



**MASSACHUSETTS**  
HEALTH POLICY COMMISSION

# **Health Policy Commission Board Meeting**

**September 11, 2019**



## **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**)



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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.



## **AGENDA**

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- Appointment of Vice Chair (**VOTE**)
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- **Market Oversight and Transparency**
  - Material Change Notices
  - Preview of Market Retrospective Study and Hospital Inpatient Coding Analysis
- Publications
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## Types of Market Transactions Reported to the HPC Since 2013

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Physician group merger, acquisition, or network affiliation	23	22%
Clinical affiliation	23	22%
Acute hospital merger, acquisition, or network affiliation	22	21%
Formation of a contracting entity	19	18%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	12	11%
Change in ownership or merger of corporately affiliated entities	5	5%
Affiliation between a provider and a carrier	1	1%

## Transactions Currently Under Review

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■ 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.

Received Since 7/24

■ 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

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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.

## Transactions for which the HPC Elected Not to Proceed to a Cost and Market Impact Review

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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.



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

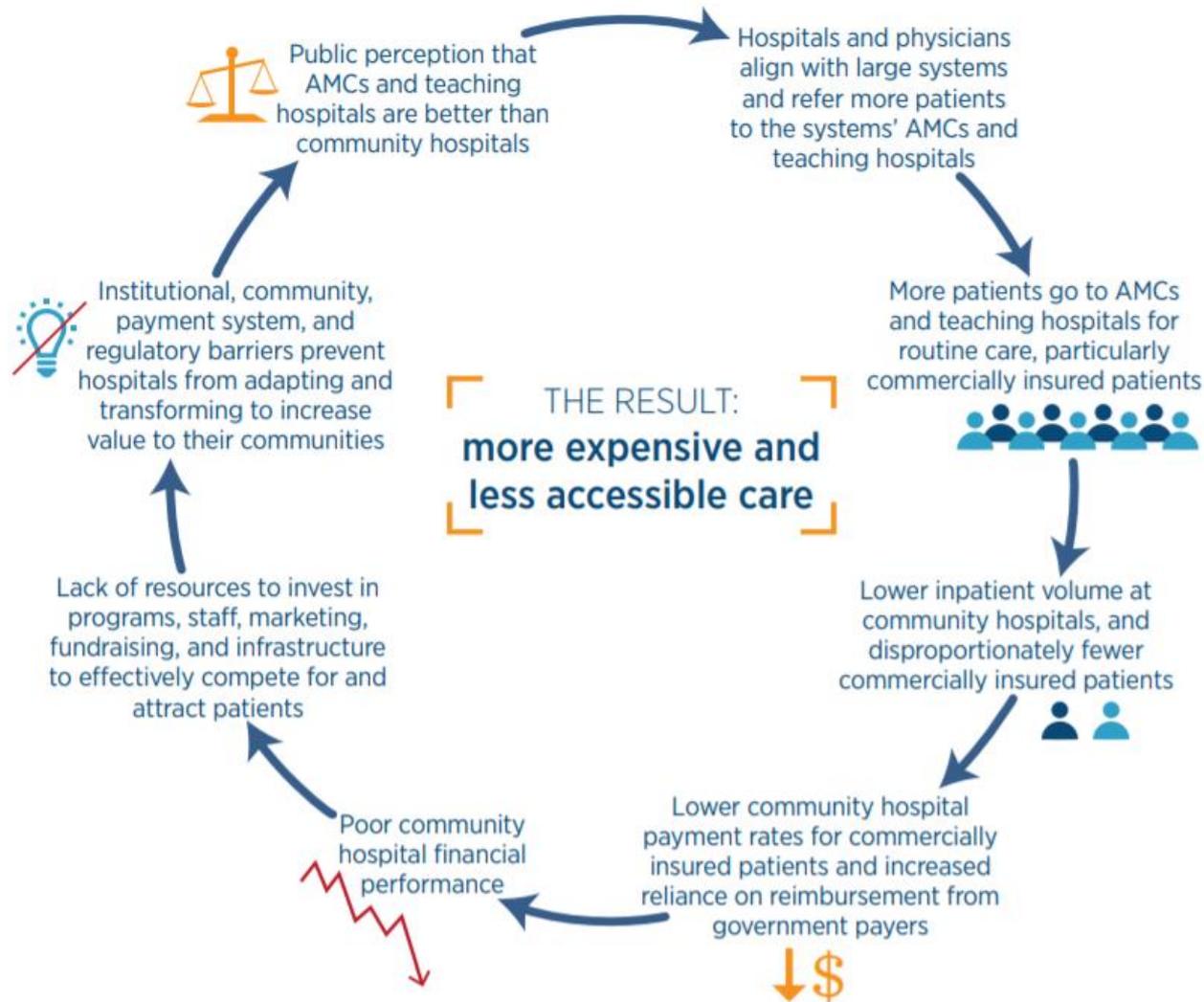
- The HPC has monitored the provider market through its authority to analyze **material changes** through ongoing research and standalone publications like the **Community Hospitals at a Crossroads**.
- HPC expects to publish some of the findings from its ongoing monitoring, including:
  - ✓ Analyses 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.

Material Changes Received To Date

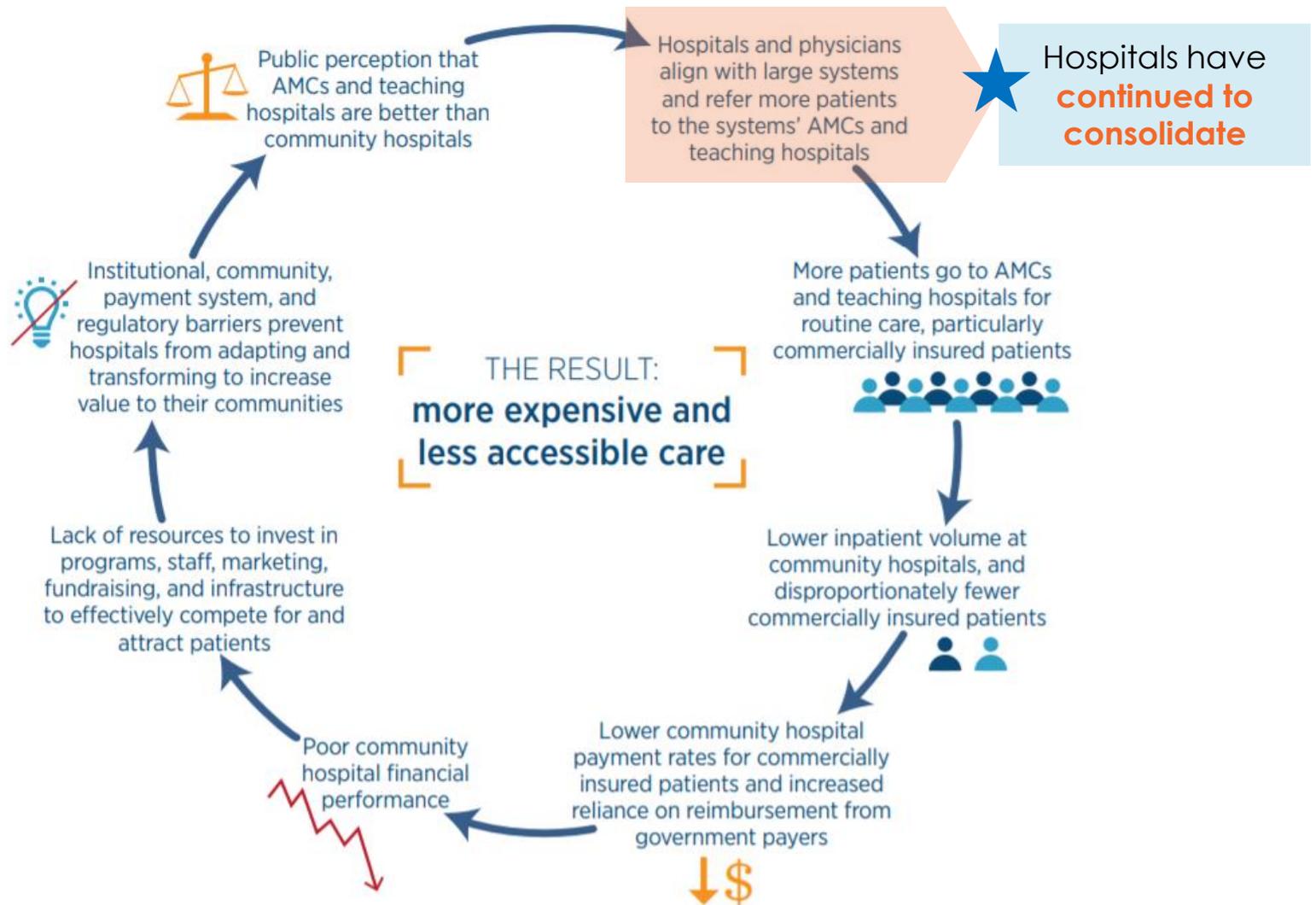
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# The HPC's 2016 *Community Hospitals at a Crossroads* report identified challenges for community hospital sustainability and a need for action.

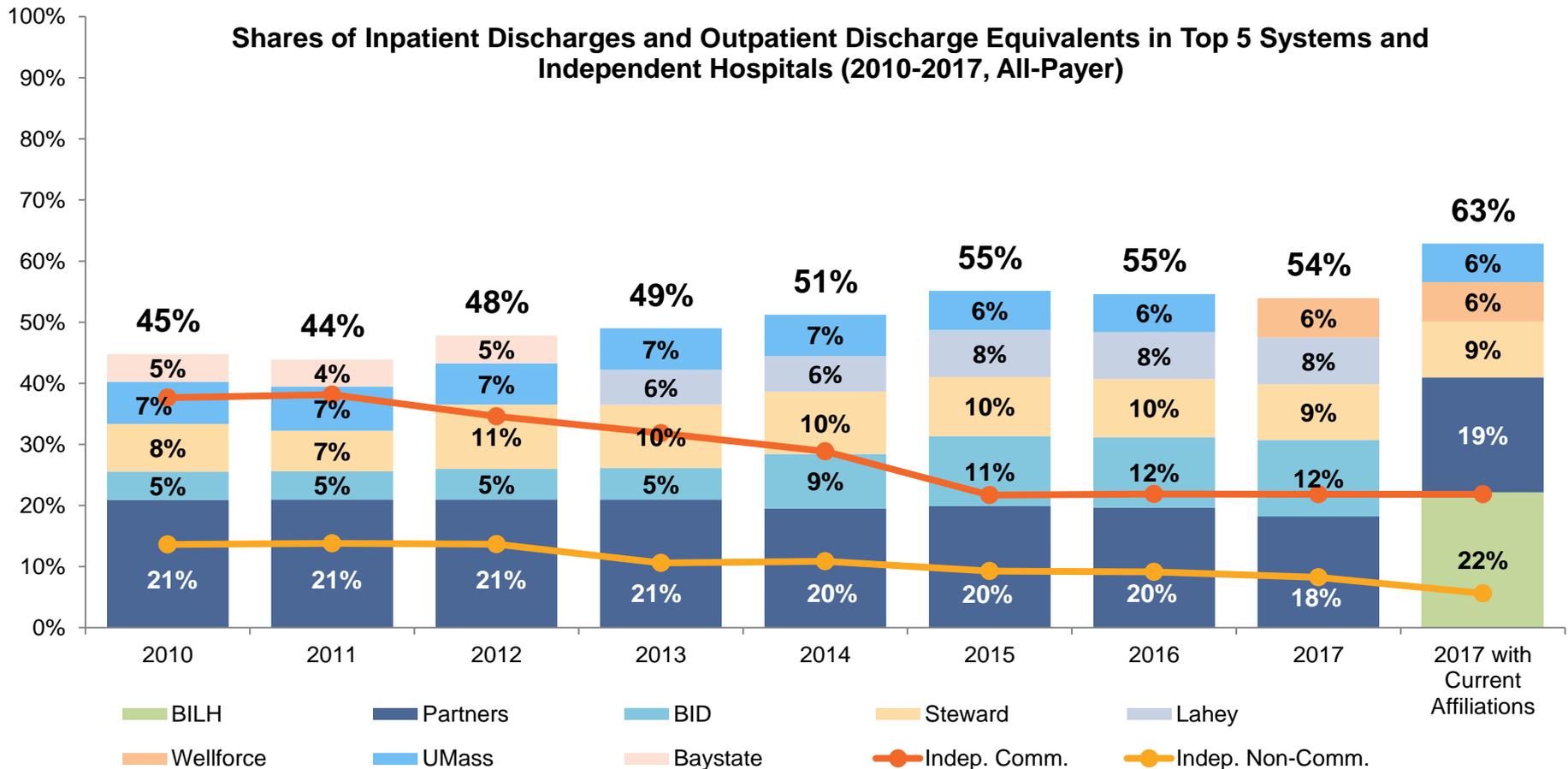


# Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist.

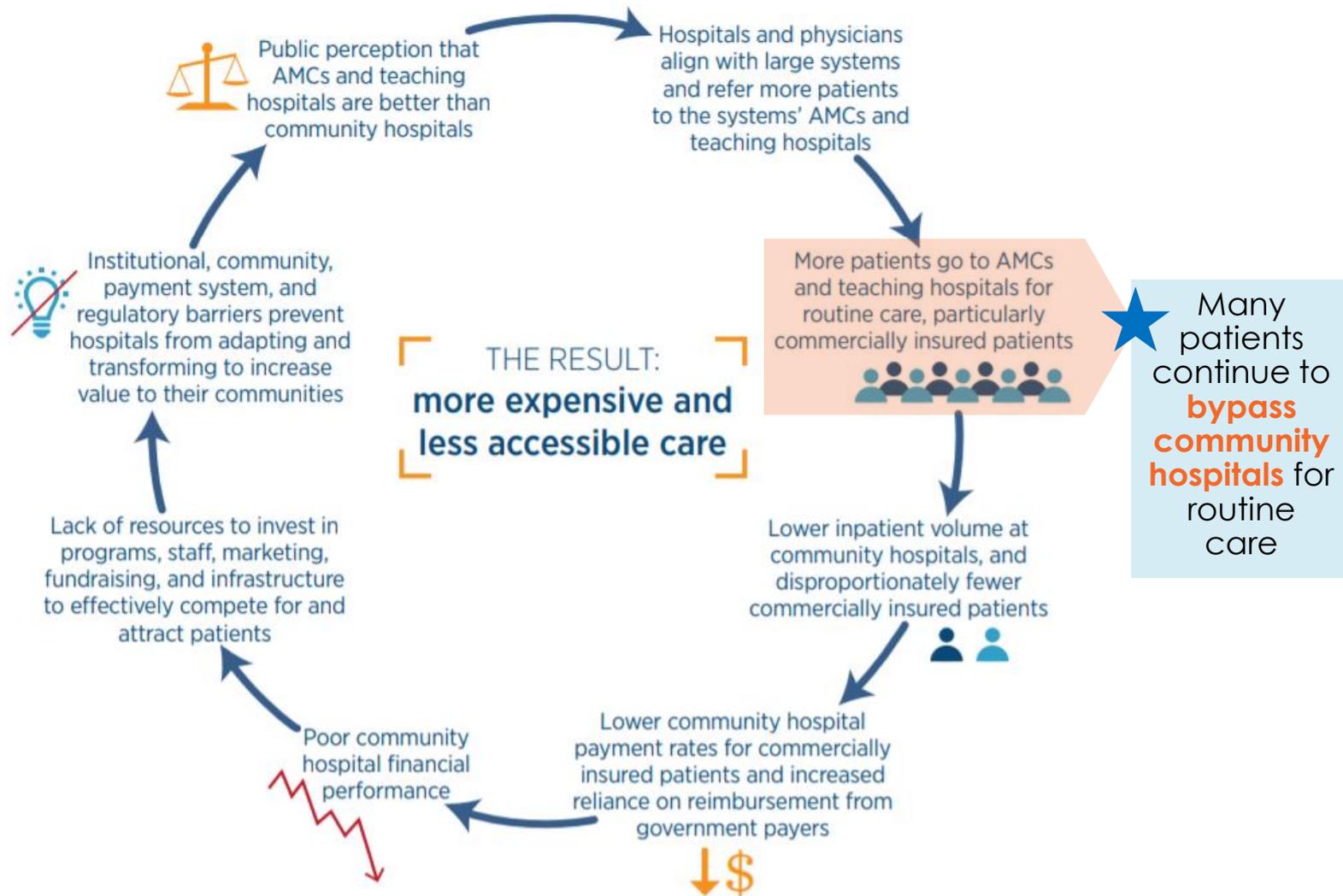


# Hospitals continue to consolidate, and care is increasingly concentrated in the largest health systems.

- 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**.



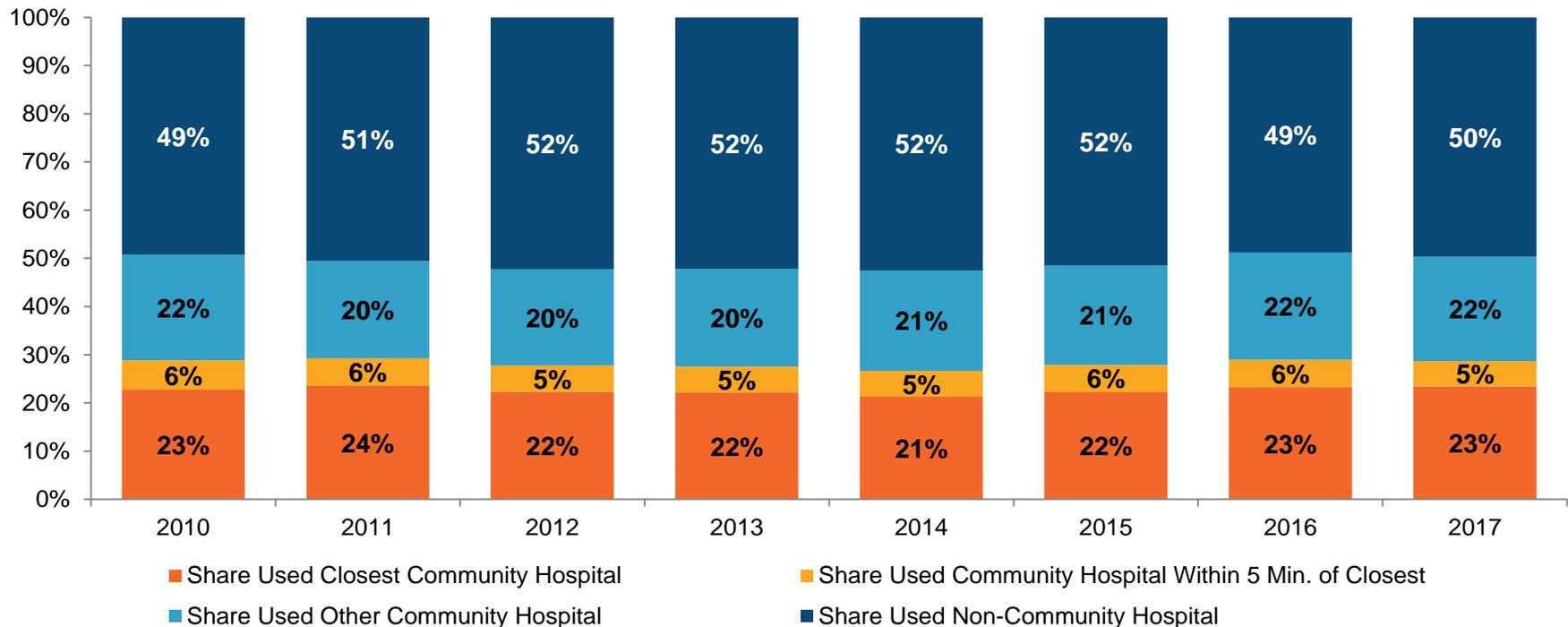
# Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist.



## 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.

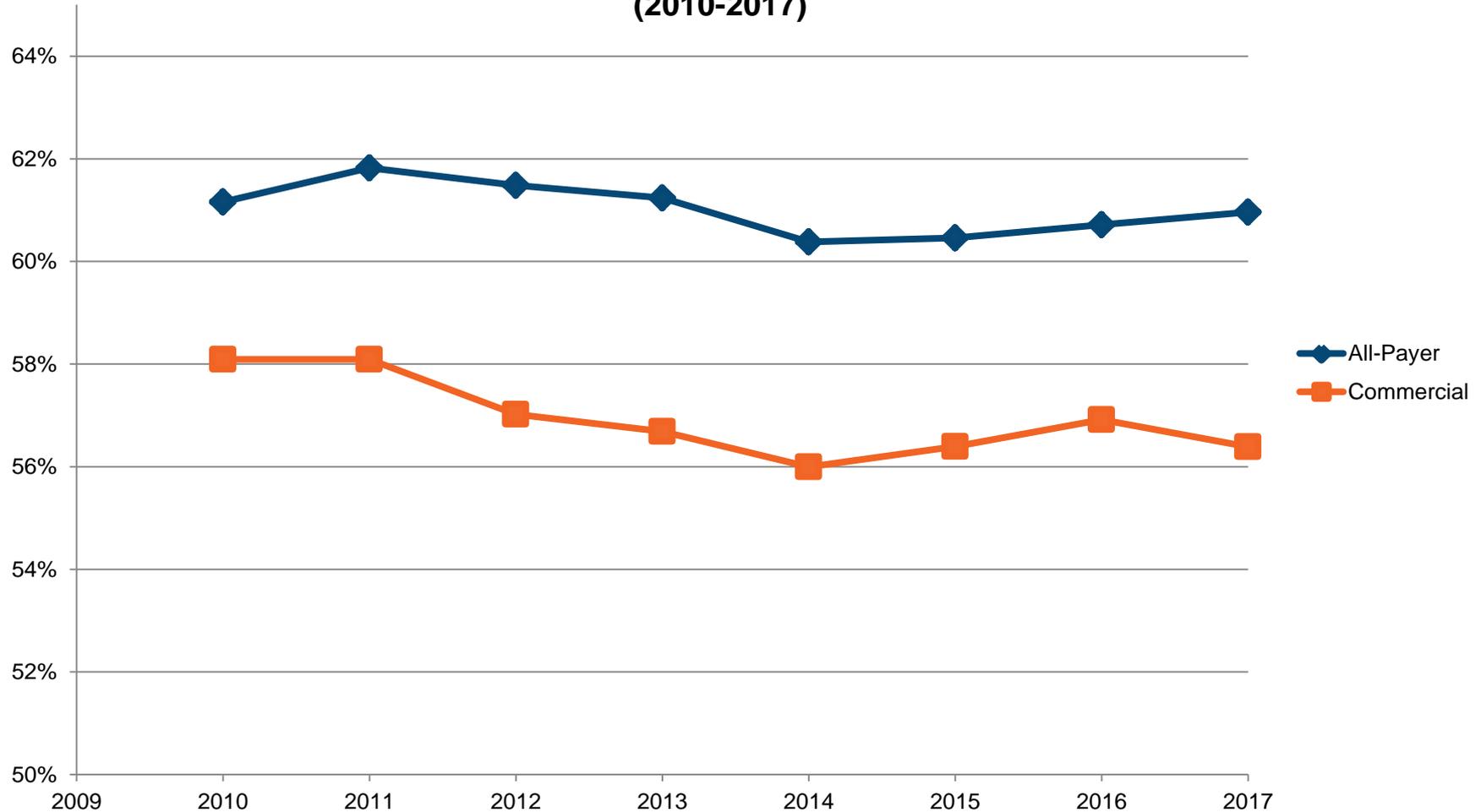
Site of Care for Adult Patients Receiving Scheduled, Non-Maternity Community-Appropriate Services Whose Closest Hospital is a Community Hospital (2010 – 2017, Commercial)



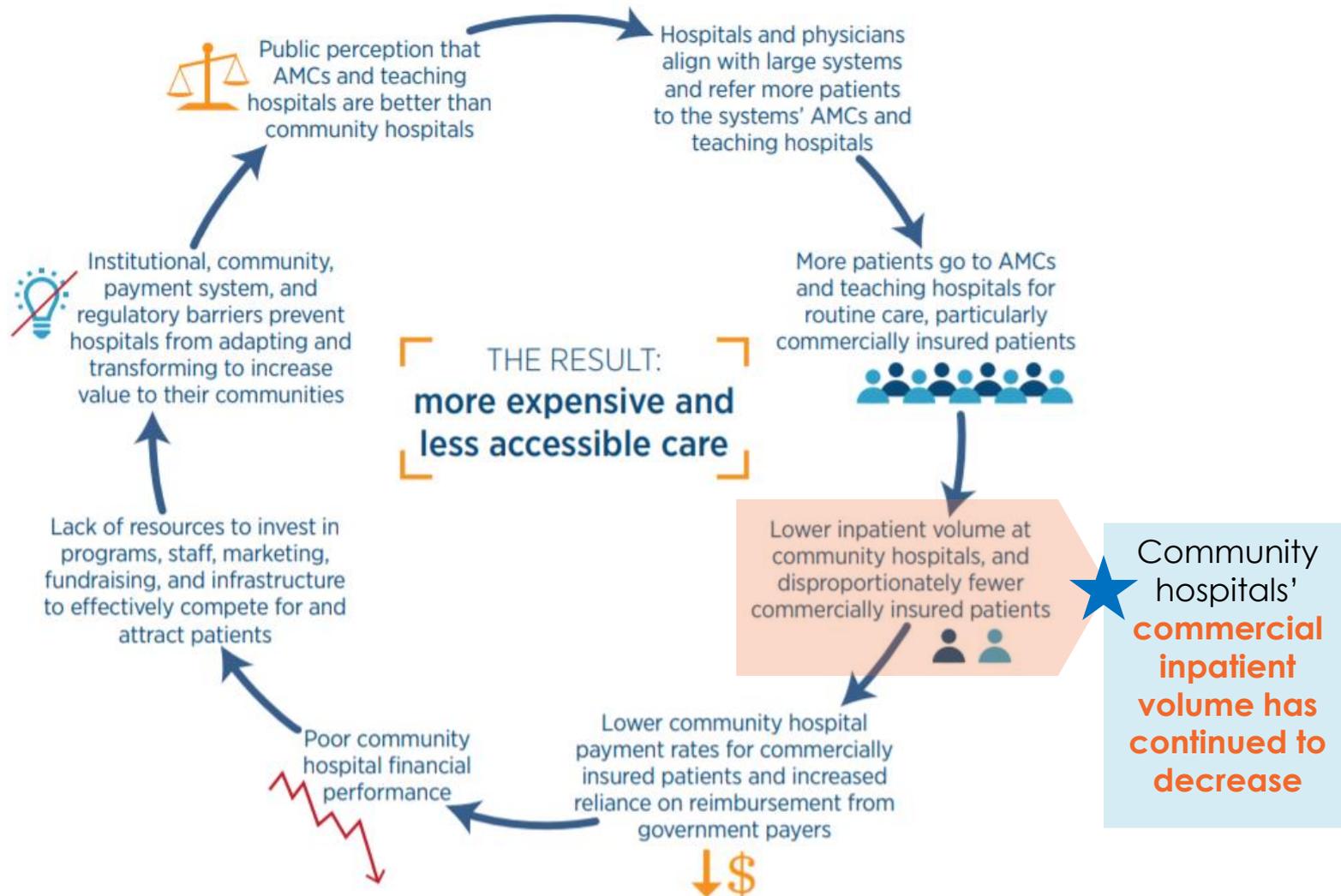
Notes: Community-appropriate discharges represent a narrow set of inpatient services that could likely be performed effectively in any hospital setting.

# Community hospitals' share of community-appropriate discharges has not increased over time.

## Community Hospital Share of Community-Appropriate Discharges Statewide (2010-2017)

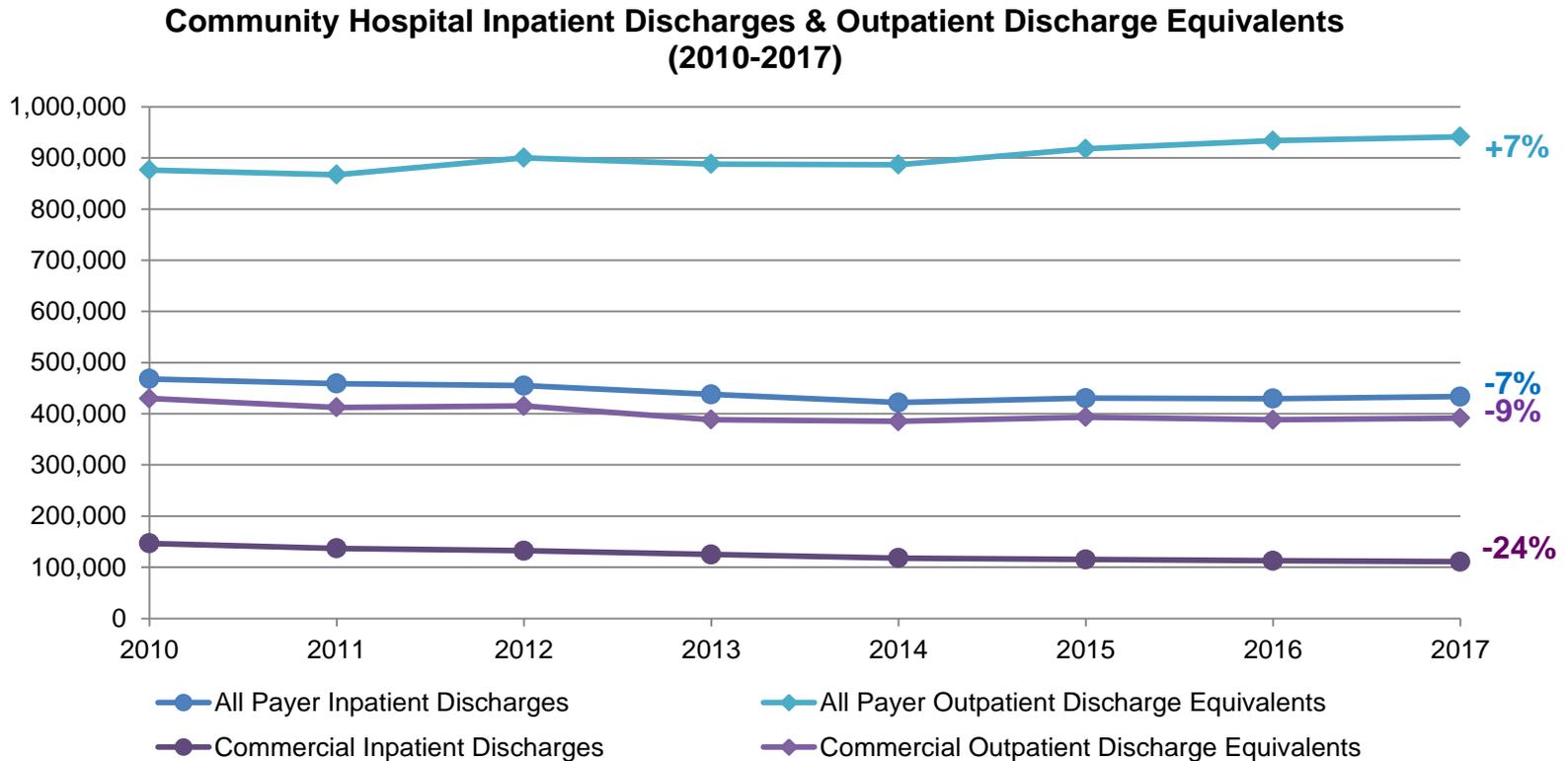


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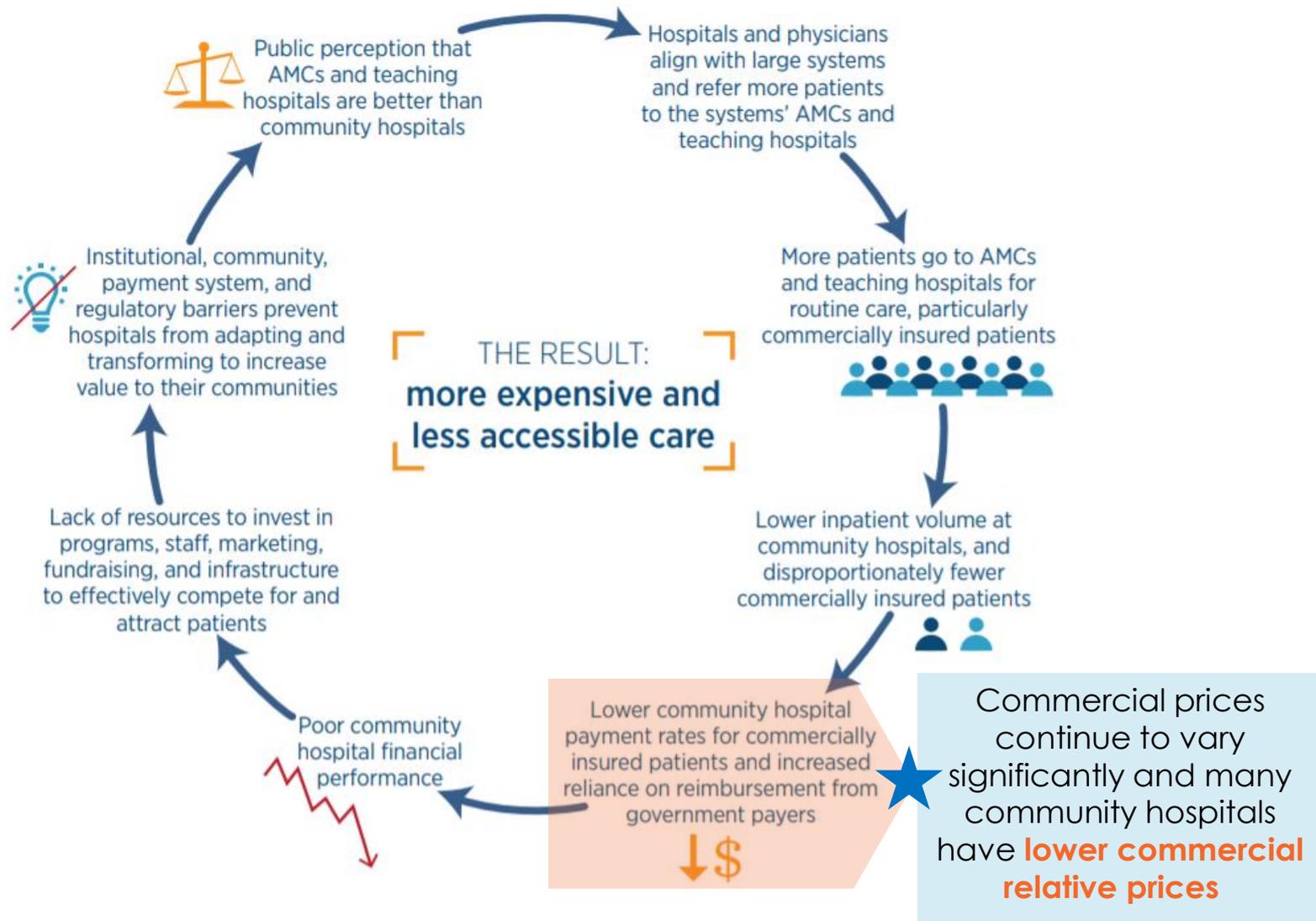


## Commercial inpatient volume at community hospitals decreased 24% from 2010 to 2017.

- 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**.

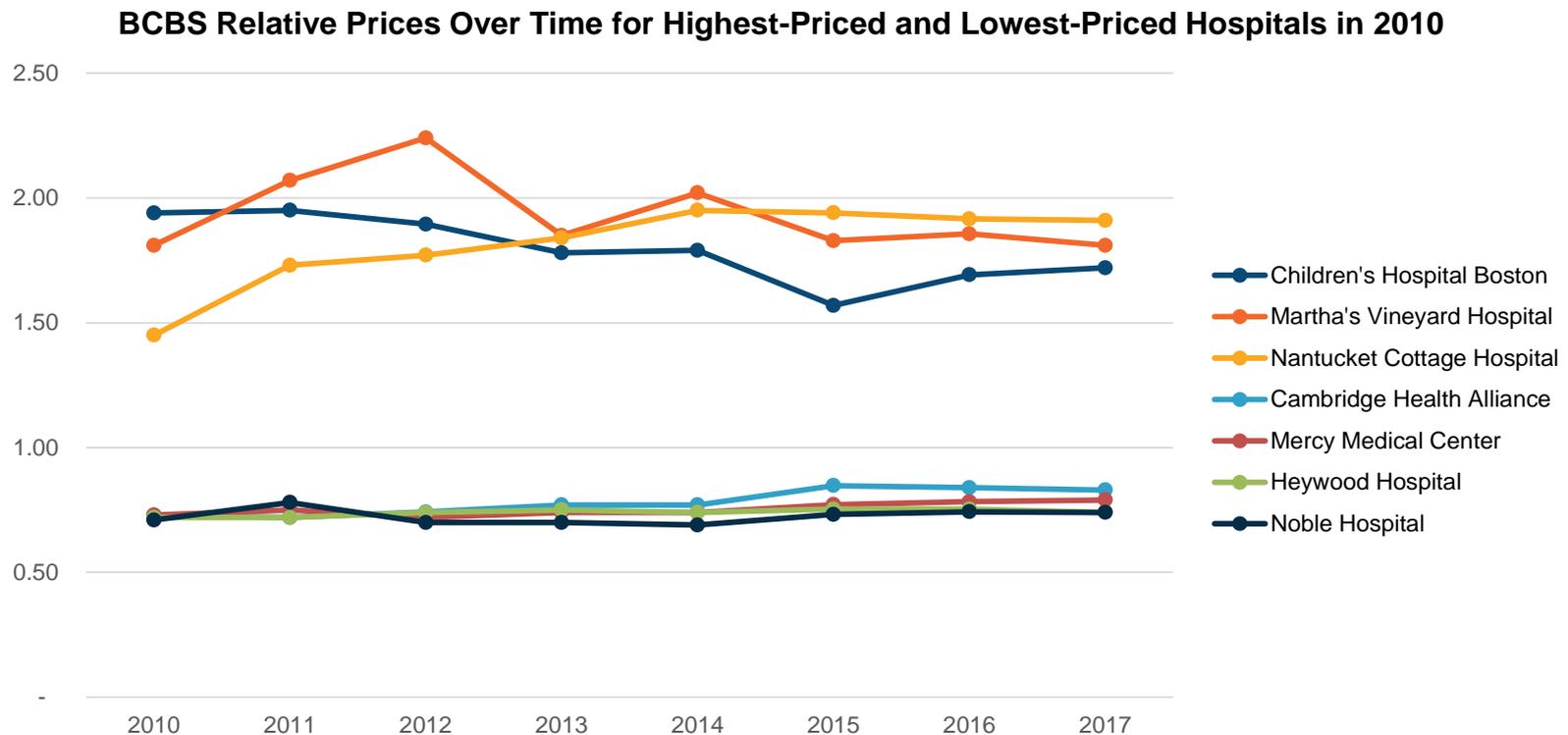


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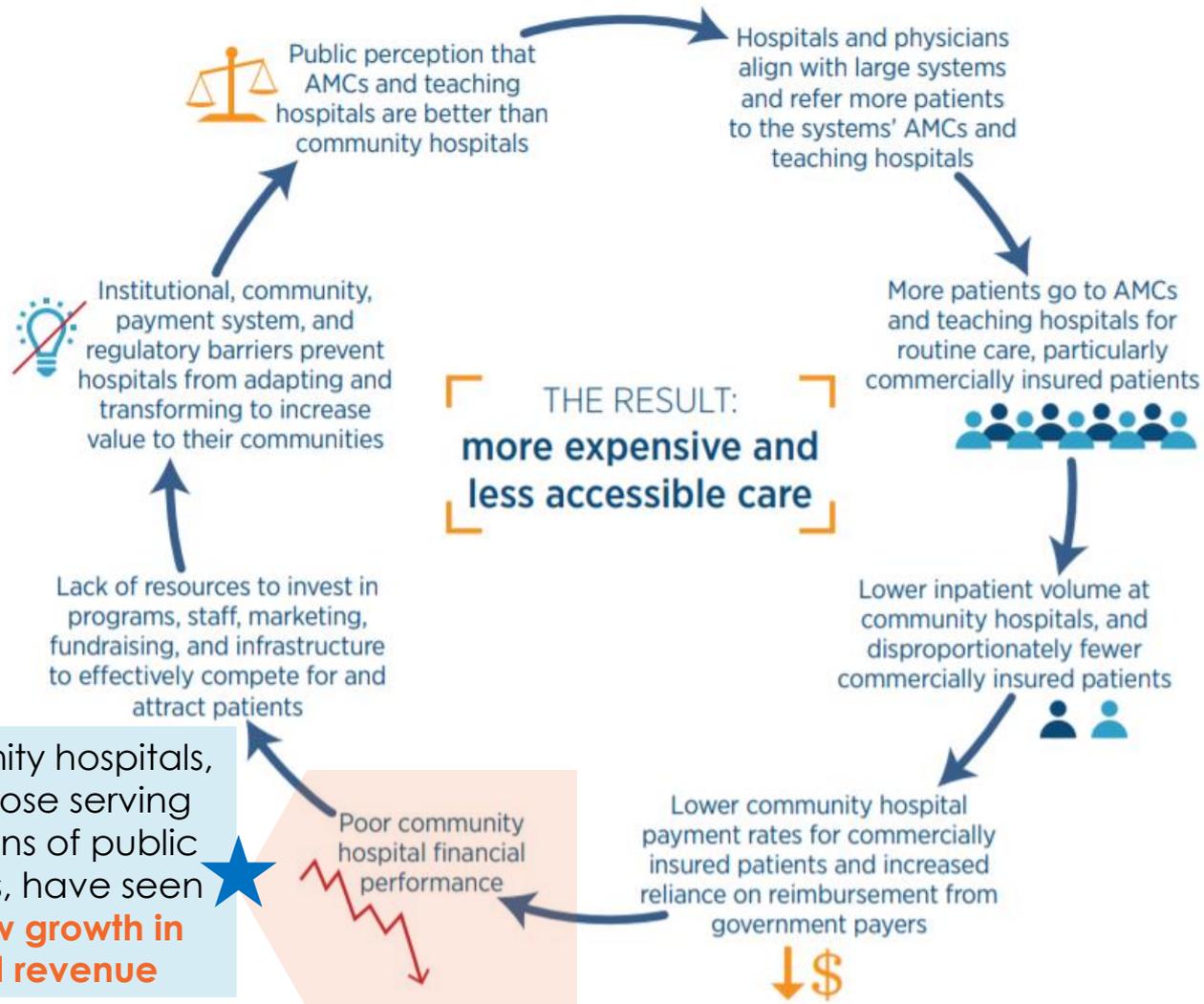


## Lower priced hospitals (many of which are community hospitals) have generally remained lower priced over time.

- 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.



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



## Community hospitals have seen slower growth in revenue over time than other hospitals.

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- 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.

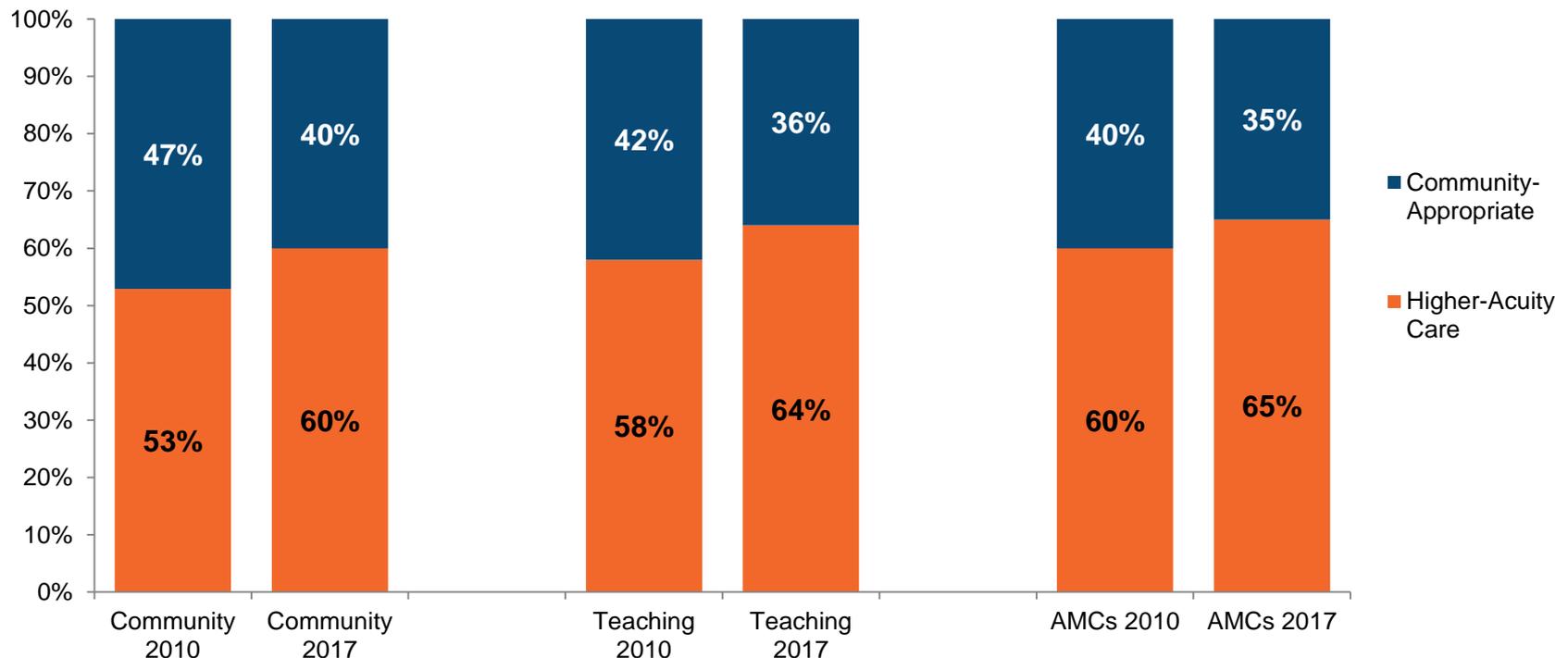
# Updated analyses suggest that many of the challenges identified in *Community Hospitals at a Crossroads* persist.



## 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.

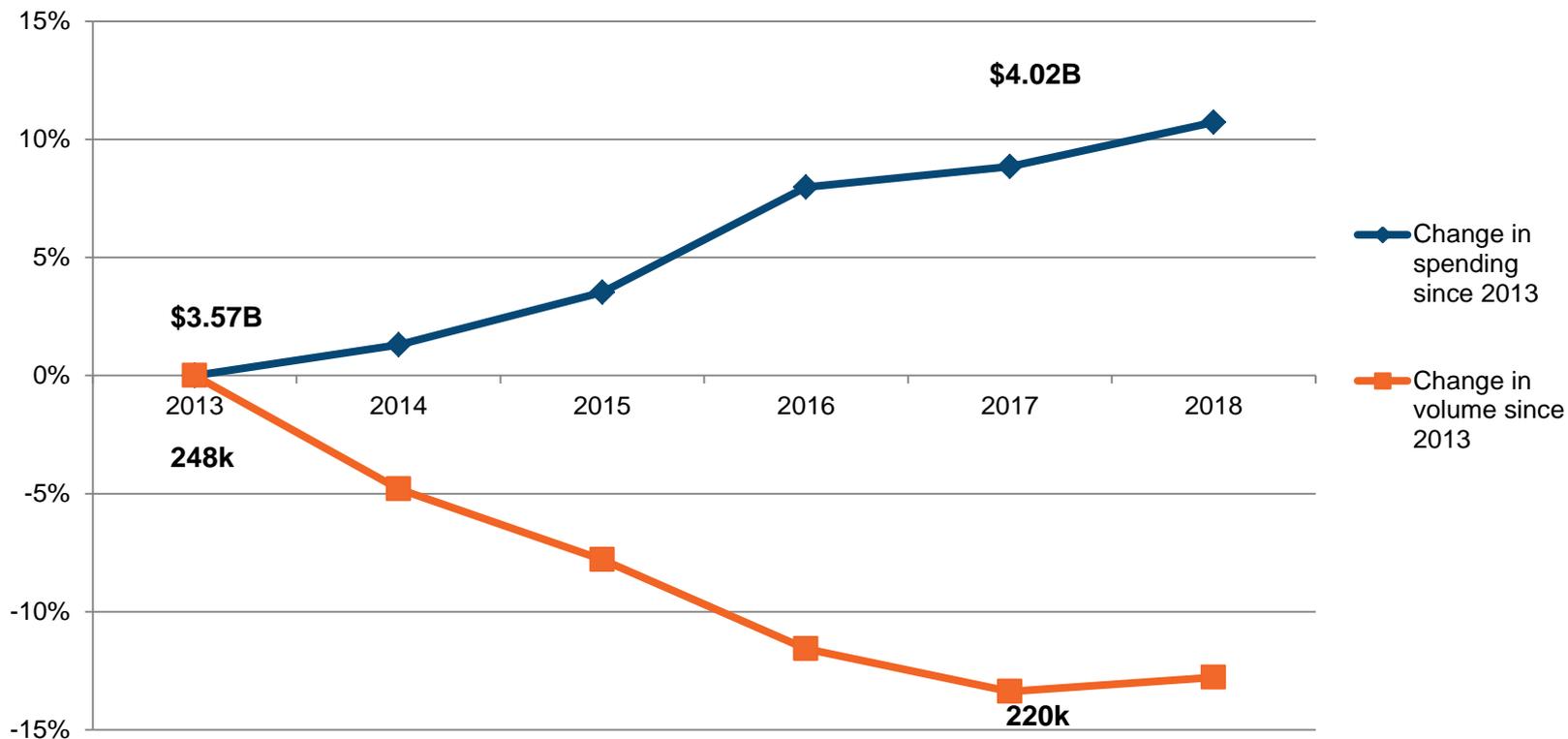
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- **Decrease** in community-appropriate discharges (defined as low-acuity hospital discharges)
- **Increase** in patient risk scores
- **Increase** in acuity/complexity of inpatient hospital stays

- **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*

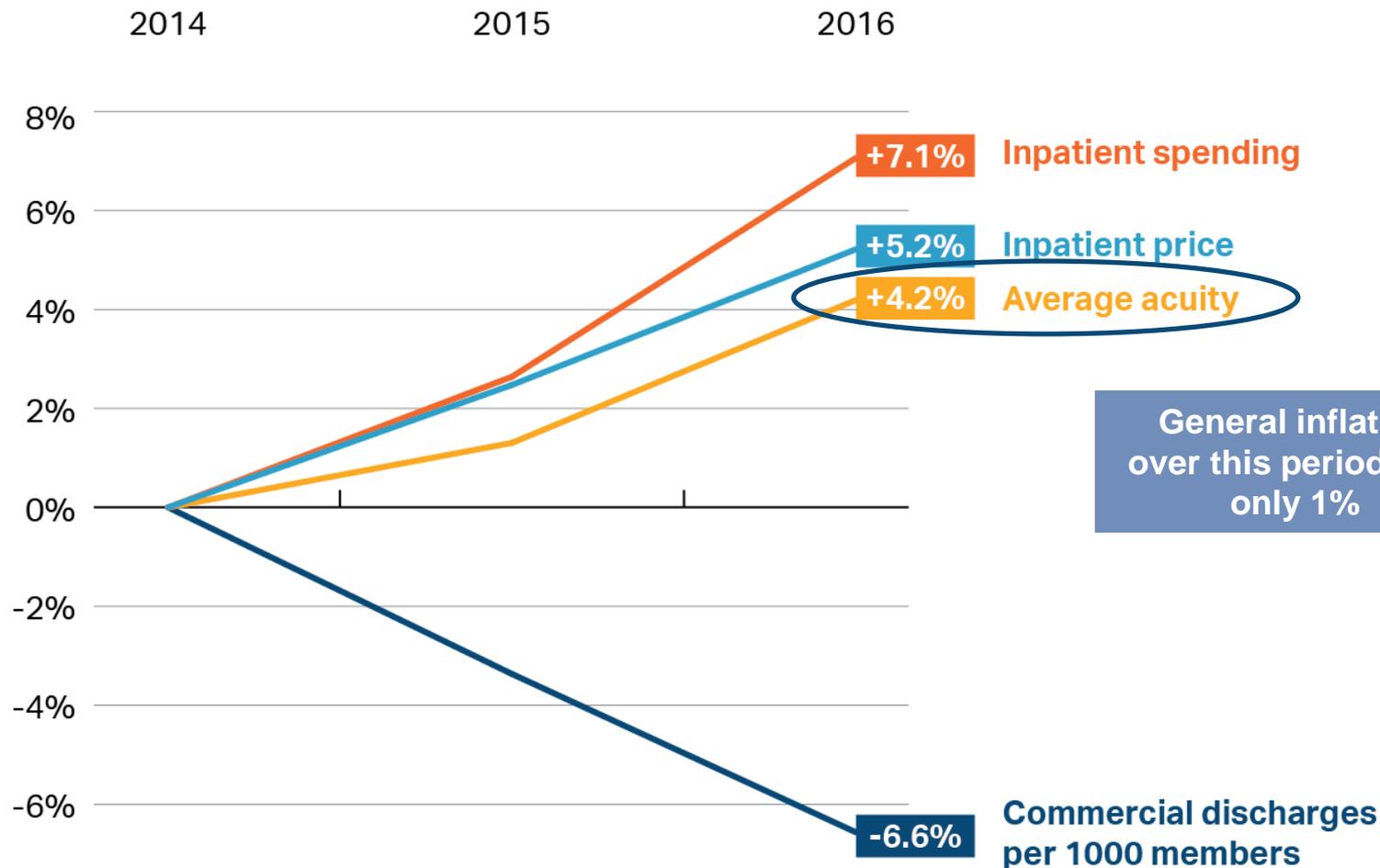


Hospital spending per discharge grew 5% annually, from \$14,400 to \$18,300 between 2013-2018

Notes: Data points indicate percent growth from previous year (2013=0). Volume data correspond to fiscal years while spending data correspond to calendar years. Sources: CHIA Hospital Inpatient Discharge Data, 2013-2018. Commercial full-claims TME from CHIA Annual Report TME Databooks. 2019 Annual report (for 2017-8 growth), 2018 Annual Report (for 2015-6 and 2016-7), 2017 annual report (for 2014-2015) and 2016 Annual Report (for 2013-4 growth). Inpatient volume data for 2018 for Berkshire Medical Center is extrapolated due to missing data in initial release of HIDD.

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

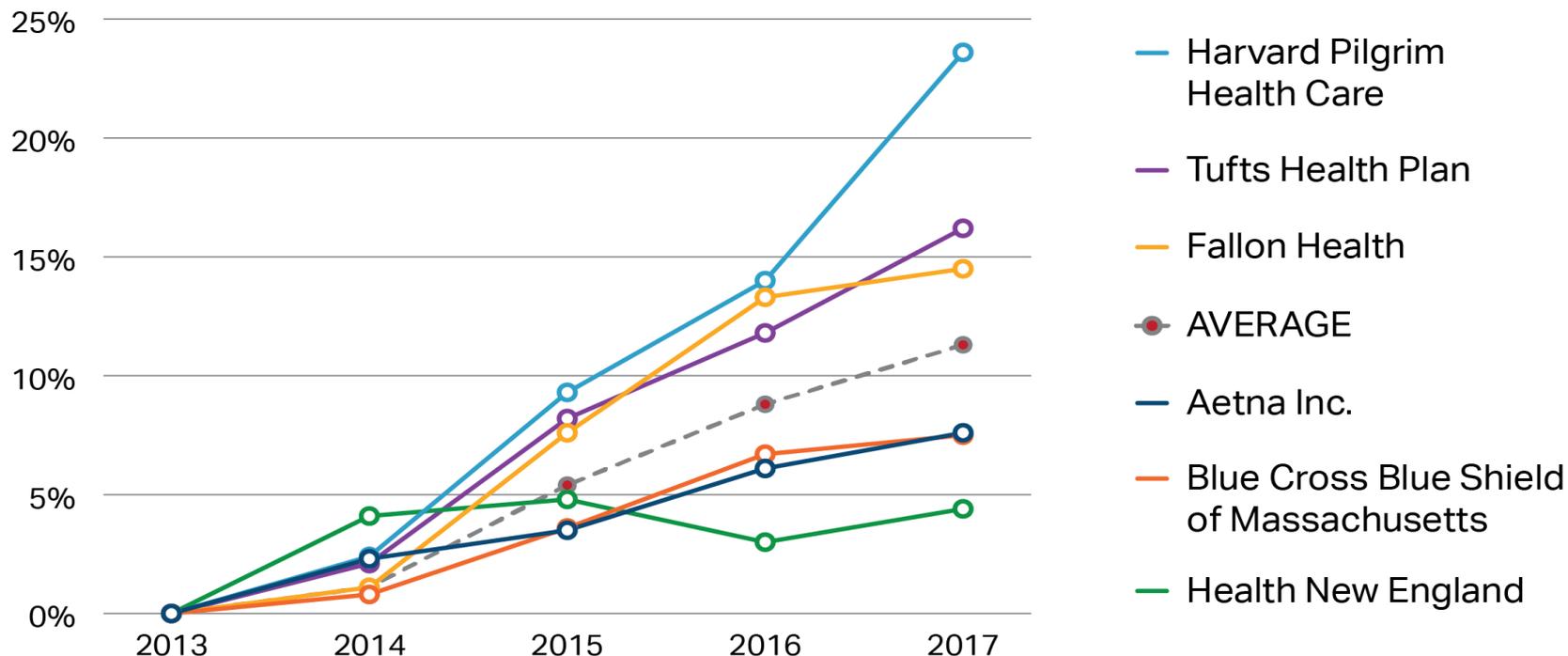
Change in average commercial inpatient prices, utilization, acuity, and spending, 2014-2016



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.

Cumulative change in overall member risk since 2013



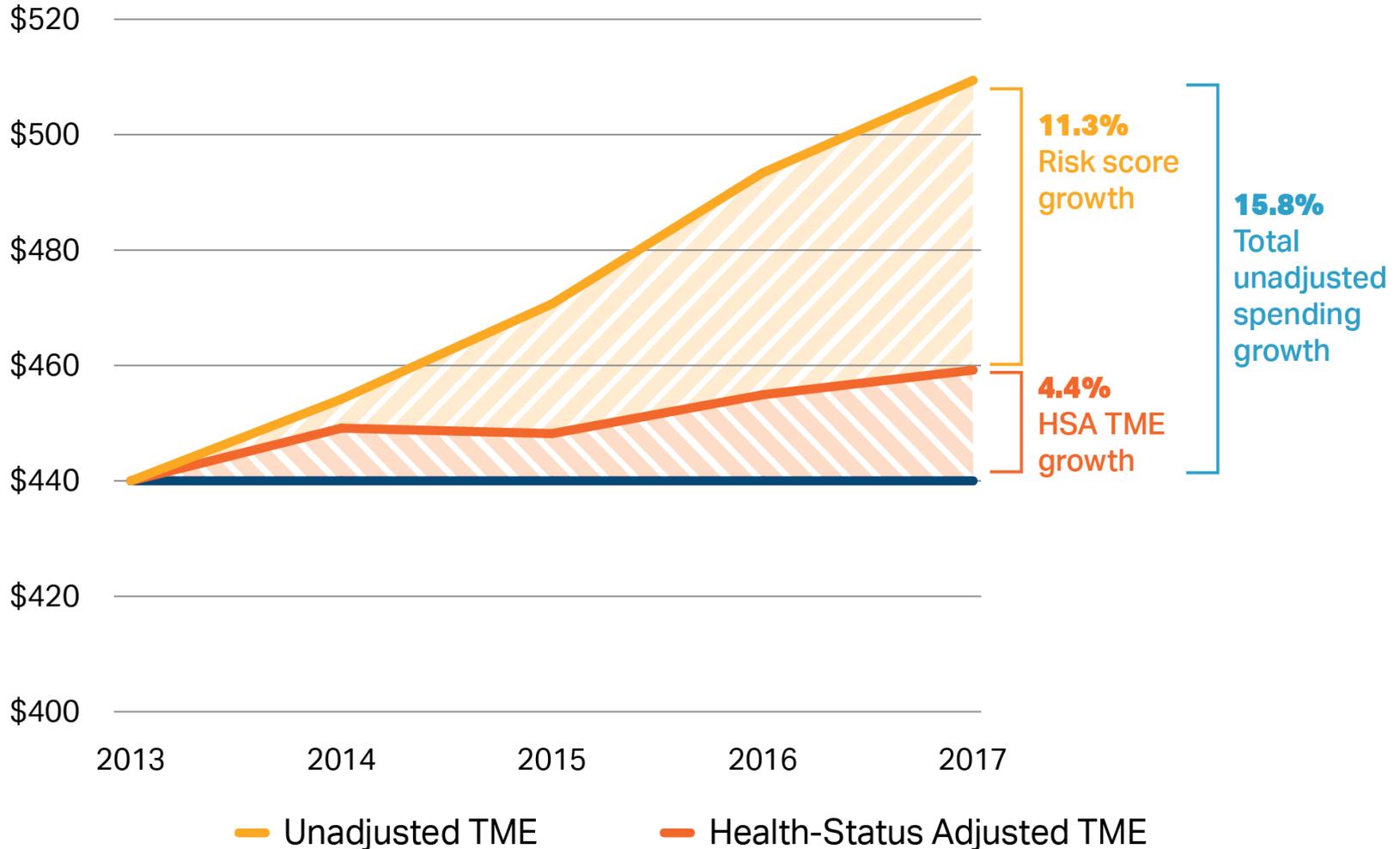
Over this period, the average patient risk score increased **11.3%**



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.

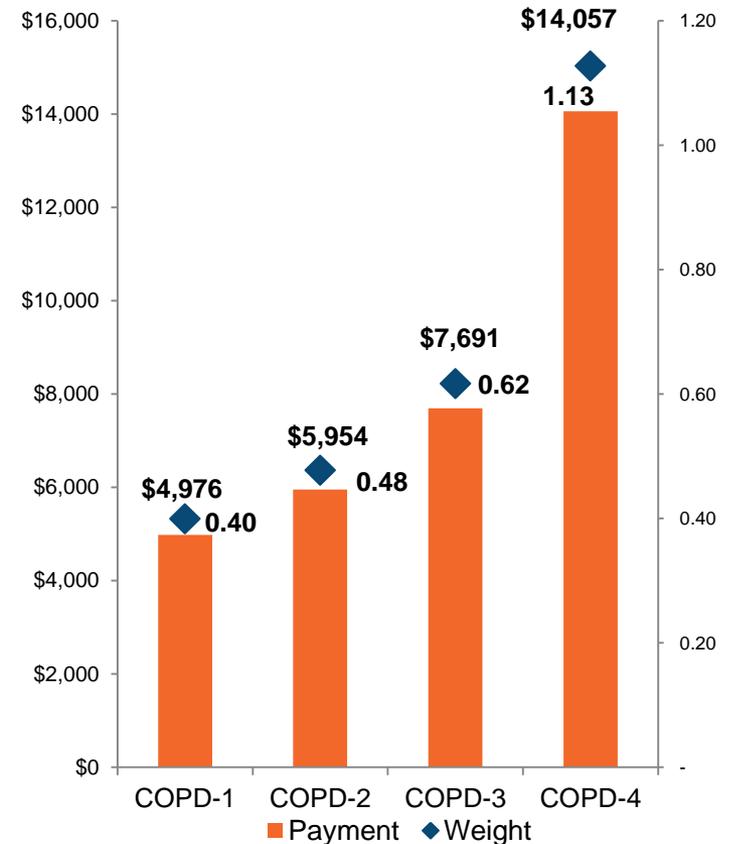
Commercial spending PMPM



# The HPC also examined changes in patient acuity by analyzing shifts in hospital inpatient stay classifications.

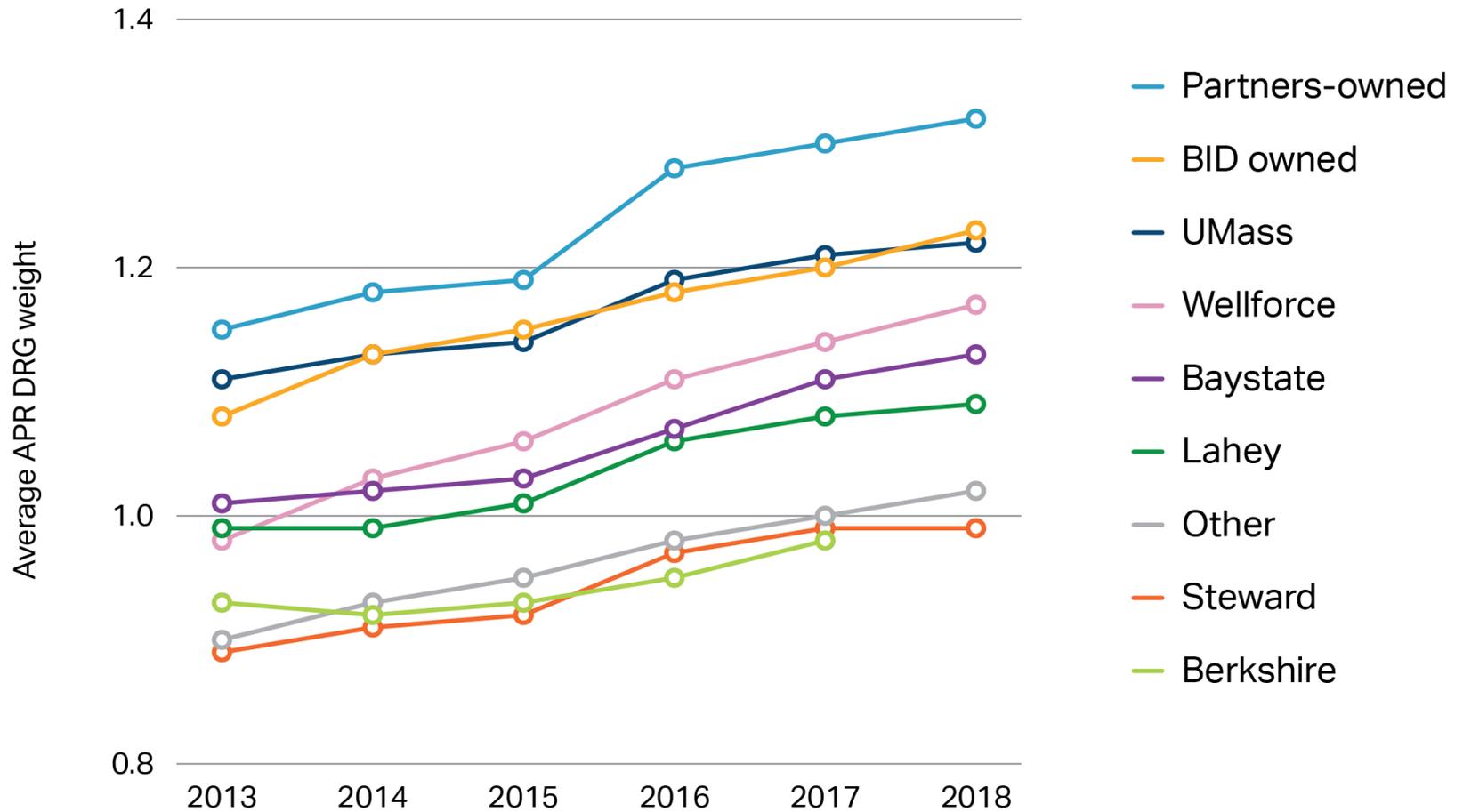
DRG Grouper	Description
<b>MS-DRG (Medicare Severity)</b>	<ul style="list-style-type: none"> <li>754 DRGs</li> <li>Each has an assigned weight</li> <li>Most DRGs combine a condition with up to three levels of severity:                             <ul style="list-style-type: none"> <li>Without complications (W/O CC)</li> <li>With complications/comorbidities (CC)</li> <li>With major complications/comorbidities (MCC)</li> </ul> </li> <li>Used by Medicare &amp; some commercial (17%, e.g., Fallon)</li> </ul>
<b>APR-DRG (All-Payer Refined)</b>	<ul style="list-style-type: none"> <li>315 DRGs</li> <li>Each DRG has four severity levels (1-lowest)</li> <li>Each DRG-severity combination has an assigned weight</li> <li>Used by MassHealth &amp; most commercial (72%, e.g., Blue Cross)</li> </ul>

MassHealth Weights & Payments for COPD, 2018



***DRG payment = base rate \* DRG weight***

From 2013-2018, all major hospital systems had increasing patient acuity; for Partners-owned hospitals, the increase was 15%.

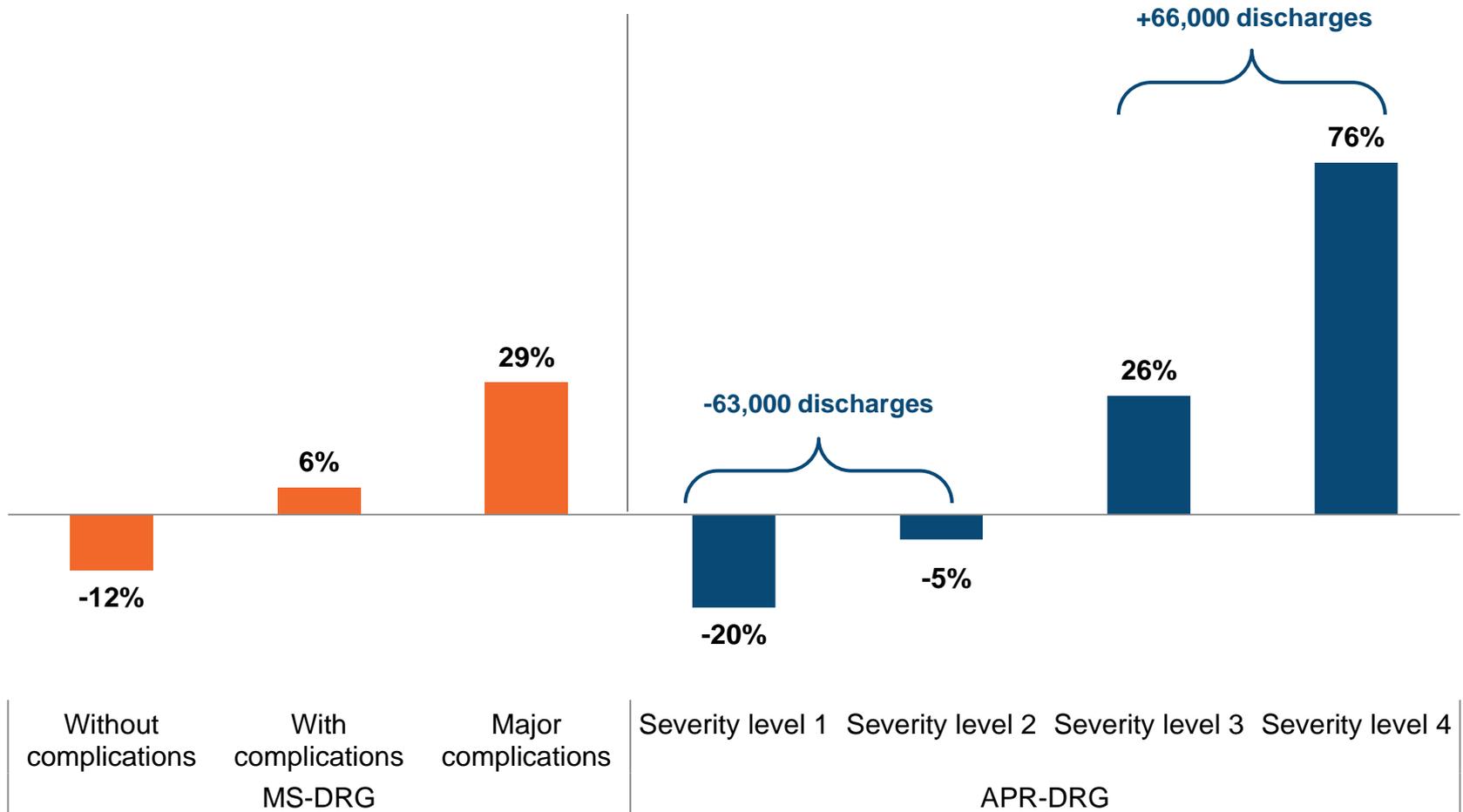


Notes: Berkshire hospital system removed due to data anomalies in 2018

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



## 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”

BUSINESS DAY

### *Medicare Bills Rise as Records Turn Electronic*

By REED ABELSON, JULIE CRESWELL and GRIFF PALMER SEPT. 21, 2012

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

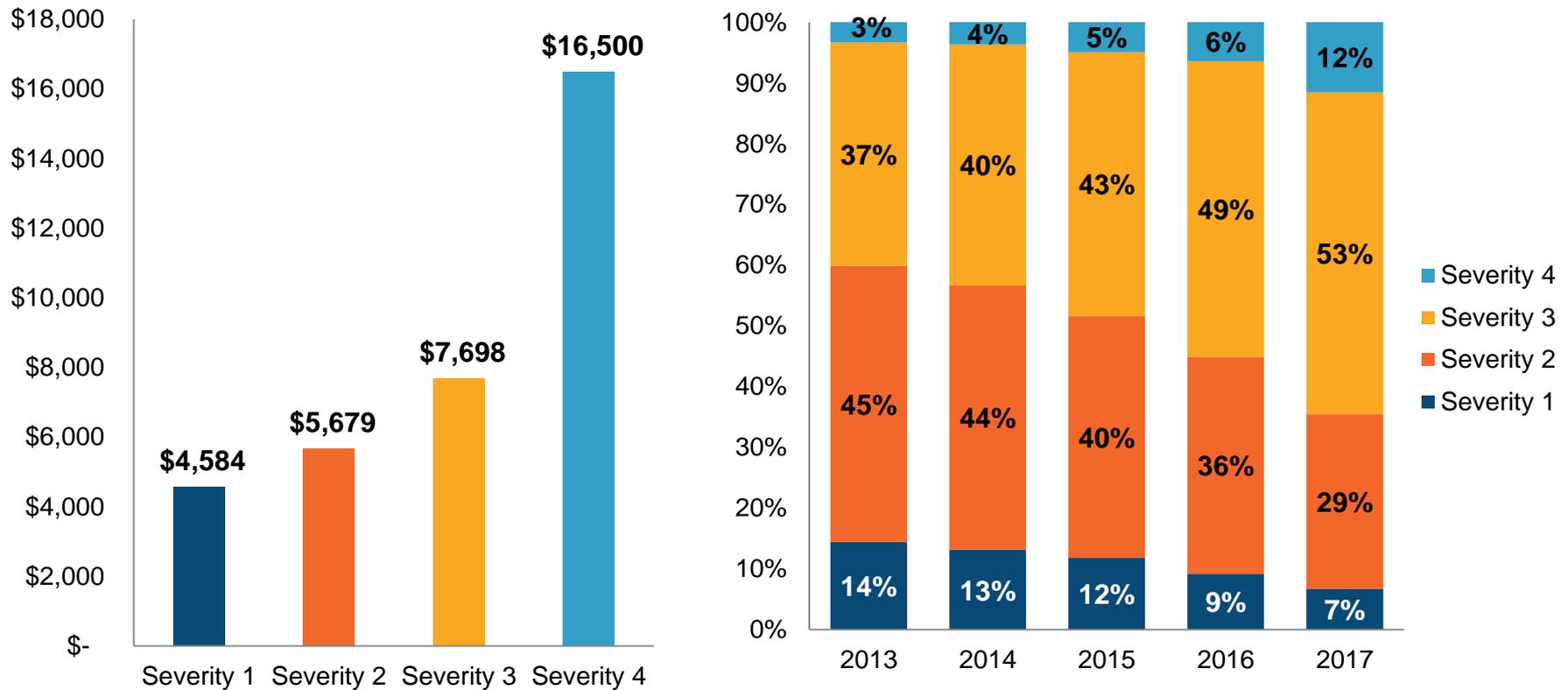
“...It’s far easier to increase margin by increasing coding than by reducing costs.”

“...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.”

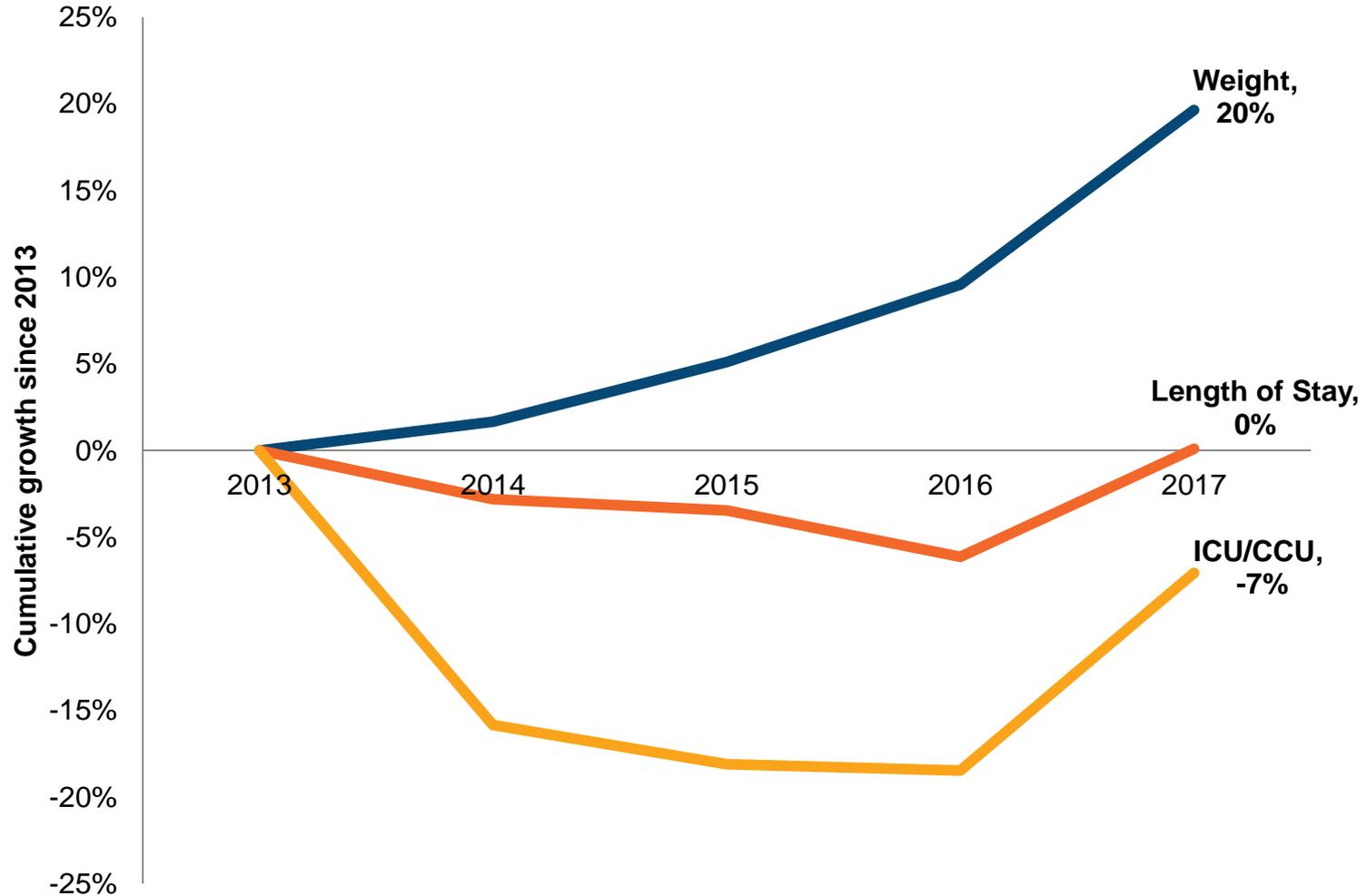
## Hospitals benefit financially when patients are coded as higher-acuity.

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



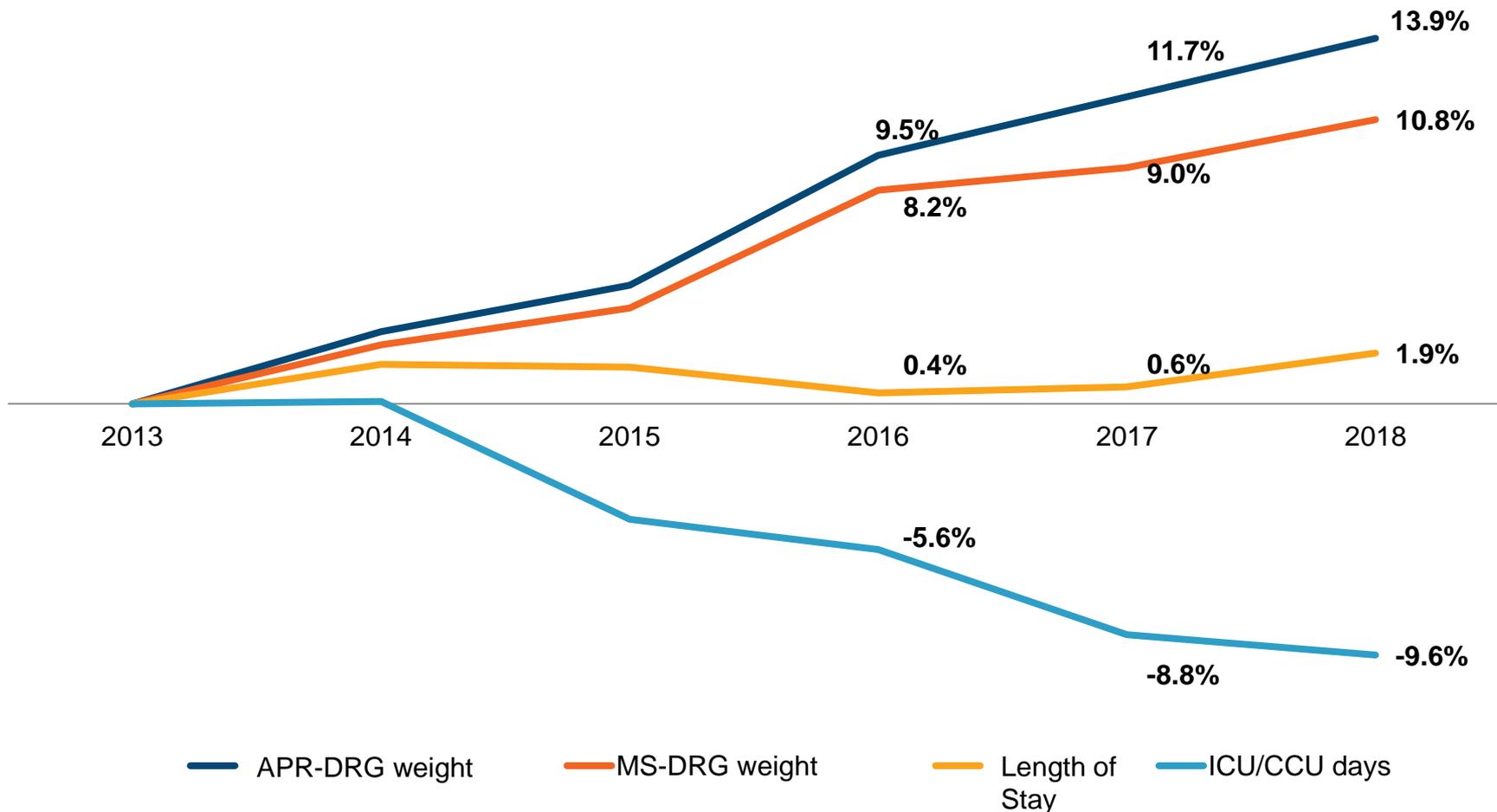
# Among COPD patients, DRG weights increased by 20% from 2013 to 2017, while other indicators of clinical severity did not increase.

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



# Private Insurers Can Have Mixed Incentives With Regard to Changes in Patient Acuity

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**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.

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- **Added costs** for patients and payers.
  - Due to increases in inpatient acuity between 2013 and 2017, Massachusetts incurred **~\$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

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### 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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  - CHART Program Impact Brief
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# DataPoints, Issue #14: The Price is Right? Variation in Potential Out-of-Network Provider Payment Benchmarks



## Background

- 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.

# DataPoints Issue #14: Research Methods & Takeaways

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## Research Methods

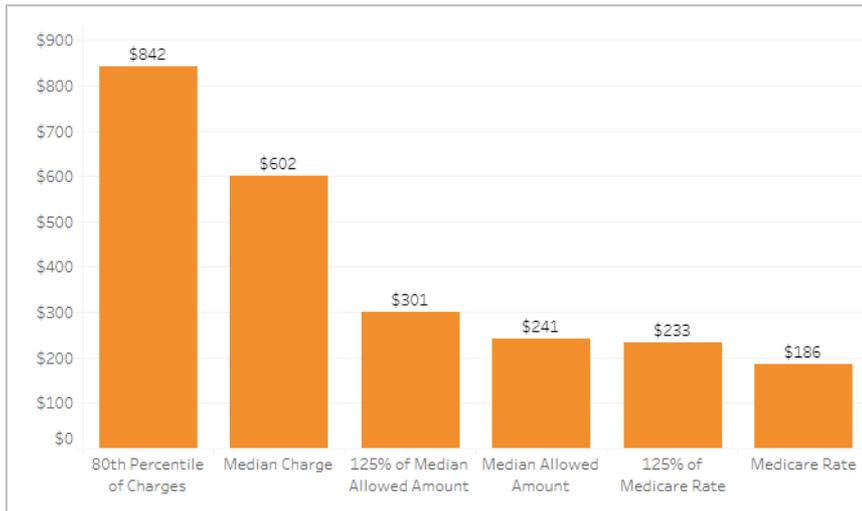
- Payment benchmarks are typically based on **charges** (i.e., list prices), negotiated **“allowed amounts”** for in-network providers, and/or **Medicare** rates; the HPC analyzed six potential payment benchmarks often used in other states or legislative proposals.
- The specific procedure codes were chosen because they are more likely than others to occur in surprise billing scenarios; **“ERAP” providers**<sup>1</sup> 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](#).

## Takeaways

- 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).

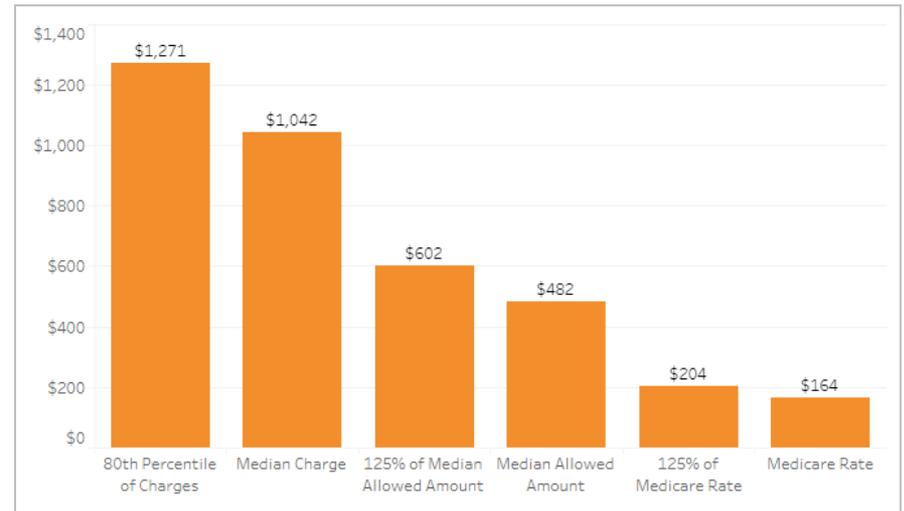
# The HPC found significant variation among different payment benchmarks, with those based on charges typically 2-3x higher than the median allowed amount.

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



- Payment at the 80<sup>th</sup> 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 80<sup>th</sup> 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 80<sup>th</sup> percentile of charges is over 7.5 times higher than Medicare).



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# CHART Program Impact Brief

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.

**MASSACHUSETTS HEALTH POLICY COMMISSION**

## CHART Investment Program

Engaging Patients, Building Partnerships, and Transforming Care

**The CHART Investment Program**

The Massachusetts Health Policy Commission (HPC) launched the Community Hospital Acceleration, Revitalization, and Transformation (CHART) program in 2014. The goal was to establish the foundation for sustainable care delivery transformation through innovative investments in the Commonwealth's community hospitals. The program was funded through an assessment established in Massachusetts' landmark health care cost containment law, Chapter 224 of the Acts of 2012.

Community hospitals are vital providers of care in their communities, often serving patients with a variety of medical, behavioral health, and social needs. This role gives them a unique opportunity to leverage investment support and make improvements that have the potential to both enhance patient care and reduce overall health care costs for the Commonwealth.

The CHART program invested approximately \$70 million in 30 community hospitals through two phases of funding. Combined with hospital in-kind contributions, the total program investment exceeded \$85 million. The funds enabled the hospitals to assess local needs, modify services, and expand relationships with medical, social, and behavioral health community organizations. The investment was critical in helping community hospitals transition into the new era of value-based care.

**From Traditional Care to CHART Care**

**Medical Model**  
**In-Hospital Care**  
**Fee for Service**  
**Limited Use of IT**

**GOAL 1**  
Integrated Medical, Behavioral Health, and Social Services

**GOAL 2**  
Care in the Community

**GOAL 3**  
Value-Based Care

**GOAL 4**  
Better Data and Analytics

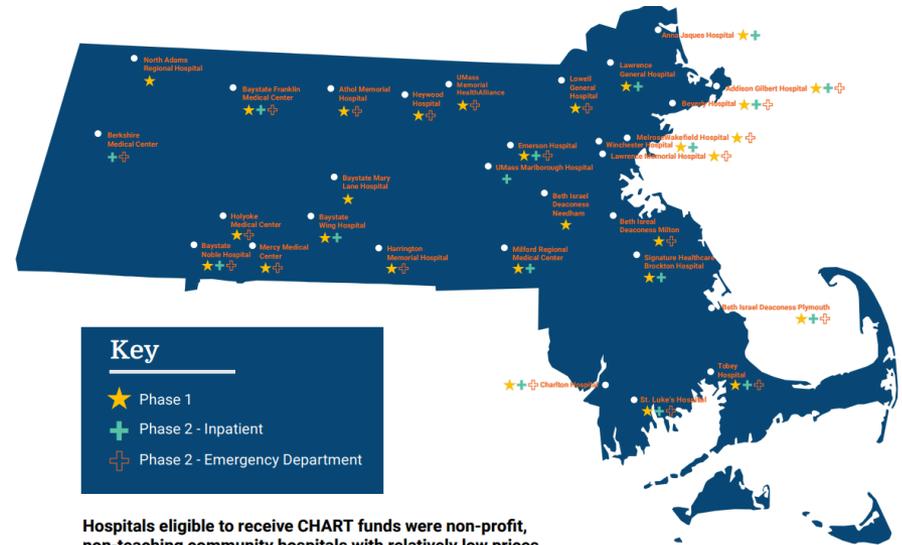
**Phase 1: 2014, \$10 million, 28 awards**  
 CHART hospitals engaged in business planning, capacity building, and program piloting to prepare for implementing their full CHART programs.

**Phase 2: 2015-2018, \$60 million, 24 awards**  
 CHART hospitals implemented innovative new care models requiring significant transformation in their delivery.

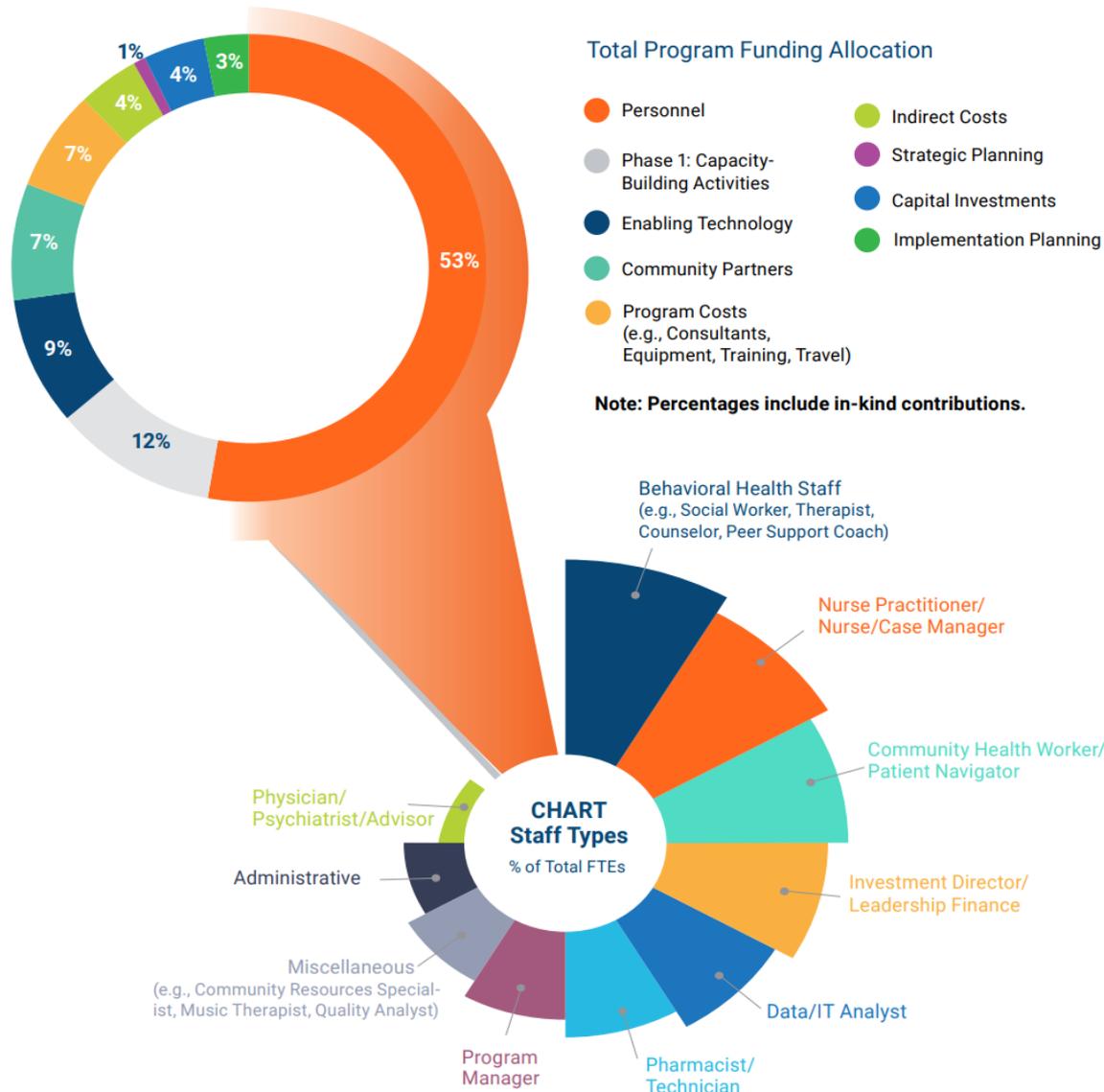
**20** awardees met or made significant improvement toward their target aims, such as reducing hospital readmissions and/or emergency department revisits by at least 20%.

“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



# CHART Program: Goals and Achievements



## GOAL 1:

Deliver Integrated Care Across Medical, Behavioral Health, and Social Needs



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

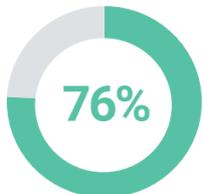
~10,000

**fewer ED visits** at CHART hospitals than expected over the 24-month program.<sup>2</sup>



## GOAL 3:

Prepare to Succeed in Value-Based Care Models



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



## GOAL 4:

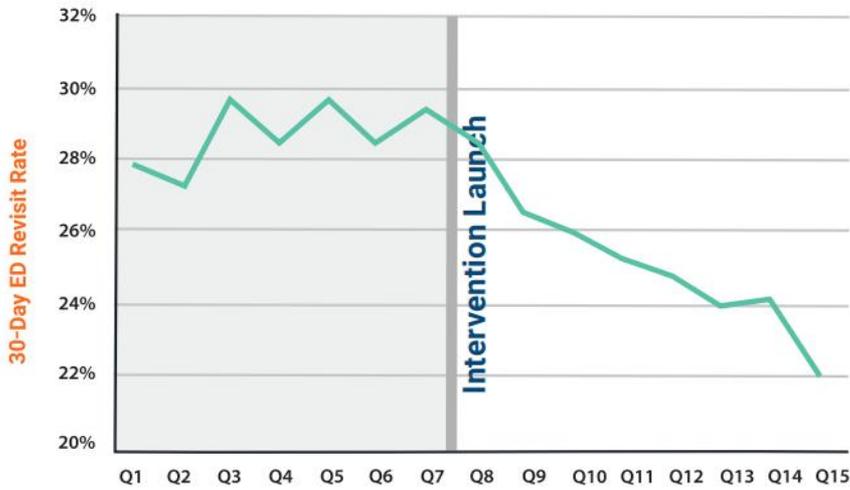
Use Data and Analytics to Better Serve Patients

24

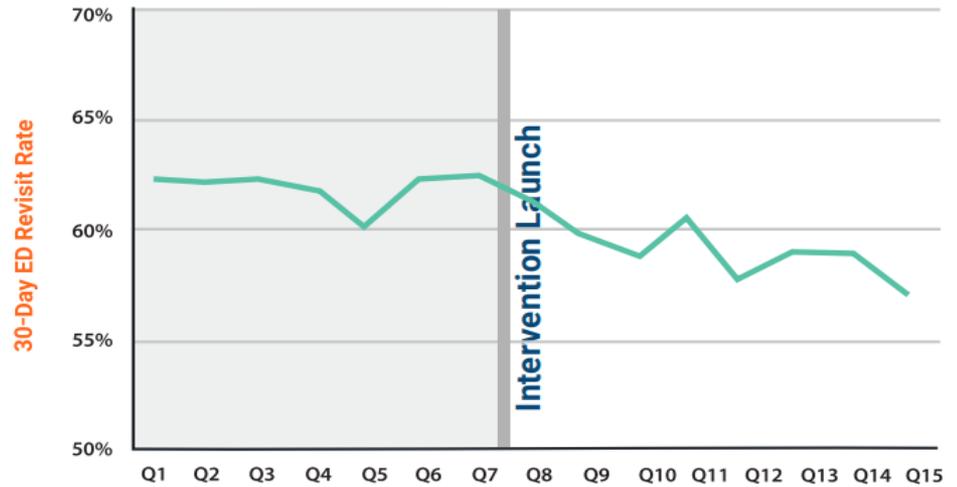
awardees invested in a case management platform to track target population patients, measure services delivered by CHART team members, and generate reports.

# CHART Program: Impact on Reducing Acute Care Utilization

## 30-Day ED Revisits: Any BH Diagnosis



## 30-Day ED Revisits: High Utilizers



20

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

Signature Brockton

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**

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- 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

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### 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.

## Statutory Language Directing the HPC to Complete a Study on Use of Prescription Drug Coupons in the Commonwealth

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.

Print a **\$10** coupon\*  
now!

Ready to save on ADVIR<sup>®</sup> without registering, you can print a coupon to save up to \$10 on your next prescription.

- Bring the coupon and your prescription to your pharmacy
- Offer can only be redeemed once per month
- Coupon expires 45 days after the date you print it

**\$0 Co-pay Offer**  
on Your Next MULTAQ<sup>®</sup>  
Prescription\*

RxBIN: 61052  
RxPProv: Loyal  
RxGR: 507777  
ISSUE: (0840)  
ID: XXXXXXXXXX  
Expires: 12/31/2019

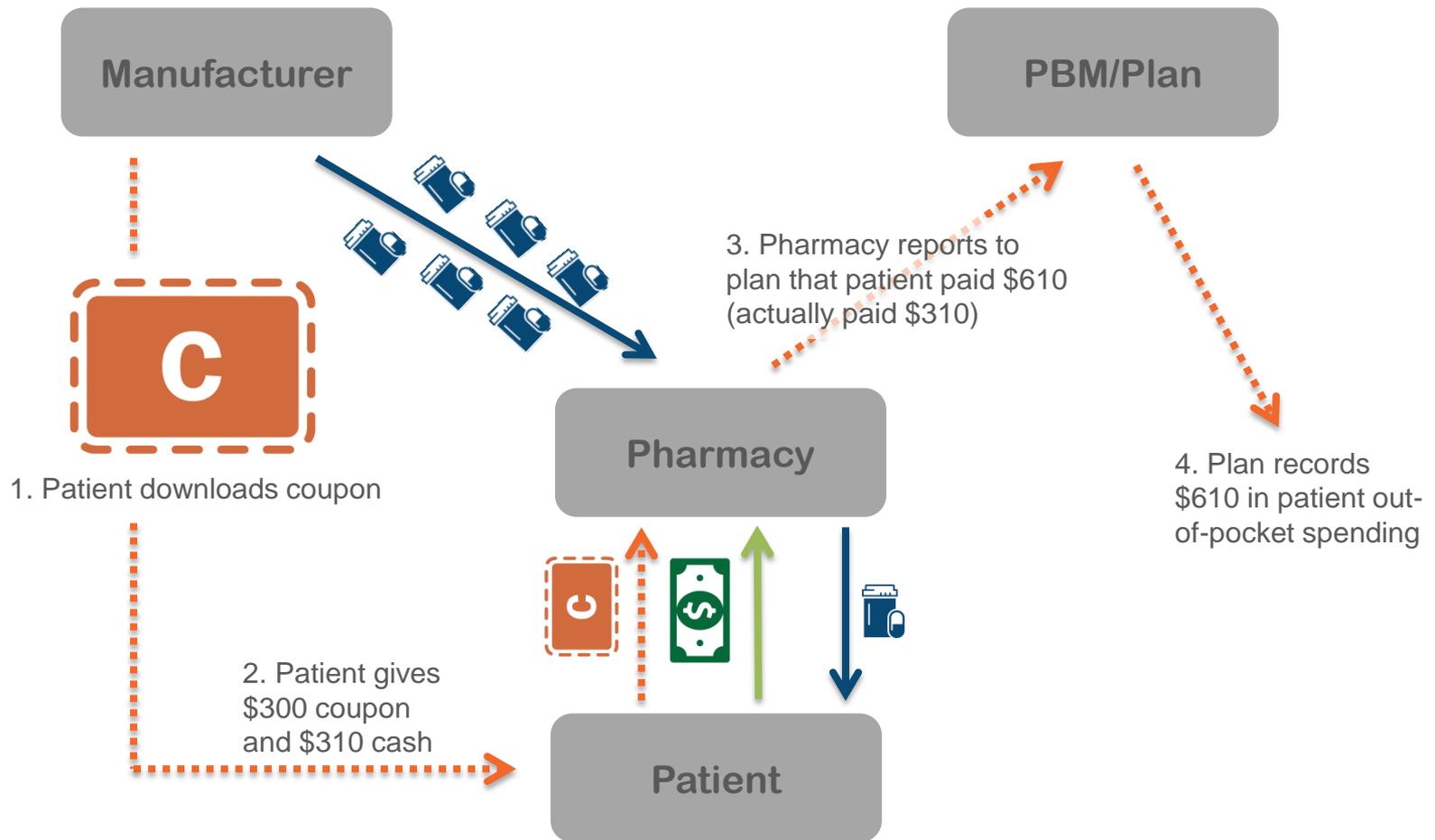
MULTAQ<sup>®</sup>  
(dronedarone) 400<sup>mg</sup> Tablets

\*Eligible commercially insured patients may receive a savings of up to \$300 per monthly fill, up to 12 fills. Maximum annual benefit of \$3,000. Eligible cash patients may receive a savings of up to \$150 per monthly fill, up to 12 fills. Maximum annual benefit of \$1,050. Sonofi US reserves the right to rescind, revoke, or amend this offer without notice. Certain restrictions apply. See details on back of card.

Please see Medication Guide and Full Prescribing Information including boxed WARNING that accompanies the kit.

# Flow of Drug Coupons in Patient Out-of-Pocket Spending

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



## Data Sources Used for HPC Drug Coupon Research

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- 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)<sup>®</sup> 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.

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- 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

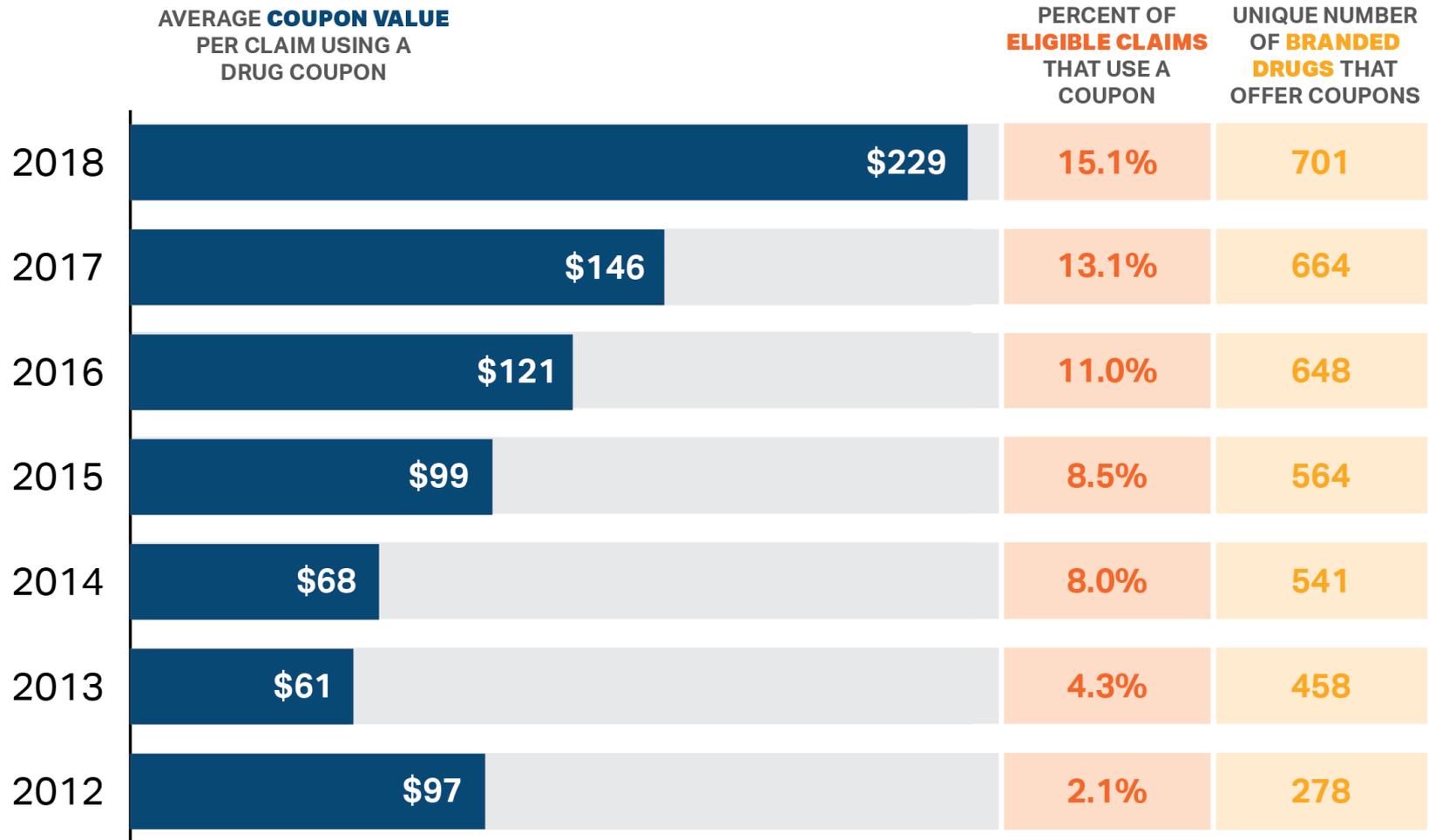
## DISTRIBUTION OF COUPON VALUE IN 2018



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.

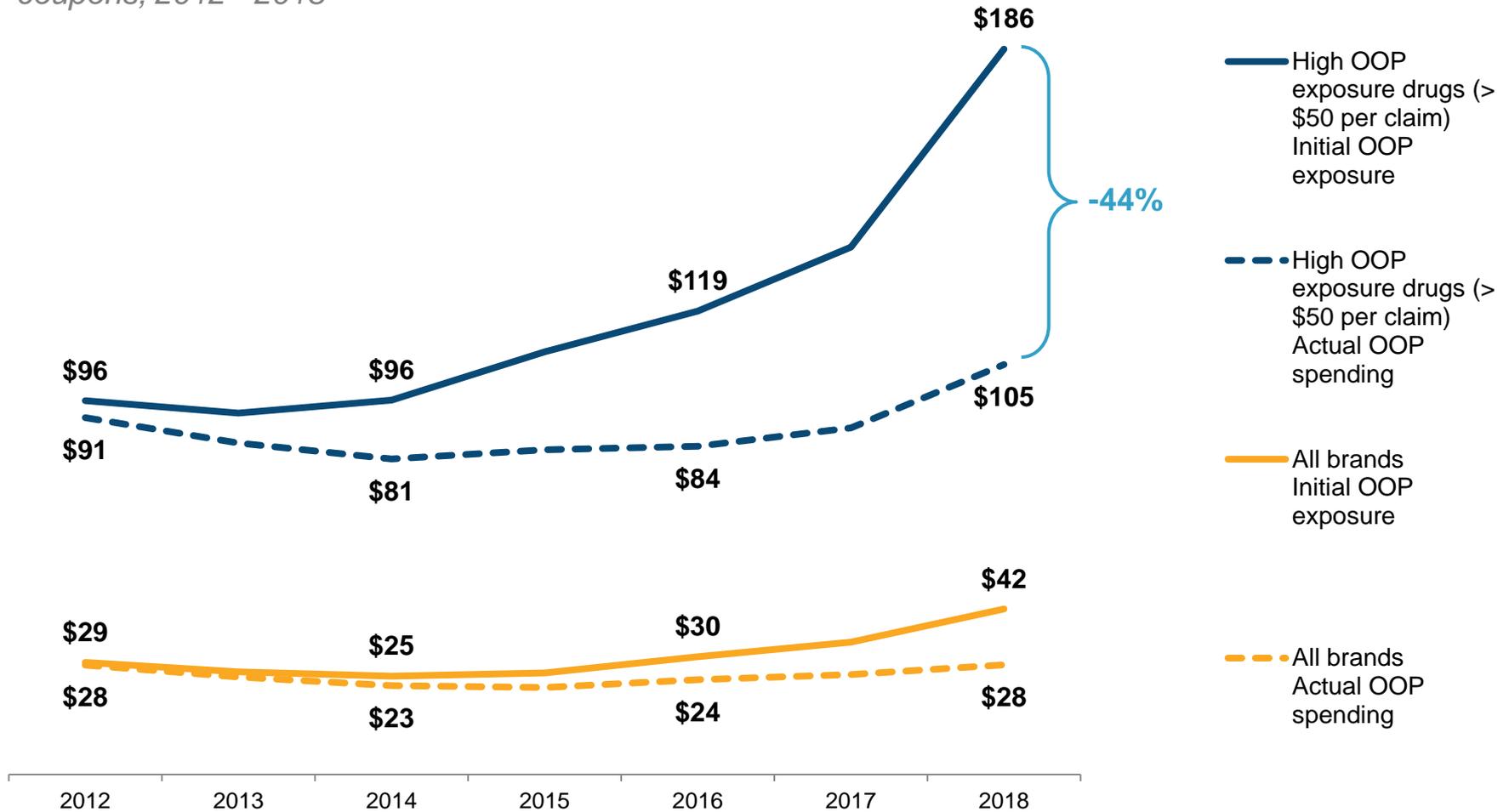
# Coupon programs and their uptake have expanded in Massachusetts since 2012, and average coupon values continue to rise.

*Average coupon value per claim using a drug coupon, 2012 - 2018*



# 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

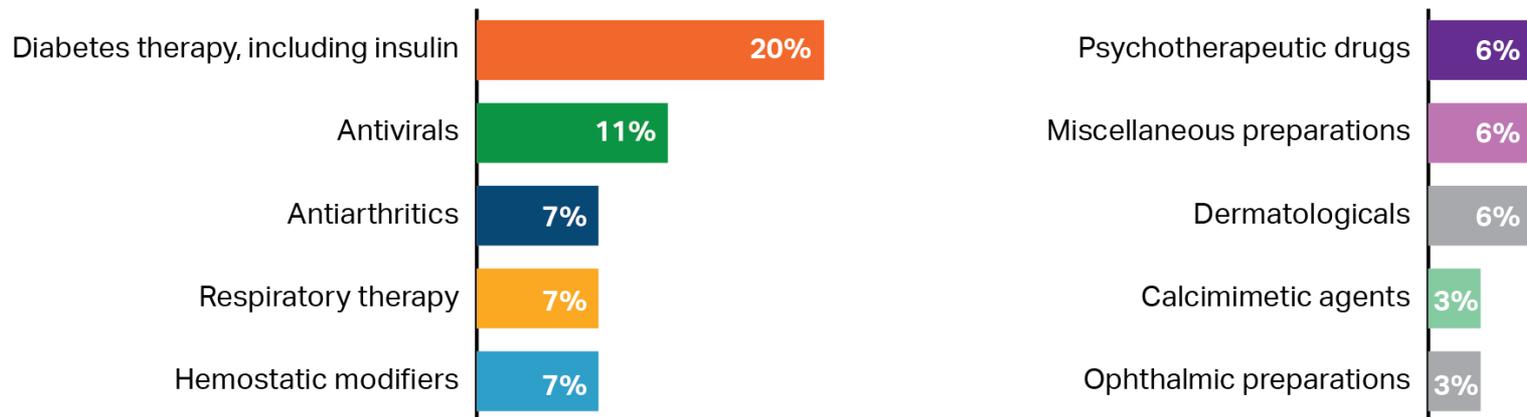


# Top Drugs by Total Volume of Coupons Used in Massachusetts, 2018

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

## Top therapeutic categories of coupon use by volume

*Percent of total coupon volume*



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

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- **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)



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# **SAVE THE DATE**

## **2019 HEALTH CARE COST TRENDS HEARING**

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TUESDAY, **OCTOBER 22** AND WEDNESDAY, **OCTOBER 23**  
**SUFFOLK UNIVERSITY LAW SCHOOL**  
120 TREMONT STREET, BOSTON, MA 02108

# 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*



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  - FY 2019 Summary
  - FY 2020 Proposal
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### Statutory Authority

Chapter 41 of the Acts of 2019, ***An Act Making Appropriations for the Fiscal Year 2020 for the Maintenance of the Departments, Boards, Commissions, Institutions and Certain Activities of the Commonwealth, for Interest, Sinking Fund and Serial Bond Requirements and for Certain Permanent Improvements***, (the “Budget”) was signed by Governor Baker on July 31, 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

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### 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

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### 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

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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**.

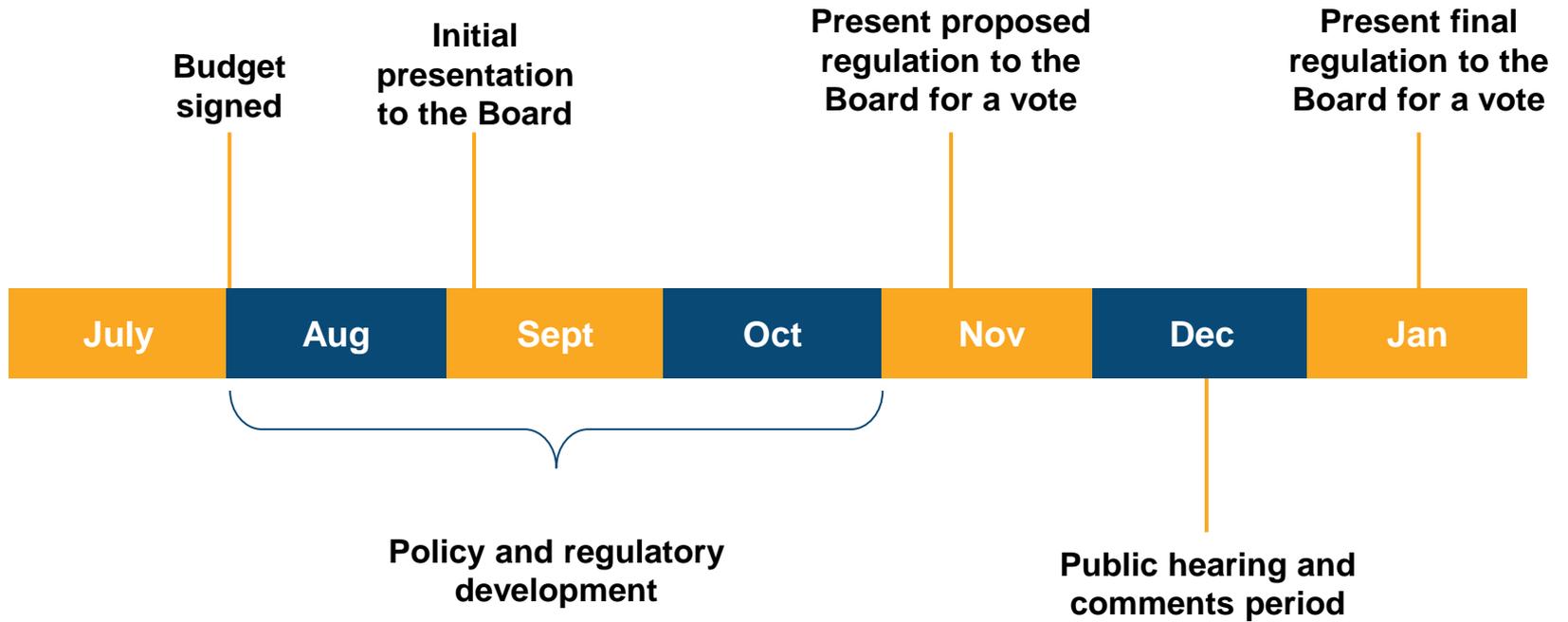
## The HPC Process

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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



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**



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# FY 2019 Summary: Funding Sources and Projected Spending

## Annual State Budget Sources

1

### 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

2

### 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

## Trust Fund Sources

3

### Distressed Hospital Trust Fund

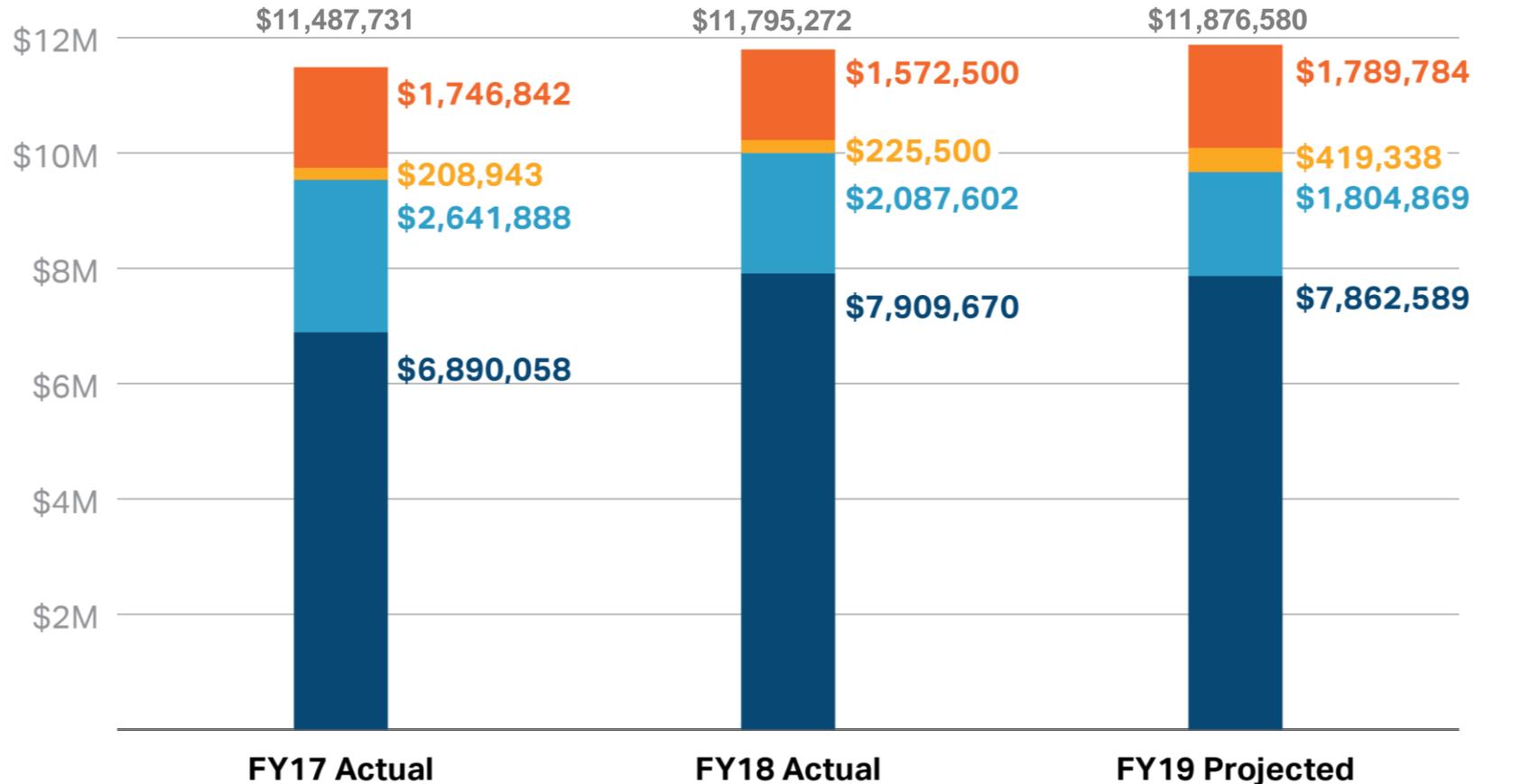
- Board-approved budget: **\$2,188,373**
- Projected Spending: **\$1,804,869**
- Main use: Grant administration, technical assistance, and evaluation activities for CHART-eligible investments

4

### 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.



■ HPC Line-Item    
 ■ Distressed Hospital Trust Fund    
 ■ Payment Reform Trust Fund    
 ■ Fringe



\*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)

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



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**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.**

## State Budget Process

### **Governor's FY 2020 Budget Proposal**

1450-1200: *For the operation of the Health Policy Commission...* \$9,003,931

### **House FY 2020 Budget Proposal**

1450-1200: *For the operation of the Health Policy Commission...* \$9,036,682

1450-1200: *For a program to evaluate and reduce pregnancy-related deaths and improve pregnancy outcomes in the commonwealth...* \$500,000

### **Senate FY 2020 Budget Proposal**

1450-1200: *For the operation of the Health Policy Commission...* \$9,032,999

1450-1200: *For a childhood grant program to support and care for families with substance exposed newborns...* \$300,000

### **Final Budget – Chapter 41 of the Acts of 2019**

1450-1200: *For the operation of the Health Policy Commission...* \$9,036,682

1450-1200: *For a childhood grant program to support and care for families with substance exposed newborns...* \$300,000

1450-1200: *For a program to evaluate and reduce pregnancy-related deaths and improve pregnancy outcomes in the commonwealth...* \$500,000

## Budget Overview: Summary of FY 2020 Budget Proposal

Source of Funds	1 Line Item	2 Supplemental Line Item Programs	3 Payment Reform Trust Fund	4 Distressed Hospital Trust Fund
Approved Budget	\$9,036,682	\$800,000	\$1,000,000	\$1,050,894
Use	General operating expenses	Targeted improvement investments (maternal health/SEN newborns)	HPC's Health Care Innovation Investment program and ACO technical assistance (no payroll)	Operating expenses related to DHTF-supported grant programs
Summary	Modest <b>3% increase</b>	Two new grant/research opportunities	<b>Level-funding</b> to the FY19 Board-approved budget	<b>52% reduction</b> to the FY19 Board-approved budget

## FY 2019 – FY 2020 Line Item Appropriation Crosswalk

Category	Approved FY 2019 Spending	Proposed FY 2020 Spending	Difference (FY 2020 minus FY 2019)
Payroll	\$5,447,546	\$5,913,339	\$465,793
Rent/Utilities	\$626,500	\$620,000	(\$6,500)
Professional Services and ISAs	\$2,269,000	\$2,050,000	(\$219,000)
Admin/IT Support	\$426,885	\$453,343	\$26,458
<b>Line Item Total</b>	<b>\$8,769,931</b>	<b>\$9,036,682</b>	<b>\$266,751</b>

### 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

Category	Approved FY 2019 Spending	Proposed FY 2019 Spending	Difference (FY 2019 minus FY 2018)
Payroll	\$613,234	\$342,000	(\$271,234)
Rent/Utilities	\$112,500	\$95,000	(\$17,500)
Professional Services and ISAs	\$1,049,552	\$400,000	(\$649,552)
Admin/IT Support	\$81,750	\$45,000	(\$36,750)
State Comptroller Assessment	\$121,323	\$40,000	(\$81,323)
Employee Fringe Assessment	\$210,014	\$128,894	(\$81,120)
<b>Totals</b>	<b>\$2,188,373</b>	<b>\$1,050,894</b>	<b>(\$1,137,479)</b>

### 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.

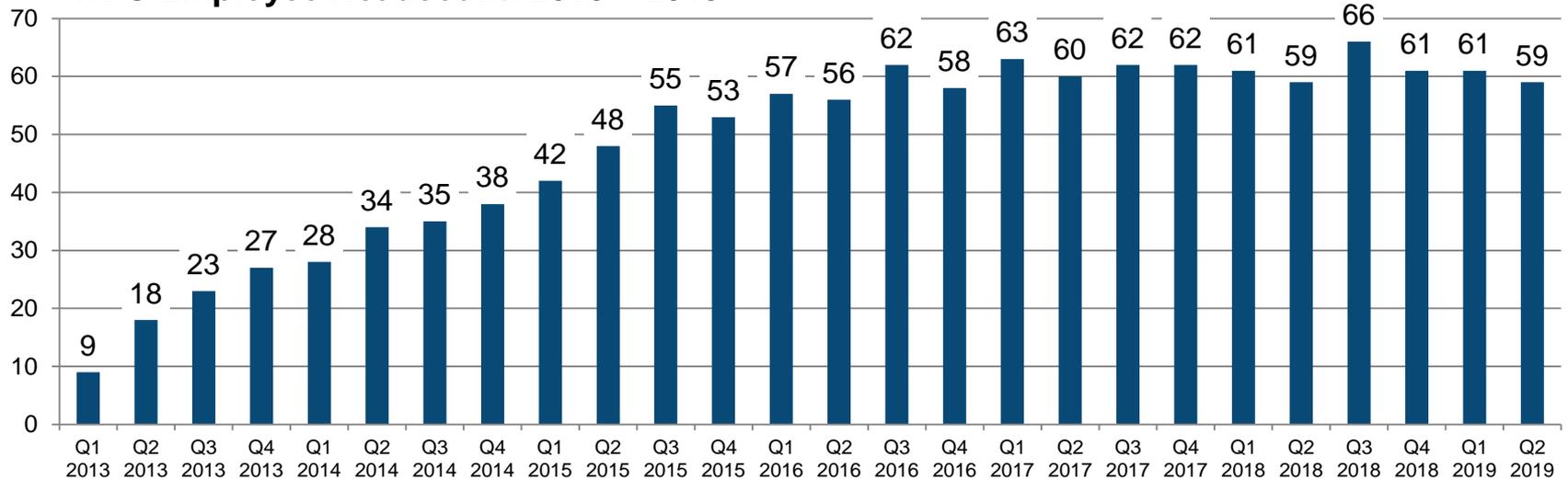
\*Note: This table does not reflect direct grant spending to providers through the CHART and Health Care Innovation Investment program. These allocations were approved separately from the annual budget.

## FY 2020 Interagency Service Agreements (ISAs)

Interagency Service Agreements (FY19)				
Agency	Funds Flow	Purpose	FY20 Amount	End Date
DPH	HPC to DPH	Implementation and evaluation of HPC's Neonatal Abstinence Syndrome (NAS) investment initiative	\$70,000	6/30/2020
EOHHS	HPC to EOHHS	HPC's financial contribution towards the MassHealth Patient Experience Survey	\$290,000	6/30/2020
EOHHS	HPC to EOHHS	HPC's financial contribution toward EOHHS' quality measurement alignment Task Force, supporting an expert facilitator	\$25,000	6/30/2020

# 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\***



## FTE by Department, September 1, 2019

Care Transformation and Innovation	17
Market Oversight and Transparency	10.4
Research and Cost Trends	7.4
Internal/External Operations + EXEC	14.2
Legal/Office of Patient Protection	10
<b>Total FTE</b>	<b>59</b>

\*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](mailto:HPC-Info@mass.gov)



## Special Events

**2019 Cost Trends Hearing**  
Day 1 – Tuesday, October 22  
Day 2 – Wednesday, October 23



**MASSACHUSETTS**  
HEALTH POLICY COMMISSION

# APPENDIX

## Top Drugs by Coupon Penetration Represented by Dermatology and Antiarthritic Therapies, Among Other Therapeutic Categories

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

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

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

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.

Source: Symphony Health IDV® database, 2018