Commonwealth of Massachusetts

Executive Office of Health and Human Services

Public Payer Commission

September 18, 2014

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Outline

- Approval of minutes (VOTE)
- Reminder of statutory charge and schedule of work
- Focus on behavioral health
- Presentation by Beacon Health Strategies
- Continuing discussion of draft findings and recommendations

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Statutory Charge

- Section 270 of Chapter 224 of the Acts of 2012 created the Special Commission to review public payer reimbursement rates and payment systems for health care services and the impact of such rates and payment systems on providers and on health insurance premiums in the Commonwealth.
- The Commission's charge was further amended by Section 153 of Chapter 38 of the Acts of 2013.

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Updated Draft Workplan

January	Overview of Commission Administrative Tasks Introduction to MassHealth Payment
March	Prioritization of Areas for Payment/Cost Analysis Overview of Medicare Payment Issues (Dr. Katherine Baicker)
April	Innovations in Payment (Medicaid Managed Care Entities)
May	Issues in Payment Integration in Medicaid (Tricia McGinnis; MassHealth)
June	Cost-Shifting and Price Variation Interim Discussion: Draft Findings and Recommendations
September	Behavioral Health Draft Findings and Recommendations
October	Long Term Care Finalize Findings and Recommendations/Report

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Focus on Behavioral Health

- Behavioral health is of great interest and importance
  - Over the course of a year, nearly 30 percent of the adult population in the United States suffers from a behavioral health disorder, with a high prevalence of mood, anxiety and substance use disorders.
  - Behavioral health problems are 2-3 times higher in patients with chronic conditions.
  - Untreated behavioral health disorders lead to functional impairment and complications with physical health care issues, and some treatments for behavioral health conditions can increase the likelihood of some chronic conditions.
  - Recent HPC analysis showed that patients with co-morbid behavioral health and chronic medical conditions had expenditures 2.0 to 2.5 times as high as those for patients with a chronic medical condition but no behavioral health condition
  - Individuals with a serious mental illness live, on average, 25 years less than individuals without behavioral health issues; Individuals with substance use disorders live, on average, 22.5 years less than those without the diagnosis.
- Access to behavioral health services is a subject of concern
  - Recent substance abuse legislation
  - Health Planning effort focusing on behavioral health

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Focus on Behavioral Health

- Overview of trends in behavioral health
- Behavioral health in the context of alternative payment methodologies

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Overview of Behavioral Health Trends

- To provide an overview of behavioral health spending within MassHealth, MassHealth analytics team calculated behavioral health spend in SFY2013
  - Includes spending by MCOs and MCEs as well as direct payments
  - Does not include SCO
  - Does not include pharmacy
  - Based on primary diagnosis code (290.XX-319.XX)
- SFY2013 behavioral health spending calculated based on claims and encounter data was $1.8 billion
  - Average of 1.4M members during SFY2013=>PMPM of ~ $110
- Diagnostic range includes intellectual and developmental disabilities, as well as dementia

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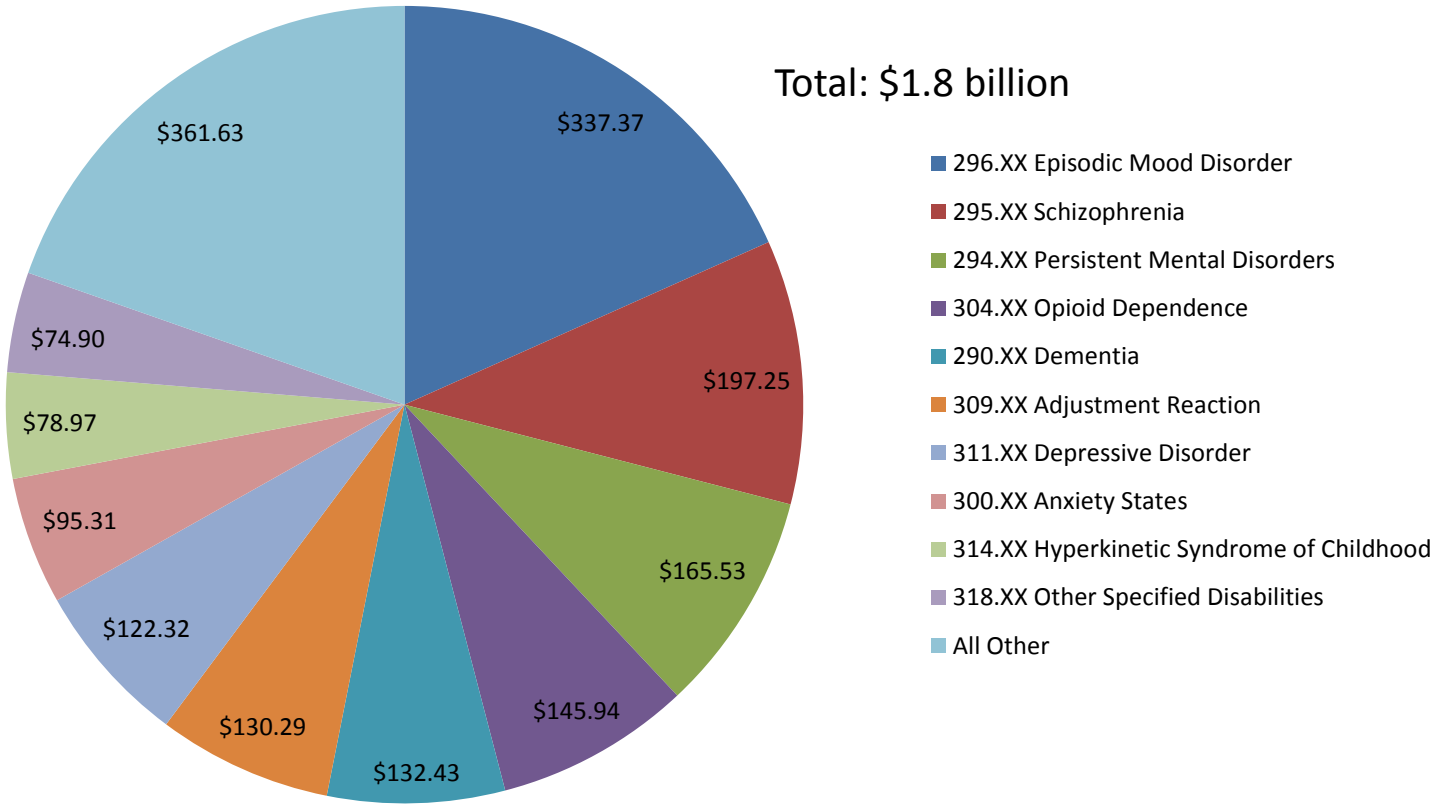
Top 10 Primary Behavioral Health Diagnoses, by SFY2013 Behavioral Health Spending (in millions)



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Overview of Behavioral Health Trends

- Pharmacy expenditures examined to understand drivers of pharmacy cost
- Calculation does not include pharmacy spend by MCOs; does include pharmacy spend for PCC and FFS
- Spending on behavioral health medications is a significant component of overall MassHealth pharmacy spending

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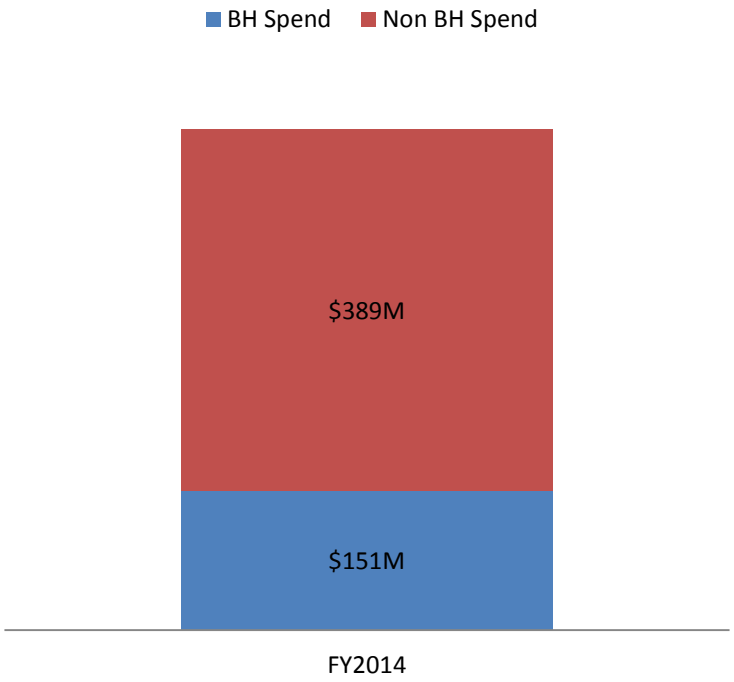
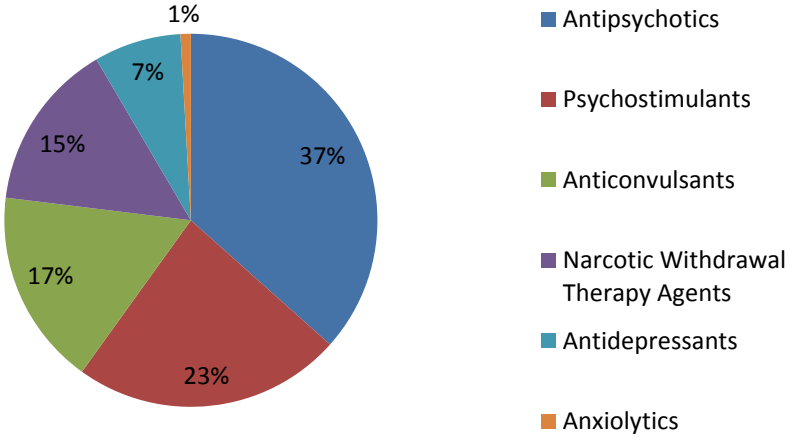
Overview of Behavioral Health Trends

Pharmacy Spend



BH Pharmacy Spend FY2014



*narcotic withdrawal agents primarily includes suboxone

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Overview of Behavioral Health Trends

- Utilization of behavioral health services calculated as part of Health Planning Council work
  - Includes spending by MCOs and MCEs as well as direct payments
  - Excludes SCO
  - Based on primary diagnosis code (290.XX-316.XX)
- Utilization for individuals with Medicare and Commercial coverage also calculated

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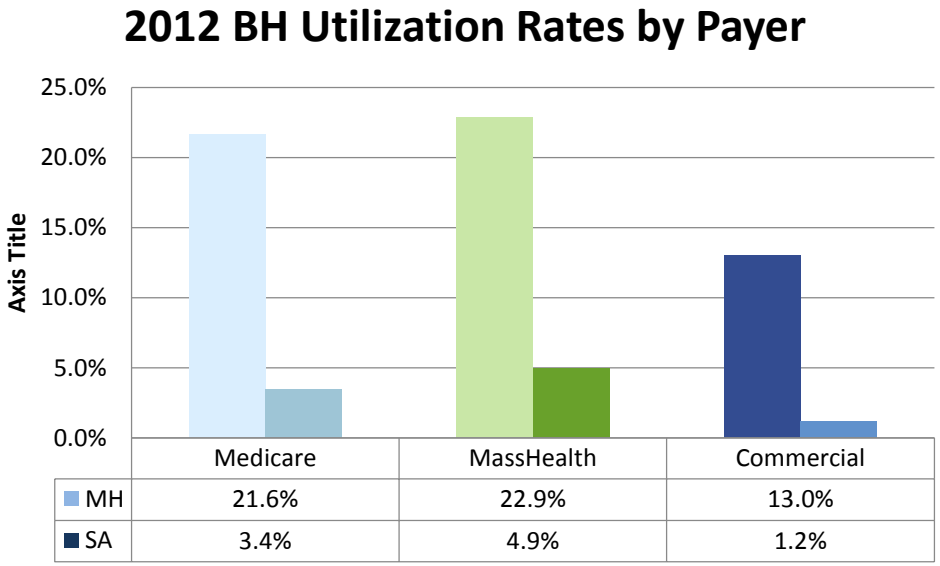
Overview of Behavioral Health Trends

- More than 1 in 5 MassHealth members utilized a mental health service in 2012. Roughly 1 in 20 has utilized a substance abuse service.



Analysis for the Health Planning Council, July 2014.

Overview of Behavioral Health Trends

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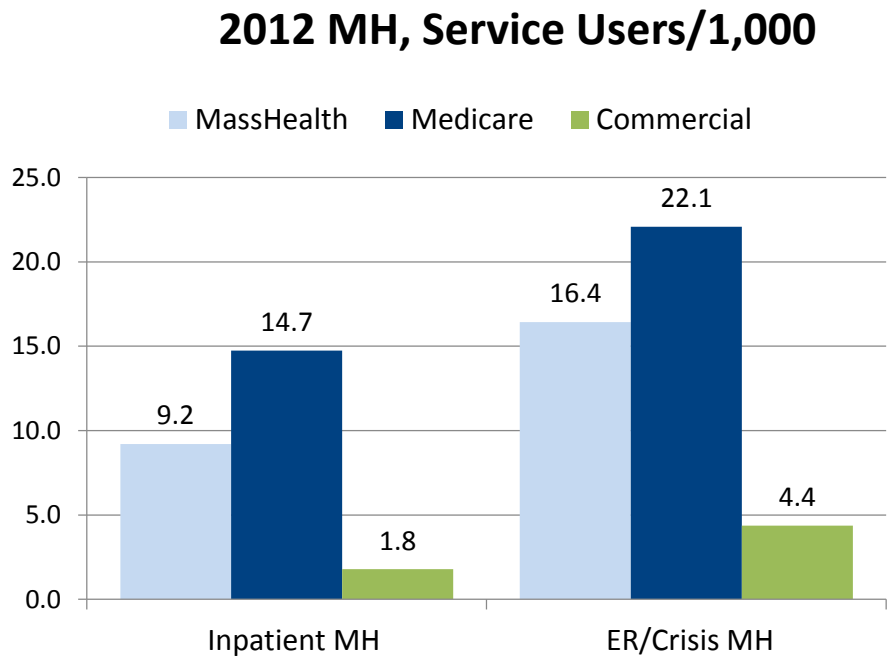
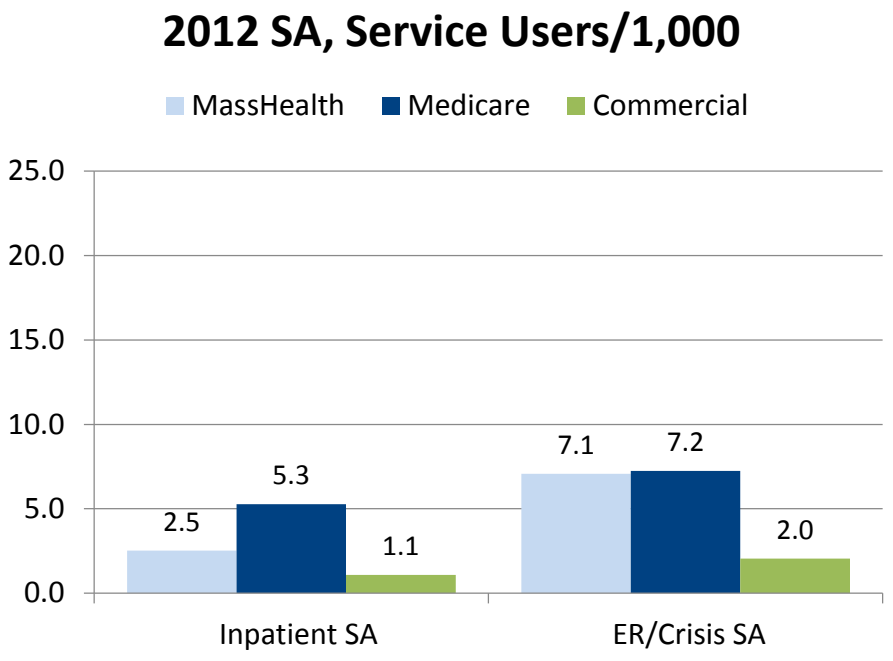
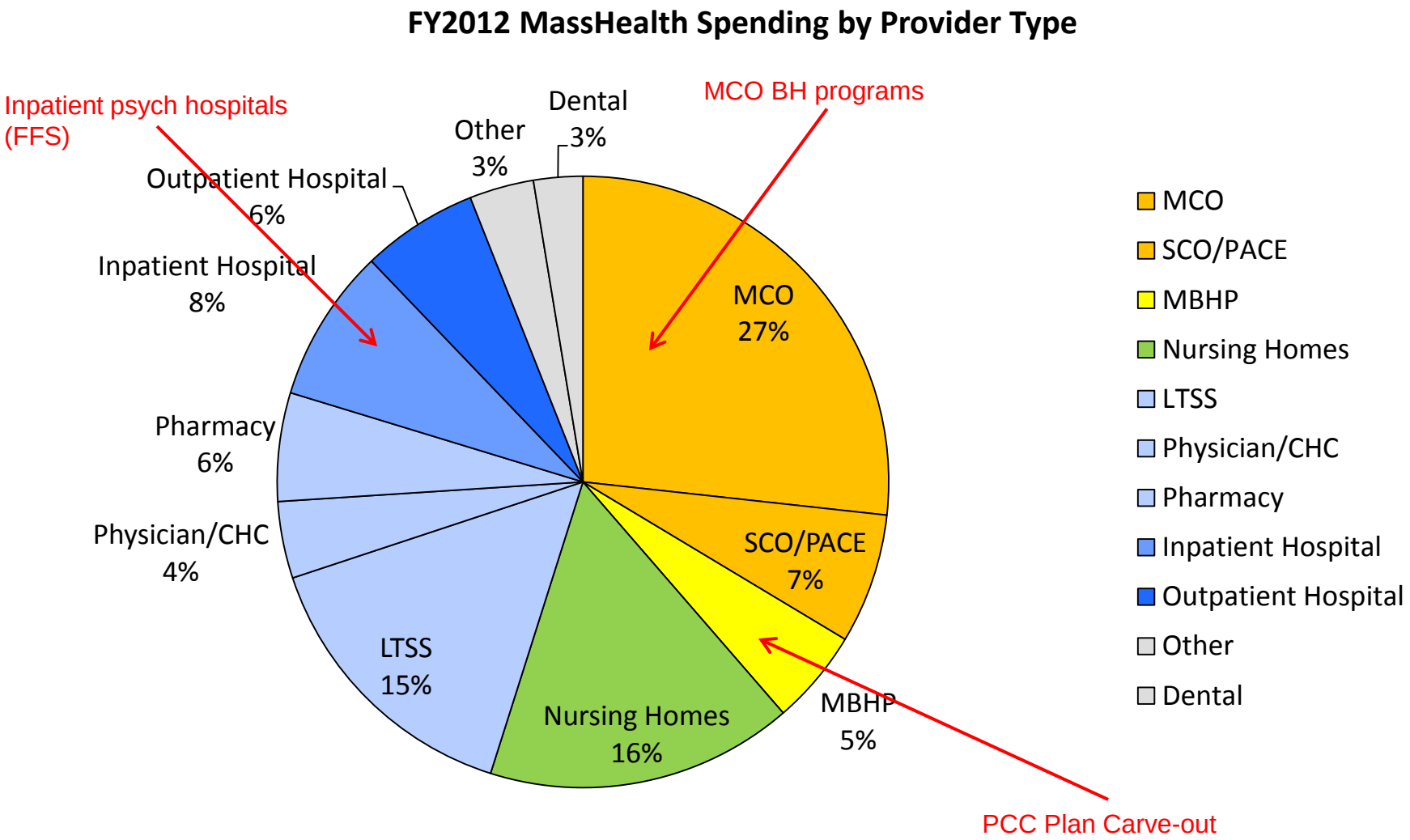




- Less than 1% of MassHealth members had an inpatient mental health stay.
- Less than 2% had an emergency visit for a primary mental health reason.
- Utilization by dual eligibles counted under Medicare, rather than MassHealth
- More information: www.mass.gov/dph/hpc

Behavioral Health Payments Are Spread Across Programs



Source: MassHealth Budget Office, EOHHS Data Warehouse

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Behavioral Health Payment Methods Vary

Type of Service	PCC Plan	FFS	MCO
Inpatient Behavioral Health	MBHP Individually contracted	Per-diem rate	MCO/BH Vendor Individually contracted
Outpatient Behavioral Health	MBHP Individually contracted	Fee Schedule	MCO/BH Vendor Individually contracted

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Rates Established Using Cost Report Data

- Cost reports (403 Cost Report, UFR) are an important source of data for establishing rates
- However, cost reports have important limitations:
  - The cost per day calculated from cost reports is measured across all patients served at a given facility, and is not specific to a particular patient population
    - Wide variability between patients, even those with same diagnosis
  - Allocation of costs may not be done consistently across facilities/providers
    - For example, independent (PCG) analysis of outpatient rates based on cost reports shows wide range in some calculated costs per unit:
      - Group therapy: $6.89 to $697.45
      - Family consultation: $24.59 to $217.57
    - Also, wide range in reported units of service across providers

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Recent Enhancements to Behavioral Health Rates

October 2014:

- Inpatient psychiatric rates (FFS) increase by 4%

July 2014:

- Average 2% rate increase across all behavioral health services managed by MBHP for the PCC plan members

FY2015 budget:

- $12M DSH add-on

January 2014:

- MassHealth contract negotiations with MBHP resulted in an average of 4% rate increases for behavioral health providers
- Mental health outpatient payment amendments to implement Current Procedural Terminology (CPT) evaluation and management (E/M) codes for behavioral health services.

August 2013:

- MassHealth increased rates for one of the CBHI services, Intensive Care Coordination by 20% effective. This rate applies to all MassHealth MCO's and MBHP.

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Behavioral Health and Alternative Payment Methodologies

- Behavioral health integration can increase the ability of medical providers to address behavioral health issues and the ability of behavioral health providers to address medical issues
- Integration can improve treatment outcomes for both mental health and substance use disorders.
- Integrated care has potential to reduce healthcare costs.
- Several MassHealth initiatives have a strong behavioral health focus and seek to strengthen behavioral health through care coordination and integration

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Behavioral Health Integration at MassHealth

- One Care
  - Integrated, capitated health plan option for dual-eligible members ages 21-64
  - Program started October 2013, covers over 18,000 members as of August 2014
  - Plans contract with community-based organizations for independent LTS Coordinators
- PCMHI/integration toolkit
  - Practice transformation payments and technical assistance, coupled with data reports and a shared savings program
  - Pathway to the PCMH model, focusing on BH integration in primary care practices
- PCPR
  - Capitation replaces FFS payments for a bundle of primary care services, with two optional additional tiers that include some outpatient BH services
  - Data reports, quality reporting with incentive payments, and a shared savings program
  - Contractual clinical milestones require Participants to have clinical care managers; identify high-risk panel members and draft plans for their treatment; employ team-based coordinated care; and provide panel members with prompt access to behavioral health providers
- Health Home
  - A model for targeted intensive care management for especially complex members with chronic conditions and/or SPMI
  - MassHealth is developing its Health Homes proposals and working to integrate them into its other APMs and integrated payment programs

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Behavioral Health and Medicaid ACOs

State	BH in Medicaid ACO payment model?	BH in quality measures?
CO	No. BH is carved out in Medicaid and managed by Behavioral Health Organizations (BHOs)	
ME	ACOs must include at least one BH provider. BH included in total cost of care.	2 core BH metrics (tied to payment): • Rate of initiation and engagement of alcohol and other drug dependence treatment; • Rate of follow-up within 7 days of hospitalization for mental illness
MN	Outpatient mental health and chemical dependency services are included in ACO's total cost of care calculation.	ACOs must report on depression remission at 6 months (tied to payment)
NJ	ACOs must include at least four behavioral health providers, at least one of which is mental health, and one substance abuse. ACOs may include BH as part of total cost of care arrangements.	2 BH metrics (may be tied to payment depending on gainsharing arrangement) • Initiation and engagement of alcohol and other drug dependence treatment; • Anti-depressant medication management
OR	BH services included in total cost of care and financed by a global payment	4 BH metrics (tied to payment): • Follow-up care for children prescribed ADHD meds • Alcohol or other substance misuse (SBIRT) • Screening for clinical depression and follow-up plan • Follow-up after hospitalization for mental illness
VT	Governing board must include BH provider. ACOs incented to include BH in total cost of care in year 2 of the program, and may be required to do so in year 3.	2 BH metrics (tied to payment): • Rate of depression screening by 18 years of age; • Rate of follow-up within 7 days of hospitalization for mental illness

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Considerations in Adopting APMs

- Understanding determinants of costs, including social determinants
  - Risk adjustment models
  - SIF program and other examples
- Quality measures
  - HEDIS ACO Measures include:
    - Antidepressant medication management
    - Follow-up care for children prescribed ADHD medication
    - Follow-up after hospitalization for mental illness
  - 2015 HEDIS will add new measures on antipsychotic use in children/adolescents
- Carve-outs
  - If behavioral health services are handled by a carve-out, what strategies could or should be used to improve coordination

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Behavioral Health and APMs

Summary:

- Integration of behavioral health with primary care has many potential benefits
- However, behavioral health is currently incompletely integrated in many existing APM models.
- Integrating behavioral health payments requires careful attention to risk adjustment, quality measurement, and payment structure.

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Updated Draft Findings and Recommendations

- During the last session, we discussed several findings and recommendations from previous sessions. These are reproduced on the following slides, incorporating feedback from that session.
- In addition, Commissioners filled out worksheets, providing feedback on priorities for ACO design. The results of these worksheets have been summarized and are presented after the recommendations

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Findings (draft for discussion)

- Sessions 1 and 3
  - MassHealth, the MassHealth MCEs, Medicare, and Commercial payers each have several innovative payment initiatives in the Commonwealth. While these programs each have unique features, they share many objectives, including fostering integrated care, increasing value, and improving health
- Session 2
  - Evidence from the Medicare population suggests that care can be delivered in a more consistent, higher value, and more efficient manner. Medicare is pursuing integrated care and value-based, innovative payment methods as strategies to achieve these goals
- Session 4
  - In designing accountable care models within Medicaid, states have made different decisions on fundamental design issues, such as the structure of the ACO, the attribution model, and the payment model

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Findings (draft for discussion)

- Session 5 (revised)
  - Providers may respond to public payer payment levels in a number of ways. The ability of providers to cost-shift depends on their specific circumstances. Payment system that pay for value can simplify the incentives faced by hospitals.

- Session 6 (new)
  - Integration of behavioral health with primary care has many potential benefits. However, behavioral health is not included in some existing APM models.

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Recommendations (draft for discussion)

- In developing its MassHealth ACO program, MassHealth should consider the following objectives:
  - Encourage healthcare delivery models that promote efficient use of public funds and align incentives to drive high-value care
  - Promote high quality outcomes and integration of care across the healthcare continuum
  - Enhance member experience by promoting better coordination, better care, and better health
  - Create a flexible model that attracts a wide range of entities and aligns with developments in the marketplace among private and other public payers

- Provider entities should not be mandated to participate in MassHealth's ACO program; participation should be voluntary
- MassHealth should align the principles and goals of its ACO initiative with those of other integrated payment programs in the Commonwealth
  - MassHealth should, in particular, aim to account for the existing structuring of the provider network and the lists of quality measures that other value-based payment initiatives collect

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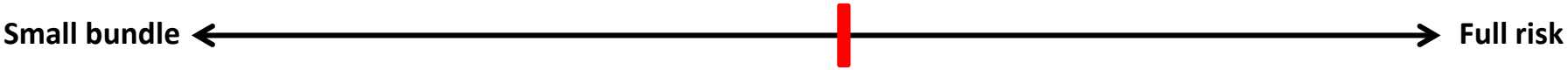
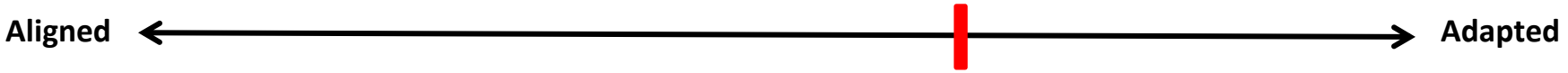
ACO Design Worksheet Results

MassHealth's ACO can be designed to be as flexible as possible, allowing participation by all providers within the Commonwealth; on the other hand, it can be designed restrictively, to accommodate only a few sophisticated provider entities. My recommendation on the optimal balance between these two is:

ACO models are partly defined by payment mechanisms, generally structured around a bundle of at-risk services. MassHealth's ACO can be based around a small bundle of services (e.g., primary care, like for Tier 1 PCPR providers) or can place ACOs at risk for the full range of covered services. My recommendation on the optimal balance between these two is:



MassHealth's ACO can closely mimic pre-existing ACO models, like MSSP or Medicare Pioneer, achieving close alignment for providers who are already part of these other programs; alternatively, MassHealth can adapt these models, recognizing underlying differences in the member population. My recommendation on the optimal balance between these two is:



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Recommendations (draft for discussion)

Recommendations (new, for discussion):

- MassHealth's ACO model should explore accountability for behavioral health services in its payment model.

- MassHealth's ACO should have a flexible design that can work for a range of providers.

- There is not consensus as to whether the MassHealth ACO model should extend to a small bundle of services as opposed to full risk. Therefore, MassHealth should continue to explore both types of models.

- Alignment with existing APMs in the Commonwealth is a key design consideration, although on balance, the Commission believes that MassHealth should adapt its ACO design to fit the needs of its member population rather than aligning its model strictly with existing ACO models such as MSSP and Pioneer.