



MASSACHUSETTS HEALTH POLICY COMMISSION

By: Nicole Dube, Principal Analyst
James Orlando, Associate Attorney

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- The commission is an independent state agency created by the legislature in 2012.
- Its charge includes developing health policy to reduce health care cost growth and improve the quality of care.
- It also monitors the state's health care delivery and payment systems.
- The commission is governed by an 11-member board and employs an executive director and 40 to 50 staff members.
- Currently, it is funded through the state's Health Care Payment Reform Fund.
- Starting in 2016, it will be funded by an annual assessment on acute hospitals, ambulatory surgical centers, and certain surcharge payors.

ISSUE

This report provides a brief overview of the Massachusetts Health Policy Commission, including its legislative history, charge, governance, and structure.

SUMMARY

The Massachusetts Health Policy Commission is an independent state agency established by the legislature in 2012. The commission replaced the state's Health Care Quality and Cost Council and is charged with (1) developing health policy to reduce overall health care cost growth and improve quality of care and (2) monitoring the state's health care delivery and payment systems.

Among other things, the commission establishes annual statewide benchmarks for the growth of total health care expenditures (the 2014 benchmark is 3.6%). It also tracks changes in the health care provider market, such as mergers, consolidations, and nonprofit hospital conversions. The law requires health care providers and provider organizations (e.g., hospitals and physician organizations) to notify the commission before making any material change to their operations or governance structure.

The commission conducts a preliminary review of such proposed material changes and, in some cases, a comprehensive cost and market impact review (CMIR). The review assesses the proposal's impact on, among other things, short- and long-term health care spending, quality of care, and patient access to services. It also identifies areas for further review or monitoring and the commission may refer its review to other state agencies charged with health care market oversight, such as the Attorney General's Office, Center for Health Information and Analysis, Department of Public Health, and Division of Insurance. The law prohibits a proposed material change from taking effect until 30 days after the commission issues its final CMIR.

The commission is governed by an 11-member board. Its day-to-day operations are supervised by an executive director, who manages a staff of 40 to 50. There is also an advisory council to the commission, with representatives from various components of the health care system.

Currently, the commission is funded through the state's Health Care Payment Reform Fund, which includes revenue from (1) a one-time assessment on certain acute hospitals and surcharge payors and (2) certain one-time gaming licensing fees. Starting July 1, 2016, the commission will be funded by an annual assessment on acute hospitals, ambulatory surgical centers, and surcharge payors (Mass. Gen. Laws ch. 6D, § 6).

COMMISSION'S CHARGE

The Massachusetts Health Policy Commission was created in 2012 as part of the state's new health care cost containment law ([Chapter 224 of the Acts of 2012](#)). This law charges the commission with monitoring the reform of the state's health care delivery and payment systems by:

1. setting annual statewide benchmarks for health care cost growth;
2. annually reporting to the legislature on health care spending trends and underlying factors and recommendations to increase the health care system's efficiency;
3. enhancing transparency of provider organizations, including developing and administering a provider organization registration program;
4. requiring certain health care entities that exceed state benchmarks for healthcare cost growth to file and implement performance improvement plans with the commission;

5. certifying and monitoring accountable care organizations and patient-centered medical homes;
6. monitoring the adoption of alternative payment methodologies;
7. fostering innovative health care delivery and payment models that lower health care cost growth and improve patient care quality;
8. monitoring and reviewing the impact of health care market changes, including material changes to provider organizations (e.g., mergers, acquisitions, and nonprofit hospital conversions);
9. holding annual public hearings based on the Massachusetts Center for Health Information and Analysis' annual report comparing the state's total health care expenditures to the previous calendar year's benchmark (see below);
10. administering Healthcare Payment Reform Fund program grants and providing technical assistance to help health care entities to develop, implement, or evaluate promising models in health care payment and service delivery; and
11. protecting patient access to necessary health care services (Mass. Gen. Laws ch. 6D).

We provide some examples of the commission's charge in greater detail below.

Health Care Cost Growth Benchmarks

The law requires the commission, by April 15th of each year, to establish a statewide goal for reducing the average growth in health care costs for the next calendar year. The commission must calculate benchmarks as follows:

1. for calendar years 2014 through 2017, the benchmark must equal the growth rate of potential gross state product;
2. for calendar years 2018 through 2022, the benchmark must equal the growth rate of potential gross state product, minus 0.5%; and
3. for calendar years 2023 and beyond, the benchmark must equal the growth rate of potential gross state product (Mass. Gen. Laws ch. 6D, § 9).

2018-2022 Benchmarks. The commission may modify benchmarks by a specified amount for 2018 through 2022 if it takes certain actions, including (1) holding a public hearing on the proposed modification that includes a review of the Center for Health Information and Analysis' annual report on health care cost trends and (2) notifying the legislature's Joint Committee on Health Care Financing.

The Joint Committee on Health Care Financing must then hold a public hearing on the commission's proposed modification and report its findings and recommendations to the legislature, along with any necessary legislation. If the legislature does not enact such legislation within 45 days after the joint committee's public hearing, the board's modification to the benchmark takes effect (Mass. Gen. Laws ch. 6D, § 9).

2023-2032 Benchmarks. From 2023 through 2032, the commission may modify benchmarks by any amount if it takes the same actions listed above. However, the Joint Committee on Health Care Financing is permitted, but not required, to hold a public hearing on the commission's proposed modification and notify the legislature of its findings, recommendations, and any necessary legislation (Mass. Gen. Laws ch. 6D, § 9).

Reviewing Material Changes to Provider Organizations

The law requires a health care provider or provider organization (e.g., hospital, physician organization, provider network, etc.) to notify the commission at least 60 days before making any material change to its operations or governance structure (e.g., mergers, acquisitions, non-profit hospital conversions, etc.). Within 30 days after receiving the notice, the commission must conduct a preliminary review of the proposed transaction. The commission may conduct a cost and market impact review (CMIR) if it determines that the proposal will significantly impact the (1) competitive market or (2) state's ability to meet its health care cost growth benchmark (Mass.Gen. Laws ch. 6D, § 13).

CMIR. The CMIR examines how the proposal affects short- and long-term health care spending, quality of care, and patient access to services. It may examine factors such as:

1. the provider's or provider organization's size and market share, medical expenses, and patient care quality;
2. statewide total health expenditures and provider cost trends;
3. the availability and accessibility of services similar to those proposed by the transaction;
4. the proposal's impact on existing health care providers and competing options for health care service delivery;
5. the methods used to attract patients and recruit health care providers or facilities;

6. the provider's or provider organization's role in serving at-risk, underserved, and public assistance patient populations, including those with mental health and substance abuse conditions;
7. the provider's or provider organization's role in providing charity and uncompensated care, within its primary service areas;
8. consumer concerns; and
9. any other factors the commission determines are in the public interest.

The commission must issue a preliminary CMIR and identify any provider or provider organizations that:

1. has a dominant market share for the services it provides,
2. charges prices for health care services that are materially higher than the median prices charged by other providers for the same services in the same market, and
3. has a health status adjusted total medical expense that is materially higher than the median total medical expense for all other providers for the same services in the same market.

The provider or provider organization may respond in writing to the preliminary CMIR findings within 30 days after it is released, after which the commission must issue its final CMIR. The final CMIR may identify areas for further review or monitoring, or be referred to other states agencies. For example, the commission must send the final CMIR to the attorney general if it identifies any provider or provider organization that meets the above listed criteria.

While the commission cannot approve or deny a proposed transaction, the law prohibits such a transaction from taking effect until 30 days after the commission issues its final CMIR.

Other Conditions for Conducting a CMIR. The commission may also conduct a CMIR of any provider organization the Center for Health Information and Analysis identifies as having exceeded the state benchmark for health care cost growth in the previous calendar year (Mass. Gen. Laws ch. 6D, § 13).

COMMISSION: GOVERNANCE AND STRUCTURE

The commission is within the state's Executive Office for Administration and Finance, but not subject to that office's control. By law, the commission is not subject to the supervision and control of any other executive office, department, or similar entity (Mass. Gen. Laws ch. 6D, § 2(b)).

Governing Board. The commission is governed by an 11-member board. Table 1 shows the required qualifications for the board and the appointing authorities, as established by statute (Mass. Gen. Laws ch. 6D, § 2(b)). For information on the current board members, see the commission’s [website](#).

Table 1: Massachusetts Health Policy Commission, Board Qualifications

<i>Required Experience/Position</i>	<i>Appointing Authority</i>
Demonstrated expertise in health care delivery, health care management at a senior level, or health care finance and administration, including payment methodologies (this member must serve as commission chairperson)	Governor
Demonstrated expertise in health plan administration and finance	Governor
Primary care physician	Governor
Demonstrated expertise in health care consumer advocacy	Attorney General
Health economist	Attorney General
Expertise in behavioral health, substance use disorder, mental health services, and mental health reimbursement systems	Attorney General
Demonstrated expertise in representing the health care workforce as a labor organization leader	Auditor
Demonstrated expertise as a purchaser of health insurance representing business management or health benefits administration	Auditor
Demonstrated expertise in the development and use of innovative medical technologies and treatments for patient care	Auditor
Secretary for Administration and Finance (or a designee)	Ex officio (the governor appoints the secretary)
Secretary of Health and Human Services (or a designee)	Ex officio (the governor appoints the secretary)

Board members also generally serve on two [standing committees](#) organized around specific topics. The committees include (1) care delivery and payment system transformation, (2) community health care investment and consumer involvement, (3) cost trends and market performance, (4) quality improvement and patient protection, and (5) administration and finance.

Executive Director and Staff. By law, the commission’s [executive director](#) supervises its operations. The board appoints the executive director (Mass. Gen. Laws ch. 6D, § 2(e)).

The commission’s staff is divided into teams. There are two executive teams: the Office of the Chief of Staff and Office of the General Counsel. There are also policy, research, and program development teams in the following areas: (1) accountable

care, (2) market performance, (3) patient protection, (4) research and cost trends, and (5) system performance and strategic investment. The commission's [website](#) has more details about each team's work.

Advisory Council. By law, the commission's executive director must choose an [advisory council](#), to advise on the commission's overall operation and policy. The council's membership must include diverse perspectives on the health care system, including health care professionals and providers; consumers; and representatives of educational institutions, medical device manufacturers, representatives of the biotechnology industry, pharmaceutical manufacturers, provider organizations, labor organizations, and public and private payers (Mass. Gen. Laws ch. 6D, § 4).

COMMISSION FUNDING

Healthcare Payment Reform Fund

The commission is currently funded through the state's Health Care Payment Reform Fund, which the commission administers.

The fund includes 5% of a one-time \$225 million assessment on certain acute hospitals (\$60 million) and surcharge payors (such as insurers) (\$165 million). In general, the hospital assessment applies to hospitals or hospital systems with more than \$1 billion in net assets and less than 50% of revenues from public payers.

The assessment can be paid in four annual installments; the first payment was due June 30, 2013. The law prohibits hospitals or surcharge payors from increasing rates to pay for this assessment ([Chapter 224 of the Acts of 2012](#), § 241).

The Health Care Payment Reform fund also includes 23% of certain one-time licensing fees for casinos and a slots parlor ([Chapter 194 of the Acts of 2011](#), § 93).

Annual Assessment

Starting July 1, 2016, the commission will be funded by an annual assessment on acute hospitals, ambulatory surgical centers (ASCs), and surcharge payors. (Surcharge payors are certain entities or individuals, including HMOs, that make payments to acute hospitals and ambulatory surgical centers for the purchase of health care services.) Generally, the assessment on (1) hospitals and ASCs must be no less than 33% of the commission's appropriated budget and (2) surcharge payors must be no less than 33% of the budget (Mass. Gen. Laws ch. 6D, § 6).

SOURCES AND ADDITIONAL INFORMATION

Massachusetts Health Policy Commission website,
<http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/>, last visited November 7, 2014.

Massachusetts 2011 Session Law, Chapter 194, *An Act Establishing Expanded Gaming in the Commonwealth*,
<https://malegislature.gov/Laws/SessionLaws/Acts/2011/Chapter194>, last visited November 7, 2014.

Massachusetts 2012 Session Law, Chapter 224, *An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation*, <https://malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter224>, last visited November 7, 2014.

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