MINUTES OF THE JOINT COMMITTEE MEETING

CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION QUALITY IMPROVEMENT AND PATIENT PROTECTION

Meeting of November 30, 2016

MASSACHUSETTS HEALTH POLICY COMMISSION

JOINT COMMITTEE MEETING
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, November 30, 2016, 9:30 AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Care Delivery & Payment System Transformation (CDPST) and Quality Improvement & Patient Protection (QIPP) Committees held a joint meeting on Wednesday, November 30, 2016, at the HPC's offices, 50 Milk Street, 8th Floor, Boston, MA.

Members present included Dr. Carole Allen (Chair, CDPST), Mr. Martin Cohen (Chair, QIPP), Dr. David Cutler, Dr. Don Berwick, Dr. Stuart Altman (Chair, HPC), and Undersecretary Alice Moore, designee for Secretary Marylou Sudders, Executive Office of Health and Human Services. Dr. Wendy Everett participated via phone.

The meeting notice and agenda can be found here.
The presentation from the meeting can be found here.

Dr. Allen called the meeting to order at 9:34 AM and offered a brief introduction.

ITEM 1: Approval of minutes from November 2, 2016

Dr. Allen asked for a motion to approve the minutes from CDPST's November 2, 2016 meeting. Dr. Cutler motioned to approve the minutes. Mr. Cohen seconded. Committee members voted unanimously to approve the minutes, as presented.

ITEM 2: Community Resource Directories

Ms. Katie Shea Barrett, Policy Director, Accountable Care, introduced the HPC's work around a statewide community resource directory (CRD). For more information, see slides 7-8.

Dr. Cutler asked whether staff had identified any provider systems that currently had state-of-the–art CRDs. Ms. Barrett responded that, from a high-level perspective, systems with more resources tend to be more invested in these programs.

Dr. Allen stated that she disagreed that larger systems invest more in CRDs. In pediatrics, she stated, doctors are encouraged to screen for social determinants of health (SDH). Dr. Allen noted that she did not believe that larger systems provide resources for patients to address certain SDH, particularly those related to their environments. Dr. Allen said this issue needs to be addressed.

Ms. Barrett thanked Dr. Allen for her perspective and added that staff would discuss the difference between simply having a CRD and having one that is useable. She clarified that, in the current presentation, staff only examined whether systems had CRDs.

Dr. Allen clarified that even the most sophisticated systems may not actually provide the information that patients need.

Ms. Barrett introduced Ms. Lauren Melby, Program Manager for Strategic Investment. Ms. Melby overviewed the existing CRD landscape in the Commonwealth. For more information, see slides 9-13.

Dr. Allen said that the HPC should be cautious when making assumptions about what people want or need. She encouraged the HPC to ask people what they need and respond to that information. Ms. Melby agreed, noting that this illustrated why it is important that CRDs have a range of services to offer and that a CRD cannot replace a provider-patient conversation about which services are needed. Ms. Barrett added that some providers offer a patient rating of these resources, which can be a helpful way to solicit that feedback.

Dr. Cutler stated the provider directories published by health plans suffer from a number of issues. He asked how the state could do a better job maintaining a CRD to ensure that it has the most up-to-date information for patients. Ms. Barrett responded that this important question merits further discussion. She said that there are private companies that have entered the CRD landscape to aid in their maintenance. She added that staff heard from providers that there is some utility in the state acting as a curator in concert with these private companies.

Ms. Barrett asked Board members to consider what role the HPC should play in the CRD landscape.

Dr. Allen responded that the Medicaid population would likely need this service more than some other populations. Noting this, she stated that the state would have to manage and pay for these services.

Undersecretary Moore said that the HPC will have to have some agility in its work in this area. She noted that, as the Medicaid waiver is implemented, the HPC should work to determine how its statutory mandate for a CRD aligns with what is occurring at MassHealth. She added that creating a system for continuity of care is a challenge and that everyone had been working together quite well to address this.

Mr. David Seltz, Executive Director, added that the statutory mandate is in Chapter 224. He noted that it has been challenging for the HPC to find a path forward on a CRD. He said that the value of CRDs is clear but determining the Commonwealth and HPC's role has been difficult. He added that the goal of the day's discussion was to encourage Board members to think about potential HPC activities within the CRD landscape.

Dr. Cutler noted that this is an incredibly important topic. He noted that the creation of a CRD should be done centrally to avoid providers duplicating work. He said that his main concern is whether the HPC's CRD will be a better resource than those already created by health plans.

Mr. Cohen agreed that a centralized approach is important. He added that all services are local and that the HPC needs to consider that when devising any system.

ITEM 3: Dual Diagnosis Study

Ms. Katherine Record, Deputy Policy Director for Behavioral Health Integration & Accountable Care, provided a brief introduction to the HPC's dual diagnosis study. Ms. Adrienne Anderson, Policy Associate for Behavioral Health Integration, provided an overview of the statistics on dual diagnosis patients in the Commonwealth. For more information, see slides 15-16.

Dr. Allen asked for clarification on the amount of overlap between Massachusetts residents who have mental illnesses and those who suffer from substance abuse disorder (SUD). Ms. Record responded that there is no state level data available on this co-occurrence. Mr. Cohen said that the co-occurrence rate was high.

Ms. Record provided an overview of the findings of the HPC's upcoming dual diagnosis study. For more information, see slides 17-22.

Dr. Allen said that she could understand why behavioral health (BH) providers might not have experience treating SUD but had difficulty understanding why SUD providers would not be able to at least diagnose a mental illness. Dr. Allen asked whether a provider who treats both SUD and BH needs to be licensed separately in each. Ms. Record responded that this depends on the level of care provided.

Dr. Allen asked whether this required an entirely separate license application. Undersecretary Moore responded that there is an ongoing effort to streamline the licensing provisions to see where there can be cases of co-licensing without multiple applications.

Dr. Allen stated that the HPC should not only map what is available, but also what barriers exist to people being able to access these services. She added that the HPC should also ensure it is getting input from patients and community members when mapping these resources.

Ms. Record agreed and said this input was critical, adding that staff could either meet with consumer representatives or convene a consumer focus group.

Dr. Allen reiterated that the HPC must be careful about the assumptions being made when mapping these resources. She cited the example of an individual not wanting to use resources in their immediate vicinity due to privacy issues.

Ms. Record agreed and pointed out that others might be faced with the opposite challenge: not having transportation to reach services that are far away.

Mr. Cohen said that the two examples provided on slides 19 and 20 underscore the importance of this issue. He said that they raise a capacity question in that the Commonwealth has varying levels of providers and some do not have the resources to meet the needs of BH clients. He pointed out the discrepancy in treatment of minority populations.

Mr. Cohen cited a study from the Substance Abuse and Mental Health Services Administration (SAMHSA) that examined the efficacy of treatment modalities and suggested its findings might be useful for staff to examine. He added that there are many new resources coming online for BH.

Dr. Allen said that telemedicine is becoming more important.

Mr. Foley added that culture and language competencies in these resources were extremely important. He asked whether there was any overlap between this mapping of resources and the CRDs. Ms. Record responded that a CRD would be primarily of use to primary care providers (PCPs) to refer patients for non-pharmaceutical support. She said that Mr. Foley was right that there would be overlap but that the hope was that the work would be more synergistic than repetitive.

Mr. Seltz added that the CRDs are aimed at giving providers actionable information whereas the primary goal with this mapping is understanding the landscape in Massachusetts and identifying where there is unmet need. He said that the dual diagnosis mapping effort is aimed more at getting a static snapshot to inform policy decisions.

Undersecretary Moore said that, in the Medicaid context, there is an inventory of these services. She also noted that there is ongoing work at the Department of Public Health (DPH) and the Department of Mental Health (DMH) on their mapping processes of Medicaid resources.

Dr. Cutler said that it was inconceivable to him that there is any part of Massachusetts where there is not a shortage of dual diagnosis resources.

Dr. Cutler said that the HPC could consider whether some of the providers who have dual diagnosis treatment capacity might be able to extend their reach and possibly give advice to providers who did not have this capacity.

Ms. Record thanked the Board members for their comments and questions.

ITEM 4: Patient-Centered Medical Home Certification Program

Mr. Seltz provided a brief introduction to the Patient-Centered Medical Home (PCMH) Certification Program update. Ms. Catherine Harrison, Senior Manager for Accountable Care,

then provided a brief update on the number of practices participating in PCMH PRIME. For more information, see slide 24.

Ms. Kelsey Brykman, Policy Associate, Accountable Care, updated the Board on the National Committee for Quality Assurance (NCQA) PCMH Recognition program, which is undergoing a redesign in 2017, and its potential implications on PCMH PRIME. For more information, see slides 25-27.

Dr. Allen asked how the new PCMH recognition program redesign would affect the cost structure for practices. Ms. Brykman responded that staff were still determining the impact. She noted that, based on preliminary information, annual cost would be less. She said that it was still not clear how this would affect PCMH PRIME. Dr. Allen said that she was encouraged to see some of the real-time aspects of the new design, noting that this would be valuable for practices. She voiced concern that NCQA would raise the recognition price to a level that fewer practices could afford.

Mr. Seltz stated that a lot of the changes that NCQA is proposing address some of the concerns the HPC heard from practices when first partnering with NCQA on the program.

Ms. Harrison stated that NCQA is planning to create a behavioral health distinction module that will serve as a special designation. She said that the NCQA 2017 draft standards include all of the HPC's PCMH PRIME criteria with the exception of specific screening for postpartum depression. She said that the distinction program could be another way that a particular practice could distinguish itself.

Dr. Allen asked how about the duration of NCQA recognition for practices certified under the 2014 guidelines. Ms. Brykman responded that 2011 and 2014 NCQA recognitions continue to be valid for three years. Ms. Harrison added that there are a number of ways that practices can extend their NCQA recognitions beyond the three-year time span by upgrading to a higher level. She said that there would still be practices recognized under prior standards in Massachusetts through 2019. As such, she said that the number of Massachusetts practices seeking certification under the 2017 standards in the near term is likely to be relatively small.

ITEM 5: Adjournment

Dr. Allen asked if there was further comment from any of the Committee members. Dr. Everett thanked the staff and said that it had been very helpful to listen to the discussion.

Dr. Allen asked if there were any members of the public who had comments. None were heard. Dr. Allen adjourned the meeting at 10:52AM.