



Advisory Council Meeting

February 29, 2024



Agenda



CALL TO ORDER

Understanding Access Challenges Across the Health Care System

Developing a New Affordability Index

Adjourn

Advisory Council Membership



Dr. Christopher Andreoli, President of Atrius Health
Lisette Blondet, Executive Director, Massachusetts Association of Community Health Workers
Aimee Brewer, President and CEO, Sturdy Memorial Hospital
Michael Caljouw, Vice President of Government & Regulatory Affairs, Blue Cross Blue Shield of Massachusetts
Dr. Jeanette Callahan, Pediatrician, Cambridge Health Alliance; Medical Director-DYS Northeast Region Health Services, Justice Resource Institute
Christopher Carlozzi, State Director, National Federation of Independent Business (NFIB)
JD Chesloff, Executive Director, Massachusetts Business Roundtable
Dr. Cheryl Clark, Associate Chief, Division of General Internal Medicine and Primary Care, Brigham and Women's Hospital
Ed Coppinger, Head of Government Affairs, MassBio
Michael Curry, President and CEO, Massachusetts League of Community Health Centers
Dr. Ronald Dunlap, Cardiologist and Past President, Massachusetts Medical Society
Audrey Gasteier, Executive Director, Massachusetts Health Connector
Tara Gregorio, President and CEO, Mass Senior Care Association
Eric Gulko, President, Innovo Benefits; Legislative Chair and Vice President, National Association of Brokers and Insurance Professionals
Susan J. Hernandez, CNM, MSN, FACNM, Mass General Brigham, MA ACNM Legislative Co-Chair

Jon Hurst, President, Retailers Association of Massachusetts
Colin Killick, Executive Director, Disability Policy Consortium
Jake Krilovich, Executive Director, Home Care Alliance of Massachusetts
Juan Fernando Lopera, Chief Diversity, Equity, and Inclusion Officer, Beth Israel Lahey Health
David Matteodo, Executive Director, Massachusetts Association of Behavioral Health Systems
Dr. Danna Mauch, President and CEO, Massachusetts Association for Mental Health
Patricia McMullin, Executive Director, Conference of Boston Teaching Hospitals
Nicole Obi, President and CEO, Black Economic Council of Massachusetts
Carlene Pavlos, Executive Director, Massachusetts Public Health Association
Krina Patel, Head of U.S. State & Local Government Affairs, Biogen
Lora Pellegrini, President and CEO, Massachusetts Association of Health Plans
Julie Pinkham, Executive Director, Massachusetts Nurses Association
Dr. Myisha Rodrigues, Executive Director, NAMI Massachusetts
Amy Rosenthal, Executive Director, Health Care For All
Christine Schuster, President and CEO, Emerson Hospital
Matthew Veno, Executive Director, Group Insurance Commission
Steven Walsh, President and CEO, Massachusetts Health and Hospital Association and previously Massachusetts Council of Community Hospitals
Elizabeth Wills-O'Gilvie, Chair, Springfield Food Policy Council

2024 Advisory Council Meetings



Thursday, February 29



Thursday, June 27



Thursday, September 26



Thursday, December 5

2024 Hearing on the Health Care Cost Growth Benchmark



Thursday, March 14 at 12:00 PM
Gardner Auditorium
Massachusetts State House

Chapter 224 prescribes the formula that the HPC must use to establish the benchmark each year. Since 2018, the HPC has had authority to modify the benchmark if an adjustment is “reasonably warranted.”

For the years 2023 through 2032, the health care cost growth benchmark will be set equal to potential gross state product (PGSP), or 3.6%, unless the HPC determines that an adjustment to the benchmark is reasonably warranted. In that case, the HPC Board may choose to modify the benchmark to any amount.

Please email Ashley Caunter, HPC Government Affairs Manager, to sign up for public testimony: ashley.caunter@mass.gov



Agenda



Call to Order



UNDERSTANDING ACCESS CHALLENGES ACROSS THE HEALTH CARE SYSTEM

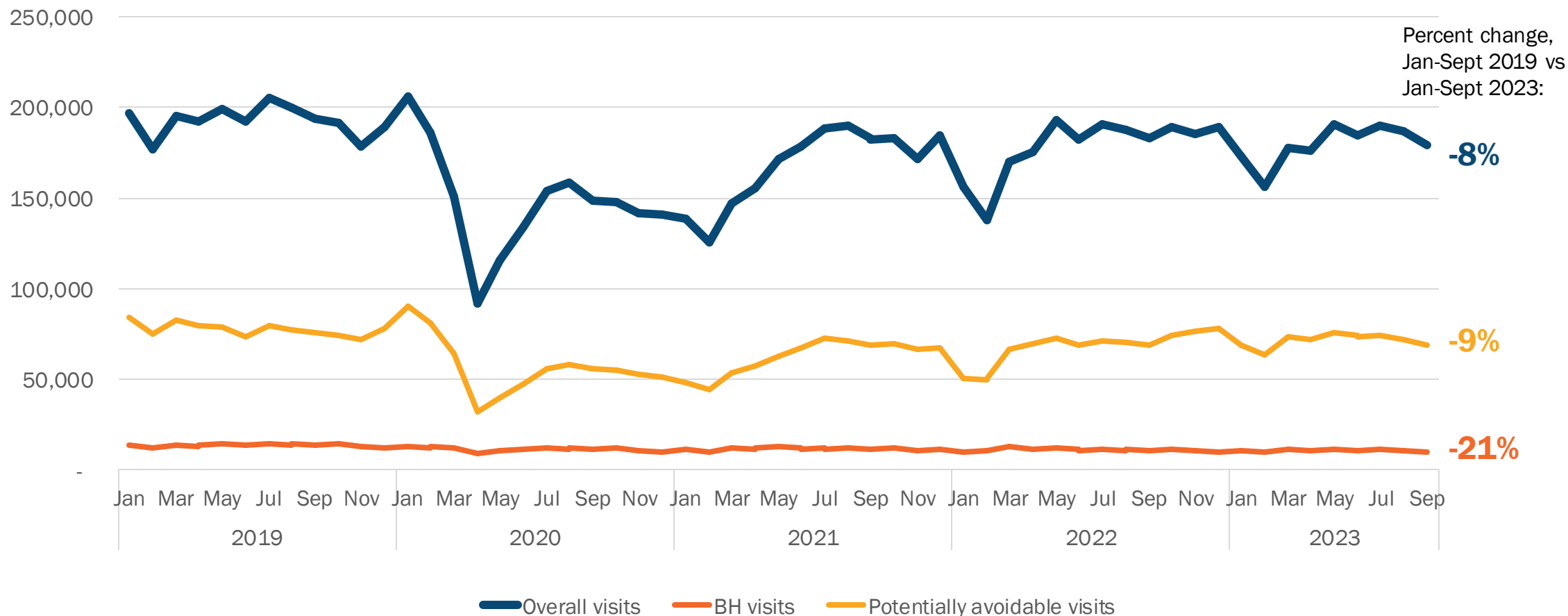
Developing a New Affordability Index

Adjourn

Total ED visits remain below pre-pandemic levels. The proportion of visits that were potentially avoidable has remained consistent at roughly 40%.



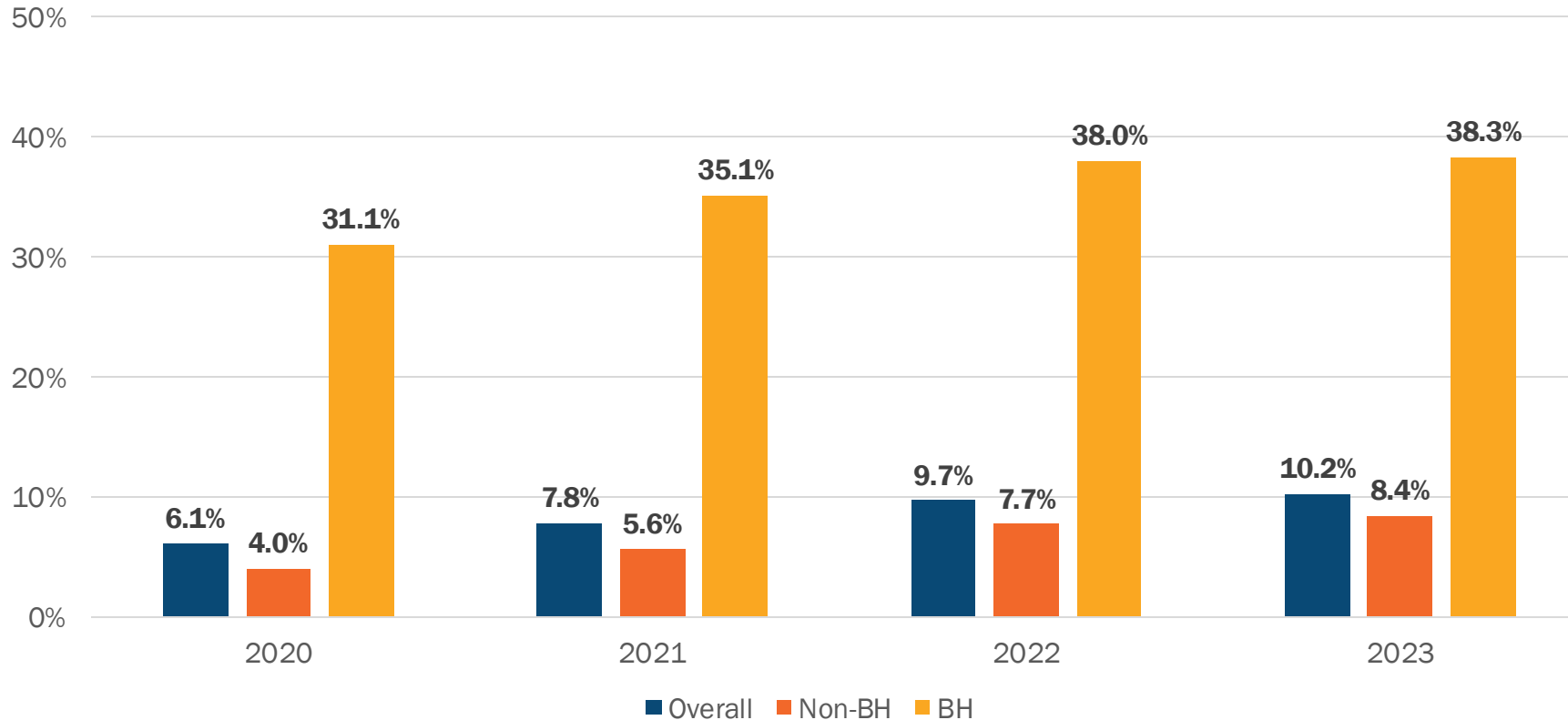
All ED visits, potentially avoidable ED visits, and behavioral health (BH) ED visits, January 2019 to September 2023



Notes: Includes out-of-state residents. Avoidable ED visits are based on the Billings algorithm, which classifies an ED visit into the following categories: Emergent - ED care needed and not avoidable; Emergent - ED care needed but avoidable; Emergent - primary care treatable; and Non-emergent - primary care treatable. "Avoidable" is defined here as ED visits that were emergent - primary care treatable or non-emergent - primary care treatable. Behavioral health ED visits were identified based on a principal diagnosis related to mental health and/or substance use disorder using the Clinical Classifications Revised Software (CCSR) diagnostic classifications. To improve classification rate, diagnosis codes unclassified by the Billings algorithm were truncated and shortened codes were re-classified. Please see the technical appendix for additional details. Two hospitals were excluded for the entire study period due to missing data for one or more quarters.
Sources: HPC analysis of Center for Health Information and Analysis Emergency Department Database, FY2019 to FY2023, preliminary FY2023.

Between 2020 and 2023, the percentage of ED visits that boarded (stayed longer than 12 hours) increased from 6.1% to 10.2%.

Percent of ED visits that boarded (≥ 12 hours in ED) by type and fiscal year, 2020 to 2023



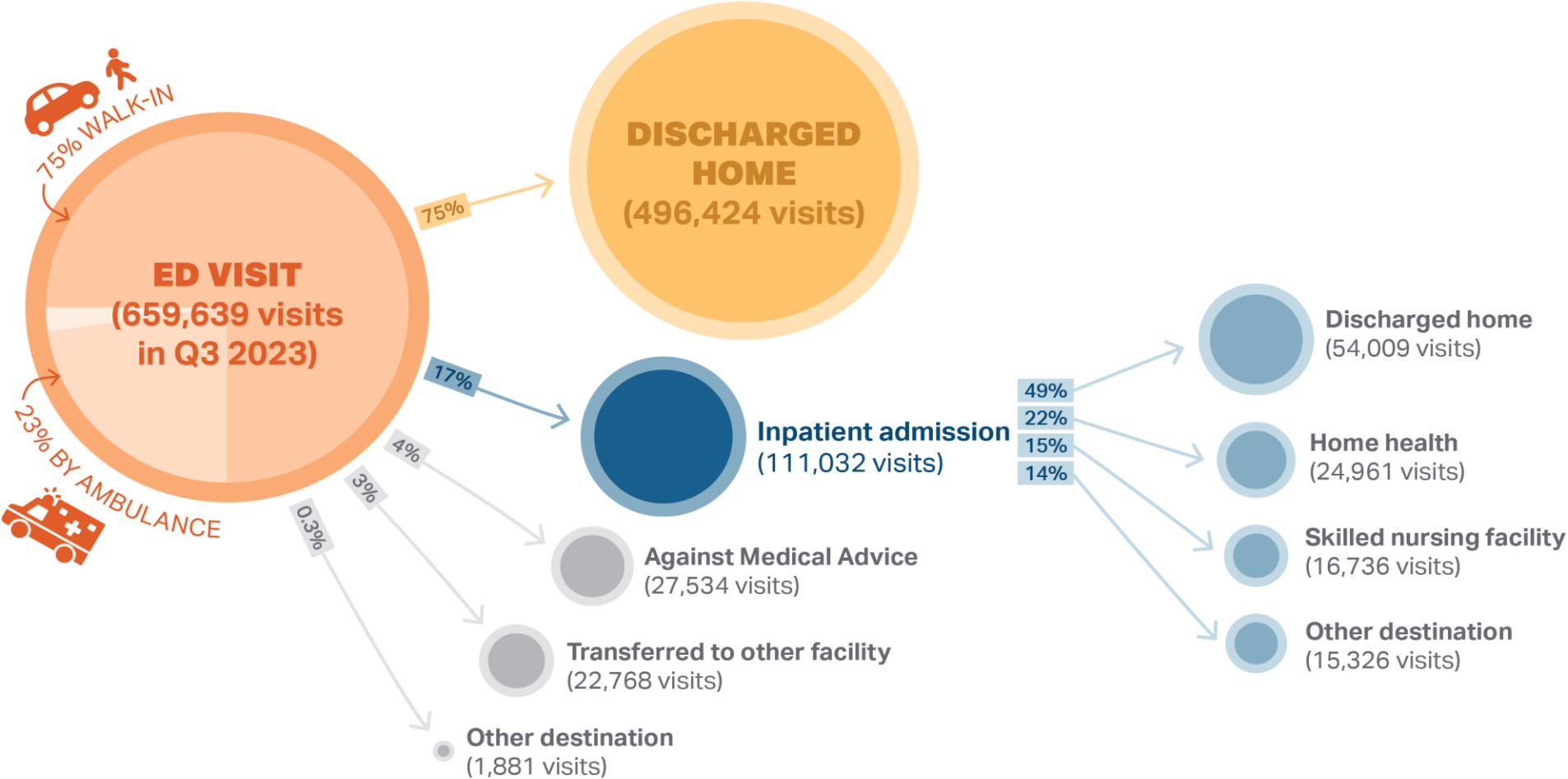
Notes: Emergency department visits identified using both emergency department and inpatient data. The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Does not include visits that resulted in an observation stay. Visits at specialty hospitals and “hospital at home” programs are excluded, as well as visits at two hospitals with incomplete data during the study period. One additional hospital was excluded due to irregular length of stay data. Due to incomplete ED length of stay information in inpatient data, visits at the following hospitals were assumed to have boarded if they lasted more than one calendar day: UMass Memorial Medical Center – University Campus and Memorial Campuses, HealthAlliance Clinton Hospital, HealthAlliance Leominster Hospital, and Marlborough Hospital.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix Emergency Department Database (EDD) and Hospital Inpatient Discharge Database (HIDD), FY2020 to FY2023.

- These ED boarding numbers include patients who boarded in the ED prior to being admitted to the same acute care hospital.
- CHIA’s EDD dashboard finds average ED for “treat and release” wait time increased from 4.2 hours in Oct-Dec 2018 to 5.5 hours in Apr-June 2023.

Most ED patients are walk-ins; 1 in 6 are ultimately admitted to an inpatient bed while 75% are discharged home.

Origin and destinations of ED visits, July to September 2023

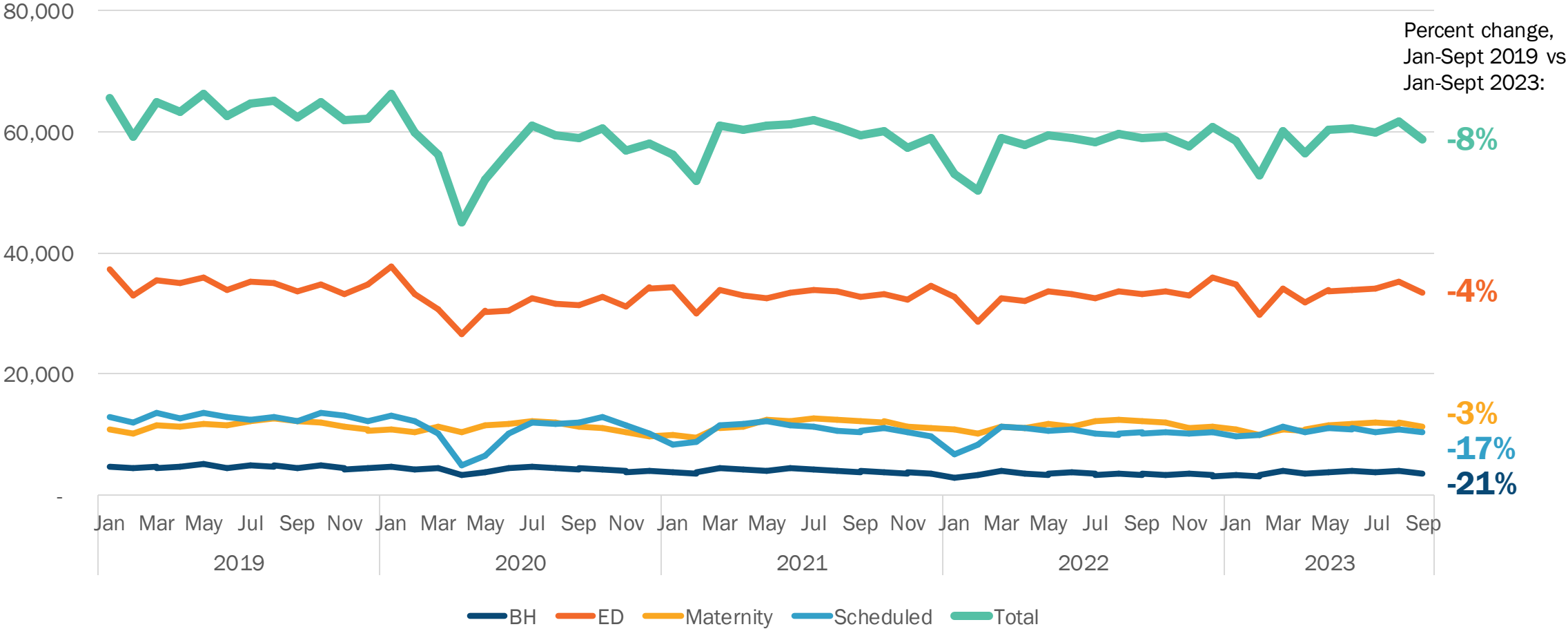


Notes: Ambulance transport category includes ambulance and helicopter; non-ambulance and non-walk-in transport category includes law enforcement and “other”; Against Medical Advice destination category includes against medical advice and eloped. Emergency department visits identified using both emergency department and inpatient data. Transport information only available for ED visits identified in emergency department data (i.e., not admitted to inpatient). Does not include visits that resulted in an observation stay. Visits at specialty hospitals and “hospital at home” programs are excluded, as well as visits at two hospitals with incomplete data during the study period.
 Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix Emergency Department Database (EDD) and Hospital Inpatient Discharge Database (HIDD), FY2023.

Total hospital admissions have declined across all categories since before the pandemic.



Number of acute care hospital inpatient discharges by admission type, January 2019 to September 2023



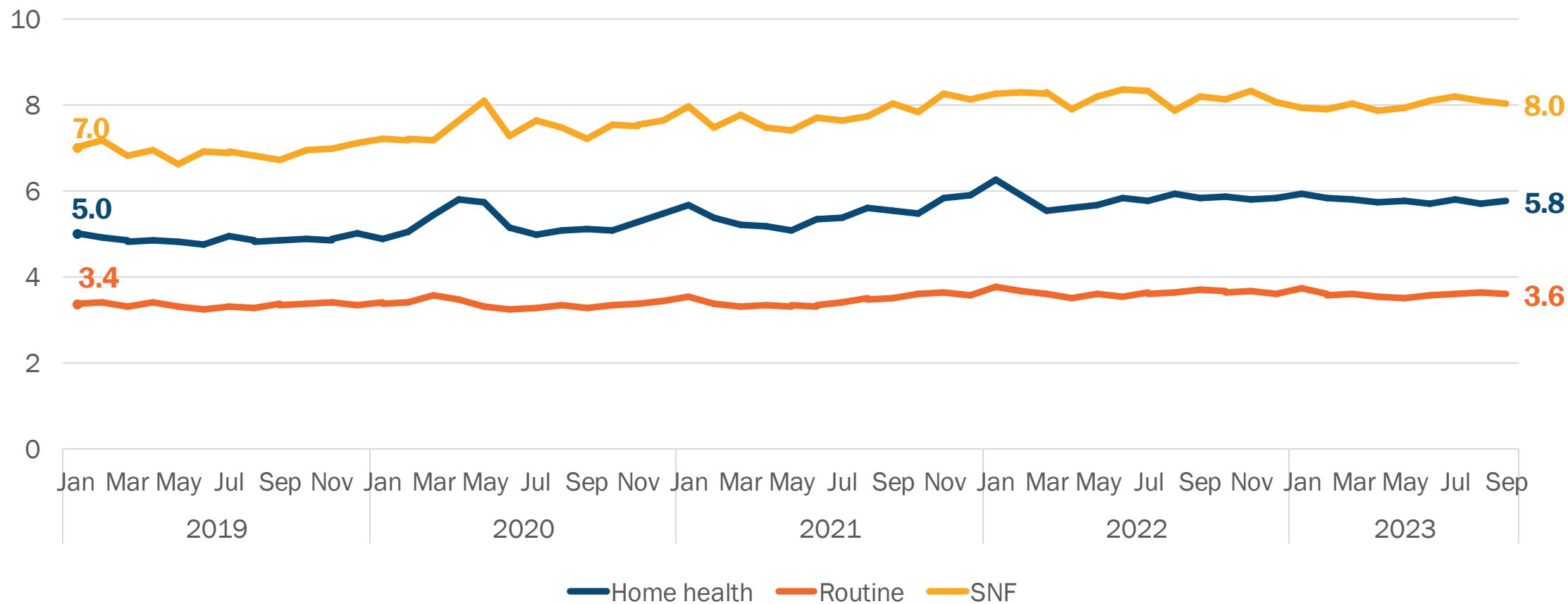
Notes: Includes out-of-state residents. Discharges were excluded if they were transfers, had a length of stay greater than 180 days, or rehabilitation. Two hospitals were excluded for the entire study period due to missing data for one or more quarters.

Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, FY2019 to FY2023, preliminary FY2023

Average length of stay has increased by a roughly half a day since 2019, but the increase has been almost entirely among stays discharged to SNFs and home health care.



Average length of stay (days) for scheduled admissions and admissions from the ED (combined) by discharge disposition, January 2019 to September 2023



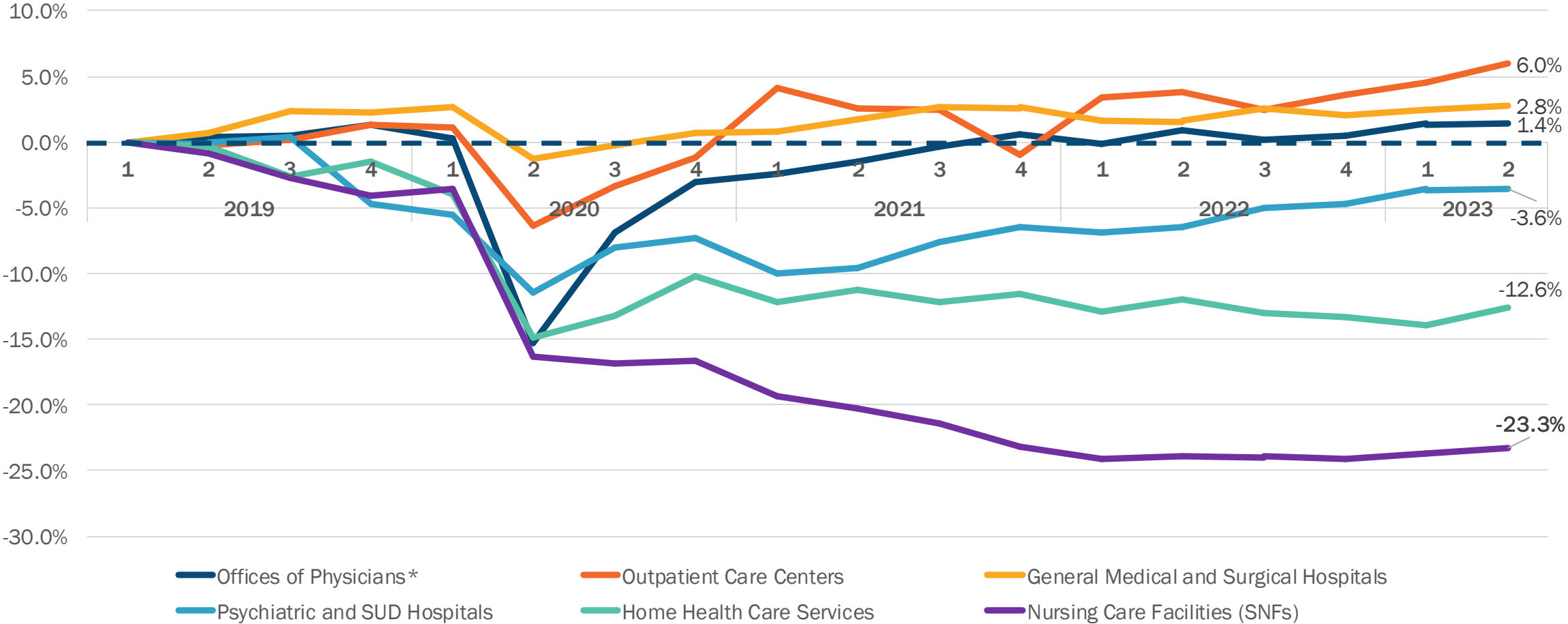
Notes: Based on patient discharge date and includes only admissions from the emergency department and scheduled admissions. COVID-related discharges are excluded. Excludes pediatric, maternity, BH, and rehabilitation admissions and admissions with length of stay greater than 180 days. Two hospitals were excluded for the entire study period due to missing data for one or more quarters.

Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, FY2019 to FY2023, preliminary FY2023

Total employment in nursing care facilities and home health care is significantly below pre-pandemic levels, while outpatient and acute care hospital employment has increased.



Average monthly employment in selected health care settings relative to Q1 2019: 2019 - 2023



Notes: Offices of physicians does not include offices of mental health specialists. All percent changes in employment are relative to Q1 of 2019. Sources: Quarterly Census of Employment and Wages Single Use Files, Bureau of Labor Statistics, 2019 - 2023

Nearly 50% of all Massachusetts adults report delaying or skipping necessary care due to cost; affordability burdens are even higher for BIPOC populations.



Percent of Massachusetts adults who reported the following outcomes based on survey of 1,158 Massachusetts adults, May 2021

46% of Massachusetts adults delayed or skipped care due to cost, including:



Skipped needed dental care (27%)



Delayed going to the doctor or having a procedure done (25%)



Cut pills in half, skipped doses of medicine, or did not fill a prescription (22%)

Almost 10% of adults reported that due to the cost of medical bills, they:



Were unable to pay for basic necessities like food, heat, or housing



Used up all or most of their savings



Were contacted by a collection agency



3 in 4 Massachusetts residents are worried about affording health care in the future.

6 Reduce Administrative Complexity. The Legislature should require standardization in payer claims administration and processing, build upon the momentum from recent federal initiatives, and require automation of prior authorization processes, and mandate the adoption of a standardized measure set to reduce reporting burdens and ensure consistency.

- **Require Greater Standardization in Payer Processes**
- **Automate Prior Authorization**
- **Mandate Adoption of the Aligned Quality Measure Set**

7 Strengthen Tools to Monitor the Provider Market and Align the Supply and Distribution of Services With Community Need.

The HPC recommends enhanced regulatory measures including focused, data-driven assessments of service supply and distribution based on identified needs and updates to the state's existing regulatory tools such as the Essential Services Closures process, the Determination of Need (DoN) program, and the HPC's material change notice (MCN) oversight authority.

- **Conduct Focused Assessments of Need, Supply, and Distribution**
- **Strengthen Tools to Monitor and Regulate Supply of Health Care Services**
- **Enhance the HPC's Market Oversight Authority of For-Profit Investment**

8 Support and Invest in the Commonwealth's Health Care Workforce. The state and health care organizations should build on recent state investments to stabilize and strengthen the health care workforce. The Commonwealth should offer initial financial assistance to ease the costs of education and training, minimize entry barriers, explore policy adjustments for improved wages in underserved sectors, and should adopt the [Nurse Licensure Compact](#) to simplify hiring from other states. Health care delivery organizations should invest in their workforces, improve working conditions, provide opportunities for advancement, improve compensation for non-clinical staff (e.g., community health workers, community navigators, and peer recovery coaches) and take collaborative steps to enhance workforce diversity.

- **Public Investments and Policy Change**
- **Health Care Delivery Organizations Should Invest in their Workforces**
- **Ensure Adequate Compensation for Non-Clinical Workforces**
- **Support Workforce Diversity**

9 Strengthen Primary and Behavioral Health Care. Payers and providers should increase investment in primary care and behavioral health while adhering to cost growth benchmarks. Addressing the need for behavioral health services involves measures such as enhancing access to appropriate care, expanding inpatient beds, investing in community-based alternatives, aligning the behavioral health workforce to current needs, employing telehealth, and improving access to treatment for opioid use disorder particularly in places where existing inequities present barriers.

- **Focus Investment in Primary Care and Behavioral Health Care**
- **Increase Access to Behavioral Health Services**
- **Improve Access to Treatment for Opioid Use Disorder**

Agenda



Call to Order

Understanding Access Challenges Across the Health Care System



DEVELOPING A NEW AFFORDABILITY INDEX

Adjourn

HPC 2023 Policy Recommendations: Focus on Affordability



MODERNIZE THE COMMONWEALTH'S BENCHMARK FRAMEWORK TO PRIORITIZE HEALTH CARE AFFORDABILITY AND EQUITY FOR ALL.

Establish New Affordability Benchmark(s).

- To both **complement** and **bolster** the health care cost growth benchmark, the Commonwealth should develop an accountability framework for **affordability of care** for Massachusetts residents.
- As part of a strategy that tracks improvement on indicators of affordability, including the differential impact of both health plan premiums and consumer out-of-pocket spending by income, geography, market segment, and other factors, an **affordability index** should be measured annually in a benchmark-like process.
- To enable public transparency and accountability, the state's performance on the affordability index and other measures should be **incorporated into CHIA's Annual Report and the HPC's Annual Cost Trends Hearing**. Such targets should inform the development of new health plan affordability standards at the Division of Insurance (DOI) that play a central role in DOI's review and approval of health plan rates.

HPC Next Steps to Enhance the Commonwealth's Focus on Affordability



HPC Principles toward Developing an Affordability Index

- **Include the “employer-paid” portion of the premium**
 - These dollars are directly subtracted from what would otherwise be paid out as employee wages
- **Include the deductible amount in the calculation**
 - High deductibles lead people to avoid care, whether the dollars are spent or not
 - They are particularly burdensome for people with chronic health conditions or who give birth
- **Go beyond averages**
 - Individuals may face higher-than-average premiums because they have chronic health care needs or are pooled with individuals who do
- **Consider health care cost burden in the context of income or wages**

Exploration of an Affordability Index, 2022



Index = (Premium + paid coinsurance and copayments + full deductible amount) / Total Compensation. Data from 2022.

Affordability Index Scenario	Income	Family Premium	Employer Share	Other cost-sharing	Deductible	Health Care Share of Compensation
40th percentile income, average premium, cost-sharing and deductible	\$90,669	\$23,348	\$17,472	\$1,025	\$3,680	25.9%
40th percentile income, 75th percentile premium, average cost-sharing and deductible	\$90,669	\$27,000	\$21,000	\$1,025	\$3,680	28.4%
Median income (50th percentile), average premium, cost-sharing and deductible	\$119,068	\$23,348	\$17,472	\$1,025	\$3,680	20.5%
Median income (50th percentile), 75th percentile premium, average cost-sharing and deductible	\$119,068	\$27,000	\$21,000	\$1,025	\$3,680	22.6%

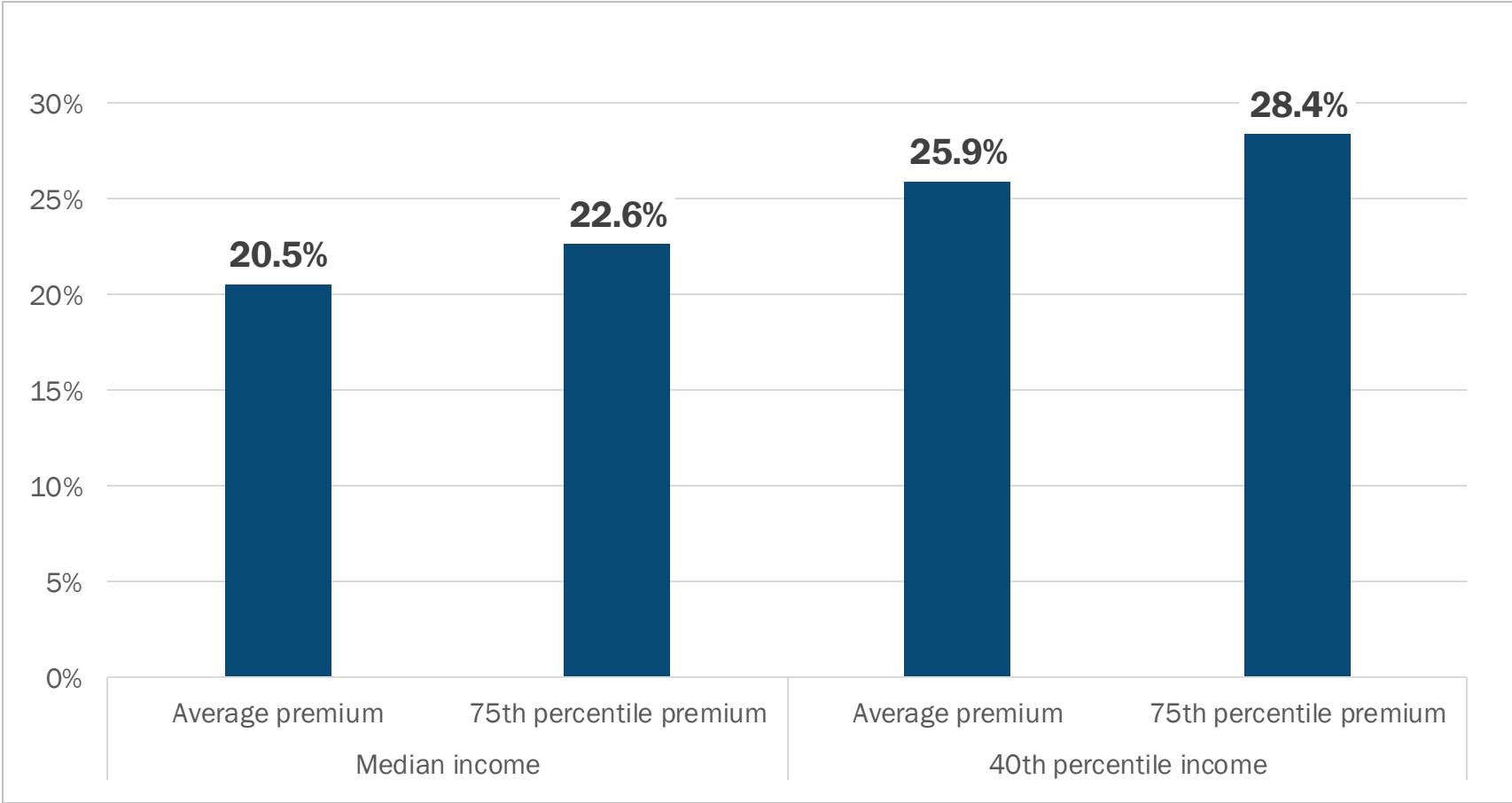
Notes: Family income distribution is based on families in Massachusetts with employer-sponsored coverage during the study period. Seniors, those in group quarters, and single persons without children were excluded. The ASEC distinguishes between households (primary family and any related sub-families) and families (primary family); this study defines “family” as the primary family only. Other cost sharing includes copays and coinsurance and presumes a family of 4. Compensation is the sum of income as reported in the survey and the employer premium contribution.

Source: CPS Annual Social and Economic Component, 2017-2022; Medical Expenditure Panel Survey (MEPS), 2017 – 2022, CHIA Annual Report, 2024.

Health care spending comprised nearly 30% of total compensation for a household with family coverage, earnings at the 40th percentile, a higher-than-average premium, and an average deductible in 2022.



Affordability index for several scenarios.



- Index currently calculated using statewide premium figures.
- Ultimately, the index could be **calculated separately for each payer** to ensure accountability.

Notes: Family income distribution is based on families in Massachusetts with employer-sponsored coverage during the study period. Seniors, those in group quarters, and single persons without children were excluded. The ASEC distinguishes between households (primary family and any related sub-families) and families (primary family); this study defines “family” as the primary family only. Other cost sharing includes copays and coinsurance and presumes a family of 4. Compensation is the sum of income as reported in the survey and the employer premium contribution.

Source: CPS Annual Social and Economic Component, 2017-2022; Medical Expenditure Panel Survey (MEPS), 2017 – 2022, CHIA Annual Report, 2024.

Discussion Questions



- What principles should guide the development of a health care affordability index?
- What specific measures of individual/family health care spending should be included in the affordability index? How can such measures be incorporated? For example, how should cost-sharing be accounted for?
- How would you recommend the Commonwealth approach setting measurable goals for improving affordability?
- Looking forward, what are important considerations for developing an accountability framework for affordability of care?

HPC Next Steps to Enhance the Commonwealth's Focus on Affordability



Current HPC Activities to Develop an Affordability Index

- Continued collaboration with CHIA to identify measures of affordability and develop an affordability index
- Solicit input on affordability index from a range of interested stakeholders, including those most acutely impacted by affordability challenges
- Consider the differential impact of affordability challenges based on different demographic subgroups (e.g. income, age, race/ethnicity, activity limitations, geography, etc.) and track progress in reducing disparities
- Include annual reporting on affordability measures the CHIA and HPC annual reports on the cost growth benchmark
- Incorporate focus on affordability in annual Cost Trends Hearings

HPC Next Steps to Enhance the Commonwealth's Focus on Affordability



Opportunities for Legislative Action

- Update the state's health care benchmark framework to incorporate affordability in the annual measurement and oversight activities of HPC and CHIA, including data collection, reporting and an annual review of an affordability measures in relation to a newly established index
- Establish an accountability framework for health care entities, including health plans, hospitals, and provider organizations, that promotes affordability, such as:
 - assessing performance against goals in the existing or complementary performance improvement plan (PIP) process;
 - requiring the division of insurance (DOI) to establish affordability standards and examine premiums and cost sharing in the rate review process;
 - incorporating affordability goals in department of public health (DPH) licensure or determination of need (DoN) processes; or
 - a newly established process.

Agenda



Call to Order

Understanding Access Challenges Across the Health Care System

Developing a New Affordability Index



ADJOURN

2024 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

- Thursday, January 25
- Thursday, April 11
- Thursday, June 13
- Thursday, July 18
- Thursday, September 19
- Thursday, December 12

COMMITTEE MEETINGS

- Thursday, February 15
- Thursday, May 9
- Monday, July 15 (ANF)
- Thursday, October 10

ADVISORY COUNCIL

- Thursday, February 29
- Thursday, June 27
- Thursday, September 26
- Thursday, December 5

SPECIAL EVENTS

- Thursday, March 14 – Benchmark Hearing
- Thursday, November 14 – Cost Trends Hearing

Schedule of Upcoming Meetings



BOARD

- April 11
- June 13
- July 18
- September 19
- December 12



Mass.gov/HPC

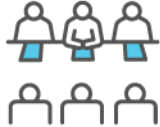


COMMITTEE

- May 9
- July 15 (ANF)
- October 10



HPC-info@mass.gov



ADVISORY COUNCIL

- June 27
- September 26
- December 5



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SPECIAL EVENTS

- March 14
Benchmark Hearing
- November 14
Cost Trends Hearing



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