Quality Improvement and Patient Protection

Health Policy Commission

Committee Meeting

August 13, 2014

Agenda

- Approval of Minutes from June 11, 2014 Meeting
- Discussion on HPC's 2014 Behavioral Health Agenda
- Update on Nurse Staffing Law (Ch. 155 of the Acts of 2014)
- Schedule of Next Committee Meeting (October 29, 2014)

Agenda

- **Approval of Minutes from June 11, 2014 Meeting**
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Vote: Approving minutes

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the minutes of the Joint Committee meeting held on June 11, 2014, as presented.

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2014 Behavioral Health Agenda

Chapter 224 sets a broad vision for a more affordable, effective and accountable health care system in Massachusetts. The successful integration of behavioral health care is essential for realizing the goals of improving outcomes and containing long-term cost growth.

The Health Policy Commission, through its various policy Committees, should work to ensure that behavioral health issues are appropriately considered and addressed in the spectrum of initiatives led by the Commission.

In addition, the HPC plays a prominent public role in discussing and developing health care policy for Massachusetts. Through the QIPP Committee, the HPC can provide a forum for discussion of barriers to and opportunities for behavioral health integration. These discussions may lead to additional recommendations for public and private initiatives to improve and advance integration.

2014 Behavioral Health Agenda

Despite a history of progressive state policies and a commitment by many stakeholders, including health care providers and payers, there are a number of persistent barriers to behavioral health integration in Massachusetts. HPC, in coordination with other public and private actors, is working to advance behavioral health care policy in 2014 by:

1. **Promoting clinical standards through accountable care models**
2. **Promoting integrated care models through investment**
3. **Research, evaluation, and analysis**
4. **Health planning activities**
5. **Public forum for policy discussion**
6. **Protecting patient access to necessary care**

For discussion:

How can the HPC continue to move this agenda forward for the rest of 2014?

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BH Agenda: Promoting integrated care delivery models through investment

CHART Phase 2: Driving transformation to accountable care

Support sustainability of outcomes-based aims

Enhance impact of outcome-based aims

Outcome-based aims

Each hospital chooses one or more

Maximize appropriate hospital use	Enhance behavioral health care	Improve hospital-wide processes to reduce waste and improve safety
Maximize appropriate use of community hospitals through strategies that retain appropriate volume (e.g., reduction of outmigration to tertiary care facilities), reduce avoidable use of hospitals (e.g., PHM, ED use and readmission reduction, etc), and right-size hospital capacity (e.g., reconfiguration or closure of services)	Improve care for patients with behavioral health needs (both mental health and substance use disorders) in communities served by CHART hospitals, including both hospital and community-based initiatives	Reduce hospital costs and improve reliability through approaches that maximize efficiency as well as those that enhance safety and harm reduction

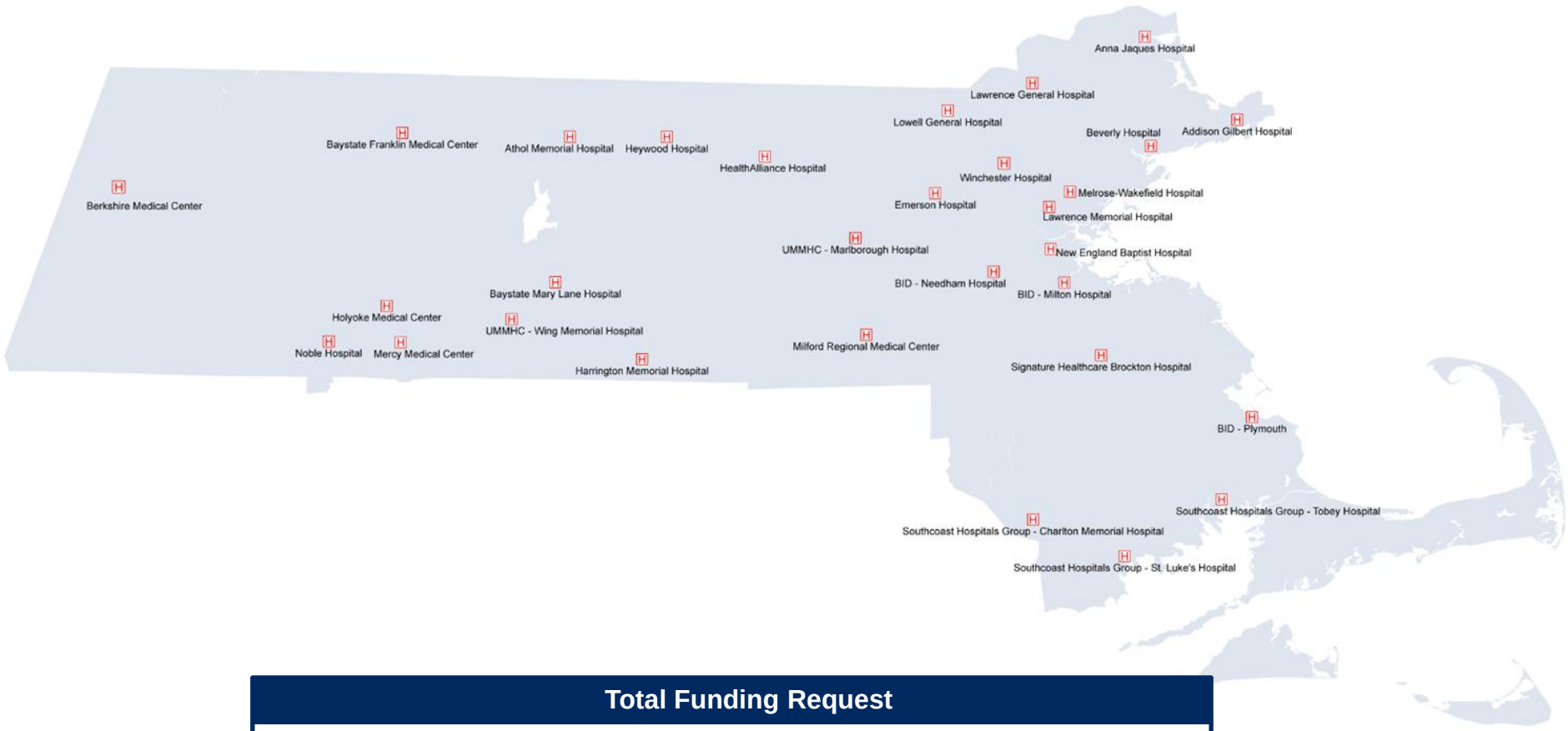
Emerging technologies

Connected health	Maximize use of effective or emerging technologies and innovative application of lightweight tools to promote efficient, interconnected health care delivery

Strategic planning

Strategic planning	Empower CHART hospitals to engage in long term (5-10 year) planning initiatives to facilitate transformation of community hospitals to meet evolving community needs; enhance efforts to sustain CHART Phase 2 activities

BH Agenda: Promoting integrated care delivery models through investment



Total Funding Request

$153 million

24 Hospital-specific and 7 Joint Hospital

Many Initiatives had a core **behavioral health** focus.

BH Agenda: Promoting integrated care delivery models through investment

NEW PCMH BH Integration Initiative

The final FY15 state operating budget includes $2 million for a behavioral health integration initiative, administered by the HPC. This one-time reserve money is appropriated for the acceleration and support of behavioral health integration within patient-centered medical homes.

This investment could support:

- Technical assistance staff and faculty expertise assigned to practice sites
- Capacity mapping for behavioral health resources in selected communities
- Assistance with developing/strengthening patient referral and tracking systems for successful integrated care delivery
- Regional learning events
- Virtual coaching assistance to participating practices
- Distillation of implementation strategies for successful BH integration
- Evaluation of cost and quality impact

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BH Agenda: Research, Evaluation, and Analysis

Behavioral Health Cost Trends Research

Highlights from 2013 report

- Spending for patients with comorbid behavioral health and chronic medical conditions was 2.0 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition

July 2014 findings

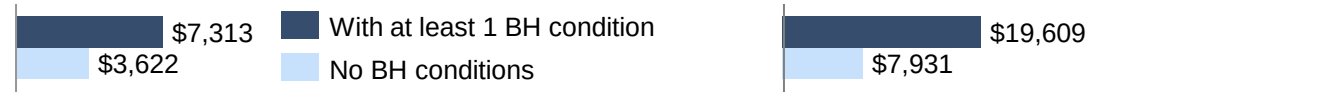
- Higher spending for patients with behavioral health conditions is concentrated in ED and inpatient care
- Where any behavioral health condition is present, costs of treating the patient's other conditions rises. Where mental health and SUD conditions are both present, costs of treating other conditions rises further.
- Both findings suggest opportunities to improve care and reduce overall long-term costs through a focus on integrated care, care management, and the use of lower-intensity settings, when possible and appropriate

BH Agenda: Research, Evaluation, and Analysis

Higher spending for people with behavioral health conditions is concentrated in inpatient and ED spending

SPENDING BY CATEGORY OF SERVICE FOR PATIENTS WITH AND WITHOUT BEHAVIORAL HEALTH CONDITIONS

Claims-based medical expenditures by category of service†, for people with and without behavioral health (BH) conditions‡, 2011*



Category of Service	Spending per person per category	% difference between people with and without BH conditions	Spending per person per category	% difference between people with and without BH conditions
ED	$291 / $122	+140%	$419 / $131	+220%
Inpatient	$2,245 / $1,000	+125%	$8,496 / $2,810	+202%
Outpatient	$926 / $515	+80%	$1,635 / $1,086	+51%
Long-Term Care and Home Health	$66 / $17	+279%	$4,715 / $1,191	+296%
Lab and X-ray	$782 / $524	+49%	$828 / $668	+24%
Professional[1]	$3,003 / $1,444	+108%	$3,516 / $2,045	+72%

* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

† For detailed definitions of categories of service, see CHIA and HPC publication, "Massachusetts Commercial Medical Care Spending: Findings from the All-Payer Claims Database." Lab/x-ray category includes professional services associated with laboratory and imaging.

‡ Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software

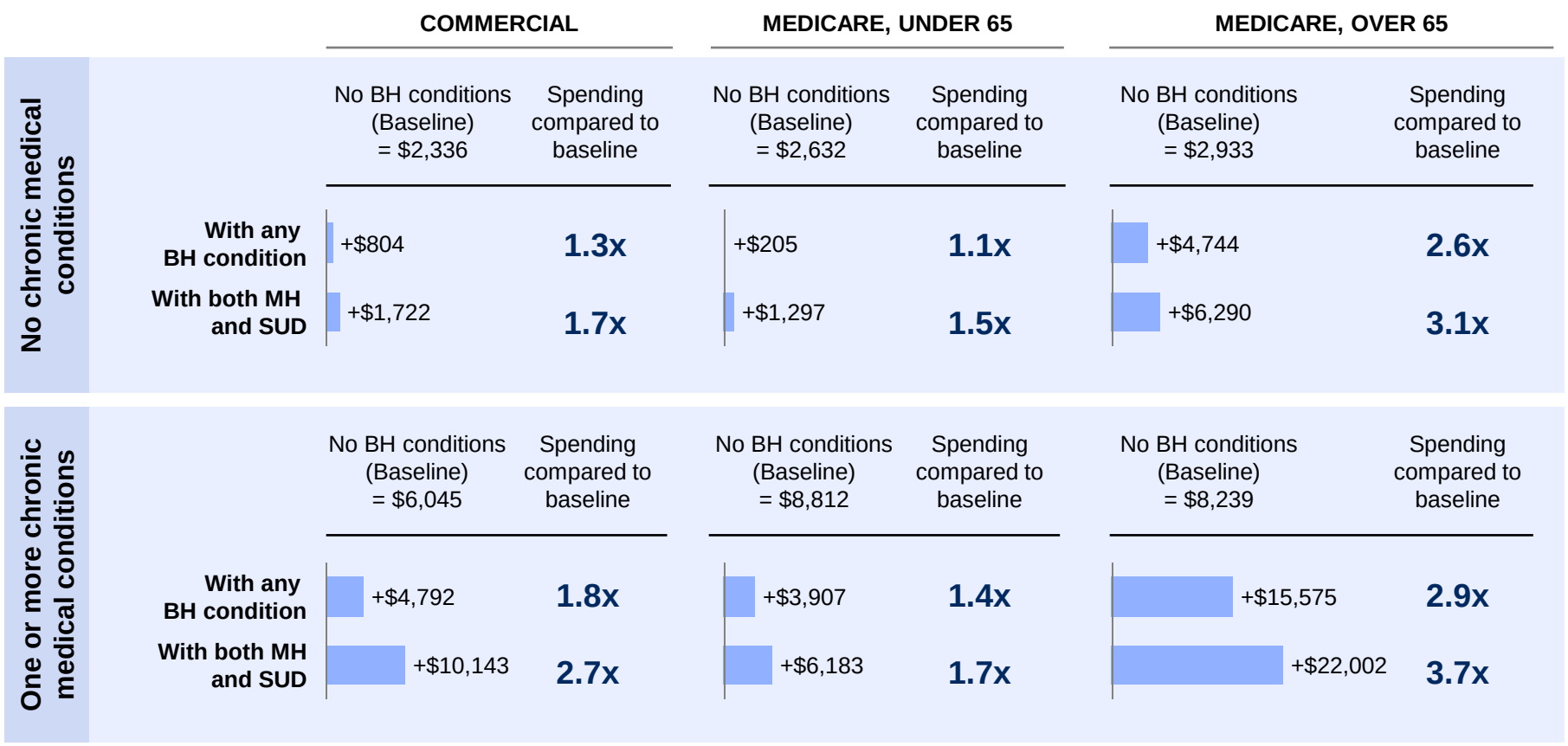
SOURCE: HPC analysis of the All-Payer Claims Database

BH Agenda: Research, Evaluation, and Analysis

For patients with behavioral health conditions, higher expenditures are observed for medical expenditures outside of behavioral health

IMPACT OF BEHAVIORAL HEALTH COMORBIDITY ON SPENDING FOR NON-BEHAVIORAL HEALTH CONDITIONS

Per person claims-based medical expenditures on non-behavioral health conditions based on presence of behavioral health (BH) comorbidity†, 2012 (Commercial) and 2011 (Medicare)*



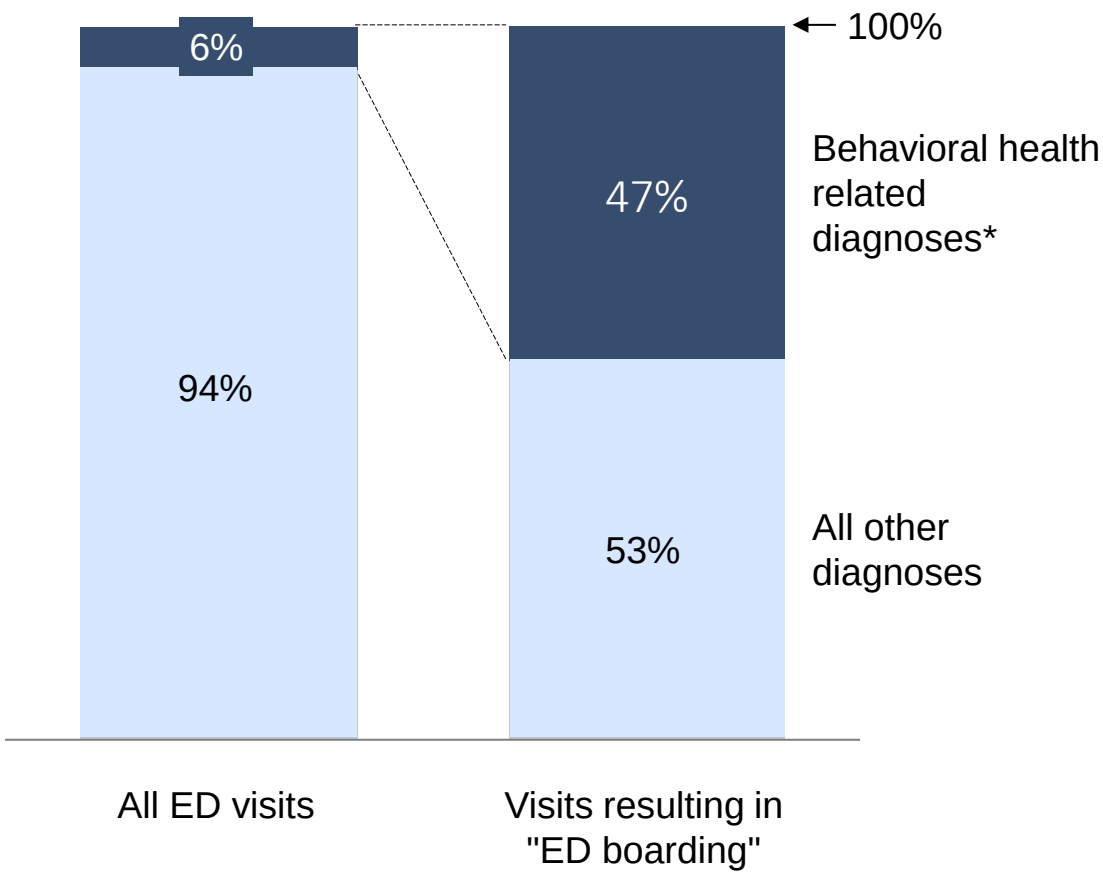
* Analysis is based on a sample that consists of claims submitted by the three largest commercial payers – Blue Cross Blue Shield of Massachusetts (BCBS), Harvard Pilgrim Health Care (HPHC), and Tufts Health Plan (THP) – representing 66 percent of commercially insured lives. Claims-based medical expenditure measure excludes pharmacy spending and payments made outside the claims system (such as shared savings, pay-for-performance, and capitation payments).

† Presence of behavioral health condition identified based on diagnostic codes in claims using Optum ERG software. Expenditures for non-behavioral health conditions were identified using Optum ETG episode grouper. Additional detail is available in a technical appendix.

SOURCE: HPC analysis of the All-Payer Claims Database

BH Agenda: Research, Evaluation, and Analysis

Visits to the ED for behavioral health related diagnoses disproportionately result in "ED Boarding"



*Behavioral health related diagnoses defined as having a primary ICD-9 code between the values of 290.0 and 319
SOURCE: DPH ED Boarding Data (Hospital Self-Reported); CHIA Cost Trends Report 2012

BH Agenda: Research, Evaluation, and Analysis

Behavioral Health Cost Trends Research

Recommendations from the July 2014 report

- **Hospitals should work to optimize use of post-acute services**, including enhancing efficacy of care coordination and transitions for behavioral health patients. Where aligned with project goals, the Commission will work with community hospitals receiving CHART investments to achieve these goals.
- Payers and providers should continue **to increase integration of behavioral health and primary care** through use of incentives and new delivery models.
- The Commission will **support provision of behavioral health services in primary care settings through its PCMH and ACO certification program**s.
- CHIA should convene state agencies to **increase transparency in behavioral health** spending, quality of care, and the market for behavioral health services.

BH Agenda: Research, evaluation, and analysis

NEW Substance Use Disorder Treatment Report

The Legislature recently passed, and the Governor signed Chapter 258 of the Acts of 2014, a comprehensive law regarding substance use disorder treatment and recovery. The law requires the Center for Health Information and Analysis (CHIA) to conduct a review of the accessibility of substance use disorder treatment and the adequacy of insurance coverage for such treatment in the commonwealth and issue a report, not later than February 15, 2015.

The law then requires the HPC to issue a further report recommending policies intended to ensure access to and coverage for substance use disorder treatment throughout the commonwealth not later than May 30, 2015.

The report shall include but not be limited to:

(i) specific recommendations for legislation or regulatory changes, including appropriate coverage mandates;

(ii) an evaluation of the availability of medication-assisted opioid therapy such as methadone, buprenorphine and extended-release naltrexone in clinical stabilization services, including insurance coverage, regulatory or licensure barriers to accessing such medications prior to discharge and recommendations for changes to ensure patient access; and

(iii) recommendations for the continuing study of substance use disorder

2014 Behavioral Health Agenda

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BH Agenda: Protecting Patient Access to Necessary Care

Main Responsibilities

- Regulating internal and external review for fully-insured plans
- Administering external review for fully-insured plans
- Consumer assistance and education
- Administering open enrollment waivers
- Receiving and analyzing annual reports from health plans about appeals, disenrollment of providers, quality of care, medical loss ratio

Protecting Access to Care

- **Consumer protection**: OPP will continue to build on its consumer protection role
- **Consumer education**: OPP is expanding its consumer education efforts, in collaboration with stakeholders
- **Access to care**: OPP's connection with consumers provides a direct source of information about health care access
- **Increased Data**: OPP will continue to publish real-time data on external reviews for fully insured plans. Today the committee will hear a summary of data from **January 1, 2014 to June 30, 2014**.

BH Agenda: Protecting Patient Access to Necessary Care

Number of external reviews

The data below is for external reviews received by the Office of Patient Protection from January 1, 2014 to June 30, 2014.

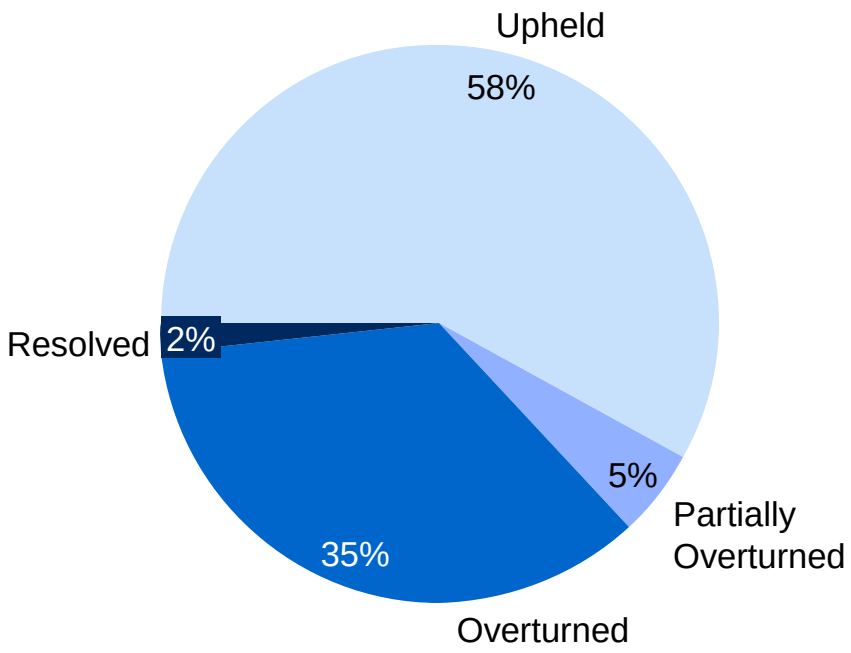
147 total external reviews

- 119 eligible
  - 69 upheld
  - 6 partially overturned
  - 42 overturned
  - 2 resolved

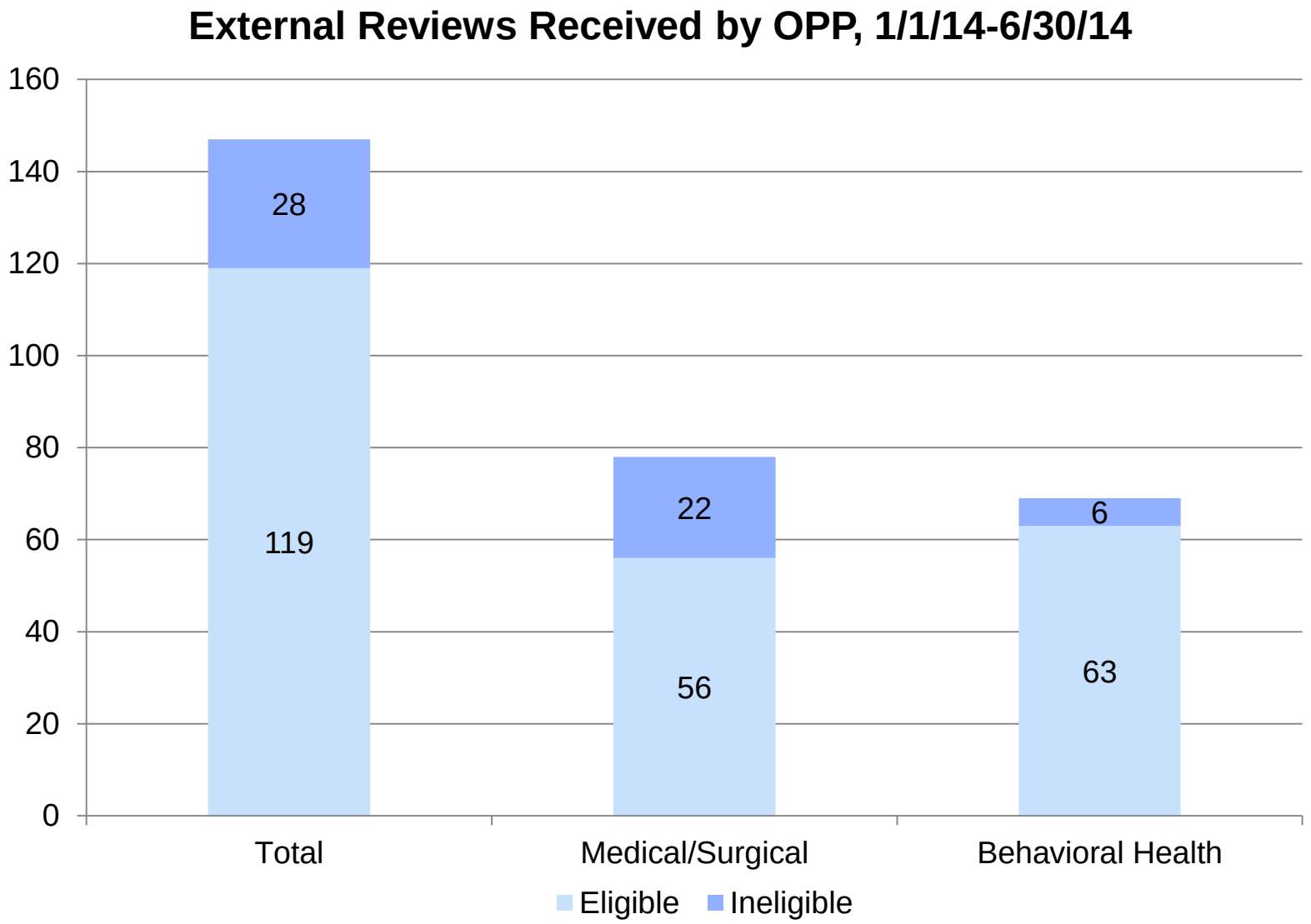
Results in Q1 and Q2 2014

Results for external reviews received by the Office of Patient Protection, 1/1/14-6/30/14

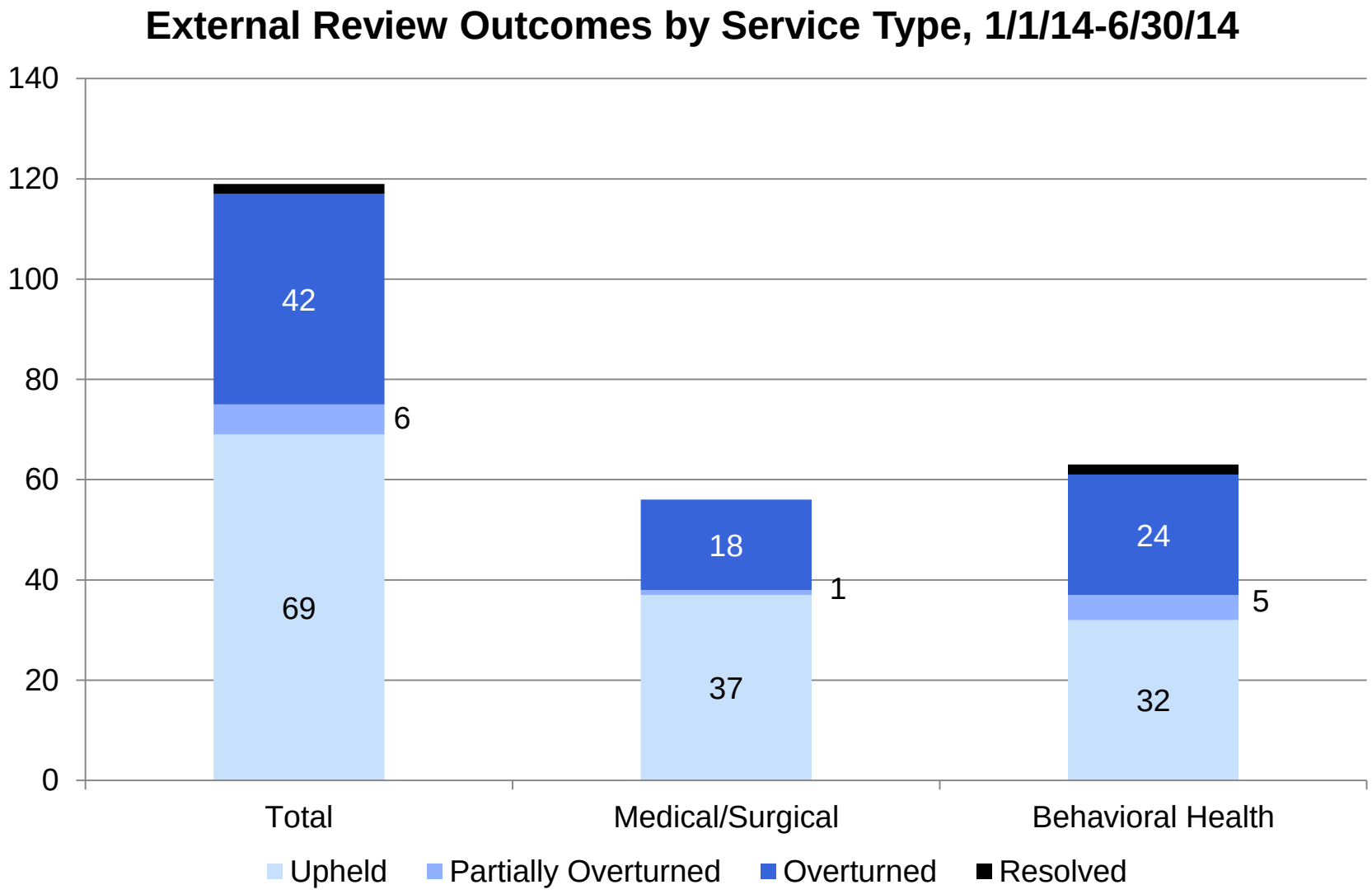
100% = 119



BH Agenda: Protecting Patient Access to Necessary Care

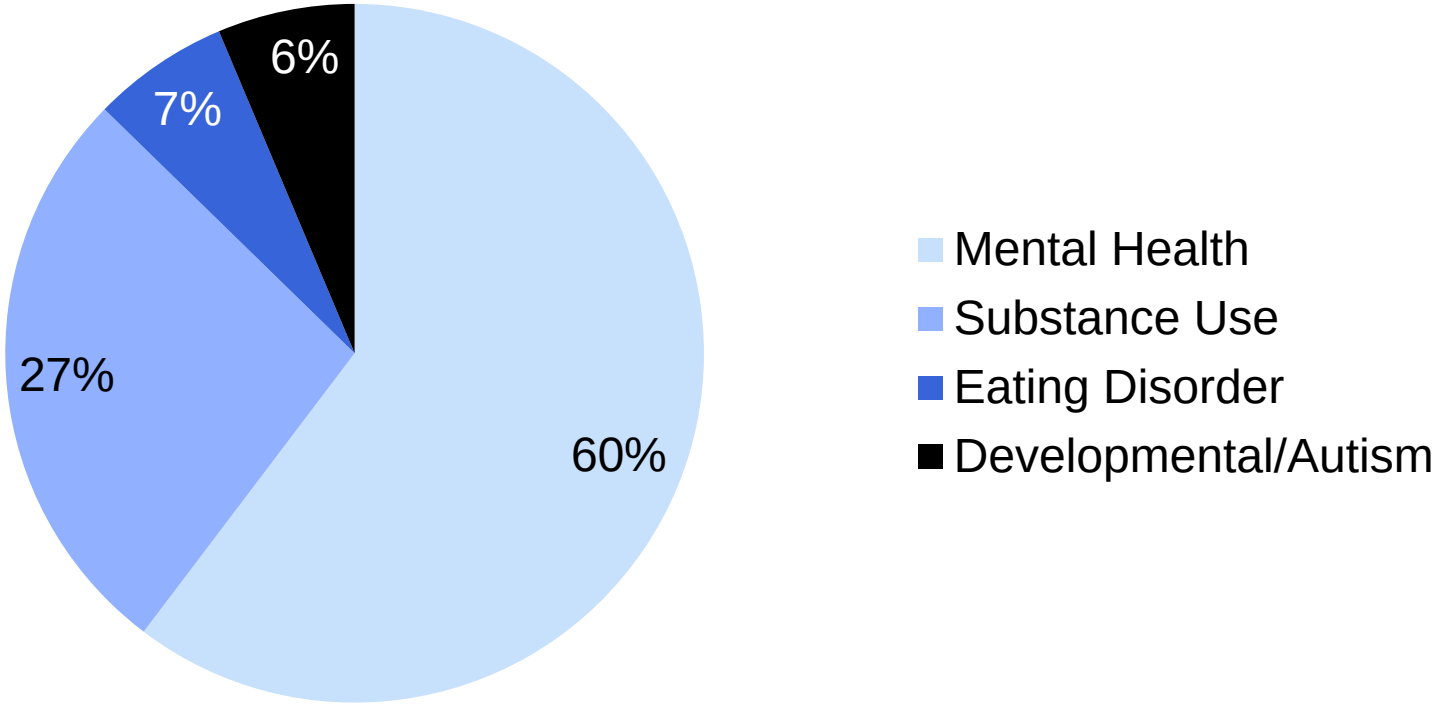


BH Agenda: Protecting Patient Access to Necessary Care



BH Agenda: Protecting Patient Access to Necessary Care

Categories of Behavioral Health External Reviews* 1/1/14-6/30/14



*Eligible behavioral health external reviews = 63

OPP operations update

- OPP Outreach
  - Met with consumer groups to plan outreach
  - Webinars to inform consumers about appeal rights (upcoming on 8/20, 9/17)
  - Convening outreach meeting with providers (9/16)

- Data collection
  - Upgraded databases for external reviews and consumer inquiries
  - Expect to gather more detailed data based on changes to 2014 reports from carriers

- Consumer assistance and access
  - Additional staff enhance consumer assistance
  - Materials in non-English languages
  - Developing updated website, educational materials

2014 Behavioral Health Agenda

	Next steps
1 **Promoting clinical standards through accountable care models**	▪ Continue to develop behavioral health (BH) criteria and standards to be included in the PCMH program (joint effort of the CDPST and QIPP committees); develop evaluation and measurement metrics for BH in the PCMH setting; and engage with payers regarding payment to support integrated BH services. Progress on development of the ACO certification program in Q3 and Q4 of 2014.
2 **Promoting integrated care delivery models through investment**	▪ Complete CHART Phase 1 projects and explore opportunities for the dissemination of lessons learned and best practices; accept and review final proposals for Phase 2 with a goal of making awards in Q4 of 2014. Continue to provide CHART hospitals with capacity-building opportunities through training, leadership support, analytics and other forms of technical assistance. Develop and administer a new BH integration investment program for PCMHs.
3 **Research, evaluation, and analysis**	▪ Wherever possible, extend BH related analyses to the MassHealth population; continue to identify BH data and information gaps and collaborate with other state agencies on identifying solutions; coordinate research and evaluation work with the Attorney General and the Public Payer Commission, particularly with regard to BH payment and so-called “carve-out contracting”; include BH as a topic for discussion at the 2014 cost trends hearing. Begin research related to the substance use disorder treatment report, as mandated by ch. 258 of the acts of 2014.

2014 Behavioral Health Agenda

Next steps, continued	
4 Health planning activities	▪ The Health Planning Council is expected to approve a final report on behavioral health capacity in Q4; the HPC ED will continue to participate in on-going council activities with HPC staff providing in-kind support to the Council; administer the registration of provider organization (RPO) program which will generate key information on capacity and current market landscape; and consideration of community hospital capacity to provide inpatient BH services as it relates to the Community Hospital study.
5 Public forum for policy discussion	▪ Focused discussions and deliberations by the QIPP committee and other stakeholders and experts as appropriate on the challenges and opportunities for behavioral health integration; receive periodic updates on the progress of the HPC and by other state agencies in implementing key Chapter 224 strategies for advancing integration such as DOI/AGO on parity issues, DMH, and the Public Payer Reimbursement Commission. (Note: New Behavioral Health Task Force focusing on BH data collection is expected to report by July 1, 2015, pursuant to sec. 230 of FY15 budget)
6 Protecting patient access to necessary care	▪ Continue to promote awareness of patient protection rights authorized through OPP; prepare an annual report of trends related to internal and external appeals; issue guidance clarifying obligations of health insurance plans to provide access to medical necessity criteria, as prescribed by recently enacted legislation

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Nurse Staffing Law (Ch. 155 of the Acts of 2014)

Law	*An Act relative to patient limits in all hospital intensive care units* (Chapter 155 of the Acts of 2014) signed June 30, 2014, with effective date of September 28, 2014
Overview	Establishes Nurse: Patient staffing ratio of 1:1 or 1:2 in hospital ICUs depending on stability of the patient as assessed by: (a) "acuity tool" developed or chosen by hospital; and (b) staff nurses; and (c) nurse manager (or nurse manager's designee) to resolve disagreement
HPC's Role	The HPC is charged with promulgating regulations including: (a) Formulation of the acuity tool (to be certified by DPH) (b) Method of public reporting of hospital compliance (c) Identification of 3-5 related patient safety quality indicators to be measured and publicly reported by hospitals

Nurse Staffing Law (Ch. 155 of the Acts of 2014)

Next Steps

- Background Research & Analysis
  - Acuity tools
  - Reporting methodologies
  - Quality measures
- Stakeholder meetings and listening sessions
- Regulatory Process
  - Draft regulations
  - Public comment period and hearings to begin late fall/early winter

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Contact information

For more information about the Health Policy Commission:

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