MASSACHUSETTS
HEALTH POLICY COMMISSION

Health Policy Commission
Board Meeting

September 7, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Approval of Minutes from the July 27, 2016 Meeting
- Cost Trends and Market Performance
- 2016 Health Care Cost Trends Hearing and Report
- Quality Improvement and Patient Protection
- Report from the Executive Director
- Schedule of Next Meeting

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HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Commission hereby approves the minutes of the Commission meeting held on July 27, 2016, as presented.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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  - Notices of Material Change
  - Final Cost and Market Impact Review Report (VOTE)
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Types of Transactions Noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Clinical affiliation	16	25%
Physician group merger, acquisition or network affiliation	16	25%
Acute hospital merger, acquisition or network affiliation	13	20%
Formation of a contracting entity	9	14%
Merger, acquisition or network affiliation of other provider type (e.g., post-acute)	6	9%
Change in ownership or merger of corporately affiliated entities	4	6%
Affiliation between a provider and a carrier	1	2%

Update on Notices of Material Change

Notices Received Since Last Commission Meeting

- Proposed corporate affiliation between **Southcoast Health System** (Southcoast) and **Care New England Health System** (CNE) under a new corporate parent (NewCo Health System). Southcoast includes three hospital campuses, Tobey Hospital, St. Luke's Hospital, and Charlton Memorial Hospital, satellite facilities, and approximately 425 physicians. CNE is a health system in Rhode Island that includes Women & Infants Hospital of Rhode Island, a specialty hospital for women and newborns; two general acute care hospitals, Kent County Memorial Hospital and Memorial Hospital of Rhode Island; and a psychiatric hospital, Butler Hospital.

- Proposed acquisition of **Hallmark Health System** (Hallmark), which consists of two hospital campuses, Lawrence Memorial Hospital and Melrose-Wakefield Hospital, satellite facilities, and an owned physician group, by **Wellforce**, which principally consists of Lowell General Hospital, Tufts Medical Center, New England Quality Care Alliance (NEQCA), and Lowell General PHO.

- Proposed contracting affiliation between **Hallmark Health PHO,** which is partially owned by Hallmark and contracts on behalf of Hallmark's two owned hospital campuses and approximately 400 physicians, and **NEQCA**, which currently contracts on behalf of Tufts Medical Center and approximately 1,800 community and academic physicians.

Update on Notices of Material Change

Notices Received Since Last Commission Meeting

- Proposed contracting affiliation between the **Pediatric Physicians' Organization at Children's, LLC**, a contracting organization partially owned by Children's Hospital Corporation with 295 primary care pediatricians, and **Child Health Associates**, a 12-physician pediatric primary care group located in Auburn and Shrewsbury.

- Proposed clinical affiliation between **Boston Children's Hospital** and **South Shore Medical Center**, a multi-specialty private practice with more than 100 providers in Norwell, MA, owned by South Shore Health System.

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Preliminary and Final Reports on the current CMIRs

Preliminary Report & Response

- Preliminary Report issued July 27
- Joint written response from the parties received on August 19th
- HPC analyzed the parties' response, including:
  - Discussing key points with the parties
  - Review by key HPC staff and outside experts
  - Consideration of feedback provided by commissioners

Final Report

- Reflects consideration and analysis of the parties' response
- Parties' response and the HPC's analysis of the response are attached as Exhibits A and B of the Final Report, respectively
- Includes an expectation of continued monitoring by the HPC, but does not include a referral to the Massachusetts Attorney General's Office
- The proposed transactions may not be finalized until 30 days after issuance of the final report

HPC

Principal findings: Cost and market impact

- The proposed transactions would **increase market concentration** and solidify BIDCO's position as the second largest hospital network in the Commonwealth. This could strengthen BIDCO's ability to negotiate **higher prices** or other favorable contract terms.

- As NEBCIO physicians join BIDCO contracts, there would be a small to moderate increase in total health care spending of **up to $4.5 million annually**.

- If BIDCO retains its low to mid-range prices and redirects volume away from higher-priced systems, the transactions **may reduce health care spending**. However, BIDCO has had limited success to-date redirecting commercial patients away from higher-priced systems.

Principal findings: Care delivery and quality impact

- Available information suggests **potential for NEBH to help BIDCO hospitals improve** performance on key quality measures; however, the parties have not yet developed specific plans, timelines, or resource commitments to transmit best practices to non-owned BIDCO hospitals

- The transactions are unlikely to significantly impact MetroWest's overall quality; however, several specific elements of the clinical affiliation suggest the potential for some **targeted quality and care delivery improvements at MetroWest**

Principal findings: Access impact

- NEBH currently provides a very low share of orthopedic and musculoskeletal services to Medicaid patients. **NEBH has stated it is committed to increasing access** to its services for Medicaid patients, though the timeline is unclear.
  - In the Parties' Response, NEBH committed to care for a share of Medicaid patients proportionate to that of BIDMC's orthopedic patients over time and states that NEBH's "in-network" status for BIDCO PCPs will advance this commitment
- The MetroWest transactions **may increase access to certain services**:
  - Evidence suggests that expansion of services targeted in the BIDMC/HMFP clinical affiliation will help to fill identified community needs.
  - The proposed transactions could represent an opportunity for collaboration among BIDCO hospitals serving significant behavioral health populations if the parties make such collaboration a priority
  - In the Parties' Response, MetroWest, BIDMC, and HMFP committed to maintaining behavioral health services at MetroWest, evaluating opportunities to collaborate on behavioral health programs, and facilitating access to psychiatric services for patients of new primary care practices. They also committed that new primary care practices will accept all payers

Specific issues highlighted for the parties to address

Based on the findings in the Preliminary Report and concerns highlighted by Commissioners, the HPC identified certain key issues for the parties to address in their response:

- Specific commitments to mitigate concerns about increases in spending due to NEBCIO physician rate increases, potential increased utilization of BIDMC, and the potential for the transactions to strengthen BIDCO's negotiating position with commercial payers
- Data indicating that BIDCO affiliation has been responsible for decreased spending and/or improved quality for current affiliates
- Details regarding how quality improvement would be achieved, such as how progress toward quality improvement would be measured, specific improvements or benchmarks that would be expected in specific time periods, and how progress would be made transparent to the public
- Additional information regarding NEBH's payer mix and commitments to improve access for Medicaid patients
- Commitments to maintain (or further enhance) behavioral health services at MetroWest and commitments that new primary care providers would serve Medicaid patients

Parties' response to the HPC's findings

- The parties' response included minor technical suggestions and somewhat different interpretations of HPC findings, but did not generally dispute the HPC's findings that the transactions would result in increases in market share and market concentration, small to moderate price increases, and the potential for quality and access improvements.

- Key differences in the parties' interpretation include:
  - The parties claim that the potential for cost and market impacts will be mitigated by the fact that BIDCO will "remain a tenuous #2 hospital network, not within competitive reach of the current market leader" and that there would remain "a high degree of competition for orthopedic and MSK services throughout all relevant service areas"
  - Based on an alternative analysis, the parties also submit that increases in NEBCIO physician prices would result in a $1.3 million per year increase in spending

Parties' specific commitments regarding highlighted issues

- **Access:** As noted, NEBH committed to increase its share of Medicaid patients over time to levels comparable to BIDMC's orthopedic patients, the parties committed to maintain and support behavioral health services at MetroWest, and the parties committed that new MetroWest-area primary care practices would accept Medicaid.

- **All other issues:** The parties committed to supporting the HPC's role and Chapter 224 objectives, but stated they could not specify a timeframe by which certain results could be demonstrated, declined to adhere to any additional reporting or monitoring requirements, and stated that they had already provided all available information regarding their plans and performance to date.

Conclusion

- The HPC is disappointed that the parties did not identify specific commitments, outside of compliance with their existing legal requirements, to further enhance transparency and accountability for the impacts of the proposed transactions
- Recognizing both the potential for positive and negative impacts from these transactions, the HPC recommends monitoring of the parties' performance, including the parties' progress on specific commitments and other stated goals of the transactions
- The HPC will assess the parties' performance over time through its ongoing authority to monitor the health care market including, but not limited to:
  - Potentially requiring specific written and oral testimony in connection with the HPC's annual cost trends hearings
  - Evaluating future transactions in light of the parties' performance
  - Potentially requiring a performance improvement plan or cost and market impact review if a party is identified by CHIA as having excessive health care cost growth
- However, based on the findings in the Final Report and the parties' written response, the HPC declines to refer the Final Report to the Massachusetts Attorney General's Office pursuant to MASS. GEN. LAWS c. 6D

MASSACHUSETTS
HEALTH POLICY COMMISSION

Vote: Issuance of a Final CMIR Report

Motion: That pursuant to section 13 of chapter 6D of the Massachusetts General Laws, the Commission hereby authorizes the issuance of the attached final report on the cost and market impact review of the proposed contract affiliation between Beth Israel Deaconess Physician Organization, LLC d/b/a Beth Israel Deaconess Care Organization, New England Baptist Hospital, and New England Baptist Clinical Integration Organization, LLC, the proposed contracting affiliation between Beth Israel Deaconess Physician Organization, LLC d/b/a Beth Israel Deaconess Care Organization and MetroWest Medical Center, and the proposed clinical affiliation between Beth Israel Deaconess Medical Center, Harvard Medical Faculty Physicians and MetroWest Medical Center.

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CENTER FOR HEALTH INFORMATION AND ANALYSIS

PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

ANNUAL REPORT
SEPTEMBER 2016

PRESENTATION TO THE
HEALTH POLICY COMMISSION

CHIA.

2015
THCE
Growth

Factors
Underlying
Growth in THCE

KEY FINDINGS

Changes in the
Merged Market

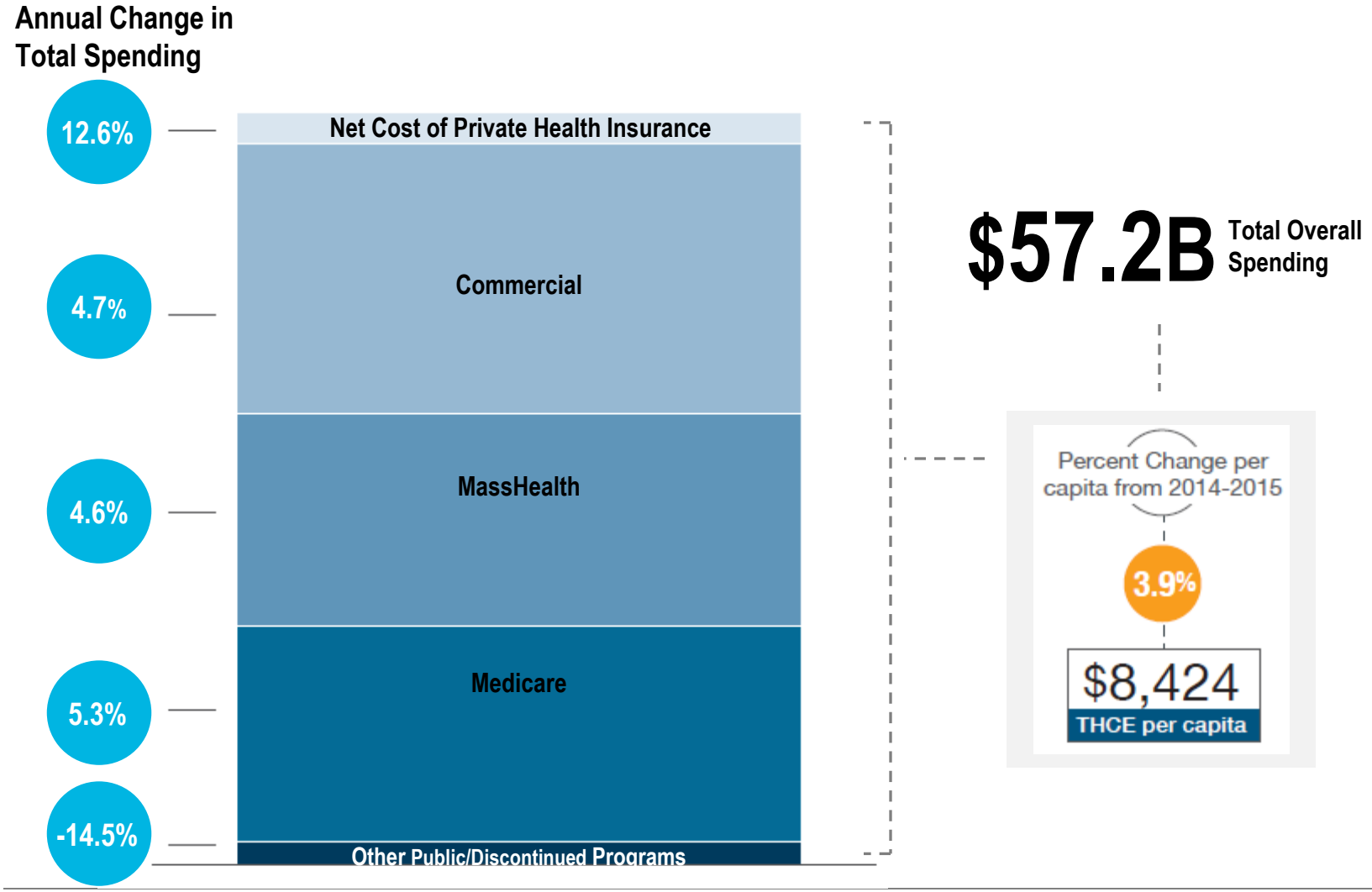
Member
Cost-Sharing

APM
Adoption

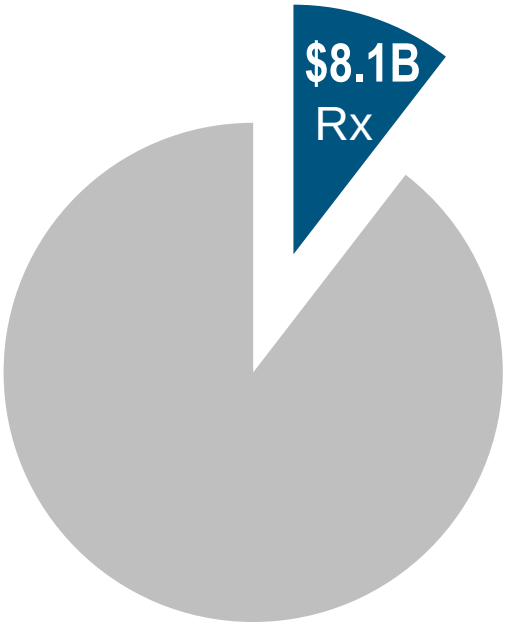
CHIA.

Total Health Care Expenditures grew by 3.9%, exceeding the 3.6% cost growth benchmark set by the Health Policy Commission.

2015 THCE Growth



Payers reported prescription drug spending of $8.1 billion, representing 14% of THCE. Pharmacy spending accounted for 35% of the growth in THCE.



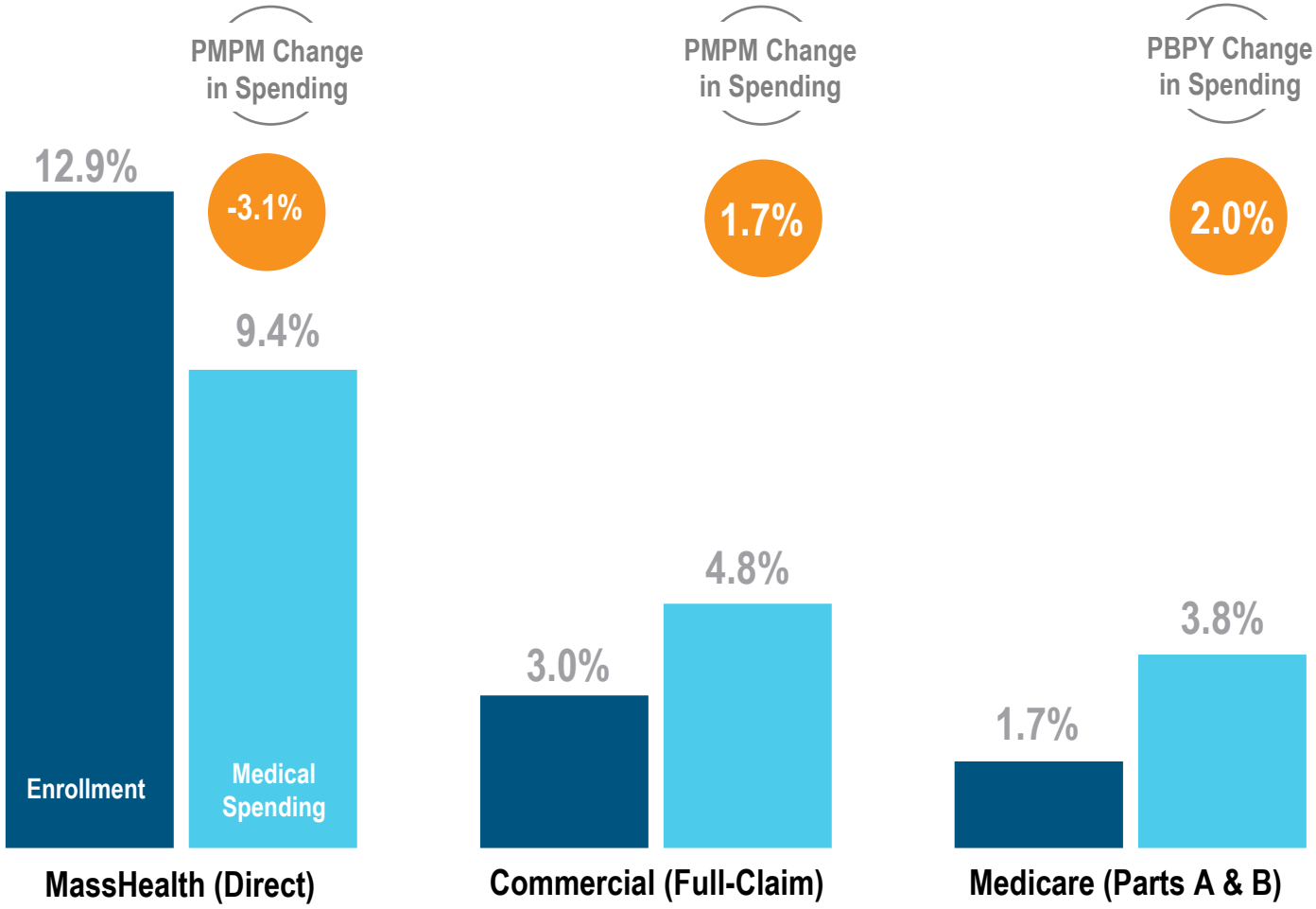
2015 THCE
($57.2B)

THCE GROWTH
($2.1B)

Note: Pharmacy data shown above excludes insurance categories for which pharmacy spending data is unavailable (e.g., HSN, VA, MSP).

Factors Contributing to Growth

Shifts in coverage contributed to an uptick in enrollment that drove growth in THCE. Comparing enrollment against medical spending reveals PMPM spending either declined or grew moderately for major coverage categories.



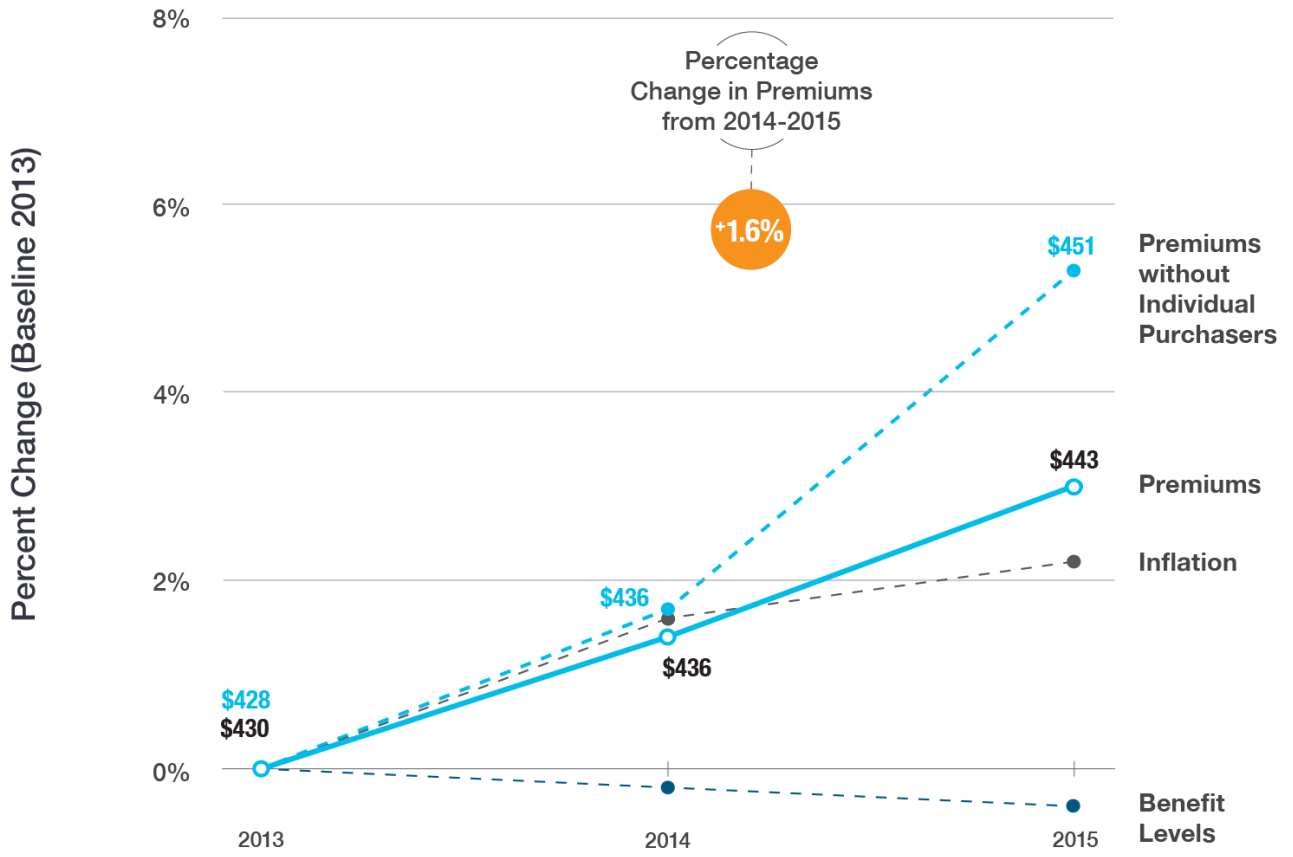
CHIA.

Individual enrollment in the commercial market more than doubled as new forms of subsidized and unsubsidized coverage became available. These members were associated with lower premiums, impacting the market as a whole.

Changes in the Merged Market

+90,000

New Individual Purchasers

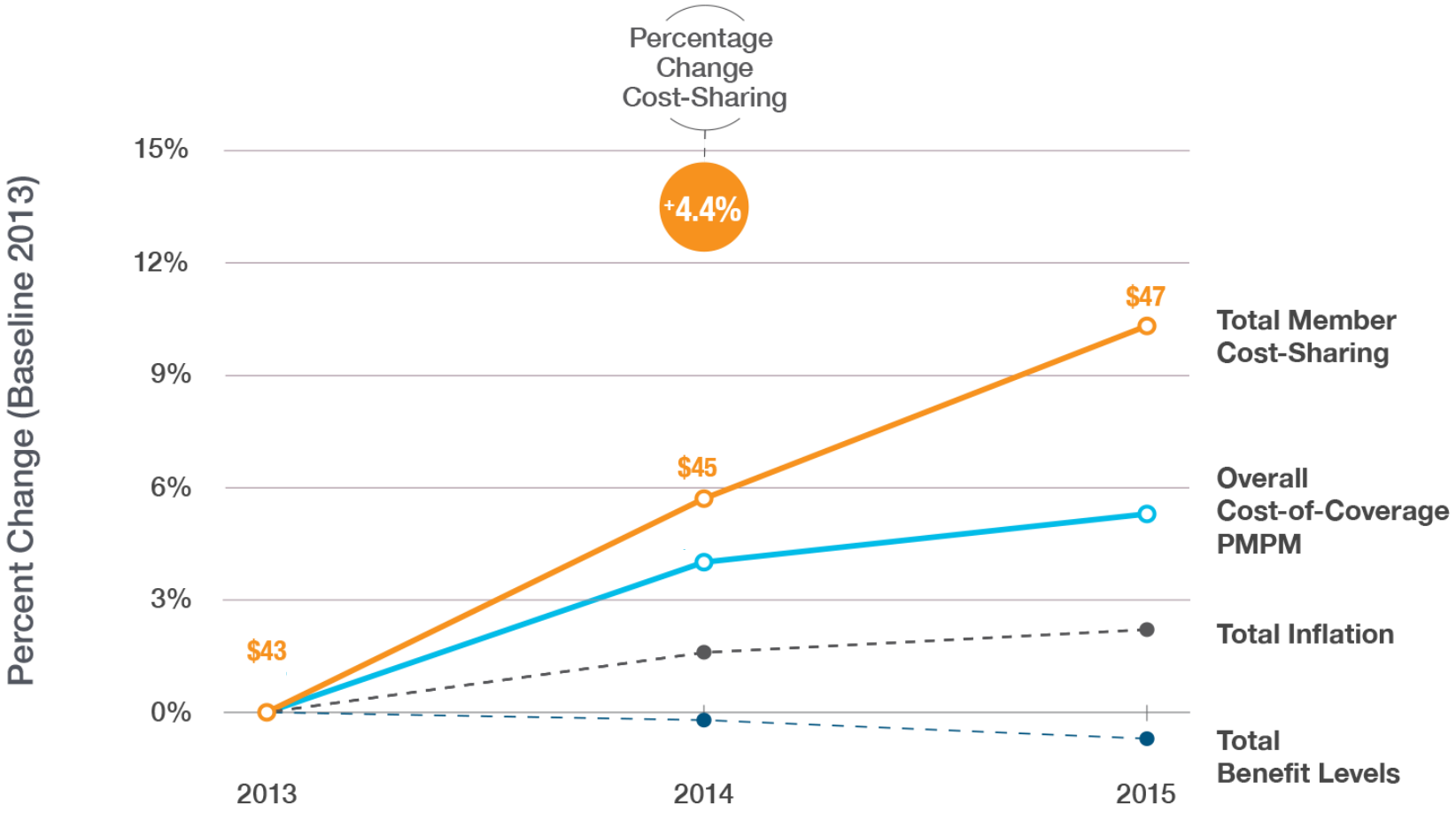


CHIA.

Member Cost-Sharing

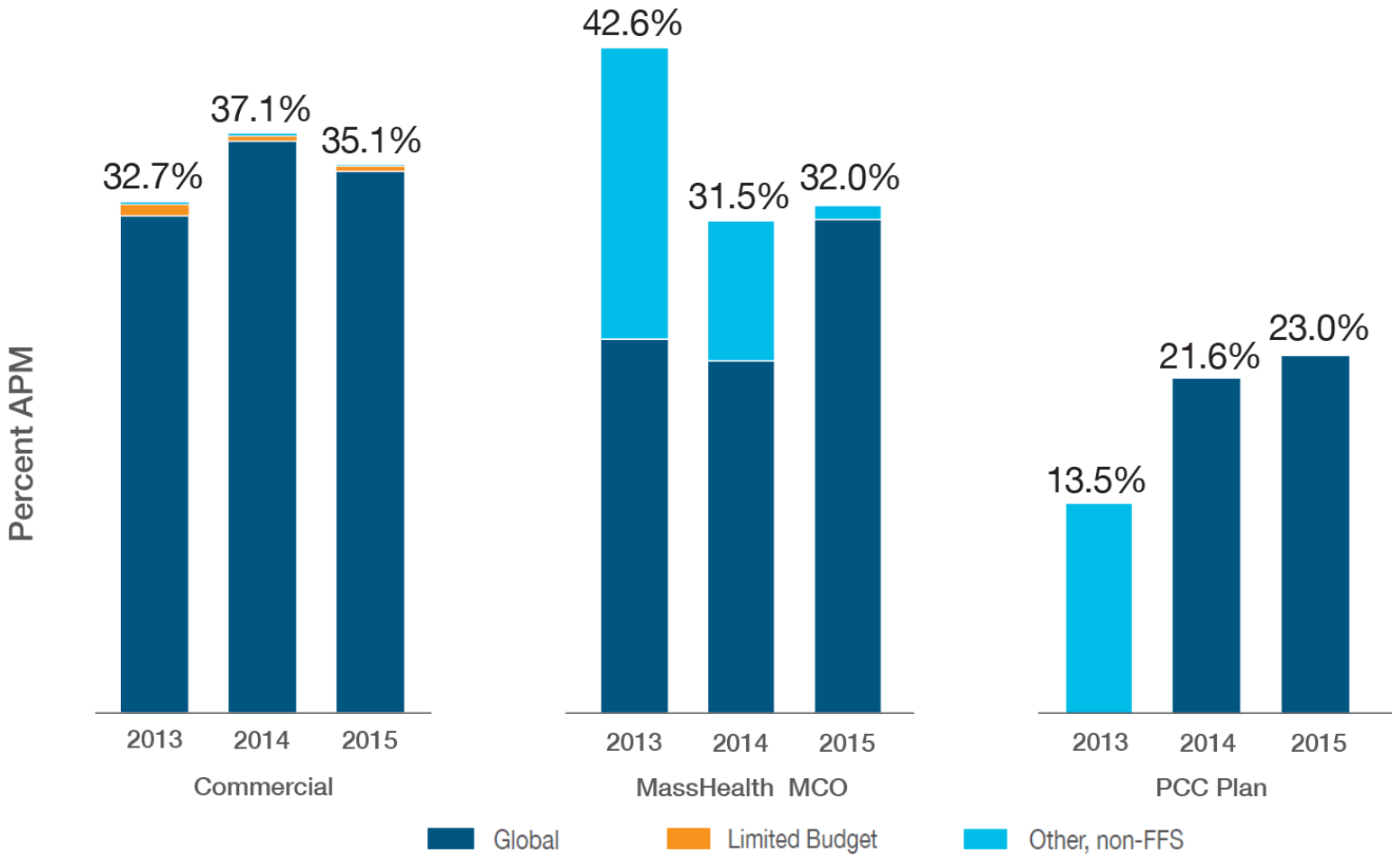
Private commercial member cost-sharing continues to increase faster than inflation, wage growth, and overall cost of insurance coverage.

One in five commercial members were enrolled in a high deductible health plan.



After several years of gains, the proportion of commercial members whose care was paid for through an alternative payment method fell by approximately two percentage points, to 35% of the market.

APM Adoption



THCE grew 3.9%, exceeding the benchmark (3.6%)

Pharmacy accounted for 35% of the growth in THCE

Shifts in enrollment increased overall spending, but PMPM spending only rose moderately

CONCLUSION

An influx of individual purchasers entered the private market into lower-premium plans, deflating overall market trends

Member cost-sharing outpaced the overall cost of insurance

One in five commercial members were enrolled in an HDHP

The proportion of commercial members whose care was paid for using APMs fell approximately 2 percentage points, to 35% of the market

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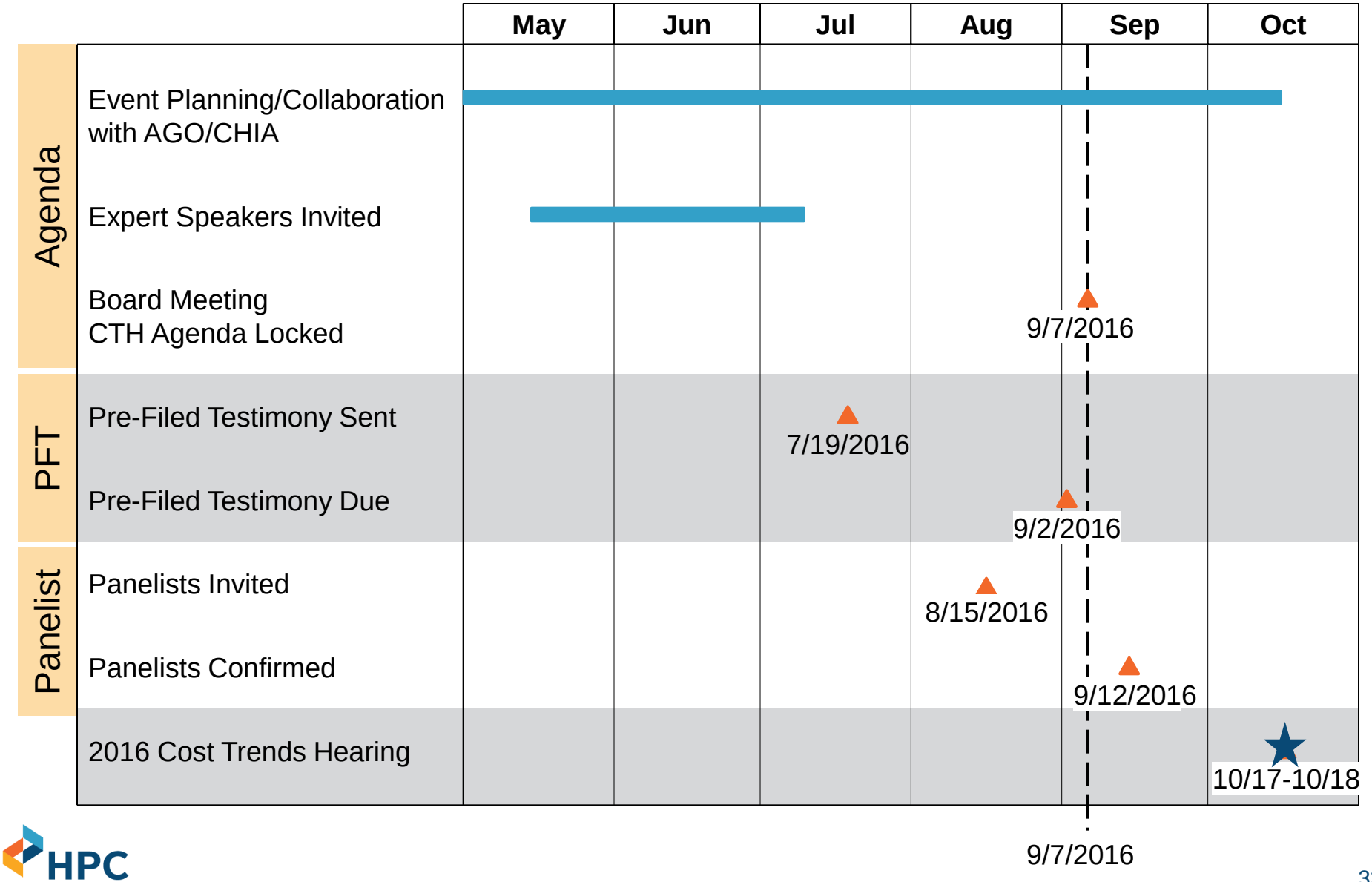
SAVE THE DATE

2016 HEALTH CARE COST TRENDS HEARING

October 17 and 18, 2016
Suffolk University Law School
120 Tremont Street

2016 Cost Trends Hearing



2016 Cost Trends Hearing Update

Agenda

Opening Remarks

The Honorable Suzanne Bump, Auditor
The Honorable Stanley Rosenberg, Senate President
Dr. Stuart Altman, Chair, Health Policy Commission

Keynote Remarks

Governor Charlie Baker PENDING CONFIRMATION
Attorney General Maura Healey

Presentation

Mr. Ray Campbell, Executive Director, Center for Health Information and Analysis
Staff, Office of the Attorney General
Dr. David Auerbach, Director, Research and Cost Trends, HPC

National Perspectives

Mr. Robert Berenson, Institute Fellow, The Urban Institute
Ms. Lauren Taylor, Harvard Business School, Health Policy and Management

Witness Panels

Meeting the Health Care Cost Growth Benchmark
Strategies to Address Pharmaceutical Growth
The Consolidation of the Provider Market
Health Care Innovations to Address Social Determinants of Health
Payment Reform: Progress Toward APMs in Massachusetts
Employers and Consumers Role in Cost Containment

Public Testimony

HPC

2016 Cost Trends Hearing Update

Pre-File Testimony

Questions	Requests for Testimony	Pre-Filed Testimony
Hospitals Exhibits and Questions	Berkshire Medical Center	Berkshire Medical Center - 2016 Pre-Filed Testimony
	Beth Israel Deaconess Medical Center	Beth Israel Deaconess Medical Center - 2016 Pre-Filed Testimony
	Boston Children's Hospital	Boston Children's Hospital - 2016 Pre-Filed Testimony
	Boston Medical Center	Boston Medical Center - 2016 Pre-Filed Testimony
	Brigham and Women's Hospital	Brigham and Women's Hospital - 2016 Pre-Filed Testimony
	Cambridge Health Alliance	Cambridge Health Alliance - 2016 Pre-Filed Testimony
	Cape Cod Hospital	Cape Cod Hospital - 2016 Pre-Filed Testimony
	Holyoke Medical Center	Holyoke Medical Center - 2016 Pre-Filed Testimony
	Lowell General Hospital	
	Massachusetts General Hospital	Massachusetts General Hospital - 2016 Pre-Filed Testimony
	Signature Healthcare Brockton Hospital	Signature Healthcare Brockton Hospital - 2016 Pre-Filed Testimony
	Southcoast Health	Southcoast Health - 2016 Pre-Filed Testimony
	Tufts Medical Center	
Payers Exhibits and Questions	Aetna	
	Blue Cross Blue Shield of Massachusetts	Blue Cross Blue Shield of Massachusetts - 2016 Pre-Filed Testimony
	BMC Healthnet Plan	BMC Healthnet Plan - 2016 Pre-Filed Testimony
	Celticare Health	CeltiCare Health - 2016 Pre-Filed Testimony
	Commonwealth Care Alliance	Commonwealth Care Alliance - 2016 Pre-Filed Testimony
	Fallon Community Health Plan	Fallon Community Health Plan - 2016 Pre-Filed

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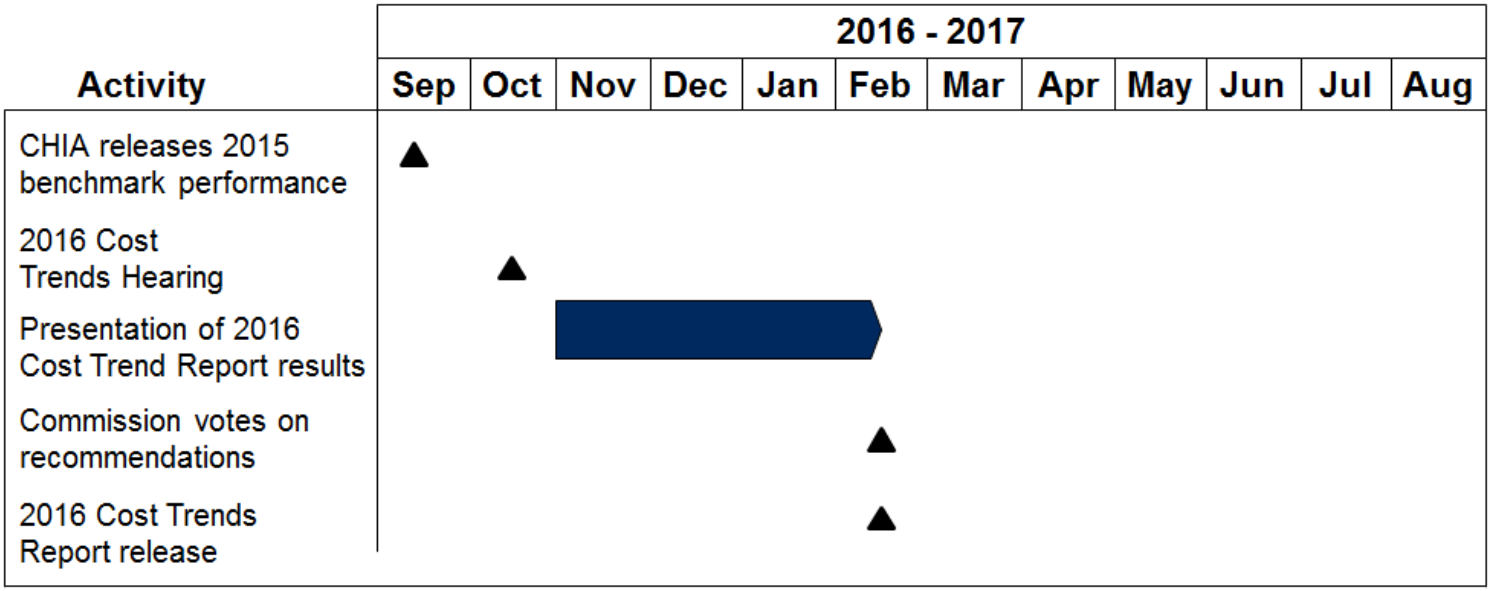
Timeline of HPC 2016 Cost Trends Report

HPC's fourth Annual Cost Trends Report will include new topic areas as well as progress on ongoing issues



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    - Mandates for HPC and other agency work targeting opioid epidemic
    - HPC analyses on the impact of the opioid epidemic on the health care system
    - HPC investments to address the opioid epidemic
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Several laws direct HPC and other state agencies to target the opioid epidemic, resulting in 2 reports being released next week

2014	Ch. 258: *An Act to Increase Opportunities for Long-Term Substance Abuse Recovery*	Basis for HPC's emerging report on opioid use disorder in Massachusetts
2016	Ch. 55: *An Act Requiring Certain Reports for Opiate Overdoses*	Basis for DPH's emerging report analyzing causes of opioid overdoses
2016	Ch. 52: *An Act Relative to Substance Use, Treatment, Education and Prevention*	Directs future HPC work related to the opioid epidemic (see appendix)

HPC

Ch. 55: Legislature tasked DPH to study root causes of opioid overdoses

In 2015, the Legislature passed ch. 55 of the Acts of 2016, *An Act Requiring Certain Reports for Opiate Overdoses.*

Recognizing that the complexity of the opioid overdose epidemic is captured across a multitude of datasets, Ch. 55 charged DPH to **link databases** and **analyze overdoses** using shared information to **promote understanding of the following factors:**

1. Receipt of prescriptions from **multiple providers**;
2. Access to **multiple prescriptions** for drugs that increase likelihood of overdose when combined with opioids;
3. Opioid **prescription history** including whether individual had opioid prescription at the time of death;
4. History of voluntary or involuntary **treatment for SUD** or **mental illness**, including for overdose
5. History of **previous attempts** at entry and denial to entry to treatment
6. History of **detention or incarceration**, including treatment during that time

DPH is issuing its report on this effort, *An Assessment of Opioid-Related Deaths in Massachusetts (2013 – 2014)*

Focus of DPH report is on opioid-related mortality

Ch. 258: Legislature tasked HPC to study opioid use disorder trends and make recommendations

In 2014, the Legislature passed a comprehensive health care law, ch. 258 of the Acts of 2014, *An Act to Increase Opportunities for Long-Term Substance Abuse Recovery*.

Recognizing the HPC's mission and role in developing and promoting evidence-based health policy that improves the **transparency, accountability, efficacy, and efficiency** of our health care system, **ch.258 charged HPC to put forward recommendations on:**

1. Improving the adequacy of **coverage** by public and private payers where necessary;
2. Improving the **availability of opioid therapy** where inadequate; and
3. **Identifying the need for further analyses**.

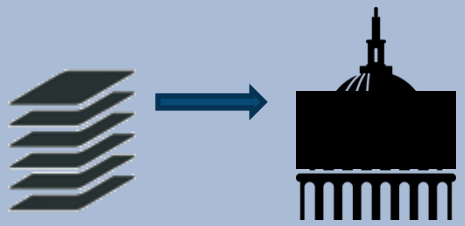
Focus of HPC report is on the impact of opioid-related discharges on the health care system

HPC

HPC identified care delivery and payment reform innovations that would contribute to the Commonwealth's effort to address opioid abuse

1

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



2

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

3

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

Outline of the HPC's Opioid Use Disorder Report

- **The State of the Opioid Epidemic in Massachusetts**
  - Opioid-Related Mortality
  - Opioid-Related Hospital Discharges
    - Impact on Communities
    - Impact on Populations
    - Impact on Exposed Infants
  - Availability of Pharmacologic Treatment of Opioid Use Disorder
- **HPC Efforts to Address the Opioid Epidemic**
  - Integrating Behavioral Health into Primary Care
  - Fully Integrated Accountable Care Delivery Systems
  - Broad-based Community Coalitions
  - Investing in Innovative Models of Care
- **Policy Recommendations**
  - Improved data collection & monitoring
  - Care delivery integration & payment reform
  - Community-based multi-stakeholder coalitions
  - Testing & scaling innovative care models to improve access to and quality of treatment
- **Conclusion**
  - Data Notes
  - Appendices
  - References

HPC

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Key definitions and methods (HPC analyses)

Methods

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

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

Definitions

Hospital discharges

Includes **inpatient discharges and emergency department visits**

- Some analyses include only **inpatient discharges** (e.g., stratification by gender, age, and income)

Opioid-related

Hospital discharges with a primary or secondary diagnosis related to abuse and/or misuse of prescription opioids and/or heroin**

- This set of diagnoses is broader than the set used to calculate DPH's previously published estimates of deaths averted (see appendix for ICD-9 codes used in each analysis)

Geographic regions

The HPC's standard regions, described in the HPC's Cost Trends Report***

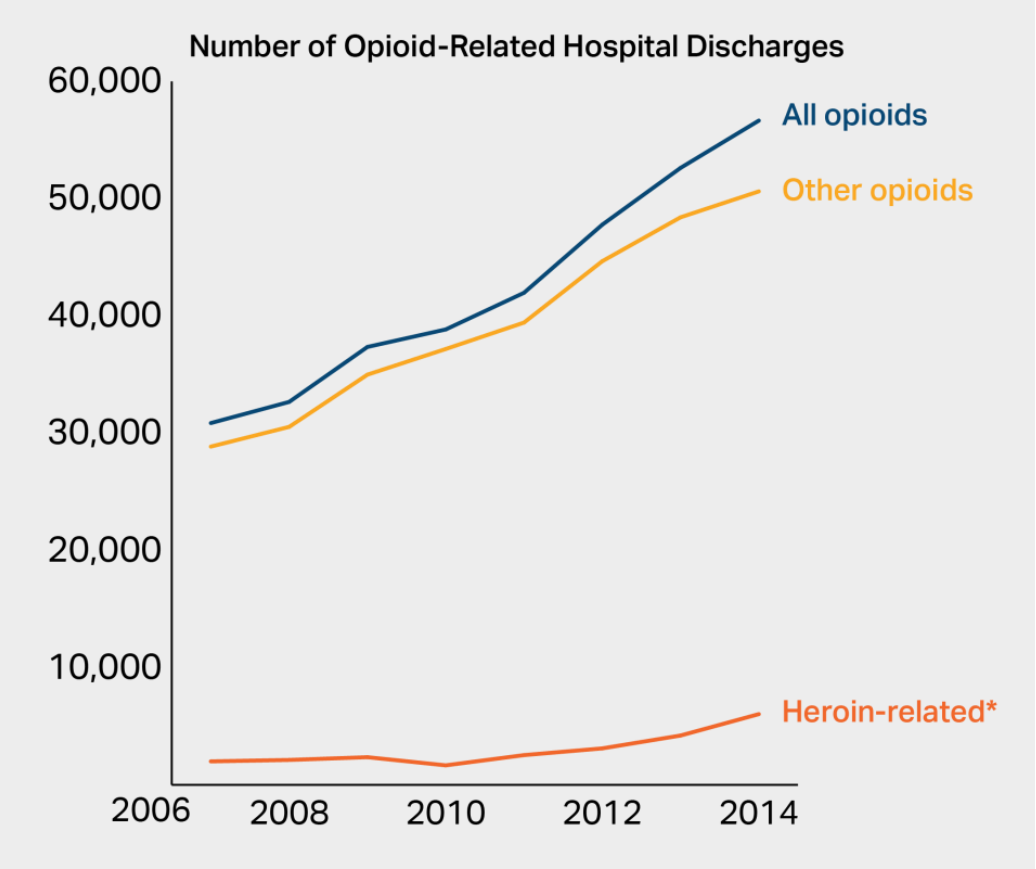
Note: *Methadone data as of 11/20/2015; Buprenorphine data as of 11/5/2015; Naltrexone data received on 8/20/2015 - Naltrexone data only includes those providers who prescribed Vivitrol for 10 or more patients between July 2014 and June 2015

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

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

HPC

HPC analyses show the number of opioid-related hospital discharges increased substantially since 2007, driven by illicit & prescription opioids



Rate of Change of Opioid-Related Hospital Discharges

Years	Heroin-related	Other opioids
2007-2008	6%	6%
2008-2009	11%	15%
2009-2010	-29%	6%
2010-2011	52%	6%
2011-2012	23%	13%
2012-2013	35%	8%
2013-2014	43%	5%

201%

increase in heroin-related hospital discharges between 2007 and 2014

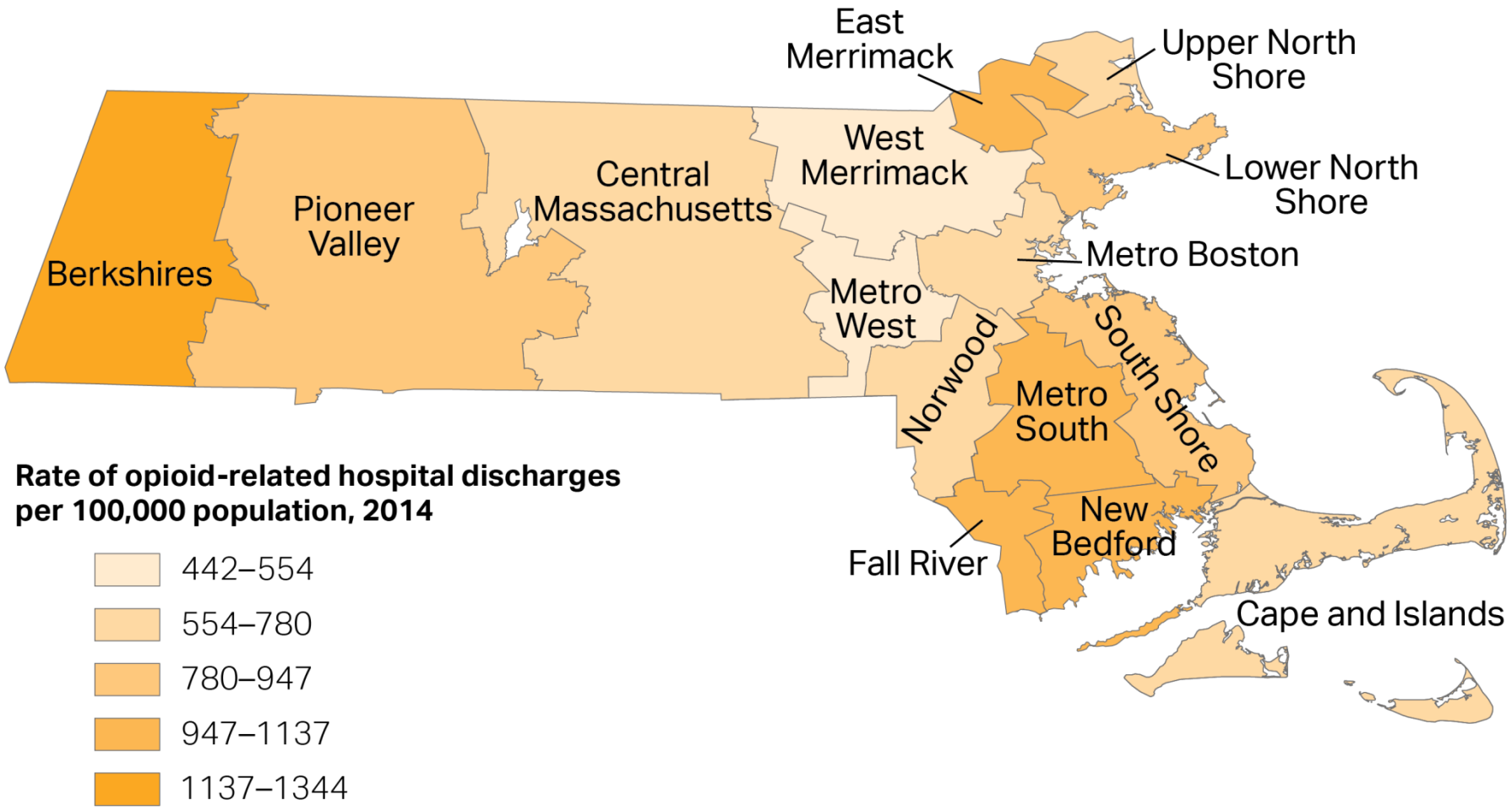
Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database, Outpatient Observation Database, and Emergency Department Database, 2007-2014

Note: Hospital discharges include ED discharges, inpatient discharges, and observation stay discharges. The remainder of analyses do not include observation stay discharges. Discharges with both a "heroin-related" and "other opioid" discharge code are counted only once in the "all opioids category", as well as in both of the sub-categories. For example, a patient coded with a heroin overdose and a non-heroin overdose would be counted once in the "heroin -related" category and once in the "other opioid" category. However, if a discharge had multiple diagnoses for the same sub-category (e.g., both a heroin overdose and heroin poisoning), the discharge would be counted only once in the heroin-related sub-category.

* This analysis is based on ICD-9 codes and includes discharges with an opioid-related primary or secondary diagnosis. As with all analyses dependent on ICD-9 codes, provider coding may not always fully accurately reflect the patient's clinical condition. In particular, heroin-related codes are considered specific, but not necessarily sensitive. For example, some hospitals may only use heroin-related codes for cases of poisoning/overdose. As result, some heroin abuse/dependence is likely captured in the "other opioids" category. Furthermore, some non-heroin opioid cases are likely captured in the "heroin-related" category.

HPC

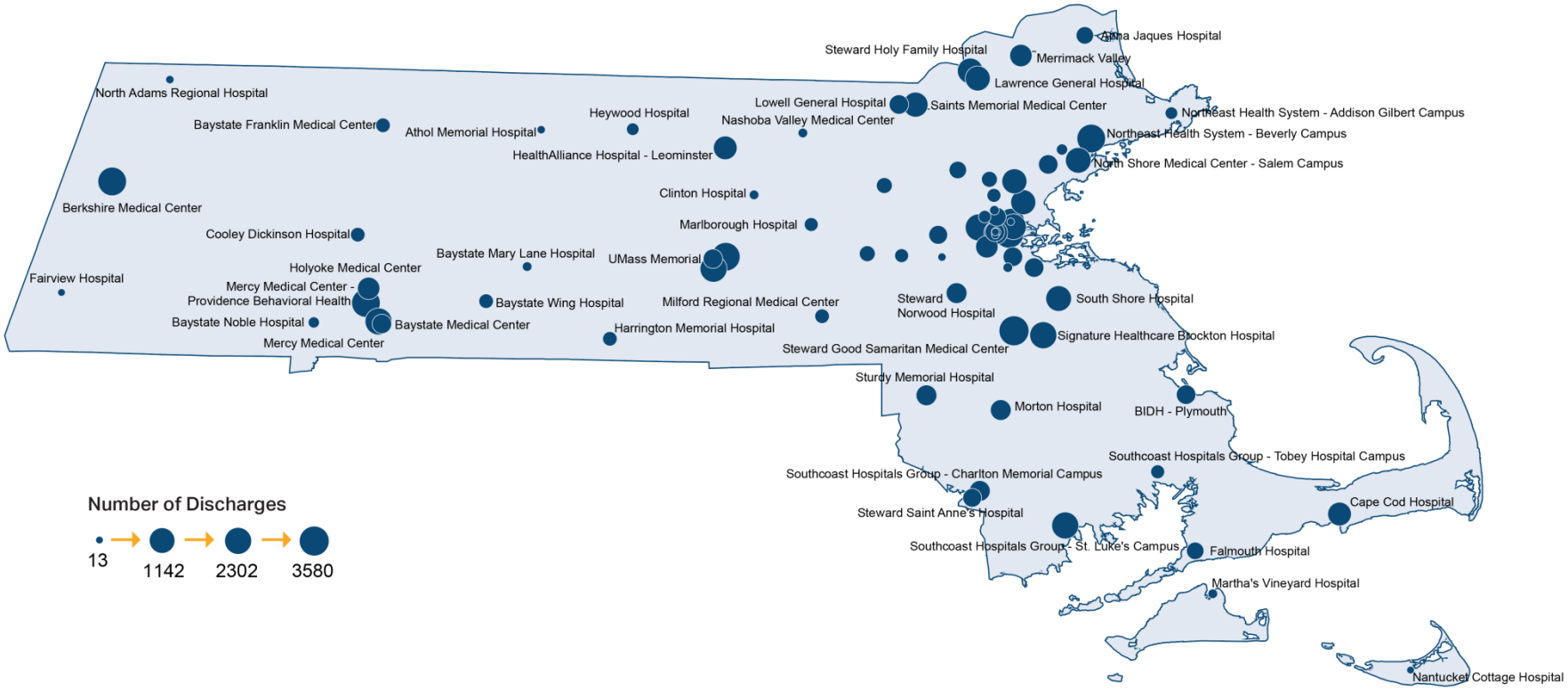
The rate of opioid-related hospital discharges varies significantly across the Commonwealth (mapped by patient's zip code, not site of care)



Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014; 2010-2014 American Community Survey 5 year estimates

Note: Hospital discharges include both ED and inpatient discharges, but not observation stays. Rate per 100,000 is comprised of averaged census data between 2010 and 2014.

Several hospitals across the Commonwealth treat large numbers of patients for opioid-related illness (mapped by total volume per hospital)

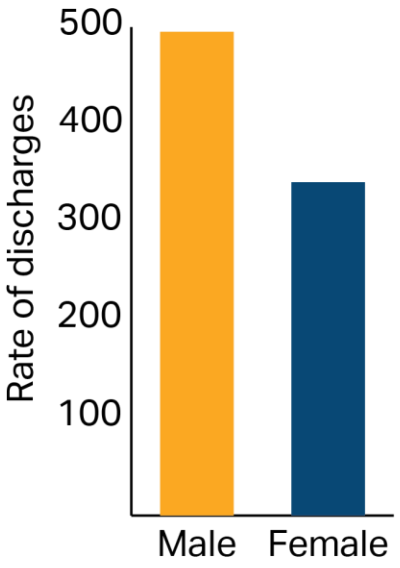


Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database and Emergency Department Database, 2014
Note: Hospital discharges includes both ED and inpatient discharges, but not observation stays.

Males, young adults and individuals from low-income communities were more likely to have opioid-related inpatient discharges in 2014

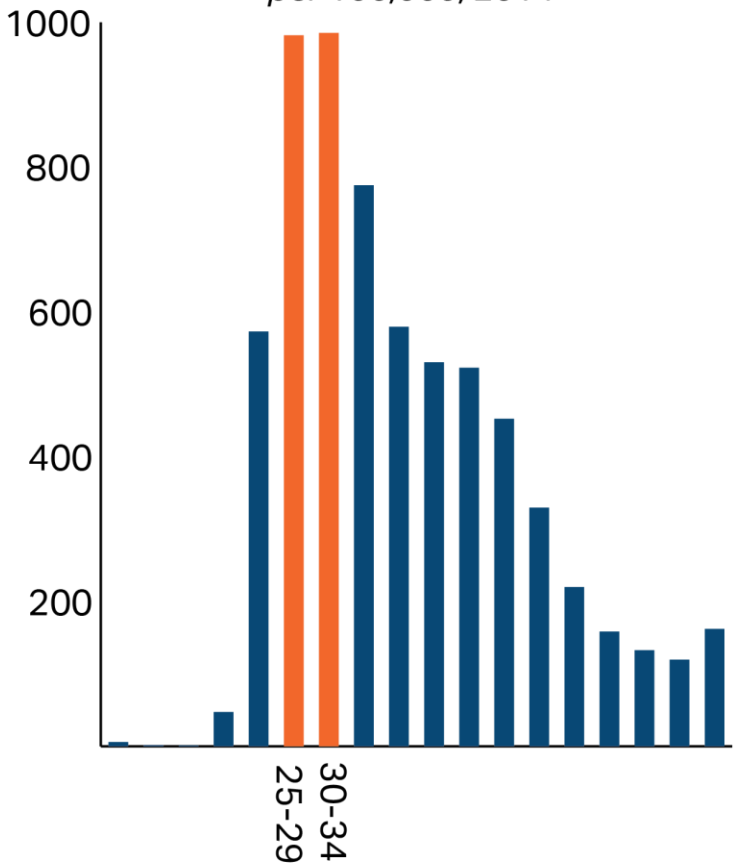
Inpatient Discharges by Gender

Opioid–related inpatient discharges per 100,000, 2014



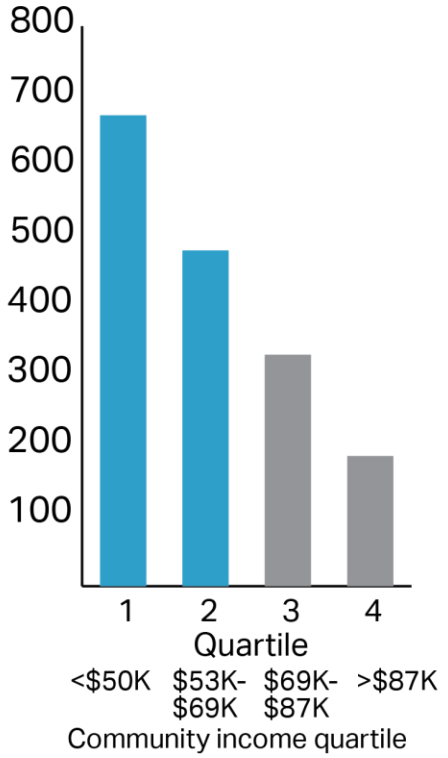
Inpatient Discharges by Age

Opioid–related inpatient discharges per 100,000, 2014



Inpatient Discharges by Income Quartile

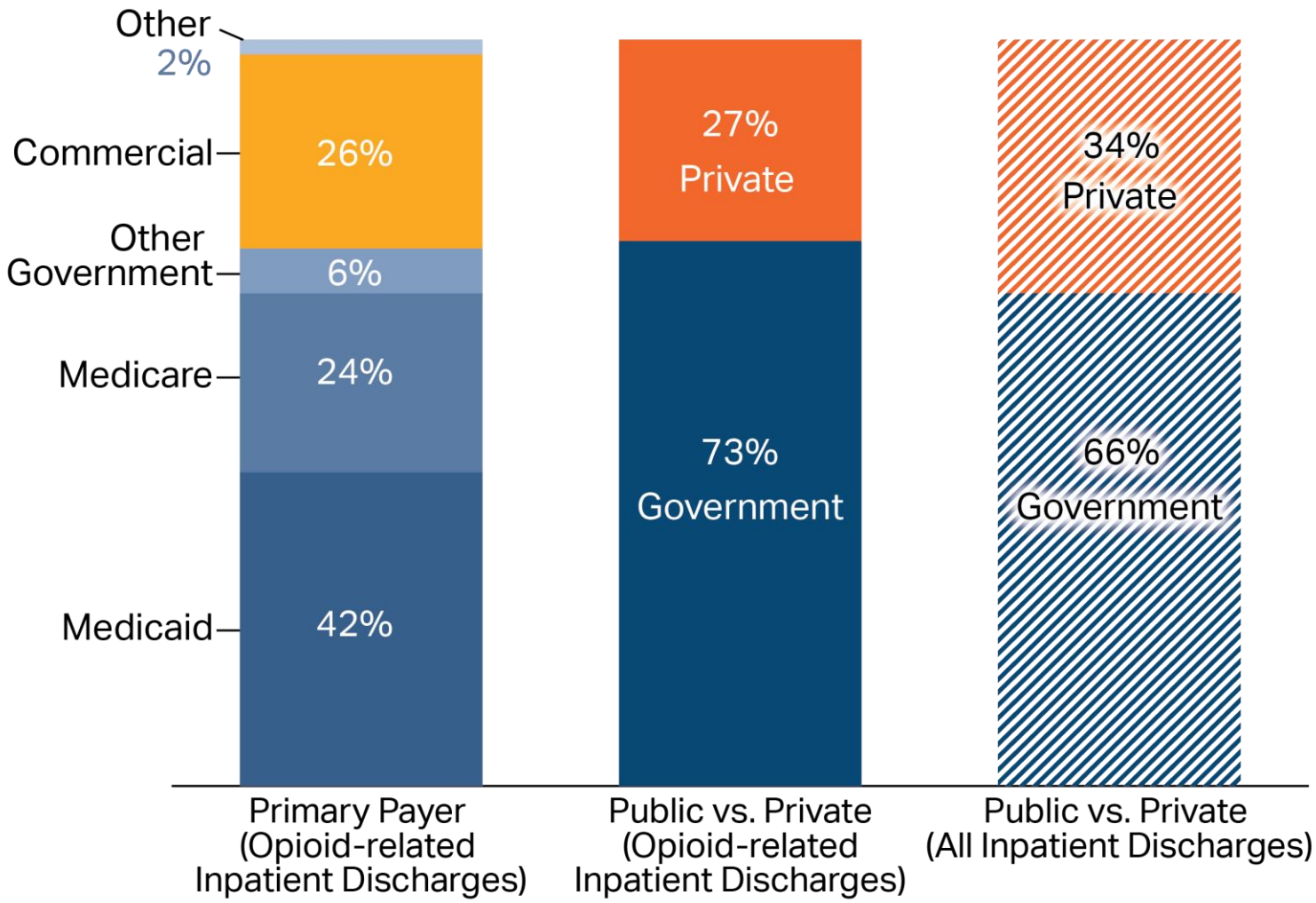
Opioid–related inpatient discharges per 100,000, 2014



Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database, 2014; 2010-2014 American Community Survey 5 year estimates

Note: Data includes only inpatient discharges not ED discharges or observation stays. Rate per 100,000 is comprised of averaged census data between 2010 and 2014.

Public payers cover the majority of cost of opioid-related inpatient discharges



Source: HPC Analysis—CHIA, Hospital Inpatient Discharge Database, 2014

Note: The percentages indicate the principal payer for opioid-related inpatient discharges in 2014 (n=17,756). For those dually eligible for Medicaid and Medicare, Medicare is the principal payer. Data includes only inpatient discharges, and does not include ED discharges or observation stays.

The rate of neonatal abstinence syndrome (NAS) is increasing as the opioid epidemic worsens, due to increased rates of in utero exposure to opioids

- NAS is a clinical syndrome caused by in utero exposure to opioids or other substances* that is marked by low birth weight, respiratory distress, feeding difficulty, tremors, increased irritability and crying, diarrhea, and occasionally, seizures.
- Nationally, the number of infants born with NAS has increased fivefold in the past decade.
- In 2009, the rate of NAS in Massachusetts was approximately three times higher than the national average.
- Although pharmacologic treatment (e.g., buprenorphine, methadone) can cause NAS, pregnant women should not have limited access to treatment, due to the associated risk of addiction relapse, which can cause far greater harm to fetal development and early development.

* (e.g., selective serotonin reuptake inhibitors, benzodiazepines, inhalants, and methamphetamine).

Source:

American College of Obstetricians and Gynecologists. Opioid abuse, dependence, and addiction in pregnancy. Committee Opinion No. 524. Obstetrics & Gynecology. 2012;119(5):1070-6.

Gupta, M. and Picarillo, A. Neonatal abstinence syndrome (NAS): improvement efforts in Massachusetts. NeoQIC Meeting. January 2015.

Kocherlakota, P. Neonatal abstinence syndrome. 2014. *Pediatrics*. 134(2): 547 – 561

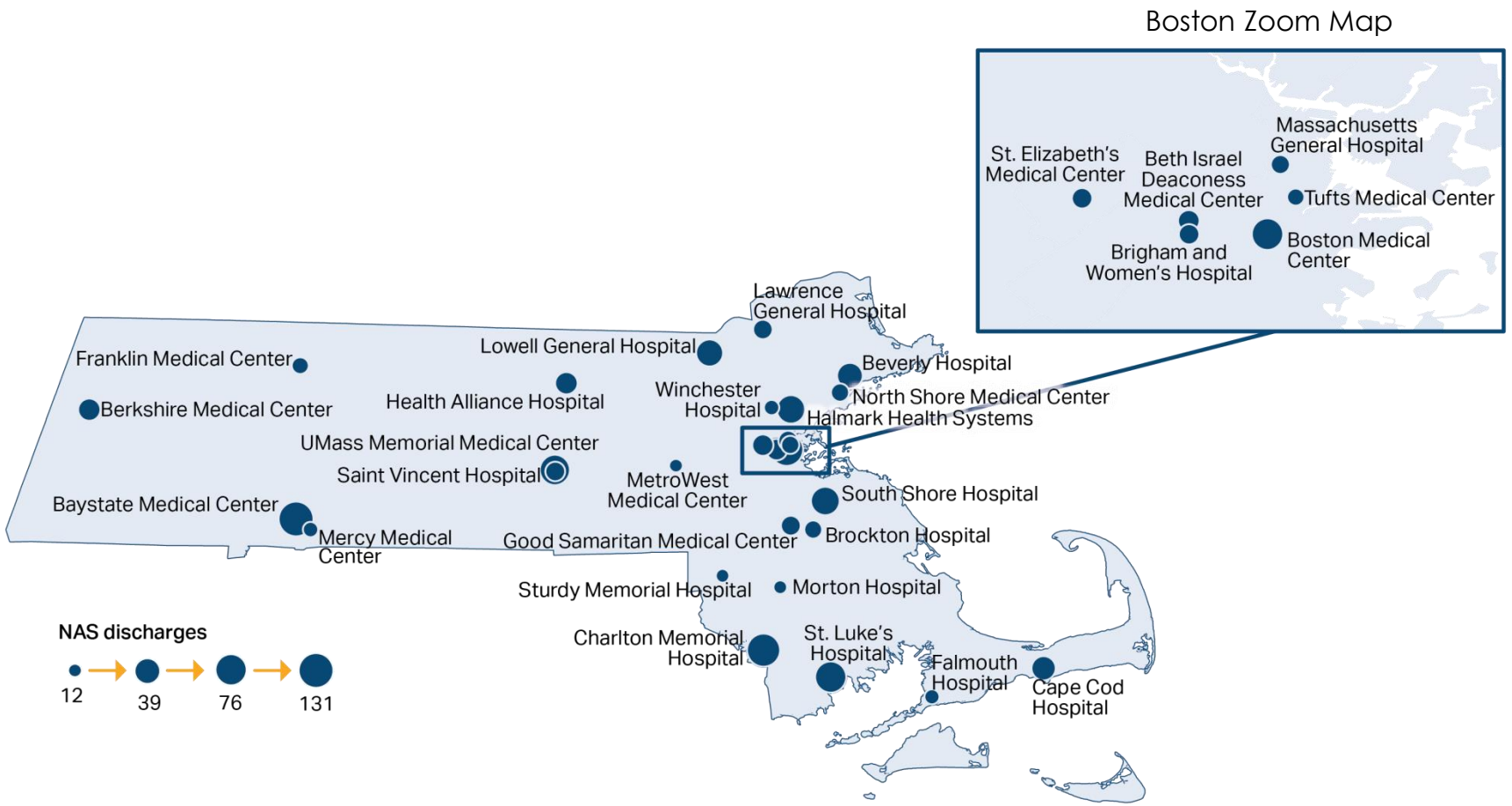
Lee, K.G. Neonatal abstinence syndrome. National Institute of Health, U.S. National Library of Medicine, MedlinePlus. https://www.nlm.nih.gov/medlineplus/ency/article/007313.htm. January 31, 2014. Accessed December 8, 2015.

Meyer, H. Weaning pregnant women off addictive drugs not harmful to fetus, study says. Modern Healthcare. 2016 Mar 31. Available from: http://www.modernhealthcare.com/article/20160331/NEWS/160339989?utm_source=modernhealthcare&utm_medium=email&utm_content=20160331-NEWS-160339989&utm_campaign=dose

Patrick SW, Schumacher RE, Benneyworth BD, Krans EE, McAllister JM, Davis MM. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. *JAMA*. 2012. 307(18):1934-40.

Peltz, G and Anand, K.J.S.. Long-Acting Opioids for Treating Neonatal Abstinence Syndrome: A High Price for a Short Stay?. 2015.

The volume of NAS varies among hospitals and across the Commonwealth



Source: HPC analysis of Center for Health Information and Analysis, Inpatient Discharge Database, 2014
Note: Only includes hospitals with 12 or more NAS discharges using ICD-9-CM diagnosis code 779.5 (drug withdrawal syndrome in a newborn). Data does not include ED discharges or observation stays.

High rates of opioid-related hospital utilization suggest outpatient pharmacologic treatment options are not easily accessible

Opioid addiction is most effectively treated with protocols that combine prescription medication with behavioral health services. Pharmacologic treatment reduces rates of addiction, infectious disease transmission, and opioid-related hospital utilization.

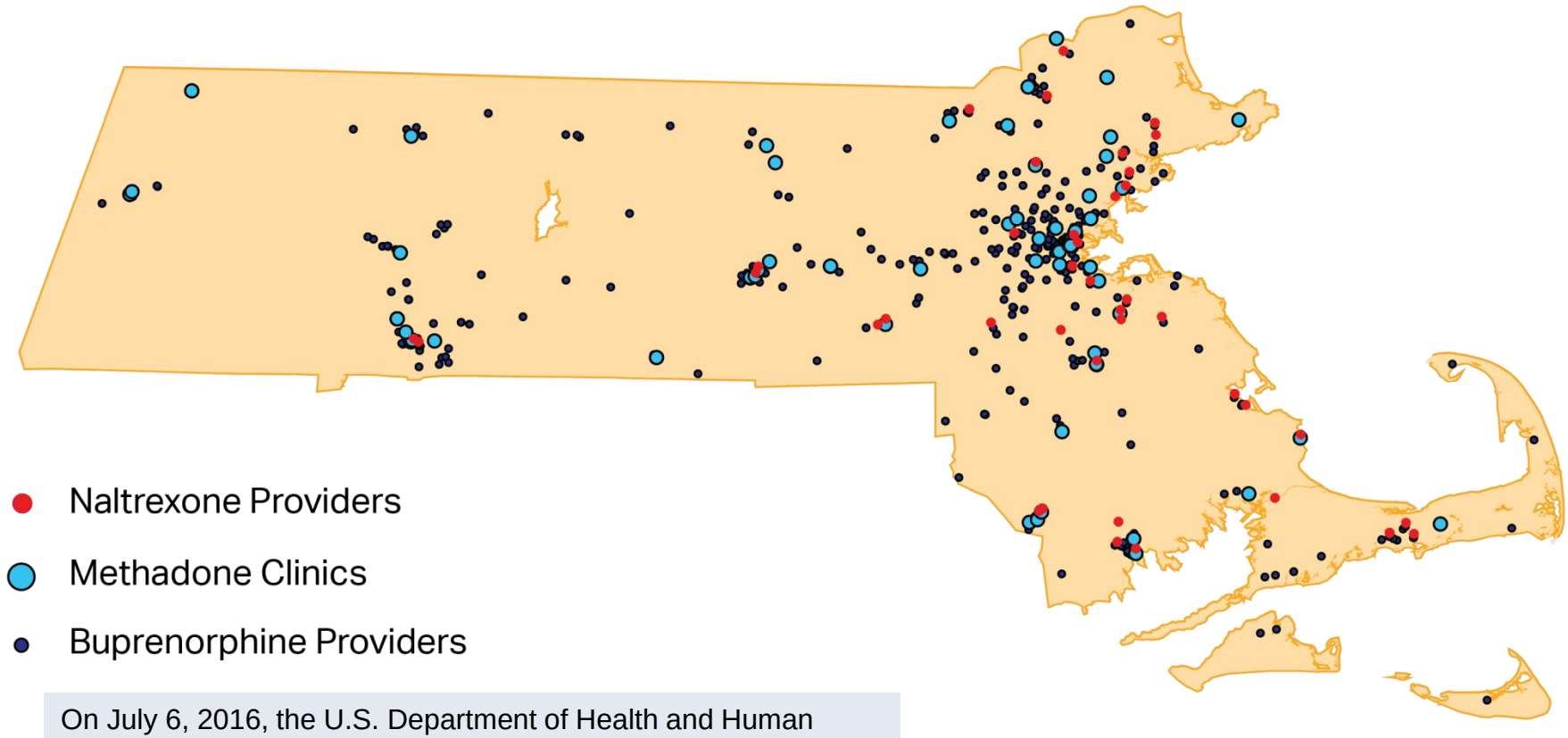
Yet, pharmacologic treatments for opioid use disorder are not widely utilized – in 2012, **fewer than 50%** of adults and adolescents suffering from opioid addiction received pharmacologic treatment (nationally).

Three types of pharmacologic intervention
Methadone – Reduces addiction cravings and blocks opiate receptors. Must be administered daily in **federally licensed** Opioid Treatment Program, which can limit access due to travel and cost constraints; many patients are not able or willing to attend and/or pay for daily visits.
Buprenorphine – Reduces addiction cravings and blocks opiate receptors. Patients can receive a prescription from any buprenorphine-licensed **physician**, rather than having to regularly visit a specialized clinic.
Naltrexone – Blocks opiate receptors. Can be prescribed by any health care **provider** licensed to prescribe medications.

Source: Federal Register. Medication Assisted Treatment for Opioid Use Disorders. https://www.federalregister.gov/articles/2016/07/08/2016-16120/medication-assisted-treatment-for-opioid-use-disorders July 2016. Accessed July 8, 2016..; 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.; 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

HPC

Availability of pharmacologic treatment intervention varies widely by region, with no clear relationship to the burden of the epidemic



On July 6, 2016, the U.S. Department of Health and Human Services **increased the federal buprenorphine patient cap from 100 to 275**

Source:

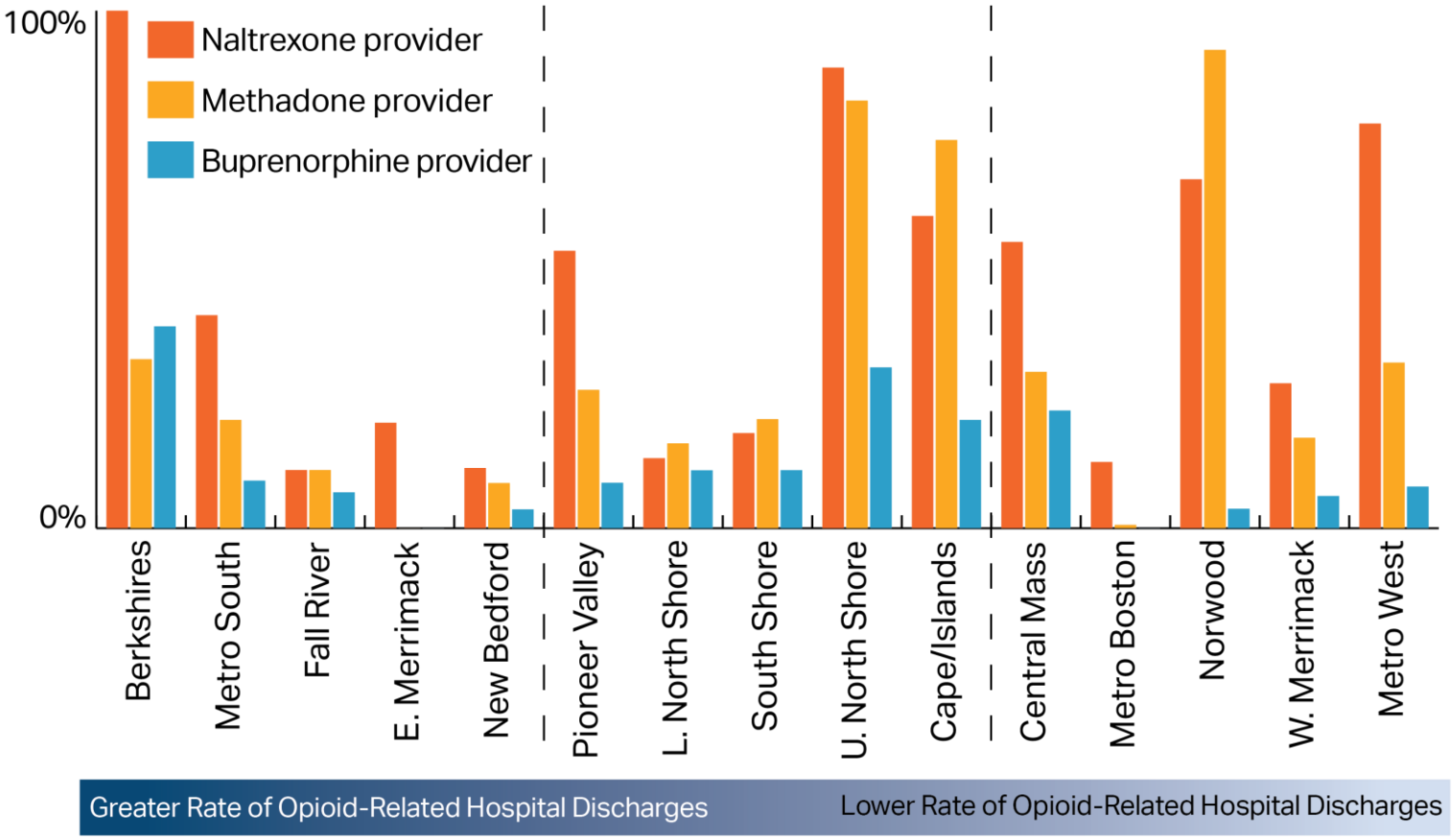
Methadone: Substance Abuse and Mental Health Services Administration. Opioid Treatment Program Directory (data retrieved from http://dpt2.samhsa.gov/treatment/directory.aspx on 11/20/2015)

Buprenorphine: Substance Abuse and Mental Health Services Administration. Buprenorphine Treatment Physician Locator (data retrieved from http://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator on 11/5/2015)

Naltrexone: Prescriber lists provided by Alkermes Pharmaceuticals (data received on 8/20/2015). Naltrexone list include only those who prescribed Vivitrol for 10 or more patients between July 2014 and June 2015

HPC

There is regional variation in the percentage of patients who had opioid-related hospital discharges who would have to travel more than 5 miles to access pharmacologic treatment for opioid use disorder



HPC **Source**: HPC analysis-CHIA Hospital Inpatient Discharge Database and Emergency Department Database, 2014

MASSACHUSETTS
HEALTH POLICY COMMISSION

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    - Mandates for HPC and other agency work targeting opioid epidemic
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Integrating behavioral health into primary care: PCMH PRIME

Criteria (practice must meet ≥ 7 out of 13)
The practice has MOUs with BHPs and/or co-located BHPs (e.g., same building)
The practice integrates BHPs within the practice
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
The practice collects and regularly updates a comprehensive health assessment that includes developmental screening using a standardized tool
The practice collects and regularly updates a comprehensive health assessment that includes depression screening using a standardized tool
The practice collects and regularly updates a comprehensive health assessment that includes anxiety screening using a standardized tool
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)
For patients who have recently given birth, the practice screens for post-partum depression using a standardized tool (e.g., at 6 weeks and 4 months)
The practice tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports
The practice implements clinical decision support following evidence based guidelines for a mental health and substance use disorder
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
The practice has at least one clinician who is providing treatment for substance use disorder with both medication-assisted treatment (MAT) and behavioral therapy. Behavioral therapy may be provided either directly or via referral.
If practice includes a care manager, s/he must be qualified to identify/coordinate behavioral health needs

HEALTH POLICY COMMISSION PCMH PRIME CERTIFIED 2016

HPC

BHI TA for Pathway to PRIME practices

HPC is working with Health Management Associates to create, monitor, manage the technical assistance program that includes each of the 13 PRIME criteria.

Requirement for TA	Description
Includes mix of broad and practice-specific TA modes	• Includes some one-on-one practice coaching opportunities • Includes broad-based learning opportunities for all practices (e.g. learning collaboratives) • Does not rely on webinars or online modules • Matches practices with appropriate content and mode
Focuses on most challenging PCMH PRIME criteria	• Prioritizes delivering TA on the criteria practices need most help with • Able to offer TA on any of the 13 PCMH PRIME criteria as needed
Accommodates practices on different timelines	• Allows multiple opportunities for practices to receive similar content/assistance • Ensures whenever a practice enters the TA program, it has opportunities to learn from other practices
Delivers maximum value to practices and HPC	• Hiring one vendor instead of multiple minimizes administrative costs and maximizes the share of contract dollars spent on direct practice TA • Utilizes current TA available / partners with MA organizations already providing support to practices • Reports regularly to HPC on practice progress

Fully integrated care delivery systems: ACO certification

Vision of Accountable Care	A health care system that efficiently delivers well-coordinated, patient-centered, high-quality health care, integrates behavioral and physical health, and produces optimal health outcomes and health status.
Behavioral Health Integration and Accountable Care	ACO certification criteria incents providers to better meet the needs of patients with behavioral health disorders. For example: • An ACO must routinely stratify entire patient population and use the results to **implement programs targeted at improving health outcomes for highest need patients**. At least one program must address **behavioral health** and at least one program must address **social determinants of health** to reduce health disparities within the ACO population. • To **coordinate care and services across the care continuum**, the ACO must **collaborate with providers outside the ACO** as necessary, including behavioral health providers, specialists, post-acute care and hospitals.

HPC CHART investments: Supporting broad-based community health coalitions

Highlight: Beth Israel Deaconess Hospital - Plymouth

- Working to reduce ED utilization for patients with a primary behavioral health diagnosis through its **Integrated Care Initiative (ICI)**
- The ICI provides patients with an addiction assessment in the ED, coupled with follow-up services and linkage to detox, outpatient MAT and primary care
- Partnership with **Clean Slate Centers and Harbor Health Services** to provide outpatient **MAT** upon discharge from ED
- Collaboration with the **Plymouth Police Overdose OUTREACH** (Opioid User Taskforce to Reduce Epidemic And Care Humanely) Program to provide outreach and services to patients that have overdosed
- ICI clinicians provide referrals to the **Plymouth Drug and Mental Health Court** for patients with open charges that appear to be related to addiction.

Other CHART Investments Profiled

- Berkshire Medical Center
- Harrington Memorial Hospital
- Hallmark Health System
- HealthAlliance Hospital

HPC

This slide provides a sample of CHART initiatives focusing interventions for patients with opioid dependence and is not exhaustive.

HPC Investments: Testing and scaling promising models of care delivery that improve access to and/or quality of behavioral health services

1. **Mother and Infant-Focused NAS Interventions**
   Investing in hospital quality improvement initiatives to reduce TCOC between delivery and discharge of opioid exposed newborns and working with DPH to improve retention in pharmacologic treatment for pregnant and post-partum women

2. **Targeted Cost Challenge Investments**
   Funding collaborations that improve SUD care coordination and increase access to and efficiency of treatment while reducing TCOC

3. **Telemedicine Pilots**
   Increasing access to SUD treatment by funding bedside consults and post-discharge follow-up for patients hospitalized with co-morbid diagnoses

4. **Initiation of pharmacologic treatment for SUD in the ED setting**
   Initiating pharmacologic treatment and establishing partnerships that will facilitate connection with outpatient providers

5. **Data-Driven Provider Performance Improvement Initiatives**
   Providing prescribers with data to improve ability to address pain in ED settings

HPC

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Proposed policy recommendations for discussion

- **Improved data collection & monitoring:** the Commonwealth should systematically track the impact of the opioid epidemic on the health care system and the availability of evidence-based pharmacologic treatment.
- **Care delivery integration & payment reform :** the Commonwealth should increase access to opioid use disorder treatment by integrating pharmacologic interventions into systems of care.

  Payers should support the **integration** of opioid use disorder treatment into **primary care**, ensure **adequate networks of community-based behavioral health providers** to improve access to community-based care, support **initiation of opioid use disorder treatment in acute care settings** in coordination with accountable, integrated systems that allow for timely access to follow-up care, and **facilitate collaboration** between providers of different levels of care to **minimize loss to follow-up during transitions between settings**.
- **Community-based multi-stakeholder coalitions:** the Commonwealth should support coordinated, multi-stakeholder coalitions to address the impact of the opioid epidemic locally.
- **Testing & scaling innovative care models to improve access to and quality of treatment**: the Commonwealth should test, evaluate, and scale innovative care models for treating opioid use disorder and related conditions (e.g., NAS).

MASSACHUSETTS
HEALTH POLICY COMMISSION

Vote: Issuance of report on opioid use disorder in Massachusetts

Motion: That, pursuant to section 31 of chapter 258 of the Acts of 2014, the Commission hereby authorizes the issuance of the attached report on opioid use disorder in Massachusetts.

MASSACHUSETTS
HEALTH POLICY COMMISSION

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CHART Phase 2: Progress as of September 2016

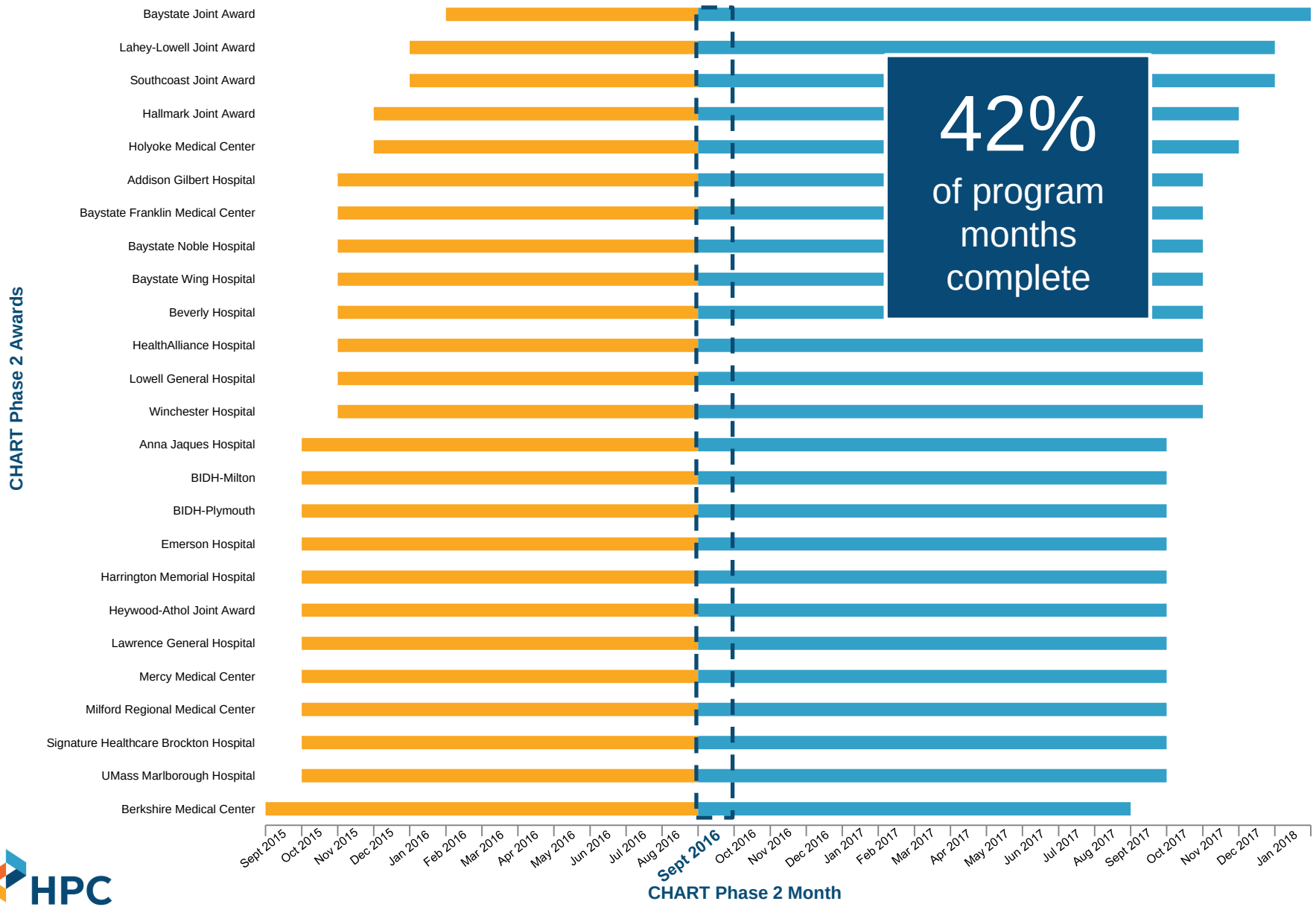


CHART Phase 2: Activities since program launch[1]

8

regional meetings

with

400+

hospital and community provider attendees

120

technical assistance working meetings

380+

hours of coaching phone calls

9

CHART newsletters


March 2016

Welcome

Featured Topic

CHART Patient Story

Measure Update

CHART Evaluation Data Requirement

NE QIN-QIO

Share Your Work

COMMUNITY HOSPITAL ACCELERATION, REVITALIZATION AND TRANSFORMATION PROGRAM

MASSACHUSETTS

CHART Regional Meetings

Welcome!

Featured Topic: Notes from Community Partnerships

2,150 unique visits to the CHART hospital resource page

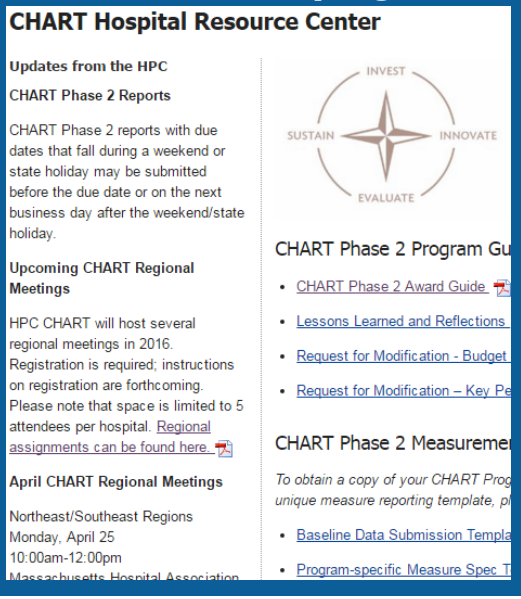


CHART Hospital Resource Center

Updates from the HPC

CHART Phase 2 Reports

CHART Phase 2 reports with due dates that fall during a weekend or state holiday may be submitted before the due date or on the next business day after the weekend/state holiday.

Upcoming CHART Regional Meetings

HPC CHART will host several regional meetings in 2016. Registration is required; instructions on registration are forthcoming. Please note that space is limited to 5 attendees per hospital. Regional assignments can be found here.

April CHART Regional Meetings

Northeast/Southeast Regions
Monday, April 25
10:00am-12:00pm
Massachusetts Hospital Association

INVEST
SUSTAIN
INNOVATE
EVALUATE

CHART Phase 2 Program Gu

- CHART Phase 2 Award Guide
- Lessons Learned and Reflections
- Request for Modification - Budget
- Request for Modification – Key Pe

CHART Phase 2 Measuremer

To obtain a copy of your CHART Prog unique measure reporting template, pl

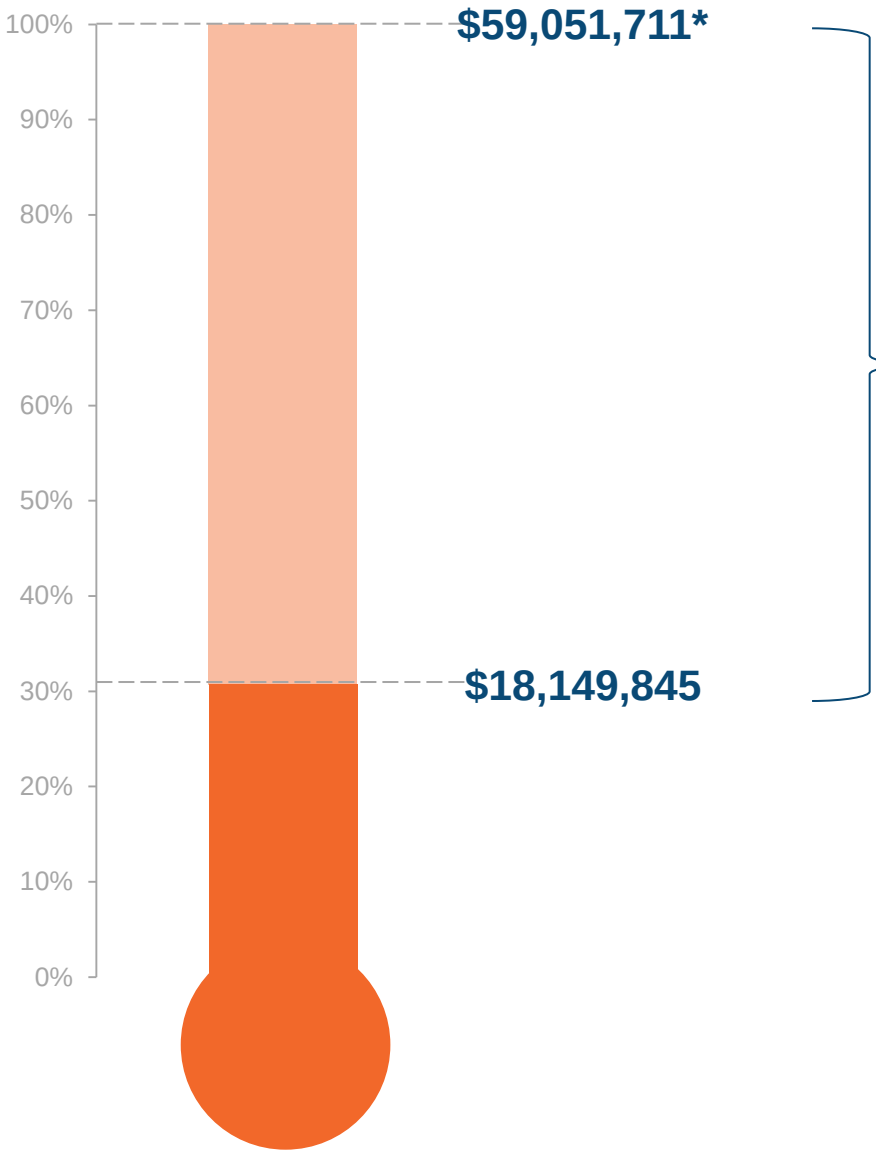
- Baseline Data Submission Templa
- Program-specific Measure Spec T

225+

data reports received

[1] Updated through August 25 2016. Phase 2 hospital programs launched on a rolling basis beginning September 1, 2015

CHART Phase 2: The HPC has disbursed $18.1M to date



Remaining
$40,901,866
is inclusive of
$7,217,898
maximum outcome-based Achievement Payment opportunity

Updated August 28, 2016

* Not inclusive of Implementation Planning Period contracts. $100,000 per awardee hospital authorized March 11, 2015.

PCMH PRIME update: 49 participating practices in 8 months since program launch

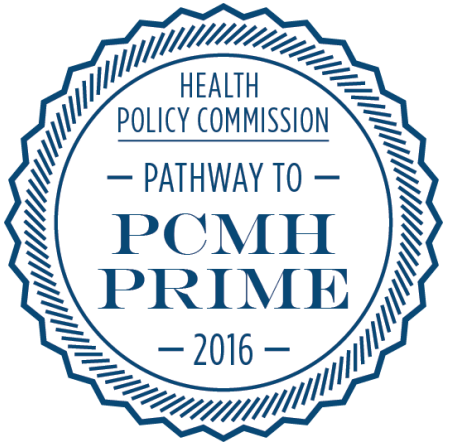
Since January 1, 2016 program launch:

3 practices
are PCMH PRIME Certified
Fenway South End
Lynn Community Health Center
East Boston Neighborhood Health Center

6 practices
have applications under review for PCMH PRIME Certification

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

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



HPC

RPO Program: Status Update

Initial Registration Part 1

In the first year of the program the HPC divided the registration requirement into two parts to minimize the burden on Provider Organizations.

Initial Registration Part 2

Provider Organizations submitted information in the categories outlined in the HPC's statute. Provider Organizations are required to renew their registration biennially.

Annual reporting

Provider Organizations annually report information in the categories outlined in CHIA's statute. Three of the ten categories appear in the HPC's statute.

RPO Program: Approach to Future Development and Administration

Collaborative Program Development

HPC CHIA

Agencies jointly define and prioritize data elements and design the online submission platform

Single-Agency Program Administration

HPC

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

MASSACHUSETTS
HEALTH POLICY COMMISSION

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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

MASSACHUSETTS
HEALTH POLICY COMMISSION

APPENDIX: OPIOID USE DISORDER REPORT

An Act relative to Substance Use, Treatment, Education and Prevention (1/2)

Bill. No. 4056

Passed unanimously and signed on March 14, 2016 by Governor Baker

Includes a number of recommendations from the Governor's Opioid Working Group

Key provisions relating to health care system

Mandatory evaluation of patients presenting with opioid overdose symptoms (effective July 1, 2016)

- Must be conducted w/in 24 hrs of arrival at ED
- If treatment is indicated, must be offered (inpatient or outpatient)
- If patient refuses treatment, must be provided with information on outpatient resources
- Evaluation must be covered by all payers

7-Day supply limit on opiate prescriptions (effective immediately)

- First time prescriptions to adults cannot exceed 7 day supply
- No prescription to minor can exceed 7 day supply
- Exceptions for emergencies, chronic pain, palliative care, oncology

Partially filling prescriptions (effective immediately)

- Pharmacist may partially fill schedule 2 drug at patient's request, but may elect not to
- Unfilled portion of prescription is void

HPC

An Act relative to Substance Use, Treatment, Education and Prevention (2/2)

Sections of particular relevance to the HPC

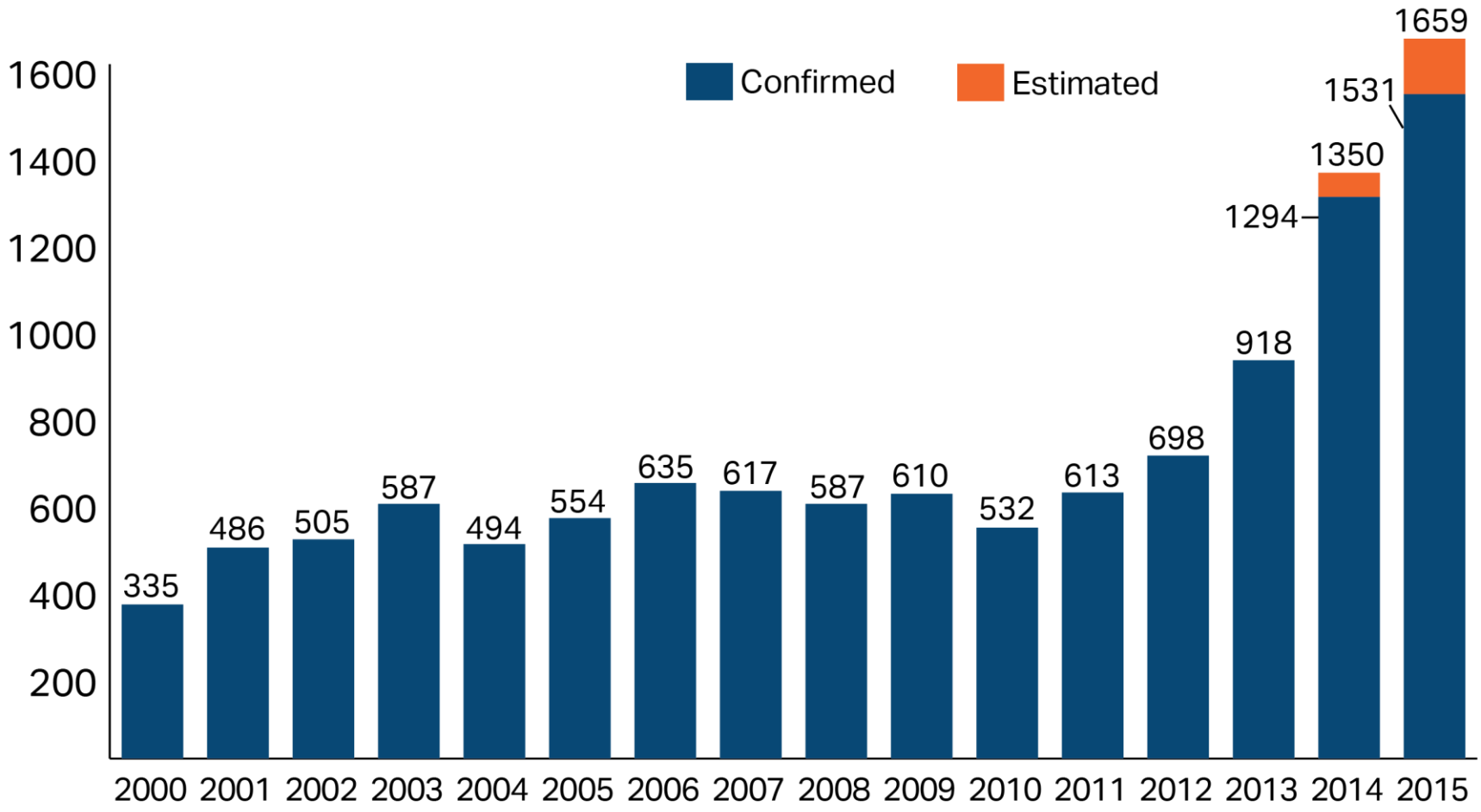
1. Requires the HPC, in consultation with DPH and DMH, to study and report on the availability of health care providers that serve patients with dual diagnoses of substance use disorder and mental illness, in inpatient and outpatient settings. The commission shall report to the joint committee on mental health and substance abuse and the house and senate committees on ways and means no later than 12 months following completion of the study.

2. Establishes a special commission to examine the feasibility of establishing a pain management access program, with the goal of increasing access to pain management for patients in need of comprehensive pain management resources. The executive director of the HPC shall serve on the commission. The commission shall begin meeting in June, 2016, and submit its recommendations along with drafts of any legislation by December 1, 2016.

3. Requires carriers to report to the Office of Patient Protection (OPP) on the total number of medical or surgical claims and mental health or substance use disorder claims submitted to and denied by the carrier.

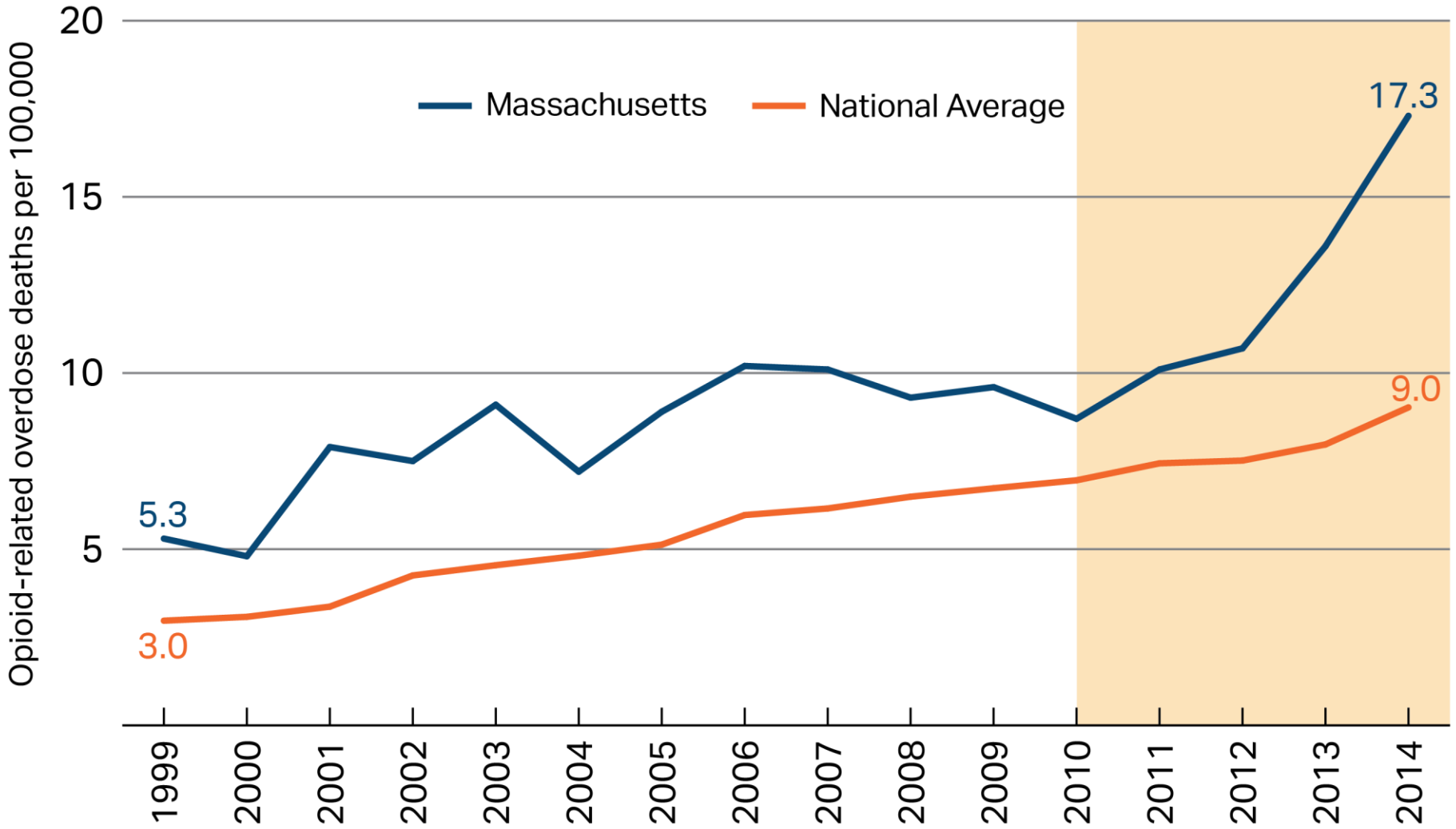
4. Amends statute governing consumer appeal process for risk-bearing provider organizations (RBPOs) & accountable care organizations (ACOs) to require provider denials to inform patients of the right to appeal the decision to the OPP.

DPH data on opioid-related deaths demonstrate marked increase in opioid use disorder since 2000



Source: Massachusetts Department of Public Health, August 2016
Note: Suicides are excluded from this analysis.

The rate of opioid-related drug overdose deaths in Massachusetts increased more rapidly than nationally (2010-2014)



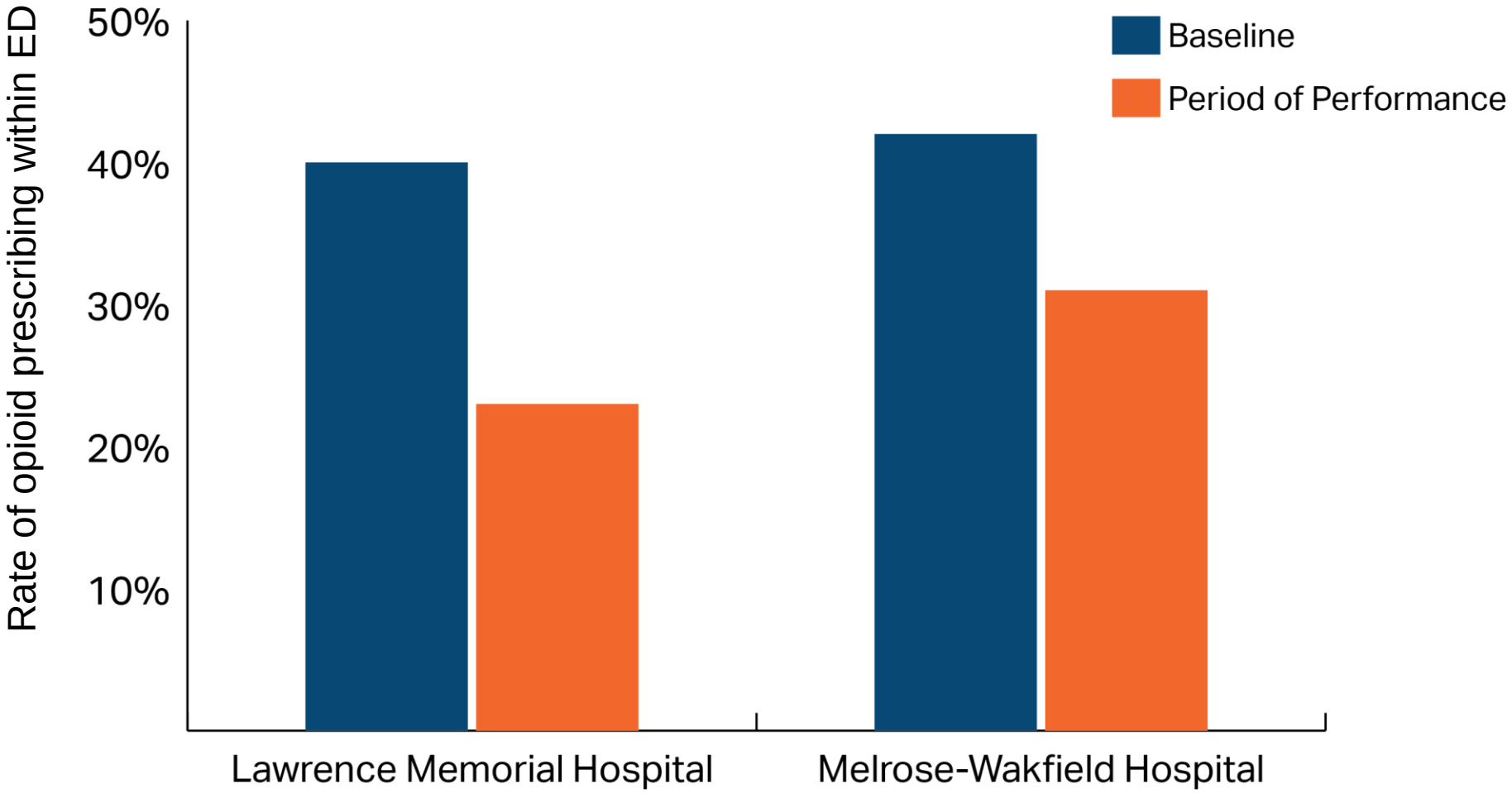
See data note

Source: Multiple Cause of Death data (1999-2014) are produced by the Division of Vital Statistics, National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services (US DHHS)

Note: **Rates based on NCHS data differ from DPH published rates because DPH uses a statistical file that is closed later than the NCHS file and includes more cases that have a final cause of death assigned.** Massachusetts numbers are not included in the age-adjusted weighted national average. 2015 data are not yet available from the CDC.

HPC

Innovative ways to make practice pattern data available to providers improves ability to treat pain in emergency settings



Source: Data provided by Hallmark Hospital System. Figure adapted from the Health Policy Commission Community Hospital Acceleration, Revitalization, and Transformation Program: Phase 1 – Foundational Investments for Transformation Report

ICD-9-diagnosis codes used in HPC and DPH opioid-related hospital discharge analyses

ICD-9-CM diagnosis code	Description	HPC	DPH
304	OPIOID DEPENDENCE-UNSPECIFIED	X	
304.01	OPIOID DEPENDENCE-CONTINUOUS	X	
304.02	OPIOID DEPENDENCE-EPISODIC	X	
304.03	OPIOID DEPENDENCE, IN REMISSION	X	
304.7	OPIOID OTHER DEP-UNSPECIFIED	X	
304.71	OPIOID OTHER DEP-CONTINUOUS	X	
304.72	OPIOID OTHER DEP-EPISODIC	X	
304.73	OPIOID OTHER DEP-IN REMISSION	X	
305.5	OPIOID ABUSE-UNSPECIFIED	X	
305.51	OPIOID ABUSE-CONTINUOUS	X	
305.52	OPIOID ABUSE-EPISODIC	X	
305.53	OPIOID ABUSE-IN REMISSION	X	
965	OPIUM POISONING	X	X
965.01	HEROIN POISONING	X	X
965.09	POISONING BY OTHER OPIATES AND RELATED NARCOTICS	X	X
E850.0	ACCIDENTAL POISONING BY HEROIN	X	X
E850.2	ACCIDENTAL POISONING BY OTHER OPIATES AND RELATED NARCOTICS	X	X
E935.0	ADVERSE EFFECTS OF HEROIN	X	
E935.2	OTHER OPIATES AND RELATED NARCOTICS CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE	X	

HPC

Note: HPC's methodology is adapted from a method developed by AHRQ (http://www.ncbi.nlm.nih.gov/books/NBK246983/).