



## A GLOSSARY OF COST CONTAINMENT TERMS

*As required by Chapter 224 of the Acts of 2012, by October 1 each year, the Health Policy Commission (HPC) must hold public hearings based on the [Annual Report on the Massachusetts Health Care Market](#) produced by the Center for Health Information and Analysis (CHIA). The 2013 Cost Trends Hearings took place on October 1 and 2, 2013. ([Click here](#) for more information.) These hearings examined health care cost growth and the underlying factors, relied on a number of witnesses (including providers and payers) who were compelled to provide testimony under oath, and will inform the HPC's annual end-of-year cost trends report as well as its future work. Below are some of the key terms necessary to understand how health care cost growth will be discussed and measured in the upcoming years in the Commonwealth.*

### **Health Policy Commission (HPC)**

Created by Chapter 224, this independent state agency is charged with implementing major provisions of Chapter 224, including establishing a cost growth benchmark, monitoring cost containment progress through annual hearings, registering provider organizations, reviewing certain changes to provider organizations, certifying Accountable Care Organizations (ACOs) and Patient Centered Medical Homes (PCMHs), and administering the Healthcare Payment Reform Fund and other investments in the health care community. The HPC is governed by an 11-member board appointed by the Governor, the Attorney General, and the Auditor, and is chaired by Dr. Stuart Altman of Brandeis University.

### **Center for Health Information and Analysis (CHIA)**

CHIA is an independent state agency created by Chapter 224. CHIA's responsibilities include compiling an annual report on the health care market, managing the All-Payer Claims Database, monitoring the performance and financial stability of hospitals and health plans, and analyzing Total Medical Expenses (TME), Relative Prices (RP), and Total Health Care Expenditures (THCE). CHIA is tasked with additional data collection responsibilities as well as managing a consumer health information website, housing the Betsy Lehman Center for Patient Safety and Medical Error Reduction (previously located in the Department of Public Health), and developing a Standard Quality Measure Set. CHIA assumed many of the responsibilities of the former Division of Health Care Finance and Policy (DHCFP).

### **Total Medical Expenses (TME)**

TME measures the total health spending for a defined population on a per member per month basis. TME includes all payments made by insurers to providers, including both claims-based payments and other payments, such as performance bonuses, shared savings, infrastructure payments, and other adjustments. TME also includes payments made by patients to providers for covered services, such as deductibles, cost-sharing, and co-payments. TME is often adjusted for patient health status within each specific payer's data to account for providers that care for sicker populations.

TME is only one component of THCE. To date, CHIA has reported data and trends only for commercial insurers. (See [this 2009 Baseline Report](#) for 2009 TME data and this [2013 Annual Report on the Massachusetts Health Care Market](#) for 2010 and 2011 TME data.)

### **Total Health Care Expenditures (THCE)**

Total Health Care Expenditures (THCE) is the per capita cost figure that will be used to determine if the state is meeting the cost growth benchmark. The law defines THCE as the total per capita sum of public and private health care expenditures, including non-claims payments and patient cost sharing amounts, and the net cost of private health insurance. The state has never calculated THCE before, but is planning to publish a draft THCE calculation methodology by December 2013. Therefore, it is not entirely known how THCE will be calculated.

Beginning in calendar year 2015, if CHIA finds that growth in THCE in the previous year exceeded the cost growth benchmark for that year, the HPC can require certain health care entities to file a “performance improvement plan” with the goal of reducing cost growth.

### **Growth Rate of Potential Gross State Product (PGSP) and How It Relates to the Cost Growth Benchmark**

Potential gross state product is the value of the state’s economy, excluding fluctuations due to the business cycle. The growth rate of PGSP represents a more stable measure of economic growth than actual GSP, which can fluctuate from year to year with short-term economic conditions.

In the context of Chapter 224, the “health care cost growth benchmark” is pegged to the growth rate of PGSP (see table below). Chapter 224 set the growth rate of PGSP and the cost growth benchmark at 3.6 per cent for calendar year 2013. By January 15 of each year, the Secretary of the Executive Office for Administration and Finance and the House and Senate Ways and Means Committees must jointly forecast the growth rate of PGSP for the upcoming calendar year. By April 15 of each year, the HPC must set the cost growth benchmark (which in the initial years may just mean formally accepting the forecasted growth rate of PGSP).

*The State Cost Growth Benchmark as a Measure of the Growth Rate of PGSP*

<b>Calendar Years</b>	<b>Health Care Cost Growth Benchmark</b>
2013 – 2017	Growth Rate of Potential Gross State Product (PGSP)
2018 – 2022	Growth Rate of PGSP – 0.5% (can be modified up to PGSP)
2023 and beyond	Growth Rate of PGSP (can be modified to any figure)

### **Alternative Payment Methodologies (APMs)**

APMs are any kind of payment from an insurer to a provider or provider organization that is not solely based on fee-for-service. APMs are intended to promote higher quality, lower cost care in comparison to fee-for-service payments that promote higher quantities of care. There are many different types of APMs, including bundled payments, global payments, and shared savings, all of which – to some degree – reward patient-centered, coordinated care and positive health outcomes.

In an effort to tame health care costs, Chapter 224 requires that the Commonwealth Health Insurance Connector, the Group Insurance Commission, and the Office of Medicaid implement APMs to the maximum extent possible. (The law requires that 80 per cent of MassHealth members are enrolled in APM contracts by July 1, 2015.) Private health plans are also required, to the maximum extent possible, to reduce use of fee-for-service payments.

### **Risk-Bearing Provider Organizations**

Risk-bearing provider organizations are those that assume financial risk through APM contracts with insurers. Such financial risk allows provider organizations to share in savings (or losses) associated with

reduced total health care spending and higher quality of care. Chapter 224 requires that all risk-bearing provider organizations apply for a risk certificate through the Division of Insurance (DOI) pursuant to regulations in development. The purpose of this process is to annually demonstrate that the financial risk that these organizations are assuming doesn't threaten their financial solvency. This requirement will take effect in 2014, as the state has [declared](#) November 4, 2012 (the effective date of Chapter 224) through December 31, 2013 as a Transition Period.

### **Registered Provider Organizations (RPOs)**

A Registered Provider Organization is a risk-bearing provider organization (as defined by DOI), or any provider or provider organization with a patient panel greater than 15,000 and which represents providers who collectively receive \$25 million or more in annual net patient service revenue from carriers or third-party administrators. RPOs are required to register with the HPC and to submit a series of operational, financial, and structural elements to the HPC and to CHIA. Requiring that RPOs register with the HPC enhances transparency of the health care marketplace in the Commonwealth by gathering information on the composition, structure, and relationships among and within Massachusetts health care providers. It is hoped that this information will allow the HPC to better understand and monitor the provider delivery system, including clinical affiliations, capacity, and market share, as well as support such functions as health resource planning, determination of need, cost and market impact reviews, evaluation of health care cost trends, health system investments, and certification programs.

### **Cost and Market Impact Reviews (CMIRs)**

The HPC can conduct CMIRs if it determines that a material change in the structure (merger or acquisition, for example) of a health system or provider organization is likely to significantly impact the competitive market or the state's ability to meet the cost growth benchmark. The HPC must refer to the Attorney General (AG) any entity that meets the following three criteria: 1) has a dominant share for the services it provides; 2) charges prices for services that are higher than the median prices charged by all other providers, and 3) has TME that are higher than the median for all other providers. The AG has the power to conduct further investigations and take action to protect consumers.

### **Accountable Care Organizations (ACOs)**

Generally, ACOs are organizations of health care providers formed with the goal of providing high quality, efficient, coordinated health care to a defined population. The term "ACO" is defined differently based on the certifying entity or organization. CMS has specific requirements for ACOs that provide care for Medicare patients. However, the ACO model can be used to provide coordinated care to other populations as well. Chapter 224 requires that the HPC certify ACOs, and that a registered ACO must use alternative payment methodologies, provide medical and behavioral health services across the continuum, and allow for health care price transparency, among other requirements. Registration will be voluntary and will last for two years.

### **Patient-Centered Medical Homes (PCMHs)**

The PCMH model is an approach to providing comprehensive care that relies on a primary care provider to coordinate a patient's care among different providers. It promotes a patient-centered approach and demonstrates a commitment to high quality, safe, accessible care. Under Chapter 224, the HPC – in collaboration with the Office of Medicaid – must develop and implement standards for certifying PCMHs along with a model payment system for PCMHs and a PCMH training program in 2014. The National Committee for Quality Assurance (NCQA) has a well-respected national Patient-Centered Medical Home Recognition program, which the HPC will take into account as it develops its process.