BROOKLINE COMMUNITY
MENTAL HEALTH CENTER

September 1, 2016

David Seltz
Executive Director
Health Policy Commission
50 Milk St., 8th Floor
Boston, MA 02109

Dear Mr. Seltz,

We are very pleased to enclose our written testimony for the 2016 Annual Health Care Cost Trends Hearing. These materials are in response to the HPC and AGO questions. Please let us know if you have any questions regarding our submission, which is signed under pains and penalties of perjury.

Sincerely,

Cynthia D. Price, DBA
Executive Director

Henry S. White, MD
Clinical Director

Exhibit B: HPC Questions for Written Testimony

From Brookline Community Mental Health Center

Testimony: **Brookline Community Mental Health Center, 41 Garrison Rd, Brookline, MA 02445**
Henry White, MD, Clinical Director
Cynthia Price, DBA, Executive Director

1. Strategies to Address Health Care Cost Growth.

Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark has been set at 3.6% each year since 2013; however, beginning in 2017 the HPC may set a lower growth rate target.

a. What are your top areas of concern for meeting the Health Care Cost Growth Benchmark in Massachusetts? (Please limit your answer to no more than three areas of concern)

We strongly support the growth benchmark. However, at present, reimbursement rates for behavioral health are very low, and have not increased significantly in over ten years, particularly in contrast to other kinds of services. We are concerned that if there are across the board cuts in rates, this will disproportionately adversely affect behavioral health providers.

Market based incentives have been ineffective in impacting price variation among large hospital systems. This is now coupled with new incentives to be implemented through MassHealth Medicaid reform for ACOs (mostly large hospital systems) to be the locus of control for 'integrated' services with very weak incentives to use community based care providers, especially for behavioral health and long term support services.

As the economy has improved over the past year, hospital outpatient departments and primary care practices have started hiring additional behavioral health providers. Given the shortages of psychiatrists and child/adolescent behavioral health professionals in MA, these systems are now offering significantly increased salaries to attract these providers. Community mental health centers have lost significant numbers of experienced staff to hospital based practices due to salary differentials, which reflect underlying insurance reimbursement differentials. This has the unintended consequence of reducing access to care for seriously mentally ill children and adults, who then use hospital ERs for more frequent and costly urgent care episodes.

b. What are the top changes in policy, payment, regulation, or statute you would recommend to support the goal of meeting the Health Care Cost Growth Benchmark? (Please limit your answer to no more than three changes)

We believe that specifically targeting high cost, high need patients is a most effective strategy for reducing healthcare costs. An investment in behavioral health and care coordination services designed for this population will have outsized returns, if implemented using community based providers where costs are lower. However, without policy or legislative incentives, it is unlikely this population will be

served by low cost community providers; it is most likely that ACOs will hire staff to duplicate existing community services at higher salaries and greatly increased indirect care costs.

Increased reimbursement for community-based out-patient behavioral health care, equitable with that of hospital-based outpatient departments and medical/PCP offices for the same type of care, same-levels of high risk, seriously mentally ill/substance abused patients is greatly needed.

We favor any legislative or policy remedies to control cost of pharmaceuticals and very high cost medical equipment.

2. Strategies to Address Pharmaceutical Spending.

In addition to concerns raised by payers, providers, and patients on the growing unaffordability and inaccessibility of clinically appropriate pharmaceutical treatment, the HPC's 2015 Cost Trends Report identified rising drug prices and spending as a policy concern for the state's ability to meet the Health Care Cost Growth Benchmark.

a. Below, please find a list of potential strategies aimed at addressing pharmaceutical spending trends, including prescribing and utilization. By using the drop down menu for each strategy, please specify if your organization is currently implementing such a strategy, plans to implement it in the next 12 months, or does not plan to implement it in the next 12 months.

i. Providing education and information to prescribers on cost-effectiveness of clinically appropriate and therapeutically equivalent specific drug choices and/or treatment alternatives (e.g. academic detailing)

Currently Implementing

ii. Monitoring variation in provider prescribing patterns and trends and conduct outreach to providers with outlier trends

Does NOT Plan to Implement in the Next 12 Months

iii. Implementing internal "best practices" such as clinical protocols or guidelines for prescribing of high-cost drugs

Plans to Implement in the Next 12 Months

iv. Establishing internal formularies for prescribing of high-cost drugs

Does NOT Plan to Implement in the Next 12 Months

v. Implementing programs or strategies to improve medication adherence/compliance

Currently Implementing

vi. Entering into alternative payment contracts with payers that include accountability for pharmaceutical spending

Does NOT Apply to my Organization

vii. Other: Insert Text Here

Click Here

viii. Other: Insert Text Here

Click Here

ix. Other: Insert Text Here

Click Here

3. Strategies to Integrate Behavioral Health Care.

Given the prevalence of mental illnesses and substance use disorders (collectively referred to as behavioral health), the timely identification and successful integration of behavioral health care into the broader health

care system is essential for realizing the Commonwealth's goals of improving outcomes and containing overall long-term cost growth.

a. What are the top strategies your organization is pursuing to enhance and/or integrate behavioral health care for your patients? (Please limit your answer to no more than three strategies)

We are focusing on improving outcomes for high-risk/high-cost adult patients with high levels of avoidable ED or hospitalization use by building a program of integrated care management. Working with patients at Beth Israel Deaconess, Bowdoin Street Health Center and Brookline Community Mental Health Center, the Healthy Lives program utilizes an efficient, community-based "care connection" model that engages high-cost patients in their homes and local environments, assesses patients' needs and provider realities; strengthens connections with current providers to build a durable system in which patients can assume responsibility for their own care in less than a year. For a caseload of 50 clients, staff include a community nurse (BSN) and a community health workers. To date, significant costs savings have resulted. The Healthy Lives program will be expanded to integrate with the BIDCO Care Management Program in the fall 2016, with the support of an HPC Innovation Investment Grant.

For adolescents, Brookline Mental Health Center created the Bridge to Resilient Youth (BRYT) Program ten years ago to assist teens hospitalized for mental health crises to systematically re-enter high school and resume academic and social performance. BRYT is a short term 8-12 week intervention has now been adopted by over 40 suburban high schools in MA, and is funded entirely outside the health care system, primarily by high schools with some ancillary grant support. Formal evaluations conducted on the program document a significantly reduced hospital re-admission rate in comparison to control school youth and a 95% graduation rate for BRYT youth. In order for large, urban school systems to initiate BRYT-like programs to benefit more low income and minority youth, either state or grant incentives will be needed.

b. What are the top barriers to enhancing or integrating behavioral health care in your organization? (Please limit your answer to no more than three barriers)

1. Lack of reimbursement for care management and care coordination activities.

2. Need for EHR integration between behavioral health system and primary care providers.

3. Lack of incentives for hospital/ACO systems to use community based care providers, rather than building more costly, duplicative hospital based care management systems.

4. Strategies to Recognize and Address Social Determinants of Health.

There is growing recognition and evidence that social, economic and physical conditions, such as socioeconomic status, housing, domestic violence, and food insecurity, are important drivers of health outcomes and that addressing social determinants of health (SDH) is important for achieving greater health equity for racial and ethnic minorities, low-income and other vulnerable communities. Routine screening for SDH issues and developing programs to address those issues are core competencies of accountable, high performing health care systems.

a. What are the top strategies your organization is pursuing to understand and/or address the social determinants of health for your patients? (Please limit your answer to no more than three strategies)

1. As a community mental health center, in addition to clinical services we offer a broad range of social services to our patients and their families including housing support, mediation in Boston

courts to address eviction and foreclosures, emergency financial assistance, and access to food, transportation or other basic necessities. We also embed outreach clinicians in public housing authority developments, and all nine Brookline public schools. Often patients can't focus on their health issues until these needs are addressed.

2. We used a community-based approach including home visits rather than just office-based services. By engaging patients in their home environment, we are better able to observe and address their most urgent needs.

b. What are the top barriers to understanding and/or addressing the social determinants of health for your patients? (Please limit your answer to no more than three barriers)

1. As noted above, there are limited reimbursement for care management and care coordination services.

2. We have found that gaining access to services is very difficult. There are many concrete barriers that stand in the way of patients seeking services. These include including inaccessible office locations, long waiting lists, poor customer service, extremely long telephone hold times, and highly fragmented health, substance abuse and social service systems.

5. Strategies to Encourage High-Value Referrals.

In the HPC's 2015 report, Community Hospitals at a Crossroads, the HPC found that the increased consolidation of the healthcare provider market has driven referrals away from independent and community providers and toward academic medical centers and their affiliated providers.

a. Briefly describe how you encourage providers within your organization to refer patients to high-value specialty care, ancillary care, or community providers regardless of system affiliation.

Not applicable to our organization. As a behavioral health provider, we make very few referrals to specialty care providers.

b. Does your electronic health record system incorporate provider cost and/or quality information of providers affiliated with your organization, either through corporate affiliation or joint contracting, that is available at the point of referral?

No

i. If yes, please describe what information is included.
Click here to enter text.

ii. If no, why not?
Our providers are all direct employees, not affiliated agents who contract with us.

c. Does your electronic health record system incorporate provider cost and/or quality information of providers not affiliated with your organization, either through corporate affiliation or joint contracting,that is available at the point of referral?

No

i. If yes, please describe what information is included.
Click here to enter text.

ii. If no, why not?

Our EHR does not have this capability. Question is not applicable to our organization.

d. Does your electronic health record system support any form of interface with other provider organizations' systems which are not corporately affiliated or jointly contracting with your organization such that each organization can retrieve electronic health records on the other organization's electronic health record system?

No

i. If yes, please briefly describe the type(s) of interfaces that are available to outside organizations (e.g. full access, view only) and any conditions the outside organization must satisfy for such an interface.
Click here to enter text.

ii. If no, why not?
Our EHR does not directly interface with other providers' EHRs. Some of our staff are credentialed users of other provider systems and can access information about shared patients via remote logins.

6. Strategies to Increase the Adoption of Alternative Payment Methodologies.

In the 2015 Cost Trends Report, the HPC recommended that payers and providers should continue to increase their use of alternate payment methodologies (APMs), with the goal that 80% of the state HMO population and 33% of the state PPO population be enrolled in APMs by 2017.

a. What are the top strategies your organization is pursuing to increase the adoption of alternative payment methods (e.g., risk-based contracts, ACOs, PCMHs, global budgets, capitation, bundled or episode-based-payments)? (Please limit your answer to no more than three strategies)

There have been no state or privately-directed APMs that are applicable to out-patient community-based mental health care visits. All visits are currently reimbursed on a fee for service basis without the ability to negotiate rates. Given this, we have opted to develop pilot programs that showcase high quality, cost effective means for integrating behavioral health and medical care for for high utilizer patients. To date, neither public nor commercial insurers or ACOs have elected to use this model as part of an APM, even on a pilot basis. We continue to promote this approach to policy makers, legislators and vertically integrated health care systems as a means of reducing cost through incorporation of this model into an APM on a pilot basis.

b. What are the top barriers to your organization's increased adoption of APMs and how should such barriers be addressed? (Please limit your answer to no more than three barriers)
Please see our response above (part a.). We believe that the size of an organization's healthcare market share will continue to dominate the process of developing effective APMs. Therefore, to insure that there is equitable inclusion of smaller, low-cost, community based behavioral health and substance abuse treatment providers in these payment mechanisms, state sponsored regulations, policies and/or financial subsidies will be necessary.

c. Are behavioral health services included in your APM contracts with payers?
Required Answer: Click Here

i. If no, why not?
Not applicable to our organization, please see section a and b above.

7. **Strategies to Improve Quality Reporting.**
At the Cost Trends Hearings in 2013, 2014, and 2015, providers consistently called for statewide alignment on quality measures, both to reduce administrative burden and to create clear direction for focusing quality-improvement efforts. Providers have demonstrated that the level of operational resources (e.g. FTEs, amount spent on contracted resources) needed to comply with different quality reporting requirements for different health plans can be significant.

a. Please describe the extent to which lack of alignment in quality reporting poses challenges for your organization and how your organization has sought to address any such challenges.

Most of the quality measures are not applicable to behavioral health organizations such as our center. They were developed for medical facilities or primary care practices.

We did an in-depth examination of the costs involved in connecting to and utilizing the data systems and reporting mechanisms for quality measures (such as PQRS). We found that connecting to these systems would require a major financial investment in software and licensing fees that was actually much larger than the cost of decreased reimbursement from Medicaid that would be incurred for not reporting.

b. Please describe any suggested strategies to promote alignment in the number, type (i.e. process, outcome or patient experience), and specifications of quality measures in use as well as the quality measurement reporting requirements to payers (e.g., reporting frequency and reporting format).

There is a great need for practical, informative, and cost-effective measures that are designed specifically for behavioral health organizations. We suggest convening a group of providers and experts who could develop consensus about a minimal set of measures that can be adopted by both large and small behavioral health providers.

To faciliatate state-wide reporting of quality, there is need for subsidies or grants to behavioral health providers to help cover the costs of software, licensing fees, administrative time associated with developing and adopting quality measure reporting systems.

8. **Optional Supplemental Information.** On a voluntary basis, please provide any supplemental information on topics addressed in your response including, for example, any other policy, regulatory, payment, or statutory changes you would recommend to: a.) address the growth in pharmaceutical prices and spending; b.) enable the integration of behavioral health care; c.) enable the incorporation of services to address social determinants of health for your patients; d.) encourage the utilization of high-value providers, regardless of system affiliation; e.) enable the adoption of APMs; and f.) promote alignment of quality measurement and reporting.

To better integrate medical, behavioral health and long term support services, having sponsored conversations between payers and providers of various types is an important step. There are so few multi-stakeholder gatherings that address the barriers and challenges to integration in a concerted way. HPC sponsored such a gathering a year or so ago, and we found it very useful in raising key questions, and dispelling some of the myths and misinformation among stakeholders. Arranging such conversations in order to better prepare players for the deep challenges of integrated care would be productive.

Any positive steps that might be taken to assure more transparent claims data, would be enormously helpful, especially in regards to integrating behavioral health within APM arrangements. Such data could help validate the cost savings associated with integrated behavioral health care.

Exhibit C: AGO Questions for Written Testimony

The following questions were included by the Office of the Attorney General. For any inquiries regarding these questions, please contact Assistant Attorney General Emily Gabrault, Emily.Gabrault@state.ma.us or (617)963-2636

1. Please submit a summary table showing for each year 2012 to 2015 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters reflected in the attached **AGO Provider Exhibit 1,** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

   To be submitted at a later date. Of note, all of our revenue for 2012-15 is through fee for service arrangements. We are not participating in any P4P or risk contracts

2. Chapter 224 requires providers to make available to patients and prospective patients requested price for admissions, procedures, and services.

   a. Please describe any systems or processes your organization has in place to respond to consumer inquiries regarding the price of admissions, procedures, or services, and how those systems or processes may have changed since Chapter 224.

   Upon initial call to the Center, clients are informed by a 'live' Intake Workers (social worker) that the Center accepts most commercial and public insurances that generally reimburse for all services offered. In addition, the Center offers a sliding fee to clients based on income and number of dependents.

   Prior to the first visit, or at the first visit, clients are contacted or talk to our Registration staff and are informed again regarding what types of services there insurance will reimburse for, and how additional services will be requested from insurers as these are needed. A copy of the sliding fee scale is shared with clients at this time.

   The Center also offers clients the opportunity to request a lower sliding fee at any point by providing income information and a request to a Fee Committee composed of clinicians and administrative staff.

   b. Please describe any monitoring or analysis you conduct concerning the accuracy and/or timeliness of your responses to consumer requests for price information, and the results of any such monitoring or analyses.

   As part of annual consumer satisfaction surveys, clients are queried regarding their experience with fee setting and fee setting practices at the Center.

   c. What barriers do you encounter in accurately/timely responding to consumer inquiries for price information? How have you sought to address each of these barriers?

   To date, we have not encountered any barriers to accurate or timely responses to patients' inquiries about prices.