

June 30, 2017

Remarks by David Seltz, executive director of the Massachusetts Health Policy Commission, as delivered to the Delaware Center for Health Innovation/DHSS Cross-Committee Meeting on Accelerating Payment Reform on June 28 in Dover.

I'm just really excited about the leadership that Delaware is showing in engaging in these big conversations. I really want to echo both of my previous speakers to say we've here to help. We truly are passionate about health care and health care policy and improving our health care systems for the benefit of our residents. And I think we are all true believers that states as laboratories for driving these improvements is really the best way to do this. And so we want to be able to provide any type of information, data, consulting – please, please, please call on us.

I'm impressed with the work that has been done here in Delaware and the momentum that you guys have in terms of really thinking about some of these issues. And so I think part of my goal here today is to inspire you to keep that momentum going and to keep the urgency going on some of these issues. But also to assure you that it's hard. This is hard, hard work, and you are not alone. There are many here who are sharing in the difficult challenges that face our health care system and how to really move forward on this. So, keep it up, but know that you're not alone.

Before I talk a little bit about what's going on in Massachusetts and some of the ways that we've approached some of these same challenges, I do think it's important to give a little bit of context about Massachusetts because it's very different than the previous two speakers [from Maryland and Vermont].

I think if you think about the different approach that we've taken – and the three different states have taken – I think you can think about this as kind a spectrum in terms of regulatory intervention, with a rate-setting commission, an all-payer rate-setting commission being kind of the most regulatory in terms of the role of government, and then kind of moving across this panel to Massachusetts, where we have more of an approach of working with the health care market – working with the private health care market – less of a direct intervention regulatory approach and more of a public-private partnership, but with shared and common goals that we track and we hold ourselves accountable to.

Some very different things about Massachusetts. We had a rate-setting system, like most other states except for Maryland, we deregulated from that rate-setting system a long time ago. We're all small states, but we're a bigger state here. We have 6 and a half million residents in Massachusetts and, in terms of the health care system, I think it was mentioned there are about two ACOs in Vermont. In Massachusetts, we have over 25 organizations who call themselves Accountable Care Organizations. And we have one big dominant health care system that is founded with two very expensive tertiary hospitals, Mass General Hospital and the Brigham & Women's Hospital. Health care is the number one employer in Massachusetts and is

heavily connected to our great research, life sciences and innovation economies as well. So a little bit of a different context.

With Massachusetts, we always have prided ourselves as a state on really pushing the boundaries in terms of health care policy, so we have a long history of adopting state-based reforms to try and improve access, quality and cost. I was working in the state legislature throughout the 2000s and I was there when in 2006, the state – with a broad coalition of employers, consumers, the hospitals, the physicians and the health insurance companies – came together around a plan to ensure access to affordable health insurance for all of our residents. That plan, sometimes referred to as RomneyCare, became in many ways a model for the Affordable Care Act. But after the passage of our reform in 2006, which was and remains to this day highly successful – we have the lowest rate of uninsurance of any state in the country – we really turned our focus to the cost side of this equation because we had made this promise to our residents that they would have access to affordable health insurance and if the costs in the health care system continued to increase at an unsustainable rate, we were very likely to break that promise. And so the public focus after access really shifted towards the cost side.

In 2009, we were a very expensive state in Massachusetts. According to that same data that [Delaware Department of Health and Social Services Secretary] Dr. [Kara Odom] Walker showed before from CMS in comparing different states, in 2009 we were the number one most expensive state on a per capita basis for health care expenditures. And, of course, number one in the United States, which as we all know, the United States is much more expensive than most other developed countries when it comes to health care. So we were as a state one of the most expensive places in the entire world when it came to health care. Some call that a challenge; some call that an opportunity. I'll let you know where we are with some updated numbers a little bit later.

But I think an important contextual thing here is as this policy conversation evolved, it really became about our economic competitiveness as a state. This became a jobs issue for Massachusetts because we were so far and more expensive than other states and growing at such a rate that it was crowding out our ability to make investments across the board. You saw the earlier slide about what happens in state government when the spending on health care goes up. We have that exact same slide in Massachusetts, except we spent 40 percent of our budget on health care, not 25 percent [as Delaware does]. And that limits your ability to make investments in all different types of areas of government.

And the same story is true for employers, who see their premiums and their share of premiums going up year over year. And they're making difficult decisions around, "Do I give wage increases? Do I hire more people? Or do I keep providing a good benefit to my employees?" And, finally, that crowding out for individuals and families, who during this period are getting very small, if any, wage increases and seeing all of that money going in the form of higher deductibles, higher premiums and higher co-pays. So it's crowding out every single part of our economy's ability to make other investments.

All of this is prelude to the reform we passed in 2012, which is an act of improving the quality of health care, reducing costs through increased transparency, efficiency and innovation. What a bill title. And this is our legislative leadership all together signing this big piece of legislation, and hereto again, this is a piece of legislation that the entire stakeholder community came back and said we're committed to this new effort. The hospitals, the health plans, the consumers, the employers, everyone came together around this new bill, which has at its center this idea of a goal. A goal that we can reduce the growth in health care spending to a more sustainable rates.

The law establishes this as a health care cost growth benchmark. And this is really the central and organizing principle of the state's efforts, is to be able to meet this health care cost growth benchmark, which is set basically through a process that is tied to the growth of the overall state's economy, similar to what was mentioned earlier. And, again, that's all about can we make sure that it's not crowding out our economic growth, but still growing, importantly, still growing. We are not talking about cuts in terms of absolute dollars, and so the rate we had set that at, there is a process for updating this, is 3.6 percent annual growth. Importantly, this is an all-in measurement.

This includes Medicaid, it includes commercial health insurance, it includes Medicare, it also includes the out-of-pocket spending that consumers are making. So it includes cost-sharing amounts, such as deductibles and co-payments and the net cost of private health insurance. And the reason you want to have an all-in figure like that is because we know in health care if you're just going to press down in one area, inevitably it's going to pop up someplace else. And we could see a scenario where maybe we were very successful in reducing total health care expenditures, but it came on the backs of consumers in the forms of higher co-pays, deductibles and premiums. And that isn't true health care savings to the system. So we really wanted to have this all-in, and what we call a total health care expenditures measure that we would track over time. So that's the big idea, that's set in law and the Health Policy Commission, which we'll talk a little bit about coming up, is an agency that can hold individual systems, both providers and health plans, accountable to that benchmark if they are excessively growing.

Underneath that big idea of saying all right, let's try to meet this health care cost growth benchmark is a number of sub-strategies and they are all strategies that we have been talking about and that you have been working on and that need to work together. So one is transforming the way that care is being delivered in the health care system, moving toward a more integrated and coordinated health care system that's team-based, has strong primary care, that shares information seamlessly across settings in order to reduce waste and avoidable utilization.

Changing the way that we pay for care, obviously, a big focus of the conversation here today, if we change those financial incentives, suddenly that rewards providers for doing the right thing, for improving health outcomes and for making sure that their patients aren't showing up in the

most expensive settings and receiving the most expensive care. So here, too, we're moving towards more global budgets, which we think really unlock that financial incentive to moving in the right direction. Developing a value-based health care market, as I mentioned earlier, we do not rate set. We still rely on private negotiations, confidential negotiations, between health plans and providers to set commercial rates. And what we know in Massachusetts is that there is a lot of variation in where those commercial rates are set for different providers, for the exact same service, and the rates that are being provided are not necessarily related to the quality or value of the care that's being delivered, but more to the market leverage of those institutions to be able to extract higher prices from the insurance companies that they negotiate with. So if we are going to rely on the market, we need to make the market work better or to ensure that it's truly delivering value.

And then, finally, our final strategy here is engaging purchasers and here, purchasers is really meant to mean both consumers and employers. Give them information about price and quality, in new ways, engage them in decisions ranging from what type of health plan they choose, to what type of primary care doctor they choose, where they seek their care. But give them information incentives to have them be a part of this transformation effort as well. And in order to be able to make all of this work for a more transparent and affordable health care system in Massachusetts.

A little bit about some other things that this law did. The law set up basically two new state agencies. One agency was an agency that existed before, but got a brand new name. This is the Center for Health Information Analysis, or CHIA. So this was an agency that previously existed, but got a new name and little bit of an updated mandate. Really, this is our data hub. This is the state's place where we are collecting information, objective information, about the performance of our health care system. We have an all-payer claims database, extremely powerful data source, we collect and report of a wide variety of information about the utilization, the price and the performance of our health care system. And CHIA is also in development of making some of this kind of cost and quality information available to consumers through a searchable website, thinking about a shop-able health initiative.

And the other state agency that was created is the Health Policy Commission, which I am the Executive Director of. This was a brand new agency. I was the first employee of said agency and so it was both a startup and a government agency all in the same. This is really the policy hub. This is the place where we think about and promote the policies that I talked about in those four strategies that will allow us to make sure that we hit the benchmark. We set the benchmark through the commission's process, we hold annual hearings where we can call witnesses, hospital CEOs, and health plan CEOs to testify under oath around what they are doing to ensure that we meet the benchmark. We do have this ability to require certain entities to take kind of remedial action if they're growing at too fast a rate. And it has some other programs and I'll talk a little bit more in depth about.

This is our kind of who we are, mission and vision. There's a lot of text [on the slide], so I'm not going through all this, except to highlight one thing in our mission, which is the second line here, which is, "HPC's goal is better health and better care at a lower cost." And it's really important for us to combine these three different ideas and that our mission not just be around lowering cost. We can think about many ways that we could get a lot of spending out of our health care system. The best way to cut spending is to cut. But we also know that that would be counter to our values as a state. So it really is around how can we lower costs though improving both the health and the care that's being delivered through our health care system?

A little bit about our structure. We are an independent state agency. I report to a board. The board is appointed by the governor, the attorney general, and the state auditor, who are all independently constitutional officers elected. Each of these different state officials has a number of appointments to the board. The appointments are in different areas of expertise relevant to the mission of the organization. You can see they will have a primary care physician, we'll have someone who is a health economist, a behavioral health expert, a consumer advocate, a waiver or workforce spot as well.

One important note about how this was designed, was that there was very strong language written into the legislation around ensuring that none of these appointees had a financial stake or incentive in our health care system. The reason that that was put in place is that we really wanted to have appointees who were there because of their expertise, not because they were there to represent one specific interest.

What this allowed us to do is to get out of what we had seen from some other commissions, is that everyone is there to play defense and everyone is there representing the hospitals, representing the health plans, and we're here just to make sure that nothing bad happens to us. And our role on said board is to just make sure that we can protect the status quo, in some cases, as much as possible. And so, what this has allowed, this financial conflict has allowed, for people who are really there because of their expertise and understanding of how health insurance works, how well the health care system works, who are also interested in moving forward with the overall mission of the organization. We do have, of course, ties to the governor and the administration through ex-officio appointments of the Secretary of Health and Human Services, as well as the Secretary of Administration and Finance. These are all staggered terms, such that it won't roll over depending on a specific election. Again, attempting to get some stability and political inflection over time for the commission to be able to do its work.

This is the kind of strategies that we deploy to drive our mission and to drive the state's ability to meet the benchmark. One is our research and reporting. We have an amazing staff that has and takes that great data from CHIA and puts out incredible reports clearly identifying where are those opportunities to get some savings out the of health care system and to make sure that we're publically putting this information out and, in some cases, using that to help the market to be able to make progress.

More convener. We know and have learned that for many organizations they do not view the government agency as being the best voice in terms of telling them how to transform and change their health care delivery system. So what we found is more effective is being in a place where we can bring people together and bring the best experts together so it's not necessarily us, government, we know best, but really a place where we can engage the best minds and the best thinking to identify what some of those solutions could be. We're a partner, so we work directly with provider organizations and health plans through some grant programs, some investment programs, actually seeding money into the health care system and working together to meet some of these goals.

And then, finally, we're a little bit of a watchdog, which is to say we also will identify things we think are truly areas for potential negative action in the health care market or health care spending and to highlight those organizations that are contributing to the excessive cost growth or that are engaging in market activity that is counter to our overall goals.

Just so you have a good sense of kind of our footprint, we have about 55 FTEs now as a state agency goes, and our annual operating budget is around \$8.5 million and those costs are annually assessed to hospitals, surgery centers and health plans such as we are kind of budget neutral to the state.

So these are our big four main responsibilities that align with kind of those strategies I mentioned before:

- Monitoring system transformation and cost-drivers.
- Making investments.
- Promoting a more efficient delivery system.
- And then, finally, where there are changes that are occurring in our health care market, how can we ensure that they are happening in the best interest of the consumers and businesses that bear the cost of our health care system?

So I'll take these quickly in turn and then I'll sit down and we can engage in more conversation.

First of all, how have we done in terms of our effort here? This [slide] is all total health care expenditures, basically Massachusetts versus the United States. The U.S. is the blue line; Massachusetts is the kind of goldish line here. And you can see that since 2009, which what I said is our high-water mark, we have been about at or below the nation when it comes to total health care spending growth. And as you can see that's a big change from where we were throughout the 2000s, where we were very consistently much higher spending growth than the country. So, great that we have been at or below, but also a big change from the previous decade.

I mentioned earlier that we were number one in that 2009 data. Well, the new data just came out I think last week. So 2014 data has come out. And great news. We're no longer number one. We're number two. In 2009, I looked this up, Delaware was number five and now you guys

are number three in terms of that most updated number. So we're number two and number three. We can figure this out together. But, importantly, from 2009 to 2014, when it comes to spending growth, Massachusetts was 46th in the country. We had the fourth-lowest spending growth of all states in the country during that period of time and Delaware had the seventh-highest spending growth during that period of time. So we were able to bring our spending growth down over the last couple of years and that has allowed for more of a convergence between us and the United States. All of this to say, still a lot of tremendous work to be done and some significant challenges that remain.

This is just on the commercial spending growth, which is something that we look at a lot as well. And here you can see even a more significant divergence between Massachusetts and the United States in terms of commercial spending growth during this period of time. Good news, we are still number five most expensive when it comes to commercial health insurance of any state in the country.

So I mentioned that we have this 3.6 percent benchmark. So how have we done in terms of performance against this benchmark? Well we've measured ourselves over three years and you can see 2.4 percent in 2013, 4.2 percent in 2014 and 4.1 percent in 2015. So, yes, we did exceed the benchmark on the last two years of performance but I always like to do this average growth rate 3.57 percent. Take it to that extra decimal point so you can see that we've been pretty much in line with the benchmark over this period of time.

Importantly, there were other contextual things going on. In 2014 and 2015, in particular, we had very high growth in pharmacy expenditures. I think about 13 percent growth in 2014 and about 8 or 9 percent growth in 2015. So, if pharmaceuticals had grown at the say 3.6 percent benchmark, then we would have hit the benchmark in all three years. So pharmacy is a particular challenge right now.

The next thing that we do is we do make investments directly into our health care system. We have a grant program that is specifically for community hospitals. I will put this slide up, but not talk through it too much other than to say community hospitals provide a lot of value to our health care system. We think they are a big part of the solution. They face a lot of very unique challenges and have seen a lot of that routine care in Massachusetts go to our more expensive academic medical centers. So we've had grant programs in place to try to work with our community hospitals and many of the things that those grants are doing are exactly the same things that [we were] talking about earlier.

We're actually designing a grant program where we are giving money to hospitals to help them reduce their hospital utilization. So reduce readmissions, reduce avoidable EDUs, reduce avoidable admissions. And it's a really interesting grant project because when we go and talk to these hospitals and we say, we talk to their chief medical officer or their director for population health, they say, "This grant is amazing. It has unlocked our potential to do so much in terms of getting the patients out of the hospital, back into the community and the supports they need in

the community so that they're not returning to the hospital. We are able to use community health workers in ways that are just truly dramatic and really bringing the care to where the patients are. And these are really vulnerable, high-cost patients. Multiple ED visits in a month. Lots of readmissions. Huge behavioral health needs. Social needs. And we're bringing that care to them. This is an amazing program."

And then I talk to the CFO, and the CFO says, "Yeah, this is all great and good, but I'm losing money because of this program. We're losing revenue because we count on revenue from people showing up in the hospital."

And so we in Massachusetts are still in this place of on one hand and on the other hand. There are so many different metaphors that are used in terms of, feet in canoes, whatever it may be. It's the fee-for-service world on one hand and the new global budget world and reform payment world on the other hand. And when the CFO is thinking about heads in beds and I need to get people in there, that's the fee-for-service world. When the population health director is talking about building connections with schools, with law enforcement, to try to provide care outside of the four walls of that hospital, that's the global budget world. We're still stuck in the middle in Massachusetts but we are driving very hard to try to get to that other side and to make sure that everyone is really in that population health side of the world.

The next thing that we do is really on that care delivery side in kind of promoting models that we think will be truly effective in meeting these goals. And so we have two kind of recognition and certification programs that we've established. One is for patient-centered medical homes. That has a specific component to it where we're really focused on behavioral health integration into primary care as a setting of care. And the second is around certifying ACOs. Everyone I think probably has a very different idea of what it means to be an Accountable Care Organization. Many people call themselves Accountable Care Organizations, but they're providing care in the exact same way that they were yesterday. And so we would now have a standard in Massachusetts where we say, "We're going to actually certify you as an ACO, and test and understand what are you actually doing differently that is consistent with that more coordinated, value-based health care delivery system?" Both of these programs are technically voluntary, although I would say in the case of the ACO program, our state's Medicaid program has made that a requirement to participate in their next model of payment reform. So that is kind of direct linkage. Also importantly, this is all payer. Both of these programs are all-payer certification programs. And I think you've heard from all of us a testament to all-payer approaches to this work.

And then, finally, the last thing that we do, which may not be as directly relevant to Delaware, is that we do know that the way our health care market is organized can have a significant impact on the delivery, the cost and the access to care. And so we know that consolidations are occurring at an extremely rapid pace across the country in terms of both hospital and physician consolidations. And so we have established through us a new process where organizations that are seeking to merge, or consolidate or create new relationships have to go through a review

process by us, which will test and kind of evaluate what the cost, quality and access impacts of said proposed transaction would be. It's different than a determination of need process which traditionally just looks at kind of access issues or capital expenditures. This really is around kind of market consolidation. We don't have the ability to deny at the end of the day, but we do bring public transparency to those transactions. And through that, we have found that it has changed market behavior. Even shining a spotlight can change market behavior and asking questions, "Why is this in the interest of the public to pursue this new relationship?" And we're then holding the providers' in our market feet to the fire and holding them accountable to making sure those promises are actually delivered upon.

So with that, I'll conclude my remarks. Again, happy to make connections with you. Really, if I couldn't say it enough at the beginning, I encourage you to keep moving and to keep going on this path and journey that you're on. Maryland, Vermont and Massachusetts -- I get invited to a lot of different panels across the country with the three of us all together. It would be great to have a fourth at this table. Delaware, I feel like you could do it. One of my favorite quotes, which is from Franklin Roosevelt. "It is common sense to take a method and try it. If it fails, admit it frankly and try another. But above all, try something."

Thank you very much.

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NOTE: Watch the video of David Seltz's remarks on DHSS' YouTube page:

<https://www.youtube.com/watch?v=Skp7I9RoRvA>