2017 NAAG PRESIDENTIAL INITIATIVE SUMMIT

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## PROGRESSION OF HEALTH CARE REFORM IN MASSACHUSETTS

<table>
<thead>
<tr>
<th>YEAR</th>
<th>HEALTH CARE REFORMS</th>
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</table>
| 1990s | Insurance Market Reforms  
• Guaranteed Issue; Modified Community Rating; Pre-Existing Condition Limitations |
| 2006 | Expansion of Insurance Coverage  
• Individual Mandate  
• Employer Responsibility  
• Medicaid Expansion  
• Insurance Exchange |
| 2008 | Chapter 305 – Cost Containment Legislation I  
• AG Authority to Examine Cost Trends |
| 2010 | Chapter 288 – Cost Containment Legislation II  
• Transparency  
• Tiered/Limited Network Products  
• Reform of Unfair Contracting Practices |
| 2012 | Chapter 224 – Cost Containment Legislation III  
• Oversight of Payment Reform & Provider Registration  
• Benchmark Health Spending to Gross State Product  
• Price Transparency for Consumers |
| 2014 | Chapter 258 – Substance Use Disorder Treatment |
Authority to conduct examinations:
- G.L. c. 12, § 11N to monitor trends in the health care market.
- G.L. c. 12C, § 17 to issue subpoenas for documents, interrogatory responses, and testimony under oath related to health care costs and cost trends.

Engaged experts in health care contracting, actuarial sciences, economics, and clinical quality measurement.

Findings and reports issued since 2010:

- March 16, 2010
- June 22, 2011
- April 24, 2013
- June 30, 2015
- Sept. 18, 2015
1. Provider prices vary significantly in ways not explained by quality, patient complexity, or other common measures of consumer value.

2. Price variation is correlated to market leverage.

3. Global budgets vary significantly and globally paid providers do not have consistently lower medical spending.

4. Price increases, not utilization, have been the primary driver of health care cost growth over the last decade.

5. Total medical spending is higher for the care of patients from higher income communities relative to health burden.

6. Despite a variety of payment and contracting approaches, health plans paid similar prices, and experienced similar growth in prices, across 10 specialty drugs examined.
MARKET TRANSPARENCY

- Real-time information on price and *consumer cost-sharing* by service
- Annual reporting of provider *relative prices* and *global budgets*, including variation in prices by payer and provider
- Annual reporting of *total medical expenses* by provider and geography
- Database of *standardized quality metrics* used to evaluate provider performance (Standard Quality Measure Set)
- *APCD* and corresponding database of *provider organizational structure and affiliations* (Registration of Provider Organizations)
- *Real-time updates* to provider organizational structure and affiliations (Provider Material Change Notices)
April 2013 to Present

<table>
<thead>
<tr>
<th>Type of Transaction</th>
<th>Frequency</th>
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<tbody>
<tr>
<td>Clinical affiliation</td>
<td>24%</td>
</tr>
<tr>
<td>Physician group acquisition or affiliation</td>
<td>24%</td>
</tr>
<tr>
<td>Acute hospital acquisition or affiliation</td>
<td>20%</td>
</tr>
<tr>
<td>Formation of a contracting entity</td>
<td>17%</td>
</tr>
<tr>
<td>Acquisition or affiliation of other provider type (e.g., post-acute)</td>
<td>8%</td>
</tr>
<tr>
<td>Change in ownership or merger of corporately affiliated entities</td>
<td>7%</td>
</tr>
<tr>
<td>Affiliation between a provider and a carrier</td>
<td>1%</td>
</tr>
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</table>
MARKET ORIENTED INITIATIVES

• Prohibiting unfair contracting practices

• Regularly reporting standardized metrics of provider cost and quality

• Evaluating and rewarding providers based on those metrics
  – Developing tiered and limited network products that differentiate providers based on standardized cost and quality metrics
  – Certifying PCMHs and ACOs based on standardized cost and quality metrics
  – Awarding care delivery transformation grants based on standardized cost and quality metrics
ONGOING MONITORING

- Analyzing and reporting on health care cost drivers in connection with annual cost trend hearings
- Evaluating the impact of market changes on cost, quality, and access (Cost and Market Impact Reviews)
- Monitoring payer and provider performance under the statewide cost growth benchmark (Performance Improvement Plans)
The Health Policy Commission tracks proposed “material changes” to the structure or operations of provider organizations and conducts Cost and Market Impact Reviews of:

1. Transactions anticipated to have a significant impact on costs or market functioning
2. Providers identified as having excessive cost growth relative to the statewide cost growth benchmark

What it is

- Comprehensive, multi-factor review of the providers and their proposed transaction
- Consists of a preliminary report, an opportunity for the providers to respond, followed by a final report
- Promotes transparency and accountability, encouraging providers to address negative impacts and enhance positive outcomes of transactions
- Proposed changes cannot be completed until 30 days after the HPC issues its final report, which may be referred to the state Attorney General for further investigation

What it is not

- Differs from Determination of Need reviews by Department of Public Health
- Distinct from antitrust or other law enforcement review by state or federal agencies
### EXEMPLAR QUESTIONS FOR EVALUATING MARKET IMPACT

<table>
<thead>
<tr>
<th>What do we know from the terms of the transaction?</th>
<th>Costs</th>
<th>Quality</th>
<th>Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Will prices change?</td>
<td>▪ What areas are identified for quality improvement?</td>
<td>▪ Any proposed changes in services?</td>
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<tr>
<td>▪ Will care shift to lower or higher priced providers?</td>
<td>▪ How do the parties propose to address these areas?</td>
<td>▪ How do any changes affect any shortages/oversupply of services?</td>
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<table>
<thead>
<tr>
<th>How will provider and market structure change?</th>
<th>Costs</th>
<th>Quality</th>
<th>Access</th>
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<tbody>
<tr>
<td>▪ Will market share or concentration increase/decrease?</td>
<td>▪ How are the parties aligning incentives?</td>
<td>▪ Will the resulting organization have higher or lower public payer mix?</td>
<td></td>
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<tr>
<td>▪ What is the anticipated impact on bargaining leverage?</td>
<td>▪ Does the proposed structure support greater clinical integration/population care management?</td>
<td>▪ Higher or lower mix of low/negative margin services?</td>
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<table>
<thead>
<tr>
<th>Ongoing evaluation of the parties’ goals and plans</th>
<th>Costs</th>
<th>Quality</th>
<th>Access</th>
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<tbody>
<tr>
<td>Continued evaluation with additional data, production, and interchange. E.g.,</td>
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<tr>
<td>▪ Are the parties’ plans internally consistent/supported by historic results?</td>
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<td>▪ Are proposed changes both necessary and sufficient?</td>
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<tr>
<td>▪ Are cost savings likely to be passed on to purchasers?</td>
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RESOURCES

Attorney General’s Market Examinations
•  http://www.mass.gov/ago/bureaus/hcfc/the-health-care-division/

Health Policy Commission Cost & Market Impact Reviews

Center for Health Information & Analysis Price Variation Reports
•  www.chiamass.gov/relative-price-and-provider-price-variation

Massachusetts Health Care Cost Containment Legislation
•  bluecrossmafoundation.org/chapter-288-acts-2010
•  bluecrossmafoundation.org/publication/summary-chapter-224-acts-2012