Health Policy Commission Advisory Council

July 10, 2019

AGENDA

- **Executive Director's Report**
  - 2019 Cost Trends Hearing
  - Quality Measurement Taskforce
  - DataPoints, Issue #12: Cracking Open the Black Box of Pharmacy Benefit Managers
  - Report on the Statewide Availability of Health Care Providers that Serve Patients with Co-Occurring Substance Use Disorder and Mental Illness
  - Chartpack on Opioid-Related Acute Hospital Utilization
- HPC Policy Priority: Reducing Administrative Complexity – Advisory Council Survey Results and Discussion
- HPC Policy Priority: Addressing the Social Determinants Of Health – Introduction to the MassUP Interagency Initiative

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2019 COST TRENDS HEARING

SAVE THE DATE

TUESDAY **OCTOBER 22** AND WEDNESDAY **OCTOBER 23**

The prominent, two-day hearing hosted annually by the Health Policy Commission will feature in-person testimony from top health care executives, industry leaders, and government officials. Questions will be posed from Massachusetts and national health care experts about the drivers of health care costs, health care reform efforts, and the state's performance under the Health Care Cost Growth Benchmark, measured by growth in Total Health Care Expenditures (THCE).

MASSACHUSETTS
HEALTH POLICY COMMISSION

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Quality Measure Alignment Taskforce

In May 2017, the Executive Office of Health and Human Services (EOHHS), the HPC, and the Center for Health Information Analysis (CHIA) convened a Quality Measure Alignment Taskforce to recommend an aligned measure set for voluntary adoption by payers and providers in global budget-based risk contracts.

- **Encourage adoption of the Massachusetts Aligned Measure Set** for global budget-based risk contracts effective 1/1/2020.
- **Apply to be on the Taskforce:** The State is re-procuring Taskforce membership. We invite providers, payers, employers, consumers, and consumer advocates to apply through COMMBUYS (BD-17-1039-EHS01-EHS01-14113) by **Monday, July 22.** This is an opportunity to shape the future design of the measure set.
- **Visit the Taskforce website**: Recently the Taskforce has launched a website that provides information about the Taskforce and its ongoing work, implementation parameters to assist with adoption of the Aligned Measure Set for 2020, and presentations from previous Taskforce meetings. Visit the website at: https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce

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HPC DataPoints, Issue #12: Cracking Open the Black Box of Pharmacy Benefit Managers

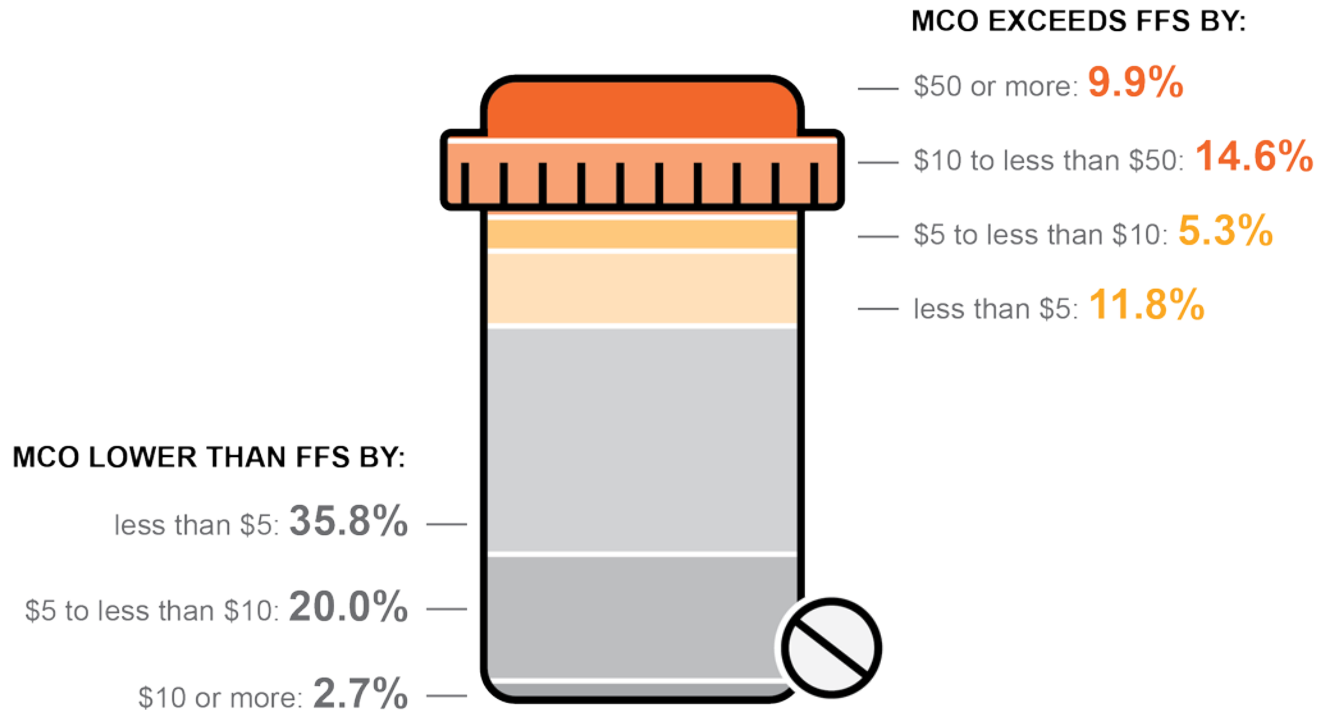
Background

- Prescription drug spending continues to drive health care costs in MA:
  - Total prescription drug spending at pharmacies grew **4.1% in Massachusetts in 2017**, net of manufacturer rebates and discounts.
  - MassHealth prescription drug spending **nearly doubled in five years**, from $1.1 billion in 2012 to $1.9 billion in 2017, growing twice as fast as other spending.
- The 12th issue of HPC DataPoints contains new data on pricing practices of pharmacy benefit managers (PBMs) known as "spread pricing" and its impact on prescription drug spending in both the public and commercial markets in MA. The online version features interactive graphics and is available at mass.gov/service-details/hpc-datapoints-series.

Source: Herkert D, Vijayakumar P, Luo J, et al. Cost-Related Insulin Underuse Among Patients With Diabetes. *JAMA Intern Med.* 2019;179(1):112–114.

MassHealth Results: For drugs where MCOs paid a higher price than FFS, the difference was often substantial

In 2018 Q4, MCO/PBM prices were higher than acquisition costs for 95% of the unique drugs analyzed and exceeded FFS prices for 42% of unique drugs



Whether the MCO price is higher or lower than the FFS price, it is unclear how much of the payment the PBMs apportion to the pharmacy and how much is retained as revenue

HPC

Despite a 60% decrease in the acquisition cost for Buprenorphine-Naloxone (generic Suboxone), MCO/PBM prices increased 13% between 2016 and 2018

Average pharmacy acquisition cost and MCO price for Buprenorphine-Naloxone 8-2mg SL, per tablet

Quarter	MCO price	Acquisition cost
2016 Q1	$4.73	$5.11
2016 Q2	$4.53	$4.75
2016 Q3	$4.10	$4.53
2016 Q4	$3.95	$4.47
2017 Q1	$4.43	$4.18
2017 Q2	$4.97	$3.96
2017 Q3	$4.99	$3.52
2017 Q4	$5.07	$2.97
2018 Q1	$5.07	$2.61
2018 Q2	$5.42	$2.45
2018 Q3	$4.58	$2.32
2018 Q4	$5.33	$2.07

Legend: MCO price; Acquisition cost

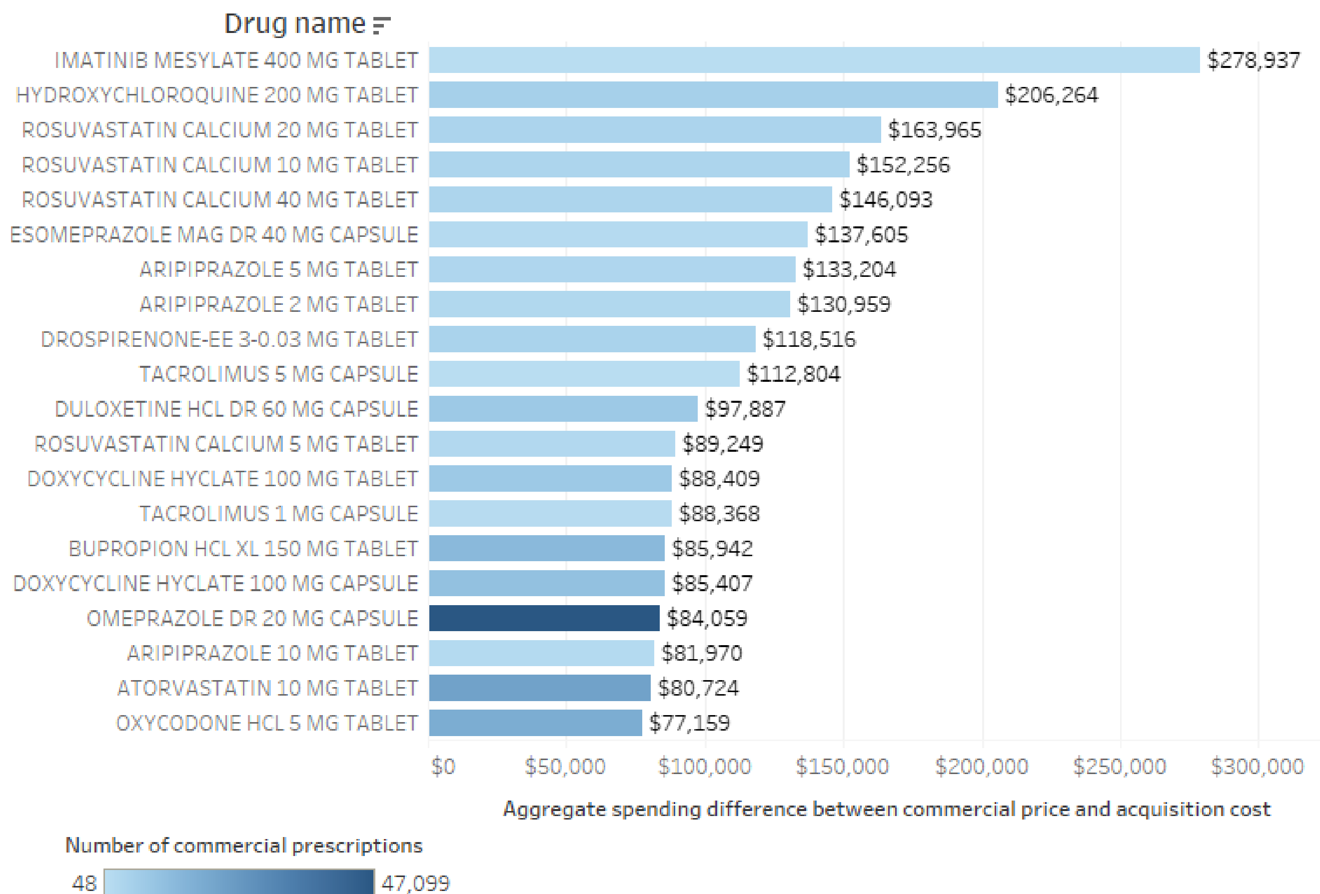
Y-axis: $0.00, $1.00, $2.00, $3.00, $4.00, $5.00

Buprenorphine-Naloxone is a critical evidence-based treatment option for opioid use disorder

Sources: Centers for Medicare and Medicaid Services, State Drug Utilization Data (SDUD) and National Average Drug Acquisition Cost (NADAC) database.
Notes: National Drug Code 00054018913.

Higher commercial PBM prices for generic drugs contributed to significantly higher aggregate spending compared to acquisition costs

Top 20 generic drugs by aggregate spending difference between Massachusetts commercial price and acquisition cost, 2016 Q4



Sources: Centers for Medicare and Medicaid Services, National Average Drug Acquisition Cost (NADAC) database. Center for Health Information and Analysis, Massachusetts All-Payer Claims Database (APCD).

Notes: Analysis includes only generic oral solids. Each drug represents a single dosage form and dosage strength. Average unit price and average number of units per prescription reflects a weighted average across package sizes. Drugs with 11 or fewer prescriptions dispensed were omitted. For each drug, claims in the top and bottom 1 percentile of price were excluded to minimize the influence of outliers. HPC methodology is adapted from 46Brooklyn.com.

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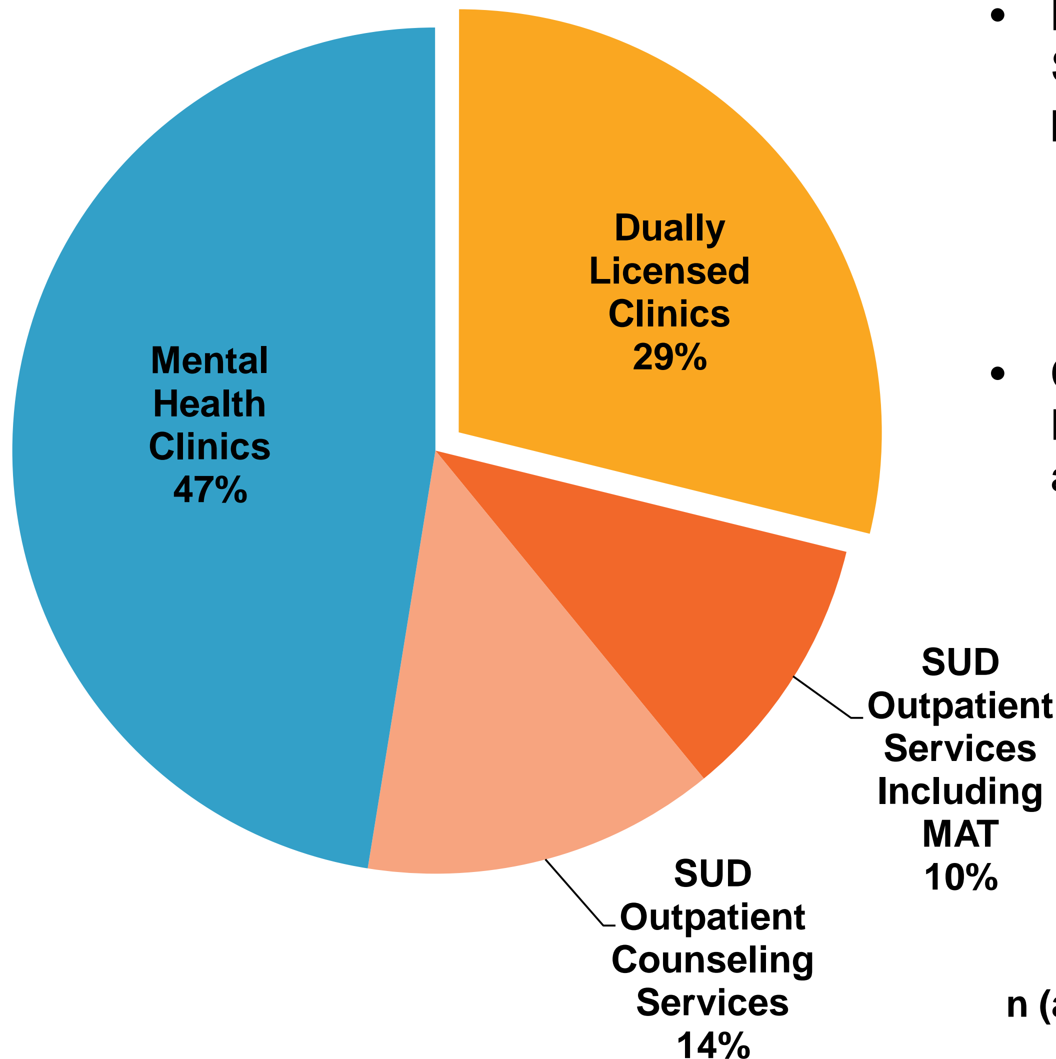
Statutory language directs the HPC to study the statewide availability of providers treating co-occurring mental illness and substance use disorder

Chapter 52 of the 2016 Session Laws, ***An Act Relative to Substance Use, Treatment, Education and Prevention***, charges the HPC, in consultation with the Department of Public Health and the Department of Mental Health, with assessing the availability of providers treating "dual diagnosis," or co-occurring mental illness and substance use disorder (SUD).

1. Create an **inventory of health care providers capable of treating patients (child, adolescent, and/or adult) with dual diagnoses**, including the location and nature of services offered at each such provider.
2. **Assess sufficiency of and barriers to treatment**, given population density, geographic barriers to access, insurance coverage and network design, and prevalence of mental illness and SUD.
3. **Make recommendations to reduce barriers to care.**

HPC

Only a quarter of behavioral health clinics and counseling sites are licensed to treat both mental illness and SUD

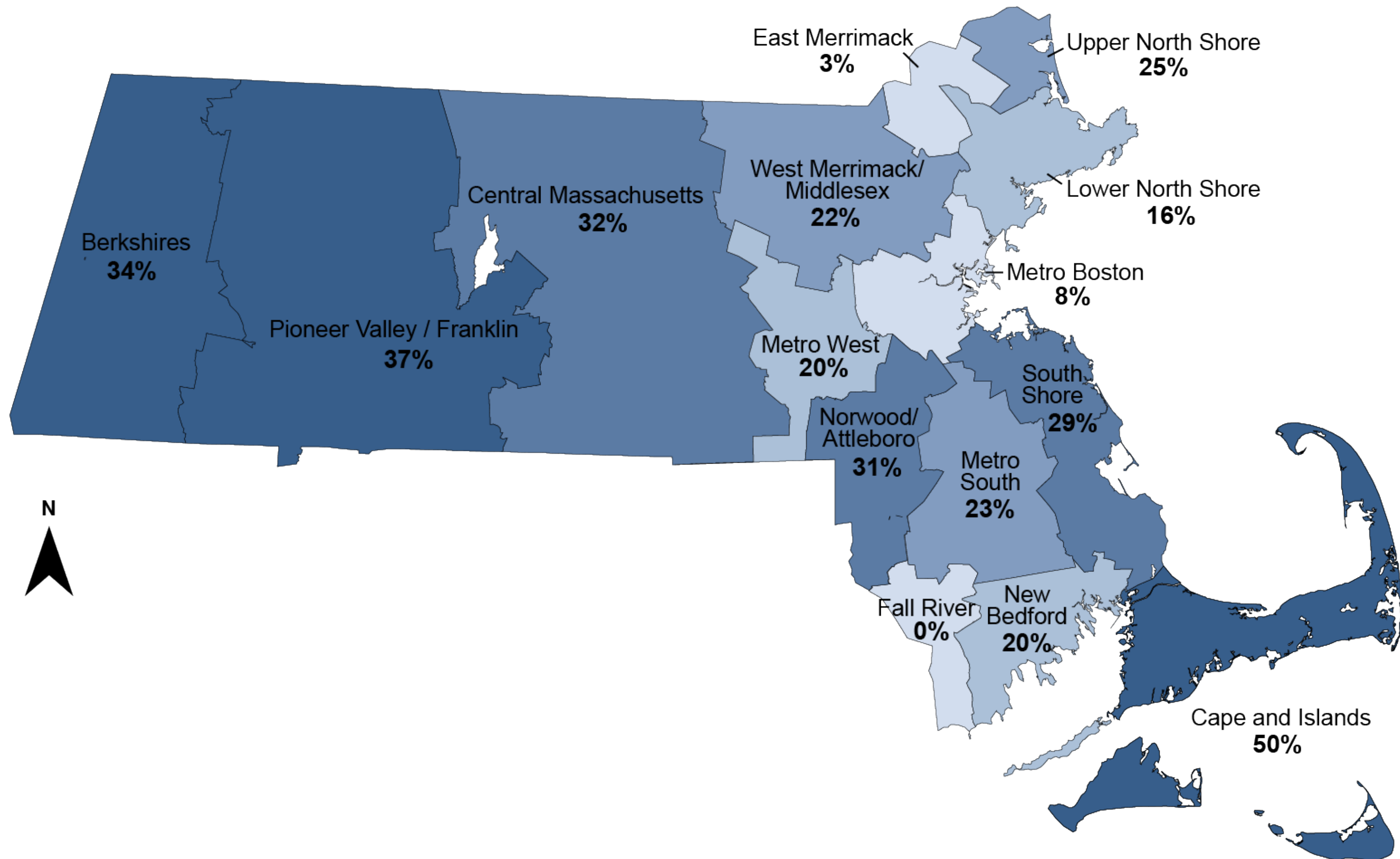


- Mental health clinics without an SUD license represent 50% of providers
  - These sites may still treat patients with SUD, per individual staff members' clinical licenses
- Clinics with dual licensure follow BSAS requirements for staffing and treatment protocols

n (all license types) = 586

Source: HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) licensing data. Note: while community health centers (CHC) that have mental health or SUD licenses are included, any CHC or primary care provider not licensed as a mental health or SUD clinic is not included, regardless of whether it provides prescribing for mental health or SUD.

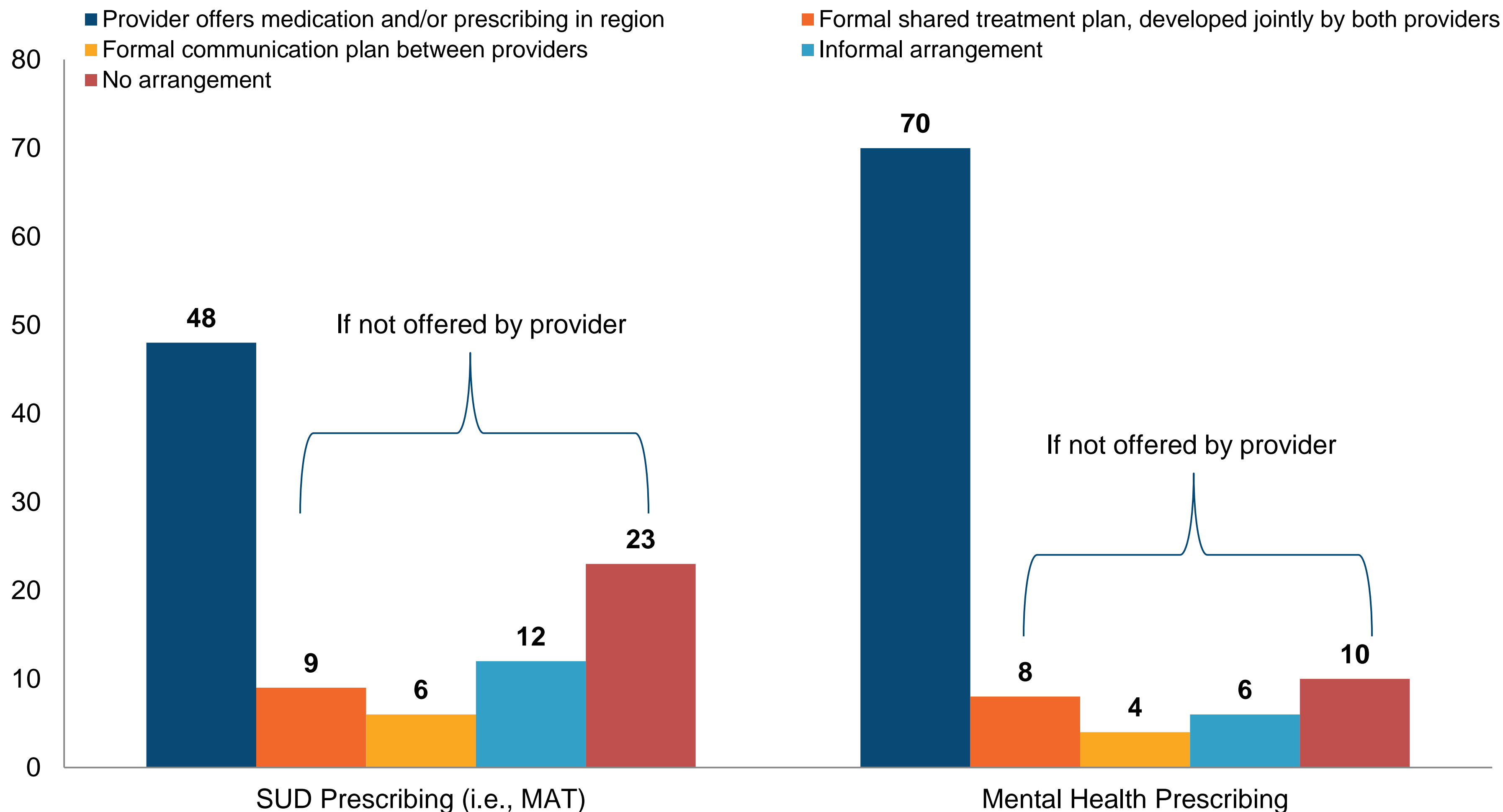
Percent of population over 18 who live more than a 15 minute drive from the nearest dually licensed clinic, 2018



Note: There are 15 HPC regions, which are based on patterns of patient travel for inpatient care. For more information on how HPC created these regions, please see: http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf. Driving distance is based on HPC analysis of population by zip code from American Community Survey, 5 year estimates, 2016, U.S. Census Bureau

HPC

Providers reported a range of prescribing arrangements; some have no arrangements for providing medication

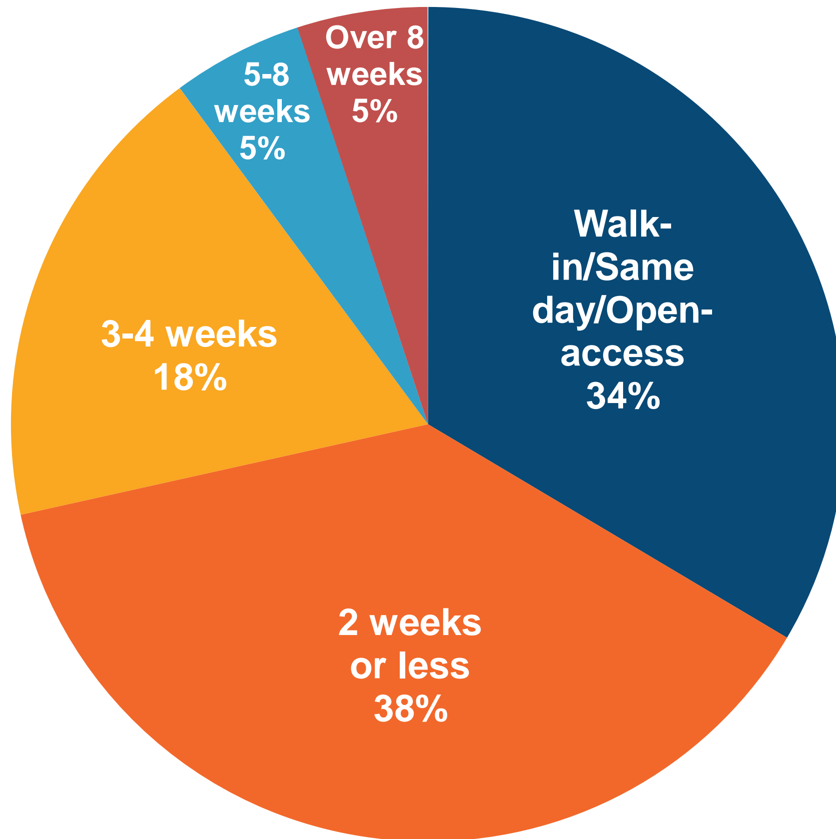


*Of all survey respondents that reported offering outpatient services for mental health and SUD, 98 responded to both 1) a question about SUD prescribing and 2) about mental health prescribing.

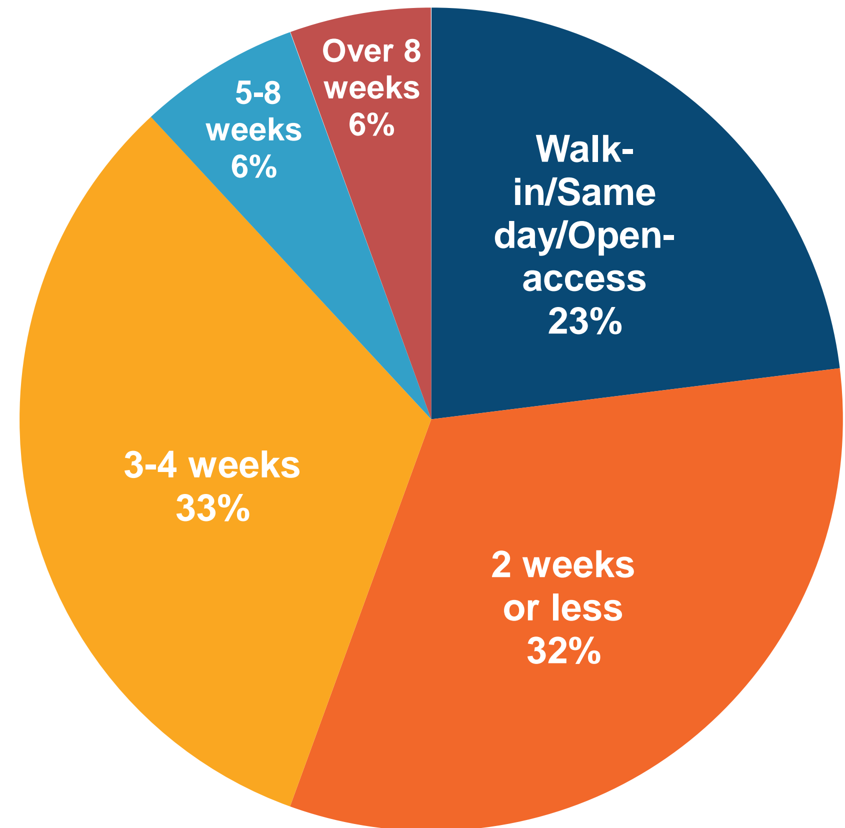
HPC

Patients at responding providers' sites face longer waits for co-occurring disorders care if they do not speak English

Time to first appointment for adults with co-occurring disorders who speak English



Time to first appointment for adults with co-occurring disorders who do not speak English



Note: the survey did not distinguish between prescribing versus non-prescribing services within questions about access based on language needs.

HPC

Summary of Recommendations

Licensing and Regulation

- The Commonwealth should continue **to develop a systematic approach to identifying and monitoring** prevalence of co-occurring disorders and the corresponding service capacity and availability.
- EOHHS should continue its efforts to **streamline the licensure process** for providers seeking both SUD and mental health licenses.

Integrated Care Models

- The Commonwealth should continue to **promote and fund evidence-based integrated care models** for the treatment of co-occurring disorders, particularly those that integrate care with community based organizations, primary care providers, and social service organizations.
- The Commonwealth should **strengthen access to behavioral health medication treatment** and recognize it as a standard of care.

Workforce

- The Commonwealth should continue to invest in developing a **diverse, well-trained, and supported** behavioral health workforce.

Payment Policy

- Payers should **improve reimbursement rates and payment policies** to encourage access to and integration of behavioral health care.

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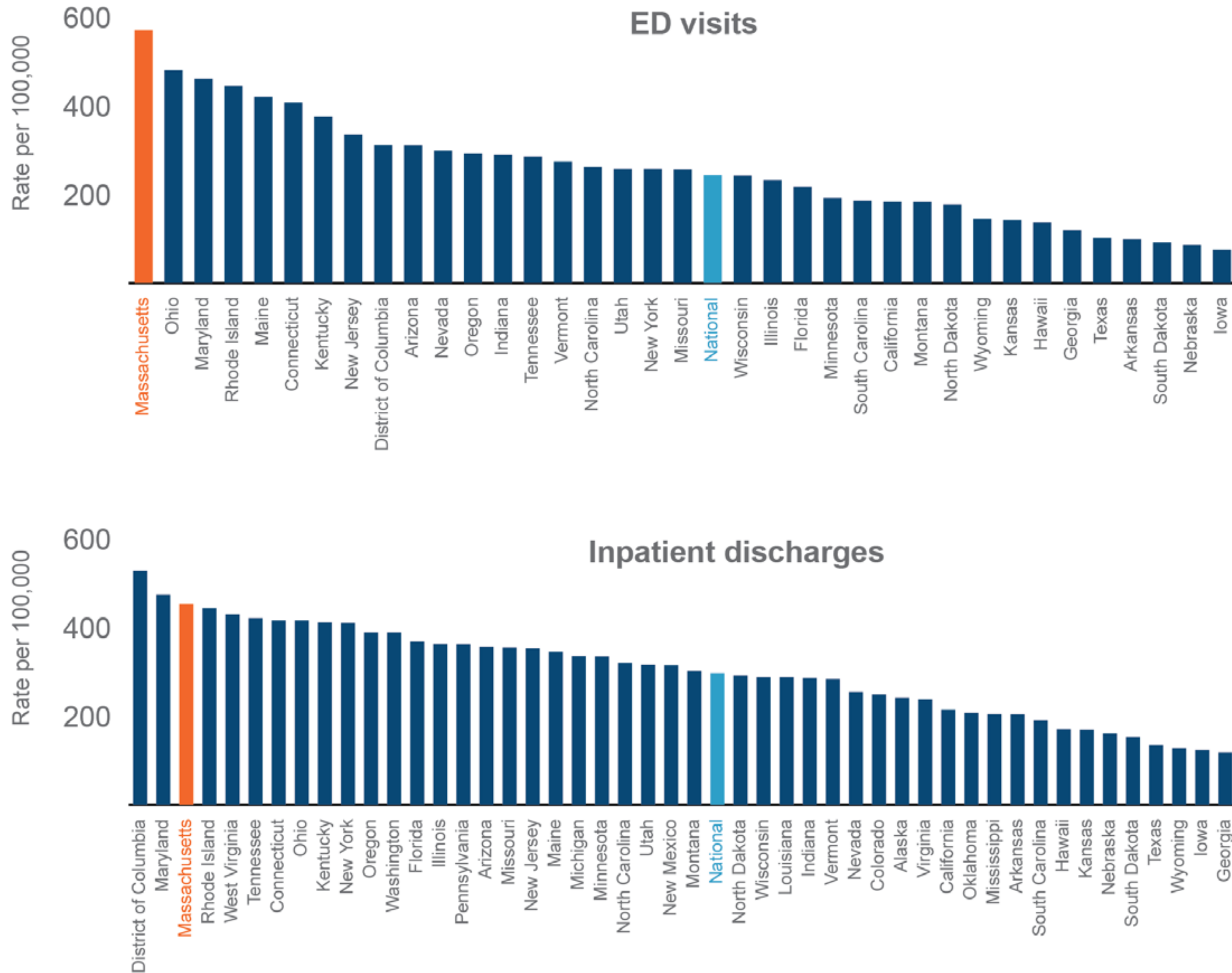
Opioid-related hospital utilization by state, 2016



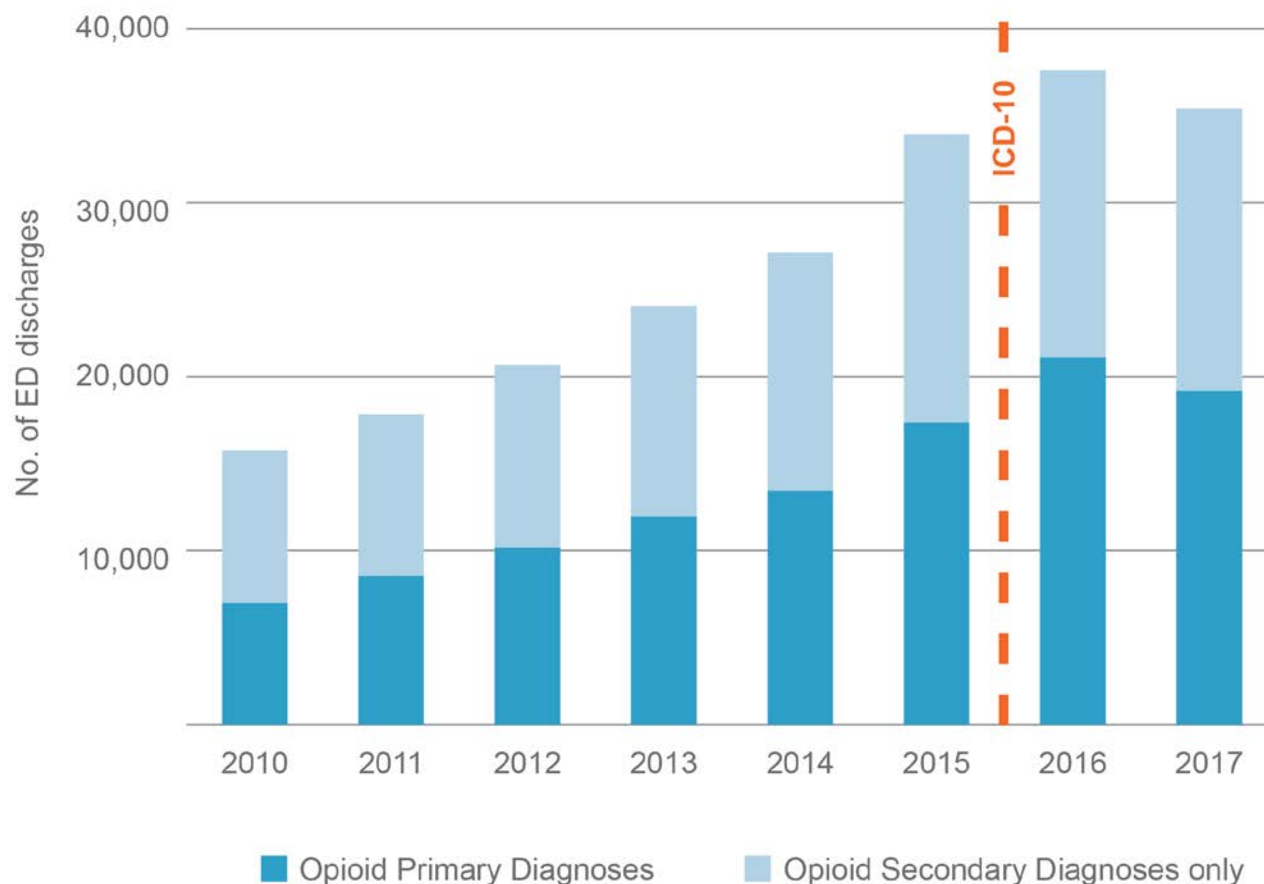
HPC

Source: HCUP Fast Stats. Healthcare Cost and Utilization Project (HCUP). October 2018. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/faststats/opioid/opioidusemap.jsp?setting=ED

Notes: ED visits are limited to 37 states that reported data and inpatient discharges are limited to 48 states that reported data.

Opioid-related acute care hospital ED utilization, 2010-2017

ED



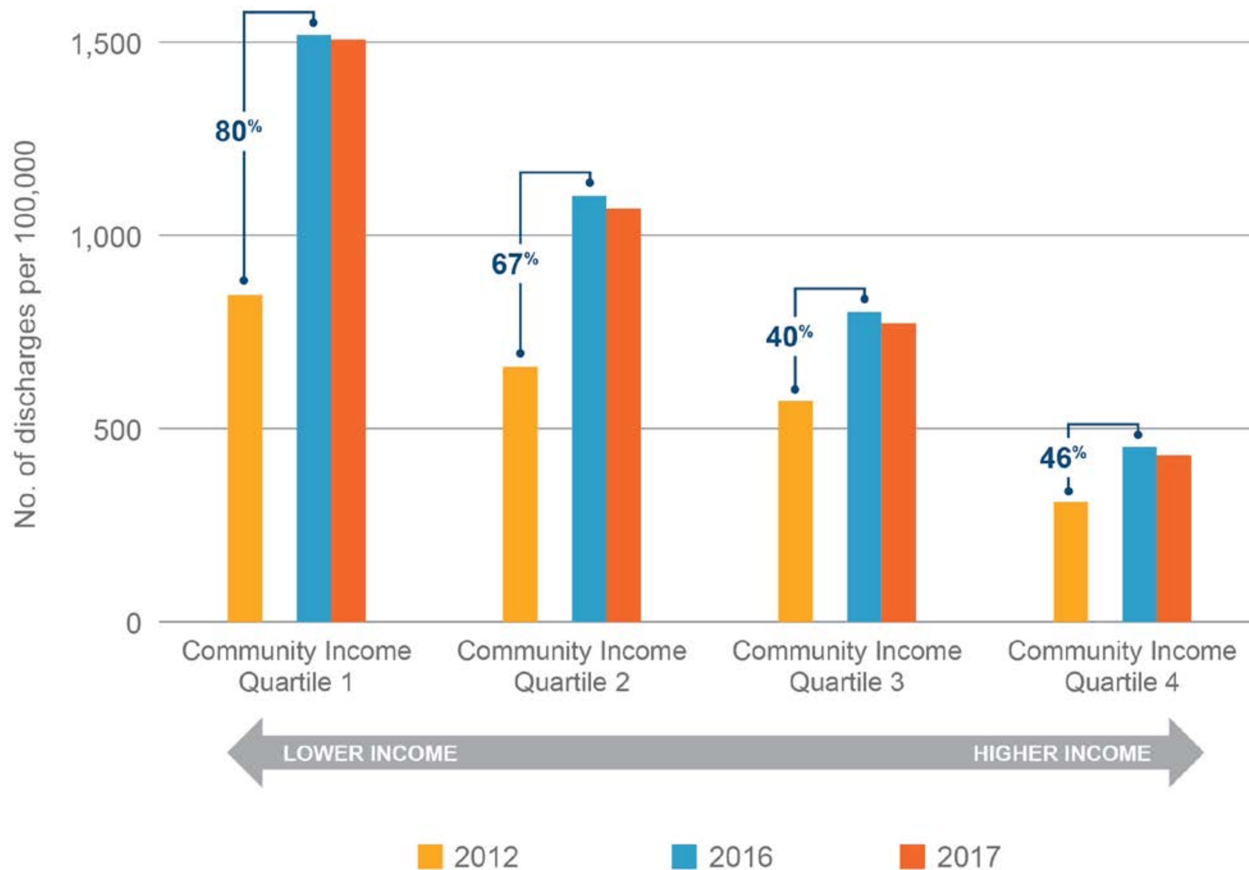
In 2017, ED visits represented just over half of all opioid-related utilization in acute care hospitals. Over half of those visits had an opioid-related primary diagnosis (e.g., dependence, poisoning, etc.).

Between 2016 and 2017, the overall volume of opioid-related ED discharges decreased by 5.9%.

Source: Data: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital ED Databases, 2010-2017.
Note: From 2011 to 2014, the CHIA databases included only the patient's first 15 diagnosis codes. However, as of 2015 all of a patient's diagnosis codes are included. This had almost no impact on ED discharge counts, only 19 additional ED stays with secondary opioid-related diagnoses were counted between 2015 and 2017 due to the expansion of the number of diagnoses codes present in the data.

Opioid-related hospital discharge rates per 100,000 by community income quartile, 2012, 2016, and 2017

Inpatient and ED



Residents of the lowest income quartile areas of the state had the highest rate of opioid-related hospital discharges in 2017. Despite accounting for only 25% of the Commonwealth's population, these residents accounted for 40% of all opioid-related discharges. Those living in the highest income quartile areas of the state accounted for 11% of opioid-related discharges.

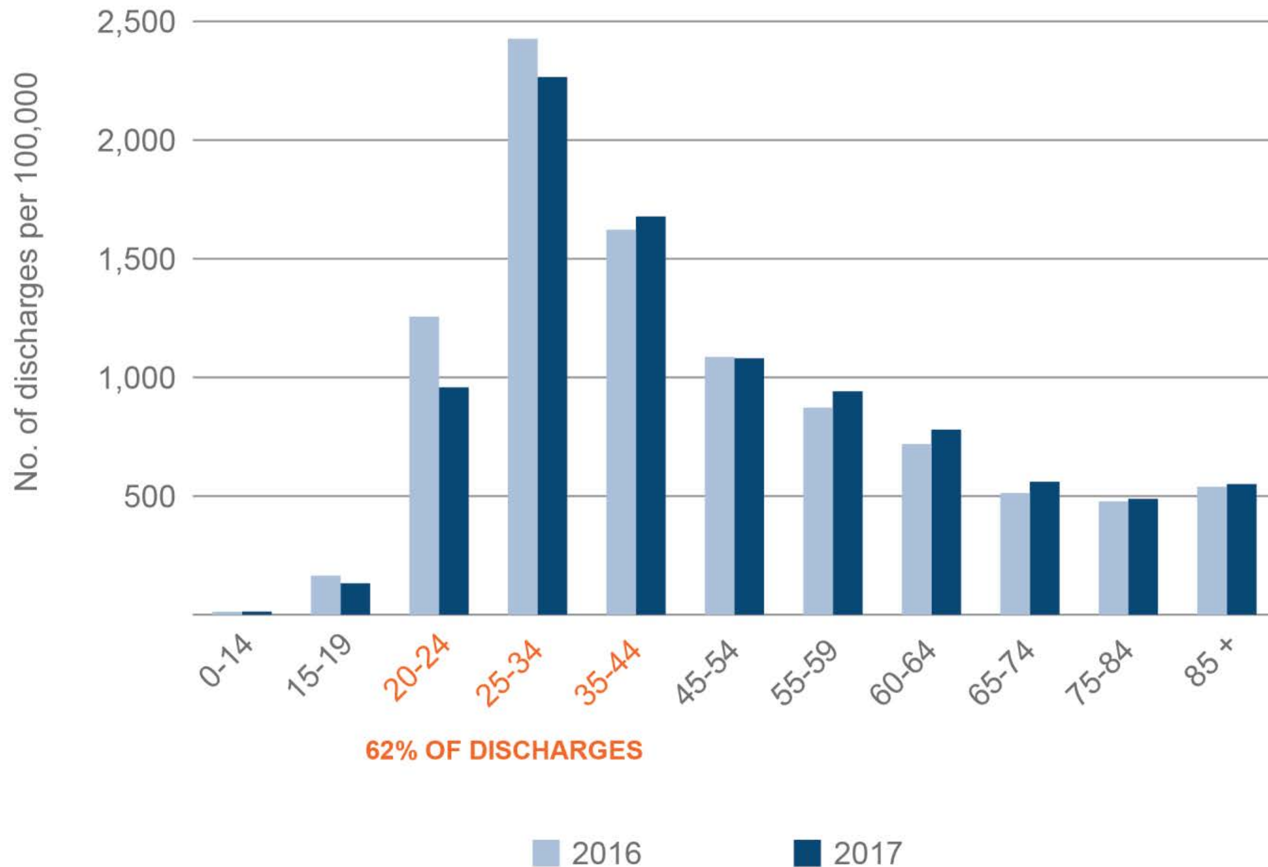
The rate of opioid-related discharges in the highest income quartile increased by 46% between 2012 and 2016, compared to 80% in the lowest income quartile. From 2016 to 2017, opioid-related hospital discharge rates declined by less than 1% in the lowest income communities compared to 4.6% in the highest income communities.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2012, 2016, 2017, and U.S. Census, ACS 5 Year Population Estimates, Median Income by Zip Code Tabulation Areas (ZCTA), 2012 and 2017.

Note: Income quartiles were calculated from 2017 median income by ZCTA and are based on the median income of a patient's residential community, rather than the patient's actual income.

Opioid-related hospital discharge rates per 100,000 by age group, 2016 and 2017

Inpatient and ED



While the rate of opioid-related discharges for older adults increased from 2016 to 2017, the rate among patients under 35 declined overall. The largest decline occurred among patients between 20 and 24 years old (24% decrease).

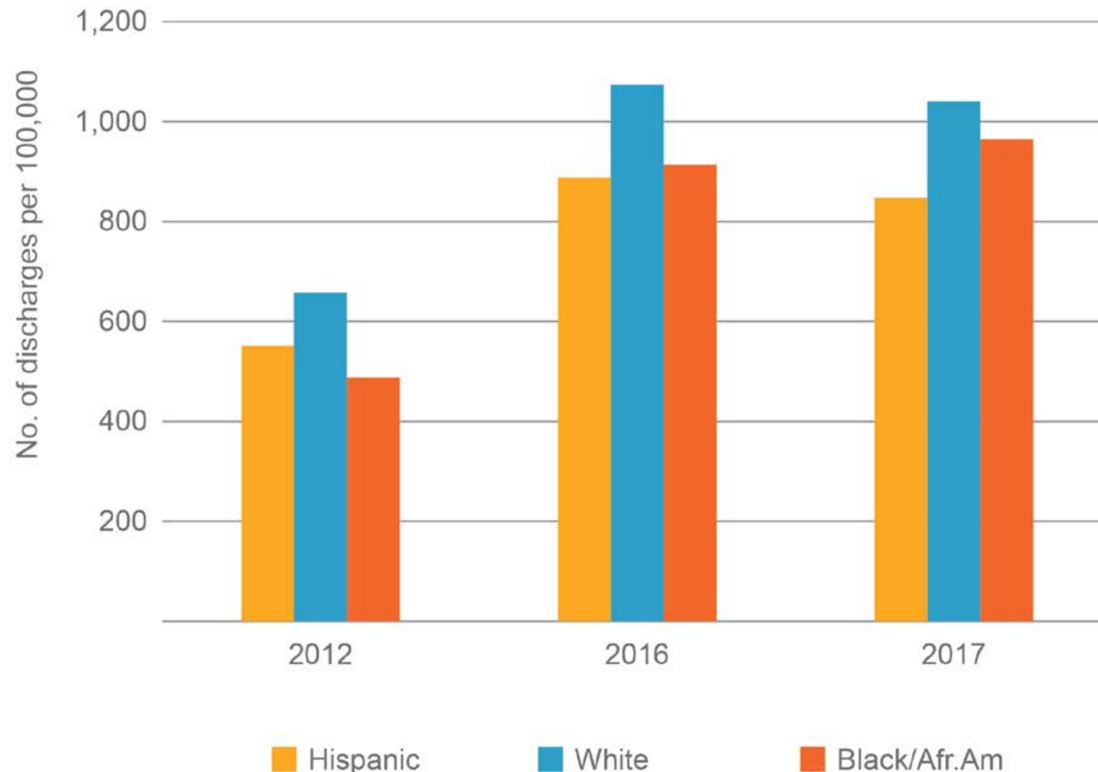
Despite those declines, opioid-related hospital discharges remain disproportionately concentrated among younger adults. Although people between the ages of 20 and 44 represent only 33% of the Commonwealth's population, patients in this age group accounted for 62% of opioid-related hospital discharges in 2017. Patients aged 25-34 still had the highest rate of opioid-related discharges (2,265 per 100,000 people) in 2017.

HPC

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2016 and 2017.
Note: Age groups are based on those used by the American Community Survey.

Opioid-related hospital discharge rates per 100,000 by race and ethnicity, 2012, 2016, and 2017

Inpatient and ED



In 2017, patients identified in the data as non-Hispanic White had the highest rate of opioid-related discharges (1,040 discharges per 100,000 people) but experienced a 3% decrease from 2016. Those identified as Hispanic also experienced a 4.6% reduction in the rate of opioid-related discharges between 2016 and 2017.

However, the rate increased more than 5% from 2016 to 2017 among those identified as Black/African American, to 964 discharges per 100,000.

For all individuals with race identifiers available in the data, the rate increased by 58% between 2012 and 2017; among those identified as Black/African American, the rate increased by 98% in that time period.

Source: HPC Analysis of the Center for Health Information and Analysis (CHIA), Hospital Inpatient Discharge and ED Databases, 2012, 2016, 2017; U.S. Census, ACS 5 Year demographic and housing estimates, 2012, 2016, 2017.

Notes: U.S. Census data used for the calculation of the rate included only people with single race. The census estimates of multi-racial populations are not included in the rate calculation. Racial data from the Hospital Inpatient Discharge Database may classify people with two or more races differently than the census data does, so rates per 100,000 should be interpreted with caution. Each year's rate is calculated in the same manner, so the rates can be compared over time. The analysis does not include racial classifications of Asian or Other, as each had low numbers and together comprised 2% of the data. Racial data was missing from 1.6% of opioid-related discharges.

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Administrative complexity drives up the cost of health care for patients and purchasers.

> In 2016, the United States spent nearly twice as much as 10 high-income countries on medical care.... Prices of labor and goods, including pharmaceuticals and devices, and **administrative costs appeared to be the main drivers** of the differences in spending.

Health Care Spending in the United States and Other High-Income Countries (2018)
Irene Papanicolas, PhD; Liana R. Woskie, MSc; Ashish K. Jha, MD, MPH

HPC

Massachusetts payers and providers believe that administrative complexity threatens the Commonwealth's ability to meet the benchmark.

The challenge of administrative complexity – and its unintended consequences – has been identified in pre-filed testimony before every annual cost trends hearing.

Examples from pre-filed testimony

- Provider credentialing
- Eligibility verification
- Prior authorization
- Claims submission, denials and appeals
- EHR integration, data-sharing, interoperability
- Government regulations, reporting requirements
- Duplicative care management programs
- Quality performance measurement
- Variation in risk contract terms

Clinician confusion, discomfort, burn-out

Decreased time with patients

Distraction from other priorities

Confusion and anxiety for patients

HPC

Some areas of administrative complexity add value; others do not.

Policy Recommendation:

The Commonwealth should take action to identify and address areas of administrative complexity **that add costs** to the health care system **without improving the value or accessibility of care**.

Potential markers of administrative complexity without value

Takes clinician time or attention away from patient care

Driven or constrained by current technology and its limitations

Must be repeated or done differently to accommodate non-standard forms or processes

Costs outweigh financial benefits

HPC

Proposed Principles for Selecting Focus Areas

1. Reducing complexity in this area would measurably reduce health care costs in Massachusetts **without jeopardizing quality or access**
2. Massachusetts **stakeholders have prioritized action** in this area
3. The issue can be addressed **at the state level**
4. Work in this area could **complement without duplicating** existing efforts

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HPC

Identifying Stakeholder Priorities

- The HPC has met with several individuals and organizations that are interested in reducing administrative complexity, including:

Payers	Trade associations	Clearinghouses
Providers	Government agencies	Non-profits

- Many are already working to reduce administrative complexity, on their own and/or collaboratively. Priority areas vary based on the strategic interests of the organization.
- The HPC distributed the **Reducing Administrative Complexity Advisory Council Survey** in May to more formally identify stakeholders' top priorities
  - Respondents were asked to rate 12 areas as a **High**, **Medium**, or **Low** priority, rating no more 3 areas as High priority
- The HPC received 15 completed surveys
- The HPC evaluated priority areas by:
  - Total points earned, where **High** = 2 points; **Medium** = 1 point; **Low** = 0 points
  - Total number of "High" ratings

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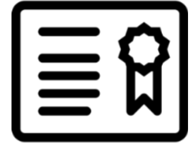
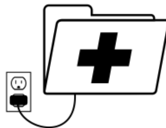
Advisory Council Survey: Areas of Administrative Complexity



Billing and Claims Processing	Provider Credentialing
Clinical Documentation and Coding	Provider Directory Management
Clinician Licensure	Quality Measurement and Reporting
EHR Interoperability	Referral Management
Eligibility/Benefit Verification	Variations in Benefit Design
Prior Authorization	Variations in Payer-Provider Contract Terms



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Advisory Council Survey: Results at a Glance

Billing and Claims Processing	Provider Credentialing
Clinical Documentation and Coding	Provider Directory Management
Clinician Licensure	Quality Measurement and Reporting
EHR Interoperability	Referral Management
Eligibility/Benefit Verification	Variations in Benefit Design
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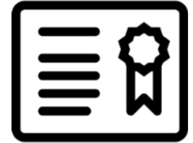

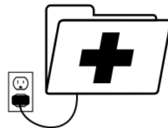

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Advisory Council Survey: Results

	Top Priority Areas	
	By Total Points	**By Total "High" Rankings**
1	Variations in Benefit Design (19)	Variations in Benefit Design (7)
2	Prior Authorization (19)	Prior Authorization (6)
3	Provider Credentialing (17)	Provider Credentialing (6)
4	Eligibility/ Benefit Verification & Coordination of Benefits (17)	
5	Billing & Claims Processing (17)	
6	EHR Interoperability (17)	

Each of the top priority areas were identified by multiple types of organizations (i.e., a combination of payers, providers, employers and patient advocates)

HPC

Reducing Administrative Complexity: Discussion Questions

1. What challenges might the Commonwealth face in addressing these areas?
2. Are there successful models – pilot programs, state policies, international approaches – that could inform a solution?
3. How should the Commonwealth collaborate with organizations that are already working on these topics?
4. How should we engage your organization and other stakeholders on these issues?

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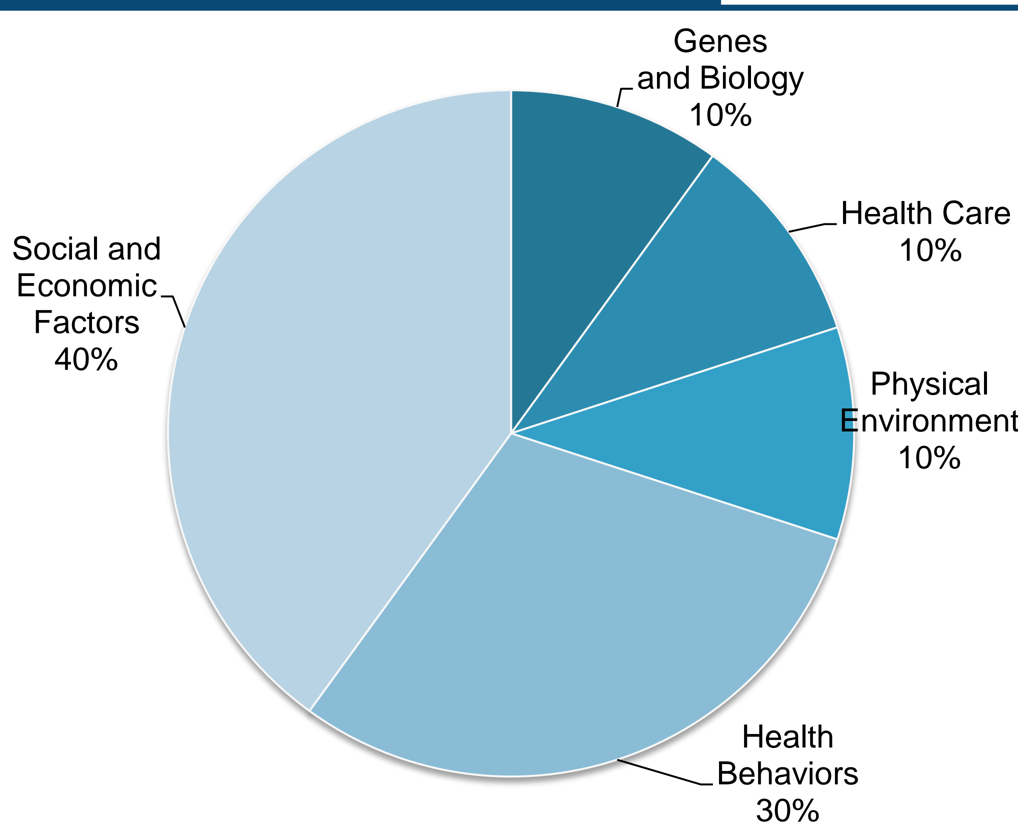
There is a strong consensus that addressing social determinants of health is essential to improving population health, reducing health inequities, and controlling health care costs.

Factors that Impact Health



2018 Annual Health Care

COST TRENDS REPORT

PROMOTING AN EFFICIENT, HIGH-QUALITY HEALTH CARE DELIVERY SYSTEM

#8. SOCIAL DETERMINANTS OF HEALTH. The Commonwealth should continue to address the impact of social determinants of health (SDH) on health care access, outcomes, and costs.

SOURCE: Tarlov, A. Public Policy Frameworks for improving population health. Annals of the New York Academy of Sciences. 1999. 896. 281-93

The HPC seeks to advance health equity through many workstreams.

The **HPC's care delivery transformation mission** is to promote an efficient, high-quality system with aligned incentives that reduces spending and improves health by delivering coordinated, **patient-centered care that accounts for patients' behavioral, social, and medical needs**

Investments

Investment programs offer opportunity to **identify issues related to health inequity**

SHIFT-Care Challenge includes a track specifically designed to address an identified social need

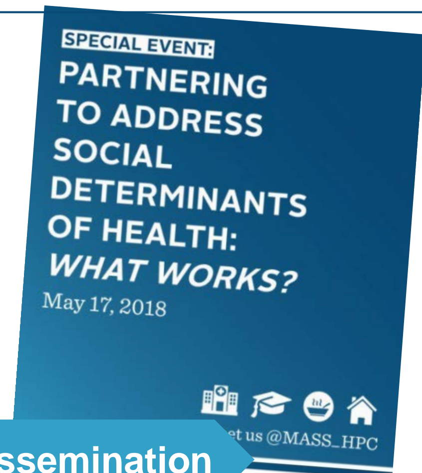
Many **CHART programs** focused on addressing health-related social needs (HRSN) to reduce avoidable acute care use

Certification Standards

ACO Certification program standards encourage providers to prioritize population health management programs that address behavioral health needs and social determinants of health

Research

HPC's research often focuses on identifying gaps in care and areas of inequity (e.g. co-occurring disorders care)



Learning and Dissemination

Creates opportunities to share learnings and **provide forums for collaboration** across state agencies, local municipalities, and with advocacy groups

In May 2018, the HPC hosted an event entitled, "**Partnering to Address the Social Determinants of Health: What Works?**" which convened policymakers, experts, and market participants to highlight the need for cross-system partnerships to address HRSNs

HPC

The Case for a Coordinated Strategy to Align Health Care System and Community Health Initiatives

Context

- Health systems and accountable care organizations (ACOs) **have clinical and financial interest in improving population health and reducing health inequities**
- **Strong partnerships are necessary** for success; communities and health systems/ACOs need **technical assistance and capacity-building investment** to partner effectively

Challenges

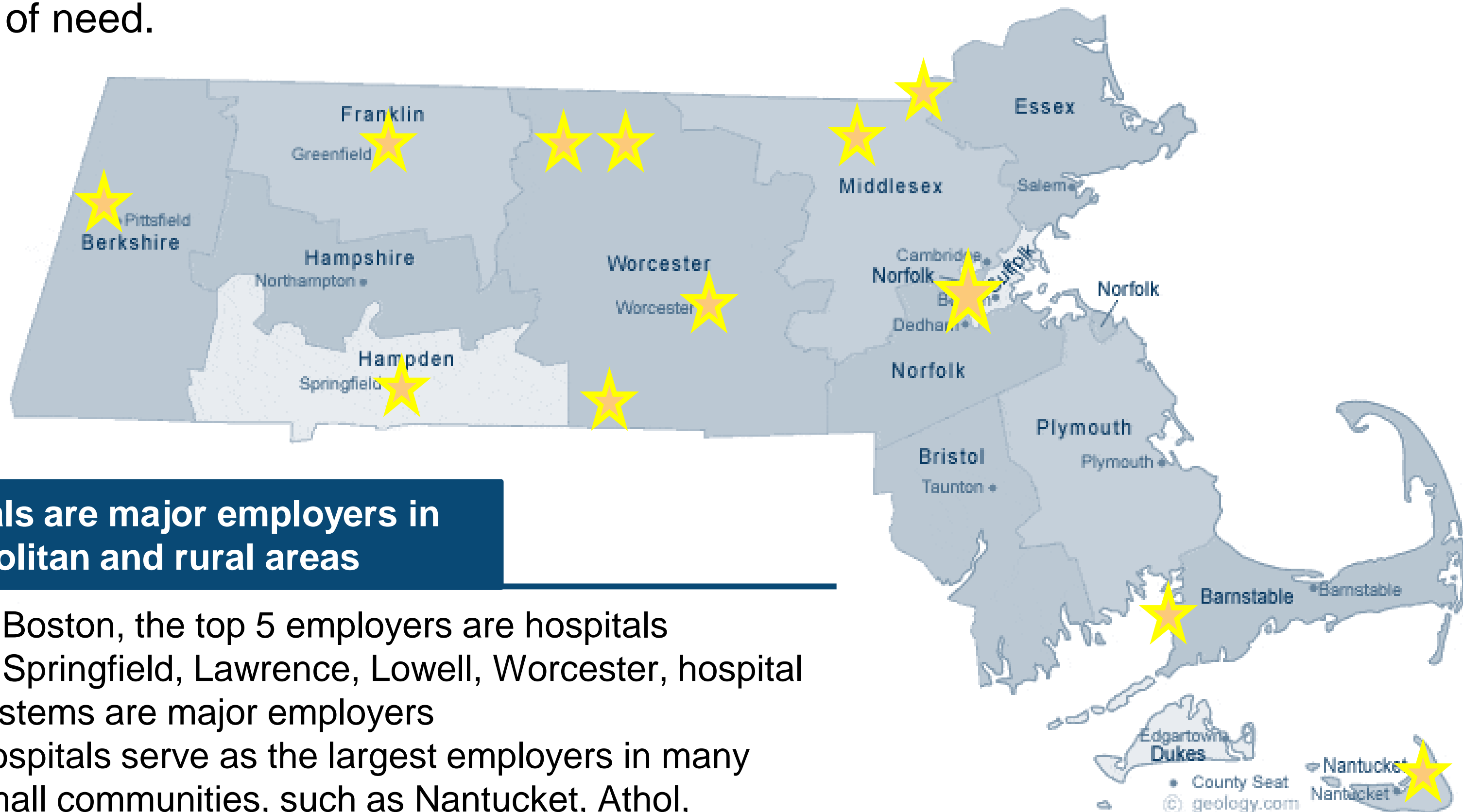
- Difficulties working within individual health systems/ACOs, as well as in collaboration with external health systems, municipal governments, and community organizations to address HRSN
- Data can inform and promote collaborations between health systems/ACOs and communities to address the SDoH, but challenges and barriers exist that limit ability to share and collaborate effectively

Opportunity

- Support the development of **community collaborations that better align resources and policy levers**, including community health needs planning, community benefits programs, ACO population health approaches, municipal public health efforts, and determination of need programs, particularly in areas with demonstrated health needs/inequities

Health systems play an important role in their communities and are well-positioned to collaborate on “upstream” initiatives to improve health.

Hospitals and health care systems play an important role in communities as anchor institutions, care providers, employers, and community development collaborators. This provides a unique opportunity **to address health upstream**, collaborating with community-based and social service organizations and local municipalities to address areas of need.



Hospitals are major employers in metropolitan and rural areas

- In Boston, the top 5 employers are hospitals
- In Springfield, Lawrence, Lowell, Worcester, hospital systems are major employers
- Hospitals serve as the largest employers in many small communities, such as Nantucket, Athol, Gardner, and Southbridge

HPC

Source: Executive Office of Labor and Workforce Development, Largest Employers by Area; Massachusetts Health & Hospital Association, Hospital Directory:

There is an opportunity to leverage HPC's ACO technical assistance resources to drive "upstream" health system - community collaborations

~$2.5 million in funding over 3 years

- Overall HPC ACO Certification program goal is to **enable acceleration of care delivery transformation** towards value-based, integrated care, that addresses the behavioral, social, and physical needs of patients and communities
- TA program should **complement other HPC and state-wide efforts** that support ACOs to address HRSN (e.g., DSRIP)
- Opportunity to **support success and sustainability** of ACO Certification competencies including **population health management**

Introducing Moving Massachusetts Upstream (MassUP)

MassUP Vision:
Better health, lower costs, and reduced health inequities — across communities and populations in Massachusetts — through effective partnerships between government, health care systems, and communities to address the social determinants of health.

- **A partnership across state agencies — DPH, MassHealth, AGO, and HPC**
- Goal: to engage in **policy alignment activities** and make **investments to support health care system–community collaborations** to more effectively address the “upstream” causes of poor health outcomes and health inequity

The MassUP action plan is envisioned to include four key strategies

Investment Program

- The HPC will fund a **competitive grant opportunity** for two community collaboratives to align SDoH investments across all three streams of the health inequity pathway: policies and environment, increased risk, and health-related social needs

Technical Assistance

- DPH will **provide dedicated TA either through staff or contracted resources** to the community collaboratives (e.g., programmatic content expertise, data expertise, convening/facilitation expertise)

Evaluation

- DPH **will analyze, document, and disseminate the design elements necessary to address the SDoH** in clinical and community collaboratives

Aligning Policy

- MassUP will **identify policy opportunities and work to alleviate state-level policy barriers** across MassUP agencies and other SDoH influencing agencies

HPC

MassUP Program Tentative Timeline

	Investment Program	Policy Work Group
2019	**June - July** • HPC-DPH draft and execute ISA	
	July – August • Stakeholder engagement: RFI and Listening Session(s) **September – October** • Finalize investment program design • Prepare RFR **November** • Issue investment program RFR	**July – August** • Convene work group and begin planning AGO-sponsored Learning Forum **Fall** • Continue regular meetings to plan Learning Forum and discuss MassUP alignment with other agency workstreams
2020	**March** • Receive proposals • Select investment awardees **April** • Announce awards • Contract with awardees; program launch	**Winter** • Hold Learning Forum • Identify next steps/priorities for work group

HPC

Contact Information

For more information about the Health Policy Commission:

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