



Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump

Making government work better

October 6, 2015

Chapter 224: Stakeholders Study

Humberto Reynoso-Vallejo, PhD*., Michelle V. Porche, EdD., and Chris Stuck-Girard, Esq., MPH.

*Corresponding author: humberto.reynoso@sao.state.ma.us 857-242-5543



TABLE OF CONTENTS

INTRODUCTION 1

METHODOLOGY 2

RESULTS 3

CONCLUSION 39

LIST OF ABBREVIATIONS

ACO	Accountable Care Organization
ATS	Acute Treatment Services
ACA	Affordable Care Act
APM	Alternative Payment Method
CHIA	Center for Health Information and Analysis
CMS	Centers for Medicare & Medicaid Services
CHC	Community Health Center
CHART	Community Hospital Acceleration, Revitalizations, and Transformation
CMIR	Cost and Market Impact Review
DPH	Department of Public Health
DON	Determination of Need
EHR	Electronic Health Records
EOHHS	Executive Office of Health and Human Services
HPC	Health Policy Commission
MLR	Medical Loss Ratio
OSA	Office of the State Auditor

INTRODUCTION

The main purpose of Chapter 224 of the Acts of 2012 is to reduce healthcare costs and improve access to and quality of care by increasing transparency, efficiency, and innovation. The Legislature charged the Office of the State Auditor (OSA) with examining the impact of Chapter 224 on the Commonwealth's healthcare payment and delivery system, on healthcare consumers, the healthcare workforce, and the general public. The law requires OSA to undertake a comprehensive review of these domains, produce a report detailing our findings, and provide recommendations to forward Chapter 224's aims.

As part of our work, OSA has identified key stakeholders with expertise in aspects of the Massachusetts healthcare system. They include representatives from academia, consumer advocacy organizations, government, interest groups, payers, providers, professional organizations, research organizations, and consultants.

As Chapter 224 continues to be implemented, we developed an online survey to elicit stakeholder feedback. Survey themes included cost containment, quality improvement, the law's positive impact to date, barriers to successful implementation, planned changes to support implementation, and factors besides Chapter 224 that may be influencing healthcare cost containment.

The purpose of this study is to present a summary of the survey results and a brief analysis of some contextual factors associated with the findings.

METHODS

1. Administration of Online Survey: The online survey invitations were sent to potential respondents on February 18, 2015. Additional invitations were sent to members of our Chapter 224 Advisory Committee on April 2. We started receiving responses immediately and sent several reminders to participants who had not responded. We sent the last invitation on April 2. The final set of responses was received on April 26.
2. Sample: We sent 105 survey invitations and received completed surveys from 46 stakeholders (a response rate of 43.8%).

Respondent Category	n
Academia	5
Consumer Advocacy	9
Government	8
Interest Group	2
Payer	5
Provider	7
Professional Organizations	6
Research Organization	3
Consultant	1

3. Coding and Analysis: The survey was uploaded to Checkbox 6 (<https://www.checkbox.com/>) and the survey link was distributed to participants. Once the data was captured, we created an output that was exported to an Excel file. This file was entered onto Atlas.ti 7 software (<http://atlasti.com/>) for further analysis. Then, we developed categories of relevant codes, which were double-checked for validity by the Director of Research and Policy; output records for each code were created for final analysis.

RESULTS

For each survey question, categories of codes are summarized with specific quotes from respondents highlighted to illustrate interpretation. In many cases, respondents provided several different answers for the individual questions; thus, portions of a single response may be coded in various categories. The number of responses for a particular category is noted for each code (n=number of responses).

We report on the full range of responses from key informants so the reader can review their opinions and assessments about the ongoing implementation of Chapter 224. Throughout the summary of survey results, we include background information *in italicized boxes* that discusses contextual factors, explicitly describes legislation, describes agencies and entities involved, and dispels inaccuracies or misunderstandings regarding the law as stated by respondents.

Question 1: With which aspect(s) of Chapter 224 do you have expertise and/or direct interactions (Check all that apply):

Respondents reported on which of the following four areas they had expertise:

- A. Healthcare costs
- B. Access and quality of care regionally and for vulnerable populations, such as children, people with disabilities, and low income
- C. Access and quality of care for specific services including primary care and behavioral health (substance use and mental health)
- D. Impact on public health including prevention, workplace wellness, and racial/ethnic disparities

Almost a third (28%) of respondents reported expertise in all four areas, 17% reported expertise with healthcare costs only, 7% reported expertise regarding access and quality of care regionally and for vulnerable populations, and 11% reported expertise regarding access and

quality of care for specific services. The remainder reported various combinations of expertise, as shown in the table below.

Area of Expertise	Number
A. Healthcare costs	8
B. Access and quality of care regionally and for vulnerable populations	3
C. Access and quality of care for specific services	5
D. Impact on public health including prevention	0
ABCD: Expertise in all areas	13
A. Healthcare costs B. Access and quality of care regionally and for vulnerable populations C. Access and quality of care for specific services	2
A. Healthcare costs B. Access and quality of care regionally and for vulnerable populations D. Impact on public health	1
A. Healthcare costs C. Access and quality of care for specific services	2
A. Healthcare costs C. Access and quality of care for specific services D. Impact on public health	1
A. Healthcare costs D. Impact on public health	1
B. Access and quality regionally and for vulnerable populations C. Access and quality for specific services	5
B. Access and quality regionally and for vulnerable populations C. Access and quality for specific services D. Impact on public health	1
B. Access and quality regionally and for vulnerable populations D. Impact on public health	1

Note: Three respondents did not report areas of expertise.

Question 2: What are some examples of observable cost containment, quality improvement, or positive impacts related to Chapter 224?

Responses describing examples of observable cost containment, quality improvement, or positive impacts were coded in seven categories: integration of care/access (n=13); legislation (n=20); new or improved organizations, agencies, initiatives, and regulations (n=8); quality measures (n=2); review of mergers (n=7); cost transparency (n=10); and non-specific answer (n=5).

Integration of Care/Access (n=13).

Respondents reported that “there has been significant movement to better integration of primary and behavioral health care” including “CHART [Community Hospital Acceleration, Revitalization, & Transformation Program] investments” and the “OPP’s [Office of Patient Protection’s] monitoring of mental health parity compliance” to support integration. Much of this emphasis was attributed to Chapter 224 legislation and the Affordable Care Act (ACA). Specifically for substance abuse treatment, the use of “certified peer specialists” or “recovery coaches” who share “lived experience” of the patients/clients they assist is gaining momentum. One community Health Center [CHC] opened new sites “to accommodate access to primary care for the underinsured or uninsured and keep primary care in the office setting and out of the emergency room;” these sites provided integrated care. Although some recommendations of the Behavioral Health Integration Task Force (such as Patient-Centered Medical Home, or PCMH, standards) were not yet enacted at the time of the survey, respondents expressed confidence that these would make a difference: “Once the PCMH certification program is in effect, our expectation is that primary care services will become more comprehensive, accessible, and streamlined and that care coordination for all populations, but especially vulnerable populations and those with serious or chronic conditions, will be enhanced.” In addition, “the use of so-called ‘global payments’ will incentivize providers to pay attention to preventative measures as well.” Moreover, “the payment reform associated with Chapter 224

has created a care coordination focus that I feel has improved the safety net” for seniors who are dually eligible for both Medicare and Medicaid, as well as those under 65 with a disability, often identified as substance abuse or mental health issues. Comments about integration underscored the fact that there has been some progress toward this goal, but that there is much work to do: “some integration has occurred in the sector on a voluntary basis but evidence of its effectiveness financially and on quality is too soon to establish.”

The opiate epidemic has highlighted the gap between primary care and behavioral health service. Because unaddressed behavioral health needs can spiral into acute emergencies, triage at the primary care level is critical. Chapter 224 strives to bridge the gap between these services by integrating care, but complex barriers have limited progress.

Licensing regulation restricts the services primary care clinics can provide. For example, many primary care clinics lack the required license for mental health services. Even though a primary care clinic with a mental health license can provide substance use treatment, a clinic with a substance use treatment license may not provide mental health services. Additionally, applicants report that the licensing process lasts for months and that the requirement to seek relicensing every two years is a burden.¹

Privacy laws, including the federal Health Insurance Portability and Accountability Act (HIPAA) are another barrier to integration. These laws make it harder for providers to exchange information about a shared patient. For example, state regulations require substance use treatment programs to keep substance use treatment records separate from a patient’s other records, thus preventing co-located programs from easily sharing information regarding a patient’s treatment. Providers may seek files from their peers, but this often requires patient consent, which can substantially delay referrals or other care.²

A third barrier to integration is reimbursement. For example, MassHealth policies limiting the number of behavioral health and physical health services it will pay for in one day create payment obstacles for providers (and consumers) who want to address both domains in one visit. Moreover, as of June 2015, MassHealth has not activated the care management billing codes that would compensate providers for coordinating integration.³

The Commonwealth has taken some strides toward integration. The One Care program, though modest in population (12,205⁴), integrates MassHealth and Medicare benefits for non-elderly adults with disabilities. Also, the MassHealth Primary Care Payment Reform program promotes integration and disperses capitated payments to primary care providers for some behavioral health services.

Legislation (n=20).

The most frequently named observable impact was elements of the legislation itself. For instance, “the [Group Insurance Commission] has contracted with its health plan for five years including performance standards that encompass most of the goals of Chapter 224, with financial penalties for failure to perform.” Because of Chapter 224, “health insurers feel greater ability in price negotiations with providers to push back against price increases because of the cost growth benchmark.” The cost benchmark was identified as “an important tool for overall healthcare spending.” One example of practical application of the legislation is “insurer-provider negotiations where the 3.6% goal is translated into a hard 3.6% cap on contract increases.” One large healthcare organization reported that it has “structured its delivery of care to comply with the cost containment goals of Chapter 224” while also maintaining high levels of quality.

More specifically, the “creation of guidelines for mandatory nurse overtime use” was reported. Additional new regulations including those from the Division of Insurance [DOI] “enforcing the mental health parity laws,” Chapter 258 of the Acts of 2014 (An Act to increase opportunities for long-term substance abuse recovery), “change of DON [Determination of Need] regulations,” and “ACO [Accountable Care Organization] certification that will lead to a focus on health outcomes,” are designed to reduce spending over time. “The transfer of the Office of Patient Protection from DPH [the Department of Public Health] to the Health Policy Commission [HPC] has resulted in a more responsive system for patient issues with insurers to be resolved” where calls are answered in a more timely manner than was previously the case.

Chapter 224 introduced various regulatory reforms and funding streams that have reformed health care delivery in the Commonwealth.

**HPC’s Community Hospital Acceleration, Revitalization, and Transformation (CHART) investment program provides grants for non-profit, non-teaching hospitals that have low relative prices. During Phase 1 of the program, \$9.5 million was disbursed, with awards ranging from \$65,000 to \$500,000. Up to \$60 million is available for Phase 2; hospitals will be eligible for up to \$6 million each. Thirty of Massachusetts’ 77 acute-care hospitals are eligible for Phase 2 grants. Including the Phase 2 funds, \$119.08 million will be available over the next few years. Numerous CHART-funded programs have already yielded quality and cost improvements. According to HPC’s website, “The goal of the program is promote care coordination, integration, and delivery transformations; advance electronic health records (EHR) adoption and information exchange among providers; increase alternative payment methods (APMs) and Accountable Care Organizations (ACOs); and enhance patient safety, access to behavioral health services, and coordination between hospitals and community-based providers and organizations.”⁵*

**PCMHs: In a system where patients are often charged with coordinating their own complex care needs, patient-centered medical homes (PCMHs) strive to integrate care across providers in a primary care environment. In PCMHs, primary care providers and members of a patient’s “care team” coordinate health needs, including chronic condition management, hospital admissions, specialist visits, and preventative care.⁶ HPC is developing regulations to guide the certification of PCMHs. The PCMH model draws from proposals suggested by delivery reform advocates. Some primary care practices involved with the PCMH program have already seen significant improvements to key adult and pediatric quality measures.⁷ HPC says cost containment, improved quality, and improved patient experience and engagement are among the goals of the PCMH program.⁸ PCMH certification signals to consumers and payers that a particular provider/provider group provides a threshold of integrated care.*

The annual cost growth benchmark is the central provision of Chapter 224. Every year, HPC must set the benchmark, the target growth rate for the state’s per person medical spending for the next year. For the purposes of the benchmark, spending includes all means of medical expenses, all payments to providers, all patient cost-sharing contributions, and the net cost of private health insurance.⁹ This benchmark is pegged to the potential growth rate of the Commonwealth’s economy. Starting in 2018, HPC will have discretion to set the benchmark. Each year, HPC must notify all healthcare institutions – provider groups, hospitals, payers, and ACOs – that they have exceeded the benchmark and may compel those entities to enact performance improvement plans. HPC can fine entities up to \$500,000 for failure to file, enact, or report on performance improvement plans.

In 2013, the most recent year with available data, average total person medical spending increased 2.3%; the cost growth benchmarks for the year was 3.6%.¹⁰

New or improved Organizations/Agencies, Initiatives/Regulations (n=8).

As a result of Chapter 224, several new organizations and/or initiatives were created or restructured. Four respondents specifically mentioned the Prevention and Wellness Trust Fund, noting that it “will improve population health and reduce costs impacting all 4 areas listed [in Question 1].” Two projects in Worcester and Hudson bring together medical, behavioral, dental, and pharmacy; other projects will “prevent disease and disparities reduction.” CHART grants have a public health focus “to address high risk / high cost conditions” and these also have the potential to “connect community hospitals to their community needs and resources.” Also cited was the Department of Public Health (DPH) Health Planning Council and the DPH Invasive Cardiac Services Advisory Committee’s “adoption of a new rule that will eliminate new duplication of percutaneous coronary intervention programs around the state.” This is an example of planning to prevent the too common “duplication of a costly medical technology.” The potential to advance patient safety will be supported by the “re-establishing the Betsy Lehman Center under the leadership of Barbara Fain.” The establishment of CHIA is cited as having “the potential to provide independent data about cost and quality.” With the establishment of new agencies and on-going restructuring there is increased “inter-agency and inter-system dialogue.”

Established by chapter 224, HPC succeeds the Division of Health Care Finance and Policy as the state’s foremost healthcare policy agency. HPC’s Cost and Market Impact Reviews (CMIRs) analyze the impact of proposed mergers, acquisitions, and affiliation changes. HPC’s CHART program has catalyzed innovation and investment in community hospitals. HPC’s Office of Patient Protection reviews service denials and other consumer affairs grievances. HPC’s committees drill down on specific health policy domains.

The Center for Health Information and Analysis (CHIA), also created by Chapter 224, is the “agency of record” for healthcare information in Massachusetts. Governor Charlie Baker has proposed moving CHIA, currently an independent agency, into the Executive Office of Health and Human Services (EOHHS). Some advocates worry that this would limit CHIA’s independence, but proponents argue that the reform would improve efficiency and coordination with EOHHS programs like MassHealth. Among other functions, CHIA facilitates the Statewide Quality Advisory Committee (SQAC), a body of stakeholders charged with aligning healthcare performance metrics and developing the Standard Quality Measure Set (SQMS).

Chapter 224 revived the Betsy Lehman Center for Patient Safety and Medical Error Reduction as an independent agency residing within CHIA. According to its website, the center collaborates “with healthcare providers, government agencies, patient advocates, and the public to reduce medical harm across the Commonwealth through research, improved channels of communication, data analysis, and education.” Research by the center found nearly 25% of Massachusetts residents have experienced a medical error in the care or the care of someone close to them within the last five years.¹¹

The law also charges the attorney general with new oversight duties, including responsibility for investigating any provider organization referred by HPC after a CMIR.¹² Attorney General Maura Healey, after moving to oppose Partners HealthCare’s attempted acquisition of South Shore Hospital, announced support for pending legislation that would allow her office to use CMIR findings as judicial evidence in proceedings to delay or block such acquisitions.¹³

Chapter 224 also created the Health Planning Council, which develops the State Health Resource Plan (an effort to evaluate the healthcare needs of residents and resources available to them).

Quality measures (n=2).

Two respondents emphasized the focus on quality measures: “DMH has focused on aligning its quality measures with national standards” including interagency quality efforts. CHIA’s “A Focus on Provider Quality” analysis “is the state’s first report on provider quality and aims to serve as a baseline for future review.”

Chapter 224 gives CHIA responsibility for overseeing SQMS, a collection of quality metrics

that are either prescribed by law or developed by SQAC. The committee has identified six “quality measurement priority areas”: behavioral health, care coordination, end-of-life care, overuse/misuse of resources, patient-centered care, and pediatric care. SQMS measures can be used to monitor and improve provider performance in strategically targeted domains, The SQAC – composed of consumer advocates, providers, and insurers – can recommend revisions/additions to SQMS each year.¹⁴

State law requires health plans with more than 5,000 enrollees to use SQMS measures if they sort providers into quality tiers. Policymakers and employers hope that tiered network plans – which feature financial incentives that steer consumers toward high-value providers – can help recognize clinicians and institutions that perform well on SQMS.¹⁵

Review of mergers (n=7).

Seven respondents reported that the review of proposed hospital mergers and acquisitions and recommendations that the mergers not be allowed “was one of the most obvious cost containment impacts so far to come out of the relatively new law.”

Chapter 224 has increased regulatory scrutiny of changes to affiliation and administration of Massachusetts providers, hospitals, and payers. Partners’ Healthcare’s attempted acquisition of South Shore Hospital was a political flashpoint, but other “material changes” to the healthcare market have also received attention from the HPC and the attorney general’s office.

In April, Attorney General Healey declared support for the Bill (H.2013) sponsored by House Majority Leader Ronald Mariano that would allow the Attorney General to use HPC findings as judicial evidence in proceedings to temporarily block mergers. According to the Boston Globe, Steward Health Care, Lahey Health, and the Massachusetts Association of Health Plans, are among the bill’s supporters. The Massachusetts Hospital Association opposed the bill, and other major players (including Partners, UMass Memorial Health Care, and Beth Israel Deaconess Medical Center), have not taken a position.¹⁶

Cost Transparency (n=10).

Ten respondents pointed to efforts to promote cost transparency as critical examples of observable impacts. For example, one responded, “the establishment of a novel means of tracking healthcare spending (Total Health Care Expenditures) and standardized quality metrics (Statewide Quality Measure Set)—both were developed by a coalition of stakeholders, including the agents of the Commonwealth, payers, and providers—represent significant accomplishments which will serve as the jumping off point for additional cost containment efforts.” Attention to cost transparency has “changed the mindset” of providers who previously had come to expect annual increases in reimbursement. Availability of cost and quality data has also helped consumers in decision-making and allows “organizations to track, manage and educate employees” regarding healthcare spending. One advisory board member reported, “I find that the level of transparency in respect to dollars spent/wasted to be extremely informative and unprecedented.”

Chapter 224 compels providers, including hospitals, to provide potential patients with prices for a medical procedure within two days. Health plans also must offer price estimates via website and toll-free number; these estimates are binding.

Despite the intentions behind the law, most consumers remain unaware of these transparency reforms. Moreover, industry has struggled to execute them. A recent survey of 10 clinics and 22 acute-care hospitals found that it took these providers 2-4 days, and considerable prompting, to provide the price of a common procedure (an MRI of the left knee without contrast).¹⁷

Non-Specific answer (n=5).

Two respondents reported not having sufficient expertise to comment and two reported that it was too soon to assess the law. One respondent suggested a follow up phone call for further discussion.

END NOTES – Question 2

¹The Blue Cross Blue Shield of Massachusetts Foundation. (2015, June). *Barriers to Behavioral and Physical Health Integration in Massachusetts*. Retrieved from http://bluecrossfoundation.org/sites/default/files/download/publication/Barriers%20to%20Behavioral%20and%20Physical%20Health%20Integration%20in%20MA_Final.pdf (Accessed: July 30, 2015).

²Ibid.

³Ibid.

⁴MassHealth. (2015). *One Care: MassHealth plus Medicare*. Retrieved from <http://www.mass.gov/eohhs/docs/masshealth/onecare/enrollment-reports/enrollment-report-june2015.pdf> (Accessed: July 30, 2015).

⁵Health Policy Commission. (2015). *CHART*. Retrieved from www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/chart/ (Accessed: July 16, 2015).

⁶Executive Office of Health and Human Services. (2015). *Massachusetts Patient-Centered Medical Home Initiative*. Retrieved from www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/pcmhi/ (Accessed: July 16, 2015).

⁷Cherala, S. (2014, November). Using quantitative data to focus medical home facilitation interventions in the Massachusetts Patient Centered Medical Home Initiative (MA PCMHI). In *142nd APHA Annual Meeting and Exposition (November 15-November 19, 2014)*. APHA. (Accessed: July 16, 2015).

⁸Health Policy Commission. (2015). *Patient-Centered Medical Homes*. Retrieved from www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-centered-medical-homes/ (Accessed: July 16, 2015).

⁹The Blue Cross Blue Shield of Massachusetts Foundation. (2012, September). *Summary of Chapter 224 of the Acts of 2012*. Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20summary_1.pdf (Accessed: July 16, 2015).

¹⁰Center for Health Information and Analysis. (2014, September). *Annual Report on the Performance of the Massachusetts Health Care System*. Retrieved from www.chiamass.gov/assets/docs/r/pubs/14/chia-annual-report-2014-supplement-01-thce.pdf (Accessed: July 16, 2015).

¹¹Betsy Lehman Center for Patient Safety and Medical Error Reduction. (2015). *Betsy Lehman Center for Patient Safety and Medical Error Reduction*. Retrieved from www.chiamass.gov/betsy-lehman-center (Accessed: July 30, 2015).

¹²The Blue Cross Blue Shield of Massachusetts Foundation. (2012, September). *Summary of Chapter 224 of the Acts of 2012*. Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20summary_1.pdf (Accessed: July 30, 2015).

¹³Schoenberg, S. (2015, April 7). *AG Maura Healey backs bill giving more power to Massachusetts' Health Policy Commission*. MassLive LLC. Retrieved from www.masslive.com
(Accessed: July 30, 2015).

¹⁴Center for Health Information and Analysis. (2015). *Standard Quality Measure Set (SQMS)*. Retrieved from www.chiamass.gov/framework/main.php?url=/sqms/
(Accessed: July 30, 2015).

¹⁵Massachusetts Statewide Quality Advisory Committee. (2014, November). *Year 3 Final Report*. Retrieved from www.chiamass.gov/assets/docs/g/sqac/2014/2014-sqac-final-report.pdf
(Accessed: July 30, 2015).

¹⁶McCluskey, P.D. (2015, May 14). *Hospital industry split over health care legislation*. The Boston Globe. Retrieved from www.bostonglobe.com
(Accessed: July 30, 2015).

Question 3: What are some of the observable barriers to successful implementation of Chapter 224?

Responses describing barriers were coded in nine categories: Limited Accountability and Authority, Cost Transparency Not Achieved, Critique of Mandate, Funding Limitations, Infrastructure, Lack of Providers, Resistance to Change, No Barriers, and Non-Specific Answer.

Limited Authority and Accountability (n=8).

While the response to the Chapter 224 legislation was generally positive, there were concerns about the ability of the legislation to have an impact on outcome goals because of “lack of specific ‘teeth’ in the event of excess cost growth.” In addition, one respondent argued that the “purely advisory role of the Commission” will limit its “power to control healthcare costs.” There is a call for the “HPC or Attorney General to be given greater authority to stop transactions that they believe will increase costs.”

However, we note that although HPC cannot mandate reduced spending, it can issue fines (up to \$500,000) to healthcare institutions that fail to submit, enact, or report on a remediation plan after a year of cost growth that exceeds the cost benchmark. However, large payers and providers may see the maximum fine (\$500,000) as a cost of doing business. For example, in 2014, Partners HealthCare’s net revenue was about \$11 billion,¹⁸ and Blue Cross and Blue Shield of Massachusetts collected more than \$6.5 billion in premiums.¹⁹

In addition, the HPC can reward innovative ideas and strong performance with grants, including those of the CHART program.

There was also criticism that Chapter 224 had not yet “lowered the rate of growth in healthcare premiums and employee costs.” Moving Medicaid “toward alternative payment methods” was an issue that came up for this question as well as the other survey questions. There was clear frustration about “ZERO reforms at Medicaid,” which drives much of the cost of health care.

Respondents also pointed to the parts of Chapter 224 not yet enacted. Delays in regulatory deadlines were noted, as well as the law's call for a "16-member pharmaceutical cost containment commission to examine ways to lower prescription drug costs for both public and private payers, including the options of bulk purchasing and establishing a single-payer prescription drug system" that has not yet been formed. Further, "the requirement regarding the use of checklists in hospital care has not been implemented by DPH." One respondent suggested that "silos, both in the healthcare and government systems, and established by the statute itself, inhibit HPC work," and as an example, said "the Behavioral Health Task Force was given a mandate to examine [behavioral health] care and make recommendations but was not empowered with oversight of implementation."

Some policymakers have already proposed reforms to supposed shortcomings of Chapter 224. For example, there is a bill that would give HPC CMIRs evidentiary significance in proceedings regarding mergers.²⁰ Other bills – including one proposed by Senator Ben Downing that would create upper and lower limits for how much insurers can pay hospitals for certain procedures²¹ – are aimed at adding to the regulatory strategy to contain health costs. Other advocates, including former gubernatorial candidate and Centers for Medicare & Medicaid Services (CMS) administrator Donald Berwick, argue that nothing short of switching to a single-payer system will provide consumers with consistent access at reasonable costs.²²

Transparency Not Achieved (n=9).

Cost transparency is one of the key goals of the legislation and the various ways that costs are not known to consumers was noted as representing "a major barrier to making informed decisions." Another respondent argued that the work of the HPC "should be fully funded" to ensure transparency is achieved.²³ An "inventory of costly medical technologies" was one of the specific missing pieces of cost transparency, mentioned several times along with drug costs. More generally, lack of transparency limited the ability of providers to have "real time bedside conversations about potential costs and co-pays for tests and procedures." "Lack of access to timely and complete data from CHIA" was also cited. The "websites set up by insurance carriers

are in some cases hard to find, are not user-friendly, do not have quality information.” Information could also be included regarding “which hospital systems are LESS expensive than most.” In addition to Medicaid’s lack of cost transparency, concerns about similar lack of information about MassHealth were listed, such as “lack of adoption of APMs.” One respondent suggested that “the state should move to immediately release all identified data from the All-Payer Claims Database to the public. Government can serve as a convening platform to help non-profits and private companies sort out the complex pricing system that exists in the state and help patients navigate it.”

Critique of Mandate (n=5).

Several respondents took issue with the Chapter 224 legislation itself, in sum or in part. Although the law links healthcare spending to overall state economic growth, there are concerns that “there is little connection between healthcare growth and state economic growth” with scant historical evidence to know what the trends will be. Although the growth rate is capped, and every healthcare entity may grow at the same rate going forward, but not all are beginning from the same starting point,” those that start out with higher rates have an unfair advantage. Reporting requirements for “various state agencies responsible for implementation...are resulting in additional administrative and operational expenses for providers” These additional regulations may also “hamper innovation.” Additionally, “[Prevention and Wellness Trust Fund] communities started the work late and have compressed timelines to show cost savings.”

Some interest groups are suspicious of Chapter 224’s reliance on accountable care organizations, which they see as a contemporary version of the unpopular HMOs of the 1990s. Others believe that marginalized populations will bear the brunt of linking medical expenditures to economic growth; patients with intensive needs enrolled in APMs may encounter resistance to obtaining needed, though expensive, care.

Funding Limitations (n=7).

Respondents noted funding limitations, especially those pertaining to behavioral health. Funding mandated to “support health information technology adoption among behavioral health providers, in particular” has not yet been made available to providers. In addition, “funding for infrastructure improvements within the [behavioral health] system is essential to support integration” and has not yet been realized. Further, “direct funding to improve access to treatment or reduce treatment disparities for those with behavioral health or substance abuse [needs]” is lacking. Concerns with Medicaid cuts and lack of “fair and timely” reimbursements” create strain on providers and patients. A “significant increase in drug expenditures” and the new and very expensive Hepatitis C drugs are significant cost drivers.

After signing Chapter 224 into law in 2012, Governor Deval Patrick said, “Massachusetts has been a model for the nation for access to healthcare. Today we become the first to crack the code on costs.” The law and subsequent appropriation bills provided substantial funds for investments in health care, but these investments may not be sufficient to “crack the code.” Indeed, despite CHART, the financial well-being of community hospitals has worsened, and even though the law encourages APMs, Chapter 224 does not provide funding for providers to add competencies they need to navigate the ACO and PCMH certifications. Finally, some areas of the state budget, including the Department of Mental Health, were recently reduced, limiting the availability of affordable behavioral health services.

Infrastructure (n=9).

The calls for infrastructure improvements are primarily focused on “medical and behavioral health integration.” Respondents also suggested the development of working groups: “The absence of state-convened but private-sector led voluntary regional planning efforts is a serious barrier to cost containment.” Because “HPC is increasingly asked to take on a regulatory role,” which is very time consuming, modification of “existing infrastructure or development of alternative systems” should be considered to monitor cost containment. The complexity of the healthcare system remains a barrier to effective reform: “Billing rules are not standardized between carriers, making multi-payer claims analysis more difficult. The multitudes of legal and

financial relationships between physicians make it difficult to craft a meaningful standard approach.” Because private mental health providers are “made up of solo practitioners with little savvy about the structural components needed for integration and few resources to establish them,” targeted support for these providers should be developed.

Chapter 224 reforms will increase the need for new information technology and personnel capabilities. The law provides funding to help providers establish EHR systems, but other problems remain. For example, because healthcare payers and providers are largely private companies, it is difficult to coordinate EHR compatibility across institutions. For instance, while Partners HealthCare recently launched a comprehensive EHR system, Beth Israel Deaconess Medical Center maintains several EHR systems that can share information.²⁴

Additionally, integrating physical and behavioral health will require providers to accommodate more services they may not currently provide.

Lack of Providers (n=8).

There were strong concerns about a lack of providers, which in some cases is driven by insurance reimbursement: “the greatest barrier in the behavioral health area is the shortage of clinicians who actually accept insurance”. The rates are so inadequate that most insurers have so-called “phantom panels” that is, clinicians listed as part of their network who no longer accept insurance. Physicians in Massachusetts receive low reimbursement rates relative to “the high cost of living,” which “contributes to physicians taking employment in other states” while those staying in the state struggle in clinics with low reimbursement rates. Other limitations include a “lack of mental health and substance abuse counselors” to meet expanded needs in behavioral health. “Lack of psychiatric beds and the poor reimbursement rates from MassHealth and commercial services” were named as specific barriers. The integration of medical and behavioral health, and enhancing primary care coordination, is essential because “MassHealth has stated that about 25% of its members make up 80% of spending.” Quality of care may also be affected, as one way hospitals have chosen to reduce costs is to have “less clinical people providing your care.”

Regarding substance abuse, as of April, in the Commonwealth, there were nearly three times more acute treatment services (ATS) beds than clinical stabilization services and transitional support services beds. Because ATS treatment has a shorter duration than the other two services, there is a bottleneck, and many patients are unable to transition to less intensive, longer term substance abuse care.²⁵ Additionally, in 2012, 19.2% of non-elderly adults reported problems getting care in the last year; 13% were told by a doctor or clinic they were not accepting insurance, and 12% were told the doctor or clinic was not accepting the patient's insurance.²⁶ As is generally true nationally, Medicaid pays providers less than commercial insurance; as a result, Medicaid enrollees experience difficulty finding doctors that will accept them.

Resistance to Change (n=10).

The most common answer was the “reluctance of physician and hospital groups to commit to the necessary changes.” Many providers are reported to “struggle with the shift from a focus on revenue generation to cost reduction and process improvement.” Changes in “legal and cultural barriers to data sharing” are necessary to ensure “optimal quality measurement and service tracking.” Some institutions’ actions are inconsistent with the spirit of Chapter 224. For example, “the prohibition of Mandatory Overtime was part of Chapter 224 and the hospitals have taken an ‘emergency exemption’ written into the regulations and used it to completely ignore the prohibition of mandatory overtime for nurses.” Providers continue to use a “fee for service mindset” and have wide variation in practice patterns; “this unexplained variation needs to be addressed through peer review of care practices.” Consumers are also reluctant to change and along with physicians have a “paralyzing fear of the unknown.” To address this “paralyzing fear of the unknown” one respondent suggests “some sort of public service announcement that helps the population grasp what we are working towards.” Looking beyond whether “health insurance premiums have increased or whether the charge to third party payers for a particular medical procedure has increased over a started percentage cap” consideration should include the value of having a “healthy workforce” and coverage that increases workforce retention, as well as prevention programs.

In addition to hospitals and payers struggling to produce consumer-friendly price transparency tools, numerous other healthcare institutions have been slow to adapt to the letter and spirit of Chapter 224. Because the law attempts to hold institutions accountable for cost growth, these growing pains are not surprising. Like other healthcare institutions, hospitals may be required to explain (and offer remedial measures) if and when their cost growth exceeds the benchmark rate.^{27,27} Health plans must provide consumers binding costs estimates upon request.²⁸ Clinicians must show how they are proficient with EHR as a condition of licensure.²⁹ Finally, consumers, especially those in tiered or limited networks, may have more restrictions on their choice of provider and more “skin in the game” with cost sharing.³⁰

As is true of Chapter 57 reforms and the ACA, Chapter 224 is a broad-ranging law that balances new mandates and resources on numerous healthcare stakeholders. While many stand to gain, many must sacrifice.

No Barriers (n=2).

Two respondents reported that there were no barriers to successful implementation of Chapter 224.

Non-Specific Answer (n=2).

One respondent claimed to lack sufficient expertise to comment and another deferred to answer at a later date

END NOTES – Question 3

¹⁷Pioneer Institute. (2015). *Survey: Price Information Difficult to Obtain From Massachusetts Hospitals*. Retrieved from pioneerinstitute.org/healthcare/survey-price-information-difficult-to-obtain-from-massachusetts-hospitals/ (Accessed: July 30, 2015).

¹⁸McCluskey, P.D. (2014, December 12). *Partners HealthCare posts \$22m loss, first in 15 years*. The Boston Globe. Retrieved from www.bostonglobe.com (Accessed: July 30, 2015).

¹⁹Blue Cross and Blue Shield of Massachusetts, Inc. (2014, December). *Combined Statutory-Basis Balance Sheets*. Retrieved from www.bluecrossma.com/visitor/annual-report/annual-report-2014/downloads/Combined%20Financials%20December%202014.pdf (Accessed: July 30, 2015).

²⁰McCluskey, P.D. (2015, April 7). *Healey backs bill to bolster hospital watchdog*. The Boston Globe. Retrieved from www.bostonglobe.com (Accessed: July 30, 2015).

²¹Schoenberg, S. (2015, June 19). *Bill proposed by Western Massachusetts senator would limit hospital price disparities by regulating private insurers*. MassLive LLC. Retrieved from masslive.com (Accessed: July 30, 2015).

²²Quinn, C. (2015, January 16). *Democrat Don Berwick still pushing for single-payer health care system in Massachusetts*. MassLive LLC. Retrieved from masslive.com (Accessed: July 30, 2015).

²³HPC's operating budget for supporting ongoing HPC activities and implementing new Chapter 224 initiatives is drawn from trust funds and will be \$13,475,444 in fiscal year 2016, according to the agency's website. In fiscal year 2016, HPC is approaching full staffing levels and full program implementation capability. HPC anticipates that its operating expenses will reach a steady state in future fiscal years. Phased CHART investments will continue over the next few years, but without new funds, CHART will likely be exhausted in fiscal year 2018.

²⁴McCluskey, P.D. (2015, June 1). *Partners' \$1.2b patient data system seen as key to future*. The Boston Globe. Retrieved from www.bostonglobe.com (Accessed: July 30, 2015).

²⁵Center for Health Information and Analysis. (2015, April). *Access to Substance Use Disorder Treatment in Massachusetts*. Retrieved from www.chiamass.gov/assets/Uploads/SUD-REPORT.pdf (Accessed: July 30, 2015).

²⁶The Blue Cross Blue Shield of Massachusetts Foundation. (2014, March). *Health insurance coverage and health care access, use, and affordability in Massachusetts*. Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/MHRS_2012%20Full%20Report.pdf (Accessed: July 30, 2015).

Question 4: In your direct work/responsibilities in health care, have you had to make, or do you plan to make, any specific changes to support the implementation of Chapter 224? If yes, please describe.

Responses describing specific changes made were coded in eight categories including Advocacy, Care Delivery, Data Collection/Tools, Infrastructure, Training, No Examples of Changes, Not Applicable, and Non-Specific Answer.

Advocacy (n=2).

One respondent reported engaging “in strike votes and other public strategies to require the enforcement of the prohibition of mandatory overtime” and also filed a ballot initiative petition and legislation “to address the disparate payment and gross market disparity that exist.”

Another reported that they “testified on some of the Risk Bearing Entity guidelines.”

In a surprise to no one who knows the state’s political culture, Massachusetts’ healthcare sector is a hotbed of advocacy activity, Industry groups (including those representing health plans, hospitals, and biomedical players), professional associations (including the Massachusetts Medical Society), and advocacy groups (including Pioneer Foundation and Health Care For All) help set the healthcare agenda. These stakeholders are vital to healthcare policymaking in the Commonwealth. Indeed, after the Massachusetts Nurses Association launched an effort to bring a hospital nurse staffing ratio referendum before voters, the Legislature passed a compromise bill with the input of nurses and hospital administrators.³¹

Care Delivery (n-5).

Issues related to the development of website-based information gathering and dissemination by providers were cited as “overwhelming for patients and staff” as one agency moved “from fee for service to a quality based reimbursement system” in which they “had to rethink” care delivery. A provider described work on the Person-Centered Care Plan and Team Based Care and how important it is to “change the experience of care to one where there is a trusted relationship with the care team.” Further, this is an experience that “is very possible to teach, it doesn’t take a tremendous amount of time but that there does seem to require an intervention.” An agency that works to “assist people and families in finding services” has hired “more people with ‘lived experience’ (mental illnesses and substance use disorders) who have been trained and are in recovery to work as peer navigators or peer specialists.” One organization “has invested significant resources to create an Integrated Community Care Model that improves access to high quality, cost-efficient, community-based health care.” This is achieved by “providing care among high quality, lower cost community settings and through local primary care providers where most Massachusetts residents live, instead of higher priced and highly paid teaching hospitals.” In addition, a “new centralized model to oversee behavioral health within the system” was adopted.

Data Collection/Tools (n=4).

The development and implementation of data collection to help with evaluation and decision making was reported by four respondents. Suggestions included amendment of a consumer satisfaction survey “to align with national, Joint Commission standards”; support of a cost transparency tool; CHIA reporting on healthcare system performance indicators; and the use of a “licensed transparency solution from Castlight [Health] to meet requirements that address consumer tools.”

Chapter 224 creates CHIA and charges the agency with administering the All Payer Claims Database. The law gave CHIA new powers to collect health data from providers and payers

and compels certain provider organizations to submit information about their organizational structure, finances, and business practices. CHIA must also provide provider specific information on its website.³² Additionally, healthcare facilities are required to report data regarding use (or non-use) of model checklists to DPH.

Care Delivery/Personnel-Based Reforms (n=7).

Changes to infrastructure included major organizational changes and expanding growth in specific areas. In order to lower medical expenses, one organization “employed lean process improvement” to move primary care away from hospitals; this began before Chapter 224 legislation but was cited as a substantial and ongoing “change to the infrastructure of a healthcare provider.” Another organization expanded IT capacity and Electronic Medical Record implementation. In response to Chapter 258 of the Acts of 2014 (An Act to increase opportunities for long-term substance abuse recovery), there was advocacy for “addiction counselors be on accountable care teams and be insurance reimbursed.” One strategy for integrated care included “the use of psychiatrists embedded in primary care clinics.” A hospital organization named six strategies: “(i) care coordination; (ii) high risk patient management; (iii) better management of chronic disease; (iv) ensuring that our patients receive care in the right place at the right time; (v) increased focus on the use of the “right” care (e.g., reducing overuse, misuse, and underuse to reduce total cost of care and improve quality); and (vi) improving internal efficiencies to reduce cost.”

Training (n=3).

Three respondents reported implementation of new training, including “time sensitive, customized training to staff—particularly at CHCs;” “training for community health workers and providers to enhance integration of disciplines to maximize the healthcare workforce potential;” and assistance for physicians to understand “ACOs and risk taking arrangements... reporting and regulatory requirements... and established a practice resource center to assist physicians and educate physicians about practice requirements.”

Chapter 224 created programs to fund training, recruitment, and retention of primary care physicians and other clinicians at community health centers.³³ Also, HPC is charged with creating a PCMH training program.³⁴

No Examples of Change (n=11).

The largest group of respondents cited no examples of change, because of their type of agency or position. For example, “as an emergency physician I have no role in implementing any of the goals of 224.” Another respondent reported that the type of data collected had not changed.

Not Applicable (n=8).

Eight respondents reported that making specific changes was not applicable to their organization or position; reasons cited included “no direct work responsibilities in health care beyond HPC and some other boards” and “not applicable to this advocacy organization.”

Non-Specific Answer (n=4).

These included a request for a follow-up phone interview, being “unsure,” and a partially completed answer.

END NOTES – Question 4

²⁷The Blue Cross Blue Shield of Massachusetts Foundation. (2012, November). *Chapter 224: What does it mean for hospitals and hospital systems?* Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20Hospital%20Systems.pdf (Accessed: July 30, 2015).

²⁸The Blue Cross Blue Shield of Massachusetts Foundation. (2012, November). *Chapter 224: What does it mean for health plans?* Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20Health%20Plans.pdf (Accessed: July 30, 2015).

²⁹The Blue Cross Blue Shield of Massachusetts Foundation. (2012, November). *Chapter 224: What does it mean for clinicians?* Retrieved from <http://bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20Clinicians.pdf> (Accessed: July 30, 2015).

³⁰The Blue Cross Blue Shield of Massachusetts Foundation. (2012, November). *Chapter 224: What does it mean for consumers?* Retrieved from <http://bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20Consumers.pdf> (Accessed: July 30, 2015).

³¹Metzger, A. (2015, June 10). *Mass. Adopts Final ICU Nurse Staffing Rules*. WBUR's CommonHealth. Retrieved from wbur.org (Accessed: July 30, 2015).

³²The Blue Cross Blue Shield of Massachusetts Foundation. (2012, September). *Summary of Chapter 224 of the Acts of 2012*. Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20summary_1.pdf (Accessed: July 30, 2015).

³³The Blue Cross Blue Shield of Massachusetts Foundation. (2012, September). *Summary of Chapter 224 of the Acts of 2012*. Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20summary_1.pdf (Accessed: July 30, 2015).

Question 5: Do you think there are other forces at work that influence healthcare cost containment besides Chapter 224 legislation? If yes, please elaborate.

Responses describing other forces were coded in thirteen categories: the Affordable Care Act (n=7), Behavioral Health and Integrated Care (n=7), Cost Transparency (n=3), Decision making/Structural (n=9), Demographic Trends (n=2), Economic Trends (n=7), Expensive Medication and Medical Technology (n=10), Financial Factors (n=16), Mergers (n=3), Prevention Approach (n=4), Training (n=2), None (n=1), and Non-Specific Answer (n=2).

Affordable Care Act (ACA) (n=7).

Although Massachusetts was a leader on expanding access to health care, “the Affordable Care Act and other policies have significant influence on Massachusetts health care system performance.” Several specific ACA policies were noted, including “Medicare rules regarding medically unnecessary re-admissions.” Some mixed results were also identified as challenges faced by providers in responding to ACA legislation: “Providers are interested in providing better care at lower cost and are looking to HPC for some help with that but are also wary of costs and mandates. Even so, small practices are having more difficulty surviving.”

The ACA established large funding increases for Medicaid and insurance subsidies, new pilot programs, and additional consumer protections.³⁵ However, the ACA has not been all good news for Massachusetts. But for the ACA, the Commonwealth would not have developed the new Health Connector website. Another ACA reform is the Medicare Hospital Readmission Reduction Program, which penalizes hospitals with relatively high rates of Medicare readmissions.³⁶ Readmission rates fell from 2012-2015, which is obviously a positive development for consumers. However, these fines may bring troubled community hospitals closer to the financial edge.

Behavioral Health and Integrated Care (n=7).

The goal of integrated care is aligned with “extraordinary demands for services from the public in both Mental Health and Substance Abuse.” However, “true parity” is still a long way off and respondents described challenges to integration: “behavioral health reimbursements are so low that these services often are cut, because hospitals and other providers cannot survive financially.” Insurance carriers and other third-party payers “continue to negotiate rates that are not realistic, particularly in the behavioral health field,” which results in providers deciding not to accept insurance; thus, patients must pay out of pocket for services. Further, “insurance companies should not be allowed to have mental health carve-outs as this works directly against the concept of integrated care.

Cost Transparency (n=3).

Several respondents described cost and data transparency as other factors that could also be expanded: “Smaller companies, unlike their larger counterparts, are often prohibited from accessing health claims from their insurer. The legislature should level the playing field by allowing companies of all sizes access to their own claims information so they can serve employees more effectively and understand and control health care costs.” In addition, it was suggested that small businesses receive “a breakdown of broker service costs” to help companies and individuals assess whether there is any conflict of interest in advice they receive.

Decision-Making/Structural (n=9).

A number of respondents expressed concerns that “independent decisions by health system leaders to adopt costly medical technology has been shown to result in competitive duplication for extremely high cost procedures across a variety of conditions.” The critique is that the “system favors independent decision-making” by a single agency director rather than “health planning activities” developed in collaboration that emphasize revenue generation over “improving value for patient health.” Planning was also noted for state systems including “the CMS Preventive Services Rule change that will allow for state Medicaid office to apply for a

state plan amendment related to payment services recommended by a licensed provider for non-licensed personnel.” Decisions by health leaders, and large businesses including insurance providers, have an impact on the structure of the health system: “Private insurers have significant impact on the cost, quality and access to the commercial market. The lack of enforceability and oversight of the parity laws in the Commonwealth.” One example of a large structural concern related to children’s health care is that “many of the health services needed are provided by school nurses employed in educational settings. The dollars needed to fund these services are local taxpayer and state EDUCATION dollars; many of these services received no financial support of the child’s healthcare insurance provider unless it is through state Medicaid. In other words, much of the healthcare costs and oversight of that spending is done by non-healthcare individuals in local school districts” which furthers healthcare disparities because of differences in district funding levels.

Massachusetts “recently strengthened its DON [determination of need] statutes. DON statutes and regulations artificially restrict the variety and number of care settings and equipment that can be utilized to treat patients.” In contrast, other states have moved toward limiting DON, which “create[s] barriers to new healthcare competitors entering the market.” Unintended consequences of the Commonwealth’s medical loss ratio (MLR) “mandate that 90 percent of all premium dollars collected be spent on direct medical care and some specific activities to increase the overall quality of care” include a lack of incentive for “consumer-oriented tools like health insurance plans paired with [health savings accounts]” and also for plans for cost transparency initiatives. The new MLR rules cause “instability at the local health plans” and “limit the selling of innovative products.” The mandates result in “small employers and individuals purchasing coverage on their own or through the [Health] Connector. Larger employers can afford to become self-insured, which exempts them from most state mandates” and leads to “fewer people covered by each new mandate.” The “increasing move to value based reimbursement” across the country is also a factor.

Because the healthcare economy is comprised of a myriad of public and private institutions, rallying around a common goal can be a monumental task. The Health Planning Council – which is comprised of the leaders of several state healthcare agencies and three experts appointed by the Governor – develops the State Health Resource Plan, which strives to assess residents’ health needs and the resources available to them.³⁷ But the council lacks regulatory power, so it cannot enforce the plan; overall, the Commonwealth lacks a central healthcare planning authority. Even though Chapter 224 gives the Attorney General power to delay or block proposed mergers, the state could do little if a hospital proposed an expensive and redundant expansion of services, or ending services (such as emergency departments) that are critical to regional health access.

Demographic Trends (n=2).

Respondents expressed concern over the aging population, which leads to “expanding Medicaid rolls.” In addition, there is a “lack of comprehensive strategy to address end of life care.”

Since 2000, MassHealth enrollment has grown steadily, with recession-related layoffs and expanded eligibility under the ACA bumping program enrollment from 1.5 million in 2014 to 1.8 million this year.³⁸ There are 270,000 MassHealth members that are also enrolled in Medicare, the public insurance program for those 65 and older. By 2030, the youngest Baby Boomers will turn 65, and the 65+ population will double, growing to 71.5 million.³⁹ This “grey boom” should further increase MassHealth dual eligible population. Another factor is the state’s poverty rate, which rose from less than 9.9% in 2007 to 11.9% in 2012, increasing the share of households eligible for MassHealth.⁴⁰

Economic Trends (n=7).

State and national economic trends were identified as ongoing contributing factors. These included “general inflationary trends” and the specific response to recent events with “decreased utilization post-recession.” Because of the downturn in the economy, “patients are delaying care due to high deductibles and health care... patients were delaying care either because they were out of work or did not want to take time off from work for appointments.”

From 2007 to 2011, US healthcare spending grew at half the rate it did from 2000-2007; by comparing regions that suffered to varying degrees during the recession, researchers found that 70% of this slowdown was attributable to the bad economy.⁴¹ Nationally, increased prevalence of cost-sharing arrangements has revealed troublesome effects of consumers having more “skin in the game.” Increasing co-payments can depress use of preventative services, substance use treatment, and mental health care.⁴² In 2006, 10 % of workers were enrolled in a single coverage plan with an annual deductible of at least \$1,000. In 2014, 41% of workers were enrolled in such a plan.⁴³ This could make more consumers hesitate to see (needed or unneeded) care.

Expensive Medication and Medical Technology (n=10).

Almost a quarter of respondents named “new drugs, devices and diagnostic technologies” as a cost driver. One recommendation, acknowledging that “technology is a driver of both costs and innovation,” is that “the state should invest in accelerating telemedicine and use of technology in patient care, as well as establishing uniform standards for EHRs, including interconnectivity.”

Telemedicine presents (or seems to present) regulatory, clinical, and financial burdens for practices and payers. Because Massachusetts considers telemedicine as within the practice of medicine, those who provide it to Bay State patients must be licensed to practice in the Commonwealth.⁴⁴ Telemedicine can improve access to primary care during off hours and for people with mobility issues, which can help divert patients from costly emergency departments.

Telemedicine has potential, especially in types of medicine (including mental health) that may not require a physical exam. A meta-analysis of 380 studies found no difference in effectiveness between telepsychiatry and “in-person” psychiatric assessments.⁴⁵ Despite telemedicine’s promise, adoption has been slow. However, UnitedHealthCare now covers doctor “visits” made via video chat,⁴⁶ Baystate Franklin Medical Center (in Greenfield) and Baystate Mary Lane Hospital (in Ware) have been praised for using telemedicine to (among other things) connect those recovering from strokes with a remote neurologist.⁴⁷

Financial Factors (n=6).

Over a third of respondents described various forces related to the financial aspects of health care as important forces while also underscoring the “complexities of health care finance” and noting that health care is, in the end, a business. “The movement for delivery system reform and payment reform all influence healthcare costs. Increasing adoption of alternative payment methodologies in [Massachusetts], including within MassHealth and Group Insurance Commission programs as a means of improving quality and affordability.” Even while regulations and initiatives were put in place, “the cost of doing business continued to escalate—overhead, insurance, risk management, training, EHRs, etc.” Other factors include “increasing patient engagement and shifting of financial costs to patients (high deductible or tiered plans).”

Chapter 224 compelled MassHealth to enroll at least 80% of members in APMs by July 1, 2015. The state fell short of this goal, but the Baker Administration is striving to reach in 2017. Because MassHealth covers such a large share of the Commonwealth’s residents, this change to the program could yield substantial changes in Massachusetts health economy.

Another crucial trend in Massachusetts health care finance is the struggles of community hospitals. In less than 10 years, from 2005 to 2014, the state went from having 17 disproportionate-share hospitals (those that receive a least 63% of their gross patient service revenue from Medicaid, Medicare, other governmental payers, and free care) to having 34, with the majority of change at the community hospital level.⁴⁸ Conversely, the major teaching hospitals in the Boston area have benefitted from a high share of commercial insurance payments by increased discharges.

Mergers (n=3).

Several respondents reported that “provider consolidation” as well as “hospital and insurance mergers and acquisitions” play a role in cost containment.

In a 2012 The New Yorker article, Atul Gawande explored how medicine could learn from the restaurant industry, where chains like the Cheesecake Factory have streamlined and standardized operations, leveraged economies of scale, and improved technology via robust capital projects that only industry elites can afford.⁴⁹ Gawande analyzes how “big medicine,” like big business, could embrace innovations that lower costs for consumers. Possible applications to medicine include telemedicine, implementation of protocols (for sanitation, catheterization, and other crucial matters), and assigning personnel to tasks appropriate for their skill level. Conversely, market consolidation threatens to increase prices and decrease consumer choice.

Prevention approach (n=4).

The Prevention and Wellness Trust was named as playing “a major role in reducing costs as it funds programs that are innovative and replicable to improve population health particularly in the poorest of our communities.” There were calls for state government to increase investment in prevention efforts and to move away from a “disease oriented health system” that waits to respond to illness and work toward a system that understands the “true ‘value’ of a healthy workforce or citizen.”

As a counter to a healthcare system critics say is fixated on “sick care,” Chapter 224 established funding streams and initiatives to advance personal wellness in the Commonwealth.

One of the most significant efforts, the Prevention and Wellness Trust fund, is funded by \$57 million assessment on payers and acute hospitals. All fund expenditures must advance the goal of meeting the healthcare cost growth benchmark.⁵⁰ Chapter 224 mandates that at least \$42.5 million go toward wellness grants; fund administrators can also allocate up to \$5.7 million to workplace wellness programs and up to \$8.55 million for program evaluation and administration. Nine grantees were funded in 2014.

Additionally, Chapter 224 creates a temporary tax credit (2013-2017) for businesses with less than 200 employees that establish wellness program. Businesses can receive a tax credit (up to \$10,000 each year) for 25 % of the cost of setting up a qualified wellness plan. The Commissioner of Revenue must file a report, and any legislative recommendations regarding the program by 2017.⁵¹ The state issued \$243,869.54 of credits in 2013 and \$206,703.34 in 2014.⁵²

Training (n=2).

Two respondents argued for greater state investment in “training programs for community health workers, [licensed practical nurses], and social workers and examin[ing] outdated regulations that interfere with these programs.” Increasing the healthcare work force through this approach will “slow the rise in costs” and “help to reduce the long wait times in Massachusetts.”

None (n=1).

One respondent claimed there were no other forces at work.

Non-Specific Answer (n=2).

One respondent suggested that public pressure is needed and that Chapter 224 has “done relatively little” and another respondent deferred to answer in a later conference call.

END NOTES – QUESTION 5

³⁴By July 1, 2014 the HPC must establish a training program for providers to learn the best practices of the PCMH model.

³⁵Center for Health Law and Economics, University of Massachusetts Medical School. (2010, June). *Re-forming Reform*. Retrieved from bluecrossfoundation.org/sites/default/files/062110NHRReportFINAL.pdf (Accessed: July 30, 2015).

³⁶Boccuti, C., Casillas, G. (2015, January 29). *Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program*. Retrieved from kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/ (Accessed: July 30, 2015).

³⁷Executive Office of Health and Human Services. (2015). *Health Planning Council*. Retrieved from www.mass.gov/eohhs/gov/departments/dph/programs/admin/hpc/ (Accessed: July 30, 2015).

³⁸The Blue Cross Blue Shield of Massachusetts Foundation. (2014, September). *The Future of MassHealth: Five Priority Issues for the New Administration*. Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/Future-of-MassHealth_Webversion_FINAL.pdf (Accessed: July 30, 2015).

³⁹CNN. (2014, September 1). *Baby Boomer Generation Fast Facts*. CNN. Retrieved from cnn.com (Accessed: July 30, 2015).

⁴⁰Massachusetts Budget and Policy Center. (2013, September). *New Census Data on Income, Poverty, Health, and Child Well-Being*. Retrieved from www.massbudget.org/report_window.php?loc=acs_2013.html (Accessed: July 30, 2015).

⁴¹Dranove, D., Garthwaite, C., & Ody, C. (2014). Health spending slowdown is mostly due to economic factors, not structural change in the health care sector. *Health Affairs*, 33(8), 1399-1406. (Accessed: July 30, 2015).

⁴²Swartz, K. (2010). Cost-sharing: Effects on spending and outcomes. *Robert Wood Johnson Foundation*. Retrieved from http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2010/rwjf402103/subassets/rwjf402103_1 (Accessed: July 30, 2015).

⁴³The Henry J. Kaiser Family Foundation. *2014 Employer Health Benefits Survey*, September 2015, p. 126. (Accessed: July 30, 2015).

⁴⁴Leehan, G., Sossong, S., Lactman, N. (2015, March 5). *Telemedicine in Massachusetts: What Providers Need to Know*. Retrieved from healthlawreporter.bbablogs.org/2015/03/05/telemedicine-in-massachusetts-what-providers-need-to-know/ (Accessed: July 30, 2015).

⁴⁵Hylar, S. E., Gangure, D. P., & Batchelder, S. T. (2005). *Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies*. *CNS spectrums*, 10(05), 403-415. (Accessed: July 30, 2015).

Chapter 224: Stakeholders Study Results

⁴⁶Subbaraman, N. (2015, May 1). *UnitedHealthcare now covers a doctor visit via video chat*. BetaBoston. Retrieved from betaboston.com
(Accessed: July 30, 2015).

⁴⁷Mckiernan, K. (2015, May 9). *Baystate Health lauded for use of telemedicine*. The Greenfield Recorder. Retrieved from recorder.com
(Accessed: July 30, 2015).

⁴⁸Health Policy Commission. (2015). *Community Health Care Investment and Consumer Involvement Committee*. Retrieved from www.mass.gov/anf/docs/hpc/chci/20150601-commission-document-chici-deck-vfinal.pdf
(Accessed: July 30, 2015).

⁴⁹Gawande, A. (2012, August 13). *Big Med*. The New Yorker. Retrieved from www.newyorker.com
(Accessed: July 30, 2015).

⁵⁰Massachusetts Department of Public Health. (2015, January). *The Massachusetts Prevention and Wellness Trust Fund 2014 Legislative Report*. Retrieved from www.mass.gov/eohhs/docs/dph/com-health/prev-wellness-advisory-board/annual-report-2014.pdf
(Accessed: July 30, 2015).

⁵¹The Blue Cross Blue Shield of Massachusetts Foundation. (2012, September). *Summary of Chapter 224 of the Acts of 2012*. Retrieved from bluecrossmafoundation.org/sites/default/files/download/publication/Chapter%20224%20summary_1.pdf
(Accessed: July 30, 2015).

⁵²Executive Office of Health and Human Services (2015). *Wellness Tax Credit Summary*. Retrieved from www.mass.gov/eohhs/consumer/wellness/health-promotion/wellness-tax-credit-summary.html
(Accessed: July 30, 2015).

CONCLUSION

Even though Chapter 224 of the Acts of 2012 was signed into law three years ago, numerous elements of the law are still unfolding. Some programs, including Patient-Centered Medical Home certification from the HPC, remain in the planning stage, while others, including commissions on medical price variation and pharmaceutical costs, have not been implemented. In our survey, many key stakeholders reported that the law is making a significant impact on various aspects of the healthcare system. But others say they have noticed no change, say it is too early to tell, or were critical of the law's approach. It is no surprise that these diverse perspectives exist within the healthcare community, where autonomy and individuality are highly valued and myriad institutions each play a part.

Forty-three of the 46 respondents to our survey reported a specific area of healthcare expertise. Many respondents cited the CHART program, the Prevention and Wellness Trust Fund, Cost and Market Impact Reviews, and cost transparency rules as having a positive impact on healthcare in the Commonwealth. Respondents also noted obstacles to the law's success, including limited enforcement powers, insufficient funding for healthcare infrastructure improvements, and the failure to raise reimbursement rates for MassHealth and behavioral health. Besides Chapter 224, respondents noted that external factors, including the economy and adoption of expensive medications and medical technology, will impact cost containment efforts.

As the Commonwealth implements and monitors Chapter 224, government leaders must continue to consult with experts who keep a finger on the pulse of Massachusetts healthcare. The use of qualitative methods, such as the one used here, help us understand and complement quantitative analysis and findings. The Office of the State Auditor is committed to use mixed-methodologies in order to present a more robust set of results with the purpose of informing policymakers and the general public.