



# HPC Board Meeting

April 13, 2022



# Agenda



## **CALL TO ORDER**

**Approval of Minutes (VOTE)**

**Recognition of Black Maternal Health Week**

**Market Oversight and Transparency**

**Care Delivery Transformation**

**Executive Director's Report**

**Schedule of Upcoming Meetings**

# Agenda



Call to Order



## **APPROVAL OF MINUTES (VOTE)**

Recognition of Black Maternal Health Week

Market Oversight and Transparency

Care Delivery Transformation

Executive Director's Report

Schedule of Upcoming Meetings

# VOTE

## Approval of Minutes from the January 25, 2022 Board Meeting

### MOTION

That the Commission hereby approves the minutes of the Commission meeting held on January 25, 2022, as presented.

# Agenda



Call to Order

Approval of Minutes (**VOTE**)



**RECOGNITION OF BLACK MATERNAL HEALTH WEEK**

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- Black Maternal Health Week, established five years ago by the Black Mamas Matter Alliance, takes place every year April 11 – April 17.
- In 2021, the White House issued a proclamation officially recognizing Black Maternal Health Week.
- According to the Black Mamas Matter Alliance, “the campaign and activities for Black Maternal Health Week serve to amplify the voices of Black Mamas and center the values and traditions of the reproductive and birth justice movements. Activities during BMHW are rooted in human rights, reproductive justice, and birth justice frameworks.”



**APRIL 11-17, 2022**

**BLACK MATERNAL  
HEALTH WEEK**

**#BMHW22**

# Maternal Health Activities in the Commonwealth



Call to Order

Approval of Minutes (**VOTE**)

Recognition of Black Maternal Health Week



## **MARKET OVERSIGHT AND TRANSPARENCY**

- Mass General Brigham Performance Improvement Plan: Request for Extension (**VOTE**)
- 2023 Health Care Cost Growth Benchmark (**VOTE**)
- Recent Market Changes
- Research Presentation: Trends in Emergency Department Use Among Massachusetts Residents

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**➤ MASS GENERAL BRIGHAM PERFORMANCE IMPROVEMENT PLAN: REQUEST FOR EXTENSION (VOTE)**

- 2023 Health Care Cost Growth Benchmark (**VOTE**)
- Recent Market Changes
- Research Presentation: Trends in Emergency Department Use Among Massachusetts Residents

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# Performance Improvement Plans: MGB Request for Extension



MAY 2022						
Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	★ 16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4

- On **January 25, 2022**, the Board voted to require Mass General Brigham (MGB) to develop and file a Performance Improvement Plan (PIP). MGB was required to file a proposal, request for waiver, or request for an extension within 45 days.
- On March 14<sup>th</sup>, MGB requested an extension of the deadline to file its proposed PIP to **May 16, 2022**.
- The approximately 60-day extension request can only be approved by **vote of the Board**.
- MGB states that it requires additional time to develop a plan that **addresses both TME for its primary care patients and Total Health Care Expenditures for the state**, in accordance with the standards laid out in the PIP regulation. MGB also indicated that it would be beneficial to file its proposal after the DPH staff reports were released on the separate matter of MGB's Determination of Need applications.
- Staff recommends **approving the request**.

# VOTE

## Mass General Brigham Performance Improvement Plan: Request for Extension

### MOTION

That the Commission hereby approves, pursuant to 958 CMR 10.08, Mass General Brigham's request for an extension to May 16, 2022 to submit a Performance Improvement Plan proposal.

# Agenda



Call to Order

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Recognition of Black Maternal Health Week

Market Oversight and Transparency

- Mass General Brigham Performance Improvement Plan: Request for Extension (**VOTE**)
- **2023 HEALTH CARE COST GROWTH BENCHMARK (VOTE)**
- Recent Market Changes
- Research Presentation: Trends in Emergency Department Use Among Massachusetts Residents

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# In 2012, Massachusetts became the first state to establish a target for sustainable health care spending growth.

## CHAPTER 224 OF THE ACTS OF 2012



An Act Improving the Quality of Health Care and **Reducing Costs** through Increased **Transparency, Efficiency, and Innovation.**

## GOAL



Reduce total health care spending growth to meet the **Health Care Cost Growth Benchmark**, which is set by the HPC and tied to the state's overall economic growth.

## VISION

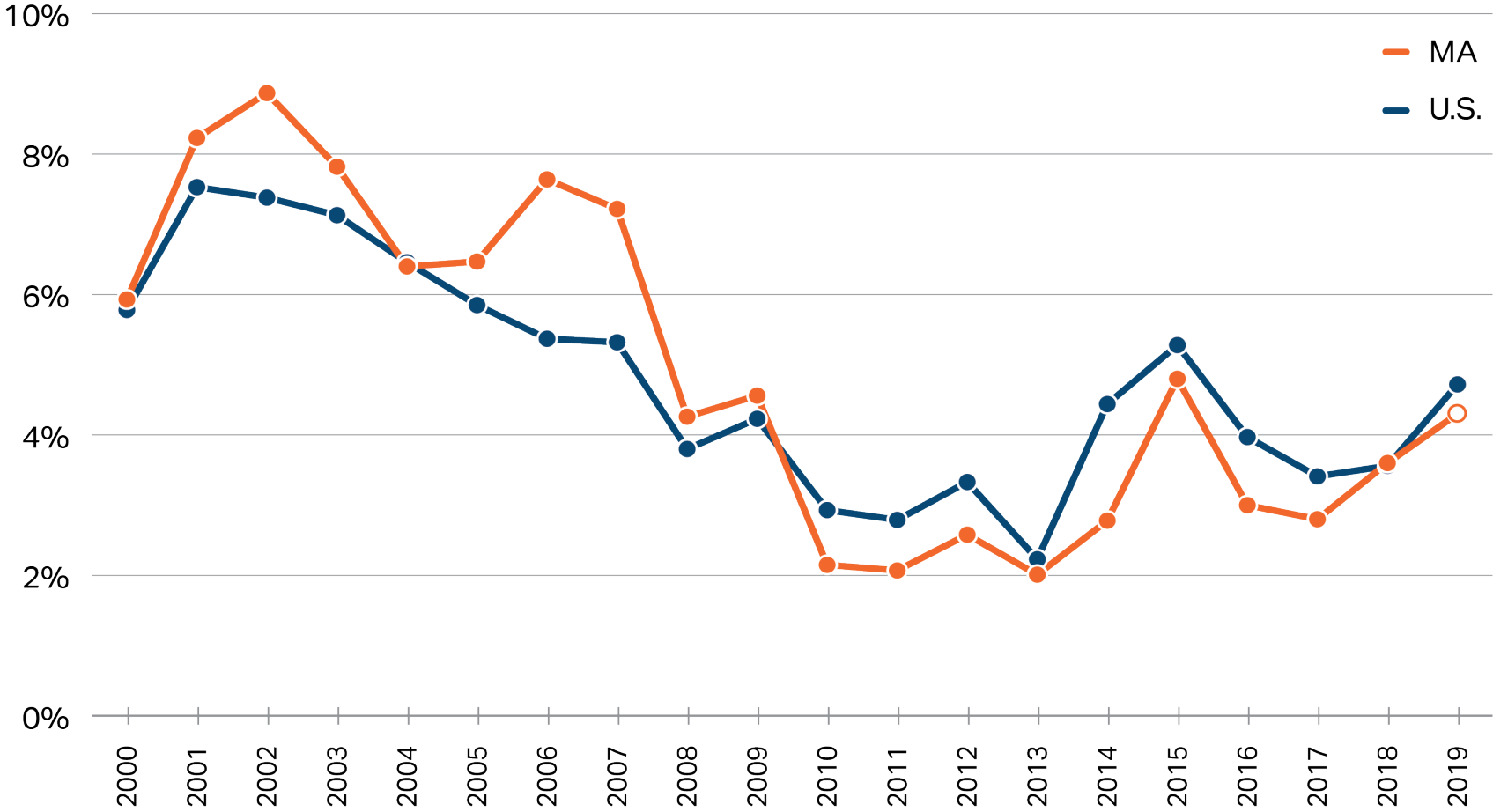


A transparent and **innovative** healthcare system that is **accountable** for producing **better health** and **better care** at a **lower cost** for all the people of the Commonwealth.

# Massachusetts spending growth has been below the U.S. since 2010, but the gap nearly closed in 2018 and 2019.



Massachusetts and national annual per-capita total health care spending growth, 2000 to 2019



Notes: U.S. data includes Massachusetts. Massachusetts 2018-2019 spending growth estimate is preliminary.  
Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures Data, 2014-2019 and State Healthcare Expenditure Accounts, 1999-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2019

## The Health Care Cost Growth Benchmark

The benchmark is not a bright line limit applied indiscriminately to all payers, providers, spending categories, or insurance sectors.

- Setting a statewide benchmark is effective as a collective call to action to address the **unsustainable growth of health care costs**, which threaten the financial well-being of our residents, the competitiveness of the state's economy, and efforts to reduce health care disparities.
- The benchmark is a **prospective target** for controlling the **growth** of total health care expenditures across all payers (public and private) tied to the state's long-term economic growth rate.
- The health care cost growth benchmark is **not a cap on spending or provider price increases**, but rather a measurable goal for moderating excessive health care spending growth and **advancing health care affordability and equity**.
- To promote accountability for meeting the state's benchmark target, the HPC can require health care providers and health plans to implement **Performance Improvement Plans (PIP)** and submit to public monitoring.

- The HPC may require any entity referred to it by CHIA to complete a Performance Improvement Plan (PIP) if, after a review of regulatory factors, it identifies **significant concerns** about the Entity's costs and determines that a PIP could result in **meaningful, cost-saving reforms**.
- The HPC interprets the inclusion of these factors in its review process as a directive to **consider contextualizing factors** for the payers, providers, and communities where growth is occurring. Factors include evaluating spending and pricing trends over time, payer mix, the entity's market position, and cost drivers outside of the entity's control, among other factors.
- The consideration of these factors in enforcement of the benchmark promotes accountability, while recognizing that **spending growth may be more concerning in some cases** (e.g., at already high-priced, high-spend providers), and in others may represent appropriate growth that improves access and outcomes.



## How the HPC Contextualizes Spending Performance: Examples

### Regulatory Factor: Pricing patterns and trends over time

- High baseline prices
- Price increases that exacerbate provider price variation
- High spending growth over multiple years
- Low baseline prices
- Price increases that mitigate provider price variation
- Corrections to underpriced services or provider types

### Regulatory Factor: Population(s) served, payer mix, product lines, and services provided

- Spending growth concentrated in higher-income communities
- Payer mix disproportionately commercial
- Growth due to changes in service mix or provider mix that increase costs without improving value
- Growth in lower income communities that may correct patterns of historical underutilization
- Payer mix disproportionately public
- Growth due to increased spending on primary care or behavioral health

### Regulatory Factor: Factors leading to increased costs that are outside the Entity's control

- No indication that factors outside of the entity's control drove spending
- Mandated coverage of new high-cost drugs
- Documented changes in patient health
- Emergency response

More likely to PIP

Less likely to PIP

# The HPC's authority to modify the benchmark is prescribed by law and subject to potential legislative review.



1-5 years

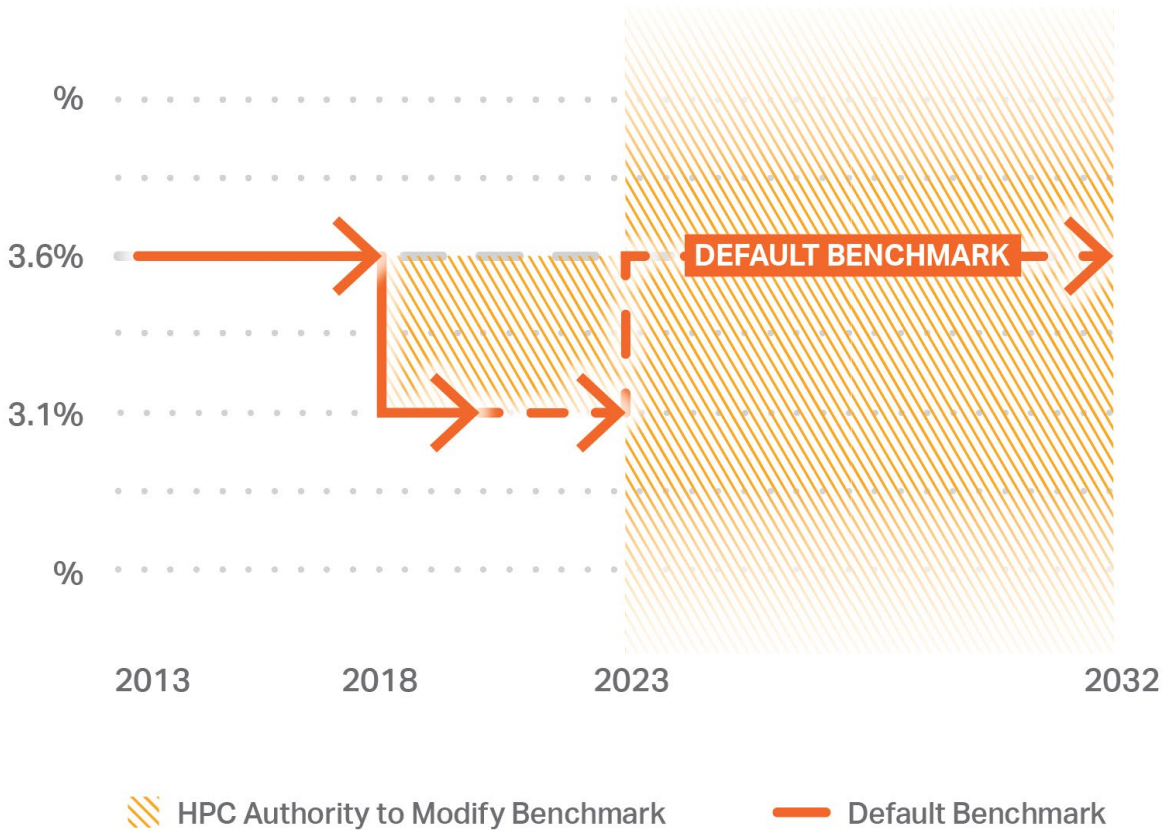
The benchmark is established by law at the state's long-term potential economic growth rate of Massachusetts (PGSP), as determined annually by the Legislature and the Governor.

6-10 years

The benchmark is established by law at a **default rate of at PGSP minus 0.5% (3.1%)**; The HPC had the authority to modify the benchmark up to 3.6% by a 2/3<sup>rd</sup> vote of the Board, subject to legislative review. The HPC elected not to modify the benchmark during this time period.

10-20 years

The benchmark is established by law at a **default rate of PGSP (3.6%)**; HPC can modify to any amount, by a 2/3 vote of the Board, subject to legislative review.



## HPC PROCESS TO MODIFY

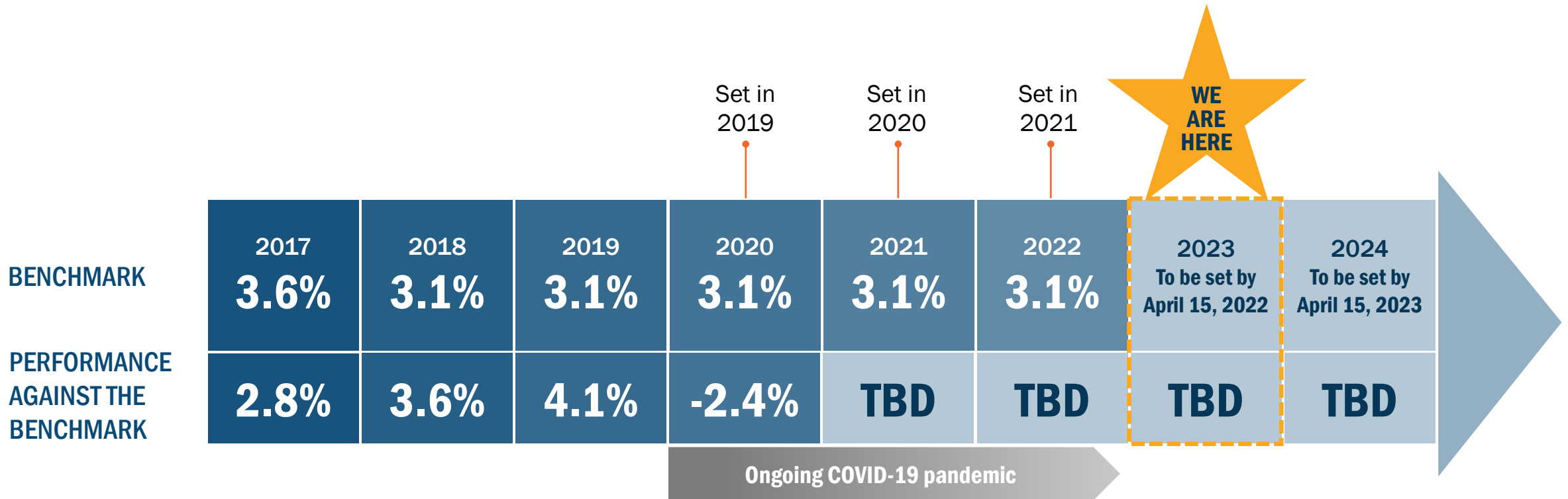
- Prior to any modification of the benchmark, the HPC's Board must hold a **public hearing** on whether modification is warranted. The hearing must examine recent **data** on provider and payer costs, prices, and cost trends as well as **stakeholder testimony**.
- Members of the Joint Committee on Health Care Financing participate in the hearing.
  - ↳ If the HPC's Board votes to maintain the benchmark at the default rate of 3.6%, the **annual process is complete**.
  - ↳ If the HPC's Board votes to modify the benchmark to any other number, the HPC must submit notice of its intent to modify the benchmark to the Joint Committee **for potential further legislative review**.

## POTENTIAL LEGISLATIVE REVIEW

- Following notice from the HPC of an intent to modify, the Joint Committee may hold a public hearing within 30 days and may submit findings and recommendations, including any legislative recommendations, to the General Court within 30 days of that hearing.

<b>ORGANIZATION</b>	<b>POSITION</b>
Association for Behavioral Healthcare	Not specified
Atrius Health	3.6% (or higher)
Blue Cross Blue Shield of MA	3.1%
Conference of Boston Teaching Hospitals	Suspend benchmark
Health Care For All	3.1% (or lower)
Lawrence General Hospital	Not specified
Massachusetts Association of Health Plans	3.6% (or lower)
Massachusetts Health and Hospital Association	Suspend benchmark
Massachusetts Medical Society	Not specified
National Federation of Independent Business	Not specified
Retailers Association of Massachusetts	3.1%

# The health care cost growth benchmark is set prospectively for the upcoming calendar year, while actual performance is measured retrospectively.



# The HPC's 2021 Policy Recommendations



As the Commonwealth approaches the **ten-year anniversary** of its benchmark-anchored cost containment effort, the HPC recommends the Commonwealth take immediate action to strengthen and enhance the state's strategy for addressing the intersecting challenges of **cost containment, affordability, and health equity** to improve outcomes and lower costs for all. In addition to implementing the following items, this includes sustaining the successful innovations made during the COVID-19 pandemic, such as expanded access to telehealth, workforce flexibilities, and new care models.



## AREAS OF FOCUS

- 1**  
Strengthen Accountability for Excessive Spending
- 2**  
Constrain Excessive Provider Prices
- 3**  
Make Health Plans Accountable for Affordability
- 4**  
Advance Health Equity for All
- 5**  
Implement Targeted Strategies and Policies

## Recommendation #1: Strengthen Accountability for Excessive Spending



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The Legislature should take action to improve the annual performance improvement plan (PIP) process by allowing the Center for Health Information and Analysis (CHIA) to **use metrics other than health status adjusted total medical expense** growth to identify entities contributing to concerning spending...The PIPs process can be further strengthened by **increasing financial penalties** for above-benchmark spending or non-compliance.

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# Recommendation #1: Strengthen Accountability for Excessive Spending



## The recommended legislative changes would enhance accountability and market functioning in multiple ways:

### Use Metrics Other than HSA TME

CHIA could include a **broader range of provider types** in the PIPs referral process, beyond those for which total medical expenses can be calculated (i.e., primary care groups).

Referral could be decoupled from changes in payer and provider risk scores, which are influenced by medical coding efforts.

CHIA could base its referrals on a **wider range of metrics** that capture differences in baseline size, spending, or price, and could potentially have a **higher bar for referrals for smaller, lower-priced, or lower-spend entities**.

### Increase Financial Penalties

**Financial penalties may be a stronger deterrent effect** than a PIP alone, as other states have recognized. For example, Oregon has recommended that “payers and providers who exceed its cost growth target with statistical certainty and without a reasonable basis across multiple years be subject to a meaningful financial penalty...**the amount of the financial penalty would vary based on how much a payer or provider has exceeded the cost growth target.**”

Any funds collected from these penalties could be used to **improve health care quality, access, and affordability**, including potentially to **support providers that care for a larger share of publicly insured patients** or to support populations adversely impacted by high costs.



## Recommendation #2: Constrain Excessive Provider Prices



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The Legislature should take action to **cap prices for the highest-priced providers** (i.e., limiting the highest, service-specific commercial prices with the greatest impact on spending) and **limit price growth** (e.g., limiting annual service-, insurer-, and provider-specific price growth). Such price caps, targeted specifically at the highest-priced providers in Massachusetts, would be an important complement to the health care cost growth benchmark, which is [currently] not designed to directly address prices. Such caps would **reduce unwarranted price variation and promote equity** by ensuring that future price increases can accrue appropriately to lower-priced providers, including many **community hospitals and other providers that care for populations facing the greatest health inequities**, ensuring the viability of these critical resources.

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## Recommendation #2: Constrain Excessive Provider Prices



### Examples of policy options to constrain excessive provider prices include:

#### Price in the PIPs Process

- Reforming the PIPs process as previously described would allow the HPC to address price levels and price growth, the primary driver of spending growth in Massachusetts.

#### Price Growth Caps

- Delaware's Department of Insurance set a **target for commercial payer aggregate unit price growth** for non-professional services (inpatient, outpatient, and other medical services). Progress on achieving the target will inform, but not determine, their rate review decisions.
- Rhode Island requires that insurers **limit annual hospital inpatient and outpatient price growth**.

#### Montana Level Caps

- **Cap on state employee health plan payments** for inpatient and outpatient hospital services (average price of all services at hospital): Payments limited to **234%** of Medicare rates.
- State was able to secure all major hospitals in network, due partly to public pressure from workers and unions.

#### Hamilton Project Caps

- Set **rate caps** to limit prices for health care services at the very top of the commercial price distribution (5x the 20th percentile of the market's truncated commercial price distribution).
- Annual **price growth caps** specific to each insurer-provider-service combination to reduce price growth and variation.

### #3. MAKE HEALTH PLANS ACCOUNTABLE FOR AFFORDABILITY

As both health insurance premiums and consumer cost-sharing growth continued to outpace increases in total claims spending, wage growth, and inflation between 2017 and 2019, the Commonwealth should require greater accountability of health plans for delivering value for consumers and **ensure that any savings that accrue to health plans are passed along to consumers.**

**This recommendation would improve affordability by:**

- Requiring that the DOI Rate Review process assess payer rate filings against statewide affordability standards
- Allowing DOI to reject proposed increases that do not meet the standards; and
- Increasing transparency into DOI's process.

### #5.C.I. FOCUS INVESTMENT IN PRIMARY 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 cost growth benchmark. These spending increases should prioritize non-claims-based spending such as capitation, infrastructure, and workforce investments. CHIA and the HPC should continue to track and report on primary care and behavioral health care spending trends annually and hold entities accountable for meeting improvement targets if they fall short of established targets.

**This recommendation would improve health equity by:**

- Actively encouraging spending growth in high value service lines; and
- Transforming health care spending by requiring significant investments in primary care and behavioral health in the context of a statewide spending growth target.

**Taken together these recommendations will advance the state's cost containment efforts by:**

- Focusing accountability on the entities most responsible for unwarranted spending growth;
- Addressing unwarranted price variation and promoting equity;
- Helping to ensure the viability of lower priced providers and other providers that care for populations facing the greatest health inequities;
- Advancing affordability by ensuring that health plans pass along savings to consumers in the form of lower premiums, deductibles, and co-pays; and
- Shifting health care resources over time to invest in high-value services, such as primary care and behavioral health care.

# VOTE

## 2023 Health Care Cost Growth Benchmark

### MOTION

That, pursuant to G.L. c. 6D, § 9, the Commission hereby establishes the health care cost benchmark for calendar year 2023 as \_\_\_\_\_, subject to the further process set forth in G.L. c. 6D, § 9 (e).

Call to Order

Approval of Minutes (**VOTE**)

Recognition of Black Maternal Health Week

Market Oversight and Transparency

- Mass General Brigham Performance Improvement Plan: Request for Extension (**VOTE**)
- 2023 Health Care Cost Growth Benchmark (**VOTE**)

 **RECENT MARKET CHANGES**

- Research Presentation: Trends in Emergency Department Use Among Massachusetts Residents

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## Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	33	24%
Physician group merger, acquisition, or network affiliation	29	21%
Clinical affiliation	28	20%
Acute hospital merger, acquisition, or network affiliation	24	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	20	14%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

## Elected Not to Proceed

- A proposed joint venture between **BILH Surgery Center Plymouth Hospital Holdco**, a subsidiary of Beth Israel Deaconess Hospital - Plymouth, and **Pilgrim ASC** to own and operate a freestanding ASC in Plymouth.
- A proposed clinical affiliation between **Atrius Health** and **South Shore Hospital** under which South Shore would be designated as a preferred hospital provider for Atrius patients.
- A proposed transaction between **Spire Orthopedic Partners** (Spire) and **Sports Medicine North Orthopedic Surgery** (SMN), a physician group practice on the North Shore, under which Spire would acquire certain non-clinical assets of and provide administrative services for SMN.
- A proposed joint venture between **NEBSC Hospital Holdings**, comprising NE Baptist and Constitution Surgery Alliance MA, and **NEBSC Surgeon Holdings**, comprising orthopedic surgeons on the medical staff at NE Baptist, to own and operate a freestanding ASC in Dedham.



## Elected Not to Proceed

- A proposed contracting affiliation between **South Shore Health Integrated Delivery Network** and **Compass Medical, P.C.**, a professional corporation providing primary care, urgent care, and specialty care in southeastern Massachusetts.

### RECEIVED SINCE 1/25

- A proposed clinical affiliation between **Beth Israel Lahey Health (BILH)** and **Cape Cod Health Care (CCHC)** under which the parties would jointly provide clinical services and recruit primary care providers in CCHC's service area and would enter into a preferred provider relationship.

## Material Change Notices Currently Under Review

- A proposed transaction between **Signature Healthcare**, **South Shore Health System**, **Sturdy Memorial Hospital**, and **Southeast Massachusetts Behavioral Health**, a subsidiary of US HealthVest, to own and operate a new psychiatric hospital in Southeastern Massachusetts.

### RECEIVED SINCE 1/25

- A proposed clinical affiliation between **Lawrence General Hospital** (LGH) and **Steward Healthcare** (Steward), under which LGH and Steward would engage in clinical collaboration, and joint Medicare managed care contracting.
- A clinical affiliation between **Atrius Health** and **Emerson Hospital** under which Emerson would be designated a preferred hospital for Atrius patients.
- The proposed acquisition of **Franciscan Hospital for Children**, a Catholic non-profit specialty hospital that focuses on pediatric chronic care, mental health disorders, and rehabilitation services by **Children's Hospital Boston**. This acquisition is subject to review under both the HPC's Material Change Notice and DPH's DoN review processes.

# Determination of Need (DoN) Application by Children's Hospital Boston to Expand Outpatient Services Outside of Boston



- On July 14, 2021, The Children's Medical Center Corporation (Children's), filed a Determination of Need application for a capital expenditure for three ambulatory sites outside of Boston, totaling **\$435 million**:
  - Expansion and renovation of an existing multi-specialty site in **Waltham**;
  - Creation of a new multi-specialty site in **Needham**, to include eight ambulatory surgery operating rooms and one MRI; and
  - Creation of a new multi-specialty site in **Weymouth**, to include one MRI.
- Children's states that the expansions would expand access, improve coordination of care, and expand behavioral health capacity. Children's also states that its satellite locations receive **20% lower commercial prices** than its main campus.
- Some key information about the project is unclear from the materials filed to date, including:
  - The expected volume by service at each of the locations.
  - Whether facility fees will be charged for certain services at the project locations.
- On September 9, 2021, the Department of Public Health notified Children's that it was requiring an **Independent Cost Analysis (ICA)** be conducted. The ICA is currently underway.
- A public hearing was conducted on December 9, 2021, and a number of entities have provided comment in support of the application.

# Tufts Medical Center's Proposed Closure of Pediatric Inpatient Beds and Plans to Transition Services to Children's



- Tufts Medical Center (Tufts) has announced plans to **close its 41 pediatric inpatient beds** and convert them into adult med/surg and ICU beds as of July 1, 2022.
  - Tufts Children's Hospital (formerly Floating Hospital for Children) is part of Tufts Medical Center in Boston and provides a variety of services to children in the Commonwealth.
  - In fiscal year 2019, Tufts Medical Center had approximately 2,800 pediatric inpatient discharges.
- Tufts has stated it **will maintain** its 40-bed NICU, pediatric emergency department, outpatient services at its main campuses and community satellites, and pediatric hospitalist staffing at affiliated community hospitals.
- Tufts has stated that it has a **letter of intent with Children's** to provide continuity of care to Tufts' patients, including ensuring that pediatric inpatient care for Tufts patients will be provided at Children's.
- Tufts has filed a 90-day essential service closure notice with DPH and will need to provide a more complete notice at least 60 days prior to proposed closure, including a plan for continuity of care.
- DPH will also conduct a public hearing on the proposed closure in the coming weeks.
- Any affiliation between Tufts Medical Center and Children's Hospital Boston to transition services or staff from Tufts to Children's would **likely require an MCN filing with the HPC**.

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**➤ RESEARCH PRESENTATION: TRENDS IN EMERGENCY DEPARTMENT USE AMONG MASSACHUSETTS RESIDENTS**

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## BACKGROUND

- Emergency Department (ED) visits fell sharply in spring 2020, decreasing 55% between January and April; the number of ED visits from January to September 2020 was 23% below the total from the same months in 2019.
- From April to September 2020, the total number of potentially avoidable ED visits was 38% lower than in the same months in 2019.
  - Historically, around 30-40% of ED visits in Massachusetts are potentially avoidable visits that could more effectively be cared for in another clinical setting.

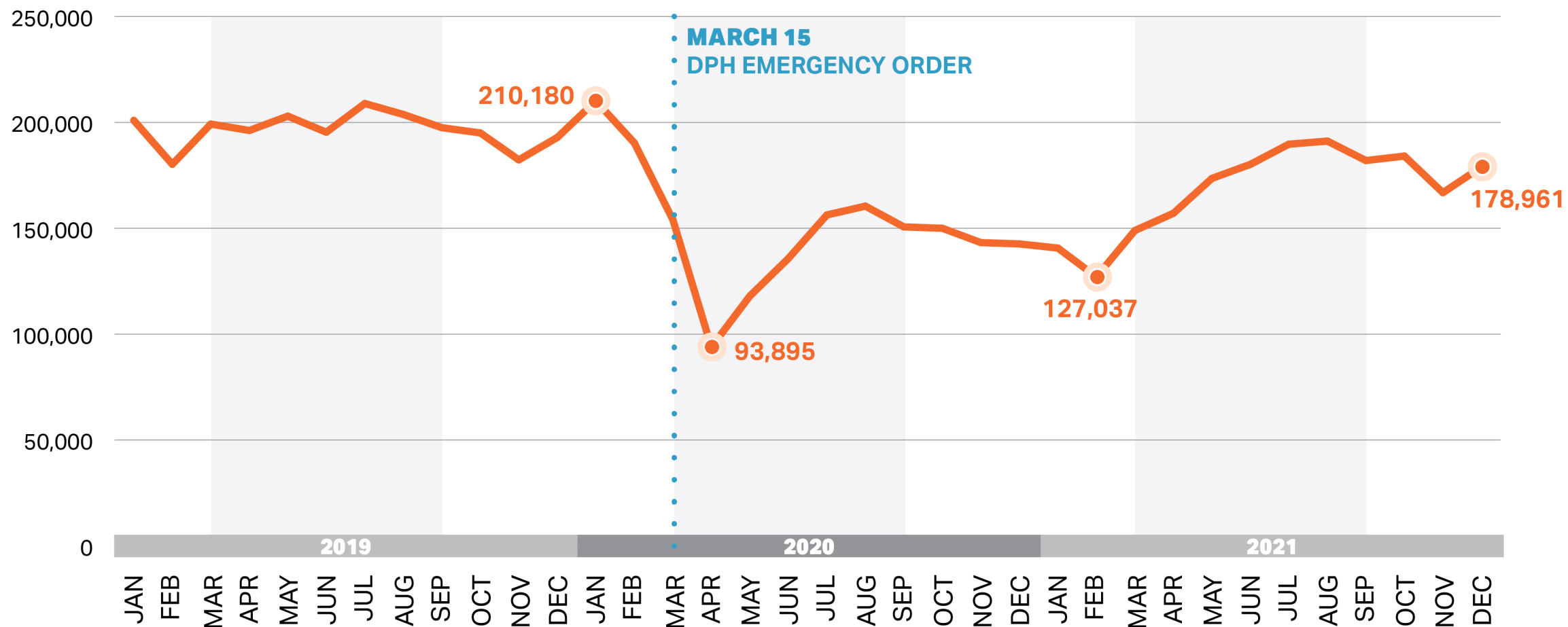
## DATA

- 2019-2020 Case Mix Emergency Department Database (EDD), Preliminary 2021 and 2022 Case Mix EDD.
  - **Exclusions:** ED sites missing a quarter or more of data: Beth Israel Deaconess Hospital – Needham and Sturdy Memorial Hospital
- All-Payer Claims Database v10.0, 2018-2020

# By December 2021, ED visits were higher than 2020 levels, but still had not returned to 2019 levels.



Number of ED visits by month, January 2019 to December 2021



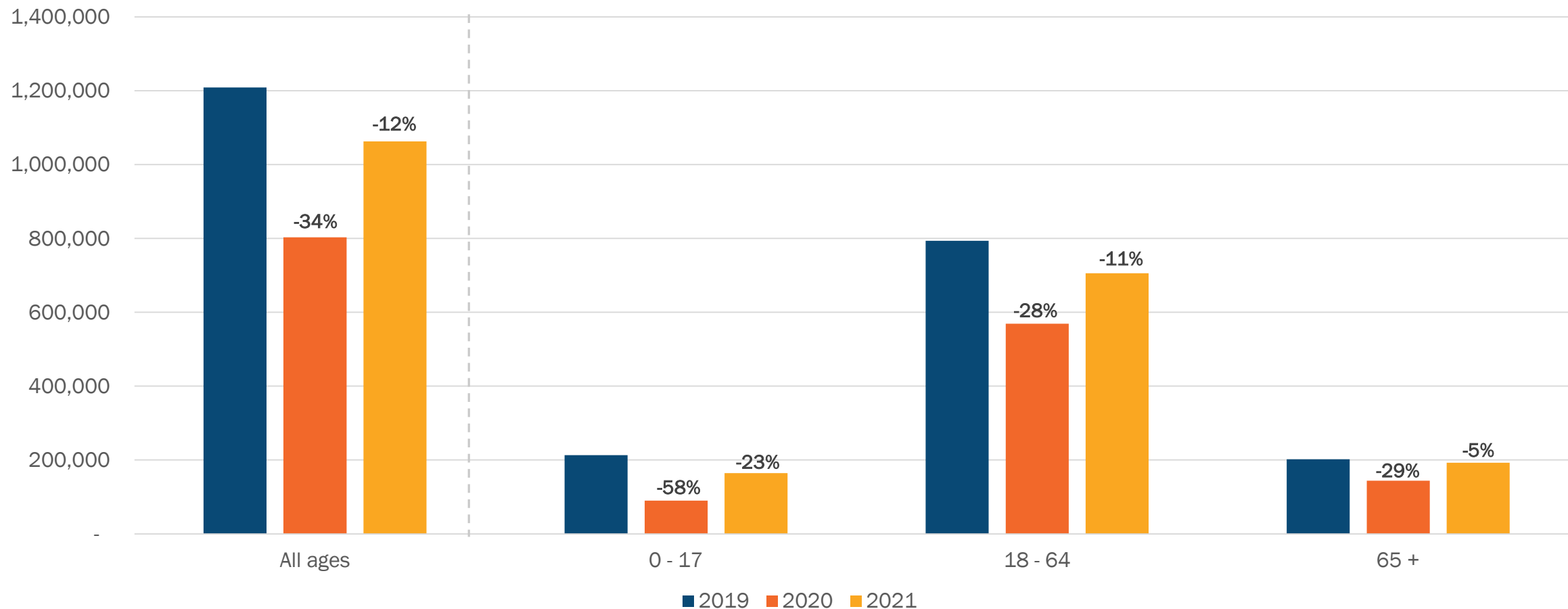
Notes: Excludes two ED sites due to missing data.

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021 and 2022q1

## By 2021, ED visits remained 12% below 2019 levels. The reduction was largest for children (23%) and smallest for adults aged 65+ (5%).

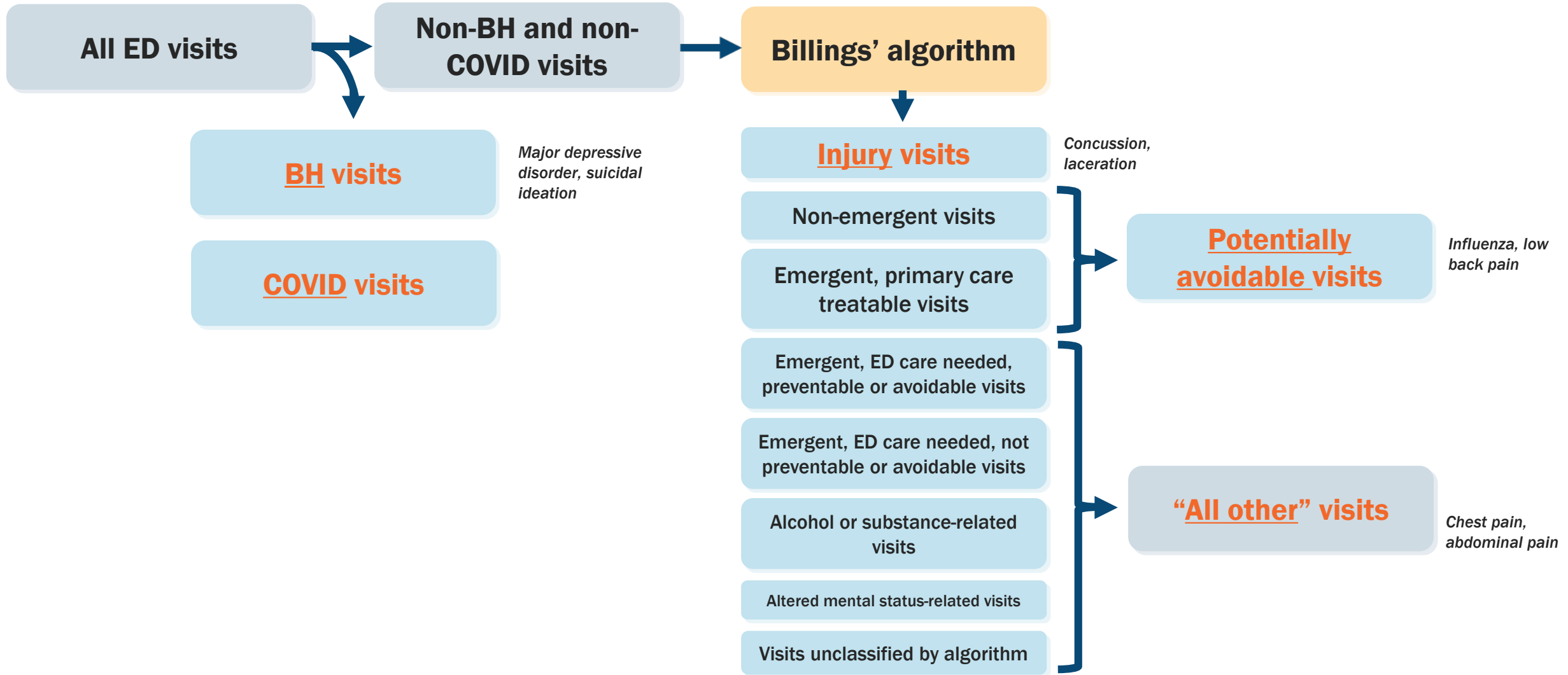


Number of ED visits by age group and percent change from the March to September 2019 time period, March 2019 to September 2021





# Identification and Classification of ED Visits into 5 Categories

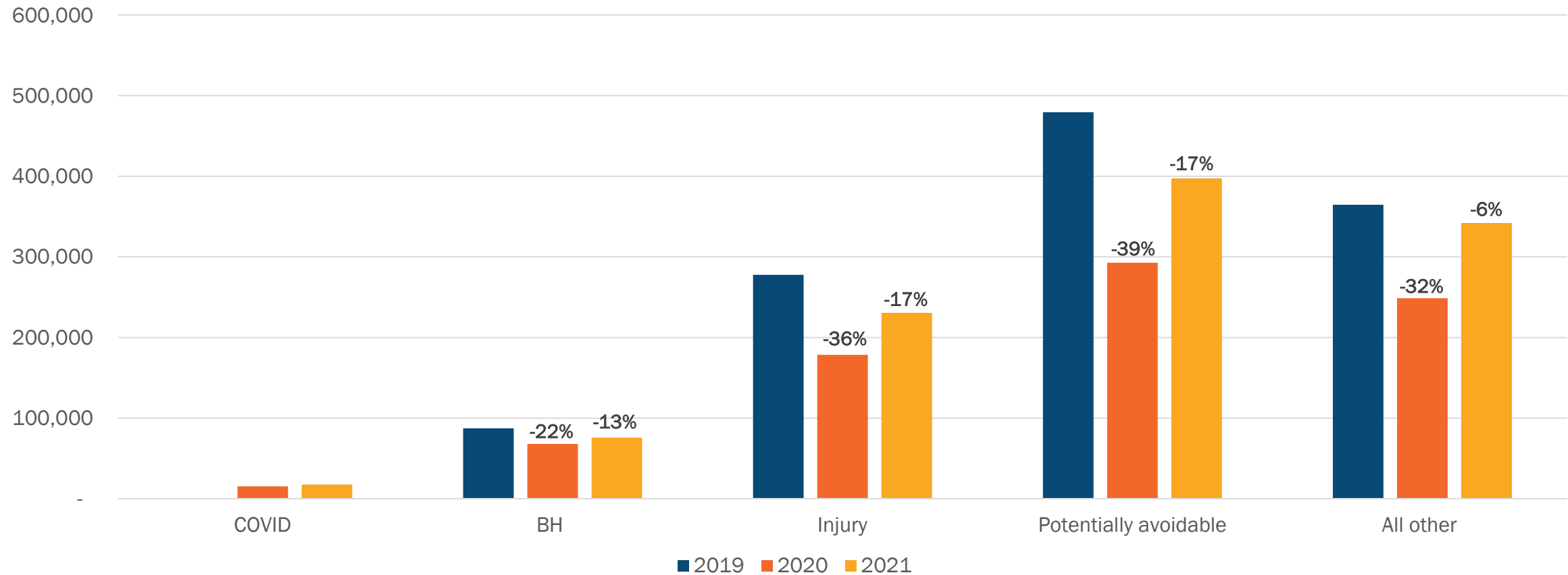


Notes: BH visits were defined using AHRQ CCSR MBD001-MDB034. Injury and avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent. All other are the total sum of ED visits minus avoidable ED, BH visits, COVID-19, and injury visits.

## All categories of ED visits declined from 2019 to 2021, with the largest declines for potentially avoidable and injury visits (17%).



Number of ED visits by visit category and percent change relative to same period in 2019



Notes: Includes ED visits between March 16<sup>th</sup> and September 15<sup>th</sup> of each year. Excludes two ED sites due to missing data. BH visits were defined using AHRQ CCSR MBD001-MDB034. Injury and avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent. All other are the total sum of ED visits minus avoidable ED, BH, COVID, and injury visits. COVID visits are defined as ED visits with a primary or secondary U071 ("COVID-19") diagnosis code.

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021

## Potentially avoidable ED visits among children dropped by two-thirds (60,000 visits) in 2020 and were still one-third below 2019 levels by 2021.



Number of potentially avoidable ED visits by age group and percent change relative to same period in 2019

AGE GROUP	2019	2020	2021
0-17	89,016	29,608 (-67%)	61,215 (-31%)
18-64	313,733	211,778 (-32%)	265,094 (-16%)
65+	76,640	51,454 (-33%)	71,037 (-7%)

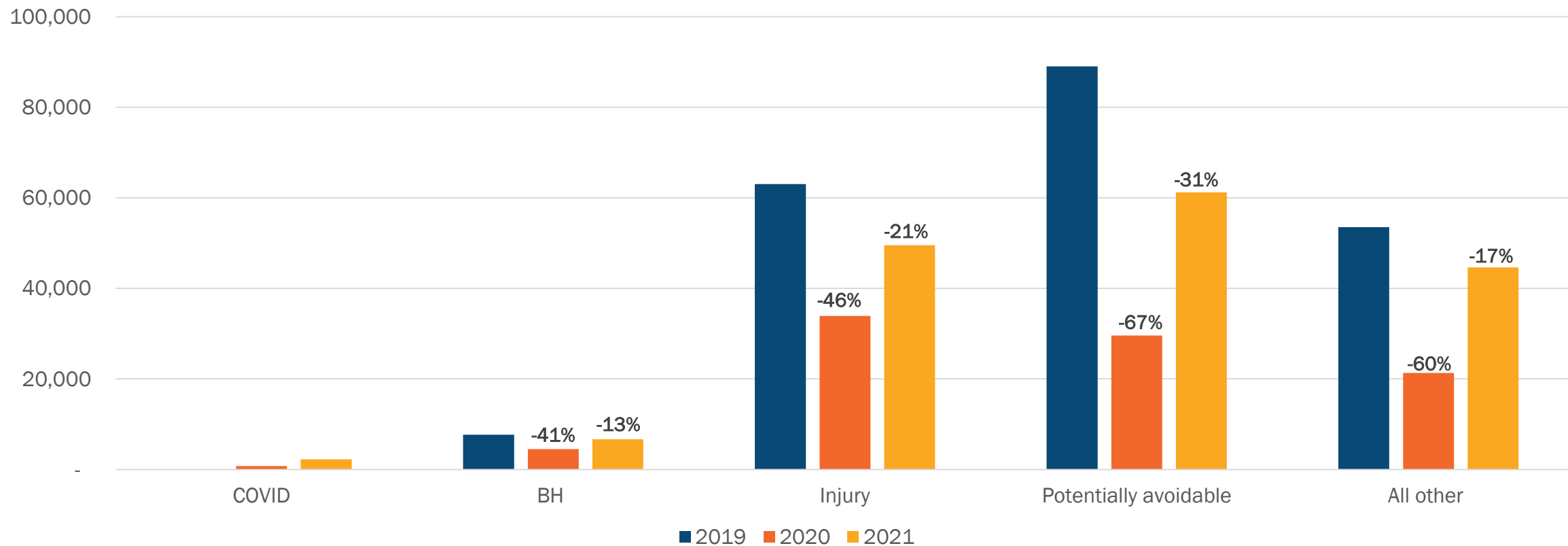
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Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021

## Among children, the decline was greatest for avoidable ED visits; behavioral health ED visits declined the least between 2019 and 2021.



Number of ED visits for children aged 0-17 by visit category and percent change relative to same period in 2019



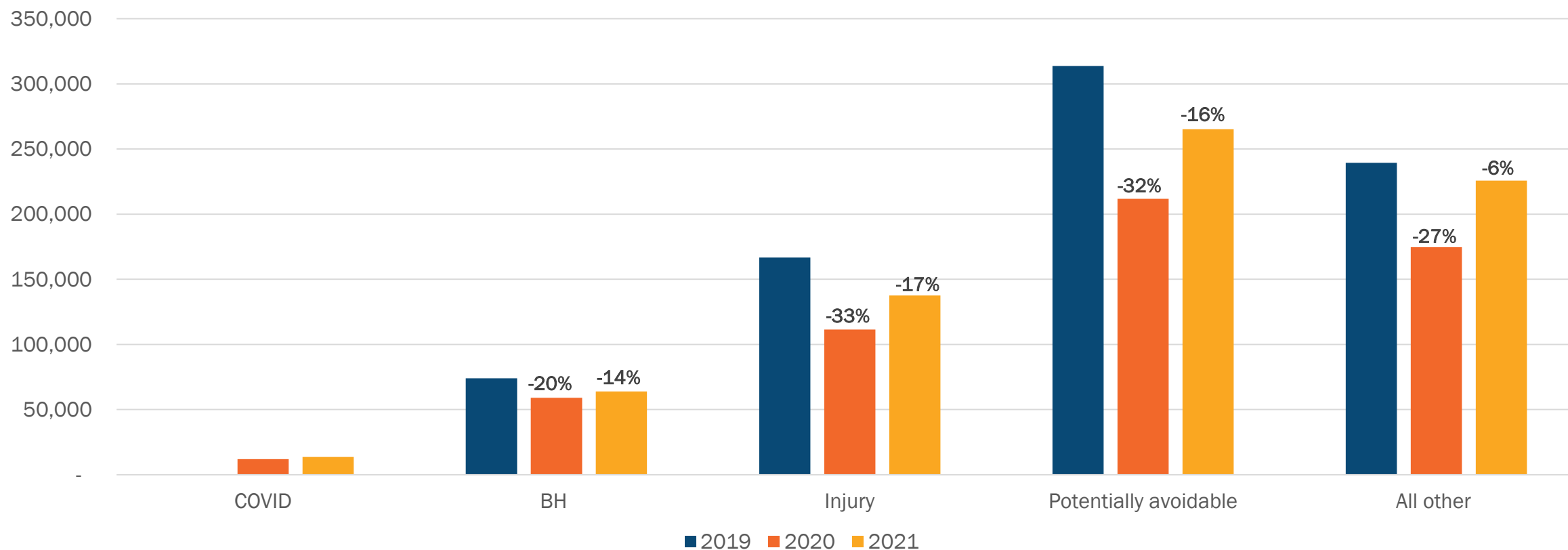
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Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021

## For adults aged 18-64, potentially avoidable and injury ED visits declined the most (17% and 16%) between 2019 and 2021.



Number of ED visits for adults aged 18-64 by visit category and percent change relative to same period in 2019



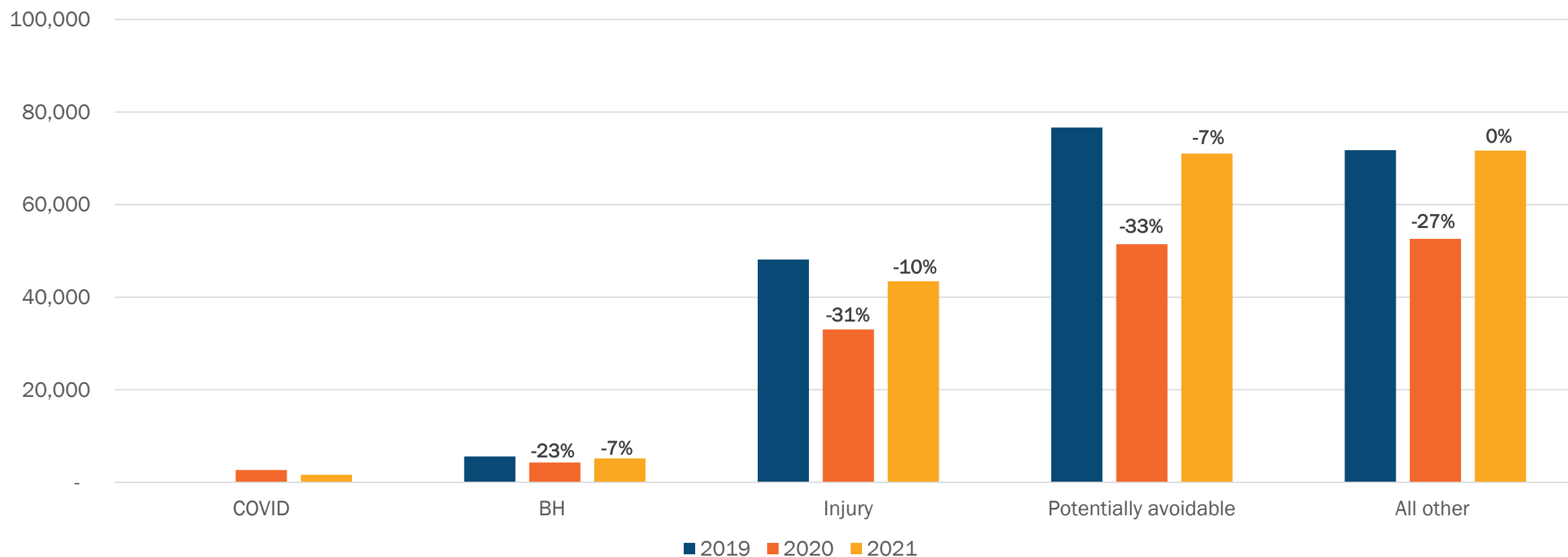
Notes: Includes ED visits between March 16<sup>th</sup> and September 15<sup>th</sup> of each year. Excludes two ED sites due to missing data. BH visits were defined using AHRQ CCSR MBD001-MDB034. Injury and avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent. All other are the total sum of ED visits minus avoidable ED, BH, COVID, and injury visits. COVID visits are defined as ED visits with a primary or secondary U071 ("COVID-19") diagnosis code.

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021

## For adults aged 65+, 2021 ED visits approached 2019 levels for all categories.



Number of ED visits for adults aged 65+ by visit category and percent change relative to same period in 2019



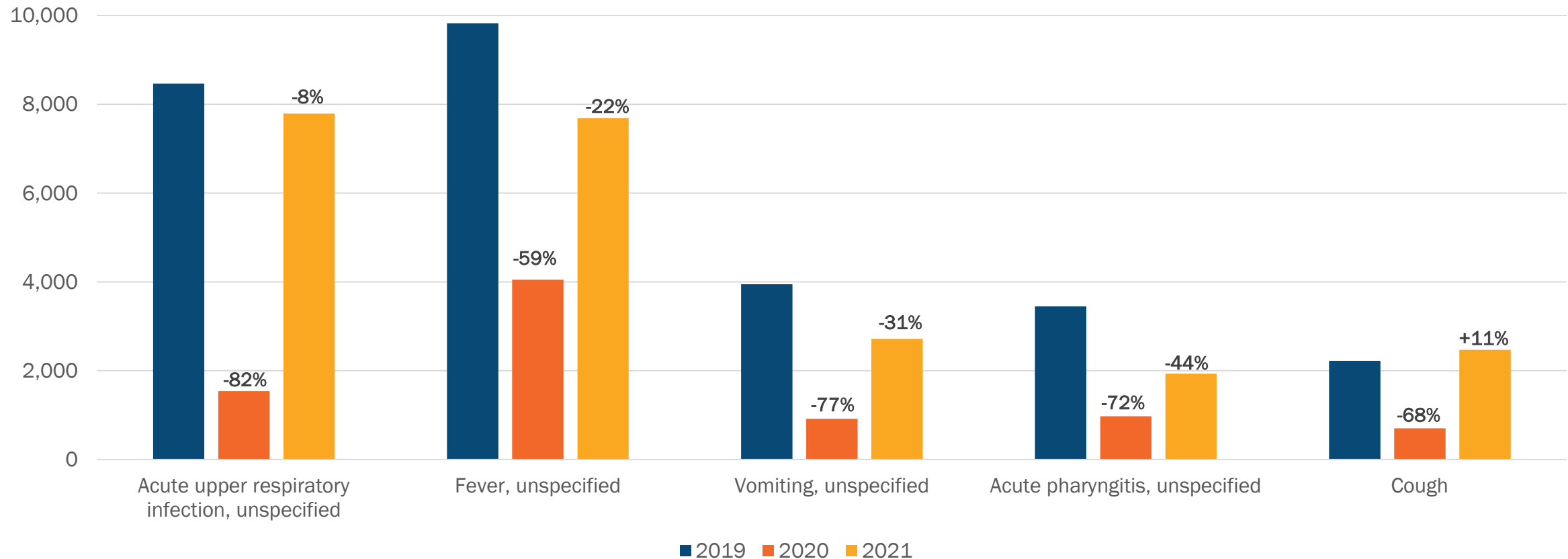
Notes: Includes ED visits between March 16<sup>th</sup> and September 15<sup>th</sup> of each year. Excludes two ED sites due to missing data. BH visits were defined using AHRQ CCSR MBD001-MDB034. Injury and avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent. All other are the total sum of ED visits minus avoidable ED, BH, COVID, and injury visits. COVID visits are defined as ED visits with a primary or secondary U071 ("COVID-19") diagnosis code.

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021

## Among high-volume potentially avoidable ED diagnoses for children, visits declined for infection/illness-related diagnoses such as vomiting and fever.



Number of potentially avoidable ED visits for children aged 0-17 for top primary diagnoses (excluding influenza) between March 2019 and March 2020 and percent change relative to same period in 2019



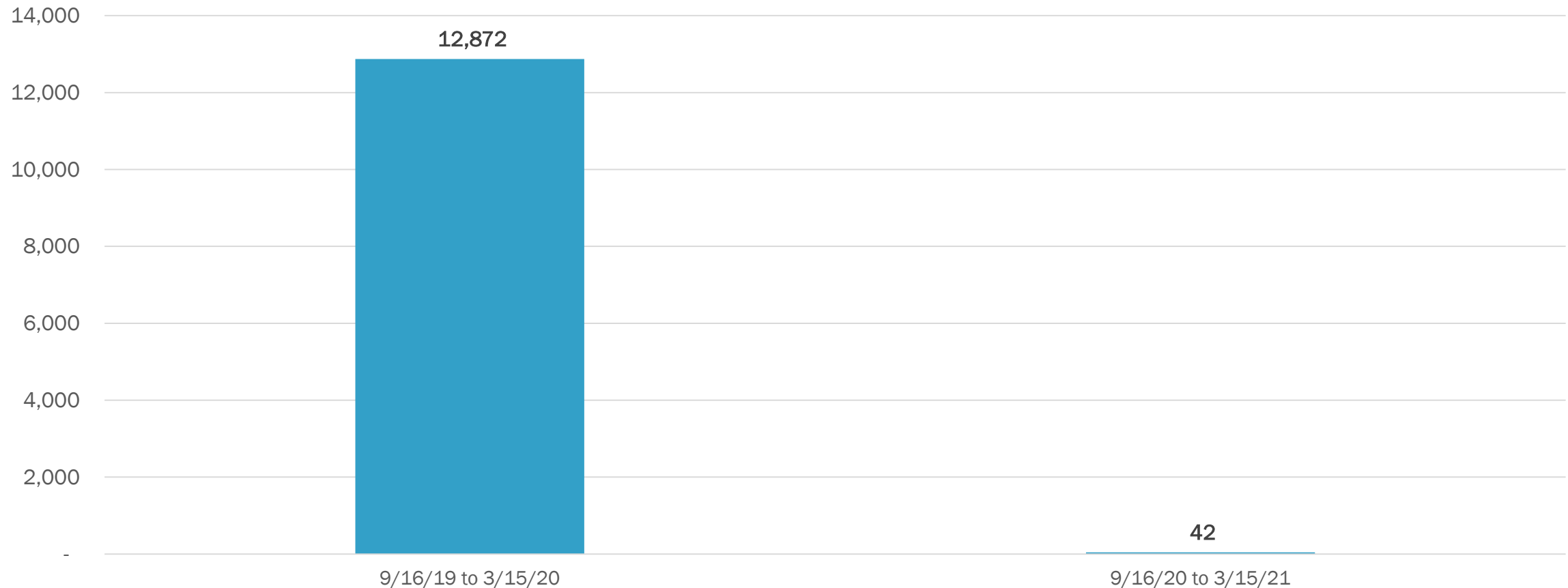
Notes: Includes ED visits between March 16<sup>th</sup> and September 15<sup>th</sup> of each year. Excludes two ED sites due to missing data. Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories "Avoidable" is defined here as ED visits that had at least a 70% probability of being emergent - primary care treatable or non-emergent. Top five diagnosis codes include: J069 (Acute upper respiratory infection, unspecified), R509 (Fever, unspecified), R1110 (Vomiting, unspecified), J029 (Acute pharyngitis, unspecified), and R05 (Cough).

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021

# Potentially avoidable visits for influenza among children nearly disappeared for the period of September 2020 to March 2021.



Number of potentially avoidable ED visits for children aged 0-17 for influenza, September 2019 to March 2020 versus September 2020 to March 2021



Notes: Influenza includes "Influenza due to other identified influenza virus with other respiratory manifestations" (J101) and "Influenza due to unidentified influenza virus with other respiratory manifestations" (J111).

"Avoidable" is defined here as ED visits that had at least a 70% probability of being emergent - primary care treatable or non-emergent. Excludes two ED sites due to missing data.

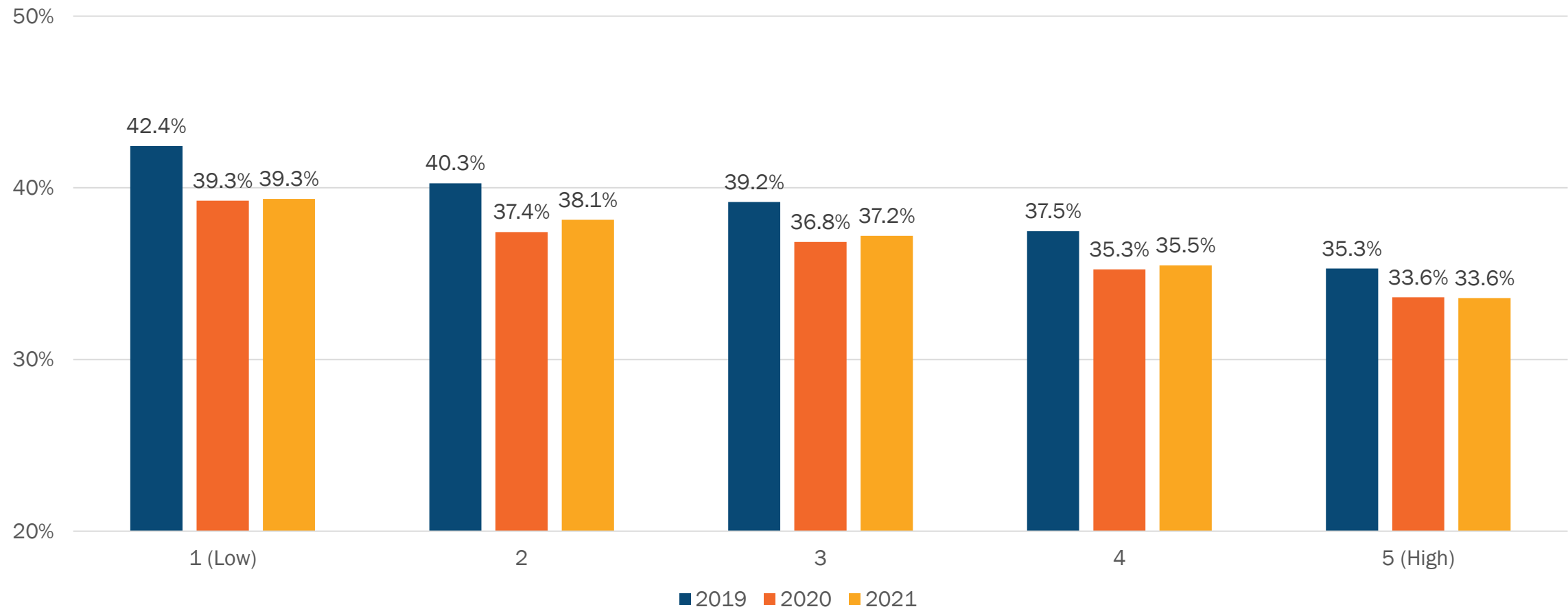
Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021



## The percentage of ED visits that were potentially avoidable declined the most for residents living in the lowest-income areas but remained higher than for other residents.



Percent of ED visits that were potentially avoidable by zip-income quintile, March to September 2019 to 2021



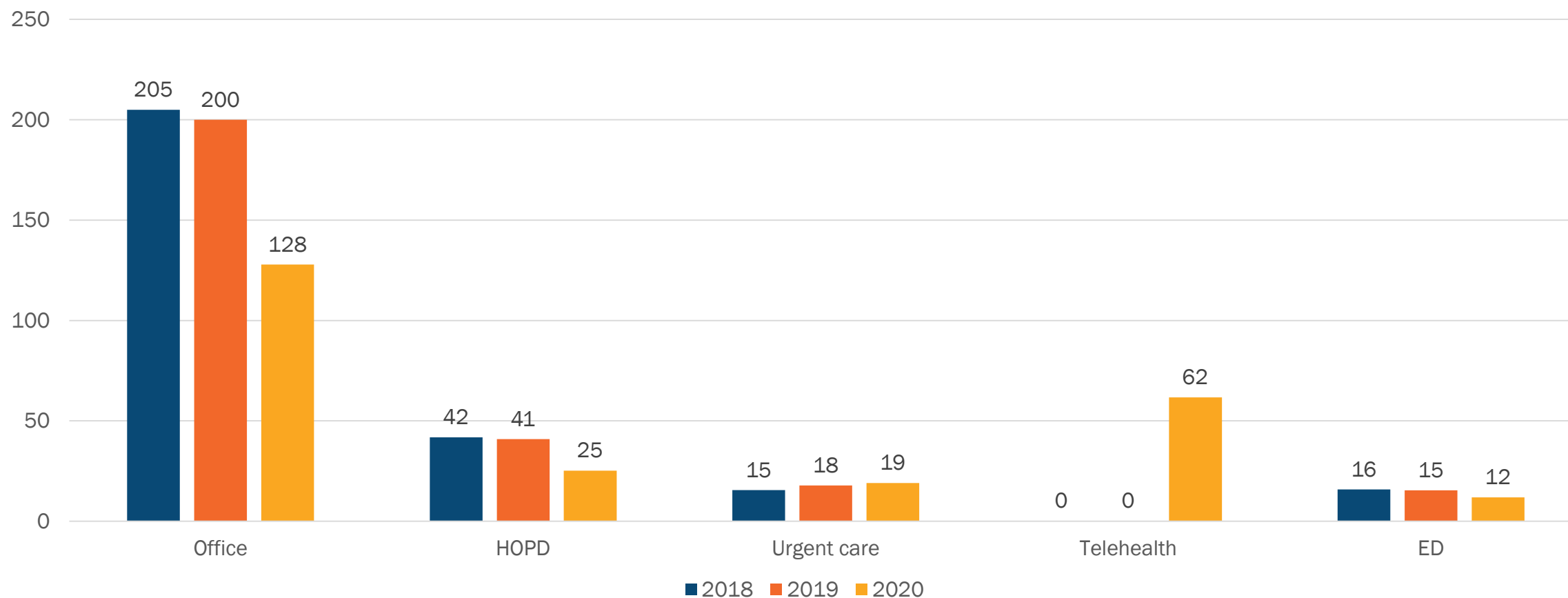
Notes: Includes ED visits between March 1<sup>st</sup> and September 30<sup>th</sup> of each year. Excludes two ED sites due to missing data. Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent. Results are reported according to community income level linked to zip code tabulation area.

Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, 2019-2020, preliminary 2021

## Between 2018 and 2020, fewer evaluation and management visits occurred in the office, HOPD, and ED settings while more occurred in urgent cares and via telehealth.



Number of evaluation and management (E&M) visits per 1,000 member months by site type and year for commercially-insured patients, 2018 to 2020



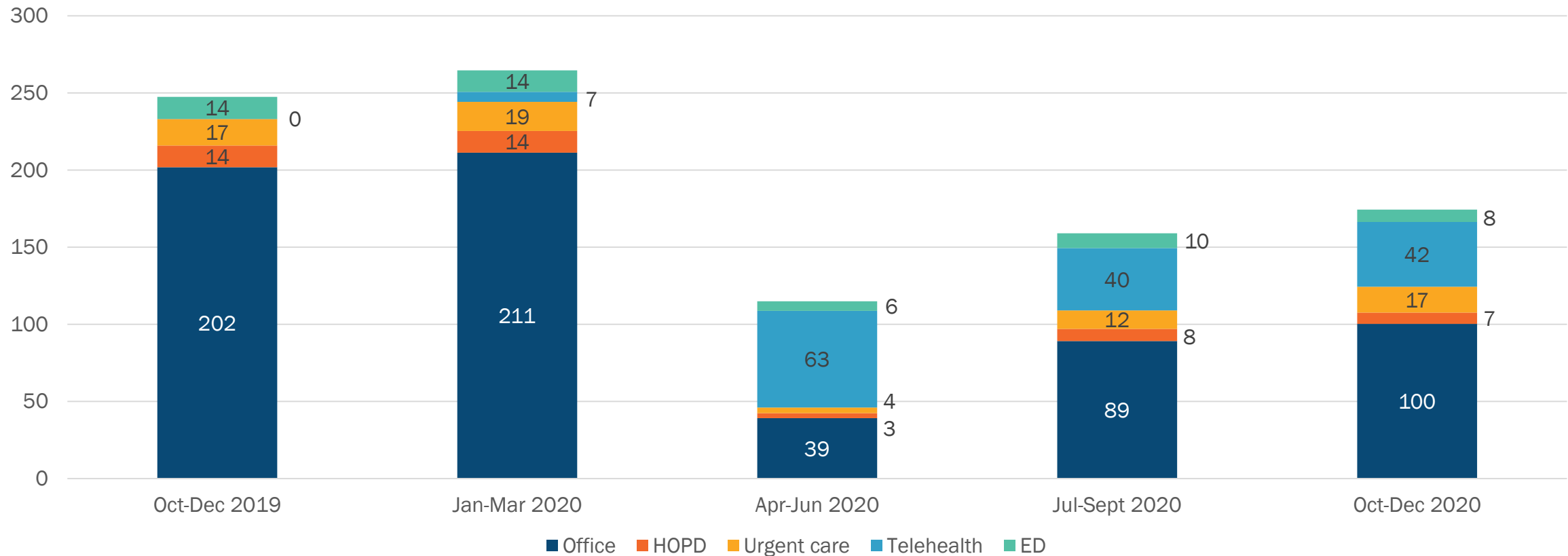
Notes: Population includes commercially-insured individuals with full coverage. Behavioral health, therapy, and counseling-related evaluation and management visits were excluded. Evaluation and management codes include: 99201-99205, 99211-99215, 99281-99285 (ED visits).

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2018-2020

## By the end of 2020, the number of evaluation and management visits for children were still down by 30%, but a smaller proportion of these visits took place in offices and emergency departments.



Number of evaluation and management (E&M) visits among children aged 0-17 per 1,000 member months by site type for commercially-insured patients, October 2019 to December 2020



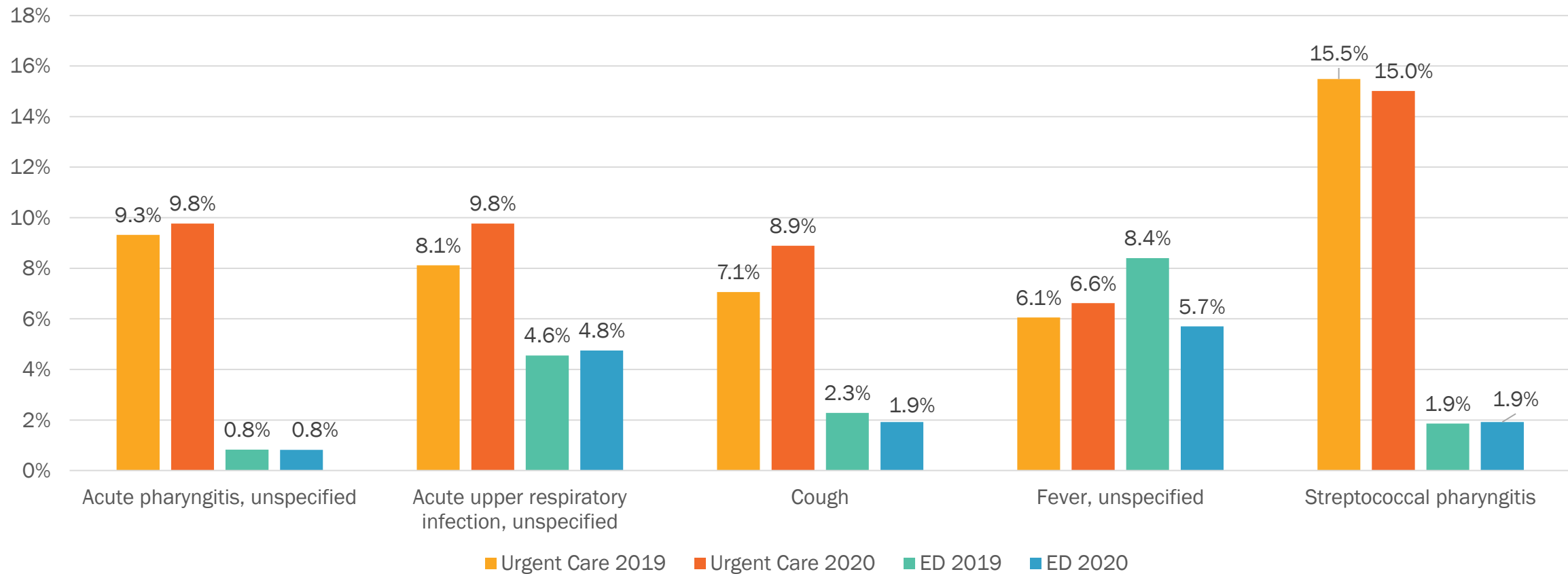
Notes: Population includes commercially-insured individuals with full coverage. Behavioral health, therapy, and counseling-related evaluation and management visits were excluded. Notes: Population includes commercially-insured individuals with full coverage. Behavioral health, therapy, and counseling-related evaluation and management visits were excluded. Evaluation and management codes include: 99201-99205, 99211-99215, 99281-99285 (ED visits).

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2018-2020

## The proportion of all visits for common pediatric conditions taking place at urgent care centers increased slightly in 2020 while remaining similar or declining in the ED, suggesting possible care shifting away from the ED.



Share of visits at urgent care centers vs the ED for five common primary diagnoses among children aged 0-17, 2019-2020

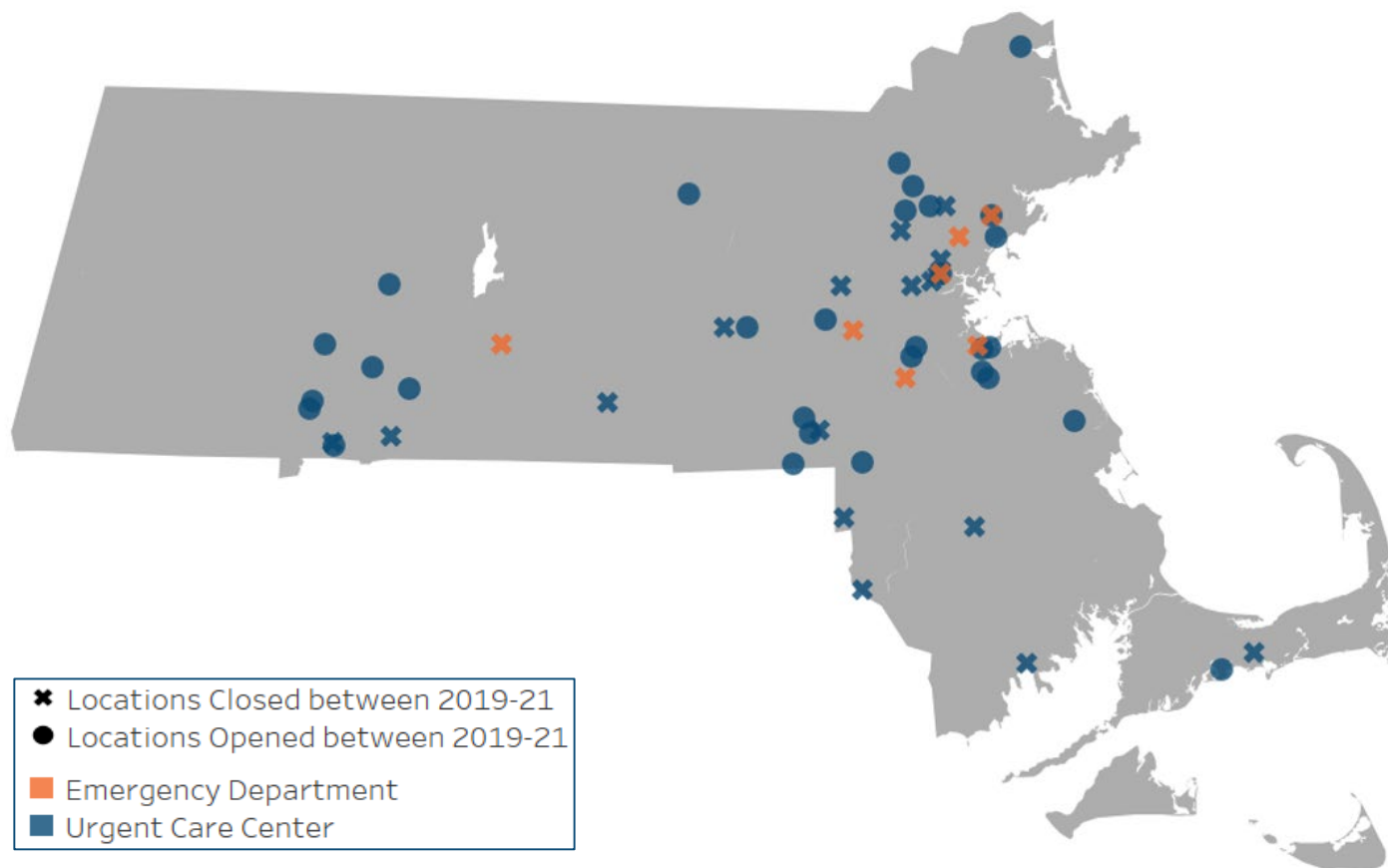


Notes: Five diagnosis codes were: J029 (Acute pharyngitis, unspecified), J069 (Acute upper respiratory infection, unspecified), R05 (Cough), R509 (Fever, unspecified), and J020 (Streptococcal pharyngitis). These diagnoses were among the top non-COVID related conditions for children aged 0-17 with significant presence at both urgent care centers and EDs. The following care types were included in the total number of visits for each diagnosis: urgent care centers, EDs, offices, and retail clinics.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2019-2020

# While 7 emergency department sites closed from 2019-2021, the Commonwealth saw a net growth of 13 new urgent care centers open during the same time period.

Changes in Emergency Department and Urgent Care Center Sites, 2019-2021



Between 2019 and 2021:

- 7 emergency departments closed. Collectively, these had accounted for 3.5% of ED visits in 2018.
- 30 new urgent care centers opened, while 17 closed.

The next issue of the [HPC DataPoints](#) series will feature more detail on changes in urgent care centers in Massachusetts.

Notes: In 2019, EDs at Melrose Wakefield Hospital Lawrence Memorial Campus and North Shore Medical Center Union Campus closed. In 2020, EDs at Steward Norwood Hospital, MetroWest Medical Center - Leonard Morse Campus, Cambridge Health Alliance - Somerville Campus, and Steward Satellite Emergency Facility - Quincy closed. In 2021, the Satellite Emergency Facility at Baystate Mary Lane Outpatient Center closed.

# Conclusions

- Overall, the number of ED visits in 2021 increased from 2020 levels but **remained below pre-pandemic 2019 levels.**
- There were declines in all types of ED visits between 2019 and 2021, with the largest declines in **potentially avoidable ED visits** and the smallest declines in **BH-related ED visits.**
- Declines in ED visits, especially potentially avoidable ED visits, were largest for **children.**
- There is some evidence of small shifts in care to other settings, including urgent care and telehealth. Other mechanisms leading to the decline in ED visits include **changes in care seeking behavior** (postponing or not seeking care in the formal health care system) and **reduced transmission** of non-COVID-19 communicable diseases.

# Agenda



Call to Order

Approval of Minutes (**VOTE**)

Recognition of Black Maternal Health Week

Market Oversight and Transparency

Care Delivery Transformation

 **ACCOUNTABLE CARE ORGANIZATION (ACO) CERTIFICATION**

Executive Director's Report

Schedule of Upcoming Meetings

# ACO LEAP 2022-2023 Certifications

- Atrius Health, Inc.
- Baycare Health Partners, Inc.
- Beth Israel Lahey Performance Network
- BMC Health System, Inc.
- Cambridge Health Alliance
- Children's Medical Center Corporation
- Community Care Cooperative, Inc.
- Mass General Brigham
- Reliant Medical Group, Inc.
- Signature Healthcare
- Southcoast Health System, Inc.
- Steward Health Care Network, Inc.
- Trinity Health of New England
- Wellforce, Inc.





# ACO Certification Elements



## PATIENT-CENTEREDNESS

The Certified ACOs are most commonly using periodic **patient experience surveys** to understand their patients' experiences and preferences, and to design and iterate on patient experience improvements.

This information has been used to guide ACO-wide **strategic plans**, design **staff training opportunities**, and to make **refinements to telehealth or digital care experiences**, particularly those first implemented in response to the pandemic.



## CULTURE OF PERFORMANCE IMPROVEMENT

Many Certified ACOs identified leadership engagement in **tracking and reviewing performance** and/or **periodically convening clinical and/or business leaders** to discuss performance improvement goals and strategies as key approaches to ensuring a culture of performance improvement. Several highlighted that they offer **financial incentives** to hold providers accountable for performance goals.

# ACO Certification Elements



## DATA-DRIVEN DECISION-MAKING

Certified ACOs are using multiple approaches to help clinicians make the best possible clinical decisions, with most developing and/or disseminating **evidence-based protocols** to ACO providers or making available **structured learning opportunities**. Many have also developed or encouraged use of **clinical decision support tools**, in some cases in conjunction with evidence-based protocols disseminated by the ACO.



## POPULATION HEALTH MANAGEMENT PROGRAMS

Certified ACOs highlighted **64 distinct population health management programs** in operation, including a variety of care management and/or transitions of care programs.

These programs each have **specific metrics and goals** targeting improvements in process, utilization, and/or outcomes measures, with many of the ACOs making adjustments or programmatic changes to PHM programs in the past two years based on measured performance.

# ACO Certification Elements



## WHOLE-PERSON CARE

Certified ACOs are **advancing behavioral health integration**, offering a range of financial, technical, and operational supports to facilitate steps like co-location, information-sharing across settings, and supporting e-consults and virtual linkages between primary care and behavioral health providers.

All of the Certified ACOs have implemented screenings and referral processes for **health-related social needs**, in some cases beginning with the MassHealth population and expanding to commercial and Medicare populations in stages.



## HEALTH EQUITY

Activity in this area is in early development for most ACOs. Many of the initiatives described focused on **closing gaps** in quality outcomes, **expanding access** to services, or modifying current **population health interventions** to better target health inequities. Several examples highlighted by ACOs focused on initiatives directly related to COVID-19.



## 2.8 MILLION COVERED LIVES ACROSS 95 RISK CONTRACTS

93% of covered lives are in contracts with **downside** risk, a slight uptick from 2019; 8 of 14 ACOs have at least one **PPO** risk contract



## TOP STRATEGIES FOR CONTROLLING TME GROWTH

- **Complex care management** programs
- **Reductions** in avoidable inpatient or PAC
- Investments in **primary care** and/or **behavioral health** capacity



## MOST COMMON STEPS TO PROMOTE EQUITY

Provider or staff **training**, provider or staff **recruitment**, **quality improvement** strategies, and **telehealth** access expansions



## TOP CHALLENGES TO CONTROLLING TME GROWTH

- **Price growth** for drugs, medical supplies, etc.
- Difficulty translating risk contract incentives into **incentives for clinicians**
- **Prices of providers** outside of the ACO



## COMMON TELEHEALTH SUPPORTS

Interpreter services, a common technology platform, and provider technical assistance



## TOP DIGITAL HEALTH STRATEGIES

Patient portals, virtual visits, remote patient monitoring, and **e-consults** (PCP-Specialist)

# Agenda



Call to Order

Approval of Minutes (**VOTE**)

Recognition of Black Maternal Health Week

Market Oversight and Transparency

Care Delivery Transformation



**EXECUTIVE DIRECTOR'S REPORT**

Schedule of Upcoming Meetings

## RECENTLY RELEASED



- **Investment Program Profiles:** Moving Massachusetts Upstream “MassUP” (March 2022)
- **DataPoints Issue #22:** Growth in Out-of-Pocket Spending for Pregnancy, Delivery, and Postpartum Care in Massachusetts (March 2022)
- **Annual Report:** Office of Patient Protection (March 2022)
- **Report to the Legislature:** Children with Medical Complexity in the Commonwealth (February 2022)
- **DataPoints Issue #21:** Quality Measure Alignment Taskforce’s Evaluation of Payer Adherence to the Massachusetts Aligned Measure Set (February 2022)
- **HPC Public Comment:** MGB Determination of Need (January 2022)

## UPCOMING



- **Innovation Spotlight:** Medical Legal Partnerships
- **DataPoints Issue #23:** Growth in Alternative Care Sites Over Time in Massachusetts
- **HPC Shorts:** Growth in Out-of-Pocket Spending for Pregnancy, Delivery, and Postpartum Care in Massachusetts
- **Video:** SHIFT Opioid Use Disorder Initiative Spotlight - Harrington Hospital
- **Report to the Legislature:** Impact of COVID-19 on the Health Care Workforce
- **Evaluation Report:** SHIFT-Care Challenge
- **Impact Brief:** SHIFT Opioid Use Disorder Cohort

## Background on Contract Extension Request



- The HPC has ongoing hourly rate contracts with several professional service firms to support its market oversight and other activities, including with experts in economics, actuarial science, accounting, care delivery improvement, quality measurement, and payer-provider contracting.
- Understanding the unpredictability and need for flexibility in market oversight activities, the HPC's by-laws allow the Executive Director to enter into contracts up to \$500,000. Board approval is required again for contracts valued at more than \$500,000.
- As the end of the state fiscal year (FY22) approaches, the Executive Director anticipates exceeding \$500,000 for one contract and is seeking the Board's authorization to expend beyond this amount.
- The contract is for the primary team of expert economic consultants assisting with the economic modeling for the HPC's market oversight projects this year. This contractor's work in the current fiscal year has included conducting analyses relating to an unprecedented number of MCN reviews, the MGB DoN applications, the anticipated changes to the pediatric provider market, and analytic assistance on multiple other projects. Much of this work is ongoing.
- The additional funding request **is fully accounted for within the current Board-approved budget for FY22 and is not net new spending**. The additional funds for this contractor will be shifted from funds previously allocated for other contractors.

# VOTE

## Professional Services Contract Extension



### MOTION

That, pursuant to Section 6.2 of the Health Policy Commission's By-Laws and vote of the Commission on October 16, 2013, the Commission hereby authorizes the Executive Director to increase the maximum allowable contract amount for Bates White by \$250,000 through June 30, 2022, for economic expertise in support of the Commission's ongoing measuring and monitoring of provider relationships and market changes, subject to further agreement on terms deemed advisable by the Executive Director.



# Agenda



Call to Order

Approval of Minutes (**VOTE**)

Recognition of Black Maternal Health Week

Market Oversight and Transparency

Care Delivery Transformation

Executive Director's Report



**SCHEDULE OF UPCOMING MEETINGS**

# 2022 Public Meeting Calendar



**- JANUARY -**

S	M	T	W	T	F	S
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**- FEBRUARY -**

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**- MARCH -**

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**- APRIL -**

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**- MAY -**

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**- JUNE -**

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**- JULY -**

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**- AUGUST -**

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**- SEPTEMBER -**

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**- OCTOBER -**

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**- NOVEMBER -**

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**- DECEMBER -**

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## BOARD MEETINGS

- Tuesday, January 25
- Wednesday, March 16 – Benchmark Hearing
- Wednesday, April 13
- Wednesday, June 8
- Wednesday, July 13
- Wednesday, September 14
- Wednesday, December 14

## COMMITTEE MEETINGS

- Wednesday, February 9
- Wednesday, May 11
- Wednesday, October 12

## ADVISORY COUNCIL

- Wednesday, March 30
- Wednesday, June 22
- Wednesday, September 21
- Wednesday, December 7

## COST TRENDS HEARING

- Wednesday, November 2

# Schedule of Upcoming Meetings



## BOARD

- June 8
- July 13
- September 14
- December 14



[Mass.gov/HPC](https://Mass.gov/HPC)



## COMMITTEE

- May 11
- October 12



[HPC-info@mass.gov](mailto:HPC-info@mass.gov)



## ADVISORY COUNCIL

- June 22
- September 21
- December 7



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## SPECIAL EVENTS

- November 2  
*Cost Trends Hearing*



[tinyurl.com/hpc-linkedin](https://tinyurl.com/hpc-linkedin)