MEETING MINUTES:

MARKET OVERSIGHT AND TRANSPARENCY COMMITTEE

Meeting of October 6, 2021

MASSACHUSETTS HEALTH POLICY COMMISSION

Market Oversight and Transparency Committee
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, October 6, 2021, 9:30 AM

PROCEEDINGS
The Massachusetts Health Policy Commission's (HPC) Market Oversight and Transparency (MOAT) Committee held a virtual meeting on Wednesday, October 6, 2021, at 9:30 AM.

Members attending remotely included Dr. David Cutler (Chair); Ms. Patricia Houpt; Mr. Ron Mastrogiovanni; and Ms. Cassandra Roeder, designee for Secretary of Administration and Finance Michael Heffernan. Mr. Timothy Foley joined the meeting after the vote on the June 2, 2021 minutes.

Dr. Stuart Altman (HPC Chair), Mr. Martin Cohen (HPC Vice Chair), Dr. Donald Berwick, and Ms. Barbara Blakeney were also in attendance virtually.

The meeting notice and agenda can be found here.
The presentation from the meeting can be found here.
A video of the meeting can be seen here.

ITEM 1: APPROVAL OF MINUTES FROM THE JUNE 2, 2021, MEETING
Dr. Cutler called for a motion to approve the minutes from the June 2, 2021, meeting. Ms. Houpt motioned to approve the minutes. Mr. Mastrogiovanni seconded the motion. The vote was taken by roll call. The minutes were approved with four votes in the affirmative.

Dr. Cutler turned the presentation over to Mr. David Seltz, Executive Director, who provided a brief introduction to the meeting.

ITEM 2: REPORT FINDINGS: *CHILDREN WITH MEDICAL COMPLEXITY IN THE COMMONWEALTH*
Mr. Seltz turned the presentation over to Dr. Sasha Albert, Senior Researcher, Research and Cost Trends, who gave an overview of the HPC's report on children with medical complexity in Massachusetts. For more information, see slides 6-37. The portion of the meeting on the *Children with Medical Complexity in the Commonwealth* report can be viewed here.

Dr. Altman asked whether staff had spoken with people at Tufts Children's Hospital for this report. Dr. Albert said that Tufts was not one of the stakeholders engaged at this point.

Dr. Cutler said that the findings presented led him to believe that a coordinating database for families with children with medical complexity would be very helpful. Dr. Albert said that the legislature had asked for recommendations on that area and noted testimony the bill in which this report was included emphasized the need for centralized data collection and resources to help inform families of what programs they might qualify for. Dr. Cutler added that the Centers for Medicare & Medicaid Services (CMS) office of Dual Eligibles to examine their most expensive segment of patients and that this might be an informative model.

Mr. Cohen asked if the report contained any findings related to pediatric nursing home care or long-term care facilities. Dr. Albert said that had not been examined in this preliminary report. Mr. Seltz noted that the report was still being developed and that staff were open to suggestions on who should be consulted as the work continued. Regarding the bullet on slide 34 on regional public health agencies, Mr. Cohen said that he did not believe there were regional public health agencies in Massachusetts. Dr. Albert reported that some stakeholders believed that, were there to once again be a robust regional public health system in the Commonwealth, it could play a valuable role in care coordination in this area.

Ms. Blakeney seconded Dr. Cutler's point on the importance of centralizing data and care coordination for families with children with medical complexities. She noted that the COVID-19 pandemic had exacerbated many of the pre-existing issues with pediatric behavioral health (BH) care and said that data was suggesting the emergence of a BH crisis for adolescents. She said that in the next phase of this report, it would be crucial to closely examine this issue and consider policy recommendations to increase access to BH care for children. Dr. Albert agreed that this was an important area of inquiry and noted that both inpatient medical and inpatient psychiatric settings are often not equipped to support the other type of health need.

Dr. Cutler asked if there was any further insight into what the legislature expected from the HPC with this report. Mr. Seltz said that developing a greater understanding of the scope of the issue, the patient population, and barriers to care were important aspects of the report, as well as laying out the policy implications of this information. Dr. Albert added that outlining the need for greater centralization and data collection and systemic improvement in care coordination was also an important objective of the report.

Mr. Seltz noted that staff hoped to have the final report, including recommendations, back to the legislature in the coming months.

ITEM 3: HPC 2021 POLICY RECOMMENDATIONS

Mr. Seltz provided an introduction to the presentation on the first two policy recommendations in the 2021 Health Care Cost Trends Report.

Dr. Altman said that he was very concerned with the increase in pricing in late 2020 and early 2021 and asked whether it was possible to do some additional analysis on the market in 2021 to make the data somewhat more current. Mr. Seltz noted that the data source for hospital pricing was national and being updated on an almost monthly basis so it might be possible that more updated numbers were available. He added that the HPC's pre-filed testimony (PFT) requests to payors and providers ahead of the cost trends hearing (CTH) would also provide some real-time data to help better illuminate this trend.

Item 3a: Strengthen Accountability for Excessive Spending

Mr. Seltz introduced Ms. Katherine Mills, Senior Director, Market Oversight and Transparency (MOAT), who presented on the framework of the HPC's recommendation to strengthen accountability for excessive spending in the system. For more information, see slides 41-45. The portion of the meeting on strengthening accountability for excessive spending can be viewed here.

Ms. Mills turned the presentation over to Dr. David Auerbach, Senior Director, Research and Cost Trends (RCT), who presented on updated data on risk scores. For more information, see slides 46-50.

Dr. Auerbach turned the presentation back over to Ms. Mills to round out the conversation on the accountability framework for the health care cost growth benchmark. For more information, see slide 51.

Dr. Altman asked how great the difference was in unadjusted total spending growth compared to the health status adjusted (HSA) total medical expenditure (TME) growth examined in the performance improvement plans (PIPs) process. Dr. Auerbach said that, on average, risk scores had been growing about three percent annually and that, statewide, there was about three percent growth in unadjusted TME and about zero percent growth in HSA TME making for about a three to four percent delta between the two measures. Dr. Altman said that there might be opportunity to learn more by digging into some of the practices that providers and plans were using to increase their coding. Dr. Auerbach said that staff had done some investigating of this, but it was hard to find data on the topic. Mr. Seltz agreed with Dr. Altman that this was an important area for further inquiry. He noted, anecdotally, that a previous conversation with a leader from a large health care organization in Massachusetts had suggested that there was substantial return on investment (ROI) on hiring administrative staff to work on coding strategies.

Dr. Berwick asked whether staff were examining comparative data from other states. Dr. Auerbach said that there was a recent report from the Office of the Inspector General of the U.S. Department of Health and Human Services that on the severity of hospital patients that found similar numbers. He added that there was likely more to learn from claims data that staff had not yet had the opportunity to do.

Dr. Cutler asked which was a more accurate portrayal: unadjusted TME or HSA TME. Dr. Auerbach said that he suspected that the unadjusted TME was more accurate. He noted that the patient populations do not change significantly year-over-year and reported that actuarial consultants advised staff that unadjusted or age/sex adjusted spending is better used for this process. Ms. Mills added that staff were not suggesting that risk adjustment was without value, but that *growth* in health status adjusted spending within a given payer or provider is heavily influenced by coding practices, and that there generally are not major changes in the patient population. She said that health status adjustment is important when comparing providers that may have different risk profiles, but basing the criteria for the PIPs process solely on HSA TME growth is potentially problematic for the reasons outlined in the presentation.

Item 3b: Constrain Excessive Provider Prices

Dr. Auerbach presented on the second recommendation: constrain excessive provider prices. For more information, see slides 53-71. The portion of the meeting on this recommendation can be viewed here.

Dr. Berwick asked if the Medicare numbers on slide 70 included Medicare Advantage. Dr. Auerbach said that these were just fee-for-service (FFS) Medicare numbers.

Dr. Cutler asked whether the proposals to constrain excessive prices could be different for different types of organizations. Dr. Auerbach said that they could and noted that there had been a proposal several years ago that would have grouped hospitals by their relative price level and allowed different rates of growth based on their current prices.

Dr. Berwick asked why, at the HPC's inception, had the agency been limited to monitoring primary care plans and hospital expenditure levels had not been included in its purview. Ms. Mills said that the TME

data used in the PIPs process is a useful measure to comprehensively capture utilization and price, but that there was not a comparable measure on the hospital side whereas the state had been collecting TME data for some time. Mr. Seltz added that the recommendation to the legislature would be to remove the requirement that HSA TME be the sole metric for referral to the Center for Health Information and Analysis (CHIA). He noted that this was included in proposed legislation by Governor Baker prior to the pandemic.

Dr. Cutler noted that the TME measure could make more sense if care generally stayed within a given system, but that the current system in Massachusetts often results in very sick patients going to the same small set of highly-specialized providers, and primary care providers are not able to control that spending well. He also noted that many of these referral destinations continue to be paid on a fee-for service basis. For these reasons, he stated that we need to think of other tools for accountability that do not put all of the onus on the primary care provider.

Dr. Altman suggested that staff take a closer look at Maryland and its longstanding spending controls to get a sense of the factors that state considers when making adjustments for hospitals. Dr. Auerbach said that staff had looked into Maryland's system and agreed that there was more to understand and discuss on this topic.

Mr. Foley asked what the next step in the process for these recommendations would be and what the involvement of the Board would be in these next steps. Mr. Seltz said that the purpose of this work was to dive deeper into these recommendations and bring research and data expertise to exploring their implications. He noted that this would be an iterative workstream over the coming months and said that if the Board chose to take a clarifying position on these recommendations, that could be on the table. Mr. Foley asked if the CTH would be a useful opportunity to get reactions from stakeholders on these recommendations and advance these conversations. Mr. Seltz said that it would be.

ITEM 4: ADJOURNMENT

Dr. Cutler adjourned the meeting at 11:05 AM.