MINUTES OF THE CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION COMMITTEE

Meeting of December 9, 2015

MASSACHUSETTS HEALTH POLICY COMMISSION

THE CARE DELIVERY AND PAYMENT SYSTEM TRANSFORMATION COMMITTEE OF THE MASSACHUSETTS HEALTH POLICY COMMISSION
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA

Docket: Wednesday, December 9th, 2015, 9:30AM

PROCEEDINGS

The Massachusetts Health Policy Commission's (HPC) Care Delivery and Payment System Transformation (CDPST) Committee held a meeting on Wednesday, December 9, 2015, at the HPC's offices, 50 Milk Street, 8th Floor, Boston, MA.

Members present included Dr. Carole Allen (Chair), Dr. Paul Hattis, Mr. Martin Cohen, Dr. David Cutler, and Undersecretary Alice Moore, designee for Ms. Marylou Sudders, Secretary of Health and Human Services.

Dr. Allen called the meeting to order at 9:31 AM.

ITEM 1: Approval of minutes

Dr. Allen asked for a motion to approve the minutes from November 12, 2015. **Dr. Cutler** made the motion to approve the minutes. **Undersecretary Moore** seconded the motion. The members present voted unanimously to approve the minutes.

ITEM 2: Patient-Centered Medical Home Certification (PCMH)

Dr. Allen laid out the agenda for the day's meeting and introduced Ms. Katie Shea Barrett, Policy Director for Accountable Care.

Ms. Barrett noted that Ms. Sarah Lee, a program manager from NCQA, would join the meeting via phone to answer technical questions regarding PCMH certification.

Ms. Barrett explained that the meeting would focus on documentation requirements for new HPC factors for PCMH certification rather than pre-existing NCQA elements. She noted that, in order to meet the January 1, 2016 deadline for program launch, NCQA has already integrated the language and details that will be presented to the committee into its database. Ms. Barrett stated that the HPC could update these standards for the March 2016 NCQA release.

Ms. Katherine Record, Deputy Director of Accountable Care and Behavioral Health Integration, reviewed the PCMH PRIME criteria. She noted that practices must meet seven of the 13 criteria to achieve PCMH PRIME.

Ms. Record reviewed a change made to the HPC's medication-assisted treatment (MAT) criteria. Following the discussion at the November 18 board meeting, HPC will give certification credit to providers who prescribe any MAT, not just providers who prescribe buprenorphine.

Ms. Barrett stated that the HPC and NCQA have been working collaboratively to create documentation requirements for each of the criteria. She stated that there are eight existing NCQA criteria for PCMH PRIME. She noted that the HPC will use existing NCQA documentation requirements for these criteria.

Ms. Barrett stated that there are five new HPC criteria for which the agency has been working to define documentation requirements. She explained that the HPC used existing NCQA methodologies to structure its documentation requirements for the new PCMH certification criteria. She noted that this would help providers as they are already familiar with the documentation processes.

Ms. Record reviewed the proposed documentation requirements for each of the PCMH PRIME criteria:

1) *Coordination with behavioral health providers*.
   Ms. Record explained that criterion recognizes that practices are on a continuum of integration. She stated that a practice will receive credit if it is co-located with behavioral health providers or has a memorandum of understanding (MOU) with them.

   Ms. Record explained that practices must provide at least one example of a formal agreement (e.g., MOU) or a list of behavioral health providers (names and credentials) who work in the same physical location (e.g., provider address) to receive credit for this criterion.

2) *Integration with behavioral health providers.*
   Ms. Record noted that practices must provide a list of behavioral health providers and their position and role within the practice site to meet this requirement.

3) *Assessment: behavioral health history of patient and family.*
   Ms. Record noted that the HPC will use NCQA's requirements for the documentation of this criterion. She stated that, to meet this requirement, NCQA reviews a report generated by the practice, which includes a ratio of patients assessed in a recent three month period.

   Dr. Allen asked for clarification on the ratio's denominator. Ms. Barrett replied that it is all unique patients seen by the practice in a three month period.

   Dr. Allen asked for clarification on the ratio's numerator. Ms. Record responded that the numerator is all patients who have their behavioral health history assessed by

the practice. She noted that the assessment must be evidence-based, but the frequency at which it is completed is determined by the practice.

Ms. Lee noted that NCQA recognizes that not all practices have the capacity to generate a report of this nature and thus accepts other methods of documentation if they provide comparable results.

4) *Assessment: developmental screening.*
Ms. Record noted that the HPC will use NCQA's requirements for the documentation of this criterion.

Dr. Allen asked whether the development screening is only required of practices that see pediatric patients. Ms. Record responded in the affirmative.

5) *Assessment: depression screening.*
Ms. Record noted that the HPC will use NCQA's requirements for the documentation of this criterion.

6) *Assessment: anxiety screening.*
Ms. Record explained that this is a new factor created by the HPC for PCMH PRIME. She stated that practices are free to choose any standard anxiety screening tool, but must submit information to NCQA to demonstrate that it is evidence-based. Ms. Record noted that practices must also report a ratio of patients screened to total unique patients seen in a three month period. She added that there is no prescriptive ratio that practices much reach to achieve this criterion.

Dr. Allen asked how practices can differentiate between the various types of screenings so that they receive credit for the specific type of screening performed. Ms. Lee replied that NCQA works with practices to ensure that they receive credit for the screenings performed through an electronic reporting method or a sampling of patient charts.

Ms. Barrett noted a potential concern that practices are actually screening patients who need it. She stated that the HPC could update the technical language such that the denominator is only patients who need to be screened and not all patients seen by the practice. Ms. Barrett stated that the purpose of the criterion was to incentivize primary care practices to screen more patients.

Dr. Allen noted potential logistic issues with the screenings. She asked HPC staff to consult with stakeholders to better understand the implementation of such a criterion. Ms. Record commented that the HPC staff could do additional outreach to stakeholders to ensure that they are comfortable using the new reporting codes for screenings.

Ms. Barrett noted that practices do not have to meet all of the criteria in order to be certified, only seven out of 13.

Ms. Record noted that the HPC is working on the details of technical assistance grants that will be provided to the practices to facilitate the integration of behavioral health care.

7) *Assessment: substance use disorder screening.*
Ms. Record explained that this is a new HPC factor. She stated that the practice must show that it is using a validated tool to screen for substance use disorder. She noted the documentation requirements for this criterion closely mirrors those for anxiety screening.

8) *Assessment: post-partum depression screening.*
Ms. Record noted that this is a new HPC criterion. She stated that it differs from the other screening requirements because it only applies to family practices, PCPs whose patients recently gave birth, and pediatric practices whose patients include new mothers. She added that the practice may select any validated, evidence-based tool to conduct the screen.

9) *Behavioral health referrals.*
Ms. Record explained that this is a NCQA requirement which requires practices to demonstrate that they have a system for flagging and following up on referrals.

10) *Evidence-based decision support.*
Ms. Record noted that this is a modified NCQA factor that requires practices to implement clinical decision support (e.g. point-of-care reminders) following evidence-based guidelines for a mental health condition *and* substance use disorder.

Dr. Allen asked if substance abuse includes tobacco. Ms. Record replied that tobacco use does not fall under substance use, but that it would be included in a patient's medical history under behaviors affecting health.

11) *Identifying patients for care management.*
Ms. Record explained that this NCQA factor requires practices to establish a process for identifying patients who may benefit from care management.

12) *Treatment for opioid addiction.*
Ms. Record noted that this new HPC factor requires that one or more providers in a practice are actively treating patients suffering from addiction with MAT, appropriate counseling, and behavioral therapies (directly or via referral).

Ms. Record stated that providers will meet this criterion if they use any approved MAT. Practices must send NCQA a scanned copy of the certification letter showing they are licensed to prescribe buprenorphine or a de-identified screenshot showing evidence of a naltrexone prescription.

13) *Care manager qualifications.*
    Ms. Record highlighted that this is a modified NCQA factor which requires practices to have at least one care manager who is trained to coordinate behavioral and physical health needs. She added that the requirement was intentionally non-prescriptive.

Dr. Cutler noted that there is no requirement that a PCP is notified if their patient is brought to the emergency room suffering from an overdose. Ms. Record responded that such a capability could be developed in future iterations of the certification process. Ms. Barrett noted that such a capability might be easier to technically implement through ACO certification.

Ms. Catherine Harrison, Senior Manager for Accountable Care, discussed the operational plan for PCMH certification. She noted that work is ongoing to meet the HPC PCMH PRIME program launch date of January 1, 2016. She stated that the HPC will have an opportunity to update the technical platform in March 2016.

Ms. Harrison stated that the HPC is continuing work with NCQA to operationalize the technical aspects of certification. She noted that the HPC is actively seeking a consultant to assist with marketing and communications functions. Ms. Harrison explained that the consultant would be expected to produce materials by March 2016, but noted that the HPC and NCQA would release communications on the PCMH PRIME program prior to that point.

Ms. Harrison noted that work is currently underway to assess what type of technical assistance practices may need to meet the PCMH PRIME criteria. She explained that the HPC has released survey to garner feedback.

Ms. Harrison noted that, in the coming months, NCQA will reach out to certain practices with which they have a pre-existing relationship (e.g. practices that already have some level of NCQA recognition) to inform them of the opportunity to apply for PCMH PRIME. She added that the HPC has already received inquiries from practices that are interested in learning more about PRIME.

Mr. Cohen asked for clarification on the marketing and communications consultant work. Ms. Harrison replied that the firm would produce marketing materials that are enticing and highlight the value of pursuing PRIME. Ms. Barrett commented that a major tool in enhancing the reach of PRIME is working closely with NCQA to build off of their established reputation.

Ms. Harrison noted that NCQA will develop trainings to inform practices on the PRIME certification program, its documentation requirements, and the application process. She added that the HPC is developing an internal process to receive and score PRIME applications once they have been evaluated by NCQA.

Ms. Harrison provided an overview of how a practice navigates the PRIME certification process. She highlighted two hypothetical examples: (1) a practice that is already NCQA

recognized and applying for PRIME and (2) a practice who is also applying for NCQA and PRIME recognition. Ms. Harrison highlighted that the major differences between the two examples is how a practice would initially enter the certification pipeline. She noted that a practice that already has NCQA recognition would need to sign an application with the HPC stating that they are agreeing to go through the PRIME process. In return the HPC would grant them "HPC Certification," which means that the practice is committed to the process.

Undersecretary Moore asked for clarification on the benefit of a practice receiving "HPC Certification." Ms. Harrison replied that it allows a practice to generate public awareness of its behavioral health integration efforts.

Mr. Cohen asked whether the HPC or NCQA would notify a practice of their PRIME status. Ms. Barrett responded that this notification would come from the HPC.

ITEM 3: ACO Public Comment Update

Ms. Barrett provided an update on public comment for certification standards relative to the HPC's ACO Certification Program. She explained that draft ACO certification criteria will be released for public comment by the end of the day on the HPC's website. She noted that the public comment period ends in late January 2016. Ms. Barrett noted that the January 6, 2016 CDPST meeting will serve as a public hearing on the draft criteria.

Dr. Cutler asked whether organizations were planning on offering comments at the hearing. Ms. Barrett replied in the affirmative.

ITEM 4: Preliminary Findings from the 2015 Cost Trends Report

Dr. Marian Wrobel, Director of Research and Cost Trends, introduced the preliminary findings from the 2015 Cost Trends Report. She noted that the day's meeting would focus on two findings: emergency department usage and alternative payment methodologies (APMs).

Dr. Huong Trieu, Senior Researcher, reminded the committee of the 2014 Cost Trends Report findings relative to emergency department (ED) utilization. She stated that ED use is relatively high in Massachusetts and varies strongly by region, income level, and insurance coverage. She added that avoidable ED visits accounted for almost half of all ED visits in 2014. Dr. Trieu explained that the 2014 Cost Trends Report identified methods to reduce avoidable ED use by coordinating care, advancing clinical integration across settings, and caring for patients in community settings.

Dr. Trieu highlighted that, in the 2015 Cost Trends Report, the HPC found that total ED use declined in 2014 to just below 2010 levels. The HPC also found that avoidable ED use has declined.

Dr. Trieu noted that, while overall use declined, behavioral health-related ED utilization increased by 24% from 2010 to 2014. She explained that certain regions of the state

experienced even sharper growth in behavioral health-related emergency department use. She added that, for pediatric patients, over 50% of long-stay ED visits (at least 8 hours) were related to a mental health condition. Dr. Trieu stated that greater access to after-hour care options is strongly associated with lower ED use.

Dr. Allen asked whether the HPC found an increase in behavioral health-related visits to primary care providers (PCPs) and other non-ED medical locations. Dr. Trieu responded that the number of behavioral health-related visits across sites of care has grown while the overall number of ED visits has declined slightly. Dr. Allen asked for clarification on the drivers of increased behavioral health-related visits. Dr. Wrobel replied that it is an important questions, but one that the HPC has not yet been able to address directly.

Dr. Trieu explained that the slight drop in ED visits in 2014 could be partially explained by the increased level of insurance coverage as a result of the Affordable Care Act and Medicaid expansion.

Dr. Cutler asked what share of behavioral health ED visits are necessary and appropriate. Dr. Trieu replied that the HPC did not disaggregate the behavioral health data to that level.

Mr. Cohen asked what percent of ED visits were for emergency psychiatric patients. Dr. Trieu responded that, of the seven percent of ED visits related to behavioral health, 61% were mental health related, six percent were substance abuse related, and 33% were alcohol related. Dr. Trieu explained that the categorization of ED visit is based only on the ED primary diagnosis. She predicted that, once information on secondary diagnoses becomes available, the number of ED visits associated with substance abuse and mental health will increase.

Mr. David Seltz, Executive Director, noted that the HPC is pursuing an analysis on opioid and heroin related ED visits. He explained that early results are consistent with other reports on the opioid crisis and show a striking increase in visits from 2010 to 2014.

Dr. Cutler commented that there might be areas in the state where the opioid crisis is pronounced, but has not translated to higher behavioral health-related ED usage. If such areas exist, there could be lessons learned from them.

Ms. Trieu reviewed a regional analysis of behavioral health-related ED visits. She highlighted that the growth in behavioral health-related ED visits skyrocketed in certain regions in the Commonwealth, noting that Fall River and New Bedford saw respective increases of 53% and 48%.

Dr. Allen asked staff to create a similar map that demonstrates the location of Massachusetts behavioral health providers. Dr. David Auerbach, Deputy Director for Research and Cost Trends, stated that there is a striking relationship between areas of the state that have fewer behavioral health providers and areas of the state that have high behavioral health ED usage.

Dr. Trieu discussed findings relative to ED boarding, or ED stays that last for at least eight hours. In 2014, over 60% of long-stay ED visits for children aged 10-14 and over 50% for ages 15-19 were mental health-related. She added that over 80% of children aged 10-14 who were in the ED for greater than 24 hours had a mental health-related diagnosis.

Dr. Trieu noted that a small number of patients account for a large share of ED visits. She explained that, in 2014, seven percent of patients accounted for 33% of ED visits, with each patient visiting the ED five or more times. She noted that behavioral health-related issues were more prevalent among this seven percent of patients.

Undersecretary Moore asked how the HPC determined that behavioral health-related issues were more prevalent among this seven percent of patients. Dr. Trieu responded that the HPC examined the primary diagnosis for the frequent population and non-frequent population. She noted that alcohol and mood disorders were among the top ten conditions for those individuals in the seven percent. Undersecretary Moore asked for a full list of the ten conditions.

Dr. Auerbach discussed factors that could contribute to the increase in behavioral health-related ED visits, specifically access to after-hours care. He noted that survey data from CHIA found that 60% of state residents said their last ED visit took place because they could not get an appointment at a doctor's office or clinic as soon as they needed.

Dr. Auerbach highlighted that the prevalence of retail and urgent care clinics has grown in recent years, in part due to the unmet need of after-hours care. He noted that a majority of Massachusetts residents now live within five miles of an urgent care or retail clinic.

Dr. Allen asked how many of the urgent care or retail clinics are equipped to deal with behavioral health issues. Dr. Auerbach replied that he was unsure of how well the clinics could deal with such issues. Mr. Cohen commented that he does not believe that they are well equipped. He added that this speaks to the issues of access to behavioral health care.

Dr. Cutler asked whether an increase in the supply of behavioral health providers would lead to a decrease in behavioral health-related ED visits and/or an increase in general access to behavioral health care. Undersecretary Moore noted that DPH, DMH, and MassHealth are examining data to better understand this issue.

Mr. Seltz commented that the HPC has completed an analysis on the location of behavioral health providers and the number of behavioral health-related ED visits. The HPC found that there are fewer behavioral health-related ED visits in areas where there are more behavioral health providers. He noted the limitations in determining the location of all behavioral health providers.

Dr. Auerbach highlighted that patients who live within five miles of an urgent care or retail clinic are 30% less likely to use the ED than patients who do not live within five miles of such a facility.

Dr. Allen noted that retail and urgent care clinics are more likely to be located in areas with higher income levels. Dr. Auerbach acknowledged this and added that the HPC has run regressions that control for income level and still found the effect to be present.

Dr. Cutler asked whether the HPC could determine what percentage of people seeking care outside of normal business hours are seeking the care for a behavioral health condition. Dr. Auerbach replied that CHIA's survey may not contain that depth of information. Dr. Trieu noted that the HPC could discuss such questions with CHIA as it prepares its 2016 household survey.

Dr. Wrobel reminded the committee of the role of APMs. She stated that the 2014 Cost Trends Report recommended that (1) all payers should use APMs for 60% of HMO lives in 2016; (2) the coalition which formed around a shared attribution method should expand to include more members; and (3) all coalition members should begin introducing APMs into PPO in 2016, with goal of reaching one third of PPO lives in that year.

Dr. Wrobel noted that the 2014 growth in APMs was small – increasing from 35% (2013) to 37% (2014). She explained that the growth reflected increases in APMs in the commercial market, MassHealth PCC, and original Medicare. She stated that this growth was offset by decreases in Medicare Advantage and MassHealth MCO.

Dr. Wrobel highlighted that the major commercial payers have many of their HMO and few of their PPO members in APMs. She noted that Blue Cross Blue Shield of Massachusetts announced that it would be expanding APMs into its PPO market.

Ms. Katie Shea Barrett, Policy Director for Accountable Care, noted that Tufts/Network Health was the only plan to have a significant share of its PPO members in an APM. She explained that this was because of a shift in GIC plans.

Dr. Wrobel reviewed possible recommendations for discussion.

Dr. Cutler commented that the research shows several positive signs, for example that APMs are expanding. He noted, however, that there are two issues that should be of importance to the HPC: (1) technical issues of alignment and (2) bundled payments. He added that, as Medicare starts releasing mandatory bundled payments, it will open the door for all payers to start exploring this APM. He noted that Massachusetts should explore ways to move forward with this.

Dr. Wrobel noted that there have not been many signs of movement, outside of Medicare, in terms of bundled payments.

Ms. Barrett stated that the HPC needs guidance from commissioners on the agency's role in technical issues of alignment. Dr. Cutler responded that the HPC should act as a convener as payers and providers work on this issue.

Dr. Allen commented that behavioral health has to be included in the APM discussion. Mr. Cohen added that long-term services and supports should also be included.

Dr. Everett commented, from the audience, that while it is true that Medicare leads the way in many circumstances, aggregate private insurers have also taken the lead at times and Medicare has followed.

A member of the public commented that behavioral healthcare in the ED should not be universally negatively viewed. She noted that the recovery community encourages families to go to the ED when dealing with acute, behavioral health-related issues if they cannot determine what setting would otherwise be appropriate.

Schedule of Next Committee Meeting

Dr. Allen announced that CDPST would meet on January 6, 2016. She adjourned the meeting at 11:01am.