MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission Board Meeting

September 15, 2020

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Welcome by HPC Chair Stuart Altman**
- Approval of Minutes from July 22, 2020 Meeting **(VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
- Impact of COVID-19 Pandemic in Massachusetts
- Schedule of Next Meeting **(December 16, 2020)**

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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **July 22, 2020** as presented.

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Update on HPC Health Equity and Internal Diversity, Equity, and Inclusion Workstreams

WATCHDOG

- Enhanced Equity Approach to Market Changes
- Developing Enhanced Outreach Strategy for OPP

RESEARCH AND REPORT

- Integrate Race/Ethnicity Data in APCD
- Equity Style Guide: Best Practices and Terminology for HPC Work Products *(In Development)*

PARTNER

- MassUP Initiative and Investment Program
- Maternal Health Program
- Integrating Equity-Focused Measures in ACO Certification Criteria
- Supporting MassChallenge HealthTech Equity Working Group
- Collaboration with Other State Agencies

CONVENE

- Hiring of Diversity, Equity, and Inclusion Consultant
- Internal Staff Convenings on Anti-Racism and Health Equity
- Engagement with HPC Advisory Council
- Upcoming Cost Trends Hearing

New and Upcoming HPC Publications in 2020

Market Retrospective Study

Report on provider market trends over the past five years, including updated analyses from the HPC's *Community Hospitals at a Crossroads* report.

CHART Playbook

Practical resource based on lessons learned from CHART program awardees for providers working to address the needs of medically and socially complex patients.

HPC-Certified ACO Profiles

High-level summary of each HPC-certified Accountable Care Organization recertified in December 2019.

CHART Phase 2 Evaluation Report

Findings from the CHART Phase 2 Investment Program, including key outcomes related to the operational use of data, integration of whole-person care, partnerships, hospital utilization, and patient experience.

DataPoints: HPC-Certified Accountable Care Organizations in Massachusetts

Key facts about HPC-certified ACOs, focusing on risk contracts, approaches to provider compensation, and delivery system improvement efforts.

Policy Brief: Serious Illness and End of Life Care in the Commonwealth

New data on end of life care for Medicare beneficiaries in Massachusetts by race and ethnicity including service intensity and hospice use, and early trends in the use of advance care planning.

Performance Improvement Plans in Massachusetts: Reflections on Five Years of Evaluating Payer and Provider Spending Performance

Overview of successes and challenges in the process for monitoring and enforcing payer and provider performance relative to the health care cost growth benchmark.

2020 HEALTH CARE COST TRENDS HEARING

COVID-19 AND THE MA HEALTH CARE SYSTEM: ASSESSING IMPACT, ADVANCING EQUITY

TUESDAY, OCTOBER 20, 9:00 AM – 12:30 PM

A VIRTUAL EVENT FOCUSED ON THE IMPACT OF THE NOVEL CORONAVIRUS ON THE MASSACHUSETTS HEALTH CARE SYSTEM AND POPULATION.

MASSACHUSETTS
HEALTH POLICY COMMISSION

SAVE THE DATE
–
OCTOBER 20, 2020

REGISTER ONLINE:
tinyurl.com/CTH2020

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Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Physician group merger, acquisition, or network affiliation	24	21%
Formation of a contracting entity	24	21%
Clinical affiliation	23	21%
Acute hospital merger, acquisition, or network affiliation	22	20%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	13	12%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

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Elected Not to Proceed

- A proposal by **South Shore Health System**, the parent corporation of South Shore Hospital, to form a new contracting entity called the South Shore Health Integrated Delivery Network, which will replace the existing South Shore Physician Hospital Organization.

- The formation of a joint venture to establish a freestanding endoscopy ambulatory surgery center by **Emerson Hospital** and **Physicians Endoscopy**, a company that owns and manages over 50 endoscopy centers nation-wide, including one in Massachusetts.

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Drug Pricing Review Overview: The MassHealth Process

Direct Negotiations

MassHealth negotiates directly with a drug manufacturer for a supplemental rebate.

Proposed Value & Public Input

If negotiations fail for high cost drugs, MassHealth may propose a value for the drug and solicit public input on the proposed value for the drug.

Further Negotiations

MassHealth updates its proposed value for the drug as necessary and solicits further negotiations with the manufacturer.

Referral to the HPC

HPC

If negotiations with the manufacturer fail, MassHealth may refer the manufacturer to the HPC for review.

The HPC Process

HPC

Drug Pricing Review Overview: The HPC Process

Notice & Requests for Information

HPC notifies the manufacturer that it has been referred by MassHealth for review and requests information, including completion of the Standard Reporting Form.

Review

HPC reviews information submitted by the manufacturer.

Determination

HPC may:

- Identify a proposed value for the drug;
- In consultation with MassHealth, propose a supplemental rebate for the drug;
- Determine that the manufacturer's pricing of the drug is unreasonable or excessive in relation to HPC's proposed value for the drug; or
- Close its review of the drug.

- HPC determines that a manufacturer's pricing is *potentially unreasonable or excessive*
- Notifies the manufacturer, and requests additional information.

- HPC solicits information from stakeholders.

- Within 60 days of receiving completed information from the manufacturer, HPC issues a determination on whether the manufacturer's pricing of the drug is unreasonable or excessive in relation to HPC's proposed value for the drug.

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Developing a Process and Framework for Drug Pricing Reviews: Key Principles

Aligned with statutory and regulatory requirements

The framework and process for assessing value and pricing must be aligned with the program's governing statute and regulation

Informed by research

The framework and process should be informed by research and technical expertise on value assessment science and methodologies

Modeled on other HPC market oversight processes

The drug pricing review process should build upon lessons learned in other HPC market oversight processes, such as Cost and Market Impact Reviews and the annual Performance Improvement Plan process

Incorporates input from stakeholders

The framework and process should incorporate input from stakeholders, such as manufacturers, patients and caregivers, and clinicians

HPC

Process for Drug Pricing Reviews

INPUTS

- Data and documents:
  - **From EOHHS**, including information supporting its target value;
  - **From the Manufacturer**, including:
    - Its own assessment of value;
    - Responses to Standard Reporting Form and other HPC requests; and
    - Other information the Manufacturer believes pertinent to HPC review; and
  - **From patients, clinicians, and other stakeholders**, including information provided in response to standard information requests;
- Publicly available information, including assessments from health technology assessment bodies;
- Support from expert consultants; and
- Feedback from Commissioners.

OUTPUTS

- The HPC will issue a determination of whether **pricing for a Drug is unreasonable or excessive in relation to the HPC's proposed value** of the Drug.
  - Before making a final determination, the HPC must give notice to the Manufacturer that the pricing is *potentially* unreasonable or excessive and solicit additional information.
- Data and documents disclosed by a Manufacturer **must remain confidential**, and the HPC cannot identify specific prices or rebates for drugs.
- The HPC will **disclose third party analyses** it relies upon, and will carefully consider their methodologies and models, as well as assumptions and limitations.

Drug Pricing Review: Standard Reporting Form

- As part of its Drug Pricing authority, the HPC was required to create a Standard Reporting Form that details **standardized information HPC would collect from all pharmaceutical manufacturers** referred by EOHHS.
- HPC **released a draft** Standard Reporting Form in November 2019 and met with key stakeholders, including manufacturers, to solicit feedback.
- The **final form was published to the HPC website** (https://www.mass.gov/service-details/drug-pricing-review) on August 4, reflecting updates to address key feedback from stakeholders including manufacturers, patient and disability advocates, and payers as well as experts in pharmaceutical pricing and policy.
- The form may **be updated over time**, with advance notice to and input from Manufacturers and other stakeholders.

Key Feedback from Manufacturers and Responsive Updates to the Standard Reporting Form

Key Feedback	Summary of Updates
Ensure that confidentiality is protected, especially related to pricing and financials of companies	Described **HPC's obligations under law to keep information confidential** and **obscured confidential pricing information** by asking for averages across payers.
Allow more flexibility in reporting to take into consideration the variability in which companies account for information	Provided more **flexibility in the response format**, including by allowing manufacturers to submit substantially similar information where information may not exist in the requested format, and requesting information in formats used by other decision-making bodies. **Simplified requests and provided more flexibility in reporting financial information** such as by removing requirements to provide expenditures in detailed categories, such as salaries and benefits, and by removing the requirement to report lobbying budget and expenditures.
Manufacturers may not have certain information specified in the draft form	Revised certain requirements to better capture **information available to manufacturers**, for instance, asking for average net price for commercial and Medicare payers rather than payer-specific prices on a regional-level.
Clarify certain requests and provide more information about what constitutes a complete response	Updated several requests to ensure that the **information reported will be reliable**, such as by requesting certain information to be reported separately for different indications or for different package sizes and updated instructions to provide more **detail, clarity, page limits** and other guidelines to communicate the level of detail expected.

Key Information Requested through the Standard Reporting Form

Topic	Information Requests
Part I: General Information	General information, such as national drug code(s) (NDC), and FDA-approved indications for use; and information related to each indication in which the Drug is approved, such as estimated eligible population for treatment, method of administration, dosing, treatment duration, and FDA approval pathway(s)
Part II: Clinical Effectiveness, Efficacy and Outcomes	Summary of key clinical trials for the drug; additional evidence of clinical efficacy, effectiveness, and outcomes, such as non-randomized and non-controlled evidence if applicable; and a complete list of all clinical studies related to the Drug
Part III: Pricing	Information on Wholesale Acquisition Costs (WAC), net prices in the U.S., international prices, and information to support drug pricing
Part IV: Utilization	Information on utilization in Massachusetts and the U.S. for the previous 5 years and a description of projected utilization in the next 5 calendar years
Part V: Financial Information	Budget and expenditures for research and development**,** including funding sources; acquisition cost, if relevant**;** budget and expenditures for manufacturing, production, and distribution; and marketing budget and expenditures

Regulatory Factors for Review

- Information on clinical efficacy, effectiveness and outcomes
- Characteristics of the drug, including side effects, interactions and contraindications, potential for misuse or abuse
- Existence of therapeutic equivalents
- Seriousness and prevalence of the condition
- Extent to which Drug addresses unmet need
- Impact on subpopulations
- Impact on reducing need for other care, reducing caregiver burden or enhancing quality of life
- Extent of utilization and expected utilization
- Information on the pricing of the Drug, including prices paid by other countries
- Net price compared to therapeutic benefits
- Analyses by independent third parties, including consideration of methods, models, assumptions and limitations
- Other factors the HPC considers relevant, e.g.
  - Information from the Standard Reporting Form, including the Manufacturer's pricing strategy, research and development expenditures for the drug, etc.

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Example Drug Pricing Review Questions

- What clinical benefits are offered by the Drug compared to alternatives (e.g. impacts on clinical outcomes, quality of life, need for other care or caregiver burden, ease of treatment regimen), including differences for subpopulations?
- What are the potential negative impacts from the Drug compared to alternatives (e.g. side effects, interactions or contraindications, potential for misuse), including differences for subpopulations?
- What societal benefits are offered by the Drug? For example, to what extent does the Drug address an unmet need or treat a rare or serious disease for which limited alternatives are available? How does the Drug impact disadvantaged or underserved populations?

Across each domain, the HPC will also assess the quality of the evidence, models or methodologies underlying analyses, and assumptions or limitations

Example Drug Pricing Review Questions

- How does pricing for the Drug compare to alternative treatments and the costs for care that could be avoided?
- What does formal economic analysis indicate as a value-based pricing range?
- How does pricing compare between different payers (e.g., MassHealth, other Medicaid programs, VA, Medicare, commercial, and international)?
- What would the budget impact be to MassHealth based on pricing at different levels?
- What does the Manufacturer describe as the value of the drug and the rationale for its pricing, including any price increases over time?
- What were the manufacturer's costs to develop, manufacture and distribute the drug and how do those compare to its pricing?

Across each domain, the HPC will also assess the quality of the evidence, models or methodologies underlying analyses, and assumptions or limitations

HPC

Example Drug Pricing Review Questions

- Are there any special considerations relating to the Drug not included elsewhere?
- Are there any special considerations regarding the condition, the affected populations, or treatment with the Drug that are not included elsewhere?

Across each domain, the HPC will also assess the quality of the evidence, models or methodologies underlying analyses, and assumptions or limitations

Example Analysis

More Likely Reasonable

- Strong evidence that the Drug offers substantial benefits compared to alternative treatments, (e.g. improved clinical outcomes, improved quality of life, reduced need for other care)
- Few, if any, negative impacts (e.g. few side effects compared to alternatives)
- Drug addresses an unmet need and/or addresses the needs of underserved populations
- Pricing is in line with pricing ranges suggested by formal economic analysis and/or pricing is relatively comparable between different payers in the US and internationally

More Likely Unreasonable

- Drug offers minimal improvement compared to alternative treatments, or the evidence for improvement is weak
- Significant potential negative impacts (e.g. significant side effects compared to alternatives)
- Pricing is comparatively high when comparing between payers in the US and internationally and/or when compared to pricing ranges suggested by formal economic analysis
- Manufacturer offers little rationale for price level and/or price increases

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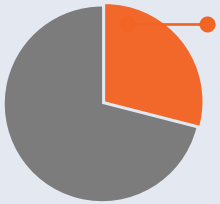
Many patients do not receive high quality care at the end of life; this is particularly true for people of color and those with lower socioeconomic status.

- High quality serious illness care addresses medical and emotional needs, with patients receiving care based on their individual preferences and priorities.
- Numerous factors result in differences between best practices and care received at the end of life, particularly for people of color and people with lower income or education.

According to a 2018 Massachusetts survey:



29% of people with a loved one who died in the past year said that health care providers **did not fully follow their loved one's wishes.**

People of color were more likely to state that their loved one's wishes were not followed by providers (41% versus 27% for White respondents).*

Sources: (1) Massachusetts Coalition for Serious Illness Care. Massachusetts Survey on Advance Care Planning and Serious Illness Care: Spring 2018 Survey of Massachusetts Residents. 2018. Available at: http://maseriouscare.org/uploads/2018-consumer-survey-full-results.pdf

* Due to sample size limitations, this difference was not statistically significant at the 5% level in the 2018 survey. A 2016 version of the survey found a larger and statistically significant difference on this measure (69% versus 43%) by race. See: Massachusetts Coalition for Serious Illness Care. Massachusetts Survey on Advance Care Planning and Serious Illness Care: Spring 2016 Survey of Massachusetts Residents. 2016. Available at: http://maseriouscare.org/uploads/Coalition-Commitments-and-Survey.compressed.pdf

HPC

Early communication about preferences leads to higher quality care, but many patients and clinicians do not have these conversations.

- Communication that impacts outcomes addresses emotion, prognostic awareness, treatment options, goals for care, spirituality, and costs of care.[1]
  - Only **27% of adults in Massachusetts with a serious health condition reported having a conversation** with a health care provider about end-of-life care wishes.[2]
- Among older adults in the U.S. with serious illness, White adults (65%) are more likely than Black (38%) or Hispanic adults (41%) to have documented their wishes for medical care.[3]
- The COVID-19 pandemic and its exposure of steep health inequities accentuates the importance of early conversations about preferences of care for all patients.

"My cousin got her planning done in advance, but a friend of mine wasn't so lucky. Her husband, having tested positive for the coronavirus, was texting her instructions for accessing their finances while being wheeled into a Boston intensive care unit for worsening shortness of breath."

– Zitter JN. "Covid or No Covid, It's Important to Plan." New York Times. April 16, 2020

Sources: (1) Tulsky et al. A Research Agenda for Communication Between Health Care Professionals and Patients Living with Serious Illness. JAMA Intern Med. 2017; 177(9): 1361-1366. (2) Massachusetts Coalition for Serious Illness Care. Massachusetts Survey on Advance Care Planning and Serious Illness Care: Spring 2018 Survey of Massachusetts Residents. 2018. Available at: http://maseriouscare.org/uploads/2018-consumer-survey-full-results.pdf (3) Kaiser Family Foundation. Serious Illness in Late Life: The Public's Views and Experiences. Nov 2017. Available at: http://files.kff.org/attachment/Report-Serious-Illness-in-Late-Life-The-Publics-Views-and-Experiences

Variation in intensity of care at the end of life often indicates a need for quality improvement.

Previous research shows substantial variation in intensity of service use at the end of life within Massachusetts and throughout the U.S., which cannot be explained by differences in patient preferences.

- Research suggests most people prefer **less intensive care at the end of life**, but Black and Hispanic patients are more likely to prefer intensive end of life care than other patients.
  - Cultural and socioeconomic factors are associated with preferences for intensive care, including greater religiousness, living alone, knowledge of options, not having a regular doctor, and distrust of the health care system.
  - Black patients are more likely to believe that they would receive lower quality treatment if they completed an advance directive, stemming from historic mistreatment by the medical system and concerns based on receiving lower quality care and worse access.
- While individual preferences for intensity of care vary, **health system characteristics** and **provider practice patterns** have been found to be the most predictive factors of regional variation in care.

Sources: Barnato AE et al. Racial and ethnic differences in preferences for end-of-life treatment. Journal of general internal medicine. 2009; 24(6), 695–701. Orlovic M et al. Racial and ethnic differences in end-of-life care in the United States: Evidence from the Health and Retirement Study (HRS). SSM - population health. 2018; 7, 100331. Givens JL et al. Racial and ethnic differences in hospice use among patients with heart failure. Archives of Internal Medicine. 2010;170(5):427–432. Chen EE et al. A longitudinal analysis of site of death: The effects of continuous enrollment in medicare advantage versus conventional medicare. Research on Aging. 2017;39(8):960–986. Fisher ES et al. Associations among hospital capacity, utilization, and mortality of US Medicare beneficiaries, controlling for sociodemographic factors. Health Serv Res. 2000;34(6):1351-1362.

Data Sources

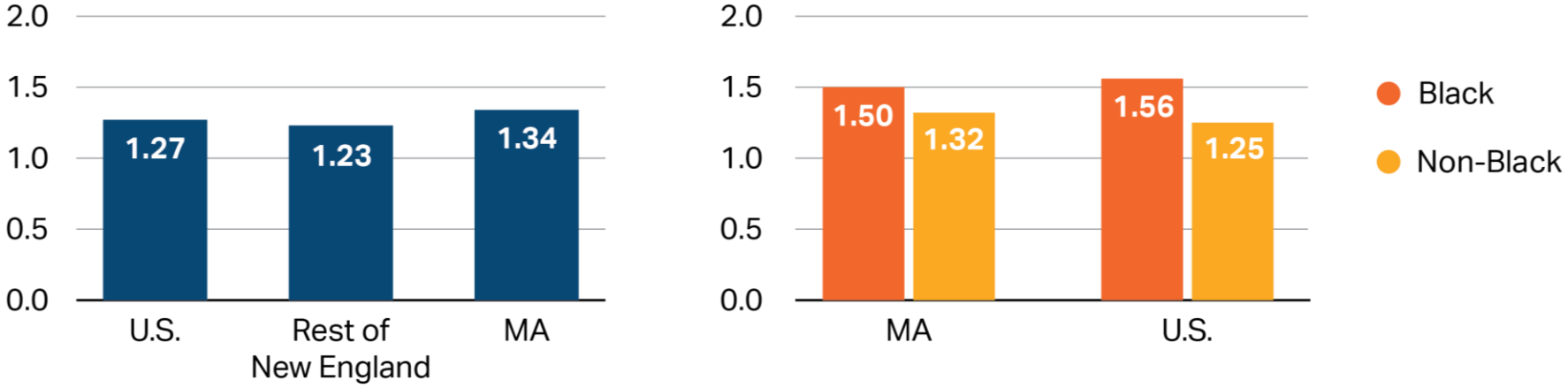
HPC analysis used publicly available Medicare data to examine differences in care received at the end of life by race and ethnicity in Massachusetts:

- Metrics of service intensity in the last 6 months of life (Dartmouth Atlas)
- Hospice use (Medicare Public Use Files & NCPHO)
- Advance care planning use (Medicare Public Use Files)

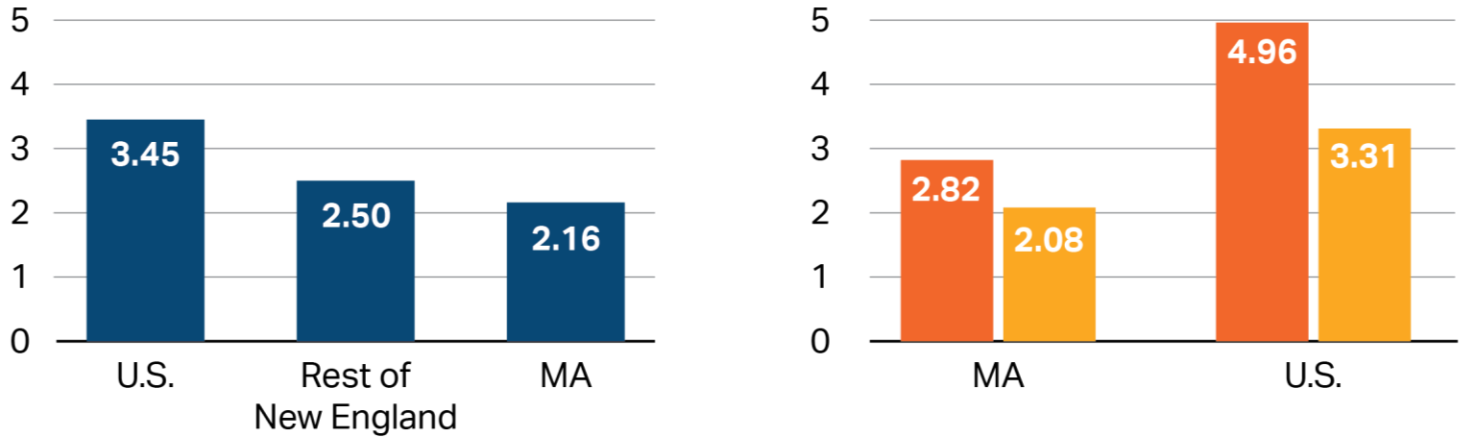
The HPC expects to publish findings in a research brief in Fall 2020

Medicare decedents in Massachusetts have more hospitalizations, but substantially less ICU use than the U.S. average; within MA, Black patients are more likely than non-Black patients to be hospitalized, and if they are hospitalized, they are much more likely to be in the ICU.

Hospital Admissions per Decedent During the Last Six Months of Life, 2017



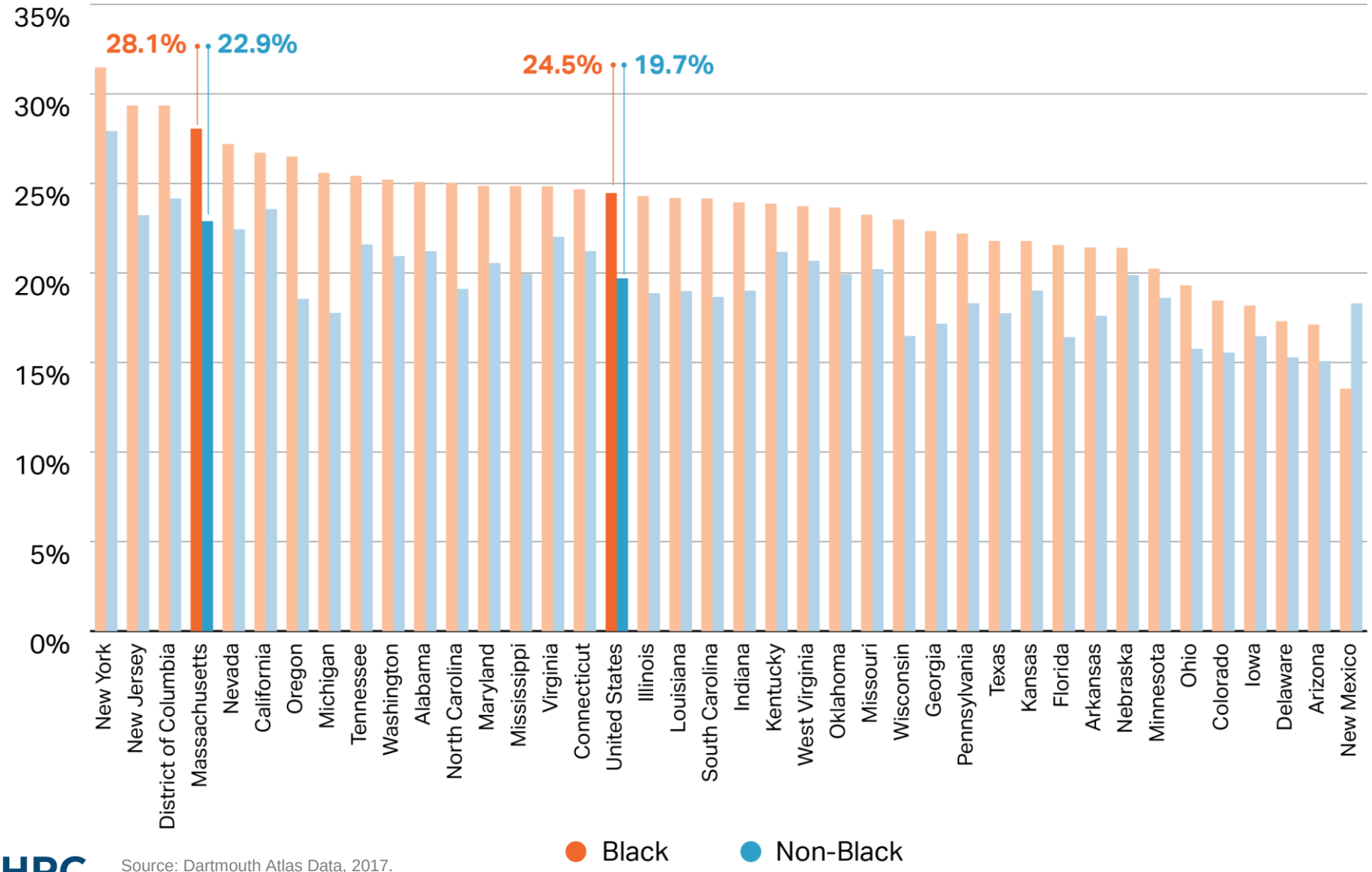
ICU/CCU Days per Decedent During the Last 6 Months of Life, 2017



Sources: Dartmouth Atlas Data, 2017
Notes: "Rest of New England" does not include Massachusetts.

Massachusetts has the 4th highest percentage of Medicare deaths that occur in the hospital among Black decedents and the 5th highest percentage for non-Black decedents.

Percent of Medicare deaths occurring in the hospital, by state and Black vs. non-Black beneficiaries 2017

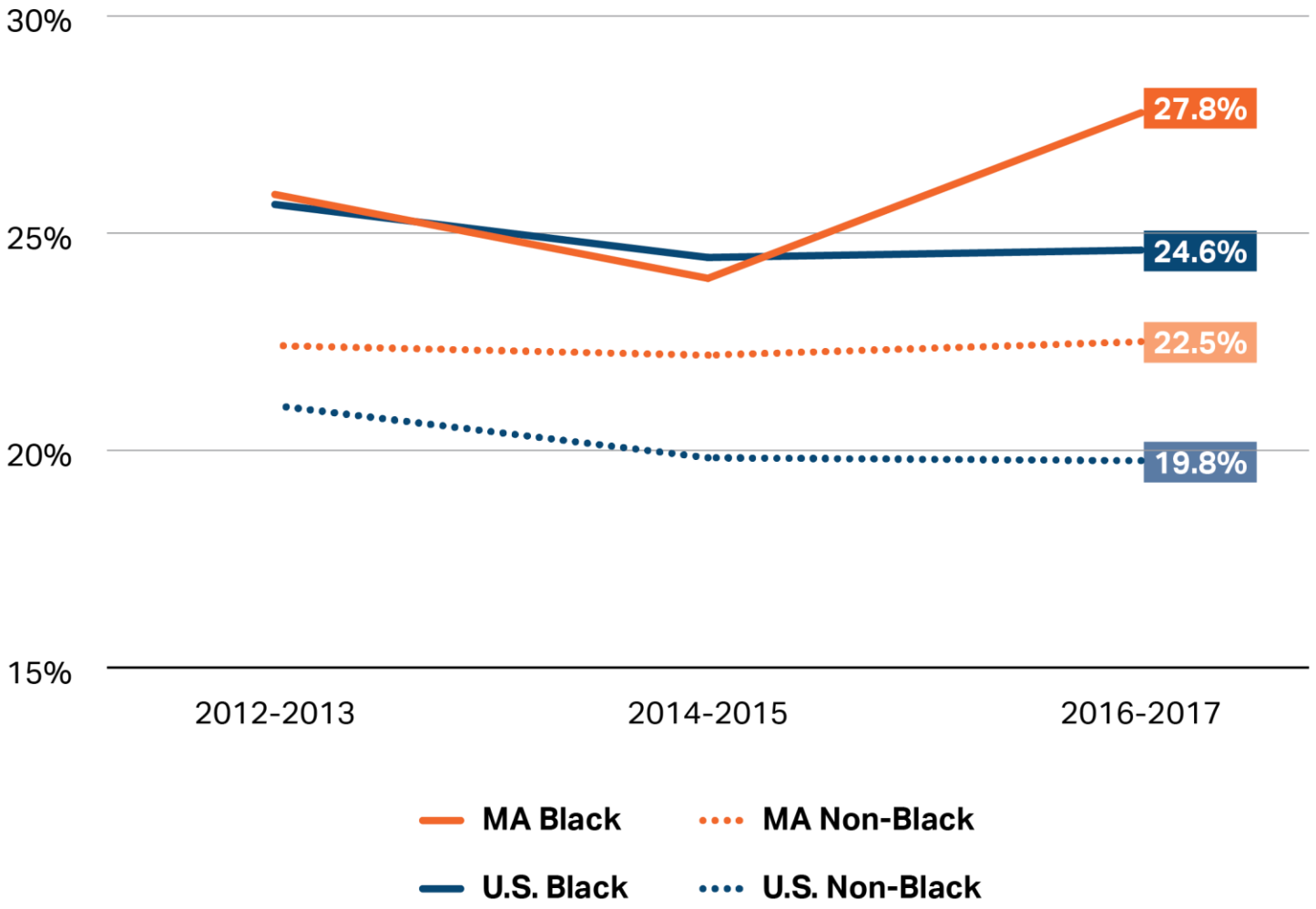


Source: Dartmouth Atlas Data, 2017.

Notes: Seven states do not have data available by race and are not shown in this figure.

Medicare beneficiaries in Massachusetts are increasingly more likely to die in the hospital compared to the U.S. average, with even greater differences by race.

Percent of Medicare deaths occurring in the hospital, Massachusetts and U.S., Black vs. Non-Black beneficiaries 2012-2017



Source: Dartmouth Atlas Data, 2012-2017

Hospice use is relatively low in Massachusetts compared to the U.S. overall.

HOSPICE is a comprehensive palliative care service with the goal of addressing pain and other symptoms while providing emotional support for the patient and their caregivers.

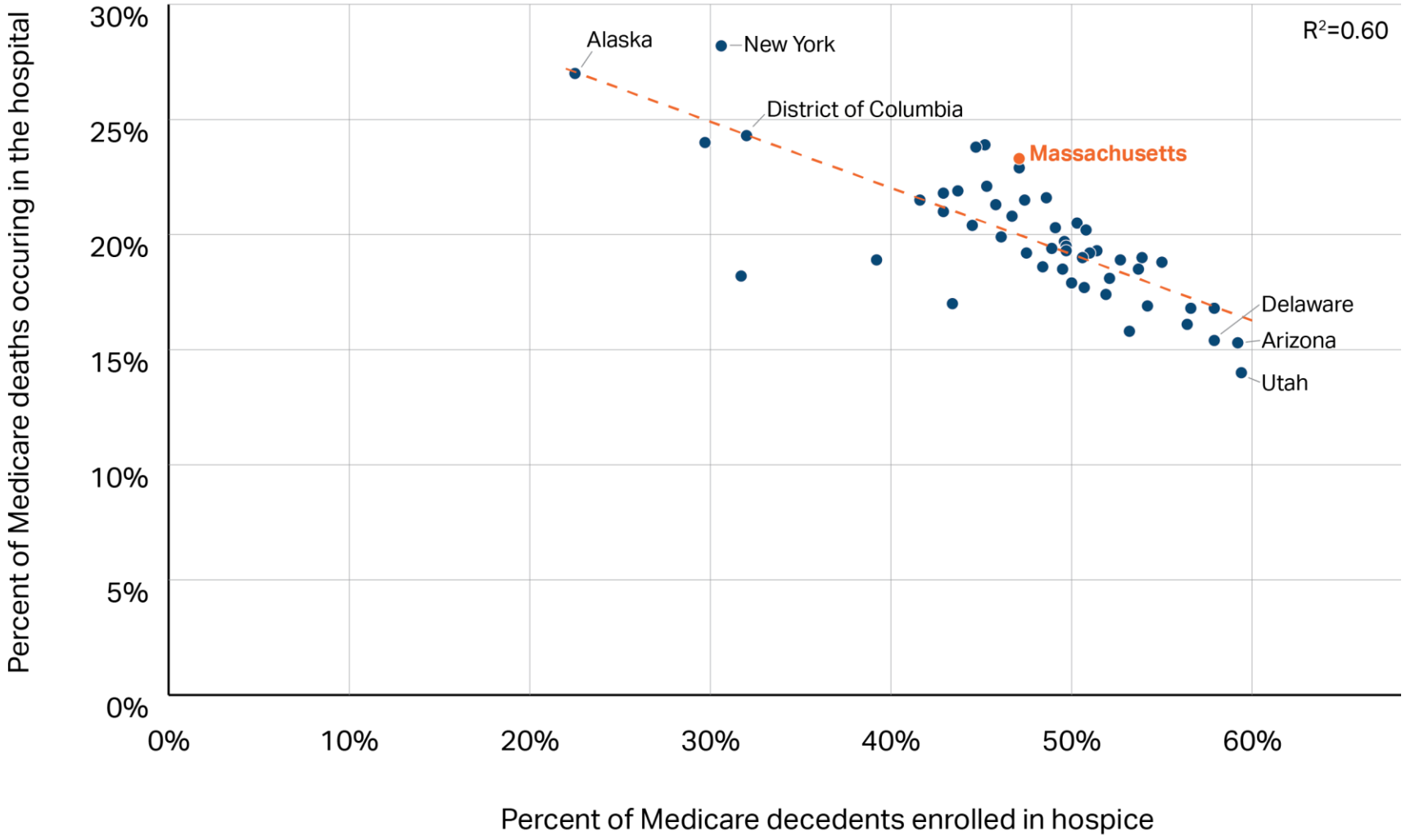
- Care is typically provided in the patient's home (or nursing home) but can also be delivered in a hospital or freestanding unit.
- Medicare eligibility for hospice requires that patients forgo curative services, and a doctor must certify that the patient has less than six months to live, although eligibility can be extended.
- Hospice is associated with less pain and higher rated quality of care.[1]

- **47.1% of Massachusetts Medicare beneficiaries** who died in 2017 were enrolled in hospice at the time of their death, lower than the **national average of 48.2%**[2]
- Among Medicare decedents who did use hospice, about **one-quarter used the service for only one week or less** in both Massachusetts (24%) and the U.S. (26%) in 2017

Sources: (1) Miller SC, Mor V, Teno J. Hospice enrollment and pain assessment and management in nursing homes. J Pain Symptom Manage. 2003;26:791–9. (2) National Hospice and Palliative Care Organization. NHPCO Facts and Figures: 2018 Edition (Revision 7-2-2019). Available at: https://39k5cm1a9u1968hg74aj3x51-wpengine.netdna-ssl.com/wp-content/uploads/2019/07/2018_NHPCO_Facts_Figures.pdf

States with a higher percent of Medicare decedents enrolled in hospice tend to have a lower percent of Medicare deaths occurring in the hospital.

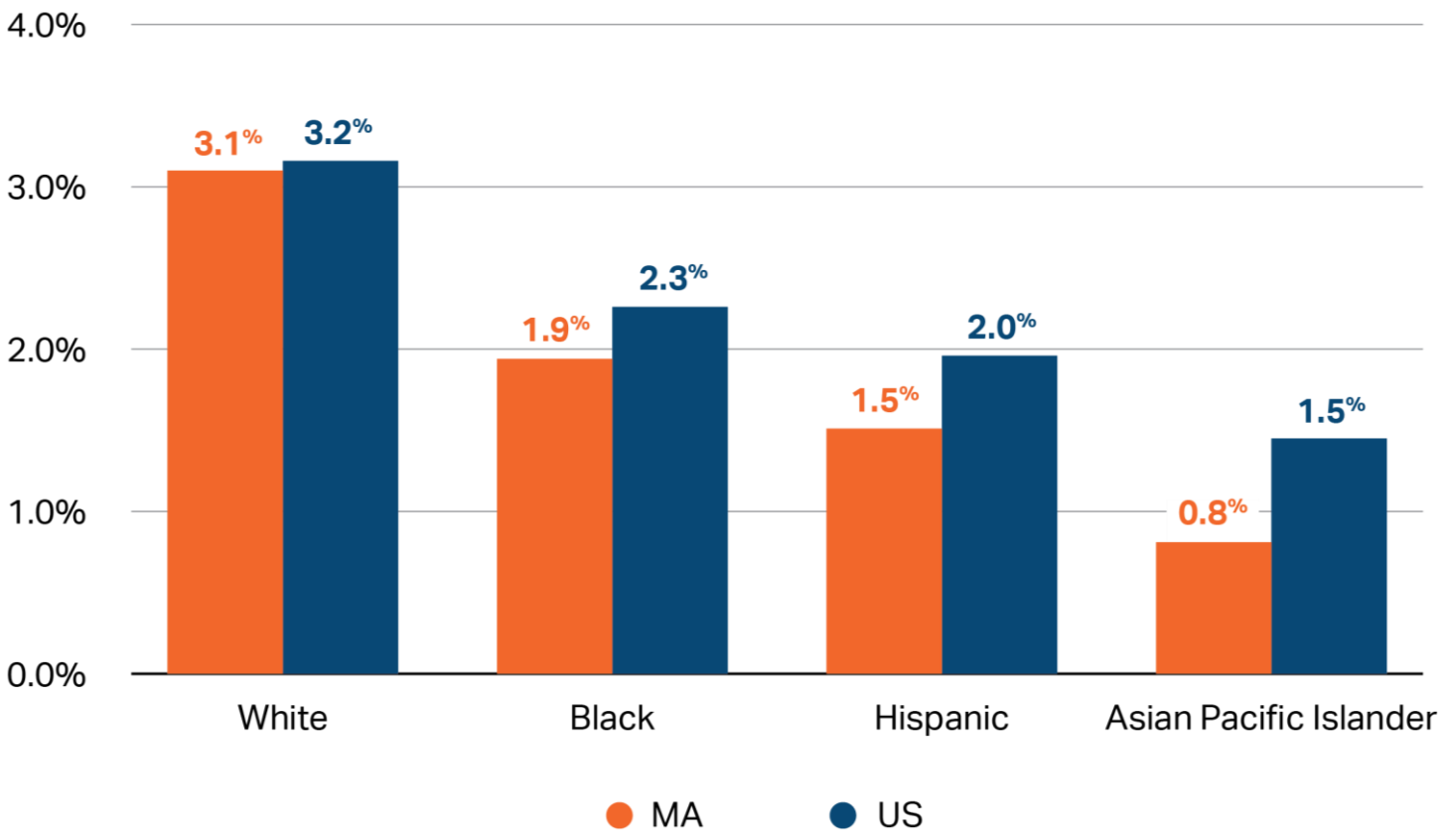
Correlation between percentage of Medicare deaths occurring in the hospital and percentage of beneficiaries enrolled in hospice at the time of death, 2017



Source: HPC analysis of Dartmouth Atlas data (percentage of Medicare deaths in the hospital) and National Hospice and Palliative Care Organization data (percentage of decedents enrolled in hospice at the time of death), 2017.

Medicare beneficiaries of color receive hospice care less than white beneficiaries in Massachusetts and nationally; gaps are wider in Massachusetts.

Percent of all Medicare beneficiaries receiving hospice services by race/ethnicity, Massachusetts vs. US, 2017



Sources: Hospice users from Medicare Fee-For-Service Post-Acute Care Provider Public Use Files, Calendar Year 2017; population numbers and distribution of all Medicare beneficiaries by race/ethnicity from Kaiser Family Foundation, 2017.

Notes: Race/ethnicity categories included all had >1% of the population distribution of beneficiaries and were not listed as "Other/Unknown". "Other" is not shown in the figure. Hospice users include beneficiaries enrolled in both fee-for-service and Medicare Advantage. Rates of hospice use are lower than in previous slides because they are reported as a percentage of all Medicare beneficiaries, not just decedents, due to data limitations.

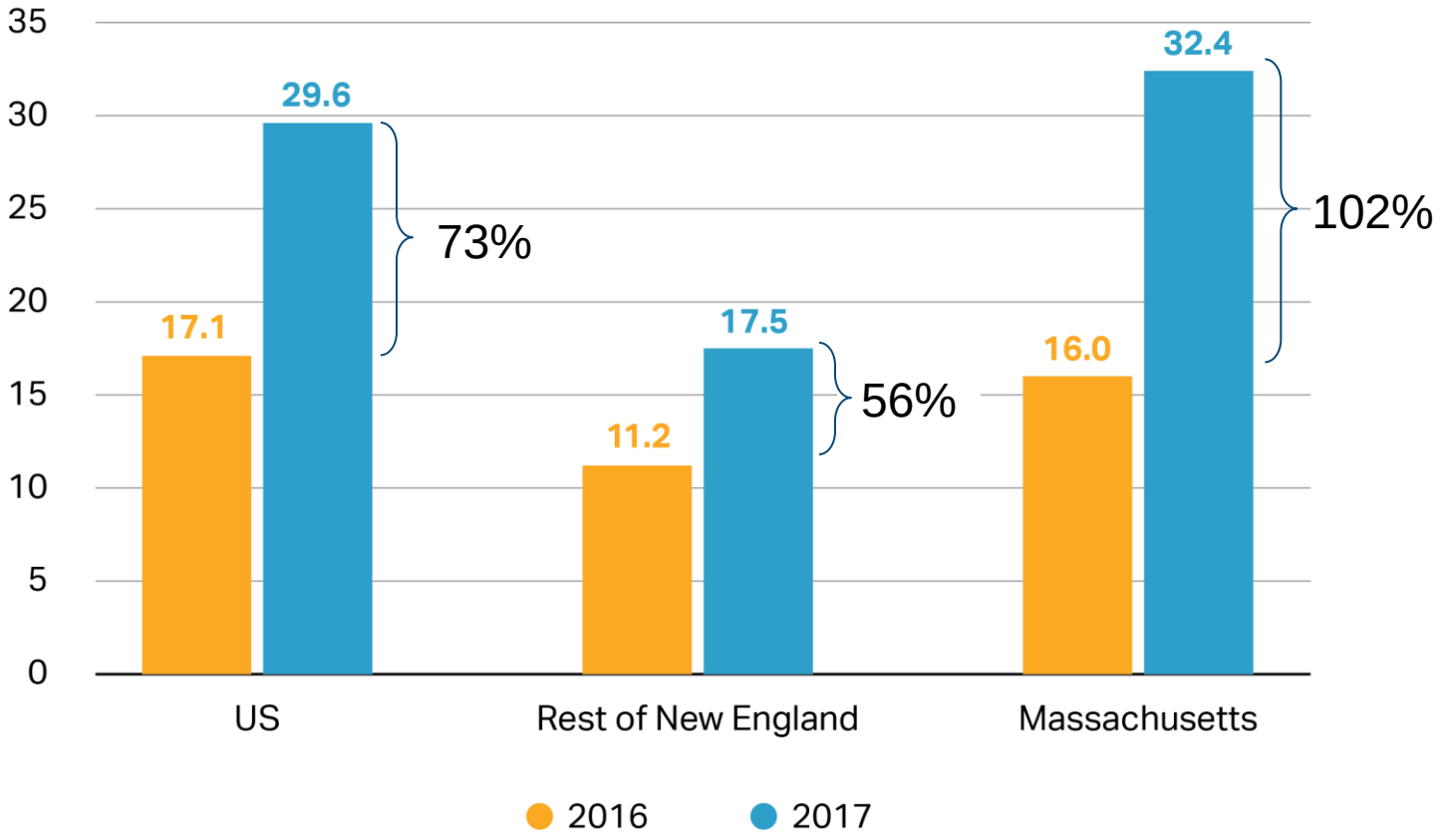
HPC

Background on Advance Care Planning

- Planning for end-of-life care is a central part of ensuring patient-centered care
  - Patients can discuss advance care planning with their provider, and can include family members in the discussion, to help make informed choices about the care they would want to receive
- CMS introduced advance care planning codes (initial conversation = CPT 99497) in 2016; data is available for 2016 and 2017
- Advance care planning may occur without a provider billing for the discussion, so the rates of discussions reflected in claims are likely an underestimate

Advance care planning in the Medicare population doubled in Massachusetts in the year following the code's introduction.

Advance care planning per 1,000 FFS Medicare beneficiaries, U.S., Rest of New England, Massachusetts, 2016-2017



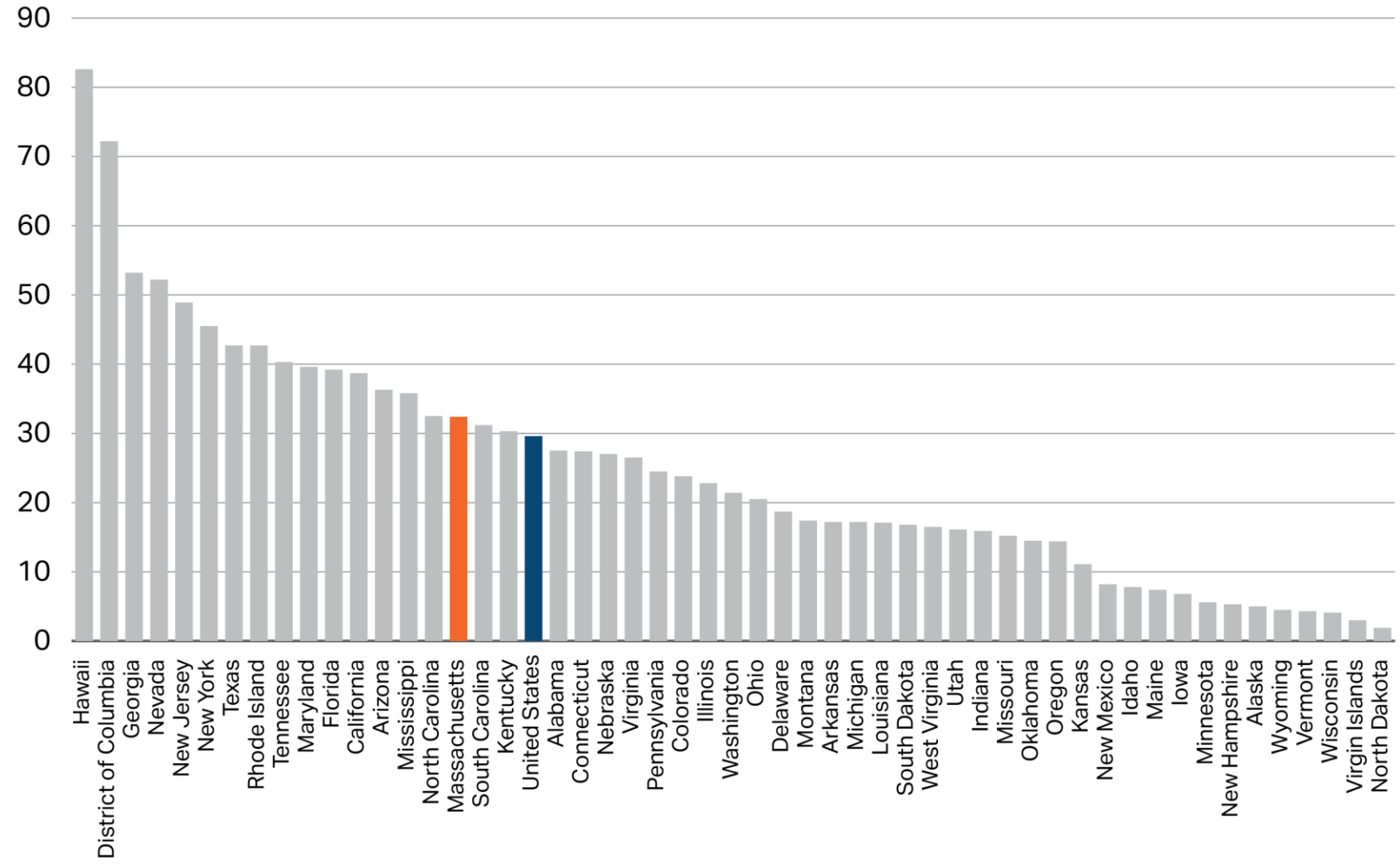
The number of unique providers who provided an advance care planning discussion grew by about 50% in MA (47%) and the U.S. (49%)

Sources: Medicare State and National HCPCS Aggregate Data, CY2016 & CY 2017

Notes: Data represent unique beneficiary interactions coded using CPT 99497 in either an office or facility setting.

Use of advance care planning in the Massachusetts Medicare population ranked 16th in the U.S.

Advance care planning per 1,000 FFS Medicare beneficiaries, 2017



Sources: Medicare State and National HCPCS Aggregate Data, CY 2017

Notes: Data represent unique beneficiary interactions coded using CPT 99497 in either an office or facility setting; double-counting is possible but likely small.

Disparities in Advance Care Planning

Despite the critical role of provider communication in high quality care, literature suggests that providers are less likely to initiate advance care planning conversations with patients of color.

- A 2016 study in New England found that Black, Hispanic, and Asian Medicare beneficiaries were significantly less likely than White beneficiaries to have a claim for an advance care planning discussion.[1]
  - Early national data suggests that increases in discussions were greater among Black beneficiaries compared to White beneficiaries.[2]
- Clinician perspectives and resources play a critical role in advance care planning, with approaches that facilitate more equitable advance care planning including the following: appropriate training and translation services, rejecting stereotypes, and assessing individual preferences.

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Sources: (1) Pelland K, Morphis B, Harris D, Gardner R. Assessment of First-Year Use of Medicare's Advance Care Planning Billing Codes. JAMA Intern Med. 2019;179(6):827-829. (2) Gazarian P. Uptake and Trends in the Use of Medicare Advance Care Planning Visits. Presented at Academy Health's 2020 Annual Research Meeting on July 30, 2020.

Summary

- Research suggests that preferences between groups vary, but most people prefer less intensive care at the end of life; differences in preference do not explain the magnitude of the variation in care by race and by region.
- In Massachusetts, Black patients are more likely than non-Black patients to be hospitalized at the end of life, and if they are hospitalized , they are much more likely to be in the ICU.
- Massachusetts has the 4th highest percentage of Medicare deaths that occur in the hospital among Black decedents and the 5th highest among non-Black decedents.
- Medicare beneficiaries of color use hospice less than White beneficiaries in Massachusetts and nationally; gaps are wider in Massachusetts.
- Advance care planning in the Medicare population doubled in Massachusetts in the year following the code's introduction, although more data is needed by patient demographics.

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Opportunities to Advance Serious Illness Care in Massachusetts

- Massachusetts Coalition for Serious Illness Care is a leader on this issue
  - The Coalition has recently partnered with The Conversation Project and others to develop tools in response to the COVID-19 pandemic

- Most Massachusetts ACOs report having processes for advance care planning (ACP), many report providing training for clinicians
- With health equity considerations in mind, health systems should support clinicians to engage in ACP, with a particular focus on improving initiation of ACP for patients of color
- Continued quantitative and qualitative data monitoring – from claims, survey data, and patient perspectives – are essential to support high quality equitable care for all populations at the end of life
- Health system and policy leaders in Massachusetts should continue momentum to facilitate conversations between family and loved ones and support a range of strategies to support advance directives before patients experience serious illness

MASSACHUSETTS
HEALTH POLICY COMMISSION

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- Executive Director's Report
- Market Oversight and Transparency
- **Impact of COVID-19 Pandemic in Massachusetts**
  - Impact of COVID-19 Pandemic on Health Care Spending and Costs
  - Status of the Health Coverage Market from the Division of Insurance Perspective
- Schedule of Next Meeting **(December 16, 2020)**

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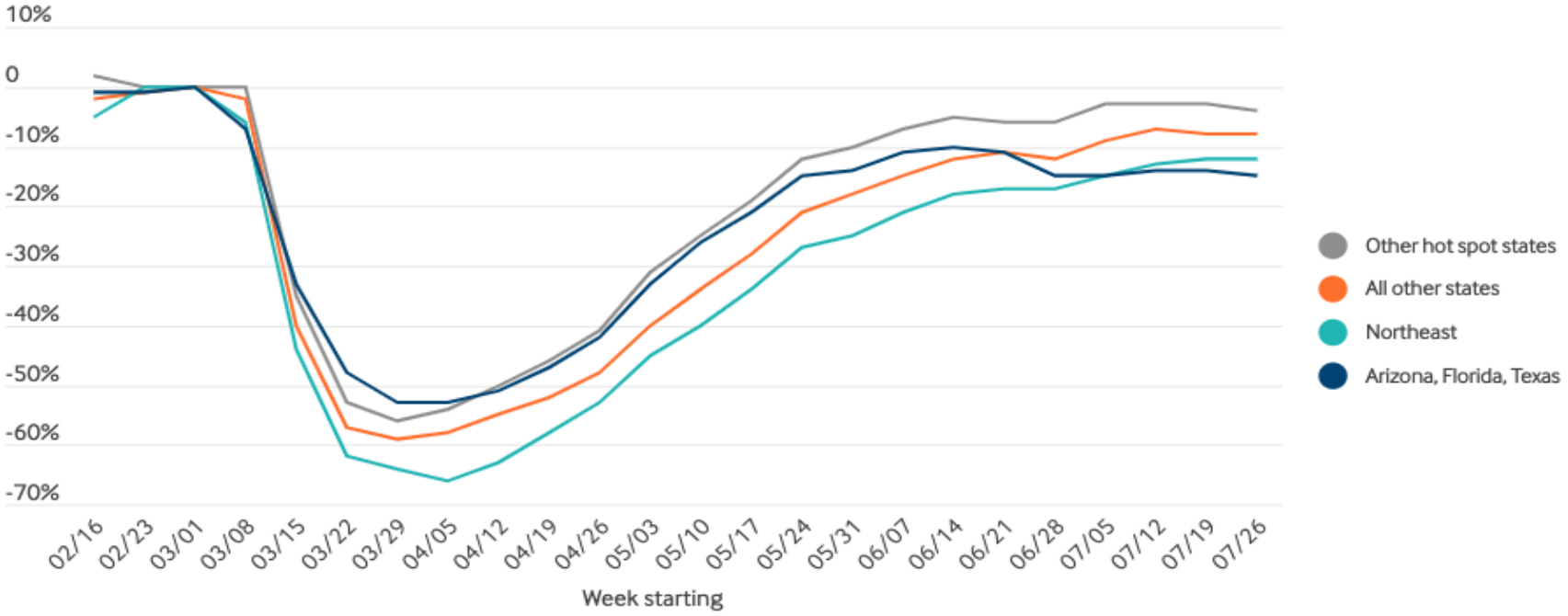
By the end of July, outpatient visits in the Northeast had stabilized at 10% below baseline. Regional spikes in COVID-19 cases depressed visits in those areas.

Percent change in visits from baseline: visit counts include telehealth



Download data

Data are presented as a percentage change in the number of visits in a given week from the baseline week (March 1–7). Hot spot states were the top 10 states in terms of new cases per capita in the weeks of June 28th and July 4th, according to data from the *New York Times*. These hot spots were divided into two groups: 1) Arizona, Florida, and Texas, which clearly had a different trajectory of visits, and 2) Alabama, Georgia, Idaho, Louisiana, Nevada, and South Carolina. The Northeast includes Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

Source: Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots* (Commonwealth Fund, Aug. 2020). https://doi.org/10.26099/yaqe-q550

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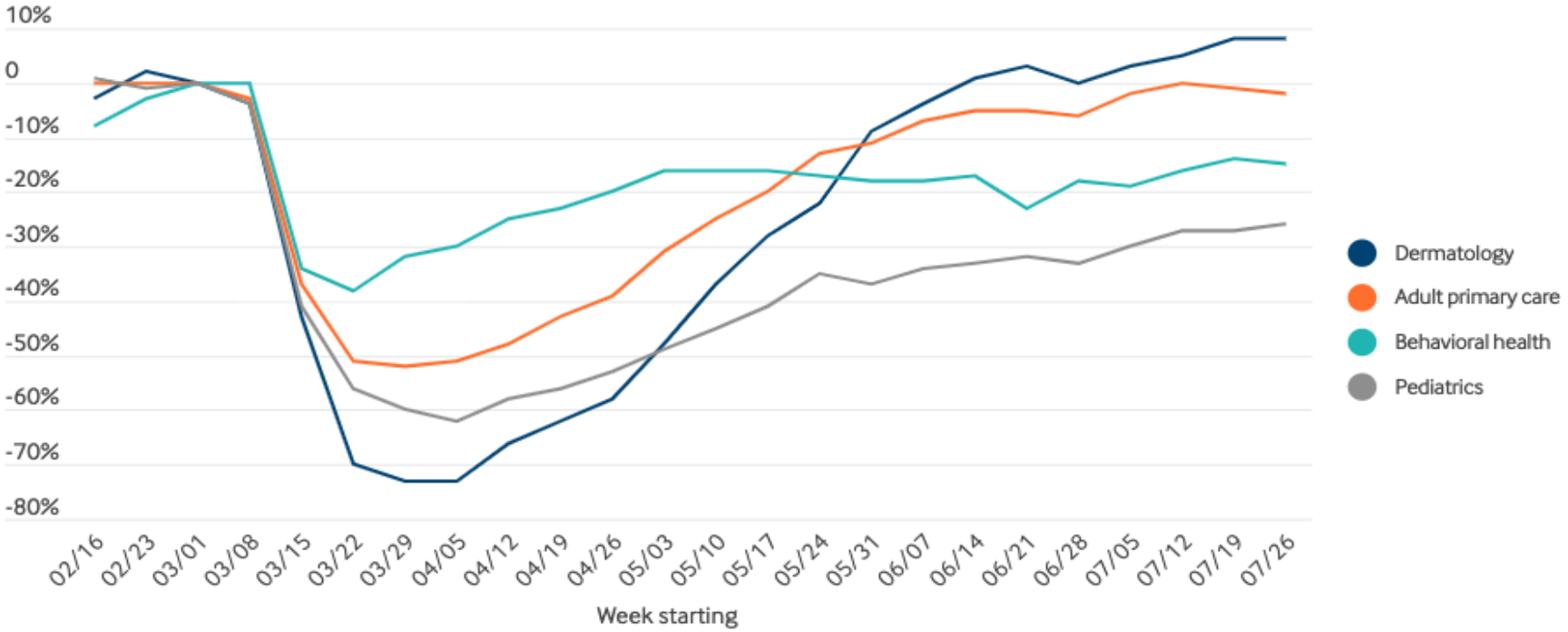
Pediatric visits remain 25% below baseline. Behavioral health visits did not drop as dramatically, but remain 15% below baseline levels.

Percent change in visits from baseline: visit counts include telehealth



Download data

Data for only four specialty areas shown to illustrate the range of trajectories. The decline shown is reflective of all visit types (in-person and telemedicine). Visits from nurse practitioners and physician assistants are not included. Behavioral health includes psychiatrists, psychologists, and social workers. Urgent care center visits are not included in adult primary care or pediatrics.

Source: Ateev Mehrotra et al., *The Impact of the COVID-19 Pandemic on Outpatient Visits: Changing Patterns of Care in the Newest COVID-19 Hot Spots* (Commonwealth Fund, Aug. 2020). https://doi.org/10.26099/yaqe-q550

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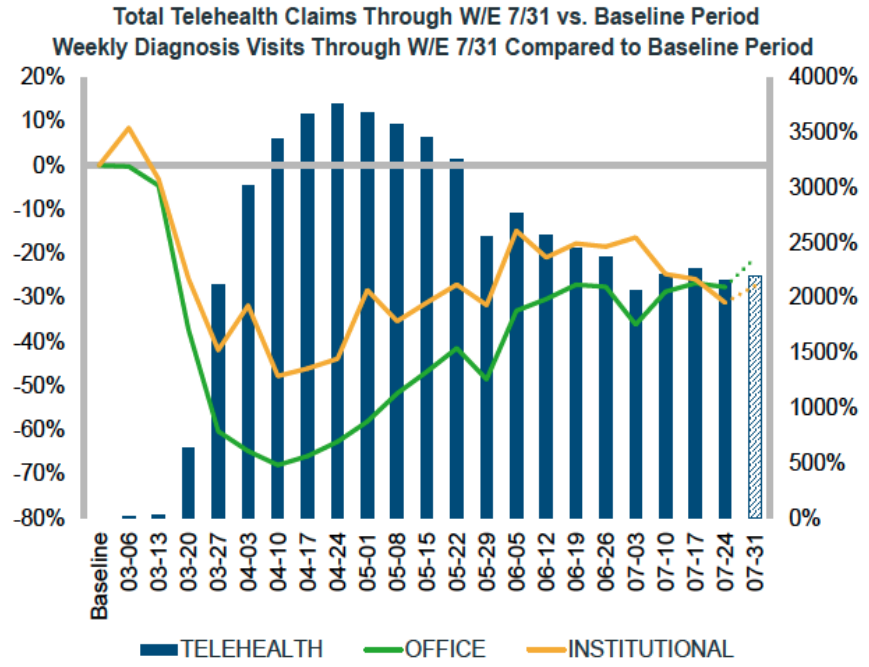
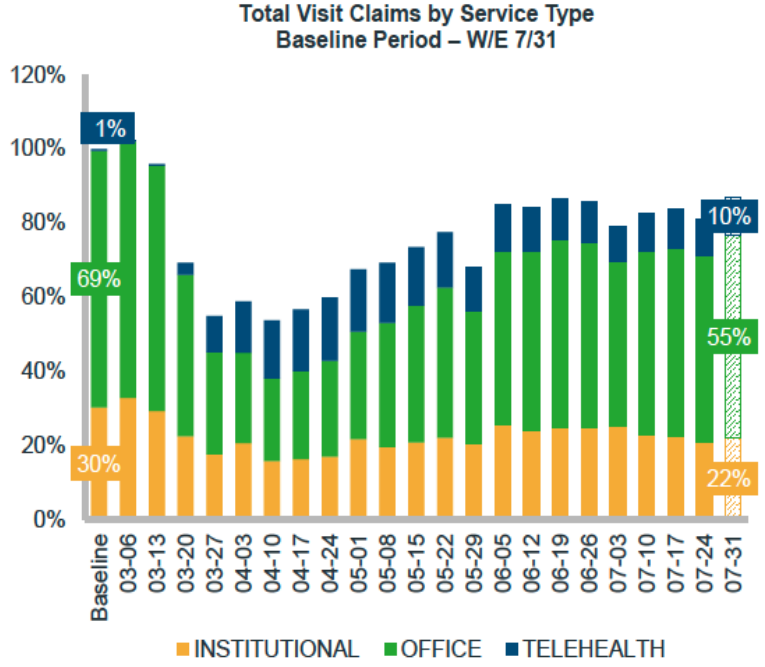
Telehealth visits declined by about a third from their peak in April, and accounted for roughly 10% of visits by the end of July.

Changes in visits by telehealth/office/institutional relative to February baseline





Data for latest week date controlled against prior periods; estimates have been applied to reflect anticipated late-adjudicated claims based on historical rates

Source: IQVIA: Medical Claims Data Analysis, 2020; Baseline = Average of claims for period W/E 1/10/2020-2/28/2020,
Estimated amounts for latest weeks applied based on likely claims still to be received due to data latency or claim processing delays; See Appendix for further details

COVID-19 Market Impact - w/e July 31, 2020

IQVIA

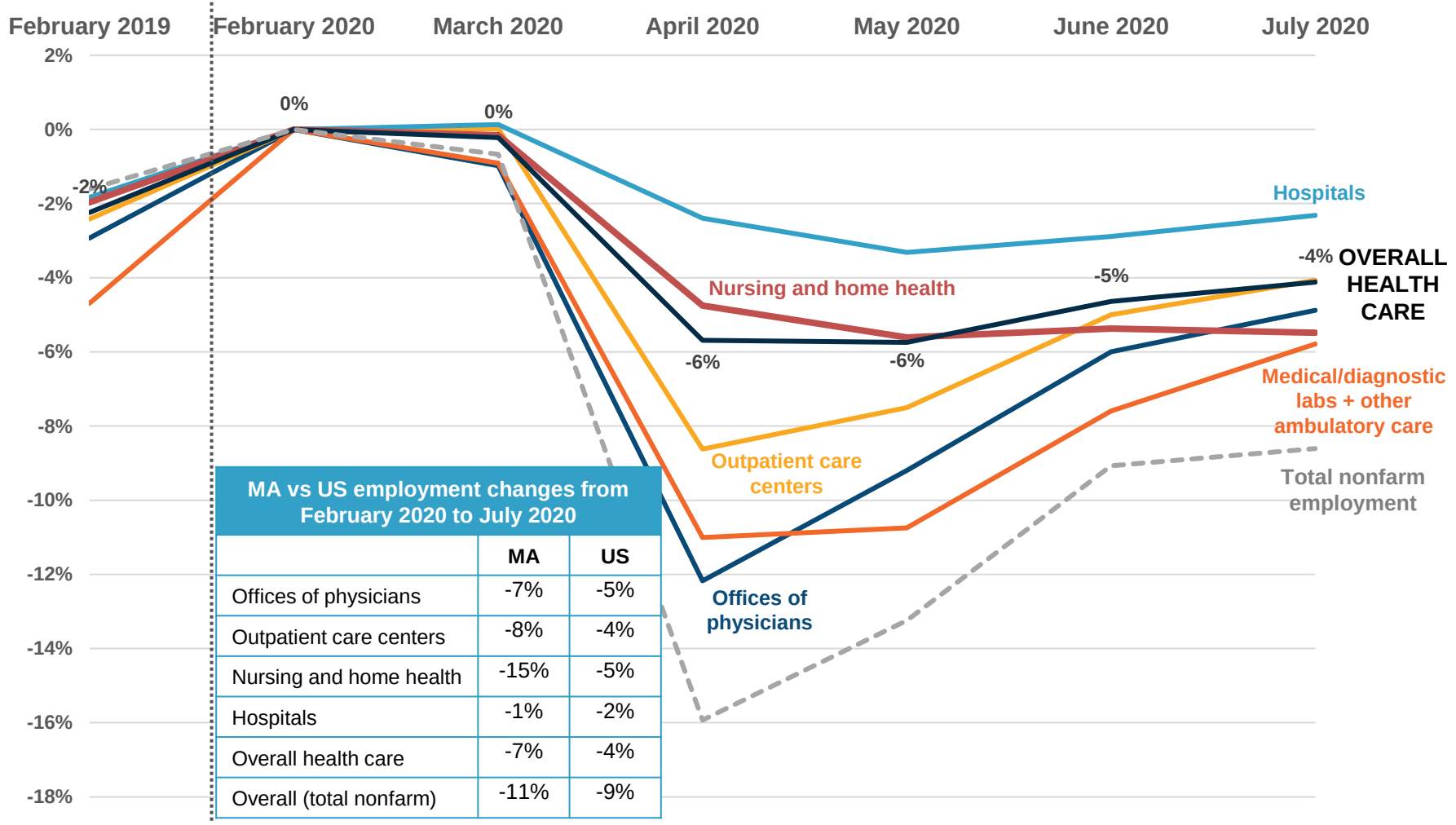
10

HPC

Sources: IQVIA, Monitoring the impact of COVID-19 on the Pharmaceutical Market, June 26, 2020, data week ending June 12, 2020.

National health care employment remained 4% below February levels, with variation by sector. Physician office employment dropped more in Massachusetts than nationally; hospital employment dropped less.

Percent change in national health care industry employment, by sector, February 2019 – July 2020



MA vs US employment changes from February 2020 to July 2020		
	MA	US
Offices of physicians	-7%	-5%
Outpatient care centers	-8%	-4%
Nursing and home health	-15%	-5%
Hospitals	-1%	-2%
Overall health care	-7%	-4%
Overall (total nonfarm)	-11%	-9%

Sources: BLS: Table B-1. Employees on nonfarm payrolls by industry sector and selected industry detail released on July 2, 2020, June 5, 2020, May 8, 2020, and March 6, 2020.

Notes: *Overall and figure excludes office of dentists and other health practitioners. "Nursing and home health" includes employment numbers for nursing and residential care facilities and home health care services.

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Commonwealth of Massachusetts

Status of Insured Health Plan Market

A Division of Insurance Perspective

Commonwealth of Massachusetts

Overview of Membership Changes due to COVID-19

Membership Trends

The Health Care Access Bureau is responsible to monitor access to insured health coverage within the Massachusetts market.

- DOI collects numerous reports that outline access to coverage within many separate health coverage markets.
- Due to concerns that COVID-19 presented, the DOI called a special examination to get quick monthly reporting of carrier membership across merged market, large group, self-funded and government markets.
  - Due to special examination, information is available in aggregate form
  - Carriers report information on 15th of each month about membership as of the last day of the prior month.

Membership Changes

- There is very little difference between June 2020 and July 2020 total membership.
- Over the past four months,
  - the overall number of covered lives is 10,510 lower in July 2020 than it was in April 2020;
    - 40,500 fewer covered under commercial accounts; and
    - 30,000 more covered under governmental accounts.

AGGREGATE MEMBERSHIP CHANGES	March 2020	April 2020	May 2020	June 2020	July 2020	Change from Jun 2020 to July 2020	Change from Apr 2020 to July 2020
Indvidual Merged Market		378,751	375,034	376,493	376,684	191	(2,067)
Small Group (2-50) Merged Market		400,436	394,609	394,240	391,410	(2,830)	(9,026)
Total Merged Market Accounts (Small Group and Individual)	780,529	779,187	769,643	770,733	768,094	(2,639)	(11,093)
Large Group Accounts	1,093,602	1,086,048	1,079,291	1,075,859	1,062,226	(13,633)	(23,822)
ASO Self-Funded Groups (including GIC)	2,913,759	2,904,822	2,896,683	2,889,319	2,899,253	9,934	(5,569)
Medicare		584,093	587,485	590,043	589,654	(389)	5,561
Medicaid (including dually eligible individuals; including those in SCO or One Care Programs)		833,538	844,468	851,482	857,829	6,347	24,291
All Other		149,360	149,302	149,172	149,482	310	122
Governmental Accounts (including Mdcr/Mdcd)	1,534,467	1,566,991	1,581,255	1,590,697	1,596,965	6,268	29,974
Total	**6,322,357**	**6,337,048**	**6,326,872**	**6,326,608**	**6,326,538**	(70)	(10,510)

Membership Overview

DOI initiated its examination to collect timely information to inform decision makers if there were dramatic changes in the number of persons covered in Massachusetts.

It is not intended to duplicate information presented by the Center for Health Information and Analysis. Please also note the following if you may try to compare DOI-reported figures to reports recently issued by CHIA:

- The DOI report is one month ahead of the CHIA report.
- DOI reports membership based on individual/group coverage issued in MA and may include persons living outside MA who are covered under MA-issued group coverage; CHIA reports only those covered persons who live in MA.
- DOI reports membership as of the end of the month; CHIA reports based on the middle of the month.
- DOI reports self-funded membership as reported by carriers; CHIA's self-funded information is estimated.
- DOI and CHIA have different ways to capture the split between Medicaid and Medicare membership.

Both DOI and CHIA are most interested in examining membership trends and find that our reports are consistent regarding changes in membership trends over the past few months of the coronavirus.

Commonwealth of Massachusetts

Overview of Utilization Changes due to COVID-19

Utilization Overview

- Utilization information is not as timely or readily available as membership information.
- It can take 4-5 months of claims runout to get reliable data
- DOI has relied on collecting informal information from carriers under its special examination statute.

Utilization Overview

Utilization Payments (some expect utilization to be significantly increased for 2021)

- March payments 10-20% lower than February payments
  - Stockpiling of prescriptions; early refills
  - Big increase in telehealth utilization
- April-May payments 35-50% lower than for normal hosp/ER/med office payments
  - Partially made up by telehealth; partially made up by COVID-19 treatment costs
- June-July payments closer to normal payment levels
  - Combo of telehealth/normal utilization bring back to normal levels
  - Increased testing for close contacts and hospital admissions/procedures
- Aug – Sept payments 5-20% higher than normal payments levels
  - Catch up demand (postponed surgeries)
  - Providers available on weekends/other days to catch up with demand
  - Increased severity costs for those postponing care
- Oct and later payments approximately 10% higher than normal levels
  - Providers pushing for higher unit costs (past losses and new COVID prevention costs)
  - New vaccines with testing adds to costs
  - Higher intensity of services due to delayed costs

Utilization Overview

Other costs/pressures

If there is a fall surge, it is estimated that this could further increase utilization in 2021

Carriers have made over $50M in cash advances to health care providers

Potential losses in government programs

Potential growth in future capitation payments to guarantee steady payments to providers

Carriers indicate significant reductions in investment portfolios

Commonwealth of Massachusetts

Refunds and MLR Rebates

Premium Refunds

Carriers within the automobile, dental and medical lines have filed to return earned premiums through 2020 refunds to members due to lower than expected claims filed due to COVID-19:

- The Division has looked to see that refunds/discounts are issued on a nondiscriminatory basis and are not intended to be inducements to future renewals of coverage.
- Certain carriers (HPHC and BCBSMA) have filed and received approval to refund portions of earned premiums to persons/groups covered in the spring of 2020 to account for COVID-19 related dips in utilization
- Other companies have contacted the DOI and may also make similar filings
- Recent federal guidance is about premium discounts which does not apply to these refunds that have been granted by carriers.

Premium Rebates

Health insurance carriers are required to meet federal and state Medical Loss Ratio thresholds and refund premiums if they fall below thresholds:

For large groups (50+ employees), federal MLR threshold is 80%; and

For small group/individual, state MLR threshold is 88%.

- Carriers filed their MLR calculations in mid-August, and DOI is completing review.
- Five carriers are expected to refund $44.0 million of 2019 premiums to small group/individual members by the end of September.
- Carriers have filed MLR calculations with the federal government, but it is not clear what the federal refunds may be for large group accounts.

Commonwealth of Massachusetts

Overview of Rate Changes due to COVID-19

Merged Market Health Rate Increases

Division's Process

- Carriers are required to file a standard data sheet that includes detail about membership, claims history, administrative expenses and trends that support future projections and calculation of rates
- Carriers are expected to provide significant details about certain assumptions, including risk adjustment and taxes.
- DOI assigns each carrier's filing to a consulting actuary who reviews all assumptions and sends inquiries to challenge all assumptions made in filings.
- After 30 days, consulting actuaries report findings to DOI, and areas where company actuarial assumptions can then be debated.
- DOI staff then contacts carriers to point out issues and seek carriers' amendments to filings so that lower rates may be achieved outside of the adversarial hearing process.

1Q2021 Merged Market Health Rate Increases

- On August 14, 2020, DOI completed its review of rates for 1Q2021 for all but the THPP rate filings:
  - During the review, questioned all carrier assumptions and pushed back where carriers were being conservative. DOI was able to negotiate many carriers to reducing requested increases by 1% or more.
  - DOI considered disapproving rates filed at a level above 10% and going through a hearing, but elected not to take this route because it would disrupt need to have rates available for upcoming 2021 open enrollment process.
  - Carriers were made aware that 2Q2021 rates would go through different process that could lead to a hearing.
- Final average rates for 1Q2021 are 7.9% higher than those for 1Q2020.

Key Facts

CARRIER	Renewing Members	Current Change in 1Q21 Rates over 1Q20 Rates
AllWays	25,889	9.0%
BCBS HMO BLUE	80,108	5.4%
BMCHP	85,055	2.5%
CONNECTICARE	73	-14.7%
FALLON HMO	15,891	4.0%
FALLON Ins Co	28	4.5%
HNE	14,521	2.6%
HPHC HMO	18,043	5.5%
HPHC Ins Co	363	-0.1%
TUFTS HEALTH PUBLIC PLANS	189,761	12.2%
TUFTS HMO	26,149	7.2%
TUFTS Ins Co	1,368	7.0%
UHC	5,867	9.9%
Total/Average	463,116	7.9%

Key Facts

- Rate changes vary by company and reflect carriers' expectation of 2021 expenses:
  - Utilization returning to pre-COVID levels
  - Providers negotiating higher unit costs to reflect the cost of PPE and COVID preventive activities, as well as increased use of high-cost technology
  - Costs of new pharmaceuticals, vaccines and testing
  - Increased costs for certain behavioral health care
    - Behavioral health for children and adolescents

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Upcoming 2020 Meetings and Contact Information

Board Meetings

Wednesday, December 16

Cost Trends Hearing

Tuesday, October 20

Committee Meetings

Wednesday, September 30

Wednesday, November 18

Contact Us

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