MASSACHUSETTS
HEALTH POLICY COMMISSION

Quality Improvement and Patient Protection Committee Meeting.

January 25, 2017

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Call to Order**
- Approval of Minutes from the January 11, 2017 (VOTE)
- Updated Neonatal Abstinence Syndrome Trends
- Office of Patient Protection Annual Report
- Schedule of Next Committee Meeting (March 15, 2017)

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HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the QIPP meeting held on January 11, 2017, as presented.

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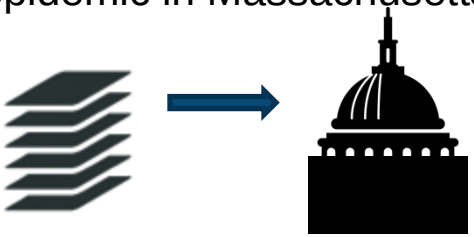
HPC's Sept 2016 report identified care delivery and payment reform innovations that could contribute to the Commonwealth's effort to address opioid use disorder

Opioid Use Disorder in Massachusetts: an Analysis of its Impact on the Health Care System, Pharmacological Treatment, and Recommendations for Payment and Care Delivery Reform

1

Provide new research and data analyses to support and inform policy on the opioid epidemic in Massachusetts



2

Draw on our experience with investment, certification, and technical assistance programs to inform scaling of emerging best practices

3

Identify strategic policy opportunities to promote innovative care delivery and payment models for opioid use disorder treatment that are likely to result in reduced spending and improved quality and/or access

HPC

Updating HPC analyses for 2015

One recommendation in HPC's report was that the Commonwealth continue to track the impact of opioid use disorder and related conditions on the health care system.

HPC conducted the following analyses in 2014, and plans to update them annually:

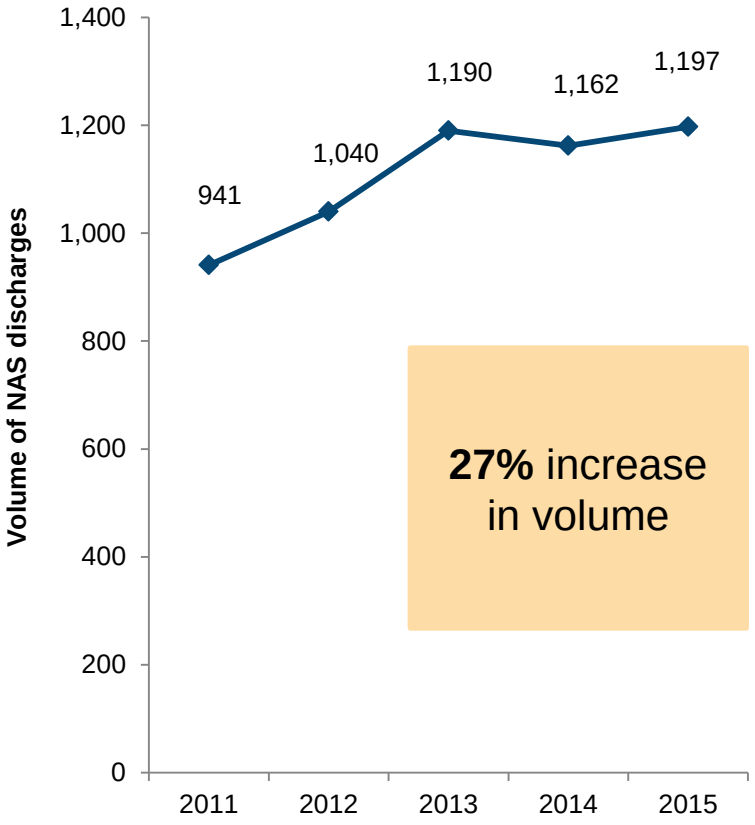
- Opioid-related hospital discharges (ED visits and inpatient admissions)
- Impact on communities (discharges mapped by HPC region)
- Impact on populations (admissions stratified by income, gender, and age)
- **Impact on exposed infants (Neonatal Abstinence Syndrome)**

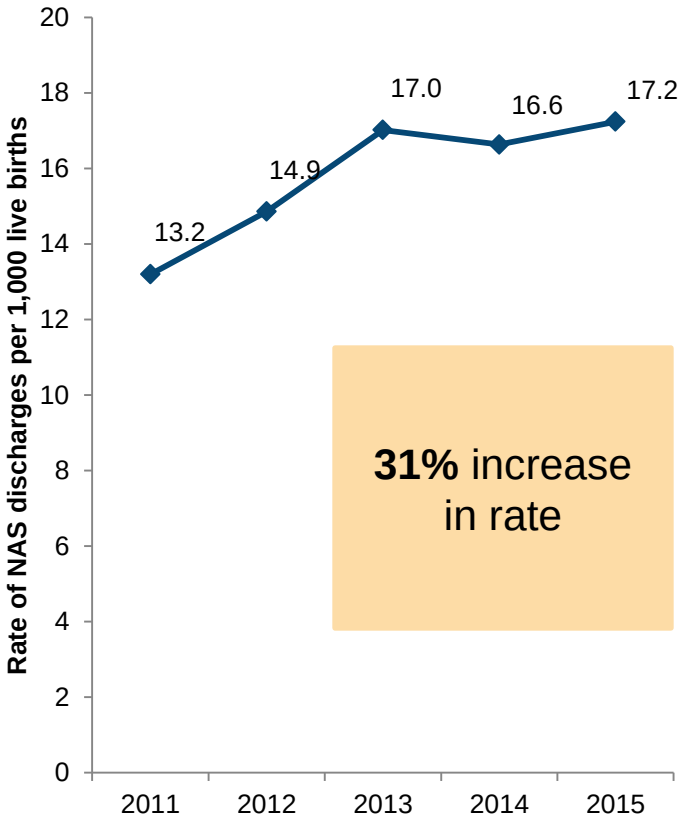
2015 update for today's discussion

HPC

See appendix for analyses methods

NAS increased significantly in Massachusetts between 2011 and 2015

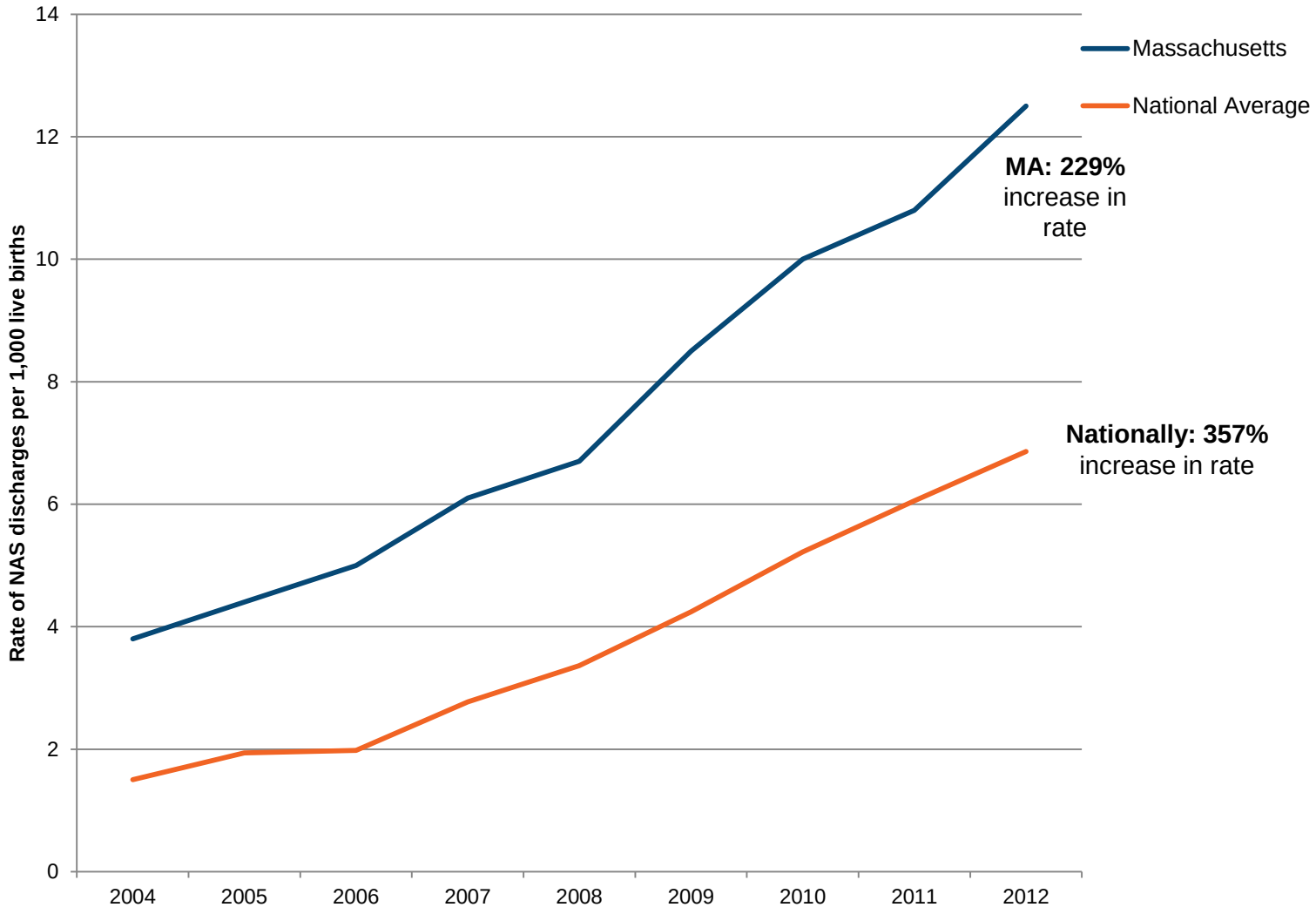




Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database 2011-2015

Notes: NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn).

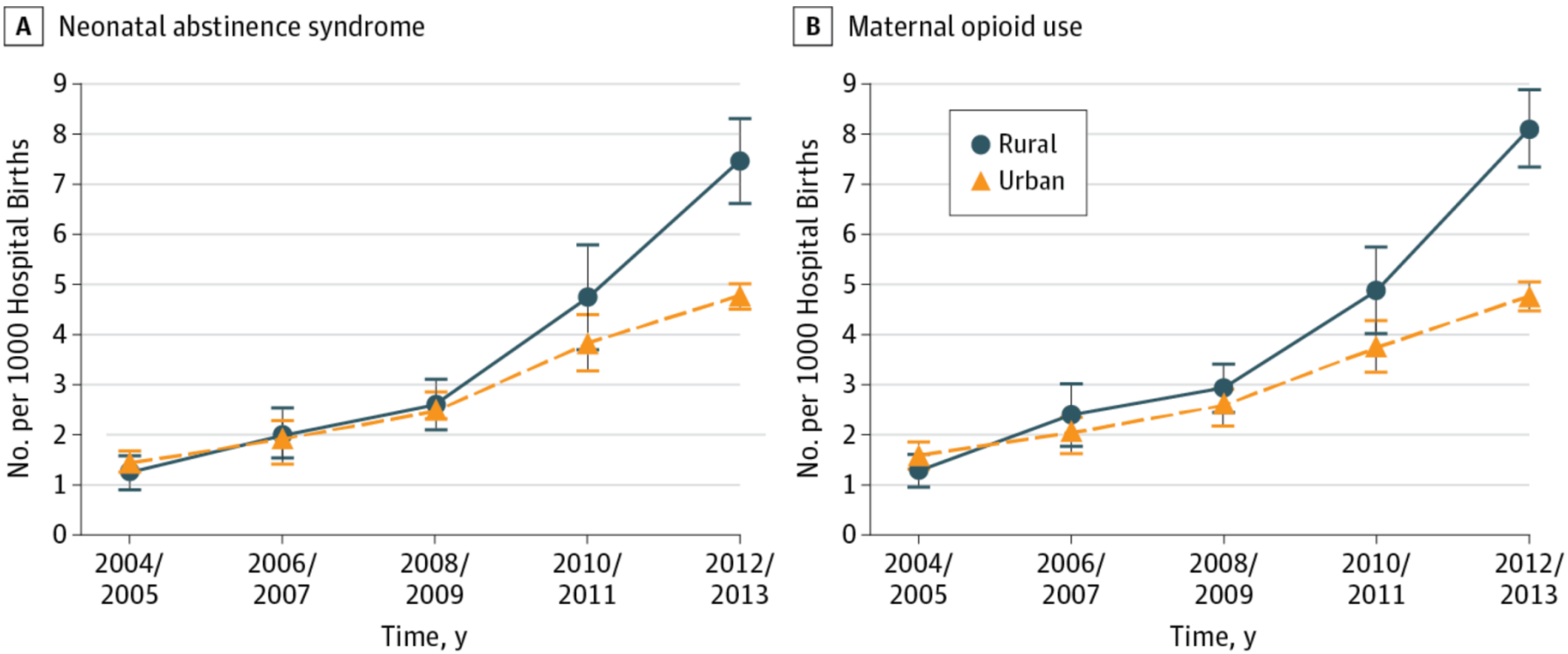
NAS is increasing significantly throughout the nation but particularly rapidly in certain states



Source: Ko JY, Patrick SW, Tong VT, Patel R, Lind JN, Barfield WD. Incidence of Neonatal Abstinence Syndrome — 28 States, 1999–2013. MMWR Morb Mortal Wkly Rep 2016;65:799–802. DOI: http://dx.doi.org/10.15585/mmwr.mm6531a2

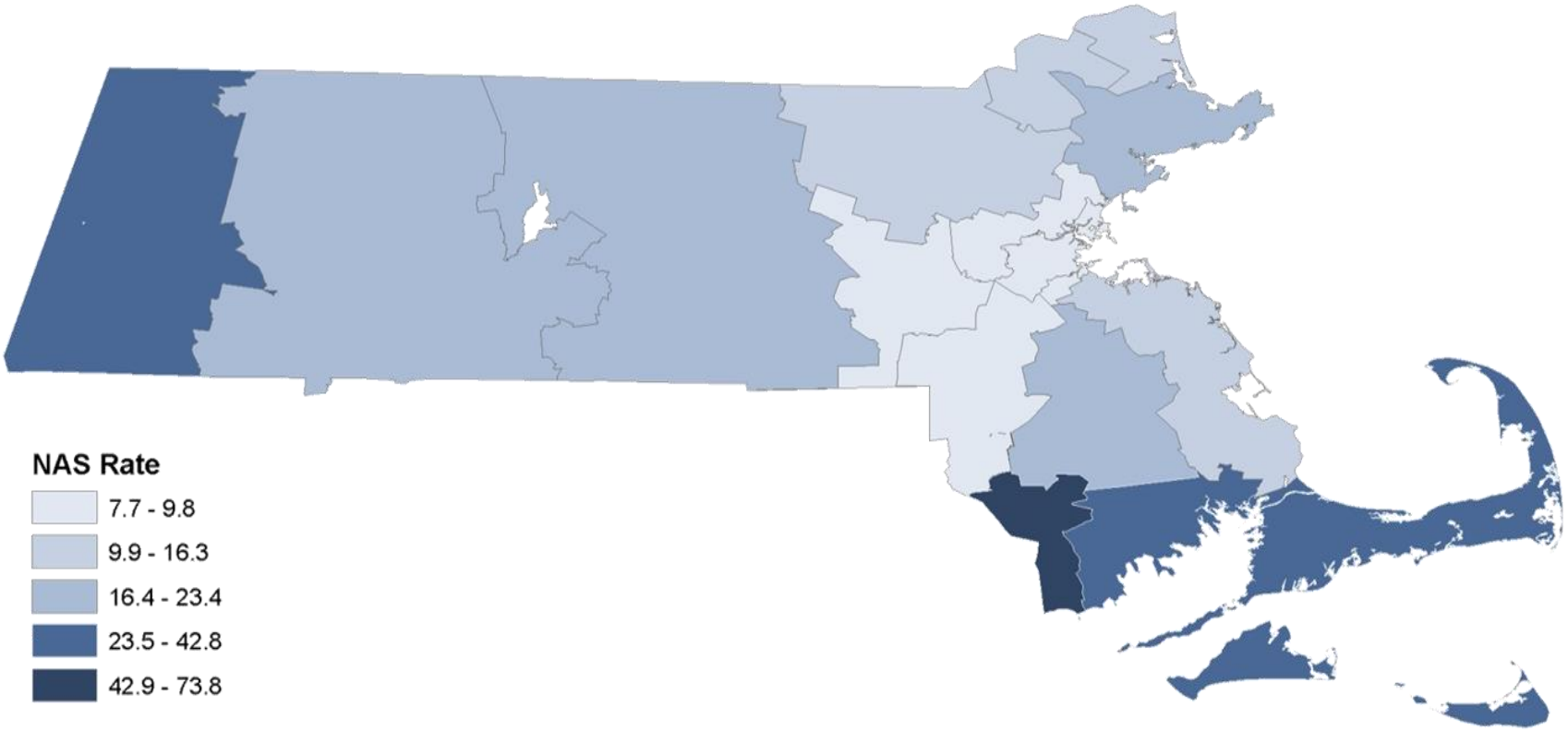
Nationally, the rate of NAS is increasing most quickly in rural areas

Rural and Urban Differences in Neonatal Abstinence Syndrome and Maternal Opioid Use, 2004 to 2013



JAMA Pediatr. Published online December 12, 2016. doi:10.1001/jamapediatrics.2016.3750

Rate of NAS discharges per 1,000 live births, by HPC region, in 2015



Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database 2015

Notes: NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn).

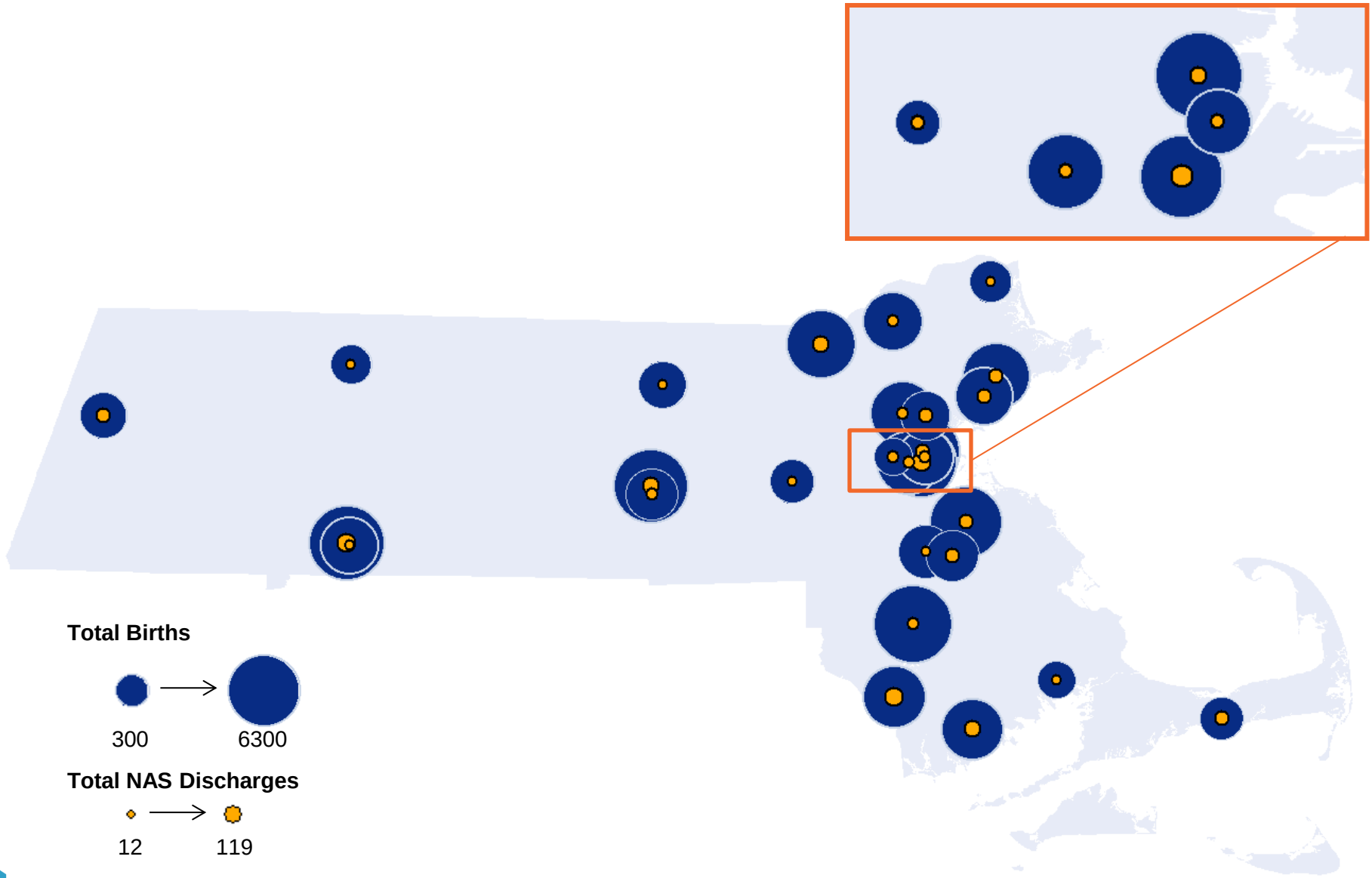
2015 NAS discharges by hospital volume

See Appendix for hospital names

Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database 2015

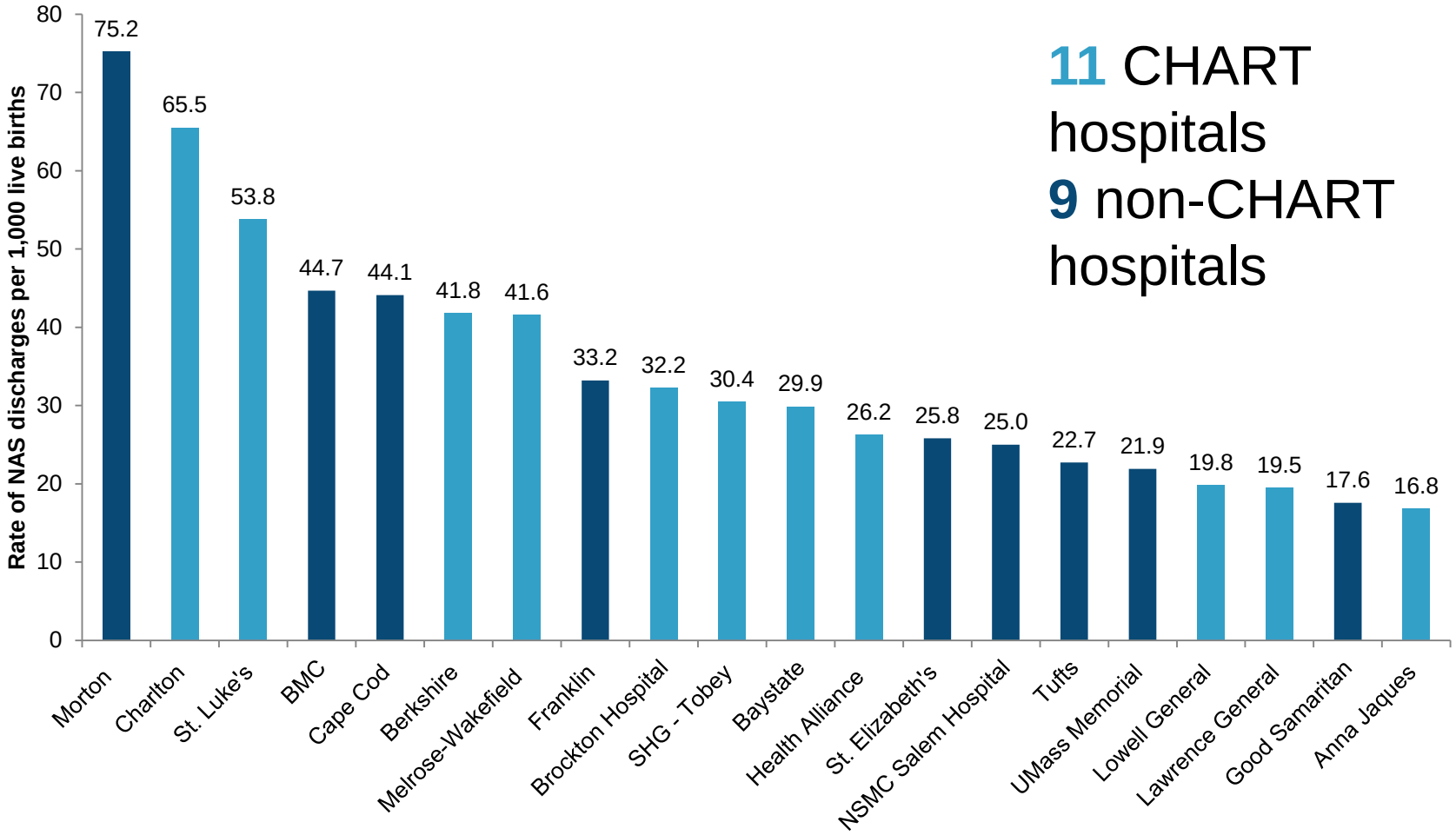
Notes: NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn). Only includes hospitals with 12 or more NAS discharges.

2015 NAS discharges by hospital volume, relative to total obstetric volume



See appendix for hospital names

MA hospitals with highest rate of NAS in 2015



11 CHART hospitals
9 non-CHART hospitals

Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database 2015

Notes: NAS discharges were identified using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn). Only includes hospitals with 12 or more NAS discharges.

HPC

Due to rapidly increasing rates of NAS, the Commonwealth is focusing on quality and availability of treatment

The FY2017 budget created an **NAS taskforce**(co-chaired by Secretary of EOHHS & the Office of the Attorney General) and **advisory council**, to develop recommendations **to improve quality of and access to treatment.**

Recommended **state plan of action**, along with any **proposed legislation or regulatory amendments**, expected March 2017.

State Plan of Action

1. State plan for the coordination of care and services for newborns with neonatal abstinence syndrome and substance exposed newborns including, but not limited to, those related to early intervention, substance use disorders and healthcare access issues;
2. Include an inventory of the services and programs available in the Commonwealth to serve newborns with neonatal abstinence syndrome and substance exposed newborns;
3. Identify gaps in available services and programs;
4. Formulate a plan to address identified gaps; and,
5. Develop an interagency plan for collecting data, develop outcome goals and ensuring quality service is delivered

HPC

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Office of Patient Protection Overview

History of the Office of Patient Protection

- Created in 2000 to protect Massachusetts managed care consumers (Ch. 141)
- OPP operated within the Department of Public Health (DPH)
  - Consumer rights to challenge health plan coverage denials
  - Massachusetts fully-insured plans only
- Chapter 224 moved OPP from DPH to HPC
- OPP transfer took effect April 20, 2013

Core Responsibilities

- Regulating internal and external review for fully-insured plans
- Administering external review for fully-insured plans
- Consumer assistance and education
- Administering enrollment waivers to purchase non-group health insurance
- Receiving and analyzing annual reports from health plans about appeals, disenrollment of providers, other mandated information
- Developing and regulating an appeals process for patients in risk bearing provider organizations (RBPOs) and HPC-certified accountable care organizations (ACOs)

Internal review process

Process for consumer with a fully-insured Mass. health plan

1. Consumer receives denial letter from carrier

- Denial of prior authorization or denial of claim, must be in writing
- May be based on medical necessity or other reasons
- Consumer may request expedited internal review
- Consumer may request continuation of coverage

2. Consumer appeals directly to carrier

- May appeal in writing or over the phone (carrier puts in writing)
- Carrier responds within 30 days unless voluntary extension
- Carrier responds within two days if expedited

3. Carrier responds to consumer

- Written response to consumer
- Carrier may reverse, modify or uphold original decision

4. Further appeal rights

- Voluntary reconsideration if offered by carrier
- If denial based on **medical necessity**, may seek external review through OPP

HPC

External review process

Process for consumer with a fully-insured Mass. health plan, after pursuing internal review

1. Consumer receives 2nd denial from carrier

- Consumer receives written denial notice/final adverse determination from carrier
- External review if **medical necessity**
- Consumer may request expedited external review
- Consumer may request continuation of coverage

2. Consumer requests external review

- Deadline: 4 months from the date the insured receives the final adverse determination
- Submit completed external review form, copy of final adverse or adverse determination & $25 fee if applicable, any supporting documents

3. Independent external review

- OPP reviews for eligibility
- If eligible, OPP sends to external review agency (ERA)
- ERA requests file from carrier
- ERA applies Mass. medical necessity standard
- Standard: 45 days
- Expedited: 72 hours

4. Next steps

- ERA may uphold, overturn, or partially overturn
- ERA sends written decision to insured, representative, OPP, carrier
- Carrier must respond within 5 days, implement without delay
- Final and binding decision

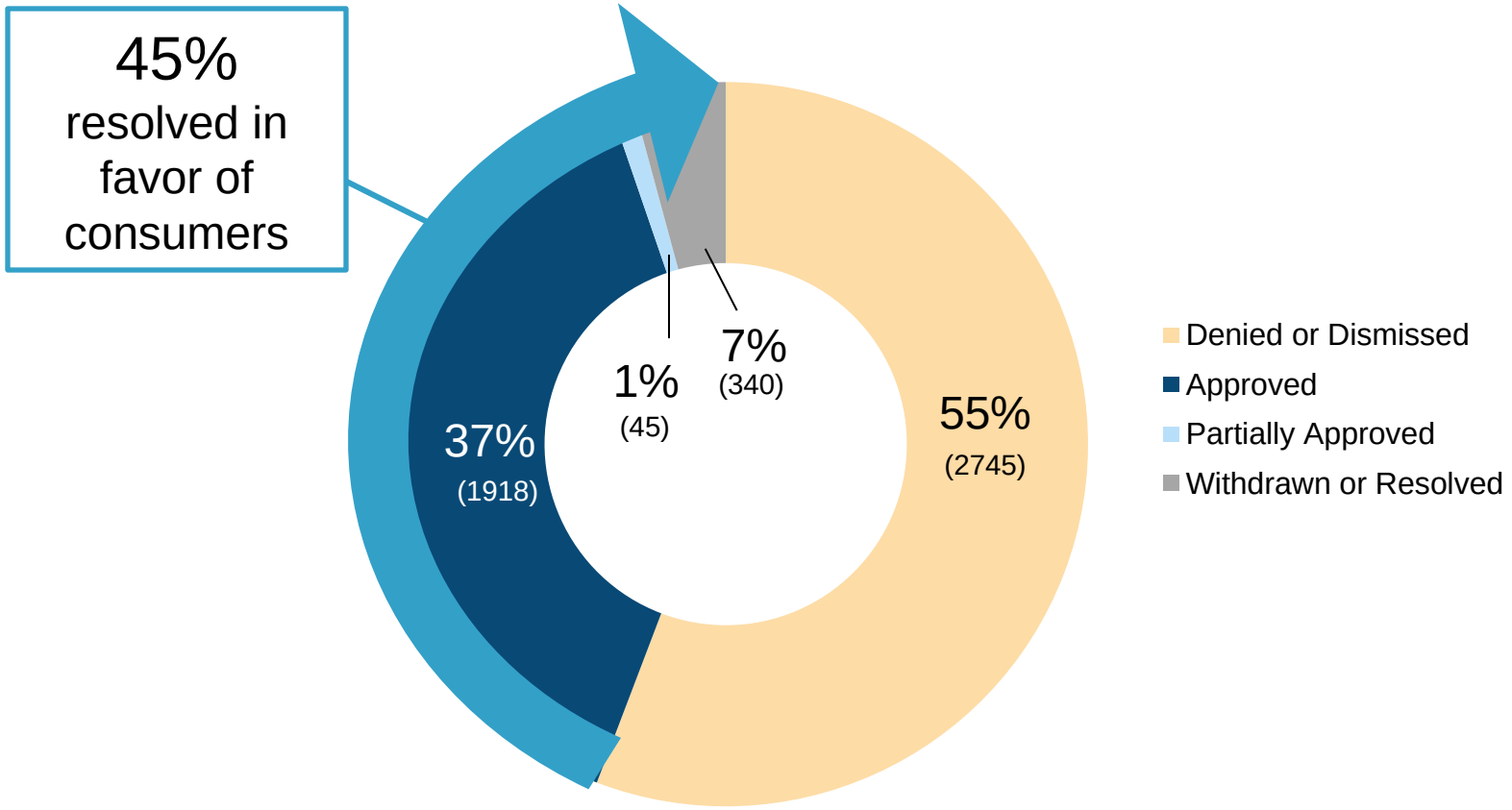
HPC

In 2015, insurance companies received 12,429 complaints from members. Of these, 5,115 were member grievances based on adverse determinations, & insurers resolved 42% fully/partially in favor of the member.

Internal Review

Adverse Determinations

Insurance companies reported 5,115 member grievances in 2014, which were internally reviewed by the insurance companies.



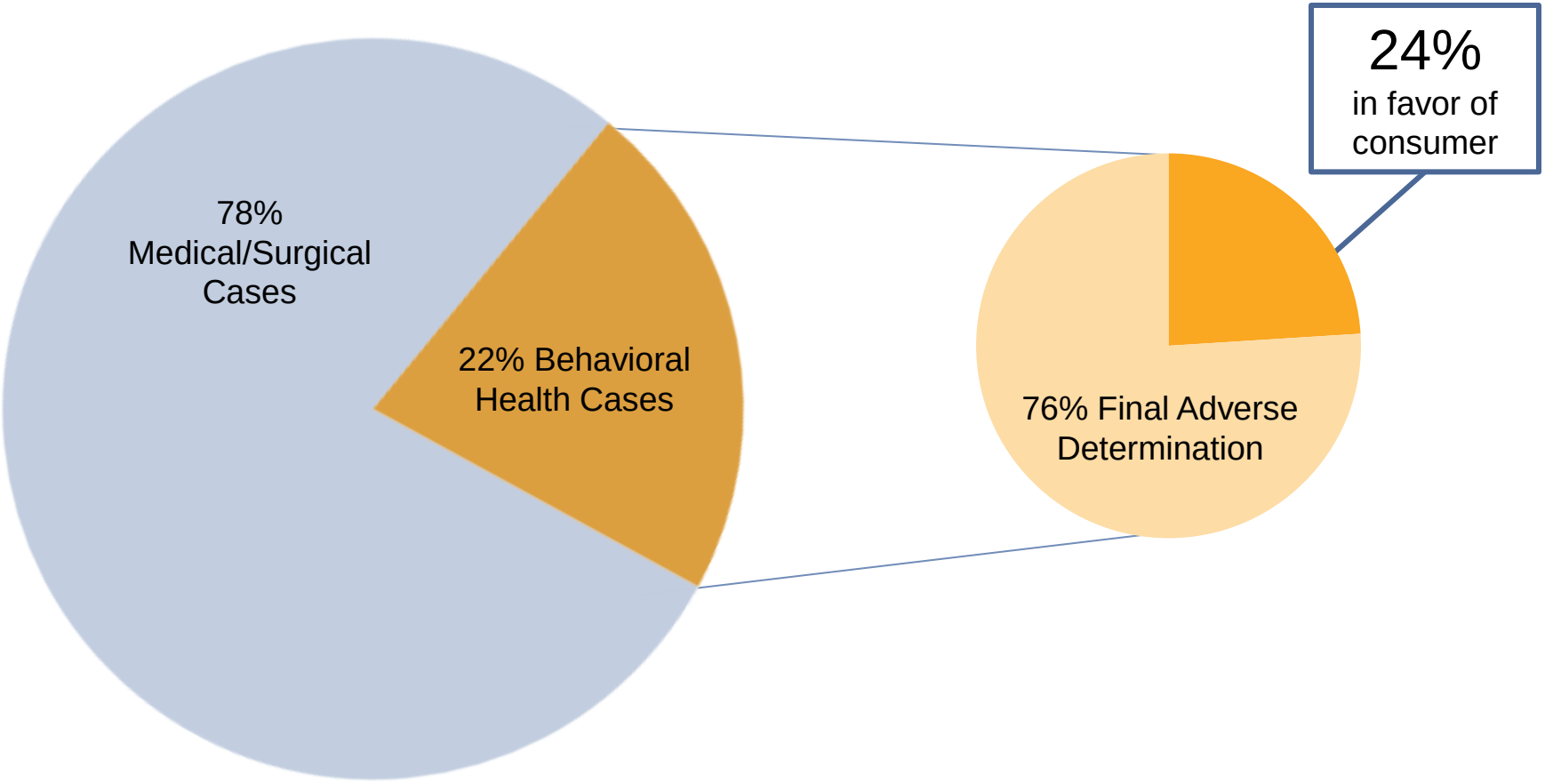
Source: 2015 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

Insurers reported that about 22% of requests for internal review (grievances) involved behavioral health services. Insurers resolved about 24% in favor of the member

Internal Review

Adverse Determinations

Behavioral Health



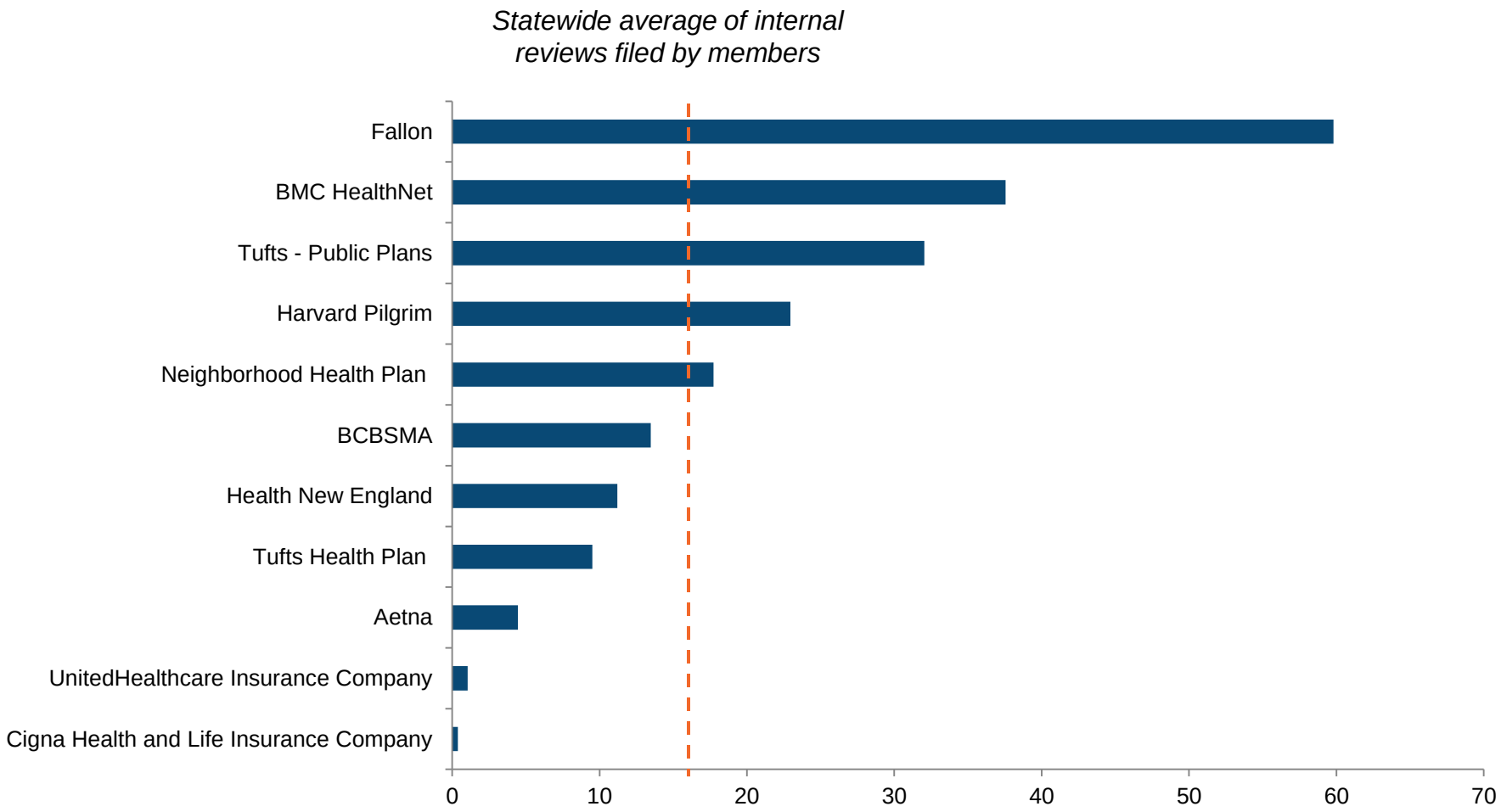
HPC

When weighted for the number of members in each plan, Fallon reported the highest proportion of internal reviews

Internal Review

Adverse Determinations

Number of internal reviews per 100,000 members reported by insurance company, weighted by reported member months by insurance company



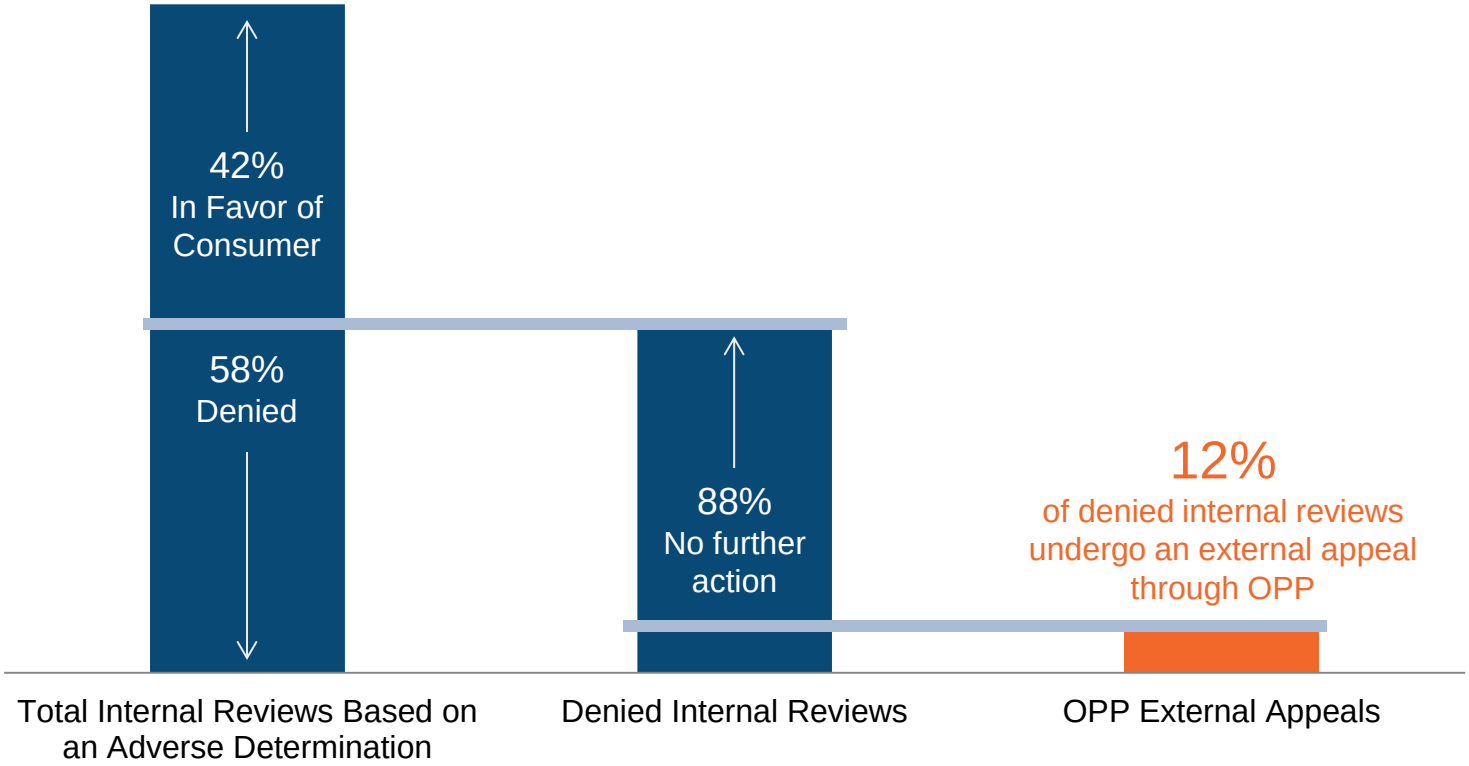
Source: 2015 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600.
Weighted by dividing number of internal reviews by most recent health plan reported member month data. Center for Health Information and Analysis, 2013

Of those receiving adverse determinations during 2015, 12% of members with internal reviews that were denied or partially denied then pursued external appeals through OPP.

Internal Review

Adverse Determinations

The proportion of members who were denied or partially denied during the internal review process and who filed eligible external review requests with OPP

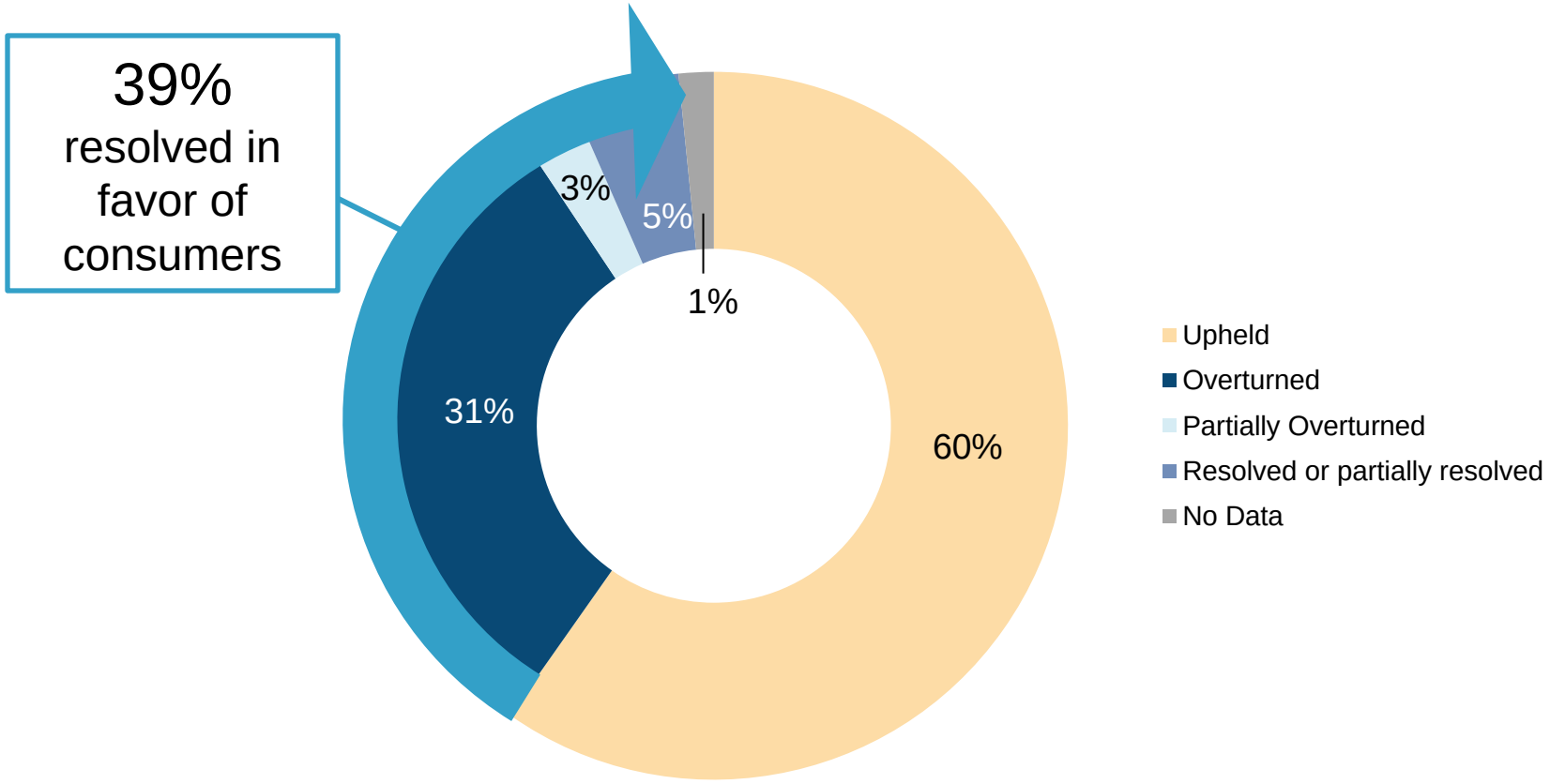


Source: 2015 Office of Patient Protection external review data; 2015 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600
In Favor of Consumer includes Approved, Partially Approved, and Withdrawn or Resolved

OPP received 250 eligible requests for external review during 2015.

External Review

Percentage of external review cases by outcome, 2015

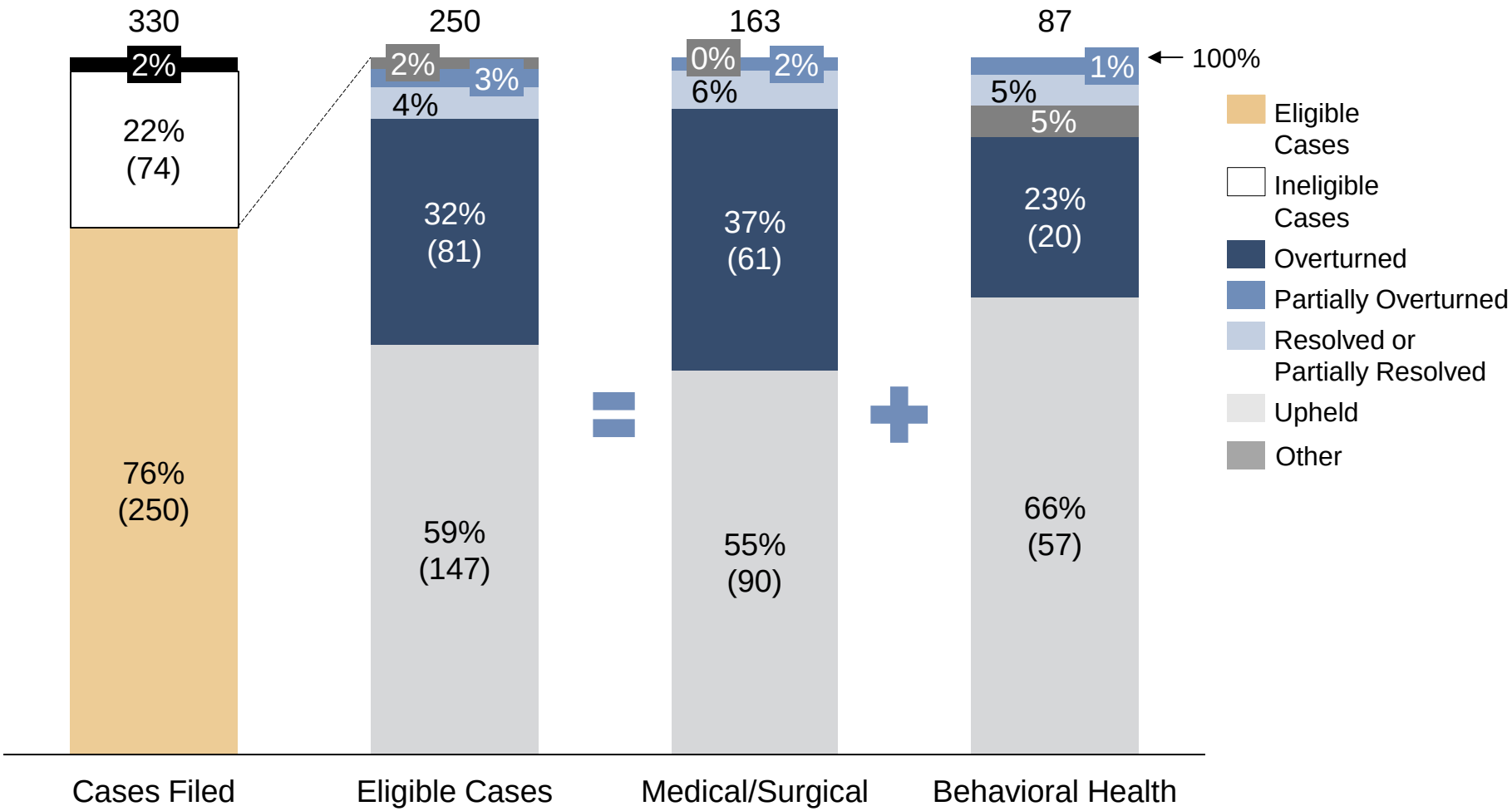


Source: 2015 Office of Patient Protection external review data

During 2015, OPP received 330 external review requests. Of the 250 eligible cases, OPP received 163 requests for medical/surgical treatment and 87 requests for behavioral health treatment.

External Review

Percentage of external review cases by disposition, by type of case (Medical/Surgical Care vs. Behavioral Health Care), 2015



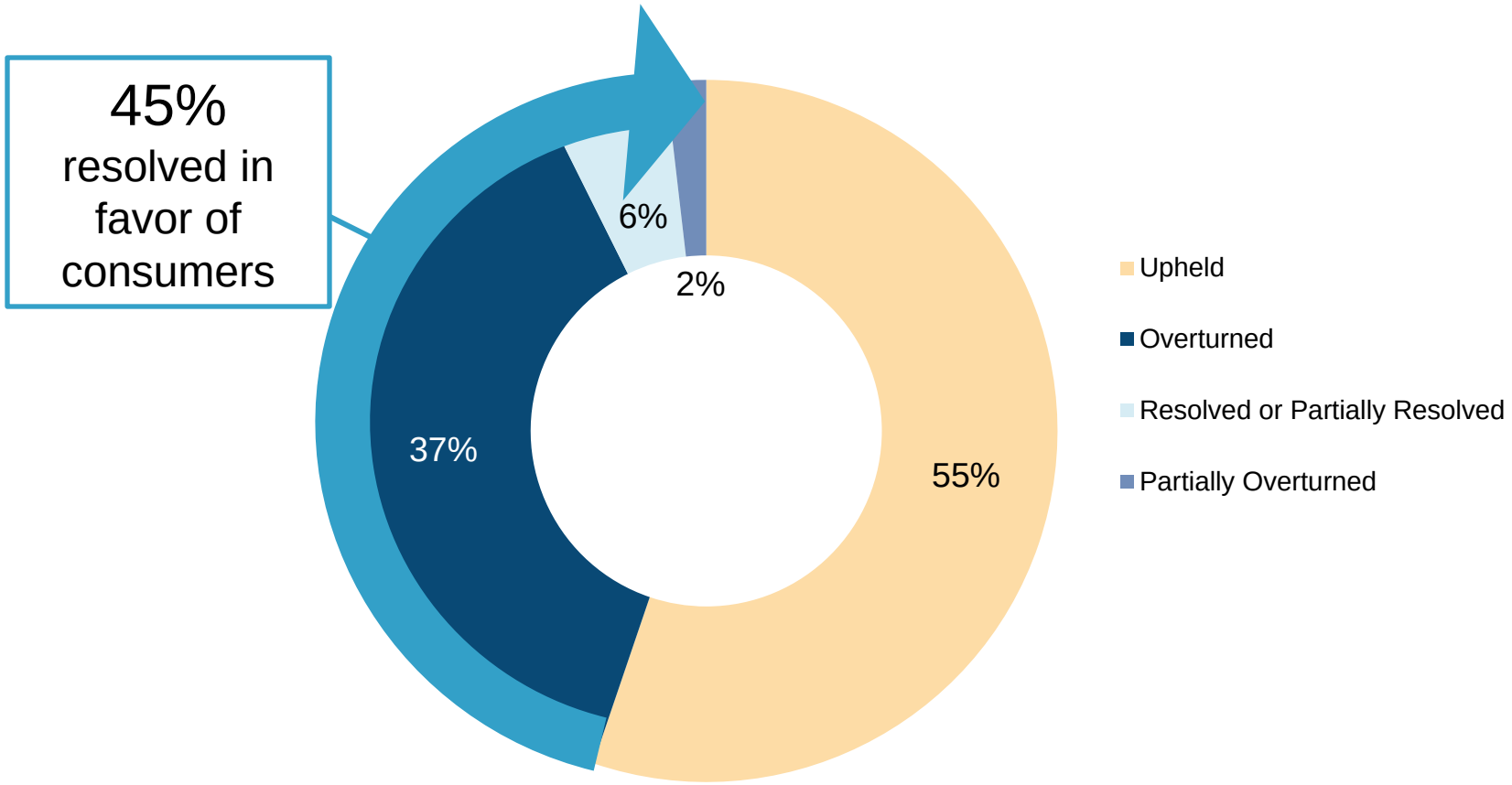
Source: 2014 Office of Patient Protection external review data

45% of the medical/surgical treatment requests were resolved fully or partially in favor of the patient.

External Review

Medical/Surgical

Outcomes of eligible external reviews for medical/surgical service requests in 2015



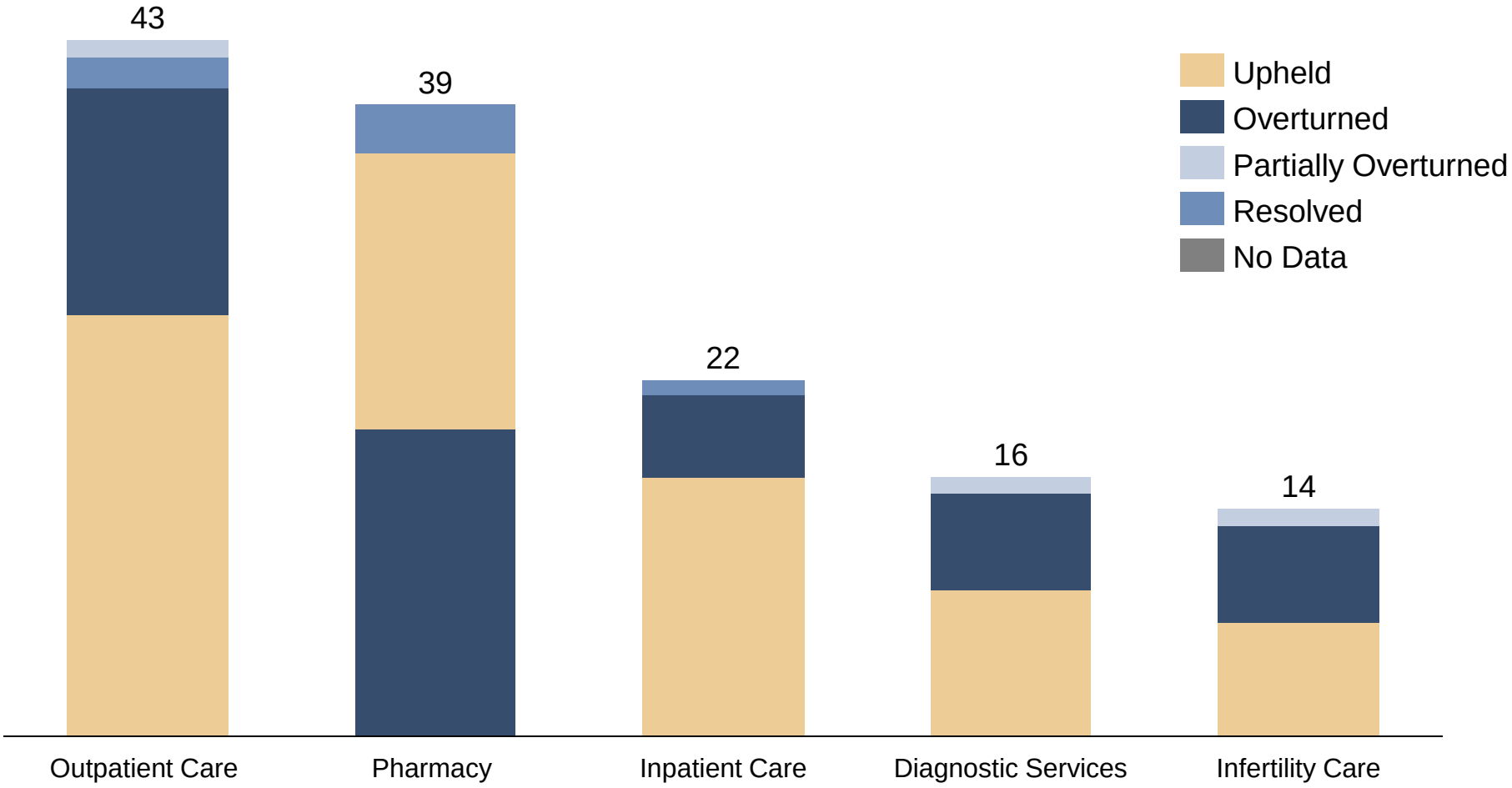
Outcomes of eligible external reviews for medical/surgical service requests in 2015.
Source: 2015 Office of Patient Protection external review data

In 2015, patients filed requests for external review for the following types of medical or surgical treatment.

External Review

Medical/Surgical

Proportion of eligible external reviews in Medical/Surgical Care by category of treatment (2015)



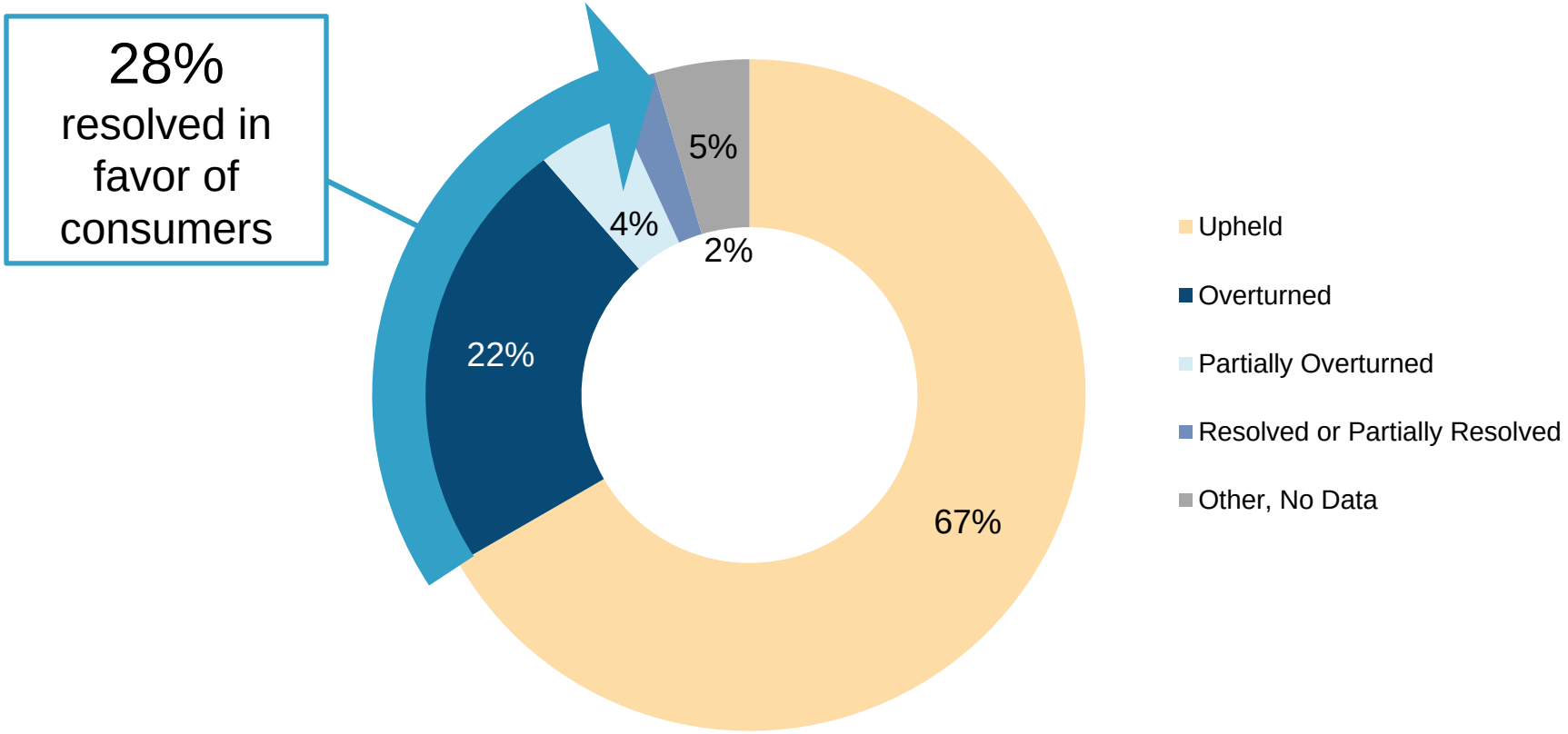
Source: 2015 Office of Patient Protection external review data

28% of eligible external review cases for behavioral health treatment were decided fully or partly in favor of the patient, a decrease from 2014.

External Review

Behavioral Health

Eligible external reviews related to behavioral health treatment by outcome, 2015



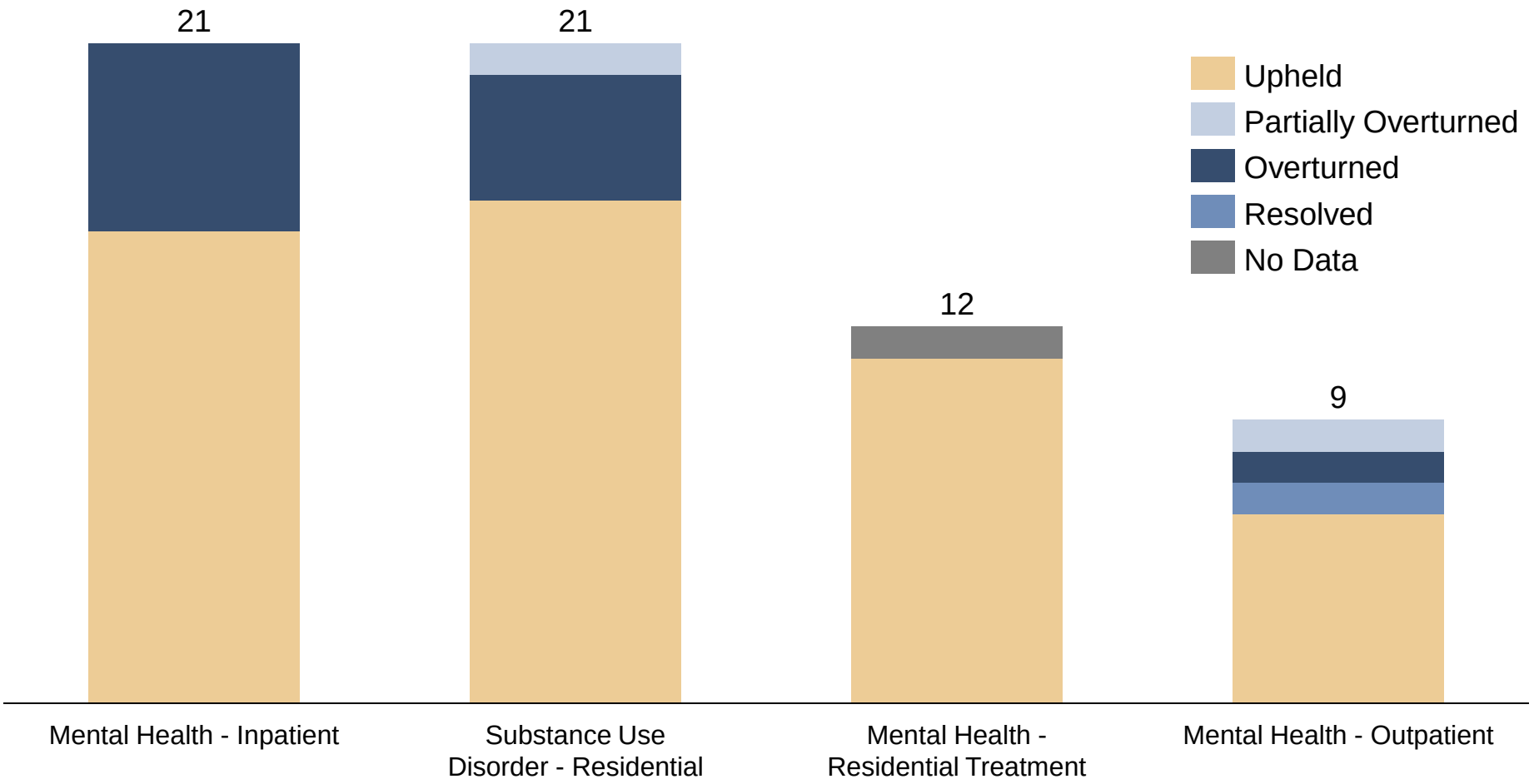
Eligible external reviews related to behavioral health treatment by outcome, 2015
Source: 2015 Office of Patient Protection external review data

Inpatient mental health and residential substance use disorder topped the main categories of behavioral health external review.

External Review

Behavioral Health

Eligible external reviews related to behavioral health treatment by outcome and type of service requested, 2015

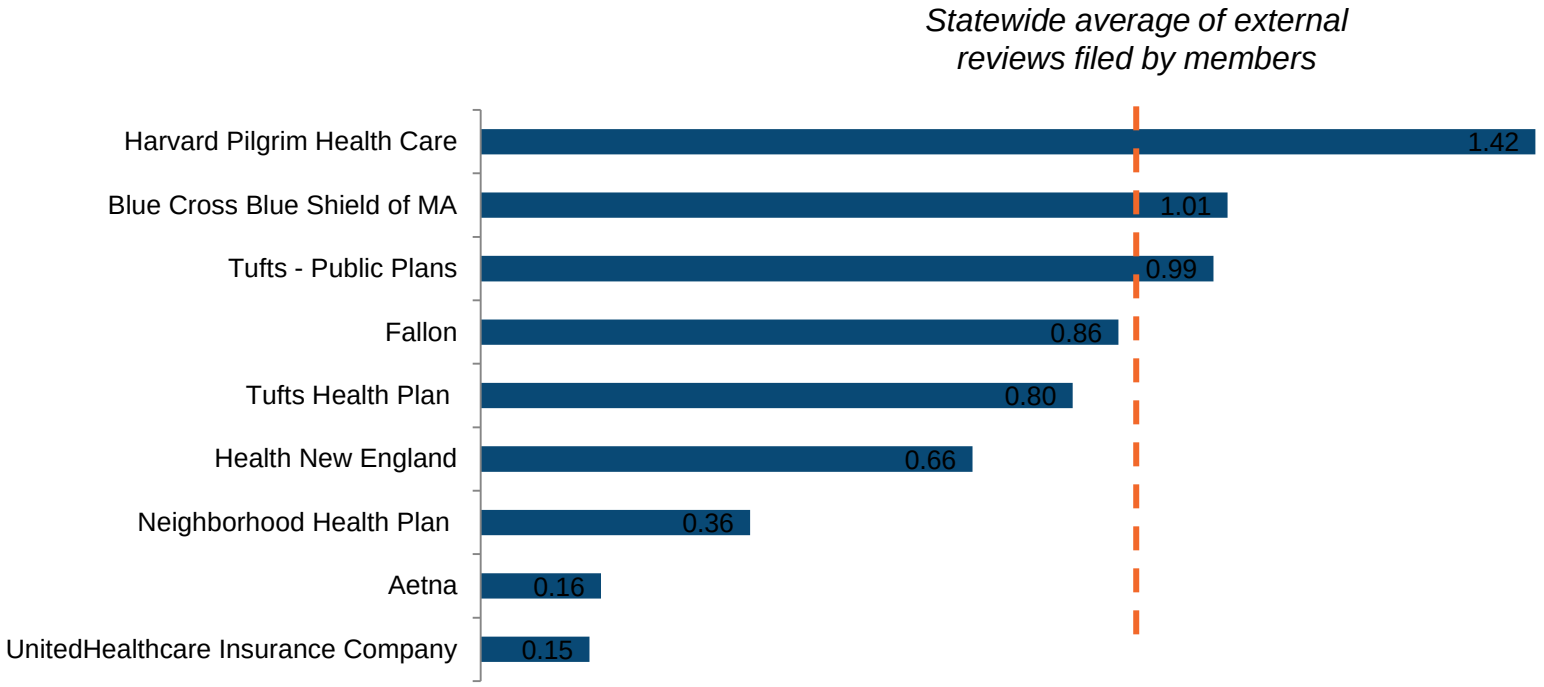


Source: 2015 Office of Patient Protection external review data

When weighted by number of members, members of three large carriers sought a higher than average number of external reviews

External Review

Number of external reviews (2015) per 1,000,000 members weighted by number of enrolled member months



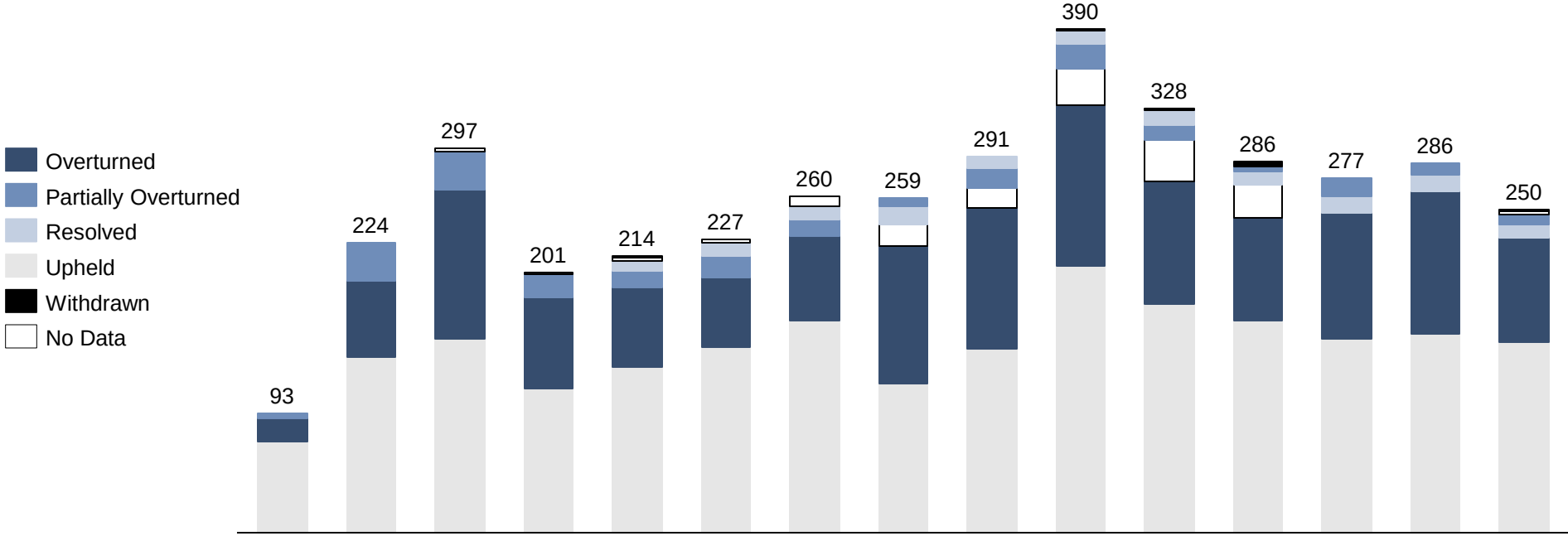
Note: Weighted by dividing number of external reviews by most recent health plan reported member month data. Center for Health Information and Analysis, 2013

Source: 2015 Office of Patient Protection external review data, Member months from Center for Health Information and Analysis, 2012

The number of external review cases has varied, but the proportion of cases resolved in favor of the patient has remained relatively constant.

External Review

Number of eligible external review cases over time, by disposition, 2001 to 2014



Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Overturned	18	59	115	71	62	53	66	107	109	125	95	80	97	110	78
Partially Overturned	4	29	30	18	13	17	12	6	15	19	12	4	15	9	7
Resolved	0	0	0	0	8	10	11	15	9	11	11	10	14	13	12
Upheld	70	136	150	111	128	144	164	115	143	206	177	164	150	154	149
Withdrawn	0	0	0	0	1	0	0	0	0	1	1	3	1	0	2
No Data	1	0	2	1	2	3	7	16	15	28	32	26	0	0	2
Total	**93**	**224**	**297**	**201**	**214**	**227**	**260**	**259**	**291**	**390**	**328**	**287**	**277**	**286**	**250**

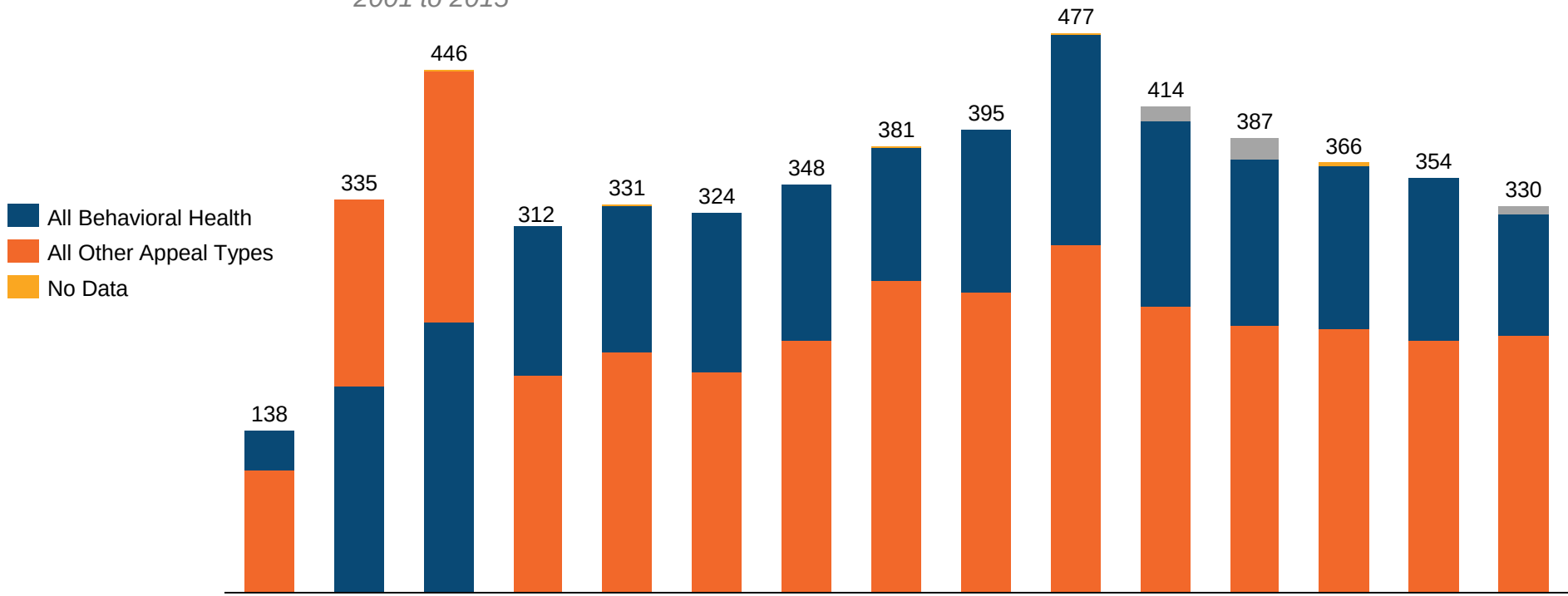
HPC

Source: 2001-2015 Office of Patient Protection external review data

Comparison of the number of medical/surgical external review requests to the behavioral health external review requests from 2001 to 2015

External Review

Number of all external review requests (ineligible and eligible) over time, by type of service 2001 to 2015



Year	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
All Behavioral Health	35	176	230	128	126	136	133	114	139	178	158	142	140	139	103
All Other Appeal Types (medical/surgical)	103	159	215	184	204	188	215	265	256	297	244	227	224	215	219
No Data	0	0	1	0	1	0	0	2	0	2	12	18	2	0	8
Total	**138**	**335**	**446**	**312**	**331**	**324**	**348**	**381**	**395**	**477**	**414**	**387**	**366**	**354**	**330**

Source: 2001-2015 Office of Patient Protection external review data

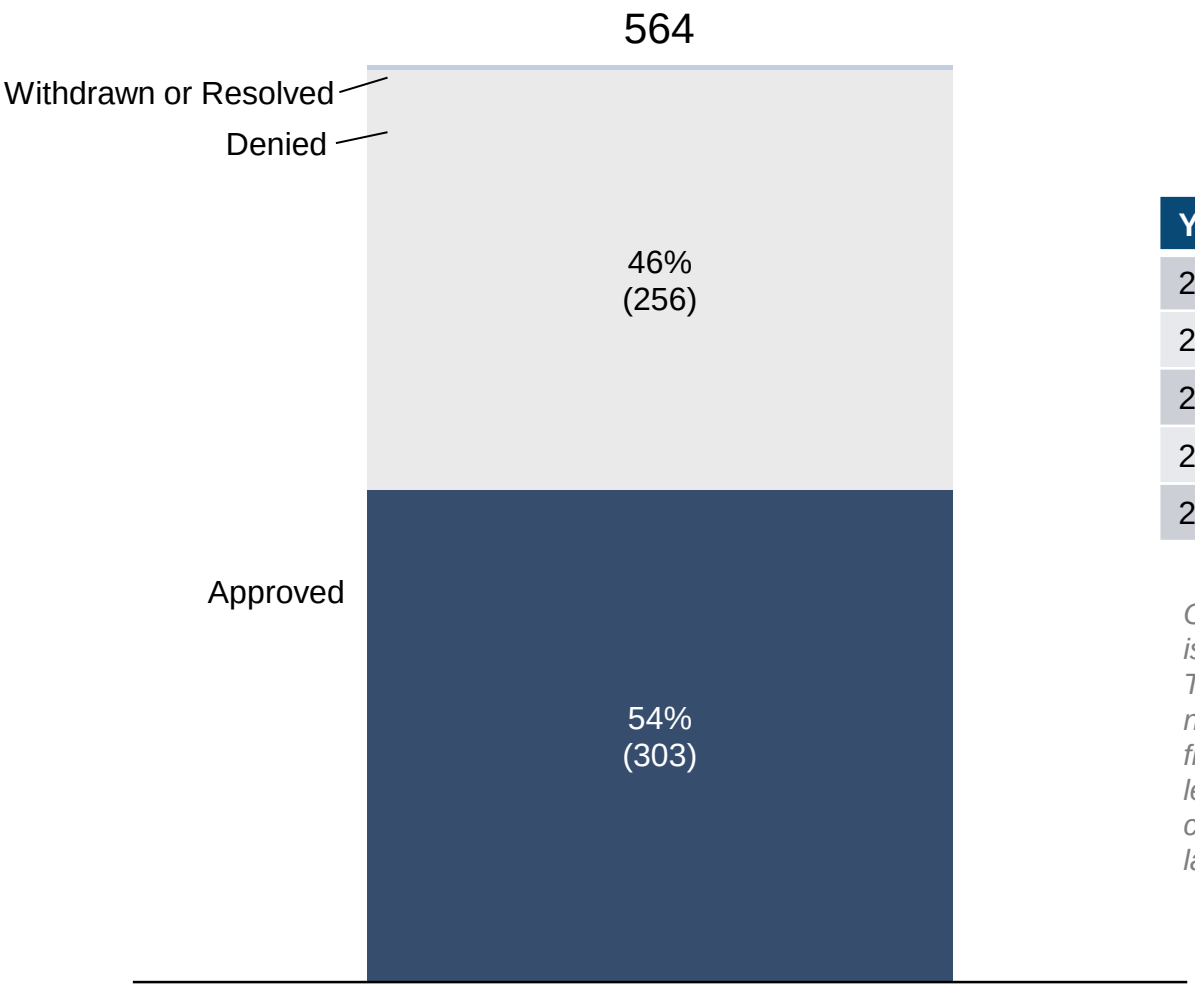
Waivers to buy non-group health insurance outside of open enrollment

OPP responsibility pursuant to M.G.L. c. 176J, §4(4)

- 2016 open enrollment through the Health Connector ended Jan. 31, 2016; 2017 open enrollment began on November 1, 2016 and ends this month
- When enrollment is closed, you can usually buy insurance if you have a qualifying event or special enrollment period, e.g.,
  - Eligible for subsidized insurance (income below 300% FPL)
  - You lost insurance coverage recently (usually within the past 60 or 63 days)
  - You are a small business owner buying insurance for your business
- May be eligible for an enrollment waiver if Massachusetts resident and, e.g.,
  - You are uninsured and did not intentionally forgo enrollment in health insurance
  - You lost insurance coverage but did not find out until after 60 days had passed

HPC

Outcomes of 2015 open enrollment waiver applications



Year	Total Waiver Applications
2011	276
2012	576
2013	416
2014	316
2015	564

OPP was given the statutory authority to issue enrollment waivers beginning in 2011. The numbers of applications and the numbers of waivers approved have fluctuated for a variety of reasons (e.g. length of open enrollment periods, changes to state and federal enrollment laws).

Source: 2011-2015 Office of Patient Protection Waiver Data

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Appendix

Key definitions and methods used in HPC analyses

Methods

To assess the impact of the opioid epidemic on the Massachusetts health care system, HPC examined the number of **opioid-related hospital discharges**.

To assess the availability of pharmacologic treatment, an evidence-based protocol that combines medication with behavioral therapies to treat individuals with opioid use disorder, the HPC examined the **location**, **geographic region**, and **patient travel distances** for all three types of pharmacologic treatment. For the purposes of this analysis, **pharmacologic treatment** includes outpatient methadone clinics, buprenorphine prescribers, and naltrexone providers.*

Definitions

Hospital discharges	Includes **inpatient discharges and emergency department visits** – Some analyses include only **inpatient discharges** (e.g., stratification by gender, age, and income)
Opioid-related	Hospital discharges with a primary or secondary diagnosis related to abuse and/or misuse of prescription opioids and/or heroin** – This set of diagnoses is broader than the set used to calculate DPH's previously published estimates of deaths averted (see appendix for ICD-9 codes used in each analysis)
Geographic regions	The HPC's standard regions, described in the HPC's Cost Trends Report***

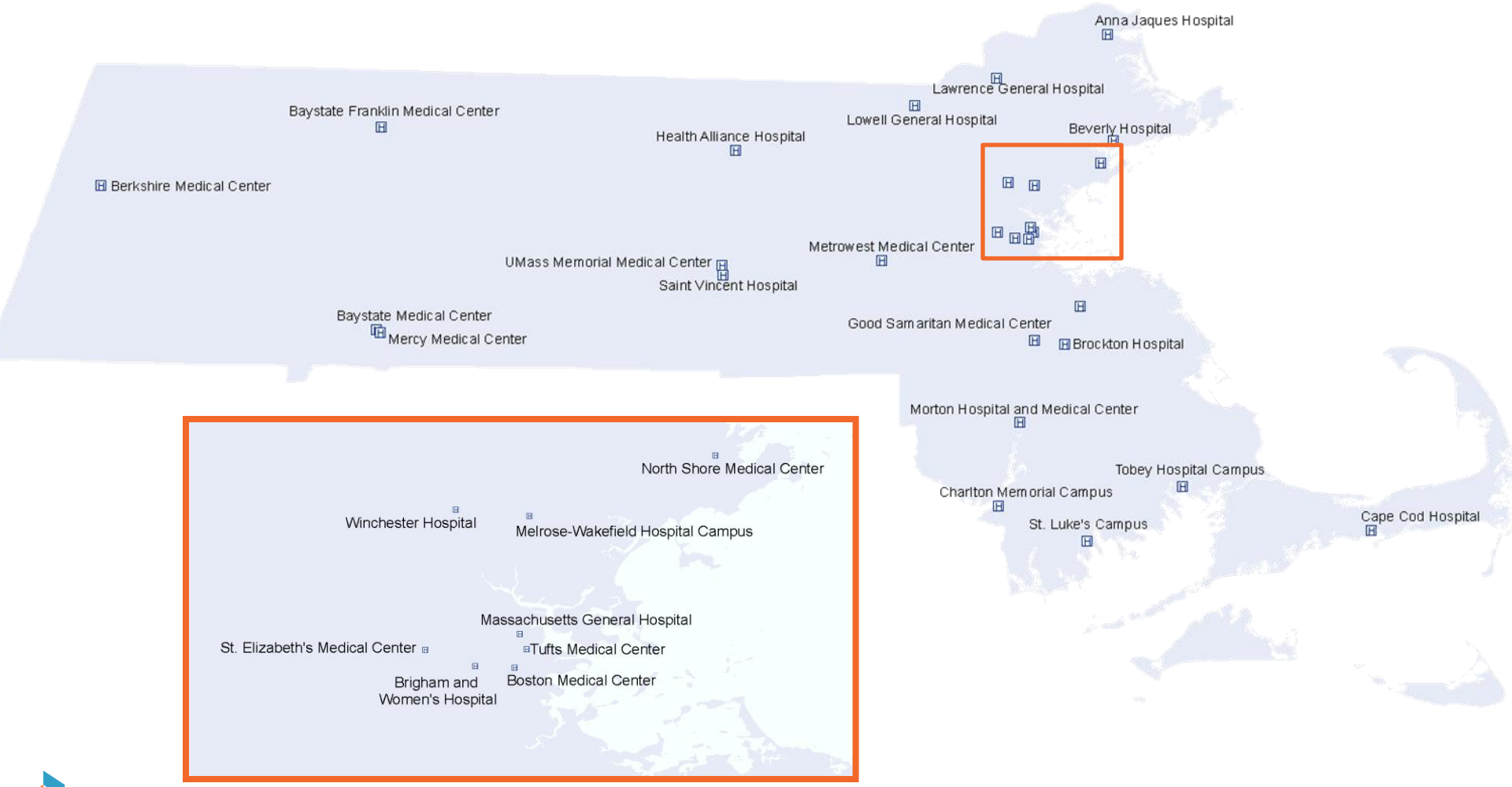
Note: *Methadone data as of 11/20/2015; Buprenorphine data as of 11/5/2015; Naltrexone data received on 8/20/2015 - Naltrexone data only includes those providers who prescribed Vivitrol for 10 or more patients between July 2014 and June 2015

**Analysis adapted from AHRQ H-CUP methodology. See appendix for comparison of codes

***For more information on the HPC's regions, please see http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf

HPC

Hospital names (associated with NAS volume maps)



HPC