MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

October 4, 2023

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

Reducing Unnecessary Administrative Complexity

DataPoints Issue #25: Shifts in Flu Vaccine Administration Sites in Massachusetts

Schedule of Upcoming Meetings

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

Reducing Unnecessary Administrative Complexity

DataPoints Issue #25: Shifts in Flu Vaccine Administration Sites in Massachusetts

Schedule of Upcoming Meetings

VOTE

Approval of Minutes

MOTION

That the Members hereby approve the minutes of the Committee meeting held on **May 10, 2023**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

REDUCING UNNECESSARY ADMINISTRATIVE COMPLEXITY

DataPoints Issue #25: Shifts in Flu Vaccine Administration Sites in Massachusetts

Schedule of Upcoming Meetings

Administrative complexity is a major driver of health care spending.

- Administrative costs have been estimated to be as high as **34% of total health care spending nationally** or $812 billion annually, significantly greater than other countries.[1]
- Many of these costs are driven by the complexity of a system that includes multiple private and public payers, all with different rules and processes.
- **Billing and insurance-related activities,** a subset of health care administration that includes claims processing, referral management, prior authorization, and more, were estimated to cost U.S. payers and providers **$496 billion** annually.[2]
- **Reducing administrative complexity** could benefit the system without jeopardizing quality or access, such as by:
  - Reducing time, cost, and administrative burden for patients, providers, and payers;
  - Allowing providers to reallocate staff time and resources to higher-value activities;
  - Addressing drivers of clinician burnout; and
  - Reducing delays in care.

1. Himmelstein, Campbell, and Woolhandler. Health Care Administrative Costs in the United States and Canada, 2017. Annals of Internal Medicine. 2020. 272 (2). 2. Gee and Spiro. Excess Administrative Costs Burden the U.S. Health Care System. Center for American Progress. 2019. Available at: https://www.americanprogress.org/article/excess-administrative-costs-burden-u-s-health-care-system/

2023 Policy Recommendation: Administrative Complexity

REDUCE ADMINISTRATIVE COMPLEXITY. Administrative complexity that does not add value permeates the Massachusetts health care system, from the wide array of plan options that are not easily comparable by consumers and employers, to non-standard contract terms and differing rules for provider credentialing, claims submission, and utilization management which consume significant provider time and resources. Prior authorization, often a multi-step, manual process, is particularly burdensome for providers and can result in patient challenges and delayed care, particularly for those with fewer resources. Standardizing among plans and streamlining processing can ease the administrative burden for providers, payers, and patients, and allow for the reallocation of health care resources to higher value tasks and improve equity.

- **Require Greater Standardization in Payer Processes.** The Legislature should require standardization in payer claims administration rules and processes. In particular, the standardization requirements should focus on uniform medical necessity criteria and a uniform set of limited services appropriate for prior authorization.

- **Automate Prior Authorization.** When prior authorization can be warranted to protect patient safety and avoid overuse, automation could streamline the prior authorization process by reducing uncertainty about prior authorization requirements and decreasing the time between prior authorization submission and decision. Efforts to automate prior authorization are already underway for certain public payers, as the proposed federal rule from the Centers for Medicare and Medicaid Services (CMS) would require certain public payers to automate their prior authorization processes by January 2026. The Legislature should build upon this momentum and mandate that others in Massachusetts, including commercial payers, automate their prior authorization processes according to a statewide roadmap, with technical and financial assistance, to support successful implementation.

- **Mandate Adoption of the Aligned Quality Measure Set.** While the Quality Measure Alignment Taskforce has achieved substantial voluntary adoption of its standard, aligned quality measure set for use in global budget-based risk contracts, even after several years, payer adherence remains variable. To promote alignment and mitigate the reporting burden for providers, the Legislature should mandate adoption of the aligned measure set, as further refined by the Taskforce, and approved by the Secretary of Health and Human Services.

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Automation in Massachusetts

INCLUDE COMMERCIAL PAYERS

STATEWIDE ROADMAP

SUPPORTIVE STRUCTURES

- The HPC's recommendation to automate prior authorization was **developed in collaboration** with the Network for Excellence in Health Innovation (NEHI), Massachusetts Health Data Consortium (MHDC), and the New England Healthcare Exchange Network (NEHEN).
- The recommendation builds on a **on CMS's Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P)** that requires certain public payers to automate prior authorization. The Commonwealth could leverage federal activity in this space by:
  - Expanding the requirement for automation to include **commercial payers**;
  - Developing a **statewide roadmap** to guide uniform implementation; and
  - Establishing **supportive structures**, such as a technical assistance center, a stakeholder task force, and financial assistance.
- CMS published the CMS-0057-P on 12/6/2022 and accepted comments through 3/13/2023. **A final rule has not yet been released.**

Automate Prior Authorization: Potential Benefits

Though not a solution for all PA pain points, automating prior authorization would provide **real-world process improvements** for MA payers, providers, and patients, such as:

- Reducing provider **uncertainty about when PA is required**, which could eliminate a significant number of PAs submitted currently
- **Decreasing the time** from PA submission to disposition.
- Reducing payer and provider **manual paperwork**.
- Establishing a **data foundation** against which to evaluate PA volume and variation which could inform further reform efforts.
- Providing opportunities for **greater standardization of PA programs** across payers

Automate Prior Authorization: Current Status

In alignment with the proposed federal rule, **Massachusetts market participants are working to develop a centralized, coordinated approach** to automating prior authorization.

- MHDC and NEHEN have been meeting regularly with MA market participants and recently released a Request for Proposals for a technology vendor who can incorporate core automated prior authorization services into the existing NEHEN service platform.
- These upgrades may also allow for automated exchange of quality measure data and equity data between payers and providers.
- Most MA-based payers (including BCBSMA, Point32Health, MGB Health Plan, Fallon Health, Health New England, and Wellsense Health Plan) use NEHEN services, as do several large MA providers and over 200+ provider practices.

While this activity moves MA toward the vision of a uniform standard for automating prior authorization, it relies on **voluntary participation by market participants** and as such will not achieve the universal, uniform implementation desired. Legislative action is necessary to ensure market-wide participation and fidelity to technological standards.

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Mandate Adoption of the Aligned Quality Measure Set: Current Status

YEAR	STATEWIDE FIDELITY TO THE ALIGNED MEASURE SET
2019	65%
2020	72%
2021	83%
2022	85%
2023	92%

- The Massachusetts **Quality Measure Alignment Taskforce (QMAT)** annually publishes an Aligned Measure Set for voluntary adoption by payers and providers in their global-budget-based risk contracts.
- The QMAT released the 2024 Aligned Measure Set in June of 2023, for implementation starting 1/1/2024.
- Though adoption is voluntary, CHIA tracks and reports annually on **fidelity to the Aligned Measure Set**, defined as the proportion of measures used in contracts that are endorsed.
  - The overall **statewide adherence rate has increased over time**, from 65% in 2019 up to 92% in 2023.
  - MassHealth has adhered completely to the Aligned Measure Set in all five years.
  - Private payer adherence in 2023 varied across payers, ranging from 99% (BCBSMA) to 40% (UnitedHealthcare).
- The most recent years of data suggest that, despite progress, **additional state action to mandate adoption** may be required to achieve full alignment and eliminate wide variation in adherence rates across private payers.

Presentation to the Care Delivery Transformation committee of the Health Policy Commission. October 12, 2022. Available at: https://www.mass.gov/doc/presentation-10122022-cdt-meeting/download

Mandatory Measure Alignment in Other States

RHODE ISLAND

Aligned Measure Set developed for use in commercial provider contracts in 2015[1]

Adoption is required for insurers under the state's health insurance affordability standards

Medicaid has committed to voluntary alignment

MINNESOTA

Physician clinics and hospitals have been required to submit data on a standardized set of quality measures ("Statewide Quality Reporting and Measurement System") for public reporting since 2010[2]

Health plans may only require providers to submit data on measures that are part of the standardized set

OREGON

Aligned Measures Menu Set adopted for use in Medicaid, public employee benefits plans, and the health insurance exchange in 2018[3]

These programs are not required to adopt all of the measures in the set but may not adopt any that are not included in the set

1 Measure Alignment | Office of The Health Insurance Commissioner (ri.gov)
2 Health Care Quality Measures - MN Dept. of Health (state.mn.us)
3 Oregon Health Authority : Health Plan Quality Metrics Committee : Office of Health Analytics : State of Oregon

E-Clinical Quality Measures (eCQMs)

eCQMs are clinical quality measures that are specified in a standard electronic format. They allow for the electronic extraction of data from EHRs to measure the quality of health care provided, reducing the administrative burden of manual reporting.

The QMAT's Electronic Clinical Quality Measurement Work Group was charged with exploring how the Commonwealth can advance eCQMs and identifying goals and barriers to inform the QMAT's next steps. In a survey of Taskforce members conducted by the Work Group, respondents identified the following:

- Benefits of eCQMs (among others)
  - Population-based reporting
  - Improved metric accuracy
  - Real-time data and timely reporting
- Barriers to moving eCQMs forward (among others)
  - Multiplicity of systems and inconsistencies in workflows and structured fields in EHRs
  - Technical readiness of contractors and investment in resources and infrastructure

Rhode Island has been working to simplify data collection (including clinical data from EHR systems, claims, and other data), measure calculation, and data exchange for quality reporting purposes. They are exploring opportunities to reduce provider administrative burden and cost by leveraging existing EHR interfaces to provide data to the state's health information exchange platform.

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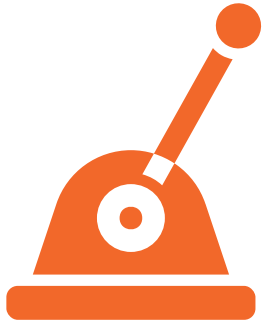
The Need for Greater Standardization

- The U.S. healthcare system is notoriously fragmented, with multiple public insurance programs and a multi-payer private market, leading to significant administrative complexity for patients, providers, and payers.
- U.S. administrative costs are higher even than those of other countries with private-payer markers, in part because other systems impose greater standardization on private payers, such as through standard billing codes, contract terms, and list prices.[1, 2]
- By reducing variation in health plan systems and processes, Massachusetts could lower the amount that providers spend to navigate our multi-payer system.
- Greater standardization can be achieved not only by establishing standard operating procedures that apply across plans, but also by adopting technologies and eliminating low-value tasks.

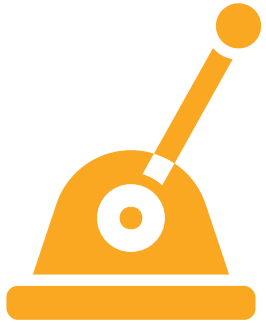
1. Himmelstein et. al. A Comparison Of Hospital Administrative Costs In Eight Nations: US Costs Exceed All Others By Far. Health Affairs. 2014. 33(9). 2. Richman et. al. Billing And Insurance–Related Administrative Costs: A Cross-National Analysis. Health Affairs. 2022. 14(8).

Approaches to Achieving Greater Standardization



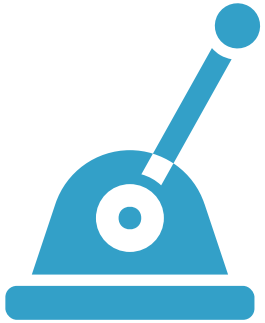
REDUCE VARIATION & DUPLICATION

- Improve processes that require unnecessary repetition
- Standardize requirements and processes across organizations



LEVERAGE TECHNOLOGY

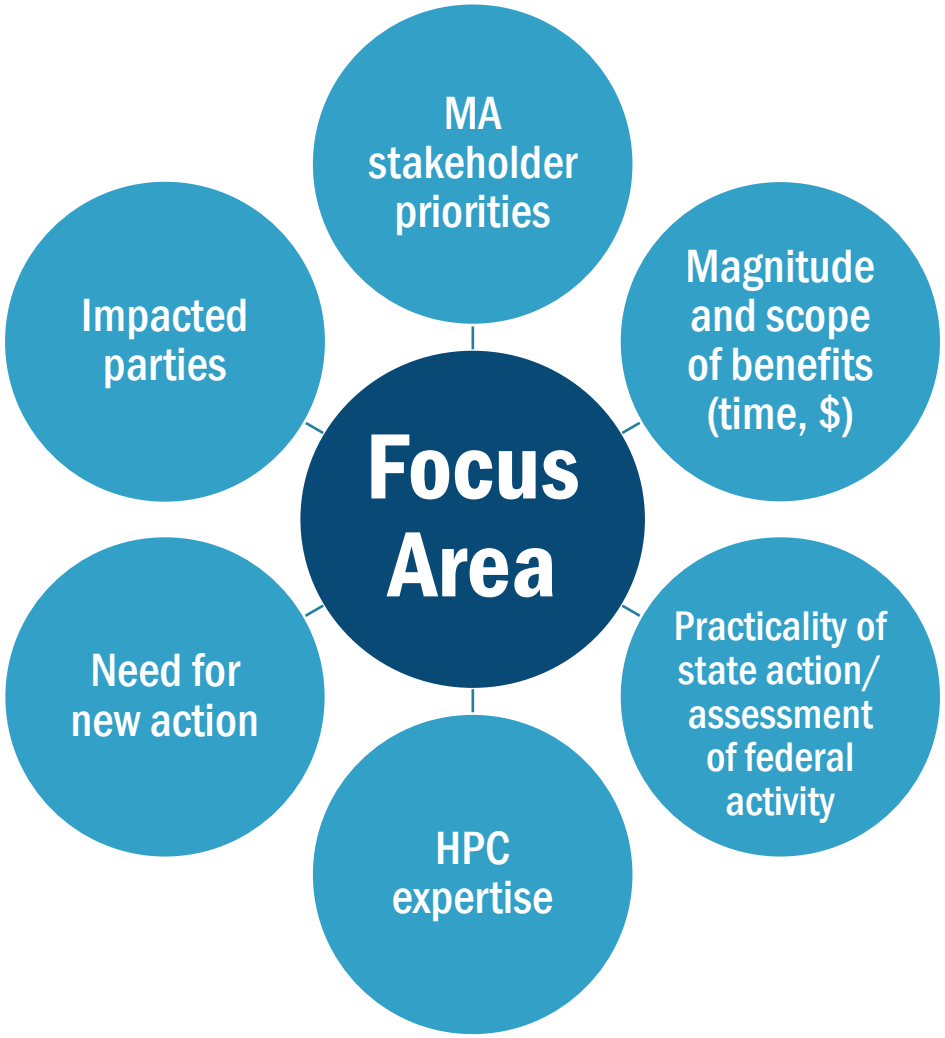
- Reduce the use of faxing, phone, email
- Integrate processes into existing workflows
- Review existing IT systems against new technology



ELIMINATE LOW-VALUE TASKS

- Identify tasks that are no longer achieving their intended purpose
- Determine whether task is valuable in all circumstances and consider differential application

Areas of Administrative Complexity Previously Considered and Criteria for Consideration



EXAMPLE AREAS OF COMPLEXITY

- Billing and Claims Processing
- Clinical Documentation and Coding
- Clinician Licensure
- Electronic Health Record Interoperability
- Eligibility/Benefit Verification and Coordination of Benefits
- Prior Authorization
- Provider Credentialing
- Provider Directory Management
- Quality Measurement and Reporting
- Referral Management
- Variations in Benefit
- Variations in Payer-Provider Contract Terms

Discussion and Next Steps

DISCUSSION

- What should the HPC prioritize in its 2023-2024 work on administrative complexity? Should the HPC organize its work around a specific topic (e.g., credentialing) or a specific policy lever (e.g., standardization)?
- How do specific topics or policy levers align with the criteria for consideration?
- What information or context should the HPC prioritize in its stakeholder engagement?

NEXT STEPS

- Staff research
- Stakeholder engagement
- Update to the MOAT committee in late 2023 or early 2024

Areas of Administrative Complexity: Provider Credentialing

PROVIDER CREDENTIALING

- Many MA stakeholders use the term credentialing to refer to a range of activities that must be undertaken before a clinician can provide care, including licensure with the state, registration with the DEA, credentialing with payers, and privileging at hospitals where they will practice.
- The credentialing process is designed to protect patient safety by ensuring that the clinician has the proper training and qualifications to provide care.
- Complexity in the credentialing process primarily stems from the fact that multiple entities, including the employing provider, licensing agencies, health care payers, and local hospitals, have different processes for verifying the same or similar academic, professional, and legal records.
- Providers must be recredentialed at regular intervals and when they change employers or job sites, adding complication and delays to the process.

Areas of Administrative Complexity: Provider Directories

PROVIDER DIRECTORIES

HPC

- Provider directories are meant to enable easy identification of providers participating in health plan network, supplying important information such as clinician specialty, practice location, contact information, network tier (if applicable), languages spoken, open panel status, and more.
- Maintenance of provider directories is difficult for health plans, as changes in a clinician's information can occur at any time; likewise, providers may need to update their status with multiple different payers.
- High error rates have been identified in directories.
  - In 2016, CMS studied the accuracy of online directories for some Medicare Advantage Plans and found that nearly half of the practice locations listed are incorrect. [1]
  - In 2018, the American Medical Association released the results of a survey that found that over half of physicians said patients encounter coverage issues due to inaccurate information in payer directories.[1]

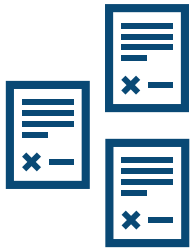
1. CAQH. The Hidden Causes of Inaccurate Provider Directories. 2019.

Areas of Administrative Complexity: EHR Interoperability

EHR INTEROPERABILITY

- The 21st Century Cures Act of 2016 defines interoperability as "the secure exchange of information with, and use of electronic health information from, other health information technology without special effort on the part of the user."
- EHR interoperability facilitates the exchange of health information, which can improve care, quality, and outcomes.
- Differences in and/or disparate data elements, classes, and standards can make integration of information shared via messaging or by other mechanisms slow, costly, and/or challenging because it takes additional work and effort to incorporate differently-formatted data into an existing medical record.
- Interoperability challenges can be compounded by information blocking, in which a provider, payer, or developer interferes with, prevents, or discourages the exchange, use, or access of information.

Areas of Administrative Complexity: Variation in Payer/Provider Contract Terms



VARIATION IN PAYER/PROVIDER CONTRACT TERMS

Payer-provider interactions (e.g., network participation, patient eligibility checks, fee establishment, claims submission) are dictated by their contract terms.

Variation in contractual provisions has been well documented. For example, in 2018 the MA Attorney General's Office described variation in:

- Reimbursement methods (e.g., for inpatient care alone, diagnosis-related groups (DRGs), per diem payments, percent of charges)
- Grouping of services for fee schedule negotiation
- Reimbursement methods for cases not captured by standard fee schedules

Such variation results not only in administrative burden and associated costs for providers, but also has downstream effects on patients, diverting resources that could be spent on patient care and making effective price comparisons difficult.

Some researchers have called for modular contract terms that could increase overall standardization while still leaving important business decisions to the market.

OFF. OF ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS (October 11, 2018), available at https://www.mass.gov/doc/2018-examination-of-health-care-cost-trends-and-cost-drivers/download; B Richman et al., Billing and Insurance-Related Administrative Costs: A Cross-National Analysis, 41 Health Affairs 8 (August 2022).

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Reducing Unnecessary Administrative Complexity

DATAPOINTS ISSUE #25: SHIFTS IN FLU VACCINE ADMINISTRATION SITES IN MASSACHUSETTS

Schedule of Upcoming Meetings

Background

- Influenza (flu) vaccines have been found to reduce severity of illness and the risk of flu-associated hospitalization[1] and are widely considered to be an important preventive care service.
- The Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices recommends that **individuals aged 6 months and older** should receive a flu vaccine every season.[1]
  - During the 2021-2022 influenza season, **62.9%** of individuals aged 6 months and older in Massachusetts received a flu vaccine, compared to **51.4%** of individuals nationally.[2]
- Flu vaccines may be administered in a variety of settings, including doctor's offices, hospital outpatient departments (HOPDs), pharmacies, and retail clinics, and mass immunization centers. The setting of administration may have different implications for cost and access.
  - Mass immunization centers include pop-up vaccination sites (e.g., stadiums, convention centers, parking lots, etc.), but may also include existing community-based sites.[3]

Sources: (1) Centers for Disease Control and Prevention. Seasonal Flu Vaccines. Available at: https://www.cdc.gov/flu/prevent/flushot.htm. (2) Kaiser Family Foundation. State Health Facts. Flu Vaccination Rate. Available at: https://www.kff.org/other/state-indicator/flu-vaccination-rate/. (3) Centers for Medicare and Medicaid Services. Place of Service Code Set. Available at: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets.

Methods

DATA SOURCE

- Massachusetts All-Payer Claims Database (APCD), V2021.
- Commercial medical (professional and facility) and pharmacy claims were included in the analysis.

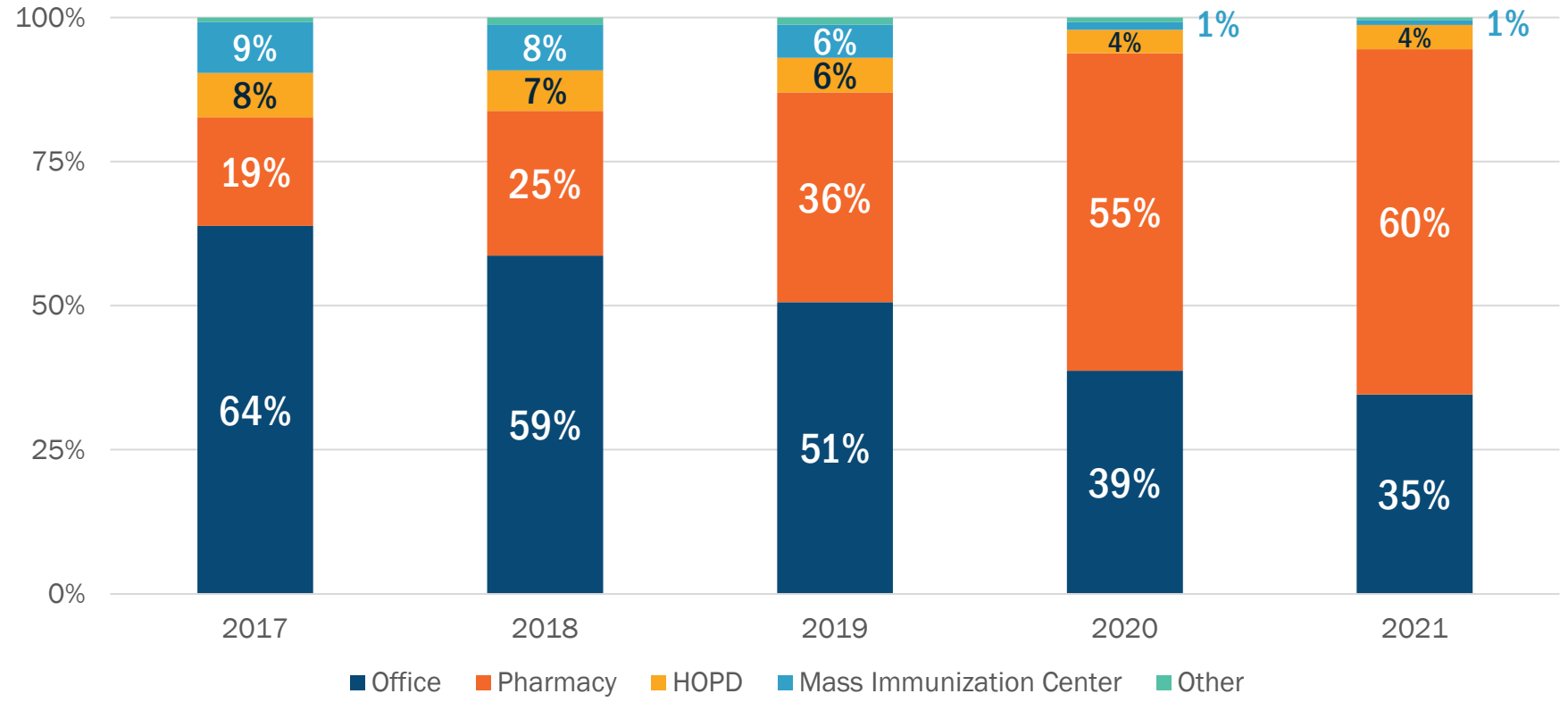
ANALYIC NOTES

- **Population:** Commercially-insured Massachusetts residents aged 3-64 with 12 months of medical and pharmacy coverage in that year.
- **Unit of analysis:** Same member, same date, same site "encounters" where a flu vaccine was administered. Vaccines and vaccine administrations were identified using Current Procedural Terminology (CPT) and National Drug Classification (NDC) codes.
- **Limitations:** This analysis only captures vaccines that were billed to insurance. Individuals with commercial insurance may receive flu vaccines covered by other sources, such as work or school.

- The HPC analyzed setting of administration and cost for flu vaccines for commercially-insured Massachusetts residents who got a flu vaccine, 2017 – 2021.

Most flu vaccines among commercially-insured Massachusetts residents occurred in offices in 2017; by 2021, most occurred in pharmacies.

Percent of flu vaccines among commercially-insured Massachusetts residents by setting of administration, 2017 to 2021



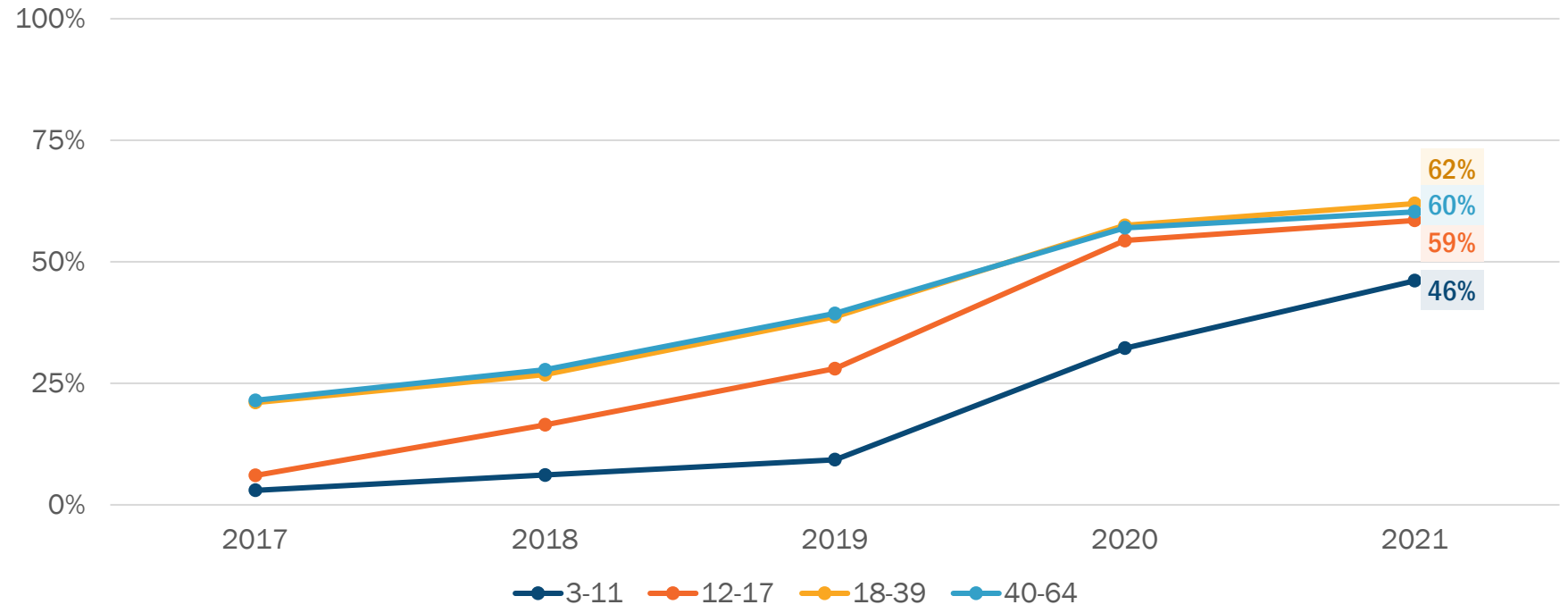
Notes: Population is commercially-insured Massachusetts residents aged 3 to 64 years of age with full medical and pharmacy coverage. Vaccinations were identified using Current Procedural Terminology (CPT) and National Drug Classification (NDC) codes. "Pharmacy" includes walk-in retail clinics. "Other" includes sites such as federal qualified health centers, urgent care facilities, and rural health clinics, among others.

Sources: (1) Massachusetts Health Policy Commission analysis of Massachusetts All-Payer Claims Database (APCD) data, 2017-2021, V2021. (2) Amin K et al. Where Do Americans Get Vaccines and How Much Does it Cost to Administer Them? Kaiser Family Foundation. Feb. 2021. Available at: https://www.healthsystemtracker.org/chart-collection/where-do-americans-get-vaccines-and-how-much-does-it-cost-to-administer-them/. (3) HPC analysis of the Center for Disease Control and Prevention's Weekly Cumulative Estimated Number of Influenza Vaccinations Administered in Pharmacies and Physician Medical Offices, Adults 18 years and older, United States. Available at: https://data.cdc.gov/Vaccinations/Weekly-Cumulative-Estimated-Number-of-Influenza-Va/83ng-twza.

- Nationally, of adults (all-payer) who received a flu vaccine in **2018**, 40% received their vaccine in a doctor's office, 26% in a retail pharmacy or store health clinic, 14% in a workplace or school, and 20% at other settings.[2]
- During the **2020-2021** flu season, of U.S. adults (all-payer) who received a flu vaccine, 59% received their vaccine in a pharmacy and 41% in a physician's office.[3]

The shift to pharmacies was particularly large among children and adolescents.

Percent of flu vaccines among commercially-insured Massachusetts residents provided in pharmacies by age group, 2017 to 2021



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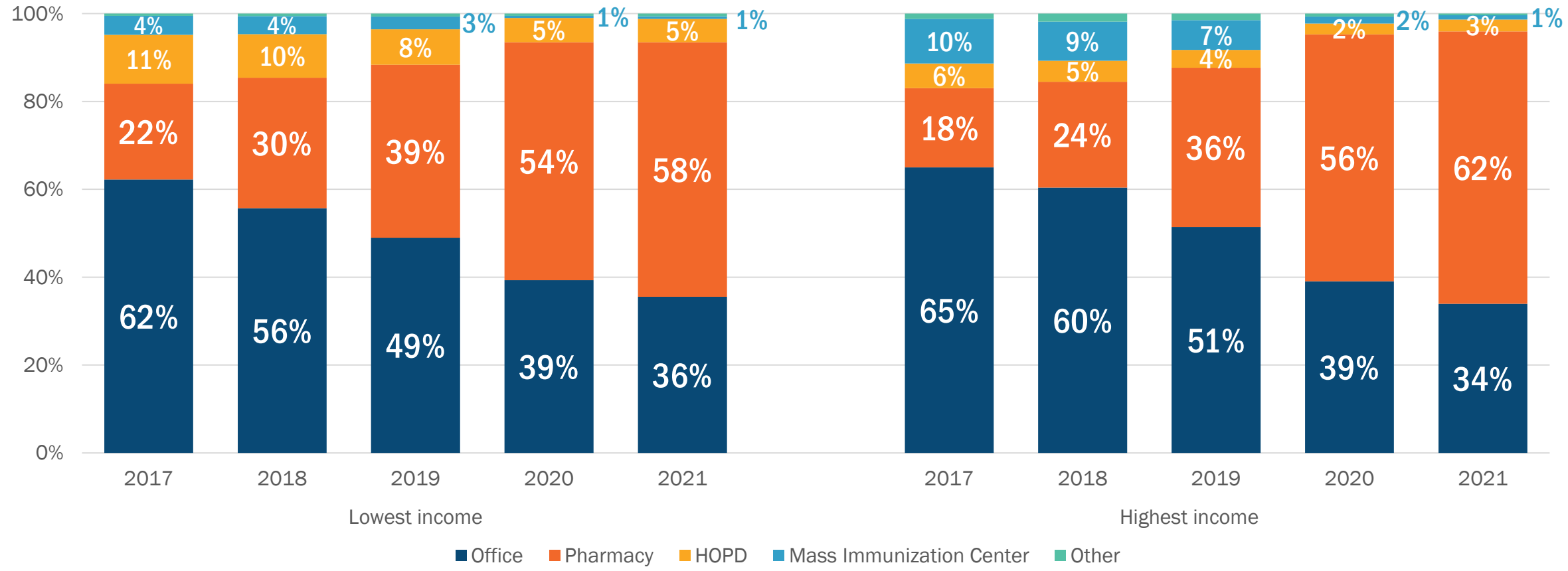
- Prior to the COVID-19 public health emergency (beginning in 2017), pharmacists and pharmacy interns in MA were authorized by MA Dept. of Public Health (DPH) to administer flu (and other) vaccines to individuals **9 years of age and older**.[2]
- Beginning in 2020 during the COVID-19 public health emergency, and in accordance with the Public Readiness and Emergency Preparedness (PREP) Act, qualified pharmacy personnel were authorized to administer flu vaccines (and others, including COVID-19) to individuals **3 years of age or older**.[3]
- As of spring 2023, MA DPH authorizes qualified pharmacy personnel to administer flu vaccines (and others, including COVID-19) to individuals **5 years of age or older**.[4]

Prior to and during the pandemic, similar shares of commercially-insured residents in the lowest-income and highest-income areas got their flu shots in pharmacies.

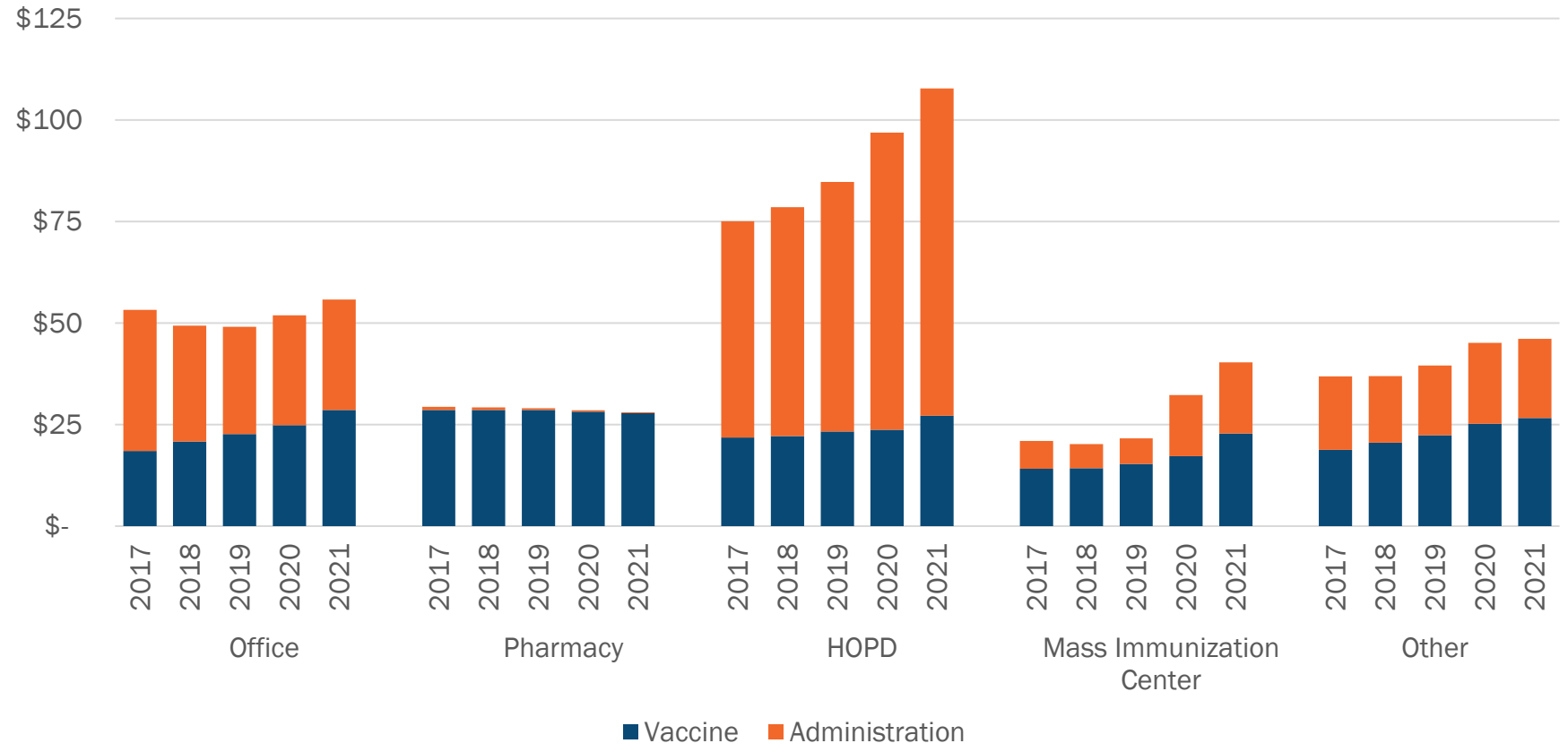
Percent of flu vaccines among commercially-insured Massachusetts residents by setting of administration and community income decile, 2017 to 2021



Notes: Population is commercially-insured Massachusetts residents aged 3 to 64 years of age with full medical and pharmacy coverage. Vaccinations were identified using Current Procedural Terminology (CPT) and National Drug Classification (NDC) codes. "Pharmacy" includes walk-in retail clinics. "Other" includes sites such as federal qualified health centers, urgent care facilities, and rural health clinics, among others. Income is based on American Community Survey (ACS) population estimates. "Lowest income" areas are those in the 1st income decile and "highest income" areas are those in the 10th income decile.
Sources: Massachusetts Health Policy Commission analysis of Massachusetts All-Payer Claims Database (APCD) data, 2017-2021, V2021.

While average prices for vaccines are generally similar across sites and have remained relatively stable over time, administration costs differ widely across sites.

Average price of flu vaccines among commercially-insured Massachusetts residents by component of price and setting of administration, 2017 to 2021

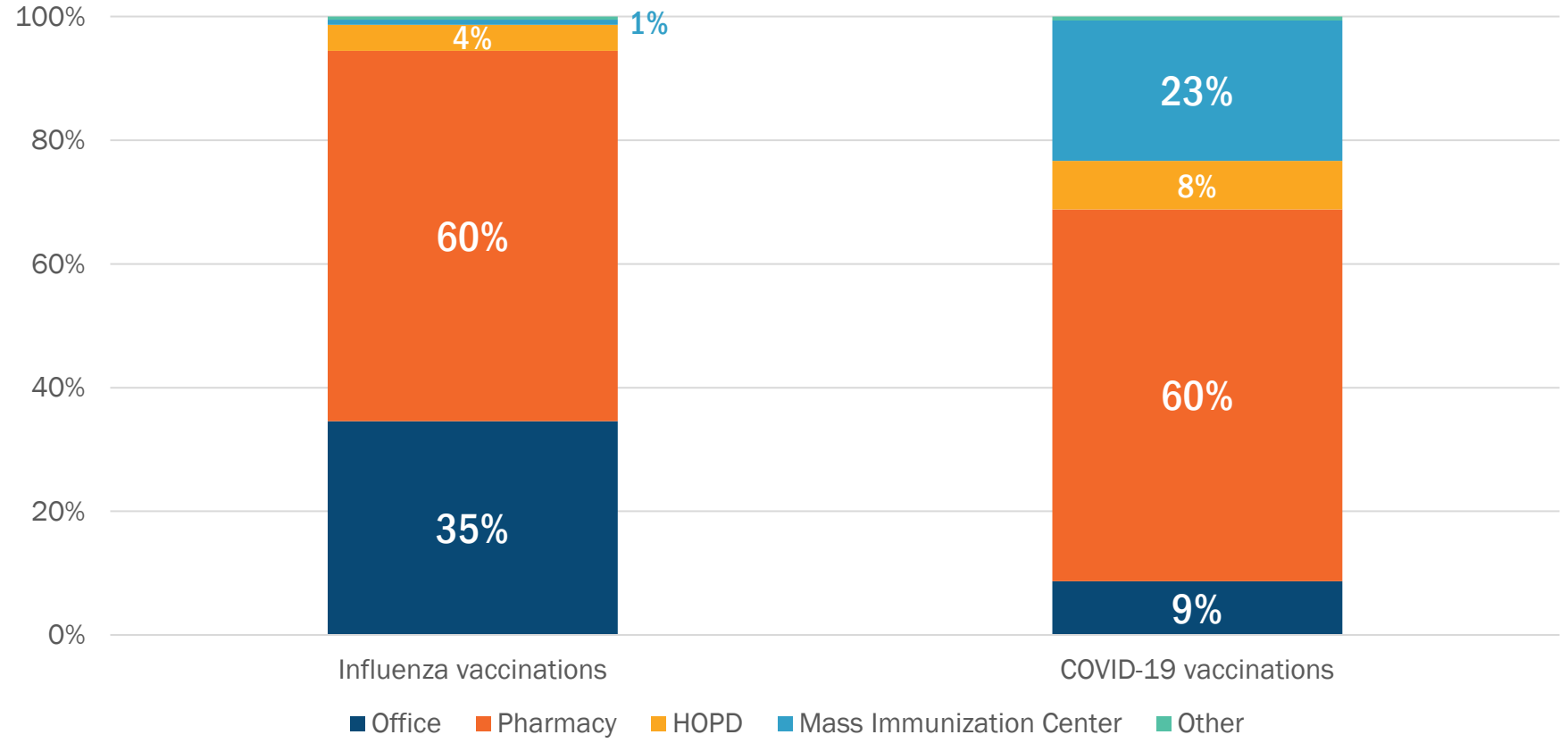


Notes: HOPD = hospital outpatient department. Prices are for visits where only one influenza vaccine and no COVID-19 vaccinations were administered. Pharmacy price does not include dispensing fee, if any. Population is commercially-insured Massachusetts residents aged 3 to 64 years of age with full medical and pharmacy coverage. Vaccinations were identified using Current Procedural Terminology (CPT) and National Drug Classification (NDC) codes. "Pharmacy" includes walk-in retail clinics. "Other" includes sites such as federal qualified health centers, urgent care facilities, and rural health clinics, among others.
Sources: Massachusetts Health Policy Commission analysis of Massachusetts All-Payer Claims Database (APCD) data, 2017-2021, V2021.

- In 2021, the total price for a flu vaccine in a HOPD was **double** the price in other settings, due to high prices for vaccine administration.
- Flu vaccines are typically covered with no patient cost sharing.

In 2021, most COVID-19 vaccines among commercially-insured residents also were provided in pharmacies, though more were provided in mass immunization centers than flu vaccines.

Percent of flu and COVID-19 vaccines among commercially-insured Massachusetts residents by setting of administration, 2021



Notes: COVID-19 vaccinations include the primary series as well as booster doses. Population is commercially-insured Massachusetts residents aged 3 to 64 years of age with full medical and pharmacy coverage. Vaccinations were identified using Current Procedural Terminology (CPT) and National Drug Classification (NDC) codes. "Pharmacy" includes walk-in retail clinics. "Other" includes sites such as federal qualified health centers, urgent care facilities, and rural health clinics, among others.
Sources: (1) Massachusetts Health Policy Commission analysis of Massachusetts All-Payer Claims Database (APCD) data, 2017-2021, V2021. (2) Massachusetts Department of Public Health. Massachusetts' COVID-19 Vaccination Phases. Available at: https://www.mass.gov/info-details/massachusetts-covid-19-vaccination-phases.

- In Massachusetts, COVID-19 vaccines were administered using a **phased approach**. Between December 2020 and April 2021, defined priority groups became eligible for vaccination. On April 19th, 2021, all individuals aged 12+ became eligible, followed by children aged 5 to 11 on November 3rd, 2021.[2]

Conclusions

- By 2021, most flu vaccines among commercially-insured residents were administered in **pharmacies** (60%), followed by **offices** (35%), and **other settings** (6%). This is a dramatic change from previous years where most were administered in offices.
- An increasing proportion of flu vaccines occurring in pharmacies was observed among commercially-insured residents of **all age and income groups**, though particularly for children.
- In 2021, the total price for a flu vaccine in a HOPD was **double** the price in other settings, due to **high prices for vaccine administration**.
- Further analysis should done on patient access to vaccine administration sites throughout the Commonwealth, including pharmacies.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Reducing Unnecessary Administrative Complexity

DataPoints Issue #25: Shifts in Flu Vaccine Administration Sites in Massachusetts

SCHEDULE OF UPCOMING MEETINGS

SAVE THE DATE

2023

HEALTH CARE COST TRENDS HEARING

WEDNESDAY, NOVEMBER 8

9:00AM – 4:00PM

MASSACHUSETTS
HEALTH POLICY COMMISSION

SUFFOLK UNIVERSITY
LAW SCHOOL
120 Tremont Street, Boston

LIVESTREAM: tinyurl.com/hpc-video

REGISTER ONLINE: tinyurl.com/CTH23reg

*The event will be open to a limited number of pre-registered members of the public

2023 Public Meeting Calendar

HPC

– JANUARY –

S	M	T	W	T	F	S
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– 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, December 6

SPECIAL EVENTS

Thursday, March 2 – OPP Regulation Hearing
Wednesday, March 15 – Benchmark Hearing
Wednesday, March 29 – Health Care Workforce Event
Wednesday, November 8 – 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.