MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Joint Committee Meeting

November 2, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Care Delivery and Payment System Transformation**
  - Approval of Minutes from the April 27, 2016 Meeting
  - Registration of Provider Organization (RPO) Program Updates
  - Care Delivery Certification Programs: Status and Updates
  - Current State of Quality Measurement in Massachusetts
- Joint Meeting on Serious Illness Care in Massachusetts
- Quality Improvement and Patient Protection

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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the CDPST meeting held on April 27, 2016, as presented.

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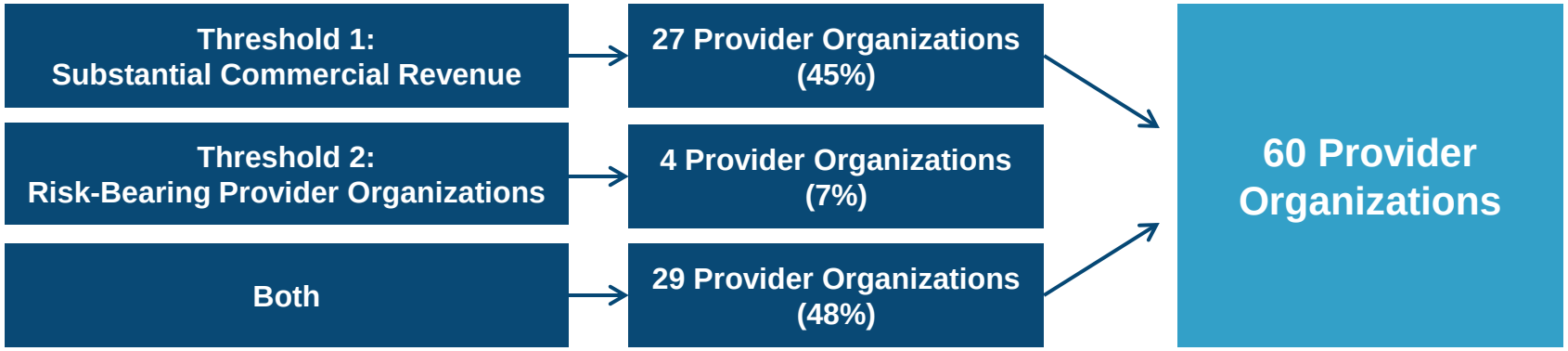
Overview of the MA-RPO Program

The Massachusetts Registration of Provider Organizations (MA-RPO) Program is a first-in-the-nation initiative through which the largest Massachusetts health systems submit information about their corporate, contracting, and clinical relationships. “Provider Organizations” include, for example, physician organizations, physician-hospital organizations, independent practice associations, provider networks, ACOs, and any other organization that contracts with Carriers or Third-Party Administrators for payment for Health Care Services.



Initial Registration Data

The dataset captures each Provider Organization's:

Internal corporate and contracting structure	External contracting and clinical relationships
A list of the clinical and non-clinical entities that the organization owns or controls	Identifying information about physician groups, hospitals, and other providers on whose behalf the Provider Organization establishes payer contracts
Corporate organizational charts	
List of owned, licensed facilities	Descriptions of key clinical partnerships
Information on contracting practices	Standardized physician rosters

HPC

Stakeholder Engagement

The MA-RPO Program extends its sincere thanks to the individuals and organizations that have provided feedback and insight throughout Initial Registration and in preparation of the 2017 filing.

Training Sessions	**Stakeholder Feedback Sessions**
One-on-One Meetings	**Anonymous Survey**

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Notable Results from Initial Registration

The RPO dataset is a robust source of information that includes all of the general acute care hospitals and a significant portion of physicians in Massachusetts.

All general acute care hospitals (57) and four specialty hospitals located in Massachusetts are accounted for in the data.

21,678	85.5%
Total MA-based physicians captured	Percent of all MA-licensed physicians

91.9 & 105.1%

Physician overlap between RPO dataset and similar commercial datasets

Market participants anticipate using RPO data for a number of purposes.

- **Providers** have indicated these data may inform key business decisions (e.g., service line expansions, planning for new care delivery models)
- **Payers** may use the data to understand, track and report on provider performance in a more standardized manner

Researchers anticipate using RPO data to:

- complement APCDs and other datasets to evaluate the effects of providers' organizational structure on their performance; and
- more accurately attribute providers to their corporate and contracting networks

State Agencies are already using RPO data for key analytic tasks and will more robustly use these data in the future, e.g.

- **HPC** has attributed physicians' to contracting networks for Cost Trends Report analyses, used data in its review of MCNs and CMIR analyses, and used data to inform conversations regarding program design for state initiatives
- **CHIA** anticipates using RPO data to standardize TME and RP reporting; and
- **MassHealth** has expressed an interest in using the data for a number of purposes

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Approach to MA-RPO Program Development and Administration

Massachusetts RPO Program

Collaborative Program Development	Single-Agency Program Administration
HPC, CHIA	HPC
Agencies jointly define and prioritize data elements and design the online submission platform	HPC administers the program by holding training sessions, serving as the Provider Organizations' point of contact, and reviewing submitted files

Benefits

- Reduces potential confusion and administrative burden on Provider Organizations
- One annual filing to a single program
- One point of contact for Provider Organizations
- No off-cycle updates

2017 Filing Overview

Data submitted in Initial Registration **will be prepopulated** in the online submission platform. Provider Organizations will **review and update** this information.

New Information	Updates to Existing Information
The MA-RPO Program will collect information in three new categories identified in CHIA's statute.	The MA-RPO Program will make minor updates to existing files based on Provider Organization feedback and data user needs.

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Priority Areas for Collection in Next Annual Filing

M.G.L. c. 12C, § 9		
(b)(1)	organizational charts showing the ownership, governance and operational structure of the provider organization, including any clinical affiliations and community advisory boards	Review and update
(b)(2)	the number of affiliated health care professional full-time equivalents by license type, specialty, name and address of principal practice location and whether the professional is employed by the organization	Review and update
(b)(3)	the name and address of licensed facilities…	Review and update
(b)(4)	a comprehensive financial statement, including information on parent entities and corporate affiliates as applicable…	Propose to collect in Annual Filing
(b)(5)	information on stop-loss insurance and any non-fee-for-service payment arrangements	Propose to collect non-FFS info in Annual Filing
(b)(6)	information on clinical quality, care coordination and patient referral practices	Future area for collection
(b)(7)	information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions	Future area for collection
(b)(8)	information regarding charitable care and community benefit programs	Satisfied elsewhere for certain entities
(b)(9)	for any risk-bearing provider organization, certificate from the division of insurance under chapter 176U	Satisfied elsewhere
(b)(10)	such other information as the center considers appropriate as set forth in the center's regulations	Future area for collection
M.G.L. c. 12C, § 8		
(a)	any agreements through which provider agrees to furnish another provider with a discount, rebate or any other type of refund or remuneration in exchange for, or in any way related to, the provision of health care services.	Propose to collect in Annual Filing

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Financial Statements

Pursuant to M.G.L. c. 12C, § 9(b)(4)

Description

- The MA-RPO Program proposes to collect standardized summary financial statement information including a Balance Sheet, Statement of Operations, and Statement of Cash Flow.
- Hospitals currently submit similar financial performance data to CHIA; they will therefore not have to submit any additional financial statements.

Value

- Allows users to understand the financial performance of the system and the financial performance of hospitals in the context of the system.
- Allows users to better compare performance across physician groups and systems. This comparison is difficult to perform without standardized reporting formats.

Alternative Payment Method (APM) Data

Pursuant to M.G.L. c. 12C, § 9(b)(5)

Description

- The MA-RPO Program proposes to collect information on APM contract establishment and participation with various payers or payer categories and corresponding revenue.
- Revenue collection modeled after Pre-Filed Testimony (AGO Exhibit 1) for the annual Cost Trends Hearing; organizations will report on revenue for services provided in 2015.

Value

- Provides detailed payer-mix information for Provider Organizations' physician groups, including by payer type (e.g., government, commercial) and by payment type (e.g., FFS, global budget).
- Complements payer-reported APM data collected by CHIA.

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Provider-to-Provider Discount Arrangements

Pursuant to M.G.L. c. 12C, § 9(b)(4)

Description

- The MA-RPO Program proposes to collect information on provider-to-provider discount arrangements through its existing Clinical Affiliations file

Value

- Information on new discount arrangements is submitted through the material change notice process; this will enhance understanding of discount arrangements existing in the market that pre-dated the material change notice process

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Updates to Existing Files

Provider Organizations have **shared lessons learned** with the MA-RPO Program from Initial Registration. In response to those comments, the proposed 2017 DSM includes **updates to several existing questions** that were identified as being high-burden and low-value.

Facilities File
Consolidating the list of reportable services lines from 32 to 8

Physician Roster
Removing the requirement to provide Employer Identification Numbers for physician practice sites and medical groups

Contracting Affiliations File
Adding a reporting threshold that would only require a Provider Organization to report physician practices that include five or more physicians

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Anticipated Timeline

Anticipated 2017 Annual Filing Timeline					
	Summer 2016	Fall 2016	Winter 2017	Spring 2017	Summer 2017
Stakeholder Meetings					
Initial Registration Data Release*					
Public Comment on the Draft DSM					
Updates to DSM and online submission platform					
Release Final DSM and any filing templates					
Online submission platform open					
Annual filing materials due					★
*Dates are approximate.					

*HPC staff will present further on information collected through initial registration at the November 9 Board meeting.

Contact Us

- The MA-RPO Program anticipates releasing a draft DSM for public comment in the coming weeks.
- The draft DSM will be posted on the HPC's website and e-mailed to everyone on the program's listserv. Please send comments to HPC-RPO@state.ma.us.
- Interested parties are welcome to reach out to staff to learn more about the MA-RPO program!

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Practices participating in PCMH PRIME

Since January 1, 2016 program launch:

8 practices
are PCMH PRIME Certified

Boston Health Care for the Homeless Program (BHCHP) (3 sites)

East Boston Neighborhood Health Center
Family Doctors, LLC
Fenway South End
Lynn Community Health Center
Whittier Street Health Center

19 practices
have applications under review for PCMH PRIME Certification

28 practices
are on the **Pathway to PCMH PRIME**

2 practices
are working toward NCQA PCMH Recognition and PCMH PRIME Certification concurrently

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PCMH PRIME trainings since January 2016

NCQA
Measuring quality. Improving health care.

PCMH PRIME webinars

- 3 webinars held to date (April, June, August) and another to be held November 3
- Provided an overview of PCMH PRIME, reviewed criteria and documentation requirements, and described the process to pursue certification
- 90 individuals have participated
- Overall, 83% of participants have responded that the training was effective, including clearly explaining PCMH PRIME standards and documentation requirements

PCMH and PCMH PRIME in-person trainings

- 2 in-person trainings held to date (May and September)
- Provided an overview of NCQA PCMH 2014 and PCMH PRIME requirements, documentation, and application processes. Included interactive learning activities in which participants practiced examining and scoring documentation to support an NCQA PCMH application
- 65 individuals have participated
- Overall, 88% of participants have responded that the training was effective, including clearly explaining the programs' standards and documentation requirements

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PCMH PRIME technical assistance contract

The HPC signed the PCMH PRIME TA contract with Health Management Associates on September 15. The contract includes technical assistance design, delivery, and evaluation components.

Technical Assistance Contract Deliverables

Phase 1: Design

- Project and communication plans
- Interviews with other organizations/agencies providing BHI TA
- Identification of participating practices
- Practice self-assessment tool
- Curriculum outline
- Virtual Learning Community (TA website) development

Phase 2: Delivery

- Administer and review practice self-assessments
- Webinars (6 per cohort)
- Learning collaboratives (2 per cohort)
- Regional knowledge sharing opportunities (2 per cohort)
- Individual practice coaching as appropriate

Evaluation and Reporting

- Quarterly TA status reports
- Evaluation subcontracted to Day Health Strategies
  - Evaluation plan
  - Interim evaluation reports every six months
  - Final evaluation at culmination of TA

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Design phase: key activities

	Description	Projected Completion
Qualitative interviews	HMA to interview other organizations/agencies in order to align PCMH PRIME TA with other programs. • Massachusetts Behavioral Health Partnership/Massachusetts Child Psychiatry Access Project • UMMS Center for Integrated Primary Care • Blue Cross Blue Shield of MA Foundation • MassHealth/Children's Behavioral Health Initiative • Department of Mental Health • Department of Public Health	Nov. 15
Identification of participating practices for Cohort 1	Practices will be divided into 4 cohorts, each receiving 6 months of TA. Current efforts are focused on recruiting cohort 1: • Practice outreach • Introduction to PCMH PRIME TA Webinar • Practices sign MOUs with HPC	Oct. 15-Dec. 9
Practice self-assessment tool	HMA to develop tool to assess practice BHI capabilities and determine intensity of TA needed by each practice.	Nov. 15
Curriculum outline	HMA to develop overview of TA curriculum including major content areas and delivery modes.	Dec. 16
Virtual learning community	HMA to develop TA website which will facilitate communication and sharing of materials with practices. Website will hold materials such as TA calendars, the self-assessment tool, and resources on BHI.	Dec. 31

Cohort 1 recruitment process

Publicize TA launch

- **HPC sends email announcement** to PCMH PRIME participants and stakeholder distribution list
- **NCQA sends email announcement** to PCMH Recognized practices in MA

Introductory webinar

- HPC and HMA hold **Introduction to PCMH PRIME TA webinar on November 16**
- HMA will present an overview of the TA approach
- Practices will have an opportunity to ask HMA and HPC questions about the TA program

Practices sign MOUs

- HPC has drafted a Memorandum of Understanding for participating practices
- The MOU provides an overview of the TA program and HPC's expectations for practices
- **Practices wishing to participate in TA cohort 1 must sign the MOU by December**

TA delivery begins

- Once the HPC receives signed MOUs, **HMA will engage with cohort 1** practices
  - Administration of practice self-assessments
  - Practices gain access to TA website
- A **learning collaborative in January** will kick-off cohort 1 TA events

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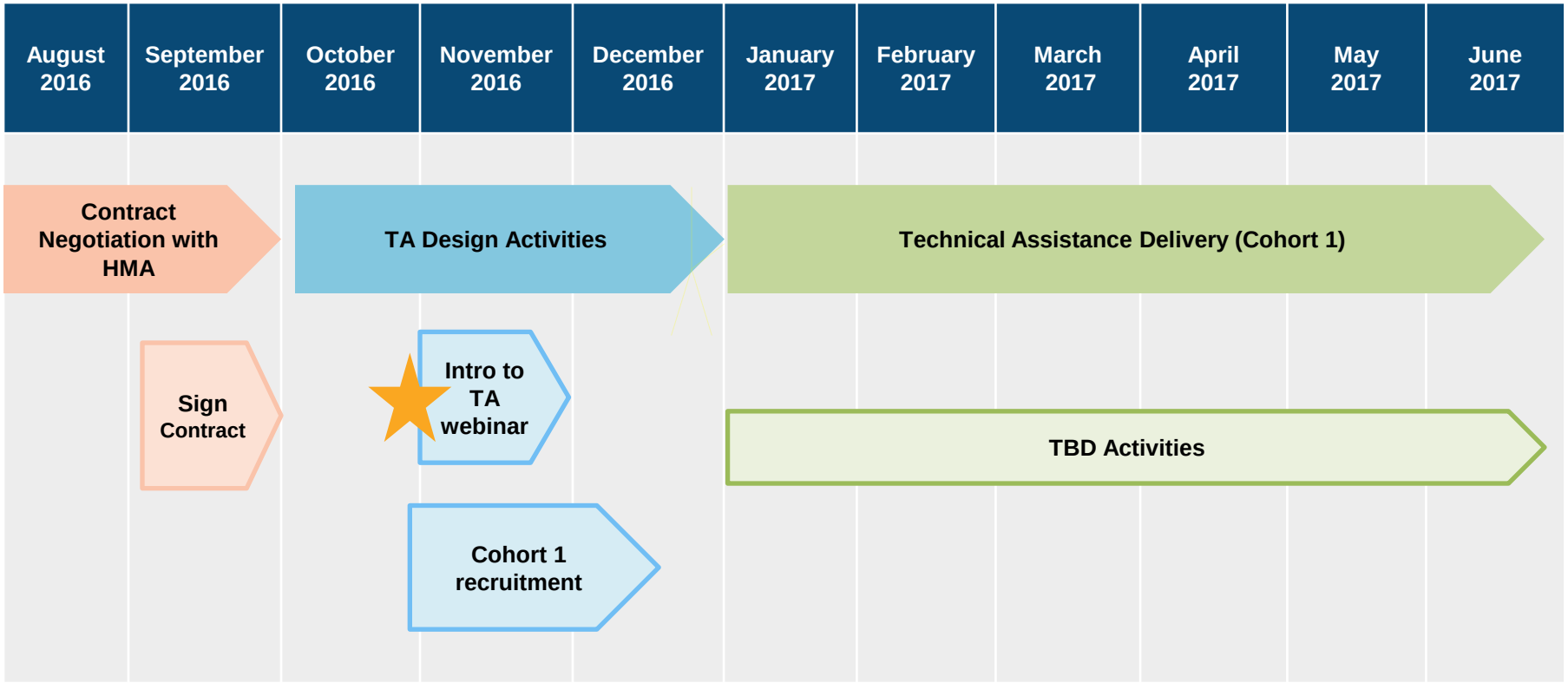
PCMH PRIME technical assistance timeline



ACO certification program key activities

- [x] Board approval of the ACO certification criteria
- [ ] Work with MassIT to develop a web-based application platform
- [ ] Develop platform user guide for ACO applicants
    - Detailed documentation requirements
    - Technical guidance

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Goals of ACO application platform development

Provide an **intuitive web-based application tool** for **ACO users**

Provide an **efficient & organized** web-based **evaluation tool** for the HPC

Happy ACO user

Standardized information collection

Efficient HPC evaluation

Adaptability for future cycles

Standardize **collection of information** on ACOs

Create a **dynamic** tool for use throughout **multiple cycles of ACO certification**

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Proposed DataBank statement of work (SOW) and timeline

Define Functional Specifications

Complete by mid-November

- Work cooperatively with DataBank to define detailed specifications for platform

Solution Development and Configuration

Through end of December

- Development and configuration by DataBank, based on Functional Specifications

Testing and Implementation

Early January 2017

- DataBank performs initial tests, then User Acceptance Testing (UAT)
- Deploy the solution to production environment
- Test for successful deployment and finalize application for users

User Training

Mid January 2017

- DataBank provides training to system users

Final Go-Live

Late January 2017

- Platform is fully functional and ready for ACO certification applications

Ongoing Support

- Including 90-day warranty.

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Platform user guide (PUG) overview

HPC is developing a user guide with detailed information for ACOs on certification requirements and platform use. The guide will include:

- Criteria
- Documentation requirements
- Key definitions
- Platform instructions
- Timelines

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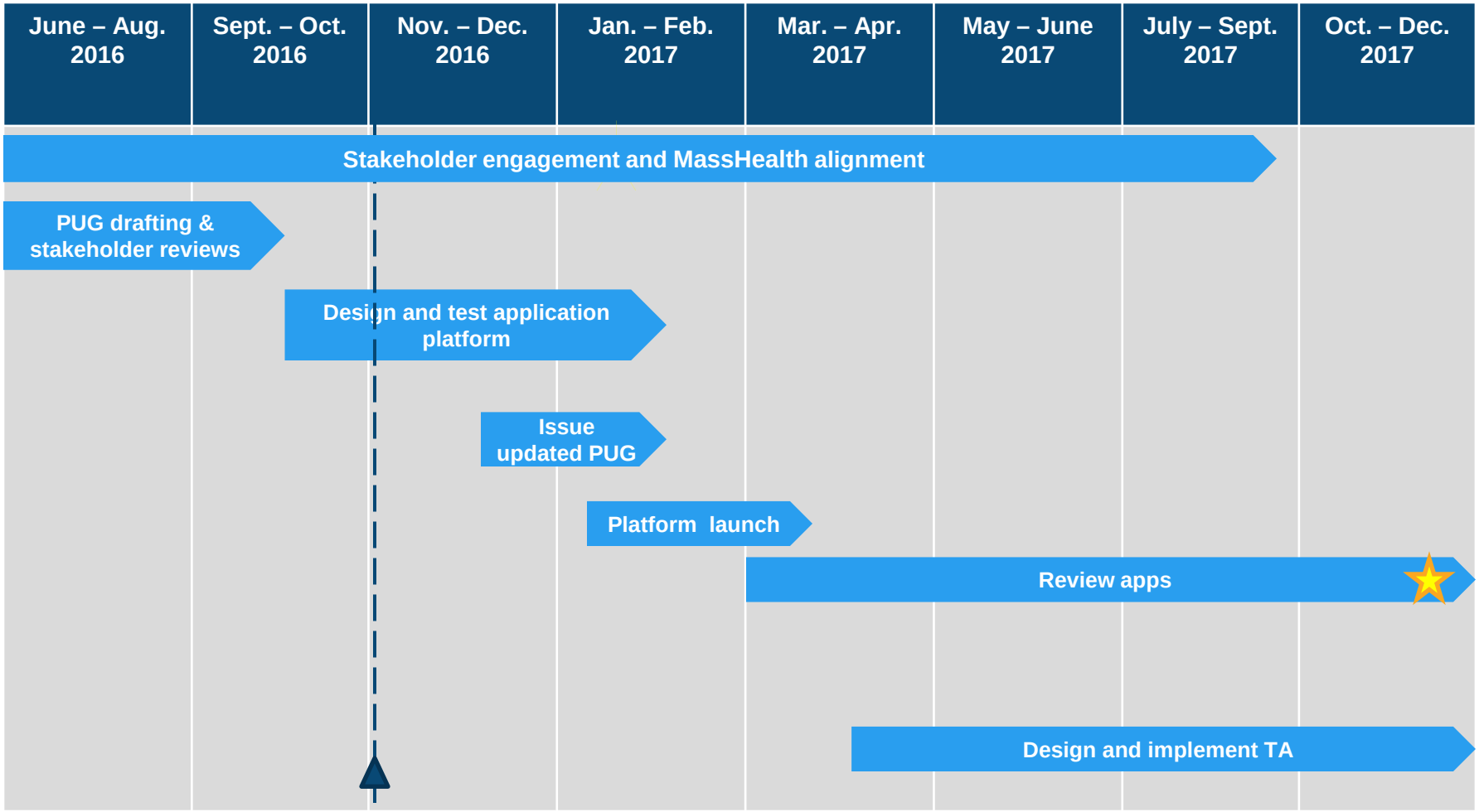
ACO certification timeline and next steps



Deadline for MassHealth ACOs to be HPC certified

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The case for advancing a coordinated quality strategy

- Quality measurement is fragmented across public and private programs with few similar measures used to assess healthcare performance across all programs.
- Providers do not receive a unified message on quality measurement, diluting the impact and increasing administrative burden.
- Policymakers in the Commonwealth currently rely on a set of mostly process measures (through the Statewide Quality Measure Set) to assess the quality of non-hospital based healthcare in the Commonwealth.
- There is a growing interest in using outcome measures to more meaningfully evaluate quality. At present, outcome measures are burdensome to report for providers and payers alike in the absence of a centralized method for data collection and abstraction.
- More payers and health care organizations are entering into Alternative Payment Models (APMs), which tie financial rewards to performance on quality measures.

Potential Vision:

A coordinated quality strategy that focuses the improvement of healthcare quality for all residents of the Commonwealth and reduces the administrative burden on provider and payer organizations.

Providers and payers are calling for alignment of quality measures and data reporting

Providers and payers have consistently called for alignment of quality measures to simplify reporting and to focus quality-improvement efforts.

PARTNERS HEALTHCARE

"[T]rying to focus on too many measures **dilutes the ability to focus on each measure**"

Atrius Health

"The lack of alignment means that…staff…must further **divide their attention** and…attempt to identify which measures and activities should be priorities… [t]his is particularly stressful for clinicians, contributing to **physician burnout** and the potential for…a **decline in the overall quality of care and time spent with patients**."

RELIANT MEDICAL GROUP

"[L]ack of alignment we believe only **adds to the cost** of providing high value care **without any clear clinical benefit.**"

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UnitedHealthcare

"Measures that require information, other than what can be gathered from a claim submission, can be **both time consuming and costly.** This is especially the case when measures require a chart audit, as it can be **a major inconvenience to the providers**."

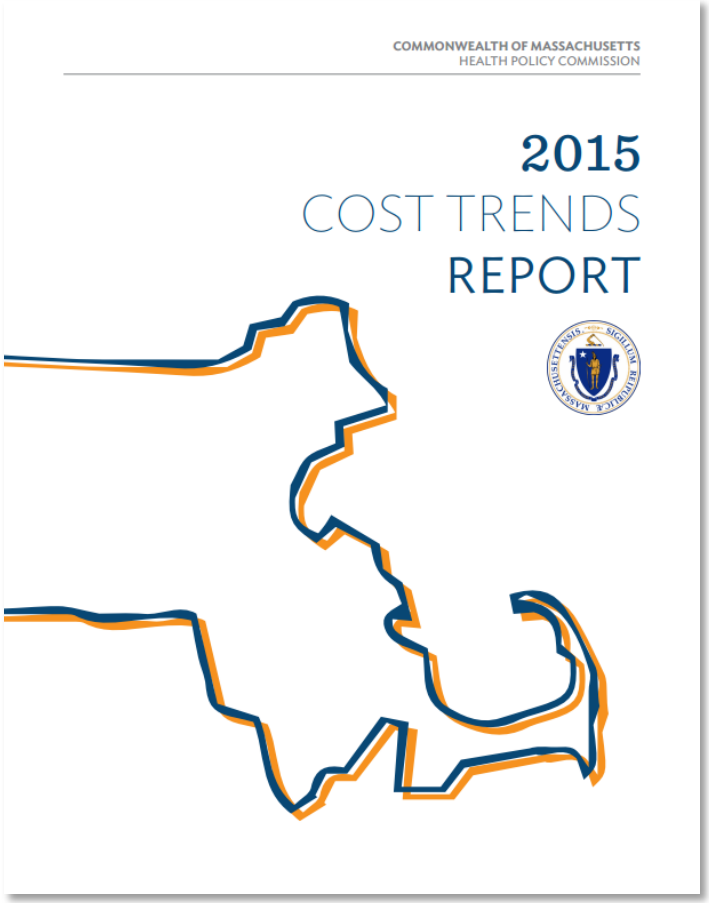
CELTICARE Health Plan of Massachusetts

"[R]equirements are **currently being driven by multiple payers** in different ways and **without coordination**…There is a role for government to play in developing common standards to align APMs to **ease the burden on providers** and **increase the likelihood of success** in achieving improved cost and quality outcomes."

Other factors in favor of a coordinated quality strategy

- **Strong "across the aisle" payer and provider support for alignment**
  - Many payers and providers report to the HPC in pre-filed testimony a strong desire (on the part of plans) and need (on the part of providers) to align quality measures, particularly for use in APM contracts.
- **Reducing administrative burden is a priority of state government**
  - At the 2016 Cost Trend Hearing, Governor Baker emphasized the need for data consistency and transparency. He has also spoken publicly about reducing administrative burden within the healthcare system.
  - The Executive Office for Administration & Finance has convened a health care reporting working group to address reporting burden of payers and providers and achieve alignment across state agencies.
- **MassHealth ACO implementation**
  - MassHealth is implementing an ACO pilot in December 2016, with the aim of launching the full ACO program in October 2017.
  - As part of this program, MassHealth will introduce a set of measures and method for collecting clinical outcome measures in order to evaluate contractual performance.
- **CMS implementation of MACRA Quality Payment Program**
  - The Medicare Access & CHIP Reauthorization Act (MACRA) of 2015 will replace a patchwork system of Medicare reporting programs with a flexible system that includes two paths that link quality to payments: 1) the Merit-Based Incentive Payment System (MIPS), and 2) Advanced Alternative Payment Models (APMs).
  - This will introduce a new set of quality measures, while allowing providers some flexibility over which measures they are held accountable to.

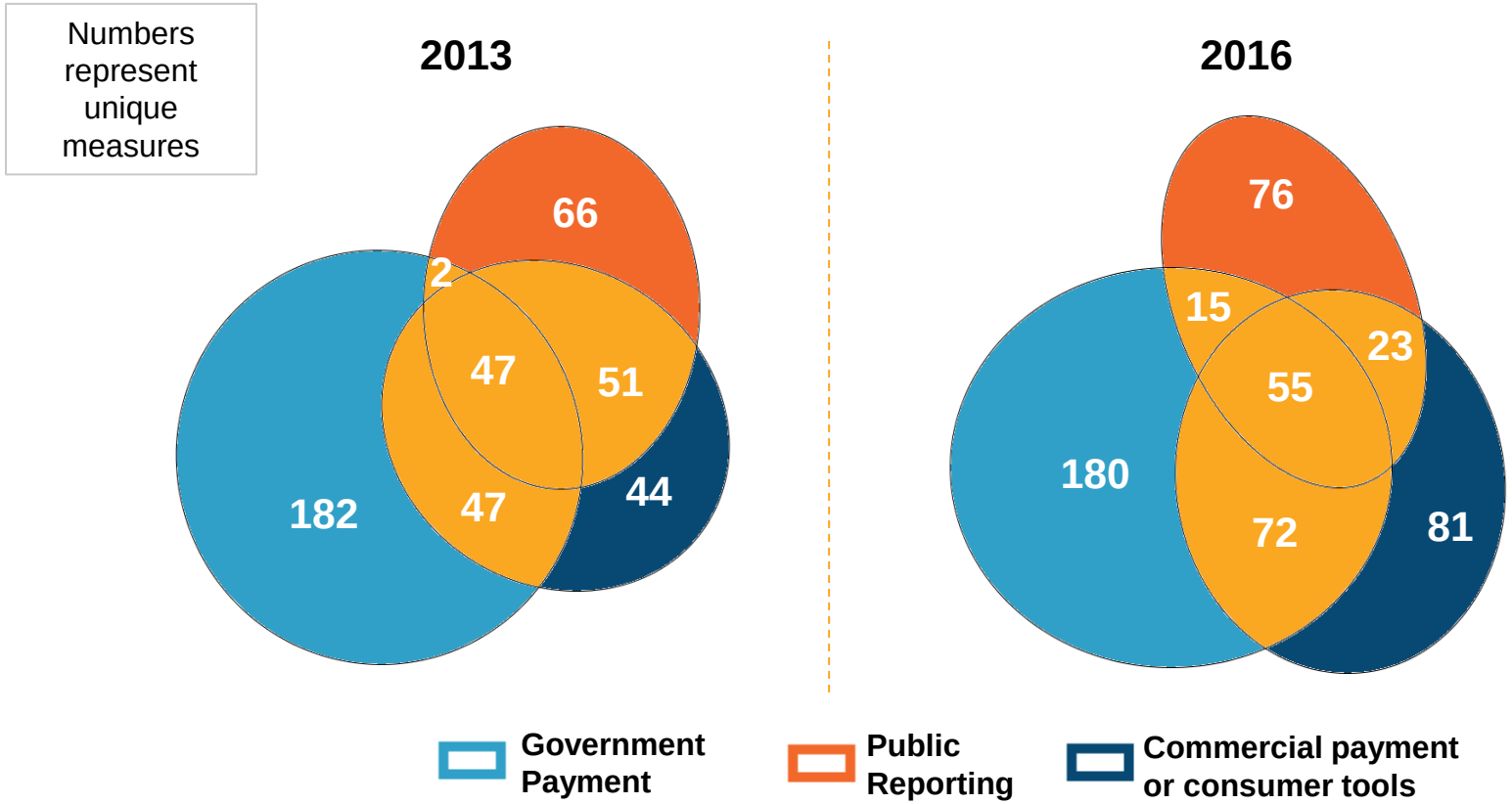
The HPC identified the need for quality alignment in the 2015 Cost Trends Report



RECOMMENDATION #12

The Commonwealth should develop a coordinated quality strategy that is aligned across public agencies and market participants.

Currently quality measurement programs among Massachusetts plans and public reporting programs are not well aligned



- Over 500 quality measures are currently used in Massachusetts
- Few quality measures are collected by multiple programs
- Minimal improvements in quality measure alignment noted since 2013

Source: 2016 Massachusetts Quality Measure Catalog as developed and analyzed by Analysis (CHIA).

Quality measures are used to help guide payment in global budget alternative payment models (APMs)

Medicare ACO

- 32 core measures in Shared Savings, Pioneer and Next Gen ACO Programs
- % of shared savings based on performance on quality measures

MassHealth ACO

- 38 proposed measures
- % of shared savings will be based on performance on quality

BCBS

- Alternative Quality Contract
- 64 core measures (32 hospital/32 outpatient)
- % of shared savings awarded based on performance on quality

Tufts Health Plan

- Coordinated Care Model and Provider Engagement Model
- Uses 5 high-priority measures per provider contract on average

Harvard Pilgrim Health Care

- Quality Advance Contract; Rewards for Excellence
- Performance incentives for achieving quality metrics

Quality measure sets typically vary by payer-to-provider contract.

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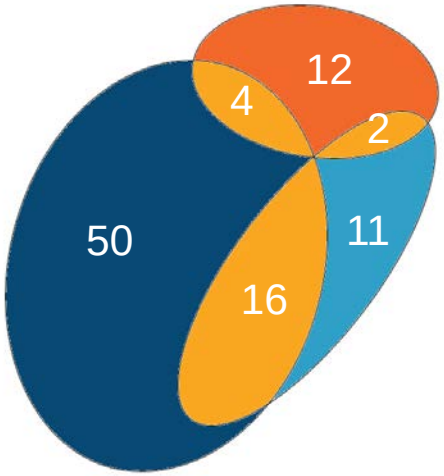
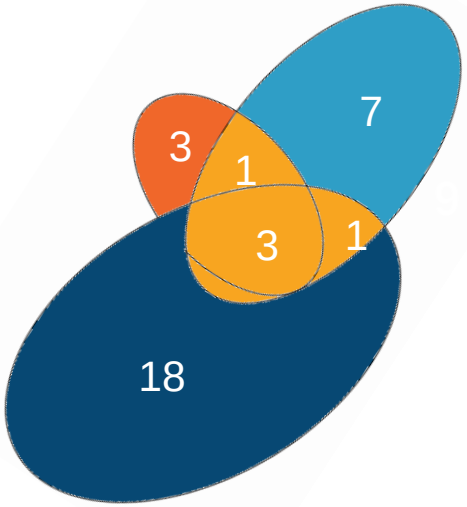
Specifically, there are many different quality measures in use by Massachusetts payers in APMs

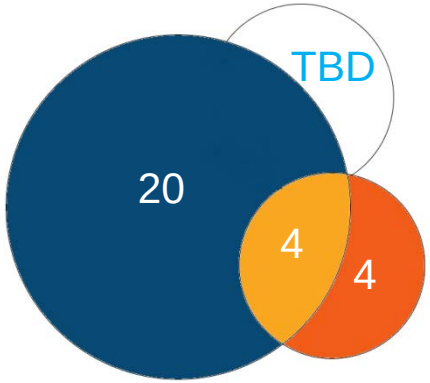
Process



Outcome



Patient Experience



Numbers represent unique measures

Any Commercial | Medicaid | Medicare

Note: Includes all Claims and Clinical Quality Measures (CQMs) currently in use by population-based payment models in Massachusetts as collected by CHIA as of February 2016. Excludes measures only used for reporting pediatric quality. Commercial represents: Blue Cross Blue Shield of Massachusetts, Tufts Health Plan, and Harvard Pilgrim Health Care.

Current state of outcome measurement in APMs in Massachusetts

Providers manually report 14 clinical outcome measures, which cannot be obtained from administrative data (e.g., claims, hospital discharge data)

Medicare ACO	
Medicaid ACO	
Blue Cross Blue Shield	
Harvard Pilgrim Health Care	
Tufts Health Plan	

2 measures are collected by every payer
3 measures are collected by ≥1 payer
All other measures collected by only 1 payer

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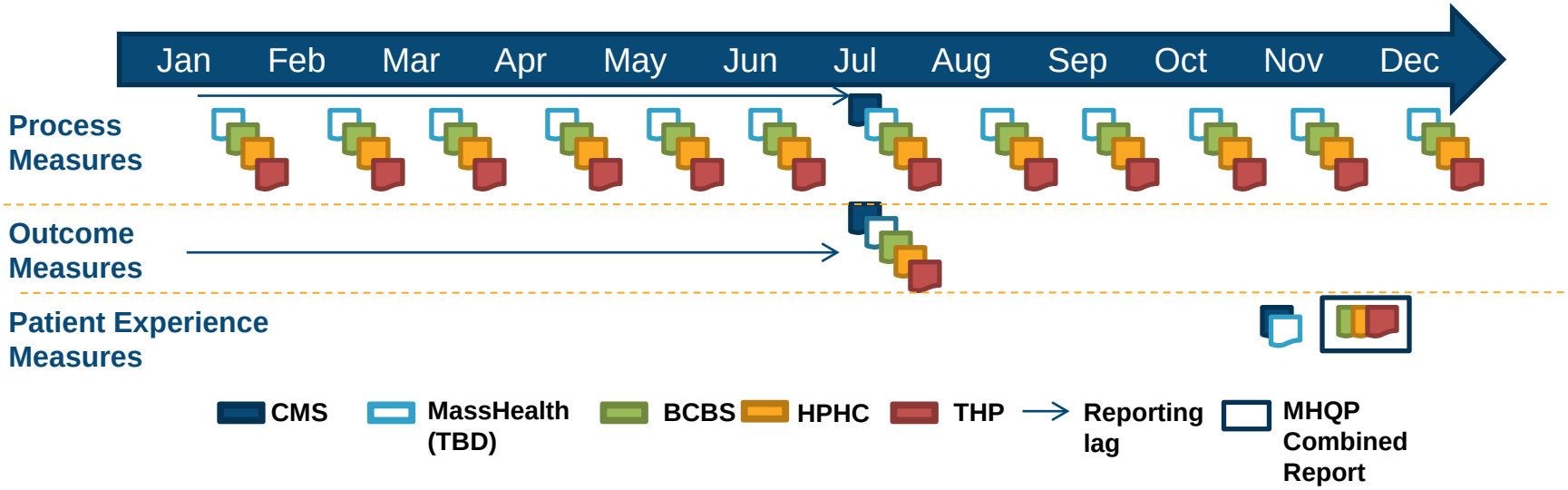
Providers in turn receive an array of reports from payers on their performance

- Provider organizations receive a number of reports from payers to inform them about their performance on contractual quality measures.
- These reports are not practical for quality improvement for providers as they are payer-specific and vary by time intervals (e.g., monthly or annual), measure sets, and measure specifications between contractual agreements.



In the absence of a unified report on quality measures, many provider organizations dedicate their resources to measure cost and quality in a way that is meaningful and actionable for quality improvement.

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Benchmarking approaches also vary among payers

BCBS

- Use absolute rather than relative performance, with 5 possible levels of performance ("gates").
- The lowest level (Gate 1) is set at about the network median, and the highest level (Gate 5) is what evidence suggests could be achieved by an optimally performing physician group/hospital.
- Outcome measures are triple weighted in the aggregated quality score, on which the annual payment is based.

Tufts Health Plan

- Use a combination of benchmarks, including 90th percentile (national), THP average (peer comparison), and the provider organization's performance in that measure the previous year.
- Payment is based on meeting the benchmark for a certain percent of measures.

Harvard Pilgrim Health Care

- For process/outcome measures, use a national benchmark (eligible for payment at 75th percentile; full payment if >95th percentile)
- For patient experience measures, use HPHC percentile performance calculation (eligible to share in savings at 50th percentile; full payment if >75th percentile)

Medicare ACO

- Rewards both improvement and absolute performance
- Based on Medicare FFS data
- 30th percentile represents the minimum attainment level and 90th percentile corresponds to the maximum attainment level

MassHealth ACO

- Will reward both improvement and absolute performance
- Pay for reporting for initial years to create benchmark; payment will be tied to performance on some of the quality measures starting in 2019

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Alignment: warranted and unwarranted differences

There are different reasons for why quality measure sets differ among health plans and programs:

Warranted Differences	Unwarranted Differences
▪ Differences in member population may require the use of certain measures to evaluate health services provided to particular demographic groups (e.g., age and life stage, case mix, low SES) ▪ More mature payer-provider partnerships may have capabilities to innovate and test new measures	▪ It is not always clear which measure is “the best” ▪ Plans may prefer to use certain measures over others ▪ Measures may use different inclusion and exclusion criteria ▪ Adjusting for differences in patient illness (risk-adjustment) may be different in different measures

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Serious Illness and End of Life Care in the Commonwealth

November 02, 2016

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- Defining quality serious illness care & need for improvement in quality
- Spending and utilization in MA among Medicare decedents
- Analysis of Medicare decedents with poor prognosis cancer
- Strategies for improvement

Serious illness care is an important focus area for quality improvement and cost containment

- High quality serious illness care addresses medical and emotional needs, with patients receiving care based on their individual preferences and priorities
  - However, numerous challenges often drive a disconnect between best practices and actual practices, with well-documented deficiencies in quality of care

- 25% of all Medicare spending in the US occurs in last year of life
  - Better aligning care with individual patient preferences will not reduce spending in all cases: failure to base care on patient preferences results in some receiving more services than they wish, while others receive less than they wish
  - However, literature suggests that increasing quality of end of life care tends to reduce total healthcare spending overall

- HPC has defined end of life care / serious illness care as critical components of accountable, effective care
  - Investments in improving care through HCII grants and CHART hospital activities
  - Inclusion in ACO certification standards: must support patient-centered advanced illness care

HPC

Gerald F. Riley and James D. Lubitz, "Long-Term Trends in Medicare Payments in the Last Year of Life," Health Services Research 2010;45 (2): 565-76; Christopher Hogan et al., "Medicare Beneficiaries' Costs of Care In The Last Year of Life," Health Affairs (Millwood) 2001;20(4):188-95.

Elements of high quality serious illness care

The terminology of “serious illness care” reflects attending to a patient’s needs and discussing goals and options before death is imminent – challenging decisions are often required even for those who survive

Essential elements of high quality care cited by experts include:

Patients receive care based on their individual preferences and priorities

- As part of Advanced Care Planning, physicians should begin discussing patient goals and preferences early in a patient’s course of illness, before death is imminent

Includes shared decision making:

- Physicians assist patients in choosing course of action, regularly reviewed and updated, based on mutual understanding of full range of choices, and of individual preferences/values
- Facilitates patient autonomy; requires patients to have information about full range of choices, and that preferences for care are documented, readily retrievable, and respected

Includes access to palliative care:

- Includes medical and other efforts to relieve suffering and improve quality of life, including emotional and spiritual support for patients and families/caregivers, in addition to symptom management
  - Efforts can be provided concurrently with curative or life-prolonging treatments
- Plan is conceptualized, created, and coordinated by interdisciplinary team-based approach including care team, family, patient
- Can include hospice care, a type of comprehensive palliative care service that is most frequently provided in the patient’s home (or nursing home), but can also be delivered in a hospital or freestanding facility
  - Hospice providers receive a per diem payment intended to cover all of the patient’s care
  - Medicare requires hospice patients to agree to forgo curative services and must be certified as having less than six months to live; some private insurers are less restrictive

HPC

Patient Centered Care and Human Mortality: The Urgency of Health System Reforms to Ensure Respect for Patients' Wishes and Accountability for Excellence in Care. Report and Recommendations of the Massachusetts Expert Panel of End-of-Life Care, October 2010. National Hospice and Palliative Care Organization. NHPCO’s Facts and Figures: Hospice Care in America 2015.

Despite known best practices for serious illness care, patients often do not receive high quality care

Quality of care at the end of life appears to be decreasing in the US overall

- In 2000, **57%** of family members or close friends of decedents reported excellent end of life care, but by 2011-2013 that number had decreased to **47%** of those surveyed
- Those surveyed reported frequent unmet need for pain management, anxiety/sadness, and dyspnea

Individual preferences vary widely, but research suggests many prefer less aggressive treatment

- A study of 1,146 families of decedents found strong correlations between rating “excellent” end of life care and usage of hospice >3 days, no ICU admissions within 30 days of death, and death not in a hospital setting

Teno JM, Freedman VA, Kasper JD, Gozalo P, Mor V. Is Care for the Dying Improving in the United States? J Palliat Med. 2015;18(8):662-6. Wright AA, Keating NL, Ayanian JZ, Chrischilles EA, Kahn KL, et al. Family Perspectives on Aggressive Cancer Care Near the End of Life. JAMA. 2016;315(3):284-92.

Intensity of care varies substantially by region across the US, largely impacted by health system characteristics and provider practice patterns

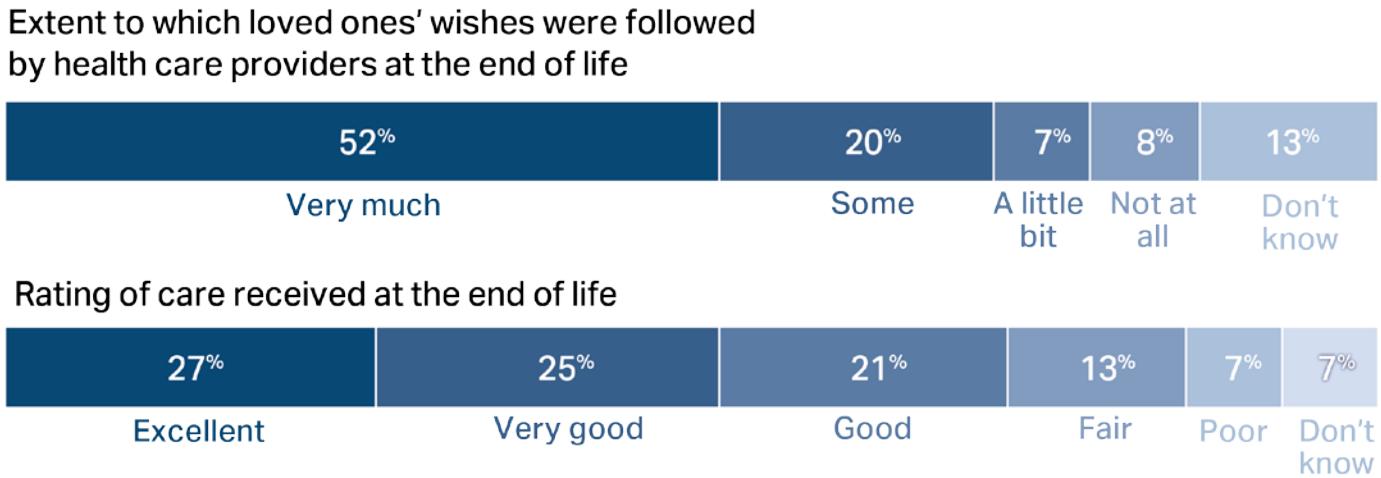
Intensity of service use varies substantially by region across the US and is not explained by patient preferences or illness level

- Regional differences in intensity of care vary **2-fold**, including percentage of patients who die in the hospital, hospital admissions, ICU rates; hospice enrollment also varies widely
- Studies report differences in preferences based on race and ethnic background, but large majority in all groups express preferences not to have intensive care
- Health system characteristics and provider practice patterns are the most predictive factors of the intensity of care that patients receive, with differences in patient characteristics (including race, ethnicity, age, and sex) being less significant
  - Intensity of service use at the end of life by region is highly correlated to overall health spending levels
  - Physicians who practice in regions with more specialists and higher hospital capacity tend to generate more referrals and recommend more intensive strategies for end of life care
  - A study of patients with poor prognosis cancer found that the proportion of a physician's patients who were enrolled in hospice was the most significant predictor of whether the physician's other patients would enroll in hospice

Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. Annals of internal medicine. 2003;138(4). Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ. Variations in the longitudinal efficiency of academic medical centers. Health Affairs. 2004:VAR19. Wennberg JE, Fisher ES, Goodman DC, Skinner JS. Tracking the Care of Patients with Severe Chronic Illness-The Dartmouth Atlas of Health Care 2008. Duffy SA, Jackson FC, Schim SM, Ronis DL, Fowler KE. Racial/Ethnic Preferences, Sex Preferences, and Perceived Discrimination Related to End-of-Life Care. Journal of the American Geriatrics Society. 2006;54(1):150-7. Obermeyer Z, Powers BW, Makar M, Keating NL, Cutler DM. Physician characteristics strongly predict patient enrollment in hospice. Health Affairs. 2015; 34(6).

Massachusetts 2016 survey results indicate need for improvement in quality of care at end of life

Among those in Massachusetts who experienced the death of a loved one in the past 12 months:



Patients often do not receive care according to their preferences

- A 2016 MA survey found **over one-third (35%)** of people with a loved one who died in the past 12 months said that health care providers did not fully follow the person's wishes
- *Significant disparities exist:* White respondents and respondents with higher levels of education were significantly more likely to state that their loved one's wishes were very much followed by providers

20% rated the care their loved one received as fair or poor, and only 27% felt it was excellent

- While 54% of white respondents who had lost someone rated that person's care as excellent or very good, only 35% of non-white respondents felt the same

Source: University of Massachusetts Medical School. Appears in: Freyer FJ. "When you die, will your wishes be known?" Boston Globe. May 12, 2016.

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Review findings:
  - Defining serious illness care & need for improvement in quality
  - **Spending and utilization in MA among Medicare decedents**
  - Analysis of Medicare decedents with poor prognosis cancer
  - MA based initiatives
  - Strategies for improvement

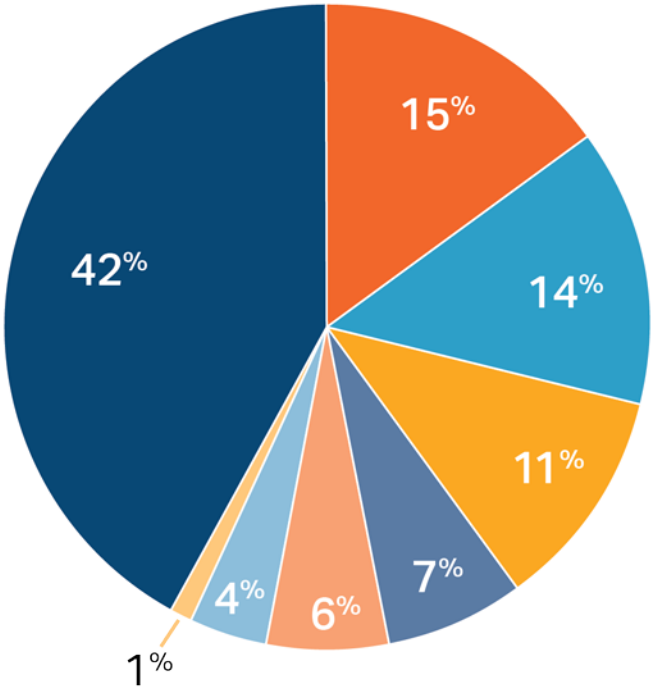
Data methods

- Using the All-Payer Claims Database, we identified a population of Medicare fee-for-service beneficiaries (65+) who died in 2012 and were continuously enrolled in Medicare Parts A and B in the month of death and 12 months prior
- Nearly all (99.9%) of decedents in the database had a home zip code that could be assigned to an HPC region
- Spending estimates include Medicare and beneficiary payments for Medicare-covered services for 365 days before death (including data for 2011 and 2012)
- Estimates exclude decedents with total spending below the 5th or above the 95th percentile

HPC

Among Medicare decedents in Massachusetts, spending in last six months of life is concentrated in the inpatient hospital setting

Total use of Medicare services in last six months of life averaged **$39,194**, with inpatient hospital spending the largest contributor to spending (~ **42%** of spending)



Spending by category in the last six months of life among Medicare decedents, 2012

Acute care hospital inpatient	$16,477
SNF	$6,040
Professional services - total	$5,560
Hospice Services	$4,426
Other hospital	$2,475
Acute care hospital outpatient	$2,403
Home health	$1,473
DME	$339
Total spending	**$39,194**

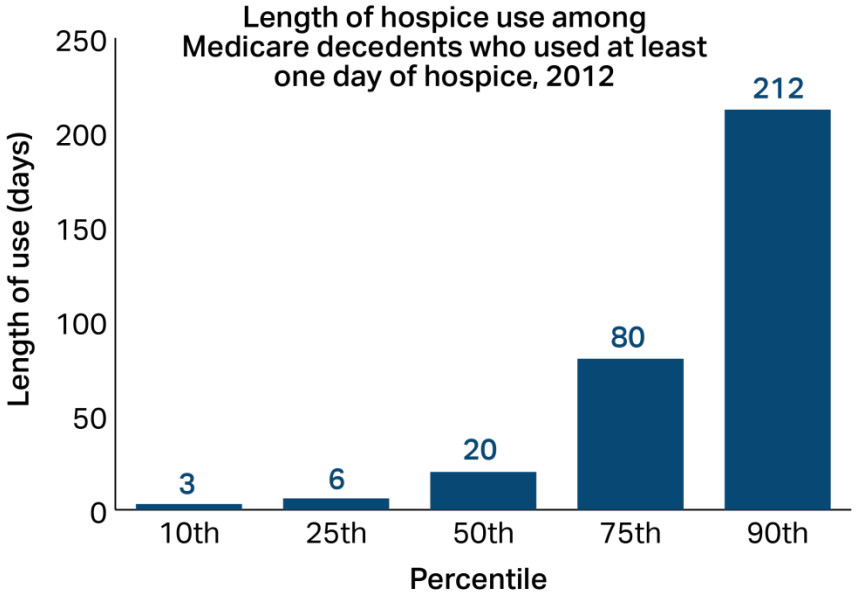
Spending in the last six months of life totals over $1 billion in Massachusetts for the HPC examined Medicare population alone

HPC

Source: HPC analysis of 2011-2012 APCD Medicare FFS data
Note: SNF = skilled nursing facility, DME = durable medical equipment

Many patients who use hospice only receive benefits for a few days before death

- **49%** of all Medicare decedents in MA used hospice for at least one day in the last year of life
- The median length of hospice enrollment in MA was **20 days** in 2012, similar to the national average of **18 days**
- **25%** of all decedents who used hospice were enrolled for less than one week, similar to the national results (in the US overall, the 25th percentile was 5 days)
- Availability of hospice is not likely to explain short use, as every region in the state* has at least one hospice provider and providers travel to the patient's home



Source: HPC analysis of 2011-2012 APCD Medicare FFS data

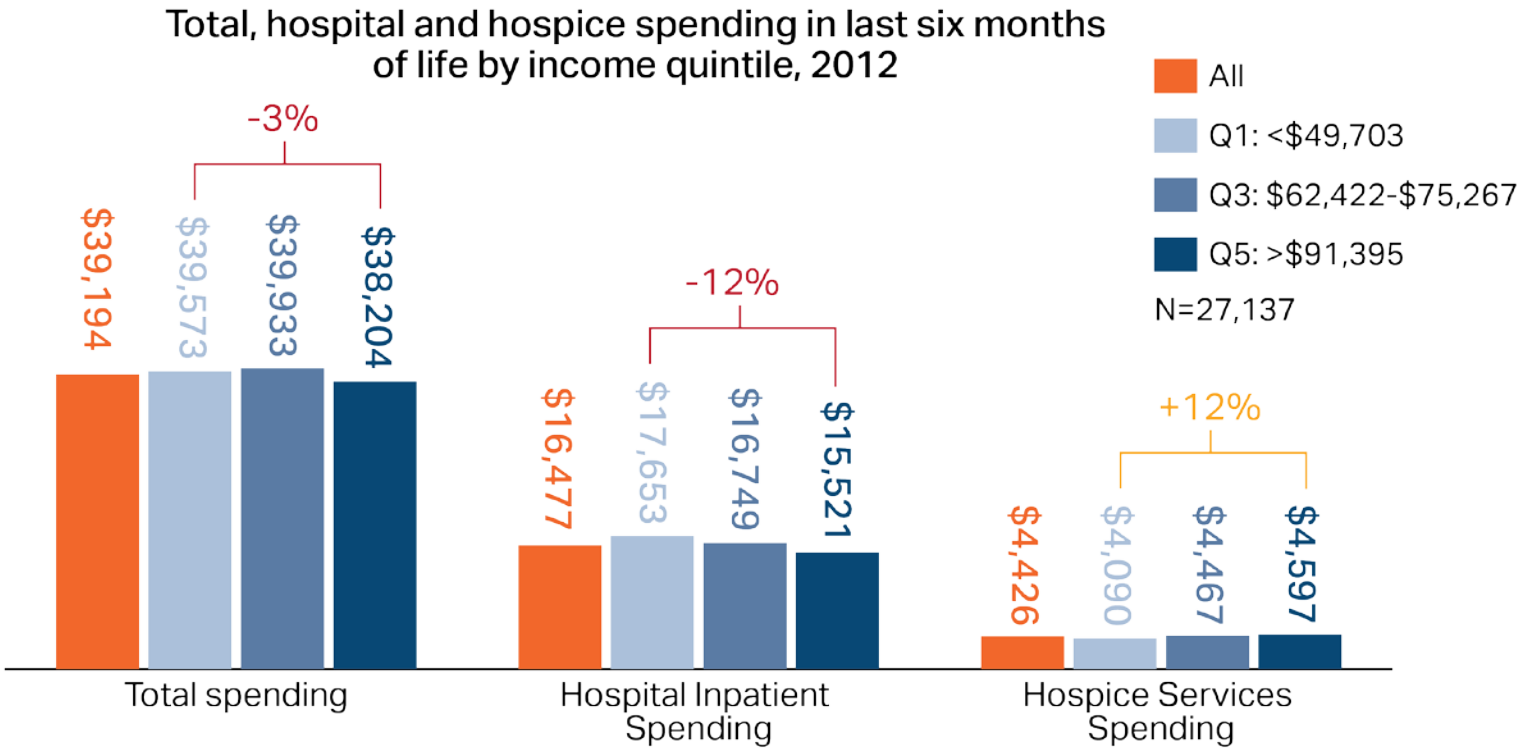
Trends of short enrollment in hospice suggest a greater opportunities for patients to benefit from hospice services such as symptom management and support

Source for US numbers: Medicare Payment Advisory Commission. March 2016 Report to the Congress: Medicare Payment Policy. 2016.
** Based on HPC region*

Decedents from higher income communities have higher hospice spending and lower inpatient hospital spending at the end of life

Total spending was slightly lower among decedents from the highest income communities (highest quintile) compared to the lowest income communities (lowest quintile), reflecting lower inpatient hospital spending and higher hospice spending in the highest income communities

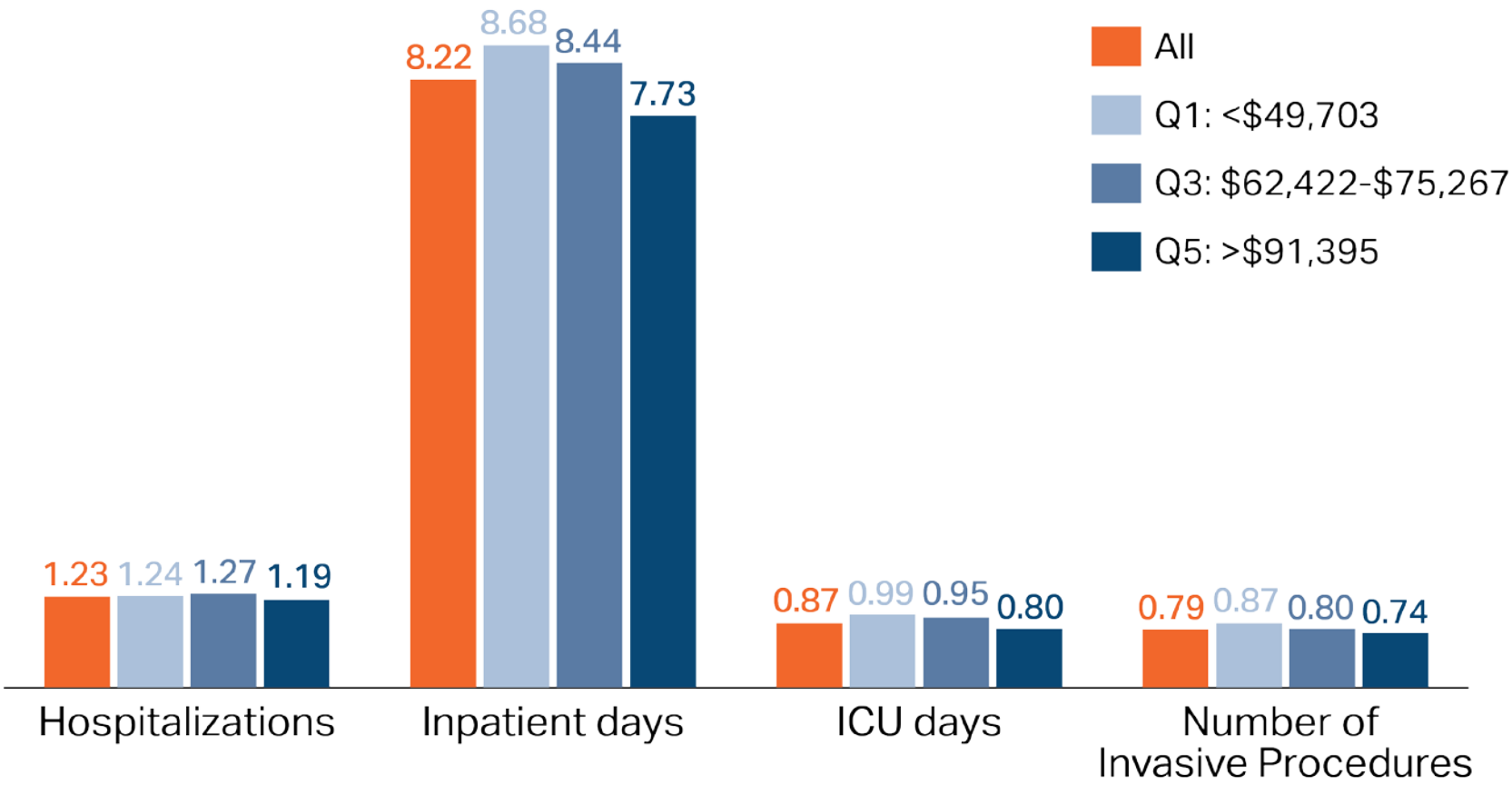
- Differences in service use and spending by community income could potentially reflect factors including differences in condition, preferences, location of care or provider, or provider interaction (e.g. likelihood of advanced care planning discussions occurring)



Source: HPC analysis of 2011-2012 APCD Medicare FFS data

Among all Medicare decedents, those in highest income communities have the lowest intensity of service use at the end of life

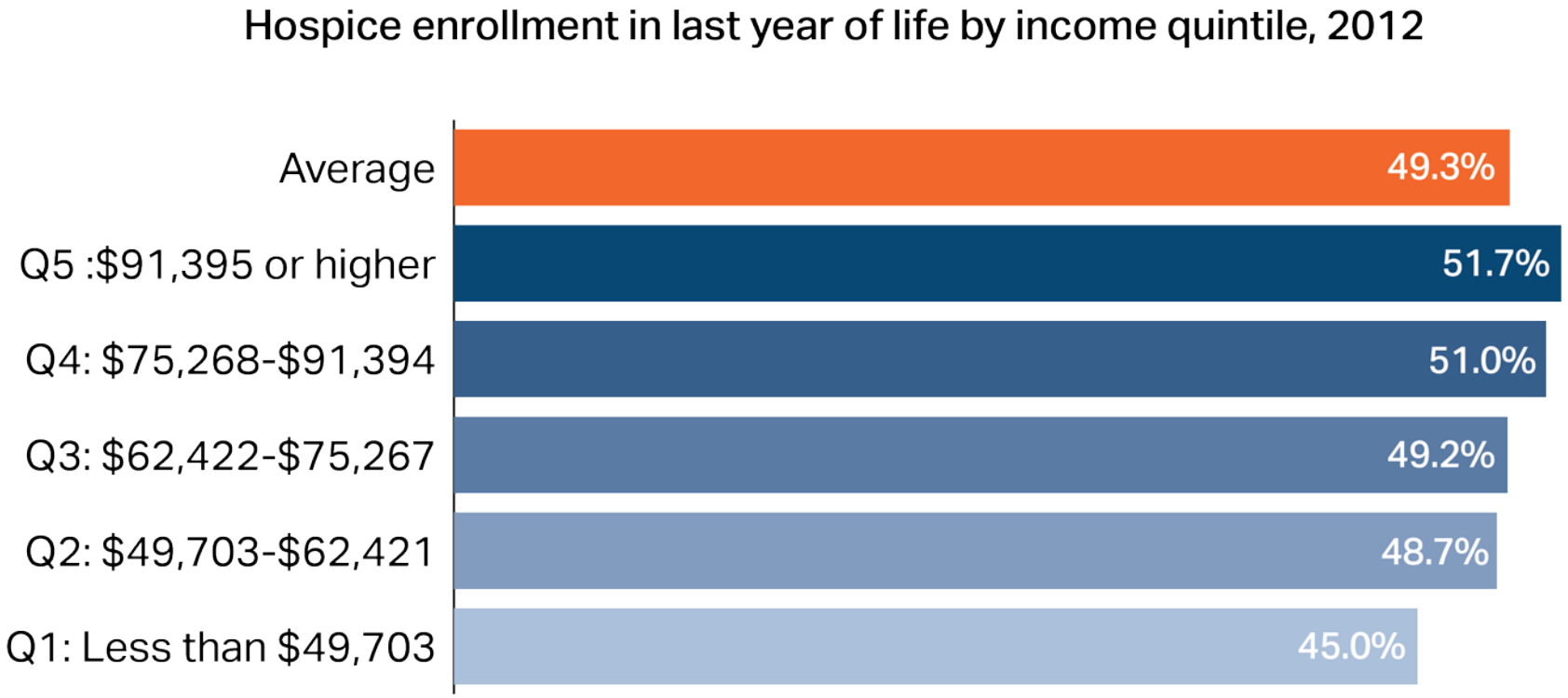
Select metrics of intensity of service use in last six months of life by income quintile, 2012



Source: HPC analysis of 2011-2012 APCD Medicare FFS data
Note: Decedents are defined as beneficiaries who died in 2012. Estimates include decedents' use of Medicare-covered services in 2011 and 2012. Estimates exclude decedents with total spending below the 5th percentile or above the 95th percentile. An admission, transfer, and admission from transfer are regarded as a single hospitalization. Spending includes Medicare and beneficiary payments for Medicare-covered services. Invasive procedures are defined as follows: insertion of venous catheter (38.93; 38.95; 38.97; 86.07), endotracheal intubation (96.04; 96.71; 96.72), packed cell transfusion (99.04), platelet or plasma transfusion (99.05; 99.07), noninvasive ventilation (93.9), thoracentesis (34.91), hemodialysis (39.95), cardiopulmonary resuscitation (99.6), closed bronchial biopsy (33.24), arterial catheterization (38.91). Invasive procedure methodology based on: Massachusetts Division of Health Care Finance and Policy. "Hospital Resource Use on End-of-Life Patients Varies." July 2006.

HPC

Hospice enrollment varies by income among Medicare decedents



Hospice enrollment also varied by age (age 65-74 = 44% versus age 85+ = 52%) and sex (men = 45% versus women = 52%), although results do not control for differences in condition or other factors

While differences in hospice use and service utilization by income may reflect differences in condition or preferences, these differences may also reflect differences in access to care

HPC

Source: HPC analysis of 2011-2012 APCD Medicare FFS data
Note: Income defined by median community income associated with the decedent's zip code of residence

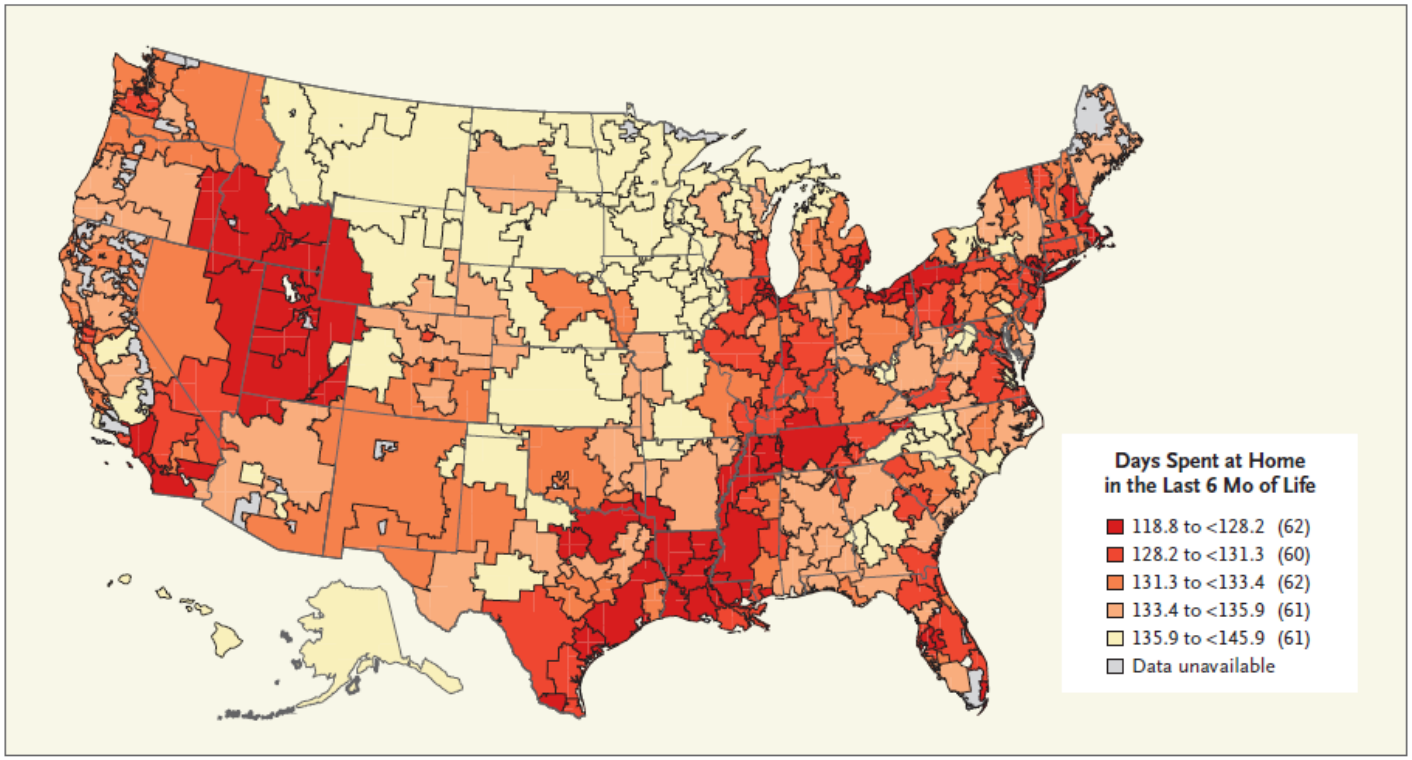
Compared to the national average, MA has higher hospital use and lower ICU use in the last six months of life

End of life care resource use indicators: MA & OR vs. USA					
Medicare decedents, 2012					
	MA	**OR***	**US average**	**10th percentile**	**MA Rank**
Hospital admissions per 1,000 decedents during the last six months of life (ICU level of care intensity)	429	381	627	361.5	**14**
Hospital admissions per 1,000 decedents during the last six months of life (overall level of care intensity)	1366	990	1337	1,056	**38**
Percent of decedents hospitalized at least once during the last six months of life (ICU level of care intensity)	31.2%	28.6%	41.8%	27.6%	**14**
Percent of decedents hospitalized at least once during the last six months of life (overall level of care intensity)	66.9%	59.1%	68.3%	61.1%	**19**
Percent of deaths occurring in a hospital	23.6%	18.8%	22.1%	18.1%	**34**
Average total spending per decedent in last six months of life	$41,420	$27,948	$31,660	$27,240	**45**
Percent of decedents enrolled in hospice during the last six months of life	46.1%	55.7%	50.6%	32.2%	**33**
** Oregon as benchmark of state with "best practices" in end of life care*					
Source: Dartmouth Atlas analysis of 2012 Medicare data					

While Massachusetts has a substantially lower use of ICUs in the last six months of life than the US overall, the rate of hospitalizations is higher, consistent with the state's higher admissions rate among all Medicare beneficiaries

Source: Dartmouth analysis of 2012 Medicare data.
Note: Results for percentage enrolled in hospice and total hospice differ from HPC estimates. Total spending displayed here for Massachusetts ($41,420) are calculated by the Dartmouth Atlas group and are slightly higher than the HPC results displayed on slide 9 ($39,194). Differences may be due in part to HPC exclusion of patients with outlier spending (patients with the highest and lowest 5% of spending), potential differences in data cleaning techniques, etc.

Massachusetts (particularly Eastern MA) ranks among the lowest for average numbers of days spent at home in the last six months life among Medicare decedents, a patient-centered outcome measure



Mean Number of Days Spent at Home in the Last 6 Months of Life, by Hospital Referral Region, for Medicare Beneficiaries Who Died in 2012 or 2013.

Findings of high institutionalization at the end of life in Massachusetts are consistent with practice patterns favoring institutionalization across many measures in the state, including high rates of hospital admissions and institutional post-acute care

HPC

Source: Groff AC, Colla CH, Lee TH. Days spent at home– a patient-centered goal and outcome. NEJM, 2016. 375(17).

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- Review findings:
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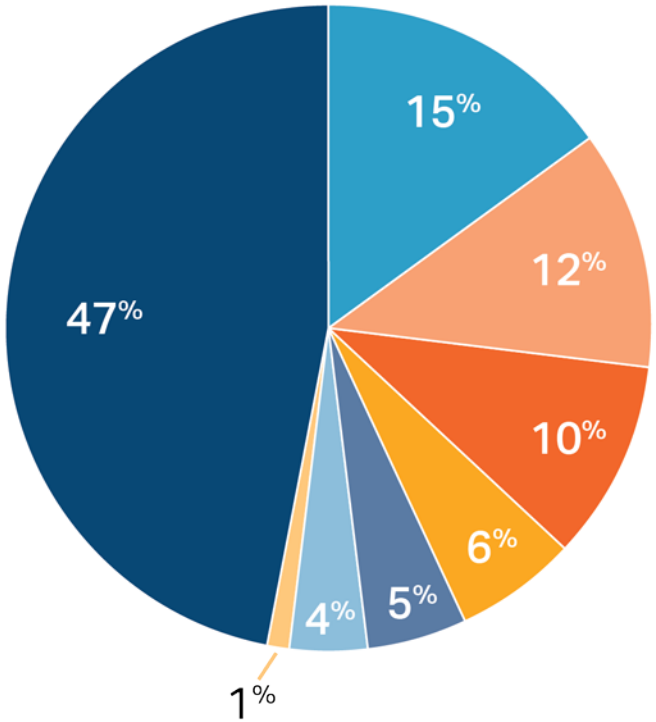
Analysis of Medicare decedents in Massachusetts with poor prognosis cancer

- Focusing on decedents with poor prognosis cancer reduces limitation that differences by population or region may be due to differences in patient cause of death
- Poor prognosis cancer patients defined using ICD-9 codes corresponding to poor-prognosis malignancies used by Obermeyer et al. (*JAMA*, 2014)
- Using the All-Payer Claims Database, we defined a base population of Medicare fee-for-service beneficiaries (65+) who died in 2012 and were continuously enrolled in Medicare Parts A and B in the month of death and 12 months prior
- Identified the poor prognosis subset using APCD claims data to flag Medicare patients who died in 2012 who presented with a relevant ICD-9 code in the 12 months prior to death
- Estimates exclude decedents with total spending below the 5th or above the 95th percentile

Obermeyer Z, Makar M, Abujaber S, Dominici F, Block S, Cutler DM. Association Between the Medicare Hospice Benefit and Health Care Utilization and Costs for Patients With Poor-Prognosis Cancer. *JAMA*.2014;312(18):1888-1896. doi:10.1001/jama.2014.14950. ICD-9 codes can be found in Supplementary Online Content eTable 1.

Among Medicare decedents with poor prognosis cancer, spending distribution is similar to the total population of Medicare decedents, but with more hospital spending and less spending on hospice and SNFs

Total use of Medicare services in last six months of life averaged **$67,600**, with inpatient hospital spending the largest contributor to spending (~**47%** of spending)



Spending by category in the last six months of life among Medicare decedents with poor prognosis cancer, 2012

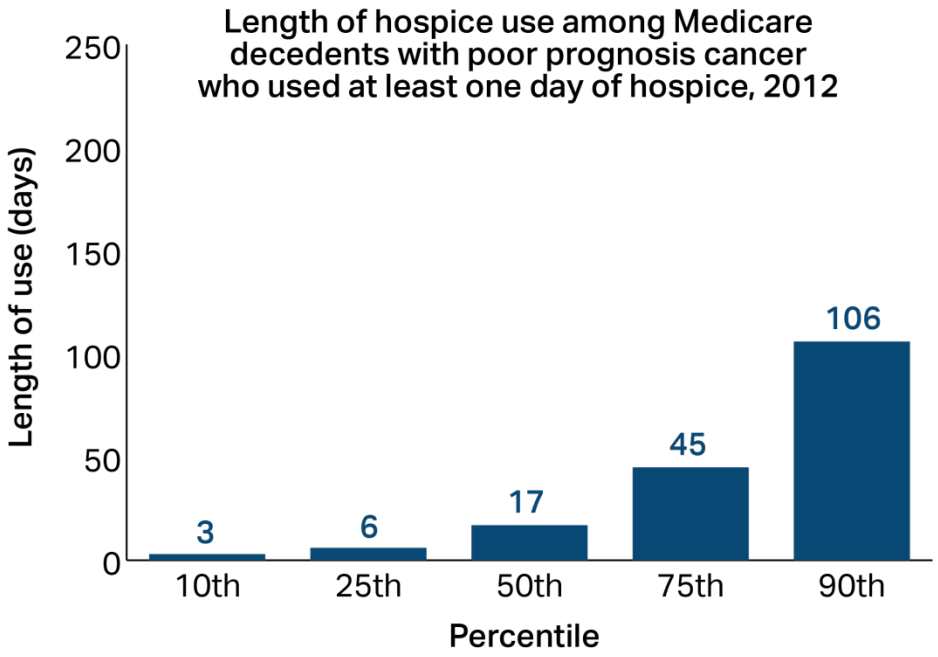
Acute care hospital inpatient	$31,459
Professional services - total	$10,291
Acute care hospital outpatient	$8,426
SNF	$6,865
Hospice Services	$4,220
Other hospital	$3,057
Home health	$2,597
DME	$696
Total Spending	**$67,611**

Source: HPC analysis of 2011-2012 APCD Medicare FFS data
Note: SNF = skilled nursing facility, DME = durable medical equipment

Hospice enrollment is higher among poor prognosis cancer patients, but share of decedents with short use is the same as in the total decedent population

Length of use

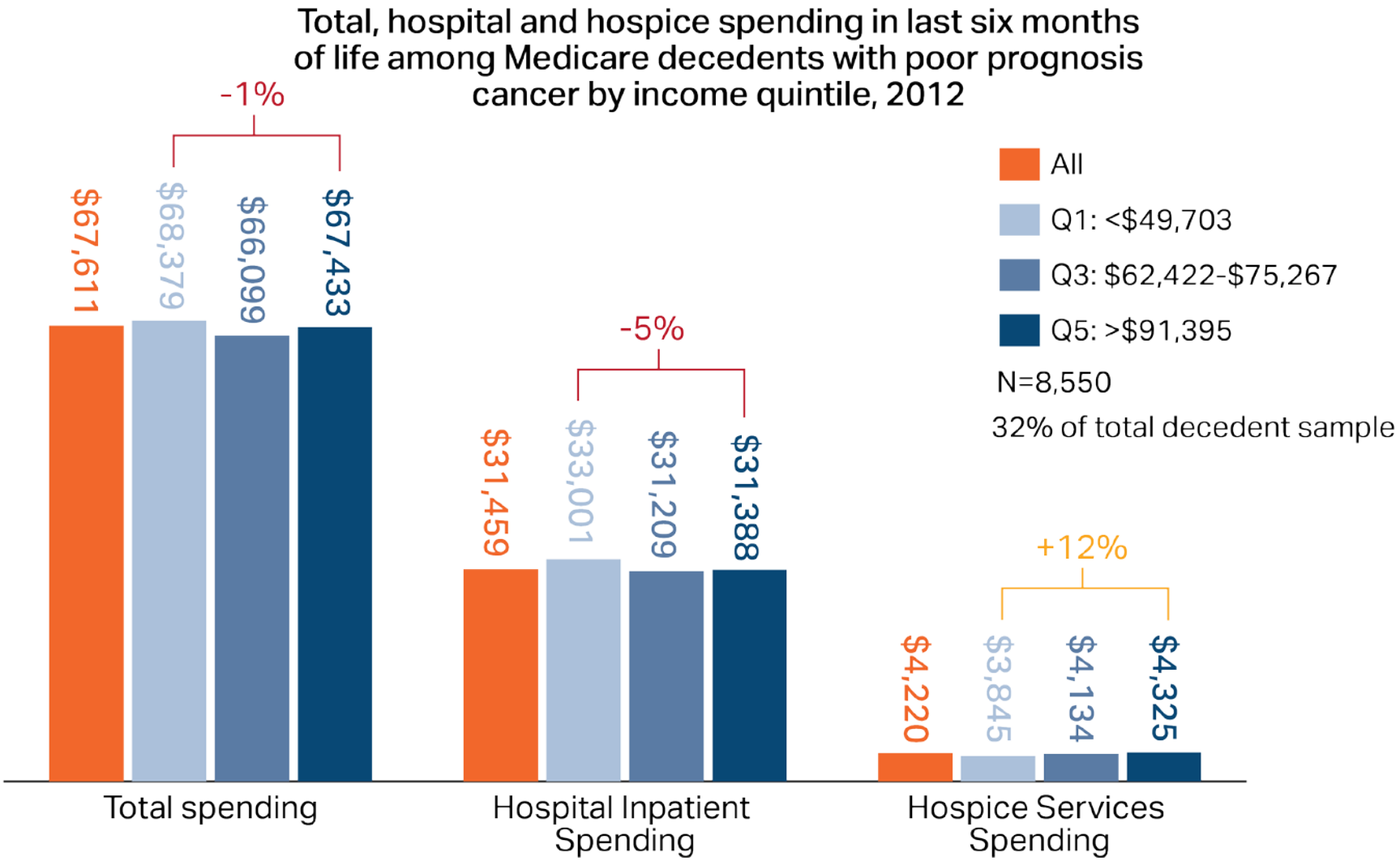
- 61% of Medicare decedents with poor prognosis cancer used hospice in the last year of life, higher than enrollment across all Medicare decedents (49%)
- 25% of all decedents who used hospice were enrolled for less than one week (6 days), the same as the total population of Medicare decedents in Massachusetts



Source: HPC analysis of 2011-2012 APCD Medicare FFS data

Source: HPC analysis of 2011-2012 APCD Medicare FFS data

Among decedents with poor prognosis cancer, those from higher income communities have higher hospice spending and lower inpatient hospital spending at the end of life

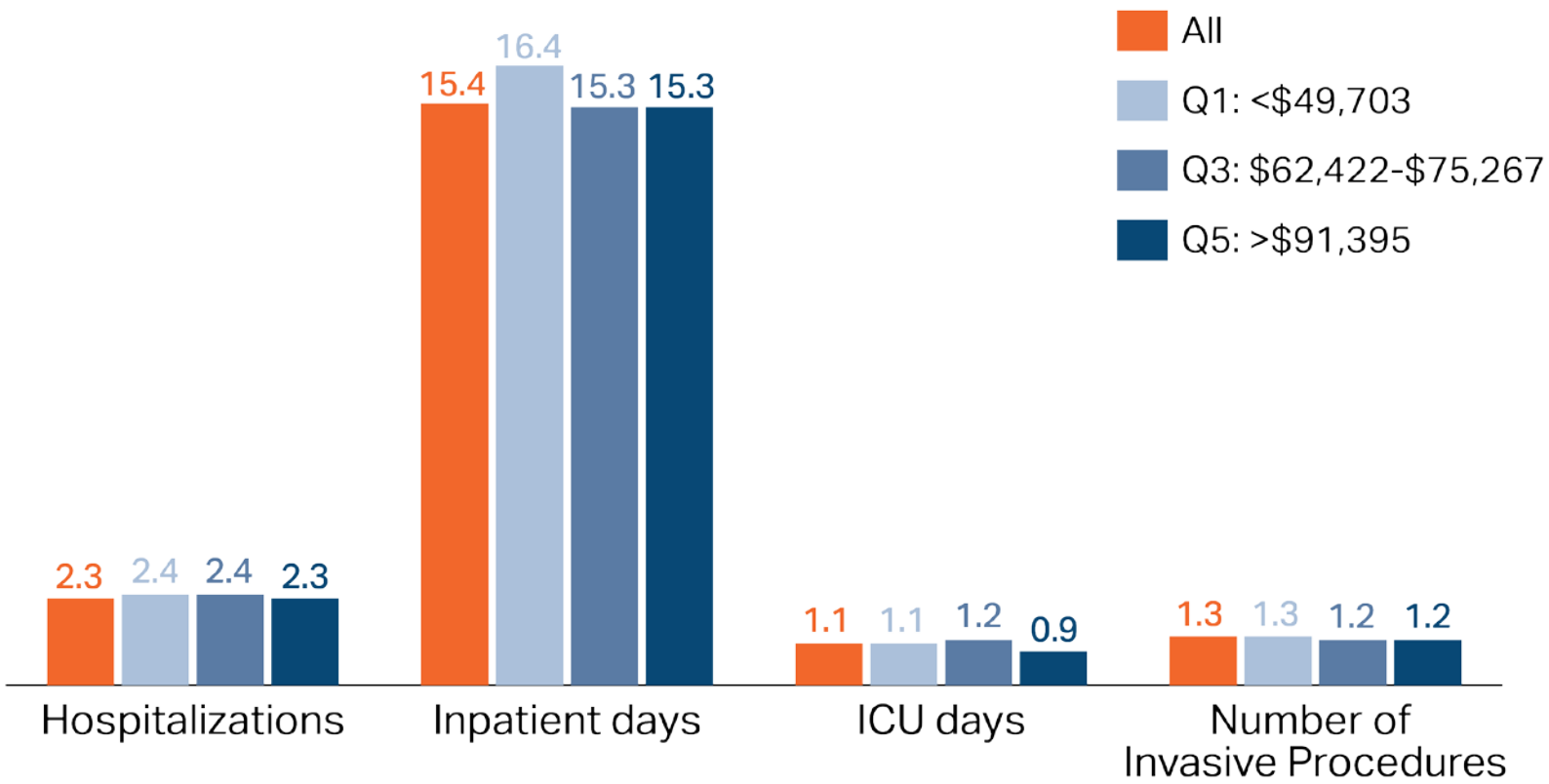


HPC

Source: HPC analysis of 2011-2012 APCD Medicare FFS data

Among decedents with poor prognosis cancer, those in higher income communities have the lowest intensity of service use at the end of life, but the difference by income is less than in the total decedent population

Select metrics of intensity of service use in last six months of life among Medicare decedents with poor prognosis cancer by income quintile, 2012



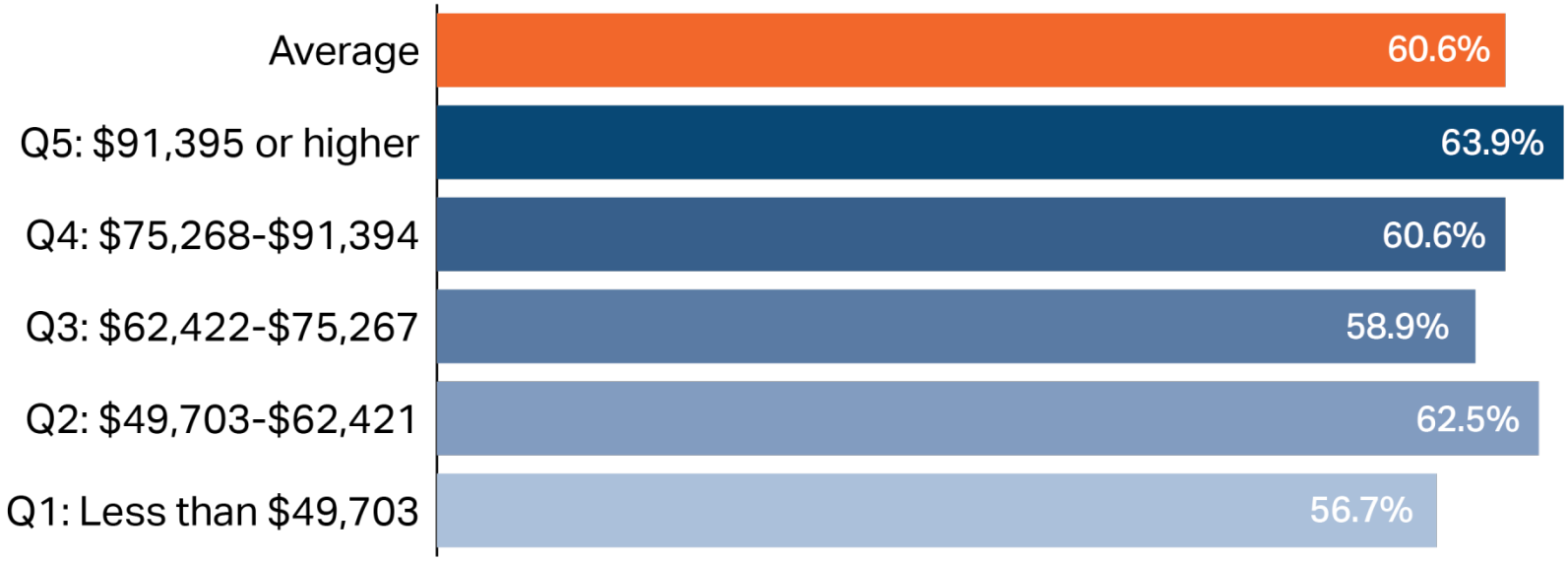
Source: HPC analysis of 2011-2012 APCD Medicare FFS data

Note: Decedents are defined as beneficiaries who died in 2012 with an ICD-9 code corresponding to poor prognosis malignancies (see Obermeyer et al, JAMA, 2014). Estimates include decedents' use of Medicare-covered services in 2011 and 2012. Estimates exclude decedents with total spending below the 5th percentile or above the 95th percentile. An admission, transfer, and admission from transfer are regarded as a single hospitalization. Spending includes Medicare and beneficiary payments for Medicare-covered services. Invasive procedures are defined as follows: insertion of venous catheter (38.93; 38.95; 38.97; 86.07), endotracheal intubation (96.04; 96.71; 96.72), packed cell transfusion (99.04), platelet or plasma transfusion (99.05; 99.07), noninvasive ventilation (93.9), thoracentesis (34.91), hemodialysis (39.95), cardiopulmonary resuscitation (99.6), closed bronchial biopsy (33.24), arterial catheterization (38.91). Invasive procedure methodology based on: Massachusetts Division of Health Care Finance and Policy. "Hospital Resource Use on End-of-Life Patients Varies." July 2006.

HPC

Hospice enrollment varies by income among Medicare decedents with poor prognosis cancer

Hospice enrollment in last six months of life among Medicare decedents with poor prognosis cancer by income quintile, 2012



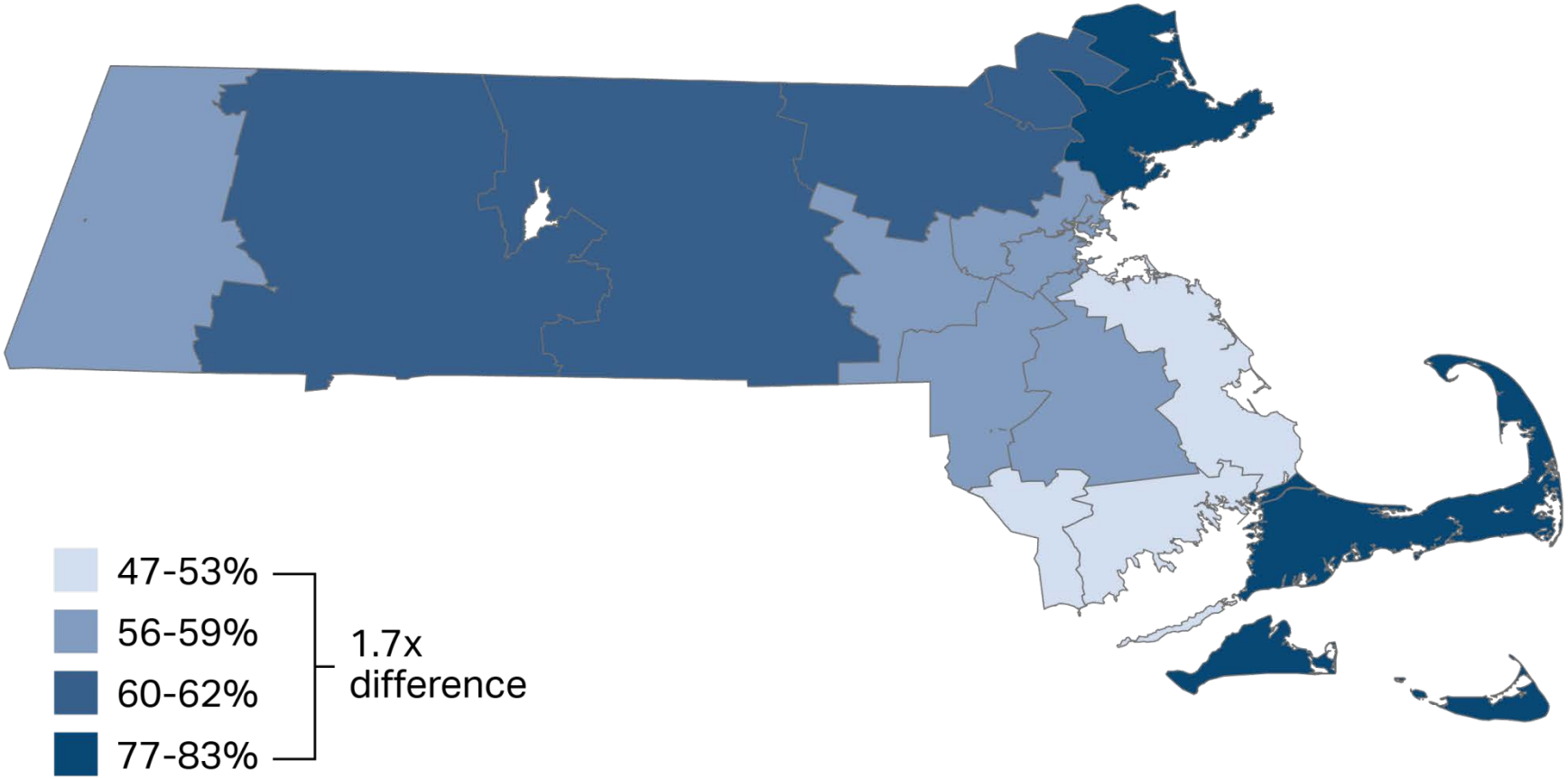
Variation in hospice enrollment

- Differences in hospice enrollment were minimal by age (age 65-74 = 60% versus age 85+ = 61%), but varied by sex (men = 57% versus women = 64%) and income
  - Difference by income among decedents with poor prognosis cancer is similar to difference by income in the total Medicare decedent population
- However, hospice enrollment and service use varied more by region than by age, sex, or income

Source: HPC analysis of 2011-2012 APCD Medicare FFS data
Note: Income defined by median community income associated with the decedent's zip code of residence

Hospice enrollment in last year of life varies widely by region within Massachusetts among Medicare decedents with poor prognosis cancer, 2012

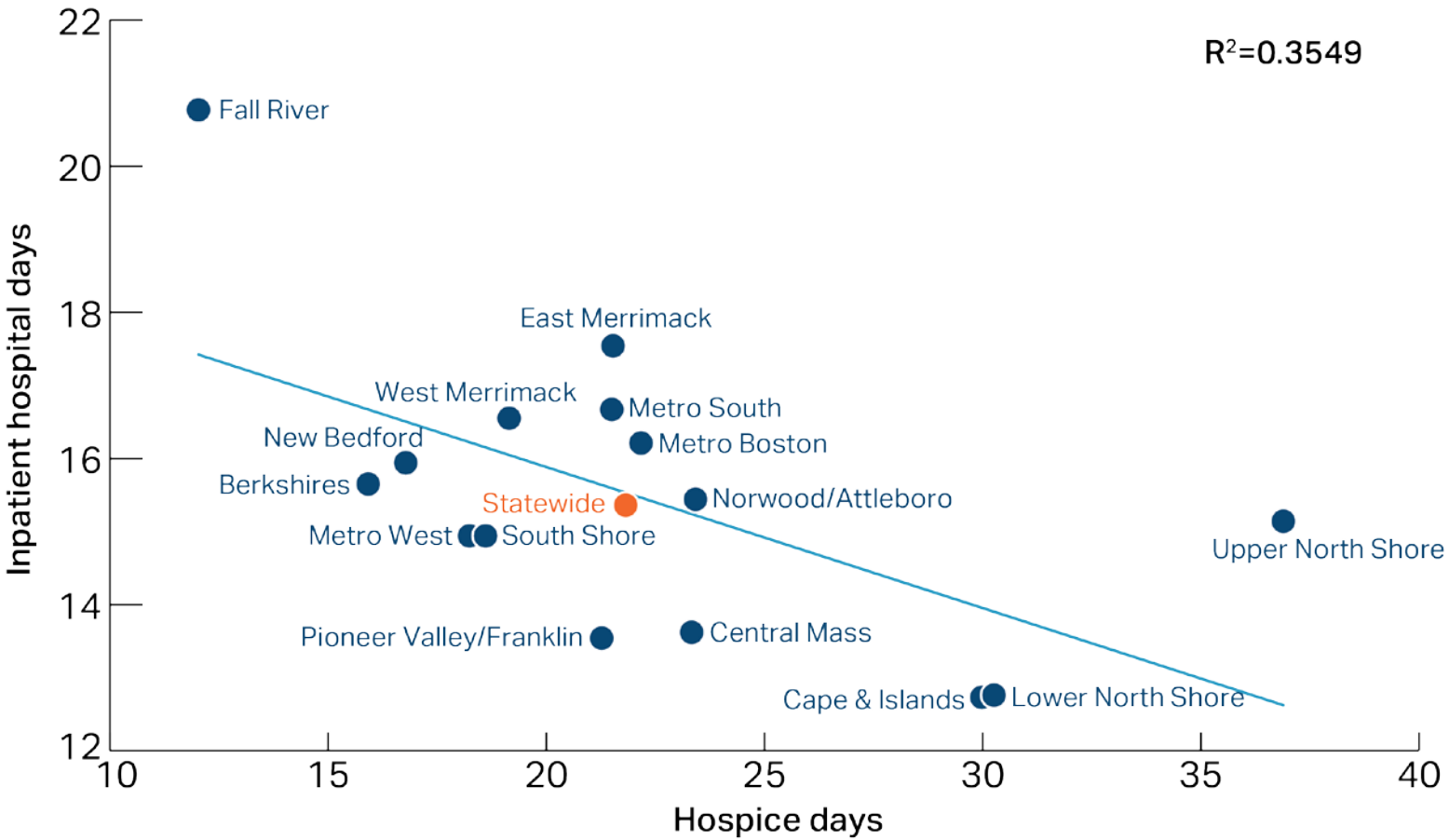
Hospice enrollment in last year of life by region among Medicare decedents with poor prognosis cancer, 2012



Source: HPC analysis of 2011-2012 APCD Medicare FFS data

Regions with higher hospice use tend to have lower hospital use

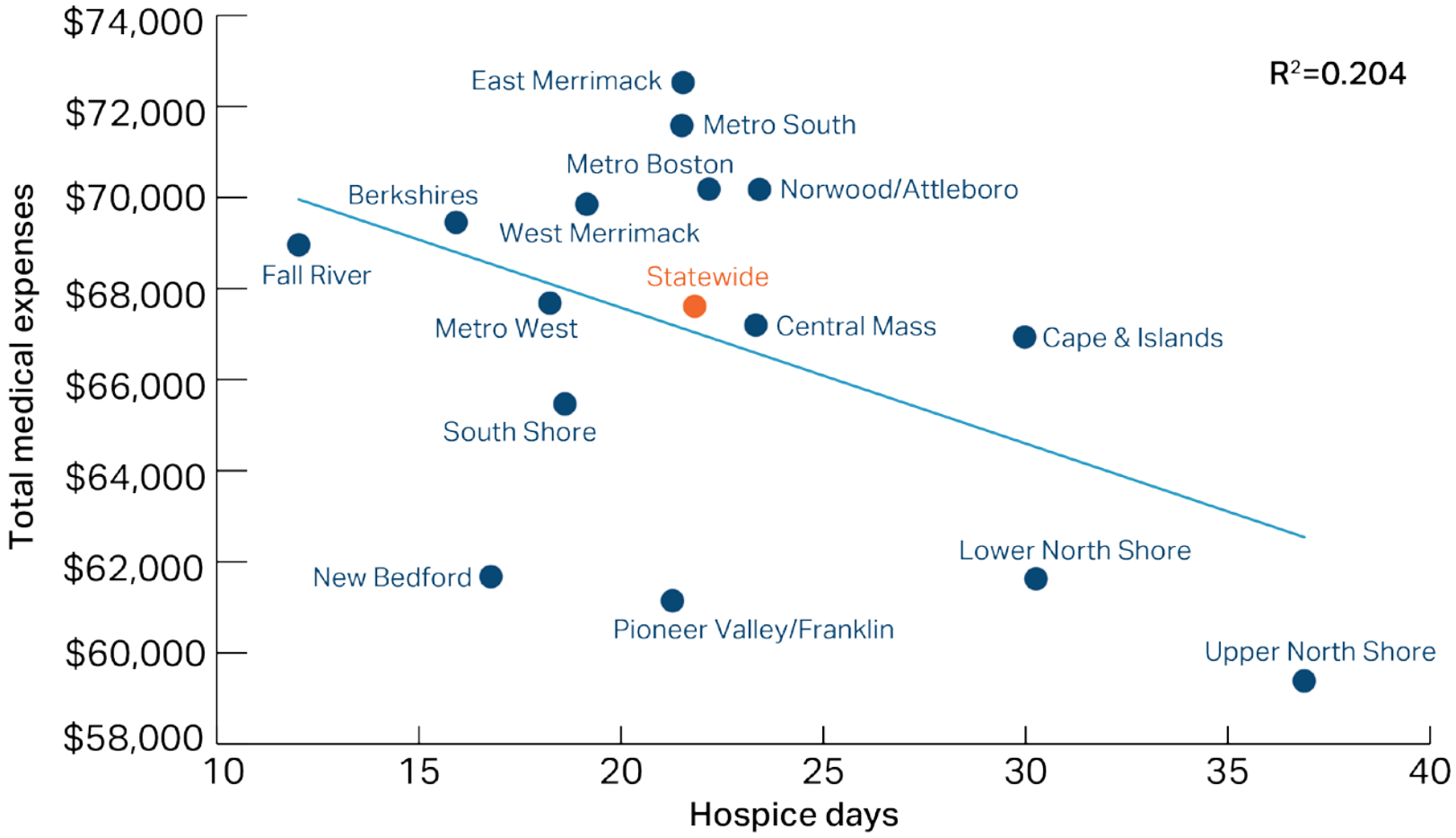
Average number of days of hospice and inpatient hospital days in last six months of life among Medicare decedents with poor prognosis cancer, 2012



Source: HPC analysis of 2011-2012 APCD Medicare FFS data

Regions with higher hospice use tend to have lower total medical spending

Average hospice days and total medical spending in last six months of life for Medicare decedents with poor prognosis cancer, 2012



Source: HPC analysis of 2011-2012 APCD Medicare FFS data

Conclusions

Poor prognosis cancer analysis

- Higher hospice use was correlated with lower hospital use and total spending in this population, reflecting national results with this patient population
- Differences in hospice enrollment by sex and income were moderate, but the variation by region was more pronounced
  - Even areas with highest hospice enrollment have room for improvement
- Regional differences are not likely due to patient characteristics, but instead may support the conclusions from national research that local practice patterns, health system characteristics, and individual physician tendencies to refer to hospice are the most significant predictors of hospice use
  - More research is needed to better understand provider differences in Massachusetts

Conclusions

Overall Conclusions

- Difference in use by population and region as well as late enrollment trends suggest need for attention to access to care, particularly earlier conversations about preferences and shared decision making regarding options
  - Need to ensure that patients with serious illness have access to palliative care services before enrolling in hospice, given the current Medicare hospice requirement to forgo curative treatment
- In Massachusetts, over $1billion is spent on the last six months of life in the Medicare population alone, but widespread, severe problems in quality persist (2016 UMass survey) and variation by region and population suggests issues in access to care
- These findings emphasize the urgent need for improvement in the Commonwealth, including leveraging and expanding on current initiatives

Recent initiatives position MA to be a leader in improving serious illness care

Leadership from state government

- Recommendations from 2010 Massachusetts Expert Panel on End of Life Care (created under Chapter 305 of the Acts of 2008)
- Requirements in Chapter 224 of the Acts of 2012 for providers to inform patients with serious illness about their options, implemented by Department of Public Health (DPH) in 2014
- Establishment of DPH interdisciplinary advisory council on palliative care and quality of life (2015)

Improve patient engagement

the conversation project

Increase portable documentation of patient preferences

- DPH implemented Medicare Orders for Life Sustaining Treatment (MOLST) program for documenting advanced directives

MOLST

Physician training

- Ariadne Labs – a joint center between Brigham and Women's Hospital and Harvard TH Chan School of Public Health – emphasizes open communication with patients and families/caregivers and approaches to identify patients at high risk of death

ARIADNE LABS

Changing practice culture through institutional policies

- DFCI requires universal documentation of health care proxy in EMRs
- BIDMC expanded its definition of informed consent:
  - In implementing state law and DPH regulations, informed consent for patients with serious advancing illness requires offering information and counseling to the patient about palliative care and end of life options, and documenting having done so in the medical record

Massachusetts Serious Illness Care Coalition and other task forces

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As part of the Health Care Innovation Investment (HCII) Program, the HPC awarded Care Dimensions $750,000 to reduce inpatient use and increase conversations and hospice use in patients with serious illness

Primary Aim

Reduce emergency department and inpatient utilization by 30% for 528 high-risk patients with life-limiting illness

Secondary Aims

Secondary Aim 1: Increase hospice length of stay by 5% for the target population by the end of the Implementation Period.

Secondary Aim 2: Achieve a 90% rate of completion of advance directives conversations for the enrolled population by the end of the Implementation Period.

Service Model

Integrate palliative care staff into primary care sites to increase early identification of patients requiring those services, and bridge the gap in care that occurs between curative care and end of life care by utilizing telemedicine technology.

Partner

- North Shore Physicians Group, Inc.

CareDimensions
HOSPICE | PALLIATIVE CARE | SUPPORT SERVICES

Total Initiative Cost	Requested HPC Funding	Estimated Savings
$750,000	$750,000	$7,233,600

HPC

Previously identified strategies to improve serious illness care in Massachusetts for discussion

2010 Massachusetts Expert Panel Recommendations:

1. Inform and empower residents of Massachusetts
2. Support a health care system that ensures high quality patient-centered care
3. Ensure a knowledgeable, competent, and compassionate workforce
4. Create financing structures that promote patient-centered care
5. Create a responsible entity to ensure excellent and accountability
6. Employ quality indicators and performance measurement

A 2014 report evaluated progress against the 2010 recommendations and detailed priorities for further action in each area

Highlight: Need for state-wide outcomes-based quality measurement

- Develop and implement regularly administered post-death survey of family/caregivers of decedents
- Adapt existing vehicles to measure and track progress on serious illness care, such as Cost Trends Report dashboard and patient surveys
- Ensure accountability for progress as a state, and health care organizations (providers and insurers)

HPC

Source: MA Expert Panel on End of Life Report: Looking Forward: 2014 and Beyond. University of Massachusetts Medical School, 2014.

Next steps

- Engage with MA Serious Illness Care Coalition and others on these findings
  - Opportunities for collaboration with other state government partners
- Update results with 2015 data and include time trends
  - Issue policy brief in 2017 with updated analyses
- Explore opportunities to expand data capabilities to include decedents covered by payers other than Medicare and other demographic differences
- Explore opportunities to link practice pattern variation to health systems
- Dashboard metrics
- Additional research
  - What additional data or analyses would be valuable?

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HEALTH POLICY COMMISSION

AGENDA

- Care Delivery and Payment System Transformation
- Joint Meeting on Serious Illness Care in Massachusetts
- **Quality Improvement and Patient Protection**
  - Approval of Minutes from the June 22, 2016 Meeting
    Overview of New Grant Pilot Program: Initiation of Pharmacologic Treatment for Substance Use Disorders in the Emergency Department (ED)
  - Office of Patient Protection Regulations

MASSACHUSETTS
HEALTH POLICY COMMISSION

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MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the QIPP meeting held on June 22, 2016, as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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The FY17 State Budget directs the HPC to implement a new pilot program for ED SUD treatment

Summary of HPC mandate in FY17 budget*

1. The HPC (in consultation with DPH) shall implement a **2-year pilot grant program** to further test a model of **emergency department (ED) initiated pharmacologic treatment** of substance use disorder

2. Grantees shall provide **referrals to outpatient follow up treatment** with the goals of increasing rates of engagement and retention in evidence-based pharmacologic care (including behavioral health services)

3. The HPC may direct up to **$3,000,000** from its Distressed Hospital Trust Fund to implement the program at **no more than 3 sites**, to be selected through a **competitive process**

**See appendix for statutory language*

HPC

Directing the $3,000,000 allocation to support ongoing state efforts to target the opioid epidemic

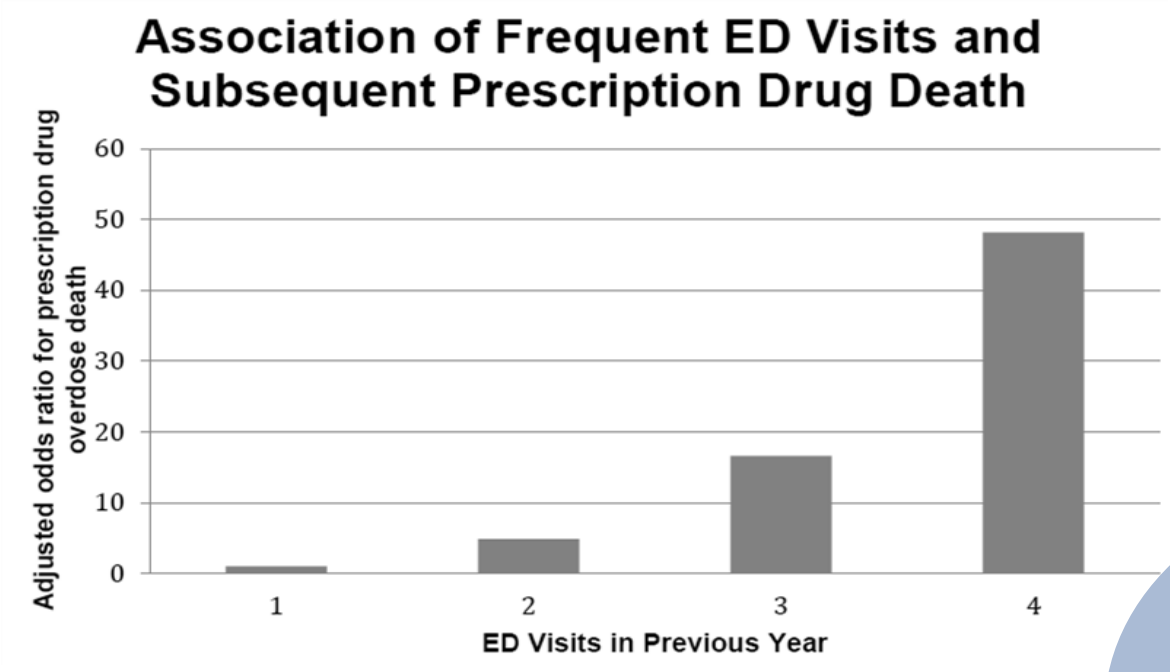
- The HPC's September 2016 report, ***Opioid Use Disorder in Massachusetts: An Analysis of its Impact on the Health Care System, Availability of Pharmacologic Treatment, and Recommendations for Payment and Care Delivery Reform***, set forth several recommendations for ways in which the Commonwealth could invest in mechanisms to improve the efficiency of treatment of opioid use disorder treatment.

- One recommendation included allocating money to support hospitals to **initiate pharmacologic treatment in the ED** when patients present with **opioid dependence** and/or have experienced a **non-fatal opioid overdose.**

- The HPC could direct this $3,000,000 pilot to support EDs experiencing particularly high volumes of opioid dependence to **train providers to initiate treatment and establish partnerships that will facilitate timely follow up** with outpatient providers.

HPC

From the Evidence: Frequent ED utilization is correlated with fatal overdoses



EDs provide opportunity to engage high-risk patients in treatment

Joanne E. Brady et al., "Emergency Department Utilization and Subsequent Prescription Drug Overdose Death," *Annals of Epidemiology* 25, no. 8 (August 2015): 613-19.e2, doi:10.1016/j.annepidem.2015.03.018; Joseph Logan et al., "Opioid Prescribing in Emergency Departments: The Prevalence of Potentially Inappropriate Prescribing and Misuse," *Medical Care* 51, no. 8 (2013): 646-53, doi:10.1097/MLR.0b013e318293c2c0; Kohei Hasegawa et al., "Epidemiology of Emergency Department Visits for Opioid Overdose: A Population-Based Study," *Mayo Clinic Proceedings* 89, no. 4 (2014): 462-71, doi:10.1016/j.mayocp.2013.12.008.

HPC

Although pharmacologic treatment for substance use disorder is evidence-based, it is not widely accessible

Access to pharmacologic treatment **reduces rates of relapse** and **inpatient admissions**[1]

Yet **fewer than 50%** of patients with opioid addiction received **pharmacologic treatment** in 2012[2]

Access to pharmacologic treatment **varies widely across the state** (naltrexone, buprenorphine, and methadone)[3]

Initiating treatment in the ED will be successful only if **EDs closely collaborate** with **outpatient pharmacologic prescribers** and **BH providers**[4]

1. National Institute on Drug Abuse. Medication-Assisted Treatment for Opioid Addiction – April 2012.
Topics in Brief. https://www.drugabuse.gov/sites/default/files/tib_mat_opioid.pdf. April 2012. Accessed December 3, 2015.

2. Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013

3 See Health Policy Commission's report on *Opioid Use Disorder in Massachusetts*, 2016, http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/opioid-use-disorder-report.pdf

4 D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., ... & Fiellin, D. A. (2015). Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA, 313(16), 1636-1644.

HPC

Justification for initiating pharmacologic treatment in the ED

Nearly 10% of fatal overdoses are preceded by a **non-fatal** overdose.[1] Pharmacologic intervention significantly reduces mortality.

Individuals on treatment that blocks opiate receptors (e.g., buprenorphine or methadone) are half as likely to fatally overdose.[1]

In particular, patients treated with buprenorphine experienced a 75% reduced mortality versus patients treated with psychosocial interventions alone.[2]

ED initiation of buprenorphine is proven to increase engagement in treatment after ED discharge and retention after 30 days.[3]

1 Massachusetts Department of Public Health. "An Assessment of Opioid-Related Deaths in Massachusetts (2013-2014)". Available from: http://www.mass.gov/eohhs/docs/dph/stop-addiction/dph-legislative-report-chapter-55-opioid-overdose-study-9-15-2016.pdf

→ "Since not all opioid-related overdoses are captured by MATRIS, these values are almost certainly underestimates."

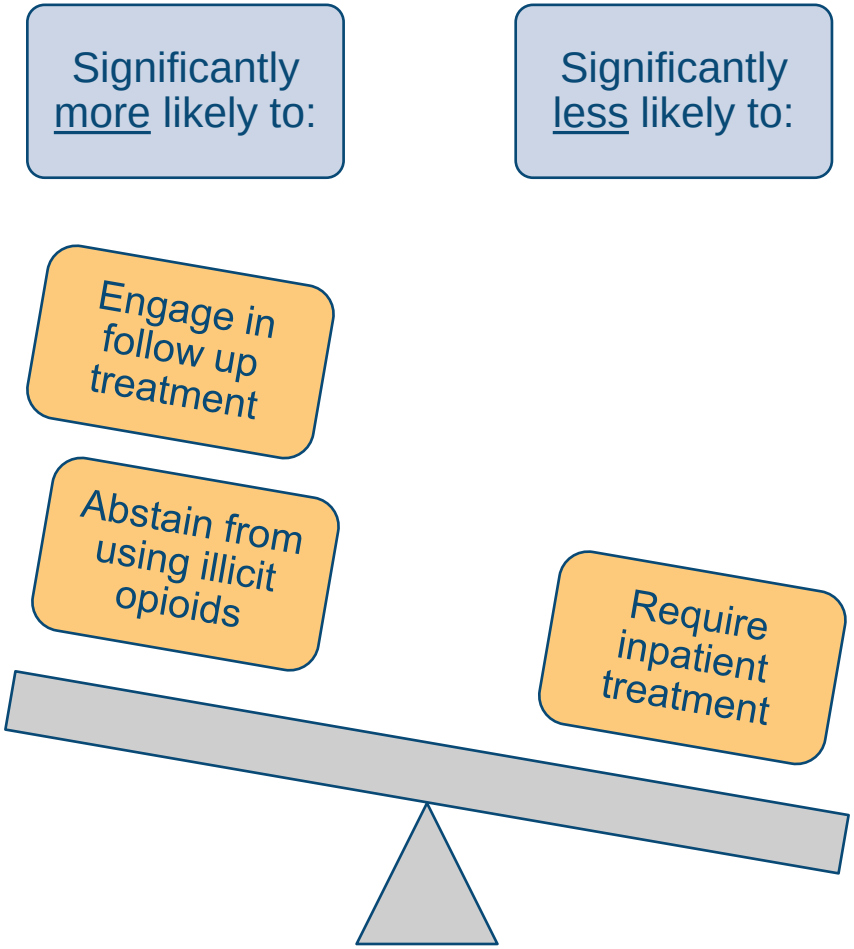
2 Robin E. Clark et al., "The Evidence Doesn't Justify Steps by State Medicaid Programs to Restrict Opioid Addiction Treatment with Buprenorphine," *Health Affairs* 30, no. 8 (2011): 1425-33, doi:10.1377/hlthaff.2010.0532.

3 D'Onofrio G, O'Connor PG, Pantalon MV, Chawarski MC, Busch SH, Owens PH, Bernstein SL, Fiellin DA. Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA. 2015 Apr 28;313(16):1636-44.

HPC

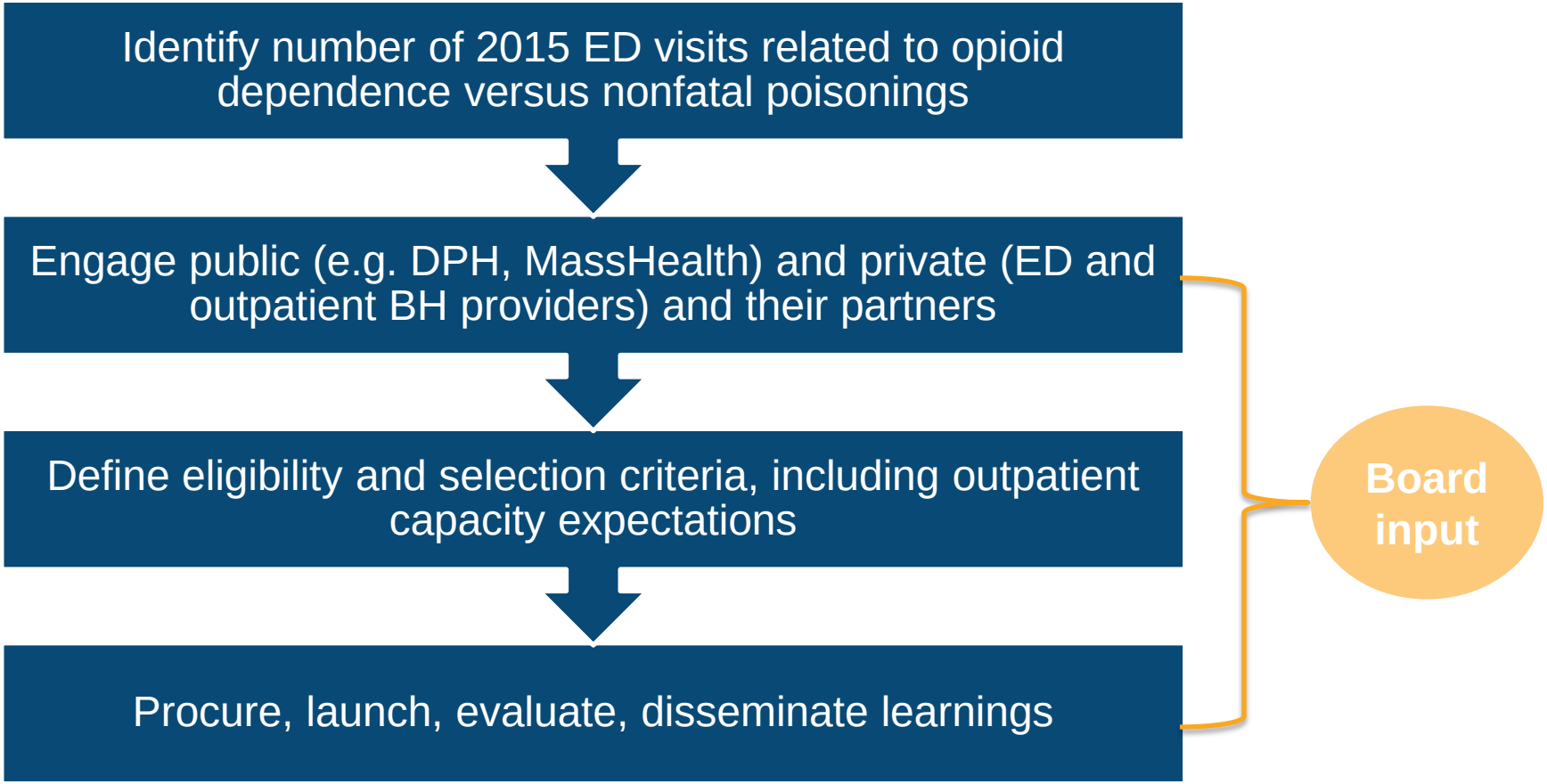
Evidence base for initiation of pharmacologic treatment in the ED

Randomized clinical trial of 3 interventions for ED presentation of opioid use disorder at Yale New Haven Hospital found that, compared with patients who received screening and referral into treatment, patients who initiate buprenorphine treatment prior to discharge are:



D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., ... & Fiellin, D. A. (2015). Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA, 313(16), 1636-1644.

Proposed pilot design process



Proposed pilot design timeline

	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.
Pilot design	QIPP Meeting										
Procurement and evaluation development				Board Meeting							
Selection process				Staff Releases RFR				Board Announces Awards			
Contracting and launch											**Pilot Launch** ★

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

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OPP Regulatory Amendment – 958 CMR 3.000

- As previewed with the Committee in May 2016, Chapter 52 of the Acts of 2016 amended M.G.L. c. 176O, sec. 7 to add new **carrier reporting requirements on claims and claims denials** to the Office of Patient Protection (OPP) during annual reporting:

> SECTION 53. Said section 7 of said chapter 176O, as so appearing, is hereby further amended by inserting after the word "age", in line 68, the following words:- ; and
>
> (5) a report detailing for the previous calendar year the total number of: (i) medical or surgical claims submitted to the carrier; (ii) medical or surgical claims denied by the carrier; (iii) mental health or substance use disorder claims submitted to the carrier; (iv) mental health or substance use disorder claims denied by the carrier; and (v) medical or surgical claims and mental health or substance use disorder claims denied by the carrier because: (A) the insured failed to obtain pre-treatment authorization or referral for services; (B) the service was not medically necessary; (C) the service was experimental or investigational; (D) the insured was not covered or eligible for benefits at the time services occurred; (E) the carrier does not cover the service or the provider under the insured's plan; (F) duplicate claims had been submitted; (G) incomplete claims had been submitted; (H) coding errors had occurred; or (I) of any other specified reason.

- Accordingly, OPP's regulation ***958 CMR 3.00: Health Insurance Consumer Protection*** is being amended to incorporate the new statutory requirements

HPC

Regulatory Development: Stakeholder Engagement/Feedback

- Since previewing the regulatory revisions with the Committee, HPC staff have conducted significant **stakeholder outreach** with carriers (MAHP, BCBS) to get input in developing the proposed regulation
- HPC staff have also been working closely with the **Division of Insurance** (DOI), given DOI's authority regarding parity certification and the related reporting requirements
- HPC staff have also conducted preliminary outreach to **other states** (VT, CT, MD) that have similar carrier reporting requirements

HPC

Regulatory Development: Key Considerations

- HPC staff seek to **minimize administrative burden** for carriers to the extent possible in implementing the new requirements
- HPC staff are developing a proposed **reporting template** to guide submissions, on which staff is soliciting feedback from carriers and DOI; staff encourage comments on the reporting template during the public comment period
- The new required information would be **first reported to OPP in 2018** (reporting on 2017 data)
- Stakeholders will have additional opportunities to provide feedback on 958 CMR 3.00 during the upcoming **public comment period**, which includes a public hearing

HPC

Overview of new information to be reported by carriers

- The new reporting requirements:
  - **Provide greater transparency** regarding the total "universe" of fully insured claims/requests for services submitted and denied, with further specificity about the reasons for which claims are denied
  - **Broaden the data currently reported to OPP** which is limited to data on internal grievances and external reviews of adverse determinations for medical necessity
  - **Supplement information submitted to DOI** pursuant to DOI's parity authority. DOI's parity bulletin requires reporting only about services that require prior authorization (comparing medical/surgical and mental health/substance use disorder) and excludes pharmacy claims

- New requirements would **capture** additional information, not currently collected. For example:
  - Post-service denials and claims regarding treatments/services that do not require prior authorization:
    - From an out-of-network provider
    - For a service that is not covered under the insured's particular plan
  - Administrative denials (e.g., duplicate/incomplete claims, coding errors)

HPC

Update on Proposed Timeline

***May 18, 2016** – Previewed regulatory revision with the QIPP Committee*

***June 1, 2016 –** Preview of regulatory revision to full Board*

November 2, 2016 – QIPP Committee votes to advance proposed regulation

November 9, 2016 – Full Board to review proposed regulation; vote to release proposed regulation

November 30, 2016 – Public hearing on proposed regulation; deadline to submit comments (5 p.m.)

December 7, 2016 – QIPP Committee to review final regulation

December 14, 2016 – Commission to review final regulation

**Dates may be subject to change.*

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

VOTE: Approving Advancement of Office of Patient Protection Regulation for Public Comment

MOTION: That the Quality Improvement and Patient Protection Committee hereby approves the advancement of the proposed updates to Office of Patient Protection regulation, 958 CMR 3.00, *Health Insurance Consumer Protection,* to the Commission.

Contact Information

For more information about the Massachusetts Health Policy Commission:

Contact Us:
HPC-INFO@state.ma.us

Visit us:
http://www.mass.gov/hpc

Follow us:
@Mass_HPC

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Appendix – End of Life Report

Selected measures of service use and spending among decedents in 2012: Medicare fee-for-service beneficiaries by age, sex, and income quintile

		Age			Sex		Income Quintile				
	All	65-74	75-84	85+	Men	Women	Bottom Quintile	Quintile 2	Quintile 3	Quintile 4	Top Quintile
Number of decedents[a]	27,137	4,162	8,489	14,486	11,344	15,793	4,665	5,694	5,697	5,762	5,262
Distribution of decedents	100%	15%	31%	53%	42%	58%	17%	21%	21%	21%	19%
12 months before death											
Average number of hospice days	32.3	22.2	27.8	37.8	24.9	37.6	30.1	31.9	32.2	32.8	34.2
Percent using any hospice in year prior to death	49.3%	43.8%	46.9%	52.2%	45.1%	52.3%	45.0%	48.7%	49.2%	51.0%	51.7%
6 months before death											
Acute care hospitals											
Number of hospitalizations per decedent	1.23	1.37	1.36	1.11	1.31	1.17	1.24	1.24	1.27	1.20	1.19
Number of inpatient days per decedent	8.22	9.77	9.51	7.01	8.87	7.75	8.68	8.33	8.44	7.98	7.73
Number of ICU days per decedent	0.87	1.35	1.14	0.58	1.02	0.77	0.99	0.89	0.95	0.77	0.80
Number of Non-ICU days per decedent	7.3	8.4	8.4	6.4	7.8	7.0	7.7	7.4	7.5	7.2	6.9
Non-acute hospitals[b]											
Number of hospitalizations per decedent	0.10	0.12	0.12	0.08	0.12	0.09	0.09	0.10	0.11	0.10	0.10
Average number of invasive procedures per hospitalized decedent	0.79	1.26	1.01	0.53	0.93	0.69	0.87	0.78	0.80	0.77	0.74
Spending per decedent											
All services	$39,194	$45,670	$43,517	$34,799	$41,524	$37,520	$39,573	$39,502	$39,933	$38,845	$38,204
Acute care hospital inpatient	$16,477	$20,964	$19,343	$13,508	$18,075	$15,330	$17,653	$16,992	$16,749	$15,668	$15,521
Other hospital inpatient	$1,805	$2,079	$2,226	$1,479	$2,139	$1,565	$1,484	$1,770	$1,997	$1,911	$1,813
Acute care hospital outpatient	$2,403	$5,317	$2,992	$1,221	$2,971	$1,996	$2,180	$2,266	$2,482	$2,579	$2,490
Other hospital outpatient	$670	$701	$686	$651	$682	$661	$818	$686	$652	$658	$547
Hospice Services	$4,426	$3,461	$3,953	$4,981	$3,568	$5,043	$4,090	$4,357	$4,467	$4,563	$4,597
SNF	$6,040	$3,747	$5,826	$6,825	$5,966	$6,093	$6,051	$6,028	$6,072	$6,194	$5,856
Home health	$1,473	$1,452	$1,544	$1,437	$1,525	$1,435	$1,366	$1,445	$1,487	$1,466	$1,589
DME	$339	$609	$410	$220	$379	$310	$381	$335	$330	$311	$348
Professional services - total	$5,560	$7,341	$6,536	$4,477	$6,219	$5,087	$5,551	$5,623	$5,697	$5,495	$5,443

Note: Decedents are defined as beneficiaries who died in 2013. Estimates include decedents' use of Medicare-covered services in 2012 and 2013. Estimates exclude decedents with total spending below the 5th percentile or above the 95th percentile. An admission, transfer, and admission from transfer are regarded as a single hospitalization. Invasive procedures are defined as follows: insertion of venous catheter (38.93; 38.95; 38.97; 86.07), endotracheal intubation (96.04; 96.71; 96.72), packed cell transfusion (99.04), platelet or plasma transfusion (99.05; 99.07), noninvasive ventilation (93.9), thoracentesis (34.91), hemodialysis (39.95), cardiopulmonary resuscitation (99.6), closed bronchial biopsy (33.24), arterial catheterization (38.91). Spending includes Medicare and beneficiary payments for Medicare-covered services.

[a] Includes inpatient stays in long-term care, psychiatric, rehabilitation, and VA hospitals.

Service use and spending among decedents in 2012: Medicare fee-for-service beneficiaries with poor prognosis cancers by age, sex, and income quintile

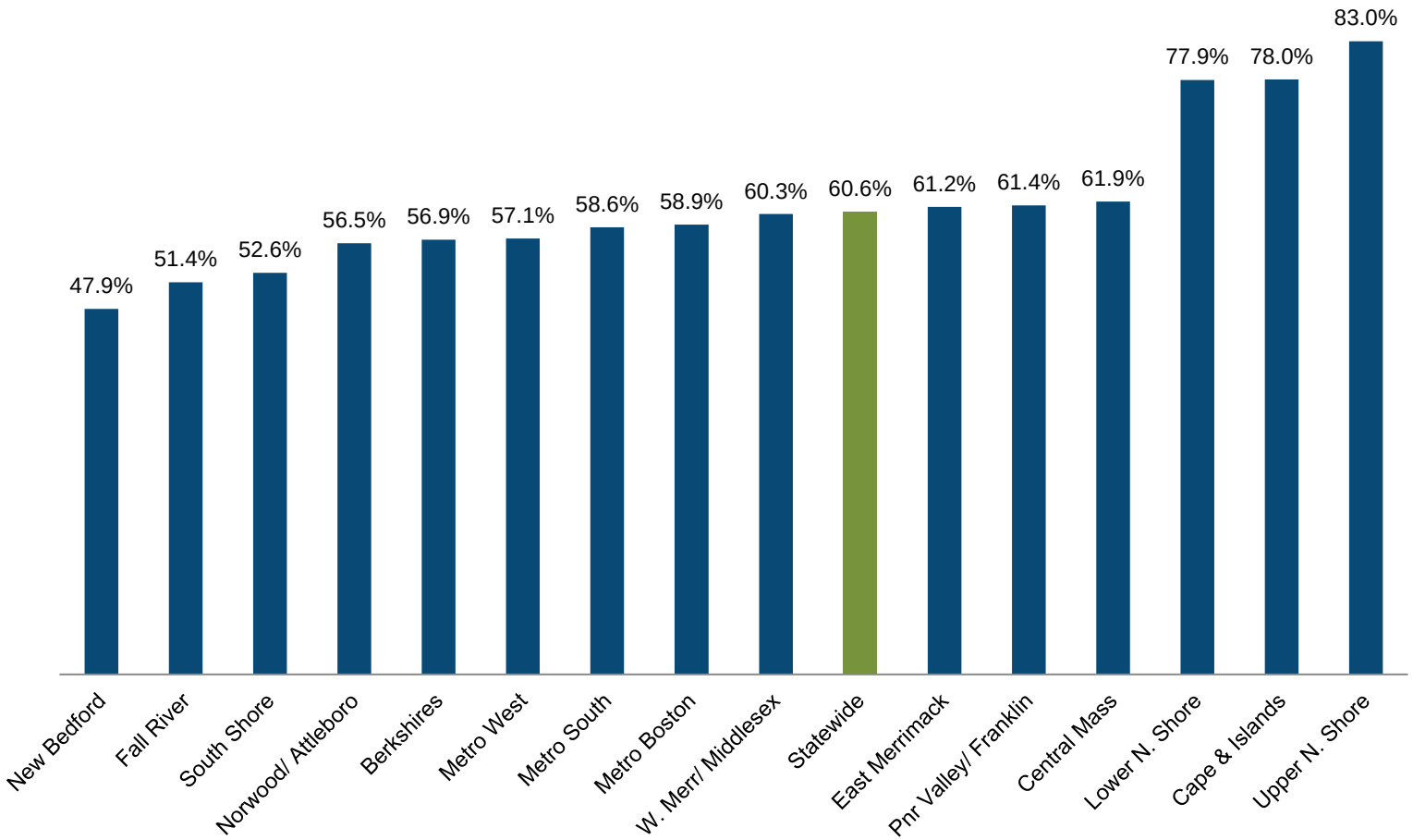
		Age			Sex		Income quintiles				
	All	65-74	75-84	85+	Men	Women	Bottom Quintile	Quintile 2	Quintile 3	Quintile 4	Top Quintile
Number of decedents[a]	8,550	3,162	3,614	1,774	4,205	4,345	1,376	1,711	1,793	1,963	1,702
Distribution of decedents	100%	37%	42%	21%	49%	51%	16%	20%	21%	23%	20%
12 months before death											
Average number of hospice days	24.23	24.65	22.39	27.22	21.22	27.14	22.57	26.9	24.44	20.92	26.48
Percent using any hospice in year prior to death	60.6%	60.3%	60.8%	61.1%	56.7%	64.4%	56.7%	62.5%	58.9%	60.6%	63.9%
6 months before death											
Acute care hospitals											
Number of hospitalizations per decedent	2.32	2.39	2.35	2.15	2.4	2.26	2.38	2.23	2.37	2.34	2.32
Number of inpatient days per decedent	15.36	15.84	15.49	14.25	15.61	15.13	16.44	14.83	15.33	15.21	15.26
Number of ICU days per decedent	1.06	1.34	0.98	0.72	1.14	0.98	1.08	0.95	1.2	1.19	0.86
Number of Non-ICU days per decedent	14.3	14.49	14.52	13.53	14.46	14.15	15.36	13.88	14.13	14.02	14.4
Non-acute hospitals[b]											
Number of hospitalizations per decedent	0.13	0.13	0.14	0.09	0.14	0.12	0.11	0.13	0.13	0.13	0.12
Average number of invasive procedures per hospitalized decedent	1.25	1.41	1.22	1.04	1.4	1.11	1.28	1.18	1.21	1.39	1.19
Spending per decedent											
All services	$67,611	$72,219	$67,967	$58,671	$69,261	$66,014	$68,379	$66,782	$66,099	$69,305	$67,433
Acute hospital inpatient	$31,459	$34,042	$31,525	$26,720	$32,864	$30,099	$33,001	$30,342	$31,209	$31,684	$31,388
Other hospital inpatient	$2,769	$2,622	$3,159	$2,234	$2,957	$2,587	$2,037	$2,768	$2,748	$3,360	$2,631
Acute hospital outpatient	$8,426	$11,702	$7,733	$3,996	$9,130	$7,743	$7,898	$7,490	$8,094	$9,494	$8,926
Other hospital outpatient	$288	$276	$238	$414	$307	$271	$406	$227	$251	$252	$336
Hospice Services	$4,220	$4,400	$3,963	$4,421	$3,649	$4,772	$3,845	$4,698	$4,134	$4,026	$4,325
SNF	$6,865	$4,988	$7,153	$9,624	$6,432	$7,284	$7,888	$7,418	$6,235	$6,960	$6,039
Home health	$2,597	$2,553	$2,640	$2,589	$2,547	$2,646	$2,349	$2,689	$2,630	$2,505	$2,767
DME	$696	$754	$786	$410	$713	$680	$574	$819	$755	$674	$635
Professional services - total	$10,291	$10,881	$10,769	$8,264	$10,663	$9,931	$10,381	$10,330	$10,042	$10,349	$10,385

Note: Decedents are defined as beneficiaries who died in 2012. Estimates include decedents' use of Medicare-covered services in 2011 and 2012. Estimates exclude decedents with total spending below the 5th percentile or above the 95th percentile. An admission, transfer, and admission from transfer are regarded as a single hospitalization. Invasive procedures are defined as follows: insertion of venous catheter (38.93; 38.95; 38.97; 86.07), endotracheal intubation (96.04; 96.71; 96.72), packed cell transfusion (99.04), platelet or plasma transfusion (99.05; 99.07), noninvasive ventilation (93.9), thoracentesis (34.91), hemodialysis (39.95), cardiopulmonary resuscitation (99.6), closed bronchial biopsy (33.24), arterial catheterization (38.91). Spending includes Medicare and beneficiary payments for Medicare-covered services.

[a] Includes inpatient stays in long-term care, psychiatric, rehabilitation, and VA hospitals.

HPC

Hospice enrollment in last year of life varies widely by region within Massachusetts among Medicare decedents with poor prognosis cancer, 2012



Source: HPC analysis of 2011-2012 APCD Medicare FFS data

ACO certification program – year 1 design

Pre-requisites

4 pre-reqs.
Attestation only

- ✓ Risk-bearing provider organizations (RBPO) certificate, if applicable
- ✓ Any required Material Change Notices (MCNs) filed
- ✓ Anti-trust laws
- ✓ Patient protection

1 Assessment Criteria

6 criteria
Sample documents, narrative descriptions

- ✓ Patient-centered, accountable governance structure
- ✓ Participation in quality-based risk contracts
- ✓ Population health management programs
- ✓ Cross continuum care: coordination with BH, hospital, specialist, and long-term care services

2 Required Supplemental Information

9 criteria
Narrative or data
Not evaluated by HPC but must respond

- ✓ Supports patient-centered primary care
- ✓ Assesses needs and preferences of ACO patient population
- ✓ Develops community-based health programs
- ✓ Supports patient-centered advanced illness care
- ✓ Performs quality, financial analytics and shares with providers
- ✓ Evaluates and seeks to improve patient experiences of care
- ✓ Distributes shared savings or deficit in a transparent manner
- ✓ Commits to advanced health information technology (HIT) integration and adoption
- ✓ Commits to consumer price transparency

HPC

Appendix – Pilot Program

Evidence base for the initiation of buprenorphine in the ED

Randomized clinical trial of 3 interventions for ED presentation of opioid use disorder at Yale New Haven Hospital

Interventions

1. Screening and referral to treatment (n=104)
2. Screening, brief intervention, and referral to community-based treatment (n=111)
3. **Screening, brief intervention, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up** (n=114)

Outcomes

Significantly **more likely to engage in follow-up treatment**

Significantly **more likely to have abstained from illicit drug use** 30 days later

Significantly **less likely to require inpatient treatment**

HPC

D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., ... & Fiellin, D. A. (2015). Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial. JAMA, 313(16), 1636-1644.

Section 178 of Ch. 133 of the Acts of 2016 (FY17 State Budget)

The **health policy commission**, in **consultation with the department of public health**, shall implement a **2-year pilot program** to further **test a model of emergency department initiated medication-assisted treatment**, including but not limited to buprenorphine and naltrexone, for individuals suffering from substance use disorder. The program shall include referral to and connection with outpatient medication assisted treatment with the **goals of increasing rates of engagement and retention in evidence-based treatment.** The commission shall implement the program at no more than **3 sites in the commonwealth**, to be selected by the commission through a competitive process. Applicants shall demonstrate community need and the capacity to implement the integrated model aimed at providing care for individuals with substance use disorder who **present in the emergency setting with symptoms of an overdose or after being administered naloxone**. The commission shall consider evidence-based practices from successful programs implemented nationally in the development of the program. The commission may direct not more than **$3,000,000 from the Distressed Hospital Trust Fund** established in section 2GGGG of chapter 29 of the General Laws to fund the implementation of the program. The commission shall report to the joint committee on mental health and substance abuse and the house and senate committees on ways and means not later than 12 months following completion of the program on the results of the program, including effectiveness, efficiency and sustainability.

Appendix – RPO

Proposed APM and Other Revenue File

Alternative Payment Method (APM) and Other Revenue File															
	P4P Contracts				**Risk Contracts**						**FFS Arrangements**		**Other Payer Revenue**		
	Claims-Based Revenue		Incentive-Based Revenue		Claims-Based Revenue		Budget Surplus/ (Deficit) Revenue		Quality Incentive Revenue						
Payer	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield															
Tufts Health Plan															
Harvard Pilgrim Health Care															
Fallon Community Health Plan															
Health New England															
CIGNA															
United Healthcare															
Aetna															
Other Commercial															
Total Commercial															
MassHealth MCO															
MassHealth ACO															
MassHealth SCO/PACE/OneCare															
Other MassHealth															
Total MassHealth															
Commercial Medicare															
Traditional Medicare															
Total Medicare															
Other Government															
Other															
GRAND TOTAL															

HPC