MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

October 12, 2022

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

Research Presentation: Utilization of Telehealth in the Commonwealth

Examination of Recent Provider Expansions

Office of Patient Protection Regulatory Changes

Schedule of Upcoming Meetings

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

Research Presentation: Utilization of Telehealth in the Commonwealth

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VOTE

Approval of Minutes

MOTION

That the Members hereby approve the minutes of the Committee meeting held on **May 11, 2022**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

RESEARCH PRESENTATION: UTILIZATION OF TELEHEALTH IN THE COMMONWEALTH

- Overall Use of Telehealth Services in Massachusetts in 2020
- Variation in Use of Telehealth Services
- Impact of Cost-sharing on Telehealth Use
- Telehealth's Effect on Total Spending
- Stakeholder Perspectives and Policy Considerations

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Background: Telehealth Policy in the Commonwealth

March 2020: Emergency Order

In response to a state of emergency, Governor Charlie Baker issued an executive order mandating the coverage of clinically appropriate and medically necessary telehealth services. The order also established that telehealth services be reimbursed at the same rates as in-person services.[1]

January 2021: Chapter 260 of the Acts of 2020

Chapter 260 mandated that all services that can be appropriately delivered via telehealth will continue to be covered permanently. In addition:

- It required that **behavioral health services** delivered via telehealth be reimbursed on par with in-person services **in perpetuity**.
- It mandated reimbursement parity for **primary care and chronic disease management** provided via telehealth **until January 1, 2023**.
- The requirement to reimburse **all other services** delivered via telehealth at parity would **no longer be statutorily mandated** as of September 13, 2021 (90 days after the end of the governor's state of emergency).

1. Commonwealth of Massachusetts, order expanding access to telehealth services and to protect health care providers, March 10, 2020. https://www.mass.gov/doc/march-15-2020-telehealth-order/download

Legislatively Mandated Report on Telehealth Use in the Commonwealth

Chapter 260 also directs the HPC in consultation with CHIA to issue a report on the use of telehealth services and their impact on healthcare access and costs.

The HPC is charged with:

- **Analyzing utilization and spending trends:** such as telehealth use by type of service, provider organization, payer, patient demographics, and geographic region and total healthcare expenditures on telehealth services and impact on total healthcare spending;
- **Assessing patient access:** including impact of payer coverage and payment rates and cost of care, barriers to increased telehealth use, such as provider technology infrastructure and patient broadband and cellular access, and equity in access for low-income patients;
- **Providing policy recommendations** on reimbursement levels, including facility fees; the appropriateness of pre-authorization and other utilization management tools on telehealth, and ways to expand the use of and services provided through telehealth

Methods for Quantitative Analysis

Data source

- Massachusetts All-Payer Claims Database (APCD), V10.0, five large commercial payers
- Includes both professional and facility claims; claims on the same day for the same patient were combined
- Sample restricted to commercial members under 65

Identify telehealth

- Telehealth identified by:
  - Place of service code 02
  - Procedure modifiers
  - Telehealth specific procedure codes
- Remote patient monitoring and chronic care management codes were excluded

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- **OVERALL USE OF TELEHEALTH SERVICES IN MASSACHUSETTS IN 2020**
- Variation in Use of Telehealth Services
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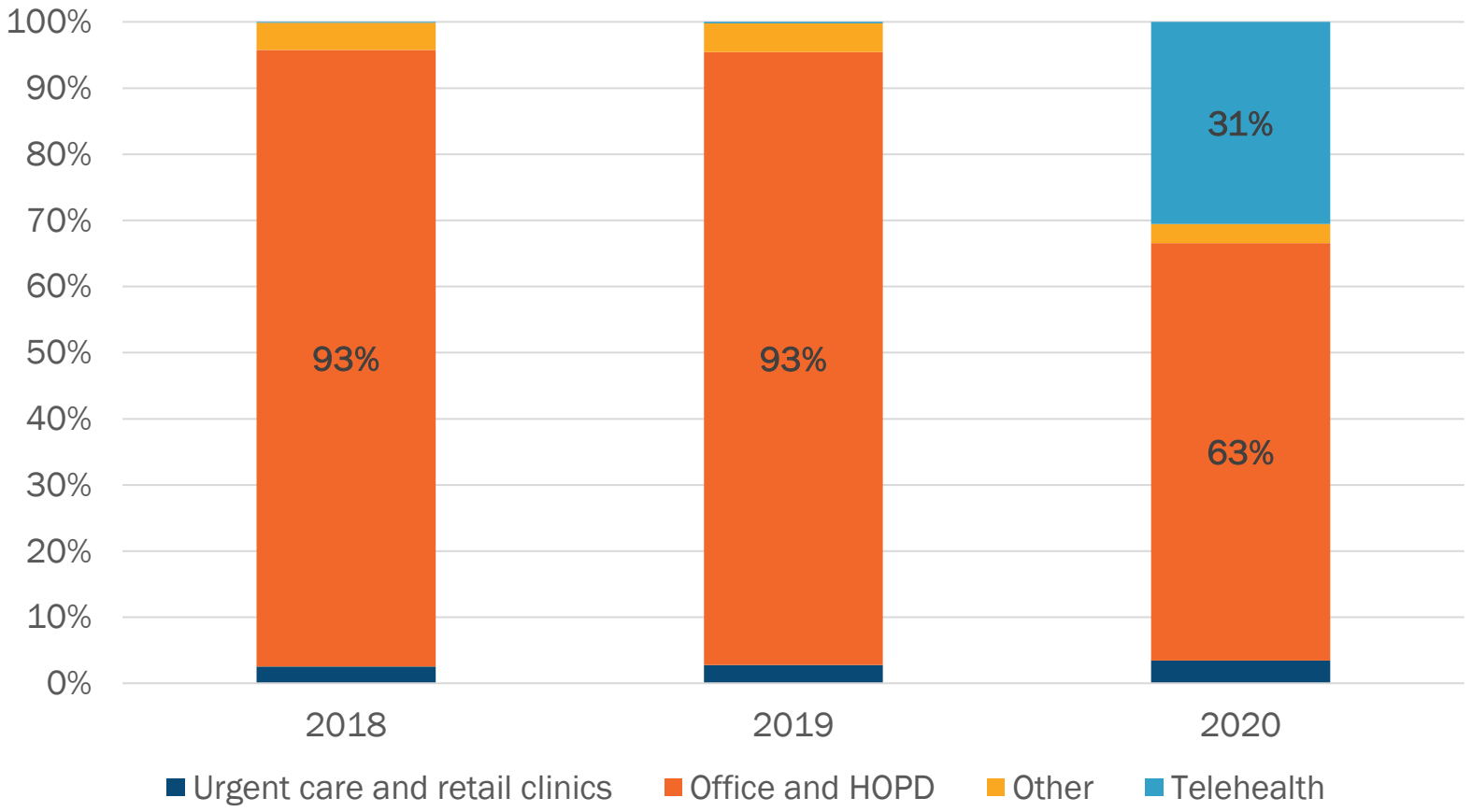
Over half of commercial members had some telehealth use in 2020 with telehealth accounting for nearly 1/3 of all ambulatory visits.

Share of ambulatory visits by site, 2018-2020



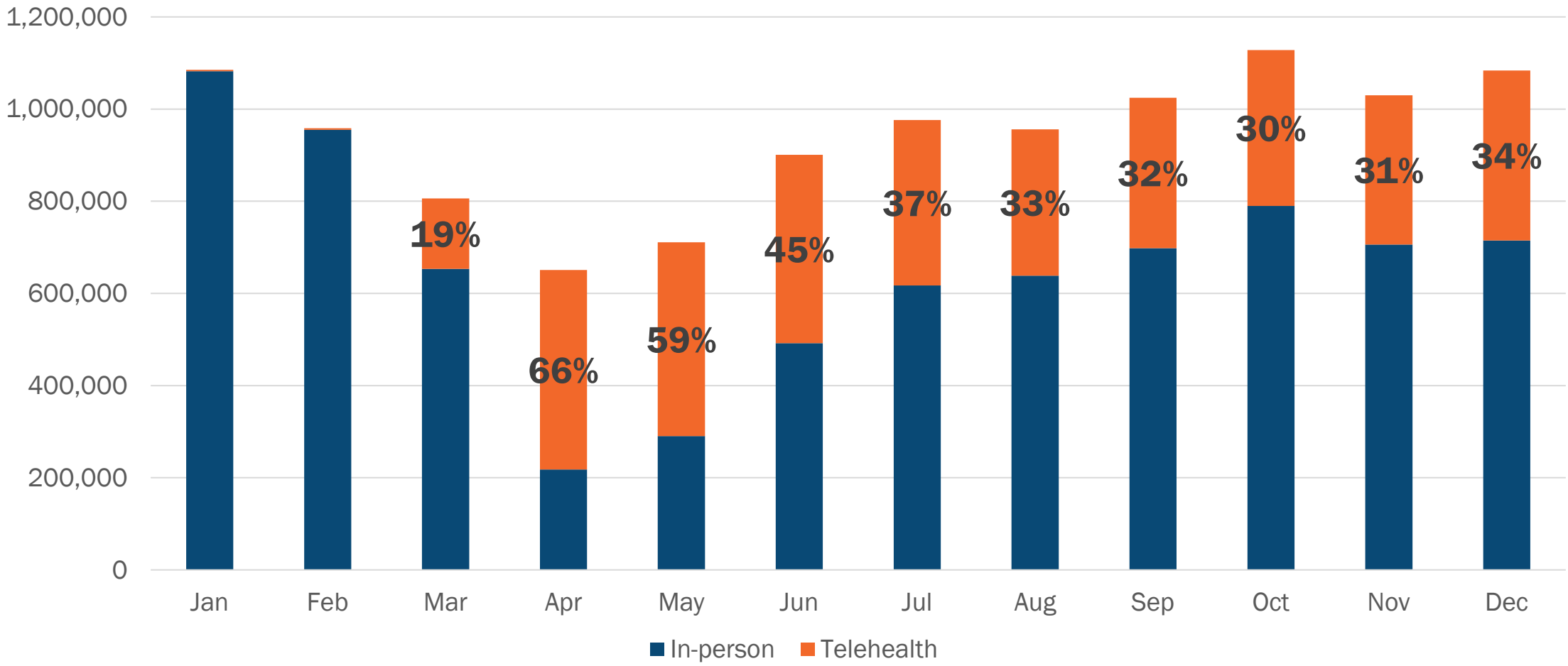
Share of commercial members who had any telehealth use:

- 2018: 0.3%
- 2019: 0.6%
- 2020: 53.5%

Notes: Ambulatory visits for all diagnoses are included, including for mental health. Analysis by ambulatory sites includes members with partial year coverage; share of members by telehealth use include members with full year coverage only.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

Telehealth enabled ambulatory visit volume to return toward baseline levels later in 2020.

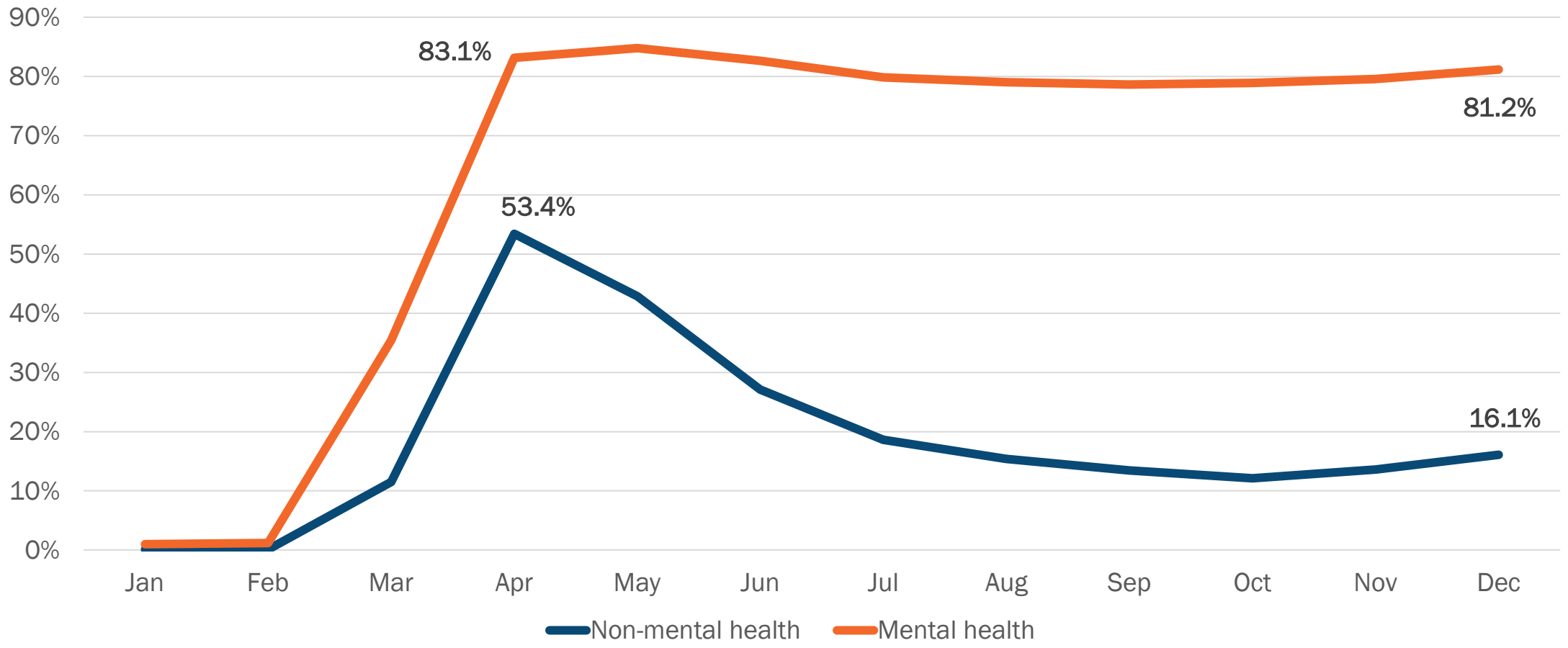
Number of in-person and telehealth ambulatory visits by month, 2020



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

High telehealth use for mental health conditions continued through the end of 2020.

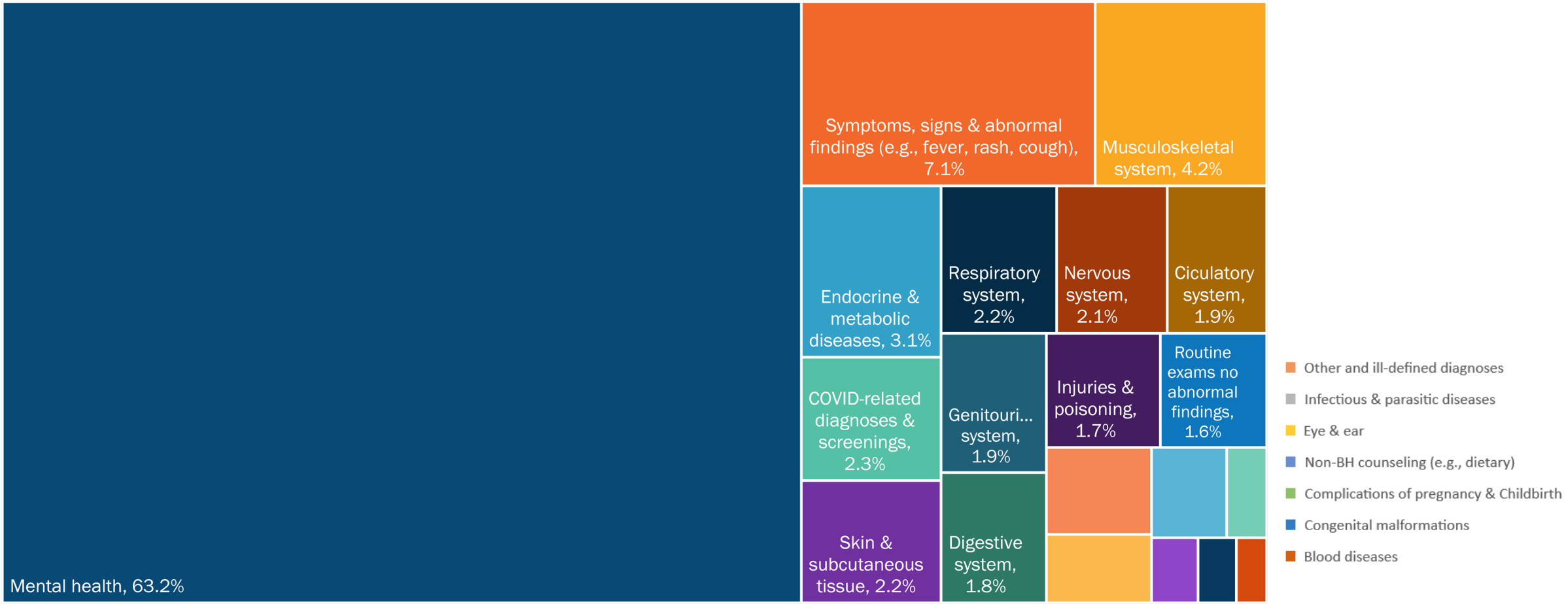
Percent of ambulatory visits that were telehealth by month and type of condition, 2020



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

63% of all telehealth visits in 2020 were for mental health conditions.

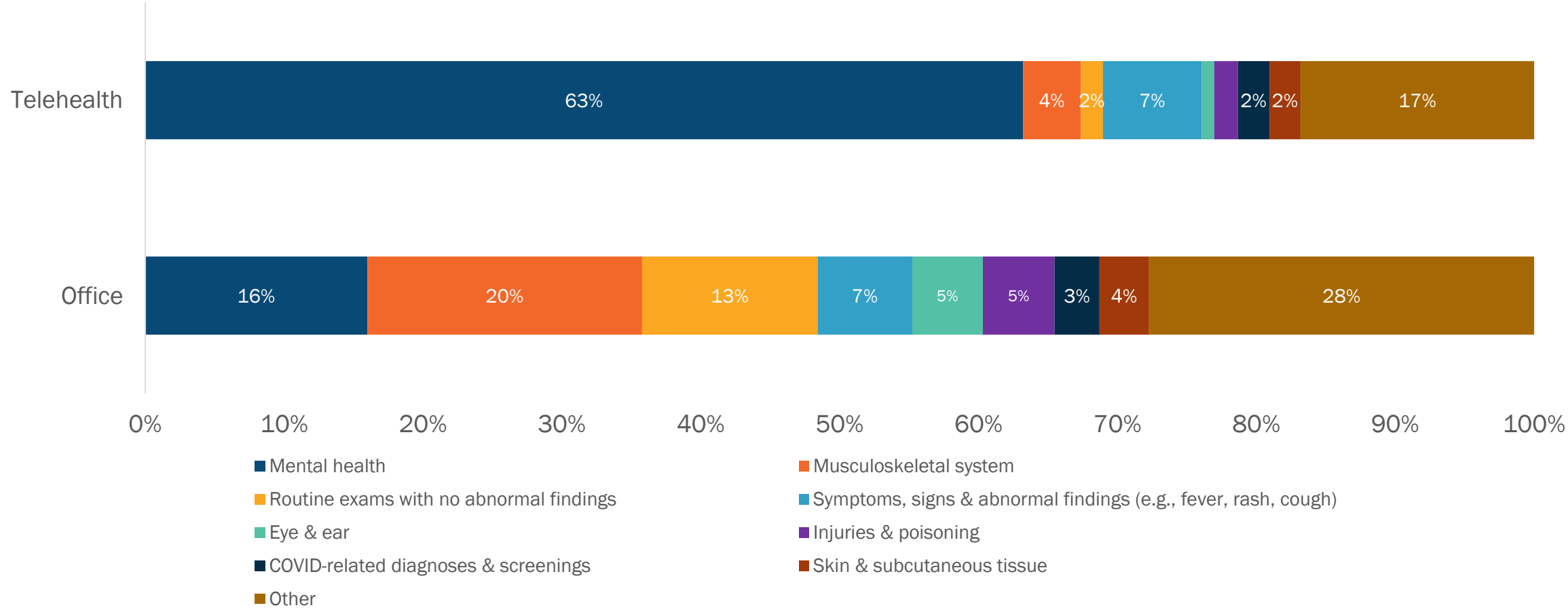
Telehealth visits by clinical areas, 2020



Notes: clinical areas adapted from Clinical Classification System (CCS).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

In contrast, musculoskeletal visits were largely conducted in person in 2020.

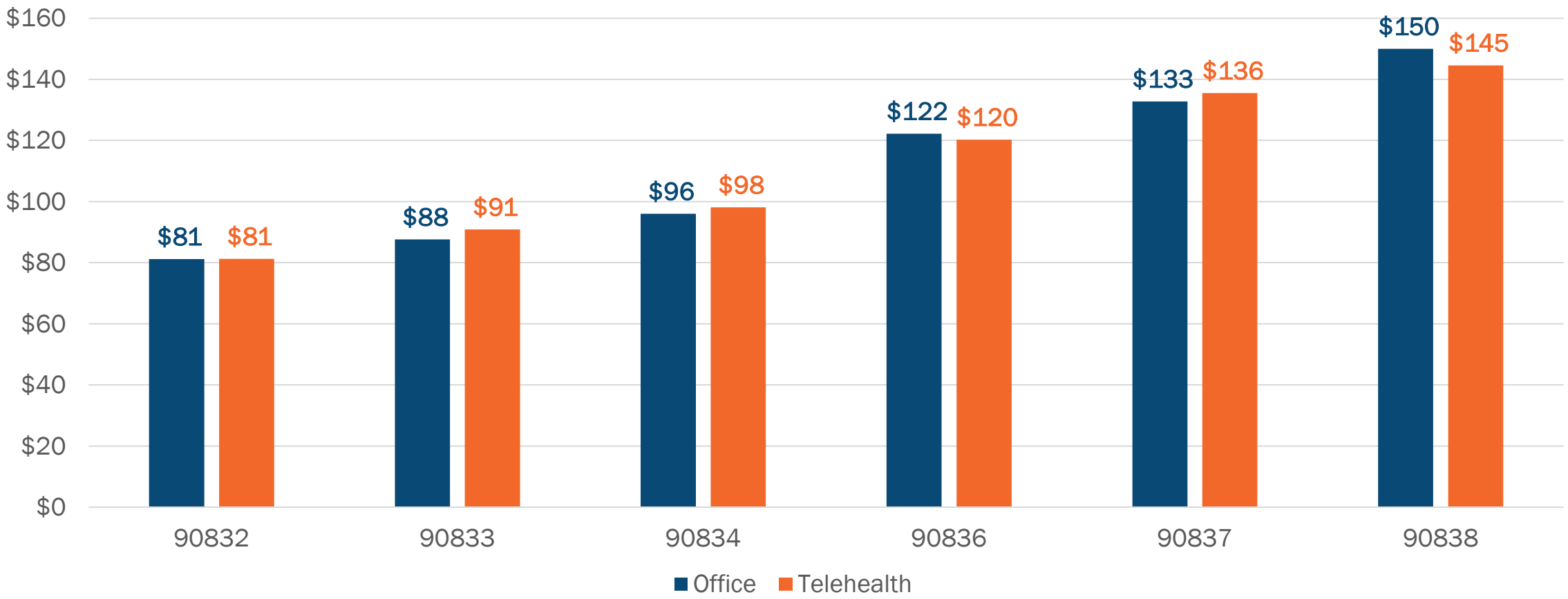
Telehealth and office visits by clinical areas, 2020



Notes: clinical areas adapted from Clinical Classification System (CCS).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Telehealth and in-person office psychotherapy services were paid at roughly the same rates, consistent with the payment parity mandate.

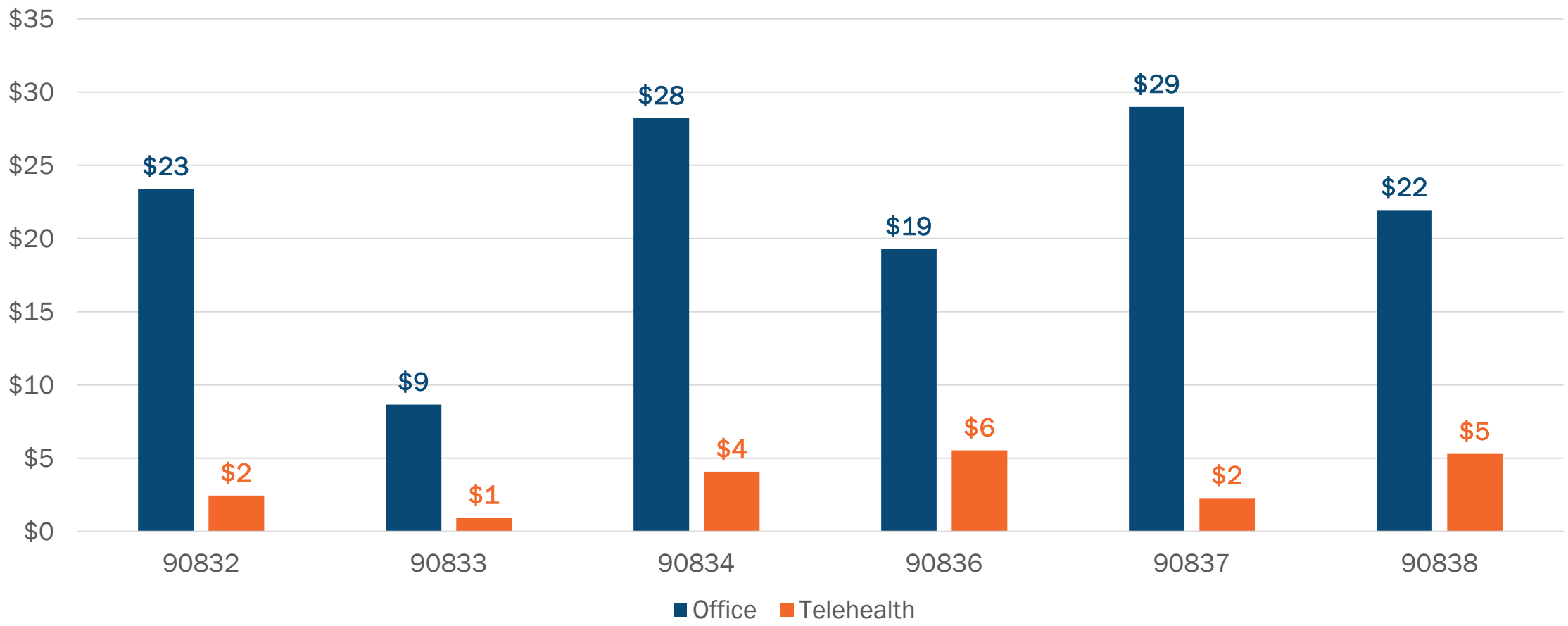
Average payment for select psychotherapy codes (including payer amount and patient cost-sharing), 2020



Notes: Claim lines for the same patient, same day and same procedure code were combined into one visit.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Telehealth psychotherapy services were generally offered without cost-sharing in 2020.

Average cost-sharing per visit for select psychotherapy codes, 2020



Notes: Claim lines for the same patient, same day and same procedure code were combined into one visit.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

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- Overall Use of Telehealth Services in Massachusetts in 2020
- **VARIATION IN USE OF TELEHEALTH SERVICES**
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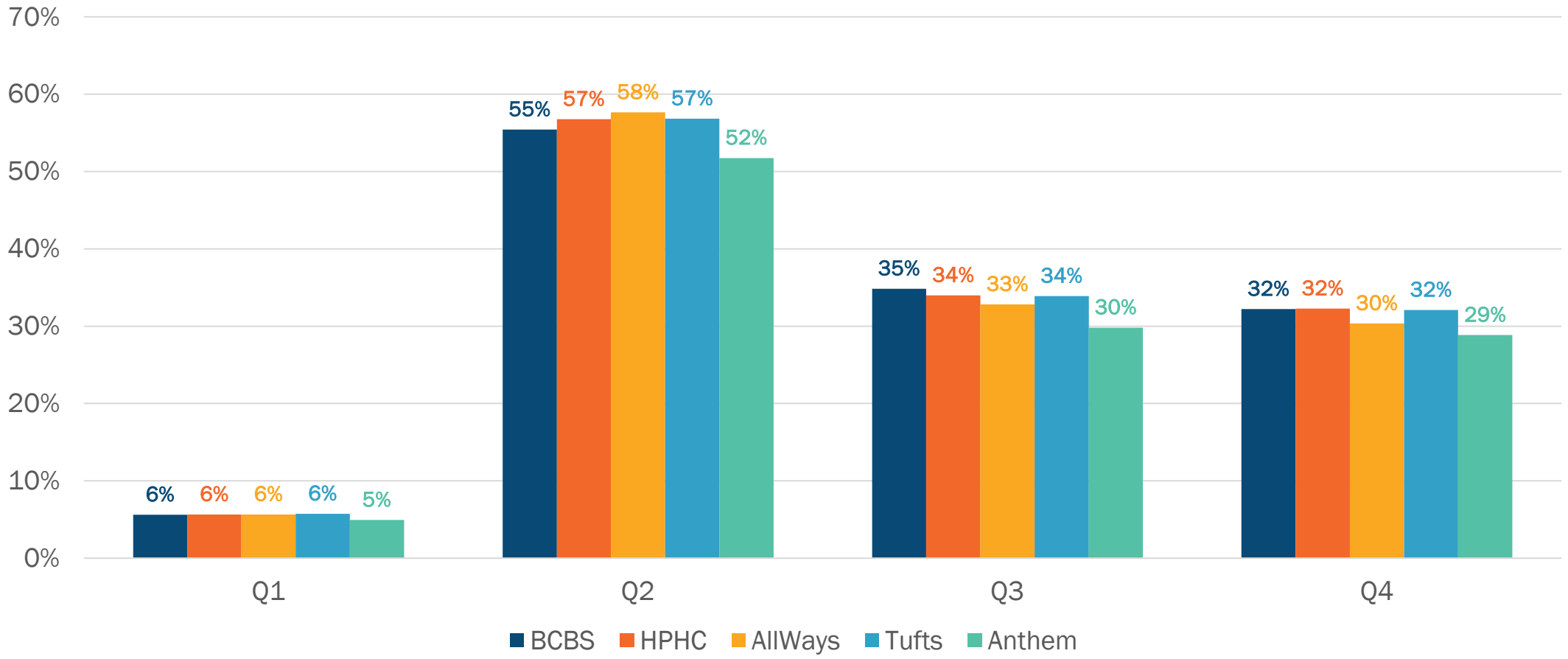
Telehealth use was similar across commercial health plans in 2020.

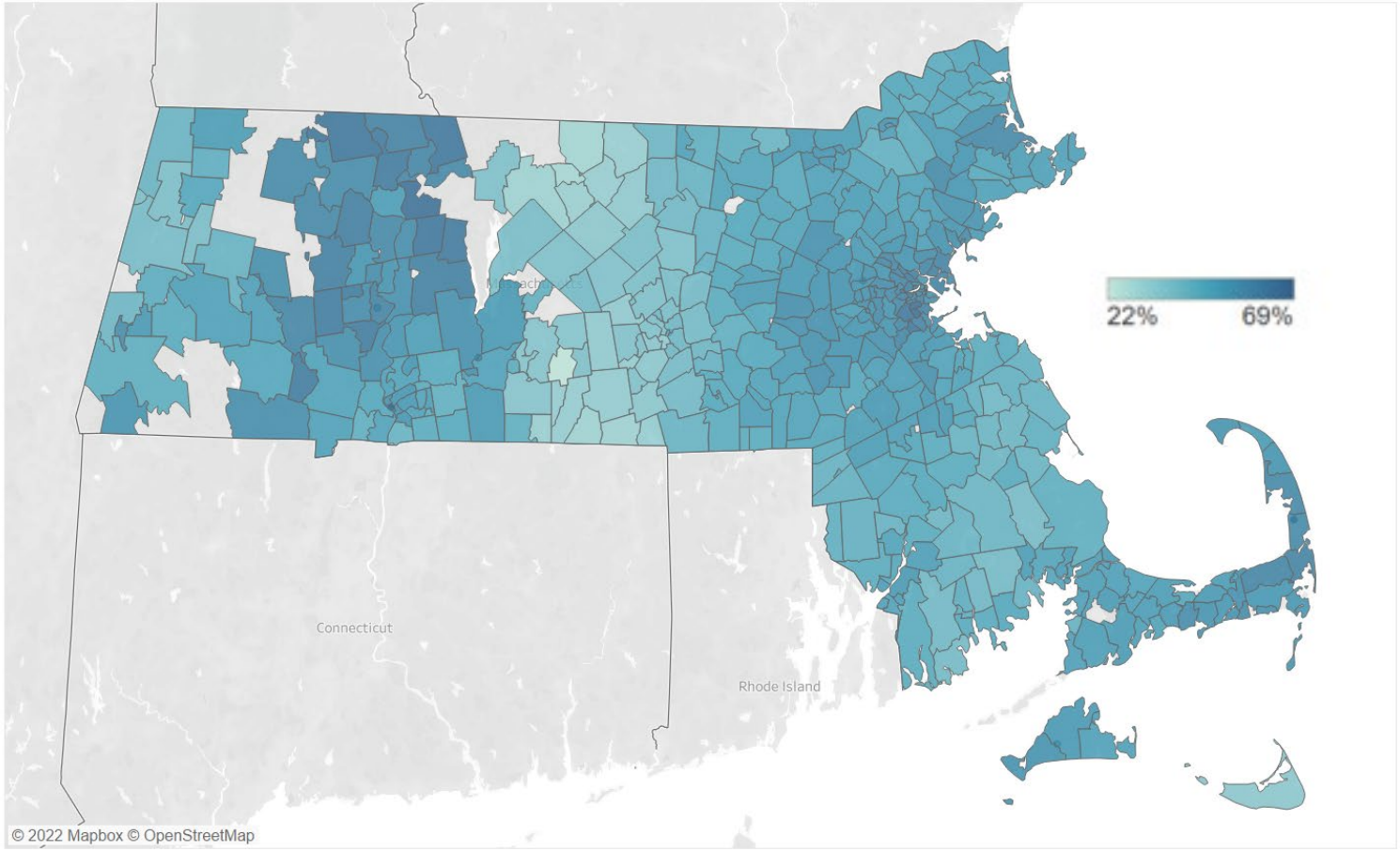
Percent of ambulatory visits that were telehealth by payer and quarter, 2020



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Telehealth use for non-mental health services was higher for residents in Metro Boston and the Pioneer Valley/Franklin region.

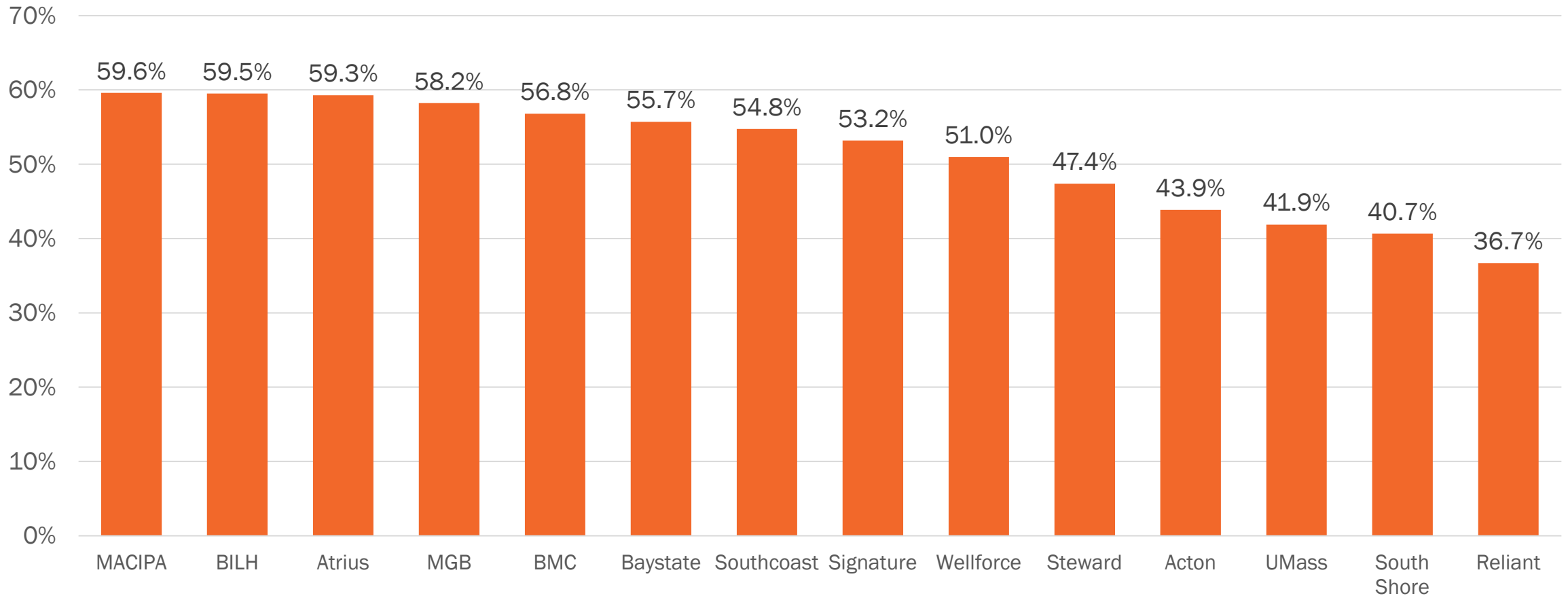
Among members with at least one visit for a non-mental health condition, percent with any telehealth use for such conditions by zip code, March 15-December 31, 2020



Notes: Analysis includes members who had health care utilization for non-mental health conditions between March 15-December 31, 2020. Zip codes for which the number of telehealth users or non-telehealth users was less than 11 were omitted.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Telehealth use for non-mental health services by provider organization ranged from 37% to 60%.

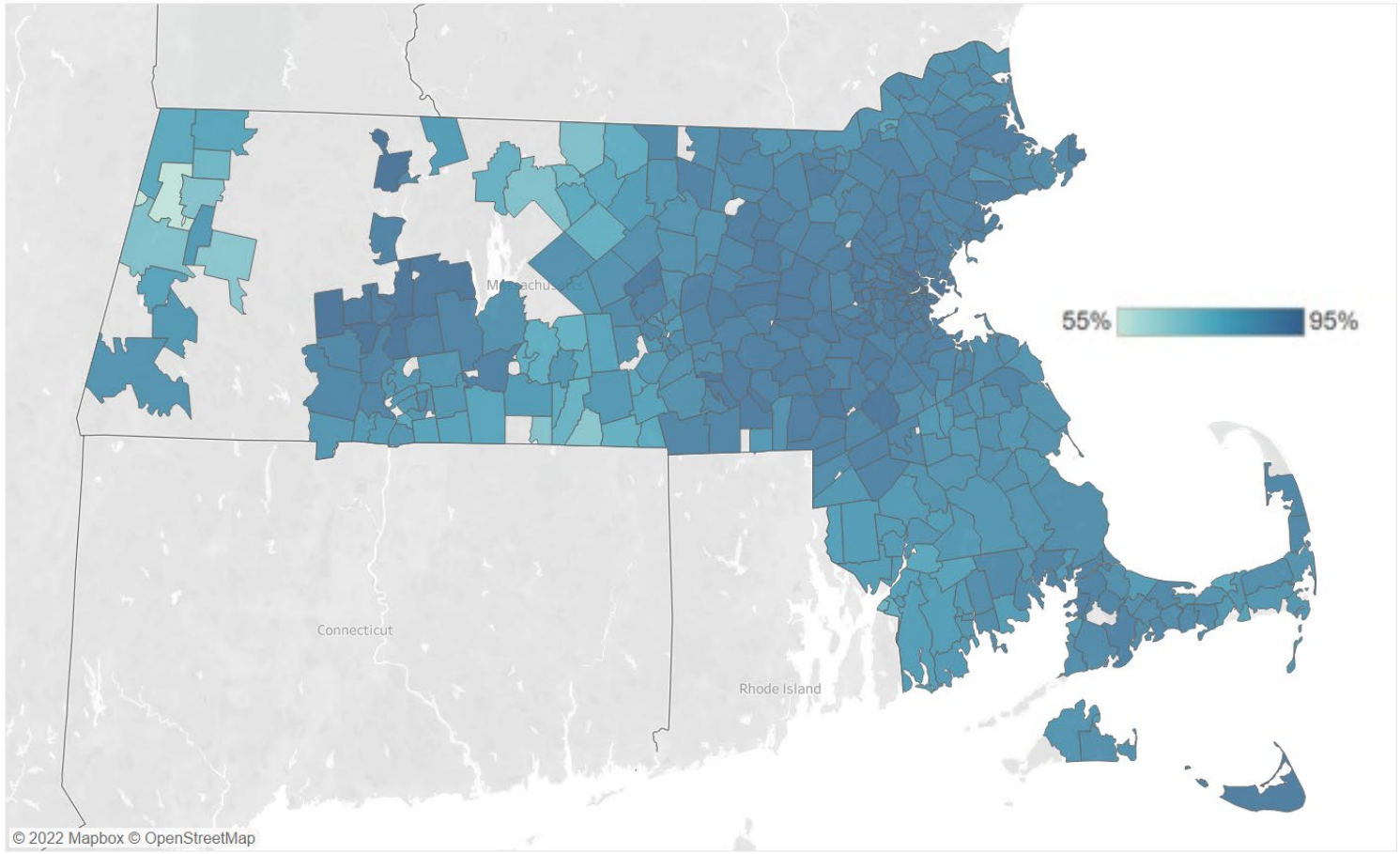
Among members with at least one visit for a non-mental health condition, percent with any telehealth use for such conditions by provider organization, March 15-December 31, 2020



Notes: Analysis restricted to members who had at least a visit for non-mental health conditions between March 15-December 31, 2020. Results for members attributed to other provider organizations are not shown.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Telehealth use for mental health conditions was higher overall, but also varied by zip code.

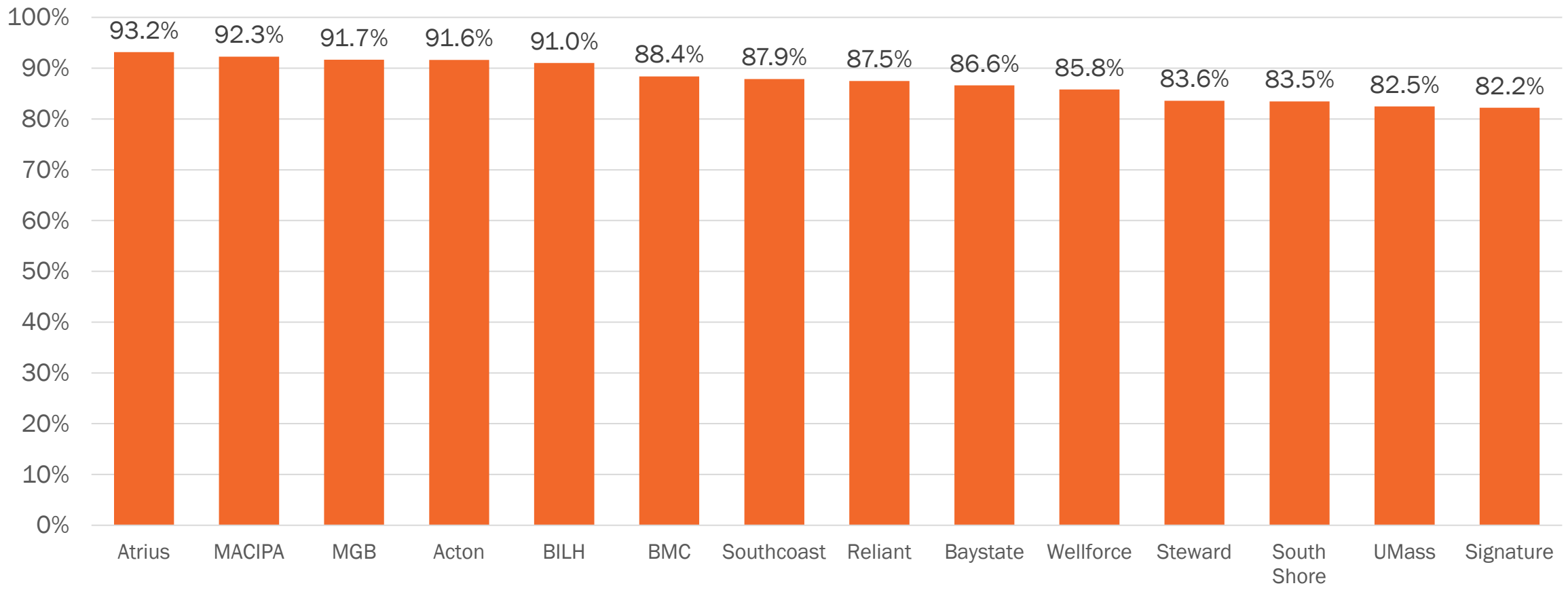
Among members with at least one visit for a mental health condition, percent with any telehealth use for such conditions by zip code, March 15-December 31, 2020



Notes: Analysis includes members who had health care utilization for mental health conditions between March 15-December 31, 2020. Zip codes for which the number of telehealth users or non-telehealth users was less than 11 were omitted.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Telehealth use for mental health conditions varied less by provider organization compared to other conditions.

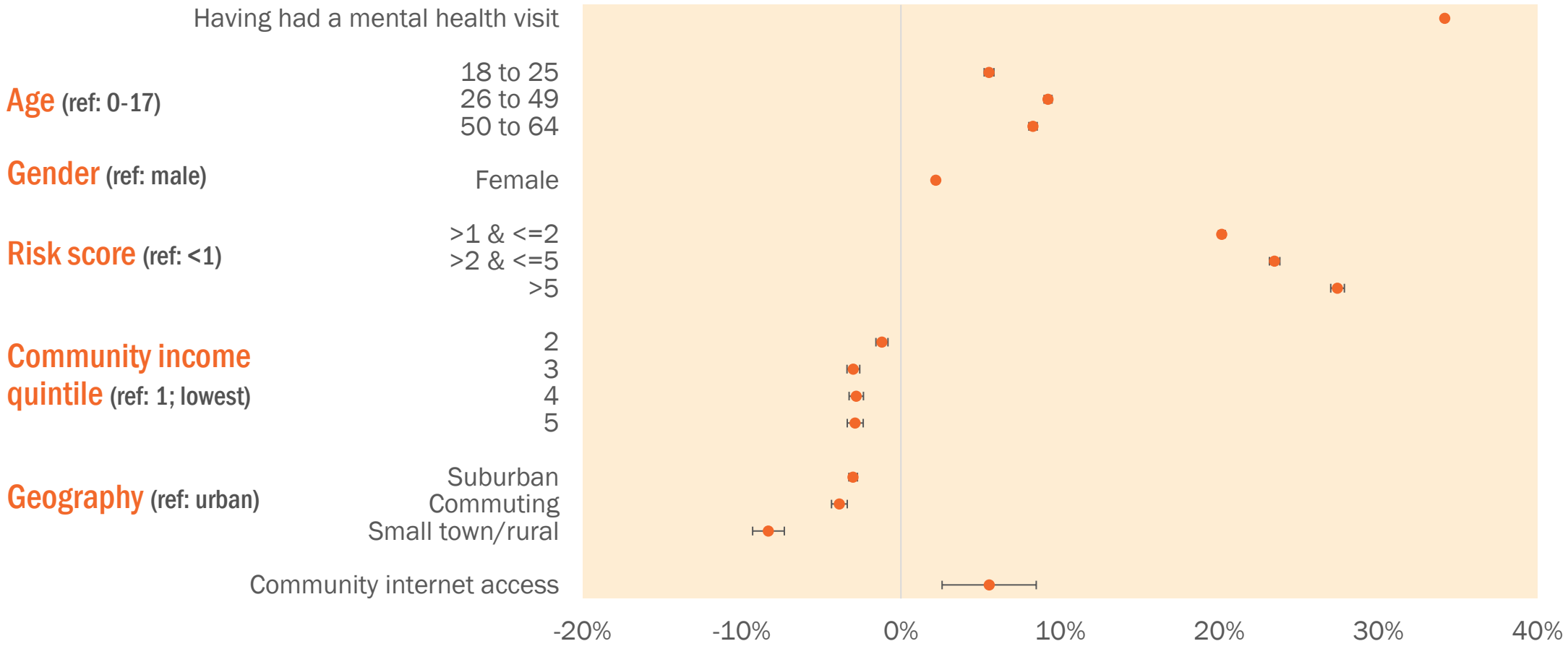
Among members with at least one visit for a mental health condition, percent with any telehealth use for such conditions by provider organization, March 15-December 31, 2020



Notes: Analysis restricted to members who had at least one visit for mental health conditions between March 15-December 31, 2020. Results for members attributed to other provider organizations are not shown.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Telehealth use was higher for those in communities that were more urban and had a high level of internet access; there were minimal differences by community income.

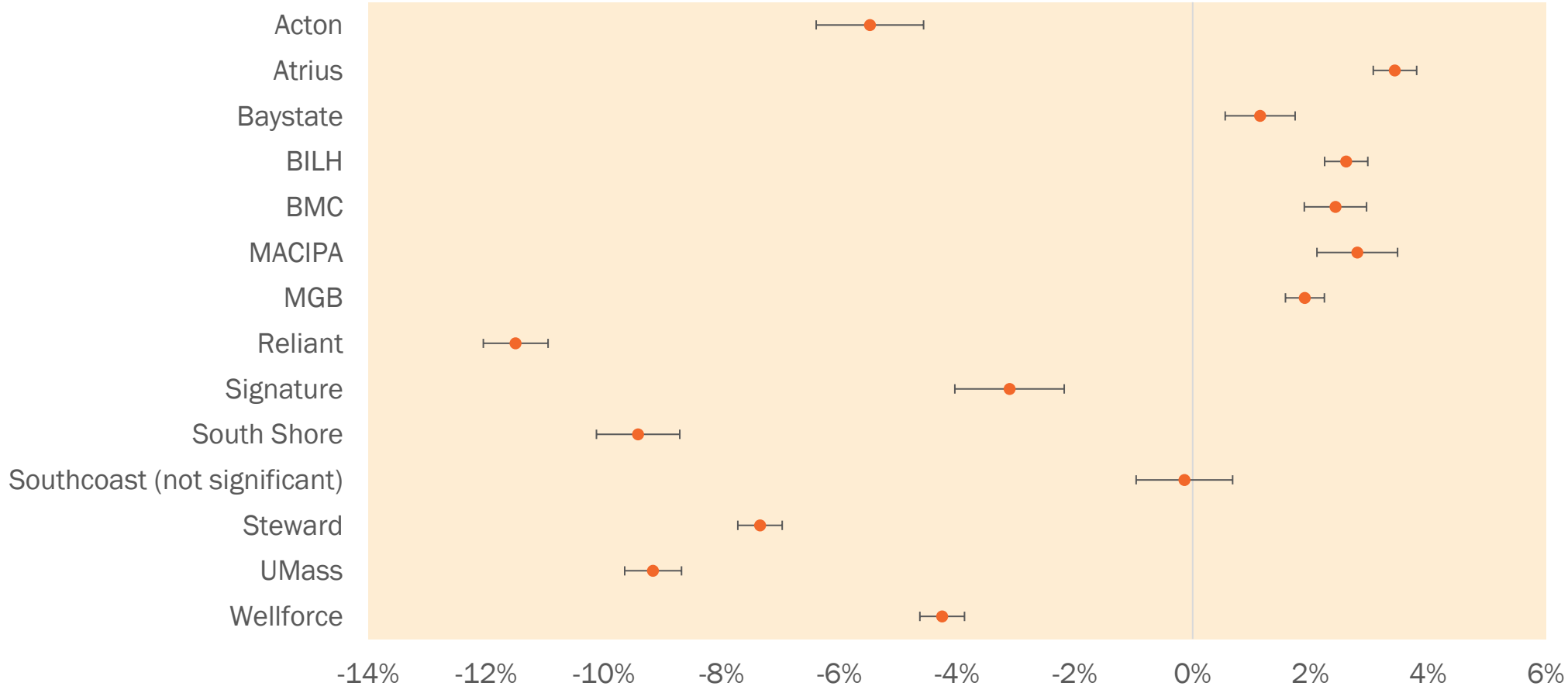
Percentage point difference in likelihood (and 95% CI's) of any telehealth use relative to the omitted group, from March 15-December 31, 2020



Notes: Analysis excludes members without any health care utilization between March 15 – December 31, 2020. Community internet access measured by percent of households with an internet subscription, which includes cellular data plans (American Community Survey 5-year estimates, 2020). Regression also adjusted for provider organization, payer and total number of visits (coefficients not shown).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Variation in telehealth use by provider organization persisted even after controlling for differences in their patient population.

Percentage point difference in likelihood and 95% CIs of any telehealth use relative to the omitted group, from March 15-December 31, 2020



Notes: Reference group is members who are attributed to other provider organizations. Regression also adjusted age, gender, risk score, community income, geography, mental health visit history, and community internet access – results are shown on the previous slide. Results not shown for payer and each member's total number of visits, which were also included in the regression.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

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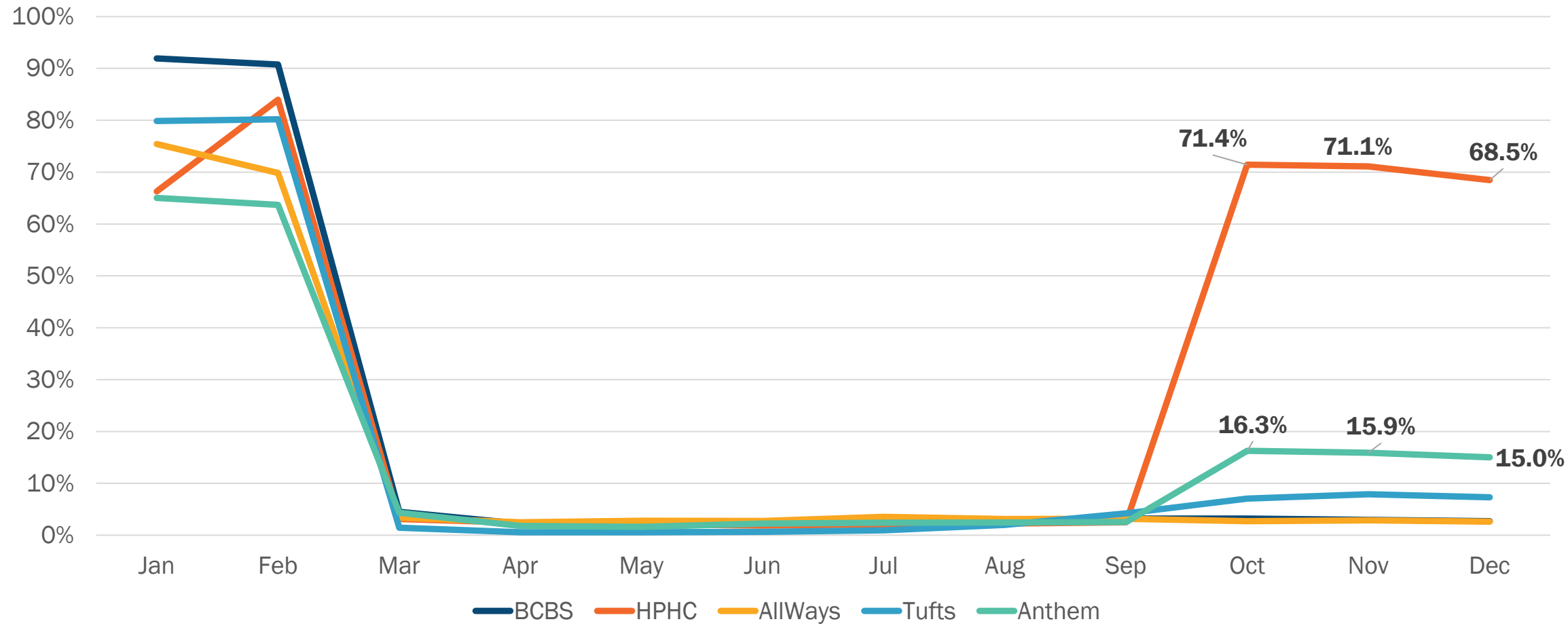
Payers waived virtually all cost-sharing for telehealth in the first 6 months of the COVID-19 pandemic.

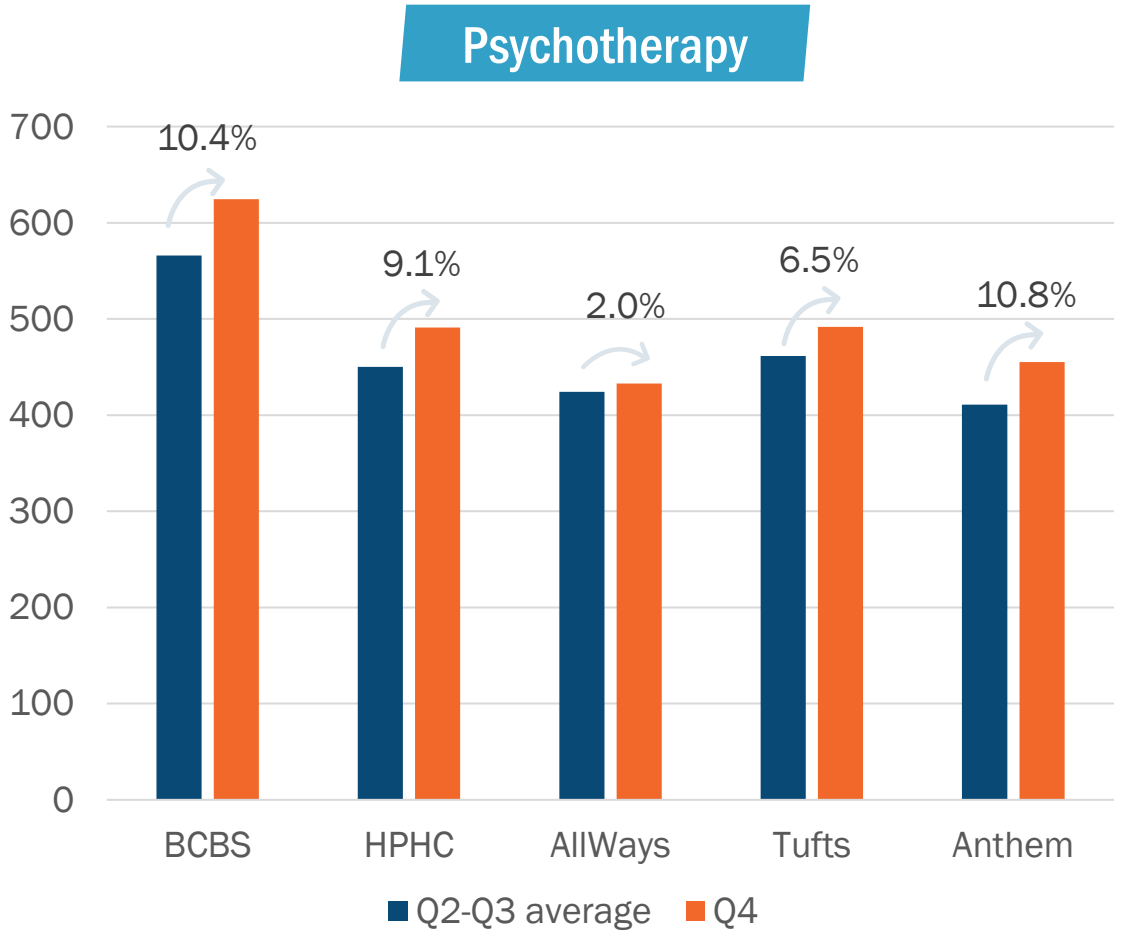
Percent of telehealth visits with any cost-sharing by month and payer, 2020

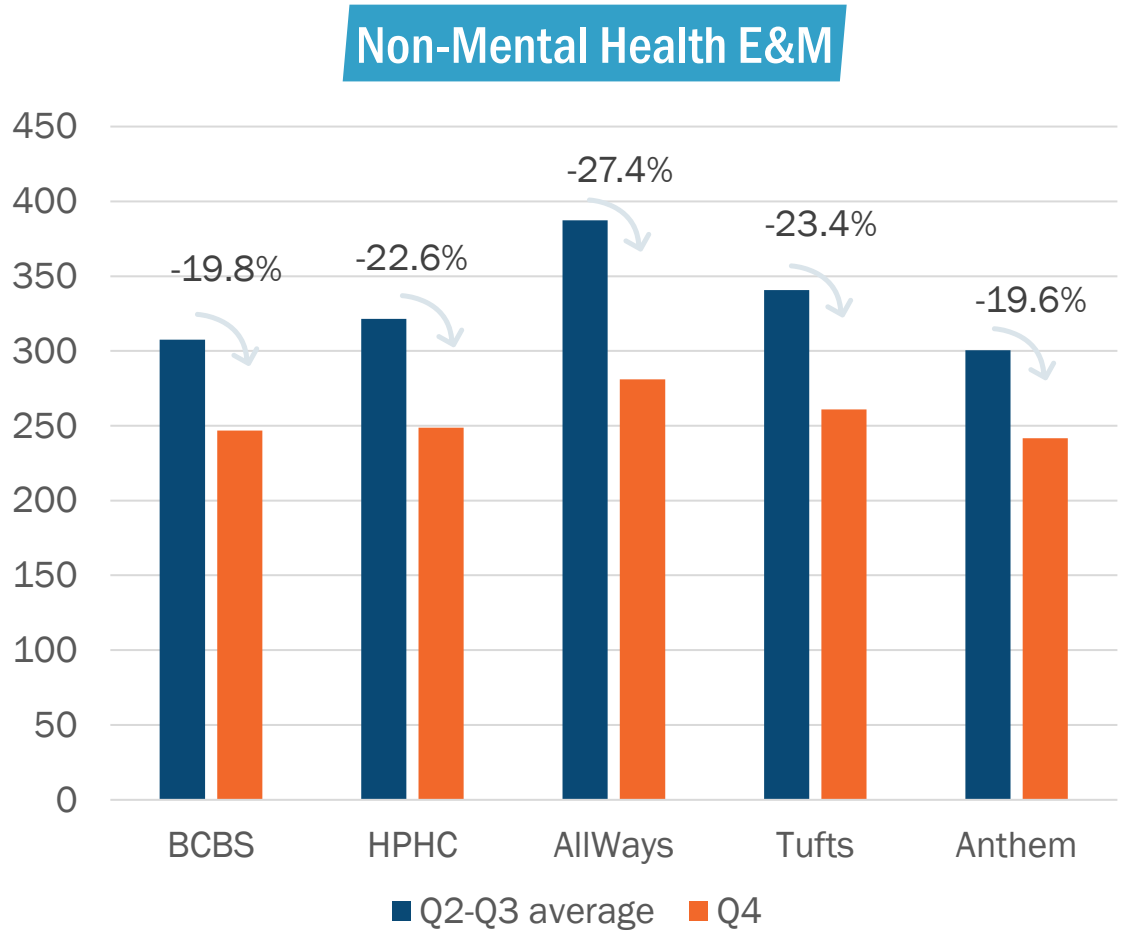


Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

HPHC's reinstating of cost-sharing for telehealth in Q4 2020 did not appear to impact telehealth utilization.

Number of telehealth visits for select services per 1,000 people by payer and quarter, 2020

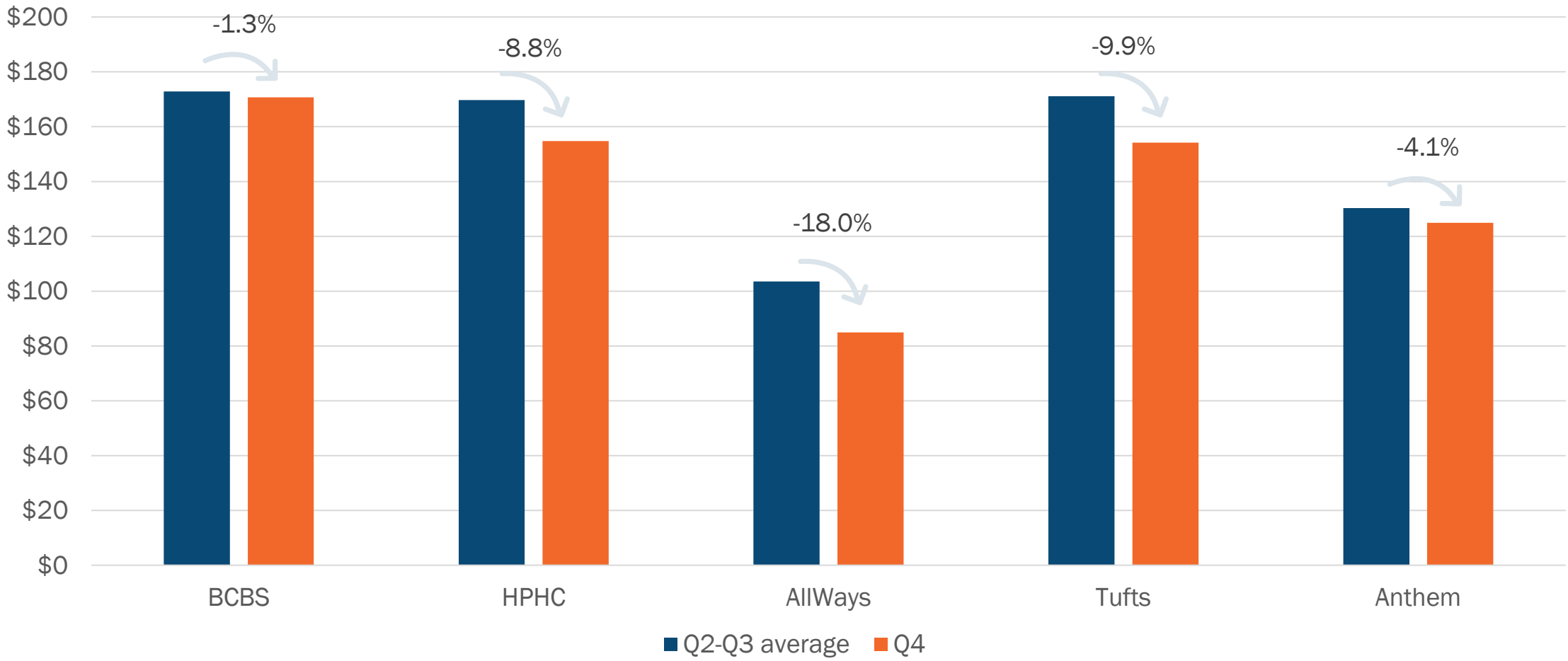




Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

HPHC's reinstating of cost-sharing for telehealth in Q4 2020 also did not appear to impact telehealth spending.

Average telehealth spending per member by payer and quarter, 2020



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

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How has the availability of telehealth impacted total health spending?

- **Challenge:** Telehealth use increased dramatically in 2020 but overall spending decreased due to pandemic-related shutdowns and restricted access to care.
- **Approach:** Imitate a randomized experiment by comparing the **change in spending and use of care** from 2019 to 2020 for **patients with greater telehealth adoption versus those with less adoption** but who were otherwise similar.
  - Patients are sorted into high-adoption and low-adoption groups according to their zip code.

For members living in high-adoption zip codes, 34% of routine E&M visits were telehealth vs. 19% in low-adoption zip codes.

Sort zip codes

Sort zip codes by percentage of routine E&M visits that were telehealth in July-December 2020. Identify the highest and lowest quartiles of zip codes by telehealth rate.

Identify claims

Identify ambulatory claims for members in high- and low quartile zip codes. These are our naturally occurring experimental groups.

Changes from 2019-2020

Calculate how in per-person utilization and spending changed from 2019 to 2020 by group.

Difference between groups

Calculate the difference in how the high-telehealth-adoption group changed from 2019 to 2020, and how the low-telehealth-adoption group changed.

Zip code quartile	Telehealth as % of E&M visits
1	18.7%
2	23.6%
3	27.4%
4	33.7%

Notes: Anthem members not included due to lack of pharmacy claims. Routine E&M visits exclude those with a mental health diagnosis.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0.

Patients were categorized into three clinically similar cohorts.

CARDIOMETABOLIC

- Aged 18-64 in 2019
- Full coverage in all of 2019 and 2020
- Designated as having cardiovascular disease, diabetes, or hypertension in 2019

ASTHMA

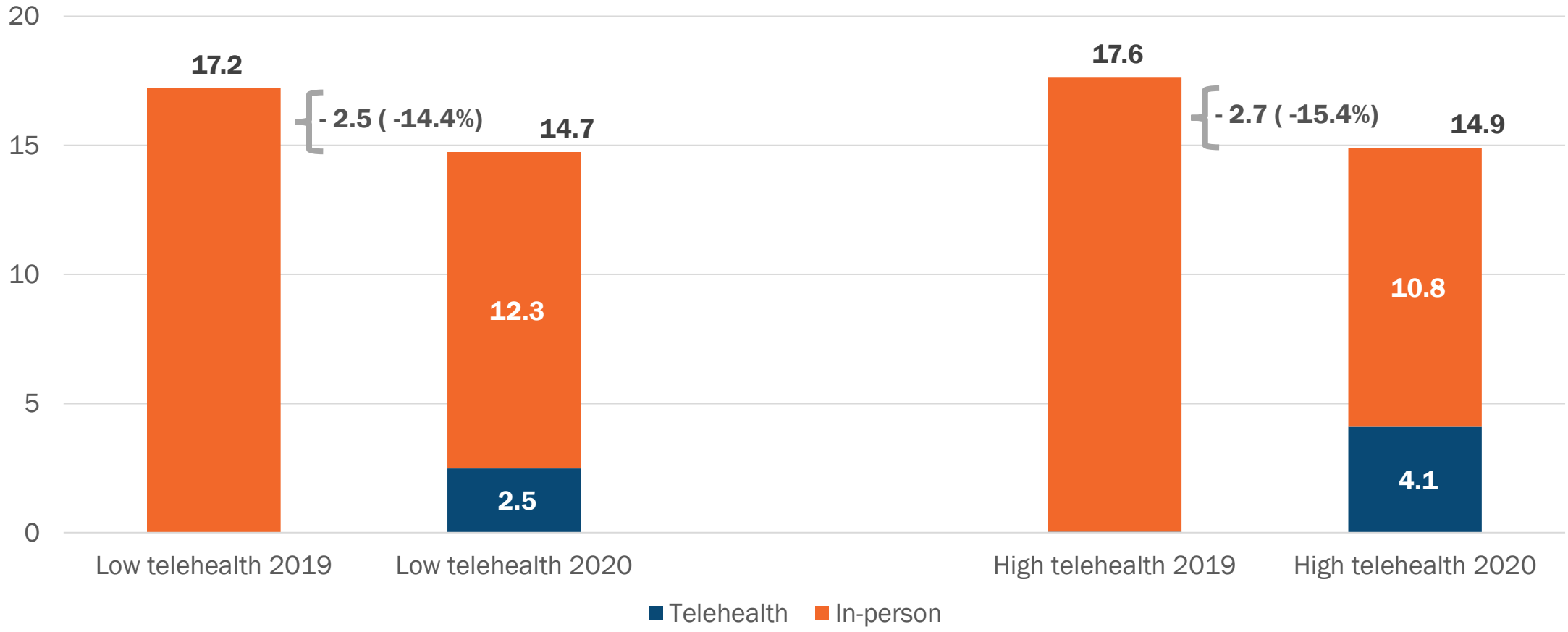
- Aged 18-64 in 2019
- Full coverage in all of 2019 and 2020
- Designated as having asthma in 2019

HEALTHY

- Aged 18-64 in 2019
- Full coverage in all of 2019 and 2020
- Designated as having no chronic condition in 2019 or 2020, and having an ACG risk score less than 2.0

The change in ambulatory care utilization from 2019 to 2020 for the cardiometabolic cohort was similar for the high and low telehealth group. The high telehealth group had more telehealth visits and fewer in-person visits.

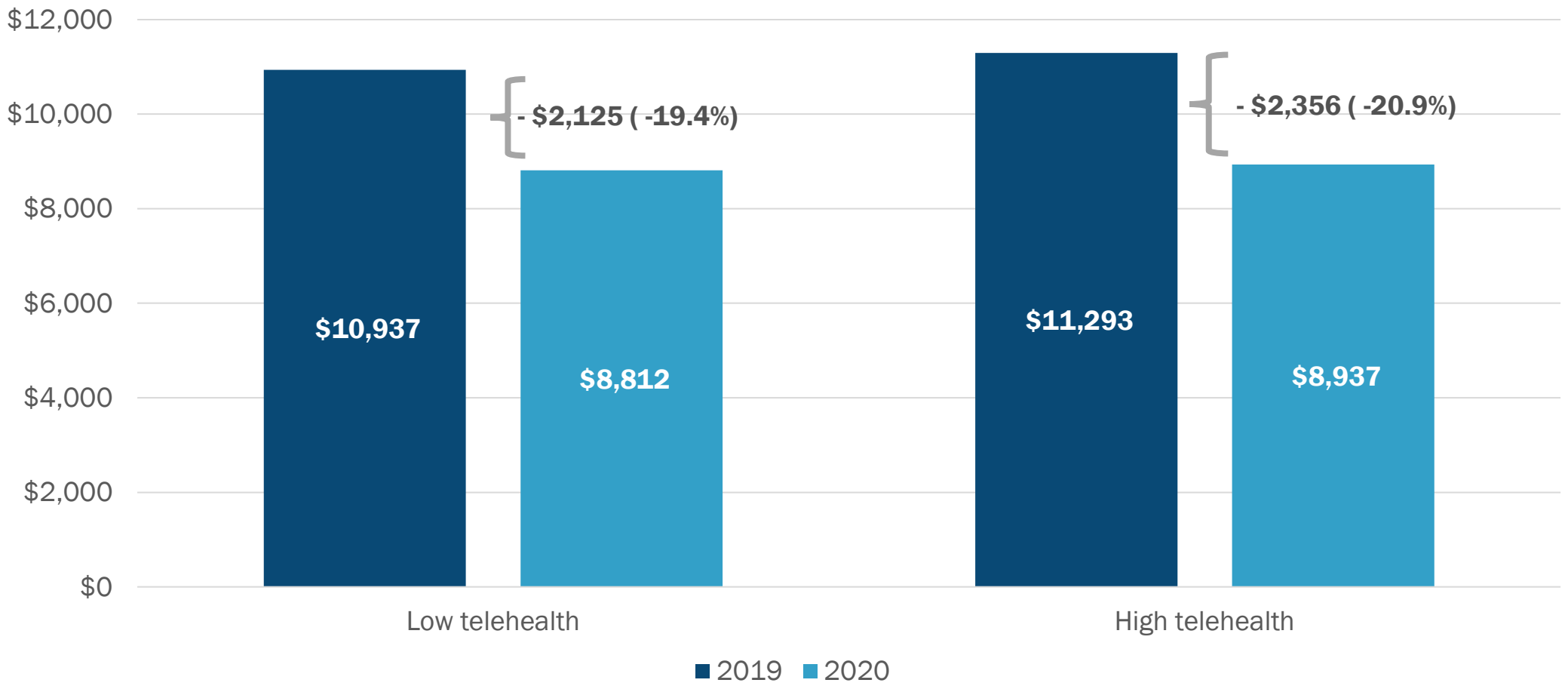
Number of ambulatory visits per member in the cardiometabolic cohort



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

The reduction in spending was slightly larger (21% vs 19%) for the high telehealth group.

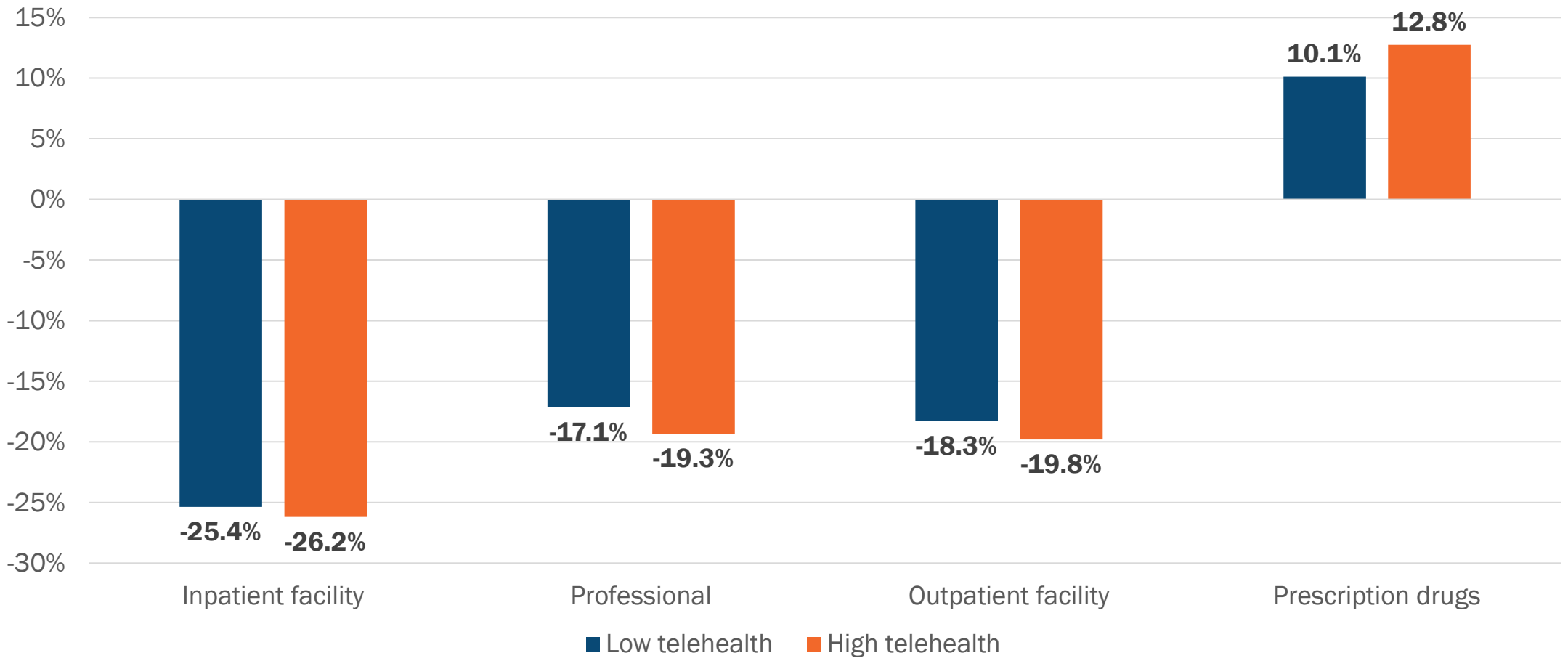
Average spending per member in the cardiometabolic cohort



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

Reduction in spending was slightly larger for the high telehealth group in each category except for prescription drugs.

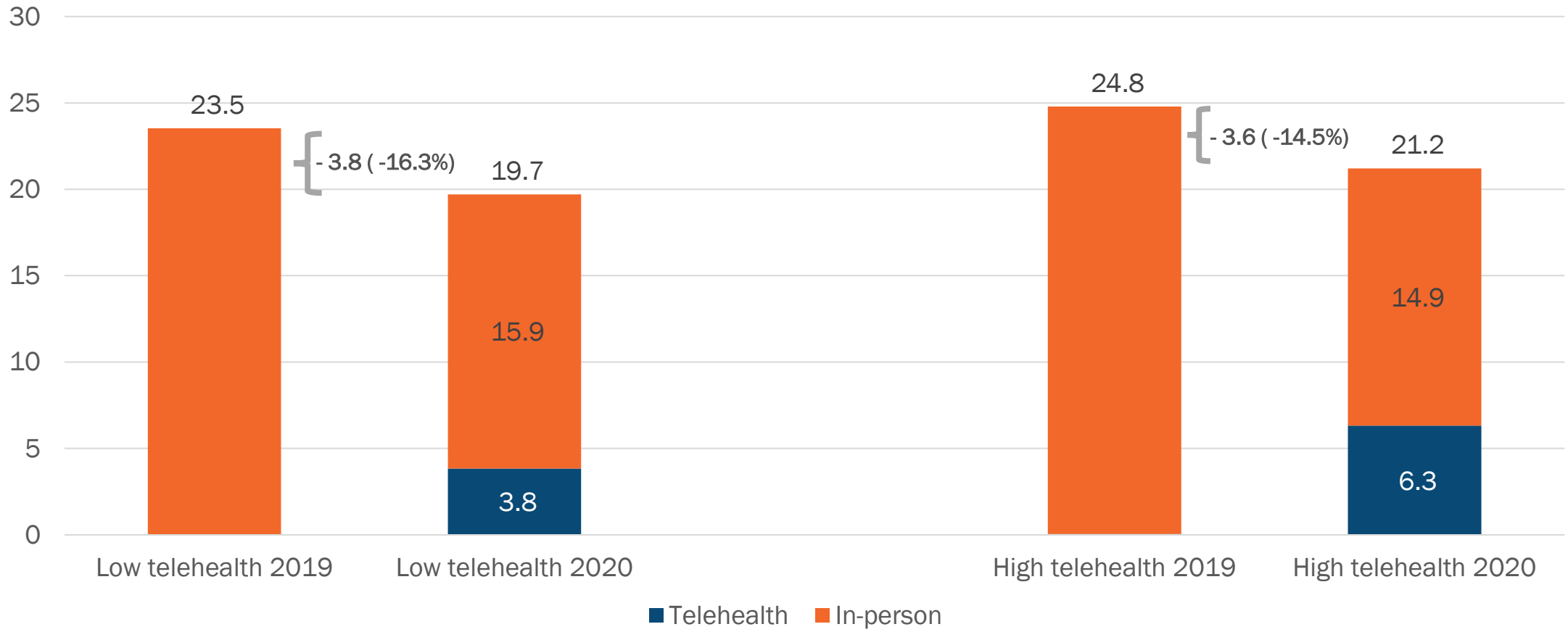
Change in average spending by category per member in the cardiometabolic cohort, 2019 to 2020



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

Reduction in ambulatory care utilization was slightly larger for the low telehealth group.

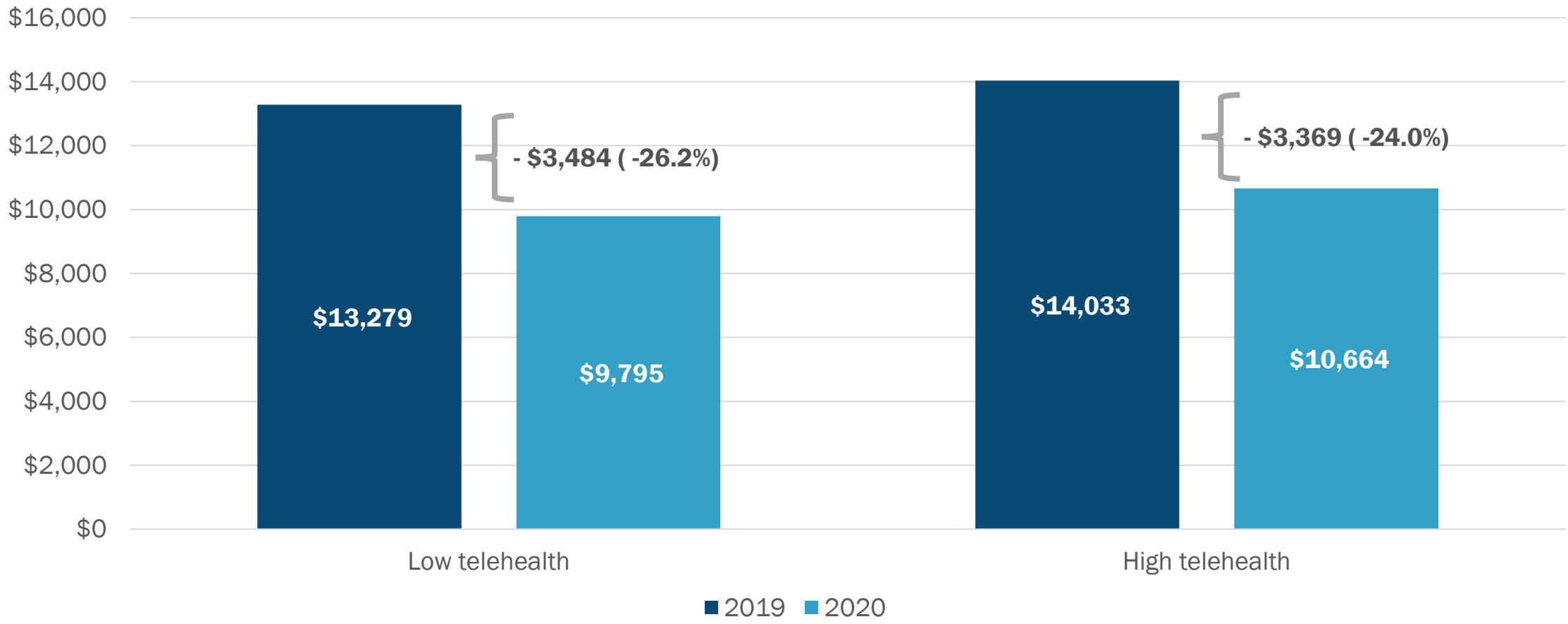
Number of ambulatory visits per member in asthma cohort, by zip code quartile



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

Reduction in spending from 2019 to 2020 was $114 greater for the low telehealth group.

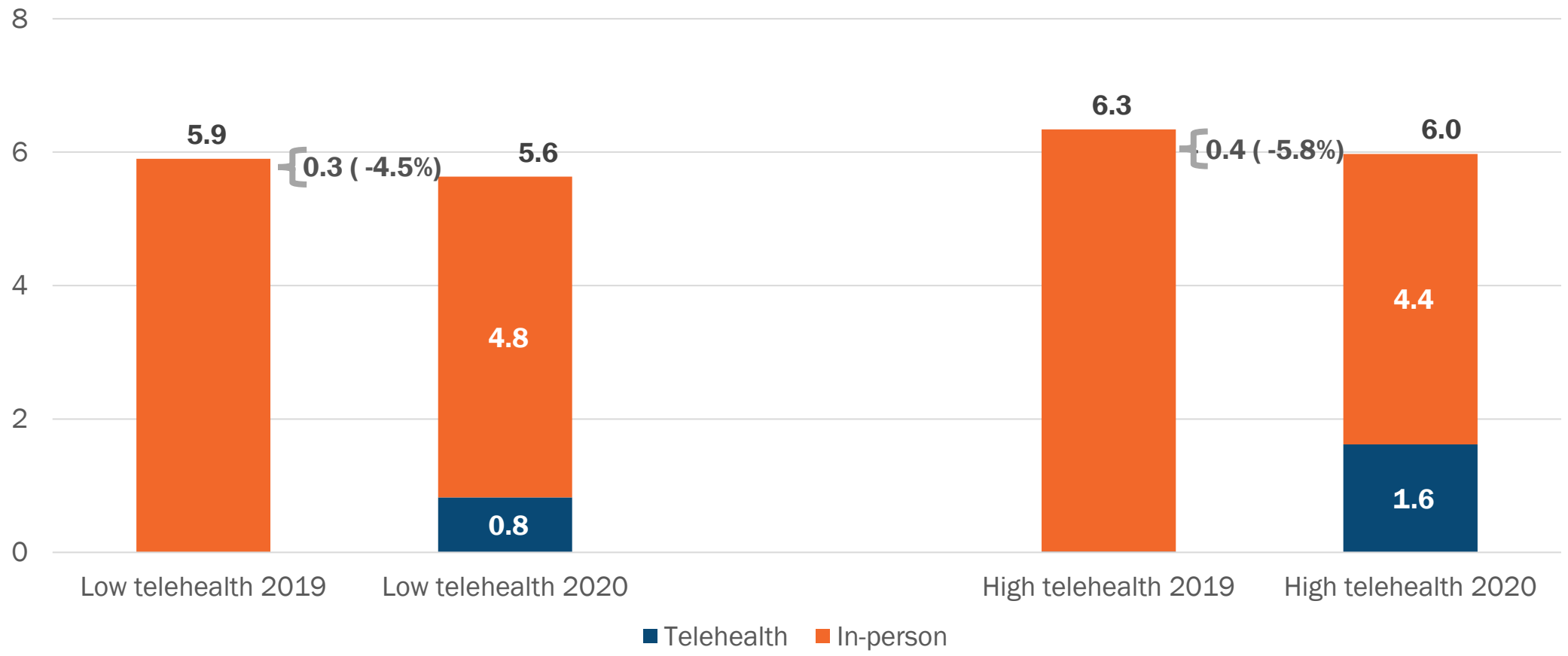
Spending per member in the asthma cohort, by zip code quartile



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

Reduction in ambulatory care utilization for the healthy cohort was similar for the high and low telehealth group.

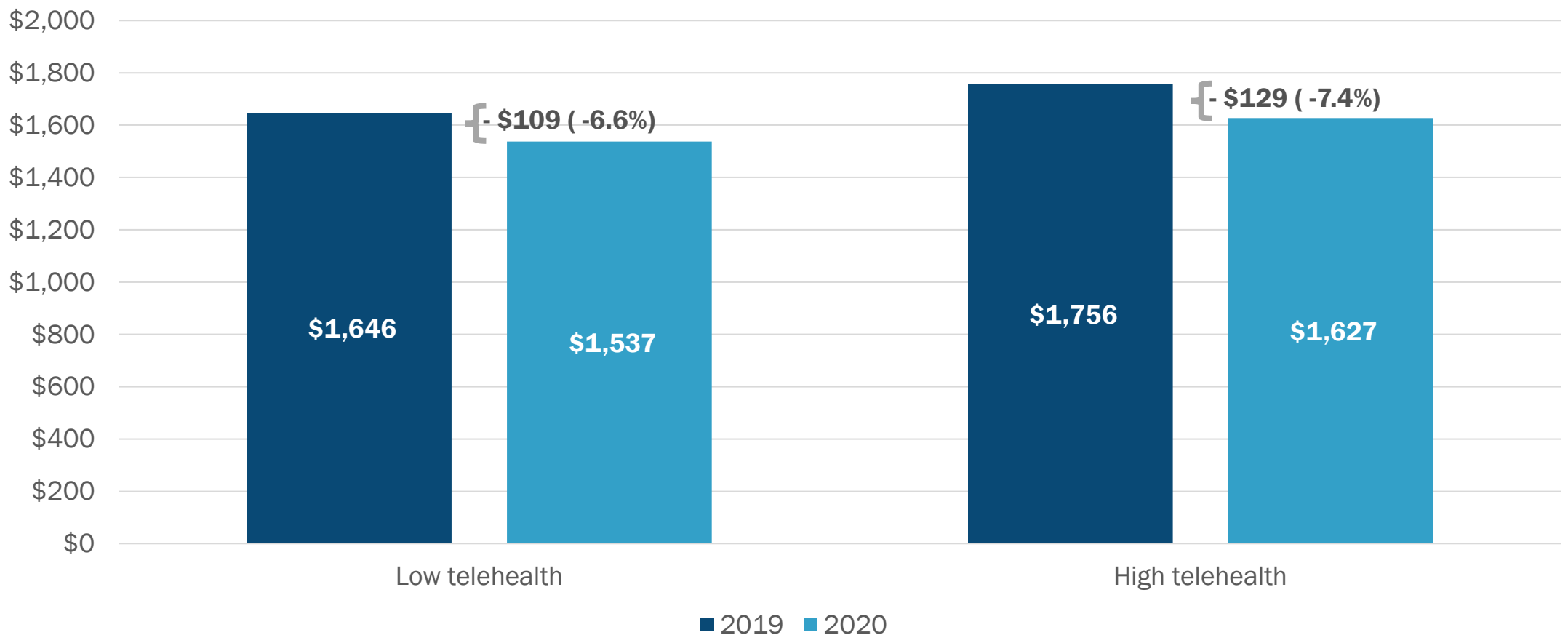
Number of ambulatory visits per member in the healthy cohort



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

Change in spending from 2019 to 2020 was similar between high and low adoption groups.

Spending per member in the healthy cohort, by zip code quartile



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

Telehealth Study Summary Findings

- Telehealth accounted for a third of all commercial ambulatory visits in 2020; nearly 2/3 of telehealth visits were for mental health conditions
- There were significant differences in telehealth use by the patient's attributed provider organization but few differences by payer
- Telehealth use was higher for patients with higher risk scores and those in more urban communities and with better internet access; there were minimal differences by community income.
- Cost-sharing for telehealth did not appear to affect demand
  - HPC plans to continue monitoring data on cost-sharing for 2021
- Telehealth use did not appear to increase total utilization or spending

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- **STAKEHOLDER PERSPECTIVES AND POLICY CONSIDERATIONS**

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Stakeholder Perspectives

Provider Expense Of Providing Telehealth Services

- Some **providers** that offer both in-office and telehealth services say that offering telehealth services does not reduce their total practice expenses
  - Telehealth services may still require in-office expenses such as office space or administrative staff
  - Provider organizations have some additional expenses for technology to support telehealth
  - Telehealth may improve practice efficiency by reducing no-show appointments
- Some **payers** note that the marginal expense of a telehealth visit may be lower (e.g. providers may conduct telehealth visits from home)

Access To Care And Quality Of Care

- Telehealth services have particular benefits for **access to care for patients with chronic conditions and those who live far from medical centers**
- **Audio-only vs video:** While video visits may be preferrable in many aspects, audio-only visits allows for increased access for certain populations (e.g., older patients, patients without reliable internet due to connectivity or financial barriers), supporting health equity

The HPC plans to gather additional stakeholder input and welcomes further comments.

- Sources include provider groups across different regions of Massachusetts, payers, community health groups, and patient advocacy groups; MAHP study conducted by the Harvard Pilgrim Institute and national literature

Policy Considerations

- **Reimbursement**
  - Is payment parity for telehealth vs in-office visits appropriate (non-mental health services)? For all services, or for primary care and chronic disease management services? Other services?
  - When are differential payments for telehealth vs. in-office services appropriate?
  - Telehealth in global payment models to improve access/transparency
- **Policies To Expand Access And Ensure Quality Of Care**
  - Clinical guidelines for when a telehealth vs in-person visit is appropriate vs. coverage/utilization management requirements
  - Policies to support equitable access to telehealth services
  - Policies to address the provision of telehealth when providers are out of state and when patients travel out of state
  - Policies that incorporate telehealth consideration in network adequacy requirements
- **Virtual Visits Provided Through Video Vs. Audio Only**
  - Should coverage or payment policies differ by modality?
- **Facility Fees**
  - The HPC has previously recommended prohibiting facility fees for E&M visits, which would include most telehealth services
- **Role of third-party companies** providing telehealth services such as Teledoc and alternative models of care such as TalkSpace

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Research Presentation: Utilization of Telehealth in the Commonwealth

EXAMINATION OF RECENT PROVIDER EXPANSIONS

Office of Patient Protection Regulatory Changes

Schedule of Upcoming Meetings

HPC Policy Recommendation #2: Constrain Excessive Provider Prices

Since prices continue to be a primary driver of health care spending growth in Massachusetts and divert resources away from smaller, community providers, the HPC recommends the following actions:

a. **Establish Price Caps for the Highest Priced Providers in Massachusetts.** As a complement to the statewide benchmark, cap prices for the highest priced providers (i.e., limiting the highest, service-specific commercial prices with the greatest impact on spending) and limit price growth (e.g., limiting annual service-, insurer-, and provider-specific price growth) to reduce unwarranted price variation and promote equity.

b. **Limit Facility Fees.** Require site-neutral payments for certain common ambulatory services (e.g., basic office visits) and limit the cases in which both newly licensed and existing sites can bill as hospital outpatient departments and require clear disclosure of facility fees to patients, prior to delivering care.

c. **Enhance Scrutiny and Monitoring of Provider Expansions and Ambulatory Care.** Improve data collection on ambulatory care and continue to closely examine the impact of plans for major expansions of services or new facilities, particularly for outpatient services and for higher-priced providers, on health care costs, quality, access, and market competition, and ensure that any such expansions are well informed by health equity considerations.

d. **Adopt Default Out-of-Network Payment Rate.** As a constraint on the spending and market impact of excessive prices charged by out-of-network providers, the Legislature should enact the default out-of-network payment rate for "surprise billing" situations recommended by the Executive Office of Health and Human Services in its Report to the Massachusetts Legislature: Out-of-Network Rate Recommendations.

Determination of Need (DoN) Review Overview

DETERMINATION OF NEED (DON) PROCESS

Providers must file a DoN application with the Department of Public Health (DPH) when they make substantial **capital expenditures**, make substantial **changes in services**, add **specific major equipment**, **change ownership**, or make other specific operational changes.

- Most DoNs **do not require a material change notice** and separate review by the HPC.
- The HPC is a "**party of record**" in the DoN process and receives all DoN filings.
- The HPC **may provide comment** to the DoN program at certain points in the review.

DON REVIEW FACTORS

DoN applications are **evaluated based on DoN factors** in 105 CMR 100.210(A). Factors that are particularly relevant to the HPC's charge of developing policies to reduce overall cost growth while improving quality, including efforts to foster the continued development of a competitive, value-based health care market include:

- The applicant must demonstrate that the project aligns with the **needs** of its patient panel, will provide **public health value** including improved health outcomes for its patients and **reasonable assurances of health equity**, and will compete on the basis of **price**, **total medical expenses**, **provider costs**, and other recognized measures of **health care spending**.
- The applicant must also demonstrate that the project will meaningfully contribute to the Commonwealth's goals for **cost containment**, improved public health outcomes, and delivery system transformation.

Overview of Two DoNs Currently Under Review: Inpatient Bed Expansions for UMass Memorial Medical Center and Boston Medical Center

UMass Memorial Medical Center (UMass MMC)

- DoN filed on July 5, 2022, to expand inpatient capacity.
- Proposed project includes:
  - Renovation of a 6-story building adjacent to UMass MC's University Campus for 72 additional med/surg beds
  - 19 additional med/surg beds at UMass MMC's Memorial Campus
  - 1 additional CT Unit
- Expansion would result in a total of 553 med/surg beds (19.7% increase).
- Total value of the project is estimated to be $143.2M, with an incremental cost of $118.6M.
- DPH hosted a public hearing August 23, 2022, and several TTGs have commented, including those formed by competitors St. Vincent Hospital and Mass. General Brigham.
- DPH issued the Staff Report on October 7, 2022.

Boston Medical Center (BMC)

- DoN filed on September 9, 2022, to expand inpatient capacity.
- Proposed project includes:
  - Accommodation of 70 new inpatient beds, including 60 med/surg beds and 10 additional ICU beds
  - The addition of 5 new inpatient operating rooms, as well as pre- and post-operative/post-anesthesia care unit space
- Expansion would result in a total of 461 acute beds (15.8% increase) and 23 inpatient operating rooms (27.8% increase)
- BMC currently has 63 unlicensed acute beds due to the COVID-19 pandemic; BMC indicates the project will not impact this capacity.
- Total value of the project is estimated at $121.2M, with an incremental cost of $76.0M.
- On October 7, 2022, a TTG formed by Mass. General Brigham requested both an independent cost analysis (ICA) and public hearing on the proposed expansion. A public hearing has been scheduled for October 28, 2022.

HPC Analysis: Construction of additional beds would likely divert patients to UMass and BMC from other local providers.

Although UMass and BMC offer many specialized services, most patients who would receive inpatient care in new beds would likely otherwise receive care at other hospitals. We used econometric patient choice models to predict where commercial patients would likely otherwise receive care.

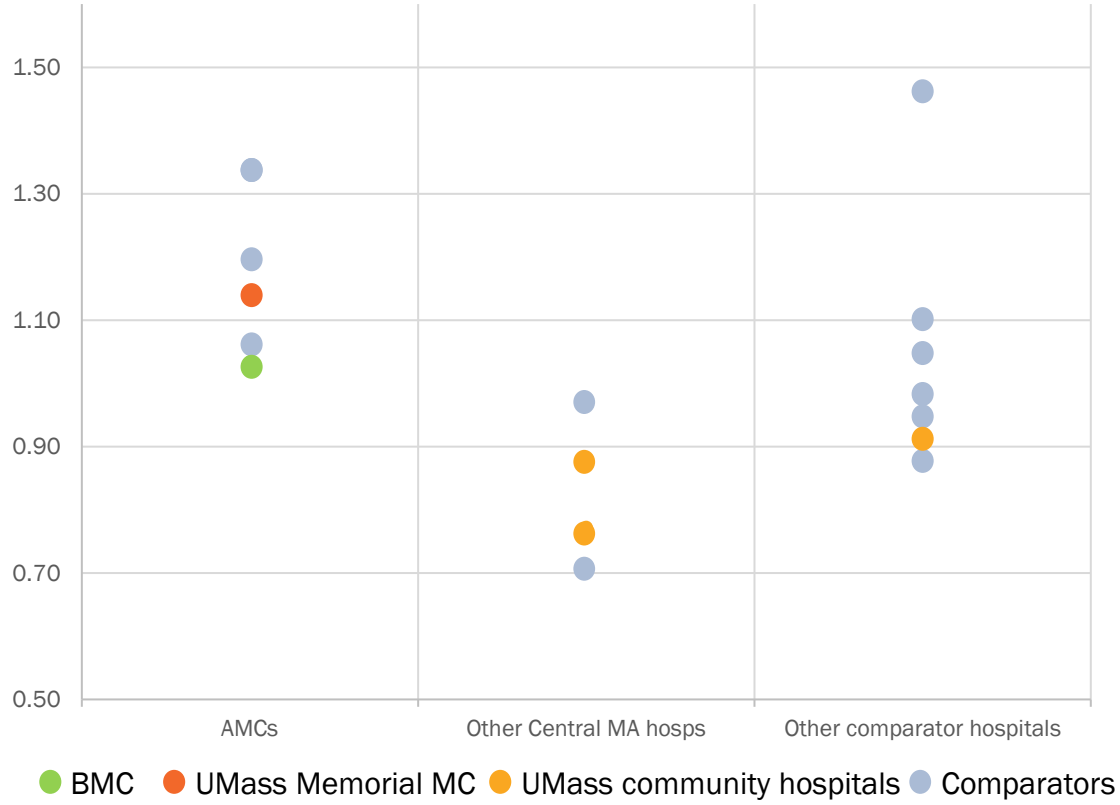
Commercial Discharge Shifts to Fill Proposed Inpatient Capacity		
	Number of Predicted New Commercial Discharges	**Diverted Primarily From**
UMass Memorial MC	~2,100	St. Vincent Hospital (~35%) UMass system community hospitals (~10%) Brigham & Women's Hospital (~6%) Milford Regional Med. Ctr. (~6%) Mass. General Hospital (~5%) Newton Wellesley Hospital (~5%)
BMC	~600	Mass. General Hospital (~16%) Brigham & Women's Hospital (~15%) Beth Israel Deaconess Med. Ctr. (~12%) South Shore Hospital (~9%)

Source: HPC analysis of 2019 CHIA hospital discharge data.

HPC Analysis: Potential spending impacts of hospital expansions are largely driven by variation in commercial prices.

- Expansions by different hospitals impact spending differently, based largely on the pricing of the expanding hospital relative to other providers from whom patients would have otherwise received care, as well as the volume of commercial patients.
  - The proposed expansion of UMass is likely to *increase* annual commercial spending by $5.1M to $5.9M due to moderate inpatient pricing and commercial mix.
  - The proposed expansion of BMC is likely to *decrease* annual commercial spending by approximately $1.8M to $2.2M due to low inpatient pricing and commercial payer mix.
  - By comparison, as the HPC commented earlier this year, the proposed expansion of MGH was anticipated to increase annual commercial spending by $23.7M to $40.6M due to high inpatient pricing and commercial payer mix.
- Policy approaches to reduce unwarranted variation in provider prices would mitigate spending increases from major expansions, and would allow providers, community stakeholders, and regulators to focus on the quality, access, and health equity implications of expansions.

Inpatient Relative Prices for MA Academic Medical Centers (BCBS, 2020)



Source: HPC analysis of 2019 CHIA hospital relative price data.
Note: Comparator AMCs are Brigham & Woman's Hospital, Mass. General Hospital, Tufts Med. Ctr., and Beth Israel Deaconess Med. Ctr. Other Central Mass. hospitals are St. Vincent Hospital, HealthAlliance Hospital, Harrington Memorial Hospital, Heywood Hospital, and Athol Hospital. Other comparator hospitals are Boston Children's Hospital, Winchester Hospital, Newton-Wellesley Hospital, South Shore Hospital, Emerson Hospital, Marlborough Hospital, and Milford Regional Med. Ctr. Other comparator hospitals represent all hospitals not included in the other categories that contribute at least 3% of diverted commercial discharges for either UMass Memorial Med. Ctr. or BMC in HPC econometric models.

Agenda

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Research Presentation: Utilization of Telehealth in the Commonwealth

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OFFICE OF PATIENT PROTECTION REGULATORY CHANGES

Schedule of Upcoming Meetings

The HPC was also given new mandates and responsibilities through Chapter 177 of the Acts of 2022, *An Act Addressing Barriers to Care for Mental Health,* signed in August 2022.

- *Public Hearing and Cost Trends Report Additions.* Directs the HPC to include behavioral health expenditures in the annual cost trends report and cost trends hearing.
- *Standard Release Form.* Directs the HPC to create a standard release form and regulation for securely exchanging confidential mental health and substance use disorder information for use by public and private entities in compliance with state and federal laws including HIPAA. The law also directs the HPC to *convene a 14-member advisory group,* with the Executive Director acting as chair, to inform the HPC's development of the standard release form.
- ***Statutory Changes to Internal and External Grievance Processes.*** Requires OPP to update its regulation to implement several changes in the insurance consumer protection law, chapter 176O.
- *Behavioral Health Managers Report.* Directs the HPC to work with DOI to study the effects of behavioral health managers on the quality and accessibility of behavioral health services, oversight practices in other states, and any other topics deemed relevant to the report.
- *Pediatric Behavioral Health Planning Report.* Directs the HPC to consult with DMH and DDS to develop a new report to analyze the status of pediatric behavioral health planning in the Commonwealth. The first report is due 18 months after the effective date, and future reports are recurring every three years.
- *Special Commission for Medically Necessary Determinations in Behavioral Health.* Creates a new commission led by the Commissioner of Mental Health to create a common set of criteria for providers and payers to use in making medical necessity determinations for behavioral health treatment. The HPC is a member of the commission.

Office of Patient Protection (OPP) Responsibilities

OPEN ENROLLMENT WAIVERS

Administering waivers to allow purchase of non-group health insurance outside of open enrollment

HEALTH INSURANCE APPEALS

Regulating internal grievances and administering external reviews for members of fully-insured health plans

RISK-BEARING PROVIDER ORGANIZATION APPEALS

Regulating internal appeals and administering external reviews for patients of risk-bearing provider organizations

CONSUMER ASSISTANCE AND INFORMATION

Serving as a resource for consumers through our hotline, website, and outreach efforts

Chapter 177 of the Acts of 2022, *An Act Addressing Barriers to Care for Mental Health*, effective November 8, 2022.

OPP SECTIONS	CHANGES FROM CURRENT LAW	OPP Implementation
64-65, 71	▪ Amends the internal grievance process in several ways, including mandating that health plans send final adverse determination letters with proof of delivery ▪ Creates additional obligations on health plans related to implementing new medical necessity criteria	▪ Regulatory changes required
66-69	▪ Amends OPP's external review process, including allowing requests for continuation of coverage in non-expedited reviews and deems that health plan noncompliance with internal grievance timelines result in an external review ruled in favor of the patient	▪ Regulatory changes required ▪ Developing interim guidance to address OPP compliance prior to final regulation
22, 70	• Mandates that OPP monitor denials, identify trends, and refer complaints about mental health parity to the DOI, AGO, and GIC and that the DOI consult with OPP on mental health parity market conduct examinations	• Ongoing communication with the DOI regarding duties related to Mental Health Parity

Developing Interim Guidance on OPP Implementation of Chapter 177

- OPP is developing **interim guidance to notify health plans, external review agencies, and other parties about OPP's implementation related to the external review process** in compliance with Chapter 177.
- Interim guidance will be **effective from November 2022 until the final regulation is issued in April 2023.**

KEY AREAS TO ADDRESS

- Substantial evidence of timely notice to consumers in internal grievance process
- Processing requests for continuation of coverage
- External review agency review of medical records and relevant state laws

Proposed Regulatory Promulgation Timeline, 958 CMR 3.000

November 2022 — Chapter 177 Takes Effect

January 2023 — HPC Board Votes to Release Proposed Regulation

February 2023 — Public Hearing on Proposed Regulation

March 2023 — Public Comment Period Closes

April 2023 — HPC Board Votes to Issue Final Regulation

Agenda

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Office of Patient Protection Regulatory Changes

SCHEDULE OF UPCOMING MEETINGS

10 YEAR ANNIVERSARY

SAVE THE DATE!

IN-PERSON EVENT!

WEDNESDAY, NOVEMBER 2

2022 HEALTH CARE COST TRENDS HEARING

MASSACHUSETTS HEALTH POLICY COMMISSION

REGISTER ONLINE:
TINYURL.COM/CTH-2022

Schedule of Upcoming Meetings

BOARD

December 14

COMMITTEE

No meetings remaining for 2022

ADVISORY COUNCIL

December 7

SPECIAL EVENTS

November 2
Cost Trends Hearing

Mass.gov/HPC

HPC-info@mass.gov

@Mass_HPC

tinyurl.com/hpc-linkedin

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
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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, March 15 – Benchmark Hearing
Wednesday, April 12
Wednesday, June 7
Wednesday, July 12
Wednesday, September 13
Wednesday, December 13

COMMITTEE MEETINGS

Wednesday, February 15
Wednesday, May 10
Monday, July 10 (Administration & Finance)
Wednesday, October 4

ADVISORY COUNCIL

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

COST TRENDS HEARING

Wednesday, November 1

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