MASSACHUSETTS
HEALTH POLICY COMMISSION

HPC Board Meeting

June 8, 2022

Agenda

HPC

CALL TO ORDER

Approval of Minutes **(VOTE)**

2022 Health Care Cost Trends Report

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

Executive Director's Report

Schedule of Upcoming Meetings

Agenda

HPC

Call to Order

APPROVAL OF MINUTES (VOTE)

2022 Health Care Cost Trends Report

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

Executive Director's Report

Schedule of Upcoming Meetings

VOTE

Approval of Minutes from the April 13, 2022 Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on April 13, 2022, as presented.

Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

2022 HEALTH CARE COST TRENDS REPORT

- Massachusetts Spending Trends
- Hospital and PAC Utilization
- Provider Organization Performance Variation
- Prices

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

Executive Director's Report

Schedule of Upcoming Meetings

2022 Annual Cost Trends Report – Outline and Public Presentation Dates

HPC

- Chapter #1: Massachusetts Spending Performance – *key findings to be presented today*
- Chapter #2: Changes in Ambulatory Care During the COVID-19 Pandemic – *key findings presented at the HPC MOAT Committee meeting on May 11, 2022*
- Four Chartpacks – *key findings to be presented today*
  - Price Trends and Variation
  - Hospital Utilization and Post-Acute Care
  - Post-Acute Care
  - Provider Organization Performance Variation
- Performance Dashboard – *to be presented at the HPC Board meeting on July 13, 2022*
- Recommendations – *to be presented at the HPC Board meeting on July 13, 2022*

Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

2022 Health Care Cost Trends Report

MASSACHUSETTS SPENDING TRENDS

- Hospital and PAC Utilization
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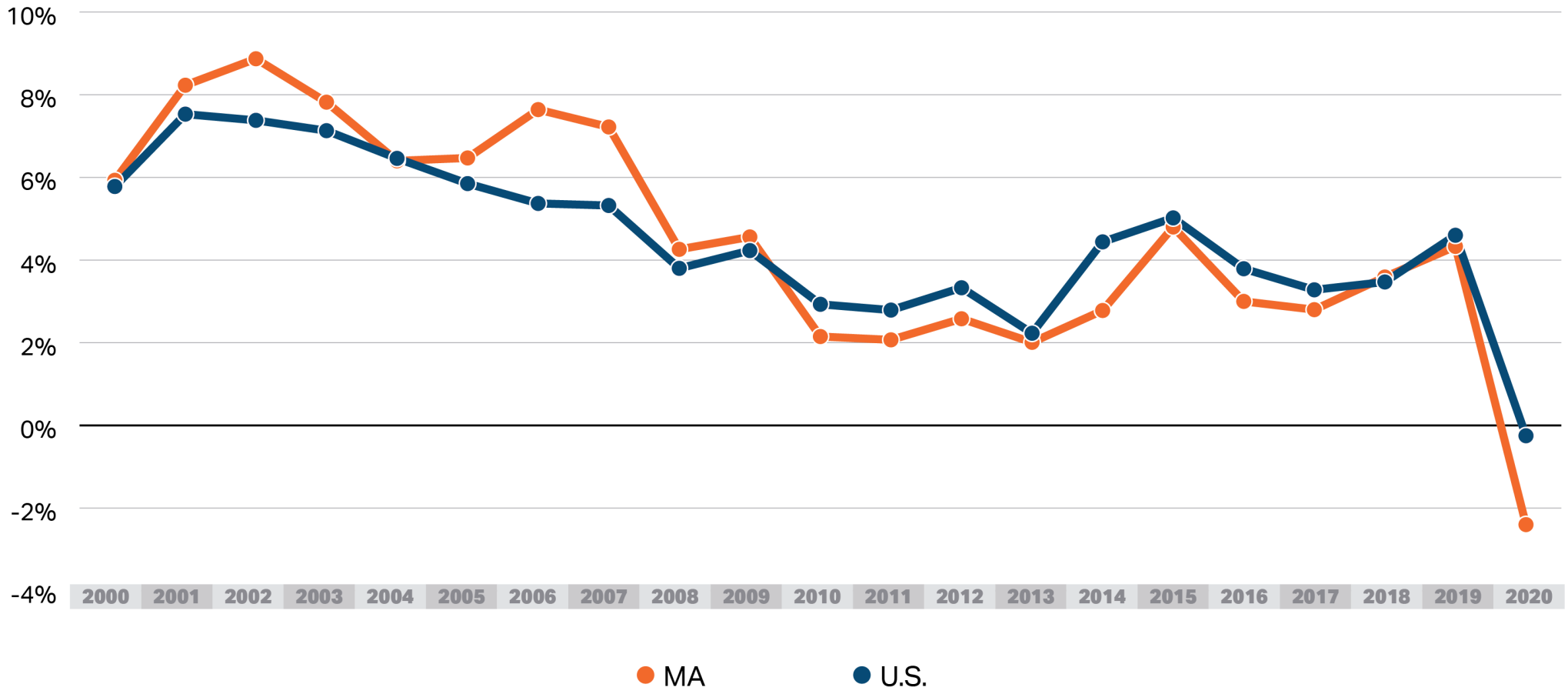
Health care spending growth in both Massachusetts and the U.S. declined in 2020, driven by COVID-19 utilization reductions. The decline was larger in Massachusetts.

HPC

Annual growth in total health care spending per capita in Massachusetts and the U.S., 2000-2020



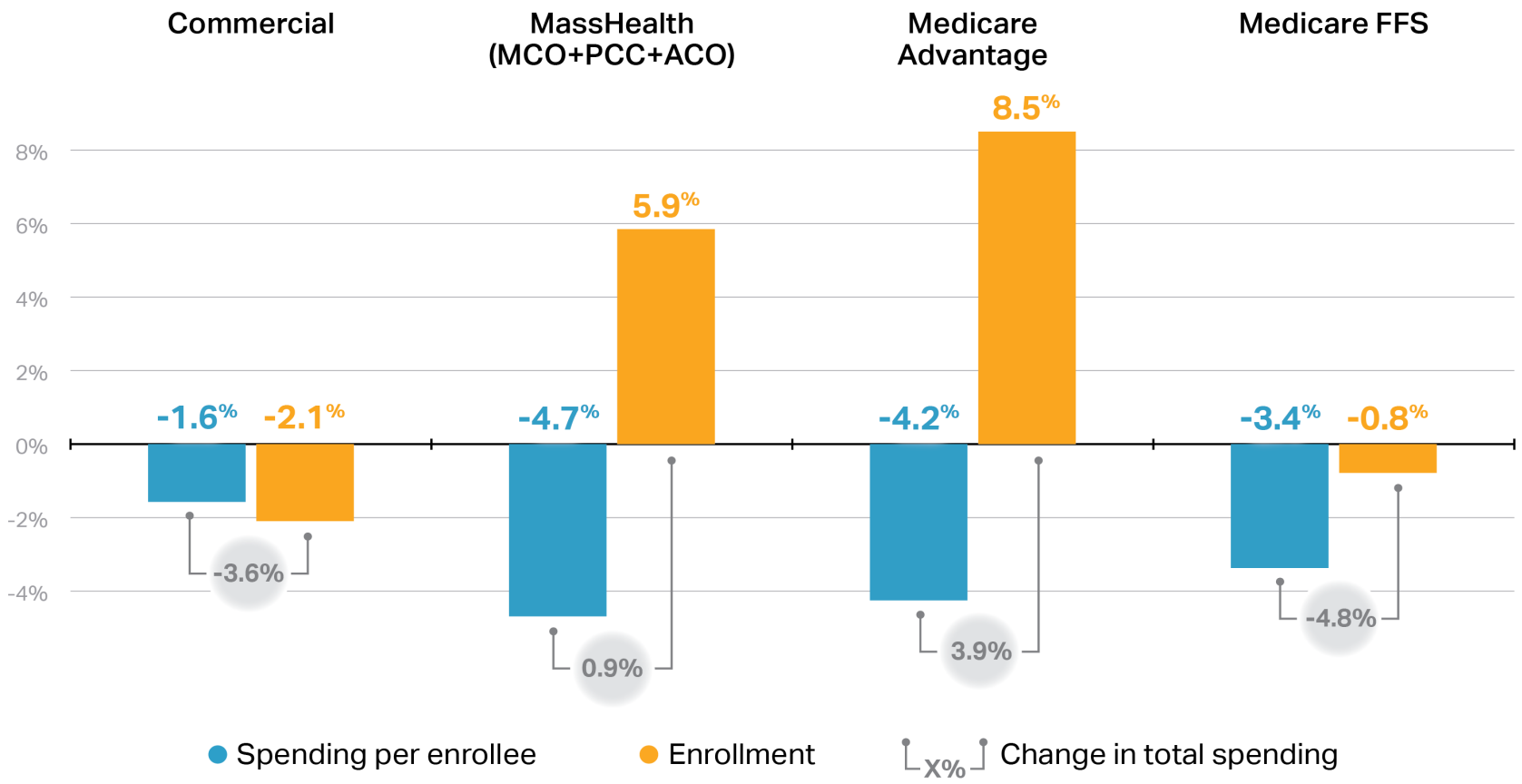
Notes: U.S. data includes Massachusetts. US data exclude federal COVID-19 relief funding. The decline in per capita spending growth in Massachusetts in 2020 reflects a 2% jump in the state's population as reported in the 2020 Decennial Census relative to that reported by the US Census Bureau for 2019 which was based on the 2010 Decennial Census.

Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2019 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2020.

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

HPC

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



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

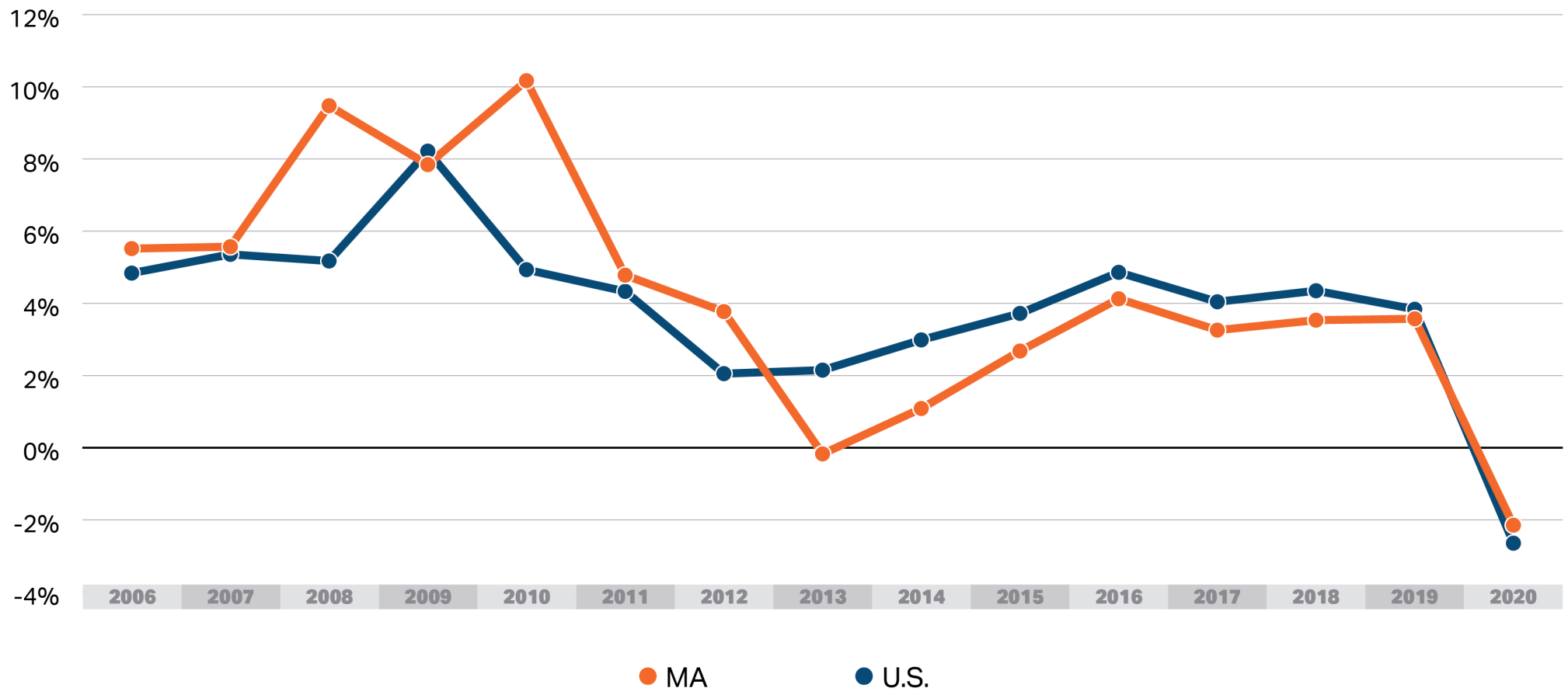
Share of Massachusetts Medicare beneficiaries in Medicare Advantage plans:

- 2015: 18.6%
- 2020: 24.1%

From 2013 to 2019, commercial spending in Massachusetts grew more slowly than the U.S. These trends converged in 2020.

HPC

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

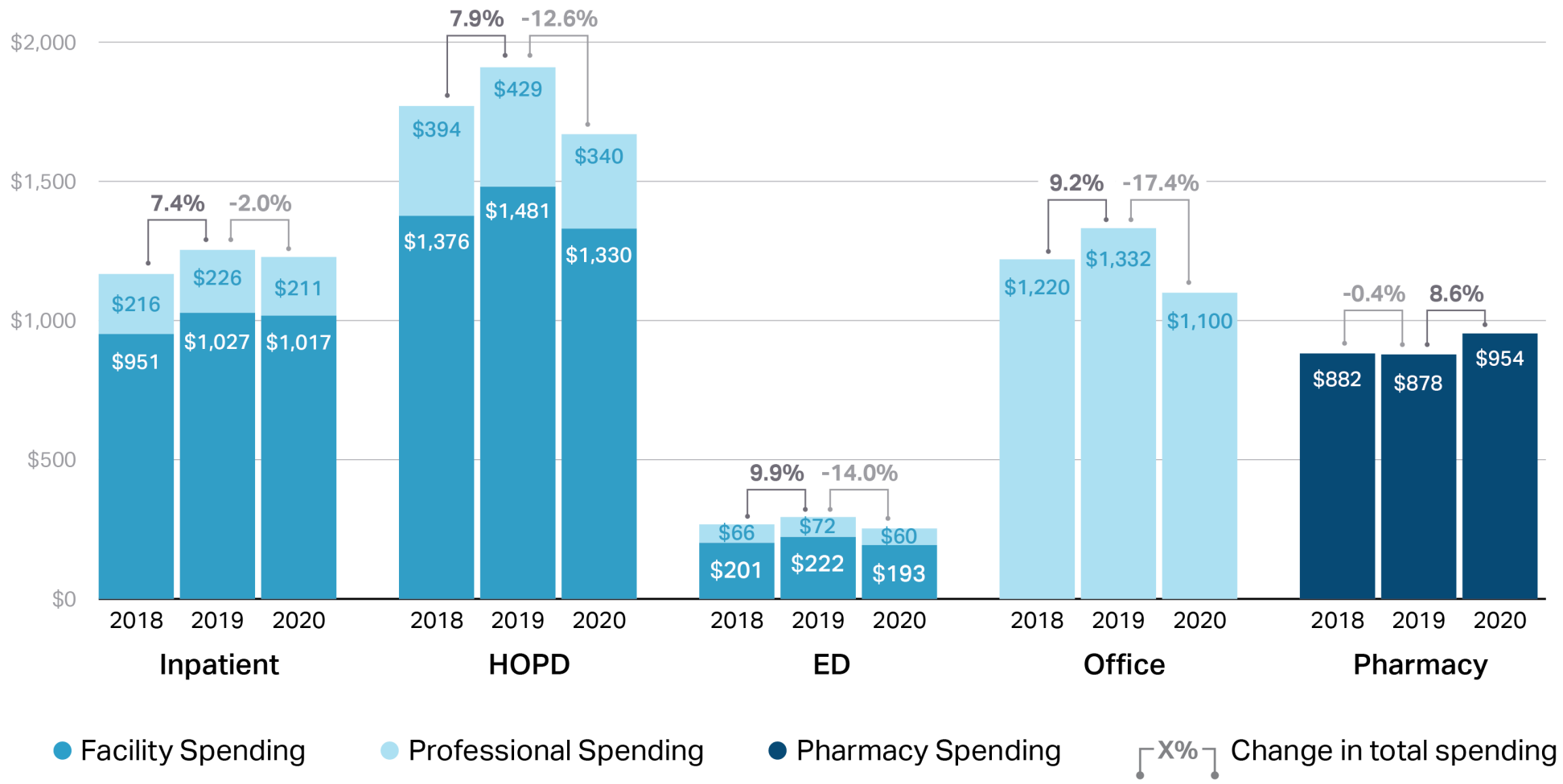


Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance.
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2019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

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

HPC

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

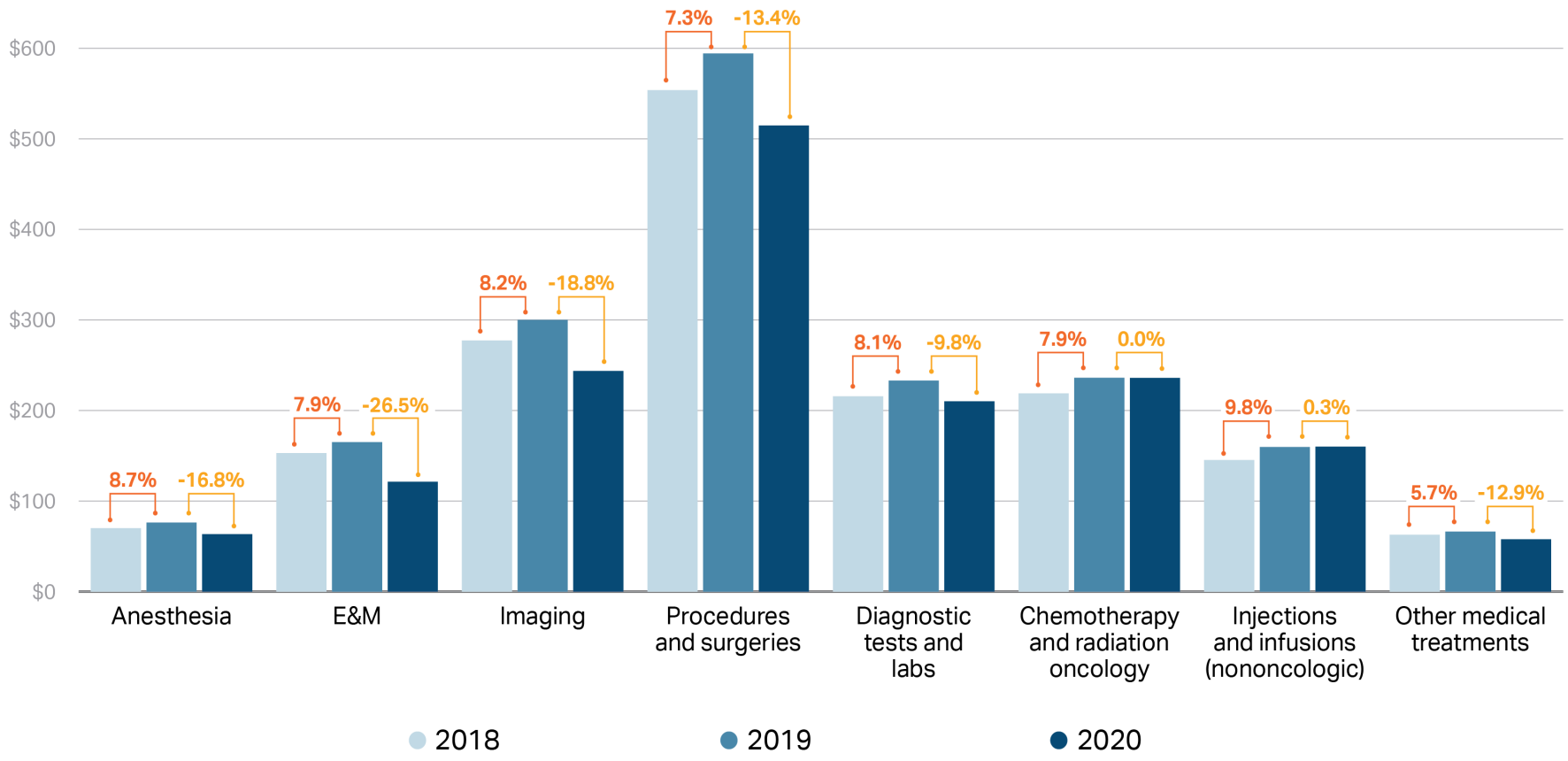


Notes: Medical spending reflect data from five payers: BCBS, HPHC, Tufts, Allways, and Anthem. Pharmacy spending is net of rebates and reflects data from four payers: BCBSMA, HPHC, Tufts, and Allways.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

Within HOPD settings, E&M spending dropped 26% and imaging dropped 19% while spending on chemotherapy, radiation oncology, injections and infusions was unchanged.

HPC

HOPD spending per member per year by type of services, 2018-2020



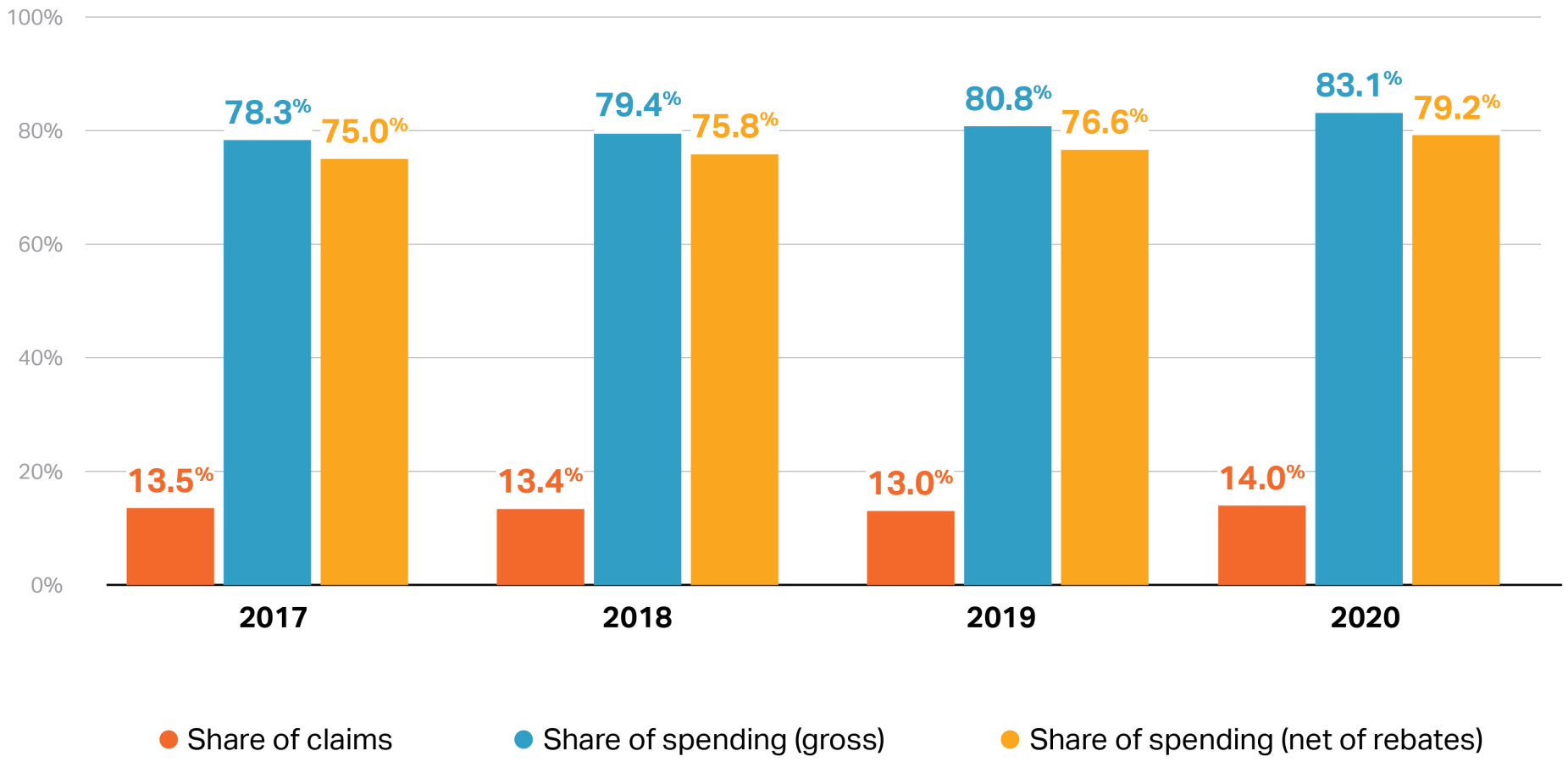
Chemotherapy, radiation oncology, injections and infusions make up **24.4%** of total HOPD spending in 2020, up from **21.2%** in 2018.

Notes: service categories adapted from the BETOS Classification System, 2021.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

Branded drugs represent the majority and a growing share of prescription drug spending.

HPC

Branded drug share of claims vs. share of net and gross spending, 2017-2020

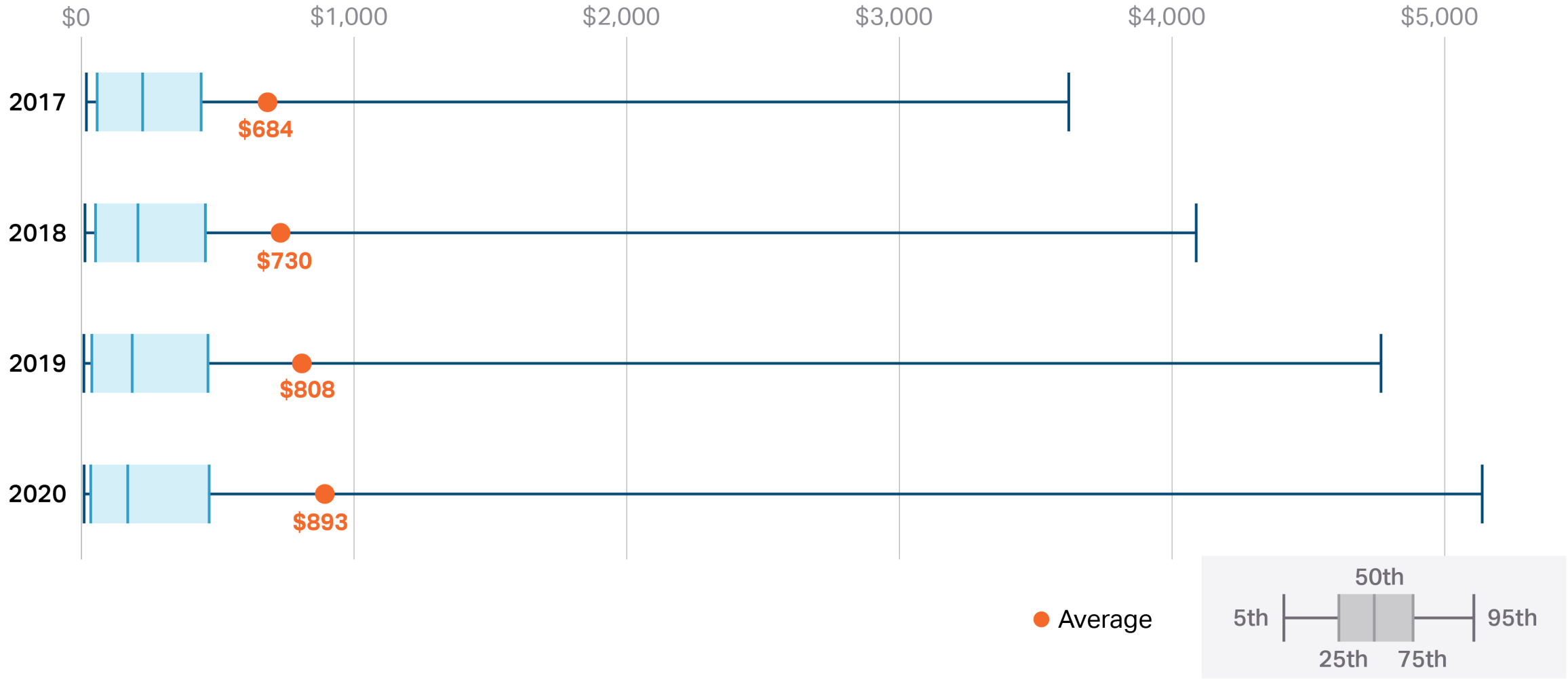


Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2017-2020, V 10.0. Pharmacy claims include data from four payers: BCBSMA, Tufts, HPHC, Allways. Rebate shares (applied to gross spending figures) were obtained from Center for Health Information and Analysis Annual Reports.

Average gross spending per branded prescription increased 11% in 2020. Spending per prescription exceeded $5,000 for 5% of branded prescriptions in 2020.

HPC

Gross spending distribution per branded prescription, 2017-2020

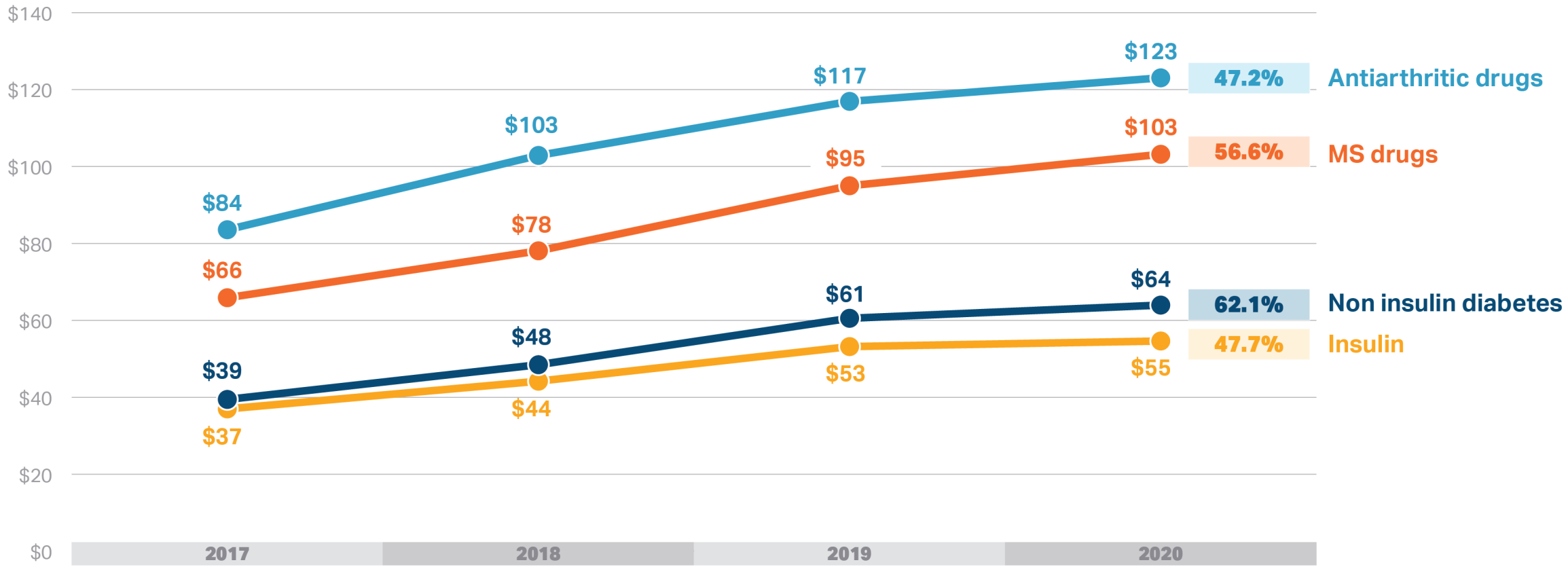


Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2017-2020, V 10.0. Pharmacy claims include data from four payers: BCBSMA, Tufts, HPHC, Allways.

Out of pocket spending for certain categories of branded drugs grew substantially from 2017 to 2020.

HPC

Average cost sharing per 30-day supply, 2017-2020



Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims database, pharmacy claims, 2017-2020, V 10.0. Pharmacy claims include data from four payers: BCBSMA, Tufts, HPHC, Allways.

Summary of Findings: Spending Trends

HPC

- Spending per enrollee declined for all market sectors in 2020, from a 1.6% decline for commercial enrollees to a 4.7% decline for those enrolled with MassHealth primary coverage.

- In 2020, commercial spending declined for most categories of care, particularly in provider offices, EDs and the professional component of HOPD. In contrast, hospital outpatient spending on **cancer care, injections and infusions was unchanged,** and **pharmacy spending increased**.

- Growth in pharmacy spending was driven by **high prices for branded drugs**. The average price per branded prescription was $893 in 2020, up from $684 in 2017.

Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

2022 Health Care Cost Trends Report

- Massachusetts Spending Trends

HOSPITAL AND PAC UTILIZATION

- Provider Organization Performance Variation
- Prices

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

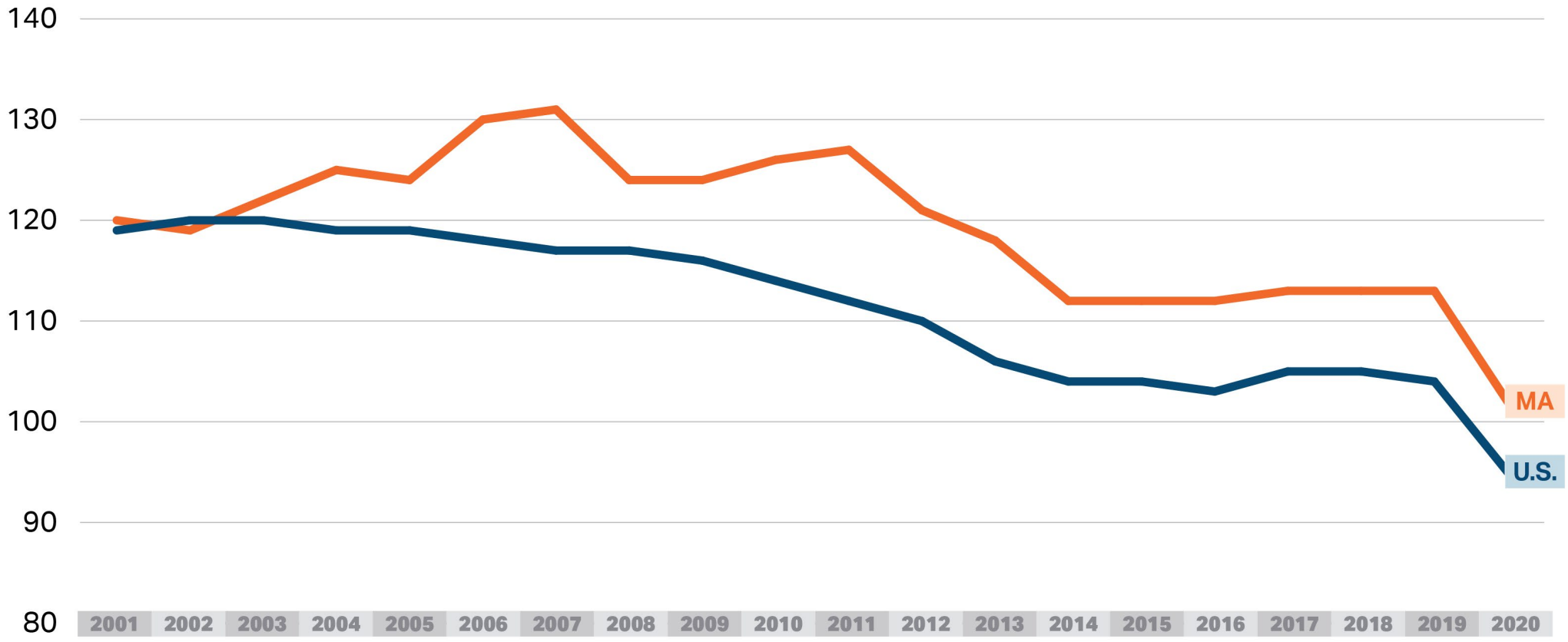
Executive Director's Report

Schedule of Upcoming Meetings

Massachusetts hospital inpatient utilization remained 7% higher than the U.S. average in 2020.

HPC

Inpatient hospital discharges per 1,000 residents in Massachusetts and the U.S., 2001-2020

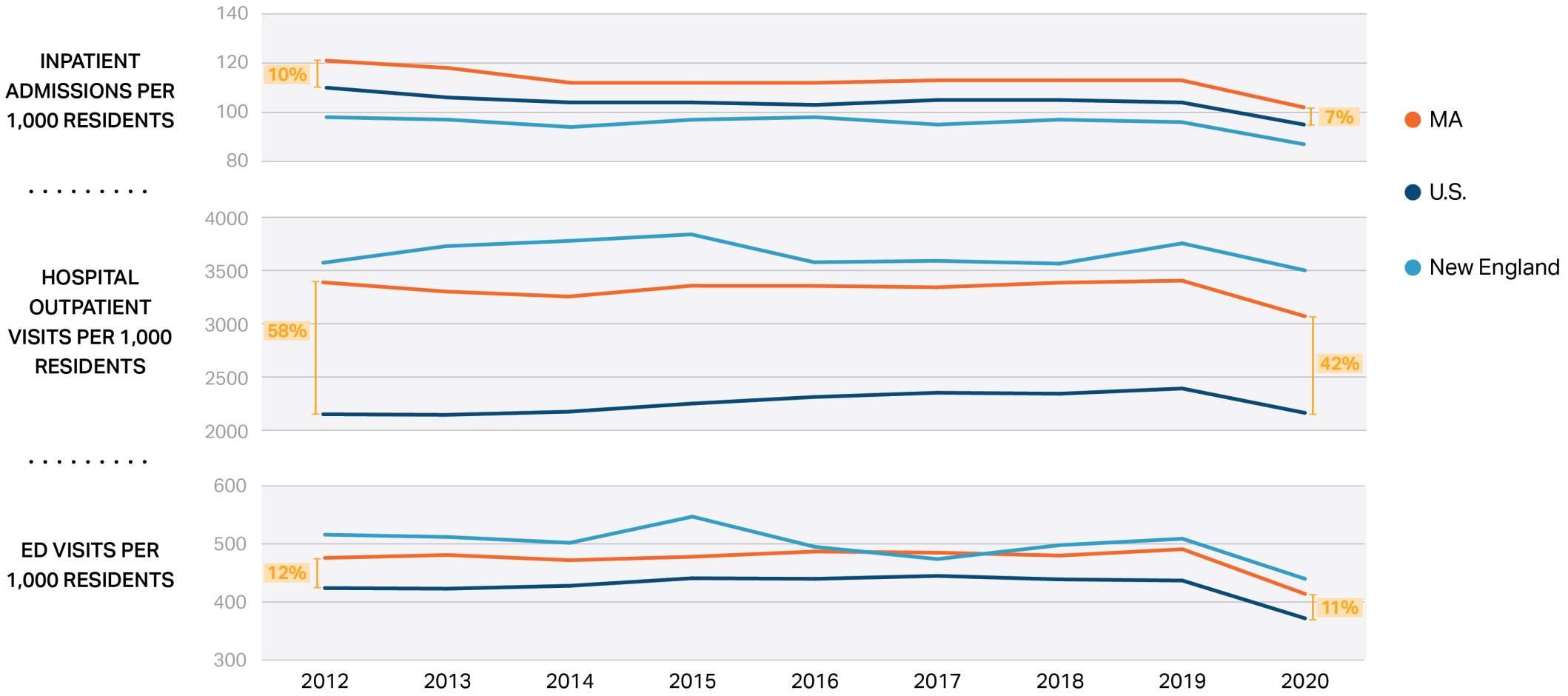


Notes: U.S. data includes Massachusetts. Data are for community hospitals as defined by Kaiser Family Foundation, which represent 85% of all hospitals.
Sources: Kaiser Family Foundation analysis of American Hospital Association data.

Massachusetts residents continued to have 7% more ED visits and 42% more hospital outpatient visits than the U.S. average, though other New England states also have high utilization of these visits.

HPC

Hospital use in Massachusetts, New England, and the U.S., 2012-2020

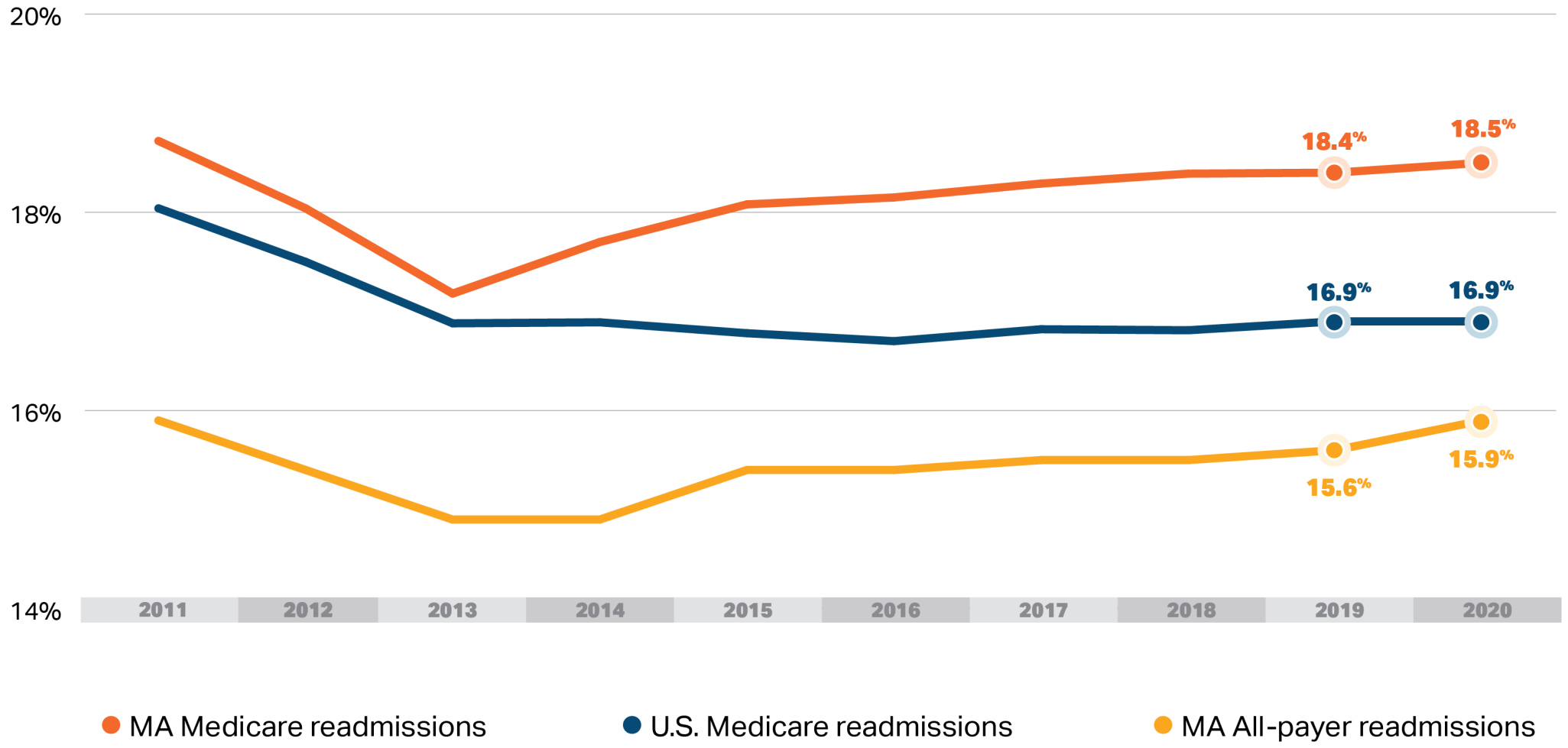


Notes: Data are for community hospitals as defined by Kaiser Family Foundation, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the intellectually disabled, and alcoholism and other chemical dependency hospitals are not included. New England includes Connecticut, Maine, New Hampshire, Rhode Island and Vermont. Massachusetts is excluded from the New England category.
Sources: Kaiser Family Foundation State Health Facts (2020). "Hospital Admissions per 1,000 Population by Ownership Type" (2012 - 2020); "Hospital Emergency Room Visits per 1,000 Population by Ownership Type" (2012-2020); "Hospital Outpatient Visits per 1,000 Population by Ownership Type" (2012-2020). http://www.kff.org/state-category/providers-service-use/hospital-utilization/

All-payer and Medicare readmission rates in Massachusetts slightly increased in 2020. Massachusetts had the 3rd highest Medicare readmission rate in 2020.

HPC

30-day readmission rates, Massachusetts and the U.S., 2011-2020

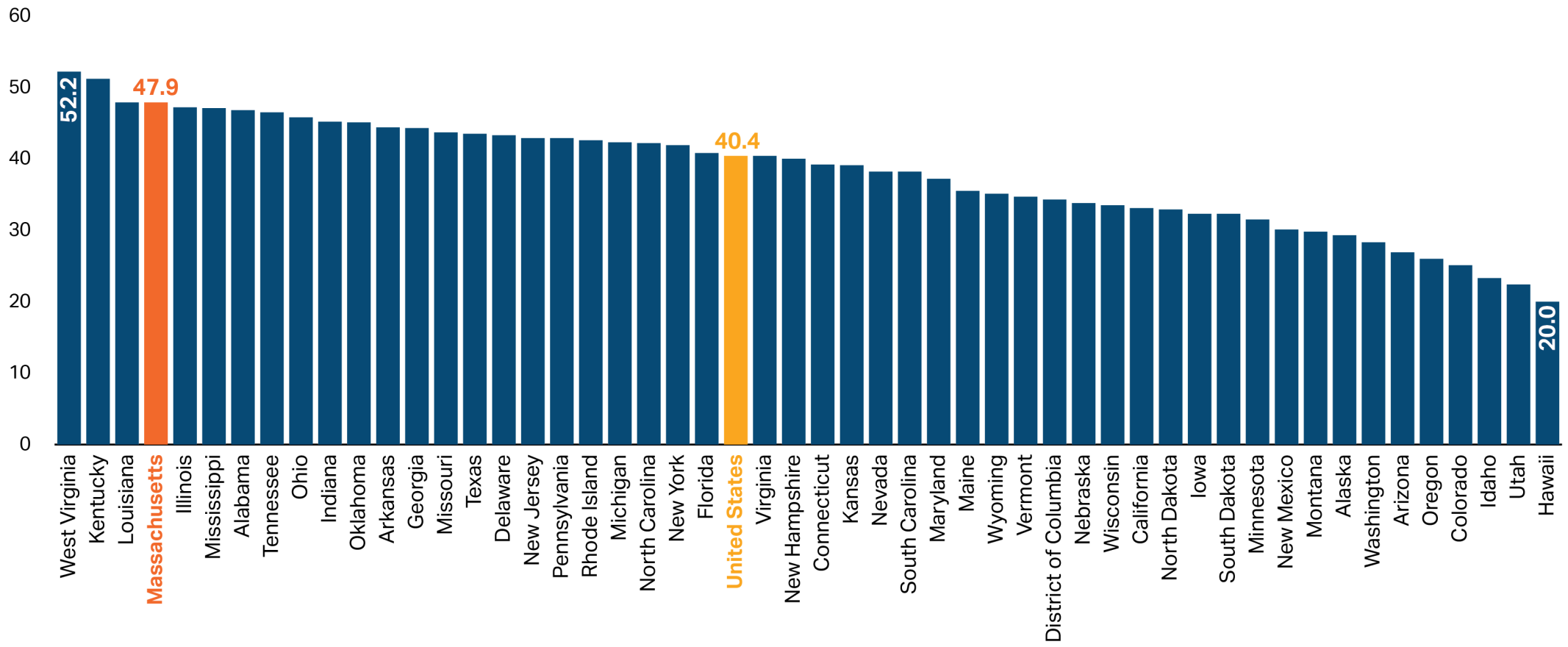


Sources: Centers for Medicare and Medicaid Services (U.S. and MA Medicare), CY2011-2020; Center for Health Information and Analysis (all-payer MA), SFY2011-2020.
The states with Medicare readmission rates higher than Massachusetts are Nevada (18.5%) and West Virginia (18.9%).

In 2019, Massachusetts had the fourth-highest rate of preventable hospitalizations among Medicare beneficiaries in the U.S.

HPC

Annual preventable hospital admissions per 1,000 FFS Medicare beneficiaries in 2019 among beneficiaries age 65+, by state

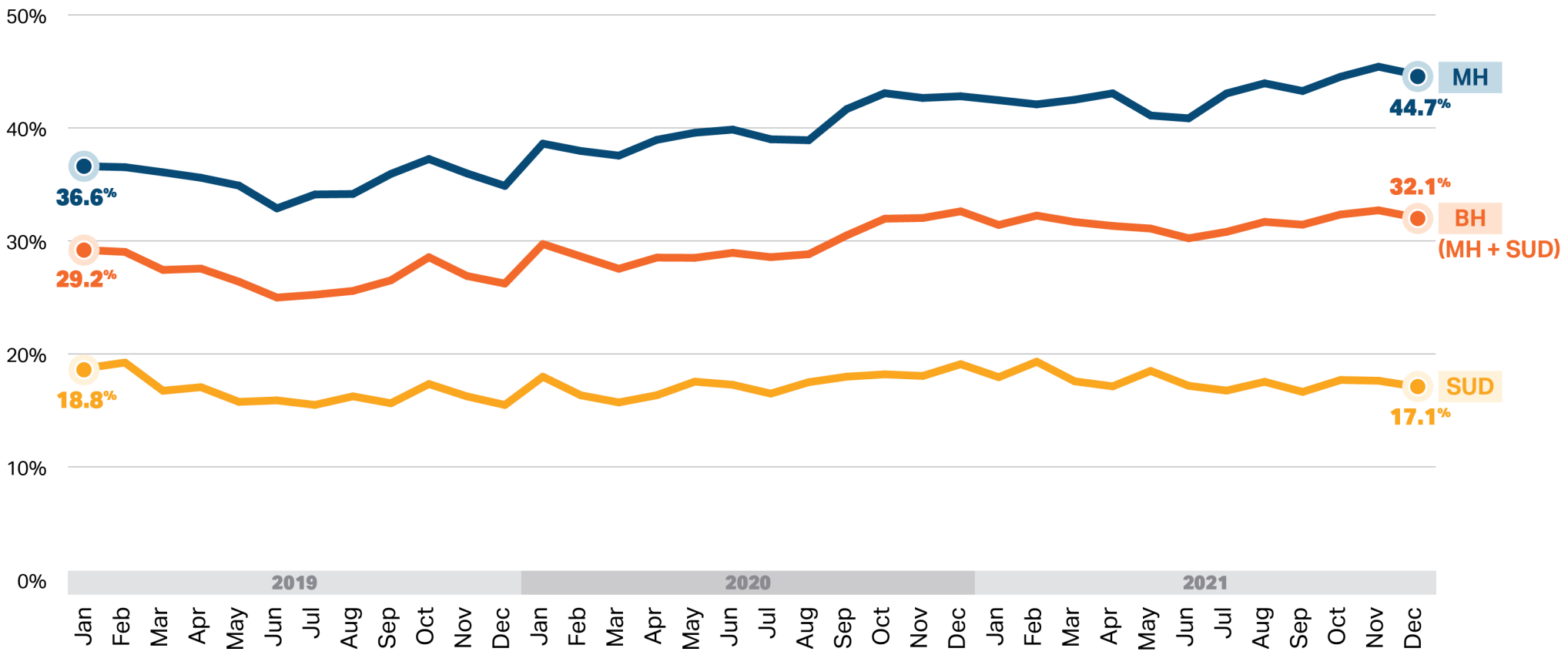


Sources: Center for Medicare and Medicaid Services Geographic Variation Public Use file via the Commonwealth Fund. https://www.commonwealthfund.org/datacenter/preventable-hospitalizations-age-65-and-older-1000-medicare-beneficiaries?redirect_source=/topics/preventable-hospitalizations-age-65-and-older. Data includes only beneficiaries enrolled in Medicare Fee for Service age 65+ and combine admissions for diabetes, COPD, asthma, hypertension, CHF, dehydration, bacterial pneumonia, UTI and lower extremity amputation.

From 2019 to 2021, behavioral health ED boarding rates grew, driven by an 8-percentage point increase in boarding for mental health-related stays (non-SUD).

HPC

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



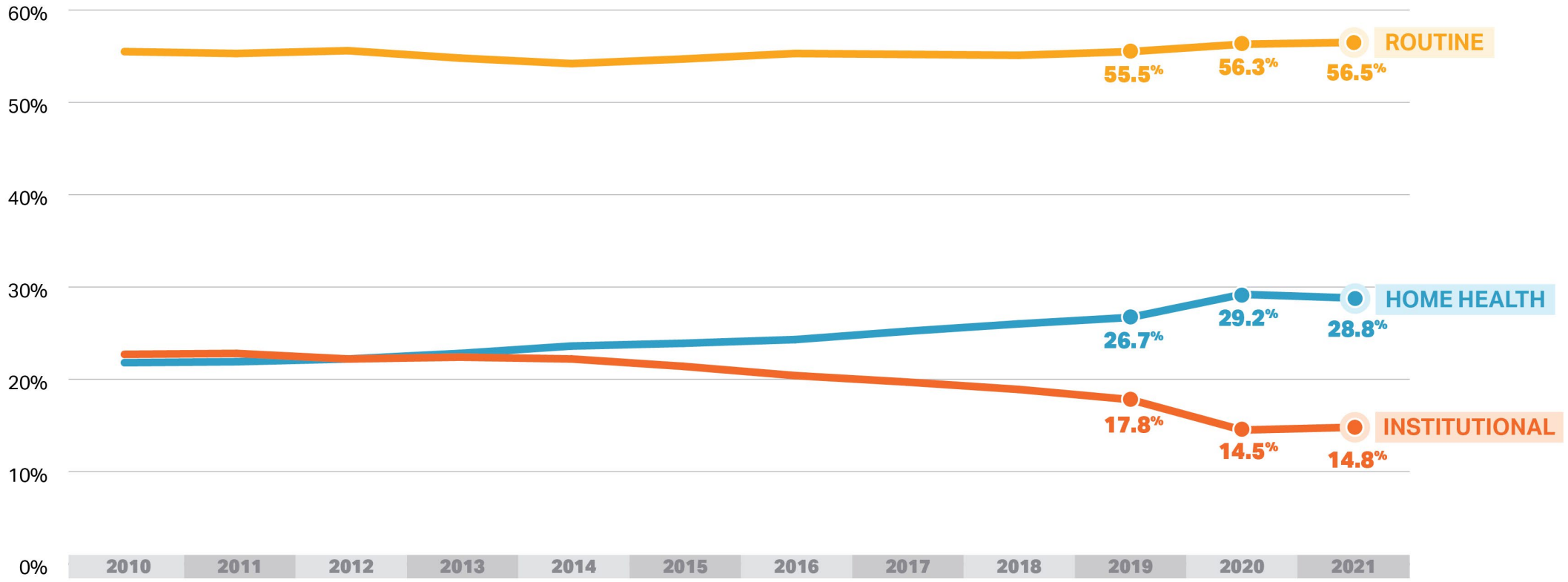
Notes: Excludes two ED sites due to missing data. Excludes an additional eight ED sites due to incomplete or irregular length of stay data. The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. ED visits where patients were admitted to the same hospital were excluded from this boarding analysis. Behavioral health visits were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034, Mental Health: MBD001-MBD013, Substance Use: MBD17-MBD34).

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

The share of hospital stays discharged to institutional post-acute care continued to decline from 17.8% in 2019 to 14.8% by 2021.

HPC

Use of post-acute care in Massachusetts following hospital discharge, all DRGs, 2010-2021



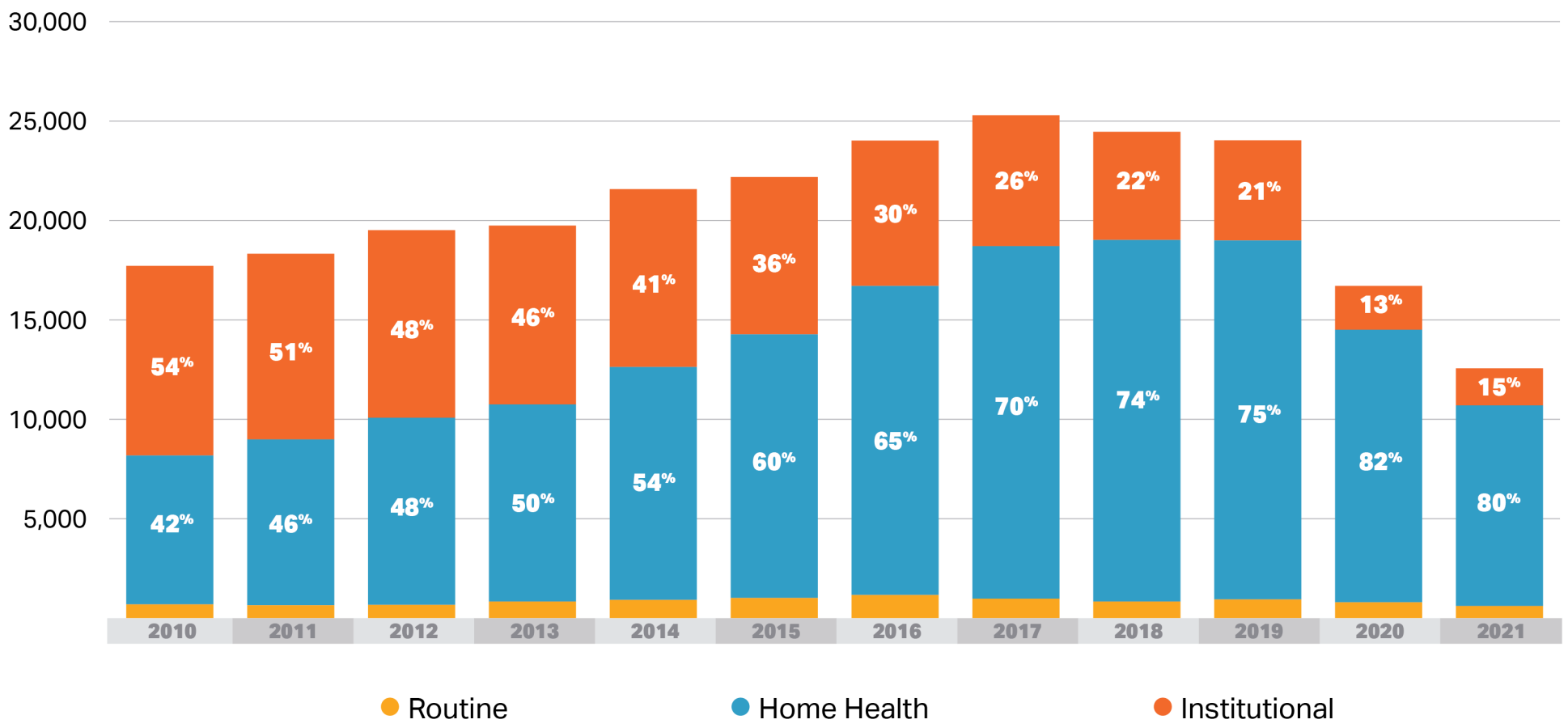
Notes: Out of state residents and those under 18 are excluded. Institutional post-acute care settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Rates adjusted using ordinary least squares (OLS) regression to control for age, sex, and changes in the mix of diagnosis-related groups (DRGs) over time. Specialty hospitals, except New England Baptist, were excluded. Several hospitals (UMass Memorial Medical Center, Clinton Hospital, Cape Cod Hospital, Falmouth Hospital, Marlborough Hospital) were excluded due to coding irregularities in the database. Sturdy Memorial Hospital was excluded due to missing data.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database , CY2010 – 2021, preliminary data for Oct-Dec 2021.

The decline in the share of stays discharged to institutional care has been driven partly by hip and knee replacements moving to home health; that trend stabilized in 2021.

HPC

Use of post-acute care in Massachusetts following a major hip and knee replacement (DRG 470), 2010-2021



Notes: Q4 2021 data are preliminary. Out of state residents and those under 18 are excluded. Institutional post-acute care settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Rates adjusted using ordinary least squares (OLS) regression to control for age, sex, and changes in the mix of diagnosis-related groups (DRGs) over time. Specialty hospitals, except New England Baptist, were excluded. Several hospitals (UMass Memorial Medical Center, Clinton Hospital, Cape Cod Hospital, Falmouth Hospital, Marlborough Hospital) were excluded due to coding irregularities in the database. Sturdy Memorial Hospital and Mount Auburn Hospital were excluded due to missing data.

Sources: HPC analysis of Center for Health Information and Analysis Hospital Inpatient Discharge Database CY 2010-2021, preliminary data for Oct-Dec 2021.

Summary of Findings: Hospital and PAC Utilization

HPC

- Massachusetts had the **third highest hospital readmission rate in 2020** and **fourth highest rate of preventable hospitalizations** among Medicare beneficiaries in the U.S. in 2019.

- The percentage of patients with mental-health related ED visits who were in the ED for more than 12 hours **increased from 37% in 2019 to 45% by the end of 2021**.

- **Nearly twice as many hospitalized patients were discharged to home health care** as were to institutional settings in 2020 while the rates were equal in 2010.

Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

2022 Health Care Cost Trends Report

- Massachusetts Spending Trends
- Hospital and PAC Utilization
- **PROVIDER ORGANIZATION PERFORMANCE VARIATION**
- Prices

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

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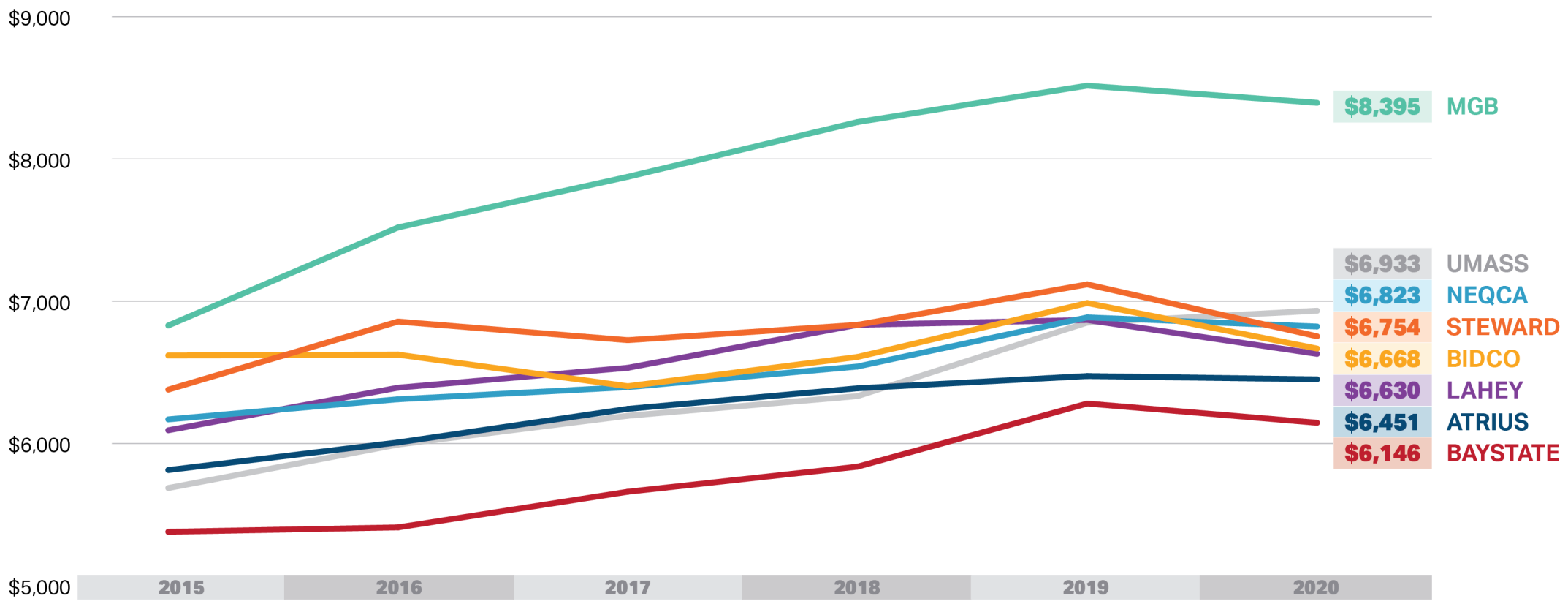
Schedule of Upcoming Meetings

Total medical spending for patients with MGB PCPs diverged from other provider groups starting around 2016 and was 21% above the next-highest group in 2020.

HPC

Unadjusted total medical spending per member per year by provider organization for the 8 largest provider groups, 2015-2020

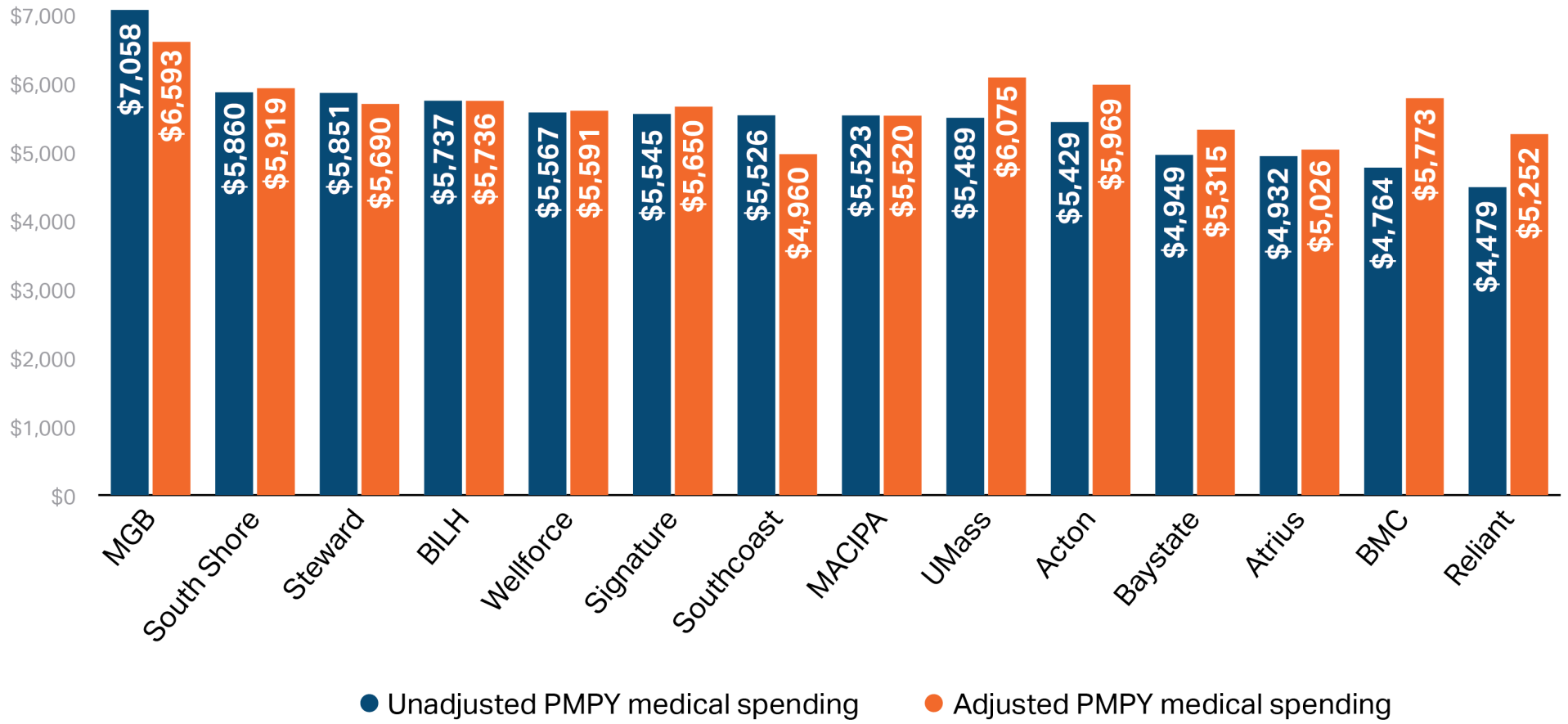


Notes: PCP = primary care provider. Provider groups include Mass General Brigham (MGB); New England Quality Care Alliance (NEQCA), a corporate affiliate of Wellforce; Beth Israel Deaconess Care Organization (BIDCO); Steward Health Care Network (Steward); Atrius Health (Atrius); Lahey Clinical Performance Network (Lahey); UMass Memorial Medical Group (UMass Memorial); Baystate Health Partners (Baystate). PMPY spending equals 12 times PMPM spending as reported by CHIA.
Sources: HPC analysis of Center for Health Information and Analysis 2018, 2019, 2021, and 2022 Annual Report TME Databooks.

After adjusting for patient risk scores and other characteristics, the variation among provider groups in medical claims spending per patient was somewhat reduced.

HPC

Unadjusted and adjusted medical claims spending per member per year by provider organization, 2019



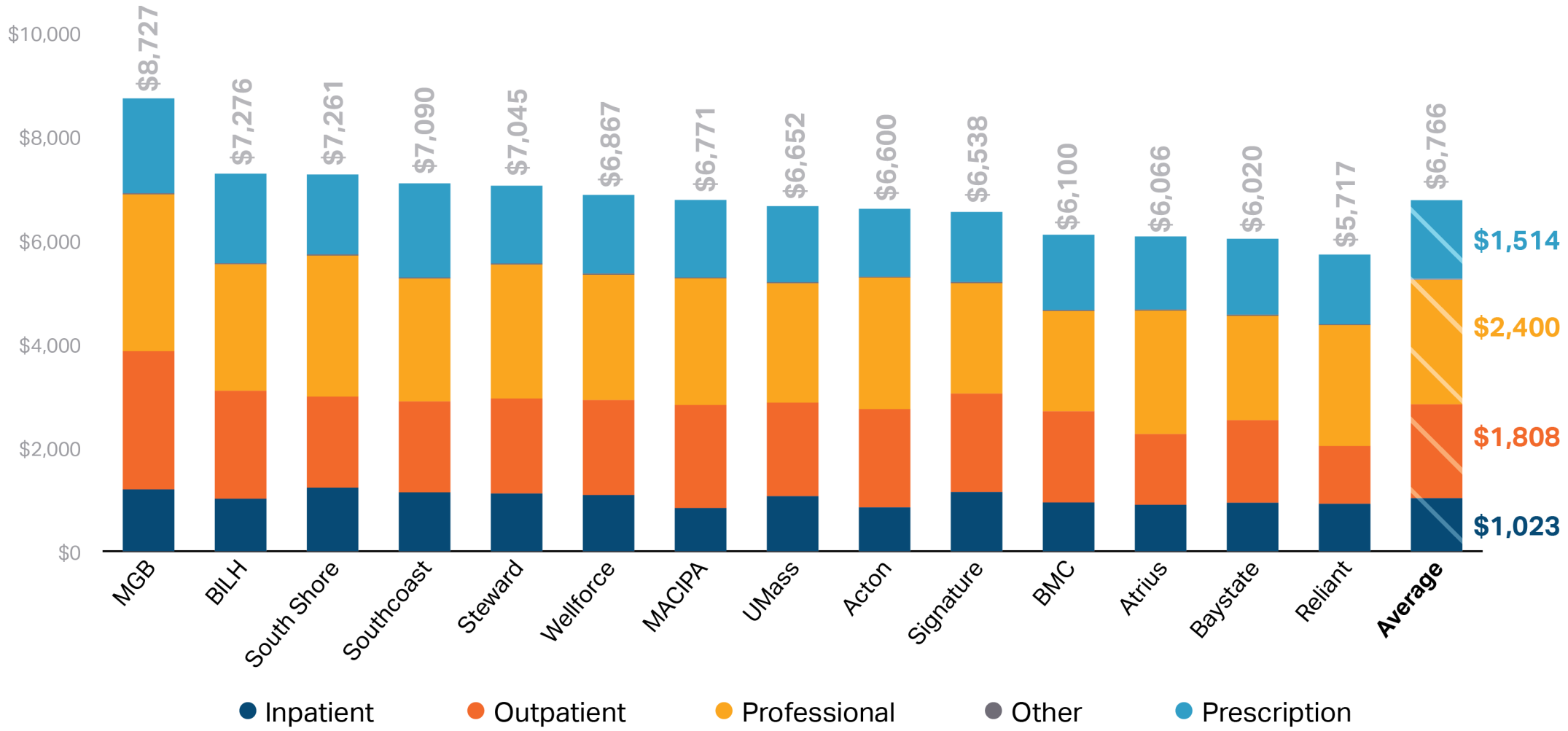
Notes: PMPY: Per member per year. Prescription drug spending and non-claims-based spending excluded. Spending results are for commercial attributed adults (N=853,777). Prescription drug spending is excluded from this analysis to increase the size of the population included in the analysis. Health status adjustment has been processed by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.

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

The largest source of variation in spending across provider groups is hospital outpatient spending.

HPC

Unadjusted total medical spending per member per year by category of spending and provider organization, 2019

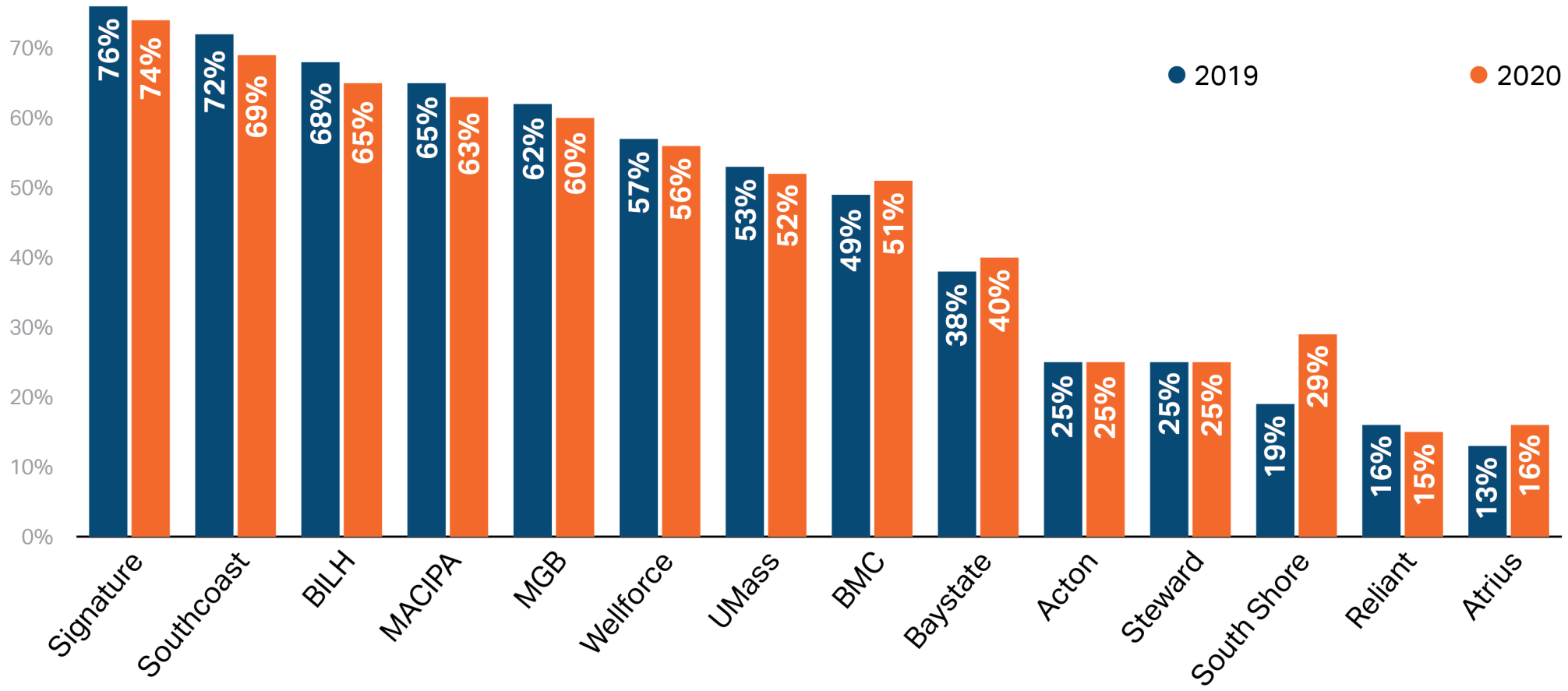


Notes: PMPY: Per member per year. Individuals without 12 months of prescription drug insurance coverage were excluded. Spending results are for commercial attributed adults (N=613,788).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019, V 10.0.

Provider groups varied extensively in the percentage of their members' 'crossover' services billed as hospital outpatient visits versus office visits.

HPC

Percent of 451 possible HOPD procedure encounters that took place in a HOPD setting, 2019 and 2020

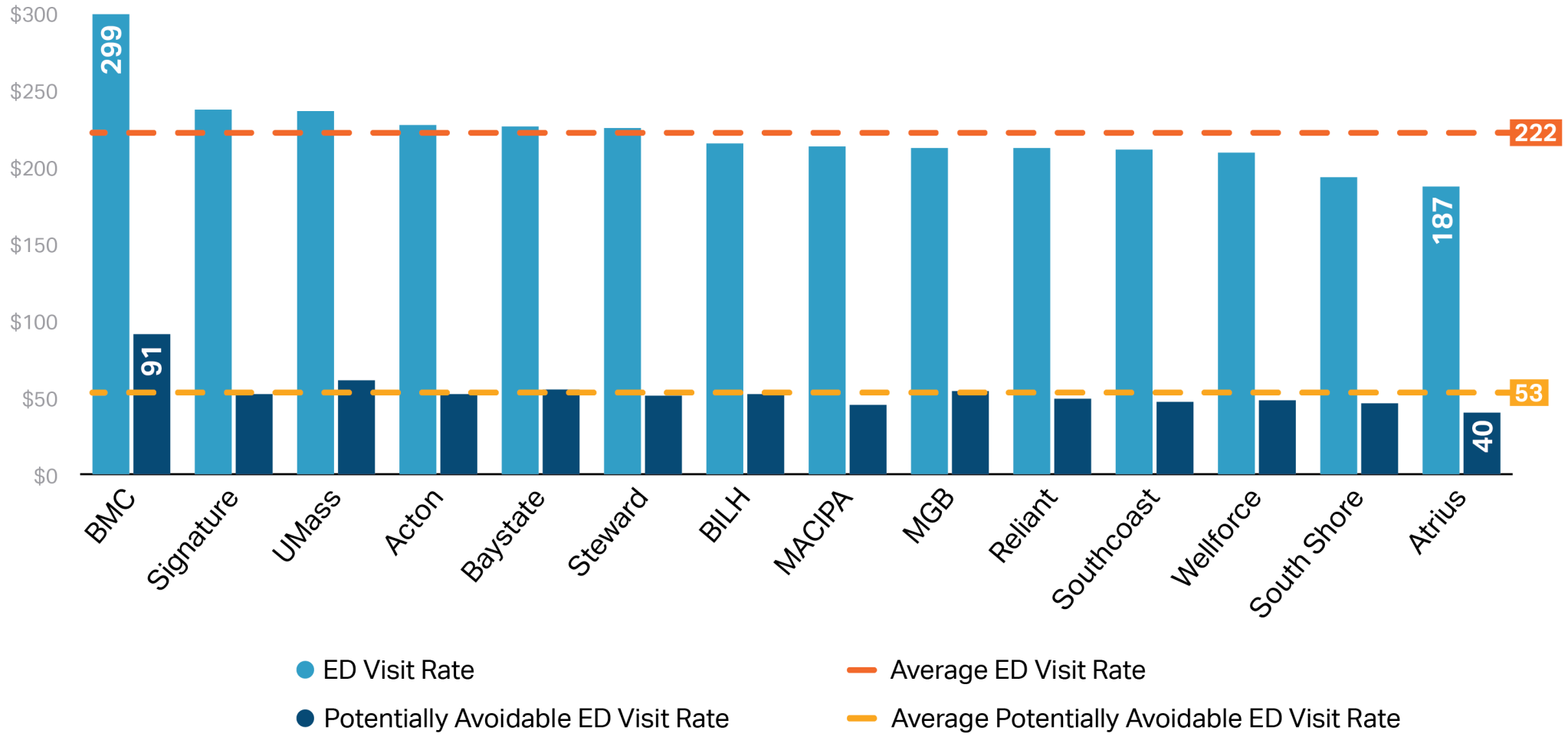


Notes: Results reflect commercial attributed adults, at least 18 years of age that received at least one of 451 procedure codes with the potential for service at a HOPD location, either in professional claims or potentially HOPD lab services. These parameters for these codes was chosen to be between 20% and 80% of possible service locations being HOPD locations and with at least 100 encounters by volume for each procedure code. (2019 N=682,493 2020 N=477,463). Results are adjusted for differences in age, sex, health status, and community-level variables related to education and socioeconomic status.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019-2020, V 10.0.

The number of ED visits varied 60% across provider groups and potentially avoidable ED visits varied more than 2:1 between patients attributed to BMC vs. Atrius Health.

HPC

Total and potentially avoidable emergency department visits per 1,000 attributed commercial patients, 2019

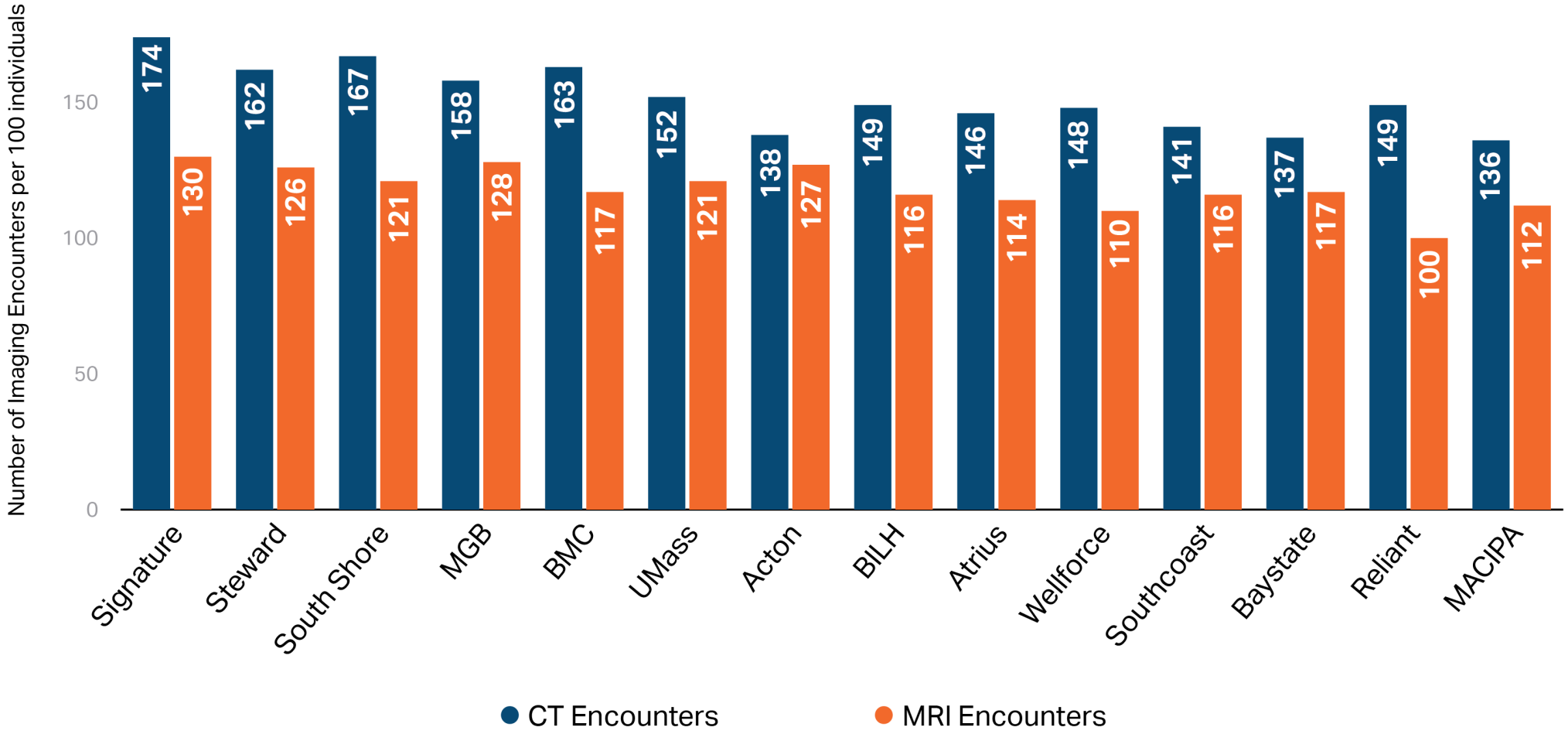


Notes: Potentially avoidable ED visits are based on the Billings algorithm. Results reflect commercial attributed adults, at least 18 years of age (N=853,777). Results are adjusted for differences in age, sex, health status, and community-level variables related to education and socioeconomic status.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019, V 10.0.

Adjusted rates of CT and MRI utilization across provider groups varied 30%.

HPC

CT and MRI encounters per 1,000 attributed commercial patients, 2019



Notes: Results reflect commercial attributed adults, at least 18 years of age (N=853,777). Results are adjusted for differences in age, sex, health status, and community-level variables related to education and socioeconomic status. Sorted by total imaging between CT and MRI encounters, largest to smallest.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019, V 10.0.

Provision of 9 low-value care (LVC) services dropped in 2020 but substantial use and variation remained.

HPC

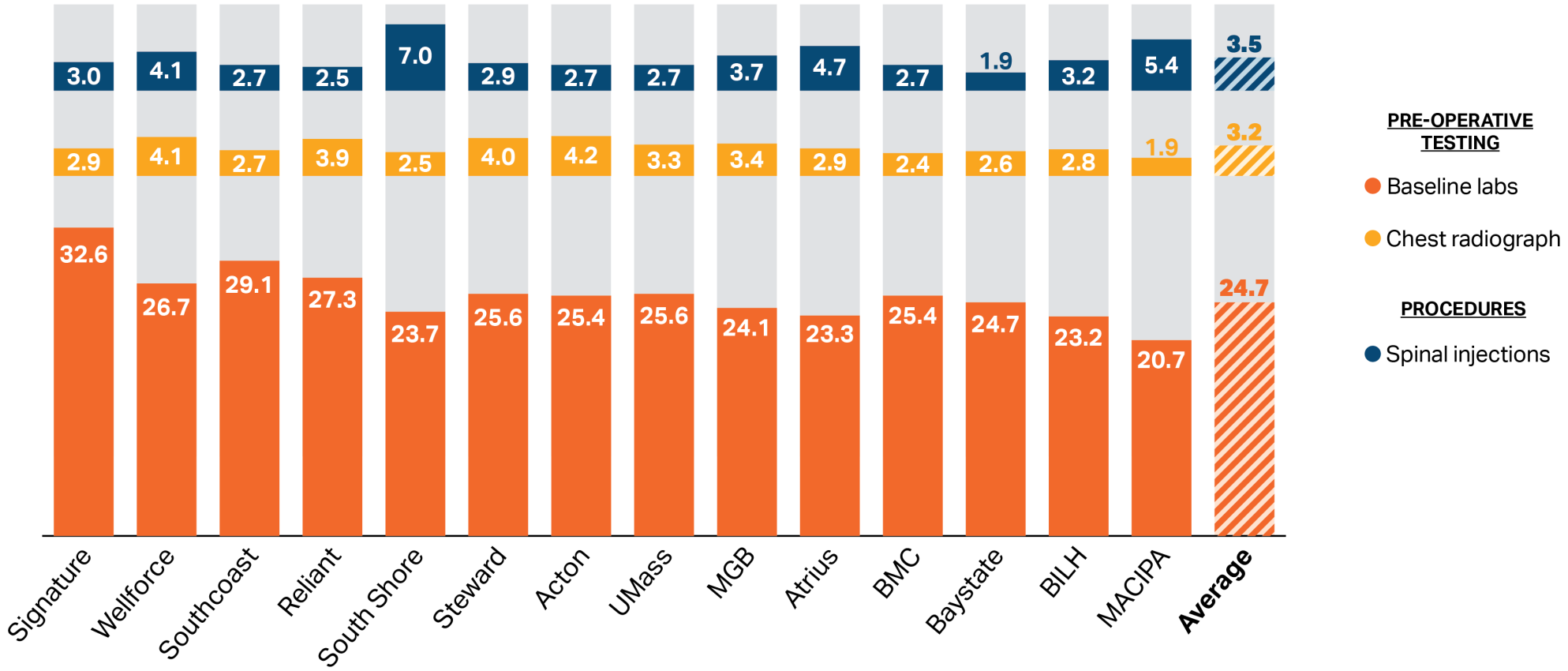
LOW-VALUE SERVICES STUDIED
Screening
T3 (Thyroid) screening for patients with hypothyroidism
Cardiac stress testing for patients with an established diagnosis of ischemic heart disease or angina
Vitamin D screening for patients without chronic conditions
PRE-OPERATIVE TESTING
Baseline labs in patients without significant systemic disease undergoing low risk surgery
Chest radiograph for patients undergoing noncardiothoracic low risk surgery
PROCEDURES
Spinal injections for lower back pain
Coronary stent for patients with an established diagnosis of ischemic heart disease or angina
IMAGING
low-value DEXA scans
Brain imaging for simple syncope

	2019	2020
Total # of patients with at least 1 LVC service	76,419	40,871
Total # of LVC services identified	127,706	78,544
Variation in LVC spending per 100 eligible members across provider organizations	2.5:1	2.2:1

Between 20% and 33% of eligible patients received unnecessary pre-operative baseline labs by provider group.

HPC

Low-value pre-operative testing and procedures per 100 eligible commercial patients, 2019: baseline labs, chest radiograph, spinal injections



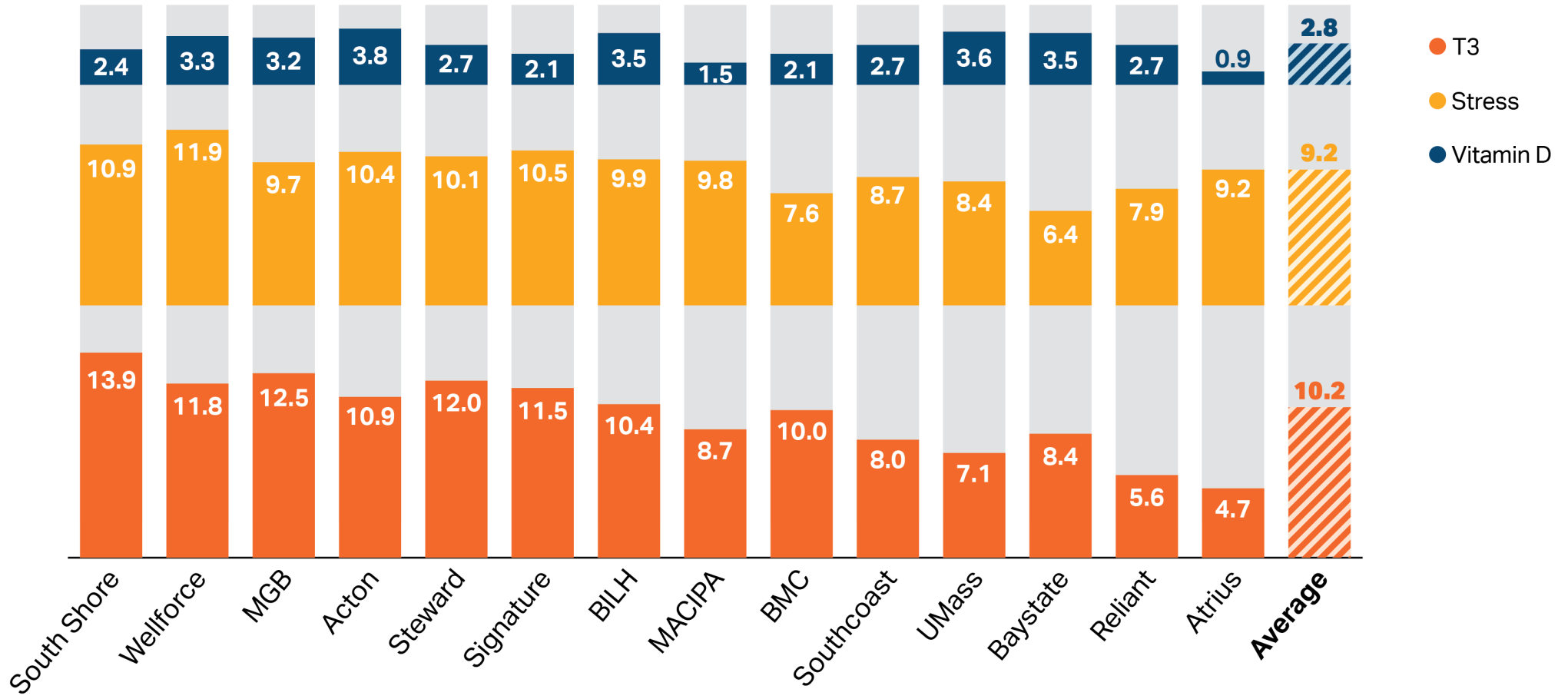
Notes: Baseline labs = Baseline labs in patients without significant systemic disease undergoing low-risk surgery; Chest radiograph = Chest radiographs occurring less than 30 days before a low or intermediate risk non-cardiothoracic surgical procedure (not associated with inpatient or emergency care). Based on a patient's medical history and inclusion criteria for each low-value measure, a patient could be counted in multiple measures. Results for the low-value stent procedure are not presented by provider organization due to small numbers at some organizations. Average reflects rate for all commercial patients, including patients not attributed to a listed provider organization.

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

Unnecessary screening tests also remained common in 2019, though routine vitamin D testing is declining in use.

HPC

Low-value screenings per 100 eligible commercial patients, 2019: T3 (Thyroid), cardiac stress, and vitamin D

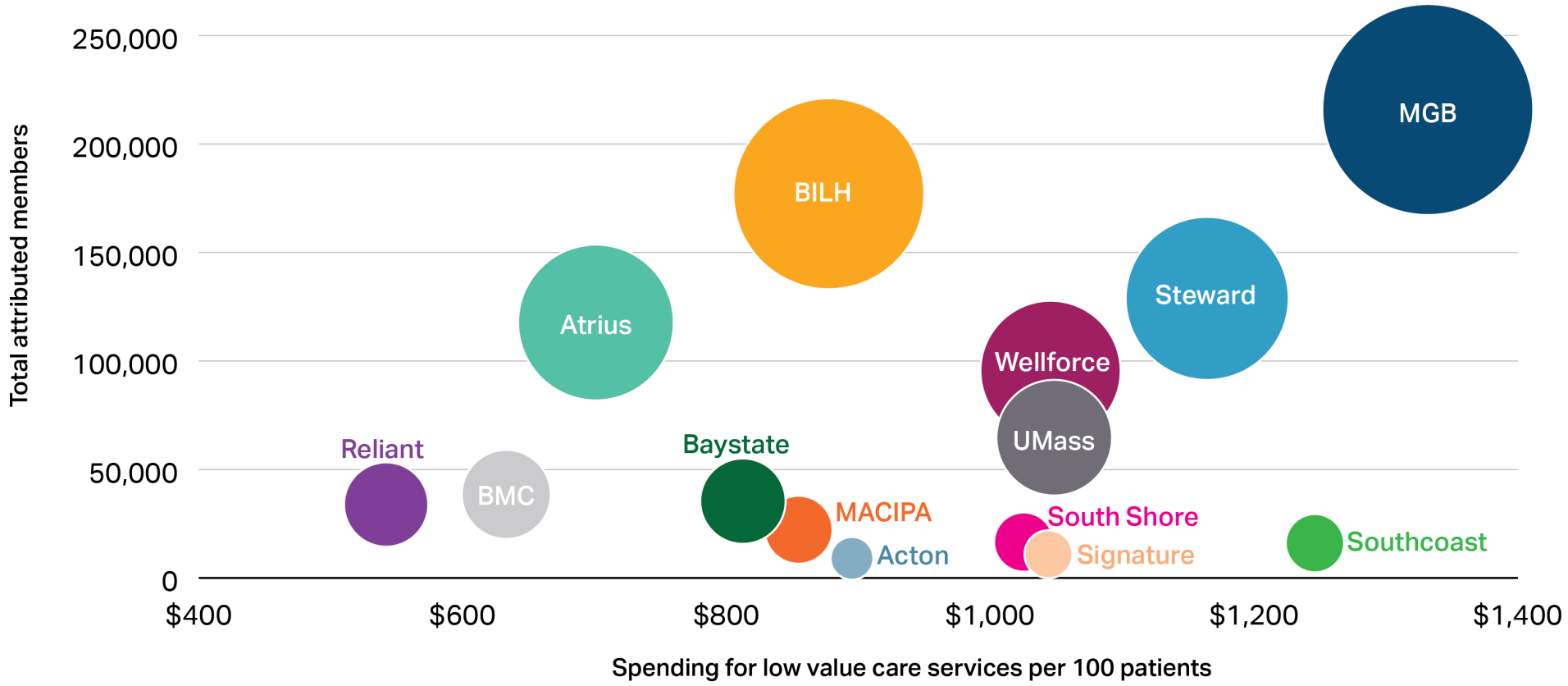


Notes: T3 = Total or free T3 level measurement in a patient with a hypothyroidism diagnosis during the year; Stress = Stress testing for patients with an established diagnosis of ischemic heart disease or angina at least 6 month before the stress test, and thus not done for screening purposes; Vitamin D = Population based screening for 25-OH-Vitamin D deficiency. Based on a patient's medical history and inclusion criteria for each low-value measure, a patient could be counted in multiple measures. Average reflects rate for all commercial patients, including patients not attributed to a listed provider organization.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019, V 10.0.

Spending on 9 low-value care services per 100 patients in 2019 varied two-fold by provider group.

HPC

Spending for nine low-value services per 100 attributed patients and total attributed patients by provider organization, 2019



Notes:: Low-value spending across all seven measures was summed by provided organization and then divided by the total number of commercial adult attributed patients and reported as a rate per 100 patients. Results for the low-value stent procedure are not presented by provider organization due to small numbers at some organizations in the two previous charts but are included here in overall spending. Patients included in this population were not restricted to 12 months of continual coverage, N=1,117,933. The size of the circle is proportional to the total number of patients attributed to each provider organization.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2019, V 10.0.

Summary of Findings: Provider Organization Performance Variation

HPC

- Between 2015 and 2020, total health care spending for patients attributed to MGB physicians **diverged from other large provider groups** reaching $8,395 annually in 2020, 21% above the next highest group (UMass Memorial; $6,933).
- **Differences in hospital outpatient spending** accounted for the largest portion of overall spending variation across provider groups, varying from $2,664 (MGB) to $1,113 (Reliant).
- Part of the difference in hospital outpatient spending stems from the fact that some provider organizations provide a **high proportion of services in hospital settings that could be safely provided in lower-cost office settings**.
- After adjusting for the health status and other characteristics of their patients, provider organizations varied 30% in **MRI and CT utilization** and more than 100% in **avoidable ED visits** among their patient populations.
- Although provision of low-value care dropped in 2020, it was still pervasive. For example, between 1 in 5 and 1 in 3 eligible patients, by provider organization, received **unnecessary baseline laboratory tests before low-risk surgery**.

Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

2022 Health Care Cost Trends Report

- Massachusetts Spending Trends
- Hospital and PAC Utilization
- Provider Organization Performance Variation

PRICES

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

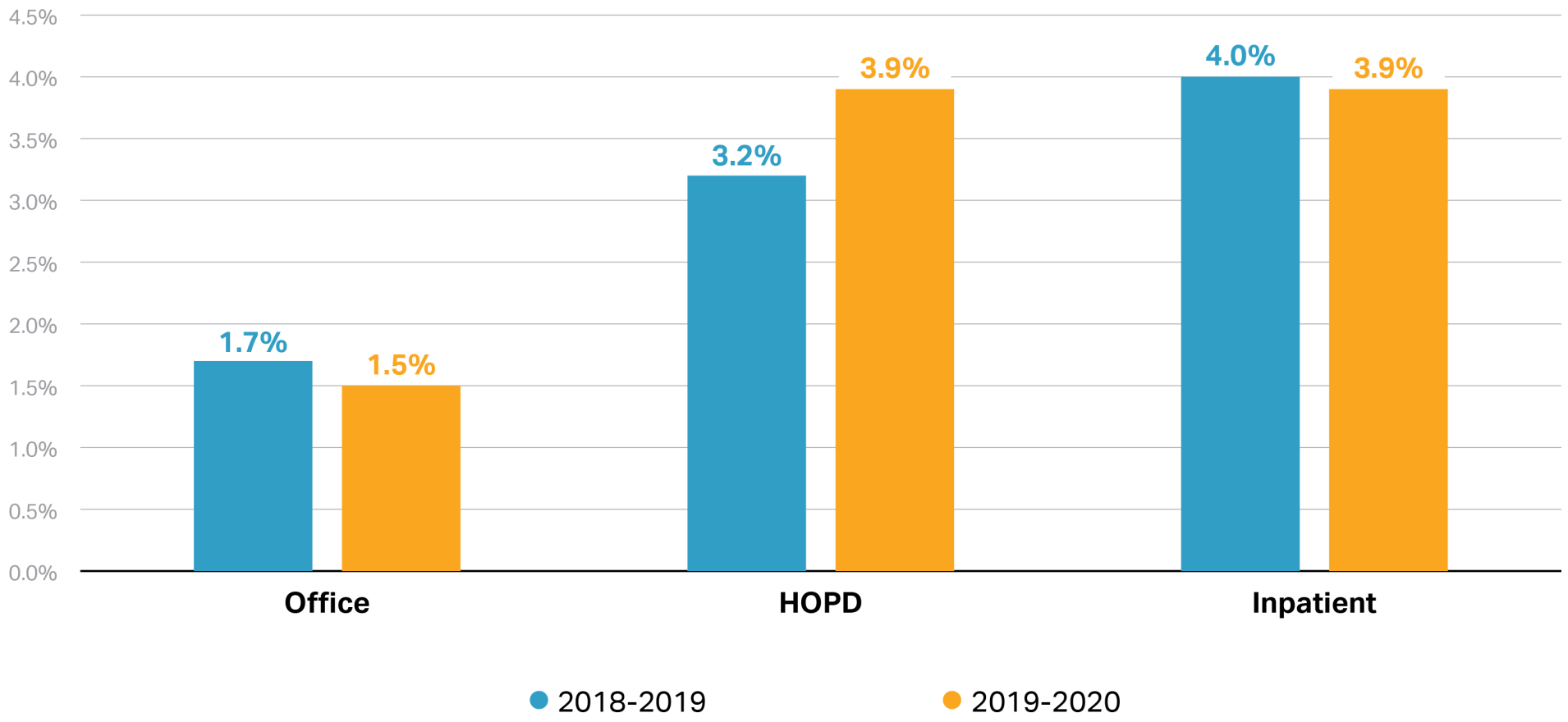
Executive Director's Report

Schedule of Upcoming Meetings

The growth in HOPD prices accelerated in 2020, as prices in both HOPD and inpatient settings grew 3.9%.

HPC

Percentage increase in aggregate prices for each care setting in the year shown



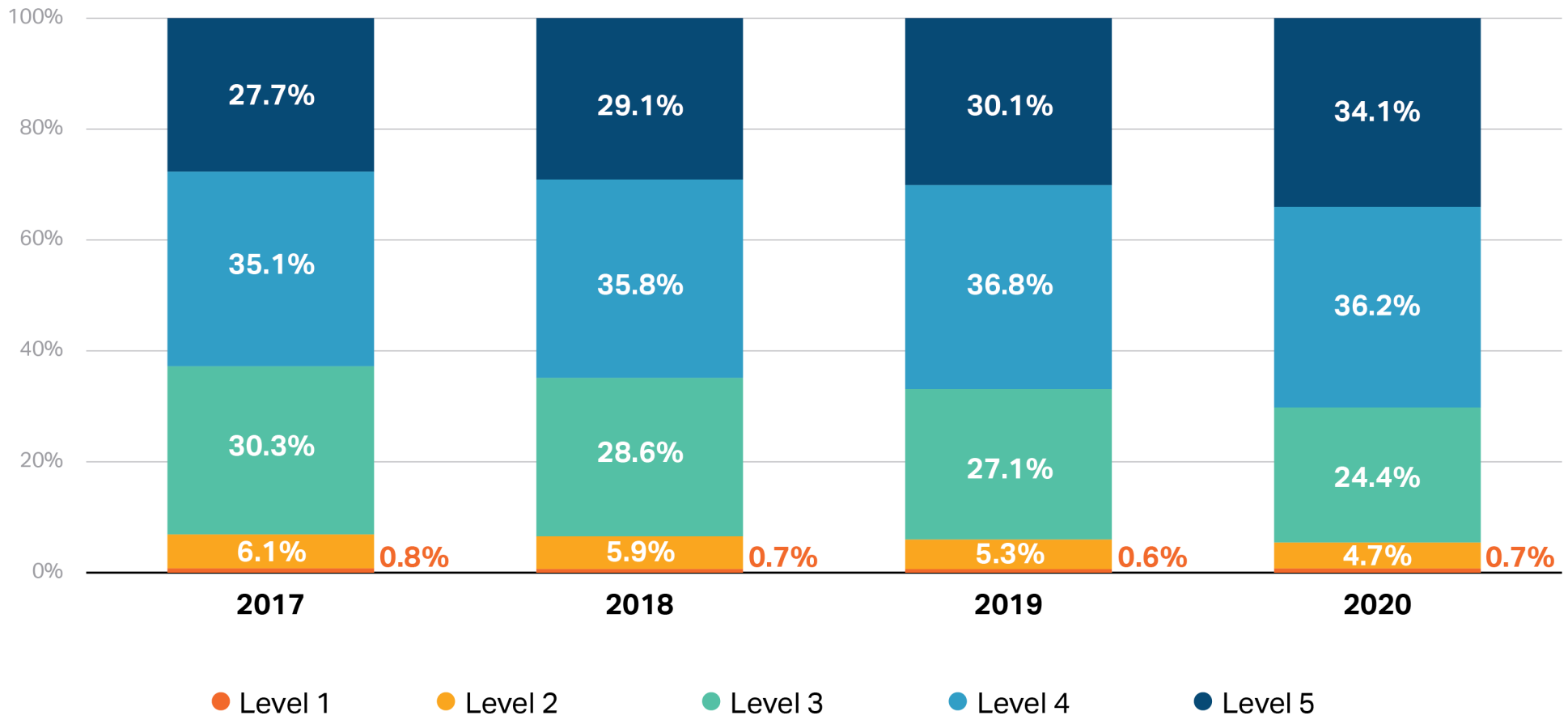
Notes: Price growth includes both facility and professional spending. Price growth is computed at the level of the procedure code or inpatient encounter. Encounters are defined as the same person, same date of service, same procedure code (or DRG) to capture the potential for both facility and professional claims billed on the same day for the same service based on the setting. Procedure codes are consistent between 2018 and 2020, and procedures codes with < 20 services or < $1,000 in aggregate spending in 2018 and 2020 were excluded. HOPD spending increase does not match HOPD index due to differences in methodology. Payment growth for inpatient stays include all services provided during the hospital stay.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

ED stays were coded at successively higher intensity levels from 2017 to 2020. 2020 visit patterns likely reflect additional impacts of the pandemic.

HPC

Share of ED visits by intensity level, 2017-2020

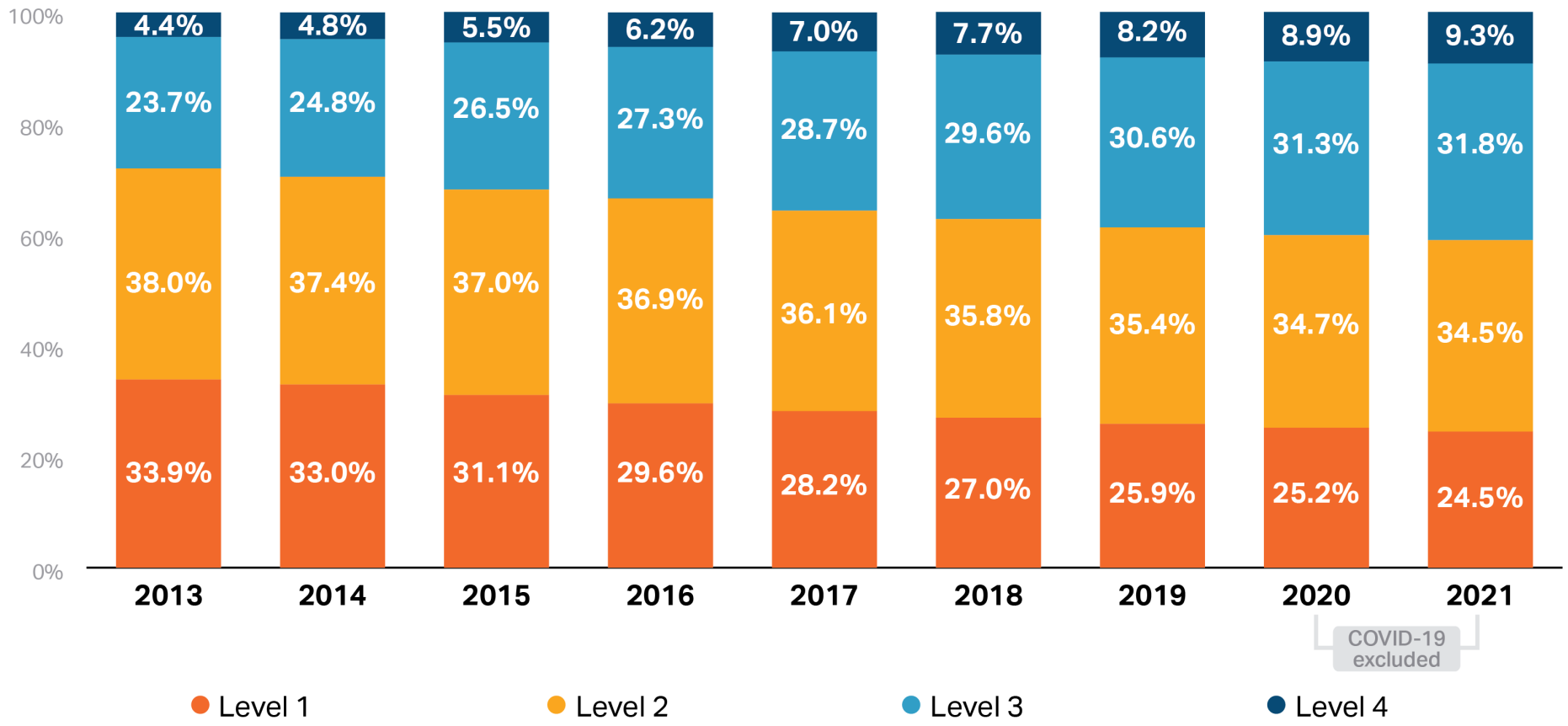


Notes: ED visits correspond to evaluation and management visits for emergency department encounters (99281-99285). Other services delivered on the same day as the ED E&M visit are not captured in this analysis.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

Coded severity of inpatient stays continued to increase in 2021, even after excluding COVID-19-related stays.

HPC

Proportional composition of inpatient discharges by patient severity of illness without COVID-19 cases, 2013-2021

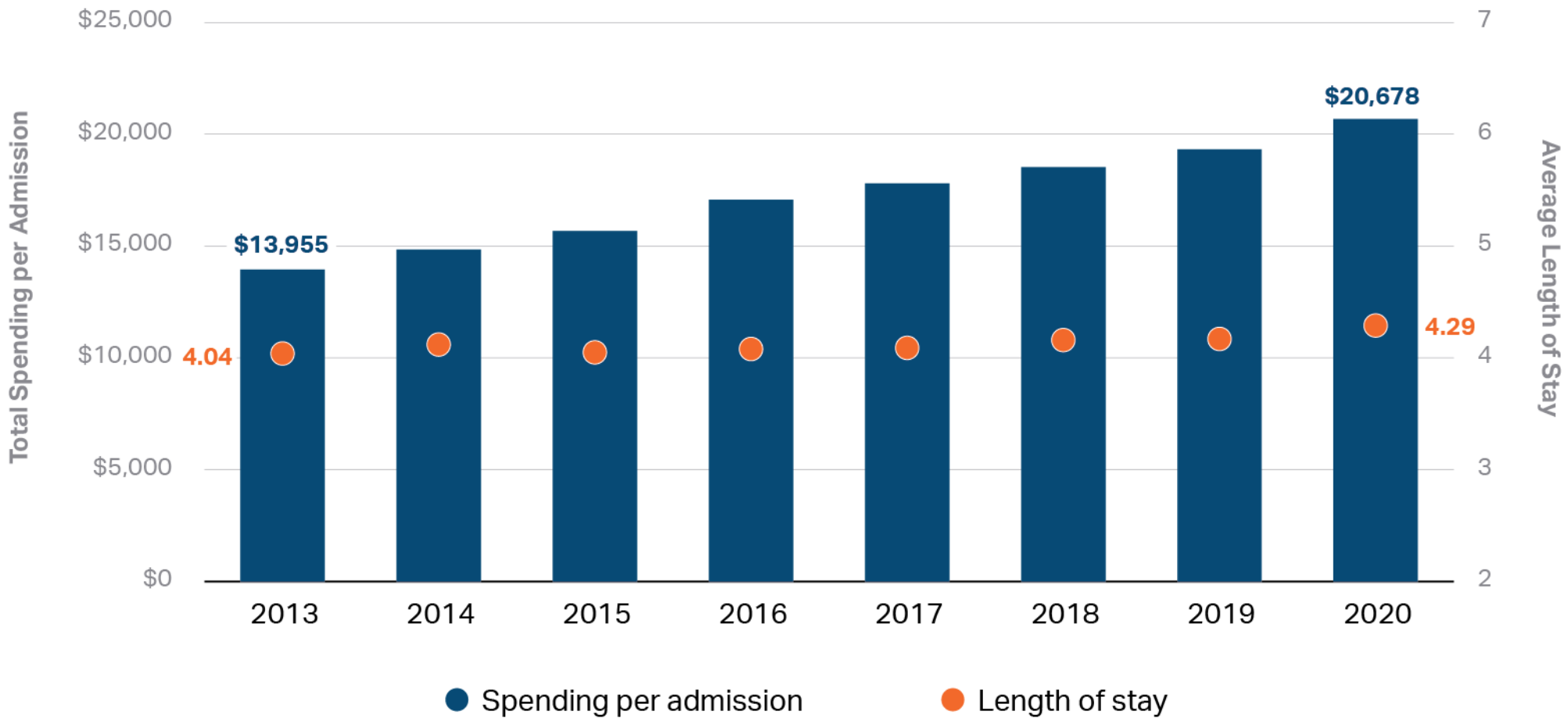


Notes: Data from the Massachusetts Hospital Inpatient Discharge Database (HIDD) from 2013-2021. Severity groups were defined using MassHealth (Medicaid) all-payer refined diagnosis related groups (APR-DRG) and patient severity of illness (SOI) on a four-level severity scale, with 4 being the highest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

Overall, commercial spending per hospital discharge increased 7.0% in 2020 and 48% since 2013.

HPC

Total inpatient spending per commercial discharge and average length of stay for commercial hospital stays, 2013-2020



Notes: Certain discharges were excluded from the analysis including transfers, rehabilitation stays, those from Shriner's Hospital, and those with LOS more than 180 days.
Sources: Center for Health Information and Analysis Hospital Inpatient Discharge Data, 2013-2020 (volume and LOS). Spending data are derived from full and partial-claims commercial spending by category for 2016-9 and full claims only from 2013-6 (based on data availability) from the Center for Health Information and Analysis' Annual reports from 2013-2022.

A market basket price index is a common way to compare numerous individual prices across entities.

A hypothetical market basket index comparing overall prices of two grocery stores

QUANTITY	ITEM	PRICE PER UNIT	TOTAL SPENT
1 gallon	2% milk	$4.39	$4.39
1 dozen	eggs	$4.39	$4.39
5 lbs	rice	$1.40 per lb	$6.99
½ lb	green beans	$2.09 per lb	$1.05
2 cans	tuna	$4.29 per can	$8.58

Store A $25.40

QUANTITY	ITEM	PRICE PER UNIT	TOTAL SPENT
1 gallon	2% milk	$3.79	$3.79
1 dozen	eggs	$3.99	$3.99
5 lbs	rice	$1.22 per lb	$6.09
½ lb	green beans	$2.29 per lb	$1.15
2 cans	tuna	$3.59 per can	$7.18

Store B $22.20

STORE A

IS $3.20 (14%)

MORE EXPENSIVE THAN

STORE B

Notes: Figures are illustrative only.

The concept can be naturally extended to hospital outpatient departments, e.g., the cost of a common set of outpatient services at BIDMC in 2018 and 2020.

HPC

The average number of each service used in 2018 for every 100 commercially-insured Massachusetts residents

BIDMC, 2018

QUANTITY	SERVICE	AVG. PRICE PER UNIT	TOTAL COST
6.4	Screening mammography	$353	$2,266
1.1	Colonoscopy w/biopsy	$1,563	$1,676
6.3	Physical Therapy, 15 min	$139	$873
4.8	Surgical pathology (Level IV)	$318	$1,534
0.8	GI Endoscopy	$1,354	$1,112
0.7	Colonscopy w/w/o collection of specimen(s)	$1,543	$1,022
	....		
	Total for **50** services:		$22,423

Quantities held **fixed** at 2018 levels

BIDMC, 2020

QUANTITY	SERVICE	AVG. PRICE PER UNIT	TOTAL COST
6.4	Screening mammography	$393	$2,523
1.1	Colonoscopy w/biopsy	$1,793	$1,923
6.3	Physical Therapy, 15 min	$148	$931
4.8	Surgical pathology (Level IV)	$347	$1,674
0.8	GI Endoscopy	$1,440	$1,183
0.7	Colonscopy w/w/o collection of specimen(s)	$1,607	$1,064
	....		
	Total for **50** services:		$23,672

BIDMC'S HOSPITAL OUTPATIENT PRICES INCREASED 5.6% FROM 2018 TO 2020

Notes: Demonstrative figure using real data values for high volume, common, HOPD services delivered at Beth Israel Deaconess Medical Center, as an example. Quantity values reflect statewide averages, not volume-specific to BIDMC. Service descriptions correspond to specific CPT codes (Screening mammography = 77067, Colonoscopy w/biopsy = 45380, Physical therapy, 15 min=97110, Surgical pathology (Level IV) = 88305, GI Endoscopy = 43239, Colonoscopy w/w/o collection of specimens(s) = 45378) that indicate procedure code encounters (same person, same day, same procedure code) to summarize encounter spending (inclusive of facility and professional spending for the CPT). The entire market-basket including 50 services was identified through evaluating common HOPD services that were delivered with sufficient frequency (at least 20 encounters) across at least 50 hospitals (85% of hospitals have a CPT with sufficient volume). This criteria yielded a list of 67 candidate procedure codes, of which the top 50 based on aggregate spending, were ultimately selected for inclusion.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

A screening mammogram is the highest-spending HOPD service, accounting for 8.1% of the full basket weight, statewide.

HPC

CPT	Description	Statewide spend, 2018	Avg spend per procedure	Volume per 100 members PY	N Hospitals with >=20 procedures	Total spending for 100 pts at average hospital	Weight of the item in the basket
77067	Screening mammography, bilateral, including CAD when performed	$ 29,769,530	$ 290	6.4	57	$ 1,863	8.1%
45380	Colonoscopy, flexible; with biopsy, single or multiple	$ 28,381,588	$ 1,718	1.1	53	$ 1,843	8.0%
45385	Colonoscopy with polypectomy	$ 24,110,934	$ 1,880	0.8	53	$ 1,521	6.6%
88305	Surgical pathology (Level IV), gross and microscopic examination	$ 22,899,980	$ 303	4.8	56	$ 1,464	6.4%
99214	Evaluation and Management Office visit - 45 minutes	$ 20,987,216	$ 184	7.8	56	$ 1,441	6.3%
43239	Esophagogastrodudenoscopy ('GI Endoscopy')	$ 18,975,394	$ 1,474	0.8	56	$ 1,211	5.3%
45378	Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed	$ 16,482,558	$ 1,576	0.7	50	$ 1,044	4.6%
74177	CT Abdomen/Pelvis; with Contrast	$ 15,543,457	$ 1,191	0.9	53	$ 1,030	4.5%
93306	Transthoracic echocardiography (TTE) w/doppler complete	$ 14,615,646	$ 1,135	0.8	53	$ 925	4.0%
97110	Physical therapy, 15 minutes	$ 13,882,467	$ 139	6.3	57	$ 874	3.8%
.....40 remaining services...						.....	

Average statewide cost of full market basket in 2018 is $22,922

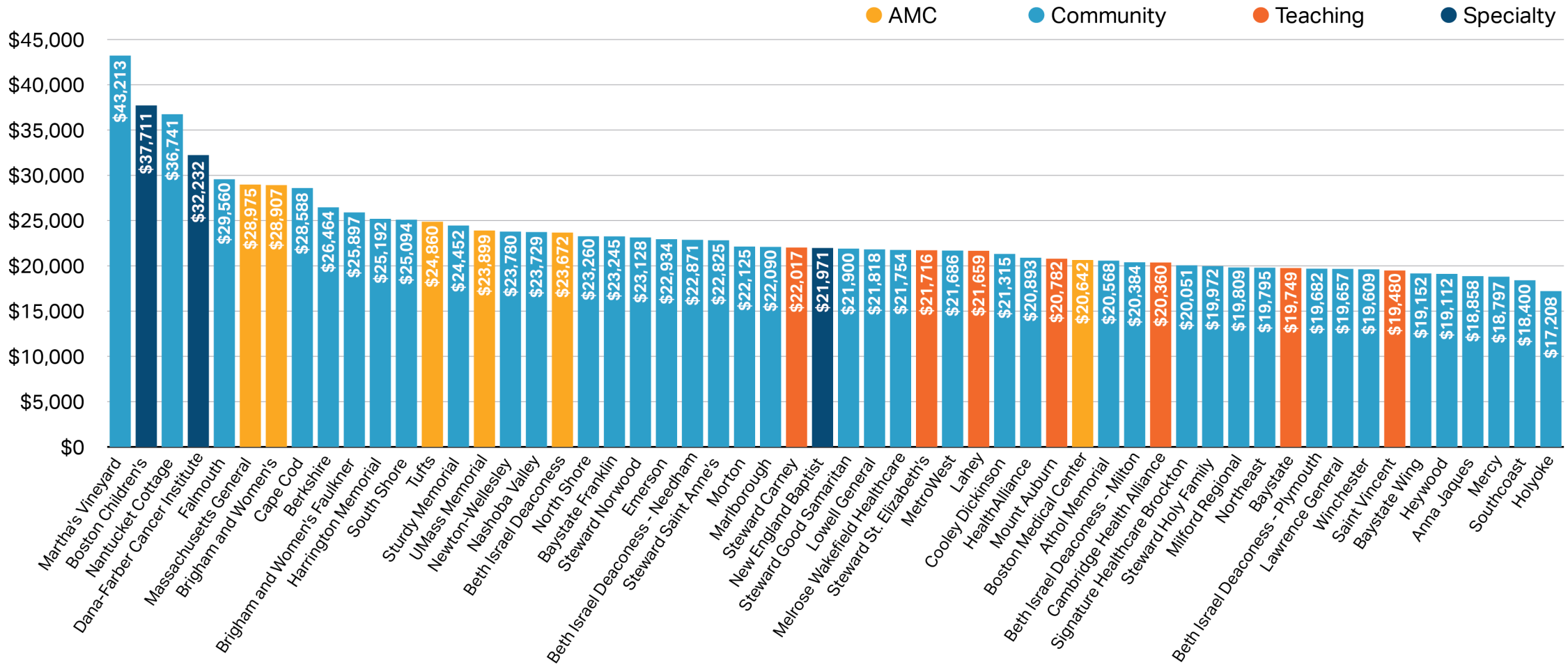
$22,922

Notes: Contents of market-basket, top 10 services based on statewide spending in 2018. Item weights are calculated by multiplying the volume (per 100 members per year) by the average price of a procedure encounter and then summing across all 50 services in the index. A small number of hospitals were excluded from the analytic dataset due to very small volumes (VA Medical Center, Shriners Hospitals for Children). Outpatient encounters from 58 identifiable hospital outpatient departments are ultimately included in the subsequent analyses.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

The cost of the HOPD market basket in 2020 varied more than 2:1 across hospitals, with higher prices for AMCs, specialty hospitals and geographically isolated hospitals.

HPC

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



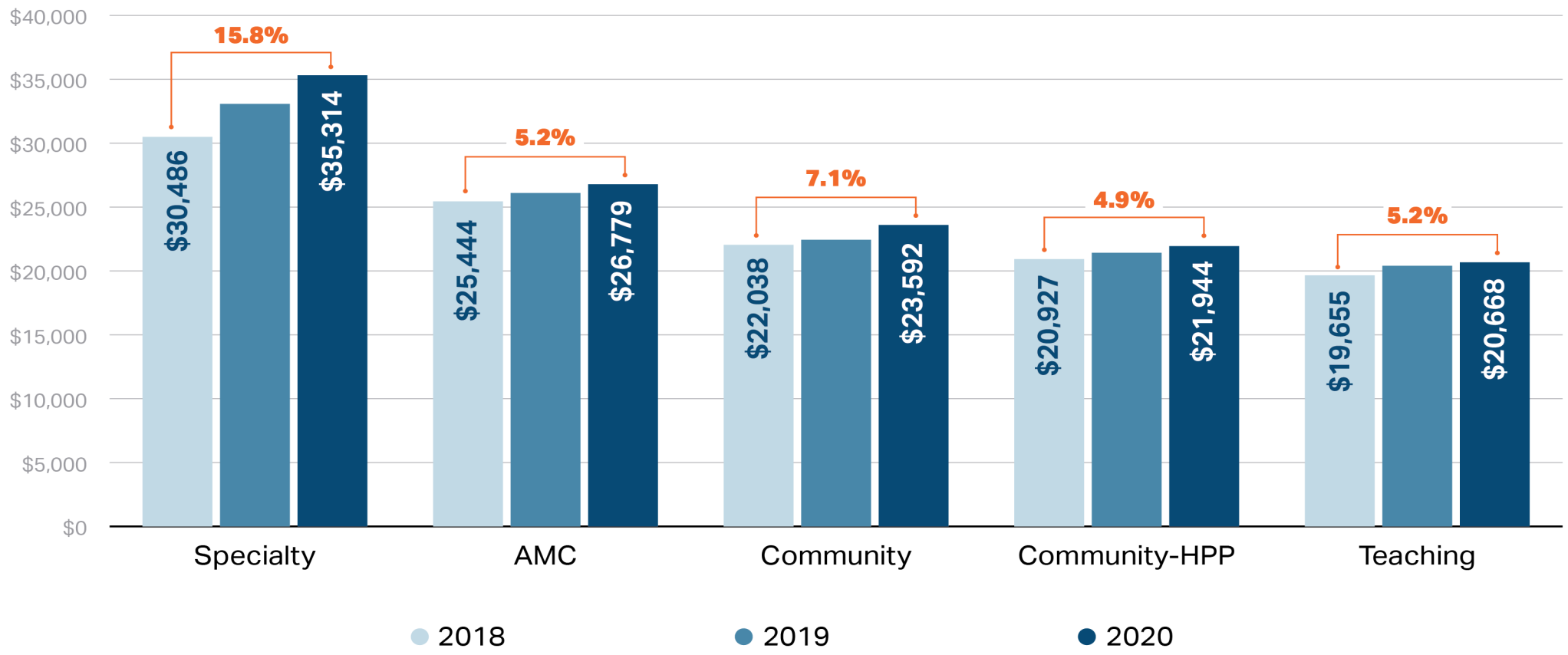
Notes: For each hospital, the same 50 procedure codes are evaluated using a fixed statewide volume (computed using 2018 data) and hospital-specific mean service prices in 2020 for each procedure code. Hospitals with fewer than 20 service encounters for any individual procedure code have imputed values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

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

Prices (and growth) were highest for specialty hospitals followed by academic medical centers.

HPC

Cost of the fixed HOPD market basket among Massachusetts hospitals by cohort, 2018-2020

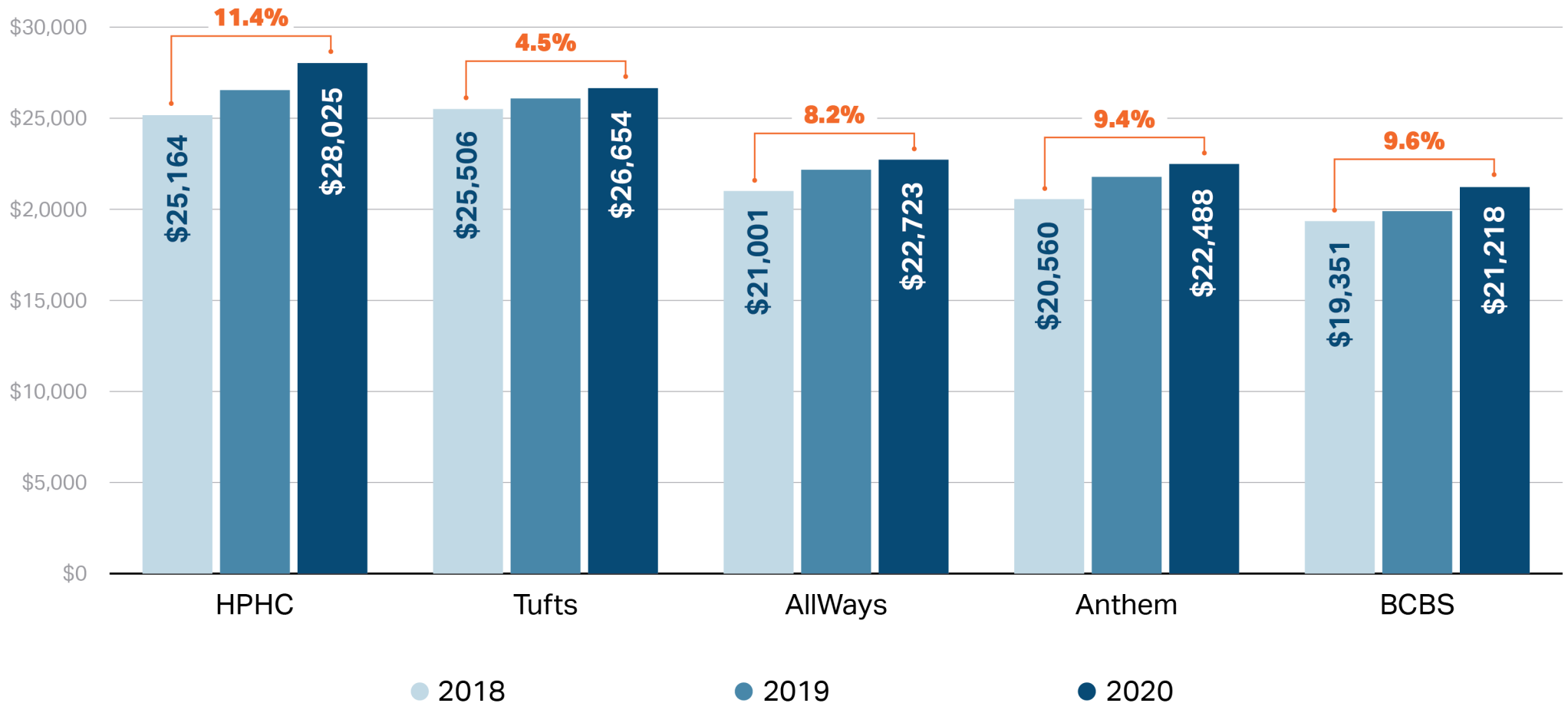


Notes: Hospital cohorts are sourced from CHIA's 2018 hospital profiles; some hospitals may be in different cohorts as of 2020. AMC=Academic Medical Center, and includes Beth Israel Deaconess Medical Center, Boston Medical Center, Brigham and Women's Hospital, Tufts Medical Center, Massachusetts General Hospital, UMass Memorial Medical Center, and Nashoba Valley Medical Center. Teaching cohort includes Baystate Medical Center, Cambridge Health Alliance, Lahey Hospital & Medical Center, Mount Auburn Hospital, Saint Vincent Hospital, Steward Carney Hospital, and Steward St. Elizabeth's Medical Center. Specialty cohort includes Dana Farber Cancer Institute, Boston Children's Hospital, and New England Baptist Hospital. See CHIA hospital profiles for Community and Community-HPP cohorts.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

HOPD prices and growth varied among major commercial plans in Massachusetts.

HPC

Cost of the fixed HOPD market basket among Massachusetts payers represented in the HPC APCD, 2018-2020

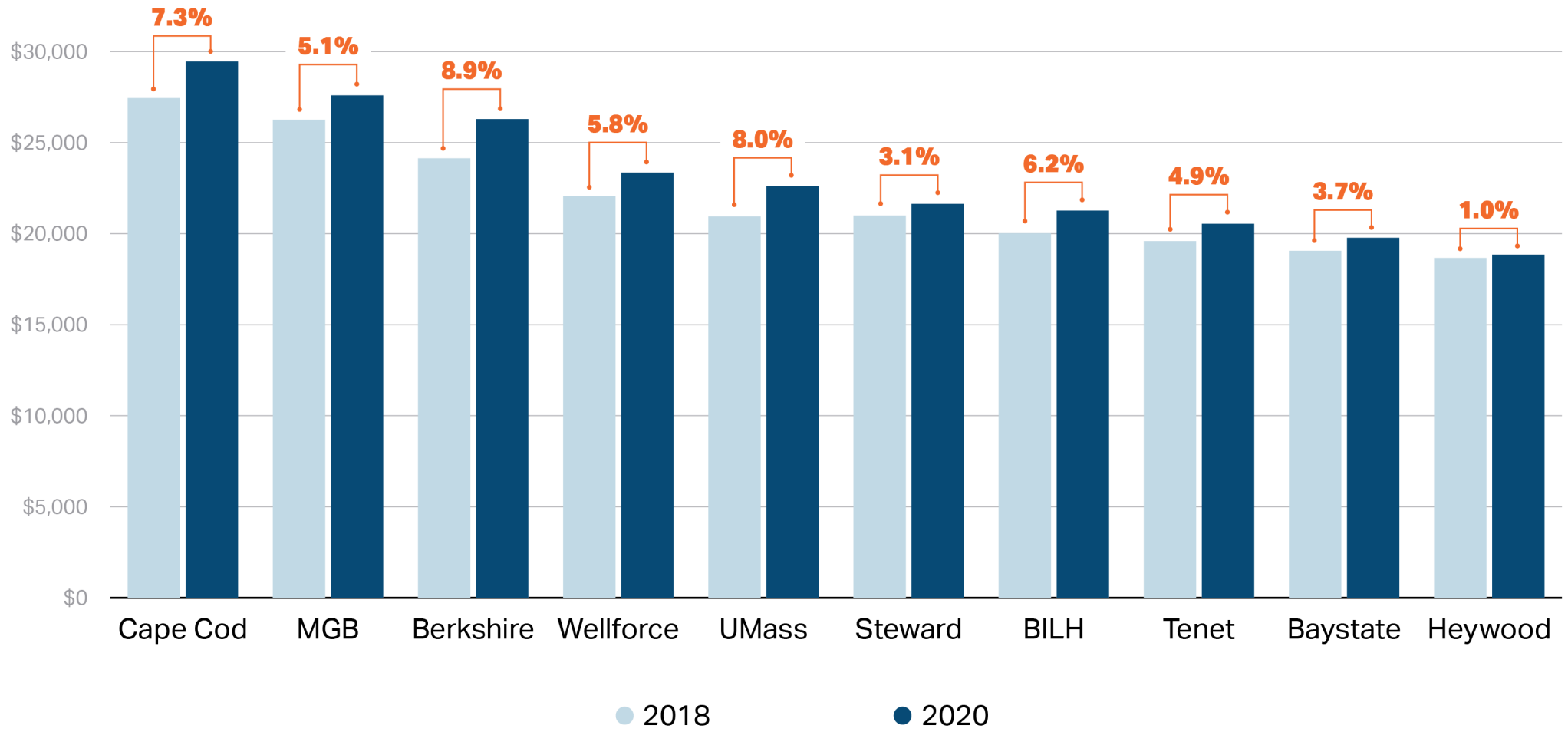


Notes: The HPC's version of the APCD includes claims for members enrolled in commercial insurance products from the five payers shown. These claims include most GIC members but otherwise are more heavily representative of members with fully-insured products and overall represent approximately 30% of the commercial market in Massachusetts. For more information on what data can be found in the APCD please see: www.chiamass.gov/ma-apcd
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

HOPD prices by hospital system varied 47% ($27,447 vs. $18,666) in 2018. That variation grew to 56% in 2020.

HPC

Cost of the fixed market basket by hospital system, 2018-2020

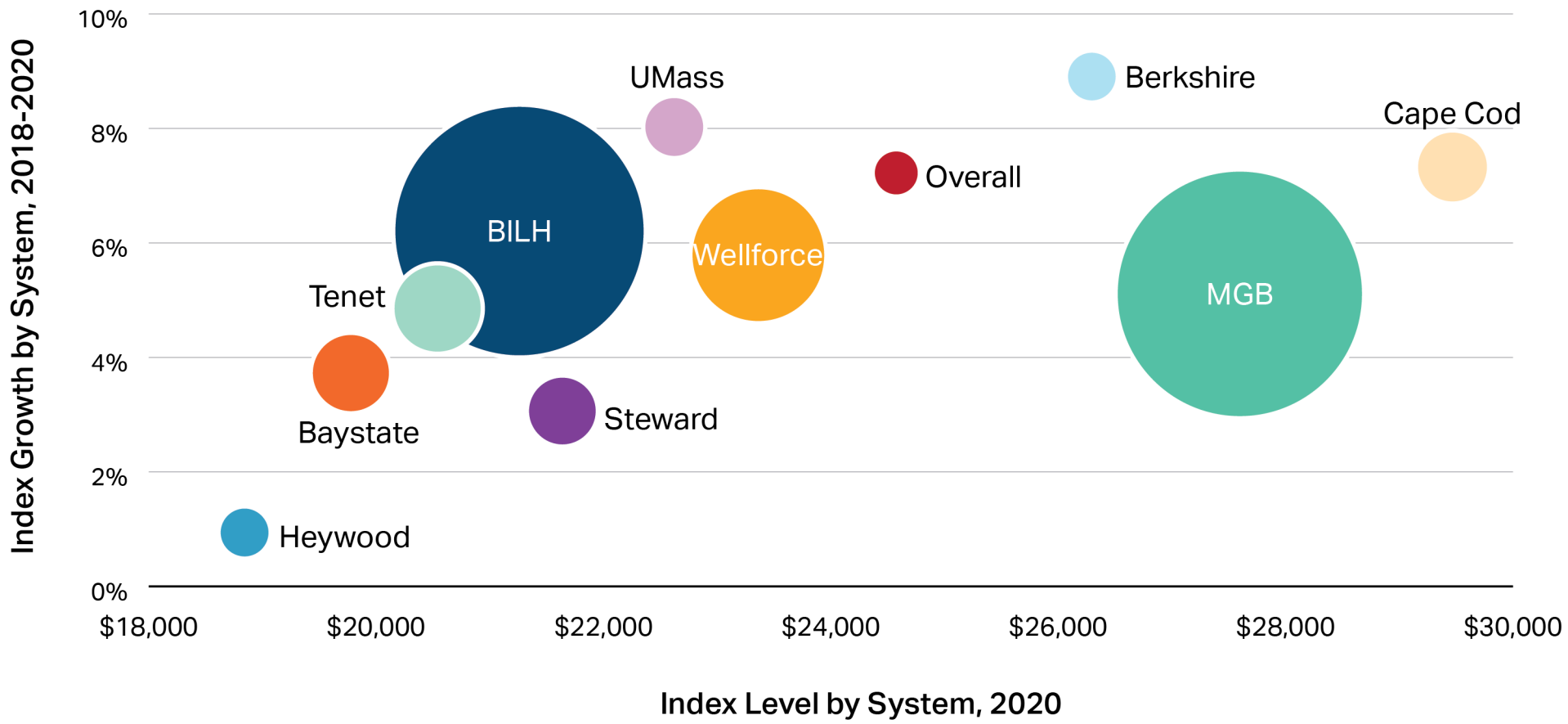


Notes: Hospital systems are sourced from CHIA's latest hospital profiles; only systems with multiple acute care hospitals were included in this graphic. 19.9% of index service volume for the 50 CPT codes takes place at hospitals not represented on this graph.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, 2018-2020, V 10.0.

Hospital systems with higher HOPD prices in 2018 also tended to have higher price growth from 2018 to 2020.

HPC

HOPD market basket cost in 2020 and 2018-2020 growth by system



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

Summary of Findings: Prices

HPC

- In 2020, prices grew 1.5% in physician offices and 3.9% for both hospital inpatient and outpatient care. The **growth in hospital outpatient prices was an acceleration** from 3.2% growth in 2019.
- Coded severity of hospital inpatient stays continued to increase in 2020 and 2021, excluding COVID stays. The **proportion of stays coded at the highest severity level has more than doubled from 2013 to 2021**.
- **Prices for a common market basket of hospital outpatient services varied more than 2:1 across hospitals**, from $43,213 (Martha's Vineyard) to $17,208 (Holyoke Medical Center). Prices were highest at specialty hospitals, academic medical centers, and hospitals on Cape Cod and the Islands.
- HOPD prices by hospital system **varied 47% ($27,447 vs. $18,666) in 2018**. That variation **grew to 56% in 2020**. The hospital systems with the highest prices also tended to have faster price growth, leading to **increasing price variation**.

Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

2022 Health Care Cost Trends Report

SHIFT-CARE CHALLENGE INVESTMENT PROGRAM: OPIOID USE DISORDER PATHWAY ALTERNATIVES

Executive Director's Report

Schedule of Upcoming Meetings

In January 2018, the HPC launched the SHIFT-Care Challenge investment program to fund interventions addressing the whole-person needs of patients through two innovative care models.

HPC

SHIFT-Care Challenge

Track 1:
Addressing health-related social needs

Track 2:
Addressing behavioral health needs

Track 2a
Provide behavioral health access for patients with complex needs to prevent unnecessary acute care utilization.

Track 2b
Expand access to opioid use disorder treatment by medication for addiction treatment in the ED and connecting patients to community-based BH services

Legislative Directive for SHIFT-Care Challenge OUD Track

HPC

ED-Initiated Pharmacological Treatment of Opioid Use Disorder (OUD)

Section 178: Chapter 133 of the Acts of 2016 Massachusetts

"The health policy commission, in consultation with the department of public health, shall implement a 2-year pilot program to further test a model of emergency department-initiated medication-assisted treatment, including but not limited to buprenorphine and naltrexone, for individuals suffering from a substance use disorder."

- Referral to and connection with **outpatient medication assisted treatment.**
- Goals of increasing **rates of engagement and retention** in evidence-based treatment.
- **Evidence-based practices** from successful programs implemented nationally.
- No more than **$3,000,000 from the Distressed Hospital Trust Fund.**
- **Report results of the program** to the joint committee on mental health and substance abuse and the house and senate committees on ways and means.

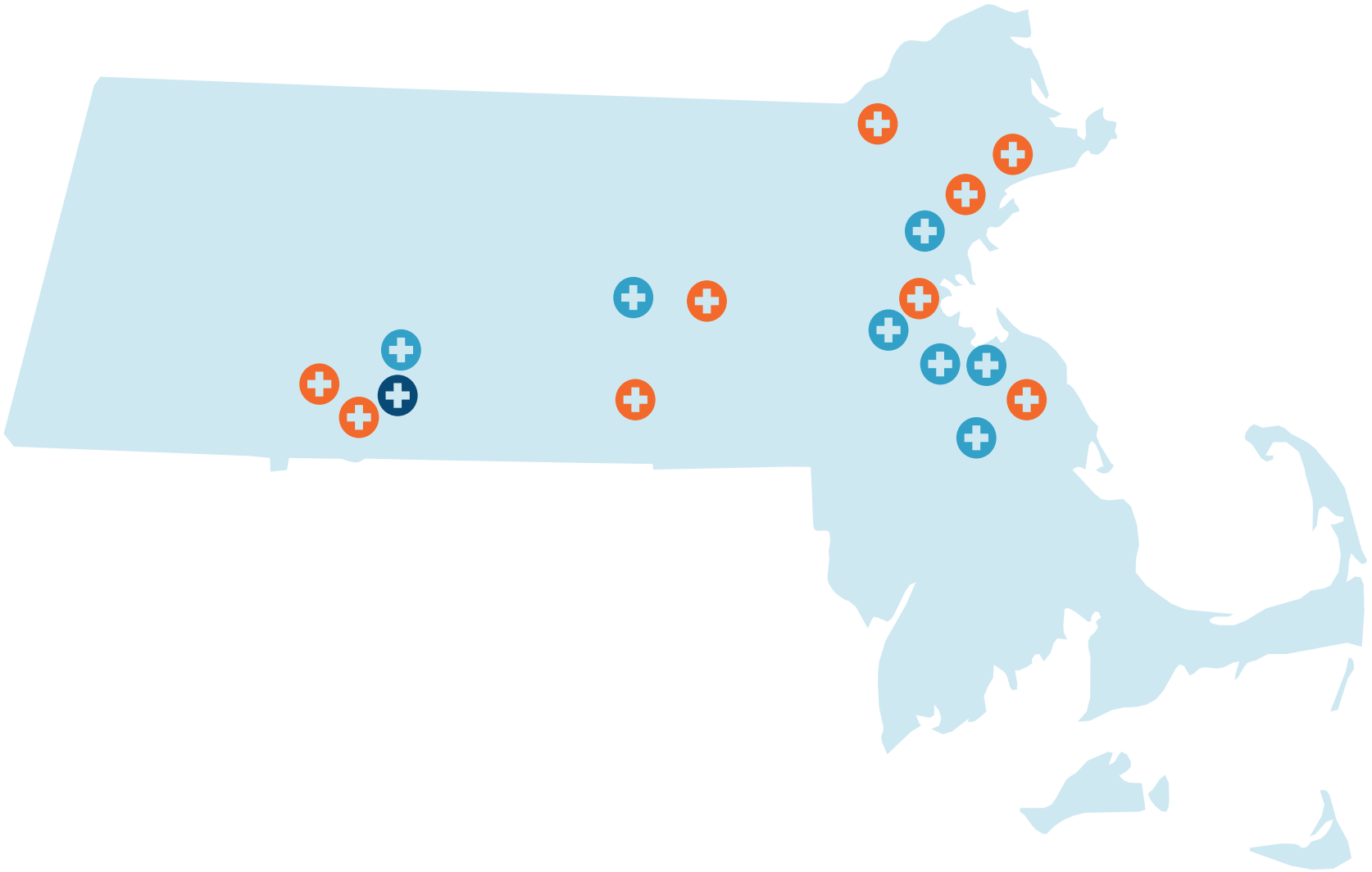
In July 2018, the Board approved the recommendation to fund 15 SHIFT-Care awardees across Massachusetts.

HPC

Health-Related Social Needs (Track 1)

Behavioral Health (Track 2a)

OUD (Track 2b)



SHIFT-Care OUD Track Awardees

HPC

AWARDEE ENTITY	AWARDEE CONTRIBUTION	HPC FUNDING
Addison Gilbert/Beverly	$375,146	$565,422
BID Plymouth	$247,469	$606,609
Harrington Memorial Hospital	$208,190	$742,407
Holyoke Medical Center	$437,353	$750,000
Lowell General Hospital	$202,204	$750,000
Mercy Medical Center	$172,016	$486,580
Mass General Hospital	$549,414	$516,048
North Shore Medical Center	$250,000	$750,000
UMass Memorial Medical Center	$383,673	$550,000
	Total Track 2b Investment: $8,727,109	

Care Model for Initiating Medication for Addiction Treatment in the ED

HPC

Modeled after Yale University Department of Emergency Medicine Program

What:

Identify patients → *Enroll in program* → *Initiate medication for addiction treatment* → *Engage in recovery services*

Patient presents with history or symptoms of OUD or overdose

SW/CHW/RC recommends patient to program. Enrolls patient in program with patient consent.

ED physician/other qualified prescriber initiates pharmacological treatment for OUD.

Patient leaves ED with medication and follow-up appointment ASAP, within 72 hours of discharge.

Where:

ED, practice sites, or in the community

Emergency Department

Outpatient Setting

While there were some consistent features across all programs, Awardees customized aspects of implementation.

HPC

Model features	AGH/BH	BID-Plymouth	Harrington	HMC	LGH	MGH	Mercy	NSMC	UMass
Identification via real-time ED tracker	X	X	X	X	X		X	X	X
Identification via ED universal screening							X	X	
Includes inpatients [i]	X	X	X	X				X	X
Includes outpatients/ community referrals			X	X	X	X			
Team members co-located in ED	X	X		X		X			
Incorporates recovery coaches	X	X		X	X	X	X	X	X
Recovery coaches employed by hospital (vs community program)	X				X	X		X	X
Incorporates bridge clinic	X		X		X	X			X
Offers ED/bridge clinic MAT initiation	X	X	X	X	X	X	X	X	X
Conducts home MAT initiation	X		X	X	X	X	X	X	X
Follow-up for discharged patients	X	In some cases	X	X	X	In some cases	X	In some cases	X

Assessing the Impact of the SHIFT-Care OUD Program

HPC

MAT Initiation Rates	Engagement and Retention in Treatment	Hospital Utilization, Mortality, Overdose	Factors for Program Success	Patient Experience
Did the program have an impact on MAT initiation rates?	Did patients who started treatment stay in treatment?	Did success in initiating MAT have an impact on hospital utilization and mortality?	What did providers identify as most important to program success?	What was the patients' experience in the SHIFT-Care program?

Brandeis Evaluation Methods

HPC

1 Quantitative Methods

Descriptive and interrupted time series pre-post implementation

Variables:

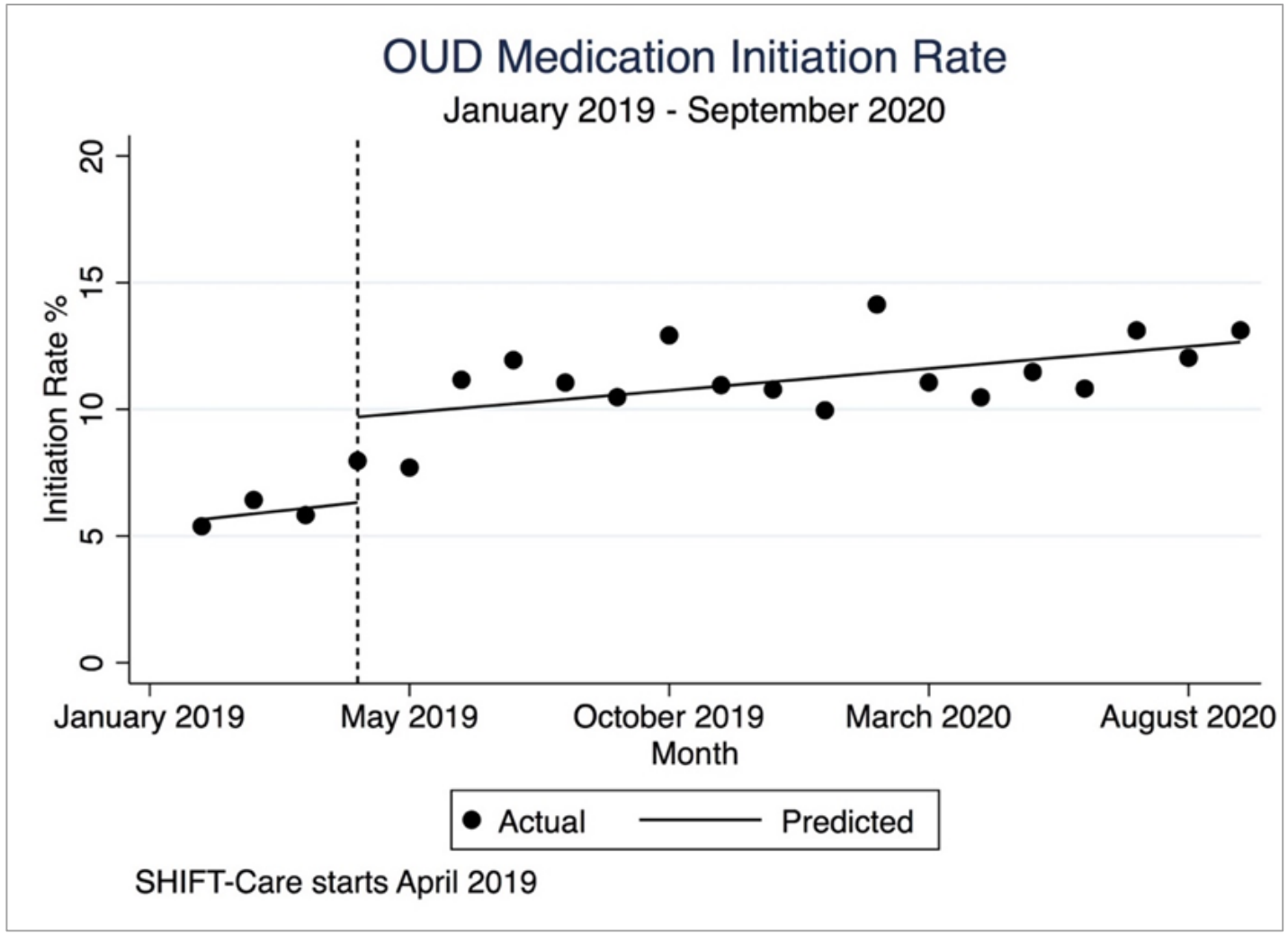
- ED revisits
- Initiation/engagement in treatment at 1/2/3/6 months
- ED, hospitalizations, all-cause mortality, lethal and non-lethal overdose

2 Qualitative Methods

Conversations with patients and staff with lived experience, document review

Conversation Type	Patients	Staff with Lived Experience	Other Staff	Total
Initial Conversations	48	25	10	83
Follow-up Conversations	13	0	0	13
Total	61	25	10	96

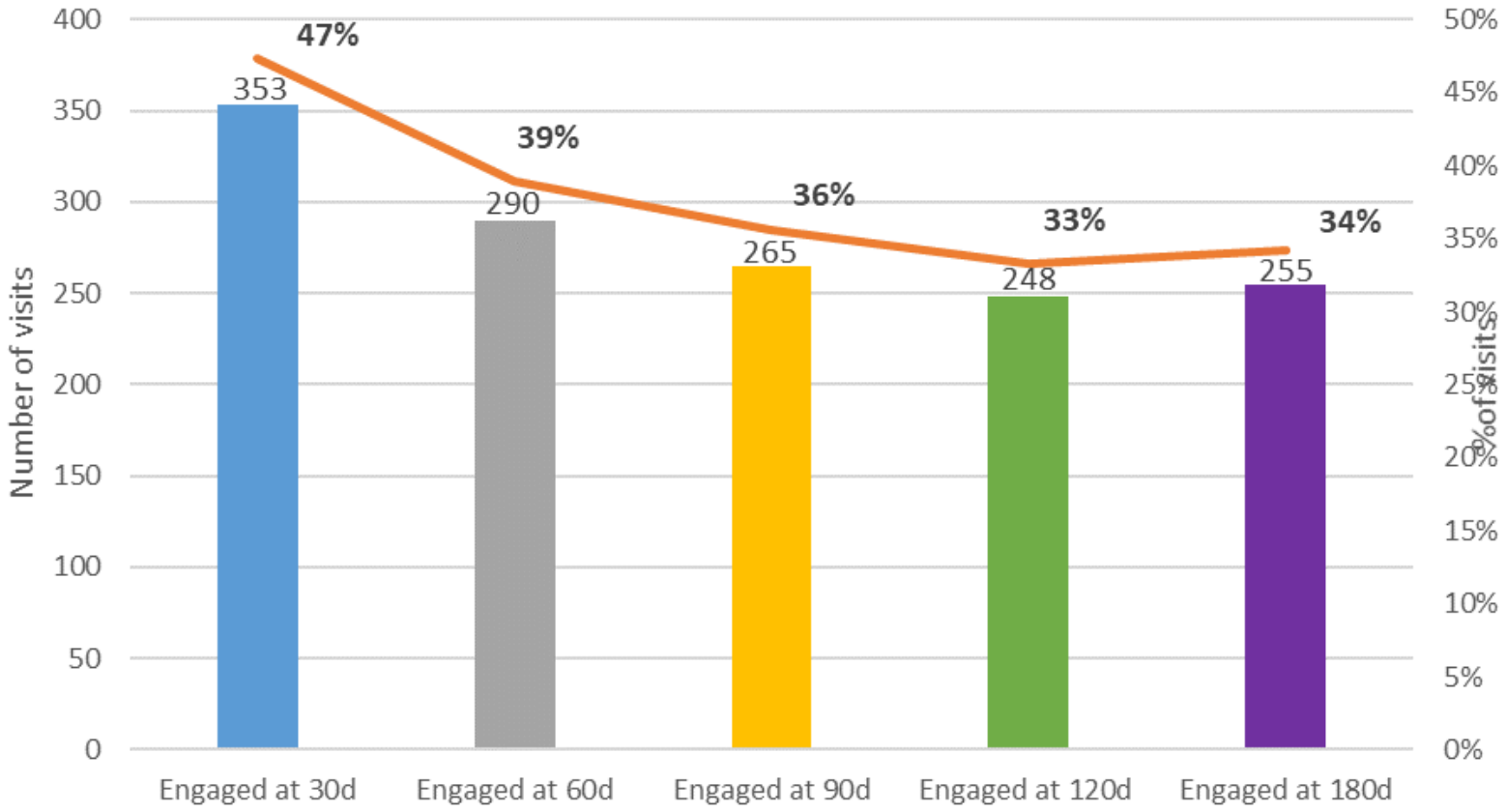
MAT initiation rate doubled from 5.8% to 11.6% over the course of the program.



- The average rate of initiation during baseline was 5.8%.
  - 1,637 eligible ED visits
  - 95 initiations
- The average rate of initiation during the intervention period was 11.6%.
  - 8,878 eligible ED visits
  - 1,030 initiations
- The rate of initiation was statistically higher during the SHIFT-Care program period.

SHIFT-Care Challenge - Medication for Addiction Treatment (MAT) in the Emergency Department, Brandeis Heller School for Social Policy and Management, June 2022.

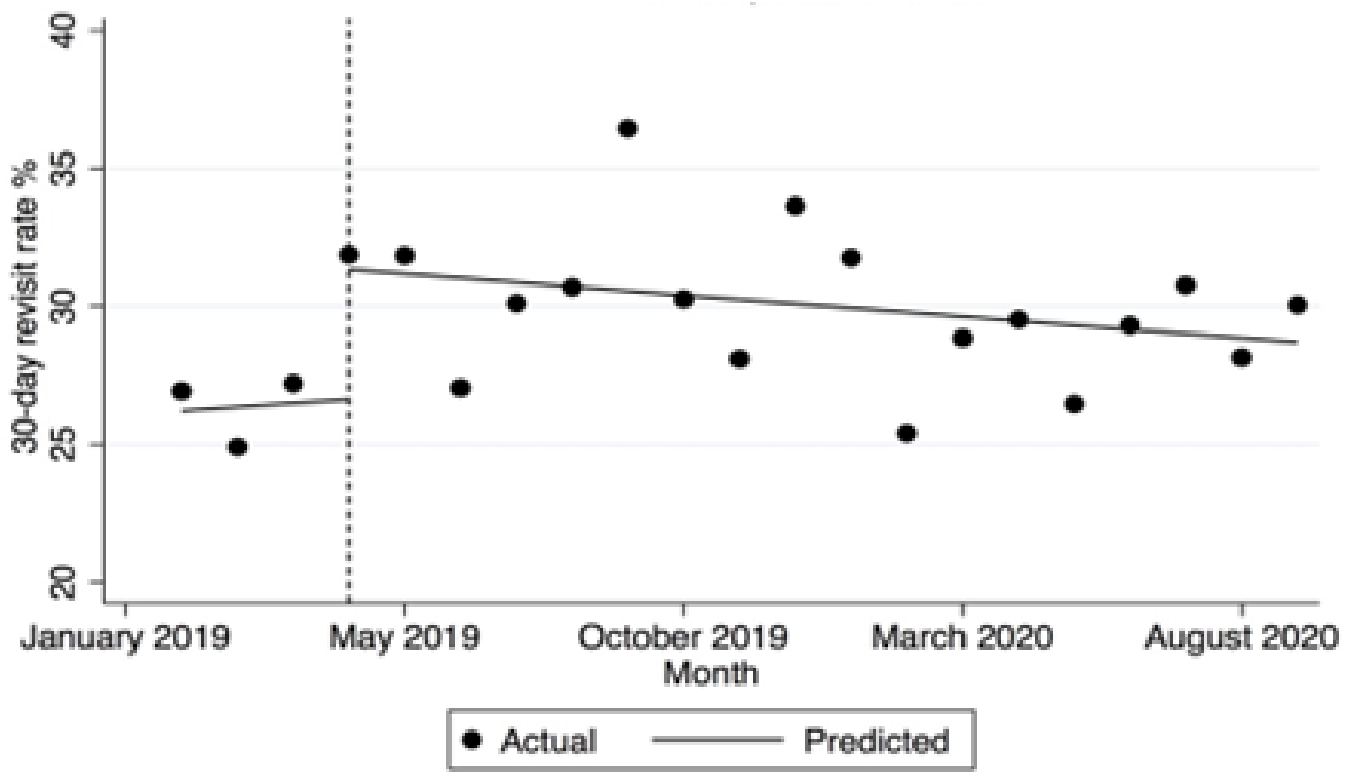
Nearly half of initiated patients remained engaged in treatment at 30 days.



- The overall 30-day engagement rate during SHIFT-Care was 45%.
- The rate of engagement changed over time, which is expected.
- These rates may be an underestimate of true rates due to limitations in following connections post-discharge.

SHIFT-Care Challenge - Medication for Addiction Treatment (MAT) in the Emergency Department, Brandeis Heller School for Social Policy and Management, June 2022.

SHIFT-Care Impact on ED Revisit Rates



- The 30-day revisit rate increased immediately after implementation and then declined over time.
- The average 30-day ED revisit rate was not significantly different between visits that included initiation and those that did not.
- Repeat ED visits could indicate positive treatment trajectory.

SHIFT-Care Challenge - Medication for Addiction Treatment (MAT) in the Emergency Department, Brandeis Heller School for Social Policy and Management, June 2022.

SHIFT-Care Impact on Hospitalizations, Mortality, and Overdose

HPC

	Pre-Post		Intervention, June 19-May 20	
6-month measure	Baseline, Jan-Mar 19	Intervention, June 19-May 20	Among initiated	Among non-initiated
Utilization measures per patient				
Hospitalizations	0.36	0.21***	0.34	0.18***
ED visits	1.06	1.91	1.98	1.90
Outcome measures per patient				
Mortality	0.03	0.03	0.02	0.03
Fatal overdose	0.00	0.00	0.00	0.00
Non-fatal overdose	0.16	0.17	0.16	0.17

- There was a statistically significant decline in hospitalizations when comparing the baseline rates to the SHIFT-Care intervention period.
  - COVID context should be considered
  - Hospitalizations were lower among non-initiated patients
- There were no statistically significant differences in mortality or overdose when comparing baseline rates to SHIFT-Care intervention period.

Notes: Mortality data reported using hospital and DPH data; all other outcomes used hospital data only. ***Significantly different from baseline or initiated at p<.001

Qualitative Findings

HPC

1. ED buy-in and education
2. Anti-stigma efforts and culture change
3. Recovery coach role and impact
4. Hospital resources and complex patient needs
5. Role of community-based resources
6. Reflections on the ED as a site for MAT initiation

SHIFT-Care staff identified ED buy-in and education as important for program success.

HPC

Awardees Learned:

- Gaining buy-in from ED leadership during program development was key to program success.
- Including cross-functional teams (e.g., nursing, pharmacy, information technology) in the development of buprenorphine dispensing protocols supported implementation success.
- Providing education to ED physicians and staff about the SHIFT-Care program and OUD facilitated buy-in.
- Addiction consult teams in the ED and/or inpatient floor provided essential support and a sense of comfort to ED physicians and nurses who may be wary of prescribing buprenorphine

We actually developed a new ED nursing role and provided training to one of the nurses in the management of psychiatric and SUD patients. She's wonderful and definitely changes the perspective of nurses and some physicians.

- SHIFT-Care staff member

SHIFT-Care staff identified anti-stigma efforts as important for program success.

HPC

Awardees Learned:

- Stigma exists at many level and impedes successful program implementation.
- ED physicians and staff often hold biases around addiction due to lack of education on this topic.
- Patients often experience stigma in the ED that affects their self-concept and openness to initiating treatment.
- Patients also experience stigma around MAT within their own communities, delaying or preventing initiation of treatment.
- The SHIFT-Care program made a notable change in the presence of stigma in the ED.

Through the efforts of the SHIFT-Care team, frontline staff now see opioid addiction as a treatable disease. Relapse is [now] viewed as a predictable part of recovery.

- SHIFT-Care staff member

Recovery coaches were found to be very valuable.

HPC

Awardees Learned:

- Recovery coaches or staff with lived experience forge meaningful connections with patients with OUD.
- The connections made between recovery coaches and patients with OUD increase the odds of initiation and facilitate retention in treatment.
- Patients find recovery coaches very influential in their recovery journeys, often shifting their own perspective on addiction and treatment.
- The connections made by recovery coaches helped patients rebuild their trust in the medical system.

He (recovery coach) told me that my addiction was a disease. Seeking support and treatment could help me. I never heard it that way. He gave me hope.

- SHIFT-Care patient

Hospital resources alone proved insufficient to meet the needs of patients with OUD.

HPC

Awardees Learned:

- Many of the patients experiencing OUD have complex medical, economic, and social histories and circumstances.
- Most teams recognized that supportive hospital services were insufficient to address all of the complex needs of patients with OUD.
- Knowledge of mental illness is essential to serving patients with OUD who often experience comorbid mental health conditions.
- Patients may have unmet basic needs like food or housing that impede their ability to begin and/or stay in treatment.

Our patients need so much. Yes, medication, along with trauma and mental health care, access to a range of credible treatment options, and they must have a way to access avenues off the streets—housing, food, work, activities if they can't work, sober support.

- SHIFT-Care staff member

Connection to community-based services was essential to retention in treatment.

HPC

Awardees Learned:

- Providers feel more comfortable prescribing buprenorphine if they know their patients will receive follow-up care.
- Bridge clinics, or sites that provide outpatient treatment until patients can access community-based care, are valuable to support retention in treatment.
- Primary care physicians can be valuable allies in supporting patient retention in treatment after ED discharge.
- Marginalized patient groups and staff with lived experience feel that MAT alone is insufficient to treat OUD.

There are so many barriers, and I know that from living it, not just reading about it. More wraparound services could mitigate things that might happen to the individuals that are seeking recovery.

- SHIFT-Care staff member

The emergency department should be only one component of a broader systemic effort to ensure access to MAT.

HPC

Awardees Learned:

- Empowering ED physicians and staff to initiate MAT was extremely valuable for patients who showed up in the ED with OUD.
- Providing the ability to initiate MAT in the ED allowed for patients who may not be connected to the healthcare system to obtain access to treatment.
- Stigma, long wait times, competing priorities, and chaotic environments can make EDs a challenging place to initiate MAT.

There are a lot of people who might not have contemplated treatment before they ended up in the ED. And for some, it might be the only option – the only place they're being seen at all by health care providers.

- SHIFT-Care staff

All awardees planned to continue and expand the SHIFT-Care program through additional operational investment and sustained culture change.

HPC

SHIFT-CARE MODEL

- HEALing Communities Study will fund **a continuation of the SHIFT-Care model** at AGH/BH, North Shore.
- Mercy will fund **a continuation of Bridge Clinic hours** at a reduced level, the **ED recovery coach role,** and monthly **meetings between ED and Bridge Clinic** teams.
- Harrington's new Addiction Immediate Care (AIC) will **sustain almost all of SHIFT-Care model.**

CULTURE CHANGE

- UMass shared that physicians felt **more comfortable prescribing buprenorphine** after using bridge services during SHIFT-Care.
- MGH saw a **notable reduction in stigma** in the ED, including **more willingness to prescribe buprenorphine.**
- Holyoke Medical Center saw a **reduction in stigma** among providers and **increased buy-in** for OUD treatment.

EXPANSION

- HEALing Communities Study will fund **additional addiction nurse** at BID-Plymouth.
- HEALing Communities Study will fund **new Addictions Consult Team** and **community partnerships** to facilitate wraparound care at Lowell.
- Holyoke Medical Center is **expanding SHIFT-Care services to medical floors.**

Note: The above bullets provide a sampling of SHIFT-Care sustainability but not a comprehensive list. Boston Medical Center is participating in the NIH HEAL Initiative by partnering with communities across Massachusetts to implement and study evidence-based solutions to reduce deaths due to opioid overdose.

Sharing the Impact of the SHIFT-Care Challenge

SHIFT-Care Challenge: Opioid Use Disorder Initiatives Video

HPC

Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

2022 Health Care Cost Trends Report

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

EXECUTIVE DIRECTOR'S REPORT

- Market Changes
- MGB Performance Improvement Plan

Schedule of Upcoming Meetings

Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

2022 Health Care Cost Trends Report

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

Executive Director's Report

MARKET CHANGES

- MGB Performance Improvement Plan

Schedule of Upcoming Meetings

Types of Transactions Noticed

HPC

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	34	24%
Physician group merger, acquisition, or network affiliation	29	21%
Clinical affiliation	28	20%
Acute hospital merger, acquisition, or network affiliation	24	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	20	14%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

HPC

- A proposed clinical affiliation between **Lawrence General Hospital** (LGH) and **Steward Healthcare** (Steward).
- A clinical affiliation between **Atrius Health** and **Emerson Hospital** under which Emerson would be designated a preferred facility for Atrius patients.

Material Change Notices Currently Under Review

HPC

- A proposed transaction between Signature Healthcare, South Shore Health System, Sturdy Memorial Hospital, and Southeast Massachusetts Behavioral Health, a subsidiary of US HealthVest, to own and operate a new psychiatric hospital in Southeastern Massachusetts.
- The proposed acquisition of Franciscan Hospital for Children, a Catholic non-profit specialty hospital that focuses on pediatric chronic care, mental health disorders, and rehabilitation services by Children's Hospital Boston. This acquisition is subject to review under both the HPC's Material Change Notice and DPH's DoN review processes.

RECEIVED SINCE 4/13

- A proposed joint venture between MelroseWakefield Healthcare (MelroseWakefield), a subsidiary of Tufts Medicine with hospital campuses in Medford and Melrose, and Shields HealthCare Group (Shields). The joint venture would own and operate a licensed clinic to provide PET/CT services to patients in MelroseWakefield's service area. It would replace a joint venture between MelroseWakefield and Alliance HealthCare Services, which would stop operations in 2023.

Other Market Changes Currently Under Review

HPC

- A Determination of Need (DoN) application by Children's Hospital Boston to expand outpatient services outside of Boston.
- Tufts Medical Center's proposed closure of pediatric inpatient beds and planned affiliation with Children's Hospital Boston for inpatient pediatric care (MCN expected to be filed soon).

Agenda

HPC

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2022 Health Care Cost Trends Report

SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

Executive Director's Report

- Market Changes

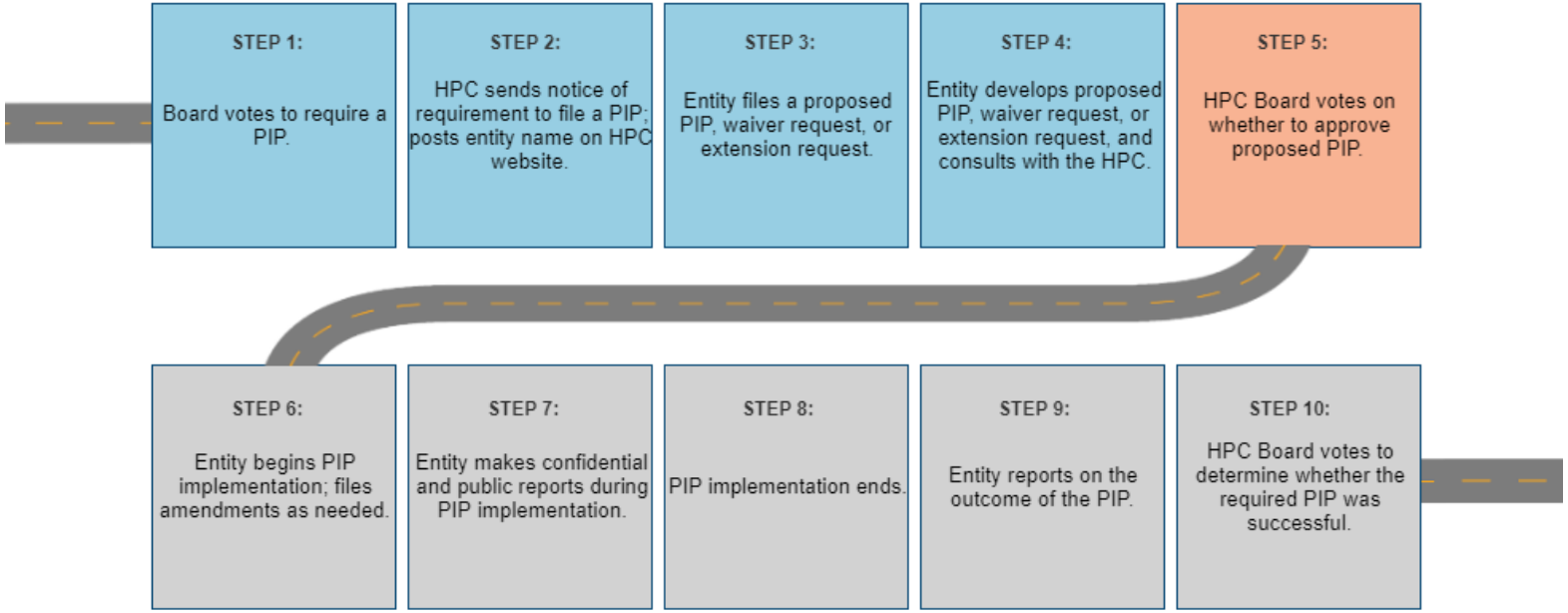
MGB PERFORMANCE IMPROVEMENT PLAN

Schedule of Upcoming Meetings

Performance Improvement Plans: MGB Proposal Received

PERFORMANCE IMPROVEMENT PLAN (PIP): MASS GENERAL BRIGHAM (MGB)

The following visualization illustrates the progress of the Performance Improvement Plan (PIP) required of Mass General Brigham (MGB). Hover over **completed**, **current**, and **next** steps for more information.



- On January 25, 2022, the Board voted to require Mass General Brigham (MGB) to develop and file a Performance Improvement Plan. MGB requested and was granted an extension of the deadline.
- MGB submitted its proposal to the HPC on May 16, 2022.
- The HPC is reviewing the proposal closely and is engaged in ongoing communication with MGB. Per the PIP regulation, MGB and the HPC may consult throughout the development of the PIP to ensure the criteria for approval have been met.
- The Board will vote on whether to approve the proposal in a future meeting.

Performance Improvement Plans: Approval Standard

HPC

STANDARD FOR APPROVAL

- The Board shall approve a proposed PIP if it determines that the PIP:
  - Is reasonably likely to successfully address the underlying causes of the entity's cost growth; and
  - That the entity will be capable of successfully implementing the plan.

REGULATORY FACTORS FOR CONSIDERATION

- Whether the PIP proposes a strategy or activity that has a reasonable economic, business, or medical rationale with a sufficient evidence base;
- The scope and likelihood of potential savings and the potential impact on the Commonwealth's ability to meet the benchmark
- Whether savings and efficiencies are likely to continue after implementation
- The extent to which a proposed PIP carries a risk of negative consequences that would be inconsistent with other policy goals of the Commonwealth; and
- Any other factors the Commission determines to be in the public interest.

Recent and Upcoming Publications

HPC

RECENTLY RELEASED

- **Video:** SHIFT-Care Opioid Use Disorder Initiative (June 2022)
- **Innovation Spotlight:** Harrington Hospital (June 2022)
- **HPC Shorts:** Growth in Out-of-Pocket Spending for Pregnancy, Delivery, and Postpartum Care in Massachusetts (April 2022)
- **Innovation Spotlight:** Medical Legal Partnerships (April 2022)
- **Investment Program Profiles:** Moving Massachusetts Upstream "MassUP" (March 2022)
- **DataPoints Issue #22:** Growth in Out-of-Pocket Spending for Pregnancy, Delivery, and Postpartum Care in Massachusetts (March 2022)
- **Annual Report:** Office of Patient Protection (March 2022)

UPCOMING

- **DataPoints Issue #23:** Growth in Alternative Care Sites Over Time in Massachusetts
- **Evaluation Report:** SHIFT-Care Challenge Investment Program
- **Impact Brief:** SHIFT-Care Opioid Use Disorder Cohort
- **Innovation Spotlight:** Emergency Medical Services Partnerships
- **Report to the Legislature:** Impact of COVID-19 on the Health Care Workforce
- **Report to the Legislature:** Utilization of Telehealth in the Commonwealth

Agenda

HPC

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SHIFT-Care Challenge Investment Program: Opioid Use Disorder Pathway Alternatives

Executive Director's Report

SCHEDULE OF UPCOMING MEETINGS

Schedule of Upcoming Meetings

HPC

BOARD

July 13

September 14

December 14

COMMITTEE

October 12

ADVISORY COUNCIL

June 22

September 21

December 7

SPECIAL EVENTS

November 2
Cost Trends Hearing

Mass.gov/HPC

HPC-info@mass.gov

@Mass_HPC

tinyurl.com/hpc-linkedin

2022 Public Meeting Calendar

HPC

– JANUARY –						
S	M	T	W	T	F	S
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– FEBRUARY –						
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– APRIL –						
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– JULY –						
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– AUGUST –						
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– SEPTEMBER –						
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– OCTOBER –						
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– NOVEMBER –						
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– DECEMBER –						
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BOARD MEETINGS

Tuesday, January 25
Wednesday, March 16 – Benchmark Hearing
Wednesday, April 13
Wednesday, June 8
Wednesday, July 13
Wednesday, September 14
Wednesday, December 14

COMMITTEE MEETINGS

Wednesday, February 9
Wednesday, May 11
Wednesday, October 12

ADVISORY COUNCIL

Wednesday, March 30
Wednesday, June 22
Wednesday, September 21
Wednesday, December 7

COST TRENDS HEARING

Wednesday, November 2

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