Governor Baker's administration and David Seltz, Executive Director of the Health Policy Commission, as key collaborators in its research efforts.

As a result of conversations with stakeholders in other states and here in Massachusetts, the overwhelming majority of the Working Group is recommending the following:

## Reduce Hospital Readmissions and Emergency Department (ED) Use

- Implement a mobile integrated health (MIH) program and encourage use
- Continue to support the Prevention and Wellness Trust Fund
- Facilitate the use of telemedicine
- Enhance access and coordination for behavioral health needs
- Strengthen integration between medical providers, care transition coordinators, and housing providers
- Expand provider versatility to increase access to lower cost providers
- Support alternative care sites for high ED utilizers
- Ensure provider focus on reducing emergency department readmissions

## Reduce Use of Institutional Post-Acute

- Enhance post-acute care transition planning to encourage appropriate placement in community settings
- Strengthen information sharing between medical and LTSS providers to improve care coordination
- Support collaboration between housing services and LTSS plans and providers



## Reduce Growth in Prescription Drug Spending

- Enhance industry oversight and transparency
- Increase consumer awareness and choice regarding prescription cost
- Encourage bulk purchasing arrangements to mitigate costs

## Commercial Market Reforms

- Increase accountability for health care entities with excessive cost growth
- Reduce unexpected costs for consumers and encourage value-based choice
- Mitigate provider price variation
- Increase adoption of alternative payment methodologies

## Medicaid Reforms

- Promote the uptake of employer sponsored insurance while ensuring needed coverage for MassHealth eligible individuals
- Increase long-term care coordination and better leverage federal funding opportunities
- Encourage data coordination and strategic planning activities
- Require MassHealth to report on the role of LTSS within the MassHealth program and MassHealth accountable care organizations.

## Other Best Practices and Transparency Reforms

- Promote and encourage implementation of best practices that improve the population health, prevention, and address the social determinants of health
- Improve stakeholder access to health care price information
- Increase transparency regarding employer sponsored insurance practices
- Address administrative barriers to improve care delivery
- Track policy outcomes to assess impact

The Working Group is submitting recommended legislation to enact these policy changes.

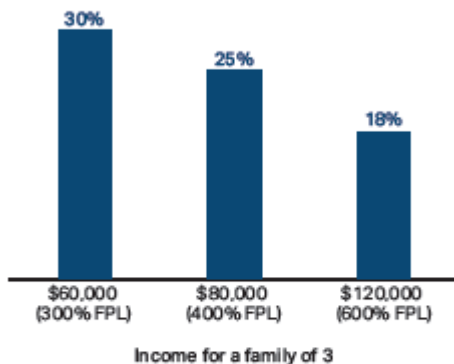
# Introduction

Working Together to Improve Our Health: Right Care, Right Place, Fair Price



Massachusetts exceeded its statutory health care cost benchmark of 3.6 percent for the prior two years with growth in total health care expenditures (THCE) of 4.1 percent from 2014-2015 and 4.2 percent growth from 2013 to 2014.<sup>1</sup> Despite coming in under-benchmark in 2015-2016, health care costs continue to grow faster than families' wages, business revenue, or the state economy as a whole. We have seen these costs also affect our state budget. The FY18 budget for MassHealth is approximately \$16.5 billion, an increase of 42 percent (gross spending) since FY13. Projected spending on MassHealth is expected to comprise 41 percent of the state budget on a gross basis and 24 percent on a net<sup>2</sup> basis in FY18. Moreover, MassHealth spending has increased at a rate higher than tax revenue growth in recent years, consuming the majority of available new resources and crowding out investment in other critical areas of state spending. This will continue into FY18 as tax revenue is projected to grow by only 1.4 percent, while MassHealth is projected to grow by 6.4 percent.<sup>3</sup>

Exhibit 1.1: Approximate combined health insurance premium and out-of-pocket spending relative to income for a family of three



Notes: FPL = federal poverty level. Data reflect families with family coverage through an employer and include health insurance premiums (including employer and employee contributions) and out-of-pocket spending. Income levels do not account for employer contribution to health insurance premiums or other employer benefits paid. See Technical Appendix for more details.

Sources: Agency for Healthcare Research and Quality and Center for Health Information and Analysis, 2015

Not only is health care a growing cost for the state budget, but it also represents a substantial cost for families and businesses. Massachusetts continues to have among the most expensive health insurance premiums in the country. High premiums have consumed more than 40 percent of family income growth over the past nine years<sup>4</sup> and disproportionately impact lower wage earners. Additionally, cost-sharing growth for members increased faster than inflation, wage growth, and premiums from 2015-2016 at a rate of 4.4 percent. Residents continue to bear an increasing cost sharing burden, putting a particular strain on the Commonwealth's low and middle income families, who may forgo needed medical care due to cost. This may also exacerbate rising income inequality.

Furthermore, the rising cost of premiums has put business owners, particularly those running small businesses, in a difficult position. While business owners may want to offer health insurance to their employees, high premium costs make it more difficult to do so in a way that doesn't constrain already tight margins.

## HPC 2016 Cost Trends Report

The high cost of care in the Commonwealth is sometimes attributed to factors such as Massachusetts being a high cost-of-living state, with an older population and more generous Medicaid benefits than other states. Yet, Massachusetts is a healthier state in comparison to much of the country, suggesting that opportunities exist to reduce cost. The Health Policy Commission (HPC) estimates that approximately \$12.1 billion to \$22.4 billion in wasteful health care spending occurred in 2015 in Massachusetts (due to overtreatment, failures of care delivery, failure of care coordination, pricing failures, and administrative complexity).

1 The benchmark is now set at 3.1 percent. Initial calculations for 2016 THCE reflect growth of 2.8 percent over 2015, which is below the cost growth benchmark. This represents more moderate growth than prior years.

2 This is due to federal offsets to MassHealth spending.

3 FY18 MassHealth and Commercial Market Reform Package presentation, July 25, 2017.

4 HPC 2016 annual cost trends report. In 2014, health insurance premiums in MA averaged \$17,702 for family coverage and \$6,348 for single coverage (approximately \$1,000 and \$500 above national averages, respectively).

Pricing failures explain much of commercial cost growth. According to last year's HPC Cost Trends Report, unit costs grew at an average of 3 percent per enrollee, while zero percent growth occurred in overall utilization, suggesting that reducing unnecessary utilization is insufficient to contain costs.<sup>5</sup> This observation is consistent with the findings of successive HPC, Center for Health Information and Analysis (CHIA), and Office of the Attorney General reports that consistently identified extensive variation in provider prices that are not otherwise explained by, among many variables, the quality of the care delivered. This has resulted in increased disparities in the allocation of financial resources across hospital systems.<sup>6</sup> A continuation of this trend could force smaller providers to close their doors, redirecting patients to higher-priced providers, further increasing overall healthcare spending.



With these issues in mind, the Working Group, in collaboration with the Baker Administration, identified four key health care cost centers (for both MassHealth and the health care system as a whole) as the focus for research with other states:

- Integration of behavioral health
- Long-term services and supports (LTSS)
- Impacts of social determinants of health and innovative care delivery models
- Pharmaceutical drug costs

The Milbank Memorial Fund identified states that have achieved positive results in each of these areas. Over the past year, through Milbank's facilitation, the Working Group conducted a series of conversations with experts and representatives from those states to review their policies in depth. Based on the information collected from these conversations, the Working Group held a series of roundtable meetings in August to gather input from an array of Massachusetts stakeholders on the issues of care delivery systems and behavioral health integration, long-term care, and chronic and acute care management. The content of those roundtable conversations and feedback provided in follow-up meetings with stakeholders form the basis for the recommendations in this report.

The "Findings" section of this report details best practices and innovative models utilized by the states engaged by the Working Group. The "Recommendations" section of this report identifies specific areas for improvement based on the findings from these other states and conversations with stakeholders here in Massachusetts. The "Recommendations" section also sets forth recommended policy solutions to improve health outcomes for the residents of the Commonwealth through a sustainable health care system. The Working Group is submitting recommended legislation to implement these policy changes.

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5 HPC Cost Trends Report 2016; Pre-Filed testimony submitted by payers to the Health Policy Commission.  
6 HPC Cost Trends Report 2016; pg 27-28.

# Findings

Working Together to Improve Our Health: Right Care, Right Place, Fair Price



## Behavioral Health Integration and Social Determinants of Health Interventions

The Working Group examined innovative models in other states that reduce emergency department (ED) visits and hospital readmissions by leveraging intervention opportunities for high-risk patients through close collaboration with providers along the care and service delivery continuum. These models prioritize a focus on social determinants of health and/or behavioral health and demonstrate enhanced partnerships between medical organizations, social service organizations, and other important community partners to enhance both upstream and post-acute care coordination. The models also provide opportunities to engage with a population outside a traditional medical setting.

### Washington

**Behavioral Health Organizations (BHO):** These organizations are designed as transitional vehicles for integrating behavioral health and substance abuse services (BH/SUD) into the health care delivery system for physical health care needs. Due to the siloed responsibility between counties and the state, the BHO transition included an early warning system to monitor key performance metrics to catch problems in a timely fashion (e.g. emergency department use rates, wait times for BH/SUD, claims denial rates). The model incorporates performance measures for medical services with additional and emphasized metrics for BH/SUD. Technical and administrative support for BH providers is a critical part of the transition to integration. Some BHOs partner with Accountable Communities of Health (ACHs), which allows for collaboration among not only behavioral health and medical providers, but key local public entities, such as patient advocates, the criminal justice system, and county government.



## Minnesota

**Accountable Care Organizations (ACOs):** Hennepin Health is an ACO with an explicit focus on BH and social determinants of health. The structure of Hennepin's ACO model incorporates units of government responsible for the administration of social services and other programs that should be aligned with BH/medical care delivery to enhance effectiveness. The model originally targeted populations with the greatest need to develop core expertise (non-disabled adults without dependents) and then added in families and children. Through Hennepin's partnerships with social service agencies and nonprofits, the ACO proactively identifies members most at risk and intervenes with supports and care coordination. In particular, Hennepin targets high-utilizers of emergency departments, typically low-income Medicaid beneficiaries with complex and unmet care needs related to mental illness, substance abuse, and/or other "non-medical challenges."

**Integrated Health Partnerships (IHPs):** IHPs (such as Allina Health) are a health care delivery transformation model with an integrated or virtual structure. The integrated systems serve as a common entity delivering the full spectrum of care, which progress to symmetrical downside risk-sharing with the state after a transition period. Virtual systems are collaborations with entities that are not hospital affiliated and only share in upside savings. Organizations are required to ensure the exchange of timely and accurate data to the state to facilitate state preparation of data-books for IHPs so the IHP can monitor patient experience and track their own performance via the state's IHP data website. IHP's are also supported through quarterly data user group meetings designed to improve usefulness of the reports and data provided to IHPs.

**Behavioral Health Homes:** This model is comprised of services within a behavioral health home that include comprehensive care management, care coordination, health promotion and wellness, comprehensive transitional care, patient and family support, and referral to community and social support services. Providers must be certified to participate in the model, which requires care delivery focused on multi-disciplinary teams designing patient-targeted plans with the goal of reducing length of stays.

**Community Paramedicine:** CP is an iteration of mobile integrated health, a model in which paramedics, emergency medical technicians, and/or other practitioners operate in expanded roles to provide urgent and routine health care interventions without the need to transport to an emergency department. The state created a specific certification for community paramedics that provide a defined set of mobile integrated health services, resulting in a pathway to establish rules and processes for payment, including Federal Financial Participation (FFP) from the Center for Medicare and Medicaid Services (CMS). This model establishes a clearly defined health care delivery system role for CPs: 1) in-home primary care/disease monitoring; 2) facilitating care transitions (e.g. post-discharge); and 3) managing an alternative care path for non-ED appropriate emergency calls (adjunctive to EMS response). CP programs also partner with Minnesota's network of rural health clinics and critical access hospitals to increase patient access to health care services.

## Oregon

**Community Care Organizations (CCOs):** These regional entities directly involve local public health departments and consumers in managing their respective global budgets, which are limited to 3.4 percent statewide per capita growth per year. Performance measures are largely process-based and CCOs have flexible spend authority to use their funds outside of traditional medical services in order to better address social determinants of health (including oral care). Focusing on non-medical services has had a significant impact on ED utilization and hospital admissions for poorly managed chronic conditions (e.g. asthma, lung diabetes). The models use public performance tracking and a state-mediated CCO learning collaborative to share best practices and improve individual CCO performance. The program is supported through Oregon's 1115 waiver.

## Texas

**ED Diversion:** The MedStar program, based in Fort Worth, is primarily an ED diversion program serving a handful of urban communities. The core element is proactive patient care management designed to both circumvent the 911 system and support the 911 system when activated. The program has been successful in providing telephone-based support and in-home visits for patients who frequently call 911 who could be treated in an outpatient setting. The program selects non-compliant patients for proactive CP services and utilizes a shared electronic health record (EHR) system to identify and better address patients at risk of readmission or high ED utilization.

## **Long-Term Services and Supports**

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The Working Group reviewed models that encourage the use of home- and community-based services for long-term care. Some states have fully leveraged federal funding opportunities to integrate Medicaid and Medicare funding to reduce fragmented care and support seniors remaining at home. Additionally, a number of models prioritize targeting services for those just above the Medicaid-eligibility threshold in order to mitigate the movement of seniors out of their homes and into more expensive nursing home care settings. The Working Group also reviewed models that require enrollment in a designated long-term care plan for Medicaid-eligible individuals.

## Minnesota

**Alternative Care program:** This program provides home care services to seniors who need nursing home level of care but are not financially eligible for Medicaid and lack income and assets to pay for 135 days of nursing facility care. The program slows the movement of these seniors out of their homes and into costly nursing facilities. When seniors have spent down to become financially eligible for Medicaid, they are able to maintain the in-home level of care they received under the Alternative Care program. Originally a state funded program created in 1980, MN began receiving federal financial participation (FFP) support in 2013 through its 1115 waiver.

**Senior Care+ and Special Needs Basic Care (SNBC):** Senior Care+ is the default managed care option for those that are eligible and has mandatory enrollment. It provides only Medicaid services. SNBC is a voluntary program for persons with disabilities aged 18-64 with Medical Assistance. It may include a care coordinator and includes behavioral health services.

**MN Senior Health Options (MSHO):** MSHO is a voluntary program that provides integrated care across Medicare and Medicaid for dual eligibles over 65 as an alternative to Senior Care+. Integrating care provides the incentive to coordinate a member's care and reduce nursing facility admissions. Passive enrollment—setting MSHO as the default for dual-eligibles with the option to opt out—tripled the number of seniors receiving integrated care in 2003, and low numbers of opt-outs since then has resulted in an integrated care program that serves 72 percent of the eligible population as of 2015.

As a result of these innovations, Minnesota's Medicaid caseload shifted from 63 percent nursing facility and 9.5 percent community waivers in 1996 to 23 percent nursing facility and 41 percent community waivers in 2014.

## Washington

**Medicaid Alternative Care program:** This program supports unpaid family caregivers of Medicaid-eligible persons who do not participate in Medicaid funded LTSS (e.g. respite services, trainings, support groups, home-delivered meals).

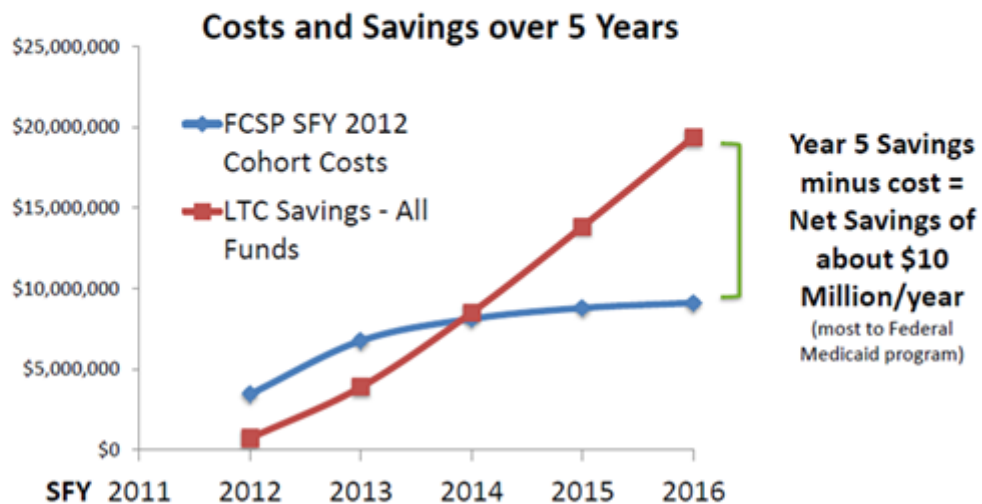
**Tailored Support for Older Adults:** WA established a new eligibility category and benefit level for individuals at future risk of Medicaid LTSS use but who are not Medicaid eligible.

**Supportive Housing Services:** This is a program financed by FFP that assists Medicaid beneficiaries in obtaining and maintaining housing.

Washington State Department of Social and Health Services

## RDA Findings: Impacts for Taxpayers

### Of Delaying Medicaid Long-Term Care Placement



Source: David Mancuso, PhD; DSHS Research and Data Analysis, Nov. 2014 (unpublished).

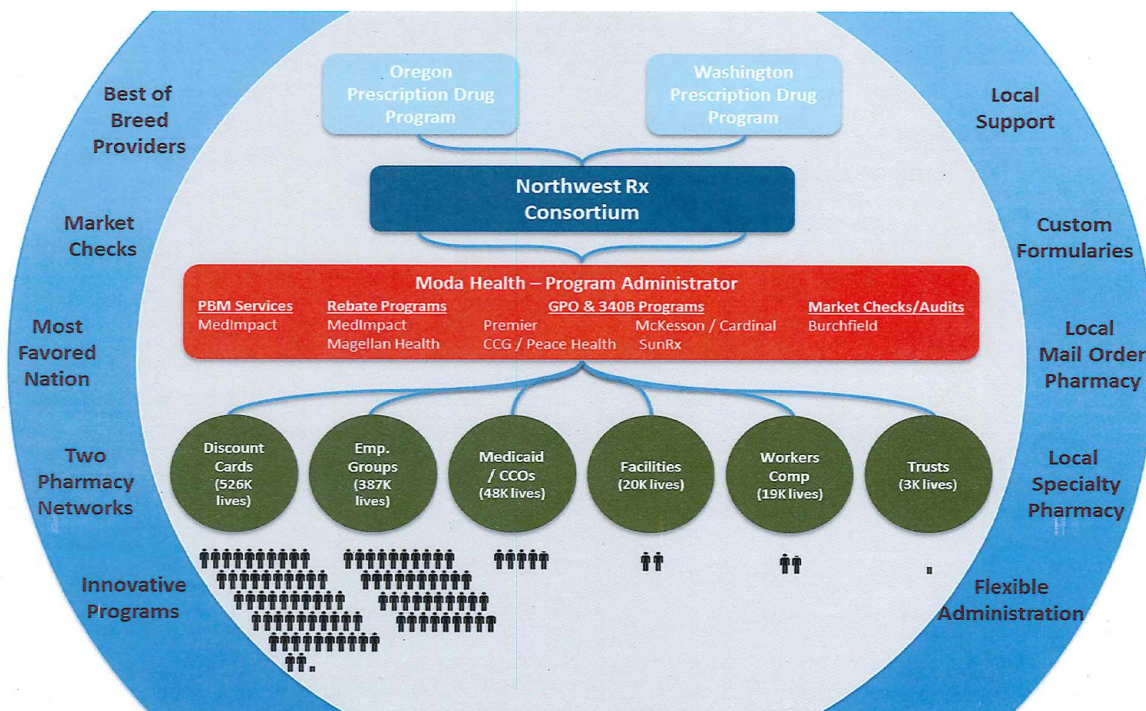
## Prescription Drug Costs

The Working Group reviewed innovative statewide efforts to reduce prescription drug costs for consumers and providers, independent of payer. Two states, Washington and Oregon, have partnered together to conduct an aggregated bulk purchasing program to provide greater rebates and lower prescription drug costs. This model represents a unique state level attempt to lower prescription drug costs through combining the purchasing power of people covered under public and commercial insurance. Typically a state is limited in its purchasing power to those residents it covers through its Medicaid program and the residents it serves through other pharmaceutical programs. Given the high costs of pharmaceuticals, it was important to understand this approach to managing a high priority issue.

### Washington and Oregon

**Purchasing Consortium:** WA and OR established a purchasing partnership in 2005. State agencies that purchase prescription drugs must participate unless they can demonstrate lower prescription drug costs through another program. Participation is open to local government, business, labor groups, and individuals. Between these categories, the partnership includes 925,000 participants with \$1 billion in prescription drug spending. It is available to all residents, regardless of age, income, or insurance status and to government, private, and organizational purchasers within each state. The program offers rebate management and tailored formularies regardless of the group's size; all prescriptions are eligible for discounts. The consortium achieves better purchasing prices than commercial rates available to other groups and rebates are passed through 100 percent. The program reports total savings by members of \$71 million from February 2007 to November 2016.

## Northwest Prescription Drug Consortium





## Other Innovative Payment and Care Delivery Models

Addressing identified cost centers led the Working Group to examine alternative approaches to managing the financing of the health care system. Other states have taken approaches to address common dysfunctions in the health care sector, such as price variation, and the resulting costs they impose in terms of money spent and appropriateness of care delivered to patients. The working group heard from Maryland and Vermont regarding the innovative payment models implemented by those states to contain health care costs and incentivize the right kinds of care in the right place.

### Vermont

**All-Payer Accountable Care Organization (ACO):** Vermont has participated in a “Global Commitment to Health” 1115(a) demonstration waiver since 2005, which restructured the state’s Medicaid program. This program was recently extended to 2022. Under the Global Commitment waiver, VT operates under a capped funding arrangement and the state utilizes Medicaid funds to finance non-Medicaid health programs to focus on reducing the number of insured and improving health outcomes. The extended demonstration project seeks to increase value-based payments, accelerate payment reform, and stabilize health care spending. To achieve this, the Green Mountain Care Board is charged with developing and implementing an All-Payer ACO Model. The Board has regulatory authority over hospital revenue, regardless of payer, and can review and certify any participating ACO. The plan for implementing the All-Payer ACO Model includes scaling the ACO initiative to achieve 70 percent All-Payer enrollment and 90 percent Medicare enrollment by 2022. The initiative includes an overall growth rate goal for the state and sets benchmarks for quality, care delivery, and process milestones. The Green Mountain Care Board’s overall growth rate goal incorporates Vermont stakeholders’ conception of what constitutes a ‘sustainable’ healthcare system, one that grows alongside wages and the economy rather than requiring an ever-increasing share of individuals’ paychecks and employers’ payroll. The creation of the Green Mountain Care Board grew out of Vermont’s attempt to develop single-payer healthcare, an effort that ultimately proved unviable because of higher-than-expected costs and lower-than-expected administrative savings.<sup>7</sup>



<sup>7</sup> John McDonough, “The Demise of Vermont’s Single-Payer Plan,” *New England Journal of Medicine*:

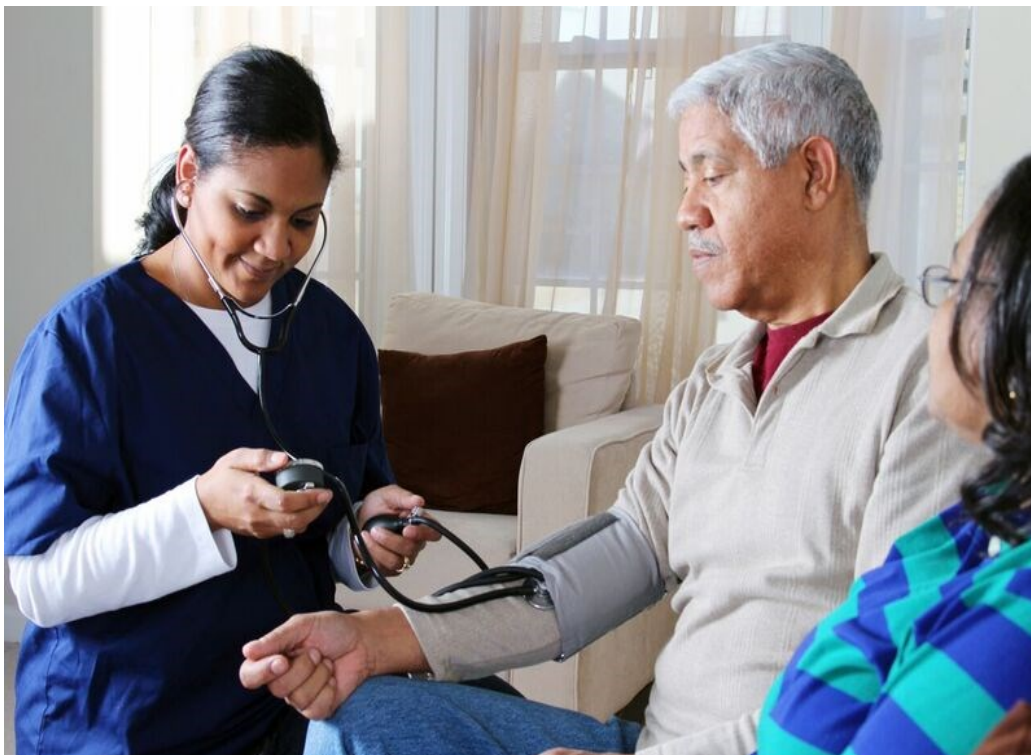
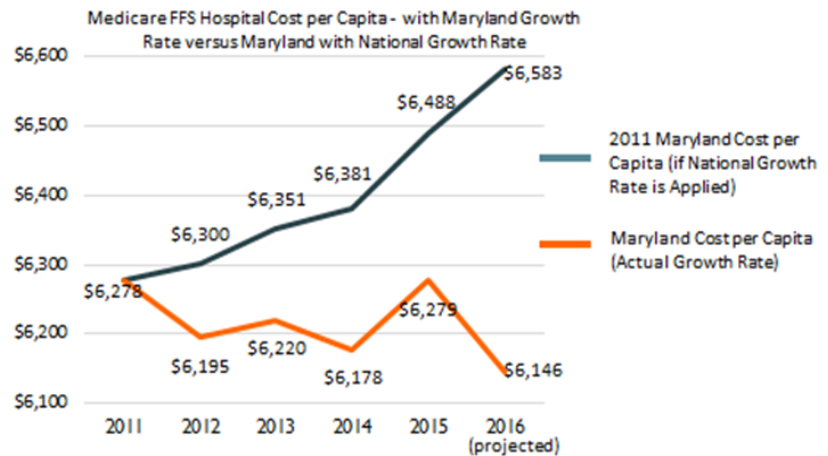
<http://www.nejm.org/doi/full/10.1056/NEJMp1501050>.

## Maryland

**All-Payer Model:** Maryland implemented the first state-based All-Payer Global Budget Model in 2014 with the goal of slowing growth in health costs and improving care for its residents. The model focuses on limited total per capita hospital spending by moving from a fee-for-service model to global hospital payments. Maryland has been engaged in all-payer rate setting for hospitals since 1971, but the 2014 waiver allowed the state to shift those payments to a value-based system. Global budgeting removes the incentives for MD hospitals to increase volume and encourages them to reduce unnecessary or avoidable utilization of services in order to reduce overall cost growth.

In recognition of the problem of avoidable hospital readmissions that appeared to need stronger specific incentives in addition to the holistic tool of global budgeting, Maryland has also moved to create a methodology of incentives and penalties related to readmission within 30 days of previous hospital discharge. This approach uses measures of either improvement or attainment to incentivize low-performing hospitals and avoid penalizing high-performing hospitals who are achieving success in this area.

**Since 2011, Maryland's Medicare hospital cost per capita growth rate is lower than the national rate**



# Recommendations

Working Together to Improve Our Health: Right Care, Right Place, Fair Price



The importance of delivering the right care at the right place for a fair price in order to maintain a sustainable health care system and improve health outcomes was consistently demonstrated in the models developed by other states and echoed in feedback provided by stakeholders here in Massachusetts. In particular, other states have focused on reducing hospital readmissions and emergency department use, reducing institutional care for long-term services and supports, creating global payment models that encourage population health and social determinant of health management, and innovative financing of the health care system to keep health care price increases to a sustainable level. The Working Group has determined that Massachusetts can realize short- and long-term savings for the state budget and health care system as a whole by prioritizing policy changes in these areas.

## Reduce Hospital Readmissions and Emergency Department (ED) Use

Massachusetts has historically been a high-use hospital state and continues to experience rates well above the national average. In 2014, inpatient, hospital outpatient, and ED utilization rates per capita in Massachusetts were 8 percent, 50 percent, and 10 percent higher than the national averages, respectively.<sup>8</sup> Behavioral health-related ED visits have dramatically increased (24 percent) over the past four years. ED use is a particular issue for

MassHealth members, and thus the state budget. As an example, MassHealth paid for a third of all ED visits overall and half of all preventable oral health ED visits. A recent CHIA report found that 26 percent of inpatient discharges were followed by a return to the ED within 30 days during state FY15.<sup>9</sup> Additionally, Massachusetts continues to have hospital readmission rates higher than the national average. In fact, over 75 percent of Massachusetts hospitals were penalized by Medicare for readmission rates higher than the national average between October 2015 and September 2016.<sup>10</sup>

Exhibit 5.2: ED visits per 1,000 population, by type, 2011-2015



Notes: ED = emergency department; BH = behavioral health. The total ED rate (in orange above the bars) includes all categories of ED visits, including unclassified ED visits which are not shown here. Unclassified visits increased 5.7 percent during this time period. ED categories are based on NYU Billings algorithm categorization of a patient's primary diagnosis and are mutually exclusive. BH ED visits include any discharge with a primary mental health, substance use disorder, or alcohol-related diagnosis code. Emergency visits include the Billings categories of requires ED care and is not potentially preventable and emergent, ED care preventable; avoidable visits include the Billings categories of non-emergent and emergent, primary care treatable. Some non-Massachusetts residents are included in the number of ED visits. In 2015, non-Massachusetts residents accounted for 4 percent of all ED visits in Massachusetts.

Sources: NYU Center for Health and Public Service Research, HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2011-2015

The HPC has calculated that 42 percent of all ED visits in Massachusetts are avoidable. Through the Senate's August roundtable series, Massachusetts stakeholders identified common themes that would assist in reducing avoidable hospital readmissions and ED use, such as promoting mobile integrated health programs, increased care coordination, reauthorization of the Prevention and Wellness Trust Fund, and telemedicine. In order to improve health outcomes and reduce costs from avoidable ED visits and hospital readmissions, the Working Group recommends the following:

- 8 HPC 2016 cost trends report
- 9 Emergency Department Visits After Inpatient Discharge: SFY2015, CHIA, July 2017
- 10 HPC 2016 cost trends report

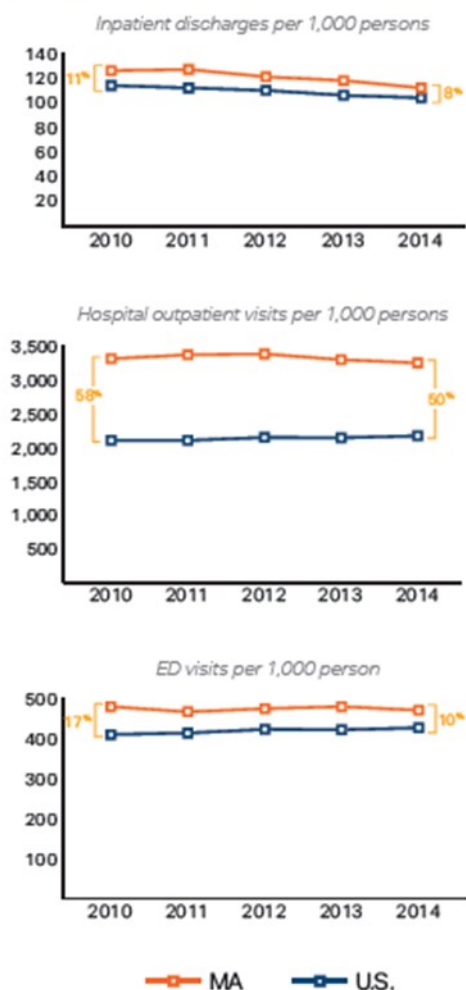
## Implement a mobile integrated health (MIH) program and encourage use

- Establish a Mobile Integrated Health Care Trust Fund to collect fees to support implementation of the MIH program. Require that the Department of Public Health (DPH) allow MIH programs to seek a waiver from any requirement that a patient be transported to the closest appropriate health care facility. Require the MIH advisory council to work with DPH to issue guidance on MIH program design to facilitate reimbursement of services provided by those programs. Require that the Center for Health Information and Analysis (CHIA) conduct a mandated health benefit review of a proposal to require coverage of services rendered by a mobile integrated health care provider. Permit the use of a mobile integrated health program to meet a requirement that an ACO demonstrate evidence-based care delivery programs aimed at reducing hospital readmissions.

## Continue to support the Prevention and Wellness Trust Fund

- Ensure that the Prevention and Wellness Trust Fund (PWTF) can continue to fund community partnerships comprised of municipal governments, health care providers, and local health and human service organizations that work together to achieve a community-wide focus on prevention and wellness by permitting the PWTF to accept other sources of funding such as settlement money from the Attorney General and updating the composition of the Prevention and Wellness Advisory Board. Based on an independent audit by Harvard Catalyst, the PWTF has a track record of addressing social determinants of health.

Exhibit 5.1: Hospital use in Massachusetts and the U.S., 2010-2014



Notes: ED = emergency department. Some non-Massachusetts residents are captured in the Massachusetts discharges. In 2015, non-Massachusetts residents accounted for 5 percent of all inpatient discharges and 4 percent of all ED visits in Massachusetts.

Source: Kaiser Family Foundation analysis of American Hospital Association data, 2010-2014

## Facilitate the use of telemedicine

- Require the Board of Registration in Medicine to permit physicians to obtain proxy credentialing and privileging for telemedicine services. Also require the Board to promulgate regulations regarding the appropriate use of telemedicine.
- Permit the coverage of telemedicine, within certain parameters, through the MassHealth program.
- Update current requirements for commercial health insurers to meet when providing coverage for telemedicine.
- Establish a licensure process for behavioral health urgent care centers.
- Require carriers to annually certify whether the carrier's coverage includes certain mental health home- and community-based services for children and adolescents under the age of 21 to support enforcement of mental health parity laws.

## Enhance access and coordination for behavioral health needs

- Establish a licensure process for behavioral health urgent care centers.
- Require carriers to annually certify whether the carrier's coverage includes certain mental health home- and community-based services for children and adolescents under the age of 21 to support enforcement of mental health parity laws.
- Permit DPH to provide data from the prescription monitoring program to practitioners through a secure electronic medical record.

## Strengthen integration between medical providers, care transition coordinators, and housing providers

- Establish a housing security task force to investigate ways to encourage housing security as a social determinant of health, including an analysis of prioritizing certain shelter beds for homeless patients discharged from ED.

## Expand provider versatility to increase access to lower cost providers

- Expand provider treatment authority for: nurse practitioners, certified registered nurse anesthetists, psychiatric clinical nurse specialists, optometrists, and podiatrists.
- Establish a mid-level dental therapist certification.

## Support alternative care sites for high ED utilizers

- Require MassHealth to permit member access to urgent care facilities for emergency services without requiring a referral or prior authorization.

## Ensure provider focus on reducing readmissions

- Require HPC to establish an annual statewide remissions reduct organizations that demonstrates excessive rates of readmissions that are excessive and threaten the ability of the state to meet the annual readmission benchmark. The HPC shall provide notice to such provider organizations and may require the provider organization to develop and implement a readmissions performance improvement plan and may assess a civil penalty on certain provider organizations that do not comply performance improvement plan requirements.

## Reduce Use of Institutional Post-Acute Care

The Massachusetts population is aging faster than the US overall, with a projected 61 percent increase in the number of seniors in the state by 2030.<sup>11</sup> Spending on long-term services and supports (LTSS) will be a significant cost driver for the state as MassHealth is the primary payer of LTSS, covering almost half of all LTSS spending in Massachusetts. Specifically, MassHealth spent approximately \$4.7 billion on LTSS in 2015, which represented an increase of 12 percent over the previous year. Moreover, Massachusetts continues to discharge patients to institutional post-acute care settings at a higher rate than the U.S. average, with 21.8 percent of patients in Massachusetts discharged to institutional care in 2013 compared to 17.1 percent in the U.S. overall.<sup>12</sup> As HPC reported in the 2016 Cost Trends Report, the median annual cost in 2016 of semi-private nursing facility services (including spending from all payers) in Massachusetts was \$135,050 (versus the national average of \$82,125), while the median cost of a full-time home health aide was \$57,200 annually.

<sup>11</sup> HPC 2016 Cost Trends Report.

<sup>12</sup> HPC 2016 Cost Trends Report.

Through the Senate’s August roundtable series, Massachusetts stakeholders identified common themes that would assist in reducing the use of institutional post-acute care, such as increased consumer and provider education, increased data sharing, housing security and coordination, and shared accountability among providers throughout a patient’s care episode through global budgets or shared savings models.

Stakeholders articulated that a model of home and community-based services has been the goal for many years, but the system is hard to navigate, and that distinctions between the care needs of persons with disabilities and of elders are important. Additionally, stakeholders recommended better leveraging existing models that have seen positive impacts, such as the Senior Care Options (SCO) plan, to improve access and coordination. In order to reduce the use of post-acute institutional care, the Working Group recommends the following:

### **Enhance post-acute care transition planning to encourage appropriate placement in community settings**

- Require development of a post-acute care referral consultation program, of regional consultation teams to assist in determining appropriate post-acute care settings and coordinating patient care. The program shall also ensure education and outreach on provider pre-admission counseling.

### **Strengthen care coordination between medical and LTSS providers**

- Require EOHHS to enroll MassHealth-eligible consumers enrolled in the Executive Office of Elder Affairs home care program into the SCO program, with the option to opt-out and with exceptions for acuity and continuity of care. Established over a decade ago, the SCO program is a longstanding integrated provider of medical and home care. Evaluations of SCO have demonstrated reduced nursing facility residency months and reduced mortality.
- Require the Executive Office of Health and Human Services (EOHHS) to maximize information sharing between the senior information management system operated by the executive office of elder affairs and electronic health records systems operated by medical providers.

### **Support collaboration between housing services and LTSS plans and providers**

- Permit EOHHS to allow housing providers and health care plans to coordinate location-based coordinated care through pooling resources, passive enrollment, and new sources of financing. Set requirements for that coordination to ensure plan competition and member choice is maintained.

## Reduce Growth in Prescription Drug Spending

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The Working Group heard at the roundtables and from stakeholders in other states about budgetary constraints attributed to the growth of prescription drug costs. Prescription drug spending growth in Massachusetts outpaces the growth of nearly all other aspects of our health care spending. In its most recent report, CHIA reports a 6.4 percent growth in pharmaceutical spending in 2016. While this represents a decrease from 2015 spending (12.1 percent), pharmacy spending remains one of the highest cost drivers and is more than double the health care cost benchmark. The Working Group heard of the need for greater oversight and transparency with respect to the costs of pharmaceuticals and the need for greater consumer protections. In order to begin to reduce the growth in prescription drug spending, the Working Group recommends the following:

### Enhance industry oversight and transparency

- Require pharmaceutical companies to report drug pricing information to CHIA.
- Require pharmaceutical participation in the HPC's cost trend hearings.
- Require the HPC to provide 'early warning' reports on pipeline drugs, generic drugs, or biosimilar drugs that may have a significant impact on state health care expenditures once brought to the market, and require pharmaceutical companies to contribute information for these reports.
- Establish an academic detailing program within the HPC to be supported through an assessment on pharmaceutical companies.
- Assess pharmaceutical companies to support HPC and CHIA oversight and reporting efforts related to pharmaceutical drugs.

### Increase consumer awareness and choice regarding prescription cost

- Require a pharmacist to disclose to a consumer if a prescription's retail price is less than the consumer's cost-sharing amount. Also requires a pharmacist, upon request from the consumer, to charge the consumer the lower cost.

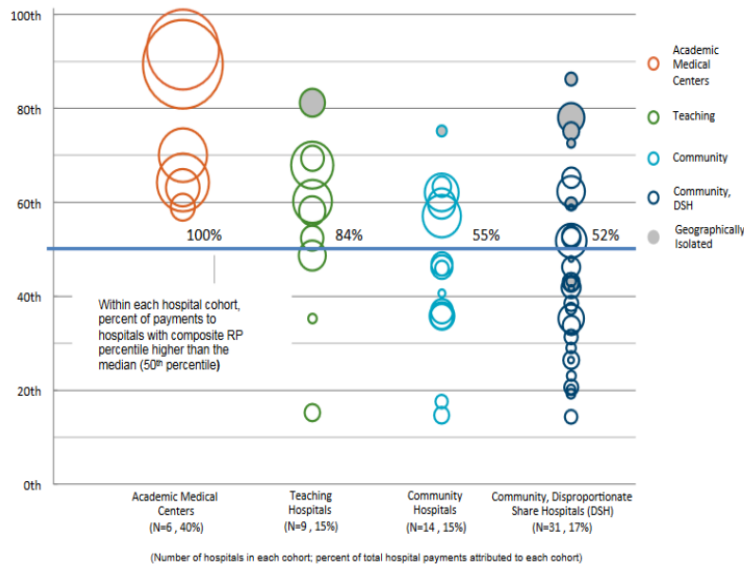
### Encourage bulk purchasing arrangements to mitigate costs

- Require a task force to investigate the impact to state agencies of joining a non-Medicaid, multistate prescription drug bulk purchase consortium, which shall consider: (i) the estimated costs savings related to joining a non-Medicaid, multistate consortium; (ii) the opportunity for counties, municipalities, and nonprofit organizations to participate in a non-Medicaid multistate consortium; (iii) the potential administrative savings and efficiencies for participants as a result of joining a non-Medicaid, multistate consortium; (iv) other bulk purchase discounts or rebates for prescription drugs, medical supplies or other medical goods purchased by state agencies, other governmental units, and nonprofit organizations; and (v) means of receiving rebates or discounts for medical supplies or medications not included under the federal 340B Drug Pricing Program for eligible entities.
- Require the office of Medicaid to provide a report on potential cost savings for prescription medications by joining a multistate Medicaid bulk purchasing consortium.

# Commercial Market Reforms

The Working Group heard from other states about the importance of supporting and incenting efficient, effective, lower cost care on the functionality of the overall health care system and containing cost growth. This has been a focus of stakeholders in Massachusetts, as well. For example, the Provider Price Variation Commission conducted extensive discussion and research on commercial market rates and where disparities may lead to dysfunction. Stakeholders continue to articulate the importance of community hospitals to the local communities and their ability to serve people where they live. Additionally, stakeholders explain that due to

Figure 1.3: Acute Hospital Blended Relative Price by Cohort, 2014<sup>31</sup>

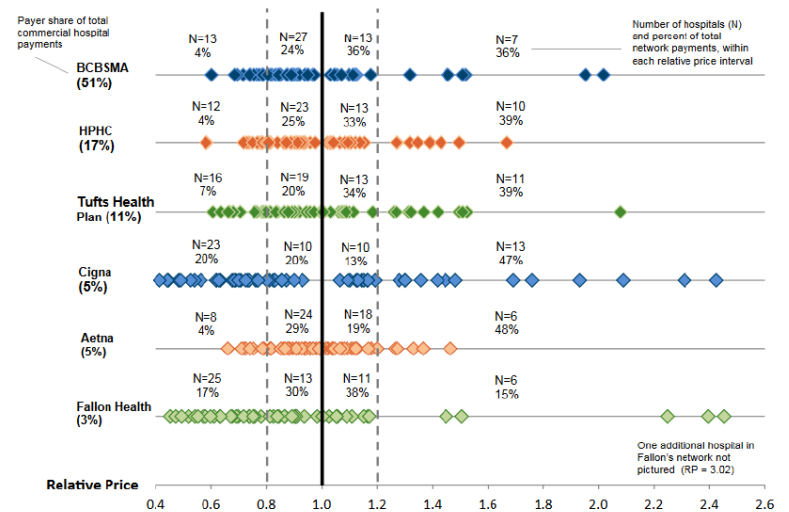


community hospitals' payer mix, which is typically comprised of higher public payers and a smaller commercial portfolio, they are disadvantaged in negotiating rates. Previous supplemental payments to these hospitals have not fixed this issue and stakeholders are requesting a sustainable mechanism that allows the market to function in a way that protects the overall medical ecosystem in Massachusetts. The Provider Price Variation Commission also grappled with consumer protection issues related to provider and carrier billing practices. Additionally, Governor Baker put forward a handful of commercial market reform proposals during the FY18 budget process. All of this feedback has been considered by the working group.

During the Senate's August roundtable series, Massachusetts stakeholders identified common themes that would protect consumers, reduce health insurance premiums or consumer cost-sharing payments, and otherwise support high quality, low cost acute and chronic care such as eliminating surprise billing (e.g. for out-of-network and facility fees), providing options for consumers to encourage value-based choice, and addressing overall commercial spending growth while providing support for lower-cost providers.

In order to foster a more sustainable, consumer-friendly, value-based market, the overwhelming majority of the working group recommends the following:

Figure 1.1: Distribution of Acute Hospital Blended Relative Price by Payer, 2014<sup>6</sup>





## Promote the uptake of employer sponsored insurance while providing support for small businesses

- Update the small group incentive program to expand the prevalence of employee health plans offered by small businesses, which shall provide subsidies and technical assistance for eligible small groups that offer health plans to employees.

## Reduce unexpected costs for consumers and encourage value-based choice

- Eliminate surprise out-of-network billing practices by establishing rates and conditions to apply a default out of network rate.
- Prohibit a hospital or hospital system from collecting a facility fee for outpatient health care services located off-site from a campus unless authorized by the DPH. Require notice to consumers by a hospital or hospital system that collects facility fees for outpatient health care services located off-site from a campus and authorized by DPH.
- Establish a process and methodology for setting emergency medical services transportation rates for ambulance service providers and include a waiver process for ambulance service providers owned and operated by a municipality. Require an insurer to directly pay an ambulance service provider, regardless if the ambulance service provider is in-network or not.
- Require a health care provider to provide to a consumer, upon request, information about whether the provider is included in the consumer's health plan network in addition to any anticipated out-of-pocket costs, including facility fees.
- Update limited and tiered network plan statutory parameters. Require a carrier to provide in at least 2 geographic areas at least 1 of the following plans: (i) a plan with a reduced or selective network of providers with at least a 19 percent premium discount; (ii) a plan that is tiered and member cost-sharing is based on a tier plan with at least a 19 percent premium discount; (iii) a plan where the premium varies based on the primary care provider selected at time of enrollment; (iv) a plan with a separate cost-sharing differential applied to shoppable health care services among the network of providers; or (v) a plan with reduced or eliminated cost-sharing differentials for high value health care services among the network of providers.

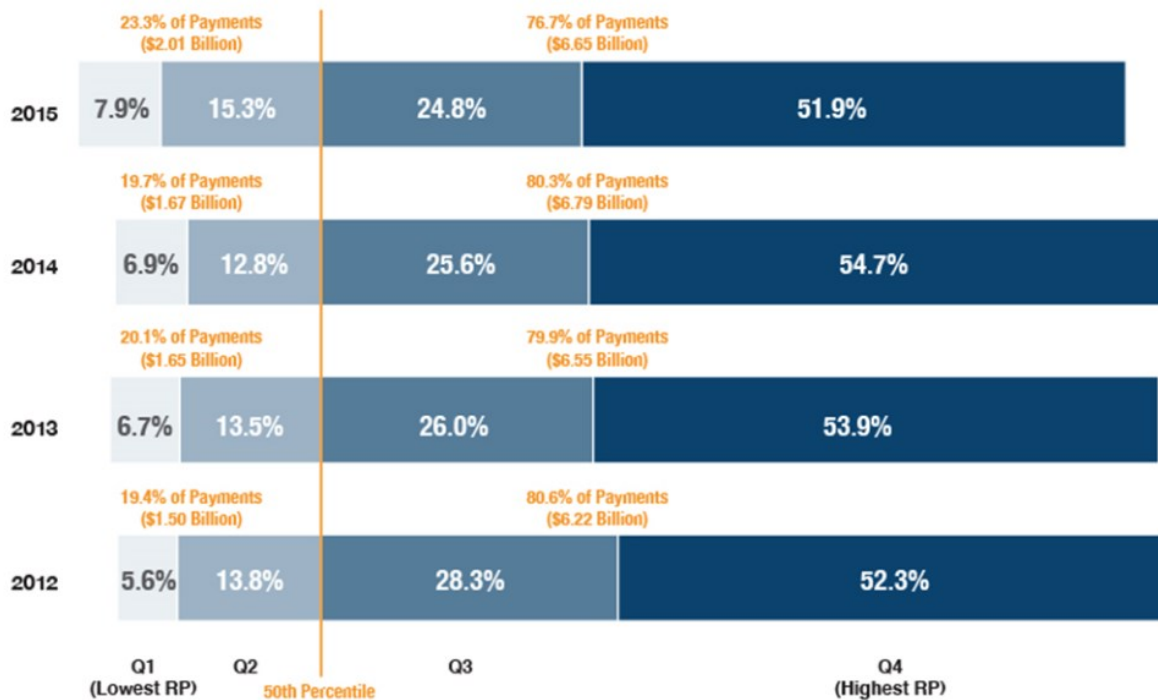
## Mitigate provider price variation

- Establish a process for increasing reimbursement rates to the lowest paid providers while establishing a glide path for slowed overall growth to hospital rates of reimbursement.

## Increase accountability for health care entities with excessive cost growth

- Increase fines related to a violation associated with a performance improvement plan and deposit fines into the Health Safety Net Trust Fund.

### Distribution of Acute Hospital Commercial Payments by Relative Price (RP) Quartile, 2012-2015



## Increase adoption of alternative payment methodologies

- Require all commercial insurers, hospital service corporations, medical service corporations, and health maintenance organizations to achieve certain benchmarks relative to the adoption of alternative payment models.



## **Medicaid Reforms**

MassHealth, Massachusetts' agency for Medicaid and the Children's Health Insurance Program, is both an increasingly crucial component of the Commonwealth's safety net and an increasing share of the Commonwealth's budget. MassHealth covers four in 10 children in the Commonwealth in low-income families, half of all people with disabilities, and six in 10 nursing facility residents, among others. Over the last decade, Massachusetts extended its safety net to encompass working poor adults under Chapter 58 of the Acts of 2006 and the federal Affordable Care Act. While MassHealth spending per member has increased at less than 2 percent per year on average, increased enrollment has driven a doubling in program spending since 2007. A variety of interlinked factors have driven this increase in enrollment to 1.9 million members, including the reduction in the uninsurance rate, growing state income inequality, the rising cost of commercial health insurance, a resulting increase in high-deductible health plans with high out-of-pocket spending, and the disproportionate share of private health care costs borne by poor residents. Under these conditions, both employers and low-income residents have opted to rely on MassHealth rather than commercial health insurance, using state and federal funding to make up for unaffordable increases in the private market.

Through the Senate's August roundtable series, stakeholders expressed that the rising costs of MassHealth and private health insurance are a challenge for the Commonwealth. However, stakeholders have also expressed concerns with shifting costs onto consumers, especially those with the least means to afford these costs. While commercial market price reform is essential to address the relationship between private insurance cost increases and MassHealth enrollment growth in the long term, other MassHealth-specific themes also emerged. These include maximizing MassHealth's ability to benefit from employer contributions through premium assistance, further encouraging global budgets in fragmented areas like long-term care to promote integration and reduce unnecessary utilization, and ensure that the Accountable Care Organization transformation involves appropriate data-sharing. The Working Group is recommending the following:

## Promote the uptake of employer sponsored insurance while ensuring needed coverage for MassHealth eligible individuals

- Establish the Health Insurance Responsibility Disclosure (HIRD) form, allowing MassHealth to improve its targeting of the Premium Assistance program for MassHealth members with access to affordable, cost-effective employer-sponsored insurance. Require MassHealth to provide a report on the proposed eligibility changes included in the 1115 Waiver based on reporting through the HIRD Form.
- Require an employer to provide, under oath, health insurance information about an employee who has applied for benefits from a state subsidized health insurance program.
- Permit MassHealth to establish an optional expanded Medicaid buy-in plan for employers.

## Increase long-term care coordination and better leverage federal funding opportunities

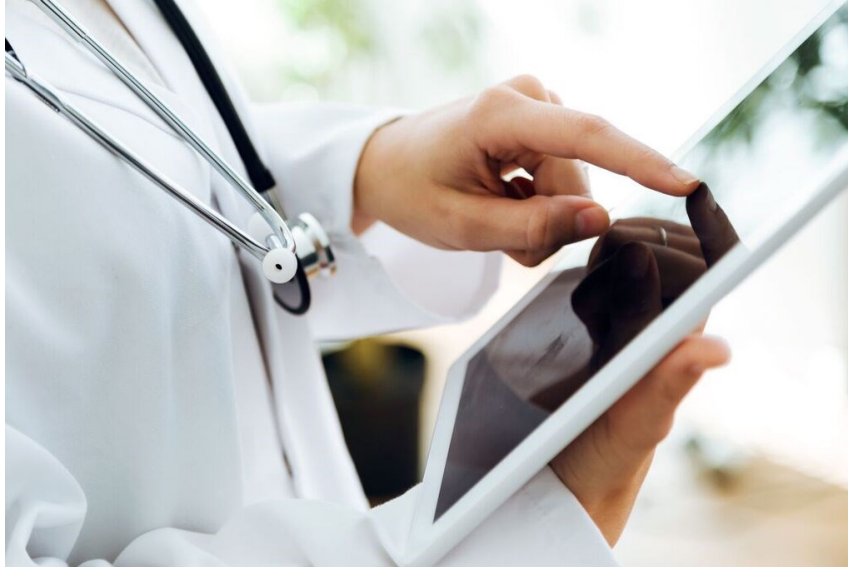
- Enroll MassHealth-eligible consumers enrolled in the home care program into the Senior Care Options program while requiring exceptions for acuity and continuity of care. This enrollment shifts consumers who do not opt out from an entirely state-funded program that has separate funding and coordination for home care services, to a federally-matched program that integrates funding and care coordination for all aspects of care.
- Encourage EOHHS to apply for a waiver to receive federal matching funds for coordinated in-home care to seniors not eligible for Medicaid, similar to that of Minnesota's Alternative Care program. In the Alternative Care program and in this waiver, seniors who do not meet the financial eligibility standards for Medicaid but cannot pay for a nursing facility on their own receive federally-reimbursable services to halt or slow the transition into costly institutional settings and the spend-down into Medicaid eligibility while improving overall quality of care.
- Encourage EOHHS to apply for a federal waiver to allow passive enrollment of persons eligible for Medicare into the MassHealth senior care options program, increasing the critical mass in coordinated care settings.
- Require MassHealth to report on the role of LTSS within the MassHealth program and MassHealth accountable care organizations.

## Encourage data coordination and strategic planning activities

- Require MassHealth to submit a plan outlining the office's method for collecting, maintaining and sharing data with providers for the purposes of ensuring compliance with benchmarks associated with the MassHealth ACO program.
- Require the secretary of health and human services to develop a strategic plan outlining changes to provider funding sources, including those related to the adoption of new financing and delivery models of care as well as current supplemental payment streams to acute care hospitals.

## Other Best Practices and Transparency Reforms

States reviewed by the Working Group have implemented systems to increase data transparency for providers, plans, consumers, and policy makers in order to improve informed decision making. During the Senate’s August roundtable series, Massachusetts stakeholders identified the need for similar transparency and administrative reforms, such as minimizing regulatory “red-tape,” especially as it relates to the adoption of new care delivery models and supporting structures to encourage information sharing among health care innovators. As a result, the Working Group is recommending the following:



### Promote and encourage implementation of best practices that improve population health

- Establish regional planning councils within the health planning council to: (i) identify innovations and best practices in health care within the region; (ii) identify interventions that improve population health at the regional or community level; and (iii) facilitate implementation of innovations, best practices and interventions throughout the region.
- Establish a “Health Care Trailblazer” designation for the purposes of rewarding organizations with recognition for their innovative practices that can be scaled and translated to similar organizations to increase their impact on the health care delivery system.

## **Improve stakeholder access to health care price information**

- Establish a process for CHIA to collect and report health care prices and related information for use by the public.
- Require insurers to implement a uniform method of communicating tiering information to their members and a process for providers to request information on how a payer's tiering methodology.

## **Increase transparency regarding employer sponsored insurance practices**

- Requires CHIA to report the 50 employers in the Commonwealth that have the highest number of employees accessing state health insurance subsidies.

## **Address administrative barriers to improve care delivery**

- Require the Massachusetts e-health Institute (MeHI) to partner with the health care and technology community to accelerate the creation and adoption of digital health. Require MeHI to provide a report identifying projects that leverage the Commonwealth's investment in electronic health record deployment and the statewide health information exchange and are likely to have a meaningful impact on cost or quality of care, and recommended funding amount.
- Establish a task force, chaired by the commissioner of public health and the executive director of the health policy commission, to make recommendations on aligned measures of health care provider quality and health system performance for the purpose of ensuring consistency in the use of quality measures in contracts between payers, including the commonwealth and carriers, and health care providers in the commonwealth, ensuring consistency in methods for evaluating providers for tiered network products, reducing administrative burden, improving transparency for consumers, improving health system monitoring and oversight by relevant state agencies, and improving quality of care.
- Establish a special commission to study and make recommendations on ways to license foreign-trained medical professionals to expand and improve access to medical services in rural and underserved areas.
- Establish a regulatory simplification task force to explore ways to streamline regulatory requirements to reduce duplicative or unnecessary administrative overhead and to increase care coordination across state agencies.

## **Track policy outcomes to assess impact**

- Require HPC to review the 5 year impact of these recommendations on (i) provider price variation; (ii) reduction in hospital readmissions; (iii) reduction in post-acute institutional care; (iv) prescription drug cost trends; and (v) movement of patients to high-value provider settings.

# Conclusion

Working Together to Improve Our Health: Right Care, Right Place, Fair Price



Massachusetts should continue to strive to be a leader on health care coverage and quality. Leadership requires reflection on areas where policy has not lived up to the standard of success that Massachusetts has set and achieved in other aspects of health care policy. It is imperative that we create a sustainable health care system—meaning a health care system that grows no faster than its funding sources, whether residents’ pocketbooks, business balance sheets, or the state budget. Without making meaningful change, Massachusetts will continue to face difficult choices in the state budget, see similar difficult choices made due to high premiums by our residents and businesses, and contend with market dysfunctions that constrain access to care. The challenge of a sustainable health care system can be met in two ways. We must reduce unnecessary care that hurts healthcare



quality, from emergency department visits that are better solved by a therapist to nursing home residents who have the capacity and desire to safely stay in their community. We must also address the unnecessarily high price of necessary care, where variation in price but not quality shows the way toward better value for needed care. By combining these two approaches, we can improve our residents’ health and make our health care system more efficient, affordable, and accessible to all. We look forward to continuing collaborative discussions on these policy proposals and encourage the legislature to adopt legislation to implement these recommendations as soon as possible.