MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Advisory Council

October 6, 2022

Agenda

CALL TO ORDER

Executive Director's Report

2022 Health Care Cost Trends Report and Policy Recommendations

Schedule of Upcoming Meetings

Advisory Council Membership

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, Chief Executive Officer, Mystic Valley Elder Services

Jon Hurst, President, Retailers Association of Massachusetts

Colin Killick, Executive Director, Disability Policy Consortium

Amanda Cassel Kraft, Acting Assistant Secretary for MassHealth

Jake Krilovich, Executive Director, Home Care Alliance of Massachusetts

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, Mass General Brigham

Dr. Claire-Cecile Pierre, Associate Chief Medical Officer and Vice President of Community Health at the Brigham and Women's Hospital

Julie Pinkham, Executive Director, Massachusetts Nurses Association

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

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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EXECUTIVE DIRECTOR'S REPORT

2022 Health Care Cost Trends Report and Policy Recommendations

Schedule of Upcoming Meetings

Mass General Brigham: Performance Improvement Plan

- The HPC approved MGB's PIP proposal on September 27, 2022.
- MGB estimates that its proposal will save $127.8M annually, including $90M in savings via commercial pricing actions.
- MGB will implement the PIP from approximately October 1, 2022 – March 31, 2024.
- MGB is required to report periodically to the HPC throughout the implementation period, and for a reasonable period of time thereafter, to allow the HPC to evaluate MGB's progress toward its stated goals.
- MGB may propose amendments to the PIP during implementation.
- At the conclusion of the PIP, the HPC must determine whether the PIP was successful using a variety of regulatory factors (958 CMR 10.13(3)).
- If the Board determines the PIP was not successful, it may:
  - Extend the implementation timetable and request amendments;
  - Require MGB to submit a new PIP; or
  - Waive or delay the requirement to file any additional PIP.

MGB PIP as Approved		
Category	**Strategies**	**Savings Estimate (M)**
Price Reductions	Outpatient AMC Rates	$59.8
	MG West	$15.3
	ConnectorCare	$11.9
	Other Insurance Product	$3
Reducing Utilization Utilization Management	Integrated Care Management Program	$15.3
	Utilization Management	$17.1
Shifting Care to Lower Cost Sites	Hospital at Home	$1.3
	Virtual Care	$4.1
Accountability Through Value-Based Care	MGB health plan product innovations (Commercial, Medicare and MassHealth)	Not quantified
	Total	**$127.8**

Outside Sections in the FY 2023 state budget direct new work to the HPC.

- ***Behavioral Health-Related Boarding.*** Directs the HPC to conduct an analysis and issue a report on the ongoing effects of the COVID-19 pandemic on behavioral health-related boarding in acute care hospital settings, including but not limited to emergency departments, medical surgical units or observation units in Massachusetts.
- ***Behavioral Health Access Line.*** Directs the HPC, in consultation with EOHHS and CHIA, to conduct an analysis and report on the use of the behavioral health access line and behavioral health crisis intervention services, including an evaluation and recommendations for developing an equitable and sustainable funding mechanisms.
- ***EOHHS Opioid Overdose Data Analysis.*** Directs EOHHS, in consultation with DPH, to examine and report on trends in prescribing and treatment history of individuals in Massachusetts who suffered a fatal overdose from 2019-2021, and to report annually thereafter. The amendment directs other state agencies, including CHIA and OPP, to provide any data necessary for DPH to conduct this work.
- ***UMass/Mt. Ida Workforce Center.*** Directs UMass Amherst, in consultation with EOHHS, to study the feasibility of establishing a School of Health Sciences and Education and Center for Health Care Workforce Innovation at the Mount Ida campus in Newton. UMass and EOHHS are directed to consult with a number of state agencies and stakeholders to conduct this study, including the HPC.
- ***Special Commission on Oral Health.*** Establishes a special commission on oral health charged with studying oral disease in the Commonwealth, identifying gaps in care and developing a strategic plan to address barriers and improve access to care. The Executive Director of the HPC or a designee is a member of this new commission.

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.

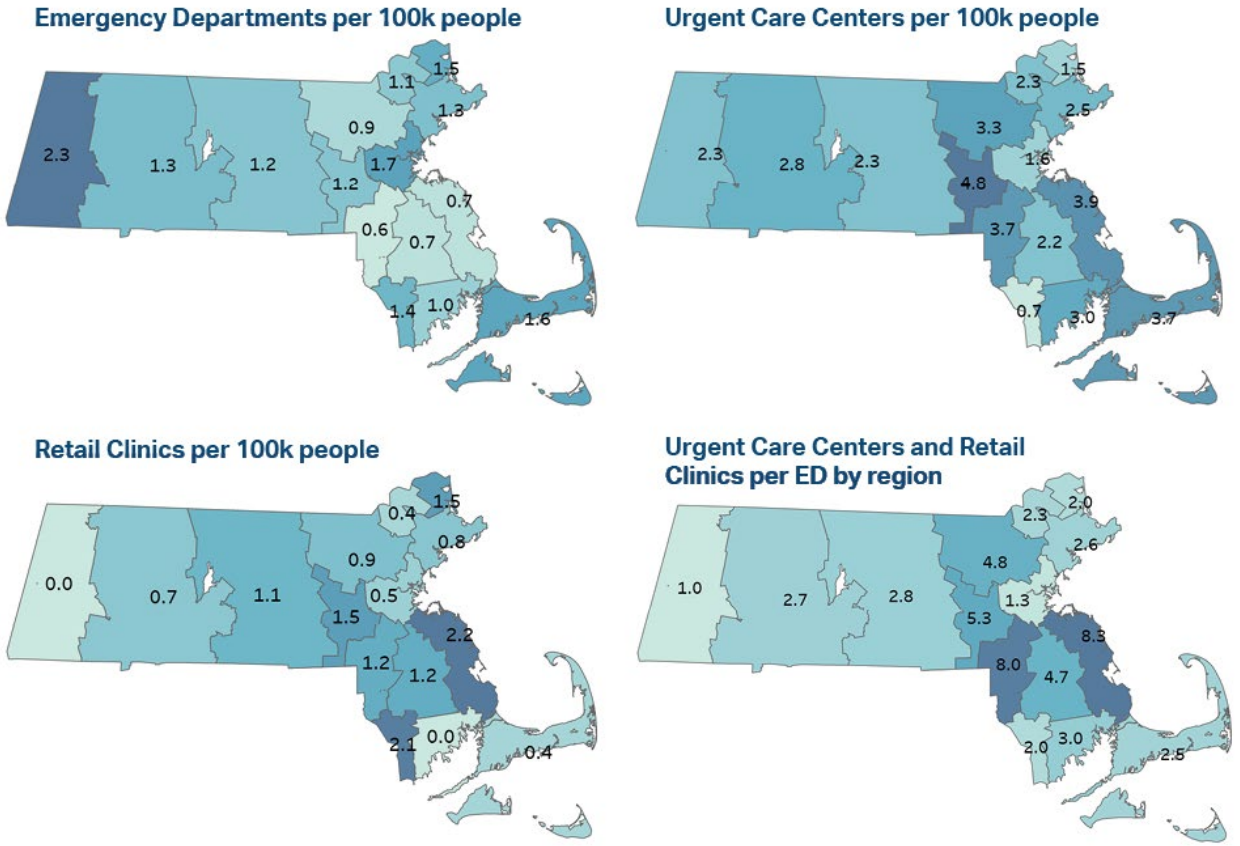
- ***Public Hearing and Cost Trends Report Additions.*** Directs the HPC to include behavioral health expenditures in the annual cost trends report and cost trends hearing.
- ***Standard Release Form.*** Directs the HPC to create a standard release form and regulation for securely exchanging confidential 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.

DataPoints Issue #23: Update on Trends in Urgent Care Centers and Retail Clinics

HPC DataPoints

TIMELY DATA AND INFORMATION FROM THE RESEARCH TEAM

- In September, the HPC released a two-part DataPoints issue on trends in urgent care centers and retail clinics.
- Part one examines the recent landscape of these alternative care sites, including trends in the number of sites; location by region and community income; and services, hours, and electronic health record systems used.
- The second installment focuses on shifts in site of care delivery in recent years and on out-of-pocket and overall spending by site of care, comparing urgent care centers, retail clinics, physician offices, hospital outpatient departments (HOPDs), and emergency departments (EDs).
- Both parts of the DataPoints issue are available on the HPC's website here.



Upcoming HPC Research Publications

- **Utilization of Telehealth in the Commonwealth.** This report will highlight telehealth utilization trends (such as by type of service, provider organization, and patient demographics), assess impact on patient access and total health care spending, and provide policy recommendations on several topics, including reimbursement levels.
  - Legislative directive through Chapter 260 of the Acts of 2020, *An Act Promoting A Resilient Health Care System That Puts Patients First*

- **Impact of COVID-19 on the Health Care Workforce.** The HPC's legislatively mandated report on the state of the healthcare workforce in the Commonwealth will focus on trends in worker supply, wages and education, and will highlight innovative approaches to augment recruitment and retention and alleviate critical provider shortages.
  - Legislative directive through Chapter 102 of the Acts of 2021, *An Act Relative to Immediate COVID-19 Recovery Needs*

- **Behavioral Health-Related Emergency Department (ED) Boarding in Massachusetts.** This analysis will expand on the HPC's prior research on ED boarding across the Commonwealth and will collaborate with the Departments of Public Health, Mental Health, and Developmental Services. This report will include more timely data on ED boarding, availability of pediatric inpatient and community-based treatment beds, and an examination of the pediatric behavioral health workforce.
  - Legislative directive through Chapter 126 of the Acts of 2022, *Fiscal Year 2023 General Appropriations Act*

Upcoming HPC Research Publications

- **Use and Spending for Emergency Ambulance Services in Massachusetts.** This research provides a first look at commercial ambulance use and payments in Massachusetts focusing on comparisons with other states and payment variation within Massachusetts by payer, region, and ownership type.

- **The Role of Health System Factors in Health Disparities.** This legislatively-mandated report will describe health disparities in Massachusetts and evaluate the role that certain health care system factors, including provider supply and financing policies, have in addressing or exacerbating inequitable health outcomes.
  - Legislative directive through Chapter 260 of the Acts of 2020, *An Act Promoting A Resilient Health Care System That Puts Patients First*

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
*PRIORITY REGISTRATION FOR ADVISORY COUNCIL MEMBERS

Agenda

Call to Order

Executive Director's Report

2022 HEALTH CARE COST TRENDS REPORT AND POLICY RECOMMENDATIONS

Schedule of Upcoming Meetings

Table of Contents: 2022 Health Care Cost Trends Report and Policy Recommendations

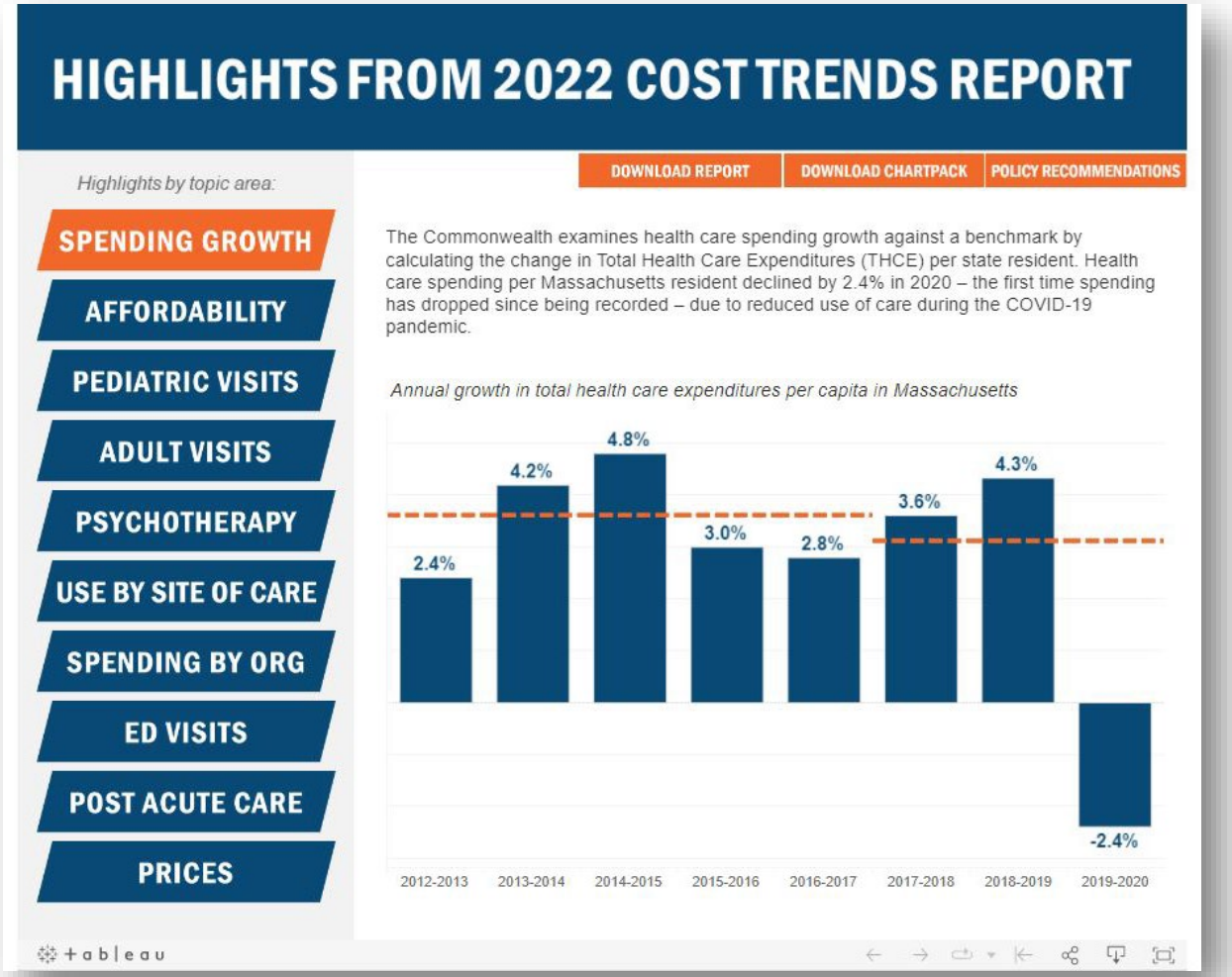
2022 REPORT AND POLICY RECOMMENDATIONS

2022 CHARTPACK

2022 Health Care Cost Trends Report and Policy Recommendations: Online Interactive Report

- For the second year, the HPC is concurrently releasing an **online, interactive version of the Health Care Cost Trends Report and Policy Recommendations.** The interactive portal allows for greater public engagement with the rich data findings included in this year's report.

- This year, the interactive version of the report is also available in a layout adapted specifically for mobile device use.

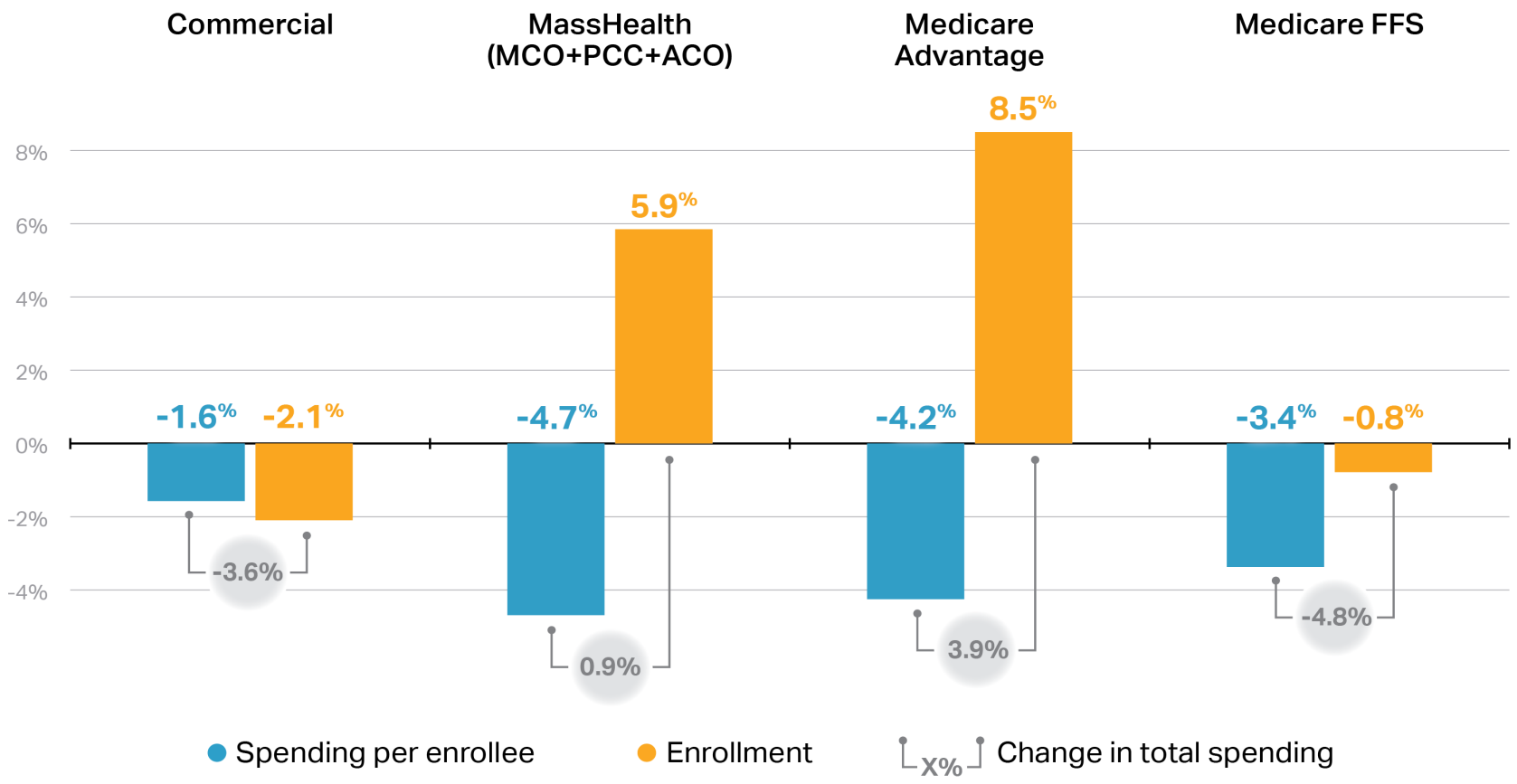


Key Findings: Massachusetts Spending Trends

- While total spending declined in 2020, large reductions in use of care were offset by commercial price increases.
- One category of care that had increased utilization in 2020 was psychotherapy visits, more than 85% of which were delivered by telehealth.
- Massachusetts commercial spending growth is no longer below the U.S. rate.
- Price increases were largest in hospitals and for prescription drugs.
- Hospital outpatient spending varied more than two-fold across hospitals and price variation increased from 2018-2020.

Spending per enrollee declined for all sectors in 2020. The decline was the smallest for those with commercial coverage.

Change in enrollment and per-enrollee spending by major market segment, 2019-2020



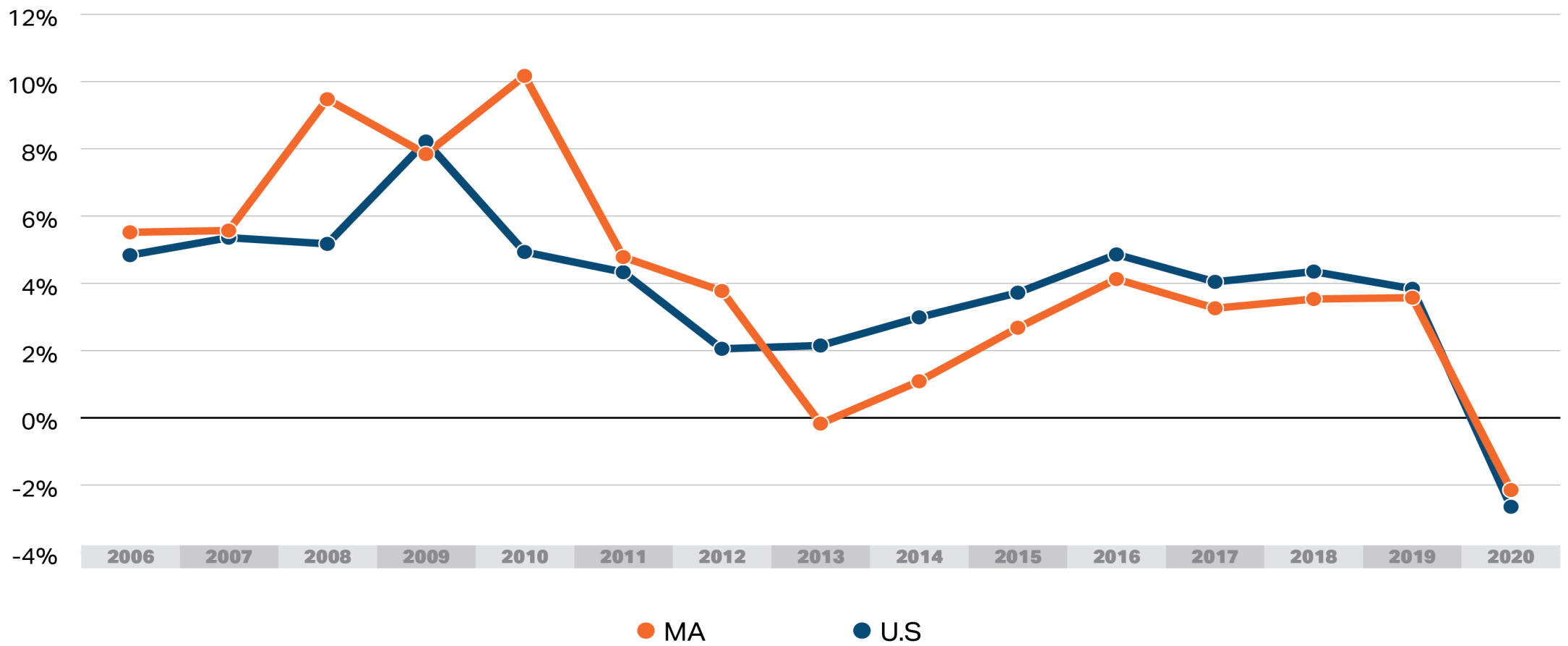
Notes: Commercial spending includes insurer administrative spending. Commercial spending and enrollment growth include enrollees with full and partial claims. MassHealth includes only full coverage enrollees in the Primary Care Clinician (PCC), Accountable Care Organization (ACO-A, ACO-B), and Managed Care Organization (MCO) programs. Figures are not adjusted for changes in health status.
Sources: HPC analysis of Center for Health Information and Analysis Annual Report, March 2022.

Share of Massachusetts Medicare beneficiaries in Medicare Advantage plans:

- **2015: 18.6%**
- **2020: 24.1%**

Massachusetts commercial spending grew slightly faster than the rest of the U.S. in 2020.

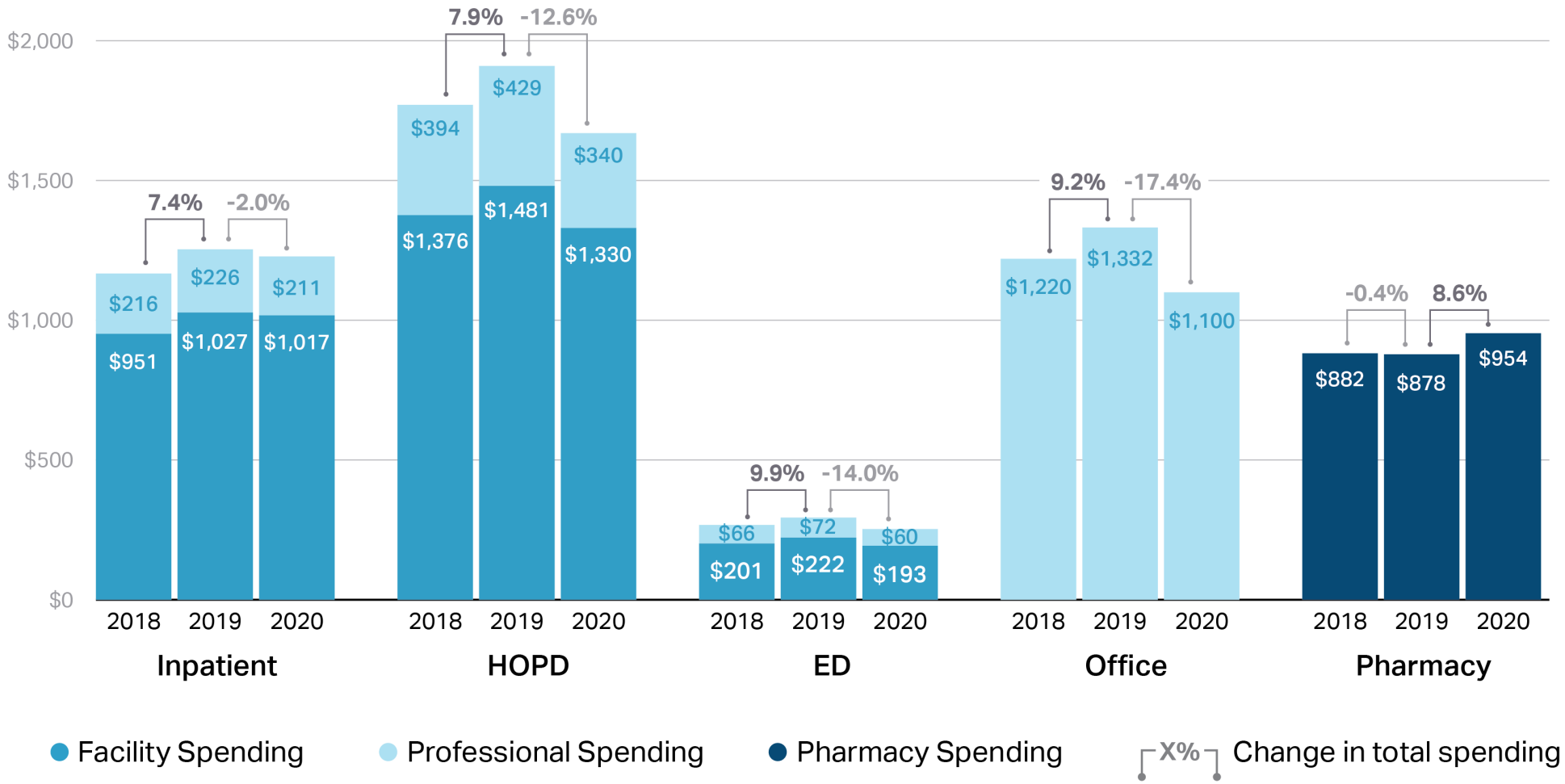
Annual growth in per capita commercial health care spending, Massachusetts and the U.S., 2006-2020



Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2019 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2020

Commercial spending in Massachusetts declined the most in provider offices, EDs and the professional component of HOPD spending, while prescription drug spending increased 8.6%.

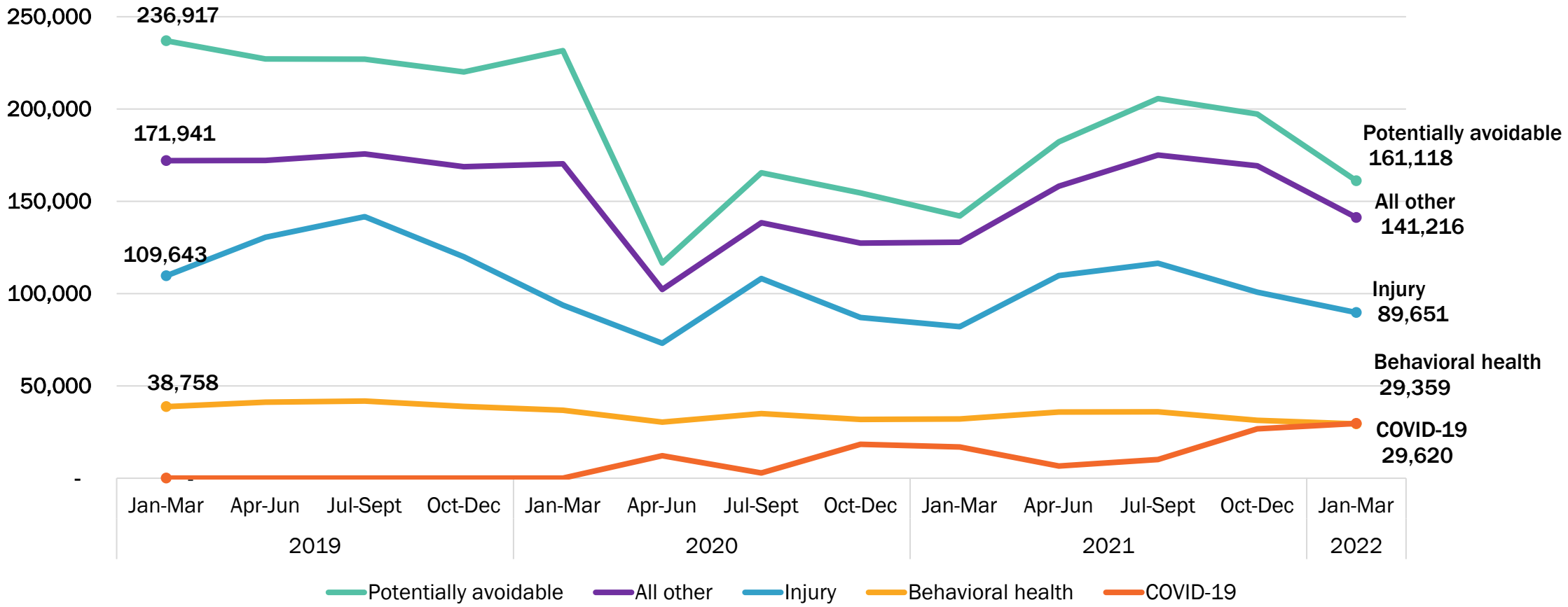
Commercial spending per member per year by category, 2018-2020



Notes: Medical spending reflect data from five payers: BCBS, HPHC, Tufts, Allways, and Anthem. Pharmacy spending is net of rebates and reflects data from four payers: BCBS, HPHC, Tufts, and Allways.
Source: HPC analysis of the All-Payer Claims Database, 2018-2020, V 10.0.

Potentially avoidable ED visits declined the most (32%) from 2019 to 2022.

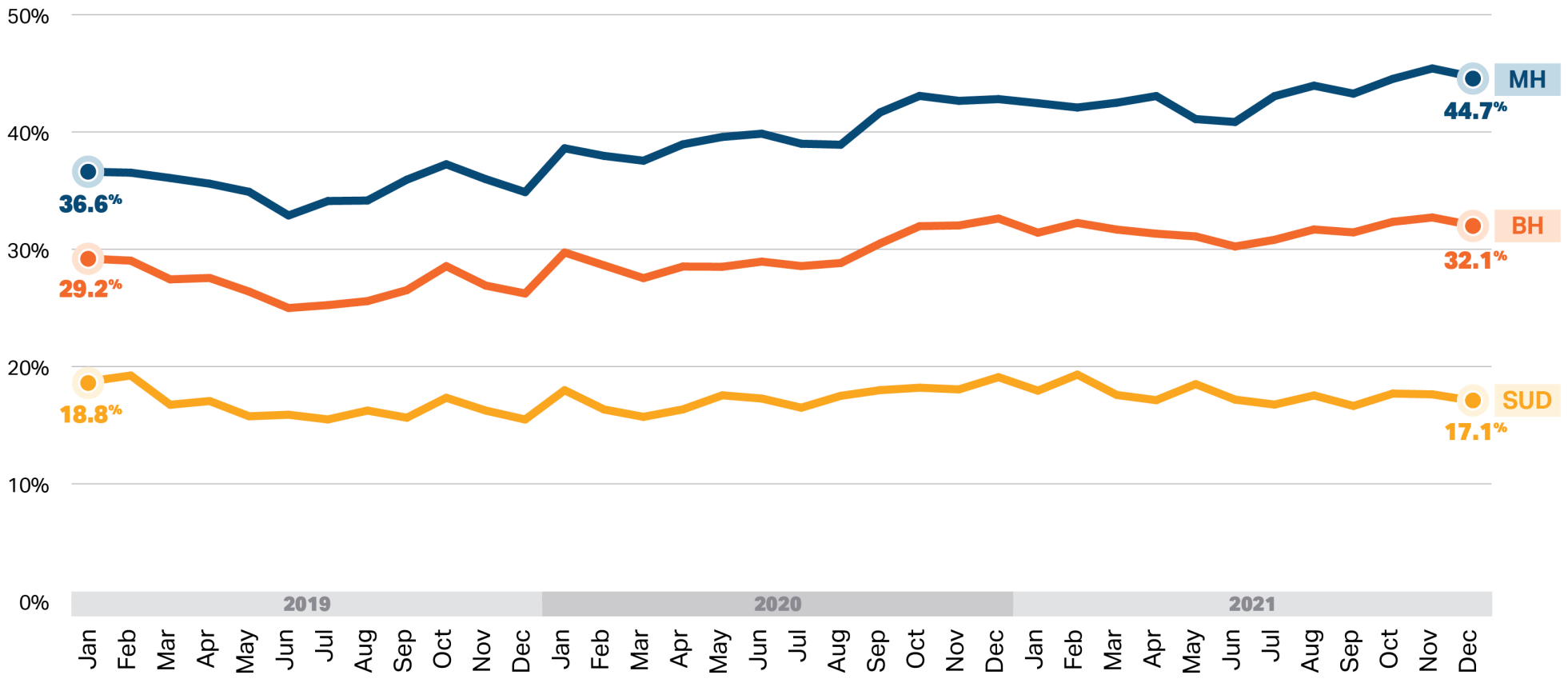
Emergency department visits by visit category and quarter, January 2019 to March 2022



Notes: Behavioral health (BH) visits were defined using AHRQ CCSR MBD001-MBD034. Injury and potentially avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Potentially avoidable" is defined as primary care treatable or non-emergent. All other are the total sum of ED visits minus potentially avoidable, BH, COVID-19, and injury visits. The following emergency departments were excluded for the entire study period due to missing data for one or more quarters: MetroWest Medical Center – Framingham Campus, Saint Vincent Hospital, Sturdy Memorial Hospital, and Beth Israel Deaconess Medical Center – Needham. In calendar year 2019, these emergency departments accounted for 6% of all emergency department visits.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Emergency Department Database, FY2018 to FY2022, preliminary FY2021 and FY2022

ED boarding rates increased in 2020 and 2021, driven by longer boarding for mental health-related stays.

Percent of behavioral health, mental health, substance use ED visits that boarded, 2019-2021

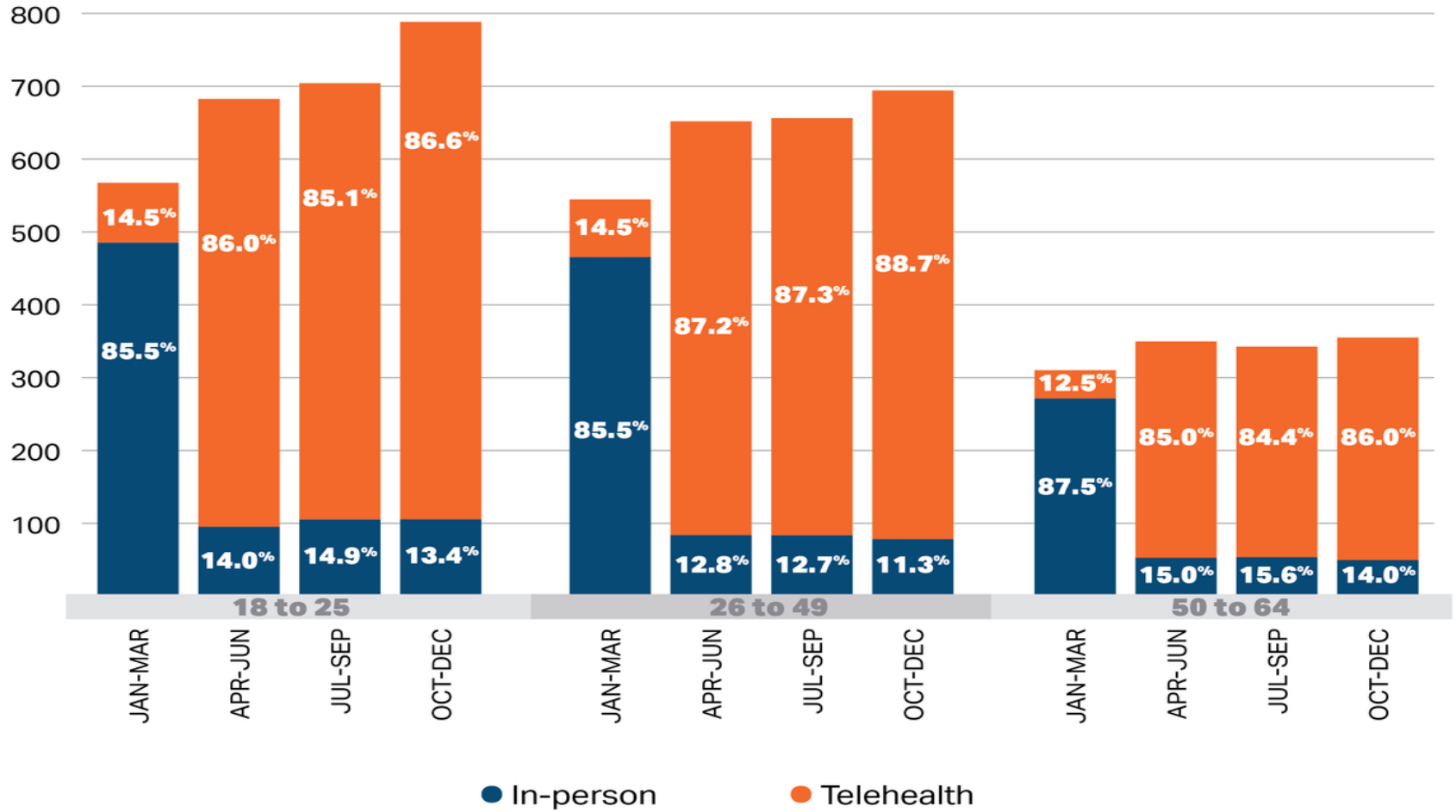


Notes: Excludes two ED sites due to missing data. Excludes an additional eight ED sites due to incomplete or irregular length of stay data. The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. ED visits where patients were admitted to the same hospital were excluded from 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).

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, CY2018 – 2021, preliminary data for Oct-Dec 2021

Mental health visits increased in 2020 unlike most service categories, especially for young adults, with the vast majority delivered via telehealth.

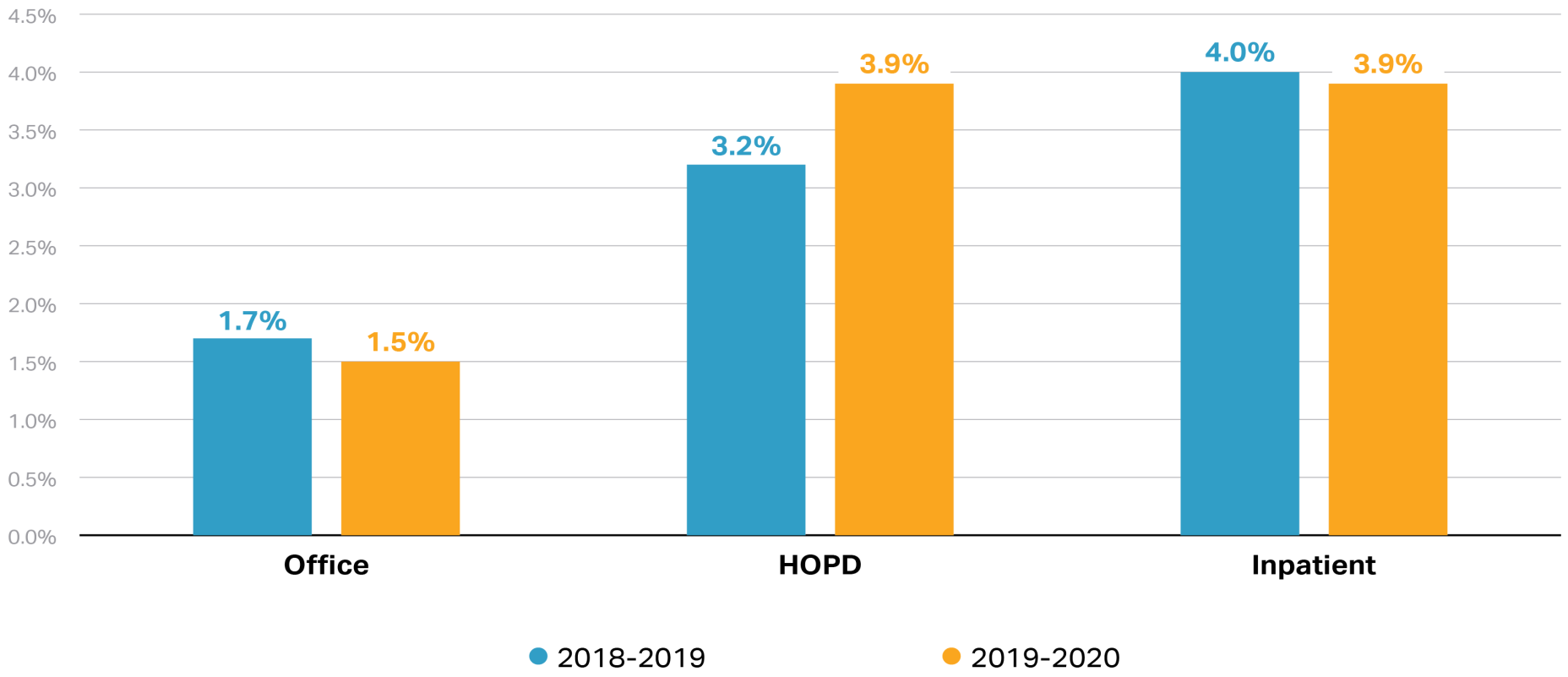
Total psychotherapy visits per 1,000 members by age group and quarter, 2020



Notes: Includes individuals ages 18-64 with 12 months of enrollment in 2020. Therapy claims identified using Current Procedural Terminology (CPT) codes 90832, 90833, 90834, 90836, 90837 and 90838. Telehealth claims identified using professional claims site of service 02, CPT code modifiers GT, 95, GQ, and G0.
Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, 2020, V 10.0

Commercial spending per encounter (prices) increased nearly 4% in both hospital inpatient and outpatient settings in 2020.

Increase in spending per encounter by setting, 2018-2019 and 2019-2020

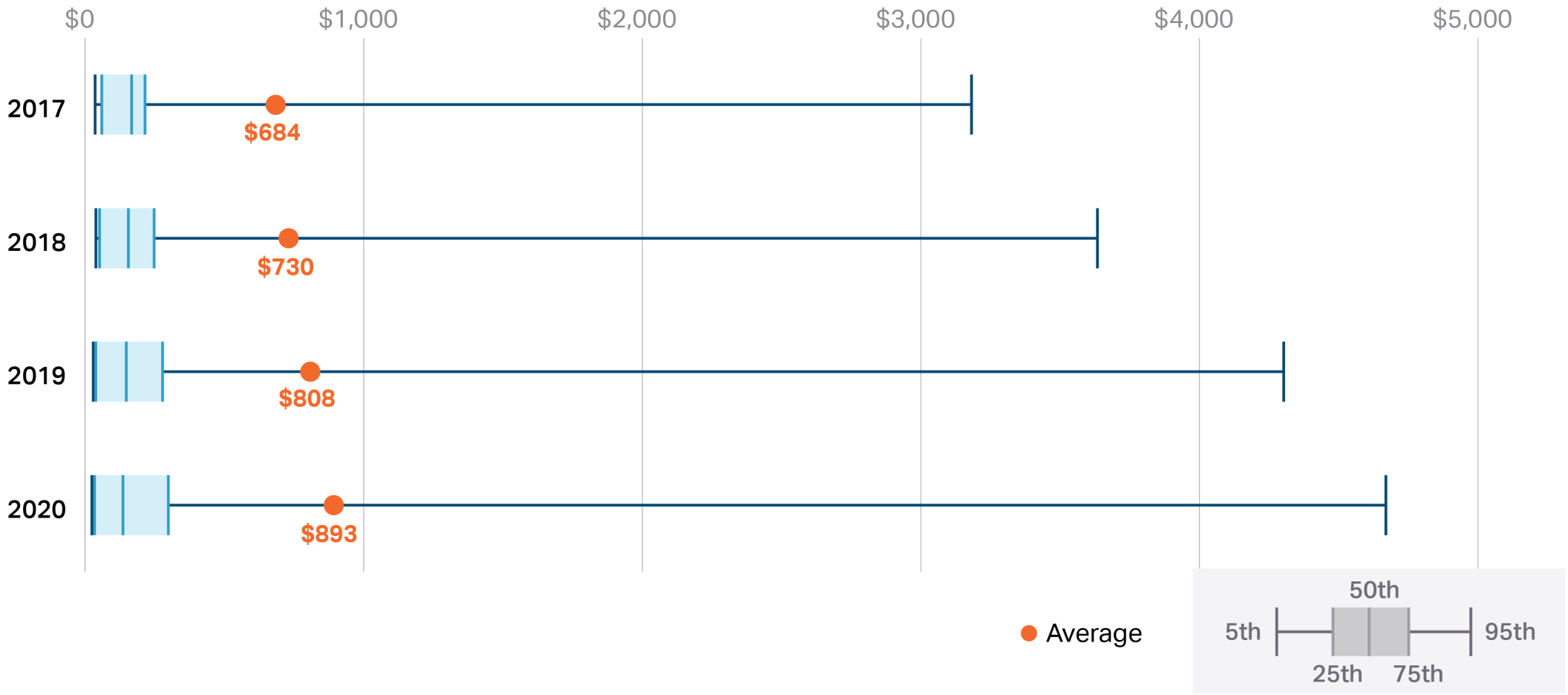


Notes: Price growth includes both facility and professional spending. Price growth is computed at the level of a procedure code encounter. Procedure code encounters are defined as the same person, same date of service, same procedure code to capture the potential for both facility and professional claims billed on the same day for the same service based on the setting. The inpatient stay "growth" is more accurately considered payment, rather than price growth. Payment growth for inpatient stays include all services provided during the hospital stay. Only procedure codes that were billed in both 2018 and 2020 were included. Procedures codes with < 20 services or < $1,000 in aggregate spending in 2018 and 2020 were excluded.

Sources: HPC analysis of the All-Payer Claims Database, 2018-2020, V 10.0.

Average gross spending per branded prescription increased 11% in 2020, faster than in prior years.

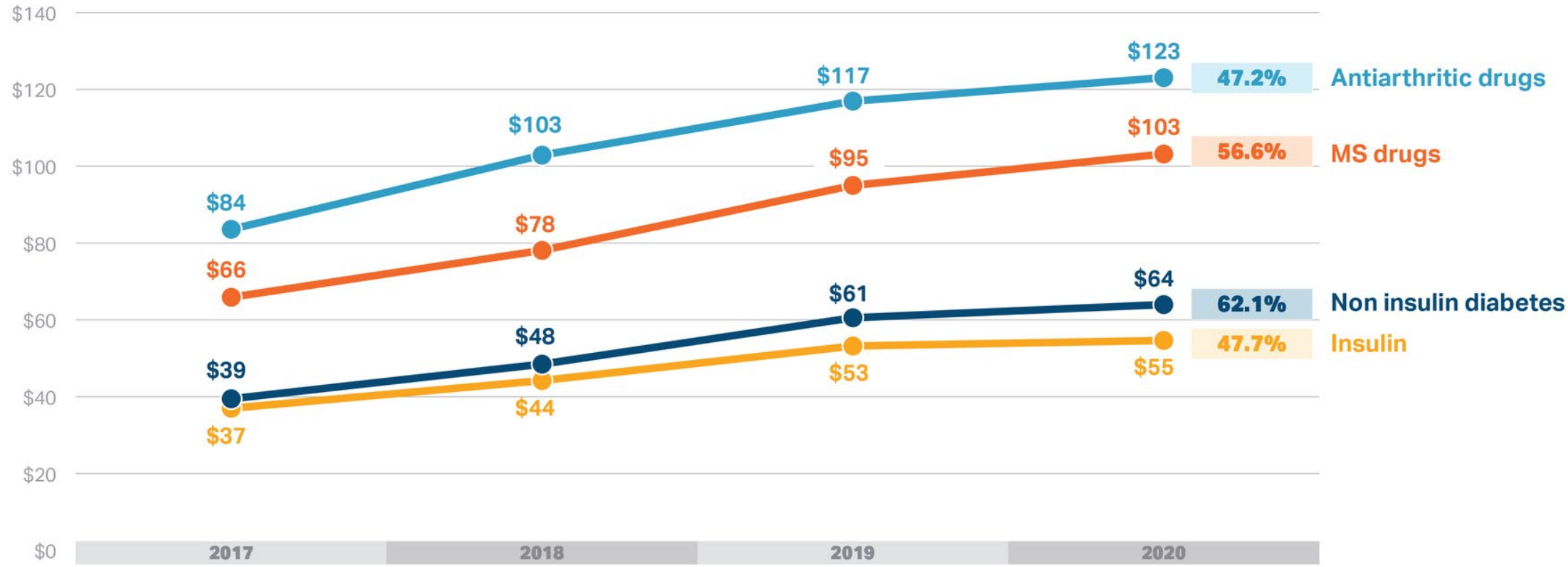
Gross spending distribution per branded prescription, 2017-2020



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

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

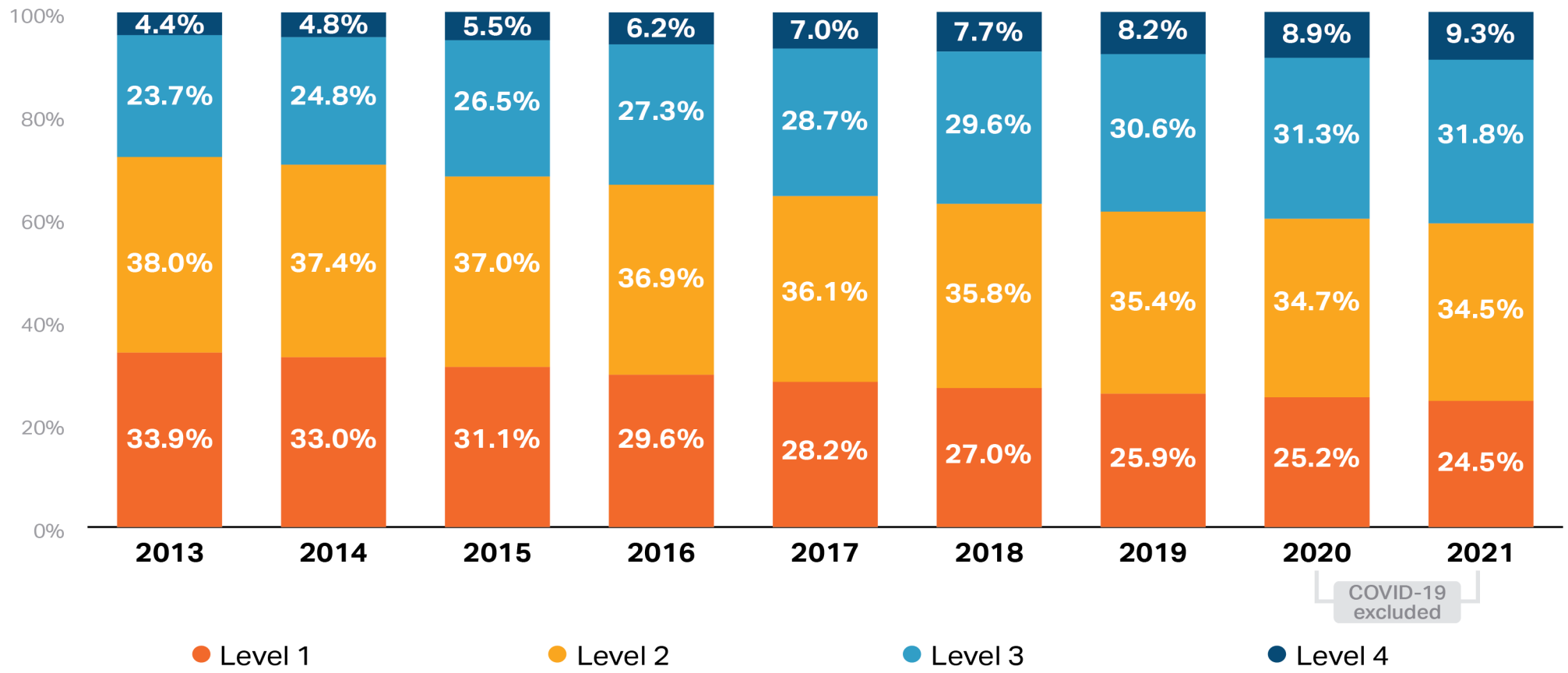
Average cost sharing per prescription (30-day supply) for selected classes of drugs, 2017-2020



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

Coded severity of inpatient stays has increased steadily from 2013 to 2021.

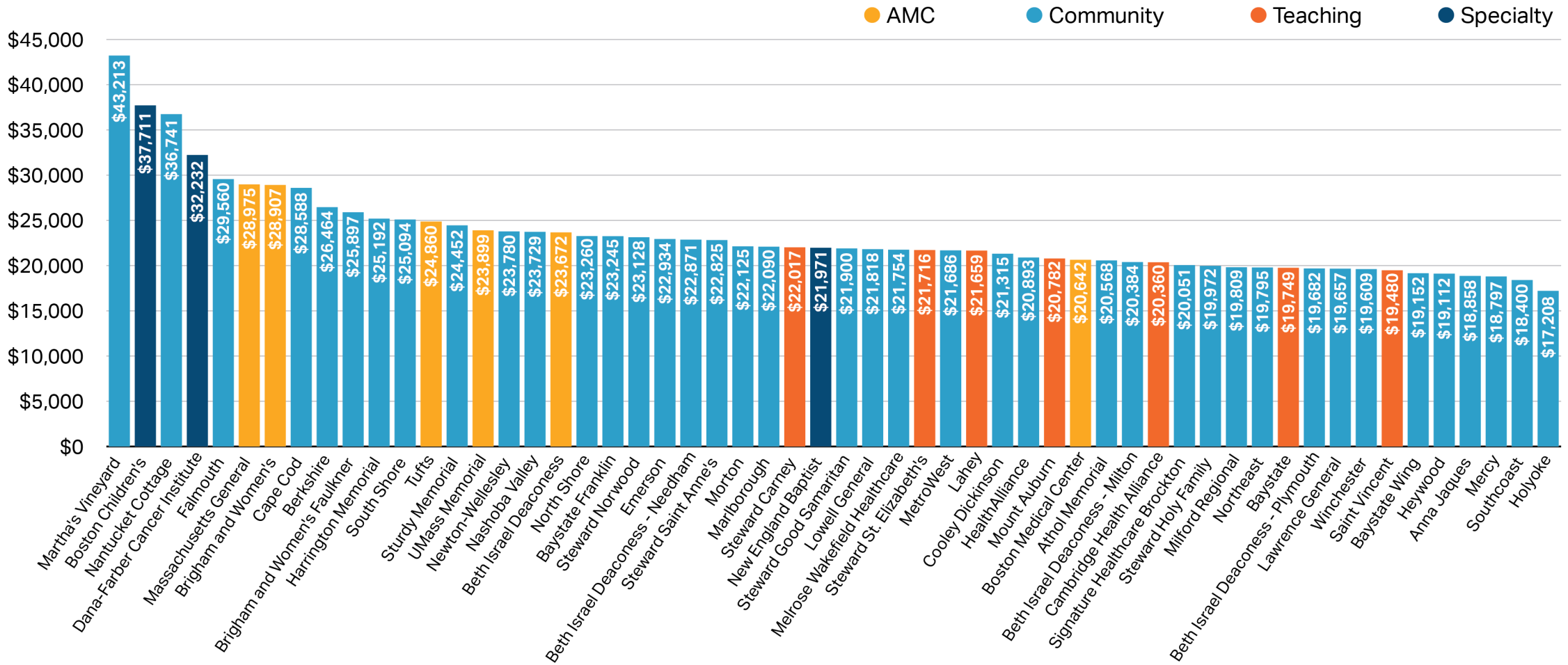
Proportional Composition of Inpatient Discharges by Patient Severity of Illness without COVID-19 Cases, 2013-2021



Notes: Data from the Massachusetts Hospital Inpatient Discharge Database (HIDD) from 2013-2021. Severity groups were defined using MassHealth (Medicaid) all-payer refined diagnosis related groups (APR-DRG) and patient severity of illness (SOI) on a four-level severity scale, with 4 being the highest acuity. The data comprised of all medical inpatient stays at acute care hospitals for Massachusetts residents, excluding behavioral health stays and extremely long length of stay because these cases are usually not paid based on DRGs. Other exclusions include transfers, patients that died, patients who went to Shriners Hospital for Children (Springfield and Boston), and discharges with some APR coding restrictions based on discrepancies with CMS major diagnostic categories. COVID-19 cases were defined as any inpatient stay with U071 for the primary or secondary diagnosis code.
Source: HPC analysis of Center for Health Information and Analysis Hospitals Inpatient Discharge Database, FY2013-2019, preliminary FY2020-2021

The cost of a market basket of 50 common hospital outpatient services in 2020 varied more than two-fold across hospitals, with higher prices for AMCs, specialty hospitals and geographically isolated hospitals.

Cost of the fixed HOPD market basket among Massachusetts hospitals in 2020

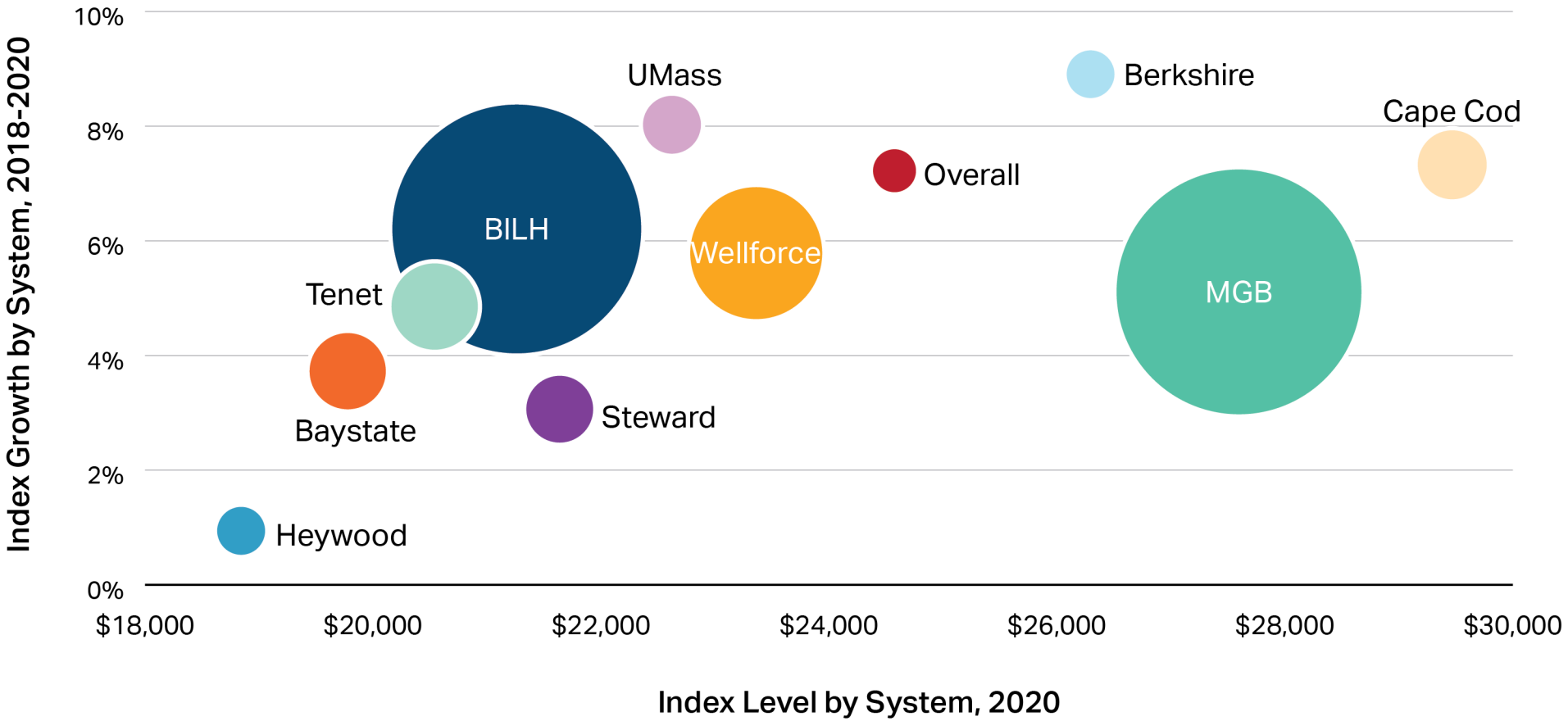


Notes: For each hospital, the same 50 procedure codes are evaluated using a fixed statewide volume (computed using 2018 data) and hospital-specific mean service prices in 2020 for each procedure code. Hospitals with less than 20 service encounters for any individual procedure code have imputed values (statewide mean price) for that particular procedure code and are not included if more than 20 procedure codes needed to be imputed. See upcoming technical appendix for more details on methodology.

Source: HPC analysis of the All-Payer Claims Database, 2018-2020, V 10.0.

Hospital systems with higher outpatient prices in 2018 also tended to have higher price growth from 2018-2020. Price variation increased.

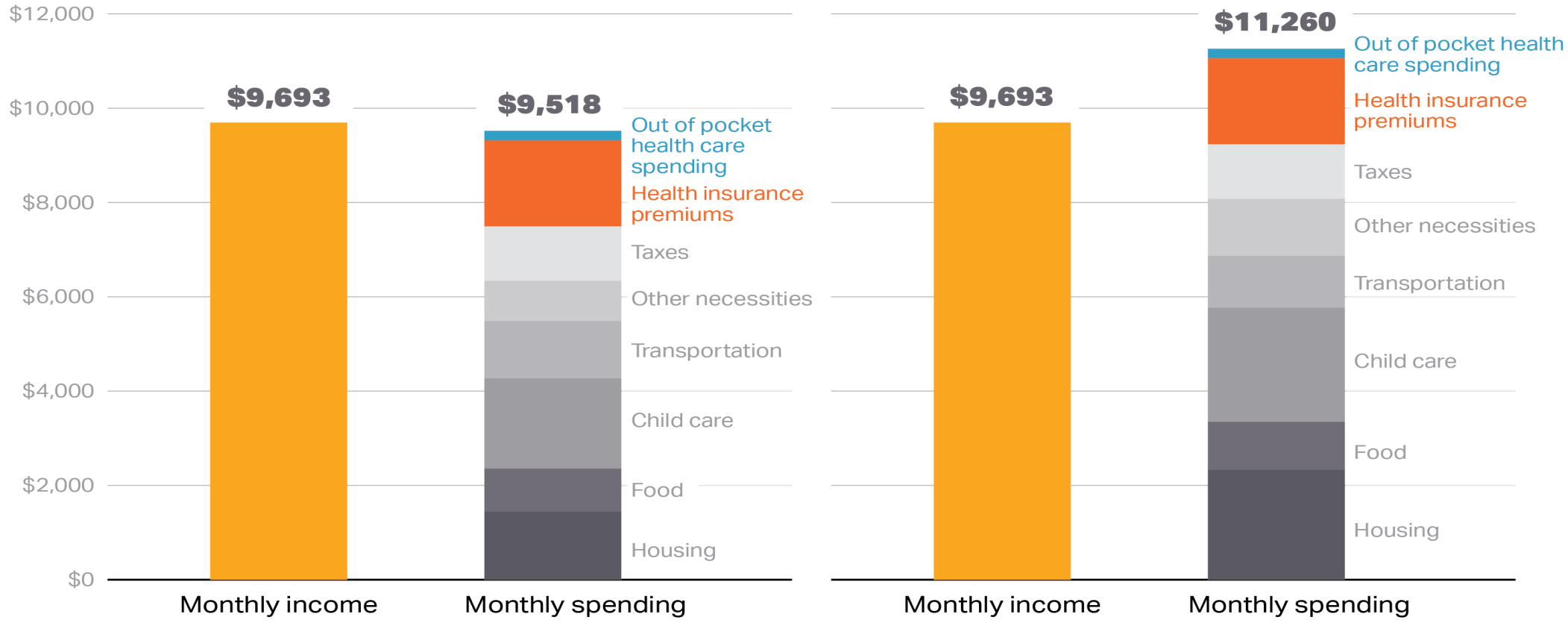
Total price of the HOPD market basket in 2020 and price growth from 2018-2020 growth by hospital system



Notes: Hospital systems are sourced from CHIA's latest hospital profiles. Bubble size corresponds to percent of index service volume affiliated with each system. 19.9% of index service volume for the 50 CPT codes is not system-affiliated. "Overall" index growth and index level is based on a weighted average. The 'Overall' data point bubble size is stylistic only.
Source: HPC analysis of the All-Payer Claims Database, 2018-2020, V 10.0.

On average, the cost of health care (including premiums and out of pocket costs) and other household expenses exceeds the income of middle-class families in the Boston area.

Average income and typical spending for a middle-class family of 4 with income between 3 and 5 times the FPL, 2020



WORCESTER METRO AREA **BOSTON METRO AREA**

Notes: Spending for non-health care categories are estimated based on typical local area expenditures by the Economic Policy Institute. Health care spending for over-the counter medicines or for providers not covered by health insurance is not included. Employer contributions to health insurance premiums are included in both health care spending and income.
Sources: Economic Policy Institute (https://www.epi.org/resources/budget/), Medical Expenditure Panel Survey – Insurance Component, Current Population Survey, Annual Social and Economic Supplement

Conclusion and Policy Recommendations:

Despite notable progress over the past ten years, persistent challenges and market failures have not been adequately addressed.

- Excessive provider price growth and extensive variation in provider prices that is unrelated to value;
- Increased market consolidation and shift in volume to high-cost sites of care;
- High, rising, and non-transparent pharmaceutical prices, which may not reflect value;
- Steadily increasing health insurance premiums, deductibles, and cost-sharing, resulting in increased costs to businesses and consumers;
- Stalled uptake of value-based payment models and innovative plan offerings; and
- Systemic and persistent disparities in health care access, affordability, and outcomes.

Priorities for Action: The HPC recommends immediate action to improve state oversight and accountability.

- **Target Above Benchmark Spending Growth.** The Commonwealth should take action to strengthen the Performance Improvement Plan (PIP) process, the HPC's primary mechanism for holding providers, payers, and other health care actors responsible for health care spending growth. Specifically, the HPC recommends that the metrics used by CHIA to identify and refer organizations to the HPC should be expanded to include measures that account for the underlying variation in provider pricing and baseline spending, and by establishing escalating financial penalties to deter excessive spending.

- **Constrain Excessive Provider and Pharmaceutical Prices.** The Commonwealth should take action to constrain excessive price levels, variation, and growth for health care services and pharmaceuticals, by imposing hospital price growth caps, enhancing scrutiny of provider mergers and expansions, limiting hospital facility fees, and expanding state oversight and transparency of the entire pharmaceutical sector, including how prices are set in relation to value.

- **Limit Increases in Health Insurance Premiums and Cost-Sharing.** The Commonwealth should take action to hold health insurance plans accountable for affordability and ensure that any savings that accrue to health plans are passed along to businesses and consumers, including by setting affordability targets and standards as part of the annual premium rate review process.

The 2022 Policy Recommendations reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity.

2022 Policy Recommendations (Abridged)

1. **Strengthen Accountability for the Health Care Cost Growth Benchmark.** As recommended in past years, the Commonwealth should strengthen the mechanisms for holding providers, payers, and other health care actors responsible for health care spending performance to support the Commonwealth's efforts to meet the health care cost growth benchmark.
   - A. **Improve Metrics and Referral Standards for Monitoring Health Care Entity Spending**
   - B. **Strengthen Enforcement Tools in PIPs Process**

2. **Constrain Excessive Provider Prices.** Prices continue to be a primary driver of health care spending growth in Massachusetts, and the significant variation in prices for Massachusetts providers (without commensurate differences in quality) continues to divert resources away from smaller and/or unaffiliated community providers, many of which serve vulnerable patient populations, and toward generally larger and more well-resourced systems.
   - A. **Establish Price Caps for the Highest-Priced Providers in Massachusetts**
   - B. **Limit Facility Fees**
   - C. **Enhance Scrutiny and Monitoring of Provider Expansions**
   - D. **Adopt Default Out-of-Network Payment Rate**

2022 Policy Recommendations (Abridged)

3 **Enhance Oversight of Pharmaceutical Spending.** As drug spending continues to grow in Massachusetts, patients are acutely feeling rising out-of-pocket costs and other barriers to access in their insurance plan design.

A. **Enhance Transparency and Data Collection**
B. **PBM Oversight**
C. **Expand Drug Pricing Reviews**
D. **Limit Out-of-Pocket Costs on High-Value Drugs**

4 **Make Health Plans Accountable for Affordability.** As both health insurance premiums and the use of higher deductibles increase, further squeezing families in Massachusetts, the Commonwealth should require greater accountability of health plans for delivering value to consumers and ensuring that any savings that accrue to health plans (e.g., from provider price caps as described above or reduced use of high-cost care) are passed along to consumers.

A. **Set New Affordability Targets and Affordability Standards**
B. **Improve Health Plan Rate Approval Process**
C. **Reduce Administrative Complexity**
D. **Improve Benefit Design and Cost-Sharing**
E. **Alternative Payment Methods (APMs)**

2022 Policy Recommendations (Abridged)

5 **Advance Health Equity for All.** Achieving health equity for all will require focused, coordinated efforts among policymakers, state agencies, and the health care system to ensure that the Commonwealth addresses inequities in both the social determinants of health (SDOH) and in health care delivery and the impact of those inequities on residents. As such, all stakeholders should have both a role in and accountability for efforts to achieve health equity for all.

- **A. Set and Report on Health Equity Targets**
- **B. Address Social Determinants of Health**
- **C. Use Payer-Provider Contracts to Advance Health Equity**
- **D. Improve Data Collection**

6 **Implement Targeted Strategies and Policies.** To further advance cost containment, affordability, and health equity, the Commonwealth should adopt the following additional strategies and policies.

- **A. Improve Primary and Behavioral Health Care**
  - **i. Focus Investment in Primary Care and Behavioral Health Care**
  - **ii. Improve Access to Behavioral Health Services**
- **B. Examine Increases in Medical Coding Intensity and Improve Patient Risk Adjustment**
- **C. Support Efforts to Reduce Low-Value Care**

Agenda

Call to Order

Executive Director's Report

2022 Health Care Cost Trends Report and Policy Recommendations

SCHEDULE OF UPCOMING MEETINGS

Schedule of Upcoming Meetings

BOARD

December 14

COMMITTEE

October 12

ADVISORY COUNCIL

December 7

SPECIAL EVENTS

November 2
Cost Trends Hearing

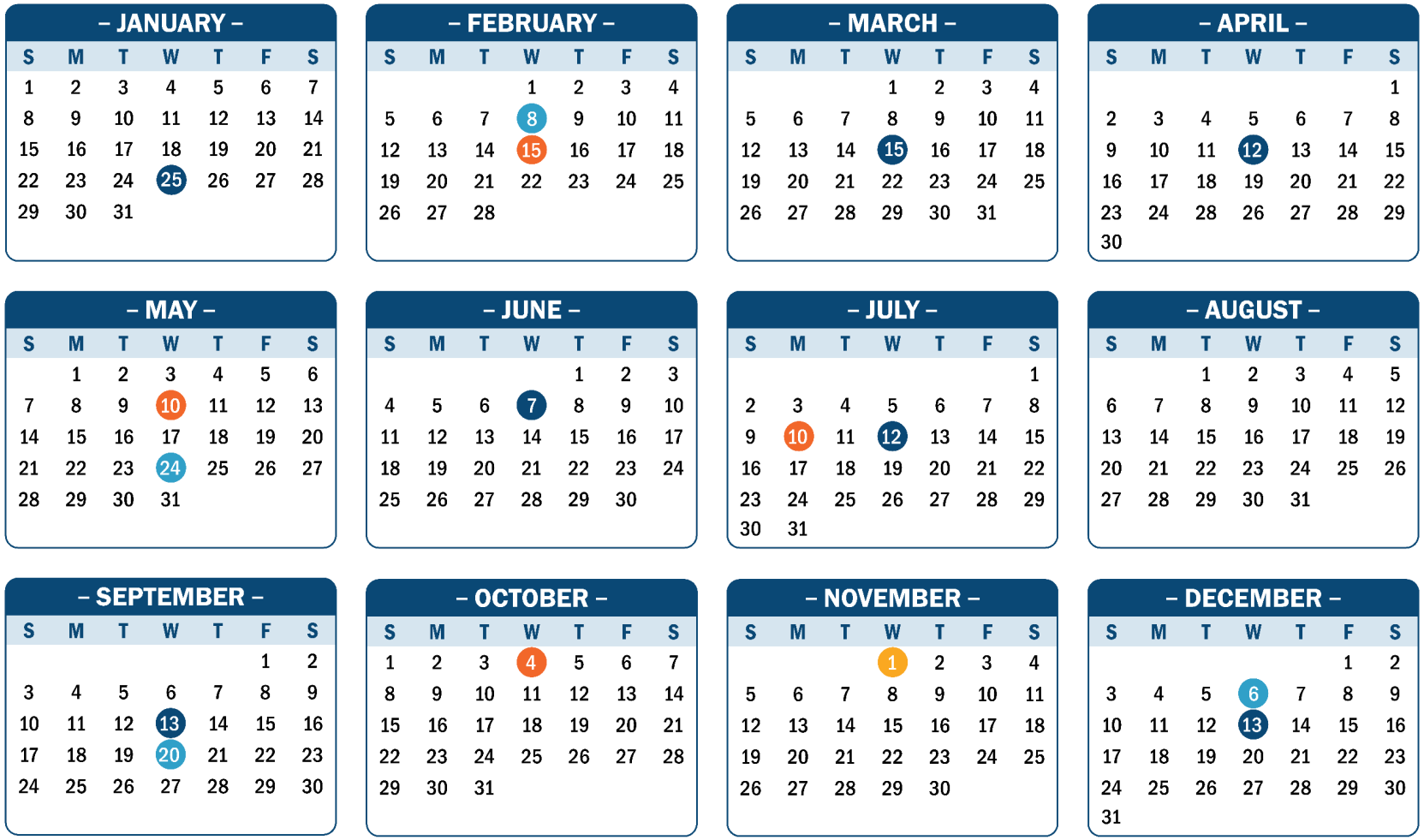
Mass.gov/HPC

HPC-info@mass.gov

@Mass_HPC

tinyurl.com/hpc-linkedin

2023 Public Meeting Calendar



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.

MASSACHUSETTS
HEALTH POLICY COMMISSION

Appendix

2022 Policy Recommendations

1. **Strengthen Accountability for the Health Care Cost Growth Benchmark.** As recommended in past years, the Commonwealth should strengthen the mechanisms for holding providers, payers, and other health care actors responsible for health care spending performance to support the Commonwealth's efforts to meet the health care cost growth benchmark. The HPC can take a range of factors into account in determining whether to require a Performance Improvement Plan (PIP) from a payer or provider referred to it by the Center for Health Information and Analysis (CHIA). However, the PIP statute requires that CHIA base its referrals on growth in health status adjusted total medical expenses (HSA TME), a metric that is limited to spending for providers' primary care patients, that is heavily influenced by medical coding efforts, and that overlooks the significant variation in baseline spending levels among entities.

    A. **Improve Metrics and Referral Standards for Monitoring Health Care Entity Spending**. The Legislature should take action to increase accountability through the annual PIP process by allowing CHIA to use metrics in addition to growth in HSA TME to identify and refer entities to the HPC for review and consideration for a PIP. These metrics should take baseline spending levels into account in addition to growth, hold providers accountable for spending for all of their patients (not only their primary care patients), include providers in addition to primary care groups (e.g., hospitals), and address the impact of medical coding efforts which can both increase spending and mask spending increases in health status adjusted measures. The measures and referral standards should also be expanded to allow the PIPs process to account for persistent variation in negotiated provider prices for the same types of services, which primarily reflects differences in size and bargaining leverage between different providers, rather than differences in quality of other indicia of value. Additionally, accountability should be extended to other market participants that contribute to health care spending growth (e.g., pharmaceutical benefit managers and manufacturers).

    B. **Strengthen Enforcement Tools in PIPs Process.** The PIP process should also be strengthened, including by allowing HPC to set savings expectations, to identify the types of strategies that should be included in a PIP, and giving the HPC greater oversight tools to ensure that any PIP results in meaningful improvement. The Legislature should also take action to deter excessive spending by allowing the HPC to apply tougher, escalating financial penalties for above-benchmark spending or non-compliance, similar to efforts in other states with health care growth targets.

These collective fixes to the benchmark and its accountability mechanisms are critically necessary to establish a more effective process to constrain excessive spending and reduce unwarranted variation in provider prices.

2022 Policy Recommendations

2. **Constrain Excessive Provider Prices.** Prices continue to be a primary driver of health care spending growth in Massachusetts, and the significant variation in prices for Massachusetts providers (without commensurate differences in quality) continues to divert resources away from smaller and/or unaffiliated community providers, many of which serve vulnerable patient populations, and toward generally larger and more well-resourced systems. For example, shifts in volume to higher-priced hospitals, combined with commercial price levels which can be three times as high as Medicare prices, were a key reason Massachusetts failed to meet the benchmark in 2018 and 2019. Many market initiatives have attempted to address high, variable, and non-transparent provider prices (e.g., tiered and narrow network products, price transparency efforts, risk contracting), but these efforts have failed to meaningfully restrain provider price growth or reduce unwarranted variation in provider prices. Accordingly, the HPC recommends the following actions:

   A. **Establish Price Caps for the Highest-Priced Providers in Massachusetts.** The Legislature should take action to 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). Such price caps—targeted specifically at the highest-priced providers in Massachusetts and those services and provider types for which competitive forces are not likely to meaningfully constrain prices—would be an important complement to the health care cost growth benchmark. Such caps would reduce unwarranted price variation and promote equity by ensuring that future price increases can accrue appropriately to lower-priced providers, including many community hospitals and other providers that care for populations facing the greatest health inequities, ensuring the viability of these critical resources.

   B. **Limit Facility Fees.** In many cases, the same services can be provided in both hospital outpatient departments and non-hospital settings such as physician offices. Nevertheless, Massachusetts residents disproportionately use hospital outpatient settings, utilizing hospital outpatient services on average, 40 percent more than residents of other states. Prices and patient cost-sharing are generally substantially higher at hospital outpatient sites due to the addition of hospital "facility fees." In many cases, patients may not realize that pricing can be substantially higher at some sites (those licensed as hospital outpatient departments) and face higher costs as a result. In order to improve market functioning and consumer protections, policymakers should take action to 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. Additionally, outpatient sites that charge facility fees should be required to conspicuously and clearly disclose this fact to patients prior to delivering care, and payers and providers should include the location where the visit occurred on claims submitted to payers and reported to the Commonwealth's all-payer claims database.

2022 Policy Recommendations

2. Constrain Excessive Provider Prices.

C. Enhance Scrutiny and Monitoring of Provider Expansions. Recognizing that the cost of care can vary substantially among different providers with significant implications for health equity and affordability, the Commonwealth should strengthen its examinations of plans for major expansions of services or new facilities, particularly for higher-priced providers and at hospitals and other higher-priced sites of care. Such examinations, which could be conducted by the HPC and incorporated into the state's existing determination of need process in lieu of the current independent cost analysis, should assess the impact of proposed expansions and new facilities on health care costs, quality, access, and market competition, and ensure that any such proposals are well informed by health equity considerations and aligned with community need. In addition, given the extent to which many such expansions focus on ambulatory care and the particular importance of hospital outpatient care in driving spending and utilization trends, the Commonwealth should improve data collection on outpatient and ambulatory care across different sites and settings, including hospital main campus and off-campus sites such as ambulatory surgery centers, and non-hospital-licensed ambulatory sites, such as urgent care centers. More accurate data, identifying the location at which services were rendered, will better enable the HPC and others to analyze the impact of outpatient and ambulatory care proposals on health care costs, quality, and access, particularly for underserved populations.

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. Broader application of out-of-network default rates should also be explored as an approach to reduce unwarranted price variation across providers and settings.

2022 Policy Recommendations

3. **Enhance Oversight of Pharmaceutical Spending.** As drug spending continues to grow in Massachusetts, patients are acutely feeling rising out-of-pocket costs and other barriers to access in their insurance plan design. Accordingly, the HPC recommends the following actions:

   A. **Enhance Transparency and Data Collection.** The Commonwealth should take action to increase both transparency of drug price growth and spending and oversight of the key stakeholders responsible for setting drug prices and establishing the policies and financial incentives that influence how patients access critical medications. The Commonwealth should authorize CHIA to collect data on pharmaceuticals from payers and pharmacy benefit managers (PBMs), including the average cost of pharmaceuticals after all discounts and rebates, markups, price increases, and launch prices of new drugs, as well as the cost of drugs administered in in provider offices and hospital outpatient departments.

   B. **PBM Oversight.** The state should also require licensure of PBMs in order to monitor their business practices with pharmacies and health plans, and their impact on patients.

   C. **Expand Drug Pricing Reviews.** Commonwealth should build on MassHealth's successful process by expanding the HPC's drug pricing review authority in order to strengthen commercial price negotiations by transparently reporting on drugs that are contributing most to commercial spending growth in Massachusetts.

   D. **Limit Out-of-Pocket Costs on High-Value Drugs.** Finally, the Commonwealth should cap monthly out-of-pocket costs for high value prescription drugs that are widely recognized to improve health outcomes for patients with no or minimal impact on health care spending.

2022 Policy Recommendations

4. **Make Health Plans Accountable for Affordability.** As both health insurance premiums and the use of higher deductibles increase, further squeezing families in Massachusetts, the Commonwealth should require greater accountability of health plans for delivering value to consumers and ensuring that any savings that accrue to health plans (e.g., from provider price caps as described above or reduced use of high-cost care) are passed along to consumers.

   A. **Set New Affordability Targets and Affordability Standards.** To both complement and bolster the health care cost growth benchmark, the Commonwealth should set measurable goals that target affordability of care for Massachusetts residents. This measurement strategy should identify and track improvement on indicators of affordability, including measures that capture the differential impact of both health plan premiums and consumer out-of-pocket spending by income, geography, market segment, and other factors. Such targets should inform the development of new health plan affordability standards which prioritize the public's interest in equitable access to quality care.

   B. **Improve Health Plan Rate Approval Process.** The Legislature should require that the health plan affordability standards discussed above be a key factor in the Division of Insurance's (DOI) review and approval of health plan rate filings. In addition, there should be greater transparency and public participation in the rate approval process by including, at a minimum, a public comment period, and written justifications for approvals of rate increases, as in DOI's proposed regulation.

2022 Policy Recommendations

4. Make Health Plans Accountable for Affordability.

C. 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 claims submission, provider credentialing, and prior authorization which consume significant provider time and resources. This lack of standardization across health plans creates unnecessary costs for all health care actors and for the Massachusetts residents and businesses and their employees who pay for this complexity in the form of higher premiums, cost-sharing, and confusion in navigating the health care system. Evidence suggests that this complexity poses particular challenges for patients with fewer resources. The Legislature should require greater cross-payer standardization of policies, programs, and processes to reduce administrative complexity, enhance affordability, and improve equity.

D. Improve Benefit Design and Cost-Sharing. As the number of Massachusetts consumers with high-deductible health plans (HDHPs) has sharply increased, the HPC has documented increasing challenges to affordability, equitable access, and experience of care, particularly for employees with lower incomes. Even in non-HDHPs, cost-sharing can disproportionately impact individuals with lower income. Health plans should work with employers to develop alternatives to high-deductible health plans and other benefit designs that can hold total spending in check without impeding access and perpetuating inequities. To put equity at the forefront, health plans and employers should revise plan designs that impose equivalent cost sharing for medical services regardless of value (such as by waiving co-payments or deductibles for high-value medical care) and adjust premium contributions to reflect different employee wage levels.

E. Alternative Payment Methods (APMs). Health plans should continue to promote the increased adoption and effectiveness of APMs (e.g., increased use of primary care capitation, APMs for preferred provider organization (PPO) populations, episode bundles, and two-sided risk models), especially in the commercial market where expansion has stalled). They should also ensure that APM payment formulas reward efficient, patient-centered care rather than coding efforts.

2022 Policy Recommendations

5. **Advance Health Equity For All.** Achieving health equity for all will require focused, coordinated efforts among policymakers, state agencies, and the health care system to ensure that the Commonwealth addresses inequities in both the social determinants of health (SDOH) and in health care delivery and the impact of those inequities on residents. As such, all stakeholders should have both a role in and accountability for efforts to achieve health equity for all.

   A. **Set and Report on Health Equity Targets.** The Commonwealth should undertake a coordinated effort across state agencies and sectors to identify a list of high-priority areas of documented disparities in health outcomes that are rooted in inequities, set measurable goals for improvement, and report annually on progress. Such goals should be developed through a collaborative approach that is guided by the perspectives of individuals and communities most affected by these disparities.

   B. **Address Social Determinants of Health.** Recognizing that success in achieving health equity targets will be difficult to achieve without addressing inequities in the social determinants of health, policymakers must continue to prioritize investments in affordable housing, improved food and transportation systems, and other community resources. Health care providers, as anchor institutions, can play a critical role in supporting community-led efforts to improve these and other social determinants.

   C. **Use Payer-Provider Contracts to Advance Health Equity.** Payers and providers should accelerate efforts to reduce health inequities among their members/patient populations by introducing health equity accountability into their provider contracts, including alternative payment model (APM) contracts. Provider contracts offer the opportunity to embed equity principles and enforce accountability (e.g., by requiring stratification of performance data by race/ethnicity). At the same time, APMs can align incentives to motivate investments in services and infrastructure (e.g., care coordination, integrated technology, and performance reporting) aimed at addressing inequities within patient populations.

   D. **Improve Data Collection.** To implement these health equity goals, policymakers, providers, and payers should commit to collection of reliable, standardized patient data on race, ethnicity, language, disability status, sexual orientation, gender identity, and sex to inform the integration of equity considerations into quality improvement, cost-control, and affordability initiatives. These efforts would be accelerated by the adoption of the data standards recommended by the Health Equity Data Standards Technical Advisory Group of the EOHHS Quality Measurement Alignment Taskforce.

2022 Policy Recommendations

6. **Implement Targeted Strategies and Policies.** To further advance cost containment, affordability, and health equity, the Commonwealth should adopt the following additional strategies and policies.

   A. **Improve Primary and Behavioral Health Care.** There is considerable evidence that health care delivery systems oriented toward primary care tend to have lower costs, higher quality, and a more equitable distribution of health care resources. Better management of behavioral health conditions has also been found to lower overall health care spending and improve quality of life. The coronavirus pandemic (COVID-19) has underscored the importance of equitable access to both types of care. Specific areas of focus should include:

      i. **Focus Investment in Primary Care and Behavioral Health Care.** Payers and providers should increase spending devoted to primary care and behavioral health while adhering to the Commonwealth's total health care cost growth benchmark. These spending increases should prioritize non-claims-based spending such as capitation, infrastructure, and workforce investments. CHIA and the HPC should continue to track and report on primary care and behavioral health care spending trends annually and hold entities accountable for meeting improvement targets if they fall short of established targets.

      ii. **Improve Access to Behavioral Health Services.** In response to the recent increased need for behavioral health services— in particular among children, young adults, and people of color — payers and providers should take steps to increase access to behavioral health services appropriate for and accessible to these populations. This must include a redoubling of the Commonwealth's efforts to provide resources and support to individuals and families suffering from the effects of the opioid epidemic, notably Black men, a population that has experienced a significant increase in overdoses since 2020. The Commonwealth can advance these goals by implementing the Executive Office of Health and Human Services' Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it, including increasing inpatient beds for behavioral health patients (including pediatric patients), investing in community-based alternatives to the emergency department, and increasing the behavioral health workforce, particularly providers who can support their communities' needs with linguistically and culturally relevant care.

2022 Policy Recommendations

6. Implement Targeted Strategies and Policies.

B. Examine Increases in Medical Coding Intensity and Improve Patient Risk Adjustment. The HPC and other researchers have documented that recent increases in patient risk scores and acuity are better explained by changes in payer and provider documentation and coding behavior than by changes in actual patient health status. This conclusion was bolstered by the finding that risk scores fell in 2020 — during a global pandemic that reduced overall life expectancy in the US — not because patients were less sick but because a reduced number of patient encounters with the medical system created fewer opportunities to document patient diagnoses. While there may be some benefits to more complete and accurate coding, efforts aimed toward increasing revenue through increased coding intensity impair performance measurement, absorb clinical and administrative personnel (for those providers able to devote such resources), and have resulted in millions in additional spending for Massachusetts payers, employers, and residents. The Commonwealth should take action to mitigate the impact of changes in clinical documentation practices on spending and performance measurement. Specific areas of action should include: adoption of risk adjustment methods for accountability and payment purposes that are not based primarily on patient diagnoses or severity, which reduces the return on investment from coding efforts; more frequent updates to clinical classification software to better align payments with actual resource use; and continued development of alternative risk adjustment methods and performance metrics that are less sensitive to coding-based acuity and that reward providers for caring for vulnerable populations facing barriers to care.

C. Support Efforts to Reduce Low-Value Care. HPC research shows that Massachusetts residents receive a significant amount of care that does not provide value, and that the provision of such care by provider organizations varies widely. While the incidence of low-value care decreased during the pandemic, the Commonwealth should act to sustain the reduction. Toward this end, payers, providers, and purchasers should convene to develop strategies, incentives, and action steps to eliminate low value care. Government regulations and internal provider policies should be reviewed and updated in order to reflect evolving clinical standards and to ensure that, at a minimum, they do not require or encourage low value care. Employers can also play a role in assisting employees and their families in accessing information useful towards making high-value treatment decisions.

The HPC stands ready to support these efforts with data insights and independent policy leadership.