



MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

September 30, 2020



AGENDA

- **Call to Order**
- Approval of Minutes from May 6, 2020 (**VOTE**)
- Serious Illness and End of Life Care in the Commonwealth
- Impact of the COVID-19 Pandemic on Market Reviews
- Opioid-Related Acute Hospitalization in Massachusetts
- Center for Health Information and Analysis: Hospital Financial Data Collected during the COVID-19 Pandemic
- Adjournment



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VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **May 6, 2020** as presented.

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

KEYNOTE SPEAKER: DAVID R. WILLIAMS, MPH, PHD

Florence Sprague Norman and Laura Smart Norman
Professor of Public Health
Chair, Department of Social and Behavioral Sciences
Harvard T.H. Chan School of Public Health



**SAVE THE
DATE**

—
OCTOBER 20, 2020

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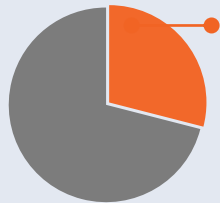
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Many patients do not receive high quality care at the end of life; this is particularly true for people of color and those with lower socioeconomic status.

- 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>

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

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.

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:

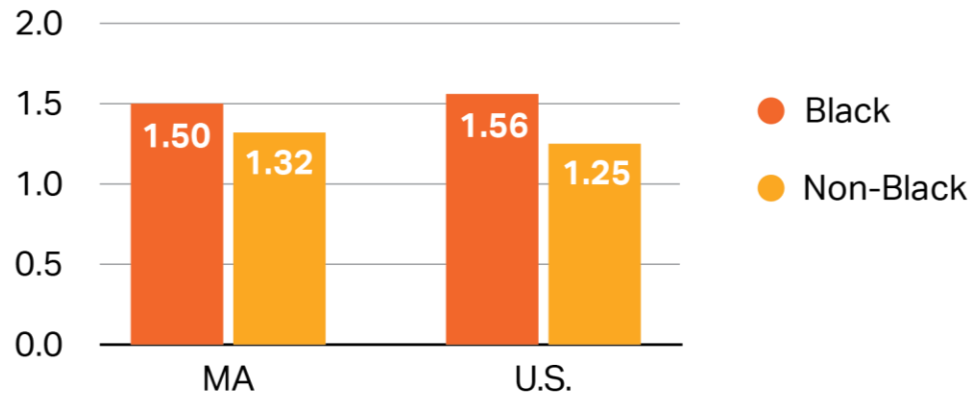
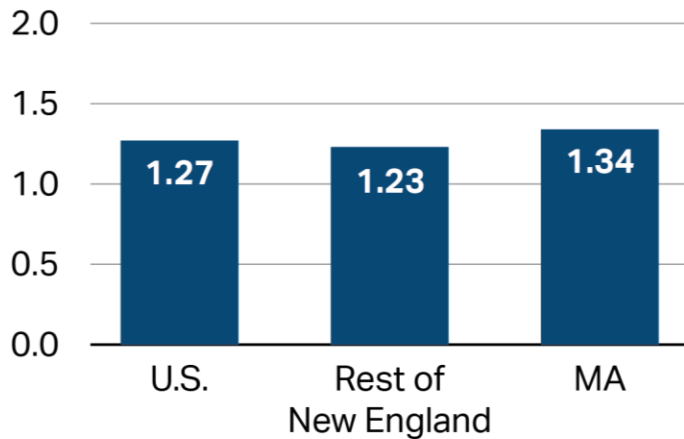
- ▶ Metrics of service intensity in the last 6 months of life (Dartmouth Atlas)
- ▶ Hospice use (Medicare Public Use Files & NCPHO)
- ▶ Advance care planning use (Medicare Public Use Files)



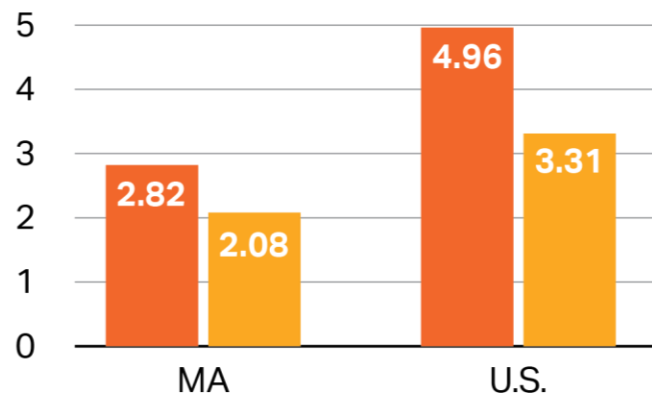
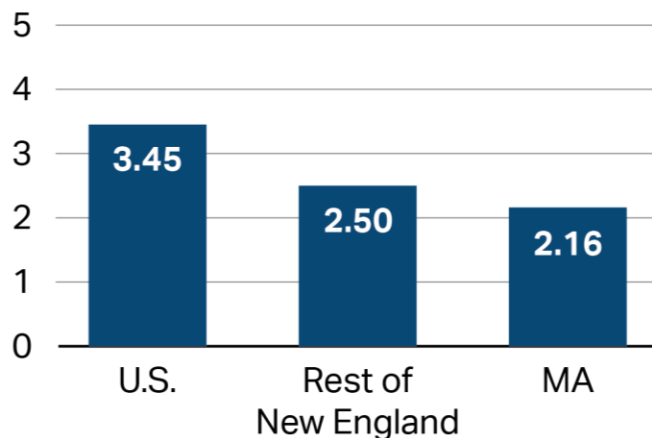
The HPC's new policy brief on serious illness care in the Commonwealth is now available online!

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

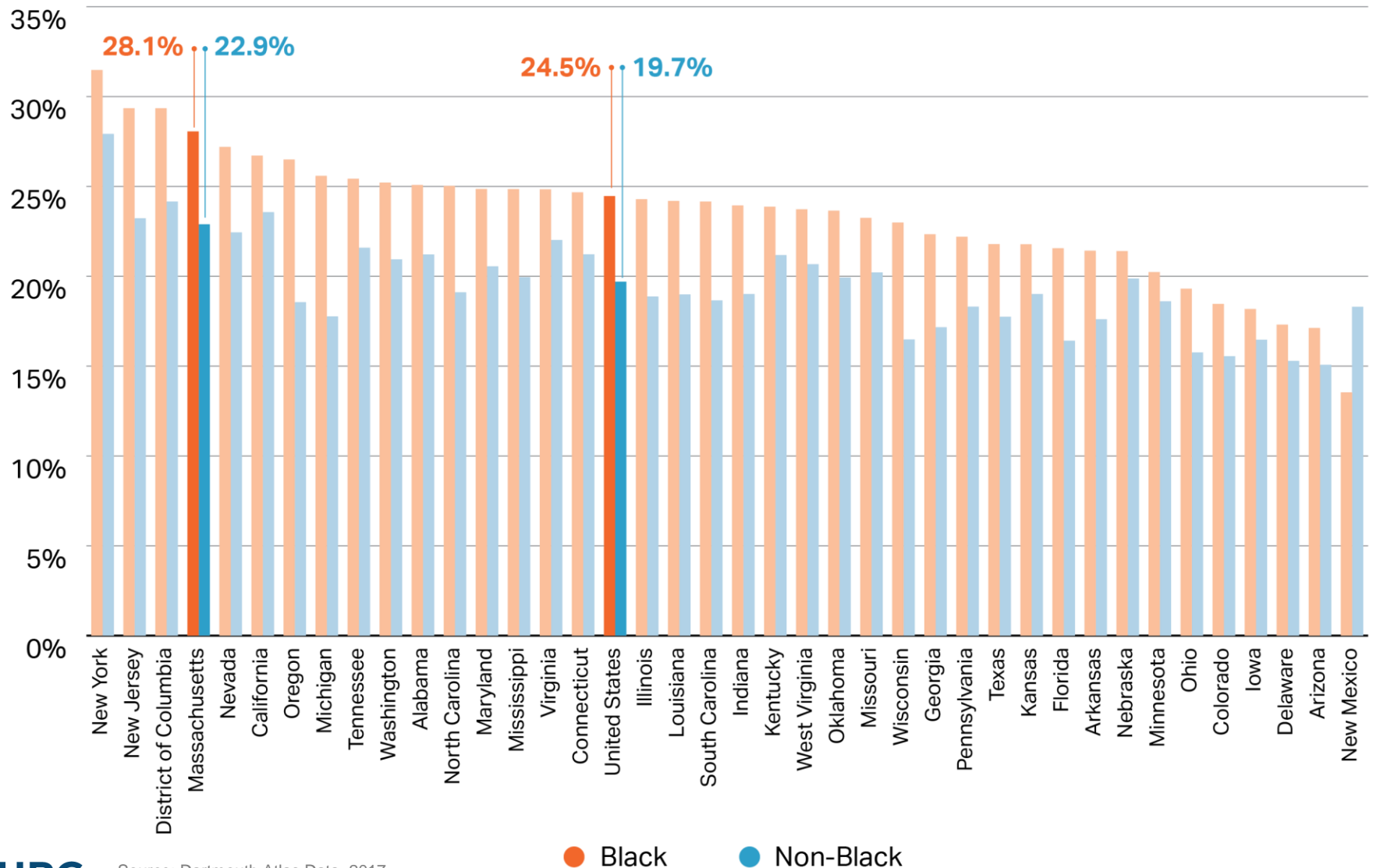


ICU/CCU Days per Decedent During the Last 6 Months of Life, 2017



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

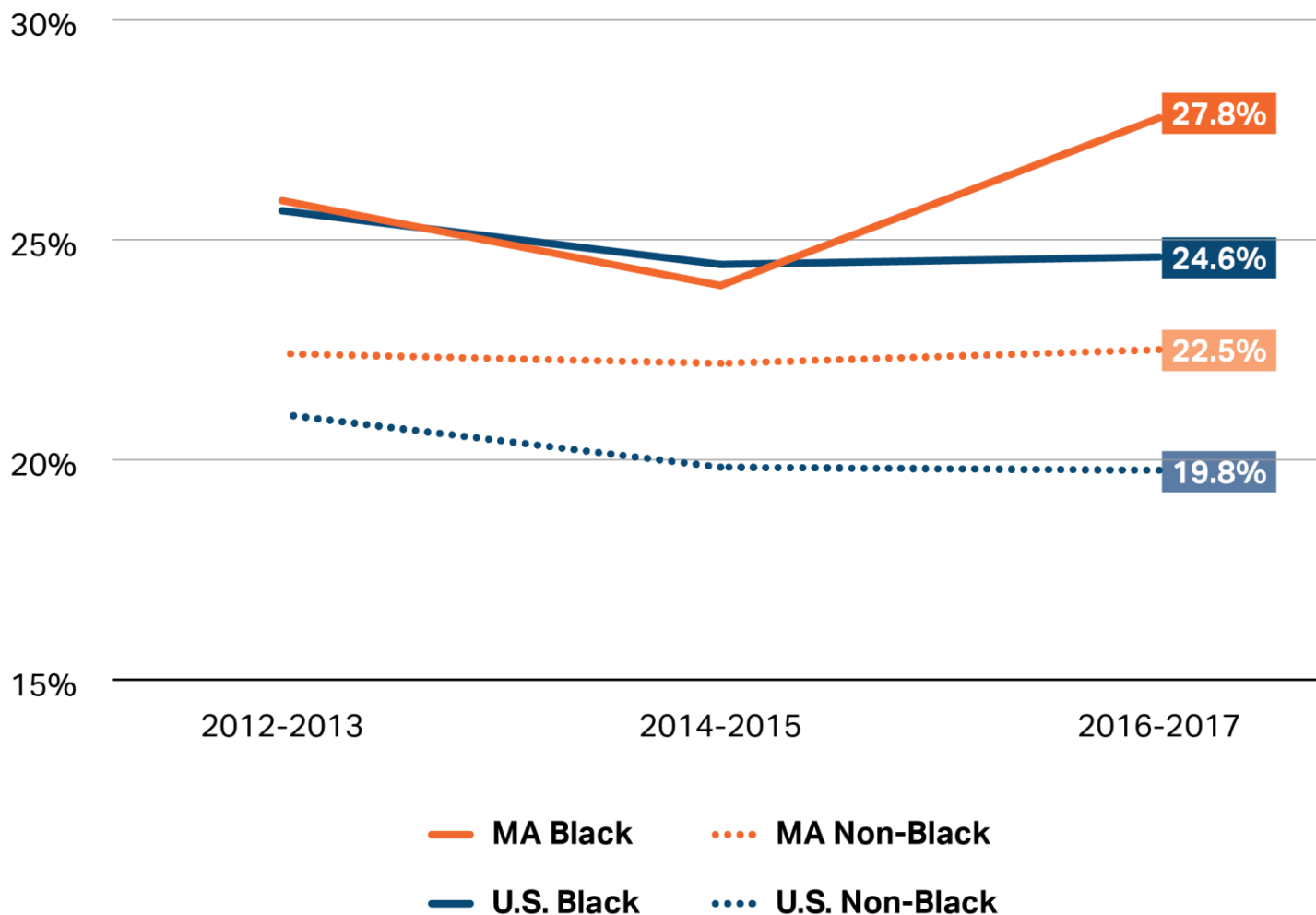


Source: Dartmouth Atlas Data, 2017.

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



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.

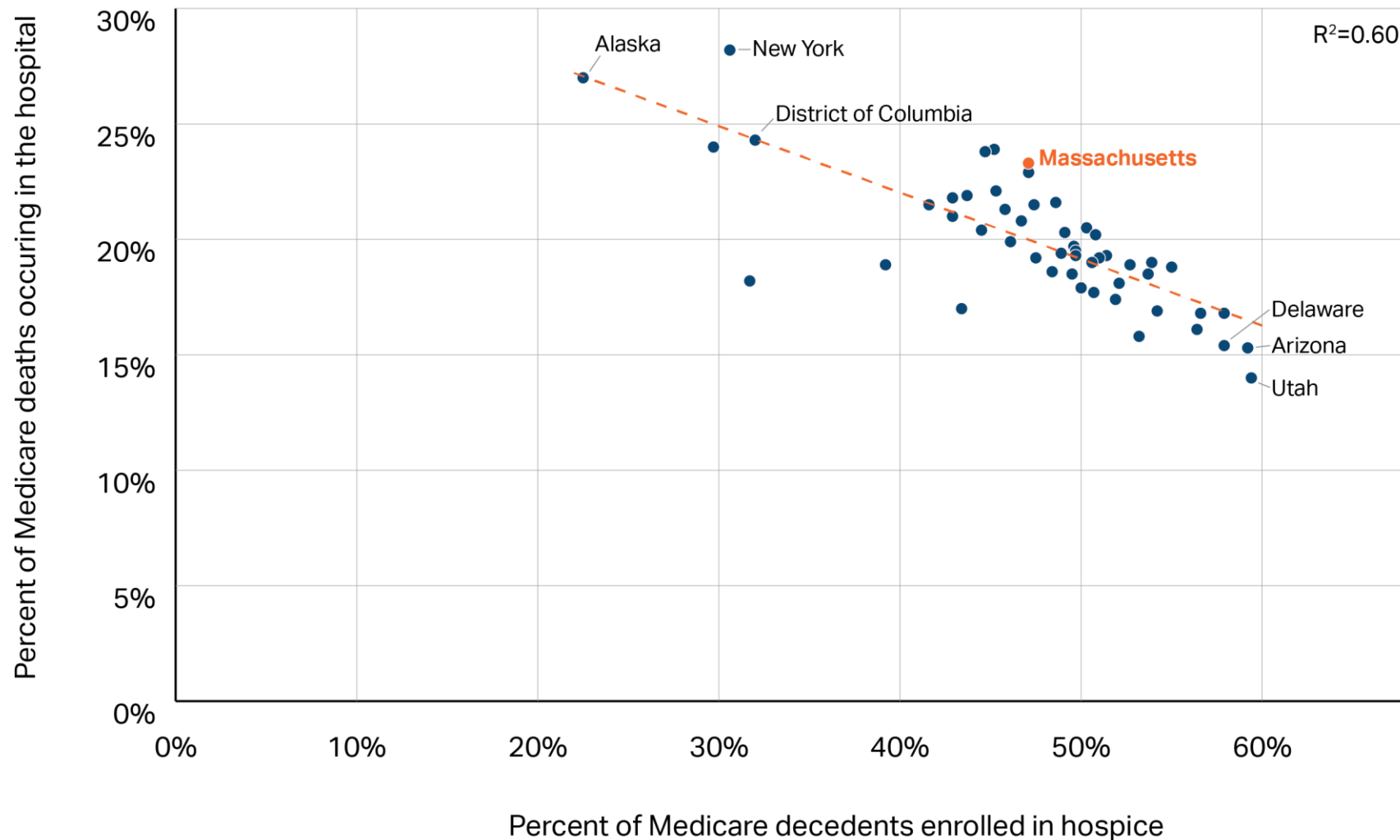
- Care is typically provided in the patient's home (or nursing home) but can also be delivered in a hospital or freestanding unit.
- Medicare eligibility for hospice requires that patients forgo curative services, and a doctor must certify that the patient has less than six months to live, although eligibility 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

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

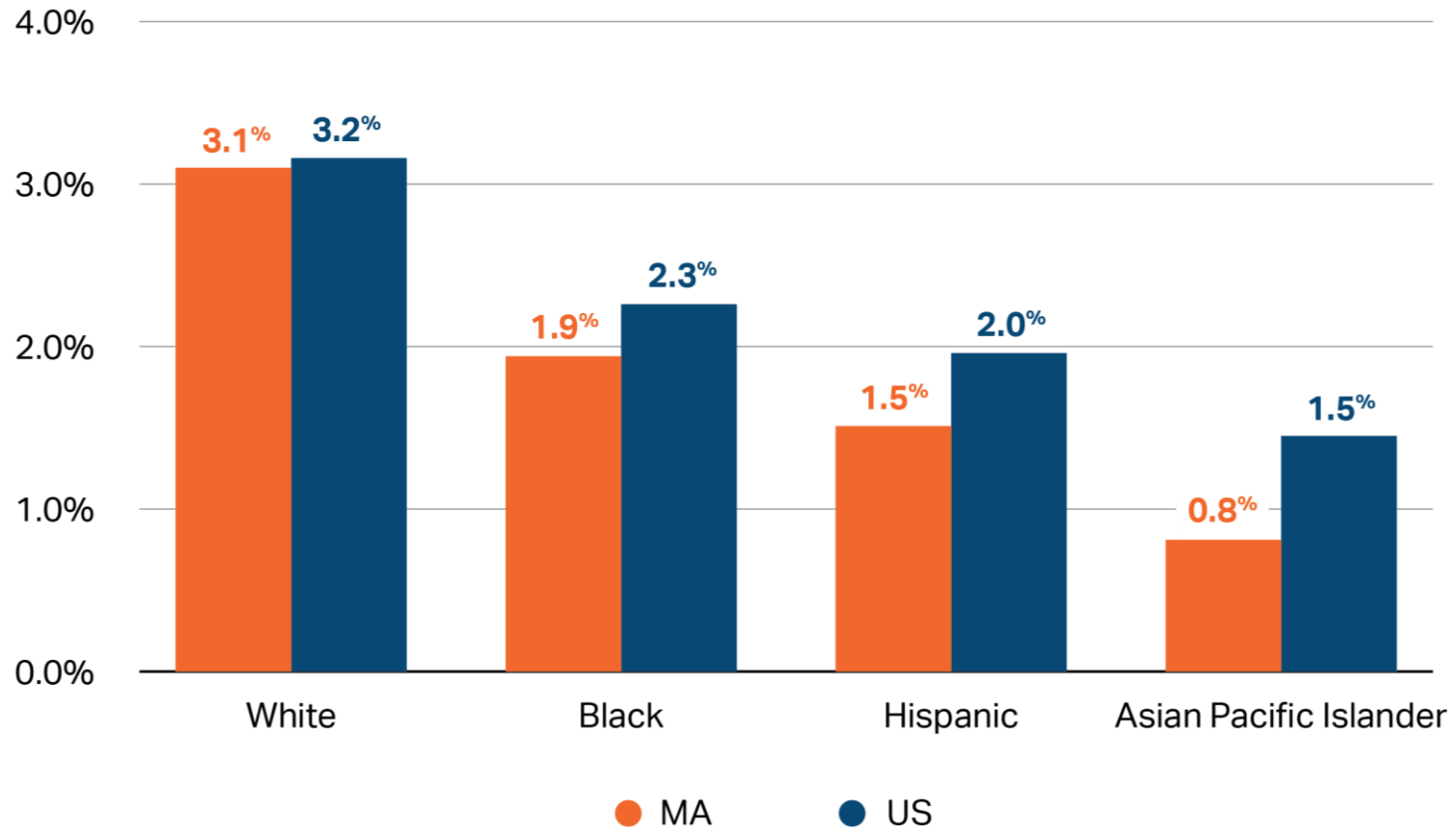
Correlation between percentage of Medicare deaths occurring in the hospital and percentage of beneficiaries enrolled in hospice at the time of death, 2017



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.

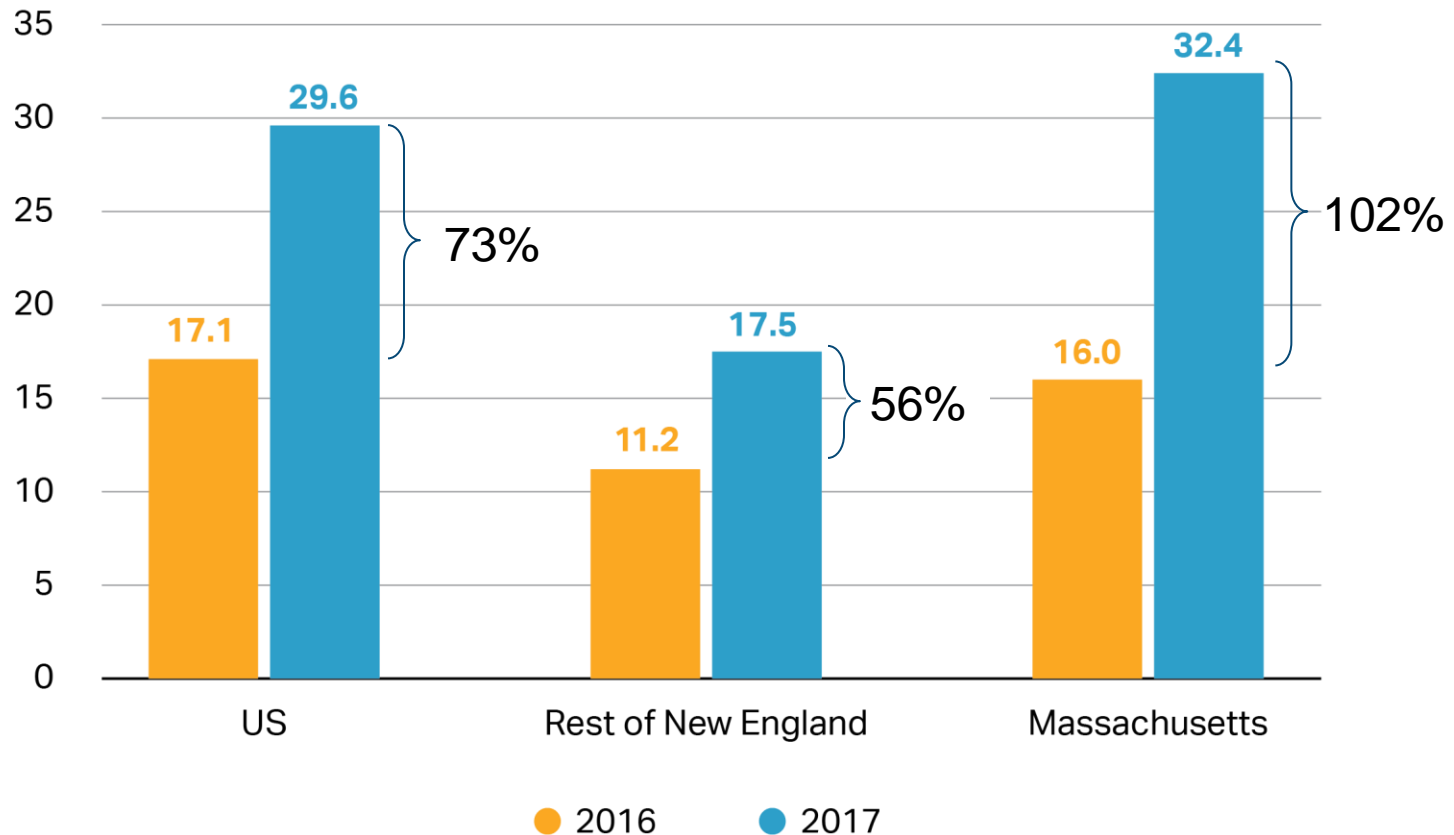
Notes: Race/ethnicity categories included all had >1% of the population distribution of beneficiaries and were not listed as "Other/Unknown". "Other" is not shown in the figure. Hospice users include beneficiaries enrolled in both fee-for-service and Medicare Advantage. Rates of hospice use are lower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

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



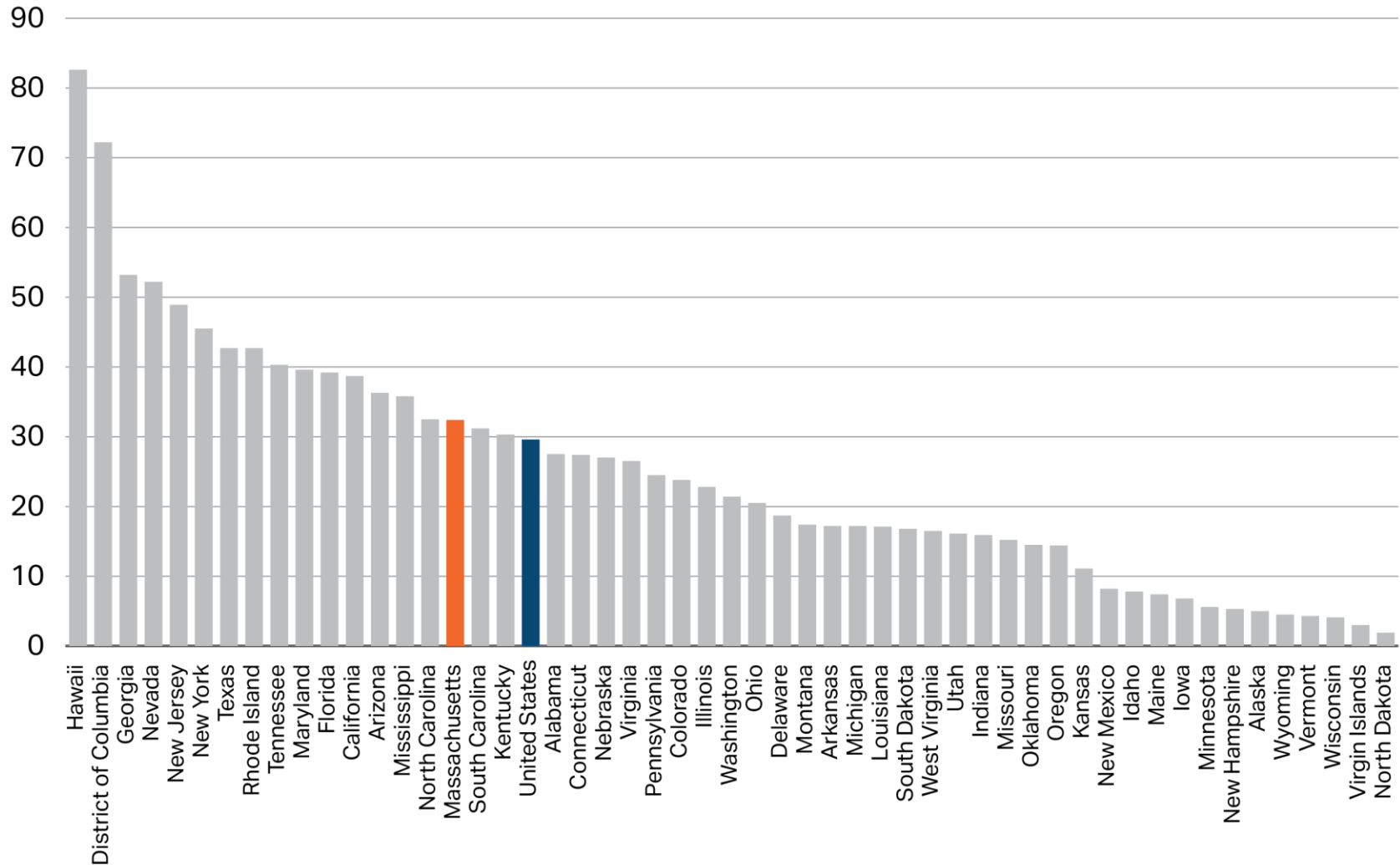
The number of unique providers who provided an advance care planning discussion grew by about 50% in MA (47%) and the U.S. (49%)

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.

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.

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





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Potential Market Responses to the COVID Pandemic

- Small physician groups under financial pressure may choose to join larger health systems or private equity groups
- Smaller hospitals or health systems may be acquired by larger systems
- Hospitals may continue to form outpatient joint ventures with for-profit companies to reduce overhead and gain volume
- There may be further vertical integration of long-term care, post-acute care, and home health care into health systems
- Payers and provider systems may form new relationships through vertical integration or novel ways to share risk for patient populations, including expansion of primary care capitation

Areas of Focus for Transactional Reviews



- Is the transaction driven or altered by the impacts of COVID-19 on one or more of the parties?
- How are the parties' post-affiliation plans informed by COVID-19 as opposed to pre-pandemic practice patterns?
 - Do the parties plan to build more physical space and fill beds, or are investments focused on telehealth, home care, partnerships, etc.?
 - Would any new or renovated physical spaces be designed for infection control and surge conversion?
- How do the parties' transaction plans contribute to health equity and care for vulnerable populations?
- What additional revenue do the parties expect to gain as a result of the transaction, and how will that impact health care spending?



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Overview

- Massachusetts continues to experience high rates of opioid-related injury and death, although this trend may have been moderating.
- The most recent DPH Opioid-Related Overdose Deaths Data Brief shows a 6% decrease in opioid-related overdose deaths from 2016 to 2019.
- The impacts of the COVID-19 pandemic may increase opioid-related injuries and deaths, especially among populations that are heavily impacted by COVID-19, including Black and Hispanic patients.
- The findings presented here are selections from what will be shown in the chart pack.



September is National Recovery Month

National Recovery Month is a national observance held every September to educate Americans that substance use treatment and mental health services can enable those with mental and substance use disorders to live healthy and rewarding lives.

COVID-19 and Opportunities for Increased Treatment of Substance Use Disorders

Potential Impact of COVID-19

Social isolation, economic insecurity, and trauma from the pandemic can lead to initiation of substance use or resumed use

Barriers to accessing in-person treatment, especially at the beginning of the pandemic

Opportunities for Increased Treatment

Expanding the role of telemedicine and telemedicine payment parity

Including initiation of buprenorphine prescribing via telehealth

Easing of restrictions on dispensing of methadone

Take-home methadone dosing has been tied to reduced hospitalizations

Additional providers able to administer or prescribe medication for the treatment of opioid use disorder

Including pharmacists to administer methadone and buprenorphine

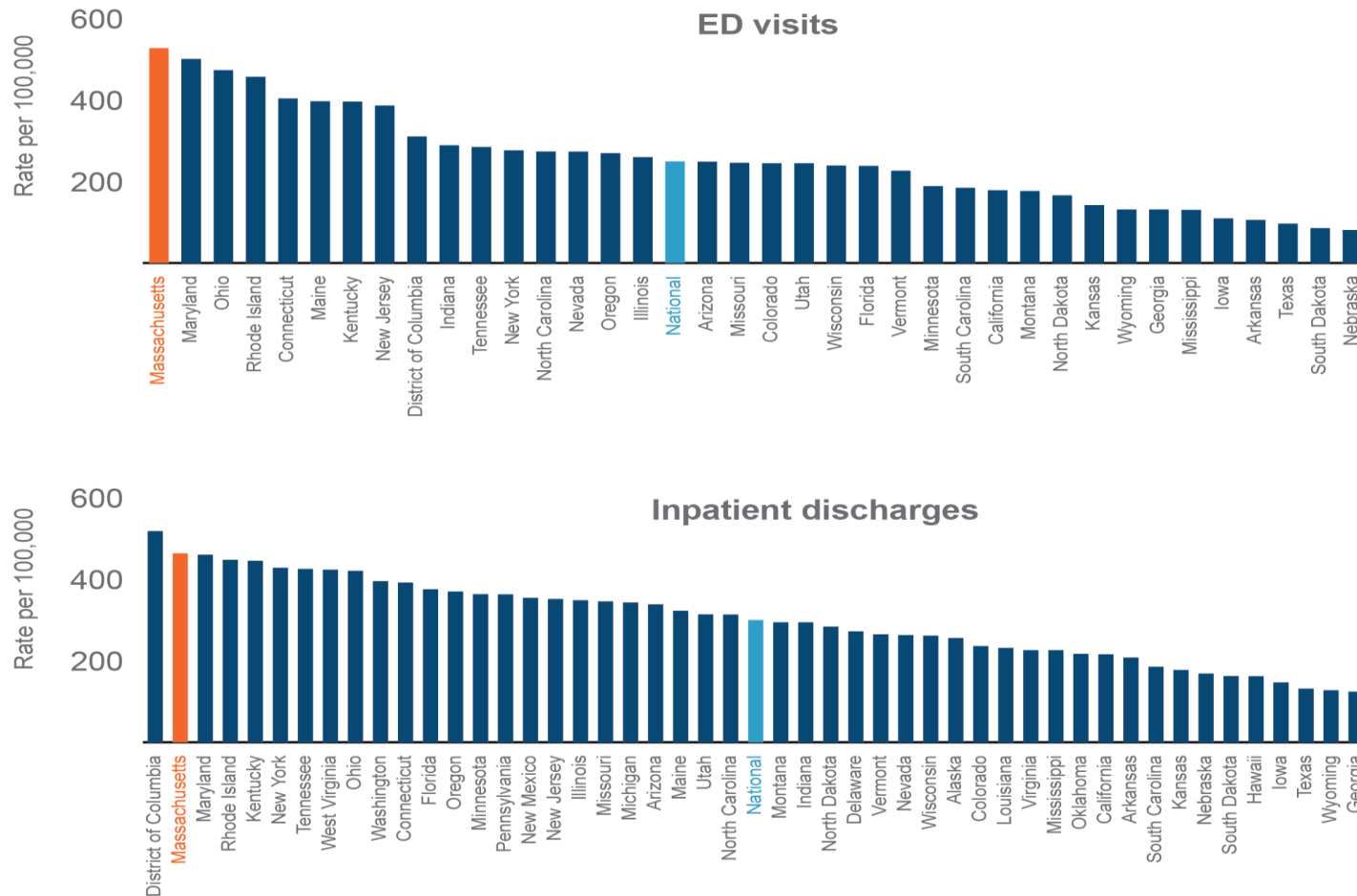
Expanded scope for APRNs to independently prescribe*

Notes: Haley DF, Saitz R. The Opioid Epidemic During the COVID-19 Pandemic. Jama Sept 18,2020.

*APRNs cannot prescribe until they have completed the 24 hours of SAMSHA required training (<https://www.samhsa.gov/medication-assisted-treatment/find-buprenorphine-waiver-training>) For more information see on treatment changes during the COVID pandemic please see: <https://www.mass.gov/doc/alert-regarding-covid-19-for-opioid-treatment-programs/download>; <https://www.mass.gov/doc/guidance-independent-practice-of-advanced-practice-registered-nurses/download>

Massachusetts continues to have one of the highest rates of emergency department and inpatient discharges for opioid-related hospital utilization in the U.S.

Opioid-related Emergency Department and Inpatient Hospitalization by State per 100,000 residents, 2017

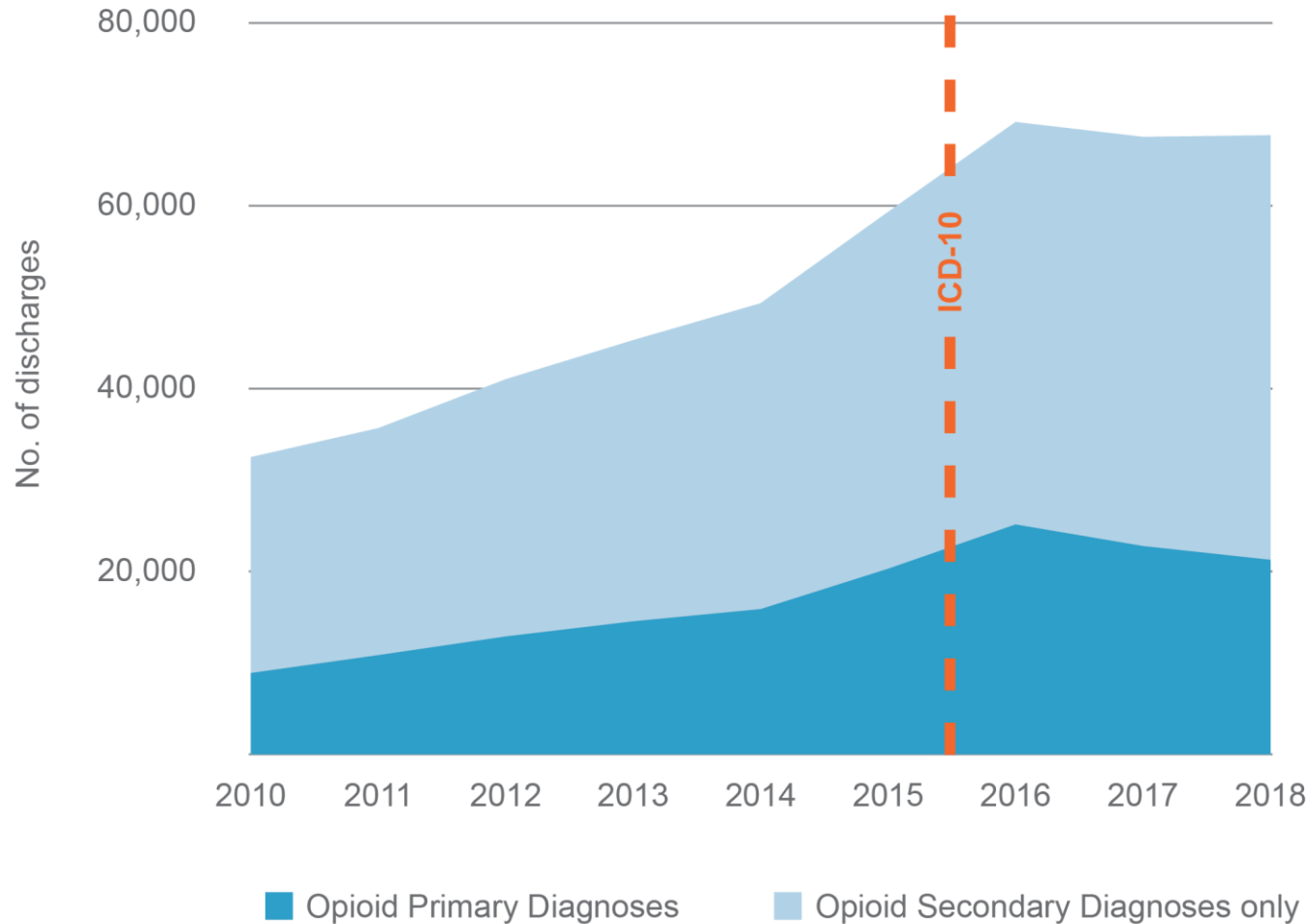


Notes: ED visits are limited to 38 states that reported data and inpatient discharges are limited to 49 states that reported data.

Source: HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). April 2020. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.hcup-us.ahrq.gov/faststats/OpioidUseServlet?setting1=IP#export>

Opioid-related hospitalizations saw a decrease of 2.1% from 2016 to 2018.

Opioid-related Acute Care Hospitalizations (ED Visits and Inpatient Admissions) by Primary or Secondary Diagnosis, 2010-2018

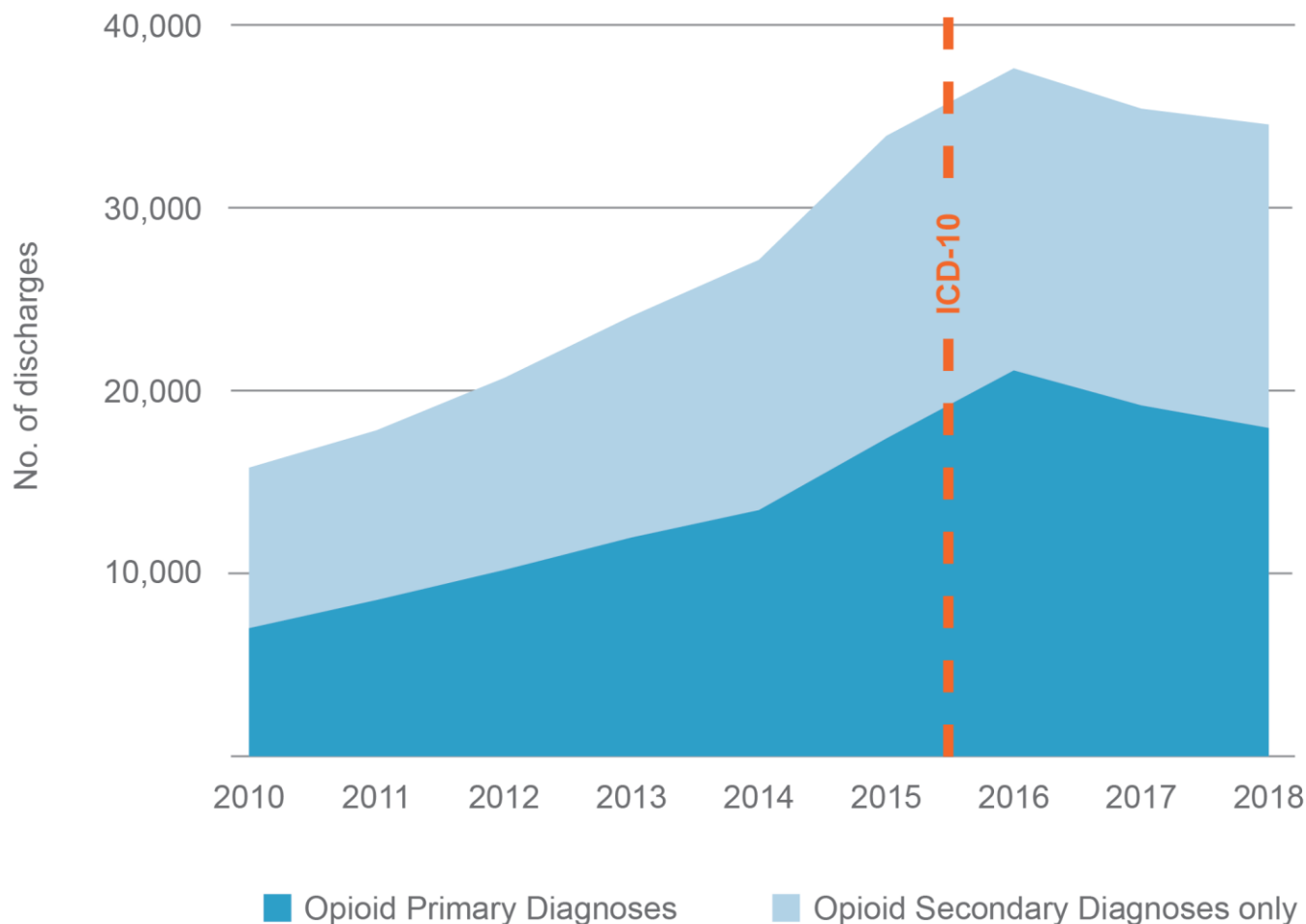


Note: Dates are based on the federal fiscal year, which runs from October 1 to September 30. Some discontinuity in trends may exist between 2015 and 2016 due to the transition from ICD-9 diagnosis codes to ICD-10 diagnosis codes on October 1, 2015. From 2011 to 2014, the CHIA databases included only the patient's first 15 diagnosis codes. However, as of 2015 all of a patient's diagnosis codes are included.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2010-2018.

Opioid-related emergency department (ED) visits declined by 8% from 2016 to 2018.

Opioid-related Acute Care Emergency Department Visits, 2010-2018

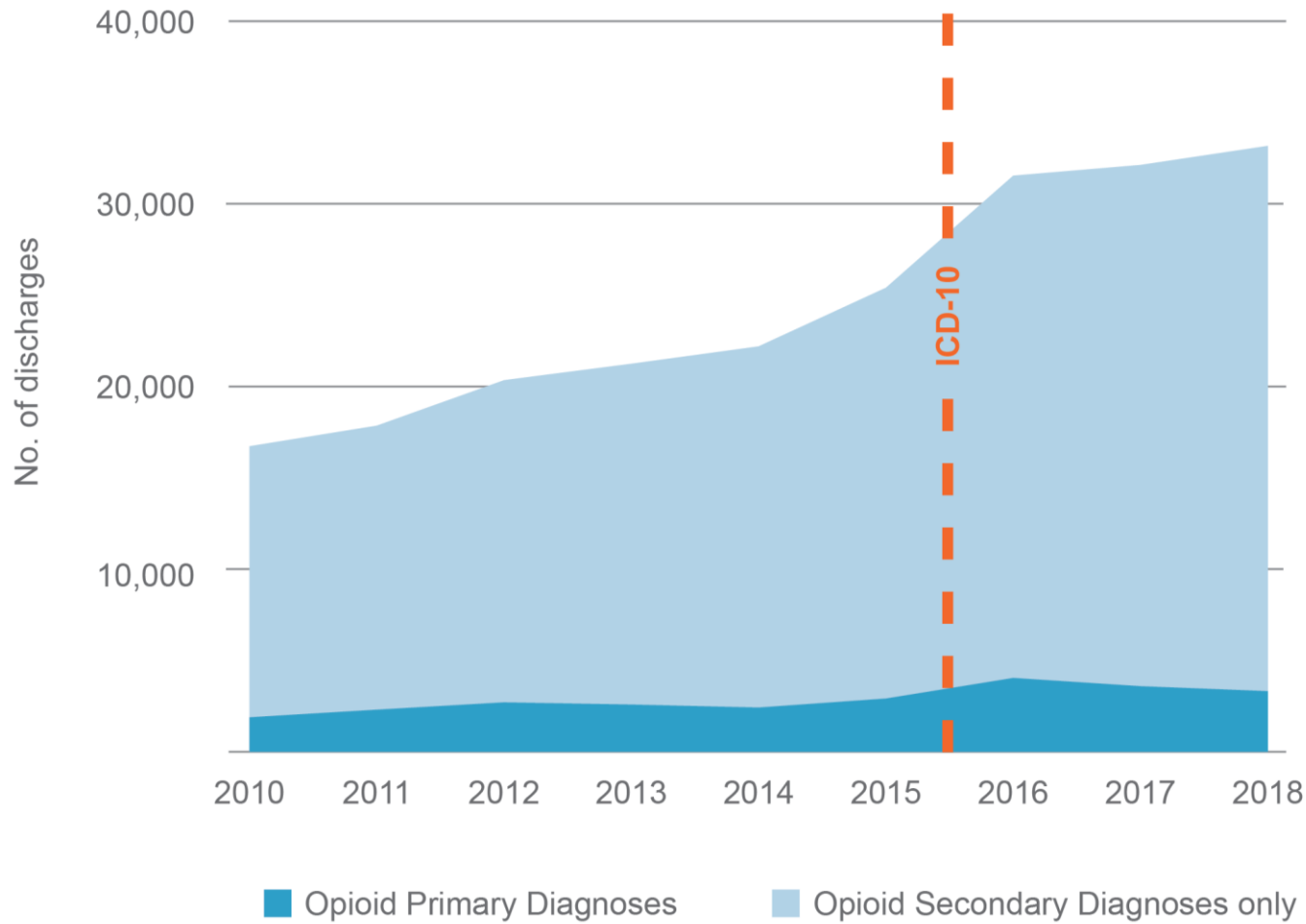


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Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2010-2018.

Opioid-related acute inpatient hospital stays increased by 5% from 2016 to 2018, driven by increases in secondary admissions.

Opioid-related Acute Care Inpatient Admissions, 2010-2018

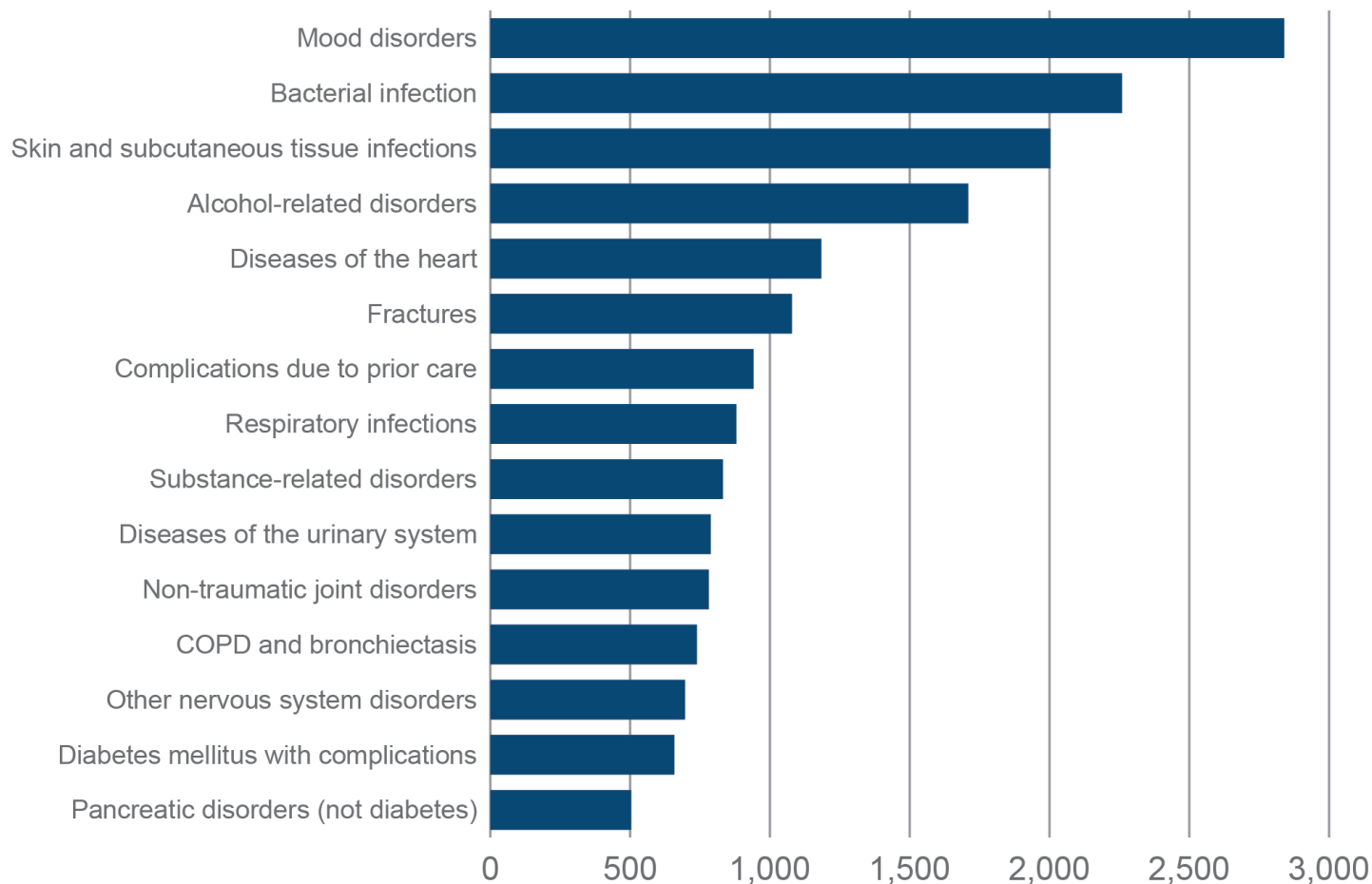


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Source: Data: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2010-2018.

Non-opioid behavioral health diagnoses accounted for 18% of primary diagnoses for patients with a secondary opioid-related diagnosis.

Primary Diagnosis CCS category for stays with secondary opioid-related diagnoses, 2018

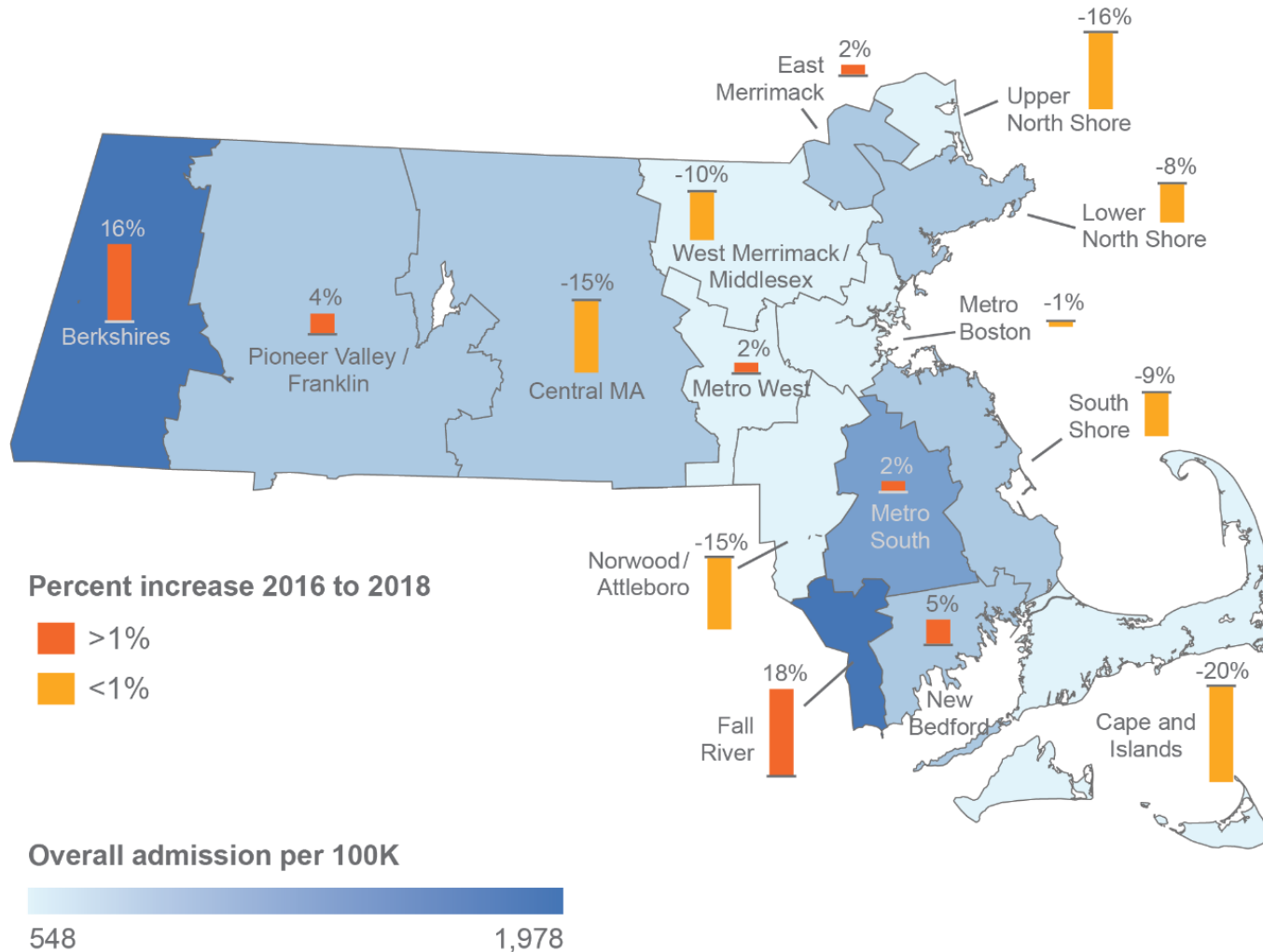


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Source: Data: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2010-2018.

Fall River saw the largest increase of opioid-related hospitalizations from 2016 to 2018, while the Cape and Islands saw the biggest decrease.

Opioid-related hospital discharges by HPC regions of patients' residence, 2016 and 2018

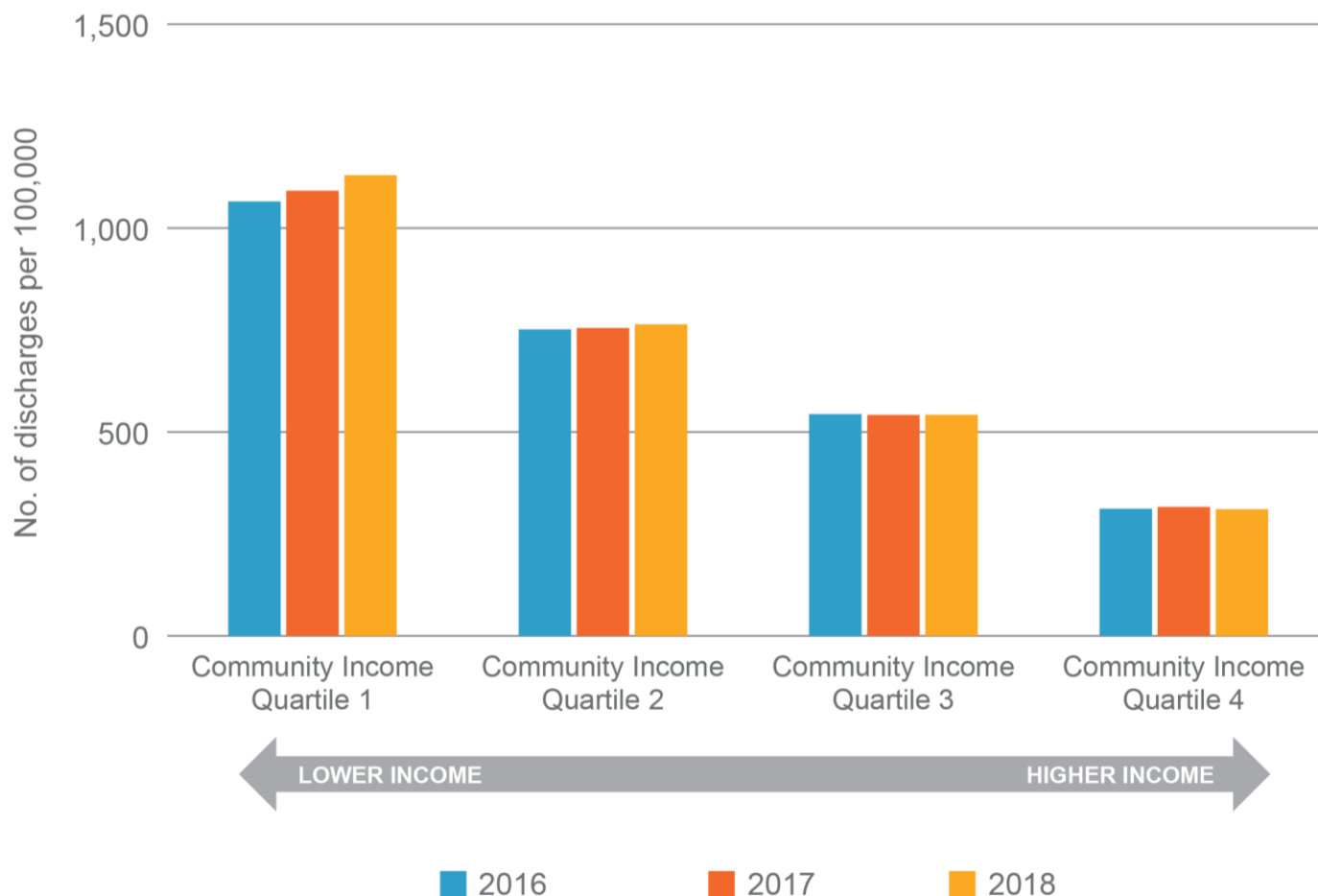


Note: Analysis only includes MA residents.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2016-2018, and U.S. Census, ACS 5 Year Population Estimates,

Residents living in lower-income areas accounted for 41% of all opioid-related discharges, and the percentage increased from 2016 to 2018.

Opioid-related Hospital Discharge Rates per 100,000 by Community Income Quartile, 2016-2018

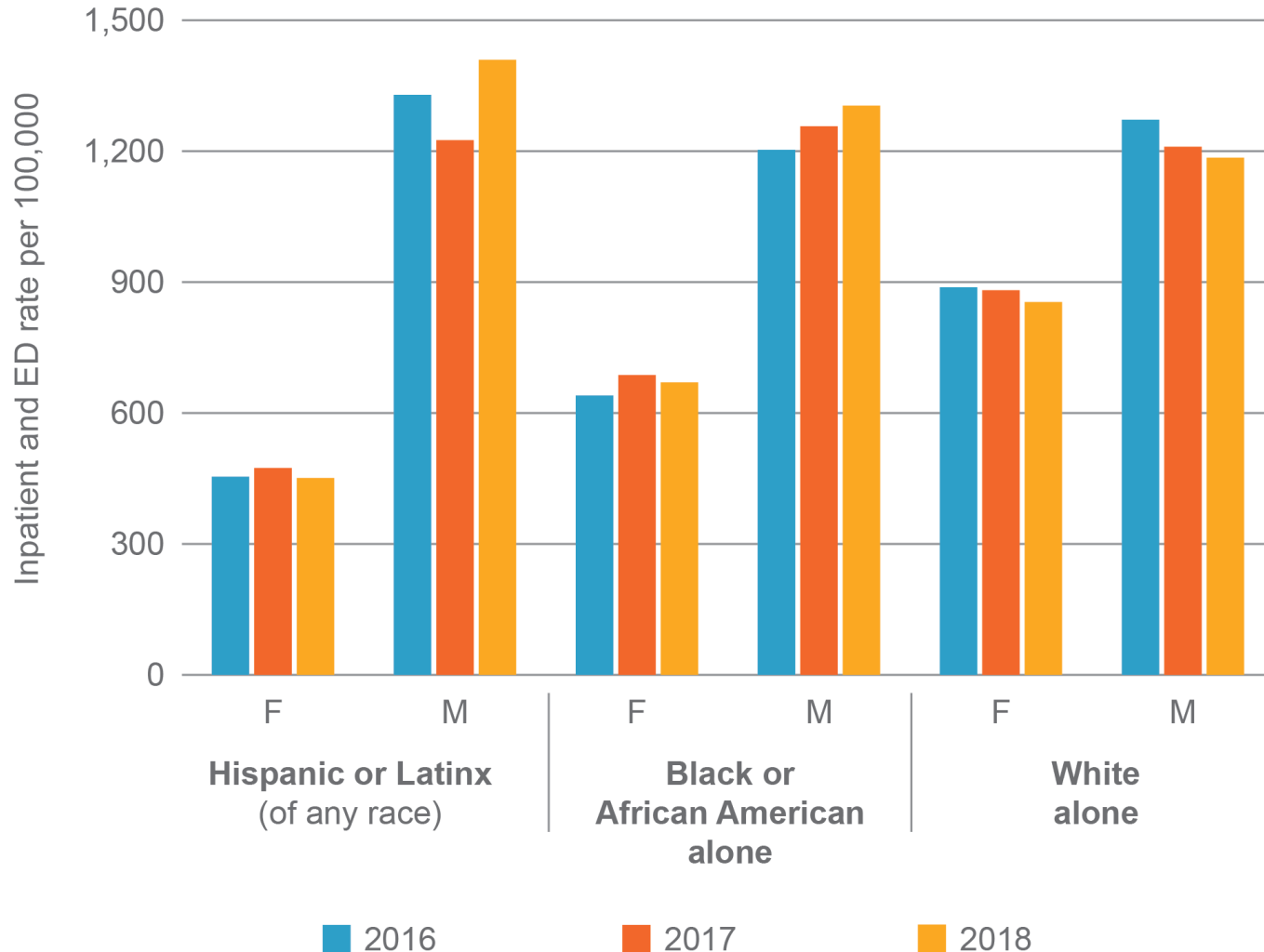


Note: Income quartiles were calculated from 2017 median income by ZCTA and are based on the median income of a patient's residential community, rather than the patient's actual income. Only MA residents are included in this analysis.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2016-2018, and U.S. Census, ACS 5 Year Population Estimates, Median Income by Zip Code Tabulation Areas (ZCTA), 2017.

Both Hispanic and Black men experienced an increase in opioid-related hospitalizations (6% and 8%), while White men saw a decrease of 6.8%.

Opioid-related hospital discharge rates per 100,000 by race, ethnicity, and sex, 2016-2018

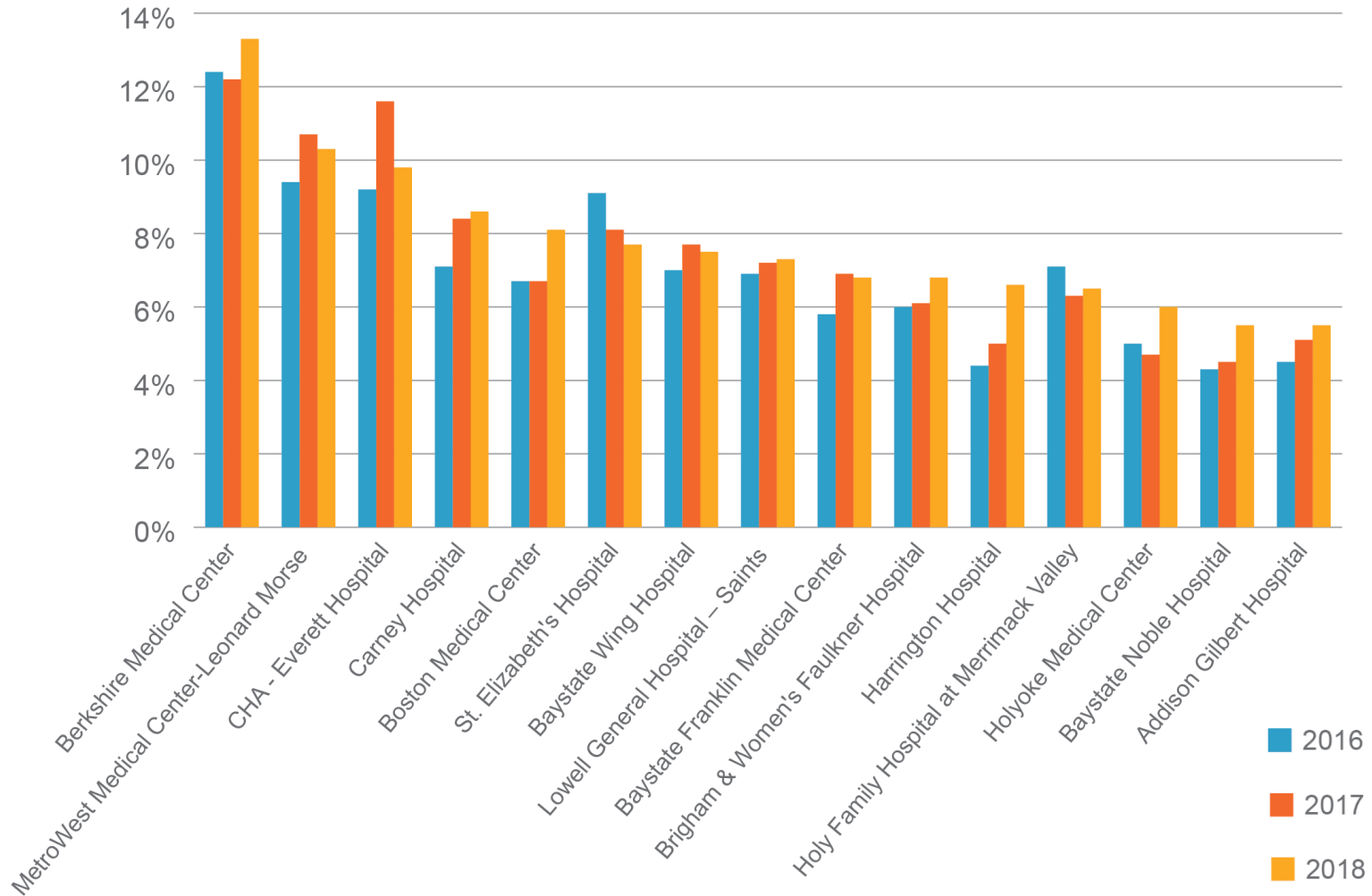


Note: Only MA residents are included in this analysis.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2016-2018, and U.S. Census, ACS 5 Year Population Estimates, Race and Ethnicity for 2016-2018.

Nineteen Massachusetts acute care hospital campuses had over 5% of their inpatient stays listed with an opioid-related diagnosis in 2018.

Percent of inpatient discharges that are opioid-related (top 15), 2016-2018



Note: 63 hospital inpatient campuses in total had over 20 opioid-related inpatient stays. Hospitals with less than 20 were not included in this analysis.
 Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2016-2018

Summary of Findings

- Statewide opioid-related hospitalization utilization declined slightly from 2016 to 2018, but the decline was not uniform across the state.
- Inpatient hospitalizations increased, primarily driven by hospitalizations that had a secondary opioid-related diagnosis. It is unclear what is driving this trend.
- Opioid-related inpatient stays represent a significant amount of inpatient hospital volume in the Commonwealth.
- The 2018 data show an increasing disparity in opioid-related hospitalizations for Hispanic and Black men compared to White men. It is unclear from the data if this is due to new opioid-use, lack of access to community-based treatment, or other causes.
- Residents of lower-income communities in Massachusetts have a disproportionately higher rate of opioid-related hospitalizations; residents of lower-income communities comprised 41% of such hospitalizations despite only accounting for 25% of the population.



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HOSPITAL FINANCIAL PERFORMANCE DURING COVID-19

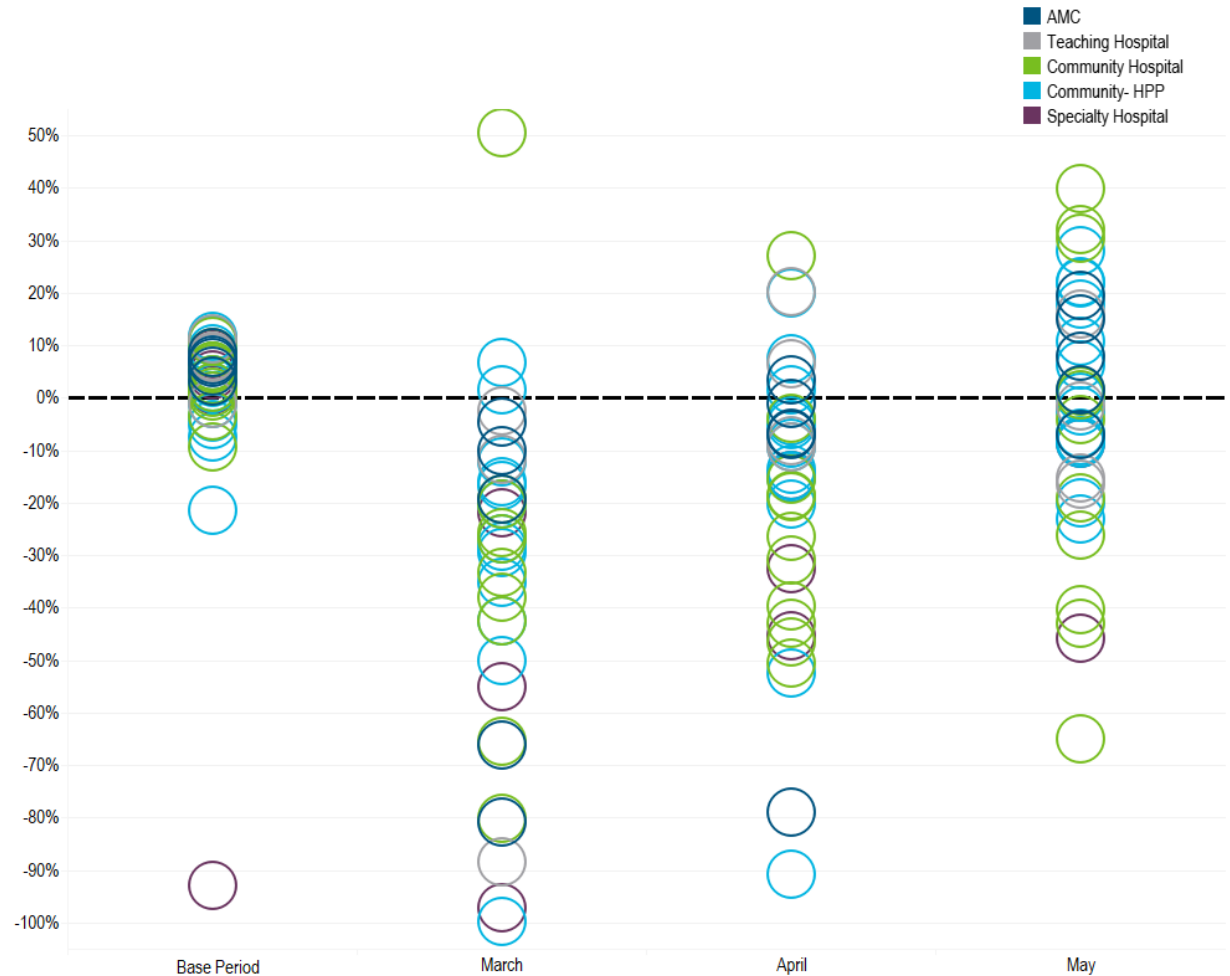
Liz Almanzor, Associate Manager

Background

- Acute care hospitals, associated hospital health systems (HHS), and affiliated physician organizations are required to submit financial statements to CHIA on a quarterly basis
- In order to provide a more timely look at the impact of COVID on the acute hospitals, CHIA worked with stakeholders to implement a voluntary monthly financial filing beginning in March
 - Only collects statement of operations data (revenue, expenses, and profit or loss)
 - Data is due approx. 30 days after month end
 - Isolates COVID relief funds received and calculates metrics with and without COVID funds – suggestion from MHA
- First report was published in August 2020 and included data for March, April, and May
 - 38 of 61 hospitals participated, representing approx. 74% of acute hospital operating revenues

Participating Hospital Total Margin by Month

- A base period was developed for comparison using pre-COVID quarterly data
- 34 of 36 hospitals reported losses in March
- April and May showed some improvement due to federal and state COVID funding



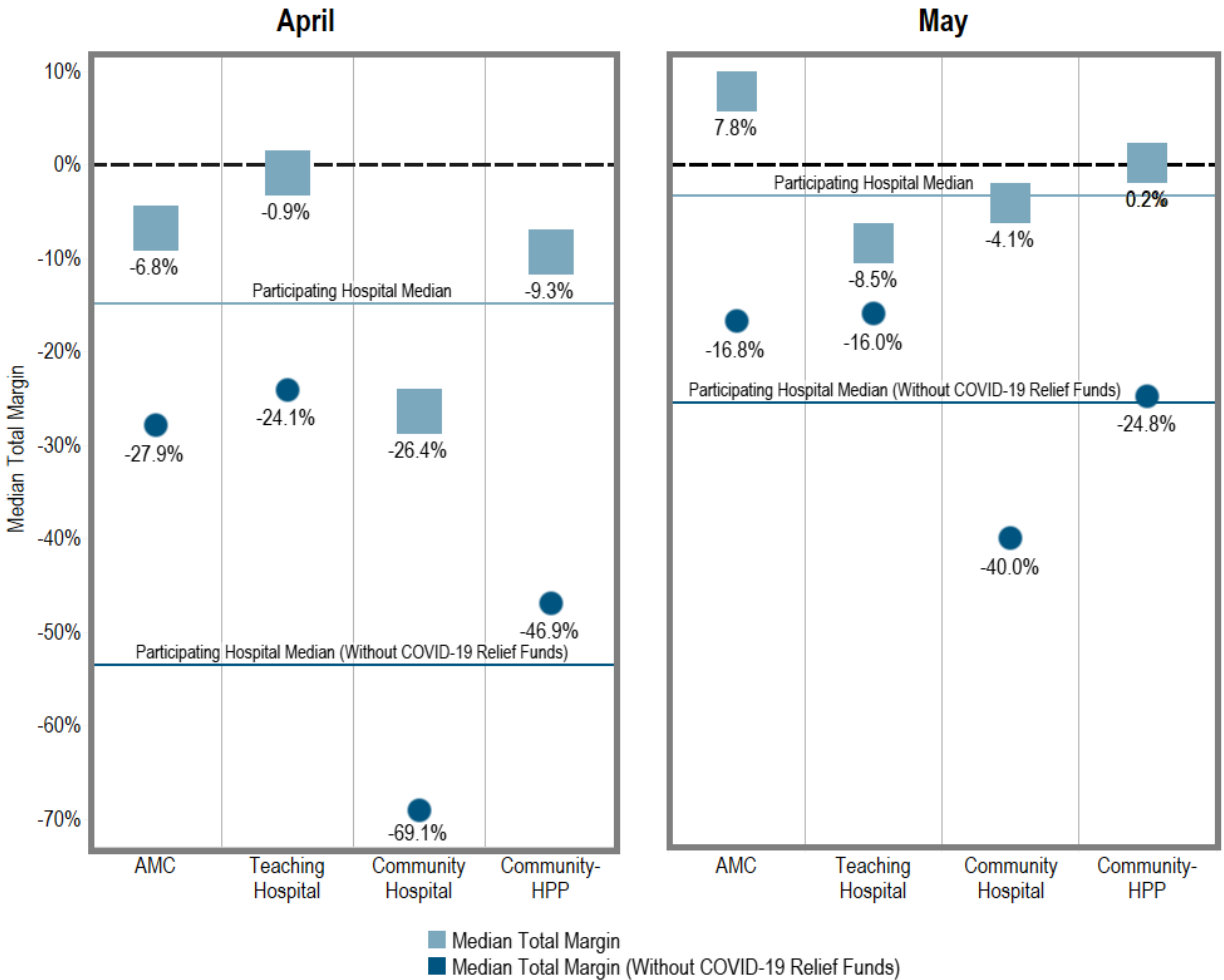
Median Total Margin by Participating Hospital Cohort and Month

	Base Period	March	April	May
Participating Hospital Median	3.4%	-28.9%	-14.9%	-3.3%
AMC (5 of 6)	6.6%	-19.4%	-6.8%	7.8%
Teaching Hospital (4 of 7)	7.9%	-50.1%	-0.9%	-8.5%
Community Hospital (11 of 12)	3.3%	-33.2%	-26.4%	-4.1%
Community- HPP (13 of 30)	1.9%	-26.9%	-9.3%	0.2%

- Median total margins decreased significantly in March across all hospital cohorts
 - Ranged from -50.1% at teaching hospitals to -19.4% at AMCs

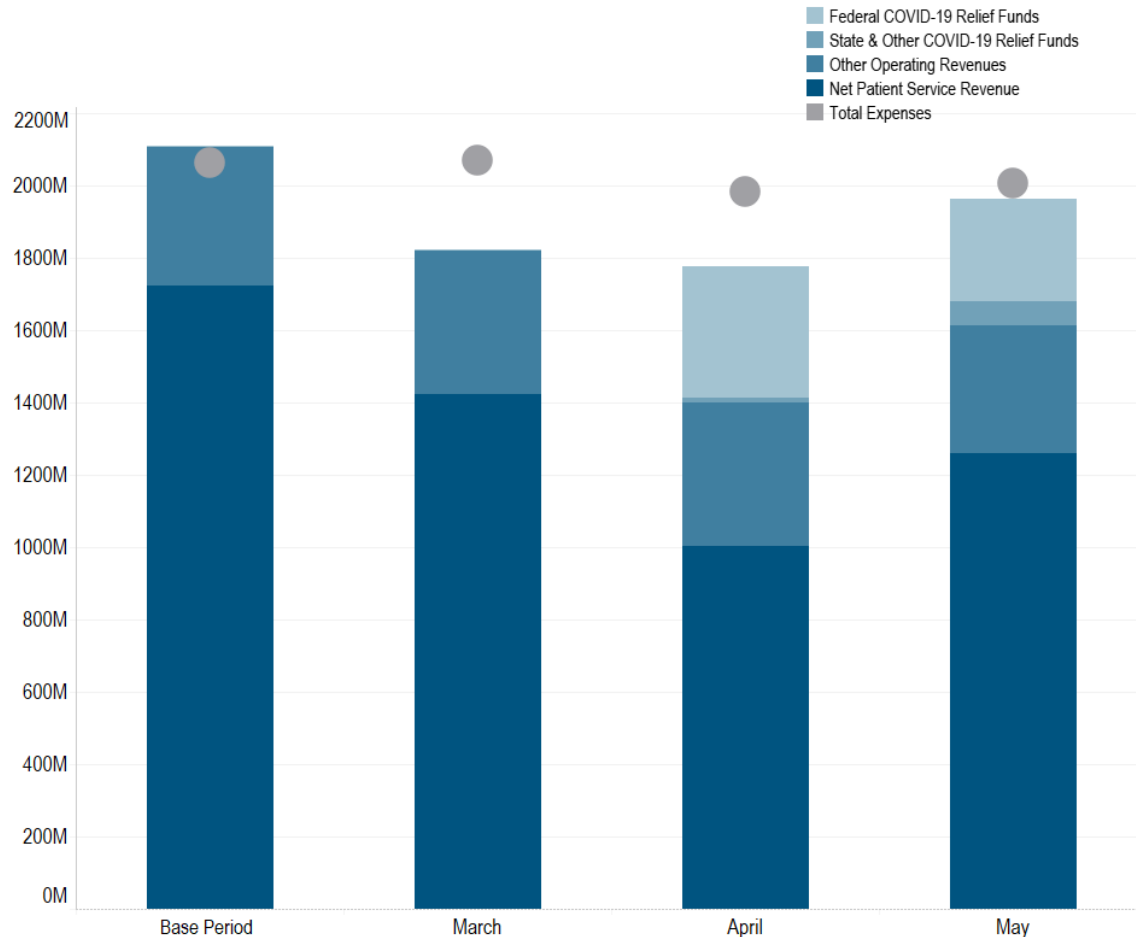
- Federal CARES Act payments improved profitability in April and May, but overall total margins remained mostly unfavorable compared to the base period

Median Total Margin, With and Without COVID Relief Funds



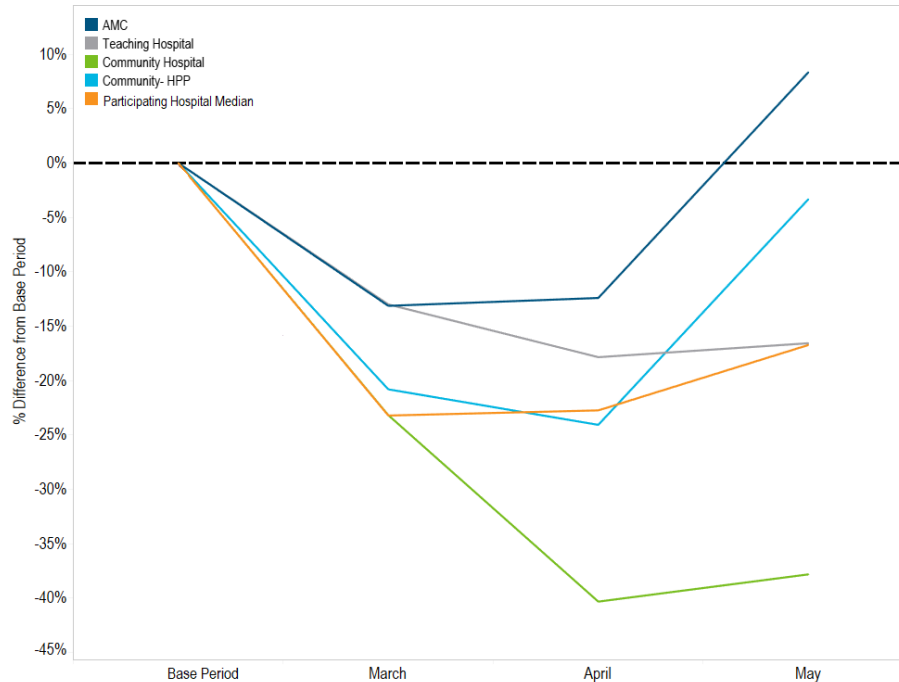
Participating Hospital Operating Revenue and Expense Trends

- Total net patient service revenue (NPSR) was lower in all three months when compared to the base period
 - April had the lowest reported total NPSR
- In aggregate, total operating revenue was lower than total expenses for all three months

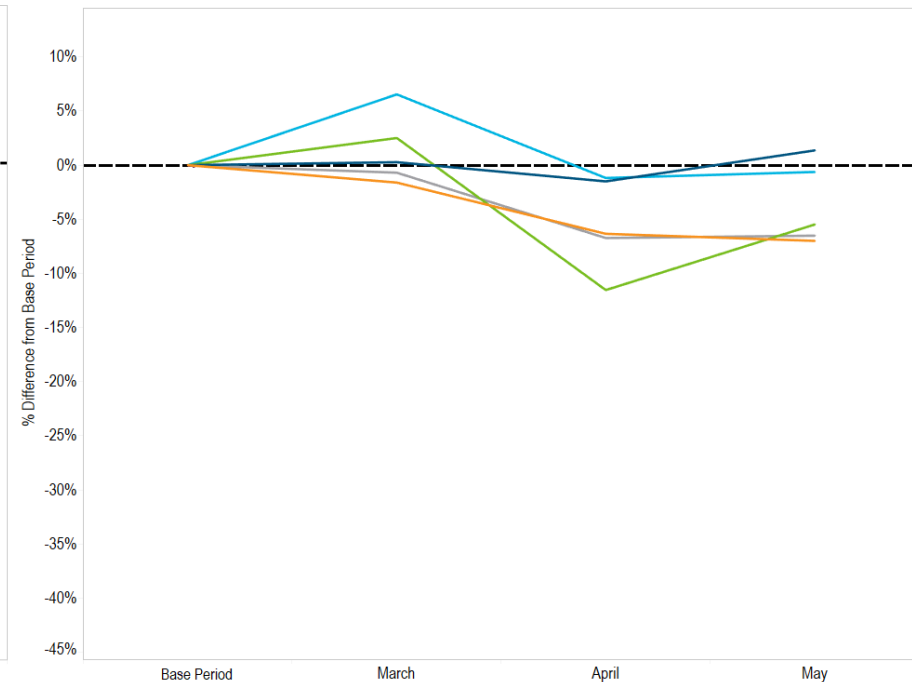


Change in Operating Revenue and Expenses

Median Change in Operating Revenue, by Participating Hospital Cohort



Median Change in Expenses, by Participating Hospital Cohort



- Operating revenue decreased significantly in March and April compared to the base period, while expenses decreased at a slower rate
- Operating revenue includes COVID relief funds received in April and May

Next Steps

- Plan to update the monthly report with June and July data – anticipate publishing in early October
 - We are still receiving and analyzing June and July data from hospitals
- Quarterly filing for the fiscal year-to-date period ending June 30, 2020 is due September 30
 - Report expected in November
 - Filing was expanded to request detailed information on COVID relief funds received

Questions?

- Reports can be found at <https://www.chiamass.gov/hospital-financial-performance/>.



AGENDA

- Call to Order
- Approval of Minutes from May 6, 2020 (**VOTE**)
- Serious Illness and End of Life Care in the Commonwealth
- Impact of the COVID-19 Pandemic on Market Reviews
- Opioid-Related Acute Hospitalization in Massachusetts
- Center for Health Information and Analysis: Hospital Financial Data Collected during the COVID-19 Pandemic
- **Adjournment**