MASSACHUSETTS
HEALTH POLICY COMMISSION

Meeting of the Care Delivery Transformation Committee

November 28, 2018

MASSACHUSETTS
HEALTH POLICY COMMISSION

AGENDA

- Call to Order
- Approval of Minutes
- MassHealth Presentation: Update on MassHealth Accountable Care Organization (ACO) and Community Partner (CP) Programs
- ACO Certification Standards
- Dual Diagnosis Study
- SHIFT-Care Evaluation
- Schedule of Next Meeting (February 27, 2019)

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HEALTH POLICY COMMISSION

VOTE: Approving Minutes

MOTION: That the Committee hereby approves the minutes of the CDT Committee meeting held on October 10, 2018, as presented.

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Current Landscape

- Since March 1, 2018, MassHealth has transitioned more than 850,000 members to Accountable Care Organizations (ACOs), and more than 200,000 to two Managed Care Organizations (MCOs).
- MassHealth's top priority during the transition has been member continuity.
- Since launching, ACOs have been actively engaging with their membership to understand their needs, and addressing them through a variety of programs (e.g. disease management, complex care management, community base supports).
- As of July 1, 2018, Community Partners are working with ACOs and MCOs to provide specialized wraparound supports and care coordination for members with complex long-term medical and/or behavioral health needs.

Product	Plan	Total Enrollment as of 7/21
ACOs	BMC HealthNet Plan Community Alliance	107,447
	BMC HealthNet Plan Mercy Alliance	28,275
	BMC HealthNet Plan Signature Alliance	18,003
	BMC HealtNet Plan Southcoast Alliance	16,152
	Berkshire Fallon Health Collaborative	15,513
	Fallon 365 Care	30,241
	Wellforce Care Plan	52,941
	BeHealthy Partnership	37,538
	My Care Family	31,754
	Tufts Health Together with Atrius Health	31,761
	Tufts Health Together with Boston Children's ACO	83,623
	Tufts Health Together with BIDCO	34,267
	Tufts Health Together with CHA	26,253
	Community Care Cooperative (C3)	113,653
	Partners Healthcare Choice	105,821
	Steward Health Choice	123,651
MCOs	MCO-BMC	70,398
	MCO-TUFTS	103,396
PCC	PCC	119,055
	Total	1,149,742

Note: This table shows enrollment for members under age 65 with MassHealth as their primary insurance, who are eligible to enroll in ACOs, MCOs and the PCC Plan. Members who are over age 65 or who have Medicare or private insurance are not eligible for these enrollment options.

HPC

MassHealth Accountable Care Organizations: Treating the Whole Person

MassHealth engaged extensively with hundreds of health care providers, advocates and other stakeholders throughout the ACO design and transition process. This has included the creation of a Delivery System Reform Implementation Advisory Council, three Technical Advisory Groups, and a monthly advocates forum.

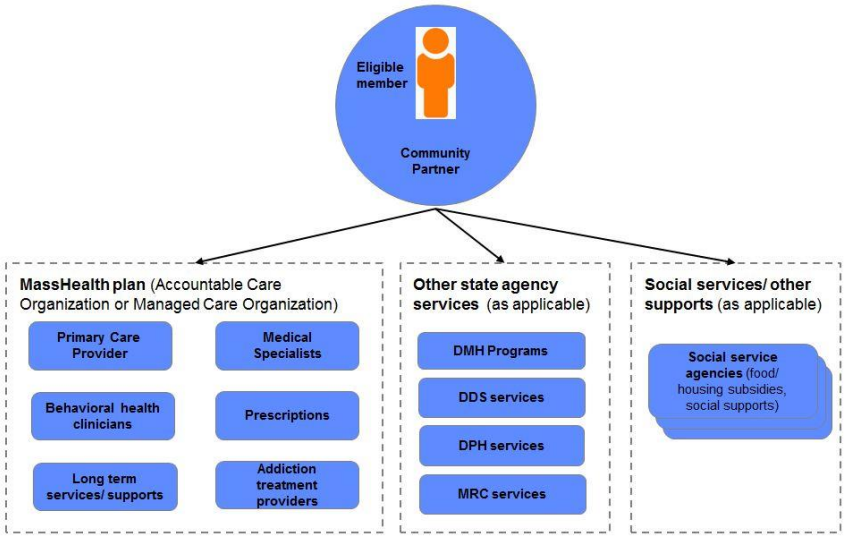
ACOs are rewarded for *value* – **better health outcomes and lower cost**– not volume. ACOs:

- Are a network of primary care providers who work in partnership with hospitals and specialists to coordinate all of a member's medical and behavioral health care.
- **Strengthen members' relationship with their primary care provider**, who engage members in their care and coordinate to help them navigate all the services they need.
- Focus on **better coordinating care** and **engaging members in their care** to improve health outcomes and reduce preventable costs (e.g., avoidable hospitalizations).
- **Integrate all care a person needs, including behavioral health and physical health care**, especially in the primary care setting, as well as **long-term services and supports.**
- Develop **innovative approaches to address social needs** (e.g., housing, food insecurity) that impact health.
- Are **accountable for the quality, member experience and cost of care** for members.

Community Partners (CP) Launch

- MassHealth has contracted with 27 community-based health care and human service organizations to provide specialized wraparound supports and care coordination for MassHealth members with complex long term medical and/or behavioral health needs who are enrolled in ACOs, MCOs, or the Adult Community Clinical Services (ACCS) program. Over time, CPs are expected to serve ~60,000 MassHealth members.
- CPs will:
  - Actively outreach and engage individual/ families
  - Assess needs, provide options and refer to services
  - Coordinate with individual and providers to develop and maintain a care plan
  - Help navigate medical, behavioral health, disability, social services
- Members will be identified for CP supports by MassHealth, ACOs, MCOs, and providers. All MassHealth members participating in the Department of Mental Health's redesigned ACCS program are also eligible for CP supports.

- CPs are receiving funds through the state's innovative five-year 1115 Medicaid waiver:
  - ~$400 million over five years to BH CPs
  - ~$145 million over five years to LTSS CPs
- CPs are financially accountable for meeting quality measures such as initiating treatment for substance use, follow-up after a behavioral health hospitalization, and maintaining members with disabilities living in the community.



Ombudsman Program Support for MassHealth Members

- The foundational work done by MassHealth and Disability Policy Consortium (DPC) through the One Care (dual eligible) program has established the ombudsman program as a critical support for members, serving as a trusted resource in the community to ensure all One Care enrollees have access to integrated, person-centered care and are able to access the benefits they need to live independently.

- As of July 1, MassHealth and DPC expanded ombudsman services to members enrolled in a range of health plans, including ACOs, MCOs, Senior Care Organizations, Program of All-Inclusive Care for the Elderly (PACE) organizations, as well as individuals enrolled in the Community Partners program.

- *My Ombudsman* provides free assistance to help members connect to community-based resources, identify and address access concerns, and support members seeking behavioral health and long term support services.

- Members can contact *My Ombudsman* by phone at 855-781-9898 (TTY users can use MassRelay at 711 to call 855-781-9898), by email at info@myombudsman.org, online at www.myombudsman.org or at the *My Ombudsman* office at 11 Dartmouth Street, Suite 301 Malden, MA 02148 by appointment or during walk-in hours on Mondays from 1 pm–4 pm and Thursdays 9 pm–12 pm.

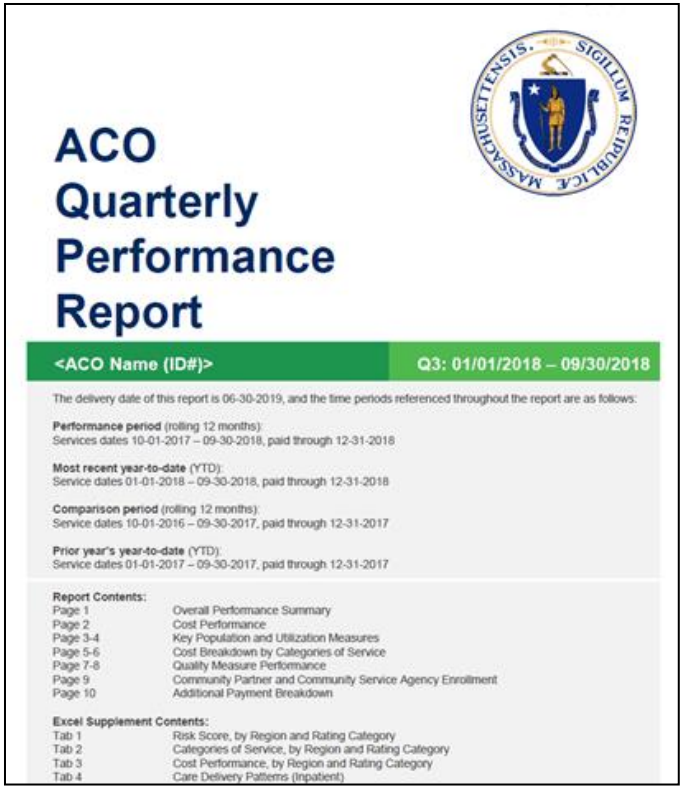
- Members are also encouraged to visit www.masshealthchoices.com or call MassHealth customer service center at 1-800-841-2900.

MY OMBUDSMAN
MASSHEALTH HEALTH PLANS

HPC

ACO and CP Quality and Integration Performance Measures

- ACOs and CPs are financially accountable for meeting specific quality measures and forfeit a portion of their funding if those measures are not met.
- Quality metrics include:
  - Providing **preventive care**
  - Managing **chronic diseases** like diabetes and heart failure
  - **Screening for behavioral health conditions** and initiating appropriate treatment for mental health, addictions, and co-occurring disorders
  - Ensuring appropriate **follow-up care** after a medical or behavioral health hospitalization
  - Maintaining **members with disabilities living in the community** rather than in nursing facilities
- Part of ACOs' quality score will be based on **member experience surveys conducted starting in early CY 2019** by Massachusetts Health Quality Partners (MHQP) an independent, objective 3rd party.



ACO Quarterly Performance Report

<ACO Name (ID#)> | Q3: 01/01/2018 – 09/30/2018

The delivery date of this report is 06-30-2019, and the time periods referenced throughout the report are as follows:

Performance period (rolling 12 months):
Services dates 10-01-2017 – 09-30-2018, paid through 12-31-2018

Most recent year-to-date (YTD):
Service dates 01-01-2018 – 09-30-2018, paid through 12-31-2018

Comparison period (rolling 12 months):
Service dates 10-01-2016 – 09-30-2017, paid through 12-31-2017

Prior year's year-to-date (YTD):
Service dates 01-01-2017 – 09-30-2017, paid through 12-31-2017

Report Contents:

Page 1	Overall Performance Summary
Page 2	Cost Performance
Page 3-4	Key Population and Utilization Measures
Page 5-6	Cost Breakdown by Categories of Service
Page 7-8	Quality Measure Performance
Page 9	Community Partner and Community Service Agency Enrollment
Page 10	Additional Payment Breakdown

Excel Supplement Contents:

Tab 1	Risk Score, by Region and Rating Category
Tab 2	Categories of Service, by Region and Rating Category
Tab 3	Cost Performance, by Region and Rating Category
Tab 4	Care Delivery Patterns (Inpatient)

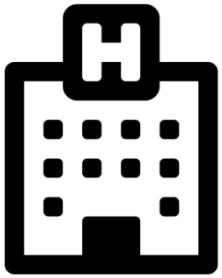
Strengthening the Health Care System Statewide

- Over the next five years, **MassHealth will allocate $115 million of its $1.8 billion Delivery System Reform Incentive Payment (DSRIP) funding to support initiatives that will strengthen the health care system statewide**.

- MassHealth is partnering with the Mass League of Community Health Centers and the Association for Behavioral Healthcare to bolster the primary care and behavioral health care workforce.

Student Loan Repayment/Behavioral Health Workforce Development Programs

- Approximately 300 applications received for the Student Loan Repayment Program and Behavioral Health Workforce Development Program. A total of 110 awardees.
- Over two years, MassHealth will disburse nearly $4 million.
- Anticipated award sizes: ~$50,000 for MDs and ~$30,000 for NPs, PAs, APRNs, and masters-prepared BH providers.



Community Health Center-based Residency Training

- ~5 slots for MD residents and ~12 slots for NP residents in year one. The actual number of MD v. NP slots funded will depend on the number and quality of applications received.
- Over one year, MassHealth will disperse nearly $2 million

Strengthening the Health Care System Statewide

MassHealth will also partner with the Executive Office of Labor and Workforce Development and Commonwealth Corporation on a series of workforce development initiatives for the frontline and extended healthcare workforce valued at a projected $12 million over the next five years.

Initial initiatives include:

- **Expansion of community health worker (CHW), CHW supervisor, and Peer Specialist training capacity** to increase the number of well-trained CHWs and Peer Specialists working in ACOs and CPs.
    - MassHealth will award grants to existing CHW core competency training programs to expand the number of training cycles they provide.
    - MassHealth will work with the Transformation Center to expand the number of Peer Specialist trainings available to peer specialists.
    - MassHealth will award a grant to a single CHW core competency training program to design and implement a CHW supervisor training program.

- **Competency-based training program** available to support frontline staff in ACOs and CPs.
    - The training will focus on health care literacy, consumer engagement, critical thinking, and communication, among other critical health care and professional development topics.

DSRIP Investments for Year 1

ACO Investments

ACO DSRIP Investment Category	Amount*	% of Total
Care Coordination & Care Management	$124.1M	39%
Clinical Integration	$34.M	11%
Community-Based Care Initiatives	$8.3M	3%
Culturally & Linguistically Appropriate Services	$2.9M	1%
Data and Population Health Analytics	$19.6M	6%
Health Information Technology	$36.5M	12%
Health-Related Social Needs	$4.9M	2%
Organizational Integration	$43.4M	14%
Workforce Development	$6.1M	2%
Other	$37.3M	12%
TOTAL	**$317.1M**	**100%**

Examples of innovative ACO investments:

- An Ambulatory Intensive Care Unit (ICU) Program that will care for members with serious medical conditions in their homes.
- Cell phones for members with complex medical and behavioral health care needs who need to keep in touch with their providers to help them follow treatment plans, which can reduce hospitalizations from poorly managed chronic disease.
- An intensive care management program that surrounds frequent ER users with a team dedicated to managing their health, wellness, and social needs.
- Implementing an Opioid Prescription Management Program that supports providers in facilitating safe and appropriate prescription of opioids and other pain management drugs.

CP Investments

Entity	Amount**
Behavioral Health Community Partners	$30.9M
Long Term Services and Supports Community Partners	$11.0M
CSA	$5.3M
TOTAL	**$47.2M**

Statewide Investments (SWI) – Key Contracts for CY18

Category	Vendor	Purpose	Amount
Capacity Building	Abt Associates	TA Program for ACOs, CPs, and CSAs	$9.6M
Workforce Development: Capacity Increase	MassLeague	Community-focused workforce development programs	$6.8M
Workforce Development: Training	Commonwealth Corporation	Workforce development programs focused on CHWs, peer specialists, and frontline healthcare workers	$1.7M

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* Prep Budget period funding of $106.4M already disbursed, Performance Year 1 funding of $210.7M being disbursed throughout 2018
** Infrastructure funding for Preparation Budget Period of $15.8M already disbursed; PY1 funding of $31.4M (Jun to Dec ’18) under review

Example priorities for 2019

- Further integrating **Community Partners** with ACOs and MCOs
- Launching the **Flexible Services Program** to address health-related social needs
- Improving MassHealth **data and reporting** for ACOs
- Improving other MassHealth supports for **Primary Care ACOs**
- While continuing to ensure:
  - Positive member experience
  - Operational stability
  - Compliance with contracts, regulations, CMS managed care rule, etc.

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Health Policy Commission Care Delivery Vision

The HPC's care delivery transformation vision is that providers and payers are patient-centered and accountable for high-value care across a patient's medical, behavioral, and health-related social needs.

ACO Certification Program Values

- Support the HPC's **care delivery vision** through certification standards-setting
- Encourage ACOs to **work with non-medical providers** in the community as needed to support the full spectrum of patient needs
- Commit to regular **assessment of the program** to ensure continuous improvement and market value
- Increase **public transparency** while balancing administrative burden for providers in Massachusetts

HPC

ACO Certification aims to promote ongoing transformation and improvement over time

Current market

- Multiple ACO programs in the market
  - Medicare ACOs (i.e., MSSP, Next Gen)
  - Commercial programs (e.g., BCBSMA's AQC)
  - MassHealth ACOs
- Evidence on the relationship between ACO capabilities and outcomes is still developing

Initial focus of HPC ACO Certification

- Create a set of **multi-payer standards** for ACOs to enable care delivery transformation and payment reform
- Build **knowledge and transparency** about ACO approaches
- Facilitate **learning** across the care delivery system
- Align with and complement **other standards and requirements** in the market, including MassHealth, Connector, and Dept of Public Health

Vision for Certification

- Develop the evidence base on how ACOs achieve improvements in quality, cost and patient experience
- Move certification standards from structural/process requirements to quality outcomes and cost performance requirements
- Create a "model ACO" distinction program to recognize exceptional performance
- Engage additional payers and purchasers

HPC

Key Themes from Stakeholder Engagement

From meetings with >30 organizations:

- **Overall support** for the ACO Certification program and topics of our certification standards
  - Call for more clarity on the purpose and **role of ACO Certification** between contributing to the evidence base on ACOs versus pushing the market
  - Overall **challenges of using process-based certification standards** when ACOs vary widely in structures and approaches
- From ACOs, concern about **changing standards too quickly,** after only one certification cycle, given the evidence around pace of change for ACOs being around 3-5 years
  - Concern about **reporting burden** – leverage existing data sources and keep certification-specific requirements modest
- From community organizations and advocates, support for using certification to promote **fair, effective partnerships** with ACOs and **scaling integrated care delivery models** across oral, behavioral, medical and social care

Overview of Proposed 2019 ACO Certification Requirements

Background information

Attestation or updates to 2017 standards

Assessment Criteria

- ✓ Governance structure
- ✓ Patient/consumer representation
- ✓ Performance improvement activities
- ✓ Population health management programs
- ✓ Cross-continuum care

Supplemental questions

HEALTH POLICY COMMISSION ACO CERTIFIED – 2017 –

Optional new performance-based distinction program

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Background Information: Summary of Applicant Organization, ACO Participants, and Risk Contracts

Summary of Applicant Organization

Descriptions of the Applicant's organization, history, and mission; Massachusetts regions in which the ACO provides care; Applicant organizational chart

ACO Participants

If not already apparent in MA-RPO data: list of participating primary care practices (site level) and hospitals, as well as a narrative of any differences between the providers that participate each risk contract

Risk Contracts and Performance

Completion of two templates reporting:

- Details of each risk contract, including payer, number of covered lives, years in contract, and financial terms (e.g. full or partial risk, max. shared savings/losses, etc.)
- For the two most recent performance years, final ACO-level quality performance on all measures included in risk contracts from the Massachusetts Aligned Measure Set, and any additional ambulatory measures in risk contracts

HPC

2019 Proposed Assessment Criteria Approach

1. **Governance structure**
2. **Patient/consumer representation**
3. **Performance improvement**
4. **Quality-based risk contracts**
5. **Population health management**
6. **Cross-continuum care**

- No changes to the 2017 assessment standards or documentation requirements, except risk contract information will be collected in Background Information section
- Applicants required to update 2017 responses to reflect any changes since submission
- If there have been no changes, Applicants may attest that the 2017 response is still fully applicable

HPC

2019 Proposed Supplemental Questions Section

Two types of questions to address distinct, complementary goals. Responses could inform future ACO certification standards and "model ACO" development.

1. Adding to the Evidence Base

Questions aimed at adding to and/or filling **identified gaps** in the current evidence base

Topics may include:

- Distribution of shared savings and performance-based provider compensation
- Providing high-value care
- Behavioral health integration into primary care
- Advanced health information technology-enabled care coordination

2. Emerging Topics

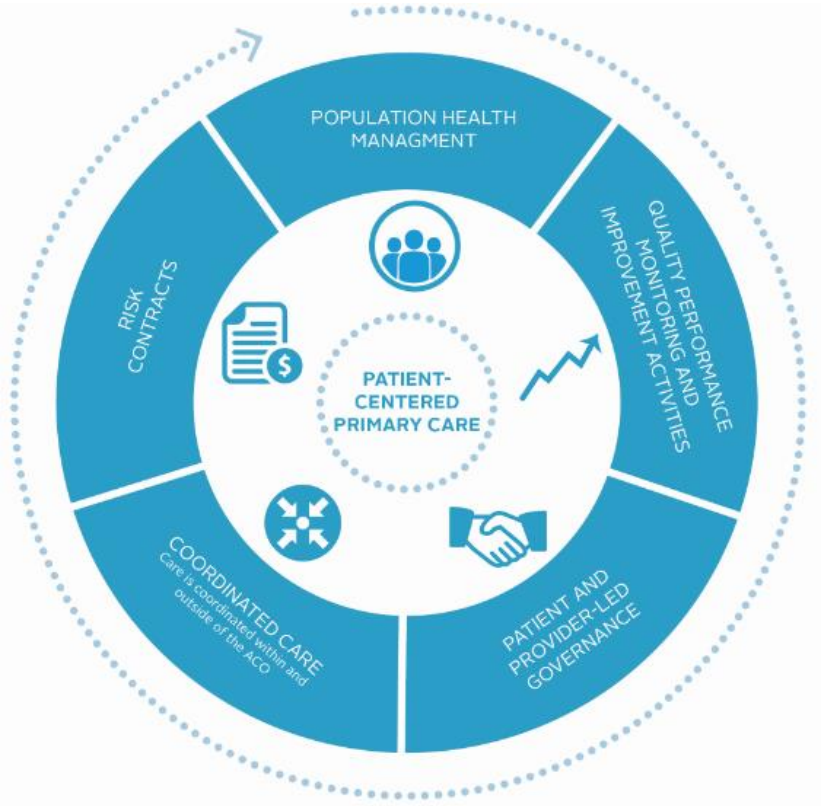
Questions to explore ACO approaches to **emerging areas of focus** in integrated, patient-centered care delivery

Topics may include:

- Workforce
  - Use of recovery coaches, community health workers, etc.
- Integrated, innovative care models
  - Patient-centered advanced illness care
  - Oral health integration
  - Medication for addiction treatment strategy
  - Care for co-occurring disorder
  - Telemedicine
  - Paramedicine/Mobile Integrated Health
- Strategic focus on the SDH
  - Food; housing; early childhood development

Proposed New Distinction Program for HPC-certified ACOs

A new, voluntary addition to basic ACO Certification, this program would recognize ACOs that have achieved performance improvements in the domains of the Triple Aim — **health outcomes, care,** and **cost** — plus **health equity**, and make commitments to continue improving.



ACO Distinction Program: Basic Requirements

1. **Performance reporting:** Report data to the HPC demonstrating that the ACO has improved its performance on three specific measures (one in each domain), while also working to address health inequities

Cost: Total medical expense or total cost of care

Access: Pediatric well visits and/or ED utilization

Quality: ACOs pick one of the **5 core measures from the aligned measure set** (controlling high blood pressure; comprehensive diabetes care; CG-CAHPs; initiation and engagement of alcohol and other drug dependence treatment; depression screening and follow-up for adolescents and adults)

Equity: *at least one* measure must be **stratified by a social determinant of health**, such as race, income, language, sexual identity

2. **Strategic planning:** Submit a strategic plan for continuing to improve on a measure in each of these domains

ACO Distinction Program: Design Details

Overall Parameters

- Awarded at the Applicant level, performance may be demonstrated by payer type (e.g. commercial, Medicaid, Medicare), but across all categories
- Effective for two or three years

1. Performance Reporting

- To meet Distinction requirements, ACO would have to demonstrate improvement across all risk contracts
- Based on most recent two years of performance data (ACO internal data, not final contract reconciliation)
- ACOs would be required to describe how improvements were achieved, which would be used to facilitate learning across the system

2. Strategic Planning

- ACOs would commit to improve performance going forward on metrics selected by the HPC
- The results of these commitments and plans would be the basis for re-evaluating the ACO for Distinction at the end of the two/three-year term

HPC

Original Proposal for 2019 Assessment Criteria Domains

2017	2019
1 Governance structure	1 Patient-centered, accountable governance
2 Patient/consumer representation	2 Goal-oriented performance improvement strategy
3 Performance improvement	3 Comprehensive population health management strategy
4 Quality-based risk contracts	4 Patient-centered primary care
5 Population health management	5 Health information technology-enabled care coordination
6 Cross-continuum care	

HPC

Comparison of Original versus Revised 2019 Proposals

1

Original Proposal

- Prioritizes raising the bar on ACO capabilities, and improving upon 2017 standards based on experience from the first cycle
- Addresses some gaps in 2017 standards, and highlights policy priorities
- Maintains focus on process-based standards
- Likely a similar level of provider burden as 2017 program

2

Revised Proposal

- Allows for tracking ACO changes/improvements in criteria topics across years
- Uses delineated groups of Supplemental Questions to advance both evidence generation and policy priorities
- Through Distinction, begins a shift toward evaluating ACOs on performance, not process
- May provide administrative relief through attestation option

HPC

Timeline and Next Steps

July 15-Sept 14, 2018	HPC drafts initial ACO criteria proposal for stakeholder review
Sept 17-Oct 5, 2018	**Stakeholder engagement phase 1:** One-on-one meetings with ACOs, state agencies, and ACO convening with MHA to gather input
Oct 5-Oct 29, 2018	HPC revises proposal per phase 1 stakeholder input
Oct 29-Nov 28, 2018	**Stakeholder engagement phase 2:** One-on-one meetings with ACOs, state agencies, and consumer groups to gather additional input
Nov 28-Dec 14, 2018	HPC prepares final proposal for public comment
Dec 14, 2018-Jan 2019	**Stakeholder engagement phase 3:** public comment period
Jan-Feb 2019	**HPC makes final revisions to proposal**
February 2019	**HPC Board approves** final ACO Certification criteria

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Basis for Report on Availability of Providers Treating Co-occurring Mental Illness and Substance Use Disorder

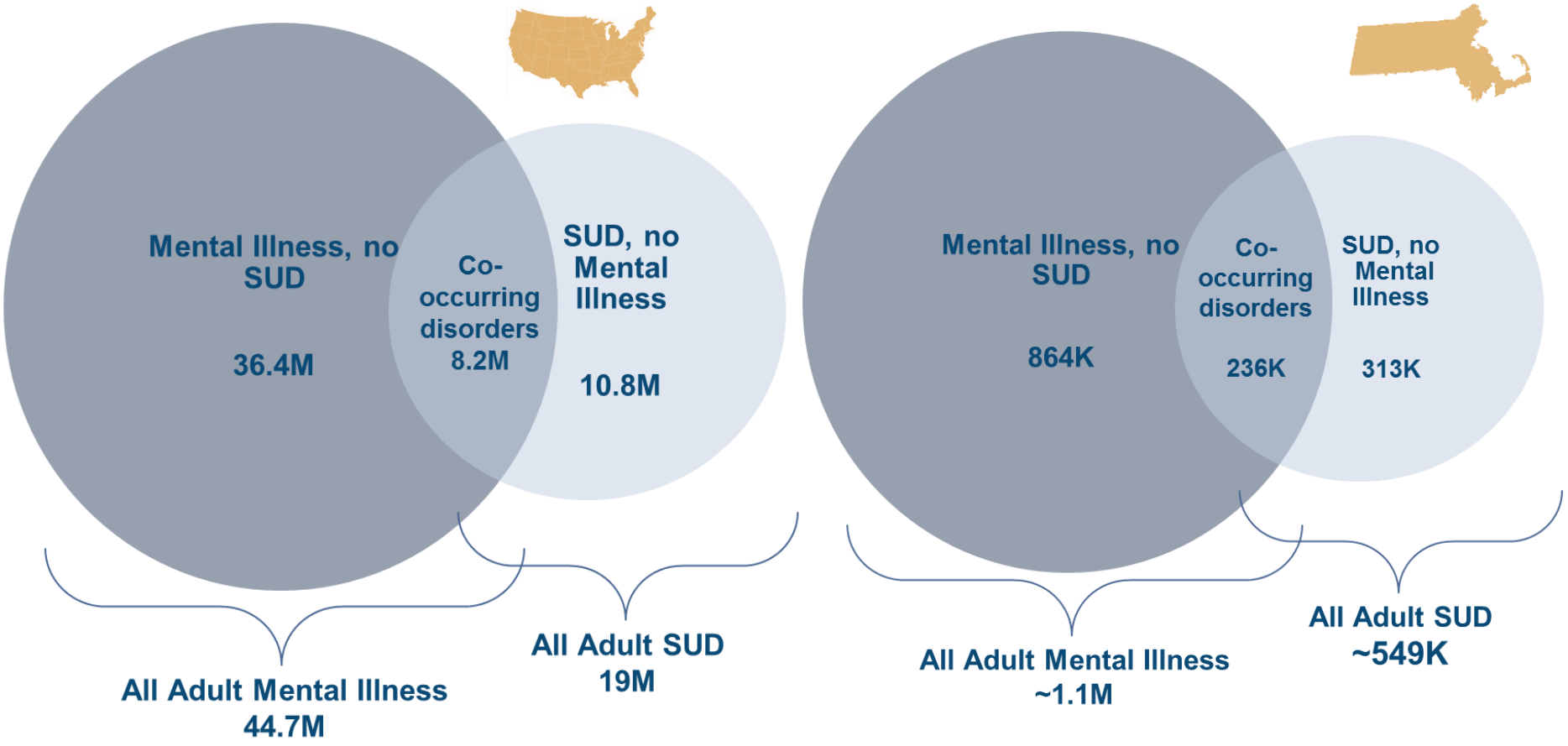
Ch. 52 of the 2016 Session Laws, *An Act Relative to Substance Use, Treatment, Education and Prevention,* charged the HPC, in consultation with DPH and DMH, with assessing the availability of providers treating "dual diagnosis", or co-occurring mental illness and substance use disorder (SUD):

1. Create an **inventory of health care providers capable of treating patients (child, adolescent, and/or adult) with dual diagnoses**, including the location and nature of services offered at each such provider.

2. **Assess sufficiency of and barriers to treatment**, given population density, geographic barriers to access, insurance coverage and network design, and prevalence of mental illness and SUD.

3. **Make recommendations to reduce barriers to care.**

Nationally, co-occurring disorders affect ~18% of adults with mental illness and ~43% of adults with SUD. Approximately 20% and 10% of Massachusetts adults reported past year mental illness or SUD, respectively



SAMHSA. *Substance Use and Mental Health Indicators in the United States: Results from the 2016 National survey on Drug Use and Health.* "Past Year SUD and Mental Illness among Adults 18 and older, 2016.". September 2017.

MA estimations interpolated based on data from: SAMHSA. 2015-2016 National Survey on Drug Use and Health: Model-Based Prevalence Estimates. Available: https://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2016/NSDUHsaePercents2016.pdf

Nationally, in 2016, treatment rates for patients with co-occurring disorder were very low

Co-occurring SUD with *any* mental illness — **3.4**% of adults

- Approximately **half** did not receive health care services for *either* condition
- Only **~7**% received both mental health care and specialty substance use treatment

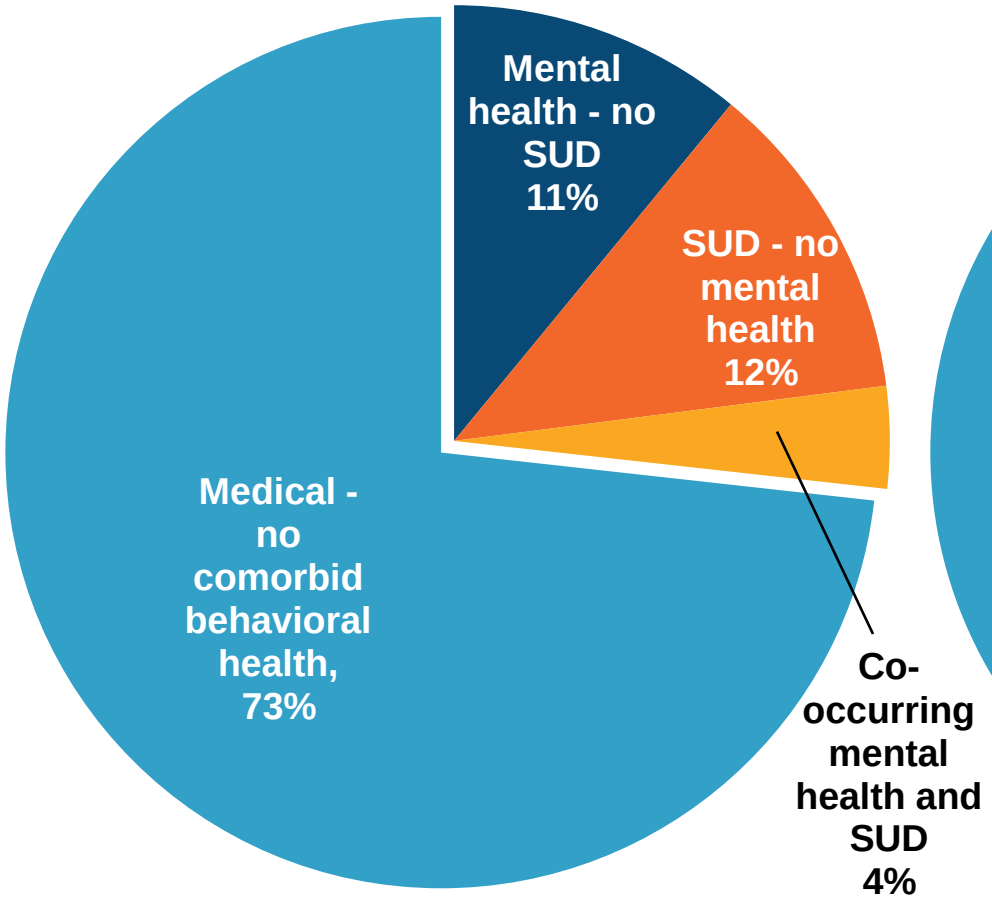
Co-occurring SUD with *Serious* Mental Illness — **1.1**% of adults

- Approximately **one third** did not receive health care services for *either* condition
- Only **1-2%** received **both** mental health care and specialty substance use treatment

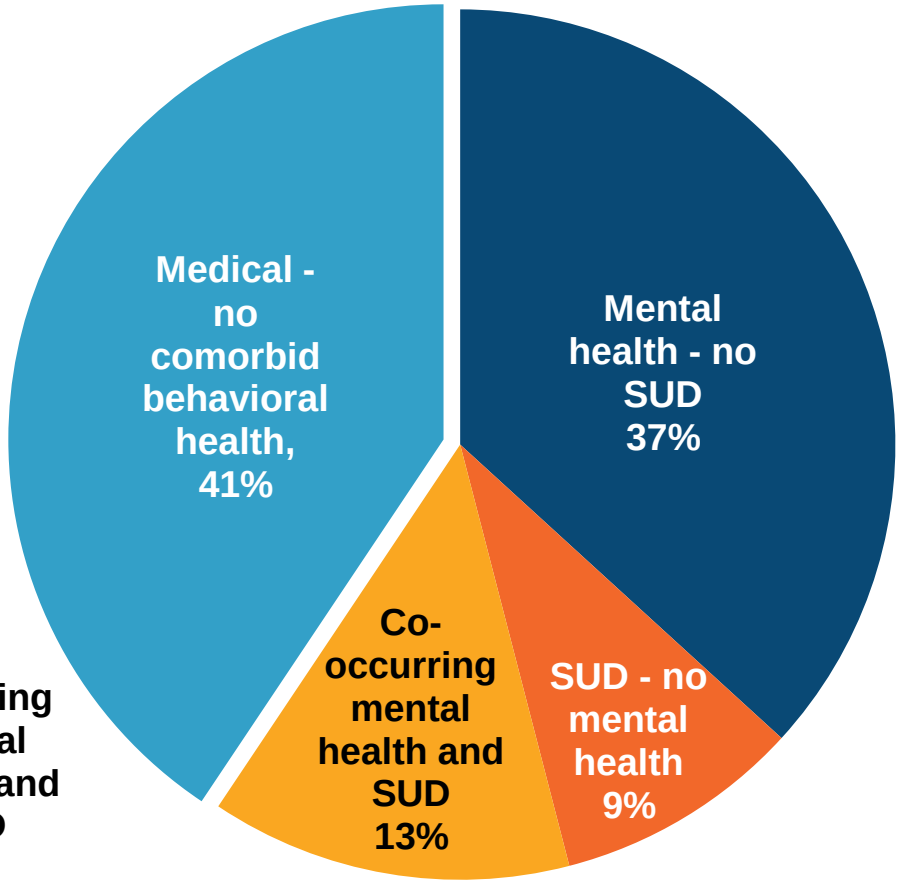
SAMHSA. *Substance Use and Mental Health Indicators in the United States: Results from the 2016 National survey on Drug Use and Health.* September 2017.

In 2016, co-occurring mental health and SUD comorbidities were identified in 6% of combined acute hospital visits (inpatient and ED)

Adult Emergency Department Visits by Diagnosis Type, FY2016; n= 1,929,455



Adult Inpatient Discharges by Diagnosis Type, FY2016; n=649,278



Source: HPC analysis of Center for Healthcare Information and Analysis Hospital Inpatient Discharge and Emergency Department Databases, 2016.

Notes: Data limited to adults eighteen and older. Mental health and SUD diagnoses were identified using the ICD-10 CCS categories in primary, admitting, discharge or secondary diagnosis fields. Co-occurring disorders were identified by records where the discharge included both a mental health and SUD diagnosis in any of the diagnosis fields. The discharges include all discharges including both those for primary medical conditions, and those with primary mental health or SUD conditions.

Importance of Integrating Mental Health and SUD Treatments

- Patients with mental illness are at higher risk than the general population for SUD, and vice versa.[1]

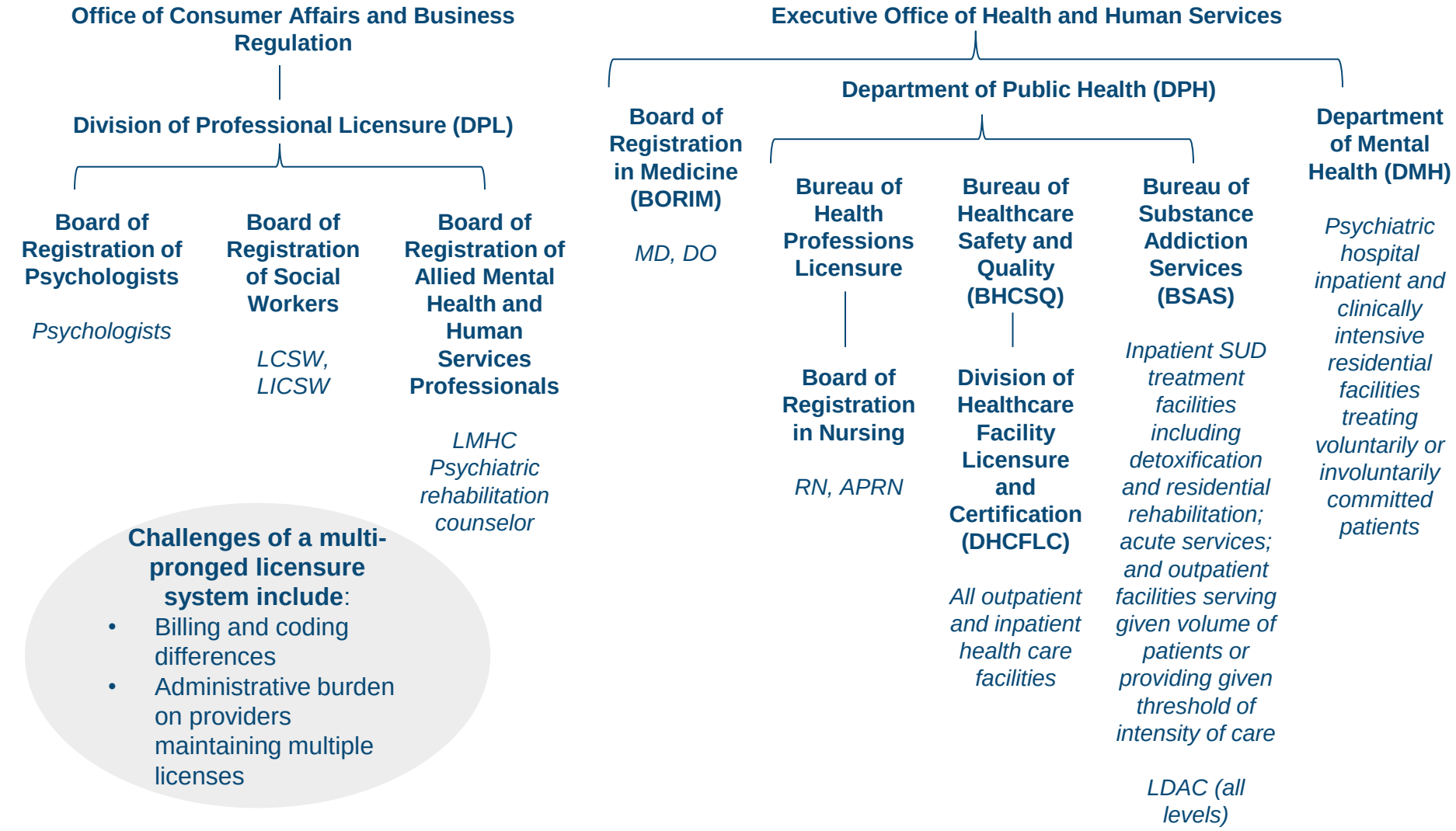
- The clinical presentations of mental illness and SUD can confound each other: without proper training in recognizing both, providers may misinterpret symptoms, misdiagnose patients, and provide suboptimal treatment.[2]

- Complications of untreated mental illness and substance use:
  - Self-medication by individuals with untreated or under-treated mental illness can affect the presentation and severity of their psychiatric symptoms.[3]
  - Patients with untreated or under-treated SUD are more likely to violate the rules of psychiatric programs or facilities and to drop out of treatment.[4]

→ **Treatment of one while screening for and, as appropriate, treating the other produces optimal care.**

1. Merikangas KR, et al. (1998). Comorbidity of substance use disorders with mood and anxiety disorders: results of the International Consortium in Psychiatric Epidemiology, *Addictive Behaviors*, 23, 893-907.
2. Crawford V, Crome IB, & Clancy C (2003). Co-existing problems of mental health and substance misuse (dual diagnosis): a literature review. *Drugs: Education, Prevention, and Policy*, 10, S1-S74.
3. National Institute of Drug Abuse (2011). Comorbidity: addiction and other mental disorders. *Drug Facts.*
4. Case N (1991). The dual-diagnosis patient in a psychiatric day treatment program: a treatment failure. *Journal of Substance Abuse Treatment*, 8 69-73.

Responsibilities for licensure of providers who treat mental illness and SUD are divided across multiple state agencies

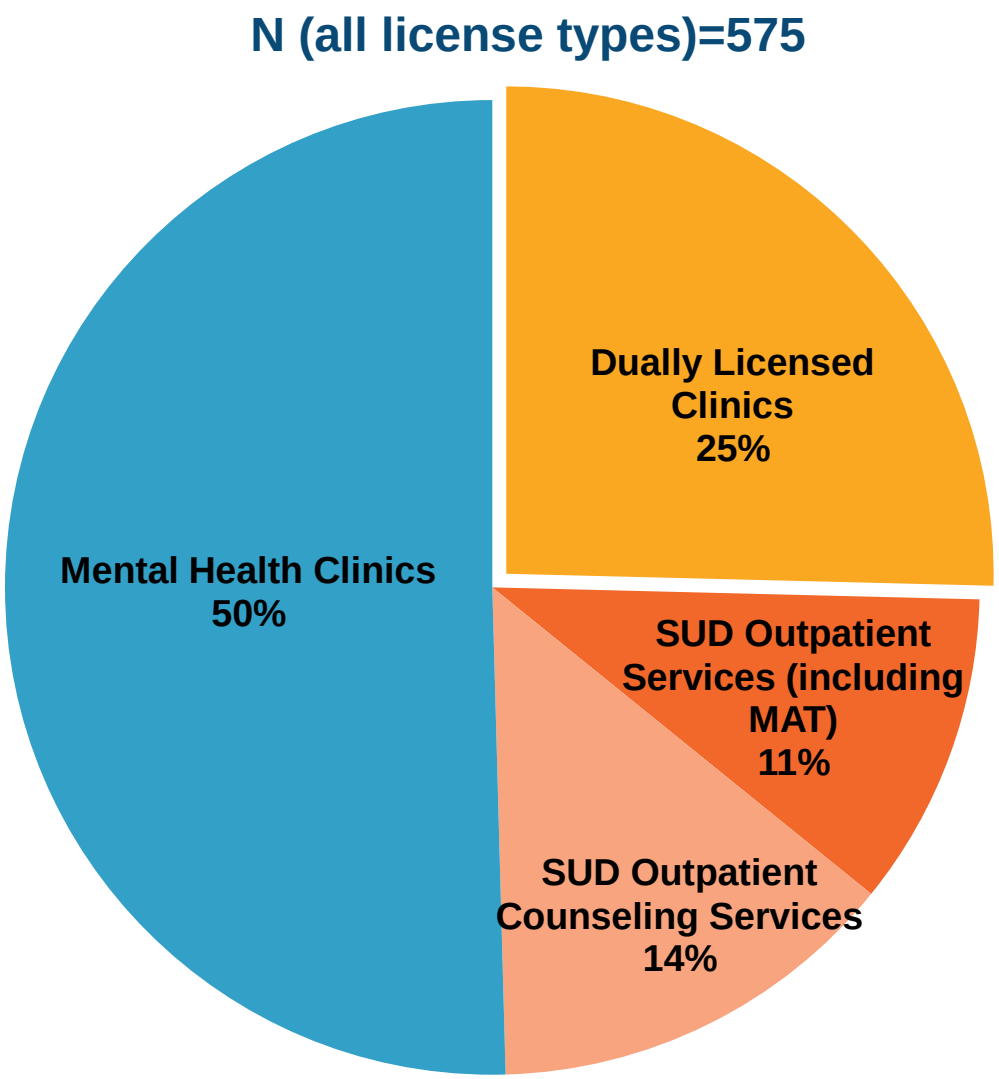


Challenges of a multi-pronged licensure system include:

- Billing and coding differences
- Administrative burden on providers maintaining multiple licenses

Some settings of care, such as VA care, public health hospitals, and section 35 units are not included in this chart.

Only a quarter of behavioral health clinics or counseling sites are licensed to treat both mental illness and SUD

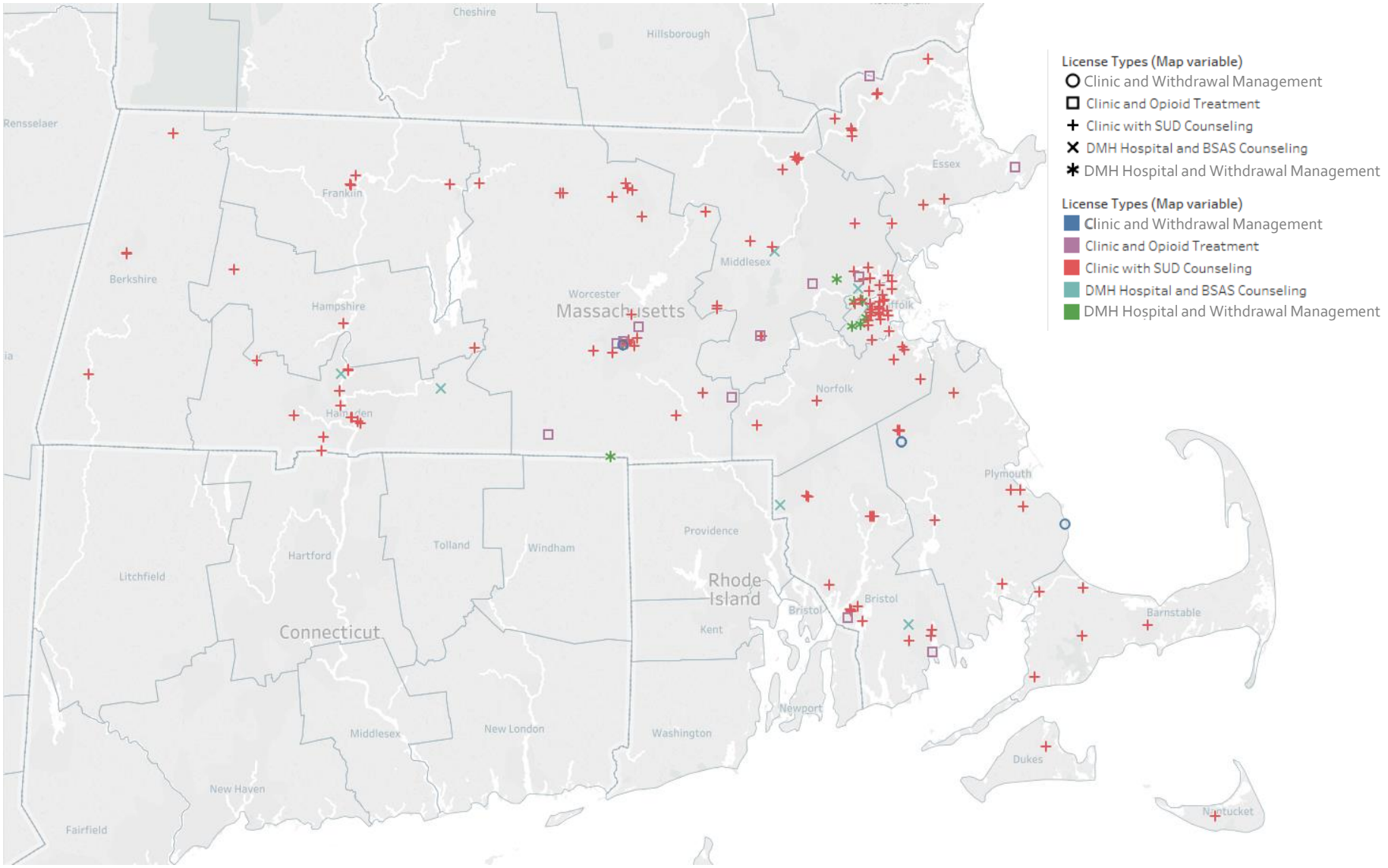


- Mental health clinics without an SUD license represent 50% of providers
  - These sites may still treat patients with SUD, per individual staff members' clinical licenses
- Clinics with dual licensure follow BSAS requirements for staffing and treatment protocols

Source: HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) licensing data.

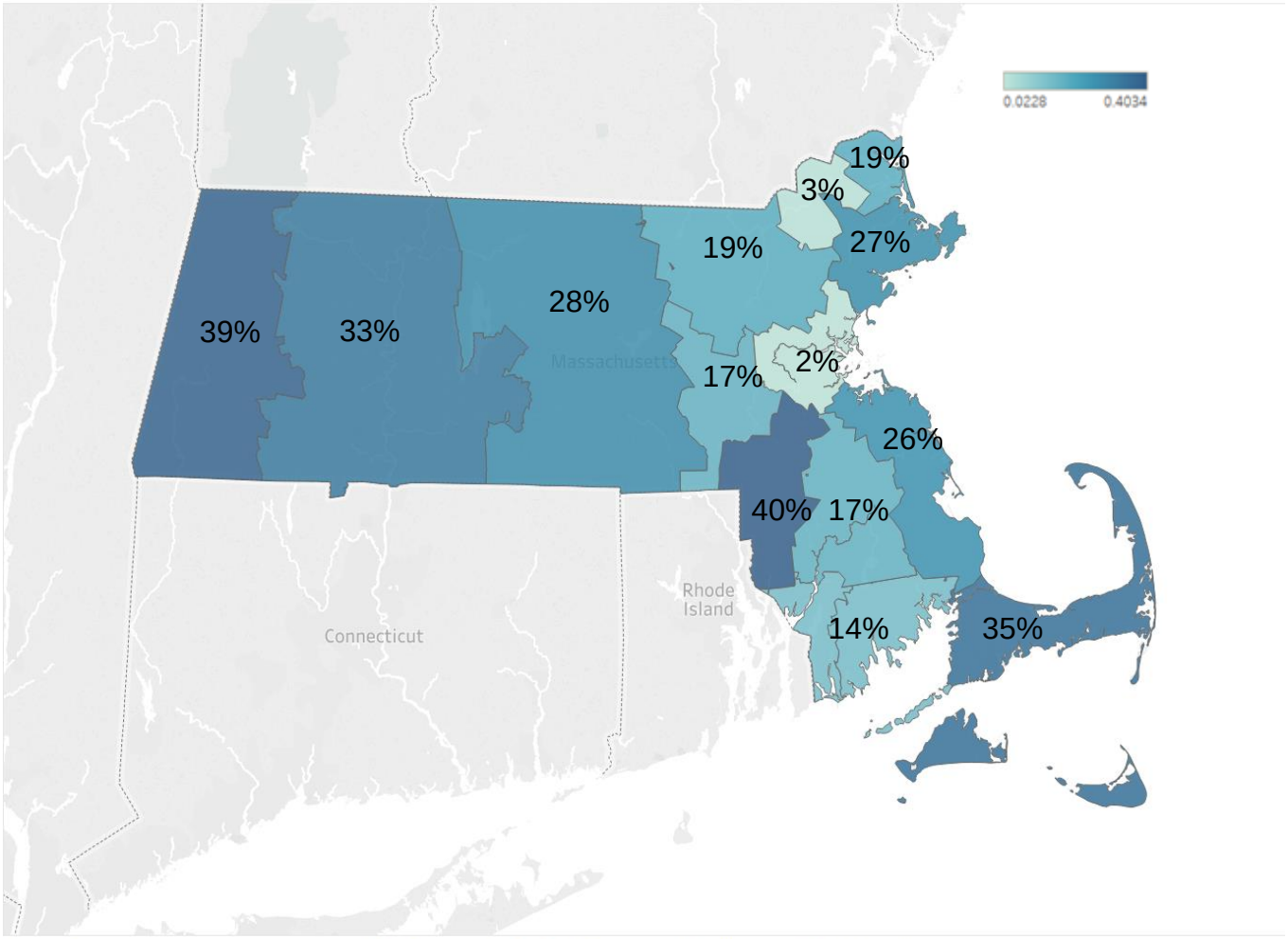
Note: while community health centers (CHC) that have mental health or SUD licenses are included, any CHC or primary care provider not licensed as a mental health or SUD clinic is not included, regardless of whether it provides prescribing for mental health or SUD.

Locations of All Dually Licensed Provider Sites in Massachusetts, 2018



HPC analysis of DPH (Division of Health Care Facility Licensure and Certification and Bureau of Substance Addiction Services) and Department of Mental Health licensing data.

Percent of Population Over 18 Living Five or More Miles from Nearest Dually Licensed Clinic



Map based on Longitude (generated) and Latitude (generated). Color shows average of % Of Population With Distance To Nearest Dually Licensed Clinic Over 5 Miles. Details are shown for HPC secondary region.

Note: There are 15 HPC regions, which are based on patterns of patient travel for inpatient care. For more information on how HPC created these regions, please see: http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf

MASSACHUSETTS
HEALTH POLICY COMMISSION

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HPC's Survey of Providers Treating Co-occurring Disorders: Methods

- HPC combined data from **commercial payers' provider directories** and data from the Substance Abuse and Mental Health Services Administration (**SAMHSA**) with **state licensing data** from **DMH** and multiple bureaus within **DPH**.
- HPC cross-referenced these files by address and provider name to identify the number of licensed provider sites by type(s) of license and HPC region.
- HPC contracted with a vendor to survey providers to determine:
  - services provided
  - populations served
  - the extent to which services specifically for co-occurring disorders are provided
  - barriers to providing integrated care for co-occurring disorders
- The survey received responses from 405 sites of service, representing slightly more than 50% of licensed behavioral health treatment sites in Massachusetts.
- In addition, the survey received responses from 170 independent clinicians in active practice who represent an important component of commercial payers' behavioral health provider networks.

Survey Research Questions

Populations Served

- To what extent are behavioral health providers treating patients with co-occurring disorders?
- Do providers explicitly exclude patients with co-occurring disorders?
- Are there certain populations (e.g., by age group, specialized need, or diagnoses) for which there are fewer organizations or clinicians providing services?
- Are there levels of care (e.g., inpatient, intensive outpatient, etc.) for which services for people with co-occurring disorders are less available?

Integrated Services Available

- To what extent is care provided in an integrated setting?
- Are SUD providers able to provide or arrange for mental health prescribing?
- Are providers who treat co-occurring disorders able to provide or arrange for SUD prescribing (e.g., methadone, buprenorphine, naltrexone)?

Barriers

- What do providers perceive as the major barriers to care for this population?
- How does language affect ability to provide care?
- What are wait times for initiating care? How does this vary by language, geography and services?
- Are staff trained on co-occurring disorders?
- What administrative, insurance and payment issues impact availability of care?

Survey Findings Topic Areas

Licensing and Regulation

- Number of providers offering services for mental illness, SUD, or both, versus those licensed to do so

Integrated Care Models

- Providers' prescribing arrangements for psychiatric medication and MAT
- Wait times for MAT

Workforce

- Wait times for patients who do not speak English
- Staff trained in co-occurring disorders care

Payment

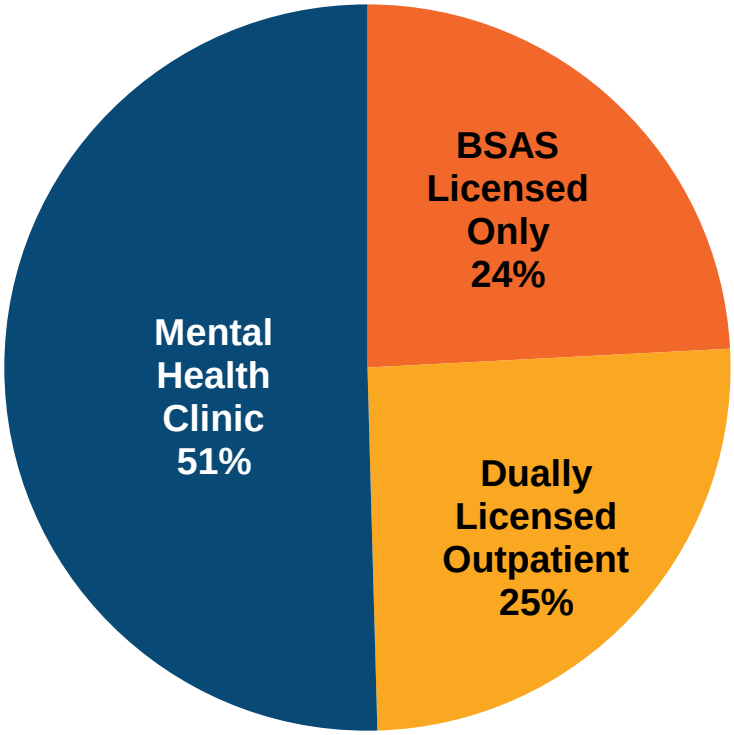
- Payment rate disparities
- Payment policy barriers to integration (e.g. no same day billing)

HPC

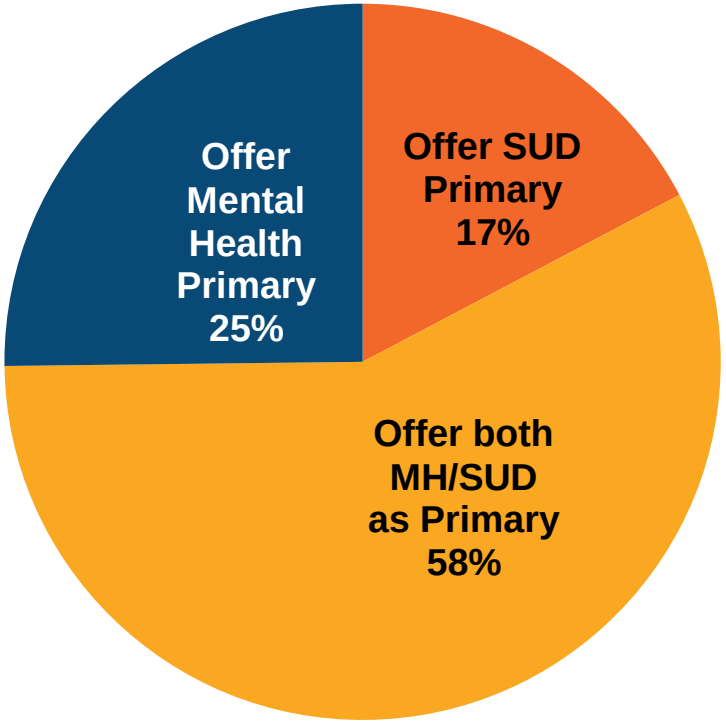
Nearly 60% of providers report offering both mental health and SUD services as primary treatment services, but dual licensure is less common

Clinics that are licensed only to provide mental health services are allowed to treat SUD, as their individual clinicians' professional licenses authorize them to treat *any* behavioral health diagnoses. While these sites may choose not to pursue parallel BSAS licensure, they still serve patients with co-occurring disorders.*

Licensed Clinic By Types, as of March 2018, N=575



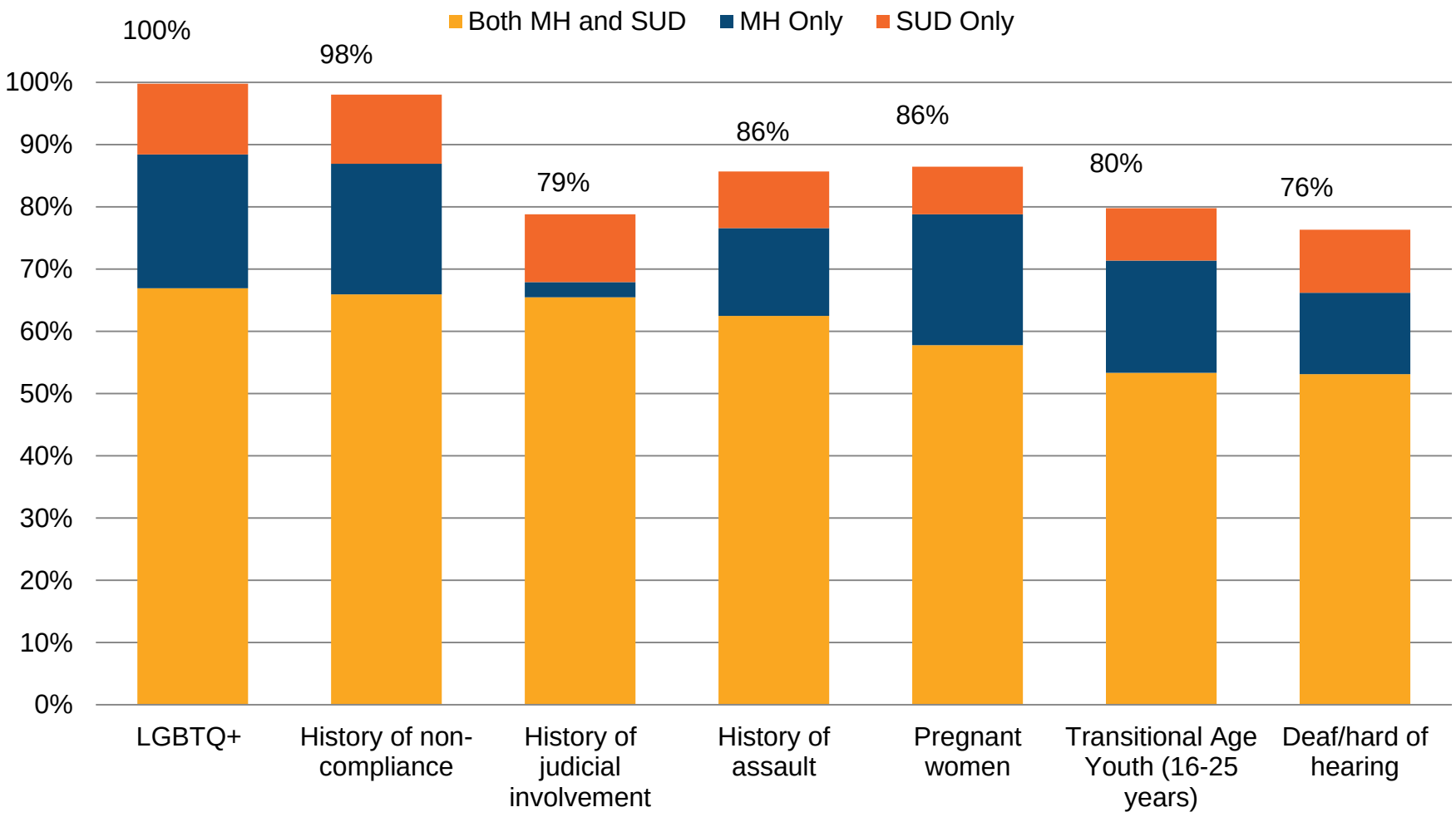
Survey respondents by Primary Service, N=405



* This situation is also true for clinics that are licensed to provide SUD services and do not seek parallel mental health clinic licensure.

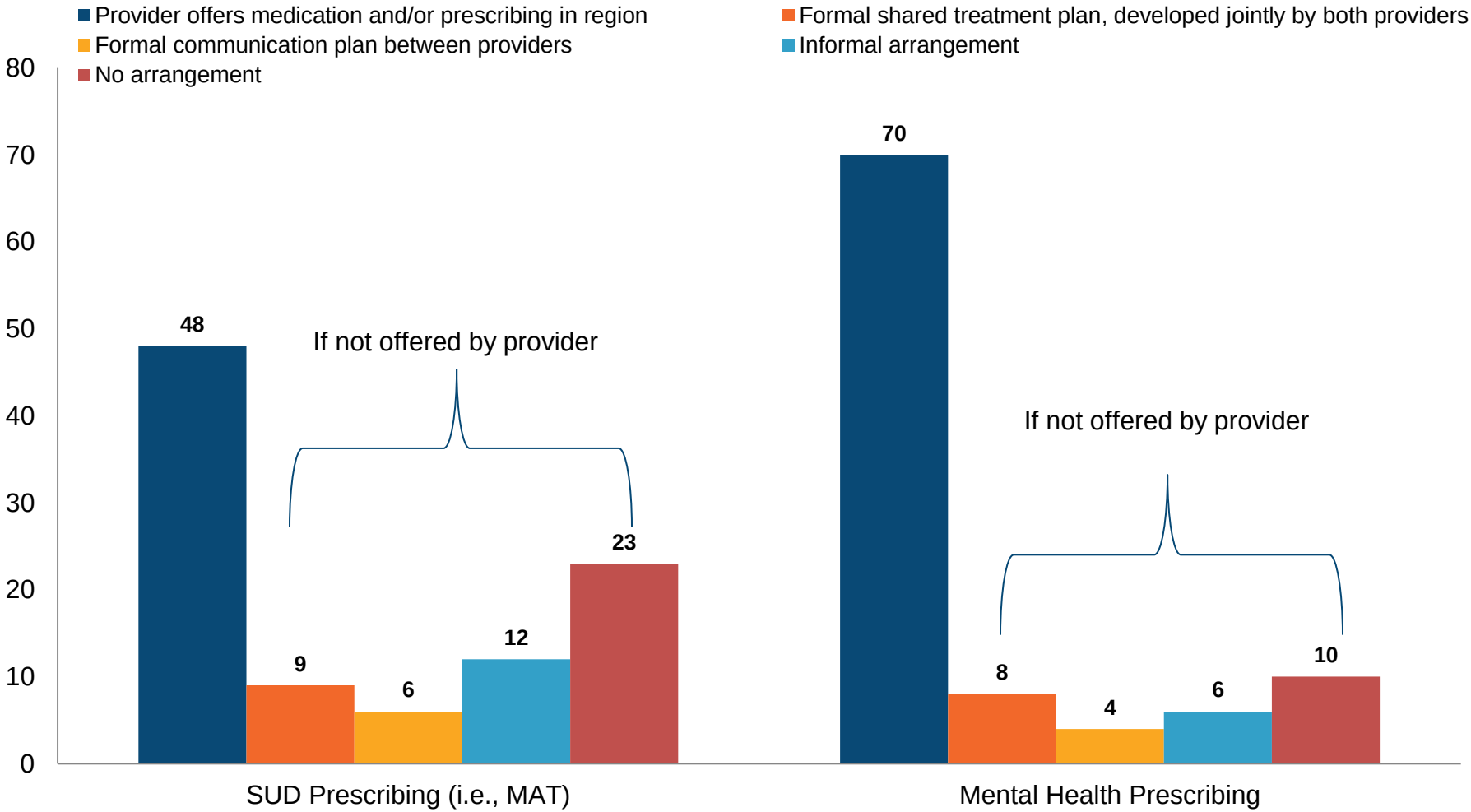
Providers report serving vulnerable populations with co-occurring disorders, but there may be access issues for patients who are deaf, have a history of judicial involvement and are between 16 and 25 years old

Percentage of responding providers that treat vulnerable populations



While many provider facilities report offering prescribing of psychiatric medications, there is room for improvement on access to evidence-based treatment for patients with SUD

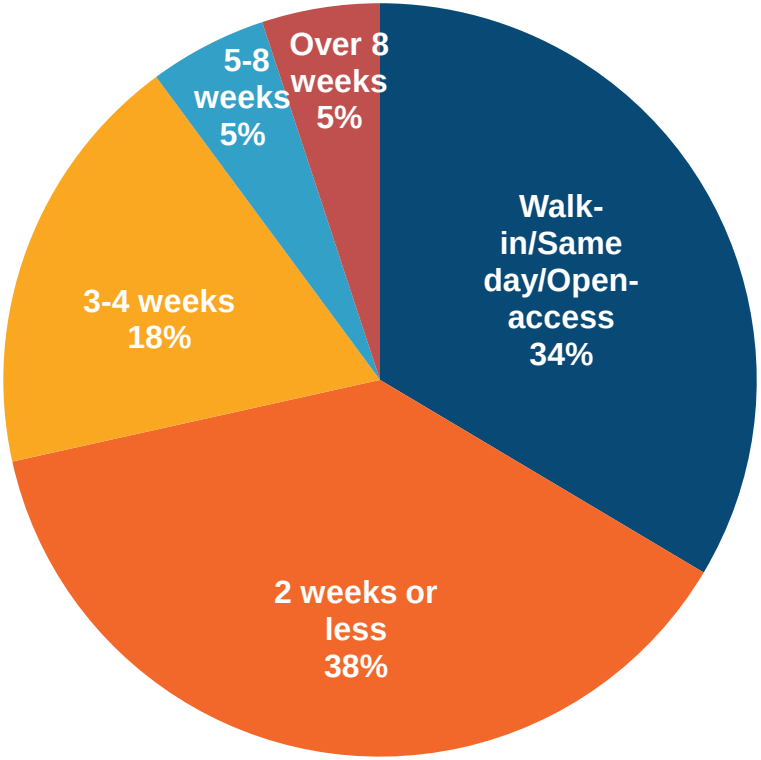
Prescribing and medication arrangements at providers who report serving co-occurring disorder (n=98*)



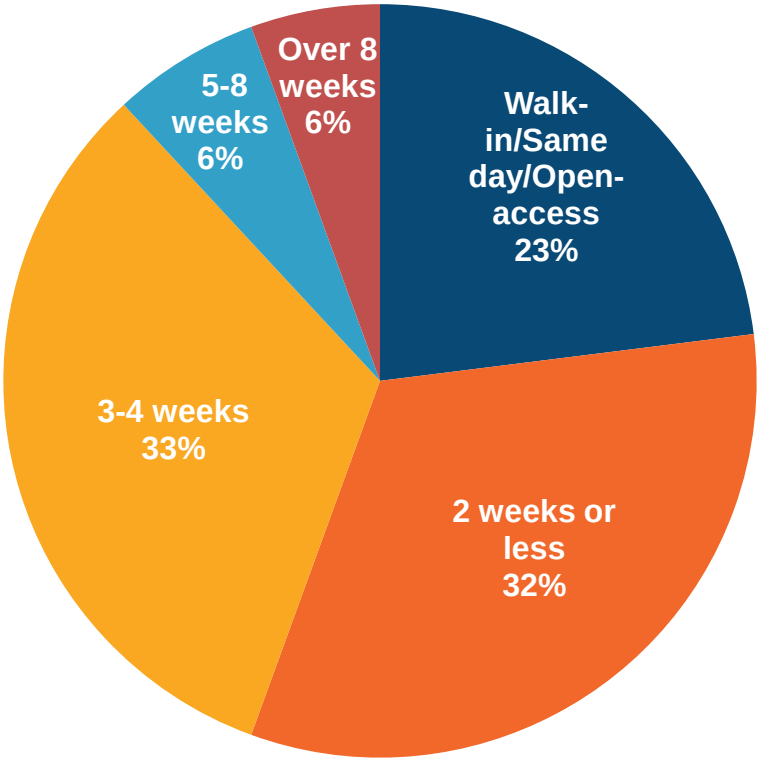
*Of all survey respondents that reported offering outpatient services for mental health and SUD, 98 responded to both 1) a question about SUD prescribing and 2) about mental health prescribing.

Providers reported that adults with co-occurring disorders who do not speak English have less access to same-day appointments and appointments within two weeks than adults with co-occurring disorders who speak English

Adults who speak English



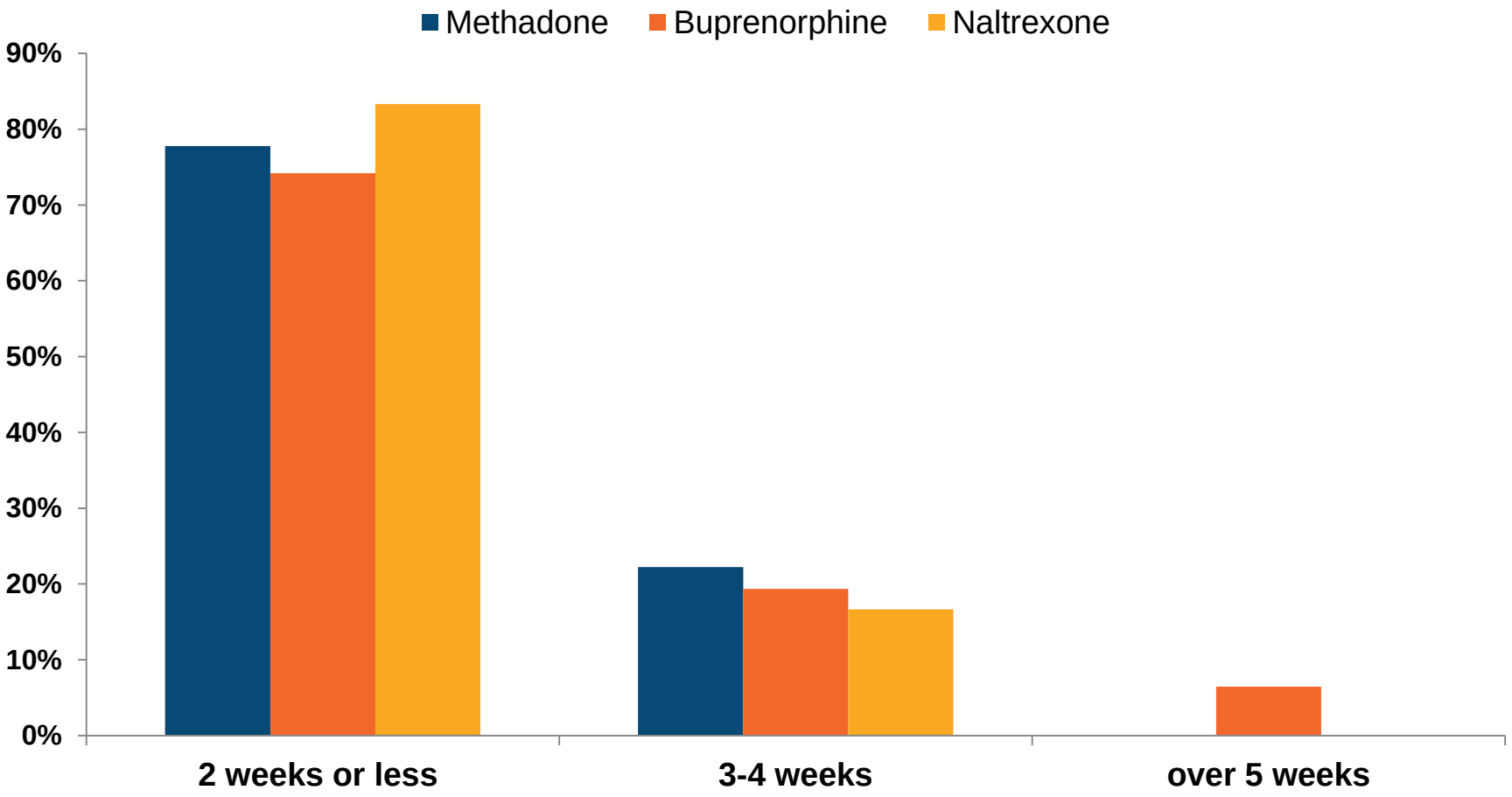
Adults who do not speak English



Note: the survey did not distinguish between prescribing versus non-prescribing services within questions about access based on language needs.

While the majority of providers who offer any type of MAT reported wait times of two weeks or less, responding providers who offer buprenorphine reported the widest range of wait times

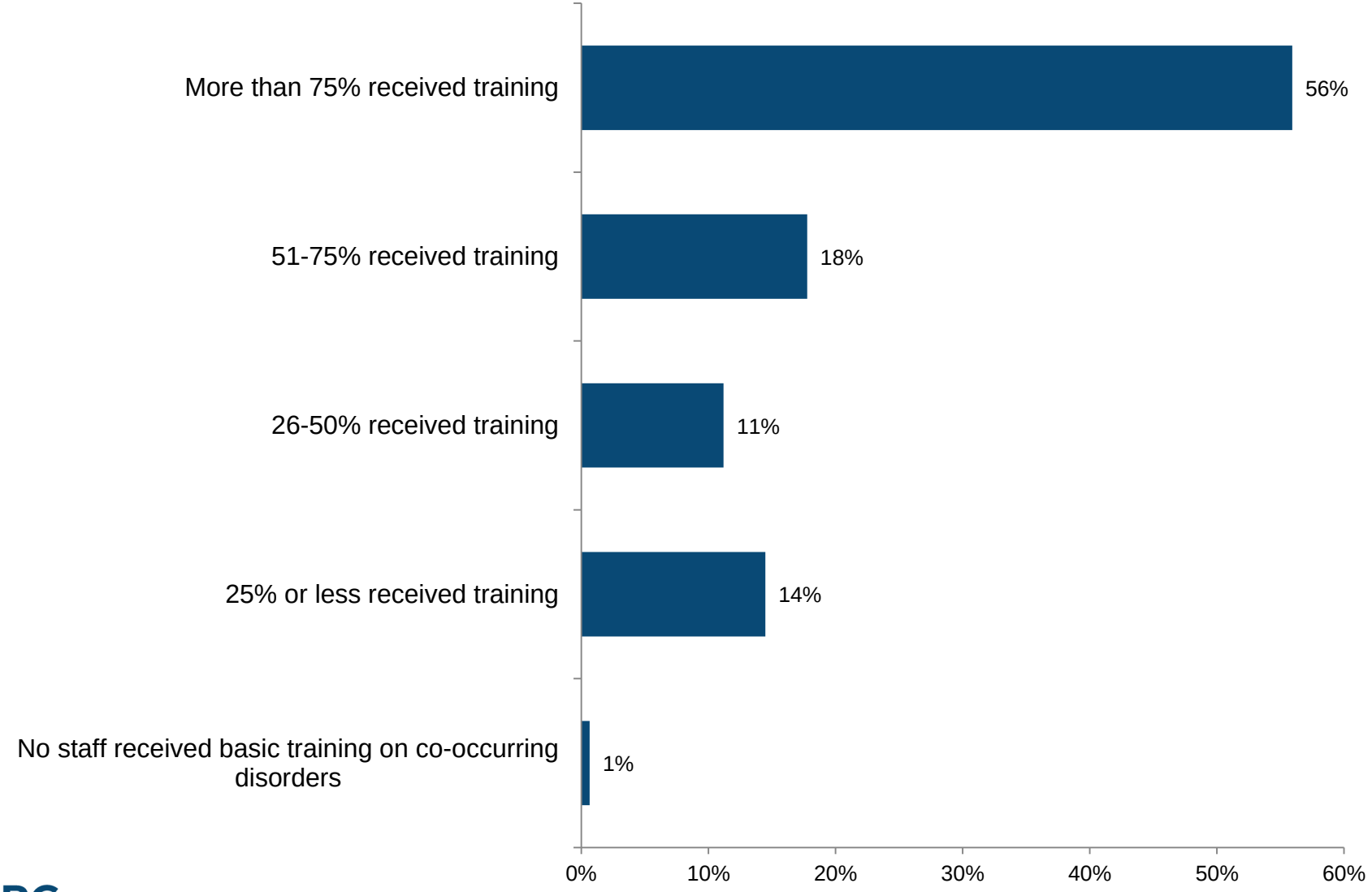
Time to first appointments for MAT for people with co-occurring disorders, by type of MAT



Note: Naltrexone may only be initiated after detoxification, so a same-day *assessment* and dose are not standard-of-care for this medication. Regardless of the medication chosen, short wait periods are essential given the high risk of relapse for patients with OUD.

More than half of providers reported that at least 75% of their staff received basic training on co-occurring disorders, but there is room for improvement

Staff with basic training on co-occurring disorders, percent of responses



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Draft Policy Recommendation Areas to Improve Access to Treatment for Co-occurring Disorders in the Commonwealth

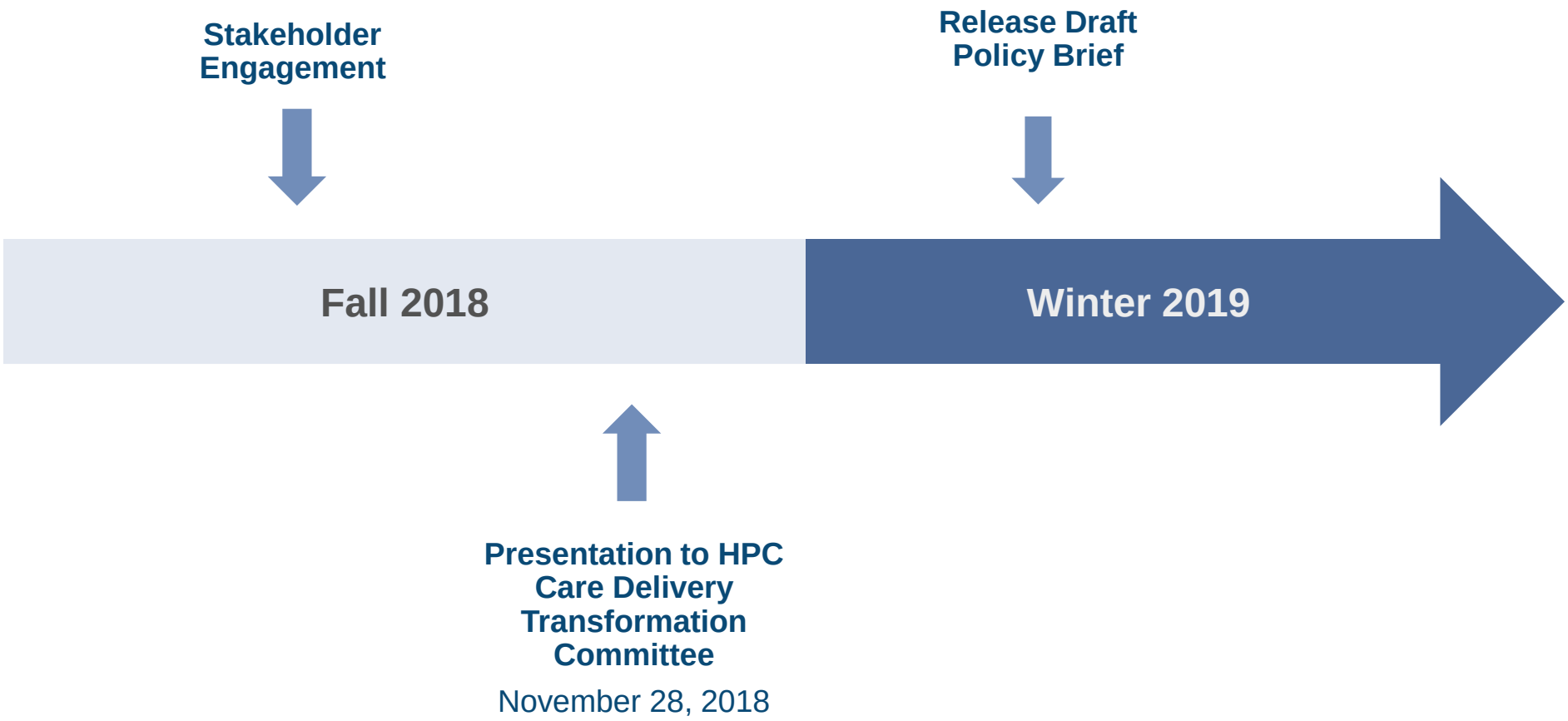
Licensing and Regulation

Integrated Care Models

Workforce

Data, Infrastructure and Payment Support

Next Steps


Stakeholder Engagement
Release Draft Policy Brief
Fall 2018
Winter 2019
Presentation to HPC Care Delivery Transformation Committee
November 28, 2018

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Procurement for Evaluation for Select SHIFT-Care Awards

Nine awards enhancing opioid use disorder (OUD) treatment

- HPC identified value in conducting a centralized evaluation for the OUD treatment cohort, allowing for the opportunity to make important contributions to the evidence base for OUD treatment.
- Evaluation will address implementation of innovative treatment models at the individual hospital sites and cohort overall, and will assess ED utilization, initiation and engagement in treatment, and patient and provider experience.

Mercy Medical Center

NSMC North Shore Medical Center

Beverly Hospital
Addison Gilbert Hospital
Members of Lahey Health

Beth Israel Deaconess Hospital
Plymouth

Harrington Hospital

Holyoke Medical Center

MGH 1811 Massachusetts General Hospital

UMassMemorial Medical Center

Lowell General Hospital

HPC

Procurement Overview and Timeline

Scope

Finalize design with HPC to conduct a mixed-methods evaluation of nine SHIFT-Care initiatives that promote timely access to behavioral health care by supporting care models that make pharmacologic treatment for opioid use disorder (OUD) and referral to outpatient services available through the emergency department (ED).

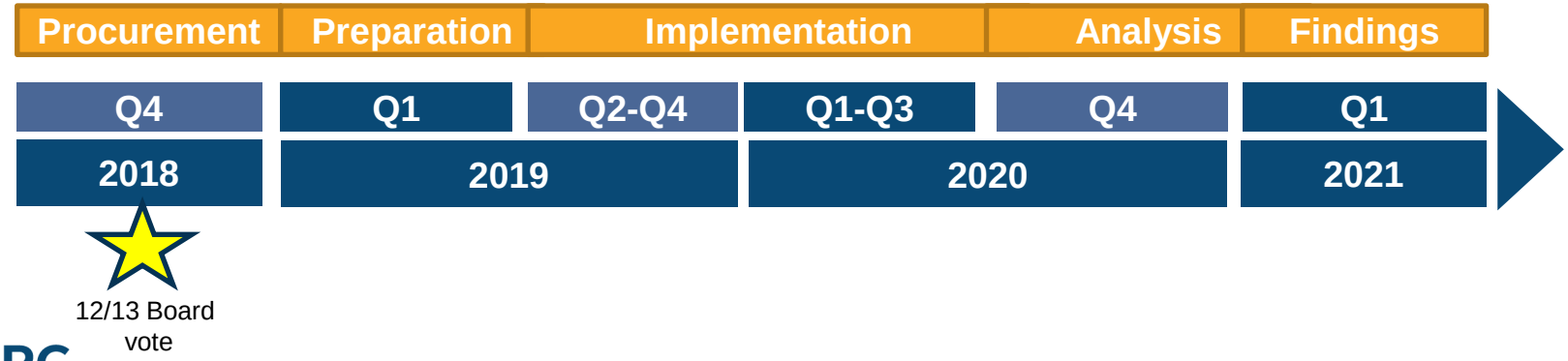
Award Cap

$600,000

Bids

7 organizations

Timing



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2018 Meetings and Contact Information

Board Meetings

Thursday, December 13, 2018

Committee Meetings

Wednesday, February 27, 2019

Contact Us

Mass.Gov/HPC
@Mass_HPC
HPC-Info@state.ma.us

Special Events

Massachusetts Employer Health Coalition (MEHC) Kickoff Breakfast: December 11, 2018, 8:00 AM – 10:00 AM

MASSACHUSETTS
HEALTH POLICY COMMISSION

APPENDIX

Overview of 2017 ACO Certification Criteria

Pre-requisites

4 pre-reqs.
Attestation only

- ✓ Risk-bearing provider organizations (RBPO) certificate, if applicable
- ✓ Any required Material Change Notices (MCNs) filed
- ✓ Anti-trust laws
- ✓ Patient protection

1 Assessment Criteria

6 criteria
Sample documents, narrative descriptions

- ✓ Patient-centered, accountable governance structure
- ✓ Participation in quality-based risk contracts
- ✓ Population health management programs
- ✓ Cross-continuum care: coordination with BH, hospital, specialist, and long-term care services

2 Required Supplemental Information

9 criteria
Narrative or data
Not evaluated by HPC but must respond

- ✓ Supports patient-centered primary care
- ✓ Assesses needs and preferences of ACO patient population
- ✓ Develops community-based health programs
- ✓ Supports patient-centered advanced illness care
- ✓ Performs quality, financial analytics and shares with providers
- ✓ Evaluates and seeks to improve patient experiences of care
- ✓ Distributes shared savings or deficit in a transparent manner
- ✓ Commits to advanced health information technology (HIT) integration and adoption
- ✓ Commits to consumer price transparency

HPC

Governance Structure

Domain	Criterion	Documentation requirements
Patient-centered, accountable governance structure	The ACO has an identifiable and unique Governing Body with authority to execute the functions of the ACO. The ACO provides for **meaningful participation in the composition and control of the Governing Body for its participants** or their representatives.	Excerpts of **Governing Body by-laws** or other authoritative documents that demonstrate the Governing Body's authority to execute the functions of the ACO**.** ***Organizational chart(s) of the Governance Structure(s)****, including Governing Body, executive committees, and executive management** **Governance Structure key personnel template,** including the following identifying information for Governing Body members, executive committee members, and executive management staff: name; title and clinical degree/specialty; role within the Governance Structure Attestation that **ACO Participants have at least 75% control of the Governing Body**

*To be captured in Background Information section.

Patient / Consumer Representation

Domain	Criterion	Documentation requirements
Patient-centered, accountable governance structure	The ACO governance structure is designed to serve the needs of its patient population, including by having **at least one patient or consumer advocate within the governance structure and having a patient and family advisory committee.**	***Identify the patient(s) or consumer advocate(s)*** *on the organizational chart(s) and template submitted for AC #1** **Description of at least one patient and family advisory committee (PFAC)** or other group that is composed of patients, families, and/or consumer advocates. If the Applicant intends to use an existing hospital-based Patient and Family Advisory Council (PFAC) to satisfy this requirement, **excerpted meeting minutes of most recent PFAC** meeting where issues pertaining to the ACO(s) were discussed. **Publicly available narrative** demonstrating one or more ways the Governance Structure(s) seeks to be **responsive to the needs of its patient population**.

*To be captured in Background Information section.

Performance Improvement Activities

Domain	Criterion	Documentation requirements
Patient-centered, accountable governance structure	The ACO **Governing Body regularly assesses the access to and quality of care provided by the ACO**, in measure domains of **access, efficiency, process, outcomes, patient safety, and patient experiences of care**, for the ACO **overall and for key subpopulations** (i.e. medically or socially high needs individuals, vulnerable populations), including measuring any racial or ethnic disparities in care. The ACO has **clear mechanisms for implementing strategies to improve its performance** and supporting provider **adherence to evidence-based guidelines**.	**Narrative of how the Governing Body(ies) assesses performance and sets strategic performance improvement goals**, no less frequently than annually. **Performance dashboard(s)** with measure name detail and a description of **how often the Governing Body(ies) reviews the dashboard** and related strategic goals (at least annually). The dashboard **must include at least one measure in each domain** (process, efficiency, outcomes, and patient experience) and **indicate which measures are stratified by sub-population** and by which sub-populations. **At least one measure must be stratified by a sub-population**.

Population Health Management Programs

Domain	Criterion	Documentation requirements
Population health management programs	The ACO routinely **stratifies** its entire patient population and uses the results to **implement programs** targeted at **improving health outcomes for its highest need patients.** At least one program addresses **behavioral health** and at least one program addresses **social determinants of health** to reduce health disparities within the ACO population.	**Description of the Applicant's approach to stratifying its patient population including**: frequency (at least annually), factors on which stratification is completed, data sources and methodology, and any differences among subpopulations. **Description of at least one program operated by the Applicant that addresses BH and at least one program that addresses SDH including**: patient targeting, specific intervention and staffing model, target performance metrics, size of program, and linkages to community resources or organizations.

Cross-continuum Care

Domain	Criterion	Documentation requirements
Cross continuum care	To **coordinate care and services** across the care continuum, the ACO **collaborates** with providers **outside the ACO** as necessary, including: - Hospitals - Specialists - Long-term services/supports - Behavioral health providers Providers and facilities **within the ACO** collaborate to coordinate care, including **following up on tests and referrals across care rendered within the ACO.**	**Structured data responses, including radio buttons and text boxes, describing how the ACO collaborates with each category of clinical partners** (hospitals, specialist, long-term services and supports, and behavioral health). Applicants must submit the providers that are in the ACO or that the ACO holds written collaborative agreements with these entities and must provide information on which factors are considered when entering into arrangements. Applicants without such agreements must provide a description of other arrangements or plans to enter into written agreements.