MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

April 14, 2021

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Welcome by HPC Chair Stuart Altman**
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- **Approval of Minutes from January 13, 2021 Meeting (VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on **January 13, 2021** as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- **Election of Vice Chair (VOTE)**
- Market Oversight and Transparency
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Electing Vice Chair

Motion: That, pursuant to Section 2.3 of the By-Laws, the Commission hereby appoints _____ to serve as Vice Chairperson of the Health Policy Commission.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- **Market Oversight and Transparency**
  - 2022 Health Care Cost Growth Benchmark **(VOTE)**
  - Market Transactions
  - Impact of COVID-19 on the Massachusetts Health Care System: Interim Report
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

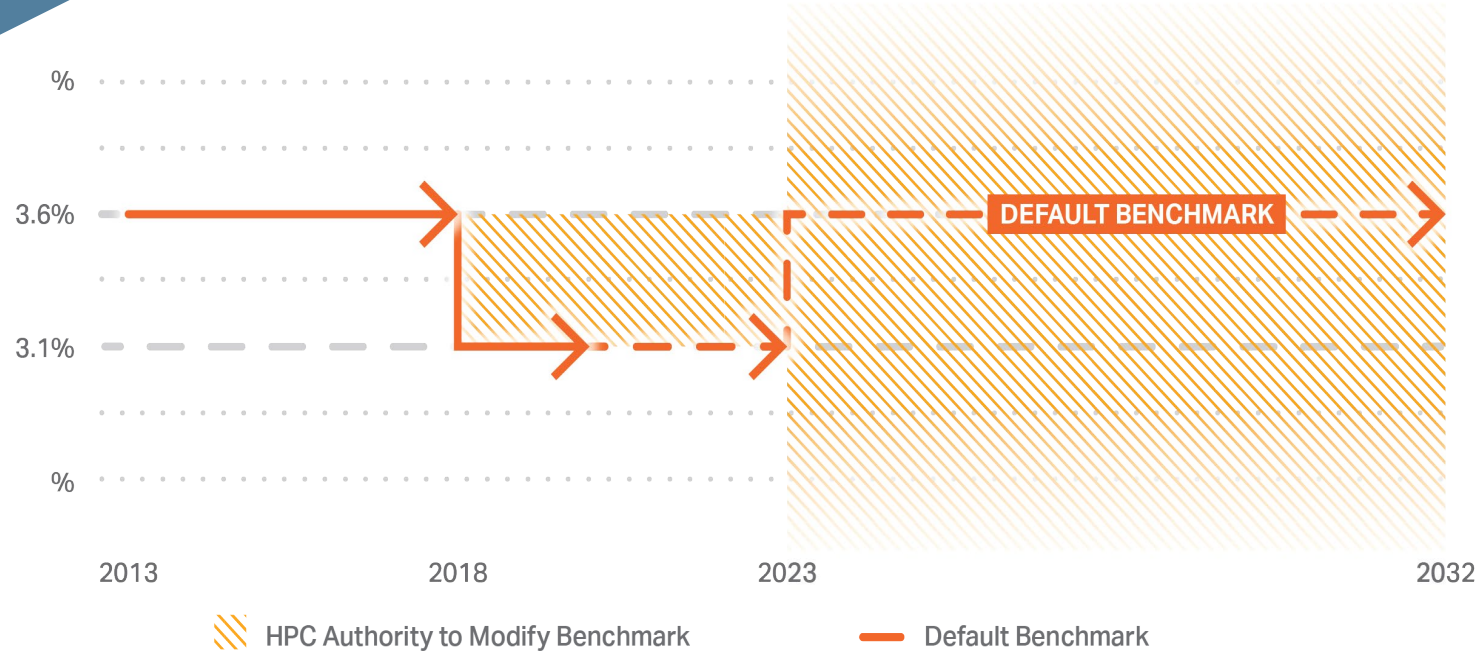
MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
  - **2022 Health Care Cost Growth Benchmark (VOTE)**
  - Market Transactions
  - Impact of COVID-19 on the Massachusetts Health Care System: Interim Report
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

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

YEARS	
1–5	Benchmark established by law at PGSP (3.6%)
6–10	Benchmark established by law at a default rate of at PGSP minus 0.5% (3.1%); the HPC can modify the benchmark up to 3.6%, subject to legislative review.
10–20	Benchmark established by law at a default rate of PGSP; the HPC can modify to any amount, subject to legislative review.



HPC

Benchmark Modification Process: 2021 Timeline

January 15, 2021

3.1% PGSP established in consensus revenue process

March 25, 2021

Public hearing of HPC Board and Joint Committee on potential modification of benchmark

April 14, 2021

Board votes whether to modify benchmark; if Board votes to modify, it submits notice of intent to modify to Joint Committee on Health Care Financing

April 15, 2021

Statutory deadline for Board to set benchmark

April/May 2021

Joint Committee holds a hearing within 30 days of notice

May/June 2021

Joint Committee reports findings and recommended legislation to General Court within 30 days of hearing; Legislature has 45 days from hearing to enact legislation which may establish benchmark; if no legislation is enacted, the Board's vote to modify takes effect

HPC

Key Takeaways from the Benchmark Hearing

1. Massachusetts total health care expenditures (THCE) per capita **grew 4.3% from 2018 to 2019**, above the health care cost growth benchmark.

2. The **majority of organizations testifying at the hearing supported the 3.1% benchmark**. The remainder did not specify a position.

3. **Inpatient and outpatient spending**, **pharmaceutical costs**, and **delivery of care in high-cost settings** were identified as key drivers of spending to watch. Testifiers also expressed concerns about continued COVID-19 impacts, especially disruptions in care, vaccine administration costs, and operational costs (e.g., PPE).

4. Community hospital testifiers expressed support for applying a health equity lens to the benchmark, citing longstanding price variation and inadequate reimbursement for high public payer hospitals serving the most impoverished and vulnerable populations.

5. Employers emphasized the **need to address significant affordability challenges**, including continued premium and cost sharing growth, and consumers additionally testified about deferred care and racial disparities.

Summary of Testimony

Organization	Position
Association for Behavioral Healthcare	Not specified
Atrius Health	3.1%
Blue Cross Blue Shield of MA	3.1%
Conference of Boston Teaching Hospitals	Not specified
Health Care For All	3.1%
Howard D. Trachtman, Certified Peer Specialist	Not specified
Ms. Lauren Omartian	Not specified
Lawrence General Hospital	Objected to 3.1%
Massachusetts Association of Health Plans	3.1%
Massachusetts Health and Hospital Association	3.1%
Mental Health Legal Advisors Committee	Not specified
National Federation of Independent Business	Not specified
Retailers Association of Massachusetts	3.1%
Signature Healthcare	Objected to 3.1%
Thomas Brown, Certified Peer Specialist	Not specified

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: 2022 Health Care Cost Growth Benchmark

MOTION: That, pursuant to G.L. c. 6D, § 9 (c), the Commission hereby establishes the health care cost benchmark for calendar year 2022 as _____, subject to the further process set forth in G.L. c. 6D, § 9 (d).

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
  - 2022 Health Care Cost Growth Benchmark **(VOTE)**
  - **Market Transactions**
    - Notices of Material Change
    - Mass General Brigham Determination of Need Applications
  - Impact of COVID-19 on the Massachusetts Health Care System: Interim Report
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
  - 2022 Health Care Cost Growth Benchmark **(VOTE)**
  - Market Transactions
    - **Notices of Material Change**
    - Mass General Brigham Determination of Need Applications
  - Impact of COVID-19 on the Massachusetts Health Care System: Interim Report
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

Types of Transactions Noticed

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	28	23%
Physician group merger, acquisition, or network affiliation	26	21%
Acute hospital merger, acquisition, or network affiliation	24	20%
Clinical affiliation	23	19%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	16	13%
Change in ownership or merger of corporately affiliated entities	5	4%
Affiliation between a provider and a carrier	1	1%

Notices Currently Under Review

- A proposed joint venture between **Shields Health Care Group** and **Heywood Healthcare**, an independent healthcare system serving north central Massachusetts and southern New Hampshire, to own and operate a DPH-licensed clinic for the provision of PET/CT and MRI services to Heywood patients.

- A proposal by **Ophthalmic Consultants of Boston**, a sub-specialty ophthalmic practice of 35 ophthalmologists with 10 practice sites throughout Eastern Massachusetts, to acquire **Eye Health Services**, a sub-specialty ophthalmic practice of 20 ophthalmologists with nine practice sites, also throughout Eastern Massachusetts.

- A proposal by **Collaborative Care Holdings** (CCH), a subsidiary of UnitedHealth Group's OptumCare business, to acquire the non-clinical assets of **Atrius Health** (Atrius). Atrius is the largest physician-led provider organization in the Commonwealth with approximately 1000 employed clinicians and 30 medical practice locations across Massachusetts. CCH, through OptumCare, provides a variety of services and data analytics to over 53,000 physicians nationwide, including Reliant Medical Group in Massachusetts.

Elected Not to Proceed

- A proposed acquisition of Providence Behavioral Health Hospital, the behavioral health campus of **Mercy Medical Center**, by three limited liability companies which plan to operate the facility under the name **MiraVista Behavioral Health**. The purchasers are a group of affiliated, newly formed entities comprised of a clinical management from Health Partners of New England and a real estate developer and investor, GFI partners, which currently operate TaraVista Behavioral Health Center in Devens.

- A proposal by **National Mentor Healthcare**, a health and human services provider operating in 44 states, to acquire two behavioral health provider organizations owned by **Community Intervention Services**: South Bay Community Services (South Bay) and Futures Behavioral Therapy Center (Futures). South Bay is a community-based behavioral health services and LTSS provider; Futures provides treatment to children and adolescents with autism spectrum disorders.

- The proposed acquisition of **Harrington Health Care System** by **UMass Memorial Health Care**.

Proposed Transaction

UMass Memorial Health Care (UMass) proposes to acquire **Harrington HealthCare System (Harrington).**

The Harrington HealthCare system is a small system (**$170M** in total operating revenue in FY19) in South Central Massachusetts consisting of:

- **Harrington Memorial Hospital**, a community high public payer acute care hospital (119 beds);
- A multispecialty group (more than 60 physicians), **Harrington Physician Services (HPS)**; and
- 50% ownership interest in **Harrington HealthCare Provider Organization (HHPO)** (more than 90 physicians, including HPS physicians).

UMass Memorial Health Care, Inc. is the largest health care system in Central Massachusetts with **$2.8B** in total operating revenue in FY19.

- UMass includes three hospitals, including one academic medical center and two community high public payer hospitals
- Many UMass physicians are members of UMass Memorial Medical Group, a multispecialty group medical practice with over **1,100 physicians** and practices in Worcester and Central MA.

UMass and Harrington already have a number of contracting and clinical affiliations, and UMass contracts on behalf of HHPO with most commercial payers

A preliminary examination found some scope for cost and market impacts, but also mitigating factors.

The transaction would substantially increase inpatient market concentration in Harrington's already highly concentrated inpatient primary service area (PSA).

- HHI levels are already quite high in Harrington's PSA, likely due to Harrington being somewhat geographically isolated.
- UMass is the closest AMC and already provides a significant share of services to residents of Harrington's PSA.
- As a result, HHI changes in Harrington's PSA are well above the FTC thresholds for concerns about competitive effects.

However, the impacts on bargaining leverage are likely to be small.

- Harrington Memorial Hospital's size combined with its small commercial payer mix (**12.8%**) limits the likely impact of the transaction on bargaining leverage in the commercial market for hospital services.
- UMass already contracts for physician rates on behalf of most Harrington physicians, so little change to the physician market is expected as a result of the transaction.

The same factors that lead UMass to have a high market share in Harrington's service area (extensive clinical and contracting relationships with Harrington providers and being the AMC most frequently utilized by Harrington patients) also make UMass a promising partner for Harrington.

A preliminary examination found some scope for cost and market impacts, but also mitigating factors.

Spending for some, but not most, payers could increase if Harrington prices rose to match UMass community hospital rates.

- For most of the major payers, for most services, Harrington's prices are already at or above the prices of UMass's community hospitals. However, the UMass hospitals appear to generally receive higher rates than Harrington in the Fallon network, and slightly higher rates for some services in a few other payer networks.
  - If Harrington's commercial prices across the major payers increased to those of UMass's highest-priced community hospital, annual spending could increase.
  - The likelihood and scope of such impact is unclear. UMass has not historically sought to equalize rates across its hospitals. Fallon also represents the vast majority of existing commercial price differentials, but Fallon recently announced plans to exit the commercial market.

Site of care shifts are unlikely to result in significant costs or savings

- Patients in Harrington's service area already use Harrington Hospital at a high rate for community appropriate care. Additional shifts in care from UMass to Harrington would result in savings, but the likely volume (and scope of savings) is small.
- Patients in Harrington's service area already use UMass at a high rate for higher acuity care. Additional shifts in higher acuity care from other regional hospitals (e.g. Baystate) to UMass would increase spending, but the likely volume (and scope of spending increases) is small.

The parties made several commitments to maintain and potentially enhance access in Harrington's service area, including:

- For example, UMass has committed to **retain certain Harrington services lines for at least 5 years**, including medical, surgical, emergency department, imaging, cancer, laboratory, behavioral health, and substance use services;
  - Emergency, behavioral health, and substance use services are also eligible for an **extended retention period (for a total of at least 8 years)** subject to certain financial feasibility criteria;
- UMass has also committed to fund **$42M** of capital expenditures at Harrington Memorial during the first 5 years following the transaction; and
- UMass has committed to **at least $4M** over ten years in community investment funding to address social determinants of health in Harrington's service area.

Electing Not to Proceed to a CMIR

COST AND MARKET

- While the HPC did review evidence that the transaction would increase inpatient market concentration in Harrington's already highly concentrated inpatient service area, **the impacts on bargaining leverage are likely to be small.**
- Spending for some, but not most, payers could increase if Harrington prices rose to match UMass community hospital rates, but **the scope and likelihood of any such price increases based on existing differentials is unclear.** Shifts in care are unlikely to meaningfully impact total spending, positively or negatively.

QUALITY

- While the HPC did not review evidence sufficient to show that quality is likely to improve, the parties' plans seem unlikely to impair quality.

ACCESS

- Finally, the HPC found that the parties' commitments to maintaining services in the Harrington service area, and planned investments also have real **potential to enhance access**.

On the basis of this preliminary review, the HPC has elected NOT to proceed to a cost and market impact review.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
  - 2022 Health Care Cost Growth Benchmark **(VOTE)**
  - Market Transactions
    - Notices of Material Change
    - **Mass General Brigham Determination of Need Applications**
  - Impact of COVID-19 on the Massachusetts Health Care System: Interim Report
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

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

DETERMINATION OF NEED (DoN) PROCESS

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

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

MASS. GENERAL BRIGHAM DON FILINGS

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

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

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

Updates on DoN Review Process

Ten taxpayer groups registered to comment.

- Ten taxpayer groups (TTGs) interested in commenting on the projects or requesting public hearings may register with DPH. The period for TTG registration for the proposed ambulatory sites is open until April 16, 2021.
- A large number of TTGs have registered: Ten for the MGH project, six for the Faulkner project, and 18 for the ambulatory project (to date).

DPH conducted public hearings on each of the applications.

- DPH held a total of **five telephonic hearings for public comment** on the applications, including one each for the MGH and Faulkner expansions, and one for each of the ambulatory expansion sites.
- MGB representatives, representatives of competing provider organizations, union members and leaders, politicians, representatives of civic organizations, and community members provided comments on the projects.
- DPH has also **accepted written comments** on each of the projects. The period for comment on the proposed ambulatory sites closes on April 16, 2021.
- DPH staff will consider comments when **assessing the applications' compliance with the DoN factors**.

HPC

Updates on DoN Review Process

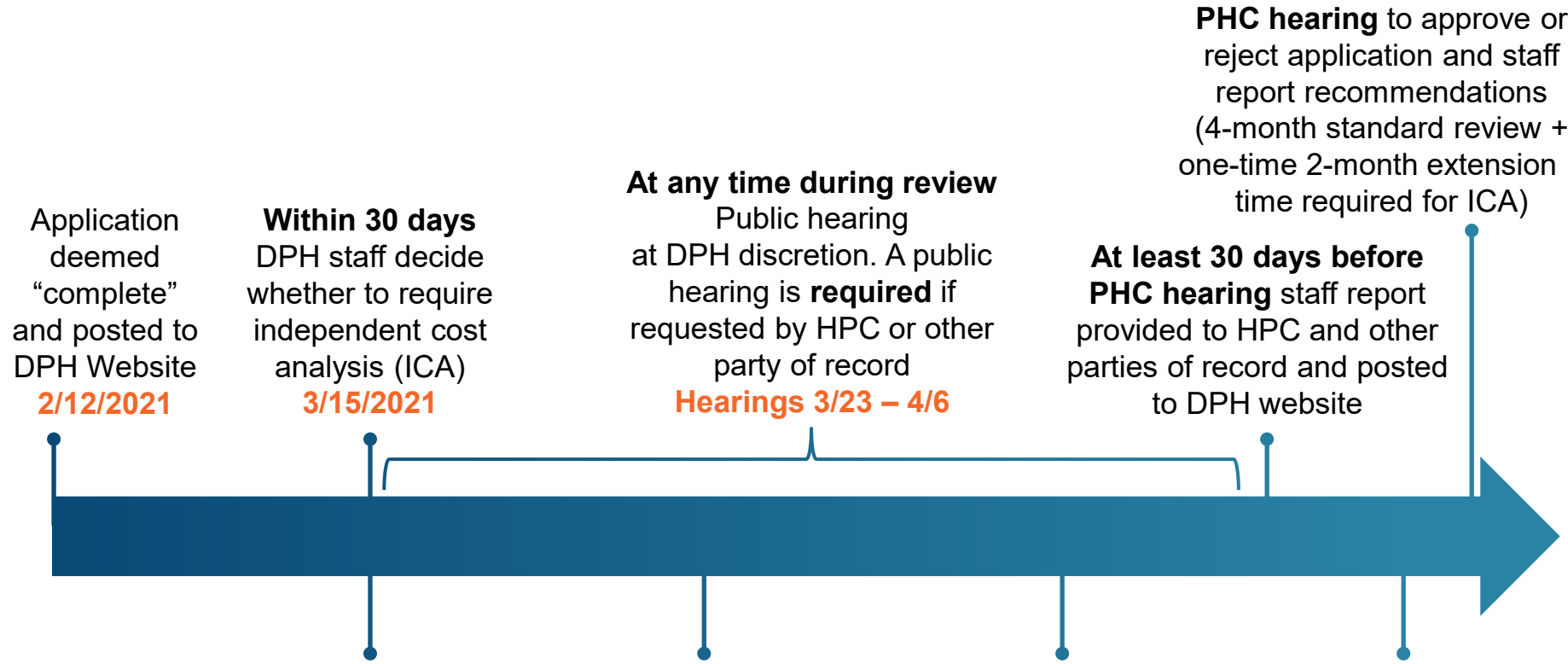
DPH has notified MGB that an Independent Cost Analysis (ICA) must be conducted for each application.

- The purpose of an ICA is to require the applicant "demonstrate that the project is **consistent with the Commonwealth's cost-containment goals**."
- The ICA is **conducted by a consultant** approved by DPH, at the expense of the applicant.
- The **timeline for DoN review is halted** while the ICA is conducted.
- Chapter 224 and the DoN regulations provide an **opportunity for the HPC comment** on an ICA once it has been provided to DPH.

Potential HPC Comment

- The HPC has previously commented to the DoN program where the project was **likely to have a significant impact on health care spending and health care market structure** and where the HPC had developed analyses that could **support DPH in its review**.
- In the past, the HPC elected to comment **after an ICA was provided** to DPH.
- The size and nature of the projects proposed by MGB suggest that they may have a significant impact on health care spending and health care market structure. It is also likely that HPC analyses could aid in DPH's review.
- An HPC comment after the ICAs are conducted will:
    - Allow the HPC to objectively analyze **all potential aspects** of MGB's plans that could impact the Commonwealth's efforts to meet its cost-containment priorities and **identify areas of potential concern;**
    - **Consider the methodologies and conclusions** in the ICAs;
    - **Provide input** to DoN program staff for consideration well in advance of their staff report and final decision by the Public Health Council.

Timeline for DoN Process and Opportunities for Potential HPC Comment



MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
  - 2022 Health Care Cost Growth Benchmark **(VOTE)**
  - Market Transactions
  - **Impact of COVID-19 on the Massachusetts Health Care System: Interim Report**
- Care Delivery Transformation
- Schedule of Next Meeting **(May 19, 2021)**

Impact of COVID-19 on the Massachusetts Health Care System: Interim Report

MASSACHUSETTS
HEALTH POLICY COMMISSION

April 2021

COVID-19 Impact Study Mandate

"An Act Promoting A Resilient Health Care System that Puts Patients First" was signed into law on January 1, 2021. It charges the HPC with conducting an analysis and issuing a report on:

> **"...the effects of the COVID-19 pandemic on the Commonwealth's health care delivery system, including on the accessibility, quality, and cost of health care services and the financial position of health care entities in the short-term, and the implications of those effects on long-term policy considerations."**

An interim report is due April 2021, and a final report is due January 2022.

Additional components of the study mandate include:

- Essential components of a robust health care system
- Inventory of all health care services
- Impact on the health care workforce
- Closures of essential services
- Analysis of health care disparities in the Commonwealth

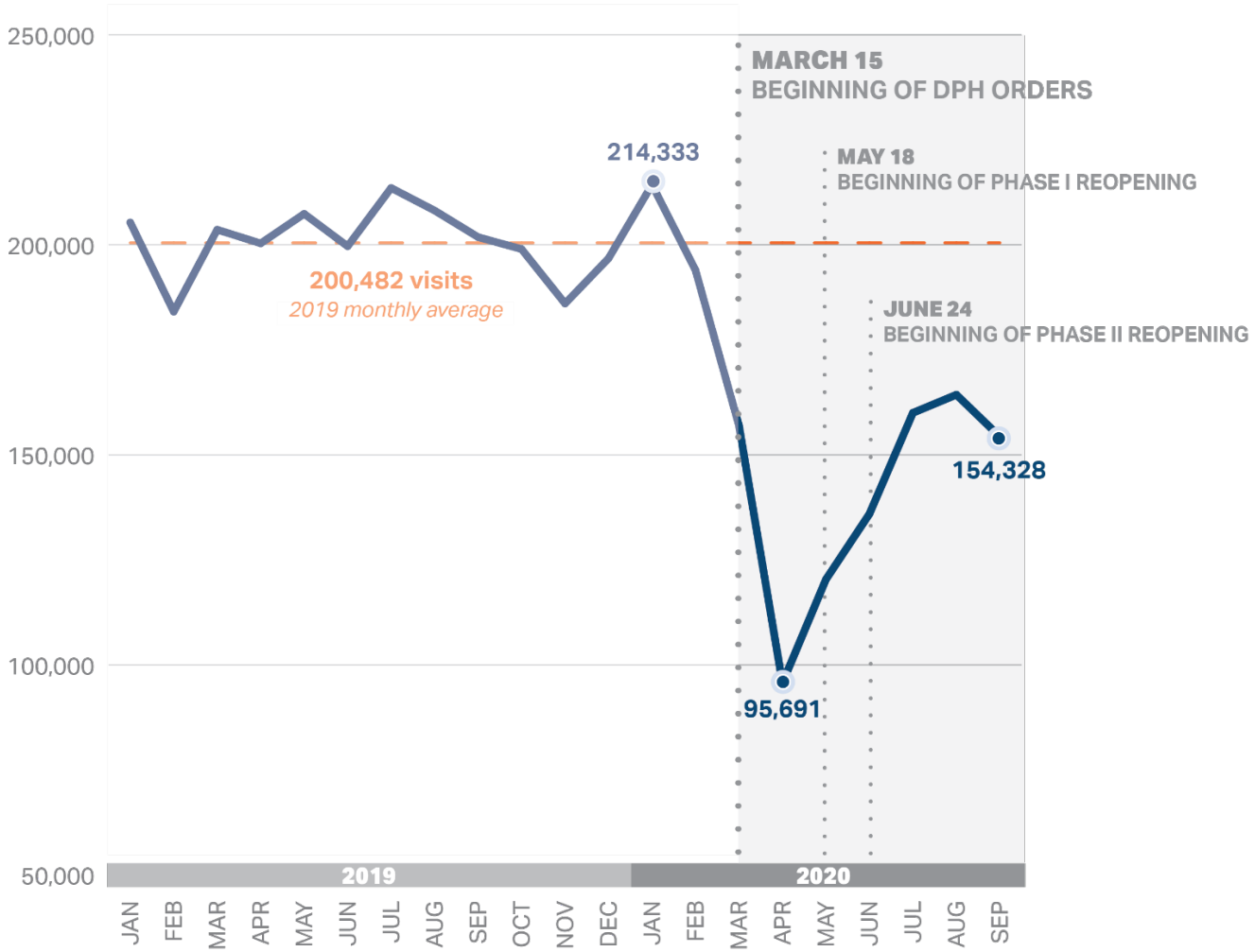
Outline

1. INTRODUCTION AND STUDY MANDATE
2. ANALYSIS OF UTILIZATION AND MARKET IMPACT TO DATE
   - Utilization
     - Hospital Care
     - Ambulatory Care
     - Telehealth
     - Behavioral Health
   - Market Impact
     - Provider Market
       - Financial Impact
       - Closures and Consolidation
     - Insurer Market
       - Financial Impact
       - Coverage
3. TOPICS FOR FUTURE STUDY

Emergency department visits decreased 55% between January and April 2020, and as of September were 24% below 2019 levels.

HOSPITAL | ED

Total ED visits, January 2019- September 2020



Emergency department (ED) visits in Massachusetts decreased sharply in the spring of 2020, falling 55% between January and April. The number of ED visits then started to increase but, as of September 2020, remained 24% below 2019 levels. These figures include ED visits for patients with COVID-19, which peaked at nearly 7,000 in April 2020.

The decrease in ED visits occurred even though hospital emergency services remained available throughout the pandemic. It is unclear the extent to which residents had less need of emergency services, were avoiding necessary care, or otherwise could not access the ED.

HPC

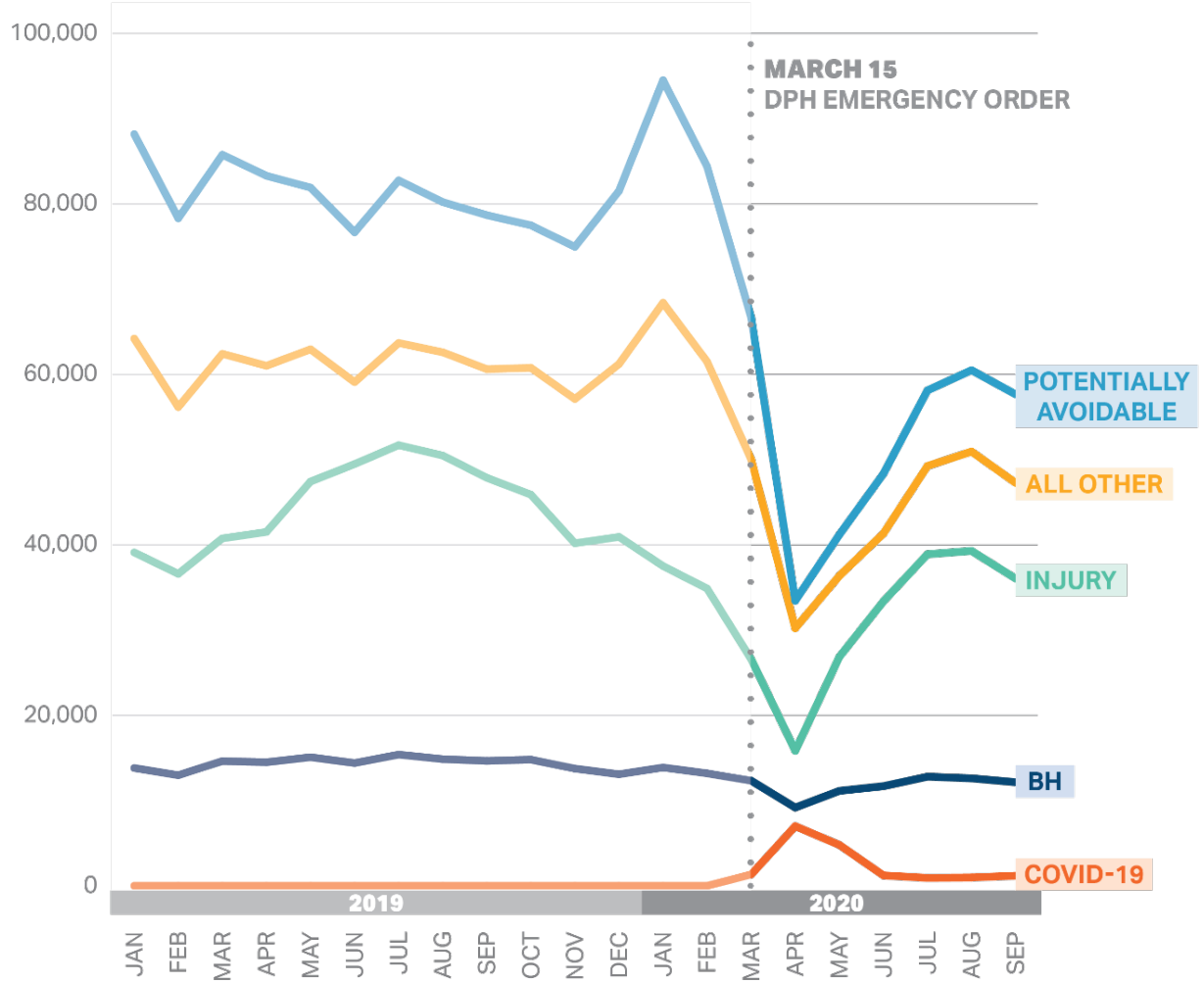
Notes: All ED visits included.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

All categories of non-COVID-19 ED visits dropped in April 2020 compared to 2019. Potentially avoidable visits decreased 60%, while BH-related visits decreased 37%.

HOSPITAL | ED

ED visit volume by type of visit, January 2019 - September 2020



Decreases in ED visit rates in 2020 varied by type of ED visit. In April 2020, potentially avoidable ED visits (-60%) and visits for injuries (-62%) experienced the largest declines with behavioral health visits declining more modestly (-37%). At the same time, ED visits for COVID-19 peaked in April at 6,995 visits.

By August 2020 ED visits had increased, but were still 25% lower for potentially avoidable visits, 22% lower for injury, 15% lower for BH, and 19% lower for all other ED visits compared to August 2019.

The HPC classifies avoidable ED visits annually as a measure of efficient health care system use. Potentially avoidable ED visits are visits to the ED that could have been treated in a primary care setting, whether the visits were emergent or non-emergent.

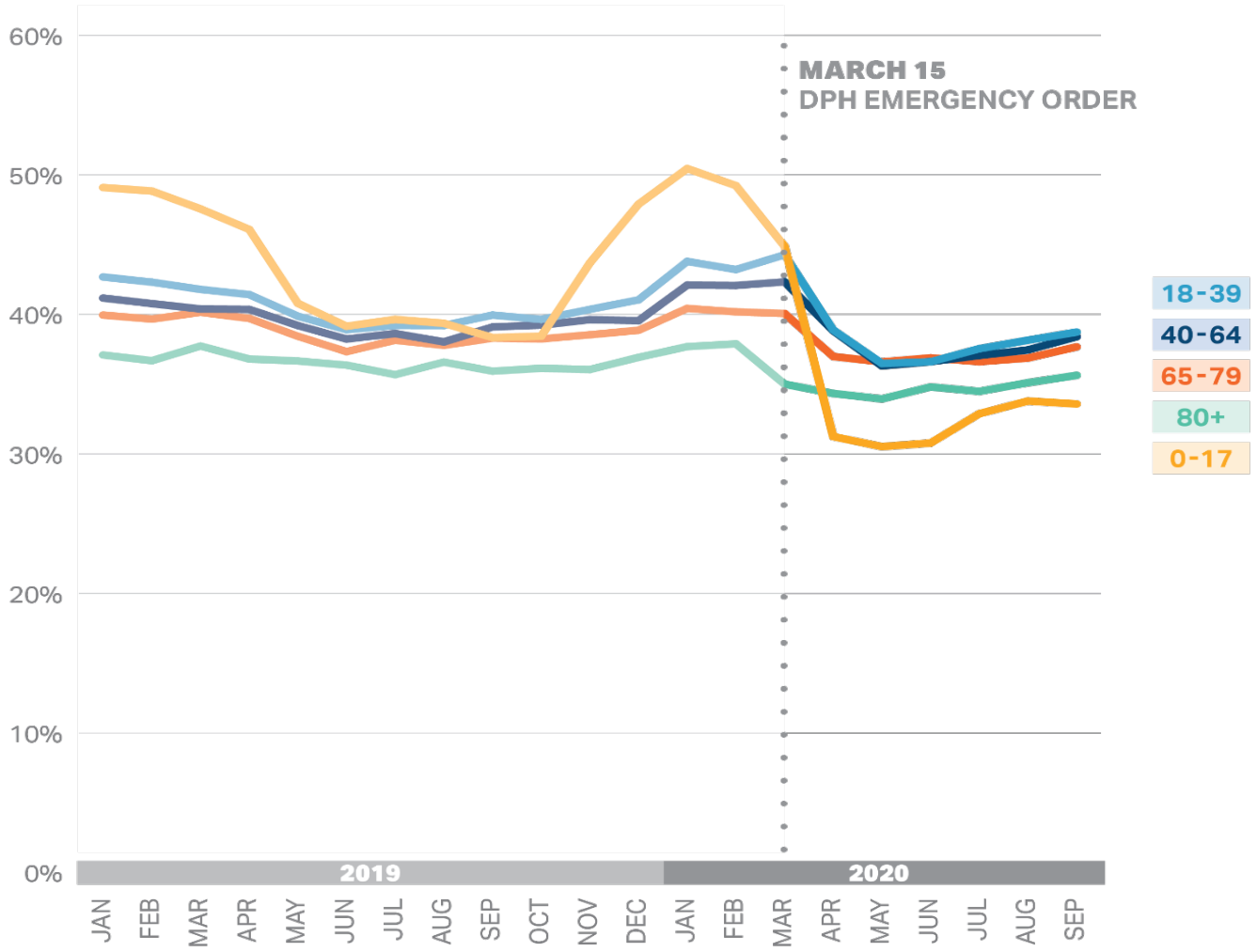
Notes: BH visits were defined using AHRQ CCSR MBD001-MDB034. Injury and avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent. All other are the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

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

The percentage of ED visits that were potentially avoidable decreased most for children compared to other age groups from March to April 2020 (13.6 percentage points).

HOSPITAL | ED

Percent potentially avoidable ED visits by age, January 2019- September 2020



The greatest decrease in potentially avoidable ED visits occurred among children ages 0-17.

In 2019, the share of ED visits for children that are potentially avoidable dropped from a peak in January to a low in September. While there is typically a decline for this population during summer months, the decrease from January through September 2020 was greater than January through September 2019 (16.9 percentage points compared to 10.8 percentage points)

Among children, potentially avoidable ED visits for upper respiratory infections had the largest volume decrease of almost 11,993 visits (81% decrease) April through September 2020 compared to the same time period in 2019. ED visits for fevers also saw a significant decrease of 5,685 visits (58% decrease).

More research is needed to understand the extent to which patients who may have otherwise gone to the ED sought alternative care (e.g., primary care visits, telehealth), did not need care (e.g., due to lower exposure), or had unmet care needs.

HPC

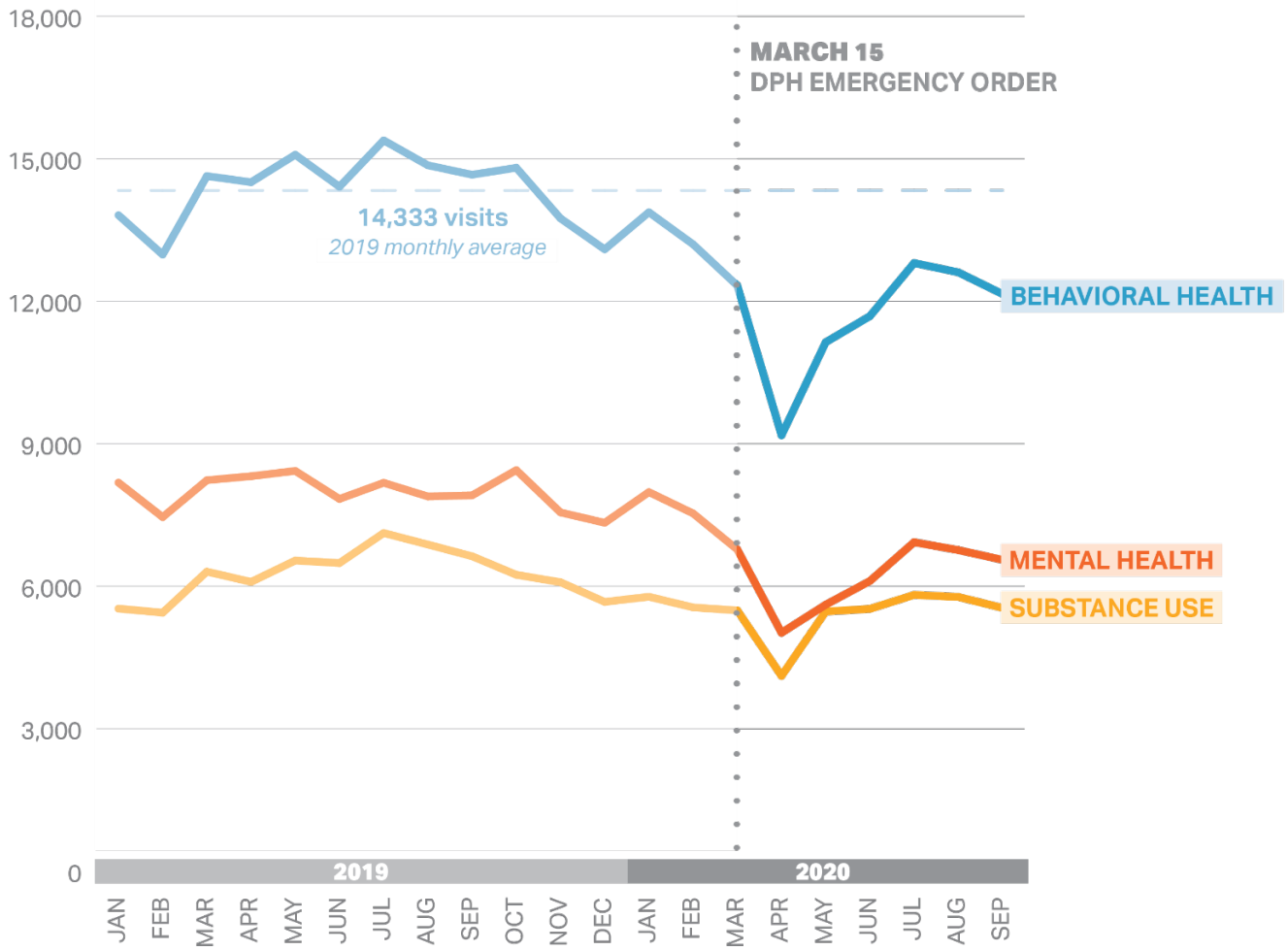
Notes: COVID-related visits excluded. Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

Mental health and substance use-related ED visits were declining slightly before the pandemic and continued to decline overall in 2020.

HOSPITAL | ED

Behavioral health ED visits, January 2019- September 2020



Behavioral health ED visits were already slightly declining pre-COVID-19 compared to 2019 levels for the first quarter (13,810 visits for Q1 2019 compared to 13,134 visits Q1 2020).

In April 2020, behavioral health ED visits dropped 37% from April 2019. However, due to larger decreases in other categories of ED visits, the proportion of all ED visits that were behavioral-health related increased from 7.2% in April-June of 2019 to 9.4% in April-June 2020

Visits began to increase in the spring and summer but stayed well below 2019 monthly averages. However, as shown in the following exhibits, a greater proportion of these visits resulted in ED boarding (12+ hours in the ED).

It is unclear if the decrease in behavioral health-related ED visits reflects patients not seeking care, barriers to access, or patients utilizing alternative care settings or resources, such as tele-behavioral health to meet these health needs.

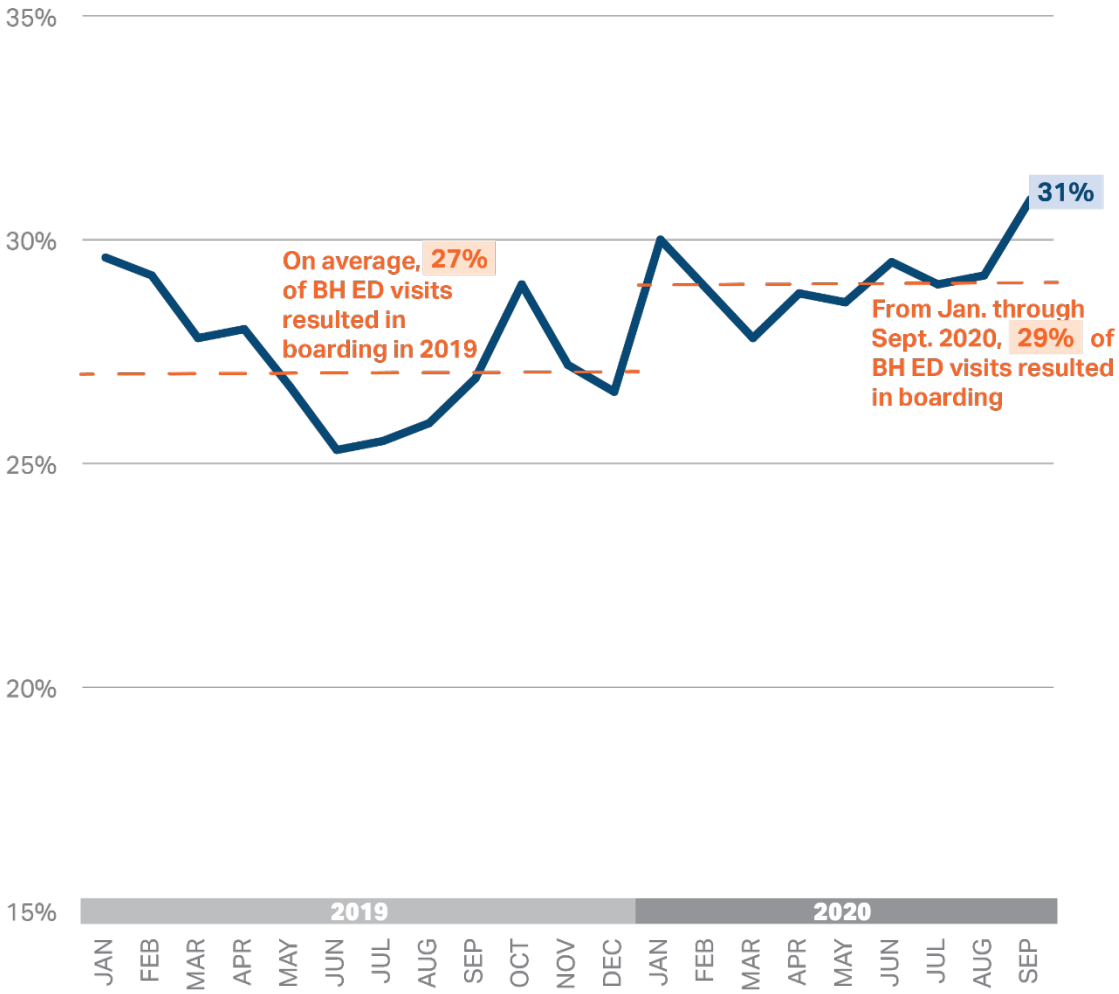
Notes: COVID-related visits are excluded. Behavioral health visits were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034, Mental Health: MBD001-MBD013, Substance Use: MBD17-MBD34).

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

From January to September 2020, more than 28,000 behavioral health-related ED visits resulted in boarding, an increase of over 2 percentage points.

HOSPITAL | ED

Percent of behavioral health ED visits that resulted in boarding, January 2019- September 2020



While the overall number of behavioral health-related ED visits decreased in 2020 compared to 2019, the percentage of visits where the patient waited over 12 hours in the ED, known as ED boarding, increased by over 2 percentage points. From January to September 2020, at least 28,000 behavioral health-related ED visits resulted in ED boarding.

By September 2020, the percentage of behavioral health-related ED visits that resulted in boarding reached a peak of 31% since January 2019.

One important contextual dynamic likely impacting the increase in behavioral health-related ED boarding is the loss of nearly 270 psychiatric beds in the Commonwealth over this time period, as described in greater detail on the next slide.

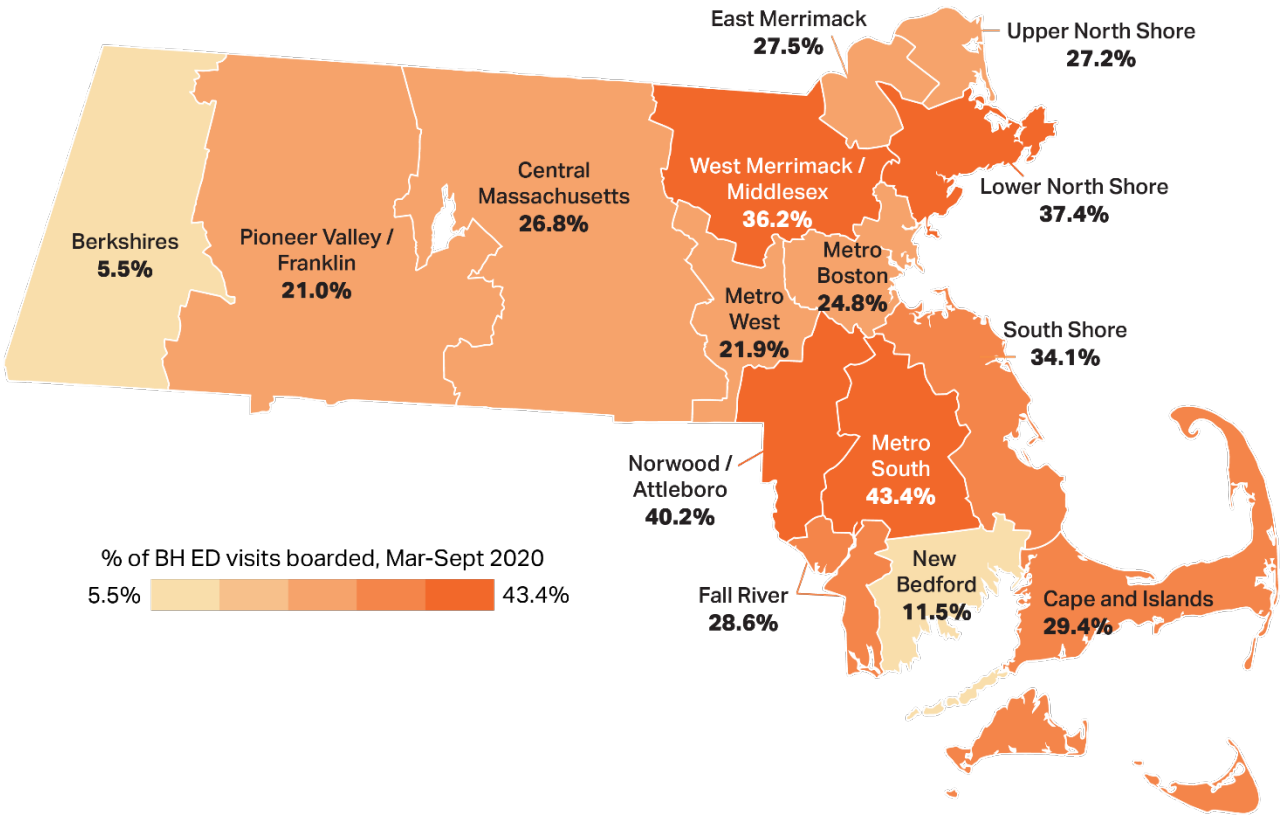
Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. ED visits where patients were admitted to the same hospital were excluded from this boarding analysis. Behavioral health visits were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034, Mental Health: MBD001-MBD013, Substance Use: MBD17-MBD34).

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

The loss of psychiatric bed capacity in 2020 likely contributed to higher behavioral health-related ED boarding rates statewide, with a greater impact in certain regions.

HOSPITAL | ED

Percent of behavioral health ED visits resulting in boarding, by HPC region, March – September 2020



Note: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. ED visits where patients were admitted to the same hospital were excluded from this boarding analysis. Behavioral health visits were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034, Mental Health: MBD001-MBD013, Substance Use: MBD17-MBD34).

For more information on the Roadmap for Behavioral Health Reform: https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform

Information on psychiatric bed closures was provided as part of the Oversight Hearing of the Joint Committee on Mental Health, Substance Use and Recovery Trends in Behavioral Healthcare During the COVID-19 Pandemic on October 23, 2020.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Emergency Department Discharge, preliminary FY2020.

The percent of behavioral health-related ED visits that resulted in boarding from January through September 2020 ranged from a low of 5.5% in the Berkshires to a high of 40.2% in Norwood/Attleboro and 43.4% in Metro South.

As mentioned on the previous slide, the reduction of psychiatric inpatient bed capacity likely resulted in high and varied percent of ED boarding across the Commonwealth. Some changes that resulted in less inpatient bed capacity include:

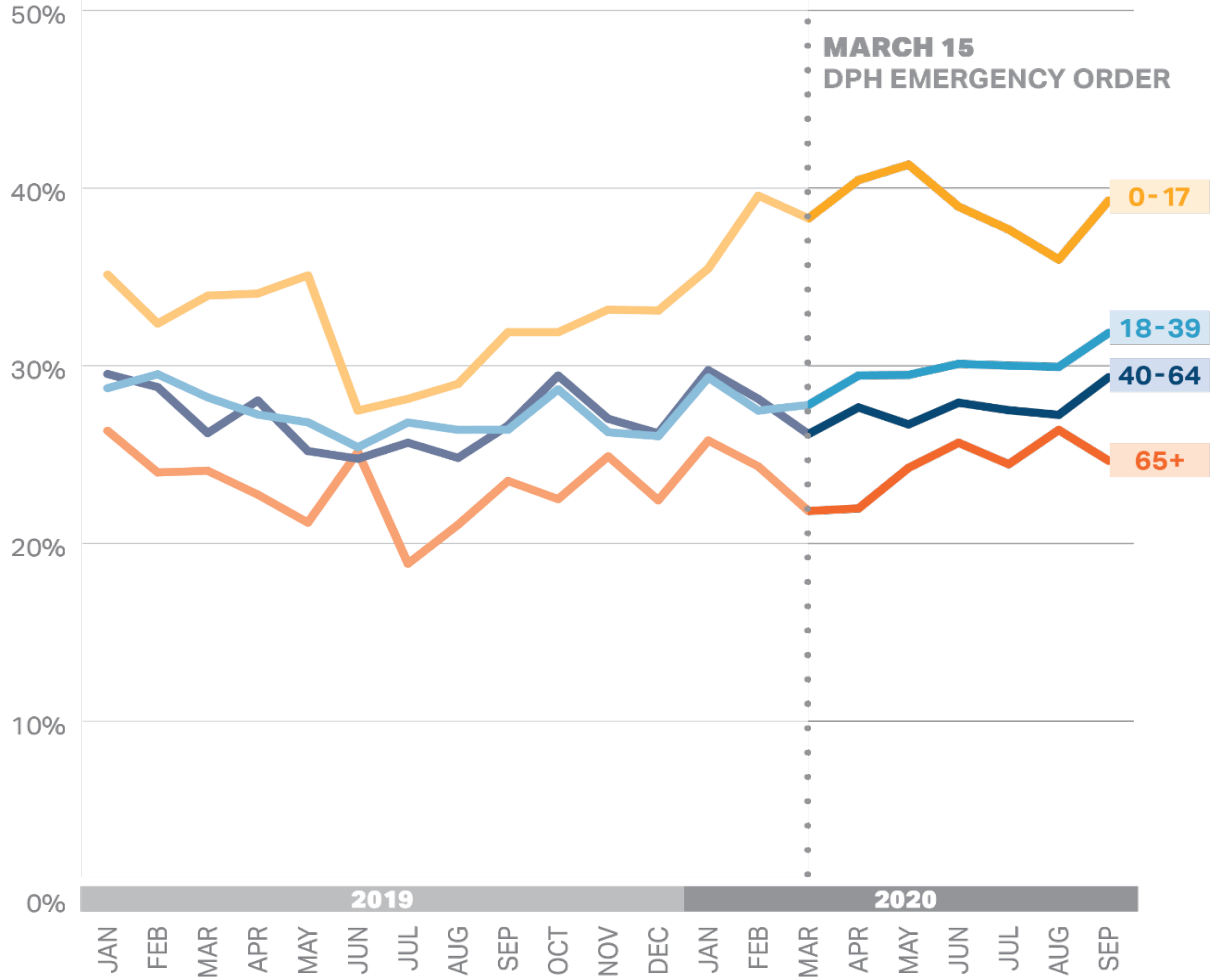
- Closure of Trinity Health's Providence Behavioral Health Hospital
- Closure of Norwood Hospital due to flooding
- Reduction of inpatient psychiatric beds to allow for COVID-related distancing and quarantine space.

There are planning efforts urgently underway to add additional beds at both new and existing facilities, including those detailed by the Executive Office of Health and Human Services' Roadmap for Behavioral Health Reform.

For pediatric behavioral health patients, the percent of ED visits that resulted in boarding increased 7 percentage points from 2019.

HOSPITAL | ED

Percent of behavioral health ED visits resulting in boarding by age group, January 2019 – September 2020



Although drivers of behavioral health ED boarding affect patients of all ages, pediatric patients face particular barriers in access to care that can result in ED boarding.

From March through September 2020, 39% of pediatric behavioral health ED visits resulted in ED boarding compared to 28% of adult behavioral health visits.

Overall, there were approximately 3,200 fewer pediatric behavioral patients who had an ED visit from March through September 2020 compared to the same months 2019, but there was a higher percentage of pediatric patient visits that resulted in boarding, increasing by 7 percentage points.

Pediatric BH patients not only had higher rates of ED boarding than other age groups, but also were more likely to experience boarding that lasted over 48 hours. In 2020, 29% of pediatric patients who experienced ED boarding spent over 48 hours in the ED (n=878).

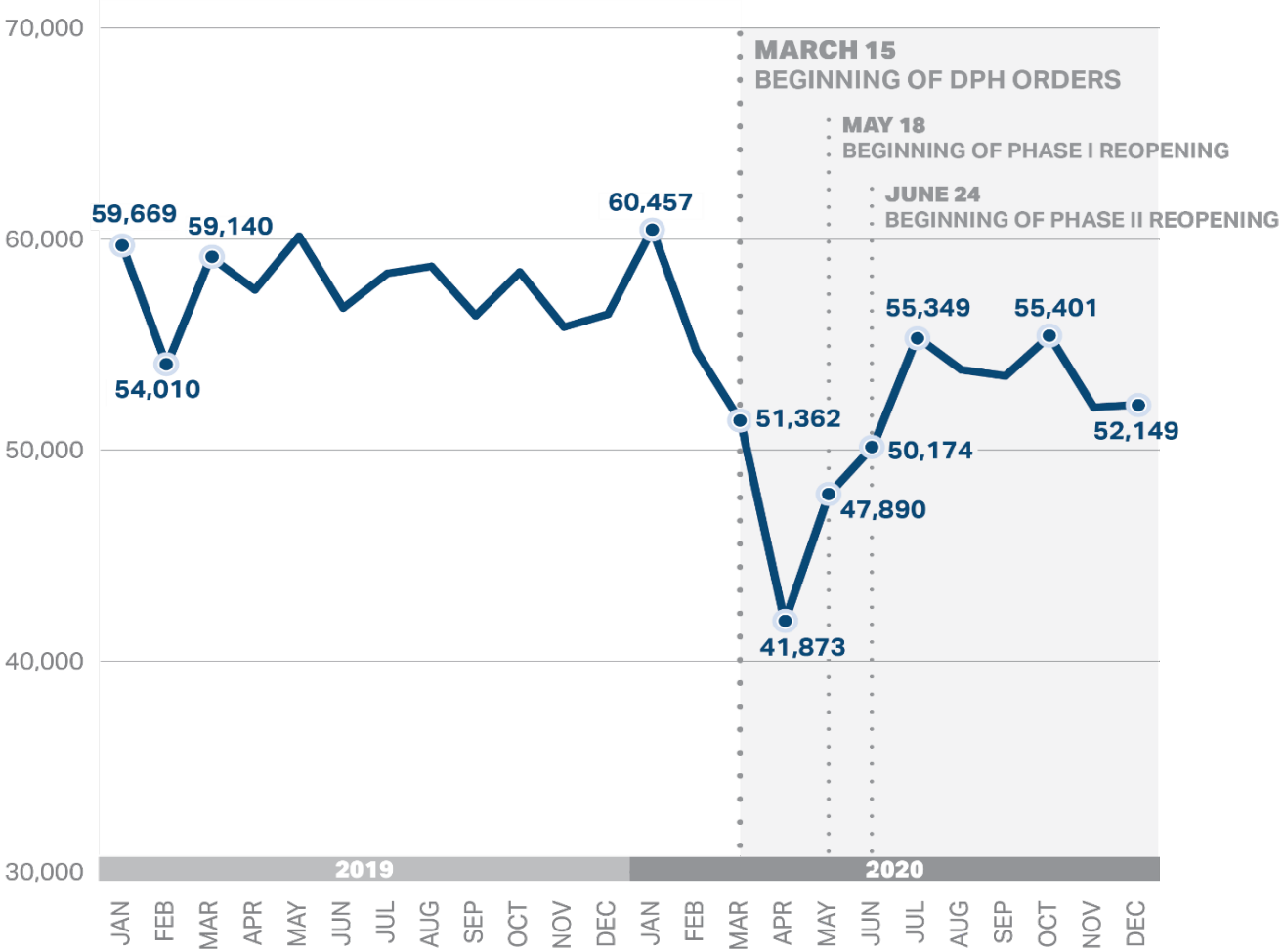
Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. ED visits where patients were admitted to the same hospital were excluded from this boarding analysis. Behavioral health visits were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034, Mental Health: MBD001-MBD013, Substance Use: MBD17-MBD34).

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Emergency Department Discharge, FY2019, preliminary FY2020.

Hospital inpatient volume dropped 31% from January to April 2020 and remained below pre-pandemic levels through December.

HOSPITAL | INPATIENT

Massachusetts acute care hospital inpatient admissions, 2019-2020



On March 15, 2020, as COVID-19 hospitalizations began to rapidly increase, DPH issued an order to postpone or cancel any nonessential elective invasive procedures. Over the next several weeks, hospital stays continued to drop to a low of 41,873 in April (15,720 fewer stays than April 2019).

These figures include admissions for patients with COVID-19, which peaked at 8,196 admissions in April 2020, representing 19.6% of all admissions that month. The acute needs of these COVID-19 patients increased the average length of stay from 4.85 to 5.96 days, an 22.9% increase compared to 2019.

In May and June, as COVID-19 hospitalizations and other public health metrics decreased, DPH issued guidance for a phased reopening of the health care system. Overall volume continued to increase but had not reached pre-pandemic levels by the end of 2020.

In late fall and early winter, hospital discharges began to decrease again as COVID-19 hospitalizations began to rise.

HPC

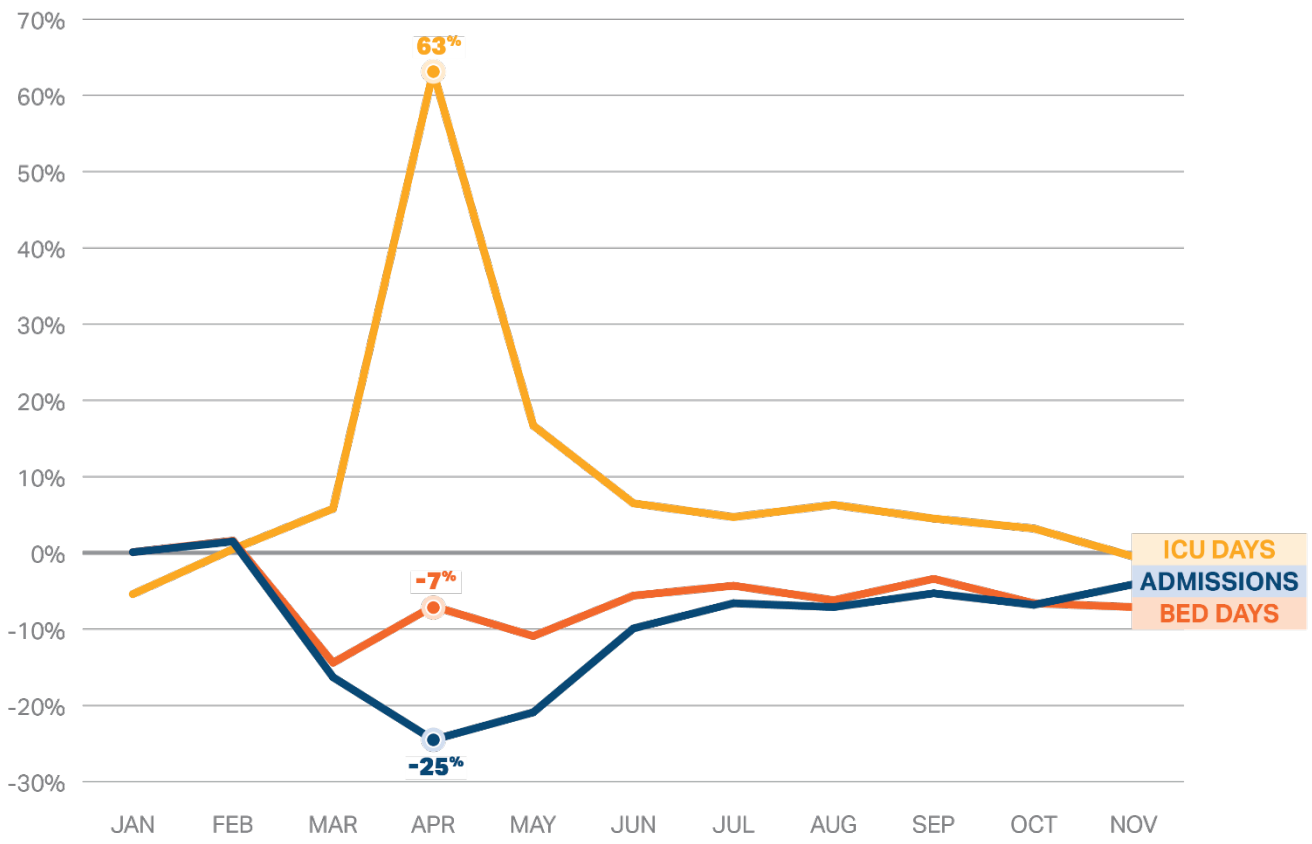
Notes: For more information on Reopening Health and Human Services, please see: https://www.mass.gov/lists/reopening-health-and-human-services-in-Massachusetts. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

ICU and critical care volume increased dramatically in April 2020, spiking 63% over 2019 levels, and remained higher throughout 2020.

HOSPITAL | INPATIENT

Percent change in admissions, bed days, and ICU/CCU days, January 2019 - November 2020



While the total number of inpatient admissions dropped in April, the number of patient days in intensive care units/critical care units (ICU/CCU) increased dramatically, spiking 63% over April 2019 levels.

While ICU/CCU use dropped after the initial surge, ICU/CCU days remained higher than 2019 levels through 2020.

Overall, from 2019 to 2020, the number of admissions decreased 9%, while ICU/CCU days increased 10%. Hospital bed-days (related to occupancy rates), did not decline as much as the number of admissions because patients with COVID-19 experienced longer hospital stays, on average.

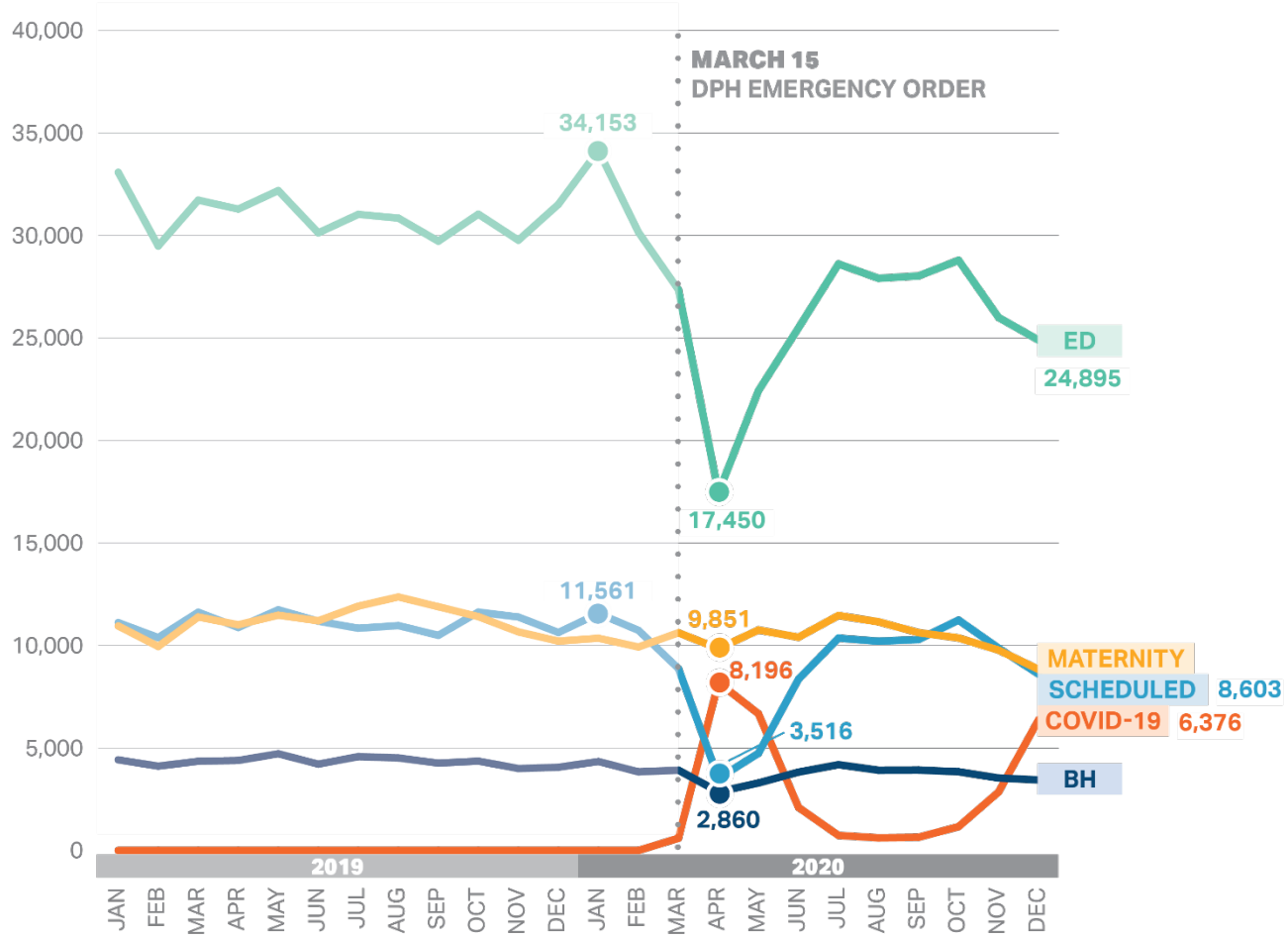
Notes: This analysis assigns the number of bed days and ICU/CCU days for each admission to the original admission date. ICU days and CCU days were identified using revenue codes (0200, 0201, 0202 and 0210); pediatric, neonatal, and intermediate ICUs were excluded from this analysis. Because many of the December stays were not discharged until January and data was not complete for January 2021, December is excluded from this graph.

HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

Admissions from the ED and scheduled admissions fluctuated throughout 2020 but remained below 2019 levels.

HOSPITAL | INPATIENT

Massachusetts acute care hospital inpatient admissions by admission type, 2019-2020



Notes: COVID-related discharges are excluded. Maternity includes all stays with a maternity-related APR-DRG. ED admissions include all stays with an ED flag or ED-specific revenue code. Behavioral Health (BH) stays include all stays with a BH diagnosis as the primary diagnosis. Scheduled includes remaining stays. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

Trends in hospital admission volume over 2020 varied by admission type. In March and April 2020, the number of admissions through the ED and scheduled admissions declined sharply. These admission types rebounded but remained below 2019 levels. In late fall and early winter, hospital discharges began to decrease again as COVID-19 hospitalizations began to rise.

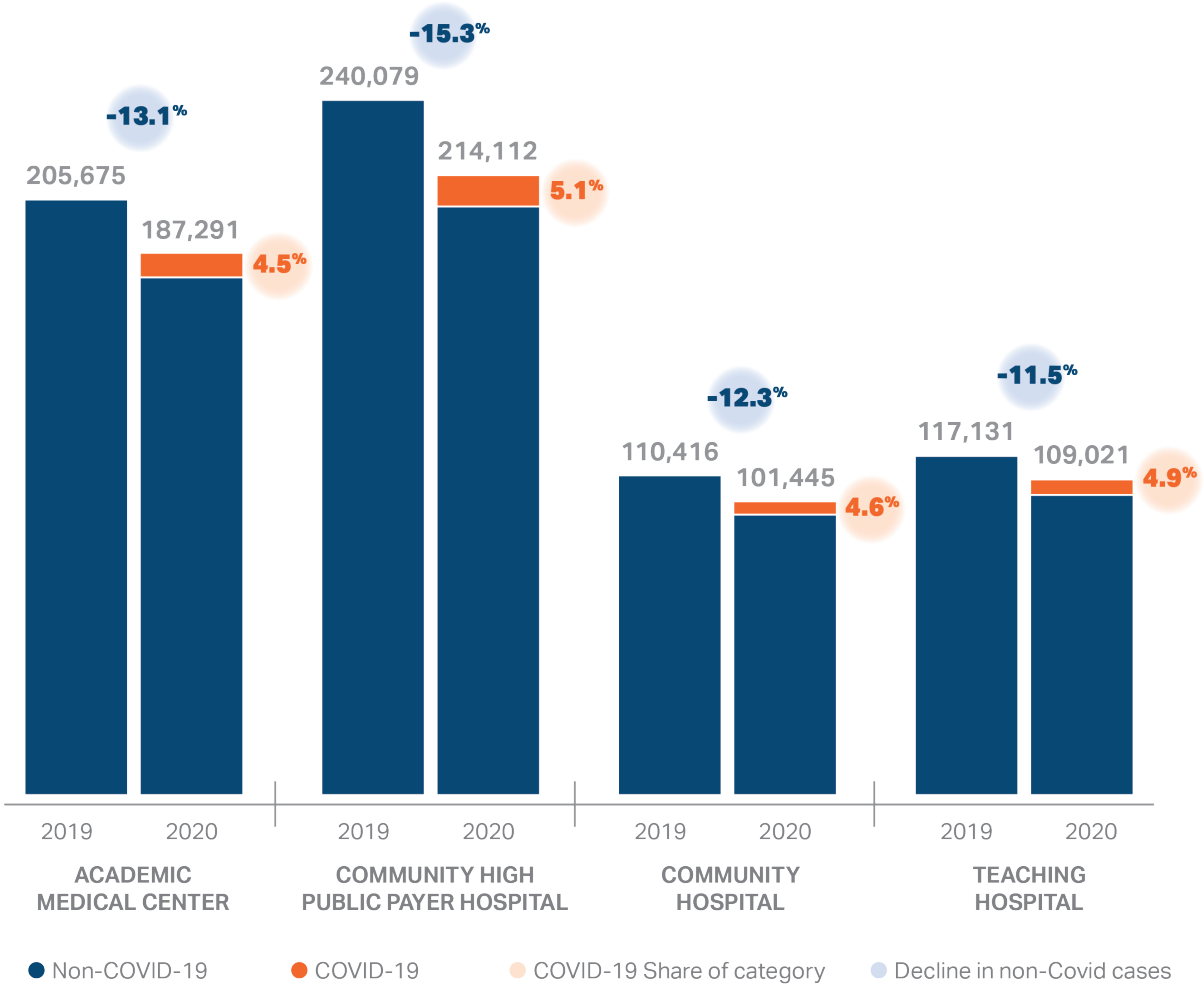
Maternity-related stays declined the least over this time period (8%). Behavioral health admissions, although a relatively small volume of acute-inpatient admissions, declined 14% from 2019-2020.

When examining behavioral health admissions, it is important to note that the data only includes information from acute care hospitals and does not include admissions at free-standing psychiatric hospitals. Additionally, the overall loss of psychiatric bed capacity, as described on previous slides, also likely impacted the volume of behavioral health admissions during this time period.

All hospital cohorts treated a similar percentage of COVID-19 patients through 2020, but community high public payer hospitals treated the largest volume of these patients while losing the most volume for other types of inpatient stays.

HOSPITAL | INPATIENT

Total inpatient admissions and percentage of admissions that were COVID-19-related, by hospital cohort, 2019 and 2020



Throughout 2020, hospitals worked with the state's COVID-19 Command Center to continuously monitor bed capacity and volume of COVID-19 patients. To ensure adequate capacity within and across hospital systems and geographic regions, hospitals worked collaboratively to balance patient needs.

The volume of COVID-19 patients as a percentage of all admissions was similar across all hospital cohorts, ranging from 4.5% of all admissions at academic medical centers (AMCs) to 5.1% at community high public payer hospitals (CHPPHs), excluding field hospitals. However, CHPPHs treated the largest volume of COVID-19 patients in 2020, totaling 10,829 patients.

Additionally, CHPPHs experienced the greatest decline in non-COVID-19 admissions, decreasing 15.3% between 2019 and 2020.

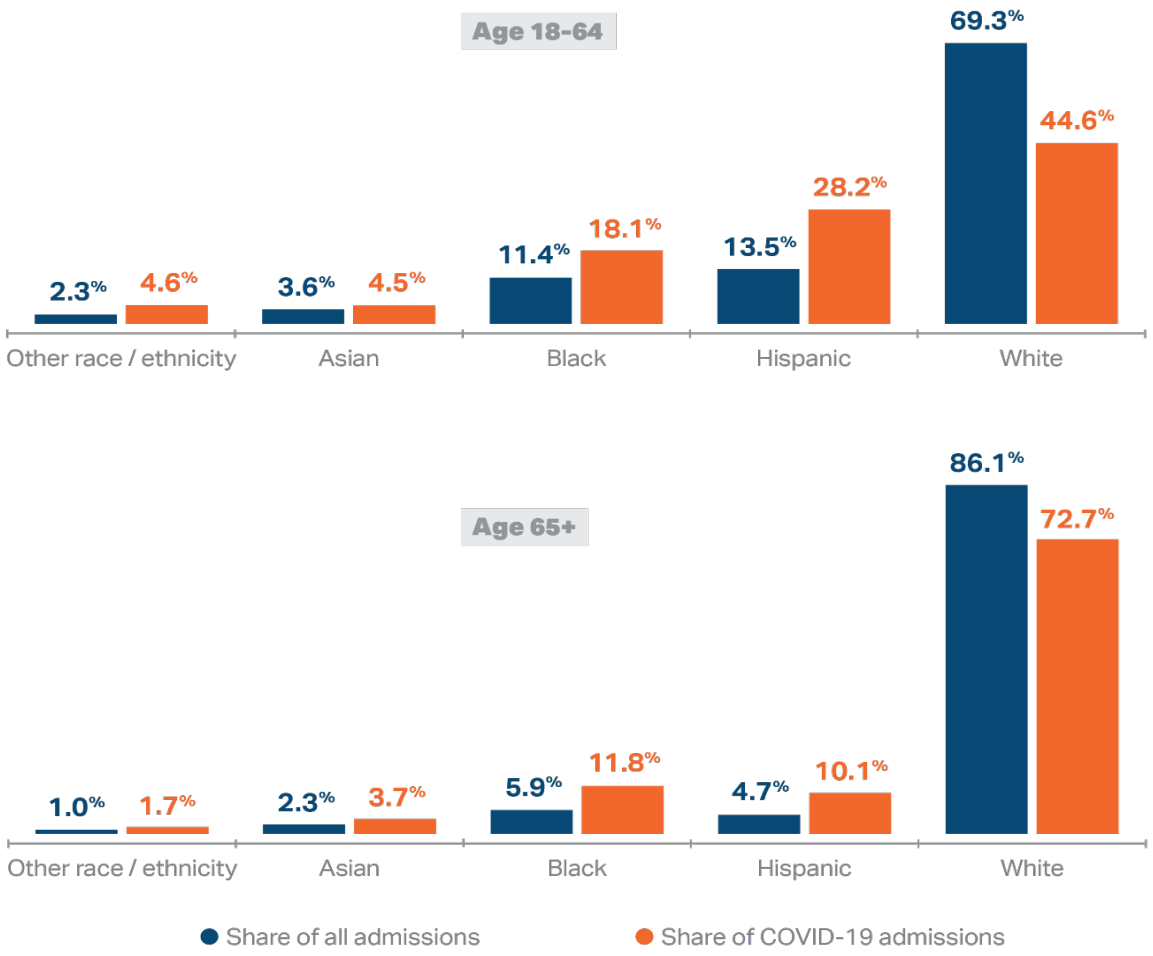
Note: Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

Hispanic and Black patients represented a disproportionate share of COVID-19-related hospital admissions in 2020.

HOSPITAL | INPATIENT

Inpatient hospital admissions by race/ethnicity, 2020



Patients of color represented a disproportionate share of COVID-19-related hospital admissions in 2020.

COVID-19 hospital admissions were particularly disproportionate for Black and Hispanic patients. Among patients age 65+, Black patients represented double the share of COVID-19 admissions, compared to their share of all admissions. Among patients age 18-64 and 65+, Hispanic patients represented more than twice the share of COVID-19 admissions, compared to their share of all admissions. Among patients age 65+, the share of COVID-19 admissions represented by Asian American patients was 65% higher than their share of all admissions.

A recent CDC study found racial and ethnic disparities in U.S. COVID-19 hospitalizations, with the proportion highest for Hispanic patients. Driving factors cited include higher risk of exposure to the virus associated with occupational and housing conditions, as well as higher risk for severe disease.[1]

Notes: Hispanic category includes Hispanic ethnicity with any race. Other Race includes American Indian/Alaska Native, Native Hawaiian, other Pacific Islander, or other race. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission).

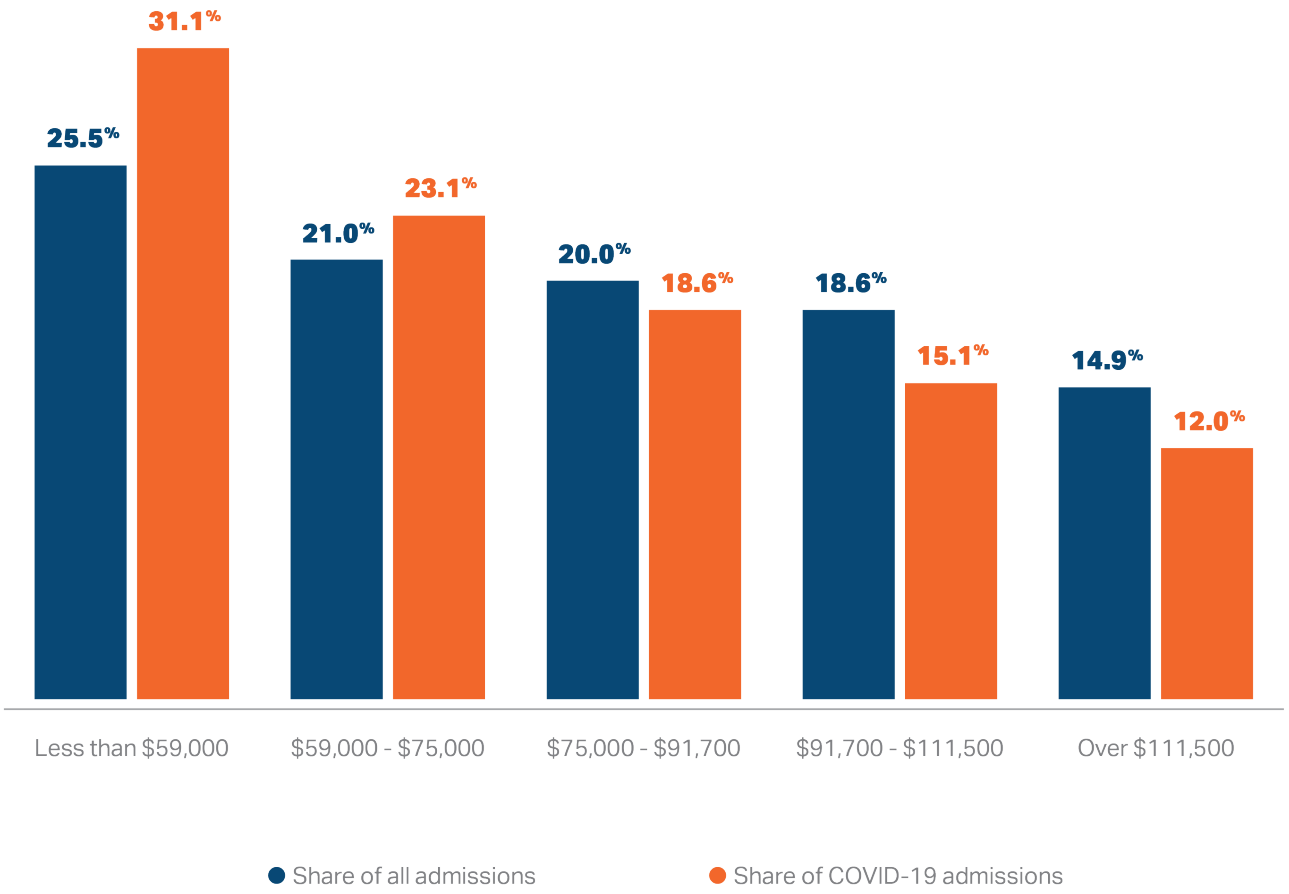
1. Treisman R. "Studies Confirm Racial, Ethnic Disparities In COVID-19 Hospitalizations And Visits." NPR. April 12, 2021. Available at: https://www.npr.org/sections/coronavirus-live-updates/2021/04/12/986513859/studies-confirm-racial-ethnic-disparities-in-covid-19-hospitalizations-and-visit

HPC

Patients from lower income communities represented a disproportionate share of COVID-19-related hospital admissions in 2020.

HOSPITAL | INPATIENT

Inpatient hospital admissions among patients age 18+ by median income of patient zip code, 2020



Patients from lower income communities in Massachusetts represented a larger share of COVID-19-related inpatient hospital admissions in 2020, compared to their share of overall inpatient admissions.

The disparity was largest for patients who live in zip codes in the lowest quintile of median community income (household income less than $59,000). Patients in the lowest quintile represented 25.5% of all admissions, but 31.1% of all COVID-19-related admissions.

Patients living in the second income quintile represented 21.0% of all admissions, but 23.1% of all COVID-19-related hospital admissions. Patients living in the highest income quintile represented 14.9% of all admissions, but only 12.0% of all COVID-19-related admissions.

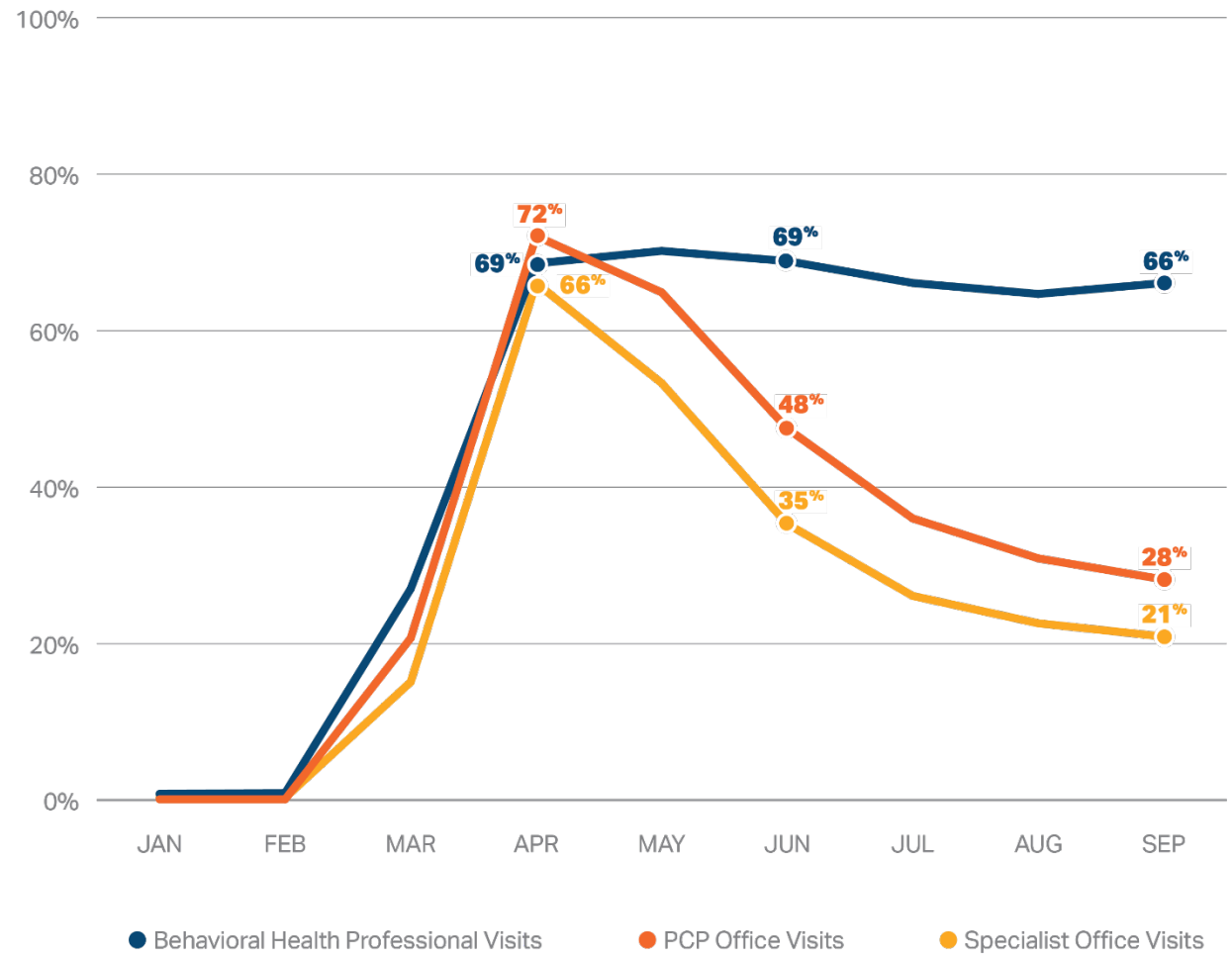
Notes: Income quintiles are based on median community income by zip code in Massachusetts. Some hospitals were excluded for the entire study period due to missing data for 1 or more quarters. This list of hospitals is available in the appendix. Discharges were excluded if they were transfers, LOS >180 days, or rehabilitation.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge, FY2018-2019, preliminary FY2020, and FYTD2021 (as of Feb 2021 submission). U.S. Census Bureau, American Community Survey 2019 Population 5-year Estimates.

Over 60% of behavioral health visits for commercially-insured Massachusetts residents were performed via telehealth starting in April 2020.

TELEHEALTH

Trend in total visits by relative percentage of telehealth and in-person encounters for fully-insured commercial members in Massachusetts, January – September 2020



Among commercially-insured Massachusetts residents, swift adoption of telehealth starting in March 2020 peaked in April, with approximately 70% of primary care, specialist, and behavioral health visits taking place via telehealth.

Starting in the spring and summer, the proportion of primary care and specialist visits provided by telehealth decreased to under 30%. In contrast, the share of behavioral health visits performed via telehealth remained high, at over 60% of visits.

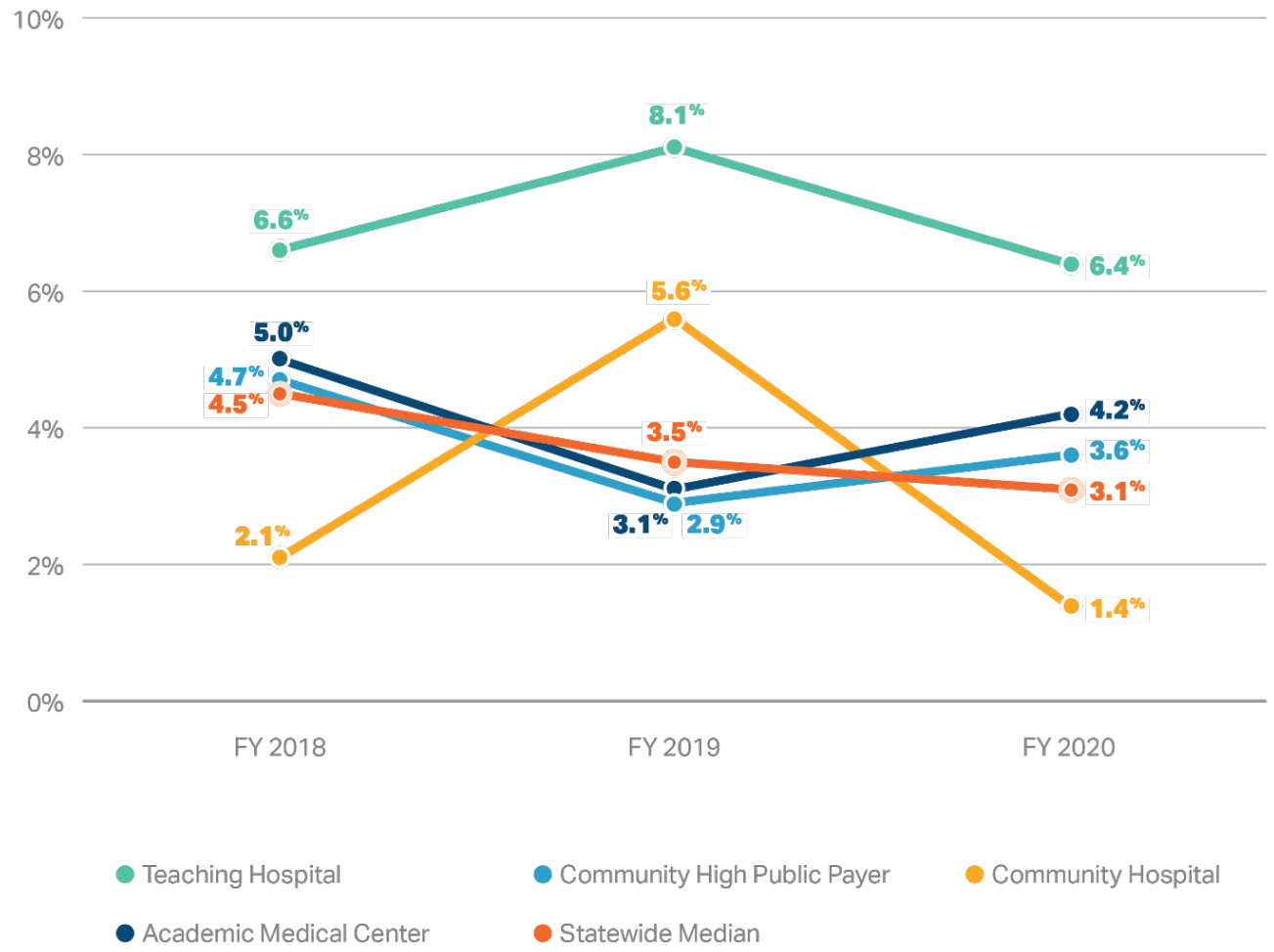
HPC

Notes: Includes fully-insured Massachusetts residents.
Source: Insurer utilization data submitted to the Massachusetts Division of Insurance for Q3 2020

Including federal and state COVID-19 relief funds, total margins were positive for all hospital cohorts in FY 2020; the statewide median declined from FY 2019.

PROVIDERS | FINANCIAL IMPACT

Median total margin by hospital cohort



The median total margin was positive for all hospitals cohorts in FY 2020. Including federal and state COVID-19 relief funds, median total margins ranged from 1.4% for community hospitals to 6.4% for teaching hospitals. Median total margins were also positive for all hospital cohorts in FY 2018 and FY 2019.

AMCs had an increase in profitability in FY 2020 compared to the last fiscal year. The median total margin for AMCs increased from 3.1% in FY 2019 to 4.2% in FY 2020. While CHPPHs also appeared to have higher margins in FY 2020 than in FY 2019, about a quarter of CHPPHs did not yet report data for FY 2020.

However, the medians and inclusion of COVID-19 relief funds mask substantial variation within cohorts: some hospitals had negative margins, while others had high profits in FY 2020. Results for individual hospitals are reported in later exhibits.

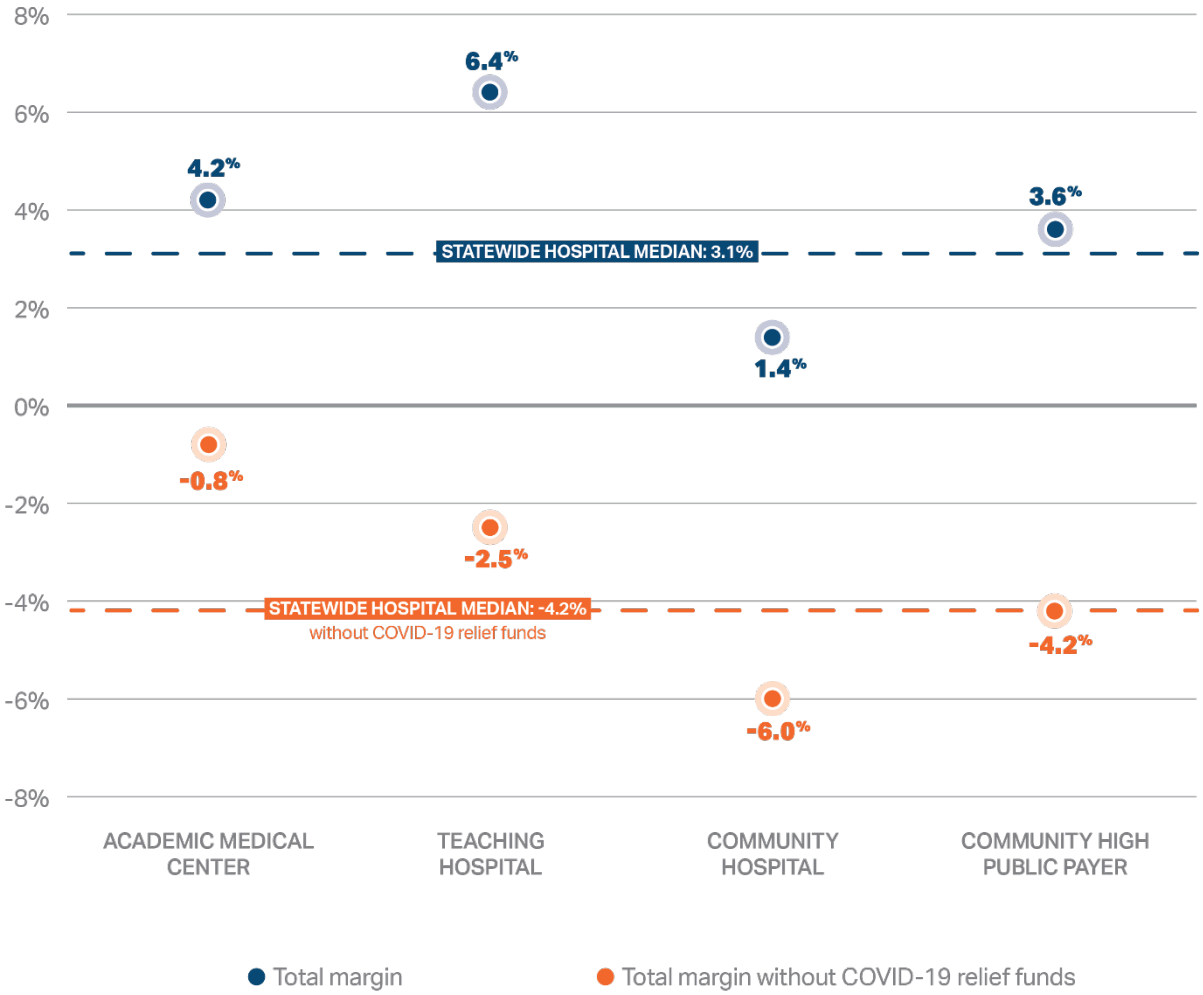
Notes: FY 2020 figures include 49 of 61 hospitals, accounting for hospitals with a June 30 or September 30 fiscal year end.

Source: Center for Health Information and Analysis. Massachusetts Acute Hospital and Health System Financial Performance: Preliminary Update on Fiscal Year 2020 Data. April 2020. Available at: https://www.chiamass.gov/hospital-financial-performance/

Without COVID-19 relief funds, the median margins of hospital cohorts would have been negative in FY 2020.

PROVIDERS | FINANCIAL IMPACT

Median total margin by hospital cohort for FY 2020, with and without COVID-19 relief funds



Without federal and state COVID-19 relief funds, total margins would have been negative for all hospital cohorts in FY 2020.

The statewide median hospital margin in FY 2020 was 3.1%. Without COVID-19 relief funds, the statewide median margin would have been -4.2%.

Community hospitals and CHPPHs would have been particularly hard hit financially without the relief funds.

Teaching hospitals had the largest overall financial benefit from relief funds, increasing margins by almost 9 percentage points.

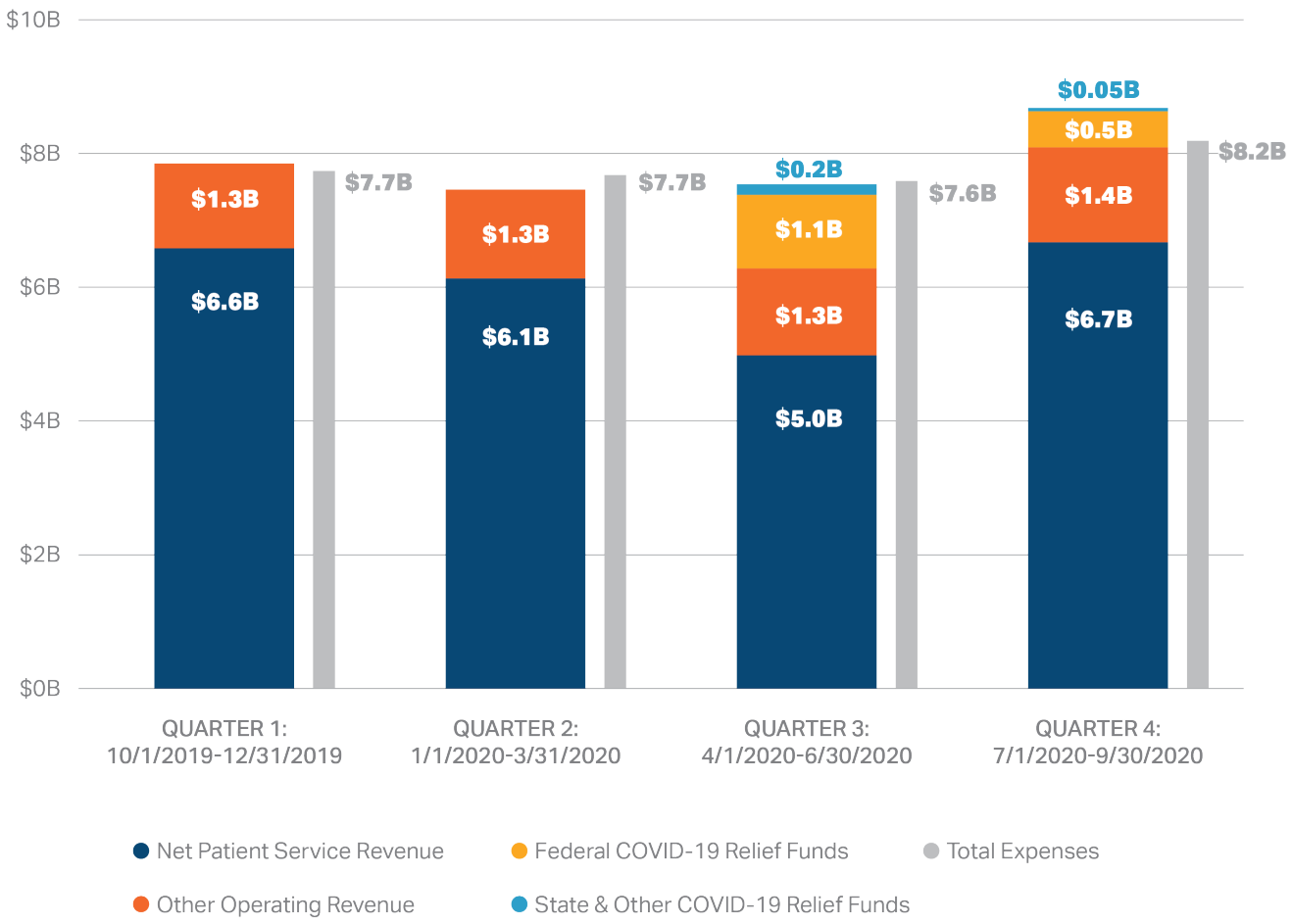
Notes: Figures include 49 of 61 hospitals, accounting for hospitals with a June 30 or September 30 fiscal year end.

Source: Center for Health Information and Analysis. Massachusetts Acute Hospital and Health System Financial Performance: Preliminary Update on Fiscal Year 2020 Data. April 2020. Available at: https://www.chiamass.gov/hospital-financial-performance/

COVID-19 relief funds prevented greater financial losses in quarter 3, but by quarter 4 revenue was near expenses even without these funds.

PROVIDERS | FINANCIAL IMPACT

Hospital operating revenue and expenses by quarter



From April through June 2020, corresponding to quarter 3, COVID-19 relief funds prevented greater financial losses. Total expenses were $1.3 billion higher than net patient service revenue (NPSR) and other operating revenue. With relief funding, expenses exceeded total operating revenue by $64 million.

In quarter 4, July through September 2020, NPSR and other operating revenue almost covered expenses even without the COVID-19 relief funds. It is uncertain whether the financial improvement at the end of FY 2020 will continue into the first two quarters of FY 2021, given the fall resurgence of COVID-19 hospitalizations.

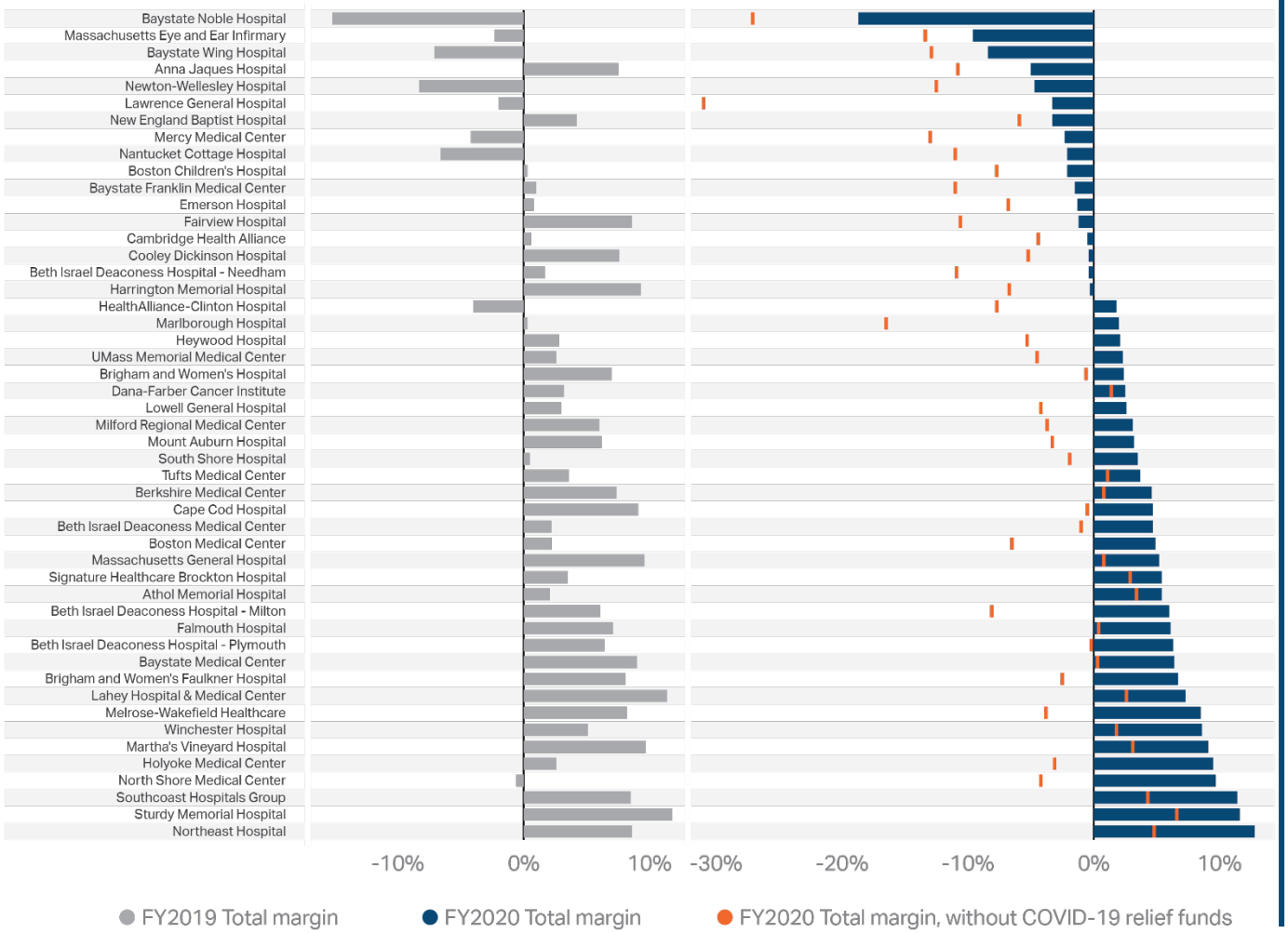
Notes: Figures include 49 of 61 hospitals, accounting for hospitals with a June 30 or September 30 fiscal year end.

Source: Center for Health Information and Analysis. Massachusetts Acute Hospital and Health System Financial Performance: Preliminary Update on Fiscal Year 2020 Data. April 2020. Available at: https://www.chiamass.gov/hospital-financial-performance/

Some hospitals had negative margins in FY 2020, but COVID-19 relief funds prevented greater losses.

PROVIDERS | FINANCIAL IMPACT

Total margin by hospital, FY 2019 and FY 2020



Some hospitals had negative margins in FY 2020, but COVID-19 relief funds prevented greater losses.

Fewer hospitals were profitable in FY 2020, compared to FY 2019. Of 49 hospitals reporting, 9 hospitals were not profitable in FY 2019 (18%). In FY 2020, 17 hospitals were not profitable (35%). Of the hospitals that were not profitable in FY 2020, 7 were CHPPHs (about one-third of CHPPHs), 6 were community hospitals (half of community hospitals), 3 were specialty hospitals (3 of 4 specialty hospitals), and 1 was a teaching hospital (20% of teaching hospitals).

Particularly for hospitals that typically have low or negative margins, uncertainty about future relief funds and other revenue sources may be a particular concern.

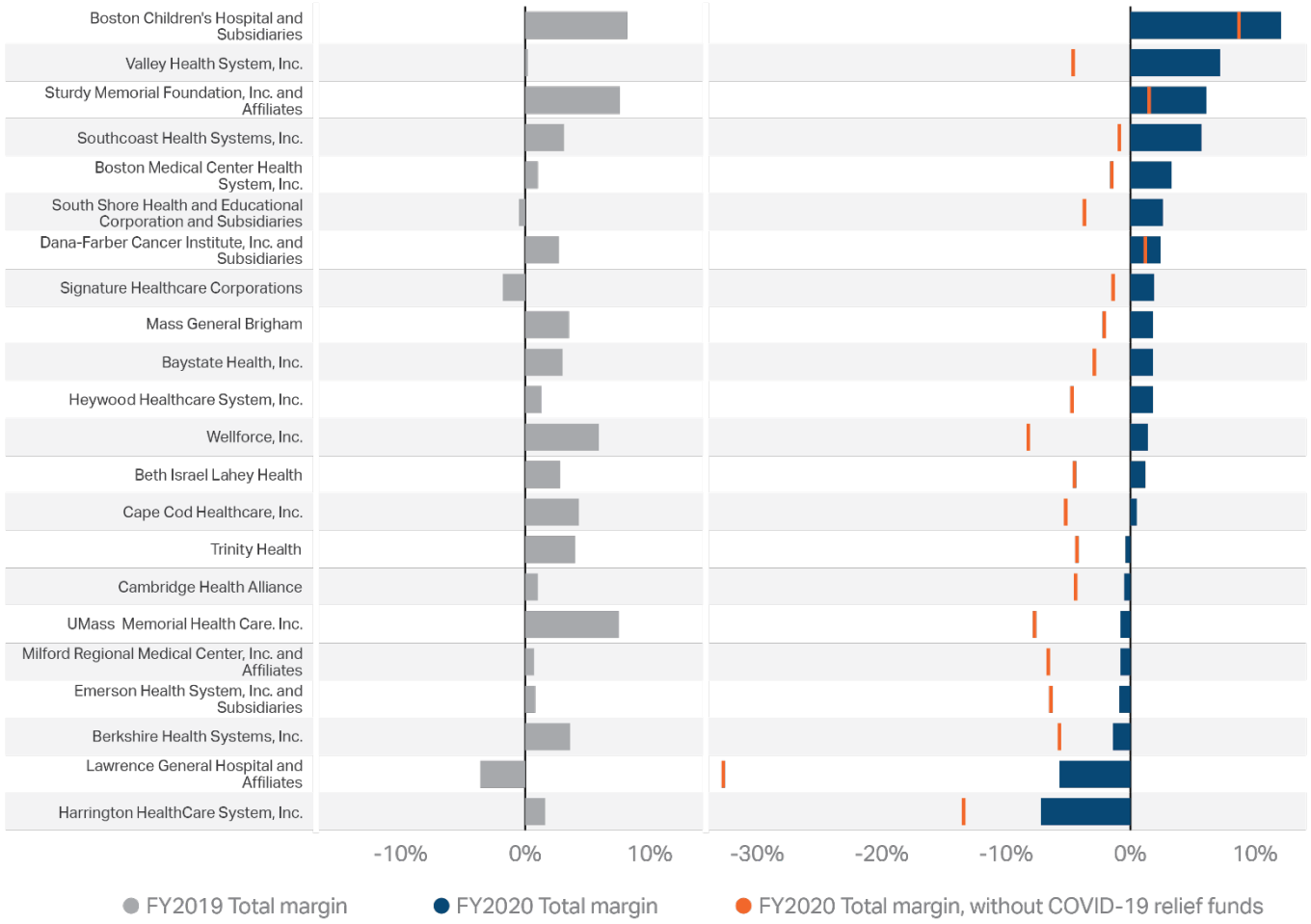
Notes: Figures include 49 of 61 hospitals, accounting for hospitals with a June 30 or September 30 fiscal year end.

Source: Center for Health Information and Analysis. Massachusetts Acute Hospital and Health System Financial Performance: Preliminary Update on Fiscal Year 2020 Data. April 2020. Available at: https://www.chiamass.gov/hospital-financial-performance/

Fewer health systems had positive margins in FY 2020 than in FY 2019, even with COVID-19 relief funds preventing greater losses.

PROVIDERS | FINANCIAL IMPACT

Total margin by health system, FY2019 and FY2020



Fewer health systems had positive margins in 2020 than in 2019, even with COVID-19 relief funds supporting hospitals in each system. Of 22 health systems, 14 had positive margins in 2020, compared to 19 in 2019.

Without COVID-19 relief funds, only 3 health systems would have had positive margins in 2020 (Boston Children's Hospital and Subsidiaries, Sturdy Memorial Foundation, Inc. and Affiliates, and Dana-Farber Cancer Institute, Inc. and Subsidiaries).

Health systems must balance finances across the different provider types in each system. For almost all health systems, physician organizations typically have negative margins year over year. Of 47 physician organizations reporting data to the Center for Health Information and Analysis (CHIA) in 2020, only 6 had positive margins, even with COVID-19 relief funds. Among these, about half had margins of -25% or lower. In 2019, of 48 entries, only 6 were positive.

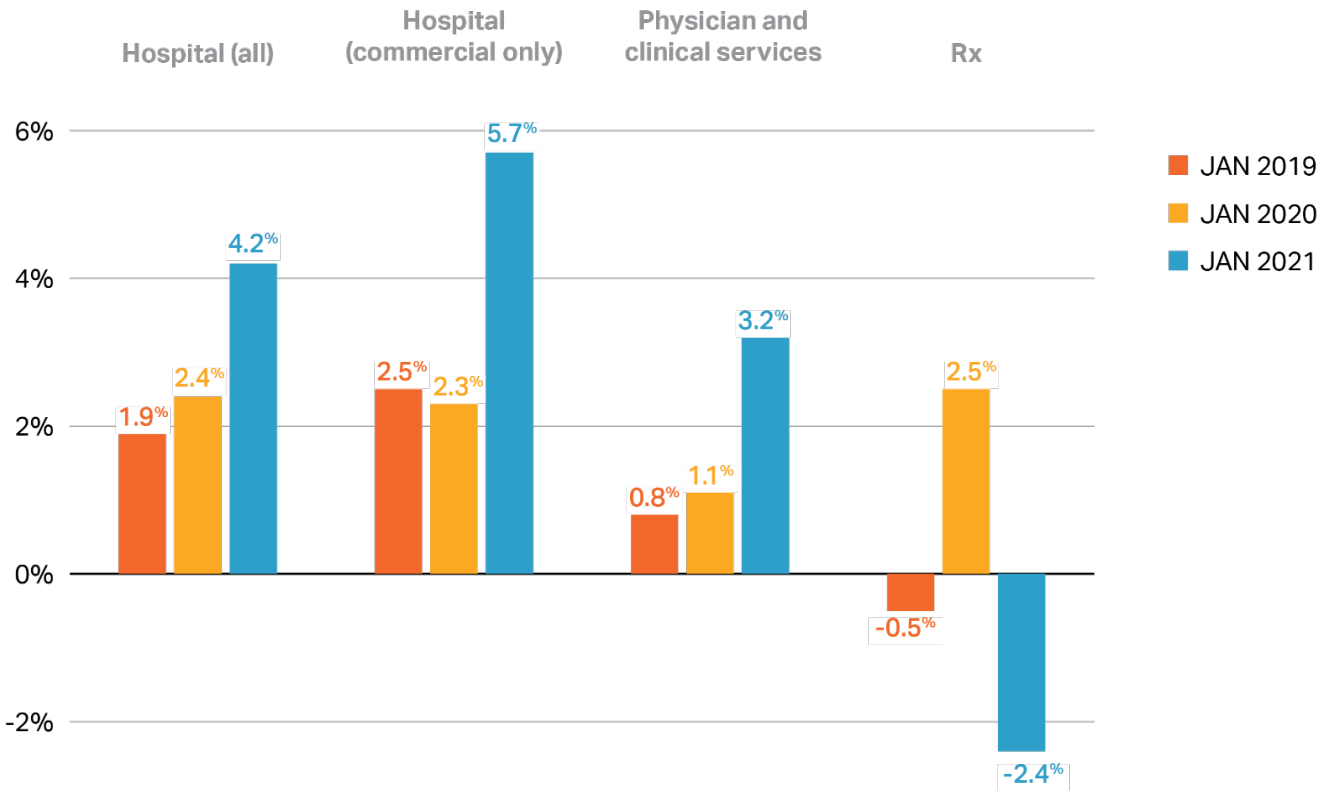
Notes: Figures include 49 of 61 hospitals, accounting for hospitals with a June 30 or September 30 fiscal year end.

Source: Center for Health Information and Analysis. Massachusetts Acute Hospital and Health System Financial Performance: Preliminary Update on Fiscal Year 2020 Data. April 2020. Available at: https://www.chiamass.gov/hospital-financial-performance/

Although national spending was down in 2020, provider price growth accelerated.

PROVIDERS | FINANCIAL IMPACT

National growth in average prices for the 12-month period ending in the date shown, by sector, all payers



In the U.S., hospital and professional prices grew dramatically in 2020.

Hospital prices increased 4.2% across all payers, with an even higher increase of 5.7% for commercial payers. Prices for physician and clinical services grew 3.2% in 2020, following two years of growth around 1% or less.

Prices for prescription drugs decreased 2.4% in 2020, although annual prices trends for drugs are more variable.

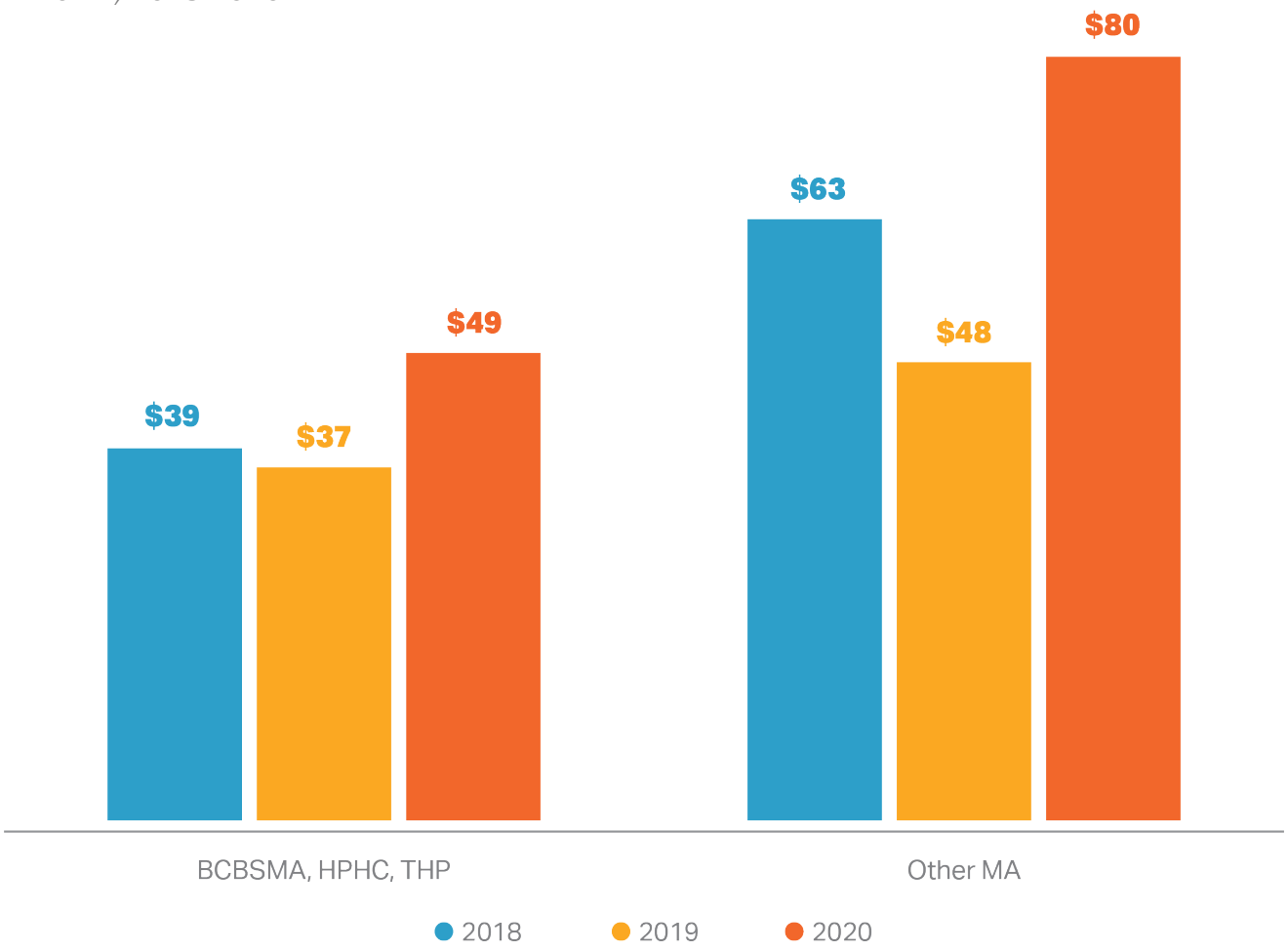
Notes: Data represents growth from January to January, for example, from January 2020 to January 2021 in the case of the most recent series.

Source: Data from the Altarum Institute. Available at: https://altarum.org/sites/default/files/uploaded-publication-files/SHSS-Price-Brief_February_2021.pdf. Underlying data from the US Bureau of Labor Statistics.

Premium income in excess of claims costs grew for Massachusetts-based commercial insurers in 2020.

INSURERS | FINANCIAL IMPACT

Average amount by which premium income exceeded the cost of claims per member per month, 2018-2020



The three largest Massachusetts-based commercial insurers saw an increase in the average amount of fully-insured premium income remaining after claims costs per member-month in 2020, from $37 in 2019 to $49 in 2020. For other MA insurers, the increase was from $48 to $80.

This measure of financial performance, sometimes referred to as average gross margin, does not necessarily indicate profit, since it does not account for other income or expenses, such as administrative expenses.

Insurer financials for 2020 are likely to be adjusted, as they do not reflect medical loss ratio rebates insurers may provide in 2021.

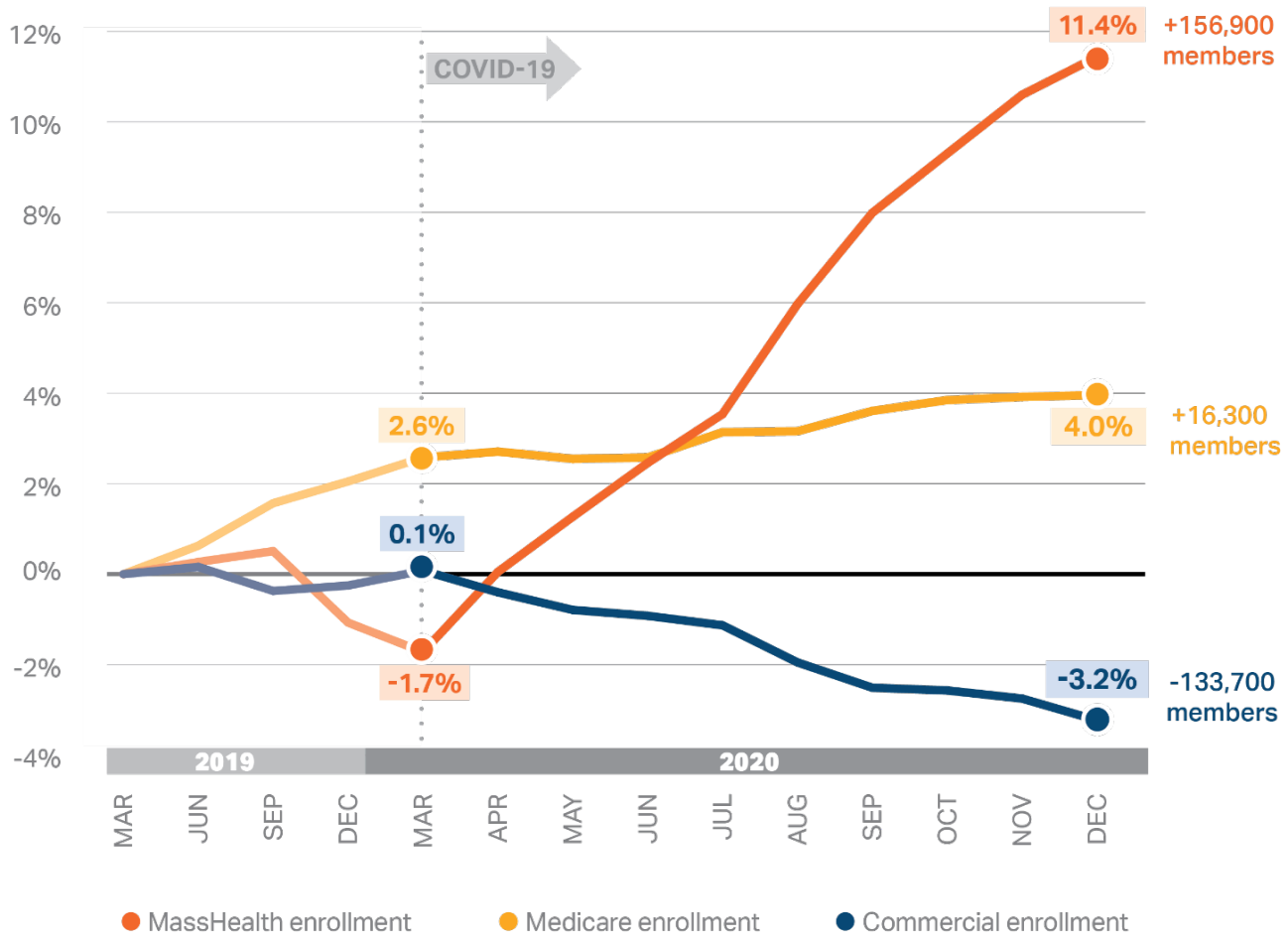
Notes: The three largest insurers in Massachusetts include Blue Cross Blue Shield of MA (BCBSMA), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan, including Tufts HMO (THP). Other Massachusetts plans include AllWays, Health New England, and Fallon Community Health Plan. Premium income is net of adjustments reported.

Sources: HPC analysis of insurer financial reports, submitted to the Massachusetts Division of Insurance for Q4 2019 and Q4 2020. Data for 2018 sourced from Q4 2019 reports; data for 2019 and 2020 sourced from Q4 2020 reports

Insurance coverage continues to shift from commercial to MassHealth, in response to economic instability and federal coverage policies.

INSURERS | COVERAGE

Massachusetts health insurance enrollment by primary source of coverage, relative to March 2019



Since the start of the pandemic, insurance coverage has steadily shifted from commercial to MassHealth, reflecting broader economic trends.

MassHealth enrollment has climbed continuously, with an increase of 13.1% between March 2020 and December 2020. MassHealth has had a net enrollment increase of 11.4% since March 2019. In contrast, commercial enrollment decreased 3.3% since March 2020. This shift represents a decrease of about 133,700 commercial members and an increase of about 156,900 MassHealth members since March 2020.

Medicare enrollment has continued to increase moderately over time, with an increase of about 16,300 members since March 2020, in line with expected trends due to the aging of the population.

Federal Medicaid maintenance of effort requirements outlined in COVID-19 relief legislation likely resulted in many individuals staying in MassHealth even after reporting changes that would normally shift them to the Health Connector or other commercial coverage.

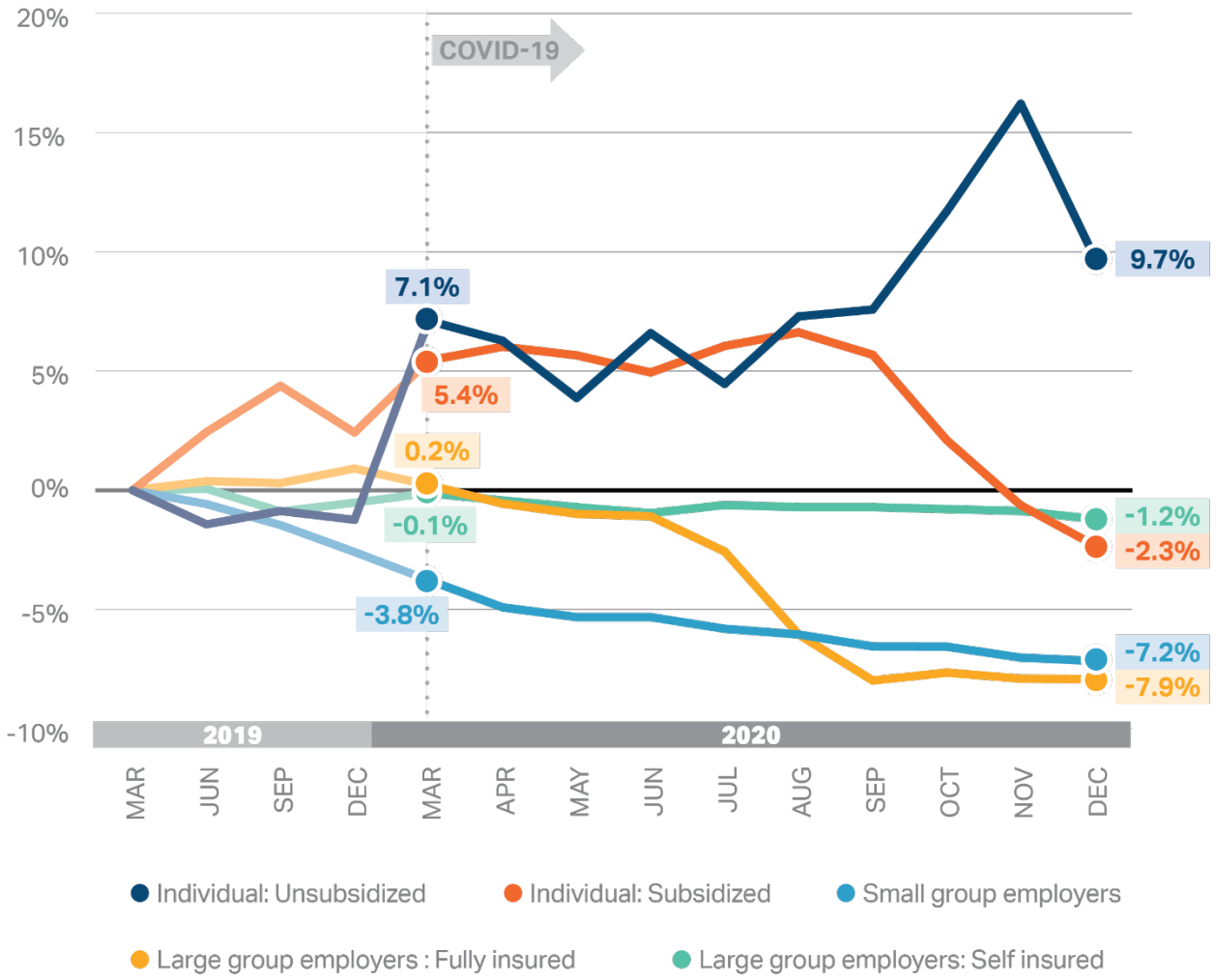
HPC

Source: HPC analysis of Center for Health Information and Analysis data "Massachusetts Health Insurance Enrollment, March 2019 through December 2020." MassHealth includes those with primary coverage through MassHealth.

For the largest employers, health insurance enrollment remained stable in 2020, while enrollment shifted from smaller employers to the individual market.

INSURERS COVERAGE

Massachusetts private health insurance enrollment by market segment, relative to March 2019



Insurance coverage in the self-insured large group market (which includes most of the largest employers) declined only 1% since the start of the pandemic, a decline of 25,200 members.

In contrast, coverage through small employers declined 3.4%, and coverage through the fully-insured large group market (which tend to be medium-sized employers) declined 8.1% in 2020, a decrease of 14,300 and 79,600 members, respectively.

Unsubsidized coverage through the individual market, which was stable in 2019, increased sharply at the start of the pandemic and continued to increase throughout 2020. Trends in the subsidized individual market remained relatively stable in 2020 until declining in the fall.

HPC

Source: HPC analysis of Center for Health Information and Analysis data "Massachusetts Health Insurance Enrollment, March 2019 through December 2020."

Key Findings: Hospitals

1 INPATIENT ADMISSIONS **Total hospital inpatient volume dropped 32% from January to April 2020**. At the same time, hospitals were converting clinical capacity to care for patients with COVID-19. The number of **COVID-19-related admissions peaked in April, totaling 20% of all admissions that month**. Non-COVID-19 volume increased after April, as capacity stabilized and the health care system reopened, but totals did not reach pre-pandemic levels by the end of 2020. Overall, the number of admissions was 9% lower in 2020 than in 2019.

Data limitations for this interim report include:

- Hospital and ED data are preliminary.
- Hospital inpatient data and hospital financial data do not currently include all Massachusetts hospitals.
- Limited data available on ambulatory care and other non-hospital providers.
- The HPC will update data and aim to identify additional data sources for the final report.

2 HIGH ACUITY INPATIENT ADMISSIONS While the total number of inpatient admissions dropped in April, **the number of patient days in intensive care units/critical care units (ICU/CCU) increased dramatically, spiking 63% over April 2019 levels**. While ICU/CCU use dropped after the initial surge, ICU/CCU days remained higher than 2019 levels through 2020. Overall, the number of ICU/CCU days increased 10% from 2019 to 2020, even as the number of admissions was lower.

3 INPATIENT ADMISSIONS BY RACE/ETHNICITY People of color represented a larger share of COVID-19-related inpatient hospital admissions, compared to their share of overall inpatient admissions. **COVID-19-related hospital admissions were particularly disproportionate for Black and Hispanic patients**. Among patients age 65+, the share of COVID-19 related admissions among Black patients was **double** their share of all hospital admissions. Among Hispanic patients 18 to 64 and age 65+, the share of COVID-19-related admissions was **more than twice** their share of all hospital admissions.

Key Findings: Hospitals

4 EMERGENCY DEPARTMENT (ED) VISITS ED visits fell sharply in spring 2020, decreasing 55% between January and April 2020. ED visits then started to increase, but as of September 2020, had not returned to 2019 levels. Overall, the number of **ED visits in January to September 2020 was 23% lower than the total from the same months in 2019.**

5 POTENTIALLY AVOIDABLE ED USE All categories of ED visits declined during the pandemic, but potentially avoidable ED visits declined most. **From April – September 2020, the total number of potentially avoidable ED visits was 38% lower than in the same months in 2019**, compared to declines of 34% for injuries, 22% for behavioral health, and 31% for all other ED visits.

- Potentially avoidable ED visits decreased most for children compared to other age groups. More research is needed to understand the extent to which patients who may have otherwise gone to the ED sought alternative care (e.g., primary care visits, telehealth), did not need care (e.g., due to lower exposure), or had unmet care needs.

6 HOSPITAL FINANCIAL IMPACT Including federal and state COVID-19 relief funding, median margins were positive for all hospital cohorts in fiscal year (FY) 2020. **However, some hospitals, particularly community hospitals and community high public payer hospitals, had negative margins in FY 2020 even with relief funding preventing greater losses.** With respect to Massachusetts' 22 larger health systems that encompass most of these hospitals and their affiliated physician organizations, 8 had negative overall margins in FY 2020 even including COVID-19 relief funds, a higher number of systems than in 2019. 7 of the 8 were community-hospital based systems.

Key Findings: Behavioral Health

7 ED BOARDING The total number of behavioral health (BH)-related ED visits was 16% lower in January to September 2020, compared to the same months in 2019. However, the percentage of these visits resulting in ED boarding (waiting over 12 hours in the ED) increased, from 27% of BH-related visits over those months in 2019 to 29% in 2020. The percentage of BH-related ED visits resulting in ED boarding increased throughout the pandemic, reaching 31% in September.

- Rates of ED boarding were highest among pediatric patients. From March to September 2020, 39% of pediatric BH ED visits resulted in ED boarding compared to 28% of adult BH visits.
- Pediatric BH patients not only had higher rates of ED boarding than other age groups but were also more likely to experience boarding that lasted over 48 hours. In 2020, 29% of pediatric patients who experienced ED boarding spent over 48 hours in the ED.
- One important dynamic likely impacting the increase in behavioral health ED boarding is the loss of nearly 270 psychiatric beds in the Commonwealth during this time period, due to closures and COVID-19 related physical distancing and quarantine protocols.

8 INPATIENT ADMISSIONS The volume of BH-related inpatient stays at acute-care hospitals decreased about 14% from 2019 to 2020. As mentioned above, this decline may be a reflection of loss of psychiatric bed capacity at these hospitals and not due to a lack of need for inpatient psychiatric beds. Information on admissions for free-standing psychiatric hospitals was not available.

9 TELEHEALTH FOR BEHAVIORAL HEALTH Utilization data from two data sources showed that over 70% of visits for BH were performed via telehealth in April, with this percentage remaining near 70% through September 2020. Although all age groups had the majority of their psychotherapy visits via telehealth in the spring, those under 10 years old and over 75 years old were slightly more likely to return to in-person therapy by the summer compared to others. Among pediatric patients who were receiving psychotherapy services before the pandemic, the majority of patients converted entirely to telehealth or a mix of in-person and telehealth (72%), but almost a quarter of these patients discontinued care.

Key Findings: Preventative Care, Telehealth, and Health Insurers

10 PREVENTATIVE CARE **Annual primary care well visits declined 28%** among Group Insurance Commission members with coverage through Health New England from March 2020 – February 2021 compared to March 2019 – February 2020.

11 TELEHEALTH Use of telehealth as a share of all healthcare services peaked in April 2020 in Massachusetts. **Among commercially-insured Massachusetts residents, approximately 70% of primary care, specialist, and BH visits were provided via telehealth in April**. Starting in May, primary care and specialist visits began returning to in-person care but use of telehealth still represented 20-30% of visits in September. Use of telehealth for BH remained consistently high.

12 INSURER FINANCIAL IMPACT **Massachusetts-based commercial insurers retained a greater amount of their premium income in 2020 than in the previous two years.** Across Massachusetts-based insurers, fully-insured premium revenue increased by 2.3% ($10.7 to $10.9 billion) from 2019 to 2020, while medical claims expenditures decreased by 1.9% ($9.5 to $9.3 billion). Profitability did not necessarily increase in proportion to these changes, however, as these figures do not include administrative expenses or potential rebates and premium credits.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
- **Care Delivery Transformation**
  - Cost-Effective, Coordinated Care for Caregivers and Substance Exposed Newborns (C4SEN) Investment Program Awardee Selection **(VOTE)**
- Schedule of Next Meeting **(May 19, 2021)**

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
- Care Delivery Transformation
  - **Cost-Effective, Coordinated Care for Caregivers and Substance Exposed Newborns (C4SEN) Investment Program Awardee Selection (VOTE)**
- Schedule of Next Meeting **(May 19, 2021)**

Cost-Effective, Coordinated Care for Caregivers and Substance Exposed Newborns (C4SEN) Program Structure

$1.5 Million

The HPC will invest $1.5 million dollars in the C4SEN Investment Program.

24 Months

The Period of Performance will be 24 months – comprised of a 3-month Planning Period and a 21-month Implementation Period.

5 Awards

The HPC will award funding of up to $300,000 to up to 4 DHTF-eligible hospitals and 1 other provider organization.

6 Months

Following the Period of Performance, there will be a 6-month Evaluation Period where the HPC will conduct an evaluation, and Awardees will participate in evaluation-related activities.

HPC

RFP Elements: Required Operational Components of Proposed Models

1. Support infant and caregiver for a minimum of 12 months.
2. Coordinate with outpatient providers and/or directly provide access to pediatric services, adult primary care, and adult behavioral health care (including medication-assisted treatment (MAT) for the caregiver).
3. Providers should demonstrate cultural humility and provide care that is free of stigma and bias.
4. Collaborate with at least one community-based or social service organization to meet the non-medical needs (including health-related social needs (HRSNs)) of caregivers and substance exposed newborns (SEN).
5. Ensure that SEN who are experiencing or at risk for developmental delays have access to supportive services, including Early Intervention (EI).

The HPC received nine proposals for funding.

Distressed Hospital Trust Fund Eligibility

- 6 of the applicants were DHTF-eligible entities.
- 3 of the applicants were non-DHTF-eligible entities.

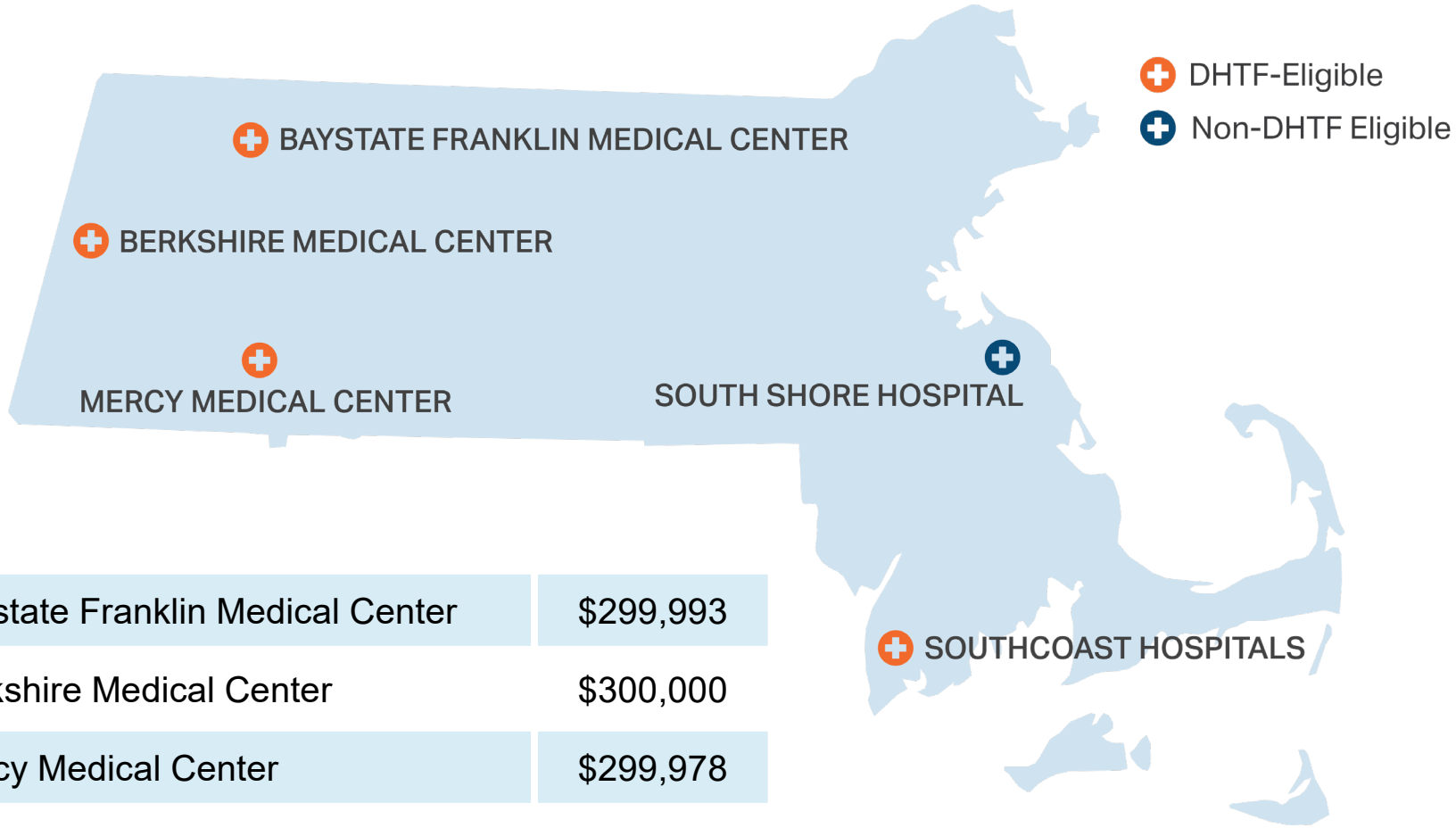
Many Applicants are Previous HPC Awardees

- 3 SHIFT-Care Awardees
- 4 HCII Awardees
- 6 CHART Awardees

Limited Range of Requested Funding

- Applicants requested between $274K and $300K in funding
- Average requested funding was $295,676
- Total requested funding across the nine applicants was $2,661,034

RSC Award Recommendations

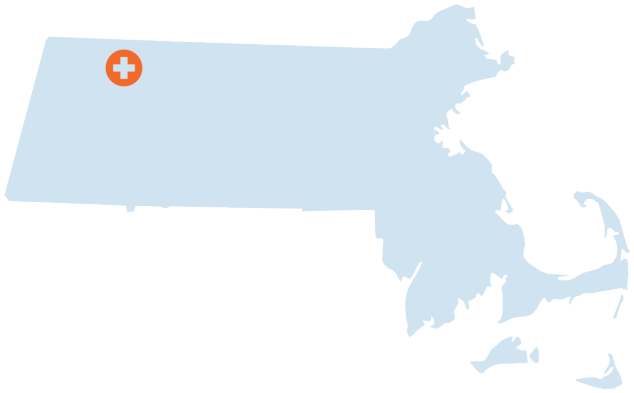


Baystate Franklin Medical Center	$299,993
Berkshire Medical Center	$300,000
Mercy Medical Center	$299,978
Southcoast Hospitals	$287,541
South Shore Hospital	$274,030

Baystate Franklin Medical Center

PROGRAM PURPOSE

To build on their existing Moms Do Care program through the creation of a new multidisciplinary clinic to optimize interactions between providers, families and Early Intervention (EI) providers and provide new services to fill gaps in existing care



PROPOSED USE OF C4SEN FUNDS

- New part-time Program Coordinator and part-time Social Worker, support for Program Leaders
- Training costs for new screenings and intervention
- Stipend for EI Partners

REQUESTED HPC FUNDING

$299,993

TARGET ENROLLMENT

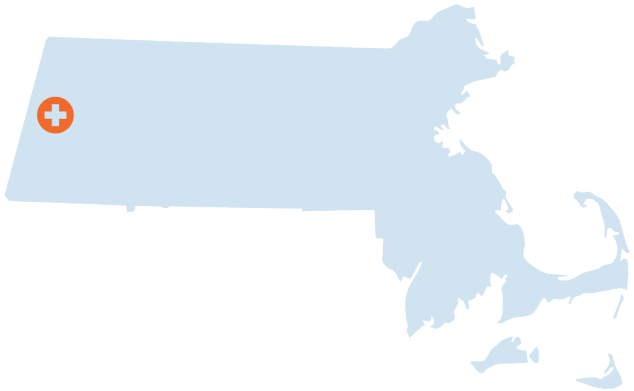
20 new caregivers per year

HPC

Berkshire Medical Center

PROGRAM PURPOSE

To create the “Berkshire Connections” program to provide individualized care coordination to caregivers beginning in pregnancy in coordination with Berkshire OBGYN and local pediatric practices



PROPOSED USE OF C4SEN FUNDS

- Full-time Program Director, part-time Grant Coordinator and Data Coordinator
- Technology for telemedicine portals
- Travel costs for Program Director and vouchers for caregivers
- Stipends for Pediatric Partners to set up information sharing and data collecting practices

REQUESTED HPC FUNDING

$300,000

TARGET ENROLLMENT

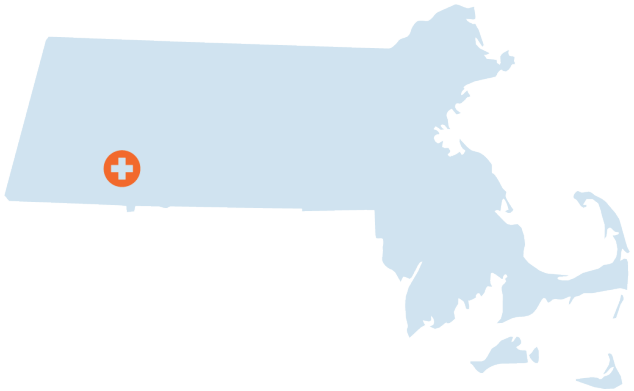
70 new caregivers per year

HPC

Mercy Medical Center

PROGRAM PURPOSE

To add technology to promote new clinical pathway and care coordination model to streamline provision of existing services to improve patient experience and care



PROPOSED USE OF C4SEN FUNDS

- Reconfigure technology platform to streamline referral and documentation system
- Increase use of telemedicine between geographically distant sites
- Staff time to operationalize new system
- Four computers for telemedicine; one computer for Award Manager
- Patient assistance funds and transportation

REQUESTED HPC FUNDING

$299,978

TARGET ENROLLMENT

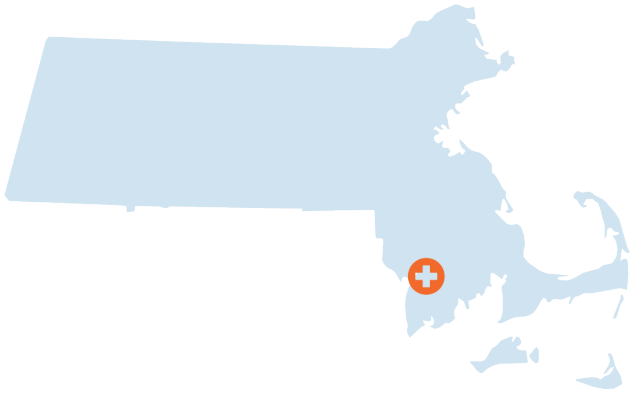
20 new caregivers per year

HPC

Southcoast Hospital

PROGRAM PURPOSE

To expand on their existing “New Beginnings” program through the addition of the “New Beginnings Community Outreach Project” and facilitate communication with providers and community agencies to increase cross-system collaboration and improve access to postpartum care



PROPOSED USE OF C4SEN FUNDS

- New role: Community Outreach Specialist
- Existing role partial fund: RN Care Coordinator
- Assistance for Caregivers to attend clinical and community appointments
- Travel between hospitals for Community Outreach Specialist

REQUESTED HPC FUNDING

$287,541

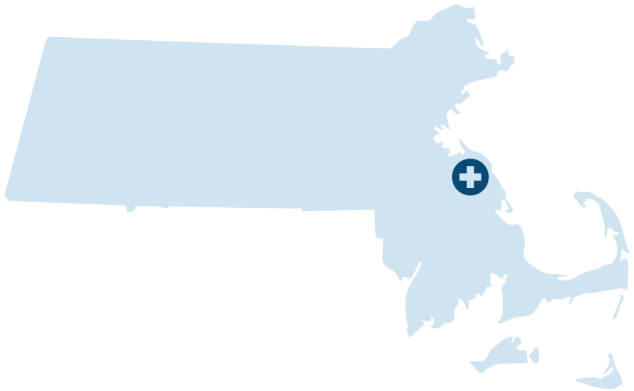
TARGET ENROLLMENT

25 new caregivers per year

South Shore Hospital

PROGRAM PURPOSE

To expand existing services provided by the SHORE program (embedded in the Perinatal Behavioral Health Program) through the introduction of a peer support role, perinatal/ pediatric care coordinator, lactation consultant, and data analyst, with the goal of doubling the service capacity



PROPOSED USE OF C4SEN FUNDS

- New direct service staff roles: Peer Support, Perinatal/Pediatric Care Coordinator, Lactation Consultant
- Data analyst and technology for data gathering
- Taxi vouchers and patient assistance (useful items for caregiver)

REQUESTED HPC FUNDING

$274,030

TARGET ENROLLMENT

25-35 new caregivers per year

HPC

C4SEN Investment Program Timeline

2021

April

- Board vote
- Begin contracting

July

- Program launch: Planning Period

October

- Program launch: Implementation Period

2023

June

- Implementation Period end

July - December

- Evaluation Period

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Cost-Effective, Coordinated Care for Caregivers and Substance Exposed Newborns (C4SEN)

Motion: That the Commission hereby accepts and approves the Executive Director's recommendations that the Applicants for the Cost-Effective, Coordinated Care for Caregivers and Substance Exposed Newborns (C4SEN) Investment Program receive award funding pursuant to G.L. c. 6D, § 19, G.L. c. 29, § 2GGGG, chapter 41 of the Acts of 2019 (1450-1200), and 958 CMR 5.07, as applicable, up to the amounts presented and subject to successful completion of Awardee contracting, and authorizes the Executive Director in his discretion to determine the final terms and amount of each award.

MASSACHUSETTS
HEALTH POLICY COMMISSION

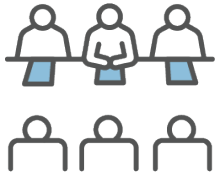
AGENDA

- Welcome by HPC Chair Stuart Altman
- Approval of Minutes from January 13, 2021 Meeting **(VOTE)**
- Election of Vice Chair **(VOTE)**
- Market Oversight and Transparency
- Care Delivery Transformation
- **Schedule of Next Meeting (May 19, 2021)**

Upcoming 2021 Meetings and Contact Information

BOARD MEETINGS

July 14
September 15
November 17



COMMITTEE MEETINGS

June 2
October 6
December 15

SPECIAL EVENTS

ADVISORY COUNCIL
May 12
September 29
December 8

Mass.gov/HPC

@Mass_HPC

HPC-info@mass.gov

HPC