Analytical Framework for State Cost Containment Models: Massachusetts

<table>
<tr><th colspan="2">Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting</th></tr>
<tr><td>What types of administrative data does the state collect?</td><td>The Massachusetts Center for Health Information and Analysis, CHIA, serves as a “hub of information and analysis” about the Massachusetts health care system. Data collected and analyzed by CHIA, as described on CHIA’s website, fall within the following categories.

All Payer Claims Database
CHIA is the single independent agency to collect data from payers in support of the state’s APCD. This data includes medical pharmacy and dental claims, as well as information on member eligibility and benefit design.

Hospital and Other Provider Data
CHIA collects and maintains large detailed datasets from hospitals and other health care providers across the Commonwealth. CHIA uses this data to support information transparency, cost containment, and quality improvement in the health care system, creating a variety of reports, including:
Hospital Cost Reports
Hospital Charge Book Data
Hospital Financial Performance Data (used by hospitals for benchmarking, strategic planning, market analyses, and clinical integration initiatives)
Adult Day Health Cost Reports
Adult Foster Care Cost Reports
Group Adult Foster Care Cost Reports
Ambulance and Chair Car Services Cost Reports
Community Health Center Cost Reports
Nursing Services Cost Reports
Nursing Facility Cost Reports
Resident Care Facility Cost Reports
Cost reports are used by CHIA and other public entities to monitor costs and for health care payment</td></tr>
</table>

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
	policy development. In addition, the MA Health Connector uses CHIA to design and implement the state's risk adjustment program. **Acute Hospital Case Mix Database** The MA Acute Hospital Case Mix Database is comprised of inpatient, outpatient and emergency department data. The case mix data includes case specific, diagnostic discharge data that describe socio-demographic characteristics of the patient, reason for the admission, services provided, duration of patient's hospital stay, and total and service-specific charges billed by the hospital. CHIA uses this data to analyze hospital utilization trends, generate comparative charge analyses, and establish payment rates. **Payments and Expenditures Data** CHIA collects data from health care payers and providers to conduct a variety of studies, including analyses of total medical expenses, of variation in provider health care service price levels, payment methods among providers, and health care market concentration. **Insurance and Coverage Data** CHIA monitors changes in the cost and benefit levels of health insurance products and also the spending of premium dollars by payers for their members over time. *Source:* *For more information regarding the data that CHIA collects, CHIA's website may be accessed here.*
What types of clinical data does the state collect?	See description of CHIA's Acute Hospital Care Mix Database above. This database captures patient-level data from hospital inpatient, observation and ED visits, and is used to identify trends.
Does the state have an HIT strategy to promote use of clinical and administrative data to promote cost containment initiatives?	Yes. One of Massachusetts key cost containment strategies is transparency around fact-based information that is collected from and made available to providers and health plans. A key initiative that supports the state's cost containment and transparency efforts, Mass HIway is a secure HIE that is accessible to all healthcare systems in the state. The Mass HIway's overall objective is to support analysis of health information so as to improve the quality and cost of care. Implemented in October 2012, the Mass HIway proffers providers and health care organizations the means of securely transmitting data electronically. As such, MassHIway offers a key tool in

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
	improving coordination, quality, patient satisfaction, and public health reporting. Mass HIway reported that between November 2013 and February 2014, total transaction volumes by use case increased 41 percent for case management, 2,469 percent for care coordination, 131 percent for quality improvement, and 35 percent for public health reporting. The Massachusetts eHealth Institute has developed a variety of tools and resources to help providers and health care organizations implement and adopt the Mass HIway. Operated by the Massachusetts Executive Office of Health and Human Services, the Mass HIway is overseen by a Health Information Technology Council; various stakeholder workgroups inform the Council's oversight. Services offered by Mass HIway include the following: • Provider education and outreach related to Mass HIway adoption; • EHR integration services; and • Mass HIway onboarding and enrollment. The Massachusetts SIM grant narrative described three approaches to strengthening the state's existing HIT initiatives: • Leveraging the APCD by establishing a provider portal that would enable providers to access claims-based reports for their panels, enabling them to receive information on patient utilization and monitor progress against shared savings targets. • Resources for HIE adoption to enable full participation of behavioral health and LTSS providers in the HIS through technical assistance. • Data infrastructure for LTSS to enhance the capability of the Executive Office of Elder Affairs case management system, and the Senior Information Management System, so that it can process clinical assessment data. *Sources:* *To learn more about the Mass HIway and the Health Information Technology Council, click here. A fact sheet about the Mass HIway may be accessed here. Click here to access the tools developed by the Massachusetts eHealth Institute.* *The Massachusetts SIM narrative may be accessed here.*
Does the state have a centralized agency or entity responsible for collecting, analyzing and reporting	The collection, analysis, and reporting of health care data are among the responsibilities of both CHIA and the Massachusetts Health Policy Commission (HPC). CHIA collects, manages, analyzes and prepares reports, as described above. HPC uses CHIA's reports and analyses to inform its own reports.

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
health care data?	CHIA is an independent state agency established by law in 2012, charged with reinforcing the state's transparency strategy. CHIA guides the state's 'light touch' regulatory strategy, through four main functions: • Set the health care cost growth benchmark and hold providers responsible. • Change the delivery system to be more efficient. • Make payment support the new health care delivery models. • Improve market performance. CHIA's highly specialized and skilled staff work to ensure data integrity across payers, and to normalize data to permit cross-payer analyses. A council provides oversight to CHIA and guides the agency in setting its research and analytic priorities. Council members include: EOHHS Secretary, HPC Executive Director, representation from the Attorney General's Office, and the Secretary of Administration and Finance. CHIA is funded through fees assessed to providers and payers. The HPC is independent state agency established by the state's landmark cost containment law, Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation" – herein after referred to as Chapter 224. Governed by a board of 11 members, HPC's charge is to "develop health policy to reduce overall cost growth while improving the quality of care, and monitor the health care delivery and payment systems in Massachusetts." Its mission is "to advance a more transparent, accountable, and innovative health care system through independent policy leadership and investment programs." HPC has five core responsibilities: 1. Monitoring the performance of the health care system; 2. Analyzing the impact of health care market transactions on cost, quality, and access; 3. Setting the health care cost growth benchmark (the projected annual percentage change in total health care expenditures in the state); 4. Investing in community health care delivery system transformation; and 5. Certifying patient-medical homes (PCMHs) and accountable care organizations (ACOs). *Sources:* *For more information about CHIA's mission and history, click here.* *For more information about the HPC, you may access its website here.*

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
Does the state have a functioning APCD that it uses to collect data?	Yes. The MA APCD is a database comprised of: medical, pharmacy, and dental claims, as well as information about member eligibility, providers, and insurance coverage. The MA APCD is managed by CHIA; the agency's enabling legislation allows for the collection of data from commercial payers, third party administrators and public programs – Medicare and MassHealth, the Massachusetts Medicaid program. *Source:* *An overview of the Massachusetts All-Payer Claims Database may be accessed here.*
Does the state report cost and quality to the public?	Yes. The HPC is required by law to "prominently publish" the annual health care cost growth benchmark on the commission's website. The Health Policy Commission regularly publishes a Cost Trends Report, which includes an analysis of trends in spending and care delivery and recommended strategies to improve quality and efficiency. The HPC issued Cost Trends Reports annually since 2013. The 2015 report reviewed overall trends, while also taking a closer look at trends in provider markets and prescription drug and hospital outpatient spending; in addition to avoidable hospital use, access to primary care and maximizing value in post-acute care, the report examined hospital-level variation in spending per episode of care for normal pregnancy and delivery. CHIA also examines health care cost and payment trends through a variety of studies. Most notably, CHIA is tasked with calculating Total Health Care Expenditures (TCHE) and with comparing growth against the health care cost growth benchmark established by the HPC. Each year CHIA publishes an initial assessment of the THCE in its Report on the Performance of the Massachusetts Health Care System. CHIA also conducts health plan premium analyses, examines price variation among providers and analyzes the payment methodologies used by health plans. • CHIA's 2016 Report on the Performance of the Massachusetts Health Care System found that the quality of the state's providers was generally at or above national benchmarks, but noted variation in performance. *Sources:* *The Health Policy Commission's 2015 Cost Trends Report may be accessed here. For information regarding CHIA's calculation of Total Health Care Expenditures, click here. For information about CHIA's other cost analyses, click here.*

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
	CHIA's 2016 Annual Report on the Performance of the Massachusetts Health Care System may be accessed here.
Does the state identify and track key cost drivers and high cost providers through analysis of a combination of administrative and clinical data?	Yes. In 2008, the Attorney General was given subpoena power to collect confidential information from plans and providers, and to examine and report on cost trends. As a result of this subpoena power, the Attorney General's office has issued five reports examining health care cost growth and the impact on consumers. These reports have found that: • Prices paid to hospitals and physician groups vary significantly. • Variation is not due to quality, patient illness or other measures of value. • Variation is correlated to provider and insurer market leverage. • Price increases have been the main driver of health care cost growth. • Providers paid under alternative payment models (e.g. global payment) do not have lower medical spending. In conjunction with publication of these reports, the Attorney General, Health Policy Commission, and CHIA, hold two-day public hearings where all of the issues related to cost containment are aired. At these hearings, executives of health plans and providers, researchers and state government leaders participate in an open conversation about the challenges and opportunities that exist within the state. *Source:* *To access the 2015 Attorney General's report, "Examination of Health Care Cost Trends and Cost Drivers," click here.*
Does the state monitor health care cost growth?	Yes, see below.
Does the state define cost growth targets?	Yes. The Health Policy Commission must set the Total Health Care Expenditure (THCE) cost growth benchmark annually by April 15, which serves as the target growth rate per person medical spending in the state for the next calendar year. The THCE is a per-capita measure that includes: • All medical expenses paid to providers by private and public payers; • All patient cost sharing amounts (e.g., deductibles, co-pays) • Net cost of private insurance (e.g. administrative expenses and operating margins for commercial payers). The health care cost growth benchmark is tied to growth in the state's economy. The Commission uses the potential gross state product (PGSP) as the indicator of growth in the state economy; for 2013-2015, consistent with the PGSP, the health care cost growth benchmark was set at 3.6 percent.

Domain #1: Administrative and Clinical Data Collection, Analysis and Reporting	
	In September 2016, CHIA released its Annual Report on the Performance of the Massachusetts Health Care System, which includes final calculation of the state's 2014 THCE and initial calculation of the 2015 TCHE. Results from this report include the following. • CHIA estimated that the initial 2015 THCE was $57.2 billion or $8,424 per capita, representing a 3.9 percent increase over 2014 and exceeding the cost growth benchmark by 0.3 percentage points. This contrasts with CHIA's 2014 report, which found that statewide health care spending increased by $7,550 per resident and at which time the THCE increased by 2.3 percent, which was 1.3 percent below the 2013 benchmark. • CHIA notes that after several years of increases, the share of commercial members whose care was paid for under APMs dropped by 1.9 percentage points in 2015 to 35.1 percent. The Secretary of the Executive Office for Administration and Finance and the House and Senate Ways and Means committees jointly agree on the PGSP for the coming calendar year. Beginning in 2018, HPC can adjust the annual cost growth benchmark after allowing for input from the Legislature. The HPC also has the authority under Chapter 224 to require health care providers and insurers with excessive cost growth and who threaten the health care cost growth benchmark to implement performance improvement initiatives and submit to ongoing monitoring. *Sources:* *For more information regarding the Massachusetts health care cost growth benchmark, click here and here.* *CHIA's 2016 Annual Report on the Performance of the Massachusetts Health Care System may be accessed here.*

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
Does the state coordinate Medicaid and state employee health plan performance requirements and cost control strategies?	To some extent. The legislature required the state employee health program (Group Insurance Commission) and the state Medicaid program to implement alternative payment models "to the extent possible."
Is the state pursuing an all-payer or Medicare waiver with CMS in order to align	Not as of December 2016.

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
cost control strategies?	
What other waivers, grants or federal demonstrations is Medicaid pursuing to promote cost containment?	MassHealth 1115 Waiver Approval In November 2016, Massachusetts received federal approval of its request to amend and extend its 1115 waiver. Under a restructured MassHealth program, the state aims to: • Implement payment and delivery system reforms that enhance coordinated care and hold providers accountable for total cost of care; • Improve integration of physical and behavioral health services as well as LTSS and health-related social services; • Maintain near-universal coverage; • Support safety net providers; and • Expand recovery-oriented substance abuse disorder services. The waiver provides for approximately $8 billion in funding over five years to support: • $1.8 billion in new, upfront investment (DSRIP) to support transition toward ACO models, plus direct funding to community-based providers of behavioral and LTSS services. To receive DSRIP funding, ACOs must partner with BH and LTSS community providers. • $4.8 billion for uncompensated care by safety net providers. • $1.3 billion for subsidies to assist consumers in securing affordable coverage through the connector. The waiver also serves to maintain the stability of the state's safety net care pool, and expands the number of safety net hospitals from 7 to 15. In addition, the waiver authorizes coverage for expanded substance use disorder services under MassHealth. Under the waiver, Massachusetts will advance implementation of a statewide Accountable Care Organization (ACO) program, which revolves around three ACO model options (described below) from which providers can choose to participate. In terms of the implementation timeline, the ACO procurement was released in September 2016, and six pilot ACOs will launch in December 2016. SIM Grant In 2013, Massachusetts received a $44 million Round One State Innovation Model (SIM) Design Award Grant from the Center for Medicare and Medicaid Innovation (CMMI) to advance the

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
	Commonwealth's health care cost containment efforts, with a focus on development and implementation of the PCPR program, and other payment reform within the MassHealth program. *Sources:* *To access a summary of the Massachusetts Section 1115 demonstration waiver program, click here.* *For more information about the Massachusetts SIM grant, click here.*
What APMs are being pursued by Medicaid?	As mentioned above, Chapter 224 requires MassHealth to implement APMs to the maximum extent possible. The law established targets for the percentage of MassHealth members to be covered under APMs (25 percent by July 2013, 50 percent by July 2014, and 80 percent by July 2015). In 2014, MassHealth launched the Primary Care Payment Reform Initiative (PCPRI), a delivery- and-payment model, which combines a capitated payment for primary care with shared savings based on total cost of care, and pushes for behavioral health integration with primary care. PCPRI ends in December 2016. MassHealth is shifting toward an integrated accountable care approach that holds provider-led organizations contractually responsible for quality, coordination and total cost of attributed members care. Under the state's 1115 waiver program, this transition involves three ACO model designs that reflect the range of provider capabilities. MassHealth's recently approved Medicaid demonstration waiver is centered around a statewide ACO program with three ACO model options for providers to participate in, reflecting the range of provider preparedness to participate in alternate payment models. • Model A ACO/MCO is an integrated partnership between a provider-led ACO and health plan. ACOs under this model will be paid prospective capitation rates and have insurance risk for their members' cost of care. • Model B ACO is an advanced provider-led entity that contracts directly with MassHealth and offers preferred provider networks to members. MassHealth will share in savings and losses based on total cost of care of the ACO's attributed members. • Model C ACO is a provider-led ACO that contracts directly with MassHealth MCOs. Each MCO shares in savings and losses with the ACO based on total cost of care for members attributed to the ACO. In 2014, prior to the ACO models, MassHealth launched the Primary Care Payment Reform Initiative (PCPRI), a delivery- and-payment model, which combines a capitated payment for primary care with

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
	shared savings based on total cost of care, and pushes for behavioral health integration with primary care. PCPRI ends in December 2016. MassHealth is shifting toward an integrated accountable care approach that holds provider-led organizations contractually responsible for quality, coordination and total cost of attributed members care. Under the state's 1115 waiver program, this transition involves three ACO model designs that reflect the range of provider capabilities. *Sources:* *The Health Policy Commission's 2015 Cost Trends Report, which describes the APM targets, may be accessed here.* *To access a fact sheet about the MassHealth 1115 Waiver Approval, click here.* *The Health Policy Commission's 2015 Cost Trend Report provides an overview of these MassHealth initiatives, click here.*
What delivery system redesign strategies are being pursued by Medicaid?	See above.
What benefit designs are being pursued by Medicaid to incentivize effective use of health care services, good health behaviors and patient responsibility?	MassHealth is planning to make the benefit design of its three ACO models more attractive to members, noting in its waiver extension request that "MassHealth's goal is to move away from our current program design, which has remained largely unchanged for decades and in which it pays for unintegrated care." The integrated ACO models will be responsible for the continuum of care, with the state planning to phase-in inclusion of LTSS into ACO responsibility. Further, MassHealth states that it is shifting toward a programmatic focus on population health by means of investments in primary care and behavioral health workforce development. A major focus of the state's recently approved 1115 waiver request is the integration of physical and behavioral health care services. This waiver envisions accomplishing this integration through a range of strategies, including incentives for ACOs to partner with BH and LTSS providers, certification of Behavioral Health Community Partners, and contract requirements for managed care plans and ACOs, as well as payment model adjustments.
Does Medicaid use MMCOs to manage care?	With implementation of the state's 2006 health reform law, Chapter 58 of the Acts of 2006 (commonly referred to as Chapter 58), MMCOs that participated in the MassHealth program in 2006 (BMCHP, Fallon, NHP and Network Health) serve individuals receiving subsidies through the Commonwealth Care program. These MMCOs also serve the commercial market and, as Qualified

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
	Health Plans, offer coverage via the state's Health Connector to individuals and small businesses. The state's CarePlus program serves the Medicaid expansion authorized by the ACA. Commonwealth Care enrollees who are not eligible for CarePlus are now served through the Connector Care program – the Health Connector's subsidized insurance program. In 2010, MassHealth selected five MCOs via a competitive bid process, adding Health New England to the original four MMCOs. These MMCOs serve over 850,000 MassHealth members via either the Medicaid or Health Connector programs. CarePlus requires members who qualify to choose one of the MMCOs available in their region. The 1115 waiver envisions the MassHealth MMCOs as "key partners" in implementing the new ACO model of care, as described above. MassHealth's upcoming MCO re-procurement will also spell out expectations for MCOs in their contracting with ACOs, in order to support providers with analytic and population management reports. Under the state's MCO re-procurement, MCOs will also transition LTSS services – over time – to MCO responsibility. *Sources:* *For more information regarding the history of MMCO participation in the MassHealth program, click here.* *To access the Massachusetts renewal request for its Section 1115 demonstration waiver program, click here.*
What reimbursement policies has Medicaid implemented to promote cost containment?	As described above, MassHealth's recent Medicaid 1115 waiver approval makes the focus of payment reforms the implementation of three ACO models, each with varying degrees of provider risk sharing, reflecting the range of provider preparedness to participate in alternate payment models. To encourage MassHealth members to enroll in an MCO or ACO rather than the state's Primary Care Clinician (PCC) plan, MassHealth – under its recently approved 1115 waiver – will provide fewer covered benefits to members who choose the PCC Plan, benefits such as chiropractic services, eye glasses and hearing aids. Of note, the ACO models under the waiver will offer "flexible services," including currently non-reimbursed services that address social determinants of health. The state has stipulated that flexible services may not include state plan or waiver services, and must fall within one of the following categories: 1. Community transition services;

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
	2. Home and community-based services that deter the placement of patients in institutions; 3. Services for safe and healthy living environments; 4. Exercise and nutrition; or 5. Other services MCOs will assume expanded responsibility for delivery of LTSS services following the state's 2017 MCO re-procurement. This expansion of MCOs' responsibility will transition in over time. *Sources:* *To read more about reimbursement policy changes under MassHealth's recently approved Medicaid 1115 waiver, click here and here.*
What initiatives has Medicaid pursued to manage cost of special populations of beneficiaries?	The state's Section 1115 demonstration waiver renewal request, approved in November 2016, describes the following initiatives aimed at special populations of beneficiaries. • Persons with persistent and serious mental illness. MassHealth will certify Behavioral Health Community Partners (BH CPs) who may then partner with ACOs to support integrated care delivery for members with complex behavioral health care needs. • Persons with developmental disabilities. MassHealth will also certify LTSS Community Partners (LTSS CPs) to partner with ACOs in meeting the needs of members with physical disabilities, TBI and ID/DD. ACOs and LTSS CPs will collaborate as an integrated care team. • Children with special healthcare needs. The MassHealth waiver renewal requests notes that one goal for the demonstration is to improve integration of services, especially of previously siloed physical health care and behavioral health care services – especially for adults and children with complex medical, behavioral health and LTSS needs. • Other high-cost, high needs patients. MassHealth currently has several programs to address high cost, high needs patients. ⇨ These include One Care, which addresses the health care needs of adults under 65 who are dual eligible. Although the program is in its early stages, Massachusetts has enrolled nearly 18,000 individuals in this program, which aims for better coordination of care, streamlined service delivery and reimbursement process, and also reduced costs. ⇨ The Money Follows the Person (MFP) demonstration targets MassHealth high cost high need individuals residing in institutions who would receive more appropriate and cost-effective care in community settings. The MFP demonstration, which is a joint federal-state initiative, provides the state with flexibility to pay for non-traditional HCBS services.

Domain #2: Medicaid Purchasing and Coverage Strategies to Contain Costs	
	Sources: *Several of these programs are described in the state's Section 1115 demonstration waiver renewal request, which can be accessed here.* *The Office of the Inspector General's January 2016 report on MassHealth's Health Safety Net Management of Healthcare and Healthcare Costs for Super-Utilizers may be accessed here.*

Domain #3: State Employee Health Plan Coverage and Payment Strategies to Contain Costs	
What APMs is the state employee health plan using to control health care costs?	The state's Group Insurance Commission (GIC) provides health insurance for state and some municipal employees. The Group Insurance Commission (GIC) is required to implement APMs to the maximum extent possible. The GIC requires its six contracted plans to cover at least 75 percent of GIC members under risk-based contracts by FY 2016 via its Integrated Risk-Bearing Organizations (IRBO) model. This model is also referred to as the Centered Care Initiative. The GIC has identified 10 key elements of Centered Care for IRBOs. These elements pertain to PCP designation and engagement, data sharing, encouraging low cost providers, expanded hours and urgent care access, ensuring a high level of care for the chronically ill, transitional care management and more. The six health plans who are contracted with GIC as IRBOs are engaging in outreach with physician practices to ensure adoption of these elements. The GIC's 2015 annual report states that the GIC's six IRBO contracts use "incentives and penalties to contract with doctors, hospitals and other providers on a global payment basis instead of the standard fee for service arrangement. The usual payment approach tends to lead to overutilization of medical procedures regardless of health outcomes. We continued to put pressure on our plans to enter into provider contracts that include increased financial accountability as well as delivery improvements." The six health plans have Memoranda of Understanding with Centered Care providers that constituted 20 percent of GIC lives in January 2014. The Centered Care Initiative has not yet had a dramatic impact on prices and providers have shown reluctance to shift to risk-bearing global payments. *Sources:* *The Health Policy Commission's 2015 Cost Trends Report may be accessed here.*

Domain #3: State Employee Health Plan Coverage and Payment Strategies to Contain Costs	
	The GIC's 2015 annual report may be accessed here.
What benefit design is the state employee health plan using to control health care costs?	The GIC has had in place for the past 10 years a Clinical Performance Improvement (CPI) initiative whereby GIC analyzed physician claims for differences in how physicians perform on nationally-recognized measures of quality and efficiency. Members pay the lowest copay for the highest-performing doctors across three tiers: Tier 1 (excellent), Tier 2 (good), and Tier 3 (standard). *Source:* *The Health Policy Commission's 2015 Cost Trends Report may be accessed here.*

Domain #4: State Actions to Enhance Competition in the Marketplace	
Does the state certify or otherwise regulate Accountable Care Organizations?	Yes. In April 2016, HPC published ACO certification standards. The HPC's ACO certification criteria include four pre-requisite criterion including certification of a risk-bearing provider organization from DOI and compliance with applicable federal and state laws and guidance (antitrust, appeals). The standards include six criterion related to governance structure, participation in quality-based risk contracts, population health management programs, and cross continuum care reflecting collaboration with providers outside the ACO, including long-term care and behavioral health providers. The standards also include nine required supplemental information questions, including: How does the ACO support patient-centered primary care transformation? To what extent has the ACO established processes and protocols for identifying, counseling, and planning for advanced illness care? How does the ACO encourage its participating providers to make price information available to consumers as required under state law and regulation? The state's demonstration waiver extension request indicates that all MassHealth ACOs must meet the HPC's ACO certification requirements. *Source:* *For access to HPC's ACO certification standards, click here.*
Does the state collect data regarding the structure of the state's health care	Yes, HPC tracks the frequency and nature of provider system changes by examining Material Change Notices filed by provider organizations. The HPC also conducts thorough review of potential transactions that may have a significant impact on health care costs through its Cost and

Domain #4: State Actions to Enhance Competition in the Marketplace	
market, such as ACO information on number of participating physicians?	Market Impact Reviews. Both these processes are described in greater detail in Domain #4. In addition, the HPC undertakes an exhaustive annual review of the market in its Cost Trends Report, which examines not only trends in spending and care delivery, but also trends in the provider markets, opportunities to increase quality and efficiency, and progress toward aligning incentives.
Does the state use the collected data to produce reports to encourage marketplace competition, such as hospital quality and cost report cards, cost impact reports?	Yes. Massachusetts has pursued transparency as a means to push the market toward cost containment. The HPC and CHIA both report on a wide variety of data as described in Domain #1. The state's two banner reports are 1) CHIA's Annual Report on the Performance of the Massachusetts Health Care System, which includes calculations of the state's Total Health Care Expenditure, a measure of statewide health care spending; and 2) the HPC's Cost Trends Report, which provides extensive information on health care expenditures as well as market place variations. These reports are intended for an audience of legislators, policymakers, payers and providers – less so consumers.
Does the state promote or set limits on consolidation of health care providers of similar services?	Yes. The HPC is required to monitor the Massachusetts health care system by requiring health care providers and provider organizations to notify the HPC before making material changes to their operations or governance structure. Material changes are defined as proposed changes involving a provider or provider organization that involve a merger, affiliation or acquisition of or by a carrier, hospital or hospital system, provider or provider organization. If the HPC determines that the change might impact health care costs, quality, access or market competitiveness, the HPC can then conduct a Cost and Market Impact Review (CMIR). A CMIR is a public report of the HPC's findings; a transaction cannot occur until the report is made public. These reports also inform the Attorney General, who can then take action to block the proposed market change. *Source:* *For more information regarding health care market oversight in Massachusetts, click here.*
Does the state promote or set limits on vertical integration of health care providers of different services?	Yes. The limits that the state places on consolidation of providers, carriers, and hospitals, also places limits on the clinical affiliation between two or more providers or provider organizations that each had annual Net Patient Service Revenue of $25 million or more in the prior year.

Domain #4: State Actions to Enhance Competition in the Marketplace	
Does the state promote or limit other types of affiliations among health care providers that impact referral and utilization practices?	No, not specifically, although the HPC's market oversight via its Material Change Notice and Cost and Market Impact Review would appear to encompass provider changes that might impact referral or utilization practices that drive up costs.
What strategies, if any, has the state's insurance department taken to ease insurer entry into the marketplace to enhance insurer competition?	No evidence of such strategies found.
Does the state have consumer protection regulations that promote cost containment?	Yes, the state's Office of Patient Protection (OPP) housed within the HPC regulates and administers health insurance consumer protections, including: • An internal review process for consumers to appeal denials of coverage; • An enrollment waiver process; • Publishing information on health plans; and • Providing information to consumers about their rights. In addition, the Attorney General's Office is actively engaged on this issue, and reports on a regular basis on the impact of cost trends and cost drivers, as discussed previously. The Attorney General's authority to act upon the HPC's Cost and Market Impact Reviews (described in greater detail in Domain #5) is in itself intended as a consumer protection action. It is important to note that the state's recently approved Medicaid 1115 waiver includes provision for an Ombudsman for members in ACO and MCO products. *Source:* *To view the Office of Patient Protection's Annual Report, click here.*

Domain #5: State Regulatory Actions to Contain Health Care Costs	
Does the state directly (vs	Not currently.

Domain #5: State Regulatory Actions to Contain Health Care Costs	
indirectly through setting or approving insurer rates) limit price increases by providers?	
Has the state mandated payment and delivery system reform?	Yes, as described in Domain #2, the legislature enacted a 2012 law that requires the state employee health program and Medicaid to implement alternative payment models "to the extent possible." While the HPC has no regulatory authority to mandate the use of APMs by commercial payers, it promotes the use of APMs by convening payers on quality measurement alignment (in conjunction with Medicaid).
Does the state have a Determination or Certificate of Need program or other programs to limit introduction of high cost services?	Yes. Massachusetts' Determination of Need (DoN) program, housed within the Department of Health and Human Services, oversees the availability and accessibility of health care services. The Department of Health and Human Services receives applications from health care facilities that are planning substantial capital expenditures or service changes. The DoN program evaluates applications and makes recommendations to the Public Health Council for approval or denial. In addition, the HPC required to conduct Cost and Market Impact Reviews. As described earlier providers and provider organization are required to provide 60 days' Material Change Notice to HPC of any material changes to their governance and operations (e.g. resulting from mergers and acquisitions). If the HPC determines that proposed changes might impact the state's cost growth benchmark, then the HPC has authority to conduct a Cost and Market Impact Review. HPC also has authority to conduct such a review on any organization identified by CHIA as having an impact on the annual cost trend. The HPC may also refer an organization to the AG for investigation, based on pre-established criteria. The AG then has authority to take action in the interest of protecting consumers. *Sources:* *For more information about the Massachusetts Determination of Need program, click here.* *For more information about the HPC's Material Change Notices and Market Impact Reviews, click here.*
Are there any requirements of commercial payers to provide comparative cost and quality data regarding	Yes. In 2013 health plans were required to provide information on prices and total out of pocket costs for certain services via a toll-free number and website.

Domain #5: State Regulatory Actions to Contain Health Care Costs	
contracted providers?	
Is the state insurance department implementing any strategies to limit provider cost increases?	No, the insurance department is not directly implementing strategies to limit provider cost increases; however, it has established a process for certifying providers that are engaging in shared-risk contracts as risk-bearing provider organizations (RBPOs). *For more information about the Division of Insurance's Risk Bearing Provider Organization Certification process, click here.*

Domain #6: Payment Reform and Delivery System Reform	
What entities are driving payment and delivery system reform in the state?	The legislature has been very influential in shaping health care policy by passing laws that create policy and by creating an infrastructure to monitor the health care system. The legislature has also been active in tasking various state agencies in studying health care problems, and then acting on those findings. In addition, several Governors have made health care reform a priority and each one has helped advance health reform in the state. The current Governor is a former Secretary of the agency that oversees health and human services in the state. With passage of Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation" the state legislature both established HPC and CHIA, and expanded the responsibilities of the Office of the Attorney General respective to health care transparency. The MassHealth restructuring envisioned by the state's 1115 waiver was led by the Baker-Polito administration, and resulted from a yearlong stakeholder engagement effort. MassHealth will be initiating a Delivery System Implementation Advisory Council in early 2017, representing diverse stakeholders.
What support has the state received to promote payment and delivery system reform?	CMS awarded Massachusetts a SIM grant of more than $44 million to advance the Commonwealth's nation-leading health care cost containment efforts. In November 2016, Massachusetts also received $1.8 billion Delivery System Reform Incentive Program (DSRIP) to support the move to ACOs, invest in Community Partners for behavioral health and long-term services and supports, and allows for

	innovative ways of addressing the social determinants of health. Through its 1115 waiver, the state also received $6 billion of additional safety-net care payments over 5 years to hospitals and the health safety net for the uninsured and underinsured, and for subsidies to assist consumers in obtaining coverage on the exchange. *Sources:* *To access a summary of the Massachusetts Section 1115 demonstration waiver program, click here.* *For more information about the Massachusetts SIM grant, click here.*

Domain #7: Environmental Context for the Cost Containment Strategies	
Does the state's culture promote cost reform?	Yes. Massachusetts is one of the most advanced states in the country in terms of health care coverage and spending growth reforms. The state's culture is such that it passed landmark health coverage reform laws in 2008 and 2010, which established the state's initial efforts at data transparency and cost trend reporting. Further legislation, Chapter 224, expanded on many of these provisions by seeking aggressively to contain health care premium cost growth in the commercial health insurance market, and encourage the adoption of APMs by both public and private payers, with specific targets for such adoption within the Medicaid program. *Source:* *A summary of Chapter 224, prepared by the Blue Cross of Massachusetts Foundation, may be found here.*
What are/were the governmental facilitators?	The state legislature, the Executive Branch, CHIA, the HPC and the Office of the Attorney General all play central and collaborative roles in the state's cost containment and transparency initiatives.
Are there any key insurers that are driving cost containment strategies?	Yes, BCBSMA has driven cost containment strategies by introducing innovative payment models. In 2009 BCBSMA's Alternative Quality Contract, an innovative global payment model, was implemented as a pilot program. In January 2016, BCBSMA introduced global payment into one-third of its in-state PPO membership. *Source:* *To read more about BCBSMA's Alternative Quality Contract, click here.*
Do health plans promote	Yes, many do.

Domain #7: Environmental Context for the Cost Containment Strategies	
use of high-quality, low cost providers in their plan designs?	
Have health plans implemented alternative payment models with providers?	Yes. As of 2014, approximately 37% of plan members across all public and private payers were covered by alternative payments models. *Source:* *The Health Policy Commission's 2015 Cost Trends Report may be accessed here.*
How have health plans promoted delivery system transformation?	It varies by health plan, but many are supporting providers in their transition to alternative payment models with support in population health management, engagement in data, and funding for discreet transformation efforts.
Are there any multi-stakeholder coalitions facilitating cost containment strategies?	Yes. Massachusetts Health Quality Partners (MHQP) is a non-profit coalition of physicians, health plans, purchasers, patients, academics and government agencies. MHQP has an established track record as the trusted leader in Massachusetts for objective, independent health care quality measurement and reporting. *Source:* *To learn more about MHQP, click here.*
Is there a strong employer purchaser coalition in the market facilitating cost containment strategies?	No.
Are there any individual employers that are driving cost control discussions and actions within the state?	No. *Source:* *Click here to access a report prepared by the BCBS Foundation examines the role and history of involvement by the state's business community.*
Does the state have a centralized agency or designated work group responsible for overseeing/driving health care cost strategies?	Yes. Massachusetts has two such agencies: the Health Policy Commission (HPC) and the Center for Health Information Analysis (CHIA).

Domain #7: Environmental Context for the Cost Containment Strategies	
Has the state or any of its executive branch agencies adopted a formal cost control strategy or roadmap?	Yes. Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation" was signed into law in August 2012. This legislation set forth a plan to control the state's health care cost growth through a variety of approaches, including the creation of new commissions and agencies to monitor cost growth, adoption of APMs, increased price transparency and other efforts. Chapter 224 set forth the following actions. • Chapter 224 established both HPC and CHIA, whose responsibilities are described immediately above. • Expanded the responsibilities of the Attorney General's office to include tracking trends in the market, and authority to collect health care data, and participate in the annual health care cost trends hearing. • Adoption of APMs, including targets for MassHealth member enrollment in alternative payment contracts. In addition, the law specified that MassHealth, the GIC and the Connector give priority to ACOs. • Established that every provider organization that enters into an alternative payment contract involving downside risk must apply for a risk certificate through the Division of Insurance. • Established registration process for provider organization to be ACO certified, overseen by HPC, and to include identification of "model ACOs" that demonstrate best practices. Chapter 224 also established a variety of efforts aimed at improved consumer data transparency (e.g., cost sharing toll free number and website), establishment of a Prevention and Wellness Trust Fund based on a one-time health plan and hospital assessment, a wellness program tax credit for smaller businesses, and created new funds for investing in primary care workforce capacity. *Source:* *A summary of Chapter 224, prepared by the Blue Cross of Massachusetts Foundation, may be found here.*
Does the state have any funding mechanism to support cost containment initiatives by unaffiliated providers such as independent primary care practices, small community hospitals or safety-net	Yes. Chapter 224 established the Community Hospital Acceleration, Revitalization and Transformation (CHART) Investment program, a grant program for Massachusetts community hospitals aimed at enhancing their delivery of efficient, effective care. Chapter 224 established eligibility for hospitals that may receive CHART funding, which is administered by the HPC. The program aims to promote care coordination, delivery transformation, as well as to advance electronic health records adoption and increase the implementation of APMs and ACOs. Under the CHART program, HPC will invest $120 million over three years. Thirty acute care hospitals across the state

Domain #7: Environmental Context for the Cost Containment Strategies	
hospitals?	are eligible for CHART funding, of which 28 received Phase 1 funding. Additional grant awards were made under a Phase 2 round of funding. In addition, the state recently received a $1.8 billion 5 year DSRIP program to support Medicaid providers. *Source:* *To read more about the Massachusetts CHART program, click here.*
Does the state have any resources and program initiatives to assist health care providers to increase quality and efficiency?	Yes. The HPC's Targeted Cost Challenge Investments aim to support innovative delivery and payment models that have potential for meaningful future impact on the Health Care Cost Growth Benchmark. The goal of this investment fund is to support eligible applicants who propose initiatives with show promise for reducing the cost of care. The HPC awarded an initial round of grants of up to $750,000 per proposal, for a total funding opportunity of $7,000.000. *Source:* *To learn more about the HPC's Targeted Cost Challenge Investments program, click here.*

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
Key Findings	Summary and Citation
1. Within a year of implementation of its 2006 comprehensive health reforms, Massachusetts expanded coverage to nearly all residents. **2. However, the state continued to struggle with rising health care costs after 2006 implementation of coverage reforms with per capita health spending 15 percent higher than the national average despite slowing of premium growth.**	The Kaiser Family Foundation examined Massachusetts' experience following 2006 implementation of comprehensive health care reforms, finding that it had the lowest rate of uninsured in the country and served as a model for federal reform – despite the state's continuing struggles with health care cost containment. *Source:* *To access the Kaiser Family Foundation's 2012 policy brief, click here.*

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
1. Unmet need was lower in 2010 compared to 2006 not only for physician services, but also for medical tests, preventive screenings and follow up care. **2. In 2010, 26.1 percent of lower income nonelderly adults reported difficulty paying for care compared to 30.7 percent in 2006.**	A 2013 *Inquiry* article by Long et al. reported on improvements in the insured rate in Massachusetts, and also gains in access and affordability of health care services. As a result of Massachusetts' 2006 reform initiative, the rate of uninsured dropped by more than 50 percent, and the state experienced improvements in access to and affordability of health care, including a 28 percent drop in unmet need for physician care, and a 38 percent decrease in out-of-pocket costs. *Source:* *To access the Inquiry article, click here.*
1. In 2015, the state's initial THCE was $57.2 billion, or $8,424 per capita, representing a 3.9 percent increase over 2014, and surpassing the health care cost growth benchmark by 0.3 percentage points. **2. In 2015, the percent of commercial members whose care was paid under APMs was 35.1%.** **3. The quality of Massachusetts providers was at or above national benchmarks, although variations exist.**	The Massachusetts Center for Health Information and Analysis prepares an annual report on performance of the Massachusetts health care system, providing a final calculation of the Total Health Care Expenditures from two years prior and an initial calculation of the prior year's THCE. The THCE is a measure of total statewide health care spending. CHIA's annual report also provides information on quality of care in the state when compared to national trends, enrollment and coverage, and premium and cost sharing information. *Source:* *CHIA's 2016 Annual Report on the Performance of the Massachusetts Health Care System may be accessed here.*
1. After 2006, improved coverage resulted in fewer reported challenges in paying medical expenses, especially among low-income adults. **2. The state's individual mandate made insurance coverage more affordable by attracting healthier individuals into pool, and thereby spreading costs.** **3. Despite these improvements, affordability challenges are**	On the 10th anniversary of Chapter 58's passage, the Blue Cross Blue Shield of Massachusetts Foundation prepared a report that summarizes the effects of the reforms on coverage, access, affordability, utilization, and outcomes. *Source:* *To access the Blue Cross Blue Shield Foundation's report, "10 Years of Impact:*

What has been the effectiveness of state strategies on cost control according to formal evaluation activity, including independent party evaluations and self-reported studies?	
still in evidence. A significant percentage of insured residents say that they are worried about paying their medical bills in the future.	*A Literature Review of Chapter 58 Acts of 2006," April 2016, click here.*