

2023

**ANNUAL HEALTH
CARE COST
TRENDS REPORT
POLICY RECOMMENDATIONS**



MASSACHUSETTS
HEALTH POLICY COMMISSION

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2023 HEALTH CARE COST TRENDS RECOMMENDATIONS

This year marks a critical inflection point in the Commonwealth's ambitious journey of health care reform which has made it a national policy leader. As documented in this 10th annual HPC report, there are many alarming trends which, if unaddressed, will result in a health care system that is unaffordable for Massachusetts residents and businesses, including:

- Massachusetts residents have high health care costs that are consistently increasing faster than wages, exacerbating existing affordability challenges that can lead to avoidance of necessary care and medical debt, and widening disparities in health outcomes based on race, ethnicity, income, and other factors. These high and increasing costs are primarily driven by high and increasing prices for some health care providers and for pharmaceuticals, with administrative spending and use of high-cost settings of care as additional drivers.
- Massachusetts employers of all sizes, but particularly small businesses, are confronting ever-rising premiums by shifting costs to employees through high deductible health plans. As a result, many employees are increasingly at risk of medical debt, relying on state Medicaid coverage, or are becoming uninsured, an alarming signal of the challenges facing a core sector of the state's economy.
- Many Massachusetts health care providers across the care continuum continue to confront serious workforce challenges and financial instability, with some providers deciding to reduce services, close units (notably pediatric and maternity hospital care) or consolidate with larger systems. The financial pressures faced by some providers are driven, in part, by persistent wide variation in prices among providers for the same types of services (with lower commercial prices paid to providers with higher public payer mix) without commensurate differences in quality or other measures of value.

It is imperative that the state take action to enhance our high-quality health care system in Massachusetts such that it is also an affordable and equitable one. In this report, the HPC has outlined several areas of excess spending related to unreasonably high prices, avoidable use of high-cost care settings, and services that confer little to no benefit to patients – all of which have the potential to reduce total health care spending while maintaining the quality that residents deserve. A renewed commitment by all stakeholders is needed to redirect resources away from unwarranted excess spending that benefits the few and towards efforts to

revitalize the health care system that benefit the many, consistent with the Commonwealth's values and goals.

The **nine policy recommendations** below reflect a comprehensive approach to reduce health care cost growth, promote affordability, and advance equity. The HPC further recommends that legislative action in 2023 and 2024 prioritize modernizing and evolving the state's policy framework, necessary to chart a path for the next decade.

POLICY RECOMMENDATIONS

1. **MODERNIZE THE COMMONWEALTH'S BENCHMARK FRAMEWORK TO PRIORITIZE HEALTH CARE AFFORDABILITY AND EQUITY FOR ALL**
2. **CONSTRAIN EXCESSIVE PROVIDER PRICES**
3. **ENHANCE OVERSIGHT OF PHARMACEUTICAL SPENDING**
4. **MAKE HEALTH PLANS ACCOUNTABLE FOR AFFORDABILITY**
5. **ADVANCE HEALTH EQUITY FOR ALL**
6. **REDUCE ADMINISTRATIVE COMPLEXITY**
7. **STRENGTHEN TOOLS TO MONITOR THE PROVIDER MARKET AND ALIGN THE SUPPLY AND DISTRIBUTION OF SERVICES WITH COMMUNITY NEED**
8. **SUPPORT AND INVEST IN THE COMMONWEALTH'S HEALTH CARE WORKFORCE**
9. **STRENGTHEN PRIMARY AND BEHAVIORAL HEALTH CARE**

1. **MODERNIZE THE COMMONWEALTH'S BENCHMARK FRAMEWORK TO PRIORITIZE HEALTH CARE AFFORDABILITY AND EQUITY FOR ALL.** The state's health care cost growth benchmark, first established in 2012, is a measurable goal for moderating total spending growth and easing the burden of health care costs on government, households, and businesses in Massachusetts. Building on this approach which has successfully moderated cost growth in Massachusetts and which other states have adopted and expanded upon, the Commonwealth can establish a more comprehensive framework for setting goals and tracking progress on other priorities, such as affordability and health equity. A modernized, aligned framework should:

a. Strengthen the Health Care Cost Growth Benchmark.

As recommended in past years, the Commonwealth should strengthen and improve the mechanisms for holding health care entities responsible for health care spending performance to support the Commonwealth's efforts to meet the health care cost growth benchmark. These collective fixes to the benchmark and its accountability mechanisms are critically necessary to establish a more effective process to constrain excessive spending. Specifically, the Legislature should strengthen the existing health care cost growth benchmark framework by:

- i. Directing CHIA to use metrics in addition to growth in health status adjusted total medical expense (HSA TME) to refer entities to the HPC for review and a potential performance improvement plan (PIP). Such a change would enable CHIA to refer entities other than payers and providers with primary care networks (e.g., hospitals and specialists) to the HPC and would ensure that real dollar spending increases are not masked by medical coding efforts that reduce growth rates in health status adjusted measures;
- ii. Directing CHIA to develop referral standards that recognize that health care entities vary considerably in their baseline spending levels, pricing levels, and populations served, and that reflect that spending growth may be more or less concerning for a given entity based on these contextual factors;
- iii. Requiring that referrals of entities to the HPC for review and a potential PIP be made public; and
- iv. Strengthening the PIP process to allow the HPC to set savings target expectations and identify the types of strategies that should be included in a PIP, to give the HPC greater oversight tools to ensure that any PIP results in meaningful improvement on the most important factors driving spending for a given entity, and to further deter excessive spending by allowing the HPC to apply tougher, escalating financial penalties for above-benchmark spending or non-compliance, similar to efforts in other states with health care growth targets.

These collective fixes to the benchmark and its accountability mechanisms have been detailed in previous Cost Trends Reports and are critically necessary to establish a more effective process to constrain excessive health care spending and allow resources to be directed to other important priorities that also impact the health and well-being of Massachusetts residents.

b. Establish New Affordability Benchmark(s). While health care spending by public and private health care payers moderated in the years following the enactment of Massachusetts' health care cost growth benchmark, health insurance premiums and cost-sharing by individuals and families have frequently increased in excess of the benchmark. To both complement and bolster the health care cost growth benchmark, the Commonwealth should develop an accountability framework for affordability of care for Massachusetts residents. As part of a strategy that tracks improvement on indicators of affordability, including the differential impact of both health plan premiums and consumer out-of-pocket spending by income, geography, market segment, and other factors, an affordability index should be measured annually in a benchmark-like process. To enable public transparency and accountability, the state's performance on the affordability index and other measures should be incorporated into CHIA's Annual Report and the HPC's Annual Cost Trends Hearing. Such targets should inform the development of new health plan affordability standards at the Division of Insurance (DOI) that play a central role in DOI's review and approval of health plan rates.

c. Establish New Health Equity Benchmark(s). To further embed the goal of advancing health equity in the state's policy framework, the Commonwealth should undertake a coordinated effort across state agencies and sectors, both in health care and in other key sectors that influence health and well-being such as education, housing and social services, to identify high-priority areas of health inequities, set measurable goals for improvement, develop a framework for accountability, and report annually on progress. To enable public transparency and accountability, the state's performance on health equity benchmark(s) and other measures should be incorporated into CHIA's Annual Report and the HPC's Annual Cost Trends Hearing.

2. CONSTRAIN EXCESSIVE PROVIDER PRICES. Prices continue to be a primary driver of health care spending growth in Massachusetts, and the significant variation in prices between Massachusetts providers for the same sets of services (without commensurate differences in quality) continues to divert resources away from smaller and/or unaffiliated community providers, many of which serve vulnerable patient populations toward generally larger and more well-resourced systems. These high and variable prices have been highlighted in more than a decade of work by the HPC and other state agencies. Past market initiatives (e.g., tiered and narrow network products, price transparency efforts, risk contracting) have failed to

meaningfully restrain provider price growth or reduce unwarranted variation in provider prices in Massachusetts, and many states (e.g., Rhode Island, Oregon, Colorado, and Maryland) are similarly recognizing that some level of price regulation, rather than market initiatives alone, may be necessary to ensure an equitable and affordable health care system. Accordingly, the HPC recommends the following actions:

a. Limit Excessive Provider Prices. The Legislature should take action to limit excessive commercial provider prices beyond reasonable benchmark amounts, as illustrated in this report. Such limits could target prices with the greatest impact on spending, as well as annual price growth. Such price limits—targeted specifically at the highest-priced providers and those services for which competitive forces are not likely to meaningfully constrain prices—would be an important complement to the health care cost growth benchmark. Such limits would reduce unwarranted price variation and promote equity by ensuring that future price increases can accrue appropriately to lower-priced providers including many community hospitals, community health centers, and other providers that care for populations facing the greatest health inequities, ensuring the viability of these critical resources.

b. Require Site-Neutral Payment. Many routine health care services are safely provided in both hospital outpatient departments and non-hospital settings such as physician offices. Commercial prices and patient cost-sharing are generally substantially higher (often twice as high or more) at hospital outpatient sites due to the addition of a hospital payment component or “facility fee.” In many cases, patients may not realize that pricing can be substantially higher at some sites (those licensed as hospital outpatient departments), and face higher costs as a result. To limit higher prices related to hospital/physician consolidation and enhance consumer protections, policymakers should take action to require site-neutral payments for certain ambulatory services that are commonly provided in office-based settings (e.g., office visits, lab tests, basic imaging and diagnostic services, and clinician-administered drugs). Additionally, remaining outpatient sites that charge facility fees should be required to disclose this fact conspicuously and clearly to patients prior to delivering care, and payers and providers should include the location where the visit occurred, including whether it was an on-or off-campus hospital outpatient department, on claims submitted to payers and reported to CHIA’s Massachusetts All-Payer Claims Database.

c. Adopt Default Out-of-Network Payment Rate. To further constrain excessive provider prices, the Legislature should enact the default out-of-network payment rate for “surprise billing” situations recommended by the Executive Office of Health and Human Services in its 2021 report. Data from early implementation of the arbitration process established by the federal No Surprises Act (to resolve out-of-network provider payment disputes) demonstrate significant administrative challenges and disadvantages of relying on the federal arbitration process. The Commonwealth should join other states that have enacted a default rate for the fully insured market, with a potential opt-in for self-insured plans. A default rate would provide predictability, transparency and simplicity, and reduce health care spending in Massachusetts. Establishing a default out-of-network rate is also a critical component of a policy response to unwarranted provider price variation.

3. ENHANCE OVERSIGHT OF PHARMACEUTICAL SPENDING.

Retail drug spending has become one of the fastest areas of spending growth in the Commonwealth, growing at an annualized rate of 7.5% between 2019 and 2020. This is largely driven by escalating prices for the highest cost branded prescription drugs. Some patients who need high-cost branded drugs are experiencing steep increases in their out-of-pocket expenses as health plans design benefit packages that shift rising pharmacy costs back to patients in the form of specific medication deductibles or specialty tiers with coinsurance or high co-pays, or face barriers to prescribed care due to utilization management designed to limit access to treatments. Without any additional oversight or regulatory tools, high drug prices will continue to shape patient access through barriers related to health plan benefit designs, and pharmacy costs will continue to steadily increase, driving individuals and employers to purchase more restrictive plans that aggressively manage pharmacy spending through cost sharing and utilization management. Accordingly, the HPC recommends the following actions:

a. Enhance Oversight/Transparency and Data Collection. At minimum, the Commonwealth should take action to increase both transparency of drug price growth and spending and oversight of the key stakeholders responsible for setting drug prices and establishing the policies that influence how patients access critical medications. The Commonwealth should add pharmaceutical manufacturers and pharmacy benefit managers explicitly into the HPC’s oversight responsibilities, and authorize CHIA to collect data on pharmaceuticals from payers and pharmacy benefit managers (PBMs), including the average cost of pharmaceuticals

after all discounts and rebates; prices on average charged by PBMs to health plans and paid to pharmacies by drug; and gross and net spending for drugs administered in provider offices and hospital outpatient departments, including through the 340B drug pricing program.

- b. PBM Oversight.** The state should also require licensure of PBMs in order to monitor their business practices with pharmacies and health plans, and their impact on patients.
- c. Expand Drug Pricing Reviews.** The Commonwealth should build on MassHealth’s successful process by exploring expansion of the HPC’s drug pricing review authority to other state and commercial payers such as the Group Insurance Commission in order to strengthen price negotiations by creating the pathway for a public escalation in negotiations that ultimately results in an investigation by the HPC if negotiations are unsuccessful.
- d. Limit Out-of-Pocket Costs on High-Value Drugs.** Finally, the Commonwealth should cap monthly out-of-pocket costs for high value prescription drugs that are widely recognized to improve health outcomes for patients with no or minimal impact on health care spending.

4. MAKE HEALTH PLANS ACCOUNTABLE FOR AFFORDABILITY.

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

- a. Enhance Scrutiny of Drivers of Health Plan Premium Growth.** State affordability targets should inform the DOI’s oversight of health plans and should be a key factor in the DOI’s review and approval of health plan rate filings. The Legislature should equip DOI with dedicated tools and resources to analyze drivers of health plan premium growth across market segments, including provider rate increases and administrative expenses, such as broker fees and contributions to reserves. The DOI should consider the need for additional reporting requirements and coordination with CHIA and the HPC and other agencies.
- b. Facilitate Small Business Enrollment in Massachusetts Connector Plans.** The small group market continues to shrink due, in part, to increasingly unaffordable premiums that outpace wage growth, leading to higher premiums, and higher rates of employee enrollment in MassHealth

or uninsurance. The HPC recommends further steps to facilitate enrollment of small business groups in plans via the Massachusetts Health Connector’s Health Connector for Business platform. These steps could include additional savings on premiums through enhanced Health Connector offerings, additional promotional efforts, reduction of enrollment barriers such as percentage-of-group participation requirements, and administrative facilitation such as automatic opt-out enrollment for the smallest employee groups in the Massachusetts small group market.

c. Improve Health Equity Through Premium Support for Employees with Lower Incomes.

As the number of Massachusetts consumers with high-deductible health plans (HDHPs) has sharply increased, the HPC has documented increasing challenges to affordability, equitable access, and experience of care, particularly for employees with lower incomes. Total health care spending, including premiums and cost-sharing, consumes more than 20 percent of total compensation for middle class families, squeezing household budgets. Employers and health plans could improve health equity by reducing premium contributions for lower wage workers via tax credits or wage-adjusted contributions.

d. Alternative Payment Methods (APMs).

Health plans should continue to promote the increased adoption and effectiveness of APMs (e.g., increased use of primary care capitation, APMs for preferred provider organization populations, episode bundles, and two-sided risk models), especially in the commercial market where expansion has stalled. Plans should leverage multi-payer alignment opportunities, to unify APMs across MassHealth, Medicare, and commercially-insured populations for participating practices.

5. ADVANCE HEALTH EQUITY FOR ALL.

A recent study by the Blue Cross Blue Shield of Massachusetts Foundation estimated that the economic burden of health inequities experienced by Black, Hispanic/Latino, and Asian populations in Massachusetts totaled \$5.9 billion each year, and that “about one-quarter of this burden, is associated with avoidable health care spending, which translates to approximately 2.2 percent of total medical spending in Massachusetts.” Achieving health equity for all will require focused, coordinated efforts among policymakers, state agencies, and the health care system to ensure that the Commonwealth addresses inequities in both the social determinants of health (SDOH) and in health care delivery, as well as the impacts of those inequities on residents. As such, all stakeholders should have both a role in and accountability for efforts to achieve health equity for all.

a. Address Social Determinants of Health. Recognizing that the Commonwealth's health equity goals will be difficult to achieve without addressing inequities in the SDOH, policy-makers must continue to prioritize investments in such areas as affordable housing, improved food and transportation systems, and climate change reduction and mitigation strategies. Health care providers can contribute meaningfully to these efforts as anchor institutions, supporting community-led initiatives to respond to these and other social determinants.

b. Use Payer-Provider Contracts to Advance Health Equity. Payers and providers should continue adopting and building on current efforts to create accountability for health equity via payer-provider contracts, including by requiring stratification of performance data by race/ethnicity and tying payment to performance on health equity targets. APM contracts, in particular, offer opportunities to align incentives to motivate investments in services and infrastructure (e.g., care coordination, integrated technology, and performance reporting) aimed at addressing health inequities within patient populations.

c. Improve Data Collection. To implement these health equity goals, policymakers, providers, and payers should commit to the adoption of the data standards recommended by the Health Equity Data Standards Technical Advisory Group of the EOHHS Quality Measurement Alignment Taskforce. Universal adoption of these standards would enable efficient and consistent collection of reliable, standardized patient data on race, ethnicity, language, disability status, sexual orientation, gender identity, and sex to inform the integration of equity considerations into quality improvement, cost-control, and affordability initiatives.

d. Support Investment in Innovative Strategies to Address Health Equity. To support providers in developing innovative solutions to achieving health equity, the Legislature should expand the approved uses of the Distressed Hospital Trust Fund and Payment Reform Trust Fund to include supporting innovative initiatives focused primarily on addressing inequities in health and health care.

e. Reduce Inequities in Maternal Health. Despite the Commonwealth's strong overall performance in measures of maternal health, recent data indicate significant, persistent inequities in maternal health outcomes. As part of a broader effort to address these outcomes, the Commonwealth should ensure that efforts to address health care workforce challenges encompass investments to expand and diversify the workforce of doulas and midwives.

6. REDUCE ADMINISTRATIVE COMPLEXITY. Administrative complexity that does not add value permeates the Massachusetts health care system, from the wide array of plan options that are not easily comparable by consumers and employers, to non-standard contract terms and differing rules for provider credentialing, claims submission, and utilization management which consume significant provider time and resources. Prior authorization, often a multi-step, manual process, is particularly burdensome for providers and can result in patient challenges and delayed care, particularly for those with fewer resources. Standardizing among plans and streamlining processing can ease the administrative burden for providers, payers, and patients, and allow for the reallocation of health care resources to higher value tasks and improve equity.

a. Require Greater Standardization in Payer Processes. The Legislature should require standardization in payer claims administration rules and processes. In particular, the standardization requirements should focus on uniform medical necessity criteria and a uniform set of limited services appropriate for prior authorization.

b. Automate Prior Authorization. When prior authorization can be warranted to protect patient safety and avoid overuse, automation could streamline the prior authorization process by reducing uncertainty about prior authorization requirements and decreasing the time between prior authorization submission and decision. Efforts to automate prior authorization are already underway for certain public payers, as the proposed federal rule from the Centers for Medicare and Medicaid Services (CMS) would require certain public payers to automate their prior authorization processes by January 2026. The Legislature should build upon this momentum and mandate that others in Massachusetts, including commercial payers, automate their prior authorization processes according to a statewide roadmap, with technical and financial assistance, to support successful implementation.

c. Mandate Adoption of the Aligned Quality Measure Set. While the Quality Measure Alignment Taskforce has achieved substantial voluntary adoption of its standard, aligned quality measure set for use in global budget-based risk contracts, payer adherence remains variable, even after several years. To promote alignment and mitigate the reporting burden for providers, the Legislature should mandate adoption of the aligned measure set, as further refined by the Taskforce, and approved by the Secretary of Health and Human Services.

7. STRENGTHEN TOOLS TO MONITOR THE PROVIDER MARKET AND ALIGN THE SUPPLY AND DISTRIBUTION OF SERVICES WITH COMMUNITY NEED.

Recent health care market activity implicating both access and cost, including both closures and proposed expansions, have highlighted the need for a better understanding of the allocation of health care resources across the Commonwealth and its implications for quality, affordability, and equity of care. In addition, there is an opportunity to enhance the current regulatory framework to ensure equitable distribution of health care resources to address need. The HPC recommends enhancing regulator tools as follows:

- a. Conduct Focused Assessments of Need, Supply, and Distribution.** The Commonwealth should conduct focused, data-driven assessments of supply and distribution of services based on identified needs or disparities in outcomes. Such targeted assessments would identify specific provider types or service lines that warrant examination (e.g., obstetrics, outpatient substance use disorder treatment, inpatient pediatric care, oncology, etc.) and relevant regions and incorporate other factors in the public interest, such as populations served. Formal findings of an assessment could include designating a specific set of services or class of providers as critical to the proper functioning of the Massachusetts health care system, identifying barriers impacting accessibility of available supply by specific populations, and/or making recommendations to address misalignment of need, supply, and distribution.
- b. Strengthen Tools to Monitor and Regulate Supply of Health Care Services.** Massachusetts' existing frameworks for monitoring and regulating provider supply and distribution, including its Determination of Need (DoN) Program, Essential Services Closures process, and Material Change Notice (MCN) process can be strengthened as follows:
 - i. Better Equip the State to Monitor and Respond to Essential Service Closures.** The Essential Services process could be improved with enhanced financial monitoring of providers who may be at risk, earlier confidential notice of potential reduction in services or closure, broadening the scope of services covered, and allowing for sensitive information to be provided confidentially to better inform regulator response.
 - ii. Strengthen the Review of Proposed Expansions to Ensure Alignment with State Cost Containment and Health Equity Goals.** The DoN program should be updated to align with the focused assessments of need,

cost growth, affordability, and health equity goals. In addition, given the significant potential for impacts on health care spending, quality, access and equity of market expansions, the existing material change notice and review process should be amended to require notice to the HPC before a provider substantially increases capacity.

- c. Enhance the HPC's Market Oversight Authority of For-Profit Investment.** The requirement that providers and provider organizations file notices of material change before engaging in certain transactions should be updated to reflect the increasing role of private equity and for-profit investment in health care. All new and significant for-profit investments in a provider or provider organization, including private equity investment, should require a material change notice filing.

8. SUPPORT AND INVEST IN THE COMMONWEALTH'S HEALTH CARE WORKFORCE.

The Massachusetts health care workforce continues to experience substantial disruption, with high turnover and shortages of care providers in many roles throughout the care continuum, especially in behavioral health care and long-term care. The COVID-19 pandemic exacerbated pre-existing challenges such as stress, inflexibility, and administrative burden – and with a tighter labor market, many care providers have left their roles seeking higher pay (e.g., at comparatively well-resourced organizations, in different health care settings, or in contract roles), have redirected their careers away from patient care to administration or research, or have left health care altogether. These trends have impeded patient access, interrupted care continuity, and resulted in patient access issues and bottlenecks, threatening the Commonwealth's efforts to advance health care affordability, access, and equity. Building on substantial new investments by the Healey-Driscoll Administration and the Legislature in the fiscal year 2024 budget, such as \$140.9 million in loan repayment for primary care and behavioral health workers and free community college education for all nursing students, there are opportunities for both the Commonwealth and the health care delivery organizations that employ care providers to stabilize and strengthen the health care workforce.

- a. Public Investments and Policy Change.** The Commonwealth should provide upfront support to alleviate the financial burden of education and training, including for advanced degrees and for the period between education and licensure for licensed roles, and should otherwise reduce barriers to entry. The Commonwealth should also consider

policy changes supporting enhanced wages for under-resourced sectors. Finally, Massachusetts should join 41 other states (including most New England states) and jurisdictions across the country by adopting the Nurse Licensure Compact to facilitate permanent hires from other states.

b. Health Care Delivery Organizations Should Invest in their Workforces. Health care delivery organizations should invest in their workforces and implement care delivery innovations to provide attractive schedules, improved work environments, and career advancement opportunities. As part of this investment, care delivery organizations should focus on job quality and retention, especially for roles with high turnover, with improvements in areas including mentoring and professional development, schedule flexibility, and compensation.

c. Ensure Adequate Compensation for Non-Clinical Workforces. Innovative, evidence-based care models for primary and behavioral health care frequently integrate non-clinical staff workforces – e.g., community health workers, community navigators, and peer recovery coaches – whose lived experience confers significant value to patients. These workers frequently assume significant operational and emotional responsibility, particularly in caring for patients with complex health and social needs but are often not compensated commensurate with that responsibility. Efforts to address compensation should also encompass increased spending on these important workforce types.

d. Support Workforce Diversity. Research shows that clinician diversity improves care for patients of color. Increasing the diversity of health care professionals and leaders requires concerted efforts by secondary and higher educational institutions, medical and nursing schools, and health care providers. Outreach and recruitment efforts to encourage students of diverse backgrounds to become health care providers should be supported by upfront funding for education and training, including the development of clear and accessible career ladders, and with improved mentoring and leadership training to support retention. Care delivery organizations should prioritize targeted recruitment and retention efforts that will create a more diverse and reflective workforce.

9. STRENGTHEN PRIMARY AND BEHAVIORAL HEALTH

CARE. There is considerable evidence that health care delivery systems oriented toward primary care tend to have lower costs, higher quality, and a more equitable distribution of health care resources. Better management of behavioral health conditions

has also been found to lower overall health care spending and improve quality of life. Specific areas of focus should include:

a. Focus Investment in Primary Care and Behavioral Health Care. Payers and providers should increase resources devoted to primary care and behavioral health while adhering to the Commonwealth's total health care cost growth benchmark. These investments should prioritize non-claims based spending such as capitation, infrastructure, and workforce investments. CHIA and the HPC should continue to track and report on primary care and behavioral health care spending trends annually.

b. Increase Access to Behavioral Health Services. In response to the critical need for behavioral health services—in particular among children, young adults, and people of color — payers and providers should take steps to increase access to behavioral health services appropriate for and accessible to these populations. The Commonwealth can advance these goals by continuing to implement the Executive Office of Health and Human Services' Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it, including increasing inpatient beds for behavioral health patients (including pediatric patients), investing in community-based alternatives to the emergency department, and aligning the behavioral health workforce with current needs, by increasing reimbursement to behavioral health providers, developing targeted recruitment and retention strategies, and using telehealth and innovative care models to extend capacity and ensure that patients have equitable access to the appropriate level of care based on their needs.

c. Improve Access to Treatment for Opioid Use Disorder. Recent studies have documented both rising rates of opioid overdose among Black and Hispanic populations and disparities in access to treatment for opioid use disorders (OUD). In response to these troubling data, payers and providers should use RELD (race, ethnicity, language, disability) data to identify inequities in access to Medication for Opioid Use Disorder (MOUD). Based on those findings, providers should undertake focused efforts to close any access gaps by engaging with community-based organizations and people with lived experience to tailor interventions to identified communities.