COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

QIPP Committee Meeting

February 10, 2016

Agenda

- Approval of Minutes from the December 9, 2015 Meeting
- Discussion of Relevant Findings from the 2015 Cost Trends Report and 2016 Quality Improvement and Patient Protection Agenda
- Discussion of Appeals Process for Risk Bearing Provider Organizations
- Discussion of Behavioral Health Integration Technical Assistance for Organizations seeking PCMH PRIME
- Schedule of Next Meeting (March 23, 2016)

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Vote: Approving Minutes

Motion: That the Quality Improvement and Patient Protection Committee hereby approves the minutes of the Committee meeting held on December 9, 2015, as presented.

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Select Findings from 2015 Cost Trends Report

Behavioral health and the ED

- In 2014, 7% of all ED visits had a BH-related primary diagnosis; including secondary diagnoses, a BH condition was a factor in 14% of all ED visits
- The number of ED visits with a primary BH diagnosis grew 24% statewide between 2010 and 2014, while the total number of all ED visits dropped 0.4% over this period
  - When including secondary diagnoses, the number of BH-related ED visits grew by 28%
- Rate of growth varied widely by region:
  - Between 2010 and 2024, BH-related ED visits grew by about 50% in New Bedford and Fall River
  - By 2014, rates of BH-related ED visits varied more than two-fold between regions:
    - 20 visits per 1,000 residents in West Merrimack/Middlesex vs 43 visits per 1,000 residents in the Fall River area
- BH conditions were more prevalent among frequent ED users (5+ visits) than other users, 11% versus 5%
- Strong negative correlation (-0.5) between numbers of BH providers in each region and rates of BH-related ED visits, suggesting need for continued research on access to care

Out-of-pocket spending for behavioral health

- Out-of-pocket spending as a proportion of total health care spending varied among populations defined by health conditions and was particularly high for individuals with BH conditions, such as mood disorders, substance abuse disorder, and psychosis

Select Findings from 2015 Cost Trends Report

Income disparities in preventable hospital admissions

- While rates of preventable hospital admissions improved slightly from 2013 to 2014 across all income quartiles, rates of preventable hospitalizations in lower income communities (median family income < $52,000) were still twice as high as rates in higher income communities (median family income > $87,000)

Affordability and access to care

- While MA has one of the lowest proportion of state residents paying more than 10% of income in out-of-pocket expenses (11% in 2013 and 2014), aggregate measures mask affordability problems for many:
  - A family of four living at twice the FPL, with employer-based insurance, would pay about 40% of their income in health insurance premiums and cost-sharing

- For Massachusetts residents who lived within 5 miles of an ED, avoidable ED use was 30% lower in 2014 if there was also an urgent-care center or retail clinic within 5 miles

Select Recommendations from 2015 Cost Trends Report

The Commonwealth should continue to focus on enhancing community-based, integrated care and reducing the unnecessary utilization of costly acute settings:

- Target to achieve a 20% reduction in all-cause, all-payer hospital readmissions, with a rate below 13% by 2019
  - Action should particularly focus on frequent utilizers
- Target to increase PCMH use: 1/3 of all primary care providers should be practicing within NCQA-recognized PCMHs by 2017 and 20% of all primary care providers should be practicing within an HPC-certified PCMH PRIME practice (with integrated BH) by 2017

The Commonwealth should develop a coordinated quality strategy that is aligned across public agencies and market participants

- Measures that pertain to BH, long-term services and supports, and measures derived from patient reported outcomes are especially needed
- The Legislature should refine the current process for developing the SQMS and better define the role of the SQAC

Payers and providers should continue to focus on increasing the adoption of alternative payment methods (APMs) and on increasing the effectiveness of APMs in promoting high quality, efficient care. Specifically, market participants should advance the inclusion of behavioral health services in their global budget models, and develop plans for including long-term supports and services in such models where applicable to the patient population.

The Commonwealth should develop alternative payment models to catalyze delivery system reform in MassHealth. Specifically, the HPC encourages MassHealth to consider certain design elements in its payment reform efforts, including a payment model the supports the integration of behavioral health and long term supports and services with medical care, and incentivizes the development of cross-continuum partnerships, especially with existing high-performing community-based providers.

To improve access to low-cost, high-quality care, particularly for low income and underserved populations, **the Massachusetts Legislature should remove scope of practice restrictions for Advanced Practice Registered Nurses** (APRNs). The Legislature should consider adopting models used in other states that allow for such providers to practice to the full extent of their license and training.

Areas of focus for QIPP in 2016

Policy	▪ Support other state and federal agencies in the development of policies and regulations that enable effective BH integration ▪ Engage payers in the inclusion of BH services in new payment models
Certification Initiatives	▪ Promote BH integration in primary care (PCMHs) and health systems (ACOs) through certification programs and associated technical assistance ▪ Develop evaluation and measurement metrics for BH in the PCMH and ACO setting
Investments	▪ Invest in integrated care delivery models, both existing and emerging, through CHART, Telemedicine, Neonatal Abstinence Syndrome (NAS) and Health Care Innovation investment programs ▪ Evaluate effectiveness and impact of such investments and contribute to evidence base on best practices, disseminate such best practices to enable broader transformation
Patient Protection	▪ Continue to monitor access to behavioral health treatment through OPP process ▪ Monitor patient appeals in RBPOs/ACOs ▪ Engage with HPC Board on “out-of-network” and “surprise billing” patient safeguards
Research	▪ Continue to conduct research on best practices for BH integration and payment models that facilitate BH integration in both ACO systems and community based settings ▪ Examine impact of BH integration in community settings on ED utilization and cost and quality
Data	▪ Continue to identify BH data and information gaps and collaborate with other state agencies on identifying solutions

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Statutory Requirements

	RBPO	ACO
M.G.L. c. 6D, §15	N/A	(b)(vi) calls for internal appeals plan as required for RBPOs; plan shall be approved by OPP; plan to be included in membership packets
M.G.L. c. 6D, §16	N/A	(a)(8) OPP to establish regs, procedure, rules for appeals re: patient choice, denials of services or quality of care (b) establish external review including expedited review
M.G.L. c. 176O, §24	(a) certified RBPOs shall create internal appeals processes (b) 14 days/3 days for expedited; written decision (b) RBPO shall not prevent patient from seeking outside medical opinion or terminate services while appeal is pending (d) OPP to establish standard and expedited external review process	ACO is to follow M.G.L. c. 176O, §24 when developing internal appeals plan (see M.G.L. c. 6D, §15(b)(vi))

RBPO Statutory Requirements – M.G.L. c. 176O § 24

(a) All risk-bearing provider organizations certified under chapter 176U shall create **internal appeals processes**. The appeals processes shall be available to the public in written format and, by request, in electronic format.

(b) The internal appeals processes in subsection (a) shall be completed in a period not longer than 14 days; provided, however, that an expedited internal appeal shall be completed in a period not longer that 3 days for a patient with an urgent medical need including, but not limited to, terminal illness or emergency situations, as defined through regulations by the office of patient protection. During the appeals process, the risk-bearing provider organization shall not: (i) prevent a patient from seeking medical opinions outside of that organization; or (ii) terminate any medical services being provided to the patient, including medical services which began prior to the appeal and are the subject of such appeal. The decision on the appeal shall be in writing and shall notify the patient of the right to file a further external appeal.

(c) Risk-bearing provider organizations shall inform any patient of the right to designate a third party to advocate on the patient's behalf during the appeals process including, but not limited to, a spouse or other family member, an attorney of record or a legal guardian. If the patient does not elect a person to serve as his or her advocate such provider organization shall offer to contact the office of patient protection and the office of patient protection may designate an ombudsman to advocate on the patient's behalf.

(d) The office of patient protection shall establish by regulation an **external review process** for the review of grievances submitted by or on behalf of patients of risk-bearing provider organizations. The process shall specify the maximum amount of time for the completion of a determination and review after a grievance is submitted and shall include the right to have benefits continued pending appeal. The office of patient protection shall establish expedited review procedures applicable to emergency and urgent care situations.

The office of patient protection shall promulgate regulations necessary to implement this section.

ACO Statutory Requirements – M.G.L. c. 6D § § 15 and 16

MGL c. 6D §15(b)	"A certified ACO shall… (vi) develop and file an **internal appeals** plan as required for risk bearing provider organizations under section 24 of chapter 176O provided, that said plan shall be approved by the office of patient protection; provided further, that the plan shall be a part of a membership packet for newly enrolled individuals;…"
MGL c. 6D §16(a)(8)	OPP shall "establish, by regulation, procedures and rules relating to appeals by consumers aggrieved by restrictions on patient choice, denials of services or quality of care resulting from any final action of an ACO, and to conduct hearings and issue rulings on appeals brought by ACO consumers that are not otherwise properly heard through the consumer's payer or provider."
MGL c. 6D §16(b)	**"**The Commission shall establish an external review system for the review of grievances submitted by or on behalf of insurers of carriers under section 14 of chapter 176O. The commission shall establish an **external review process** for the review of grievances submitted by or on behalf of ACO patients and shall specify the maximum amount of time for the completion of a determination and review after a grievance is submitted. The commission shall establish expedited review procedures applicable to emergency situations, as defined by regulation promulgated by the division."

Updates Since November QIPP Committee

Staff Research

Continued examination of applicable models

Identification of consumer issues

Ongoing Stakeholder Outreach

MassHealth

ACO Public Comments

Provider organizations

Growing consensus on the need for more data to guide implementation of RBPO/ACO appeals statutory mandates

Objectives

1. Advance consumer protection established in Chapter 224 without duplicating existing rights under carrier insurance appeals
2. Protect patients while recognizing the needs of different providers and minimizing administrative burden and expense
3. Inform consumers about RBPO/ACO providers
4. Build on existing provider mechanisms for addressing complaints
5. Gather and analyze data, to provide foundation for developing appeals processes and rules

Proposed Bulletin

Require Notice

Direct RBPOs/ACOs to:

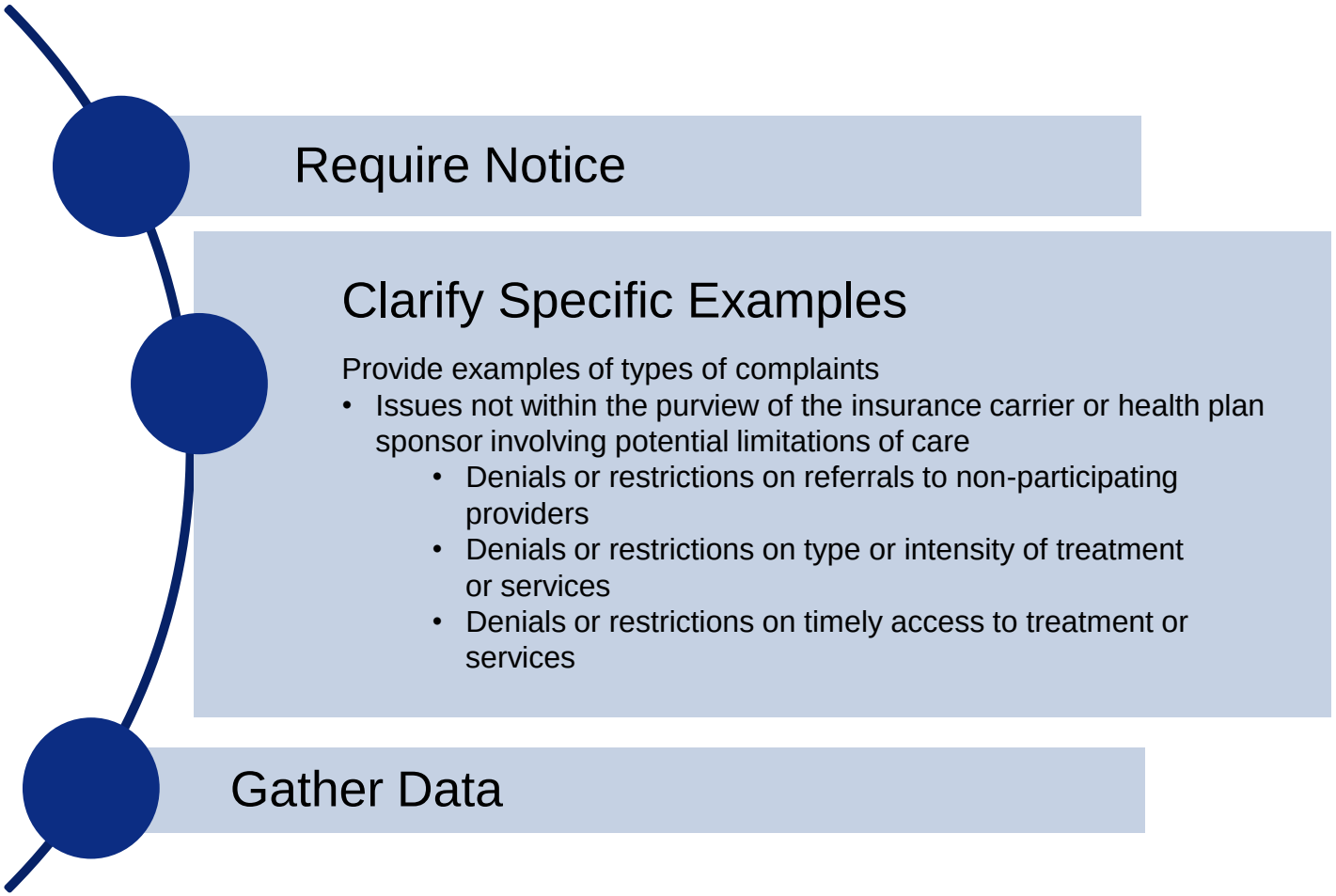
- Provide notice to consumers for whom they are at risk about ability to make complaint/file appeal
- Providers can decide best method of notice
- Establish point of contact for receipt of complaints
- Resolve complaints according to statutory timelines

HPC will provide a sample “Notice to Patients” and clarify that requirements do not apply to Medicare or Medicare Advantage patients due to application of existing federal rules

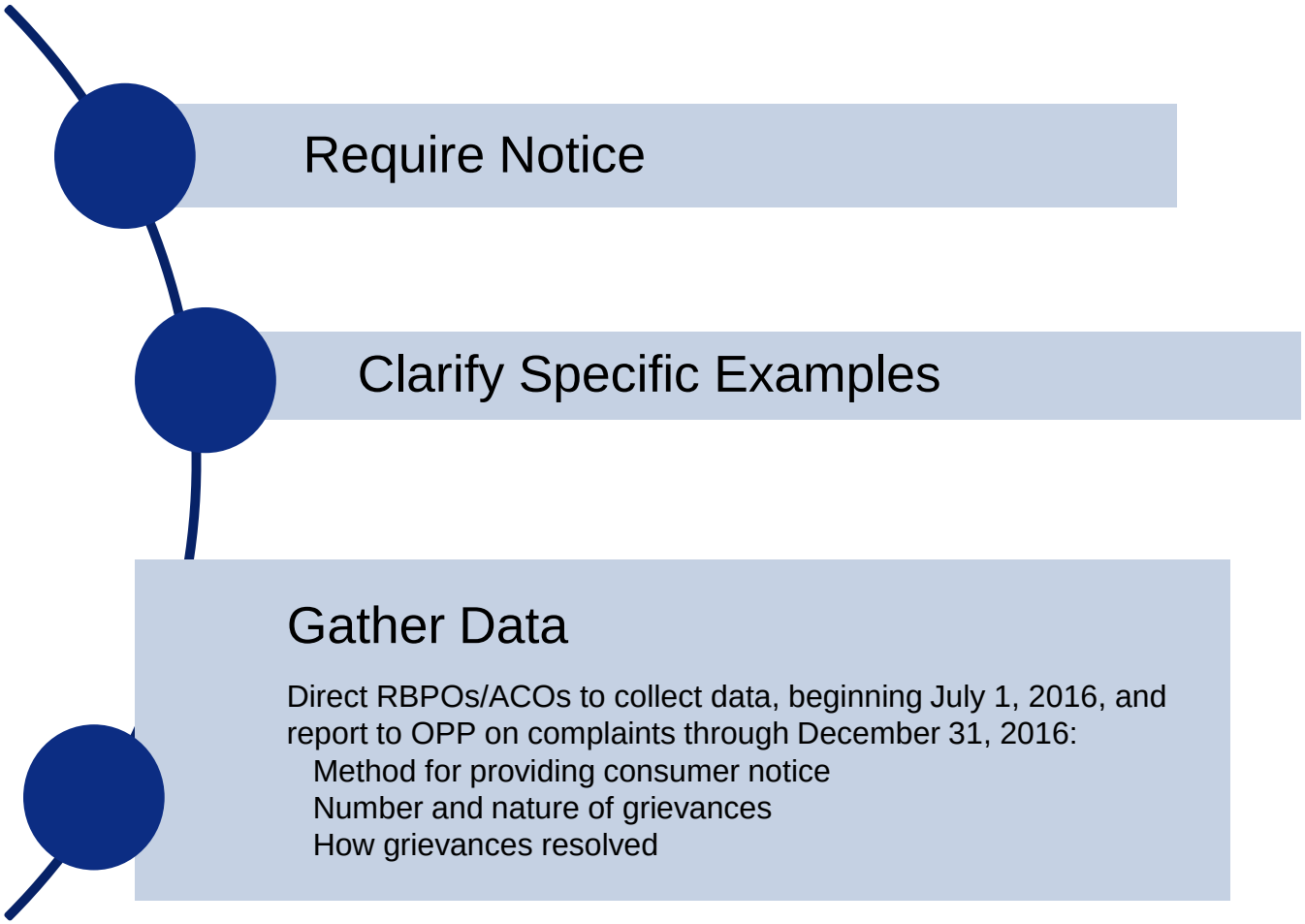
Clarify Specific Examples

Gather Data

Proposed Bulletin



Proposed Bulletin



Next Steps

Issue Bulletin in Spring 2016

Discuss Bulletin at 3/23 QIPP Committee meeting

Review data

- Opportunity to consider information gathered by RBPOs/ACOs on consumer appeals
- Consider extending reporting period

Develop Regulation

- Public process including proposed regulation and public comment period

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Communications with providers about PCMH PRIME

Since PCMH PRIME launch on January 1, 2016

2 practices

have submitted applications to HPC to participate in PCMH PRIME:

Lynn Community Health Center

Whittier Street Health Center

7 practices

have sent written questions to HPC about:

Specific criteria/documentation requirements

Application process

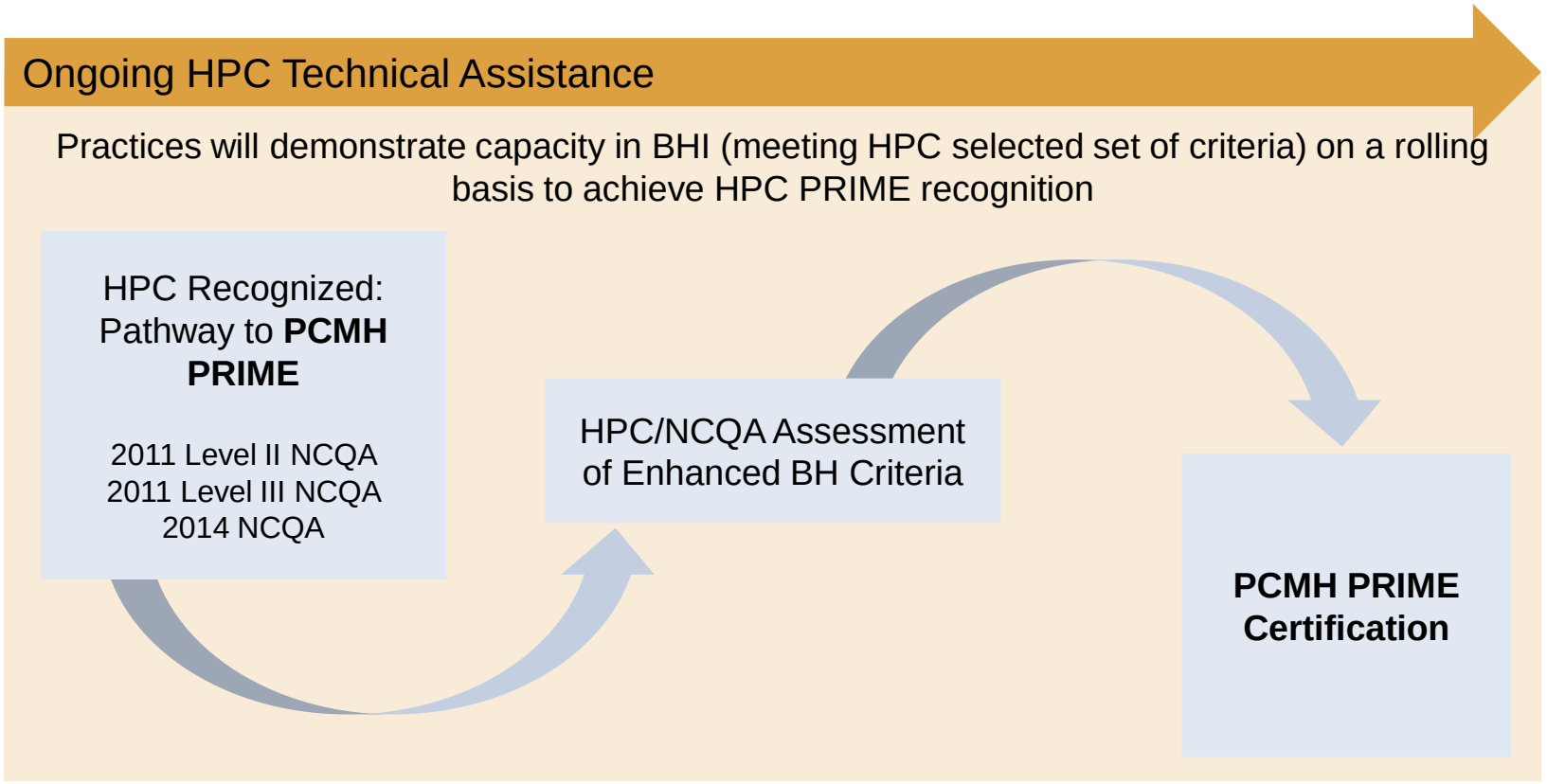
Cost

Coming Soon

Broad communications about PCMH PRIME for providers, including:

- Dedicated website at NCQA
- One-page overview flyer
- FAQ document
- Emails to currently NCQA PCMH Recognized practices; post cards to other Massachusetts practices
- Press release (joint with NCQA)

PCMH PRIME



HPC PCMH certification for practices that are NCQA certified (Level II or III).

*Practices must convert to NCQA 2014 standards at end of their current 2011 recognition period

Target practices for TA

Practices must attain 2011 NCQA PCMH recognition at Levels 2 and 3, or 2014 NCQA PCMH recognition to be eligible for PCMH PRIME. HPC also may offer TA to non-NCQA Recognized practices (budget permitting)

2011 NCQA **Level I** - 3 (not eligible for PCMH PRIME)

2014 NCQA **Level I** - 0

2011 NCQA **Level II** - 54

2014 NCQA **Level II** - 0

2011 NCQA **Level III** - 253

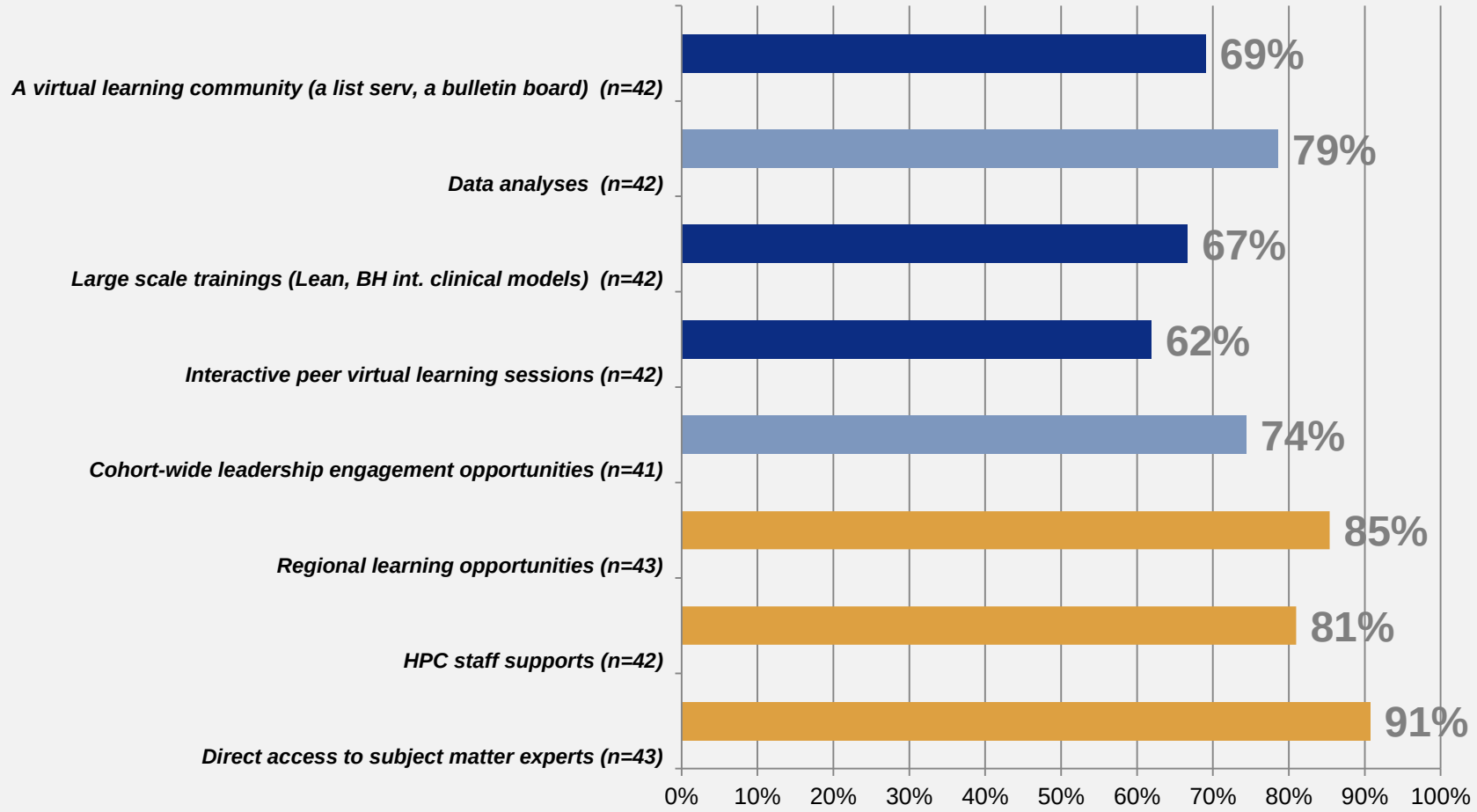
2014 NCQA **Level III** - 8

315 practices potentially eligible for PRIME

NCQA data, January 2016

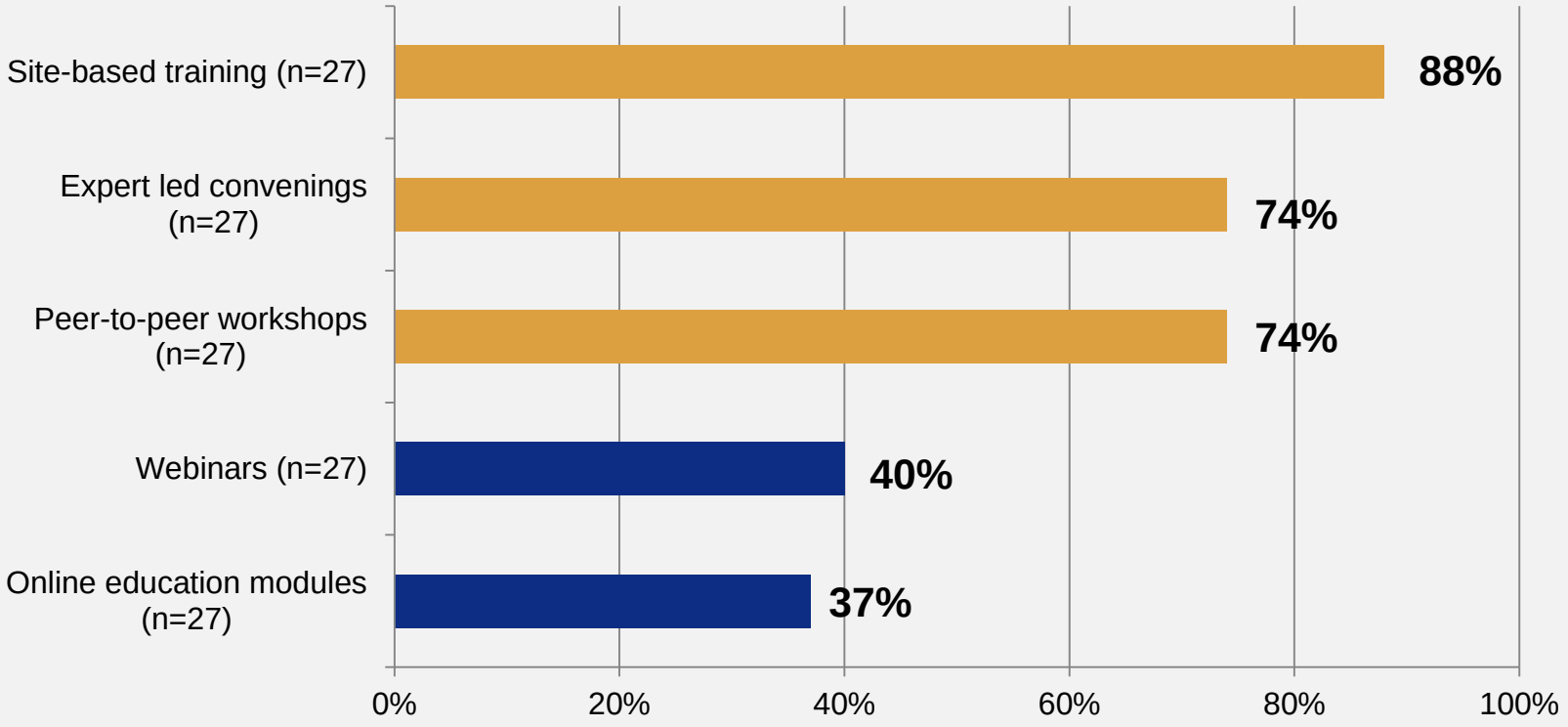
Provider preferences for technical assistance modes

Percent of CHART respondents who agreed or strongly agreed that it would be helpful for the HPC to facilitate:



Provider preferences for technical assistance modes

Percent of primary care provider respondents who indicated mode was effective or very effective



Provider preferences for PRIME criteria technical assistance

>50% of practices surveyed say TA is critical or necessary to meet the following PRIME criteria:

- The practice collects and regularly updates a comprehensive health assessment that includes **SUD screening for** adults and adolescents using a standardized tool.
- 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.
- The practice **tracks referrals** until the consultant or specialist's report is available, **flagging and following up on overdue reports.**
- The practice implements clinical decision support following **evidence based guidelines** for a mental health and substance use disorder.
- The practice has at least one **care manager** qualified to identify and coordinate behavioral health needs.

Considerations for primary care BHI TA program design

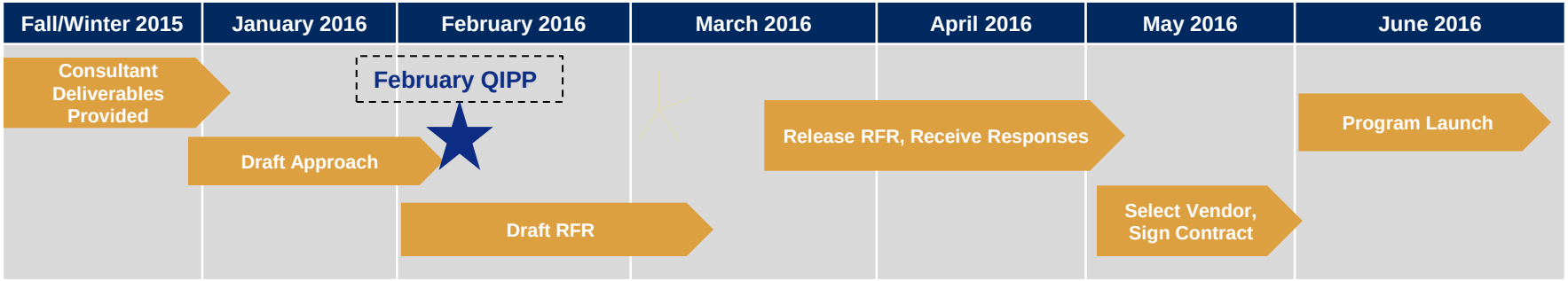
HPC would hire a vendor to manage and provide technical assistance. HPC and the vendor work in close collaboration to understand progress of the practices on behavioral health integration criteria.

Requirement for TA	Description
Includes mix of broad and practice-specific TA modes	• Includes some one-on-one practice coaching opportunities • Includes broad-based learning opportunities for all practices (e.g. learning collaboratives) • Does not rely on webinars or online modules • Matches practices with appropriate content and mode
Focuses on most challenging PCMH PRIME criteria	• Prioritizes delivering TA on the criteria practices need most help with • Able to offer TA on any of the 13 PCMH PRIME criteria as needed • Works with HPC to ensure strategy is aligned with, and not duplicative of, TA provided by other state agencies (e.g., DPH, DMH, MassHealth) • Forecasts potential future need and advises HPC on planning for TA development over time
Accommodates practices on different timelines	• Allows multiple opportunities for practices to receive similar content/assistance • Ensures whenever a practice enters the TA program, it has opportunities to learn from other practices
Delivers maximum value to practices and HPC	• Hiring one vendor instead of multiple minimizes administrative costs and maximizes the share of contract dollars spent on direct practice TA • Utilizes current TA available / partners with MA organizations already providing support to practices • Reports regularly to HPC on practice progress

Allow flexibility for bidders to propose how they will fill these needs within budget: $1 M over 2 years

Timeline and next steps

The HPC anticipates releasing an RFR for the primary care BHI TA program in Spring 2016



	Goal Setting	Program Design	Implementation
Activities	☑ Meet with subject matter experts and stakeholders on program design considerations ☑ Scan MA for existing BHI TA models ☐ Decide on TA framework, present to QIPP (Feb. 10)	☐ Draft RFR ☐ Release RFR ☐ Receive and review proposals from vendors ☐ Selection of vendor	☐ Finalize program design, measurable goals, and contract requirements with vendor'(s) ☐ Begin TA program ☐ Support program implementation as needed and monitor performance
Output	• Program Goals • Current Landscape	• RFR development • Proposal process • Vendor selection	• Operational planning • Program monitoring

PCMH PRIME criteria for behavioral health integration

#	Criteria (practice must meet ≥ 7 out of 13)
1	The practice **coordinates with behavioral healthcare providers** through formal agreements or has behavioral healthcare providers co-located at the practice site.
2	The practice **integrates BHPs** within the practice site.
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** for children under 3 years of age using a standardized tool.
5	The practice collects and regularly updates a comprehensive health assessment that includes **depression screening** for adults and adolescents using a standardized tool.
6	The practice collects and regularly updates a comprehensive health assessment that includes **anxiety screening** for adults and adolescents using a standardized tool.
7	The practice collects and regularly updates a comprehensive health assessment that includes **SUD screening for** adults and adolescents using a standardized tool.
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 at least one clinician who is providing **treatment for addiction with medication-assisted treatment** (naltrexone, buprenorphine, and/or methadone) **and behavioral therapy**, directly or via referral.*
13	The practice has at least one **care manager** qualified to identify and coordinate behavioral health needs.

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Contact Information

For more information about the Health Policy Commission:

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