MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Market Oversight and Transparency Committee

February 15, 2024

Agenda

CALL TO ORDER

Approval of Minutes **(VOTE)**

DataPoints Issue #26: Landscape and Utilization of Ambulatory Surgical Centers in Massachusetts

Federal Regulatory Update: Automation of Prior Authorization

Federal Regulatory Update: Department of Justice/Federal Trade Commission Merger Guidelines

Guest Presentation: Executive Office of Health Human Services *Advancing Health Equity in Massachusetts* – Karen Tseng, Senior Advisor for Health Policy, EHS

Agenda

Call to Order

APPROVAL OF MINUTES (VOTE)

DataPoints Issue #26: Landscape and Utilization of Ambulatory Surgical Centers in Massachusetts

Federal Regulatory Update: Automation of Prior Authorization

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VOTE

Approval of Minutes

MOTION

That the Members hereby approve the minutes of the Committee meeting held on **October 4, 2023**, as presented.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DATAPOINTS ISSUE #26: LANDSCAPE AND UTILIZATION OF AMBULATORY SURGICAL CENTERS IN MASSACHUSETTS

Federal Regulatory Update: Automation of Prior Authorization

Federal Regulatory Update: Department of Justice/Federal Trade Commission Merger Guidelines

Guest Presentation: Executive Office of Health Human Services *Advancing Health Equity in Massachusetts* – Karen Tseng, Senior Advisor for Health Policy, EHS

Ambulatory surgical centers provide many of the same lower complexity surgeries that hospital outpatient departments provide, at a lower cost.

Ambulatory surgical centers (ASCs) are **freestanding facilities capable of providing non-emergency same-day surgeries**.

- ASCs provide low-risk procedures, which may also be performed in a hospital outpatient department (HOPD), or – for the most minor procedures – in an office setting.
- Some ASCs specialize in procedures for a single specialty (such as ophthalmology), while others are multispecialty.
- The top specialty services provided by ASCs nationally are **orthopedics, ophthalmology, endoscopy and pain management.**[1]

Nationally, about 95% of ASCs are **for-profit** entities; the majority have partial or complete **physician ownership**.[2,3]

- Physician owners earn income from ASC profits, in addition to professional fees.
- ASCs are exempt from the federal physician self-referral law ("Stark Law").

The 2023 Cost Trends Report found that ASCs typically had **lower commercial prices** for their services compared to the same services delivered in a HOPD setting.

Both Medicare and MassHealth pay lower rates for the same services provided in an ASC compared to a HOPD setting.

1.Medicare-certified ASCs by specialty type: https://www.ascassociation.org/about-ascs/surgery-centers
2.Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. March 2023. Available at: https://www.medpac.gov/wp-content/uploads/2023/03/Ch5_Mar23_MedPAC_Report_To_Congress_SEC.pdf
3.ASC Ownership: https://www.ascassociation.org/asca/about-ascs/surgery-centers/ownership

ASCs in Massachusetts mirror industry characteristics nationally.

As of 2023, there are **58** ASCs in Massachusetts licensed by the Massachusetts Department of Public Health.

- **54** of these are also certified as ASCs by the Center for Medicare & Medicaid Services (CMS), which enables them to receive Medicare payment. [1,2]
- These facilities have a total of 160 operating rooms.
- The top specialties in Massachusetts are similar to the U.S.: **orthopedics, ophthalmology, endoscopy and pain management.**[2]

About 90% of Massachusetts ASCs are **for-profit** entities.[2]

Most ASCs have partial or complete **physician ownership**, including joint ventures between physicians and hospitals and / or management companies.[3]

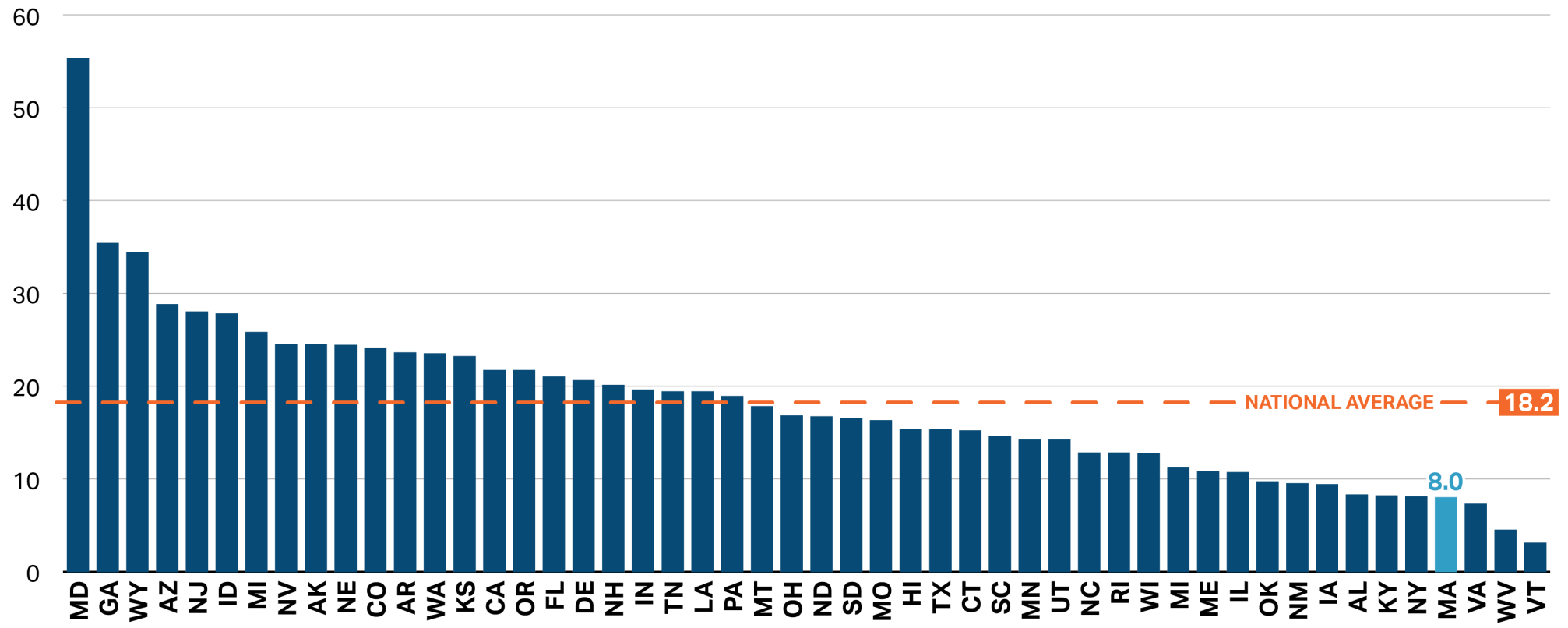
This DataPoints describes the ASC landscape in Massachusetts including:

- **location and services** provided by ASCs,
- **utilization** of ASCs services among commercial and MassHealth patients, and
- **prices and spending** for surgeries that could be performed in either an ASC or HOPD.

1. In addition to the active ASCs in the CMS provider dataset, DPH licenses 4 additional facilities, 3 of which appear to be joint ventures with hospital systems, and 1 is an abortion clinic.
2. HPC analysis of CMS Provider of Services file, Q2 2023
3. HPC communication with the Massachusetts Association of Ambulatory Surgical Centers

Massachusetts has the fourth fewest ASCs per capita among all states.

Number of ASCs per one million population, by U.S. state, 2023

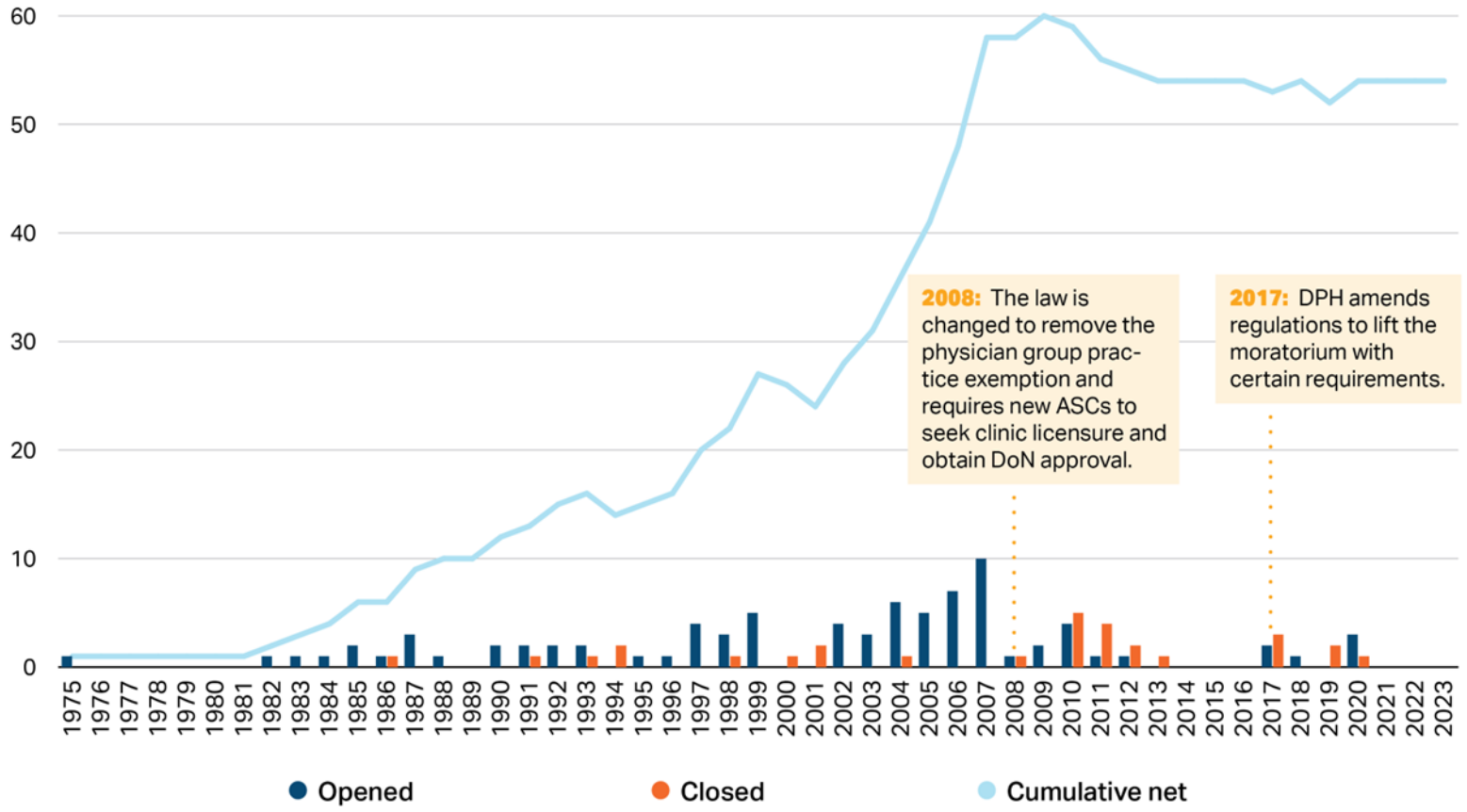


Massachusetts has 23 ASC operating rooms per 1M residents; the national average is 56 per 1M residents.

Source: HPC analysis of CMS Provider of Services file, Q2 2023 and Census population statistics, 2022

The relatively low number of ASCs in Massachusetts reflects the state's regulatory history.

Number of ASCs opened and closed by year and cumulative trend, 1982-2023

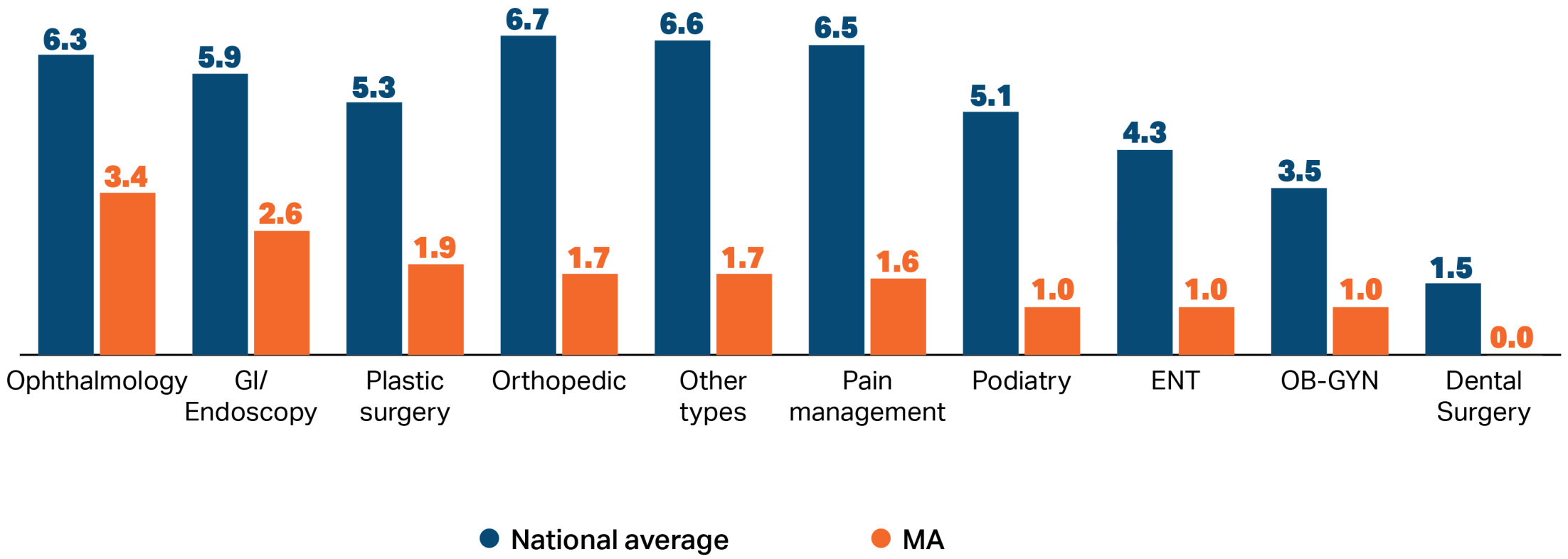


Notes: Massachusetts Department of Public Health, Determination of Need Guidelines for Freestanding Ambulatory Surgery Centers (Nov. 15, 1994); Massachusetts Department of Public Health, Memo to Interested Parties from Joan Gorga, Director, Determination of Need Program, Re: Licensure of Ambulatory Surgical Centers and Determination of Need (DoN) (June 25, 2009); 105 CMR 100.715(B)(2), available at: https://www.mass.gov/doc/105-cmr-100-determination-of-need/download; Chapter 305 of the Acts of 2008, available at: https://malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter305
Source: HPC analysis of CMS Provider of Services data, Q2 2023

- **1994:** DPH allows for limited ASC expansion. DPH will not approve any project located in the primary market area of geographically isolated hospitals.
- ASCs can open and operate under a **physician group practice exemption** from clinic licensure regulations, including regulations that required approval under the Determination of Need (DoN) program.
  - Under this exemption, a medical practice that is both wholly-owned and controlled by physicians associated with the practice is exempt from licensure and DoN requirements.
- **2008:** Chapter 305 of the Acts of 2008 removes the physician group practice exemption. New ASCs must seek clinic licensure and obtain DoN approval, effectively resulting in a moratorium on new ASCs.
- **2017:** DPH amends its regulation to lift the moratorium with certain requirements:
  - An ASC must have an affiliation with an HPC-certified ACO (most ACOs in Massachusetts are operated by or affiliated with hospital systems).
  - If an ASC plans to open within the primary service area of an independent hospital, the hospital must grant approval.

Massachusetts has fewer ASCs than the national average across all specialties.

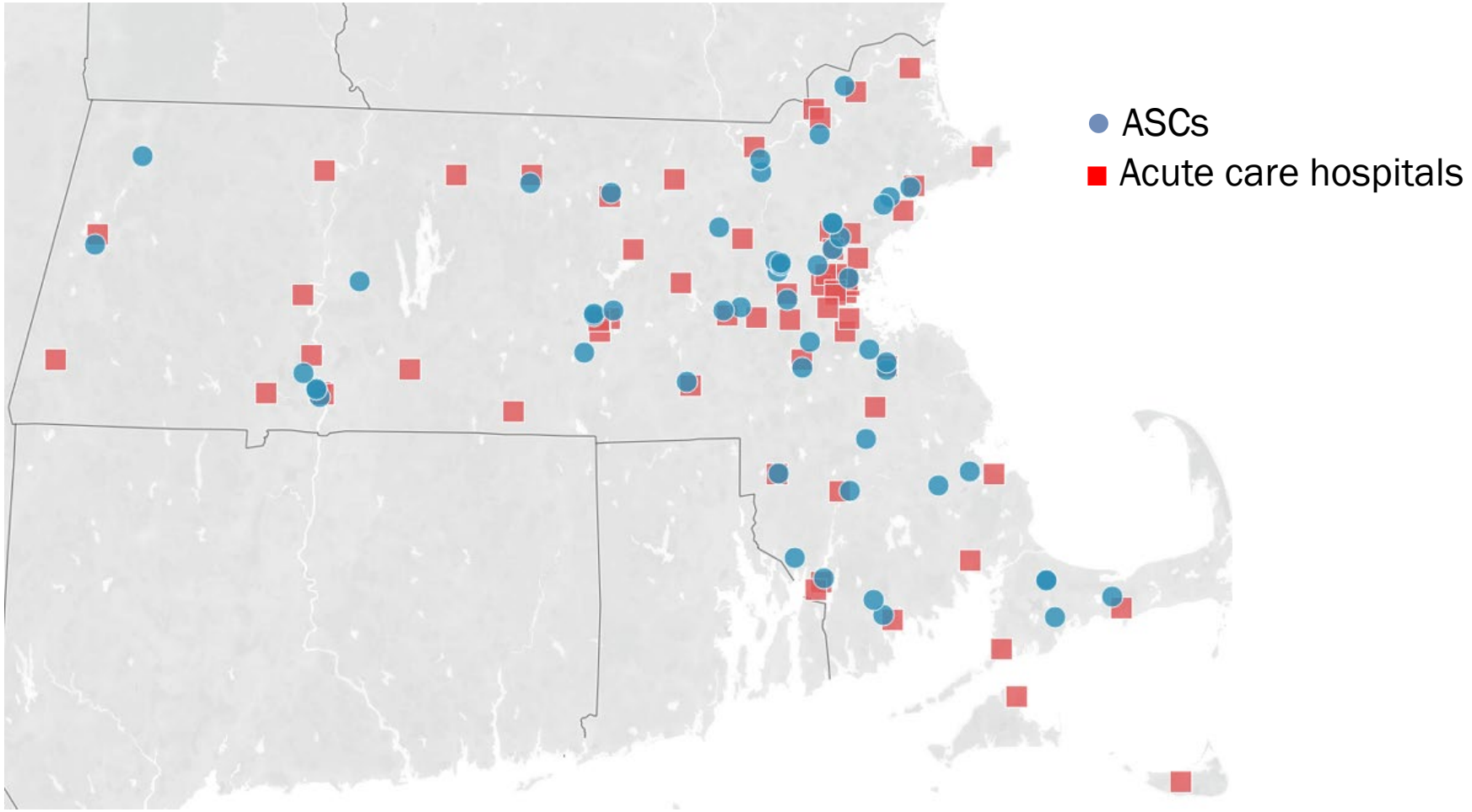
Number of ASCs that provide a given service type per one million population, Massachusetts and U.S., 2023



Note: ASCs that provide services in multiple specialties are counted in each relevant specialty bar.
Source: CMS provider database, 2023 and Census population statistics, 2022

Massachusetts ASCs generally follow the geographic distribution of acute care hospitals and are mostly located in or around population centers.

Acute care hospitals and ambulatory surgical centers, 2023

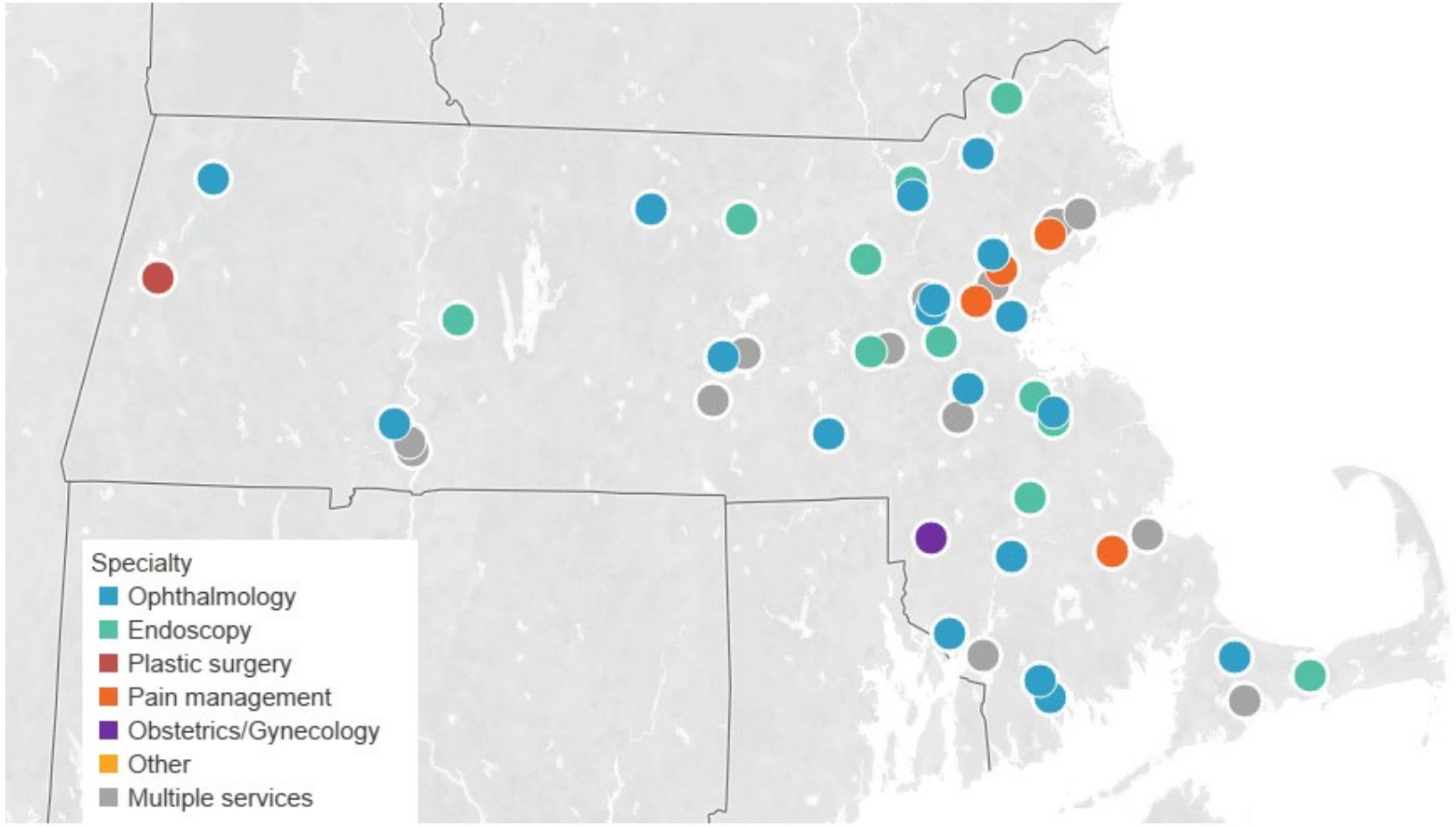


- In 1994 regulations, DPH specified that ASCs cannot be located more than 15 minutes travel time from an acute care hospital. While this requirement is no longer in effect, it may have influenced the current geographic distribution.

Source: HPC analysis of CMS Provider of Services data, 2023

ASCs specializing in ophthalmology are the most common type of ASC in Massachusetts.

Ambulatory surgical centers in Massachusetts by specialty, 2023



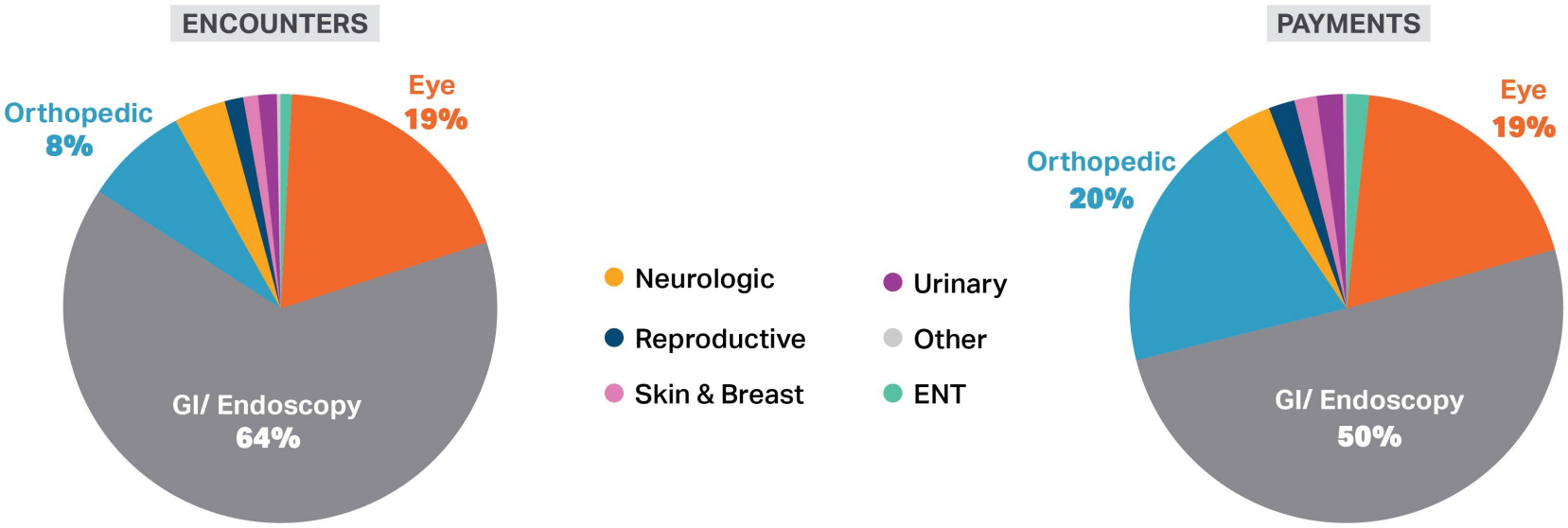
	Single-specialty ASCs	Total ASCs providing service
Ophthalmology	18	24
GI/ Endoscopy	12	18
Orthopedic	0	12
Plastic surgery	1	12
Pain management	4	11
Obstetrics/ Gynecology	1	7
Podiatry	0	7
Ear, Nose, & Throat	0	6
Other	1	12
Total ASCs	**37**	**54**

7 ASCs offer 2 service lines, and **10** provide 3 or more services

SOURCE: HPC analysis of CMS provider data, 2023

GI procedures (mostly endoscopies and colonoscopies), and orthopedic and eye surgeries account for 91% of commercial encounters and 89% of commercial payments.

Distribution of commercial encounters versus payment at ASCs, 2021

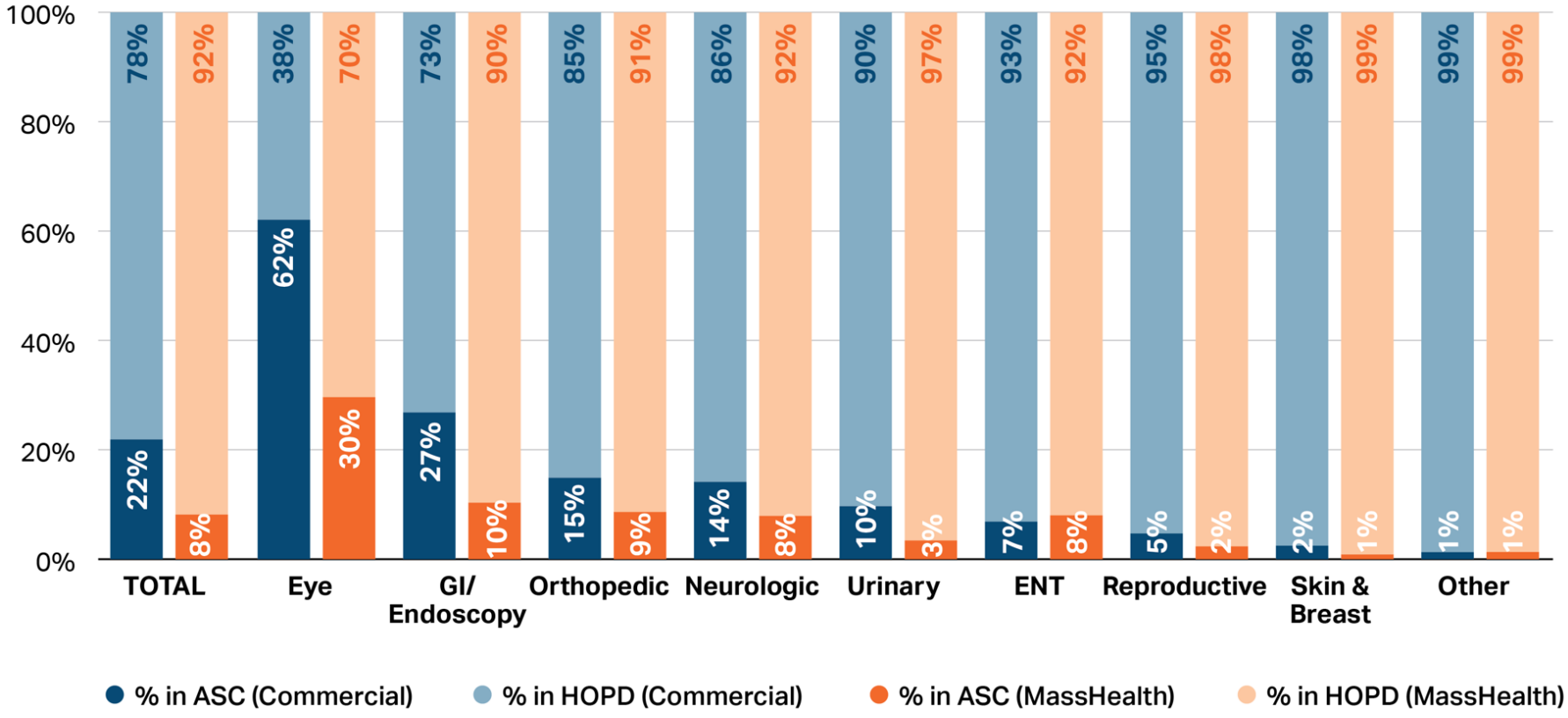


Notes: Encounter includes all services delivered on the same day as surgery at ASC. Payments include all payments for the counters (i.e. ASC facility, surgeon, anesthesiologist, lab and pathology fees). Commercial analysis includes six payers.
Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v2021, 2021

- GI procedures -- mostly endoscopies and colonoscopies – represent the largest share of commercial encounters and payments.
  - The share of volume (64%) is disproportionately higher than the share of payments (50%).
- Orthopedic surgeries – such as meniscus repair and joint replacements – are relatively expensive procedures and represent a disproportionate share of payments.
  - The share of volume is 8%, compared to 20% of payments.

Among procedures routinely performed in both ASCs and HOPDs, the vast majority are performed in HOPDs for both commercial and MassHealth patients.

Proportion of ASC-eligible surgeries performed in ASCs, out of total surgeries performed in ASCs and HOPDs, for MassHealth versus commercially-insured patients, 2021

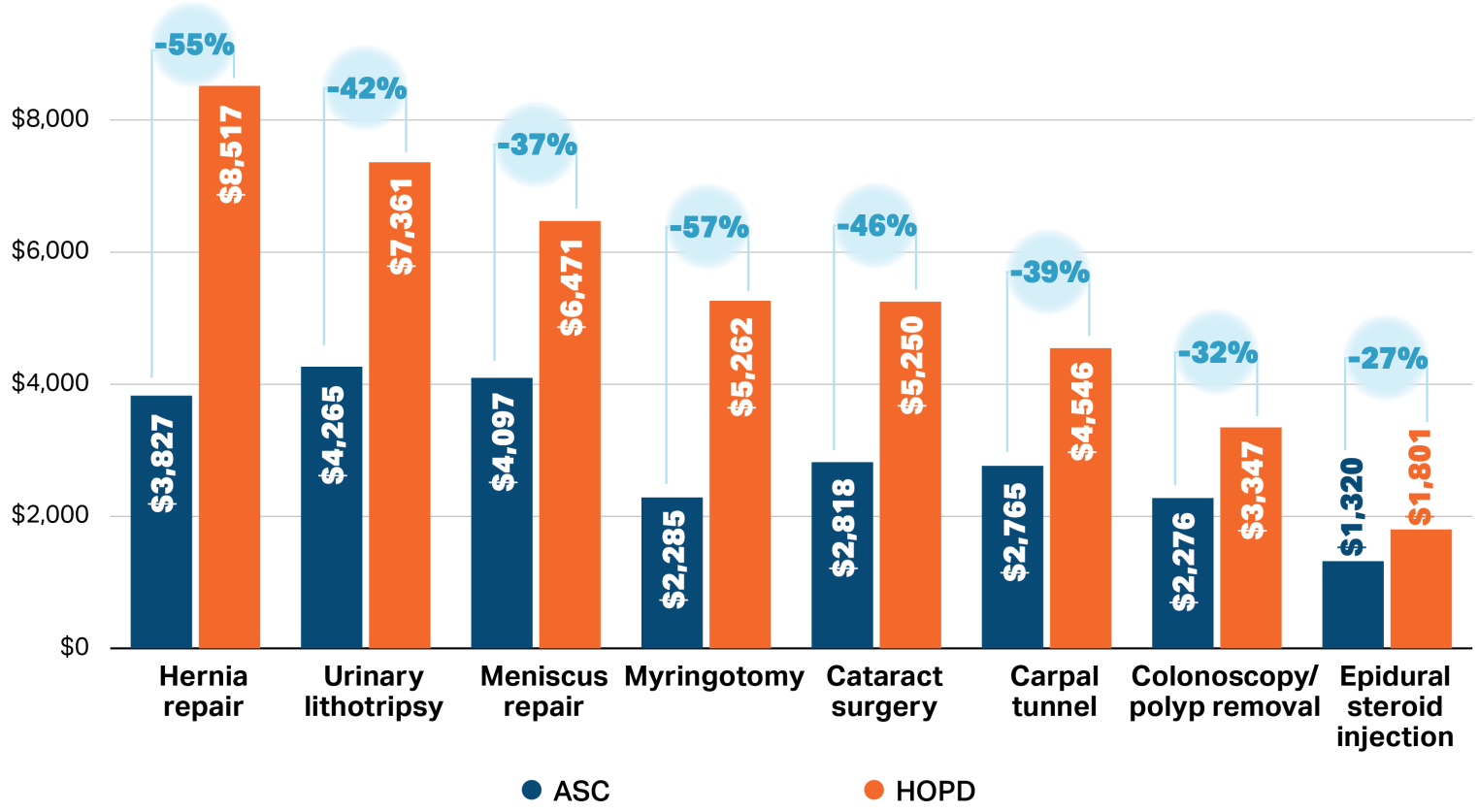


Notes: Share performed at ASC expressed as an ASC proportion of ASC and HOPD combined. The HPC defined "ASC-eligible" as services within a given category (CCS) limited by the maximum complexity service provided in an ASC. Offices provide a small share of eye surgeries and minor GI procedures (such as endoscopies). The HPC excluded procedures that occurred in an office or other sites from this analysis because these surgeries are often lower complexity compared to similar surgeries at ASCs
Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v2021, 2021

- Eye surgeries are the only category where ASCs provide more surgeries than HOPDs in the commercial population.
- For most procedures, Masshealth patients have a substantially smaller share performed in ASCs than commercial patients.
- Potential drivers of the difference could include provider referral patterns, location accessibility, and patient time or ability required to research options.

Commercial prices are generally lower in ASCs than in HOPDs for common surgical procedures.

Commercial price for common surgeries in ASCs and HOPDs and % ASC price relative to HOPD, 2021



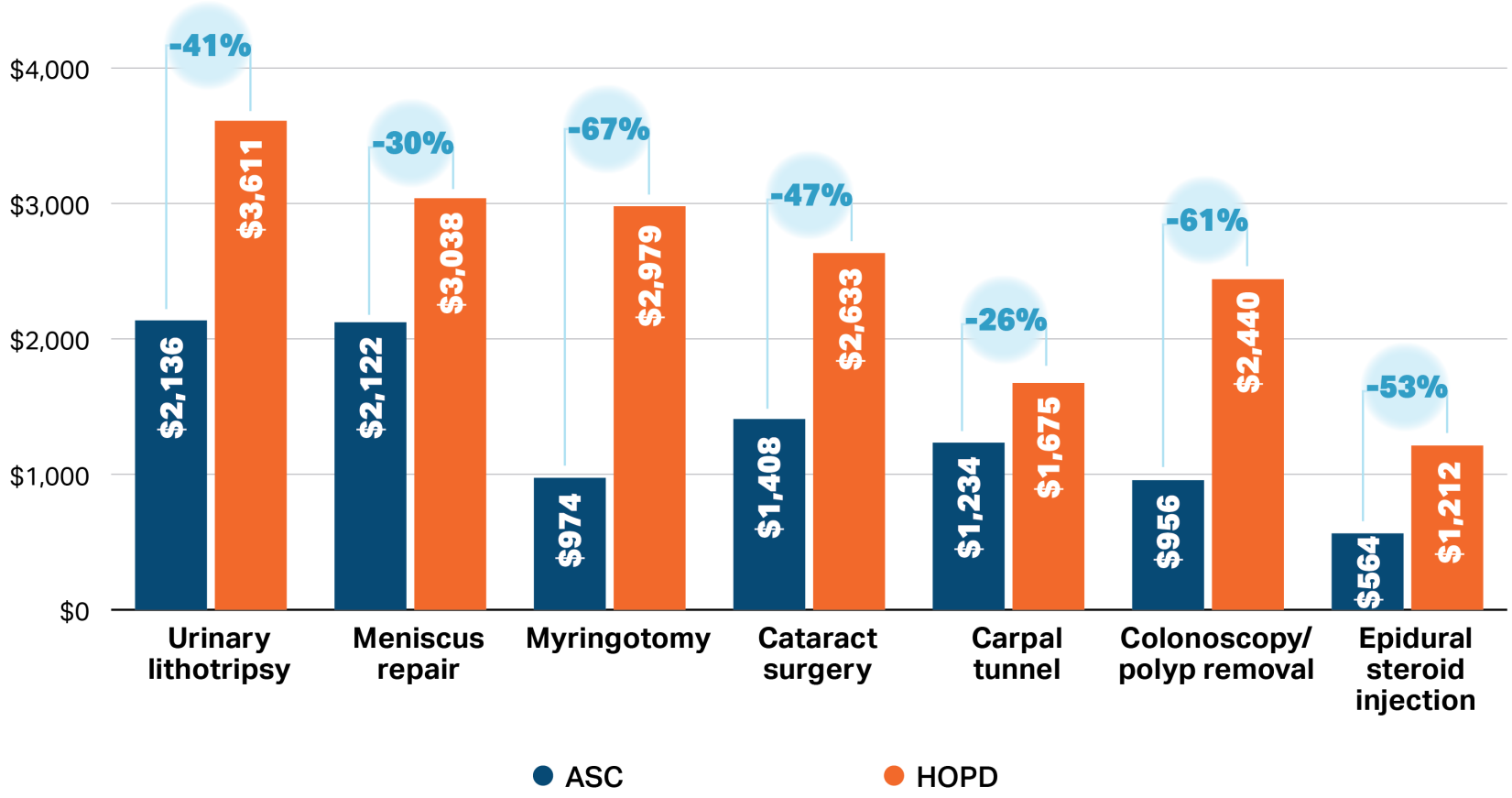
- Most of the difference in price is due to lower facility payments in ASCs compared to HOPDs. Professional payments are generally similar.
- Lower commercial ASC prices typically result in lower patient cost sharing.
  - For example, compared to a HOPD, average cost sharing in an ASC is 12% lower for a colonoscopy, 13% lower for carpal tunnel surgery, and 7% lower for cataract surgery.

Note: Selected surgeries represent a variety of types of procedures conducted at ASCs among the top 50 surgeries by spending in the commercial population. The price of the surgical encounter includes payments for all services provided on the same day as the main surgical procedure, including anesthesia, labs, pathology, or additional surgical codes. The main surgery procedure codes are: 45385, 64721, 29881, 52356, 49505, 63650, 66984, 69436. The HPC also evaluated prices for major joint replacement surgery and did not find a price difference between ASCs and HOPDs; however, the sample size of comparable surgeries was not large enough for stable estimates

Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v2021, 2021

MassHealth prices are also generally lower in ASCs than in HOPDs for common surgical procedures.

MassHealth price for common surgeries in ASCs and HOPDs and % ASC price relative to HOPD, 2021



Note: Hernia repair surgery did not have sufficient sample size in MassHealth population (<11).)The price of the surgical encounter includes payments for all services provided on the same day as the main surgical procedure, including anesthesia, labs, pathology, or additional surgical codes. The main surgery procedure codes are: 45385, 64721, 29881, 52356, 49505, 63650, 66984, 69436.
Source: HPC analysis of Center for Health Information and Analysis All-Payer Claims Database v2021, 2021

- MassHealth pays the same rate for the same professional services in HOPDs and ASCs, so the difference in total price comes from higher facility prices in HOPDs, as well as additional services that hospitals are able to provide and code for (e.g. recovery or observation room).

Conclusions

- Massachusetts has among the fewest ASCs per capita in the U.S., likely due to historical regulatory barriers.
- GI procedures, orthopedic procedures, and eye surgeries account for about 90% of commercial and MassHealth ASC volume.
- Commercial prices for procedures performed in ASCs are typically 30-55% lower than in HOPDs and also typically result in lower patient cost sharing.
  - MassHealth prices are also lower in ASCs compared to HOPDs.
- HOPDs provide the vast majority of ASC-eligible surgeries except for eye surgeries.
- ASCs are less frequently used by MassHealth patients than commercial patients. More research is needed to understand and address drivers of this difference.

Agenda

Call to Order

Approval of Minutes **(VOTE)**

DataPoints Issue #26: Landscape and Utilization of Ambulatory Surgical Centers in Massachusetts

FEDERAL REGULATORY UPDATE: AUTOMATION OF PRIOR AUTHORIZATION

Federal Regulatory Update: Department of Justice/Federal Trade Commission Merger Guidelines

Guest Presentation: Executive Office of Health Human Services *Advancing Health Equity in Massachusetts* – Karen Tseng, Senior Advisor for Health Policy, EHS

Prior Authorization Automation: HPC Policy Recommendation

INCLUDE COMMERCIAL PAYERS

STATEWIDE ROADMAP

SUPPORTIVE STRUCTURES

- The HPC's 2023 Cost Trends Report includes a recommendation to reduce administrative complexity by **automating prior authorization**.
  - The recommendation was developed in collaboration with the Network for Excellence in Health Innovation, Massachusetts Health Data Consortium (MHDC), and the New England Healthcare Exchange Network (NEHEN).
- The recommendation builds on the **CMS Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P)** that would require certain public payers to automate prior authorization. Massachusetts could leverage federal activity in this space by:
  - Expanding the requirement for automation to include **commercial payers**;
  - Developing a **statewide roadmap** to guide uniform implementation; and
  - Establishing **supportive structures**, such as a technical assistance center, a stakeholder task force, and financial assistance.
- CMS released the **CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)** on January 17, 2024.
- CMS estimates that the provisions of the final rule could result in **$15 billion in savings over 10 years** by reducing administrative burden and improving health outcomes.

CMS Interoperability and Prior Authorization Final Rule

The final rule standardizes certain elements of impacted payers' **prior authorization processes** and requires that they implement standard **technology to exchange electronic health information**.

IMPACTED PAYERS

- Medicare Advantage organizations
- Medicaid and Children's Health Insurance Program fee-for-service programs
- Medicaid Managed Care Plans
- Qualified Health Plans on federally-facilitated exchanges (not applicable in MA)

COMPLIANCE DATE

- 2026 for most provisions related to prior authorization processes
- 2027 for most provisions related to automation and health information exchange; state Medicaid and CHIP fee-for-service programs can seek a one-time, one-year extension to the information exchange compliance date.

PRIOR AUTHORIZATION POLICY PROVISIONS

1. Requires that impacted payers send prior authorization determinations within 72 hours for expedited requests and within seven calendar days for standard requests (unless faster responses are required by applicable state law).
2. Requires that impacted payers provide a reason for any denial.
3. Requires that impacted payers publicly report prior authorization metrics.

Source: https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f; https://www.ropesgray.com/en/insights/alerts/2024/01/cms-finalizes-new-electronic-prior-authorization-requirements-for-payers-and-providers

CMS Interoperability and Prior Authorization Final Rule (Ctd.)

The final rule standardizes certain elements of impacted payers' **prior authorization processes** and requires that they implement standard **technology to exchange electronic health information**.

HEALTH INFORMATION EXCHANGE PROVISIONS

PRIOR AUTHORIZATION API

Impacted payers must automate prior authorization processes using a **FHIR API** that will allow providers to electronically:

- Determine whether a prior authorization is required;
- Send a prior authorization request from within the provider's EHR or practice management system; and
- Receive a decision from the payer.

FHIR (pronounced "fire") is a standard for electronic exchange of health information.

An **API** is a piece of software that connects computer programs.

PATIENT ACCESS API

Impacted payers must now add prior authorization request and decision information to the categories of health information that they are required to make available to patients via health applications.

PROVIDER ACCESS API

Impacted payers must implement an API to make certain patient health information, including prior authorization information, available to providers that have a treatment relationship with the patient.

PAYER-TO-PAYER API

Impacted payers must implement an API through which payers could request certain health information from the last five years for a newly enrolled beneficiary or a beneficiary with multiple payers.

Source: https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f; https://www.ropesgray.com/en/insights/alerts/2024/01/cms-finalizes-new-electronic-prior-authorization-requirements-for-payers-and-providers

CMS Interoperability and Prior Authorization Final Rule (Ctd.)

In addition to the requirements placed on Impacted Payers, the final rule includes **provider incentives** for using prior authorization automation.

PROVIDER INCENTIVES TO PARTICIPATE

- CMS incentives provider adoption through:
  - **For eligible clinicians:** the CMS quality payments program (MIPs)
  - **For hospitals:** the Medicare Promoting Interoperability Program.
- The final rule establishes a new measure for the 2027 performance year called “Electronic Prior Authorization.”
  - The provider must attest “yes” to requesting a prior authorization electronically via a Prior Authorization API using data from certified electronic health record technology (CEHRT) for at least one medical item or service (and, for hospitals, one discharge) ordered during the CY 2027 performance period or (if applicable) report an exclusion.
- Providers that do not meet this standard will lose “meaningful user” status and can impact Medicare payment levels.

Source: https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f; https://www.ropesgray.com/en/insights/alerts/2024/01/cms-finalizes-new-electronic-prior-authorization-requirements-for-payers-and-providers

Prior Authorization Automation in Massachusetts

The HPC's **2023 Cost Trends Report recommendation** on automating prior authorization:

- **The Legislature should build upon this momentum and mandate that others in Massachusetts, including commercial payers, automate their prior authorization processes according to a statewide roadmap, with technical and financial assistance, to support successful implementation.**

Extending PA automation requirements to commercial payers could produce benefits including:

- Decreasing inefficient administrative costs;
- Reducing provider uncertainty about when PA is required, which could eliminate a significant number of PAs submitted currently;
- Decreasing the time from PA submission to disposition;
- Reducing payer and provider manual paperwork;
- Establishing a data foundation against which to evaluate PA volume and variation which could inform further reform efforts; and
- Providing opportunities for greater standardization of PA programs across payers.

Agenda

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Approval of Minutes **(VOTE)**

DataPoints Issue #26: Landscape and Utilization of Ambulatory Surgical Centers in Massachusetts

Federal Regulatory Update: Automation of Prior Authorization

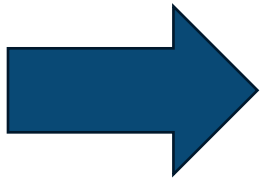
FEDERAL REGULATORY UPDATE: DEPARTMENT OF JUSTICE/FEDERAL TRADE COMMISSION MERGER GUIDELINES

Guest Presentation: Executive Office of Health Human Services *Advancing Health Equity in Massachusetts* – Karen Tseng, Senior Advisor for Health Policy, EHS

Healthcare Merger and Market Oversight

Federal agency Merger Guidelines are a helpful reference used by the HPC to review the impact of proposed transactions on the Massachusetts healthcare market.

- The Federal Trade Commission (FTC) and U.S. Department of Justice (DOJ) protect marketplace competition by enforcing federal antitrust laws and assessing the impacts of transactions such as acquisitions or mergers between competing organizations on affected markets.
- Policies and guidelines such as the agencies' Merger Guidelines help guide adherence to law and let organizations know what to expect from agency enforcement.



HPC market oversight is distinct from and deliberately broader than antitrust review. However, the HPC has referenced the FTC/DOJ screening tools in the Merger Guidelines for evaluating the potential impacts of transactions.

Recent Federal Activity

2020-2021

Legislative Changes

Enactment of laws supporting antitrust enforcement:

- ACPERA reauthorization
- Criminal Antitrust Anti-Retaliation Act
- Competitive Health Insurance Reform Act

JULY 2021

Executive Order 14036, *Promoting Competition in the American Economy*

- Puts focus on healthcare
- Directs FTC, DOJ, and HHS to strengthen antitrust guidance and rules
- Creates White House Competition Council

2022-2023

Enforcement Updates (Select)

- *US et al. v. UnitedHealth Group and Change Healthcare*
- MOU between DOJ and HHS OIG to strengthen collaboration
- *FTC v. U.S. Anesthesia Partners and Welsh Carson Anderson & Stowe*

JUN 2023

Proposed Rule to Update Premerger Reporting

- Requires parties to supply all deal information when reporting merger
- Requires 10-year background narrative about the parties
- Requires market impact analysis

JUL 2023

DOJ/FTC Updated Merger Guidelines

- Include new focus on “roll-up” or serial acquisitions
- Lower the threshold for presumption of harm
- Present new framework for assessing multistate platforms

Recent Revisions to the Merger Guidelines

- The FTC and DOJ released draft revised guidelines in July 2023 and sought extensive public input on the proposals.
- Final revised guidelines were released December 18, 2023.
- The new Merger Guidelines combine and replace the 2010 Horizontal Merger Guidelines and the 2020 Vertical Merger Guidelines.
- Major changes include lower market concentration thresholds for presuming competitive harm and a reversion to a view that mergers that result in a 30% market share are problematic.
- The Guidelines are not legally binding, and not all of the policies described in the final version have yet been successfully tested in court.

The Merger Guidelines:

1. Demonstrate federal enforcement priorities
2. Explain federal policies on competition in commercial markets
3. Describe the tools the agencies use to ensure competition remains healthy
4. Provide information and guidance to entities who are either involved in or considering a merger

Inclusions of Note in the Final 2023 Merger Guidelines

LOWER THRESHOLDS

- Certain measures of market concentration can trigger a presumption that a merger may reduce competition or create a monopoly.
- The revisions reduce the thresholds for post-merger market concentration and the merged firm's market share that are presumed potentially anticompetitive.

Indicator	Prior Threshold	Revised Threshold
Post-merger HHI	Market HHI > 2,500 + Change in HHI > 200	Market HHI > 1,800 + Change in HHI > 100
Merged Firm's Market Share	None Specified	Share > 30% + Change in HHI > 100

PARTIAL OWNERSHIP

The revisions state that the Agencies will evaluate transactions in which one of the parties acquires less than full control of a firm but is still able to influence decision-making.

SERIAL TRANSACTIONS

- Firms sometimes avoid transaction notice and reporting to federal agencies by making many small acquisitions under reporting thresholds.
- Such acquisitions can still result in consolidation and increased market share.
- The revisions identify this practice and state that the Agencies may consider the cumulative effect of multiple transactions.

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Federal Regulatory Update: Department of Justice/Federal Trade Commission Merger Guidelines

GUEST PRESENTATION: EXECUTIVE OFFICE OF HEALTH HUMAN SERVICES *ADVANCING HEALTH EQUITY IN MASSACHUSETTS* – KAREN TSENG, SENIOR ADVISOR FOR HEALTH POLICY, EHS

ADVANCING HEALTH EQUITY IN MASSACHUSETTS

Health Policy Commission Committee Meetings

February 15, 2024

AGENDA

1

INTRODUCTION AND OVERVIEW

Disparities in Massachusetts

2

GUIDEPOSTS IN OUR FIRST YEAR

Key issue areas and geographies

3

COMMUNITY ENGAGEMENT

Introducing a structure, but not imposing a paradigm

4

CALL TO ACTION

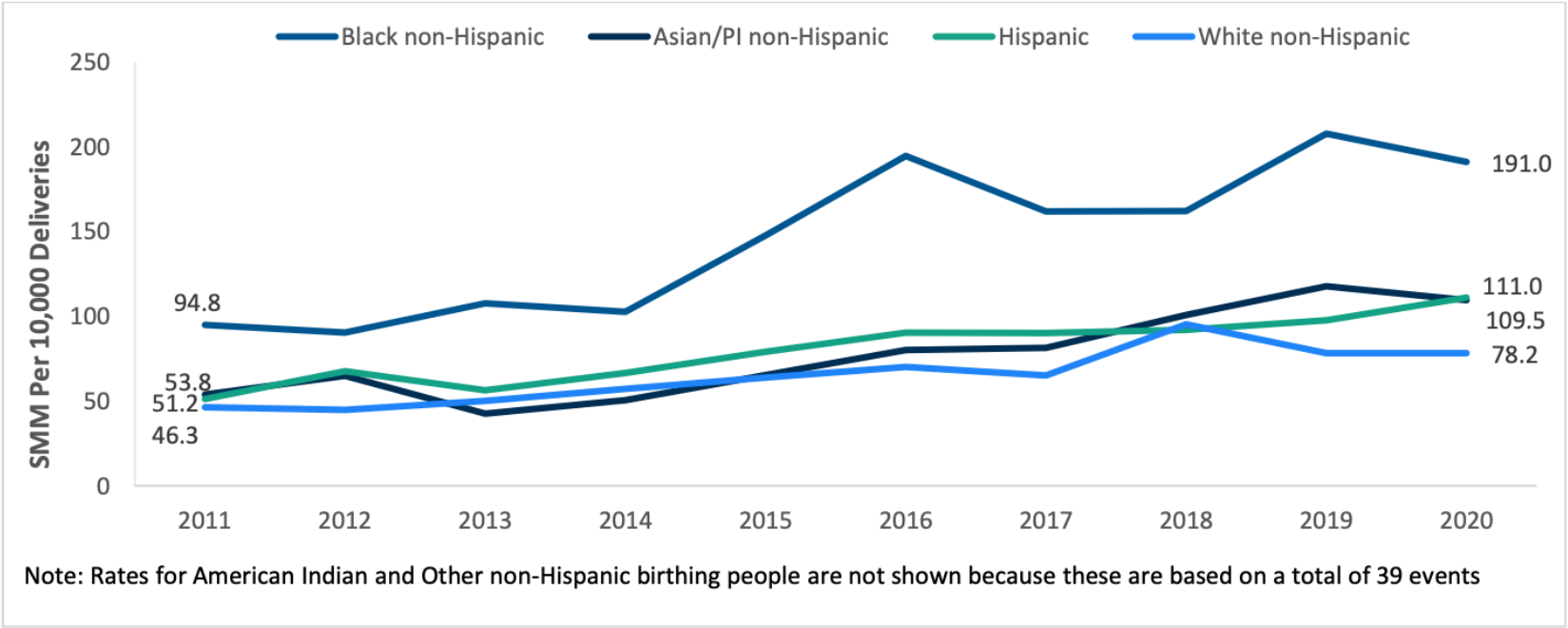
We need your help!

THE UGLY TRUTH: HEALTH (IN)EQUITY IN MA

AN ASSESSMENT OF SEVERE MATERNAL MORBIDITY IN MASSACHUSETTS: 2011-2020

Department of Public Health, July 2023

Figure 4. SMM in Massachusetts by Race and Hispanic Ethnicity: 2011-2020



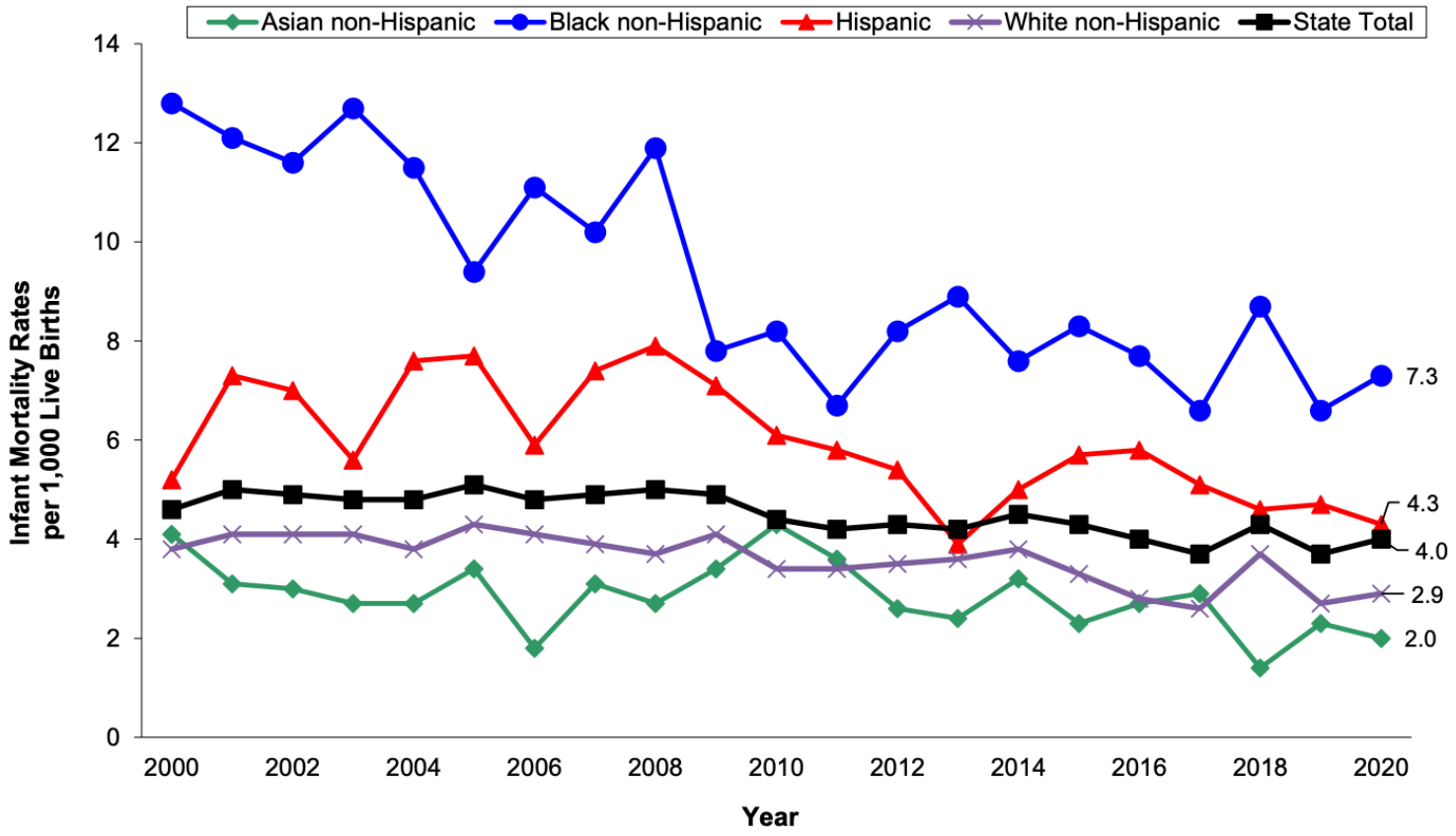
Note: Rates for American Indian and Other non-Hispanic birthing people are not shown because these are based on a total of 39 events

THE UGLY TRUTH: HEALTH (IN)EQUITY IN MA

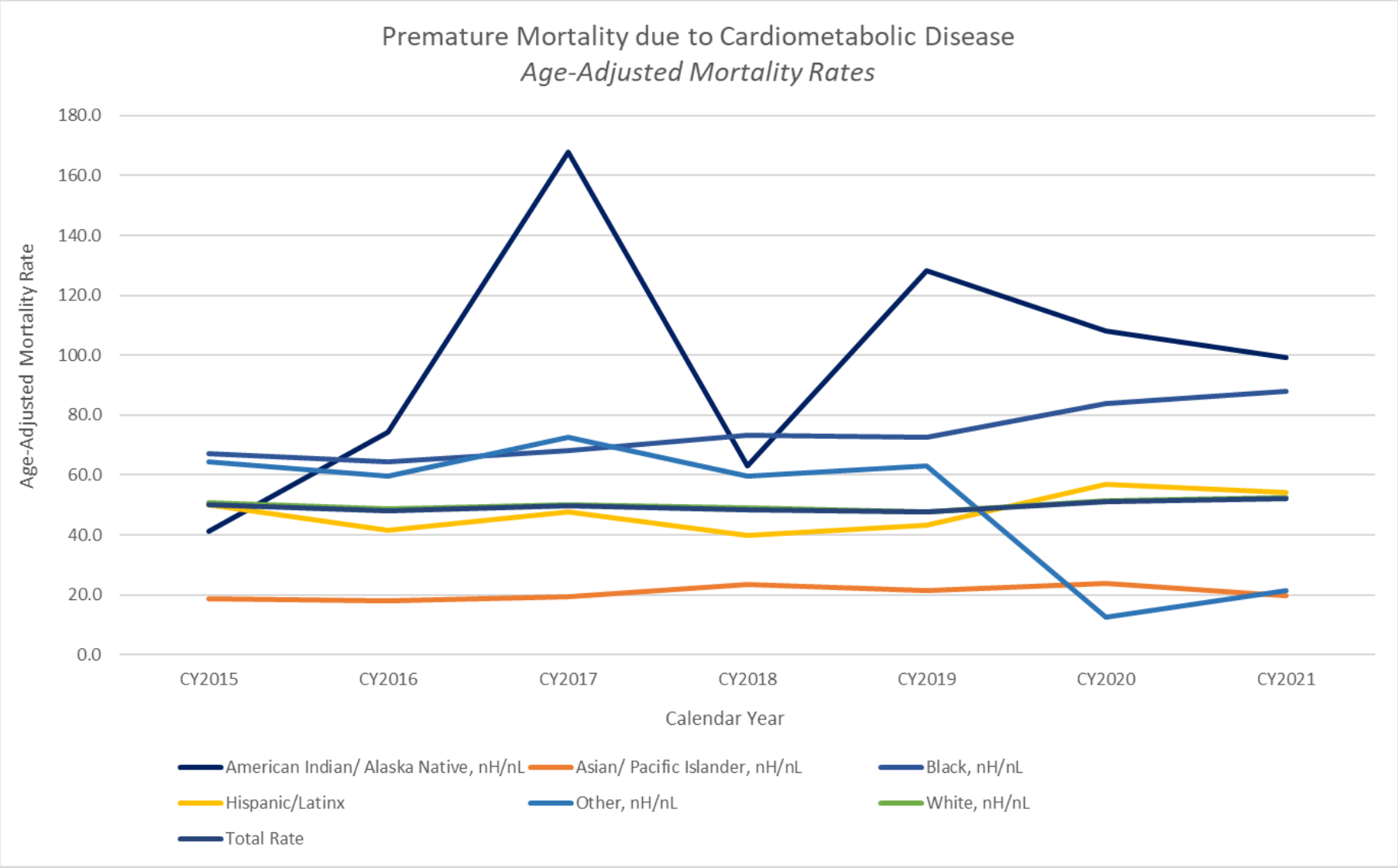
MASSACHUSETTS DEATHS REPORT - INFANT MORTALITY: 2000-2020

Department of Public Health, February 2023

Figure 8. Infant Mortality Rates by Race and Hispanic Ethnicity, Massachusetts: 2000-2020



THE UGLY TRUTH: HEALTH (IN)EQUITY IN MA



Department of Public Health, July 2023

Across the Exec. Office of Health and Human Services, we will:

Focus our efforts	• Identify and build work around specific drivers of disparities • Recognize the connection between geography and equity and pilot innovative solutions in regions with the greatest inequities
Engage communities	• Work closely with priority communities to identify which of the possible policy measures will be most impactful for residents
Collaborate	• Identify interventions within agencies across state government that will contribute to the improvement of specific outcomes • Align with private sector partners on equity objectives
Center data and outcomes	• Define outcome metrics and monitor over time • Collect actionable data on disparities and interventions to broadly measure success

An initial focus on two high disparity conditions

Interagency Taskforce

Chaired by Undersecretary Kiame Mahaniah and DPH Commissioner Robbie Goldstein

Maternal/Perinatal Health Workgroup

- Community Engagement Team
- Actionable Data Team

Social Drivers of Cardiometabolic Health Workgroup

- Community Engagement Team
- Actionable Data Team

...through a racial equity lens which is fundamental to improving outcomes

Priority Recommendations from DPH's Review of Maternal Health Services, November 2023

Increasing Maternal Care Access

- Update regulations governing birth centers
- Integrate birth centers into DPH's hospital licensure regulation's perinatal section
- Develop a public awareness campaign describing the LoMC
- Implement remote blood pressure monitoring programs across all hospitals in MA.

Expanding Care Delivery Models

- Ensure insurance coverage for remote monitoring services.
- Incentivize providers to offer Group Prenatal Care (GPC).
- Ensure all FQHCs provide prenatal and postnatal care on site.
- Expand the reach of universal postpartum home visiting.
- Include maternal/child health in the next version of local public health standards.

Improving and Augmenting the Workforce

- Develop a pathway to doula certification.
- Reimburse midwives equitably as physicians for the same service.
- Reduce requirements that limit scope of practice for midwives

Improving Access to Data

- Empower the Maternal Mortality and Morbidity Review Committee to access all info needed.
- Conduct active, population-based surveillance for stillbirths.
- Support an annual Count the Kicks campaign and give materials to providers.
- Engage with families, fathers, and other second parents to improve services.

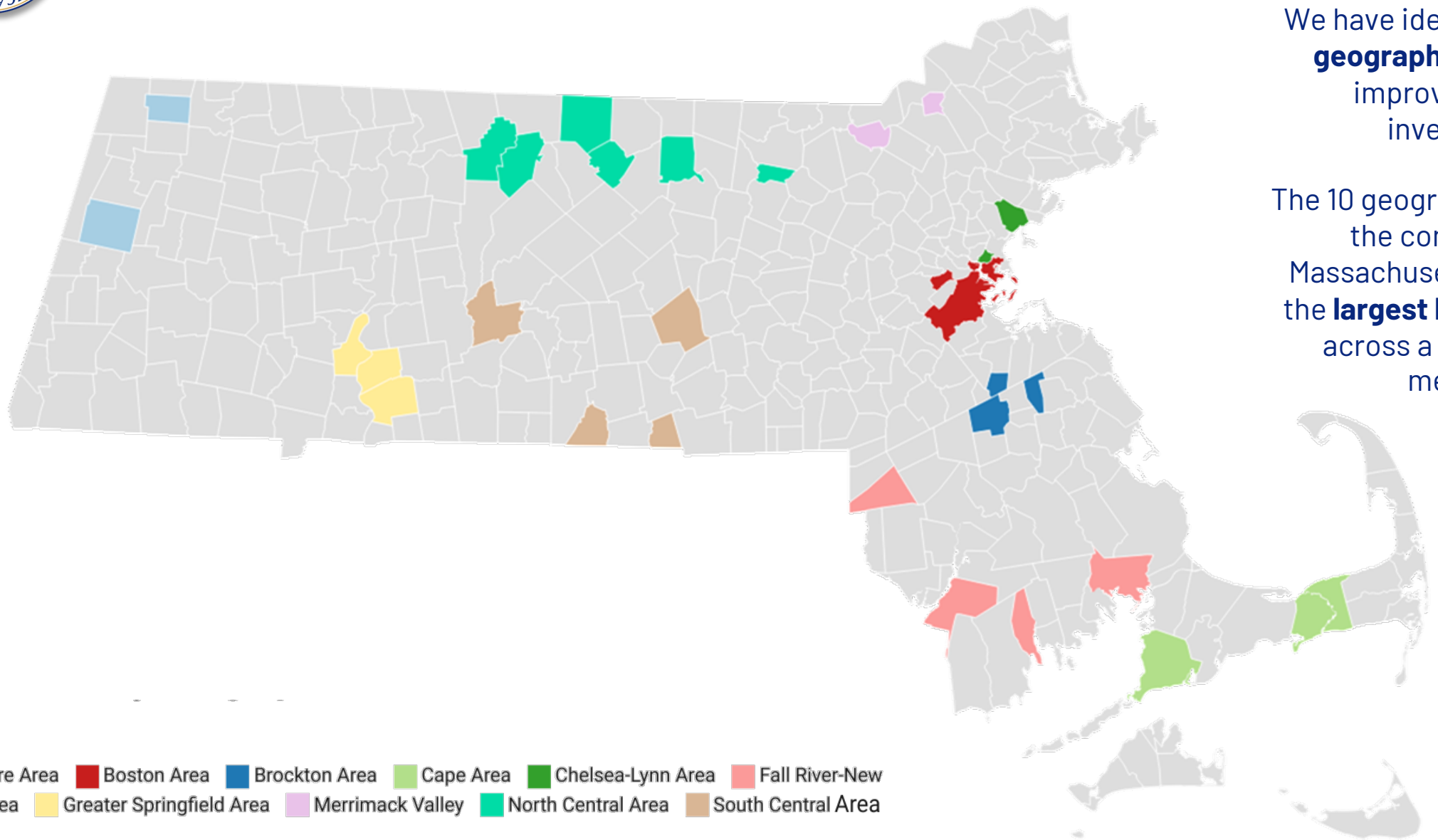
Behavioral Health

- Train providers on screening, treatment, and referral for PPD and related behavioral disorders.
- Support and amplify programs for pregnant members with SUD.
- Protect mothers of substance exposed newborns with no signs of abuse from DCF investigation.
- Create inpatient behavioral health programs where infants can stay with their moms during treatment.

Reproductive Health

- Increase access to contraceptive methods at all post-partum care providers.
- Increase access to abortion services for patients under 18.
- Encourage additional providers to offer abortion services.
- Promote awareness of and access to Paid Family and Medical Leave.

Our place-based strategy will focus our efforts in regions experiencing the greatest disparities



We have identified **10 priority geographies** for focused improvements and investments.

The 10 geographies encompass the communities in Massachusetts experiencing the **largest health disparities** across a broad range of measures.

...and must be anchored in community collaboration

REGIONS			
1	**Berkshire Area** (North Adams, Pittsfield)	6	**Fall River-New Bedford Area** (Attleboro, Fall River, New Bedford, Wareham)
2	**Boston Area** (Dorchester, Mattapan, Roxbury)	7	**Greater Springfield Area** (Chicopee, Holyoke, Springfield)
3	**Brockton Area** (Brockton, Holbrook, Rockland)	8	**Merrimack Valley** (Lawrence, Lowell)
4	**Cape Area** (Dennis, Falmouth, Yarmouth)	9	**North Central Area** (Athol, Ayer, Fitchburg, Gardner, Orange, Winchendon)
5	**Chelsea-Lynn Area** (Chelsea, Lynn)	10	**South Central Area** (Southbridge, Ware, Webster, Worcester)

COMMUNITY VOICES ARE CRITICAL TO THIS WORK

WE NEED YOUR HELP