September 8, 2014

Mr. David Seltz
Executive Director
The Commonwealth of Massachusetts Health Policy Commission
Two Boylston Street
Boston, MA 02116

Dear Mr. Seltz:

On behalf of Arbour Health System (AHS), attached is the requested written testimony in response to questions of the Health Policy Commission (HPC). AHS is the largest private behavioral health system in Massachusetts and is comprised of the following organizations representing a continuum of inpatient, acute residential, partial hospitalization, outpatient and community-based psychiatric programs for children, adolescents, and adults: Arbour Hospital, Boston, MA; Arbour-HRI Hospital, Brookline, MA; Arbour-Fuller Hospital, South Attleboro, MA; Lowell Treatment Center, Lowell, MA; The Quincy Center, Quincy, MA; Pembroke Hospital, Pembroke, MA; Westwood Lodge, Westwood, MA; Arbour Counseling Services (including outpatient locations in MA) and Arbour SeniorCare

We are submitting this testimony electronically in pdf and Word format to HPC-Testimony@state.ma.us as requested including responses to areas of inquiry identified on "Exhibit B". Should you have any questions regarding this submission, please contact Judith Merel, Regional Director, Business Development, AHS, at 617-390-1224 or at judy.merel@uhsinc.com. As AHS CEO, I am legally authorized and empowered to represent the organizations under its umbrella for the purpose of this testimony, and the testimony has been signed under the pains and penalties of perjury.

Sincerely,

Gary Gilberti
Chief Executive Officer
Arbour Health System

Questions

1. Chapter 224 of the Acts of 2012 (C. 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth between CY 2012-2013 and CY 2013-4 is 3.6%.

a. What trends has your organization experienced in revenue, utilization, and operating expenses from CY 2010-CY2013 and year-to-date 2014? Please comment on the factors driving these trends.

Arbour Health System organizations (with exception of a capitated contract for child/adolescent patients with Westwood Pembroke Health System for a small number of covered lives) are reimbursed by managed care payors and MassHealth on a per diem basis or by Medicare through the IP PPS methodology. The rate increases provided by the managed care plans and other payors has been, on average, significantly less that the benchmark for growth of 3.6%. In the case of outpatient services, reimbursement reflects for the most part statewide fee schedules which have remained stagnant with no increases over this same period. Revenue, in fact, has been negatively impacted by increased uncompensated care due to increasing numbers of patients who benefits terminate while in the hospital, exhausted days, payor denial of inpatient level of care, patients on lower payment levels (AND) as they await hospitalization in a DMH facility or other lower level of care that is not available.

The organization's revenue growth has not reflected increases in health care costs or reimbursement, but relates to the increase in service development to meet the increasing demand for behavioral health (mental health and substance abuse) services. AHS hospitals utilization has been strong over the past years, with most hospitals averaging over 90% occupancy. Utilization of services has been increasing for outpatient and community-based care, as the payor, provider and AHS system seek to provide services in outpatient and community-based settings, expanding diversionary services to better manage patients in alternative, appropriate settings that avoid unnecessary use of high cost inpatient care.

Operating expenses continue to increase, in large part due to labor (salaries/benefits) and professional (MD) fees. There have been increases in expenses in other categories including, but not limited to: pharmacy costs and development of information systems. Drivers of expense increases include the increased regulatory mandates from federal, state and payor agencies, increasing acuity of patient populations, labor costs (as a result of increased competition/lesser availability of certain positions (RN and MDs, in particular) and need to develop information systems including for care integration.

b. What action has your organization has undertaken since January 1, 2013 to reduce the total cost of care for your patients? Please comment on the factors driving these trends.

As noted in the 2013 report to the Health Policy Commission, Arbour Health System (AHS) continues to be a highly efficient provider of behavioral health services. AHS organizations have strong administrative oversight with focus on increased efficiency, however, there continue to be opportunities for cost reduction through improved coordination of care, program/network expansion for development of vertically integrated services to support patient access care at the most appropriate level at the most appropriate time, and improved use of health information technology/communication, adoption of evidenced-based practices and integration of medical and behavioral health care.

The organization has, and will continue to effectively manage the cost of care by addressing the below-listed items (in no order of priority). Additionally, there are other actions that have been taken or planned for consideration that may not be included below.

1. Developing alternative services such as acute residential, partial hospitalization and community or home-based programs to allow patients to be cared for in the right setting at the appropriate time.
2. Adhering to formularies for medications given that pharmacy expense is a significant driver of inpatient behavioral health cost.
3. Management of workers compensation expense through crisis prevention (CPI) education and training.
4. Providing centralized services such as Intake, Business Office, Human Resources, etc. which offer economies of scale.
5. Leveraging system purchasing power for contracts (lab, radiology, etc.).
6. Length of stay management and effective discharge planning to prevent readmissions.
7. Continued implementation of electronic health records/information at sites to improve communication and coordination of care with behavioral health and primary care providers.
8. Assessing health conditions, co-morbid or at high risk, amongst behavioral health child and adult populations and assuring care coordination with primary care providers.
9. Aligning/collaborating with primary or acute care providers to integrate care and improve outcomes.

c. What actions does your organization plan to undertake between now and October 1, 2015 (including but not limited to innovative care delivery approaches, use of technology and error reduction) to ensure the Commonwealth will meet the benchmark?

There continues to be opportunities to improve the quality and efficiency of care at AHS facilities. Some of these are noted below, however the list is not all inclusive but represents key issues across AHS facilities. After each point, the current factors that limit our ability to address these opportunities are noted.

1. Improve inpatient reimbursement from key payors or identify opportunities to move to appropriate pay-for-performance methodologies.

Enhanced or alternative reimbursement models could allow additional resources to address care management, care integration, coordination of care and other services not previously recognized. Barriers including budget/funding from MassHealth and other payors to enable rate increases and ability of payors to create pay-for-performance or other reimbursement models that accurately reflect the patient case mix, outlier management, outcomes, etc. that appropriately address to issues specific to managing a behavioral health population.

2. Reimburse outpatient providers for comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services.
3. Eliminate or minimize utilization management -- develop approaches to manage outlier cases and utilize staff (hospital and payor) to develop crisis plans, identify aftercare placements, assures compliance with treatment plans. Barriers include MCO willingness to shift approaches away from focused utilization management.
4. Use of telemedicine. Opportunities exist to provide evaluation and screening or consultative services through the use of telemedicine. Regulatory restrictions in Massachusetts may prevent use of telepsychiatry which has been proven effective in other states.
5. Eliminate regulatory requirements that add cost but do not affect the quality or outcomes of care based upon evidence-based practices garnered from MA and other states. Example is the continued requirement to have on-site MD 24/7 for freestanding psychiatric hospitals.
6. Lack of standard requirements and performance specifications from payors.
7. Electronic Health records/information implementation. HIT and meaningful use excluded psychiatric hospitals however this is a requirement of CMS and instrumental to care integration. AHS hospitals and outpatients organizations are implementing programs without similar funding support as for medical providers.
8. Ability to manage network to move patents across continuum (affiliations). AHS would like to develop additional levels of care to best manage patients across the continuum, however, certain payors must approve new program development and, at the same time, may not have enough providers in their networks. This results in patients remaining in hospitals for longer lengths of stay or stuck in EDs or hospital beds waiting inpatient or diversionary services.
9. Improve access to state services including DMH beds, residential programs, etc. Patients continue to remain “stuck” in expensive inpatient settings awaiting placement in more appropriate community-based settings.
10. Medically necessary behavioral services including collateral contacts, should be reimbursable outside of the behavioral health setting including

in education, community and home settings and should be included in publicly and commercially available health care benefits.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

As noted in the prior report to the Health Policy Commission, identified below are some systematic or policy changes that would help organizations such as AHS to operate more efficiency without reducing quality. As noted above, this is list is not all inclusive of changes that may support increased efficiency.

1. Improve alignment of federal and state oversight including with CMS, DMH and DPH.
2. Address state regulations or performance criteria that increase cost but do not enhance quality or outcomes of care
3. Fund/support EHR implementation -- health information technology and meaningful use were excluded for psychiatric hospitals.
4. Address inconsistent MCO requirements or procedures including for prior authorization and utilization management that increase administrative cost and reduce efficiency.
5. Improve funding of or access to services so they are adequately resourced and do not risk being eliminated or downsized, resulting in access issues and patients "stuck" in EDs or on inpatient units. This includes, but is not limited to, inpatient child and adolescent, state hospital beds, specialty programs (intellectual disabilities, medical-psychiatric services, etc.)
6. Fund primary care in intensive mental health settings such as inpatient, residential and day treatment programs.
7. Address prior authorizations requirements that exist for behavioral but not medical/primary care to create more natural work flow and support care coordination.

2. C.224 requires health plans to reduce the fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.

a. How have alternative payment methods (APMs – payment methods used by a payer to reimburse health care providers that are not solely based on the fee-for-services basis, e.g. global budget, limited budget, bundled payments, and other non-fee-for service models, but not including pay-for-performance incentives accompanying fee-for-service payments) affected your organization's overall quality performance, care delivery practices, referral patterns and operations.

At this time, the predominant payment methodologies for AHS hospitals are fee-for-service mechanisms and therefore we cannot comment on how APMs have affected our overall quality performance, care delivery practices, referral patterns and operations.

b. Attach and discuss any analyses your organization has conducted on the implementation of APMs and resulting effects on your non-clinical operations (e.g. administrative expenses, resources and burdens).

There are no analyses that Arbour Health System has to present to the Health Policy Commission on the implementation of APMs at this time.

c. Please include the results of any analyses your organization has conducted on this issue, including both for your patients paid under APMs and for your overall patient population.

As noted above, this is not applicable at this time.

3. Please comment on the adequacy or insufficiency of health status risk adjustment measures used in establishing risk contracts and other APM contracts with payers.

a. In your organization's experience, do health status risk adjustment measures sufficiently account for changes in patient population acuity, including in particular sub-populations (e.g. pediatric) or those with behavioral health conditions?
b. How do the health status risk adjustment measures used by different payers compare?
c. How does the interaction between risk adjustment measures and other risk contract elements (e.g. risk share, availability of quality or performance-based incentives) affect your organization?

As noted above, given the lack of risk contracts and other APM contracts with payers, we are not in the position to comment on the items noted above. It is important to note that we believe it will be critical for any risk contract or APM contracts to adequately address health status risk adjustment measures, case mix, outliers, etc. prior to implementing for behavioral health care.

4. A theme heard repeatedly at the 2013 Annual Cost Trends Hearing was the need for more timely, reliable, and actionable data and information to facilitate high-value care and performance under APMs. What types of data are or would be most valuable to your organization in this regard? In your response, please address (i) real time data to manage patient care and (ii) historic data or population level data that would be helpful for population health management and/or financial modeling.

There is a need for more timely, reliable and actionable information and data from both providers and payors to facilitate high-value care and performance under APMs. Some of the data items needed to be addressed to move to APMs are as follows and is data which health plans hold and should more readily share with providers.

1. Claims data to support provider care of all patients.

2. Information on projected membership growth and shifts in various products and benefit designs throughout the contract period.
3. Data to enable providers to analyze the impact of contract terms before executing contracts and during the course of contracts.
4. Cost per case mix adjusted discharge.

5. C. 224 require health plans to attribute all members to a primary care provider, to the maximum extent feasible.

a. Which attribution methodologies most accurately account for patients you care for?

b. What suggestions does your organization have for how to best formulate and implement attribution methodologies, especially those used for payment?

AHS recognizes that health plan members should be in the position to attribute all members to a primary care provider and support this requirement. Given our role as a behavioral health provider, it is difficult to response to these questions as we are unclear as to what attribution methodologies more accurately account for patients that we see in our programs and services and are not well positioned to comment on ways to best formulate and implement attribution methodologies, especially those used for payment. It is clear that some patients may choose medical homes in the future that may have a behavioral health focus. For patients with mental health and substance abuse issues, it is important to identify that BH providers may be the locus of care coordinator in the future, with linkages to PCPs.

6. Please discuss the level of effort required to report quality measures to public and private payers, the extent to which the quality measures vary across payers, and they resulting impact on your organization.

AHS has not been required to report specific quality measures to public and private payors. In many cases, the payors identify certain measures of "quality" and present these to the hospitals and outpatient programs. These measures of "quality" include, but are not limited to length of stay, case-mix adjusted (addressed differently by individual payors with lack of clarity on methodology used or variables used to case-mix adjust) length of stay, 7 day readmission rate, 30 day readmission rate, 7 day follow-up rate, 30 day follow-up rate, peer review rate, and behavioral health spend per episode. The hospitals receive data reports from certain payors on a monthly or quarterly basis and review these measures and develop actionable plans to affect each indicator or identify external factors that may impact each. These external factors (such as managed care network availability of step-down services including outpatient providers and timely access to these services) are addressed with the MCO.

7. An issue addressed both at the 2013 Annual Cost Trends Hearing and in the Commission's July 2014 Cost Trends Report Supplement is the Commonwealth's higher than average utilization of inpatient care and its reliance on academic medical centers.

a. Please attach any analyses you have conducted in inpatient utilization trends and the flow of your patients to AMCs or higher cost care settings.

There are no analyses that Arbour Health System has to present to the Health Policy Commission on inpatient utilization trends and the flow of patients to AMCs or higher cost settings. While there have been higher costs associated with psychiatric units in acute care hospitals and AMCs, this does not appear to have directly impacted utilization trends.

As noted in the prior year response to the Health Policy Commission, while Arbour Health System has not begun to benchmark items performance on operational cost structure against peer organizations, the Massachusetts Behavioral Health Partnership (MBHP) recently retained Public Consulting Group (PCG) to complete an analysis of hospital costs. The study was being commissioned to assist in identification of rate increases based upon variations in average per diems from average costs by facility type (private psychiatric and behavioral health units in general acute care hospitals). Data used to make this determination was derived from analysis of 2012 403 cost reports -- information indicates that the private psychiatric hospitals have significantly lower costs than acute care hospitals. On the PCG report, weighted average cost per day from 403 cost reports was $677.58 for private psychiatric facilities and $1,102.59 for general acute hospitals. Acute care hospital actual cost per day was identified as high as $1,768.60 in 2012.

Even with this, it was noted that the private psychiatric facilities are receiving less than 100% cost coverage. The report further noted that payors such as MBHP do not want to underfund these low cost, high quality hospitals as they may close beds and leave higher cost hospitals who will demand higher funding from payors (ACOs) to cover their costs. As stated in the PCG report, the unintended consequences of underfunding is the forced closure of units resulting in few available beds. With fewer available beds, patients remain stuck in Emergency Departments or may be required to utilize higher cost beds. With fewer beds and higher staff-to-patient ratios, hospitals are forced to turn away individuals in need of care.

In November 2012, the Center for Health Information and Analysis (CHIA) issued a report on Psychiatric Hospital and Acute Hospital Behavioral Health Unit Relative Price Analysis. This examined the relative price and payment data for psychiatric and acute hospitals with dedicated psychiatric care or substance abuse units for Blue Cross Blue Shield of MA, Fallon Community Health Plan, Harvard Pilgrim Health Plan and Tufts Health Plan. The report identified variation in relative "prices" across payers for each hospital but this appeared to be a reflection of negotiated per diems. It is unclear how this data was collected and analyzed as the information does not appear to be wholly accurate based upon knowledge of our system reimbursement/per diems. This report compared facilities with different services and is one of the concerns with benchmarking against "peer organizations". Walden and Arbour-Fuller were included in the top tier, however, both have services including eating disorders and intellectual disabilities that

have significantly higher associated costs and therefore agreed upon per diems. This report did not differentiate in any measurable way the variances in patient population/acuity associated with the higher "relative prices."

So while there have been certain reports that identified AHS hospitals as being in lower cost care settings than certain AMCs, this has not impacted patient flow or redirection as far as we can assess.

b. Please describe your organization's efforts to address these trends, including, in particular, actions your organization is taking to ensure that patients receive care in lower-cost community settings, to the extent clinically feasible, and the results of those efforts.

The hospitals and outpatient organizations routinely assess behavioral health and substance patients for current co-morbid medical conditions and assess risk of developing co-morbid medical conditions. AHS hospitals have on-site medical consultants and both hospitals and outpatient programs communicate with primary care providers for concurrent care coordination and aftercare planning/communication. The organizations plan to discuss opportunities to develop outpatient sites as health homes or co-location of behavioral health providers with inpatient or outpatient medical providers. In addition, outpatient programs have discussed opportunities to hire on-site primary care providers to support their patient population.

As one example of a current initiative, Arbour-Fuller Hospital has a full-time nurse practitioner who provides behavioral health consultative and referral support services at neighboring Sturdy Memorial Hospital as discussed further below.

8. The Commission found in its July 2014 Cost Trends Report Supplement that the use of post-acute care is higher in Massachusetts than elsewhere in the nation and that the use of post-acute care varies substantially depending upon the discharging hospital.

a. Please describe and attach analyses your organization has conducted regarding levels of care and variation in utilization and site of post-acute care, as well as your efforts to ensure that patients are discharged to the most clinically appropriate, high value setting.

b. How does your organization ensure optimal use of post-acute care?

In reviewing the July 2014 Cost Trends Report Supplement, utilization of post-acute care was more aligned with care provided in acute medical care settings (as opposed to acute behavioral health settings) and included use of nursing home and home health services. AHS organizations work to ensure efficient and effective discharge planning (when patient no longer meets medical necessity criteria for the applicable level of care) to the most appropriate follow-up setting (whether residential, respite, partial hospitalization, intensive outpatient, outpatient, community-based or other). There are no clear metrics available to AHS to assess "high value" settings in behavioral health. Discharge choices

are based upon network inclusion, available bed/opening, geography, clinical capability, patient/family choice, and other criteria that are not necessarily related to cost/price (and therefore "value").

There are no formal analyses that the organization has conducted to make assurances of discharge to the most clinically appropriate, "high value" setting. As one example of ensure optimal access to post-acute services, AHS hospital's have implemented "bridge" or "aftercare appointments" that are completed prior to patient discharge from the hospital to review discharges plans in effort to ensure compliance and follow-through, in particular, with outpatient or community-based appointments. In addition, information is provided to patients regarding crisis plans, including how to access Emergency Services Programs where applicable to avoid unnecessary us of Emergency Departments and improve knowledge and use of community crisis intervention programs.

9. C. 224 providers to provide patients and prospective patients with requested price for admissions, procedures and services. Please describe your organization's progress in this area, including available data regarding the number of individuals that seek this information (using the template below) and identify the top ten admissions, procedures and services about which individuals have requested price information. Additionally, please discuss how patients use this information, any analyses you have conducted to assess the accuracy of estimates provided, and/or any qualitative observations of the value of this increased price transparency for patients.

Over the past year, there have been no identified inquiries of patients or prospective patients to receive price information for admissions, procedures or services. This is being monitored by the organization CFOs and Community Relations Director (for website).

Health Care Services Price Inquiries				
Year		Number of Inquiries Via the Website	Number of Inquiries via Telephone or In Person	Average (approximate) Response Time to Inquiries
CY2014	Q1	0	0	NA
	Q2	0	0	NA
	Q3	0	0	NA
	TOTAL:	0	0	NA

10. Please describe the manner and extent to which tiered and limited network products affect your organization, including but not limited to any effects on contracting and/or referral practices, and attach any analyses your organization has conducted on this issue. Describe any actions your organization has taken (e.g. pricing practices) in response to tier placement and any impacts on volume you have experienced based upon tier placement.

At this time, AHS cannot comment on the manner and extend to which tiered and limited network products have affected our organization. We have not completed any analyses on this issue. The hospital has not taken any specific action in response to tier placement and impact on volume related to other organization's tiered network product referral to AHS organizations has not been assessed.

11. The Commission has identified that spending for patients with co-morbid behavioral and chronic medical conditions is 2-2.5 as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.

a. Please describe ways your organization is collaborative with other providers to integrate physical and behavioral health care services and provide care across a continuum to these high-cost, high-risk patients.

One of the ways AHS is collaborating with other providers to integrate physical and behavioral health is specific to Arbour-Fuller Hospital (AFH), South Attleboro, MA. AFH provides an on-site psychiatric nurse practitioner (PNP) consultation/liaison service to neighboring acute care facility Sturdy Memorial Hospital (SMH). The psychiatric nurse consultant complete behavioral health assessments, develop effective behavioral plans, and work with SMH staff to create and implement plans of care that are meaningful and actionable as appropriate for their medical/surgical patients. The consultant assists hospital nurses and case managers including discharge disposition, aftercare plans and responds to concerns regarding psychiatric psychopharmacological interventions. In addition, there is planned collaboration with hospital-based physicians on psychiatric issues including complex psychopharmacology, outreach to community PCPs upon patient discharge to provide important clinical information for care coordination, provision of education/training to hospital staff, and development of expertise to increase support to SMH staff for patients presenting with addictions or co-occurring addictions disorders.

AHS hospitals have on-site medical consultants to address physical health issues amongst their patients, have affiliations with local medical providers in the community for referral, and are in discussion with PCPs groups to collaborate or co-locate for care integration.

b. Please discuss ways that your organization is addressing the needs of individuals to avoid unnecessary utilization of emergency room departments and psychiatric inpatient care.

AHS actively works to educate patients on the use of community-based services including community and outpatient resources including Emergency Services Programs. This includes having urgent care availability in outpatient programs, promotion of community-based resources such as ESPs to contact for crisis intervention, and expanding development of home-based programs.

The organization has developed specific plans to address readmission and unnecessary utilization of EDs and inpatient care specific to certain patient populations/payors. An example of this is with Tufts Health Plan for their child/adolescent population capitated to Westwood Pembroke Health System (WPHS). WPHS has implemented a plan including, but not limited to, implementation of a readmission prevention risk assessment tool completed on all THP patients (which has key indicators to assess level of risk for readmission and subsequent implementation of targeted interventions), completion of follow-up calls to reinforce discharge plans, and identification of barriers to continued care as well as to coordinate care integration with PCPs. Individualized safety and crisis plans are created which are shared with outpatient treators and PCPs in addition to other important discharge information.

c. Please discuss successes and challenges your organization has experienced in providing care for these patients, including how to overcome any barriers to integration of services.

A key issue with behavioral health patients is assuring compliance with care plans and having available resources in the right settings that are accessible. This includes care management/outreach for populations including those who homeless and the persistently mentally ill. We continue to find that not all patients have PCPs or, if one has been identified for/assigned, there has been little prior relationship/communication. While payors may require all members to select a primary care provider, patients may not have seen these providers; integration or communication regarding care plans becomes problemmatic in these instances. AHS attempts to connect patients with inappropriate and excessive ED or hospital utilization to more appropriate community-based resources including primary care, behavioral health or other services that address social and environmental determinants of health, however, often services are not available in patient communities, not accessible due to wait lists or lack of inclusion in managed care networks, or support programs needed to assuring these connections are made and plans adhered to.

Successful behavioral and physical health integration and care coordination requires enhanced training on to create a greater pool of behavioral health clinicians to support expansion of community based programs as well as education of primary care clinicians to increase their knowledge of behavioral health issues. In addition, the adoption of broader and more innovative care delivery models is tied to payment models that align incentives and address case mix, increasing costs (including labor), and address policy or regulatory requirements that add cost and complexity to the system.

d. There has been increased statewide interest in data reporting across all services, inclusive of behavioral health. Please describe your organization's willingness and ability to report discharge data.

AHS cannot comment on the willingness or ability to report discharge data without further clarification on what would be requested specific to hospital or outpatient program discharge data.

12. Describe your organization's efforts and experience with implementation of patient-centered medical home (PCMH) model.

a. What percentage of your organization's primary care providers (PCPs) or other providers are in practices that are recognized or accredited by PCMHs by one or more national organizations?

b. What percentage of your organization's primary care patients received care from those PCPs or other providers?

c. Please discuss the results of any analyses your organization has conducted on the impact of PCMH recognition or accreditation, including on outcomes, quality, and costs of care.

AHS does not have current experience with the implementation of the PCMH model and therefore cannot respond to the questions noted above.

13. After reviewing the Commission's 2013 Cost Trends Report and the July 2014 Supplement to that report, please provide any commentary on the findings presented in light of your organization's experiences.

AHS has reviewed the Health Policy Commission's 2013 Cost Trends Report and more recently the July 2014 Supplement to that report. Given our focus on behavioral health, we reviewed the findings presented on behavioral health in the supplement with higher level of interest. There was an identification of increased spending for patients with behavioral health conditions concentrated in emergency department and inpatient care (using claims-based medical expenditures by category of service for people with and without BH conditions in 2011) as noted for Commercial and Medicare populations (with MassHealth data not included). In its assessment, the report includes focus on the board prevalence of co-morbid behavioral health and chronic medical conditions, and identification of need for increased integration of mental health, addictions, and physical health for care coordination, improved access and improvement of health outcomes which may affect spending. While AHS strongly supports care integration, there is also a strong opportunity to improve care at lower cost through access to appropriate treatment earlier in less intensive settings and assume patients can access these services through convenient settings and times. While the report indicates increase in spending on inpatient care, programs such as the Children's Behavioral Health Initiative (CBHI) have resulted in reduced use of inpatient services amongst child and adolescent populations over the past several years. More specific evaluation of ED and inpatient costs amongst specific behavioral health populations (child/adolescent, substance abusers, etc.) will be important in focus resources and program development for new delivery models for the future that impact on overall health spending while improving outcomes.