Joint Committee Meeting

Quality Improvement and Patient Protection
Care Delivery and Payment System Transformation

Health Policy Commission
June 11, 2014

Agenda

- Approval of Minutes
- Executive Director Report
- Presentation by the Division of Insurance on Mental Health Parity
- Update on Registration of Provider Organizations Program
- Presentation by the Department of Public Health on Health Resource Planning
- Schedule of Next Meetings (August 13)

Agenda

- **Approval of Minutes**
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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 April 9, 2014, as presented.

Vote: Approving minutes

Motion: That the Care Delivery and Payment System Transformation Committee hereby approves the minutes of the Committee meeting held on May 12, 2014, as presented.

Agenda

- Approval of Minutes
- **Executive Director Report**
  - PCMH Behavioral Health Budget Amendment
  - Senate Substance Abuse Bill
- Presentation by the Division of Insurance on Mental Health Parity
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2014 Behavioral Health Agenda

Chapter 224 sets a broad vision for a more affordable, effective and accountable health care system in Massachusetts. The successful integration of behavioral health care is essential for realizing the goals of improving outcomes and containing long-term cost growth.

The Health Policy Commission, through its various policy Committees, should work to ensure that behavioral health issues are appropriately considered and addressed in the spectrum of initiatives led by the Commission.

2014 Behavioral Health Agenda

Despite a history of progressive state policies and a commitment by many health care providers and payers, there are a number of persistent barriers to behavioral health integration in Massachusetts. As identified by the Behavioral Health Task Force these barriers include, but are not limited to:

1. Reimbursement issues, including lack of equity, restrictive billing policies, and non-aligned payment systems;
2. Regulations that are based on historically separate systems of physical health and behavioral health;
3. Difficulty accessing behavioral health treatment;
4. The need for significant training and education of both primary care and behavioral health providers;
5. Lack of interoperability and connection of the behavioral health system to electronic health records; and,
6. Privacy and data-sharing concerns.

The HPC is working to address these barriers in 2014.

2014 Behavioral Health Agenda

	Planned HPC activities for 2014
Promoting clinical standards through accountable care models	▪ The development of behavioral health (BH) criteria and standards to be included in the PCMH program (joint effort of the CDPST and QIPP committees); the development of evaluation and measurement metrics for BH in the PCHM setting; and the engagement of payers on payment support for BH services. Focus will shift to developing the ACO certification program in Q3 and Q4 of 2014.
Promoting clinical models through investment	▪ Providing CHART awardees a number of capacity-building opportunities through training, leadership assessment, and technical assistance; overseeing and evaluating Phase One projects, including the dissemination of lessons learned and best practices; developing and implementing the Phase Two CHART investment opportunity in which we plan to provide significant, strategic investments in targeted areas of HPC focus.
Research, evaluation, and analysis	▪ Extend analysis of high-need patients to the MassHealth population; coordinate with the work of the Public Payer Commission as it pertains to behavioral health; other on-going research and analysis in areas of interest to the Commission Board; and monitor research of others in this area.
Capacity and needs assessment (Health planning)	▪ On-going participation of the HPC ED in council activities; collaboration between the Council and the HPC's QIPP Committee to develop key questions and an analytic approach; HPC staff providing in-kind support to the Council.
Public forum for policy discussion	▪ Focused discussions and deliberations by the QIPP committee and other stakeholders and experts as appropriate on the challenges and opportunities for behavioral health integration; receive periodic updates on the progress of the HPC and by other state agencies in implementing key Chapter 224 strategies for advancing integration (i.e. the DOI/AGO on parity issues, DMH, and the Public Payer Reimbursement Commission.)

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Integrating Behavioral Health

What is Integrated Care?

Care from a team of primary care and behavioral health clinicians, working together with patients and families, providing patient-centered care. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses) and ineffective health care use.

The Cost

Patients in Commercial and Medicare plans with a behavioral health condition spend between 2.3 and 19.4 times as much on health care per year as those without behavioral health conditions.

The Savings

Long-term analyses have demonstrated that $1 spent on integrated care saves $6.50 in health care costs. The potential total annual savings to Massachusetts through effective integration is estimated at $2.5 to $5 billion.

The Quality of Care

Compared to patients treated with care as usual, patients in integrated care settings treated for common mental disorders have experienced:

- Substantial improvement in symptoms
- Less physical pain
- Better social and physical functioning
- Better overall quality of life
- Increased patient satisfaction

The HPC's Role in Integrating Behavioral Health

Through the continued development and implementation of a patient-centered medical home (PCMH) certification program called for in Chapter 224, the HPC intends to encourage practices to use a robust evidence-based approach to integrate behavioral and physical health care, focusing on practice screening and assessment of all patients, comprehensive care management, regular and proactive monitoring of treatment to targeted populations, and consultation for patients who do not show clinical improvement.

Behavioral Health Budget Request

1599-2004 For a reserve to be administered by the health policy commission to accelerate and support behavioral health integration within patient-centered medical homes, as certified by the commission under section 14 of chapter 6D of the general laws; provided, that this program will support efforts to build the partnerships and infrastructure needed to initiate or expand the provision of behavioral healthcare services within the primary care setting and may take the form of training, education, technical assistance, or direct grants; provided further, that the commission shall report to the joint committee on mental health and substance abuse and the house and senate committee on ways and means no later than 24 months following implementation of the program on the effectiveness, efficiency, and sustainability of the program; and provided further, that funds appropriated in this item shall not revert and shall be available for expenditure through June 30, 2016……..$1,500,000

This investment could support:

- Technical assistance staff and faculty expertise assigned to practice sites
- Capacity mapping for behavioral health resources in selected communities
- Assistance with developing/strengthening patient referral and tracking systems for successful integrated care delivery
- Regional learning events
- Virtual coaching assistance to participating practices
- Distillation of implementation strategies for successful BH integration
- Evaluation of cost and quality impact

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Senate Substance Abuse Bill

In May 2014, the Senate passed *An Act to Increase Opportunities for Long-Term Substance Abuse Recovery* to address various substance abuse issues within the state.

Impact on Insurance Coverage

- Requires all insurance carriers to reimburse for substance abuse services delivered by a licensed alcohol and drug counselor
- Removes prior authorization for Acute Treatment Services for MassHealth and commercial insurers
- Insurance providers are required to cover abuse deterrent drugs listed on the formulary and cannot impose additional cost burdens on the consumer for deterrent drugs.

The Health Policy Commission is directed to…

- Recommend policies to ensure access and coverage for substance abuse treatment
- Determine standards for effective, high quality, evidence-based substance abuse treatment
- Create a certification program for substance abuse providers

Other agencies are directed to…

- Department of Public Health
  - Issue regulations on opiates as needed
  - Detail the progress of the joint policy working group created in Chapter 224 of the Act of 2012 to study best practices of responsible opioid prescription and file a final report by March 15, 2015
- Center for Health Information and Analysis
  - Review the accessibility of substance abuse treatment and adequacy of insurance coverage
  - Report on commercial denial rates for substance abuse treatment programs

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RPO: Program Development Timeline

2013

- Winter: HPC begins planning for RPO program development
- April 23: Summary of RPO listening sessions presented to Committee
- July 25: Initial RPO framework presented to Committee
- November 20: Initial RPO framework presented to Board
- December 16: Committee voted to issue draft regulation

2014

- January 8: Board voted to issue draft regulation
- February 12: Public Hearing on regulation
- January 8 – April 25: Public comment period on regulation and DSM
- February – April: Stakeholder meetings
- April 9: Listening session on regulation and DSM
- May 12: Committee update
- June: Stakeholder meetings

RPO: Principles of Program Development

- In developing the RPO regulation and Data Submission Manual, HPC used the following principles to determine what information the registration application should contain:

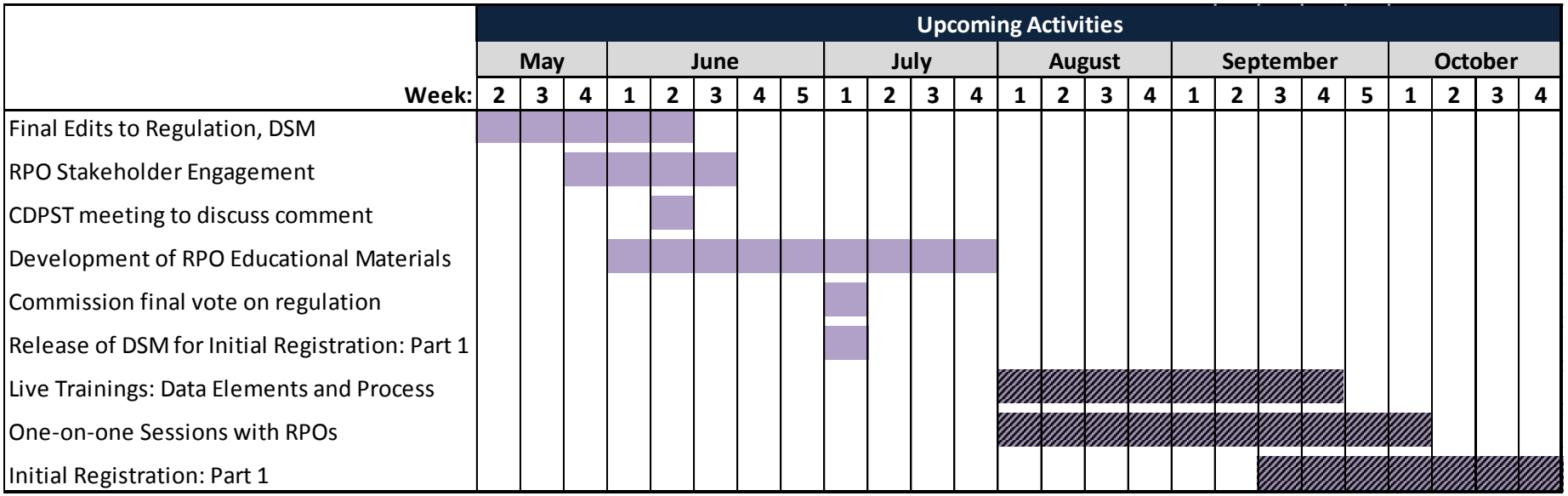
  - Provider Organizations are faced with significant new responsibilities under Chapter 224. RPO must offer a streamlined registration process that prioritizes **administrative simplification.**

  - Provider Organizations have existing points of contact with many state agencies. RPO should **avoid requesting duplicative data**.

  - RPO must **balance** the importance of collecting data elements with the burden to submitting Provider Organizations.

  - RPO should **ask high-level questions** in the registration application, knowing that additional information may be requested if necessary.

RPO: Next Steps *(Dates not finalized)*



- Staff anticipates bringing final regulations to the July 2 Board meeting for promulgation
- Development of the RPO Submission Platform, in conjunction with the CHIA IT team, is progressing
- Focus of summer months will be on providing training and education to Provider Organizations:
  - Live trainings
  - Webinars
  - One-on-one meetings
- RPO Program is on track to receive Initial Registration: Part 1 materials in Fall of 2014.

RPO: Summary of Public Comment

- HPC solicited feedback was solicited on proposed regulation and draft Data Submission Manual
- HPC received comment throughout the process, and has already incorporated some feedback received in early 2014
- 19 total comments
  - Atrius Health (2 comments)
  - Baystate Health
  - Beth Israel Deaconess Care Organization
  - Blue Cross Blue Shield
  - Boston Medical Center
  - Conference of Boston Teaching Hospitals
  - Emerson Hospital
  - Lahey Health System
  - Mass Association of Health Plans
  - Mass Health Quality Partners
  - Mass Hospital Association (2 comments)
  - Mass Medical Society
  - Mass Society of Optometrists
  - Mount Auburn Hospital
  - Mount Auburn Cambridge Independent Practice Association
  - Steward Health Care System
  - Sturdy Memorial Hospital

Summary of Comments

- Comments can be broken down into 3 large categories:

Program Structure & Process

- HPC actions in cases of non-compliance (2)
- Education and training (2)
- Timeframe for registration (10)
- Contracting threshold (1)
- Leveraging data from other state agencies (9)

Regulation

- Mandatory updates (2)
- Contracting Affiliate (2)
- Clarification of registration thresholds (1)
- Appeals Process (5)
- Providers vs. Provider Organizations(1)
- Clarification of terms:
  - Negotiate contracts
  - Represent in contracting
  - Establish contracts
  - Contract (1)

Data Submission Manual

- Clinical Affiliates (8)
- FTEs/Physician Rosters (10)
- Inclusion of additional provider types in Year 1 (1)
- Element-specific Comments (10)

(#) numbers in parentheses indicate the number of comments received on each topic

Summary of Comments: Program Structure & Process

Program Structure & Process

- **HPC actions in cases of non-compliance**
- Education and training
- Timeframe for registration
- Contracting threshold
- Leveraging data from other state agencies

Cases of Non-Compliance (2)

Comment

HPC should codify the process it will use to alert carriers, TPAs and Provider Organizations to a case of non-compliance.

HPC should codify what steps a carrier or TPA is required to take if it has a contract with a non-compliant Provider Organization or one of its Affiliates.

Analysis

HPC will publish two lists on its website:

1. Provider Organizations that have successfully registered; and
2. Provider Organizations that are out of compliance with the regulation.

This will allow carriers, TPAs and the organizations themselves to check a Provider Organization's registration status.

HPC will also proactively notify payers in cases of non-compliance.

Summary of Comments: Program Structure & Process

Program Structure & Process

- HPC actions in cases of non-compliance
- **Education and training**
- Timeframe for registration
- Contracting threshold
- Leveraging data from other state agencies

Education and Training (2)

Comment	Analysis
HPC should provide education and training to Provider Organizations to ensure that the definitions, terms and requirements are understood and applied consistently.	HPC will hold multiple training sessions in the summer and early fall to assist Provider Organizations. HPC will also offer all Provider Organizations one-on-one sessions to discuss the program requirements and answer specific questions.

Summary of Comments: Program Structure & Process

Program Structure & Process

- HPC actions in cases of non-compliance
- Education and training
- **Timeframe for registration**
- Contracting threshold
- Leveraging data from other state agencies

Timeframe for registration (10)

Comment

HPC should give RPOs more time to complete both the Part 1 and the Part 2 registration requirements.

Analysis

The proposed timeframes for registration will be extended to ensure that all Provider Organizations have ample time to familiarize themselves with the requirements and gather and submit the information.

The revised regulation allows for additional flexibility in meeting the deadlines for registration as well.

Summary of Comments: Program Structure & Process

Program Structure & Process

- HPC actions in cases of non-compliance
- Education and training
- Timeframe for registration
- **Contracting threshold**
- Leveraging data from other state agencies

Contracting Threshold (1)

Comment

The materials released by HPC reference a contracting threshold that, if met, may require some Provider Organizations that are also Contracting Affiliates of another Provider Organization to register independently. This will lead to significant duplication of reported information.

Analysis

A short-form application will be required in these circumstances. The abbreviated form will limit the information requested so as to avoid unnecessary duplication.

Summary of Comments: Program Structure & Process

Program Structure & Process

- HPC actions in cases of non-compliance
- Education and training
- Timeframe for registration
- Contracting threshold
- **Leveraging data from other state agencies**

Leveraging data from other state agencies (9)

Comment

HPC should not ask for any information that is already collected by other state agencies, including DPH, DMH, the licensing boards and CHIA.

Analysis

Staff has engaged in a comprehensive process of reviewing the information available through other state agencies, including DPH, CHIA, and BORIM, and through outside entities such as MHQP. The results of this work is reflected in the data elements that HPC has not included in the DSM, such as questions on bed counts, services provided, or financial information. This reflects HPC's effort to request new information that fills a gap in the existing data collection landscape.

Summary of Comments: Regulation

Regulation

- **Mandatory updates**
- Contracting Affiliate
- Clarification of registration thresholds
- Appeals Process
- Providers vs. Provider Organizations
- Clarification of terms:
  - Negotiate contracts
  - Represent in contracting
  - Establish contracts
  - Contract

Mandatory Updates (2)

Comment

HPC should clarify what actions undertaken by an RPO would trigger a mandatory update to the information on file in between registration periods.

Analysis

Off-cycle updates will be required for changes that:

1. Require a Material Change Notice to the HPC;

Require a Determination of Need by DPH; or

Affect an essential service, as defined by DPH (e.g. closures);

AND

2. Directly affect information on file in the RPO database

Summary of Comments: Regulation

Regulation

- Mandatory updates
- **Contracting Affiliate**
- Clarification of registration thresholds
- Appeals Process
- Providers vs. Provider Organizations
- Clarification of terms:
  - Negotiate contracts
  - Represent in contracting
  - Establish contracts
  - Contract

Contracting Affiliate (2)

Comment

HPC has used the term "Contractual Affiliate" to refer to a Provider on whose behalf an RPO negotiates contracts. The term "Contracting Affiliate" would be more precise.

Analysis

The term "Contractual Affiliate" will be replaced with the term "Contracting Affiliate" throughout the regulation and the DSM.

Summary of Comments: Regulation

Regulation

- Mandatory updates
- Contracting Affiliate
- **Clarification of registration thresholds**
- Appeals Process
- Providers vs. Provider Organizations
- Clarification of terms:
  - Negotiate contracts
  - Represent in contracting
  - Establish contracts
  - Contract

Clarification of Registration Thresholds (1)

Comment

If a Provider is the Contracting Affiliate of multiple Provider Organizations, only one Provider Organization should have to report the Affiliate, to prevent duplication.

Analysis

The Contracting Affiliate questions ask about the nature of the relationship between the Provider Organization and the Affiliate.

Asking these questions of all Provider Organizations is not meant to be duplicative, but rather to understand the differing nature of these relationships.

Summary of Comments: Regulation

Regulation

- Mandatory updates
- Contracting Affiliate
- Clarification of registration thresholds
- **Appeals Process**
- Providers vs. Provider Organizations
- Clarification of terms:
  - Negotiate contracts
  - Represent in contracting
  - Establish contracts
  - Contract

Appeals Process (5)

Comment

The RPO regulation should include an appeals process through which a Provider or a Provider Organization can seek further review by HPC in cases of non-compliance and to seek an extension in extenuating circumstances

Analysis

Providers and Provider Organizations can request further review by HPC of:

1. The determination that the Provider Organization is required to register, based on its collective NPSR and patient panel; and

2. The completeness of a submitted application.

Summary of Comments: Regulation

Regulation

- Mandatory updates
- Contracting Affiliate
- Clarification of registration thresholds
- Appeals Process
- **Providers vs. Provider Organizations**
- Clarification of terms:
  - Negotiate contracts
  - Represent in contracting
  - Establish contracts
  - Contract

Providers vs. Provider Organizations (1)

Comment

M.G.L. c. 6D s. 11 requires the registration of *Provider Organizations*. The HPC's application of the regulation to both *Providers and Provider Organizations* is inconsistent with the statute.

Analysis

The requirement to register applies to Provider Organizations -- those entities that establish contracts with carriers and TPAs.

Providers that engage in contracting are Provider Organizations.

M.G.L. c. 6D s. 12, the enforcement provision, encompasses both Providers and Provider Organizations.

Summary of Comments: Regulation

Regulation

- Mandatory updates
- Contracting Affiliate
- Clarification of registration thresholds
- Appeals Process
- Providers vs. Provider Organizations
- **Clarification of Terms:**
  - **Negotiate contracts**
  - **Represent in contracting**
  - **Establish contracts**
  - **Contract**

Clarification of Terms (1)

Comment

HPC should define the following terms, which are used throughout the regulation and the DSM, and which are essential to determining whether an entity is considered a Provider Organization and therefore required to register:

- Negotiate contracts
- Represent in contracting
- Establish contracts
- Contract

Analysis

Add language to clarify that each of the terms should be interpreted to mean the action of establishing a contract with a carrier or TPA, including for payment rates, incentives and operating terms.

Staff will clarify in guidance that these terms do not apply to entities that are covered under the terms of a contract, but did not participate in establishing those terms.

Summary of Comments: Data Submission Manual

Data Submission Manual

- **Clinical Affiliates**
- FTEs/Physician Rosters
- Inclusion of additional provider types in Year 1
- Element-specific Comments

Clinical Affiliates (8)

Comment	Analysis
HPC should set an NPSR-based threshold to limit the number of Clinical Affiliates that RPOs have to report.	The DSM will make clear that joint training programs and affiliations for research do not have to be reported. Additional clarification and examples of what constitutes a Clinical Affiliation will be included in the DSM.
HPC should clarify how Clinical Affiliates interact with Corporate and Contracting Affiliates	Clinical Affiliates only need to be reported for those acute hospitals that the RPO owns (its Corporate Affiliates). An entity that is a Corporate or Contracting Affiliate does not have to be reported as a Clinical Affiliate. Given the nature of clinical affiliations, setting an NPSR-based threshold is not appropriate.

Summary of Comments: Data Submission Manual

Data Submission Manual

- Clinical Affiliates
- **FTEs/Physician Rosters**
- Inclusion of additional provider types in Year 1
- Element-specific Comments

FTEs/Physician Rosters (10)

Comment

Provider Organizations do not have FTE information for the facilities and practice sites of their non-owned Contracting Affiliates. To collect this information would be burdensome.

Analysis

Replace the required FTE calculations with physician rosters that include the following information:

- Physician Name
- Physician NPI
- PCP or Non-PCP status
- Specialty
- Primary site of care
- Secondary site of care

In addition to lessening the burden on Provider Organizations to collect new information, rosters will support efforts to create a master provider list for the Commonwealth.

Summary of Comments: Data Submission Manual

Data Submission Manual

- Clinical Affiliates
- FTEs/Physician Rosters
- **Inclusion of additional provider types in Year 1**
- Element-specific Comments

Additional Provider Types (1)

Comment

HPC should not limit the entities required to register in Year 1 to hospitals, physician-based organizations and behavioral health providers.

HPC should include non-physician medical practitioners in Year 1 as well.

Analysis

Understanding the corporate, contracting and clinical relationships of non-physician medical practitioners will be valuable, but out of scope for Year 1 registration.

Entities that are not required to register in Year 1 are explicitly permitted to voluntarily register in the regulation.

Summary of Comments: Data Submission Manual

Data Submission Manual

- Clinical Affiliates
- FTEs/Physician Rosters
- Inclusion of additional provider types in Year 1
- **Element-specific Comments**

Element-specific Comments (10)

Comment

Remove the following elements:

RPO-30: Funds Flow

RPO-31-32: Corporate and Operational Organizational Charts

RPO-56-57: Participation Agreement Start and End Date (for Contracting Affiliates)

RPO-58: Presence of Administrative Fees, Retention, Dues (for Contracting Affiliates)

RPO-60: Direction of Administrative Fees

RPO-62: Start Date by Book of Business (for Contracting Affiliates)

RPO-100: Compensation Part of Clinical Affiliation Agreement

Analysis

The statute asks HPC to understand the corporate, contracting and clinical relationships that exist in the Commonwealth, and these questions are crucial to understanding those relationships.

RPO: Contacting the Program

- HPC will provide access to pertinent documents and templates, review FAQs and education/training materials created by HPC, and program contact information.

- Please e-mail HPC-RPO@state.ma.us if you have questions.

- HPC is developing an optional list serv that individuals and organizations can join to receive alerts and updates about the program.

    - If you would like to be added to the RPO list serv, please send the following information to HPC-RPO@state.ma.us:
        - Your full name
        - Your organization; and
        - Your preferred e-mail address

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Update on:

Health Planning Council - Behavioral Health

Madeleine Biondolillo, MD
Associate Commissioner
Department of Public Health
11 June 2014

Agenda for Presentation

- Statutory Charge
- Analytic Plan
- Deliverables
- Inventory
  - Mental Health
  - Substance Abuse
- Analysis Plan for Utilization Data
- Timeline

Statutory Charge

- Section 16T in Chapter 6A establishes a Health Planning Council within the Executive Office of Health and Human Services
- The health planning council shall submit a state health plan
- The state health plan shall:

  -identify needs of the Commonwealth in health care services, providers, programs and facilities; the resources available to meet those needs; and, the priorities for addressing those needs

  -include the location, distribution and nature of all health care resources in the Commonwealth; the statute specifies certain categories of resources

  -make recommendations for the appropriate supply and distribution of resources, programs, capacities, technologies and services on a state-wide or regional basis based on an assessment of need for the next 5 years and options for implementing such recommendations

Statutory Charge

- EOHHS with the Council shall conduct a public hearing on the plan
- The Department shall issue guidelines, rules or regulations consistent with the state health plan for making determinations of need
- The Department may prescribe uniform reporting requirements

Commonwealth of Massachusetts
Department of Public Health

Health Resources Planning:
Three levels of Analysis/Assessment

- Level 1 = Inventory Only
- Level 2 = Inventory and Forecast (population based forecast; limited narrative about issues)
- Level 3 = Inventory, Estimates of Future Need, Trends and Issues Spotlight

Level 1 – Inventory Only	Level 2 –Inventory and Forecast	Level 3 – Inventory and Estimates of Future Need, Trends and Issue Spotlight

• Dental
• Ob-Gyn
• Midwifery
• "Health Screening and Early Intervention"
  · Mammography
  · Early Intervention Programs
• Optometry
• Chiropractic
• Pharmacy and Pharmacological Services
• Assisted Living
• Rad Onc: LINAC, SRS, Proton
• MRI
• Nuclear Medicine Scanners
• CT Scanners
• Home Health Care
• Lithotripsy
• PET
• Pulmonary Specialty Care (Vent Beds in LTACs)
  · Open Heart Surgery/LVAD
• Air ambulance
• Organ Transplant Programs
• ECMO
	• Dialysis units
	• "Emergency Services"
	• "Acute Care Units"
	  · Med/Surg Beds
	  · Pedi Inpatient Beds
	  · "Surgical" - Outpatient and Inpatient Operating Room, ASC
	  · Labor & Delivery
	  · "Post OB Care"
	  · "ICU" (Adult)
	• Specialty Care Units
	  · Coronary Care Units
	  · Burn
	  · "Neonatal Care"
	  · "ICU" (Pedi)
		• **"Behavioral and Mental Health Services", includes Mental Health and "Substance Abuse Treatment and Services"**
		  · **Providers, sites of care**
		  · **Inpatient, Outpatient & Residential Behavioral Health & Substance Abuse**
		• "Primary Care Resources"
		  · Providers
		  · FQHCs
		• Post Acute Care
		  · Skilled Nursing
		  · Inpatient Rehab Units
		  · Long Term Acute Care
		  · Long Term Care
		  · Hospice and Palliative care (pending full review of data availability)
		• PCI
		• Trauma
		• ASC

Commonwealth of Massachusetts
Department of Public Health

2013 – 2014 Proposal: Deliverables

- **Deliverable 3: Level III Analysis**

Deliverable	Description	Date (2014)
Identification of key questions	• Prioritize areas for further analysis • Ascertain whether there are areas where additional targeted data collection is desirable/feasible	RFI
Estimation of Need	• By service/provider/bed type • Including projections of future need	Complete
Definitions	• Drafted and vetted with stakeholder participation • To include ideal occupancy rates and other standards	Complete
Inventory	• Start with services included in Deliverable 1 Maps, with potential for additional refinement	Complete
Analysis of Capacity	• Based on accepted industry standards, where possible • Standards vetted with experts and stakeholders, if needed	In progress
Issues Brief	• Identification of laws, policies, etc. known to affect system • Narrative description of expected effect	In progress
Public Hearings	• Goal to hold hearings in geographic areas of state identified as being over- or under-capacity in analysis	Q1 FY15
Final Report	• Completed and submitted to legislature	Q2

Analytic Outline: Current List of Services for Inclusion in the Resource Plan

Mental Health

- Acute Inpatient Psychiatric Units/Facilities (child/adult/geriatric)
- DMH Continuing Care Units/Facilities
- Licensed Outpatient Mental Health Clinics
- Outpatient Mental Health Services-General/Private Sector
- Diversionary Services:
  - Partial Hospitalization Programs
  - Day Treatment Programs
  - Emergency Service Programs
  - Crisis Stabilization Services
- Community Service Agencies
- DMH Site Offices- DMH Provided/Funded Community Support Services
- Clubhouse Services
- Recovery Learning Communities (RLCs)

Substance Abuse

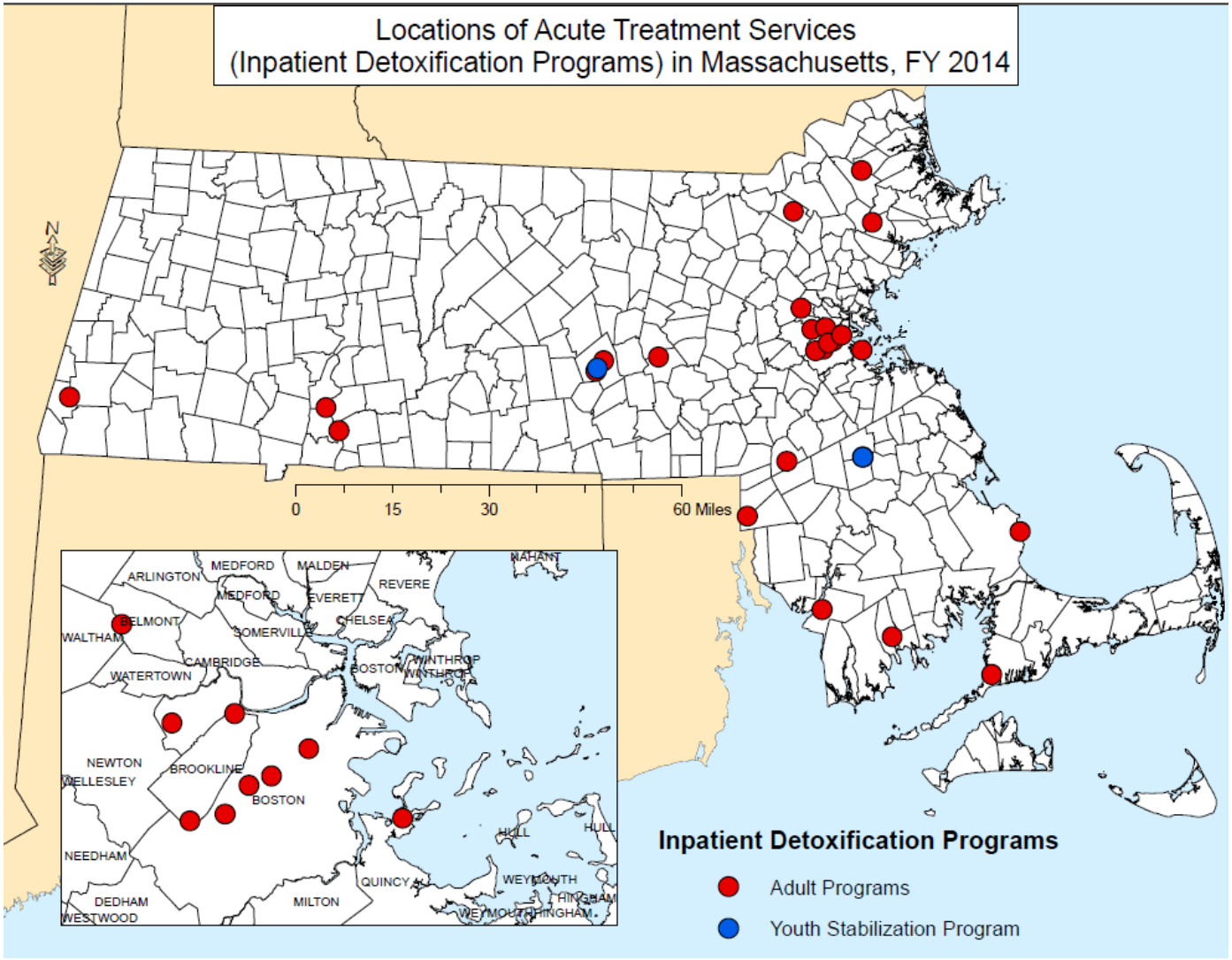
- Acute Inpatient Substance Abuse Beds (adult/youth)
- Clinical Support Services (Clinically Managed Detox)
- Short and Long Term Residential Substance Abuse Beds (adult/family/youth)
- Outpatient Substance Abuse Counseling & Day Treatment
- Opiate Treatment Service Providers (OTP, OBOT)
- Outpatient Substance Abuse Counseling-General/Private Sector including OBOT
- Recovery Support Centers
- Community Support Programs and Services

Cross Sector

- Long Term Services & Supports (BH subset); Multiple Potential Programs—such as Adult Day Centers & Rest Homes
- School-based Services
- Preventative Services

Commonwealth of Massachusetts
Department of Public Health

Service Map : Acute Treatment Services (Inpatient Detoxification Programs)



Acute Treatment Services (ATS)

•ATS programs are commonly referred to as inpatient detoxification programs. These programs operate in free standing and hospital based settings. The primary purpose of ATS programs is to medically treat withdrawal symptoms in persons who are dependent upon alcohol and/or other drugs.

•Specialized inpatient services are available to adolescents under 18 years of age who require ATS services. These services are referred to as Youth Stabilization Programs.

•All adolescent and adult programs encourage individuals who complete detoxification to continue receiving addiction treatment in other settings such as residential rehabilitation or outpatient settings.

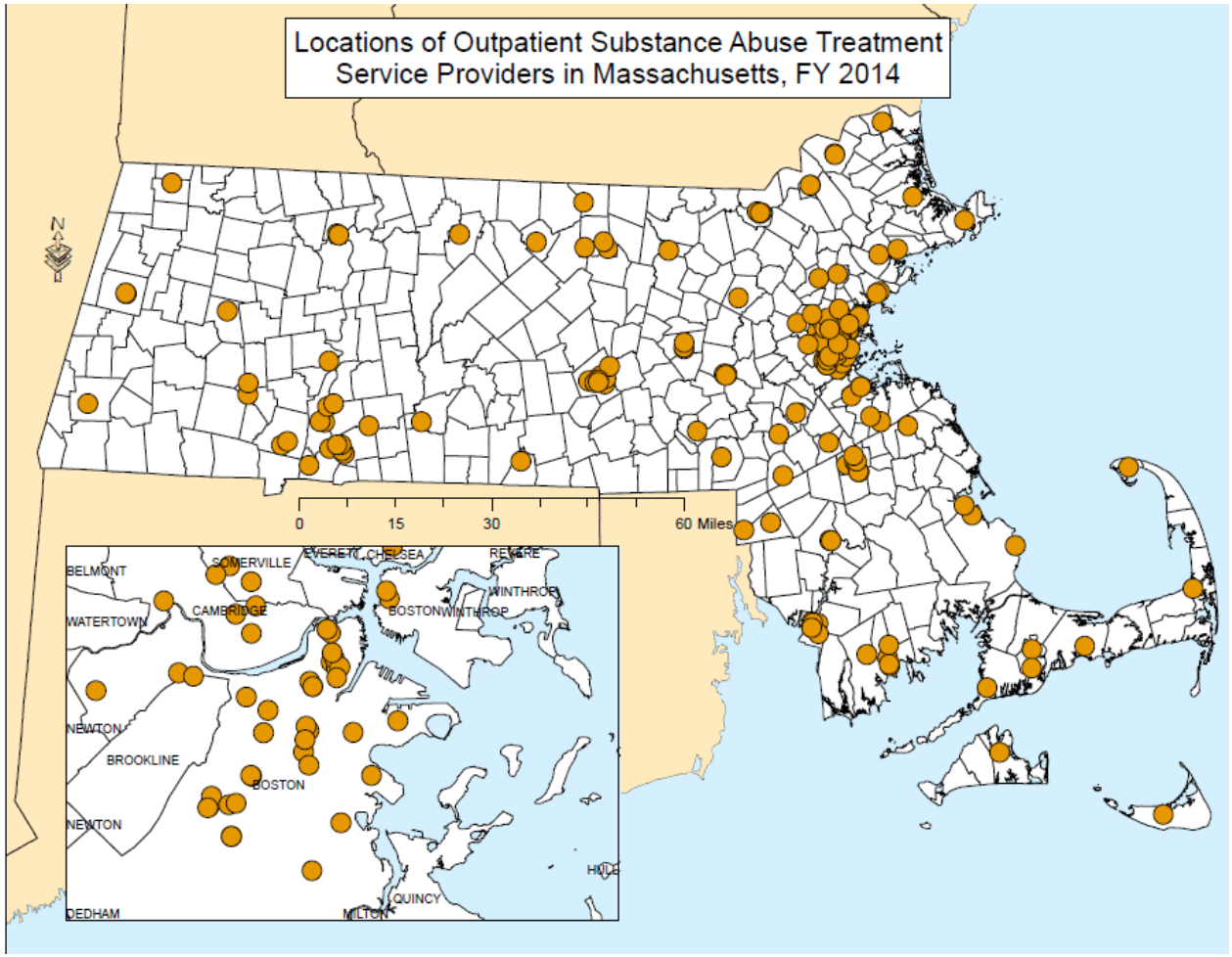
•Services are available to people with public insurance, and to those with private insurance that contract with these providers.

•Dots represent the Department of Public Health (DPH), Bureau of Substance Abuse Services (BSAS) licensed Substance Abuse Acute Treatment Services (including adult & adolescent) either as units in a hospital or a freestanding facility .

Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Commonwealth of Massachusetts
Department of Public Health

Service Map:
Outpatient Substance Abuse Treatment



Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Outpatient Substance Abuse Treatment

- Outpatient Substance Abuse Treatment is provision of in-person addiction counseling services to individuals, aged 13 and older, who are not at risk of suffering withdrawal symptoms and who can participate in organized services in an ambulatory setting such as a substance abuse treatment program, mental health clinic, hospital outpatient department or community health center.
- Services may include individual, group and family counseling, intensive day treatment and educational services for persons convicted of a first offense of driving under the influence of drugs or alcohol. Some outpatient substance abuse treatment programs meet additional regulatory requirements to provide these services to specialty populations including adolescents, age 13-17, pregnant women, persons with co-occurring mental health disorders, persons age 60 or older and persons with disabilities
- Services are available to people with public insurance, and to those with private insurance that contract with these providers.
- Dots represent programs that are either licensed or approved by the Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS).
- Although any of the locations may treat individuals with a “dual diagnosis” of substance abuse and mental health, a subset of the clinics receive additional specific licensure from the DPH, Bureau of Health Care Safety & Quality to treat persons with primary mental health problems.
- Of note, licensed mental health clinics may provide addiction counseling services to persons with primary addictive disorders under their outpatient mental health clinic licensure. Those clinics are not represented on this map. The map also does not represent any of the “private practitioners ” who offer substance abuse treatment & counseling.

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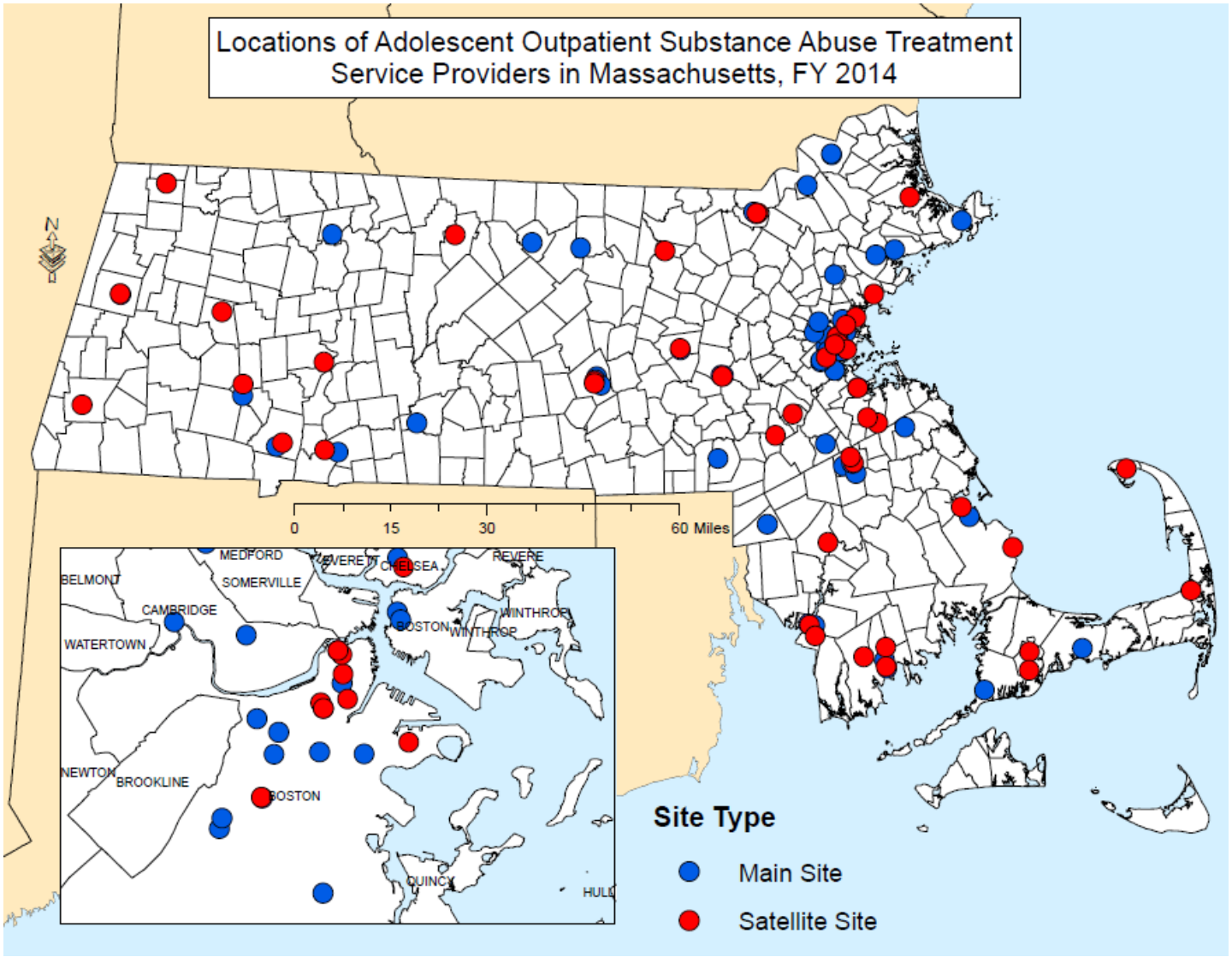
Service Map: Adolescent Outpatient Substance Abuse Treatment (Subset)



Adolescent Outpatient Substance Abuse Treatment (Subset)

- These licensed outpatient substance abuse treatment providers have met additional, regulatory requirements to provide services to adolescents, 13-17 years old.
- Of note, licensed mental health clinics may provide addiction counseling services if they maintain compliance with the Department of Public Health (DPH), Bureau of Substance Abuse Services (BSAS) regulations. However, they are not required to seek BSAS licensure or approval. Therefore this map does not represent the outpatient mental health clinics that may be providing addiction treatment services under their mental health clinic licensure.
- Dots do not represent any of the "private practitioners " who offer substance abuse treatment & counseling services.

Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

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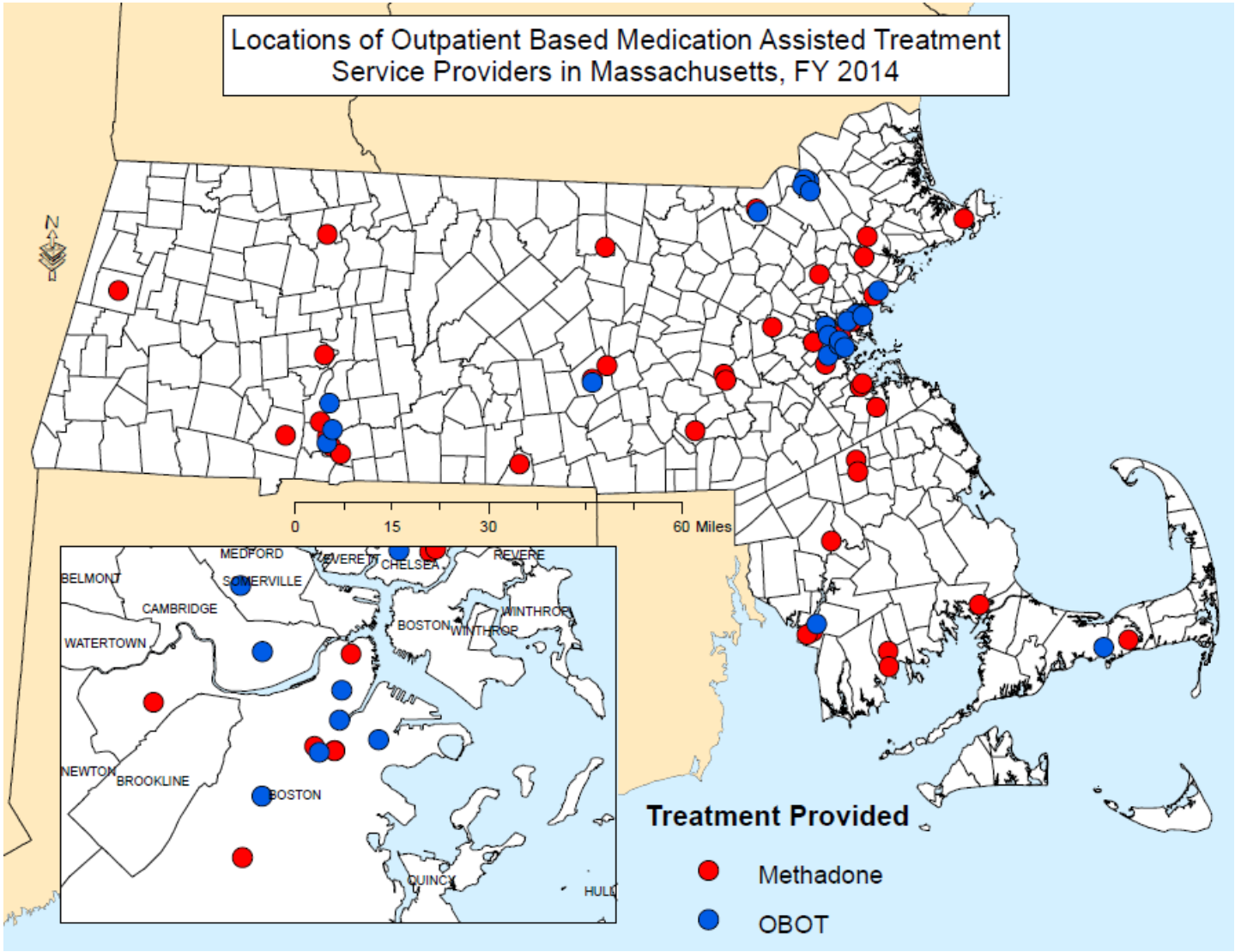
Department of Public Health

Service Map: Outpatient Based Medication Assisted Treatment Providers



Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Opioid Treatment Programs

- The Department of Public Health, Bureau of Substance Abuse Services (BSAS) licensed opiate treatment programs provide medication, such as methadone, along with a comprehensive range of medical and rehabilitative services in an ambulatory setting to individuals to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. Opioid treatment includes both maintenance and detoxification.

Office Based Opiate Treatment (OBOT) Programs

- BSAS funds 14 OBOT programs in community health centers across the state. These programs provide medication (buprenorphine) for the treatment of opiate addiction in a primary care setting. Buprenorphine treatment includes both maintenance and detoxification. This treatment does not require BSAS licensure.
- Dots represent only the 14 BSAS-funded OBOT programs and does not reflect the hundreds of physicians who are able to provide this treatment in their medical practices.

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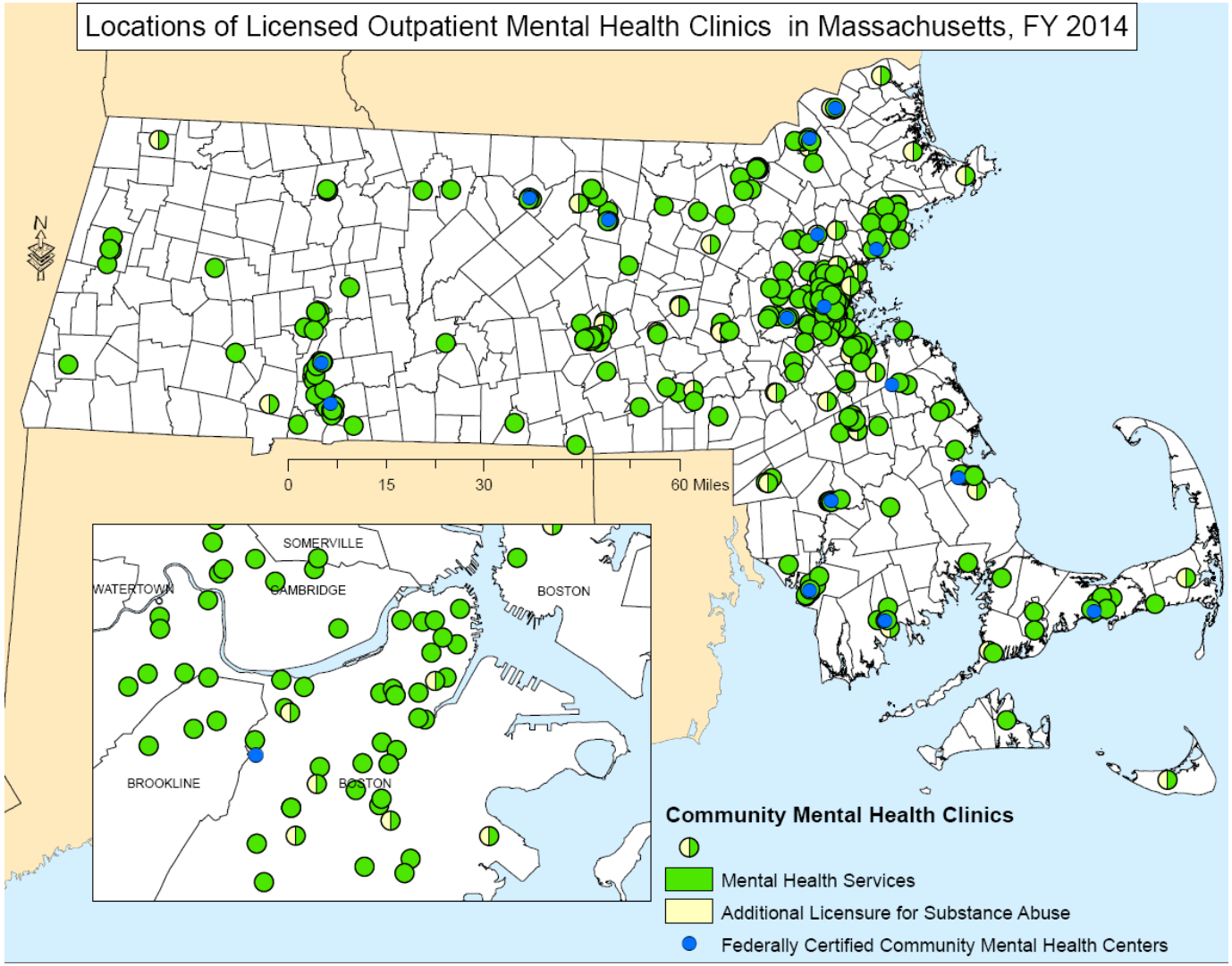
Service Map:
Outpatient Mental Health Clinics



Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Outpatient Mental Health Clinics

- Outpatient mental health clinics deliver comprehensive diagnostic and psychotherapeutic treatment services in interdisciplinary team under the medical direction of a psychiatrist. Services include: diagnosis and evaluation; medication management; consultation; and individual, family and group treatment for people with Mental Health or Substance Abuse disorders.
- The green/yellow dots represent clinics licensed by the Department of Public Health (DPH), Bureau of Health Care Safety & Quality. Blue dots represent locations that meet federal requirements for mental health centers. Although any of the locations may treat individuals with a "dual diagnosis" of mental health & substance abuse, a subset of the clinics receive additional specific licensure from the DPH, Bureau of Health Care Safety & Quality to treat substance abuse. The dots do not represent any of the "private practitioners" who offer mental health or substance abuse treatment nor the clinics that are separately licensed by the DPH, Bureau of Substance Abuse Services.
- Services are available to people with public insurance or to those with private insurance that contract with these providers.

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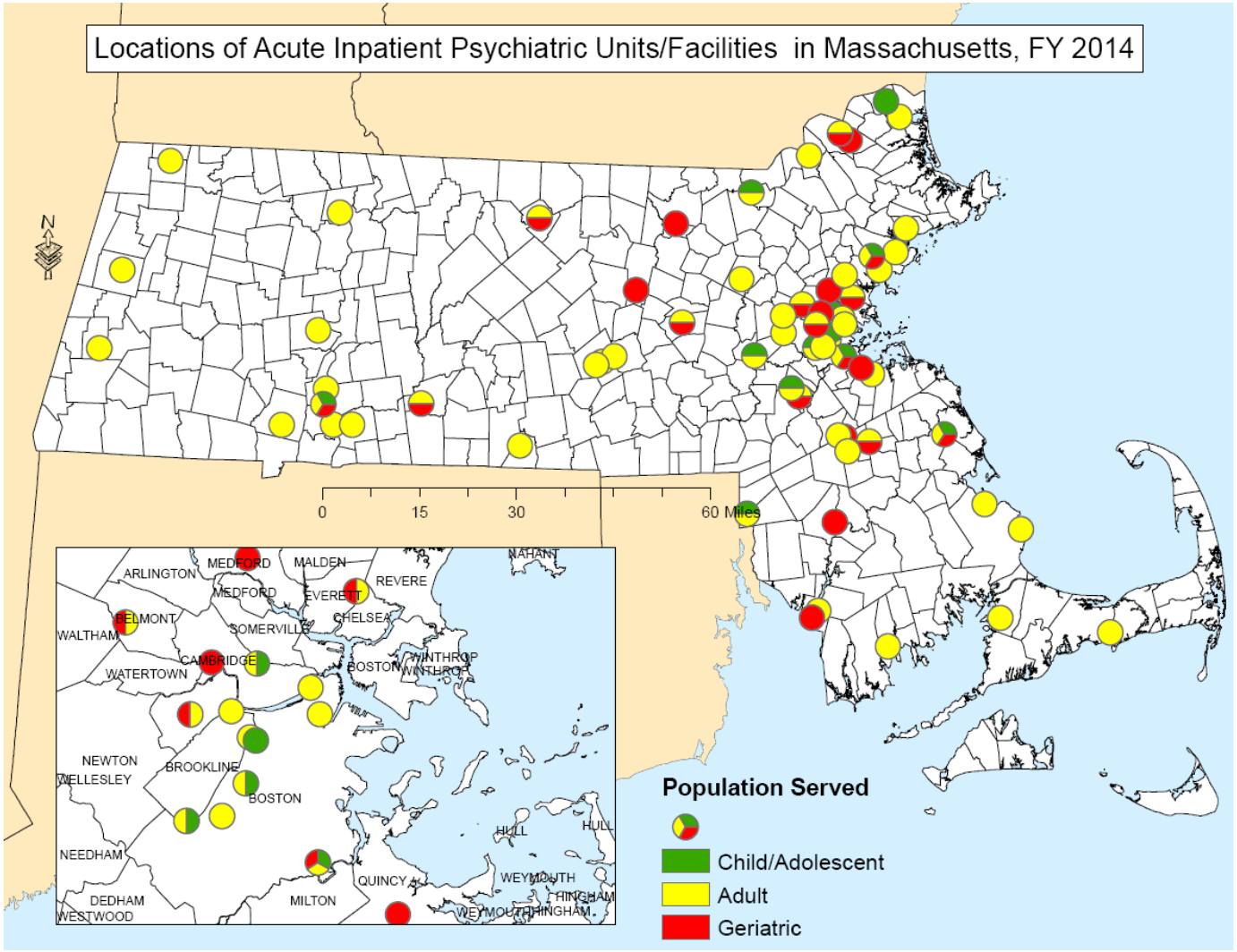
Service Map:
Acute Inpatient Psychiatric Units/Facilities



Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Acute Inpatient Psychiatric Units/Facilities

- Most individuals who need psychiatric inpatient care receive such services at an acute inpatient psychiatric unit in a general hospital or a private psychiatric facility.
- Psychiatric units in general hospitals and private psychiatric hospitals provide short-term, intensive diagnostic, evaluation, treatment and stabilization services to individuals experiencing an acute psychiatric episode.
- The dots represent the general hospital psychiatric units and private acute psychiatric hospitals licensed by the Department of Mental Health (DMH). In addition, DMH operates two inpatient units at Community Mental Health Centers in the Southeast region.
- Services are available to people with public insurance and to those with private insurance that contract with these providers.

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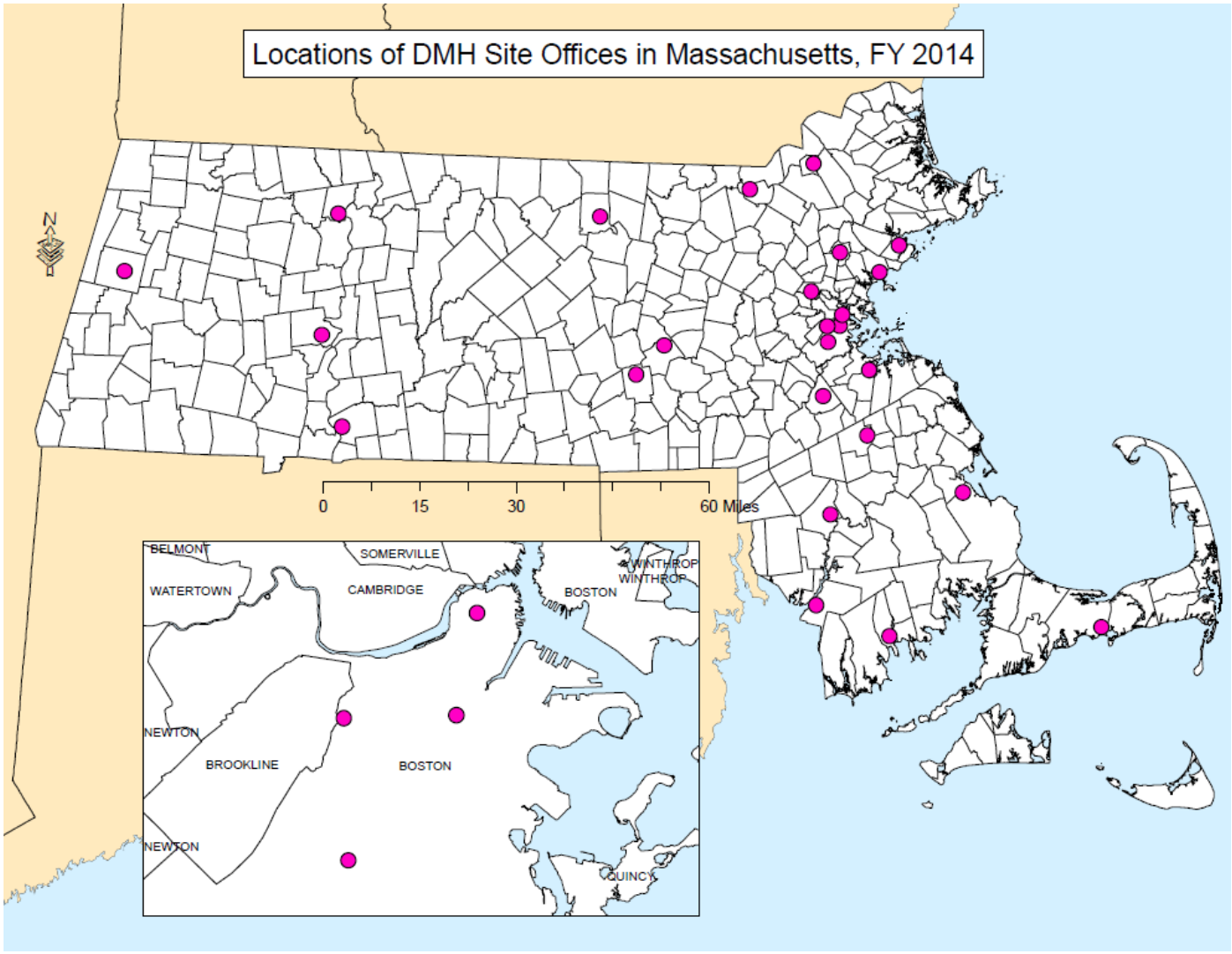
Service Map: DMH Site Offices

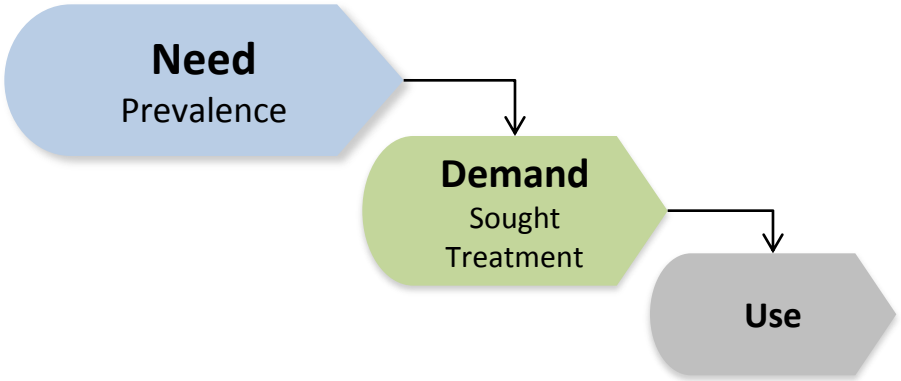


Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Department of Mental Health (DMH) Site Offices

- DMH provides services through 27 site offices within 25 locations across Massachusetts. The site offices provide case management and oversee an integrated system of community rehabilitative and recovery-based services for adults and youth.
- Individuals must apply to DMH to receive community-based services to determine they have a "qualifying mental disorder" as the primary disorder requiring treatment, and meet functional impairment and other criteria. There are "needs & means" criteria, in addition to clinical criteria, as part of the review for access.
- Services are delivered flexibly, often in individuals' homes and local communities. Services are designed to meet the behavioral health needs of individuals of all ages, enabling them to live, work, attend school and fully participate as valuable, contributing members of our communities.
- DMH also offers a range of supports to parents and people receiving mental health services through peer and parent support organizations. Individuals and families do not need to be authorized for services to access these supports.

Need, Demand and Use



Need is characterized by the fundamental *underlying conditions* in the population (prevalence data from NSDUH).

Demand is expressed as the people that *seek treatment* and it will be estimated according as the portion of people that actually *use* treatment (use) plus estimates of unmet demand.

Use is known from claims and other reporting sources though people may be duplicated in some of these sources.

Demand Estimation Methods

Step 1. Baseline demand

- Develop baseline demand based on current utilization.
- Data will be detailed by service, payer, population and summed to major service groups.
- Data sources: claims, state service data, etc.

Step 2. Unmet demand

- Estimate unmet demand as services that are sought but not received.
- Data sources: interviews, wait lists, waiting times and other sources of information.

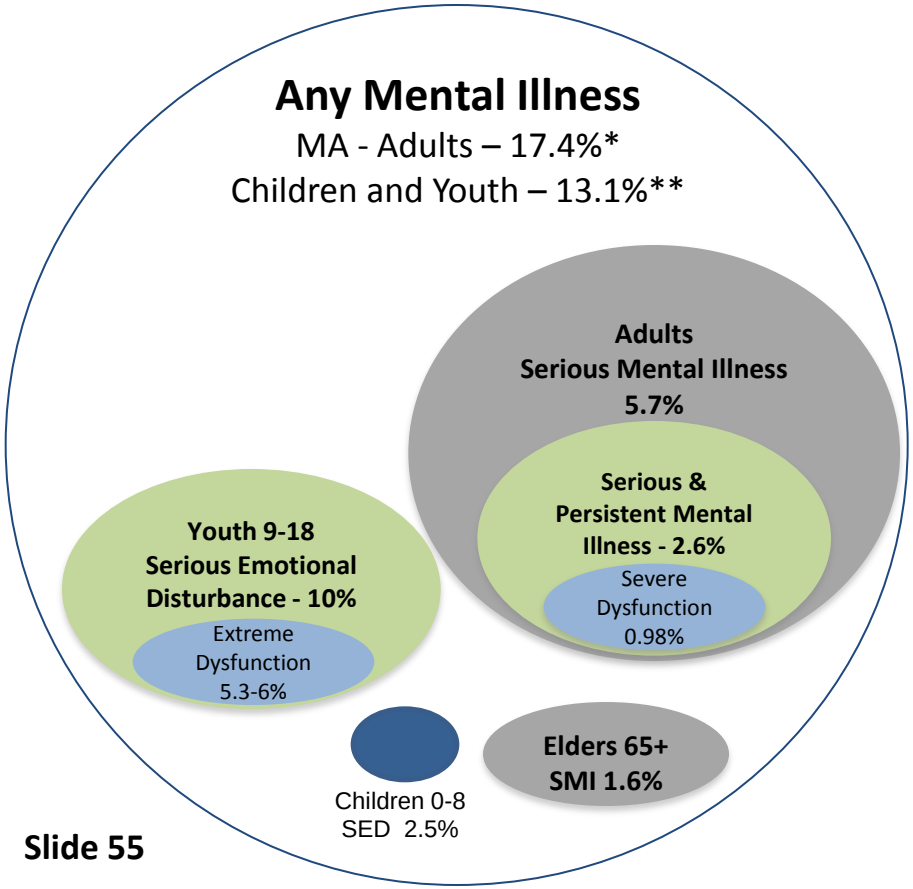
Step 3. Demand projections

- Total current demand = baseline demand + unmet demand.
- Project future demand through population changes, trends, and best practices, including integrated care; shift from institutions to community; recovery and peer support.

Mental Health Conditions

Mental Health Conditions

MA DMH State Plan: Step 2 Unmet Needs and Service Gaps



Slide 55

- - 2011/2012 National Survey of Drug Use and Health
- ** -CDC National Health and Nutrition Examination Survey – Ages 8-15

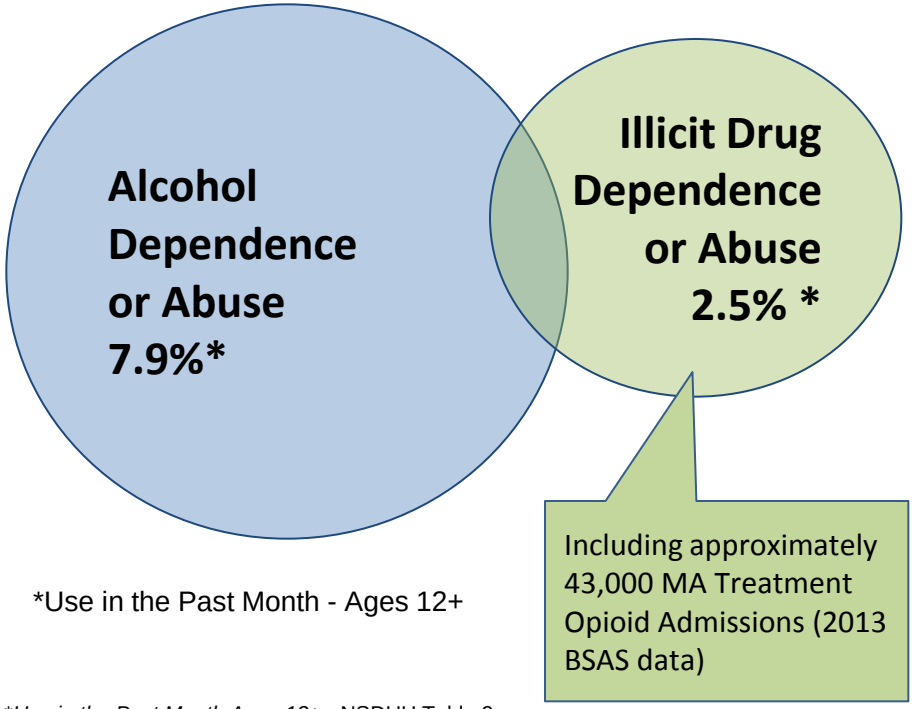
- **Any Mental Illness** (AMI): having (currently or at any time in the past year) a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM-IV, regardless of functional impairment.
- **Serious Mental Illness** (SMI) Adults 18+ is defined as having a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the 4th edition of DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities.
- **Serious Emotional Disturbance (**SED) Youth: SED is defined as a diagnosable disorder that causes problems in a child's functioning that substantially interferes with or limits the child's role in home, school or community activities; it is further distinguished by either "extreme dysfunction" or "substantial functional impairment." MA also categorizes separately children 0-8 with SED in need of mental health services from those 9-18 with SED.
- **Serious and Persistent Mental Illness** [best definition being sought].
- **Severe Dysfunction:** Those unable to provide for basic self-care

Substance Use, Dependence, Abuse (MA)

Substance Dependence and Abuse (MA)

(2011-2012 NSDUH)

Overall – 9.1% of the Population

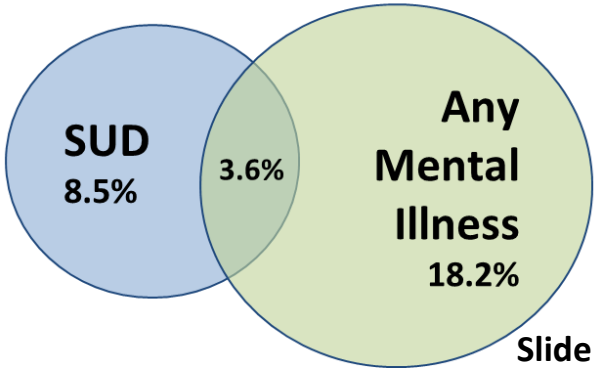


*Use in the Past Month - Ages 12+

**Use in the Past Month Ages 12+* - NSDUH Table 9, Table 10; Table 1.
*** Dependence or Abuse Past Year Ages 12+* – NSDUH Table 20; Table 16; Table 18.

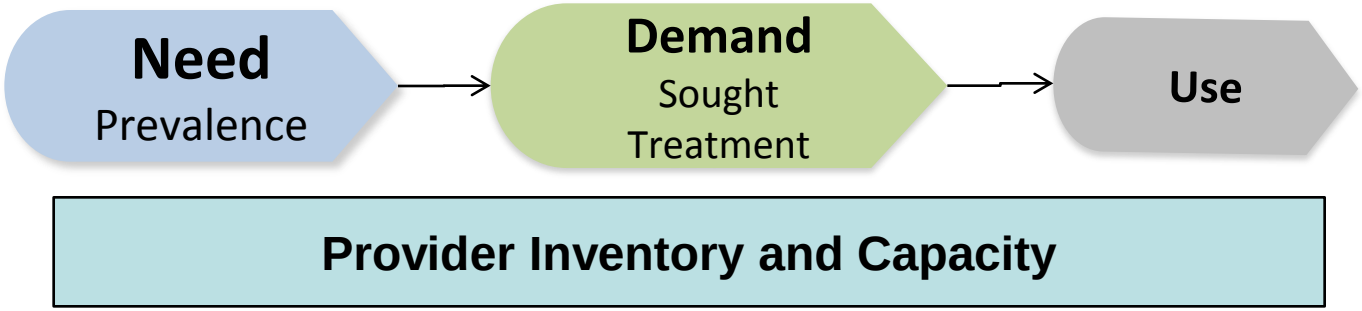
- Dependence or Abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
- Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically

Co-occurring Substance Use Disorder & Mental Illness Conditions (US – 2012)



Commonwealth of Massachusetts
Department of Public Health

Analytic Road Map and Framework – Report



- Needs will be estimated using national prevalence and survey data. The framework and the overall need data were shared last meeting.
- Demand for services in behavioral health is highly elastic and data such as wait lists are not readily available. Many people meeting diagnostic criteria are not "ready" for treatment. Interviews, document review and comparisons of claims levels will help us comment on demand.
- Use data will come from six primary sources: DPH-BSAS; DMH; MassHealth; Medicare 5%; commercial data from CHIA-APCD; and hospital discharge data which includes general acute care hospitals (not freestanding) and hospital ER.
- Provider inventory is available primarily for licensed programs and is covered in this presentation. Capacity estimates for inpatient and other selected services will be developed in the final report.

Inventory

Inventory Analysis

- Developed inventory from DMH and DPH licensing and contract data
- Uses the 15 Health Policy Commission planning regions
- Provider inventory and other data are summarized as follows:
  - Statewide and regional MH and SA bed inventory by service – total # of beds and beds/100,000
  - Hospital and other acute inventory has been mapped to display geographical distribution
  - Statewide and regional clinic locations and #s of sites (no capacity data)
  - Statewide and regional locations for CBFS and other MH services
  - Substance abuse licensed services and other programs, by location
  - Select data summarized here

Mental Health

DMH Roles

- DMH provides services to over 21,000 DMH clients:
  approximately 2,300 children with serious emotional disturbance and 19,000 adults with serious and persistent mental illness.
- More than 90% of DMH clients served in the community
- DMH services provide rehabilitation and support to enable people to live, work and participate in the community
- *Acute* care for DMH clients and all other state residents, including outpatient clinic and hospital acute care, is mostly funded through public and private insurance
- DMH licenses acute-care psychiatric units at general hospitals and at free-standing psychiatric hospitals
- *DPH* (not DMH) licenses outpatient mental health clinics

Inpatient Mental Health

- 65 acute freestanding and general psychiatric facilities across the state
- 2,399 acute inpatient psychiatric beds:
  - 44% in free-standing hospitals
  - 56% in general hospitals
- 36 acute beds per 100,000
- 10% of beds for kids, 73% of beds for adults, 17% in specialized geriatric units
- Bed capacity, from 2010 to 2014, has grown 5% among the free-standing hospitals and 2% among all hospitals; general hospital beds showed no change.

Licensed MH Clinics

- 380 clinics statewide licensed by DPH provide MH services – two-thirds of the total clinics*
- Among the 558 clinics providing medical care, mental health care or both:
  - 51% provide mental health care only
  - 17% provide both mental health and medical care
  - 32% provide medical care only
- MH Clinics can provide both mental health and substance abuse services

* Numbers of clinics include license-holding clinics and their satellite clinics, each counted separately. Among the excluded clinics are those that provide only dental, pharmacy, physical rehab or MRI services. Also not included are physician-owned offices, which are not licensed by DPH.

Other Mental Health Services

- Community Based Flexible Supports, the "cornerstone" of the DMH community mental health system for adults with serious mental illnesses
  - provides services in partnership with clients and their families to promote and facilitate recovery
  - Point-in-time capacity in 2013: 11,814 individuals
  - Includes rehabilitative and support services to manage psychiatric symptoms and medical conditions in the community and that support independent living, wellness and employment
- Other important DMH services include: adult respite, intensive residential treatment programs for children, case management, and recovery learning centers

Inpatient Psychiatric Beds

Inpatient Psychiatric Beds in Free-Standing and General Hospitals by Region, 2014

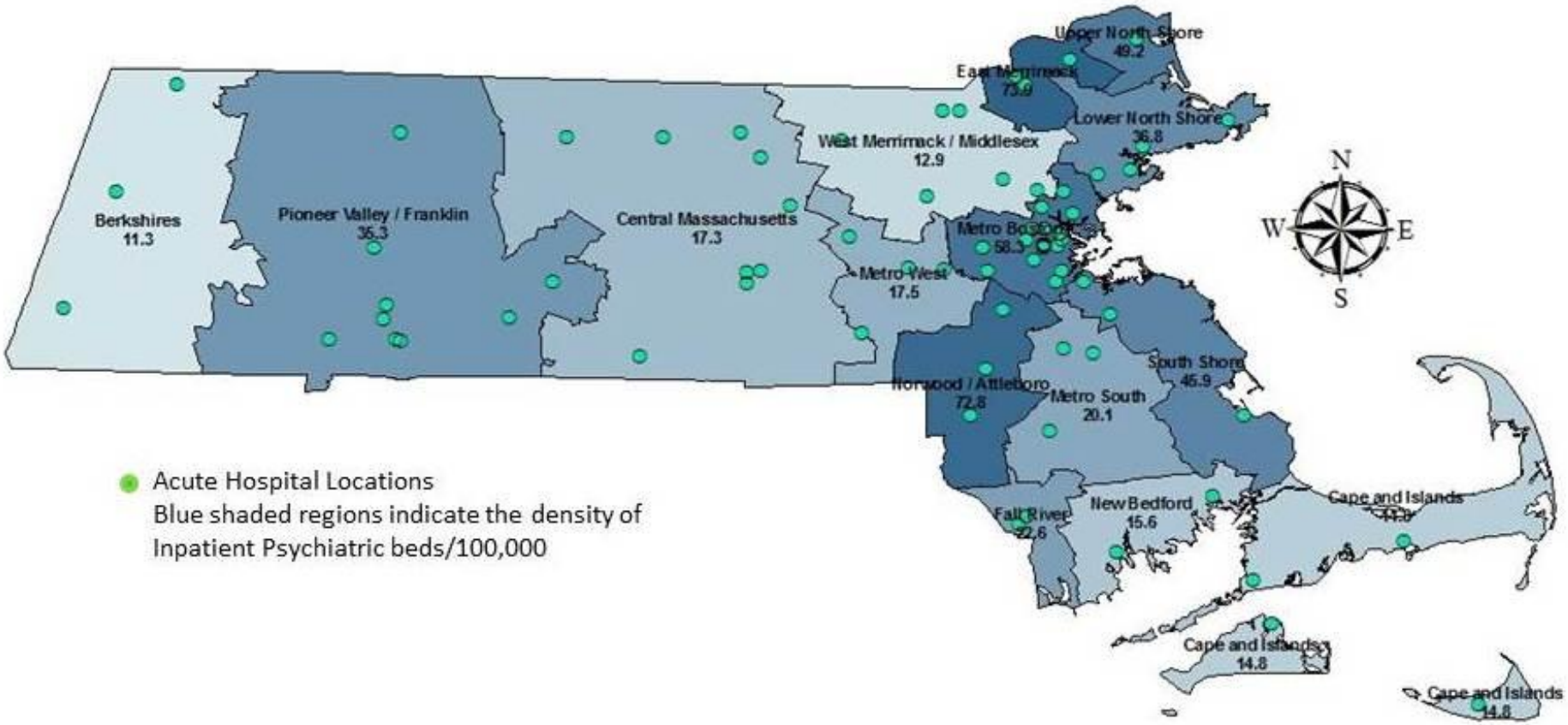
Region	# of Hospitals or Psychiatric Units*				# of Beds				Population	Beds per 100,000	Ratio to Statewide Average
	Free-Standing	General	State-Operated	Total	Free-Standing	General	State-Operated	Total			
A - Berkshires	0	2	0	2	0	15	0	15	132,821	11	0.3
B - Pioneer Valley/Franklin	1	7	0	8	30	213	0	243	689,005	35	1.0
C - Central Mass	0	6	0	6	0	132	0	132	763,769	17	0.5
D- W. Merrimack/Middlesex	1	2	0	3	41	47	0	88	680,688	13	0.4
E - East Merrimack	2	2	0	4	122	74	0	196	265,081	74	2.0
F - Upper North Shore	0	2	0	2	0	32	0	32	65,020	49	1.3
G - Metro West	0	2	0	2	0	54	0	54	333,858	16	0.4
H - Metro Boston	5	14	0	19	490	428	0	918	1,575,595	58	1.6
I - Lower North Shore	0	4	0	4	0	144	0	144	391,184	37	1.0
J - Norwood/Attleboro	2	1	0	3	177	61	0	238	326,752	73	2.0
K - Metro South	1	3	0	4	30	52	0	82	407,120	20	0.5
L - South Shore	3	2	0	5	149	41	0	190	413,670	46	1.3
M - Fall River	0	1	1	2	0	16	16	32	141,534	23	0.6
N - New Bedford	0	1	0	1	0	31	0	31	198,870	16	0.4
O - Cape and Islands	0	1	1	2	0	20	16	36	243,352	15	0.4
Statewide Total	**15**	**50**	**2**	**67**	**1,039**	**1,360**	**32**	**2,431**	**6,628,319**	**37**	1.0
Percent	22%	75%	3%	100%	43%	56%	1%	100%			

*For free-standing and general hospitals, each hospital with psychiatric beds is counted once. The two state-operated psychiatric units, Corrigan in Fall River and Pocasset on Cape Cod, are located within state mental health centers.

Commonwealth of Massachusetts
Department of Public Health

Map: Inpatient Psychiatric Beds

Inpatient Psychiatric Beds per 100,000 in Free-Standing, General, and State-Operated Hospitals by Region, 2014



Changes in Inpatient Psychiatric Beds: 2010-2014

Number of Inpatient Psychiatric Beds in Free-Standing Psychiatric Hospitals, General Hospitals and State-Operated Psychiatric Units, 2010-2014

	Number of Beds					Change 2010-2014	
Hospital Type	2010	2011	2012	2013	2014	Number	Percent
Free-Standing	990	1,005	1,025	1,034	1,039	49	5%
General	1,366	1,353	1,353	1,354	1,360	-6	0%
State-Operated	32	32	32	32	32	0	0%
Total	2,388	2,390	2,410	2,420	2,431	43	2%

- Freestanding hospital bed growth (5%) over the last four years contrasts with no growth for general acute hospital psychiatric beds that may provide care for more complex, medically involved cases.

DPH-Licensed Clinics

Licensed Outpatient Clinics Providing Mental Health and Medical Services by Region, 2014

Region	Numbers of Licensed Clinics Providing Indicated Services				
	Mental Health	**Mental Health Only**	**Mental Health *and* Medical**	**Medical Only**	**Total Three Types of Clinics (MH only, MH and Med., Med. only)**
A - Berkshires	**7**	7	0	6	13
B - Pioneer Valley/Franklin	**49**	44	5	21	70
C - Central Mass	**45**	34	11	39	84
D- West Merrimack/Middlesex	**23**	17	6	15	38
E - East Merrimack	**18**	16	2	10	28
F - Upper North Shore	**1**	1	0	1	2
G - Metro West	**12**	11	1	15	27
H - Metro Boston	**105**	61	44	21	126
I - Lower North Shore	**29**	16	13	10	39
J - Norwood/Attleboro	**9**	9	0	6	15
K - Metro South	**22**	20	2	6	28
L - South Shore	**24**	21	3	16	40
M - Fall River	**13**	11	2	5	18
N - New Bedford	**7**	7	0	2	9
O - Cape and Islands	**16**	12	4	5	21
Total Statewide	**380**	**287**	**93**	**178**	**558**
Share of All Clinics	**68%**	**51%**	**17%**	**32%**	**100%**

Notes: The clinics described in this table are ambulatory care providers licensed by the DPH Division of Health Care Quality for specific services such as medical care or mental health care. The numbers of clinics include both license-holding clinics and their satellite clinics, each counted separately. Data from April 25, 2014.

The counts of clinics in this table represent only a subset of the clinics licensed by DPH: Clinics that do not provide either mental health or medical services were excluded.

In addition, because DPH regulation excludes from its licensing requirements those medical offices and group practices wholly owned and controlled by their physicians, such offices and practices are also not included in the table.

HPC Regions and DMH Site Offices

- DMH funded services are contracted or operated from 26 local site offices. Most of these services are provided within the person's own community, often in the home or other settings chosen by the client
- DMH capacity data reflect the region with the location of the site office where the contract is held or service is operated
- DMH site offices do not align with the HPC regions. The DMH system of site offices has been built around community boundaries while the HPC regions are based upon hospital service areas and hospital referral regions. Some HPC regions have multiple site offices, some have none.

Substance Abuse

DPH: The Role of Bureau of Substance Abuse Services

- Single State Authority
- The Bureau of Substance Abuse Services (BSAS):
  - Oversees substance abuse prevention, intervention, treatment and recovery support services for adults and adolescents (available to youth and adults 13 years of age and older)
  - Licenses treatment facilities and alcohol and drug counselors
  - Funds a continuum of programs and services including detoxification, step-down services, residential rehabilitation, outpatient counseling, medication assisted treatment and community-based recovery support.
  - Tracks substance abuse trends in the state

DPH Licensing Responsibilities

- BSAS licenses substance abuse treatment programs, e.g., day treatment, methadone programs.

- The Division of Health Care Quality (DHCQ) licenses general hospitals and outpatient clinics, some of which provide substance abuse treatment services.

Substance Abuse Service Inventory

Service Group	Tables by Service
All	Overview of All Beds
All Inpatient and Other Acute Care	Number of All Acute and Other Beds and CSS Beds by Region, 2014
Inpatient and Other Acute Care	Number of Acute Level IV Inpatient Beds by Region, 2014
	Number of Acute Level III.7 Treatment Service Beds by Region, 2014
	Number of Clinical Stabilization Service Beds by Region, 2014
Intermediate Care	Number of Transitional Support Services Beds by Region, 2014
Residential Care	Number of Residential Beds by Region, 2014
Outpatient Care	Opioid Treatment Programs by Region, 2014

Note: Additional tables provided in a comprehensive set of tables on all services.

Additional detail on the inventory of services above is being developed by the team. This will include other important SA services: Day Treatment, Outpatient Substance Abuse Counseling, Recovery Support Services, Recovery High School, Naloxone distribution.

Overview of Licensed Beds

Summary of All Beds to Treat Substance Abuse Licensed by DPH

Major Service Group	Service	Beds	Beds per 100,000
Inpatient and Other Acute	Medically-managed	165	3
Inpatient and Other Acute	Medically-monitored	752	14
Inpatient and Other Acute	Clinical Stabilization Services	284	5
Inpatient and Other Acute	Section 35 (May 2014)		
	Medically monitored	56	1
	Clinical Stabilization Services	142	3
A) Inpatient & Other Acute Care	Total of services listed above	1399	25
B) Intermediate Care	Transitional Support Services	291	5
C) Residential Care	Residential Services	2341	42
	TOTAL BEDS (A + B + C)	**4031**	**73**
	Eligible population, all persons 13 years of age and older, 2010	*5,554,121*	

Note: All data except otherwise noted is based on March 2014 reports.
Note: 117 families are also served by DPH, these numbers are not noted on this overview table.

Intermediate Substance Abuse Services

- Transitional Support Services (may follow inpatient detox):
  - 7 programs
  - 291 beds
  - 5 beds per 100,000
- 49 day treatment programs
  - These 49 programs fall under the 120 licensed outpatient programs.
  - Programs must be licensed as an outpatient program to provide day treatment.

Residential Rehabilitation Services

- 2,341 residential beds
  - 42 beds per 100,000
  - 94% single adult beds
  - Gender breakdown an important planning issue
  - Proportion of beds by gender (May 2014):
    - 56% men only
    - 28% women only
    - 16% co-ed
- Additional capacity to serve 117 families in residences

BSAS licensing data as of March 27, 2014

Outpatient Care

- 120 counseling programs
- 50 medication-assisted treatment programs
  - 36 DPH-licensed opioid treatment programs (methadone)*
  - According to SAMHSA, there are 72 office based opioid treatment (OBOT) programs providing Buprenorphine in Massachusetts.
  - BSAS funds 14 OBOT programs
  - See the SAMHSA Treatment Locator for more information
    http://dpt2.samhsa.gov/treatment/directory.aspx
  - Limited capacity information

* BSAS licensing data as of March 27, 2014

Opioid Overdose Intervention

- Intervention Programs funded by DPH
  - Naloxone distribution programs for bystanders and first responders (14 programs with 19 sites)
  - Learn to Cope (one program with 12 sites)

Provides training on overdose prevention, recognition and response; distribute naloxone kits to people in the community who are likely to witness an overdose. Likely bystanders include opioid-users, their friends and family members, and human services providers who serve opioid-users.

Commonwealth of Massachusetts
Department of Public Health

Overview of All Beds Substance Abuse Services

All Inpatient and Other Acute Beds, 2014
Medically Managed, Medically Monitored, and Clinical Stabilization Services

Region	Beds	Population (≥13 y.o)	Beds per 100,000
A - Berkshires	21	115,642	18
B - Pioneer Valley/Franklin	90	583,165	15
C - Central Mass	258	617,789	42
D- West Merrimack/Middlesex	17	520,171	3
E - East Merrimack	76	225,494	34
F - Upper North Shore	0	55,053	0
G - Metro West	0	306,636	0
H - Metro Boston	270	1,336,899	20
I - Lower North Shore	79	331,980	24
J - Norwood/Attleboro	58	269,678	22
K - Metro South	64	337,324	19
L - South Shore	111	350,397	32
M - Fall River	67	121,612	55
N - New Bedford	0	167,586	0
O - Cape and Islands	90	214,695	42
Total Statewide	**1201**	**5,554,121**	**22**
Total Section 35-Medically Monitored and CSS	**198**	**5,554,121**	**4**
All Inpatient and Other Acute	**1399**	**5,554,121**	**25**

Note: Data as of March 27, 2014. Numbers may not sum to total due to rounding. Census data is 2010.

Note: This includes all medically managed and medically monitored beds including Section 35 beds, as of May 5, 2014.

Acute Inpatient Medically Managed Substance Abuse Services

Acute Inpatient Beds (Level IV), Medically Managed in a Hospital, by Region, 2014

Region	Beds	Population (≥13 y.o)	Beds per 100,000
A - Berkshires	0	115,642	0
B - Pioneer Valley/Franklin	0	583,165	0
C - Central Mass	114	617,789	18
D- West Merrimack/Middlesex	17	520,171	3
E - East Merrimack	14	225,494	6
F - Upper North Shore	0	55,053	0
G - Metro West	0	306,636	0
H - Metro Boston	20	1,336,899	1
I - Lower North Shore	0	331,980	0
J - Norwood/Attleboro	0	269,678	0
K - Metro South	0	337,324	0
L - South Shore	0	350,397	0
M - Fall River	0	121,612	0
N - New Bedford	0	167,586	0
O - Cape and Islands	0	214,695	0
Total Statewide	**165**	**5,554,121**	**3**

Note: Data as of March 27, 2014. Numbers may not sum to total due to rounding. Census data is 2010.

Clinical Stabilization Services
Substance Abuse Services

Clinical Stabilization Services, Beds by Region, 2014

Region	Beds	Population (≥13 y.o)	Beds per 100,000
A - Berkshires	0	115,642	0
B - Pioneer Valley/Franklin	30	583,165	5
C - Central Mass	30	617,789	5
D- West Merrimack/Middlesex	0	520,171	0
E - East Merrimack	0	225,494	0
F - Upper North Shore	0	55,053	0
G - Metro West	0	306,636	0
H - Metro Boston	54	1,336,899	4
I - Lower North Shore	23	331,980	7
J - Norwood/Attleboro	0	269,678	0
K - Metro South	32	337,324	9
L - South Shore	30	350,397	9
M - Fall River	30	121,612	25
N - New Bedford	0	167,586	0
O - Cape and Islands	55	214,695	26
Total Statewide	**284**	**5,554,121**	**5**

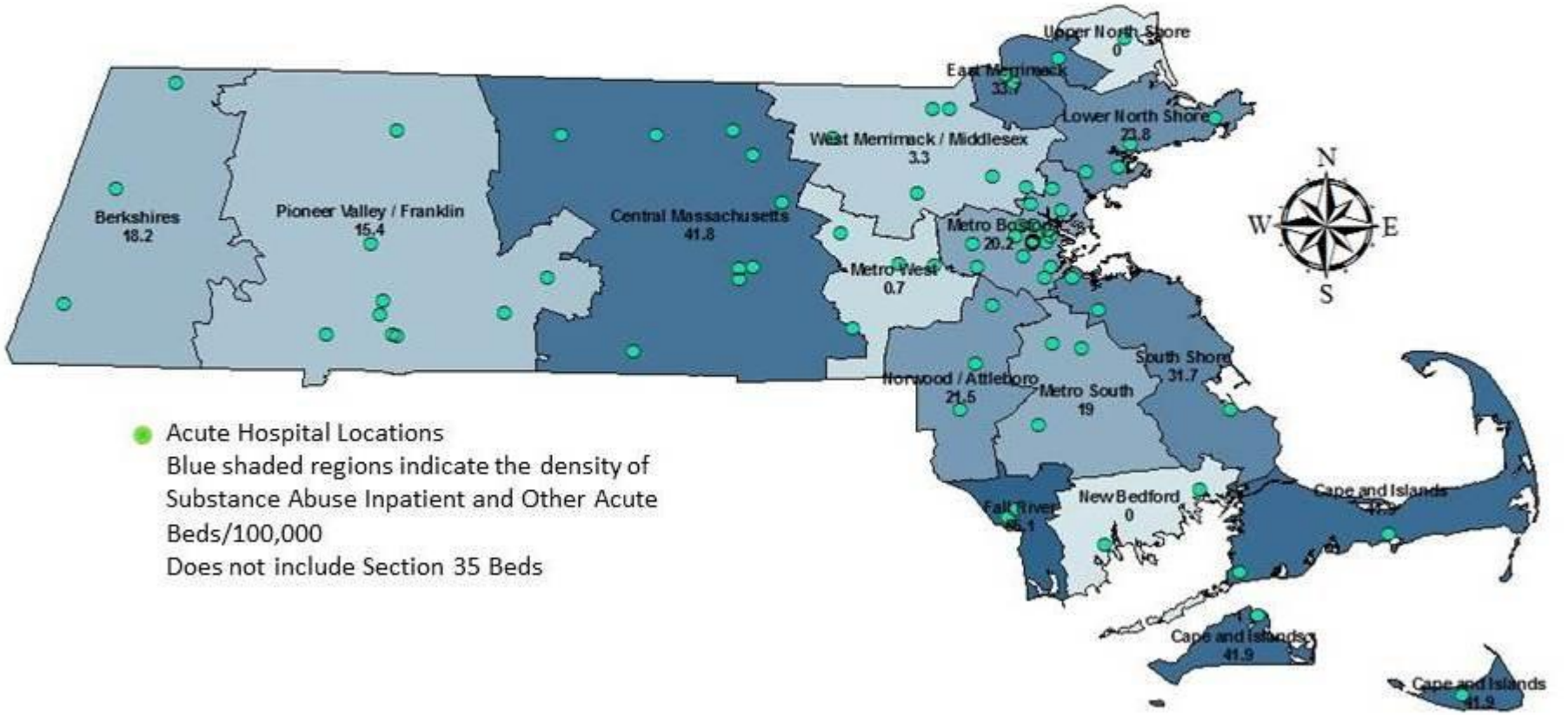
Section 35 CSS beds:

K - Metro South	76	5,554,121	1
N - New Bedford	66	5,554,121	1
Total	**142**	**5,554,121**	**3**

Note: Data as of March 27, 2014. Numbers may not sum to total due to rounding. Census data is 2010.
Note: The Section 35 beds listed on this table are CSS beds and represent only a portion of the beds funded by DPH. This data is as of May 5. 2014.

Map: Inpatient and Other Acute SA Services

Substance Abuse Inpatient and Other Acute Beds per 100,000:
Medically Managed, Medically Monitored, and Clinical Stabilization Services by Region, 2014



Transitional Support Substance Abuse Services

Transitional Support Services Beds by Region, 2014

Region	Beds	Population (≥13 y.o)	Beds per 100,000
A - Berkshires	0	115,642	0
B - Pioneer Valley/Franklin	27	583,165	5
C - Central Mass	72	617,789	12
D- West Merrimack/Middlesex	0	520,171	0
E - East Merrimack	0	225,494	0
F - Upper North Shore	0	55,053	0
G - Metro West	0	306,636	0
H - Metro Boston	71	1,336,899	5
I - Lower North Shore	25	331,980	8
J - Norwood/Attleboro	0	269,678	0
K - Metro South	0	337,324	0
L - South Shore	60	350,397	17
M - Fall River	0	121,612	0
N - New Bedford	36	167,586	21
O - Cape and Islands	0	214,695	0
Total Statewide	**291**	**5,554,121**	**5**

Note: Data as of March 27, 2014. Numbers may not sum to total due to rounding. Census data is 2010.

Note: This list includes beds that are made priority for Section 35 court-ordered treatment.

Commonwealth of Massachusetts
Department of Public Health

Residential Rehabilitation Substance Abuse Services

Total Residential Beds and Capacity to Serve Families by Region, 2014

Region	*Adults*			Beds			Calculation		Capacity to Serve Families
	Male	*Female*	*Co-Ed*	Adults	Transitional Age and Adolescents	Both	Population (≥13 y.o)	Total Beds per 100,000	
A - Berkshires	*0*	*0*	*24*	24	0	24	115,642	21	0
B - Pioneer Valley/Franklin	*113*	*65*	*47*	225	16	241	583,165	41	21
C - Central Mass	*163*	*97*	*164*	424	33	457	617,789	74	12
D- West Merrimack/Middlese	*0*	*40*	*18*	58	26	84	520,171	16	15
E - East Merrimack	*15*	*15*	*0*	30	0	30	225,494	13	0
F - Upper North Shore	*20*	*0*	*0*	20	0	20	55,053	36	0
G - Metro West	*33*	*35*	*0*	68	0	68	306,636	22	22
H - Metro Boston	*586*	*181*	*60*	827	45	872	1,336,899	65	34
I - Lower North Shore	*0*	*28*	*40*	68	15	83	331,980	25	0
J - Norwood/Attleboro	*146*	*0*	*0*	146	0	146	269,678	54	0
K - Metro South	*0*	*23*	*0*	23	0	23	337,324	7	0
L - South Shore	*72*	*0*	*0*	72	0	72	350,397	21	0
M - Fall River	*23*	*30*	*0*	53	0	53	121,612	44	0
N - New Bedford	*47*	*55*	*0*	102	0	102	167,586	61	0
O - Cape and Islands	*28*	*38*	*0*	66	0	66	214,695	31	13
Total Statewide	*1246*	*607*	*353*	**2206**	**135**	**2341**	**5,554,121**	**42**	**117**
	56%	*28%*	*16%*	**100%**					

Note: Data as of March 27, 2014. Numbers may not sum to total due to rounding. Census data is 2010.

Opioid Treatment Services
Substance Abuse Services

Opioid DPH-Licensed Treatment Programs and Office-Based DPH-Funded Treatment Programs, 2014
This list does not include satellites.

Region	Opioid Treatment Programs, Licensed by DPH, (methadone programs)	Office-Based Opioid Treatment Programs, Funded by DPH (suboxone programs)	Both program types
			Number
A - Berkshires	1	0	1
B - Pioneer Valley/Franklin	6	2	8
C - Central Mass	4	1	5
D- West Merrimack/Middlesex	1	1	2
E - East Merrimack	1	1	2
F - Upper North Shore	0	0	0
G - Metro West	2	0	2
H - Metro Boston	8	6	14
I - Lower North Shore	4	1	5
J - Norwood/Attleboro	0	0	0
K - Metro South	3	0	3
L - South Shore	0	0	0
M - Fall River	2	1	3
N - New Bedford	3	0	3
O - Cape and Islands	1	1	2
Total Statewide	**36**	**14**	**50**

Note: Data as of March 27, 2014. Numbers may not sum to total due to rounding. Census data is 2010. This is a partial list of the opioid treatment programs in Massachusetts, based on programs either licensed or funded by DPH. DPH licenses opioid treatment programs providing methadone treatment, but does not license OBOT programs. There are 72 OBOT programs licensed in MA. DPH funds 14.
611 physicians have waivers to prescribe buprenorphine/suboxone used in OBOT.
Not all certified physicians may be actively treating patients with buprenorphine and/or be accepting patients.

See http://buprenorphine.samhsa.gov/bwns_locator/dr_facilitylocatordoc.htm

Analysis Plan for Utilization Data

Proposed Approach for BH analysis

Utilization Metrics

- Setting of care
  - During an inpatient stay based on stay dates
  - Outside of inpatient stay dates
- Measures
  - Days of stay
  - Episodes/Admissions
  - Encounters – unduplicated days-provider type-patient ID counts for outpatient services
  - Users of services

Organization of Tables by Patient Type

- Demographics
- Region and region characteristics
- Administrative/Payor status
- BH condition flags
- Utilization flags

5 Overarching Findings from Interviews and RFI

The following 5 points summarize the stakeholder input:

1. Compared to public payors, commercial insurers currently provide more limited coverage of residential recovery or treatment and other community services for mental health and substance abuse care.
2. Patient access to an optimal continuum of mental health and substance abuse care is seriously reduced by the limited capacity of residential and community care and of some types of inpatient care.
3. Low payment rates and funding are reported to adversely affect system capacity and access.
4. Divided responsibilities and a lack of statewide planning capacity have inhibited comprehensive understanding and improvement of behavioral services.
5. Data sources available to document the extent of the unmet demand for community services are in need of further development

What's Next for Health Planning…

- Next up:
  - Post-Acute Care
  - PCI
  - Trauma

Commonwealth of Massachusetts
Department of Public Health

2013 – 2014: Timeline

	Oct. 2013	Nov. 2013	Dec. 2013	Jan. 2014	Feb. 2014	Mar. 2014	Q2 2014	Q3 2014	Q4 2014
Council Meetings	Strategic Plan Presented	Check point	Check point	First deliverables reviewed					
Advisory Committee Meetings		Strategic Plan Presented	Check point	First deliverables reviewed					
Deliverable 1: Analytic Outline, Service Line Maps				✦					
Deliverable 1 Complete				Deliverable 1 submitted					
Deliverable 2: Key Definitions									
Deliverable 2 Complete						Deliverable 2 submitted			
Deliverable 3: Level III Analysis									
Public Hearing on Deliverable 3								Public Hearing	
Deliverable 3 Complete									Deliverable 3 Complete

✦ = delayed by one month due to missing the November meeting

Agenda

- Approval of Minutes
- Executive Director Report
- Presentation by the Division of Insurance on Mental Health Parity
- Update on Registration of Provider Organizations Program
- Presentation by the Department of Public Health on Health Resource Planning
- **Schedule of Next Meetings (August 13)**

Contact information

For more information about the Health Policy Commission:

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