



HPC Board Meeting

June 7, 2023



Agenda



CALL TO ORDER

Approval of Minutes (VOTE)

Findings from the 2023 Health Care Cost Trends Report

Reducing Unnecessary Administrative Complexity: Policy Options

Implementation of the Federal No Surprises Act

Executive Director's Report

Adjourn

Agenda



Call to Order



APPROVAL OF MINUTES (VOTE)

Findings from the 2023 Health Care Cost Trends Report

Reducing Unnecessary Administrative Complexity: Policy Options

Implementation of the Federal No Surprises Act

Executive Director's Report

Adjourn

VOTE

Approval of Minutes from the April 13 Board Meeting

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on April 13, 2023, as presented.

Call to Order

Approval of Minutes (**VOTE**)



FINDINGS FROM THE 2023 HEALTH CARE COST TRENDS REPORT

- Massachusetts Spending Performance
- Excessive Spending in the Massachusetts Health Care System: Focus on Utilization
- Key Findings from Chartpacks

Reducing Unnecessary Administrative Complexity: Policy Options

Implementation of the Federal No Surprises Act

Executive Director's Report

Adjourn

Reducing excessive health care spending is essential to achieve an affordable, equitable, and accessible health care system for all residents of Massachusetts.



- **Commercial health care spending per person in Massachusetts grew 5% each year from 2019-2021, double the rate of income growth.** Combined family health insurance premiums and out of pocket spending neared **\$25,000 per year in 2021, on average, in Massachusetts.**
- **These trends are unsustainable for government, employers (particularly small businesses), and all residents.** Premium growth that outpaces income growth will continue to **erode take-home pay, increase avoidance of care, worsen health outcomes,** and will require more and more residents to **choose between health care and other basic needs.**
- Limiting the future growth of health care spending will require identifying **areas where spending growth can be moderated,** particularly as the policymakers and the HPC have identified the **need for investments in primary care, behavioral health care, health equity, the health care workforce,** and in **under-resourced providers.**
- In this **10th Annual Health Care Cost Trends Report,** the HPC will return to a theme of the first Annual Report (2013), which discussed unnecessary health care spending in Massachusetts.¹ This report will **highlight and quantify** areas of excessive spending throughout the health care system where **savings are achievable within the current system without harming quality and access to care.**

2023 Annual Cost Trends Report: Outline and Public Presentation Dates



- **Chapter #1: Massachusetts Spending Performance** – *some initial findings presented at the HPC Benchmark Hearing March 2023; further findings presented at the HPC Board meeting on June 7, 2023*
- **Chapter #2: Excessive Spending in the Massachusetts Health Care System**
 - Excessive Prices – *presented at the May 10, 2023 MOAT meeting*
- **Chapter #3: Excessive Utilization in the Massachusetts Health Care System**
 - Excessive Utilization - *key findings presented at the HPC Board meeting on June 7, 2023*
 - *Provision of care that adds little to no value*
 - *Use of unnecessarily high-cost sites of care*
 - Excessive Administrative Costs (Payer and Provider)
- **Five Chartpacks** – *key findings presented at the HPC Board meeting on June 7, 2023*
 - Primary Care and Behavioral Health (*new!*)
 - 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 12, 2023*
- **Policy Recommendations** – *to be presented at the HPC Board meeting on July 12, 2023*

Agenda



Call to Order

Approval of Minutes (**VOTE**)

Findings from the 2023 Health Care Cost Trends Report

➤ MASSACHUSETTS SPENDING PERFORMANCE

- Excessive Spending in the Massachusetts Health Care System: Focus on Utilization
- Key Findings from Chartpacks

Reducing Unnecessary Administrative Complexity: Policy Options

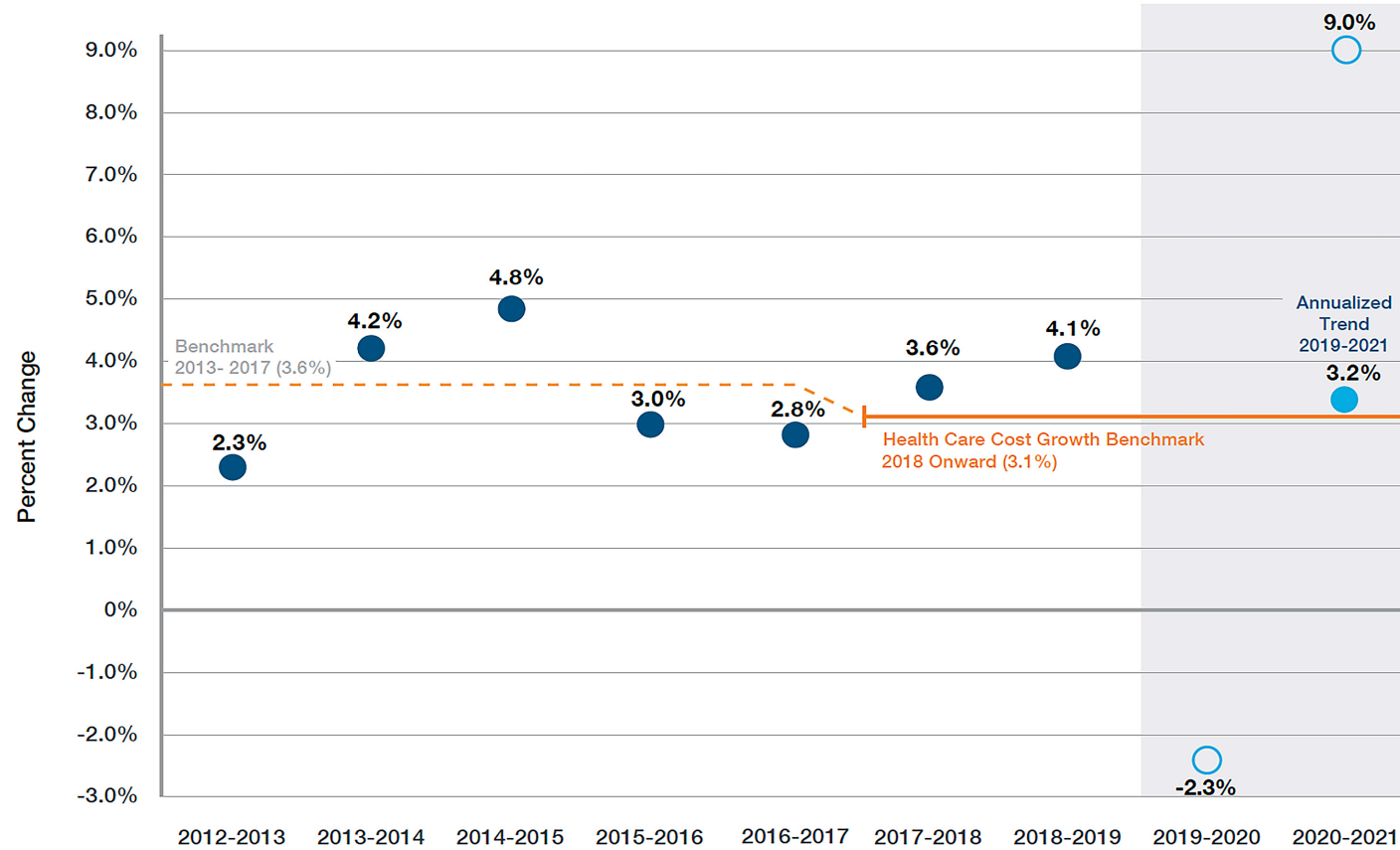
Implementation of the Federal No Surprises Act

Executive Director's Report

Adjourn

Chapter 1: Massachusetts Spending Performance

Massachusetts Benchmark Performance, 2012-2021

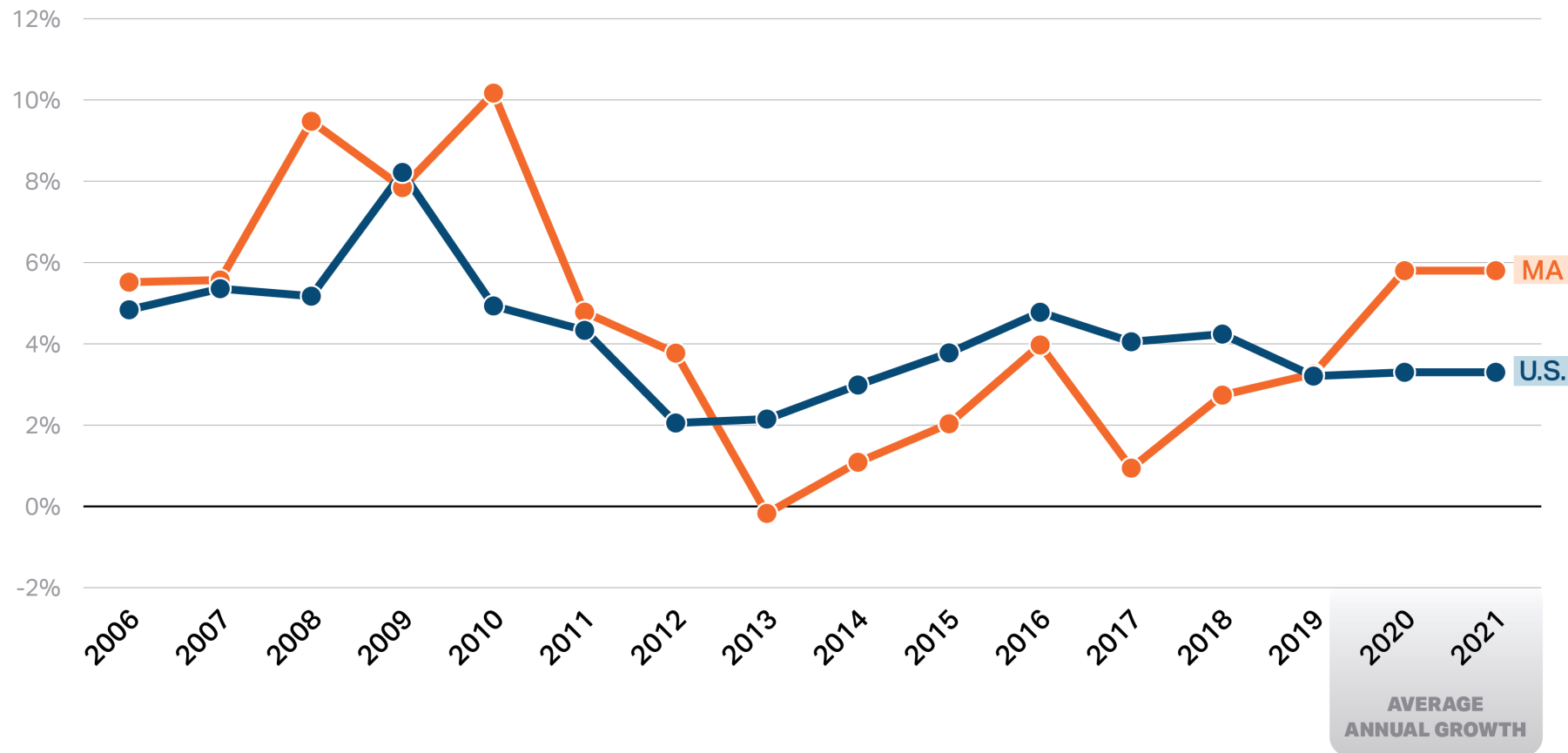


Average annual growth rate, 2012-2021: **3.52%**

After several years of lower growth, commercial spending growth in Massachusetts exceeded the U.S. average from 2019-2021.



Annual growth in per capita commercial health care spending, Massachusetts and the U.S., 2006-2021. Data for 2020 and 2021 represent average annual growth from 2019-2021. Other data points represent growth from the previous year to the year shown.

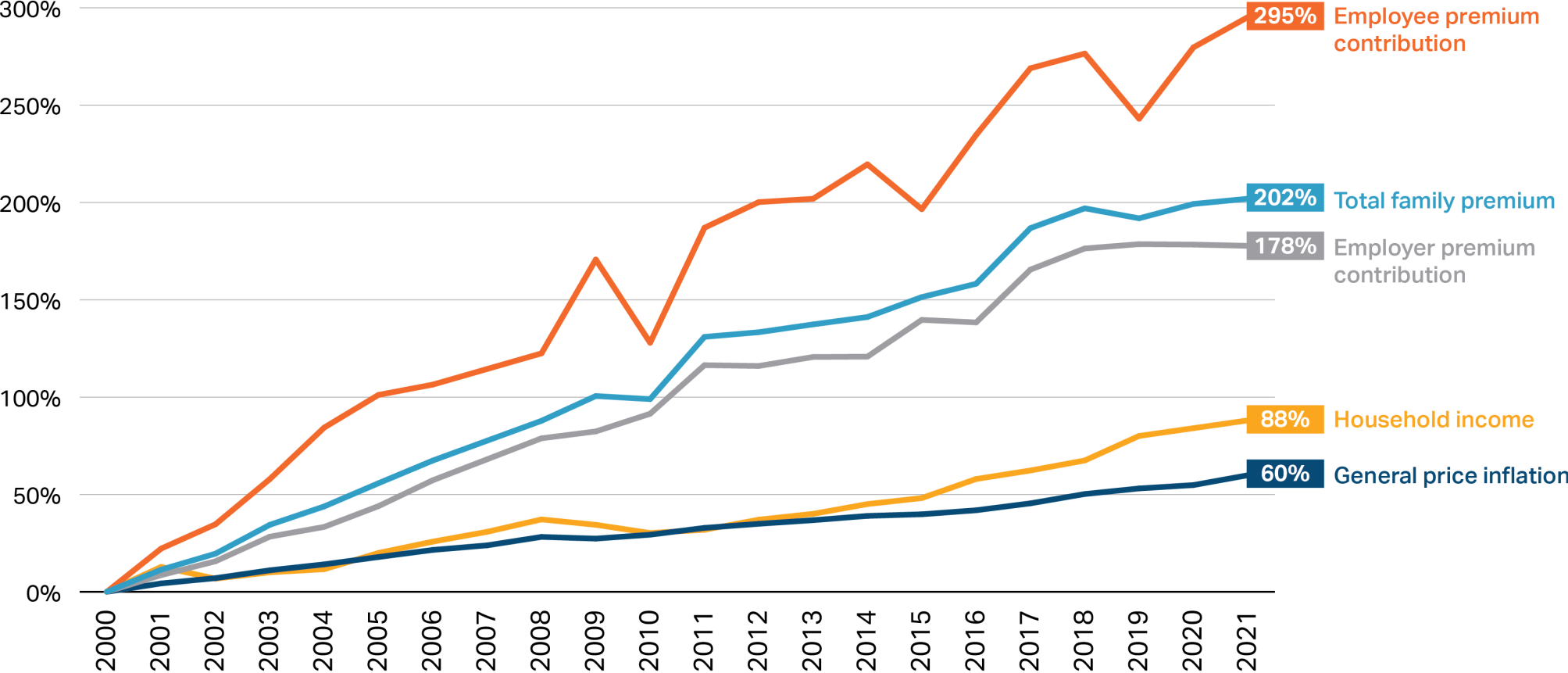


Notes: Massachusetts data include full-claims members only. Commercial spending is net of prescription drug rebates and excludes net cost of private health insurance. Sources: Centers for Medicare and Medicaid Services, National Healthcare Expenditure Accounts Personal Health Care Expenditures, 2014-2021 and State Healthcare Expenditure Accounts 2005-2014; Center for Health Information and Analysis, Total Health Care Expenditures, 2014-2021.

Overall, employee premium payments have grown 295% since 2000, more than 3 times as fast as household income and 4 times as fast as inflation.



Cumulative growth in each indicator, 2000-2021

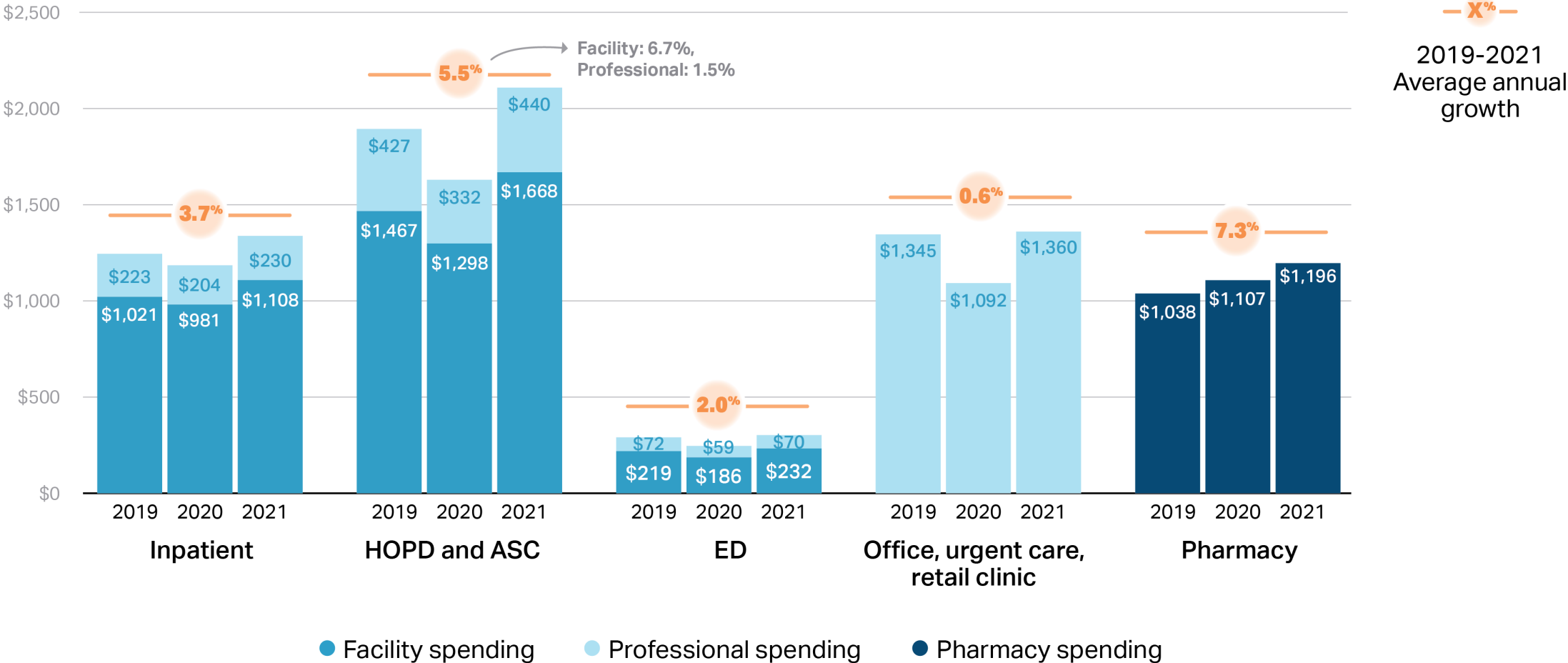


Notes: Employee contributions to family health insurance premiums have increased as a share of the total premium from 21% in 2000 to 27% in 2021.
 Sources: Agency for Healthcare Research and Quality: Medical Expenditure Panel Survey-Insurance Component; Census Bureau Current Population Survey (2000-2004); American Community Survey, 1-year (2005-2021); Bureau of Labor Statistics, CPI-U.

Hospital outpatient department and pharmacy spending were the largest drivers of commercial spending growth from 2019-2021. This growth was mostly driven by higher prices.



Commercial spending per member per year, and average annual growth, by care setting, 2019-2021



Notes: Medical spending reflects data from six payers: BCBSMA, HPHC, Tufts, AllWays, Anthem and Health New England. Pharmacy spending is net of rebate and excludes Anthem. Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2019-2021.

Call to Order

Approval of Minutes (**VOTE**)

Findings from the 2023 Health Care Cost Trends Report

- Massachusetts Spending Performance

**➤ EXCESSIVE SPENDING IN THE MASSACHUSETTS HEALTH CARE SYSTEM:
FOCUS ON UTILIZATION**

- Key Findings from Chartpacks

Reducing Unnecessary Administrative Complexity: Policy Options

Implementation of the Federal No Surprises Act

Executive Director's Report

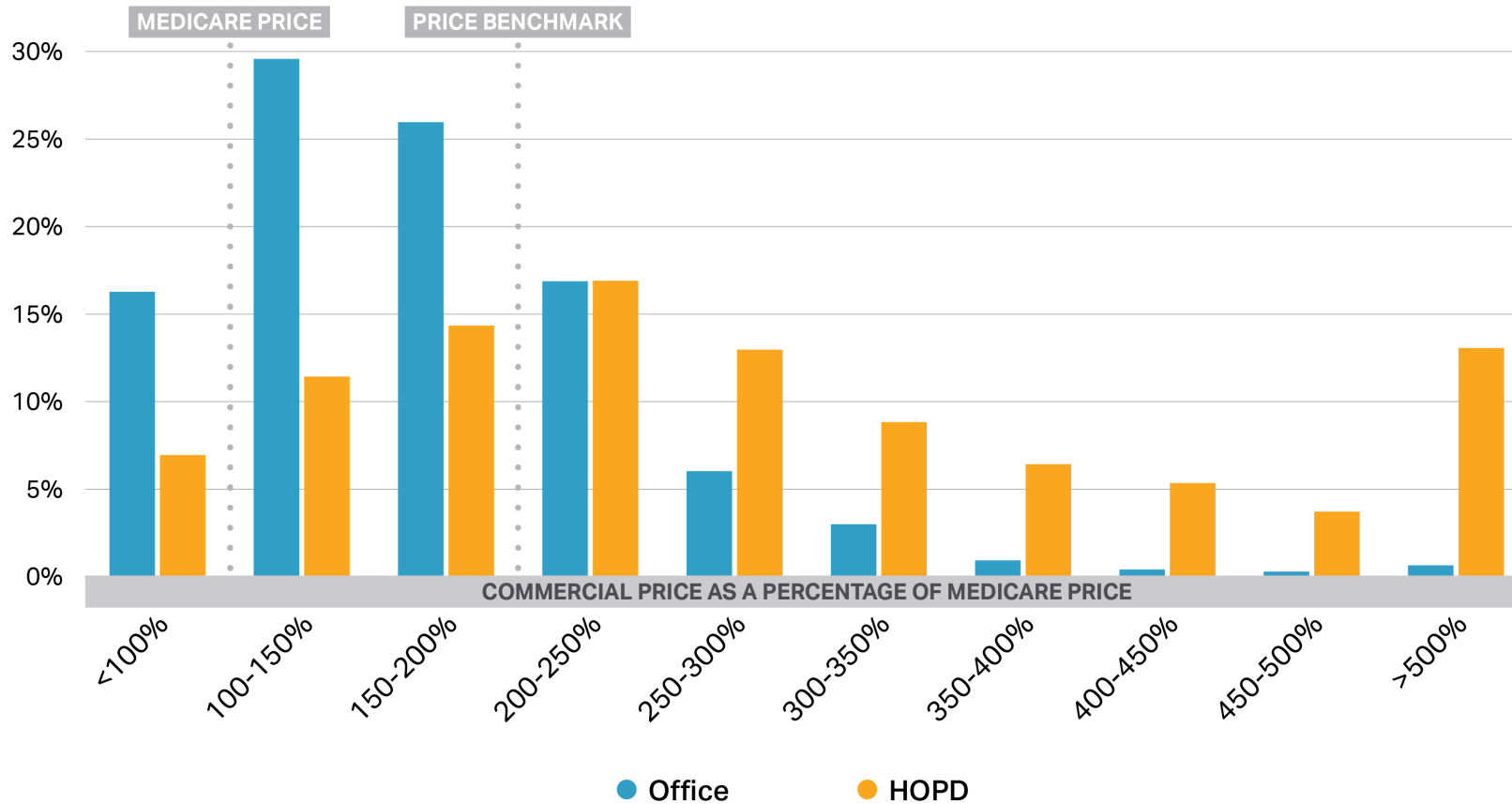
Adjourn

Chapter #2: Excessive Spending in the Massachusetts Health Care System: Prices

- Focusing on major categories of care where there are particularly high prices driven by provider **market leverage**, HPC followed prior work and research literature to define instances where payers paid providers “**excessive prices**” – typically **far beyond the cost to provide the service** for an efficient provider.
- In most cases, HPC deemed prices **beyond double what Medicare would pay** as excessive.
- For these categories of care, HPC displayed the distribution of prices paid relative to what Medicare would pay, and **summed spending above excessive price levels**.

47% of imaging services performed in HOPD settings were paid in excess of 200% of Medicare's HOPD price.

Percentage of imaging services paid at shown ranges relative to what Medicare would pay a HOPD, by setting of care, 2021



- Imaging services make up approximately 5.5% of commercial health care spending.
- 47% of imaging services performed in HOPDs were paid more than 200% of Medicare's HOPD price, as were 11% of imaging services performed in an office setting.
- 22.5% of all imaging spending was above 200% of Medicare's HOPD price.

Notes: Includes encounters for all Medicare covered imaging services. Benchmarks are applied at the level of a procedure code, and reflect the Medicare Physician Fee Schedule professional component and facility payment from the Outpatient Prospective Payment System (OPPS). For services where there is no corresponding OPPS payment (e.g., mammography), the global MPFS payment amount (which corresponds to the entire payment for relevant professional and technical components of an when delivered in an office setting) was applied. Percentages are calculated as the aggregate utilization in each bin divided by total utilization for each care setting.

Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database, 2021, V 2021; HPC analysis of information from the Centers for Medicare and Medicaid Services, Medicare Physician Fee Schedule (2021).

Overall, 27% of spending in these categories was found to be excessive due to high prices. This excessive spending amounted to \$3 billion in 2021.



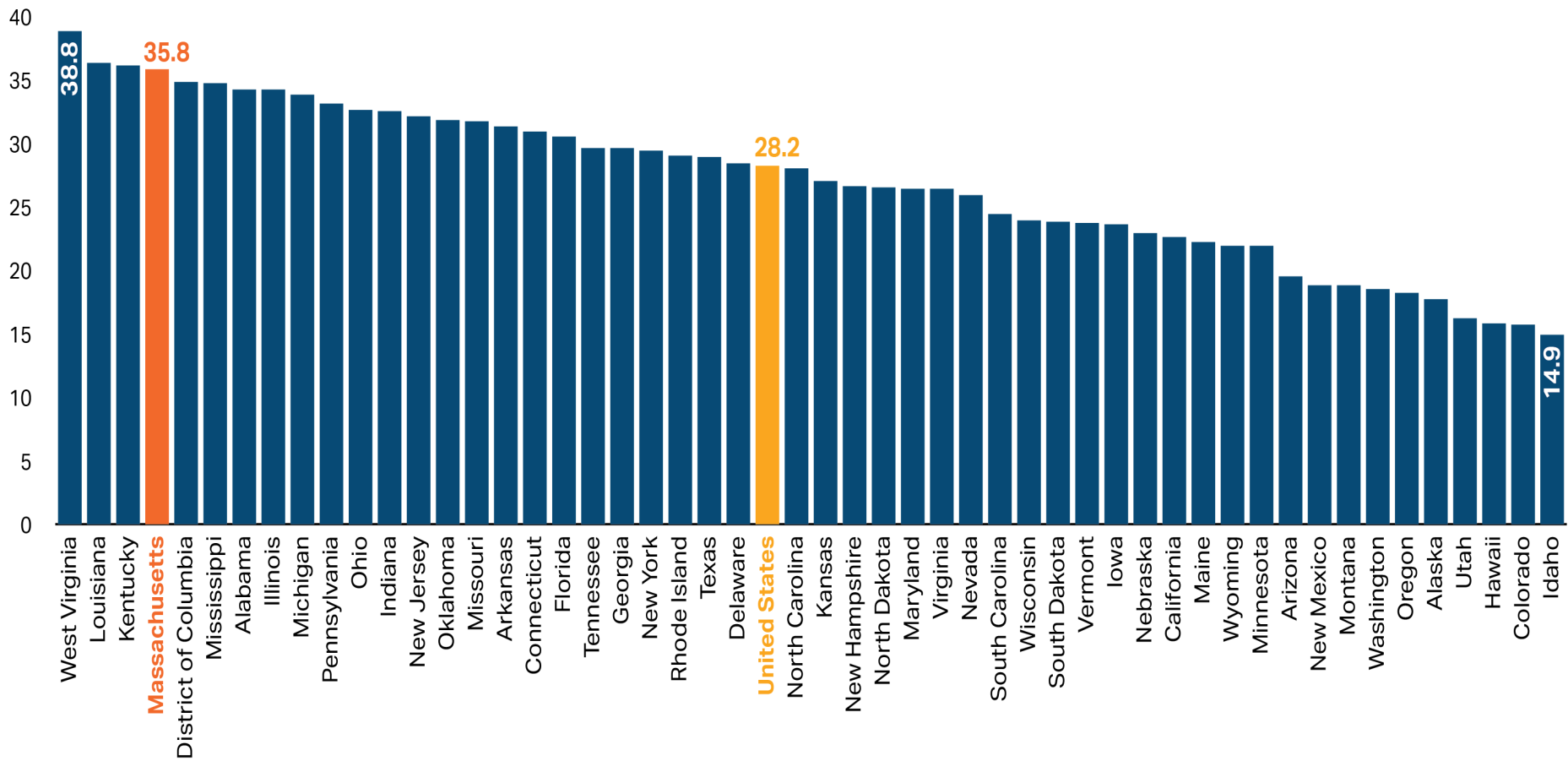
Estimated excessive spending using example benchmark for seven service categories, 2021

Service category	Modeled spending (millions), 2021	Price benchmark	% of spending over the price benchmark	Excessive spending (\$, millions)	Excessive spending (% of TME)
Labs	\$967M	200% of Medicare	22.9%	\$221M	0.9%
Specialty Services	\$618	200% of Medicare (Office)	35.4%	\$218	0.9%
Imaging	\$1,378	200% of Medicare (HOPD)	22.5%	\$309	1.2%
Endoscopy/Colonoscopy	\$342	200% of Medicare (HOPD)	3.6%	\$12	0.05%
Inpatient Stays	\$3,836	200% of MassHealth	9.0%	\$344	1.4%
Clinician-Administered drugs	\$639	200% of Medicare	13.7%	\$88	0.4%
Prescription Drugs	\$3,579	120% of international prices	52.0%	\$1,859	7.5%
Total	\$11,358 (46% of TME)		26.9%	\$3,053	12.3%

Massachusetts had the 4th highest rate of avoidable Medicare hospitalizations in 2021.



Annual avoidable hospital admissions per 1,000 FFS Medicare beneficiaries in 2021 among beneficiaries age 65+, by state



Avoidable hospitalizations are those for certain chronic conditions (diabetes, COPD, asthma, hypertension, CHF, dehydration, bacterial pneumonia, UTI, and lower extremity amputation) that could have been prevented or treated outside of an inpatient hospital setting.

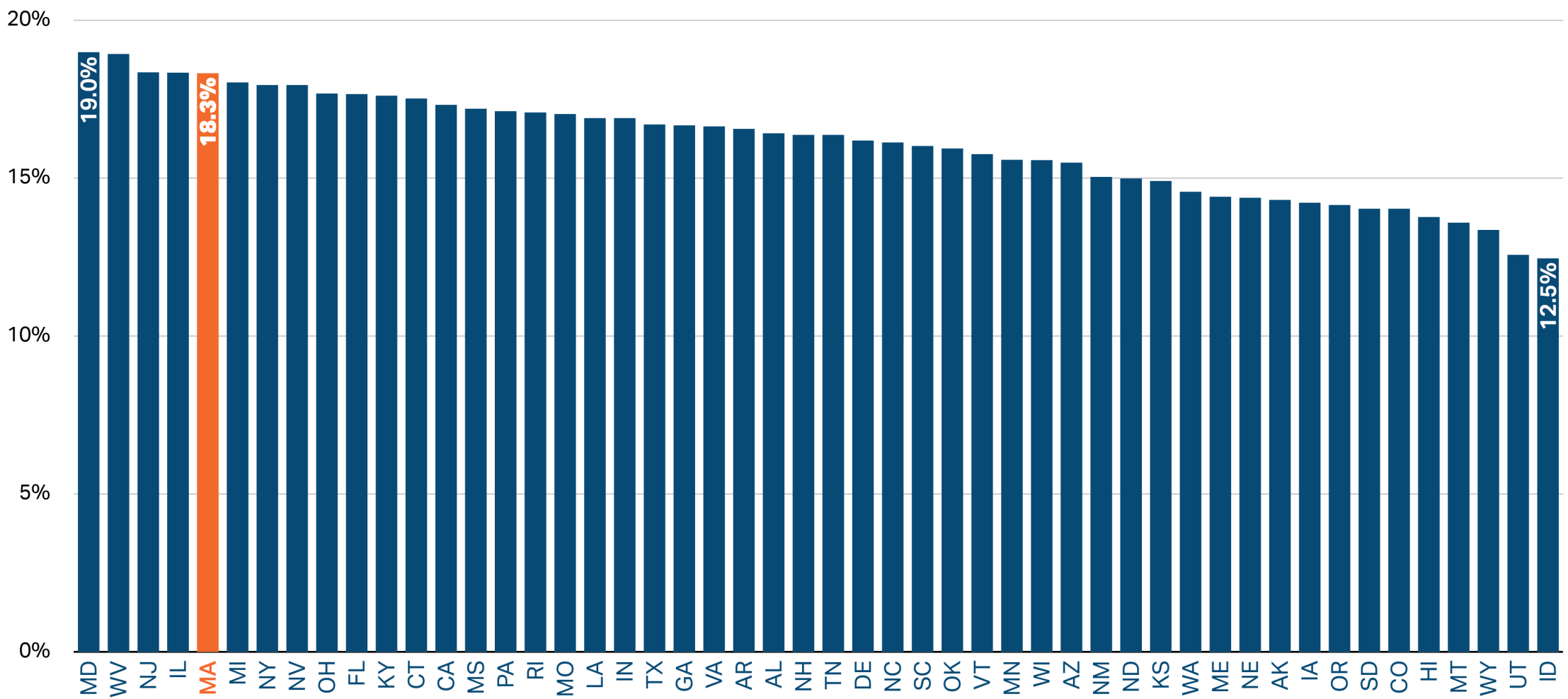
Notes: Data includes only beneficiaries enrolled in Medicare fee-for-service (FFS) aged 65+ and combine admissions for the following ambulatory care-sensitive conditions: diabetes, chronic obstructive pulmonary disease (COPD), asthma, hypertension, congestive heart failure (CHF), dehydration, bacterial pneumonia, urinary tract infection (UTI), and lower extremity amputation.

Sources: HPC analysis of the Center for Medicare and Medicaid Services Geographic Variation Public Use file, 2021.

Massachusetts had the 5th highest 30-day Medicare readmission rate.



Medicare all-cause, 30-day readmission rate, by state, 2021

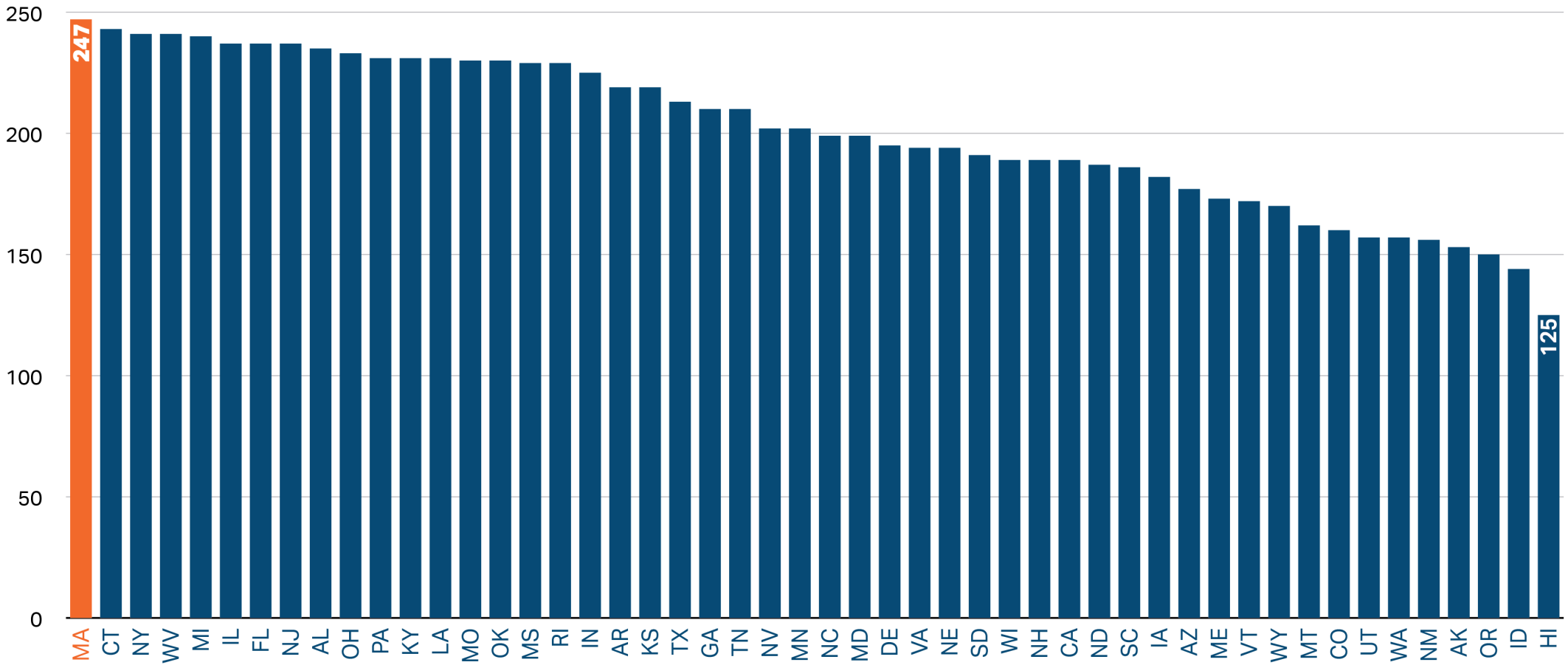


Notes: Represents the share of inpatient readmissions within thirty days of a reference acute hospital stay (within same calendar year). Hospitalization data is based on 100% of Medicare fee-for-service (FFS) claims. Sources: HPC analysis of CMS Medicare Geographic Variation Public Use File, by National, State, and County, 2021.

In total, Massachusetts Medicare beneficiaries had more hospital stays than those in any other state.



Inpatient hospitalizations per 1,000 FFS Medicare beneficiaries aged 65 and over, by state, 2021

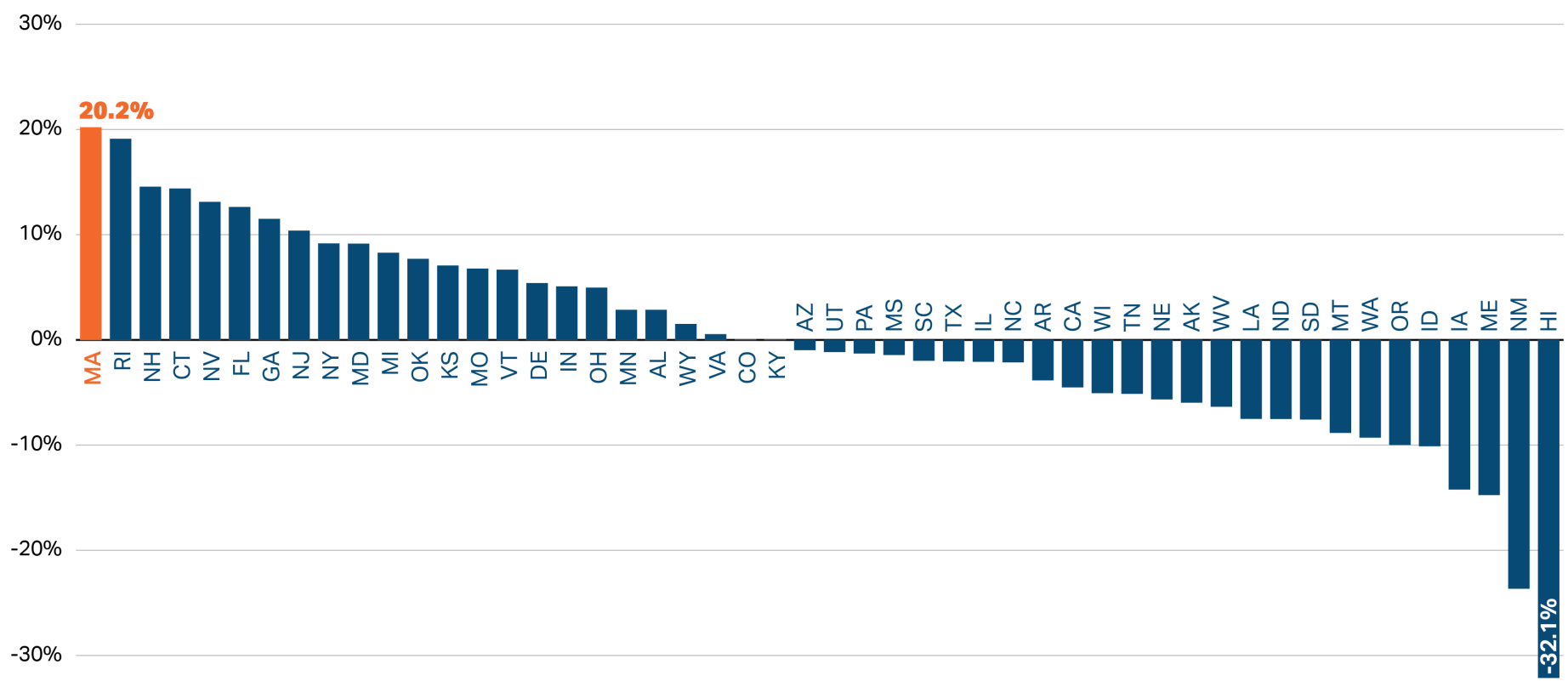


Notes: Hospitalization data is based on 100% of Medicare fee-for-service claims for Fee For Service (FFS) beneficiaries aged 65 and over.
 Sources: HPC analysis of CMS Medicare Geographic Variation Public Use File, by National, State, and County, 2021.

Accounting for age and health status, Massachusetts' Medicare population had 20% (67,000) more hospital stays than expected in 2021, the highest excess rate among all states.



Difference between observed and expected number of hospital stays among fee-for-service Medicare beneficiaries, by state, 2021

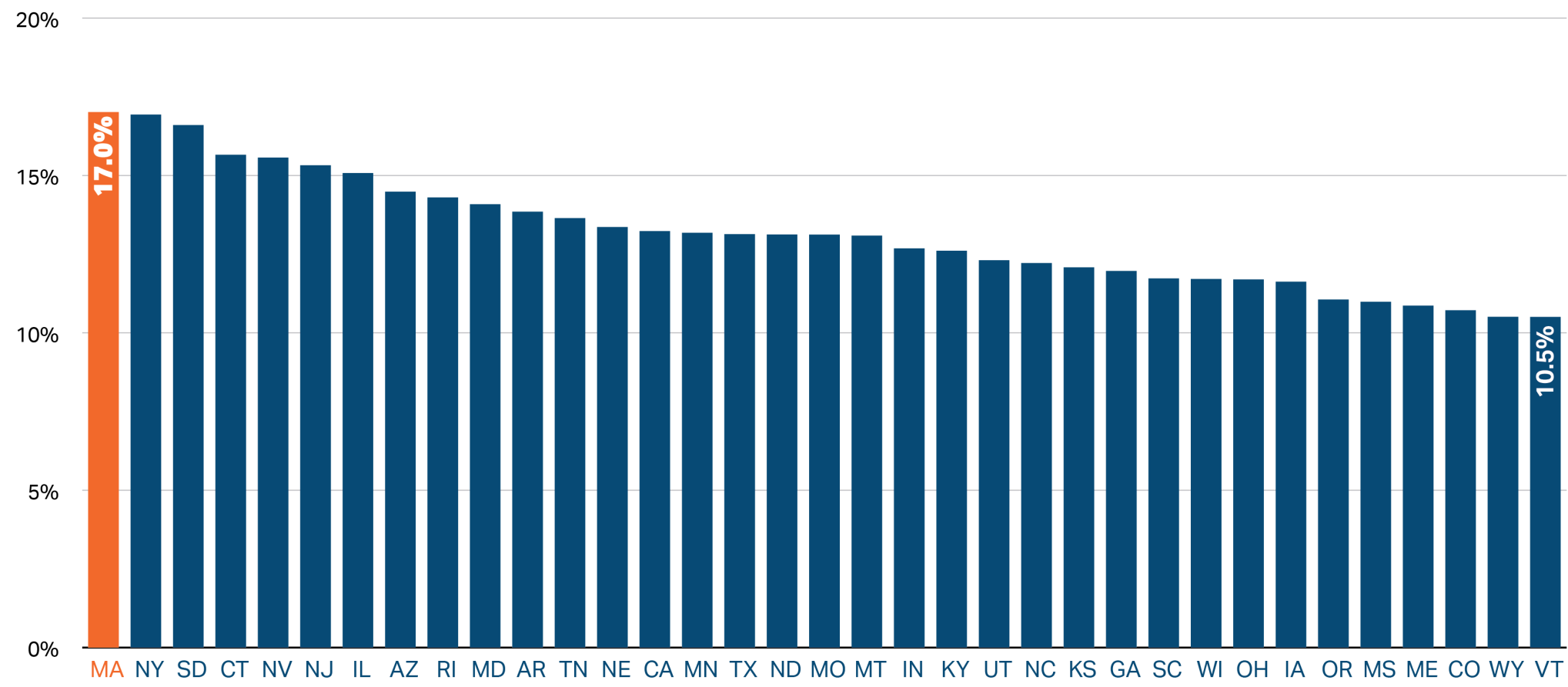


This excess of observed minus expected hospitalizations amounts to roughly 9% of all hospital stays (among all payers) in Massachusetts in 2021.

Notes: Bars represent the percentage difference between observed and expected inpatient hospitalization rates. Hospitalization data is based on 100% of Medicare fee-for-service (FFS) claims. Expected rates were created adjusting for differences in the elderly population across states, including age, Medicare advantage uptake, disability, activity limitations and health status.
 Sources: HPC analysis of CMS Medicare Geographic Variation Public Use File, by National, State, and County, 2021. Population data come from Census Bureau's ACS 5-year estimates, 2021. Population characteristics come from Behavioral Risk Factor Surveillance System (BRFSS) Prevalence Data, 2021.

Across all payers, Massachusetts had the highest rate of hospital admissions from the emergency department of all states analyzed in 2019.

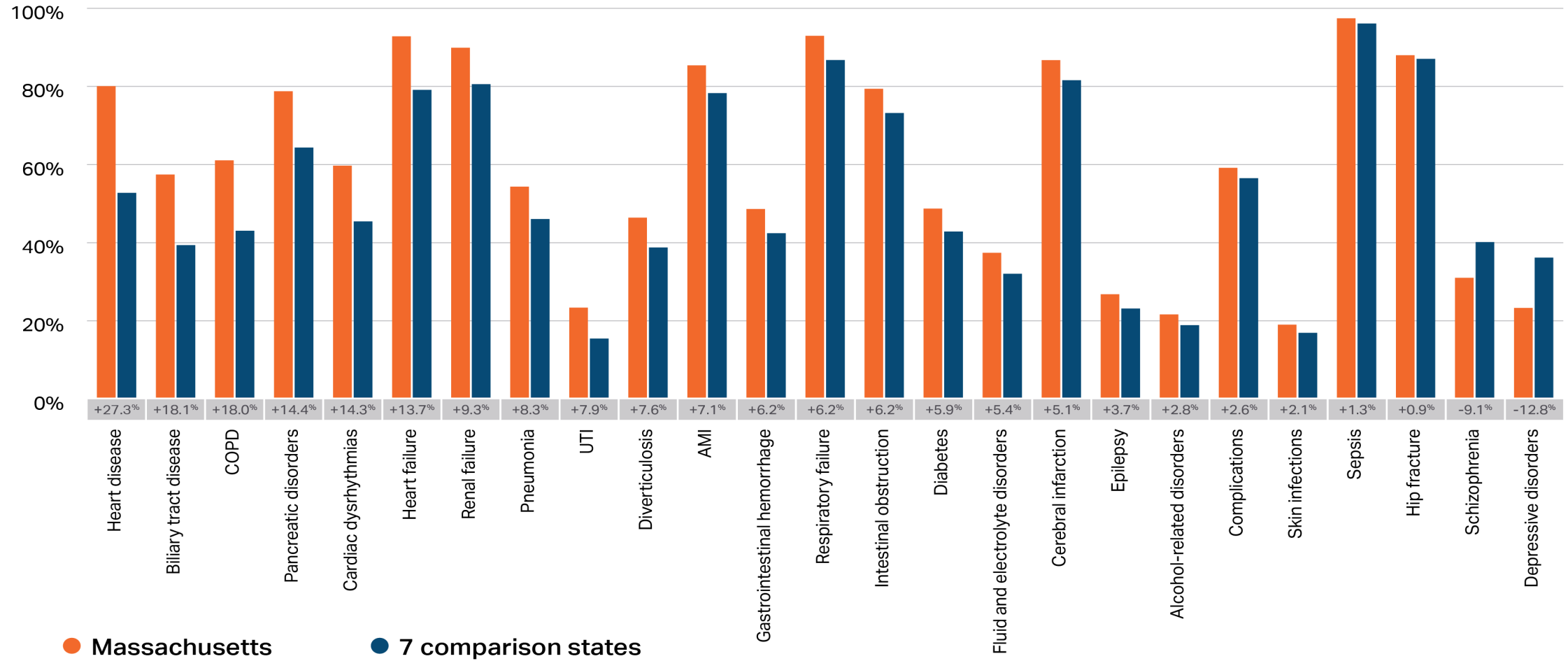
Admissions originating in an emergency department, 35 states, all patients, all payers, 2019



Notes: Represents the share of discharges originating in an ED that were ultimately admitted to an inpatient unit. Data are for all ages and payers. Not all states report data to HCUP and not all reporting states include data in both settings. States without 12 months of data in the year were excluded. This resulted in 35 states with an ED admission rate.
 Sources: HPC analysis of AHRQ HCUP Inpatient and Emergency Department Summary Trend Tables, 2019.

Massachusetts residents were more likely to be admitted to the hospital for 23 of the top 25 conditions than residents of comparison states.

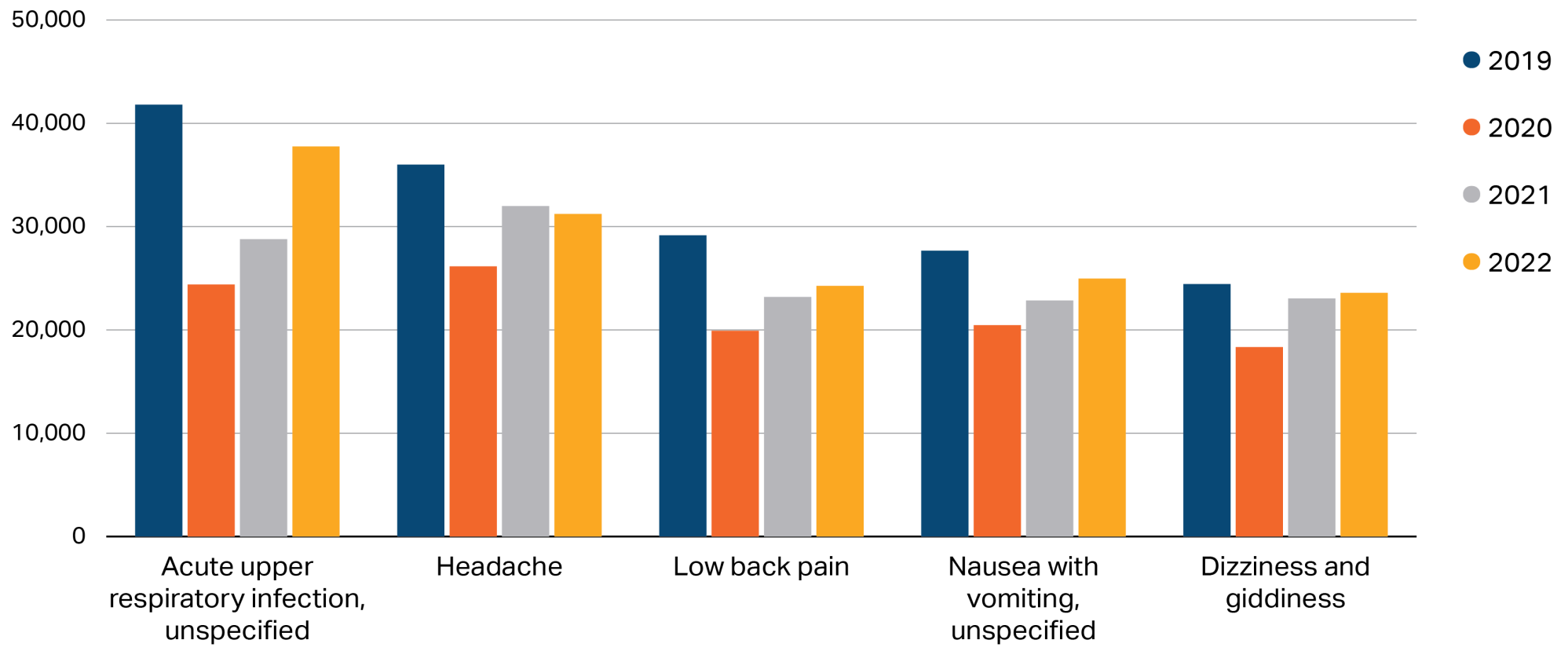
Admissions originating in an emergency department by condition, MA vs comparison states, 2019



Notes: Represents the share of discharges originating in an ED that were ultimately admitted to an inpatient unit. Children, those with a missing diagnosis, and patients who left against medical advice or expired in the ED were excluded. COPD: chronic obstructive pulmonary disease, UTI: urinary tract infection; AMI: acute myocardial infarction. Comparison states include MD, MN, NC, NJ, NY, OR, and VT. Sources: HPC analysis of AHRQ HCUP State Inpatient and Emergency Department databases (SID, SEDD), 2019.

By 2022, ED visits for the highest-volume potentially avoidable conditions remained below 2019 levels but were generally increasing.

Top diagnosis subcategories of potentially avoidable ED visits for Massachusetts residents, 2019-2022



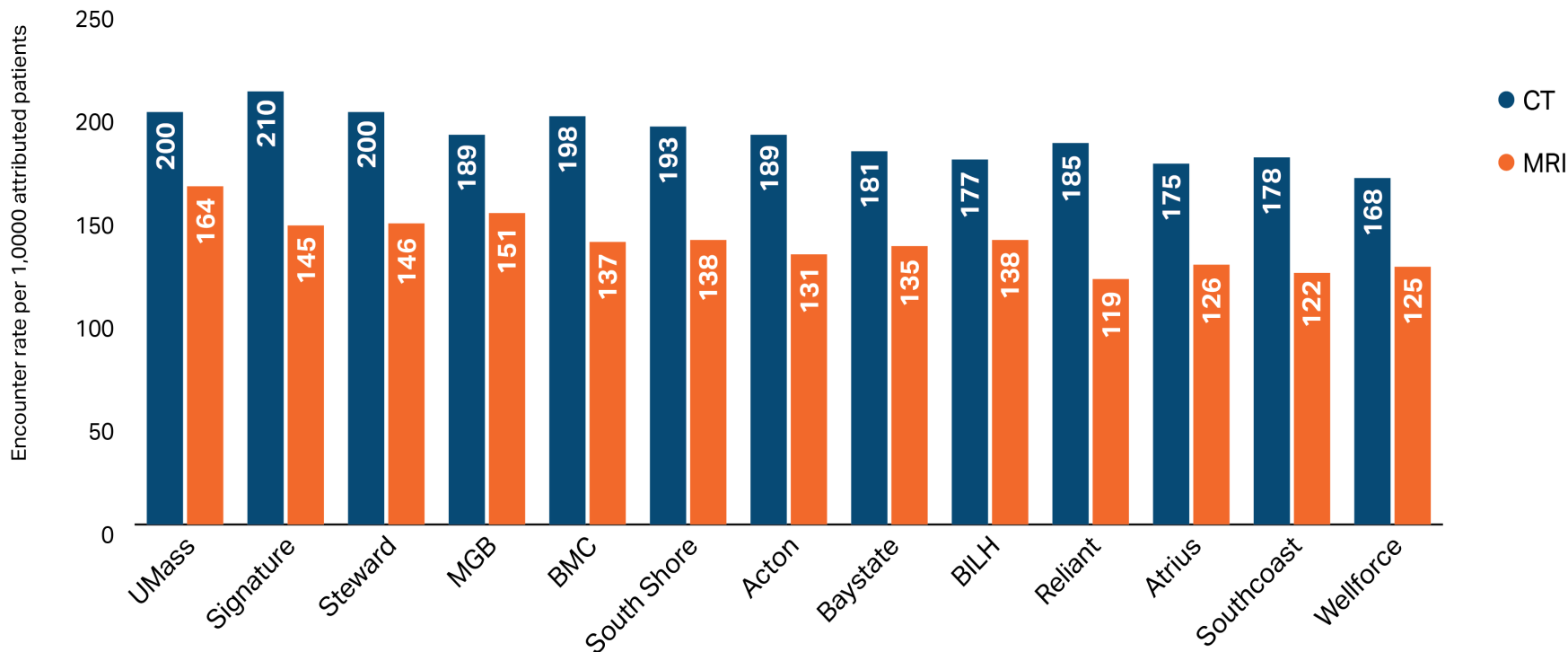
Notes: Includes Massachusetts residents of all ages. Excludes three ED sites due to missing data. Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into multiple categories. "Avoidable" is defined here as ED visits that had at least a 70% probability of being emergent - primary care treatable or non-emergent. Top five diagnosis codes include: J069 (Acute upper respiratory infection, unspecified), R51, R510, and R519 (Headache), M545, M5450, M5451, and M5459 (Low back pain), R112 (Nausea with vomiting, unspecified), and R42 (Dizziness and giddiness). More than one diagnosis code was included in the "Headache" and "Low back pain" categories to account for changes in coding guidance during the study period.

Sources: HPC analysis of Massachusetts Acute Hospital Case-Mix Emergency Department Database, FY2019-2023, preliminary FY2023 Q1.

Consistent with high rates of imaging compared to other countries and states, Massachusetts provider organizations also varied widely in their patients' use of CTs and MRIs.



Number of CT and MRI scans per 1,000 attributed patients (health-status adjusted), per attributed provider organization, 2021



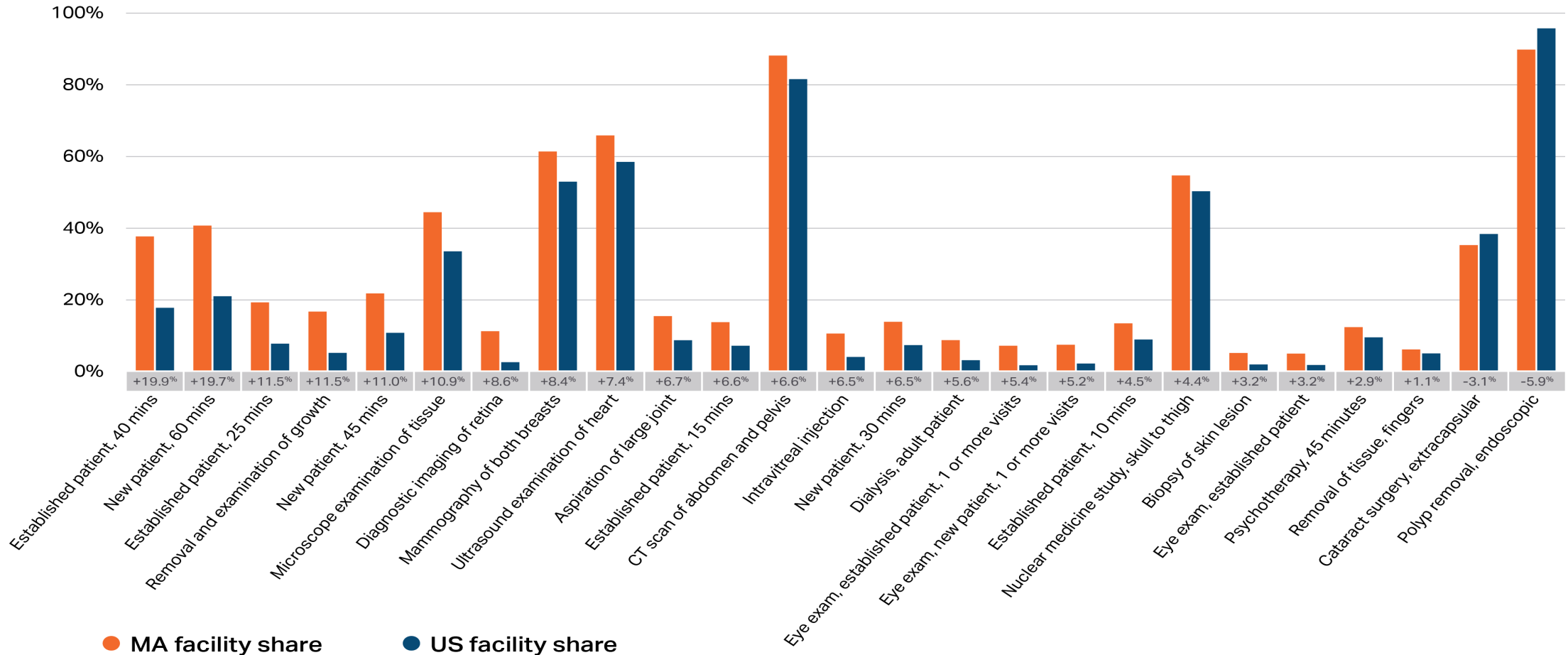
- MRI usage rates varied 39% across provider organizations. CT rates varied 24%.
- Massachusetts had the 12th highest use of imaging among Medicare beneficiaries.
- U.S. adults aged 18-64 had 30% more CT use (134 vs 103 scans per 1,000 patients) and 29% more MRI use than Canadian adults in 2016.

Notes: CT and MRI procedure codes are identified using BETOS imaging categorization in claims data. Results reflect commercial attributed adults, at least 18 years of age with 12 months of continual medical insurance coverage (N= 786,327). Results are adjusted for differences in age, sex, health status, and community-level variables related to education and socioeconomic status. Average is calculated across provider organizations.
 Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2017-2021; CMS Medicare Geographic Variation Public Use File, by National, State, and County, 2021; Smith-Bindman, R., et al. (2019). Trends in use of medical imaging in US health care systems and in Ontario, Canada, 2000-2016. *Jama*, 322(9), 843-856.

Massachusetts residents were more likely than those in other states to have care provided in a HOPD setting for 23 of the top 25 ambulatory care services.



Percentage of Medicare beneficiaries receiving each of the 25 highest-spending services in a facility setting (usually a hospital outpatient department), MA vs US, 2019

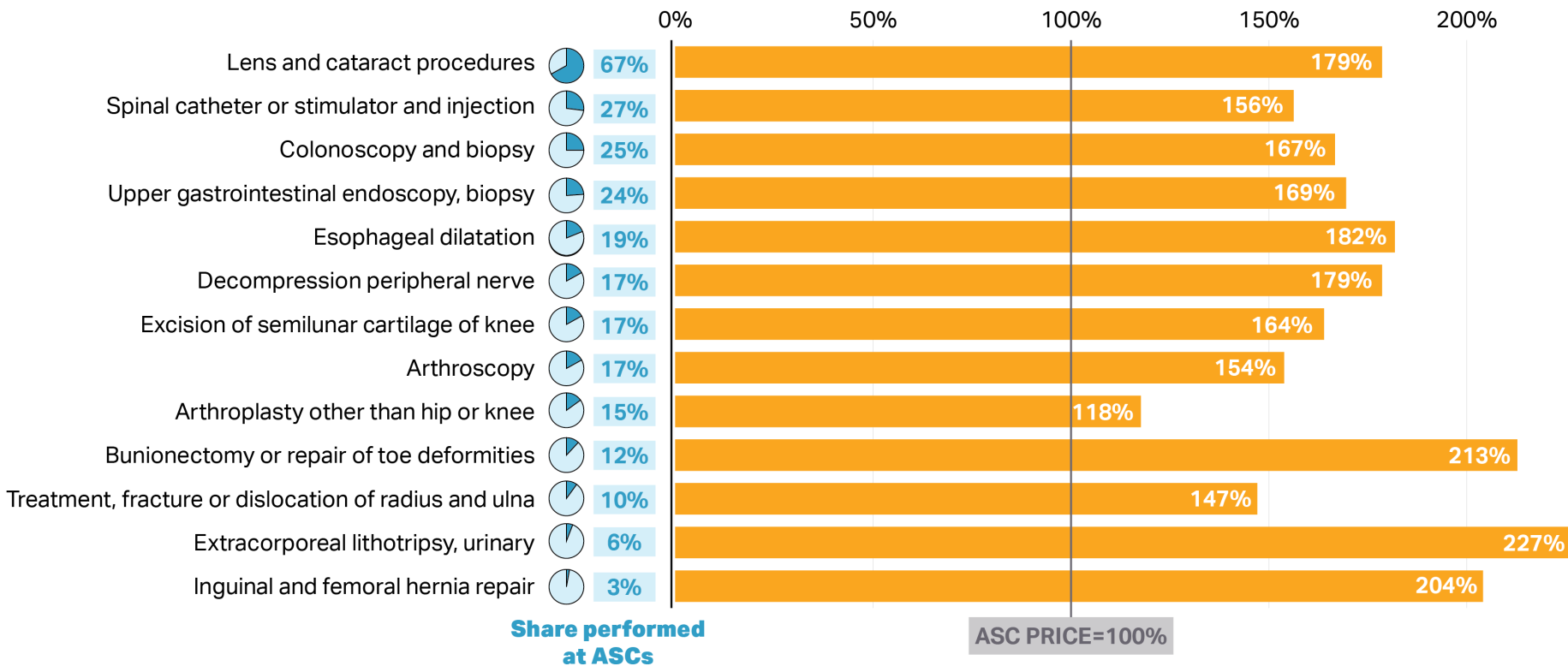


Notes: Represents the share of services taking place in a facility setting rather than an office setting. Procedures that only took place in inpatient, ED, rehabilitation and nursing facility settings were excluded. Procedures that took place in only one setting or in one geography were excluded.

Sources: HPC analysis of CMS Medicare Physician & Other Practitioners – by Geography and Service, Public Use File, 2019.

Prices are 75% higher, on average, in hospital outpatient departments (HOPDs) for surgeries commonly performed in both ambulatory surgery centers (ASCs) and HOPDs.

HOPD price for surgical encounter in comparison to ASC price for thirteen categories of surgeries commonly performed in both settings, 2021



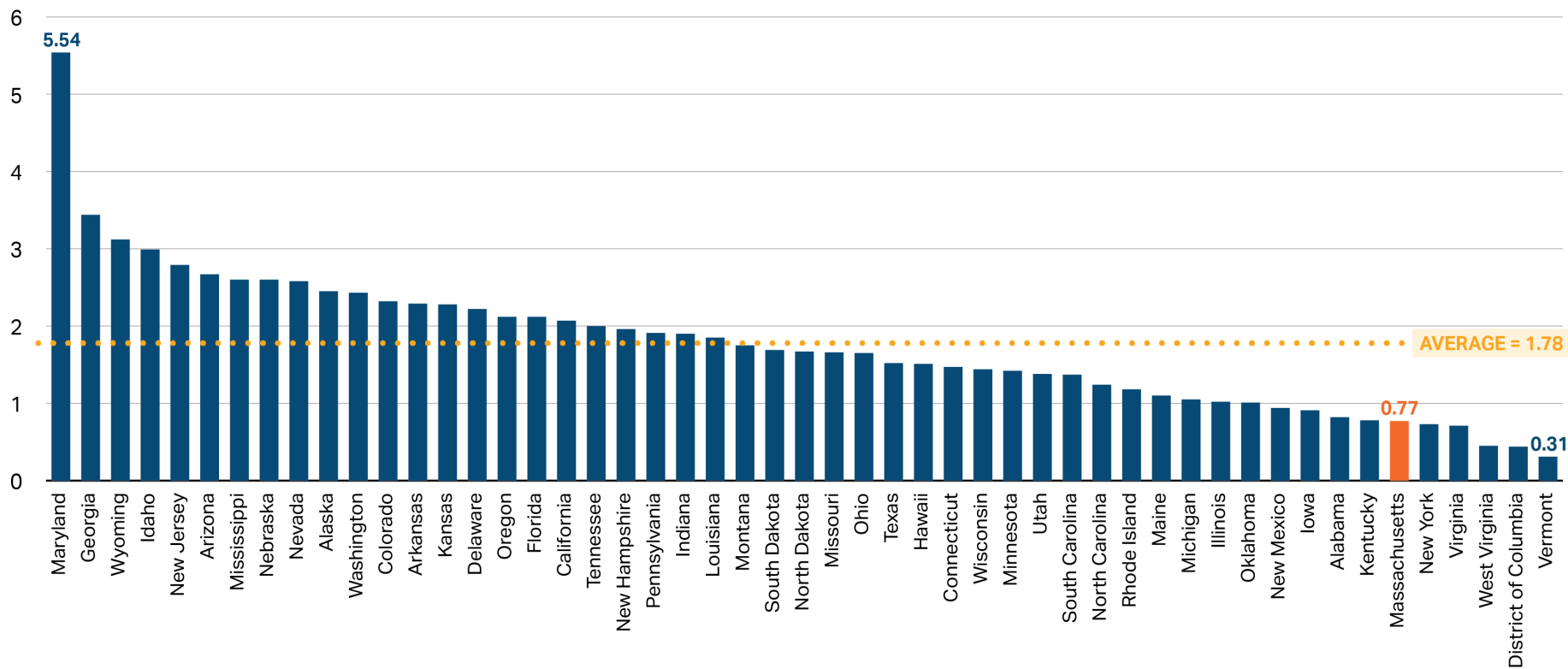
- Nearly 70% of lens and cataract procedures are performed in ASCs.
- Other procedures commonly performed in ASCs include colonoscopy with biopsy (25%) and excision of knee cartilage (17%).

Notes: Selected surgeries/procedures with the highest volume at ASCs that have similar or higher complexity as surgeries/procedures performed in HOPD (<3% difference from HOPD as measured by RVU for the main procedure surgical procedure of the encounter).

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2017-2021. Department of Public Health Division of Health Care Facility Licensure and Certification: <https://www.mass.gov/service-details/find-information-about-licensed-or-certified-health-care-facilities>.

Massachusetts has the 6th lowest per capita number of independent ambulatory surgical centers (ASCs) of all states.

Number of independent ASCs certified by CMS as of 2021 per 100K population



- Massachusetts has 59 ASCs certified by the Massachusetts Department of Public Health.
- Massachusetts enacted a moratorium on new independent ASC construction from 1971 to 2017
- The largest services lines for Massachusetts ASCs (by commercial revenue) are GI (41%), orthopedic (23%), and eye procedures (21%)

Sources: *Becker's ASC Review* has compiled populational ASC metrics for every state and the District of Columbia based on recently-released 2020 Census data and CMS figures from March 2021. Department of Public Health Division of Health Care Facility Licensure and Certification: <https://www.mass.gov/service-details/find-information-about-licensed-or-certified-health-care-facilities>.

Selected Preliminary Findings from Cost Trends Report Chapters



> EXCESSIVE PRICES

- Among lab, imaging, endoscopy, administered and prescription drugs and certain specialty procedures, commercial payers often pay **more than double** what Medicare would pay. **27% of commercial spending for these services is excessive**, amounting to **\$3B** in 2021 (12.5% of TME) in excessive spending due to overly high commercial prices.

> EXCESSIVE UTILIZATION

- Not only do Massachusetts Medicare beneficiaries have among the **highest rates of readmissions and avoidable hospitalizations**, they have **more total hospital stays than in any other state** in the country, **20% more than expected** given their age and health status. This amounted to ~67,000 hospital stays in Massachusetts in 2021 – 9% of all stays.
- Across all payers, Massachusetts had the **highest rate of hospital admissions from the emergency department** of all states analyzed.
- Massachusetts has fewer than half as many ASCs as the average state; the same **surgeries are typically paid 50-100% more** when taking place in HOPDs.

Call to Order

Approval of Minutes (**VOTE**)

Findings from the 2023 Health Care Cost Trends Report

- Massachusetts Spending Performance
- Excessive Spending in the Massachusetts Health Care System: Focus on Utilization

 **KEY FINDINGS FROM CHARTPACKS**

Reducing Unnecessary Administrative Complexity: Policy Options

Implementation of the Federal No Surprises Act

Executive Director's Report

Adjourn

1. Primary Care and Behavioral Health

2. Hospital Utilization and Post-Acute Care

3. Price Trends and Variation

4. Provider Organization Performance Variation

Context

- Policymakers across the U.S. have sought to bolster primary care and behavioral health care as services that are relatively underpaid and that are associated with **better health outcomes and more efficient use of health care overall.**^{1,2}
- CHIA began reporting aggregate spending for primary care and behavioral health in 2022.

Definitions

- **Primary care**
 - Spending is defined as professional spending on **office-type visits** (e.g., E&M), **preventive visits** (e.g., well exam), **vaccines** (including COVID-19 vaccines), and other services.
 - Services must be provided by a **primary care provider.**
- **Behavioral health**
 - CHIA defines behavioral health spending using behavioral health diagnoses, provider taxonomy, procedure codes, and specific national drug codes (NDCs).
 - HPC analyzed trends in **ED visits and acute-care hospital stays** for behavioral health (all-payer) based on diagnoses or APR-DRGs as well as **ambulatory visits for psychotherapy** defined by procedure codes (commercial only).

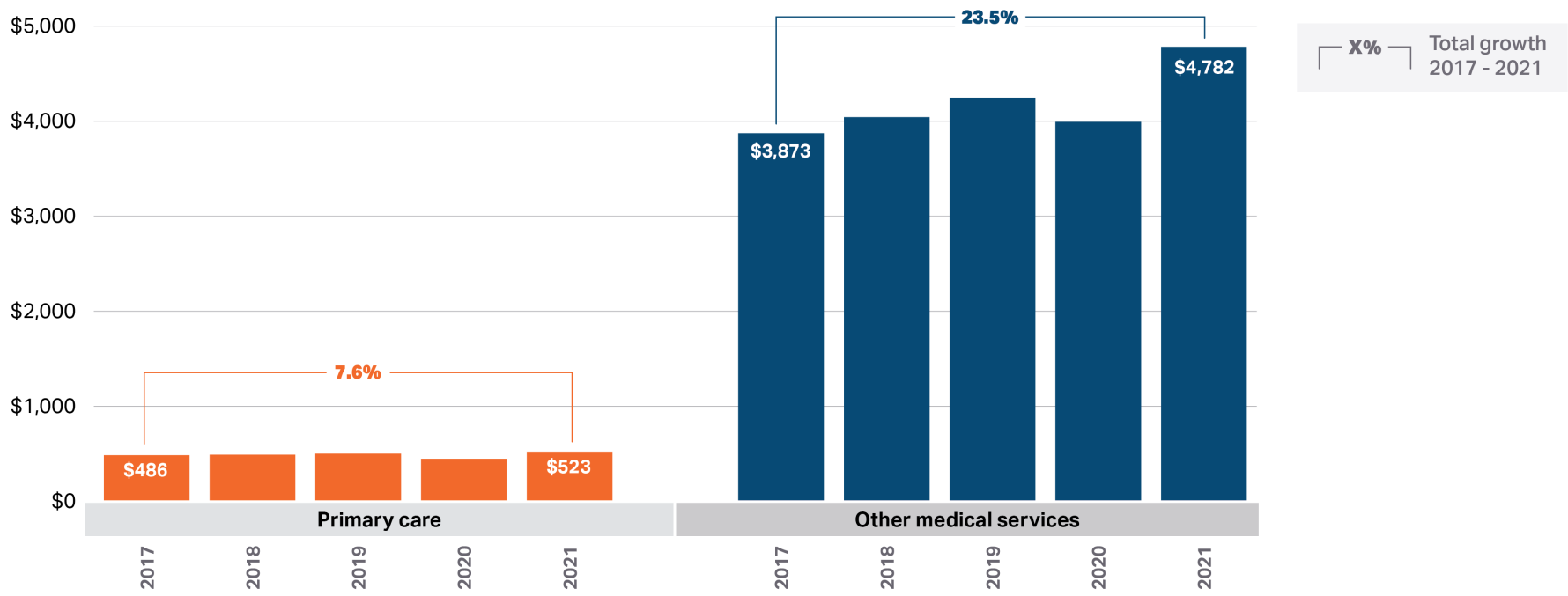
Notes: Primary care providers were identified using taxonomy codes from CHIA's primary care and behavioral health data code list (which include physicians, nurse practitioners, physician assistants), as well as HPC's PCP attribution methodology. Primary care services were also defined based on CHIA's code list; however, the HPC excluded obstetrics services. CHIA Payer Data Reporting: Primary and Behavioral Health Care Expenditures: <https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures/>

Sources: 1). National Academies of Sciences, Engineering, and Medicine. 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press.

2) Primary Care Spending: High Stakes, Low Investment December 2020. <https://doi.org/10.17226/25983.2> https://www.pcpc.org/sites/default/files/resources/PCC_Primary_Care_Spending_2020.pdf

Primary care commercial spending grew much more slowly...declining as a proportion of total spending to 8.1% in 2021.

Commercial medical spending by category per member per year, 2017-2021

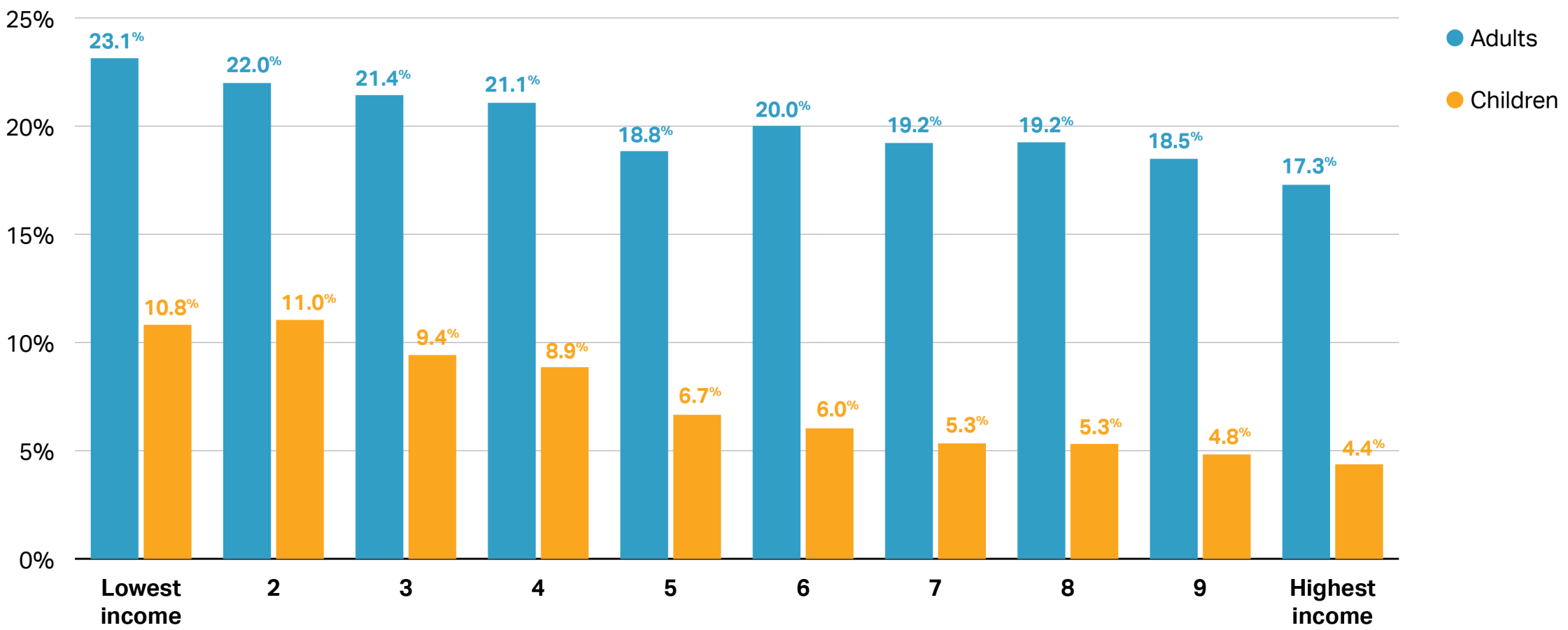


Primary care declined as a percentage of all commercial spending from 9.1% in 2017 to 8.1% in 2021.

Notes: Analysis restricted to members under 65 and those with prescription drug coverage. Prescription drug spending is not included in "Other medical services".
 Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2017-2021. Numbers on this slide are updated from the original 6/7 presentation.

Adults and children living in low-income communities were more likely to have zero primary care spending; for children, the difference varied at least 2:1 across communities.

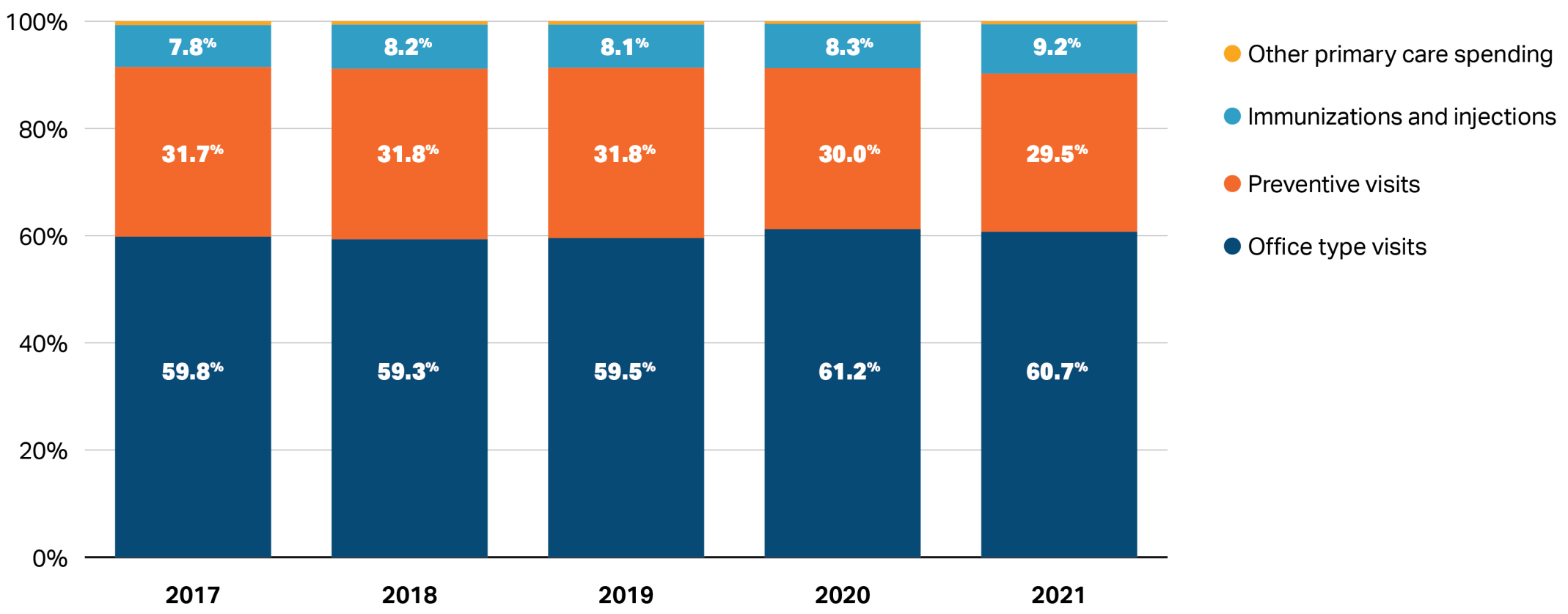
Percentage of commercial members with zero primary care spending by community income decile, 2021



Notes: Analysis restricted to members under 65 with full year medical coverage. Children are defined as those under 18 years old. Adults are those aged 18 to 64. Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2021.

Office and preventive type visits account for over 90% of primary care spending.

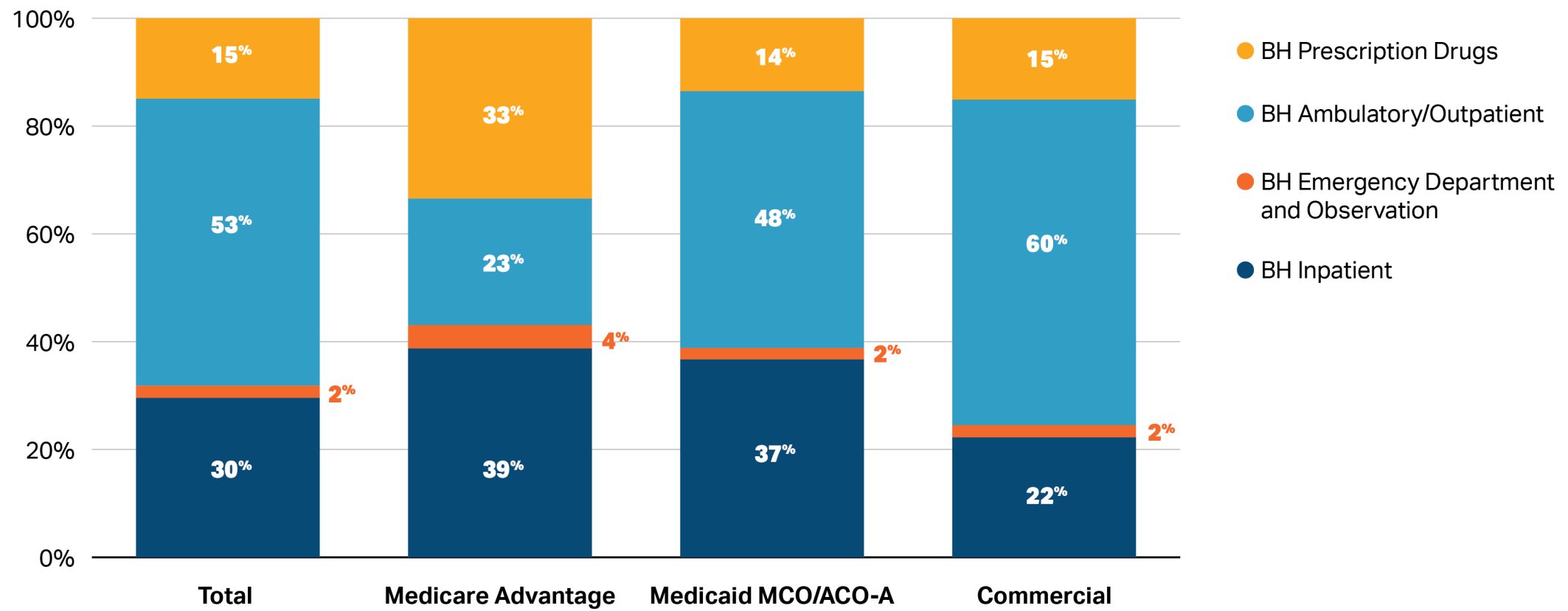
Percent of primary care spending by category for commercial payers, 2017-2021



Notes: Analysis restricted to members under 65. Categories of services defined based on CHIA's primary care and behavioral health data code list. CHIA Payer Data Reporting: Primary and Behavioral Health Care Expenditures: <https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures/>
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2017-2021.

More than half of behavioral health spending was comprised of ambulatory and outpatient care among commercial members in 2020.

Percentage of behavioral health spending by payer and category, 2020

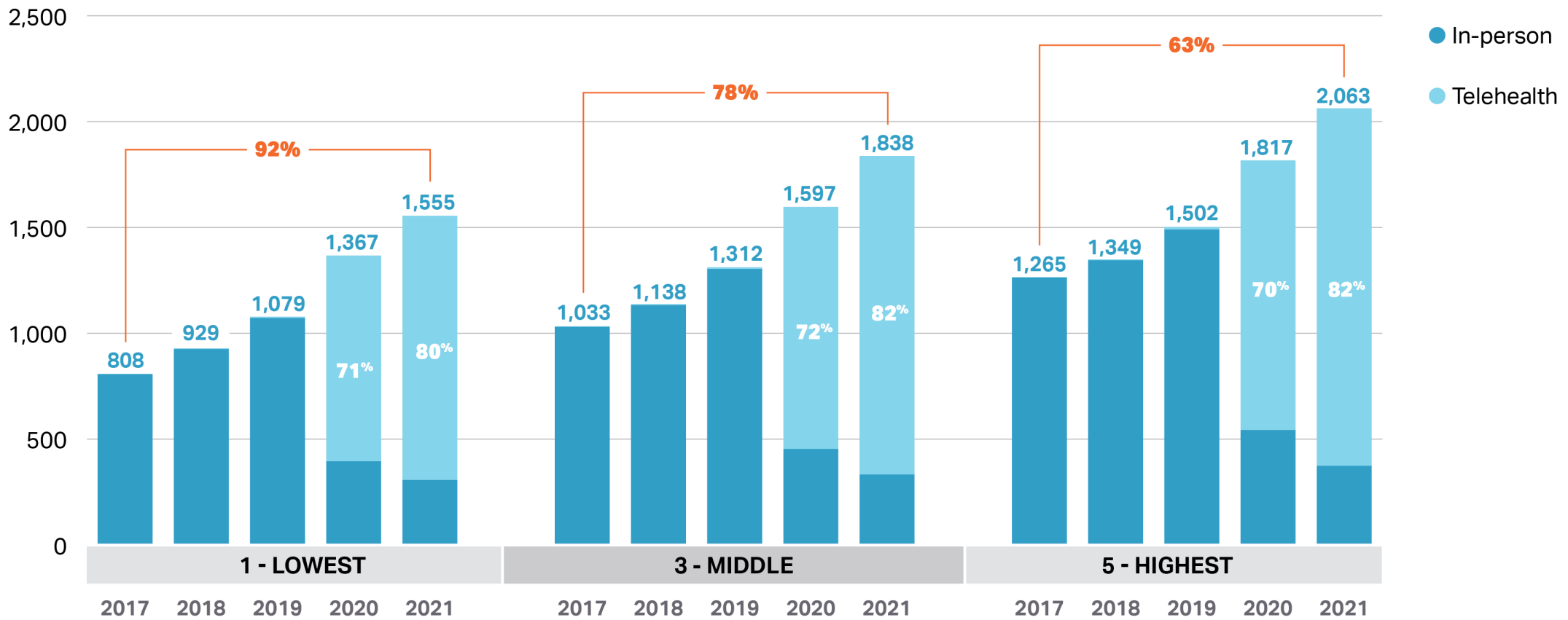


Notes: Aetna and Cigna data were excluded due to quality concerns. Figures on this page reflect data for commercial full-claim members only. Percent changes are calculated based on non-rounded expenditure amounts. Non-claims data was excluded from these percentages.

Sources: HPC Analysis of CHIA Primary Care and Behavioral Health (PCBH) Expenditures: Baseline Report September 2022 Databook. Accessed at: <https://www.chiamass.gov/pcbh>

Psychotherapy visits increased steadily from 2017 to 2021 among all income groups. Patients in lower-income communities had fewer visits but faster growth.

Number of psychotherapy visits per 1,000 members by type of visit and income quintile, commercial payers, 2017 to 2021

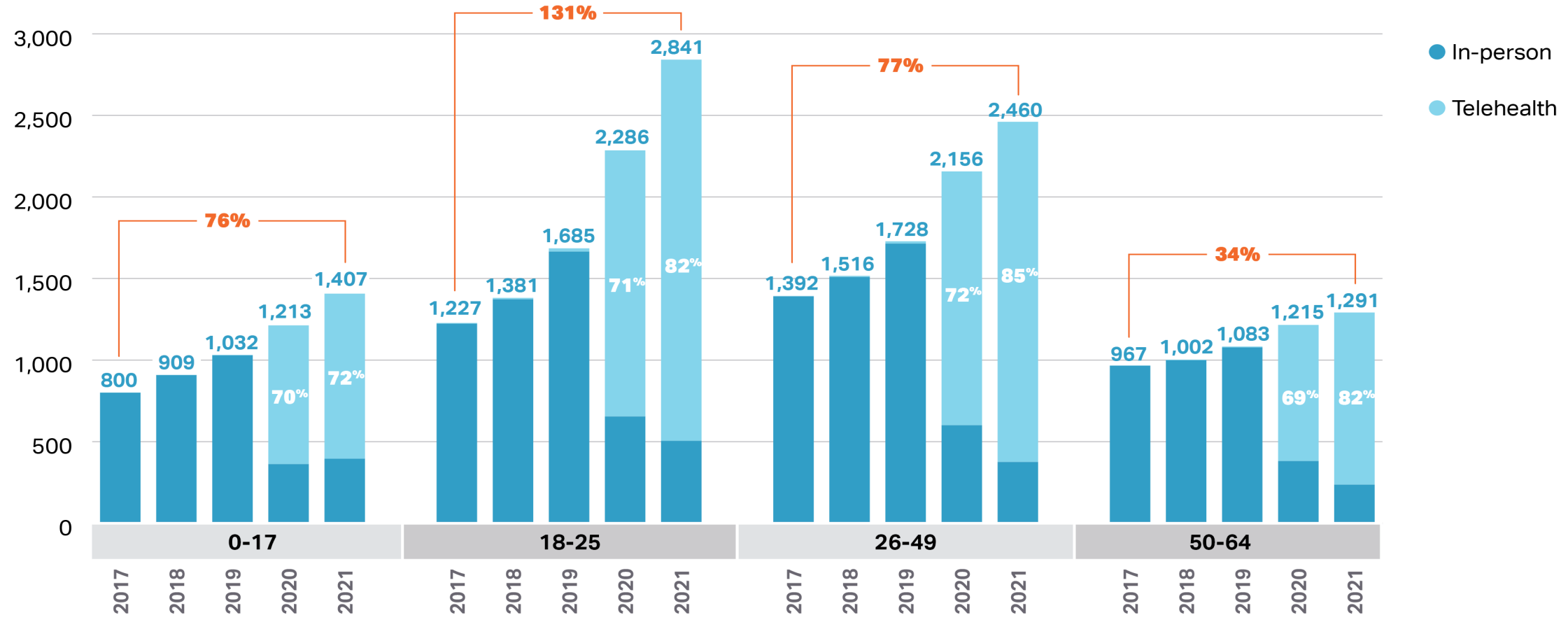


Notes: Includes psychotherapy visits for individuals ages 18-64 with 12 months of enrollment in the year (2018, 2019, or 2020). Therapy claims identified using Current Procedural Terminology codes 90832, 90833, 90834, 90836, 90837 and 90838.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2017-2021.

Commercially-insured residents aged 18-25 had the most psychotherapy visits and the fastest growth, more than doubling between 2017 and 2021.

Number of psychotherapy visits per 1,000 members by type of visit and age group, commercial payers, 2017 to 2021

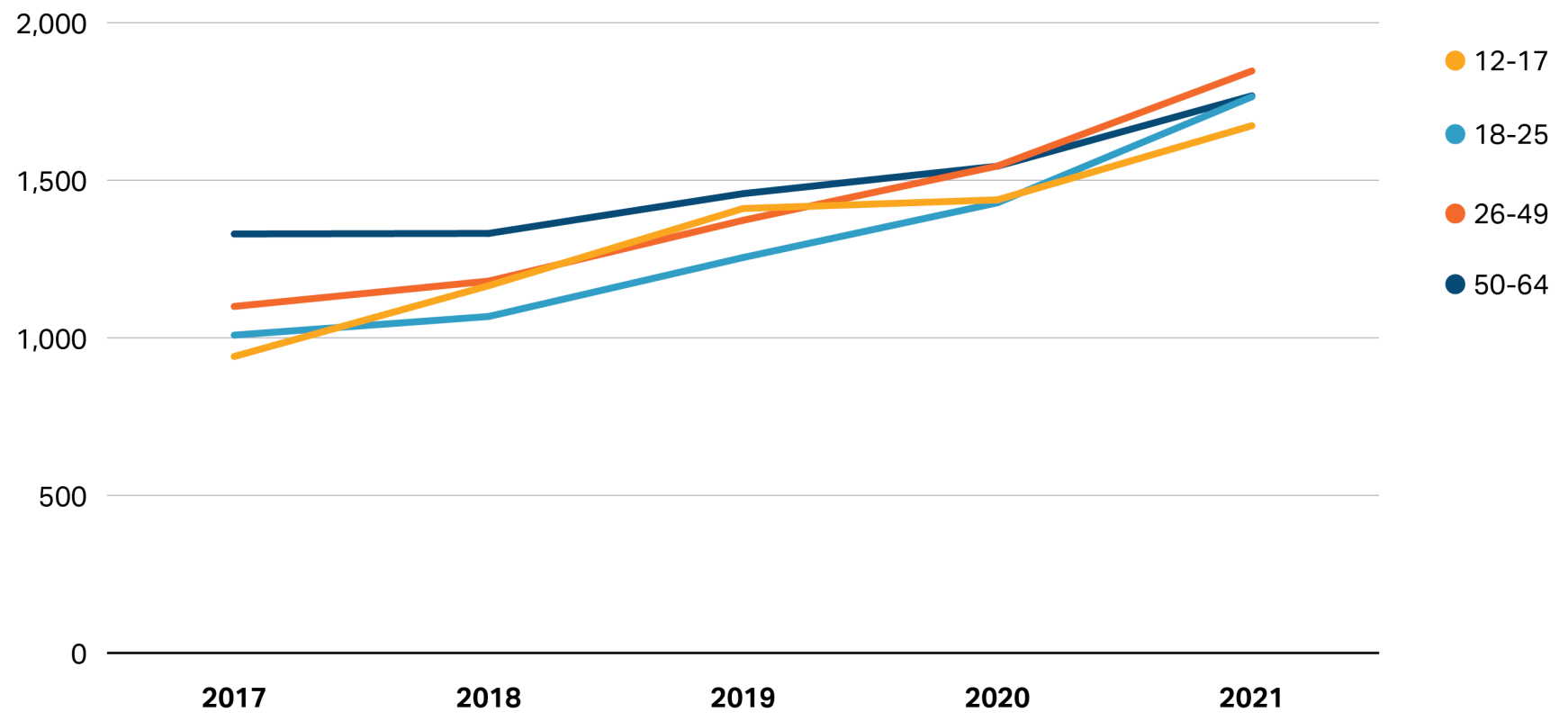


Notes: Includes psychotherapy visits for individuals ages 18-64 with 12 months of enrollment in the year (2018, 2019, or 2020). Therapy claims identified using Current Procedural Terminology codes 90832, 90833, 90834, 90836, 90837 and 90838.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2017-2021.

Use of mental health prescription drugs has increased for all age groups from 2017 to 2021, with the largest increases among resident aged 12-17.

Months supply of mental health prescription drugs per 1,000 members by age, 2017-2021

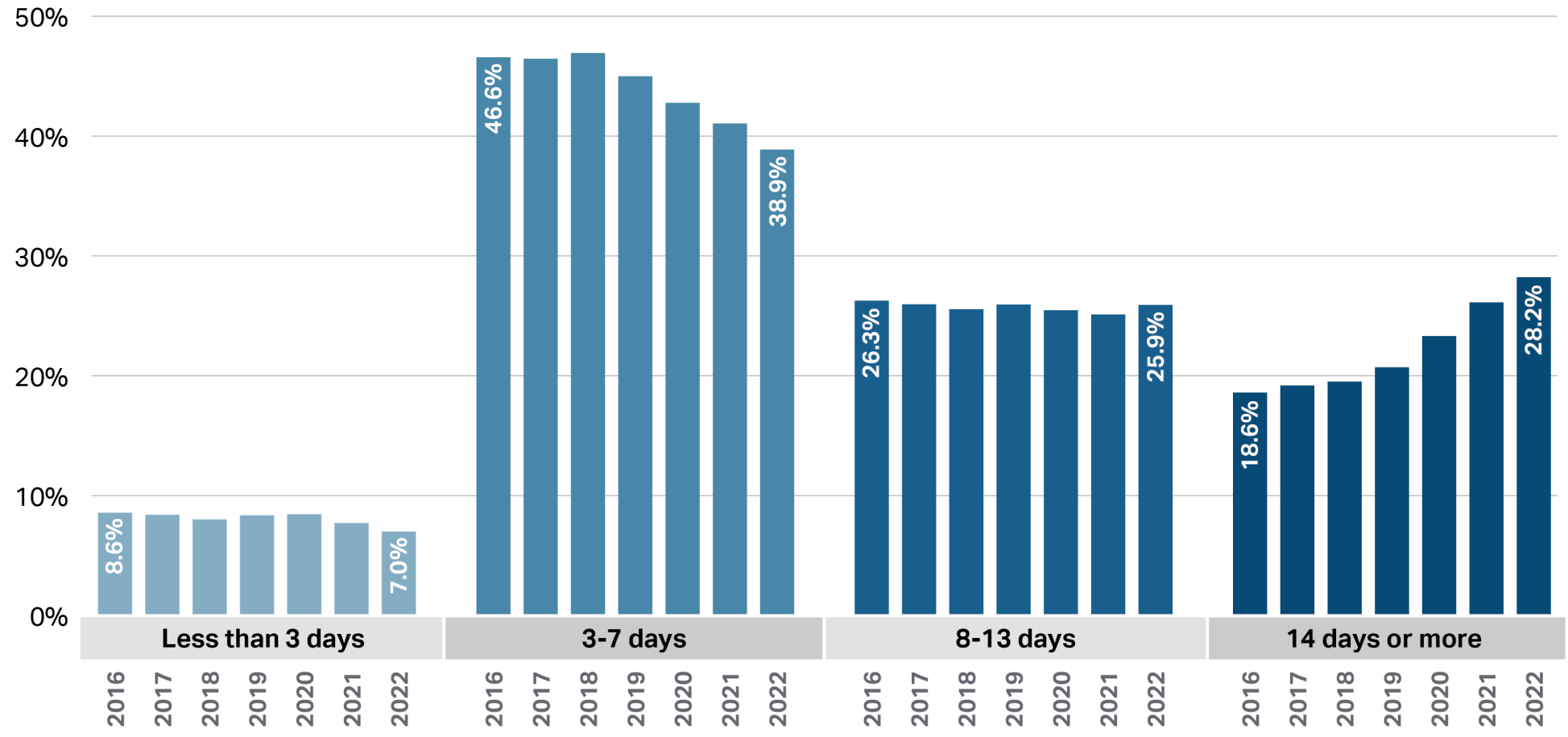


- The increase in utilization was largest for those age 12-17 (77.8% from 2017 to 2021) and smallest for those age 50-64 (33.0%).
- Despite higher utilization, spending on these drugs has remained relatively stable during the same time period, largely due to an increase in generic use. From 2017 to 2021, the share of such drugs that were generics grew from 93.1% to 95.7%. 38

Notes: Prescriptions were identified using CHIA's primary care and behavioral health data code list. CHIA Payer Data Reporting: Primary and Behavioral Health Care Expenditures: <https://www.chiamass.gov/payer-data-reporting-primary-and-behavioral-health-care-expenditures/>
 Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2017-2021.

The share of patients admitted to acute-care hospitals for mental health conditions and stayed for more than 14 days grew from 19% to 28% from 2016 to 2022.

Mental health discharges from acute-care inpatient settings by length of stay, 2016-2022

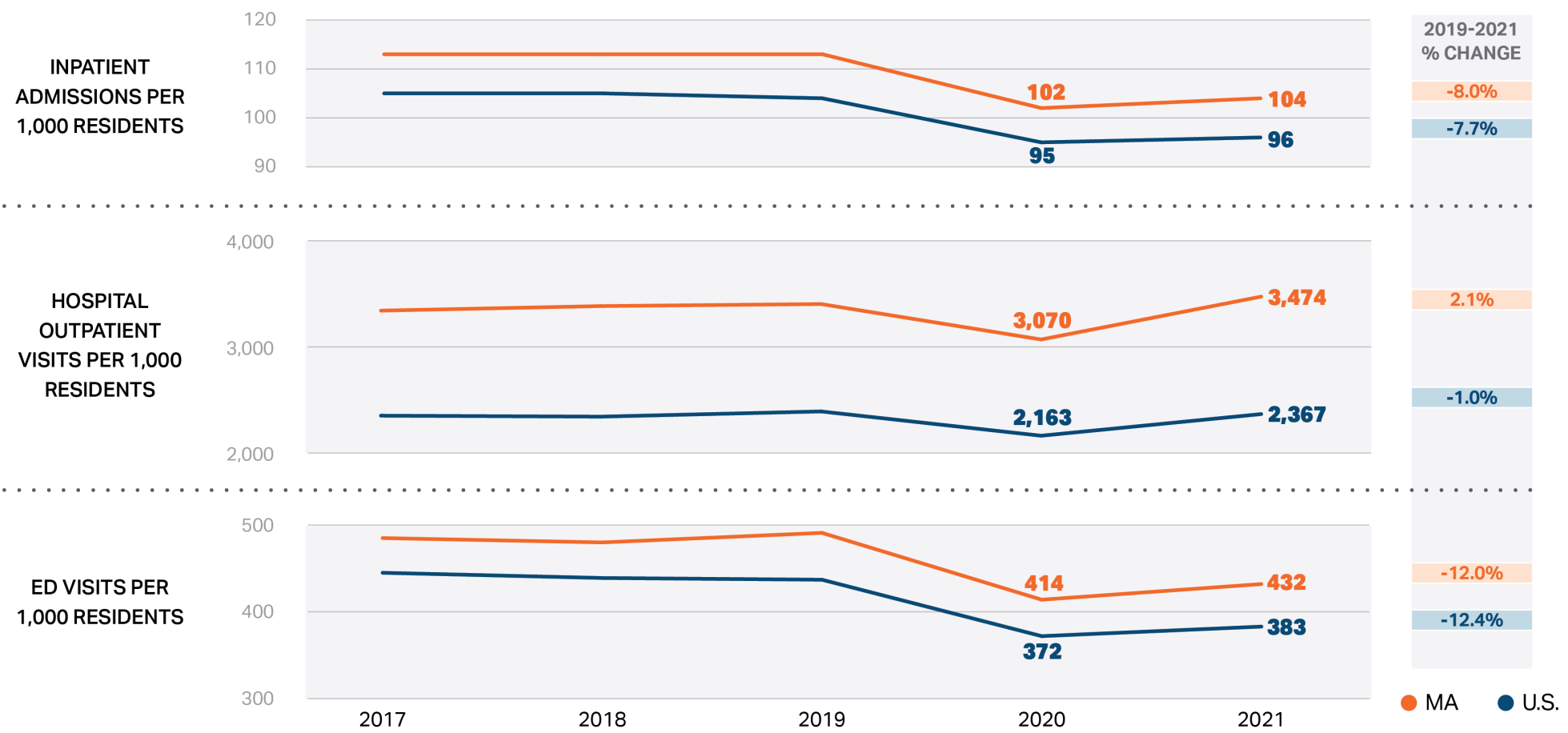


Notes: Mental health stays were defined as any stay with an APR-DRG Major Diagnostic Category Mental Diseases and Disorders. Data reported by calendar year. Sources: HPC analysis of Massachusetts Acute Hospital Case-Mix Inpatient Department Database, FY2016-2023, preliminary FY2023 Q1.

1. Primary Care and Behavioral Health
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4. Provider Organization Performance Variation

Massachusetts residents continued to have more HOPD, ED, and inpatient visits than the national average and had faster growth from 2020 to 2021.

Number of visits of each type per 1,000 residents, MA vs the U.S. overall

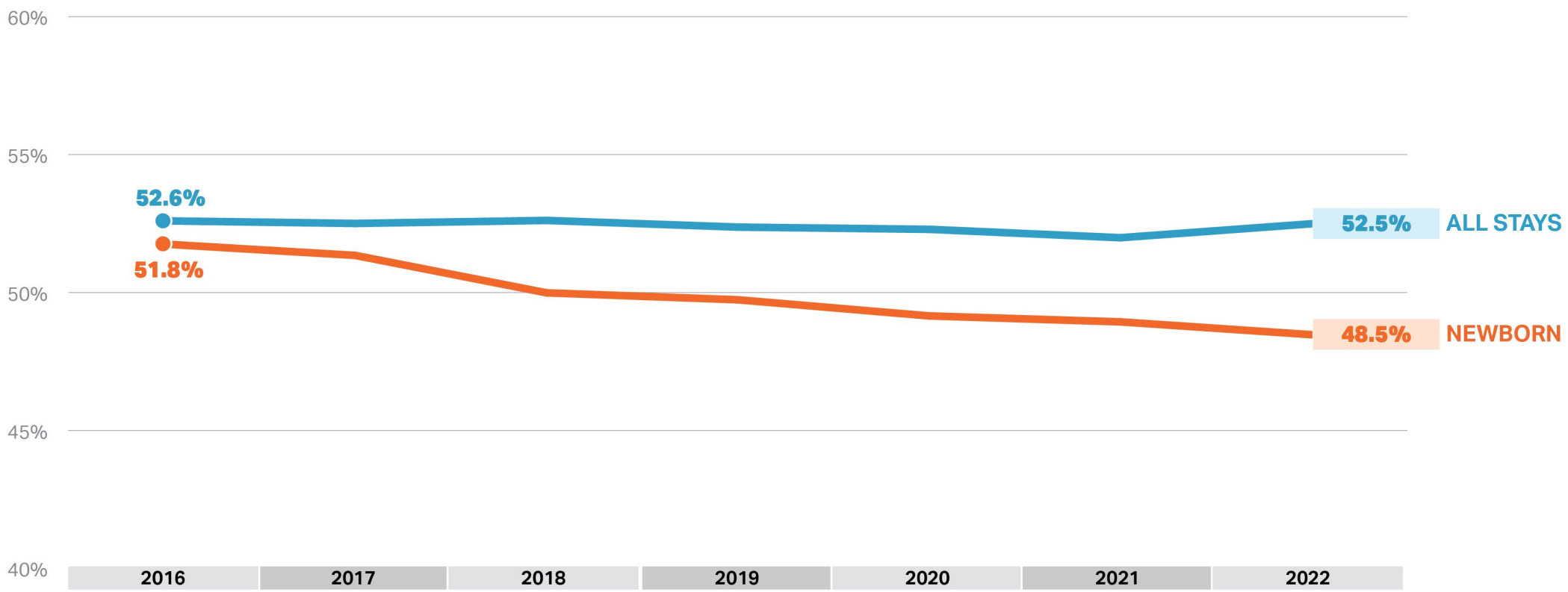


Notes: Data are for community hospitals as defined by Kaiser Family Foundation, which represent 85% of all hospitals. Federal hospitals, long term care hospitals, psychiatric hospitals, institutions for the intellectually disabled, and alcoholism and other chemical dependency hospitals are not included. The United States category includes Massachusetts. New England includes Connecticut, Maine, New Hampshire, Rhode Island and Vermont. Massachusetts is excluded from the New England category.

Sources: Kaiser Family Foundation State Health Facts (2021). "Hospital Admissions per 1,000 Population by Ownership Type" (2012 - 2021); "Hospital Emergency Room Visits per 1,000 Population by Ownership Type" (2012-2021); "Hospital Outpatient Visits per 1,000 Population by Ownership Type" (2012-2021). <http://www.kff.org/state-category/providers-service-use/hospital-utilization/>

The proportion of newborn stays taking place in community hospitals has dropped steadily from 2016 to 2022.

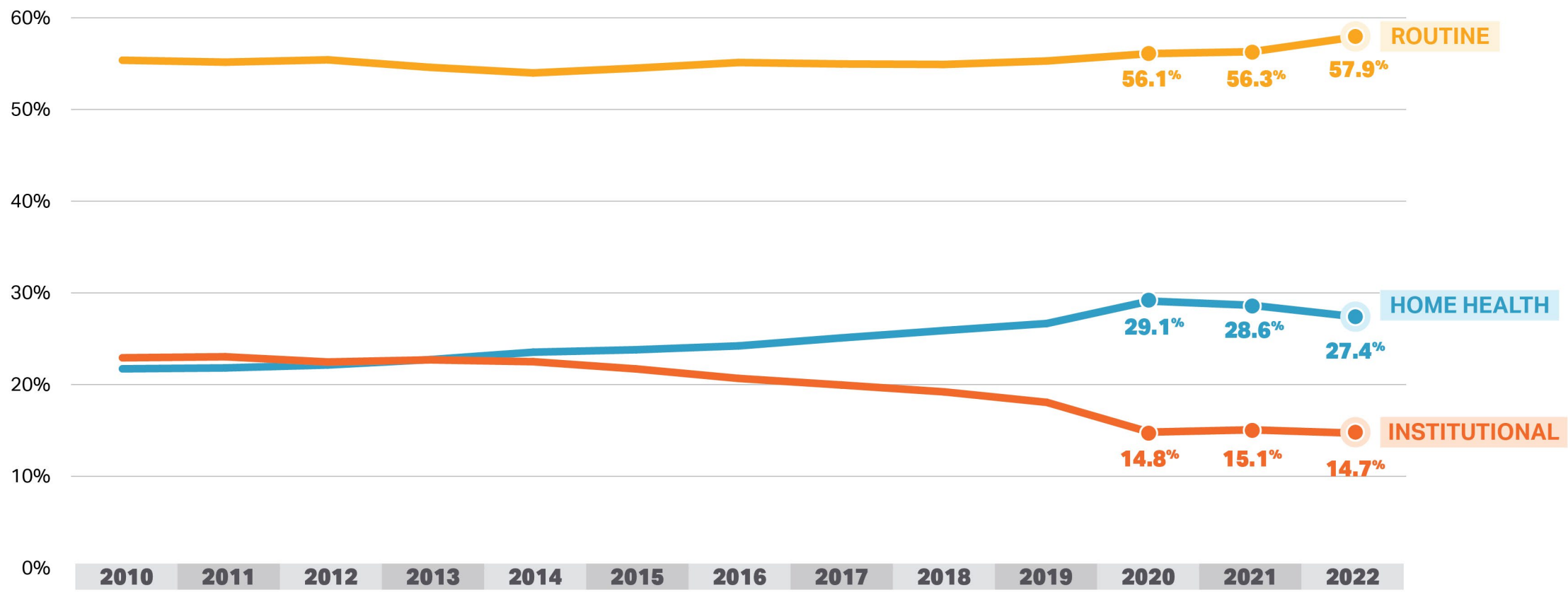
Percentage of all and newborn hospital stays taking place at community hospitals, 2016-2022



Notes: The Center for Health Information and Analysis defines community hospitals as general acute care hospitals that do not support large teaching and research programs. Data reported by calendar year. Sources: HPC analysis of Massachusetts Acute Hospital Case-Mix Inpatient Department Database, FY2016-2023, preliminary FY2023 Q1.

The percentage of hospital stays discharged to home health care dropped from 2020 to 2022, in contrast to steady growth from 2010 to 2020.

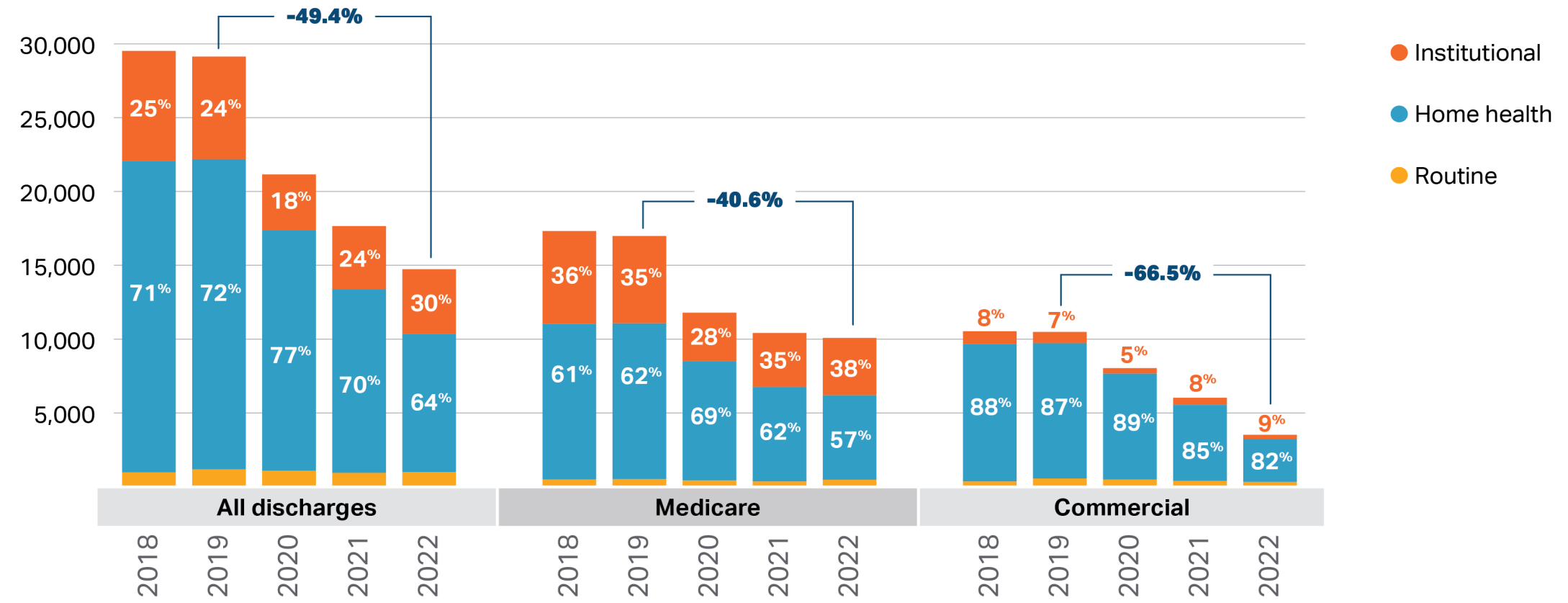
Post-acute care in Massachusetts following hospital discharge, all DRGs, 2010-2022



Notes: Out of state residents and those under 18 are excluded. Institutional post-acute care settings include skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals. Rates adjusted using ordinary least squares (OLS) regression to control for age, sex, and changes in the mix of diagnosis-related groups (DRGs) over time. Specialty hospitals, except New England Baptist, were excluded. Several hospitals (UMass Memorial Medical Center, Clinton Hospital, Cape Cod Hospital, Falmouth Hospital, Marlborough Hospital) were excluded due to coding irregularities in the database. Data reported by calendar year. Sources: HPC analysis of Massachusetts Acute Hospital Case-Mix Inpatient Department Database, FY2010-2023, preliminary FY2023 Q1.

Total inpatient volume of hip and knee replacement surgeries has fallen nearly 50% from 2018 to 2022, with many shifting to outpatient sites.

Number of inpatient surgeries and percentage receiving post-acute care by payer, 2018-2022

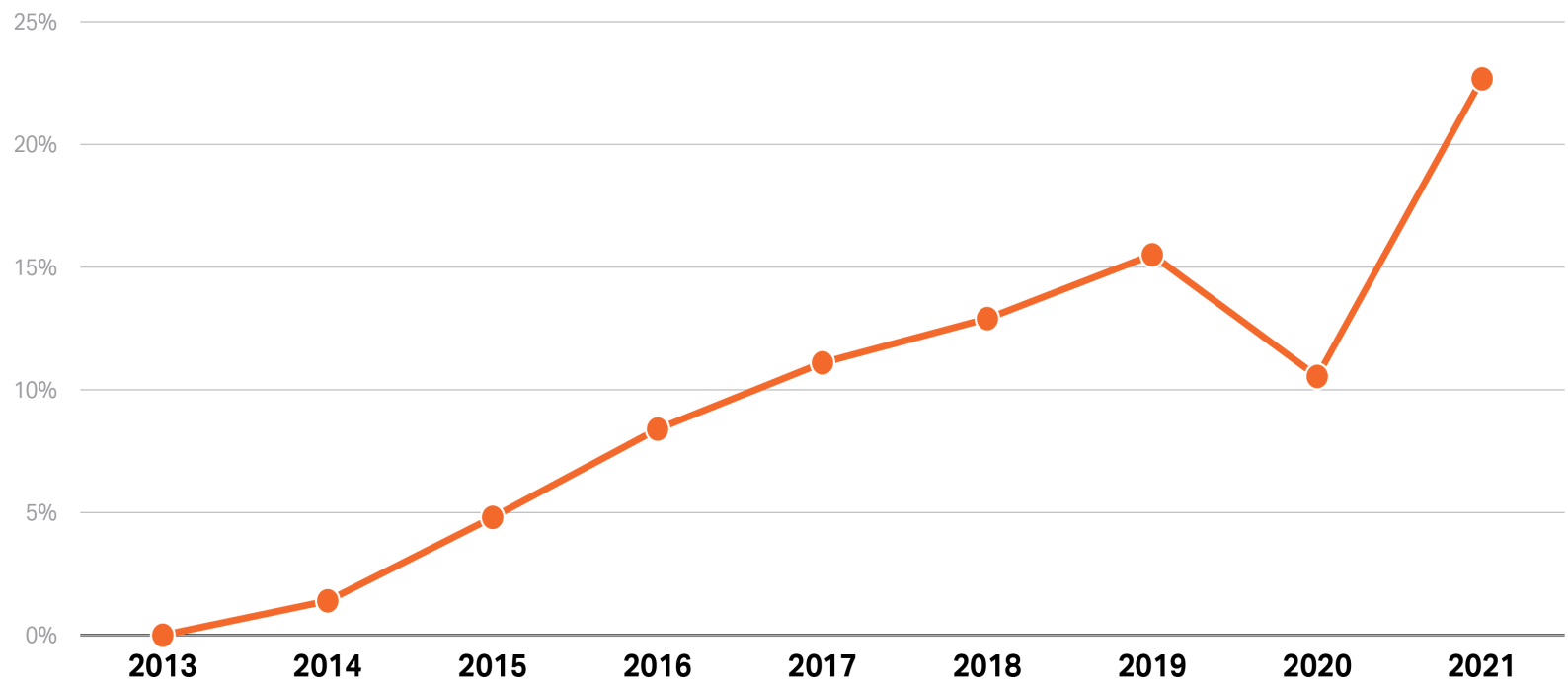


Notes: DRGs included 466, 467, 468, 469, 470, 521, 522. Out of state residents and those under 18 are excluded. Specialty hospitals, except New England Baptist, were excluded. Several hospitals (UMass Memorial Medical Center, Clinton Hospital, Cape Cod Hospital, Falmouth Hospital, Marlborough Hospital) were excluded due to coding irregularities in the database. Data reported by calendar year. Sources: HPC analysis of Massachusetts Acute Hospital Case-Mix Inpatient Department Database, FY2018-2023, preliminary FY2023 Q1.

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Average commercial member risk scores jumped 12% from 2020 to 2021.

Cumulative growth in average risk score for commercially-insured members, 2013-2021

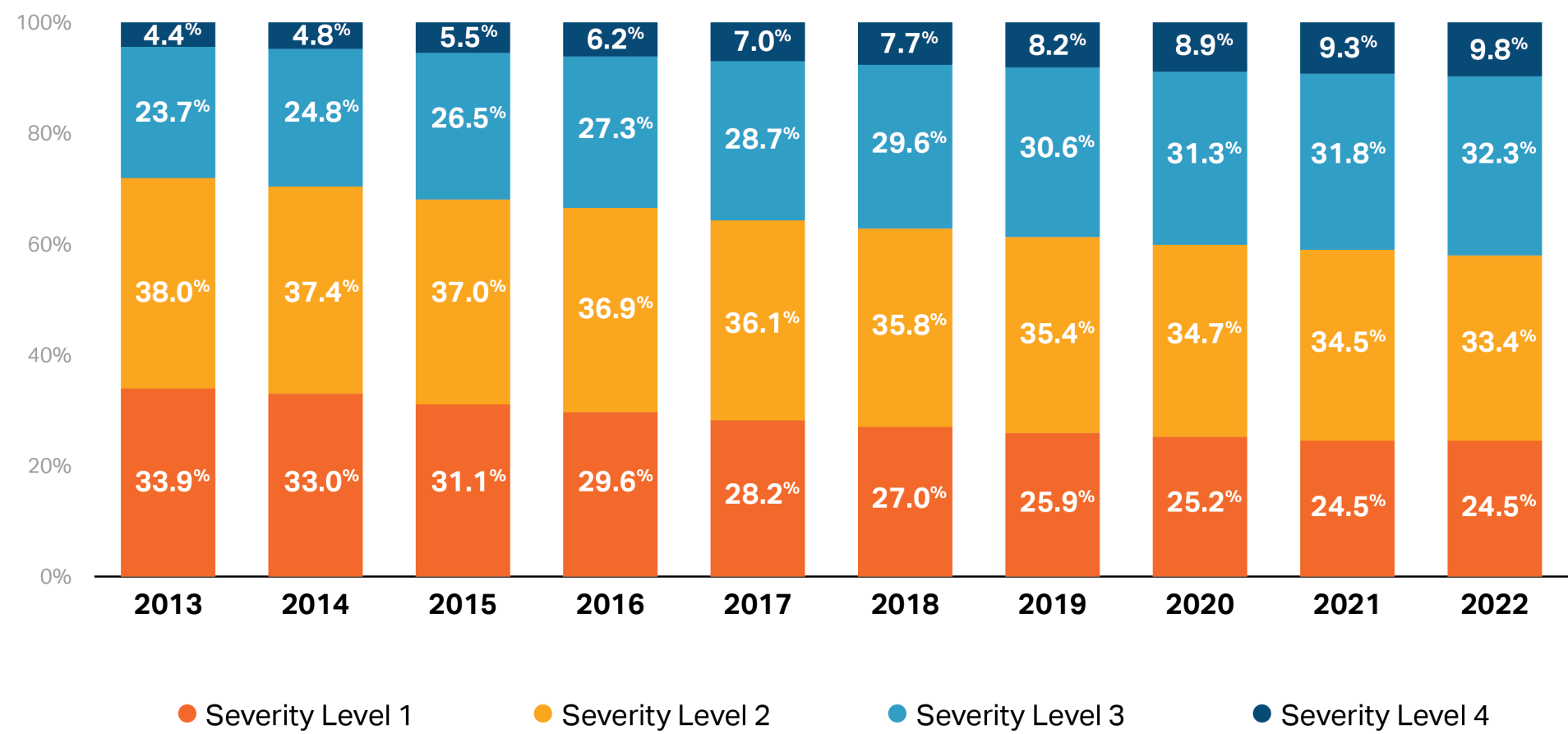


- Risk scores dropped in 2020 due to fewer encounters with the medical system leading to fewer diagnoses being recorded in patients' records.
- The overall increase from 2013-2021 was 23%, or 2.6% per year, on average.

Source: HPC analysis of Center for Health Information and Analysis 2016, 2017, 2018, 2019, 2021, 2022, and 2023 Annual Report TME Databooks. Payers included are HPHC, THP, BCBSMA, Fallon and HNE.

Inpatient stays continue to be coded at higher acuity levels.

Proportional composition of inpatient discharges by patient severity of illness, COVID-19 excluded, 2013-2022

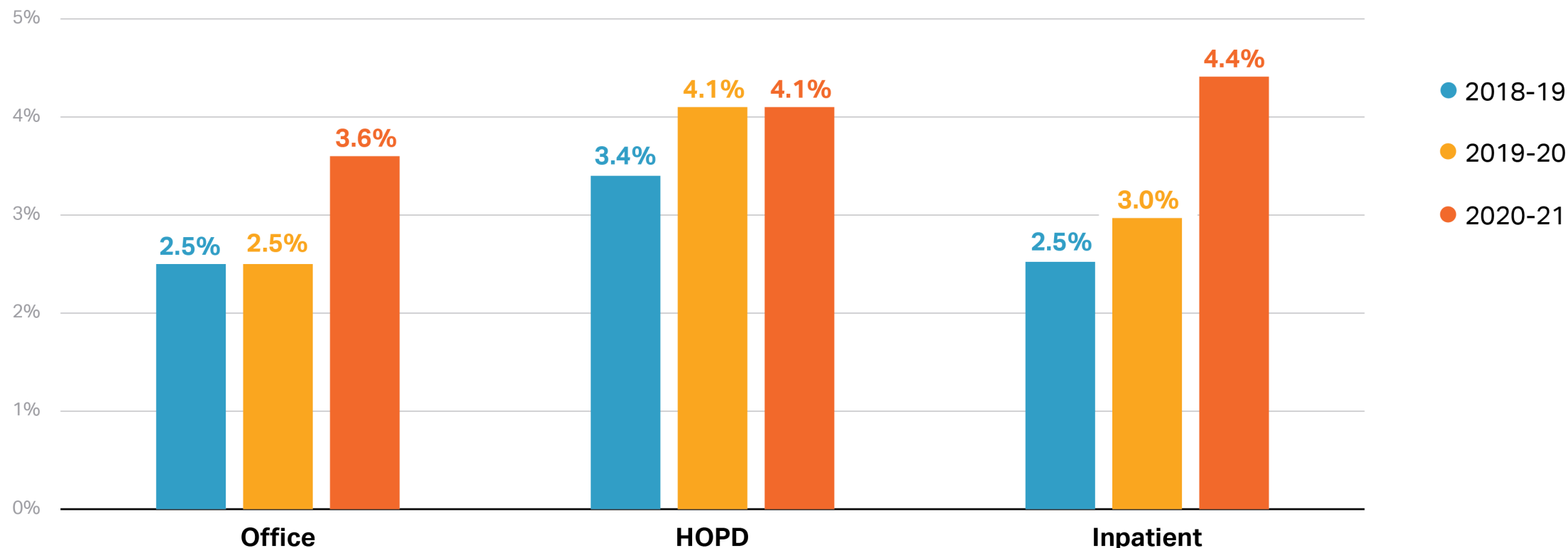


Notes: Severity groups and typical payment amounts were defined using all-payer refined diagnosis related groups (APR-DRG) and patient severity of illness (SOI) on a four-level severity scale, with 4 being the highest acuity. The data is comprised of all medical inpatient stays at acute care hospitals for Massachusetts residents, excluding behavioral health stays and extremely long length of stay because these cases are usually not paid on a DRG basis. Other exclusions include transfers, patients who died, patients who went to Shriners Hospital for Children (Springfield and Boston), and discharges with some APR coding restrictions based on discrepancies with CMS major diagnostic categories. COVID-19 cases were defined as any inpatient stay with U071 for the primary or secondary diagnosis code.
 Sources: HPC analysis of Center for Health Information Acute Hospital Case-Mix Inpatient Department Database, FY2013-2023.

Price growth for all settings accelerated in 2021, with price growth for hospital-based services (HOPD and inpatient) outpacing prices for office-based services.



Annual percentage increase in aggregate prices by setting, 2018-2021



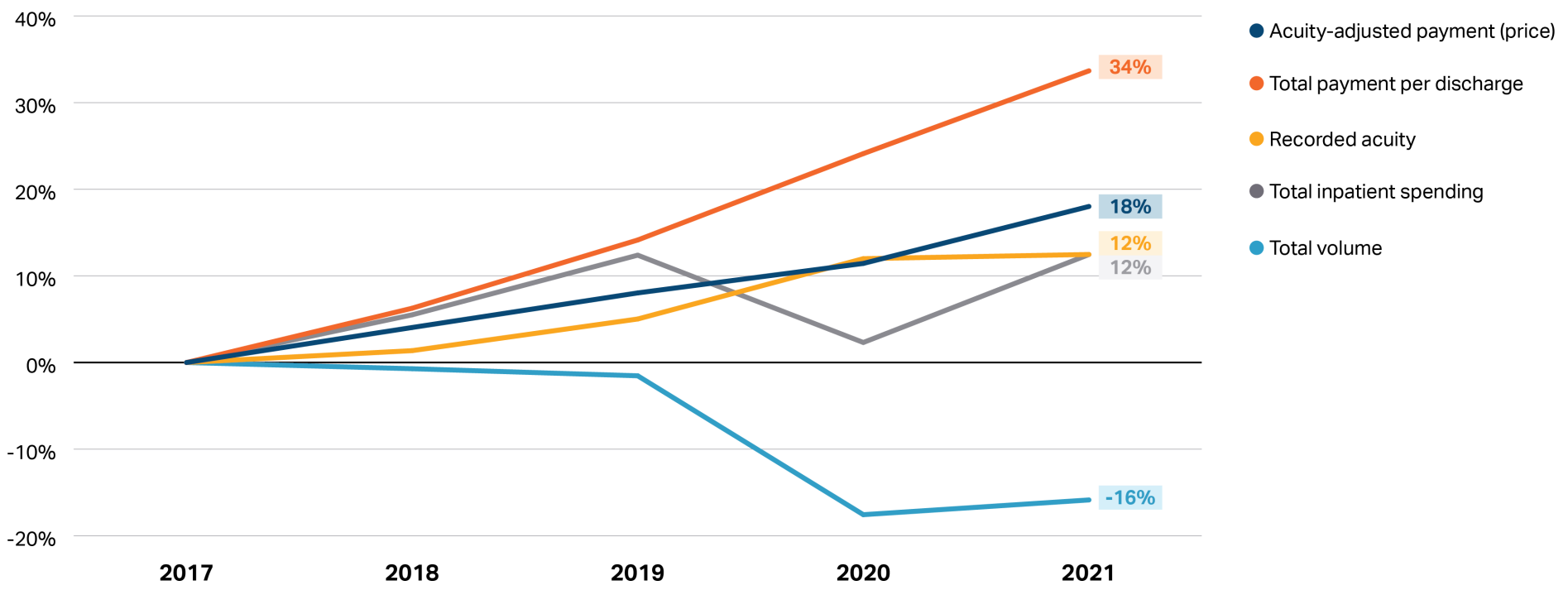
Notes: Only procedure codes that were billed from 2018 through 2021 were included (thus, COVID-related services are excluded). HOPD and office price growth includes both facility and professional spending. Price growth is computed at the level of a procedure code encounter. Procedure code encounters are defined as the same person, same date of service, and the same procedure code to capture the potential for both facility and professional claims billed on the same day for the same service based on the setting. The inpatient stay price growth reflects change in payment for inpatient stay divided by APR-DRG weight (case-mix adjusted). Payment growth for inpatient stays include all services provided during the hospital stay. Procedures codes with fewer than 20 services or \$1,000 in aggregate spending during the period were excluded. Percent changes were weighted by the most contemporary aggregate spending for each procedure code (e.g., 2019 for the 2018-19 period).

Sources: HPC analysis of the Center for Health Information and Analysis All-Payer Claims Database, V2021, 2018-2021.



Commercial spending on non-maternity inpatient stays from 2017-2021 grew 12% from 2017 to 2021 despite a 16% drop in volume. Price increases drove most of the growth.

Cumulative change in prices, spending, acuity, volume and payments per discharge for non-maternity and non-COVID commercial stays, 2017-2021

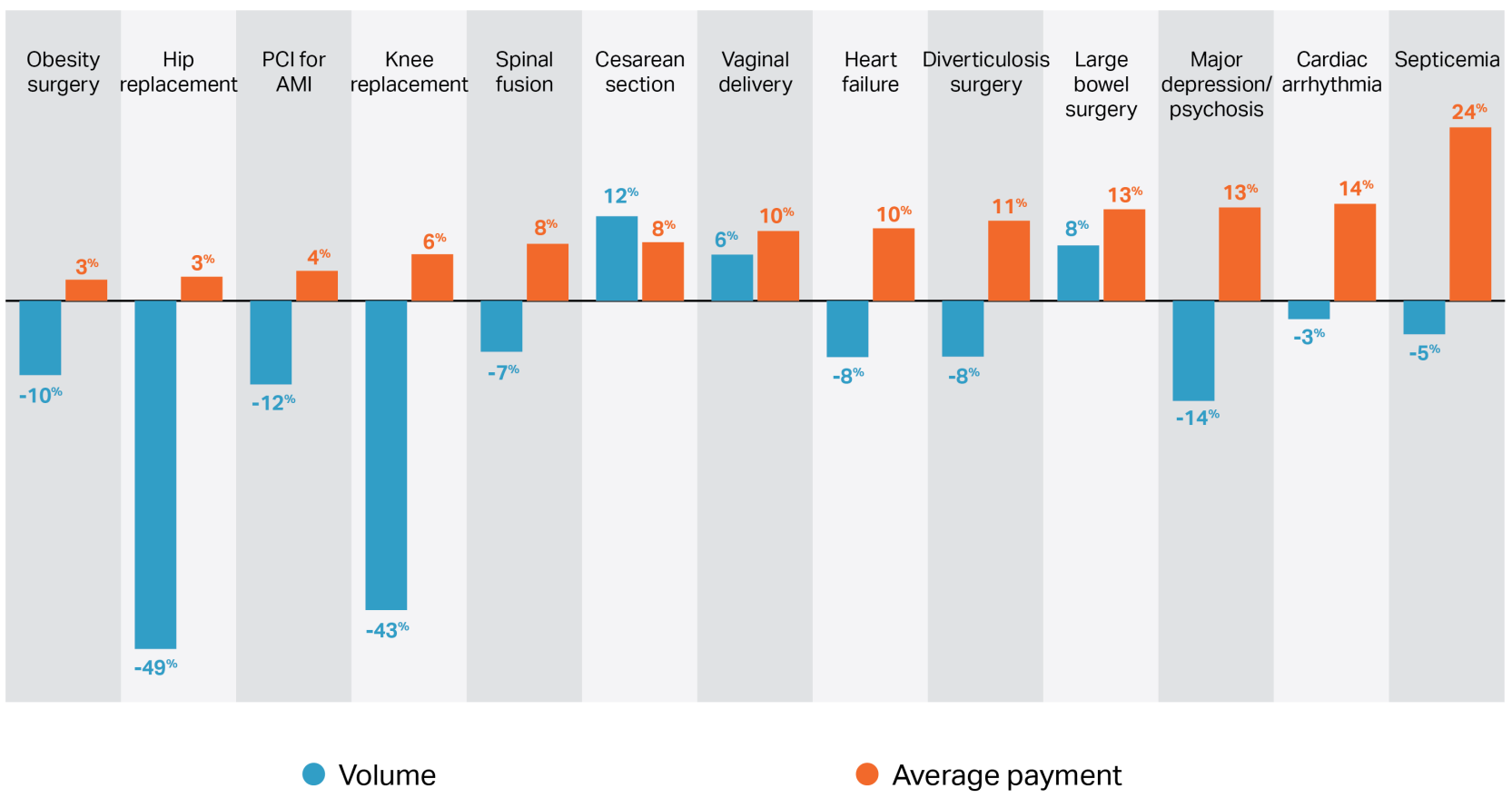


- Average payment per hospital stay grew 34%, driven mostly by price increases (18%, controlling for acuity), but also by an increase in recorded acuity (12%).
- Recorded acuity grew 5% from 2017 to 2019 and 7% from 2019 to 2021.
- In contrast, payment for maternity stays grew 10% from 2017-2021 with no change in recorded acuity.

Notes: Inpatient stays in maternity and newborn major diagnostic categories are excluded, as well as stays with primary or admitting Covid-19 diagnoses. Average payment shown includes both facility and professional claims. Stays that are outliers in length of stay and transfers are not excluded in order to correctly represent changes in total spending and volume. Adjusted payment is calculated as average of payment divided by APR-DRG weight for each stay.
 Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, V2021, 2017-2021; MassHealth APR-DRG weights, 2023.

Payments per hospital stay increased between 3% and 14% for most high-volume admission categories from 2019 to 2021. Most categories saw reduced volume.

Total (2019-2021) change in price and volume for major categories of hospital inpatient admission



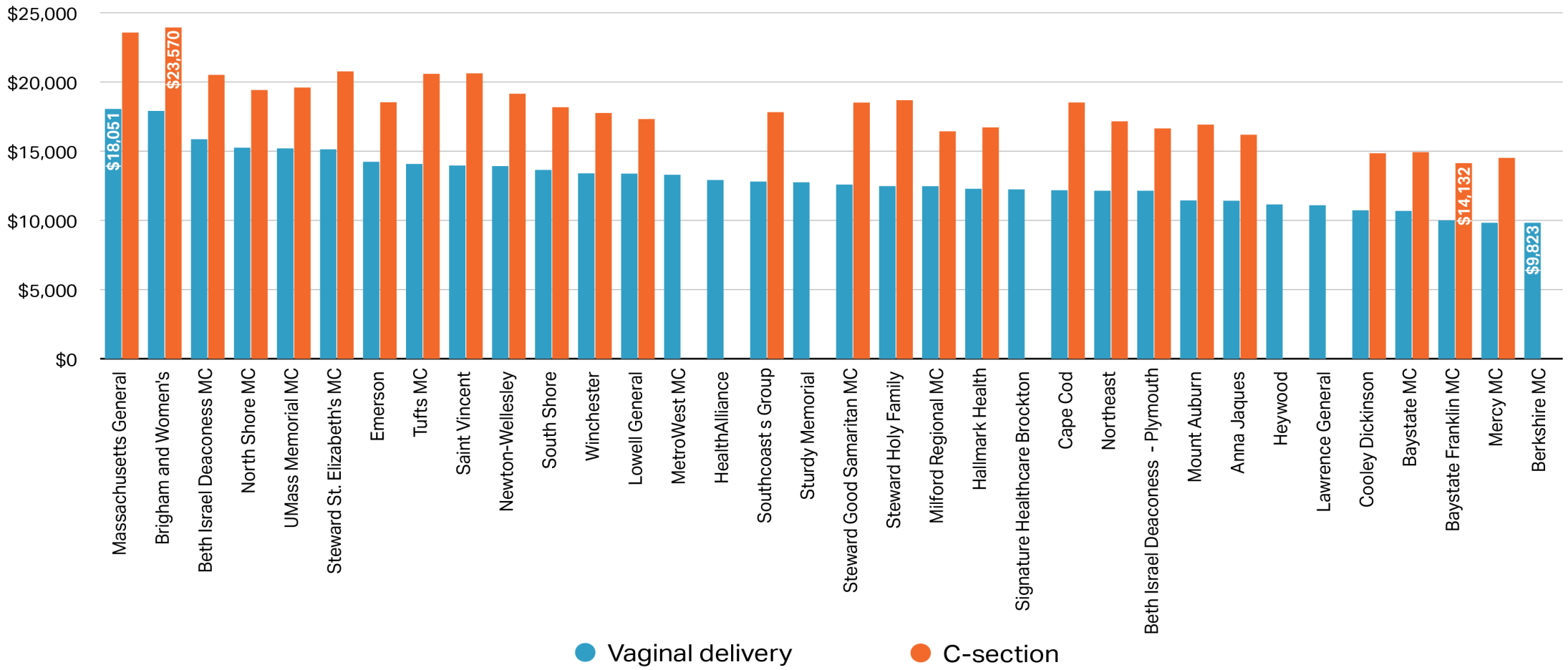
- Elective conditions with the largest drop in inpatient volume partly moved to outpatient settings.
- All conditions shown except maternity admissions and large bowel surgery had a reduction in volume.
- Septicemia had higher growth in average DRG weight (recorded acuity) than all other services.

Notes: Top 13 APR-DRG conditions by volume are selected. Average payment is calculated for each APR-DRG group of inpatient commercial stays regardless of the severity level.

Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) All-Payer Claims Database V2021, 2019 and 2021; MassHealth APR-DRG weights 2023

Prices for inpatient stays for low-acuity vaginal and cesarean section deliveries varied 2:1 across hospitals.

Average total payment for vaginal deliveries and cesarean section inpatient stays of the lowest acuity level, 2021



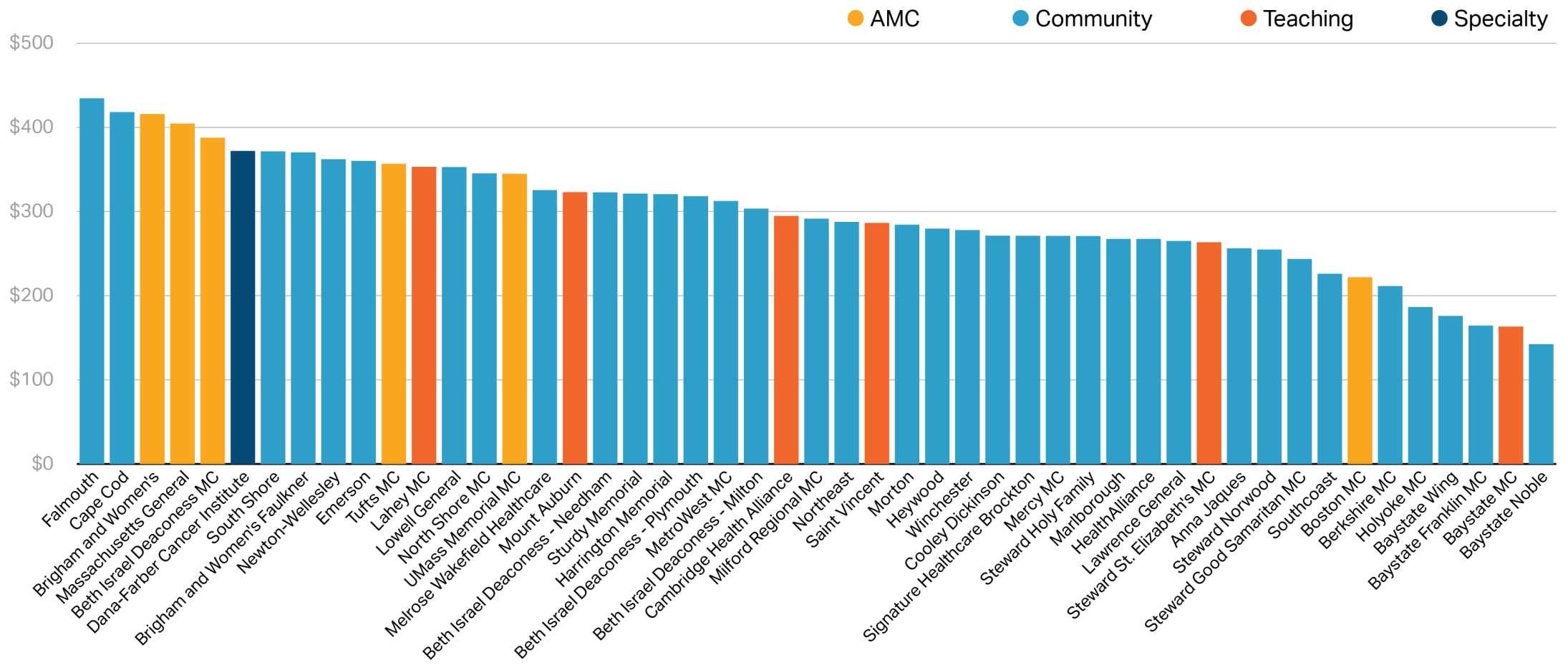
Notes: Outliers by length of stay (3 times the median) and outliers by payment (greater than 5 times the median or lower than 20% of the median) are excluded. Prices are shown for the hospitals with at least 30 commercial vaginal deliveries of acuity level 1, and at least 20 C-sections of acuity level 1.

Sources: HPC analysis of Center for Health Information and Analysis Massachusetts All-Payer Claims Database, V2021, 2021

Prices for mammography services in HOPDs varied more than 3:1 across hospitals in 2021.



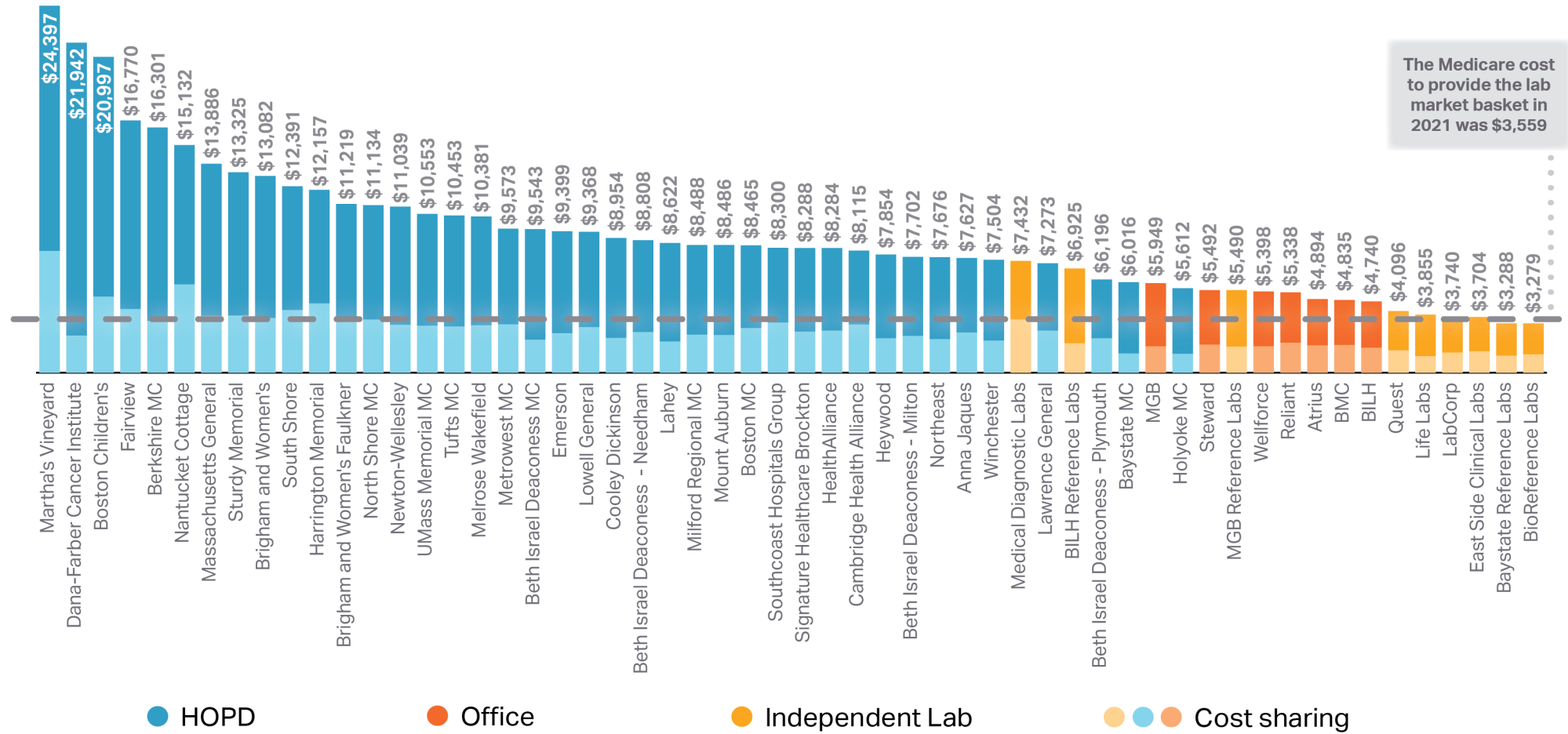
Average price for screening mammography (CPT code 77067) performed in a HOPD by hospital, 2021



Notes: Facilities listed are limited to those with at least 700 commercial encounters for the service in 2021. Prices reflect encounters (same person, same date of service, same procedure code) to capture the potential for both facility and professional claims billed on the same day. CPT 77067 is defined as: 'Screening mammography, bilateral, including computer-aided detection (CAD) when performed'.
Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database V2021, 2021.

The price of a fixed market basket of common lab services varied more than 7-fold by provider in 2021 with much higher prices when they were performed in HOPDs.

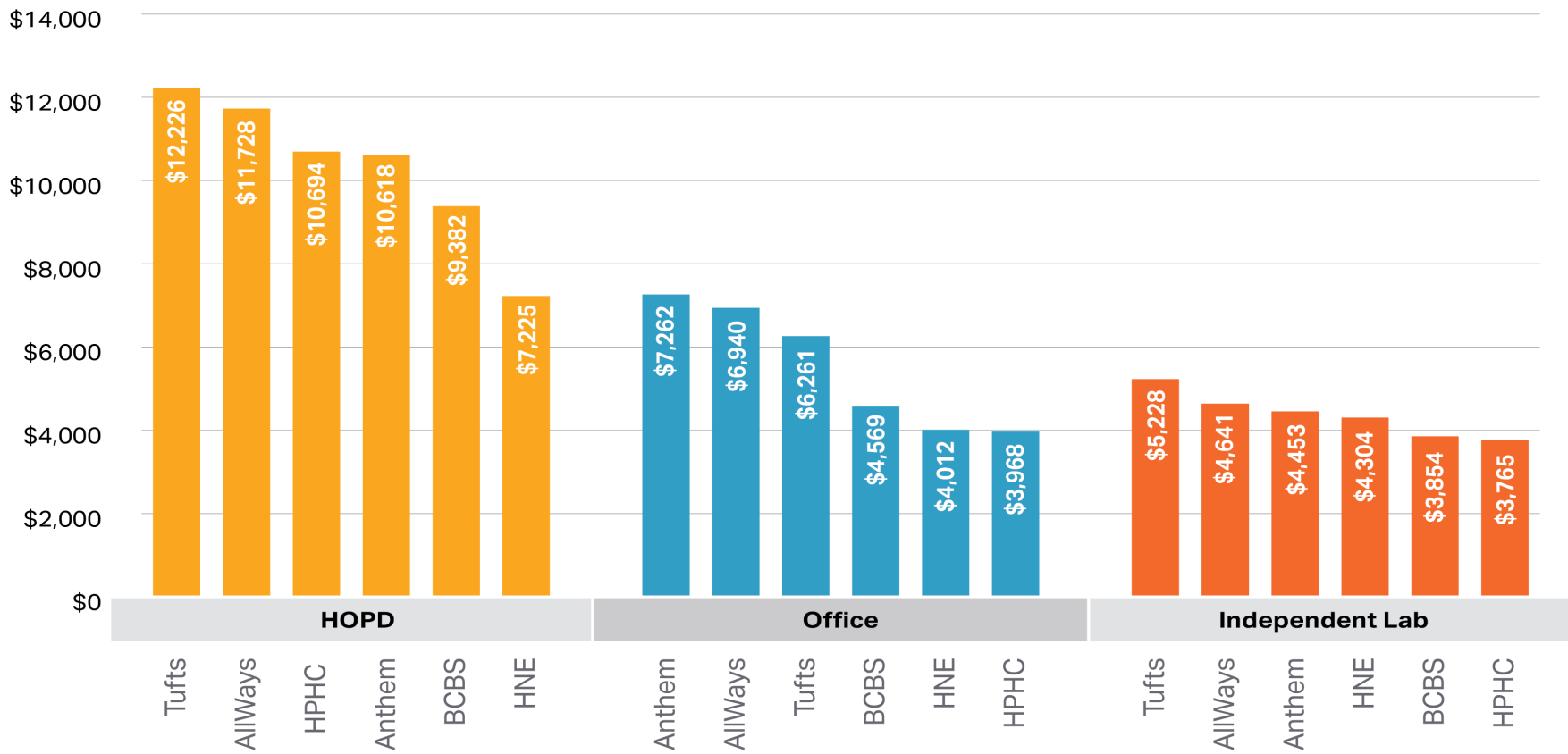
Price of a fixed 50-item lab market basket, including cost sharing, by Massachusetts providers, 2021



Notes: For each provider, the same 50 procedure codes are evaluated using a fixed statewide volume (computed using 2019 data) and provider-specific mean service prices in 2021 for each procedure code. Providers with fewer than 20 service encounters for any individual procedure code have imputed values for that procedure code and are not included if more than 25 procedure codes would have to be imputed. Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2021.

Payers differed substantially in how much they paid for lab services in 2021.

Price of the lab market basket by setting of care and payer, 2021



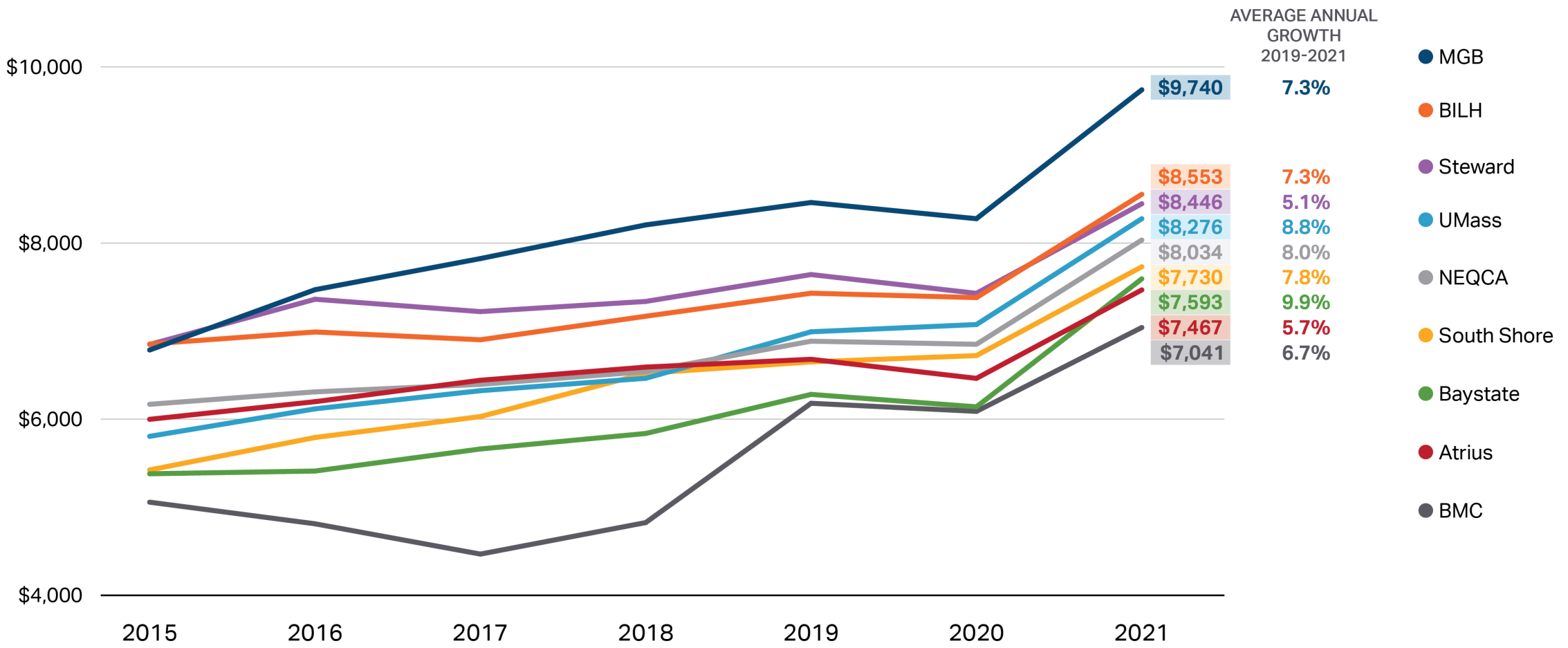
Notes: HPHC and Tufts merged in January 2021 to form Point32Health. When controlling for each payer’s provider mix, HNE’s HOPD prices increase by roughly 10% but other payers’ prices change more modestly (generally less than 5%) and the overall order remains the same. The HPC’s version of the APCD includes claims for members enrolled in commercial insurance products from the six payers shown. These claims include most GIC members but otherwise are more heavily representative of members with fully-insured products and overall represent approximately 30% of the commercial market in Massachusetts.

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2021.

1. Primary Care and Behavioral Health
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The gap between the highest-spending (unadjusted) provider group (MGB) and the next-highest group increased in 2021. All provider groups had average annual growth between 5% and 10% from 2019-2021.

Unadjusted total medical spending per member per year by provider organization for the nine largest provider groups, 2015-2021

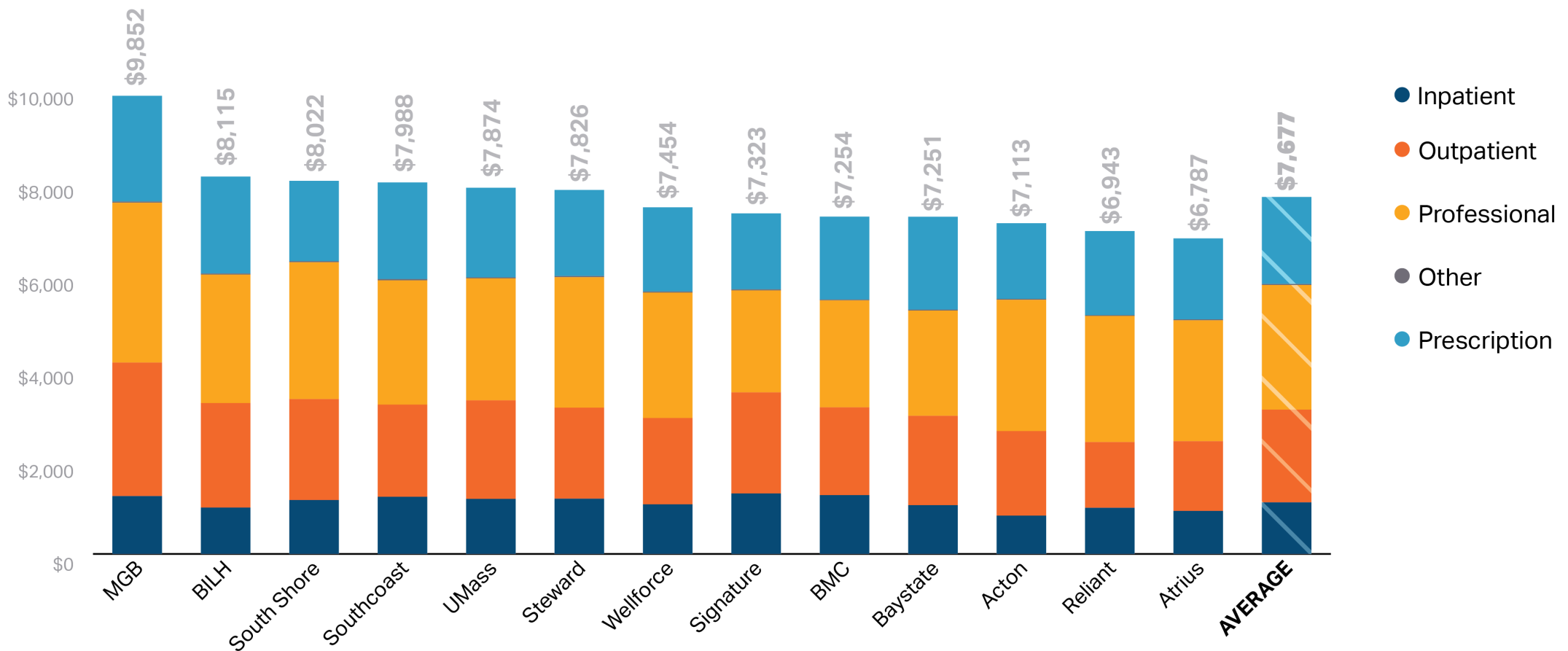


Notes: Spending is based on patients' attributed primary care provider organization. Partners HealthCare changed its name to Mass General Brigham (MGB) in 2019. Beth Israel Deaconess Care Organization (BIDCO) and Lahey Hospital and Medical Center merged in 2019 and became Beth Israel Lahey (BILH). BIDCO and Lahey data were reported separately by CHIA until 2021. Chart combines spending across all payers with the exception of Tufts Public Plan and BMC Health Net.

Sources: HPC analysis of Center for Health Information and Analysis 2018, 2019, 2021, 2022, and 2023 Annual Report TME Databooks.

HOPD spending was the largest source of variation across provider groups in total spending, ranging from \$1400 (Reliant) per member per year to \$2,900 (MGB).

Unadjusted total medical claims spending per member per year by category of spending and provider organization, 2021



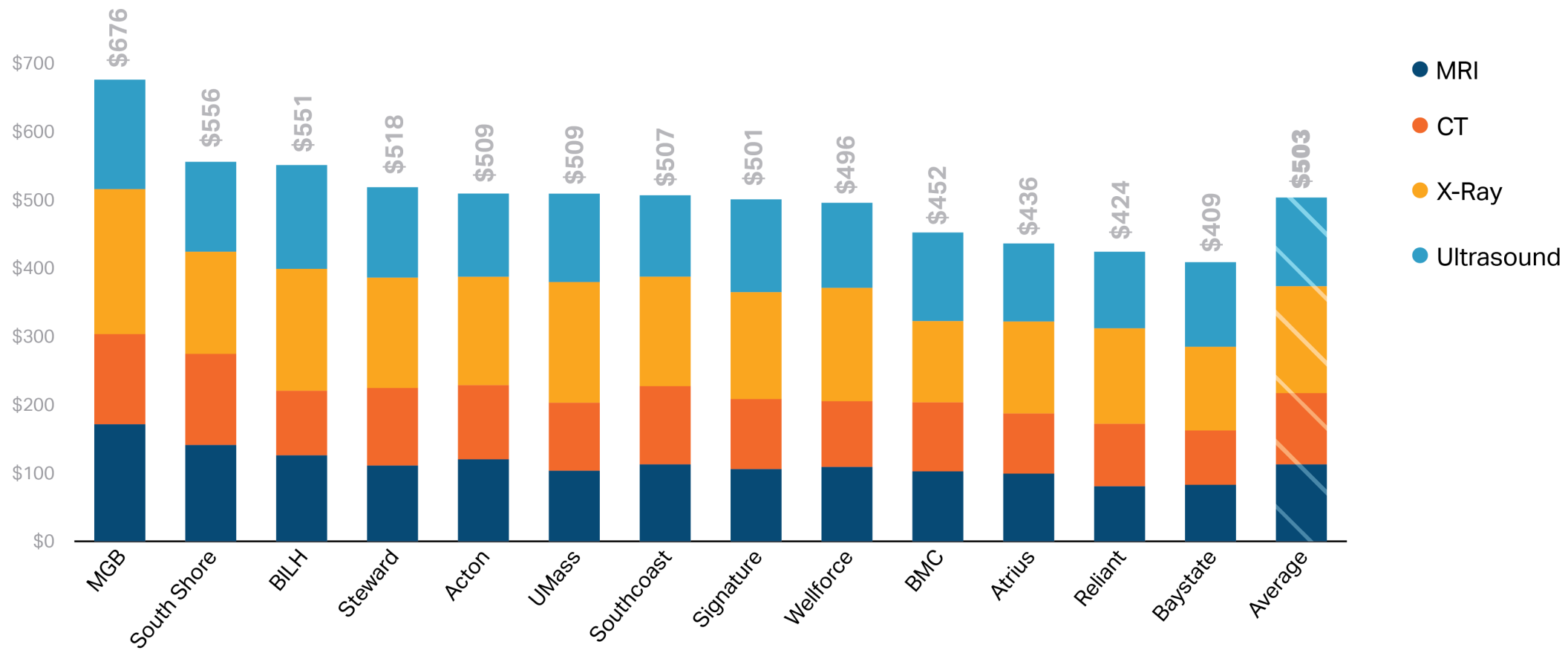
Notes: PMPY: Per member per year. Individuals without 12 months of prescription drug insurance coverage were excluded. Spending results are for commercial attributed adults with 12 months of continual medical insurance coverage (N=593,081). BILH is the consolidated previous organizations of BIDCO and Lahey. Average is calculated across provider organizations. Hospital inpatient and outpatient spending include facility spending only. Professional spending associated with these sites of care is included in "Professional".

Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2021.

Spending on imaging services (CT, MRI, Xray, Ultrasound) varied 65% by attributed provider organization.



Unadjusted imaging spending per member per year by category of imaging and provider organization, 2021



Notes: Results reflect commercial attributed adults, at least 18 years of age with 12 months of continual medical insurance coverage (N=786,327). Average is calculated across provider organizations. Sources: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database, V2021, 2021.

Chartpack: Summary of Preliminary Findings



➤ PRIMARY CARE AND BEHAVIORAL HEALTH

- Primary care spending grew **only one-third as fast** as other medical spending from 2017-2021, declining as a proportion of total spending.
- Commercially-insured residents in low-income communities were more likely to have **zero primary care spending** than those in high-income communities.
- Psychotherapy visits **more than doubled** and mental health prescriptions **increased 75%** for young adults (18-25) between 2017 and 2021.

➤ HOSPITAL AND POST-ACUTE CARE USE

- The number of hip and knee replacement surgeries taking place in hospital inpatient settings **dropped in half** from 2019-2022.

➤ PRICE TRENDS

- **Prices in all settings rose faster in 2021 than in the previous two years.**
- Prices for lab tests varied more than 7-fold across providers.

➤ PROVIDER ORGANIZATION PERFORMANCE VARIATION

- The **gap increased** between the highest-spending provider group (MGB) and the next-highest group in 2021 (to 14%). **Average annual spending growth** for the 9 largest provider groups ranged **between 5% and 10%** from 2019-2021.
- **Spending on imaging** varied 65% across provider groups.

Agenda



Call to Order

Approval of Minutes (**VOTE**)

Findings from the 2023 Health Care Cost Trends Report



REDUCING UNNECESSARY ADMINISTRATIVE COMPLEXITY: POLICY OPTIONS

Implementation of the Federal No Surprises Act

Executive Director's Report

Adjourn

2023 HPC Action Plan



Bolster the HPC's Cost Containment Activities



Address Health Care Workforce Challenges and Identify Solutions



Advance Health Equity



Enhance Pharmaceutical Pricing Transparency and Accountability



Reduce Unnecessary Administrative Complexity



Reduce Unnecessary Administrative Complexity

- Partner with stakeholders and the Network for Excellence in Health Innovation (NEHI) and the Mass Health Data Consortium (MHDC) to promote prior authorization automation.
- Identify other priority areas for streamlining, simplification, or standardization and convene stakeholders to develop and advance solutions.
- Participate on new Special Commission to Develop Common Medical Necessity Criteria in Behavioral Health.
- Continue staff support and policy leadership of the Quality Measurement Alignment Taskforce (QMAT), including convening a workgroup to advise on an electronic clinical quality measure repository.

Administrative complexity is a major driver of health care spending.

- Administrative costs have been estimated to be as high as **34% of total health care spending nationally** or \$812 billion annually, significantly greater than other countries.¹
- Many of these costs are driven by the complexity of a system that includes multiple private and public payers, all with different rules and processes.
- **Billing and insurance-related activities** – a subset of health care administration that includes claims processing, referral management, prior authorization, and more – were estimated to cost US payers and providers **\$496 billion** annually.²
- **Reducing administrative complexity** could benefit the system without jeopardizing quality or access, such as by:
 - Reducing time, cost, and administrative burden for patients, providers, and payers
 - Allowing providers to reallocate staff time and resources to higher-value activities
 - Addressing drivers of clinician burnout
 - Reducing delays in care

At the end of 2019, the HPC identified prior authorization as a priority area for further work.

- The HPC surveyed a wide range of stakeholders and found **significant stakeholder interest in prior authorization (PA)**.
 - Consistent with national surveys, MA providers report dedicating significant staff time and resources to navigating and complying with each payer's unique PA policies.
 - Consistent with recent academic findings, MA payers note that PA is an important tool for keeping down costs and broad removal of PA requirements could increase spending.
- Prior authorization reform continues to receive significant attention from **state and federal policy makers**.
- The unnecessary complexity associated with prior authorization **directly impacts patients**. For example, patients may experience delays in care while PA requests are being submitted and processed, even when their requests are ultimately approved.
- Prior Authorization is **exemplary of many of the complexities and redundancies inherent in other health care transactions**, and policy makers may be able to apply improvements to other transactions.

Massachusetts already regulates several aspects of prior authorization for commercial plans, for example:



Health plans must have a **documented process** to: 1) review and evaluate the effectiveness of their utilization management programs; 2) ensure the consistent application of utilization review criteria; and 3) ensure the timeliness of determinations.



Utilization review criteria must be **evidence-based** and developed with the input of participating physicians.



Criteria must be accessible and **up-to-date online**.



Denials or adverse determinations must be made by **a person licensed in the appropriate specialty** related to the service and, if applicable, by a provider in the same licensure category as the ordering provider.



Initial determinations must be made **within 2 working days** of obtaining all necessary information, with telephonic notice for admissions and denials within 24 hours. Concurrent review determinations must be made within 1 working day of obtaining all necessary information.



Adverse determinations must include **a substantive clinical justification**.

Yet Massachusetts providers and patients continue to report pain points.

Volume of Authorizations

Despite agreement that PA is an appropriate UM tool in some circumstances, many see its application as unreasonably broad, especially for patients with extended courses of treatment.



Lack of Standardization

Significant variation in payer processes related to PA requirements, approval criteria, medical necessity criteria, and submission processes.



Time to Approval

Requests can take multiple business days to approve, which can make accessing same-day care difficult, and approvals are only valid for a fixed amount of time.



Mid-Year Changes

Payers can update their PA policies mid-year, and on different timelines, without a grace period to allow providers to update their systems.



Retroactive Denials

Approved services are sometimes retroactively denied based on, e.g., medical necessity, a day-of decision to bill a related but distinct CPT code, or technicalities.



Patient Plan Switching

Because of the lack of standardization across payers and products, patients who experience a change in coverage may have to repeat authorization processes.





There is evidence that PA policies can **reduce spending** for targeted services^{1,2}

- Recent work (specifically examining PA policies for drugs) has also found that such savings likely persist even when accounting for payer and provider **administrative costs**.¹
- However, the cost effectiveness of prior authorization depends on **the service or drug in question**:
 - Prior authorization has been found to decrease utilization and associated spending with certain services such as medical imaging³ and non-emergency ambulance transport.^{4,5}
 - Researchers conducted a systematic literature review to assess the impacts of formulary restrictions (of which the most commonly studied restriction was PA) on spending. Over 80% of the studies found a positive relationship between PA and lower pharmacy costs; however, this is not always the case for medical or total costs. PA was associated with lower medical costs 29% of the time and lower total costs 47% of the time.²
 - The cost effectiveness of PA is influenced by the baseline rates of inappropriate or non-preferred care being ordered.³
- Yet, the complexity and variation in PA processes contributes to **inefficiency and unnecessary spending**.^{6,7,8}



PA can provide important clinical benefits, but its complexity raises **quality, access, and equity** concerns.

- PA may help target **low value care and fraud**, detect and prevent dangerous **drug interactions**, and act as a **clinical decision support tool**.¹
- Yet PA complexity can also lead to the **delay, deferral, or avoidance** of appropriate care, including based on inappropriate denials.^{2,3,4} For example, researchers have found:
 - A recent study found that 8% of non-elderly adults who had to seek PA reported delaying care, forgoing care, or both as a result.⁵
 - The OIG found that only 1% of Medicare Advantage PA denials were appealed, but that 75% of those appeals resulted in an overturned decision, raising concerns that there may have been other necessary care that was denied, but which was not appealed.⁶
 - While care delays and avoidance has been well documented, the downstream impacts of such treatment abandonment on **patient health outcomes** is less clear.⁷
- Researchers have documented **greater associated burden**, such as care delay or avoidance, on groups known to experience health disparities, who may struggle to navigate the administrative requirements.^{8,9}
 - Those who reported delaying or forgoing care for any administrative task, including PA, were more likely to be female, have a disability, have a family income below 138% of the FPL, and have public insurance. They were less likely to be white, married, and be college graduates.⁹
 - Some providers have argued that physicians with a higher government payer mix may have less resources to devote to helping their patients navigate PA.¹⁰



Beyond cost and quality impacts, PA complexity also contributes to **clinician burnout**.¹

- The U.S. Surgeon General has cited **PA inefficiencies as a driver of clinician burnout** and called for direct reforms.²
- The 2022 AMA physician survey found that the vast majority of physicians (86%) described the administrative burden associated with prior authorization as “**high or extremely high**,” and 88% said the burden has gone up in the last five years.³
- Across payers, primary care practices reported that they completed an average of 41 prior authorization requests weekly per physician (13 staff hours per week).⁴

Appropriate Use Criteria Program

- Final Rule
- Currently undergoing an educational and operations testing period
- Requires providers to consult a Clinical Decision Support Tool when billing Medicare for certain advanced imaging services; outlier physicians will be subject to prior authorization.

2024 Medicare Advantage and Part D Rule

- Final Rule
- Clarifies that MA plans cannot use PA to define narrower coverage than Traditional Medicare
- Establishes continuity of care protections for patients switching plans
- Sets standards for how long an approved PA is valid, and more

Advancing Interoperability and Improving Prior Authorization Processes

- Proposed Rule
- Would be effective January 1, 2026
- Would require that Medicare Advantage, Medicaid and CHIP managed care, state Medicaid agencies, and certain QHPs implement automated PA systems
- Would require payers to include a specific reason that a PA request is denied and decide on a request within 72 hours if it is urgent



REMOVAL OF PA REQUIREMENTS

- **Michigan:** medication-assisted-treatment drugs for Medicaid patients¹
- **Colorado:** treatment of stage 4 advanced metastatic cancer²
- **Delaware:** 72-hour supply of medication that is for a noncontrolled substance in emergency situations³
- **Iowa:** medication-assisted-treatment drugs for Medicaid patients⁴
- **North Dakota:** DME and supplies for dual-eligible individuals⁵
- **Vermont:** annual review and removal of PA requirements that are no longer necessary or that are routinely approved⁶

GOLDCARDING

- Removal of PA requirements for physicians with consistently high approval rates, such as 80% or greater (CO)², 90% or greater (TX)⁷ and 100% (WV)⁸ for at least 6 months.
- Pilot programs (VT)⁶ require carriers to automatically exempt or streamline requirements for providers that received 100% approval within a 6-month period for a procedure performed an average of 30 times per year.



ALIGNING PA CRITERIA

Vermont directs certified ACOs, payers participating in the All-Payer ACO Model, health care providers, and other interested stakeholders, to evaluate opportunities for and obstacles to aligning and reducing PA requirements under the All-Payer ACO Model.⁶



OTHER COMMON REFORMS

- **TIMING:** Requires specific turn-around times for PA approvals or denials and approval validity time (AZ⁹, CO², IN¹⁰, OR¹¹, TX⁷).
- **ELECTRONIC PORTALS:** Requires the use of an electronic portal for processing PA requests (AZ⁹, IN¹⁰, MI¹², NM¹³, WV⁸).
- **INFORMATION ACCESSIBILITY:** Requires information, including information required for a PA, PA status, and denial reasoning, to be readily available to patients (AZ⁹, CO², IL¹⁴, NM¹³, TX⁷).

PAST

- **Standard Forms:** Chapter 224 required the development and use of standard PA request forms.
- **COVID Emergency Orders:** DOI directed payers to relax PA requirements for certain conditions during the emergency, to reduce the risk of care delay and admin burden
- **Mental Health ABC Act:** Prohibits PA for acute mental health treatment and directs the state to study and make recommendations on the establishment of a common set of medical necessity criteria for BH services
- **PA Stakeholder Group:** NEHI recently led two multi-stakeholder projects aimed at identifying opportunities for PA reform, including through automation.

PROPOSED

S.1249 & H.1143 Bills

- Require annual reporting to DOI on services requiring prior authorization, approval rates, average time to approval, and more;
- Require commercial carriers to automate prior authorization;
- Require the HPC to report on PA impacts on access, administrative burden, and system costs;
- Introduce several new PA consumer protections, including related to PA response times, continuity of care for patients switching plans, and duration of approved PAs;
- Prohibit carriers from imposing PA for generic medications and for services and treatments that have low variation in utilization across providers, low denial rates across carriers, and an evidence-base for the treatment or management of “certain” chronic diseases;
- And more

Prior Authorization Reforms: Automation

- The HPC has been working closely with **Network for Excellence in Health Innovation (NEHI)** and the **Massachusetts Health Data Consortium (MHDC)** on PA over the past few years.
- Through this work, key MA stakeholders, including payers and providers, have come to a consensus that **automating PA is** an important step to address administrative burden.
- NEHI and MHDC have set forth recommendations for how the **Commonwealth could build on the CMS proposed automation rule** by expanding the requirement for automation to include commercial payers, developing a statewide roadmap to guide uniform implementation, and establishing supportive structures, such as a technical assistance center, a stakeholder task force, and financial assistance.
- Though not a solution for all PA pain points, these recommendations around automating prior authorization could **provide real-world process improvements for MA payers, providers, and patients**, such as:
 - Reducing **provider uncertainty** about when PA is required, which could eliminate a significant number of PAs submitted currently.
 - Decreasing the **time** from PA submission to disposition.
 - Reducing payer and provider **manual paperwork**.
 - Establishing a **data foundation** against which to evaluate PA volume and variation which could inform further reform efforts.
 - Providing opportunities for **greater standardization** of PA programs across payers.

Prior Authorization Reforms: Examples of Other Opportunities to Address Pain Points



Volume of Authorizations

E.g., mandatory gold-carding, elimination of PA for services with high approval rates, higher provider payment for services requiring PA



Lack of Standardization

E.g., uniform medical necessity criteria, uniform set of services requiring PA, uniform policies for use of family codes and for bundled PAs



Time to Approval

E.g., requiring PAs be valid for longer after approval, public reporting on time to disposition rates



Mid-Year Changes

E.g., limiting when PA policy changes can go into effect, strengthening notice requirements, limiting circumstances when changes can be made



Retroactive Denials

E.g., limiting timeframe for retroactive denials, limiting allowable circumstances for retroactive denials



Patient Plan Switching

E.g., prohibiting requirement that patients who switch health plans get a new PA for previously-approved treatments for a certain amount of time



Automation would alleviate some of these pain points, but there may be opportunities for additional reform.

What other areas of complexity should the HPC prioritize? Can the opportunities for PA reform be applied more broadly?

EXAMPLE MARKERS OF COMPLEXITY WITHOUT VALUE:

Takes clinician time or attention away from patient care

Driven or constrained by current technology and its limitations

Potential markers of administrative complexity without value

Must be repeated or done differently to accommodate non-standard forms or processes

Costs outweigh financial benefits

EXAMPLE AREAS OF COMPLEXITY :

- Billing and Claims Processing
- Clinical Documentation and Coding
- Clinician Licensure
- Electronic Health Record Interoperability
- Eligibility/Benefit Verification and Coordination of Benefits
- Prior Authorization
- Provider Credentialing
- Provider Directory Management
- Quality Measurement and Reporting
- Referral Management
- Variations in Benefit
- Variations in Payer-Provider Contract Terms

Potential Next Steps



1

Continue to work with NEHI and MHDC to advance automation in Massachusetts.

2

Continue research on policy opportunities to streamline prior authorization, including through the annual Cost Trends Report.

3

Prepare policy recommendations for commissioner consideration.

Agenda



Call to Order

Approval of Minutes (**VOTE**)

Findings from the 2023 Health Care Cost Trends Report

Reducing Unnecessary Administrative Complexity: Policy Options



IMPLEMENTATION OF THE FEDERAL NO SURPRISES ACT

Executive Director's Report

Adjourn

Overview of Out-of- Network Billing Updates



- 1 Background on Out-of-Network Billing and Summary of HPC's Work
- 2 Updates on the Federal *No Surprises Act*
- 3 Related Updates in Massachusetts
- 4 Out-of-Network Billing and Ground Ambulances: Federal and State Updates

- The HPC has long considered out-of-network (or “surprise”) billing a policy area of interest and has worked to magnify the issue through **research**, **publications**, **stakeholder engagement**, and **policy recommendations**.
- The scenarios at the core are: (1) **out-of-network emergencies** and (2) when a **patient inadvertently receives out-of-network care at an in-network facility**.
- Out-of-network billing issues raise not only **consumer protection concerns** (e.g., balance billing) but have significant implications for **market functioning** (e.g., absence of limits on out-of-network charges for emergency care may affect payer-provider negotiations and impact overall spending).
- The HPC has made **repeated recommendations** in annual Cost Trends Reports to **strengthen existing state law** to more comprehensively protect consumers and address market dynamics.
- Part of HPC's continued research has been tracking state and federal action on this topic, including implementation of the federal **No Surprises Act** – an update on which is a focus of today's presentation.

RELATED CONTENT

- 1 Policy Brief: [Out-of-Network Billing](#) (2016)
- 2 [Listening sessions](#) (2016)
- 3 [Annual Cost Trends Reports](#) (beginning in 2016)
- 4 Presentation: [Out-of-Network Billing in MA](#) (2017)
- 5 DataPoints: [Issue 14](#) (2019)
- 6 Chartpack: [Out-of-Network Billing in MA](#) (2020)
- 7 Chartpack: [Emergency Ground Ambulance Utilization and Payment Rates in MA](#) (2023)

The *No Surprises Act*, the federal law addressing out-of-network (or “surprise”) billing, was enacted in December 2020 as part of the Consolidated Appropriations Act, 2021.¹

Key Background Facts:

- **Effective Date:** The No Surprises Act went into effect on January 1, 2022.
- **Core Patient Protections:** The law takes patients “out of the middle,” holds them harmless, and prohibits balance billing for (1) out-of-network emergencies and (2) certain out-of-network care received at in-network facilities (including services provided by “ERAP”² providers).
- **Out-of-Network Provider Payment:** The law established an independent dispute resolution process (“IDRP”) (i.e., arbitration) to resolve remaining payer-provider payment disputes, which went live on April 15, 2022.
- **Scope of Coverage:** The law applies to fully- and self-insured health plans.
- **Ambulances:** Air ambulance providers, which are federally regulated, are in scope, and the law established an advisory committee to consider ground ambulances (see *slide 86 for additional information*).

¹ <https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf>

² Emergency, radiology, anesthesiology, and pathology providers

Providers have filed numerous lawsuits challenging implementation of the law, many focusing on the rules governing the IDR to determine payer-provider payment disputes.



Key Reminders about IDR: negotiation period required before “baseball” style arbitration; IDREs must consider the QPA (see below) and additional information submitted by the parties; and IDREs may not consider charges, usual and customary rates, or public payer rates.

- **Qualifying Payment Amount (“QPA”) & the IDR Rules.** The federal Departments (HHS, DOL, DOT) issued an Interim Final Rule in September 2021, a key component of which was effectively a “rebuttable presumption” in favor of whichever party’s final offer is closer to the QPA (a central factor in the law, and generally equivalent to an insurer’s median in-network rate), unless certain criteria were satisfied. Two lawsuits have materially modified that construct.
 - In a case referred to as *Texas Med. Assoc. (“TMA”) I* (February 2022), a federal district court judge [ruled](#) that the rebuttable presumption was unlawful because it conflicted with the statutory text of the law. In *TMA II* (February 2023), the same court [held](#) that additional provisions related to the QPA in the Departments’ Final Rule (August 2022) were invalidated, further deemphasizing the QPA in the independent dispute resolution entity’s (“IDRE”) determination.
- **Revised IDRE guidance.** The Departments have revised the guidance to IDREs in accordance with the court’s orders. After directing a pause for certain IDR disputes following *TMA II*, the Departments issued updated guidance and authorized processing of all disputes to resume on March 17, 2023.
- **Current status of the QPA in IDR.** The QPA is one factor IDREs must consider in making their determination. There is no emphasis on or order prescribed regarding its consideration. The import of the QPA is subject to ongoing litigation.

The Departments have released two initial reports and two status updates on the IDRP, which underscore high dispute volume, challenges with eligibility determinations, and continued progress on implementation.



Overall, the initial reports¹ and status updates reflect certain challenges and delays in the IDRP's first year.

Key Takeaways:

- **High volume of initiated disputes.** Between April 15, 2022 and March 31, 2023, disputing parties initiated 334,828 disputes – an amount nearly *fourteen times greater* than the Departments initially estimated for a full calendar year.²
- **Eligibility determinations.** Non-initiating parties challenged the eligibility of the dispute approximately 37% of the time.³ Regardless of challenges, IDREs must review and confirm eligibility, which is a complex process that has been the primary cause of processing delays and a larger burden than anticipated.
- **Ongoing implementation.** The Departments continue work to implement the IDRP (e.g., to automate the process to the extent feasible) and anticipate supplementing the initial reports with full reports, including all quarterly data required to be reported pursuant to the law.

¹ U.S. Dept. of Health and Human Services, U.S. Dept. of Labor, and U.S. Dept. of the Treasury, Initial Report on the Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022, available at <https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf>; U.S. Dept. of Health and Human Services, U.S. Dept. of Labor, and U.S. Dept. of the Treasury, Partial Report on the Independent Dispute Resolution (IDR) Process, October 1 – December 31, 2022, available at <https://www.cms.gov/files/document/partial-report-idr-process-octoberdecember-2022.pdf>.

² Federal Independent Dispute Resolution Process – Status Update (April 2023), available at <https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf>.

³ April 2023 Status Update. The first IDRP status update was published in August 2022, available at: <https://www.cms.gov/files/document/federal-idr-process-status-update-august-2022.pdf>.

Additional Takeaways from the Departments' Initial IDRP Reports and Status Updates



42,158

payment determinations rendered by IDREs as of March 31, 2023 (of 106,615 total closed disputes)¹



1,447

disputes initiated in Massachusetts between April 15, 2022 and December 31, 2022 (includes 60 air ambulance disputes)²



71%

of payment determinations rendered were decided in favor of the initiating party.³ According to the initial reports, the “vast majority” of disputes were initiated by providers or facilities.⁴

¹ Federal Independent Dispute Resolution Process – Status Update (April 2023), available at <https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf>. Disputes can be closed for other reasons, such as the parties withdrew the dispute or reached an outside settlement, or the dispute was closed because of unpaid fees. Id.

² U.S. Dept. of Health and Human Services, U.S. Dept. of Labor, and U.S. Dept. of the Treasury, Initial Report on the Independent Dispute Resolution (IDR) Process, April 15 – September 30, 2022, available at <https://www.cms.gov/files/document/initial-report-idr-april-15-september-30-2022.pdf>; U.S. Dept. of Health and Human Services, U.S. Dept. of Labor, and U.S. Dept. of the Treasury, Partial Report on the Independent Dispute Resolution (IDR) Process, October 1 – December 31, 2022, available at <https://www.cms.gov/files/document/partial-report-idr-process-octoberdecember-2022.pdf>.

³ See note 1.

⁴ The initial reports say that most disputes initiated in the respective quarters were for “emergency or non-emergency items or services”, and the “vast majority” of those disputes were submitted by providers and facilities. The term “emergency or non-emergency items or services” in the initial reports excludes air ambulance services.

RWJF/UI Brief on No Surprises Act Consumer Protections

In April 2023, the Robert Wood Johnson Foundation (“RWJF”) and the Urban Institute (“UI”) released a brief on perspectives on the status of consumer protection under the No Surprises Act. The study was based on more than 30 interviews with a variety of regulators and stakeholders.



PATIENTS ARE GENERALLY BEING PROTECTED

Over a year after the No Surprises Act went into effect, interview participants largely agreed that consumers are being well protected from surprise billing under the law.



TOO EARLY TO DETERMINE LONG TERM IMPACT

Researchers recognized that it is too early to evaluate long-term impacts, including, e.g., impact on premiums, effect on provider networks, and impact on provider prices. Understanding the impact of the No Surprises Act will require multiple years of experience and data.



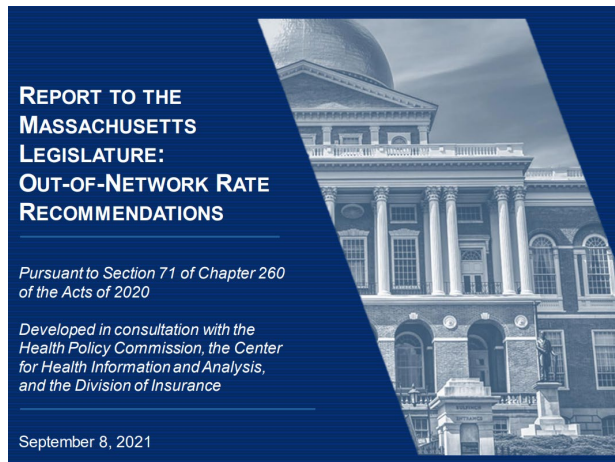
ADDITIONAL CONSIDERATIONS

Interview participants expressed concerns about coverage gaps in the law from ground ambulance services. Additionally, some expressed that it is difficult to gauge consumer awareness about the law.

- As in other states, the No Surprises Act is in effect and protects patients in **both fully- and self-insured health plans**
- Additional disclosure and transparency requirements were enacted in state law pursuant to **Chapter 260 of the Acts of 2020** (*An Act Promoting a Resilient Health Care System that Puts Patients First*)
- Massachusetts does not have its own law establishing out-of-network provider payment determination, and therefore, the **federal IDR is utilized** for payment disputes under the No Surprises Act
 - In **informal feedback**, local payers raised concerns about the IDR (e.g., the process is confusing, the negotiation period is not working as intended, and there are questions around consideration of the QPA)
- However, with respect to out-of-network payment determination, Section 71 of Chapter 260 of the Acts of 2020 directed the MA Executive Office of Health and Human Services (“EOHHS”), in consultation with the HPC, the Center for Health Information and Analysis, and the Division of Insurance, to develop a report and **make recommendations** on establishing a noncontracted, **out-of-network commercial payment rate for both emergency- and non-emergency services** – *see the next slide for additional information*

Report to the MA Legislature: Out-of-Network Rate Recommendations (2021)

- The report considered other **state approaches** and reviewed **key research** evaluating state laws, included new **data analyses** and **stakeholder feedback**, and considered the **advisability of various actions the Commonwealth can take** regarding determination of an out-of-network default rate (i.e., establish rates (set rate or a process), or take no action and let No Surprises Act govern)
- Alongside implementation of the No Surprises Act, the report recommended legislation to **establish an out-of-network default reimbursement rate** for the fully-insured market (with **consideration of** an opt-in for the self-insured market), set at the **median in-network rate**, to be evaluated after a reasonable period:



“Establishing a default reimbursement rate for unintentional out-of-network care will immediately address the longstanding, well-documented concerns of out-of-network billing costs in Massachusetts that impact patients and affect market dynamics. Capping maximum out-of-network reimbursement amounts, among the backdrop of the No Surprises Act, will buttress existing state laws on out-of-network billing, result in overall savings for the Commonwealth’s health care system, and provide cost relief to patients and health insurance purchasers at large.” (page 62)

In the 2022 Cost Trends Report, the HPC called on the legislature to enact the default rate recommended in the EOHHS report (see Recommendation 2.D).

- **Advisory Committee on Ground Ambulance and Patient Billing (“GAPB”):** While air ambulances are in scope providers under the No Surprises Act, the law directed the Secretaries of HHS, Labor, and the Treasury (the “Departments”) to establish and convene an advisory committee with respect to ground ambulances
 - Within 180 days of its first meeting (held on May 2 & 3, 2023), the 17-member GAPB committee must submit a report with recommendations on: (1) the disclosure of charges and fees for ground ambulance services and insurance coverage; (2) the consumer protection and enforcement authorities of the Departments and state authorities; and (3) and the prevention of balance billing of consumers, including legislative options for Congress to prevent balance billing¹

- **State efforts:** Several states have addressed or are working to address ground ambulance out-of-network billing²
 - Example: the Washington Office of the Insurance Commissioner was directed to lead a review of ground ambulance balance billing issues, including whether to recommend that they be subject to WA’s state balance billing law.^{3,4}
 - Additional state efforts (e.g., Vermont, Maine) are identified in the HPC’s March 2023 chartpack entitled [“Emergency Ground Ambulance Utilization and Payment Rates in Massachusetts”](#) (see slides 33-36), in which the HPC evaluated payment rates for emergency ground ambulance use among commercially-insured patients in the Commonwealth

¹ The Secretary of Health and Human Services, Charter of the Advisory Committee on Ground Ambulance and Patient Billing, available at <https://www.cms.gov/files/document/gapb-charter-signed-11-16-21.pdf>; CMS.gov, Advisory Committee on Ground Ambulance and Patient Billing (GAPB), <https://www.cms.gov/regulations-guidance/advisory-committees/advisory-committee-ground-ambulance-and-patient-billing-gapb> (last visited May 30, 2023). ² See, generally, The Commonwealth Fund, Protecting Consumers from Surprise Ambulance Bills (Nov. 15, 2021), <https://www.commonwealthfund.org/blog/2021/protecting-consumers-surprise-ambulance-bills>; The Commonwealth Fund, Map: No Surprises Act Enforcement (map on ground ambulance protections), <https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act>. ³ RCW 48.49.190 Reports to legislature, <https://app.leg.wa.gov/RCW/default.aspx?cite=48.49.190&pdf=true>. ⁴ Information about the advisory group is available at: <https://www.insurance.wa.gov/ground-ambulance-services-and-surprise-billing>.

Agenda



Call to Order

Approval of Minutes (**VOTE**)

Findings from the 2023 Health Care Cost Trends Report

Reducing Unnecessary Administrative Complexity: Policy Options

Implementation of the Federal No Surprises Act

Executive Director's Report

MATERIAL CHANGE NOTICES

- Equity in Everything Spotlight
- Mid-Year Status Update on HPC's 2023 Action Plan
- HPC Fellowship Program
- Upcoming Events and Meetings

Adjourn

Since 2013, the HPC has reviewed 151 market changes.

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Formation of a contracting entity	35	23%
Clinical affiliation	33	22%
Physician group merger, acquisition, or network affiliation	29	19%
Acute hospital merger, acquisition, or network affiliation	25	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	22	15%
Change in ownership or merger of corporately affiliated entities	6	4%
Affiliation between a provider and a carrier	1	1%

Material Change Notices Currently Under Review

- A proposed clinical affiliation between **Emergency Physician Associates of Massachusetts** (EPA), **Saint Vincent Hospital** (St. Vincent), and **MetroWest Medical Center** (MetroWest). St. Vincent and MetroWest, located in Worcester and Framingham respectively, are owned by Tenet Health Care Corporation, a national for-profit healthcare system. EPA is an affiliate of TeamHealth, a national healthcare staffing and management company. Under the proposed transaction, EPA would become the exclusive provider of emergency department services for both St. Vincent and MetroWest.
- The proposed employment of the emergency medicine clinicians of **Newton Wellesley Emergency Medicine Specialists** (NWEMS) by **Mass General Brigham** (MGB). NWEMS is a private medical group specializing in emergency medicine that staffs the emergency department at MGB-owned Newton Wellesley Hospital.
- A proposed clinical affiliation between four Beth Israel Lahey Health-affiliated entities: **Beth Israel Deaconess Medical Center** (BIDMC), **Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center** (HMFP), **Mount Auburn Hospital** (Mt. Auburn), and **Cambridge Health Alliance** (CHA). The proposed clinical affiliation would expand a longstanding affiliation between BIDMC, HMFP, and CHA to include Mt. Auburn.

Agenda



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- Material Change Notices

EQUITY IN EVERYTHING SPOTLIGHT

- Mid-Year Status Update on HPC's 2023 Action Plan
- HPC Fellowship Program
- Upcoming Events and Meetings

Adjourn

Health Equity Spotlight: Using Multiple Data Sets to Better Understand Health Inequities



WHY IT'S IMPORTANT

While some data sets do have information on race/ethnicity, sexual orientation/gender identity, immigration status, and other factors that are important to consider when trying to improve health equity, most of this data originates from survey data. However, survey data does not capture health care utilization and spending in as much detail as claims data.

WHAT WE ARE DOING

HPC researchers use two CHIA data sets for research: the All-Payer Claims Database (APCD) and the Acute Hospital Case-Mix Databases (Case-mix). Case-mix contains information on race/ethnicity for patients that have an ED visit, observation stay, or inpatient stay at an acute-care facility in MA. The APCD does not contain information on race/ethnicity, but it does contain information on spending, cost-sharing, and follow-up care received after an ED visit, observation or hospital stay.

Health Equity Spotlight: Using Multiple Data Sets to Better Understand Health Inequities



HOW WE ARE DOING IT

The Research and Cost Trends team is developing a method to **understand spending, cost-sharing, and follow-up care for persons by race/ethnicity** after emergency department, observations stays, and inpatient stays by using both the case-mix data (to calculate statewide incidence) and the APCD or public fee schedules (to track spending and follow-up care).

IN ACTION

Researchers could examine **adverse birthing morbidity events by race/ethnicity** in the case-mix data. This will provide a baseline number of adverse events in the state and the type of adverse events. Researchers will then use the APCD to **calculate additional health care costs and cost-sharing due to these adverse outcomes** for the commercial population and the MassHealth fee schedule for the MassHealth population.

Agenda



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- Equity in Everything Spotlight

 **MID-YEAR STATUS UPDATE ON HPC'S 2023 ACTION PLAN**

- HPC Fellowship Program
- Upcoming Events and Meetings

Adjourn



12

public meetings



9

unique publications



~ 1,170

in-person and remote participants in the HPC's event in March, *Building a Robust Health Care Workforce*



3.6%

benchmark set for calendar year 2024



11

students in the 2023 HPC Summer Fellowship class



37

babies born through the BESIDE Investment Program

RECENTLY RELEASED



- **Spotlight:** ACO Program Strategy Summaries (May 2023)
- **DataPoints:** Persistent Cost-sharing for Contraception in Massachusetts, 2017-2020 (May 2023)
- **HPC Shorts:** Health Care Workforce Trends and Challenges in the Era of COVID-19 (March 2023)
- **Chartpack:** Health Care Workforce Trends and Challenges in the Era of COVID-19: Current Outlook and Policy Considerations for Massachusetts (March 2023)
- **Chartpack:** Emergency Ground Ambulance Utilization and Payment Rates in Massachusetts (March 2023)
- **Report to the Legislature:** Telehealth Use in the Commonwealth and Policy Recommendations (January 2023)

UPCOMING



- **Profiles:** 2023 HPC-Certified Accountable Care Organizations
- **Evaluation Report:** SHIFT-Care Challenge Investment Program
- **Profiles:** Birth Equity and Support through the Inclusion of Doula Expertise (BESIDE) Investment Program Awardee Initiatives
- **Report:** Supply, Access, and Affordability – How Health System Factors Perpetuate Disparities
- **Report:** Trends in the Pediatric Market in Massachusetts
- **Annual Report:** 2023 Health Care Cost Trends

2023 HPC Action Plan



Bolster the HPC's Cost Containment Activities



Address Health Care Workforce Challenges and Identify Solutions



Advance Health Equity



Enhance Pharmaceutical Pricing Transparency and Accountability



Reduce Unnecessary Administrative Complexity



Bolster the HPC's Cost Containment Activities

Completed

- In partnership with the Joint Committee on Health Care Financing, the HPC held the 2023 Annual Hearing on the Health Care Cost Growth Benchmark. The Hearing included discussion of the HPC's legislative priorities to improve state oversight and accountability of health system performance.
- The HPC set the Health Care Cost Growth Benchmark for calendar year 2024 at 3.6%.

Ongoing

- The HPC is collaborating with leadership within the Healey-Driscoll Administration, the Legislature, the Attorney General's Office, and the State Auditor's Office to discuss and advance a shared affordability agenda, including the need for statutory changes to evolve the state's cost containment approach.
- The HPC is developing new approaches to review referred health providers/health plans for a potential Performance Improvement Plan in order to account for COVID-19 disruptions.
- The HPC is regularly engaging with MGB to evaluate the ongoing implementation the PIP.
- The HPC is collaborating with other states on how to optimize the impact of health care cost growth targets and implement complementary strategies to reduce spending growth.

Future Priorities

- The HPC is in early stages of preparing for the five-year post-merger report on the creation of Beth Israel Lahey Health (anticipated in 2024).

Address Health Care Workforce Challenges and Identify Solutions

Completed

- The HPC issued a new report and recommendations: *Health Care Workforce Trends and Challenges in the Era of COVID-19: Current Outlook and Policy Considerations for Massachusetts*. The report included a special focus on registered nurses, direct care workers, and behavioral health providers.
- The HPC hosted a half-day special event to convene key policymakers, system leaders, and workforce stakeholders to discuss workforce challenges and recommended solutions.
- The HPC dedicated a meeting of the HPC Advisory Council to discuss potential next steps and priorities for the HPC's workforce agenda.

Ongoing

- The HPC is partnering with CHIA on enhanced data collection and analysis, especially utilizing their new, upcoming Massachusetts Healthcare Workforce Survey to examine staffing, turnover, and workforce diversity.
- Through its care delivery transformation agenda, the HPC continues to promote innovative care models that leverage non-traditional and complementary health care workers (e.g., doulas, recovery coaches, community health workers).
- The HPC is collaborating with the Healey-Driscoll Administration to identify and advance other workforce goals.

Future Priorities

- The HPC is beginning work on a second research report, focusing on workforce trends and dynamics in the primary care sector. This research will also examine trends in supply and demand, changing workforce roles, and role of new market entrants (e.g., private equity, virtual primary care).



Advance Health Equity

Completed

- The HPC issued new, updated standards for the ACO Certification Program that include a strengthened focus on health equity capabilities across three domains: Data-Driven Interventions, Patient Engagement, and Strategy.
- The HPC issued a new research report on Telehealth Use in the Commonwealth, including policy recommendations to improve access to care and advance health equity.
- The HPC supported the Health Equity Compact with the development of the first Health Equity Trends Summit, to be held on June 13, 2023. Executive Director Seltz is participating on a discussion panel with other state leaders.

Ongoing

- The HPC is preparing to issue a new, updated edition of a public resource titled *Applying a Health Equity Lens in Principle and Practice: STYLE GUIDE, PRACTICES, AND RESOURCES FOR BRINGING AN EQUITY FOCUS*.
- The HPC is preparing a research report: *Supply, Access, and Affordability: How Health System Factors Perpetuate Disparities*.
- The HPC, through the Quality Measurement Alignment Task Force, is supporting the adoption and implementation of recommended data standards for collection of race, ethnicity, language, disability status, sexual orientation, gender identity, and sex.
- The HPC is preparing a health system performance dashboard, including metrics focused on health disparities, for release with the 2023 Annual Cost Trends Report.
- The HPC is collaborating with the Healey-Driscoll Administration to identify and advance other health equity goals.

Future Priorities

- The HPC will identify new potential HPC investment opportunities to reduce identified disparities or otherwise advance equity.

Enhance Pharmaceutical Pricing Transparency and Accountability

Completed

- The HPC released new research evaluating drug prices for the highest spending drugs and examined price variation across payers in the U.S. and internationally.
- The HPC issued a new DataPoints brief, focused on out-of-pocket costs for common contraceptive methods and services in the Commonwealth, including prescription oral contraception.

Ongoing

- The HPC continues to coordinate with MassHealth on the drug pricing review process to support their supplemental rebate negotiations.
- The HPC is collaborating with leadership within the Healey-Driscoll Administration, the Legislature, the Attorney General's Office, the State Auditor's Office, and CHIA on the need for statutory changes to evolve the state's cost containment approach to include the pharmaceutical sector (e.g., manufacturers, pharmacy benefit managers, etc.)

Future Priorities

- The HPC is continuing research on related pharmaceutical topics, such as:
 - Prescription drug prices in Massachusetts as compared to other countries
 - Spending trends and variable costs associated with pharmaceuticals that have high outpatient spending
 - Understanding out-of-pocket costs for high-cost drugs and policy options to address affordability



Reduce Unnecessary Administrative Complexity

Completed

- The HPC completed its engagement with the Network for Excellence in Health Innovation (NEHI) and the Mass Health Data Consortium (MHDC) to define policy recommendations for implementing prior authorization automation

Ongoing

- The HPC will include preliminary research on payer and provider administrative costs in this year's annual Health Care Cost Trends Report, to be released in September 2023.
- The HPC continues to participate in the Special Commission to Develop Common Medical Necessity Criteria in Behavioral Health. The Commission will issue a report this year with findings and recommendations.
- The HPC supports the work of EHS's Quality Measurement Alignment Taskforce, which is now nearing completion of its process for reviewing the Aligned Measure Set and making recommendations for 2024.

Future Priorities

- The HPC may identify additional pathways to support automation of prior authorization over the next 2.5 years, subject to commissioner direction, and is researching other potential solutions for reducing unnecessary administrative complexity in prior authorization, for discussion with commissioners at a future Board meeting.
- The HPC will identify additional priority areas of unnecessary administrative complexity for streamlining, simplification, or standardization.

Agenda



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HPC FELLOWSHIP PROGRAM

- Upcoming Events and Meetings

Adjourn

HPC Summer Fellowship Program



The HPC Fellowship Program affords students the opportunity to develop a stand-alone policy or research project within one of the HPC's five departments. Fully embedded into the HPC, fellows attend staff meetings, team outings, and manage their time to ensure they meet outlined project benchmarks and present the findings from their project to the entire agency at the end of the summer.

- 10-week program starting in June and ending in August.
- Must be enrolled in a full-time master's, PhD, law, or medical program.
- Paid \$30/hour for a total of up to \$11,250.



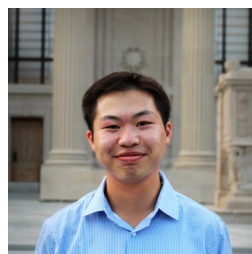
2023 HPC Summer Fellows



Jennifer Wang
Chief of Staff
Boston College School
of Law



Grace Chamberlin
HCTI
University of North
Carolina at Chapel Hill



Eric Linh
HCTI
Yale University



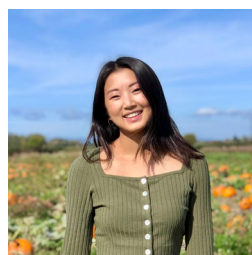
Indie Rao
HCTI
Harvard University



Sarah Sommer
HCTI
Harvard University



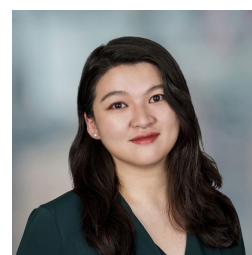
Dolma Tsering
HCTI
Yale University



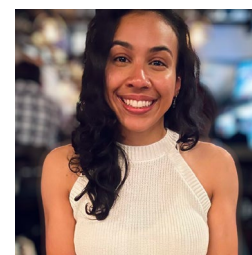
Emily Zhu
HCTI
Harvard University



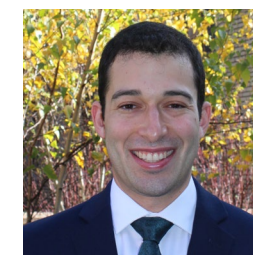
Olivia Ozkurt
Legal
Suffolk University Law
School



Yiqiu Zhou
MOAT
University of Connecticut
School of Law



Summer Rak
RCT
Harvard University



Daniel Stern
RCT
Yale University

Agenda



Call to Order

Approval of Minutes (**VOTE**)

Findings from the 2023 Health Care Cost Trends Report

Reducing Unnecessary Administrative Complexity: Policy Options

Implementation of the Federal No Surprises Act

Executive Director's Report

- Material Change Notices
- Equity in Everything Spotlight
- Mid-Year Status Update On HPC's 2023 Action Plan
- HPC Fellowship Program

 **UPCOMING EVENTS AND MEETINGS**

Adjourn



- A convening by the Health Equity Compact of Massachusetts leaders for a public discussion on actions to accelerate and achieve breakthrough health equity reform across the Commonwealth.
- **LOCATION:** UMass Boston Campus Center Ballroom, 100 William T Morrissey Blvd, Boston, MA 02125 (Virtual attendance available)
- **DATE/TIME:** Tuesday, June 13, 2023
8:00 AM – 3:30 PM
- **Register here:**
<https://healthequitycompact.org/health-equity-trends-summit-registration/#register>

SUMMIT AGENDA

8:00 am – 8:30 am	Registration & Breakfast
8:30 am – 9:15 am	Welcome & Opening Remarks
9:15 am – 10:45 am	Roadblocks and Resolutions: Healthcare Leaders' Commitment to Health Equity
10:45 am – 11:30 am	Data Presentation: The Economic Case for Massachusetts Health Equity Reform
11:30 am – 12:00 pm	Break & Lunch
12:00 pm – 1:00 pm	Harnessing The Power of Business Leaders to Advance Health Equity
1:00 pm – 2:00 pm	Driving Change at Scale: Health Equity in State Government
2:00 pm – 2:15 pm	Break
2:15 pm – 2:25 pm	Health and Human Services Secretary Walsh Remarks
2:25 pm – 3:20 pm	Mobilizing a Big, Bold, and Sustained Health Equity Movement
3:20 pm – 3:30 pm	Closing Remarks from Representative Judith Garcia

July 12, 2023 Board Meeting



- Call to Order
- Approval of Minutes (**VOTE**)
- 2023 Health Care Cost Trends Report
 - Policy Recommendations
 - Dashboard
- Trends in the Pediatric Market in Massachusetts
- Executive Director's Report
 - FY 2024 HPC Operating Budget (**VOTE**)
 - Status Update: Mass General Brigham Performance Improvement Plan
- Executive Session (**VOTE**)

2023

ANNUAL HEALTH CARE COST TRENDS HEARING



When:

Wednesday, November 8, 2023



Livestream:

tinyurl.com/hpc-video



Where:

Suffolk University Law School
120 Tremont Street, Boston



MASSACHUSETTS
HEALTH POLICY COMMISSION

Schedule of Upcoming Meetings



BOARD

July 12
September 13
December 13



Mass.gov/HPC



COMMITTEE

October 4



HPC-info@mass.gov



ADVISORY COUNCIL

September 20
December 6



[@Mass_HPC](https://twitter.com/Mass_HPC)



SPECIAL EVENTS

November 8
Cost Trends Hearing



tinyurl.com/hpc-linkedin

2023 Public Meeting Calendar



- JANUARY -

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- FEBRUARY -

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- MARCH -

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- APRIL -

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- MAY -

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- JUNE -

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- JULY -

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- AUGUST -

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- SEPTEMBER -

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- OCTOBER -

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- NOVEMBER -

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- DECEMBER -

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BOARD MEETINGS

- Wednesday, January 25
- Wednesday, April 12
- Wednesday, June 7
- Wednesday, July 12
- Wednesday, September 13
- Wednesday, December 13

COMMITTEE MEETINGS

- Tuesday, January 24 (ANF, 2:00 PM)
- Wednesday, February 15
- Wednesday, May 10
- Monday, July 10 (ANF, 2:00 PM)
- Wednesday, October 4

ADVISORY COUNCIL

- Wednesday, February 8
- Wednesday, May 24
- Wednesday, September 20
- Wednesday, December 6

SPECIAL EVENTS

- Thursday, March 2 - OPP Regulation Hearing
- Wednesday, March 15 - Benchmark Hearing
- Wednesday, March 29 - Health Care Workforce Event
- Wednesday, November 8 - Cost Trends Hearing

Agenda



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Approval of Minutes (**VOTE**)

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Executive Director's Report



ADJOURN