MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

January 25, 2023

Agenda

CALL TO ORDER

Approval of Minutes (VOTE)

Board Operations

Executive Director’s Report

Care Delivery Transformation

Market Oversight and Transparency

Video Presentation: Reflecting on the HPC’s 10 Year Anniversary Milestone

Executive Director Employment Agreement (VOTE)

Schedule of Upcoming Meetings

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

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VOTE

Approval of Minutes from the December 14 Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on December 14, 2022, as presented.

Agenda

Call to Order

Approval of Minutes (VOTE)

BOARD OPERATIONS

- Vice Chair Appointment (VOTE)
- New Commissioners Welcome and Committee Membership (VOTE)

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Board Operations

- **VICE CHAIR APPOINTMENT (VOTE)**
  - New Commissioners Welcome and Committee Membership **(VOTE)**

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VOTE

Vice Chair Election

MOTION

That, pursuant to Section 2.3 of the By-Laws, the Commission hereby elects _____ to serve as Vice Chair of the Health Policy Commission.

Agenda

Call to Order

Approval of Minutes (VOTE)

Board Operations

- Vice Chair Appointment (VOTE)

NEW COMMISSIONERS WELCOME AND COMMITTEE MEMBERSHIP (VOTE)

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VOTE

Committee Appointments

MOTION

That, pursuant to section 4.1 of the By-Laws, the Commission hereby approves the following Committee appointments:

MARKET OVERSIGHT AND TRANSPARENCY
Dr. David Cutler, Chair
Timothy Foley
Patricia Houpt
Renato Mastrogiovanni
Secretary, Executive Office for Administration and Finance

CARE DELIVERY AND TRANSFORMATION
Barbara Blakeney, Chair
Dr. Donald Berwick
Martin Cohen
Dr. Matilde Castiel,
Secretary, Executive Office of Health and Human Services

ADMINISTRATION AND FINANCE
Deborah Devaux, Chair
Martin Cohen
Patricia Houpt
Renato Mastrogiovanni
Secretary, Executive Office for Administration and Finance

Agenda

Call to Order

Approval of Minutes (VOTE)

Board Operations

EXECUTIVE DIRECTOR'S REPORT

- 2023 Policy Priorities and Activities
- Upcoming Research Publications
  - Impact of COVID-19 on the Health Care Workforce
  - Supply, Access, and Affordability: How Health System Factors Perpetuate Disparities
- Committee Meeting Agendas (February 15, 2023)

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Board Operations

Executive Director's Report

2023 POLICY PRIORITIES AND ACTIVITIES

- Upcoming Research Publications
  - Impact of COVID-19 on the Health Care Workforce
  - Supply, Access, and Affordability: How Health System Factors Perpetuate Disparities
- Committee Meeting Agendas (February 15, 2023)

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HPC Policy Priorities (January – July 2023)

To kick off 2023, the HPC is pursuing an ambitious action plan to reduce health care cost growth, promote affordability, and advance equity, in addition to ongoing workstreams and responsibilities.

This comprehensive plan will prioritize disseminating data-driven insights and policy recommendations to address the critical challenges facing the health care system today: the workforce crisis, high costs, and persistent health inequities.

1. **Bolster the HPC's Cost Containment Activities**
2. **Address Health Care Workforce Challenges and Identify Solutions**
3. **Advance Health Equity**
4. **Enhance Pharmaceutical Pricing Transparency and Accountability**
5. **Reduce Unnecessary Administrative Complexity**
6. **Upcoming Topics of Actionable Research**

HPC Policy Priorities

1 Bolster the HPC's Cost Containment Activities

a. Work with the Healey-Driscoll Administration and Legislature to expand levers for cost control as described in the HPC's 2022 Health Care Cost Trends Report, specifically prioritizing:
   i. Legislative 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;
   ii. Legislative action to constrain excessive price levels, variation, and growth for health care services and pharmaceuticals; and
   iii. Legislative 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.
b. Evolve approach to benchmark accountability in 2023 to account for COVID-19 disruptions in utilization.
c. Continue scrutiny of payer and provider spending performance, including by working with CHIA to enhance data reporting, and by conducting a robust evaluation of MGB's PIP and its impact on spending growth.
d. Continue scrutiny of provider market changes, including retrospective reviews (e.g., a five-year post-merger report on the creation of Beth Israel Lahey Health.)
e. Continue collaboration with sister agencies to enhance data reporting and with other states on how to optimize the impact of health care cost growth targets and implement complementary strategies to reduce spending growth.

HPC Policy Priorities

2 Address Health Care Workforce Challenges and Identify Solutions

a. Issue new HPC report and recommendations: Workforce Challenges and Solutions in Massachusetts.
b. Hold special event to convene stakeholders to discuss workforce challenges and recommended solutions.
c. Continue to support and promote innovative care models that leverage non-traditional and complementary health care workers (e.g., doulas, recovery coaches, community health workers).

3 Advance Health Equity

a. Issue new HPC report: *Supply, Access, and Affordability: How Health System Factors Perpetuate Disparities*.
b. Strengthen health equity standards within the ACO Certification Program.
c. Support the adoption and implementation of recommended data standards for collection of race, ethnicity, language, disability status, sexual orientation, and sex.
d. Design new HPC grant opportunities, building off current work on maternal and child health equity, to reduce identified disparities or otherwise advance equity.
e. Partner and align with public and private stakeholders (e.g., the Health Equity Compact) on shared goals.
f. Evaluate staff needs to support HPC health equity work.

HPC Policy Priorities

4 Enhance Pharmaceutical Pricing Transparency and Accountability

a. Collaborate with MassHealth on the drug pricing review process to support their supplemental rebate negotiations
b. Research and present/publish on:
    i. Prescription drug prices in Massachusetts as compared to international pricing
    ii. Impact of implementing copay caps for certain drugs
    iii. Impact of high spending outpatient drugs on spending and price trends
    iv. Different methods to align prices with value

5 Reduce Unnecessary Administrative Complexity

a. Partner with stakeholders and the Network for Excellence in Health Innovation (NEHI) to promote prior authorization automation.
b. Identify other priority areas for streamlining, simplification, or standardization and convene stakeholders to develop and advance solutions.
c. Participate on new Special Commission to Develop Common Medical Necessity Criteria in Behavioral Health.
d. Continue staff support and policy leadership of the Quality Measurement Alignment Taskforce (QMAT), including convening a workgroup to advise on an electronic clinical quality measure repository.

HPC Policy Priorities

6 Upcoming Topics of Actionable Research

a. Issue new HPC Report: *Telehealth Use in the Commonwealth and Policy Recommendations*
b. Issue new HPC Policy Paper: *Consolidation of the Pediatric Health Care Market in Massachusetts*
c. Issue new HPC Policy Paper: *Options and Implications for Capping Provider Prices*
d. Research impact of risk adjustment on spending trends.
e. Investigate role of private equity investments in Massachusetts health care.
f. Release updated data on opioid-related hospitalizations in Massachusetts.
g. Explore trends in payments for emergency ambulance services.

Agenda

Call to Order

Approval of Minutes (VOTE)

Board Operations

Executive Director's Report

- 2023 Policy Priorities and Activities

UPCOMING RESEARCH PUBLICATIONS

  - Impact of COVID-19 on the Health Care Workforce
  - Supply, Access, and Affordability: How Health System Factors Perpetuate Disparities

- Committee Meeting Agendas (February 15, 2023)

Care Delivery Transformation

Market Oversight and Transparency

Video Presentation: Reflecting on the HPC's 10 Year Anniversary Milestone

Executive Director Employment Agreement (VOTE)

Schedule of Upcoming Meetings

Agenda

Call to Order

Approval of Minutes (VOTE)

Board Operations

Executive Director's Report

- 2023 Policy Priorities and Activities
- Upcoming Research Publications
  - **IMPACT OF COVID-19 ON THE HEALTH CARE WORKFORCE**
    - Supply, Access, and Affordability: How Health System Factors Perpetuate Disparities
- Committee Meeting Agendas (February 15, 2023)

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Legislative Charge

To better understand challenges facing the Massachusetts health care workforce, the Legislature charged the Health Policy Commission in **Section 80 of Chapter 102 of the Acts of 2021:** ***An Act relative to immediate COVID-19 recovery needs*** with studying and completing a report on the state of the health care workforce in the Commonwealth, including an examination of workforce shortages and workforce development initiatives.

Scope of the Report

- High level focus on **system-wide** trends and challenges
- Priority workforces across sectors and settings of care: **nursing, direct care, behavioral health**
- Trends and challenges **throughout the workforce lifecycle**, as well as contextual factors such as cost of living

Elements explored for each stage of the workforce lifecycle include:

- Degrees and certificates awarded
- Training programs
- Educators

- Onboarding
- Employment
- Wages
- Vacancies

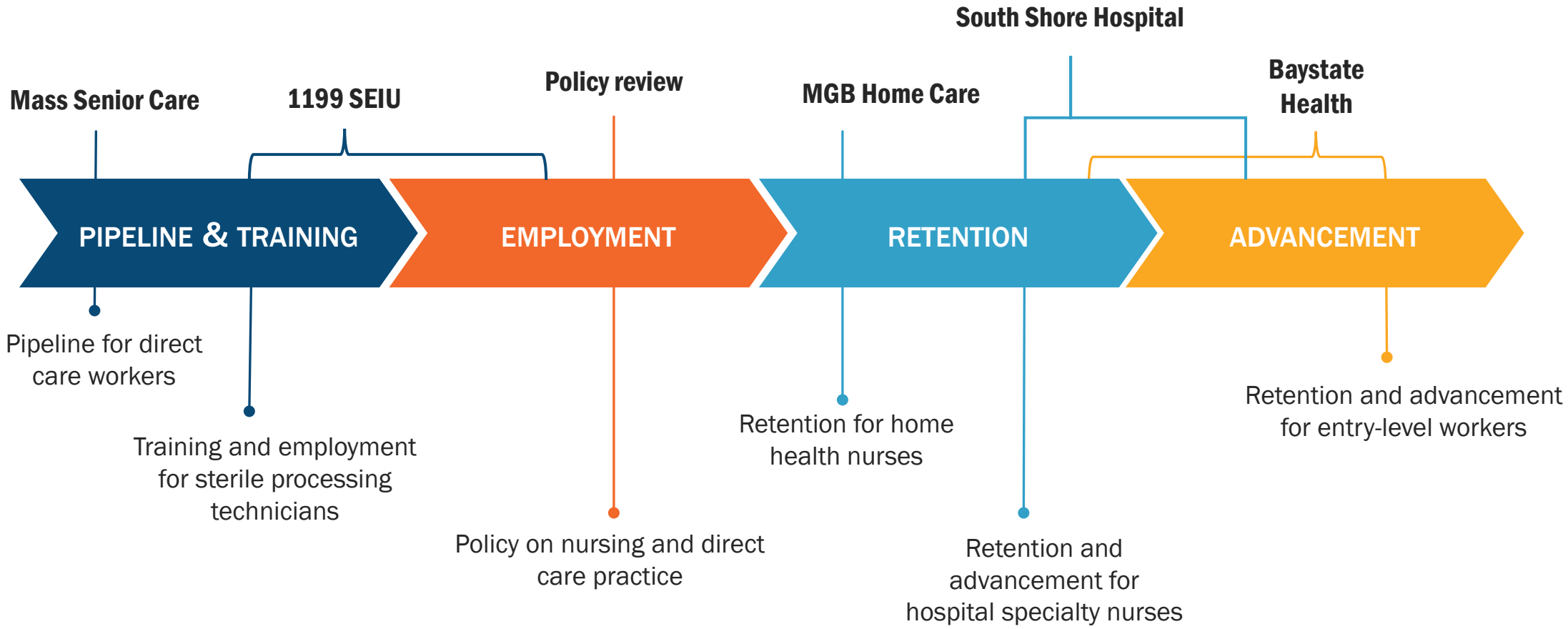
- Turnover
- Reasons for leaving

- Career ladders and upskilling

Components of the Report

- Existing research and reporting and compilation of public workforce programs
- Discussions with stakeholders
- Original quantitative analysis of workforce trends
- Examples of Massachusetts workforce initiatives addressing each stage of the workforce lifecycle
  - With Mathematica Policy Research
- Review of policy on nursing and direct care practice in MA and three comparison states (MN, NY, WA)
  - With the Philip R. Lee Institute for Health Policy Studies at the University of California San Francisco
- Recommendations

The workforce initiatives and policy review span the workforce life cycle.



SAVE THE DATE
HPC SPECIAL EVENT

Building a Robust Health Care Workforce in Massachusetts: Findings, Challenges, and Opportunities

March 29, 2023
10:00 AM – 1:00 PM

Agenda

Call to Order

Approval of Minutes (VOTE)

Board Operations

Executive Director's Report

- 2023 Policy Priorities and Activities
- Upcoming Research Publications
  - Impact of Covid-19 on the Health Care Workforce
  - **SUPPLY, ACCESS, AND AFFORDABILITY: HOW HEALTH SYSTEM FACTORS PERPETUATE DISPARITIES**
- Committee Meeting Agendas (February 15, 2023)

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The Legislature directed the HPC to evaluate the impact of COVID-19 on the health care system and assess the role of provider supply and distribution in MA health disparities.

Chapter 260 of the Acts of 2020 charged the HPC with issuing a report that includes:

DISPARITIES

- An analysis of health care disparities that exist in the commonwealth due to economic, geographic, racial or other factors.

IMPACT OF COVID-19

- The effects of the COVID-19 pandemic on the commonwealth's health care delivery system (**Published April 2021**)
- An analysis of the impact of COVID-19 on the health care workforce (**Upcoming publication**)

SUPPLY AND DISTRIBUTION

- Essential components of a robust health care system and the distribution of services and resources necessary to deliver high-quality care
- An inventory and description of all health care services
- An examination of the closures of services classified as essential
  - The impact that the loss of such essential services have had on access to and the quality of health care services to the communities affected by the closure

HPC Approach

SECTION	PROCESS
Overview of Health Disparities in Massachusetts	▪ Reviewing recent Massachusetts reports (e.g., from government, researchers, and foundations) to identify disparities in health care access and outcomes across demographic, economic, and geographic factors.
Supply and Distribution of Key Health Care Services	▪ Taking inventory and examining per capita supply of certain physicians and other clinicians, hospital beds, and facilities compared to national, international, and comparator state rates. ▪ Comparing per capita supply in MA counties to the state average and to each other to identify geographic differences, where possible. ▪ Analyzing whether certain demographic characteristics (e.g., Hispanic ethnicity, income level) of a geographic area is reliably correlated with higher or lower supply levels.
Hospital Service Closures	▪ Examining acute hospital service closures and hospital/health system, patient, and community characteristics associated with closures.
Another Driver of Disparities: Health Care Financing	▪ Identifying and researching health care financing factors (e.g., how individuals, families, and employers pay for insurance, how funds are allocated across different patients, how providers are paid for care delivered, etc.) that contribute to affordability challenges and disparities in health care access and outcomes.

Timeline and Next Steps

- Continue research and analyses with HPC expert teams
- Share preliminary findings with Commissioners

- Stakeholder engagement on findings and policy recommendations
- Release final report

All dates are approximate

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Board Operations

Executive Director's Report

- 2023 Policy Priorities and Activities
- Upcoming Research Publications
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  - Supply, Access, and Affordability: How Health System Factors Perpetuate Disparities

COMMITTEE MEETING AGENDAS (FEBRUARY 15, 2023)

Care Delivery Transformation

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Schedule of Upcoming Meetings

Committee Meeting Agendas – February 15, 2023

Market Oversight and Transparency (MOAT)

- Research Presentation: Emergency Ground Ambulance Utilization and Payment Rates in Massachusetts
- Assessing and Addressing Drug Prices in Massachusetts
- Guest Presentation: Reducing Administrative Complexity: Automation of Prior Authorization – The Network for Excellence in Health Innovation

Care Delivery Transformation (CDT)

- Guest Presentation: MassHealth's 2023 ACO Program – Ryan Schwarz, Chief, Office of Payment and Care Delivery Innovation
- HPC ACO Certification Program: Updates and Discussion of Health Equity Standard

Committee Meetings are livestreamed on the HPC's YouTube Channel.
MOAT begins at 9:30 AM and CDT begins at 11:00 AM.

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Board Operations

Executive Director's Report

CARE DELIVERY TRANSFORMATION

- Office of Patient Protection: Regulatory Changes (VOTE)

Market Oversight and Transparency

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Schedule of Upcoming Meetings

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Care Delivery Transformation

OFFICE OF PATIENT PROTECTION: REGULATORY CHANGES (VOTE)

Market Oversight and Transparency

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Executive Director Employment Agreement (VOTE)

Schedule of Upcoming Meetings

Office of Patient Protection (OPP) Responsibilities

OPEN ENROLLMENT WAIVERS

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

HEALTH INSURANCE APPEALS

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

RISK-BEARING PROVIDER ORGANIZATION APPEALS

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

CONSUMER ASSISTANCE AND INFORMATION

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

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

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

Implementation Activity to Date

- OPP **reached out to health plans and consumer advocates** in advance of issuing the Interim Guidance.
- OPP **continues discussions with the Division of Insurance regarding duties related to Mental Health Parity** and other areas of overlap between our two agencies.
- OPP released **interim guidance in October 2022 to notify health plans, external review agencies, and other parties about OPP's implementation related to the external review process** in compliance with Chapter 177.
- OPP **collected reporting** on health plan's **standard operating procedures related to the internal grievance process** pursuant to the Interim Guidance.
- OPP **issued guidance** to its contracted external review agencies regarding new processes and standard **for requests for continuation of coverage** .

Proposed Changes to Regulation: Health Plan Internal Processes

BILL SECTION	PROPOSED CHANGE	REGULATORY SECTION
SECTION 71	▪ Requires health plans to assess any new or amended medical necessity guideline to show compliance with state and federal parity requirements	958 CMR 3.101
SECTION 64	▪ Requires health plans to establish a clear process allowing the insured to appoint an authorized representative to act on the insured's behalf	958 CMR 3.300
SECTION 64	• Requires health plans to establish a process to deliver and accept medical release forms by electronic means	958 CMR 3.302

Proposed Changes to Regulation: Health Plan Internal Processes

BILL SECTION	PROPOSED CHANGE	REGULATORY SECTION
SECTION 64	• Requires health plans to send internal grievance responses by certified or registered mail or other express carrier with proof of delivery	958 CMR 3.307
SECTION 65	▪ Expands health plan obligations to insureds whose expedited internal grievances have been denied, including a right to request a conference	958 CMR 3.310

Proposed Changes to Regulation: External Review Processes

BILL SECTION	PROPOSED CHANGE	REGULATORY SECTION
SECTION 66	▪ Deems that health plan noncompliance with internal grievance timelines results in an external review ruled in favor of the patient	958 CMR 3.405
SECTION 67	▪ Clarifies the requirement that a complete medical record for an external review includes medical records and medical opinions by the insured's treating provider who requested the disputed service	958 CMR 3.409
SECTION 67	• Requires the external review agency to consider related rights under state law as directed by OPP	958 CMR 3.412

Proposed Changes to Regulation: External Review Processes

BILL SECTION	PROPOSED CHANGE	REGULATORY SECTION
SECTION 68	▪ Expands the opportunity for an insured to request continuation of coverage during an expedited or non-expedited external review ▪ Requires the external review agency to consider evidence submitted regarding a pattern of denials that have been overturned by prior internal or external reviews	958 CMR 4.414
SECTION 69	▪ Deems that a health plan's failure to comply with an external review agency's decision shall be an unfair and deceptive practice in violation of MGL c. 93A	958 CMR 3.415

Proposed Regulatory Promulgation Timeline, 958 CMR 3.000

November 8, 2022
Chapter 177 Effective Date

January 25, 2023
Board Votes on Release of Proposed Regulation

March 2, 2023
Public Hearing on Proposed Regulation

March 9, 2023
Public Comment Period Closes

April 12, 2023
Board Votes to Issue Final Regulation

VOTE

Office of Patient Protection: Proposed Regulation

MOTION

That the Commission hereby authorizes the issuance of the PROPOSED regulation on Health Insurance Consumer Protection, 958 CMR 3.000, pursuant to M.G.L. c. 6D, § 16 and M.G.L. c. 1760, §§ 13 through 16 and a public hearing and comment period on the regulation pursuant to M.G.L. c. 30A.

Agenda

Call to Order

Approval of Minutes (VOTE)

Board Operations

Executive Director's Report

Care Delivery Transformation

MARKET OVERSIGHT AND TRANSPARENCY

- Material Change Notices
- Performance Improvement Plan Review Process (2022 Cycle)
- Report to the Legislature: Telehealth Use in the Commonwealth and Policy Recommendations (VOTE)

Video Presentation: Reflecting on the HPC's 10 Year Anniversary Milestone

Executive Director Employment Agreement (VOTE)

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MATERIAL CHANGE NOTICES

- Performance Improvement Plan Review Process (2022 Cycle)
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Schedule of Upcoming Meetings

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%

Material Change Notices Currently Under Review

- The proposed purchase of **LHC Group**, a national provider of post-acute care services with several home health locations in Massachusetts, by **UnitedHealth Group**, a national diversified health care company. Under the proposed transaction, LHC Group would become part of Optum Health, a subsidiary of United. This transaction is still under review by the Federal Trade Commission.

- 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

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Board Operations

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Care Delivery Transformation

Market Oversight and Transparency

- Material Change Notices

PERFORMANCE IMPROVEMENT PLAN REVIEW PROCESS (2022 CYCLE)

- Report to the Legislature: Telehealth Use in the Commonwealth and Policy Recommendations (**VOTE**)

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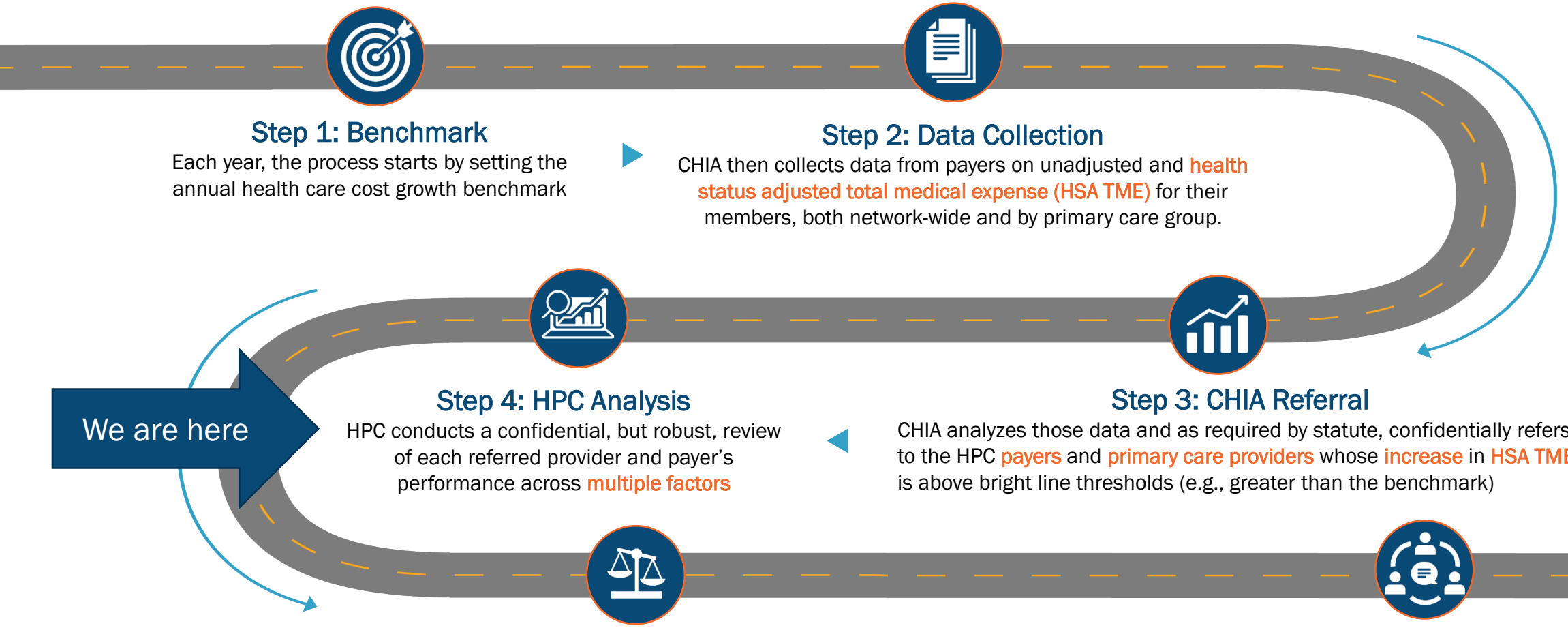
Schedule of Upcoming Meetings

Accountability for the Health Care Cost Growth Benchmark



Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and health status adjusted total medical expense (HSA TME) for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and as required by statute, confidentially refers to the HPC payers and primary care providers whose increase in HSA TME is above bright line thresholds (e.g., greater than the benchmark)

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across multiple factors

We are here

Step 5: Decision to Require a PIP

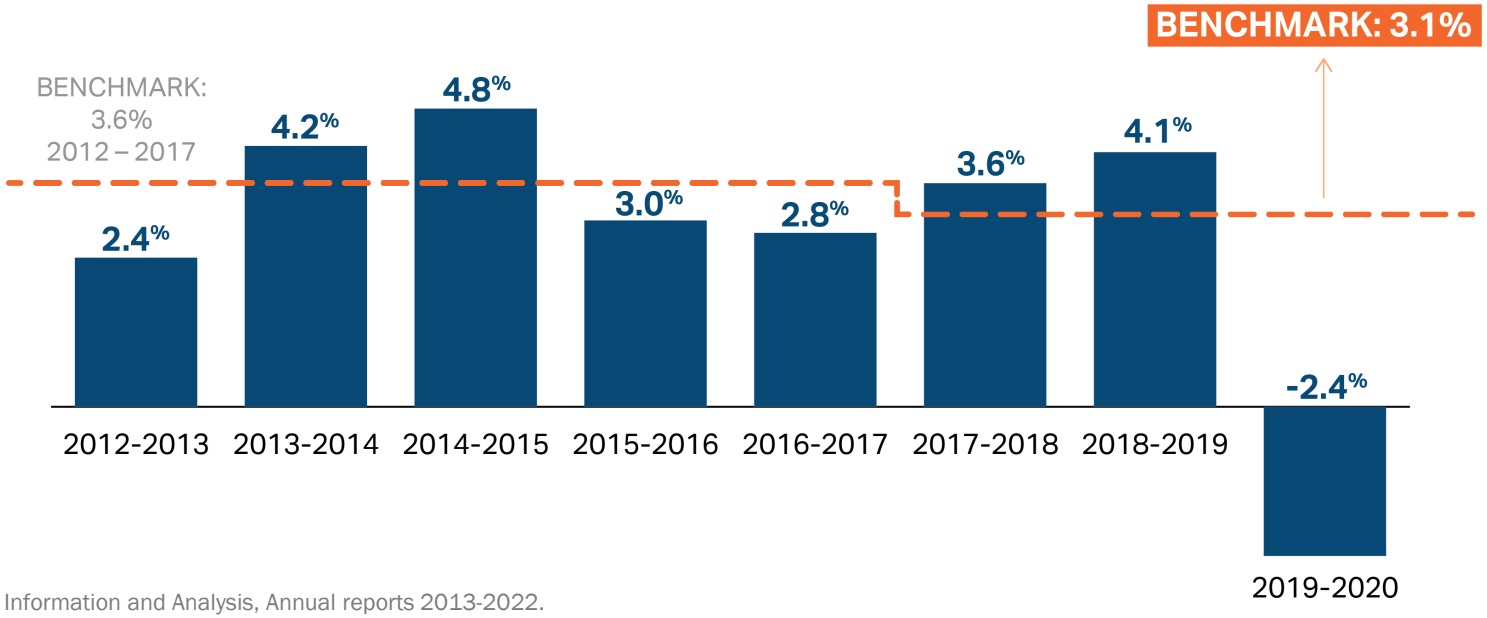
After reviewing all available information, including confidential information from payers and providers under review, the HPC Board votes to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to ongoing monitoring by the HPC during the 18-month implementation. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

2022 Review Cycle: 2018-2019 and 2019-2020 Spending Trends

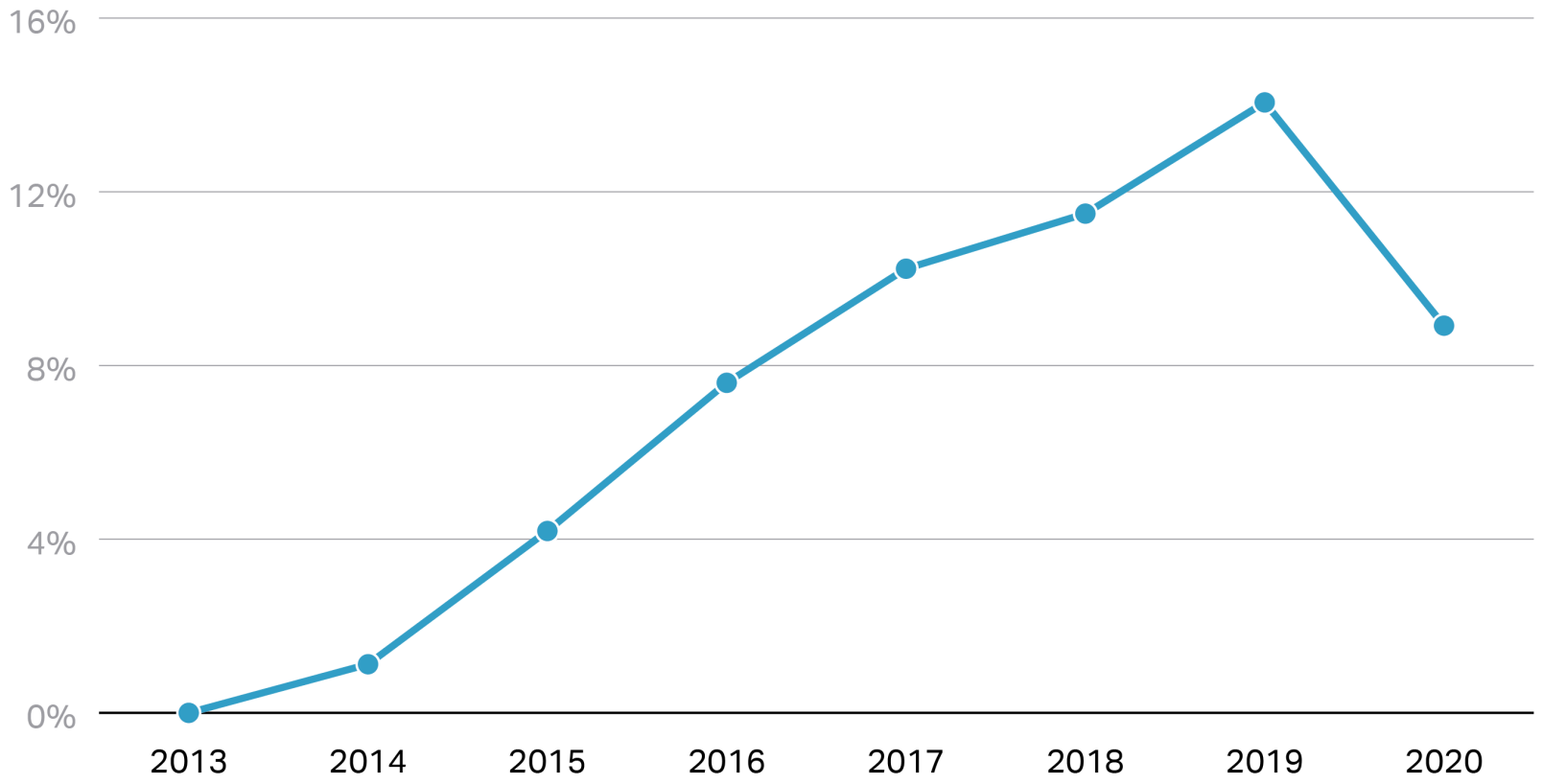
- In 2022, CHIA referred providers and payers to the HPC for review based on 20182019 and 2019-2020 *final* trends in Total Medical Expenditures (TME). Entities could be referred for spending growth in either or both years.
  - 2018-2019: HPC already reviewed *preliminary* TME trends for 2018-2019 during the 2021 PIP review cycle. Final TME trends generally aligned closely with preliminary trends.
  - 2019-2020: Individual payer and provider TME trends were extremely unusual, and unadjusted spending generally *decreased,* consistent with statewide trends for Total Health Care Expenditures (THCE).



Source: Massachusetts Center for Health Information and Analysis, Annual reports 2013-2022.

2022 Review Cycle: 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

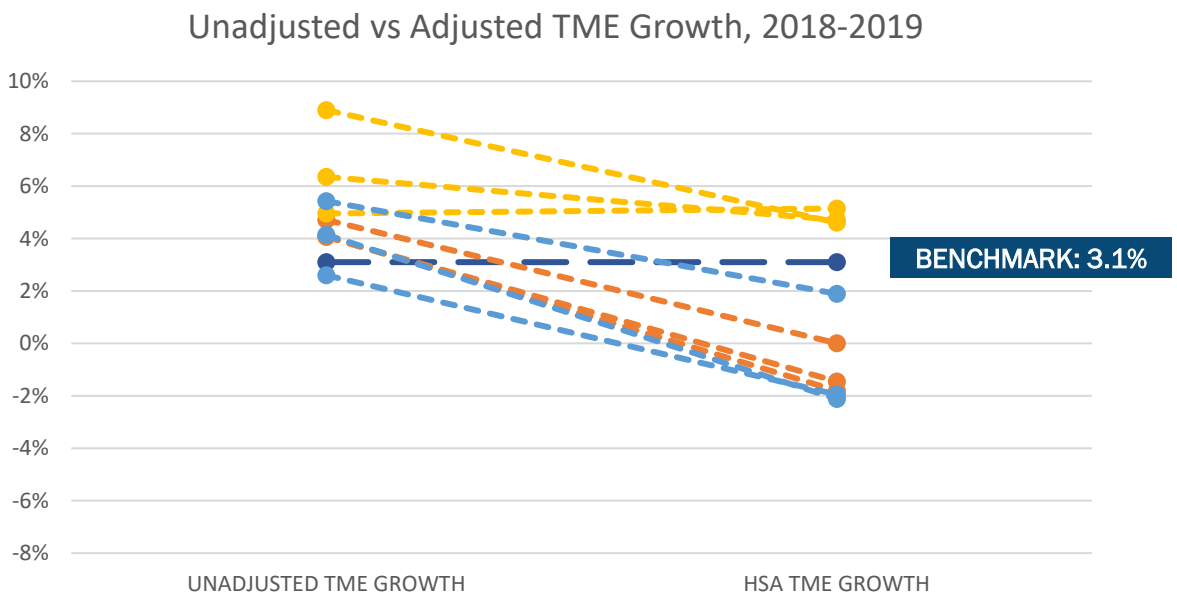


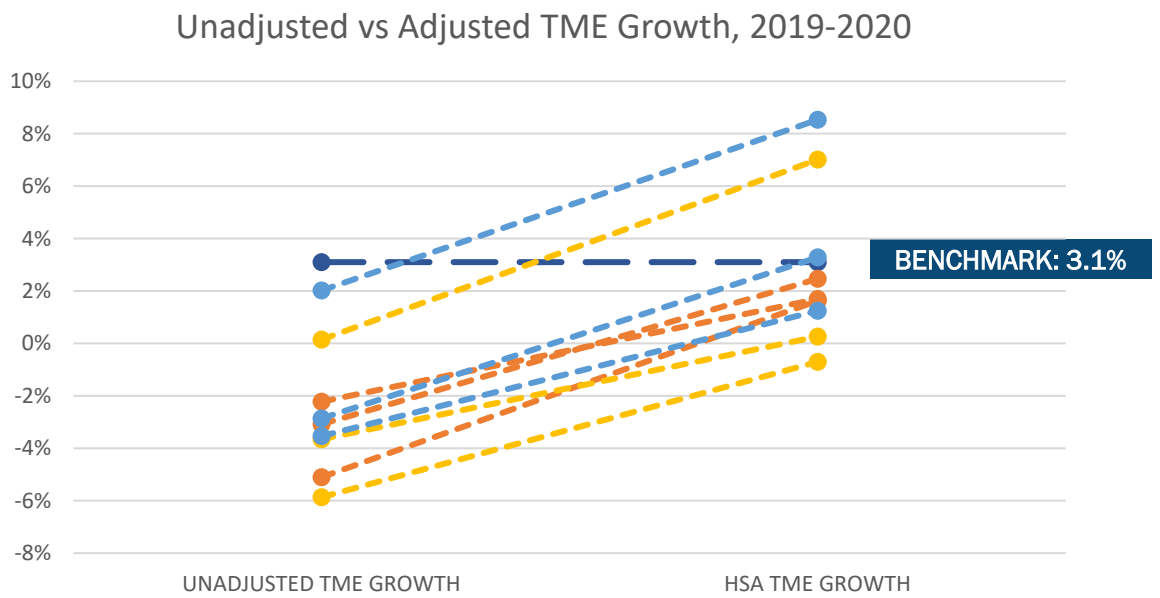
- As reported previously by HPC, risk scores generally *dropped* in 2020.
- Due to the pandemic, patient encounters with the health system fell. This led to fewer opportunities to record patient diagnoses, and thus, lower (healthier) risk scores.

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

2022 Review Cycle: Impact of Decreasing Risk Scores

- In all previous years, including 2018-2019, risk scores have generally increased, deflating growth in health status-adjusted (HSA) TME, and resulting in entities with above-benchmark spending not being referred into the HPC's review process.
- However, as a result of decreasing risk scores in 2020, a number of entities were referred into the HPC's review process in 2022 despite unadjusted spending that was low or decreasing, since the lower risk scores generally *increased* growth in HSA TME.





Note: Data are limited to three payers and three major provider groups and does not include all payers and providers for which TME is reported.
Sources: Center for Health Information Analysis

The fact that many entities were referred due to *decreasing risk scores* during a global pandemic, even where real dollar spending decreased, underscores concerns about risk coding and using growth in HSA TME as the trigger for referral into the PIPs process.

2022 Referral Closeout

After conducting a confidential, rigorous review of all referred entities, the HPC has elected not to require a PIP based on 2022 referrals.

- **Pandemic-Related Impacts in 2020.** The COVID pandemic significantly disrupted health care utilization and spending patterns in 2020, resulting in decreased spending for most entities.

- **Previously Reviewed Performance.** Final 2018-2019 TME trends were generally consistent with preliminary 2018-2019 TME trends, which were reviewed and discussed with individual payers and providers as part of the 2021 review cycle.

However, the HPC will continue to closely monitor payer and provider spending performance and may consider past referrals and all available spending data when evaluating whether to require a PIP or conduct a CMIR in the future.

Next Steps

March 15
Benchmark Hearing on statewide spending performance

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across multiple factors and may follow up with one or more entities to solicit additional information and data

CHIA confidentially refers to the HPC payers and providers whose increase in HSA TME from 2020 to 2021 is excessive

Commissioners may vote to require one or more entities to conduct a Performance Improvement Plan

Throughout this time, the HPC will also be closely monitoring implementation and progress in achieving the savings goals in Mass General Brigham's Performance Improvement Plan.

All dates are approximate

Agenda

Call to Order

Approval of Minutes (VOTE)

Board Operations

Executive Director's Report

Care Delivery Transformation

Market Oversight and Transparency

- Material Change Notices
- Performance Improvement Plan Review Process (2022 Cycle)

REPORT TO THE LEGISLATURE: TELEHEALTH USE IN THE COMMONWEALTH AND POLICY RECOMMENDATIONS (VOTE)

Video Presentation: Reflecting on the HPC's 10 Year Anniversary Milestone

Executive Director Employment Agreement (VOTE)

Schedule of Upcoming Meetings

Background: Telehealth Policy in the Commonwealth

March 2020: Emergency Order

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

January 2021: Chapter 260 of the Acts of 2020

Chapter 260 permanently mandates that MA-licensed carriers and public plans cover all medically necessary services that can be appropriately delivered via telehealth. In addition:

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

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

Legislation Requires HPC to Report on Telehealth Use in the Commonwealth

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

The HPC is charged with:

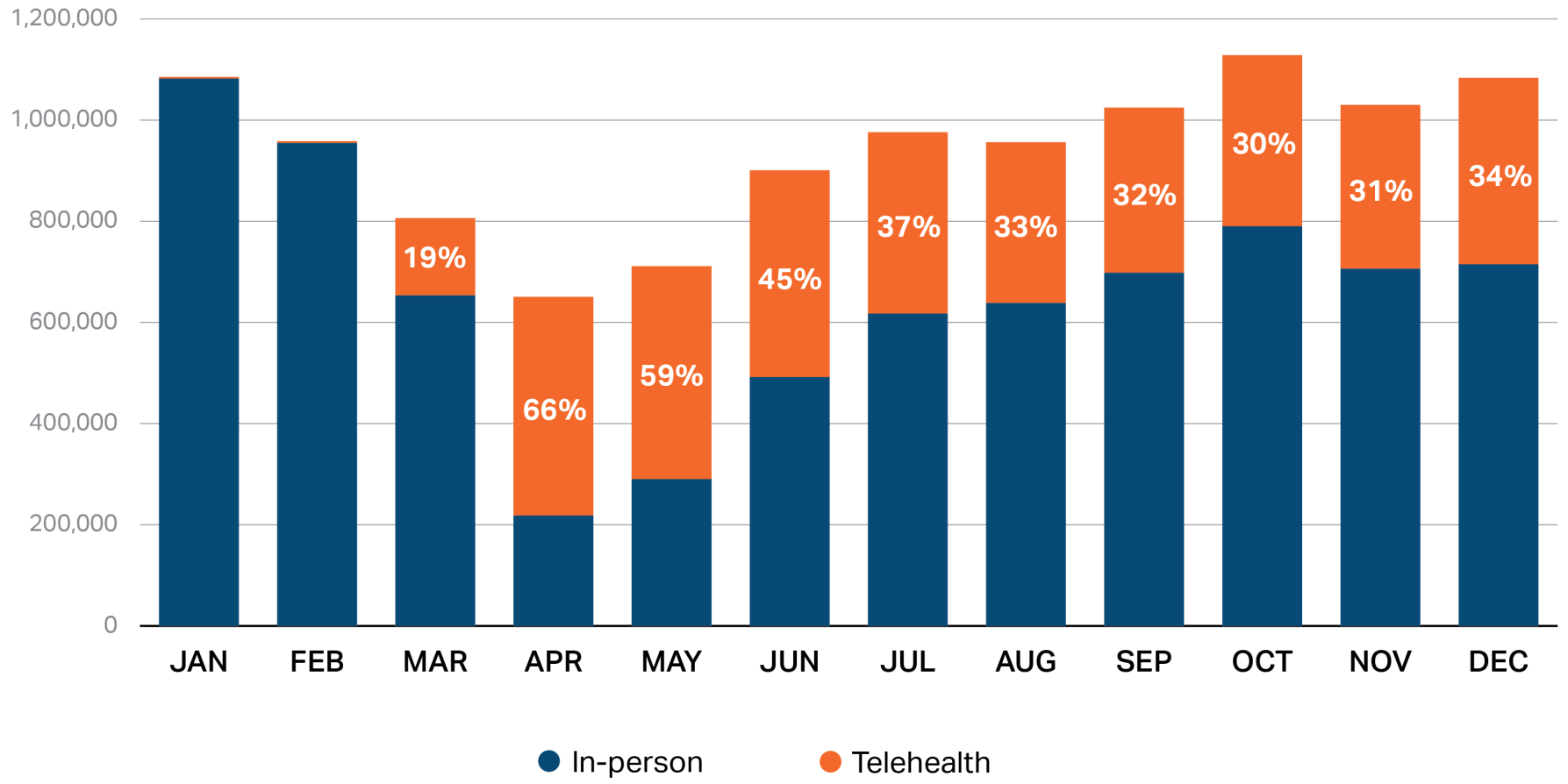
- **Analyzing utilization and spending trends:** such as telehealth use by type of service, provider organization, payer, patient demographics, and geographic region and total healthcare expenditures on telehealth services and impact on total healthcare spending;
- **Assessing patient access:** including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

Presentation Outline

1. **Overall Use of Telehealth Services in Massachusetts in 2020**
2. Variation in Use of Telehealth Services
3. Effect of Telehealth on Total Spending
4. Stakeholder Perspectives
5. Policy Recommendations

Telehealth rapidly became a major mode of ambulatory visits during the first year of the COVID-19 pandemic.

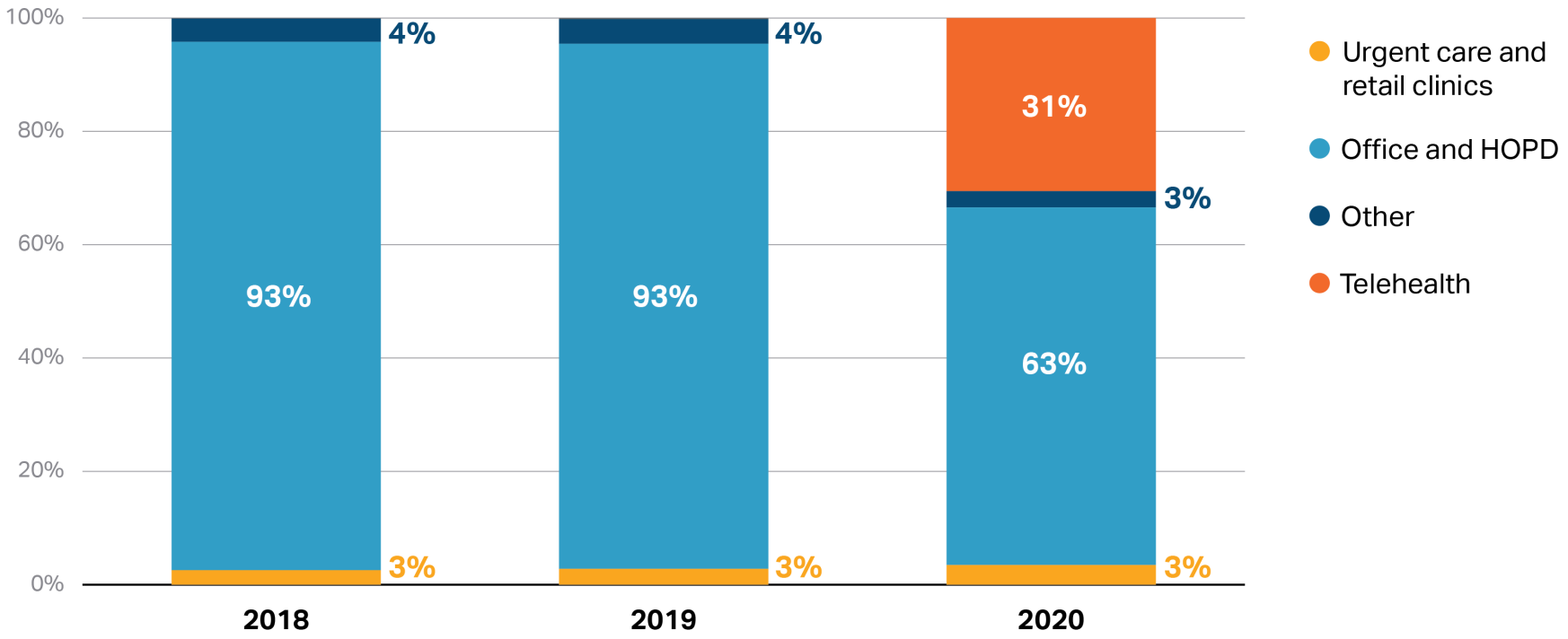
Number of in-person and telehealth ambulatory visits by month, 2020



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

Telehealth was used for nearly 1/3 of all ambulatory visits in 2020. The percentage of commercial members using telehealth grew from under 1% to more than 50%.

Share of ambulatory visits by site, 2018-2020



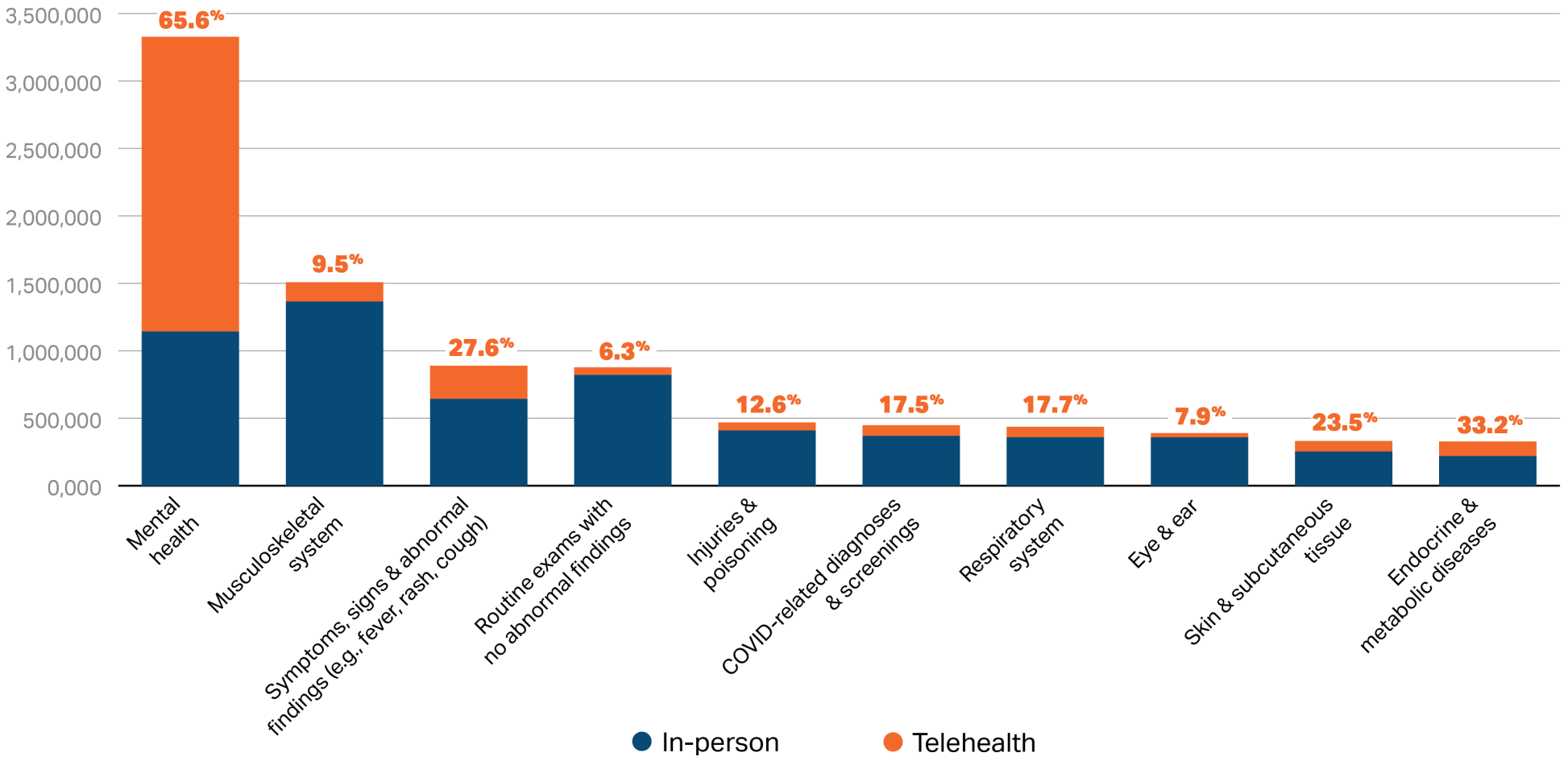
Share of commercial members who had any telehealth use:

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

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

Use of telehealth varied by type of condition; notably, it was the predominant mode of delivery for mental health visits.

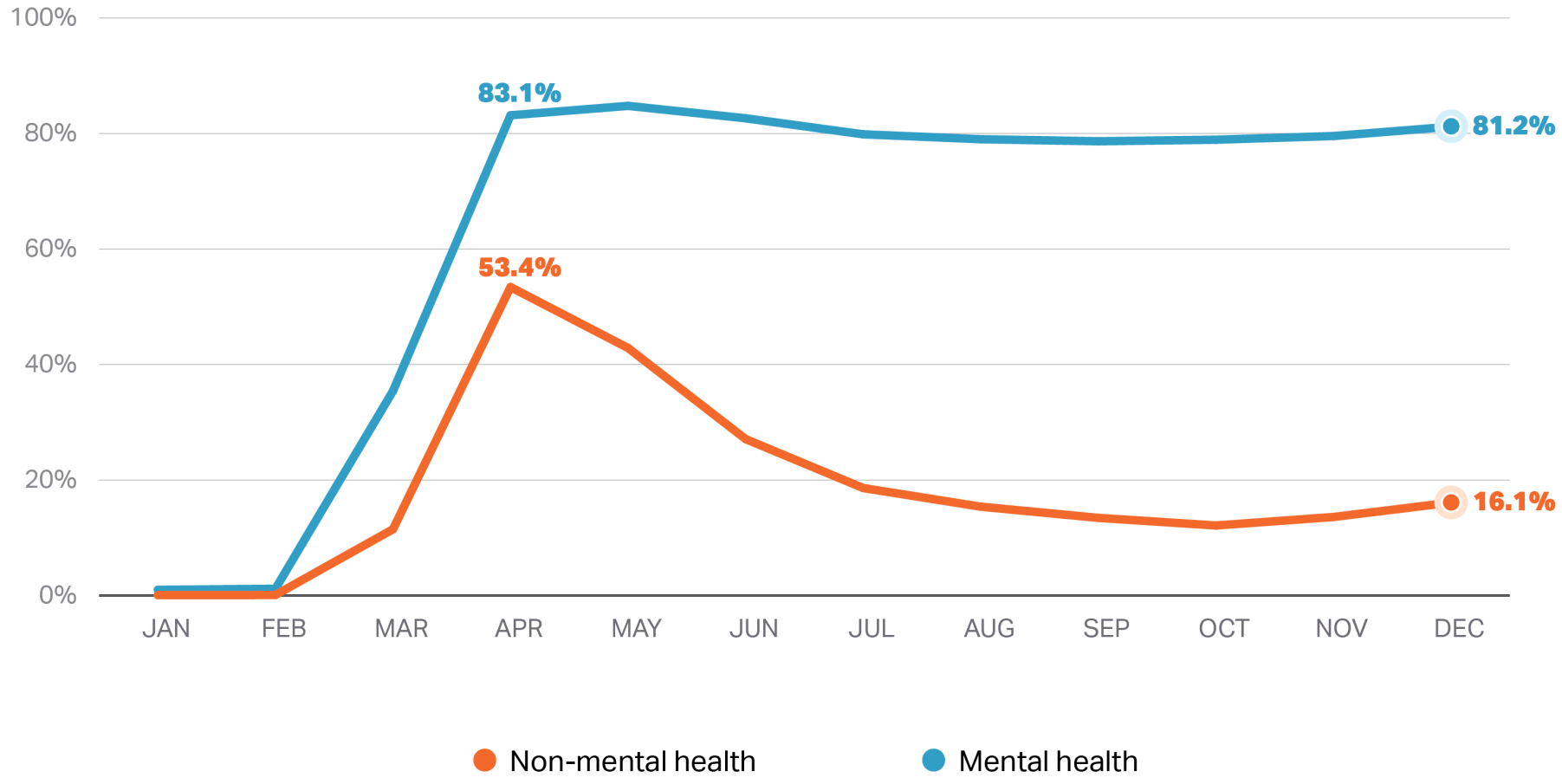
Number of in-person and telehealth visits by clinical areas, 2020



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

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

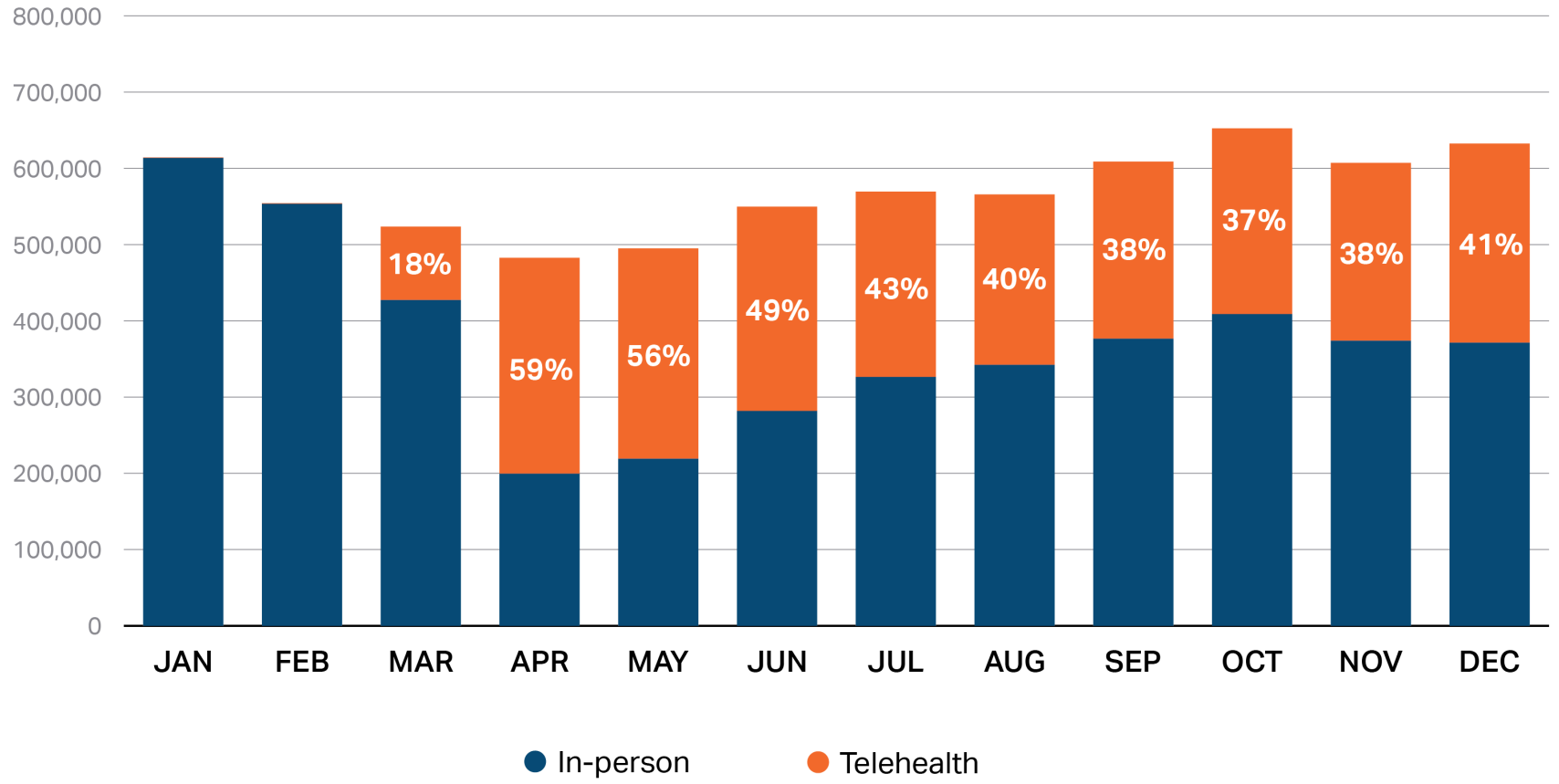
Percent of ambulatory visits that were telehealth by month and type of condition, 2020



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

Monthly patterns of telehealth use for MassHealth ACOs and MCOs mirrored those of the commercial population.

Number of in-person and telehealth ambulatory visits by month for select MassHealth ACO and MCO members, 2020



Notes: Data include AllWays, Tufts Public Plans, Health New England, Fallon 365 Care, and BMC HealthNet.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2020, V 10.0

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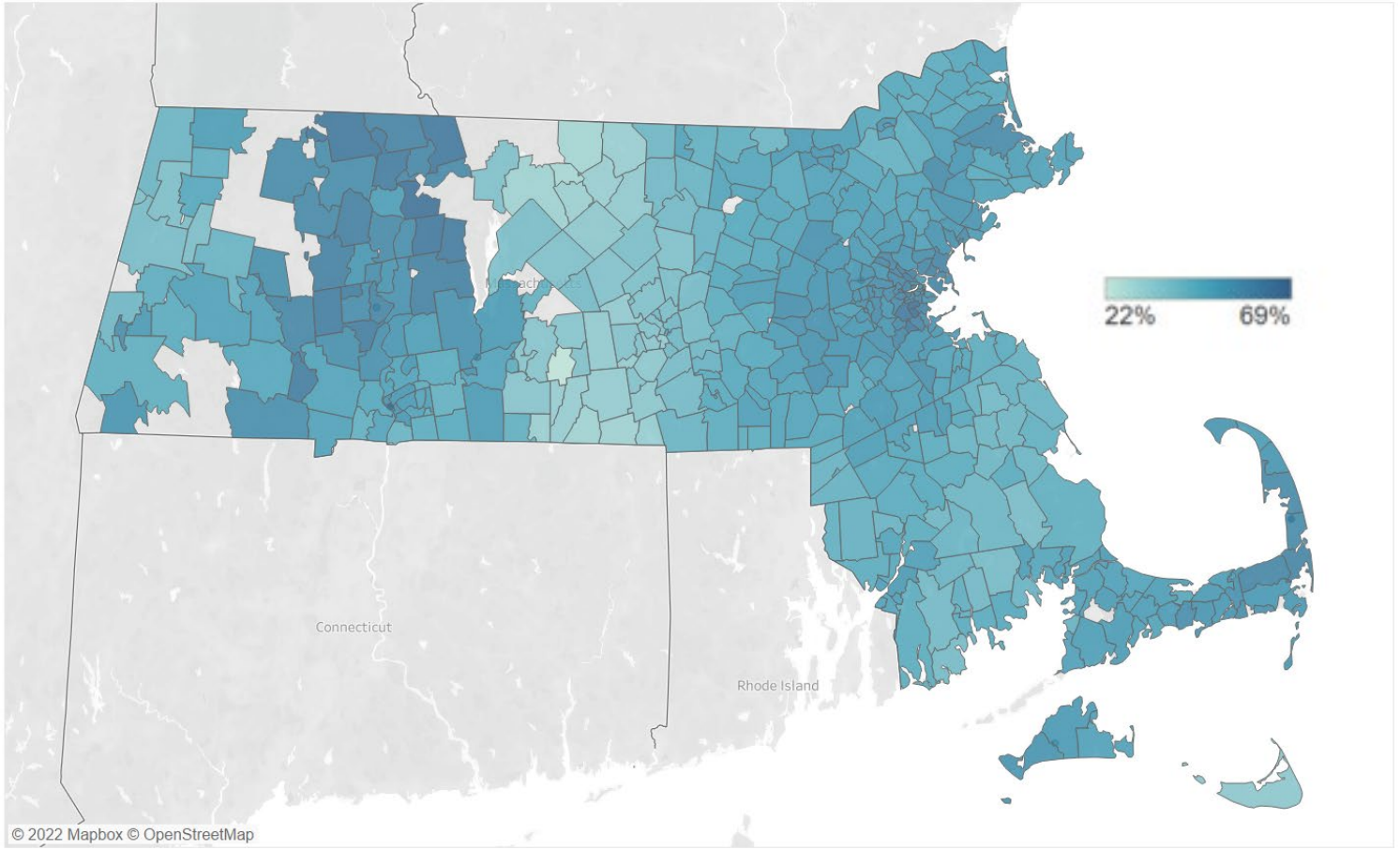
Telehealth use for non-mental health services was higher for residents in Metro Boston and the Pioneer Valley/Franklin region and lowest in Central Massachusetts.

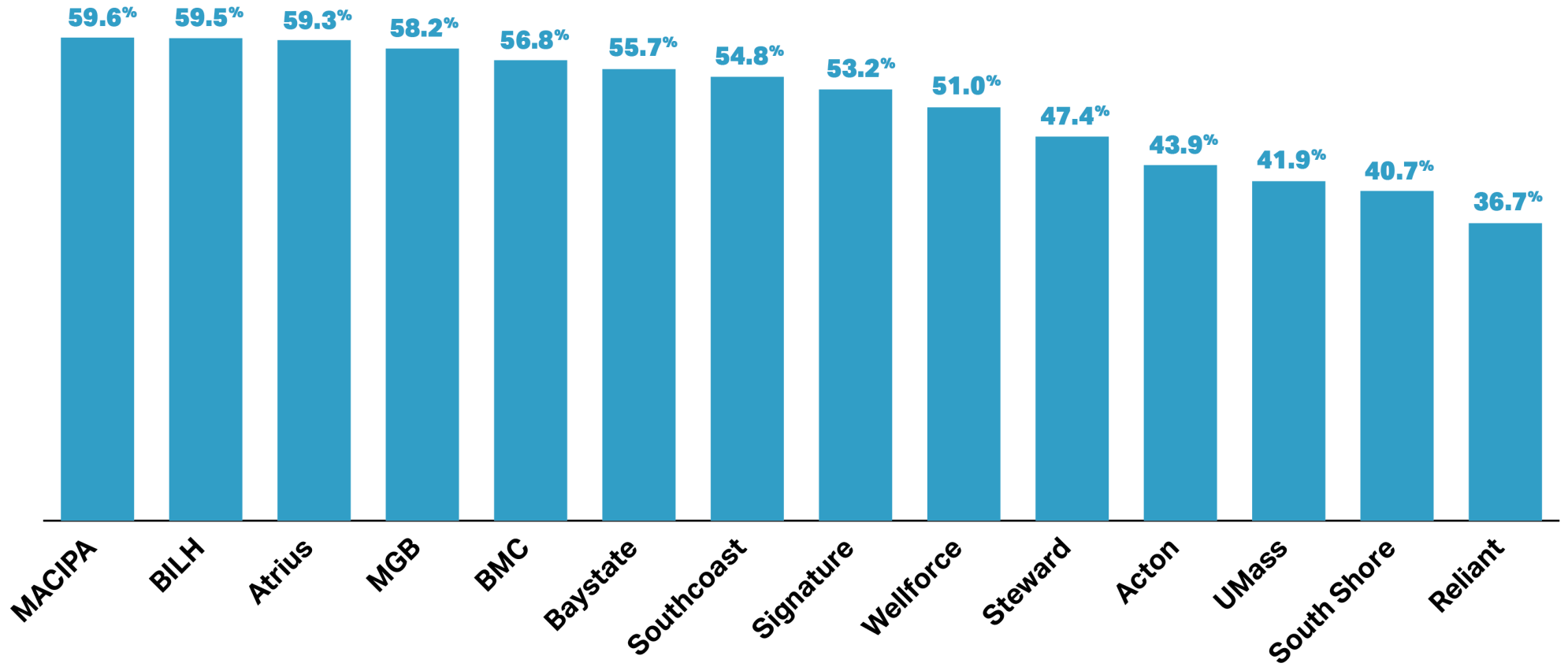
Among patients with at least one visit for a non-mental health condition, percent with any telehealth use for such conditions by zip code, March 15-December 31, 2020



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

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

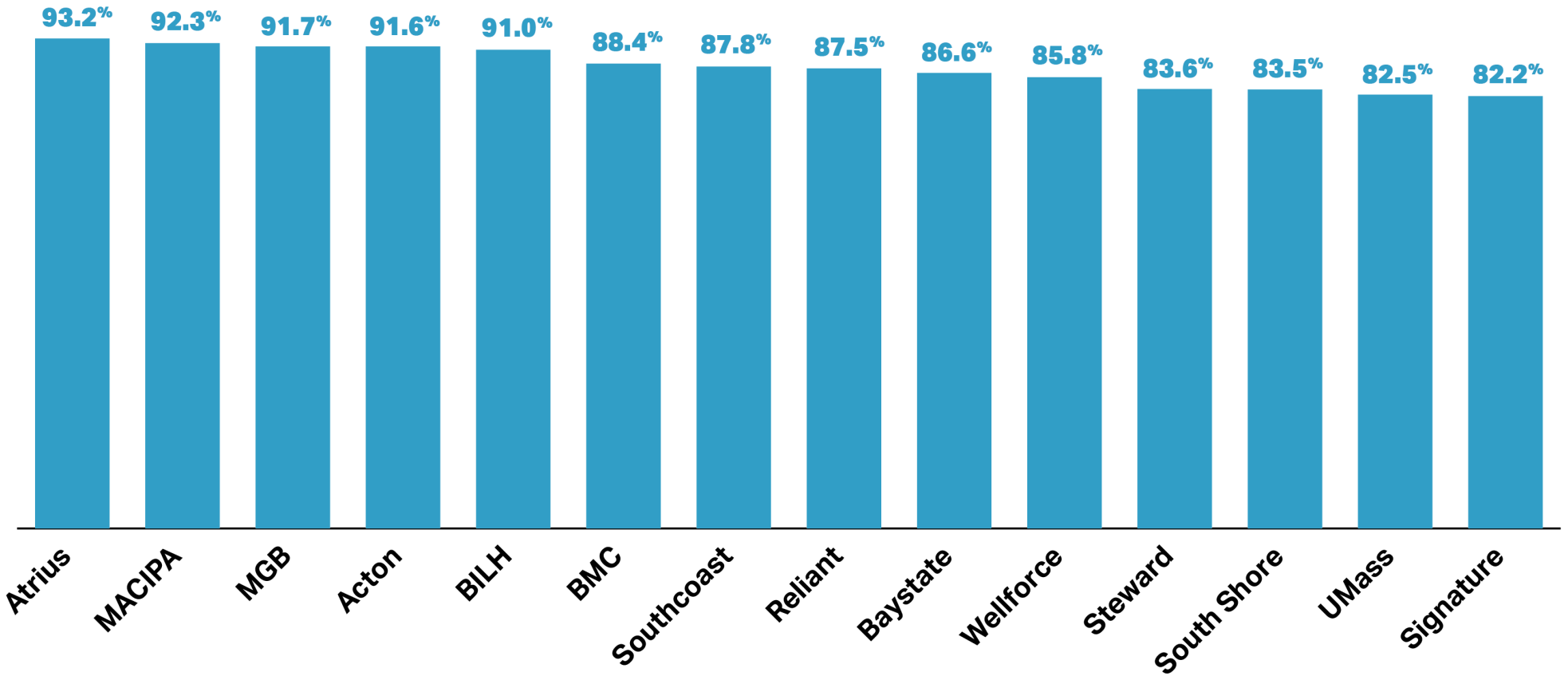
Among patients with at least one visit for a non-mental health condition, percent with any telehealth use for such conditions by provider organization, March 15-December 31, 2020



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

Telehealth use for mental health conditions was similar across provider organizations.

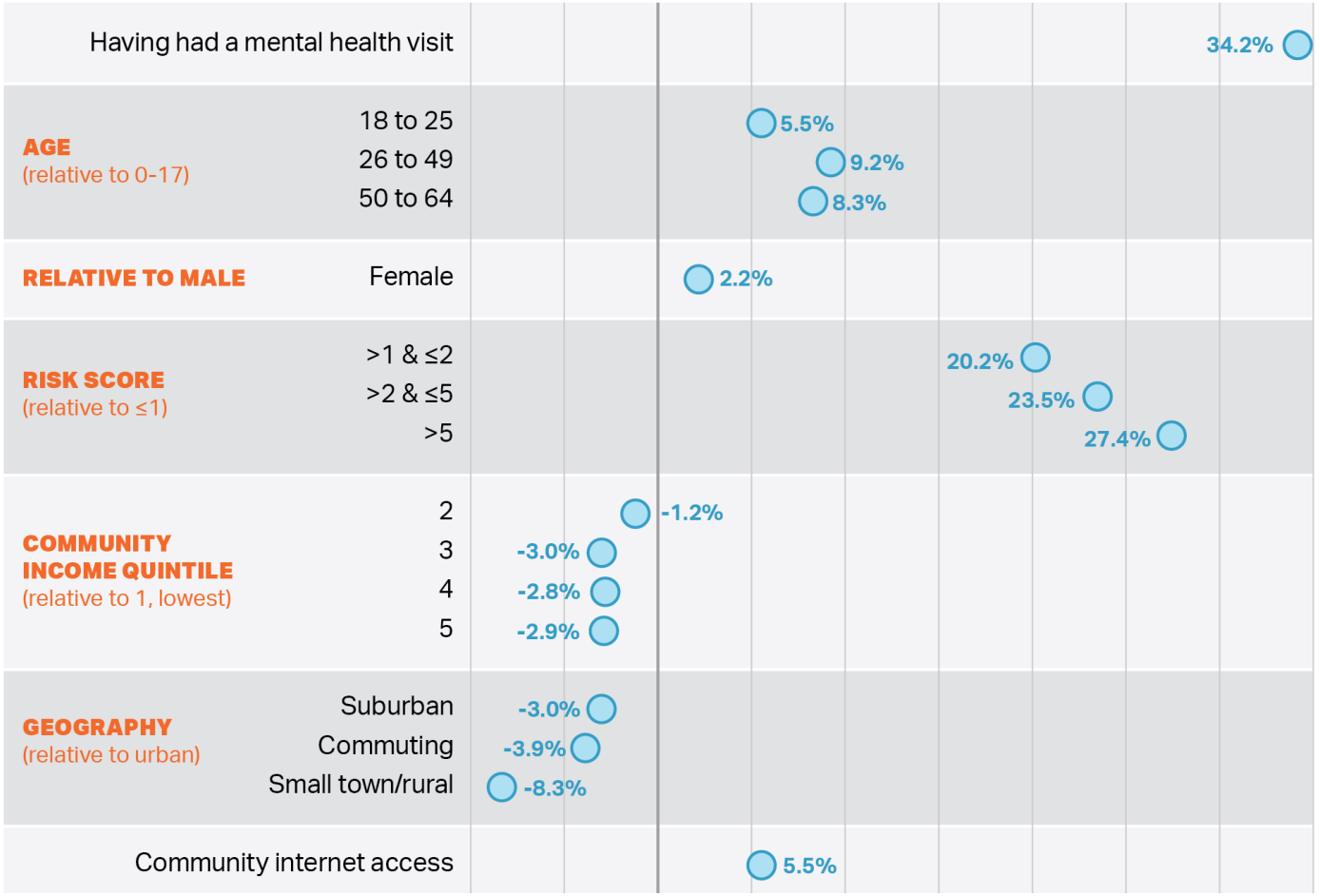
Among patients with at least one visit for a mental health condition, percent with any telehealth use for such conditions by provider organization, March 15-December 31, 2020



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

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

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



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

Research finds significant disparities in telehealth use by race and ethnicity.

- While the HPC was unable to observe differences in use of telehealth by an individual's race and ethnicity in medical claims data, surveys and medical record data generally find that the rate of telehealth use is lower among Black and Hispanic patients.
- CHIA's 2021 Massachusetts Health Insurance Survey found that 48.8% of non-Hispanic white residents reported having ever had a telehealth visit, compared to non-Hispanic Asian (39.6%), non-Hispanic Black (38.4%), other or multiple races (35.3%), and Hispanic (29.5%) residents.
- Video telehealth use is higher among white and Asian residents (see right panel).

Percent of Massachusetts adult patients who reported having a video telehealth visit in the last four weeks, 2021-2022

Race and ethnicity	Percent
Hispanic or Latino	42.4%
Non-Hispanic white	54.0%
Non-Hispanic Black	44.1%
Non-Hispanic Asian	59.9%
Two or more races and other races, not Hispanic	49.5%

Notes: Those who did not report the mode of their telehealth visits were excluded from the denominator. Survey results were averaged from July 21, 2021 to August 8, 2022.
Source: HPC analysis of the U.S. Census Bureau Household Pulse Survey.

Sources: Eberly LA, et al. Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic. JAMA Network Open. 2020 Dec 1;3(12):e2031640-.
Adepoju OE, et al. Utilization Gaps during the COVID-19 Pandemic: Racial and Ethnic Disparities in Telemedicine Uptake in Federally Qualified Health Center Clinics. Journal of General Internal Medicine. 2022 Apr;37(5):1191-7.
Center for Health Information and Analysis. Findings from the 2021 Massachusetts Health Insurance Survey. Jul, 2022.

Presentation Outline

1. Overall Use of Telehealth Services in Massachusetts in 2020
2. Variation in Use of Telehealth Services
3. **Telehealth's Effect on Total Spending**
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How has the availability of telehealth impacted total health spending?

- **Challenge:** Telehealth use increased dramatically in 2020 but overall spending decreased due to pandemic-related restricted access to care.
- **Approach:** The HPC constructed an analysis that asked: *in areas with better access to telehealth services, did spending or utilization increase more (or decrease less) than it did in areas with worse implied access to telehealth services?*
- Patients were assigned to a "high telehealth" group (better access) and a "low telehealth" group (worse access) based on their zip code.

Zip code quartile	Telehealth as % of routine E&M visits
1 "low telehealth"	18.7%
2	23.6%
3	27.4%
4 "high telehealth"	33.7%

Patients were further categorized into four clinically homogeneous cohorts.

CARDIOMETABOLIC

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

ASTHMA

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

MENTAL HEALTH

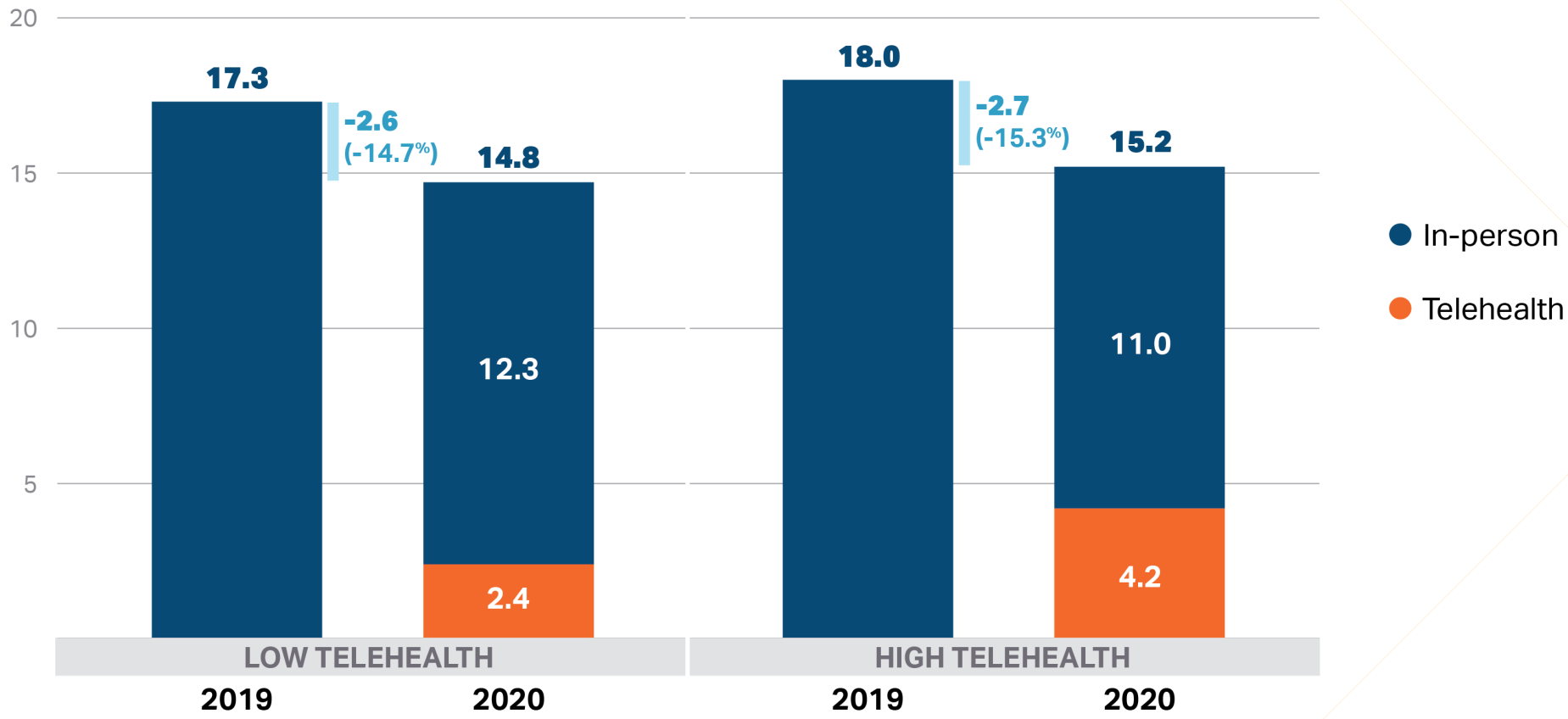
- Aged 18-64 in 2019
- Full coverage in all of 2019 and 2020
- Designated as having mood disorder or psychosis in 2019

HEALTHY

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

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

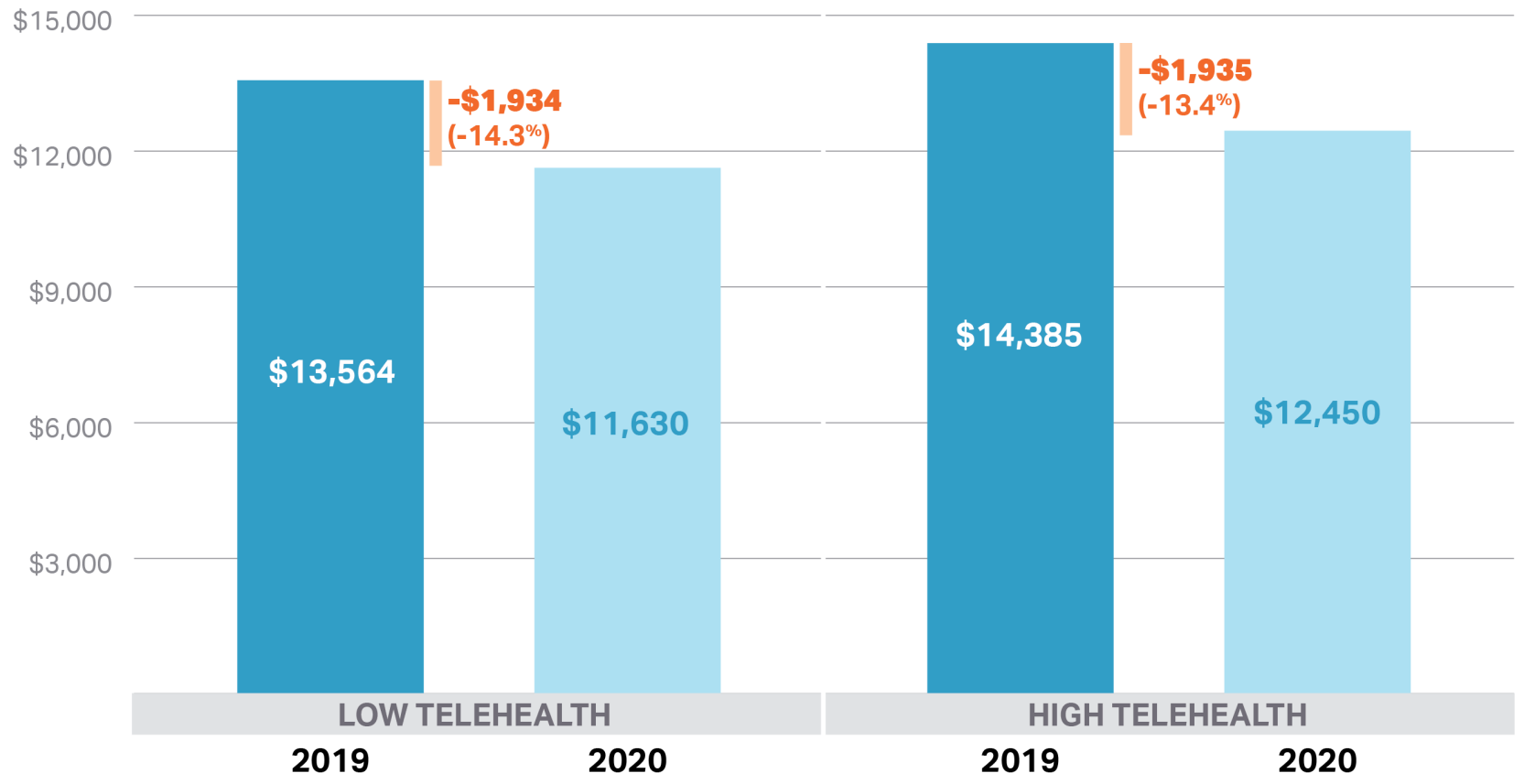
Number of ambulatory visits per patient in the cardiometabolic cohort



Notes: Results include all ambulatory visits (i.e., not limited to E&M visits).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

The change in spending was similar between the high and low-adoption group.

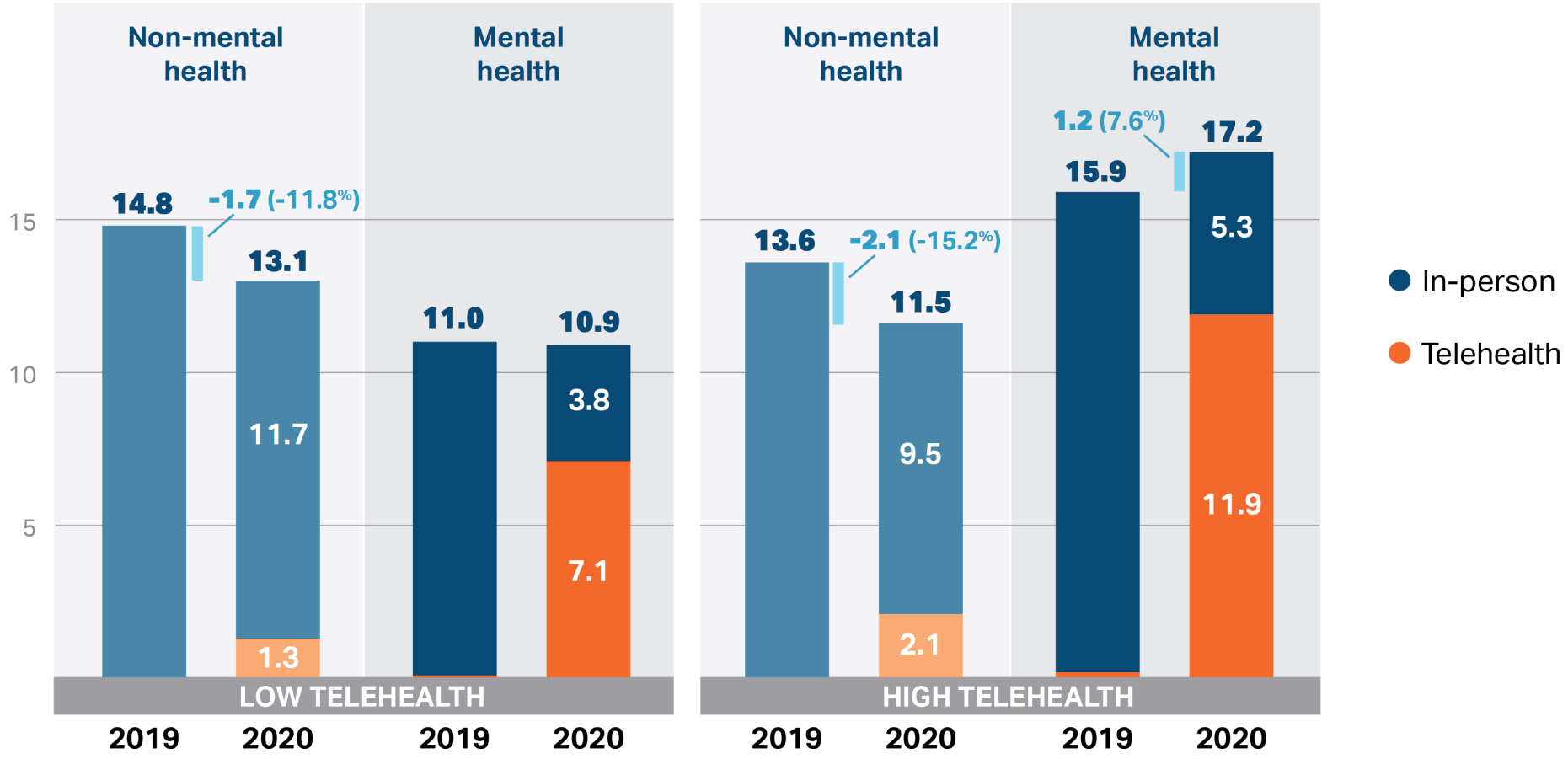
Average spending per patient in the cardiometabolic cohort



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

Mental health utilization increased for the high telehealth group while remaining similar for the low telehealth group.

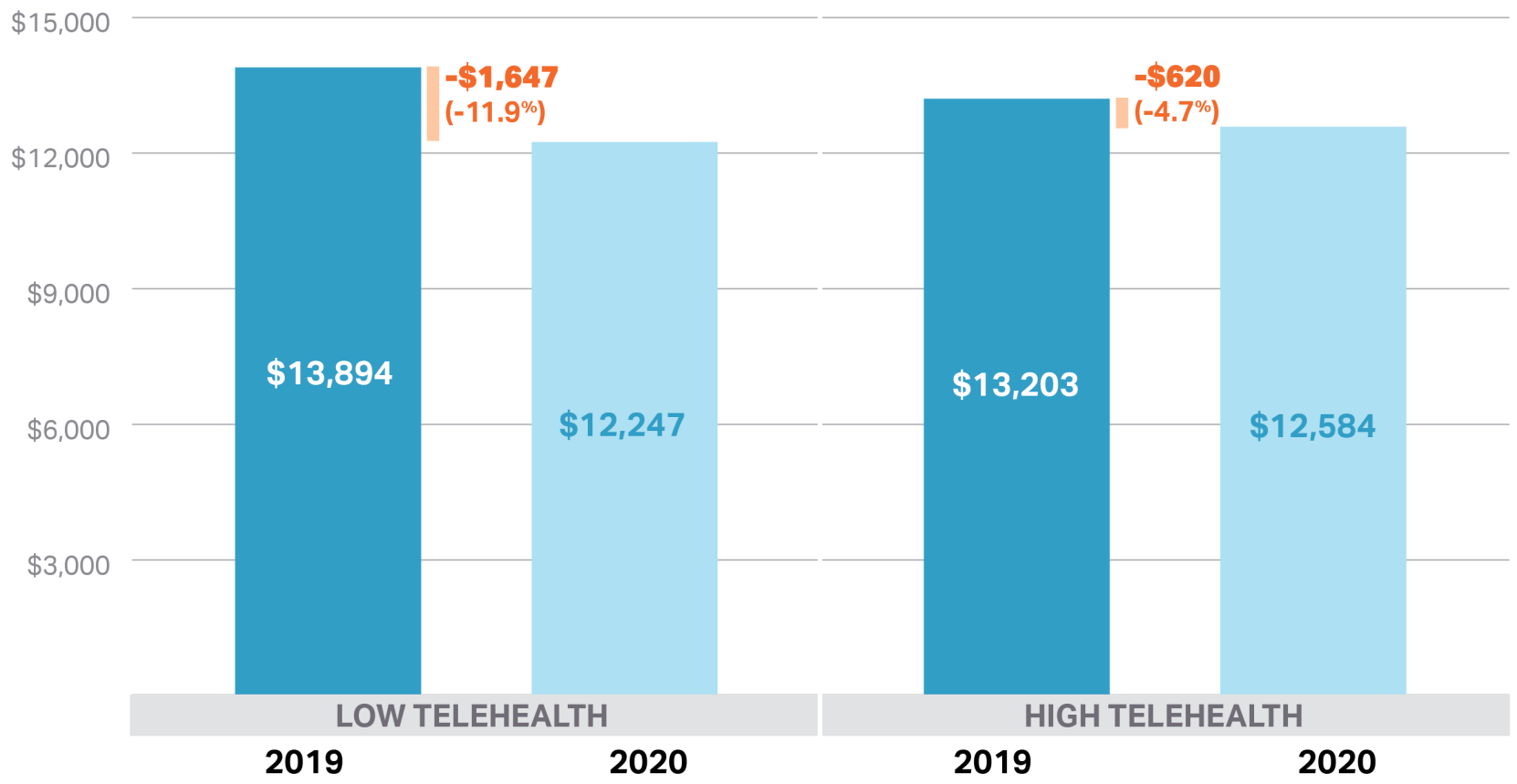
Number of ambulatory visits per patient in the mental health cohort



Notes: Results include all ambulatory visits (i.e., not limited to E&M visits).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

The reduction in spending was larger (12% vs 5%) for the low telehealth group.

Average spending per patient in the mental health cohort



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

Effect of telehealth on utilization is largely substitutive, except for mental health visits.

- Average ambulatory utilization and total spending decreased for all cohort members from 2019 to 2020.
- The extent to which utilization and spending changed was largely similar between the low and high telehealth group for patients in the cardiometabolic, asthma, and healthy cohorts.
- For patients in the mental health cohort, utilization of mental health services increased from 2019 to 2020 for the high telehealth group while utilization from 2019 to 2020 was unchanged for the low telehealth group, suggesting that **telehealth enabled greater access to mental health care during the COVID-19 pandemic and appears to have led to more visits than would have occurred without telehealth.**

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Stakeholder Perspectives

Patient Experience

- Telehealth services can especially improve **access to care for patients with chronic conditions** and **those who live in geographic areas where certain providers may be in short supply**, such as specialists and behavioral health providers
- Telehealth can greatly reduce patient time and travel costs
- Audio-only vs video: While video visits may be preferrable in many aspects, **audio-only visits allows for increased access for certain populations** (e.g., older patients, patients without reliable internet due to connectivity or financial barriers), supporting health equity

Provider Challenges

- Providers described that they are still **in the process of refining their telehealth offerings** and **developing efficient hybrid care models**
- **Telehealth billing** and **documentation requirements** are administratively complex and vary by payer
- There can be disruptions to continuity of care when **patients travel out of state**

Access Barriers

- **Low digital literacy and a lack of access to technology** were cited as the biggest barriers
- Telehealth platforms, patient portals, and other communication materials are often **not designed with an emphasis on equity** (e.g., platform unable to accommodate interpreter services)

Stakeholder Perspectives

Perspectives on Payment

- **Providers** that offer both in-office and telehealth services say that offering telehealth services has not reduced their total practice expenses
  - Telehealth services may still require in-office expenses such as office space or administrative staff
  - Provider organizations have incurred additional expenses for technology to support telehealth
  - Telehealth may improve practice efficiency by reducing no-show appointments
- Some **payers** note that the marginal expense of a telehealth visit should be lower (e.g. overhead, support staff, and other expenses should be reduced) and should therefore be reimbursed accordingly
  - Payers and others who have cautioned against parity also cite concerns of overuse and of not being able to realize the full savings potential from a more efficient mode of care

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Priorities for Action: The HPC urges the legislature to adopt the following three strategies regarding billing and payment for telehealth services.

1. **Extend Payment Parity for Certain High-Value Telehealth Services.** The Commonwealth should **extend the sunset for the payment parity mandate on a limited basis** (e.g., for 2 years) for primary care and chronic disease management. The additional time would allow providers to continue improving their telehealth platforms and workflow, and to develop efficient hybrid care models that take advantage of the lower resource needs for some telehealth visits relative to in-person visits.

2. **Prohibit Unnecessary Hospital Fees.** Consistent with HPC's long standing recommendation to limit facility fees for certain common ambulatory services (e.g., E&M services) in hospital outpatient departments, the Commonwealth should prohibit providers from charging facility fees for telehealth services to improve market fairness and consumer protections.

3. **Reduce Telehealth Billing Complexity.** Consistent with HPC's previous recommendation on administrative complexity, **coding rules and documentation requirements for telehealth services should be standardized across payers - including audio-only services - to reduce unnecessary administrative complexity** in the health care system and their associated costs. Inconsistent requirements consume significant provider time and resources without adding value to patient care.

Additional Recommendations: Billing and Payment

4 **Promote Alternative Payment Methods (APMs).** Health plans and providers should work collaboratively to adopt **APMs** that enable providers to incorporate a range of telehealth services and modalities into their practice. These models can give providers flexibility to utilize telehealth based on individual patient needs and incentivize them to adopt cost-effective use of telehealth.

5 **Continue Payment Parity between Audio and Video Visits.** Health plans should **continue payment parity between audio and video visits to ensure that audio-only telehealth remains a viable mode of care delivery** for patients facing barriers to care. Audio-only telehealth is important for patients with low digital literacy and/or no reliable internet connection/cellular data, who are more likely to be and people of color, elderly patients, and those living in lower income or rural areas.

Additional Recommendations: Access to Care and Health Equity

6 **Ensure Continuity of Care when Patients are Out of State.** The Commonwealth should consider **policy changes and interstate solutions that would enable providers to deliver telehealth services to established patients** who live in a nearby state or who are out of state temporarily.

7 **Invest in Equitable Access to and Innovative Applications of Telehealth.** The HPC supports **policies and resources to foster patient digital literacy and to increase access to high-speed internet and connected devices.** Specifically, the HPC recommends dedicated funding to the Broadband Institute and the HPC to pilot innovative applications of telehealth (e.g., remote monitoring devices) and to broaden the reach of telehealth to underserved patient populations.

8 **Design Technology for Inclusive Telehealth Delivery.** Development and adoption of **telehealth platforms that incorporate accessibility features to meet varying patient needs** should be prioritized, such as the ability to integrate interpreter services, closed captioning, and high-contrast display.

9 **Support Training and Capacity-Building for Clinicians and Support staff.** Providers are encouraged to **devote resources aimed at increasing access to telehealth services in traditionally underserved patient populations**, including investing in the capability to consistently provide high quality video visits in addition to audio, translating patient portals and other patient communication materials in multiple languages, and training clinicians and support staff to better assist patients experiencing technical difficulties.

Additional Recommendations: Consumer Transparency

10 **Increase Patient Education and Transparency on Telehealth Coverage and Cost-Sharing.** Broad expansion of telehealth has enabled providers to adopt a wide range of telehealth services and receive payments for some services that were traditionally unbillable, such as certain phone calls and messages through patient portals. However, billing practices vary by provider and payer, which can create patient confusion over what counts as a visit, what is covered, and what their cost-sharing obligation is. To increase transparency and protect patients from receiving unexpected bills, **health plans should create accessible materials to educate patients on their telehealth benefits and cost-sharing requirements. Providers should clearly disclose any billing changes in their practice and notify patients** in advance of their potential cost-sharing obligation in certain situations.

Areas for Future Research and Monitoring

- To continue building the evidence base for clinically appropriate and high value use of telehealth, the HPC highlights the following areas for future research and monitoring:
  - **Telehealth's impact on spending post-pandemic:** While telehealth does not appear to significantly raise total spending based on our analysis using 2020 data, the HPC and others will continue to examine the utilization and spending impact of telehealth beyond the pandemic, including potential variation by race and ethnicity as data collection improves in the future.
  - **Quality and outcomes:** It is important to ensure that providers deliver quality and value through telehealth services. As this modality of care matures, further research is needed on quality and patient outcomes by population, setting, and clinical condition.
  - **Third party telehealth platforms and other emerging telehealth models:** In addition to telehealth services delivered by traditional clinicians and provider systems, there are a growing number of fully virtual third-party telehealth providers (e.g., Teladoc, Doctor on Demand) and alternative digital health platforms (e.g., Omada and Livongo, which offer digital coaching for patients with chronic conditions) increasingly being adopted by health plans, employers, and patients. As telehealth technology and business landscapes continue to evolve, it is important to understand how these services are incorporated into plan designs and their impact on spending and premium so that payment and other regulatory policies remain relevant in the future.

VOTE

Report to the Legislature: Telehealth Use in the Commonwealth and Policy Recommendations

MOTION

That the Commission hereby authorizes the issuance of the attached report on telehealth utilization in the Commonwealth, pursuant to section 67 of chapter 260 of the Acts of 2020.

Agenda

Call to Order

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Board Operations

Executive Director's Report

Care Delivery Transformation

Market Oversight and Transparency

VIDEO PRESENTATION: REFLECTING ON THE HPC'S 10 YEAR ANNIVERSARY MILESTONE

Executive Director Employment Agreement (VOTE)

Schedule of Upcoming Meetings

Ten Years of the Massachusetts Health Policy Commission: A decade of advancing a more transparent, accountable, and equitable health care system

Interactive Timeline

Reflection Video

Two new releases from the HPC celebrate and commemorate the 10th anniversary of the agency's founding legislation, Chapter 224. Both are available online now: tinyurl.com/HPCat10

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EXECUTIVE DIRECTOR EMPLOYMENT AGREEMENT (VOTE)

Schedule of Upcoming Meetings

VOTE

Executive Director Contract Renewal

MOTION

That the Commission hereby authorizes the Chair to enter negotiations with David M. Seltz to renew his employment agreement for Executive Director for a multi-year term and execute the agreement on terms deemed advisable by the Chair.

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SCHEDULE OF UPCOMING MEETINGS

2023 Public Meeting Calendar

HPC

– JANUARY –

S	M	T	W	T	F	S
1	2	3	4	5	6	7
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– FEBRUARY –

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– MARCH –

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– APRIL –

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– MAY –

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– JUNE –

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– JULY –

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– AUGUST –

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– SEPTEMBER –

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– OCTOBER –

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

– NOVEMBER –

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

– DECEMBER –

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

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

Tuesday, January 24 (ANF, 2:00 PM)
Wednesday, February 15
Wednesday, May 10
Monday, July 10 (ANF, 2:00 PM)
Wednesday, October 4

ADVISORY COUNCIL

Wednesday, February 8
Wednesday, May 24
Wednesday, 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.