MINUTES OF THE JOINT COMMITTEE MEETING ON BEHAVIORAL HEALTH INTEGRATION

CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION QUALITY IMPROVEMENT AND PATIENT PROTECTION

Meeting of April 9, 2014

MASSACHUSETTS HEALTH POLICY COMMISSION

JOINT COMMITTEE MEETING
CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION
QUALITY IMPROVEMENT AND PATIENT PROTECTION
MASSACHUSETTS HEALTH POLICY COMMISSION
Center for Health Information and Analysis
Two Boylston Street
Boston, MA 02116

Docket: Wednesday, April 9, 2014, 9:30 AM – 12:00 PM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Care Delivery and Payment System Transformation (CDPST) Committee and Quality Improvement and Patient Protection (QIPP) Committee held a joint meeting regarding behavioral health integration on Wednesday, April 9, 2014 at the Center for Health Information and Analysis, Two Boylston Street, Boston, MA.

Members present were Dr. Carole Allen (Chair, CDPST), Ms. Marylou Sudders (Chair, QIPP), and Dr. Wendy Everett.

Dr. Ann Hwang, representing Mr. John Polanowicz, Secretary of Health and Human Services arrived late.

Dr. Stuart Altman, Commission Chair, and Ms. Veronica Turner attended via phone.

Commissioner Jean Yang was not present.

Ms. Sudders called the meeting to order at 9:34 AM.

ITEM 1: Approval of Minutes

Ms. Sudders asked for approval of the minutes for the February 12, 2014 QIPP meeting. She asked if any committee members had changes to the minutes. Seeing none, she asked for a motion to accept the minutes. Dr. Allen made the motion and Dr. Wendy Everett seconded. Members voted unanimously to approve the minutes.

Noting the absence of a quorum for CDPST, Dr. Allen postponed approval of minutes.

Ms. Sudders explained that this meeting would serve as a discussion between the two committees on the integration of behavioral health care. She stated that at any given time, nearly 25% of the United States' population is suffering from a behavioral health illness. She noted that the HPC would be using the "quality definition" of behavioral health, which includes substance abuse and misuse, serious psychological distress, and suicide.

Dr. Allen noted the significance of integrating behavioral health into the HPC's patient-centered medical home (PCMH) certification program. She stated that, as a pediatrician, behavioral health integration and intervention at an early age can prevent a lifetime of struggle with mental illness.

At this point, Dr. Ann Hwang, designee for Mr. John Polanowicz, Secretary of Health and Human Services, arrived at the meeting.

Noting the presence of quorum for the CDPST Committee, Dr. Allen postponed the current agenda item to consider the CDPST minutes from February 12, 2014. Dr. Allen asked if any committee members had changes for these minutes. Seeing none, she asked for a motion to accept the minutes. Ms. Sudders made the motion and Dr. Hwang seconded. Members voted unanimously to approve the minutes.

Mr. David Seltz, Executive Director, thanked the committees for convening and conveyed his enthusiasm about the day's meeting. He stated that this meeting would serve as a way to examine the integration of behavioral health statewide. Mr. Seltz noted that discussion would also assess how state and national organizations have integrated behavioral health into patient-centered care. Mr. Seltz stressed the importance of developing a method through which performance can be better measured in behavioral health.

ITEM 2: Presentation by Dr. Judith L. Steinberg, Deputy Chief Medical Officer, Commonwealth Medicine, UMass Medical School

Dr. Judith L. Steinberg, Deputy Chief Medical Officer, Commonwealth Medicine, UMass Medical School, and Dr. Sandy Blunt, Director for the Center for Integrated Primary Care and Professor of Family Medicine and Psychiatry, presented on "Healthcare Reform and Behavioral Health Integration." A copy of this presentation is available for review on the HPC's website.

Following the presentation, Ms. Sudders opened the meeting for discussion.

Mr. Seltz asked Dr. Steinberg how available state and federal grant programs to address the integration of behavioral health care are used. Dr. Steinberg indicated that grants are going toward various initiatives, such as training for technical assistance and primary care payment reform. Dr. Blunt stated that many grants are given to different universities and think tanks to sponsor research on integration initiatives. Ms. Sudders called for greater specifics about research.

While discussing fully integrated primary care, Dr. Altman asked via phone if it would be reasonable to pay newly established providers the average rate in the community or if they would initially need more funding to integrate primary and behavioral care. Dr. Blunt indicated a group may need significant start-up funding. He stated that, because of payment codes, fee-for-service models only pay for either physical health or mental health.

He stated that pay-for-performance models will be a difficult transition for behavioral health.

Dr. Everett asked for a rough sense of the current distribution of payment models in Massachusetts. Dr. Blunt responded that current primary care payment reform (PCPR) initiatives include 50 practices and 30 organizations that have a substantial Medicaid population. He clarified that ¾ of those have entered at Tier 1, which includes providers who offer care management without integrated behavioral health. He stated that Tier 2 providers offer primary care behavioral health and Tier 3 providers offer primary care plus specialty mental health.

Dr. Steinberg stated that she attended a PCMH conference with states participating in CMS's PCMH model. She explained that, in this model, states added an extra payment to the bundled payment to incentivize PCMH certification.

Dr. Hwang asked how successful practices were able to target interventions. Dr. Blunt responded that the Cherokee Health System is a prime example of a practice that has integrated behavioral health completely with primary care. He stated that, while everyone who sees the doctor is involved in this integrated system, Cherokee has programs that target the neediest populations

Ms. Sudders commented on CPT codes. She stated that behavioral health is traditionally divided into five codes. She explained that it is impossible for doctors to bill for both medical and behavioral CPT codes in the same day. Ms. Sudders emphasized that this type of limitation was not what had been envisioned in the Affordable Care Act or general behavioral health integration.

Dr. Blunt responded that some health and behavior codes are considered medical CPT codes. He stated that focusing on overall payment reform may eliminate the need for strong focus on the codes. Dr. Allen noted that she experienced mixing of behavioral codes and medical codes in pediatric practices.

Ms. Sudders asked whether behavioral health specialists are generally co-located or fully integrated in an integrated practice. She further asked whether these specialists are hired as consultants or staff. Dr. Steinberg answered that she has seen an evolution of the behavioral health model. Initially, behavioral health specialists were co-located, but not coordinated. In this model, all service was by referral and there was limited interaction between care providers. Dr. Steinberg stated that the use of electronic medical records (EMRs), has enabled care to be co-located and coordinated.

Dr. Allen expressed concerns about payment reform and carve-out policies. She stated that this is of particular concern in pediatrics, because a child may see multiple care specialists. She asked who would ultimately bill for services in a fully integrated system. Dr. Steinberg responded that the question would best be answered through a multi-stakeholder meeting of community providers and insurers.

At this point, Dr. David Cutler arrived at the meeting.

Dr. Everett thanked the presenters for their work, noting that she appreciated their approach towards segmented care. She further asked for examples of effective incentives that would inspire providers to offer primary care with specialty mental health services (Tier 3).

Dr. Cutler asked whether a single model could be applied to practices undergoing transition to Tier 3 or if there are multiple models that can be applied to individual situations. Dr. Blunt concluded that this ultimately depends on whether success is measured by patient experience or provider results. He noted that there are multiple models that will improve access and numerous other models that do not reliably change behavioral health results, but improve patient experience.

Dr. Steinberg stated that reorganizing providers into Tier 3 will require leadership engagement from providers, behavioral health specialists, and the community.
Dr. Blunt added that all parties often offer more productive care if primary care and behavioral health providers coordinate.

Ms. Sudders thanked Dr. Steinberg and Dr. Blunt for their presentation and asked for public comment.

Public comment was offered by Laura Henze Russell, David Opp, and David Matteodo.

Seeing no further comments, Ms. Sudders moved to the next agenda item.

ITEM 3: Presentation by Ms. Nancy E. Paull, Chief Executive Officer, SSTAR Addiction Treatment

Ms. Sudders introduced Ms. Nancy E. Paull, the Chief Executive Officer of SSTAR Addiction Treatment in southeastern Massachusetts.

Ms. Paull presented "SSTAR: 24 Years of Integrating Behavioral Health And Primary Care." A copy of this presentation is available for review on the HPC website.

Ms. Sudders thanked Ms. Paull for her presentation.

Dr. Cutler asked Ms. Paull to outline the ideal payment methods for SSTAR Addiction Treatment. Ms. Paull responded that bundled payments would be effective for SSTAR's patient population. She noted, however, that the bundled payments would have to be sufficient for high-risk populations.

Ms. Sudders asked for clarification on SSTAR Addiction Treatment's licensures.

Dr. Allen thanked Ms. Paull for her comments and moved to the next agenda item.

At this point, Ms. Turner left the call.

ITEM 4: Behavioral Health Integration within the HPC's Patient-Centered Medical Home (PCMH) Certification Program

Dr. Allen introduced the concept of behavioral health integration within the PCMH program. She announced that Dr. Patricia Boyce, Director of Care Delivery and Quality Improvement, left the HPC for a job with the federal government.

Chair Allen reviewed the behavioral health criteria for PCMH certification. She stated that input from the day's meeting would help inform the program. She provided an overview of remarks received through the public comment period and reviewed next steps for PCMH certification. Mr. Seltz emphasized gratitude for comments from individuals and organizations on the PCMH certification program.

ITEM 5: Adjournment of Joint Meeting

Seeing no further comments, Ms. Sudders adjourned the joint committee meeting at 11:35 AM.

ITEM 6: Public Listening Session on Draft Data Submission Manual (DSM) for the Registration of Provider Organizations (RPO) Program

Following a five minute break, the CDPST committee reconvened for a public listening session on the draft data submission manual for the RPO program.

Mr. Iyah Romm, Director of System Performance and Strategic Investment, provided a brief summary of the RPO program and the purpose of the data submission manual. He noted that the HPC would accept public comments on the draft regulations for RPO as well as the DSM through April 25, 2014.

Public testimony was provided by David Matteodo. A recording of the testimony can be found on the HPC's website.

Seeing not further public comments, Dr. Allen moved to the adjourn the listening session at 11:59 AM.