MINUTES OF THE QUALITY IMPROVEMENT AND PATIENT PROTECTION COMMITTEE

Meeting of August 13, 2014

MASSACHUSETTS HEALTH POLICY COMMISSION

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

Docket: Wednesday, August 13, 2014, 9:30 AM – 10:30 AM

PROCEEDINGS

The Massachusetts Health Policy Commission's Quality Improvement and Patient Protection (QIPP) Committee held a meeting on Wednesday, August 13, 2014 in the Daley Room at the Center for Health Information and Analysis located at Two Boylston Street, 5th Floor, Boston, MA 02116.

Committee members present were Ms. Marylou Sudders (Chair), Dr. Carole Allen, Dr. Wendy Everett, and Dr. Ann Hwang, designee for Mr. John Polanowicz, Secretary of Health & Human Services.

Ms. Veronica Turner was absent.

Ms. Sudders called the meeting to order at 9:32 AM.

ITEM 1: Approval of minutes

Ms. Sudders asked for any changes to the minutes from the June 11, 2014 meeting. Seeing none, Ms. Sudders called for a motion to approve the minutes as presented. Dr. Hwang made the motion, and Dr. Allen seconded. Members voted unanimously to approve the minutes.

ITEM 2: Update on Nurse Staffing Law

Ms. Sudders reviewed the day's agenda. She stated that the Committee would receive an update on the HPC's 2014 behavioral health initiatives and the HPC's new responsibilities pertaining to nurse staffing in intensive care units.

Ms. Sudders introduced Mr. David Seltz, Executive Director. Mr. Seltz stated that on June 30, 2014 Governor Patrick signed legislation that establishes a nurse-to-patient staffing ratio of 1:1 or 1:2 in hospital intensive care units (ICUs). The ratio depends on stability of the patient as assessed by an acuity tool developed or selected by the hospital, staff nurses, or nurse manager or their designee. Mr. Seltz noted that the HPC is charged with promulgating regulations on the formulation of an acuity tool, a method of public reporting of hospital compliance, and identification of three to five related patient safety quality

indicators to be measured and publicly reported by hospitals. The tool will be certified by the Department of Public Health (DPH).

Ms. Sudders stated that the HPC would hold a public listening session to glean information on the formulation of the regulation and the development of the acuity tool.

Dr. Hwang stated that background research would be extremely important to ensure that work is not being duplicated in different agencies across the state. She noted that certain quality measures are already reported to DPH and the federal government.

Dr. Everett asked for clarification on the intent of the legislation and the role of the QIPP committee. Mr. Seltz stated that the agency's role is to conduct research and issue the acuity tool on quality metrics in coordination with the HPC's certification of accountable care organizations (ACOs).

Dr. Everett stated that the HPC should examine the work of the Society of Critical Care Medicine (SCCM) on this issue.

Mr. Seltz reviewed next steps. He stated that the HPC would perform significant background research and analysis, host a series of stakeholder meetings and listening sessions, and enter a full regulatory process with a public comment period.

Ms. Sudders stressed the importance of stakeholder engagement and public comment.

ITEM 3: Discussion of the HPC's 2014 Behavioral Health Agenda

Mr. Seltz reviewed the HPC's 2014 behavioral health agenda. He stated that Chapter 224 set a broad vision for a more affordable, effective, and accountable health care system in Massachusetts. He noted that the successful integration of behavioral health care is essential for achieving these goals. He added that the HPC plays a prominent public role in providing a forum for discussion of barriers to and opportunities for behavioral health integration. Mr. Seltz reviewed the HPC's six-pronged behavioral health agenda.

The HPC will promote integrated care models through investment. Mr. Seltz stated that many projects in the $10 million CHART Phase 1 focused on behavioral health integration. He stated that the CHART Phase 2 request for proposals (RFP) calls for investments to enhance behavioral health care. He noted that the HPC received $153 million in total funding requests from hospitals for CHART Phase 2 and plans on dispersing $60 million in the fall. Mr. Seltz stated that many of the Phase 2 proposals have a behavioral health focus.

Mr. Seltz stated that the patient-centered medical homes (PCMH) program offered another approach to promoting integrated care models through investment. He stated that the HPC received $2 million in the FY15 state budget to accelerate the progress of the integration of behavioral health through the PCMH initiative. He stated that the appropriation language gives the HPC a great deal of flexibility in developing this program. Mr. Seltz added that the

$2 million allocation could be carried over into the next fiscal year, but that the HPC would work to ensure these funds be used effectively as soon as possible.

Ms. Sudders stated that the appropriation of these funds represents an acknowledgement from the Legislature on the need to address substance abuse and behavioral health issues. She added that these funds could be used to address emergency department (ED) boarding through the development of patient referral and tracking systems. Ms. Sudders added that the HPC could also examine integrated implementation models, pointing to the Lynn Community Health Center as an example.

Dr. Allen stated that capacity mapping is necessary in order to inform patient referral and tracking systems. She added that coordination with the Health Planning Council should be of great importance. Dr. Hwang stated that the materials developed by the Health Planning Council could be used as a starting point to inform further work.

Dr. Everett stated that the HPC should examine and synthesize national innovation and implementation strategies to help providers adopt best practices.

Dr. Hwang reviewed existing resources, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) tool kit and the primary care payment reform (PCPR) initiative. She stated that the HPC should talk to practices that have successfully integrated as well as those that have not to identify best practices and barriers.

Mr. Seltz stated that the HPC could perform qualitative interviews to gather this information. He added the greatest way to create value out of this program would be to develop learning tools that could extend to all practices interested in this initiative. He noted that the HPC is already engaged in this type of work through the CHART program. Mr. Seltz also stated that the HPC would collaborate with other state agencies to avoid duplicate work.

Mr. Seltz introduced Jingying Yang, Senior Policy Associate for Research and Cost Trends, to present behavioral health findings and recommendations from the Cost Trends Report: July 2014 Supplement.

Ms. Yang noted that the 2013 Cost Trends Report found that spending for patients with comorbid behavioral health and chronic medical conditions was 2.0 to 2.5 times as high as spending for patients with only a chronic medical condition. She stated that the HPC further examined this issue and found that higher spending for patients with behavioral health conditions is concentrated in intense care settings, such as emergency departments (ED) and inpatient facilities. Ms. Yang added that the costs of treating medical conditions rise when a patient has a behavioral health condition. She noted that both of these findings suggest opportunities to improve care and reduce overall long-term costs through a focus on integrated care.

At this point, Ms. Sudders excused herself from the meeting.

Ms. Yang reviewed findings on the difference in spending between patients with and without behavioral health conditions. She noted that findings in the commercial market demonstrate that the majority of spending differences come from inpatient and professional settings. For Medicare patients, there is an average of $12,000 more in spending per person concentrated for ED use and inpatient care.

Dr. Allen asked why spending for inpatient long-term care is so much higher for this population. Ms. Yang responded that this is a question the HPC would like to examine further. She added that early hypotheses indicate that having comorbidity can make the management of medical conditions more difficult, especially for the Medicare population, which has a more complex set of treatment.

Dr. Hwang asked if dementia was included as a behavioral health condition. Ms. Yang stated that it was not.

Ms. Yang stated that patients with behavioral health conditions had medical expenditures across payer type. She stated this data supported an original hypothesis that the Medicare over-65 population is often the most at-risk for higher cost and more complex treatment due to behavioral health comorbidity.

Dr. Hwang asked if there is a higher baseline for behavioral health condition spending reflected in this data set. Ms. Yang stated there is.

Dr. Everett stated the long-term care issue is very prominent across the Cost Trends Reports. She stated it would be interesting to see a comparison of chronic conditions to behavioral health conditions in order to determine if behavioral health costs are the driving factor behind high long-term care costs.

Dr. Hwang requested that the data be further analyzed to identify whether there are particular diagnostic-related groups that drive spending more than others.

Ms. Yang reviewed data regarding ED boarding. The report found that behavioral health diagnoses account for only 6% of all ED visits in Massachusetts, but represent 47% of visits resulting in ED boarding. She noted ED boarding is defined here as more than twelve hours in the ED without discharge.

Dr. Everett asked whether this data generally reflected behavioral health conditions without comorbidity. Ms. Yang stated this is correct.

Ms. Yang reviewed recommendations from the Cost Trends Report: July 2014 Supplement: (1) encouraging hospitals to optimize the use of post-acute services, (2) offering incentives to providers and payers to increase integration of behavioral health and primary care, (3) supporting the provision of behavioral health services in primary care settings through PCMH and ACO certification programs, and (4) convening of state agencies to increase transparency in data regarding behavioral health.

Mr. Seltz noted that the Legislature has recognized a lack of coordination on data collection for behavioral health and established a task force specifically charged with examining how to improve this. He noted that the HPC does not play a role in this task force, but that he has spoken with CHIA to encourage a robust conversation about data collection.

Dr. Everett stated that she would like to see what individual hospitals are doing about ED boarding issues to encourage the creation of best practices. Mr. Seltz stated that CHART Phase 1 had specific initiatives to address ED boarding at individual hospitals.

Mr. Seltz stated that the HPC is continuing to advance its analysis of the All-Payer Claims Database (APCD).

Mr. Seltz asked for any additional questions on the HPC's research on behavioral health integration. Seeing none, he summarized the HPC additional behavioral health initiatives.

Mr. Seltz reviewed the HPC's responsibility under substance abuse legislation recently signed into law by the Governor. He noted the legislation charges the HPC with producing policy recommendations. These recommendations would be informed by CHIA's review of the accessibility of substance use disorder treatment and the adequacy of insurance coverage for such treatment. He stated that the law further requires that the HPC hold a series of hearings on this particular issue.

Mr. Seltz reviewed the HPC's work in protecting patient access to necessary care through the Office of Patient Protection (OPP). He introduced Ms. Jenifer Bosco, Director of the Office of Patient Protection, to present on OPP's work.

Ms. Bosco noted that between January 1, 2014, and June 30, 2014, OPP received 147 requests for external reviews. She noted that 119 of those requests were eligible for external review. Of the eligible cases, 58% were upheld and the rest were resolved fully or partly in favor of the consumer, , which is consistent with past years.

Dr. Everett asked Ms. Bosco to distinguish between when cases are "upheld" and "resolved". Ms. Bosco stated that "resolved" refers to cases in which the carrier and patient are able to address the issue after the external review process has begun.

Ms. Bosco reviewed external reviews for medical and surgical appeals. She stated that the first six months of 2014 have had a higher percentage of behavioral health external reviews than in prior years. Ms. Bosco reviewed the categories of services under examination in behavioral health. She stated that mental health designation refers to conditions where there is not a primary diagnosis of substance abuse, eating disorder, or developmental delay/autism.

Ms. Bosco provided an update on the overall operation of the OPP. She stated the OPP has been engaging consumers and providers to inform them of their rights and responsibilities. She noted the OPP is nearing the end of a database upgrade that will enable the office to

gather additional data on external review. She added that the OPP has added staff to assist with overall operations and updated, multi-lingual resources.

Dr. Everett asked if the OPP analyzes aggregate data about the scope and nature of the problem that must be resolved. She clarified that it would be helpful to see if these are issues of access to a provider, access to medication, or denial of services. Dr. Hwang stated this could be done through clarification of whether it was inpatient or outpatient service. Dr. Allen added it could examine network adequacy. Ms. Bosco responded that the new database will allow OPP to analyze this type data.

Mr. Seltz commended Ms. Bosco and the OPP on their extensive work in all these areas.

ITEM 4: Schedule of Next Committee Meeting (October 29, 2014)

Dr. Everett announced the next meeting of the Quality Improvement and Patient Protection Committee (October 29, 2014) and adjourned the meeting at 10:34 AM.