State-University Partnerships: Generating Evidence to Support State Policymaking

November 3, 2016
AcademyHealth’s State-University Partnership Learning Network (SUPLN)
Today’s Speakers

• Enrique Martinez-Vidal, M.P.P.
  • Vice President for State Policy and Technical Assistance, AcademyHealth

• Julie Donohue, Ph.D.
  • Associate Professor and Vice Chair for Research, University of Pittsburgh

• Joel C. Cantor, Sc.D.
  • Distinguished Professor of Public Policy and Director, Center for State Health Policy, Rutgers University

• Cynthia H. Woodcock, M.B.A.
  • Executive Director, The Hilltop Institute, University of Maryland-Baltimore County
Today’s Presentation

• Leaders from partnerships that are participating in AcademyHealth’s State-University Partnership Learning Network will:

  • Provide examples of policy and data analyses they are conducting for their respective states

  • Discuss how state policymakers have used their studies

  • Highlight issues related to data collection, linkage, and analytic methodologies

  • Offer insights into the challenges, opportunities, and overall value of participating in such partnerships
State-University Partnerships 101

• Post ACA, states are even more focused on efforts to improve health and healthcare, particularly for low-income, vulnerable populations

• Policymakers tend to be higher users of research for decision-making when they interact with the research process in the context of research-policy networks

• State-University Partnerships:
  1. Are collaborations between a state governmental entity (generally Medicaid) and a state-related university research center
  2. Support the important dialogue needed to generate timely and relevant evidence for state policymaking
State-University Partnership Learning Network

• Launched by AcademyHealth in 2014.

• Learning network for state-based partnerships between Medicaid policymakers and their resident state or state-affiliated university research teams.

• Collaboratively works to support evidence-based state health policy and practice with a focus on transforming Medicaid-based healthcare, including improving the patient experience, improving the health of populations, and reducing the per capita cost of healthcare.
Current SUPLN Members

→ Arkansas
→ Arizona
→ California (UCSF, UCD, UCLA)
→ Connecticut
→ Delaware
→ Georgia
→ Iowa
→ Kentucky (UK, UofL)
→ Maine
→ Maryland
→ Massachusetts
→ Michigan (MSU, UM)
→ Minnesota
→ New Hampshire
→ New Jersey
→ North Carolina
→ Ohio
→ Oregon
→ Pennsylvania
→ South Carolina
→ Wisconsin
State-University Partnerships: Generating Evidence to Support State Policymaking

The Pennsylvania Experience
Julie Donohue, PhD
Medicaid Research Center
State-University Partnership Learning Network
The opioid/heroin epidemic

• On an average day in US:
  • More than 650,000 opioid prescriptions dispensed\(^1\)
  • 3,900 people initiate nonmedical use of prescription opioids\(^2\)
  • 580 people initiate heroin use\(^2\)
  • 78 people die from an opioid-related overdose\(^3\)
• 50-80% of those w/ heroin abuse use prescription opioids first\(^4\)
• 80% with opioid use disorder receive no treatment\(^3\)

States play key role

National Governors Association
Opioid Road Map Executive Summary

**THE PROBLEM**
Inappropriate opioid prescribing has fueled one of the deadliest drug epidemics in U.S. history. Though most opioid-related overdoses involve prescription opioids, an increasing number are linked to illicit opioids such as heroin and fentanyl.

**THE ROLE OF STATES**
Governors are taking action to end the opioid epidemic with a range of public health and public safety strategies across the continuum from prevention and early identification to treatment and recovery.

**THE ROAD MAP**
The road map is a tool to help states respond to the opioid crisis with effective health care and public safety strategies.

**STEP 1** Assess the Situation
- **IDENTIFY POLICY AND FINANCIAL LEVERS, AND CONDUCT HIGH-LEVEL DATA SCAN**
- **IDENTIFY OR CREATE PRESCRIPTION OPIOID AND HEROIN TASK FORCE**
- **ENSURE KEY DECISION MAKERS ARE INVOLVED**
- **CONNECT WITH PRIORITY STAKEHOLDERS AND SET VISION**

**KEY STATISTICS**
- **Every day, 78 people die from an overdose related to prescription opioids and heroin.**
- **Medicaid is the most common payer of opioid-related hospitalizations, the cost of which quadrupled between 2002 - 2012.**
- **In 2012, health care providers wrote enough opioid prescriptions for every American adult to have a bottle of pills.**
- **Heroin seizures by U.S. law enforcement rose 81% between 2010 - 2014.**
- **80% of people with an opioid use disorder are not receiving treatment.**
- **4 out of 5 heroin users reported misusing prescription opioids before moving to heroin.**
States’ role in financing and administering SUD treatment programs

Note: The designation “other private” refers to funding from private foundations, and “other federal” refers to spending by government entities such as the Substance Abuse and Mental Health Services Administration and the Department of Veterans Affairs.

Source: Substance Abuse and Mental Health Services Administration, Truven Health Analytics

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http://www.pewtrusts.org~/media/assets/2015/03/substanceusedisordersandtheroleofthestates.pdf
Why focus on Medicaid?

- Largest payer (70 million covered)
- Medicaid pays for roughly 1/8th of opioid use\(^1\)
- Medicaid enrollees prescribed a higher daily dose than commercially insured\(^2\)
- 1/4 of Medicaid enrollees with opioid medications (>90 days) have misuse\(^3\)

Our Partnership

• Pennsylvania Department of Human Services
  – Administers Medicaid, 2.8 million enrollees
  – Administers several other social service and health programs

• Medicaid Research Center
  – Provides research and policy evaluation to inform the administration of the PA Medicaid program

Findings: identify predictors of overdose?

Cochran et al *Medical Care* in press
Findings: quality of medication-assisted treatment?

Patterns and Quality of Buprenorphine Opioid Agonist Treatment in a Large Medicaid Program

Adam J. Gordon, MD, MPH, Wei-Hsuan Lo-Ciganic, PhD, Gerald Cochran, PhD, Walid F. Gellad, MD, MPH, Terri Cathers, PharmD, David Kelley, MD, and Julie M. Donohue, PhD

Objectives: Use of buprenorphine—a effective treatment for opioid use disorders (OUDs)—has increased rapidly in recent years and is often financed by Medicaid. We investigated predictors of buprenorphine treatment, patterns of care, and quality of care in a large state Medicaid program.

Methods: Data from Pennsylvania Medicaid from 2007 to 2012 provided information regarding diagnoses, demographic characteristics, enrollment, and use of inpatient and outpatient services, and prescription drugs. We identified adult enrollees using buprenorphine, and examined prevalence of OUD diagnosis and patterns of use (duration and dose) and quality of care (physician visits, receipt of behavioral health counseling, urine drug screens, and other prescription drug use). We use a mixed logistic regression model to examine enrollee characteristics associated with buprenorphine use.

Results: The share of enrollees with OUD filling prescriptions for buprenorphine increased from 2011 (0.2%) to 2012 (0.3%) from and 38.0% had other opioid and benzodiazepine claims, respectively, concomitant with buprenorphine use. Quality of care was lower among those with no OUD diagnosis recorded. The mean daily doses of buprenorphine decreased over time. We found wide variation in likelihood of buprenorphine use among those with OUD based upon age, sex, and race.

Conclusions: Increases in buprenorphine treatment in a Medicaid population were observed across time; however, increases varied by age, sex, and rate, and the quality of care received seemed to be generally poor. The quality of the provision of buprenorphine treatment occurring in Medicaid populations should be further explored.

Key Words: buprenorphine, health services, Medicaid, opioid-related disorders, opioid substitution treatment

(J Addict Med 2015;9: 470–477)
Findings: appropriate duration of treatment?

Association between trajectories of buprenorphine treatment and emergency department and in-patient utilization

Wei-Huan Lo-Ciganic1,2, Walid F. Gellad3,4, Adam J. Gordon3,4, Gerald Cochran3,4, Michael A. Zmaitis4,4, Terri Cathers5, David Kelley7 & Julie M. Donohue2,6

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ABSTRACT

Background and aims Uncertainty about optimal treatment duration for buprenorphine opioid agonist therapy may lead to substantial variation in provider and payer decision-making regarding treatment course. We aimed to identify distinct trajectories of buprenorphine use and examine outcomes associated with these trajectories to guide health system interventions regarding treatment length. Design Retrospective cohort study. Setting US Pennsylvanias Medicaid. Patients A total of 10,945 enrollees aged 18–64 years initiating buprenorphine treatment between 2007 and 2012. Measurements Group-based trajectory models were used to identify trajectories based on monthly proportion of days covered with buprenorphine in the 12 months post-treatment initiation. We used separate multivariable Cox proportional hazards models to examine associations between trajectories and time to first all-cause hospitalization and emergency department (ED) visit within 12 months after the first-year treatment. Findings 50 trajectories (Bayesian information criterion (BIC) = –86,246.70) were identified: 24.9% discontinued buprenorphine < 3 months, 18.7% discontinued between 3 and 5 months, 12.4% discontinued between 5 and 8 months. 11.3% discontinued > 8 months. 9.5% refilled intermittently and 21.2% refilled persistently for 12 months. Persistent refill trajectories were associated with an 18% lower risk of all-cause hospitalization (hazard

Figure 1. Trajectories of the first-year treatment of buprenorphine. PDC = proportion of days covered. The average predicted PDC in each group is plotted with solid lines. The average observed PDC of individuals in each group is plotted with dashed lines.
New policy initiative

45 Centers of Excellence to serve as health homes for those with opioid use disorders

Specialty and primary care settings
New funding to expand access

Increasing Access to Medication-Assisted Treatment of Opioid Abuse in Rural Primary Care Practices

An important aspect of the opioid epidemic is the lack of treatment options for millions of Americans living in rural communities. We can expand access by engaging primary care practices—the places where most rural Americans receive care. Doctors and nurses in these practices are trusted members of the community. They need information and tools to provide effective, evidence-based care for patients with opioid addictions. Medication-Assisted Treatment, or MAT, is evidence-based therapy for assisting people with opioid addiction in primary care offices. MAT involves using both medications and behavioral support to empower people to manage their addiction. The trouble is that many primary care physicians find it difficult to introduce MAT into their practice.
Seeking Opportunities to Improve Care for High-Need, High-Cost Medicaid Beneficiaries

APPAM Panel Discussion
State-University Partnerships: Generating Evidence to Support State Health Policymaking

November 3, 2016
Washington DC

Joel C. Cantor, ScD
Distinguished Professor of Public Policy
Director, Center for State Health Policy
Acknowledgement and Disclaimer

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The views expressed in this presentation are exclusively those of its author, and may not reflect those of the State of New Jersey, research collaborators, or project sponsors.

Full report available at:
NJ Medicaid Enrollment, January 2013 to July 2016

By eligibility category

Source: NJ Department of Human Services. Note: Children are under age 21.
RBHS Task Force on Medicaid High Utilizers

In his 2015 Budget Address, Governor Chris Christie requested Rutgers Biomedical and Health Sciences (RBHS) to work with others to examine opportunities to improve care, reduce cost for highest-cost beneficiaries

• Emergency department use
• Repeat inpatient stays
• Hospital stays over 30 days
• Complications of treatment of complex behavioral, mental health, substance abuse conditions
• Other high-cost patients (top 1%)
Distribution of Total NJ Medicaid Spending by Spending Group, 2013

Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
Distribution of Total NJ Medicaid Spending by Spending Group, 2013

Top 0.1% of enrollment accounts for 6.9% of spending

Enrollment & Spending share
- <0.1%
- 0.1-1%
- 1-5%
- 5-10%
- 10-25%
- 25-50%
- Bottom 50%

Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
Distribution of Total NJ Medicaid Spending by Spending Group, 2013

Top 1.0% of enrollment accounts for 28.1% of spending

Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
Distribution of Total NJ Medicaid Spending by Spending Group, 2013

Top 5.0% of enrollment accounts for 61.5% of spending

Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
Distribution of Total NJ Medicaid Spending by Spending Group, 2013

Average Monthly Spending

- Bottom 50% of enrollment accounts for 2.5% of spending

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<th>Enrollment &amp; Spending share</th>
<th>Share of Spending</th>
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<td>&lt;0.1%</td>
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<td>10-25%</td>
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Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
## Spending persistence, 2012-2013

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<th>Spending group in 2012</th>
<th>≤ 0.1%</th>
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<th>25-50%</th>
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<td>≤ 0.1%</td>
<td>63.1%</td>
<td>28.7%</td>
<td>4.3%</td>
<td>1.8%</td>
<td>0.8%</td>
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<td>19.5%</td>
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<td>67.8%</td>
<td>13.5%</td>
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<td>12.3%</td>
<td>46.6%</td>
<td>24.9%</td>
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<td>1.9%</td>
<td>8.9%</td>
<td>44.0%</td>
<td>26.6%</td>
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<td>0.1%</td>
<td>0.4%</td>
<td>1.8%</td>
<td>16.7%</td>
<td>41.4%</td>
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<tr>
<td>Bottom 50%</td>
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<td>0.03%</td>
<td>0.2%</td>
<td>0.6%</td>
<td>5.2%</td>
<td>20.2%</td>
<td>73.7%</td>
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</table>
Percent Living in Facilities within Spending Groups, 2013

- Top 0.1%: 67.1%
- 0.1% to 1.0%: 8.6%
- >1.0% to 5.0%: 43.5%
- All NJ Medicaid: 2.4%

Developmental Centers (for persons with intellectual and developmental disabilities)
Nursing Facilities

Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
Avoidable Hospitalization Rate per 1,000 Adult Recipients by Spending Group, 2013

Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
30-Day All-Cause Hospital Readmission Rate among Adult Recipients by Spending Group, 2013

- **Top 1.0%**: 33.3%
- **>1.0% to 10.0%**: 10.9%
- **Bottom 90.0%**: 3.0%

Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
Mental Health and Substance Use Disorder Diagnoses by Spending Group, 2013

Source: Rutgers Biomedical and Health Sciences Working Group on Medicaid High Utilizers
RBHS Task Force Recommendations

• Integration of Behavioral and Physical Health
• Interventions for Populations with Persistently High Costs
• Coordinate social services & public health with Medicaid
• Adopt clinical best practices
• Strengthen infrastructure and accountability
NJ Medicaid Policy & Data Developments

- Increase payments for behavioral health services
- Expand Behavioral Health Home pilot program
- Rapid transition to care of formerly incarcerated upon reentry
- Medicaid ACO demonstration project
- High-Fidelity Housing First for chronically homeless
  - 500 HFHF vouchers this year
  - Medicaid waiver application to cover supportive services
  - Link Homeless MIS to Medicaid data
- Managed mental health & substance use disorder delivery system
- Create Integrated Population Health Data (iPHD) project.
Thank You
State-University Partnerships: Generating Evidence to Support State Policymaking

The Maryland Experience

Cynthia H. Woodcock

APPAM Fall Research Conference

November 3, 2016
The 2014 federal waiver for Maryland’s All-Payer Model for hospitals has these requirements

- Shift 100% of hospital revenue to population-based global budgets
- Limit annual all-payer per capita total hospital revenue growth to 3.58%
- Achieve aggregate savings in Medicare per beneficiary total hospital cost growth over 5 years of $330 million
- Achieve quality targets for readmissions and hospital-acquired infections
- Monitor patient experience of care, population health, and health care expenditures across all payers
Other reforms are underway that are designed to align with the All-Payer Model.
Hilltop has been conducting data analytics to support the All-Payer Model

- Medicaid Total Cost of Care methodology
- Predictors of hospitalization for nursing home residents using assessment data
- Maryland’s State Innovation Model (SIM) project: Accountable Care Organizations (ACOs) for Medicare-Medicaid Enrollees (“dual eligibles”)

Hilltop’s work is carried out through its long-standing partnership with Maryland Medicaid

**Flexibility, responsiveness, quick turn-around analytics**
The SIM Project: ACOs for Dual Eligibles (D-ACO)

- Goal is to develop a single transformative model for an integrated delivery system with care coordination for high-needs patients
- Model must align with the goals of the All-Payer System
- Integrated delivery system uses data and technology to inform program development and monitoring, care coordination, and rapid cycle evaluation
- The D-ACO extends the total cost of care concept to encompass Medicare and Medicaid and D-ACOs can share in savings
Maryland’s D-ACO model is person-centered

Source: Maryland Department of Health and Mental Hygiene
D-ACOs will initially launch in Baltimore City and Baltimore, Montgomery, and Prince George’s Counties
What is Hilltop’s role?

- Data analytics to better understand Maryland’s dual eligibles
  - Chart book on Medicare and Medicaid utilization and costs
  - Reports on high utilizers, mental health conditions, and service use before/after hospitalization

- Shared savings methodology and risk adjustment based on functional status

- Health analytics hub for producing quality metrics and performance measures
Hilltop is helping Maryland address two major challenges in implementing the D-ACO model

<table>
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<tr>
<th>CHALLENGE 1</th>
<th>CHALLENGE 2</th>
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<td><strong>Medicare Data</strong></td>
<td><strong>Sophisticated Data Analytics</strong></td>
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<tr>
<td>Two-year lag (or more)</td>
<td>Shared savings model</td>
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<tr>
<td>Data use agreements (DUAs)</td>
<td>Risk adjustment</td>
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<tr>
<td>Data linking</td>
<td>Quality/performance measurement</td>
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</table>

**Hilltop’s Contribution**

- Experience with DUAs
- Medicare-Medicaid data set for dual eligibles in Maryland

**Hilltop’s Contribution**

- Extensive data warehouse
- Data linking
- Rate setting expertise
- Data scientists/programmers
- Partnership with actuaries
About The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a nationally recognized research center dedicated to improving the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels.

www.hilltopinstitute.org
Questions?
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Thank You!