Health Policy Commission Board Meeting

January 13, 2021

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Welcome by HPC Chair Stuart Altman**
- Approval of Minutes from November 18, 2020 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
- Schedule of Next Meeting (April 14, 2021)

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **November 18, 2020** as presented.

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  - Legislative Session Recap (2019 – 2020) and New HPC Responsibilities
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Update on HPC Board Composition

RICHARD LORD

Former HPC Commissioner

- Commissioner Richard Lord was appointed as a member of the inaugural HPC Board in November 2012 by State Auditor Suzanne Bump and served for eight years.
- Commissioner Lord retired in 2019 from his role as President and CEO of Associated Industries of Massachusetts (AIM).

PATRICIA HOUPT

New HPC Commissioner

- Commissioner Patricia Houpt was appointed to the HPC Board in January 2021 by State Auditor Suzanne Bump.
- Commissioner Houpt retired in 2020 from the New England Employee Benefits Council (NEEBC) where she served as executive director for eight years.

STAUTORY DESIGNATION

One member with demonstrated expertise as a purchaser of health insurance representing business management or health benefits administration.

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Happy New Year!

2020: BY THE NUMBERS

RESEARCH AND REPORTING

16
new publications

3
DataPoints and
17
unique online interactive graphics

7
HPC research presentations showcased at national health policy conferences

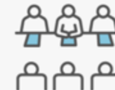
PARTNER

$3.7 million
invested in innovative care delivery models

2
health systems approved for ACO certification

3
equity-focused digital health start-ups "championed"

39
tools and resources shared as part of Learning and Dissemination activities



CONVENING

17
public meetings with
830
slides presented

434
tweets

302,534
Twitter impressions

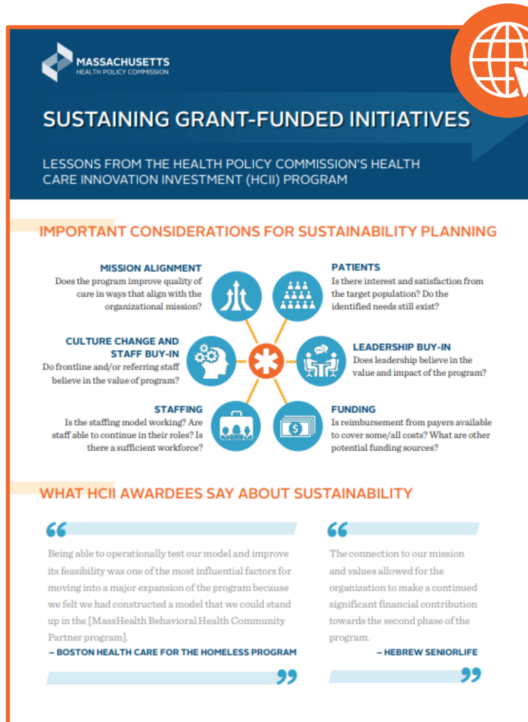
WATCHDOG

11
health market transactions reviewed

369
open enrollment waiver requests

1,221
calls to the Office of Patient Protection hotline

Two New Publications Promote Lessons Learned from HPC Investment Programs and Awardees



MASSACHUSETTS HEALTH POLICY COMMISSION

SUSTAINING GRANT-FUNDED INITIATIVES

LESSONS FROM THE HEALTH POLICY COMMISSION'S HEALTH CARE INNOVATION INVESTMENT (HCII) PROGRAM

IMPORTANT CONSIDERATIONS FOR SUSTAINABILITY PLANNING

MISSION ALIGNMENT
Does the program improve quality of care in ways that align with the organizational mission?

PATIENTS
Is there interest and satisfaction from the target population? Do the identified needs still exist?

CULTURE CHANGE AND STAFF BUY-IN
Do frontline and/or referring staff believe in the value of program?

LEADERSHIP BUY-IN
Does leadership believe in the value and impact of the program?

STAFFING
Is the staffing model working? Are staff able to continue in their roles? Is there a sufficient workforce?

FUNDING
Is reimbursement from payers available to cover some/all costs? What are other potential funding sources?

WHAT HCII AWARDEES SAY ABOUT SUSTAINABILITY

"Being able to operationally test our model and improve its feasibility was one of the most influential factors for moving into a major expansion of the program because we felt we had constructed a model that we could stand up in the [MassHealth Behavioral Health Community Partner program]."
– BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM

"The connection to our mission and values allowed for the organization to make a continued significant financial contribution towards the second phase of the program."
– HEBREW SENIORLIFE

SUSTAINING GRANT-FUNDED INITIATIVES GUIDE

A sustainability guide based on experiences from Health Care Innovation Investment Program awardees that successfully sustained their programs beyond the HPC-funded period.

RELEASED DECEMBER 2020

HEALTH CARE INNOVATION SPOTLIGHT SERIES

MASSACHUSETTS HEALTH POLICY COMMISSION

HEBREW SENIORLIFE

Supporting Older Adults through the COVID-19 Pandemic

DECEMBER 2020

*"I'm just so proud of how **nimble** our leaders and our staff have been. Watching people convert operations on a dime in an effective and caring way, **communicating well**; being able to move quickly, **manage through crisis...** and be **humble** about it."*
– KIM BROOKS, CHIEF OPERATING OFFICER, HEBREW SENIORLIFE

WHEN HEBREW SENIORLIFE (HSL) discovered the first cases of COVID-19 in its senior living community, they had some sense of what was in store for them. Nursing homes and senior living communities across the country had already witnessed first-hand the devastating effects of COVID-19 on older adults, a population that quickly proved to be especially vulnerable to the novel coronavirus. HSL acted swiftly to ensure the health and safety of its senior residents by instituting a shelter-in-place policy for residents and restricting visitors while shutting down most on-site operations and transitioning many staff to remote work. While those restrictions were critical to saving lives, they also created significant challenges for the HSL staff in meeting the day-to-day medical and non-medical needs of senior residents. HSL knew they had to completely rethink their operations to adjust to this new reality. One of the steps HSL took was to **utilize components of an existing HPC-funded program—the Right Care, Right Place, Right Time (R3) program**—to inform the system they put in place to meet the needs of all HSL residents during the pandemic.

ABOUT HEBREW SENIORLIFE

HSL, an affiliate of Harvard Medical School, offers integrated senior living and health care services for seniors. Based in Boston, HSL has provided communities and health care for seniors, research into aging, and education for geriatric care providers since 1903. HSL has six campuses in the Greater Boston area, and serves more than 3,000 seniors each day.

The Power to Redefine Aging. Hebrew SeniorLife HARVARD MEDICAL SCHOOL AFFILIATE

PROGRAM AT A GLANCE

Originally conceived for the HPC's Health Care Innovation Investment Program and continued through the HPC's SHIFT-Care Challenge, HSL's R3 program embeds wellness teams composed of wellness coaches and nurses into senior living communities. These teams conduct regular outreach to and check-ins on residents and help them manage health care needs, access social supports, and connect to other community-based social, medical, and behavioral health organizations. The goal of R3 is to improve outcomes and quality of life by providing better connection to outpatient and community-based services, ultimately reducing the need for acute care services. Prior to the pandemic, the R3 program served 400 high-risk residents at seven affordable housing sites and focused on addressing their health-related social needs. In response to the COVID-19 pandemic, HSL expanded components of the R3 program to all HSL residents and reconfigured its services to address new challenges presented by the pandemic.

*"The [R3 program] was **so foundational and appropriate** that, when [the pandemic] hit, everyone **jumped into gear to apply the principles broadly.**"*
– KIM BROOKS

- 1 -

HEBREW SENIORLIFE COVID-19 SPOTLIGHT

The first in our new Health Care Innovation Spotlight Series, this spotlight features Hebrew SeniorLife and their expansion of the HPC-funded *Right Care, Right Place, Right Time* program to support all residents during the COVID-19 pandemic.

HPC

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An Act Promoting a Resilient Health Care System that Puts Patients First

On January 1, 2021, Governor Charlie Baker signed *An Act Promoting a Resilient Health Care System that Puts Patients First* (S. 2984) into law.

- Coverage for telehealth services
  - Permanent rate parity for tele-behavioral health services and two years of rate parity for primary care and chronic disease management
- Enhanced monthly MassHealth payments for hospitals deemed "high public payer"
- Addresses "surprise billing" with enhanced notice requirements, balance billing protections and process to develop recommendations for appropriate out of network payments
- Reduces scope of practice restrictions for advance practice nurses and optometrists

PROVISIONS IMPACTING THE HPC

- Modified the statute regarding the HPC Board composition to require that one appointee must be a registered nurse with expertise in innovative treatments
- Adds the HPC as a member in two new bodies:
  - Commission on Addressing Racial Inequities in Maternal Health
  - Rare Disease Advisory Council, chaired by the Dept. of Public Health
- Support DOI in developing minimum telehealth accreditation requirements for behavioral health, chronic disease, and primary care services
- Directs the HPC to conduct two new research studies

The HPC will conduct two new studies to examine the impact of COVID-19 and inform future health care policy in Massachusetts.

IMPACT OF COVID-19 ON HEALTH CARE SYSTEM

- Study focused on:
  - Accessibility, quality, and cost of care
  - Impacts to the health care workforce
  - Financial health of health care entities
- Conducted in consultation with CHIA, along with EOHHS, providers and payers, public health and economic experts, patients and caregivers

Interim report due April 1, 2021, and final report due January 2022.

TELEHEALTH SERVICES

- Study conducted, in consultation with CHIA, on the use of telehealth services, and the impact on access and costs
- Study topic areas:
  - Frequency of use, by patient demographics, geography, and type of services
  - Aggregate savings and costs
  - Coverage and payment rates
  - Barriers to telehealth care, and impact on health care utilization and expenditures
- Report to include recommendations on appropriate reimbursement rates

Interim report due in one year and final report due in two years.

Out-of-Network Billing in Massachusetts

The new law addresses the objectives of a comprehensive out-of-network billing solution:

1. **Reduce OON billing scenarios**: New disclosure and transparency requirements for health care providers and insurers in advance of non-emergency procedures
2. **Remove patients from the payment equation**: Prohibits OON providers who fail to provide the required notifications from balance billing (subject to fines beginning in 2022)
3. **Establish reasonable and fair provider reimbursement**: Requires the Secretary of Health and Human Services, in consultation with the Health Policy Commission, Center for Health Information and Analysis, and the Division of Insurance, to develop a report and make recommendations on establishing noncontracted, OON commercial rates for emergency and non-emergency services no later than September 1, 2021.
   - Among other requirements, the report must include an assessment of potential noncontracted, OON commercial payment rates and the impact of such rates on various factors (e.g., provider financial stability, growth of total health care expenditures), and best practices in other states

HPC

https://malegislature.gov/Bills/191/S2984

Out-of-Network Billing: New Federal Law

The **No Surprises Act** addresses the objectives of a comprehensive out-of-network (OON) billing (or "surprise billing") solution for OON emergencies and certain OON care received at in-network facilities (beginning in 2022):

1. **Reduce OON billing scenarios**: New disclosure and transparency requirements for health care providers and insurers
2. **Remove patients from the payment equation**: Prohibits balance billing and holds patients harmless to in-network cost-sharing levels
3. **Establish reasonable and fair provider reimbursement**: Following a 30-day period for negotiation, providers and insurers may utilize an independent dispute resolution (IDR) process; IDR entity chooses one of the parties' final offers (i.e., binding "baseball style" arbitration)
   - Among other factors, IDR entity <u>must</u> consider median contracted rate, <u>may</u> consider parties' recent prior contracting history – but <u>may not</u> consider usual and customary or billed charges, or reimbursements paid by public payers (e.g., Medicare, Medicaid)

- Applies to **providers, facilities, and air ambulances** (establishes advisory committee for ground ambulances, which are excluded), and to **fully-insured and self-insured** health plans
- Requires numerous publications and reports (e.g., Department of Health and Human Services publication about IDR, GAO report on impact of surprise billing provisions)

https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf

Impact of new federal and state laws, and what's next?

- In recent years, many states have enacted OON billing laws; 17 states have comprehensive protections in place, and another 15 states have limited protections[1]
- The No Surprises Act **does not preempt state laws** governing OON billing
- The new federal law raises many questions, including about:
  - **Implementation of the No Surprises Act**, including rulemaking and promulgation of regulations by various federal agencies (e.g., Department of Health and Human Services, Department of Labor, Department of the Treasury) on topics including the methodology for determining the median contracted rate, and establishing the independent dispute resolution process
  - **Effect of implementation on state laws**, particularly in states with an existing payment standard and/or dispute resolution process
  - Implementation of **Massachusetts law and required study**

HPC

[1]https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/state-balance-billing-protections

FY 2021 State Budget: Analysis and Report on Nurse Licensure Compact

- The final FY 2021 state budget includes a mandate for the HPC, in consultation with the Board of Registration in Nursing (BORN), to conduct **an analysis and issue a report evaluating the Commonwealth's entry into the nurse licensure compact** (NLC)
- The NLC allows registered nurses (RNs) and licensed practical nurses (LPNs) to hold a single multi-state license to practice in their home state and other NLC states
  - 34 states have joined the NLC to date
  - Though legislation has been proposed in the past, MA is not in the NLC
- Among other requirements, the study (to be completed **no later than June 15, 2021**) includes:
  - An analysis of whether entry into the NLC would increase the Commonwealth's emergency and pandemic preparedness;
  - An analysis of other states' entry into the NLC and any impact on quality of care resulting from entry;
  - An analysis of the ability of RNs and LPNs in the Commonwealth to provide follow-up care across state lines, including via telehealth; and
  - Recommendations regarding the Commonwealth's entry into the NLC
- **Anticipated next steps include**: (1) consultation with BORN; (2) literature review; and (3) research on compact-participating states (including, e.g., New England states in the NLC)

https://malegislature.gov/Budget/FinalBudget

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- **Care Delivery Transformation**
  - ACO Certification 2022: Learning, Equity, and Patient-Centeredness (LEAP) Final Design **(VOTE)**
- Market Oversight and Transparency
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HEALTH POLICY COMMISSION

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  - **ACO Certification 2022: Learning, Equity, and Patient-Centeredness (LEAP) Final Design (VOTE)**
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Principles for Revising the HPC's ACO Certification Framework

Recognize that knowledge on ACOs is still developing

ACOs and the policy community are still learning what works: ACO cost and quality performance tends to improve with experience

Provide flexibility to ACOs

Minimize reporting burden, provide substantial flexibility to ACOs, and allow for a multitude of approaches while requiring adherence to core principles for delivery system transformation

Focus on capacity for learning, improvement, and innovation

Emphasize capacity for continuous improvement and innovation to ensure ACOs are positioned to learn from success and failures*

Advance health equity in the Commonwealth

Incorporate health equity principles into the certification standards to encourage and support systemic improvements

*Consistent with the National Academy of Medicine's (formerly the Institute of Medicine) 'Learning Health System' concept

Public Comment on Proposed Certification Updates, by the Numbers

The HPC issued a Request for Public Comment this fall to seek input on proposed updates to the ACO Certification requirements for 2022-23.

10 comment letters, 26 total pages of comments

8 HPC-certified ACOs

4 advocacy and trade organizations

Proposed Updated Requirements for ACO Certification 2022: Learning, Equity, and Patient-Centeredness (LEAP)

1 Pre-Requisites

3 required pre-reqs.
Attestations, org chart , risk contracts template

- ✓ Identifiable and unique governing body
- ✓ At least one risk contract with a public or private payer
- ✓ Legal compliance: RBPO certificate, if applicable; any required MCNs filed; anti-trust laws; patient protection; RPO filings

2 Assessment Criteria

5 criteria
Sample ACO documents, narrative descriptions, HPC templates

- ✓ Patient-centered care
- ✓ Culture of performance improvement
- ✓ Data-driven decision-making
- ✓ Population health management programs
- ✓ Whole-person approach

Must show one health-equity focused activity or initiative

3 Required Supplemental Information

3 domains
Narrative or data
Not evaluated by HPC but must respond

- ✓ Activities to improve health equity, including governance representation and patient data collection
- ✓ Use of innovative care models, including telehealth
- ✓ Strategies to control TME growth

HPC

AC-1

PATIENT-CENTERED CARE

The ACO collects and uses information from patients to improve and deliver patient-centered care.

The ACO's leadership **systematically monitors and assesses** the experience, perspectives, and/or preferences of the patient population served.

This information—collected from sources like validated patient experience data or other patient surveys and feedback—**informs the ACO's strategy and/or organization-level initiatives** for improving care delivery.

AC-2

CULTURE OF PERFORMANCE IMPROVEMENT

The ACO fosters **a culture of continuous improvement, innovation, and learning** to improve the patient experience and value of care delivery.

This culture is demonstrated by such things as: ACO-sponsored citizenship activities for ACO Participants; demonstrated leadership commitment; internal financial incentives; defined systems or pathways for innovation and improvement; selection or evaluation of partners based on alignment with ACO cultural priorities; or support for a primary care transformation strategy.

AC-3

DATA-DRIVEN DECISION-MAKING AND CARE DELIVERY

The ACO is committed to using the best available data and evidence to guide and support improved clinical decision-making.

To facilitate learning among providers, decrease unwarranted variations in care delivery, and support provider adherence to evidence-based guidelines, the **ACO adopts processes or tools that make available reliable, current clinical knowledge at the point of care**.

The ACO also collects and **offers providers actionable data** (e.g., on quality, safety, cost, and/or health outcomes) to guide clinical decision-making, identify and eliminate waste, and enable high-value care delivery.

AC-4

POPULATION HEALTH MANAGEMENT PROGRAMS

The ACO develops, implements, and refines programs and care delivery innovations to coordinate care, manage health conditions, and improve the health of its patient population.

The ACO **collects and utilizes data** to understand the health needs of its patient population. This may include use of stratification algorithms, predictive analytics, or patient screening tools in primary care settings.

The ACO uses this data to design and implement **one or more patient-facing population health management programs** that address areas of need for a defined patient population. The ACO **sets targets for and measures the impact of these programs** to support continuous performance improvement over time.

AC-5

WHOLE-PERSON CARE

The ACO recognizes the importance of non-medical factors to overall health outcomes and cost of care and seeks to integrate behavioral health and health-related social supports into its care delivery models.

The ACO has taken steps – with respect to workforce, administration, clinical operations, and/or funding – to **integrate behavioral health care** into primary care settings. The ACO also **sets and measures progress on discrete goals** for increasing integration over time.

The ACO also has taken steps to **understand and address its patients' health-related social needs** through screening and referral relationships with community-based and/or social service organizations. The ACO also **sets and measures progress on discrete goals** for improving the effectiveness of these processes.

Embedding Health Equity into the ACO Certification Standards

The proposed updated standards will require that ACOs demonstrate an intentional commitment to improving health equity.

- ACOs must show an **intentional activity or initiative to improve health equity** in any one of the Assessment Criteria domains

- In addition to meeting the requirements of that Assessment Criterion, this response and documentation must describe:

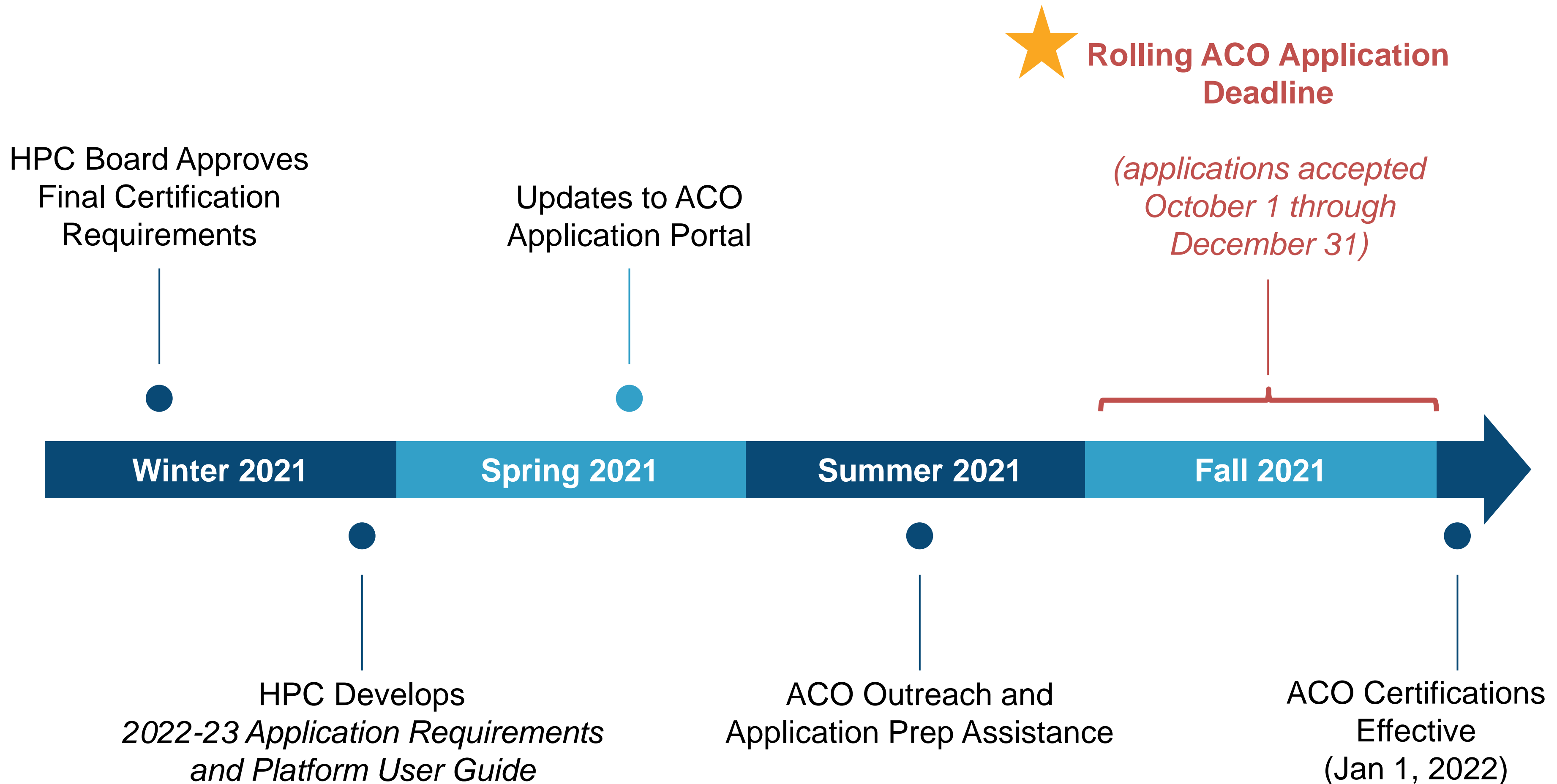
  - The specific health equity issue to be addressed, including specific populations impacted by the inequity

  - How the ACO identified the health equity issue to be addressed, including any formal or informal data sources used

  - What the ACO activity or initiative is and how it aims to address the issue, including specific goals for improvement

Supplemental Information questions will also gather structured data on overall **ACO priorities and activities** to promote health equity.

Modified ACO Certification Timeline



The rolling application deadline will accommodate organizations that find their processes are still impacted by COVID-19 in the second half of 2021.

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Final Design for ACO Certification 2022: LEAP

MOTION: That, pursuant to section 15 of chapter 6D of the Massachusetts General Laws, the Commission hereby establishes updated certification standards for accountable care organizations to be certified beginning in 2022, as presented and as shall be finalized by Commission staff.

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  - Harvard Pilgrim Health Care and Tufts Health Plan Merger
  - Presentation: High Out-of-Pocket Spending
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Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	27	22%
Physician group merger, acquisition, or network affiliation	24	20%
Acute hospital merger, acquisition, or network affiliation	24	20%
Clinical affiliation	23	19%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	14	12%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

HPC

Notices Currently Under Review

- The proposed acquisition of **Harrington Health Care System (Harrington)** by **UMass Memorial Health Care**. The Harrington system includes Harrington Memorial Hospital, with campuses in Southbridge and Webster, MA; its affiliated multispecialty physician group of over 65 physicians; and Harrington's physician hospital organization.

Elected Not to Proceed

- A proposed joint venture between **Baystate Medical Center** and **Kindred Healthcare** to build and operate a new DMH-licensed behavioral health hospital.
- A proposal by **Lawrence General Hospital** to form an integrated delivery network called the Lawrence Integrated Health Provider Network.
- A proposed affiliation between **Baystate Medical Practices** (Baystate), a subsidiary of Baystate Health, and **Valley Medical Group** (VMG), in which VMG would lease its practice locations and assign its professional revenue to Baystate in exchange for lease payments.
- A proposed acquisition of **Community Visiting Nurses Association**, based in Attleboro, by **HopeHealth**, a Rhode Island-based nonprofit system that provides home health and hospice care services in Massachusetts and Rhode Island.

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Tufts Health Plan and Harvard Pilgrim Health Care Merger

On January 1, 2021, **Tufts Health Plan (THP)** and **Harvard Pilgrim Health Care (HPHC)** officially merged.

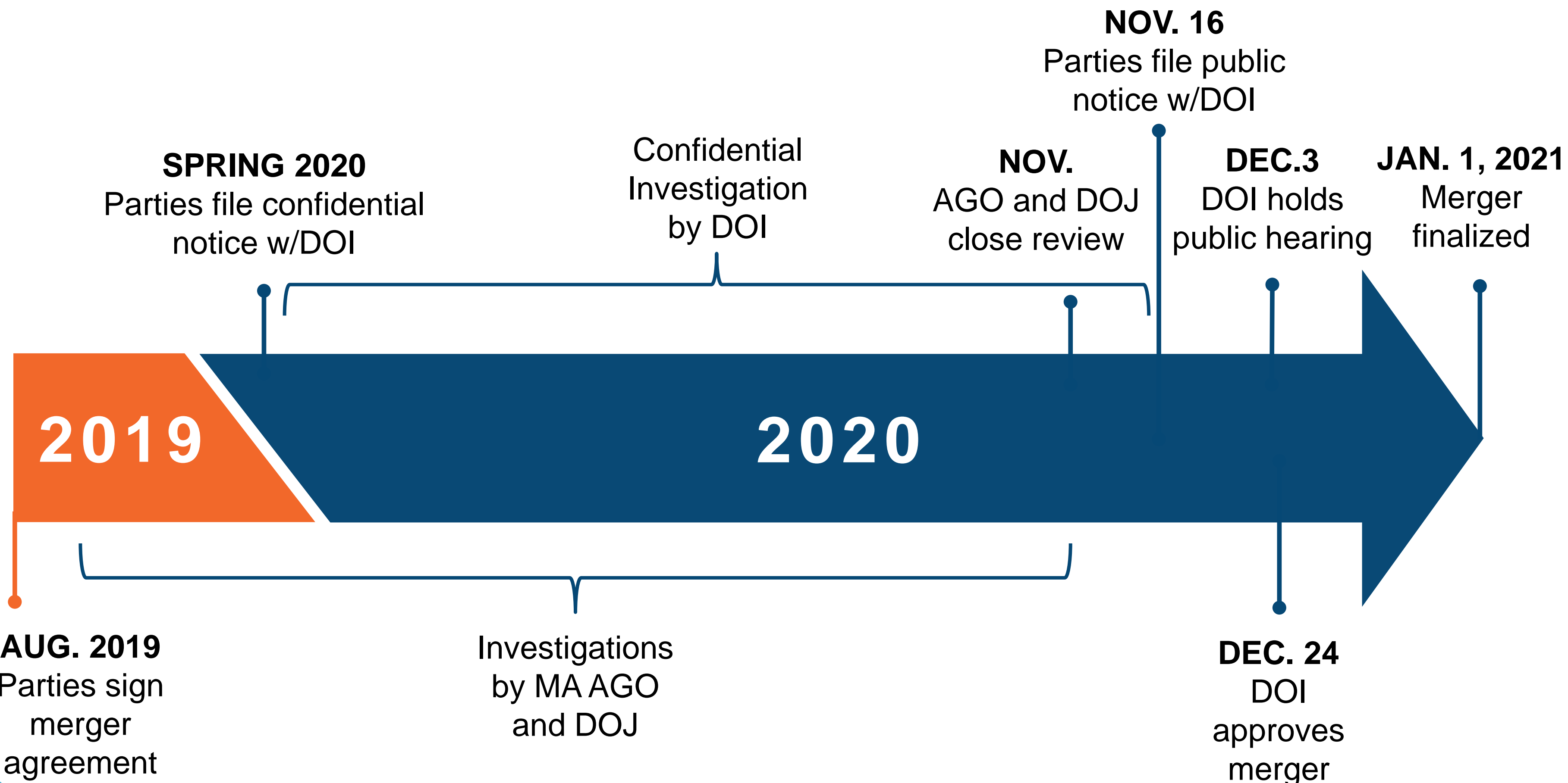
STATED GOALS

The parties state that they seek to harness the combined strengths of their respective organizations and to bring value to the community, including by:

- Improving **affordability** through scale and administrative cost efficiencies, providing high value, more affordable health plans to consumers
- Increasing **access** through geographic reach and product diversity by enhancing population health capabilities, enabling care for underserved communities and offering a broader set of insurance choices across age and income groups
- Improving **quality** of health through enhanced capabilities for population health and clinical engagement. The new organization will build upon a rich legacy of provider collaborations, promoting investments in population health capabilities
- Streamlining **customer experience** through investment in innovative tools and capabilities

Timeline of Reviews

The merger follows reviews by the **Massachusetts Attorney General's Office (AGO)** and other state attorneys general, the **US Department of Justice (DOJ)**, and the **Massachusetts Division of Insurance (DOI)**. The merger did not have to undergo HPC review.



HPC

Background on the Parties: Tufts Health Plan

- Non-profit health plan operating in Massachusetts, Rhode Island, Connecticut, and New Hampshire. Includes Tufts Health Plan (THP) and Tufts Health Public Plans (THPP) (formerly Network Health), which are corporately affiliated but operationally distinct.
  - Primary service area in Massachusetts is eastern and central MA, with limited presence in the western part of the state (Berkshires, Hampden, Franklin) and on Cape Cod.
- Combined, THP and THPP had approximately 908,500 members as of March 2020.
  - 543,000 private commercial members
  - 96,900 Medicare Advantage members
  - 201,100 MassHealth ACO members in partnership plans with Atrius, BIDCO, Children's, and Cambridge Health Alliance and 57,800 MassHealth MCO members
  - 9,700 SCO / OneCare members
- THPP has seen rapid growth in its new individual and small group commercial plans.
- Mental Health benefits are managed internally; CVS/Caremark is its PBM
- Affiliated with Cigna for national accounts
- In Massachusetts, THP and THPP combined have the second-largest total enrollment across their plans.
- Tufts Health Plan had $5.7B in revenue in FY19.

Source: CHIA Enrollment Trends Databook, September 2020; THP 2019 Audited Financial Statements

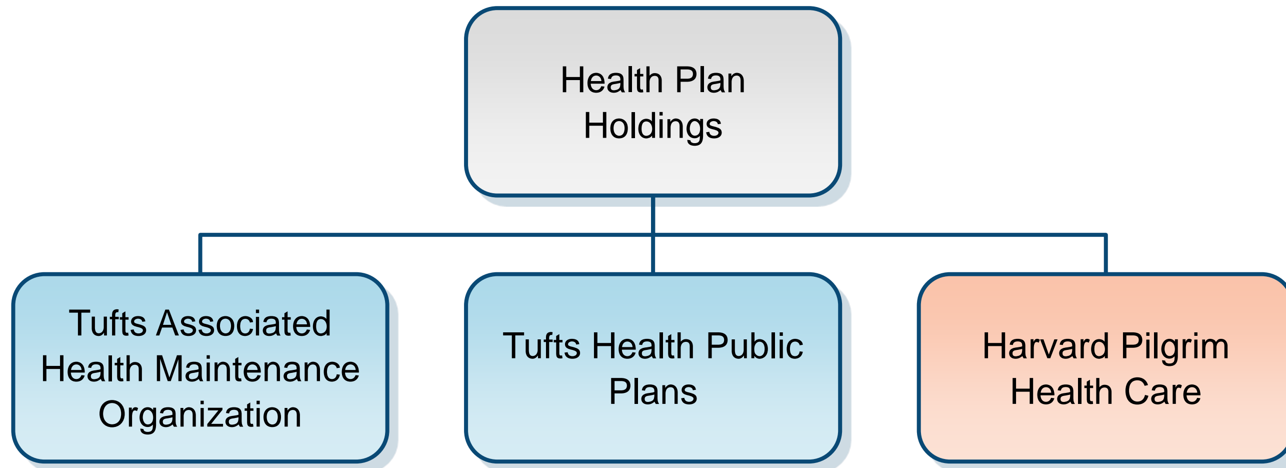
Background on the Parties: Harvard Pilgrim Health Care

- Non-profit health plan operating in Massachusetts, Connecticut, Maine, and New Hampshire.
  - Primary service area in Massachusetts is eastern and central MA, with limited presence in the western part of the state (Berkshires, Hampden, Franklin)
- Approximately 446,400 private commercial and 7,800 Medicare Advantage Massachusetts members as of March 2020.
- Mental Health benefits managed by Optum; Optum also serves as Pharmacy Benefit Manager (PBM)
- Affiliated with United for national accounts
- HPHC does not have any Massachusetts Medicaid plans.
- In Massachusetts, HPHC has the third-largest enrollment across its plans.
- HPHC had $3.1B in revenue in FY19.

Source: CHIA Enrollment Trends Databook, September 2020; HPHC 2019 Audited Financial Statements

Overview of the Transaction: Structural Changes

- Tufts Health Plan (renamed Health Plan Holdings) will be the new parent organization of Tufts Associated Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., and Harvard Pilgrim Health Care, Inc.



- Thomas Croswell, current President and CEO of Tufts Health Plan, will be the CEO of the merged organization.
- Michael Carson, current President and CEO of Harvard Pilgrim Health Care, will be the President of the merged organization.
- The Chair of HPHC's Board of Directors, Joyce Murphy, will serve as the initial Chair of the Board.

Overview of the Transaction: Operational Changes

- The Parties state that the merger:
  - allows their health plans to be provided more efficiently and cost-effectively;
  - promotes economies of scale and population health management;
  - expands the provision of quality health care services throughout the region; and
  - allows the Parties to continue their non-profit missions of working to improve the health of the communities they serve.
- Both HPHC and THP intend to largely continue to offer health plans throughout the regions in which they currently operate.
  - The exception is that THP has agreed to sell its New Hampshire business, Tufts Health Freedom Plans, to United HealthCare Services.
- There are no plans to consolidate or materially modify product offerings or services in Massachusetts immediately following closing, and the combined organization intends to continue to participate in government and subsidized programs.
- THP and HPHC provider networks will remain in place immediately following the closing. The Parties will work together to determine how to integrate their provider networks for various products over time.

Source: Form A Filing to DOI (November 16, 2020)

Overview of the Transaction: Projected Efficiencies and Improvement Plans

- HPHC and Tufts have jointly identified “well over $100 million dollars annually” of expected savings to be achieved through integration of the organizations. The parties expect to achieve savings through:
  - Consolidation of vendor contracts (PBMs, third-party administration of vision benefits, and behavioral health)
  - IT savings by combining HR, finance, and e-mail platforms
  - Workforce integration (approx. 125 positions may be eliminated in Year 1)
  - Corporate structure simplifications
- The parties state that a significant portion of these savings will be passed on as premium savings for consumers and investments in initiatives to improve access, customer experience, and community health models.
- The parties state that they intend to further invest in programs and tools focused on addressing both behavioral health access and racial disparities in health access and outcomes.

Source: Form A Filing to DOI (November 16, 2020)

Outcome of Investigations

- Both the DOJ and MA AGO closed investigations without action.
  - However, as a result of the review in New Hampshire, THP is selling its New Hampshire business, Tufts Health Freedom Plans, to United HealthCare Services.
- DOI approved the application on December 24, based largely on the DOI Working Group's report, finding that it met all statutory requirements.

KEY FINDINGS FROM THE DOI WORKING GROUP REPORT

- The Working Group did not note any matters that would lead to an adverse determination on any of the statutory standards for DOI's review.
- The transaction is "unlikely to substantially lessen competition or tend to create a monopoly" in insurance markets in Massachusetts
  - While the merger will increase concentration in most of the insurance markets in Mass., it is unlikely that the merger will increase prices, and a number of competitors will remain.
  - There is an opportunity for the merged entity to improve operational efficiency and innovation, and the parties are expected to continue to provide high-quality services
- The successful combination of the insurers is "highly dependent" on the integration of complex IT systems, and a key rationale for the transaction is the potential savings through IT synergies.
  - While the IT integration strategy is "achievable within the proposed timeframes" and the plans are "more advanced than expected at this stage", DOI should closely monitor progress given how central IT integration is to the success of the merger.
- DOI should also conduct future monitoring of the parties' strategic initiatives, integration efforts, financial reporting and enterprise risk management through its normal regulatory oversight.

Priorities for Ongoing Monitoring

Along with our sister agencies, the HPC expects to monitor the performance of the merged entity over time.

KEY PRIORITIES FOR HPC MONITORING

1. Analyzing the extent to which the merger results in true integration and achieves **efficiencies** and **administrative simplification**;
2. Ensuring that efficiencies are **passed along as savings** to insured individuals and employers;
3. Examining the impact of the merger on **health care market functioning**, including the impact on provider price variation; and
4. Ensuring that the merged entity maintains its commitment to both its **public payer members** and its **commercial members** and that it seeks to improve quality and access across its entire **diverse membership**.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

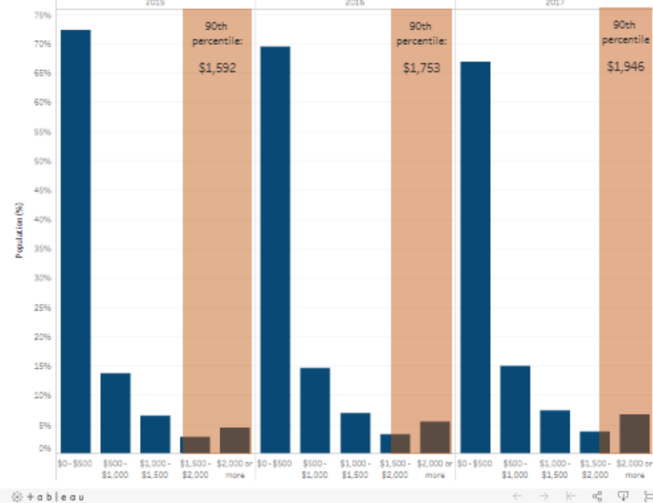
- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from November 18, 2020 Meeting **(VOTE)**
- Executive Director's Report
- Care Delivery Transformation
- Market Oversight and Transparency
  - Notices of Material Change
  - Harvard Pilgrim Health Care and Tufts Health Plan Merger
  - **Presentation: High Out-of-Pocket Spending**
- Schedule of Next Meeting (April 14, 2021)

New DataPoints: Issue 19

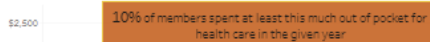
Characteristics of commercially-insured individuals with persistently high out-of-pocket spending

From 2015-2017, average annual OOP spending for the commercially insured grew about 20%, from $601 to $721. However, this average masks a great deal of variation across individuals. In 2017, half of all members spent $345 or less OOP annually, while those at or above the 90th percentile of OOP spending in all three years spent ten times more, or $3,499 on average. OOP spending also grew faster from 2015-2017 for those with the highest OOP spending. From 2015-2017, median OOP spending grew 17.5%, compared to a 22.2% increase for those at the 90th percentile.

Distribution of out-of-pocket spending, 2015 - 2017



Distribution of out-of-pocket spending by year, 2015 - 2017



This issue of DataPoints examines:

- Populations with Persistently High Out-of-Pocket Spending
- Medical Versus Prescription Out-of-Pocket Spending
- Chronic Conditions
- Firm Size
- Regional Variation
- Income Variation

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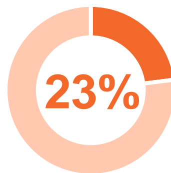
Health care affordability is a continued concern for Massachusetts residents.

HEALTH INSURANCE PREMIUMS RISE EACH YEAR EVEN AS:

- The percentage of commercially-insured residents enrolled in high deductible plans increases (from 28.5% in 2017 to 31.5% in 2018)
- Out-of-pocket (OOP) spending continues to grow (5.6% in 2018)

Nearly 40 cents of every additional dollar earned by Massachusetts families from 2016-2018 was **spent on health care**

The burden of increasing health care spending is **not distributed equally** among Massachusetts residents



of middle-class families in Massachusetts with employer coverage devoted **more than a quarter of all earnings to health care**

While acute health care episodes can lead to high OOP spending for patients at a point in time, **many patients experience *persistently* high OOP spending year after year**

Sources: Massachusetts Center for Health Information and Analysis, 2019 Annual report. Massachusetts Health Policy Commission, 2019 Annual Health Care Cost Trends Report

Analytic Plan

PRIMARY RESEARCH QUESTION

What are the characteristics of commercially-insured members experiencing high OOP spending from 2015 - 2017?

- What was average OOP spending for these members across the three years?
- What is their prevalence of chronic conditions?
- Do they have different insurance plan characteristics or firm size?
- Are they clustered regionally across Massachusetts?

SPECIFIC FOCUS: OOP spending in the highest 10% in **each** of the three years

APCD 7.0, 2015-2017

Commercially-insured members in MA with 36 months of continuous coverage

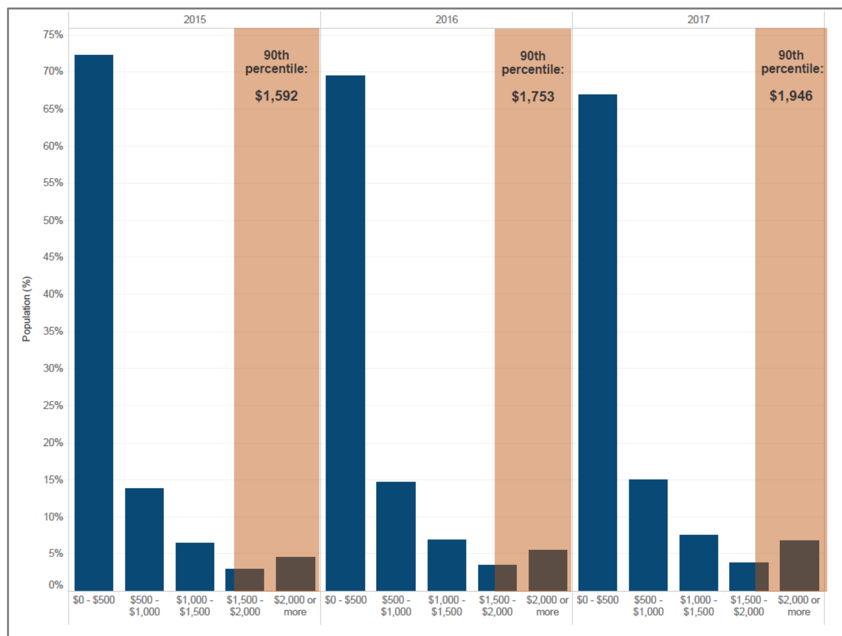
OOP spending includes copayments, co-insurance, deductibles for medical and prescription spending

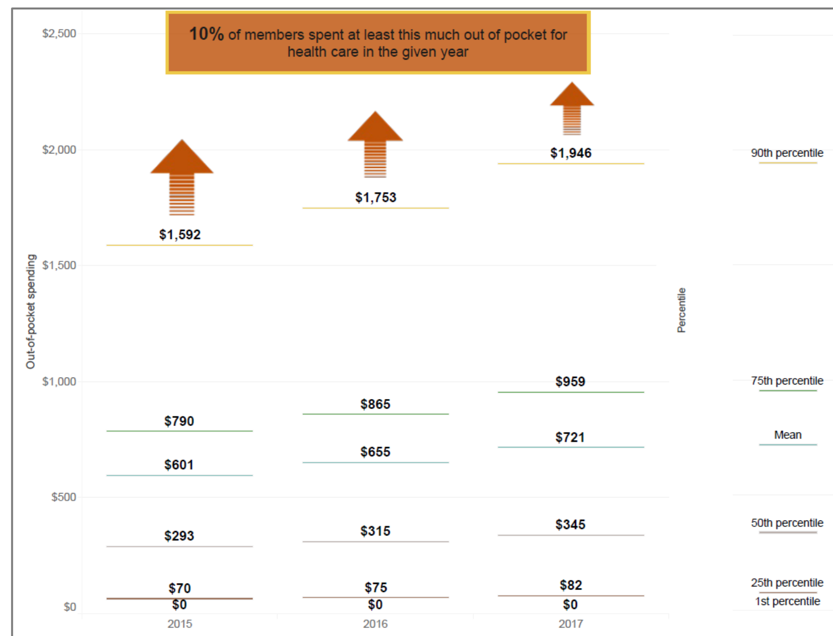
Notes: The data includes commercially-insured members of Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, Harvard Pilgrim Health Care, and AllWays Health Partners, and excludes most members of self-insured plans (which typically do not report data to the APCD). Most of this membership is from their fully-insured business as most self-insured data is no longer reported into the APCD due to the Gobeille vs. Liberty Mutual decision.

Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017

People with OOP spending in the top 10% in 2017 paid at least $1,946 that year – five times more than the median.

Distribution of out-of-pocket spending by year, 2015 - 2017





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Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017

3% of members (representing roughly 120,000 Massachusetts commercially-insured residents) have persistently high OOP spending. They spend an average $3,250 a year (almost $300/month) OOP.

Average annual out-of-pocket spending, 2015 - 2017

Years of high OOP spending from 2015-2017	Percent	Average annual OOP spending
None	80.6%	**$372**
1 year	11.7%	**$1,358**
2 years	4.6%	**$2,205**
3 years	3.0%	**$3,247**

SPENDING CHARACTERISTICS

3.0% members with persistently high OOP spending (3 years)

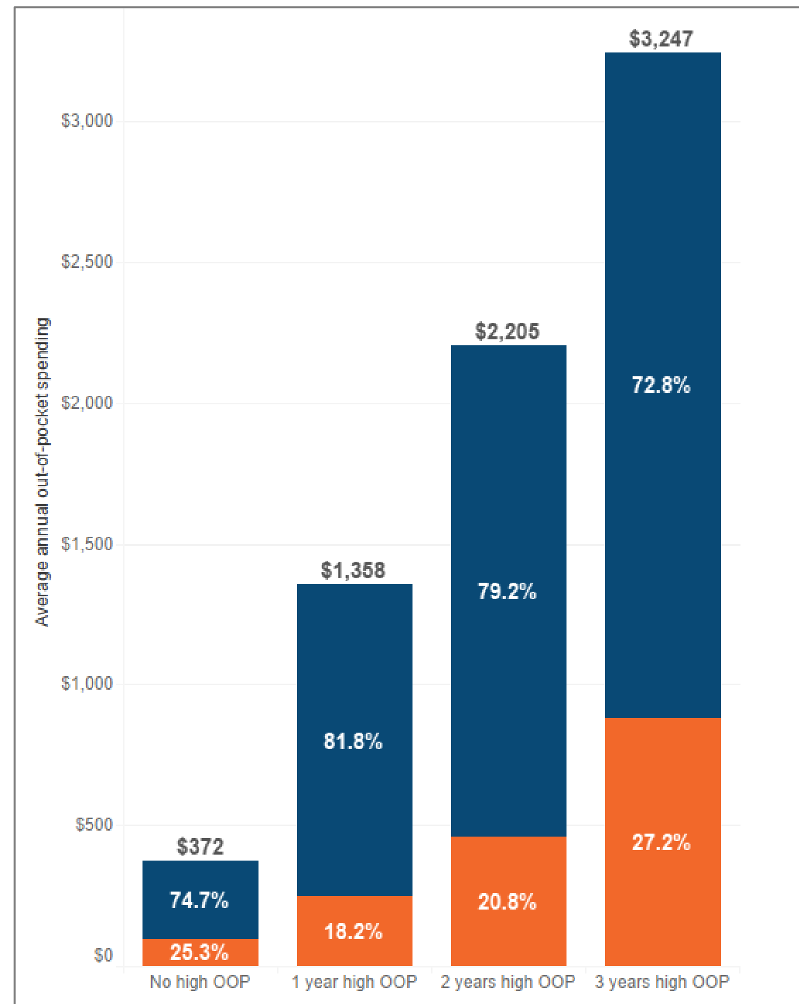
3.1% members with persistently high total spending (3 years)

4 in 10 members with persistently high OOP spending also had persistently high total spending

Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017

Prescription spending is a larger proportion (27%) of OOP spending for those with persistently high OOP spending.

Medical and prescription out-of-pocket spending, 2015 - 2017



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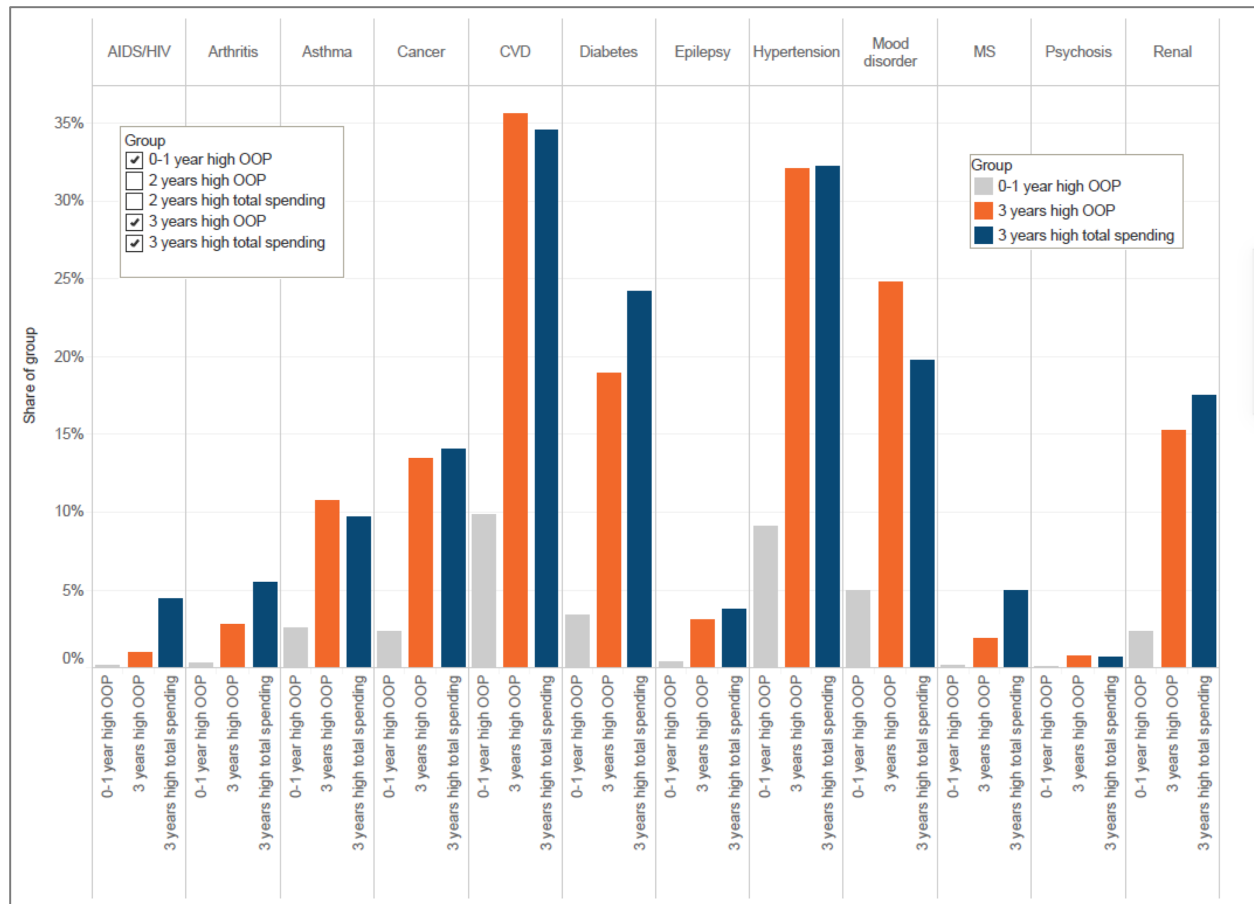
Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017

Almost 1 in 4 people with persistently high OOP spending have mood disorders.

Share of study sample with chronic condition, 2017



Notes: CVD = cardiovascular disease, MS = multiple sclerosis, and Renal = kidney disease. The information in the chronic condition analyses herein has been processed by software called The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.

The chronic condition flags are independently set each calendar year, using all available medical claims data for the enrollee during the year.

Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017

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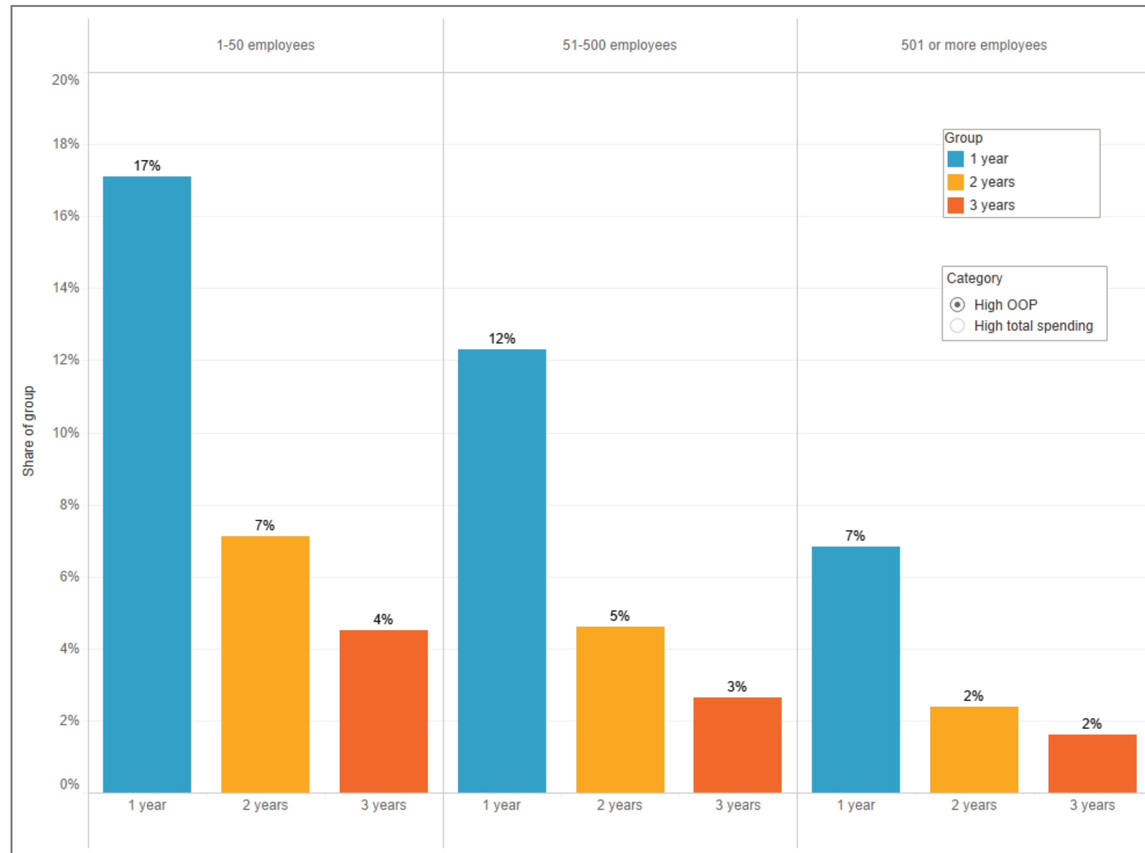
People employed by smaller firms were more likely to have persistently high OOP spending than those employed by larger firms, in contrast to patterns for total spending.

Share with high out-of-pocket and total spending by employer size, 2017



Higher OOP spending among individuals in smaller firms is not due to differences in health status; it more likely stems from the fact that small-firm employees are more likely to be enrolled in plans with high deductibles and higher cost-sharing requirements

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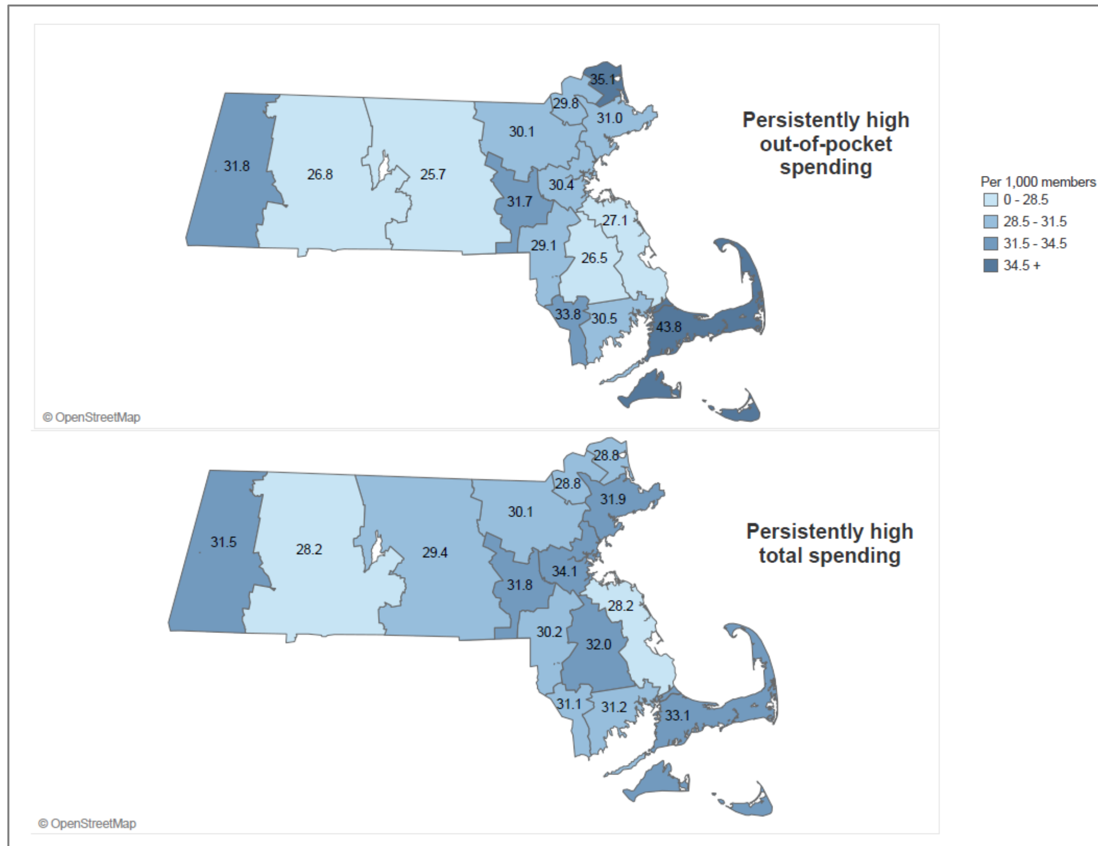
Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017

The Cape and Islands had the highest rate of people with persistently high OOP spending (43.8 per 1,000 commercial members).

Rate of persistently high out-of-pocket spending and high total spending in the commercially-insured population by HPC region, 2017



The rate of persistently high OOP spending in the population varied more by region than the rate of persistently high *total* spending

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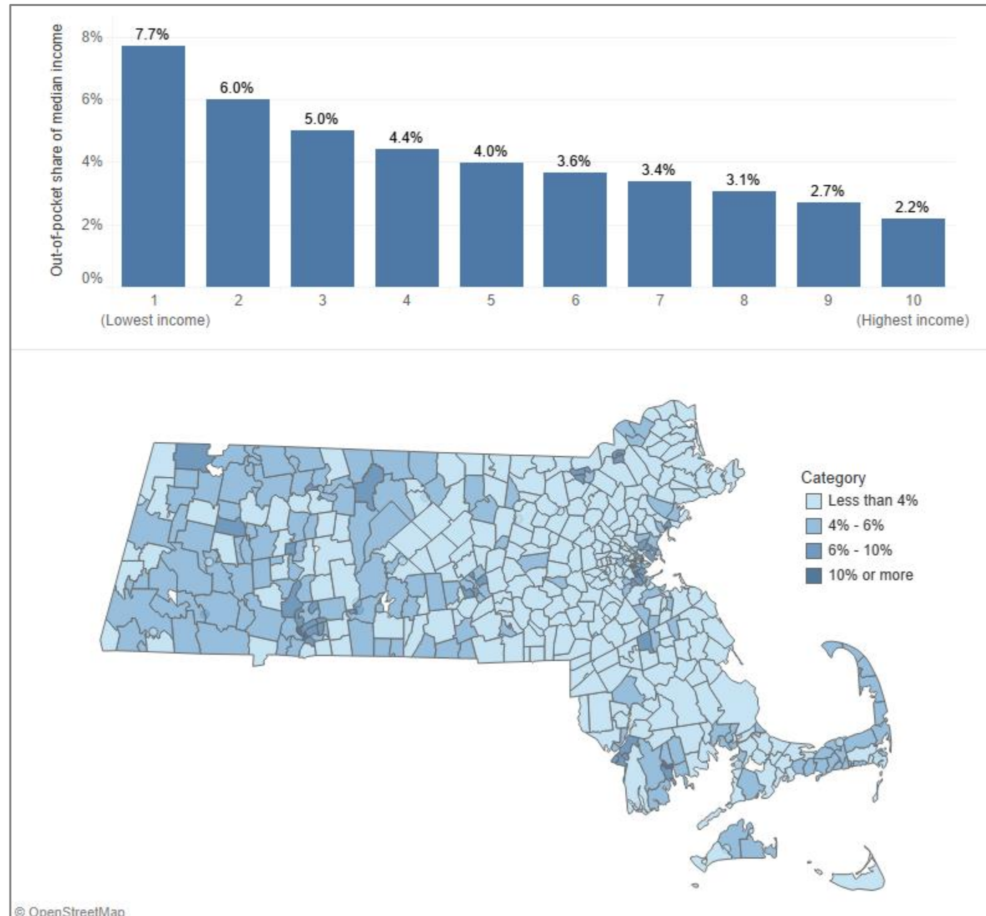
Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017

High OOP healthcare spending would consume nearly 8 percent of median income in the lowest-income areas of Massachusetts.

Among people with persistent high out-of-pocket spending, share of median income consumed by out-of-pocket spending based on their zip code of residence, 2017



Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017

Summary of Findings

- **Approximately 3%, or 120,000** commercially-insured Massachusetts residents, had **OOP spending in the top 10%** in each year 2015-2017.
- Annual OOP spending for these individuals averaged $3,247 – nearly $300 per month.
- This population is largely not the same as those who experience persistently high *total* medical spending.
- Individuals with persistently high OOP spending were more likely to:
  - Work in small firms
  - Live on the Cape and Islands
  - Have mood disorders as chronic conditions

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

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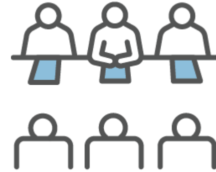
- Market Oversight and Transparency
- **Schedule of Next Meeting (April 14, 2021)**

Upcoming 2021 Meetings and Contact Information

BOARD MEETINGS

January 13
April 14
July 14
September 15
November 17



COMMITTEE MEETINGS

February 10
June 2
October 6
December 15

SPECIAL EVENTS

ADVISORY COUNCIL
February 24
May 12
September 29
December 8

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Appendix

Assessment Criterion 1: Patient-Centered Care

The ACO collects and uses information from patients to improve and deliver patient-centered care.

ACOs must provide documentation of one item from each column:

Leadership Monitoring of Patient Experience

- Example(s) of **monitoring of patient experiences** on large scale (e.g., periodic surveys, online communities, patient focus groups, PES collection)
- Data collection on **cultural, linguistic, literacy,** etc. needs
- Demonstration of **robust consumer participation** in governance and bodies informing leadership (e.g., use of PFACs)

Patient Experience Data Used Strategically

- Written plans for **identifying areas for improvement** based on patient experience monitoring and **implementing strategies** to improve
- Description of **one ACO- or system-level initiative** to improve an aspect of patient experience in past two years
- **Outreach campaigns** or mobile alert programs to engage patients

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Assessment Criterion 2: Culture of Performance Improvement

The ACO fosters a culture of continuous improvement, innovation, and learning to improve the patient experience and value of care delivery.

ACOs must provide documentation of two items:

Culture of Performance Improvement

- **ACO-sponsored improvement-oriented citizenship activities**, such as teaching or learning sessions
- **Leadership commitment to creating a culture of performance improvement**, e.g., tracking of system or ACO-level metrics against ACO goals by leadership
- **Defined systems or pathways for improvement and innovation,** such as implementation of systems learning and/or process improvement approaches
- **Internal financial incentives** encouraging improvement, e.g., funds flow or compensation
- **Metric-based selection or evaluation** of preferred clinical or non-clinical partners
- Support for an ACO-or-system-wide **primary care practice transformation strategy**

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Assessment Criterion 3: Data-Driven Decision-Making and Care Delivery

The ACO is committed to using the best available data and evidence to guide and support improved clinical decision-making.

ACOs must provide documentation of one item from each column:

Processes or tools deliver current clinical knowledge to the point of care

- Description of **data-driven initiative** to reduce waste or low-value care
- Support for use of **clinical decision support tool**, including description of prevalence of use and overrides
- Example of **evidence-based protocol or structured learning opportunity** developed or made available to clinicians

Providers receive actionable data (on quality, cost, etc.) to guide decisions

- Timely, **actionable data and/or feedback** on cost or quality performance at the provider or group level is provided periodically
- **Data analytics** offer providers understandable, actionable information on patient panels

Assessment Criterion 4: Population Health Management (PHM) Programs

The ACO develops, implements, and refines programs and care delivery innovations to coordinate care, manage health conditions, and improve the health of its patient population.

ACOs must provide documentation of one item from each column:

Data and analytics to understand patient needs

- Use of clinical, claims, and/or socio-demographic data in patient **stratification algorithms or predictive analytics**
- Routine use of **standardized screening tools** in primary care settings to identify patients who would benefit from PHM programs

PHM programs, targets, and metrics for improvement

- Template identifying key features of **PHM programs** (e.g., priority areas, populations targeted, targets and metrics)

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Assessment Criterion 5: Whole-Person Care

The ACO recognizes the importance of non-medical factors to overall health outcomes and cost of care and seeks to integrate behavioral health and health-related social supports into its care delivery models.

ACOs must provide documentation of one item from each column:

Discrete goals for increasing behavioral health integration

- Behavioral health integration **progress and targets template** identifying priority areas, goals and metrics, current performance and future targets
- Example of implementation of at least one ACO-supported initiative featuring **close collaboration approaching an integrated practice***

Discrete goals for addressing health-related social needs

- Implementation of **health-related social needs screening processes**, including description of metrics tracked and performance targets

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* As defined in the "Standard Framework for Levels of Integrated Care" developed by the SAMHSA-HRSA Center for Integrated Health Solutions: https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf

Population based on pattern of high spending, 2015 - 2017

HIGH SPENDING	YEAR 1	YEAR 2	YEAR 3	OOP	TOTAL SPENDING
No years	-	-	-	$731,409	$736,073
1 year	X	-	-	$117,827	$107,237
	-	X	-		
	-	-	X		
2 years	X	-	X	$35,223	$42,411
	X	X	-		
	-	X	X		
3 years	X	X	X	$28,542	$27,280

SAMPLE CHARACTERISTICS:

913,001
members with 36 months continuous coverage

91,300
members will be above 90th percentile in given year (10%)

4
Payers represented in final sample

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Notes: "X" represents being above the 90th percentile in that year. The data includes commercially-insured members of Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, Harvard Pilgrim Health Care, and AllWays Health Partners. Most of this membership is from their fully-insured business as most self-insured data is no longer reported into the APCD due to the Gobeille vs. Liberty Mutual decision.

Sources: HPC analysis of Center for Health Information and Analysis APCD 7.0, 2015-2017