MINUTES OF THE HEALTH POLICY COMMISSION

Meeting of June 10, 2020

MASSACHUSETTS HEALTH POLICY COMMISSION

Date of Meeting: June 10, 2020

Start Time: 12:01 PM

End Time: 2:08 PM

	Present?	ITEM 1: Approval of Minutes	ITEM 2: 2021 Cost Growth Benchmark	ITEM 3: MassUp Awardee Selection
Stuart Altman*	X	X	X	X
Don Berwick	X	X	X	M
Barbara Blakeney	X	X	X	2nd
Martin Cohen	X	X	X	X
David Cutler	X	2nd	X	X
Timothy Foley	X	X	2nd	X
Chris Kryder	X	X	N	X
Rick Lord	X	X	M	X
Ron Mastrogiovanni	X	M	X	X
Sec. Marylou Sudders	X	X	X	X
Sec. Michael Heffernan	X	X	X	X
Summary	**11 Members Attended**	**Approved with 11 votes in the affirmative**	**Approved with 10 votes in the affirmative**	**Approved with 10 votes in the affirmative**

Presented below is a summary of the meeting, including time-keeping, attendance, and votes.

*Chairman

(M): Made motion; (2nd): Seconded motion; (ab): Abstained from Vote; (A): Absent from Meeting

Proceedings

A virtual meeting of the Health Policy Commission (HPC) was held on June 10, 2020, at 12:00 PM. A recording of the meeting is available here. Meeting materials are available on the Board meetings page here.

Participating commissioners included: Dr. Stuart Altman (Chair), Mr. Martin Cohen (Vice Chair); Dr. Donald Berwick; Ms. Barbara Blakeney; Dr. David Cutler; Mr. Timothy Foley; Dr. John Christian "Chris" Kryder; Mr. Richard Lord; Mr. Ron Mastrogiovanni; Undersecretary Lauren Peters, designee for Secretary Marylou Sudders, Executive Office of Health and Human Services; and Ms. Cassandra Roeder, designee for Secretary Michael Heffernan, Executive Office of Administration and Finance.

Mr. David Seltz, Executive Director, began the meeting at 12:01 PM and welcomed the commissioners, staff, and members of the public viewing the meeting live on the HPC's YouTube channel. He provided an overview of the day's agenda.

Dr. Altman provided a brief introduction to the day's discussion.

ITEM 1: Approval of Minutes

Dr. Altman called for a vote to approve the minutes from the February 5, 2020, Board meeting. Mr. Mastrogiovanni made the motion to approve the minutes. Dr. Cutler seconded it. The vote was taken by roll call. The motion was approved unanimously.

ITEM 2: Market Oversight and Transparency

Item 2a: Impact of COVID-19 on Health Care Spending and Board Discussion of 2020 Priorities

Mr. Seltz provided an introduction to the discussion of the impact of COVID-19 on health care spending and the 2020 priorities for the HPC. He turned the presentation over to Dr. David Auerbach, Senior Director, Research and Cost Trends. For more information, see slides 7 through 18.

Regarding the chart on slide 10, Dr. Kryder asked why volume reductions in internal medicine and family practice were not included in the data. Dr. Auerbach said that this data was combined in the FP/IM/GP bar on the graph.

Dr. Altman asked whether the percentages outlined in the chart on slide 10 represented percentages of the overall baseline for physician care. Dr. Auerbach confirmed that this was the case. He noted that combining the blue and green portions of the bar represented the present of baseline of total visits to a given specialty. Dr. Altman noted that the telemedicine data showed a significant shift as in many of these specialties the baseline for telehealth may have been close to zero prior to the COVID-19 outbreak. Dr. Auerbach said that this was correct.

Dr. Kryder asked whether the baseline number for slide 10 represented the level of care in January/February 2020. Dr. Auerbach said that this was correct. Dr. Kryder said that he believed the rules allowing for expanded telemedicine in Massachusetts had been changed in the beginning of April. He noted that he had heard anecdotally that many practices were doing significantly more telehealth care than the chart seemed to suggest. He said that it might be worthwhile not jumping to conclusions from the graph as the May data would likely show greater use of telehealth. Dr. Auerbach noted that this was a good point and that we may see more in future data. Mr. Seltz added that this was national data and that factors specific to Massachusetts might not hold for other states. He said that the uptake for telehealth had been much greater in the Northeast than in other parts of the country.

Regarding slide 11, Dr. Altman noted that to the extent that telemedicine is used as an add-on rather a substitution for in-person care, it could function as an increasing factor for total cost. Dr. Auerbach said that this was correct and that while there was some substitution, there could also be an add-on effect. Mr. Seltz noted that some of these telemedicine increases could be meeting needs that were not being met before. He said that this may in particular be the case in behavioral health (BH) services where there had been a dramatic increase in use of these services. Dr. Altman noted that the increased use of telehealth for BH began prior to COVID. He said he was referring mostly to cases in which a telehealth visit led to an additional in-person visit.

Dr. Kryder noted that the data on slide 12, being from March, was at this point very outdated given the developments with the pandemic since then. He noted that the Centers for Medicare & Medicaid Services (CMS) reimbursement codes did not change until mid-April. He also addressed Dr. Altman's comment regarding telehealth visits leading to in-person visits. He noted that, depending on the reimbursement structure, this would not in and of itself be necessarily additive to cost. He noted that savings in overhead for telehealth visits, such as staff, facilities, and other factors were significant. Dr. Altman acknowledged that these were good points but added that reductions in facilities and staffing would not be immediate and in the meantime those additional telehealth visits could be additive to cost. He noted that previous reform efforts, such as the movement to cover outpatient care and home health, had ended up being cost additive over time.

Dr. Berwick asked if staff had found any information on non-billed telehealth and also whether there was any quality data associated with the increase in telehealth services. Dr. Auerbach noted that he had heard that many providers were doing a lot of quick calls and emails with patients that were not necessarily making it into the billing data. He said that there are groups looking to field patient surveys about telehealth and said that staff were in conversations with some of these people. He said that there was a lot to learn about the quality aspect with regards to telehealth.

Mr. Foley asked how furloughed workers versus those who had been laid off were accounted for in the data on slide 13. Dr. Auerbach said that this was somewhat dependent on how individuals responded to the survey but suggested that, for the most part, those individuals would be counted as having lost employment.

Regarding slide 13, Dr. Kryder asked why the Bureau of Labor Statistics (BLS) did not include employment at health insurance companies as health care employment. He said it would be helpful to know what actions payers had taken in response to COVID. Dr. Auerbach said that he had not looked into this question specifically but suggested that that category of employment might be too small for the BLS to track separately. He said he would look into it. Dr. Kryder asked if this was a number the HPC could get for Massachusetts just by surveying payers. Dr. Cutler noted that the BLS does keep these numbers but they are categorized as a different industry. He said that these numbers would be available in the life/health insurance industry category. Dr. Kryder asked if that data could be included on this slide. Dr. Auerbach said he would look into this. He said that he would want to know something about the proportions of each dedicated to life and health respectively.

Regarding slide 15, Dr. Altman noted that the numbers for increased consolidation and selling the practice could be interrelated.

Dr. Berwick said that a striking number from slide 15 was the high percentage of providers across all four groups considering closing their practices. He asked if Dr. Auerbach thought there was a real threat of that many practices closing. Dr. Auerbach noted that there might be but said there would be a clearer picture as more numbers came in. Dr. Berwick asked if there was any accompanying geographic data with this that would allow staff to look at whether underserved parts of the state were particularly at risk. Dr. Auerbach said that staff could request this information.

Dr. Altman asked whether the estimates on slide 17 were for the whole year. Dr. Auerbach confirmed that they were. He said that both projections assume that by December, care will be somewhere in the region of five to 10 percent down from where it otherwise would be.

Undersecretary Peters asked if the spending numbers on slide 17 were both public and commercial. Dr. Auerbach said that the numbers were for all payers.

Dr. Auerbach turned the presentation back over to Mr. Seltz who provided an introduction to the discussion on the HPC's priorities and workstreams for 2020. For more information, see slide 19.

Dr. Altman said that the state's health care system had done a remarkable job responding to the COVID pandemic and that the crisis had exposed both strengths and weaknesses of the Commonwealth's health care system compared to other states and countries. He noted that Massachusetts had larger percentage of intensive care unit (ICU) beds than other states and that this had always been concerning from a cost containment perspective but it proved to be valuable in to the state's effort to treat the sickest COVID patients. He noted that the crisis had also raised questions about which entities should be responsible for testing, what the proper inventory of personal protective equipment for hospitals to have on hand was, and the composition of the health care workforce. He said that another important question to consider is what the impact of forthcoming closures would be on access and consolidation.

Dr. Berwick said that Massachusetts needed to be thinking about a strategy for continued testing and for distribution of a vaccine once available. He said it was important to consider what the

approach to these issues would be in terms of access and cost. He added that there were also questions around pricing. He noted that the CMS guidelines currently reimbursed telehealth at the same rate as in-person visits. He said that this practice should be scrutinized by the HPC. He said that when vaccines and effective anti-virals become available, they are likely to be high-priced monopoly products. Another important item for the HPC to consider, he added, was what preparedness for similar crises at the state level should look like and how that preparedness would factor into cost. Dr. Berwick said that the final and most important topic for the HPC to examine is the stark racial disparities in the state's health care system that had been exacerbated and highlighted by the COVID pandemic. He said that no responsible public agency should fail to confront this issue.

Dr. Cutler said that the issue of what happens to payment policy following the crisis would be crucial. He emphasized that this was an important moment for making positive changes in the system. He said that the health care system should reject the impulse to move away from the benchmark and increase spending during this crisis. He said that it would be crucial to help providers find ways to reduce the cost of care rather than shifting those costs onto a smaller group of consumers who still had employer-provided health insurance. He added that the pandemic had highlighted major issues with care in nursing facilities, assisted living establishments, and other long-term care locations. He noted that approximately 60 percent of the COVID deaths in Massachusetts had occurred in nursing homes. He said that the HPC could engage with the state to think about how to improve care in nursing facilities.

Undersecretary Peters thanked HPC staff for their contributions to the state's response to COVID 19. She said that the COVID Command Center (CCC) had been able to leverage the HPC's expertise and fluency with the health care system to support the Commonwealth's effort to combat the virus. She said that she would welcome discussion about how the HPC could continue to support the CCC. Dr. Altman thanked Undersecretary Peters for these comments and said that there was a lot the HPC could contribute to the state in terms of data analysis.

Mr. Mastrogiovanni said that the COVID pandemic had the potential to the severly damage the financial position of smaller community hospitals. He said that this would be important context for evaluating the benchmark. He said that the HPC had to consider quality of care as well when thinking about holding entities accountable to the benchmark during this time.

Addressing Dr. Cutler's comment on nursing facilities, Dr. Kryder noted that there were dramatic differences among nursing facilities in the state in terms of COVID deaths. He said that the disparity among these entities was a public health failure and, to the extent the HPC could have a role in addressing it, the agency should be collecting data on these facilities. Dr. Altman noted that the responsibility for oversight of the nursing home industry resides with the Department of Public Health (DPH). He said that the HPC would be happy to assist DPH on this topic. Dr. Kryder said that another topic worth considering was the movement of acute care to the home setting which was cost-saving and safer from an epidemiological standpoint. He said that advances in telemedicine had enabled an expansion of this trend. He added that the post-COVID health care system would be in a more receptive place to widely adopt non fee-for-

service (FFS) payment models. He said that it might be worthwhile to survey providers and find out what they were seeing in terms of changes to reimbursement models.

Mr. Foley said that it would be important to examine all of the issues surrounding the state's pandemic preparedness through a health equity lens. He noted that the population of caregivers in Massachusetts was majority people of color and that these were the communities that suffered most from COVID-19. Compounding the issue, he said, was the fact that the health care facilities that serve these populations are the ones that find themselves in the most financial jeopardy. He said that the research into workforce capacity should be contemplated from an equity perspective given that many of those working in nursing facilities around the state are low-paid and concerned that they may not be provided with sufficient protective equipment. He echoed Dr. Kryder's point that it was important to examine workforce and revenue trends on the payer side as well as providers.

Ms. Blakeney voiced her support for a closer examination of nursing facilities. She said that there was an opportunity when examining the data on illnesses and deaths from COVID-19 to see where the state's strengths and weaknesses were. She said that, in addition to nursing facilities, the HPC should develop models to look at spread in other confined communities such as homeless shelters and prisons. She noted that communities of color had been hit especially hard by the pandemic and said that the HPC needed to consider what data is important to understand with this phenomenon. She said that the goal should be to learn from the COVID-19 crisis such that the state gets markedly better at providing services during surges that impact the medical system. Regarding the telehealth data presented earlier, she said that it was important not to move too quickly to break up the infrastructure that supports one-on-one personal engagement between providers and patients. She said that doing health care well often requires a human touch.

Ms. Roeder voiced her agreement with the comments made. She urged the HPC not to lose sight of the work being done prior to the COVID-19 crisis.

Mr. Cohen said that consideration of COVID-19's impact on the undocumented population needed to feature into the HPC's work as well. He noted that this population was hard hit and had very limited access to care. He said that it was also important for the HPC to consider the impact of the pandemic on behavioral health and substance use. He said that the pandemic had underscored how fragmented the state's health care system was. He noted that the CCC had done tremendous work during the crisis but that there was no centralized command center directing Massachusetts' health care efforts outside of the crisis. He said that it would be important to think about how the state's health care systems work together in a more coherent way moving forward.

Undersecretary Peters said that Ms. Blakeney's point about applying the lessons learned from the crisis moving forward was important. She noted that across the various workstreams of the CCC, playbooks were being developed to help inform future responses in the event of a second wave. She noted that regarding nursing facilities, the CCC had observed high levels of infection in some facilities with historically very high levels of care. She said that CCC staff were looking at

the data to discover where there might be important correlations between facilities with high rates of COVID mortality and develop strategies to prevent these localized outbreaks in the future.

Dr. Altman thanked the governor's task force and CCC for their work responding to the crisis. He said that the state's response was second-to-none in the country. He thanked all of the commissioners for their comments.

Mr. Seltz thanked the commissioners and said that staff would put together a summary of the conversation and a workplan for the rest of the year aimed at addressing the issues raised. He noted that this work would be in addition to the HPC's normal workstreams.

Item 2b: 2021Health Care Cost Growth Benchmark

Mr. Seltz presented on the process for establishing the 2021 Health Care Cost Growth Benchmark. For more information, see slides 21-26.

Dr. Altman voiced his support for setting the benchmark at 3.1 percent.

Dr. Kryder asked whether there was any opportunity to revisit the benchmark decision later in the year should the situation on the ground develop in a way in several months that could change the thinking regarding 3.1 percent cost growth as a goal. He asked if was possible to delay setting the benchmark for 2021 given the extraordinary circumstances of 2020. Dr. Altman noted that the benchmark is intended as a marker to use when looking at the health care system over time rather than for a single year. He said that it was entirely feasible that spending could rebound dramatically in 2021 and suggested staying with the 3.1 percent number for this reason. He said that he was dubious that the health care system would accept the dramatic reductions in spending brought on by COVID as a new normal but said that if this lower spending persisted, with additional authority the HPC should push the system dramatically curb spending in a more permanent basis. Mr. Seltz noted that the HPC was statutorily required to set the benchmark and that was why it was included in the day's agenda. He said that the Board could certainly lead a conversation about how the benchmark would be applied during this time period. He said that predicting growth from 2020 to 2021 was a difficult task and that the benchmark itself is not necessarily intended as a prediction tool. He said the benchmark's real purpose was as a long-term signal to the system that affordability should be a priority.

Dr. Altman noted that an area the Board had not discussed was Medicare. He said that it was his understanding that the during the crisis, the Medicare payment rates for hospitals had been boosted by 20 percent. He said that there would likely be pressure from the industry to maintain these higher rates. He said that one of the reasons the state had been able to come in consistently below the benchmark for several years was due to lower rates of spending by Medicare.

Dr. Cutler agreed with Dr. Altman that the HPC should continue with the benchmark set at 3.1 percent. He echoed Mr. Seltz's comment that the benchmark was intended to be a long-term target. He said that his sense was that the state would come in well below the benchmark in 2020. He said that it was possible that in 2021 there could be similar dynamics to when Hepatitis C treatments first came onto the market: there was short-term increase in utilization which raised

cost but the reduction in hospitalizations over time was a long-term cost saver. He said that, at the time, the HPC had asked the health system to demonstrate that these increases were due to access to these new treatments rather than increases across the board. He said the HPC could approach the COVID situation similarly and if cost growth in 2021 is higher than expected could excuse this as providers catching up on care that consumers did not get in 2021, provided this is what accounted for the increase.

Dr. Altman called for a vote to establish the 2021 Health Care Cost Growth Benchmark at 3.1 percent. Mr. Lord made the motion to establish the benchmark. Mr. Foley seconded it. The vote was taken by roll call. The motion was approved with 10 votes in favor and 1 vote against.

ITEM 3: Care Delivery Transformation

Item 3a: Moving Massachusetts Upstream (MassUP) Investment Program Awardee Selection

Mr. Seltz provided a brief introduction to the presentation on the Moving Massachusetts Upstream (MassUP) investment program. He thanked the HPC's interagency partners for their work on the program. He turned the presentation over to Ms. Kelly Hall, Senior Director, Health Care Transformation and Information. For more information, see slides 30-37.

Dr. Altman thanked the staff for their hard work on the program and on narrowing down the selection of potential awardees. He said that this was a very important program for this time.

Ms. Blakeney said that she was thrilled by the quality of the proposals that were submitted. She said that she hoped that the HPC could find a way in the future to support some of the innovative program proposals that for which there was insufficient funding to support in this round.

Mr. Cohen said that the hospital industry in Massachusetts had really stepped up with some very strong applications to this investment program.

Mr. Foley that all of these programs looked strong. He asked how a grantee's ability to fund a program without support was taken into account during selection. Ms. Hall said that this was a very fair question. She said that the first consideration of the selection committee was the quality of the proposal and that budget efficiency was also considered. She said that one aspect that was closely examined was the percentage of program dollars that would go directly to community-based organizations rather than to covering activities directly within the health care delivery organization. Mr. Seltz added that in some cases applicants were including in-kind resources with their proposals.

Dr. Altman called for a vote to award the MassUP investments to the recommended entities. Dr. Berwick made the motion. Ms. Blakeney seconded it. The vote was taken by roll call. The motion was approved unanimously.

ITEM 5: Executive Director's Report

Mr. Seltz tabled the discussion his executive director’s report in the interest of time. For information on HPC program updates and new publications, see slides 41-47.

The open session of the meeting concluded at 2:08 PM.