MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

May 11, 2022

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

DataPoints: Urgent Care Utilization in Massachusetts

Health Care Cost Trends Report 2022: Impact of COVID-19 Pandemic on Ambulatory Care

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

DataPoints: Urgent Care Utilization in Massachusetts

Health Care Cost Trends Report 2022: Impact of COVID-19 Pandemic on Ambulatory Care

VOTE

Approval of Minutes

MOTION

That the Members hereby approve the minutes of the Committee meeting held on **February 9, 2022**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DATAPOINTS: URGENT CARE UTILIZATION IN MASSACHUSETTS

Health Care Cost Trends Report 2022: Impact of COVID-19 Pandemic on Ambulatory Care

Background

In 2018, the HPC analyzed trends and growth among retail clinics and urgent care centers in Massachusetts (DataPoints #8), finding that:

- The number of urgent care centers and retail clinics had grown dramatically since 2010
- Visit costs and patient cost-sharing varied by site of care, with significantly higher costs at emergency departments
- Retail clinics and urgent care centers were disproportionately located in higher income areas, although urgent care centers were more broadly distributed

The HPC has updated and expanded upon that analysis, and will soon release DataPoints #23 on this topic, showing:

- Recent growth in urgent care centers and retail clinics;
- Changes in the community income of their locations;
- Costs compared to alternatives; and
- Services offered during the pandemic.

Data Sources and Methods

DATA SOURCES

- Survey of urgent care centers and retail clinics in Massachusetts conducted in late 2021, collecting information on location, hours, and services
- 2018 – 2020 data from the Massachusetts All-Payer Claims Database v10.0

METHODS

For some analyses, the HPC grouped urgent care centers into centers affiliated with major health systems, large chains (national or regional with at least three centers in Massachusetts), and other (including independent centers, centers affiliated with community health centers, and others).

The HPC gratefully acknowledges Massachusetts Health Quality Partners for assistance in conducting the survey of urgent care centers and retail clinics.

Urgent care centers and retail clinics can represent a convenient alternative to other settings for low-acuity care, such as a hospital outpatient department or an emergency department.

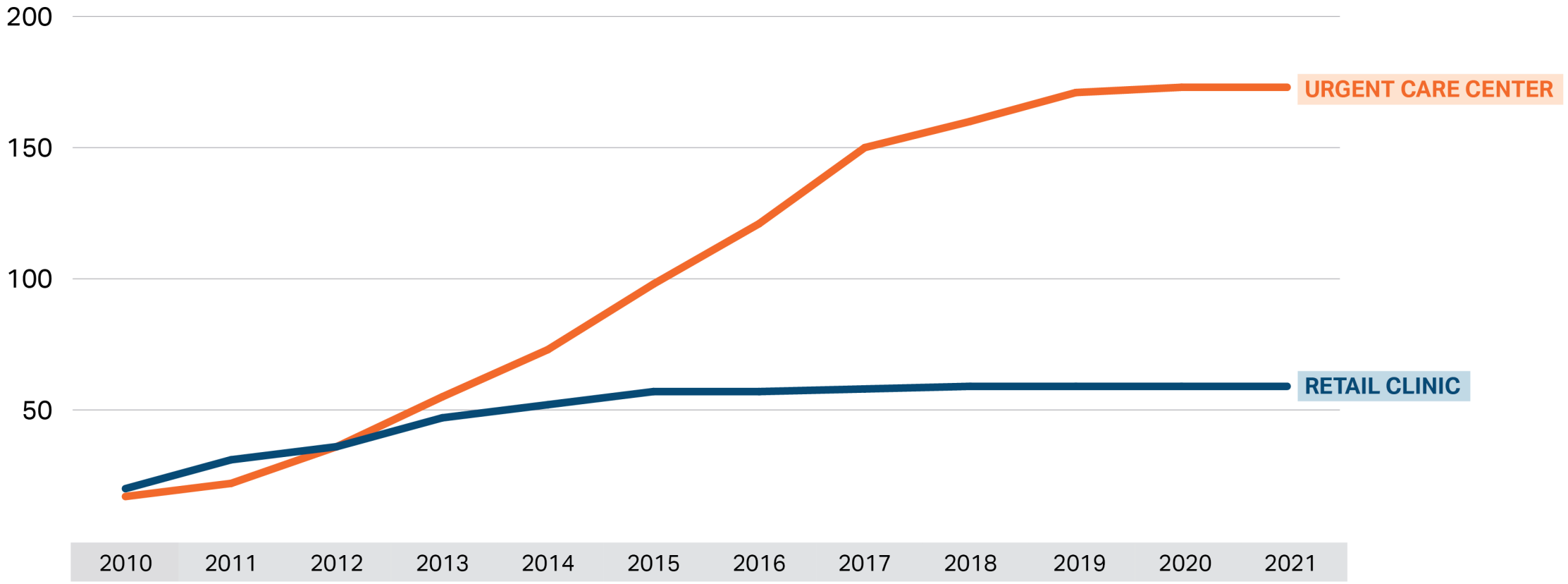
Retail clinics are typically staffed by nurse practitioners, are located within large pharmacy chain stores, and provide a limited scope of care including vaccinations, diagnosis, and treatment for conditions such as upper-respiratory and sinus infections.

- All retail clinics in Massachusetts are CVS MinuteClinics.

Urgent care centers usually include physicians and other providers on staff who provide diagnosis and treatment for more pressing conditions, including broken bones requiring x-rays and care for more complex chronic conditions that are not life-threatening.

The total number of urgent care centers grew from 15 in 2010 to 173 in 2021 and the number of retail clinics grew from 20 in 2010 to 59 in 2021.

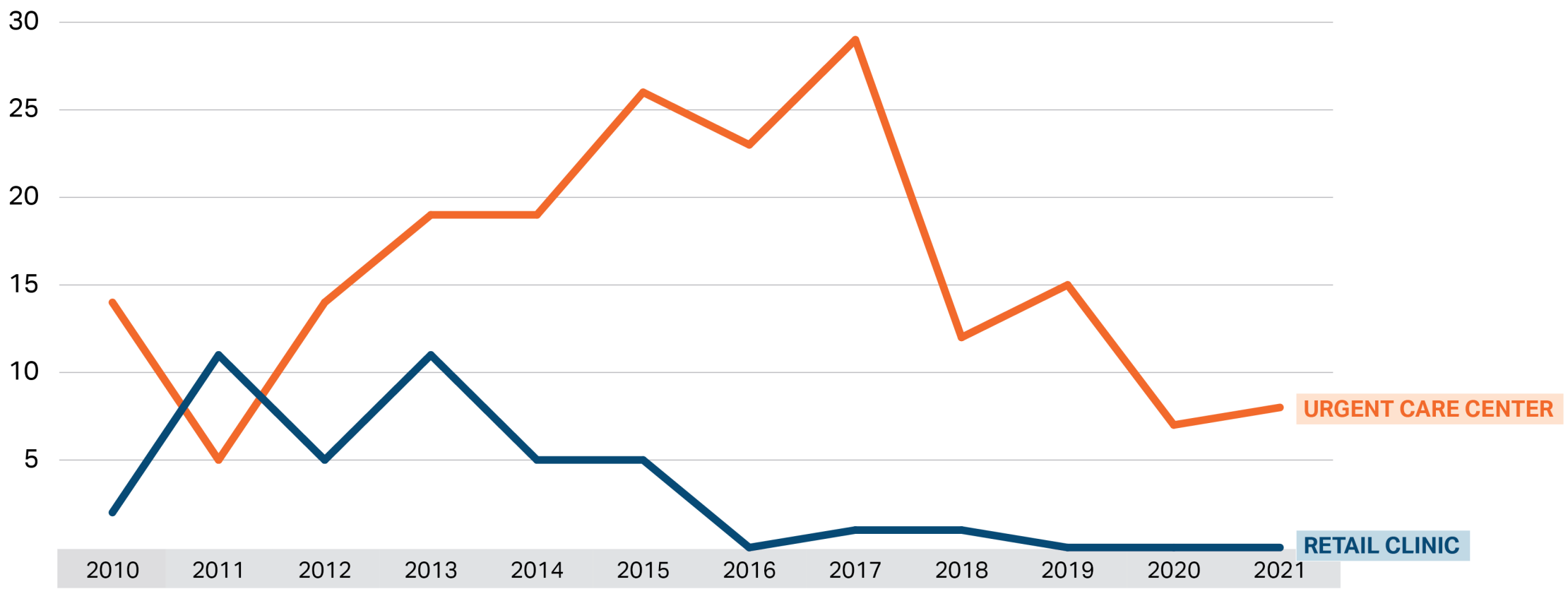
Total number of urgent care centers and retail clinic in Massachusetts, 2010 - 2021



Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

The number of new urgent care center openings peaked in 2017, but new entry continues.

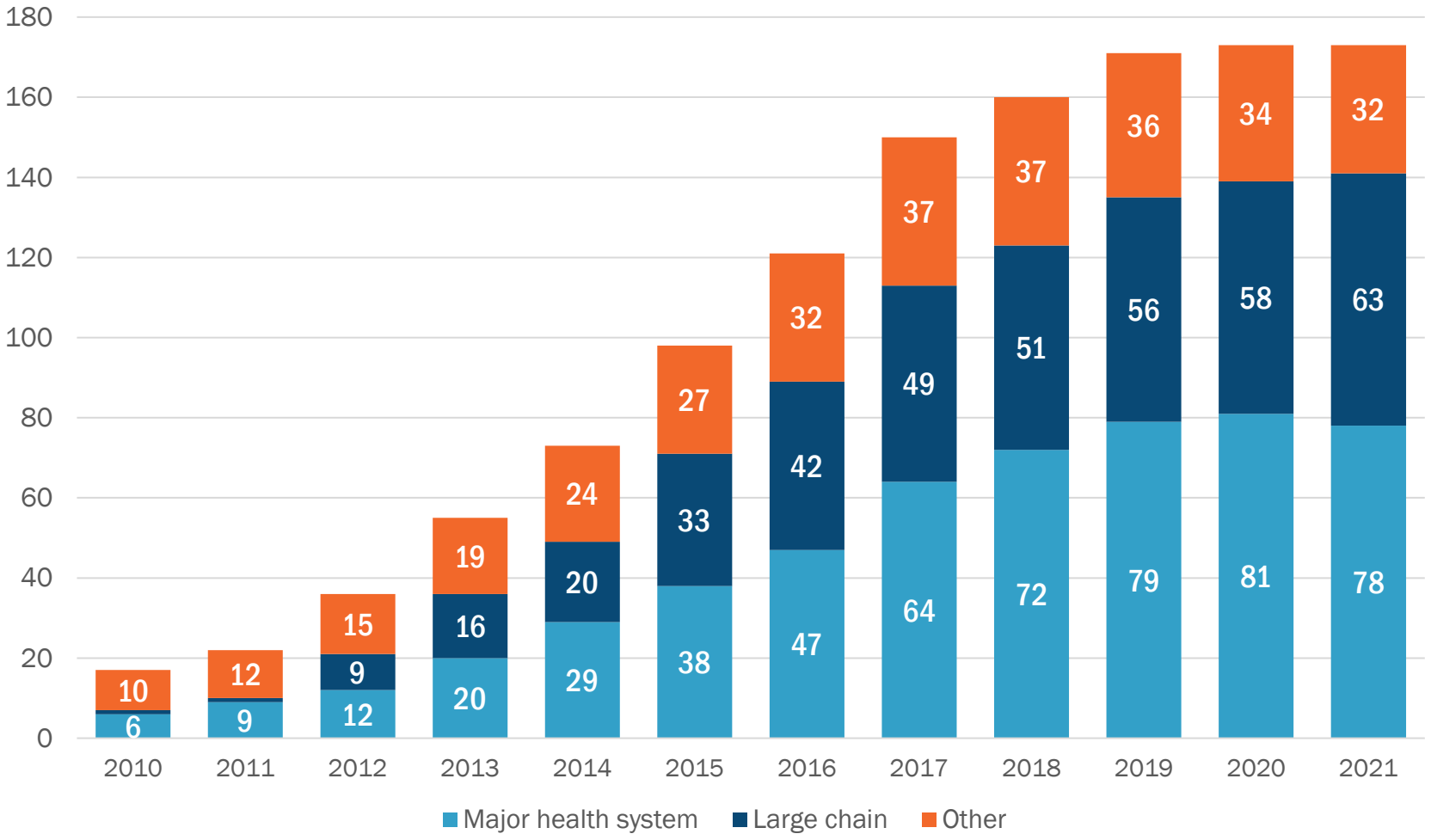
New urgent care centers and retail clinics by year of market entry, 2010 - 2021



Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

Entry from large chains has driven growth in new urgent care centers in recent years, although centers affiliated with major health systems remain the largest share.

Type of urgent care center by year opened, 2010 - 2021

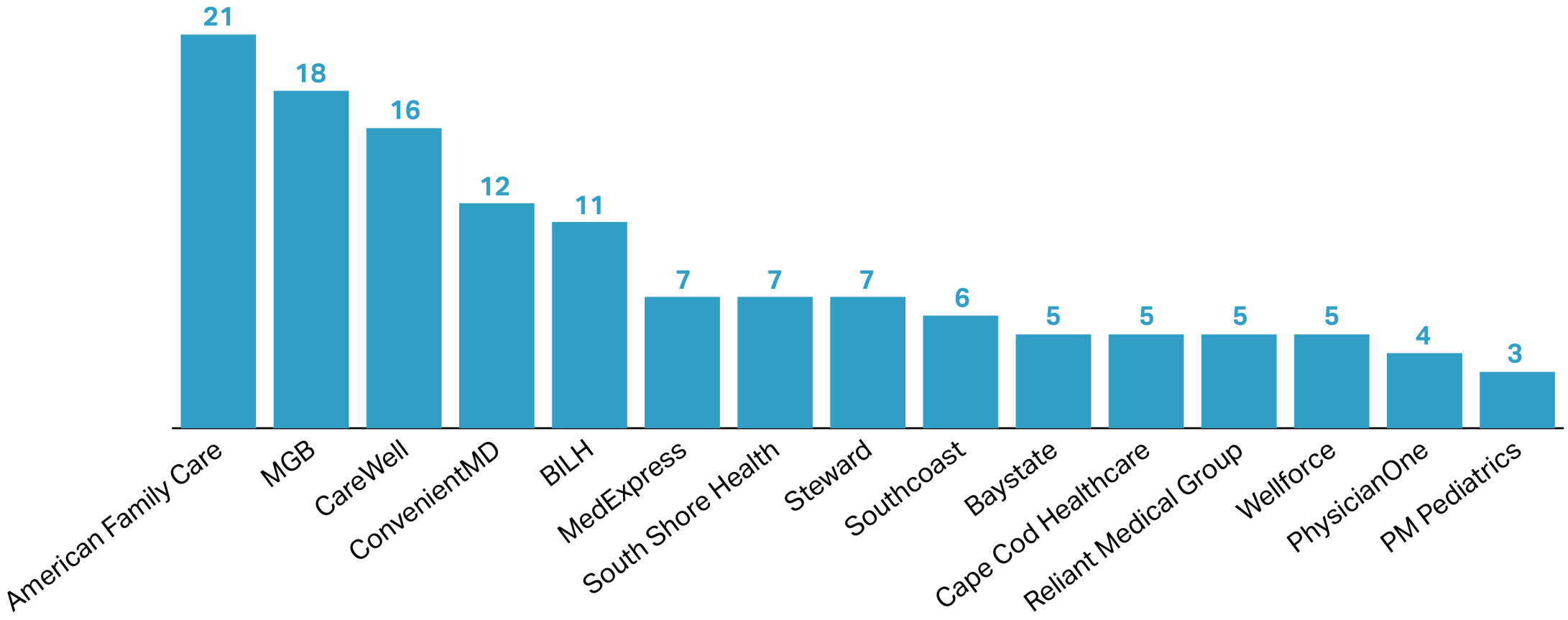


Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

- In 2021, **45%** of urgent care centers were sites operated by major health systems, **36%** were part of large chains (such as CareWell, ConvenientMD, and American Family Care), and **18%** were independent or other (affiliated with community health centers and others).
- In earlier years, independent/ other centers represented a larger share of the market.
  - In 2014, independent/ other centers represented **one third** of the market.

The top five urgent care centers by ownership include MGB, BILH and three large chains.

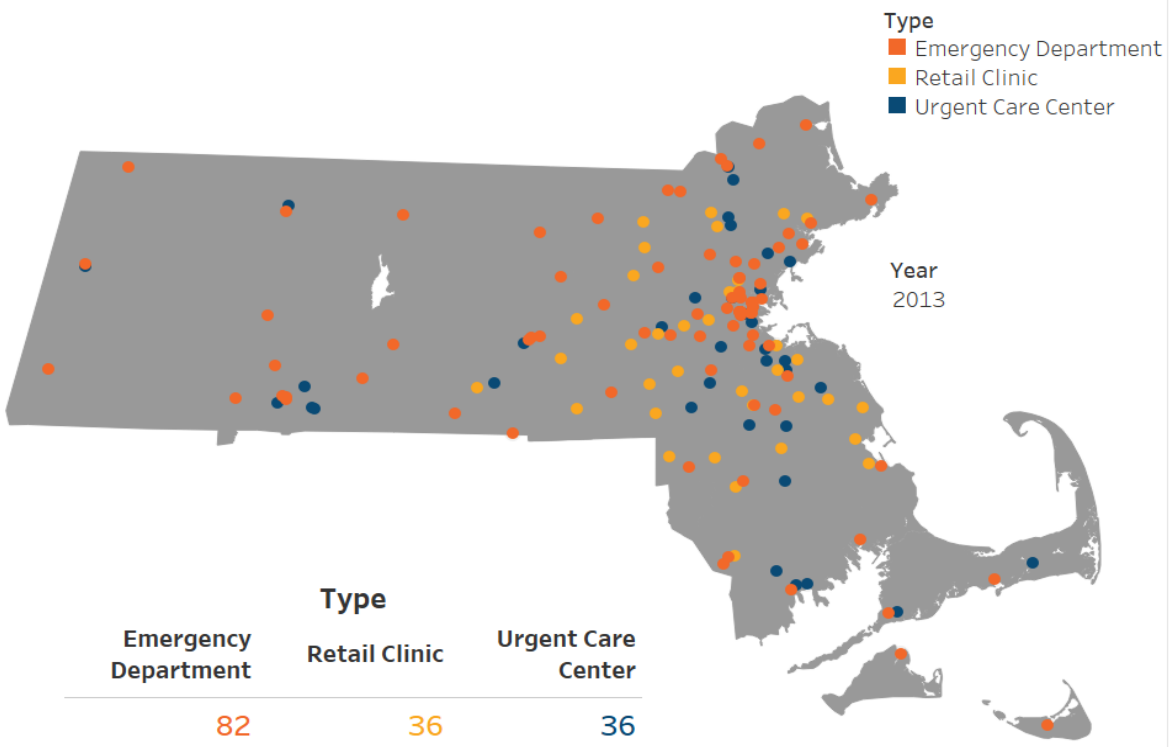
Urgent care centers by ownership (large chains and major health systems with at least 3 centers), 2021



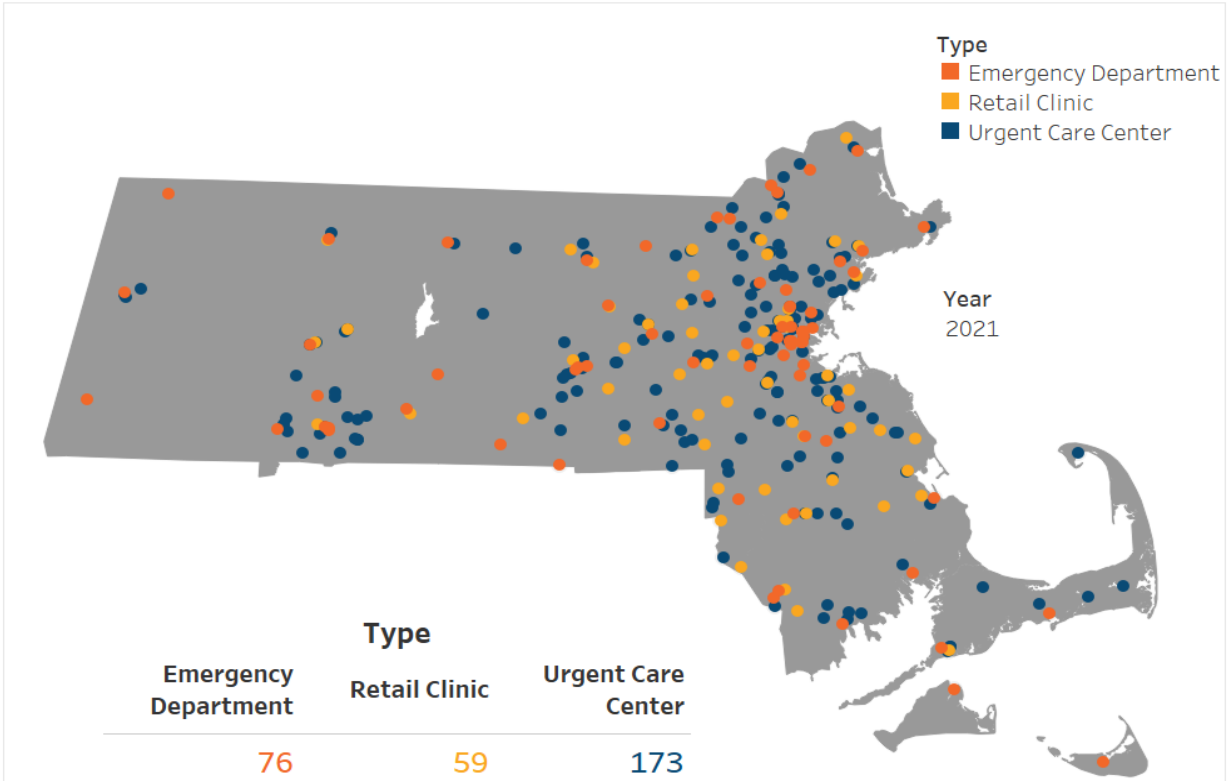
Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

Urgent care centers have grown in number and geographic diversity in Massachusetts.

Urgent care centers, retail clinics, and emergency departments, 2013 and 2021



Type		
Emergency Department	Retail Clinic	Urgent Care Center
82	36	36

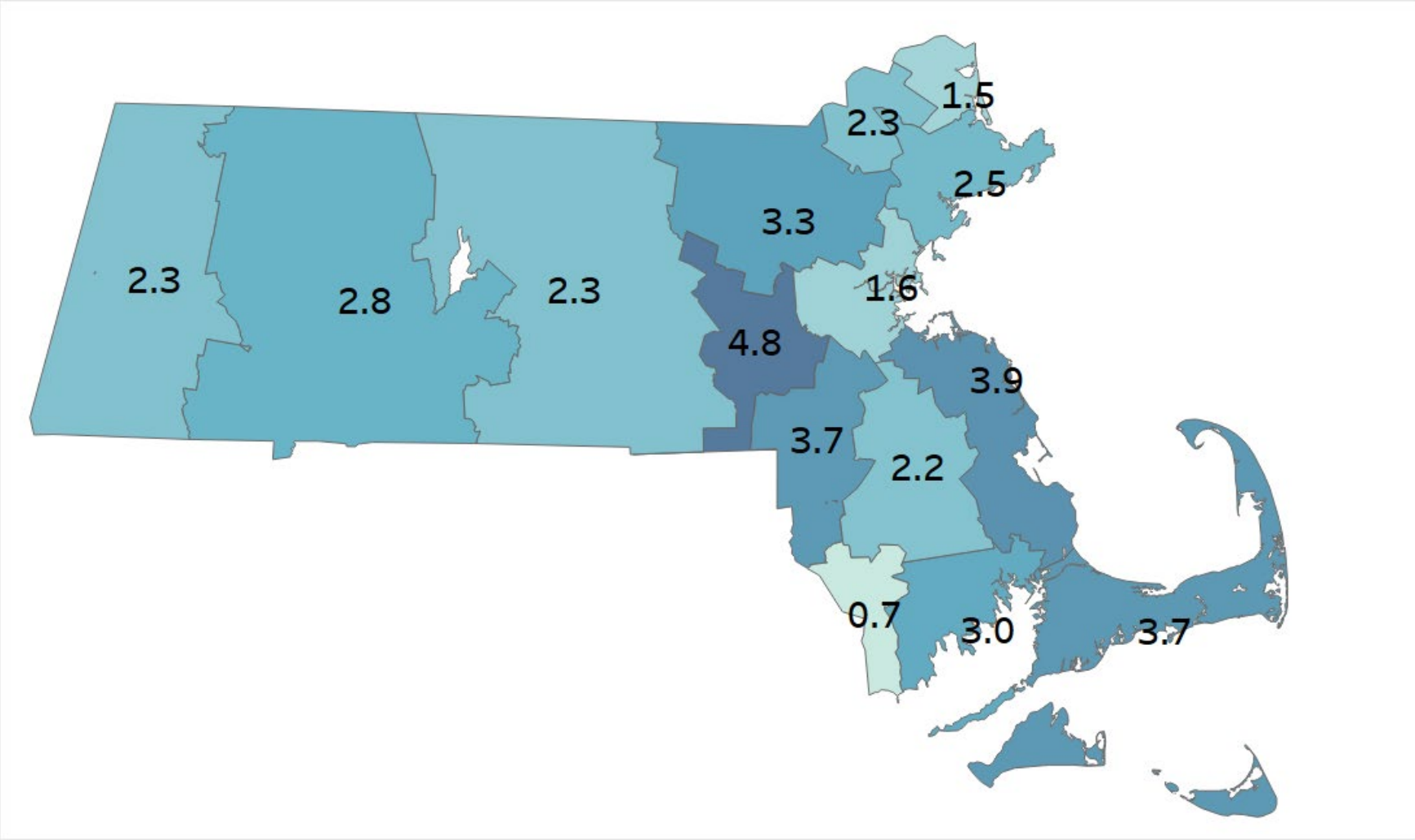


Type		
Emergency Department	Retail Clinic	Urgent Care Center
76	59	173

Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

Urgent care centers vary in number per resident across Massachusetts.

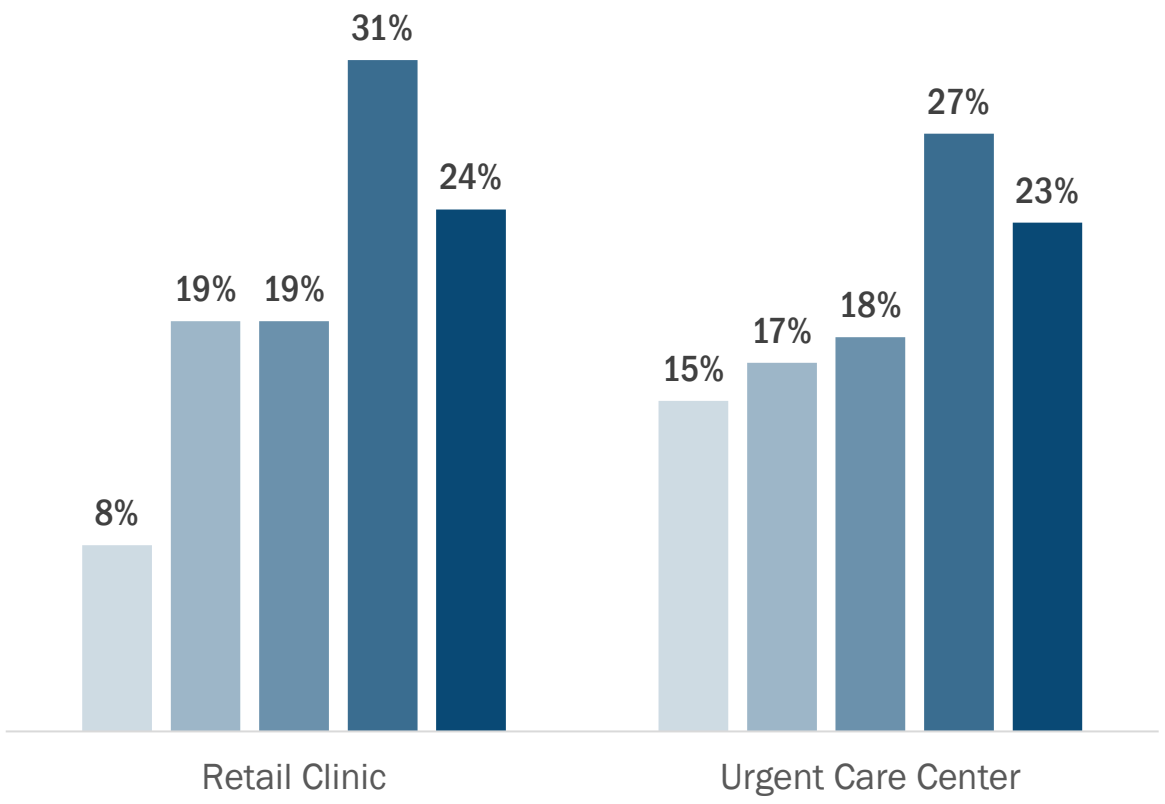
Urgent care centers per 100,000 residents, 2021



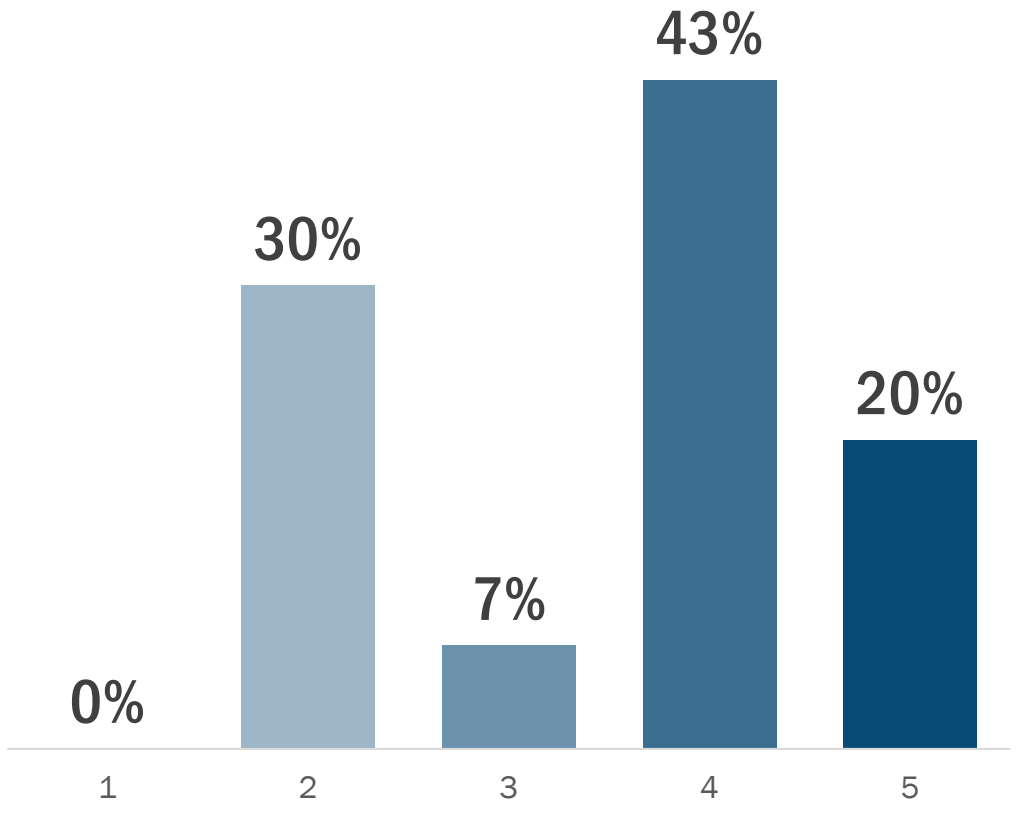
Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

Urgent care centers and retail clinics are disproportionately located in higher income areas of Massachusetts.

Retail clinics and urgent care centers by income quintile of zip code



Urgent care centers that opened 2019-2021 by income quintile of zip code

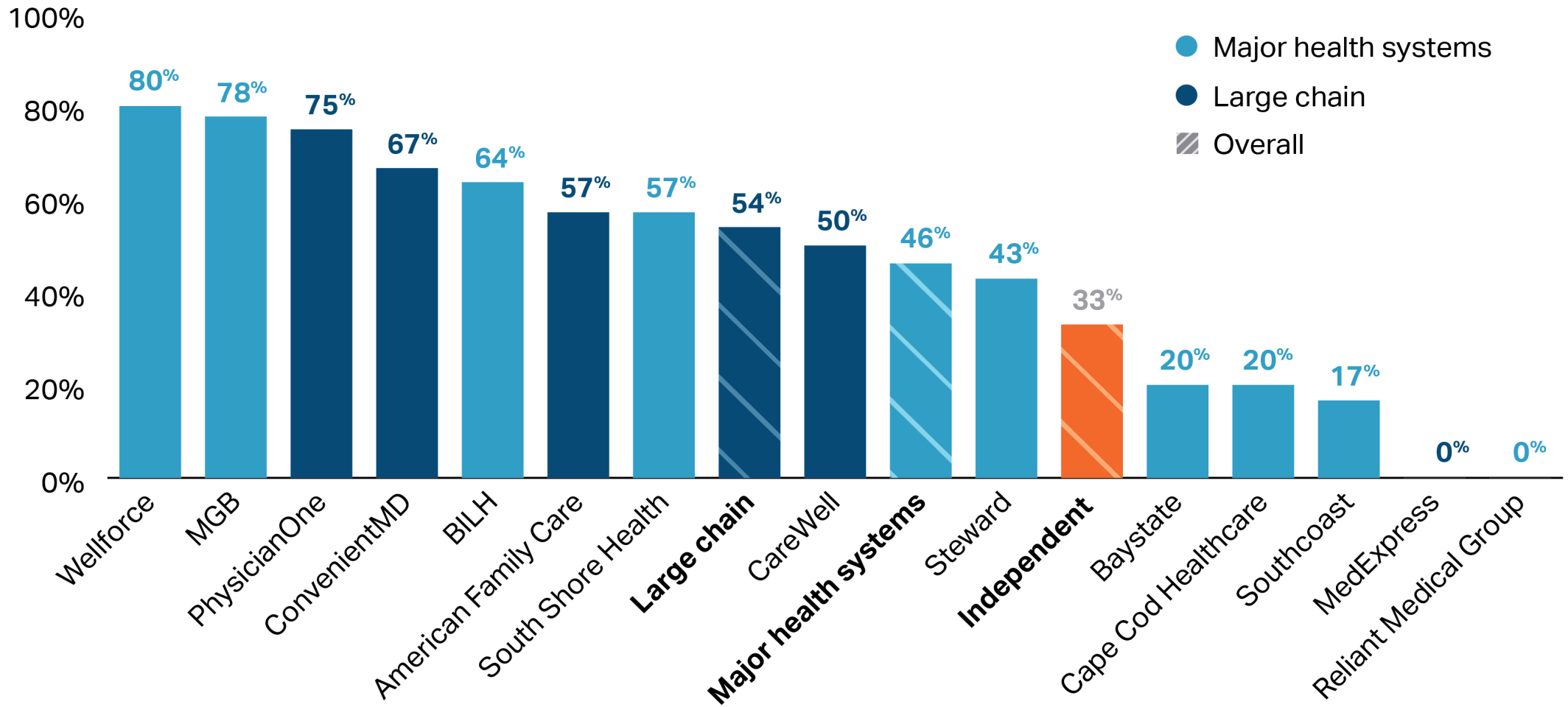


Lowest income quintile 1 2 3 4 5 Highest income quintile

Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

There is wide variation in the location of urgent care centers by ownership, with many major health systems and large chains locating urgent care centers disproportionately in higher income areas.

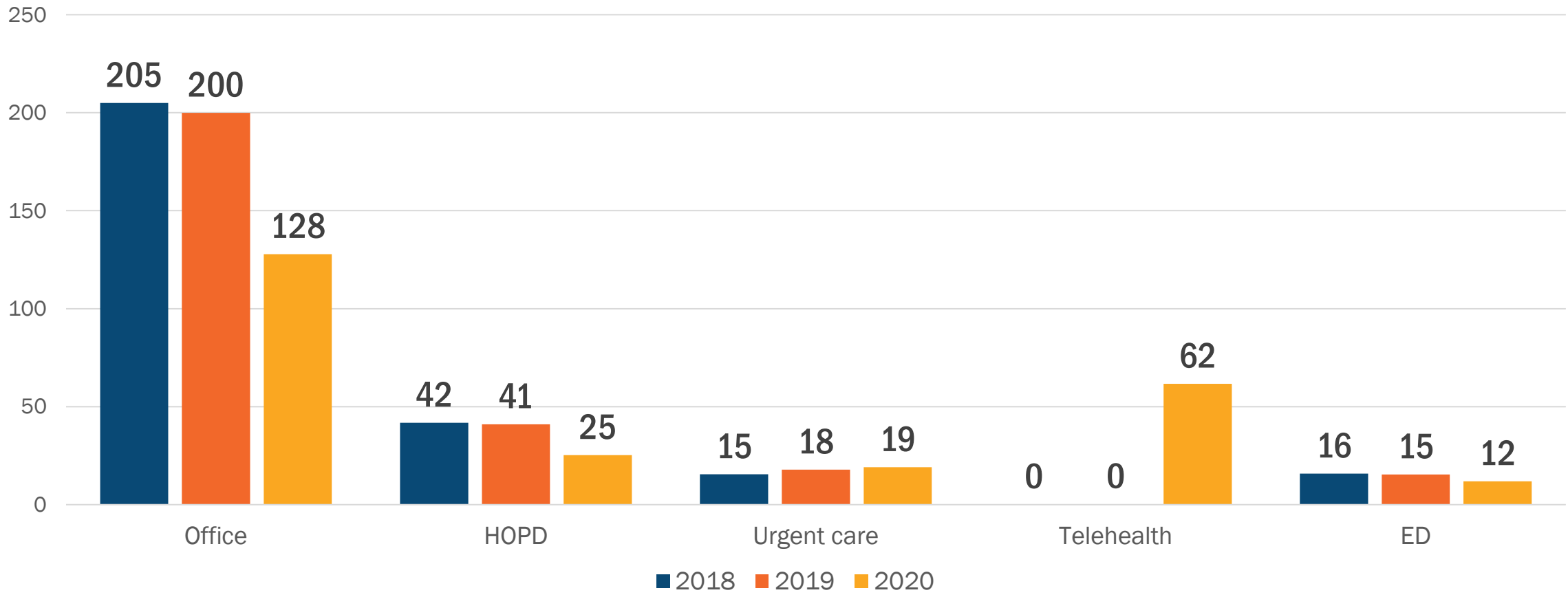
Percentage of urgent care centers in highest income areas (fourth and fifth highest quintile) by ownership with at least 4 centers, 2021



Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

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

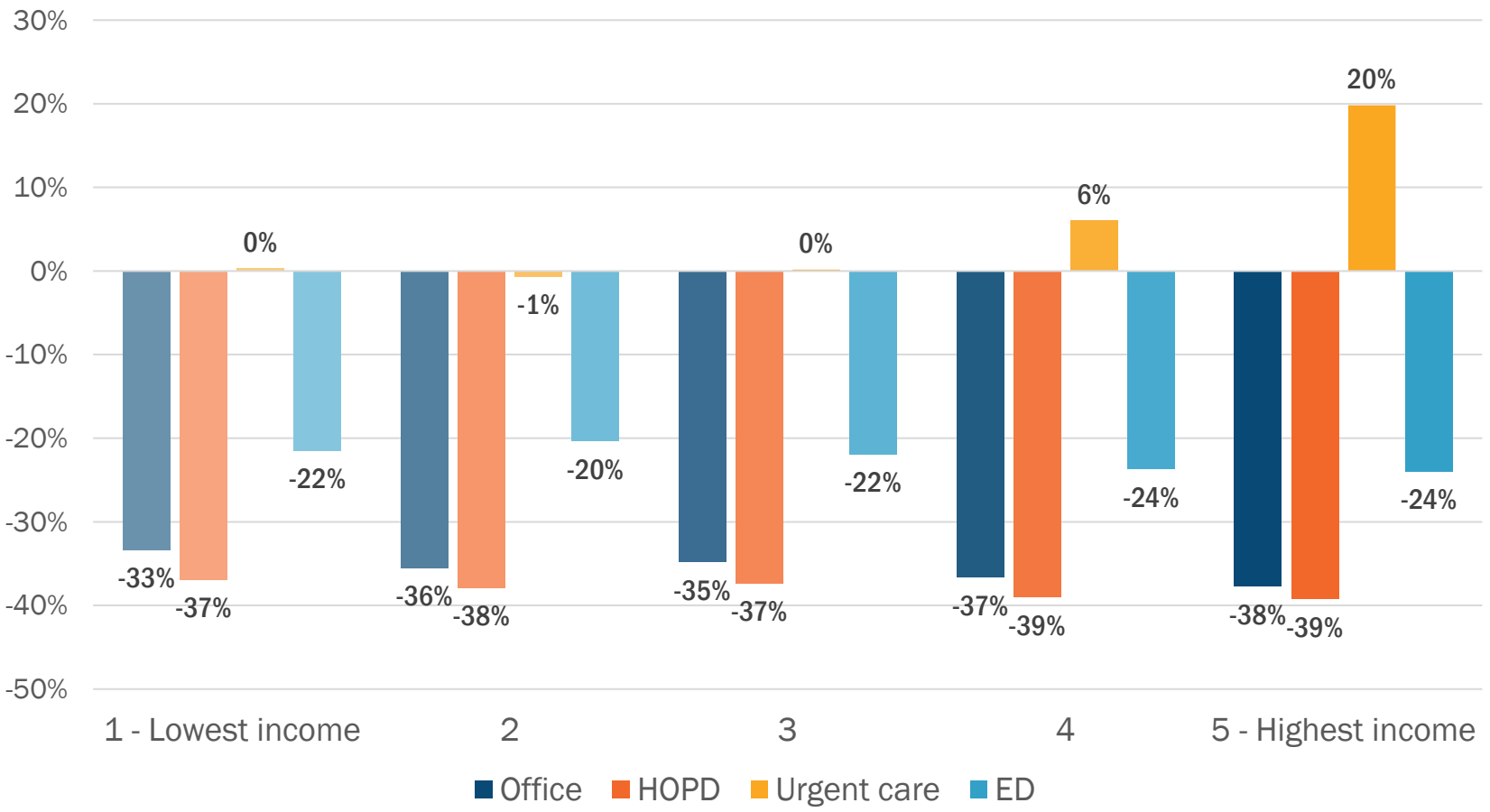
Number of evaluation and management (E&M) visits per 1,000 member months by site type and year for commercially-insured patients, 2018-2020



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

From 2019 to 2020, the growth in use of urgent care centers was concentrated among residents living in high-income areas.

Percent change in the number of evaluation and management (E&M) visits per 1,000 member months for commercially-insured patients by zip-income quintile, 2019 to 2020

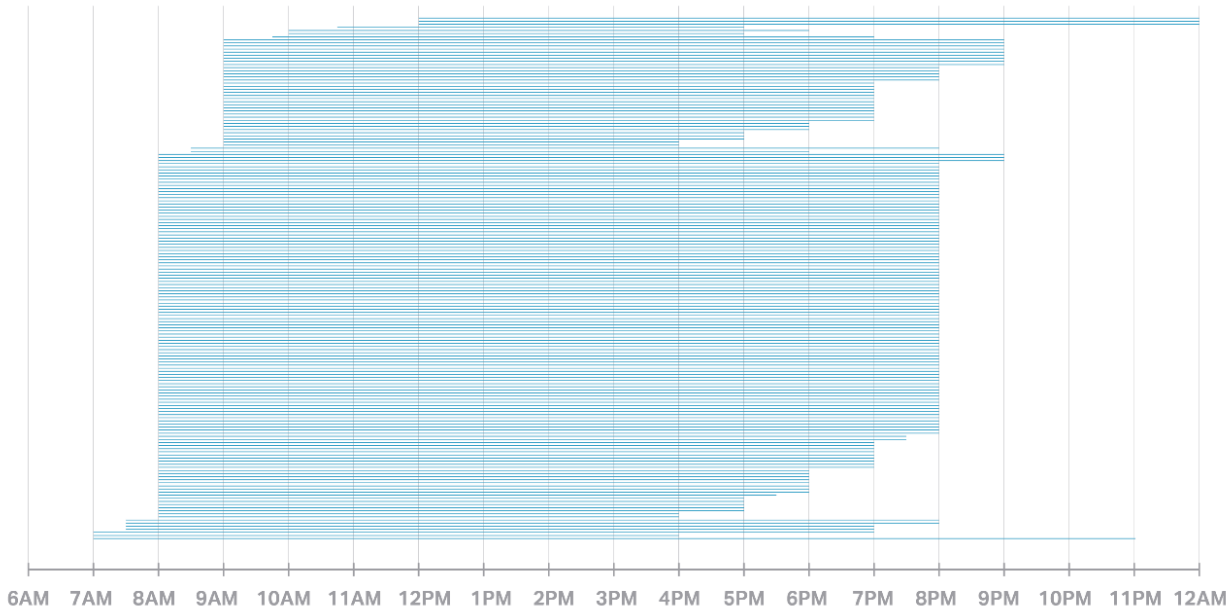


Notes: Population includes commercially-insured individuals with full coverage. Behavioral health, therapy, and counseling-related evaluation and management visits were excluded. Evaluation and management codes include: 99201-99205, 99211-99215, 99281-99285 (ED visits).
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2019-2020

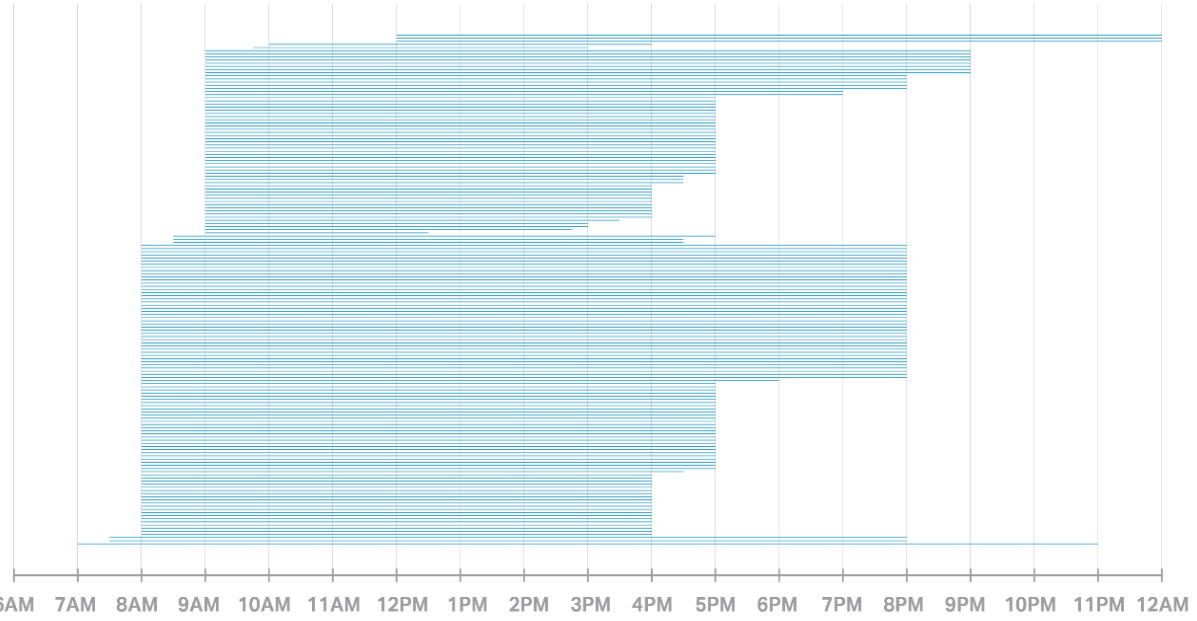
- Visit rates in 2019 were similar in the lowest and highest income areas (15 vs 16 visits per 1,000 member months); visit rates in the highest income areas increased to 19 visits per 1,000 member months in 2020.
- Starting January 1, 2021, MassHealth removed the requirement that patients need a PCP referral to go to an urgent care center – this policy change may increase incentives for urgent care centers to locate in lower income areas.

Urgent care centers vary in operating hours, but most are open outside of standard physician office hours.

Urgent care centers: Weekday hours open



Urgent care centers: Saturday hours open

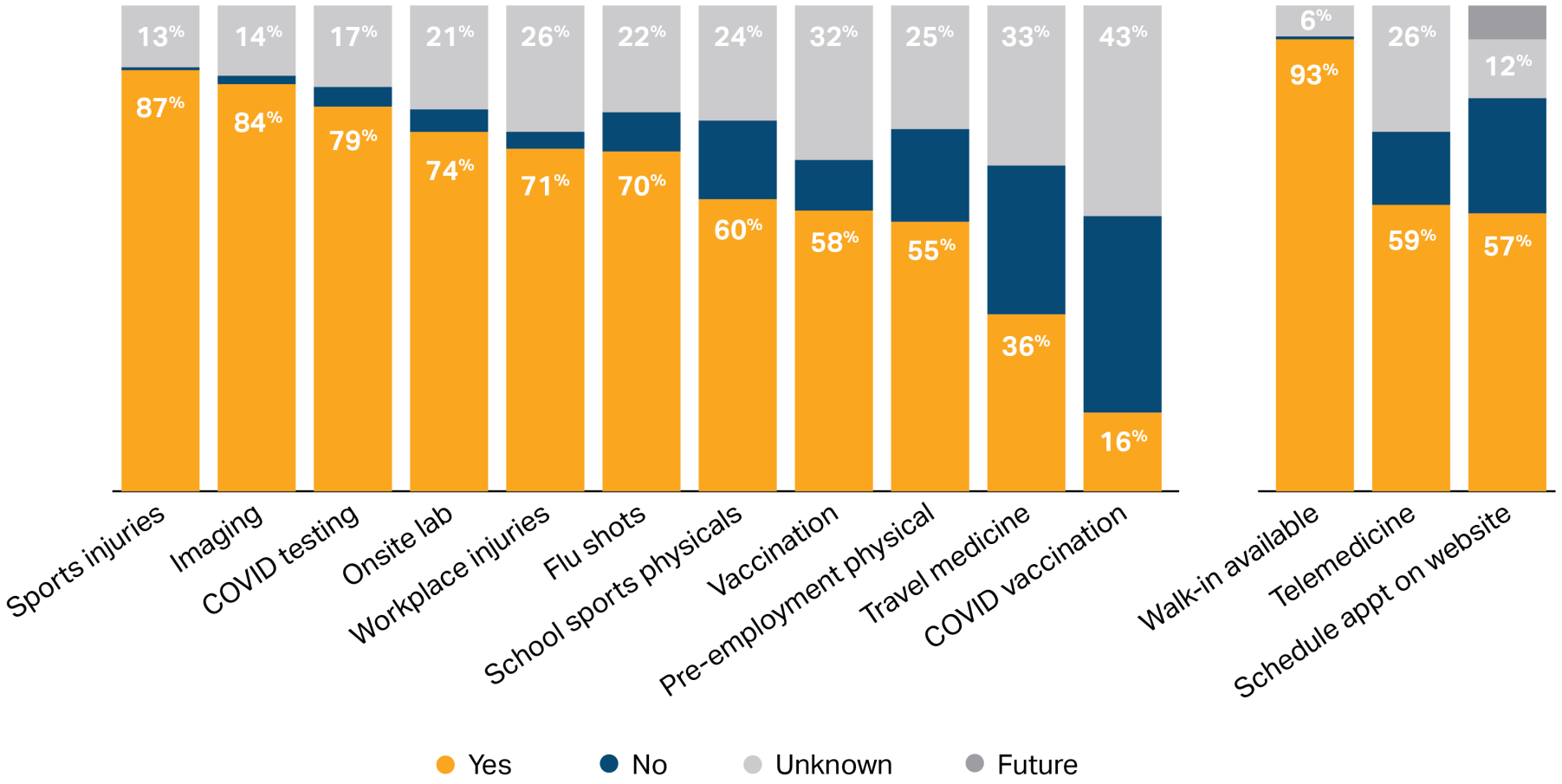


- The most common weekday operating hours (51% of centers) are 8:00AM – 8:00PM.
- The most common Saturday operating hours (25% of centers) are 8:00AM – 8:00PM. Most have similar hours on Sundays.
- All CVS MinuteClinics in Massachusetts are open weekdays 8:00AM – 7:00PM, Saturdays 9:00AM – 5:30PM, and Sundays 9:00AM – 4:30PM.

Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

Most urgent care centers offered testing for COVID-19 in 2021, in addition to common low-acuity services.

Services offered at urgent care centers, 2021

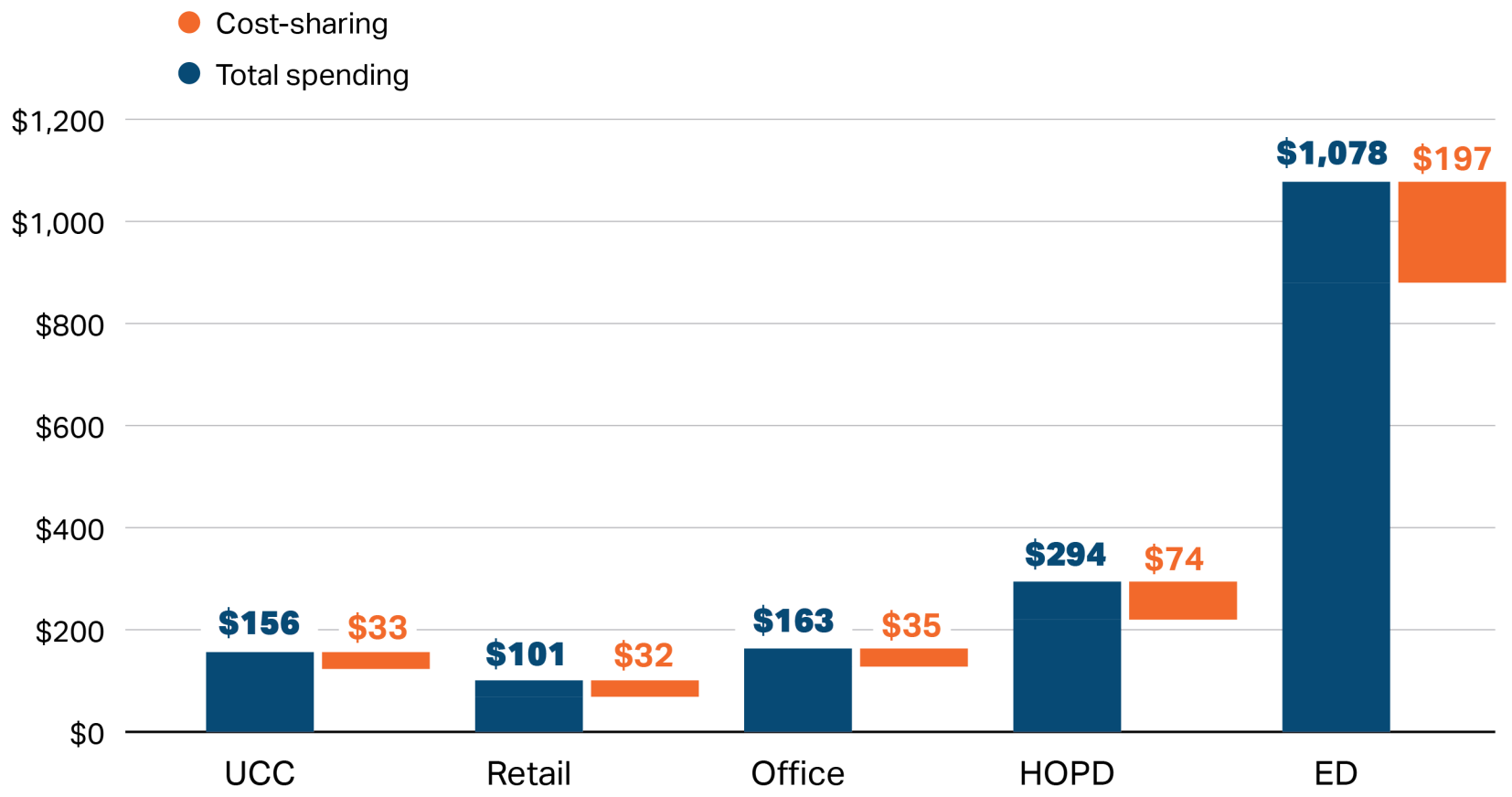


- Only 4% of urgent care centers reported not offering COVID-19 testing, as of late 2021.
- All retail clinics reported offering COVID-19 testing.

Source: Massachusetts Health Policy Commission urgent care center and retail clinic survey, 2021

Average spending for a low-acuity visit in an ED is 7 times higher than in an urgent care center and 10 times higher than in a retail clinic; cost-sharing is 6 times higher.

Mean spending and cost-sharing per low-acuity visit, by site of service, 2020

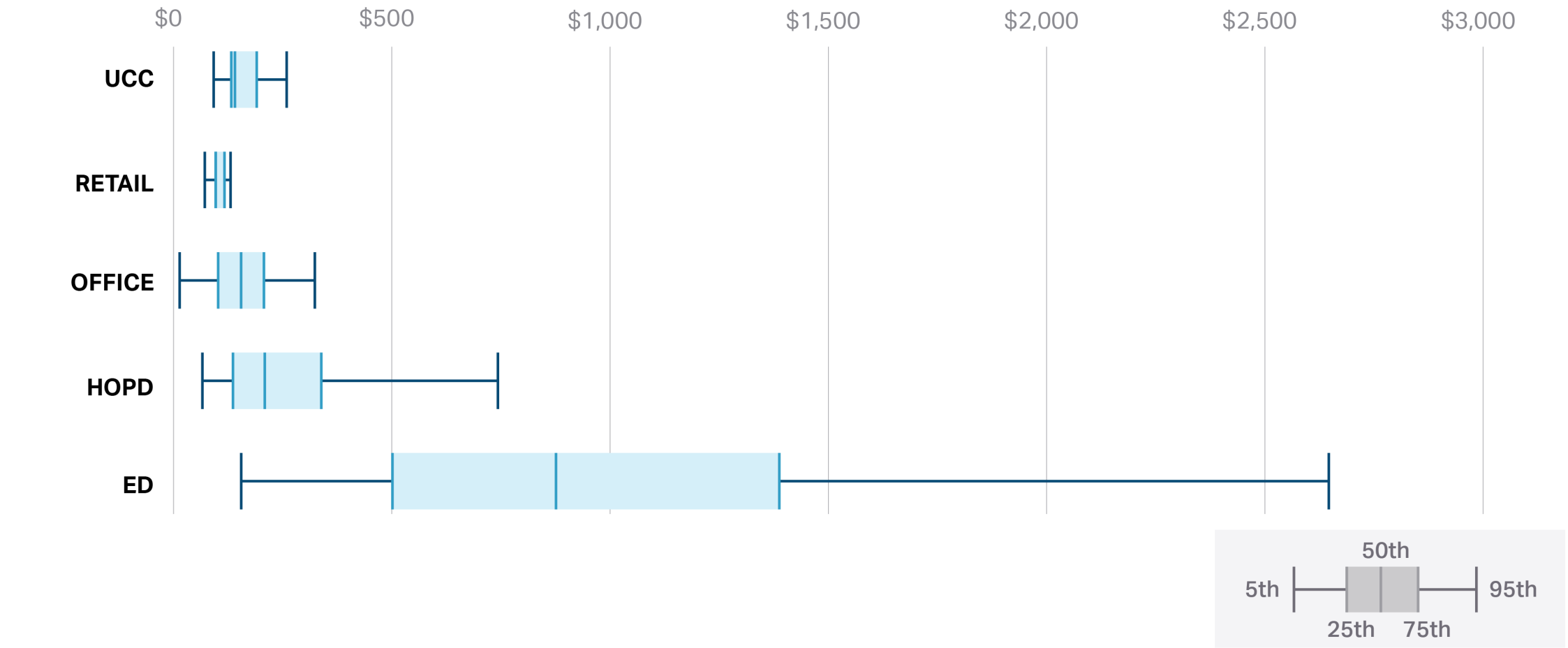


- ED spending per visit grew 34% between 2018 – 2020, the highest increase, followed by HOPD with 16% growth.
- Analysis only reflects professional fees for UCC; some UCCs affiliated with health systems may have facility fees.

Notes: HOPD and ED figures include professional and facility spending. UCC, retail and office figures include professional spending only. Claim lines for the same patient on the same day were combined into one visit.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2020

The variation in spending for low-acuity visits in the ED is much larger than in other settings of care.

Distribution of spending per low-acuity visit, by site of service, 2020

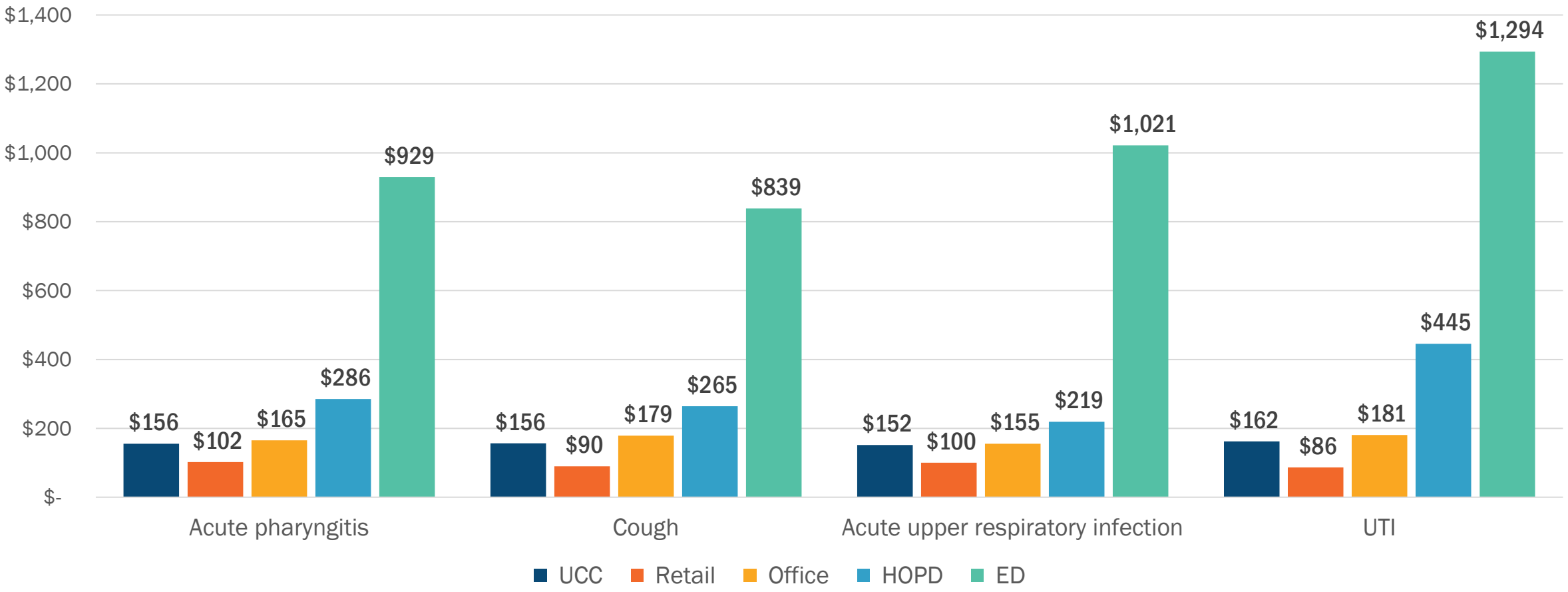


Notes: HOPD and ED figures include professional and facility spending. UCC, retail and office figures include professional spending only. Claim lines for the same patient on the same day were combined into one visit. Definitions of low-acuity conditions were based on Poon SJ, Schuur JD, Mehrotra A. Trends in Visits to Acute Care Venues for Treatment of Low-Acuity Conditions in the United States From 2008 to 2015. JAMA Intern Med. 2018 Oct 1;178(10):1342-1349

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

Spending for common conditions is highest in the ED, but HOPD spending per visit is also substantially higher than in other settings of care.

Mean spending per visit for common conditions among adults, 2020



Notes: The diagnosis codes shown here are: J029 (Acute pharyngitis, unspecified), R05 (Cough), J069 (Acute upper respiratory infection, unspecified), and N390 (Urinary track infection, site specified). HOPD and ED figures include professional and facility spending. UCC, retail and office figures include professional spending only. Claim lines for the same patient on the same day were combined into one visit.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v10.0, 2020

Billing practices vary for urgent care centers affiliated with major health systems; some bill facility fees.

PHYSICIAN OFFICE

RETAIL CLINIC

Only bills professional claims

HOSPITAL OUTPATIENT DEPARTMENT (HOPD)

EMERGENCY DEPARTMENT (ED)

Bills professional claims + facility fee claims

URGENT CARE CENTER

- Standalone chains and independent centers only bill professional claims
- Centers affiliated with major health systems:
  - Bill professional claims, but the professional claim **may** be billed as a different type of site
  - **Some centers also bill a facility fee; facility fees may appear to be claims for HOPDs or EDs**

Lack of standardization in licensure, payer rules, and billing practices for urgent care centers affiliated with major health systems can result in unexpected bills for patients and lack of transparency.

Examples of payer and provider billing practices in urgent care centers affiliated with major health systems

Massachusetts General Hospital
Founding Member, Mass General Brigham

Since the locations listed below are not considered by health insurance plans to be Urgent Care Centers, **your co-payment benefits for urgent care services typically will not apply**. Instead, your visit to these locations will likely be billed either as a physician office visit or a hospital outpatient visit.

Physician Office Locations

Urgent Care services provided at the following Mass General Brigham locations are typically billed to your health insurance plan as a physician or nurse practitioner office visit:

- Cooley Dickinson Urgent Care, Northampton, MA
- Harbor Medical Associates Urgent Care, South Weymouth, MA
- North Shore Urgent Care, Danvers, MA
- Pentucket Medical ExpressCare Andover, MA
- Lawrence, MA

Hospital Outpatient Locations

Urgent Care services provided at the following Mass General Brigham locations are typically billed to your health insurance plan as a hospital outpatient visit:

- Massachusetts General Hospital Primary Care Urgent Access Center, Boston, MA
- Massachusetts General Hospital Chelsea HealthCare Center Urgent Care, Chelsea, MA
- Brigham and Women's Urgent Care Center, Foxborough, MA

Your out-of-pocket costs for the physician or nurse practitioner visit are usually limited to the co-payment required by your health insurance plan. We will request your co-payment when you check in for the visit.

You will also be billed for what is commonly known as a "facility fee" for use of the hospital space, equipment, and support staff.

Harvard Pilgrim HealthCare

PAYMENT POLICIES

Professional Evaluation & Management services in a Facility Based Urgent Care Location

Submit services on a CMS-1500 claim form or electronic 837P.
Place of Service code 23: Emergency Room-Hospital is required.

- **Implications for patients:** Patients may choose to visit an urgent care center instead of an ED, but unexpectedly receive a similar bill to the one they would have received at an ED
- **Implications for research and accountability:** Lack of requirements and variation in payer rules and billing practices may result in undercount of visits and spending per visit

Summary

- Urgent care centers and retail clinics continued to grow in number and use in recent years in Massachusetts, and they played a prominent role during the COVID-19 pandemic.
- In 2021, there were a total of **173 urgent care centers** and total of **59 retail clinics** in Massachusetts.
  - The number of new urgent care centers opening peaked in 2017, but new entry continues. The number of retail clinics has remained at 59 since 2018.
- Entry from large chains has driven growth in new urgent care centers in recent years, although **centers affiliated with major health systems remain the largest share**.
- Urgent care centers and retail clinics remain **disproportionately located in higher income areas** of Massachusetts.
- Between 2018 – 2020, the share of evaluation and management visits occurring in urgent care centers grew; this shift was concentrated among residents living in higher income areas.
- Average spending for **a low-acuity visit in an ED is 7x higher than in an urgent care center** and **10x higher than in a retail clinic**; cost-sharing is 6x higher.
- **Lack of standardization** in licensure, payer rules, and billing practices among urgent care centers affiliated with major health systems can result in unexpected bills for patients and lack of transparency.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints: Urgent Care Utilization in Massachusetts

HEALTH CARE COST TRENDS REPORT 2022: IMPACT OF COVID-19 PANDEMIC ON AMBULATORY CARE

- Adult Ambulatory Care
- Pediatric Ambulatory Care
- Pediatric Mental Health

Impact of COVID-19 on the Health Care System

- The COVID-19 pandemic has greatly disrupted health care provision and access to care including:
  - A system-wide shut-down of all elective procedures and visits in March 2020
  - Restricted access to ambulatory in-person care and expanded access to virtual care
- Previous work by the HPC (Interim COVID Impact Report, 4/21; HPC board meeting, 4/22) found **large initial reductions in hospital inpatient and ED visits** that gradually approached 2019 baseline levels by the end of 2021.
- The **2022 HPC Cost Trends report** and future reports will focus more broadly on care patterns including ambulatory care, and will ask:
  - Were there **similar patterns** in the use of ambulatory care as were observed for hospital care?
  - What **longer-term implications of these care disruptions** may need to be addressed?
    - *Were there significant reductions in **high-value care** (e.g., preventive/well care and routine care for people with chronic conditions) that may lead to greater future needs and more missed care?*
    - *Were there **shifts in how people use care** that may be lasting, such as telehealth or urgent care use in favor of ED and hospital settings, or reductions in low-value care?*
    - *Were there **worsening disparities** in receipt of care?*

https://www.mass.gov/doc/impact-of-covid-19-on-the-massachusetts-health-care-system-interim-report/download; https://www.mass.gov/doc/presentation-board-meeting-april-13-2022/download

2022 Annual Cost Trends Report – Outline and Public Presentation Dates

- **Chapter #1: Massachusetts Spending Performance** – *key findings to be presented at the HPC Board meeting on June 8, 2022*

- **Chapter #2: Changes in Ambulatory Care During the COVID-19 Pandemic** – *key findings presented today*

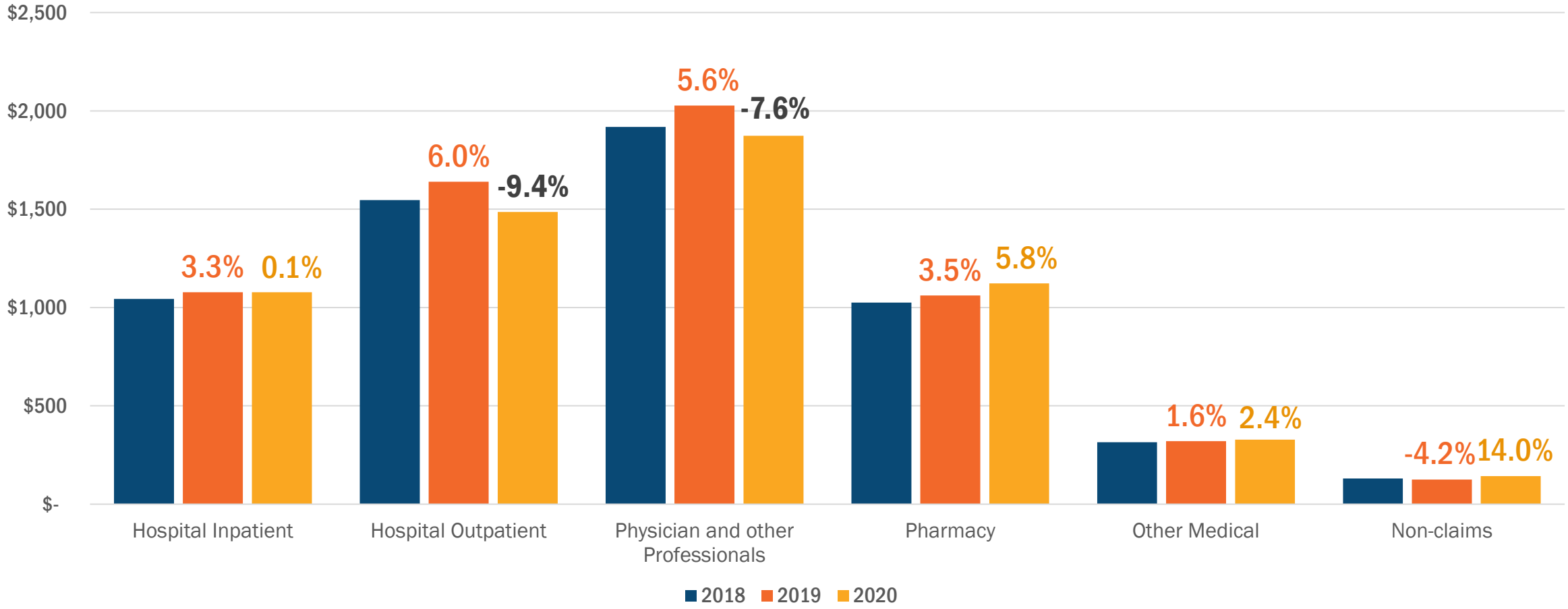
- **Four Chartpacks** – *key findings to be presented at the HPC Board meeting on June 8, 2022*
  - Price Trends and Variation
  - Hospital Utilization
  - Post-Acute Care
  - Provider Organization Performance Variation

- **Performance Dashboard** – *to be presented at the HPC Board meeting on July 13, 2022*

- **Recommendations** – *to be presented at the HPC Board meeting on July 13, 2022*

The reduction in Massachusetts commercial spending in 2020 was driven by a reduction in professional (-7.6%) and hospital outpatient (-9.4%) care.

Commercial per capita spending by service category, 2018-2020



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" includes home health care, dental, and several other smaller spending categories. Non-claims spending includes capitation-based payments.
Source: HPC Analysis of TME data from Center for Health Information and Analysis Annual Report, March 2022

Ambulatory Health Care Utilization During the COVID-19 Pandemic: Prior Findings

NATIONAL

- National data shows an overall **decrease in ambulatory care** in the spring of 2020 that remained 5-6% below 2019 levels by the end of 2020.
- **High value and low value services declined similarly at first**, but high value services were more likely to rebound faster - although this varied by service.

MASSACHUSETTS

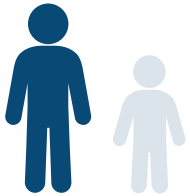
- ED visits remained below pre-pandemic levels in 2021, with the **largest declines in potentially avoidable visits and for children**.
- There was evidence of small **shifts in care to non-hospital settings**, including urgent care and telehealth, and reductions in care due to changes in care seeking behavior or reduced transmission of non-COVID-19 communicable disease.
- Use of telehealth for behavioral health visits persisted through 2020. Despite the switch to telehealth, **almost a quarter of pediatric patients discontinued care**.

Sources (National): https://www.commonwealthfund.org/publications/2021/feb/impact-covid-19-outpatient-visits-2020-visits-stable-despite-late-surge;
Changes in Use of Low-Value Services During the COVID-19 Pandemic April 22, 2022, Mahnum Shahzad, BA, Zirui Song, MD, PhD, Michael E. Chernew, PhD, A. Mark Fendrick, MD, American Journal of Managed Care

Sources (Massachusetts): https://www.mass.gov/doc/impact-of-covid-19-on-the-massachusetts-health-care-system-interim-report/download;
https://www.mass.gov/doc/presentation-board-meeting-april-13-2022/download

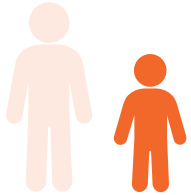
Ambulatory Areas of Focus

ADULTS



- Overall use of the health system
- Preventive and problem-based visits
- Preventive screenings
- Low-value care

PEDIATRICS



- Overall use of the health system
- Preventive and problem-based visits
- Lead testing
- Mental health therapy

Notes: CHIA All-Payer Claims Database (APCD) 10.0, 2018-2020; 5 commercial payers with ~1.3 million adult members aged 18-64 years and 320,000 pediatric members aged 0-17 represented in each year of data.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints: Urgent Care Utilization in Massachusetts

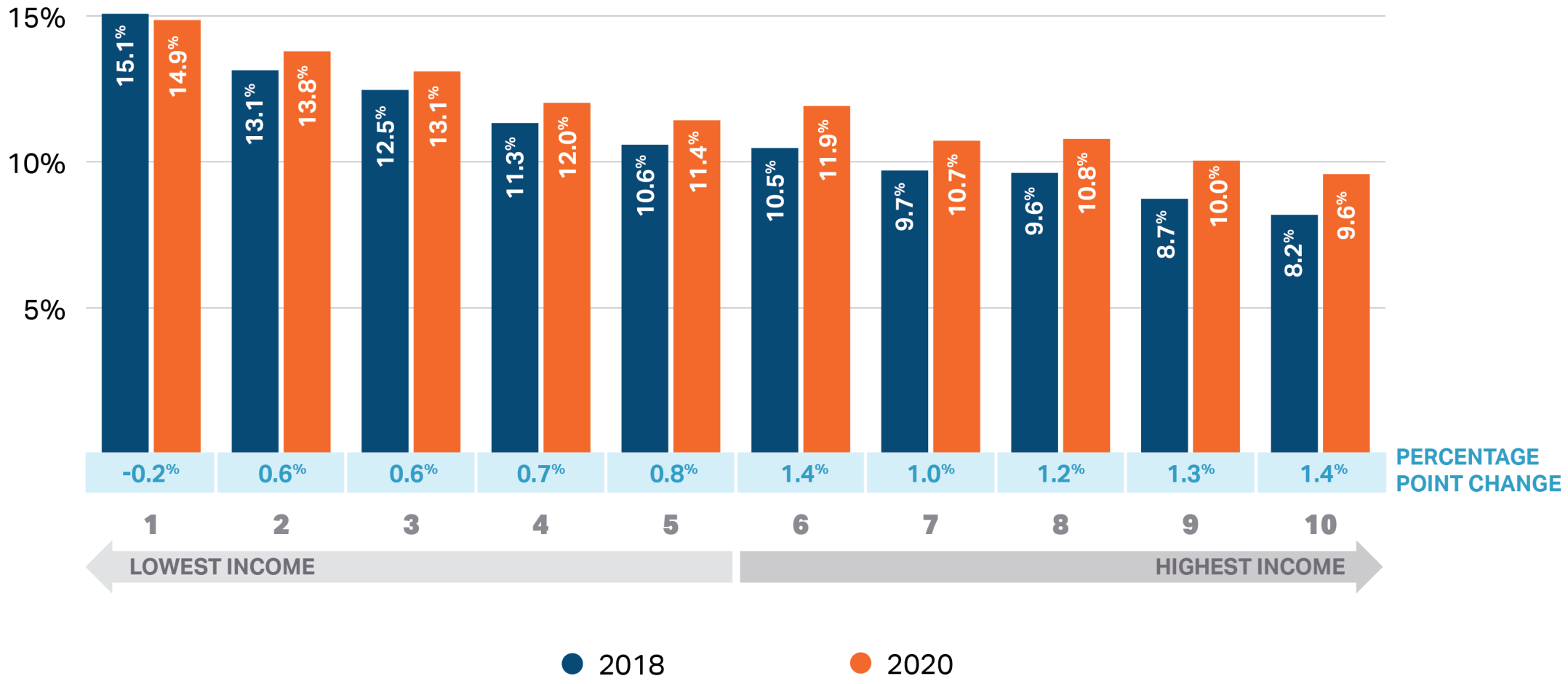
Health Care Cost Trends Report 2022: Impact of Covid-19 Pandemic on Ambulatory Care

ADULT AMBULATORY CARE

- Pediatric Ambulatory Care
- Pediatric Mental Health

Prior HPC research found that commercially-insured residents living in lower income zip codes were more likely to go without medical care. This pattern persisted in 2020, though the absolute difference was smaller in 2020.

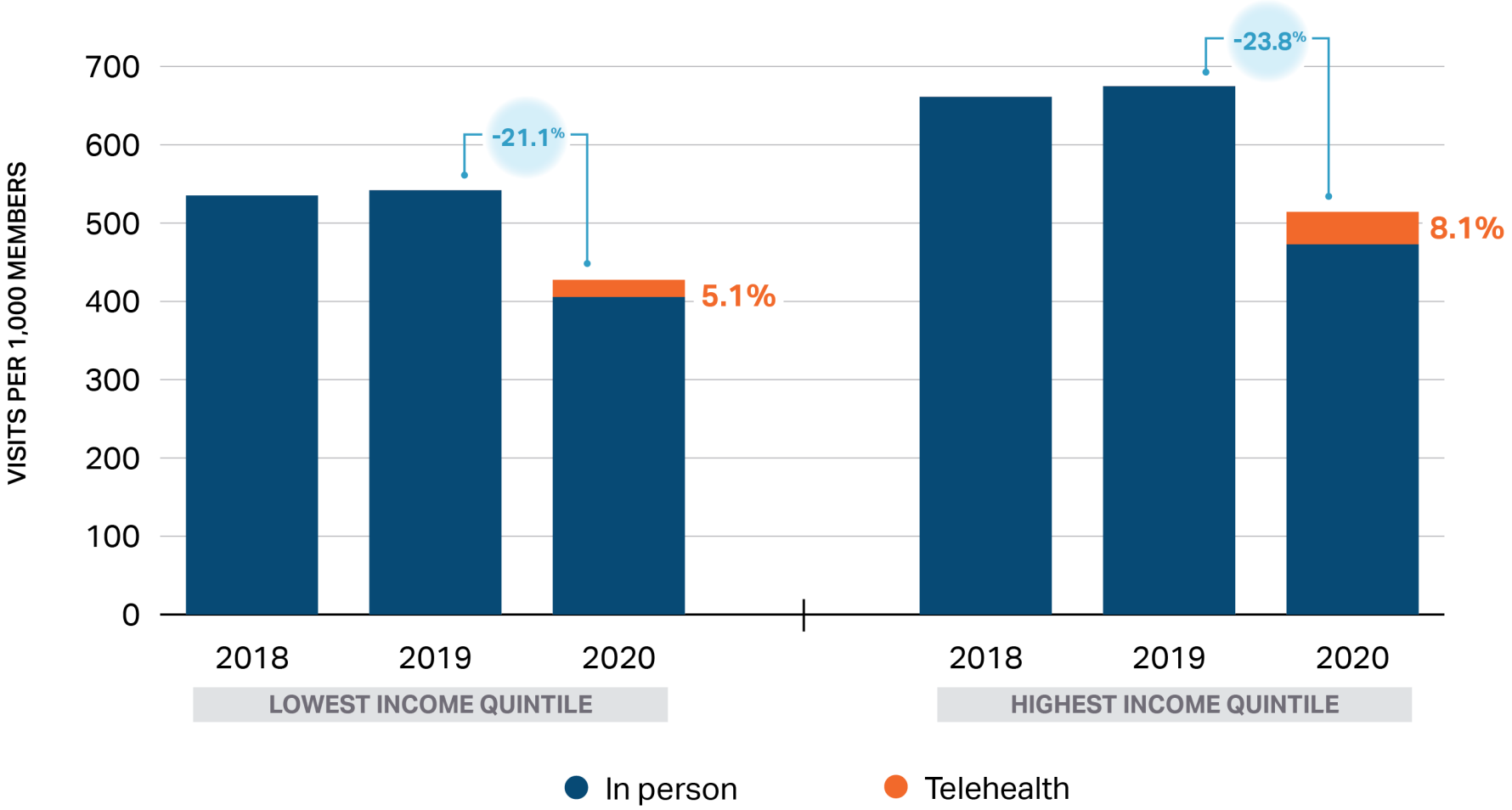
Commercially-insured adult residents without medical spending by community income decile, 2018 - 2020



Notes: Adults aged 18 – 64 with full year insurance coverage. COVID utilization is included. Income deciles were assigned based on average income of zip code. Values in boxes represent percentage point change from 2018 to 2020.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Overall, adult preventive visits decreased by 23.3% from 2019 to 2020, with a slightly greater decline for individuals in higher income communities.

Adult preventive visits by zip income with percent delivered by telehealth, 2018-2020

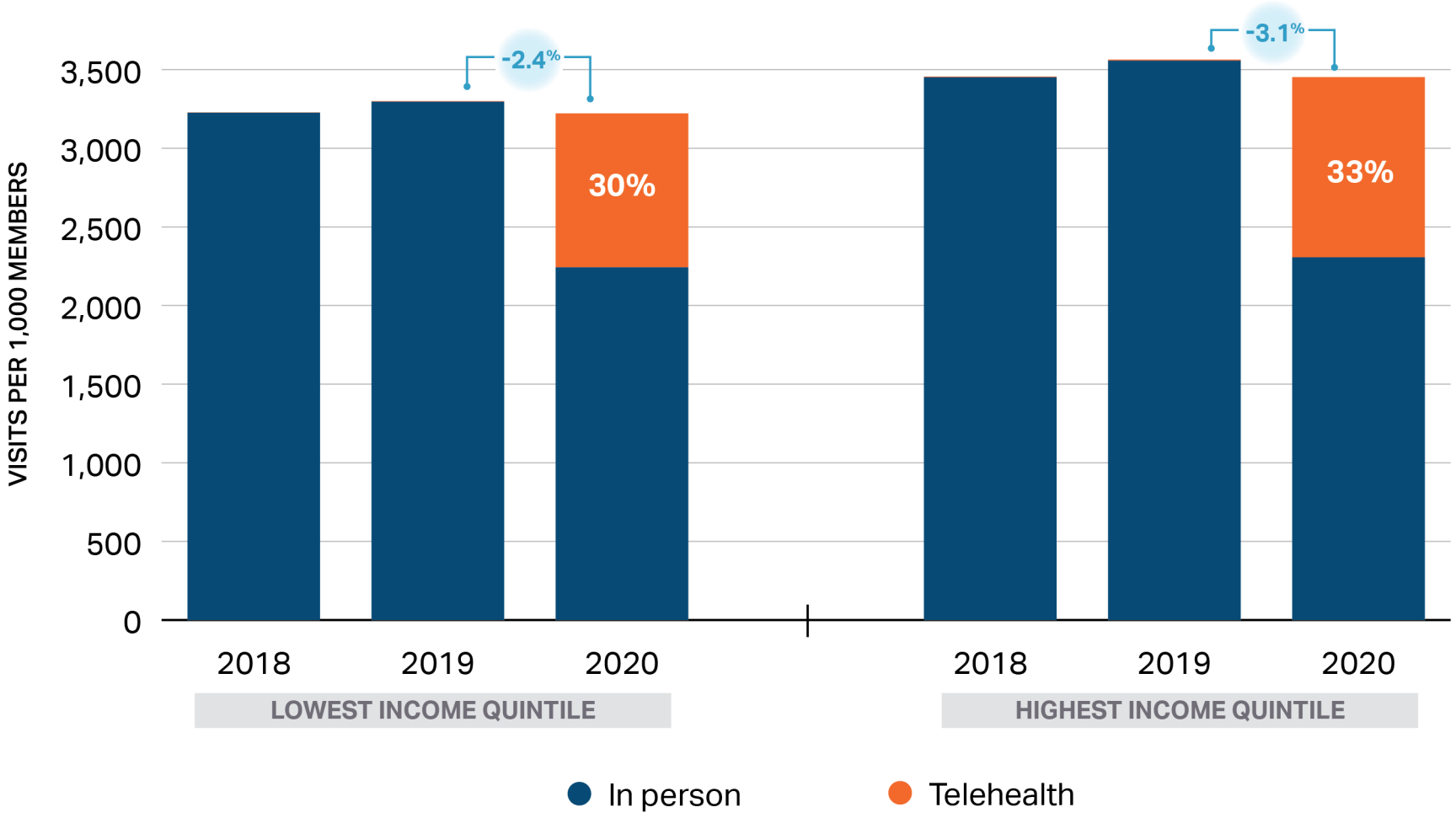


Notes: Adults aged 18 – 64 with full year insurance coverage. COVID utilization is included. Problem-based or "sick" visits included Current Procedural Terminology (CPT) codes 99201–99205; CPT 99211–99215. Adult preventive or "well" visits included CPT codes 99385–99386; CPT 99395–99396. Telehealth claims identified using professional claims site of service 02 and CPT code modifiers GT, 95, GQ, and G0.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Individuals residing in higher income areas had a slightly larger decrease, but still had more such visits than individuals in lower income areas and used telehealth for a greater proportion of their 2020 visits.

Adult problem-based visits decreased 3.5% overall and by a similar amount by area income. A slightly higher share of visits for those in higher income areas were delivered via telehealth.

Adult problem-based visits by zip income with percent delivered by telehealth, 2018-2020

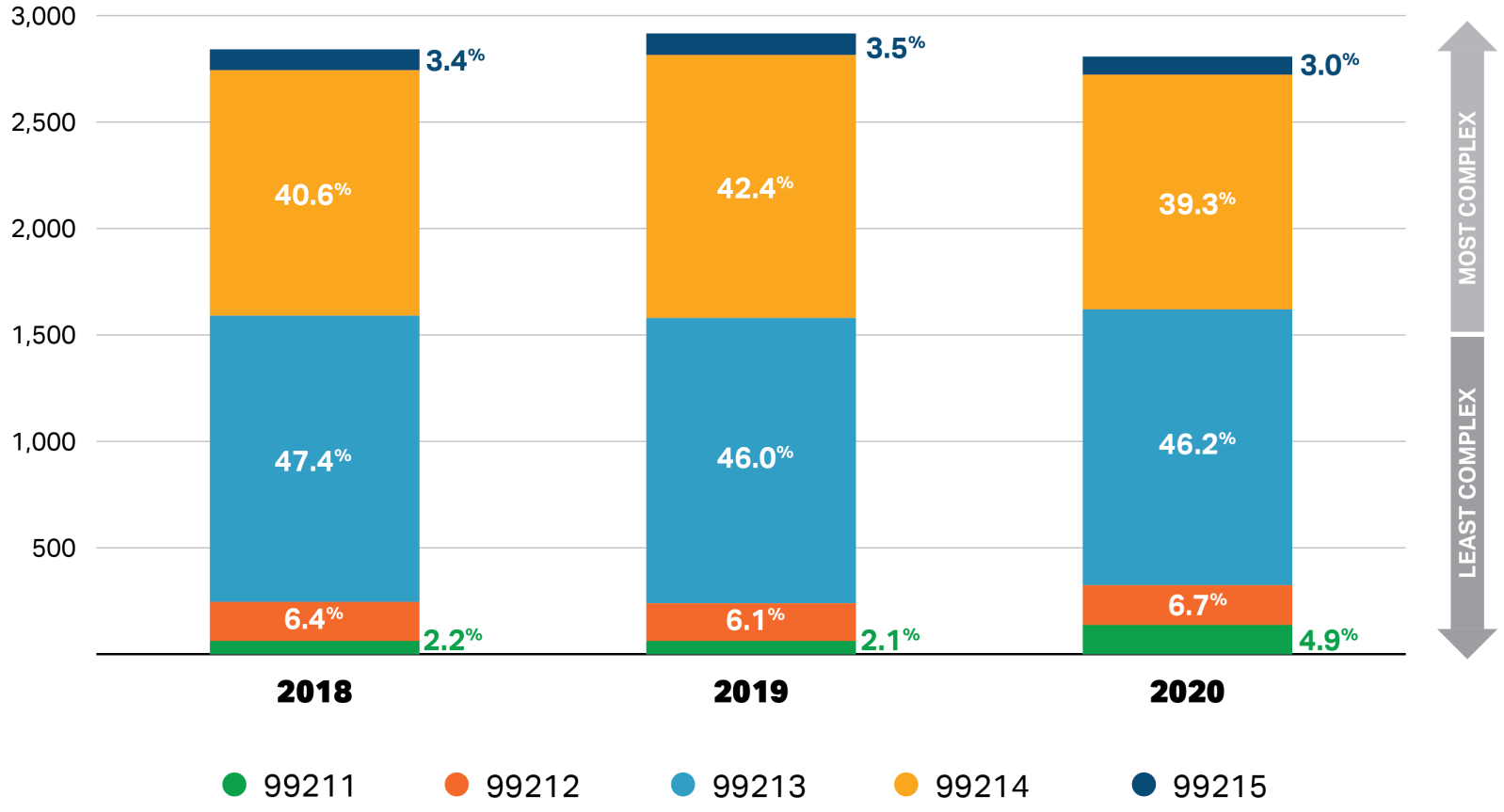


Notes: Adults aged 18 – 64 with full year insurance coverage. COVID utilization is included. Problem-based or "sick" visits included Current Procedural Terminology (CPT) codes 99201–99205; CPT 99211–99215. Adult preventive or "well" visits included CPT codes 99385–99386; CPT 99395–99396. Telehealth claims identified using professional claims site of service 02 and CPT code modifiers GT, 95, GQ, and G0
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Over 30% of problem-based visits were delivered by telehealth in 2020 with a slightly higher share among individuals living in higher-income areas.

Among problem-based visits, there was a shift toward shorter, less complex visits.

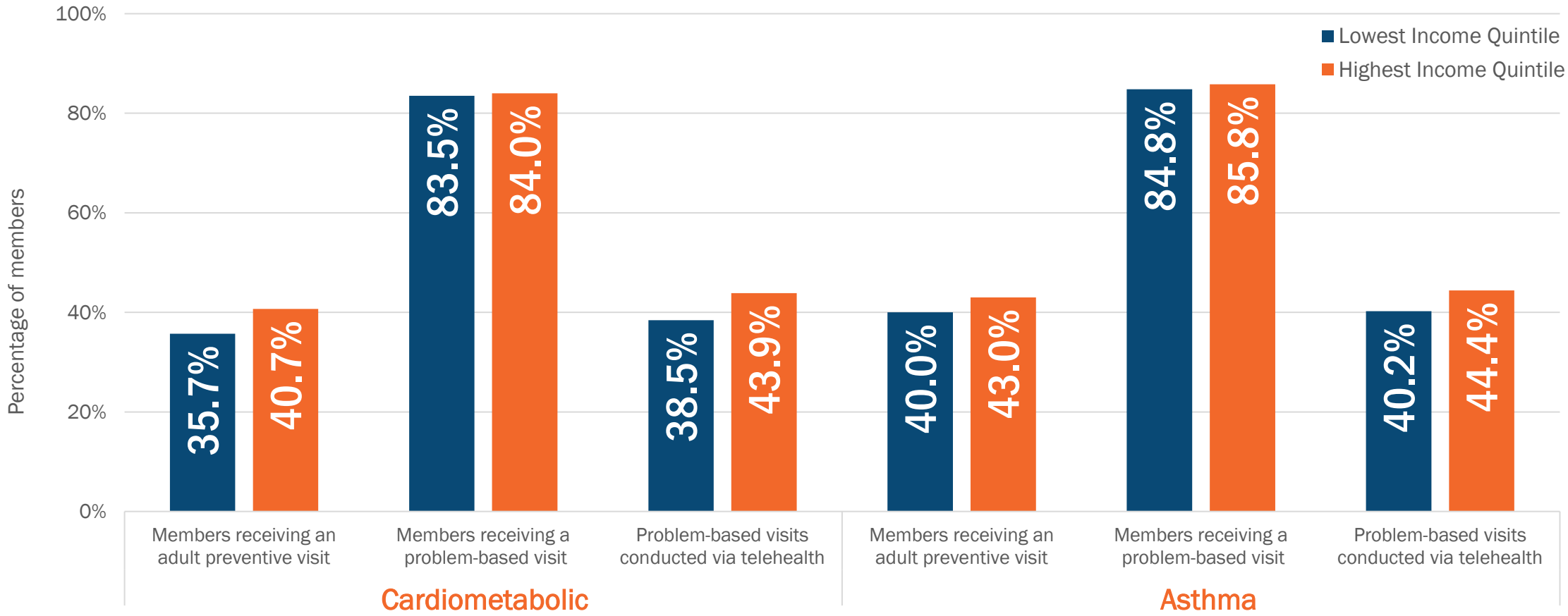
Problem-based visits by code type, established patients, 2019-2020



Notes: Adults aged 18 – 64 with full year insurance coverage. COVID utilization is included. Problem-based or "sick" visits included CPT codes 99201–99205; CPT 99211–99215. Adult preventive or "well" visits included CPT codes 99385–99386; CPT 99395–99396.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Residents with chronic conditions who lived in lower-income communities were less likely to have preventive visits and problem-visits via telehealth than residents in higher-income communities with similar health needs in 2020.

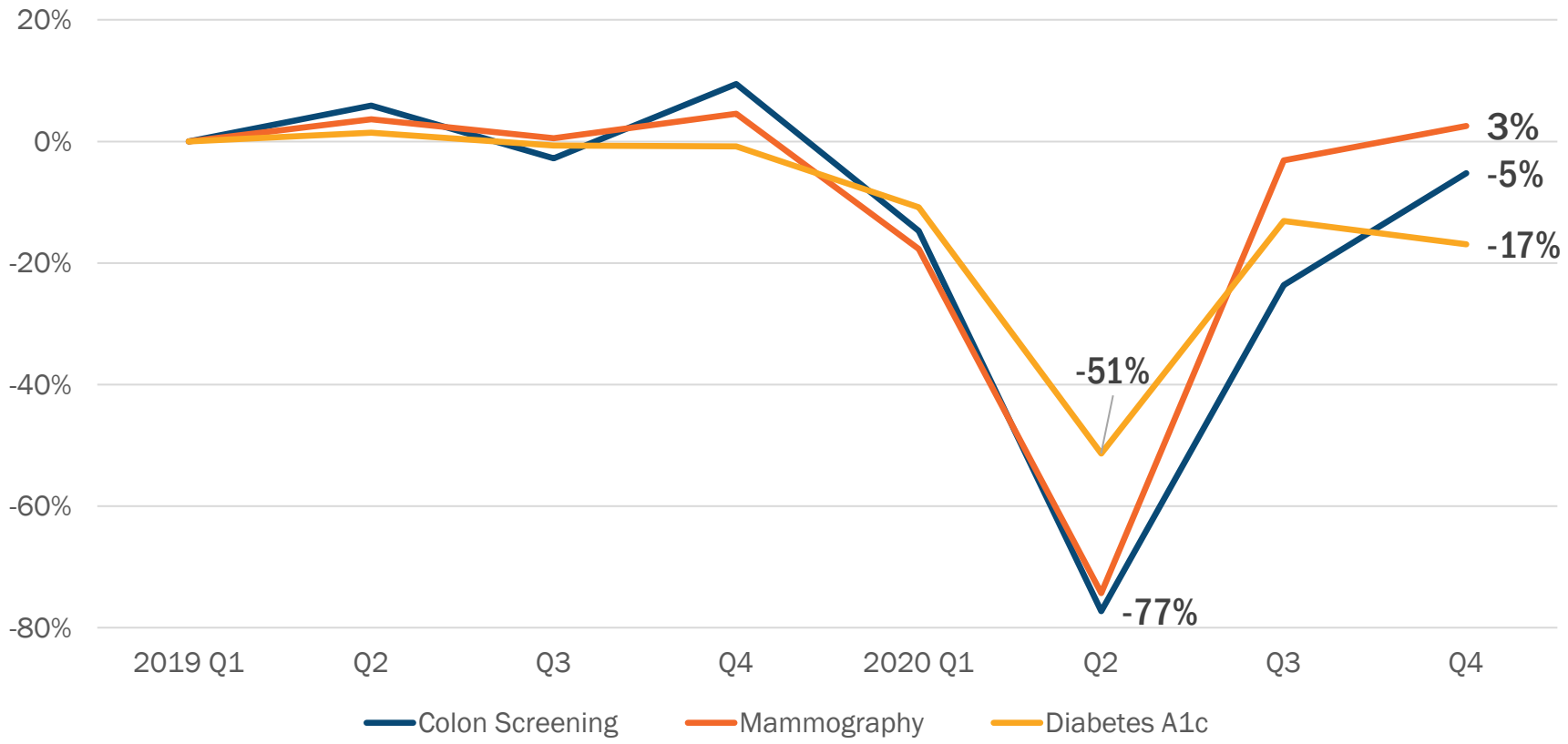
Percentage of individuals in each cohort receiving visits of the given types from March 15 to Dec 31, 2020, by zip-income quintile



Notes: Adults aged 18 – 64 with full year insurance coverage. COVID utilization is included. Income quintiles were assigned based on average income of zip code. Notes: Chronic conditions were identified using The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

The number of eligible members with any preventive care service encounter decreased 22% overall in 2020.

Percent change in eligible members each quarter with any select preventive service encounter, 2019-2020

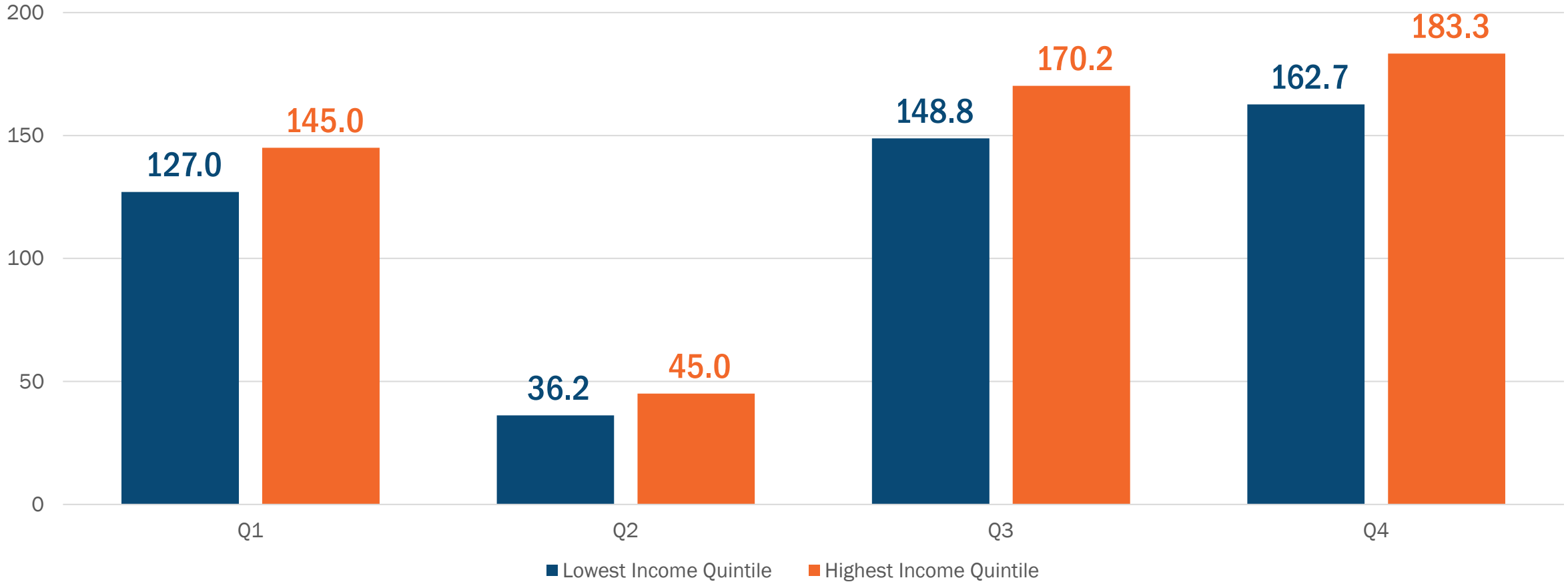


Notes: Mammogram screening is restricted to women between the ages of 45 and 64, using explicitly screening procedure codes and an algorithm developed to separate diagnostic services from ambiguous imaging codes based on Wernli et al., 2020's method. The diabetes A1c test flag was recorded for individuals with diabetes a diagnosis who received a diabetes A1c test. Colon cancer screening is a combined index of explicit screening colonoscopies and fecal occult blood tests. 45 was chosen as the cutoff for mammogram and colon cancer screenings based on American Cancer Society guidelines. Patients with diabetes were identified using The Johns Hopkins ACG® System © 1990, 2017, Johns Hopkins University. All Rights Reserved.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Diabetes A1c testing and Colon Cancer Screenings still had not reached 2019 levels by the end of 2020, but mammogram screenings did, suggesting 'catch-up' behavior.

Individuals in both low- and high-income areas resumed mammography screening in the latter half of 2020. However, the disparity in screening rates between the income groups increased somewhat between 2019 (13%) and 2020 (15%).

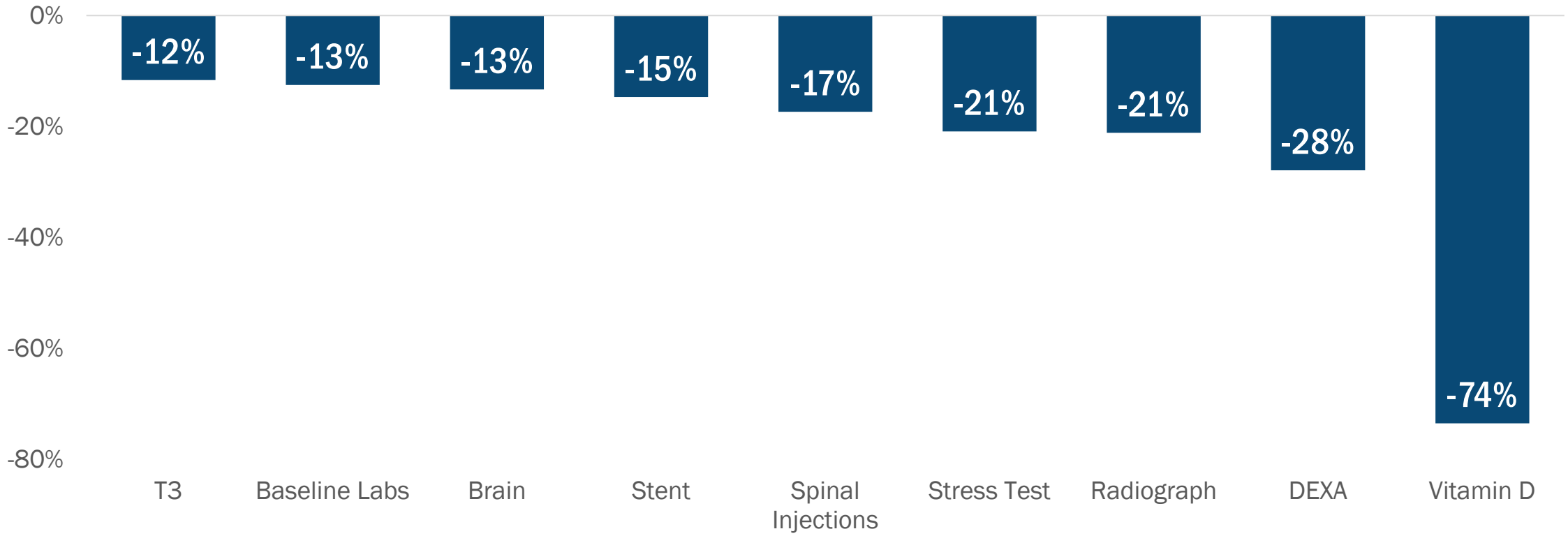
Rate of individuals with any mammography screening encounters per 1000 members by average income of residence and quarter, 2020



Notes: Mammogram screening is restricted to women between the ages of 45 and 64, using explicitly screening procedure codes and an algorithm developed to separate diagnostic services from ambiguous imaging codes based on Wernli et al., 2020's method. 45 was chosen as the cutoff for mammogram screenings based on American Cancer Society guidelines.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Utilization of low value care services decreased in 2020, ranging from a 12% reduction for T3 stress testing to 74% reduction for Vitamin D screening.

Change in Low Value Care Utilization per 100 attributed members, 2019 and 2020



Notes: T3 = Total or free T3 level measurement in a patient with a hypothyroidism diagnosis during the year; Stress = Stress testing for patients with an established diagnosis of ischemic heart disease or angina at least 6 month before the stress test, and thus not done for screening purposes; Vitamin D = Population based screening for 25-OH-Vitamin D deficiency. Baseline labs = Baseline labs in patients without significant systemic disease undergoing low-risk surgery; Chest radiograph = Chest radiographs occurring less than 30 days before a low or intermediate risk non-cardiothoracic surgical procedure (not associated with inpatient or emergency care). Brain imaging = low value CT and MRI brain imaging for simple syncope. DEXA scans = low value DEXA bone density scans. Only individuals who could be attributed to a provider organization were included in this analysis. For more information, please see 2021 Cost Trends Report Technical Appendix.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints: Urgent Care Utilization in Massachusetts

Health Care Cost Trends Report 2022: Impact of Covid-19 Pandemic on Ambulatory Care

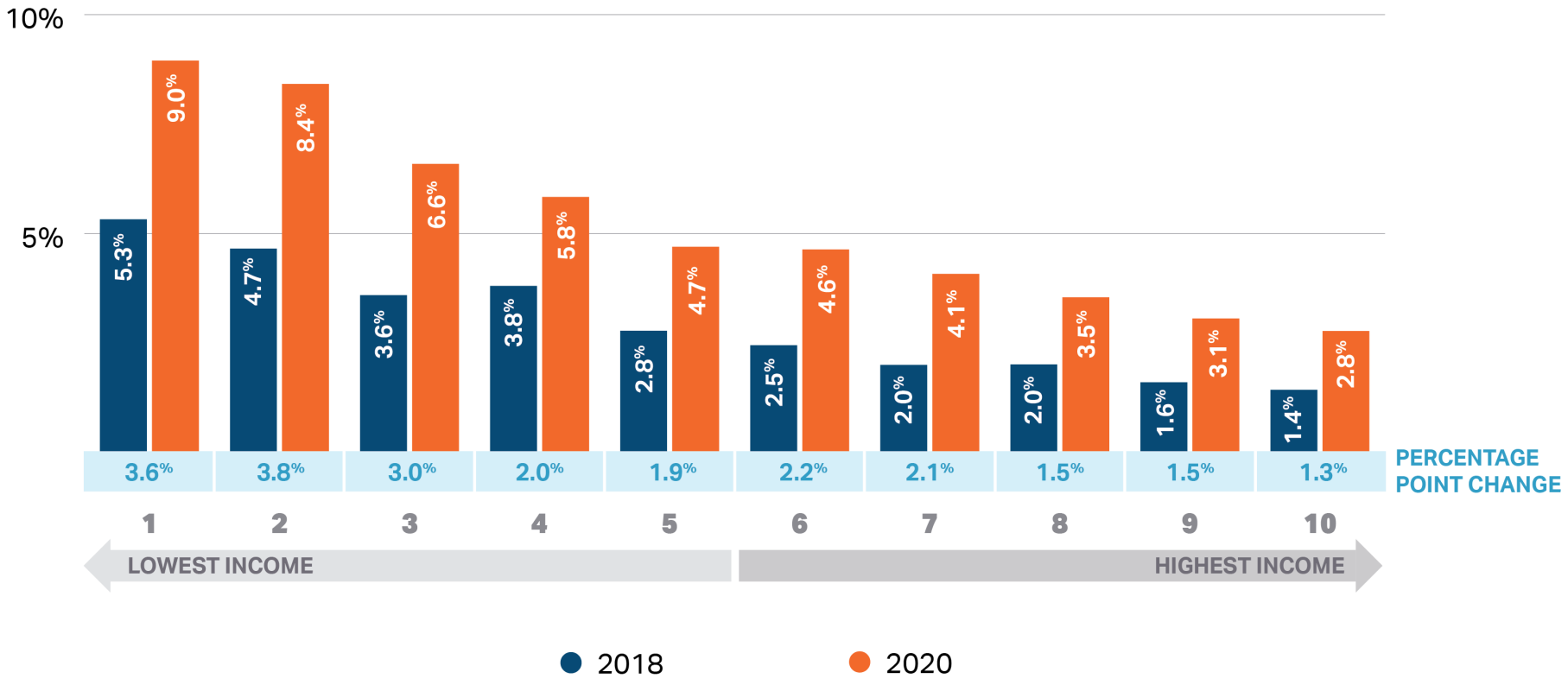
- Adult Ambulatory Care

PEDIATRIC AMBULATORY CARE

- Pediatric Mental Health

The share of Massachusetts children without medical spending nearly doubled from 2.5% in 2018 to 4.4% in 2020.

Commercially-insured pediatric residents without medical spending by community income decile, 2018-2020

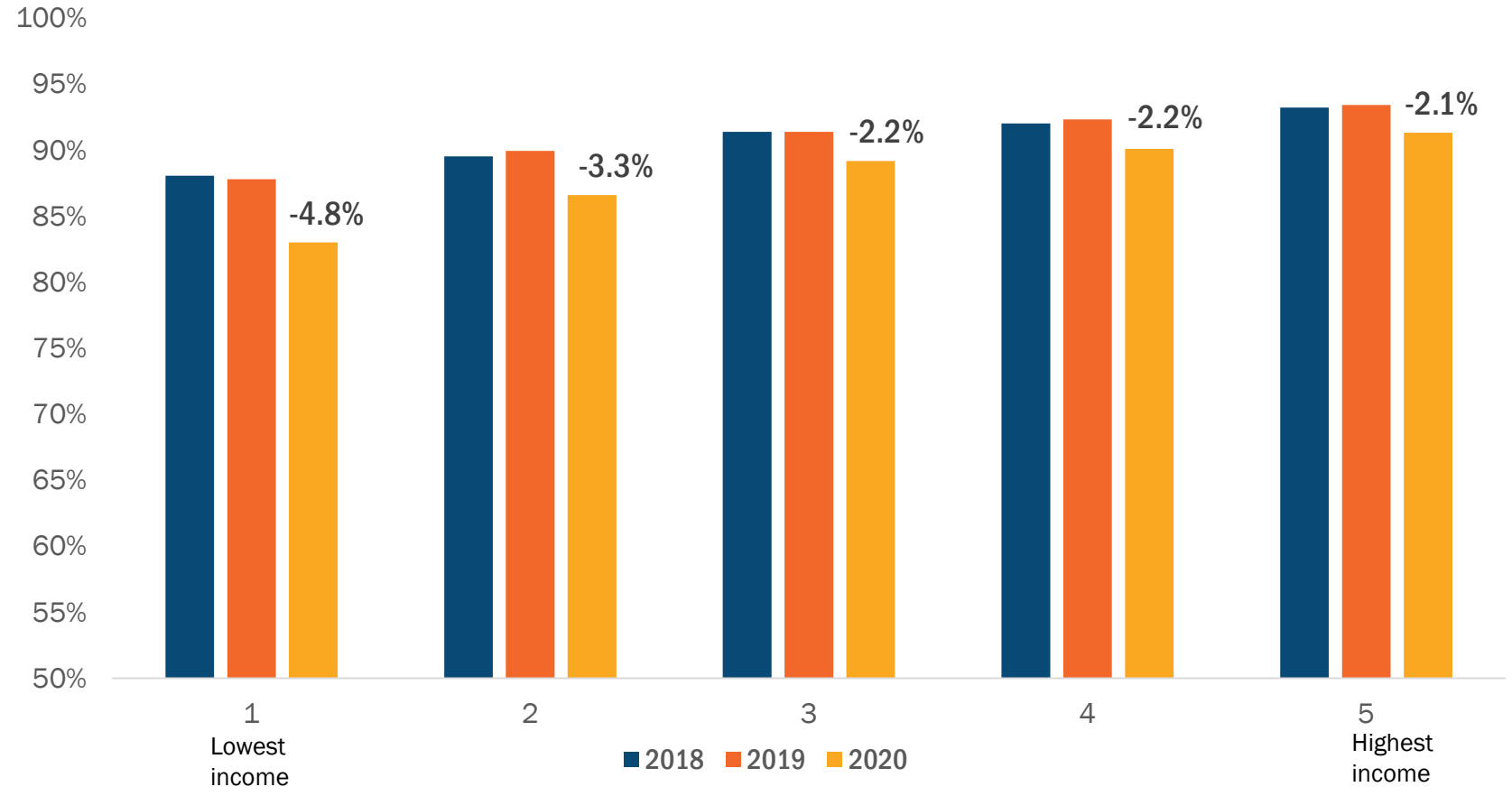


Differences across community income deciles were large and persisted in 2020.

Notes: Includes individuals ages 0-17 with 12 months of enrollment. COVID utilization is included. Income deciles were assigned based on average income of zip code. Values in boxes represent percentage point change from 2018 to 2020.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Overall rates of recommended pediatric preventive visit use remained relatively high, declining only 2.8 percentage points from 2019-2020.

Share of children with recommended preventive visit utilization by community income quintile, 2018-2020, with 2019-2020 percentage point change

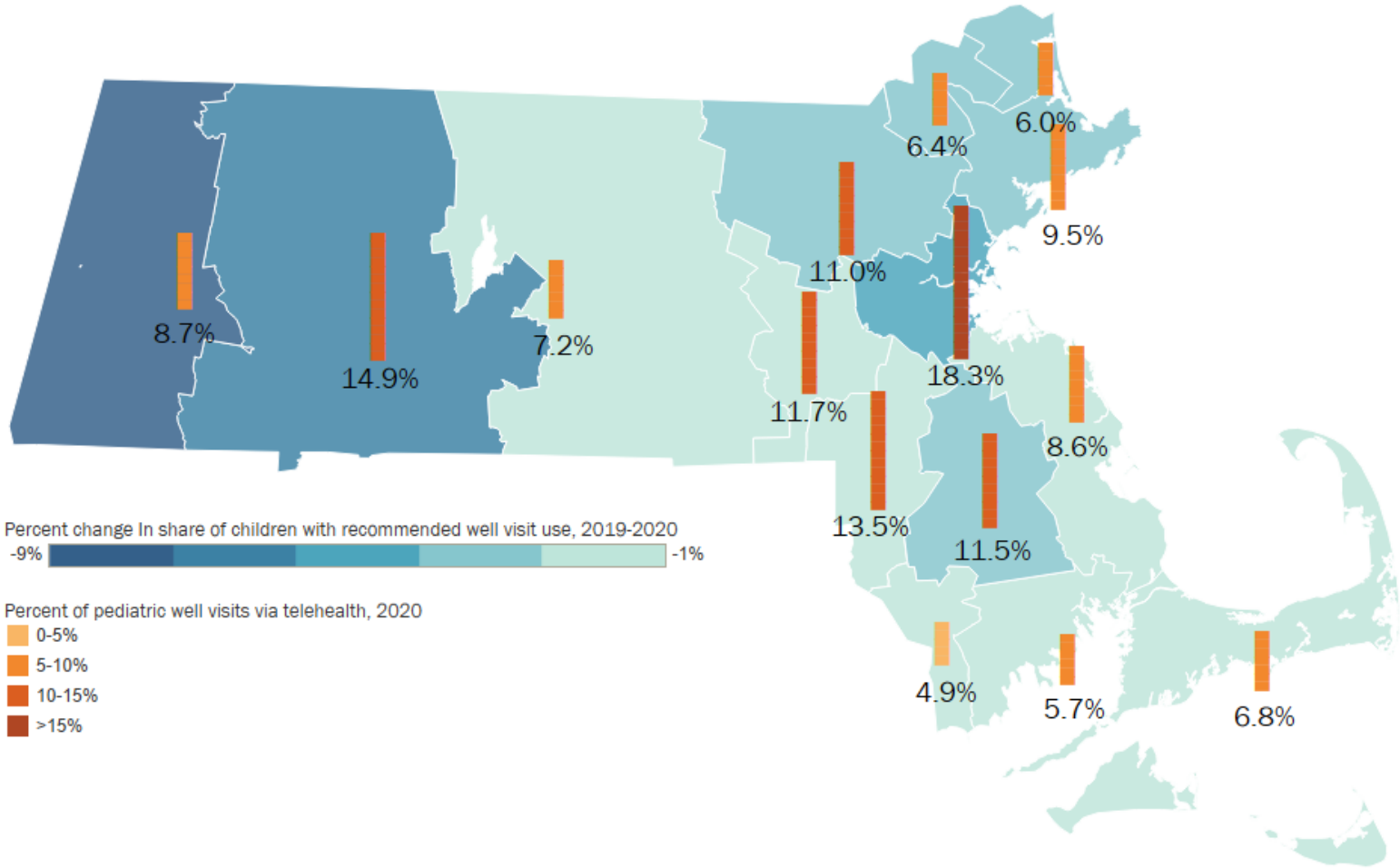


- Children living in low-income communities have consistently had the lowest rates of recommended preventive visit use and had the largest decline from 2019-2020.
- By age, teens were also more likely to lack recommended preventive visit use in 2020.

Notes: Includes individuals ages 0-17 with 12 months of enrollment and with any health care utilization. Children considered to have the recommended number of annual preventive visits varies by age: at least 4 visits for children under age 1, at least 3 visits for children age 1, and at least 1 visit for ages 2+. Preventive visits identified with Current Procedural Terminology(CPT) codes 99381-99384, 99391-99394, 99460-99464, 99441-99450, and 98966-98969. Income quintiles were assigned based on average income of zip code.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Children in the Berkshires had the steepest drop in recommended well-visit utilization (9.1%). Use of telehealth for these visits varied from 4.9% (Fall River) to 18.3% (Metro Boston) of all visits.

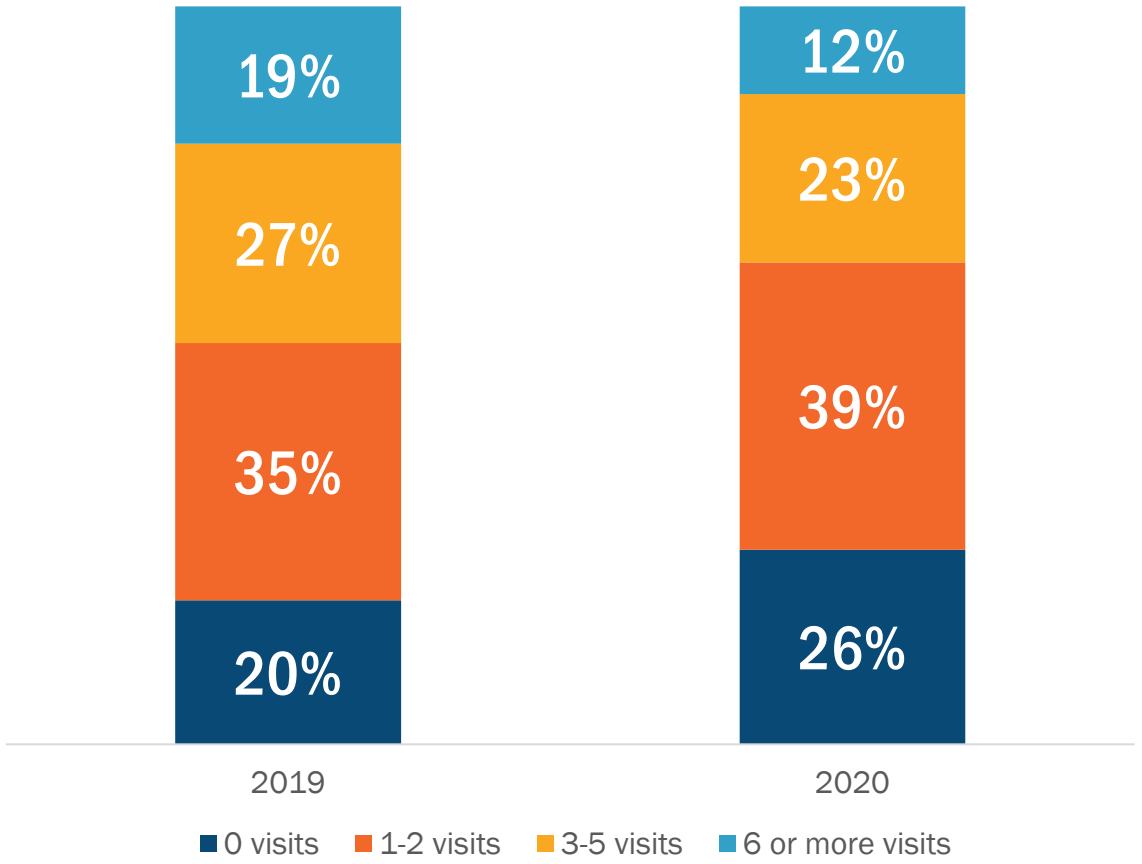
Percent change in the share of children ages 5 and older with recommended well visit utilization from 2019-2020 and share of 2020 pediatric well visits via telehealth by region



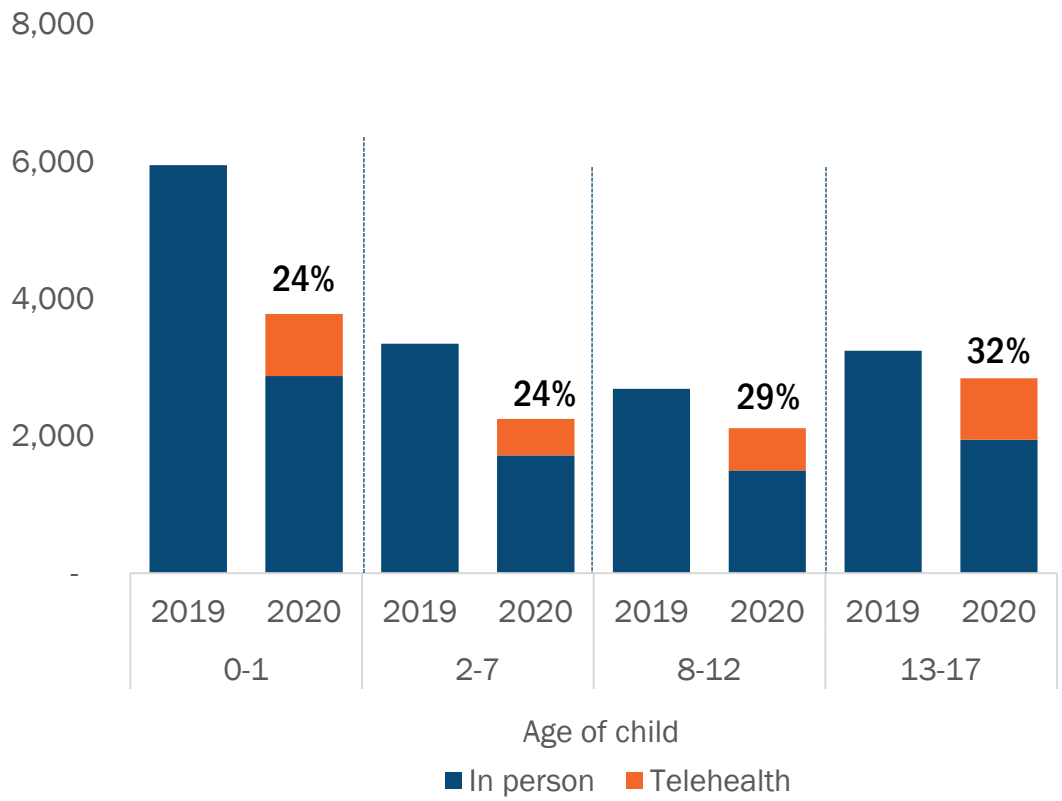
Notes: 'Includes individuals ages 5-17 with 12 months of enrollment and with any health care utilization. Children considered to have the recommended number of annual well visits varies by age: at least 4 visits for children under age 1, at least 3 visits for children age 1, and at least 1 visit for ages 2+. Preventive visits identified with Current Procedural Terminology (CPT) codes 99381-99384, 99391-99394, 99460-99464, 99441-99450, and 98966-98969. Telehealth claims identified using professional claims site of service 02, CPT codes G0406-G0408, G0425-G0427, G0508, G0509, G2010, G2012,G0071, Q3014, T1014, 98966-98972, 99358, 99359, 99421-99423, G2061-G2063, 99441-99444, and CPT code modifiers GT, 95, GQ, and G0.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Between 2019 and 2020, problem-based visits for children dropped 29.1%, driven by a decrease in the number of children with many visits during the year. Teens had the smallest drop in problem-based visits and the highest rates of telehealth use.

Share of children with different numbers of visits per year, 2019-2020



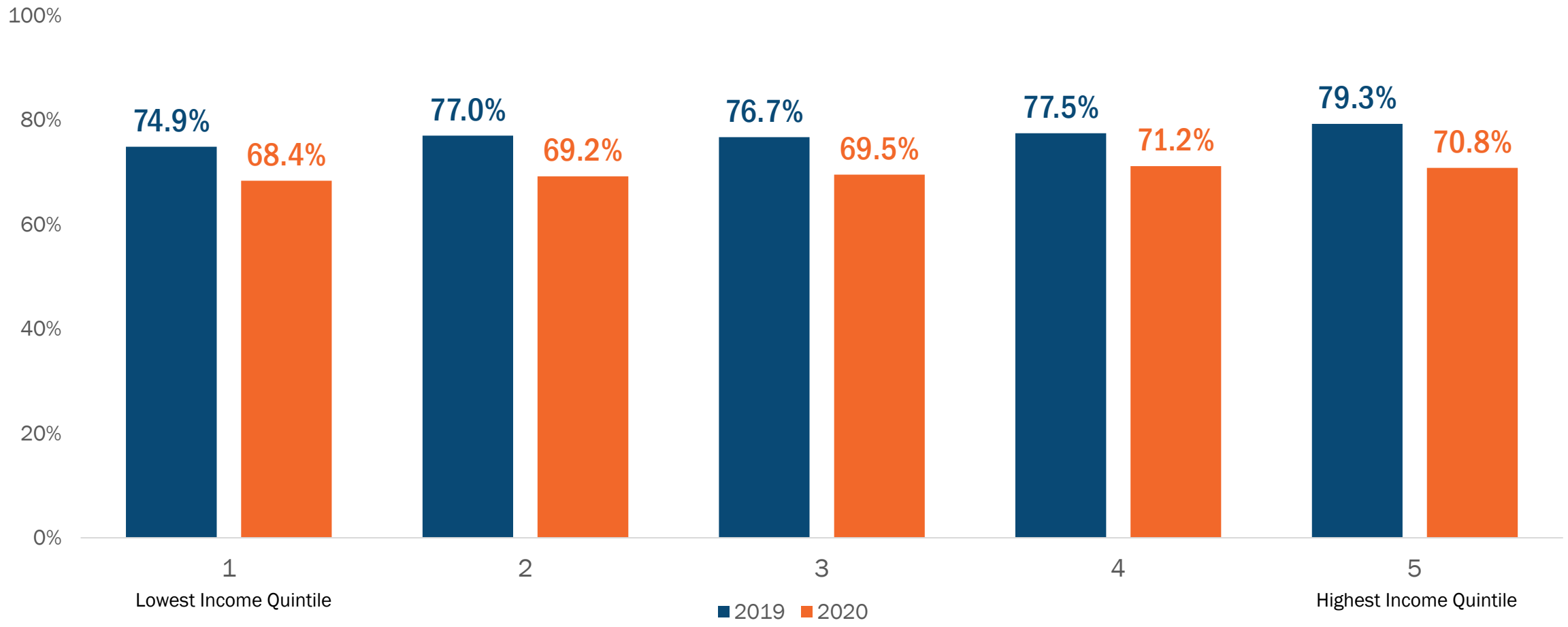
Problem-based visits per 1000 members that took place in-person and via telehealth, by age group, 2019-2020



Notes: Includes individuals ages 0-17 with 12 months of enrollment and with any health care utilization. <10 telehealth visits per 1000 members in 2019 omitted. Problem-based visits identified using Current Procedural Terminology (CPT) codes 99202-99215 and 99241-99245.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Children living in high income areas had a slightly greater decline in lead screenings in 2020 but were still more likely to have a screening than other children.

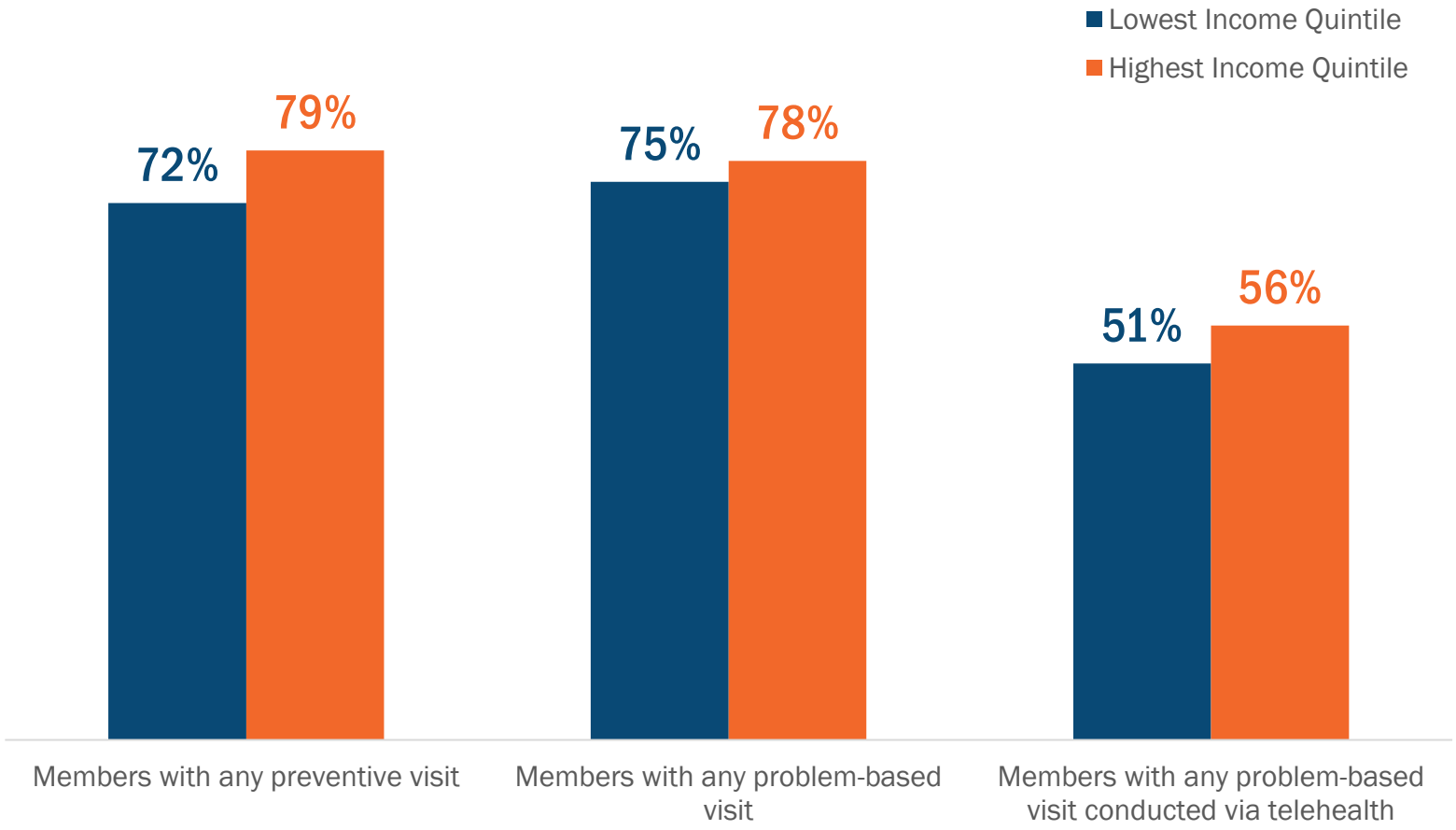
Share of children with any lead test screening by community income quintile and age, 2019-2020



Notes: Includes individuals ages 1-3 with 12 months of enrollment in 2019 and 2020. Lead test claims identified using CPT codes 83655. Income quintiles were assigned based on average income of zip code.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0 and Massachusetts Department of Public Health.

During the pandemic in 2020, children with chronic conditions who lived in higher-income areas were more likely to have preventive visits, problem-based visits, and to use telehealth than children living in lower-income areas.

Share of children living in low- and high-income communities with chronic conditions who had any preventive visits, any problem-based visits, and any problem-based visits via telehealth, March 15-December 31, 2020



Notes: Includes individuals ages 0-17 with 12 months of enrollment in 2019 and 2020. Chronic condition cohort defined as individuals with cancer, cardiovascular, diabetes, or epilepsy diagnoses as of 2019. Income quintiles were assigned based on average income of zip code. Preventive visits identified with Current Procedural Terminology (CPT) codes 99381-99384, 99391-99394, 99460-99464, 99441-99450, and 98966-98969. Problem-based visits identified using CPT codes 99202-99215 and 99241-99245.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints: Urgent Care Utilization in Massachusetts

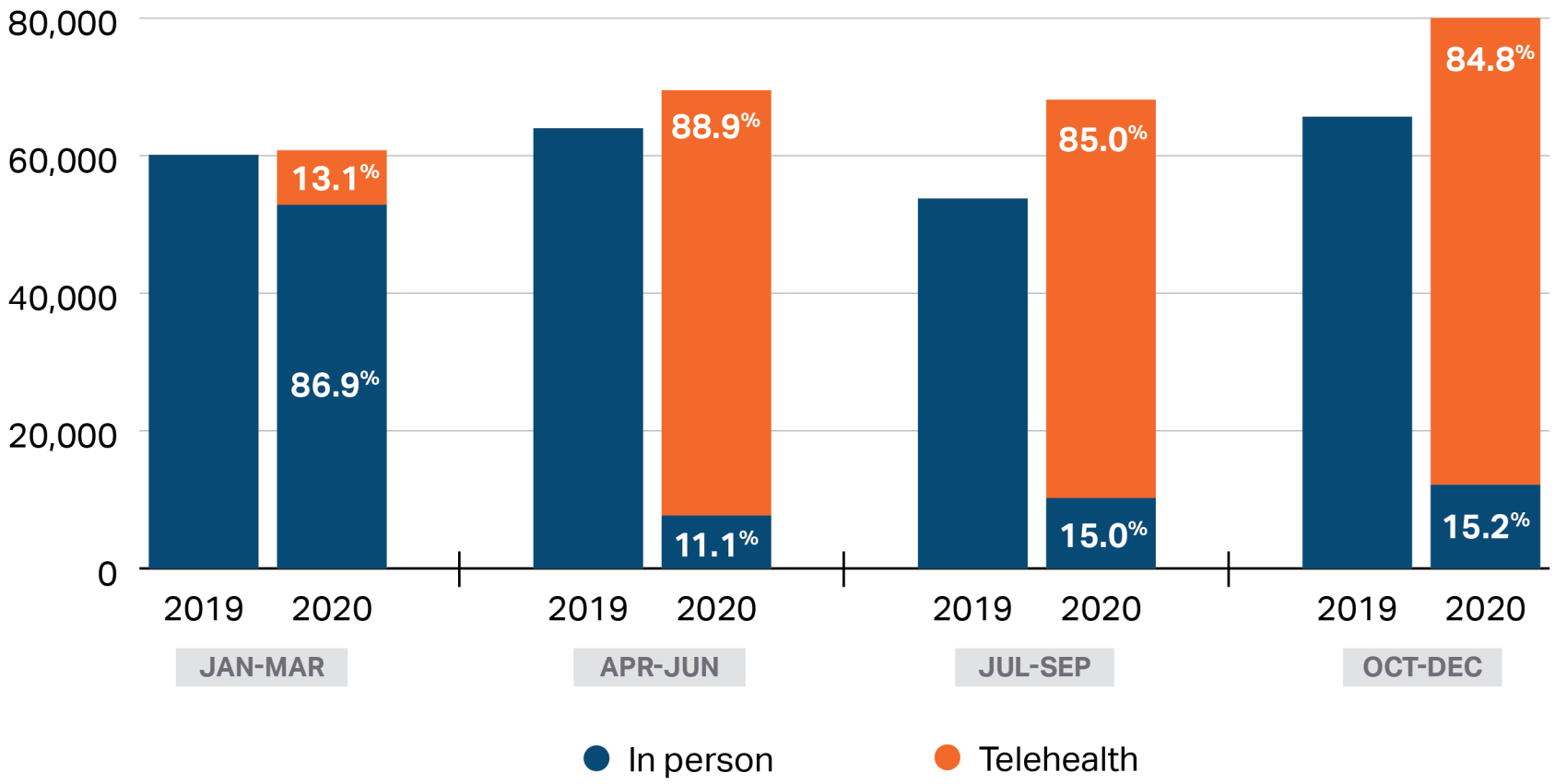
Health Care Cost Trends Report 2022: Impact of Covid-19 Pandemic on Ambulatory Care

- Adult Ambulatory Care
- Pediatric Ambulatory Care

PEDIATRIC MENTAL HEALTH

Pediatric therapy visit volume increased 23.5% for children aged 6-17 between 2019 and 2020; visits increased even in the spring of 2020.

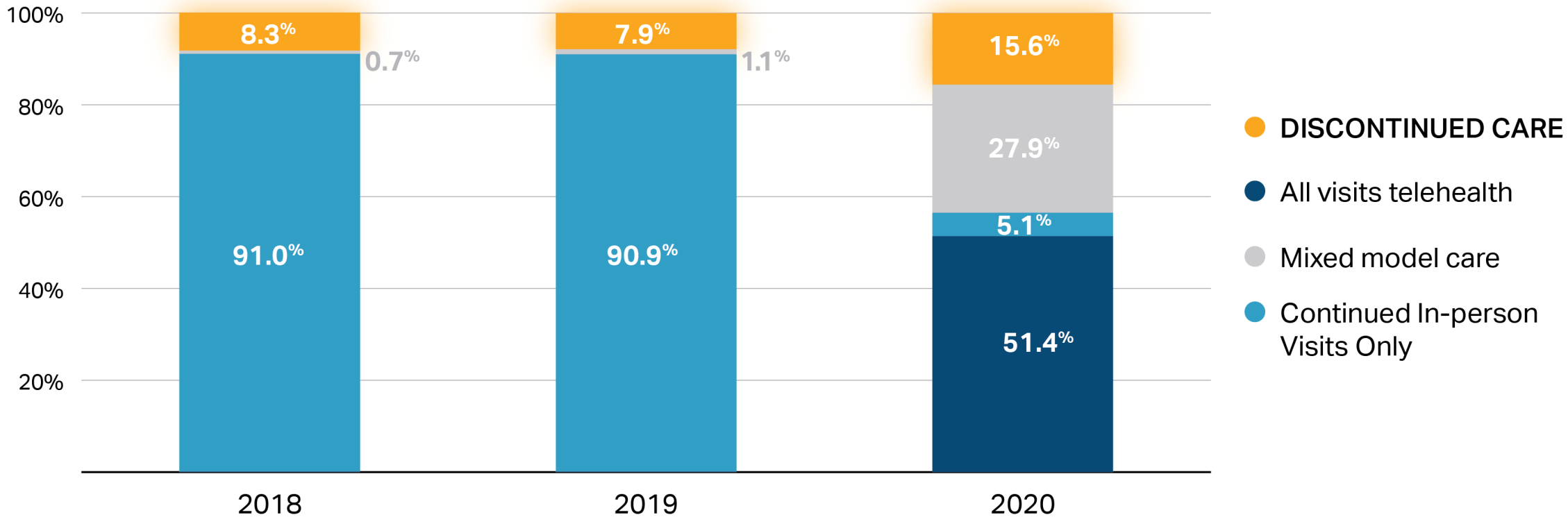
Total pediatric therapy visits in person and via telehealth by quarter and age group, 2019-2020



Notes: Includes individuals ages 6-17 with 12 months of enrollment in 2019 and 2020. Data labels for 2019 have been removed because Telehealth use omitted in 2019: telehealth represented <1% of therapy visits per age group per quarter. Telehealth claims identified using professional claims site of service 02, current Procedural Terminology (CPT) code modifiers GT, 95, GQ, and G0. Therapy claims identified using CPT codes 90832, 90833, 90834, 90836, 90837 and 90838.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

The share of children who discontinued therapy doubled in 2020 compared to prior years.

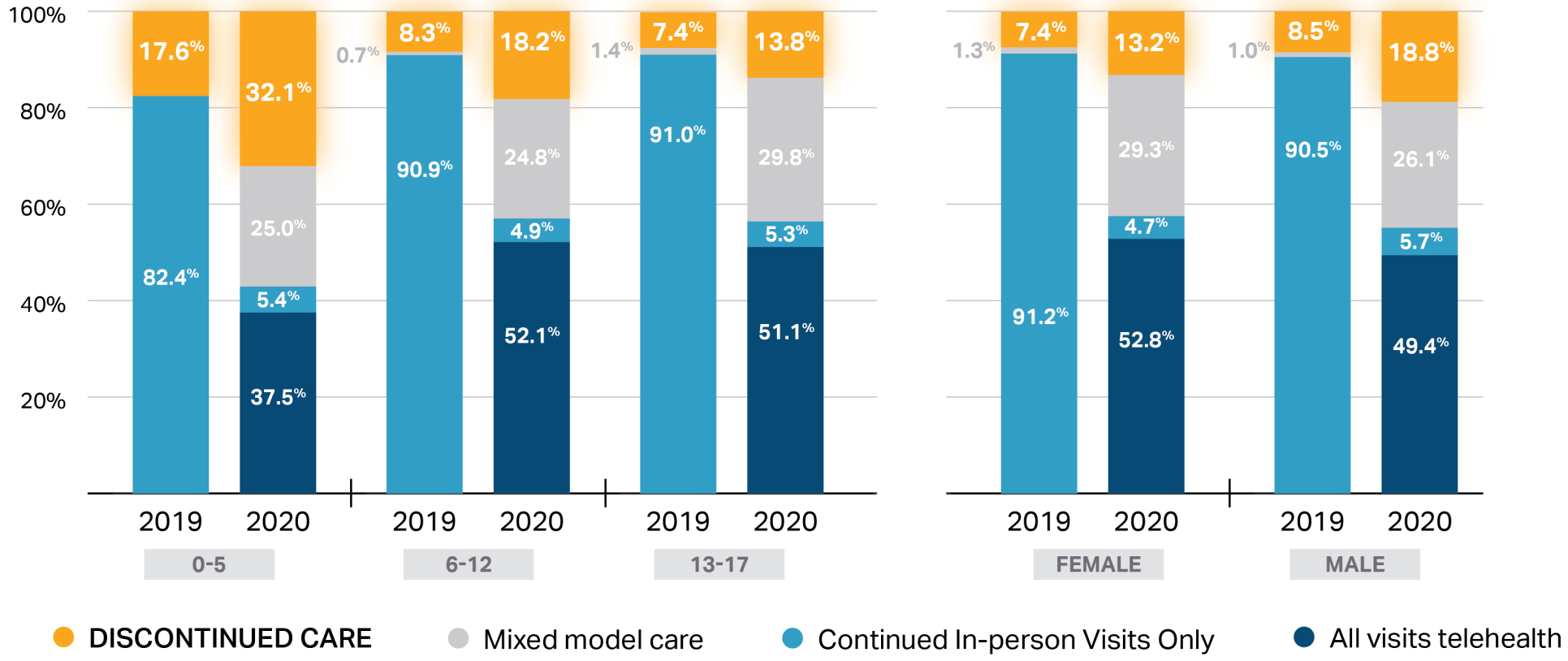
Continuation of care by mode for March 15 - December 31 each year for patients who had in-person therapy utilization in January-February of the same year, 2018-2020



Notes: Includes individuals ages 0-17 with 12 months of enrollment in 2018, 2019 and 2020. Telehealth claims identified using professional claims site of service 02, current Procedural Terminology (CPT) code modifiers GT, 95, GQ, and G0. Therapy claims identified using CPT codes 90832, 90833, 90834, 90836, 90837 and 90838. Behavioral Diagnosis codes F38, F54, F55, F61, F83, F92 were excluded and TX1491XA and TX1491XD were included. The cohort of patients with in-person therapy utilization in January-February of each year was identified by having at least 2 visits between January-February and at least one visit in February of that year.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

All children were more likely to discontinue therapy use in 2020 than 2019, but younger patients and boys were more likely to discontinue therapy utilization after the onset of the COVID-19 pandemic.

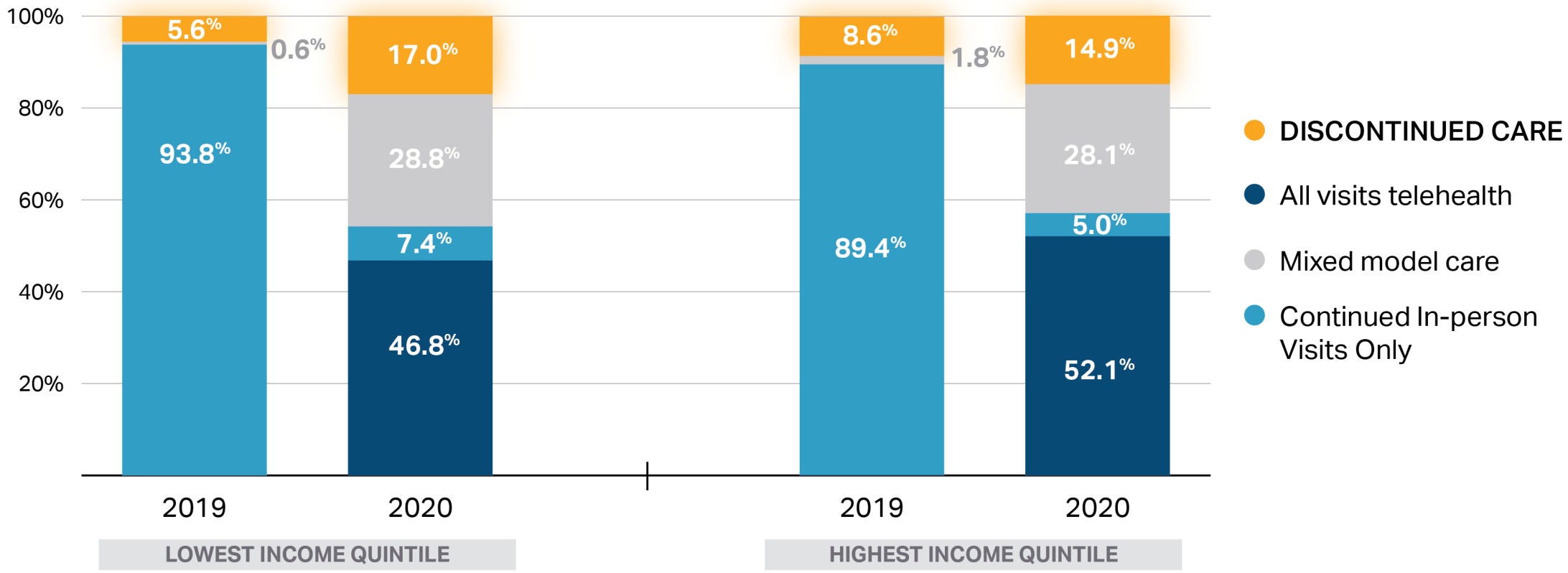
Use of telehealth versus in-person therapy March 15 - December 31 each year for patients who had in-person therapy utilization January-February by age groups and sex, 2019-2020



Notes: Includes individuals ages 0-17 with 12 months of enrollment in 2019 and 2020Telehealth claims identified using professional claims site of service 02, current Procedural Terminology (CPT) code modifiers GT, 95, GQ, and G0. Therapy claims identified using CPT codes 90832, 90833, 90834, 90836, 90837 and 90838. Behavioral Diagnosis codes F38, F54, F55, F61, F83, F92 were excluded and TX1491XA and TX1491XD were included. The cohort of patients with in-person therapy utilization in January-February of each year was identified by having at least 2 visits between January-February and at least one visit in February of that year.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Children living in lower-income communities were more likely to discontinue therapy during the pandemic.

Use of telehealth versus in-person therapy March 15 - December 31 each year for patients who had in-person therapy utilization January-February by income quintiles, 2019-2020



Notes: Includes individuals ages 0-17 with 12 months of enrollment in 2019 and 2020. Telehealth claims identified using professional claims site of service 02, current Procedural Terminology (CPT) code modifiers GT, 95, GQ, and G0. Therapy claims identified using CPT codes 90832, 90833, 90834, 90836, 90837 and 90838. Behavioral Diagnosis codes F38, F54, F55, F61, F83, F92 were excluded and TX1491XA and TX1491XD were included. The cohort of patients with in-person therapy utilization in January-February of each year was identified by having at least 2 visits between January-February and at least one visit in February of that year. Income quintiles were assigned based on average income of zip code.
Source: HPC analysis of Massachusetts All-Payer Claims Database 10.0

Conclusions

Overall, ambulatory care for commercially-insured members decreased in 2020. Low-value care services dropped more than office visits while behavioral health therapy visits for older children increased.

OVERALL CARE PATTERNS

- Adult office visits dropped 23% for preventive visits and 3.5% for problem-based visits. Problem-based visits for children dropped 29%.
  - Roughly 1/3 of problem visits were conducted via telehealth.
- **Mental health visits for children increased in 2020** (23.5% for those aged 6-17) in contrast to most other categories of care.
- Vitamin D screening dropped 74% while other low-value care services decreased between 12 and 28%.

Conclusions

Adult cancer screenings and A1c testing dropped 22% in 2020 altogether.

Disparities by community income in mammography screening, recommended pediatric well-visits and routine care for chronic conditions increased in 2020.

HIGH VALUE CARE

- **Cancer screenings and A1c testing for diabetics dropped 22% in 2020.**
  - Colon cancer screening and A1c testing were still below baseline levels by the last quarter of 2020 while mammography screening exceeded the 2019 baseline.
  - Disparities in mammography screening rates by community income level increased slightly in 2020.
- The percentage of children receiving recommended pediatric well-visits dropped by 2.8 percentage points in 2020.
  - **The drop was largest (4.8 percentage points) for children living in the lowest-income areas.**
  - Use of telehealth for these well-visits varied from 4.9% (Fall River) to 18% (Metro Boston).

Conclusions

Although overall mental health visits increased among children in 2020, twice as many children discontinued therapy altogether after the pandemic as in comparable periods in prior years.

Rates of discontinuation were greatest for youngest children (32%), males (19%) and children in lower-income communities (17%).

HIGH VALUE CARE (CONT'D)

- For both children and adults with chronic conditions, **those in higher income communities were more likely to receive routine care in 2020 and more likely to use telehealth** than those in lower-income communities.
  - For children, these disparities were greater in 2020 than 2019.
- **15.6% of children receiving mental health therapy early in 2020 discontinued such care after March 15, compared to 8% in prior years**.
  - Rates of discontinuation were greatest for youngest children (32%), males (19%) and children in lower-income communities (17%).
- Rates of lead-screening in children dropped roughly 6-8% for all community-income groups.

Schedule of Upcoming Meetings

BOARD

June 8

July 13

September 14

December 14

COMMITTEE

October 12

ADVISORY COUNCIL

June 22

September 21

December 7

SPECIAL EVENTS

November 2
Cost Trends Hearing

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