HPC Board Meeting

September 27, 2022

Agenda

CALL TO ORDER

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

Care Delivery Transformation

Executive Director's Report

Schedule of Upcoming Meetings

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

Care Delivery Transformation

Executive Director's Report

Schedule of Upcoming Meetings

VOTE

Approval of Minutes from the July 13 Board Meeting

HPC

MOTION

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

Agenda

Call to Order

Approval of Minutes (VOTE)

EXECUTIVE SESSION (VOTE)

Market Oversight and Transparency

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Schedule of Upcoming Meetings

VOTE

Enter into Executive Session

HPC

MOTION

That, having first convened in open session at its September 27, 2022 board meeting and pursuant to M.G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with M.G.L. c. 6D, § 10 and its associated regulation, 958 CMR 10.00, and M.G.L. c. 6D, § 2A, in discussions about whether to approve a proposed performance improvement plan.

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

- Mass General Brigham’s Performance Improvement Plan (PIP) Proposal (VOTE)
- 2022 Health Care Cost Trends Report (VOTE)
- Market Changes

Care Delivery Transformation

Executive Director’s Report

Schedule of Upcoming Meetings

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

- **MASS GENERAL BRIGHAM'S PERFORMANCE IMPROVEMENT PLAN (PIP) PROPOSAL (VOTE)**
- 2022 Health Care Cost Trends Report (VOTE)
- Market Changes

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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

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.

Standard for Requiring a PIP and Factors for Review

The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan if, after a review of regulatory factors, it identifies **significant concerns** about the Entity's costs and determines that a Performance Improvement Plan could result in **meaningful, cost-saving reforms.**

958 CMR 10.04(1)

REGULATORY FACTORS	
a	Baseline spending and spending trends over time, including by service category;
b	Pricing patterns and trends over time;
c	Utilization patterns and trends over time;
d	Population(s) served, payer mix, product lines, and services provided;
e	Size and market share;
f	Financial condition, including administrative spending and cost structure;
g	Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
h	Factors leading to increased costs that are outside the CHIA-identified Entity's control; and
i	Any other factors the Commission considers relevant.

Basis for MGB PIP

On January 25, 2022, the Board voted to **require a PIP from Mass General Brigham**.

The [basis for the Board's determination] is summarized as follows:

- MGB's high baseline spending levels for its primary care population, both on a health status adjusted and unadjusted basis, combined with that fact that its TME has been growing apace or even faster than the payer network average, has resulted **in greater cumulative commercial spending growth in excess of the benchmark from 2014-2019 than any other provider, totaling $293 million**. MGB acknowledged that this spending growth was not driven by a worsening of the health status of its primary care population;
- **Even in alternative payment method contracts**, spending for MGB's primary care patients is growing at rates above the benchmark across multiple years and multiple payers;
- MGB's **hospital and physician prices** are higher than nearly all other providers in the Commonwealth and price and mix were bigger drivers of spending growth for MGB's primary care patients than utilization; and
- MGB stated that its **primary strategy for controlling spending growth would be to continue its current efforts** around clinical and care management programs, shifting patients to lower cost settings, and taking on more risk in its payer contracts, strategies which have not been sufficient to restrain spending to date.

The HPC determined that a Performance Improvement Plan could result in **meaningful, cost-saving reforms**.

Initial PIP Proposal

- MGB submitted its initial proposal to the HPC on May 16, 2022. The plan proposed an annual savings target of $70 million ($105 million over the 18-month implementation timeframe).
- The proposal included three categories of strategies with quantified savings (see table), with the largest portion of savings coming through commercial pricing actions.
- The HPC analyzed the proposed PIP and solicited substantiating data and information to determine whether it was likely to meet the regulatory standard for approval.
- After close review of the proposal and discussion and consultation with MGB, the HPC encouraged MGB to submit a revised proposal that:
  1. Increased the savings target
  2. Included new strategies
  3. Demonstrated evidence of sustainability

MGB PIP Proposal: Initial Submission		
Category	**Strategies**	**Annual Savings Estimate (M)**
Price Reductions	Outpatient AMC Rates	$24.4
	MG West	$14.5
	ConnectorCare	$11.9
	Other Insurance Product	$3
Reducing Utilization	Integrated Care Management Program	$10.8
Shifting Care to Lower Cost Sites	Hospital at Home	$1.3
	Virtual Care	$4.1
Accountability Through Value-Based Care	MGB health plan product innovations (Commercial, Medicare and MassHealth)	Not quantified
	Total	**$70.0**

Revised PIP Proposal

- MGB filed a revised PIP proposal on September 20, 2022.
- MGB updated some of its proposed strategies and added new strategies to the plan, including new activities not undertaken previously.
  - Among these revisions were the inclusion of pricing actions for additional commercial payers.
- As a result of these changes, MGB estimates that its proposal will save $127.8M annually, an increase of nearly $60M from the original plan.
- Based on data and assumptions provided by MGB, annual savings estimates include:
  - $90M in savings via commercial pricing actions.

MGB PIP Proposal: Revised Submission			
Category	**Strategies**	**Original Savings Estimate (M)**	**Revised Savings Estimate (M)**
Price Reductions	Outpatient AMC Rates	$24.4	**$59.8**
	MG West	$14.5	**$15.3**
	ConnectorCare	$11.9	$11.9
	Other Insurance Product	$3	$3
Reducing Utilization Utilization Management	Integrated Care Management Program	$10.8	**$15.3**
	Utilization Management	N/A	**$17.1**
Shifting Care to Lower Cost Sites	Hospital at Home	$1.3	$1.3
	Virtual Care	$4.1	$4.1
Accountability Through Value-Based Care	MGB health plan product innovations (Commercial, Medicare and MassHealth)	Not quantified	Not quantified
	Total	**$70.0**	**$127.8**

Summary of Savings Strategies

Price Reductions

Outpatient Rates

MG West

ConnectorCare

Other Insurance Product

- MGB's plan includes savings from pricing actions related to its current contracts with Blue Cross Blue Shield of MA, Point32Health, and Mass General Brigham Health Plan (previously AllWays Health Partners). These actions impact **AMC Outpatient Rates.** MGB estimates the value of these actions at $59.8M annually.
- Part of its Outpatient Rates strategy also includes converting pricing at **MG West**, an outpatient facility in Waltham licensed under MGH, to its community hospital rate schedule with the payers identified above. MGB estimates the value of this strategy at $15.3M annually.
- MGB providers have reduced the rates they charge to MGB Health Plan for subsidized **ConnectorCare** members to 100% of Medicaid as of Q1 2021. MGB estimates the value of this strategy at $11.9M annually.
- MGB providers also propose to offer an improvement on the incremental **discount to the state** that MGB provides through Mass General Brigham Health Plan.

Summary of Savings Strategies

Reducing Utilization

Integrated Care Management Program

Utilization Management

- The **Integrated Care Management Program (iCMP)** is a high-risk care management program. MGB cites evidence that the iCMP reduces ED visits, hospitalizations, and health care expenses.
- MGB proposes to increase enrollment in the iCMP by approximately 4,000 patients, with a focus on commercial and Medicaid populations.
- MGB states that it will track enrollment metrics for the iCMP as well as quarterly metrics on inpatient utilization and TME reduction compared to previous quarters. MGB estimates the value of this strategy at $15.3M annually.
- MGB also proposes to reduce spending through a set of three new **Utilization Management** efforts:
  - MGB states that it will reduce SNF admissions and LOS through a variety of programs, with an estimated value of $10.7M annually in Medicare spending.
  - MGB states that new utilization management requirements at MGB Health Plan for members with MGB Primary Care Physicians, with an estimated value of $1.2M annually.
  - MGB states that new interventions to reduce inappropriate imaging, with an estimated value of $5.2M annually.

Summary of Savings Strategies

Shifting Care to Lower Cost Settings

Hospital at Home

Virtual Care

- MGB proposes to expand its **Hospital at Home** program, which treats patients who otherwise would have been admitted for inpatient care in their own home. MGB estimates the value of this strategy at $1.3M annually.
- MGB has negotiated Hospital at Home rates with commercial payers that are lower than its in-hospital rates.
- Under its **Virtual Care** strategy, MGB proposes to work with commercial payers to amend its current telehealth specialty rates so that the updated rates are below its in-person rates (i.e., lower than parity rates). MGB estimates the value of this strategy at $4.1M.

Implementation, Reporting, and Monitoring

- If approved, MGB will implement the PIP from approximately October 1, 2022 – March 31, 2024.
- MGB would be required to report periodically to the HPC throughout the implementation period, and for a reasonable period of time thereafter, to allow the HPC to evaluate MGB's progress toward its stated goals.
- MGB may propose amendments to the PIP during implementation.
  - Significant proposed amendments must be approved by the Board.
- At the conclusion of the PIP, the HPC must determine whether the PIP was successful by a vote of the Board (see criteria to the right). If the Board determines the PIP was not successful, it may:
  - Extend the implementation timetable and request amendments;
  - Require MGB to submit a new PIP; or
  - Waive or delay the requirement to file any additional PIP.

CRITERIA TO DETERMINE SUCCESS OF PIP

1. Whether and to what extent the Entity has addressed significant concerns about its costs.
2. Whether the Entity has fully implemented, in good faith, the strategies, adjustments and action steps of the PIP.
3. The sustainability of the efficiencies and cost savings.
4. The impact of events outside of the Entity's control on implementation or cost growth.
5. Other factors the Commission determines to be relevant.

958 CMR 10.13(3)

Determining Success: Sustainability

- At the conclusion of the PIP Implementation Period, when the Board votes on whether the PIP was successful, it may consider "the sustainability of the efficiencies and cost savings of the PIP."
- MGB's September 20 proposal included statements that:
  - MGB "commits to continuing the comprehensive market solution proposed in the PIP to address the role of pricing in cost growth in the Commonwealth";
  - MGB's "goals for future contract negotiations with local commercial payers will include continuing to decrease price variation between Mass General Brigham and the marketplace and ensuring that the value of pricing actions included in the PIP are not recouped through rate increases (as evaluated in the context of underlying market rates);" and
  - MGB "will provide the HPC data and evidence of this commitment, which may include rate increase tables and other contract figures."

Determining Success: Measurement

- The HPC will need **data sufficient for the Board to determine if the PIP was successful**, including:
  - Whether interventions and strategies were implemented as proposed;
  - Whether estimated savings targets were achieved; and
  - The impact of the PIP on overall spending performance.
- **MGB's proposal states several data sources and metrics that it will use** to measure progress on achieving the goals of the PIP, the expectation that it will report to the HPC every six months, and that it "will supply the HPC with other information as needed."
- The **HPC may specify additional reporting requirements as necessary**, for example:
  - Requiring regular meetings between MGB and HPC staff;
  - Requiring MGB to report to the HPC periodically during the 18-month implementation period and for a reasonable period thereafter; and
  - Specifying needed data or documents (e.g., evidence of pricing adjustments; payer-generated cost and use reports).

Performance Improvement Plans: Approval Standard

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.

958 CMR 10.10(1)

- The HPC's review of MGB's spending performance found that MGB's hospital and physician prices are higher than nearly all other providers in the Commonwealth and price and mix were bigger drivers of spending growth for MGB's primary care patients than utilization. MGB estimates that it will save $90M (70% of total) annually via commercial pricing strategies.

- MGB's savings target and strategies are based on a consideration of the total amount of savings that are likely to accrue to its commercial primary care population (i.e., the population on which its $293M in above benchmark spending growth from 2014 to 2019 was based).

- The HPC will receive data and documentation throughout the PIP demonstrating that the PIP has been successfully implemented.

NEXT STEPS:

- If the Board votes to approve the PIP proposal, the HPC will notify MGB, and MGB will begin implementing its plan. MGB will be subject to compliance monitoring and will be required to regularly provide both public and confidential reports as specified by the HPC.

- If the Board votes not to approve the PIP proposal, MGB will have up to 30 days to revise and resubmit their plan.

VOTE

Mass General Brigham Performance Improvement Plan Proposal

MOTION

That the Commission hereby [approves/does not approve], pursuant to 958 CMR 10.10, the Performance Improvement Plan proposal as of September 20, 2022, as submitted by Mass General Brigham.

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

- Mass General Brigham's Performance Improvement Plan (PIP) Proposal (VOTE)

2022 HEALTH CARE COST TRENDS REPORT (VOTE)

- Market Changes

Care Delivery Transformation

Executive Director's Report

Schedule of Upcoming Meetings

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

2022 REPORT AND POLICY RECOMMENDATIONS

- Introduction
- Trends in Spending and Care Delivery
- Changes in Ambulatory Care During the COVID-19 Pandemic
- Conclusion and 2022 Policy Recommendations
- Dashboard of HPC Performance Metrics

2022 CHARTPACK

- Commercial Price Trends
- Hospital Utilization
- Post-Acute Care
- Provider Organization Performance Variation

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

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

Key Findings: Massachusetts Spending Trends

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

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

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

	Commercial	MassHealth (MCO+PCC+ACO)	Medicare Advantage	Medicare FFS
Spending per enrollee	-1.6%	-4.7%	-4.2%	-3.4%
Enrollment	-2.1%	5.9%	8.5%	-0.8%
Change in total spending	-3.6%	0.9%	3.9%	-4.8%

8%
6%
4%
2%
0%
-2%
-4%

Spending per enrollee Enrollment X% Change in total spending

Share of Massachusetts Medicare beneficiaries in Medicare Advantage plans:

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

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

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

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

12%
10%
8%
6%
4%
2%
0%
-2%
-4%

2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020

MA U.S

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

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

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

Category	Year	Facility Spending	Professional Spending	Pharmacy Spending	Change in total spending
Inpatient	2018	$951	$216		
Inpatient	2019	$1,027	$226		7.4%
Inpatient	2020	$1,017	$211		-2.0%
HOPD	2018	$1,376	$394		
HOPD	2019	$1,481	$429		7.9%
HOPD	2020	$1,330	$340		-12.6%
ED	2018	$201	$66		
ED	2019	$222	$72		9.9%
ED	2020	$193	$60		-14.0%
Office	2018		$1,220		
Office	2019		$1,332		9.2%
Office	2020		$1,100		-17.4%
Pharmacy	2018			$882	
Pharmacy	2019			$878	-0.4%
Pharmacy	2020			$954	8.6%

Y-axis: $0, $500, $1,000, $1,500, $2,000

Legend: Facility Spending; Professional Spending; Pharmacy Spending; X% Change in total spending

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

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

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

250,000
200,000
150,000
100,000
50,000
-

236,917
171,941
109,643
38,758
-

Potentially avoidable 161,118
All other 141,216
Injury 89,651
Behavioral health 29,359
COVID-19 29,620

Jan-Mar Apr-Jun Jul-Sept Oct-Dec | Jan-Mar Apr-Jun Jul-Sept Oct-Dec | Jan-Mar Apr-Jun Jul-Sept Oct-Dec | Jan-Mar
2019 | 2020 | 2021 | 2022

Potentially avoidable, All other, Injury, Behavioral health, COVID-19

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

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

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

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

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

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

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

Age group	Quarter	In-person	Telehealth
18 to 25	JAN-MAR	85.5%	14.5%
18 to 25	APR-JUN	14.0%	86.0%
18 to 25	JUL-SEP	14.9%	85.1%
18 to 25	OCT-DEC	13.4%	86.6%
26 to 49	JAN-MAR	85.5%	14.5%
26 to 49	APR-JUN	12.8%	87.2%
26 to 49	JUL-SEP	12.7%	87.3%
26 to 49	OCT-DEC	11.3%	88.7%
50 to 64	JAN-MAR	87.5%	12.5%
50 to 64	APR-JUN	15.0%	85.0%
50 to 64	JUL-SEP	15.6%	84.4%
50 to 64	OCT-DEC	14.0%	86.0%

Y-axis: 100, 200, 300, 400, 500, 600, 700, 800

● In-person ● Telehealth

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

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

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

Setting	2018-2019	2019-2020
Office	1.7%	1.5%
HOPD	3.2%	3.9%
Inpatient	4.0%	3.9%

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

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

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

Gross spending distribution per branded prescription, 2017-2020

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

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

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

Drug class	2017	2018	2019	2020	Change
Antiarthritic drugs	$84	$103	$117	$123	47.2%
MS drugs	$66	$78	$95	$103	56.6%
Non insulin diabetes	$39	$48	$61	$64	62.1%
Insulin	$37	$44	$53	$55	47.7%

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

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

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

	2013	2014	2015	2016	2017	2018	2019	2020	2021
Level 4	4.4%	4.8%	5.5%	6.2%	7.0%	7.7%	8.2%	8.9%	9.3%
Level 3	23.7%	24.8%	26.5%	27.3%	28.7%	29.6%	30.6%	31.3%	31.8%
Level 2	38.0%	37.4%	37.0%	36.9%	36.1%	35.8%	35.4%	34.7%	34.5%
Level 1	33.9%	33.0%	31.1%	29.6%	28.2%	27.0%	25.9%	25.2%	24.5%

100% 80% 60% 40% 20% 0%

COVID-19 excluded (2020–2021)

Level 1 Level 2 Level 3 Level 4

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

Source: HPC analysis of Center for Health Information and Analysis Hospitals Inpatient Discharge Database, FY2013-2019, preliminary FY2020-2021

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

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

AMC · Community · Teaching · Specialty

Hospital	Cost
Martha's Vineyard	$43,213
Boston Children's	$37,711
Nantucket Cottage	$36,741
Dana-Farber Cancer Institute	$32,232
Falmouth	$29,560
Massachusetts General	$28,975
Brigham and Women's	$28,907
Cape Cod	$28,588
Berkshire	$26,464
Brigham and Women's Faulkner	$25,897
Harrington Memorial	$25,192
South Shore	$25,094
Tufts	$24,860
Sturdy Memorial	$24,452
UMass Memorial	$23,899
Newton-Wellesley	$23,780
Nashoba Valley	$23,729
Beth Israel Deaconess	$23,672
North Shore	$23,260
Baystate Franklin	$23,245
Steward Norwood	$23,128
Emerson	$22,934
Beth Israel Deaconess - Needham	$22,871
Steward Saint Anne's	$22,825
Morton	$22,125
Marlborough	$22,090
Steward Carney	$22,017
New England Baptist	$21,971
Steward Good Samaritan	$21,900
Lowell General	$21,818
Melrose Wakefield Healthcare	$21,754
Steward St. Elizabeth's	$21,716
MetroWest	$21,686
Lahey	$21,659
Cooley Dickinson	$21,315
HealthAlliance	$20,893
Mount Auburn	$20,782
Boston Medical Center	$20,642
Athol Memorial	$20,568
Beth Israel Deaconess - Milton	$20,384
Cambridge Health Alliance	$20,360
Signature Healthcare Brockton	$20,051
Steward Holy Family	$19,972
Milford Regional	$19,809
Northeast	$19,795
Baystate	$19,749
Beth Israel Deaconess - Plymouth	$19,682
Lawrence General	$19,657
Winchester	$19,609
Saint Vincent	$19,480
Baystate Wing	$19,152
Heywood	$19,112
Anna Jaques	$18,858
Mercy	$18,797
Southcoast	$18,400
Holyoke	$17,208

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

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

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

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

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

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

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

$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0

WORCESTER METRO AREA

Monthly income: $9,693

Monthly spending: $9,518
Out of pocket health care spending
Health insurance premiums
Taxes
Other necessities
Transportation
Child care
Food
Housing

BOSTON METRO AREA

Monthly income: $9,693

Monthly spending: $11,260
Out of pocket health care spending
Health insurance premiums
Taxes
Other necessities
Transportation
Child care
Food
Housing

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

Conclusion and Policy Recommendations:

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

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

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

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

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

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

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

2022 Policy Recommendations (Abridged)

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

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

2022 Policy Recommendations (Abridged)

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

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

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

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

2022 Policy Recommendations (Abridged)

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

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

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

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

Upcoming HPC Research Publications

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

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

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

VOTE

Release 2022 Health Care Cost Trends Report and Policy Recommendations

MOTION

That, pursuant to section 8(g) of chapter 6D of the Massachusetts General Laws, the Commission hereby authorizes the Executive Director to issue the annual report on cost trends as presented.

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

- Mass General Brigham's Performance Improvement Plan (PIP) Proposal (VOTE)
- 2022 Health Care Cost Trends Report

MARKET CHANGES

Care Delivery Transformation

Executive Director's Report

Schedule of Upcoming Meetings

Since 2013, the HPC has reviewed 146 market changes.

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	35	24%
Clinical affiliation	30	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)	21	14%
Change in ownership or merger of corporately affiliated entities	6	4%
Affiliation between a provider and a carrier	1	1%

Elected Not to Proceed

HPC

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

- 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 Medical Center Corporation, the corporate parent of Children's Hospital Boston. This acquisition was subject to review under both the HPC's Material Change Notice and DPH's DoN review processes.
  - Franciscan primarily serves public payer patients, but there is some potential for increased commercial spending if Franciscan's prices increase as a result of the acquisition.
  - If the parties are successful in their stated goals, the transaction may expand access to key pediatric services, including behavioral health.
  - The HPC did not review evidence that the proposed transaction would negatively impact clinical quality.

Elected Not to Proceed

A proposed clinical affiliation between Children's Medical Center Corporation and Tufts Medicine, the corporate parent of Tufts Medical Center. The affiliation would establish a preferred provider arrangement for Tufts pediatric patients in need of services closed by Tufts and a professional services agreement for Children's physicians to staff certain pediatric services at Tufts-affiliated hospitals.

- The clinical affiliation would likely only marginally increase spending and market concentration, as the majority of Tufts patients are expected to shift to Children's following the closure of Tufts Medical Center pediatric beds regardless of the affiliation.
- Children's has traditionally served a lower proportion of publicly insured pediatric patients than Tufts Medical Center. However, Children's has joined the Tufts MassHealth ACO to alleviate insurance barriers to care for MassHealth patients and has pledged to work with the few Tufts patients whose insurance networks do not include Children's.
- The HPC did not review evidence that the proposed transaction would negatively impact clinical quality.

Material Change Notices Currently Under Review

RECEIVED SINCE 7/14

- A proposed joint venture between Tufts Medicine and Acadia Healthcare Company, a national behavioral healthcare services provider that operates two behavioral health hospitals and a number of substance use disorder treatment centers across Massachusetts, to construct, own, and operate a new psychiatric hospital in Malden, Massachusetts.

- A proposed transaction between Steward Health Care System (Steward) and CareMax, a national for-profit healthcare services provider that operates clinics focused on serving Medicare Advantage patients. Under the proposed transaction, CareMax would acquire the Medicare value-based care business of Steward and act as a management services organization for Steward's national Medicare network.

- The proposed merger between the private equity-affiliated corporate parent of Monte Nido, a national provider of eating disorder treatment programs that operates several facilities in Massachusetts, including Walden Behavioral Care (acquired in 2021), and affiliates of Revelstoke Capital Partners, a health care private equity firm.

- The proposed acquisition of Exeter Health Resources (Exeter) by Beth Israel Lahey Health. Exeter serves the Seacoast Region of southern New Hampshire and Maine and includes Exeter Hospital, a 100-bed acute care community hospital in Exeter, NH, as well as a multi-specialty physician practice and a visiting nurse association and hospice.

Other Proposed Market Changes of Interest

- A Determination of Need application by The Children's Medical Center Corporation for a capital expenditure to create or expand ambulatory sites in Waltham, Needham, and Weymouth.
- A Determination of Need application by UMass Memorial Medical Center for a capital expenditure that would expand the hospital, including the addition of 91 beds across its University and Memorial campuses.
- A Determination of Need application by Boston Medical Center for a capital expenditure that would renovate and expand the hospital, including the addition of 70 beds.

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

CARE DELIVERY TRANSFORMATION

- Accountable Care Organization (ACO) Learning, Equity, and Patient-Centeredness (LEAP) 2022 Certification Process: Results and Reflections

Executive Director's Report

Schedule of Upcoming Meetings

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

Care Delivery Transformation

ACCOUNTABLE CARE ORGANIZATION (ACO) LEARNING, EQUITY, AND PATIENT-CENTEREDNESS (LEAP) 2022 CERTIFICATION PROCESS: RESULTS AND REFLECTIONS

Executive Director's Report

Schedule of Upcoming Meetings

Key ACO Certification Observations

LEAP 2022-2023 marked the HPC's third ACO Certification cycle

1. There appears to be a trend toward greater integration of ACO clinical operations and strategy over time, particularly among complex, multi-faceted ACOs.
2. APM adoption continues to sit at a plateau, though most ACO risk contracts include downside risk.
3. ACOs are taking a "learning" approach to health care transformation, supporting data collection and analytics, encouraging evidence-based care, and identifying discrete metrics and improvement targets.
4. COVID has impacted ACOs, causing some setbacks – but also spurring adoption of new technology, refinement of new care modalities, and development of new analytic and decision-making tools.
5. ACOs are exploring ways to improve health equity, but opportunities remain to further embed equity in ACOs' performance strategies.

Certified ACO Risk Contracts Over Time

	2017	2021
Total # of risk contracts	90	93
Total # of PPO risk contracts	7	10
Total # of covered lives under risk contracts	2.76M	2.78M

	2017	2021
% covered lives in contracts with downside risk	72%	94%
% covered lives in commercial risk contracts	52%	52%
% covered lives in contracts with any capitation	N/A	6%

Note: All figures are for the 14 ACOs certified by the HPC in 2017 and in 2021. Two additional ACOs certified in 2020 and holding only MassHealth risk contracts are not included here.

Self-Reported ACO Total Medical Expense Strategies

Most Successful Strategies for Controlling TME

Strategy	Number of ACOs
Complex care management programs	13
Reductions in avoidable IP, IC	9
Primary care or BH investment	8
High-value referrals	4
Other	4
Keeping secondary care in the community	3
Reductions in low-value care	2

"Other" strategies include interventions aimed at pharmacy TCOC, health-related social needs, and end-of-life care.

Self-Reported ACO Total Medical Expense Challenges

Top Challenges to Controlling TME Growth

Challenge	Number of ACOs
Price growth for drugs, medical supplies, etc.	12
Incentives for clinicians	7
Prices of providers outside the ACO	5
Other	4
Administrative complexity	4
Patient preference for costly providers	4
Lack of real-time data	4
Open network insurance products	2
Inability to identify low-value care	0

"Other" challenges include the social determinants of health, lack of payer investments in primary care, and available behavioral health capacity.

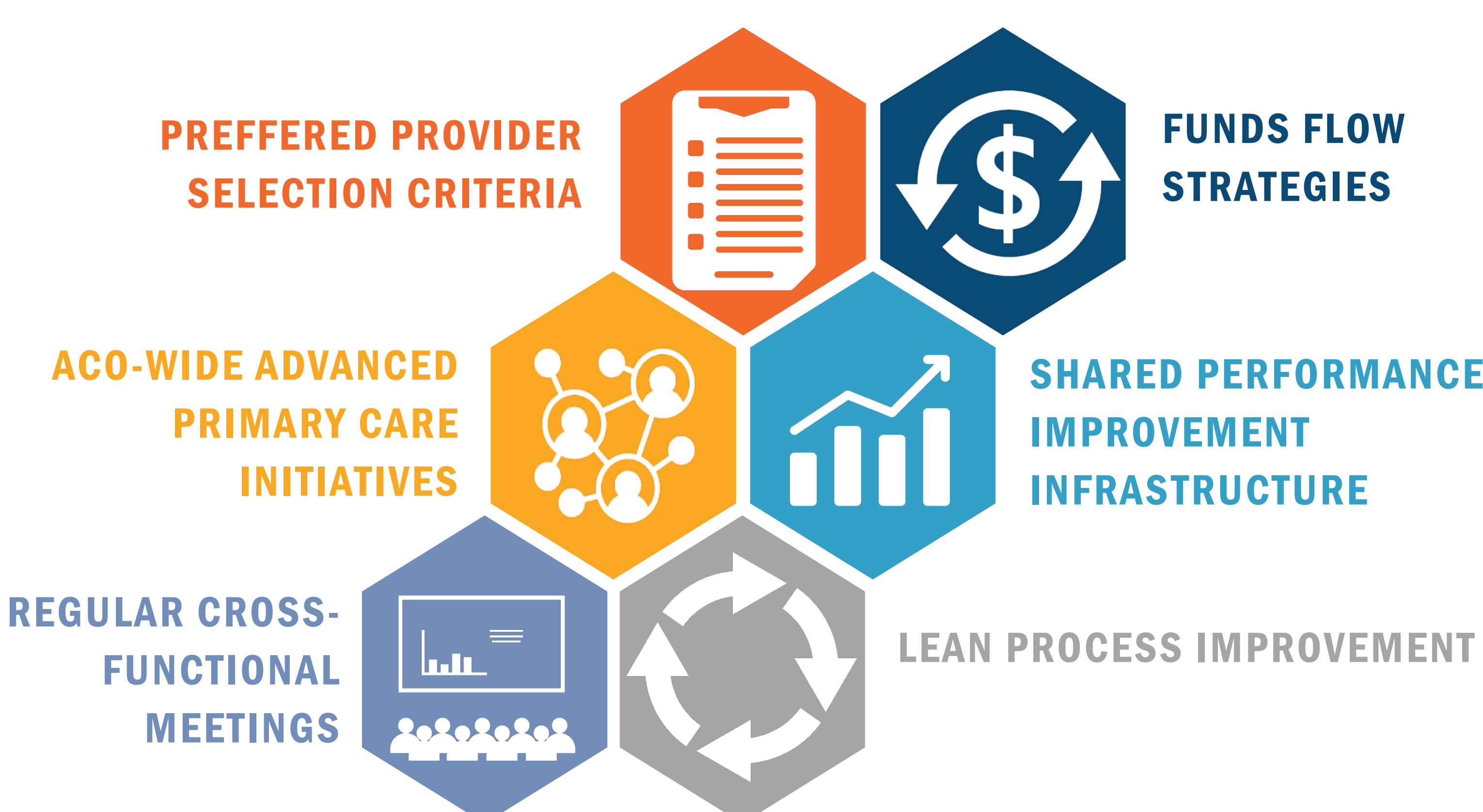
Building a Culture of Performance Improvement

HIGHLIGHTS

To build a culture of improvement, many ACOs rely on regular, cross-functional meetings dedicated to identifying opportunities to improve performance on cost and quality metrics.

ACOs with complex internal organizational structures have increasingly consolidated clinical programming and ACO functions.

FOCUSING IN: KEY STRATEGIES



Implementing Population Health Management Programs

HIGHLIGHTS

64 unique population health management programs were described by the Certified ACOs.

Many recent programmatic changes to PHM programs have involved staffing changes to expand programmatic scope, improve performance, or rebound from COVID-era staffing fluctuations.

FOCUSING IN: PHM EXAMPLES

ACO Example #1

- ✓ Predictive analytics identify patients for referral to PHM
- ✓ Chronic care management program assigns RNs and social workers; aims to reduce admissions and ED utilization
- ✓ Behavioral health clinicians provide utilization management, clinical consultation, and care coordination
- ✓ Hospital to Home program uses CHWs to support high-risk patients transitioning from acute to home settings

ACO Example #2

- ✓ Pop health platform identifies high- and rising-risk patients
- ✓ Medical care management programs have specific targets for avoidable ED and hospital admissions
- ✓ Transitions and post-discharge programs support next-site-of care decisions, provide care coordination in the community

The certified ACOs collectively identified 43 priorities shaping their BH integration strategies.

Screening-and-referral processes and co-location were common priorities.

Many ACOs view increasing BH capacity as a key precursor to or component of BH integration approach.

FOCUSING IN: KEY STRATEGIES

HIGHLIGHTS

Most ACOs have initially focused HRSN screening and referral activities on their MassHealth populations.

Strategies for acting on positive screens vary, from deployment of dedicated staff (e.g., CHWs or resource navigators) to use of electronic platforms for connecting patients to resources.

FOCUSING IN: HRSN EXAMPLES

ACO Example #3

- ✓ Tableau dashboard provides monthly updates on screenings, filterable by time period, age group, ethnicity, race, and more.
- ✓ Patient resource coordinators assist patients with identified needs
- ✓ Electronic platform allows for searches of social resource databases, referrals to SSOs, importation of screening results into electronic medical records

ACO Example #4

- ✓ HRSN screening tools are made available in seven languages and via multiple modalities (e.g., web portal, iPads on-site)
- ✓ Initial MassHealth implementation expanded in numerous practices on a payer-blind basis, along with expanded CHW staffing to assist patient with an identified need

Collecting Information About Patients' Experiences and Preferences

All ACOs indicated they monitor patients via periodic PES surveys.

Many ACOs contract directly with an external vendor (e.g., Press Ganey) for patient surveys, often delivered via text and/or email.

FOCUSING IN: PE EXAMPLES

ACO Example #5

- ✓ Surveys after every encounter
- ✓ **Practice- and provider-level reports** shared with managers monthly via web portal
- ✓ Results are further shared in **staff meetings** with medical staff, linked to **KPIs**

ACO Example #6

- ✓ PFAC "**feedback loop**"
- ✓ Key **PFAC updates** shared with ACO ops team to align work and address issues
- ✓ Updates **shared back** with PFAC members

ACO Example #7

- ✓ Text and/or email surveys
- ✓ **Data characterized** by theme, positivity
- ✓ **Summaries** prepared by practice site, service region
- ✓ Patient **demographic information** (race, language) collected

ACOs actively use the information they gather on patients' experiences and preferences.

Activities range from developing organization-wide quality plans for addressing PES results to ongoing process improvement work at the practice level.

FOCUSING IN: KEY STRATEGIES

- INFORMING STRATEGIC PLANS
- DESIGNING STAFF TRAININGS
- DEPLOYING PATIENT EXP. COACHES
- GUIDING ACCESS IMPROVEMENTS
- USING PROBLEM SOLVING SHEETS
- TARGETING TEXT OUTREACH CAMPAIGNS

LEARNING • EQUITY
HEALTH POLICY COMMISSION
ACO
CERTIFIED
2022–23
PATIENT-CENTEREDNESS

ACO Investments in Telehealth

NUMBER OF ACOS PROVIDING VARIOUS SUPPORTS FOR TELEHEALTH

Support	Number of ACOs
Interpreter services	14
Common technology platform for providers	13
Technical assistance for providers	12
Dedicated support staff	9
Patient outreach to raise awareness	9
Technology support for patients	9
Coord. w/ 3rd party telehealth providers	6
Fin. support for purchase of a platform	6
Other	2

"Other" supports include hosting monthly calls among providers to share telehealth learnings and best practices, and in-home equipment provided to patients by CHWs.

Providing Best Clinical Knowledge at the Point of Care

HIGHLIGHTS

ACOs were more likely to highlight sharing of decision support tools or evidence-based protocols than structured learning opportunities.

Technology is being used to share guidelines and analytics at the point of care.

Some ACOs have teams dedicated to creating and/or assembling condition-specific evidence-based practices.

FOCUSING IN: KEY STRATEGIES

Structured Learning Opportunities

- Academic Detailing
- Management of Chronic Conditions

Decision Support and Evidence-Based Guidelines

- COVID risk tools
- Internally developed or curated evidence-based guidelines
- Clinical vignettes
- Best practice advisories in EMR

Offering Providers Actionable Data

HIGHLIGHTS

ACOs are feeding performance data back to providers and/or practices, often through sophisticated dashboards or reporting tools.

Some ACOs share suites of reports at the level of practices or risk units, tracking performance on a range of efficiency, quality, care gaps, and cost indicators.

FOCUSING IN: DATA-SHARING EXAMPLES

ACO Example #8

- ✓ Offers both PCPs and specialists **data visualization tools** that integrate a variety of performance data (e.g., cost, quality, patient experience, utilization)

ACO Example #9

- ✓ Conducts **periodic in-person performance review meetings** with PCPs and offers coaching opportunities

ACO Example #10

- ✓ Distributes **performance reporting dashboards**
- ✓ Analytics help providers target interventions to **close gaps in care** or meet performance metrics
- ✓ Currently incorporating capabilities for **stratifying performance** using factors like race, ethnicity, and language

Self-Reported Activities to Promote Health Equity

AREAS IN WHICH THE ACO REPORTED HAVING TAKEN INTENTIONAL STEPS TO PROMOTE EQUITY

“Other” includes: the launch of internal structures or committees to prioritize health equity interventions; internal initiatives to eliminate the impacts of racism on patients; greater use of interpreter services; and data collection initiatives.

Health Equity Areas of Focus Addressed by ACOs

COVID-19

Racial and ethnic disparities in **rates of COVID vaccination, testing**, and **antibody therapy**, as well as disparities in **childhood vaccinations** and **flu vaccinations**

ACCESS

Disparities between English and non-English speakers in **access to video visits** or to **language concordant communications**, including patient instructions, consent forms and other patient-facing documents and resources

PATIENT OUTCOMES

Racial and ethnic disparities in health outcomes like **asthma complications**, **blood pressure control**, and **pregnancy outcomes**

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

Care Delivery Transformation

- 2022 Health Care Cost Trends Hearing
- 2023 Public Meeting Calendar
- FY23 HPC Operating Budget (VOTE)

Schedule of Upcoming Meetings

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

Care Delivery Transformation

Executive Director's Report

2022 HEALTH CARE COST TRENDS HEARING

- 2023 Public Meeting Calendar
- FY23 HPC Operating Budget (VOTE)

Schedule of Upcoming Meetings

SAVE THE DATE!

IN-PERSON EVENT!

WEDNESDAY, NOVEMBER 2

2022 HEALTH CARE COST TRENDS HEARING

REGISTER ONLINE:
TINYURL.COM/CTH-2022

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

Care Delivery Transformation

Executive Director's Report

- 2022 Health Care Cost Trends Hearing

2023 PUBLIC MEETING CALENDAR

- FY23 HPC Operating Budget (VOTE)

Schedule of Upcoming Meetings

2023 Public Meeting Calendar

– JANUARY –

S	M	T	W	T	F	S
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– FEBRUARY –

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– APRIL –

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– MAY –

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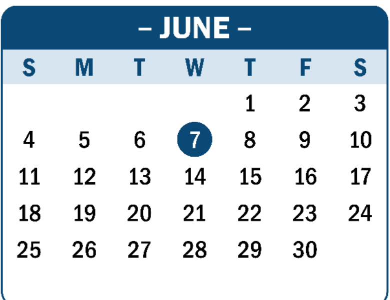

– JUNE –

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– JULY –

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– AUGUST –

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– SEPTEMBER –

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– OCTOBER –

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29	30	31				

– NOVEMBER –

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– DECEMBER –

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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

Wednesday, February 15
Wednesday, May 10
Monday, July 10 (Administration & Finance, 2:00 PM)
Wednesday, October 4

ADVISORY COUNCIL

Wednesday, February 8
Wednesday, May 24
Wednesday, September 20
Wednesday, December 6

COST TRENDS HEARING

Wednesday, November 1

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

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

Care Delivery Transformation

Executive Director's Report

- 2022 Health Care Cost Trends Hearing
- 2023 Public Meeting Calendar

FY23 HPC OPERATING BUDGET (VOTE)

Schedule of Upcoming Meetings

The HPC's 2022-2023 Priorities

Oversight of the Commonwealth's first Performance Improvement Plan.

Analyze the state of telehealth and the health care workforce in Massachusetts and share recommendations with policymakers.

Evaluate the impacts of COVID-19 and consider the future elements required for a robust health care system.

Monitor any new and ongoing health care market mergers and consolidations.

Enable upstream interventions to address social determinants of health and advance health equity.

Review the price and value of any pharmaceutical drugs as referred by MassHealth.

Invest in improvements for maternal and child health and coordinated care for substance-exposed newborns.

FY 2023 Budget

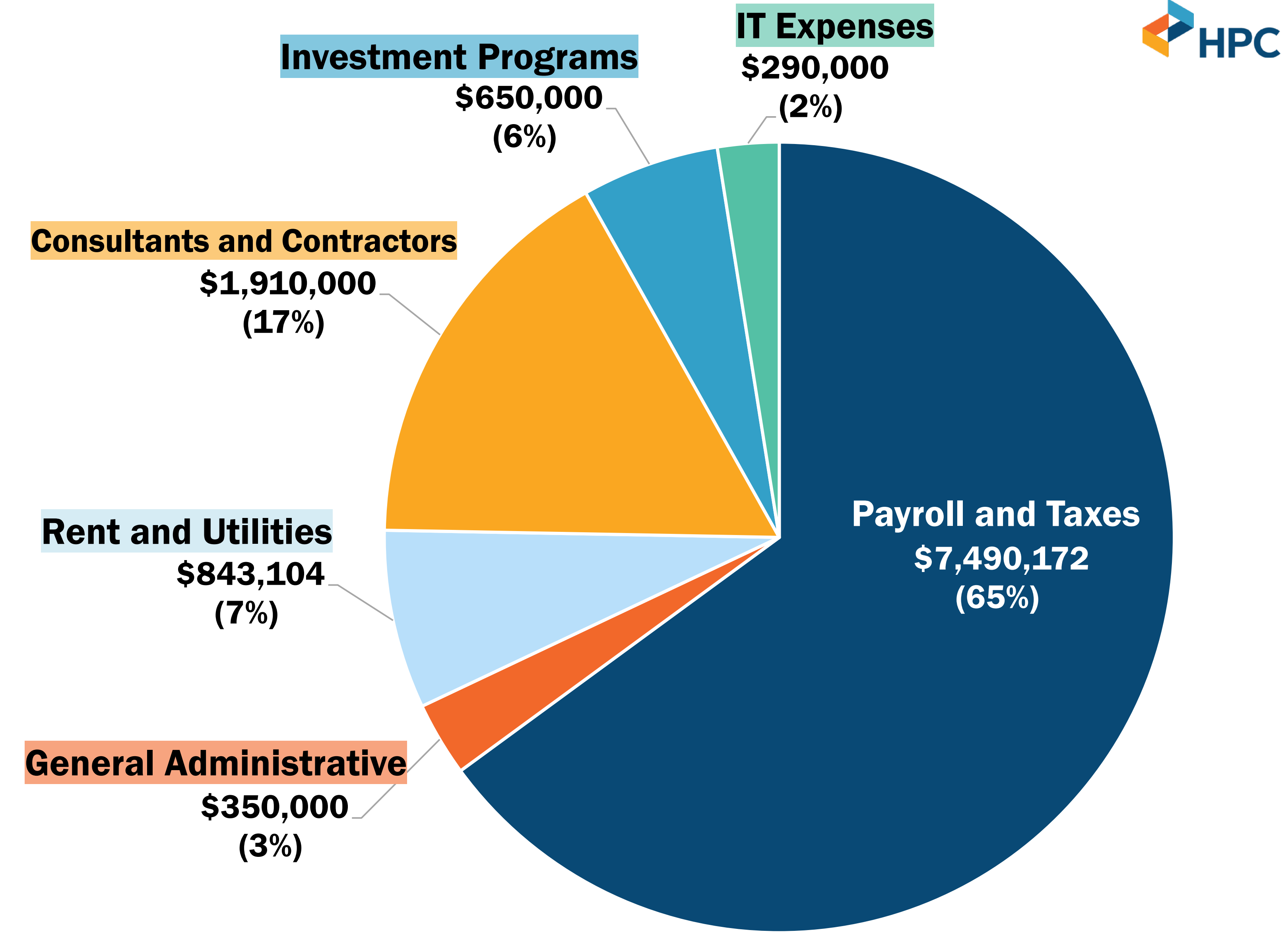
- **Background:** Beginning in 2017, the operating budget for the HPC is set in the annual state budget through an assessed account, 1450-1200. The total amount is split among an assessment on acute care hospitals, ambulatory surgical centers, and health insurance companies. Accordingly, the General Fund is "**held harmless**" for that amount as it is sourced from a dedicated revenue stream.

- **Fiscal Year 2023 Request:** For FY23, the HPC requested funding its account at **$10,883,276** through the state budget process. This **3.5% increase is lower than the increase requested last year and will not impact the General Fund**. This conservative "maintenance of effort" request will support the HPC's performance of its core duties and new responsibilities and projects that have been mandated through recent legislation.

  - This request **did not** include the need for additional resources and staff to administer new responsibilities and programs if pending health care reform legislation (in both the House and Senate) is passed this session.

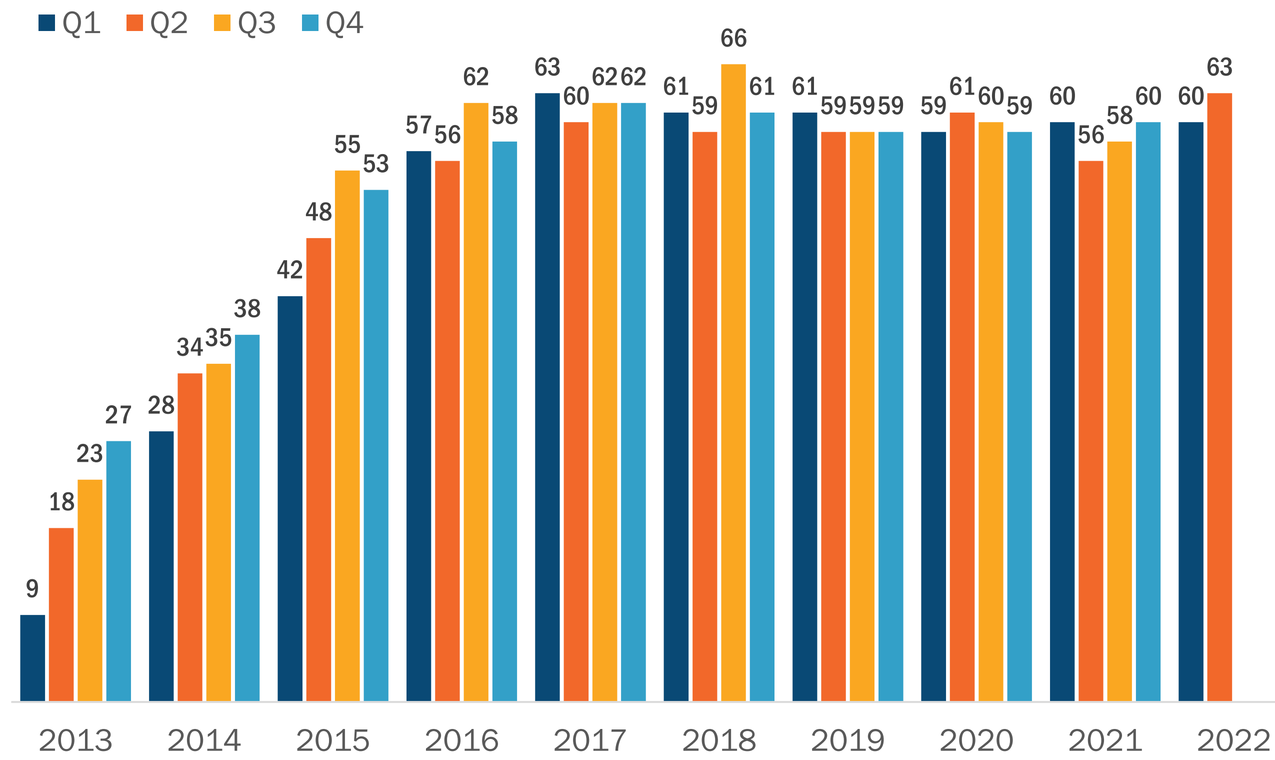
- The HPC also requested a PAC in the amount of **$650,000** to continue the funding for the C4SEN and BESIDE Investment Programs.

HPC FY 2023 Budget by Category



The number of employees has been stable at 60-65 for the past six years; the HPC will grow modestly (3-4 positions) in FY23 to staff new mandates and support agency work.

*HPC Employee Count: 2013-2022**



FTE by Department, July 1, 2022	
Health Care Transformation and Innovation	14.5
Market Oversight and Transparency	14
Research and Cost Trends	12.5
Internal/External Operations + EXEC	14.5
Legal/Office of Patient Protection	8
Total FTE	**63**

*This graph includes a count of both full time and part time paid employees, including temporary contract employees but excluding seasonal fellows. The table below is an adjusted count based on 37.5-hour work week (FTE).

The Fiscal Year 2023 Budget Process

January 2022

The Governor filed his FY 2023 Budget Proposal.
HPC Appropriation: 1450-1200.................... $10,640,204

February 2022

The HPC submitted its FY 2023 Budget Proposal to the Joint Committee on Ways and Means
HPC Appropriation: 1450-1200.................... $10,883,276

April 2022

The House of Representatives filed their FY 2023 Budget Proposal.
HPC Appropriation: 1450-1200.................... $10,883,276

May 2022

The Senate filed their FY 2023 Budget Proposal.
HPC Appropriation: 1450-1200.................... $10,883,276

June 2022

The Governor signed an interim budget, which continues to fund all departments at FY22 levels, while the Conference Committee continues their deliberations.

July 2022

Governor Baker signed the FY 2023 final budget, Chapter 126 of the Acts of 2022, on July 28, 2022.
HPC Appropriation: 1450-1200.................... $10,883,276

Outside Sections in Chapter 126 of the Acts of 2022 direct new work to the HPC.

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

The HPC was also given **new mandates and responsibilities** through Chapter 177 of the Acts of 2022, *An Act Addressing Barriers to Care for Mental Health,* signed in August 2022.

- ***Public Hearing and Cost Trends Report Additions.*** Directs the HPC to include behavioral health expenditures in the annual cost trends report and cost trends hearing.
- ***Standard Release Form.*** Directs the HPC to create a standard release form and regulation for securely exchanging confidential mental health and substance use disorder information for use by public and private entities in compliance with state and federal laws including HIPAA. The law also directs the HPC to ***convene a 14-member advisory group,*** with the Executive Director acting as chair, to inform the HPC's development of the standard release form.
- ***Statutory Changes to Internal and External Grievance Processes.*** Requires OPP to update its regulation to implement several changes in the insurance consumer protection law, chapter 176O.
- ***Behavioral Health Managers Report.*** Directs the HPC to work with DOI to study the effects of behavioral health managers on the quality and accessibility of behavioral health services, oversight practices in other states, and any other topics deemed relevant to the report.
- ***Pediatric Behavioral Health Planning Report.*** Directs the HPC to consult with DMH and DDS to develop a new report to analyze the status of pediatric behavioral health planning in the Commonwealth. The first report is due 18 months after the effective date, and future reports are recurring every three years.
- ***Special Commission for Medically Necessary Determinations in Behavioral Health.*** Creates a new commission led by the Commissioner of Mental Health to create a common set of criteria for providers and payers to use in making medical necessity determinations for behavioral health treatment. The HPC is a member of the commission.

VOTE

FY 2023 HPC Operating Budget

MOTION

That the Commission hereby accepts and approves the Commission's total operating budget for fiscal year 2023, as recommended by the Commission's Administration and Finance Committee and as presented and attached hereto and authorizes the Executive Director to expend these budgeted funds.

Agenda

Call to Order

Approval of Minutes (VOTE)

Executive Session (VOTE)

Market Oversight and Transparency

Care Delivery Transformation

Executive Director’s Report

Schedule of Upcoming Meetings

BOARD

December 14

COMMITTEE

October 12

ADVISORY COUNCIL

October 6

December 7

SPECIAL EVENTS

November 2
Cost Trends Hearing

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tinyurl.com/hpc-linkedin