MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

July 14, 2021

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Welcome by HPC Chair Stuart Altman**
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- **Approval of Minutes from June 24, 2021 Meeting (VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **June 24, 2021** as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- **Executive Director's Report**
  - New and Upcoming Publications
  - HPC Health Equity Framework
- Market Oversight and Transparency
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
  - **New and Upcoming Publications**
  - HPC Health Equity Framework
- Market Oversight and Transparency
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

New and Upcoming Publications

NAS Investment Program Evaluation Report

May 2021

Detailed findings from the NAS Investment Program, including improvements in care, outcomes, and culture change.

Anti-Stigma Resource Guide

June 2021

Practical tools and resources to address stigma in caring for families impacted by opioid use disorder based on lessons learned from awardees.

Policy Brief: Performance Improvement Plans

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

DataPoints: Avoidable Dental Care ED Use

July 2021

This DataPoints issue will identify trends in avoidable dental emergency department use in Massachusetts between 2017 and 2019, with variation by race, age, income, region, and payer type.

Health Equity Practice and Style Guide

July 2021

An internal reference tool that includes general guidance, specific recommendations, and useful resources.

2020 Health Care Cost Trends Report

Presents annual overview of trends in health care spending and delivery in Massachusetts, evaluate progress in key areas, and make recommendations for strategies to increase quality and efficiency.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
  - New and Upcoming Publications
  - **HPC Health Equity Framework**
- Market Oversight and Transparency
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

The HPC employs its four core strategies to advance health equity.

RESEARCH AND REPORT

Investigate, analyze, and report trends and insights

WATCHDOG

Monitor and intervene when necessary to assure market performance

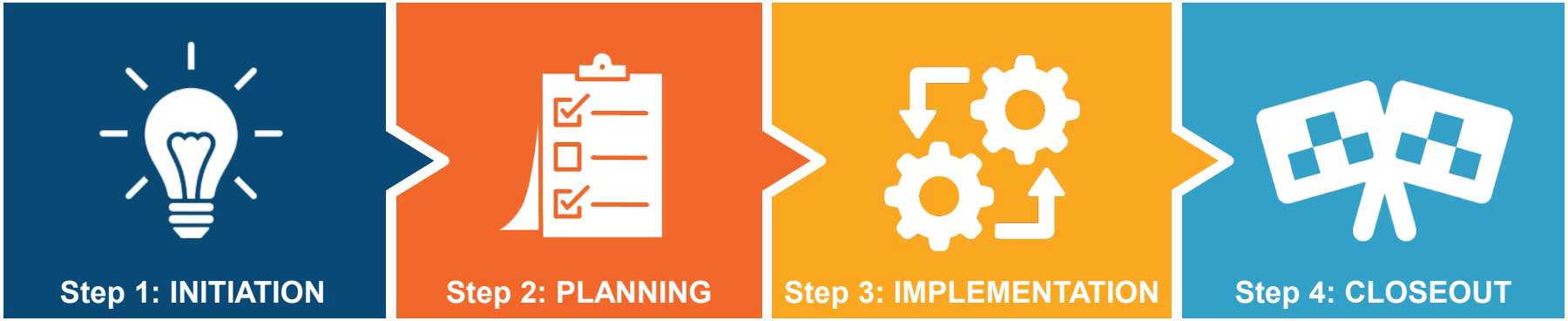
PARTNER

Engage with individuals, groups, and organizations to achieve mutual goals

CONVENE

Bring together stakeholder community to influence their actions on a topic or problem

Exemplar Questions to Guide the HPC's Work in Applying an Equity Lens



Step 1: INITIATION

- How are different populations affected by the status quo? Who might benefit from a change in practice/policy/program?
- What are the demographics and health needs of the populations relevant to this work?
- What sources did the research/data that informed this issue area rely on? Is there any existing bias?

Step 2: PLANNING

- What are the anticipated impacts of a given workstream? What are the expected outcomes and for whom?
- Could there be unintended consequences, or differential impacts by population? If so, how can they be mitigated to ensure that inequities are not exacerbated?
- Whose voices are at the table, and whose are not and how can we include them?

Step 3: IMPLEMENTATION

- Have differences correlated with social, economic, and/or environmental conditions been observed?
- How can these differences be interpreted; do they represent inequities?
- If so, how can the context (policies, practices, decisions) that contributed to these inequities be explained?
- If the data/information to speak to these inequities directly is lacking, are there available alternatives?

Step 4: CLOSEOUT

- What are the implications of the work and for whom?
- Were there unintended or inequitable effects? If so, how could the course of this work be corrected?
- What can be done differently to promote more equitable outcomes?
- Was the language used to describe all disparities and identify upstream factors consistent, precise, and respectful?
- Were results/publications/ learnings disseminated to all relevant stakeholders, in ways that could benefit them?

HPC

Implementation Activities: Research and Report

RESEARCH AND REPORT

- Updated the **Annual Cost Trends Reports** to focus on equity:
  - Expanded the affordability section in the main benchmark chapter to be an explicit “equity and affordability” section
  - Added equity-focused measures to the dashboard to be tracked on an annual basis
  - Aim to have a full, new chapter with an equity-relevant topic or analysis in each annual report
- Examine how additional data could be incorporated in the **MA Registration of Provider Organizations (MA-RPO) dataset** to support health equity work.
- Draw upon **qualitative data insights from the Office of Patient Protection** to highlight the impact of policies on consumers.
- Explore the creation of **maps and other accessible data resources** to describe the structural issues that perpetuate health inequities in the Commonwealth.

Implementation Activities: Partner

PARTNER

- Develop standard procedures and tools for embedding equity considerations into the **design, procurement process, and operations** of all investment and certification programs, including:
  - Conceptualizing program goals
  - Developing and implementing standard language for Requests for Proposals (RFPs) that defines the HPC's health equity framework and establishes baseline expectations for applicants/awardees
  - Developing and implementing a list of equity-focused questions to discuss with awardees during routine check-ins to advance equity goals
- Develop and implement **equity-focused standards for certifying Accountable Care Organizations** (ACOs) in 2022 and beyond

Implementation Activities: Convene

CONVENE

- Utilize the **Annual Cost Trends Hearings** as an opportunity to bring increased focus and attention to health equity by:
  - Highlighting issues of inequity and injustice in the Commonwealth and nationally
  - Inviting experts in health equity research and practice to contribute to discussions and presentations
  - Engaging local health care leaders and market participants
- Ensure that all event programming **includes and amplifies perspectives from underrepresented communities** through both participants and audiences
- Publish, update, and maintain **health equity webpage** with updates on HPC projects, workstreams, and resources

Implementation Activities: Watchdog

WATCHDOG

- Expand the **equity-related questions posed to providers and payers** under market oversight, either through transactional reviews or Performance Improvement Plans.
- Include impacts to equity more explicitly in summaries of anticipated impacts from individual Material Change Notice reviews.
- Include **explicit sections on health equity in Cost and Market Impact Review reports**, pharmaceutical drug pricing reports, and any similar reports.
- Continue to monitor health insurers' **implementation of language access requirements** in the Office of Patient Protection regulations and identify whether health insurer policies may negatively and disproportionately impact communities of color, residents with limited-English proficiency, and residents with low incomes.

Accountability and Action Plan

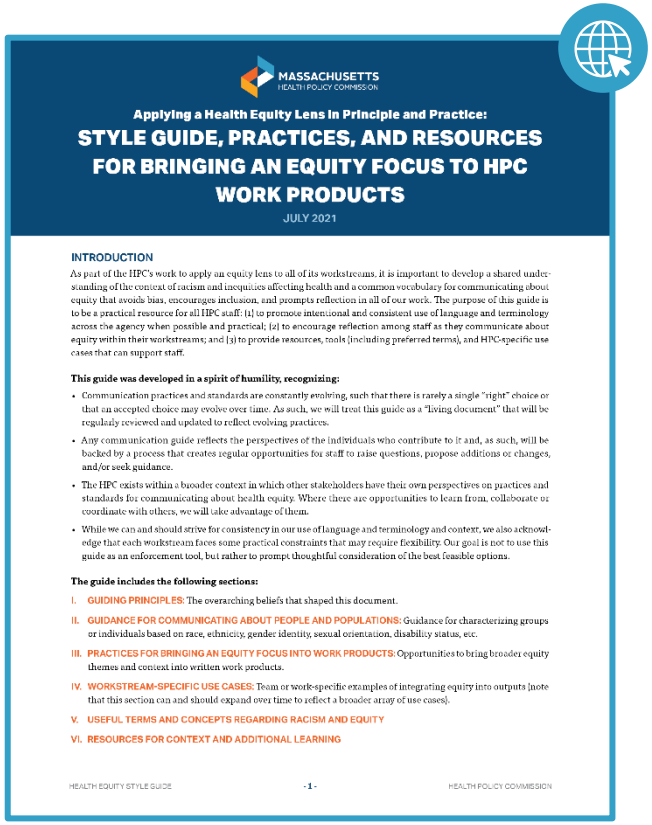
Public Commitment to Advancing Health Equity	Presentation of the Health Equity Framework and Revised Mission Statement to the HPC's Board and Advisory Council	
	Public posting of the Health Equity Framework on the HPC's website, with regular updates in consultation with HPC's Board, Advisory Council, and staff	
	Dedicated time in public meetings, including the Annual Health Care Cost Trends Hearings, to address issues of health equity and the HPC's efforts in this space	
Internal Action Steps	Development and implementation of operational framework to incorporate health equity principles and lens in all HPC workstreams	
	Promote diversity, equity, and inclusion in order to more fully cultivate the culture of anti-racism within our agency and engagement experts to provide staff workshops and discussions	
	Identification and implementation of specific goals to evaluate progress of integrating health equity principles in all HPC workstreams	
	Regular internal meetings to review the agency's health equity efforts and to inform updates to the HPC's Health Equity Framework	
	Establishment of health equity as an integrated workstream with regular assessment of resources (e.g., staff, training, funds) to support health equity focus	

HPC

 In progress

 Implemented

Health Equity Practice and Style Guide



MASSACHUSETTS
HEALTH POLICY COMMISSION

Applying a Health Equity Lens in Principle and Practice:

STYLE GUIDE, PRACTICES, AND RESOURCES FOR BRINGING AN EQUITY FOCUS TO HPC WORK PRODUCTS

JULY 2021

INTRODUCTION

As part of the HPC's work to apply an equity lens to all of its workstreams, it is important to develop a shared understanding of the context of racism and inequities affecting health and a common vocabulary for communicating about equity that avoids bias, encourages inclusion, and prompts reflection in all of our work. The purpose of this guide is to be a practical resource for all HPC staff: (1) to promote intentional and consistent use of language and terminology across the agency when possible and practical; (2) to encourage reflection among staff as they communicate about equity within their workstreams; and (3) to provide resources, tools (including preferred terms), and HPC-specific use cases that can support staff.

This guide was developed in a spirit of humility, recognizing:

- Communication practices and standards are constantly evolving, such that there is rarely a single "right" choice or that an accepted choice may evolve over time. As such, we will treat this guide as a "living document" that will be regularly reviewed and updated to reflect evolving practices.
- Any communication guide reflects the perspectives of the individuals who contribute to it and, as such, will be backed by a process that creates regular opportunities for staff to raise questions, propose additions or changes, and/or seek guidance.
- The HPC exists within a broader context in which other stakeholders have their own perspectives on practices and standards for communicating about health equity. Where there are opportunities to learn from, collaborate or coordinate with others, we will take advantage of them.
- While we can and should strive for consistency in our use of language and terminology and context, we also acknowledge that each workstream faces some practical constraints that may require flexibility. Our goal is not to use this guide as an enforcement tool, but rather to prompt thoughtful consideration of the best feasible options.

The guide includes the following sections:

I. **GUIDING PRINCIPLES:** The overarching beliefs that shaped this document.

II. **GUIDANCE FOR COMMUNICATING ABOUT PEOPLE AND POPULATIONS:** Guidance for characterizing groups or individuals based on race, ethnicity, gender identity, sexual orientation, disability status, etc.

III. **PRACTICES FOR BRINGING AN EQUITY FOCUS INTO WORK PRODUCTS:** Opportunities to bring broader equity themes and context into written work products.

IV. **WORKSTREAM-SPECIFIC USE CASES:** Team or work-specific examples of integrating equity into outputs (note that this section can and should expand over time to reflect a broader array of use cases).

V. **USEFUL TERMS AND CONCEPTS REGARDING RACISM AND EQUITY**

VI. **RESOURCES FOR CONTEXT AND ADDITIONAL LEARNING**

HEALTH EQUITY STYLE GUIDE - 1 - HEALTH POLICY COMMISSION

As part of the HPC's work to apply an equity lens to all of its workstreams, it is important to develop a **shared understanding of the context of racism and inequities affecting health and a common vocabulary for communicating about equity** that avoids bias, encourages inclusion, and prompts reflection in all of our work.

The ***Health Equity Practice and Style Guide*** is an internal reference tool that includes general guidance, specific recommendations, and useful resources.

The **Health Equity Practice and Style Guide** is available now on the HPC's website.

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
- **Market Oversight and Transparency**
  - Market Changes
  - DataPoints: Dental Emergency Department Use
  - 2021 Cost Trends Report: Policy Recommendations
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
  - **Market Changes**
  - HPC DataPoints: Dental Emergency Department Use
  - 2021 Cost Trends Report: Policy Recommendations
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	29	23%
Physician group merger, acquisition, or network affiliation	26	20%
Clinical affiliation	25	20%
Acute hospital merger, acquisition, or network affiliation	24	19%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	17	13%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

HPC

Market Changes Currently Under Review

RECEIVED SINCE 6/24

- The proposed acquisition of **Joslin Diabetes Center**, including the Joslin Clinic, by **Beth Israel Lahey Health**.

- The proposed acquisition of **Walden Behavioral Care** by **Monte Nido Corporate Holdings**.

OTHER REVIEWS

- The HPC is also reviewing Determination of Need applications by **Mass General Brigham** proposing the expansion of Mass. General Hospital and Brigham & Women's Faulkner Hospital and the construction of new ambulatory service centers. The HPC expects to provide comment on these applications to the Department of Public Health.

Elected Not to Proceed

- A proposed clinical affiliation between **Boston Children's Hospital** (Children's) and **Cape Cod Hospital** (CCH) under which Children's and its affiliated physician foundations would provide 24/7 in-house professional medical services, clinical oversight, medical leadership, and certain wrap around services to CCH's pediatric program.

- A proposed clinical affiliation between **South Shore Health System** and **Aspire Health Alliance** to collaborate on the planning, development, and implementation of integrated behavioral health clinical programs for the benefit of residents within their respective service areas.

Determination of Need (DoN) Review; Mass. General Brigham DoN Filings

DETERMINATION OF NEED (DoN) PROCESS

Providers must file a DoN application with the Department of Public Health (DPH) when they make substantial **capital expenditures**, make substantial **changes in services**, add **specific major equipment**, **change ownership**, or make other specific operational changes.

- Most DoNs **do not require a material change notice** and separate review by the HPC.
- However, the HPC is a "**party of record**" in the DoN process and receives all DoN filings.
- The HPC **may also provide comment** to the DoN program.

MASS. GENERAL BRIGHAM DON FILINGS

On January 21, 2021, Mass. General Brigham (MGB), filed Determination of Need applications for three substantial capital expenditures, totaling $2.3B:

1) Expansion, renovation and improvement of **Massachusetts General Hospital**;
2) Expansion, renovation and improvement of **Brigham and Women's Faulkner Hospital**; and
3) Creation of three **new ambulatory sites** in Westborough, Westwood, and Woburn.

MGB also proposes creating a fourth ambulatory site in Salem, New Hampshire, which is not subject to review by the Massachusetts DoN program.

Updates on DoN Review Process

The DoN program received a very high volume of public comments.

- **The period for public comment has now ended**. Due to technical issues, DPH provided a second period for public comment on the ambulatory sites application from May 24 to June 2, 2021.
- **A large number of ten taxpayer groups (TTGs)** have registered with DPH as parties of record in the DoN reviews: Eleven for the MGH project, seven for the Faulkner project, and 18 for the ambulatory project.
- DPH received **approximately one thousand written comments** on the applications: 37 on the MGH project, 9 on the Faulkner project, and over 850 on the ambulatory project. These comments can be viewed on the DoN application websites.
- Commenters included MGB representatives, representatives of competing provider organizations, union members and leaders, local and state elected officials, representatives of civic organizations, and community members.
- DPH staff will consider comments when **assessing the applications' compliance with the DoN factors**.

Updates on DoN Review Process

DPH is requiring an Independent Cost Analysis (ICA) for the applications.

- The purpose of an ICA is to require the applicant demonstrate that the project is **"consistent with the Commonwealth's cost-containment goals."**
- The ICA is **conducted by a consultant** approved by DPH, at the expense of the applicant.
- The **ICA is currently underway, and the timeline for DoN review is halted** while the ICA is conducted.
- The **HPC expects to provide comment** once the ICA has been accepted by DPH.
- The HPC's comment will consider a **range of potential impacts** of the expansions, including but not limited to:
  - Impact on site of care, provider mix, service mix, overall utilization, and market shares for relevant services;
  - Impacts of these shifts on spending;
  - Alignment of the proposed projects with identified health needs and their potential impacts on health equity.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
  - Market Changes
  - **HPC DataPoints: Dental Emergency Department Use**
  - 2021 Cost Trends Report: Policy Recommendations
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

Preventable Oral Health Emergency Department Visits

BACKGROUND

- Access to high quality and affordable oral health care continues to be a challenge for many Massachusetts residents.
- When individuals lack access to oral health care, they may turn to the emergency department (ED) for care that could have been prevented or treated in a dental office.
- Most visits to the ED for oral health conditions result in pain and symptom management, rather than definitive treatment (e.g., tooth extractions or root canals) that is provided in a dental office setting.

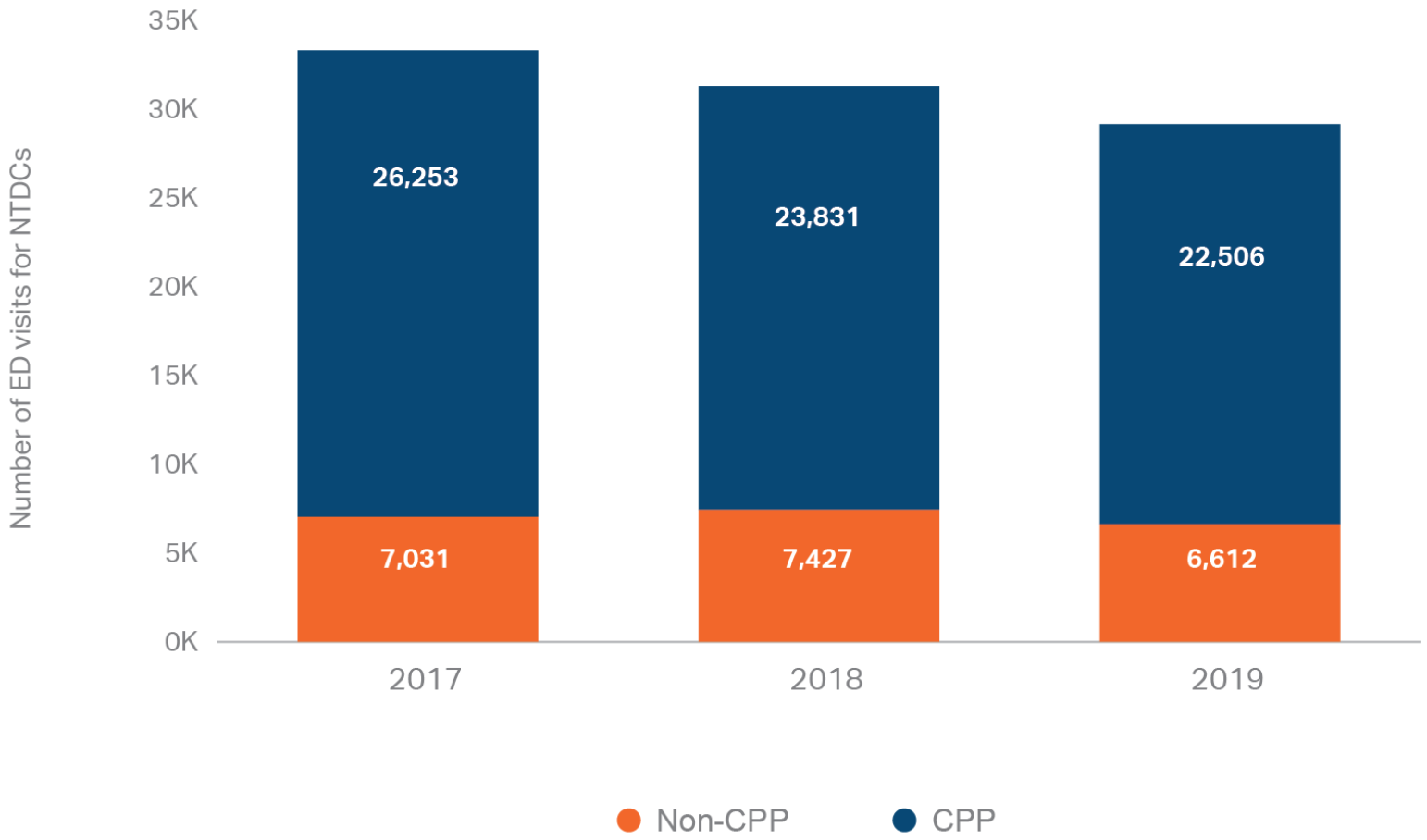
PRIOR HPC FINDINGS

- A substantial number of ED visits in Massachusetts are for preventable oral health conditions.[1]
- The HPC identified 33,467 ED visits for preventable oral health conditions in 2015, with variation by region, age, and income.[2]

[1] Health Policy Commission. HPC Policy Brief: Oral Health Care Access And Emergency Department Utilization For Avoidable Oral Health Conditions In Massachusetts. August 2016. Available at: https://www.mass.gov/doc/oral-health-brief/download.
[2] Health Policy Commission. HPC DataPoints Issue 1: Update On Preventable Oral Health ED Visits In Massachusetts. April 2017. Available at: https://www.mass.gov/info-details/hpc-datapoints-issue-1-oral-health.

ED visits for non-traumatic dental conditions (NTDCs) decreased from 2017 to 2019 by 12.5%. Most of this decrease was due to fewer visits for caries, periodontal disease, or associated preventive procedures.

Number of ED visits for NTDCs by type, 2017 to 2019

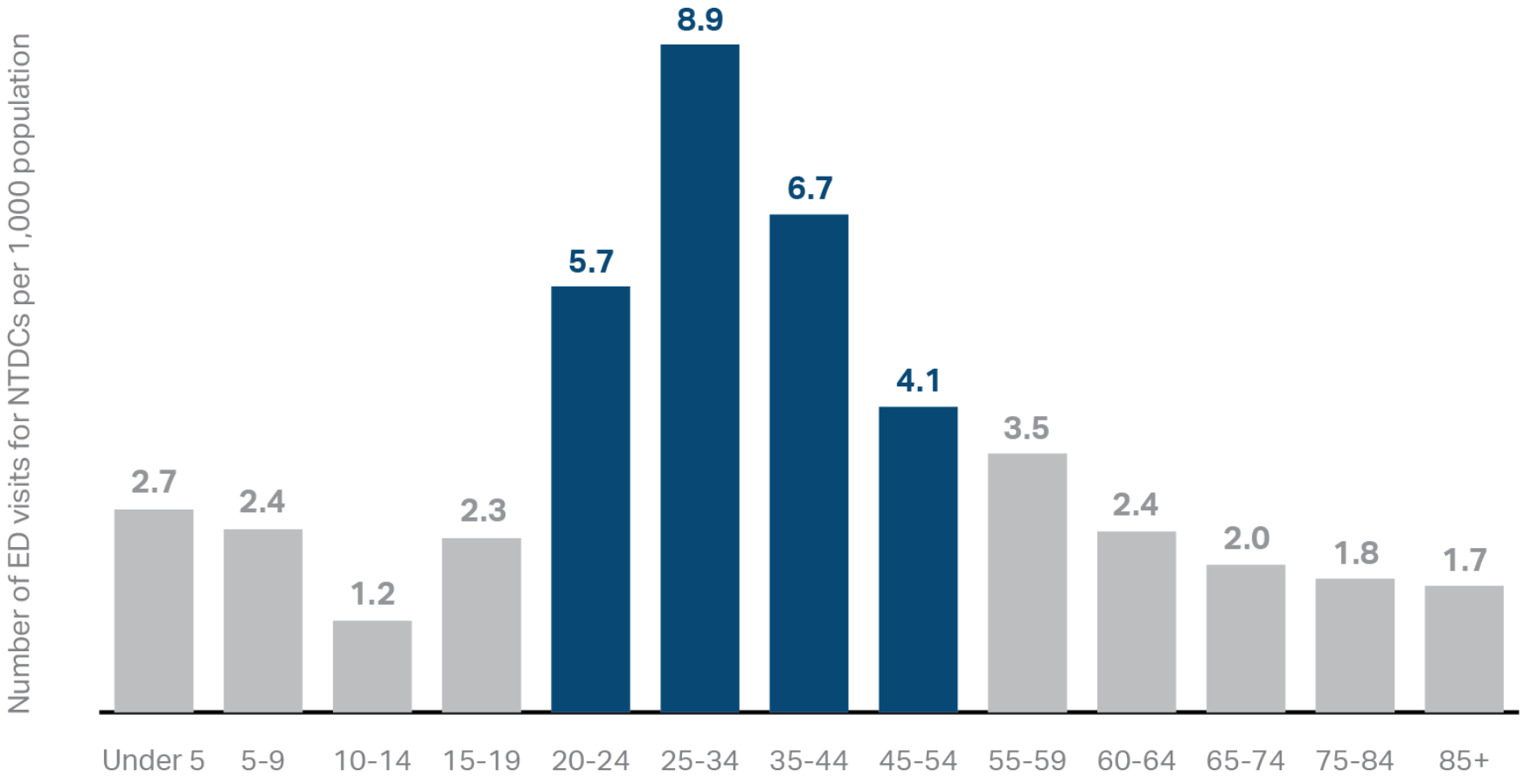


traumatic conditions associated with the oral cavity. CPP is a subset of NTDCs and includes caries, periodontal disease, or associated preventive procedures that are routinely provided in a primary general dental clinic setting.

Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2017 - 2019

Residents between ages 25 and 34 had the highest rate of ED visits for NTDCs, experiencing 8.9 visits per 1,000 population in 2019.

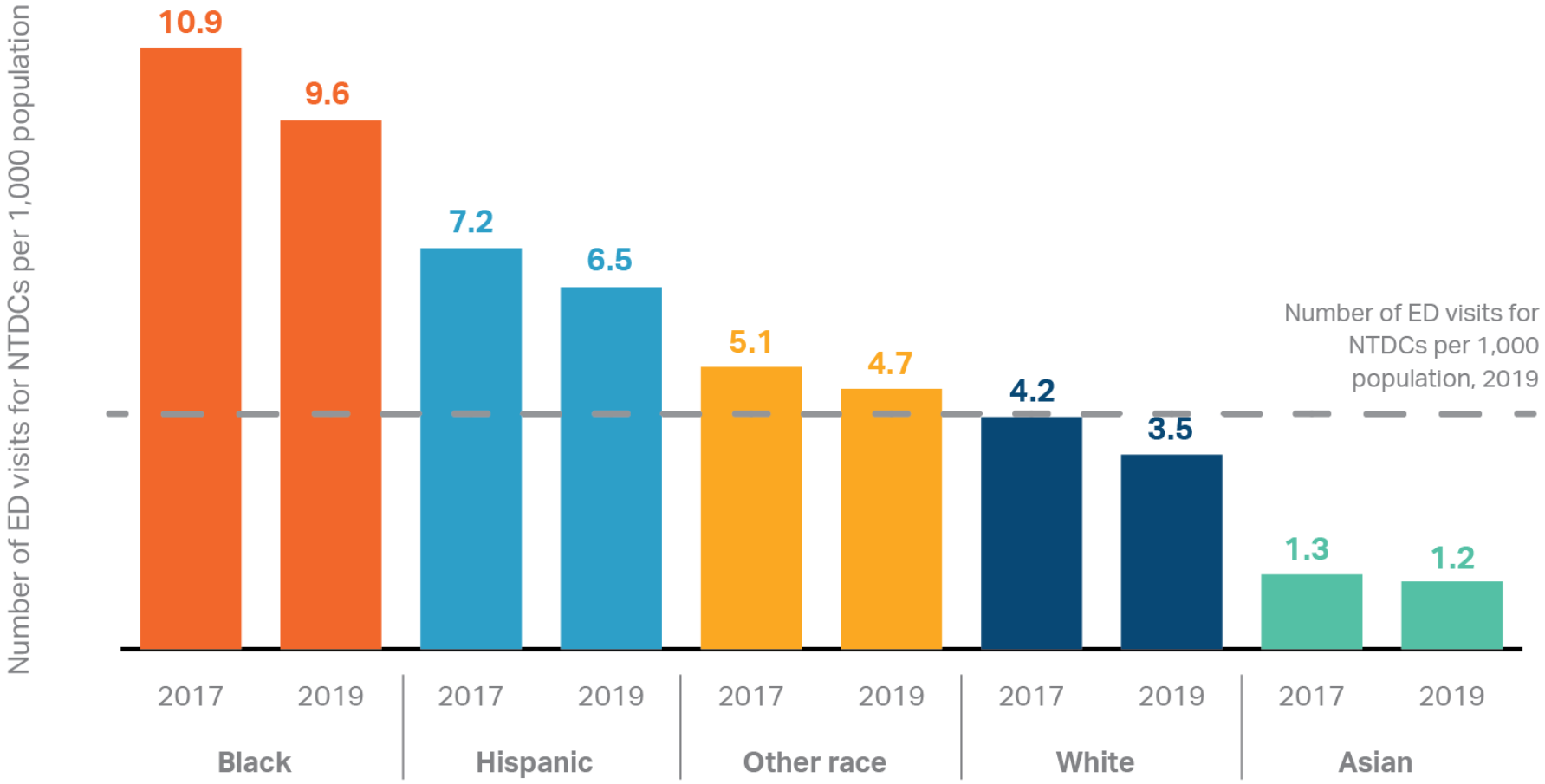
Number of ED visits for NTDCs per 1,000 population by age, 2019



Notes: Non-traumatic dental conditions (NTDCs).
Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2017 - 2019

Although there were decreases in ED visits for NTDCs from 2017 to 2019 for all residents, Black residents still experienced 2.7 times more ED visits for NTDCs than white residents in 2019.

Number of ED visits for NTDCs per 1,000 population by race and ethnicity, 2017 and 2019

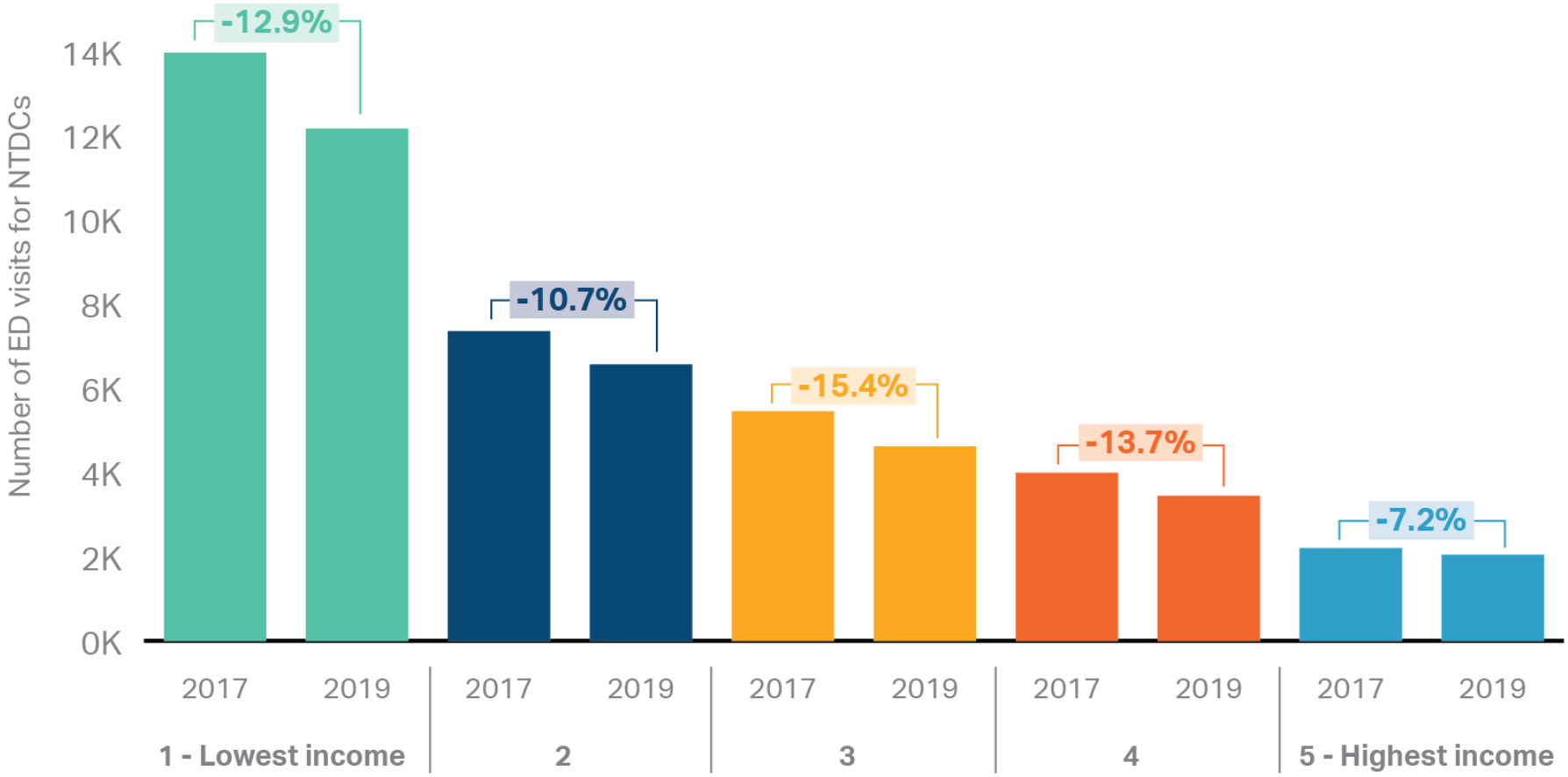


Notes: Non-traumatic dental conditions (NTDCs). Hispanic category includes Hispanic ethnicity with any race. Other Race includes American Indian/Alaska Native, Native Hawaiian, other Pacific Islander, or other race.

Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2017 - 2019

In 2019, 65% of ED visits for NTDCs were by Massachusetts residents in the lowest two community income quintiles.

Number of ED visits for NTDCs per 1,000 population by zip code median income, 2017 and 2019



Source: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2017 - 2019

Conclusions and Policy Implications

1. The HPC's research shows that ED visits for NTDCs vary by race and ethnicity, age, income, region, and payer type, suggesting **disparities in access to preventive care and treatment for dental conditions**.

2. Avoidance of routine dental care due to lack of coverage, access and/or affordability can have **long term health consequences**, both mental and physical.

3. As stated by prior oral health publications and policy recommendations, the HPC continues to recommend that the Commonwealth authorize mid-level **dental therapists** to practice as an equity-centered intervention to expand oral health care access.

4. Additional policy opportunities in Massachusetts include **ED referral programs** that link patients from the ED to dental providers, as well as **teledentistry** innovations.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
  - Market Changes
  - HPC DataPoints: Dental Emergency Department Use
  - **2021 Cost Trends Report: Policy Recommendations**
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

2021 Annual Cost Trends Report – Outline and Public Presentation Dates

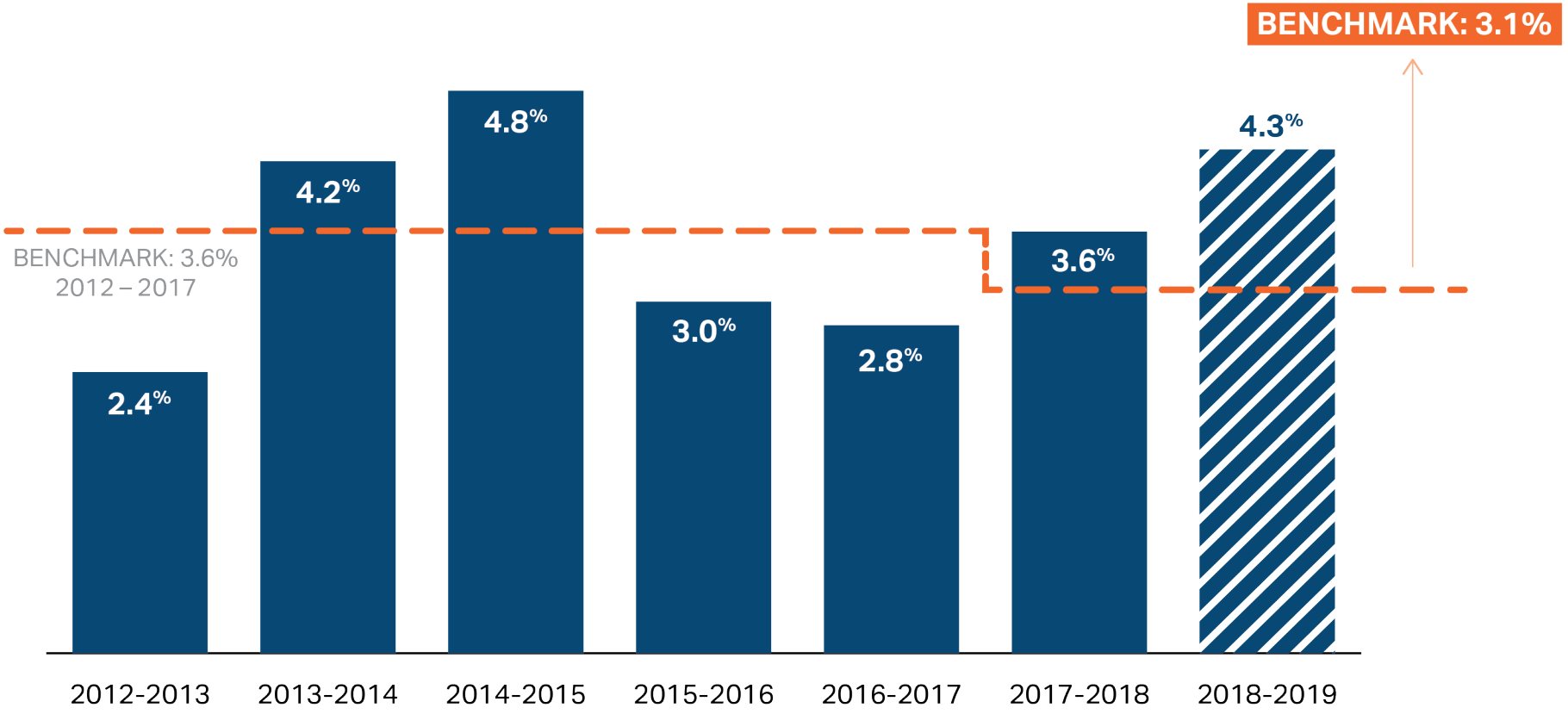
- **Chapter #1: Massachusetts Spending Performance** (Key findings presented at the Annual Hearing on the Potential Modification of the Health Care Cost Growth Benchmark on 3/25/21)
- **Chapter #2: Patterns in Health Care Spending, Access and Affordability by Income** (Key findings presented at the HPC Board meeting on 5/19/21)
- **Chartpacks** (Key findings presented at the MOAT meeting on 6/2/21)
  - Hospital Utilization and Post-Acute Care
  - Post-Acute Care
  - Alternative Payment Methods
  - Provider Organization Performance Variation
  - Price Trends and Variation **(new!)**
- **Performance Dashboard** (Previewed at the MOAT meeting on 6/2/21)
- **Policy Recommendations** (Presented today, 7/24/21)

HPC

Commonwealth of Massachusetts Office of the Attorney General Examination of Health Care Cost Trends and Cost Drivers, Oct 13, 2016
Arlene Ash., et al. "Social determinants of health in managed care payment formulas." JAMA internal medicine 177.10 (2017): 1424-1430
Sherman, Bruce W., et al. "Health care use and spending patterns vary by wage level in employer-sponsored plans." Health Affairs 36.2 (2017): 250-257.

Growth in total health care spending accelerated the past two years and exceeded the benchmark in 2018 and 2019.

Massachusetts annual growth in per capita total health care spending relative to the benchmark, 2012-2019

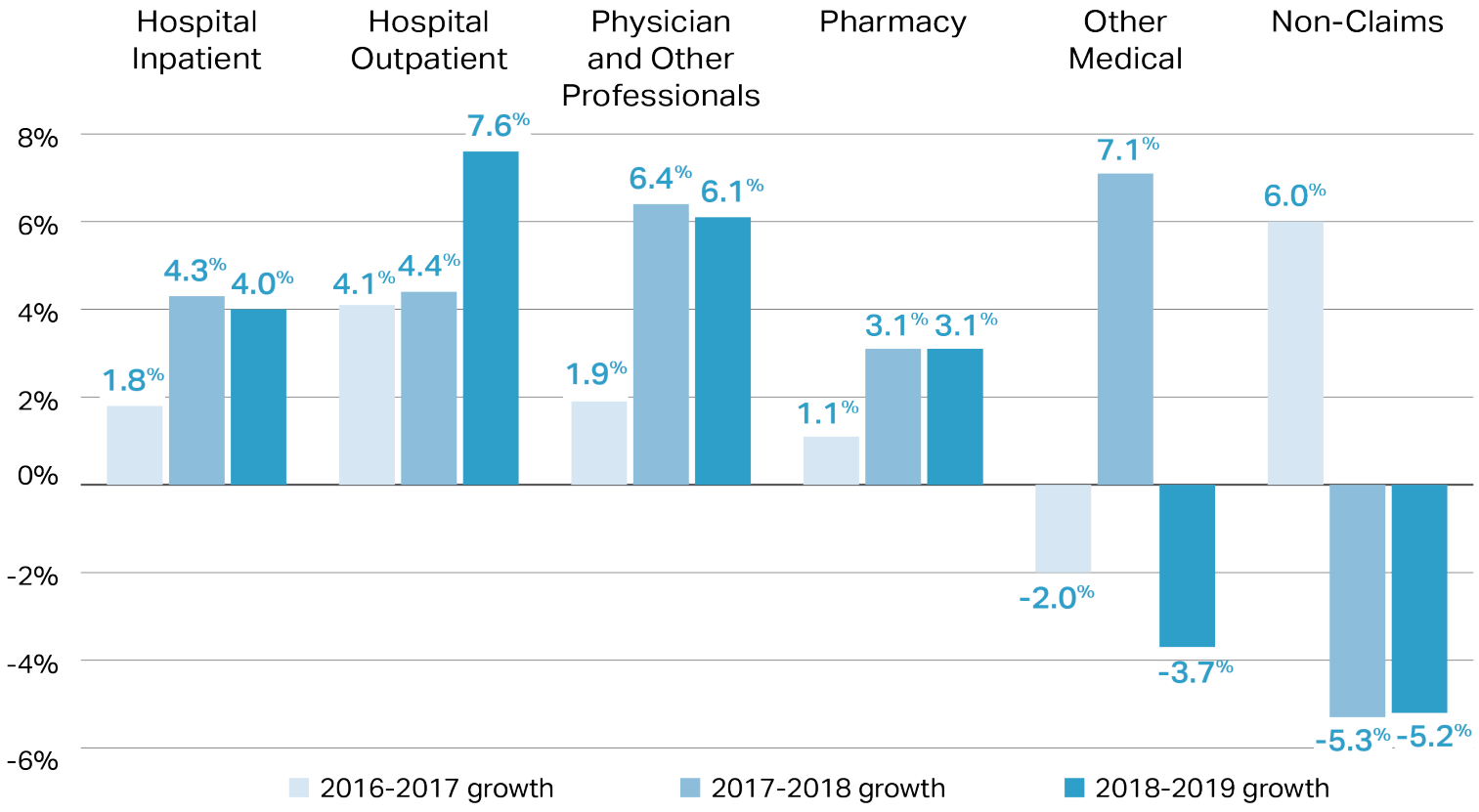


Average annual spending growth between 2012 and 2019 → **3.59%**

Notes: 2018-2019 spending growth is preliminary.
Source: Massachusetts Center for Health Information and Analysis, Annual reports 2013-2020.

Hospital outpatient and physician spending were key drivers of commercial spending growth in 2019.

Percentage annual growth in spending per capita for commercial members, 2016-2019



Hospital spending accounted for **43%** of spending in 2018 ▶ but **54%** of growth from 2018-2019

Notes: Pharmacy spending is net of rebates. Hospital spending includes facility spending only. Professional spending associated with hospital care is included in "Physician and other professionals". Other medical category includes long-term care, dental and home health and community health. Non-claims spending represents capitation-based payments.

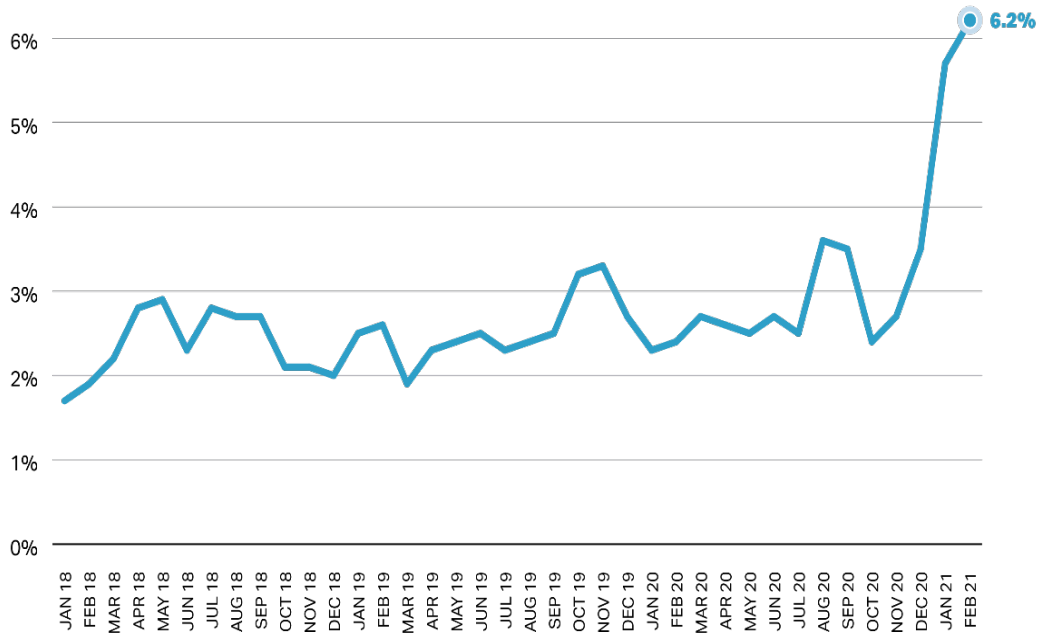
Sources: Payer reported TME data to CHIA and other public sources; HPC analysis of data from Center for Health Information and Analysis Annual Report, 2020.

HPC

Commercial spending growth has been driven more by prices than utilization.

- BCBS, Tufts and HPHC all reported annual prices grew from 2015-2018 **more than twice** the rate of utilization
- The Health Care Cost Institute found that Massachusetts commercial health care prices grew **15.6%** from 2014-2018 while utilization grew **7.0%.**
- Massachusetts 2016-2018 price growth per service category:
  - Hospital inpatient: **9.0%**
  - Hospital outpatient: **6.1%**
  - Physician office: **4.4%**

National growth in commercial hospital prices relative to the same month, 12 months prior, Altarum Institute



- Nationally, commercial hospital prices accelerated further at the end of 2020.

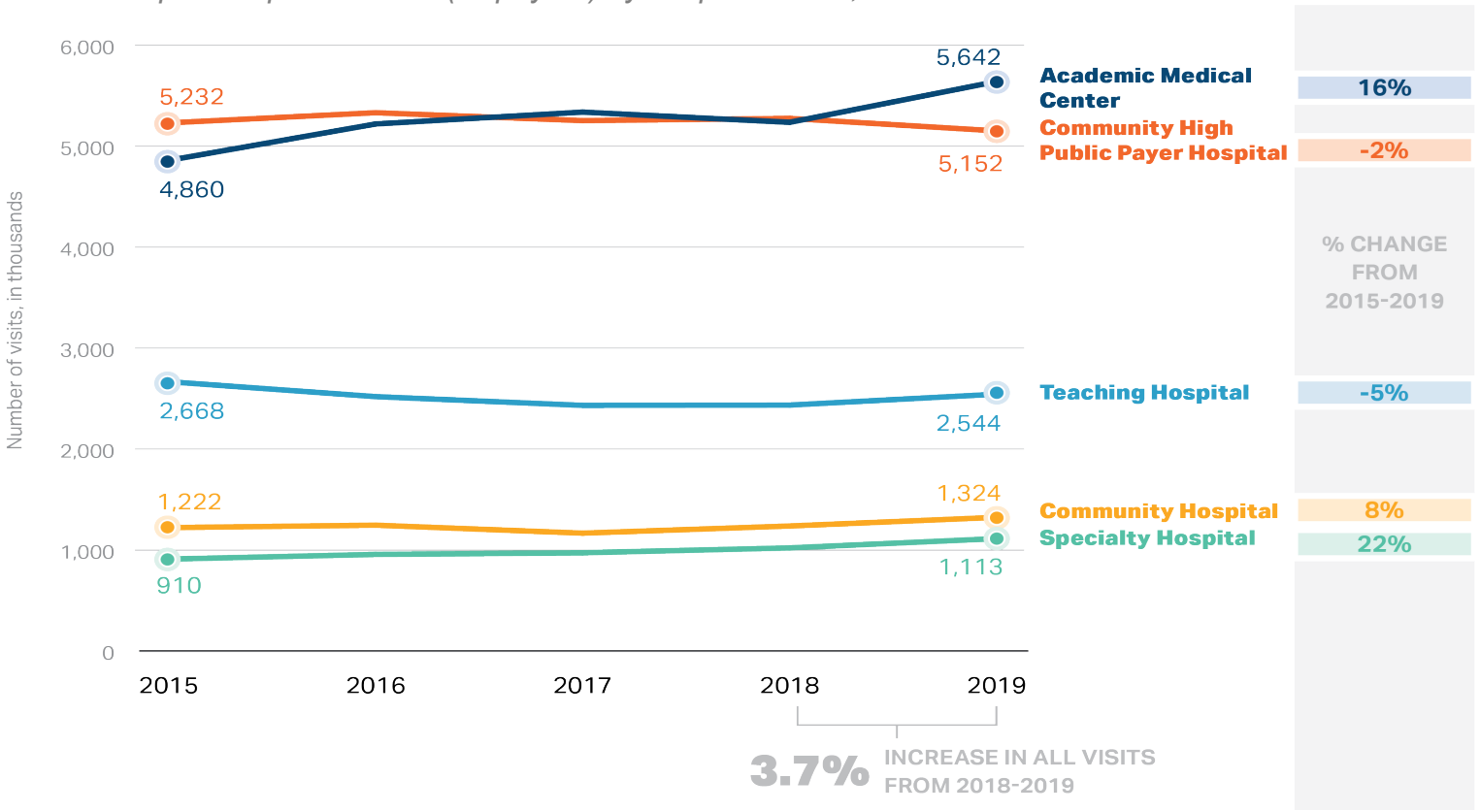
HPC

HCCI: https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report. HPC 2019 Annual Cost Trends report; HPC 2020 Benchmark Presentation: https://www.mass.gov/doc/presentation-benchmark-hearing-march-11-2020/download

Provider price variation is persistent in Massachusetts and is contributing to spending growth as care shifts to higher-priced hospitals.

- CHIA reports that **54.3%** of hospital spending in 2019 occurred at hospitals in the highest-priced quartile, up from **51.4%** in 2017
- Hospital outpatient visits have **shifted to higher-priced AMCs**

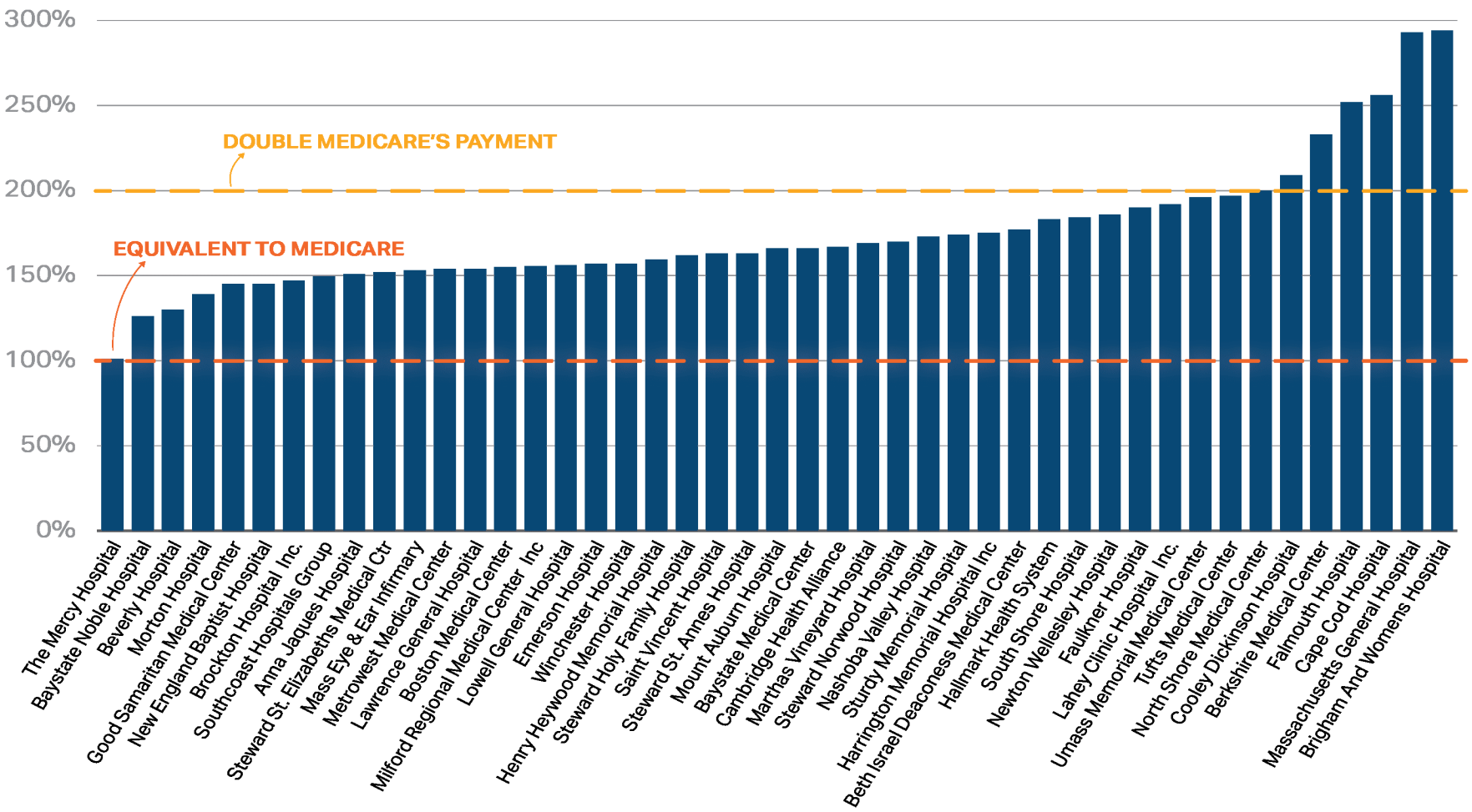
Number of hospital outpatient visits (all payers) by hospital cohort, FY2015-FY2019



Data from the Massachusetts Center for Health Information and Analysis, Acute Hospital Profiles, 2015-9. https://www.chiamass.gov/hospital-profiles/. Outpatient visits are reported by the hospitals. CHIA Relative Price and provider price variation: https://www.chiamass.gov/relative-price-and-provider-price-variation/

Commercial payment rates for hospital outpatient services vary threefold across Massachusetts hospitals, often well exceeding Medicare rates.

Aggregate commercial hospital outpatient payments to hospital relative to what they would have received from Medicare, 2016-2018

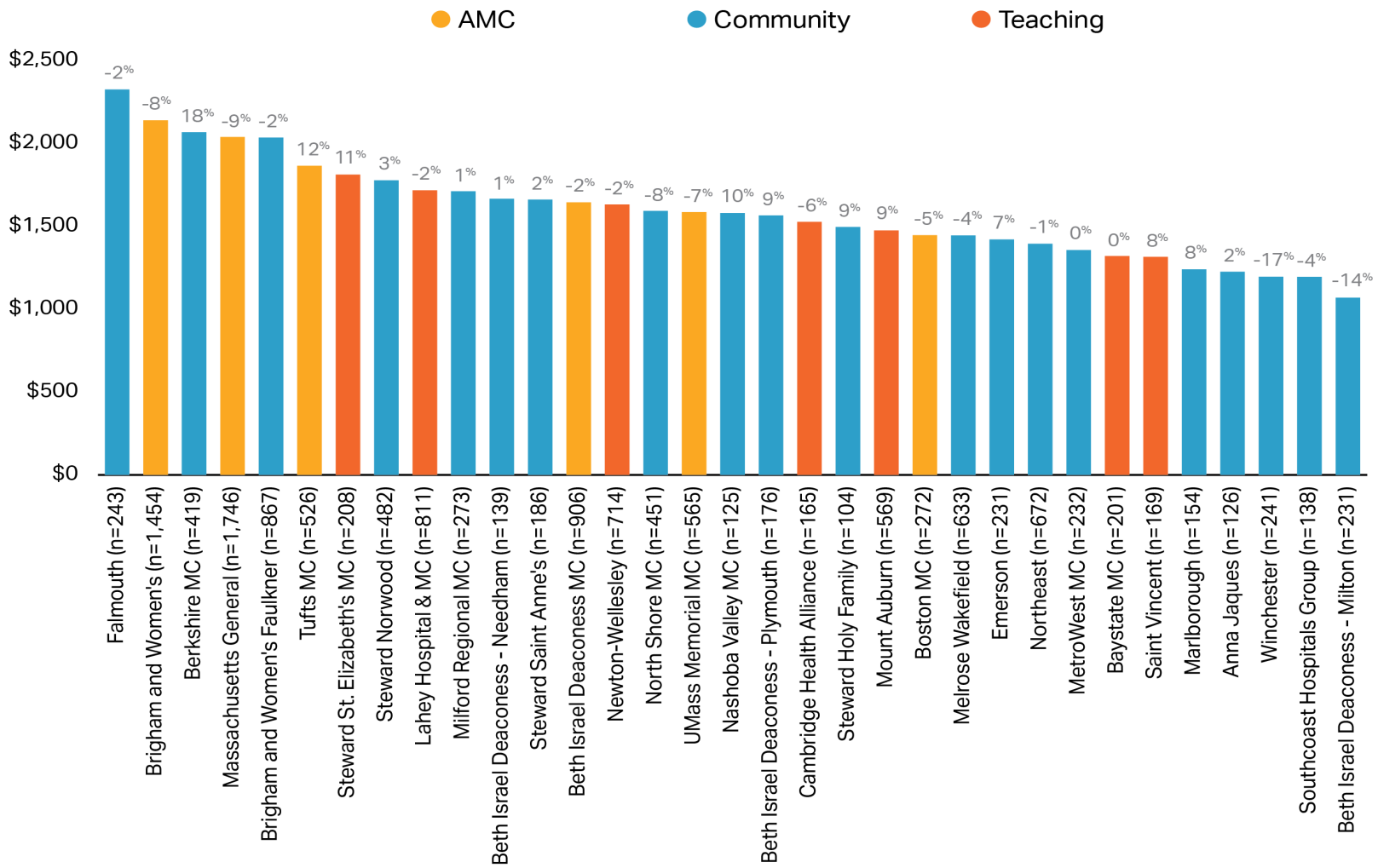


Data from supplemental data files included in the report, Nationwide Evaluation of Health Care Prices Paid by Private Health Plans: Findings from Round 3 of an Employer-Led Transparency Initiative by Christopher Whaley et al, https://www.rand.org/pubs/research_reports/RR4394.html. Data represent aggregate spending from 2016-2018. Analysis based on commercial claims-level data contributed by self-insured employers and private health plans. Authors simulated Medicare payments using 3M software that applied Medicare payment rules to claims data. Data based on more than 100,000 services provided in MA hospitals. Hospitals excluded from figure if fewer than 250 services.

HPC

In 2018, the hospital with the highest-average colonoscopy price had an average price 117% higher ($1,256) than the lowest cost hospital.

Average colonoscopy prices among high volume hospital outpatient departments, 2018



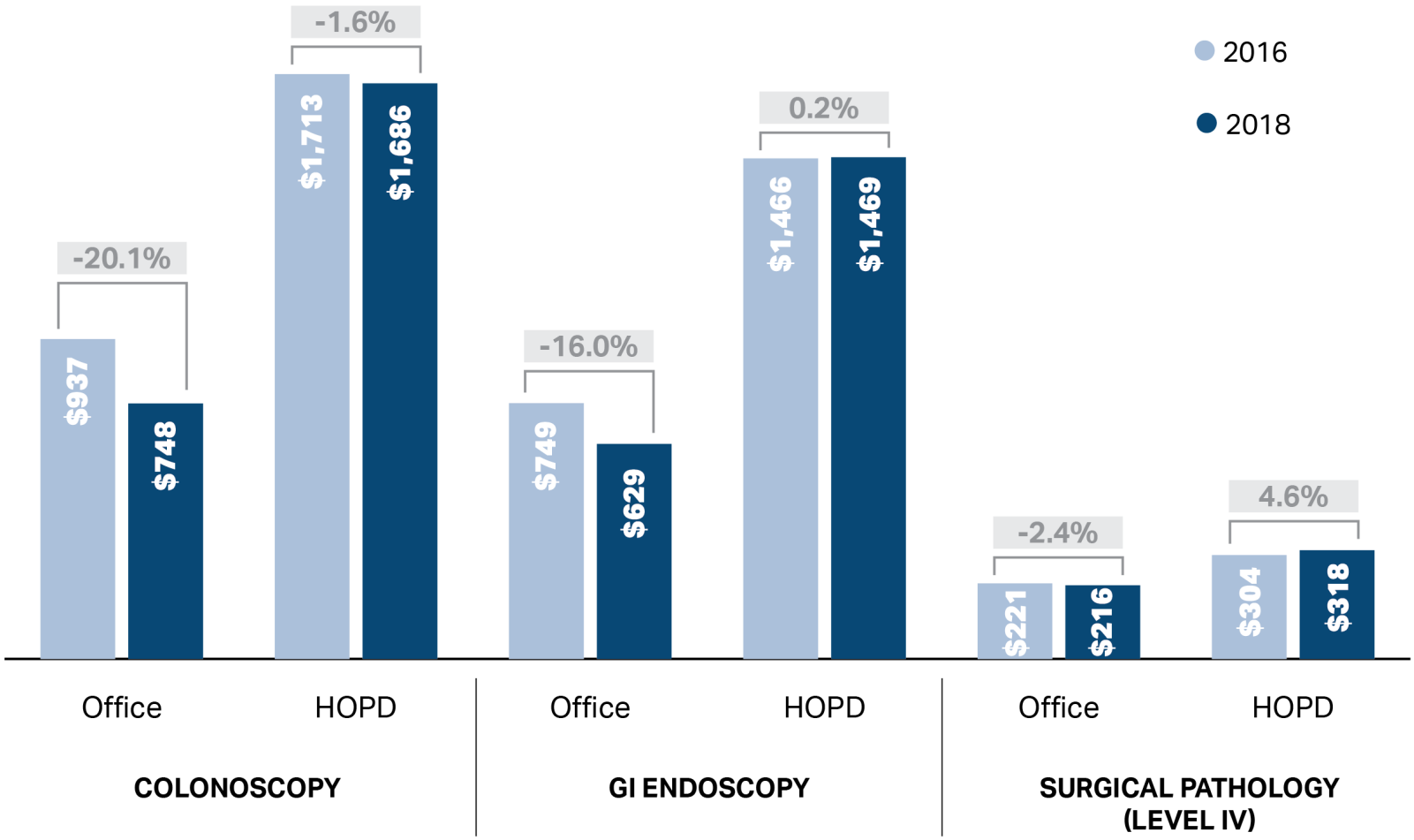
Notes: Facilities listed are limited to those with at least 100 commercial encounters delivered in 2018. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Prices for services paid under global payment arrangements or other non-fee-for-service methods are not included in the calculation of average price. Colonoscopy (CPT 45380, 'Colonoscopy, flexible; with biopsy, single or multiple')

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

HPC

Spending for three common procedures is double if performed in a HOPD versus an office setting in 2018.

Average spending and spending growth for common procedures occurring in both Office and HOPD settings, 2016-2018



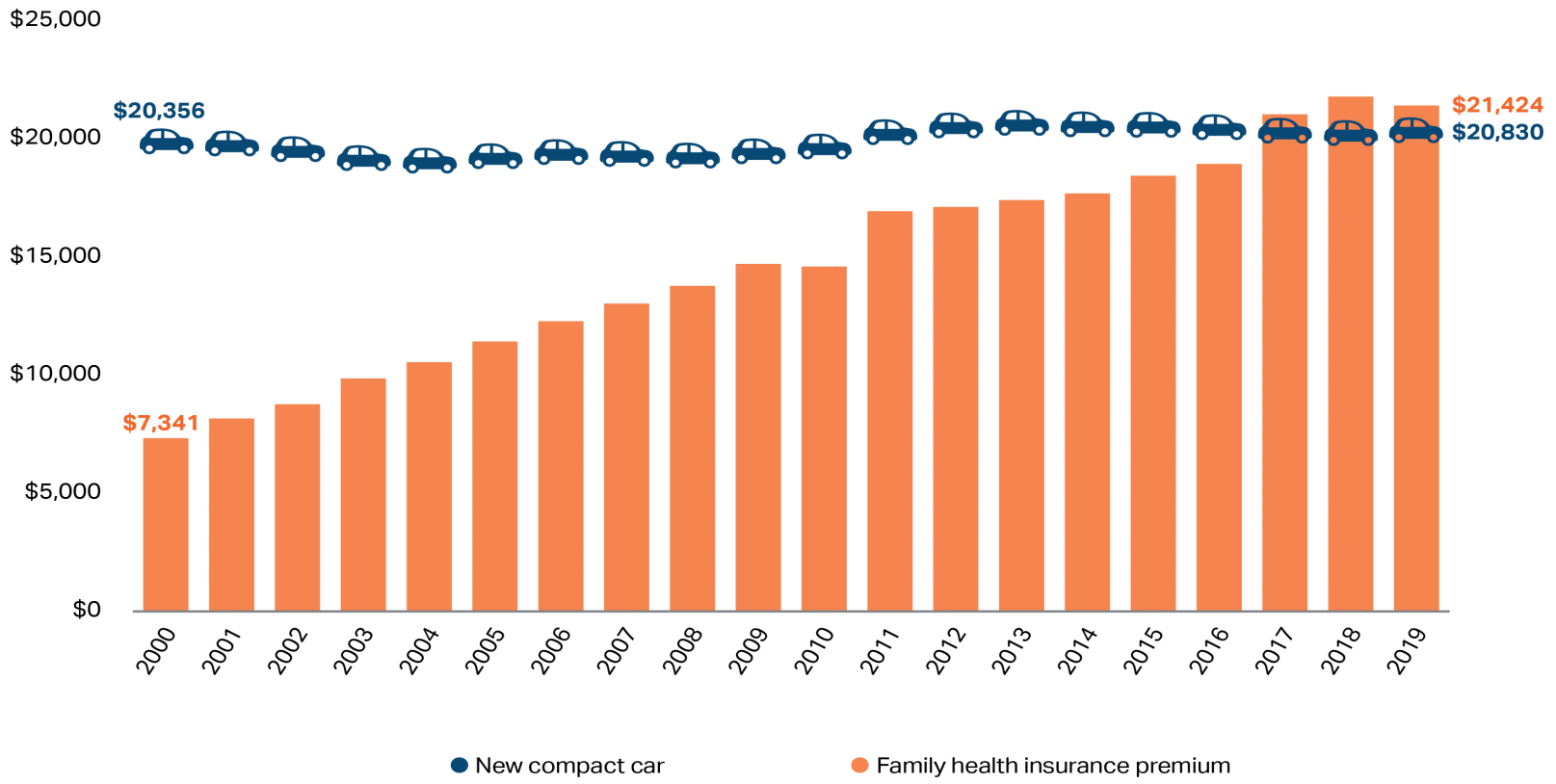
Notes: Services displayed had the highest aggregate HOPD spending in 2018 (colonoscopy: $22.9M; pathology: $20M; endoscopy: $15.6M) and were also billed in 2016. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. Colonoscopy (CPT 45380, 'Colonoscopy, flexible; with biopsy, single or multiple'); GI endoscopy (CPT 43239, 'Esophagogastroduodenoscopy'); Surgical pathology (CPT 88305, 'Level IV Surgical pathology, gross and microscopic examination').

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v8.0, 2016-2018

HPC

Massachusetts health insurance premiums have tripled in 19 years and consume an ever-larger portion of earnings for middle class families.

Average total cost for Massachusetts family health insurance premiums and national cost of a new compact car



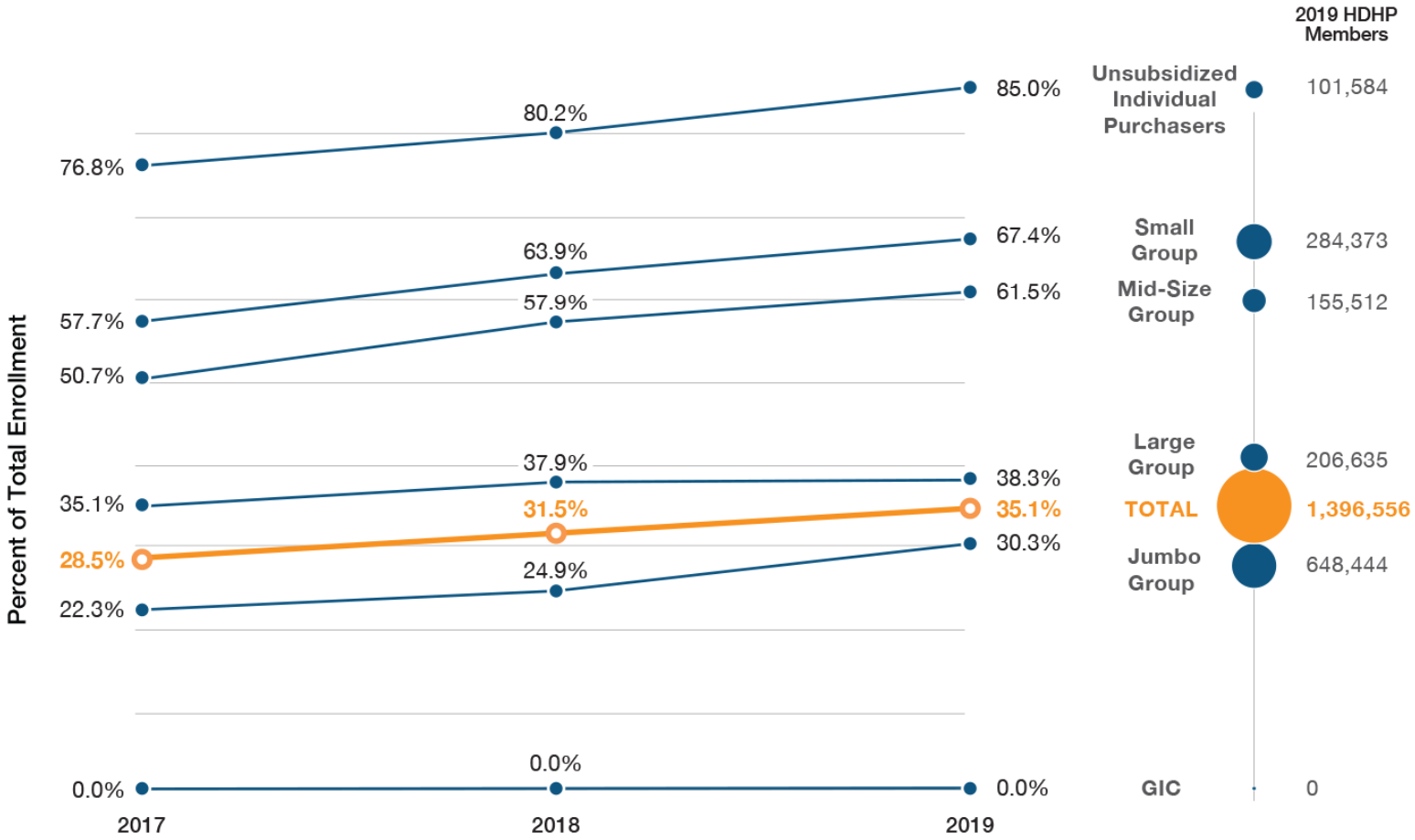
The share of middle-class commercially-insured Massachusetts families with more than ¼ of total earnings going to health care rose from **28%** in 2013-2015 to **33%** in 2016-2018.

Notes. Data are in normal dollars of the year shown.

Sources: Family Health Insurance premiums are for Massachusetts from the Agency for Health Care Quality – Medical Expenditure Panel Survey, Insurance Component. Car cost information is based on car-specific inflation from the BLS and the compact car price index from Kelly Blue Book. https://www.prnewswire.com/news-releases/average-new-car-prices-up-nearly-4-percent-year-over-year-for-may-2019-according-to-kelley-blue-book-300860710.html. Earnings calculation includes employer premium contribution in both health care payments and in earnings total. See Massachusetts HPC 2019 Annual Cost Trends Report (p.15)

HPC

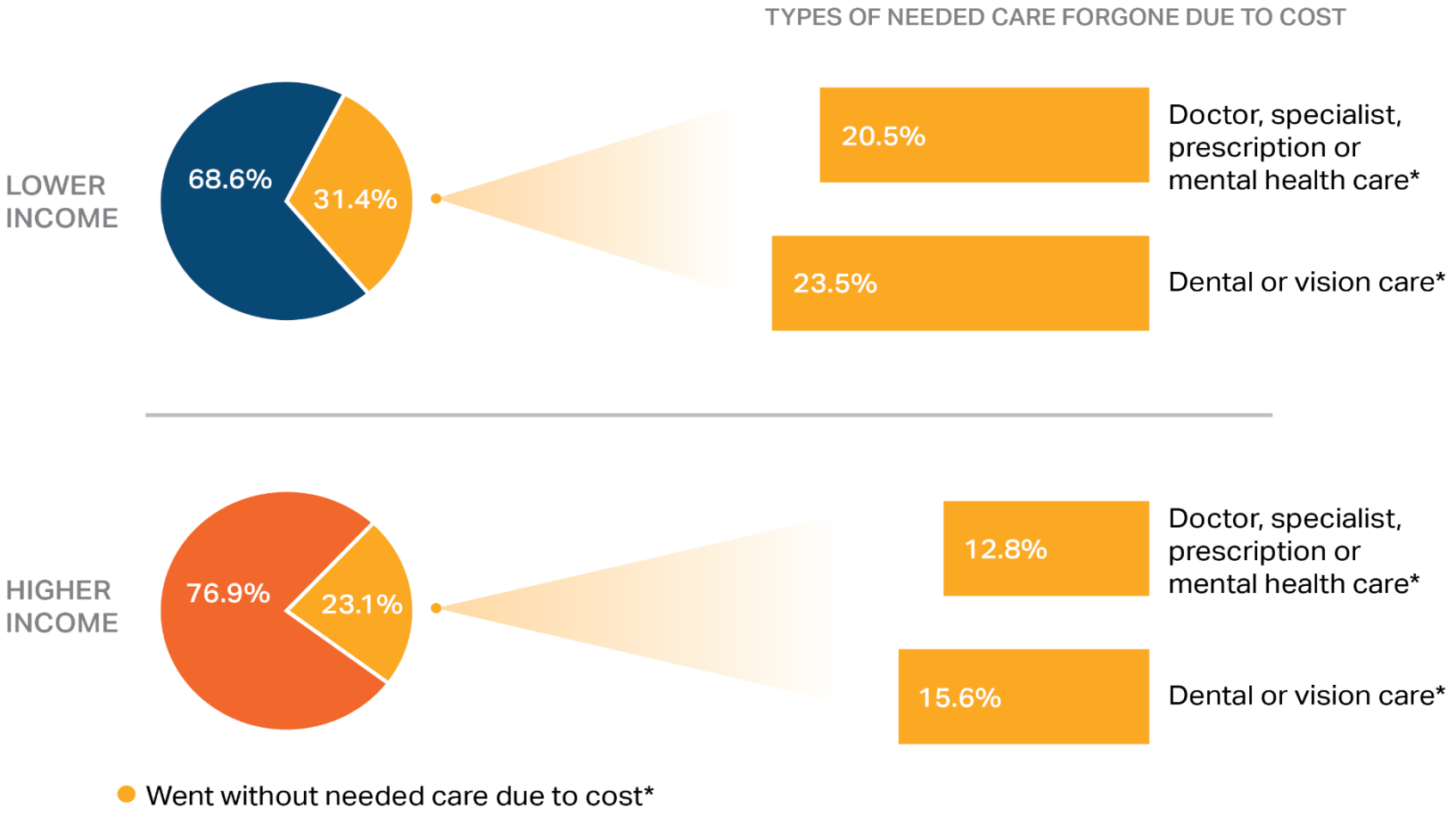
The percentage of commercially-insured residents with high deductible health plans grew markedly, 2017-2019.



HDHP enrollment continued to grow steadily across nearly all market sectors, with the fastest growth among jumbo group employers.

Adults with lower income were much more likely to go without needed health care or prescription drugs because of cost.

Percent of commercially-insured adults who went without needed care because of cost and types of needed care forgone by household income, 2019



Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. * indicates significance at P<0.05 level.

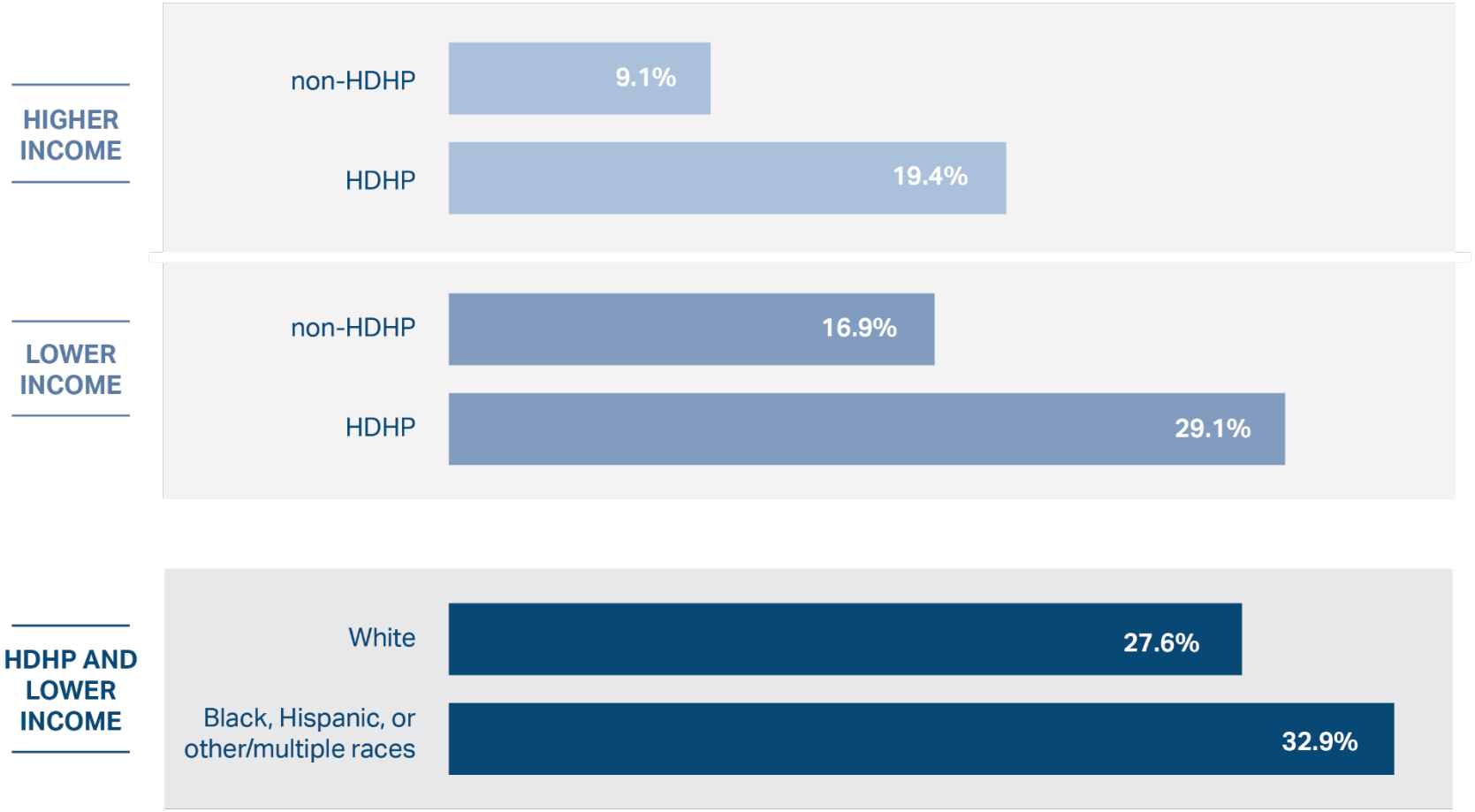
Question text: "Still thinking about the past 12 months, was there any time that you did the following because of cost?": "…not fill a prescription for medicine needed for you", "… not get doctor care that you needed", "not get specialist care that you needed", "not get mental health care or counseling that you needed", "not get dental care that you needed", "not get vision care that you needed"

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

HPC

Adults with high deductible plans were also twice as likely to go without needed health care or prescription drugs because of cost.

Percent of commercially-insured Massachusetts adults who said they went without needed doctor care, specialist care, mental health care or prescription drugs, 2019

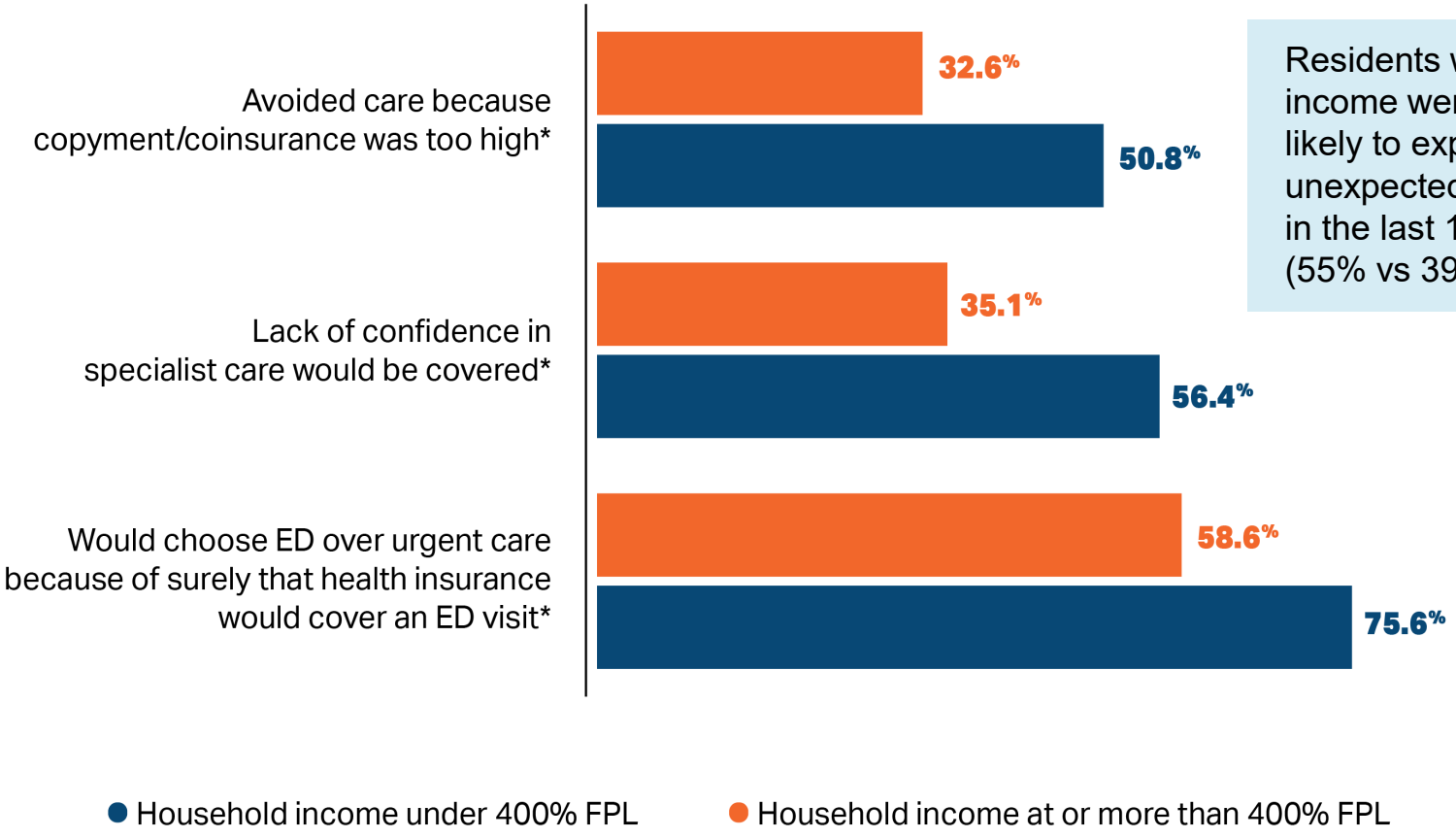


Notes: 'Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. Question text: “Because of cost, did you go without needed ___ care”, where the categories for types of care included those noted above as well as vision care, dental care, medical equipment, or care from an NP, PA or CNM.

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

Adults with lower income avoided care because of copays/coinsurance and lack of confidence that needed care would be covered.

Percent of commercially-insured adults who avoided needed care because of cost or lacked confidence in coverage, by household income status, 2019



Residents with lower income were more likely to experience an unexpected medical bill in the last 12 months (55% vs 39%).

Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. * indicates significance at P<0.05 level.

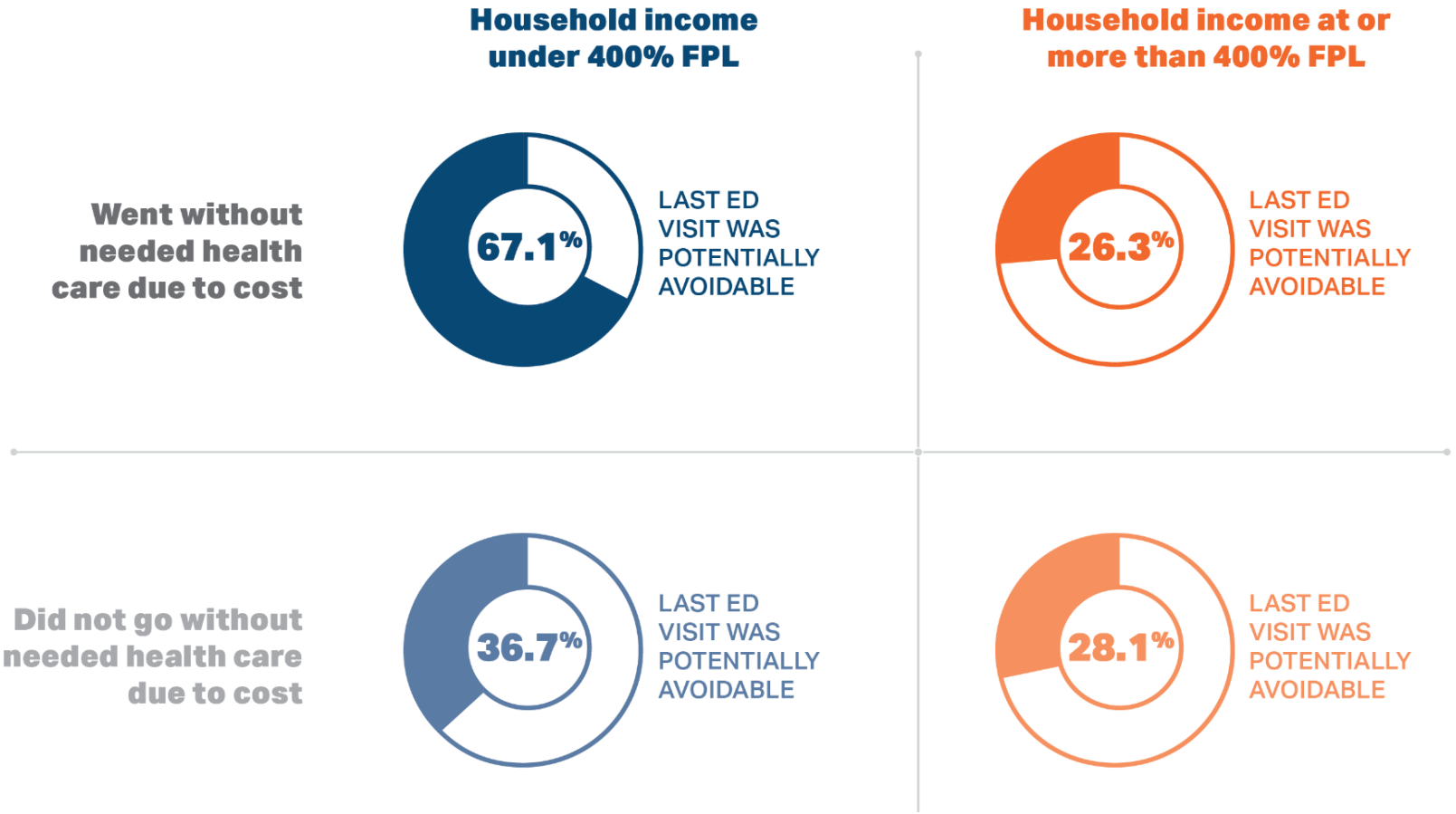
Question text: "Would any of these be important reasons for you to choose a hospital emergency room over an urgent care center or retail clinic?" "The last time you went without needed care because of cost was it because of any of the following?" "How confident are you that you know whether or not the following would be covered by your health insurance plan if it was needed?" "In the past 12 months, have you or any of your immediate family members received a medical bill where the health insurance plan paid much less than expected, or did not pay anything at all?"

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey and 2019 MHIS Recontact Survey

HPC

Those who are lower income and went without needed care due to cost were twice as likely to have had a potentially avoidable ED visit.

Percent of commercially-insured adults whose last ED visit was potentially avoidable, by household income and unmet health care needs due to cost, 2019



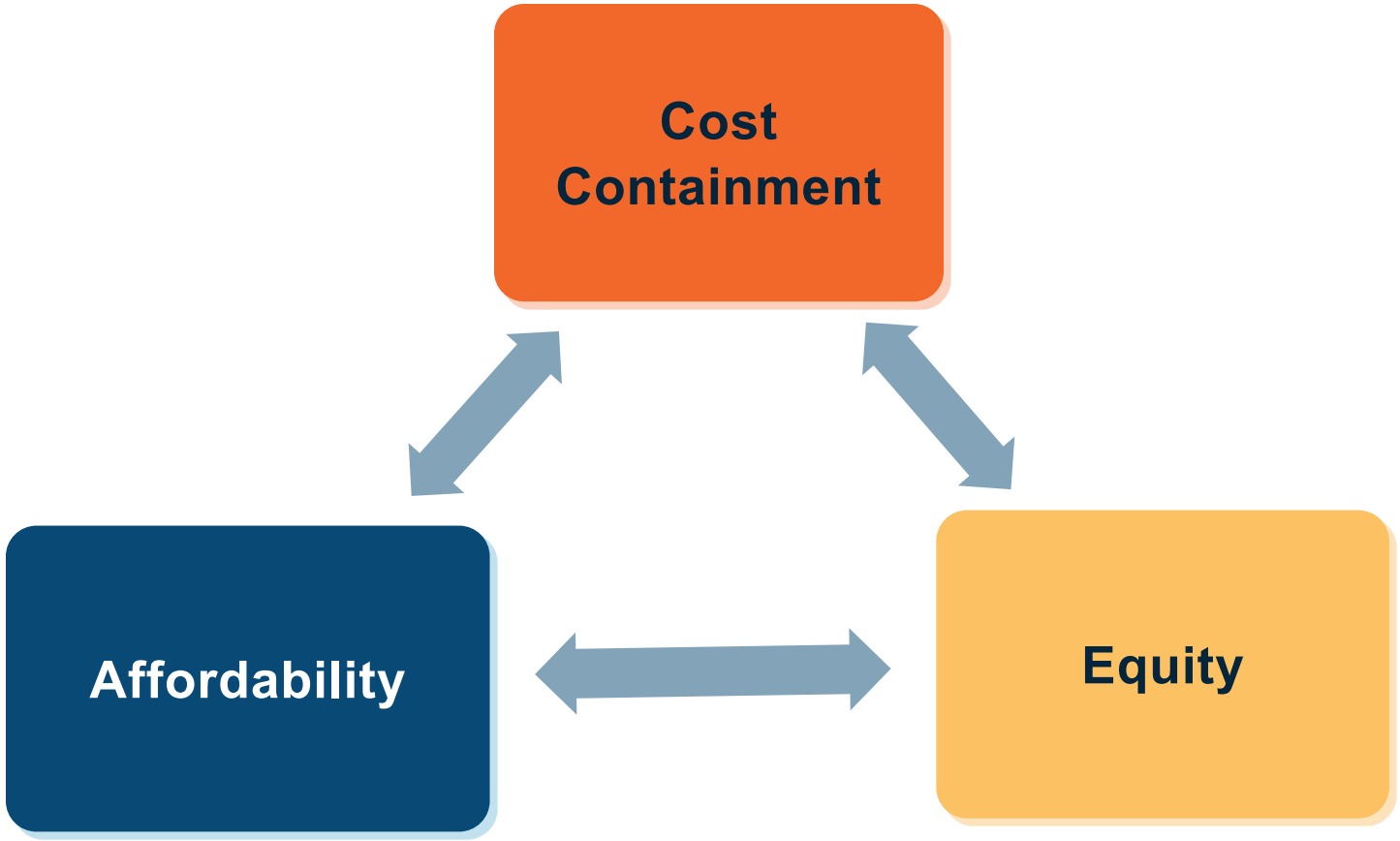
Notes: Results are reported according to self-reported income. Population includes commercially-insured adults age 18-64, with 12-months continuous coverage as of survey timeframe in 2019. Needed health care includes doctor, specialist, prescription drug, and mental health care. Clockwise from upper left quadrant, estimated number of Massachusetts residents whose last ED visit was potentially avoidable: 32,210/48,031, 18,421/70,097, 89,246/317,376, and 57,464/156,749.

Question text: "Still thinking about the past 12 months, was there any time that you did the following because of cost?": "…not fill a prescription for medicine needed for you", "… not get doctor care that you needed", "not get specialist care that you needed", "not get mental health care or counseling that you needed". "The last time you went to a hospital emergency room, was it for a condition that you thought could have been treated by a regular doctor if he or she had been available?"

Source: HPC analysis of Center for Health Information and Analysis 2019 MHIS Survey

HPC

The findings of the 2021 Cost Trends Report and the experience of the COVID-19 pandemic further highlight that containing health care costs is interrelated with addressing issues of affordability and health equity.



In developing a set of potential Policy Recommendations for inclusion in the 2021 report, the HPC aims to advance these three goals.

Board Discussion: Potential Policy Recommendations for Inclusion in the 2021 Cost Trends Report

For discussion among Board members today, the HPC has developed **10** potential policy recommendations for market participants, policymakers, and government agencies. Many of the recommendations are interrelated and are intended to work together to advance the HPC's goals of **health care cost containment, affordability, and health equity.**

The following slides summarize these proposed policy recommendations which include:

1) new recommendations, and
2) revised and refreshed recommendations featured in past Cost Trends Reports.

Final policy recommendations will be included in the 2021 Cost Trends Report, to be approved by the Board and released in September 2021.

2021 Cost Trends Report: Summary of Potential Recommendations for Discussion

Potential Recommendations

1. **Enhance the Commonwealth's Health Care Accountability Framework.** As the Commonwealth recovers from COVID-19, there is a unique opportunity to address the intersecting challenges of cost containment, affordability, and health equity -- the seriousness and urgency of which were underscored both by the pandemic and recent trends -- to improve outcomes and lower costs for all. With that opportunity in mind, the HPC proposes strengthening and expanding the state's health care accountability framework.

    a. **Strengthen Accountability for Spending Growth in Excess of the Benchmark.** In light of recent statewide spending growth performance over the benchmark, the Commonwealth should strengthen the mechanisms to hold health care entities responsible for spending growth. Policymakers should improve the annual performance improvement plan (PIP) process by allowing the Center for Health Information an Analysis (CHIA) to use metrics other than health status adjusted total medical expense to identify entities with concerning growth in spending. These measures should expand in scope to encompass providers other than primary care groups and address the impact of medical coding efforts which can mask spending increases. The PIPs process can be further strengthened by increasing financial penalties for above-benchmark spending or other non-compliance.

    b. **Set New Affordability and Health Equity Targets.** To both complement and bolster the health care cost growth benchmark, the Commonwealth should set measurable goals that target affordability of care for Massachusetts residents and advance health equity. This measurement strategy should identify and track improvement on indicators of affordability and health equity in order to ensure that every resident of the Commonwealth has the opportunity to attain their full health potential without being disadvantaged from achieving that potential because of social position (e.g., class, socioeconomic status) or socially assigned circumstance (e.g., race, gender, ethnicity, religion, sexual orientation, geography).

2021 Cost Trends Report: Summary of Potential Recommendations for Discussion

Potential Recommendations

2. **Address Excessive Provider Price Growth.** Prices continue to be a primary driver of health care spending growth in Massachusetts. Specifically, hospital prices and shifts in volume from lower-priced to higher-priced hospitals were a key reason Massachusetts failed to meet the benchmark in 2018 and 2019, hospital prices paid by commercial insurers in Massachusetts are as high as 3 times what Medicare pays for the same services, and many providers are paid significantly more than others for the same services without a demonstrable difference in quality. To date, countervailing market initiatives (e.g. tiered and narrow network products, price transparency, risk contracting) have failed to meaningfully restrain provider price growth or reduce unwarranted variation in provider prices.

    a. **Establish Provider Price Caps and Reduce Unwarranted Price Variation***:* To address provider price variation and unsustainably high price growth, particularly among currently higher-priced hospital systems, the HPC recommends a cap on provider prices (e.g., limiting the highest, service-specific commercial prices) and on price growth (e.g., limiting annual service-, insurer-, and provider-specific price growth). Such price caps would reduce price variation by focusing on only the highest-priced providers, thereby improving equity across providers and patient populations. Importantly, a cap would encourage competition and value-driven innovation among providers rather than strategies that seek to increase market share and raise prices. Finally, such a cap would ensure that future price increases can accrue appropriately to lower-priced providers, including many community hospitals and other providers that care for underserved populations, ensuring the viability of these critical resources.

2021 Cost Trends Report: Summary of Potential Recommendations for Discussion

Potential Recommendations

3. **Enhance Scrutiny of Ambulatory and Hospital Outpatient Care Trends.** Recognizing that the cost of care can vary substantially among different providers, with significant implications for health equity and affordability, the Commonwealth should continue to examine the impact of plans for major expansions of services or new facilities to evaluate the impact on health care costs, quality, access and market competition, particularly ambulatory and hospital outpatient care, and to ensure that any such services are well aligned with community need, particularly for historically underserved populations.

    a. **Enhance Monitoring of Ambulatory Care Trends**. Given the particular importance of outpatient care in driving spending and utilization trends, the Commonwealth should improve data collection on ambulatory care across different sites and settings, including urgent care, hospital main campus and off-campus sites, and non-hospital-licensed ambulatory sites, and should analyze the impact of shifts in patient care between lower and higher-priced sites on health care costs, quality and access, particularly for historically underserved populations.

    b. **Limit Facility Fees.** In many cases, the same services can be provided at both hospital outpatient departments and non-hospital settings such as physician offices, but Massachusetts residents disproportionately use hospital outpatient settings, making, on average, 40% more such visits than residents of other states. Prices and patient cost-sharing are generally substantially higher at hospital outpatient sites due to the addition of hospital “facility fees”, and in many cases patients may be unaware that an off-campus medical facility is considered a hospital outpatient department and face higher costs. In order to improve market functioning and consumer protections, policymakers should take action to require site-neutral payments for common ambulatory services (e.g., basic office visits) and limit the cases in which both newly licensed and existing sites can bill as hospital outpatient departments. Additionally, outpatient sites that charge facility fees should be required to conspicuously and clearly disclose this fact to patients, prior to delivering care.

2021 Cost Trends Report: Summary of Potential Recommendations for Discussion

Potential Recommendations

4. **Examine Increases in Medical Coding Intensity and Improve Patient Risk Adjustment.** The HPC and other agencies and independent researchers should continue to document that recent increases in patient risk scores and acuity are better explained by changes in payer and provider documentation and coding behavior than by changes in actual patient health status. While there are benefits to more complete and accurate coding, increased coding intensity impairs accurate performance measurement, absorbs and attracts resources and personnel, and has resulted in millions in additional spending for Massachusetts residents.

   The Commonwealth should take action to mitigate the impact of improved clinical documentation on spending and performance measurement. Specific areas of action include use of risk adjustment methods for accountability and payment purposes that are not based on patient diagnoses or severity, more frequent updates to clinical classification software to better align payments with actual resource use, mechanisms to offset coding-related spending impacts, and continued development of alternative risk adjustment methods and performance metrics less sensitive to coding-based acuity.

2021 Cost Trends Report: Summary of Potential Recommendations for Discussion

Potential Recommendations

5. **Monitor Pharmaceutical Spending and Pricing:** The Commonwealth should take action to reduce drug spending growth and improve affordability for patients. Among many challenges in drug spending, high-cost specialty drugs represent an increasing share of drug spending, and the large number of new specialty drugs expected to enter the market over the next decade brings not only the promise of improvement to patients' lives but also significant concerns about the impact on health care spending. These costs directly translate to higher premiums for employers and individuals and higher cost sharing for consumers, as well as drawing tax dollars away from other valuable priorities. Furthermore, recent discussions about a recently approved high-cost medication highlight the need for a focus on value in drug spending.

   Massachusetts should build on its current initiatives with further innovative approaches to reduce drug spending growth and implement policies to increase oversight and transparency for the full drug distribution chain, such as by authorizing the expansion of the HPC's drug pricing review authority to include drugs with a financial impact on the commercial market in Massachusetts and by increasing state oversight of pharmacy benefit managers' (PBMs) purchasing practices. Payers and providers should pursue strategies to maximize value and enhance access by using risk-based contracts and value-based benchmarks when negotiating prices, distributing clinical decision tools, monitoring prescribing patterns, and developing plan designs that minimize financial barriers to high-value drugs.

2021 Cost Trends Report: Summary of Potential Recommendations for Discussion

Potential Recommendations

6. **Address Social Determinants of Health and Other Drivers of Health Inequity.** The Commonwealth should continue to examine and address the social factors, including racism, at the structural, institutional, and interpersonal levels, that lead to poor health outcomes for individuals and communities. Payers and providers should cooperate with efforts by government and other stakeholders to collect reliable data on race, ethnicity, language, and disability to inform integration of equity considerations into cost-control and affordability efforts. Policymakers should seek opportunities to use their strategic levers to address inequities, and providers should expand upon their efforts to respond to long-standing inequities in the healthcare delivery system. Providers should also focus on the equity impacts of any expansions or care delivery changes and be required to show that such changes will help address inequities rather than perpetuate them.

2021 Cost Trends Report: Summary of Potential Recommendations for Discussion

Potential Recommendations

7. **Focus Investments in Primary Care and Behavioral Health:** There is considerable evidence that health care delivery systems oriented toward primary care tend to have lower costs, higher quality, and a more equitable distribution of health care resources. Better management of behavioral health conditions has also been found to lower overall health care spending and improve quality of life. The Commonwealth should take action to increase spending on primary and behavioral health care without increasing overall health care spending and expand access to these services for all residents.

    a. **Focused investment in primary health care and behavioral health care**. Payers and providers should increase spending devoted to primary care and behavioral health while adhering to the Commonwealth's total health care spending benchmark. The Center for Health Information Analysis (CHIA) and the HPC should continue to track and report on primary care and behavioral health care spending trends annually and hold entities accountable for meeting improvement targets if they fall short of established targets.

    b. **Improve Access to Behavioral Health Services**. In response to increased demand for behavioral health services as a result of the pandemic -- in particular among children, and young adults, and people of color -- payers and providers should take steps to increase access to behavioral health services appropriate for and accessible to these populations. In addition, the Commonwealth should redouble its efforts to provide resources and support to individuals and families suffering from the effects of the opioid epidemic, notably among Black men who are experiencing significant increases in overdoses. The Commonwealth can advance these goals and additional efforts to increase needed access to behavioral health care by implementing the **EOHHS Roadmap for Behavioral Health Reform: *Ensuring the right treatment when and where people need it.***

2021 Cost Trends Report: Summary of Potential Recommendations for Discussion

Potential Recommendations

8. **Reduce Administrative Complexity.** Reducing administrative complexity that does not add value can improve affordability and equity in health care. Administrative complexity permeates our health care system, from differing rules for claims submission, credentialing, and prior authorization, to non-standard APM contract terms and EHR workflows, creating unnecessary costs for all healthcare actors and for the Massachusetts residents and businesses who pay for this complexity in the form of higher premiums. The Commonwealth should identify health plan policies, programs, and processes for which cross-payer standardization would reduce administrative complexity, enhance affordability, and improve equity.

9. **Support Efforts to Reduce Low-Value Care:** The HPC continues to find that Massachusetts residents receive a significant amount care that does not provide value, and the provision of such care by provider organizations varies widely. The Commonwealth should act to reduce the incidence of low-value care. Toward this end, payers, providers, and purchasers should convene to discuss strategies and incentives needed to eliminate low-value care. Employers can also play a role in assisting employees and their families in accessing information useful in making high-value treatment decisions.

2021 Cost Trends Report: Summary of Recommendations for Discussion

Potential Recommendations

10. **Sustain Care Delivery and Payment Innovations Made During the COVID-19 Pandemic.** The Coronavirus Disease 2019 (COVID-19) has indelibly changed the lives of Massachusetts residents and the health care system that serves them. Even as vaccine administration efforts continue, recovery for residents, the health care system, and health care workers will be a long-term process. To help guide this recovery, policymakers, health care leaders, and community partners should look to lessons from the pandemic to inform opportunities for rebuilding sustainable, resilient, and equitable systems of care.

    In this context, the Legislature has charged the HPC with studying the impact of COVID-19 on the health care delivery. An Interim Report was released in April 2021 and a Final Report from the HPC is due in 2022. While many of the following topics (and more) will be more fully examined in that report, the HPC nonetheless recommends that the Commonwealth take steps to sustain innovations made during the pandemic, including, but not limited to, the following areas:

    I. Telehealth
    II. Workforce Flexibilities
    III. Innovative Care Models
    IV. Primary Care Capitation and Other Value-Based Payment Models

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
- **HPC Fiscal Year 2022 Budget (VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- Executive Session **(VOTE)**

The Legislature's FY 2022 budget proposal is under review by the Executive Branch and is awaiting imminent action by the Governor. The state is currently operating on an interim budget, set at FY 2021 levels.

State Budget Process

Governor's FY 2022 Budget Proposal, January 2021
1450-1200: *For the operation of the Health Policy Commission*..... $10,015,938

HPC's FY 2022 Budget Proposal Submitted to Joint Committee on Ways and Means, March 2021
1450-1200: *For the operation of the Health Policy Commission*..... $10,513,097

House FY 2022 Budget Proposal, May 2021
1450-1200: *For the operation of the Health Policy Commission*..... $10,513,097

Senate FY 2022 Budget Proposal, May 2021
1450-1200: *For the operation of the Health Policy Commission*..... $10,513,097

Conference Committee FY 2022 Budget Proposal
1450-1200: *For the operation of the Health Policy Commission*.....$10,513,097

Final Budget
1450-1200: *For the operation of the Health Policy Commission*...

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: HPC Fiscal Year 2022 Budget

MOTION: That the Commission hereby authorizes the Executive Director to continue spending funds to support the ongoing operations of the agency at the level of funding approved by the Commission for fiscal year 2021, until the Commission approves the final operating budget for fiscal year 2022.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

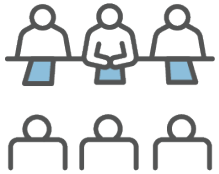
- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
- HPC Fiscal Year 2022 Budget **(VOTE)**
- **Schedule of Next Meeting (September 15, 2021)**
- Executive Session **(VOTE)**

Upcoming 2021 Meetings and Contact Information

BOARD MEETINGS

September 15

November 17



COMMITTEE MEETINGS

October 6

December 15

ADVISORY COUNCIL

September 29

December 8

Mass.gov/HPC

@Mass_HPC

HPC-info@mass.gov

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from June 24, 2021 Meeting **(VOTE)**
- Executive Director's Report
- Market Oversight and Transparency
- HPC Fiscal Year 2022 Budget **(VOTE)**
- Schedule of Next Meeting **(September 15, 2021)**
- **Executive Session (VOTE)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Enter into Executive Session

MOTION: That, having first convened in open session at its May 19, 2021 board meeting and pursuant to M.G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with M.G.L. c. 6D, § 10 and its associated regulation, 958 CMR 10.00, M.G.L. c. 6D, § 2A, and M.G.L. c. 12C, § 18, in discussions about whether to require performance improvement plans by entities confidentially identified to the Commission by the Center for Health Information and Analysis.