MASSACHUSETTS
HEALTH POLICY COMMISSION

# Health Policy Commission Advisory Council

**May 12, 2021**

MASSACHUSETTS
HEALTH POLICY COMMISSION

## AGENDA

- **Welcome**
- Executive Director's Report
- Impact of COVID-19 on the Massachusetts Health Care System: Interim Report
- Discussion and Feedback
- Next Meeting: Wednesday, September 29

# Welcome HPC Advisory Council Members!

**Lissette Blondet**, Executive Director, Massachusetts Association of Community Health Workers
**Kim Brooks**, Chief Operating Officer, Senior Living, Hebrew SeniorLife
**Michael Caljouw**, Vice President of Government & Regulatory Affairs, Blue Cross Blue Shield MA
**Christopher Carlozzi**, State Director, National Federation of Independent Business (NFIB)
**JD Chesloff**, Executive Director, Massachusetts Business Roundtable
**Dr. Cheryl Clark**, Director of Health Equity Research and Intervention, Brigham and Women's Hospital
**Michael Curry**, President and CEO, Massachusetts League of Community Health Centers
**Dr. Ronald Dunlap**, Cardiologist and Past President, Massachusetts Medical Society
**Geoffrey Gallo**, Director of State Government Affairs, AstraZeneca
**Audrey Gasteier**, Chief of Policy and Strategy, Massachusetts Health Connector
**Bonny Gilbert**, Co-Chair of Healthcare Action Team, Greater Boston Interfaith Organization (GBIO)
**Tara Gregorio**, President and CEO, Mass Senior Care Association
**Lisa Gurgone**, Executive Director, Mass Home Care
**Jon Hurst**, President, Retailers Association of Massachusetts
**Pat Kelleher**, Executive Director, Home Care Alliance of Massachusetts
**Colin Killick**, Executive Director, Disability Policy Consortium
**Ellen LaPointe**, CEO, Fenway Health
**David Matteodo**, Executive Director, Massachusetts Association of Behavioral Health Systems
**Dr. Danna Mauch**, President and CEO, Massachusetts Association for Mental Health
**Cheryl Pascucci**, Family Nurse Practitioner, Baystate Franklin Medical Center
**Carlene Pavlos**, Executive Director, Massachusetts Public Health Association
**Lora Pellegrini**, President and CEO, Massachusetts Association of Health Plans
**Christopher Philbin**, Vice President of Office of Government Affairs, Partners HealthCare System
**Judith Pare,** Director of Nursing, Massachusetts Nurses Association
**Dr. Claire-Cecile Pierre**, Chief Medical Officer, Harbor Health Services and Executive Director, Kerry Murphy Healey Center for Global Health Entrepreneurship at Babson College
**Amy Rosenthal**, Executive Director, Health Care For All
**Christine Schuster**, President and CEO, Emerson Hospital
**Zach Stanley**, Executive Vice President, MassBio
**Dr. Steven Strongwater**, President and CEO, Atrius Health
**Assistant Secretary Daniel Tsai**, Assistant Secretary for MassHealth, Executive Office of Health and Human Services
**Matthew Veno**, Executive Director, Group Insurance Commission
**Steven Walsh**, President and CEO, Massachusetts Health and Hospital Association
**Elizabeth Wills-O'Gilvie**, Chair, Springfield Food Policy Council
**Deborah Wilson**, President and CEO, Lawrence General Hospital

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**Denotes new member for 2021**

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- Welcome
- **Executive Director's Report**
  - 2022 Health Care Cost Growth Benchmark
  - Recent and Upcoming Publications
  - Investment Programs
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# Key Takeaways from the Annual Benchmark Hearing

1. Massachusetts total health care expenditures (THCE) per capita **grew 4.3% from 2018 to 2019**, above the health care cost growth benchmark.

2. The **majority of organizations testifying at the hearing supported the 3.1% benchmark**. The remainder did not specify a position.

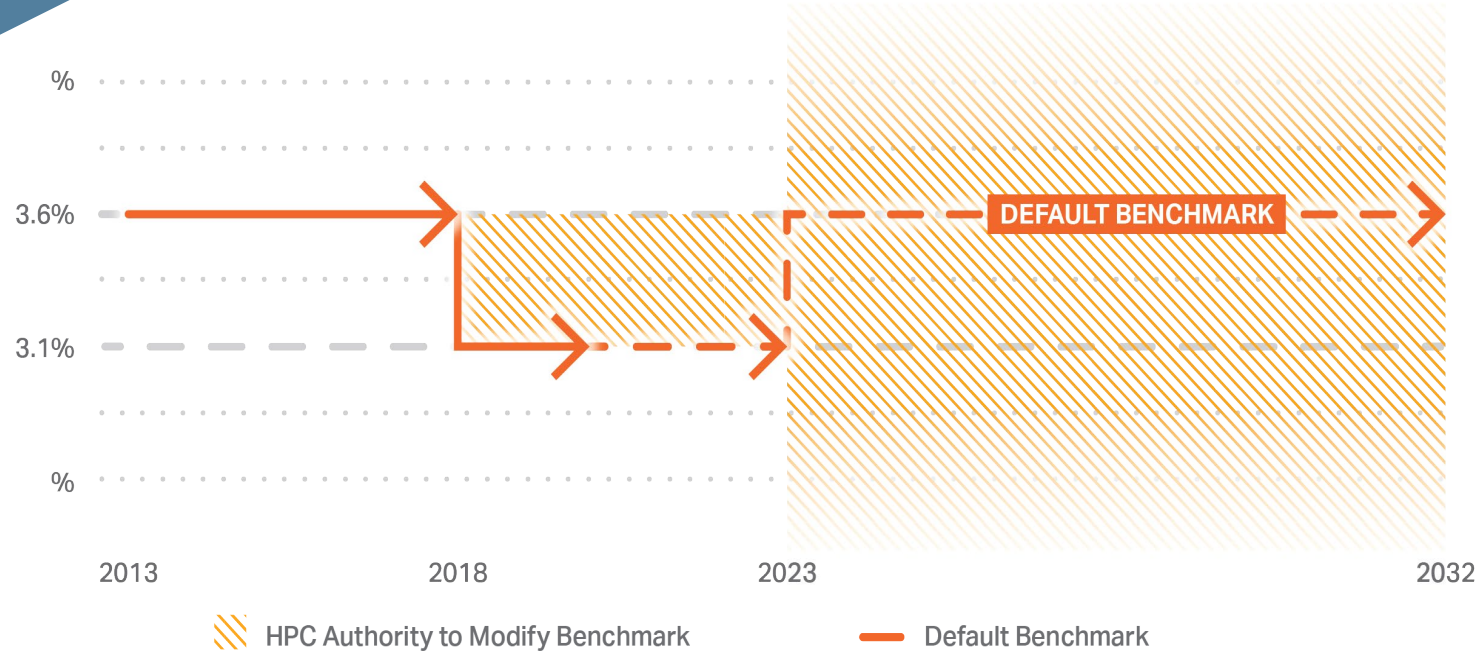
3. **Inpatient and outpatient spending**, **pharmaceutical costs**, and **delivery of care in high-cost settings** were identified as key drivers of spending to watch. Testifiers also expressed concerns about continued COVID-19 impacts, especially disruptions in care, vaccine administration costs, and operational costs (e.g., PPE).

4. Community hospital testifiers expressed support for applying a health equity lens to the benchmark, citing longstanding price variation and inadequate reimbursement for high public payer hospitals serving the most impoverished and vulnerable populations.

5. Employers emphasized the **need to address significant affordability challenges**, including continued premium and cost sharing growth, and consumers additionally testified about deferred care and racial disparities.

# The HPC Board set the 2022 health care cost growth benchmark at 3.1%.

| YEARS | |
|---|---|
| 1–5 | Benchmark established by law at PGSP (3.6%) |
| 6–10 | Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); the HPC can modify the benchmark up to 3.6%, subject to legislative review. |
| 10–20 | Benchmark established by law at a default rate of PGSP; the HPC can modify to any amount, subject to legislative review. |

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# Recent and Upcoming Publications

### COVID-19 Impact Study
*April 2021*

Study on the impact of the COVID-19 pandemic on the health care delivery system, including workforce, service delivery, and health care disparities

### TCCI Program Brief
*April 2021*

High-level summary of the Targeted Cost Challenge Investments (TCCI) Program initiatives and results.

### NAS Investment Program Brief
*April 2021*

High-level summary of the Neonatal Abstinence Syndrome (NAS) Investment Program initiatives and results.

### Sustaining Grant-Funded Initiatives Guide
*January 2021*

Sustainability guide based on experiences from Health Care Innovation Investment Program awardees that successfully sustained their programs beyond the HPC-funded period.

### OPP Annual Report
*May 2021*

Provides a comprehensive overview of activities of the Office of Patient Protection

### DataPoints: Avoidable Dental Care ED Use

This DataPoints issue will identify trends in avoidable dental emergency department use in Massachusetts between 2017 and 2019, with variation by race, age, income, region, and payer type.

### Cost Trends Report 2020

Presents annual overview of trends in health care spending and delivery in Massachusetts, evaluate progress in key areas, and make recommendations for strategies to increase quality and efficiency

### Policy Brief: Performance Improvement Plans

Overview of successes and challenges in the process for monitoring and enforcing payer and provider performance relative to the benchmark

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# Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) Program Overview

The purpose of the BESIDE investment program is to address inequities in maternal health outcomes and improve the care and patient experience of Black Birthing People by increasing access to and use of doula services. Specifically, the BESIDE investment program aims to:

1. Increase the number of Black Birthing People who are informed about the benefits of doula care and offered the opportunity to work with doulas, particularly doulas who are from the communities (e.g., geographic, cultural) of or share lived experience of inequities with Black Birthing People.
2. Improve the prenatal, labor and delivery, and postpartum care of Black Birthing People through the support of doulas.
3. Support the development of a culture of understanding and mutual respect between doulas and clinical and administrative staff within Massachusetts Birthing Hospitals and Birth Centers.
4. Embed principles of racial equity and Cultural Humility in the design and implementation of programs offering doula services.

# BESIDE Program Structure

## $500,000

Pursuant to Section 88 of Chapter 41 of the Acts of 2019, the HPC will invest $500,000 dollars in the BESIDE Investment Program.

## 3 Months

Awardees will take part in a 3-month Planning Period.

## 2 Awards

The HPC will award funding of up to $250,000 to up to 2 eligible entities (i.e., birthing hospitals and birth centers)

## 21 Months

Awardees will take part in a 21-month Implementation Period.

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# Anticipated BESIDE Program Timeline

**May/June**

- Issue RFP following Board Approval **(May 20)**
- Begin to collect and track questions, release FAQs

**July/August**

- Final day for questions: **July 2**
- Proposals due: **July 20**
- Review proposals and select awardees

**September**

- Announce awardees: **September 15**
- Begin contracting

**November**

- Program launch

**Contact Us**

HPC-BESIDE@mass.gov

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# Impact of COVID-19 on the Massachusetts Health Care System: Interim Report

MASSACHUSETTS
HEALTH POLICY COMMISSION

April 2021

# Outline

1. INTRODUCTION AND STUDY MANDATE
2. ANALYSIS OF UTILIZATION AND MARKET IMPACT TO DATE
   - Utilization
     - Hospital Care
     - Ambulatory Care
     - Telehealth
     - Behavioral Health
   - Market Impact
     - Provider Market
       - Financial Impact
       - Closures and Consolidation
     - Insurer Market
       - Financial Impact
       - Coverage
3. TOPICS FOR FUTURE STUDY

# COVID-19 Impact Study Mandate

"An Act Promoting A Resilient Health Care System that Puts Patients First" was signed into law on January 1, 2021. It charges the HPC with conducting an analysis and issuing a report on:

> **...the effects of the COVID-19 pandemic on the Commonwealth's health care delivery system, including on the accessibility, quality, and cost of health care services and the financial position of health care entities in the short-term, and the implications of those effects on long-term policy considerations.**

An interim report is due April 2021, and a final report is due January 2022.

**Additional components of the study mandate include:**

- Essential components of a robust health care system
- Inventory of all health care services
- Impact on the health care workforce
- Closures of essential services
- Analysis of health care disparities in the Commonwealth

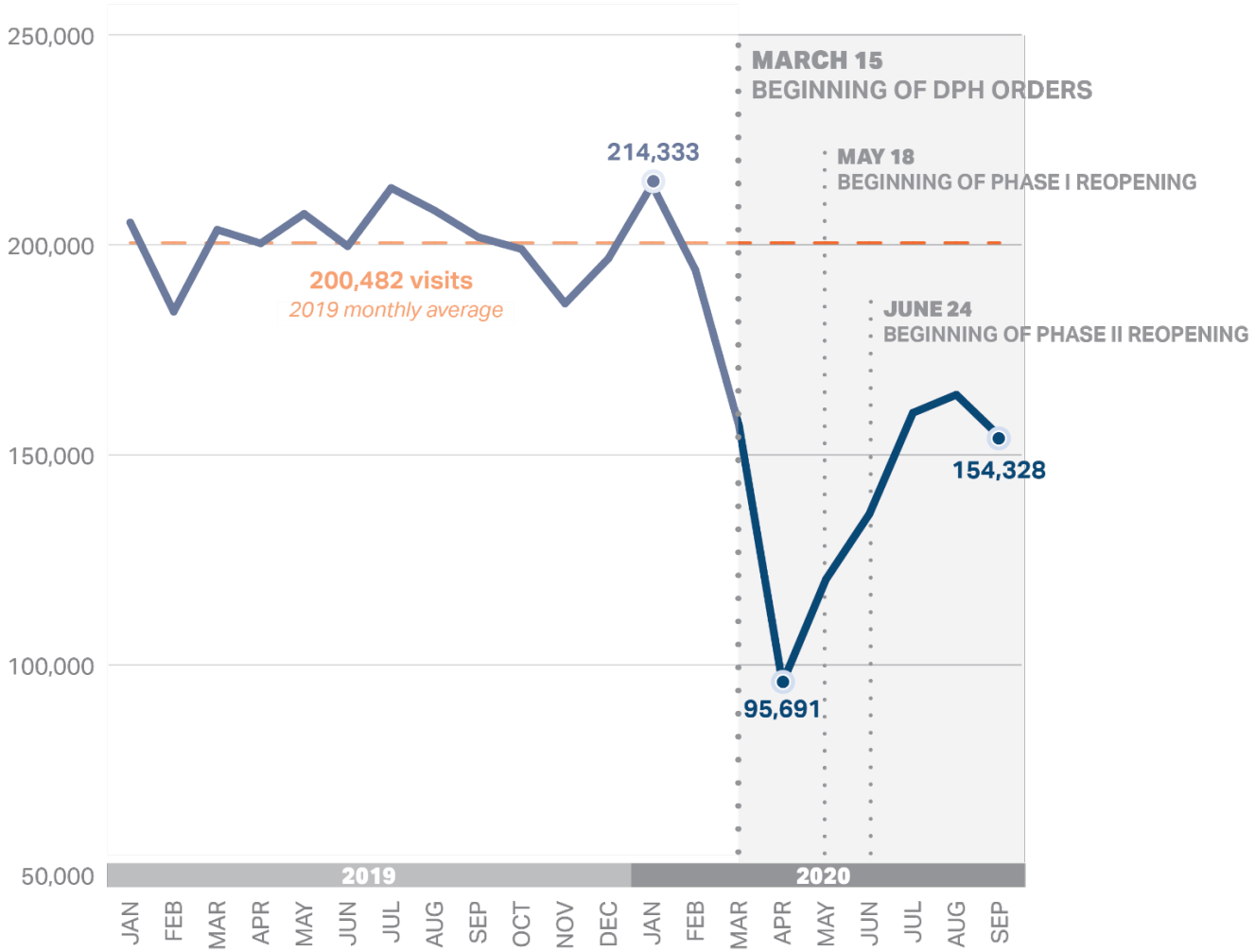
# Outline

- Introduction and Study Mandate
- Analysis of Utilization and Market Impact to Date
  - **UTILIZATION**
    - Hospital Care
    - Ambulatory Care
    - Telehealth
    - Behavioral Health
- Topics for Future Study

# Emergency department visits decreased 55% between January and April 2020, and as of September were 24% below 2019 levels.

HOSPITAL | ED

*Total ED visits, January 2019- September 2020*




Emergency department (ED) visits in Massachusetts decreased sharply in the spring of 2020, falling 55% between January and April. The number of ED visits then started to increase but, as of September 2020, remained 24% below 2019 levels. These figures include ED visits for patients with COVID-19, which peaked at nearly 7,000 in April 2020.

The decrease in ED visits occurred even though hospital emergency services remained available throughout the pandemic. More research is needed to understand the extent to which patients who may have otherwise gone to the ED sought alternative care (e.g., primary care visits, telehealth), did not need care (e.g., due to lower exposure), or had unmet care needs.

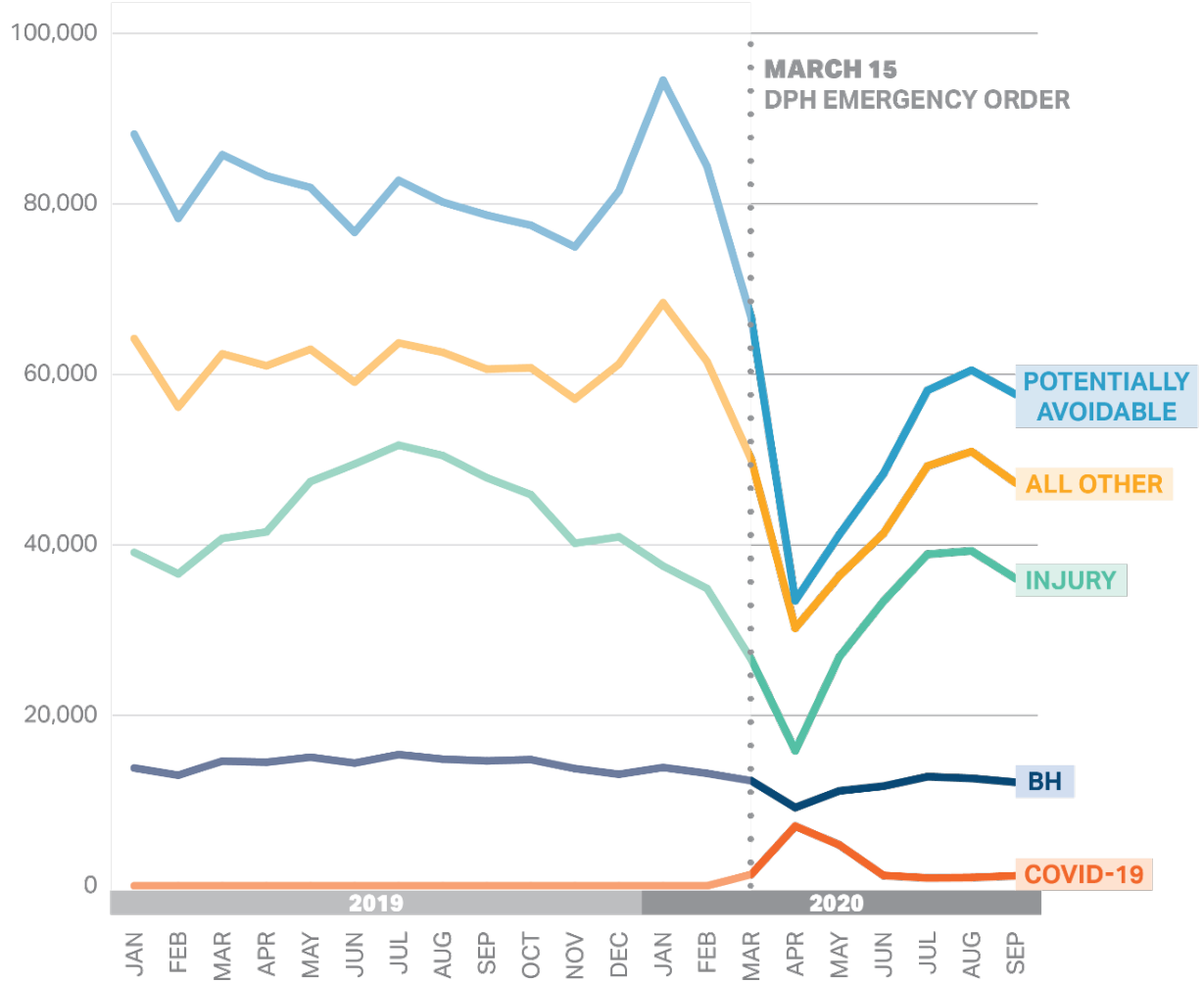
**Notes:** All ED visits included.

**Source:** HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

# All categories of non-COVID-19 ED visits dropped in April 2020 compared to 2019. Potentially avoidable visits decreased 60%, while BH-related visits decreased 37%.

HOSPITAL | ED

*ED visit volume by type of visit, January 2019 - September 2020*




Decreases in ED visit rates in 2020 varied by type of ED visit. In April 2020, potentially avoidable ED visits (-60%) and visits for injuries (-62%) experienced the largest declines with behavioral health visits declining more modestly (-37%). At the same time, ED visits for COVID-19 peaked in April at 6,995 visits.

By August 2020 ED visits had increased, but were still 25% lower for potentially avoidable visits, 22% lower for injury, 15% lower for BH, and 19% lower for all other ED visits compared to August 2019.

The HPC classifies avoidable ED visits annually as a measure of efficient health care system use. Potentially avoidable ED visits are visits to the ED that could have been treated in a primary care setting, whether the visits were emergent or non-emergent.

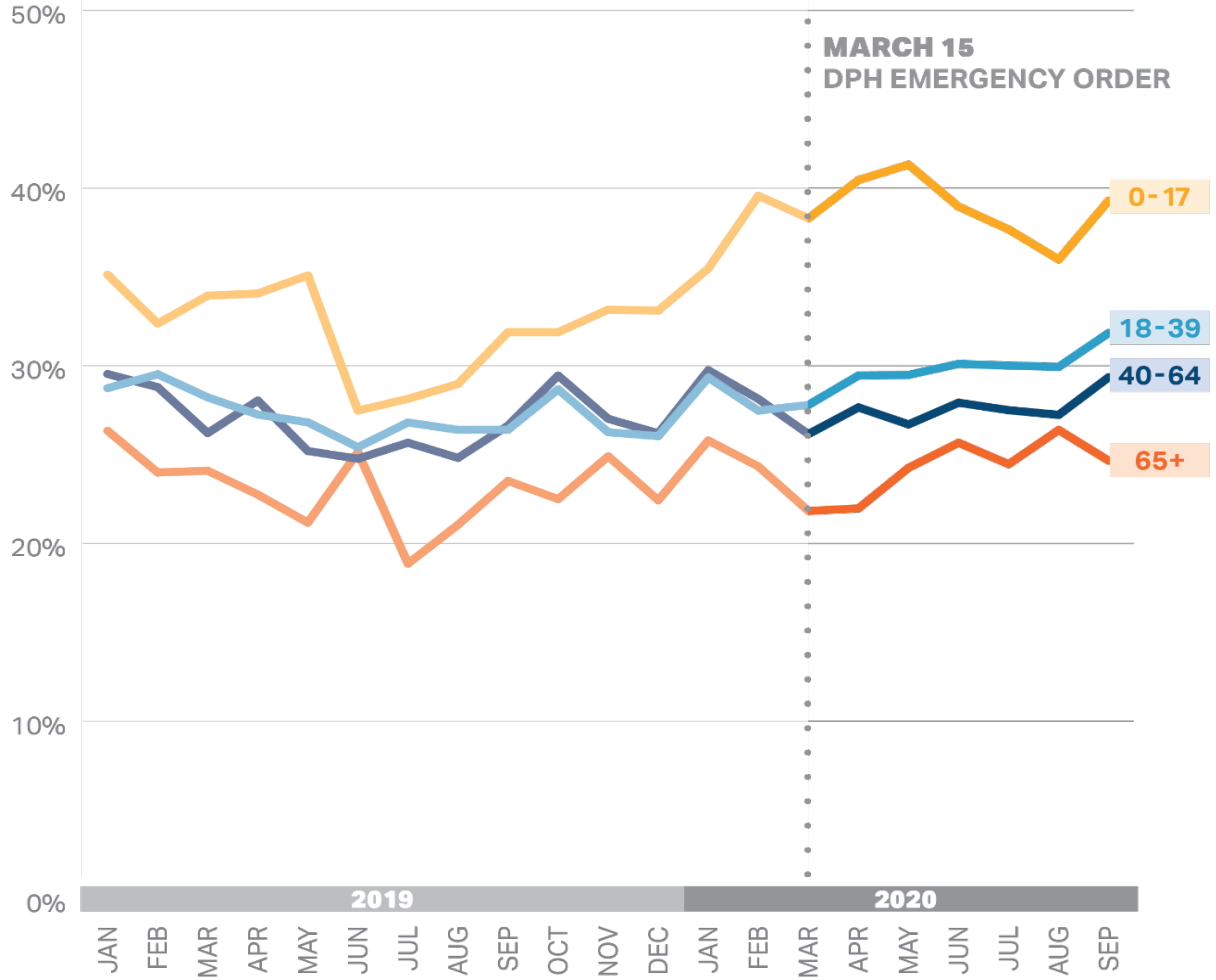
**Notes:** BH visits were defined using AHRQ CCSR MBD001-MDB034. Injury and avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent. All other are the total sum of ED visits minus avoidable ED, BH visits, COVID-19, and injury visits.

**Source:** HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

# For pediatric behavioral health patients, the percent of ED visits that resulted in boarding increased 7 percentage points from 2019.

HOSPITAL | ED

*Percent of behavioral health ED visits resulting in boarding by age group, January 2019 – September 2020*




Although drivers of behavioral health ED boarding affect patients of all ages, pediatric patients face particular barriers in access to care that can result in ED boarding.

From March through September 2020, 39% of pediatric behavioral health ED visits resulted in ED boarding compared to 28% of adult behavioral health visits.

Overall, there were approximately 3,200 fewer pediatric behavioral patients who had an ED visit from March through September 2020 compared to the same months 2019, but there was a higher percentage of pediatric patient visits that resulted in boarding, increasing by 7 percentage points.

Pediatric BH patients not only had higher rates of ED boarding than other age groups, but also were more likely to experience boarding that lasted over 48 hours. In 2020, 29% of pediatric patients who experienced ED boarding spent over 48 hours in the ED (n=878).

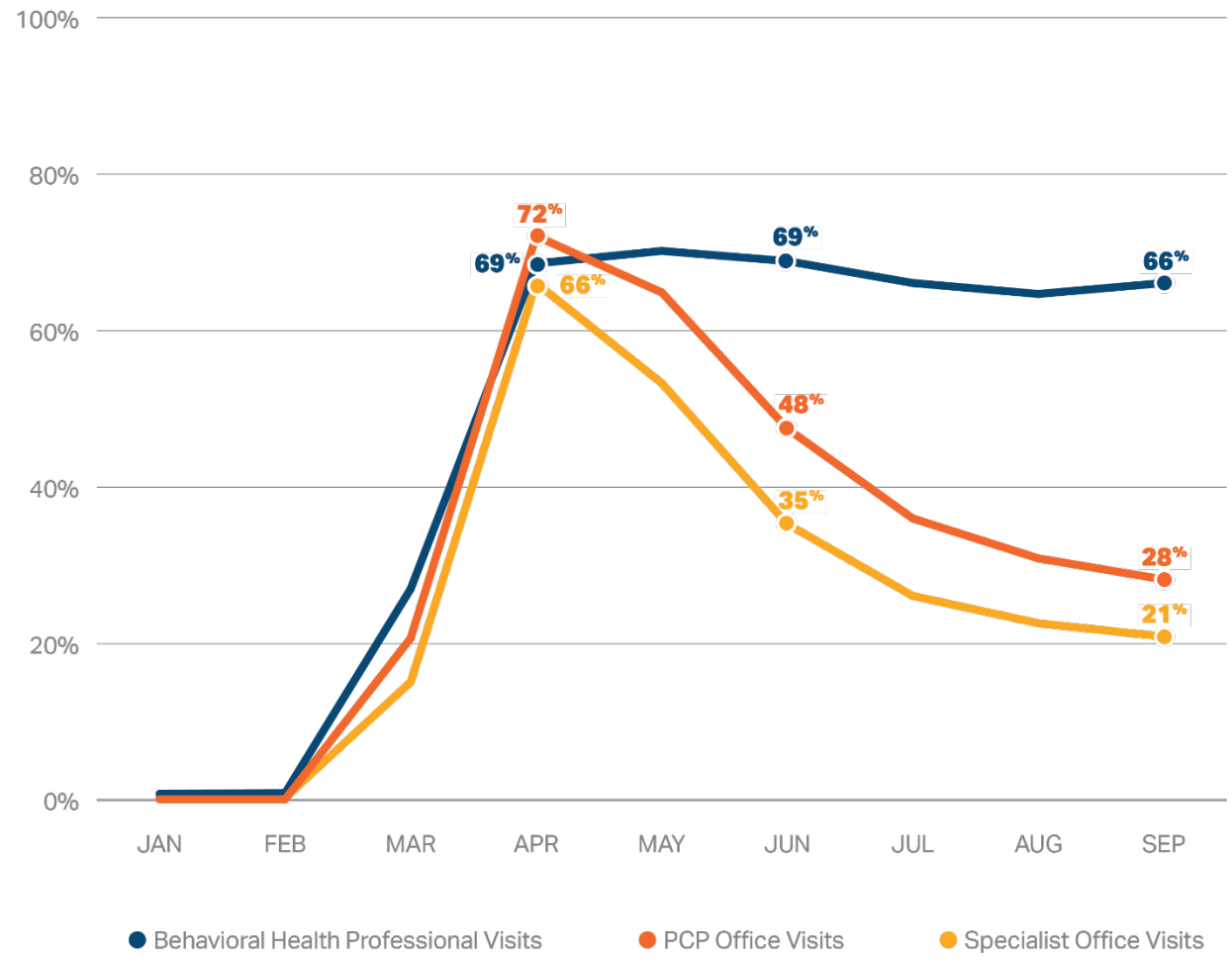
**Notes:** The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. ED visits where patients were admitted to the same hospital were excluded from this boarding analysis. Behavioral health visits were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034, Mental Health: MBD001-MBD013, Substance Use: MBD17-MBD34).

**Source:** HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

# Over 60% of behavioral health visits for commercially-insured Massachusetts residents were performed via telehealth starting in April 2020.

TELEHEALTH

*Trend in total visits by relative percentage of telehealth and in-person encounters for fully-insured commercial members in Massachusetts, January – September 2020*




Among commercially-insured Massachusetts residents, swift adoption of telehealth starting in March 2020 peaked in April, with approximately 70% of primary care, specialist, and behavioral health visits taking place via telehealth.

Starting in the spring and summer, the proportion of primary care and specialist visits provided by telehealth decreased to under 30%. In contrast, the share of behavioral health visits performed via telehealth remained high, at over 60% of visits.

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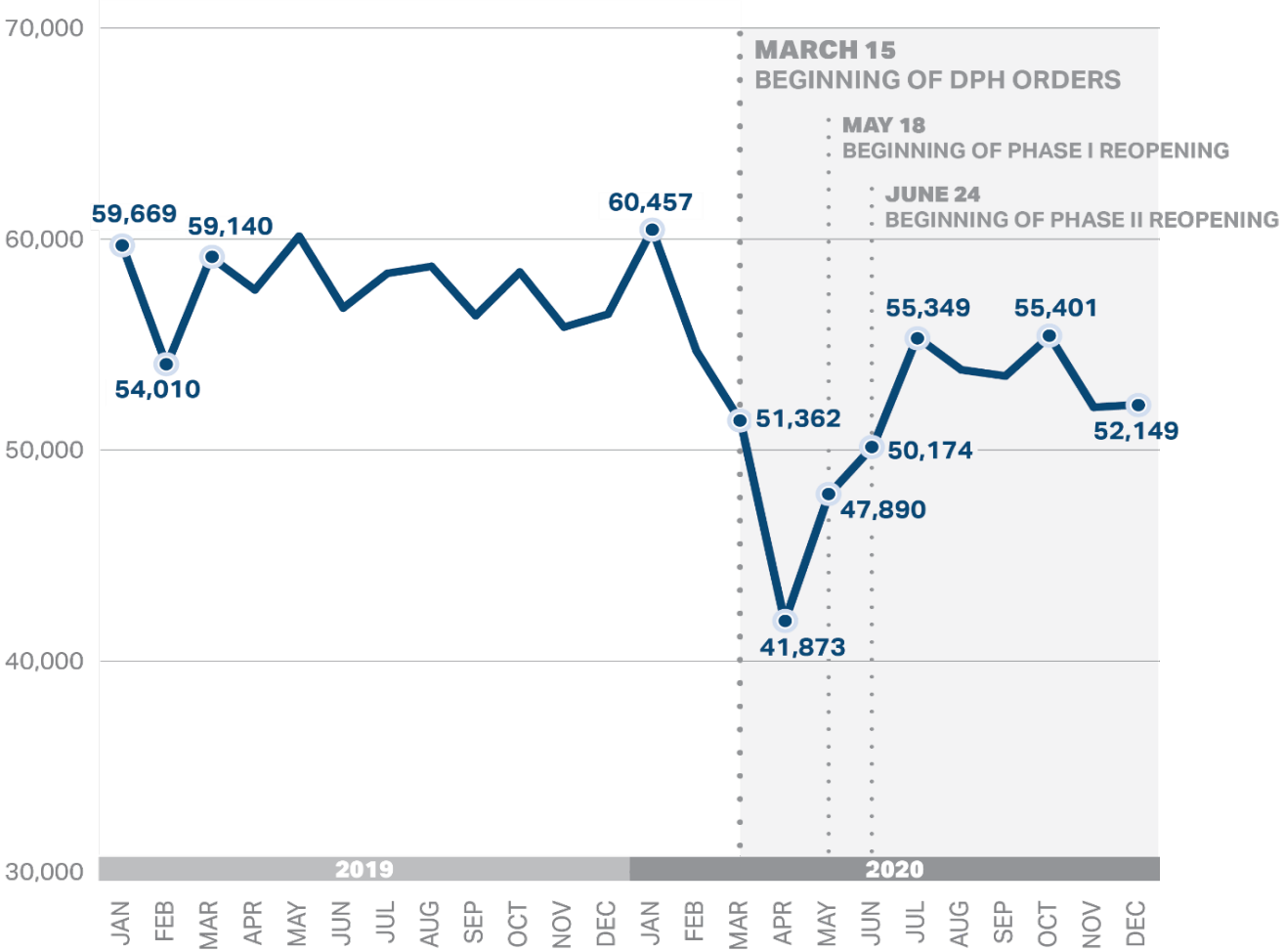
**Notes:** Includes fully-insured Massachusetts residents.
**Source:** Insurer utilization data submitted to the Massachusetts Division of Insurance for Q3 2020

# Hospital inpatient volume dropped 31% from January to April 2020 and remained below pre-pandemic levels through December.

HOSPITAL | INPATIENT

*Massachusetts acute care hospital inpatient admissions, 2019-2020*




On March 15, 2020, as COVID-19 hospitalizations began to rapidly increase, DPH issued an order to postpone or cancel any nonessential elective invasive procedures. Over the next several weeks, hospital stays continued to drop to a low of 41,873 in April (15,720 fewer stays than April 2019).

These figures include admissions for patients with COVID-19, which peaked at 8,196 admissions in April 2020, representing 19.6% of all admissions that month. The acute needs of these COVID-19 patients increased the average length of stay from 4.85 to 5.96 days, an 22.9% increase compared to 2019.

In May and June, as COVID-19 hospitalizations and other public health metrics decreased, DPH issued guidance for a phased reopening of the health care system. Overall volume continued to increase but had not reached pre-pandemic levels by the end of 2020.

In late fall and early winter, hospital discharges began to decrease again as COVID-19 hospitalizations began to rise.

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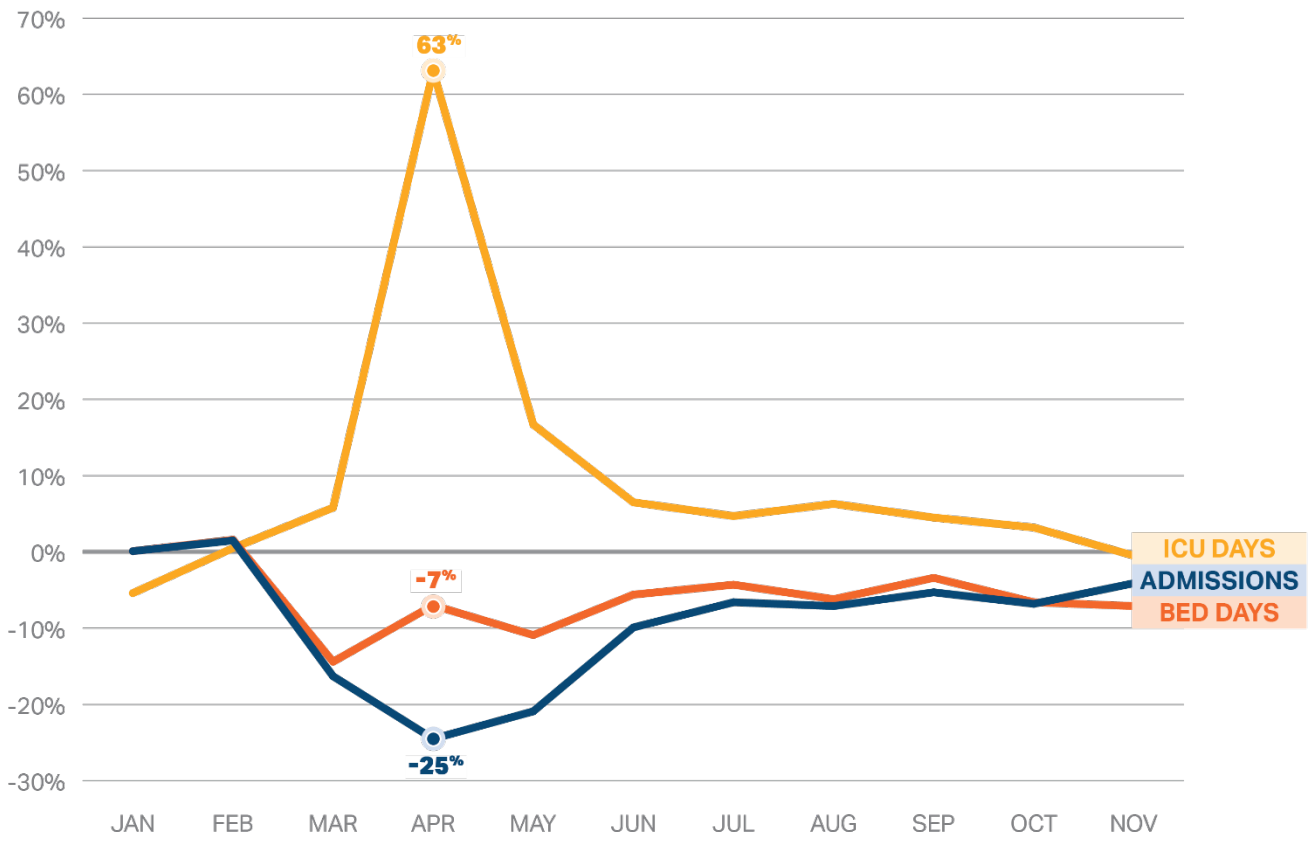
**Notes:** For more information on Reopening Health and Human Services, please see: https://www.mass.gov/lists/reopening-health-and-human-services-in-Massachusetts. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

**Source:** HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

# ICU and critical care volume increased dramatically in April 2020, spiking 63% over 2019 levels, and remained higher throughout 2020.

HOSPITAL | INPATIENT

*Percent change in admissions, bed days, and ICU/CCU days, January 2019 - November 2020*




While the total number of inpatient admissions dropped in April, the number of patient days in intensive care units/critical care units (ICU/CCU) increased dramatically, spiking 63% over April 2019 levels.

While ICU/CCU use dropped after the initial surge, ICU/CCU days remained higher than 2019 levels through 2020.

Overall, from 2019 to 2020, the number of admissions decreased 9%, while ICU/CCU days increased 10%. Hospital bed-days (related to occupancy rates), did not decline as much as the number of admissions because patients with COVID-19 experienced longer hospital stays, on average.

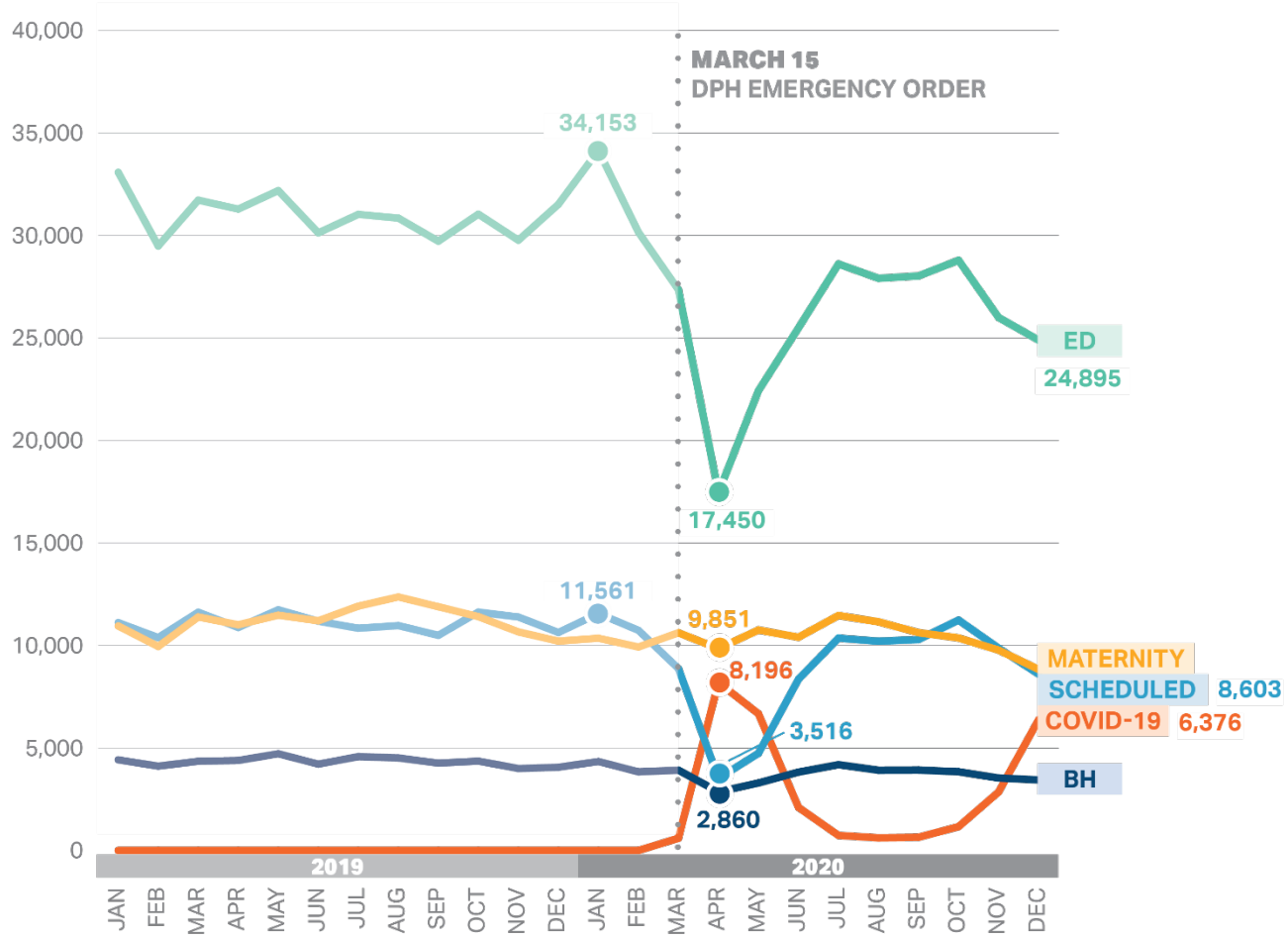
**Notes:** This analysis assigns the number of bed days and ICU/CCU days for each admission to the original admission date. ICU days and CCU days were identified using revenue codes (0200, 0201, 0202 and 0210); pediatric, neonatal, and intermediate ICUs were excluded from this analysis. Because many of the December stays were not discharged until January and data was not complete for January 2021, December is excluded from this graph.

HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

# Admissions from the ED and scheduled admissions fluctuated throughout 2020 but remained below 2019 levels.

HOSPITAL | INPATIENT

*Massachusetts acute care hospital inpatient admissions by admission type, 2019-2020*




**Notes:** COVID-related discharges are excluded. Maternity includes all stays with a maternity-related APR-DRG. ED admissions include all stays with an ED flag or ED-specific revenue code. Behavioral Health (BH) stays include all stays with a BH diagnosis as the primary diagnosis. Scheduled includes remaining stays. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

**Source:** HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

Trends in hospital admission volume over 2020 varied by admission type. In March and April 2020, the number of admissions through the ED and scheduled admissions declined sharply. These admission types rebounded but remained below 2019 levels. In late fall and early winter, hospital discharges began to decrease again as COVID-19 hospitalizations began to rise.

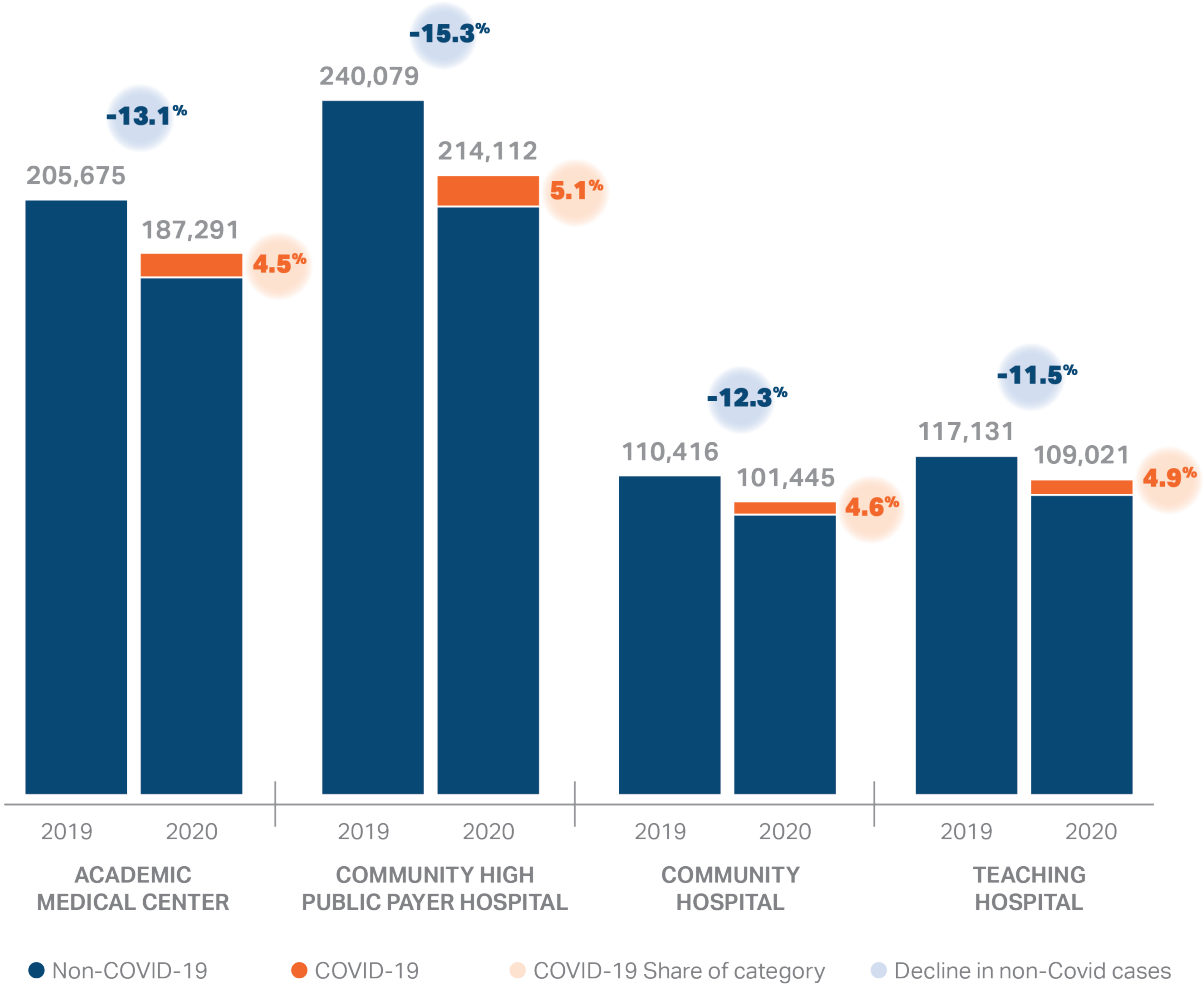
Maternity-related stays declined the least over this time period (8%). Behavioral health admissions, although a relatively small volume of acute-inpatient admissions, declined 14% from 2019-2020.

When examining behavioral health admissions, it is important to note that the data only includes information from acute care hospitals and does not include admissions at free-standing psychiatric hospitals. Additionally, the overall loss of psychiatric bed capacity, as described on previous slides, also likely impacted the volume of behavioral health admissions during this time period.

# All hospital cohorts treated a similar percentage of COVID-19 patients through 2020, but community high public payer hospitals treated the largest volume of these patients while losing the most volume for other types of inpatient stays.

HOSPITAL | INPATIENT

*Total inpatient admissions and percentage of admissions that were COVID-19-related, by hospital cohort, 2019 and 2020*




Throughout 2020, hospitals worked with the state's COVID-19 Command Center to continuously monitor bed capacity and volume of COVID-19 patients. To ensure adequate capacity within and across hospital systems and geographic regions, hospitals worked collaboratively to balance patient needs.

The volume of COVID-19 patients as a percentage of all admissions was similar across all hospital cohorts, ranging from 4.5% of all admissions at academic medical centers (AMCs) to 5.1% at community high public payer hospitals (CHPPHs), excluding field hospitals. However, CHPPHs treated the largest volume of COVID-19 patients in 2020, totaling 10,829 patients.

Additionally, CHPPHs experienced the greatest decline in non-COVID-19 admissions, decreasing 15.3% between 2019 and 2020.

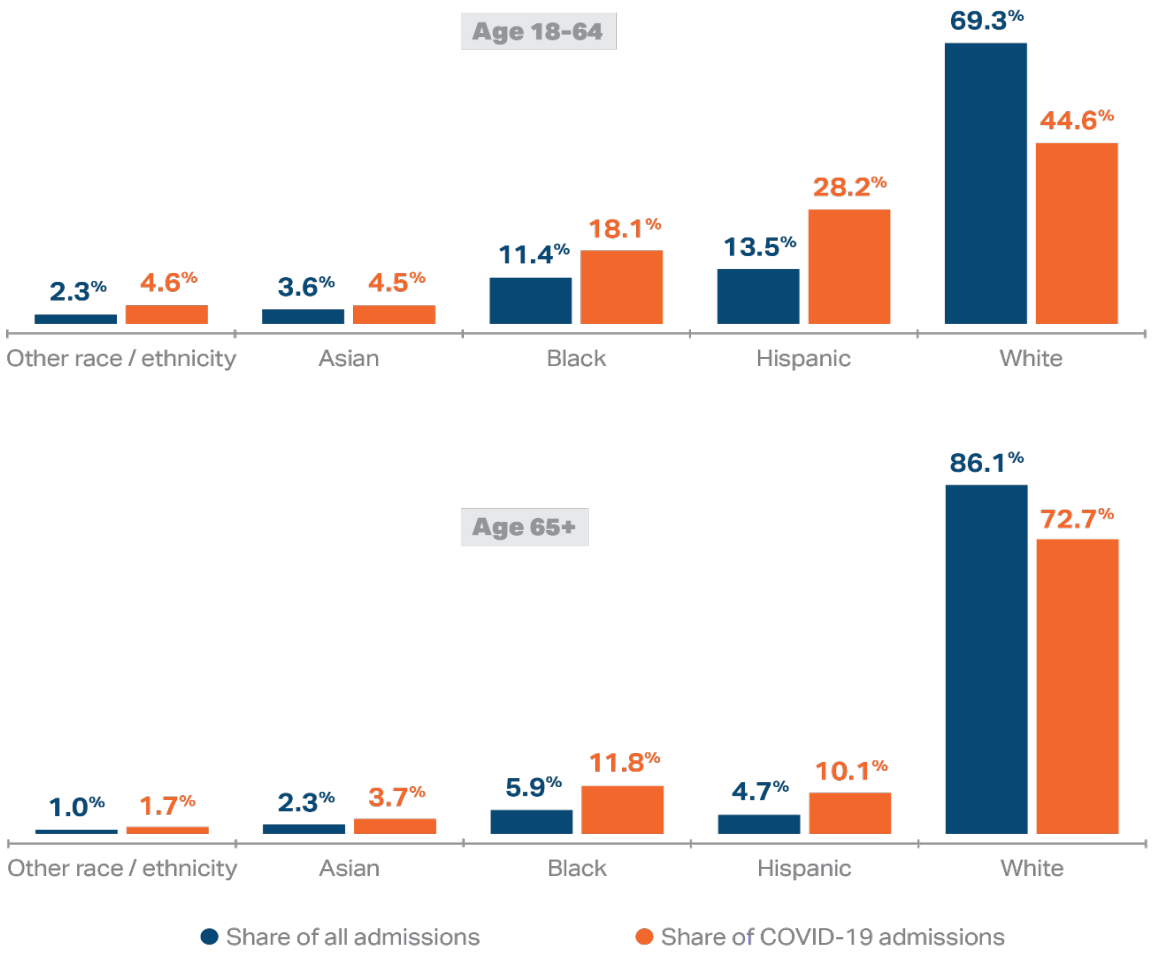
**Note:** Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

**Source:** HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

# Hispanic and Black patients represented a disproportionate share of COVID-19-related hospital admissions in 2020.

HOSPITAL | INPATIENT

*Inpatient hospital admissions by race/ethnicity, 2020*




Patients of color represented a disproportionate share of COVID-19-related hospital admissions in 2020.

COVID-19 hospital admissions were particularly disproportionate for Black and Hispanic patients. Among patients age 65+, Black patients represented double the share of COVID-19 admissions, compared to their share of all admissions. Among patients age 18-64 and 65+, Hispanic patients represented more than twice the share of COVID-19 admissions, compared to their share of all admissions. Among patients age 65+, the share of COVID-19 admissions represented by Asian American patients was 65% higher than their share of all admissions.

A recent CDC study found racial and ethnic disparities in U.S. COVID-19 hospitalizations, with the proportion highest for Hispanic patients. Driving factors cited include higher risk of exposure to the virus associated with occupational and housing conditions, as well as higher risk for severe disease.[1]

**Notes:** Hispanic category includes Hispanic ethnicity with any race. Other Race includes American Indian/Alaska Native, Native Hawaiian, other Pacific Islander, or other race. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

**Source:** HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

1. Treisman R. "Studies Confirm Racial, Ethnic Disparities In COVID-19 Hospitalizations And Visits." NPR. April 12, 2021. Available at: https://www.npr.org/sections/coronavirus-live-updates/2021/04/12/986513859/studies-confirm-racial-ethnic-disparities-in-covid-19-hospitalizations-and-visit

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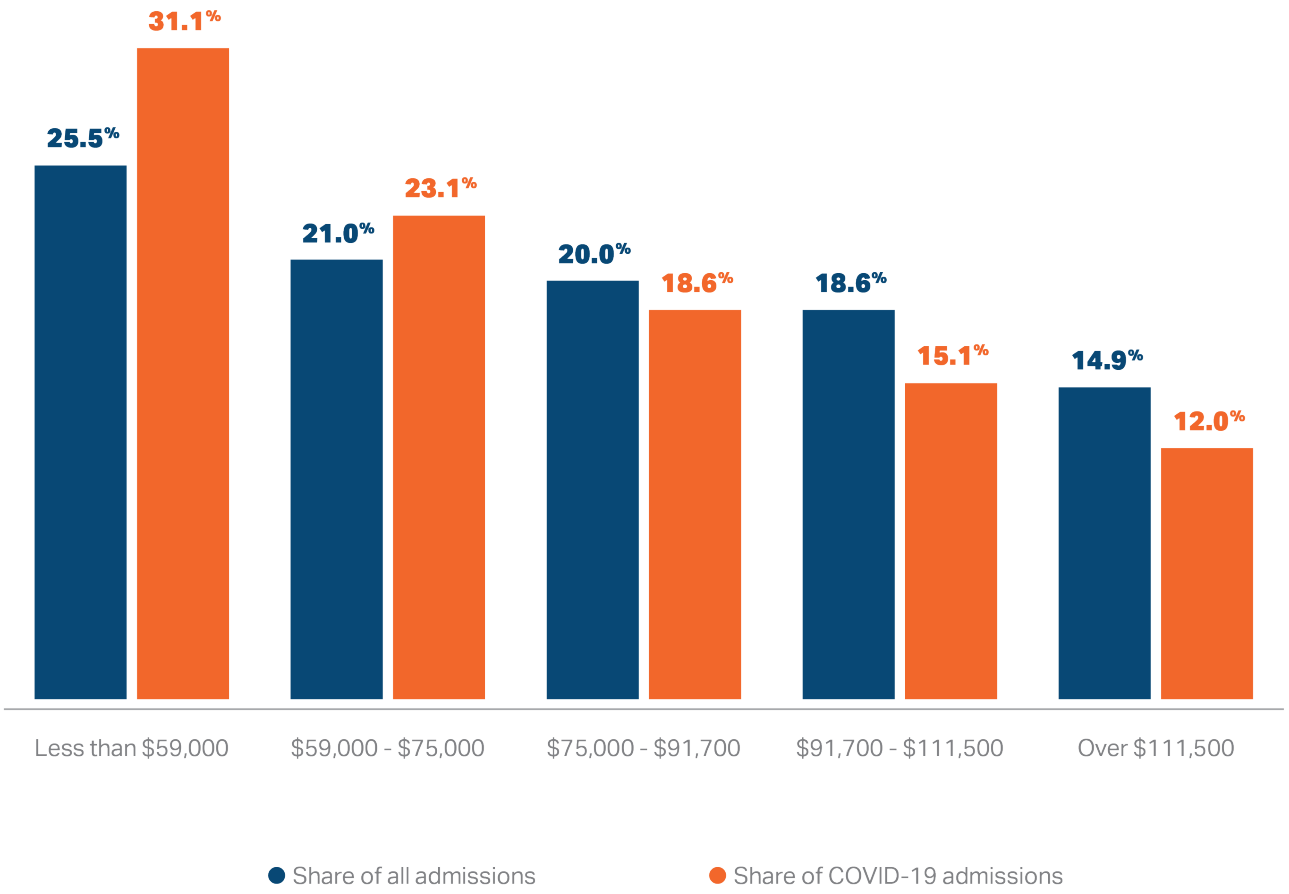
# Patients from lower income communities represented a disproportionate share of COVID-19-related hospital admissions in 2020.

HOSPITAL | INPATIENT

*Inpatient hospital admissions among patients age 18+ by median income of patient zip code, 2020*




Patients from lower income communities in Massachusetts represented a larger share of COVID-19-related inpatient hospital admissions in 2020, compared to their share of overall inpatient admissions.

The disparity was largest for patients who live in zip codes in the lowest quintile of median community income (household income less than $59,000). Patients in the lowest quintile represented 25.5% of all admissions, but 31.1% of all COVID-19-related admissions.

Patients living in the second income quintile represented 21.0% of all admissions, but 23.1% of all COVID-19-related hospital admissions. Patients living in the highest income quintile represented 14.9% of all admissions, but only 12.0% of all COVID-19-related admissions.

**Notes:** Income quintiles are based on median community income by zip code in Massachusetts. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

**Source:** HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission). U.S. Census Bureau, American Community Survey 2019 Population 5-year Estimates.

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- Analysis of Utilization and Market Impact to Date
  - Utilization
  - **MARKET IMPACT**
    - Provider Market
      - Financial Impact
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    - Insurer Market
      - Financial Impact
      - Coverage
- Topics for Future Study

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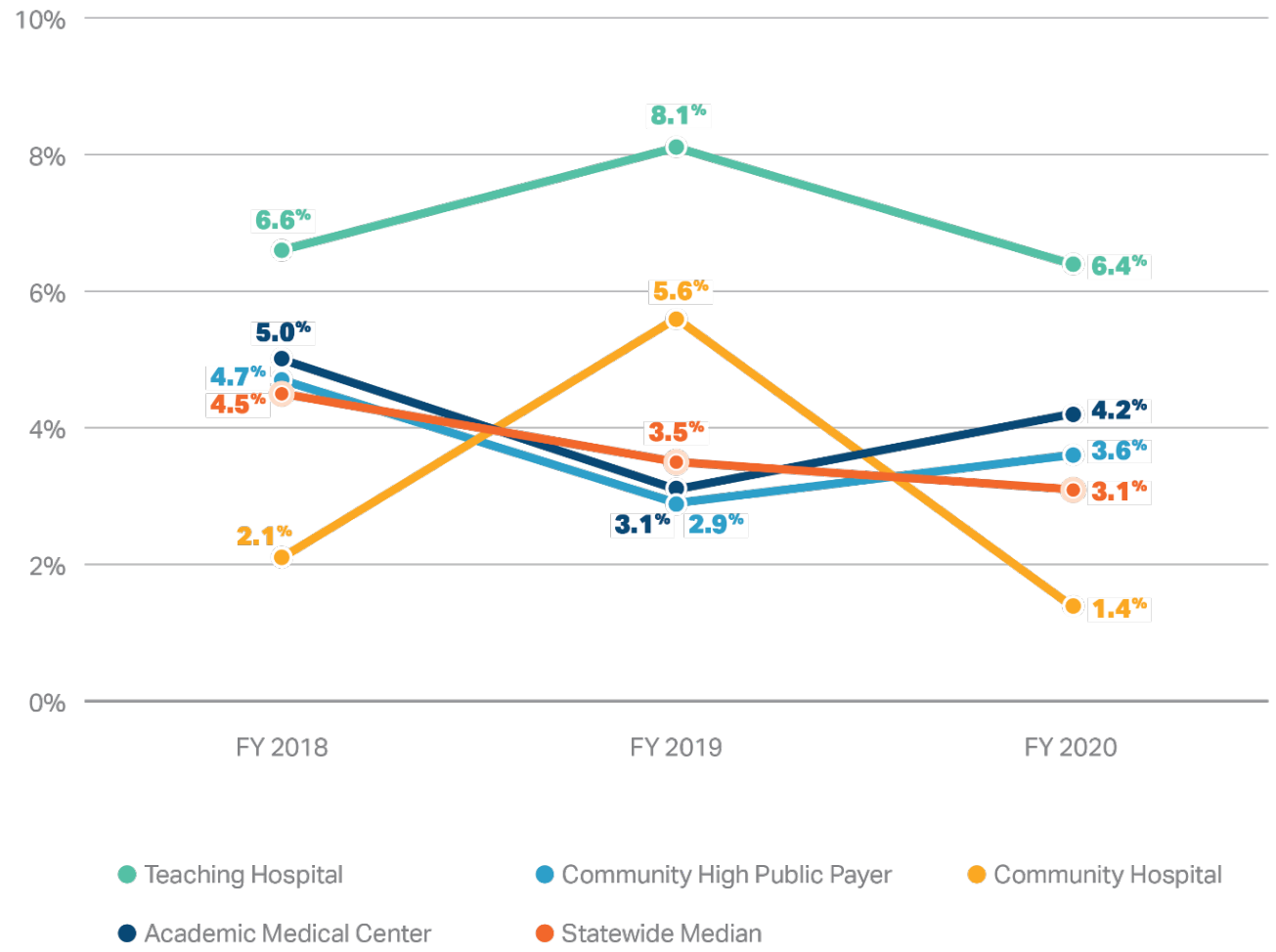
# Including federal and state COVID-19 relief funds, total margins were positive for all hospital cohorts in FY 2020; the statewide median declined from FY 2019.

PROVIDERS | FINANCIAL IMPACT

*Median total margin by hospital cohort*




The median total margin was positive for all hospitals cohorts in FY 2020. Including federal and state COVID-19 relief funds, median total margins ranged from 1.4% for community hospitals to 6.4% for teaching hospitals. Median total margins were also positive for all hospital cohorts in FY 2018 and FY 2019.

AMCs had an increase in profitability in FY 2020 compared to the last fiscal year. The median total margin for AMCs increased from 3.1% in FY 2019 to 4.2% in FY 2020. While CHPPHs also appeared to have higher margins in FY 2020 than in FY 2019, about a quarter of CHPPHs did not yet report data for FY 2020.

However, the medians and inclusion of COVID-19 relief funds mask substantial variation within cohorts: some hospitals had negative margins, while others had high profits in FY 2020. Results for individual hospitals are reported in later exhibits.

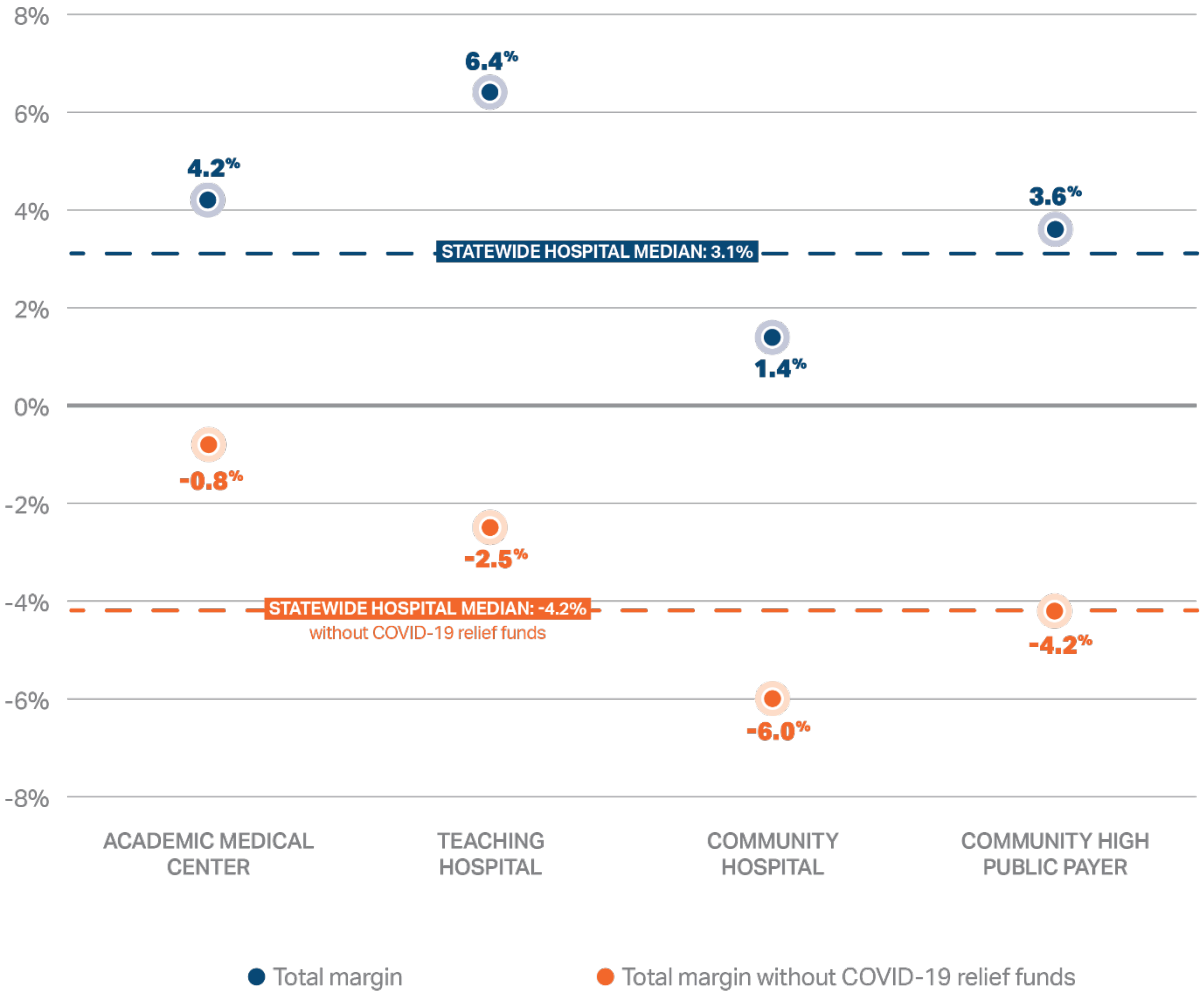
**Notes:** FY 2020 figures include 49 of 61 hospitals, accounting for hospitals with a June 30 or September 30 fiscal year end.

**Source:** Center for Health Information and Analysis. Massachusetts Acute Hospital and Health System Financial Performance: Preliminary Update on Fiscal Year 2020 Data. April 2020. Available at: https://www.chiamass.gov/hospital-financial-performance/

# Without COVID-19 relief funds, the median margins of hospital cohorts would have been negative in FY 2020.

PROVIDERS | FINANCIAL IMPACT

*Median total margin by hospital cohort for FY 2020, with and without COVID-19 relief funds*




Without federal and state COVID-19 relief funds, total margins would have been negative for all hospital cohorts in FY 2020.

The statewide median hospital margin in FY 2020 was 3.1%. Without COVID-19 relief funds, the statewide median margin would have been -4.2%.

Community hospitals and CHPPHs would have been particularly hard hit financially without the relief funds.

Teaching hospitals had the largest overall financial benefit from relief funds, increasing margins by almost 9 percentage points.

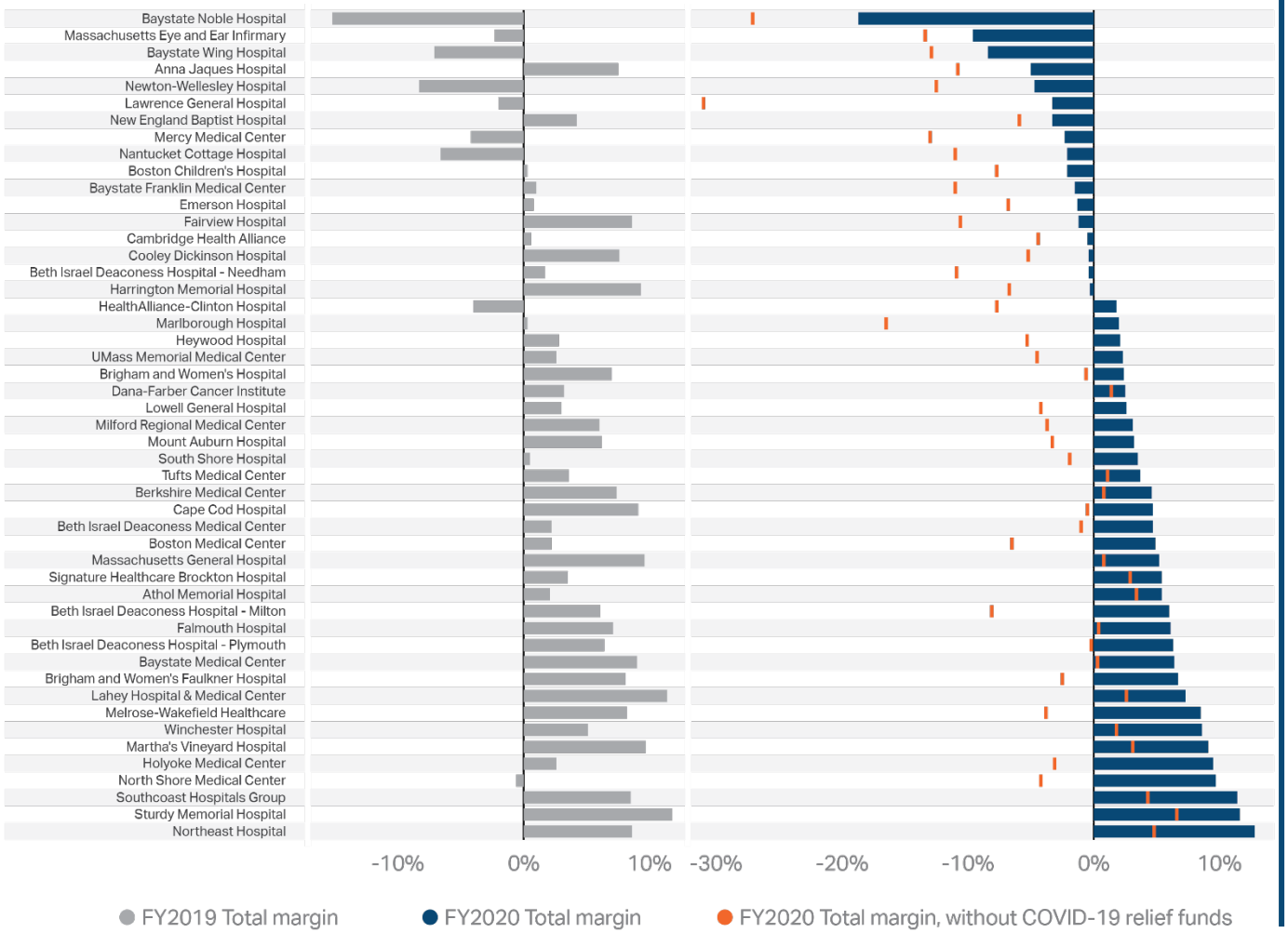
**Notes:** Figures include 49 of 61 hospitals, accounting for hospitals with a June 30 or September 30 fiscal year end.

**Source:** Center for Health Information and Analysis. Massachusetts Acute Hospital and Health System Financial Performance: Preliminary Update on Fiscal Year 2020 Data. April 2020. Available at: https://www.chiamass.gov/hospital-financial-performance/

# Some hospitals had negative margins in FY 2020, but COVID-19 relief funds prevented greater losses.

PROVIDERS | FINANCIAL IMPACT

*Total margin by hospital, FY 2019 and FY 2020*




Some hospitals had negative margins in FY 2020, but COVID-19 relief funds prevented greater losses.

Fewer hospitals were profitable in FY 2020, compared to FY 2019. Of 49 hospitals reporting, 9 hospitals were not profitable in FY 2019 (18%). In FY 2020, 17 hospitals were not profitable (35%). Of the hospitals that were not profitable in FY 2020, 7 were CHPPHs (about one-third of CHPPHs), 6 were community hospitals (half of community hospitals), 3 were specialty hospitals (3 of 4 specialty hospitals), and 1 was a teaching hospital (20% of teaching hospitals).

Particularly for hospitals that typically have low or negative margins, uncertainty about future relief funds and other revenue sources may be a particular concern.

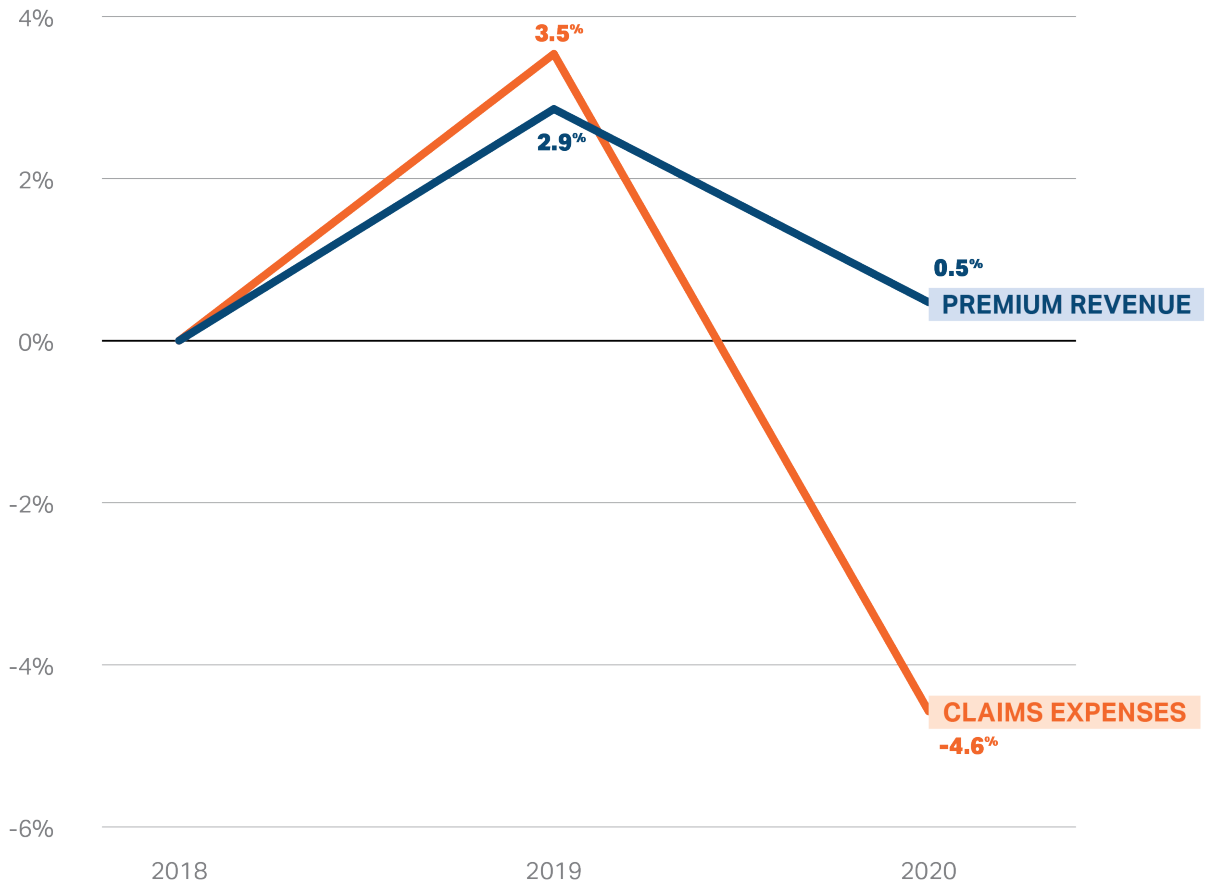
**Notes:** Figures include 49 of 61 hospitals, accounting for hospitals with a June 30 or September 30 fiscal year end.

**Source:** Center for Health Information and Analysis. Massachusetts Acute Hospital and Health System Financial Performance: Preliminary Update on Fiscal Year 2020 Data. April 2020. Available at: https://www.chiamass.gov/hospital-financial-performance/

# For large Massachusetts commercial insurers in 2020, premium revenue grew slightly while claims expenses dropped sharply.

INSURERS | FINANCIAL IMPACT

*Percent change in premium revenue and claims expenses for BCBSMA, HPHC, and THP, 2018-2020*




Notes: The three largest insurers in Massachusetts include Blue Cross Blue Shield of MA (BCBSMA and Blue Cross Blue Shield HMO Blue), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (Tufts HMO) (THP). Other Massachusetts plans include AllWays, Health New England, and Fallon Community Health Plan. Data for UniCare(Anthem) was unavailable for analysis. Premium income is net of adjustments reported.

Source: HPC analysis of insurer financial reports, submitted to the Massachusetts Division of Insurance for Q4 2019 and Q4 2020. Data for 2018 sourced from Q4 2019 reports; data for 2019 and 2020 sourced from Q4 2020 reports.

For the three largest Massachusetts-based commercial insurers (Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan), premium revenue grew 0.5% from 2019 to 2020, while claims expenses dropped 4.6%.

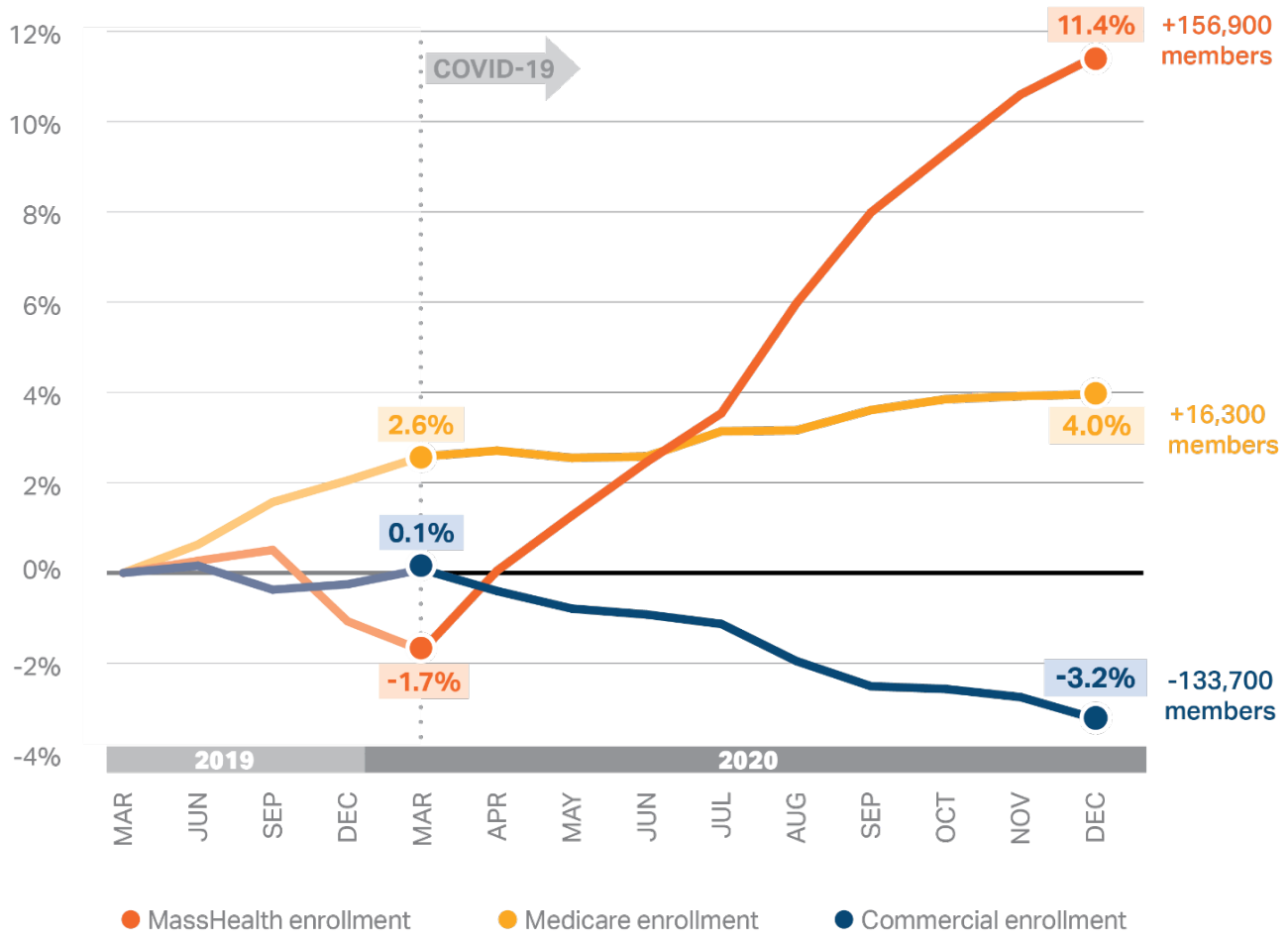
For smaller Massachusetts-based commercial insurers, there was a similar divergence in 2020, with premium revenue growing at 5.5%, while claims expenses did not change. Across all commercial Massachusetts-based insurers with available data, premium revenue increased by 1.5% ($15.8 to $16.1 billion) from 2019 to 2020, while medical claims expenditures decreased by 3.6% ($14.1 to $13.6 billion).

Profitability did not necessarily increase in proportion to these changes, however, as these figures do not include administrative expenses or potential rebates and premium credits.

# Insurance coverage continues to shift from commercial to MassHealth, in response to economic instability and federal coverage policies.

INSURERS | COVERAGE

*Massachusetts health insurance enrollment by primary source of coverage, relative to March 2019*




Since the start of the pandemic, insurance coverage has steadily shifted from commercial to MassHealth, reflecting broader economic trends.

MassHealth enrollment has climbed continuously, with an increase of 13.1% between March 2020 and December 2020. MassHealth has had a net enrollment increase of 11.4% since March 2019. In contrast, commercial enrollment decreased 3.3% since March 2020. This shift represents a decrease of about 133,700 commercial members and an increase of about 156,900 MassHealth members since March 2020.

Medicare enrollment has continued to increase moderately over time, with an increase of about 16,300 members since March 2020, in line with expected trends due to the aging of the population.

Federal Medicaid maintenance of effort requirements outlined in COVID-19 relief legislation likely resulted in many individuals staying in MassHealth even after reporting changes that would normally shift them to the Health Connector or other commercial coverage.

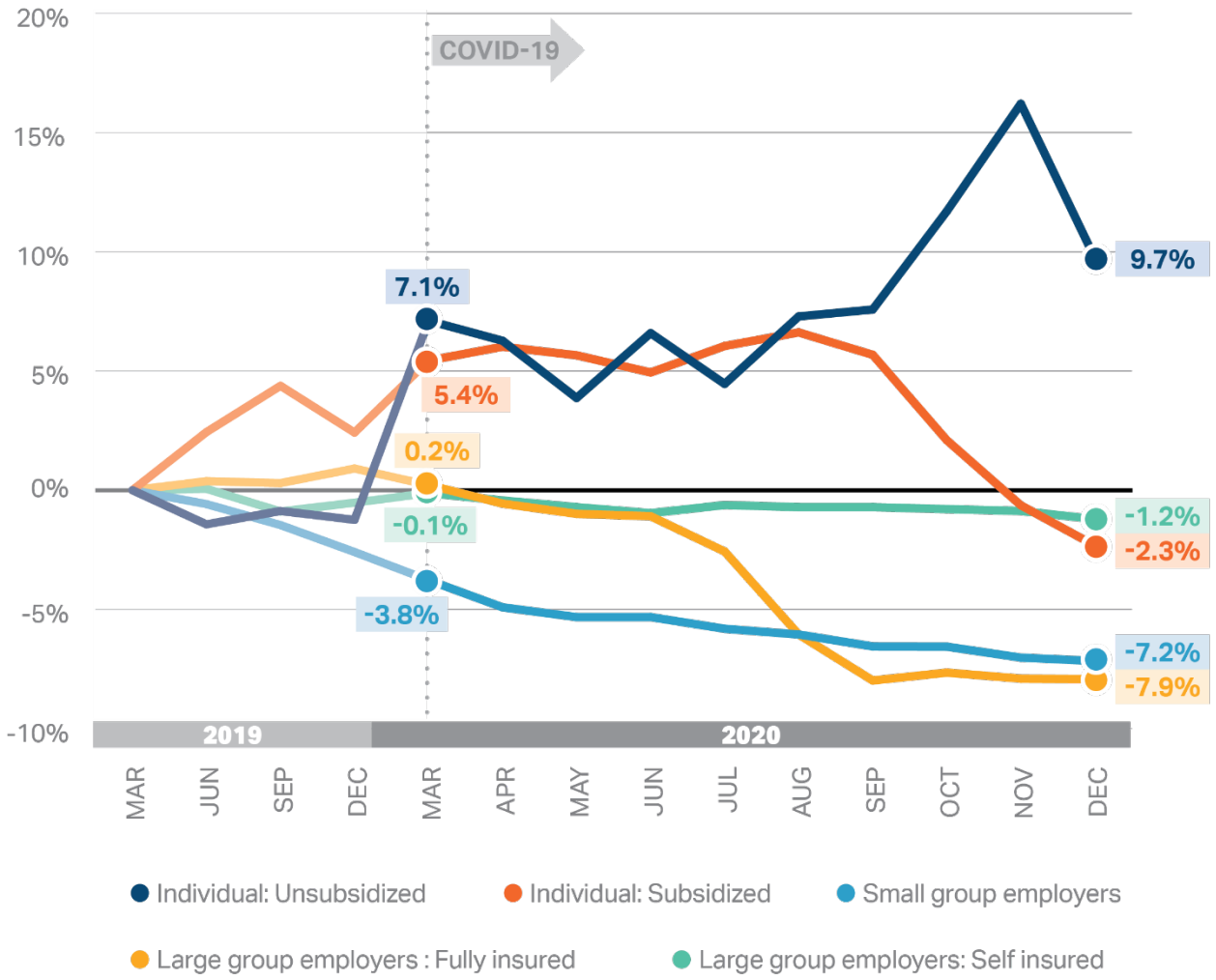
HPC

**Source:** HPC analysis of Center for Health Information and Analysis data "Massachusetts Health Insurance Enrollment, March 2019 through December 2020." MassHealth includes those with primary coverage through MassHealth.

# For the largest employers, health insurance enrollment remained stable in 2020, while enrollment shifted from smaller employers to the individual market.

INSURERS COVERAGE

*Massachusetts private health insurance enrollment by market segment, relative to March 2019*




Insurance coverage in the self-insured large group market (which includes most of the largest employers) declined only 1% since the start of the pandemic, a decline of 25,200 members.

In contrast, coverage through small employers declined 3.4%, and coverage through the fully-insured large group market (which tend to be medium-sized employers) declined 8.1% in 2020, a decrease of 14,300 and 79,600 members, respectively.

Unsubsidized coverage through the individual market, which was stable in 2019, increased sharply at the start of the pandemic and continued to increase throughout 2020. Trends in the subsidized individual market remained relatively stable in 2020 until declining in the fall.

HPC

**Source:** HPC analysis of Center for Health Information and Analysis data "Massachusetts Health Insurance Enrollment, March 2019 through December 2020."

MASSACHUSETTS
HEALTH POLICY COMMISSION

## AGENDA

- Welcome
- Executive Director's Report
- Impact of COVID-19 on the Massachusetts Health Care System: Interim Report
- **Discussion and Feedback**
- Next Meeting: Wednesday, September 29

# Topics for Discussion: COVID-19 and the Health Care Workforce

**How did the pandemic affect the health care workforce and the role of health care workers in meeting the needs of Massachusetts patients and communities?**

- Differential impact on workers in different sectors – ambulatory care, acute care, post-acute, long-term care and home care
- Lessons learned regarding planning for supplies and equipment
- Lessons learned regarding coordination among providers
- Lessons learned regarding serving patients and communities across the Commonwealth

**How should the health care system and the health care workforce transform to best meet patient needs now and in the future?**

- Different needs across provider segments (i.e,. outpatient, inpatient, post-acute, long-term care, home care)
- Composition health care workforce/training, including non-clinical providers, across health care settings
- Training needs and competencies (i.e., skills, technologies, language, culture, pandemic preparedness, etc.)
- Coordination and cooperation along the continuum
- Other?

MASSACHUSETTS
HEALTH POLICY COMMISSION

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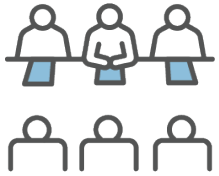
# Upcoming 2021 Meetings and Contact Information

**BOARD MEETINGS**

May 19
July 14
September 15
November 17



**COMMITTEE MEETINGS**

June 2
October 6
December 15

**SPECIAL EVENTS**

**ADVISORY COUNCIL**
September 29
December 8

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