COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Advisory Council

January 13, 2016

Agenda

- Executive Director Report
- Update on HPC Certification Programs
- Update on HPC Innovation Investment Programs
- Discussion of 2015 Cost Trends Report
- Discussion of 2016 Priorities
- Schedule of Next Advisory Council Meeting (March 30, 2016)

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HPC by the Numbers: 2015 Policy Work

21
MCNs Reviewed

5
Reports Released

4
Regulations Approved

2
CMIRs Initiated

59
Registering Provider Organizations

1
Certification Program Finalized

30+
unique data sets in 2015 Cost Trends Findings

HPC by the Numbers: Investment Programs in 2015

CHART Investment Program

Phase 2 Implementation Planning Period
(28 hospitals)

TECHNICAL ASSISTANCE

1200 hours of coaching calls

71 working meetings/site visits

7 regional convenings

Fiscal Year 2016 State Budget

Investment in the HPC

$500,000	Telemedicine Pilot
$100,000	PCP Narcan Training
$250,000	PCMH Behavioral Health Integration
$500,000	Neonatal Abstinence Syndrome Pilot
$250,000	Community Par medicine Pilot
$1,600,000	Total Funding

HPC by the Numbers: Consumer and Patient Support in 2015

In 2015, the Office of Patient Protection processed

3015

calls and emails from consumers seeking information on health insurance enrollment and appeals

325

External Review Cases filed by consumers seeking a determination of medically necessary

HPC by the Numbers: 2015 Cost Trends Hearing

4500+ attendees
550 in-person
4,000+ online

2 expert speakers

31 sworn witnesses from major payers & providers

70+ pre-filed testimony submissions

5 elected officials

HPC by the Numbers: Public Engagement in 2015

240,234
unique website hits

180
HPC articles

39
public meetings

1600+
attendees at public meetings throughout 2015

500+
meetings with over **100** different stakeholders

344
pages of minutes

14
newsletters

622
tweets

1
Completed Conference Center

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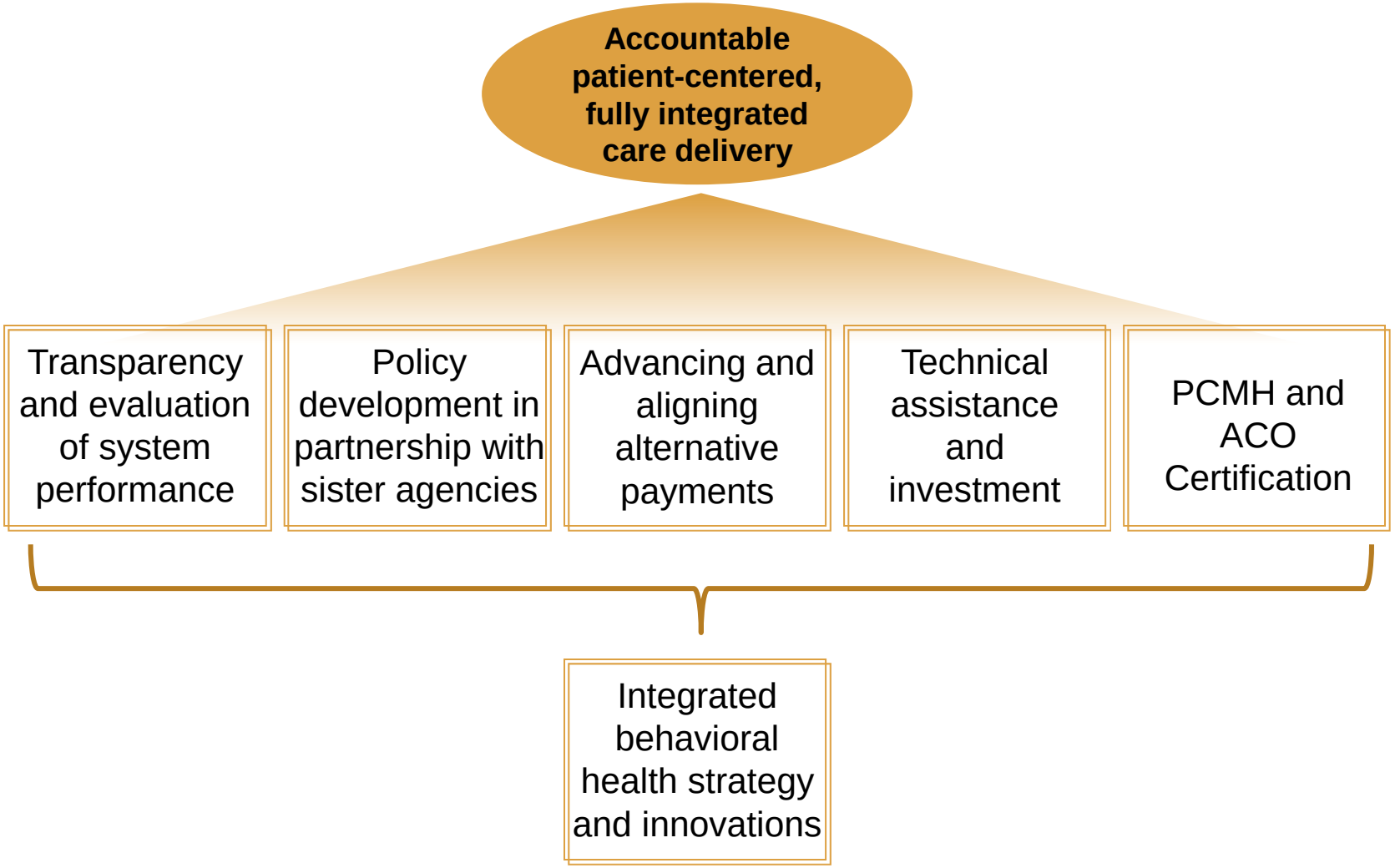
To support health care transformation in the Commonwealth, the HPC implements a comprehensive strategy of programs, investments and policy development



PCMH PRIME value statement

The HPC's patient centered medical home (PCMH) certification program - "HPC PCMH PRIME" - emphasizes the importance of behavioral health integration in primary care.

Patients

In Massachusetts, ~51% and ~86% of patients do not receive treatment for existing mental illness and SUD, respectively[1]

Payers

When unmanaged, behavioral health exacerbates total cost of care (TCOC) – e.g., TCOC for patients with major depression and diabetes is >2x patients with diabetes alone[2]

Providers

PCPs will be increasingly accountable for TCOC through alternative payment models (APMs). PRIME assists PCPs to identify and treat behavioral health that can be managed in a primary care setting

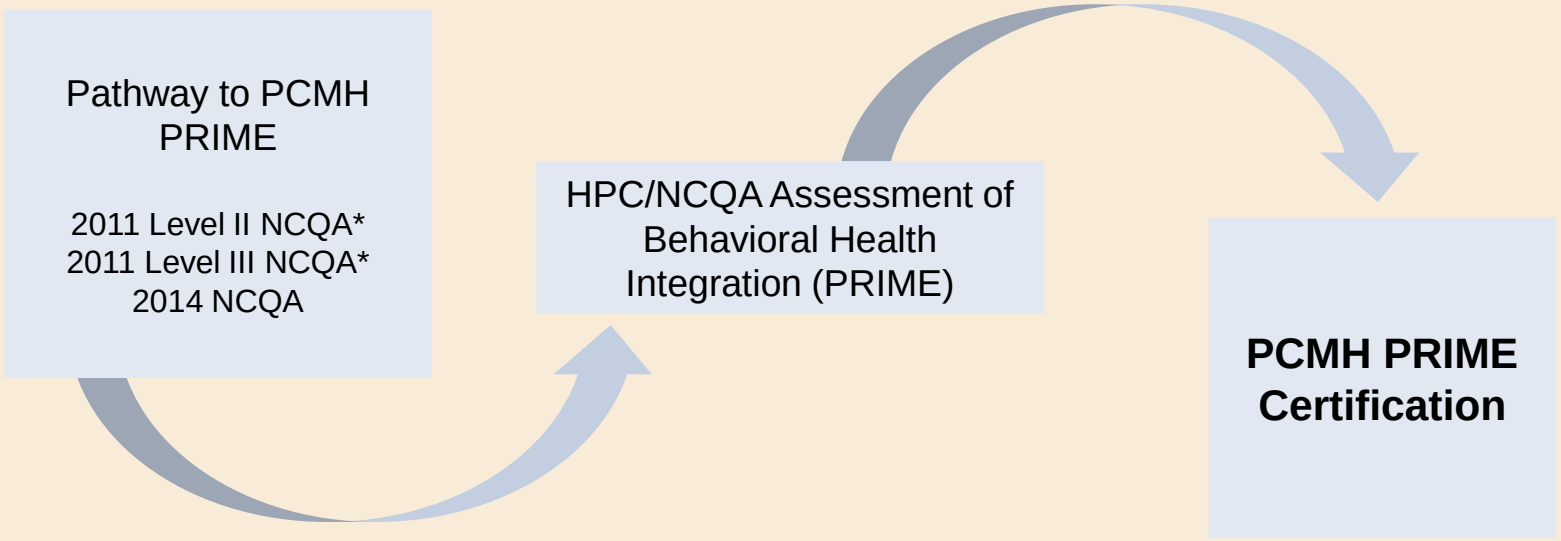
1 Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Massachusetts, 2013. HHS Publication No. SMA-13-4796MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013

2 Unutzer, Jurgen et al. *The Collaborative Care Model: An Approach for Integrating Physical and Mental Health Care in Medicaid Health Homes.* Health Home: Information Resource Center. Brief May 2013. http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Downloads/HH-IRC-Collaborative-5-13.pdf

“PCMH PRIME” recognition builds off of NCQA standards

Ongoing HPC Technical Assistance (content under development)

Practices will achieve HPC’s **PCMH PRIME** recognition by demonstrating enhanced capacity and capabilities in behavioral health integration (BHI). Practices will be initially certified on a rolling basis and must meet the HPC’s BHI criteria within a given timeline after entering the technical assistance period to maintain certification.



*Practices must convert to NCQA 2014 standards at end of their current 2011 recognition period

PCMH PRIME criteria

#	Criteria (practice must meet ≥ 7 out of 13)
1	The practice **coordinates with behavioral healthcare providers** through formal agreements or has behavioral healthcare providers co-located at the practice site.
2	The practice **integrates BHPs** within the practice
3	The practice collects and regularly updates a comprehensive health assessment that includes **behaviors affecting health and mental health/substance use history of patient and family.**
4	The practice collects and regularly updates a comprehensive health assessment that includes **developmental screening** using a standardized tool.
5	The practice collects and regularly updates a comprehensive health assessment that includes **depression screening** using a standardized tool.
6	The practice collects and regularly updates a comprehensive health assessment that includes **anxiety screening** using a standardized tool.
7	The practice collects and regularly updates a comprehensive health assessment that includes **SUD screening** using a standardized tool (N/A for practices with no adolescent or adult patients).
8	The practice collects and regularly updates a comprehensive health assessment that includes postpartum depression screening for patients who have recently given birth using a standardized tool.
9	The practice **tracks referrals** until the consultant or specialist's report is available, **flagging and following up on overdue reports.**
10	The practice implements clinical decision support following **evidence based guidelines** for a mental health and substance use disorder.
11	The practice establishes a systematic process and criteria for identifying patients who may benefit from **care management**. The process includes consideration of behavioral health conditions.
12	The practice has one or more providers in practice actively treating patients suffering from addiction with medication assisted treatment and appropriate counseling and behavioral therapies (directly or via referral)
13	If practice includes a **care manager**, s/he must be qualified to identify/coordinate behavioral health needs.

Proof of proficiency for criteria #2 automatically satisfies criteria #1

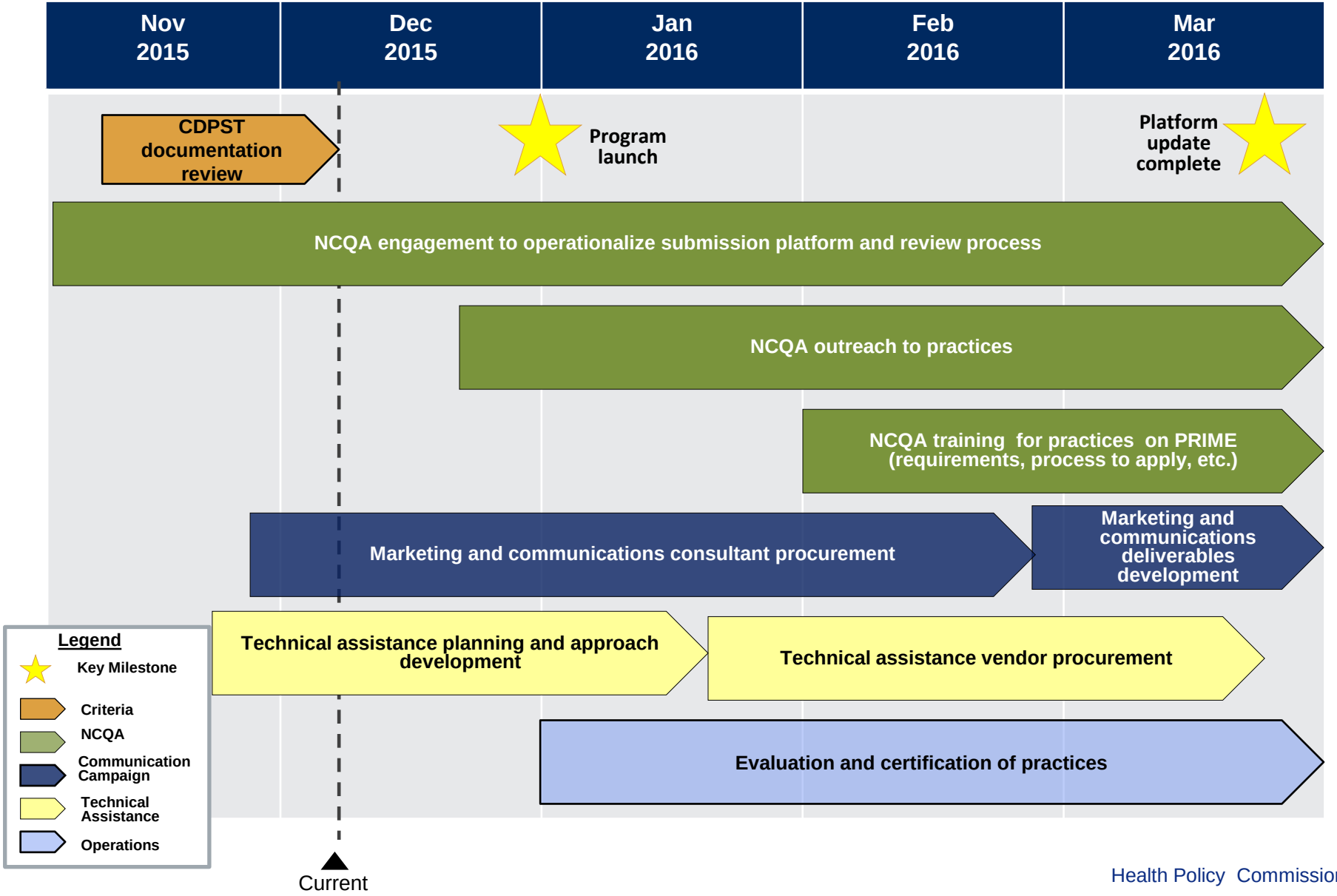
Potential technical assistance attached to PRIME

Technical assistance to enable change

Concept development currently underway; activities are budget permitting

- HPC funded continuing education modules
- Training on administration of diagnostic tools
- HPC funded buprenorphine waivers and/or support for FTE (e.g., nurse) to manage buprenorphine patient panel
- Learning collaborative on best practices to foster effective BHI (topics may include: establishing meaningful relationships between PCPs and BH providers; information sharing under state and federal law; screening and referral protocols; cost/quality measurement)
- Resource directory (ch. 224 mandate)

HPC PCMH PRIME operational plan



HPC requirements related to ACO certification

Section 15 of Chapter 224 tasks the HPC with creating an **ACO certification program** meant to "**encourage the adoption of integrated delivery systems** in the commonwealth for the purpose of **cost containment, quality improvement, and patient protection**."

Additionally, the ACO certification program should be one that:

- Reduces growth of health status adjusted **total expenses**
- Improves **quality** of health services using **standardized measures**
- Ensures **access** across care continuum
- Promotes **APMs & incentives** to drive quality & care coordination
- Improves **primary care** services
- Improves access for **vulnerable populations**
- Promotes **integration of behavioral health (BH) services** into primary care
- Promotes **patient-centeredness**
- Promotes **health information technology (HIT)** adoption
- Promotes demonstration of **care coordination & disease mgmt.**
- Promotes **protocols for provider integration**
- Promotes **community based wellness** programs
- Promotes health and well-being of **children**
- Promotes **worker training** programs
- Adopts **governance structure standards**, including those related to financial conflict of interest & transparency

ACO certification program goals

Section 15 of Chapter 224 tasks the HPC with creating an **ACO certification program** meant to "**encourage the adoption of integrated delivery systems** in the Commonwealth. Program goals include:

1. **Collaborate** with **providers, payers, and consumers** to obtain feedback on overall ACO development and enabling policy development
2. Create a **roadmap** for providers to work toward **care delivery transformation** – **balancing** the establishment of **minimum standards** with room and assistance for **innovation**
3. Establish an **evaluation framework** for data collection, information gathering, and dissemination of best practices to promote transparency
4. Enhance **patient protection and engagement**, including increasing patient access to services, especially for vulnerable populations
5. Promote **behavioral health integration** with ACOs through BH-specific criteria, quality metrics, and technical assistance
6. Develop standards that **align with payers' own principles for accountable care** (e.g., MassHealth and Group Insurance Commission (GIC)) to further link accountability
7. To the extent possible, **align** with **other state and federal programmatic requirements** to **minimize administrative burden** for providers

HPC & MassHealth alignment – potential approach

HPC ACO certification requirements

Examples:

- Capabilities and expertise necessary to advance all-payer population health management and succeed under alternative payment methodologies
- Legal and governance requirements, including meaningful participation of BH providers and patients/consumers
- Assessment of collaboration and referral structures across the care continuum
- Patient and family experience measurement
- Market and patient protections
- Standardized ACO-level reporting on cost/quality performance

MassHealth contract requirements

(in development – for discussion only)

Examples:

- Capabilities and expertise necessary to address the complex medical and service needs specific to the MassHealth population, particularly with regard to:
  - behavioral health,
  - long-term services and supports, and
  - social determinants of health (SDH)
- Innovative and meaningful beneficiary engagement
- Robust collaboration/partnerships across the care continuum

Integrated, administratively simple provider application process

ACO certification program design

1 Mandatory Criteria

- Legal and governance structures
- Risk stratification and population specific interventions
- Cross continuum network: access to BH & LTSS providers
- Participation in MassHealth APMs
- PCMH adoption rate
- Analytic capacity
- Patient and family experience
- Community health

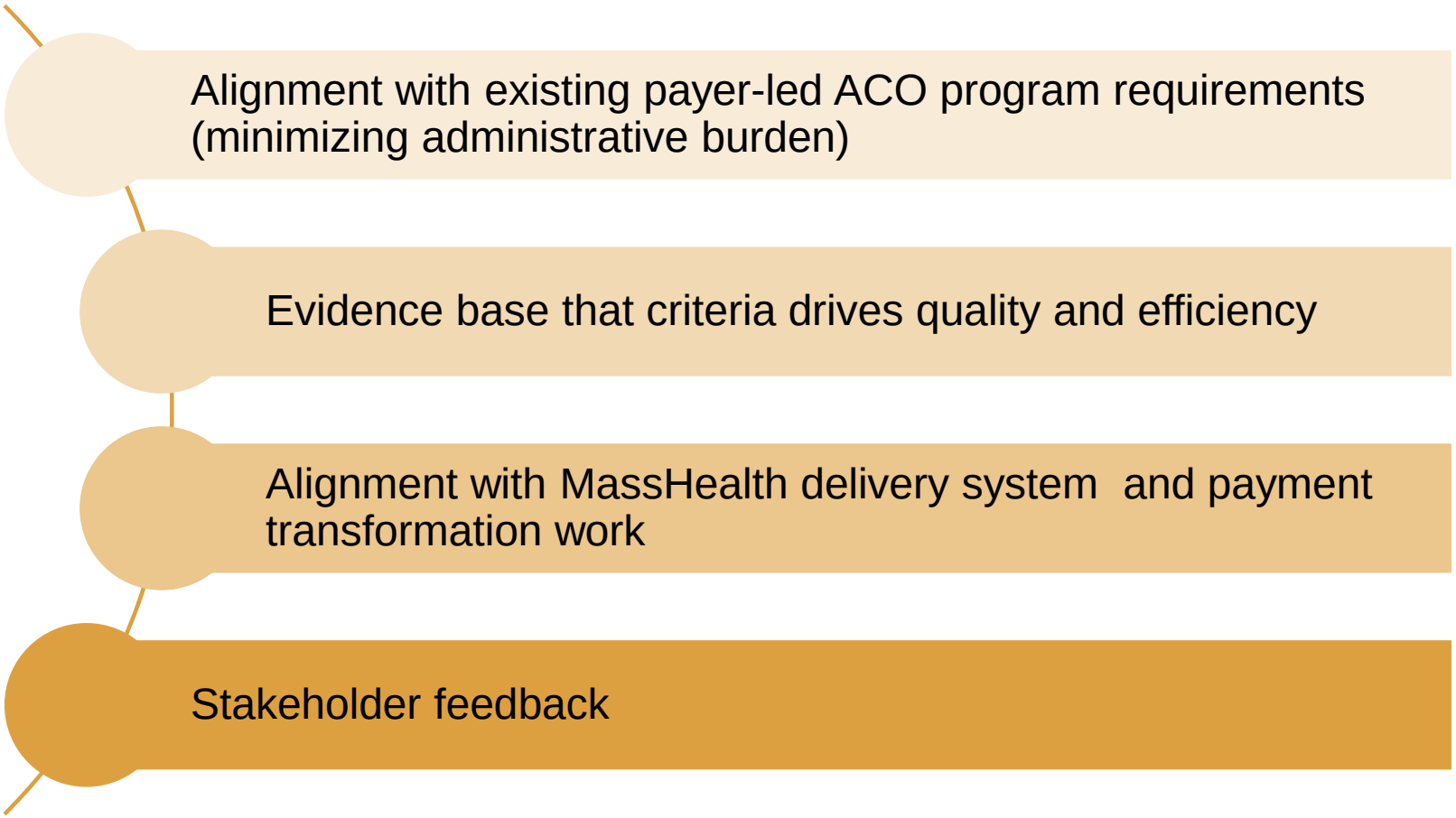
2 Market and Patient Protection

- Risk-bearing provider organizations (RBPO)
- Material Change Notices (MCNs) filing attestation
- Anti-trust laws
- Patient protection
- Quality and financial performance reporting
- Consumer price transparency

3 Reporting Only Criteria

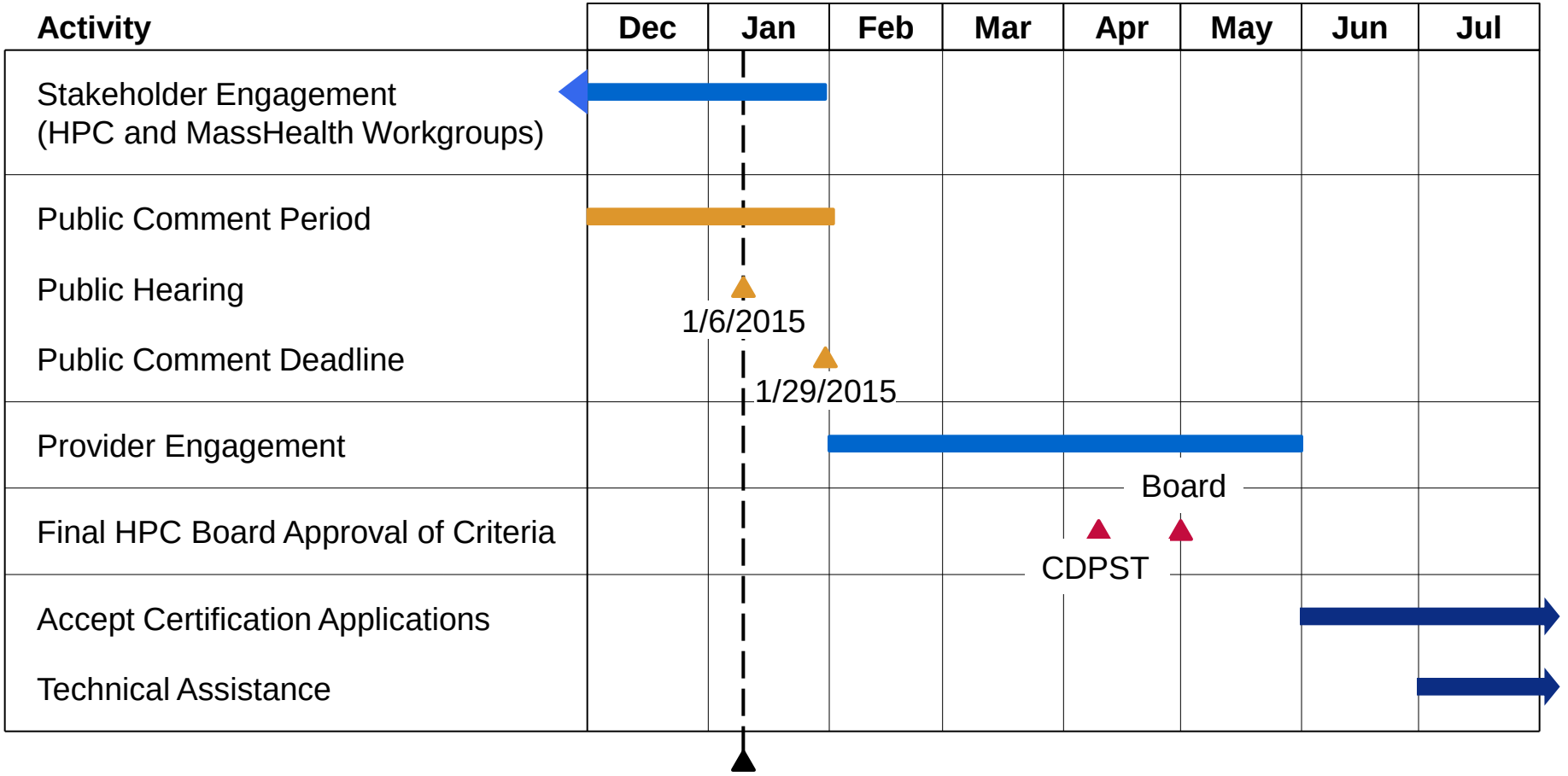
- Palliative care
- Care coordination
- Peer support
- Adherence to evidence-based guidelines
- APM adoption for primary care
- Flow of payment to providers
- ACO population demographics and preferences
- EHR interoperability commitment

Key considerations in criteria development and mandatory vs. reporting only assignment



ACO public comment update

Draft ACO certification criteria for public comment available on HPC Certification Programs website.



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Overview of HPC Investment Programs

The Health Policy Commission advances care delivery transformation through many investment activities

$120M	CHART Investments	• Transformation program for select community hospitals that supports development of population health capability, drives adoption of accountable care and alternative payment models, and supports innovative delivery models for complex populations, including HUs and patients with behavioral health conditions
$250K	Community Paramedicine	• Community paramedicine pilot administered by the HPC in the Quincy area provides funds for the HPC to develop a pilot program to triage behavioral health patients in the Quincy area affected by the recent closure of Quincy Medical Center.
$3.5M	Substance Exposed Newborns	• Provides funds to develop a pilot program to implement a model of post-natal supports for families with substance exposed newborns at up to three regional sites. The pilot will include obstetrics and gynecology, pediatrics, behavioral health, social work, early intervention, and social services to provide full family care.
$1M	Telehealth & Telemedicine	• One year regional pilot program to further the development of telemedicine in MA that will incentivize the use of community-based providers and the delivery of patient care in a community setting and facilitate collaboration between participating providers.
$6M	Innovation Investments	• Flexible investment program focused on fostering innovation in health care payment and service delivery; aligns with and enhances existing funding streams in MA with a primary focus on reducing THCE / meeting the benchmark. Diverse uses may include incentives, investments, TA, evaluation, or partnerships.
$350K	Technical Assistance	• Training and technical assistance programs to improve and expand the capacity and ability of primary care providers to integrate behavioral health within PCMHs as well as of PCPs to prescribe Narcan.

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Health Care Innovation Investment Program

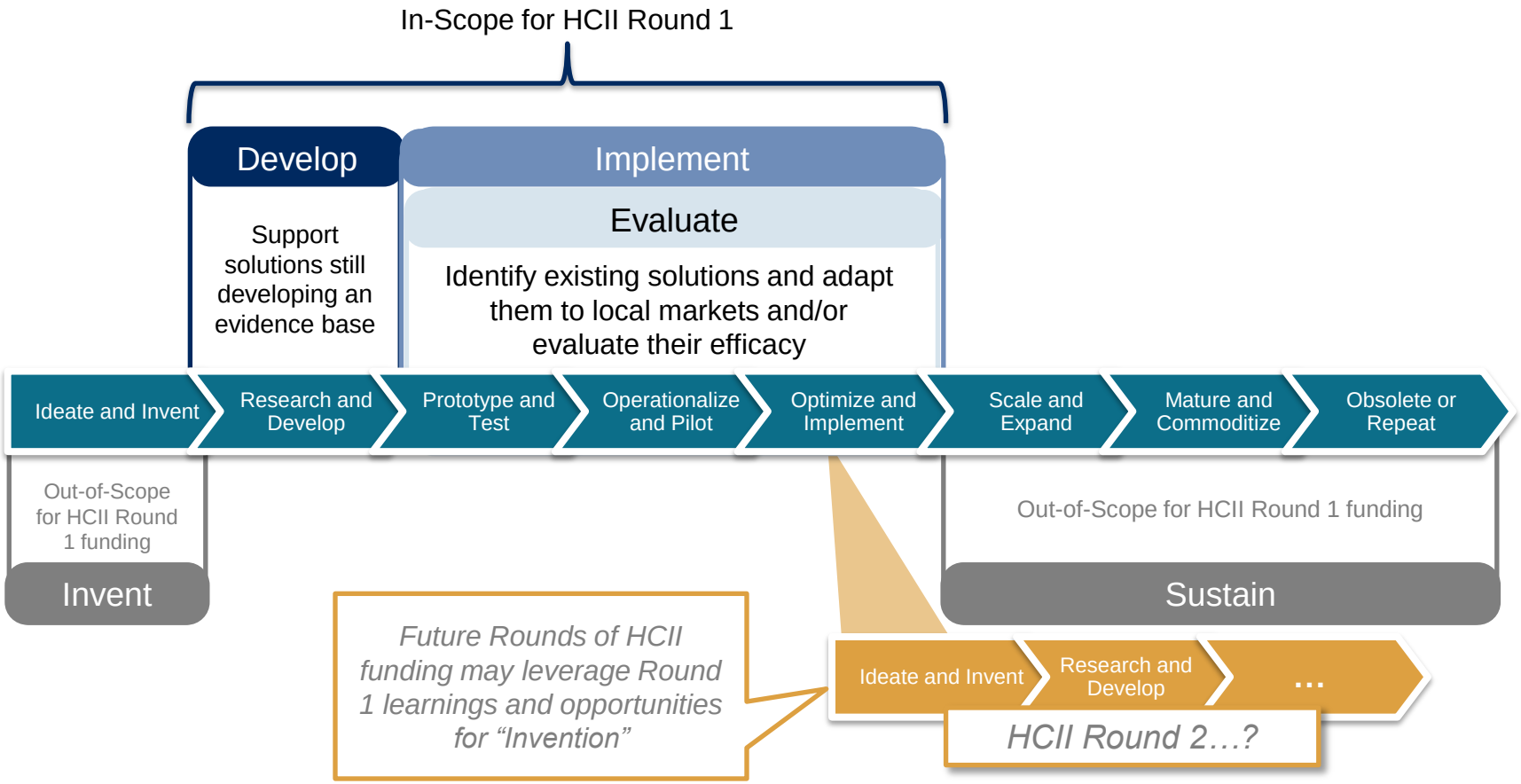
*The **HCII Program:** Focusing patient-centered innovation on Massachusetts' most complex health care cost challenges through investment in validated, emerging models*

Partnership	*Engage in meaningful collaboration to meet patients' needs* • Payers • Employers • Technology Partners • Providers • Social Services • Researchers
Sustainability	*Bring promising delivery and payment innovations to-scale to advance Accountable Care* • Rapid cycle measurement and improvement • Policy-focused evaluation
Costs	*Demonstrate rapid cost savings impact* • Measurable savings within 18 months of operations

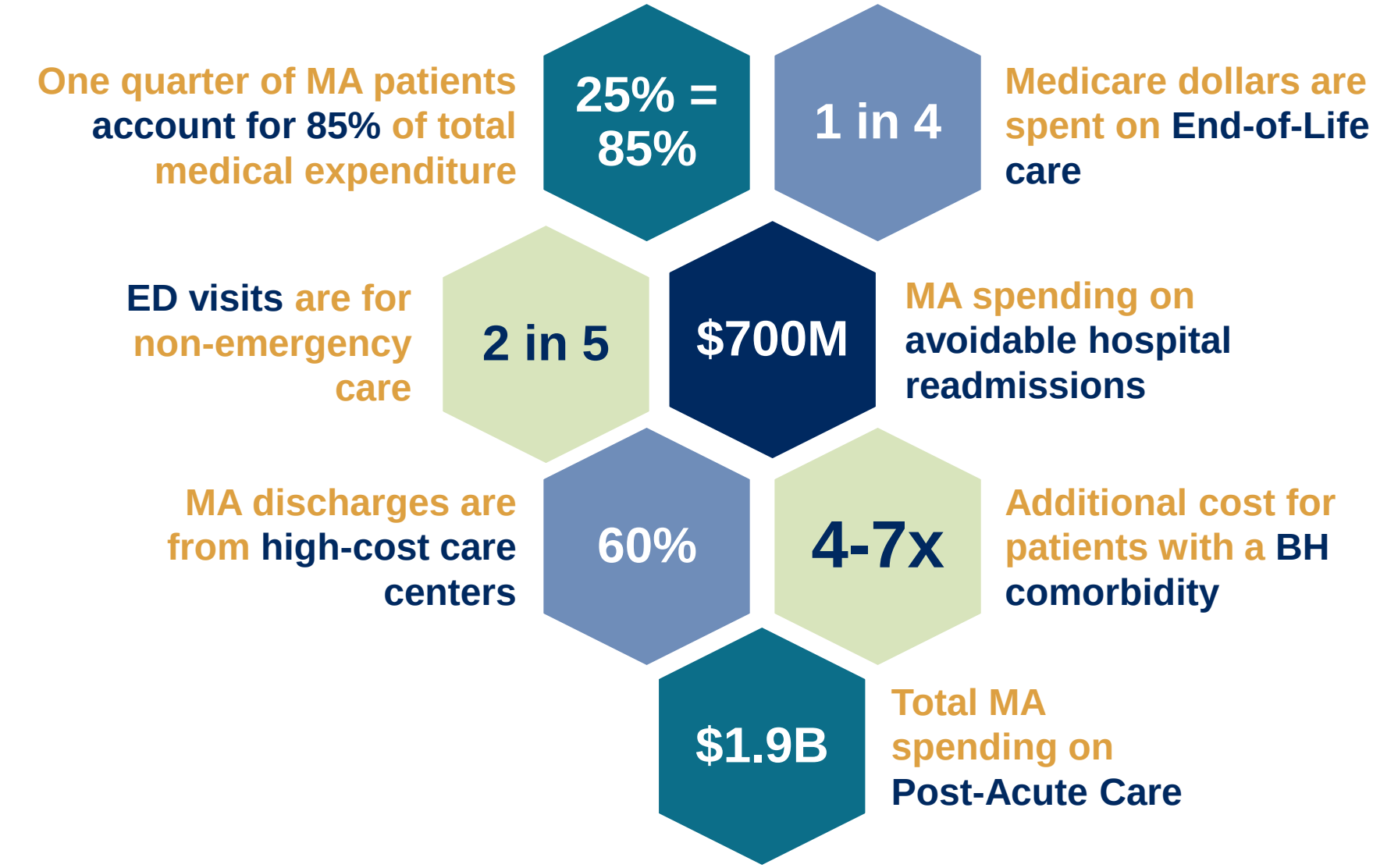
Where in the innovation life cycle can HCII be most effective?

HCII may use its funds to develop, implement, or evaluate promising models in payment and service delivery. Within this model framework, HCII Round 1 funding would focus on investment in rapid adoption of existing models with a preliminary evidence base.

1½ – 5-year "Innovation Lifecycle"



Primary cost drivers in Massachusetts identified by HPC

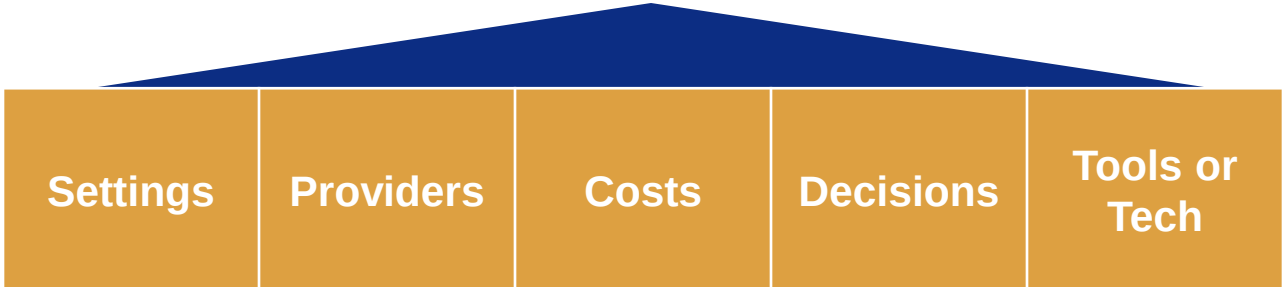


HPC 2014 Cost Trends Report
HPC July 2014 Cost Trends Supplement
HPC 2015 Annual Cost Trends Hearing – AGO Report

HCII Round 1 challenge inclusion criteria

Initial draft challenges were determined by taking cost reduction as its defining goal, and synthesizing best practice approaches to innovation with stakeholder feedback. Those factors guiding challenge inclusion are below.

Need	Innovation Opportunity	Feasibility & Sustainability
• **Persistent health challenge** for people, especially the underserved, of Massachusetts • The challenge is a significant **cost driver** that threatens the benchmark and can be improved with equal or better quality	• Existing solutions have made **limited progress** • **Preliminary evidence** of innovation potential already exists • **Synergy** with other Commonwealth investments and certification programs • Demonstrable **market interest** in disruption, primarily through substantially and rapidly changing:	• Challenge is **actionable** by potential applicants • Potential for **sustainability**, translation, and scale • Responsive to interventions enough to demonstrate measurable impacts within approximately **18 months**



HCII Round 1 proposed challenge areas

The HPC outlined inclusion criteria through which 8 Challenges were identified as potential domains applicants may elect to target in their Proposals.

Need	Innovation Opportunity
Persistent health challenge and a significant cost driver	Limited existing market progress, despite strategic importance and promising emerging solutions

Challenge	
SDH	Meet the health-related social needs of high-risk/high-cost patients
BHI	Integrate behavioral health care (including substance use disorders) with physical health services for high-risk / high-cost patients
Value-Informed Choices: Purchasers	Increase value-informed choices by purchasers that optimize patient preferences
Value-Informed Choices: Providers	Increase value-informed choices by providers that address high-cost tests, drugs, devices, and referrals

Challenge	
Cost Variation	Reduce cost variability in hip/knee replacements, deliveries, and other high-variability episodes of care
PAC	Improve hospital discharge planning to reduce over-utilization of high-intensity post-acute settings
ACP & EOL	Support patients in receiving care that is consistent with their goals and values at the end of life
Site & Scope of Care	Expand scope of care of paramedical and medical providers who can most efficiently care for high-risk / high-cost patients in community settings (e.g., through care models, partnerships, or tech)

A unique feature of the proposed program design is to require partnerships that utilize multi-stakeholder approaches to address cost challenges

Patients' health needs and approaches to address health system challenges can be best addressed through partnership between organizations spanning service types.

Partnerships required for award eligibility
Strength of partnerships will be a competitive factor in selection.

Applications will detail how proposed partnerships will collaborate, make decisions, and optimize efficiencies in order to address cost challenge(s).

Examples of strong partnerships may include:

A payer and a provider collaborating to test an innovative payment arrangement to implement a new model for supporting care at the end of life

A health system and a social services provider collaborating to meet the housing or other SDH needs of high risk patients

A payer and a researcher partnering to test a new analytics approach or to provide enhanced evaluation

A professional association and payers / providers partnering to address practice pattern variation and waste

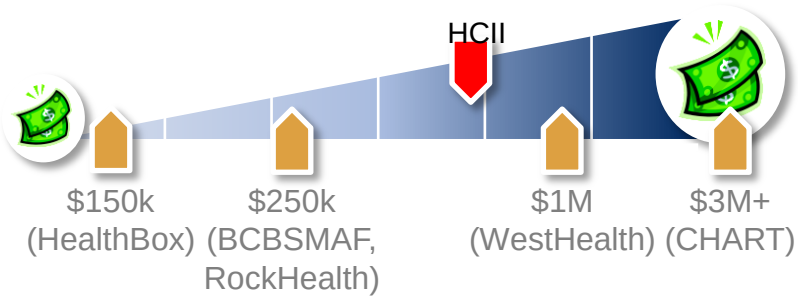
A provider, an employer, and a technology partner to test a model of direct-to-consumer telemedicine offerings to increase employee access to behavioral health services

* Technology firms only selling a product or service to an eligible applicant will not be considered a "technology partner" for the purposes of this program. Partnering vendors will need to demonstrate a collaborative approach to testing an innovative delivery approach, analytic model, tool or other solution.

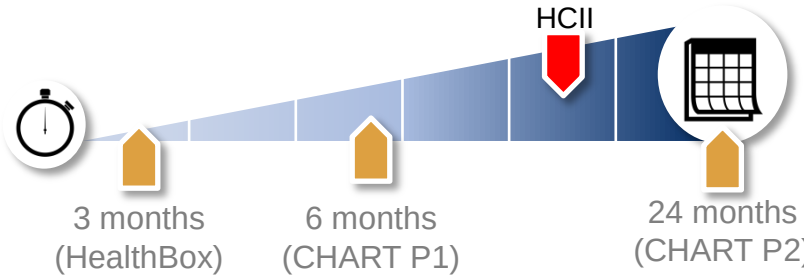
HCII Round 1 award size and duration

Other key design considerations have been made based on comparable grant and investment programs in the marketplace.

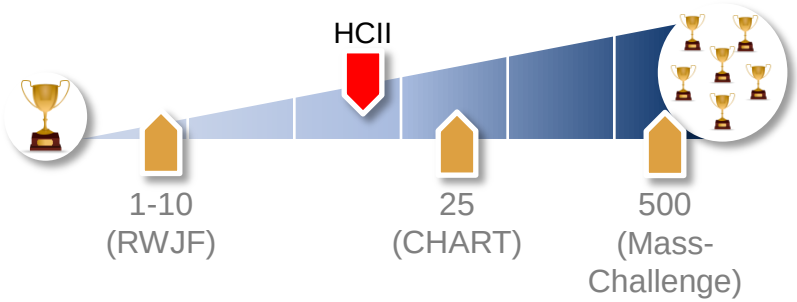
Max HCII Award **Cap**: $750k per award



HCII Award **Max Duration**: 18 Months



HCII Number of Awards: 8-12 Awards

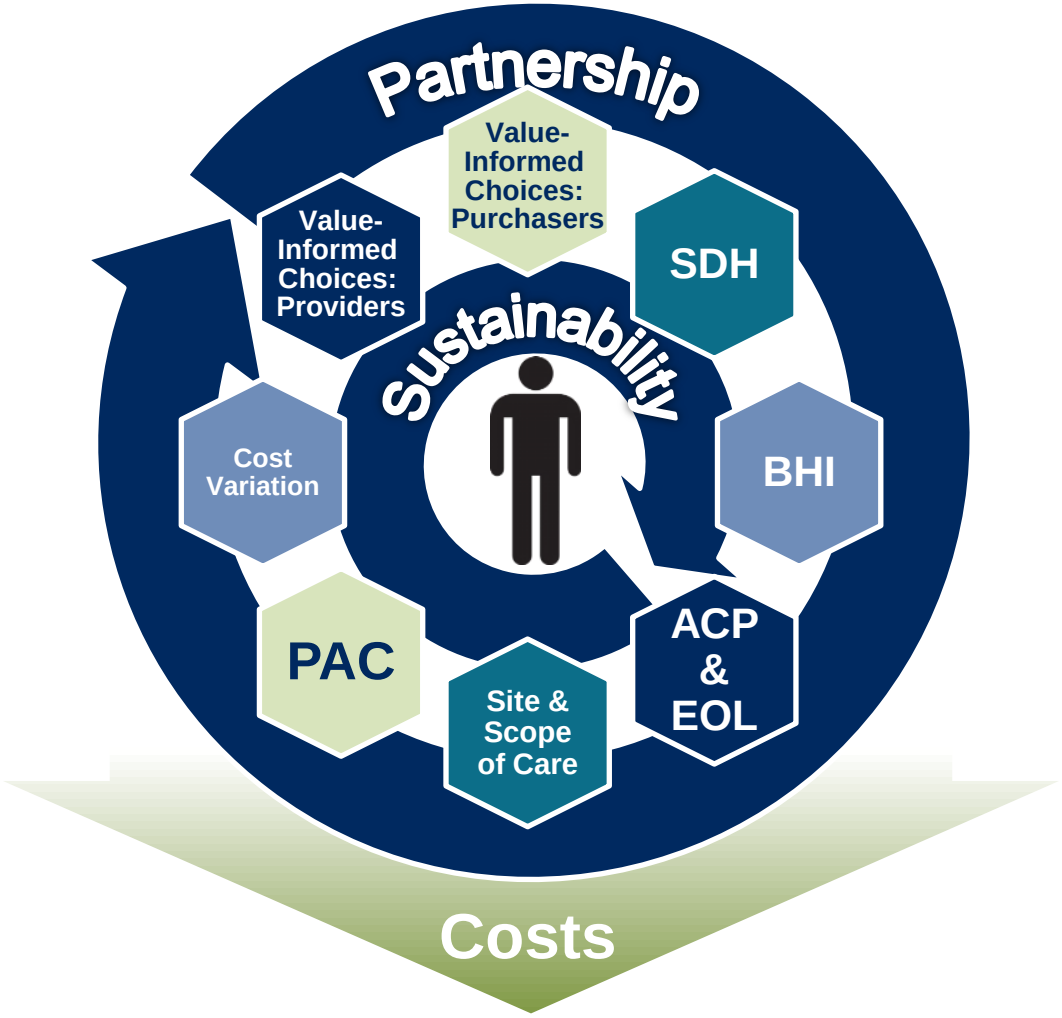


$5M investment opportunity*

* Funds from the Distressed Hospital Trust Fund may be used to supplement investments from the Health Care Payment Reform Trust Fund for eligible entities (CHART hospitals) selected for awards)

HCII: Innovations Advancing Delivery and Payment Transformation

*The **HCII Program:** Focusing patient-centered innovation on Massachusetts' most complex health care cost challenges through investment in validated, emerging models*



Broad array of eligible Challenges	Capture innovations from a diverse swath of applicants

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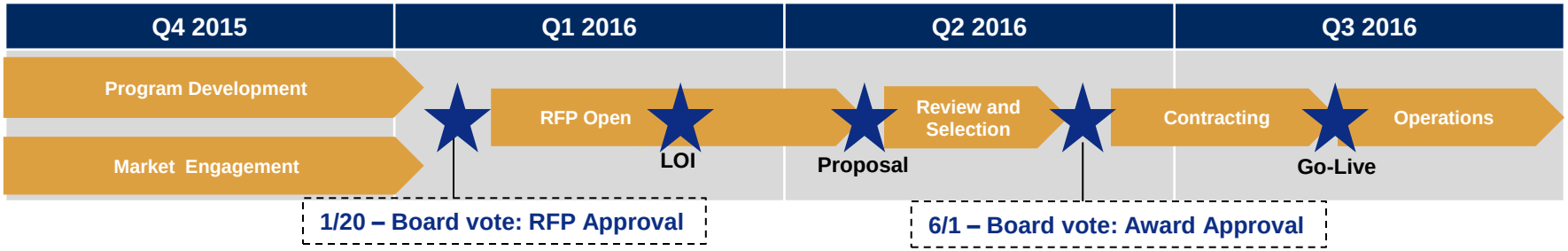
Narrow selection criteria	Define rigorous requirements for high-quality innovation and partnership in order to achieve sustainable cost-reduction

HCII Round 1 RFP Milestones



	RFP Release	LOIs Due	Proposals Due	Review & Selection
RFP Milestones	**Late January / Early February**	**Early March (~5 weeks)**	**Mid April (~5 weeks)**	**June 1**
Description of RFP Framework and Major Activity	RFP will include easy-to-read supporting documents describing each Challenge and detailing select innovative models with a promising evidence base of cost savings	LOIs are required for eligibility, but nonbinding in content. LOIs will describe Applicants' approach to domains including: •Contemplated partnerships •Selected challenge and proposed innovation •Policy relevance for system-wide sustainability •Measurable goal •Estimated funding request •Interest in partnerships with other entities for HPC publication	Applicants who submit or are named in an LOI may submit a Proposal. Proposals will be reviewed based on criteria including: •Impact •Need •Sustainability •Partnerships •Operational Feasibility •"Innovativeness" •Synergy with other state programs	Proposals will be reviewed by a Review Committee consisting of •HPC Commissioners •HPC Staff •Representatives of Massachusetts state agencies •Other subject matter experts
HPC Support	HPC hosts 1-2 Info Sessions	•**Mid-March** – Publish applicant names, challenges, and partnership interests •HPC hosts 2 Info Sessions	N/A	HPC Announces Awards after Board Approval

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Telemedicine Pilot

A 1-year regional pilot program to further the development and utilization of telemedicine in the commonwealth

$1,000,000 → **Community-based providers and telehealth suppliers**

Summary of Pilot

- The HPC is to develop and implement a one-year **regional telemedicine pilot** program to advance use of telemedicine in Massachusetts
  - The pilot shall incentivize the use of **community-based providers** and the delivery of patient care in a **community setting**
- To foster partnership, the pilot should **facilitate collaboration** between participating community providers and teaching hospitals
- Pilot is to be evaluated on cost savings, access, patient satisfaction, patient flow and quality of care by HPC

Pilot Aims

1. Demonstrate **potential** of telemedicine to address critical behavioral health access challenges in three high-need target populations
2. Demonstrate effectiveness of multi-stakeholder collaboration to serve these populations
3. Inform policy development to support care delivery and payment reform

Q3-Q4'15	Q1-Q2'16	Q3-Q4'16	Q1-Q2' 17
Pilot Planning & Community Engagement	Application; Awardee Selection; Pilot Development Implementation, and Rapid-Cycle Testing		Testing & Evaluation

Sustainability

Source: HPC Telehealth Pilot Language – Section 161

Goals of telemedicine pilot program

Payers, providers, and policymakers are interested in understanding the impact of using telemedicine for consultation, diagnosis, and treatment. Goals of piloted models may include:

1. Telemedicine should demonstrate **cost savings** and/or **enhance access to care**
2. Telemedicine should maintain or **improve patient experience** and **quality** of care
3. Telemedicine should **improve patient flow**
4. Telemedicine should **improve providers' operating efficiency** through optimal allocation of clinical staff among partnering sites and use of staff time
5. Telemedicine should enhance community-based care and **reduce the number of patients transferred for specialty evaluations** when appropriate care could be delivered at the originating setting
6. Telemedicine should **improve provider satisfaction**
7. Telemedicine care models should be closely linked back to primary providers to ensure **continuity of care**
8. Telemedicine should **not result in duplicative utilization** patterns and, where appropriate, should reduce overall utilization over an episode of care

Source: HPC Telehealth Pilot Language – Section 161; HPC Stakeholder Engagement

Telemedicine pilot design framework

Pressing Behavioral Health Needs	HPC focuses investment on high priority behavioral health access needs in Massachusetts

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Innovative, Provider-Driven Care Models	Providers compete to identify high-leverage models of care to address one or more target populations of interest utilizing telemedicine. Proposed models are tailored to local needs but emphasize scalability (low cost of intervention and high replicability)

High Impact Telemedicine Pilot

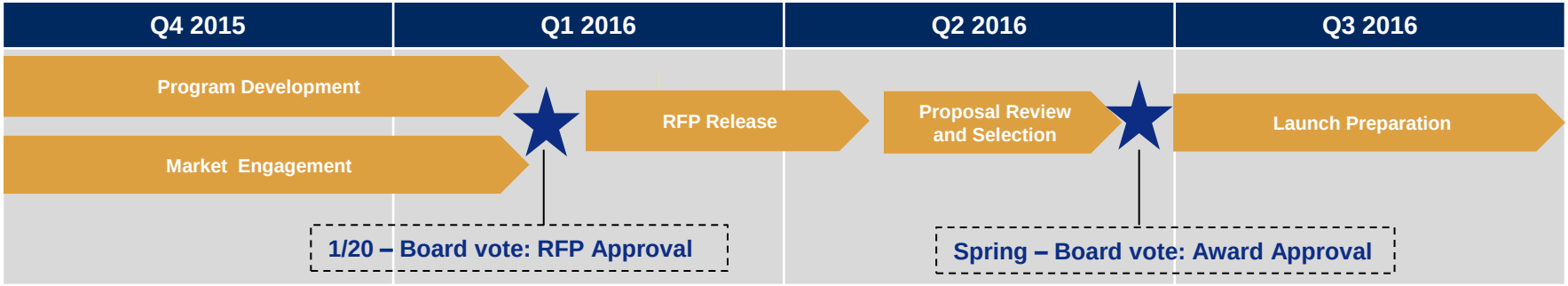
Program design provides three target populations of interest. Applicants must propose innovative uses of telemedicine to address the needs of one or more of these populations

	Use Cases of Interest	Sample of Relevant Existing Interventions
Pediatric patients with BH conditions 3,261 Discharges of patients between the ages of 10-19 spent at least 8 hours in an emergency department in 2014 for a mental health condition	**PROVIDER-PATIENT*** • Expanded access to school-based BH services • Behavioral health integration in pediatric practices	Regional model of school-based telehealth consults resulted in statistically significant reduction in symptom levels between initial visit and 3rd month visit, improved school performance, and improved social interaction. Treated 11,500+ patients in four years utmb Health
Patients aging in place w/BH conditions 20% of the 65+ population suffers from a mental health disorder. Greatest segment of prescriptions with abuse potential are among adults aged 51-70	**PROVIDER – PATIENT** • Direct in-home tele-behavioral health clinical services (med management and counseling) • Facilitated in-home tele-behavioral health with ASAP or VNA augmented with tele-BH provider	In-home telepsychology compared to traditional face-to-face delivery showed effective mental health therapy for major depressive disorder in an elderly population by in-home video teleconference VA
Patients with substance use disorder 1,256 estimated opioid-related deaths in 2014, a 88% increase over 2012 (n=668) and a 38% increase over cases for 2013 (n=911).	**PROVIDER – PATIENT** • 'Reverse integration' of emergency medical care into detox facilities to reduce acute care transfers **PROVIDER TELECONSULTS** • Consult service for addiction providers to support PCPs in MAT	TelEmergency model in Mississippi reduced unnecessary transfers to higher acuity hospitals by 20 percent UMMC Center for Telehealth Consults for pediatric primary care providers has enhanced capability or PCPs to meet clinical needs of non-complex pediatric BH patients MCPAP Massachusetts Child Psychiatry Access Project

* Provider to provider teleconsult services to address needs of pediatric patients with behavioral health conditions are currently provided by MCPAP

Telemedicine pilot timeline

The HPC anticipates releasing an RFP for the telemedicine pilot in late January 2016, with subsequent awardee selection and program launch in late Spring 2016



	Goal Setting	Program Design	Implementation
Activities	☑ Assess statutory framework for pilot and its goals ☑ Meet with subject matter experts and stakeholders on program design considerations ☑ Review reimbursement and regulatory landscape in MA ☑ Scan MA for existing pilots and at-scale programs	☑ Announce funding priority areas to providers ☑ Lock proposal selection criteria ☐ Release RFP & host information sessions ☐ Receive and review proposals ☐ Board selection of awardee Next Steps	☐ Finalize pilot design, measurable goals, and contract requirements with awardee(s) ☐ Distribute pilot funding ☐ Support pilot implementation as needed and monitor performance ☐ Conduct evaluation
Output	• Program Goals • Current Landscape	• RFP development • Proposal process • Awardee selection	• Operational planning • Performance monitoring • Evaluation

Agenda

- Executive Director Report
- Update on HPC Certification Programs
- Update on HPC Innovation Investment Programs
  - Health Care Innovation Investment Initiative
  - Telemedicine Initiative
  - **Neonatal Abstinence Syndrome Initiative**
- Discussion of 2015 Cost Trends Report
- Discussion of 2016 Priorities
- Schedule of Next Advisory Council Meeting (March 30, 2016)

Neonatal abstinence syndrome (NAS)

- Clinical diagnosis resulting from the abrupt discontinuation of exposure to substances in utero (e.g., methadone, opioid pain relievers, buprenorphine, heroin)
- Incidence and prevalence of NAS increasing rapidly in US, especially in MA
- In 2013 - 1,189 hospital discharges in MA with NAS code (21 disch. for other states)
- Average LOS = **16 days** (ranges from 9 – 79 days)

Newborns with NAS are more likely to have complications compared with all other US hospital births.

Premature birth (gestational age <37 weeks)
2.6 – 3.4 times more likely

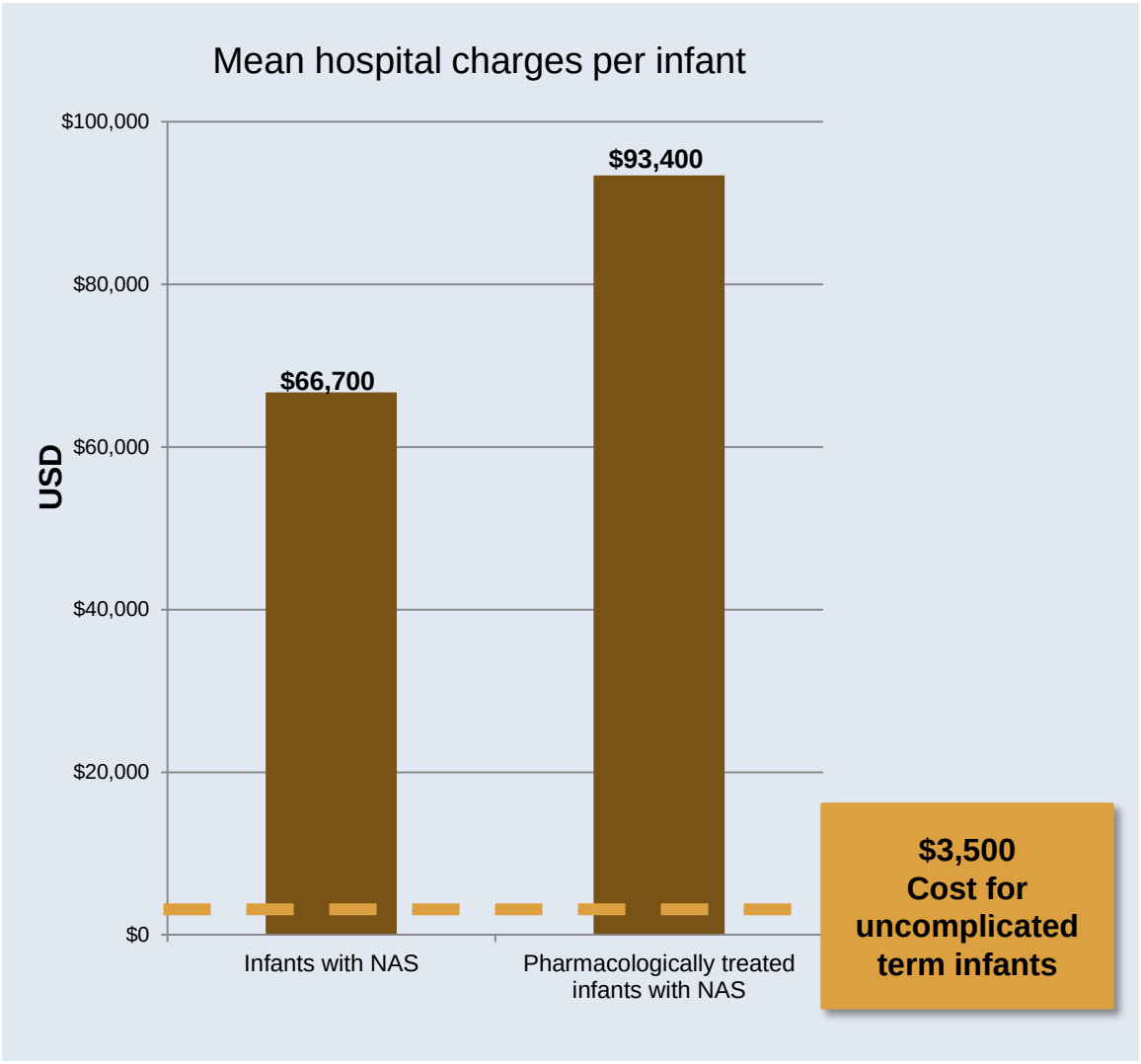
Low birthweight <2,500g
19.1% vs 7.0%

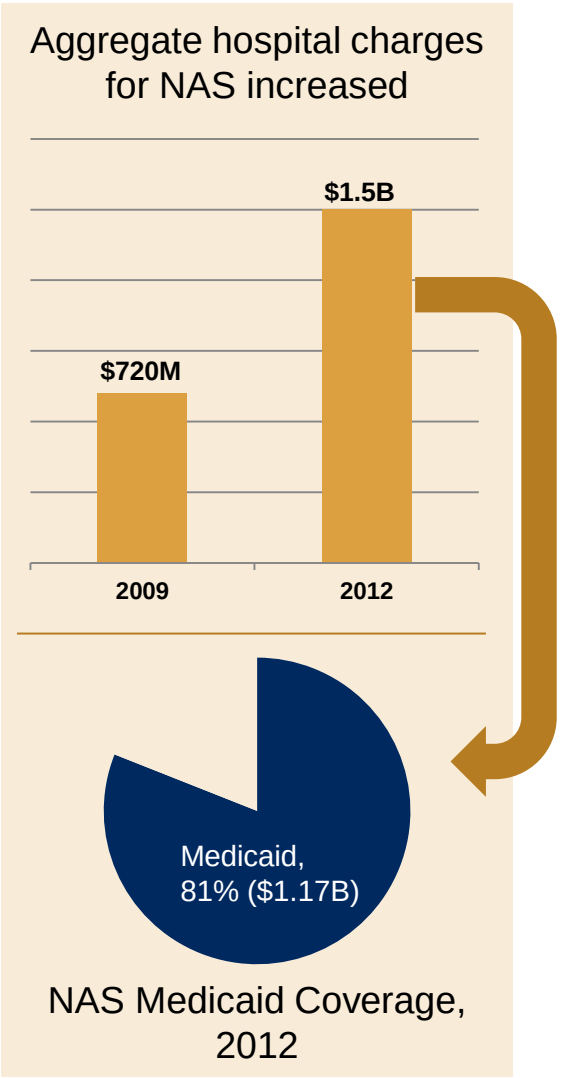
Seizures
2.3% vs 0.1%

Respiratory diagnoses
30.9% vs 8.9%

Feeding difficulties / Difficulty gaining weight
18.1% vs 2.8%

Costs of NAS nationwide

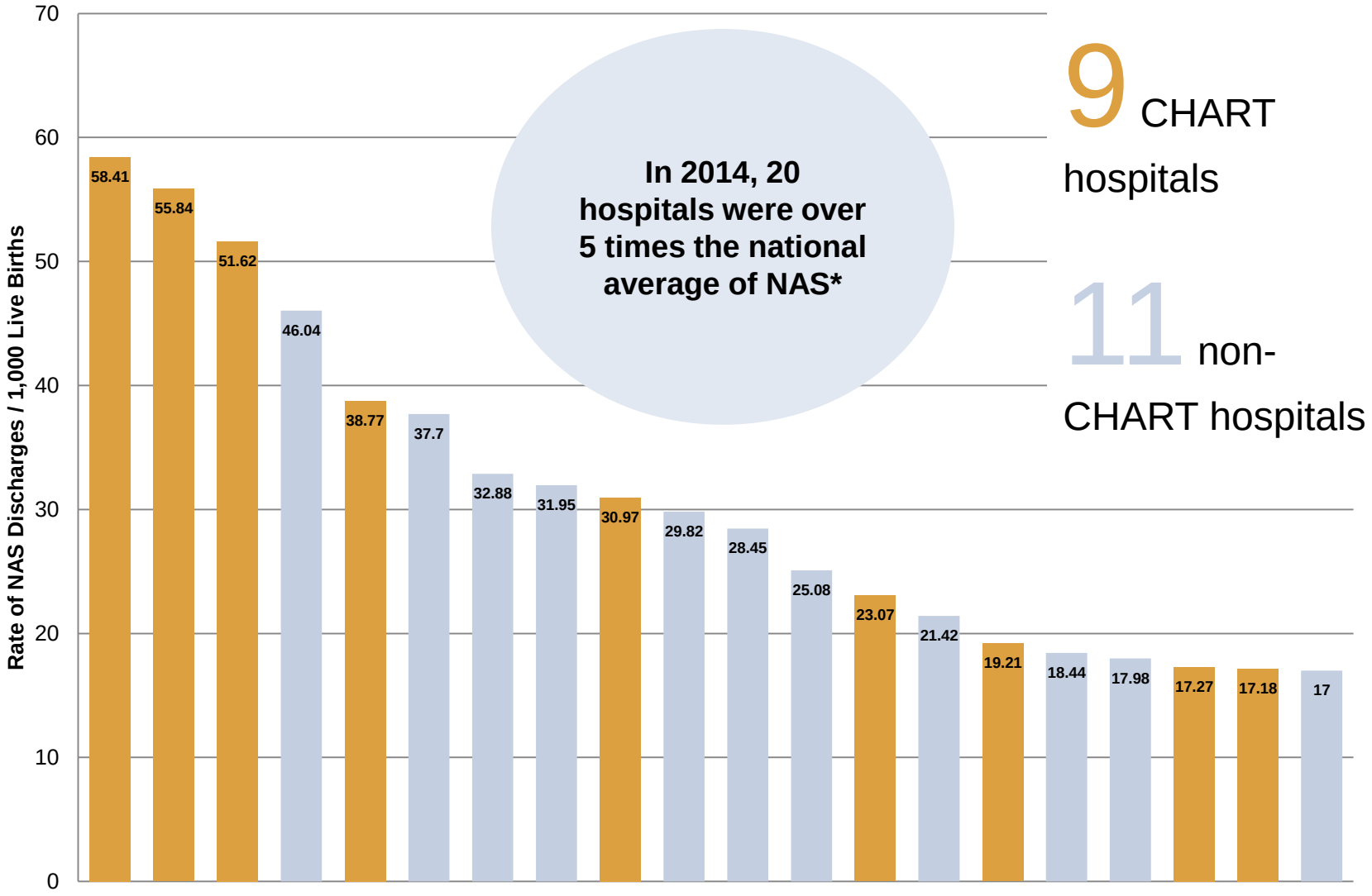




Patrick S, Schumacher R, Benneyworth B, *et al*. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. JAMA 2012;307(18):1934-40.

Patrick S, Davis M, Lehman C, Cooper W. Increasing incidence and geographic distribution of neonatal abstinence syndrome: Unites States 2009 to 2012. Journal of Perinatology 2015. Apr 30. doi: 10.1038/jp.2015.36. [Epub ahead of print]

Hospitals in Massachusetts are significantly impacted by increasing rate of NAS



*Per 2012 national average of 3.4/1000 births (eligibility criterion used by DPH for a federally funded initiative)

Source: Massachusetts Health Data Consortium (MDHC) 2014 hospital data

HPC NAS pilot project overview

Based on scan of best practices, consultation with DPH, DCF, NeoQIC, and providers, staff proposes the following investment design:

Two categories of funding:

1 Inpatient quality improvement initiative

- non-CHART-eligible hospitals with at least 60 NAS births/year or > 5x the national NAS average
- up to $250,000 per award
- in-kind funding match will be a competitive factor

2 Inpatient quality improvement initiative and replication of DPH intervention (pregnancy & first 6 months of life)

- CHART-eligible hospitals with at least 60 NAS births/year or > 5x the national NAS average
- up to $1,000,000 per award

Applicants in both categories will propose **evidence-based interventions and protocols that drive towards reduced spending** (procurement will provide non-exhaustive list of examples)

Aligning with and expanding on DPH's initiative allows for interventions to be applied across broader spectrum of continuum

HPC Pilot Program
Funded through FY16 State Budget
$500,000

DPH "Moms Do Care"
Program Funded through a federal grant
$3,000,000

HPC Expansion
Funded through CHART Investment Program to expand on DPH work
$3,000,000

Agenda

- Executive Director Report
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- Update on HPC Innovation Investment Programs
- **Discussion of 2015 Cost Trends Report**
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2015 COST TRENDS REPORT

Massachusetts Health Policy Commission

Report themes and potential areas for recommendations

Themes

Spending and the delivery system

- Spending trends
- MassHealth
- Drug spending
- Outpatient spending
- Market consolidation

Opportunities in quality & efficiency

- Variation in prices & spending
- Avoidable hospital use
- Post-acute care
- Primary care access

Progress in aligning incentives

- APMs
- Demand-side incentives

Potential areas for recommendations

- Promoting a value-based market, addressing market dysfunction
- Supporting efficient, high-quality care
- Advancing alternative payment methods, cultivating alignment
- Engaging employers and consumers in value-oriented choices
- Enhancing transparency, data, and infrastructure

Key statistics from the 2015 Cost Trends Report

2015 HPC Key Findings

$19,300
annual health insurance premium plus cost-sharing for typical family

1.0%
rate of growth of commercial spending on physician and hospital services

4.8% rate of growth of THCE

1.6% percentage points due to drug spending

3.2% percentage points due to MassHealth (2.5 excluding drugs)

74%
percent of PCPs affiliated with one of the 8 largest provider systems

$6,300
difference in spending between Mass General and Mt. Auburn for a low-risk pregnancy

56%
difference in price of colonoscopy between hospital outpatient department and community setting

~0
change in statewide rate of discharge to institutional post-acute care, 2010-2014

49/57
number of hospitals that decreased their rate of discharge to institutional post-acute care after joint replacement surgery, 2010-2014

24% statewide growth in ED visits with a primary behavioral health diagnosis, 2010-2014

~50% growth in behavioral health ED visits in New Bedford and Fall River

68%
share of HMO lives covered by alternative payment models, 2014

2%
share of PPO lives covered by alternative payment models, 2014

Select findings from the 2015 Cost Trends Report

Overview of spending and the delivery system

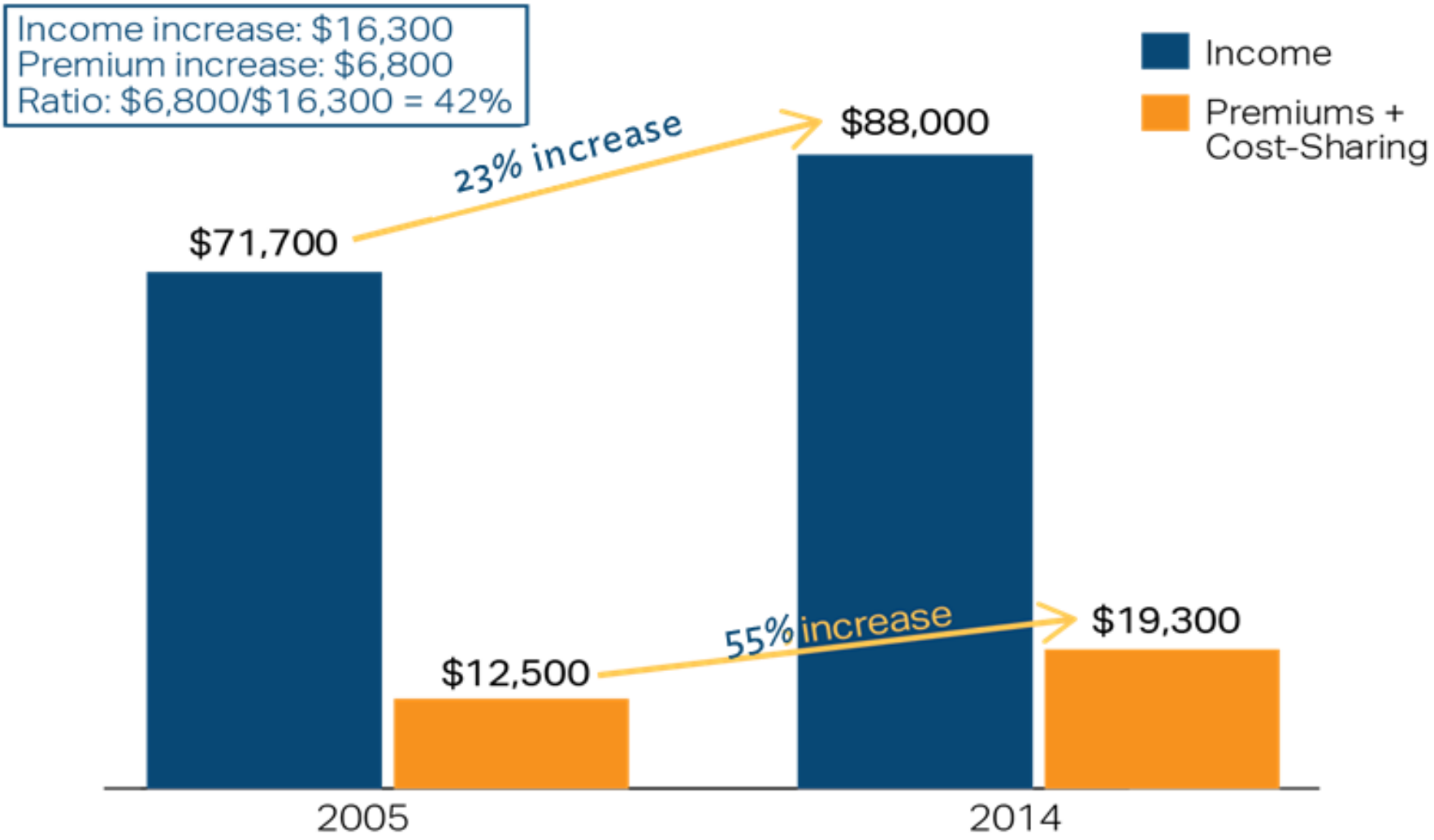
- 2014 spending growth
- Prescription drug spending
- Hospital outpatient spending
- Trends in provider markets

Opportunities to improve quality & efficiency

Progress in aligning incentives

Increases in health insurance premiums have outpaced income gains, consuming over 40% of family income growth since 2005

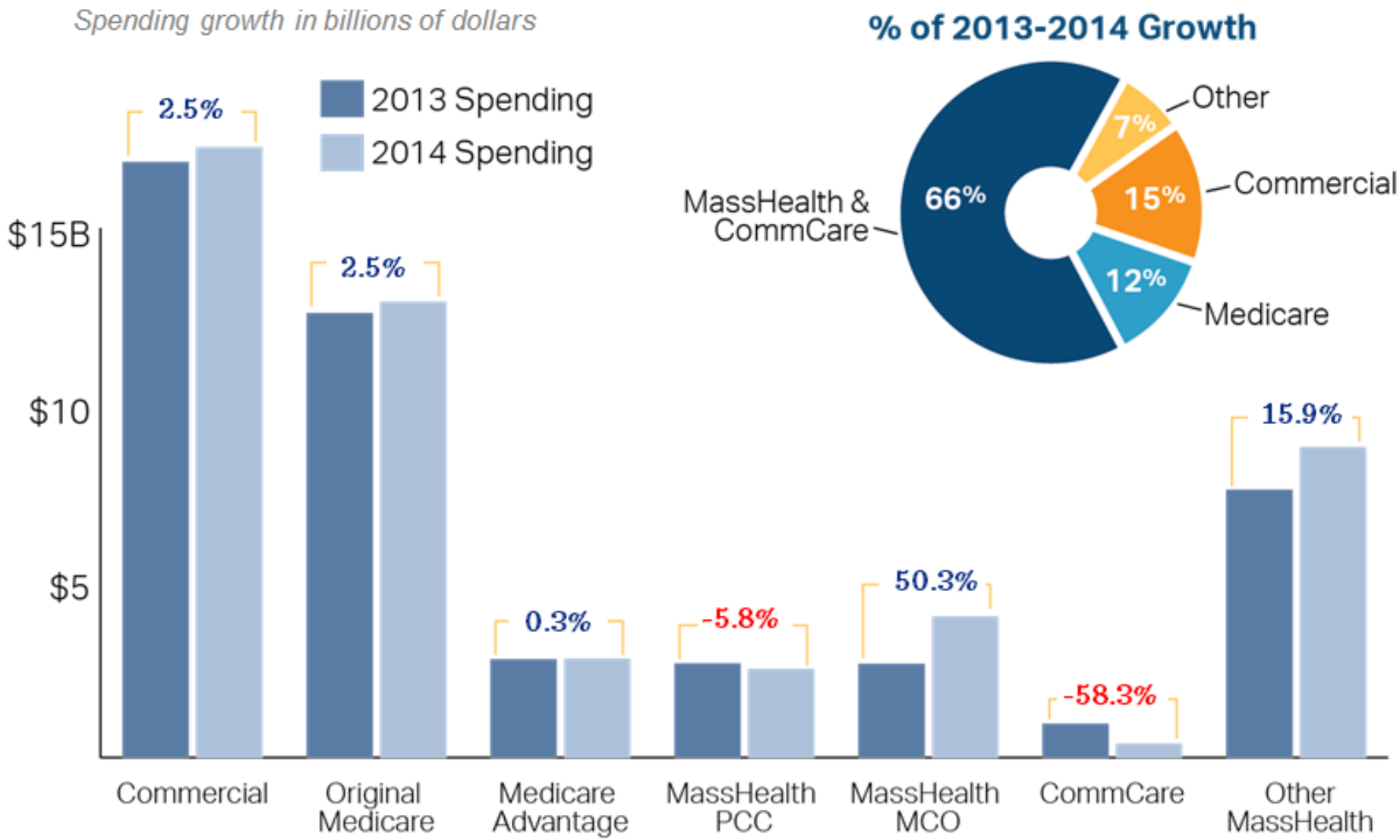
Dollars in vear shown



Note: Data are in nominal dollars. Includes cost-sharing

Source: American Community Survey (income data) , Agency for Healthcare Research and Quality (premiums) , and Center for Health Information and Analysis (cost-sharing)

MassHealth accounted for two-thirds of the 2013-2014 spending growth



Note: Commercial spending includes reported full and partial claims data for residents insured by in-state carriers. About 600,000 residents with commercial insurance via out-of-state carriers are excluded . VA and some other minor payers not included in figure. MassHealth spending include all spending by EOHHS agencies on behalf of MassHealth members, including pass-through claims for DMH and DDS services, supplemental payments to hospitals, etc.

Source: Center for Health Information and Analysis, Total Health Care Expenditures

Massachusetts health care spending growth in 2014

Summary

- MassHealth spending increased by 13% and accounted for two-thirds of the 4.8%; enrollment was an important driver
  - ACA (permanent) and operational difficulties at the Connector (temporary)
- *Per-capita* spending growth for each payer category remained below the benchmark
- Commercial hospital and physician spending grew 1% per capita
- The gap between Massachusetts family premiums and the U.S. average dropped from $2,000 in 2011 to $1,000 in 2014, yet affordability problems remain for many
- While commercial spending growth was relatively low overall, there were increases in prescription drugs, outpatient spending, and prices

Drivers of national pharmaceutical spending in 2014

1 New high-cost drugs

Sofosbuvir (Sovaldi) and other HCV drugs entered the market late 2013 and early 2014 at extremely high prices, e.g. $84,000 (list price) for 12-week treatment with Sofosbuvir

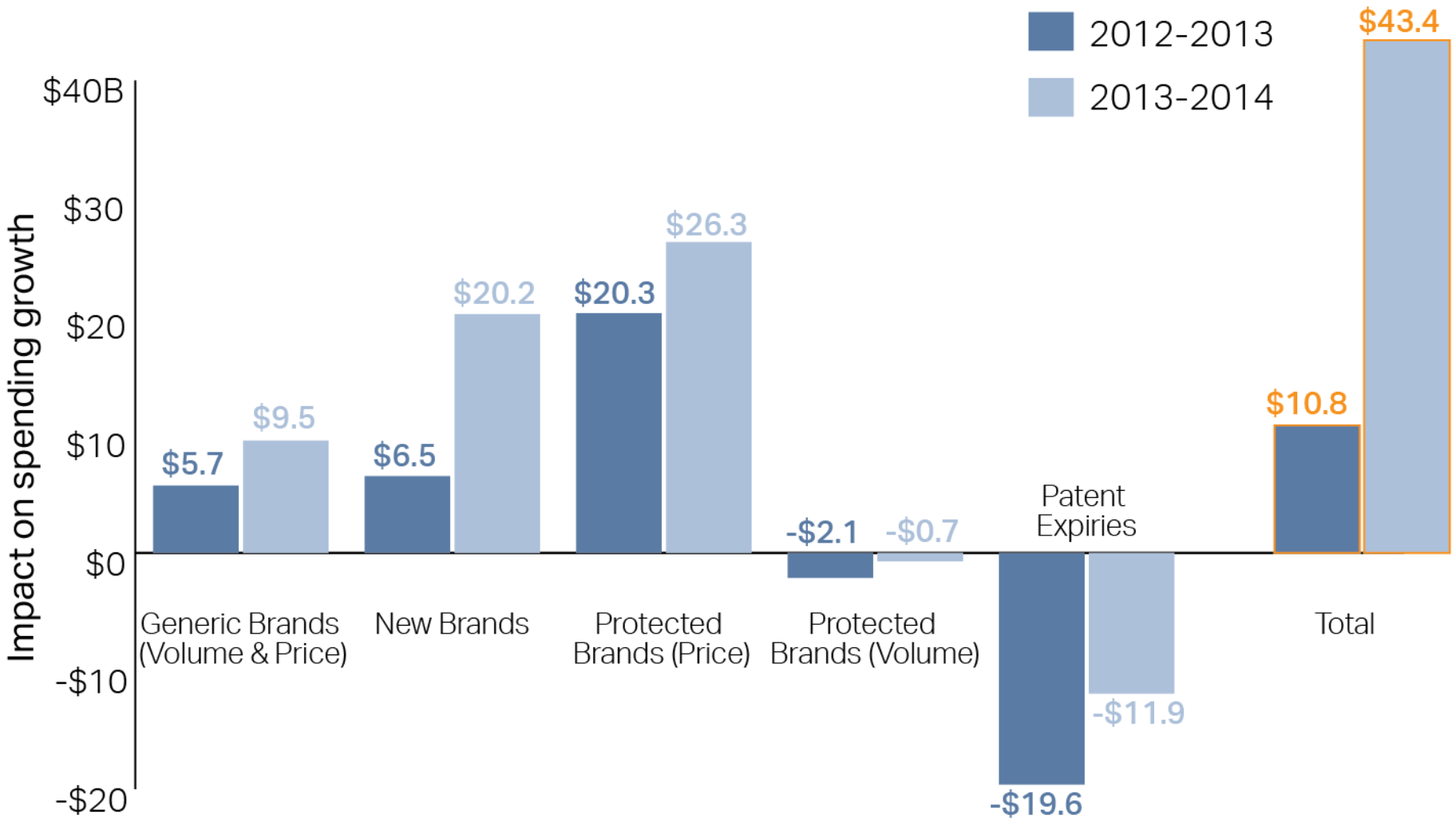
2 Large drug price increases

While price increases for brand-name drugs have the greatest impact on total spending, increases for some generics also impact spending and access

3 Low rate of patent expirations

Many factors led to increased nationwide drug spending in 2014

Components of U.S. spending growth for pharmacy and non-pharmacy drugs

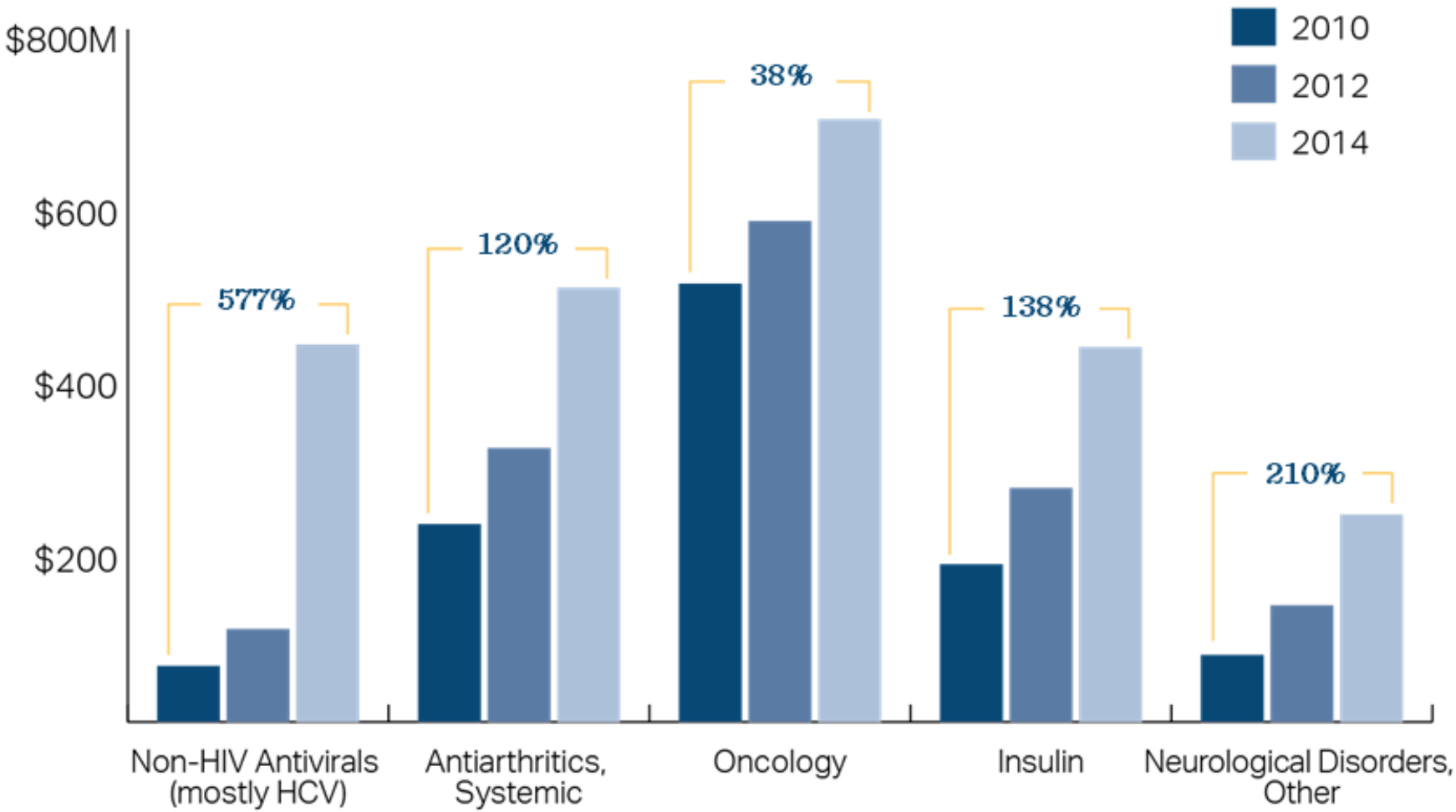


Note: Adjusted for rebates and discounts, protected brand price grew $11.8B in 2013 and $10.3B in 2014

Source: IMS, "Medicines Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014," April 2015

In Massachusetts, growth in drug spending was driven by hepatitis C drugs, but many other drug classes also had large spending increases

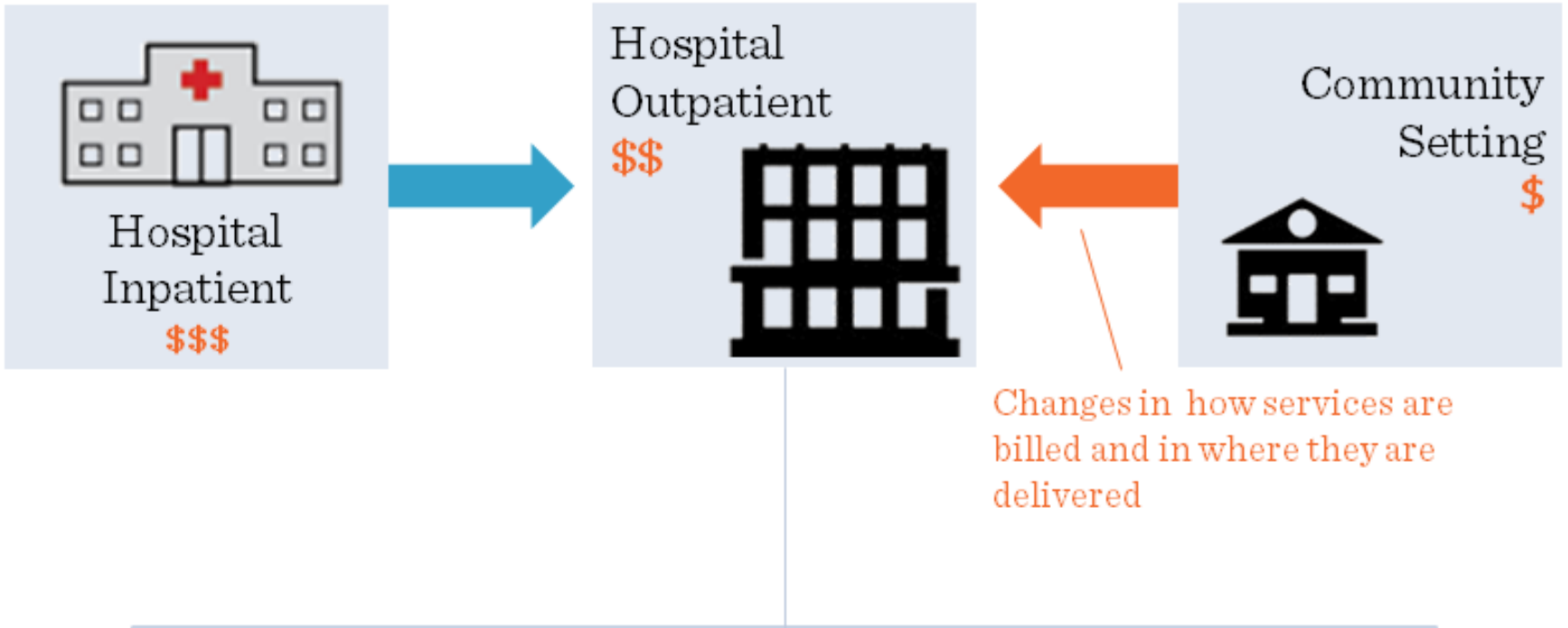
Annual spending for 5 drug classes with highest contribution to growth in 2014, millions of dollars



Note: Drug spending figures do not account for manufacturer rebates, which could affect both level and trend of spending

Source: Data from IMS Health Incorporated

Some services have shifted from inpatient to outpatient, while others have shifted from the community to outpatient

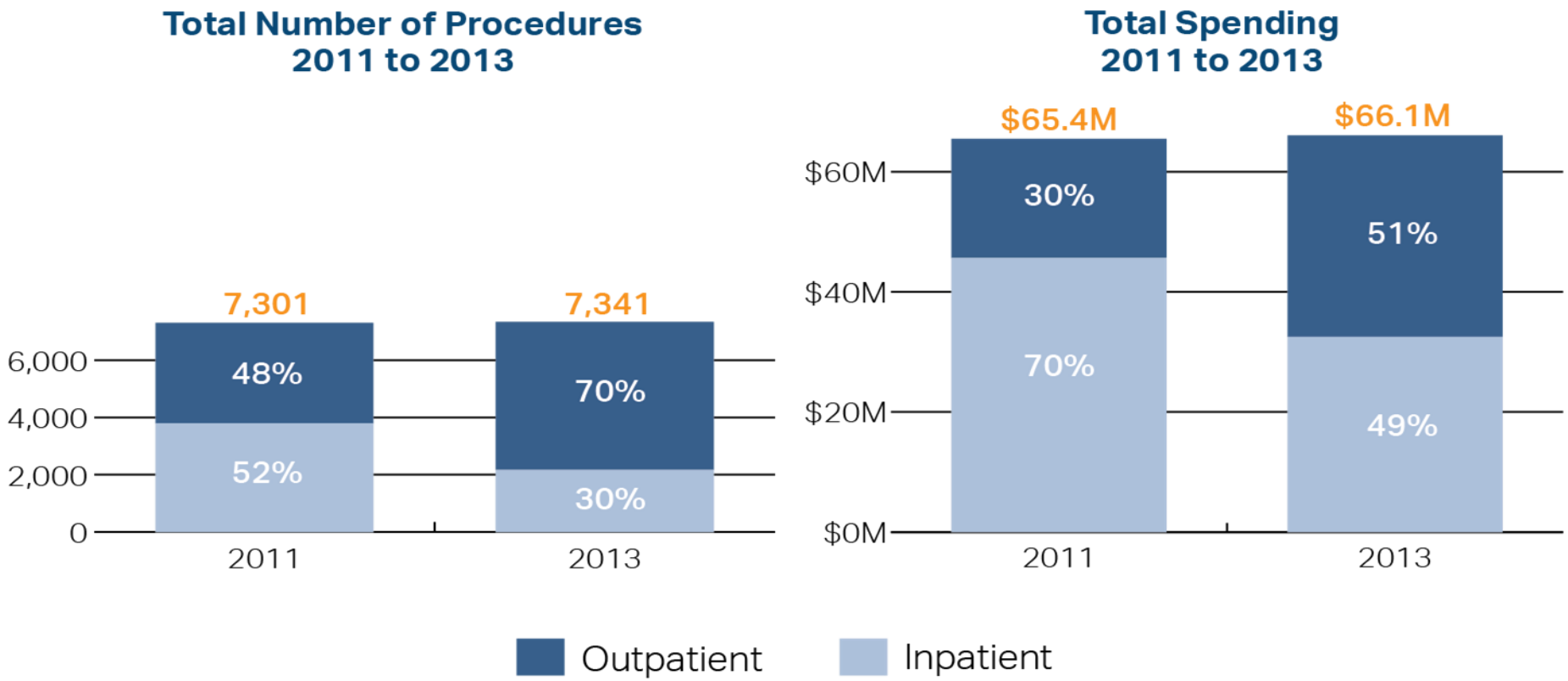


Prices for the same service in hospital outpatient departments are typically higher than in community settings because outpatient services charge both a professional fee and a facility fee

Changes in site of care: Procedures are shifting from hospital inpatient to hospital outpatient

Volume and spending for laparoscopic cholecystectomy, laparoscopic appendectomy, arthrodesis, laparoscopic total hysterectomy, and laparoscopic vaginal hysterectomy, 2011 and 2013.

Analysis of 5 High Volume Crossover Surgical Procedures

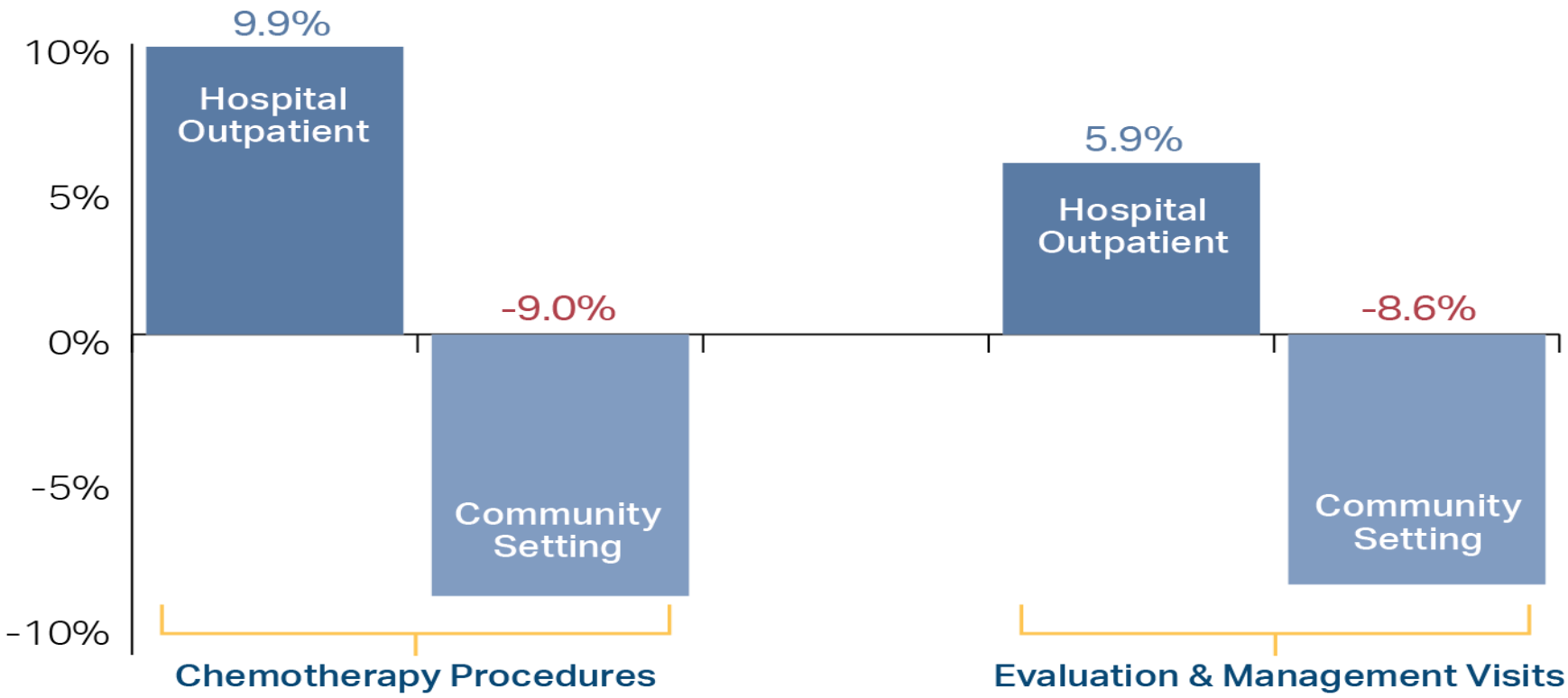


Note: The five major cross-over procedures were identified as the highest-volume procedures billed by surgeons in 2013 where at least 10 percent of the surgeries occurred at an inpatient hospital and at least 10 percent occurred in an outpatient setting. Total spending includes insurer and enrollee payments for the facility portion of the surgical procedure. Commercial FFS spending does not include capitated payments. See technical appendix

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

Changes in site of care: Chemotherapy and E&M visits are shifting from community settings to hospital outpatient departments

Change in number of procedures per 1,000 member months, 2011 - 2013



Outpatient prices are typically higher than in community settings:
for example, $298 vs $177 per procedure for chemotherapy administration in 2013*

Note: * Median price. Procedures with a missing site of service or non-community non-hospital outpatient site were excluded. Spending includes insurer and enrollee payments for both the facility and professional portion of the covered medical service, on all claim lines for the same patient on the same date with the same CPT procedure code. Commercial FFS spending does not include capitated payments. Community setting includes office, independent lab, urgent care, ambulatory surgical center, independent clinic, FQHC, public health clinic, walk-in retail health clinic, or rural health clinic. See technical appendix

Source: HPC analysis of Massachusetts All Payers Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011-2013

Summary

Drug spending

- In 2014, prescription drug spending increased by 13% per capita in 2014, accounting for 1.6% of the 4.8% growth in THCE per capita
- The 2014 spike was driven by both new high-cost drugs (including hepatitis C drugs), price increases, and a low rate of patent expirations; many trends point towards ongoing increases

Hospital outpatient spending

- Hospital outpatient spending is the fastest-growing category of care aside from the recent spike in prescription drug spending
- Some services (e.g. surgery) have shifted to outpatient departments from inpatient departments while others have shifted from community settings.
- 56% difference in median price of colonoscopy between hospital outpatient department and community setting

Provider market trends

- One driver of the shift from physician offices to outpatient departments may be the increasing share of physicians affiliated with large systems and the relicensing of physician offices as hospital outpatient departments

Select findings from the 2015 Cost Trends Report

Overview of spending and the delivery system

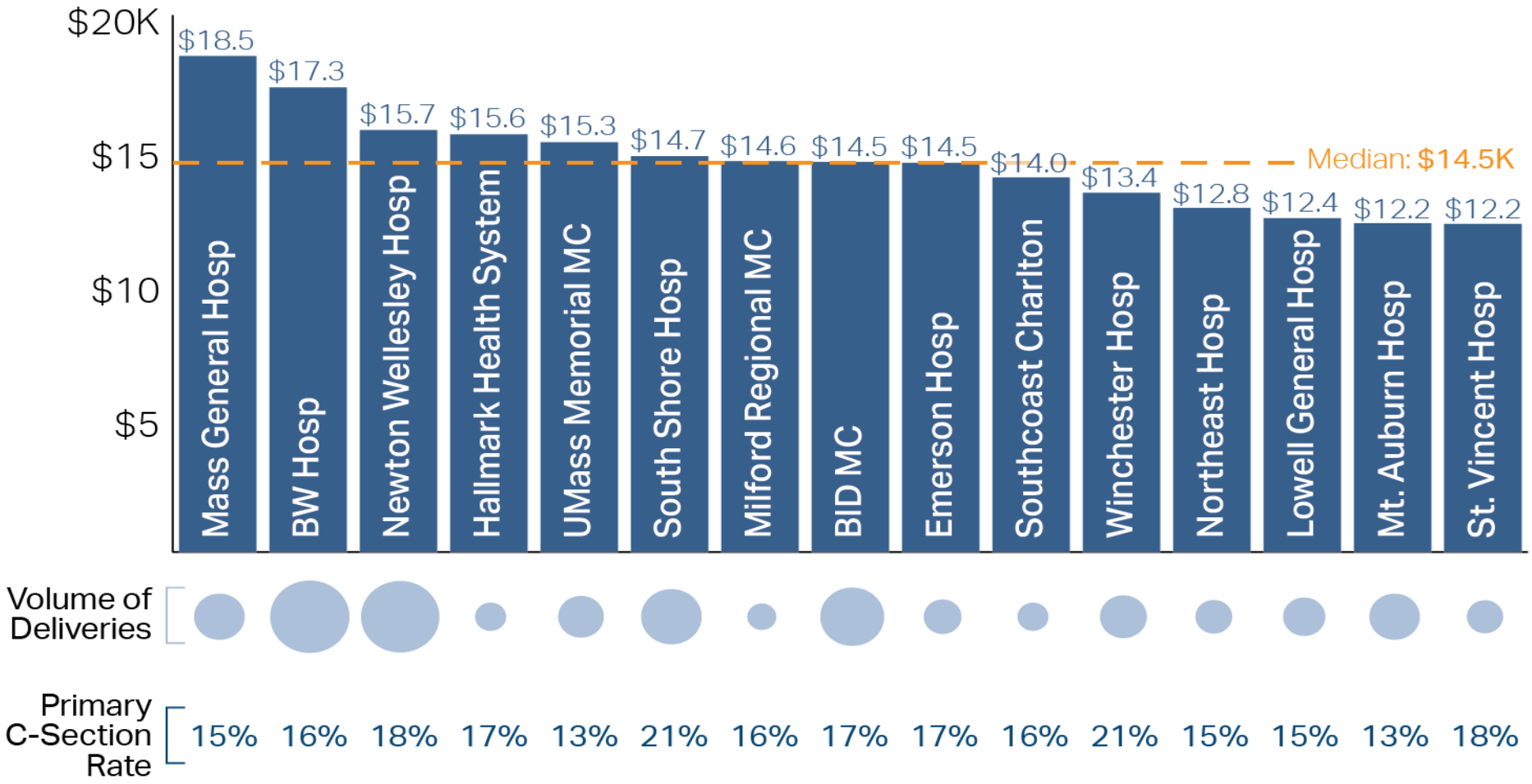
Opportunities to improve quality & efficiency

Progress in aligning incentives

- Variation in prices and spending among providers
- Avoidable hospital use
- Post-acute care
- Access to primary care

Episode spending for low-risk pregnancies varied considerably among hospitals, with volume concentrated in higher-cost hospitals

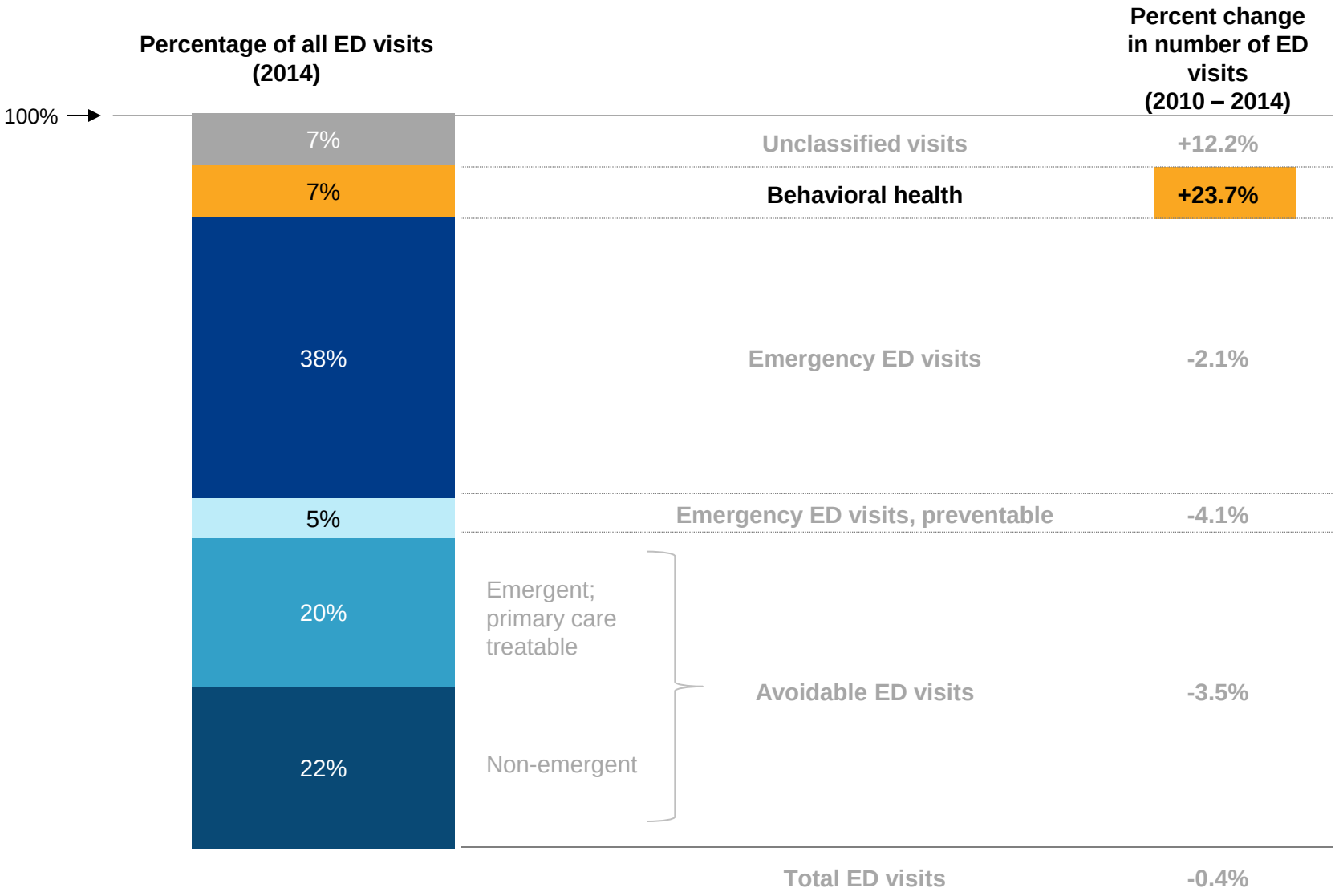
Average total payment per pregnancy episode ($K), by hospital



Note: Displayed are the 15 hospitals with the highest volume, which accounted for 78% of deliveries. Spending includes both vaginal deliveries and C-sections. Spending data include low-risk, commercial deliveries only, while C-section rates include all payers

Source: HPC Analysis of All-Payer Claims Database (payers include Blue Cross Blue Shield, Harvard Pilgrim Health Care, and Tufts Health Plan), 2011- 2012, HPC analysis of CHIA hospital discharge database, 2014

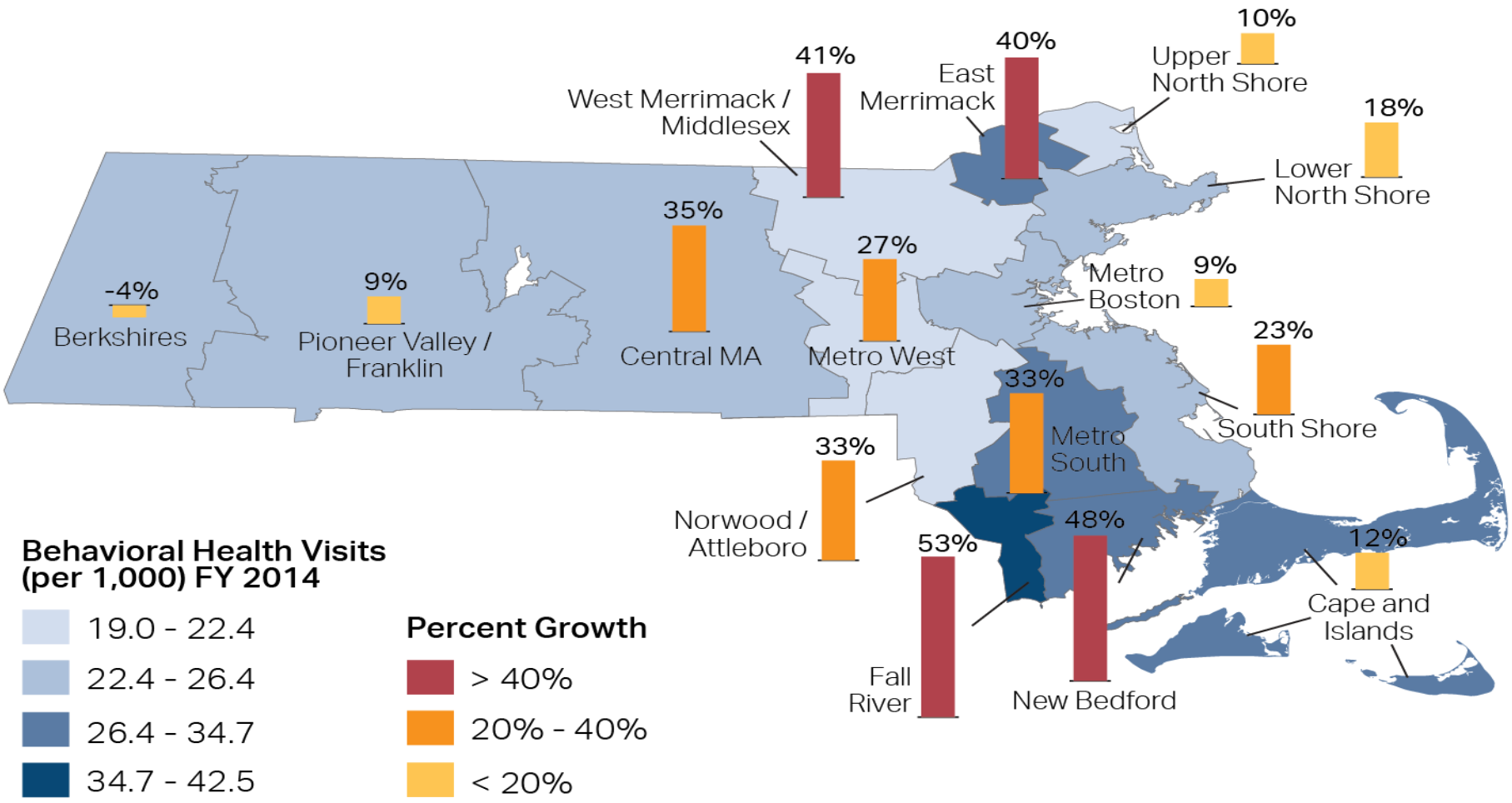
Primary behavioral health ED visits grew significantly between 2010 and 2014



Note: Definition for avoidable ED visits based on NYU Billings Algorithm

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis outpatient ED database, FY2010-FY2014

ED visits with a primary diagnosis of behavioral health increased sharply in a few regions between 2010 and 2014

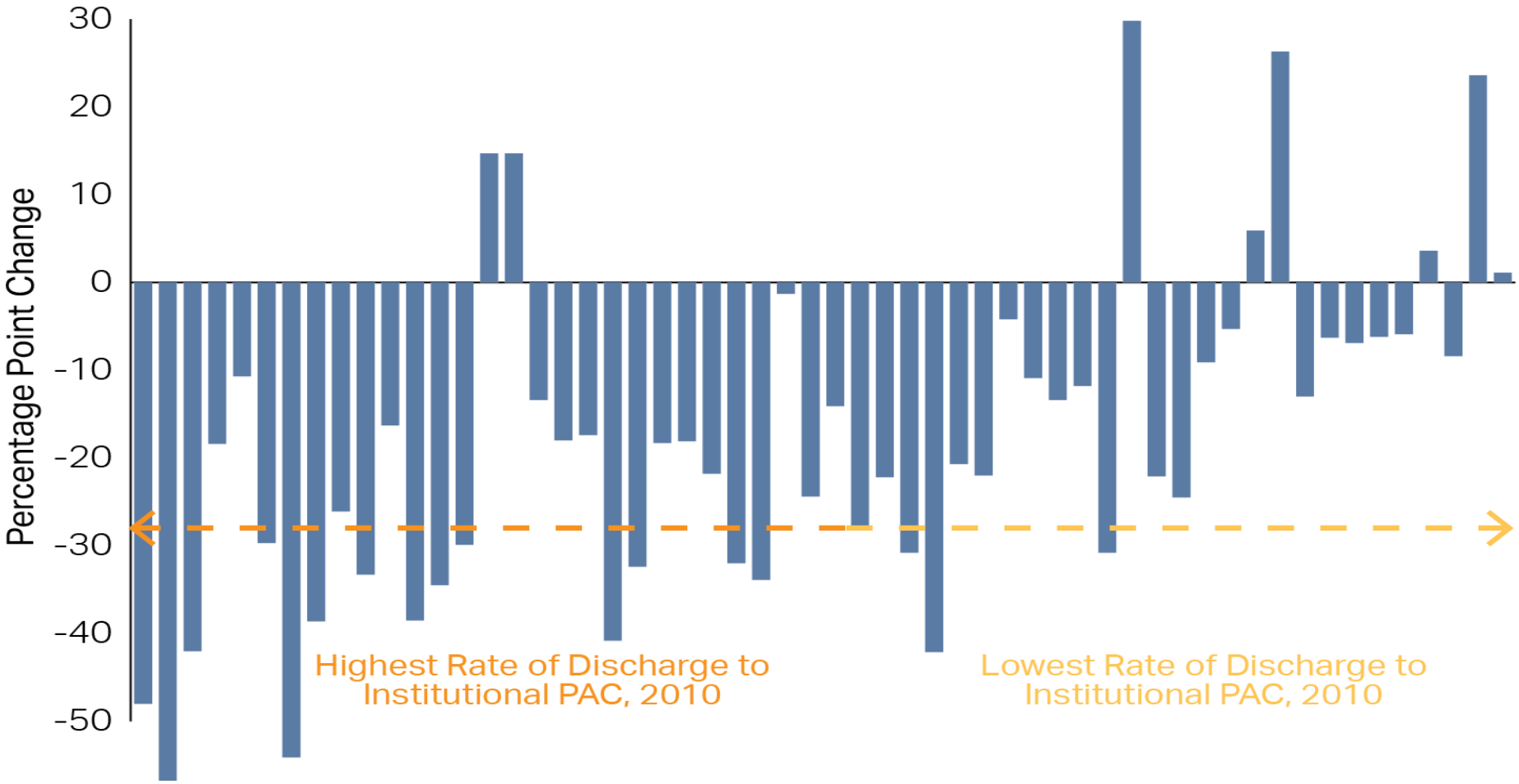


Note: Behavioral health includes mental health and substance use disorder. All conditions are based on primary diagnosis. All rates are adjusted for age and sex

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis case mix ED database, FY2010-FY2014

For total joint replacement, 49 of 57 hospitals reduced use of institutional post-acute care between 2010 and 2014

Percentage point change in probability of discharge to institutional PAC, following joint replacement surgery, by hospital, 2010-2014

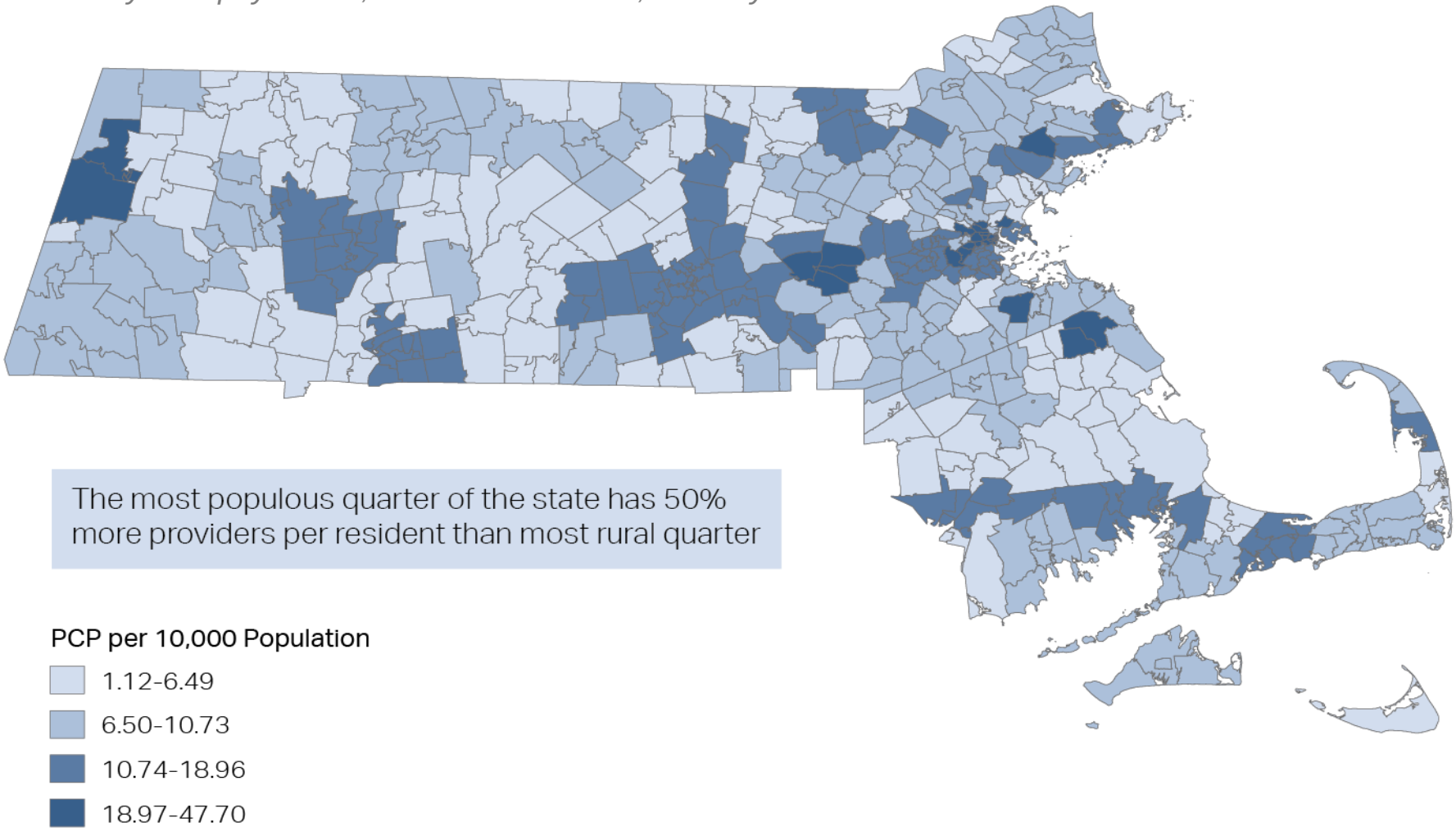


Note: Adjusted for age, sex, payer group, income, admit source of the patient, length of stay, and DRG. Sample includes only adult patients who were discharged to routine care or some form of PAC. Specialty hospitals, except New England Baptist, were excluded

Source: HPC Analysis of Massachusetts Health Data Consortium, inpatient discharge database, 2010-2014

There is substantial variation in primary care providers per resident across Massachusetts

Primary care physicians, Nurse Practitioners, and Physician Assistants



Note: Massachusetts is divided into 158 regions called Primary Care Service Areas (PCSAs). These areas were developed by researchers associated with the Dartmouth Atlas and represent a geographic approximation of patients' travel patterns to obtain to primary care services. According to common practice, Nurse Practitioners and Physician Assistants weighted as equivalent to .75 relative to a physician. See technical appendix

Source: SK&A Office Based Physician Database, September 30, 2015 and Massachusetts Department of Public Health: Health Care Workforce Center

Avoidable hospital use / post-acute care / primary care access

Summary

- Readmission rates improved slightly, but Medicare readmission rates remained worse than the national average, leading to high hospital penalties
- While overall ED use declined between 2010 and 2014, visits associated with a behavioral health diagnosis increased sharply
- Relative to the U.S., Massachusetts continued to use post-acute care at a high rate, but there were declines in institutional post-acute care use after total joint replacement
- There is substantial variation in primary care providers per resident across Massachusetts and is one of the 12 most restrictive states for Nurse Practitioners

Select findings from the 2015 Cost Trends Report

Overview of spending and the delivery system

Opportunities to improve quality & efficiency

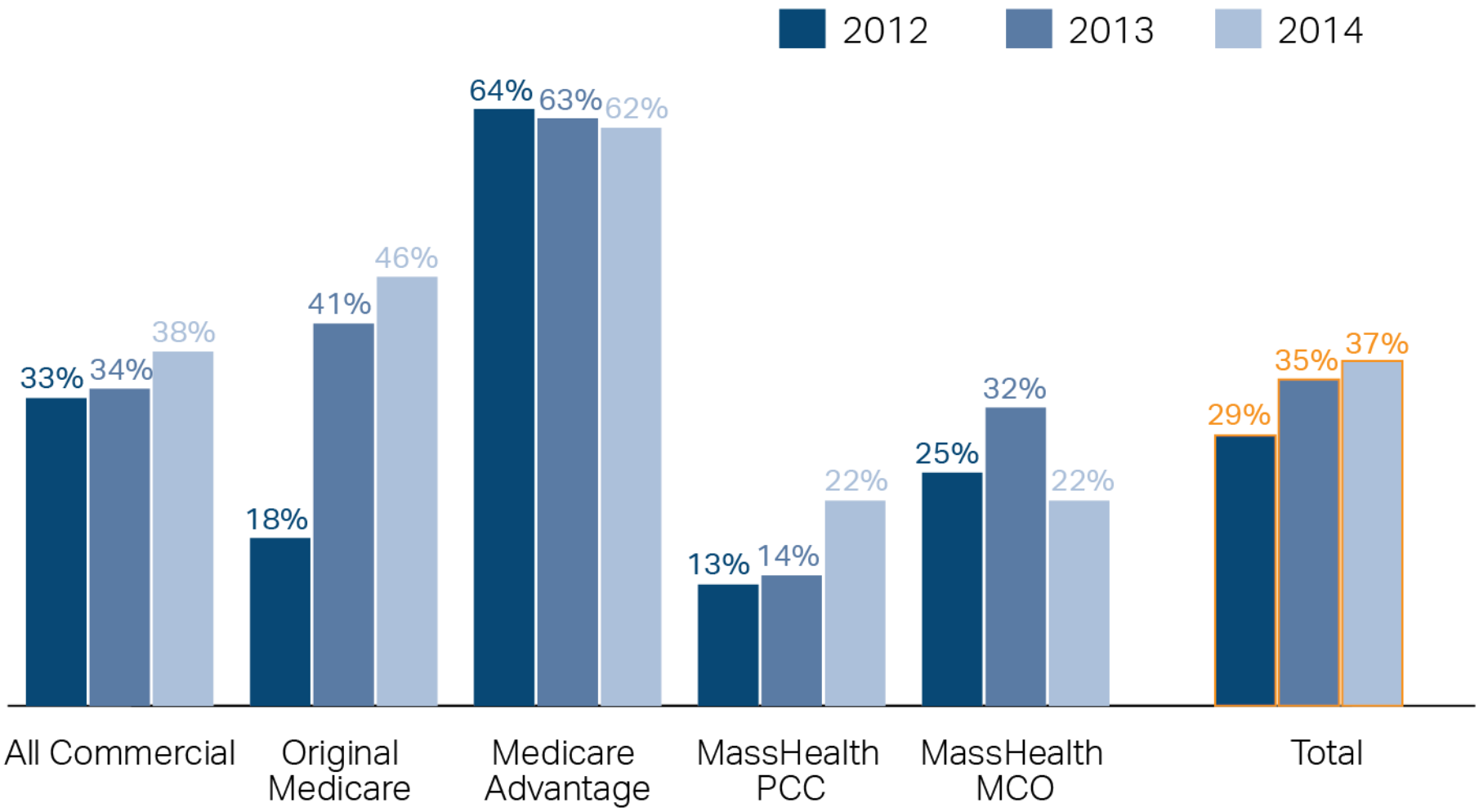
Progress in aligning incentives

Alternative payment methods

Demand-side incentives

Statewide, the rate of APM coverage increased 8 percentage points between 2012 and 2014, with differences among payers

Percentage of covered lives in APMs across all payers

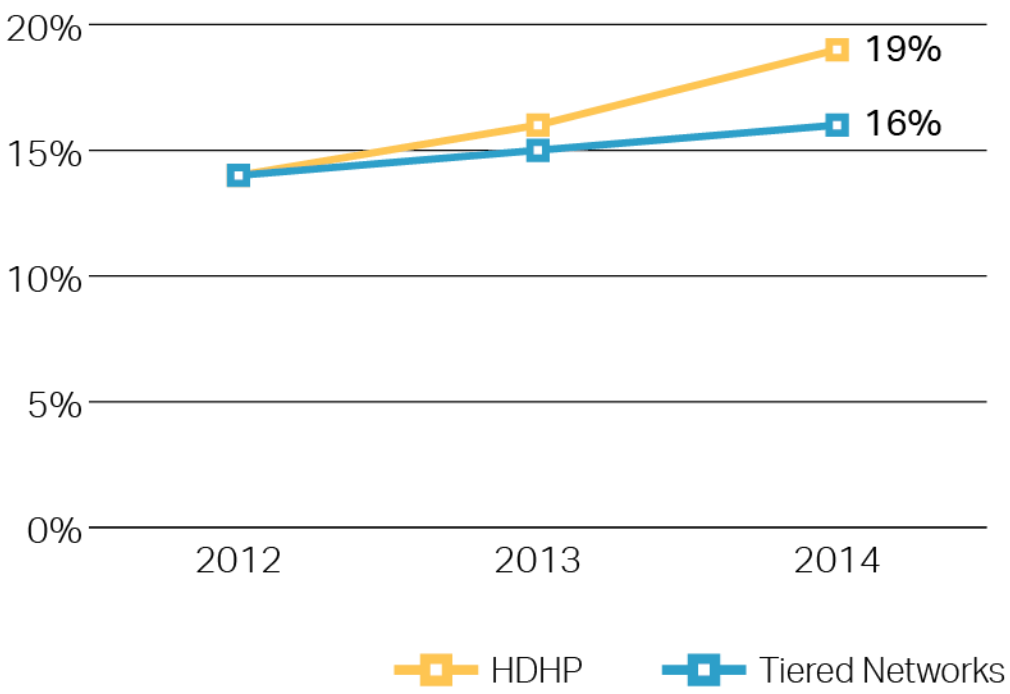


Note: See APM technical notes

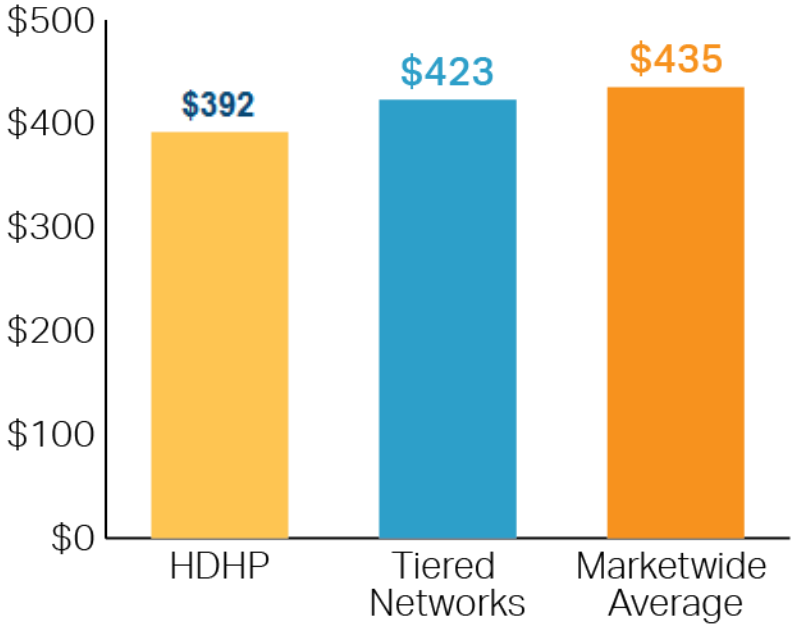
Source: Center for Health Information and Analysis 2014 Annual Report Alternative Payment Methods Data Book, 2013; Center for Health Information and Analysis 2013 Alternative Payment Methods Baseline Report Data Appendix, 2012; Centers for Medicare & Medicaid Services Shared Savings Program Performance Year 1 Results; Other publicly-available Centers for Medicare & Medicaid Services data; MassHealth personal communication

Tiered network product growth is being outpaced by high deductible health plans

Uptake of Tiered Network and High Deductible Health Plans



2014 Monthly Premium, Per Person



Note: Premiums are for fully-insured products, net of medical loss ratio rebates and scaled to account for carved-out benefits. Cost-sharing is not included

Source: Center for Health Information and Analysis Enrollment and Source of funds data book released with the September 2015 Annual Report

Future outlook – 2015 and beyond

- Reasons for concern
  - 6.3% premium growth in January 2016 in Massachusetts merged market
  - Higher U.S. spending growth through September, 2015
    - 5-6% overall; 8-9% for prescription drugs
  - Ongoing market consolidation
  - Continued high rates of readmissions, ED use, and PAC
- Reasons for optimism
  - Low rate of growth in hospital and physician services
  - Connector website is well-functioning and MassHealth enrollment growth has stabilized
  - Spread of APMs (PPO, MassHealth) may enhance providers' incentives to contain costs and improve quality

Source: Altarum Institute, Massachusetts Division of Insurance, Center for Health Information and Analysis

Presentation themes and potential areas for recommendations

Themes

Spending and the delivery system

- Spending trends
- MassHealth
- Drug spending
- Outpatient spending
- Market consolidation

Opportunities in quality & efficiency

- Variation in prices & spending
- Avoidable hospital use
- Post-acute care
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Potential areas for recommendations

- Promoting a value-based market, addressing market dysfunction
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- Engaging employers and consumers in value-oriented choices
- Enhancing transparency, data, and infrastructure

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- Executive Director Report
- Update on HPC Certification Programs
- Update on HPC Innovation Investment Programs
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- Discussion of 2016 Priorities
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Potential policy research topics for 2016 – for discussion

Value-Based Market	- Market consolidation and effects on prices, spending, practice patterns, billing practices
Efficient Care Delivery	- Avoidable use of hospital and post-acute care - Behavioral health spending and use, including trends in provider markets - After-hours care (retail clinics/urgent care centers); growth, access and impact on ED use and hospitals - End-of-life care
APMs	- APM uptake, especially in PPO
Demand-Side Incentives	- Uptake of tiered network products/markets for employer-based health insurance/public and private exchanges - Consumer choice (funded by RWJF)
Cross Cutting	- MassHealth enrollment, utilization, and spending, including LTSS - Drug spending - Health information technology (ENS, telehealth)

Upcoming Meeting Schedule

HPC Board Meetings	Wednesday, March 2, 2016 Wednesday, April 27, 2016 Wednesday, June 1, 2016 Wednesday, July 27, 2016 Wednesday, September 7, 2016 Wednesday, November 9, 2016 Wednesday, December 14, 2016
Advisory Council Meetings	Wednesday, March 30, 2016 Wednesday, June 15, 2016 Wednesday. September 14, 2016

Contact information

For more information about the Health Policy Commission:

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

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us

Appendix

NAS Program: RFP development summary

	HPC NAS Reserve $500,000	CHART Funds to extend DPH program up to $3,000,000
Eligible Applicants	Any non-CHART birthing hospital with: ▪ At least 60 NAS births per year, or ▪ > 5x NAS national average	Any CHART birthing hospital with: ▪ At least 60 NAS births per year, or ▪ > 5x NAS national average
Proposed Award Cap	Up to $250,000	Up to $1,000,000
Matching funds	In-kind funding match will be a competitive selection factor	NA
QI initiative	Describe quality improvement initiative that will reduce spending over 12 months	Describe quality improvement initiative that will reduce spending over 24 months
Internal/ External collaboration	• Describe plan to collaborate with outpatient providers (ob/gyn, primary care, pediatrics, addiction medicine) and procedure for creating first appointment prior to discharge	Describe plan to coordinate peer moms & identify outpatient providers for collaboration: • Ob/gyns, PCPs will participate in buprenorphine waiver trainings • Addiction medicine providers who will participate in training on treating women during pregnancy • Coordination with pediatricians, EI providers
Data collection	• Submit NAS discharge volume, reimbursements, and cost for June-Dec 2015 period • Describe plan to track QI measures throughout intervention	• Submit NAS discharge volume, reimbursements, and cost for June-Dec 2015 period • Describe plan to track QI measures throughout intervention
Existing NAS protocols	Applicants with existing protocols will be more competitive if proposal includes plan to participate in peer-peer learning sessions as the trainer	Applicants with existing protocols will be more competitive if proposal includes plan to participate in peer-peer learning sessions as the trainer

Telemedicine Program: RFP development summary

	Recommendation	Considerations
Eligible Applicants	• Any **provider** • A single entity may apply on behalf of a **consortium** of providers • Require some **level of collaboration** with a teaching hospital; no funding requirement	• The HPC seeks to engage a diverse array of market participants and encourage meaningful partnerships
Award Cap, Duration, and Opportunity	• **$500k** award **cap; $1M** total opportunity • Up to **two awards** • **18 months duration:** 6 month funded design period; 12 month implementation period	• Two regional awards • Integrated planning period (driven by awardee) for clinical protocol development, clinician engagement, etc.
Investment Focus	**Behavioral health** initiatives focused on **pediatric** BH needs, **homebound adults** with BH needs, and/or patients with **opioid use disorders**	• Combine high priority areas of focus with opportunities for provider innovation
Matching or In-Kind Funds	• Require **matching/in-kind** funds • No minimum amount, though **relative contribution** amount will be a **competitive factor** in selection	• Validate strategic importance of project to applicants without unfairly burdening smaller applicants
Application Process	• **Conventional**, brief proposal describing target population, measurable aim, driver diagram, operational model, budget, etc.	• Encourage competitive application pool
Selection Factors	• Level of access expansion OR cost savings (or both); evidence base for proposed model, including anticipated impact on patient experience and quality; demonstration of how pilot will improve operating efficiency and provider satisfaction; prior experience with telehealth; likelihood of sustainability;	• Prioritize anticipated impact, evidence of model, and applicant's past experience (and therefore likelihood of success) • Emphasize opportunities to scale successful models
Required Activities	• **Measurement** Applicants must indicate key outcomes of interest, measures to assess those outcomes, and include a plan for rapid-cycle evaluation	• Require rapid cycle evaluation to encourage learning and potential for transference • Maximize impact through multi-stakeholder partnerships

HCII Program: RFP development summary

	Recommendation	Considerations
Eligible Applicants	• Any **Payer or Provider** (includes a broad array of provider types) • Applicants **must propose partnership**	• The HPC seeks to engage a diverse array of market participants and encourage meaningful partnerships
Award Cap, Duration, and Opportunity	• **$750k award cap** ○ $500k per year of operations; up to 18 months of operations • **$5 million** total opportunity	• Generate impact while maximizing the number of innovations being funded • Generate measurable outcomes without 'overfunding' beyond HCII's targeted innovation lifecycle phases
Investment Focus	**Globally-emerging**, but **locally relevant** solutions addressing the most **persistent challenges** facing the state	• Minimize risk and achieve cost savings within short timeframe • Combine learnings of HPC programs and research with stakeholder feedback
Matching or In-Kind Funds	• Require **matching/in-kind** funds • No minimum amount, though **relative contribution** amount will be a **competitive factor** in selection	• Validate strategic importance of project to applicants without unfairly burdening smaller applicants
Application Process	• Require submission of a (nonbinding) **Letter of Intent (LOI)** as prerequisite to Proposal • HPC to release companion illustrations of the **best emerging innovations** with a promising **evidence base of cost savings**	• Gain foresight into the field prior to Proposal submission • Make program goals and process accessible to a wide variety of applicants
Selection Factors	• **Impact** - Cost Savings, Quality, and Access • **Evidence Base** Strength • **Innovativeness** – Partnership, Process, Tools • Sustainability • Operational **Feasibility**	• Promote highly competitive process to identify leading edge evidence-based innovations with strongest cost-saving potential • Emphasize value of multi-stakeholder partnerships • Maximize impact on cost savings while prioritizing policy-relevant solutions

Required Activities	• **Measurement**
	  ○ Patient- and Provider-reported measures
	  ○ Rapid-cycle improvement
		• Emphasize scalability by requiring customer-centric approaches to evaluation
		• Require rapid cycle evaluation to encourage learning and potential for transference