MEETING MINUTES:

MARKET OVERSIGHT AND TRANSPARENCY COMMITTEE

Meeting of September 30, 2020

MASSACHUSETTS HEALTH POLICY COMMISSION

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

Docket: Wednesday, September 30, 2020, 9:30 AM

PROCEEDINGS
The Massachusetts Health Policy Commission's (HPC) Market Oversight and Transparency (MOAT) Committee held a virtual meeting on Wednesday, September 30, 2020, at 9:30 AM.

Members present included Dr. David Cutler (Chair); Mr. Richard Lord; Mr. Timothy Foley; Mr. Ron Mastrogiovanni; and Ms. Cassandra Roeder, designee for Secretary of Administration and Finance Michael Heffernan.

Dr. Stuart Altman, HPC Chair, Mr. Marty Cohen, HPC Vice Chair, Ms. Barbara Blakeney, Dr. Don Berwick, and Dr. Chris Kryder, also attended remotely.

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.

Mr. David Seltz, Executive Director, provided an introduction to the virtual meeting. He turned the presentation over to Dr. Cutler, who gave opening remarks.

ITEM 1: APPROVAL OF MINUTES FROM THE MAY 6, 2020 MEETING
Dr. Cutler called for a motion to approve the minutes from the May 6, 2020, meeting. Mr. Roeder motioned to approve the minutes. Mr. Mastrogiovanni seconded the motion. The vote was taken by roll call. The minutes were approved unanimously.

Mr. Seltz provided a brief preview of the upcoming cost trends hearing. For more information, see slide 6.

ITEM 2: – SERIOUS ILLNESS AND END OF LIFE CARE IN THE COMMONWEALTH
Mr. Seltz introduced the presentation on serious illness and end of life care in the Commonwealth. He turned the presentation over to Ms. Sara Sadownik, Deputy Director, and Ms. Hannah James, Senior Research Associate, Research and Cost Trends. For more information, see slides 8-22.

Mr. Mastrogiovanni noted that many patients might have expressed their end of life care wishes many years prior to actually receiving the care. He asked if that might sometimes impact the care actually delivered in certain cases. Ms. Sadownik said that the ideal situation was likely that these conversations were ongoing and that any changes to preferences were articulated prior to the care being needed. She added that a health care proxy may be designated and that hopefully conversations would be ongoing with that individual. Ms. Blakeney said that it was critical that both the provider and patient recognize that this be an ongoing process of discussion with all parties involved. She said that she believed it was the provider's responsibility, as the party that best understands the process, to ensure this occurs.

Regarding the chart on slide 19, Dr. Cutler said it was important to note that in many parts of the country, other than Massachusetts, hospice care is not well administered and there were many unscrupulous hospice providers who take advantage of their clients. Ms. James said that in Massachusetts there had been a great deal of work done to educate both providers and patients about hospice and its purpose. Ms. Sadownik added that much of the fraud in hospice use was related to the length of service. She noted that this chart displayed the rate at which Medicare patients received any hospice services at all.

Dr. Cutler thanked the staff for the presentation. He asked if Dr. Berwick and Ms. Blakeney had anything to add from their own experience with this topic.

Dr. Berwick said that the Institute for Healthcare Improvement's (IHI's) Conversation Project touched on a lot of these issues. He said that it was crucial to provide resources and education to families to help them have conversations around advanced care planning in an anticipatory way. He said that the tools provided by the Conversation Project in this realm were very useful. He noted that there were several communities around the U.S. that had made astonishing progress and were approaching almost 100 percent advanced care planning across their Medicare populations and that it would be worth looking at these places to see what could be learned. He said that the other target of the Conversation Project was providers and that it was equally important that organizations have the mechanisms in place to map advanced care planning into their care processes.

Ms. Blakeney echoed Dr. Berwick's support for the Conversation Project. She said that these conversations with families and providers could be very difficult and said that it was best to have them more frequently than people might think necessary. She noted that the discrepancy in end of life care between white and non-white populations was significant and that it was important to think about how to close that gap and ensure more equitable services and resources. She said that often a barrier to offering palliative or hospice care is reluctance on the part of the clinician, which underscores the importance of communication among all parties so that the resources available to people at the end of life were delivered at the optimal time.

Mr. Foley asked whether the equity issues regarding end of life care may be due to the diversity or lack-thereof among clinicians and if there were any data on whether there was a relationship between those factors. Ms. Sadownik said that there was some research that suggested this might be a factor and that it was important to think about the implications of the backgrounds of clinicians, but also of other staff such as chaplains and social workers who might be involved in these conversations.

Dr. Berwick said that The Support Project, a 1996 study, had documented that a majority of patients and providers did not want a lot of intensive care unit (ICU) care and other interventions at the very late stages of their last illness. He said that, while these should be options for those who want them, the study also showed that most patients end up receiving care that they do not want at the end of life. He said that deeper investigation and conversations were crucial to ensure that the care patients receive shifts to being in line with their wishes. Dr. Cutler said that, as he recalled the study, it had found that interventions to improve this situation had not been effective. Dr. Berwick noted that the study was a couple of decades old but said that yes, that had been the case.

Dr. Kryder said that this was a very complex topic, noting that people often change their perspectives on their desires for care as they age or deal with illnesses over the course of their lives. He noted that what had been presented today was exclusively fee-for-service (FFS) data andthat FFS promotes

fragmentation of care and therefore few advanced directives, fewer health care proxies, and, as a result, more death in the ICU and hospital and decreased hospice care. He said that he suspected that with more data from the MassHealth accountable care organization (ACO) initiatives and Medicare Advantage that the HPC would see an improvement in some of these numbers. He said that value-based care forced engagement between physicians and patients which helped ameliorate some of these issues. He said he hoped that the HPC could get some of that data promptly and if not perhaps could look at some of the Kaiser Family Foundations (KFF) data in this area. Ms. Sadownik agreed that coordination of care was crucial to improving outcomes for patients.

ITEM 3: IMPACT OF COVID-19 PANDEMIC ON MARKET REVIEWS

Mr. Seltz briefly introduced the presentation on the impact of the pandemic on market reviews. He turned the meeting over to Ms. Katherine Mills, Senior Director, Market Oversight and Transparency (MOAT), and Ms. Megan Wulff, Director, Market Performance. For more information, see slides 24-25.

Dr. Kyrder said that he was anecdotally aware of activities around the country in which primary care groups were growing and being acquired by hospitals and in which financially strapped hospitals were offering early retirement to expensive, senior physicians while not providing jobs to younger physicians coming out of residency. He said this activity might portend some of the bigger moves ahead in the market. He noted that private equity is getting more involved and tends to be buying specialty, rather than primary care, groups. He said that it remained to be seen if whether over time independent practice groups would grow or contract as a result of all the changes underway, and that a move to greater capitation could allow them to grow. He said that he anticipated the HPC seeing a lot of activity in the coming months. Dr. Cutler said that an added complication was that budgets of everyone, including states, localities, and employers, would be stretched in the coming months. He said that despite some recovery over the summer, the economic situation was far from positive.

Mr. Cohen observed that a large number of the notices received recently had been related to ambulatory surgery centers. He said that normally these reviews looked closely at the price difference between the ambulatory surgery center and the hospital where a surgery would have otherwise occurred but said it might make sense for the HPC to look at the impact on volume compared to where that surgery would have taken place previously and how that might impact hospital capacity moving forward.

Dr. Berwick noted that one of the trends that had been observed since the start of the pandemic was the expansion of telehealth and growth of telehealth companies. He said that he was not entirely sure how the growth of this sector of the health industry was being financed but that structural changes like this would be something the HPC should track closely moving forward. He said pricing of telehealth was something that would need to be considered seriously moving forward and whether or not telehealth would function as an add-on rather than a replacement for services previously conducted face-to-face. Dr. Cutler said that this was being tracked and that telehealth was declining both as a share of visits and in absolute numbers. He said that no one had really determined definitively whether they would be integrated into existing care models or added on top moving forward. Dr. Berwick asked whether a telehealth vendor could enter the market as a provider on its own. Dr. Kryder said that to enter the market as a provider in Massachusetts, an organization must have a network involving licensed physicians in Massachusetts providing the care. He said that the pricing question was crucial here. He said that it was impossible to imagine that telehealth visits could not be delivered at far less cost than in-person alternatives because of the lack of overhead. He said that he was still aware of organizations that were delivering 70 to 80 percent of their behavioral health (BH) care remotely. He said that he hoped

the HPC could further investigate this topic. Dr. Berwick said that two days earlier he had testified to a commission in Vermont looking into pricing and quality for telephone visits.

Mr. Foley noted that there was a great deal of volatility in the health care market at this moment and that the outcome of the November election was likely to impact market changes. He asked what role the HPC had in transactions involving home care or long-term care facilities as, given the impact of the pandemic, many of those models would likely be rethought moving forward. Ms. Wulff said that through its transactional review authority, the HPC does receive requests in situations such as a system acquiring a post-acute care entity as long as the system's net patient service revenue increased by $10 million or more. She said that the HPC would also receive notice of a transaction between a payer and one of those entities, provided it met the definition of a provider. Mr. Seltz said that while the HPC did have authority in this area, these kinds of transactions had been few and far between over the duration of the agency's existence. He said that Mr. Foley's comment was a great call for the HPC to think critically about what data resources would be useful in evaluating these transactions with the potential now for more of them. He said that the COVID pandemic had resulted in new investments in data collection and processing across the health care continuum. He said that the Center for Health Information and Analysis (CHIA) had been improving much of the data collection around nursing facilities and this could present new opportunities to see what data was available to bring to bear.

ITEM 4: OPIOID-RELATED ACUTE HOSPITALIZATION IN MASSACHUSETTS

Mr. Seltz turned the presentation over to Dr. Laura Nasuti, Associate Director, Research and Cost Trends. Dr. Nasuti presented the update on opioid-related acute hospitalization in Massachusetts. For more information, see slides 27-38.

Dr. Cutler asked if there was any informal evidence regarding what was happening in 2020 to opioid hospitalizations. Dr. Nasuti said that, at this time, there was not. She said there was a small study she had read out of an emergency department (ED) in a Virginia hospital that saw a disproportionate increase in the number of Black patients admitted for opioid use. She noted that the Department of Public Health's next opioid overdose report would be released in November but she was unsure how much 2020 data would be captured there.

Dr. Berwick noted that the pattern of opioid hospitalizations in the incarcerated and previously incarcerated population was a major issue. He asked if it might be worthwhile for the HPC at some point to dedicate time to looking specifically at the incarcerated population.

ITEM 5: CENTER FOR HEALTH INFORMATION AND ANALYSIS: HOSPITAL FINANCIAL DATA COLLECTED DURING THE COVID-19 PANDEMIC

Mr. Seltz introduced the presenters from CHIA who provided an update on the hospital financial data collected during the COVID 19 pandemic. For more information, see slides 40-48. The video of the CHIA presentation portion of the meeting can be viewed here.

ITEM 6: ADJOURNMENT

Dr. Cutler thanked the Committee and the staff. The meeting adjourned at 11:02 a.m.