MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

December 14, 2022

Agenda

CALL TO ORDER

Approval of Minutes (VOTE)

Market Oversight and Transparency

Executive Director’s Report

Schedule of Upcoming Meetings

Executive Session (VOTE)

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

Market Oversight and Transparency

Executive Director's Report

Schedule of Upcoming Meetings

Executive Session (VOTE)

VOTE

Approval of Minutes from the September 27 Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on September 27, 2022, as presented.

Agenda

Call to Order

Approval of Minutes (VOTE)

MARKET OVERSIGHT AND TRANSPARENCY

- Material Change Notices
- Changes in the Pediatric Market in Massachusetts
- Use and Implications of Risk Adjustment in Massachusetts

Executive Director's Report

Schedule of Upcoming Meetings

Executive Session (VOTE)

Agenda

Call to Order

Approval of Minutes (VOTE)

Market Oversight and Transparency

MATERIAL CHANGE NOTICES

- Changes in the Pediatric Market in Massachusetts
- Use and Implications of Risk Adjustment in Massachusetts

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Executive Session (VOTE)

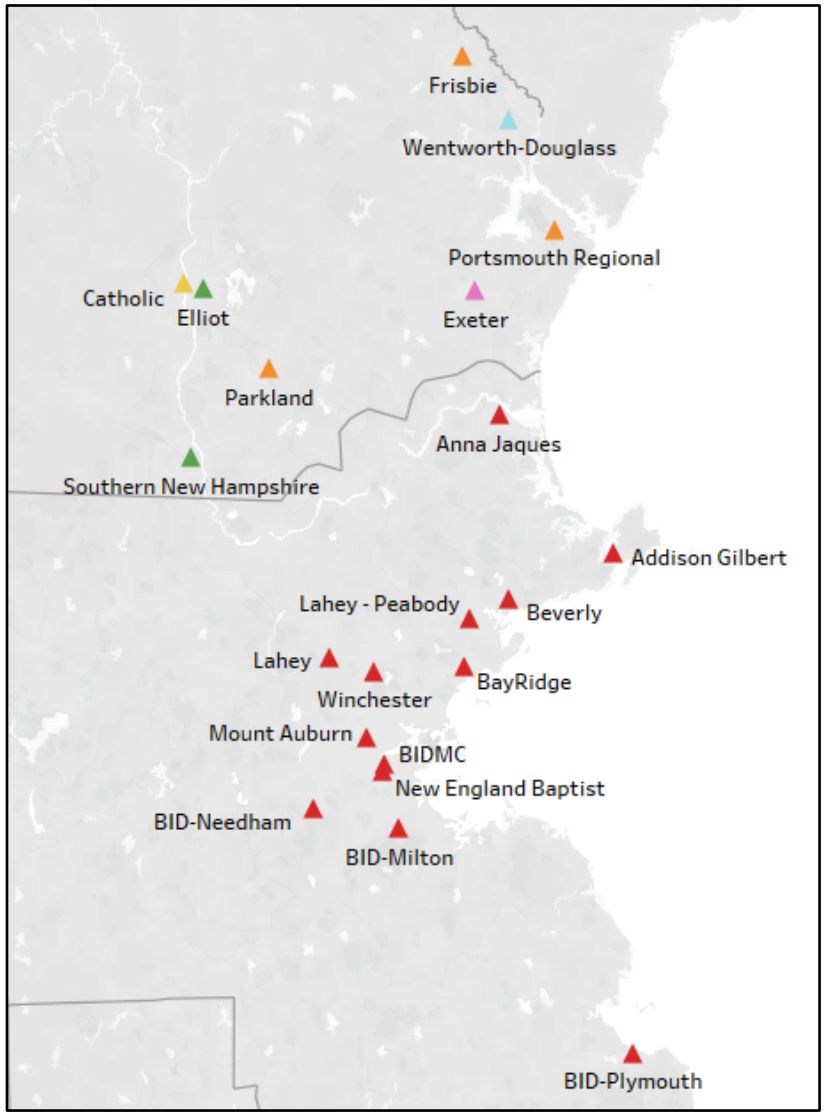
Since 2013, the HPC has reviewed 148 market changes.

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	35	24%
Clinical affiliation	31	21%
Physician group merger, acquisition, or network affiliation	28	19%
Acute hospital merger, acquisition, or network affiliation	25	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	22	15%
Change in ownership or merger of corporately affiliated entities	6	4%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

- A proposed joint venture between **Tufts Medicine** and **Acadia Healthcare Company**, a national behavioral healthcare services provider that operates two behavioral health hospitals and a number of substance use disorder treatment centers across Massachusetts, to construct, own, and operate a new psychiatric hospital in Malden, Massachusetts.
- A proposed transaction between **Steward Health Care System** (Steward) and **CareMax**, a national for-profit healthcare services provider that operates clinics focused on serving Medicare Advantage patients. Under the proposed transaction, CareMax would acquire the Medicare value-based care business of Steward and act as a management services organization for Steward's national Medicare network.
- The proposed acquisition of the private equity-affiliated corporate parent of **Monte Nido**, a national provider of eating disorder treatment programs that operates several facilities in Massachusetts, including Walden Behavioral Care (acquired in 2021), by affiliates of **Revelstoke Capital Partners**, a health care private equity firm.
- The proposed acquisition of **Exeter Health Resources** (Exeter) by **Beth Israel Lahey Health**. Exeter serves the Seacoast Region of southern New Hampshire and Maine and includes Exeter Hospital, a 100-bed acute care community hospital in Exeter, NH, as well as a multi-specialty physician practice and a visiting nurse association and hospice.

BILH, Exeter, and Nearby New Hampshire Hospitals and Hospital Systems



System
- BILH
- GraniteOne Health
- HCA Healthcare
- Independent
- MGB
- Solution Health

The proposed transaction's impacts on Massachusetts patients and payers is likely to be limited. It may have greater impacts in New Hampshire.

- Exeter Hospital sees few patients covered by Massachusetts health plans each year, with the majority of these patients using Exeter for outpatient care. This low volume limits the potential impacts of any changes on Massachusetts patients and payers.
- We found Exeter Hospital was more expensive than relevant Massachusetts community hospitals for the services we examined, but was significantly less expensive than other New Hampshire hospitals where Massachusetts patients also seek care. Shifts of Massachusetts patients to Exeter from nearby hospitals would result in only small net changes in commercial spending.
- Shifts of patients to BIDMC and Lahey as a result of the transaction would likely be slightly cost-saving, given their lower prices relative to other Boston-area tertiary hospitals commonly used by Exeter patients.
- The transaction will increase market concentration and raises the potential for increased prices at Exeter. However, even substantial price increases would have limited impact on Massachusetts payers due to the low volume of their patients using Exeter.
- There is a potential for more significant impacts on spending and market dynamics for New Hampshire since most of Exeter's patients are covered by New Hampshire payers.
- There may be some potential for improved quality and expanded access as a result of the transaction if the stated goals of the parties are fulfilled. The impact of the transaction would likely be greater in NH than in MA, however the few MA patients that seek care at Exeter would be affected by any such quality and access improvements.

Material Change Notices Currently Under Review

RECEIVED SINCE 9/27

The proposed acquisition of **LHC Group**, a national provider of post-acute care services with several home health locations in Massachusetts, by **United HealthCare**, a national diversified health care company. Under the proposed transaction, LHC Group would become part of Optum Health, a subsidiary of United.

A proposed clinical affiliation between **Tufts Medical Center** and **Commonwealth Radiology Associates** (CRA), a large radiology physician group practicing in multiple locations in northeastern Massachusetts, including in two other Tufts Medicine hospitals, Lowell General Hospital and Melrose-Wakefield Hospital. Under the proposed affiliation, CRA would become the exclusive provider of professional radiology services at Tufts Medical Center.

Agenda

Call to Order

Approval of Minutes (VOTE)

Market Oversight and Transparency

- Material Change Notices

CHANGES IN THE PEDIATRIC MARKET IN MASSACHUSETTS

- Use and Implications of Risk Adjustment in Massachusetts

Executive Director's Report

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Executive Session (VOTE)

Recent changes highlight the importance of studying market dynamics for pediatric services.

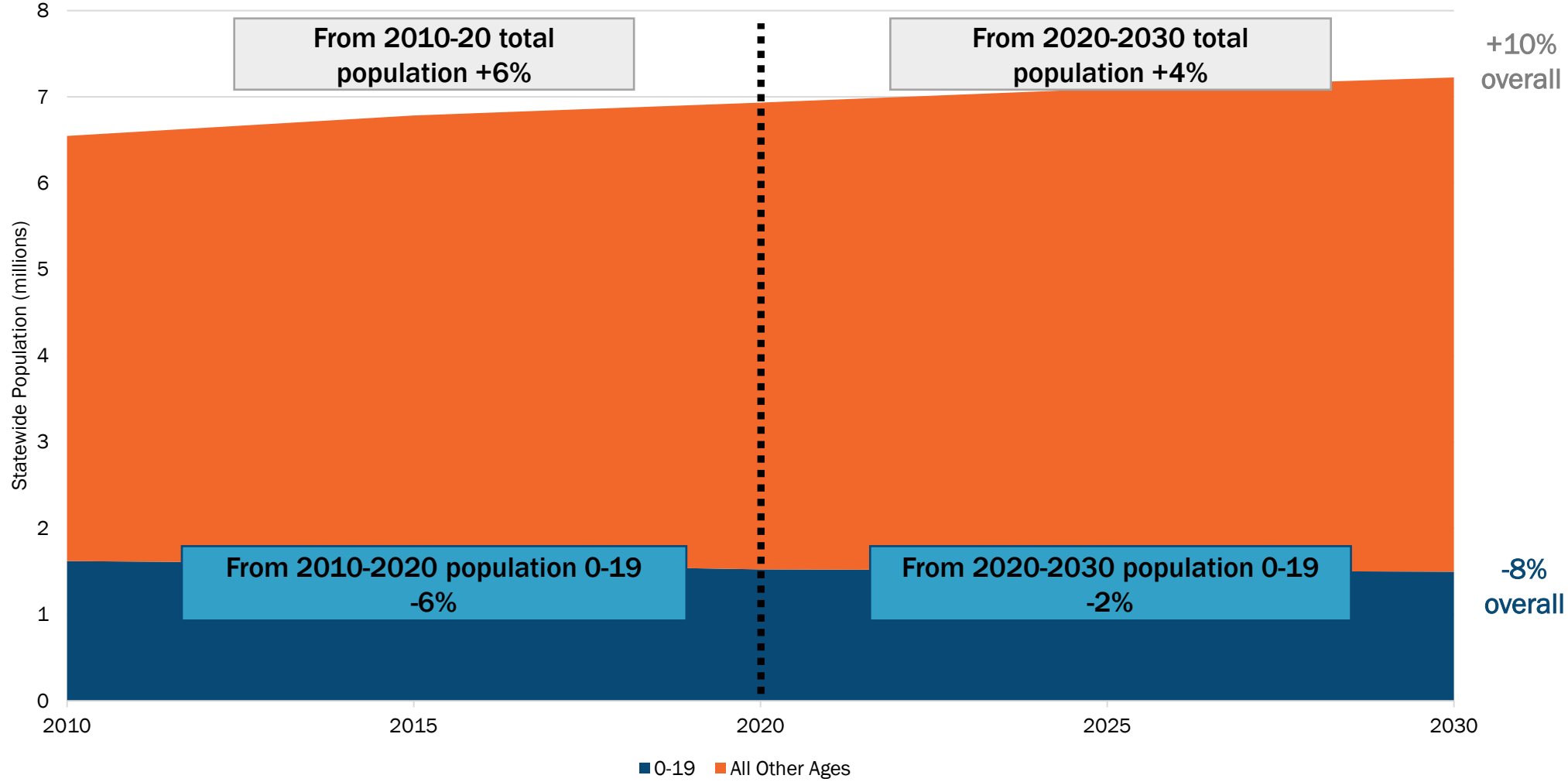
- Since 2013, the HPC has evaluated the potential impacts of provider market changes in the Commonwealth, including clinical affiliations, acquisitions, network affiliations, and expansions and closures of services. Many of these changes have involved pediatric services.
- The potential impacts of most of these changes, considered individually, have been limited. However, they have collectively resulted in, and reflect, substantial changes to the pediatric services landscape, with an increasing share of pediatric services being provided by a few provider organizations. These trends are similar to those occurring nationwide.
- Although pediatric services accounted for only 14% of statewide commercial health care spending in 2019, access to quality, affordable pediatric care is an important component of a well-functioning delivery system.
- As part of its mission to advance a more transparent, accountable, and equitable health care system, the HPC is examining trends in the pediatric services market and their impacts on health care spending, quality, and access.

Presentation Outline

1. **Background: A Changing Pediatric Services Landscape**
2. Analysis: Pediatric services in the Commonwealth are concentrated at two provider systems and have become more concentrated.
3. Analysis: The largest providers of pediatric services have high commercial prices and spending relative to other providers.
4. Analysis: Recent changes create opportunities for improving access and quality, but also pose challenges, including to affordability.
5. Discussion: How to promote affordable access to high-quality pediatric care in a changing and increasingly concentrated market.

Despite projected population growth in Massachusetts through 2030, the number of residents ages 0-19 is declining.

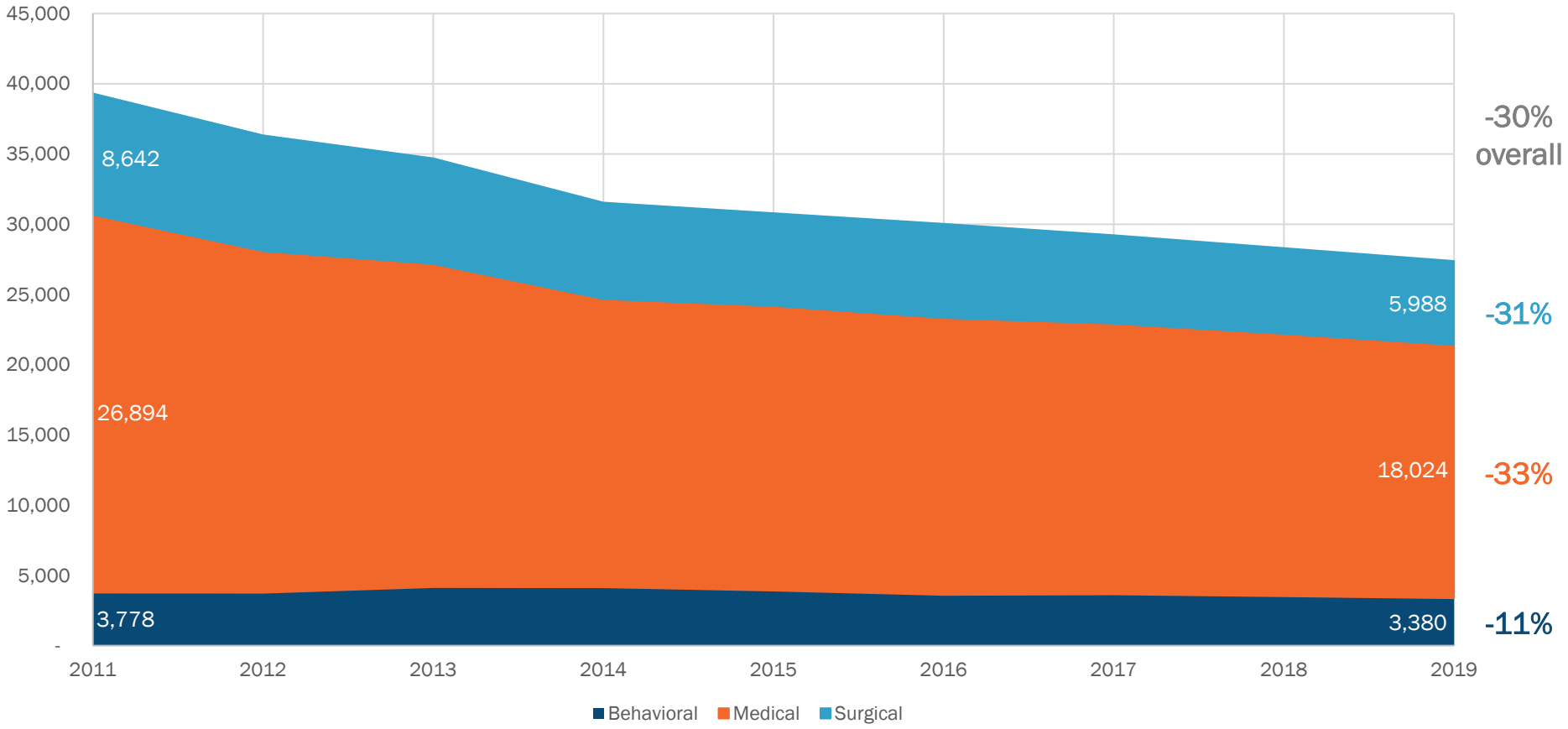
Massachusetts Population By Age (2010 - 2030 Projected)



Source: HPC Analysis of UMass Donahue Institute MassDOT Vintage 2018 Population Projections. September 2018. (UMDI-DOT V2018)
Note: All values shown above, aside from 2010 which was collected from the census, are projections by UMDI-DOT

The total volume of pediatric discharges, excluding deliveries, at general acute care hospitals statewide has declined.

Statewide Pediatric Discharges by Service Type at General Acute Care Hospitals, Excluding Deliveries, by Primary Diagnosis Category (2011-2019)

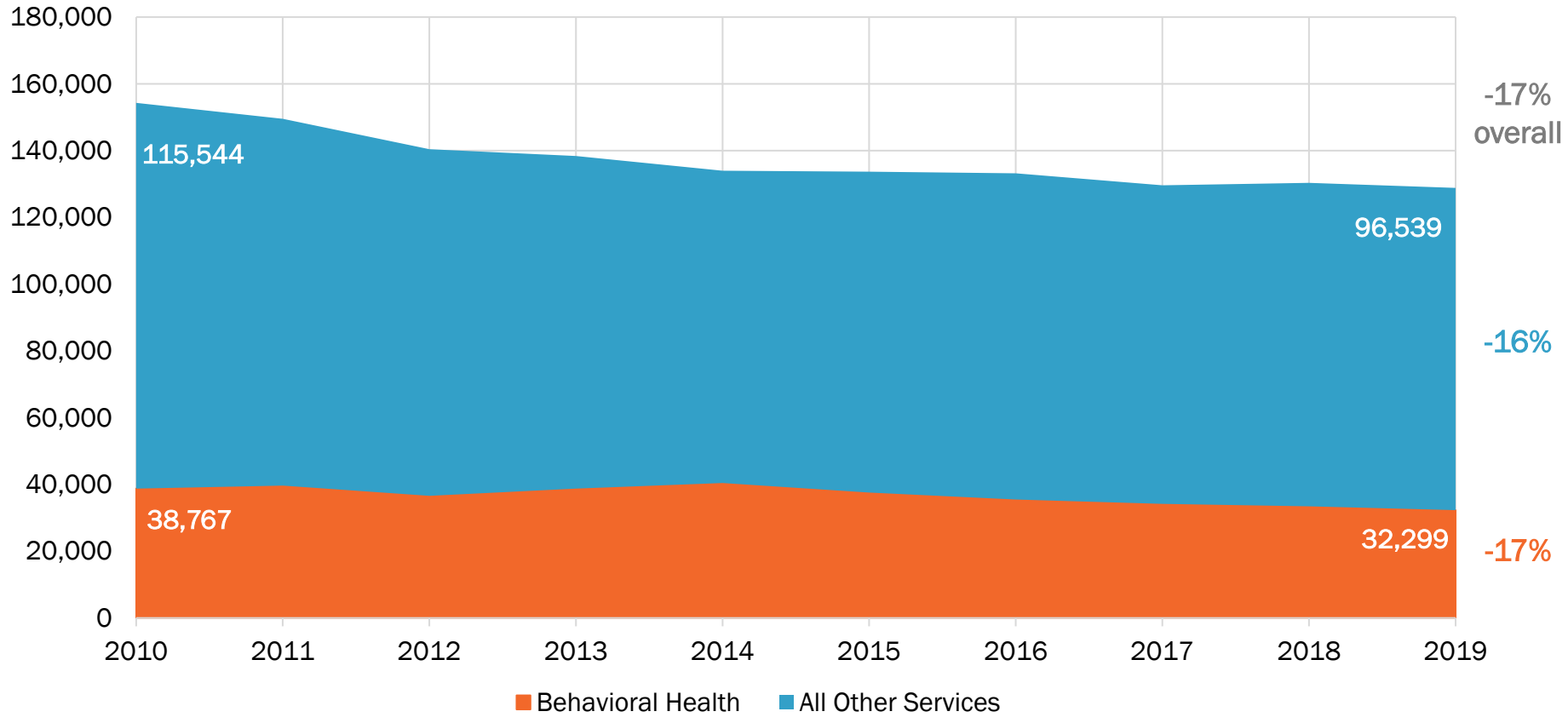


Source: HPC analysis of CHIA hospital discharge database
Notes: Excludes discharges for patients age 18 and older, residing outside of Massachusetts, or with primary DRG in MDC 14. Behavioral discharges defined as those with a primary DRG in MDC 19 or 20. Excludes Shriners Hospitals for Children and specialty behavioral health and rehabilitation hospitals.

The trend shown is for discharges at acute hospitals, including Boston Children's Hospital, but excluding specialty behavioral health and rehabilitation hospitals.

Pediatric inpatient bed days at general acute care hospitals have declined over time, despite increasing average lengths of stay.

Pediatric Inpatient Bed Days at General Acute Hospitals in Massachusetts by Service Type (2010-2019)



Source: HPC analysis of CHIA hospital discharge database
Notes: Excludes discharges for patients age 18 and older, residing outside of Massachusetts, or with primary DRG in MDC 14. Behavioral health discharges defined as those with a primary DRG in MDC 19 or 20. Excludes Shriners Hospitals for Children and specialty behavioral health and rehabilitation hospitals.

The trend shown is for discharges at acute hospitals, including Boston Children's Hospital, but excluding specialty behavioral health and rehabilitation hospitals.

Many hospitals have substantially reduced their pediatric inpatient services in recent years, while Children's and MGB have grown through clinical affiliations, expansions, and acquisitions.

	Pediatric Inpatient Bed Closures	Clinical Affiliations	Expansions and Acquisitions
2015		• Children's designated preferred pediatric AMC for Lahey patients. • MGB affiliates with Steward HealthCare hospitals to staff pediatric inpatient services.	• Children's files DoN to construct 11-story addition in Longwood and 8-story ambulatory services building in Brookline.
2016		• Tufts pediatricians begin staffing Cape Cod Hospital pediatrics. • Children's designated preferred pediatric AMC for Mount Auburn and South Shore Medical Center.	• Children's acquires Child Health Associates, a primary care physician group in Auburn and Shrewsbury.
2017	Shriner's Hospital for Children – Springfield (20 beds)	• Children's and Southcoast expand existing pediatric affiliation.	
2018	Health Alliance Hospital (11 beds) Sturdy Memorial Hospital (10 beds) Harrington Memorial Hospital (11 beds)		
2019	Baystate Noble Hospital (6 beds) North Shore Medical Center (20 psych beds)		• Children's adds two primary care pediatric groups in Woburn/North Andover and Brockton.
2020	Falmouth Hospital (5 beds) Framingham Union Hospital (21 beds) Newton-Wellesley Hospital (12 beds) Shriner's Hospital for Children – Boston (13 beds)		
2021	Holyoke Medical Center (infant nursery)	• Children's affiliates with Cape Cod Hospital to staff pediatric services.	• Children's files a DoN for the expansion of three ambulatory sites in Waltham, Needham, and Weymouth.
2022	Tufts Medical Center (41 beds)	• Children's affiliates with Tufts Medicine for inpatient care following the closure of Tufts Medical Center pediatric beds.	• Children's acquires Franciscan Hospital for Children.

Note: The transactions listed on this slide are only those that require notice to the HPC and do not include changes such as out-of-state transactions, acquisition of some small physician practices, etc.

Children's, Mass. General Brigham, and Tufts Medicine staff pediatric service lines at many community hospitals.

Boston Children's Hospital currently has clinical affiliations with 6 Massachusetts hospitals at which Children's completely or substantially staffs the pediatric service line:

- Beverly Hospital
- Winchester Hospital
- Milford Regional Medical Center
- South Shore Hospital
- Southcoast (St. Luke's and Charlton)
- Cape Cod Hospital

Boston Children's Hospital currently has clinical affiliations with 3 Mass General Brigham hospitals at which Children's staffs certain limited subspecialties:

- Brigham and Women's Hospital
- Brigham and Women's Faulkner Hospital
- Massachusetts General Hospital

Tufts Medical Center currently has clinical affiliations with 3 Massachusetts hospitals at which Tufts completely or substantially staffs the pediatric service line with physicians leased from Children's:

- Lawrence General Hospital
- MetroWest Medical Center – Framingham
- Signature Healthcare Brockton

Tufts Medical Center also has clinical affiliations with 2 Massachusetts hospitals at which it substantially staffs the maternal-fetal medicine service line:

- Beverly Hospital
- Winchester Hospital

Mass General Brigham currently has a clinical affiliation with 5 Steward hospitals in which MGB completely or substantially staffs the pediatric inpatient and newborn medicine service lines

Trends in Massachusetts reflect national trends in pediatric care.

Declining Pediatric Hospital Capacity

The number of pediatric inpatient units nationwide decreased by 19% and the number of beds decreased 11% between 2008-2018.[1]

Increase in transfers

Between 2008-2016, fewer hospitals were able to care for children in an inpatient setting and transfers increased 28%.[2]

Growth at freestanding Children's Hospitals

While several studies report a decline in pediatric inpatient and intensive care units across all hospitals, they also found an increase in critical care beds at large, freestanding children's hospitals.[1,3]

1: Cushing AM, Bucholz EM, Chien AT, Rauch DA, Michelson KA. Availability of Pediatric Inpatient Services in the United States. Pediatrics. 2021 Jul;148(1):e2020041723. doi: 10.1542/peds.2020-041723. Epub 2021 Jun 14.
2. Kenneth A. Michelson, Joel D. Hudgins, Todd W. Lyons, Michael C. Monuteaux, Richard G. Bachur, Jonathan A. Finkelstein; Trends in Capability of Hospitals to Provide Definitive Acute Care for Children: 2008 to 2016. Pediatrics January 2020; 145 (1): e20192203. 10.1542/peds.2019-2203.
3. Horak, Robin V., et al. "Growth and changing characteristics of pediatric inten2sive care 2001–2016." Critical care medicine 47.8 (2019): 1135-1142.

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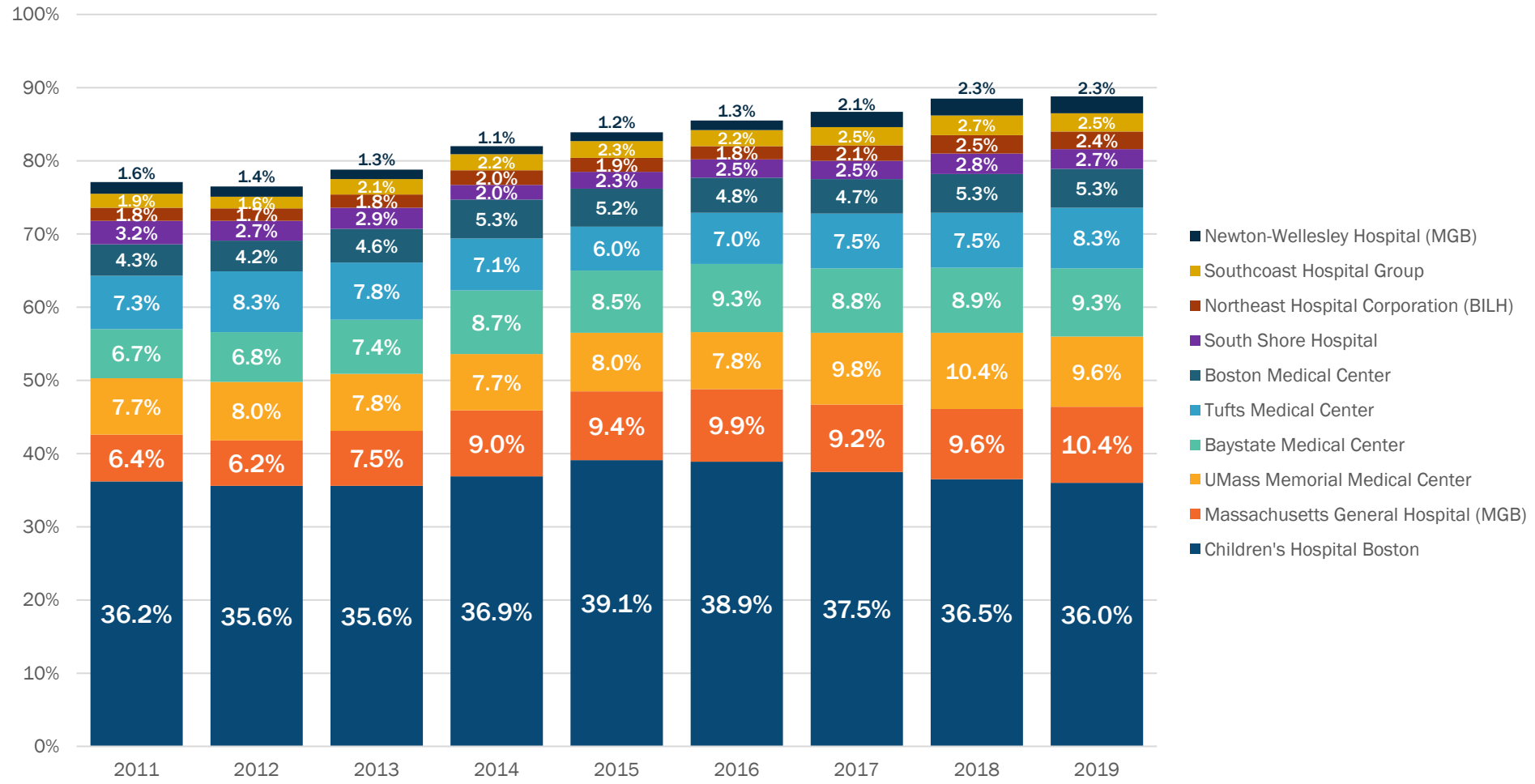
Pediatric inpatient care has become more concentrated at those hospitals with the highest pediatric volume.

All-Payer Shares of Pediatric Discharges in Massachusetts



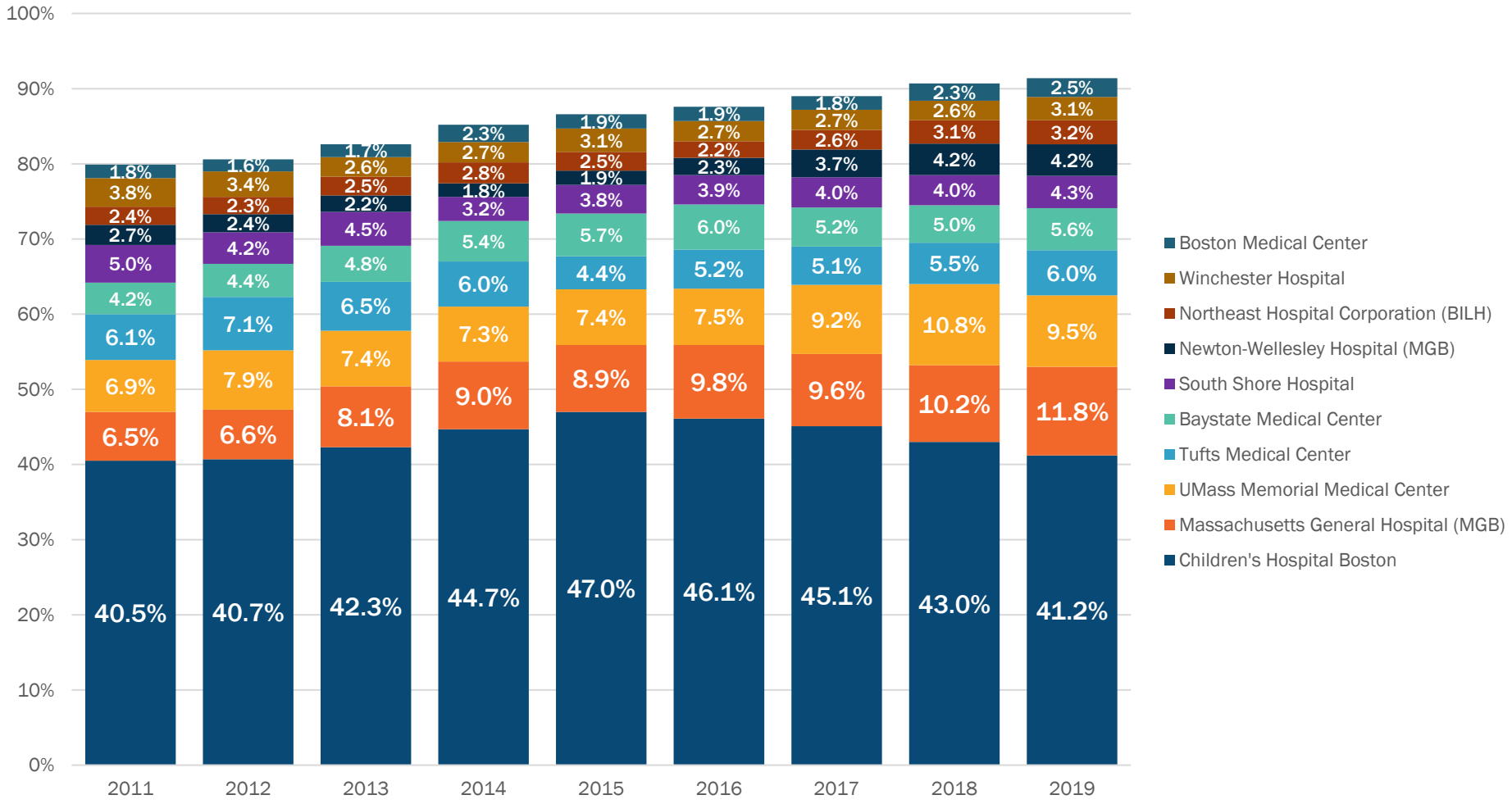
The **5 hospitals** with the most pediatric discharges **accounted for 73.6%** of pediatric discharges in 2019, up from 64.2% in 2011.

Hospitals **owned by or clinically affiliated with MGB or Children's** accounted for **68.6%** of pediatric discharges in 2019.

Notes: Excludes discharges for patients age 18 and older; residing outside of Massachusetts; with primary DRG in MDCs 14, 15, 19, or 20; or with length of stay greater than 180 days.
Source: HPC analysis of CHIA hospital discharge database

The largest pediatric hospital providers have an even larger share of commercial pediatric patients, and their share has grown over time.

Shares of Commercial Pediatric Discharges in Massachusetts



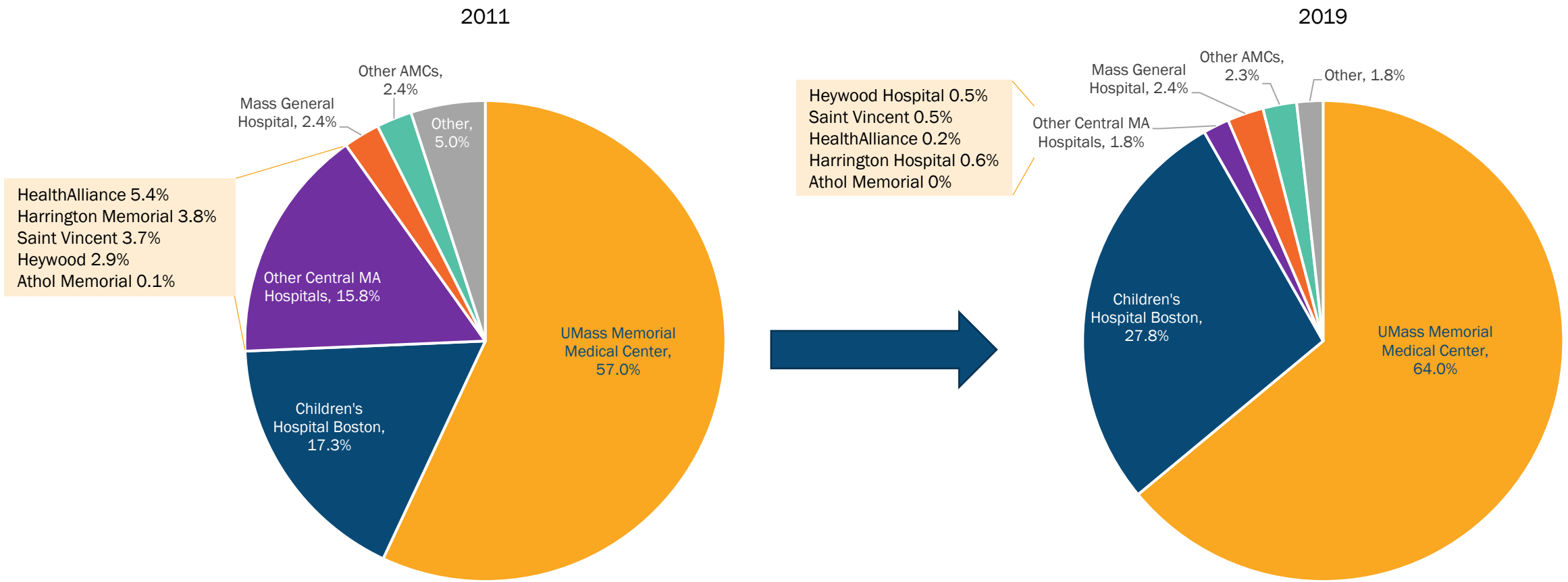
The **5 hospitals** with the most commercial pediatric discharges **accounted for 74.1%** of commercial pediatric discharges in 2019, up from 64.2% in 2011.

Hospitals **owned by or clinically affiliated with MGB or Children's** accounted for **77.3%** of commercial pediatric discharges in 2019.

Notes: Excludes discharges for patients age 18 and older; residing outside of Massachusetts; with primary DRG in MDCs 14, 15, 19, or 20; or with length of stay greater than 180 days.
Source: HPC analysis of CHIA hospital discharge database

Example of increasing consolidation: Commercial pediatric patients in Central Massachusetts have shifted toward larger hospitals over time.

Share of Commercial Pediatric Discharges for Patients Living in Central MA

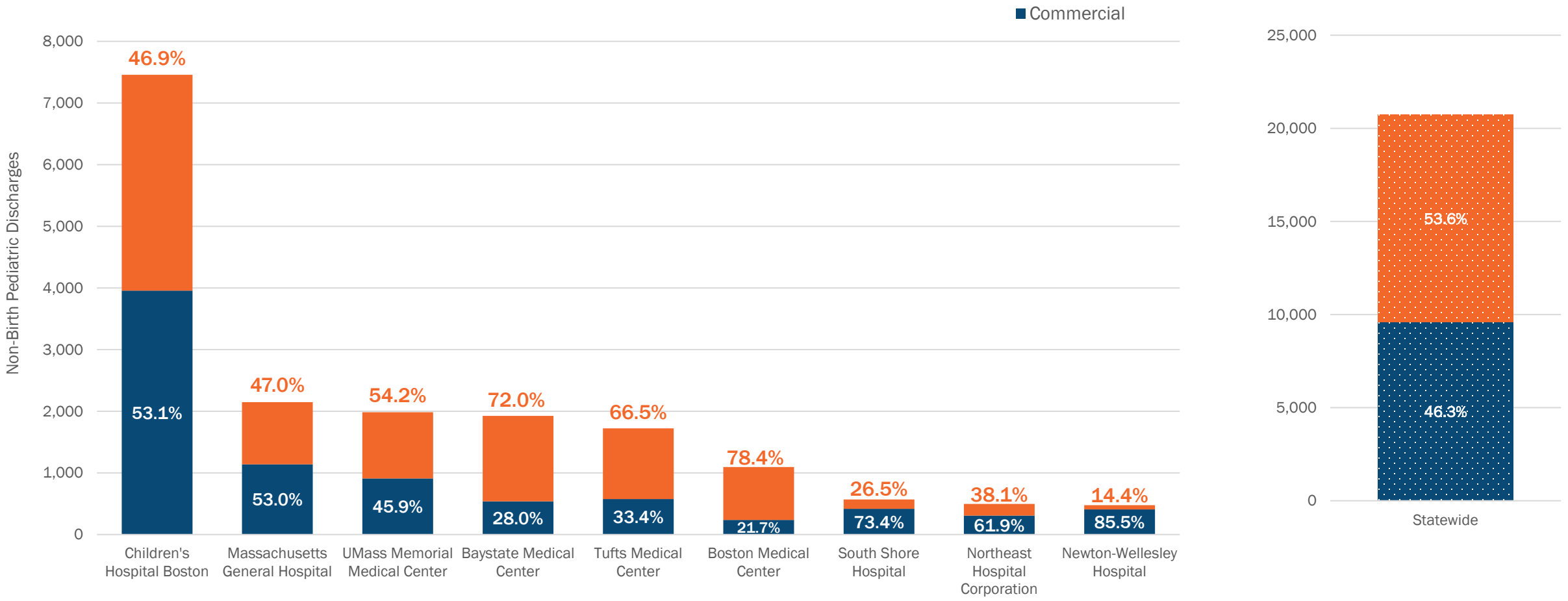


Notes: Excludes discharges for patients age 18 and older; residing outside of Massachusetts; with primary DRG in MDCs 14, 15, 19, or 20; or with length of stay greater than 180 days. Includes only residents of the Central Massachusetts HPC region. See Mass. Health Policy Comm'n, 2013 Cost Trends Report Pursuant to M.G.L. c. 6D, § 8(g): July 2014 Supplement Technical Appendix B3 (Jul. 2014), available at https://www.mass.gov/doc/b3-regions-of-massachusetts/download.

Source: HPC analysis of CHIA hospital discharge database

Many of the largest pediatric hospital providers also tend to have higher commercial payer mix for pediatric discharges than the statewide average.

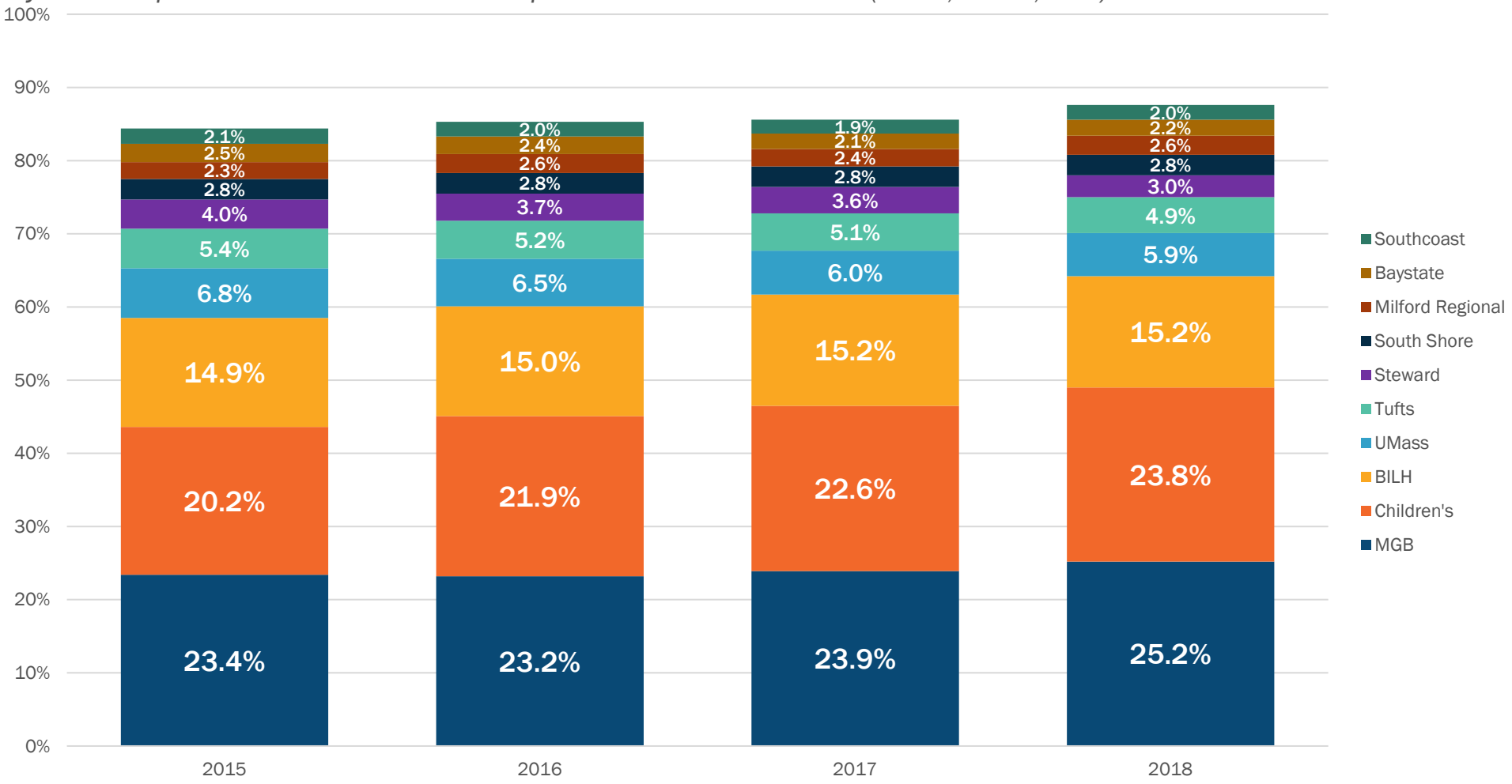
Payer Mix for Non-birth Pediatric Inpatients from Massachusetts at Top Ten Pediatric Hospitals (2019)



Notes: Excludes discharges for patients age 18 and older; residing outside of Massachusetts; with primary DRG in MDCs 14, 15, 19, or 20; Excludes Southcoast discharges due to data anomalies
Source: HPC analysis of CHIA hospital discharge data

Commercial pediatric outpatient care is also increasingly concentrated in a few provider systems.

System Hospital and ASC Commercial Outpatient Visit Shares for MA (BCBS, HPHC, THP)

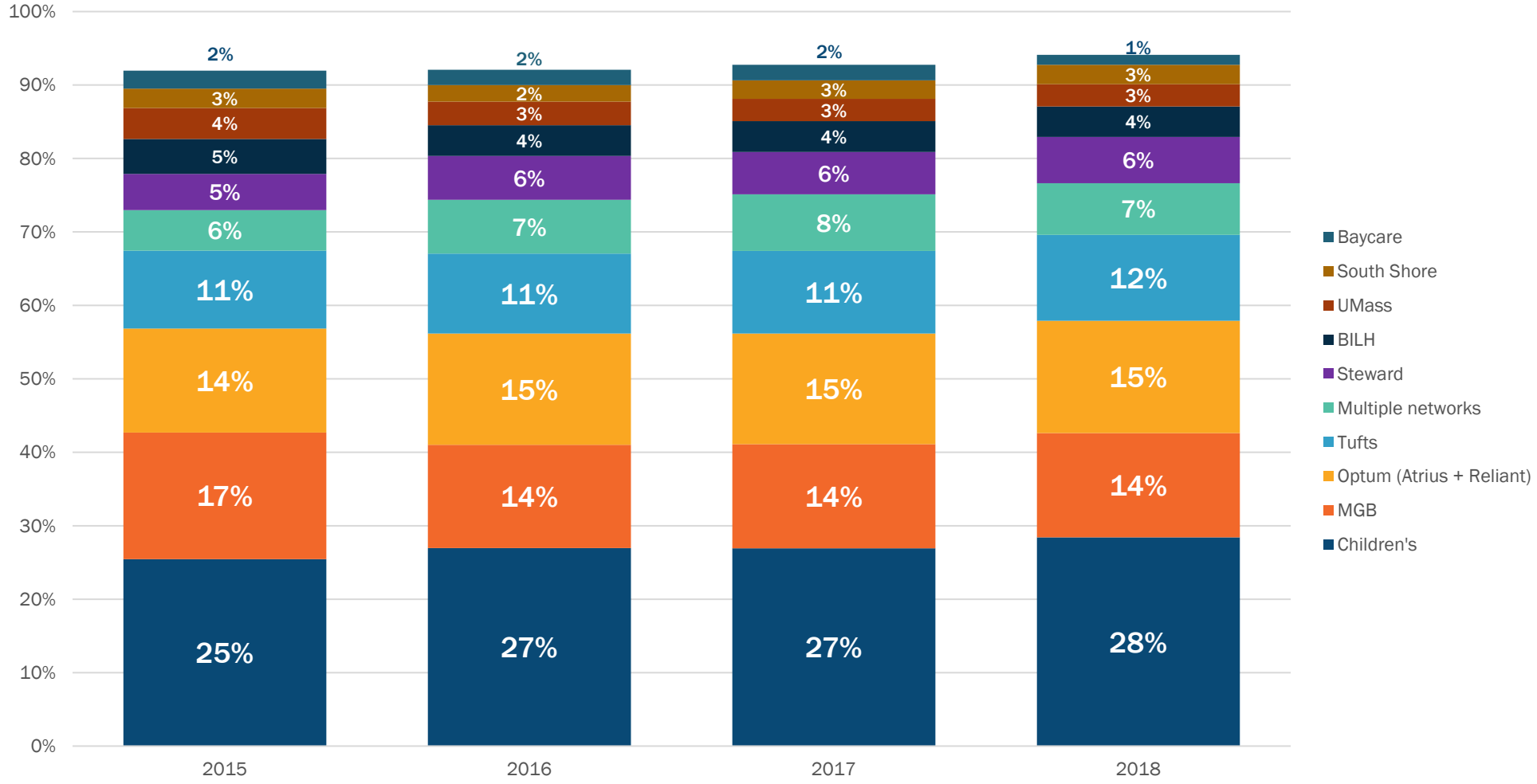


Notes: Reflects outpatient shares for each system for outpatient facility (HOPD and ASC) visits. The HPC defines all services rendered to a patient on a given day at a single institution as one visit.
Source: HPC analysis of APCD 8.0

The **5 systems** with the most commercial pediatric outpatient visits **accounted for 75%** of commercial pediatric outpatient visits in 2019, up from 70.7% in 2015.

Several large physician networks deliver a majority of commercial pediatric primary care services.

System Shares of Commercial Pediatric Primary Care Visits (BCBS, HPHC, THP)



Notes: Reflects shares of visits for each system for pediatric primary care services. The HPC defines all services rendered to a patient on a given day at a single institution as one visit.
Source: HPC analysis of APCD 8.0

The **4 systems** with the most commercial pediatric primary care visits **accounted for 70%** of commercial pediatric primary care visits in 2019, up from 67% in 2015.

Pediatric care will likely continue to consolidate as a result of recent market changes.

- Pediatric care in Massachusetts was already highly concentrated.
  - For example, in 2019, the Herfindahl-Hirschman Index (HHI) for inpatient pediatric care in Boston Children Hospital's primary service area, which constitutes much of eastern Massachusetts, was over the 2500 threshold that constitutes a "highly concentrated" market.
- But the market has continued to evolve since that time. In just the past year:
  - Tufts Medical Center closed 41 pediatric beds;
  - Children's established a new clinical affiliation with Tufts Medicine;
  - Children's acquired Franciscan Hospital for Children;
  - Children's has begun to open beds in a new clinical tower on its Longwood campus; and
  - Children's has been approved to expand outpatient hospital sites around Boston
- Each of these changes will likely result in additional patients seeking pediatric care at Children's, with the closure of Tufts pediatric beds also likely to shift some patients to MGH.

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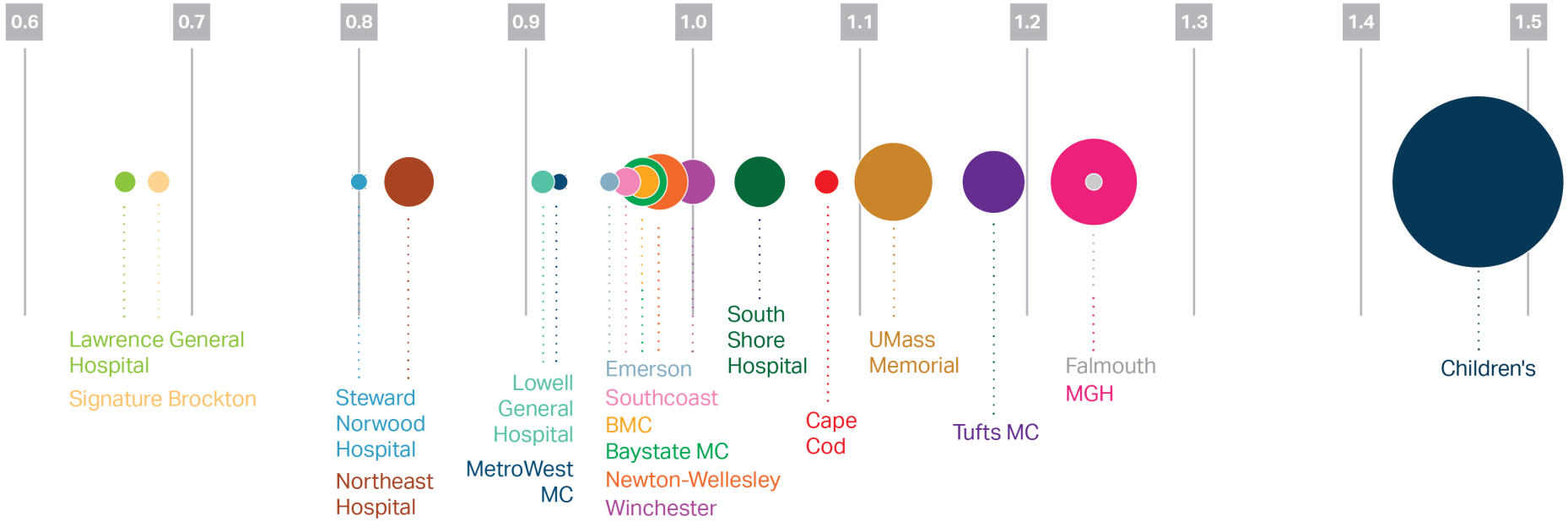
The largest providers of hospital-based pediatric care in the Commonwealth have the highest inpatient commercial prices, even after adjusting for differences in patient acuity.

Acuity-Adjusted Commercial Hospital Prices per Pediatric Discharge Relative to Sample Average (2018)

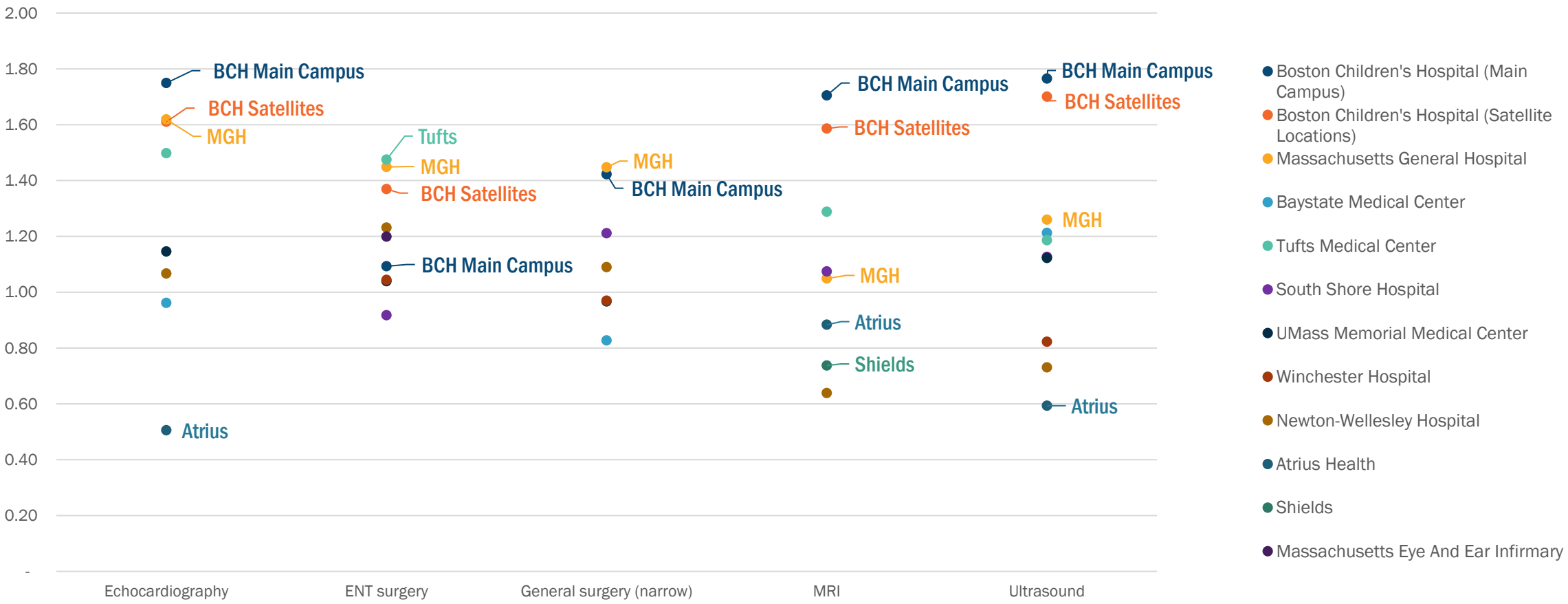


Source: HPC analysis of 2018 APCD and 2018 CHIA hospital discharge database.
Notes: Average revenue per discharge for patients under age 18, adjusted by MS-DRG and APR-DRG weights, compared to average among sample hospitals, weighted by mix of pediatric discharges across BCBS, HPHC, and THP. Excludes MDCs 14 and 15 and DRG 999. Excludes hospitals with <11 discharges total across the three payers included. Excludes specialty behavioral health, rehabilitation, and service-specific hospitals.

- The HPC used claims data to examine average prices per discharge for pediatric patients.
- To compensate for differences in patient acuity among hospitals, we adjusted prices using reported diagnosis codes.
- Prices shown are relative to the average price among the sample hospitals. The size of each hospital's point corresponds to volume.

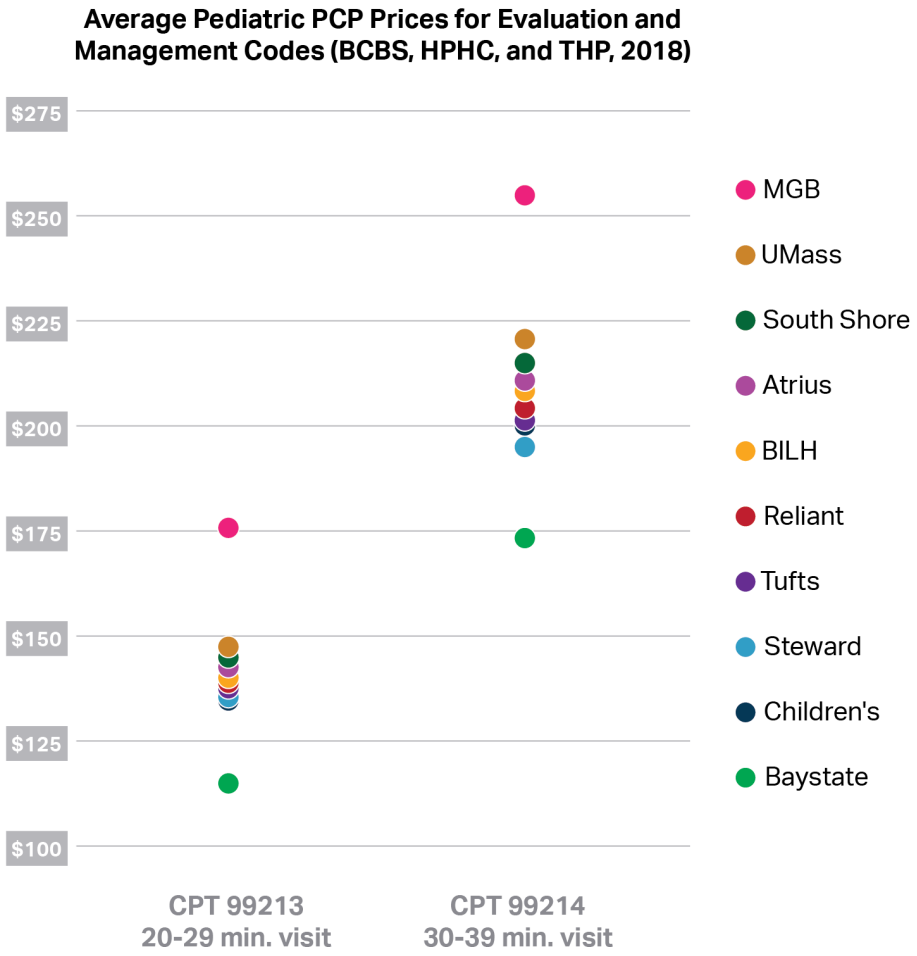
Although prices for outpatient pediatric services vary by service type, the largest pediatric providers tend to receive high commercial prices relative to others.

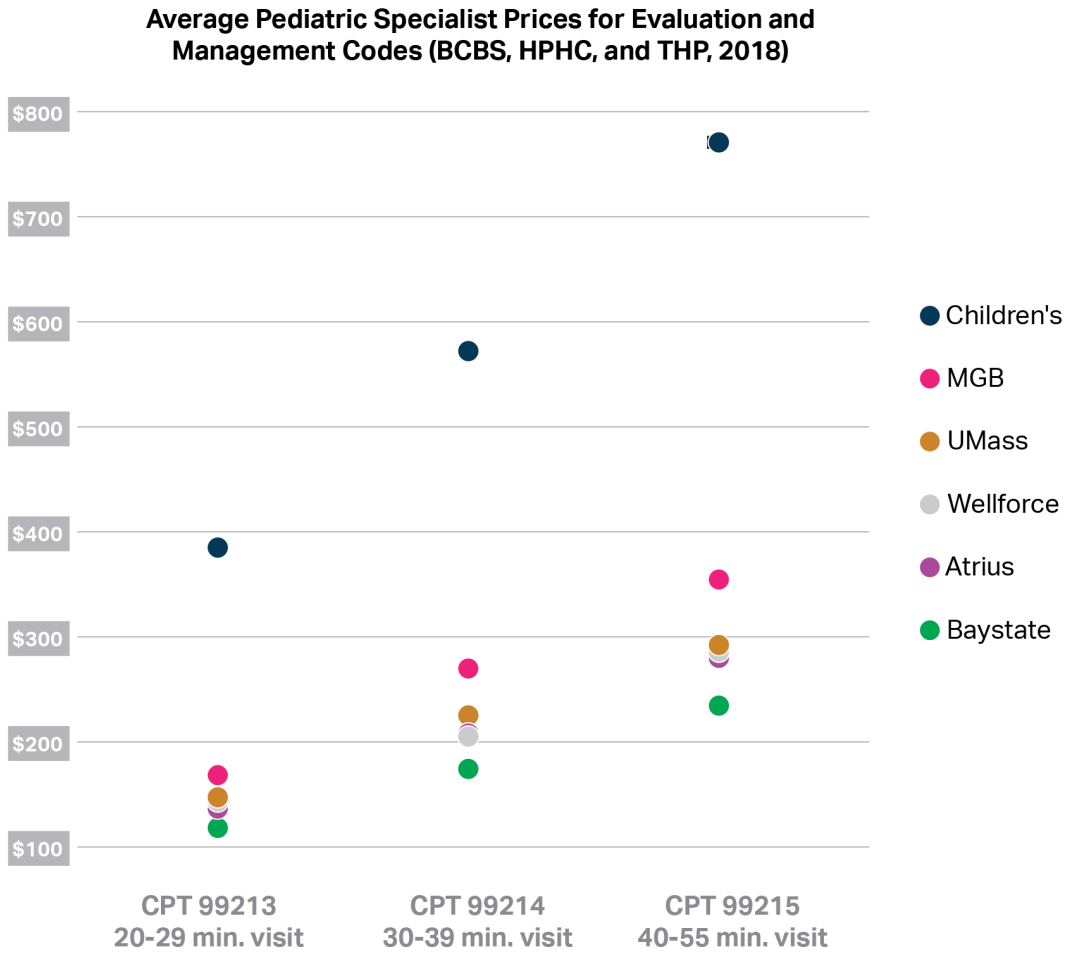
Outpatient Prices by Service Cluster for Top Pediatric Providers Relative to Payer Network Average (BCBS 2018)



Source: HPC analysis of 2018 APCD
Notes: Excludes patients age 18 or older. The HPC defined service clusters composed of clinically related CPTs. Relative prices are based on facility and professional allowed amounts for CPTs in each cluster. Limited to fee-for-service BCBS episodes of care with a facility or non-person professional claim.

Prices for clinic-based evaluation and management services for pediatric patients vary somewhat, with some outliers among the largest pediatric providers.





Source: HPC analysis of 2018 APCD and 2018 RPO.
Notes: Includes BCBS, HPHC, and THP claims only. Average revenue per CPT in clinic office site of service for patients under age 18. Specialist prices exclude psychiatry. CPTs shown represent highest-volume E&M codes overall.

The largest pediatrics providers serve many medically complex children but have higher annual spending per patient for non-medically complex pediatric patients.

Prevalence and Annual Spending for Commercially-insured Children with and without Medical Complexities by Provider Organization (2018)

	Number of Children w/medical complexities (CMC)	Number of Non-CMC	% CMC
Children's	2,434	42,552	5.4%
MGB	1,553	31,011	4.8%
Wellforce	1,005	23,129	4.2%
Atrius	1,010	21,741	4.4%
Steward	574	13,418	4.1%
UMass	396	9,238	4.1%
Lahey	263	6,365	4.0%
Baystate	220	5,837	3.6%
Reliant	224	5,434	4.0%
BIDCO	220	4,838	4.3%
South Shore	220	4,509	4.7%

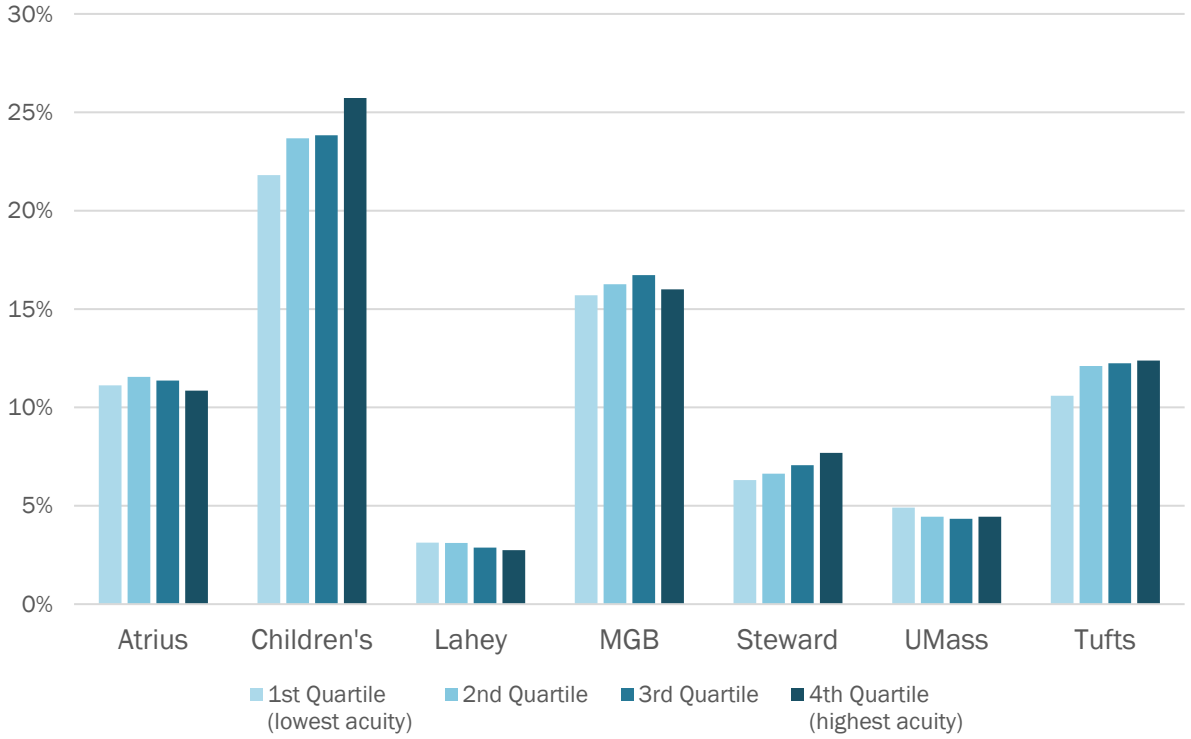
	CMC spending (Mean)	CMC spending (Median)
UMass	$37844	$17243
Steward	$34651	$13435
Children's	$31599	$14145
Atrius	$30192	$13479
Reliant	$30020	$16191
Wellforce	$29349	$13908
South Shore	$29075	$13616
Lahey	$28993	$15951
Baystate	$28927	$14829
MGB	$28798	$14121
BIDCO	$27380	$14265

	Non-CMC spending (Mean)
MGB	$1872
Children's	$1834
South Shore	$1739
Lahey	$1671
Wellforce	$1658
Steward	$1647
BIDCO	$1644
Atrius	$1543
UMass	$1520
Reliant	$1518
Baystate	$1343

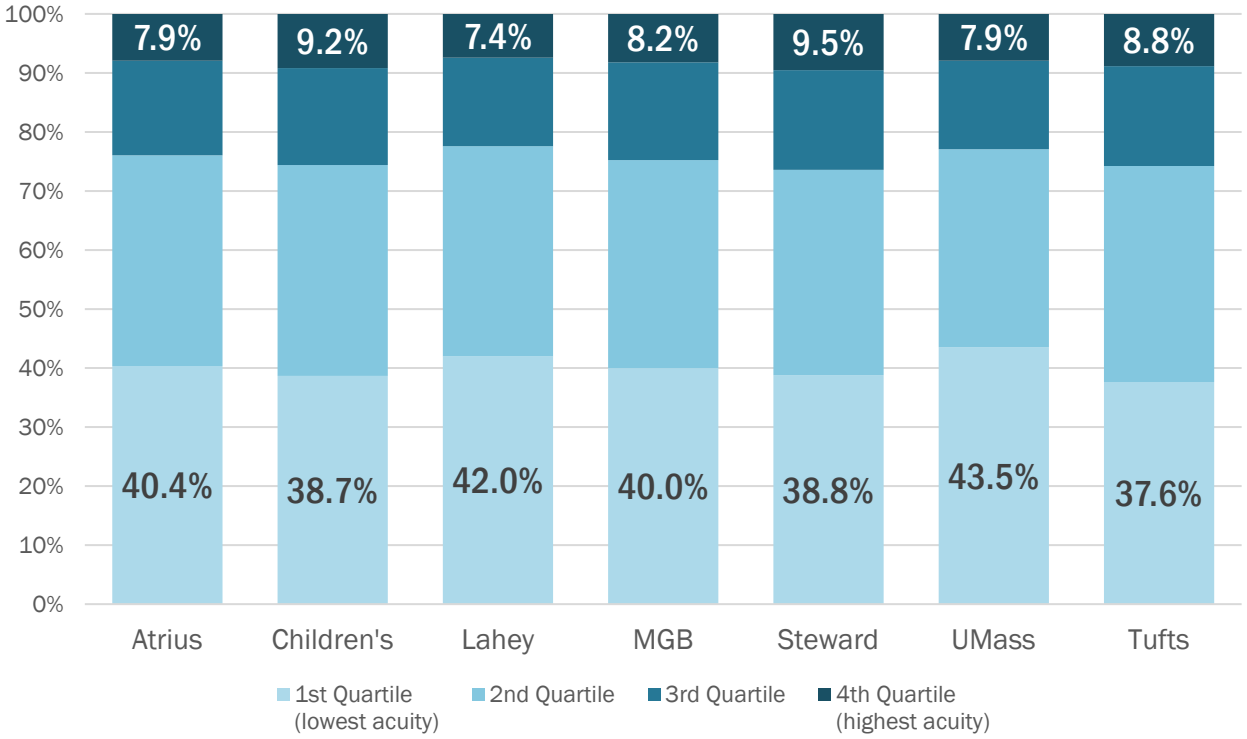
Notes: See more at Mass. Health Policy Comm'n., Children with Medical Complexity in the Commonwealth (Feb. 2022), *available at* https://www.mass.gov/doc/children-with-medical-complexity-in-the-commonwealth/download. Excludes provider groups with <100 lives in observed in 2018. Mean and median spending reported for CMC due to outliers.
Source: HPC analysis of All-Payer Claims Database 8.0.

The two largest pediatrics providers have high shares of high-acuity pediatric primary care patients, but the overall proportion of high-acuity pediatric patients is similar across the largest pediatric provider networks.

Market Share of Attributed Commercial Pediatric Patients by Risk Quartile



Percentage of Attributed Commercial Pediatric Patient Population by Risk Quartile



Notes: Patients with missing or unattributed primary care providers excluded. Acuity quartiles based on processing by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved. Acuity quartiles do not align with the HPC's definition of children with medical complexities.
Source: HPC analysis of All-Payer Claims Database 8.0.

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Large, highly specialized pediatric providers may offer benefits in terms of quality and access to services. Consolidation of services at these providers requires consideration of access and affordability impacts.

The largest pediatric providers in the commonwealth have invested in developing their services and clinical networks and are proposing additional investments that could improve access to certain types of pediatric care.

The Commonwealth's largest pediatric provider systems provide high-quality care. Research indicates that there are likely some quality benefits of concentrating pediatric care at specialist provider systems, especially for patients with rare diagnoses, those requiring high-acuity care, and those in need of specialized equipment or services designed for children.[1]

However, consolidation of services may also pose access challenges for pediatric patients and their families[2] as well as affordability challenges. Provider organizations, community advocates, and the Commonwealth have an opportunity to work closely to identify community needs and ensure appropriate distribution and affordability of pediatric services.

1. *See, e.g.*, Craig Newguard at al., JAMA Pediatrics, Evaluation of Emergency Department Pediatric Readiness and Outcomes Among US Trauma Centers (Sept. 2021), *available at* https://pubmed.ncbi.nlm.nih.gov/34096991/ (finding lower incidence of mortality for pediatric patients, especially those with severe trauma, treated at hospitals with high ED pediatric readiness scores).
2. *See, e.g.*, Urbano França and Michael McManus, JAMA Pediatrics, Availability of Definitive Hospital Care for Children (Sept. 2017), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6583506/ (finding that the likelihood that a Massachusetts hospital could complete a pediatric patient's care without a transfer declined from 2004 to 2014, with almost all of the shift from nonacademic to academic hospitals).

Presentation Outline

1. Background: A Changing Pediatric Services Landscape
2. Analysis: Pediatric services in the Commonwealth are concentrated at two provider systems and have become more concentrated.
3. Analysis: The largest providers of pediatric services have high commercial prices and spending relative to other providers.
4. Analysis: Recent changes create opportunities for improving access and quality, but also pose challenges, including to affordability.
5. **Discussion: How to promote affordable access to high-quality pediatric care in a changing and increasingly concentrated market.**

The HPC will continue to study the pediatrics market and consider how to promote access to affordable, high-quality pediatric care.

Pediatric services are an important component of the provider landscape in the Commonwealth. The HPC's analyses indicate substantial changes in the pediatrics market, including:

- declining inpatient volume;
- increasing concentration at larger provider systems, especially of commercial pediatric patients; and
- provider price variation, with larger providers tending to have higher commercial prices.

Some of these trends are similar to trends in adult care and align with trends in pediatric care nationwide.

Policymakers, provider organizations, and other stakeholders must consider how to best promote access to affordable, high-quality pediatric care, including the extent to which the HPC's recommendations in its annual Cost Trends Report may address these goals.

The HPC will continue to develop analyses to enhance understanding of the pediatric market and plans to publish a policy brief in early 2023.

Agenda

Call to Order

Approval of Minutes (VOTE)

Market Oversight and Transparency

- Material Change Notices
- Changes in the Pediatric Market in Massachusetts

USE AND IMPLICATIONS OF RISK ADJUSTMENT IN MASSACHUSETTS

Executive Director's Report

Schedule of Upcoming Meetings

Executive Session (VOTE)

Presentation Outline

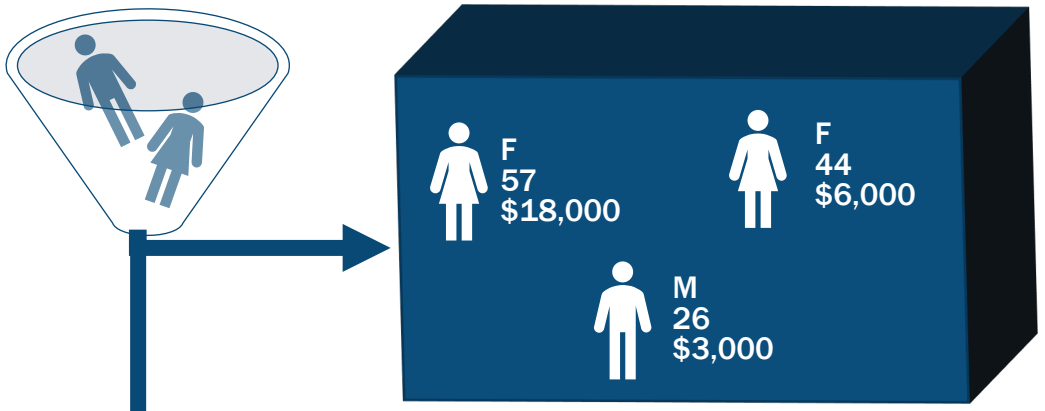
1. **HPC: Background, Current Use, and Challenges with Risk Adjustment**
2. AGO: Presentation of 2022 AGO Cost Trends Report
3. HPC: Policy Considerations

What is risk adjustment?

- **Risk adjustment (or health status adjustment)** is a process whereby a payment, quality, or performance measure is modified (typically multiplied or divided) by a **risk score**.
- A **risk score** is an estimate of **how much it will cost to care for a patient** based on their underlying characteristics relative to a population average. Risk scores are typically derived from equations that relate health care expenditures to patient characteristics using **health care claims data**.
- Risk scores have been used for decades by **private insurers to help set future premiums**.
- In recent years, policymakers and payers have used risk scores in different ways **in an attempt to solve problems in health care policy and payment**.

How is a risk score derived?

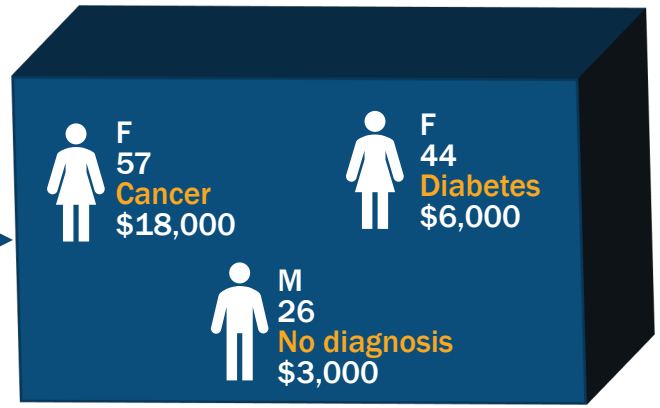
Insurance claims data



Age/sex-based risk model

Factor	Additional cost
Age	$100 per year of age
Gender	$1,000 higher for females

Adding diagnoses improves the model's predictions of who will cost more.



Age/sex/diagnosis-based risk model

Factor	Additional cost
Age	$100 per year of age
Gender	$1,000 higher for females
Diabetes	$3,000

*The risk score is the **sum** of an individual's factors expressed relative a population average of 1.0.*

Use of Diagnosis-based Risk Scores to Solve a Policy Problem: Medicare Advantage

Medicare Advantage (MA) was established in 1997 as a privately managed Medicare alternative. Private insurers were paid a **fixed amount** to provide all care for a Medicare beneficiary in a given year.

At first, the amount was set to **95%** of what a given beneficiary was expected to have cost Traditional Medicare.

- *Payments were adjusted by age, sex, institutional status*

Analysts found that **Medicare Advantage plans were enrolling healthier beneficiaries** (on average) and therefore earning excessive profits. In other words, *the 95% payment was still more than needed to cover care costs.*

In response, policymakers sought to better match payments with care costs **(i.e. to not reward plans who enroll healthier beneficiaries or penalize those who enroll sicker beneficiaries).** They did this by incorporating patient diagnoses into the formula used to pay MA plans, i.e. ***diagnosis-based risk adjustment***.

Diagnosis-based risk scores were subsequently widely adopted in other health care contexts.

- **By 2007 (after a 3-year phase-in), payments to Medicare Advantage plans were proportionally risk-adjusted using CMS' Hierarchical Conditions Category risk adjustment model.**
  - **Annual payment = risk score * base dollar amount (e.g. $10,000).** If a diagnosis of diabetes increases the risk score from 1.0 to 1.3, the plan receives an additional $3,000 for enrolling this individual.
  - CMS also made it more difficult for enrollees to switch plans mid-year
  - Evidence suggests this combination of changes reduced selective enrollment behavior of plans by roughly 5-10%.
- **Diagnosis-based risk adjustment soon became widely adopted throughout health care.**
  - **Commercial payers** use risk adjustment in global budget targets (e.g. BCBS Alternative Quality Contract, 2008)
  - **Medicare ACOs** (2010) use risk-adjusted spending targets, but don't pay for risk score increases > 3%*
  - **ACA exchanges** are required to transfer money from plans with lower risk scores to plans with higher risk scores
  - **Quality and performance measures** often use risk-adjusted metrics under the premise that risk scores reflect underlying health status
    - The Medicare hospital readmissions reduction program
    - HPC Performance Improvement Plan thresholds for referral
  - Relatedly, the original **DRGs** used in Medicare FFS hospital payment were modified in 2007 (and adopted in the private sector) to include higher payments for patients coded with higher-severity diagnoses.

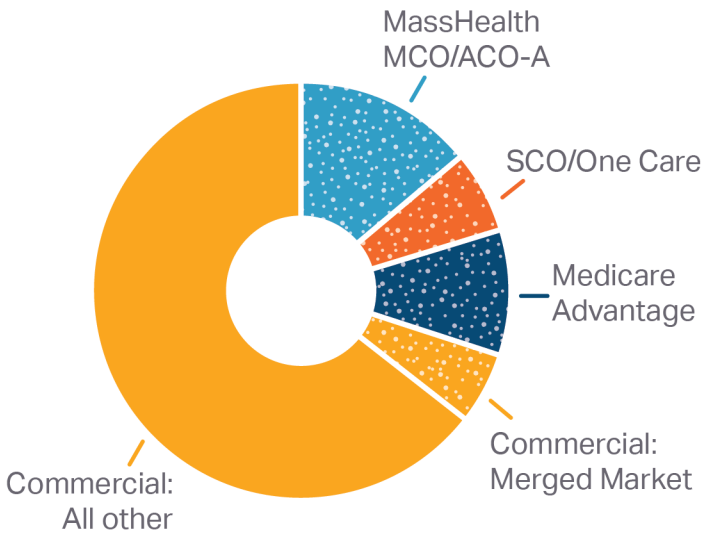
*Recently, CMS has proposed a slight modification to this formula in which payments for risk score growth would be capped at 3% over and above the change in demographic/administrative-based risk scores
McWilliams, J. Michael, John Hsu, and Joseph P. Newhouse. "New risk-adjustment system was associated with reduced favorable selection in Medicare Advantage." Health Affairs 31.12 (2012): 2630-2640

Diagnosis-based risk adjustment is used for payment purposes throughout the Massachusetts health care system.

Massachusetts insurer and provider revenue, and spending by category. Shaded areas indicate spending that is subject to diagnosis-based risk adjustment or is severity-adjusted

36%

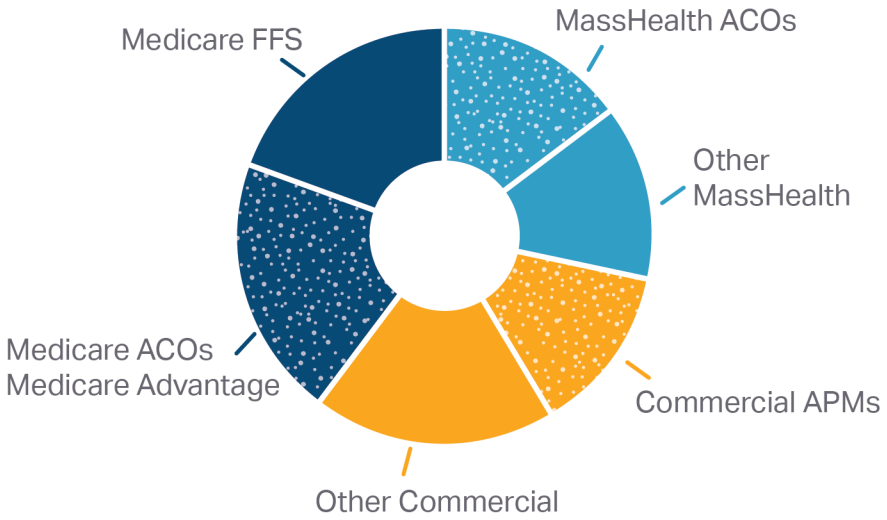
Commercial business subject to risk adjustment by government payers



Massachusetts commercial insurer revenue

48%

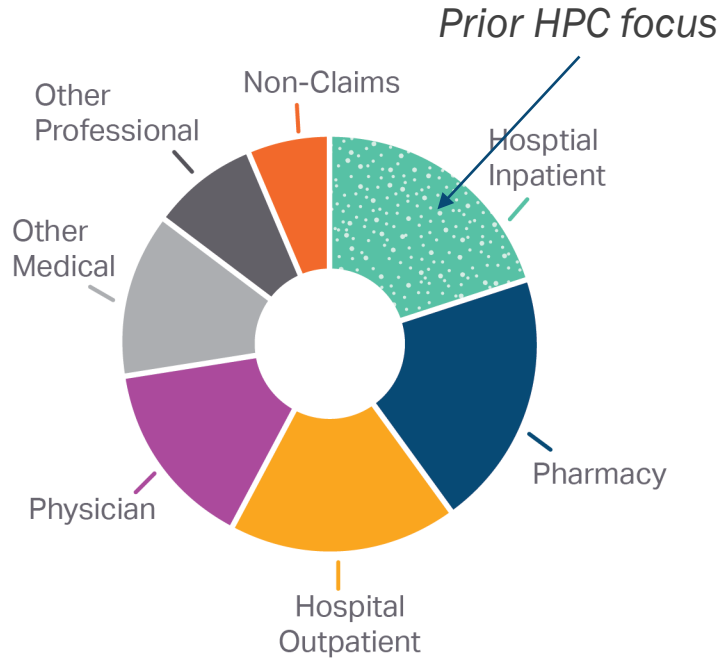
Provider revenue subject to risk adjustment from commercial or government payers



Massachusetts health care provider revenue

20%

Provider service categories subject to severity-adjusted payment



Massachusetts health care spending by category of care

Source: CHIA Annual Report, 2022; HPC Cost Trends Report, 2022

Challenges with Using Diagnosis-based Risk Adjustment for Payment or Performance Measurement

Diagnosis-based risk scores can be influenced by the entity subject to the risk adjustment.

- Risk scores are based on diagnosis codes recorded by providers with clinical discretion. Audits are limited tools for addressing abuses. Providers and payers (when subject to risk adjustment) are **increasingly adept** at recording diagnoses thereby raising risk scores.

The financial payoff from increasing risk scores under current payment formulas is large.

- Proportional risk adjustment to APM budgets generally means that a 1% increase in risk score provides the **same financial reward** as a 1% reduction in total spending.

Diagnosis-based risk adjustment does not necessarily improve health equity.

- The presence of claims-based diagnoses can reflect better access to care rather than true underlying disease burden or need.

The opportunity to increase revenue through increasing risk scores soon became clear to payers, providers and consultants.

Key Strategies Used by Medicare Advantage Plans

- **Nurse home visits** to identify diagnoses
- **Hire third-party consultants** to deploy clinicians to review medical records and document unrecorded diagnoses.
  - Typical ROIs can range from 6:1 to 30:1
- **Collaboration agreements with physicians** with financial incentives to increase risk scores ("pay for coding")

One recently published paper estimated that CMS overpayments to Medicare Advantage plans resulting from excessive risk score coding could reach $273 billion from 2017 – 2026.

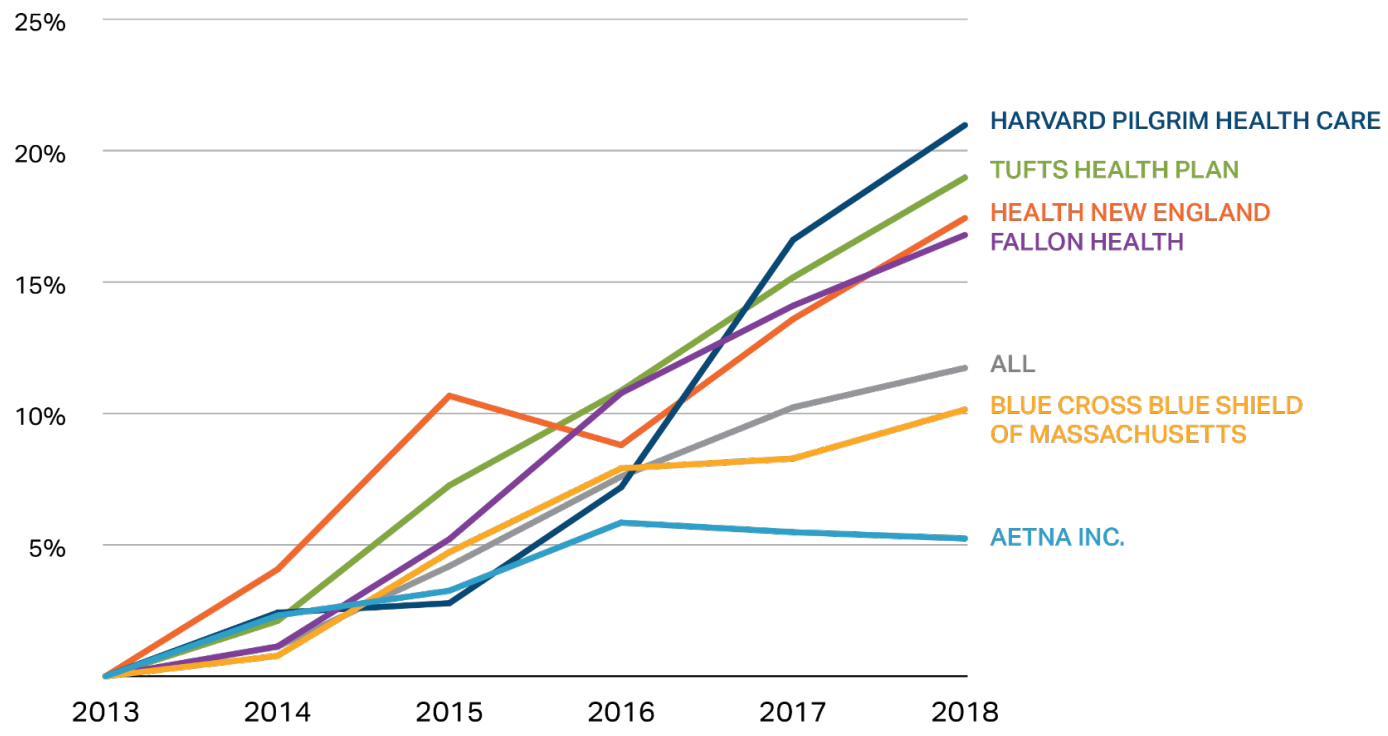
Key Strategies Used by Providers

- **Bonus payments** to physicians for coding more diagnoses
- **Leveraging EHRs**, with administrative prompts and consultant-led coding trainings

Sources: MedPAC reports to the Congress, March, 2018, p.371; March, 2021. p.378. https://www.medpac.gov/wp-content/uploads/2021/10/mar21_medpac_report_ch12_sec.pdf; Gilfillan, R., and D. Berwick. "Medicare Advantage, direct contracting, and the Medicare "money machine," Part 1: the risk score game." Health Affairs blog. Published September 29 (2021); Kronick, Richard. "Projected coding intensity in Medicare Advantage could increase Medicare spending by $200 billion over ten years." Health Affairs 36.2 (2017): 320-327; https://prospect.org/health/hospital-billing-crime-against-american-patients/;

Through this activity, risk scores have steadily increased in Massachusetts without a worsening in overall health status.

Change in average risk score for all members, by payer, 2013-2018

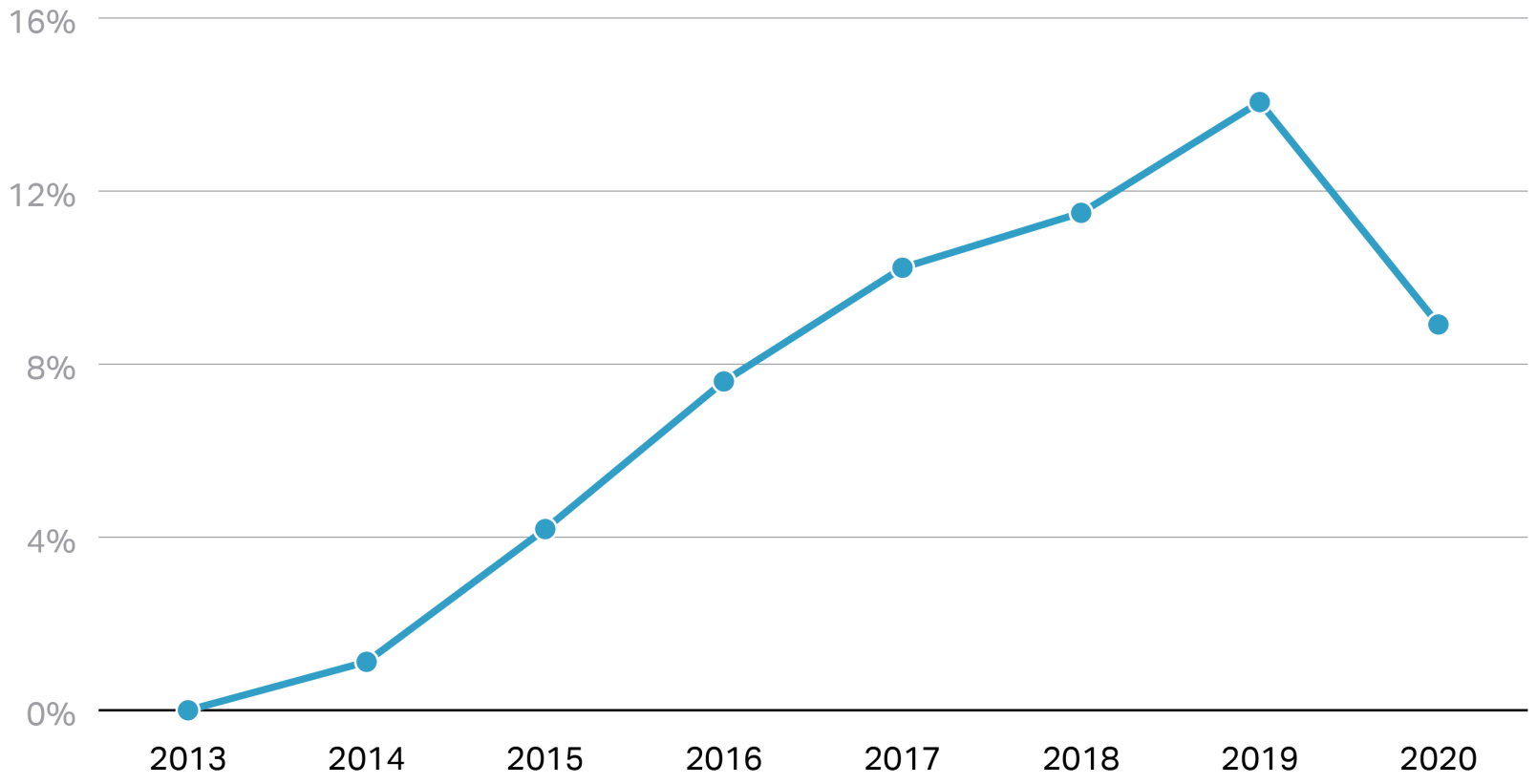


Notes: Risk scores normalized to 1.0 in 2013. United, Cigna, BMC Healthnet, Minuteman, NHP and Celticare excluded due to data anomalies or fluctuating membership.
Sources: CHIA TME databooks, 2016 and 2018. Federal Register vol 78 no. 47 March 11, 2013, Adult Risk Adjustment Model Factors. Burden of chronic disease analyzed using the CDC's BRFSS survey; Impact of population aging assessed using insurer demographic data combined with age/sex/spending profiles from the APCD. Additional data as reported in https://2020scorecard.commonwealthfund.org/files/Radley_State_Scorecard_2020.pdf

- The growth of risk scores from 2013-2018 is equivalent to 430,000 more privately-insured Massachusetts residents with complex diabetes or 920,000 more residents with cerebral palsy.
- Changes in the age-sex mix of the commercial population explains 0.5% of the 11.7% increase.
- No overall increase in underlying burden of chronic disease (BRFSS, 2013-6).
- Mortality amenable to health care decreased from 60.4 to 57.4 from 2012-3 to 2016-7.
- Adults reporting fair or poor health status remained 13% from 2014 to 2018.

Risk scores dropped in 2020 despite the onset of the COVID-19 pandemic.

Change in average risk score for all members, by payer, 2013-2020

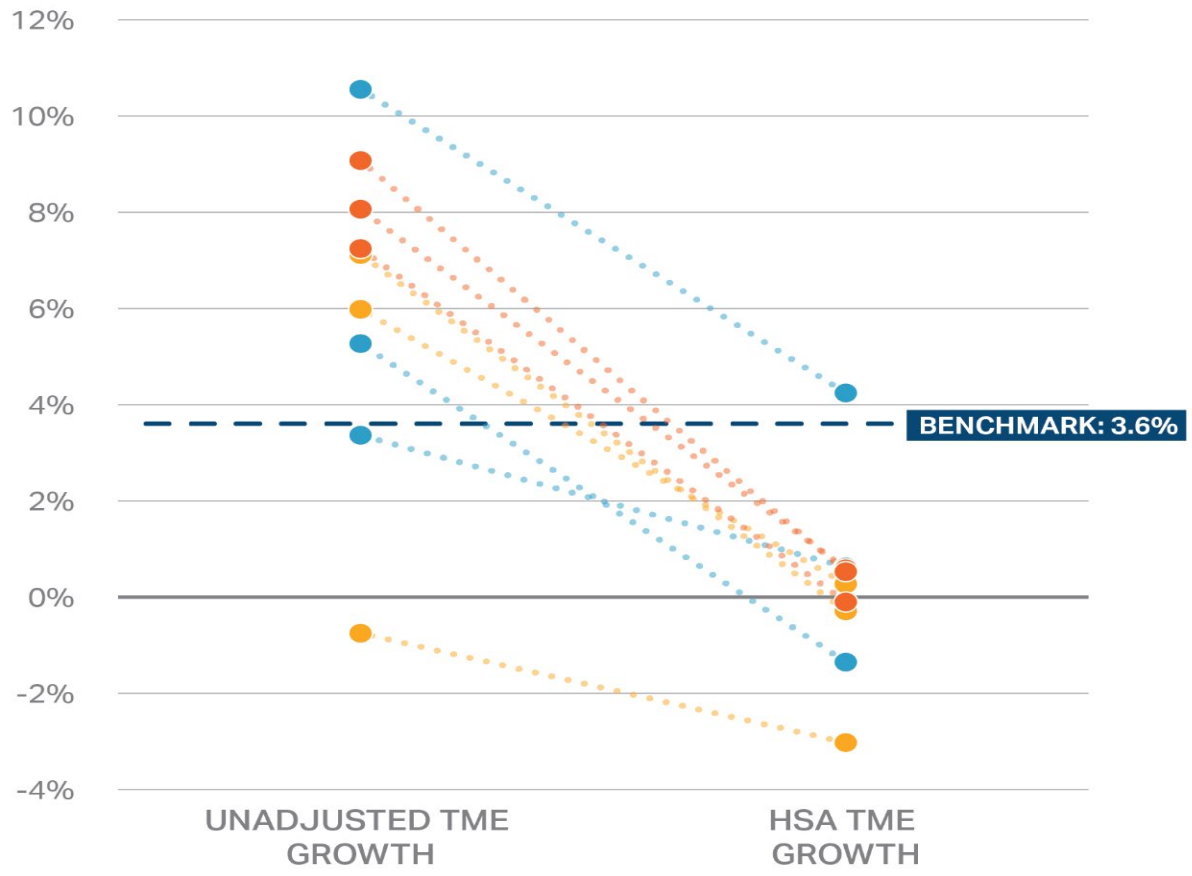


- Due to the pandemic, patient encounters with the health system fell. This led to fewer opportunities to record patient diagnoses, and thus, lower (healthier) risk scores.

Notes: Risk scores normalized to 1.0 in 2013. United, Cigna, BMC Healthnet, Minuteman, NHP and Celticare excluded due to data anomalies or fluctuating membership.
Sources: CHIA TME databooks, 2014-2022

Risk score growth has resulted in fewer referrals for payers and provider groups to to HPC's performance improvement plan process.

Percentage increase in unadjusted vs. health-status adjusted (HSA) TME for three large provider groups and the three major payers.

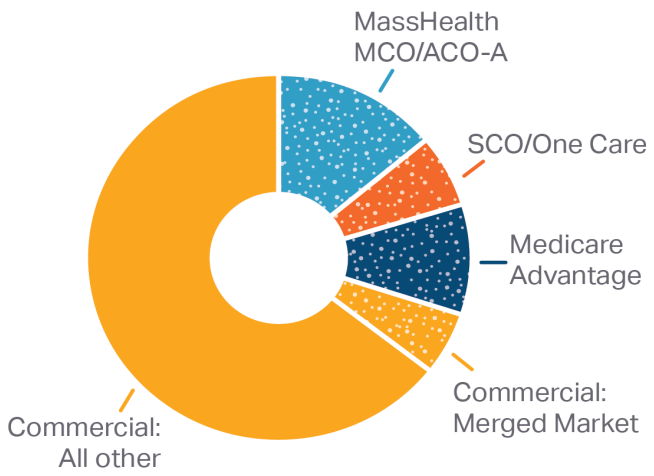


Notes: The number of referred contracts shown on this slide may not reflect the actual number of referrals as CHIA refers some contracts or books of business with HSA TME growth below 3.6% in accordance with its published referral methodology.
Sources: Center for Health Information Analysis

- For example, in one year, among 71 payer-provider contracts, unadjusted TME growth exceeded the benchmark for 47 (66%), but only 17 (24%) had HSA TME growth that exceeded the benchmark, triggering referral.
- The chart on the left shows this dynamic for a representative subset of providers and payers.

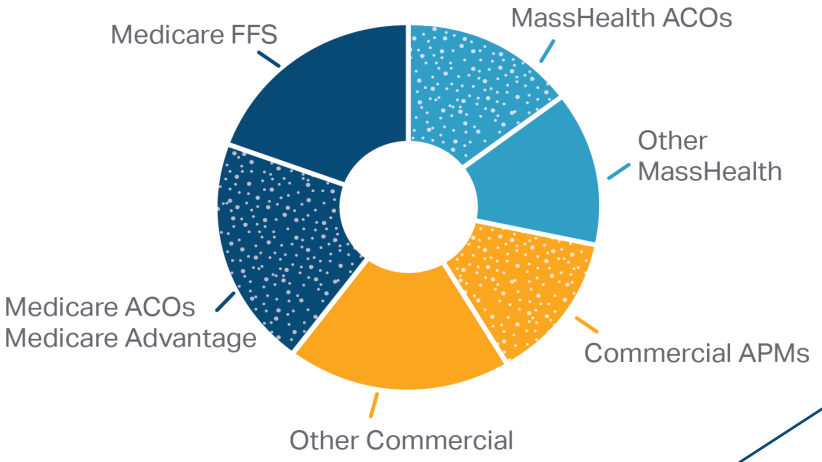
Increases in coded diagnoses can lead to higher coded inpatient acuity when patients are hospitalized.

36%
Commercial business subject to risk adjustment by government payers



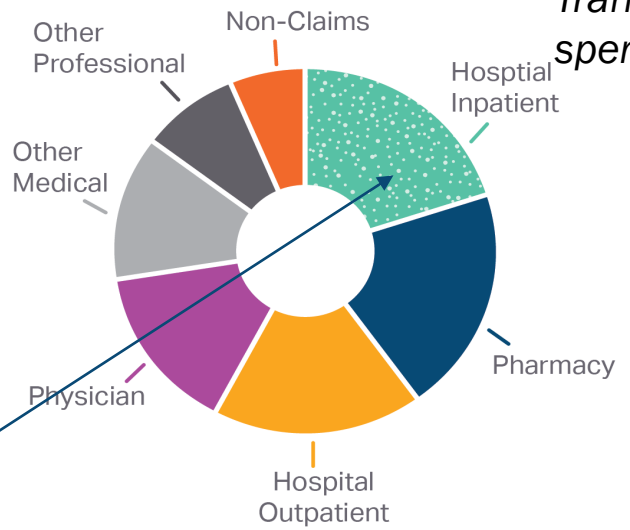
Massachusetts commercial insurer revenue

48%
Provider revenue subject to risk adjustment from commercial or government payers



Massachusetts health care provider revenue

20%
Provider service categories subject to severity-adjusted payment



Massachusetts health care spending by category of care

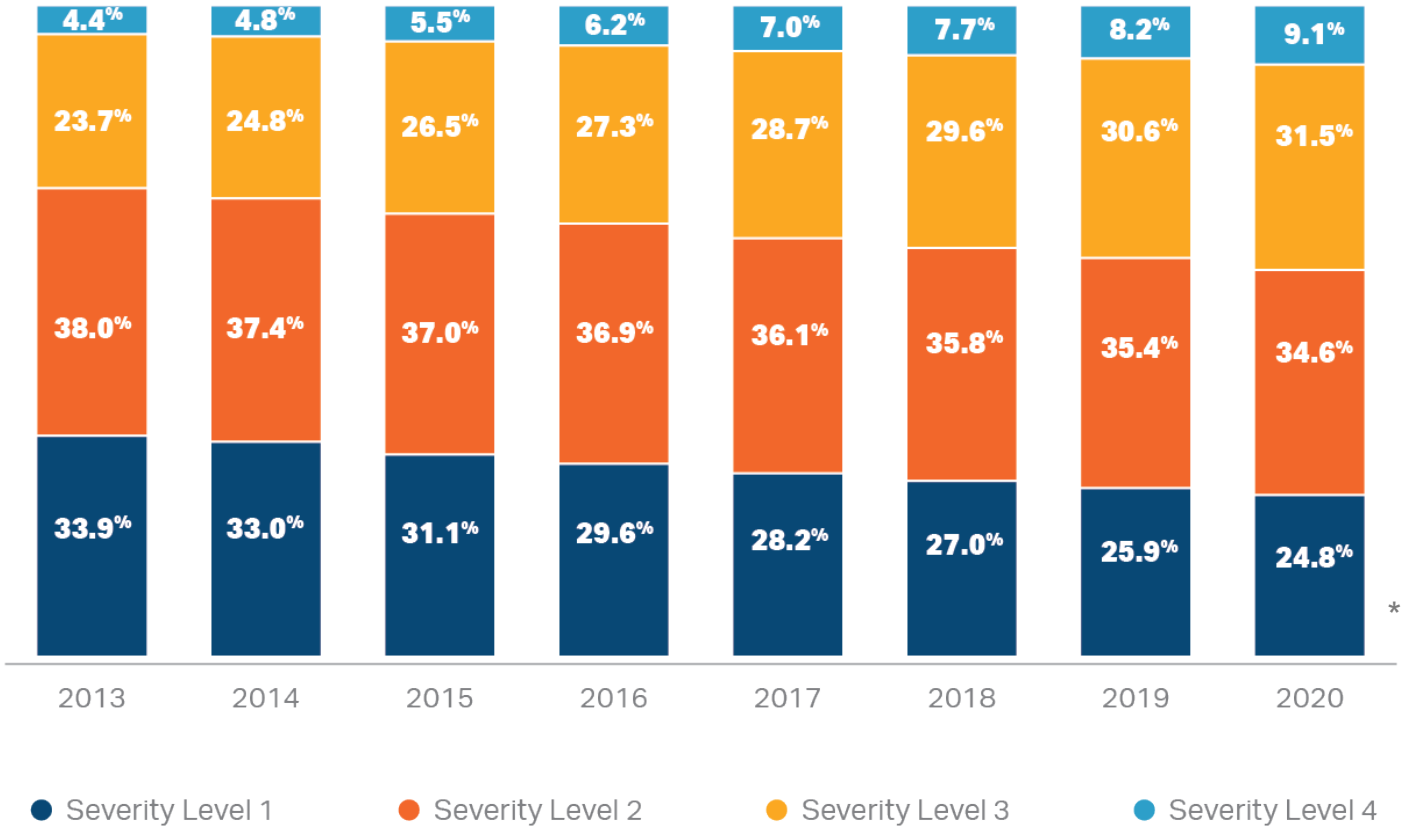
Translates to higher spending here

More coded diagnoses due to risk adjustment here…

CHIA Annual Report, 2022; HPC Cost Trends Report, 2022
https://www.mass.gov/doc/presentation-5112022-guest-presentation-brady-post/download

Severity level 4 admissions are paid $26,000 more than severity level 3, on average. Their proportion of inpatient admissions doubled from 2013 to 2020.

Change in number of hospital admissions (non-COVID) at each severity/complications level, 2013 to 2020



Notes: Level 1 is least severe and Level 4 is most severe. *COVID hospitalizations have been excluded from 2020 data. Spending amounts are based on MassHealth Rate Year 2019 payment levels and DRG weights not including hospital-specific multipliers and excluding outlier payments. These rates were applied to the full Massachusetts FY 2019 distribution of discharges across all payers. Data shown are for fiscal years. Certain discharges were excluded from the analysis including transfers, rehabilitation stays, those from Shriner's Hospital, patients who died in the hospital, those with LOS more than 5 times the median for the given DRG.
Sources: CHIA HIDD Acute Case-mix Database, 2013-2020; APR-DRG classification system

- Average spending per hospital admission at each severity level in 2019:
  - Level 1: $6,600
  - Level 2: $9,200
  - Level 3: $13,100
  - Level 4: $39,000

Providers in the United States spend far more on coding than providers in other high-income countries.

EXHIBIT 3

Billing and insurance–related costs in six countries, by activity category, derived from a time-driven activity-based costing study, 2018–20

SOURCE Authors' calculations based on data collected for the study from Australia, Canada, Germany, the Netherlands, and Singapore. US data (for 2017) are from Tseng P, et al. Administrative costs associated with physician billing and insurance–related activities at an academic health care system (see note 5 in text). **NOTES** Values are 2020 purchasing power parity–adjusted US dollars. Bills from Australia, Germany, and the US represent inpatient surgical bills; those from Singapore represent combined surgical and nonsurgical inpatient bills; those from Canada represent nonsurgical inpatient bills; and those from the Netherlands do not distinguish processes among surgical and nonsurgical billing. Coding in the Netherlands is done by physicians; procedure codes also serve as billing codes, so there is no need for a separate team of coders.

Richman, Barak D., et al. "Billing And Insurance–Related Administrative Costs: A Cross-National Analysis: Study examines health care billing and insurance related administrative costs across several countries." *Health Affairs* 41.8 (2022): 1098-1106.

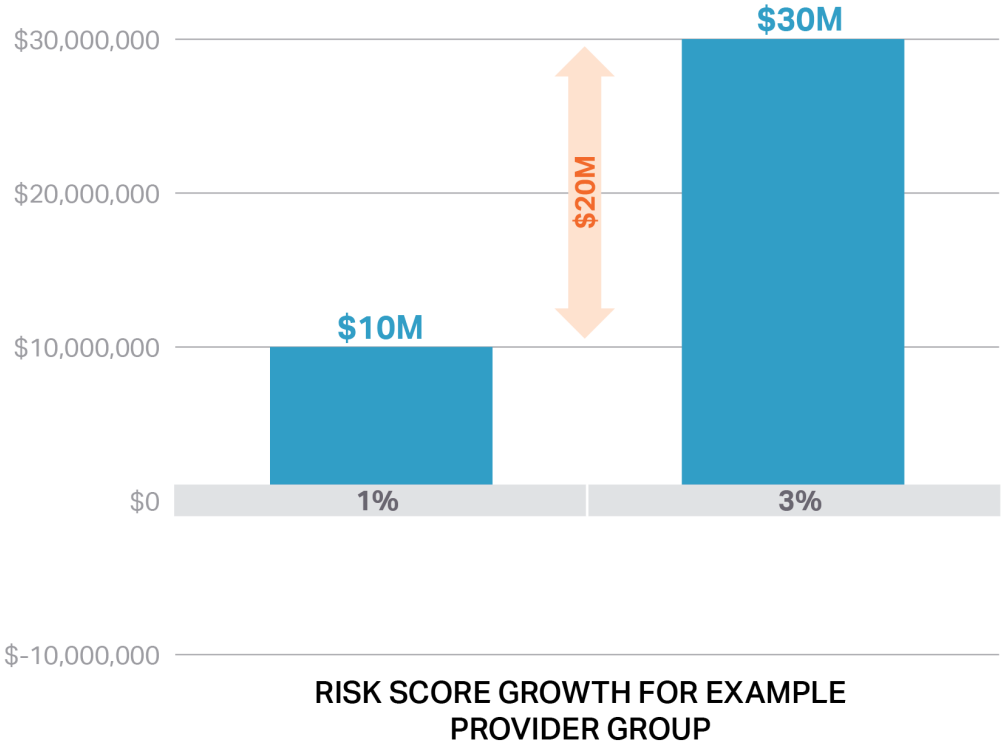
Normalization of risk scores in risk contracts likely intensifies the imperative to invest in coding.

- Payers typically **subtract market-wide risk score growth from all providers' global budget targets ("normalization")**.
- In the short run, the payer is insulated from paying out more $ due to overall rising risk scores.
- But this creates incentives for providers to record diagnoses as **their own shared savings payouts are reduced if other provider groups code more than they do**.
  - *Those with fewer resources to invest in coding can lose $ to those with more resources.*
- Short-term savings to payers from normalization may be offset by **higher inpatient spending** resulting from the additional diagnoses recorded in patients' medical records.

If a payer uses normalization, a provider group loses money if other groups code more than they do.

Shared savings payout for an example provider group with and without normalization.

Example: Each 1% of shared savings is worth $10m to the provider. Market-wide risk score growth = 2%



NO NORMALIZATION

NORMALIZATION

Average provider risk score growth = 2%
Payer subtracts 2% from all groups' targets

Presentation Outline

1. HPC: Background, Current Use, and Challenges with Risk Adjustment
2. **AGO: Presentation of 2022 AGO Cost Trends Report**
3. HPC: Policy Considerations

Presentation Outline

1. HPC: Background, Current Use, and Challenges with Risk Adjustment
2. AGO: Presentation of 2022 AGO Cost Trends Report
3. **HPC: Policy Considerations**

Payment based on diagnosis-based risk adjustment as currently implemented increases both administrative and total spending, impairs accountability, and perpetuates health inequity.

Added Costs For Patients And Payers

- Due to increases in inpatient acuity between 2013 and 2019, Massachusetts incurred ~$250 million more in inpatient spending per year. An increase in coded diagnoses contributes to this added cost.
- Because of the ROI opportunity, coding efforts can take precedence over efforts to reduce spending in APMs.

Persistent Health Inequity

- Better-resourced providers have more resources to invest in increasing risk scores.
- Poor access to care can result in lower risk scores. Risk adjustment can reinforce this disparity.

Impaired Accountability

- To the extent that risk scores reflect coding efforts rather than true patient acuity, risk adjusted performance metrics are flawed (e.g., readmission rates, health-status adjusted TME, mortality, or other quality or process measures).

Added Administrative Waste

- Clinician and leadership time, money, and effort is redirected away from clinical care and toward coding. This added administrative burden can also increase clinician burnout.

Landon, Bruce E., and Robert E. Mechanic. "The paradox of coding: Policy concerns in the move to risk-based provider contracts." The New England journal of medicine 377.13 (2017): 1211; Spending impact based on analysis of inpatient acuity trends using the Massachusetts APCD and Hospital Inpatient Discharge Database.

Policy Considerations

Risk adjustment has become a key feature of payment policy that strongly influences health care spending, provider behavior, administrative costs, health equity, and even provider consolidation and organization. Given this importance, risk adjustment should be a focus of payers, health system leaders and policymakers in ensuring that adverse unintended consequences are minimized, and positive opportunities are capitalized upon to ensure high quality, efficient and equitable health care.

Those making use of risk adjustment should consider:

- 1) How risk adjustment is used in payment
- 2) Methodologies used to predict health care need

Post, B., et al. (2022). Hospital-physician integration and risk-coding intensity. Health Economics, 31(7), 1423-1437.

Consideration 1: Modifying How Diagnosis-Based Risk Scores Are Used in Payment Formulas

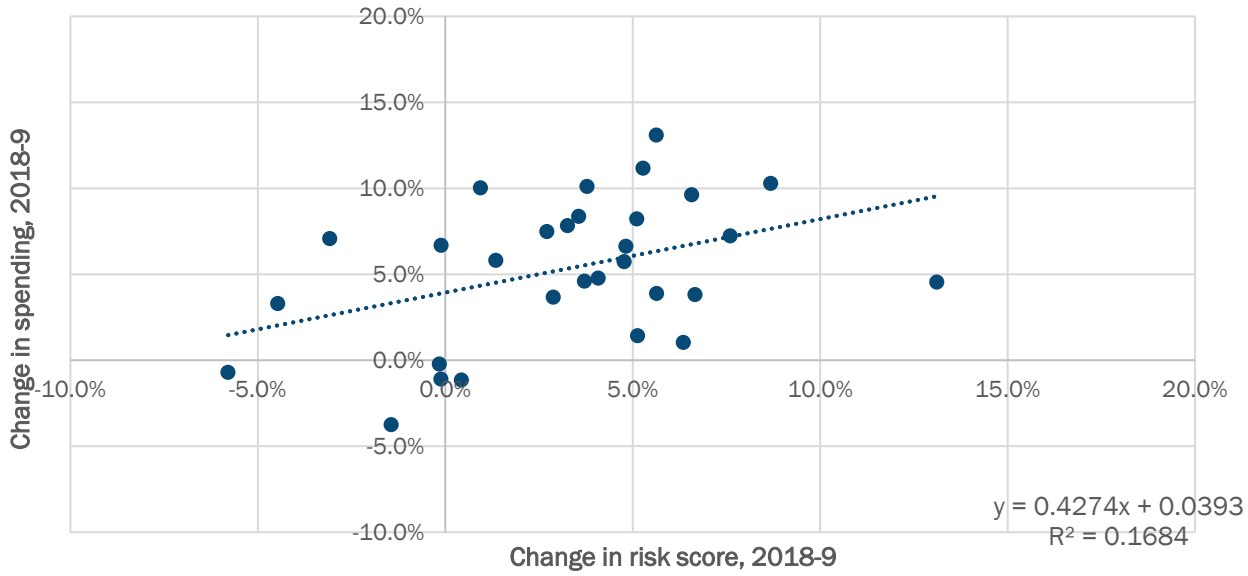
Examples include:

- Payments for increasing risk scores could be **capped** at some limit
  - *Medicare ACOs don't pay providers for risk score growth beyond 3%*
- Non-linear formulas can **attenuate the incentive to code more diagnoses**
  - *For example, quadratic terms can reflect a less than 1-for-1 relationship between risk scores and costs*
- A **blend** of a non-diagnosis-based risk score (age/sex/SDOH/government program eligibility) and a diagnosis-based risk score can attenuate coding incentives.
  - *A blend was used by Medicare Advantage during the phase-in period*
- For large populations, risk adjustment of spending growth may not be necessary at all

Spending for members attributed to large Massachusetts provider groups does not increase proportionally with risk score growth, suggesting overpayment for risk scores.

- Analysis of spending data for BCBS, Tufts and HPHC members attributed to the ten largest provider groups found that, on average, **each additional 5% in risk score growth was associated with an additional 2% in spending growth.**
  - Yet providers under most APM contracts would receive **5% more in payment for 5% growth in risk scores**
  - This suggests overpayment for risk scores

Relationship between risk score growth and spending growth for 30 large payer-provider pairs, 2018-9



Notes: Data from the Massachusetts APCD including PCP-attributed members from 30 payer-provider pairs representing BCBS, THP and HPHC and the ten largest provider groups. Spending includes medical and pharmacy claims spending and excludes any non-claims spending. Risk scores were computed using the Johns Hopkins ACG® System
Source: Massachusetts APCD.

Consideration 2: Modifying the Methodologies Used to Predict Health Care Need

Identifying diagnoses based on prescriptions is a way to discriminate between diagnoses under active treatment, and those that are less clinically relevant.

- *MassHealth and some payers currently incorporate an Rx based risk adjuster*

Deliberately increasing risk scores for patients facing adverse social determinants of health is a straightforward way to ensure that risk adjustment improves health equity.

- MassHealth uses **Neighborhood Stress Scores** to deliberately add to the risk score

See https://www.mass.gov/lists/masshealth-risk-adjustment-methodology. NSS are based on the % of families with incomes < 100% of FPL, % < 200% of FPL, % of adults who are unemployed, % of households receiving public assistance, % of households with no car, % of households with children and a single parent, and % of people aged 25 or older who have no HS degree. More details regarding MassHealth's current approach to risk adjustment can be found here: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-22-1039-EHS01-ASHWA-71410 under "Risk Adjustment Methodology RY23".

Next Steps

The HPC will continue to work with stakeholders and academics regarding diagnosis-based risk adjustment and will seek to facilitate research, discussion, and the adoption of best practices.

Agenda

Call to Order

Approval of Minutes (VOTE)

Market Oversight and Transparency

EXECUTIVE DIRECTOR'S REPORT

- Board Discussion: 2022 Health Care Cost Trends Hearing

Schedule of Upcoming Meetings

Executive Session (VOTE)

Agenda

Call to Order

Approval of Minutes (VOTE)

Market Oversight and Transparency

Executive Director's Report

BOARD DISCUSSION: 2022 HEALTH CARE COST TRENDS HEARING

Schedule of Upcoming Meetings

Executive Session (VOTE)

Highlights from Elected Officials Remarks

- Governor Charlie Baker discussed the **impact of COVID-19 on the state and Massachusetts' health care systems**, citing workforce challenges and access to mental and behavioral health services, and detailed steps that his Administration has taken to address these concerns.

- U.S. Senator Ed Markey emphasized the need to eliminate health inequities that were exacerbated by the pandemic and advocated for bold action to **achieve a more affordable, equitable, and innovative health care system**.

- Governor-Elect and Attorney General Maura Healey outlined her goals for the **future of health care in Massachusetts in the next decade**, including a workforce that reflects its patient population and aligning health spending with health need.

Keynote Speaker Dr. Barak Richman

- Dr. Richman's presentation, "Provider Consolidation and the Limits of Antitrust Law," examined the history of antitrust enforcement in the hospital sector, the limitations of antitrust law in that context, and the potential lessons for policy makers as a result.
- He **advocated for changing the political economy of health care** and shared his suggestions to accomplish these goals, noting the importance of the **HPC's role to bring attention to issues of price and spending**.
- Dr. Richman recommended that the HPC leverage information to influence purchasers, specifically large employers, educate reporters and media, develop new reports, and consider more local collaboration.

Key Themes from Witness Panel 1: "Implications of Persistent Health Care Affordability Challenges in the Commonwealth"

Michael Curry, Esq., President and CEO, Massachusetts League of Community Health Centers

Bill Grant, Chief Financial Officer and Senior Vice President, Cummings Properties

Colin Killick, Executive Director, Disability Policy Consortium

Amy Rosenthal, Executive Director, Health Care for All

1. **Workforce** Witnesses described staff vacancies, and the disproportionate impact of these shortages on communities of color, people who are unhoused, rural communities, and individuals with less means.

2. **High cost of care, constraining options for consumers** Witnesses identified the high cost of pharmaceuticals, medical supplies, and insurance, and highlighted the impact of high costs on people with disabilities and the racial disparities in who faces affordability challenges.

3. **Potential steps to mitigate costs and issues with quality, and to promote equity** Witnesses raised policy solutions such as utilizing peer supports, improving data collection to better understand the impacts of cost of care, ensuring diverse perspectives in the workforce, and improving data for drug pricing transparency.

4. **Shared responsibility and action** Witnesses discussed the need to bring together industry groups and community advocates to develop proposals that reduce cost, improve access, and improve quality of care.

5. **Systemic racism** Witnesses highlighted the importance of identifying systemic racism to enable the health care system to fully and adequately address it, including through improved hiring practices, data collection, and reimbursement.

Key Themes from Witness Panel 2: "Health System Leaders: What is the Path Forward for Massachusetts?"

Dr. Kevin Churchwell, President and CEO, Boston Children's Hospital

Dr. Eric Dickson, President and CEO, UMass Memorial Medical Center

Andrew Dreyfus, President and CEO, Blue Cross Blue Shield of Massachusetts

Cain Hayes, President and CEO, Point32Health

Dr. Anne Klibanski, President and CEO, Mass General Brigham

1. **Workforce challenges** Provider witnesses cited rising labor costs and staffing shortages in post-acute care settings that have led to hospital discharge delays.

2. **Capacity constraints** Providers described their systems feeling unprepared to handle the demand for behavioral health care services, which has often resulted in ED boarding.

3. **Increased behavioral health care needs** In addition to these capacity constraints, witnesses described the impact of the COVID-19 pandemic on the behavioral health of pediatric patients. They provided updates on telehealth, which has reduced patient burdens in many cases, but a "digital divide" still exists.

4. **Affordability challenges** Provider witnesses cited inflation, workforce costs, and supply costs as significant drivers of health care costs and challenges for affordability, and identified pharmaceutical costs as the largest driver of growth. Health plan witnesses raised continued concerns about consumer affordability while recognizing the current environment.

5. **Potential solutions for affordability** Witness suggestions included incentivizing primary care to integrate behavioral health, deploying technology to reduce administrative complexity, increased flexibility with licensure, and requiring pharmaceutical companies and pharmacy benefit managers (PBMs) to be at the table for these discussions.

6. **Health equity** Provider and payer witnesses highlighted the importance of addressing health inequities and are willing to partner with the state to solve health equity issues, which impact access to care.

MASSACHUSETTS
HEALTH POLICY COMMISSION

2022: BY THE NUMBERS

RESEARCH AND REPORTING

14
new publications

4
DataPoints with
23
online interactive graphics

5
HPC presesentations at conferences

3
original videos

PARTNER

16
babies born to
26
Black birthing people receiving doula support through BESIDE[1]

100+
caregivers of substance exposed newborns enrolled in the C4SEN program[1]

16
ACOs certified in ACO LEAP 2022

CONVENING

13
public meetings

933
slides presented[2]

434
tweets[2]

189,018
Twitter impressions[2]

WATCHDOG

16
health care market transactions reviewed[2]

285
external review requests

1,334
open enrollment waiver requests

2,089
calls to the Office of Patient Protection hotline

[1] as of the end of September 2022

[2] as of December 9, 2022

Agenda

Call to Order

Approval of Minutes (VOTE)

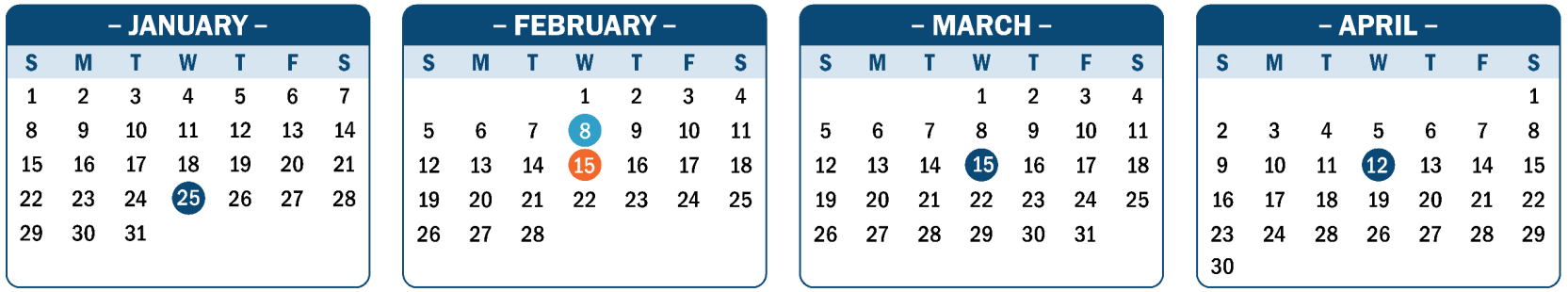
Market Oversight and Transparency

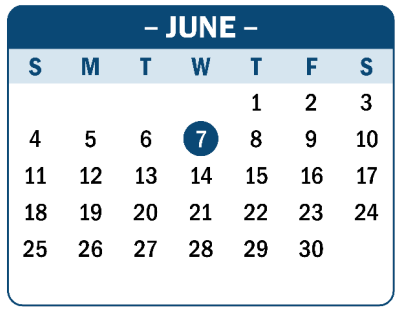
Executive Director's Report

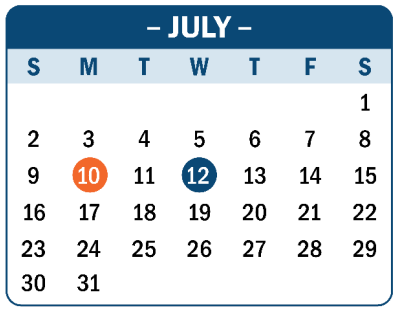
SCHEDULE OF UPCOMING MEETINGS

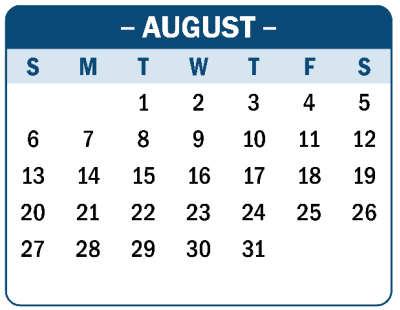
Executive Session (VOTE)

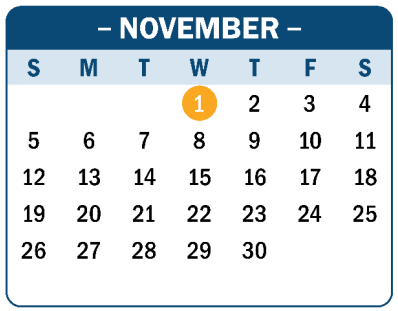
2023 Public Meeting Calendar

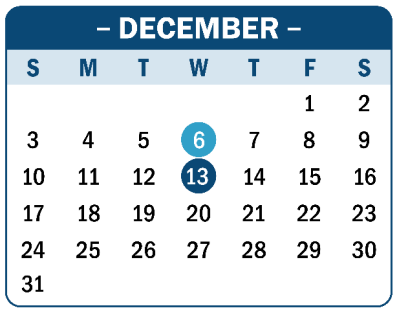












BOARD MEETINGS

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 (A & F, 2:00 PM)
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.

Agenda

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Schedule of Upcoming Meetings

EXECUTIVE SESSION (VOTE)

VOTE

Enter into Executive Session

MOTION

That, having first convened in open session at its December 14, 2022 board meeting and pursuant to M.G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with M.G.L. c. 6D, § 10 and its associated regulation, 958 CMR 10.00, and M.G.L. c. 6D, § 2A, in discussions about entities confidentially referred by the Center for Health Information and Analysis.