VOTE 1: MEETING MINUTES

Date of Meeting: January 16, 2025
Start Time: 12:00 PM
End Time: 2:25 PM

	Present?	Vote 1: Approval of Minutes (December 12, 2024)
Deborah Devaux*	X	M
Matilde Castiel	X	X
Martin Cohen	X	X
Karen Coughlin	X	ab
David Cutler	X	X
Timothy Foley	X	X
Patricia Houpt	X	2nd
Ron Mastrogiovanni	X	X
Alecia McGregor	X	X
Secretary Kate Walsh or Kiame Mahaniah (Designee)	X	ab
Secretary Matthew Gorzkowicz or Dana Sullivan (Designee)	X	X
Summary	**11 Members Attended**	**Approved with 9 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 January 16, 2025 at 12 PM. Commissioners attended the meeting remote, via Zoom. A recording of the meeting and the meeting materials are available on the HPC's website.

Participating commissioners who attended virtually were Ms. Deborah Devaux (Chair); Mr. Martin Cohen (Vice Chair); Dr. Matilde Castiel; Ms. Karen Coughlin, Dr. David Cutler; Mr. Timothy Foley; Ms. Patty Houpt; Mr. Ron Mastrogiovanni; Dr. Alecia McGregor, Undersecretary Dr. Kiame Mahaniah, Executive Office of Health and Human Services (EHS); and Ms. Dana Sullivan, designee for Sec. Matthew Gorzkowicz, Executive Office of Administration and Finance (ANF).

Ms. Devaux began the meeting at 12 PM and welcomed the commissioners, staff, and members of the public viewing the meeting on the livestream. Ms. Devaux introduced Commissioner Coughlin, the most recently appointed commissioner to the HPC Board, and turned to Ms. Coughlin to share introductory remarks and share her professional background.

ITEM 1: Approval of Minutes

Ms. Coleen Elstermeyer, Deputy Executive Director, managed the roll call vote to approve the minutes of the December 12, 2024 Board meeting. Ms. Devaux made the motion to approve the minutes, and Ms. Houpt seconded it. The vote was taken by a roll call. The motion was approved.

ITEM 2: Behavioral Health Workforce Center

Mr. David Seltz, Executive Director, introduced Ms. Amy Doyle, Director, Behavioral Health Workforce Center (BHWC), to share an update regarding the HPC's BHWC and the BHWC Advisory Group. Ms. Doyle shared an overview of the goals of the BHWC Advisory Group and announced the inaugural members of the Advisory Group. For more information, see slides 6-8.

Ms. Coughlin asked about direct care workforce representation in the Advisory Group and potential representation from the Department of Mental Health. Ms. Doyle responded that it was an intentional decision at the beginning of the procurement process to ask state employees not to apply to the Advisory Group, given the HPC's and BHWC's close partnership and regular meetings with agencies such as the Department of Public Health, Department of Mental Health, and MassHealth. She also noted that there are several members of the group who provide direct care within their respective roles. Ms. Coughlin added that there is often a different perspective between the direct care workforce and administrative staff within the agencies.

Ms. Elstermeyer invited more direct engagement with Ms. Coughlin regarding the BHWC and BHWC Advisory Group's work.

Dr. McGregor asked if any of the members of the Advisory Group worked at the intersection of maternal health and mental health. Ms. Doyle identified one of the members, Dr. Lenna Mittal, who has been working with Massachusetts Child Psychiatry Access Program (MCPAP) for Moms and her career has been focused on maternal and perinatal mental health.

Dr. Castiel commented that increased representation from Central Massachusetts is ideal since those individuals will often have a different perspective from those in the Boston area. Ms. Doyle thanked Dr.

Castiel for her feedback and offered to share aggregate data on the composition of the Advisory Group. She said that during the review process the team paid close attention to demographic and geographic distribution to ensure representation from across the Commonwealth, and to include representation from Central and Western Massachusetts and the Cape and islands. Ms. Devaux commented that the additional data on to composition of the Advisory Group may be useful for the Commissioners.

ITEM 3: Overview of New Legislation: *An Act enhancing the market review process and An Act relative to pharmaceutical access, costs, and transparency*

Mr. Seltz began the presentation focused on the new legislation signed by Governor Healey, *An Act enhancing the market review process and An Act relative to pharmaceutical access, costs, and transparency.* Mr. Seltz reviewed the new responsibilities and key legislative components of the new health care laws applicable to the HPC. For more information, see slides 10-21.

Mr. Foley asked about the staggered appointments of the Board of Commissioners outlined in the new laws to confirm if it is the appointing authorities' decision on how to stagger the terms. Mr. Seltz responded in the affirmative and noted that in the original legislation the staggered appointment terms were listed out, but in the signed law the appointing authority will decide how the Board appointments will be staggered.

Mr. Cohen asked about how the expanded pharmaceutical and pharmacy benefit manager oversight relates to the current mandate for the HPC to review pharmaceutical drug pricing in relation to MassHealth's pricing negotiations. Mr. Seltz said that new legislative changes complement the HPC's existing authority on drug pricing reviews and expand the ability for the HPC and Office of Pharmaceutical and Policy Analysis to collect information from CHIA.

Mr. Foley asked about the new Office of Pharmaceutical and Policy Access (OPPA) and if the legislation included additional funding or resources in the agency's budget to accommodate hiring needs related to the new responsibilities charged to the HPC. Mr. Seltz said that he anticipates that OPPA will be a hub for pharmaceutical policy recommendations and that other agencies will look to OPPA for guidance so it will need to be equipped to meet the expectations of the legislature. He affirmed that there would need to be additional staff hired and dedicated resources for these new responsibilities. He said that many of the new mandates are built off of areas where the HPC has a foundation and laid groundwork in these areas; noting that there are current members of staff who already do work in the areas where the HPC's responsibilities were expanded. He also said that the law recalculates the HPC's industry assessment of acute care hospitals and health plans, which supports the annual budget, and broadens the entities under the assessment to include pharmaceutical manufacturers and pharmacy benefit managers. He added that the HPC's budget is set by the legislature and the Governor through the annual state budget process so the agency will be working closely with the legislature during their budgetary process to predict the budgetary needs of the agency for the years to come.

Dr. Cutler said that particular expertise is required in areas the HPC oversees, such as the cost and market impact review process, which requires deep economic knowledge of the industry. He said that the HPC's new pharmaceutical oversight is equivalent to that, requiring a similarly deep, nuanced understanding of the various aspects of the pharmaceutical industry. He said that the same processes for the cost and market impact reviews will apply for pharmaceutical and PBM oversight, with a combination of internal staff and external consultants involved in the industry. Mr. Seltz agreed with the points Dr. Cutler made and said that

bringing in external experts in the industry will be crucial for the HPC to make meaningful policy recommendations in the pharmaceutical space.

Dr. McGregor asked about the caps on out-of-pocket costs for prescriptions addressed in the legislation and how these changes will apply to health plans sold on the Massachusetts Health Connector, and if there are any health insurance enrollees that potentially have been left out of the co-pay caps. Mr. Seltz said that the mandate would apply to the Connector's health plans and that it cannot be applied to the ERISA exempt self-insured plans. Ms. Lois Johnson, General Counsel, clarified that the cap applied to anyone on a fully insured health plan licensed by the Division of Insurance (DOI). Dr. McGregor asked if individuals who are employed through a large company or organization would not have the benefit of the copay caps. Ms. Johnson said that it would not apply to anyone with a self-insured plan since that is not within the scope of the state's authority (under ERISA). Dr. McGregor said that she was not sure what percentage of health insurance enrollees that make up the self-insured market but that she estimates it to be a large share of individuals. Dr. Cutler said that he estimates that half of the privately insured population is self-insured. He also said that almost all large employers are self-insured and likely some smaller ones too, noting that her concern was not a trivial matter. Dr. McGregor responded that point was important to note regarding the legislation and that it was a good step forward. Mr. Seltz noted that in areas where the state has made a mandate for coverage of a benefit or a co-payment cap on the fully insured market, there are times when self-insured plans may follow that same mandate in their plan design even if they are not required to. He said that this will be an area the HPC examines further to see if self-insured plans are following the lead of the fully insured market. Mr. Seltz said that another important component of the legislation is that the HPC will be required to examine the program and ideally demonstrate that is mandate is beneficial for patients and can lower long term costs within the agency's review and make the economic case that is mandate should be more widely applicable.

Mr. Seltz turned to Ms. Kara Vidal, Director, Health Systems Planning and Performance, to shared an overview of the new Office of Health Resource Planning within the HPC.

Ms. Devaux asked for clarity on the timeline for the state health plan, asking if the outlook for projected needs is five-years. Ms. Vidal confirmed and said that the state's health resource plan specifically defines a five-year planning period, and that the focused assessments do not have a defined time period associated with them. Ms. Devaux asked if the plan would be refreshed every five years. Ms. Vidal said that expectation would be that it would be refreshed every five years, or possibly earlier, depending on various components of the plan.

Dr. Cutler said that he sees the hardest part of state health planning is setting up the structure where data is fed in and synthesized, including information on all of the facilities within the state or the available beds in a hospital, and then the statewide need is projected from there. He said once the data structure is complete the information could be updated continuously, but setting up the structure to capture all of the facilities in the area, the population size, population needs, and the number of hospital beds in different areas will take time. Ms. Devaux thanked Dr. Cutler for his comment, noting that it helped her better understand the possibilities of the new health planning tools.

Ms. Johnson provided an overview of the law's impact on the HPC's market oversight authority and market monitoring tools. Mr. Seltz then shared an overview of the new primary care payment and delivery taskforce that will be co-chaired by the HPC and EOHHS.

Dr. McGregor underscored the significance of the health resource planning aspect of the new law and explained how this will better ensure equity in the health care system and promote equitable access to care. She commented on the number of recent hospital closures and loss of critical service lines in vulnerable communities. She said that while this is devastating to the entire health care system, the state needs to have a better geographical sense of the impact of these closures, and the health planning resources will give the state an increased ability to track the supply of services, the workforce, and health gaps in various communities. She thanked the legislature, the HPC and various health policy advocates for ensuring that equity was the center of this provision of the legislation. Ms. Devaux echoed the comments of Dr. McGregor about how critical the new legislation will be for addressing the ongoing issues of the Commonwealth's healthcare system and underscored the importance of all the new responsibilities for the HPC.

Mr. Seltz finished the presentation with an overview of the key dates for the implementation of the new laws.

ITEM 4: A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action – *Special Report from the HPC on Primary Care Workforce, Access, and Spending Trends*

Ms. Devaux turned to Dr. Castiel to introduce the presentation focused on the primary care workforce, access, and spending trends. Dr. Castiel turned to Dr. Sasha Albert, Associate Director, Research and Cost Trends, to begin the presentation. Dr. Albert turned to Ms. Charlotte Burlingame, Senior Associate, Research and Cost Trends, to present on concerning trends related to primary workforce and access to care. Ms. Burlingame turned back to Dr. Albert to present the remainder of the presentation. For more information, see slides 23-71.

Ms. Devaux thanked Dr. Albert for the timeliness of the release of the primary care report and opened the discussion for commissioners.

Dr. Cutler brought up one of the themes in the report focused on alternative payment model use. He said that one of the goals behind the Alternative Quality Contract (AQC) and goal in the Commonwealth is that the AQC would increase the demand for primary care and reduce demand for specialists. He asked if compensation for doctors on a Fee-for-Service (FFS) model is too low and if Massachusetts, being a leader in alternative payment use, has any effect on the demand to pay primary care doctors. Dr. Albert responded that the FFS model is a big part of the picture, noting that the only activity of primary care that is paid for with FFS is when the clinician is in the room with the patient. She noted that there is a lot of work of primary care that FFS does not cover, such as patient correspondence and negotiating with insurance companies. She added that it is challenging to have an adequate care team under the FFS model when clinicians are compensated for only part of the work they do. Dr. Castiel added that she personally has colleagues who work 30 hours a week seeing patients and work an additional 50 hours a week doing the rest of the paperwork and administrative tasks. She said that the idea of physicians decreasing their hours of work does not decrease the hours of work needed to be done.

Ms. Devaux added that it would be helpful to explore what has and has not worked with alternative payment models, noting that it could be an important focus of this next phase of work on the primary care sector. She added that it would be helpful in better understanding Dr. Castiel's point about the administrative burden that primary care doctors face and what can be done to address it.

Dr. Mahaniah mentioned his experience as a former CEO of Lynn Community Health Center and seeing patients there. He said that with MassHealth's move towards a capitation model, clinicians got a monthly

fee, but that about 50 percent of patients were still on FFS models, so providers would still have to maintain FFS frameworks while building out support mechanisms for team-based care. He said that part of the difficulty for most providers is that there has not been an overwhelming proportion of patients that are in an alternative payment model, adding that while Blue Cross Blue Shield pioneered alternative payment models, not many commercial payers followed suit, and the incentive was not big enough for practices to switch to these payment models. He said that the incentives need to be around 15-20 percent of total compensation, and most places do not do that. He also said that in integrated health systems there is no mechanism for payers, once getting an incentive, to force money to go to primary care.

Dr. Cutler asked Undersecretary Mahaniah a follow up question on the payer mix at Lynn Community Health Center (CHC), noting that MassHealth was the dominant payer at the CHC, he asked what the second highest most used payer was at the CHC. Dr. Mahaniah responded that Medicare was the second highest most-used insurance plan, and while he was there the CHC joined a version of Medicare that was heavily incentive-based and looked like a capitation model. Mr. Seltz informed Dr. Cutler that while Massachusetts was a leader in alternative payment model adoption, the state plateaued in the adoption of alternative payment models in the commercial space about six years ago. Dr. Cutler expressed interest in further discussing the various payers and payment models for primary care including those of MassHealth and Medicare.

Ms. Devaux commented that it would be important to see what utilizing various payment models looks like from a primary care provider's or nurse practitioner's perspective. She emphasized the need to understand the various incentives and alternative payment models of Medicare, Medicaid and Commercial plans since they are all different, and that adds an additional level of complexity for the providers. She said that looking at this issue through the lens of a provider would be helpful.

Ms. Coughlin asked about the research regarding the availability of primary care physicians across the Commonwealth, noting the difference in the primary care physicians per resident in Suffolk County compared to other surrounding counties such as Bristol County. She asked if certain aspects of the regions were researched further, such as affordability of housing and cost of living in certain regions of the state, and if the cost of living across Massachusetts reduces the number of physicians willing and able to live and practice in the region. Dr. Albert said that was an important point, especially knowing that Massachusetts is a high cost of living state. She said that in a previous workforce report there are some graphics on cost of living relative to what certain provider types make for a living. She noted that the high amount of educational debt and high cost of living can definitely drive decision-making when choosing a specialty. Mr. Seltz asked Dr. Albert if CHIA had shared any data on cost of living, housing or childcare in relation to the provider workforce and she noted that she would investigate that data further.

Mr. Cohen said that while working in the Metro West area, trying to find housing for new primary care physicians was nearly impossible. He also mentioned the importance of primary care in relation to behavioral health, noting that primary care is where early screenings are happening for mental health and substance abuse cases, and it is also where treatment is taking place, through prescriptions or referrals to behavioral health practitioners. He added that on the behavioral health side there has been push for integrated care models for primary care and behavioral health to lower the cost of health care for patients, but if there are not primary care practitioners to lead those efforts then behavioral health access will become worse. Mr. Cohen said that the long wait times to see a primary care doctor or get a behavioral health appointment can often result in people needing to utilize the emergency department when they have an issue. Dr. Albert acknowledged the importance of Mr. Cohen's point and said that it closely ties to the work focused on the importance of adequate care teams and maintaining those care teams, given the way primary care is paid for.

Dr. McGregor asked about the slow bounce back, post-COVID, for the employment of primary care physicians in an office setting in Massachusetts, compared to the rest of the country. She mentioned past acquisitions of various primary care providers and recent unionization efforts of primary care doctors which have been fueled by physician burnout and the corporatization of care. She asked if there would be a way to assess the impact of increased corporate or for-profit actors in the primary care space and the extent to which this is the cause of a deteriorating work environment for primary care doctors. Dr. Albert said that based on Massachusetts' Registration of Provider Organizations (RPO), about half of Massachusetts PCPs are affiliated with only four provider organizations and that area should be looked into further. Mr. Seltz also addressed Dr. McGregor's question and said that he would be interested in having the HPC look further into the for-profit sector's impact on primary care.

Ms. Devaux added that learning about how Massachusetts is different from other states in the primary care sector will help inform and provide a jumping off point for the new Primary Care Task Force to identify solutions to this issue in Massachusetts.

Mr. Foley thanked the HPC for the timeliness of this report and emphasized the need to further address the ongoing workforce issues in the health care sector and noted that this report reinforces the need to keep working towards alleviating these issues felt across the workforce.

ITEM 5: Executive Director's Report

Mr. Seltz began the Executive Director's Report and turned to Ms. Kate Mills, Senior Director, Market Oversight and Transparency, to provide an update on the notices of material change (MCNs) received since the last Board meeting.

Mr. Seltz also shared information about the 2025 Summer Fellowship Program and the upcoming application deadline. He also highlighted the 2024 Summer Fellowship Program Report, which was released in December 2024 and is available on the HPC's website. For more information, see slides 73-78.

Undersecretary Mahaniah said that he would likely be the EOHHS co-chair for the Primary Care Task Force and emphasized his excitement to work with the HPC to address the primary care crisis in the Commonwealth and update Commissioners regularly on the progress of the task force.

ITEM 6: Adjourn

The meeting adjourned at 2:25 PM