MINUTES OF THE QUALITY IMPROVEMENT AND PATIENT PROTECTION COMMITTEE

Meeting of April 3, 2013

MASSACHUSETTS HEALTH POLICY COMMISSION

THE QUALITY IMPROVEMENT AND PATIENT PROTECTION COMMITTEE OF MASSACHUSETTS HEALTH POLICY COMMISSION
Center for Health Information and Analysis
2 Boylston Street, 5th Floor, Boston, MA 02116

Docket: Wednesday, April 3, 2013, 9:00 AM – 11:00 AM

PROCEEDINGS

The third meeting of the Massachusetts Health Policy Commission's Quality Improvement and Patient Protection Committee was held on Wednesday, April 3, 2013 at the Center for Health Information and Analysis, 2 Boylston Street, 5th Floor, Boston, MA.

Members present were Chair Marylou Sudders, Dr. Carole Allen, Dr. Wendy Everett, and Mr. John Polanowicz, Secretary, Health and Human Services.

Members absent were Ms. Veronica Turner.

Executive Director David Seltz, General Counsel Lois Johnson, and other Commission staff participated in the meeting.

Chair Sudders called the meeting to order at 9:00 AM and reviewed the agenda.

ITEM 1: Approval of the minutes from the February 22, 2013 meeting

Committee members present approved the minutes unanimously.

ITEM 2: Update on behavioral health integration in the MassHealth program

Dr. Julian Harris, Director of the Office of Medicaid, provided the Committee with an update on behavioral health integration projects undertaken by MassHealth. Dr. Harris offered a brief overview of MassHealth membership who struggle with behavioral health issues, the goals of greater quality and efficiency through primary care coordination and integration of behavioral health services, and barriers to effective integration. He provided an in-depth analysis of three major efforts by MassHealth: the Massachusetts Behavioral Health Partnership ("MBHP") Integrated Care Management Program, the Primary Care Payment Reform Initiative ("PCPRI"), and a Demonstration project for non-elderly adults who are dually eligible for Medicaid and Medicare ("Duals Demonstration").

The "MBHP" program provides direct care management services to members enrolled in the MassHealth Primary Care Clinician ("PCC") plan. The program focuses on a team-based approach to providing clinical services and member identification and engagement. PCPRI allows a "bundled payment" for primary care and behavioral health with the goal of incentivizing integration and accountability for cost and quality. The initiative includes three

tiers of primary care-behavioral health integration to encourage participation from a range of providers. Care delivery is based on the patient-centered medical home model where members can receive a range of services at either a primary care or a behavioral health care "home." The Duals Demonstration program targets 111,000 dual eligible people ages 21-64 with full Medicaid and Medicare benefits. The purpose of the program is to identify, support and evaluate person-centered models that integrate primary care, acute care, behavioral health, and long-term services and supports. Integrated Care Organizations ("ICOs") will receive global payments to address the full range of patients' needs through integrated, individualized care planning and delivery. MassHealth will work with health plans that become ICOs and will work to ensure integration through ongoing monitoring using standard metrics.

Chair Sudders inquired about whether there was a "tier 1" for behavioral health care providers under PCPRI. Dr. Harris responded that behavioral health providers begin at tier 2 or tier 3 in combination with primary care providers, so there is not a tier 1 for behavioral health providers on their own. The expectation is for tier 1 primary care providers to coordinate with behavioral health providers rather than providing the behavioral health services directly.

Dr. Everett asked Dr. Harris to explain how bundled payments function within tier three of the PCPRI. He explained that the tiers relate to how behavioral health services will operate within an integrated primary care delivery model. Capitated payments get larger from tier 1 to tier 3, with corresponding increases in expectations of how behavioral health services will be provided and coordinated. Capitated payments go directly to the ICOs.

Dr. Everett asked about the pilot status of these programs. Dr. Harris said that MassHealth hopes and expects that the Duals Demonstration program will become the new care delivery model for this population. He added that the PCPRI is not a pilot because it is a statutory responsibility under Chapter 224 of the Acts of 2012. The MBHP program is also not a pilot program, he stated, although the state has a variety of other programs both in MassHealth and at other state agencies.

Dr. Everett asked about patient uptake in these programs. Dr. Harris explained that neither the Duals Demonstration nor PCPRI has launched, but the programs are scheduled to begin in late summer.

Chair Sudders stated that care integration assumes parity, but that "parity" has not yet been defined.

ITEM 3: Update on mental health parity regulations

Kevin Beagan, Deputy Commissioner for the Division of Insurance's Health Care Access Bureau, presented the Division's new regulations on mental health parity. He explained that federal mental health parity law has changed within the past month to now require that all benefits for biologically-based and non-biologically based conditions be covered on a parity basis with physical health beginning on January 1, 2014. DOI issued a bulletin to advise all

Massachusetts health plans about this new responsibility. Under its duty per Chapter 224, DOI held a hearing within the last week about new regulations pertaining to implementation of federal mental health parity rules in Massachusetts. Parties offered an array of testimony that will help DOI craft its approach to this issue. The regulations require health plans to certify with DOI regarding compliance with the federal parity rules. DOI has developed a relationship with its colleagues in Washington, D.C., to ensure consistency with all federal regulations. The Division is considering how to monitor this issue, including through interagency efforts and meetings with key stakeholders. Mr. Beagan noted that DOI can regulate only fully-insured health plans; the Division routinely receives complaints about coverage under self-insured plans, government programs, or plans issued in other states, but the agency has no authority over these insurance products. The stated goal of the regulations is to improve DOI's ability to collect, monitor, and investigate complaints. Mr. Beagan recognized that the regulations are a starting point to enable DOI to enforce mental health parity.

Dr. Allen asked Mr. Beagan to clarify whether DOI has jurisdiction over self-insured plans. Mr. Beagan said that DOI does not have authority to regulate such plans because of ERISA preemption, nothing half of the Massachusetts health insurance market is self-insured.

Dr. Allen commented that Affordable Care Act rules cover self-insured plans. Mr. Beagan agreed and added that federal mental health parity rules also cover all plans. DOI's jurisdiction over the Massachusetts health insurance market is limited to medical benefits—whether physical or behavioral—covered by fully-insured plans.

Chair Sudders expressed concern that DOI's regulations only require health plans to certify with the Division rather than also outline their compliance with mental health parity rules as Chapter 224 requires. Mr. Beagan responded that DOI is looking to address this issue in its final regulations.

David Seltz thanked both Mr. Beagan and Dr. Harris for speaking about state efforts to address fragmentation in the health care system – also a key goal of the Health Policy Commission.

ITEM 4: Mandatory Nurse Overtime

Chair Sudders introduced the issue of mandatory nurse overtime and offered an overview of the Commission's efforts, including a public listening session in February, collection of written testimony from an array of stakeholders, and research into collective bargaining agreements and laws in other states. Mr. Seltz said that this issue is directly aligned with the Commission's goal of promoting better quality care for patients through protecting workers and reducing medical errors.

Ms. Lois Johnson provided an overview of the law and explained the Commission's limited role in defining "emergency situation." She further described the Commission's process in addressing this responsibility and highlighted key findings from the staff's research into collective bargaining agreements and similar laws in other states. Ms. Johnson offered

example definitions of "emergency situation" and associated terms. She presented possibilities for ongoing monitoring and offered several questions for discussion by the Committee.

Dr. Everett asked for clarification regarding how often the Department of Public Health would review the reports of mandatory overtime use. Secretary Polanowicz responded that EOHHS will seek to standardize the reporting system. He said that the agency plans to receive the reports on a regular basis, but the timeframe for review has yet to be determined. Dr. Everett said that an annual review by the Commission may not be sufficient to implement the intent of the law, suggesting a quarterly review, at least initially.

Dr. Allen added that there was a tension expressed during the listening session about who should have the power to declare an emergency, a hospital's administration or an outside authority. She said the example definitions did a good job of straddling the goals of allowing hospitals some flexibility to respond to emergencies while ensuring that mandatory overtime is not abused as a staffing practice.

Chair Sudders noted that in all of the collective bargaining agreements reviewed by the Commission, the power to declare an emergency rested with the hospital and not with an outside agency. She added that many of the agreements contained internal review and monitoring processes, which could be added to the examples of good practices.

Dr. Everett asked whether the example definitions were proposals that Committee would bring before the whole Commission. Mr. Seltz responded that the example definitions were intended only to prompt discussion and solicit input from the Committee. Commission staff will continue to hear input from other effected parties, consider alternatives, and do further research in the coming weeks. Staff will bring a proposal before the full Commission at its April 24 meeting in advance of the hearing on April 26.

Dr. Everett said there was very compelling testimony at the listening session from advanced practice nurses, including nurse anesthetists, nurse midwives, and nurse practitioners, who advocated for exemption from the law. Ms. Johnson said the law does not give the Commission authority to weigh in on this issue. Secretary Polanowicz explained that terms such as "nurse" and "hospital" are defined in other places in the general laws. Chair Sudders noted that collective bargaining agreements refer to "shift nurses" and "direct care nurses."

Dr. Allen asked how the law intends to ensure patient safety; whether overtime is voluntary or mandatory. She said that patients should receive the right kinds of services by professionals who possess the right set of skills to address their particular care needs, while not stressing the workforce in ways that are inappropriate. Ms. Johnson added that the Commission is seeking input about ways to amplify patient safety through the guidance.

Secretary Polanowicz asked about hospitals' flexibility to respond to emergent circumstances given the list of possibilities in the example definitions. He asked about the continuing role of collective bargaining agreements in the context of the new mandatory

overtime provisions. Mr. Seltz responded that even with the new guidelines, there will be emergency situations that require mandatory overtime. He explained that the example definitions contain lists that are intended to illustrate various possibilities, rather than limit the scope of such possibilities. Ms. Johnson said that the Commission does not have the authority to define how collective bargaining agreements will operate within the context of the new law, but the plain language of the statute does not seek to amend these agreements. She said that staff looked to provisions in other states to develop the list of illustrations for each example definition. Chair Sudders noted that the definitions refer to hospital disaster plans because they seek to build on existing systems that honor established chains of command. Also, she stated that she interprets the definition of "hospital" within the statute to include free-standing psychiatric hospitals operated by the state. Mr. Seltz said that the Commission and EOHHS will continue working together to clarify the scope of the statute.

ITEM 5: Office of Patient Protection

Mr. David Seltz introduced Ms. Jenifer Bosco, Director of the Office of Patient Protection ("OPP"). He acknowledged excellent collaboration and work by the Department of Public Health, which has served as a steward of this program.

Ms. Bosco spoke about the transition of the OPP from the Department of Public Health to the Commission, which includes various logistics and an April 20 transfer date. She discussed upcoming work, including the filing of emergency regulations, taking steps to ensure ACA compliance, and developing an appeal process for ACOs. The OPP will expand on its current role to become a source for consumer information, educational materials, and data to help to inform the broader mission of the Commission.

ITEM 6: HPC Implementation Timeline

Mr. Seltz presented an implementation timeline for the Committee's work in 2013. He described 2013 as a "foundational year" that will lay the groundwork for all future HPC work. He discussed the work performed in the first quarter of 2013 and outlined an array of projects that the Committee will be tackling during the remainder of the year.

ITEM 7: Public Comment

Chair Sudders opened the floor to comments by the attending public. Julie Pinkham, Executive Director of the Massachusetts Nurses Association, stated that she was pleased with the quick timeline for developing the mandatory nurse overtime guidelines. She looks forward to additional opportunities to offer input. Ms. Pinkham highlighted an element of collective bargaining agreements that was not addressed by the guidance: allowing nurses to refuse a mandatory overtime shift.

ITEM 8: Closing

Chair Sudders thanked everyone for coming and adjourned the meeting at 11:00 AM.