MASSACHUSETTS
HEALTH POLICY COMMISSION

Joint Committee Meeting

November 30, 2016

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- **Joint Committee Meeting**
  - Call to Order
  - Approval of Minutes from the November 2, 2016 Meeting
  - Community Resource Directories
  - Dual Diagnosis Study
  - Patient-Centered Medical Home Certification Program
  - Other Business
- Quality Improvement and Patient Protection: Public Hearing

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VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the joint QIPP/CDPST meeting held on November 2, 2016, as presented.

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HPC's Role in Supporting Community Resource Directories (CRD)

Statutory requirement within ch. 224 (Section 14 of MGL c.6D)

*"The commission shall develop and distribute a **directory of key existing referral systems and resources** that can assist patients in obtaining housing, food, transportation, child care, elder services, long-term care services, peer services and other community-based services. This directory shall be made available to patient-centered medical homes **in order to connect patients to services in their community**."*

CRD alignment with HPC care delivery objectives

Providers in accountable care models should be able to address patients' social needs, in addition to behavioral and medical care.

Cost Trends Hearings 2016: Social Determinants of Health Panel

"**We need to learn who is around us**, we are **actually mapping the services** now…it's embarrassing how little I know about what's going on 3 blocks outside of BMC."

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HPC Principles For a Community Resource Directory (CRD)

Proposed guiding principles

1. Align goals with statewide payment reform activities and priorities
2. Leverage and align with complementary state resource directory capabilities
3. Fill gaps where resource directory capabilities are minimal or do not exist
4. Lead with simple but high value directory functionality while incrementally enhancing capabilities over time

Range of capabilities of existing provider-facing community resource directories

If provider has no directory:
Then CRD becomes exclusive resource

If provider has poorly maintained directory:
Then CRD fills gaps or potentially replaces

If provider has directory with good geographic coverage but incomplete provider info:
Then CRD integrates and enhances by providing new provider information

If provider has directory with good community provider info but incomplete geographic coverage:
Then CRD integrates and enhances existing directory by adding geographic information

If provider has complete and well-maintained directory:
Then CRD integrates and adds local directory information to develop an accurate statewide resource

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A number of platforms and directories of social services and resources exist nationally and across the Commonwealth.

1 Assessed current landscape

Existing resource directories range from simple to complex (e.g., from .pdf lists to sophisticated, interactive directories).

Connecting the Dots: Alignment of CRD Efforts

2 Identified alignment with other agency programs and objectives

HPC staff learned there are many resource mapping and connecting efforts ongoing within state agencies, in addition to the private provider market.

HPC	Chapter 224 mandate; care delivery reform through certification and investment programs, research and analytics, and market monitoring
Elder Affairs	MassOptions and Mass 2-1-1 elder service listings
Mass Health	SIM investments focused on integrated community services
	Payment reform program to hold provider systems accountable for integrating behavioral, medical and social care
DPH	e-Referral pilot connecting providers to social service providers, with feedback loop

What do provider systems need in a CRD?

3 Conducted provider stakeholder interviews

Providers reported that a web-based resource directory with the ability to be personalized based on-site (e.g., integration with existing referral system or EHR) would help better address patient social needs. The capability to identify resources in the community is critical to the success of ACOs.

Provider reported current state

- Fragmented approach to resource identification (e.g., paper binders, institutional knowledge, some directory capability)
- Referral processes are not a closed loop; providers do not know if patient connected with a given resource

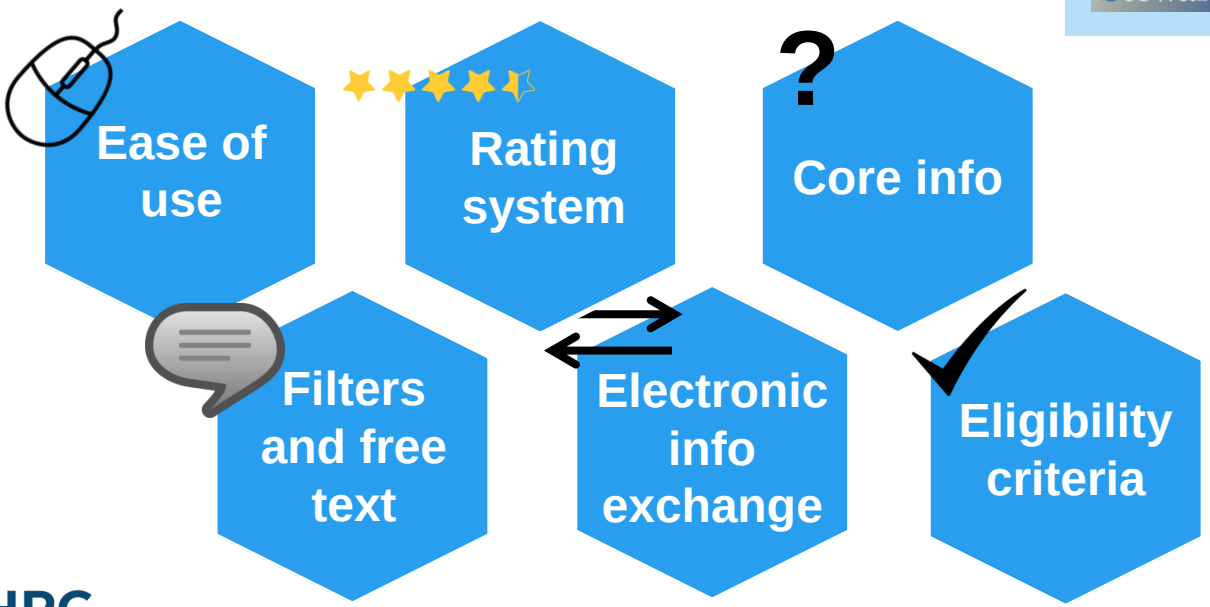
Lowell General Hospital

NEQCA
New England Quality Care Alliance
Affiliated with Tufts Medical Center

Steward

Baystate Wing Hospital

Provider reported desired business requirements



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Good Availability and Variety of Directories in the Market

4 Conducted subject matter expert interviews

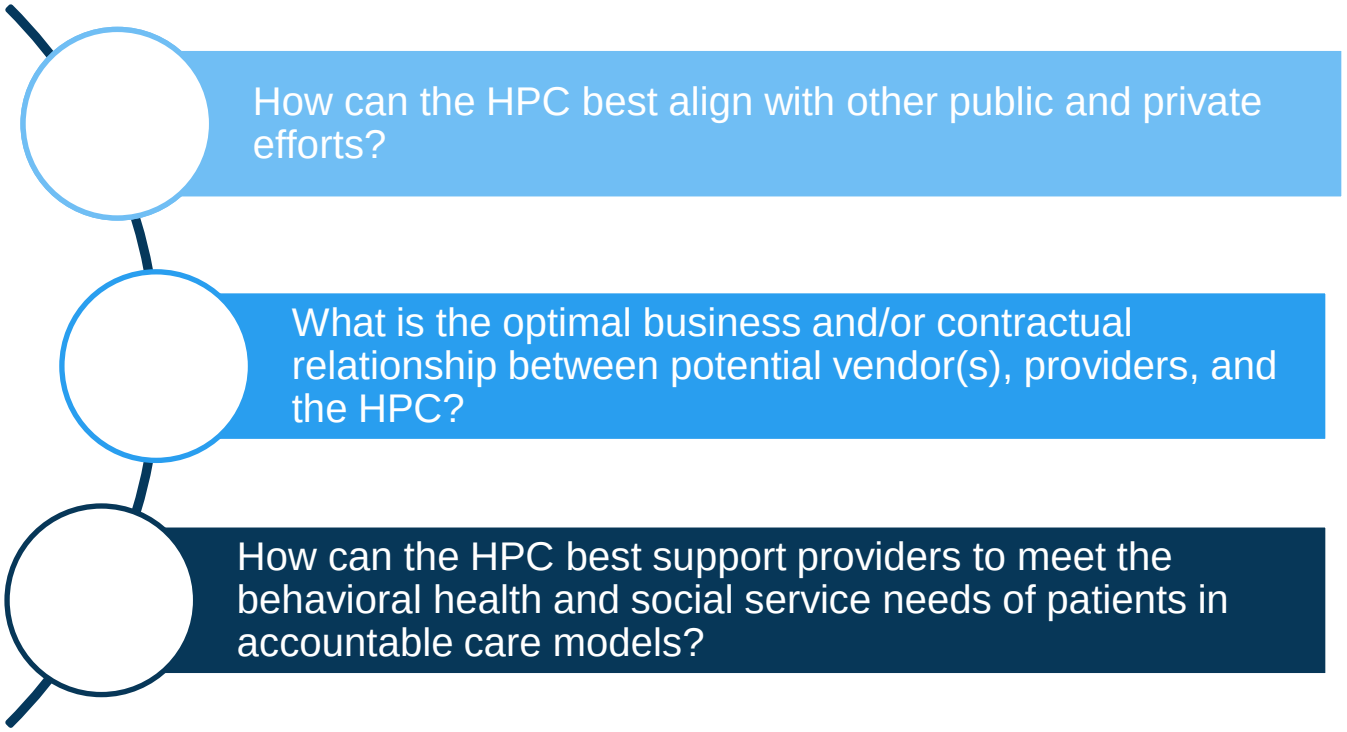
Directory technology tends to be either **consumer or provider-facing**. Experts consistently report that **quality** of resources (e.g., vetted, continuously maintained data) is more important than **quantity**, that **user-friendly features** result in increased adoption, and that **active and ongoing connections** between providers and resources is critical to the success of a directory.

Potential components for a successful resource directory implementation

Questions for Discussion

5 **Consider a path forward in creating a CRD-like service**

Key Considerations



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AGENDA

- Joint Committee Meeting
  - Call to Order
  - Approval of Minutes from the November 2, 2016 Meeting
  - Statewide Community Resource Directories
  - **Dual Diagnosis Study**
  - Patient-Centered Medical Home Certification Program
  - Other Business
- Quality Improvement and Patient Protection: Public Hearing

The opioid legislation of 2016 charged the HPC with measuring the availability of providers treating co-occurring mental illness and substance use disorder (SUD).

1. Create an **inventory of health care providers capable of treating patients (child, adolescent, and/or adult) with dual diagnoses**, including the location and nature of services offered at each such provider.

2. **Assess sufficiency of and barriers to treatment**, given population density, geographic barriers to access, insurance coverage and network design, and prevalence of mental illness and SUD.

3. **Make recommendations to reduce barriers to care.**

Dual Diagnosis is the term used to describe patients with both mental illness and SUD.

See appendix for complete statutory language.

Both mental illness and substance use disorder are growing more common, but treatment availability is not increasing.

~20% and ~10% of Massachusetts residents have a mental illness or SUD, respectively.[1]

Mental illness and SUD rates are increasing among veterans.[1]

Only about half of adults with mental illness receive treatment; rates are even lower for SUD treatment.[2]

Minorities access behavioral health treatment at lower rates than non-minority residents of the Commonwealth, and are less likely to be able to complete a course of treatment once started.[3] Minorities are also experiencing higher rates of opioid-related mortality.[4]

1. 2015 Health Planning Council's State Health Plan: Behavioral Health (SHP-BH)
2. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014. Tables 2 and 54.
3. Health Resources in Action, 2012, Massachusetts Substance Abuse and Mental Health Concerns: Native American Indians and Military Families & Veterans.
4. Recommendations of the Governor's Opioid Working Group (2015) Commonwealth of Massachusetts.

Importance of Integrating Mental Illness and Substance Use Disorder Treatment

Mental illness and SUD each can **confound** the other's presentation. Treatment of one **while** screening/treating the other produces **optimal care**.

Mental illness and SUD are strongly correlated and can be confused, even by trained providers

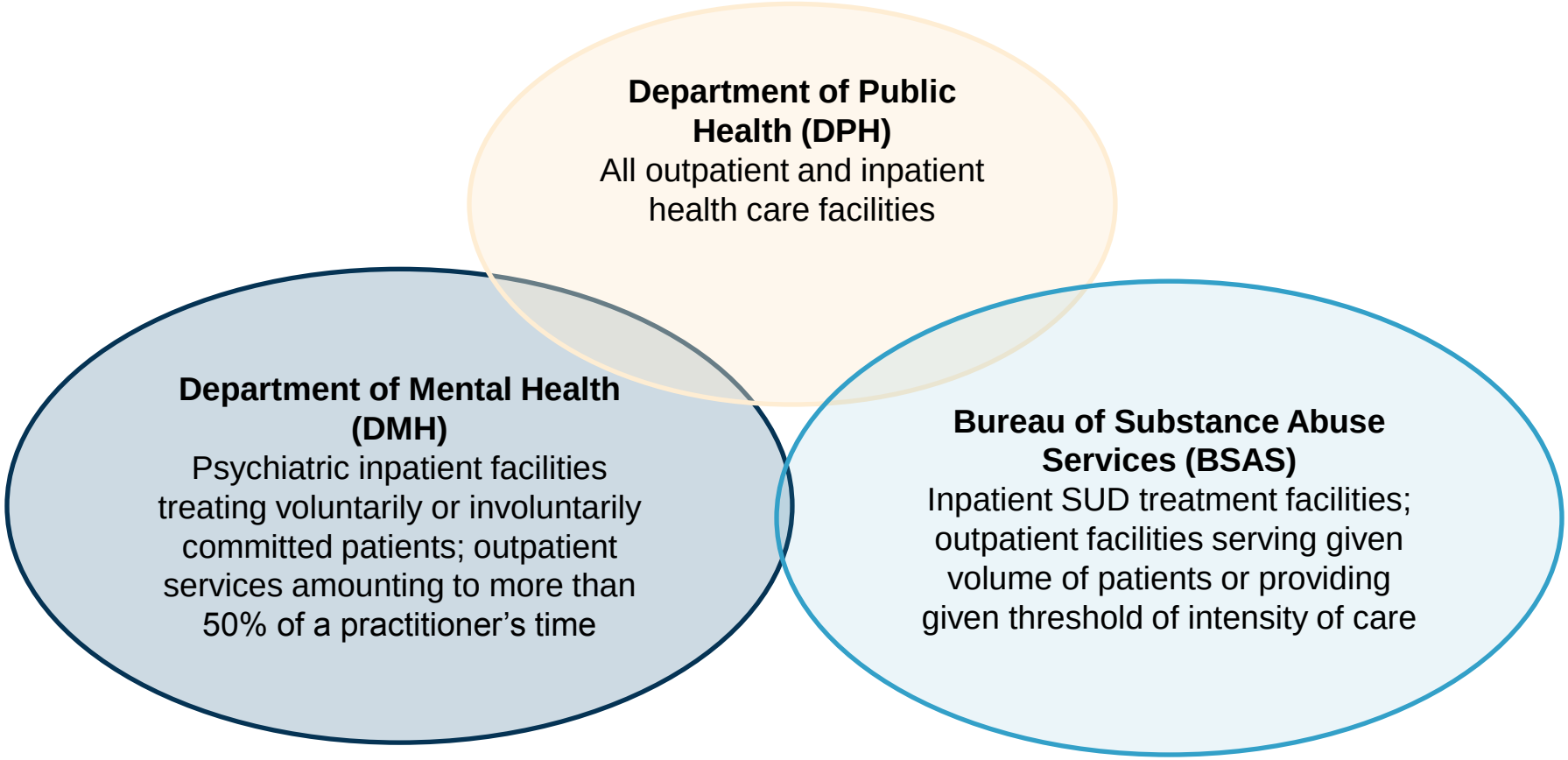
- Patients with a mental illness are at **higher risk** than the general population for SUD, and visa versa.[1]
- Providers not trained to recognize both may **mis/under-diagnose patients.**[2]

Treatment of one affects treatment of the other

- "Self-medication" by individuals with **un/under-treated mental illness** can affect the presentation and severity of psychiatric symptoms.[3]
- Patients with **un/under-treated SUD are** more likely to violate psychiatric program/facility rules and/or drop out of treatment.[4]

1. Merikangas KR, et al. (1998). Comorbidity of substance use disorders with mood and anxiety disorders: results of the International Consortium in Psychiatric Epidemiology, *Addictive Behaviors*, 23, 893-907.
2. Crawford V, Crome IB, & Clancy C (2003). Co-existing problems of mental health and substance misuse (dual diagnosis): a literature review. *Drugs: Education, Prevention, and Policy*, 10, S1-S74.
3. National Institute of Drug Abuse (2011). Comorbidity: addiction and other mental disorders. *Drug Facts.*
4. Case N (1991). The dual-diagnosis patient in a psychiatric day treatment program: a treatment failure. *Journal of Substance Abuse Treatment*, 8 69-73.

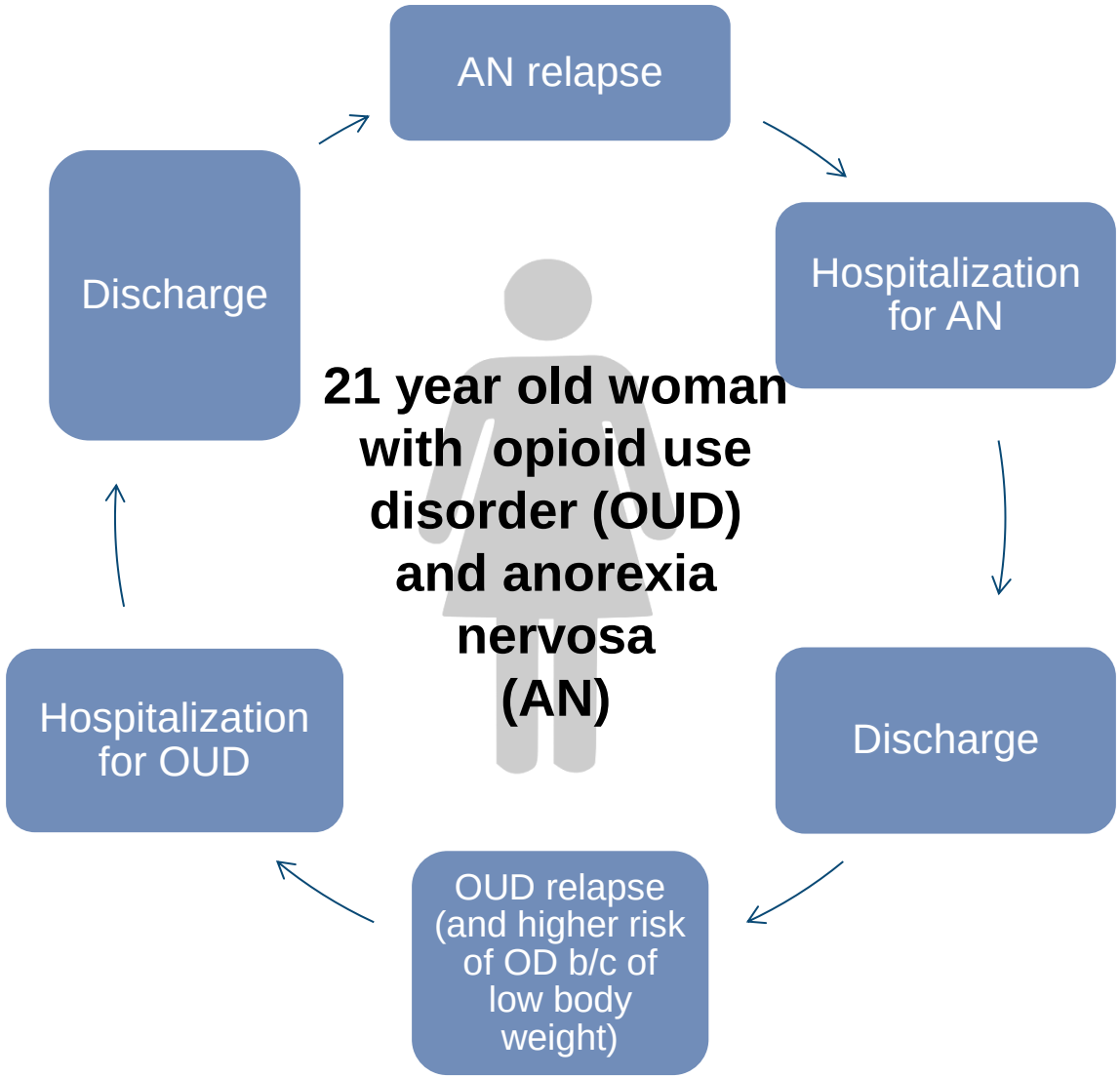
Multiple state agencies are responsible for licensing providers who treat mental illness and SUD.



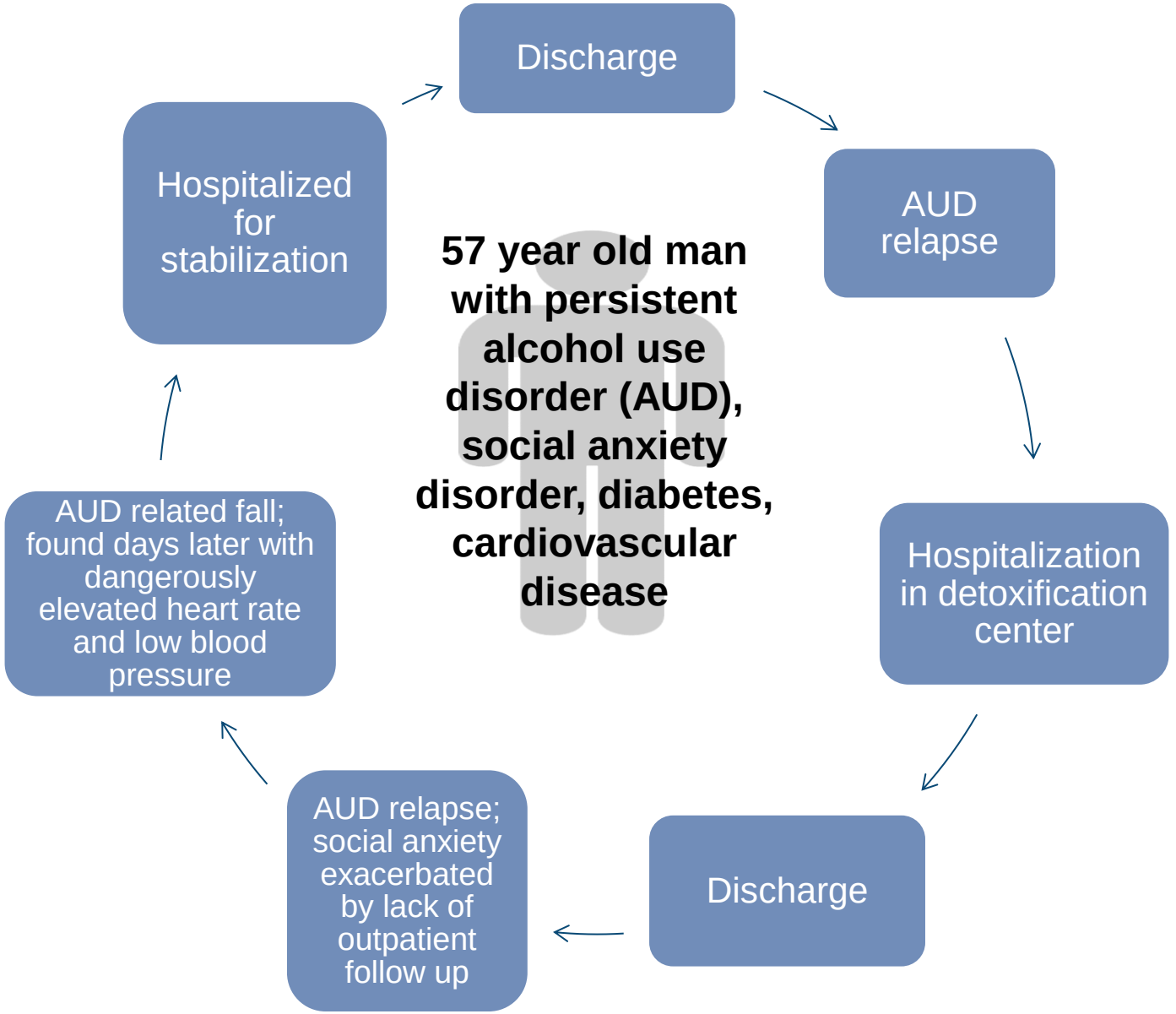
Example challenges of multi-pronged licensure system:

- Billing varies by payer with respect to current procedural terminology codes (CTP) (e.g., billing Behavioral Health carve out versus medical insurance company)
- Providers, such as social workers, need multiple licensures to treat both SUD and mental illness

Danger of Bifurcated Treatment: Example 1



Danger of Bifurcated Treatment: Example 2



Study and Report: Proposed Process

1. **Consult with other state agencies (DPH/DMH)**
2. **Conduct scan of existing databases, literature review, and semi-structured interviews with academics (see appendix)**
3. **Create "map-able" inventory of providers**
4. **Map providers against:**
   - HPC region
   - Population density
   - Age group(s) served
   - Accepted payment type(s)
   - State-level prevalence data
5. **Stakeholder engagement**
   - Providers, payers, advocates, patient representatives
6. **Policy recommendations to reduce barriers to care**

Committee input

Key questions for committee

- What is the value of mapping providers against these factors?
- Are there other approaches to quantifying availability of providers?
- Should HPC prioritize mapping treatment modalities (listed below) with strongest evidence base?

Cognitive Behavioral Therapy

Trauma Therapy

Couples / Family Therapy

Activity Therapy

Electroconvulsive Therapy

Group Therapy

Integrated Dual Disorders Treatment

Individual Psychotherapy

Psychotropic Medication

Telemedicine Therapy

Behavior Modification

Dialectical Behavior Therapy

Substance Abuse Counseling Approach

Rational Emotive Behavioral Therapy

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Practices Participating in PCMH PRIME

Since January 1, 2016 program launch

25 practices
are PCMH PRIME Certified

Newly certified practices include:

Codman Square Health Center

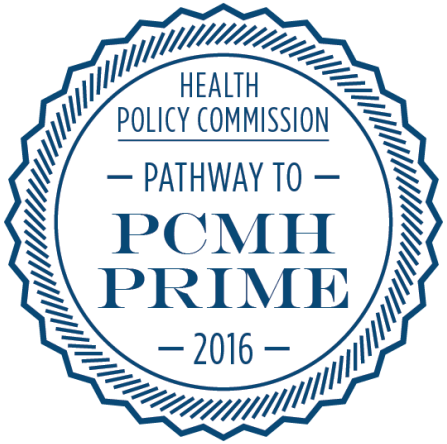
Community Health Center of Cape Cod (3 sites)

Yogman Pediatrics

Cambridge Health Alliance (12 sites)

33 practices

are on the **Pathway to PCMH PRIME**



3 practices

are working toward NCQA PCMH Recognition and PCMH PRIME Certification concurrently

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NCQA PCMH 2017 Redesign: New Standards

The NCQA PCMH Recognition program is releasing 2017 standards on March 31, 2017.

- PCMH 2017 standards streamline PCMH requirements to increase program focus on high-value capabilities
- PCMH 2017 removes PCMH recognition levels to encourage practices to focus on depth of practice transformation rather than quantity of criteria met
- Compared to PCMH 2014 standards, proposed PCMH 2017 standards further emphasize capabilities addressing behavioral health, social determinants of health, oral health, and coordination with community providers
- Proposed PCMH 2017 standards include 4 PCMH PRIME criteria that were not already part of PCMH 2014 standards. 2017 program also offers “Behavioral Health Distinction” module that includes most of the PCMH PRIME criteria plus additional capabilities

NCQA PCMH 2017 Redesign: New Evaluation Process

Current Process

- Practices complete application and submit documentation with little guidance from NCQA
- NCQA scores applications and follows up with practices as needed
- Practices renew recognition by undergoing a full review every three years

Redesigned Process

- Practices complete an online assessment and collaborate with NCQA to formulate evaluation plan
- Practices submit documentation at intervals according to evaluation plan and regularly check in with NCQA through a series of virtual reviews (three on average)
- NCQA scores practice applications once all documents are submitted
- Practices sustain recognition through annual check-ins with reduced reporting requirements

NCQA Redesign Implications for PCMH PRIME

HPC has begun discussions with NCQA on aligning PCMH PRIME with the PCMH Recognition redesign and 2017 standards.

Key Program Design Considerations

- Duration of PCMH PRIME Certification under new NCQA annual review approach
- How to align PCMH PRIME review/renewal process with NCQA's abbreviated renewal process
- Implications of PCMH 2017's increased focus on behavioral health, including "Distinction" program

Key Contract Considerations

- PCMH PRIME submission process and pricing under new NCQA platform and review process
- Incorporation of new NCQA standards and application process into HPC-sponsored NCQA trainings
- Communication strategy with practices about programmatic changes

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- **Quality Improvement and Patient Protection**
  - PUBLIC HEARING: Regulation Governing the Office of Patient Protection

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- Quality Improvement and Patient Protection
  - **PUBLIC HEARING: Regulation Governing the Office of Patient Protection**

Public Hearing on Proposed Regulation 958 CMR 3.000; Regulatory Timeline

May 18, 2016 *– Previewed regulatory revision with the QIPP Committee*

June 1, 2016 – *Previewed regulatory revision to full Board*

November 2, 2016 *– QIPP Committee voted to advance proposed regulation*

November 9, 2016 – *Full Board voted to release proposed regulation*

November 30, 2016 – Public hearing on proposed regulation
Deadline to submit comments is today at 5:00PM
Submit written comments to HPC-regulations@state.ma.us

January, 2017 (TBD) – QIPP Committee to review final regulation

January 11, 2017 – Full Board to review final regulation

**Dates may be subject to change.*

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APPENDICES

- Statutory language
- Existing provider databases
- “Map-able” treatment modalities

Session Law 2016, Ch. 52: *An act relative to substance use, treatment, and prevention*

The health policy commission, in consultation with the department of public health and the department of mental health, shall conduct a study on the availability of health care providers that serve patients with dual diagnoses of substance use disorder and mental illness, in inpatient and outpatient settings. The study shall include:

(i) an inventory of health care providers with the capability of caring for patients with dual diagnoses, including the location and nature of services offered at each such provider;

(ii) an inventory of health care providers specializing in caring for child and adolescent patients with dual diagnoses, including the location and nature of services offered at each such provider; and

(iii) an assessment of the sufficiency of dual diagnosis resources in the commonwealth considering multiple factors, including but not limited to population density, geographic barriers to access, insurance coverage and network design, incidence of mental illness and substance use disorders and the needs of individuals with dual diagnoses.

The study shall also consider barriers to access to comprehensive mental health and substance use disorder treatment for adults, seniors, children and adolescents and shall include recommendations to reduce barriers to treatment for patients with dual diagnoses, including the appropriate supply and distribution of health care providers with such capability.

The commission shall report to the joint committee on mental health and substance abuse and the house and senate committees on ways and means not later than 12 months following the completion of the study.

HPC Scan of Existing Data on Providers Treating Co-Occurring Mental Illness and SUD

National Survey of Substance Abuse Treatment (N-SSAT)

- Annual census of public and private facilities providing SUD treatment (as of 2013)
- Includes:
  - Outpatient, inpatient, partial hospitalization, and residential treatment options
  - Accepted forms of payment
  - Age groups served
  - Number providing mental health services
  - Number offering various forms of pharmacotherapy
- Limitations:
  - Relies on voluntary self-reporting by facility (93.2% survey response rate in 2013)
  - Number providing mental health services varies significantly from number reporting DMH licensure

National Mental Health Services Survey (NMHSS)

- Annual census of public and private facilities providing mental health services as reported by DPH (as of 2015)
- Includes:
  - Outpatient, inpatient, partial hospitalization, and residential treatment options
  - Accepted forms of payment
  - Age groups served
  - Number providing SUD services
- Limitations:
  - Does not identify pharmacotherapy availability

Other data sources and/or limitations?

HPC