MASSACHUSETTS
HEALTH POLICY COMMISSION

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

Executive Session **(VOTE)**

Guest Presentation from the Office of the Attorney General: Findings from the AGO Cost Trends Report – Assistant Attorney General Lisa Gaulin and Assistant Attorney General Chloe Cable

HPC Evaluation of Mass General Brigham's Performance Improvement Plan

Mass General Brigham's Performance Improvement Plan **(VOTE)**

Research Presentation: Behavioral Health Emergency Department Boarding in Massachusetts

Executive Director's Report

Adjourn

Agenda

HPC

Call to Order

APPROVAL OF MINUTES (VOTE)

Executive Session **(VOTE)**

Guest Presentation from the Office of the Attorney General: Findings from the AGO Cost Trends Report – Assistant Attorney General Lisa Gaulin and Assistant Attorney General Chloe Cable

HPC Evaluation of Mass General Brigham's Performance Improvement Plan

Mass General Brigham's Performance Improvement Plan **(VOTE)**

Research Presentation: Behavioral Health Emergency Department Boarding in Massachusetts

Executive Director's Report

Adjourn

VOTE

Approval of Minutes from the October 10, 2024 Board Meeting

HPC

MOTION

That the Commission hereby approves the minutes of the Commission meeting held on **October 10, 2024**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

EXECUTIVE SESSION (VOTE)

Guest Presentation from the Office of the Attorney General: Findings from the AGO Cost Trends Report – Assistant Attorney General Lisa Gaulin and Assistant Attorney General Chloe Cable

HPC Evaluation of Mass General Brigham's Performance Improvement Plan

Mass General Brigham's Performance Improvement Plan **(VOTE)**

Research Presentation: Behavioral Health Emergency Department Boarding in Massachusetts

Executive Director's Report

Adjourn

VOTE

Enter Executive Session

MOTION

That having first convened in open session at its December 12, 2024 board meeting and pursuant to M.G.L. c. 30A, § 21(a)(7), the Commission hereby approves going into executive session for the purpose of complying with c. 6D, § 2A, to discuss confidential information provided to the Commission by Mass General Brigham during the implementation and evaluation of its Performance Improvement Plan.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Executive Session **(VOTE)**

GUEST PRESENTATION FROM THE OFFICE OF THE ATTORNEY GENERAL: FINDINGS FROM THE AGO COST TRENDS REPORT – ASSISTANT ATTORNEY GENERAL LISA GAULIN AND ASSISTANT ATTORNEY GENERAL CHLOE CABLE

HPC Evaluation of Mass General Brigham's Performance Improvement Plan

Mass General Brigham's Performance Improvement Plan **(VOTE)**

Research Presentation: Behavioral Health Emergency Department Boarding in Massachusetts

Executive Director's Report

Adjourn

Office of the Attorney General Cost Trends Report 2024: Health Care Affordability

Lisa Gaulin, Assistant Attorney General
Chloe Cable, Assistant Attorney General

December 12, 2024

AGO Cost Trends Authority

- AGO authority to conduct examinations:
  - G.L. c. 12, § 11N: monitor trends in the health care market.
  - G.L. c. 12C, § 17: issue subpoenas for documents, interrogatory responses, and testimony under oath related to health care costs and cost trends.
- Findings and reports issued in conjunction with HPC Annual Cost Trends hearing since 2010.

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Cost Trends Examination 2024: Overview

With a focus on MA residents enrolled in commercial health plans, we examined health care affordability through multiple lenses:

(1) How much are MA households with commercial health insurance spending on health care expenses, including through OOP cost sharing and premium contribution, relative to their income?

- Methodology: CIDs to eleven MA commercial health plans; received cost share data and benefit design by zip code, as well as reporting on member premium contributions, among other data.

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Cost Trends Examination 2024: Overview

With a focus on MA residents enrolled in commercial health plans, we examined health care affordability through multiple lenses:

(2) To what extent are commercial health plan members incurring medical debt from hospital bills?

(3) To what extent are Massachusetts safety net and lower-cost hospitals burdened by bad debt?

- Methodology: CIDs to 12 hospitals across Massachusetts, seeking financial assistance policies and commercial patient debt arising from services rendered in 2022.

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Questions Considered: Household Expenditures for Health Care

At the household level, what was the total OOP exposure for cost share expenditures and premium contribution for MA commercial health plan members *relative to income* in 2022?

- **Are consumers in lower-income communities disproportionately enrolled in higher deductible health plans?**
- **To what extent do actual cost sharing expenditures and member premium contributions vary as a percentage of household income across income quintiles?**
- **How do affordability burdens for MA commercial health plan members differ across different regions of the state?**

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In 2022, Commercial Enrollment by Deductible Levels Was Evenly Distributed Across Income Quintiles

Deductible Levels	Q1 Lowest Income	Q2	Q3	Q4	Q5 Highest Income
$5,000+	2%	2%	1%	1%	1%
$2,500-$4,999	13%	13%	12%	12%	13%
$1,000-$2,499	26%	27%	28%	29%	31%
$500-$999	14%	16%	15%	14%	13%
$1-$499	18%	16%	17%	17%	14%
None	28%	27%	27%	27%	27%

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Questions Considered: Household Expenditures for Health Care

At the household level, what was the total OOP exposure for cost share expenditures and premium contribution for MA commercial health plan members *relative to income* in 2022?

- **Are consumers in lower-income communities disproportionately enrolled in higher deductible health plans?**
- **To what extent do actual cost sharing expenditures and member premium contributions vary as a percentage of household income across income quintiles?**
- **How do affordability burdens for MA commercial health plan members differ across different regions of the state?**

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In 2022, MA Households in Highest-Income Zip Codes, on Average, Incurred Approx. $450 More in Cost Share Expenditures Than MA Households in Lowest-Income Zip Codes

Income Quintile	PHPY Cost Sharing
($0 - $70,354)	$1,646
($70,354 - $86,737)	$1,915
($86,737 - $111,544)	$1,947
($111,544 - $164,299)	$1,943
($164,299 - $1,960,079)	$2,105

Y-axis: PHPY Cost Sharing ($0 – $2,500); X-axis: Income Quintile; Legend: PHPY Cost Sharing

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In 2022, MA Households in Lowest-Income Zip Codes Spent the Highest Share of Income on Cost Sharing (2.9%), 4.5 Times More Than MA Households in Highest-Income Zip Codes (0.6%)

PHPY Cost Sharing as a Percent of Income

3%
2%
1%
0%

($0 - $70,354)
($70,354 - $86,737)
($86,737 - $111,544)
($111,544 - $164,299)
($164,299 - $1,960,079)

Income Quintile

PHPY Cost Sharing

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In 2022, Households in Lowest-Income Zip Codes With Employer-Sponsored Plans Had a Higher Percentage of Income Spent on Cost Sharing (3.1%) Than Households in Lowest-Income Zip Codes Enrolled in the Individual Market (2.1%)

PHPY Cost Sharing as a Percent of Income

4%
3%
2%
1%
0%

($0 - $70,354)
($70,354 - $86,737)
($86,737 - $111,544)
($111,544 - $164,299)
($164,299 - $1,960,079)

Income Quintile

Individual Market
Employer Market

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MA Fully-Insured Households in Lowest-Income Quintile Spent, on Average, 13% of Income on Premium Contribution Plus Cost Sharing in 2022 — Nearly Five Times More Than Households in Highest-Income Quintile

PHPY Health Care Costs as a Percent of Income

14%
12%
10%
8%
6%
4%
2%
0%

($0 - $70,354)
($70,354 - $86,737)
($86,737 - $111,544)
($111,544 - $164,299)
($164,299 - $1,960,079)

Income Quintile

PHPY Cost Sharing
PHPY Premium Contribution

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Questions Considered: Household Expenditures for Health Care

At the household level, what was the total OOP exposure for cost share expenditures and premium contribution for MA commercial health plan members *relative to income* in 2022?

- **Are consumers in lower-income communities disproportionately enrolled in higher deductible health plans?**
- **To what extent do actual cost sharing expenditures and member premium contributions vary as a percentage of household income across income quintiles?**
- **How do affordability burdens for MA commercial health plan members differ across different regions of the state?**

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In 2022, There Was Significant Regional Variation in Average Percentage of Income Spent on Cost Share Plus Premium Contributions for Fully-Insured Households

PHPY Health Care Costs as a Percent of Income

12%
10%
8%
6%
4%
2%
0%

9.1%
8.2%
4.3%
6.5%
3.9%
9.2%
9.6%

$250,000
$200,000
$150,000
$100,000
$50,000
$0

Income

Western	Central	Metrowest / Metrosouth	North Eastern	Eastern	South Eastern	Cape Cod / Islands
1	2	3	4	5	6	7

Rating Area

PHPY Cost Sharing
PHPY Premium Contribution
Average Income

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Average Percentage of Income Spent on Premium Contribution Plus Cost Share for Fully-Insured Households in Sample Zip Codes From Rating Area 4 Reflects Significant Intra-Regional Variation

PHPY Health Care Costs as a Percent of Income
16%
14%
12%
10%
8%
6%
4%
2%
0%
$500,000
$400,000
$300,000
$200,000
$100,000
$0
Income
Manchester 01944
Winchester 01890
Marblehead 01945
Essex 01929
Beverly 01915
Dracut 01826
Methuen 01844
Haverhill 01832
Lowell 01852
Lowell 01854
Lowell 01851
Lawrence 01843
Lawrence 01841
Lowell 01850
Lawrence 01840
Municipality & Zip Code
PHPY Cost Sharing
PHPY Premium Contribution
Average Income

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Questions Considered: Medical Debt and Financial Assistance

(2) To what extent are commercial health plan members incurring medical debt from hospital bills?

- **What populations are most likely to incur medical debt?**

- **How do hospital Financial Assistance Policies support patients who cannot afford their medical bills?**

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In 2022, Patients in Lower-Income Zip Codes Accounted for Significantly More Debt Than Patients in Higher-Income Zip Codes at Sampled Hospitals

Zip code income quintile	Percentage of Sampled Debt	Average Amount of Debt Per Patient With Debt
Q1 Lowest Income	31%	$554
Q2	22%	$640
Q3	15%	$526
Q4	13%	$472
Q5 Highest Income	6%	$502

Legend: Percentage of Debt (bars); Average Amount of Debt Per Patient With Debt (line)

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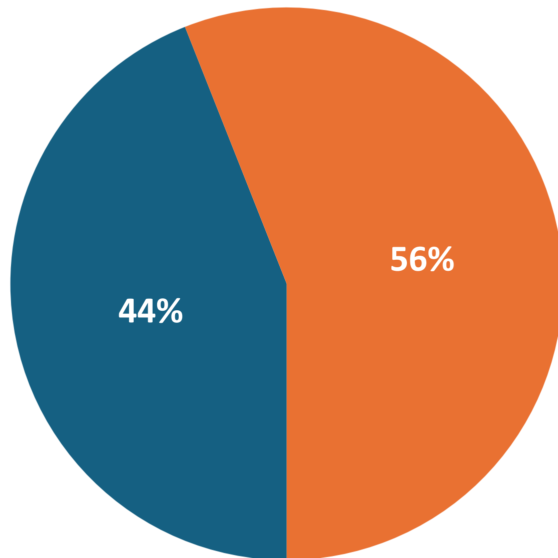
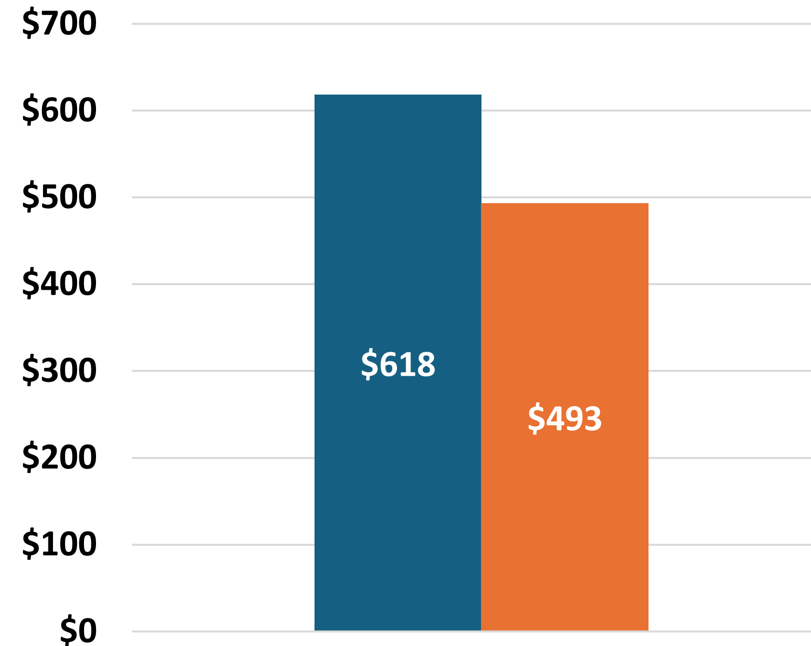
In 2022, Female Patients Had More Debt, While Male Patients Had Higher Amounts of Debt on Average at Sampled Hospitals





Male Female

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Within the Hospitals Sampled, Black Patients Made Up a Higher Percentage Of Patients With Medical Debt Compared to Share of Statewide Population

- The proportion of patients from sampled hospitals with debt who identified as Black (12%) is higher than the proportion of Massachusetts residents who identified as Black in response to the 2020 Census (7%).

- In contrast, white patients made up a smaller proportion of patients with hospital debt (63%) compared to their share of the statewide population (68%). Asian patients also made up a smaller proportion of patients with hospital debt (3%) compared to the statewide population (7%).

- Due to data limitations, conclusions could not be reached regarding other racial categories.

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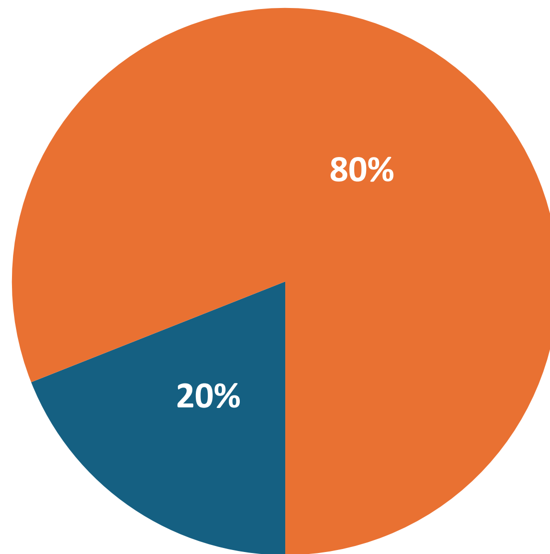
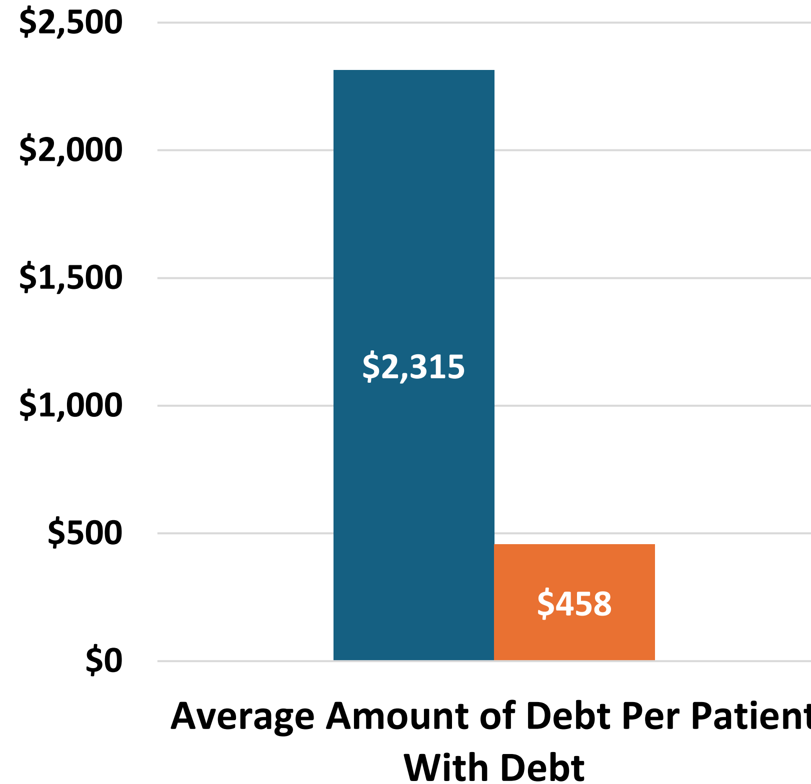
In 2022, Outpatient Services Generated More Debt, While Inpatient Services Generated Higher Amounts of Debt on Average at Sampled Hospitals





Inpatient Outpatient

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Questions Considered: Medical Debt and Financial Assistance

(2) To what extent are commercial health plan members incurring medical debt from hospital bills?

- **What populations are most likely to incur medical debt?**
- **How do hospital Financial Assistance Policies support patients who cannot afford their medical bills?**

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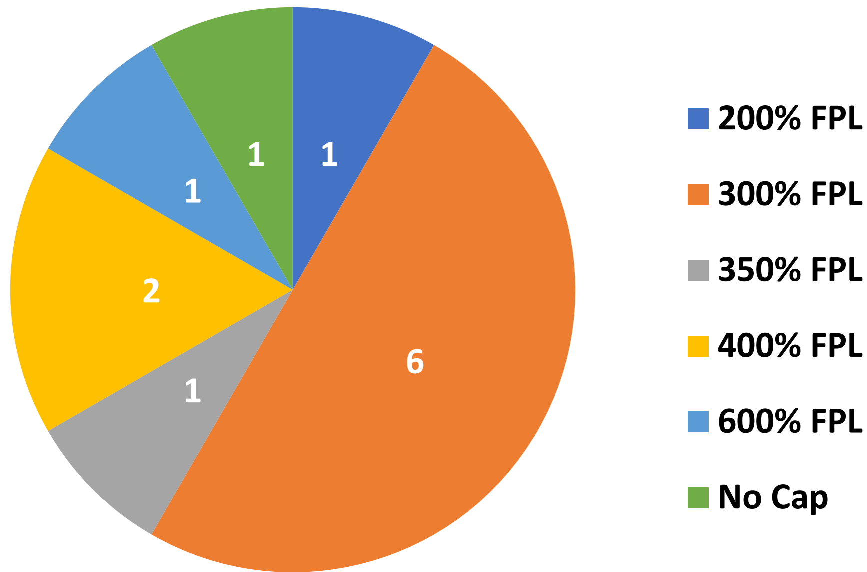
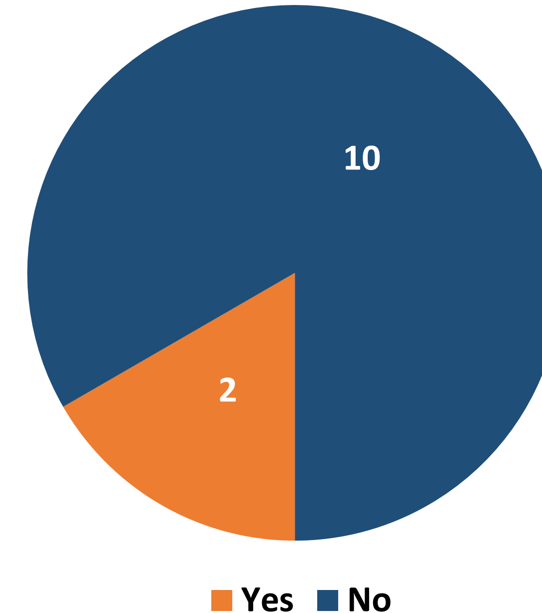
Qualification for Hospital Financial Assistance Policies Varies Across Hospitals

What is the Maximum Income Eligible for Income-Based Assistance?



Are Further Discounts Available to a Patient Receiving HSN?



These charts reflect the number of hospital FAPs out of the sample of twelve hospitals that included the criteria above.

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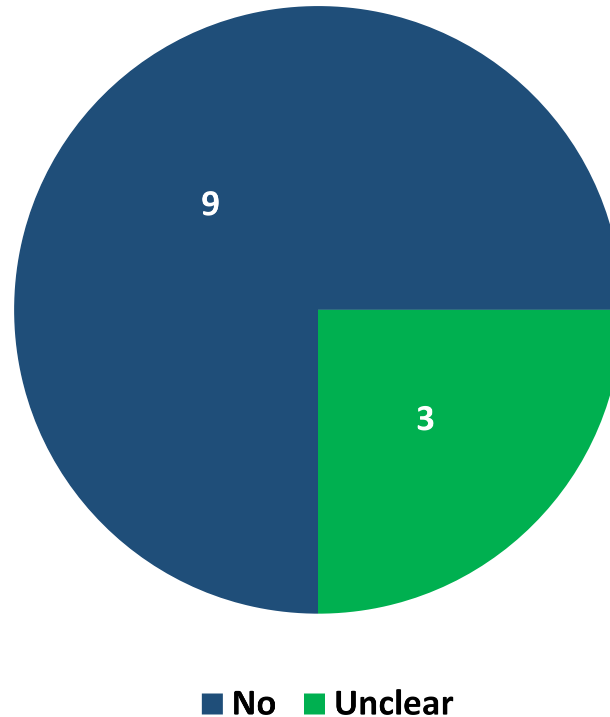
Very Few Hospitals Provide Financial Assistance with Deductibles and/or Co-Insurance



This chart reflect the number of hospital FAPs out of the sample of twelve hospitals that included the criteria above.

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Questions Considered: Bad Debt

(3) To what extent are Massachusetts safety net and lower-cost hospitals burdened by bad debt?

- **How does a hospital's public payor mix and commercial relative price correlate with its reported level of bad debt?**

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In Our Sample, Hospitals With a Higher Medicaid/Subsidized Population Payer Mix Had a Higher Percentage of Commercial Bad Debt Relative to Their Commercial Gross Patient Services Revenue

Medicaid/Subsidized Population Payer Mix

60%
50%
40%
30%
20%
10%
0%

0.0%
0.5%
1.0%
1.5%
2.0%
2.5%
3.0%

Commercial Bad Debt as a Percentage of Commercial Gross Patient Services Revenue

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In Our Sample, Hospitals With a Lower Commercial Relative Price Had a Higher Percentage of Commercial Bad Debt Relative to Their Commercial Gross Patient Services Revenue

Hospital Commercial Relative Price

1.4
1.2
1
0.8
0.6
0.4
0.2
0

0.0% 0.5% 1.0% 1.5% 2.0% 2.5% 3.0%

Commercial Bad Debt as a Percentage of Commercial Gross Patient Services Revenue

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Recommendations: Affordability Measures

- The legislature should consider creating an **affordability index** that measures how much Massachusetts consumers are paying for health care, including through deductibles, co-payments, and premiums (both employer and employee share), relative to income.

- Affordability index should allow policymakers to monitor trends at a municipal or zip-code level so that affordability burdens in lower-income communities are not obscured in state-wide or regional averages.

- In conjunction with the affordability index, the legislature should consider creating a target affordability benchmark.

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Recommendations: Consumer Protections

- The legislature should consider enhanced consumer protections:
  - Around collection and reporting of medical debt, such as limitations on collections and "extraordinary collection actions" during good faith bill disputes, and limitations on reporting medical debt to credit bureaus.
  - Around providers' Financial Assistance Policies and practices, including uniform income thresholds for eligibility; screening requirements; discounts that apply to cost sharing; affordable payment plans; and applicability to other health care providers beyond hospitals.
- Hospitals should adhere to the AGO's recommended medical debt reporting practices.

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Recommendations: Lower-Cost Coverage for Lower-Income Households

- Stakeholders should continue efforts to support MA residents with commercial insurance who are falling within affordability gaps, including:

  - Maintaining enhanced subsidies for Connector participants.

  - For employer-sponsored insurance, awareness and consideration of pay-based premium contributions and cost sharing programs.

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Recommendations: Support for Lower-Cost Hospitals

- The legislature should consider increased support for lower-cost and safety net hospitals that are disproportionally shouldering bad debt, including strategies to reduce unwarranted provider price variation.

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Agenda

HPC

Call to Order

Approval of Minutes **(VOTE)**

Executive Session **(VOTE)**

Guest Presentation from the Office of the Attorney General: Findings from the AGO Cost Trends Report – Assistant Attorney General Lisa Gaulin and Assistant Attorney General Chloe Cable

HPC EVALUATION OF MASS GENERAL BRIGHAM'S PERFORMANCE IMPROVEMENT PLAN

Mass General Brigham's Performance Improvement Plan **(VOTE)**

Research Presentation: Behavioral Health Emergency Department Boarding in Massachusetts

Executive Director's Report

Adjourn

CHIA and the HPC share responsibility for monitoring performance against the health care cost growth benchmark.

Step 1: Benchmark

Each year, the process starts by setting the annual health care cost growth benchmark

Step 2: Data Collection

CHIA then collects data from payers on unadjusted and **health status adjusted total medical expense (HSA TME)** for their members, both network-wide and by primary care group.

Step 3: CHIA Referral

CHIA analyzes those data and as required by statute, confidentially refers to the HPC **payers** and **primary care providers** whose **increase** in **HSA TME** is above bright line thresholds (e.g. greater than the benchmark)

Step 4: HPC Analysis

HPC conducts a confidential, but robust, review of each referred provider and payer's performance across **multiple factors**

Step 5: Decision to Require a PIP

After reviewing all available information, including confidential information from payers and providers under review, the **HPC Board votes** to require a PIP if it identifies significant concerns and finds that a PIP could result in meaningful, cost-saving reforms. The entity's identity is public once a PIP is required.

Step 6: PIP Implementation

The payer or provider must propose the PIP and is subject to **ongoing monitoring** by the HPC during the **18-month implementation**. A fine of up to $500,000 can be assessed as a last resort in certain circumstances.

HPC

REQUIRING A PIP

- The HPC may require any CHIA-identified Entity to file a PIP if, after a review of certain factors, the Commission **identifies significant concerns about the entity's costs** and **determines that a PIP could result in meaningful, cost-saving reforms.**
- The HPC shall base its determination on a review of the following factors:
  a) Baseline spending and spending trends over time, including by service category;
  b) Pricing patterns and trends over time;
  c) Utilization patterns and trends over time;
  d) Population(s) served, payer mix, product lines, and services provided;
  e) Size and market share;
  f) Financial condition, including administrative spending and cost structure;
  g) Ongoing strategies or investments to improve efficiency or reduce spending growth over time;
  h) Factors leading to increased costs that are outside the CHIA-identified Entity's control; and
  i) Any other factors the Commission considers relevant.

Recap of HPC Rationale for Requiring a PIP from MGB

HPC

- MGB regularly had spending growth above the benchmark, with a cumulative spending impact of **$293 million in above-benchmark unadjusted spending growth** for its commercially insured primary care patients from 2014 through 2019, more than any other Massachusetts provider or system
- MGB had higher absolute **spending levels** for its patients than most other systems, as well as higher hospital and physician prices than nearly all other providers in the Commonwealth
- **Price and mix** were the primary drivers of MGB's spending growth, rather than utilization; and
- Other factors considered (e.g., the acuity and payer mix of patients served, MGB's financial condition) did not mitigate concerns.

Recap of HPC Rationale for Requiring a PIP from MGB

HPC

The Board voted to **require a Performance Improvement Plan from Mass General Brigham**.

In reviewing MGB's long term spending trends and the regulatory factors[1], the HPC found that:

- Spending performance for **MGB raised significant concerns** and had likely already impacted the state's ability to meet the health care cost growth benchmark.
- Unless addressed, MGB's spending performance was likely to continue to **impact the state's ability to meet the benchmark**.
- The information provided by MGB in meetings and in response to HPC's requests **did not allay the concerns** identified by the HPC in its analyses of MGB's performance.

The HPC determined that a Performance Improvement Plan could result in **meaningful, cost-saving reforms**.

1. The Board examined a wide array of both public and confidential data sources during the PIPs review. In accordance with its statute, the HPC is only releasing confidential information in summary form or when it has determined that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anticompetitive considerations.

Performance Improvement Plans: Regulatory Overview

HPC

PIP Proposals

Any proposed **PIP shall be developed by the entity** and shall include, among other required items:

a) Identification of the cause(s) of the entity's cost growth

b) Specific strategies, adjustments, and action steps the entity proposes to implement to improve health care spending performance without compromising quality of or access to needed services

c) A proposed timetable for implementing each strategy, adjustment or action step, with an overall timetable for implementation of 18 months or less

d) Specific identifiable and measurable expected outcomes, with a timetable for measurement, achievement, and reporting of such outcomes

PIP Approval

The HPC shall approve a proposed PIP by vote of the Board if it determines that the proposed PIP is **reasonably likely to successfully address the underlying cause(s) of the entity's cost growth** and has a reasonable expectation that the **entity will be capable of successfully implementing the proposed PIP.**

Overview of MGB's PIP

SAVINGS TARGET

- MGB's PIP set a total savings target of $176.7 million over the 18-month period.
- MGB anchored its savings target to the financial impact of its cumulative above-benchmark spending growth for its primary care patient population from 2014-2019.

STRATEGIES

- MGB's PIP included 10 strategies organized into 3 categories (see table).
- MGB also described efforts to control costs through its value-based care strategy, but did not quantify savings associated with these efforts.
- The majority of the target savings ($125M, 70%) were associated with four Price Reductions strategies, which targeted MGB's commercial prices, consistent with HPC's identification of price, rather than utilization, as the primary driver of MGB's spending growth.
- The PIP was expected to generate savings not only for MGB's primary care population, but also for other health care systems' primary care population and total health care expenditures generally.

Strategy	Total Savings Target ($M)
Price Reductions	
Reducing Outpatient Rates	$86.8
Mass General Waltham Rates	$19.2
Reducing ConnectorCare Rates	$17.9
Other Insurance Discount	$1.5
Reducing Utilization	
Integrated Care Management Program	$23.0
SNF Utilization Reduction	$13.4
MGB Health Plan Utilization Management	$1.5
MRI and CT Utilization	$6.5
Shifting Care to Lower Cost Sites	
Home Hospital	$1.9
Virtual Care Discount	$5.1
Total	**$176.7**

Overview of MGB's PIP

HPC

TIMING

- The full 18-month PIP implementation period ran from October 2022 through March 2024.
- Five strategies either began immediately on October 1, 2022 or had start dates that pre-dated the PIP implementation period, but which were continued or expanded during the PIP.
- Several strategies were designated to start on January 1, 2023, to align with payer contract cycles.
- Though some of its strategies pre-dated the PIP, MGB's savings methodologies only account for savings generated during the implementation period.

Strategy	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024
Price Reductions						
Reducing Outpatient Rates	*					
Mass General Waltham Rates						
Reducing ConnectorCare Rates	*					
Other Insurance Discount						
Reducing Utilization						
Integrated Care Management Program						
SNF Utilization Reduction						
MGB Health Plan Utilization						
MRI and CT Utilization	*					
Shifting Care to Lower Cost Sites						
Home Hospital	*					
Virtual Care Discount						

Note: Quarters in blue are those in which at least one sub-component of the strategy was operational, even if not all components were operational. Stars indicate that at least one sub-component of the strategy was initiated prior to the PIP Implementation Period. MGB's integrated care management program pre-dates the PIP implementation period, but MGB expanded the program capacity and began increasing its enrollment numbers on October 1, 2022.

MGB's Reported Savings

- Based on its methodology for calculating savings, MGB reported saving a total of $197.1M, exceeding its target by more than $20M, or 12%.
- MGB noted that the Price Reductions and Reducing Utilization categories both outperformed expectations. According to MGB:
  - **Price Reductions:** *"Results were driven by reductions in rates for On-Campus Outpatient procedures and services, MG West procedures and services, and MGB pricing on MGB Health Plan Connector Care products."*
  - **Reducing Utilization:** *"Results were driven by strong performance in MRI and CT utilization management along with on-target performance for expansion of the Integrated Care Management Program (iCMP) and new utilization management interventions by MGB Health Plan."*
  - **Shifting Care to Lower Cost Sites:** *"Savings were driven by increasing discounts on the price for virtual care visits with MGB specialist care providers. [T]he Hospital at Home program …fell short of the target due to staffing challenges, but we continue to see strong momentum in this innovative solution."*

Strategy	Total Savings Target ($M)	Total Savings ($M)
Price Reductions		
Reducing Outpatient Rates	$86.8	$85.3
Mass General Waltham Rates	$19.2	$24.8
Reducing ConnectorCare Rates	$17.9	$29.5
Other Insurance Discount	$1.5	$3.3
Reducing Utilization		
Integrated Care Management Program	$23.0	$24.9
SNF Utilization Reduction	$13.4	$7.3
MGB Health Plan Utilization Management	$1.5	$1.5
MRI and CT Utilization	$6.5	$14.4
Shifting Care to Lower Cost Sites		
Home Hospital	$1.9	$0.9
Virtual Care Discount	$5.1	$5.4
Total	**$176.7**	**$197.1**

HPC

PIP Evaluation

The HPC shall **determine whether the PIP was successful by vote of the Board**. The HPC may consider the following factors when determining whether a PIP was successful:

1. Whether and to what extent the entity has addressed significant concerns about its costs, i.e., by achieving the target outcomes as specified in the PIP, in accordance with the Commonwealth's policy goals, including those concerning the cost, quality and accessibility of care;
2. Whether the entity has fully implemented, in good faith, the strategies, adjustments and action steps of the PIP;
3. The sustainability of the efficiencies and cost savings of the PIP;
4. The impact of events outside of the entity's control on implementation or cost growth; and
5. Other factors the Commission determines to be relevant.

HPC Approach to Evaluation

HPC

A ACHIEVING TARGET OUTCOMES

To what extent did MGB implement its strategies in good faith and achieve the target savings specified in the PIP?

B SPENDING AND PRICING DURING THE PIP

To what extent did MGB address significant concerns about its costs, i.e., by impacting its spending and pricing during the PIP?

C SUSTAINABILITY

To what extent are the strategies and savings from the PIP likely to be sustained?

Summary of Findings

HPC

ACHIEVING TARGET OUTCOMES

Finding A.1: MGB implemented the strategies in its approved PIP in good faith.

Finding A.2: MGB achieved the savings target set forth in its approved PIP.

SPENDING AND PRICING DURING THE PIP

Finding B.1: During the PIP, MGB's spending growth was meaningfully reduced. Though MGB's spending growth with local commercial payers exceeded the benchmark in 2023 based on preliminary TME data, its growth was less than network average growth during this time period. MGB's overall spending growth likely would have exceeded network average growth if its spending were increased by the magnitude of the estimated PIP savings.

Finding B.2: During the PIP, MGB's pricing was likely modestly reduced relative to the market. HPC analysis indicates that MGB's contracted rate changes during the PIP likely slightly reduced its prices relative to the average with each of the local commercial payers, consistent with MGB's stated goal of decreasing price variation.

SUSTAINABILITY

Finding C.1: MGB has stated that it will continue implementing several of its strategies after the PIP.

Finding C.2: MGB's rate increases in recently finalized agreements suggest that MGB is not recouping the savings generated under the PIP Price Reductions strategies in current payer contracts.

Finding C.3: Other factors that MGB identified as evidence of the sustainability of the PIP have not previously been shown to be sufficient to constrain MGB's spending growth. Given the role of pricing in driving MGB's historically high spending growth, the long-term sustainability of the PIP savings will depend on MGB maintaining a commitment to keep pricing at levels consistent with compliance with the benchmark, including in value-based care arrangements..

Key Findings

HPC

Finding A.1

MGB implemented the strategies in its approved PIP in good faith.

- Despite the ongoing challenges that the health care system has faced in recent years, MGB worked collaboratively with HPC throughout the PIP process, showing a good faith commitment to the process and its implementation of the PIP.
- When implementation challenges arose, MGB transparently identified and, to the extent possible, addressed these challenges.
- MGB made a commitment to the HPC early in the PIP implementation period that it would achieve its total savings target, even if it did not achieve its target savings for each individual strategy.

Key Findings

HPC

Finding A.2

MGB achieved the savings target set forth in its approved PIP.

- The HPC carefully reviewed MGB's savings methodologies and calculations, and MGB made some adjustments to its calculations based on HPC feedback.
- The HPC found MGB's final savings methodologies and estimates to be generally reasonable. Savings associated with addressing MGB's prices with commercial insurers had the most impact.
- The HPC notes that certain ancillary impacts could not be accounted for and that a portion of the reported PIP savings was returned to MGB as revenue through shared savings payments pursuant to MGB's value-based care arrangements with local payers.
- Overall, the scope of savings achieved was consistent with the expectations in MGB's approved PIP. The HPC therefore finds that MGB met its PIP savings target.

Key Findings

HPC

Finding B.1

During the PIP, MGB's spending growth was meaningfully reduced.

- The HPC reviewed MGB’s spending trends in the context of the significant strain that has faced the health care system in recent years.
- Based on preliminary TME data, spending growth for MGB’s largest physician group, Partners Community Physicians Organization, generally exceeded the benchmark between 2022 and 2023.
- However, when compared to average spending growth during this time, MGB’s spending growth was generally below that average. These trends differ from MGB’s unadjusted spending trends prior to the PIP, when MGB’s growth was at or above the network average with three of the four payers.
- The HPC estimates that if PIP savings were added to MGB’s 2023 TME spending with local commercial payers its 2023 spending growth would have exceeded network average trends for three of the four local payers evaluated.

Commercial Spending Growth (Preliminary TME):

Payer	MGB Compared to Network Average: 2022 – 2023	
	HSA TME	Unadjusted TME
Payer 1	-0.5 ppts	-0.6 ppts
Payer 2	-0.3 ppts	-0.1 ppts
Payer 3	-3.2 ppts	-5.7 ppts
Payer 4	-1.8 ppts	-2.3 ppts

Finding B.1

During the PIP, MGB's spending growth was meaningfully reduced.

- The HPC also examined MGB's outpatient spending trends, which should have been notably impacted by MGB's Reducing Outpatient Rates and Mass General Waltham Rates strategies.
- MGB's 2022-2023 outpatient spending growth was high, tracking statewide commercial trends, but was generally growing more slowly than each payer's network average from 2022 to 2023.
- This was an improvement from MGB's historical performance; its annualized outpatient TME growth from 2013-2022 had been higher than the network average outpatient growth with each of the local commercial payers.

Outpatient Spending Growth (Preliminary TME)

Payer	MGB Compared to Network Average	
	2013-2022 Annualized	2022-2023
Payer 1	+2.0 ppts	-0.7 ppts
Payer 2	+4.6 ppts	-1.6 ppts
Payer 3	+1.6 ppts	-5.8 ppts
Payer 4	+0.1 ppts	-2.1 ppts

Key Findings

HPC

Finding B.2

During the PIP, MGB's pricing was likely modestly reduced relative to the market.

- In its approved PIP, MGB stated that one of its goals for future contract negotiations with local commercial payers was "to decrease price variation between MGB and the marketplace."
- The HPC's estimated MGB's system-level pricing with local commercial payers compared to average in 2022, finding that MGB's system pricing was:
  - Between 9% and 35% above average on an inpatient basis; and
  - Between 14% below and 35% above average on an outpatient basis.
- After taking into account 2023 and 2024 rate increases for MGB and other provider systems, the HPC estimates that MGB's price differential decreased modestly by 2024, resulting in estimated prices for MGB that are:
  - Between 5% and 28% above average on an inpatient basis; and
  - Between 17% below and 30% above average on an outpatient basis.
- The HPC therefore finds that MGB's contracted rate changes during the PIP likely slightly reduced its prices relative to the average with each of the local commercial payers, consistent with MGB's stated goal of decreasing price variation.

Key Findings

HPC

Finding C.1

MGB has stated that it will continue implementing several of its strategies after the PIP.

- Within the context of the PIP, MGB has made specific statements regarding the continuity of some of its PIP strategies, including that:
  - The MG West facility will continue to receive community hospital rates, rather than AMC rates, with local commercial payers; and
  - MGB intends to continue strengthening its SNF strategy after the implementation period.
- Outside the context of the PIP, MGB has made public statements that signal its intention to continue implementing some strategies. For example:
  - MGB announced the attainment of a new "capacity milestone" in its Home Hospital program in August 2024, several months after the close of the PIP implementation period. Since the beginning of the PIP implementation period, MGB has expanded its Home Hospital program from BWH and MGH to include Newton-Wellesley Hospital, Salem Hospital, and Brigham and Women's Faulkner Hospital.
- A few of MGB's strategies, such as the iCMP, pre-dated the PIP, and can therefore be credibly viewed as existing parts of MGB's cost containment portfolio that are likely to continue.

Key Findings

HPC

Finding C.2

MGB's rate increases in recently finalized agreements suggest that MGB is not recouping the savings generated under the PIP Price Reductions strategies in current payer contracts.

- The HPC considers MGB's strategies targeting its commercial prices to be of particular importance to the overall success of the PIP, not only because they constitute more than 70% of MGB's total claimed savings, but also because the HPC had identified price as a key spending driver for MGB.
- In its approved PIP, MGB stated that it would not recoup the savings generated from its pricing actions during the PIP via future rate increases.
- The HPC examined MGB's 2024 and 2025 aggregate price increases with local commercial payers compared to the health care cost growth benchmark, MGB's historical increases, and the payer's network average increase for each year, when available.
- Evidence reviewed by the HPC regarding MGB's rates in recently finalized agreements with local commercial payers suggests that it is unlikely MGB recouped the revenue it forewent during the PIP through higher rate increases than it would have sought otherwise.

Key Findings

HPC

Finding C.3

Other factors that MGB identified as evidence of the sustainability of the PIP have not previously been shown to be sufficient to constrain MGB's spending growth.

- MGB's final public report on the PIP includes a commitment to short-term and long-term sustainability. MGB cites specific examples of this commitment, such as its use of benchmark data from CHIA, its use of multi-year payer contracts that extend beyond the PIP period, and its participation in value-based care arrangements with payers.
- The HPC notes that most of the factors that MGB cites were in place prior to the requirement that it implement a PIP and were insufficient constraints to prevent MGB from having high unadjusted TME growth across multiple books of business and multiple years, leading to the HPC's decision to require a PIP.
- Ultimately, given the role of pricing in driving MGB's historically high spending growth, the long-term sustainability of the PIP savings will depend on MGB maintaining a commitment to keep pricing at levels consistent with compliance with the benchmark, including in value-based care arrangements.

Recap of Findings

HPC

A

ACHIEVING TARGET OUTCOMES

Finding A.1: MGB implemented the strategies in its approved PIP in good faith.

Finding A.2: MGB achieved the savings target set forth in its approved PIP.

B

SPENDING AND PRICING DURING THE PIP

Finding B.1: During the PIP, MGB's spending growth was meaningfully reduced.

Finding B.2: During the PIP, MGB's pricing was likely modestly reduced relative to the market.

C

SUSTAINABILITY

Finding C.1: MGB has stated that it will continue implementing several of its strategies after the PIP.

Finding C.2: MGB's rate increases in recently finalized agreements suggest that MGB is not recouping the savings generated under the PIP Price Reductions strategies in current payer contracts.

Finding C.3: Other factors that MGB identified as evidence of the sustainability of the PIP have not previously been shown to be sufficient to constrain MGB's spending growth.

HPC

PIP Evaluation

- The HPC shall **determine whether the PIP was successful by vote of the Board**. The HPC may consider the following factors when determining whether a PIP was successful:
  a) To what extent the entity addressed significant concerns about its costs, i.e., by achieving the target outcomes as specified in the PIP;
  b) Whether the entity fully implemented, in good faith, the strategies of the PIP;
  c) The sustainability of the efficiencies and cost savings of the PIP;
  d) The impact of events outside of the entity's control on implementation or cost growth; and
  e) Other factors the Commission determines to be relevant.

- **If the HPC finds the PIP to be unsuccessful**, the HPC may:
  a) Extend the implementation timetable of the PIP and request amendments to the PIP;
  b) Require the entity to submit a new PIP; or
  c) Waive or delay the requirement to file any additional PIP.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Executive Session **(VOTE)**

Guest Presentation from the Office of the Attorney General: Findings from the AGO Cost Trends Report – Assistant Attorney General Lisa Gaulin and Assistant Attorney General Chloe Cable

HPC Evaluation of Mass General Brigham's Performance Improvement Plan

MASS GENERAL BRIGHAM'S PERFORMANCE IMPROVEMENT PLAN (VOTE)

Research Presentation: Behavioral Health Emergency Department Boarding in Massachusetts

Executive Director's Report

Adjourn

VOTE

Mass General Brigham's Performance Improvement Plan

MOTION

That, the Commission hereby determines pursuant to 958 CMR 10.13(2) that the Performance Improvement Plan implemented by Mass General Brigham [was/was not] successful.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Executive Session **(VOTE)**

Guest Presentation from the Office of the Attorney General: Findings from the AGO Cost Trends Report – Assistant Attorney General Lisa Gaulin and Assistant Attorney General Chloe Cable

HPC Evaluation of Mass General Brigham's Performance Improvement Plan

Mass General Brigham's Performance Improvement Plan **(VOTE)**

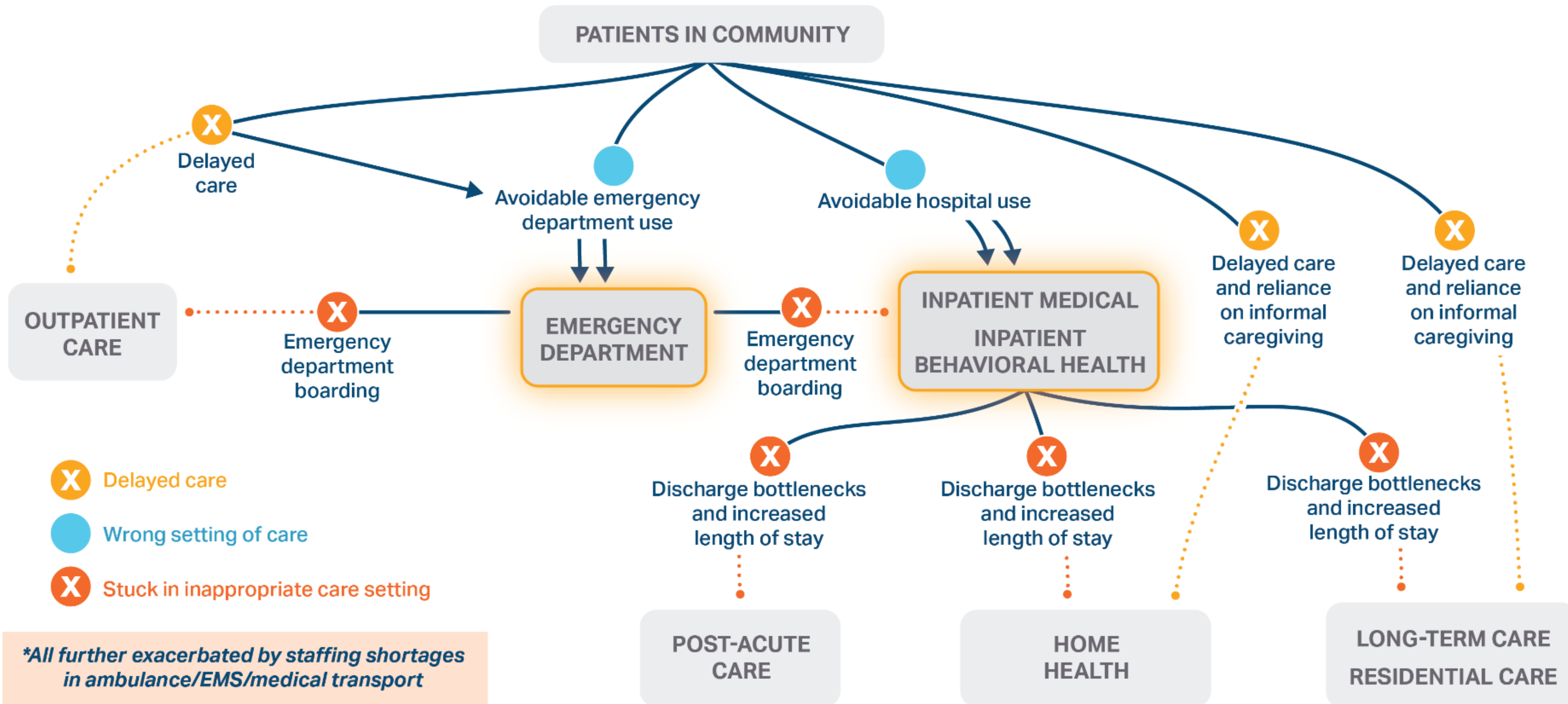
RESEARCH PRESENTATION: BEHAVIORAL HEALTH EMERGENCY DEPARTMENT BOARDING IN MASSACHUSETTS

Executive Director's Report

Adjourn

Prior HPC work has examined systemic linkages and bottlenecks that can lead to capacity issues and patients stuck in the wrong setting of care.

HPC

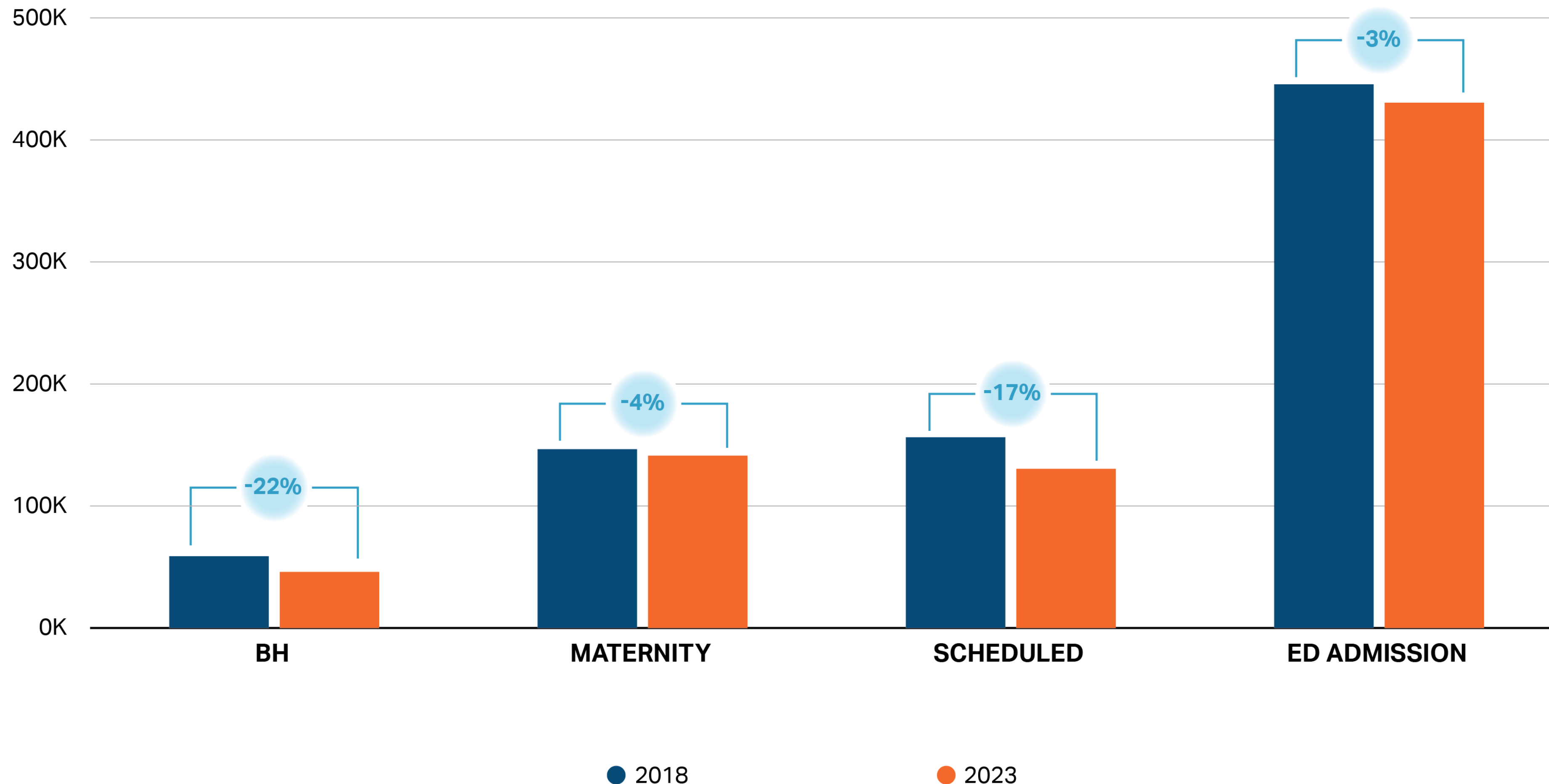


Sources: Massachusetts HPC, "Health Care Workforce Trends and Challenges in the Era of COVID-19" March 2023. Available at: https://masshpc.gov/publications/policyresearch-brief/health-care-workforce-trends-and-challenges-era-covid-19

All categories of inpatient stays decreased from 2018 to 2023.

HPC

Inpatient stays by type of inpatient stay, 2018 and 2023

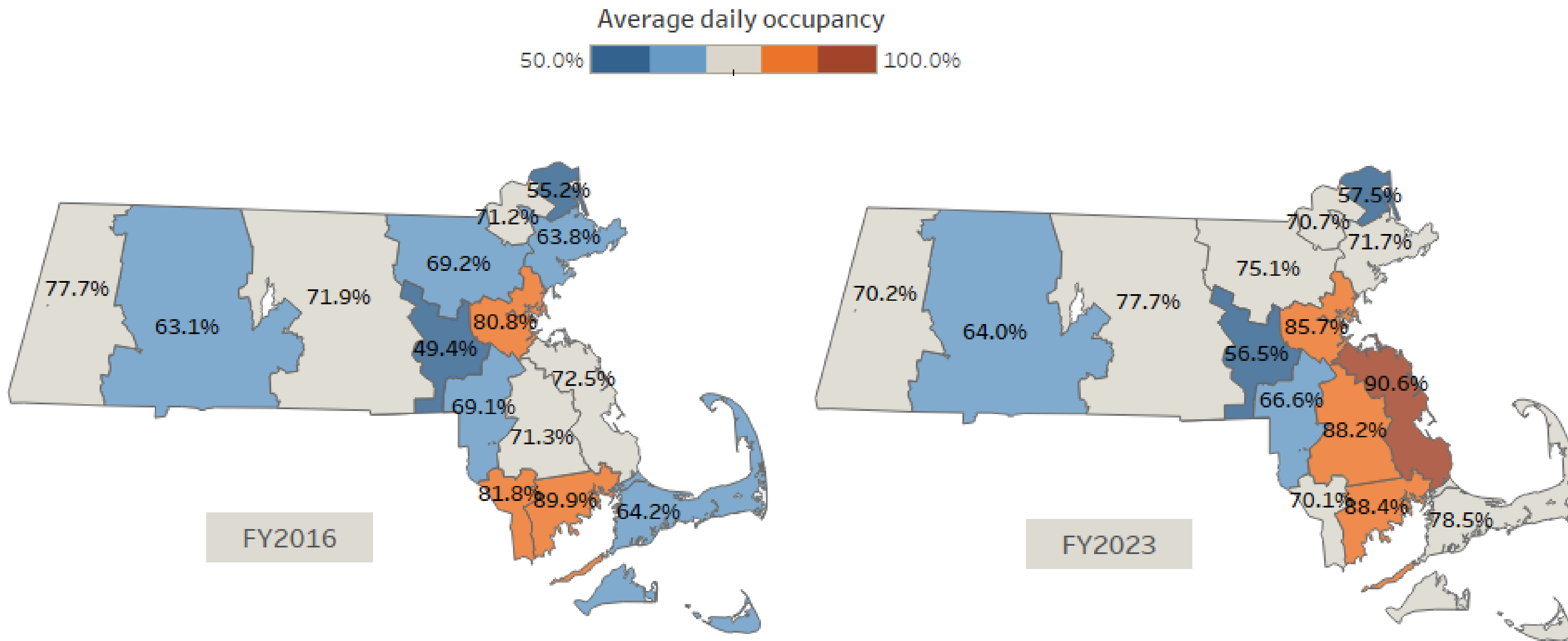


Notes: ED admission were identified using ED flags, admission source codes and ED revenue codes after excluding any BH or maternity stays. APR-DRG codes were used to identify Maternity (14,15) and BH (19,20) stays. Scheduled includes all stays that were not BH, maternity, or ED admissions. Includes COVID related discharges. Excludes rehabilitation admissions and admissions with length of stay greater than 180 days.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, FY2017-2023, preliminary FY2024

Despite a decrease in inpatient stays, hospital occupancy increased from 2016 to 2023, particularly in the Eastern half of the state.

HPC

Ratio of average daily bed days to statewide acute-care staffed beds (occupancy), FY2016-FY2023



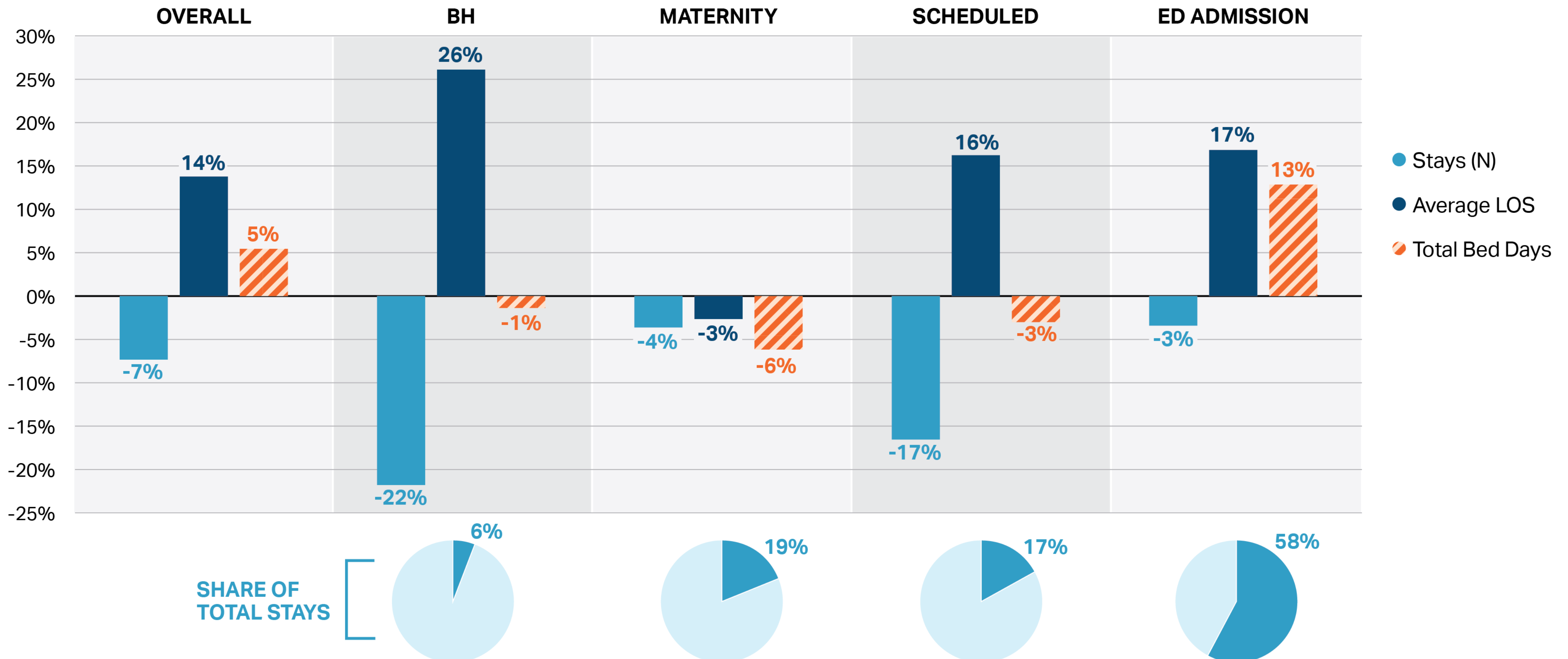
Notes: Includes all discharges from acute care and specialty hospitals. 2023 beds have yet to be reported—using 2022 bed numbers with 2023 utilization.
Source: HPC's analysis of Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database and Hospital Profiles, FY2016-FY2023

- The total number of staffed acute-care hospital beds have increased by **2.7%** from FY2016 to FY2023.
- The average daily census increased by nearly **10%** over this same time period, resulting in higher occupancy rates and less available beds.
- On August 31st, 2024, Nashoba and Carney Hospitals closed representing **a loss of approximately 129 beds**. HPC and others in the state are tracking the impact of these closures on statewide inpatient capacity.

Total hospital use (bed days) increased from 2018 to 2023 despite a decrease in admissions because of longer average length of stay.

HPC

Percent change from 2018 to 2023 in number of stays, average length of stay, and total days for inpatient stays, 2018 and 2023



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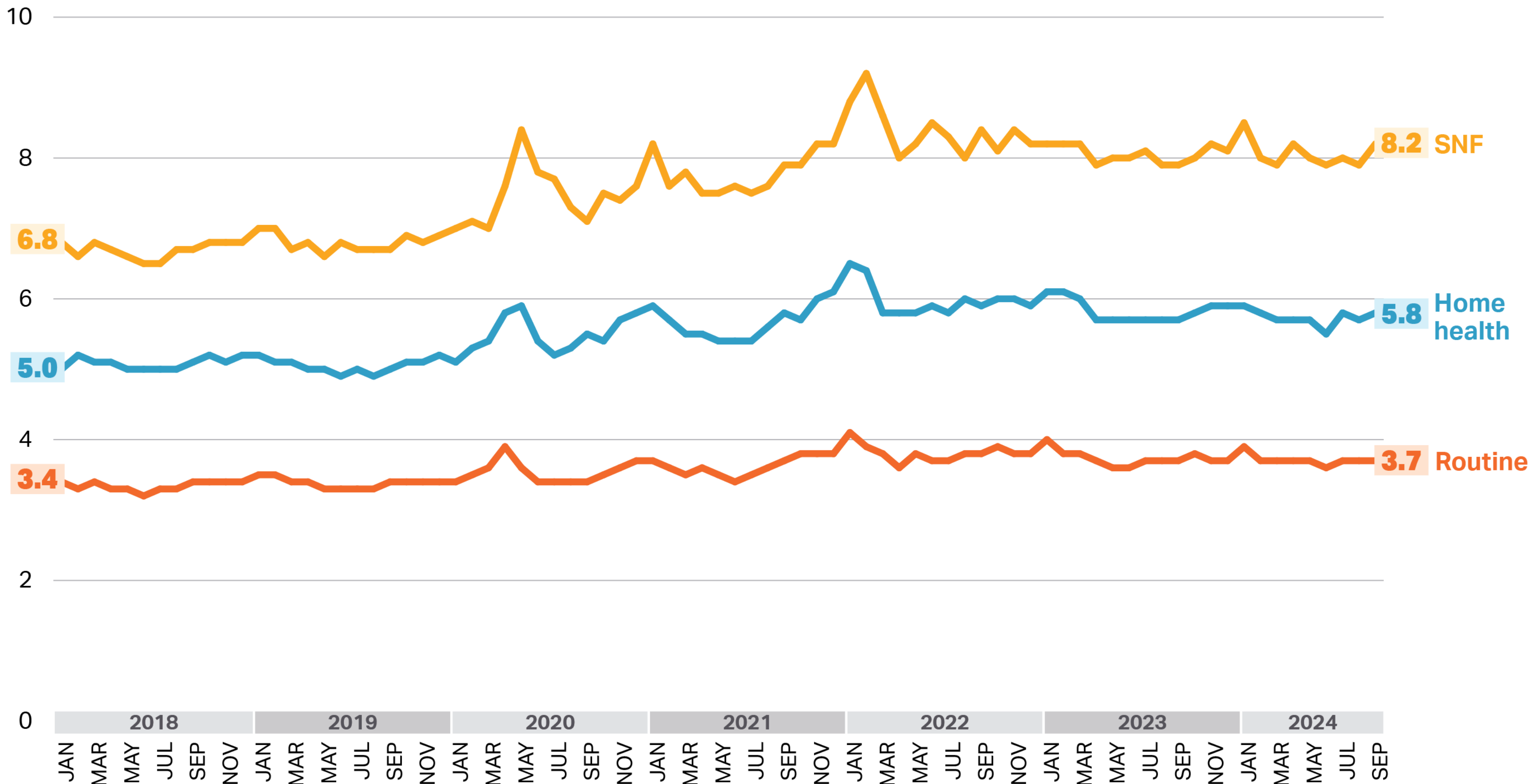
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, CY2018 to CY2023

The increase in length of stay is concentrated among patients ultimately discharged to post-acute care.

HPC

Average length of stay (days) for admissions from the ED (combined) by discharge destination, 2018 to 2024



Notes: Based on patient discharge data and includes only stays admitted from the emergency department (as defined in prior slides). Includes COVID-related discharges. Excludes pediatric, maternity, BH, scheduled, and rehabilitation stays. Stays with length of stay greater than 180 days.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, FY2017 to FY2023, preliminary FY2024

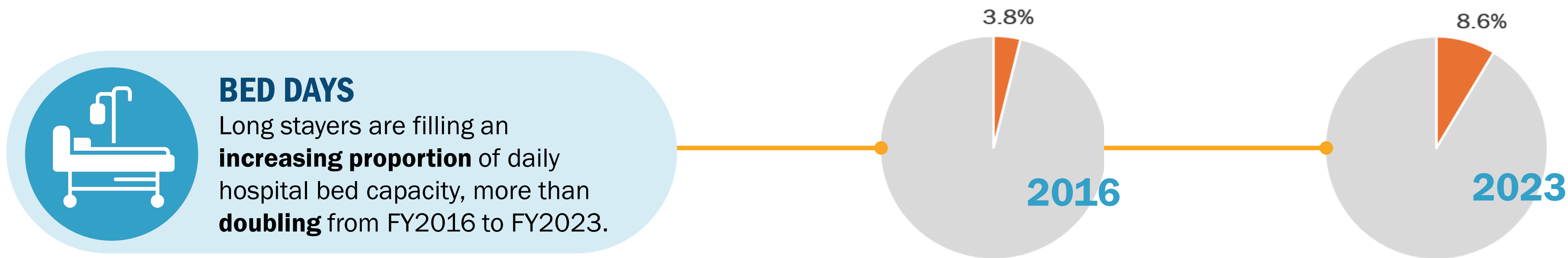
- HPC has previously reported on hospital capacity issues, highlighting the lack of post-acute beds as well as the prior authorizations needed as an impediment to discharging patients in a timely manner.
- Starting in 2021 as part of pandemic response, the DOI asked carriers to waive prior authorizations. This ended in May 2022.

https://www.mass.gov/doc/bulletin-2022-03-extended-relaxation-of-prior-authorization-in-response-to-health-facility-capacity-constraints-issued-february-23-2022/download

Extra long lengths of stay are increasing as a proportion of hospital stays

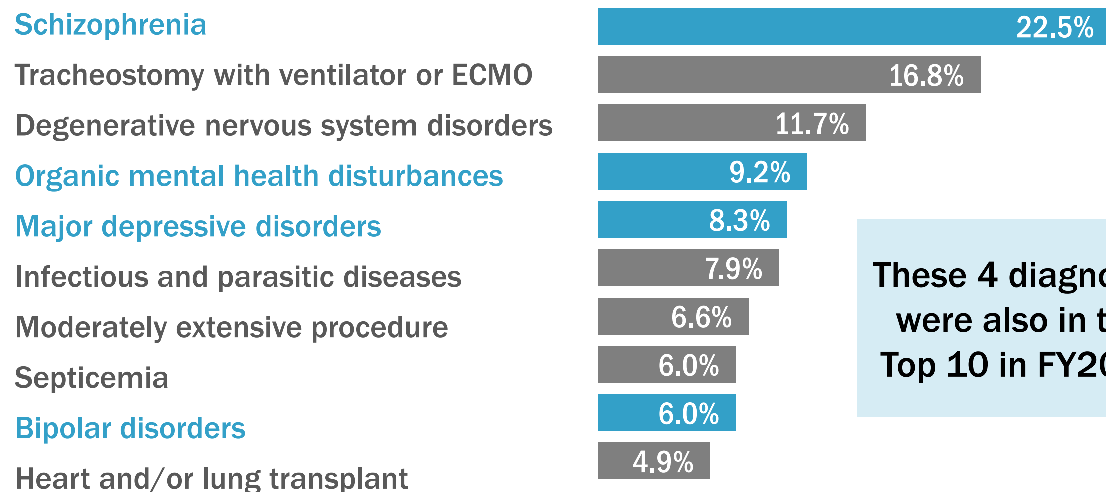
HPC

Characteristics of extra long stays (over 30 days) on a given day, FY2016 and FY2023



BEHAVIORAL HEALTH

4 of the top 10 diagnoses among long stayers are for behavioral health conditions, such as schizophrenia and bipolar disorders.

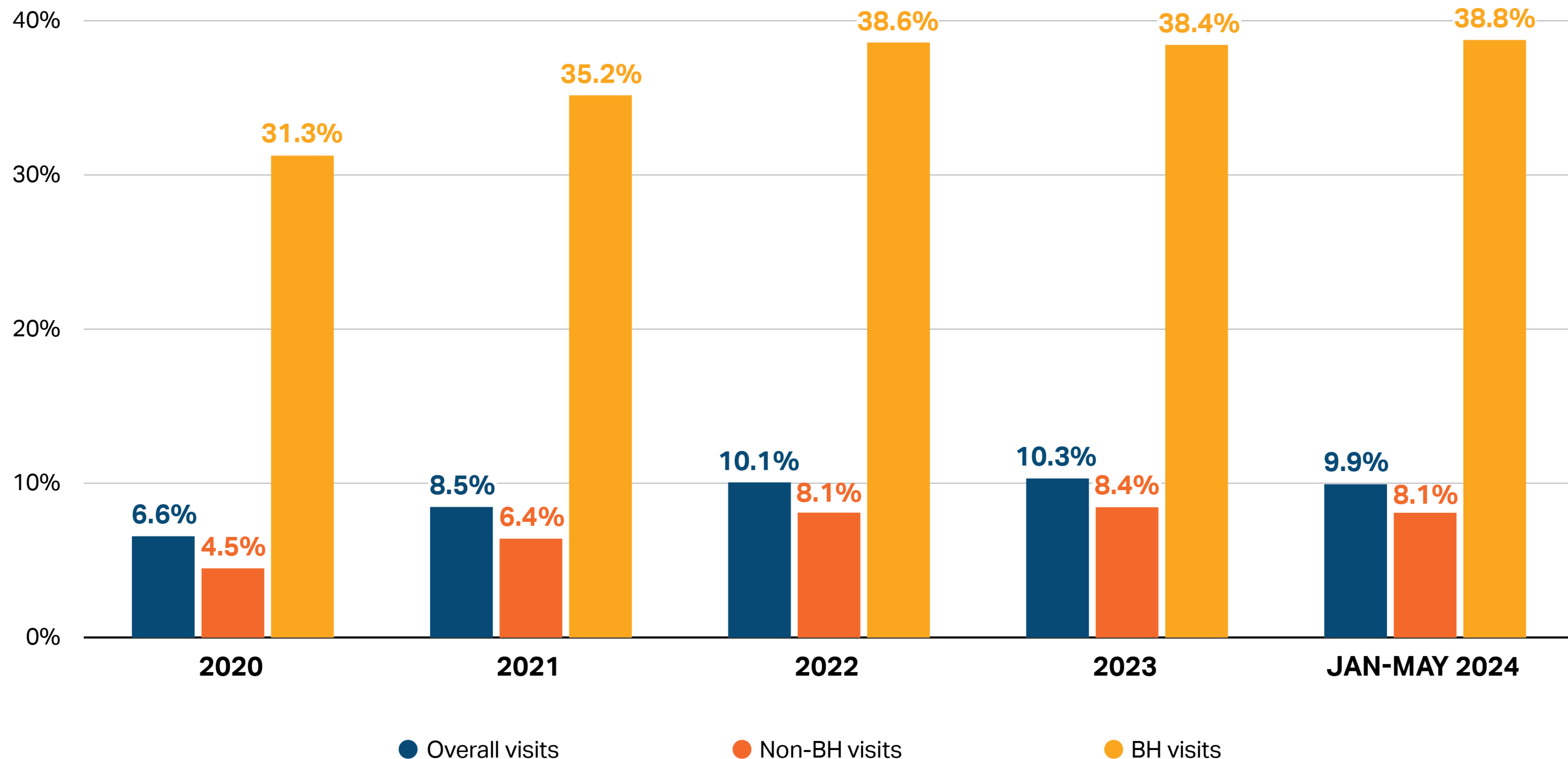


Notes: Data based on characteristics of patients in acute hospital beds on April 1st in each year. Statistics represent those whose stay as of April 1 had exceeded 30 days. Includes all discharges from acute care and specialty hospitals.
Sources: HPC's analysis of Center for Health Information and Analysis (CHIA) Hospital Inpatient Discharge Database, FY2016-FY2023

Long stays are also increasing in the ED. The percent of ED visits that boarded has grown both for BH-related visits and other visits as well.

HPC

Percent of emergency department visits that boarded (visits that were ≥12 hours in the ED) by type of visit, January 2020 to May 2024



Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Analysis includes both "treat and release" ED visits as well as ED visits ultimately admitted to a higher level of care. Does not include visits by non-Massachusetts residents. Behavioral health emergency department visits, observation stays, and inpatient stays were identified using AHRQ's CCSR for the primary diagnosis (BH: MBD001-MBD034).
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix Hospital Inpatient, Observation, and Emergency Department databases, FY2018 to FY2024

The HPC's Behavioral Health-related Emergency Department Boarding Study

Pursuant to Section 145 of Chapter 126 of the Acts of 2022

HPC

- This legislation instructs the Health Policy Commission to conduct an analysis and issue a report on the ongoing effects of the COVID-19 pandemic on behavioral health-related boarding in acute care hospital settings, including but not limited to, boarding in EDs, medical surgical units or observation units.
- The study should include visits that are for mental health, behavioral health, or substance use disorders.
- The study should review:
  - Length of stay, primary reason for wait, and level of care required
  - Type of insurance coverage
  - Payer reimbursement
  - Demographics of patients including race/ethnicity, age, gender, housing status
  - Ability to facilitate care coordination
  - Effects of COVID-19 on length of stay, workforce, and workforce shortages
  - Outcomes and quality of care for patient boarded in acute care hospitals
- The final report will include recommendations on how to address the burden on acute care hospitals and payer reimbursement.

Behavioral health emergency department (ED) boarding has been a continuing crisis in Massachusetts.

HPC

- **ED boarding occurs when patients are held in the emergency department awaiting further treatment such as an inpatient level of care, whether medical or psychiatric.**
  - For most of the analyses in this study, the HPC considers a patient to have experienced behavioral health ED boarding if they have a primary diagnosis of a behavioral health condition and **spend 12 or more hours in the ED**.
  - Other state agencies and organizations have implemented several different definitions of BH boarding to track the ongoing ED boarding crisis.
- Behavioral health ED boarding may occur for several reasons such as:
  - **Delayed psychiatric evaluations, lab tests, and determining level of care needed**
  - **No available inpatient beds** either in acute-care hospitals or freestanding psychiatric hospitals for patients with a need for an inpatient level of care.
  - **Delays in finding appropriate care in the community** for patients who do not need an inpatient level of care.
- Behavioral health ED boarding is not only harmful for these patients and their families, but also impacts the hospital staff, non-BH patients, and emergency medical services.

Behavioral Health Emergency Department Boarding

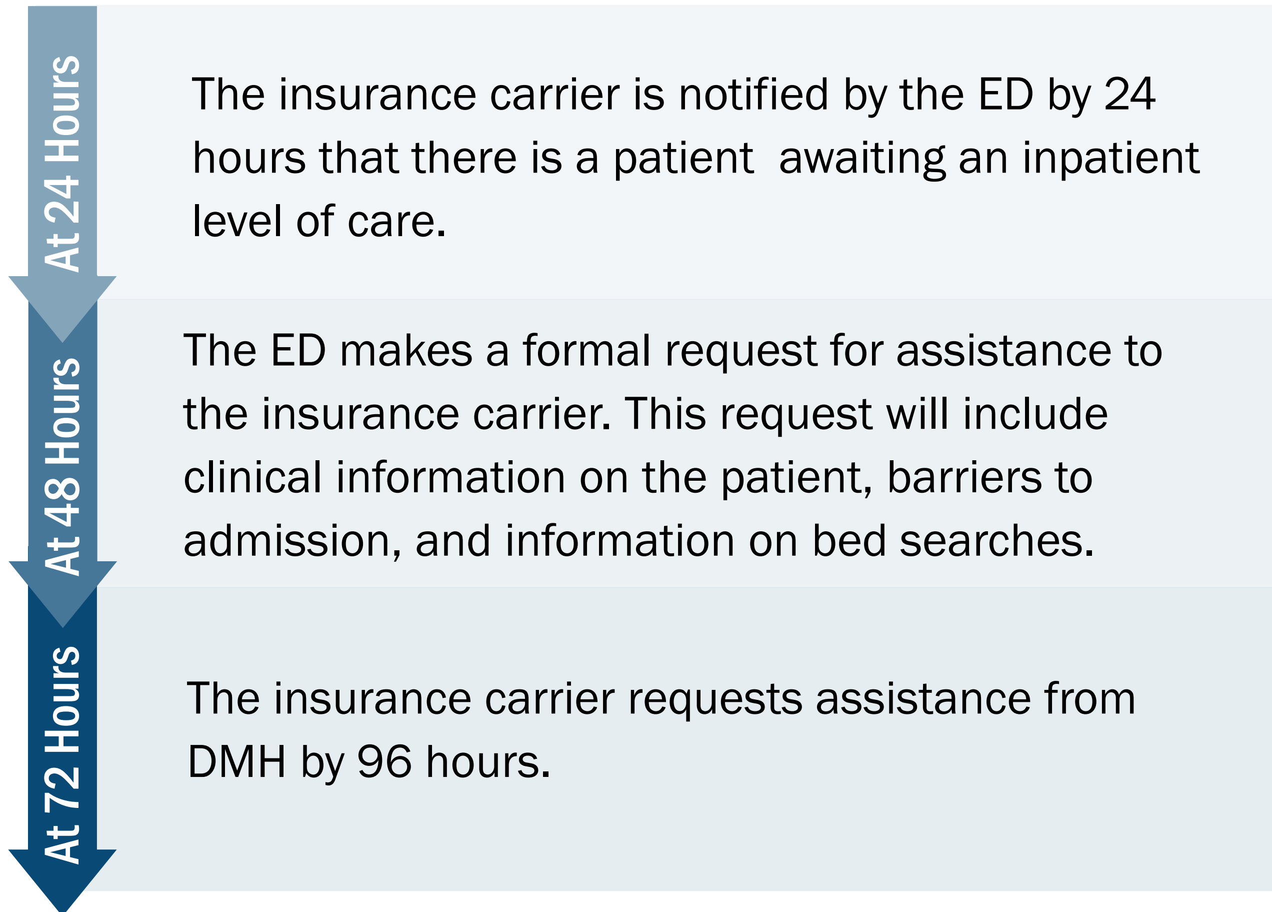
Researchers, state agencies, and organizations representing parts of the health care system have different ways they define behavioral health ED boarding. These definitions vary based on the availability of data and the problem they are trying to understand or address.

- The American College of Emergency Physicians says any patient remaining in the ED for over 4 hours should be considered as “boarding”.
- Massachusetts Hospital Association conducts a weekly “point in time” survey of their hospitals on Monday mornings. They count any patients in the ED or in a med/surg bed needing a BH bed as “boarders”.
- The Expedited Inpatient Admission Protocol (EPIA) was originally developed as part of a 2017 Expedited Admissions Task Force and focused on patients spending 24 or more hours in the ED awaiting an inpatient behavioral health bed.
- Chapter 177 of the Acts of 122 (the ABC Mental Health Act) defines boarding as “waiting not less than 12 hours” to be placed in an appropriate therapeutic setting (inpatient, crisis stabilization, community program, or residential) after being assessed.

Except where otherwise noted, any patient staying 12 hours or more in the ED with a primary behavioral health diagnosis will be counted as experiencing boarding regardless of their discharge destination (e.g. inpatient, home, or observation).

One intervention that has been implemented to address long waits for psychiatric inpatient beds from the ED is the Expedited Psychiatric Inpatient Admissions (EPIA) policy.

Expedited Psychiatric Inpatient Admissions Policy



- Starting in 2018, the EPIA policy was implemented to facilitate the placement of patients in need of inpatient psychiatric hospitalization. This policy was developed through a task force that included: carriers, providers, hospital & carrier trade associations, professional associations, and several state agencies.
- The policy sets clear steps and responsibility for escalating cases where placement has not been achieved in a reasonable period of time to insurance carriers, inpatient psychiatric units, and, ultimately, the Massachusetts Department of Mental Health (DMH).

Sources: Massachusetts Executive Office of Health and Human Services. Expedited Psychiatric Inpatient Admission (EPIA) Policy. Available at: https://www.mass.gov/info-details/expedited-psychiatric-inpatient-admissions-epia-policy

The monthly number of referrals to the EPIA has decreased since 2022.

Number of referrals to the Expedited Psychiatric Inpatient Program, January 2021 – October 2024

Source: Massachusetts Executive Office of Health and Human Services. Expedited Psychiatric Inpatient Admission (EPIA) Dashboards. EPIA External Report October 2024. Available at: https://www.mass.gov/lists/expedited-psychiatric-inpatient-admission-epia-dashboards.

- The EPIA protocol only applies to patients who are determined to need an inpatient level of care and have spent at least 24 hours in the ED.
- In October 2024, there were 216 referrals through the EPIA policy, with an average time to placement of 2.3 days[1]
- Of those referrals, 42.6% were insured by MassHealth ACO/MCO, 21.8% were dually-insured by MassHealth & Medicare, and 7.9% were commercially-insured.

Other state efforts aimed at improving BH ED boarding

HPC

- The Massachusetts launched the **Behavioral Health Help Line** and a statewide network of **Community Behavioral Health Centers** in 2023. These efforts were part of the Commonwealth's **Roadmap for Behavioral Health Reform.**[1]
  - The goal is to get Massachusetts residents "the mental health and substance use care they need, when and where they need it."
  - CBHCs are open 24 hours a day and are an alternative to the ED for certain patients in behavioral health crisis, regardless of insurance or ability to pay.
  - Some patients will still need to seek care at an ED after visiting a CBHC if they are determined to need an inpatient bed and there are none available, or if patients are told they need additional medical clearance.
- DOI issued an additional bulletin during COVID and an increase in ED boarding to emphasize the importance of the EPIA process for commercial insurers and hospital providers including arranging payments for specialty needs (known as "specialing"). This could include additional services such as an individual room or 1:1 staff/patient ratio. [2]

Sources: (1) Massachusetts Executive Office of Health and Human Services. Roadmap for Behavioral Health Reform. Available at: https://www.mass.gov/roadmap-for-behavioral-health-reform. (2) DOI Bulletin 2021-07 "Updated Protocols for the Prevention of Emergency Department Boarding of Patients under EPIA Protocols"

The HPC identified patients with BH-related ED boarding using inpatient, observation, and emergency department data.

DATA SOURCE

- Massachusetts Center for Health Information and Analysis (CHIA) Massachusetts Acute Care Hospital Case-Mix Databases:
  - Hospital Inpatient, Observation, Emergency Department Discharge Data
- Massachusetts All-Payer Claims Database
  - Commercial & MassHealth (mental health diagnoses only)

ANALYIC NOTES

- **Population:** Massachusetts residents with an emergency department visit or an inpatient or observation stay that was admitted through the ED
- **Linkage to APCD:** Case-mix data was linked to APCD data to estimate spending and examine follow-up care for patients who seek care in the ED for a mental health problem.
- **Exclusions:** Several hospitals were excluded for analyses based on poor data quality for ED length of stay. MGB hospitals were excluded prior to 2023 due to incorrect submission of observation stays as ED visits.

By May 2024, nearly half of mental health-related ED visits boarded.

Percent of behavioral health-related ED visits that boarded (visits that were ≥12 hours in the ED) by type of visit, January 2020 to May 2024

Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Analysis includes both "treat and release" ED visits as well as ED visits ultimately admitted to a higher level of care. Does not include visits by non-Massachusetts residents. Behavioral health ED visits, observation stays, and inpatient stays were identified using AHRQ's CCSR for the primary diagnosis. BH visits were identified using CCSR categories MBD001-MBD034, MH visits were identified using CCSR categories MBD001-MBD013 and MBD027, and SUD visits were identified using MBD017-MBD025 and MBD028-MBD033. Visits with diagnosis codes identified as MBD026 or MBD034 were categorized as mental health-related or substance use disorder-related based on categorizations from CHIA *Massachusetts Acute Care Hospital Emergency Department Data – Quarterly Update* methodology (November 2023).
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix databases, FY2018 to FY2024

Residents who boarded during a BH ED visit were more often covered by MassHealth, Asian, Black, or Hispanic, and living in the lowest income communities.

Characteristics of Massachusetts residents who boarded during a behavioral health-related ED visit, 2023

11%

were children aged 0-17

10% of BH ED visits overall were children

33%

were Asian, Black, Hispanic, or a race other than White

33% of BH ED visits overall were among residents of color

56%

were male

59% of BH ED visits overall were among male residents

49%

had health insurance coverage through MassHealth

47% of BH ED visits overall were covered by MassHealth

35%

lived in the lowest income communities

34% of BH ED visits overall were among residents in the lowest-income communities

17%

did not have permanent housing

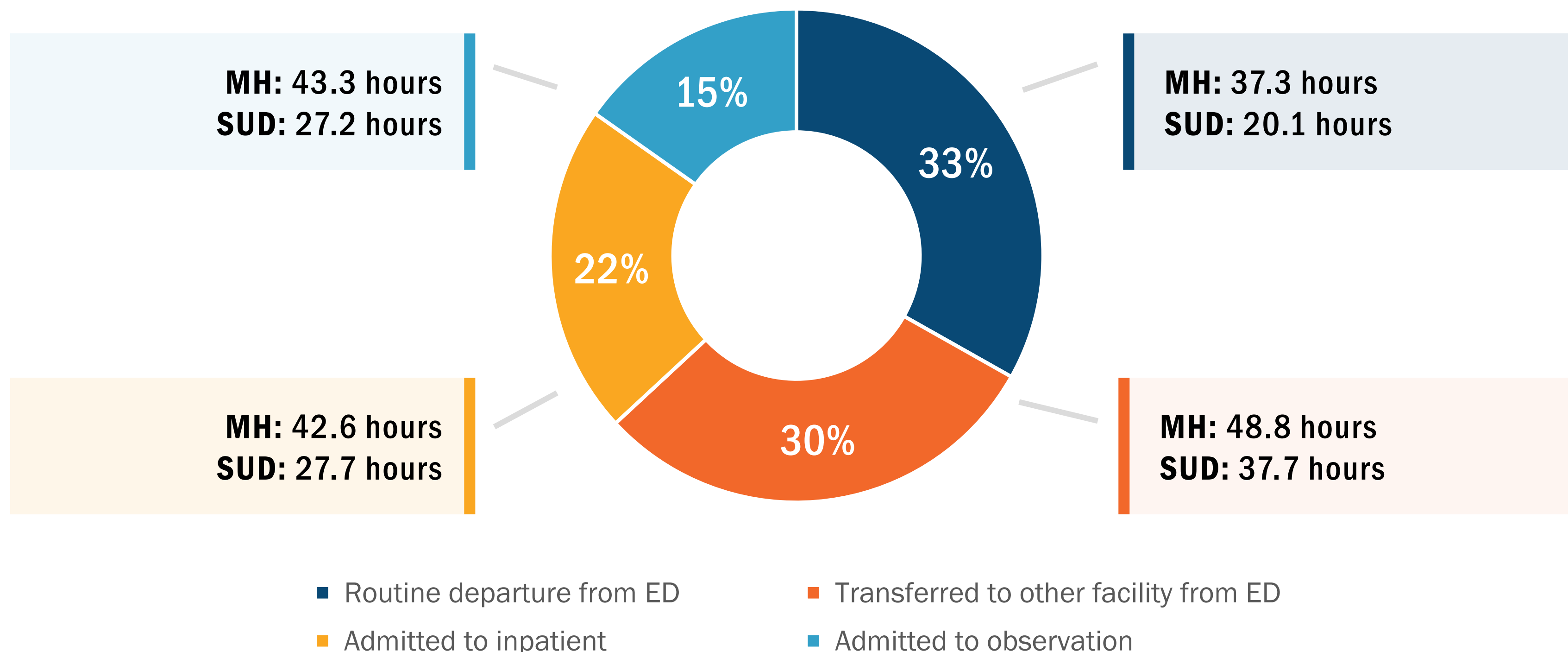
17% of BH ED visits overall were among residents without permanent housing

Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Analysis includes both "treat and release" ED visits as well as ED visits ultimately admitted to a higher level of care. Does not include visits by non-Massachusetts residents. Behavioral health ED visits, observation stays, and inpatient stays were identified using AHRQ's CCSR for the primary diagnosis. BH visits were identified using CCSR categories MBD001-MBD034, MH visits were identified using CCSR categories MBD001-MBD013 and MBD027, and SUD visits were identified using MBD017-MBD025 and MBD028-MBD033. Visits with diagnosis codes identified as MBD026 or MBD034 were categorized as mental health-related or substance use disorder-related based on categorizations from CHIA *Massachusetts Acute Care Hospital Emergency Department Data – Quarterly Update* methodology (November 2023). Lowest income communities are zip codes with median income in the first income quintile, based on the 2022 American Community Survey (ACS). MassHealth category includes MassHealth, self pay, free care, health safety net, and CommonwealthCare/ConnectorCare plans.
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix databases, FY2018 to FY2024

Approximately a third of patients that experience BH ED boarding are discharged directly from the ED and not sent to a higher level of care. This has remained consistent over time.

HPC

Behavioral health-related ED visits that boarded (visits that were ≥12 hours in the ED) by departure status and average lengths of stay (hours), 2023



- Routine departure from the ED (i.e., discharge home) differed by type of BH ED visit. For mental health-related ED visits, 26% were discharged home, while 42% of substance use disorder-related visits were discharged home.
- Observation services are hospital outpatient services that a patient receives while awaiting an admission decision. Depending on the hospital, patients may still be in the ED or in separate area.[1]
- Some hospital stakeholders indicated that they would move BH patients in the ED to observation status when it was clear that a patient would not have an inpatient bed within 24 hours.

Notes: Visits that left against medical advice, eloped, or had another departure from the ED accounted for approximately 1% of visits each year and are not shown. The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Analysis includes both "treat and release" ED visits as well as ED visits ultimately admitted to a higher level of care. Does not include visits by non-Massachusetts residents. Behavioral health ED visits, observation stays, and inpatient stays were identified using AHRQ's CCSR for the primary diagnosis. BH visits were identified using CCSR categories MBD001-MBD034, MH visits were identified using CCSR categories MBD001-MBD013 and MBD027, and SUD visits were identified using MBD017-MBD025 and MBD028-MBD033. Visits with diagnosis codes identified as MBD026 or MBD034 were categorized as mental health-related or substance use disorder-related based on categorizations from CHIA *Massachusetts Acute Care Hospital Emergency Department Data – Quarterly Update* methodology (November 2023).
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix databases, FY2018 to FY2024. (1) Medicare.gov. Inpatient or outpatient hospital status affects your costs. Available at: https://www.medicare.gov/coverage/inpatient-hospital-care/inpatient-outpatient-status.

Among adults ultimately admitted to an inpatient psychiatric bed at an acute care hospital, more than half spent over 24 hours in the ED in 2022. That proportion has declined recently.

Time until admission to a psychiatric bed among behavioral health-related ED visits for adults, January 2020 to May 2024

	2020	2021	2022	2023	JAN-MAY 2024
60+ hours	8%	13%	17%	13%	9%
24-60 hours	28%	34%	35%	33%	31%
0-24 hours	64%	52%	47%	54%	60%

Notes: Only includes admissions to psychiatric beds in acute care hospitals. Analysis includes both “treat and release” ED visits as well as ED visits ultimately admitted to a higher level of care. Does not include visits by non-Massachusetts residents. Behavioral health ED visits, observation stays, and inpatient stays were identified using AHRQ's CCSR for the primary diagnosis (MBD001-MBD034).
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix databases, FY2018 to FY2024

Among children who were ultimately admitted to a psychiatric bed in an acute care hospital, the proportion staying in the ED more than 24 hours has steadily increased to 47% in 2024.

Time until admission to a psychiatric bed among behavioral health-related ED visits for children, January 2020 to May 2024

	0-24 hours	24-48 hours	48+ hours
2020	71%	22%	7%
2021	58%	27%	15%
2022	55%	24%	21%
2023	56%	24%	20%
JAN-MAY 2024	53%	28%	20%

Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Analysis includes both "treat and release" ED visits as well as ED visits ultimately admitted to a higher level of care. Does not include visits by non-Massachusetts residents. Behavioral health ED visits, observation stays, and inpatient stays were identified using AHRQ's CCSR for the primary diagnosis (MBD001-MBD034).
Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix databases, FY2018 to FY2024

In the past several years, state policies have been updated to increase payments and services for patients experiencing emergency department boarding.

INPATIENT PAYMENT POLICIES

- MassHealth and several commercial payers pay on a **per diem basis starting the day of their ED visit** for patients who end up admitted to an inpatient stay. As of 2022, HPC has identified only one major commercial payer that currently pays for BH stays on a per stay (e.g. DRG) basis.
  - For example, the spending related to boarding for the majority of commercial and MassHealth BH inpatient stays will add on to the inpatient stay as a visit (e.g., if a patient came to the ED on Saturday, was moved to inpatient on Tuesday, and discharged Friday the total inpatient stay would be 7 days at the per diem rate).
- Medicare pays per diem for stays at inpatient psychiatric facilities and per stay for BH stays at acute care hospitals.

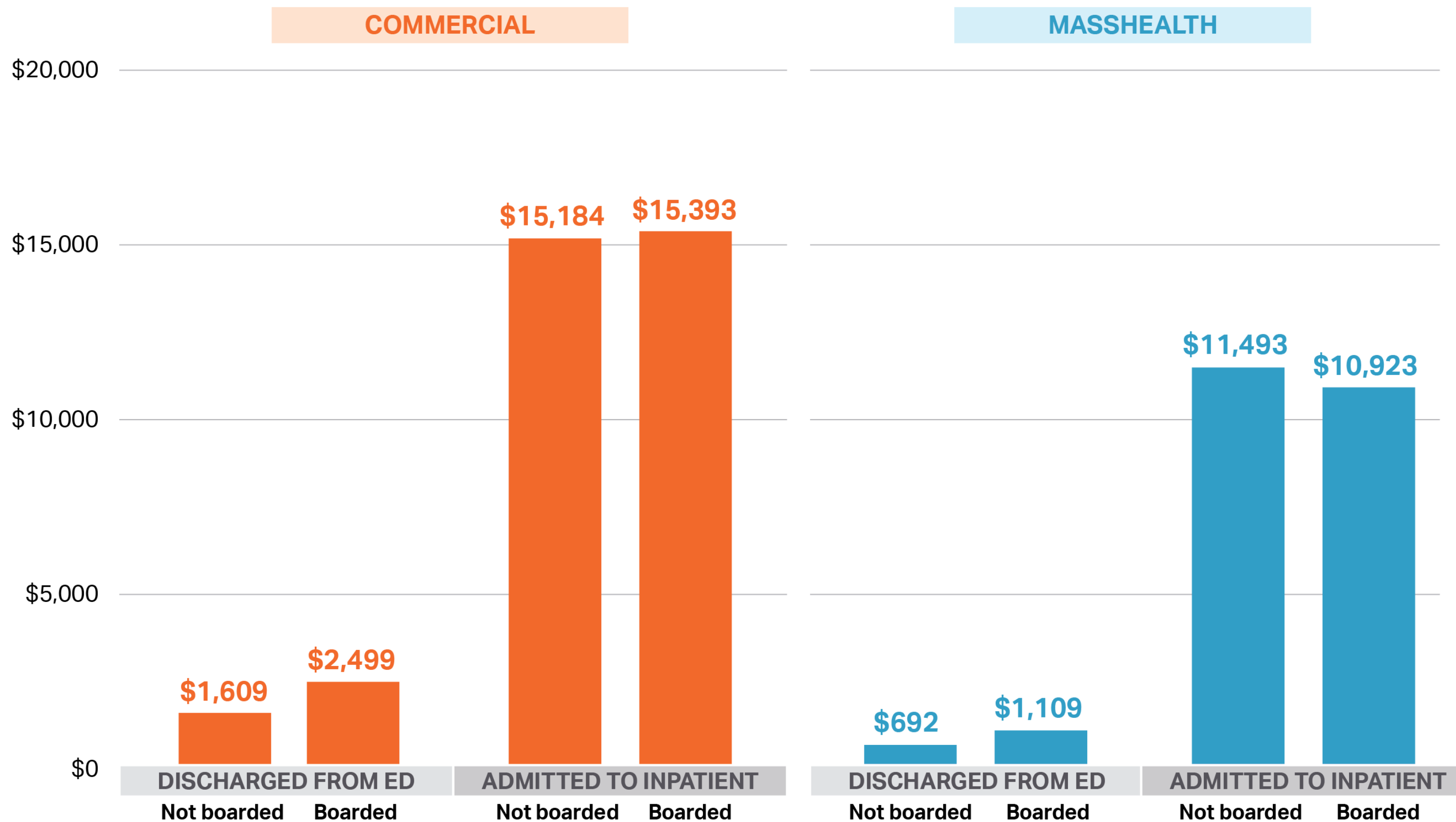
PAYMENT POLICIES RELATED TO BH ED BOARDING

- As of January 2023, MassHealth managed care entities pay hospitals directly for crisis evaluations instead of requiring patients to be first evaluated by Emergency Service Providers (ESP) and Mobile Crisis Intervention (MCI) teams to determine the right level of care. This payment is in addition to the standard ED payment (e.g. for facility and professional services in the ED). [1]
- As of September 2023, in accordance with the *ABC Mental Health Act,* section 78 of chapter 177 of the Acts of 2022 [2], the Division of Insurance expects commercial **carriers to reimburse acute care hospitals for ongoing monitoring and stabilization for patients awaiting inpatient psychiatric placement** at a rate "at least equivalent to crisis intervention services as reimbursed by MassHealth". [3]
- As of October of 2022, MassHealth pays an additional per admission rate for weekend admissions and admissions for harder-to-place patients such as children.[1]
  - Stakeholders noted that finding inpatient placements on weekends and holidays was especially challenging.

Sources: (1) MassHealth Managed Care Entity Bulletin 93, November 2022. (2) Mass General Laws Chapter 177 of the Act of 2022 Section 78. (3) DOI Bulletin 2022-08 Reimbursing Acute Care Hospitals for Services Provided to Behavioral Health Patients Awaiting Psychiatric Inpatient Admissions.

Both commercial payers and MassHealth paid more for ED visits that boarded and were ultimately discharged from the ED (55% and 60% more, respectively). Commercial patients had similar spending for inpatient admissions, regardless of boarding status.

Median allowed amounts for mental health-related ED episodes among commercially-insured and MassHealth-insured residents by admission and boarding status, 2022

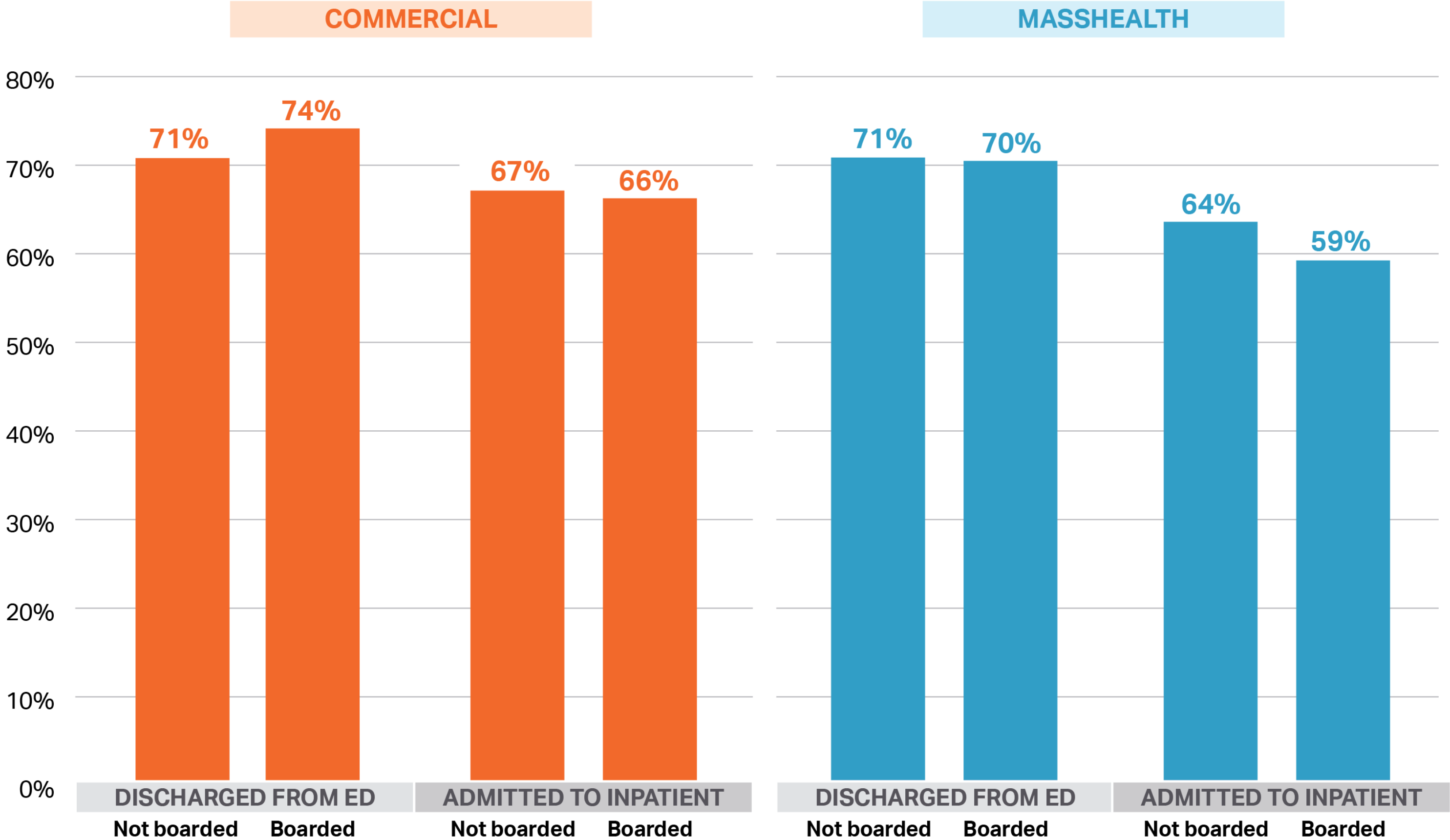


- The higher spending for boarded patients among those discharged home from the ED is consistent with HPC expectations.
- The fact that observed spending is not higher for boarded patients who are ultimately admitted to an inpatient stay is still being explored.

Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Mental health-related emergency department visits were defined as any ED visit or observation or inpatient stay that resulted from an ED visit with a primary diagnosis code in AHRQ CCSR categories MBD001-MBD013 or MBD027 in the Case Mix datasets. Data shown are for ED visits from the Case Mix databases that were matched (same person, same date) to commercial or MassHealth APCD claims data.
Sources: HPC analysis of Massachusetts Acute Case-Mix Databases, CY2022, All-Payer Claims Database, V2022, 2022.

Regardless of boarding status or payer, patients discharged from the ED were more likely to receive additional services within 7 days than those who had an inpatient stay.

Percent of mental health-related ED episodes that incurred at least one medical claim for any service within seven days by boarding status and discharge destination, 2022



Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Restricted to residents with 12 months of coverage in 2022. Mental health-related ED visits were defined as any ED visit or observation or inpatient stay that resulted from an ED visit with a primary diagnosis code in AHRQ CCSR categories MBD001-MBD013 or MBD027 in the Case Mix datasets. Data shown are for ED visits from the Case Mix databases that were matched (same person, same date) to commercial or MassHealth APCD claims data.
Sources: (1) HPC analysis of Massachusetts All-Payer Claims Database, V2022, 2022. (2). Center for Health Information and Analysis. Quality of Care in the Commonwealth: Select Clinical Quality and Patient Experience Measures: 2020-2022. August 2024. Available at: https://www.chiamass.gov/a-focus-on-provider-quality-selected-clinical-measures.

- A recent CHIA report on quality of care found that 77.0% of members aged 6 years of age and older with an ED visit for mental illness had a follow-up visit for mental illness within seven days of their ED visit.
- For those who were hospitalized for mental illness, CHIA reported 62.1% had a follow-up visit by a mental health provider within seven days of their discharge.[2]

Additional ED Boarding Study Analyses and Behavioral Health Reporting

The HPC's full report will also include:

- Information on behavioral-health related boarding in other states and other state policies to address BH ED boarding
- More information from stakeholder meetings, including resources provided by health plans to care for boarders, the impact on acute care hospitals, the ability to facilitate care communication, and the impact of workforce on ED boarding
- Policy recommendations

Additional upcoming studies will also help understand BH ED boarding in the Commonwealth:

- Behavioral Health Access Line and Behavioral Health Crisis Intervention
- Pediatric Behavioral Health Planning Report
  - This report will also include BH Treatment and Referral Platform data from PointClickCare. The platform is intended to reduce BH ED boarding times by facilitating inpatient placement.[1]

HPC will continue to monitor and research hospital capacity.

Sources: (1) https://www.hcinnovationgroup.com/population-health-management/behavioral-health/news/53067802/pointclickcare-to-develop-massachusetts-behavioral-health-treatment-referral-platform

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Executive Session **(VOTE)**

Guest Presentation from the Office of the Attorney General: Findings from the AGO Cost Trends Report – Assistant Attorney General Lisa Gaulin and Assistant Attorney General Chloe Cable

HPC Evaluation of Mass General Brigham's Performance Improvement Plan

Mass General Brigham's Performance Improvement Plan **(VOTE)**

Research Presentation: Behavioral Health Emergency Department Boarding in Massachusetts

EXECUTIVE DIRECTOR'S REPORT

Adjourn

Since 2013, the HPC has reviewed 184 market changes.

TYPE OF TRANSACTION	NUMBER	FREQUENCY
Physician group merger, acquisition, or network affiliation	41	22%
Formation of a contracting entity	40	22%
Clinical affiliation	36	20%
Acute hospital merger, acquisition, or network affiliation	31	17%
Merger, acquisition, or network affiliation of other provider type (e.g., post-acute)	30	16%
Change in ownership or merger of corporately affiliated entities	5	3%
Affiliation between a provider and a carrier	1	1%

Cost and Market Impact Reviews in Progress

A proposed clinical affiliation between **Dana-Farber Cancer Institute**, **Beth Israel Deaconess Medical Center**, and the **Harvard Medical Faculty Physicians**. On May 23, 2024, the HPC formally initiated the CMIR process.

Timeline for Cost and Market Impact Report (CMIR) Review

Transaction parties submit material change notices and relevant information

30 DAYS — HPC conducts initial review of completed material change notice.

HPC Board authorizes initiation of CMIR and provides notice to parties.

21 DAYS* — Parties respond to and substantially comply with HPC information requests.

CMIR Initiated May 23, 2024

74 – 104 DAYS — HPC staff conduct CMIR, interchange with parties and stakeholders, and provide regular updates to HPC committees and Board.

WE ARE HERE

HPC issues preliminary report.

UP TO 30 DAYS — Parties may respond.

UP TO 30 DAYS — HPC staff review responses and develop final report.

HPC Board votes to issue final report, with or without referrals**

* The parties may request extensions to this timeline which may likewise affect the timing of the report

** The parties must wait 30 days following the issuance of the final report to close the transaction

Elected Not to Proceed

- The proposed sale of Steward subsidiary **Stewardship Health**, the parent of Stewardship Health Medical Group, which employs primary care and other clinicians across nine states, and Steward Health Care Network, a provider contracting network, to **Brady Health Buyers, LLC**, an affiliate of Rural Healthcare Group and subsidiary of Kinderhook Industries.
- The proposed creation of **Northeast Orthopaedic Alliance** and an affiliated management services organization by four existing orthopedic group practices in Massachusetts and New Hampshire: Boston Sports and Shoulder Center, EONE Medical, EONE Medical Subsidiary, and New England Orthopedic Surgeons.
- A proposed contracting affiliation between **Mass General Brigham** and **Healthcare South**, a for-profit Family Practice, Internal Medicine, and Pediatric Primary Care practice with nine locations in the South Shore and which is currently a contracting affiliate of Tufts Medicine Integrated Network.

Elected Not to Proceed (cont.)

- The proposed acquisition of **Alden Court Nursing Care & Rehabilitation Center**, a 142-bed licensed nursing facility in Fairhaven owed by for-profit Gordon Operating Company, LLC, by **Southcoast Health System**, a non-profit healthcare system that includes St. Luke's, Charlton Memorial, and Tobey hospital campuses.
- The proposed acquisition of **Rotech Healthcare, Inc.**, a national provider of home medical equipment, by **Owens & Minor, Inc.**, a national manufacturer and distributor of medical supplies.

Material Change Notices Currently Under Review

- The proposed acquisition of **Vibra Hospital of Western Massachusetts**, the for-profit owner and operator of both an inpatient long term acute care hospital and a skilled nursing facility in Rochdale, Massachusetts, by **Everest Hospital, LLC**, a newly formed Massachusetts corporation in coordination with Nielk Equities, LLC.

RECEIVED SINCE 10/10/2024

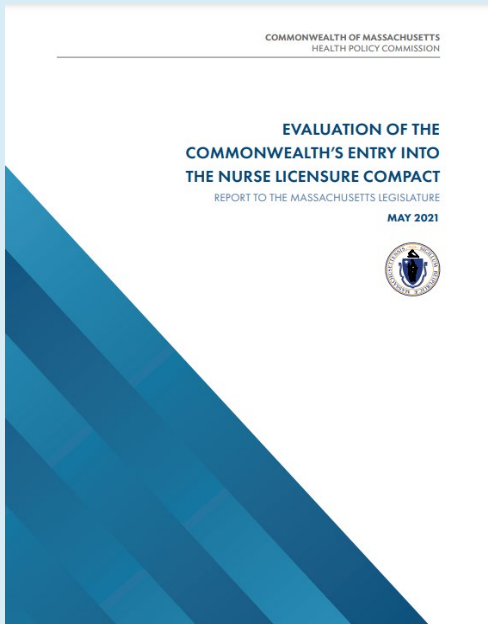
- The proposed acquisition of **Springfield Anesthesia Service, Inc.**, a privately owned physician practice located in Western Massachusetts specializing in anesthesia delivery, by **Baystate Medical Practices**, a subsidiary of Baystate Health.
- The proposed acquisition of **Commonwealth Pathology Partners, P.C.**, a private practice pathology group employing 16 clinical and laboratory pathologists and additional pathology staff, by **Mass General Brigham**.

Health Care Workforce Update: Background on the Nurse Licensure Compact

- The Nurse Licensure Compact ("NLC" or "Compact") is an **interstate compact** that allows eligible **registered nurses** ("RNs") and **licensed practical nurses** to hold a multi-state license to practice in their home state and all other Compact states.
- Nurses are required to be licensed to practice where their patient is located at the time services are provided. A Compact license enables nurses to provide care **in person or via telehealth** to patients in any Compact state, subject to each state's practice laws and subject to continued residency in the license-issuing state.
- The National Council of State Boards of Nursing ("NCSBN") developed and released the original NLC in 1999; an enhanced version was enacted in 2017 and implemented in 2018.
- The NCSBN and Compact administrators **identify numerous benefits** of the NLC, e.g., it expands access to care, enables telehealth practice, facilitates disaster relief, is cost effective for nurses and providers, addresses access for rural populations and areas of healthcare shortages, and provides administrative efficiency.
- A **state must enact legislation** to authorize the Compact, as well as undertake any administrative efforts required for implementation.

Recap: HPC Report Evaluating the Commonwealth's Entry into the NLC (2021)

HPC



- **Legislative Report.** As required by **Chapter 227 of the Acts of 2020**, the HPC, in consultation with the Board of Registration in Nursing ("BORN"), conducted a multi-faceted analysis and issued the following report: *Evaluation of the Commonwealth's Entry into the Nurse Licensure Compact*.[1]

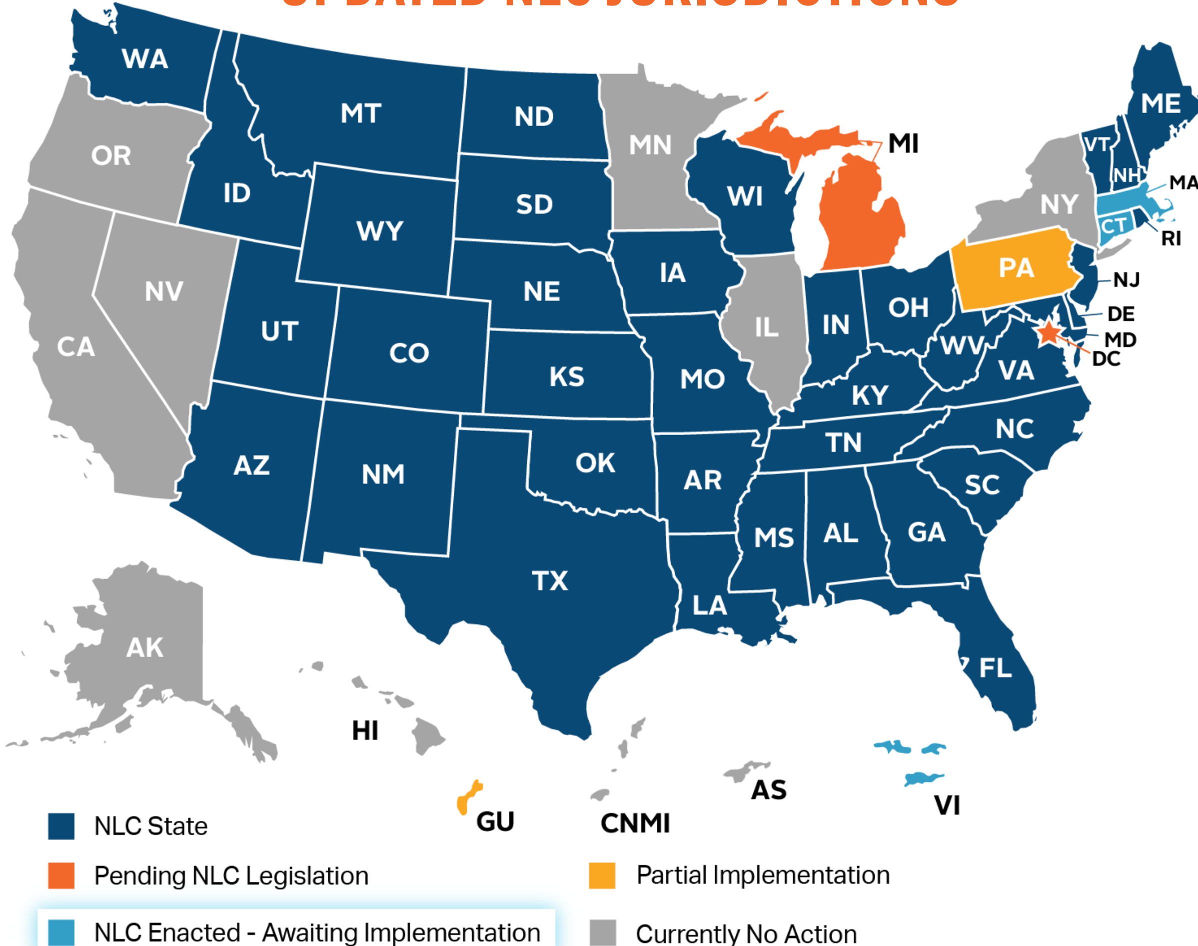
- **Summary.** Among other benefits, the analysis found that membership in the NLC would likely:
  - Enhance the MA health care industry's ability to **prepare for emergencies** and other **unforeseen and sudden staffing needs**
    - *Note: this finding may be particularly important in light of slower projected growth of the Massachusetts RN workforce relative to other states*[2]
  - Facilitate the provision of **telehealth** and other care delivery transformations
  - Benefit the state **nursing board, employers,** and **nurses**

  Further, there was no evidence that joining would negatively affect nursing care quality in MA.

- **Conclusion.** Given the key findings presented in the report, the **HPC recommended that the Massachusetts legislature enact legislation enabling Massachusetts to join the Compact.**

1 The HPC's May 2021 presentation to the Board on the report is available here (slides 46-57).
2 Health Resources Services Agency: https://data.hrsa.gov/topics/health-workforce/workforce-projections

NEW: Massachusetts Becomes the 41st State to Enact the Nurse Licensure Compact



Current as of December 4, 2024
Source: https://www.nursecompact.com

- Since the HPC's report, the number of states that have joined the NLC increased from 34 to 40.[1] Most notably, **Vermont**, **Rhode Island**[2], and **Connecticut** enacted the NLC in 2021, 2023, and 2024 (respectively), leaving MA as the sole non-Compact state in New England.
- On November 20, 2024, Governor Maura Healey signed *An act relative to strengthening Massachusetts' economic leadership* into law (Chapter 238 of the Acts of 2024), which **enacts the NLC in Massachusetts** through the creation of Chapter 112A[3].
- Anticipated **next steps** include guidance from BORN regarding implementation (including timeline, necessary process updates, etc.).

[1] There were a total of 35 participating jurisdictions at the time of HPC's report. Just prior to MA's enactment, there were 42 total participating jurisdictions.
[2] Rhode Island was an original NLC member until 2018 and rejoined in 2023.
[3] Sections 14, 227, 229, and 287

HPC 2024 Cost Trends Hearing: Opening Remarks from Governor Maura Healey and Attorney General Andrea Campbell

"I am prepared to ensure that the next generation does better than the last, especially when it comes to health outcomes…You have a partner in the AG's office, and we are here to work and get things done on behalf of the people."

Attorney General Andrea Joy Campbell outlined her priorities for the upcoming legislative session, including **increased oversight and accountability** to ensure that agencies like the HPC have the authority needed to protect Massachusetts consumers.

Governor Maura Healey acknowledged the ongoing challenges that residents of the Commonwealth face due to **increasingly unaffordable and inaccessible health care**. She stressed the importance of **bold and innovative action** to continue expanding access to equitable and affordable health care.

"We got an historically bad operator out of Massachusetts, and we saved six hospitals that were at risk of closing."

HPC 2024 Cost Trends Hearing: The Path to a More Affordable, Accessible, and Equitable Health Care System Witness Panels 1 and 2

What Comes Next? The Future of the Former Steward Hospitals and Physician Network

> "The state stepped forward to help these acquirers to keep services going. But what is important is the underlying financial model of these institutions given they are receiving significant funding from the state."
>
> — Dr. Alastair Bell

Putting Patients First: Voices of Impacted Providers, Workers, and Communities on Recent Disruptions

> "This breaking point presents us with an opportunity to evaluate the entire ecosystem of our healthcare system and make structural changes to the ways in which care is delivered and paid for."
>
> — Dr. Bisola Ojikutu

HPC 2024 Cost Trends Hearing: The Path to a More Affordable, Accessible, and Equitable Health Care System Witness Panels 3 and 4

From Crisis to Stability: Industry Leaders on the Threats and Opportunities Facing the Commonwealth's Health Care System

"We should set a benchmark with teeth, set an audacious goal and try to control costs... Our ability to be innovative about that is the only thing that will fix this."

— Eileen Auen

The Cost of Inaction: Building Consensus on Policy Solutions to Achieve Health Care Affordability, Accessibility, and Equity for All

"When there are issues with the system and crises unfold, we need to involve impacted communities in a genuine way from the beginning of the process."

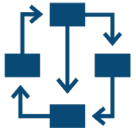
— Amy Rosenthal

Future Priority Areas for Discussion

HPC

Promoting Affordability

Strengthening Primary Care



Proactive Planning of Health System Supply and Distribution

Protecting Health Market from Predatory Actors

Addressing Health Care Workforce Challenges

Advancing Health Equity

Health System Capacity Constraints and Patient Throughput Challenges

Evolving Value Based Care and Patient Centered Care Models

Examining Pharmaceutical Pricing Trends and PBMs

Reducing Unnecessary Administrative Complexity

HPC Summer Fellowship Program

- In 2024, the HPC hosted 7 fellows from 5 graduate programs in public health, research, and law across the country.
- The HPC Summer Fellowship is a 10-week paid opportunity for graduate students with an interest in health policy.
- Summer Fellows work alongside colleagues in each HPC department to complete a standalone research project or other deliverable.
- Applications for the 2025 Summer Fellowship Program will be accepted beginning **December 20**.

masshpc.gov/about/job-opportunities

MASSACHUSETTS
HEALTH POLICY COMMISSION

2024: BY THE NUMBERS

PUBLIC ENGAGEMENT AND OUTPUTS

80+
news articles mentioning the HPC and
1
TV interview on "@Issue" NBC Boston

18
publications and videos

14K
total users on masshpc.gov since its launch in July

24
press releases and statements

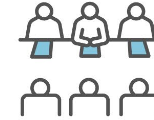
MEETINGS AND CONFERENCES

17
public meetings convened by the HPC

872
slides presented in HPC public meetings

6
posters and
1
podium presentation at AcademyHealth's 2024 Annual Research Meeting

8
additional invited presentations and panel discussions



COST TRENDS HEARING

~3k
views of the Cost Trends Hearing livestream

1.5K
views of the Cost Trends Hearing page

17
panelists (11 new panelists)

37
pieces of pre-filed, oral, and written testimony

MASSACHUSETTS
HEALTH POLICY COMMISSION

2024: BY THE NUMBERS

MARKET OVERSIGHT

21
new Material Change Notices

5
transaction reviews were closed on the same day

1st
Performance Improvement Plan evaluation completed

48
expected registrants for RPO

PARTNERSHIPS

5
HEART-BP awardees selected to receive a combined total of
$1,498,861

2
C4SEN awardee programs sustained through additional state funding

132
total birthing people enrolled for doula services and
117
total babies birthed through BESIDE

42
Behavioral Health Workforce Center stakeholder meetings

OFFICE OF PATIENT PROTECTION

343
health insurance external review requests

4
ACO/RBPO external review requests

874
open enrollment waiver requests

1,476
calls to the OPP hotline

Agenda

Call to Order

Approval of Minutes **(VOTE)**

Executive Session **(VOTE)**

Guest Presentation from the Office of the Attorney General: Findings from the AGO Cost Trends Report – Assistant Attorney General Lisa Gaulin and Assistant Attorney General Chloe Cable

HPC Evaluation of Mass General Brigham's Performance Improvement Plan

Mass General Brigham's Performance Improvement Plan **(VOTE)**

Research Presentation: Behavioral Health Emergency Department Boarding in Massachusetts

Executive Director's Report

ADJOURN