COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Care Delivery and Payment System Transformation Meeting

December 9, 2015

Agenda

- **Approval of Minutes from November 12, 2015**
- Patient-Centered Medical Home Certification
- ACO Public Comment Update
- Preliminary Findings from the 2015 Cost Trends Report
- Schedule of Next Committee Meeting (January 6, 2016)

Vote: Approving Minutes

Motion: That the Care Delivery and Payment System Transformation Committee hereby approves the minutes of the Committee meeting held on November 12, 2015, as presented.

Agenda

- Approval of Minutes from November 12, 2015
- **Patient-Centered Medical Home Certification**
  - PRIME Criteria and Documentation Requirements
  - Operational Plan
  - Sample Certification Process Flows
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Discussion Preview: PCMH Certification Criteria

Agenda Topic

Patient-Centered Medical Home Certification Criteria Discussion

Description

Staff will present detail for each PCMH PRIME criteria, mapping to current NCQA standards and documentation requirements. Staff will also present an update on program operations to get ready for January 1 launch.

Key Questions for Discussion and Consideration

Feedback on the documentation requirements for the 5 new HPC only criteria.

Decision Points

No votes proposed.

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PCMH PRIME criteria

#	Criteria (practice must meet ≥ 7 out of 13)
1	The practice **coordinates with behavioral healthcare providers** through formal agreements or has behavioral health providers located at the practice site.
2	The practice **integrates BHPs** within the practice
3	The practice collects and regularly updates a comprehensive health assessment that includes **behaviors affecting health and mental health/substance use history of patient and family.**
4	The practice collects and regularly updates a comprehensive health assessment that includes **developmental screening** using a standardized tool.
5	The practice collects and regularly updates a comprehensive health assessment that includes **depression screening** using a standardized tool.
6	The practice collects and regularly updates a comprehensive health assessment that includes **anxiety screening** using a standardized tool.
7	The practice collects and regularly updates a comprehensive health assessment that includes **SUD screening** using a standardized tool (N/A for practices with no adolescent or adult patients).
8	The practice collects and regularly updates a comprehensive health assessment that includes postpartum depression screening for patients who have recently given birth using a standardized tool.
9	The practice **tracks referrals** until the consultant or specialist's report is available, **flagging and following up on overdue reports.**
10	The practice implements clinical decision support following **evidence based guidelines** for a mental health and substance use disorder.
11	The practice establishes a systematic process and criteria for identifying patients who may benefit from **care management**. The process includes consideration of behavioral health conditions.
12	The practice has one or more providers in practice actively treating patients suffering from addiction with medication assisted treatment and appropriate counseling and behavioral therapies (directly or via referral)
13	If practice includes a **care manager**, s/he must be qualified to identify/coordinate behavioral health needs.

Proof of proficiency for criteria #2 automatically satisfies criteria #1

HPC and NCQA collaboration on documentation requirements

8
NCQA Criteria

For existing NCQA criteria, HPC did not amend existing documentation requirements in order to:

- Maintain consistency
- Reduce administrative burden on practices
- Reduce costs/changes needs to NCQA technical platform for certification

5
New HPC Criteria

For existing new criteria, HPC worked closely with NCQA to create documentation requirements that meet the policy intention of the criteria but align with type(i.e. screen shots) and level (i.e. patient or practice) of documentation requirements of existing NCQA criteria.

1. Coordination with behavioral health providers

DRAFT - FOR DISCUSSION

New HPC factor

Factor	Documentation Requirements
The practice coordinates with behavioral healthcare providers through formal agreements or has behavioral healthcare providers co-located at the practice site. .	The practice provides at least one example of a formal agreement(s) (e.g., MOU) or a list of behavioral health providers (names and credentials) who work in the same physical location (e.g., provide address).

* To the extent possible, this will be done in coordination with the RPO process.

2. Integration with behavioral health providers

DRAFT - FOR DISCUSSION

NCQA factor

Factor	Documentation Requirements
The practice integrates behavioral healthcare providers within the practice site. (NCQA (2014, Element 5B, Factor 4)	The practice provides a list of behavioral health providers and their position/role within the practice site.

* To the extent possible, this will be done in coordination with the RPO process.

3. Assessment: behavioral health history of patient and family

DRAFT - FOR DISCUSSION

NCQA factor

Factor	Documentation Requirements
To understand the behavioral health-related needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes behaviors affecting health and mental health/substance use history of patient and family.* NCQA (2011, Element 2C, Factors 6 and 7; 2014, Element 3C, Factors 6 and 7)	NCQA reviews a practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor and the percentage must be submitted in the open data field.

*For all factors that require a documented process for staff, the documented process for staff includes a date of implementation or revision and has been in place for at least three months prior to submitting the Survey Tool.

4. Assessment: developmental screening

DRAFT - FOR DISCUSSION

NCQA factor

Factor	Documentation Requirements
To understand the behavioral health-related needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes developmental screening for children under 3 years of age.* NCQA (2011, Element 2C, Factor 8; 2014, Element 3C, Factor 8)	NCQA reviews a practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor and the percentage must be submitted in the open data field. In addition to the method chosen, the practice must provide a standardized survey form to receive credit.

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5. Assessment: depression screening

DRAFT - FOR DISCUSSION

NCQA factor

Factor	Documentation Requirements
To understand the behavioral health-related needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes depression screening for adults and adolescents.* NCQA (2011, Element 2C, Factor 9; 2014, Element 3C, Factor 9)	NCQA reviews a practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor and the percentage must be submitted in the open data field. In addition to the method chosen, the practice must provide a standardized survey form to receive credit.

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6. Assessment: anxiety screening

DRAFT - FOR DISCUSSION

New HPC factor

Factor	Documentation Requirements
To understand the behavioral health-related needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes anxiety screening for adults and adolescents using a standardized tool.*	NCQA reviews a practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor and the percentage must be submitted in the open data field. In addition to the method chosen, the practice must provide a standardized survey form to receive credit.

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7. Assessment: substance use disorder screening

DRAFT - FOR DISCUSSION

New HPC factor

Factor	Documentation Requirements
To understand the behavioral health-related needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes substance use disorder screening for adults and adolescents using a standardized tool.*	NCQA reviews a practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor and the percentage must be submitted in the open data field. In addition to the method chosen, the practice must provide a standardized survey form to receive credit.

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8. Assessment: post-partum depression screening

DRAFT - FOR DISCUSSION

New HPC factor

Factor	Documentation Requirements
To understand the behavioral health-related needs of patients/families, the practice collects and regularly updates a comprehensive health assessment that includes postpartum depression screening for patients who have recently given birth using a standardized tool.*	NCQA reviews a practice system generated report with a numerator and denominator based on all unique patients in a recent 3 month period. The report must clearly indicate how many patients had an assessment for each factor and the percentage must be submitted in the open data field. In addition to the method chosen, the practice must provide a standardized survey form to receive credit.

*For all factors that require a documented process for staff, the documented process for staff includes a date of implementation or revision and has been in place for at least three months prior to submitting the Survey Tool.

9. Behavioral health referrals

DRAFT - FOR DISCUSSION

NCQA factor

Factor	Documentation Requirements
The practice tracks behavioral health referrals until the consultant or specialist's report is available, flagging and following up on overdue reports. NCQA (2011, Element 5B; 2014, Element 5B, Factor 8)	NCQA reviews a documented process and a report, log, or other means of demonstrating that its process is followed. A paper log or screen shot showing electronic capabilities is acceptable. The report may be system generated or may be based on at least one week (five days) of referrals, with de-identified patient data. Documentation does not need to be exclusively related to behavioral health referrals but must not exclude behavioral health from the referral tracking process.

10. Evidence-based decision support

DRAFT - FOR DISCUSSION

NCQA factor - modified

Factor	Documentation Requirements
The practice implements clinical decision support (e.g. point-of-care reminders) following evidence-based guidelines for a mental health **and** substance use disorder. NCQA (2014 Element 3E, Factor 1 – *modified* to require both mental health and SUD)	NCQA reviews the conditions that the practice identified for each condition; the source of guidelines used by the practice for each condition; and examples of guideline implementation, such as tools to manage patient care, organizers, flow sheets or electronic system organizer (e.g. registry, EHR, or other system) templates based on condition-specific guidelines, enabling the practice to develop treatment plans and document patient status and progress.

11. Identifying patients for care management

DRAFT - FOR DISCUSSION

NCQA factor

Factor	Documentation Requirements
The practice establishes a systematic process and criteria for identifying patients who may benefit from care management. The process includes consideration of behavioral health conditions. NCQA (2014, Element 4A, Factor 1)	The practice has specific criteria for identifying patients with behavioral conditions for whole-person care planning and management. Criteria are developed from a profile of patient assessments, and may include the following, or a combination of the following: • A diagnosis of a behavioral issue (e.g., visits, medication, treatment or other measures related to behavioral health). • Psychiatric hospitalizations (e.g., two or more in the past year). • Substance use treatment. • A positive screening result from a standardized behavioral health screener (including substance use).

12. Treatment for opioid addiction

DRAFT - FOR DISCUSSION

New HPC factor

Factor	Documentation Requirements
One or more providers in practice actively treating patients suffering from addiction with medication assisted treatment and appropriate counseling and behavioral therapies (directly or via referral)	If the practice is meeting the factor by having one PCP on staff licensed to prescribed buprenorphine, NCQA reviews a scan of the certification letter (waiver);. The special DEA identification number ("X" number) on the certification letter must be de-identified. Otherwise, NCQA reviews a screen shot from the practice's electronic medical record system showing active medication assisted treatment and behavioral therapy for at least one (de-identified) patient.*

*Language may be modified based on NCQA review and feedback.

13. Care manager qualifications

DRAFT - FOR DISCUSSION

NCQA factor - modified

Factor	Documentation Requirements
The practice uses a team to provide a range of behavioral health patient care services. The practice has at least one care manager qualified to identify and **coordinate behavioral health needs**.* NCQA (2011, Element 1G, Factor 6; 2014, Element 2D, Factor 7 – *modified* to specify behavioral health qualifications)	NCQA reviews a dated description of staff positions or documented process describing staff roles and qualifications needed for the care manager role and documents demonstrating current staff possess the required qualifications (e.g., training program completion, specific degrees, etc.)

*For all factors that require a documented process for staff, the documented process for staff includes a date of implementation or revision and has been in place for at least three months prior to submitting the Survey Tool.

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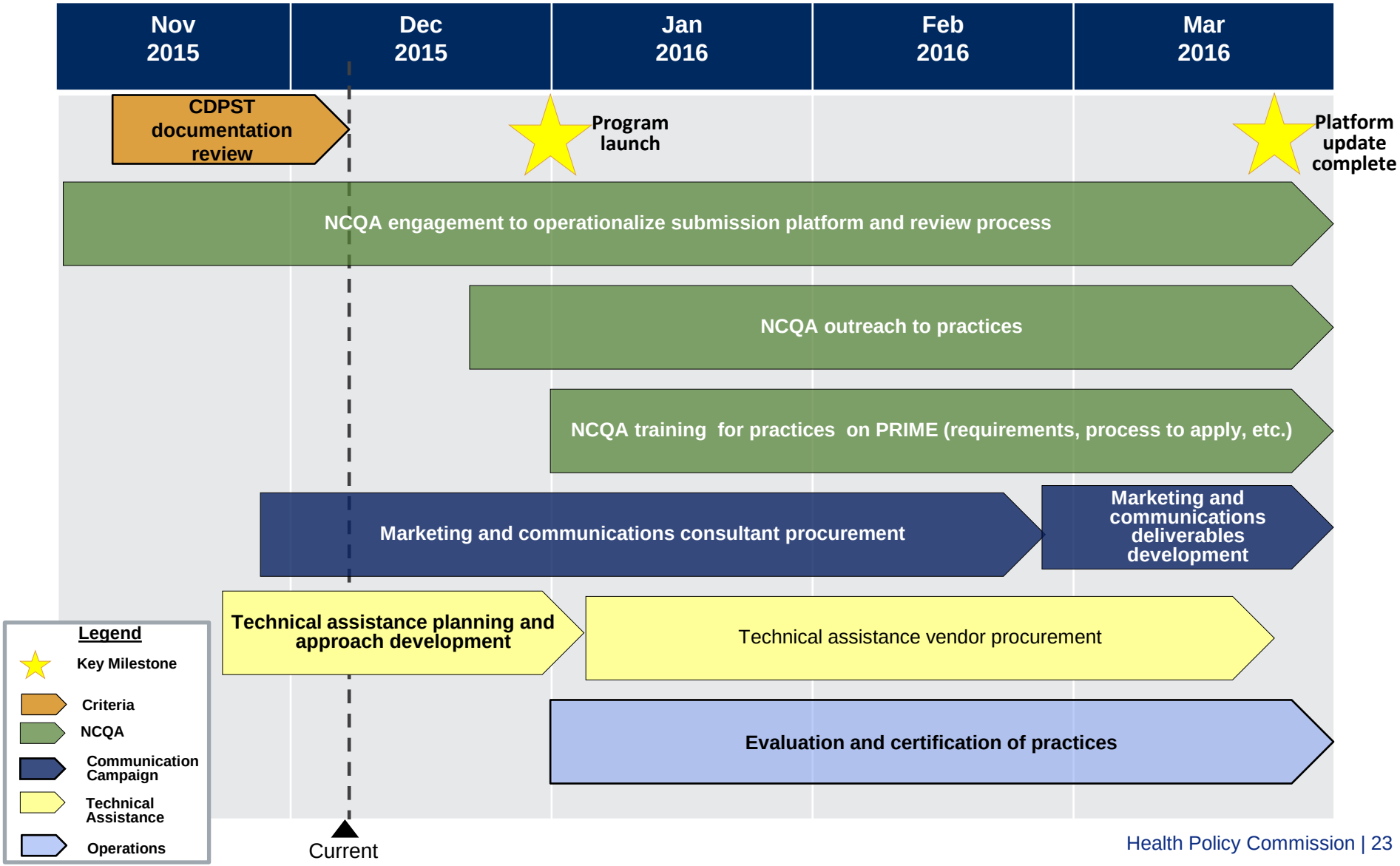
HPC PCMH PRIME operational plan



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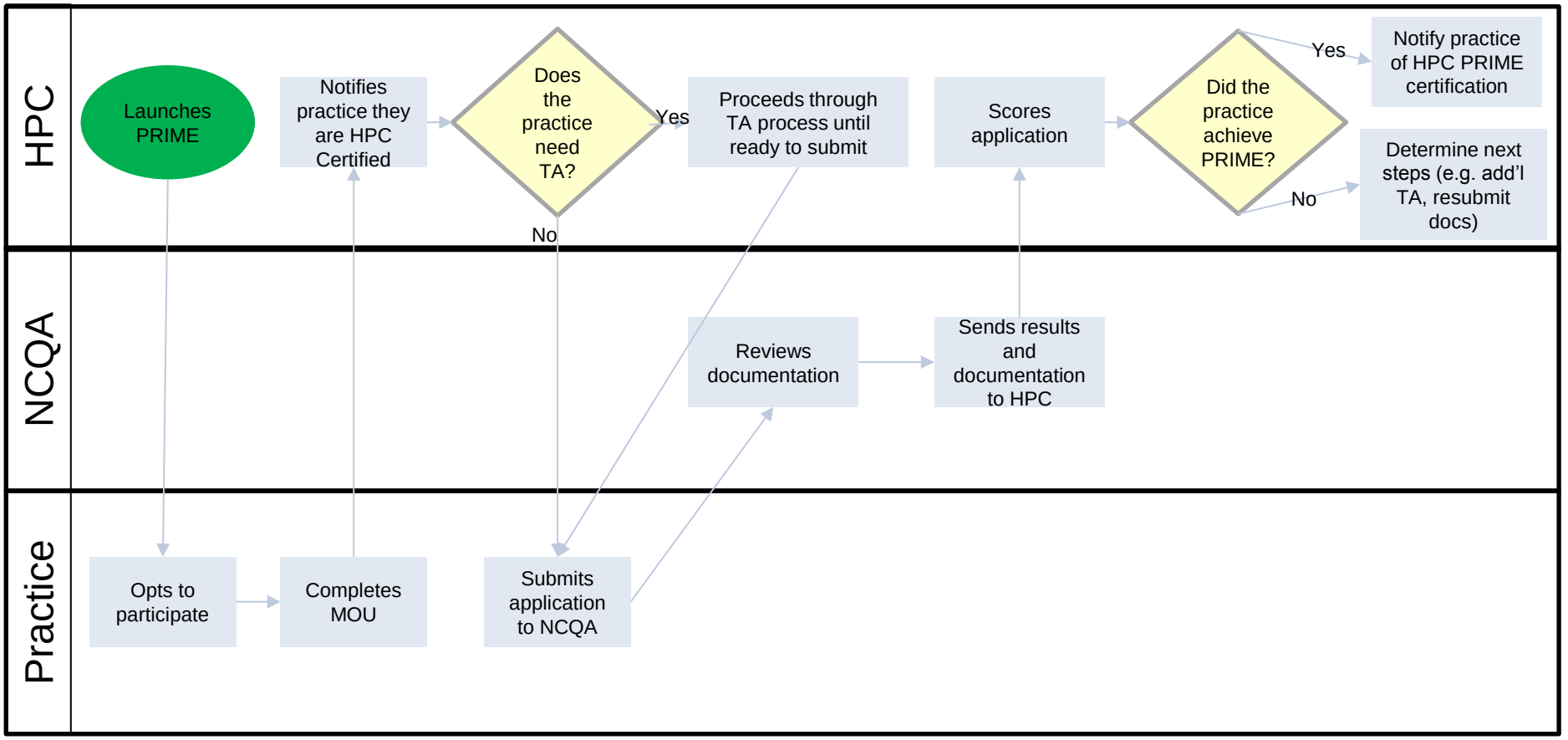
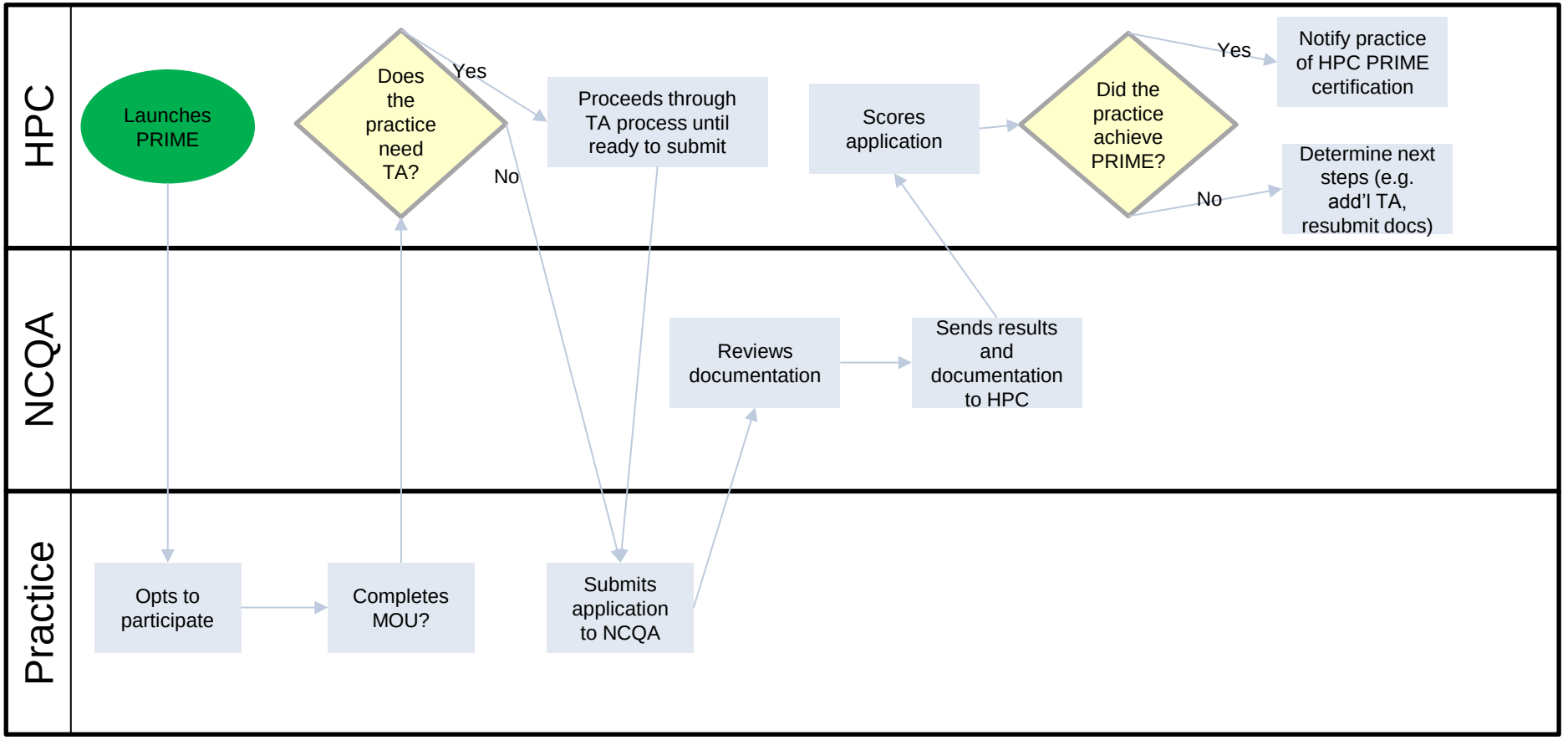
Process to achieve PRIME certification if a practice is already NCQA recognized

DRAFT – under development



Process to achieve PRIME if a practice is also applying for NCQA recognition

DRAFT – under development



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- **ACO Public Comment Update**
- Preliminary Findings from the 2015 Cost Trends Report
- Schedule of Next Committee Meeting (January 6, 2016)

ACO public comment update

- ✓ **Draft ACO certification criteria for public comment to be released today**
- ✓ **Will be posted Posted at HPC Certification Programs website.**
- ✓ **Comments are due by January 29th.**

Stakeholder engagement & HPC/MassHealth workgroups
9/2015 - ongoing

Public comment
December 2015 – January 2016
Public hearing
January 6

Final HPC Board approval
February/March 2016

Provider engagement
February – March 2016

Accept certification applications
Spring – Summer 2016

Technical Assistance
Summer 2016 – beyond

Agenda

- Approval of Minutes from November 12, 2015
- Patient-Centered Medical Home Certification
- ACO Public Comment Update
- **Preliminary Findings from the 2015 Cost Trends Report**
- Schedule of Next Committee Meeting (January 6, 2016)

Discussion Preview: 2015 Cost Trends Report

Agenda Topic

Selected Preliminary Findings from the Cost Trends Report

Description

Staff will present summary findings from the Cost Trends Report, focusing on emergency department use and APM coverage. While overall ED use declined between 2013 and 2014, visits associated with a behavioral health diagnosis increased sharply and were concentrated in certain communities.

Key Questions for Discussion and Consideration

Significance of the findings, implications for HPC's program and policy agenda, implications for recommendations to be included in the 2015 Cost Trends Report.

Decision Points

No votes proposed. Commissioners will be asked to provide feedback on findings and to consider the questions above. The full Board will discuss findings at the December meeting and recommendations in January, and the report will be published in January.

2015 COST TRENDS REPORT

Massachusetts Health Policy Commission

2015 COST TRENDS REPORT

Finding:

Emergency Department Utilization

Emergency department utilization

Previous findings

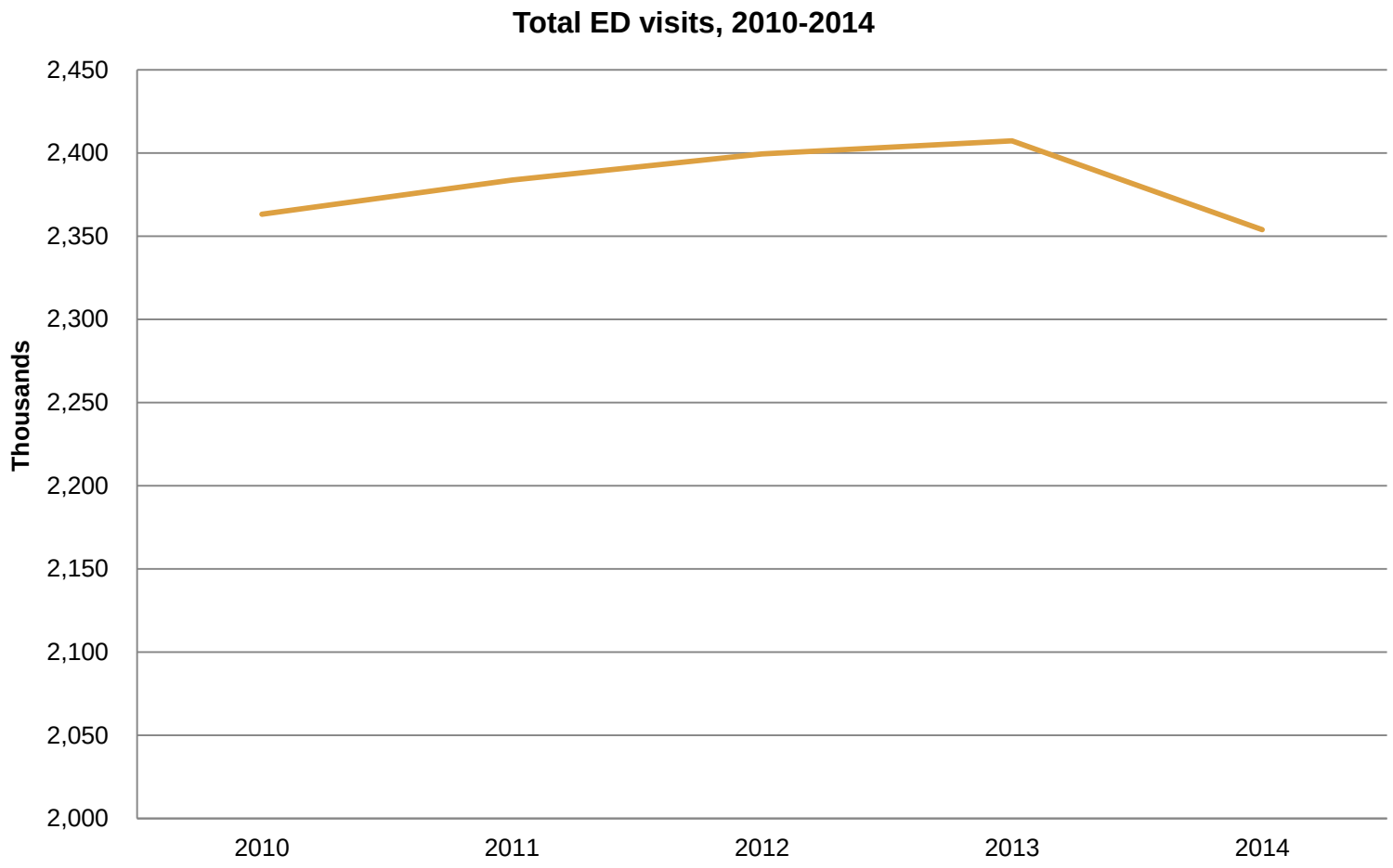
- ED use is relatively high in Massachusetts, and varies strongly by region, income, and insurance coverage
- Avoidable ED visits make up almost half of all ED visits
- In the 2014 Cost Trends Report, the HPC identified areas for improvement:
  - Reducing avoidable ED use
  - Coordinating care and advancing clinical integration across settings
  - Caring for patients in community settings
  - Treating behavioral health conditions, especially via integrated models

New findings/market developments

- Overall total emergency department (ED) use declined in 2014 to just below the 2010 amount
  - ED utilization associated with a behavioral health conditions (includes mental health and substance use disorders) increased dramatically, with a 24% statewide increase between 2010 and 2014
  - Certain regions of the state experienced even sharper growth of behavioral health related emergency department use, with a ~50% increase in Fall River and New Bedford
- Over 50% of long-stay ED visits (more than 8 hours) for pediatric patients were related to a mental health condition
- Greater access to after-hour care options is strongly associated with lower ED use

Total statewide ED visits decreased slightly in 2014

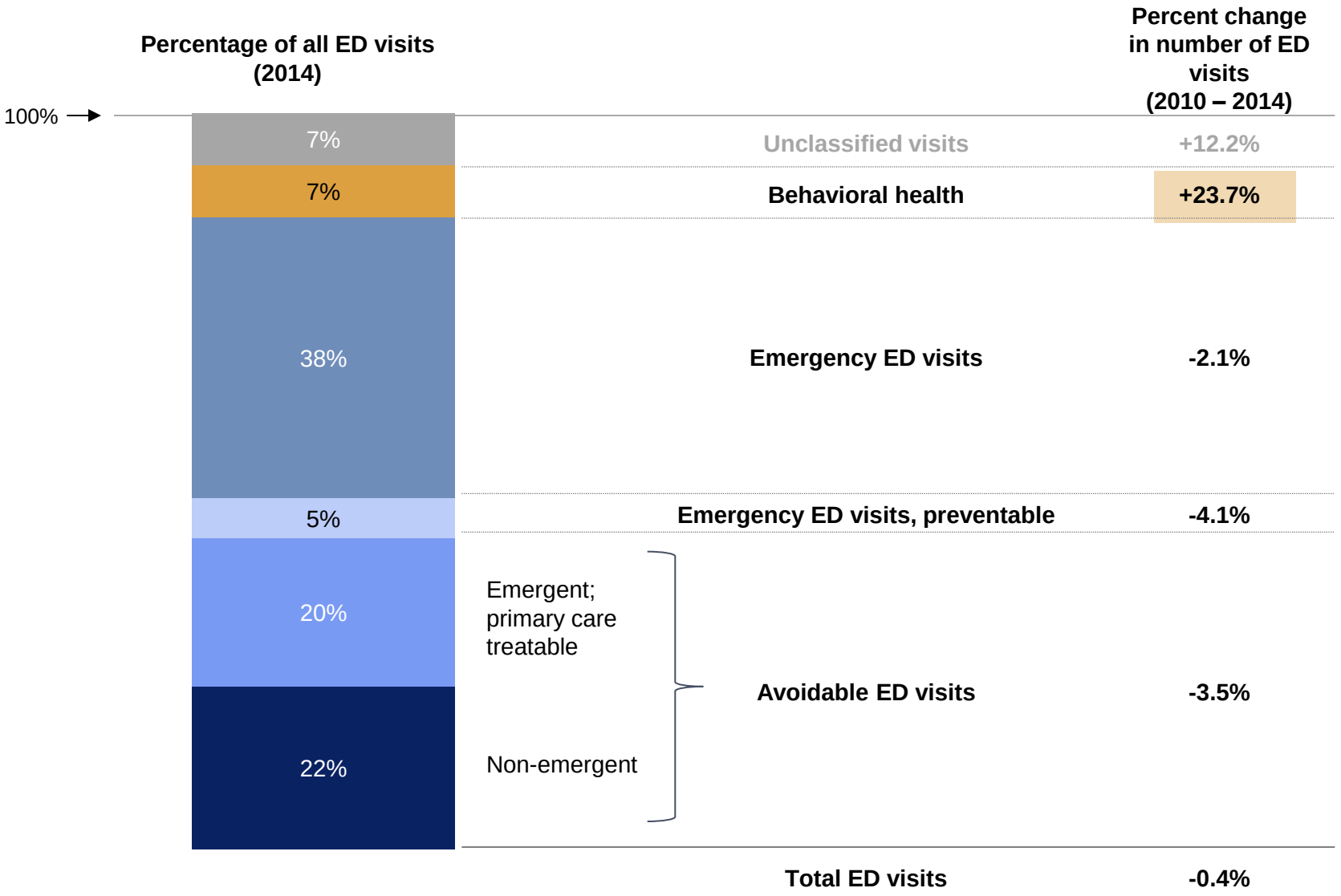
Total number of visits among Massachusetts residents



Note: ED visits limited to MA residents with non-missing sex and age information

Source: HPC analysis of Centers for Health Information and Analysis case mix ED database, FY2010-FY2014

Behavioral health ED visits grew significantly between 2010 and 2014

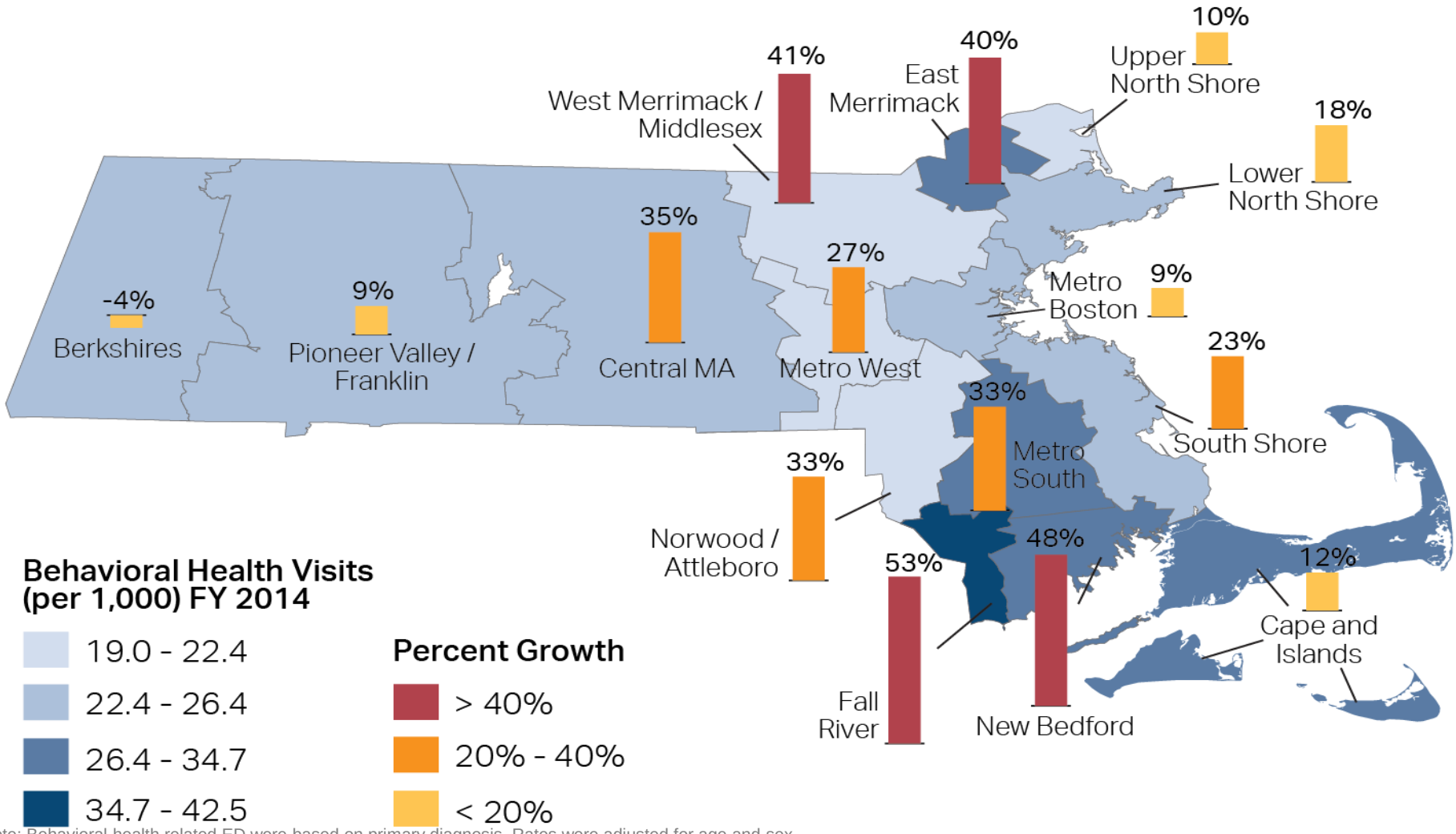


Note: Definition for avoidable ED visits based on NYU Billings Algorithm

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis outpatient ED database, FY2010-FY2014

Behavioral health-related ED visits skyrocketed in a few regions

Per-capita visit rate (shaded) and percent growth in visit rate, 2010-2014 (vertical bars)

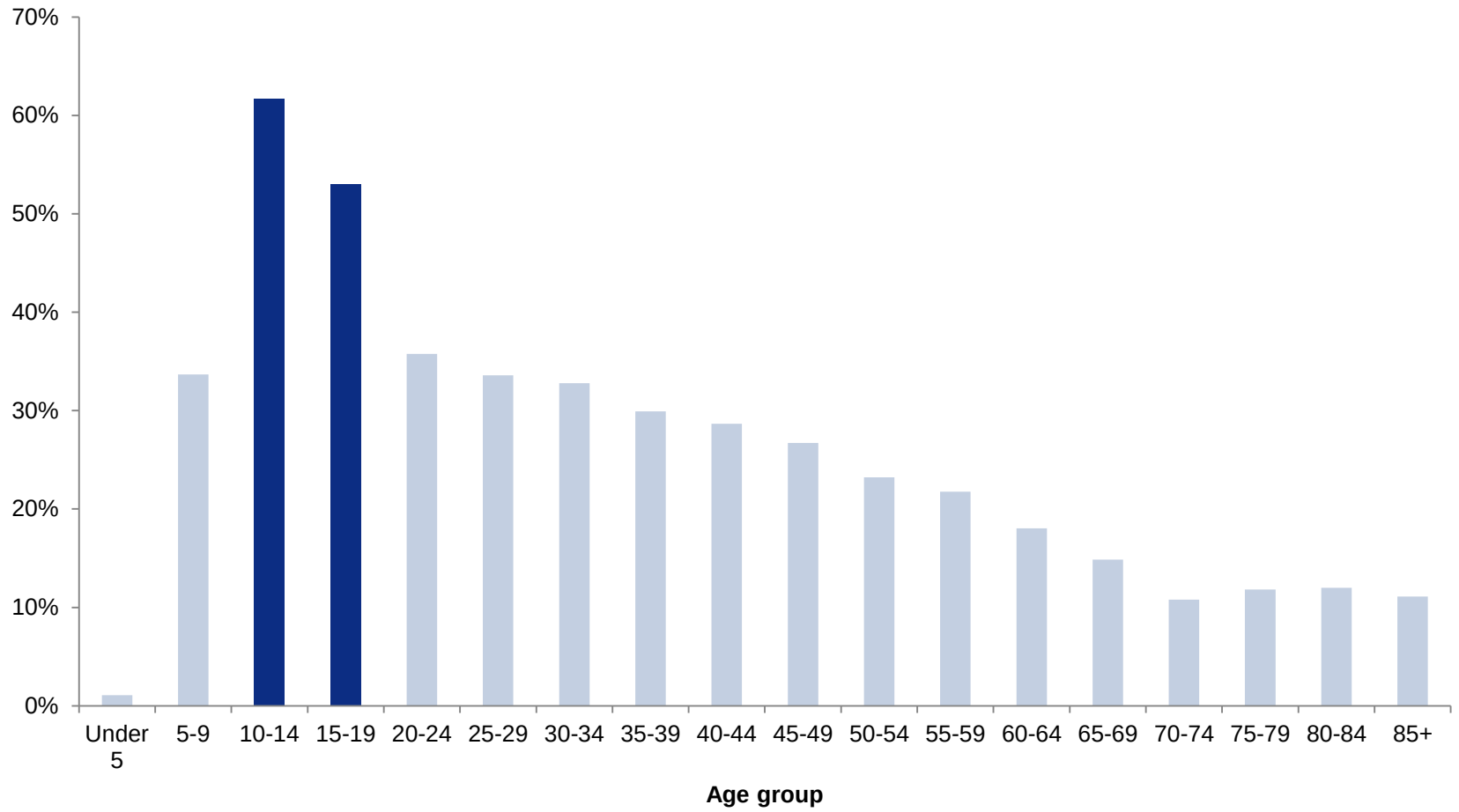


Note: Behavioral health related ED were based on primary diagnosis. Rates were adjusted for age and sex.

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis outpatient ED database, FY2010-FY2014

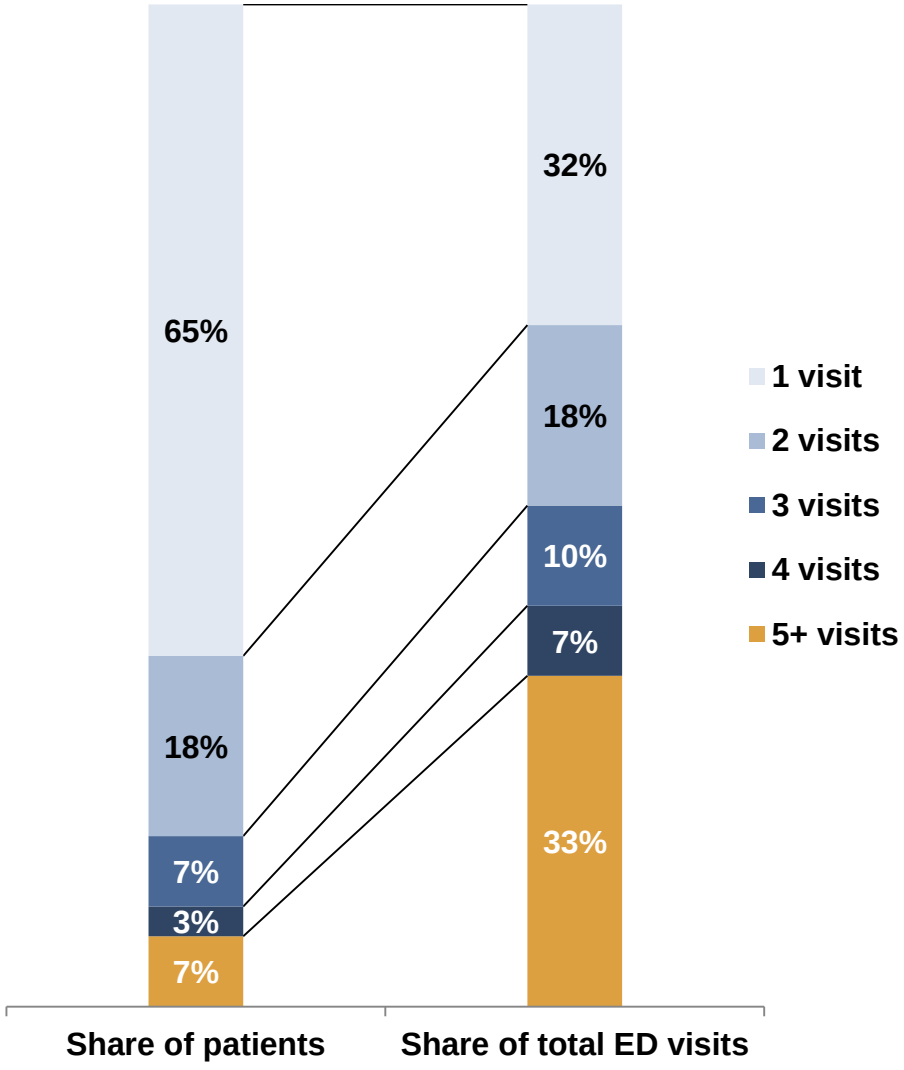
Most long-stay mental health-related ED visits were among teens in 2014

Percent of long-stay (>8 hrs) ED visits that are mental health-related



Source: HPC analysis of Centers for Health Information and Analysis case mix ED database, FY2014

7% of patients accounted for one-third of ED visits in 2014



Note: Unique patient ID were identified using SSN, birthdate, and sex

Source: HPC analysis of Centers for Health Information and Analysis outpatient ED database, FY2014

A high share of ED visits stem from poor access to care after-hours

Among Emergency Department (ED) visits in the past 12 months

40%

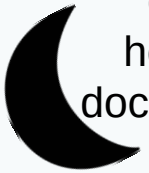
Of recent ED visits were for a non-emergency condition

60%

Of recent emergency room visits were unable to get an appointment at a doctor's office or clinic as soon as needed

76%

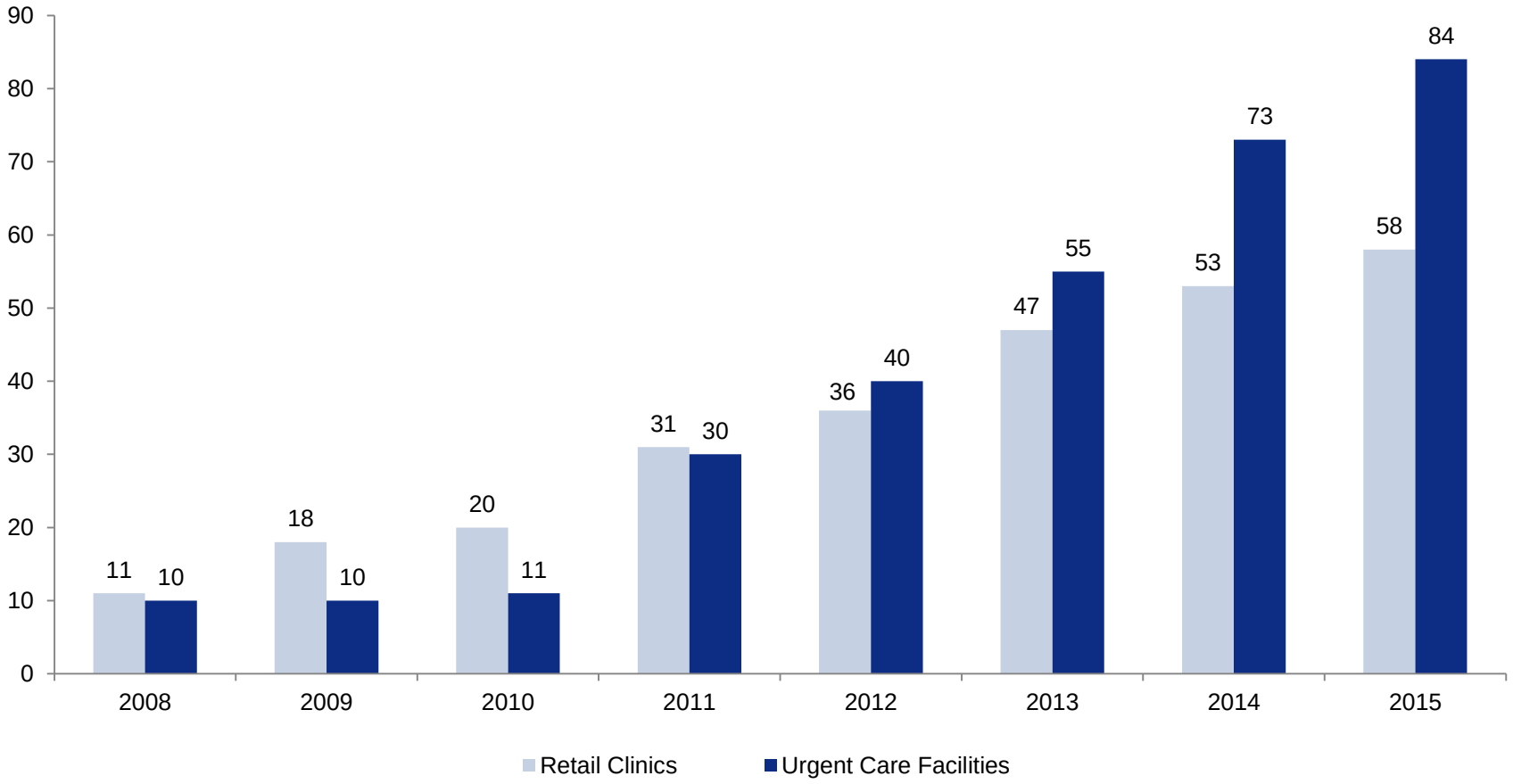
Of recent emergency room visits was for care after normal operating hours at the doctor's office or clinic



Note: A non-emergency condition is one that the respondent thought could have been treated by a regular doctor if one had been available.
Source: 2014 Massachusetts Health Insurance Survey

Retail clinics and urgent care facilities have expanded dramatically

Number of facilities in Massachusetts

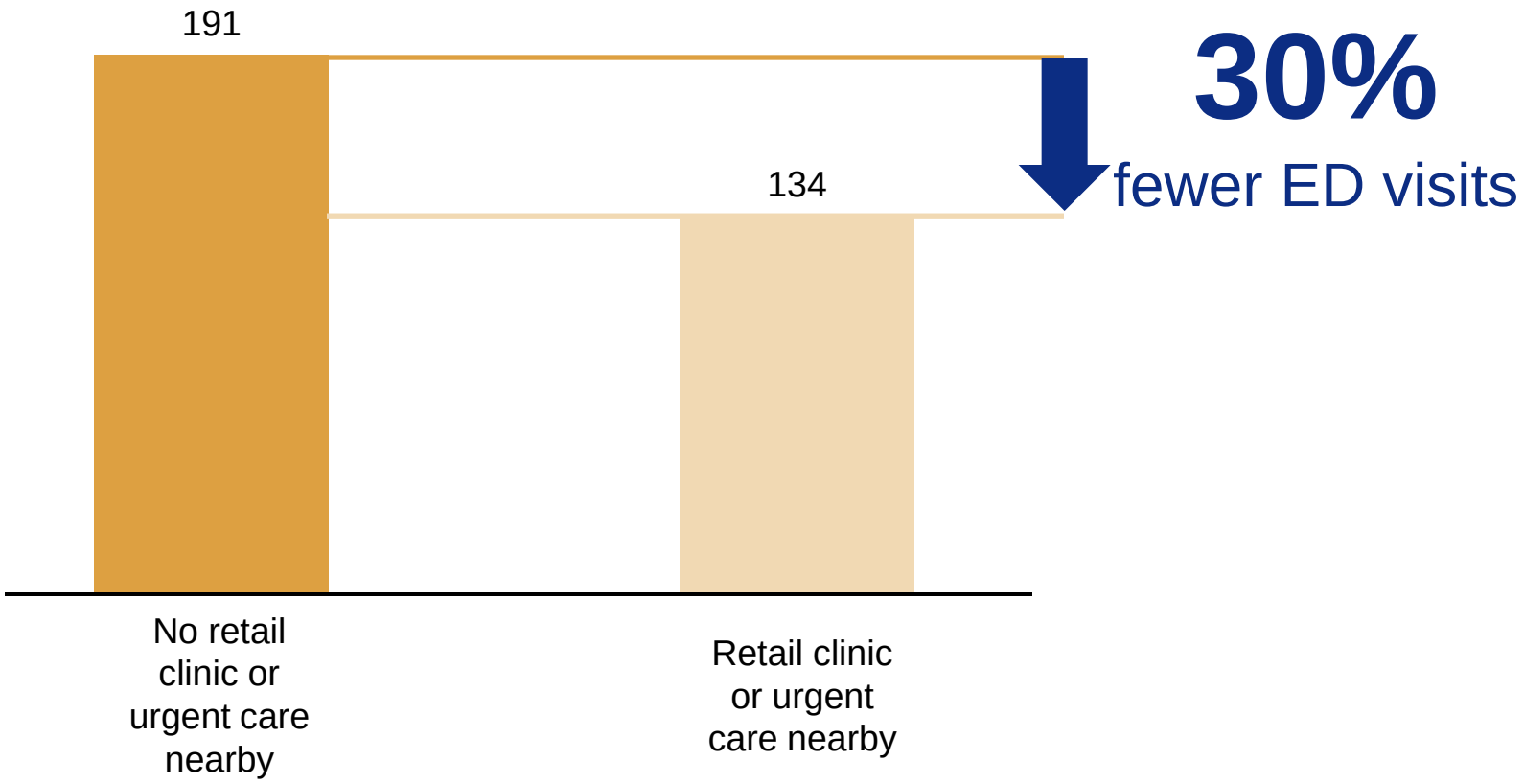


Retail clinics, located in retail stores, are typically staffed by nurse practitioners and treat a limited range of health conditions, such as minor infections and injuries. Annual data from CVS.

Urgent care centers typically are freestanding physicians' offices with extended hours; on-site x-ray machines and laboratory testing; and an expanded treatment range, including care for fractures and lacerations. Annual data from NPI Registry.

Presence of nearby retail clinics and urgent care centers is associated with lower ED use

Annual ED visits per 1,000 residents



Note: Alternative sites include retail clinics and urgent care centers that were accessible in 2014. Residents shown all live within 5 miles of an emergency department. Residents who do not live within 5 miles of an emergency department are excluded from figure.

2015 COST TRENDS REPORT

Finding:

Alternative Payment Methodologies

Alternative payment methods

Previous findings

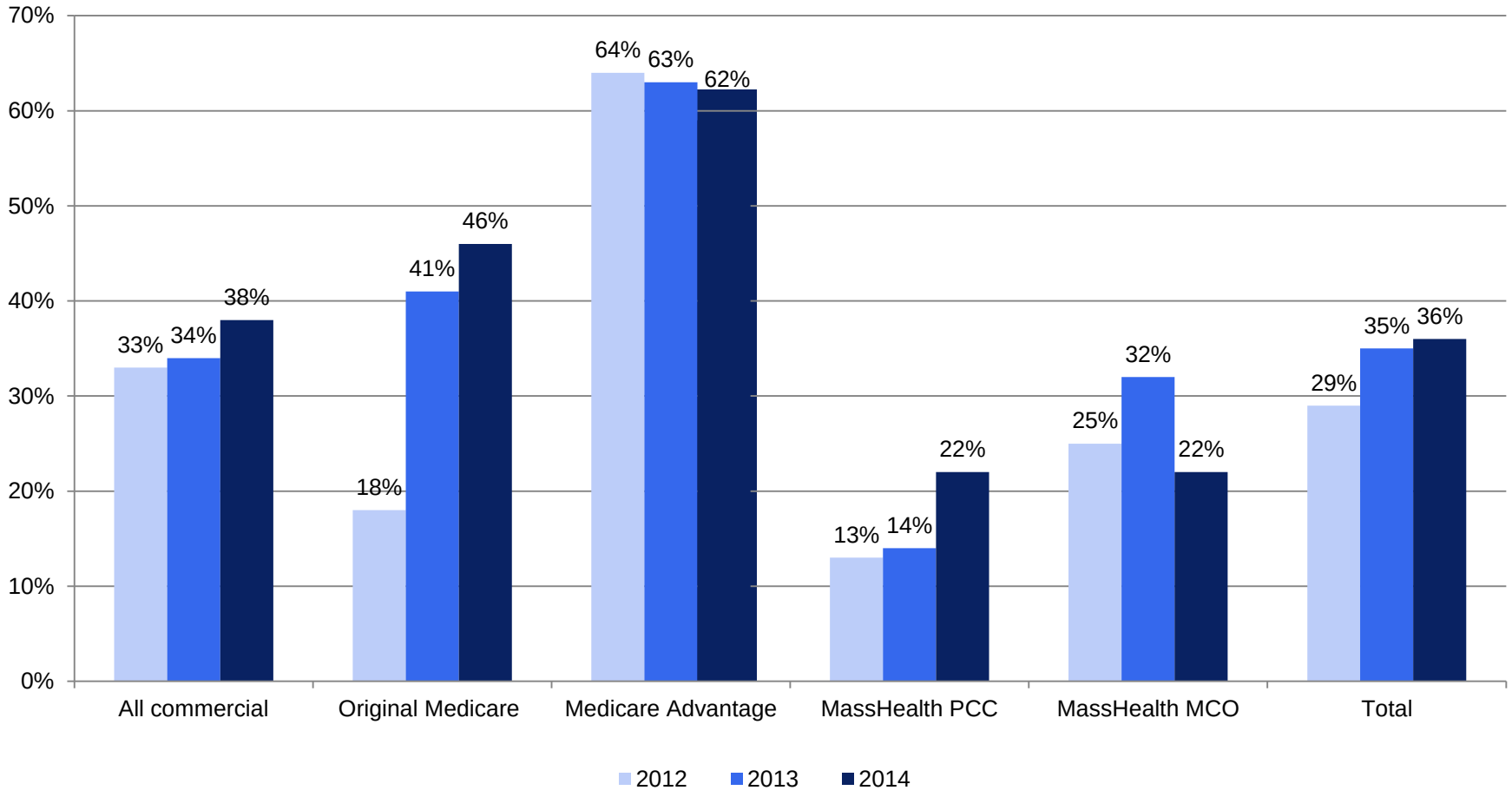
- Alternative payment methods offer incentives that support value and reward high-quality care
- For commercial payers, APM coverage was 61 percent in HMO, ~1 percent in PPO
- To advance APMs, payer/provider coalition developed attribution method in 2014
- Recommendations in 2014 Cost Trends Report
  - All payers should use APMs for 60 percent of HMO lives in 2016
  - Coalition should expand to include more members
  - All members should begin introducing APMs into PPO in 2016, with goal of reaching one third of PPO lives in that year

New findings/market developments

- Between 2013 and 2014, commercial payers made limited progress in extending APMs, with HPHC the one exception
- In 2014, APM rates in HMO exceeded 60 percent for three largest commercial payers.
- In 2015, BCBS and four providers committed to extending APMs to PPO in 2016
- Also, more payers are including BH spending in APM contracts
- In coordination with HPC, MassHealth initiated work groups to establish guiding principles for a MassHealth ACO
- At the hearings, providers continued to emphasize the need for cross-payer alignment in APMs

Little overall growth in APMs

Alternative payment method (APM) coverage by payer type, 2012-2014



Source: HPC, 2014 Cost Trends Report. Center for Health Information and Analysis, 2015 Annual Report, 2015 APM data. CMS program data, downloaded 2015.

Very little progress yet in PPO, although recent announcement from payer/provider coalition is promising

APM coverage by payer, HMO and PPO, 2014

	HMO members as percent of all members	Percent of HMO members covered by APMs	PPO members as percent of all members	Percent of PPO members covered by APMs	Percent of all members covered by APMs
BCBS	53%	91%	47%	0%	48%
HPHC HPI	71%	65%	27%	0%	46%
Tufts/Network	67%	60%	33%	11%	44%
Other	33%	34%	55%	3%	13%
Total	**52%**	**69%**	**44%**	**2%**	**38%**

Source: CHIA 2015 Annual Report, and HPC analysis of CHIA 2015 Annual Report APM data book

Alternative payment methods

Possible 2015 recommendations for discussion

1. Extend APMs to Medicaid, PPO and self-insured products

2. Improve APMs though:
   - Moving away from historical spending in budget
   - Payer alignment of technical elements including risk adjustment, quality measures
   - Inclusion of behavioral health spending in risk budget

3. Increase rates of bundled payments from payers and within provider systems

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Contact Information

For more information about the Health Policy Commission:

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