MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

February 15, 2023

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

Research Presentation: Emergency Ground Ambulance Utilization and Payment Rates in Massachusetts

Assessing and Addressing Drug Prices in Massachusetts

Schedule of Upcoming Meetings

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

Research Presentation: Emergency Ground Ambulance Utilization and Payment Rates in Massachusetts

Assessing and Addressing Drug Prices in Massachusetts

Schedule of Upcoming Meetings

VOTE

Approval of Minutes

MOTION

That the Members hereby approve the minutes of the Committee meeting held on **October 12, 2022**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

RESEARCH PRESENTATION: EMERGENCY GROUND AMBULANCE UTILIZATION AND PAYMENT RATES IN MASSACHUSETTS

Assessing and Addressing Drug Prices in Massachusetts

Schedule of Upcoming Meetings

Presentation Outline

1. **Introduction**
2. Ground Ambulance Landscape in Massachusetts
3. Commercial Payment for Ambulance Services
4. Other Payment Approaches
5. Conclusion

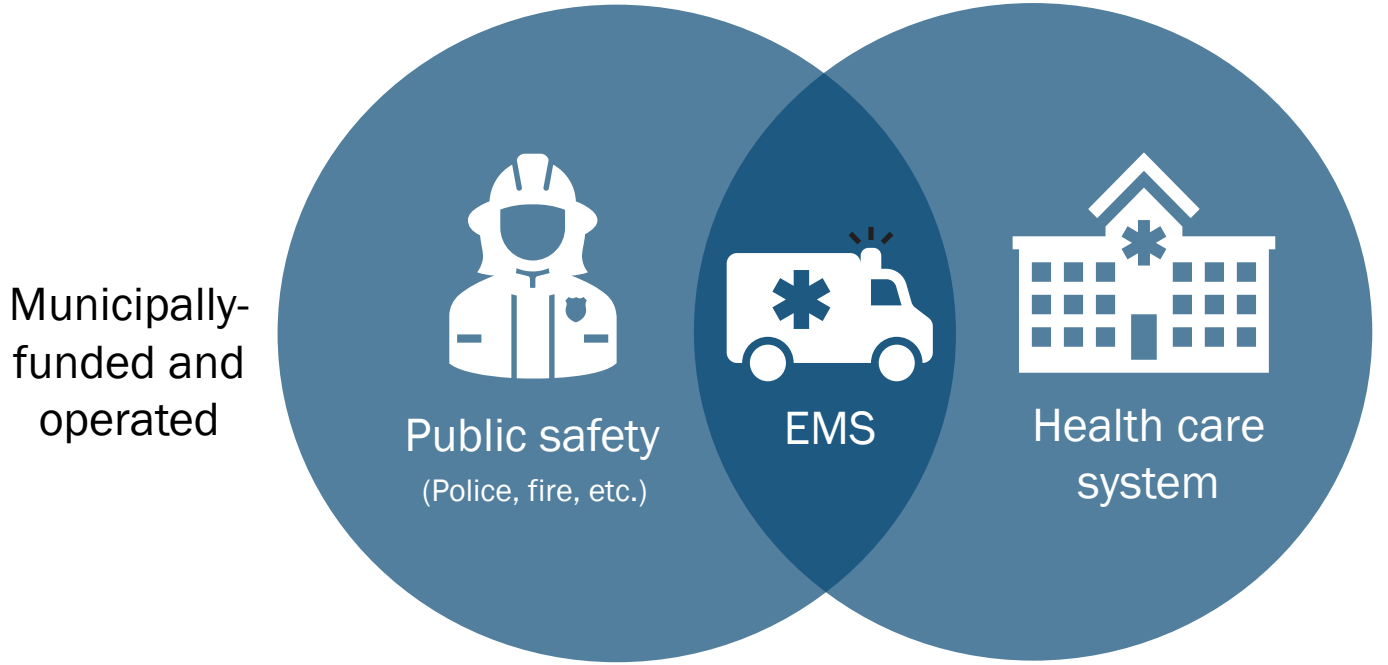
Emergency medical services (EMS) bridge public safety and health care systems and reflect characteristics of both.

EMS IN MASSACHUSETTS

EMS is the pre-hospital assessment, treatment and other services utilized in responding to an emergency or provided during the emergency.[1] In 2020, there were 1.6 million EMS patient transports in Massachusetts.[2]

In Massachusetts, EMS is regulated by the Office of Emergency Medical Services (OEMS) of the Department of Public Health, which also certifies EMS personnel and licenses ambulance services in the Commonwealth.

Each local jurisdiction in the Commonwealth must designate a primary ambulance service to provide EMS services.[3] As described in more detail later in the chartpack, ambulance service providers may be publicly-owned (e.g., provided by a municipality's fire department, or other department) or privately-owned (e.g., a for-profit or not-for-profit entity).



(1) 105 CMR 170.000: *Emergency Medical Services System*
(2) National Association of State EMS Officials. 2020 National Emergency Medical Services Assessment. May 27, 2020. Available at: https://www.ems.gov/pdf/National_EMS_Assessment_2020.pdf
(3) M.G.L. c. 111C, § 10; 105 CMR 170.510

Ambulance Services

Ambulances are vehicles used in the provision of EMS. Based on the level of intervention provided, ambulance services may be broadly categorized into three distinct categories:

- **Basic Life Support (BLS)**
  - Interventions that do not puncture the skin, such as cardiopulmonary resuscitation (CPR), burn care, spinal immobilization, splinting, and wound care.[1]
- **Advanced Life Support (ALS)**
  - Interventions that puncture the skin or are otherwise more invasive or complex, such as intravenous medication administration, nasotracheal intubation, needle decompression, and manual defibrillation.[2]
- **Critical Care Transport**
  - Transport of a critically ill or injured patient using medical techniques, pharmacology, and technological life support systems that exceed those in the Statewide EMS Treatment Protocols, including the ALS Interfacility Transfer Protocol.[3]

BLS and ALS transports may be further subdivided into emergency and non-emergency categories.

(1) Massachusetts Office of Emergency Medical Services, Department of Public Health. Emergency Medical Services Pre-Hospital Statewide Treatment Protocols. Official Version 2022.1. June 1, 2022. Available at: https://www.mass.gov/doc/emergency-medical-services-statewide-treatment-protocols-version-20221-effective-june-1-2022/download
(2) Ibid.
(3) 105 CMR 170.000: *Emergency Medical Services System*

Out-of-Network or "Surprise Billing"

Out-of-network billing issues **may particularly arise for ambulance services** because patients do not have the ability to choose an ambulance provider in their insurer's network. [1]

If the ambulance provider is not in the patient's network, the patient's insurer has **no agreed-upon rate** to pay the ambulance provider and may pay up to full charges. While difficult to determine how frequently it occurs, this may lead to a **"surprise bill"** for the patient, in which the ambulance provider expects the patient to pay the full difference between what the ambulance provider charges, and what it was paid by the patient's insurer (i.e., "**balance billing**").

As referenced on the next slide, out-of-network or surprise billing in Massachusetts has been an area of continued policy interest for the Health Policy Commission (HPC)[2,3,4].

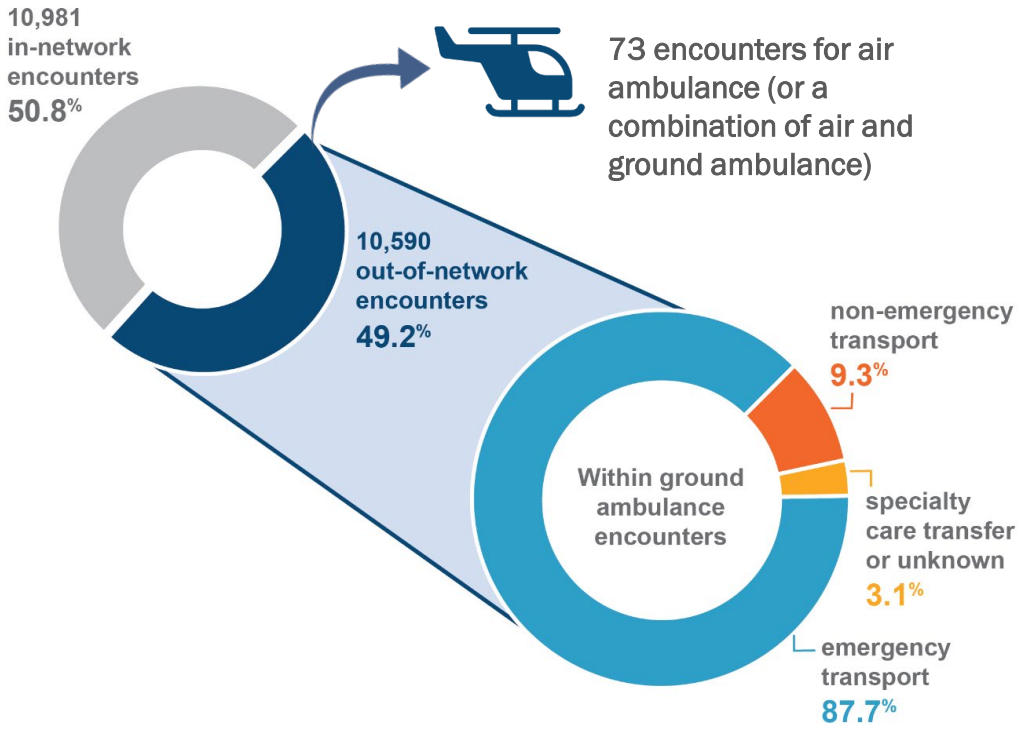
(1) U.S. Public Interest Research Group (PIRG). Emergency: The High Cost of Ambulance Surprise Bills. December 2022. Available at: https://publicinterestnetwork.org/wp-content/uploads/2022/12/EMERGENCY-The-high-cost-of-ambulance-surprise-bills-USPIRG-Education-Fund-December-2022-Final.pdf
(2) Massachusetts Health Policy Commission. Out-of-Network Billing in Massachusetts. May 2020. Available at: https://www.mass.gov/doc/out-of-network-billing-in-massachusetts-chartpack/download
(3) Massachusetts Health Policy Commission. HPC DataPoints, Issue 14: The Price is Right? Variation in Potential Out-of-Network Provider Payment Benchmarks. August 2019. Available at: https://www.mass.gov/info-details/hpc-datapoints-issue-14-the-price-is-right-variation-in-potential-out-of-network-provider-payment-benchmarks
(4) Massachusetts Health Policy Commission. Policy Brief on Out-of-Network Billing. January 2016. Available at: https://www.mass.gov/files/documents/2016/07/xu/2015-ctr-out-of-network.pdf

Ground Ambulance and Potential Surprise Billing

At the federal level, the No Surprises Act took effect on January 1, 2022, and protects individuals from receiving surprise medical bills when they receive most emergency services, including services from out-of-network air ambulance service providers. However, ground ambulance services were excluded from these billing protections. In light of this exclusion, recent work has sought to examine the prevalence of potential surprise billing for ground ambulance transports nationally.[1]

The HPC has previously reported on out-of-network billing in the context of ambulance transports and found that nearly half of ambulance encounters in 2017 resulted in at least one one-of-network claim. In the absence of protections, potential surprise billing for emergency ground ambulance transports continues to impact commercially-insured Massachusetts residents.[1,2]

Out-of-Network Claims for Ambulance-Based Services, 2017



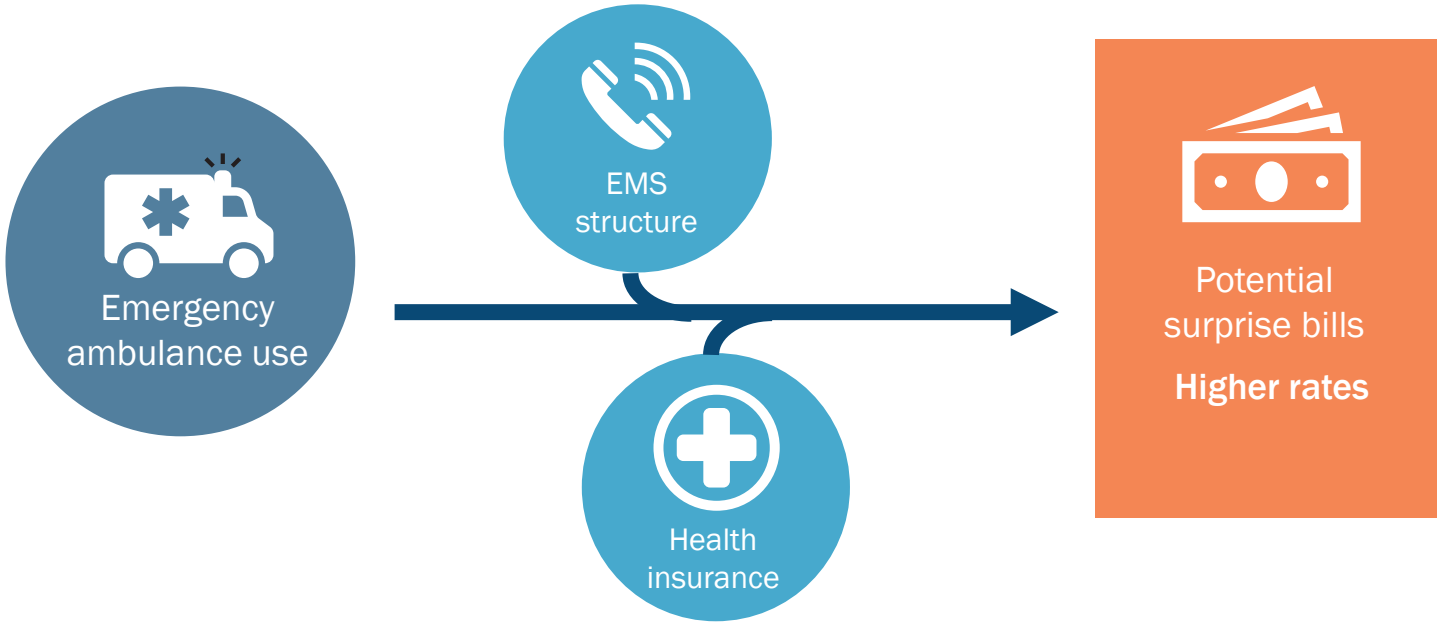
(1) Adler L, Ly B, Duffy E, Hannick K, Hall M, Trish E. Ground Ambulance Billing and Prices Differ by Ownership Structure. Health Affairs. January 18, 2023. Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00738?journalCode=hlthaff
(2) Murphy SP. An Ambulance Bill Could Make You Sick. The Boston Globe. October 14, 2021. Available at: https://www.bostonglobe.com/2021/10/14/business/an-ambulance-bill-could-make-you-sick/
(3) Fraser D. Cape Cod Ambulance Fees Take Patients by Surprise. Cape Cod Times. August 1, 2020. Available at: https://www.capecodtimes.com/story/special/special-sections/2020/08/01/cape-cod-ambulance-fees-take-patients-by-surprise/114063410/

Data notes: Ambulance claims were identified using a combination of site of service codes and CMS' Healthcare Common Procedure Coding System (HCPCS) codes. Each ambulance encounter includes charges for activation (e.g., advance life support or basic life support), mileage, and any other supplies or services provided (e.g., IV therapy). Includes claims from three large Massachusetts commercial payers that had an out-of-network indicator well-populated for the majority of their claims: Tufts Health Plan, Neighborhood Health Plan (now AllWays), and Anthem.
Data sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, v7.0 for 2017.

Characteristics of the Ground Ambulance Landscape

In addition to the potential for surprise billing, differences in the structure of EMS (i.e., what type of ambulance service responds to 9-1-1 calls) between individual municipalities may additionally contribute to the existence of higher rates for emergency ambulance services.

This publication seeks to explore this additional dimension of emergency ground ambulance use among commercially-insured patients in the Commonwealth by examining payment rates for transports by the type of ambulance service that responded.



The aim of this report is to build upon prior research to develop a more comprehensive understanding of the emergency ground ambulance landscape in the Commonwealth.

AIMS

- Characterize emergency ground ambulance use among commercially-insured members in the Commonwealth, regardless of out-of-network status, including:
  - Utilization rates of BLS Emergency and ALS 1 Emergency services
  - Charges and total paid amounts for BLS Emergency and ALS 1 Emergency ambulance services
  - Use of municipally-operated versus privately-owned ambulance services
- To the extent possible, compare commercial ground ambulance payment rates to those of other payers (i.e., MassHealth and Medicare) and states

METHODS

- Data: Massachusetts All-Payer Claims Database v10 , 2017-2020
- Examined ambulance encounters (same member, same date) and excluded round-trip ambulance encounters and ambulance encounters with non-Massachusetts ambulance companies
- Other notes: Encounters are those with a ground mileage procedure code (A0425) claim line and a transport type procedure code (A0426, A0427, A0428, A0429, or A0433) claim line. This study does not account for potential balance billing.

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Ambulance Staffing in Massachusetts

In Massachusetts, OEMS licenses ambulance services at the BLS, ALS (Advanced and Paramedic), and critical care service levels. Ambulances may be staffed by EMS first responders (EFRs) and emergency medical technicians (EMTs). EMTs are further classified into the categories of EMT-Basic, Advanced EMT, and Paramedic.[1] The different categories of EMTs differ in the amount of training required, and, consequently, in the interventions that they are qualified to perform.

Prior to the onset of the COVID-19 pandemic, ambulances operating at the BLS and ALS level in Massachusetts were required to be staffed with at least two EMTs, with BLS transports requiring staff certified at the EMT-Basic level and ALS transports requiring at least one staff certified at the EMT-Advanced or EMT-Paramedic levels, dependent on the type of ALS transport.[2] In March 2020, in order to ensure sufficient staffing during the public health emergency, DPH allowed ambulances at the BLS and ALS levels to be staffed with one EMT at the ambulance transport level, who would provide patient care, and one first responder, who would drive the vehicle.[3] This change in regards to BLS transports was made permanent, effective January 6th, 2023.

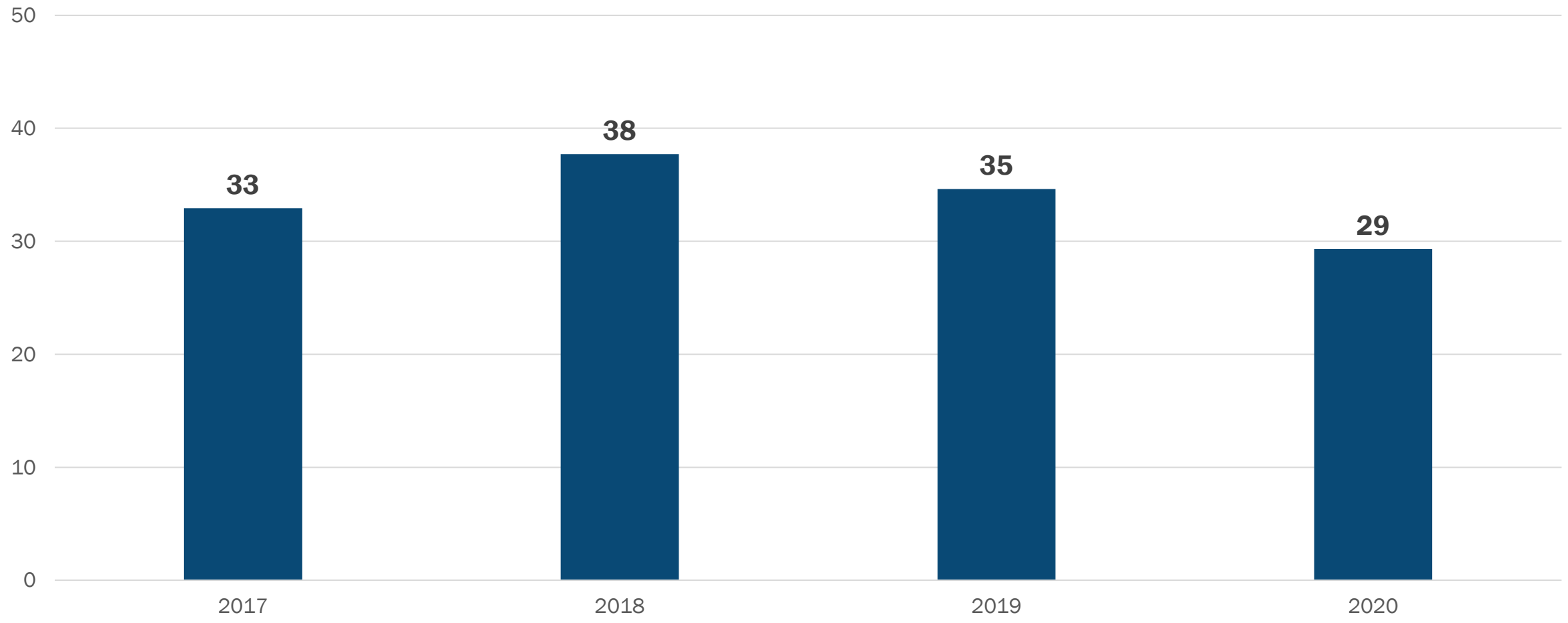
STAFFING CHALLENGES

EMS staffing challenges have been reported in Massachusetts[4] and nationally. Nationally, wages, work-life balance, and burnout have been reported as factors in EMS staffing turnover.[5] To address EMS staffing challenges, other states are considering policy options including adjusting licensure and certification requirements, expanding recruiting and retention efforts, and addressing burnout and safety concerns.[6]

(1) 105 CMR 170.000: *Emergency Medical Services System*
(2) Ibid.
(3) Order to the Commissioner of Public Health Providing for Continuity of Emergency Medical Services Care. March 17, 2020. Available at: https://www.mass.gov/doc/march-17-2020-ems-care-order/download
(4) Bebinger, M. Hospitals and Nursing Homes Frustrated by Ambulance Staffing Shortage. WBUR. November 21, 2021. Available at: https://www.wbur.org/news/2021/11/24/ambulance-staffing-shortage-massachusetts
(5) Mercer, M. States Strive to Reverse Shortage of Paramedics, EMTs. The Pew Charitable Trusts. February 6, 2023. Available at: https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2023/02/06/states-strive-to-reverse-shortage-of-paramedics-emts
(6) George K, Sweeney S. State Actions to Address EMS Workforce Shortages. National Conference of State Legislatures. July 27, 2022. Available at: https://www.ncsl.org/health/state-actions-to-address-ems-workforce-shortages

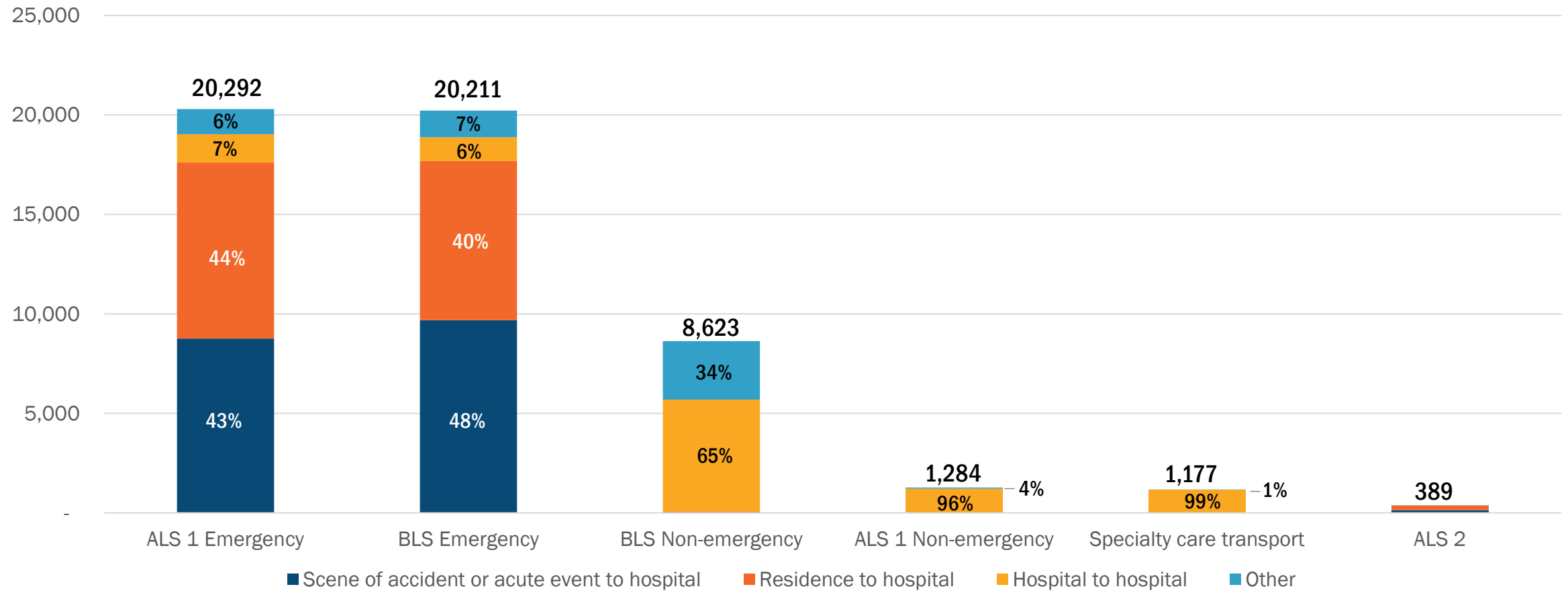
Between 2017 and 2019, there were between 33 and 38 ambulance transports per year per 1,000 commercially-insured members, with fewer transports in 2020.

Number of ambulance encounters among commercially-insured patients per 1,000 member-years, 2017 to 2020



Notes: Includes the following transport types: ALS 1 Non-emergency, ALS 1 Emergency, BLS Non-emergency, BLS Emergency, ALS 2, and specialty care transport. Member-years by year: 1,638,560 in 2017, 1,598,429 in 2018, 1,501,434 in 2019, and 1,407,052 in 2020.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020

Number of ambulance encounters by transport type and origin and destination points among commercially-insured patients by transport type, 2019



Notes: Percentages less than 1% and volumes less than 11 were omitted from the exhibit. Transport types were identified using procedure codes A0426 (ALS 1 Non-emergency), A0427 (ALS 1 Emergency), A0428 (BLS Non-emergency), A0429 (BLS Emergency), A0433 (ALS 2), and A0434 (Specialty Care Transport). Origin and destination points identified using the following procedure modifier codes: "H" for hospital, "R" for residence, and "S" for scene of accident or acute event. The "Specialty Care Transport" category includes ambulance transports that may not be defined as "Critical Care Transports" by the MA DPH OEMS.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020.

Ambulance Service Ownership Structure

In Massachusetts, ambulance services are provided by both publicly and privately owned entities, with privately-owned entities being either for-profit or not-for-profit.

- **Publicly-owned ambulance services** are generally municipal entities and are commonly associated with fire departments, although some are standalone, non-fire entities that are categorized as a "third service" (e.g., Boston EMS, Fall River EMS). Two ambulance services in the Commonwealth are operated by their town's police department.[1]

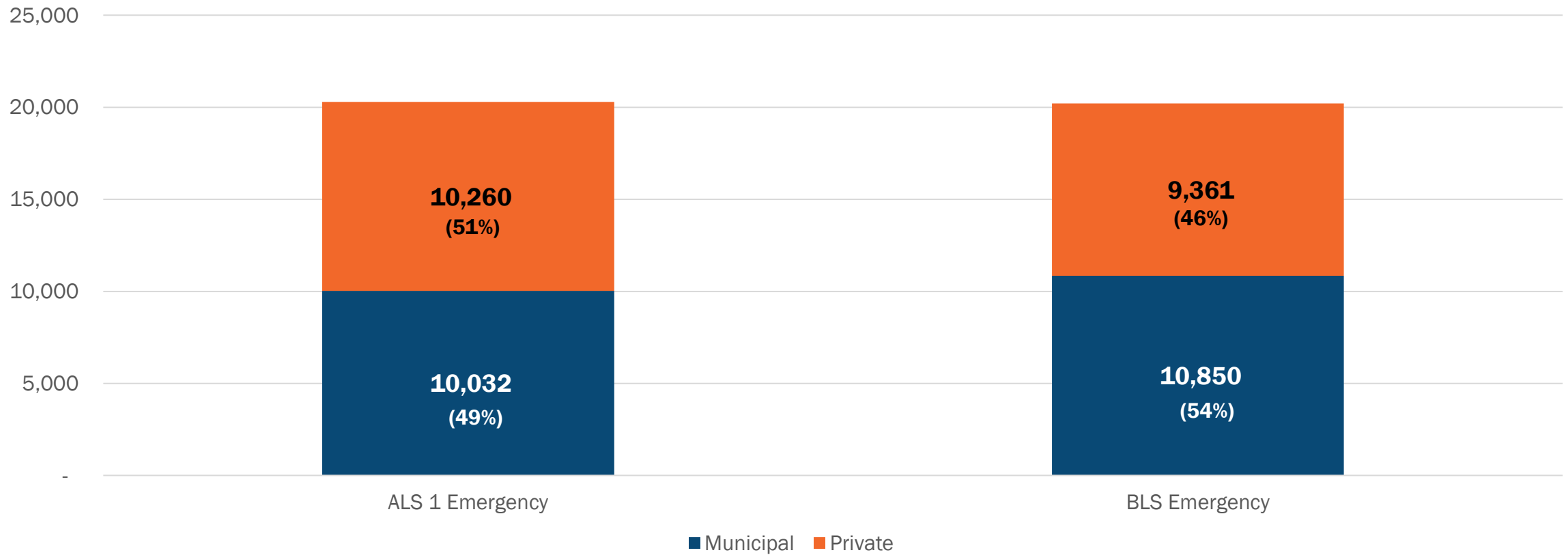
- **Privately-owned ambulance services** can be either **not-for-profit** services sometimes associated with hospitals or with colleges and universities,[2] or **for-profit,** stand-alone entities.

In the following exhibits, publicly-owned ambulance services are referred to as "municipal" services and privately-owned ambulance services are referred to as "private" services.

(1) Office of Emergency Medical Services, Department of Public Health. Ambulance Services List – March 2022. Accessed at: https://www.mass.gov/service-details/find-an-ambulance-service-in-massachusetts
(2) Ibid.
(3) Amin K, Pollitz K, Claxton G, Rae M, and Cox C. Ground Ambulance Rides and the Potential for Surprise Billing. Peterson-KFF Health System Tracker. June 24, 2021. Available at: https://www.healthsystemtracker.org/brief/ground-ambulance-rides-and-potential-for-surprise-billing/

In 2019, private and municipal ambulance services accounted for similar shares of ALS 1 Emergency and BLS Emergency transports among commercially-insured patients.

Number of ambulance encounters serviced by private or municipal ambulance services among commercially-insured patients by transport type, 2019



Notes: Amounts include service and ground mileage components. ALS 1 Emergency ambulance transports were identified using procedure code A0427 and BLS Emergency transports were identified using procedure code A0429. Ambulance providers were categorized as municipal if their national billing provider identifier (NPI) organization name included the terms “town”, “city”, or “fire”, or were otherwise identified as municipal in the March 2022 version of the Office of Emergency Medical Service’s Ambulance Services List.
Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) Office of Emergency Medical Services, Department of Public Health. Ambulance Services List – March 2022. Accessed at: https://www.mass.gov/service-details/find-an-ambulance-service-in-massachusetts

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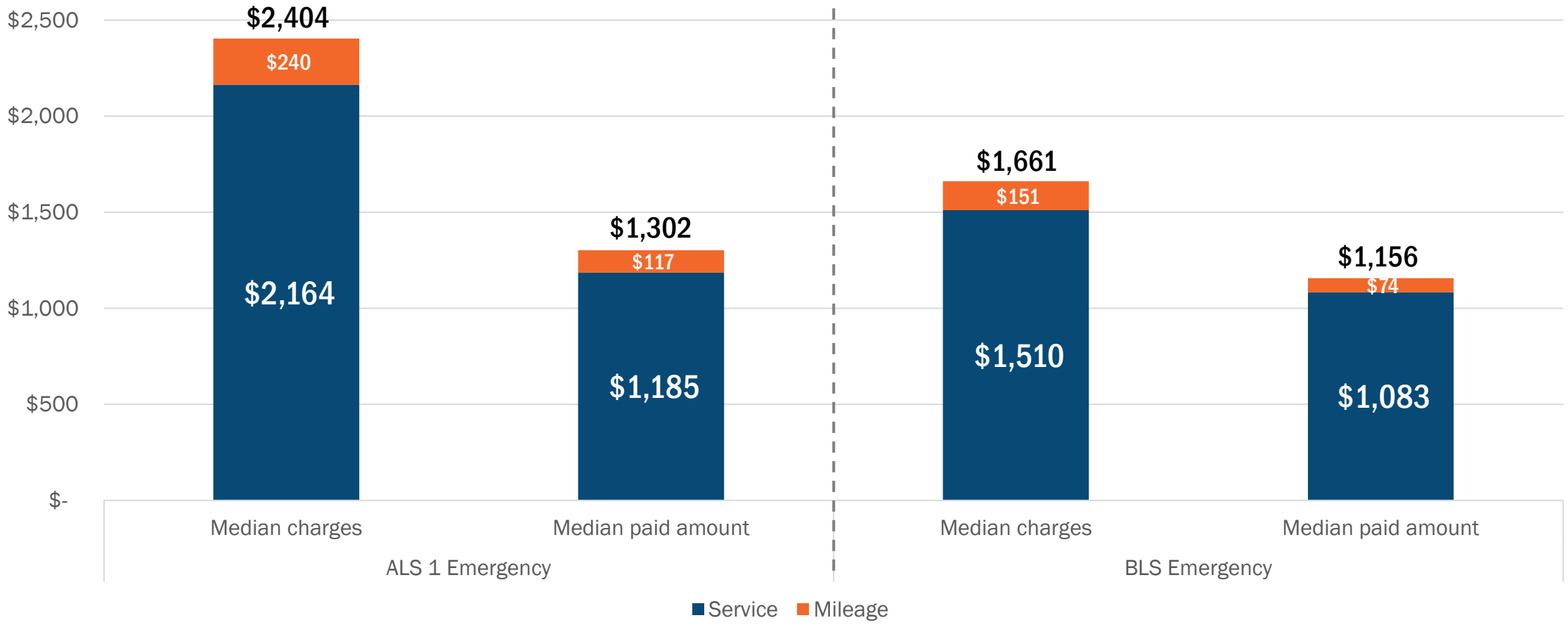
Most of the payment for ambulance encounters is for the service component – mileage is a relatively small portion.

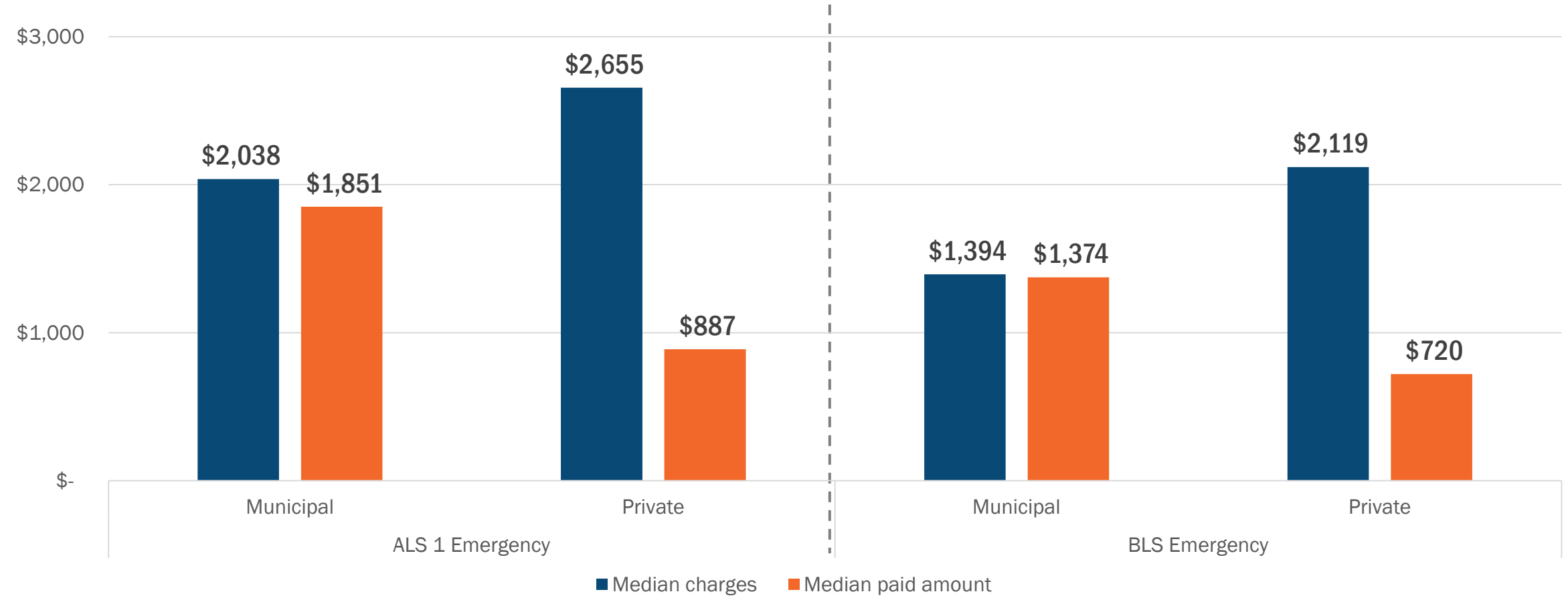
Median charges and paid amounts for ambulance encounters among commercially-insured patients by billing component and transport type, 2019



Notes: ALS 1 Emergency ambulance transports were identified using procedure code A0427 and BLS Emergency transports were identified using procedure code A0429. Ground mileage was identified using procedure code A0425.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020.

Payers paid municipal ambulance services roughly double what they paid private ambulance services per transport.

Median charges and paid amounts for ambulance encounters among commercially insured patients by ambulance service type, 2019

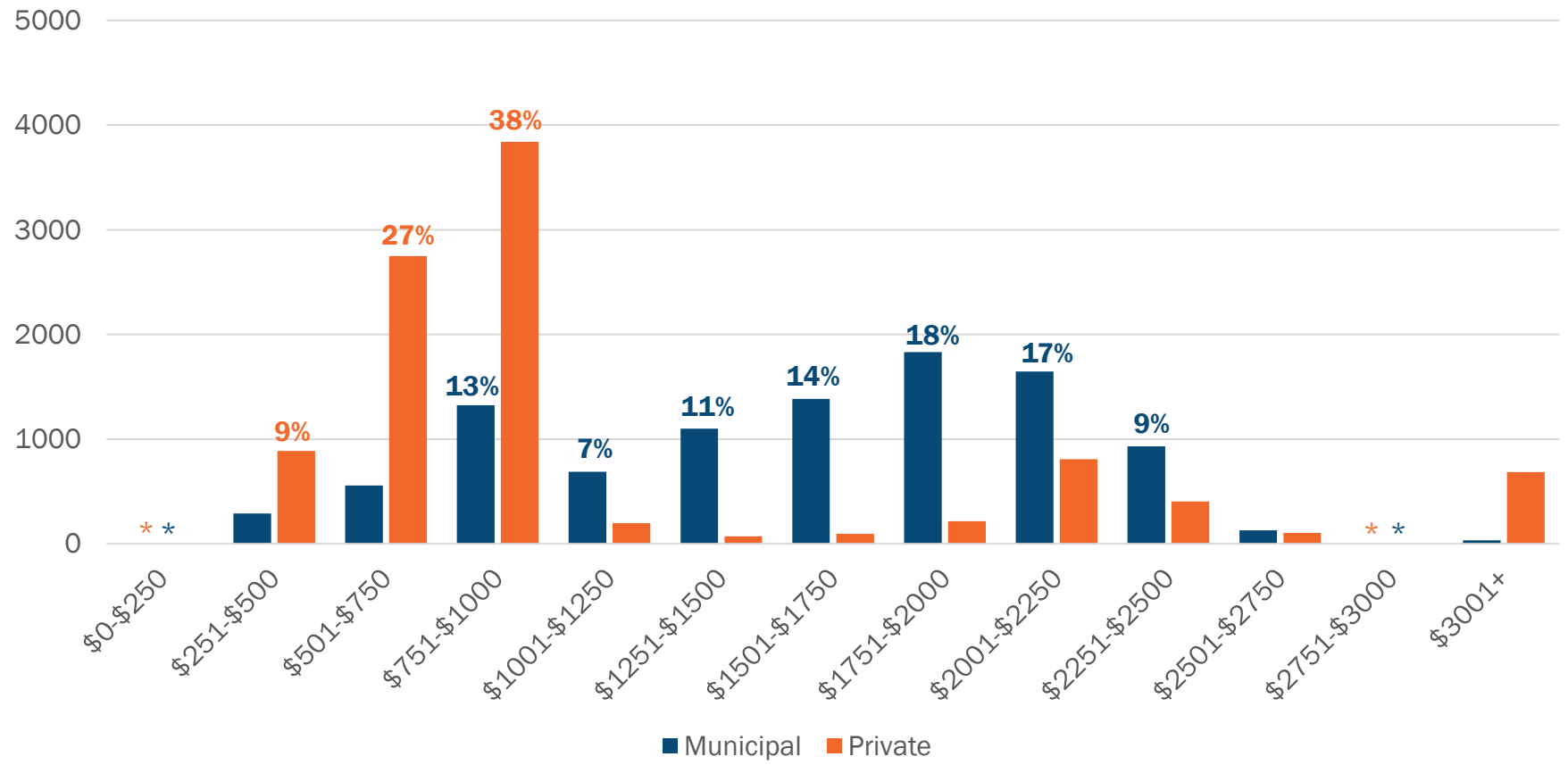


Notes: Amounts include service and ground mileage components. ALS 1 Emergency ambulance transports were identified using procedure code A0427 and BLS Emergency transports were identified using procedure code A0429. Ambulance providers were categorized as municipal if their national billing provider identifier (NPI) organization name included the terms “town”, “city”, or “fire”, or were otherwise identified as municipal in the March 2022 version of the Office of Emergency Medical Service’s Ambulance Services List.

Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) Office of Emergency Medical Services, Department of Public Health. Ambulance Services List – March 2022. Accessed at: https://www.mass.gov/service-details/find-an-ambulance-service-in-massachusetts

Most payments (excluding mileage) for ALS 1 encounters to private services were between $500 and $1,000 while payments to municipal services were between $750 and $2,500.

Number of ALS 1 Emergency ambulance encounters by ambulance service type and paid amount, 2019

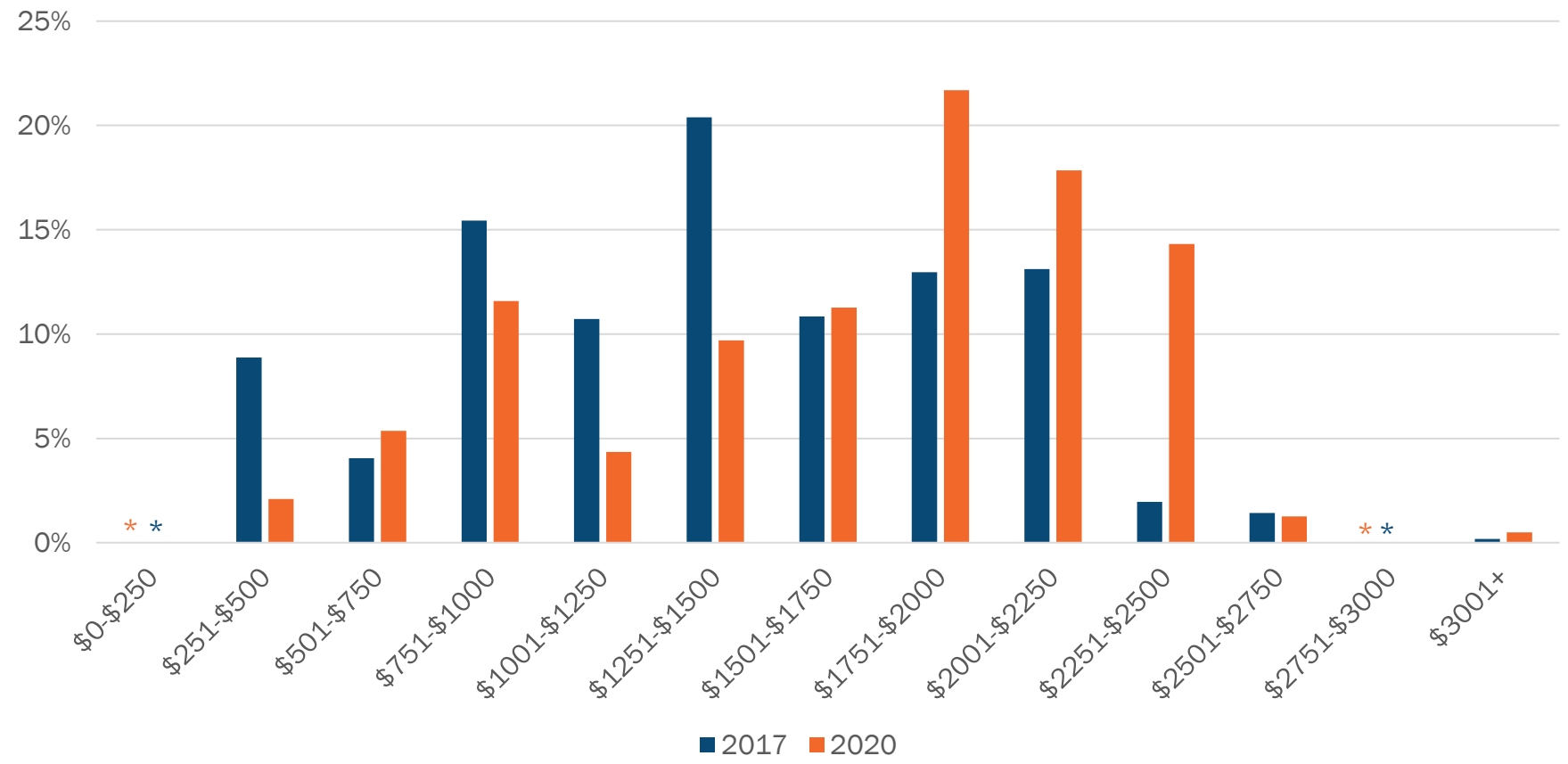


Notes: Amounts exclude ground mileage component. * indicates values that are protected due to small cell sizes. ALS 1 Emergency ambulance transports were identified using procedure code A0427. Ambulance providers were categorized as municipal if their national billing provider identifier (NPI) organization name included the terms "town", "city", or "fire", or were otherwise identified as municipal in the March 2022 version of the Office of Emergency Medical Service's Ambulance Services List.
Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) Office of Emergency Medical Services, Department of Public Health. Ambulance Services List – March 2022. Accessed at: https://www.mass.gov/service-details/find-an-ambulance-service-in-massachusetts

For paid amounts (excluding mileage) among BLS Emergency ambulance encounters, 58% of those with private services ranged from $501 to $750 and 47% of those with municipal services ranged from $1,251 to $1,500. Boston EMS provided a significant portion of BLS Emergency encounters in the dataset.

17% of payments to municipal services for ALS 1 Emergency encounters exceeded $2,000 in 2017. That proportion doubled to 34% in 2020.

Percent of ALS 1 Emergency encounters via municipal ambulance services by paid amount, 2017 versus 2020

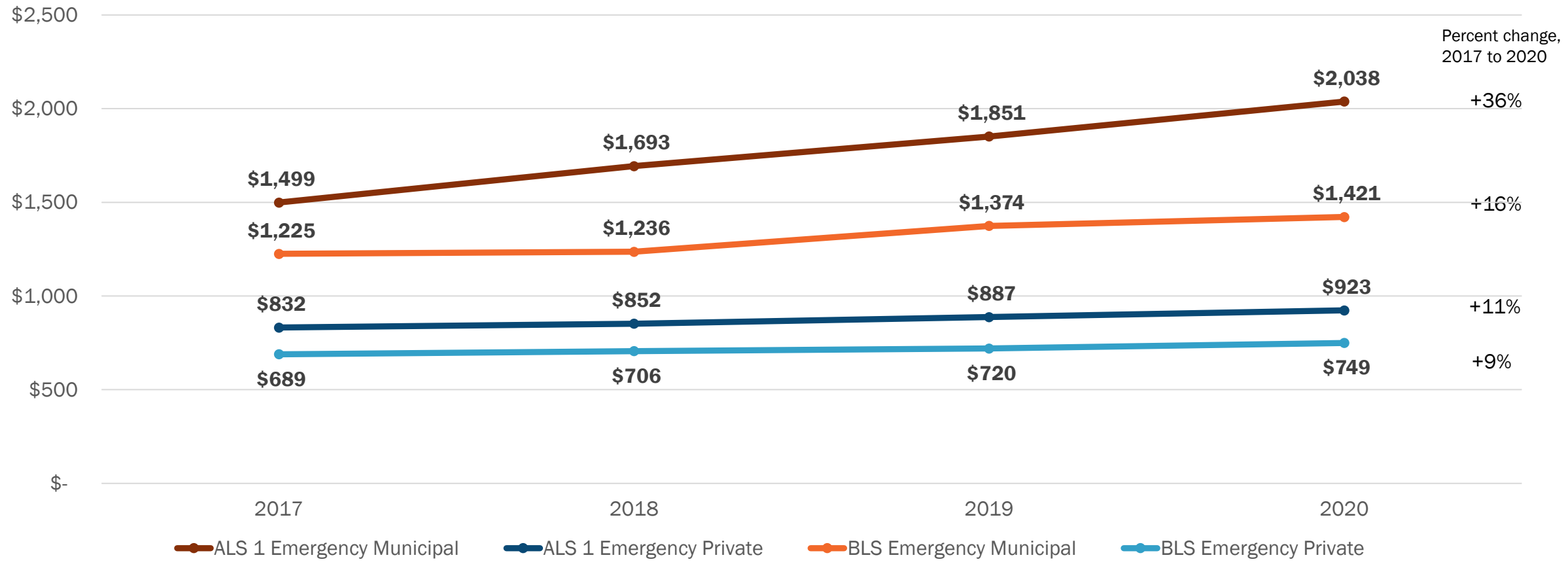


Notes: Amounts exclude ground mileage component. * indicates values that are protected due to small cell sizes. ALS 1 Emergency ambulance transports were identified using procedure code A0427. Ambulance providers were categorized as municipal if their national billing provider identifier (NPI) organization name included the terms "town", "city", or "fire", or were otherwise identified as municipal in the March 2022 version of the Office of Emergency Medical Service's Ambulance Services List.
Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) Office of Emergency Medical Services, Department of Public Health. Ambulance Services List – March 2022. Accessed at: https://www.mass.gov/service-details/find-an-ambulance-service-in-massachusetts

Between 2017 and 2020, paid amounts for BLS Emergency encounters via municipal ambulance services also increased, with more transports exceeding $1,250 per encounter in 2020 (59%) compared to 2017 (14%).

Median paid amounts have grown the fastest for ambulance encounters with municipal ambulance services.

Median paid amounts for ambulance encounters among commercially-insured patients by transport type and service type, 2017 to 2020

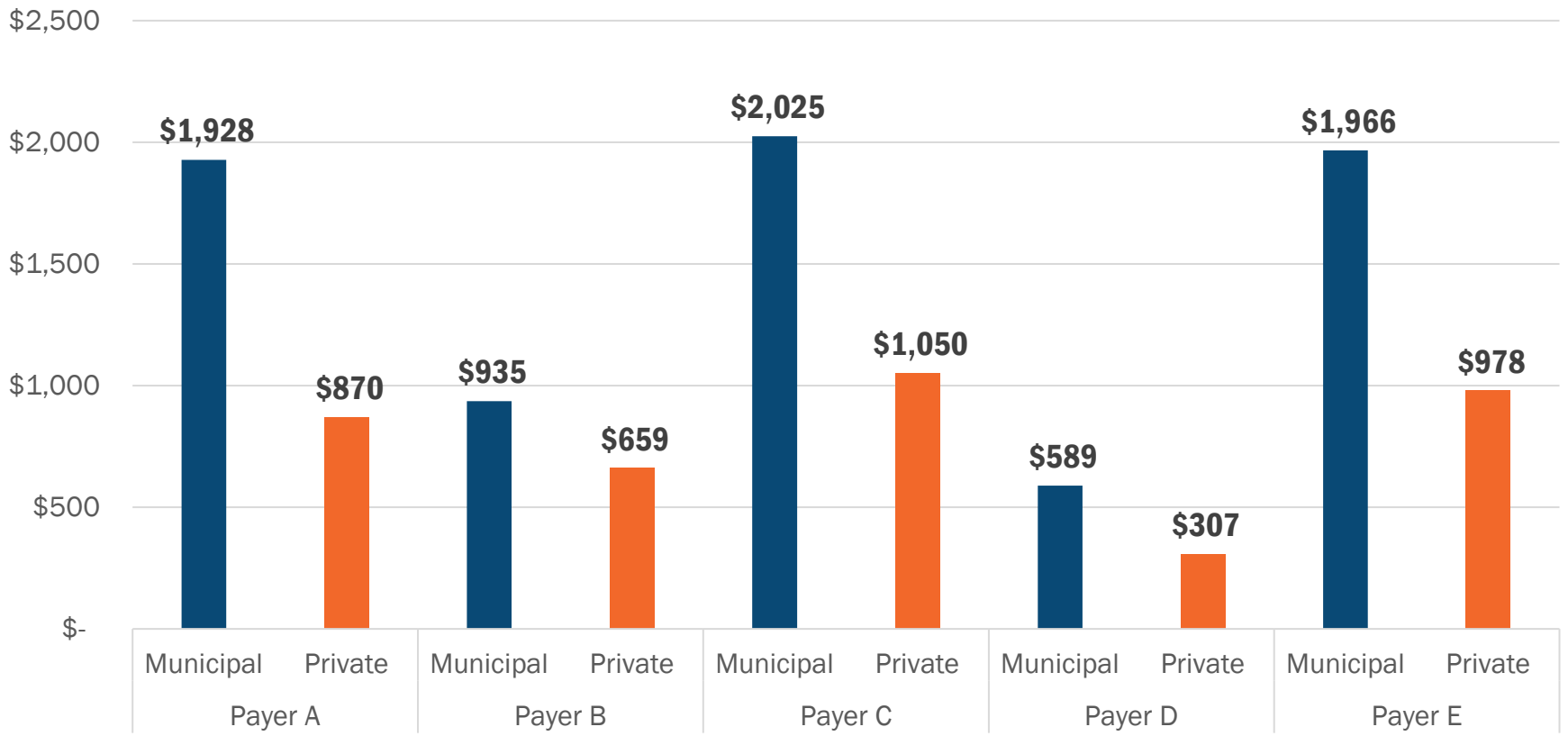


Notes: Amounts include service and ground mileage components. ALS 1 Emergency ambulance transports were identified using procedure code A0427 and BLS Emergency transports were identified using procedure code A0429. Ambulance providers were categorized as municipal if their national billing provider identifier (NPI) organization name included the terms “town”, “city”, or “fire”, or were otherwise identified as municipal in the March 2022 version of the Office of Emergency Medical Service’s Ambulance Services List.

Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) Office of Emergency Medical Services, Department of Public Health. Ambulance Services List – March 2022. Accessed at: https://www.mass.gov/service-details/find-an-ambulance-service-in-massachusetts

All payers paid substantially more to municipal than private ambulance services, with significant variation across payers.

Median paid amounts for ALS 1 Emergency ambulance encounters by service type and payer, 2019

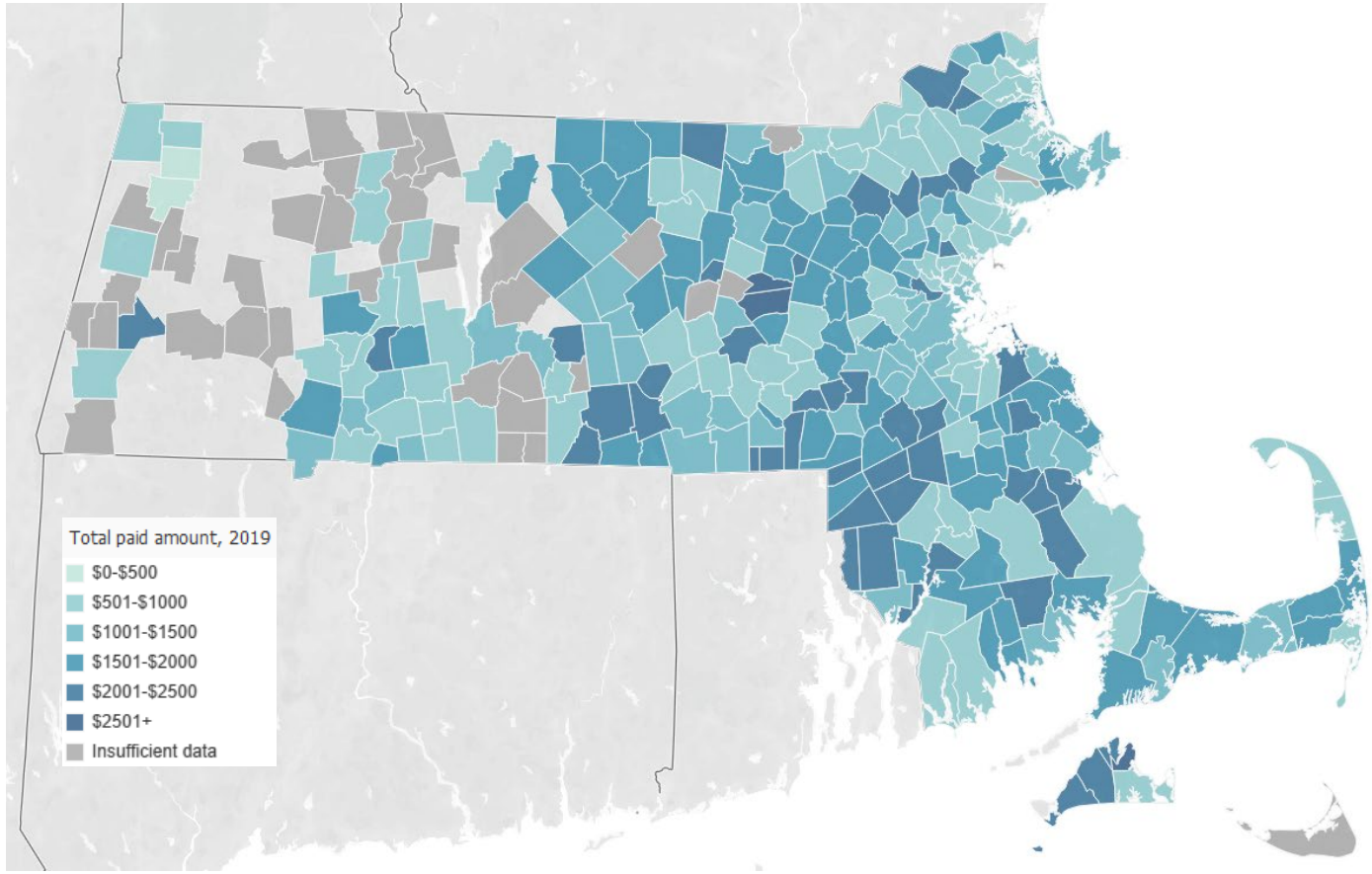


Notes: Payers include AllWays Health Partners, Anthem, Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan. Amounts include service and ground mileage components. ALS 1 Emergency ambulance transports were identified using procedure code A0427. Ambulance providers were categorized as municipal if their national billing provider identifier (NPI) organization name included the terms "town", "city", or "fire", or were otherwise identified as municipal in the March 2022 version of the Office of Emergency Medical Service's Ambulance Services List.
Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) Office of Emergency Medical Services, Department of Public Health. Ambulance Services List – March 2022. Accessed at: https://www.mass.gov/service-details/find-an-ambulance-service-in-massachusetts

- Payments for BLS Emergency transports by municipal ambulance services were also much higher than private payments for each payer.
- Differences in payment within each commercial health insurer may be related to intra-payer differences in rates of contracting with private versus municipal ambulance services.

Due to both variation in EMS structure and mix of commercial payers, there is wide variation in median paid amounts for ALS 1 Emergency encounters by patient municipality.

Median paid amounts for ALS 1 Emergency encounters by municipality, 2019



Notes: Amounts exclude ground mileage component. The municipality where an ambulance transport occurred was determined using patient zip code. ALS 1 Emergency ambulance transports were identified using procedure code A0427. Ambulance providers were categorized as municipal if their national billing provider identifier (NPI) organization name included the terms “town”, “city”, or “fire”, or were otherwise identified as municipal in the March 2022 version of the Office of Emergency Medical Service’s Ambulance Services List.

(1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) Office of Emergency Medical Services, Department of Public Health. Ambulance Services List – March 2022. Accessed at: https://www.mass.gov/service-details/find-an-ambulance-service-in-massachusetts

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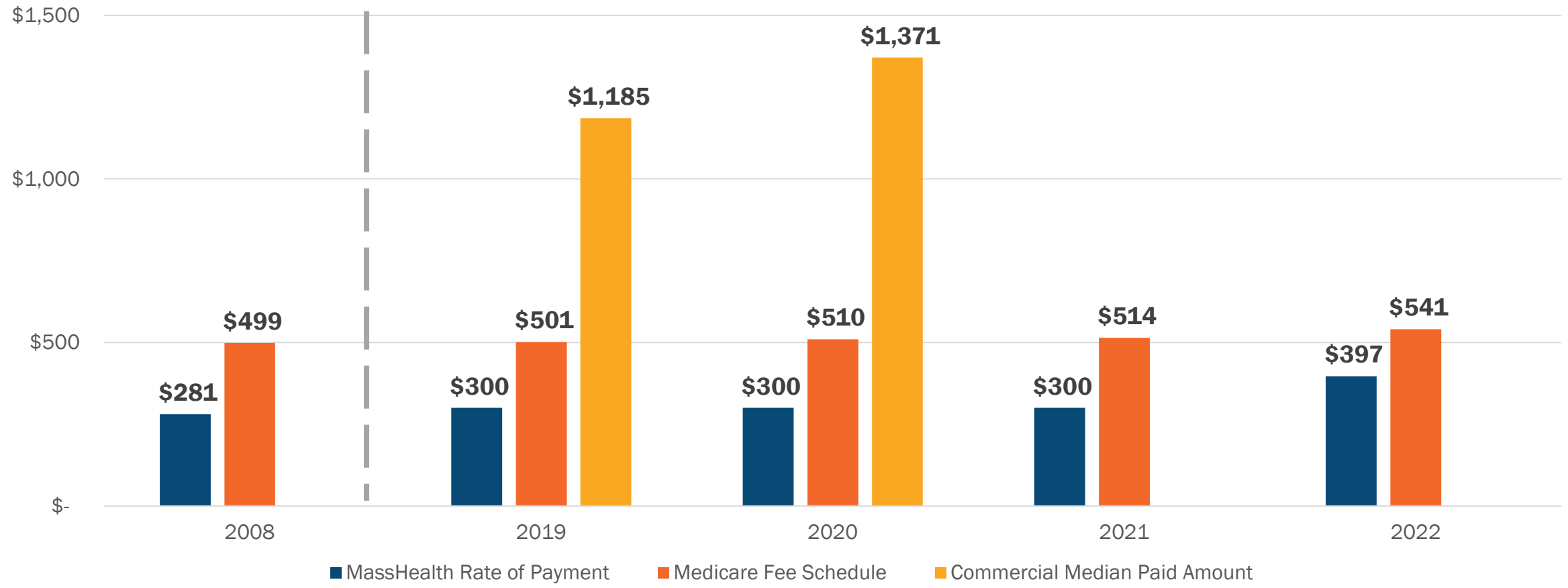
Commercial paid amounts for ALS 1 Emergency ambulance encounters were far higher than MassHealth or Medicare rates of payment in 2019 and 2020. However, both MassHealth and Medicare payment rates increased in 2022.

Rates of payment for ALS 1 Emergency ambulance encounters by payer, 2008 and 2019-2022



Notes: All calculated amounts exclude ground mileage. Commercial Paid Amount is a median. Medicare Fee Schedule amount assumes Metropolitan Boston geographic area (Middlesex, Norfolk, and Suffolk counties). Commercial paid amount is what the payer reports as being paid on the claim but does not include potential balance billing.
Sources: (1) Commercial total paid amount from HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) Medicare fee schedule amounts from Medicare Ambulance Fee Schedule Public Use File, 2008 to 2022, available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/afspuf. (3) MassHealth Rate of Payment for 2008 to 2022 from HPC review of 114.3 CMR 27.00 as published in Massachusetts Register issue 1108 and 101 CMR 327.00 as published in Massachusetts Register issues 1407, 1412, 1456, and 1482.

Neighboring Maine and Connecticut have addressed ambulance billing reimbursement.

Maine

- In 2021, the Maine legislature enacted a law (Maine P.L. 2021,ch. 241) that requires payers to reimburse out-of-network ambulance service providers for emergency services according to certain guidelines, unless the payer and the service provider agree otherwise, until December 31st, 2023. In addition, the law requires payers to offer a standard contract to all ambulance service providers willing to participate in their provider network.[1]
  - P.L. 2021, ch. 241 requires reimbursement at the lesser of: (1) the ambulance service provider's rate OR (2) 180% or 200% of the Medicare rate for that service (depending on whether the ambulance service is an out-of-network or in-network provider for that payer, respectively), plus any adjustment required for rurality

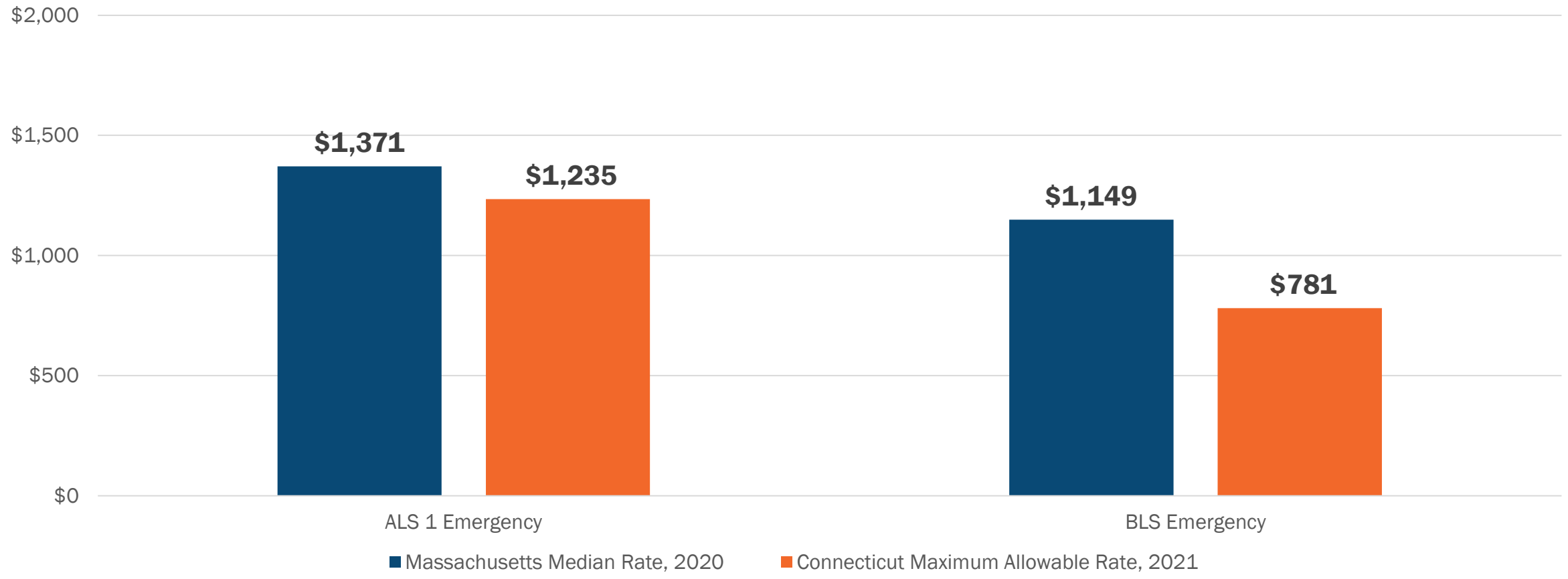
Connecticut

- Since 1988, the Connecticut Office of EMS maintains the rates for which ambulance services are paid and annually adjusts the rates based upon a federal cost index. For 2023, providers may request a rate increase of up to 2.8%.[2] As of 2022, the Connecticut Office of EMS publishes the maximum allowable rates for individual EMS organizations.

(1) Maine P.L. 2021, ch. 241. Available at: http://www.mainelegislature.org/legis/bills/display_ps.asp?ld=1258&PID=1456&snum=130
(2) State of Connecticut Department of Public Health Office of Emergency Medical Services. Short-Form Rate Application Package for Requesting 2023 Rates. Available at: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/ems/pdf/Home/2023-Short-Form-Rate-app.pdf

In 2020, emergency ambulance encounters in Massachusetts were paid at higher median rates than the maximum allowable 2021 rate in Connecticut, a state with reimbursement guidelines.

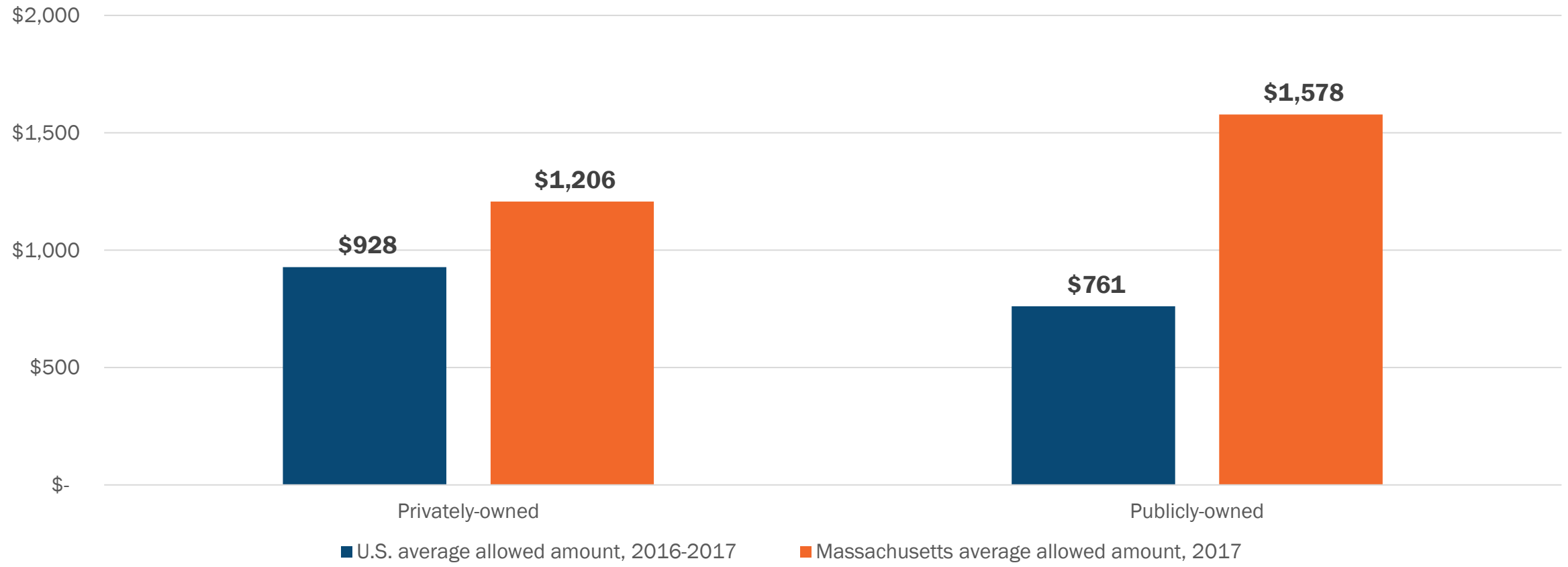
Rates for ambulance encounters by state and transport type, 2020 and 2021



Notes: Massachusetts rate is median total paid amount for ambulance encounters among commercially-insured patients in 2020. Connecticut rate is the maximum allowable rate for ambulance encounters among all patients in 2021. Rates do not include ground mileage or other ancillary charges.
Sources: (1) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020. (2) State of Connecticut Department of Public Health Office of Emergency Medical Services. Schedule of Maximum Allowable Rates, Effective January 1, 2021 through December 31, 2021. Available at: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/ems/pdf/Home/ShortFormAppMemo_wAttachment_June9_2020.pdf

Average paid amounts for ALS 1 Emergency transports via publicly-owned ambulance services in Massachusetts were twice as high as average paid amounts for similar transports among commercially-insured patients nationally.

Allowed amounts for ALS 1 Emergency ambulance transports among commercially-insured patients, U.S. and Massachusetts



Notes: For the U.S. category, privately-owned means private, independent ambulance services (i.e., not private equity, facility, or non-profit) and publicly-owned means public sector ambulance services. For the Massachusetts category, privately-owned means private ambulance service of any type (i.e., for-profit or not-for-profit) and publicly-owned means municipal ambulance services. U.S. average allowed amount is for ambulance transports with an urban pickup point and a standardized mileage of 8 miles using data winsorized at the 1st and 99th percentiles Massachusetts average allowed amount includes all pickup points and actual mileage, excluding encounters with allowed amounts outside of the 1st and 99th percentiles.

Sources: (1) Adler L, Ly B, Duffy E, Hannick K, Hall M, Trish E. Ground Ambulance Billing and Prices Differ by Ownership Structure. Health Affairs. January 18, 2023. Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.00738?journalCode=hlthaff (2) HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2017-2020.

Presentation Outline

1. Introduction
2. Ground Ambulance Landscape in Massachusetts
3. Commercial Payment for Ambulance Services
4. Other Payment Approaches
5. **Conclusion**

Key Findings

- **Most (78%) ambulance encounters in Massachusetts in 2019 were ALS 1 Emergency or BLS Emergency transports**. Most of these encounters originated at a residence or at the scene of an accident or acute event.
- About **half** of ALS 1 Emergency and BLS Emergency ambulance encounters in the Commonwealth were serviced by **privately-owned** ambulance services with the remainder serviced by **municipally-owned** services.
- For both ALS 1 Emergency and BLS Emergency encounters, **paid amounts varied more than three-fold across commercial payers**.
- **In contrast to national findings, commercial payers paid municipally-owned services about twice as much per transport as they paid privately-owned services**. Payments to municipally-owned services were also more highly variable and growing faster, with median payments for municipally-owned ALS 1 Emergency services growing from **just under $1,500** in 2017 to **more than $2,000** in 2020.
- **Median commercial ambulance payments in Massachusetts in 2019 were 2.7 and 4.6 times higher than Medicare and MassHealth rates, respectively.** They were also higher than maximum allowable rates in Connecticut, which regulates rates through its Office of Emergency Management Services.

Areas for Future Potential Research and Monitoring

Areas for future potential research and monitoring include:

- Investigating the impact of the COVID-19 pandemic on emergency ground ambulance use and rates, especially into 2021 and beyond
- The work and recommendations of the federal Advisory Committee on Ground Ambulance and Patient Billing
- Progress in other states on addressing emergency ground ambulance billing and rates (e.g., Maine and Connecticut)

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Research Presentation: Emergency Ground Ambulance Utilization and Payment Rates in Massachusetts

ASSESSING AND ADDRESSING DRUG PRICES IN MASSACHUSETTS

Schedule of Upcoming Meetings

Presentation Outline

1. **Policy Recommendation: Constrain Excessive Pharmaceutical Prices**
2. Methods for Assessing Drug Prices
3. Analysis: How do drug prices in the U.S. compare to international prices?
4. Policy Discussion

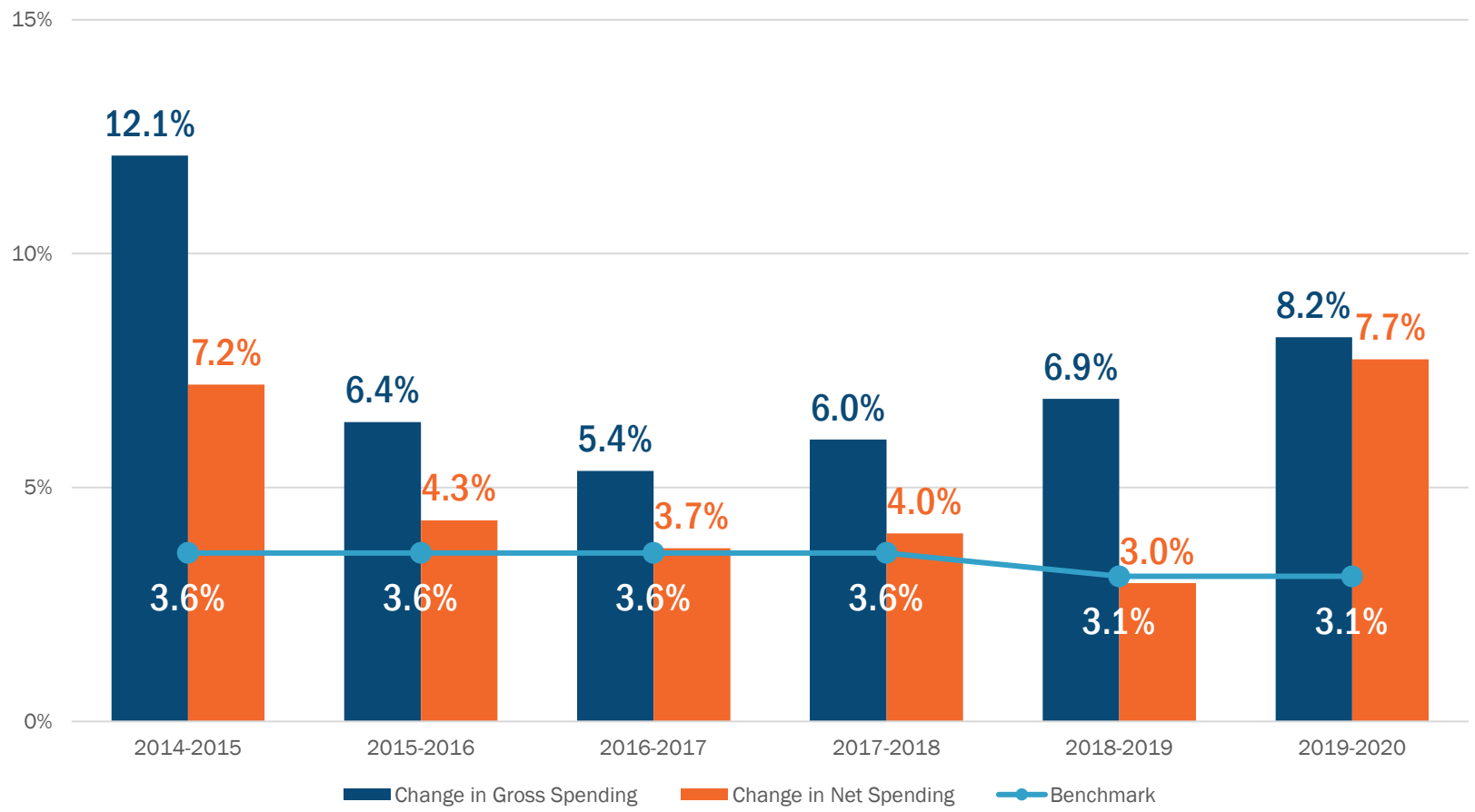
Constrain Excessive Provider and Pharmaceutical Prices

THE COMMONWEALTH SHOULD TAKE ACTION to constrain excessive price levels, variation, and growth for health care services and pharmaceuticals, by… expanding state oversight and transparency of the entire pharmaceutical sector, including how prices are set in relation to value.

Notes: Excerpt of policy recommendations in the 2022 Health Care Cost Trends Report and Policy Recommendations. Available here: https://www.mass.gov/doc/2022-health-care-cost-trends-report-and-policy-recommendations/download

Annual growth in retail drug spending in Massachusetts, net of rebates, has been above the benchmark in most years since 2014.

Change in gross and net drug spending in Massachusetts, 2014-2020

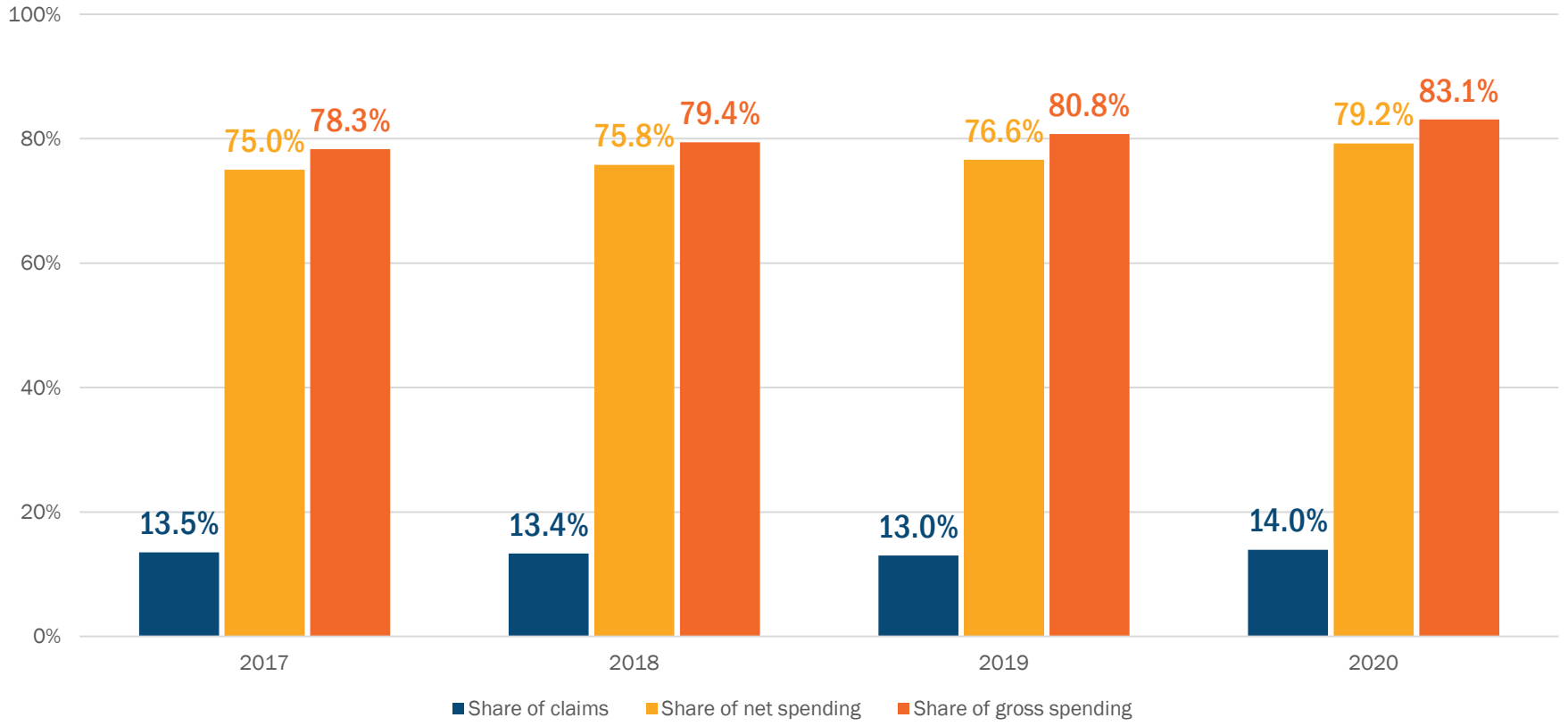


Gross spending is the amount paid to pharmacies for members' prescription drugs. **Net spending** is the amount paid to pharmacies for members' prescription drugs less rebates received by the health plan from manufacturers.

Source: Center for Health Information and Analysis (CHIA), Annual Reports on Total Health Care Expenditures: https://www.chiamass.gov/thce-tme-apm/

In Massachusetts, branded drugs represent the largest and growing share of retail drug spending.

Branded drug share of claims vs. share of net and gross spending, 2017-2020



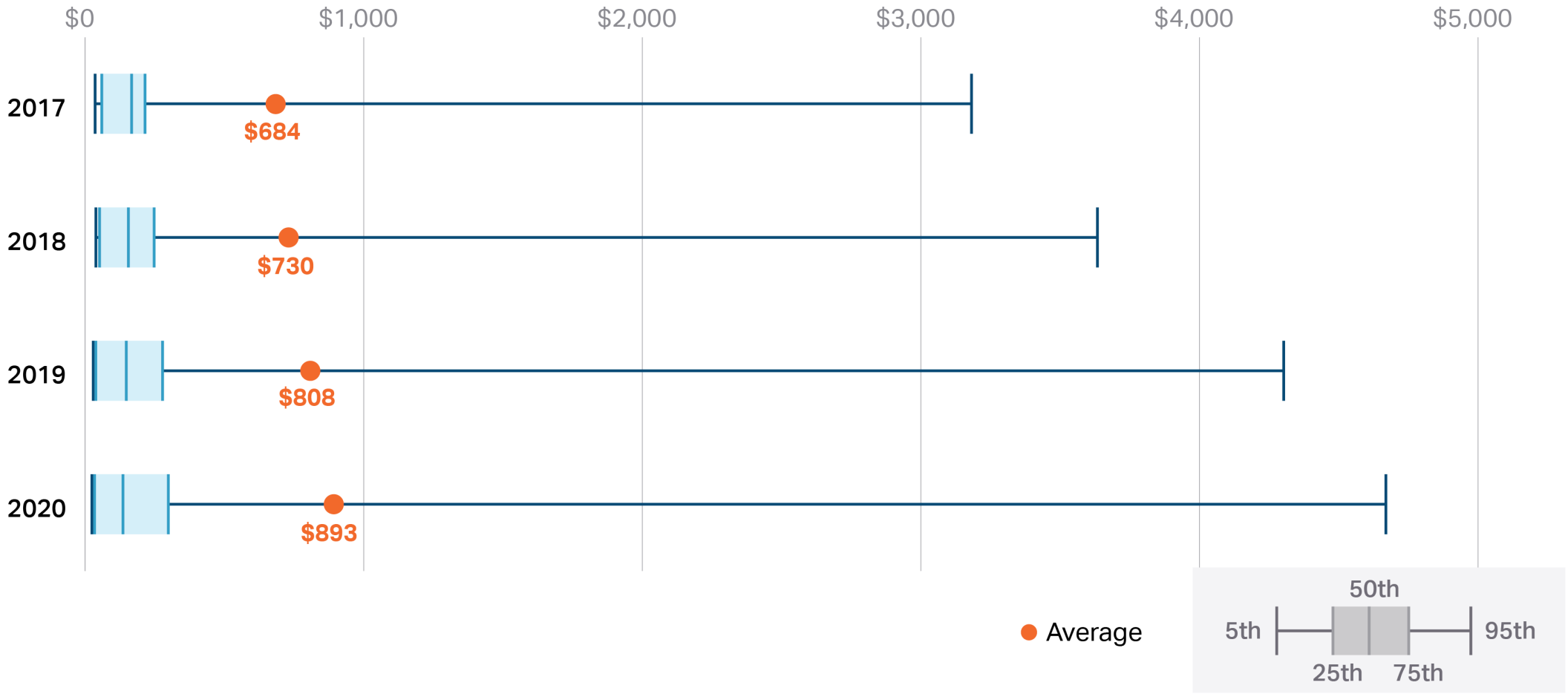
Notes: HPC analysis of the CHIA's All-Payer Claims database, pharmacy claims, 2017-2020. Pharmacy claims include data from four payers: BCBSMA, Tufts, HPHC, Allways. Reported rebate shares (applied to gross spending figures) were obtained from Center for Health Information and Analysis (CHIA), Annual Reports on Total Health Care Expenditures.

Sources: [1] Congressional Budget Office. Prescription Drugs: Spending, Use, and Prices. January 2022. https://www.cbo.gov/publication/57772; [2] CMS. National Health Expenditure Projection: 2021-2030. Forecast Summary. Accessed here: https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf

Growth in spending on branded drugs has been offset by growing utilization of generic drugs over the past decade, but that effect may be limited going forward.[1] High launch prices and price increases of existing branded drugs are the key drivers of drug spending increases.[2]

Average gross spending per branded prescription in Massachusetts increased 11% in 2020.

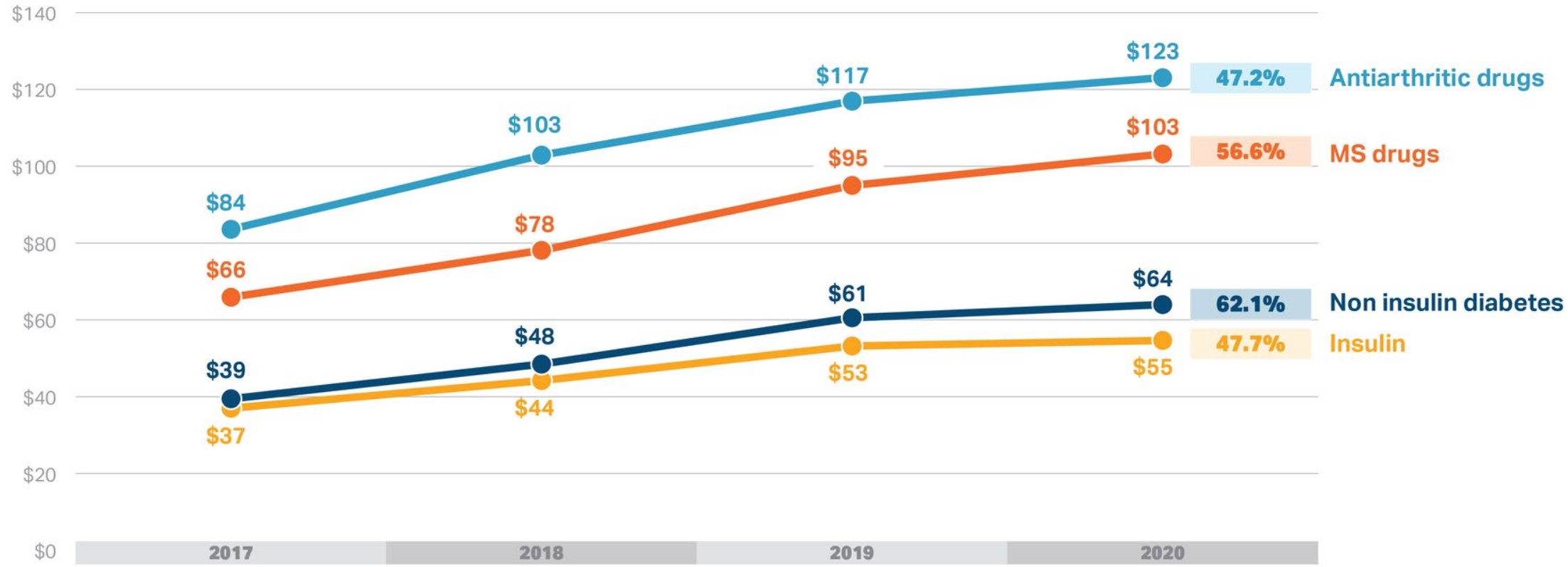
Gross spending distribution per branded prescription, 2017-2020



Source: HPC analysis of the CHIA's All-Payer Claims database, pharmacy claims, 2017-2020. Pharmacy claims include data from four payers: BCBSMA, Tufts, HPHC, Allways.

Average out of pocket spending for a 30-day supply of prescription drugs for common chronic conditions in Massachusetts grew approximately 50% from 2017 to 2020.

Average cost sharing per prescription (30-day supply) for selected classes of drugs, 2017-2020



Notes: Drugs were identified based on lists or clinical guidelines published by the Arthritis Foundation, American College of Rheumatology, American Diabetes Association, and National MS society. Clinician-administered drugs, which are typically covered under a plan's medical benefits, are excluded. Pharmacy claims include data from four payers: BCBSMA, Tufts, HPHC, AllWays.
Source: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims database, 2017-2020, V 10.0

Presentation Outline

1. Policy Recommendation: Constrain Excessive Pharmaceutical Prices
2. **Methods for Assessing Drug Prices**
3. Analysis: How do drug prices in the U.S. compare to international prices?
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Analytic Goals

Research Question

- How do drug prices for the highest spending drugs vary across payers in the U.S. and internationally?

Goals

- To contribute to the evidence base on pharmaceutical prices, variation between payers in the U.S. and internationally, and the impact of pharmaceutical prices on health care spending in Massachusetts
- To understand the policy factors that contribute to variation in prices, particularly in Massachusetts
- To inform policy discussions regarding options to better align pharmaceutical pricing with value for Massachusetts residents

Identifying High-Cost Drugs for U.S. Payers: Commercial, Medicare and Medicaid

Therapeutic Class	Brand Name	List of 25 Highest Spending Drugs	>10K/Claim and in top 100 of highest spending drugs
Cancer	Ibrance	√	√√√
	Imbruvica	√	√√
	Jakafi		√√
	Revlimid	√√	√√√
	Sprycel		√√√
	Tagrisso		√√√
Diabetes	Januvia	√√√	
	Trulicity	√√	
Infectious disease	Biktarvy	√√	
	Genvoya	√√	
Autoimmune	Enbrel	√√√	
	Humira	√√√	
	Stelara	√√	√√√
Psychiatry	Invega Sustenna	√√	
	Latuda	√√	
Cystic Fibrosis	Orkambi		√√
	Trikafta	√	√√
Cardiovascular	Eliquis	√√	

Note: HPC focused its review on drugs that were either in the top 25 highest spending drugs and/or were on the list of top 100 highest spending drugs with a cost greater than $10k per claim for at least 2 of the 3 major payer types (commercial, Medicare, and Medicaid). Each √ represents how many payer types for which the drug met the criteria for further review.
Sources: CMS Website: Medicare Part D Spending by Drug (2020); Medicaid Spending by Drug (2020); HPC analysis of the CHIA's All-Payer Claims database, pharmacy claims, 2017

Methods for Assessing Drug Prices: Commercial and Medicare

Drugs Prices at Commercial and Medicare Part D Plans

- Commercial and Medicare plans typically negotiate their prices for drugs with drug manufacturers through **pharmacy benefit managers (PBMs).**[1]
- **Health plans contract with national PBMs** to negotiate discounts – in the form of rebates– on drugs with drug manufacturers.[2,3]
- Rebates are **confidential** and are usually negotiated as a percentage off the publicly available list price of the drug.

Data Source

- **SSR Health** estimates drug specific rebates by comparing publicly reported manufacturer revenue with estimated utilization data.[4]

Sources:

1 A 2018 CHIA Report stated that Commercial plans in Massachusetts reported that they received rebates equal to 12.4% of total pharmacy spending, Medicare plans reported rebates equal to 15.2% and 17.9% for Medicare Advantage and Medicare Prescription Drug Plans. Report available here.

2 HPC analysis of pre-filed testimony pursuant to the 2018 Annual Cost Trends Hearing. Slide 46. (October 2018). Available here.

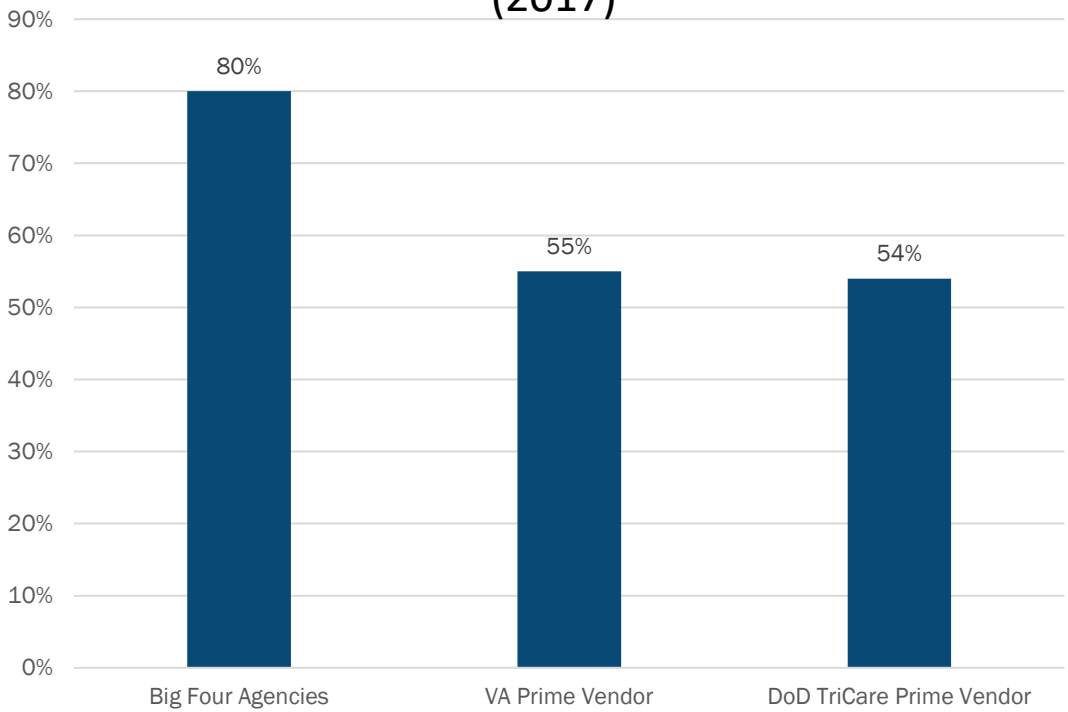
3 Adam Fein. The Top Pharmacy Benefit Managers of 2021: The Big Get Even Bigger. Drug Channels. Available here.

4 SSR Health estimates rebate amounts by comparing publicly reported manufacturer revenue with estimated utilization data. One drug (lenalidomide, Revlimid) did not have rebate estimates in SSR Health. However, a 2020 Congressional report found that the "largest negotiated discount that Celgene provided for Revlimid in the commercial market was 5%" (House Committee on Oversite and Reform, p. 33). As a result, we assumed a rebate of 5% for lenalidomide.

Methods for Assessing Drug Prices: Direct Federal Purchasers

- The VA, Department of Defense, Public Health Service and Coast Guard are the **four largest direct federal purchasers** of prescription drugs (known as the 'Big Four').
- Drug prices for the Big Four are regulated and **publicly available in a fee schedule**, but each agency can subsequently negotiate additional price concessions.
- If a drug was excluded from the VA's formulary based on publicly available information, it was **excluded from the analysis.**

Average Price of Top-Selling Brand-Name Drugs as a Percentage of their Average Net Price in Medicare Part D (2017)

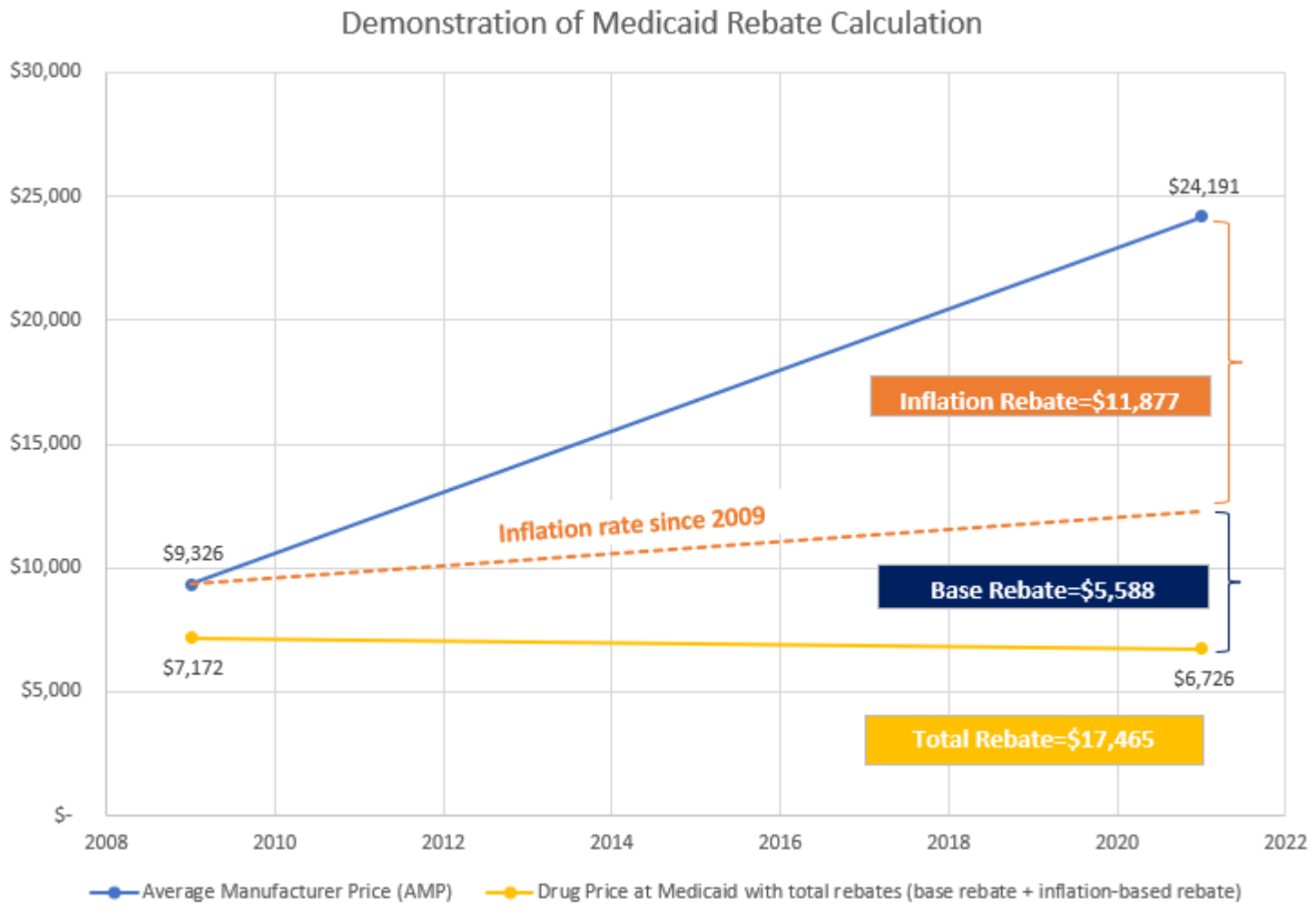


Source: Graph adapted from CBO Report: A Comparison of Brand-Name Drug Prices Among Select Federal Programs

Notes: Pharmaceutical prices for the Big Four are publicly available on the VA website here. Prices for the Big Four are regulated and subject to at least a 24% discount from the drug's non-Federal average manufacturer price, plus additional discounts if the price rises faster than inflation. The VA can restrict its formulary further to negotiate higher discounts through national contract prices. National contracts are available publicly online. The VA formulary is available online here.

Methods for Assessing Drug Prices: Medicaid

- Manufacturers must provide the **best price or a minimum base rebate of 23.1%** off the Average Manufacturer's Price (AMP).
- Manufacturers must provide an **additional rebate based on** inflation, or the difference between the current drug price and the price of the drug if it grew at inflation from the time of market launch.
- **Medicaid Drug Price** is equal to the current Price minus **the base rebate** minus the **additional rebate based on inflation.**
- Since AMP is confidential, Medicaid price estimates are based on publicly available list price and list price growth (Wholesale acquisition cost or 'WAC').



Notes: Average Manufacturer Price (AMP) is the average price that drug manufacturers charge Wholesalers to purchase their drug for distribution. AMP is reported confidentially by drug manufacturers to CMS. Medicaid prices were calculated using a formula available on the Medicaid website. Because AMP is confidential, rebates were calculated based on WAC. Historic WAC at drug launch was identified from IBM Micromedex Red Book.

Methods for Assessing Drug Prices: Comparator Countries

*Many countries **establish and publish public ceiling prices** for drugs based on an assessment that compares the clinical benefit of the treatment relative to existing treatment options.*

U.K.

- Prices are negotiated by the **National Health Service (NHS)** based on a national health technology assessment conducted by the **National Institute for Health and Care Excellence (NICE).**
- Many prices are available in **publicly available** fee schedules, but increasingly, certain prices are **confidentially negotiated** and are not publicly available.

France

- Prices are negotiated by representatives in the **French government** and national sickness funds following an evaluation by **Haute Autorité de Santé (HAS).**
- Prices are **publicly available** in a fee schedule.

Canada

- Prices are negotiated by each province based on a national health technology assessment conducted by the **Canadian Agency for Drugs and Technologies in Health (CADTH).**
- Our analysis considers prices in Quebec.
- Prices might vary slightly by province.

Australia

- Prices are negotiated by representatives in the Australian Medicare program that covers all residents based on an evaluation by the **Pharmaceutical Benefits Advisory Committee (PBAC).**
- Prices are **publicly available** in a fee schedule.

Notes: These four countries make prices publicly available. The published prices represent the 'maximum' being paid (akin to list prices in the U.S.) and may be subject to additional confidential discounts or rebates.
Source: Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services. For a full summary of drug price negotiation processes in peer countries, see Rand, et al. Pharmacoeconomics, Getting the Price Right: Lessons for Medicare Price Negotiation from Peer Countries (Dec 2022). Available here: https://pubmed.ncbi.nlm.nih.gov/36348153/

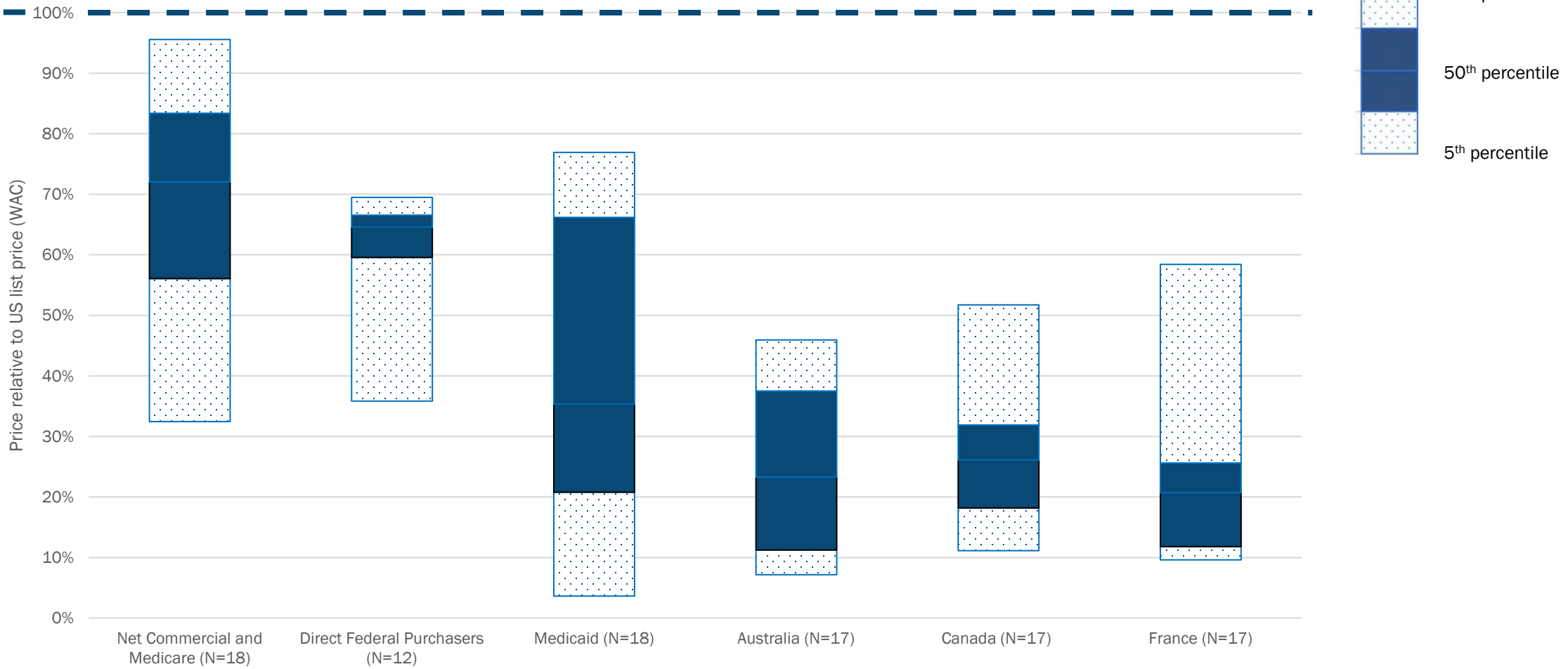
Presentation Outline

1. Policy Recommendation: Constrain Excessive Pharmaceutical Prices
2. Methods for Assessing Drug Prices
3. **Analysis: How do drug prices in the U.S. compare to international prices?**
4. Policy Discussion

U.S. payers generally pay more for high spending drugs than comparator countries.

Net Prices for U.S. and International Payers (18 high spending drugs)

List Prices in the U.S.

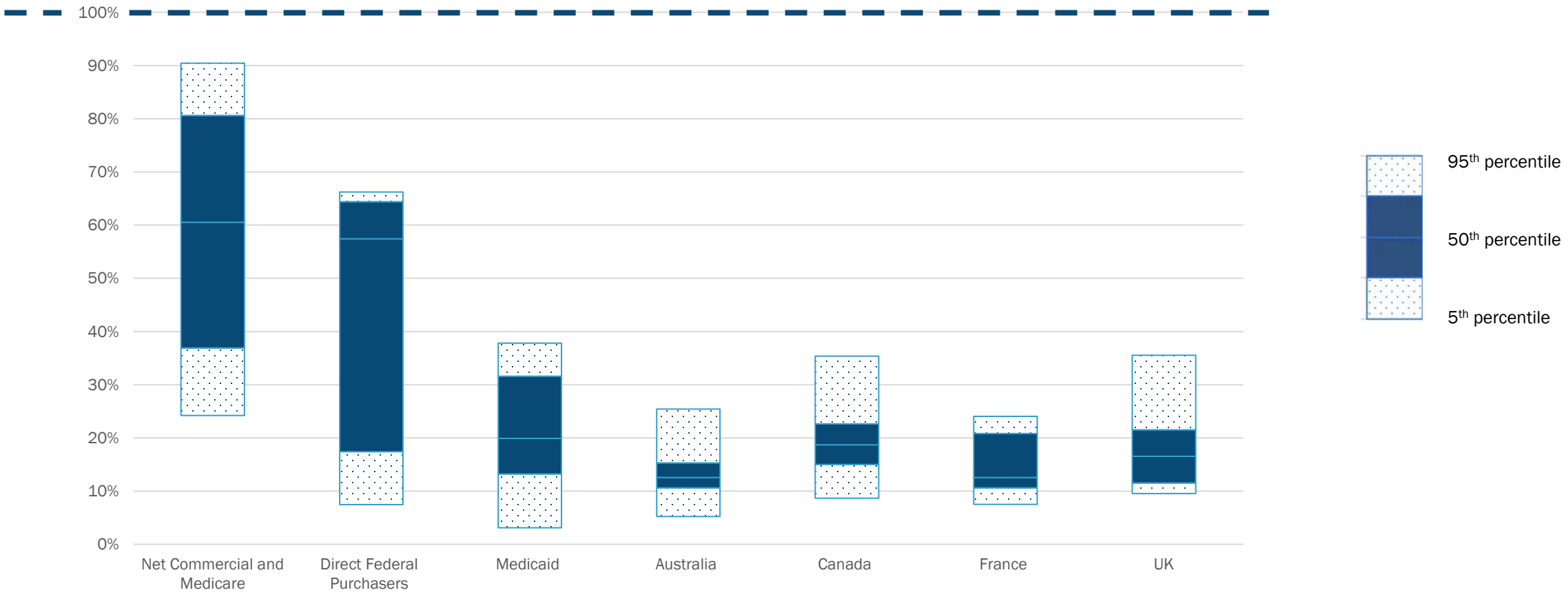


Notes: All prices were as of December 2021. The list price is also known as the Wholesale Acquisition Cost (WAC) and is the price charged by drug manufacturers to wholesalers or pharmacies, before discounts or rebates are applied. Net commercial and Medicare prices were obtained from SSR Health and are calculated by comparing publicly reported manufacturer revenue with estimated utilization data. Medicaid prices were calculated using Medicaid's formula available online. Drug prices for federal purchasers and comparator countries were publicly available online in fee schedules and represent the "maximum" being paid in other countries.
Sources: IBM Red Book; SSR Health; VA Office of Procurement, Acquisition, and Logistics; Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services

U.S. payers generally pay more for high spending drugs than comparator countries.

Price comparisons for 9 high spending drugs relative to US list prices

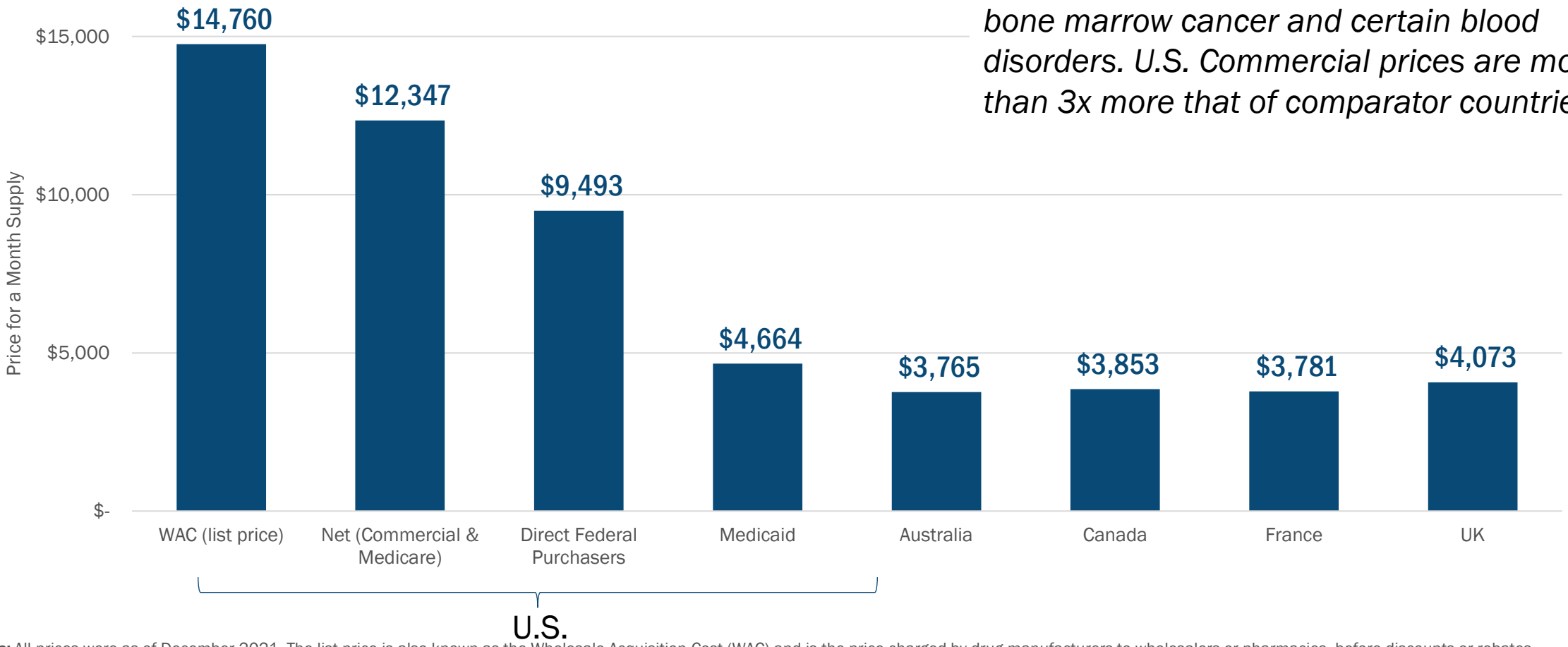
List Prices in the U.S.



Notes: Drugs include Eliquis, Enbrel, Humira, Jakafi, Januvia, Latuda, Revllimid, Sprycel, and Trulicity. All prices were as of December 2021. The list price is also known as the Wholesale Acquisition Cost (WAC) and is the price charged by drug manufacturers to wholesalers or pharmacies, before discounts or rebates are applied. Net commercial and Medicare prices were obtained from SSR Health and are calculated by comparing publicly reported manufacturer revenue with estimated utilization data, to estimate quarterly rebate amounts. Medicaid prices were calculated using Medicaid's formula available online. Drug prices for federal purchasers and comparator countries were publicly available online in fee schedules and represent the "maximum" being paid in other countries. Januvia and Trulicity were excluded from the VA formulary, and alogliptin and semaglutide were both listed as within-class therapies on the formulary instead. The prices of the on-formulary drugs at the VA were imputed as proxies on price for comparing the same drug mix across payers.
Sources: IBM Red Book; SSR Health; VA Office of Procurement, Acquisition, and Logistics; Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services

For two thirds of the high spending drugs examined, commercial prices are at least 2x more expensive than prices in four comparator countries.

Jakafi

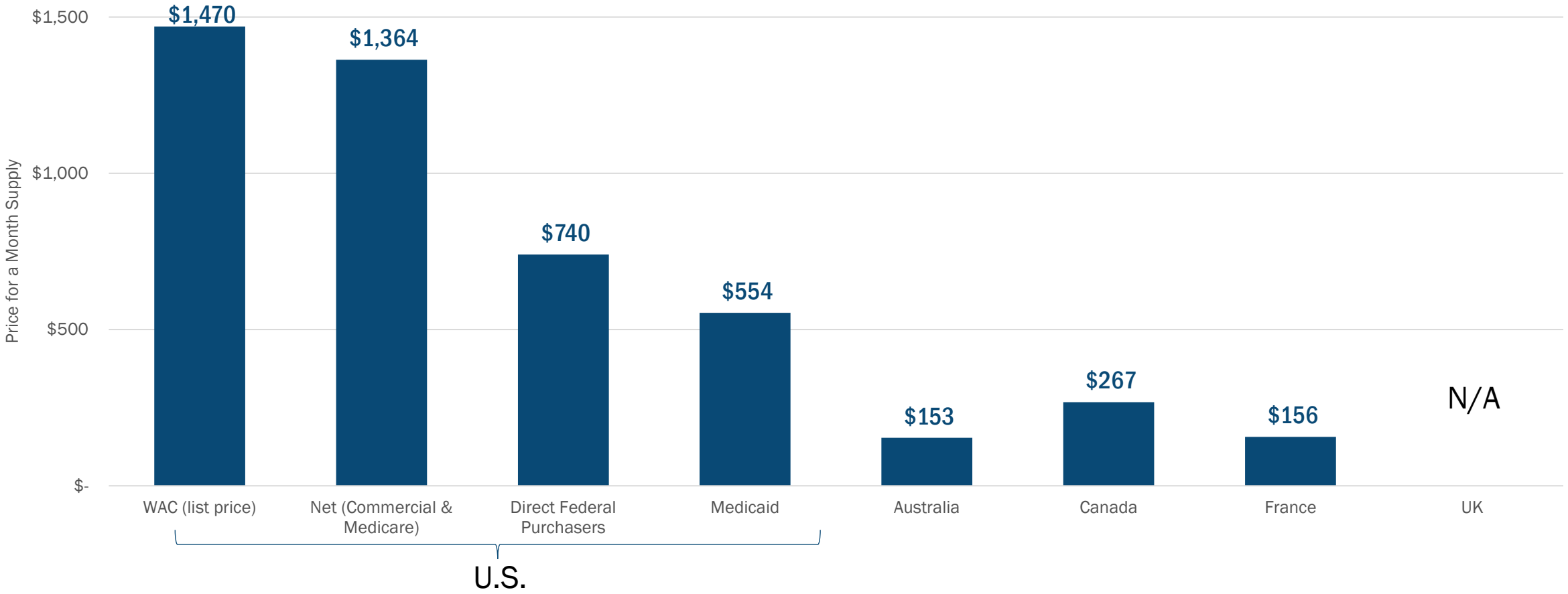


Jakafi is an oral oncology drug used to treat bone marrow cancer and certain blood disorders. U.S. Commercial prices are more than 3x more that of comparator countries.

Notes: All prices were as of December 2021. The list price is also known as the Wholesale Acquisition Cost (WAC) and is the price charged by drug manufacturers to wholesalers or pharmacies, before discounts or rebates are applied. Net commercial and Medicare prices were obtained from SSR Health and are calculated by comparing publicly reported manufacturer revenue with estimated utilization data. Medicaid prices were calculated using Medicaid's formula available online. Drug prices for federal purchasers and comparator countries were publicly available online in fee schedules and represent the "maximum" being paid in other countries.
Sources: IBM Red Book; SSR Health; VA Office of Procurement, Acquisition, and Logistics; Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services

Invega, a psychiatry drug used to treat schizophrenia and schizoaffective disorder, is 5-8x more expensive in the U.S. than in the other countries.

Invega Sustenna

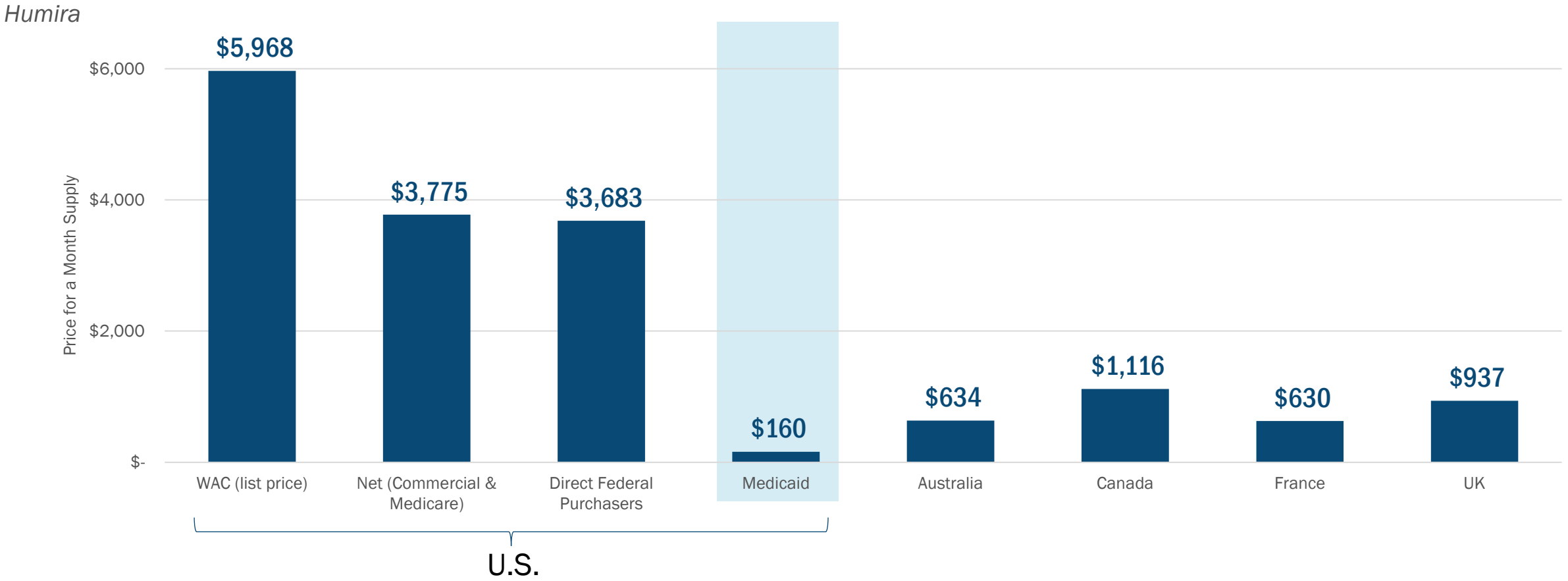


Notes: Price not available in the U.K. due to a confidential negotiation. All prices were as of December 2021. The list price is also known as the Wholesale Acquisition Cost (WAC) and is the price charged by drug manufacturers to wholesalers or pharmacies, before discounts or rebates are applied. Net commercial and Medicare prices were obtained from SSR Health and are calculated by comparing publicly reported manufacturer revenue with estimated utilization data. Medicaid prices were calculated using Medicaid's formula available online. Drug prices for federal purchasers and comparator countries were publicly available online in fee schedules and represent the "maximum" being paid in other countries.

Sources: IBM Red Book; SSR Health; VA Office of Procurement, Acquisition, and Logistics; Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services

For some older drugs, Medicaid achieves lower prices than international comparators because of statutory inflation-based rebates that started at the time of a drug launch.

Commercial and non-Medicare Federal Payers in the U.S. still pay substantially more than other countries.

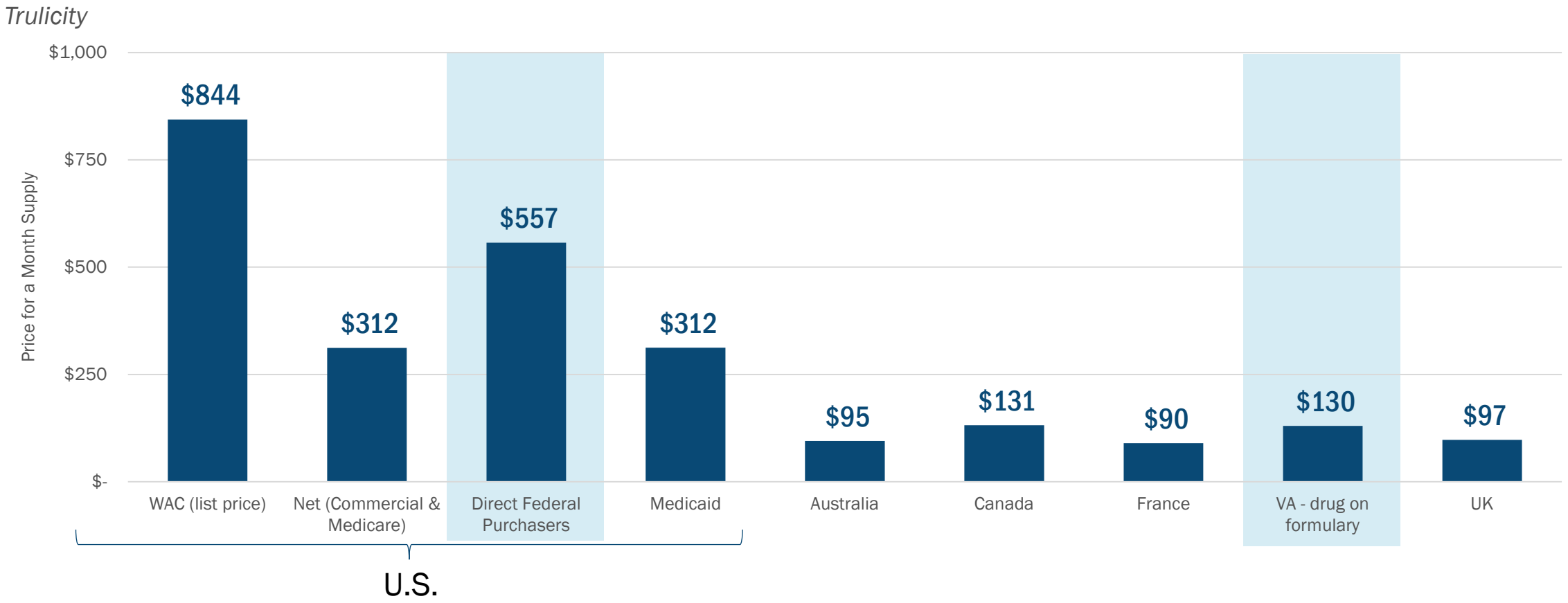


Notes: All prices were as of December 2021. The list price is also known as the Wholesale Acquisition Cost (WAC) and is the price charged by drug manufacturers to wholesalers or pharmacies, before discounts or rebates are applied. Net commercial and Medicare prices were obtained from SSR Health and are calculated by comparing publicly reported manufacturer revenue with estimated utilization data, to estimate quarterly rebate amounts. Medicaid prices were calculated using Medicaid's formula available online. Drug prices for federal purchasers and comparator countries were publicly available online in fee schedules and represent the "maximum" being paid in other countries.

Source: IBM Red Book; SSR Health; VA Office of Procurement, Acquisition, and Logistics; Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services

Like commercial payers, the VA negotiates lower drug prices within competitive drug classes by offering coverage on its formulary.

The VA excluded Trulicity from its formulary, and instead covers Ozempic at a far lower price.



Notes: All prices were as of December 2021. The list price is also known as the Wholesale Acquisition Cost (WAC) and is the price charged by drug manufacturers to wholesalers or pharmacies, before discounts or rebates are applied. Net commercial and Medicare prices were obtained from SSR Health and are calculated by comparing publicly reported manufacturer revenue with estimated utilization data, to estimate quarterly rebate amounts. Medicaid prices were calculated using Medicaid's formula available online. Drug prices for federal purchasers and comparator countries were publicly available online in fee schedules and represent the "maximum" being paid in other countries.

Sources: IBM Red Book; SSR Health; VA Office of Procurement, Acquisition, and Logistics; Australia Fee Schedule; Canada (Quebec) List of Medications; French Public Drug Database; NHS Prescription Services

Presentation Outline

1. Policy Recommendation: Constrain Excessive Pharmaceutical Prices
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4. **Policy Discussion**

Policies and Factors Impacting Drug Pricing

- **Key Finding:** U.S. drug prices are variable depending on the payer and are usually higher than what is paid in other countries.
  - When prices at specific U.S. payers are not higher than in other countries, there is a policy explanation, such as inflation-based rebates at Medicaid, or the ability of VA to negotiate prices and formulary placement
- There are several possible factors contributing to pharmaceutical spending that has exceeded the benchmark in most years
  - **High launch prices.** According to one study, median launch prices increased from $2115 per year per year in 2008 to $180 007 per year in 2021.[1]
  - **Drug price inflation**, especially for some older drugs. An HHS report found that In January 2022, the average list price increase was nearly $150 per drug (10%), and that there were over 1,200 products whose price increases exceeded the inflation rate, with an average price increase for these drugs of 31.6%.[2]
  - **Already high utilization of generics and uncertain impact of biosimilars.** The CBO suggests that generic utilization has reached a saturation point.[4] Many of the highest cost biologic drugs are not subject to competition from biosimilars, which are taking longer to enter the market and have varied effect.[3,4]

Sources: (1) Trends in Prescription Drug Launch Prices, 2008-2021 (Rome, et al. 2022); (2) Congressional Budget Office. Prescription Drugs: Spending, Use, and Prices. January 2022. ; (3) Press Release: New HHS Reports Illustrate Potential Positive Impact of Inflation Reduction Act on Prescription Drug Prices (Accessed here) (4) Comparison of Uptake and Prices of Biosimilars in the US, Germany, and Switzerland (Carl, et al. 2022)

Potential Policy Opportunities for Controlling Drug Spending Growth

ADDRESSING PRICE INCREASES

- The Inflation Reduction Act was signed by President Biden in August 2022 and requires drug manufacturers to pay a rebate to Medicare if the price of certain drugs increase faster than the rate of inflation beginning in January 2023.[1,2] Experts have commented that there is uncertainty on how this new Medicare policy will impact private payers and state Medicaid programs.
- In March 2022, former Governor Baker filed legislation that would establish a penalty on drug manufacturers for excessive price increases, defined as the price of a drug that exceeds the three-year average rate of inflation from the date it was first marketed in the United States.[3]

OVERSIGHT OF HIGH-COST DRUGS

- Since 2019, the HPC has had authority to review the pricing and value of certain high cost drugs if MassHealth is unable to negotiate a supplemental rebate. To date, MassHealth has had significant success negotiating supplemental rebates and has not referred a drug to the HPC.
- Last session, the Massachusetts legislature debated proposals that would have broadened the HPC's oversight for high-cost drugs for commercial payers in Massachusetts. Such provisions were included in the Senate's "Prescription Access, Cost, and Transparency (PACT)" Act.[4]

TRANSPARENCY AND REPORTING

- Understanding drug prices and cost drivers in pharmaceuticals spending requires many assumption and calculations
- Several bills, including the PACT Act and Governor Baker's legislation, incorporate pharmaceutical companies and PBMs into the HPC's oversight authority and require that they submit new data to CHIA for evaluation and monitoring.

Sources: (1) Kaiser Family Foundation. (2) The Senate parliamentarian struck provisions that would require drug makers to pay rebates to private insurers if their prices rose above the rate of inflation. (3) S.2774: An Act Investing in the Future of Our Health (4) S2695 passed in the Senate in February 2022 and was referred to the House Committee on Ways and Means.

Upcoming Research on Pharmaceuticals

Prescription drug prices in Massachusetts as compared to other countries (Part II): Policies to align prices with value

Spending trends and variable costs associated with pharmaceuticals that have high outpatient spending

Understanding out-of-pocket costs for high-cost drugs and policy options to address affordability

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Research Presentation: Emergency Ground Ambulance Utilization and Payment Rates in Massachusetts

Assessing and Addressing Drug Prices in Massachusetts

SCHEDULE OF UPCOMING MEETINGS

2023 Hearing on the Health Care Cost Growth Benchmark

Wednesday, March 15 at 12:00 PM
GARDNER AUDITORIUM
Massachusetts State House

Chapter 224 prescribes the formula that the HPC must use to establish the benchmark each year. Since 2018, the HPC has had limited authority to modify the benchmark if an adjustment is "reasonably warranted."

For the years 2023 through 2032, the health care cost growth benchmark will be set equal to potential gross state product (PGSP), or 3.6%, unless the HPC determines that an adjustment to the benchmark is reasonably warranted. In that case, the HPC Board may choose to modify the benchmark to any amount.

To sign up to provide PUBLIC TESTIMONY, please email Ashley Caunter, HPC Government Affairs Manager:
ashley.caunter@mass.gov

SAVE THE DATE!

Building a Robust Health Care Workforce in Massachusetts: Findings, Challenges, and Opportunities

March 29, 2023

2023 Public Meeting Calendar

HPC

– JANUARY –

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

– FEBRUARY –

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– MARCH –

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– APRIL –

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– MAY –

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– JUNE –

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– JULY –

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– AUGUST –

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– SEPTEMBER –

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– OCTOBER –

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– NOVEMBER –

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– DECEMBER –

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BOARD MEETINGS

Wednesday, January 25
Wednesday, April 12
Wednesday, June 7
Wednesday, July 12
Wednesday, September 13
Wednesday, December 13

COMMITTEE MEETINGS

Tuesday, January 24 (ANF, 2:00 PM)
Wednesday, February 15
Wednesday, May 10
Monday, July 10 (ANF, 2:00 PM)
Wednesday, October 4

ADVISORY COUNCIL

Wednesday, February 8
Wednesday, May 24
Wednesday, September 20
Wednesday, December 6

SPECIAL EVENTS

Thursday, March 2 – OPP Regulation Hearing
Wednesday, March 15 – Benchmark Hearing
Wednesday, March 29 – Health Care Workforce Event
Wednesday, November 1 – Cost Trends Hearing

All meetings will be held virtually unless otherwise noted. This schedule is subject to change, and additional meetings and hearings may be added.