Call to Order

Appointment of Vice Chair (VOTE)

Approval of Minutes from July 24, 2019 Meeting (VOTE)

Market Oversight and Transparency

Publications

Cost Trends Hearing Preview

FY 2020 Budget Approval (VOTE)

Schedule of Next Meeting (December 16, 2019)
AGENDA

- Call to Order
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VOTE: Appointment of Vice Chair

MOTION: That, pursuant to Section 2.3 of the By-Laws, the Commission hereby appoints ______________ to serve as Vice Chairperson of the Health Policy Commission.
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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on July 24, 2019 as presented.
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▪ Call to Order
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▪ Market Oversight and Transparency
  – Material Change Notices
  – Preview of Market Retrospective Study and Hospital Inpatient Coding Analysis
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### Types of Market Transactions Reported to the HPC Since 2013

<table>
<thead>
<tr>
<th>TYPE OF TRANSACTION</th>
<th>NUMBER</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician group merger, acquisition, or network affiliation</td>
<td>23</td>
<td>22%</td>
</tr>
<tr>
<td>Clinical affiliation</td>
<td>23</td>
<td>22%</td>
</tr>
<tr>
<td>Acute hospital merger, acquisition, or network affiliation</td>
<td>22</td>
<td>21%</td>
</tr>
<tr>
<td>Formation of a contracting entity</td>
<td>19</td>
<td>18%</td>
</tr>
<tr>
<td>Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)</td>
<td>12</td>
<td>11%</td>
</tr>
<tr>
<td>Change in ownership or merger of corporately affiliated entities</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Affiliation between a provider and a carrier</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>
Proposed partnership between Baystate Health System (Baystate) and AmSurg Holdings (AmSurg) under which the parties would acquire AmSurg’s current 62% ownership interest in Pioneer Valley Surgicenter (PVS), an ambulatory surgery center located in Springfield.

Proposed acquisition of Exeter Health Resources (EHR) by Partners HealthCare System (Partners). EHR serves the Seacoast Region of southern New Hampshire and Maine and includes an acute care hospital, Exeter Hospital, a multi-specialty physician practice, Core Physicians, and a visiting nurse association and hospice.
Transactions for which the HPC Elected Not to Proceed to a Cost and Market Impact Review

Proposed contracting affiliation between Sturdy Memorial Associates (SMA) and South Shore Physician Hospital Organization (SSPHO) under which SMA providers would participate in risk contracts negotiated through SSPHO, and SSPHO would provide medical management support services for SMA providers.

- Our analysis suggested limited scope for increases in health care spending. While SSPHO is somewhat higher-priced than SMA, total medical spending for SSPHO’s patients is generally lower than spending for SMA’s patients.
- We did not review evidence suggesting negative impacts on quality or access to care.
Proposed clinical affiliation between Partners HealthCare System (Partners) and Boston Children’s Hospital (Children’s) under which Brigham & Women’s physicians would provide maternity care at a new integrated Maternal Fetal Care Center housed on Children’s campus.

- Our analysis suggested limited scope for increases in health care spending, and we found some potential for enhanced coordination of services and information-sharing between Children’s and Brigham & Women’s specialists.

- We did not review evidence indicating that the transaction is likely to negatively impact access to care.
Call to Order

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The HPC will publish a retrospective examination of provider market dynamics in early 2020.

The HPC has monitored the provider market through its authority to analyze material changes through ongoing research and standalone publications like the Community Hospitals at a Crossroads.

HPC expects to publish some of the findings from its ongoing monitoring, including:

✓ Analyses of the impacts of select past transactions, and

✓ Analyses of overall market trends for the past five years, including updated analyses from the Community Hospitals at a Crossroads report

This is a preview of initial findings; we expect to release full findings in early 2020.
The HPC’s 2016 *Community Hospitals at a Crossroads* report identified challenges for community hospital sustainability and a need for action.
Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist.
Hospitals continue to consolidate, and care is increasingly concentrated in the largest health systems.

- The share of volume in the top five systems increased 18 percentage points from 2010 to 2017 (accounting for current affiliations). The share of volume in independent community hospitals declined 16 percentage points.

**Shares of Inpatient Discharges and Outpatient Discharge Equivalents in Top 5 Systems and Independent Hospitals (2010-2017, All-Payer)**

- **BILH**
- **Partners**
- **BID**
- **Steward**
- **Lahey**
- **Wellforce**
- **UMass**
- **Baystate**
- **Independence**
- **Independent Non-Comm.**

<table>
<thead>
<tr>
<th>Year</th>
<th>BILH</th>
<th>Partners</th>
<th>BID</th>
<th>Steward</th>
<th>Lahey</th>
<th>Wellforce</th>
<th>UMass</th>
<th>Baystate</th>
<th>Independence Non-Comm.</th>
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<tr>
<td>2010</td>
<td>45%</td>
<td>5%</td>
<td>7%</td>
<td>5%</td>
<td>11%</td>
<td>10%</td>
<td>5%</td>
<td>5%</td>
<td>21%</td>
</tr>
<tr>
<td>2011</td>
<td>44%</td>
<td>4%</td>
<td>7%</td>
<td>6%</td>
<td>10%</td>
<td>9%</td>
<td>5%</td>
<td>5%</td>
<td>21%</td>
</tr>
<tr>
<td>2012</td>
<td>48%</td>
<td>5%</td>
<td>7%</td>
<td>7%</td>
<td>10%</td>
<td>10%</td>
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<tr>
<td>2013</td>
<td>49%</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
<td>11%</td>
<td>11%</td>
<td>5%</td>
<td>5%</td>
<td>21%</td>
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<tr>
<td>2014</td>
<td>51%</td>
<td>7%</td>
<td>6%</td>
<td>9%</td>
<td>11%</td>
<td>12%</td>
<td>5%</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>2015</td>
<td>55%</td>
<td>6%</td>
<td>8%</td>
<td>11%</td>
<td>12%</td>
<td>12%</td>
<td>5%</td>
<td>5%</td>
<td>20%</td>
</tr>
<tr>
<td>2016</td>
<td>55%</td>
<td>6%</td>
<td>8%</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td>5%</td>
<td>5%</td>
<td>18%</td>
</tr>
</tbody>
</table>
| 2017  | 54%  | 6%       | 9%  | 9%      | 19%   | 22%       | 5%  | 5%       | 17%                    | 2017 with Current Affiliations

- **63%**
Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist.

Many patients continue to bypass community hospitals for routine care.
Patients continue to bypass community hospitals for community-appropriate care, despite provider efforts to keep care local.

- A community hospital was the closest option for 80% of commercial patients who received scheduled, community-appropriate care.

- From 2010 to 2017, approximately half of patients whose closest hospital was a community hospital traveled to a non-community hospital for scheduled, non-maternity, community-appropriate care.

**Site of Care for Adult Patients Receiving Scheduled, Non-Maternity Community-Appropriate Services Whose Closest Hospital is a Community Hospital (2010 – 2017, Commercial)**

- Share Used Closest Community Hospital
- Share Used Community Hospital Within 5 Min. of Closest
- Share Used Other Community Hospital
- Share Used Non-Community Hospital

Notes: Community-appropriate discharges represent a narrow set of inpatient services that could likely be performed effectively in any hospital setting.
Community hospitals’ share of community-appropriate discharges has not increased over time.

Notes: Community-appropriate discharges represent a narrow set of inpatient services that could likely be performed effectively in any hospital setting.
Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist.
Commercial inpatient volume at community hospitals decreased 24% from 2010 to 2017.

- Community hospitals have seen their proportion of public payer volume grow faster than the proportion of public payer volume at teaching hospitals and AMCs.
- Consistent with market-wide trends, community hospital volume has shifted toward outpatient services over time.
Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist.

Commercial prices continue to vary significantly and many community hospitals have lower commercial relative prices.
Lower priced hospitals (many of which are community hospitals) have generally remained lower priced over time.

- While some community hospitals have moderate to high prices, **median community hospital prices remain lower than other hospital prices**.

- For the three largest commercial payers, seven to nine of the ten lowest-priced community hospitals in 2010 remained in the bottom ten in 2017 and the average relative price for the ten lowest-priced community hospitals has not increased substantially over time.

**BCBS Relative Prices Over Time for Highest-Priced and Lowest-Priced Hospitals in 2010**
Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist.

Many community hospitals, particularly those serving high proportions of public payer patients, have seen relatively slow growth in volume and revenue.
Community hospitals have seen slower growth in revenue over time than other hospitals.

• Community hospitals have a **broad range of financial performance**. The cohort analyzed includes some financially strong and some relatively weak hospitals, including several that closed or merged their licenses with other hospitals due in part to financial pressure.

• As a group, community hospitals achieved financial margins similar to **statewide averages** from 2012 to 2017.

• However, community hospitals, especially community high public payer (HPP) hospitals, experienced **slower growth in volume and patient service revenue than other hospitals**.

• Slower revenue growth may **threaten the long-term ability of community hospitals to invest in care transformation**, which in turn may further drive trends toward consolidation.
Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist. Providers may be responding to some of these pressures through a heightened focus on coding.
There has been an increase in high-acuity discharges and a corresponding decrease in community-appropriate discharges over time.

- Among Massachusetts hospitals, there are shifts toward higher-acuity codes and away from discharges coded as community-appropriate care.

- The proportion of higher-acuity discharges in the state increased by 6.4 percentage points from 2010 to 2017 (from 56% to 62%). Community hospitals experienced slightly greater increases in their proportion of higher-acuity discharges than teaching hospitals and AMCs in this time.

Share of Community-Appropriate Discharges by Hospital Cohort (2010 and 2017, All-Payer)

Notes: Higher acuity discharges refer to all discharges not defined as community-appropriate, i.e. inpatient services that likely could not be performed effectively in any hospital setting.
The HPC has observed increases in recorded patient acuity in several contexts.

- **Decrease** in community-appropriate discharges (defined as low-acuity hospital discharges)
- **Increase** in patient risk scores
- **Increase** in acuity/complexity of inpatient hospital stays

- What is behind these trends?
- What are the implications?
Since 2013, commercial inpatient spending grew 10.7%, even while volume decreased by 12.8%.

Cumulative change in commercial inpatient hospital volume and commercial inpatient hospital spending, 2013-2018

Hospital spending per discharge grew 5% annually, from $14,400 to $18,300 between 2013-2018

Inpatient spending growth has been driven **both** by increasing prices for a given stay and increasing acuity of inpatient stays.

*Change in average commercial inpatient prices, utilization, acuity, and spending, 2014-2016*

- **Inpatient spending** increased by 7.1%
- **Inpatient price** increased by 5.2%
- **Average acuity** increased by 4.2%
- **Commercial discharges per 1000 members** decreased by 6.6%

General inflation over this period was only 1%.

Notes: Price analysis includes facility portion only, adjusted for changes in acuity and provider mix over time, and excludes claims with invalid payment codes, outlier claims at each hospital, and some maternity claims for which discharge of mother and newborn cannot be distinguished. Commercial TME trend represents facility payments to the three largest commercial payers in MA, acuity trend was calculated for all commercial discharges using Medicare DRG case weights, and discharge trend is per 1000 commercial members for all commercial payers.

Sources: HPC analysis of All-Payer Claims Database, 2016; CHIA hospital discharge data sets for 2014-2016; CHIA Total Medical Expense files.
Statewide commercial risk scores rose 3% per year from 2013-2017 on average, while some health plans experienced even greater increases.

Over this period, the average patient risk score increased 11.3% This is equivalent to an additional 413,000 commercially insured Massachusetts residents having diabetes with complications or 888,000 having cerebral palsy.

Unadjusted spending is growing 3.6 times faster than health-status adjusted TME, due to significant risk score growth.

Notes: United, Cigna, BMC Healthnet, Minuteman, NHP and Celticare excluded due to data anomalies or fluctuating membership.
Sources: CHIA TME databooks, 2016 and 2018.
The HPC also examined changes in patient acuity by analyzing shifts in hospital inpatient stay classifications.

**DRG Grouper** | **Description**
--- | ---
**MS-DRG (Medicare Severity)** | - 754 DRGs
- Each has an assigned weight
- Most DRGs combine a condition with up to three levels of severity:
  - Without complications (W/O CC)
  - With complications/comorbidities (CC)
  - With major complications/comorbidities (MCC)
- Used by Medicare & some commercial (17%, e.g., Fallon)

**APR-DRG (All-Payer Refined)** | - 315 DRGs
- Each DRG has four severity levels (1-lowest)
- Each DRG-severity combination has an assigned weight
- Used by MassHealth & most commercial (72%, e.g., Blue Cross)

**MassHealth Weights & Payments for COPD, 2018**

$\text{DRG payment} = \text{base rate} \times \text{DRG weight}$

Notes: Example to the right shows that Payment for COPD is the product of MassHealth base payment ($12,247) and a corresponding DRG-severity weight.

Source: MA EOHHS Acute Hospital FY19 MassHealthDRG Weights
From 2013-2018, all major hospital systems had increasing patient acuity; for Partners-owned hospitals, the increase was 15%.

Notes: Berkshire hospital system removed due to data anomalies in 2018
Sources: CHIA Hospital Inpatient Discharge Dataset, 2013-2018. Weights calculated based on APR-DRG version 30 in all years
Low-acuity discharges are decreasing, while high-acuity discharges are increasing.

Change in number of hospital admissions at each severity/complications level, 2013-2018

Notes: APR-DRG Level 1 is least severe and Level 4 is most severe. MS DRG portion only includes the subset of DRG’s that have multiple complication levels - single level DRGs are dropped from this analysis.

Source: CHIA HIDD Acute Case-mix Database, 2013-201; MS-DRG classification system, APR-DRG classification system
Evidence Points to Rising Acuity Driven by Changing Coding Practices

An industry has formed around leveraging electronic health record systems (e.g., EPIC) to mine patient clinical history to increase the number and complexity of diagnoses coded to maximize reimbursement.

“Revenue Cycle Management”
“Coding/Case-Mix Improvement”

08/14/19 Massachusetts hospital job posting for “Clinical Documentation Improvement Specialist, RN” to “…identify…diagnoses including conditions qualifying as…major complications that impact severity of illness and quality measures” and other “…areas of opportunity”. Typical salary >$100k.

Anecdotes from Industry Participants

“…It’s far easier to increase margin by increasing coding than by reducing costs.”

“…The ROI from hiring more billers and coders shows no signs of diminishing.”

[From newly hired CEO of a large health system] “…Though I’d love to work on care delivery reforms and population health, my initial focus has to be entirely on coding maximization.”

Hospitals benefit financially when patients are coded as higher-acuity.

Medicaid hospital payment for a patient with COPD for each severity level (2017) and percent of COPD discharges (all payer) at each severity level

Notes: Payment levels reflect APR-DRG system used by MassHealth and most commercial payers in Massachusetts.
Among COPD patients, DRG weights increased by 20% from 2013 to 2017, while other indicators of clinical severity did not increase.

Percent increase in APR-DRG weights for COPD patients compared to LOS & ICU/CCU days, 2013-2018

Overall, DRG weights grew more than 10% between 2013 and 2018, while other indicators of clinical severity did not increase.

Percent increase in MS-DRG & APR-DRG weights compared to LOS & ICU/CCU days, 2013-2018

Notes: ICU/CCU: intensive care unit/cardiac care unit
Source: CHIA HIDD Acute Case-mix Database, 2013-2018; MS-DRG classification system, APR-DRG classification system
Private Insurers Can Have Mixed Incentives With Regard to Changes in Patient Acuity

Increasing patient acuity can lead to both:

**Losses**
- Losses for risk contracts that are tied to population risk level.
  - However, some payers have mechanisms in place to offset acuity increases or may take these into account during the next contract negotiation cycle.
- Losses from higher payments (e.g., DRGs) that are directly tied to patient acuity.

**Gains**
- Gains from ACA risk-adjustment transfers for Connector enrollees.
- Gains for Medicare Advantage members.
- Lower chance of being referred to the HPC for a potential performance improvement plan.
Increased coding intensity has significant implications for health care spending, market functioning, and care delivery.

**Added costs** for patients and payers.
- Due to increases in inpatient acuity between 2013 and 2017, Massachusetts incurred \(\sim \$280\) million more in inpatient Medicare costs and up to \(\$300\) million more in inpatient commercial costs in 2017 alone.
- Even if payers are able to offset some of the increased spending from coding intensity, it requires additional time and resources from payers and auditors.

**Increasing disparities in financial well-being** between hospitals that can invest in more complex EHR systems and coding staff vs. hospitals less able to do so.

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

**Mixed effects on patient care and outcomes.**
- Some patient care may be improved with additional documentation, but care may also be worsened:
  - Clinician time and effort may be redirected away from clinical care and toward coding. This added administrative burden also can increase clinician burnout.
  - Important clinical information may be masked by additional or no-longer-relevant diagnoses added to records, merely for billing purposes.
  - Time and attention from hospital leadership and administrators is spent on coding and billing that could otherwise be spent improving patient care and quality.

Commercial spending impacts are more ambiguous than our Medicare calculation for two main reasons: these spending impacts depend on (1) which version of the software is used to group inpatient stays into DRGs and (2) individual contract arrangements between private insurers and a given provider system. Updated versions of the grouper software, in recent years, have tended to reduce the payment (weight) and frequency of assignment to higher-severity DRGs. Commercial cost impacts could also be lower if payer contracts require pricing or other adjustments that offset acuity increases. The dollar figure indicated here is calculated as if payers used the same software version and weights throughout 2013 to 2017. For example, BCBS of MA used the same version (version 26) of APR-DRGs from 2009 to 2017 according to the Center for Health Information and Analysis but updated to version 34 in July of 2018.
Next Steps

Market Retrospective Study

✓ Continue to refine and expand current analyses.

✓ Add additional years of data as it becomes available (e.g., 2017 APCD, 2018 case-mix discharges).

Hospital Inpatient Coding Analysis

✓ Separate inpatient trends by payer (Commercial, Medicare, MassHealth).

✓ Track shifting from lower to higher paying DRGs.

✓ Examine impacts of using different versions of the APR-DRG grouper.

✓ Describe increases in acuity in some ambulatory settings (ED, E&M).
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- DataPoints Issue #14: Out-of-Network (OON) Billing Benchmarks
- CHART Program Impact Brief
- Preliminary Results of Prescription Drug Coupon Study

- Cost Trends Hearing Preview
- FY 2020 Budget Approval (VOTE)

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Out-of-network (OON) or “surprise” billing remains a priority policy issue for the HPC.

The HPC has consistently recommended comprehensive state action to enhance OON billing protections for Massachusetts consumers, including the establishment of a process for fair and reasonable reimbursement to providers.

Around the U.S., efforts to address OON billing generally reflect an emerging consensus on protecting the patient, but determining provider reimbursement is a significant challenge.

In state and federal legislative solutions, payment benchmarks can be used in both primary approaches to determining provider payment: (1) setting a default reimbursement rate; and (2) establishing a dispute resolution process.

Building on HPC’s prior OON billing work, DataPoints Issue #14 illustrates the range of payments associated with various benchmarks for several services often involved in surprise billing scenarios.
Payment benchmarks are typically based on charges (i.e., list prices), negotiated “allowed amounts” for in-network providers, and/or Medicare rates; the HPC analyzed six potential payment benchmarks often used in other states or legislative proposals.

The specific procedure codes were chosen because they are more likely than others to occur in surprise billing scenarios; “ERAP” providers\(^1\) are common in such scenarios.

The HPC worked with FAIR Health, Inc., a national, independent, non-profit organization whose mission is to increase transparency around health care costs and health insurance information, to obtain the Massachusetts claims data for DataPoints Issue #14.

The analysis highlights how provider payments would vary under different potential OON payment benchmarks.

Overall, there is significant variation among the different benchmarks, with those based on charges typically two to three times higher than those based on allowed amounts or Medicare rates.

In considering policy solutions to address OON billing, it is important to consider the impact of different potential payment benchmarks (e.g., on overall health care spending).

\(^1\)Emergency, radiology, anesthesiology, and pathology providers.
The HPC found significant variation among different payment benchmarks, with those based on charges typically 2-3x higher than the median allowed amount.

Varying payment benchmarks for emergency department visits with high severity and threatening function (CPT code 99285), Massachusetts, 2018-2019

- Payment at the 80th percentile of charges ($842) would be **3.5 times higher** than the median allowed amount ($241).
- A benchmark set at 125% of the Medicare rate ($233) would result in payment just below the median allowed amount ($241).

Varying payment benchmarks for anesthesia for lower intestinal endoscopic procedures (CPT code 00812), Massachusetts, 2018-2019

- Payment at the 80th percentile of charges ($1,271) would be approximately **2.5 times higher** than the median allowed amount ($482).
- In this case, the median allowed amount is nearly three times higher than the Medicare rate (and the 80th percentile of charges is over 7.5 times higher than Medicare).

Sources: HPC, DataPoints Issue #14. Data © 2019, FAIR Health, Inc. Used by permission. Research for DataPoints Issue #14 is based upon healthcare claims data compiled and maintained by FAIR Health, Inc. The Massachusetts Health Policy Commission is solely responsible for the research and conclusions reflected in the DataPoints issue. FAIR Health, Inc. is not responsible for the conduct of the research or for any of the opinions expressed in the DataPoints issue.
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Through the CHART Program, the HPC invested $70 million across 30 community hospitals between 2014 and 2018. The CHART Program Impact Brief provides an overview of the program and highlights community hospital achievements in reducing acute care utilization and establishing a foundation for sustainable care delivery transformation.

“The CHART program has produced a change in how care is approached by introducing a holistic, person-centered approach... They address the patient’s most pressing needs... Local organizations are now better connected.”

- CHART Hospital Staff
The Power of Multidisciplinary Care Teams in the CHART Program

Total Program Funding Allocation

- Personnel
- Indirect Costs
- Phase 1: Capacity-Building Activities
- Strategic Planning
- Enabling Technology
- Capital Investments
- Community Partners
- Implementation Planning
- Program Costs (e.g., Consultants, Equipment, Training, Travel)

Note: Percentages include in-kind contributions.

CHART Staff Types

- Behavioral Health Staff (e.g., Social Worker, Therapist, Counselor, Peer Support Coach)
- Nurse Practitioner/Nurse/Case Manager
- Community Health Worker/Patient Navigator
- Investment Director/Leadership Finance
- Data/IT Analyst
- Pharmacist/Technician
- Program Manager
- Administrative
- Physician/Psychiatrist/Advisor
- Miscellaneous (e.g., Community Resources Specialist, Music Therapist, Quality Analyst)
CHART Program: Goals and Achievements

GOAL 1:
Deliver Integrated Care Across Medical, Behavioral Health, and Social Needs

- 81% of hospitals instituted new staffing models or processes to integrate behavioral health and medical care.

GOAL 2:
Shift Care From the Hospital to the Community

- ~10,000 fewer ED visits at CHART hospitals than expected over the 24-month program.2

GOAL 3:
Prepare to Succeed in Value-Based Care Models

- 76% of hospitals reported that CHART facilitated broader hospital culture changes that helped prepare them to participate in the new MassHealth ACO program.

GOAL 4:
Use Data and Analytics to Better Serve Patients

- 24 awardees invested in a case management platform to track target population patients, measure services delivered by CHART team members, and generate reports.

---

2 This estimate covers all ED patients, not only those who were served by the CHART program. CHART funding is likely one of many factors contributing to a decline in ED visits at community hospitals.
CHART Program: Impact on Reducing Acute Care Utilization

30-Day ED Revisits: Any BH Diagnosis

30-Day ED Revisits: High Utilizers

Awardees met or made significant improvement toward their target aims, such as reducing hospital readmissions and/or emergency department revisits by at least 20%.
CHART Program: Impact on Patients

One Patient’s Story

Patient with multiple medical conditions had not seen a primary care provider in years.

A social worker and community health worker on the CHART team connected the patient with a primary care provider, a blindness advocate, and transportation to appointments.

Overwhelmed by the waiting room, the patient was referred to a private practice primary care provider within walking distance from his house. The patient loved the new office and the doctor.

The CHART social worker called the patient weekly to check in.

The patient’s diabetes stabilized, and he has not returned to the hospital.

“[My care team] helped me with medical information and resources... They worked with me and my nutritionist on my eating plan; they set me up with a great therapist; and maybe most importantly, they supported me, always checked in on me, held me accountable, but did not judge me when I slipped up.”

- CHART Patient

22 awardees worked to address CHART patients’ health-related social needs.
# CHART Program Close-Out Upcoming Outputs

## CHART Playbook
A practical guide that includes resources used by CHART awardees as well as key lessons, including:
- Patient identification
- Patient engagement
- Patient collaboration
- Team staffing and management
- Measurement

## CHART Profiles
A compilation of CHART awardee profiles including information on:
- Funding
- Focus areas
- Target populations
- Care models
- Data highlights
- Transformation achievements
- Provider quotes
- Patient stories

## CHART Phase 2 Evaluation
A comprehensive analysis of the CHART program, including:
- Design and implementation
- Impact on acute care utilization, operational use of data, provision of integrated whole-person care and development of community partnerships
- Patient perspective study
- Sustainable organizational change
AGENDA

- Call to Order
- Appointment of Vice Chair (VOTE)
- Approval of Minutes from July 24, 2019 Meeting (VOTE)
- Market Oversight and Transparency
- Publications
  - DataPoints Issue #14: Out-of-Network (OON) Billing Benchmarks
  - CHART Program Impact Brief
  - Preliminary Results of Prescription Drug Coupon Study
- Cost Trends Hearing Preview
- FY 2020 Budget Approval (VOTE)
- Schedule of Next Meeting (December 16, 2019)
Background: Authorization of Drug Coupons in the Commonwealth

**Legislative History**

- **Chapter 139 of the Acts of 2012** authorizes drug manufacturers to provide consumers with drug coupons and vouchers.
  - Continues ban on drug coupons for AB rated generic equivalents.
  - Sunsets the authorization of drug coupons (January 2015).

- In 2014 and 2016, the Legislature delayed the sunset on drug coupon authorization.

- **Chapter 363 of the Acts of 2018** delays the sunsets until January 1, 2020, and directs the HPC to conduct a study on the matter by June 1, 2019.
Chapter 363 of the 2018 Session Laws, *An Act Extending the Authorization for the Use of Certain Discount Vouchers for Prescription Drugs*, was signed into law on January 2, 2019. It charges the HPC with conducting an analysis and issuing a report evaluating the effect of drug coupons and product vouchers for prescription drugs on pharmaceutical spending and health care costs in Massachusetts.

1. **Analyze the total number and value of coupons** redeemed in the Commonwealth, and the **types of drugs** for which coupons were most frequently redeemed.

2. **Compare any change in utilization of generic versus brand name prescription drugs** and any change in utilization among **therapeutically-equivalent brand name drugs**.

3. **Analyze effects on patient adherence and access to innovative therapies**.

4. **Study the availability of coupons** or discounts upon renewals and the **cost impact on consumers** upon expiration of coupons.

5. **Analyze the impact of drug coupons on health care cost containment goals** adopted by the Commonwealth and commercial and GIC health insurance premiums and drug costs.
Defining Drug Coupons for HPC Analysis

- Prescription drug coupons offered by manufacturers **reduce the amount of a patient’s cost-sharing**, as established by the patient’s insurance plan.
  - Common terms: coupon, voucher, copay card
  - Distinct from:
    - Patient assistance programs offered by manufacturers, states, or charities for patients who cannot afford their medication.
    - Cards or offers that reduce prices for patients without insurance.
- Public payers (e.g., Medicare, Medicaid, VA) do not allow the use of coupons.
Flow of Drug Coupons in Patient Out-of-Pocket Spending

Example: patient is responsible for cost-sharing of $610, based on insurance plan

1. Patient downloads coupon
2. Patient gives $300 coupon and $310 cash
3. Pharmacy reports to plan that patient paid $610 (actually paid $310)
4. Plan records $610 in patient out-of-pocket spending

Source: Adapted from Memorial Sloan Kettering Cancer Center: Copay Assistance Programs. Available at: https://comm.ncsl.org/productfiles/119423533/DrugPricing-ChenPowerPoint.pdf
Data Sources Used for HPC Drug Coupon Research

- Academic literature
- Public testimony
- All Payer Claims Database
- Vendor data: Symphony Health

Symphony Health is a national data services vendor. Symphony’s Integrated Dataverse (IDV)® database contains pharmacy transaction data including:

- All commercially available Symphony pharmacy claims across multiple payers in Massachusetts, 2011-2018.
- Plan payments, patient out of pocket payments, coupon use.

- Database has pharmacy claims for 1.1 million unique commercial patients in 2018.
- Based on HPC analysis of CHIA data, an estimated 2.9 million unique commercial members had at least one pharmacy claim.
Chapter 363 of the 2018 Session Laws, *An Act Extending the Authorization for the Use of Certain Discount Vouchers for Prescription Drugs*, was signed into law on January 2, 2019. It charges the HPC with conducting an analysis and issuing a report evaluating the effect of drug coupons and product vouchers for prescription drugs on pharmaceutical spending and health care costs in Massachusetts.

1. Analyze the total number and value of coupons redeemed in the Commonwealth, and the types of drugs for which coupons were most frequently redeemed.

2. Compare any change in utilization of generic versus brand name prescription drugs and any change in utilization among therapeutically-equivalent brand name drugs.

3. Analyze effects on patient adherence and access to innovative therapies.

4. Study the availability of coupons or discounts upon renewals and the cost impact on consumers upon expiration of coupons.

5. Analyze the impact of drug coupons on health care cost containment goals adopted by the Commonwealth and commercial and GIC health insurance premiums and drug costs.
Drug coupon values vary widely, with an average value of $229 and a median value of $55 in 2018.

Among commercial patients who filled a prescription for any drug in 2018:
- 3% of commercial patients used a coupon.

Among patients who used at least one drug coupon in 2018:
- 3.17 claims with coupons per patient per year.
- $229 average coupon value per claim.

Distribution of coupon value in 2018:

<table>
<thead>
<tr>
<th>Coupon Value</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5</td>
<td>1%</td>
</tr>
<tr>
<td>$10</td>
<td>5%</td>
</tr>
<tr>
<td>$30</td>
<td>25%</td>
</tr>
<tr>
<td>$55</td>
<td>50%</td>
</tr>
<tr>
<td>$150</td>
<td>75%</td>
</tr>
<tr>
<td>$807</td>
<td>95%</td>
</tr>
<tr>
<td>$2,999</td>
<td>99%</td>
</tr>
</tbody>
</table>

For drugs where coupons were used, patient out-of-pocket exposure was 21% of total spending; but using coupons, patients only paid 3% of total spending out-of-pocket.

Notes: Analysis restricted to commercial patients and claims with coupons used for branded drugs. Source: Symphony Health IDV® database.
Coupon programs and their uptake have expanded in Massachusetts since 2012, and average coupon values continue to rise.

<table>
<thead>
<tr>
<th>Year</th>
<th>Average Coupon Value per Claim</th>
<th>Percent of Eligible Claims That Use a Coupon</th>
<th>Unique Number of Branded Drugs That Offer Coupons</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>$229</td>
<td>15.1%</td>
<td>701</td>
</tr>
<tr>
<td>2017</td>
<td>$146</td>
<td>13.1%</td>
<td>664</td>
</tr>
<tr>
<td>2016</td>
<td>$121</td>
<td>11.0%</td>
<td>648</td>
</tr>
<tr>
<td>2015</td>
<td>$99</td>
<td>8.5%</td>
<td>564</td>
</tr>
<tr>
<td>2014</td>
<td>$68</td>
<td>8.0%</td>
<td>541</td>
</tr>
<tr>
<td>2013</td>
<td>$61</td>
<td>4.3%</td>
<td>458</td>
</tr>
<tr>
<td>2012</td>
<td>$97</td>
<td>2.1%</td>
<td>278</td>
</tr>
</tbody>
</table>

Notes: Analysis restricted to commercial patients and claims with coupons used for branded drugs.
Source: Symphony Health IDV® database
As patient out-of-pocket exposure continues to rise, coupons have the largest benefit for patients with high out-of-pocket exposure.

Average patient out of pocket exposure per branded drug claim and patient spending net of coupons, 2012 - 2018

Notes: Analysis restricted to commercial patients and claims for branded drugs. Analysis includes claims with and without coupons.
Source: Symphony Health IDV® database
## Top Drugs by Total Volume of Coupons Used in Massachusetts, 2018

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Therapeutic class</th>
<th>Number of claims using a coupon</th>
<th>Percent of claims using a coupon</th>
<th>Average coupon value</th>
<th>Average patient OOP spending after coupon</th>
<th>Average insurer payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRUVADA</td>
<td>Antivirals</td>
<td>6,793</td>
<td>40%</td>
<td>$117</td>
<td>$0</td>
<td>$1,693</td>
</tr>
<tr>
<td>TRULICITY</td>
<td>Diabetes</td>
<td>5,007</td>
<td>26%</td>
<td>$41</td>
<td>$32</td>
<td>$720</td>
</tr>
<tr>
<td>SUBOXONE (FILM)</td>
<td>Miscellaneous preparations</td>
<td>4,546</td>
<td>15%</td>
<td>$43</td>
<td>$12</td>
<td>$275</td>
</tr>
<tr>
<td>HUMIRA PEN</td>
<td>Antiarthritics</td>
<td>4,168</td>
<td>76%</td>
<td>$159</td>
<td>$15</td>
<td>$5,805</td>
</tr>
<tr>
<td>ELIQUIS</td>
<td>Hemostatic modifiers</td>
<td>3,890</td>
<td>18%</td>
<td>$85</td>
<td>$12</td>
<td>$399</td>
</tr>
<tr>
<td>SENSIPAR</td>
<td>Calcimimetic agents</td>
<td>3,845</td>
<td>87%</td>
<td>$251</td>
<td>$5</td>
<td>$1,311</td>
</tr>
<tr>
<td>VYVANSE</td>
<td>Psychotherapeutic drugs</td>
<td>3,018</td>
<td>9%</td>
<td>$39</td>
<td>$37</td>
<td>$211</td>
</tr>
<tr>
<td>SYMBICORT</td>
<td>Respiratory</td>
<td>2,468</td>
<td>12%</td>
<td>$73</td>
<td>$4</td>
<td>$261</td>
</tr>
<tr>
<td>XARELTO</td>
<td>Hemostatic modifiers</td>
<td>2,308</td>
<td>15%</td>
<td>$74</td>
<td>$14</td>
<td>$401</td>
</tr>
<tr>
<td>LANTUS SOLOSTAR</td>
<td>Diabetes</td>
<td>1,971</td>
<td>8%</td>
<td>$123</td>
<td>$0</td>
<td>$411</td>
</tr>
</tbody>
</table>

### Top therapeutic categories of coupon use by volume

- **Diabetes therapy, including insulin**: 20%
- **Antivirals**: 11%
- **Antiarthritics**: 7%
- **Respiratory therapy**: 7%
- **Hemostatic modifiers**: 7%
- **Psychotherapeutic drugs**: 6%
- **Miscellaneous preparations**: 6%
- **Dermatologicals**: 6%
- **Calcimimetic agents**: 3%
- **Ophthalmic preparations**: 3%

Notes: Analysis restricted to commercial patients and claims with coupons used for branded drugs. Table only includes branded drugs with at least 11 claims that used a coupon. Spending values are based on claims for which the insurer is the primary payer. Number of claims include all claims for which a coupon was used. Source: Symphony Health IDV® database
Summary and Next Steps

- **Coupon values vary widely**: the average coupon value was $229 in 2018, but for the majority of people who used a coupon, the value was smaller.

- Coupon programs and their uptake have expanded in Massachusetts since 2012.

- Diabetes therapy and antivirals are the top therapeutic categories of coupon use, with a combined 31% of coupon volume.

- For patients with high out-of-pocket exposure, coupons reduced average out-of-pocket spending by 44% per branded drug claim.

**Additional analysis:**
- Impact of coupons on total spending
- Impact of coupons on adherence

**Next presentation:**
- MOAT Committee meeting (Wednesday, October 2, 2019, at 9:30 AM)
AGENDA

- Call to Order
- Appointment of Vice Chair (VOTE)
- Approval of Minutes from July 24, 2019 Meeting (VOTE)
- Market Oversight and Transparency
- Publications

- Cost Trends Hearing Preview

- FY 2020 Budget Approval (VOTE)
- Schedule of Next Meeting (December 16, 2019)
SAVE THE DATE
2019 HEALTH CARE COST TRENDS HEARING
TUESDAY, OCTOBER 22 AND WEDNESDAY, OCTOBER 23
SUFFOLK UNIVERSITY LAW SCHOOL
120 TREMONT STREET, BOSTON, MA 02108

Reserve your seat: tinyurl.com/HCCTH2019
2019 Cost Trends Hearing Update

Tuesday, October 22

**MEETING THE HEALTH CARE COST GROWTH BENCHMARK**

**Guest Speakers:**
- The Honorable Charles Baker, Governor
- The Honorable Robert DeLeo, Speaker of the House

**Presentation on Health Care Cost Trends and Affordability in Massachusetts:**
- Ray Campbell, Executive Director, Center for Health Information and Analysis
- David Auerbach, Senior Director of Research and Cost Trends, Health Policy Commission

**Witness Panel 1:** *Trends Driving Hospital Spending Growth*

**Witness Panel 2:** *Trends Driving Pharmaceutical Spending Growth*

Wednesday, October 23

**INNOVATIONS TO IMPROVE VALUE**

**Guest Speakers:**
- The Honorable Maura Healey, Attorney General
- The Honorable Karen Spilka, Senate President

**Presentation on State Policy Innovations to Strengthen Primary Care:**
- Marie Ganim, Health Insurance Commissioner, State of Rhode Island
- Chris Koller, President, Milbank Memorial Fund

**Witness Panel 3:** *Strengthening Primary Care and Behavioral Health Care*

**Witness Panel 4:** *Reducing Administrative Complexity*
AGENDA

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  - FY 2019 Summary
  - FY 2020 Proposal
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Schedule of Next Meeting (December 16, 2019)

Sections 46 and 6 give the Executive Office of Health and Human Services and the HPC, respectively, authority to negotiate directly with pharmaceutical drug manufacturers for supplemental rebates and to investigate the manufacturer’s drug pricing practices if an agreement cannot be reached.
Key Definitions

What is a supplemental rebate?

- Under the federal Medicaid Drug Rebate Program, pharmaceutical drug manufacturers provide rebates to the state Medicaid agencies, which are shared with the federal government, in exchange for participation in and payment under the Medicaid program.

- The federal rebate amount is determined using a statutory formula.

- A supplemental rebate is a rebate negotiated by each state’s Medicaid agency that is in addition to the federal rebate. It is often negotiated in exchange for placement on the state’s preferred drug list.
Key Definitions

What is a high cost drug?

A drug whose post-rebate annual cost per utilizer to MassHealth is $25,000 or more; or

A drug whose post-rebate aggregate annual cost to MassHealth is $10,000,000 or more.
The MassHealth Process

The Budget gives MassHealth the authority to negotiate directly with pharmaceutical drug manufacturers for supplemental drug rebates and to refer certain high cost drugs to the HPC for review if an agreement cannot be reached.

1. MassHealth seeks and enters into negotiations for supplemental rebates with a manufacturer with a goal of maximizing value to the Commonwealth.

2. If the parties are unable to successfully conclude negotiations on certain high cost drugs, MassHealth may:
   • identify a proposed value for such drug; and
   • Solicit public input related to the proposed value.

3. After considering such information, MassHealth shall make necessary updates to its proposed value and shall solicit further negotiations with the drug manufacturer.

4. If the parties are unable to successfully conclude negotiations after gathering and considering the additional information, MassHealth may refer the manufacturer to the HPC for review.
The HPC Process

The Budget gives the HPC the authority to review the value and pricing of certain high cost drugs.

1. The HPC receives a referral from MassHealth for review of a manufacturer.

2. The HPC may require the manufacturer to disclose information relating to the manufacturer’s pricing of the drug. The HPC can request information through a standard reporting form developed with input of the manufacturers and can request additional relevant information.

3. If, based on all the records furnished, the HPC determines that the manufacturer’s pricing of the drug is potentially unreasonable or excessive in relation to the HPC’s proposed value of the drug, the HPC may:
   - request the manufacturer provide further information related to the pricing of the drug and the manufacturer’s justification for the pricing; and
   - identify other relevant parties who may provide information to the HPC.

4. Not later than 60 days after receiving information from the manufacturer, the HPC shall issue a determination on whether the manufacturer’s pricing of the drug is unreasonable or excessive in relation to the HPC’s proposed value for the drug.
Regulatory Development Timeline

- **July**: Budget signed
- **Aug**: Initial presentation to the Board
- **Sept**: Policy and regulatory development
- **Oct**: Present proposed regulation to the Board for a vote
- **Nov**: Present final regulation to the Board for a vote
- **Dec**: Public hearing and comments period
- **Jan**: Present final regulation to the Board for a vote

All dates are approximate and subject to change.
Investment Programs

Substance-Exposed Newborns

Subject to appropriation, the health policy commission, in consultation with the department of public health, shall create and administer an early childhood investment opportunity grant program for programs to support and care for families with substance exposed newborns, including the study of long-term effects of neonatal abstinence syndrome on children up to the age of 18. The program shall support a model that includes both medical services and traditionally non-reimbursed services and may support services provided in clinic settings or in-home visits. The commission shall report to the joint committee on mental health, substance use and recovery and the house and senate committees on ways and means not later than 12 months following completion of the grant program on the results of the programs and the findings of the study on the long-term effects of neonatal abstinence syndrome, including their effectiveness, efficiency, and sustainability.

Funding allocated in the FY 2020 GAA for language in Section 19, Chapter 208 of the Acts of 2018........$300,000

Pregnancy-Related Deaths

The health policy commission, in consultation with the department of public health and the Betsy Lehman center for patient safety and medical error reduction, shall implement a 2-year pilot program to reduce pregnancy-related deaths and improve pregnancy outcomes. The commission shall consider evidence-based practices from successful programs implemented nationally and internationally in the development of the program. The department of public health shall provide relevant data to the commission in order to determine scope and scale of the program, including data on volume and prevalence of pregnancy-related deaths. The commission shall select implementation sites through a competitive process in which applicants shall demonstrate: (i) community need; (ii) the capacity to address preventable causes of complications and death related to pregnancy and child birth; (iii) the ability to facilitate care coordination among health care providers; and (iv) a plan to formalize relationships between health care providers, including hospitals and community-based care providers. The commission shall collect data to gauge the success of the program in decreasing pregnancy-related deaths and track trends within the patient population, including, but not limited to, variance by age, race, and co-morbidities. The commission shall issue a report annually, on or before June 30, to the joint committee on public health and the clerks of the house of representatives and the senate, which shall include program progress updates and outcomes data………………………………… $500,000
AGENDA

- Call to Order
- Appointment of Vice Chair (VOTE)
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  - FY 2019 Summary
  - FY 2020 Proposal
- Schedule of Next Meeting (December 16, 2019)
FY 2019 Summary: Funding Sources and Projected Spending

**Main Line-Item Appropriation**
- Available Funds: $8,769,931
- Projected Spending: $7,862,589
- Main use: General HPC operations
- Funded through annual assessment on hospitals, health plans, and ASC

**Supplementary Line-Item Appropriation**
- Available Funds: $150,000
- Projected Spending: $40,000
- Main use: To implement a new prescription drug outreach and education program for Massachusetts providers

**Distressed Hospital Trust Fund**
- Board-approved budget: $2,188,373
- Projected Spending: $1,804,869
- Main use: Grant administration, technical assistance, and evaluation activities for CHART-eligible investments

**Health Care Payment Reform Trust Fund**
- Board-approved budget: $1,000,000
- Projected Spending: $419,338
- Main use: Technical assistance, learning and dissemination, and evaluation for investments and certification programs
Across all funding sources, the HPC’s total combined spending was essentially level from FY 2017 – FY 2019.

*Note: This table does not reflect direct grant spending to providers through the CHART, the Health Care Innovation Investment programs, and the SHIFT-Care programs. These allocations were approved separately from the annual budget.
## FY 2019 Interagency Service Agreements (ISAs)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Funds Flow</th>
<th>Purpose</th>
<th>FY19 Amount</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPH</td>
<td>HPC to DPH</td>
<td>Implementation and evaluation of HPC's Neonatal Abstinence Syndrome (NAS) investment initiative</td>
<td>$444,681</td>
<td>6/30/2020</td>
</tr>
<tr>
<td>EOHHS</td>
<td>HPC to EOHHS</td>
<td>HPC’s financial contribution towards the MassHealth Patient Experience Survey</td>
<td>$290,000</td>
<td>6/30/2020</td>
</tr>
<tr>
<td>EOHHS</td>
<td>HPC to EOHHS</td>
<td>HPC’s financial contribution toward EOHHS’ quality measurement alignment Task Force, supporting an expert facilitator</td>
<td>$67,900</td>
<td>6/30/2019</td>
</tr>
<tr>
<td>CHIA</td>
<td>HPC to CHIA</td>
<td>HPC’s financial contribution to a jointly administered project to develop hospital efficiency measures</td>
<td>$75,000</td>
<td>6/30/2019</td>
</tr>
</tbody>
</table>
AGENDA

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- Schedule of Next Meeting (December 16, 2019)
The final FY 2020 state budget provides a modest increase (3%) for the operation of the HPC, and an additional $800,000 for targeted investments.

<table>
<thead>
<tr>
<th>State Budget Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governor’s FY 2020 Budget Proposal</strong></td>
</tr>
<tr>
<td>1450-1200: <em>For the operation of the Health Policy Commission...</em> $9,003,931</td>
</tr>
<tr>
<td><strong>House FY 2020 Budget Proposal</strong></td>
</tr>
<tr>
<td>1450-1200: <em>For the operation of the Health Policy Commission...</em> $9,036,682</td>
</tr>
<tr>
<td>1450-1200: <em>For a program to evaluate and reduce pregnancy-related deaths and improve pregnancy outcomes in the commonwealth...</em> $500,000</td>
</tr>
<tr>
<td><strong>Senate FY 2020 Budget Proposal</strong></td>
</tr>
<tr>
<td>1450-1200: <em>For the operation of the Health Policy Commission...</em> $9,032,999</td>
</tr>
<tr>
<td>1450-1200: <em>For a childhood grant program to support and care for families with substance exposed newborns...</em> $300,000</td>
</tr>
<tr>
<td><strong>Final Budget – Chapter 41 of the Acts of 2019</strong></td>
</tr>
<tr>
<td>1450-1200: <em>For the operation of the Health Policy Commission...</em> $9,036,682</td>
</tr>
<tr>
<td>1450-1200: <em>For a childhood grant program to support and care for families with substance exposed newborns...</em> $300,000</td>
</tr>
<tr>
<td>1450-1200: <em>For a program to evaluate and reduce pregnancy-related deaths and improve pregnancy outcomes in the commonwealth...</em> $500,000</td>
</tr>
</tbody>
</table>
## Budget Overview: Summary of FY 2020 Budget Proposal

<table>
<thead>
<tr>
<th>Source of Funds</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Approved Budget</strong></td>
<td>$9,036,682</td>
<td>$800,000</td>
<td>$1,000,000</td>
<td>$1,050,894</td>
</tr>
<tr>
<td><strong>Use</strong></td>
<td>General operating expenses</td>
<td>Targeted improvement investments (maternal health/SEN newborns)</td>
<td>HPC’s Health Care Innovation Investment program and ACO technical assistance (no payroll)</td>
<td>Operating expenses related to DHTF-supported grant programs</td>
</tr>
<tr>
<td><strong>Summary</strong></td>
<td>Modest 3% increase</td>
<td>Two new grant/research opportunities</td>
<td>Level-funding to the FY19 Board-approved budget</td>
<td>52% reduction to the FY19 Board-approved budget</td>
</tr>
</tbody>
</table>
# FY 2019 – FY 2020 Line Item Appropriation Crosswalk

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll</td>
<td>$5,447,546</td>
<td>$5,913,339</td>
<td>$465,793</td>
</tr>
<tr>
<td>Rent/Utilities</td>
<td>$626,500</td>
<td>$620,000</td>
<td>($6,500)</td>
</tr>
<tr>
<td>Professional Services and ISAs</td>
<td>$2,269,000</td>
<td>$2,050,000</td>
<td>($219,000)</td>
</tr>
<tr>
<td>Admin/IT Support</td>
<td>$426,885</td>
<td>$453,343</td>
<td>$26,458</td>
</tr>
<tr>
<td><strong>Line Item Total</strong></td>
<td><strong>$8,769,931</strong></td>
<td><strong>$9,036,682</strong></td>
<td><strong>$266,751</strong></td>
</tr>
</tbody>
</table>

### NOTABLE VARIANCES:
- The projected increase in payroll is primarily due to: 1) annualized salary adjustments and promotions, 2) partial shift of payroll expenses from the Distressed Hospital Trust Fund to the line-item over time, 3) partial shift of contracted services to employed staff, and 4) an increase in the payroll tax increased from 1.9% in FY19 to 2.43% in FY20.
- The projected increase in Admin/IT is due to an increased assessment by the state’s Executive Office of Technology Services and Security (EOTTS) for IT equipment and support.
### FY 2019 – FY 2020 Distressed Hospital Trust Fund Crosswalk

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payroll</td>
<td>$613,234</td>
<td>$342,000</td>
<td>($271,234)</td>
</tr>
<tr>
<td>Rent/Utilities</td>
<td>$112,500</td>
<td>$95,000</td>
<td>($17,500)</td>
</tr>
<tr>
<td>Professional Services and ISAs</td>
<td>$1,049,552</td>
<td>$400,000</td>
<td>($649,552)</td>
</tr>
<tr>
<td>Admin/IT Support</td>
<td>$81,750</td>
<td>$45,000</td>
<td>($36,750)</td>
</tr>
<tr>
<td>State Comptroller Assessment</td>
<td>$121,323</td>
<td>$40,000</td>
<td>($81,323)</td>
</tr>
<tr>
<td>Employee Fringe Assessment</td>
<td>$210,014</td>
<td>$128,894</td>
<td>($81,120)</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>$2,188,373</strong></td>
<td><strong>$1,050,894</strong></td>
<td><strong>($1,137,479)</strong></td>
</tr>
</tbody>
</table>

### NOTABLE VARIANCES:

- The projected decrease in payroll is primarily due to the shift of payroll expenses from the Distressed Hospital Trust Fund to the line-item over time, reflecting the changing portfolio of HPC investment programs.

- The projected decrease in professional services is primarily due to the conclusion of two significant, multi-year evaluation contracts in FY20, for the CHART and Moms do Care Investment programs.

*Note: This table does not reflect direct grant spending to providers through the CHART and Health Care Innovation Investment program. These allocations were approved separately from the annual budget.*
## FY 2020 Interagency Service Agreements (ISAs)

### Interagency Service Agreements (FY19)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Funds Flow</th>
<th>Purpose</th>
<th>FY20 Amount</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPH</td>
<td>HPC to DPH</td>
<td>Implementation and evaluation of HPC's Neonatal Abstinence Syndrome (NAS) investment initiative</td>
<td>$70,000</td>
<td>6/30/2020</td>
</tr>
<tr>
<td>EOHHS</td>
<td>HPC to EOHHS</td>
<td>HPC's financial contribution towards the MassHealth Patient Experience Survey</td>
<td>$290,000</td>
<td>6/30/2020</td>
</tr>
<tr>
<td>EOHHS</td>
<td>HPC to EOHHS</td>
<td>HPC’s financial contribution toward EOHHS' quality measurement alignment Task Force, supporting an expert facilitator</td>
<td>$25,000</td>
<td>6/30/2020</td>
</tr>
</tbody>
</table>
The total number of HPC employees has been stable over the past four years, even as agency responsibilities and activities have grown.

### HPC Employee Headcount: 2013 – 2019*

<table>
<thead>
<tr>
<th>Year/Quarter</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>9</td>
<td>18</td>
<td>23</td>
<td>27</td>
<td>28</td>
<td>34</td>
<td>35</td>
</tr>
<tr>
<td>Q2</td>
<td>18</td>
<td>23</td>
<td>27</td>
<td>28</td>
<td>34</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Q3</td>
<td>23</td>
<td>27</td>
<td>28</td>
<td>34</td>
<td>35</td>
<td>38</td>
<td>42</td>
</tr>
<tr>
<td>Q4</td>
<td>27</td>
<td>28</td>
<td>34</td>
<td>35</td>
<td>38</td>
<td>42</td>
<td>48</td>
</tr>
<tr>
<td>Q1 2014</td>
<td>28</td>
<td>34</td>
<td>35</td>
<td>38</td>
<td>42</td>
<td>48</td>
<td>53</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>34</td>
<td>35</td>
<td>38</td>
<td>42</td>
<td>48</td>
<td>53</td>
<td>55</td>
</tr>
<tr>
<td>Q3 2014</td>
<td>35</td>
<td>38</td>
<td>42</td>
<td>53</td>
<td>55</td>
<td>57</td>
<td>56</td>
</tr>
<tr>
<td>Q4 2014</td>
<td>38</td>
<td>42</td>
<td>53</td>
<td>55</td>
<td>57</td>
<td>56</td>
<td>62</td>
</tr>
<tr>
<td>Q1 2015</td>
<td>42</td>
<td>53</td>
<td>55</td>
<td>57</td>
<td>56</td>
<td>62</td>
<td>60</td>
</tr>
<tr>
<td>Q2 2015</td>
<td>53</td>
<td>55</td>
<td>57</td>
<td>56</td>
<td>62</td>
<td>60</td>
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<tr>
<td>Q3 2015</td>
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<tr>
<td>Q1 2016</td>
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<td>60</td>
<td>63</td>
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<td>62</td>
<td>62</td>
<td>62</td>
</tr>
<tr>
<td>Q3 2016</td>
<td>60</td>
<td>63</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
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<tr>
<td>Q4 2016</td>
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<td>62</td>
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<tr>
<td>Q1 2017</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
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<tr>
<td>Q2 2017</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
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<tr>
<td>Q3 2017</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
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<tr>
<td>Q1 2018</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
</tr>
<tr>
<td>Q1 2019</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
<td>62</td>
</tr>
</tbody>
</table>

*Note: This graph includes a headcount of both full time and part time paid employees, including temporary employees. The table below is an adjusted count based on 37.5 hour work week (FTE).
VOTE: Approving FY 2020 Spending Plan

MOTION: That the Commission hereby accepts and approves the Commission’s total operating budget for fiscal year 2020, 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
- Appointment of Vice-Chair (VOTE)
- Approval of Minutes from July 24, 2019 Meeting (VOTE)
- Market Oversight and Transparency
- Publications
- Cost Trends Hearing Preview
- FY 2020 Budget Approval (VOTE)

- Schedule of Next Meeting (December 16, 2019)
Upcoming 2019 Meetings and Contact Information

Board Meetings

Monday, December 16

Committee Meetings

Wednesday, October 2
Wednesday, November 20

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@mass.gov

Special Events

2019 Cost Trends Hearing
Day 1 – Tuesday, October 22
Day 2 – Wednesday, October 23
APPENDIX
## Top Drugs by Coupon Penetration Represented by Dermatology and Antiarthritic Therapies, Among Other Therapeutic Categories

<table>
<thead>
<tr>
<th>Rank</th>
<th>Drug name</th>
<th>Percent of eligible claims that used a coupon</th>
<th>Therapeutic category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>UTOPIQUE</td>
<td>99%</td>
<td>Dermatologicals</td>
</tr>
<tr>
<td>2</td>
<td>TALTZ AUTOINJECTOR</td>
<td>95%</td>
<td>Immunologic Agents</td>
</tr>
<tr>
<td>3</td>
<td>AVAR LS</td>
<td>93%</td>
<td>Dermatologicals</td>
</tr>
<tr>
<td>4</td>
<td>BROMSITE</td>
<td>90%</td>
<td>Ophthalmic Preparations</td>
</tr>
<tr>
<td>5</td>
<td>ADIPEX-P</td>
<td>87%</td>
<td>Miscellaneous Unassigned Products</td>
</tr>
<tr>
<td>6</td>
<td>SENSIPAR</td>
<td>87%</td>
<td>Calcimimetic Agents</td>
</tr>
<tr>
<td>7</td>
<td>KERALAC</td>
<td>86%</td>
<td>Dermatologicals</td>
</tr>
<tr>
<td>8</td>
<td>TALTZ AUTOINJECTOR (2 PACK)</td>
<td>85%</td>
<td>Immunologic Agents</td>
</tr>
<tr>
<td>9</td>
<td>TARGADOX</td>
<td>85%</td>
<td>Anti-infectives, Systemic</td>
</tr>
<tr>
<td>10</td>
<td>PLEXION</td>
<td>84%</td>
<td>Dermatologicals</td>
</tr>
<tr>
<td>11</td>
<td>VSL#3</td>
<td>83%</td>
<td>Natural Medicine</td>
</tr>
<tr>
<td>12</td>
<td>HUMIRA(CF)</td>
<td>83%</td>
<td>Antiarthritics</td>
</tr>
<tr>
<td>13</td>
<td>VIMOVO</td>
<td>82%</td>
<td>Antiarthritics</td>
</tr>
<tr>
<td>14</td>
<td>OTOVEL</td>
<td>82%</td>
<td>Otic Preparations</td>
</tr>
<tr>
<td>15</td>
<td>DUEXIS</td>
<td>82%</td>
<td>Antiarthritics</td>
</tr>
<tr>
<td>16</td>
<td>PENNSAID</td>
<td>81%</td>
<td>Antiarthritics</td>
</tr>
<tr>
<td>17</td>
<td>AUBAGIO</td>
<td>81%</td>
<td>Immunologic Agents</td>
</tr>
<tr>
<td>18</td>
<td>HUMATROPE</td>
<td>79%</td>
<td>Hormones</td>
</tr>
<tr>
<td>19</td>
<td>AVAR</td>
<td>79%</td>
<td>Dermatologicals</td>
</tr>
<tr>
<td>20</td>
<td>RAYOS</td>
<td>78%</td>
<td>Hormones</td>
</tr>
</tbody>
</table>

Notes: Analysis restricted to commercial patients and claims with coupons used for branded drugs. Table includes drugs with at least 50 claims.
Source: Symphony Health IDV® database, 2018
Top Drugs by Total Coupon Spending Represented by Range of Therapeutic Categories

<table>
<thead>
<tr>
<th>Rank</th>
<th>Drug Name</th>
<th>Total Coupon Amount</th>
<th>Therapeutic Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SENSIPAR</td>
<td>$5,627,635</td>
<td>Calcimimetic Agents</td>
</tr>
<tr>
<td>2</td>
<td>TALTZ AUTOINJECTOR</td>
<td>$1,921,849</td>
<td>Immunologic Agents</td>
</tr>
<tr>
<td>3</td>
<td>TRUVADA</td>
<td>$1,081,284</td>
<td>Antivirals</td>
</tr>
<tr>
<td>4</td>
<td>HUMIRA PEN</td>
<td>$791,816</td>
<td>Antiarthritis</td>
</tr>
<tr>
<td>5</td>
<td>ELIQUIS</td>
<td>$759,028</td>
<td>Hemostatic Modifiers</td>
</tr>
<tr>
<td>6</td>
<td>TALTZ AUTOINJECTOR (2 PACK)</td>
<td>$451,659</td>
<td>Immunologic Agents</td>
</tr>
<tr>
<td>7</td>
<td>EPIDUO FORTE</td>
<td>$412,889</td>
<td>Dermatologicals</td>
</tr>
<tr>
<td>8</td>
<td>GENVOYA</td>
<td>$330,951</td>
<td>Antivirals</td>
</tr>
<tr>
<td>9</td>
<td>ORACEA</td>
<td>$322,098</td>
<td>Anti-infectives, Systemic</td>
</tr>
<tr>
<td>10</td>
<td>XARELTO</td>
<td>$307,985</td>
<td>Hemostatic Modifiers</td>
</tr>
<tr>
<td>11</td>
<td>LANTUS SOLOSTAR</td>
<td>$296,085</td>
<td>Diabetes Therapy</td>
</tr>
<tr>
<td>12</td>
<td>ENSTILAR</td>
<td>$272,201</td>
<td>Hormones</td>
</tr>
<tr>
<td>13</td>
<td>TALTZ AUTOINJECTOR (3 PACK)</td>
<td>$268,380</td>
<td>Immunologic Agents</td>
</tr>
<tr>
<td>14</td>
<td>SOOLANTRA</td>
<td>$238,301</td>
<td>Dermatologicals</td>
</tr>
<tr>
<td>15</td>
<td>SYMBICORT</td>
<td>$230,667</td>
<td>Respiratory Therapy</td>
</tr>
<tr>
<td>16</td>
<td>TRULICITY</td>
<td>$216,001</td>
<td>Diabetes Therapy</td>
</tr>
<tr>
<td>17</td>
<td>BRILINTA</td>
<td>$200,918</td>
<td>Hemostatic Modifiers</td>
</tr>
<tr>
<td>18</td>
<td>DUEXIS</td>
<td>$196,973</td>
<td>Antiarthritis</td>
</tr>
<tr>
<td>19</td>
<td>PENNSAID</td>
<td>$194,317</td>
<td>Antiarthritis</td>
</tr>
<tr>
<td>20</td>
<td>BROMSITE</td>
<td>$187,850</td>
<td>Ophthalmic Preparations</td>
</tr>
</tbody>
</table>