MENTAL HEALTH
LEGAL ADVISORS COMMITTEE
Commonwealth of Massachusetts
Supreme Judicial Court

MaMHCA
Massachusetts Mental Health
Counselors Association, Inc.

Testimony of
Mental Health Legal Advisors Committee
and
Massachusetts Mental Health Counselors Association
on the

2018 Annual Health Care Cost Trends Report

March 22, 2019

This testimony is submitted on behalf of Mental Health Legal Advisors Committee (MHLAC) and the Massachusetts Mental Health Counselors Association (MaMHCA). MHLAC is an agency under the Massachusetts Supreme Judicial Court that provides representation to low-income persons with psychiatric challenges. MHLAC also provides information and advice to any Commonwealth resident, including the legislature, other agencies and commissions on mental health legal matters. In this role, MHLAC has extensive hands-on experience in the barriers people with psychiatric diagnoses have with respect to accessing health care services and obtaining quality care once those services are obtained. Based upon our familiarity with these problems and in-depth research, MHLAC presented oral testimony at the March 13, 2019 Health Cost Trend Hearing. MaMHCA is dedicated to providing essential professional information and ongoing education and training to Licensed Mental Health Counselors, mental health counseling students and educators, and other related professionals. MaMHCA advocates for the advancement of the high quality mental health services and the mental health counseling profession through public policy initiatives for both mental health professionals and consumers of mental health services.

Our testimony is directed primarily to the recommendations of the Health Policy Commission in its 2018Annual Health Care Cost Trends Report[1] on how to control health care costs. We are delighted that the Commission has included social determinants of health and strategies to control pharmaceutical costs through negotiation of prices and

[1] The 2018 Annual Health Care Cost Trends Report will hereinafter be cited as "Report."

parameters for PBM activities. For such suggestions, we offer modifications that will increase their efficacy without unintended consequences. For other Commission suggestions, we ask that you reconsider them and instead adopt other strategies for cost control that do not harm quality of care and the financial stability of patients.

Key points include:

- **Demand-side incentives** are ineffective and likely to harm quality of care.
    - Patients do not shop for medical care like typical consumer goods, nor do they generally have the expertise or health to do so when services are needed.
    - Tiering lacks transparency, is primarily based on cost and not quality, is insufficiently granular to ensure optimal care, and does not account for the individual characteristics of each patient.
    - Higher patient costs lead to avoidance of appropriate use of care, which ultimately leads to more expensive modalities of treatment.[2]
- **Treatment protocols** are problematic.
    - Treatment protocols ignore individual circumstances and patient preferences, weakening patient engagement and amenability to provider treatment recommendations.
    - The bases for designating services as "low-value" are often flimsy and tainted by financial conflicts of interest.
- **Pharmaceutical costs** should be addressed through price controls and negotiation, not by pricing certain medications beyond the reach of some patients.
    - New medications can lower ultimate costs.
    - Individuals, due to side effects of generics or prior trials of same, may need to use more expensive brand-name drugs.
    - Patients cannot dictate which medical conditions they have and what medications are available for their condition.
- **Limited networks** impair access to suitable care and disrupt continuity of care.
- **Alternative payment arrangements** and shared risk are likely to have negative affects on patient care.
    - Some of the negative consequences of placing providers and provider groups in the role of insurers include cherry-picking, manipulation of data to the detriment of research, denial of necessary care, and over-reliance on fundamentally flawed and inapplicable restrictive protocols.

[2] The health care system should not increase disease by increasing the financial burdens of consumers. Money, finances, and debt are the most common source of anxiety and are linked to the aggravation of mental health conditions. Financial difficulty drastically reduces recovery rates for common mental health conditions. Financial difficulties also increase demand for health care services. K. Evans, *The link between financial difficulty and mental health problems*, 27 J. Mental Health 487 (2018).

    - Outcome measurements currently relied upon do not control harmful practices spurred by capitation and shared risk.
- **Social determinants of health** should be funded directly by insurers and/or provider groups.
    - Referrals to public assistance programs either directly or through community organization partnerships are insufficient, because public programs are insufficiently funded to meet the requests of all who seek services.
    - Insurers and/or providers groups will reap the savings from funding social determinants of health and therefore should contribute directly to their provisions.
- **Telehealth** should be offered but with strictures.
    - Telehealth providers should not be relied upon to meet network adequacy requirements.
    - Patients must have the choice to see a provider in person at a copay no higher than that levied for telehealth providers.
- **Integrated care** can endanger the access to adequate physical health care for persons with psychiatric diagnoses due to provider bias toward persons with psychiatric challenges and diagnostic overshadowing.
    - Integrated care systems must be monitored closely to ensure that persons with psychiatric diagnoses are getting physical health care comparable to that of persons without behavioral health diagnoses.
    - Peer workers in health care settings and "Open Notes" should be utilized to lessen implicit bias.
    - Patient control of psychiatric information, beyond that protected by HIPAA, should be explored.
- **Alternative and innovative services** and treatments offer the opportunity to lower health care costs and should be covered by insurance.
    - Meditation, massage, and acupuncture lessen reliance on pain medication, thereby reducing the likelihood of addiction.
    - Multi-generational housing can lessen the need for expensive residential and in-home care for seniors.
    - Peer respites and Housing First are proven to reduce health care costs.
    - Funding for research should be targeted to those services and treatments that are not likely to be otherwise funded because they will not produce large profits for corporations.
    - Providing people with services that they desire increases engagement and the potential for recovery as compared with involuntary or undesirable treatment.

Treatment Protocols and Value-Based Care

Treatment protocols and value-based care are touted as evidence-based approaches to reducing cost by reducing unnecessary services. However, the evidence behind the determination of what services are necessary is flawed. The choice of variables to include in developing protocols and determining value are subject to bias, desired outcomes of the authors, social and financial pressures, and availability of research and evidence.

Great care should be taken in designating and discouraging so-called low-value screening, tests, and services. The evidence that the Choosing Wisely Campaign relies upon to identify low-value health care items is shaky at best. A 2018 study of the evidence basis for the Choosing Wisely Campaign recommendations found that 7.8% cited case series, review articles, editorials, or lower quality data as their highest level of evidence. Only about 22% of the recommendations relied upon primary research as their highest level of evidence. The majority of recommendations, 77% relied upon Clinical Practice guidelines.[3] Clinical practice guidelines are based on questionable evidence. For example, 46% of interventional guidelines don't grade their evidence. When graded, the majority of evidence was of the lowest level. Most guidelines did not comment on conflicts of interest. In those that did, 91% of the guidelines had conflicts of interest.[4]

Value is not an objective measurement. What lacks value to one patient is invaluable to another. Quality Adjusted Life Years (QALYs) are sometimes used to determine the value of prescription drugs and treatments. QALYs are described as an objective measure that captures the total value of individuals' lives, accounting for both the number of years they live and the quality of those years. Yet this so-called objective measure values the lives of people with disabilities as a percentage of the value of the lives of people without disabilities, thus utterly misrepresenting the lived experiences of people with disabilities. This misrepresentation has potentially harmful consequences for both disease mitigation and life-extension. Even with recent proposals to modify QALYs, they still do not reflect the value that people with disabilities or chronic illnesses place on their own lives and their ability to obtain healthcare, including needed medications.

[3] Appraising the Evidence Supporting Choosing Wisely® RecommendationsAndrew J. Admon, MD, MPH 688 Journal of Hospital Medicine Vol 13 | No 10 | October 2018

[4] Mayo Clin Proc. 2014 Jan;89(1):16-24. doi: 10.1016/j.mayocp.2013.09.013.Systematic analysis underlying the quality of the scientific evidence and conflicts of interest in interventional medicine subspecialty guidelines. Feuerstein JD et al.; see also Semin Arthritis Rheum. 2016 Feb;45(4):379-85. doi: 10.1016/j.semarthrit.2015.09.002. Epub 2015 Oct 1. Systematic analysis of the quality of the scientific evidence and conflicts of interest in osteoarthritis of the hip and knee practice guidelines. Feuerstein JD, et al.

Another problem with value designations is that many promising approaches to treatment and recovery are not being researched and thus are not included in the list of high-value care. Until alternative funding is found, research will continue to exclude modalities of care that are not likely to be attractive to corporations that fund the majority of healthcare research.[5]

Pharmaceutical Spending

We support the HPC's proposal to require pharmacies be notified if medication copays are higher than over-the-counter prices or through a discount program. (Report 2c). Pharmacies should be required, rather than "encouraged" to provide this information to consumers, as the pharmacy is the place where provision of this information is most useful.

We also support requiring PBM to disclose rebates it receives and pass the savings on to patients (Report 2c) and to monitor PBM pricing (Report 2d). However, we suggest that the excess profit from spread pricing be used to lower medication copays and subsidize patients using medications without generics rather than protect the profits of large pharmacy chains.[6]

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[5] The majority of funding for medical and health care research is from biopharmaceutical developers, medical technology developers, and healthcare service companies. These industries accounted for 67.4% of all spending for medical and health care research in 2016. K. Davio, Report: US Medical Health Research Spending on the Rise, but for How Long?, Am. J. Managed Care (Nov. 2017) https://www.ajmc.com/focus-of-the-week/report-us-medical-health-research-spending-on-the-rise-but-for-how-long (last accessed 3/21/2019).

[6] The 2018 prescription drug market share of CVS was 24.2% and of Walgreens was 17.5%. CVS Health's gross profit in FY18 was over $31.5 billion. http://apps.indigotools.com/IR/IAC/?Ticker=CVS&Exchange=NYSE# (last accessed 3/16/2019) CVS retail pharmacy segment had a gross profit of over $24 billion and its pharmacy service segment a gross profits of over $6 billion. http://apps.indigotools.com/IR/IAC/?Ticker=CVS&Exchange=NYSE# (last accessed 3/16/2019) Walgreens Boots Alliance gross profit was over $30.7 billion in FY18, net income of over $5 billion. The company's United States retail pharmacies had 2018 gross profits of over $23.7 billion. https://www.walgreensbootsalliance.com/newsroom/news/walgreens-boots-alliance-reports-fiscal-year-2018-results.htm (last accessed 3/16/2019). Chain pharmacies like these do not need protection from spread pricing. In fact, these bohemoths own PBM, like CVS Caremark and Rite Aid's EnvisionRX, or are partnering with PBM and insurers, like AllianceRX Walgreens Prime. Limitation of PBM spread pricing may be warranted for individually-owned pharmacies.

Treatment protocols and guidelines, including ones that are allegedly evidence- and value-based (Report 2f), are detrimental to patients.[7] These protocols and guidelines will inevitably be used by insurers and other payers to either deny coverage of particular medications or make copays for higher tiered drugs exorbitant. Health systems and Accountable Care Organizations (ACOs), particularly those subject to risk sharing and capitation, will inevitably put pressure on providers to avoid prescription of particular drugs even when beneficial to their patients.

Through no fault of their own, patients may need to take medications for which there is no generic. Or generics may contain non-active ingredients that particular enrollees cannot tolerate.[8] These enrollees should not have to pay higher copays than that for first tier medications. Patients should not be denied or have a higher copay for more effective high-cost drugs or if the generic is inappropriate.[9] As discussed at the hearing, new Hepatitis C drugs that cure the condition are an example of high-cost drugs that could fall

[7] An example of harmful guidelines is insurer fail-first protocols that require the unsuccessful use of a less expensive medication before coverage of the medication that the prescriber determined would better address the patient's condition. See, e.g., J. Chambers, *et al.*, *Variations in the Use of Step Therapy Protocols Across US Health Plans*, Health Affairs Blog (Sept. 14, 2018) https://www.healthaffairs.org/do/10.1377/hblog20180912.391231/full/ (last accessed 3/17/19) While calling for evidence-based protocols, the problems with which are discussed herein, the article also calls for transparency in plan bases for their protocols and legislation to ensure a reasonable and expedited process to obtain exceptions. A commentator notes that for persons with certain diseases, like mental illness, the delay in obtaining the correct medication can be disabling and lead to higher medical costs.

The value to the patient of limiting the amount of time she or he suffers from a condition is rarely considered in the calculation of whether a drug is valuable in designing such protocols. Reliance should be placed on conflict-free prescribers as to the necessity of a medication. Prescribers are closer to the patient than insurers and are more aware of the particulars of each patient. Guidelines and protocols by their very nature are not applicable to every patient, each being unique. Therefore, treating clinicians are better able to assess which medications should be prescribed.

[8] An individual may have an adverse reaction to non-active ingredients in generic medications. D. Reker, *et al.*, *"Inactive" ingredients in oral* medications, 11 Sci. Translational Med. (March 13, 2019) (a majority of oral medications contain inactive ingredients that could cause adverse reactions). For example, a patient may have allergies or sensitivities to lactose, gluten, sulfites, or tartrazine.

[9] Generics that claim to have the same active ingredient may not actually work in the same manner as the brand-name medication. See, https://www.fda.gov/Drugs/DrugSafety/ucm322161.htm (generic versions of Wellbutrin from two different manufacturers found not to be therapeutically equivalent to the brand name medication) (last accessed 2/11/19). Bio-equivalence is not the same as therapeutic equivalence.

prey to misguided treatment protocols and guidelines, as well as restrictive formularies.[10] Cost control methods should be targeted to the originators of high prices, such as the pharmaceutical industry,[11] not patients.

If medication treatment protocols and guidelines (Report 2f) are implemented, payers, PBMs, and at-risk entities should not be involved in their development. Given the conflicts of interest inherent in the manufacturing, distribution (both retail and wholesale), PBM, and insurance coverage of pharmaceuticals, treatment protocols and guidelines for the use of medications are likely to be tainted by the financial incentives of payers.[12] Likewise, information on pharmaceuticals and alternatives disseminated to prescribers (Report 2f) should be uniform throughout the health system and approved by a government entity that has a large representation of patient advocates on its governing

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[10] See, M. Fox, *Hepatitis C cure eludes patients as states struggle with costs*, https://www.nbcnews.com/health/health-news/hepatitis-c-cure-eludes-patients-states-struggle-costs-n870846 (last accessed 3/17/2019). *Id.*, describing insurers that require moderate or severe liver damage prior to authorizing coverage for the newer Hepatitis C drugs, find arbitrary reasons to deny eligibility for a drug, and refuse to cover an additional treatment if the first course of treatment fails. Prior authorization requirements also delay treatment, which can permanently damage the patient's functioning or even put the individual's life at risk. Procedures to obtain prior authorization often are time-consuming for providers, who are thus discouraged to prescribe medication that clearly would promote their patients' well-being. And because there is no significant penalty for wrongly denying coverage, insurers sometimes take that route to limit costs, safe in the knowledge that a limited portion of patients will pursue appeal procedures that often require a useless appeal to the insurer before pursuit of an administrative appeal. Even if the patient prevails, the insurer's liability is generally limited to payment for the treatment that was denied.

[11] Price controls merit consideration and implementation. M. Womow, *Just What the Doctor Ordered: The Case for Drug Price Controls*, Harvard Pol. Rev. (Dec. 2, 2018). In addition, companies which develop medications with the assistance of public funding, including grants and the use of state universities, should discount these drugs for low- and middle-income patients, as well as Medicaid and other public assistance programs. Pharmaceutical companies that have received state and local tax abatements or which pay lower tax rate than is reasonable relevant to their gross profits also could be asked to contribute to a fund to provide access to new medications.

[12] See *supra* n.5 for partnerships or ownership of pharmacies, PBM and insurers. Three companies accounted for more than 90 percent of all revenues from drug distribution in the United States in 2017: AmerisourceBergen Corporation, Cardinal Health, Inc., and McKesson Corporation. https://www.mdm.com/2017-top-pharmaceuticals-distributors McKesson also advises insurers and employers on formularies.

body. What information is disseminated should not be left to health systems and ACOs that are riddled with conflicts of interest.[13]

Out-of-Network Issues

We agree that consumers should receive notice in advance of rendering of non-emergency services that a provider is out-of-network. (Report 3a) This notice should be given at the time of scheduling the service, not close to the time the time the service is to be rendered. Specialty services are often difficult to schedule and consumers who have waited a lengthy time for a specialist visit cannot be expected to wait even longer to get an appointment with an in-network specialist. Notice, however, is unlikely to change consumer behavior. Patients choose doctors and hospitals based on other factors.[14]

We also agree that consumer co-pays for unintentional use of out-of-network services should be limited to in-network costs and balancing billing by providers should be

[13] For example, United Health Group owns OptumCare, which provides primary and urgent care to patients, a PBM (OptumRX), recommends care management, tiering of providers, formularies, and risk management strategies to insurers and providers through the use of its analytics segment, as well as controls one of the top seven dispensing pharmacies that accounted for more than 40 percent of wholesalers' combined U.S. drug distribution revenues in 2017. It owns the Lewin Group, a policy research and consulting firm that contracts with clients to provide economic analysis of health care and human services issues and policies and allows those clients to bury studies that do not produce the results they desire. Nexus ACO, a national ACO, is owned by United Health Group. https://www.unitedhealthgroup.com/businesses/optum.html; https://www.optum.com/solutions/population-health/behavioral-health/behavioral-health-health-plans.html ; https://www.mdm.com/2017-top-pharmaceuticals-distributors; http://www.washingtonpost.com/wp-dyn/content/article/2009/07/22/AR2009072202216.html?sub=AR&noredirect=on; https://www.forbes.com/sites/brucejapsen/2018/07/18/unitedhealth-group-says-national-acos-enrollment-to-double/#141bfaa162dc (Last accessed 3/17/2019) Other insurers are buying practice groups. Humana has bought into Kindred Healthcare, CVS and Aetna, which has Express Scripts PBM have partnered, Optum Health bought DaVita's medical group, Medicaid managed-care insurer Centene Corp. in March said it was buying Community Medical Group, a primary-care provider, and insurer Anthem announced a deal in May 2018 to buy Aspire Health, a non-hospice palliative-care company

The idea that a business that distributes medications, owns provider groups, and consults with insurers and employers on maximizing revenue should be responsible for disseminating information on best practices in an unbiased fashion is absurd.

[14] One survey found that 85% of patients ranked compassion and being knowledgeable as very important in choosing a doctor, while only 31% said low cost was very important . https://www.businesswire.com/news/home/20180206005704/en/Survey-Reveals-85-Percent-Patients-Choose-Compassion (Feb. 6, 2018) (last accessed 3/19/19).

prohibited. (Report 3b) Consumers should have the choice of whether their share of costs should be applied to in-network or out-of-network deductibles if such deductibles are applicable.

Of course, payments to out-of-network providers should be reasonable and fair. (Report 3c) To date, insurers typically underpay a large swath of behavioral health clinicians.[15] In assessing the level of "reasonable and fair" payments, attention must be paid not just to the ability of insurers to force acceptance of low reimbursement rates, but also the provider cost of doing business, including educational debt, quality and parity.[16]

We disagree that supporting tiered and limited network products should be the basis for any health care policy. (Report 3) Tiering is fundamentally flawed. Limited network products disrupt continuity of care and limit access to appropriate and high quality care.

In fact, we fervently urge HPC to recommend that payers protect existing clinician-patient relations and that payers be required to offer single-case agreements with out-of-network providers upon request of patients. Incentivizing limited network plans hurts low-wage and moderate income consumers. If the consumer cannot afford a plan with his or her providers, this scheme will interrupt continuity of care, which is detrimental to care and to costs. Plan allowances for coverage while transitioning to a new provider, if any, are inadequate. From the point of view of both the insurer and the insured, [17] it makes no

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[15] See, e.g., Smith v. United Healthcare Insurance Co. and United Behavioral Health, Case No. 3:18-cv-06336 (N.D. Cal. filed Oct. 2018) (patient class action against insurer for paying mental health provider less than comparable medical/surgical providers); J. Gold, *Health Insurers Are Still Skimping On Mental Health Coverage*, National Public Radio (2017) (insurer payments to Massachusetts primary care providers when they provided mental health care were 50% higher than payments to mental health providers) https://www.npr.org/sections/health-shots/2017/11/29/567264925/health-insurers-are-still-skimping-on-mental-health-coverage (last accessed 3/21/2019).

[16] Quality measures should take into account the socio-economic circumstances of the patient, acuity, overall health status, and patient reported outcome measures. Preferably, quality measures should be developed by an entity that has representation from a substantial number of patient advocates and should be subject to public hearings and government approval. These measures should be used throughout the healthcare system.

[17]While not providing a totally unlimited ability to choose one's mental health provider, England has recognized the value of provider choice to both the patient and the health care system. Indeed, a guidance states: "We're aware of some … policies that require the use of local providers either exclusively or for all initial referrals. These policies may prevent people from choosing the provider of care that is best for them; they aren't appropriate." NHS Improvement, *Choice in mental health: advice for commissioners* at 2 (April 2016),

sense to require someone to transition from a provider with whom they have a successful working relationship. Such a cut-off risks re-traumatization of persons with psychiatric challenges and decompensation. Indeed, there is no reason to disrupt any solid working relationship and, for mental health treatment, definite reasons not to breach a developed therapeutic alliance. The therapeutic relationship is the single most accurate predictor of successful outcome of treatment.[18] Single-case out-of-network agreements should be available for an unlimited time period to providers who are willing to abide by a plan's reasonable administrative and care coordination requirements.[19]

Provider price variations

Provider prices variations must not be assumed to be "unwarranted" merely because an entity charges more than another for the same set of services, even if current outcome measures are the same as lower cost entities.[20] (Report 4) Quality of equipment used, location, availability of emergency and post-acute treatment for patients with co-morbidities, health status of patients served, and other relevant factors must be considered in determining whether price variations are "unwarranted." Price variations due to near monopoly pricing power may be "unwarranted." Careful examination of where excess

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https://improvement.nhs.uk/documents/59/choice_in_mh_services_commissioners_2.pdf (last accessed Oct. 11, 2018).

Health care plans can use information about the choices people make to improve services. If more people are choosing to go to a particular out-of-network provider or provider group, the insurer could contract with that provider or group. The insurer could also consider contracting or establishing clinics to fill service gaps identified. *See id.*

[18] J. Safran, et al., *Alliance, Negotiation and Rupture Resolution,* in Handbook of Evidence Based Psychodynamic Therapy, at 208 (2009)(˜the quality of the patient-therapist relationship is more important than the treatment modality). *See also,* J. Sharf, et al., *Dropout and Therapeutic Alliance: a Meta-Analysis of Adult Individual Psychotherapy,* 47 Psychotherapy Theory, Research, Practice, Training, 637-645 (2010). *See also,* B. Arnow, et al., *The Relationship Between the Therapeutic Alliance and Treatment Outcome in Two Distinct Psychotherapies for Chronic Depression,* 81 J. Consulting and Clinical Psychol. 627 (2013); J. Norcross, ed., Evidence-Based Therapy Relationships (2011) at 8 ("Alliances with both youth and their parents are predictive of treatment outcomes.") and at 15-16 (outcomes and patient well-being is considerably enhanced with a better collaborative relationship and goal consensus).

[19] An Act relative to the continuity of care of mental health treatment, H.907, 191st Session (Mass. 2019).

[20] Outcome measures often rely on faulty criteria, like hospital readmission rates. In addition, they do not account for patient satisfaction or sequela of the treatment that may not appear within the short periods of time within which most outcomes are measured.

profit from higher prices.is directed (e.g., subsidizing high cost services to increase consumer access or paying extravagant CEO salaries) ought to be included in any determination of whether higher prices are unwarranted.

Site-based and Provider-based Billing Reform

As with provider price variation, a careful assessment should be made of whether a legitimate basis exists for higher costs at certain sites of service. The HPC seems to recognize that the patient's unique treatment needs may be a reason for using a hospital outpatient department. (Report 5).For example, the patient may have co-morbidities that require easy access to hospital facilities should complications occur or the hospital outpatient department may have specialization in the patient's condition not found in physician's offices. Experience and quality of equipment also are factors to be considered.[21] However, if optimization of patient care is not at issue, as determined by the treating clinician and patient in conjunction with public policy guidelines established through a process in which patients are adequately represented as decision-makers, site neutral payments are justifiable.

We support protecting consumers from higher cost-sharing due to the use of outpatient hospital departments. (Report 5) As previously discussed, notice of costs is not an effective or ethical means of shifting patient choices to reduce health care spending. People do not shop for health care in the same manner as they shop for appliances. It is unreasonable to expect patients to have the knowledge or energy to do so. Patients rely on their doctors for referrals as well they should. Doctors who have a standing relationship with a particular specialist or service site will know about the quality of the equipment used, the expertise of the provider,[22] and what access to relevant services the site can provide.

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[21] MRI imaging of women with high risk of breast cancer catches the disease at an earlier stage more often than mammograms and ultrasounds. However, because the models used to estimate the risk of genetic mutations that predispose one to breast cancer largely within the domain of genetic counselors, primary care providers will not refer women for an MRI unless recommended by a specialist. See, W. Berg, *et al.*, *Reasons Women at Elevated Risk of Breast Cancer Refuse Breast MR Imaging Screening: ACRIN 6666,* 254 Radiology 79, 85 (2010). Genetic counselors are not typically located in the offices of primary care providers. Add financial pressures on the primary care provider to limit referrals to specialists and the result is women whose breast cancer could have been found and treated at an earlier stage are put in danger.

[22] Not all health care clinicians are alike. *See, e.g.,* D. Muenzel, *et al*., *Intra- and inter-observer variability in measurement of target lesions: implication on response evaluation according to*

Those patients that do choose solely on the basis of cost are likely to be people who are forced to do so because they are financially strapped. We should not be adopting policies that add to the inequities in our health care system.

Demand Side Incentives

While we agree that small businesses ought to consider purchasing health insurance through the Massachusetts Health Connector, we disagree that employees should purposely incentivize employees to choose low-cost plans over higher cost plans. (Report 6a) Employees look at a number of different legitimate factors in choosing a health insurer: inclusion of existing providers in the network, location and hours of network providers, coverage of services, including non-traditional services and payment for social determinants of health, and ability to access specialists. Employees also may choose a plan that provides a larger network of providers or covers additional services because they recognize that they cannot predict their future health. In the alternative, employees reasonably may anticipate needing particular services based on family history and want relevant specialists recognized for their expertise and quality to be in the plan's network. Penalizing these thoughtful employees for choosing a plan that meets their needs increases health care costs in the long run.[23] As discussed, continuity of care helps to improve outcomes. Use of alternative services can lower treatment costs. Patient ability to access outpatient providers when the patient's schedule permits or when the need is urgent improves access to preventive care and reduces hospital emergency department visits.[24] Specialization, expertise, and experience in providing treatment for particular conditions is related to better outcomes.[25]

RECIST 1.1, 46 Radiology Oncology 8 (2012)(finding high variability between readers in change in size of lesion, which is a factor in determining response to treatment); M. Wilson, *et al., Inter and intra-observer variability with the assessment of RECIST in ovarian cancer*, 36 J. Clin. Oncology 5555 (2018) (inter-observer assessment of size of a single lesion varied by 22%)

[23] Research confirms that high costs of medical treatment will result in not following professional recommendations for care. See, e.g. S. Zafar, *et al., The financial toxicity of cancer treatment: a pilot study assessing out-of-pocket expenses and the insured cancer patient's experience,* 18 Oncologist 381 (2013) (20% of participants studied took less than the prescribed amount of medication, 19% partially filled prescriptions, and 24% avoided filling prescriptions altogether).

[25]See, e.g., U. Benedetto, *et. al, Comparison of Outcomes for Off-Pump Versus On-Pump Coronary Artery Bypass Grafting in Low-Volume and High-Volume Centers and by Low-Volume and High-Volume Surgeons*, 121 Am. J. Cardiology 552 (2018) (high volume centers and high-volume surgeons had lower mortality rates); J. Dimick, *et al., Surgeon specialty and provider volumes are related to outcome of intact abdominal aortic aneurysm repair in the United States*, 38 J. Vascular Surg. 739 (2003) (In a risk-adjusted analysis, high-volume hospital, vascular surgery specialty, and high-volume surgeon were all independently associated with lower risk of mortality.).

Patients should not be penalized for choosing a particular provider. (Report 6b) As previously mentioned, continuity of care is related to outcomes and lower health care costs in the long run. Also as previously discussed, assessments of quality and efficiency (unless the latter is solely measured by amounts charged to payers) are variable, flawed, and subject to bias. Tiering of providers varies by plan, the criteria for which is not made available to consumers. Tiering may be by provider groups or association with low-cost primary care providers. Tiering of hospitals is not service specific. These types of tiering cannot possibly be based on quality because they do not account for the better procedure specific outcomes of high-volume facilities and high-volume providers.[26]

Price information alone is not useful to consumers. Quality information is also necessary. However, not just any measurement is useful. Meaningful quality measures are informed by health care clinicians, *who are not subject to financial incentives that might bias their choice of how quality is measured*, and consumers who have personal experience with the type of services rendered by the provider or hospital.[27] (Report 6c[28])

We heartily agree that self-insured employers and payers should contribute claims information to the Massachusetts All-Payers Claims Database and other publicly available databases. (Report 6c)

We ask the Commission to clarify that payers should not use demand-side incentives like deductibles and significant copayments to reduce costs. Payers have instituted significant copays for advanced imaging despite indications that imaging is a vital tool in diagnosing

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[26] See n.24, *supra.*

[27] Consumers of outpatient psychiatric services and providers of psychiatric services should be involved in developing quality criteria for providers and departments of general hospitals that provide such services. Likewise, consumers who have been in psychiatric inpatient hospitals should be involved in developing criteria for inpatient psychiatric hospitals; consumers of outpatient therapy services should be involved in developing criteria for mental health clinicians who provide therapy, etc.

[28] If quality assessments are distributed to the public, the content, source of data, and weight of each factor contributing to the determination should be clearly described in close proximity to the assessment. The financial conflicts of the authors of quality evidence relied upon and of those persons developing the quality assessments likewise should be provided in close proximity to each assessment. Financial conflicts should include those that might arise due to an employer's financial interests as well as the individual's participation in any shared savings or bonus arrangements based on cost savings or contracts with entities that have a financial interest in cost reductions relevant to the subject of assessment..

a patient's symptoms.[29] One study found that in three common primary care scenarios, primary care physicians changed their leading diagnosis after a CT for 50% or more of their patients.[30] Copays and deductibles also increase health care inequities because they discourage low and moderate income persons from obtaining necessary services. [31]

Unnecessary Utilization

The Commission suggests that providers should be accountable for shifting costs to "high-value, low-cost settings." As previously discussed, designations of value are not reliable and care in higher-cost settings may be warranted. We urge the Commission to clarify that providers should not be subject to financial pressures for their clinical decisions, including the use of particular medicines, referrals to specialists or out-of-network providers, and ordering of laboratory tests or imaging like MRIs or PET scans.

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[29] See, e.g., J. Seidel, et al., Retrospective Analysis of Emergency Computed Tomography Imaging Utilization at an Academic Centre: An Analysis of Clinical Indications and Outcomes, 70 Can. A. Radiol. J. 13 (Feb. 2019) (although 56% of CT scans had a final diagnosis of nil acute, 41% revealed serious clinical findings, including pulmonary embolisms and heart failure, that affected patient care and management). The authors concluded that the even with the high rate of nil acute results and the level of incidental findings requiring additional tests, "the risks associated with not imaging and potentially missing a critical diagnosis are serious." *See also*, D. Bruining, et al., Benefit of Computed Tomography Enterography in Crohn's Disease: Effects on Patient Management and Physician Level of Confidence, 18 Inflamm. Bowel Dis. 219 (2012)(CTE altered management plans in nearly half of patients and medication of in 24% of patients already diagnosed with the disease); M. Slowinska, et al., Early diagnosis of tuberous sclerosis complex: a race against time. How to make the diagnosis before seizures?, Ophanet J. Rare Dis. 13:25 (2018)(prenatal MRI allows early diagnosis and treatment to enhance outcomes and prevent mortality)**;** P. Higgins, et al., Computed Tomographic Enterography Adds Information to Clinical Management in Small Bowel Crohn's Disease, 13 Inflamm. Bowel Dis. 262 (2007)(CTE changes clinical decision-making and outcomes).

[30] P. Pandharipande, *et al.*, *Changes in physician decision making after CT: a prospective multicenter study in primary care settings*, 281 Radiology 835 (Dec. 2016). The study found that management of the patient's treatment also changed in approximately one-fourth or more of the patients, with fewer patients with abdominal pain being referred to specialists.

[31] In a study of women with a high risk of breast cancer, 12.1% refused MRI screening with contrast due to cost concerns, even though their financial contribution was limited by the study. W. Berg, *et al.*, *Reasons Women at Elevated Risk of Breast Cancer Refuse Breast MR Imaging Screening: ACRIN 6666*, 254 Radiology 79, 85 (2010). These high-risk women were likely low-income or, if not, burdened with expenses that were both sizeable and important enough for them to refuse a test that could potentially save their lives. Copays and deductibles discourage the use of essential diagnostic tools and, because they disproportionately affect persons concerned about finances, increase health care inequities.

Nevertheless, we agree that steps can be taken to reduce the use of emergency department visits by making outpatient care available weekends and evenings and by expanding the use of peer respites. Other options are available to decrease hospital costs that benefit payers, providers, and patients. One example, is a clinic that found a way to offer care when the patient needs and wants it. It found that offering behavioral health walk-in appointments reduced their costs by reducing no-shows.[32]

Social Determinants of Health

We applaud the Commission's recognition that social determinants of health are an important part of health care delivery. (Report 8)We also agree that non-profit hospitals should direct their Community Health Needs Assessments to address social determinants of health in their communities. (Report 8c) Payment for health-related social needs is a huge issue. (Report 8a) Public funds are not adequate to meet existing need. We suggest that the primary recipients of savings from efforts to address social determinants of health – health care plans and employers – be required to invest in and contribute to the cost of addressing these determinants. Collaboration with community programs for referral to under-funded public resources is not enough.

Health Care Workforce

We support the use of recovery coaches and peers in the behavioral health care system. (Report 9b) Practicing recovery coaches and peer counselors and specialists should be integrally involved in the development of any certification standards to insure that people with lived experience are not excluded from certification because of arbitrary barriers, e.g. training beyond their economic means. Peers also should be involved in determining the content of any training.

Scaling innovations in integrated care

Integrated care should not be assumed to be beneficial for all persons or to result in decreased health care expenditures.[33] (Report 10) Studies show very variable results from

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[32] Walk-in clinics also generally improve access to needed behavioral health care. See, J. Lowry, *Pilot Walk-in Clinic Improves Access to Mental Health Care* (Dec. 2018) https://www.medscape.com/viewarticle/906276 (last accessed 3/21/2019). For one example of a walk-in clinic, see https://gandaracenter.org/outpatient-clinic/ (last accessed 3/21/2019), the website for the Gándara Center in western Massachusetts.

[33] D. Cooper, *et al*., *Association Between Mental Health Staffing Level and Primary Care-Mental Health Integration Level on Provision of Depression Care in Veteran's Affairs Medical Facilities*, 45 Adm. Policy Mental Health 131 (2018)(finding level of integration of primary care and mental health did not significantly affect likelihood of adequate psychotherapy for patients

the integration of mental and physical health care, both in terms of cost savings and quality. In those studies where improvements are seen, the improvements result from the addition of added resources or from other factors not related to integration per se. The research on delivery systems that show improvements in care or cost savings often cannot attribute the improvements to the delivery model itself. Rather improvement may be attributable to additional or altered services that have been incorporated and which could be incorporated in other delivery systems without adopting potentially damaging payment incentives.[34]

The impact of integrated care on the physical health care of persons with psychiatric diagnoses is of great concern. Americans with depression, bipolar disorder or other serious mental illnesses die 15 to 30 years younger than those without mental illness — *a disparity larger than for race, ethnicity, geography or socioeconomic status*.[35] MHLAC has had numerous complaints from people with mental health diagnoses that medical providers quickly attribute physical symptoms to psychiatric diagnoses. One client was told that her itching hands were psychosomatic. Only after seeking care at more than five health care sites was she diagnosed with a bacterial infection. Another client described how she was having severe shortness of breath and was told by hospital emergency department staff to breathe into a paper bag after they saw the client's diagnosis of anxiety disorder in her health record. She was in anaphylactic shock.

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with either new or chronic depression or adequacy of antidepressant treatment); E. Stuart, *et al.*, *Effects of accountable care and payment reform on substance use disorder treatment: evidence from the initial 3 years of the alternative quality contract*, 112 Addiction 124 (2017) (finding accountable care model did not lead to substantial changes in use of substance use disorder services).

[34] "Studies that did not find improved patient outcomes were generally in settings without additional personnel, training, and oversight or had small sample sizes." M. Gerrity, *Evolving Models of Behavioral Health Integration: Evidence Update 2010-2015* (Milbank Memorial Fund 2016) at 18. One may assume that studies that found improved patient outcomes had additional personnel, training and oversight. The review of studies also concluded that care managers with training and who consistently follow up were the ones who had a large impact on mental health outcomes and the limited reported medical outcome results, the latter of which were tenuous. The impact of collaborative case management (CCM) on medical outcome varied across the studies reviewed. *Id.* at 14. Even with respect to mental health outcomes, "[based on high-quality evidence, CCM results in small to moderate improvements in symptoms from mood disorders and mental health-related quality of life." *Id.* at 18.

[35] D. Khullar, *The Largest Health Disparity We Don't Talk About*, NYT (May 30, 2018).

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Failure to believe people with psychiatric diagnoses and to give them adequate care is common.[36]

There is no evidence that the overall healthcare of persons with psychiatric diagnoses improves by virtue of information sharing by mental health and physical health providers. In fact, the opposite is true. Stigma associated with psychiatric diagnoses is well-documented and undue attribution of physical symptoms to mental illness in persons with psychiatric histories undermines care.[37]

Discrimination against persons with mental health challenges is costly to payers. People who have experienced this discrimination are likely to avoid care – mental, physical or

[36] Among all physicians who said bias affected treatment, 72% said that emotional problems had a negative effect on treatment. C. Peckham, *Medscape Psychiatry Lifestyle Report 2016: Bias and Burnout 2016*, Slide 7, available at http://www.medscape.com/features/slideshow/lifestyle/2016/psychiatry (last accessed April 13, 2016).

[37] G. Thornicroft *et al*., *Discrimination in Health Care Against People with Mental Illness*, 19 INT'L REV. PSYCHIATRY 113 (2007) (discussing discrimination in health care against people with mental illness); Among all physicians who said bias affected treatment, 72% said that emotional problems had a negative effect on treatment. C. Peckham, *Medscape Psychiatry Lifestyle Report 2016: Bias and Burnout 2016*, Slide 7, available at http://www.medscape.com/features/slideshow/lifestyle/2016/psychiatry (last accessed April 13, 2016). As noted in M. De Hert, *et al., Physical illness in patients with severe mental disorders*, 10 World Psychiatry 138, 138-39 (2011), integration of physical and mental health care will not solve the problem of inferior care. The authors state that "… in developing as well as in developed countries, stigmatization, discrimination, erroneous beliefs and negative attitudes associated with SMI will have to be eliminated to achieve parity in health care access and provision." *Id.* Even those who suggest care coordination between mental health providers and primary care physicians recognize the danger to the physical health of persons diagnosed with mental illness and recommend evaluation of integrated care programs on their actual effectiveness in reducing excess mortality risk factors. N. Liu, *et al., Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy, and research agendas*, 16 World Psych. 34 (Feb. 2017)(citations omitted). ("Few randomized trials have tested care coordination programmes for physical health conditions and cardiovascular risk factors in adults with SMD.") Integrated care also should be monitored for its effect on physical health care for conditions that produce discomfort or affect quality of life. As long ago as 2008, Simon Jones, Louise Howard, and Graham Thornicroft concluded that "the concept of 'diagnostic (and treatment) overshadowing' in patients with mental illness seems to be an important under-investigated problem." Simon Jones, *'Diagnostic overshadowing': worse physical health care for people with mental illness*, 118 ACTA PSYCHIATR. SCAND. 169, 170 (2008).

both. Inadequate care leads to health problems that require more intensive treatment. Both raise health care costs.[38]

Health care professionals rarely discriminate against persons with mental health diagnoses intentionally. The inferior care is a function of implicit bias, something that cannot be cured with a one day training.[39] Persons with psychiatric diagnoses cannot wait for assurances that their care will not be compromised due to bias until that future time when discrimination is eliminated – their lives are at stake.

We recommend that integrated care not be promoted as unequivocally beneficial without further investigation. For those integrated care plans that exist, we suggest that monitoring of the impact of integration on the physical health care of persons with psychiatric diagnoses be carefully monitored and reported to the Health Policy Commission and the Center for Health Information and Analysis.[40]

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[38] *See* S. Parle, *How does discrimination affect people with mental illness?* 108 NURSING TIMES 28:12-14 (2012) (citations omitted). Another study indicates that persons with psychiatric diagnoses who experience discrimination in the health care system may incur higher health care costs, and a reduction over time in health care use and leisure activities that can assist recovery. B. Osumili, *The economic costs of mental health-related discrimination,* 134 ACTA PSYCHIATR. SCAND. Sup. 446, 34 (2016). *See also,;* S. Evans-Lacko, *et al.*, *How much does mental health discrimination cost: valuing experienced discrimination in relation to healthcare care costs and community participation.* 24 EPIDEMIOL. AND PSYCHIATR. SCI. 423 (2015)(Cost of health services used for individuals who reported previous experiences of discrimination in a healthcare setting was almost twice as high as for those who did not report any discrimination during the last 12 months and this was maintained after controlling for symptoms and functioning.)

[39] According to a majority of the evidence, the best means of ridding stigma is to expose health care providers to persons who have achieved success notwithstanding behavioral health challenges. L. Stromwall, L. Holley, and D. Kondrat. *Peer Employees' and Clinicians' Perceptions of Public Mental Illness Stigma and Discrimination*. Psychiatric Rehabilitation Journal 2012, Vol. 35, No.5, 406-408; A. Llerena, M. Caceres, and E. Penas-LLedo. *Schizophrenia stigma among medical and nursing undergraduates*. Eur Psychiatry 2002; 17: 298-9 (students who had exposure to persons with schizophrenia less likely to view them as violent); G. Thornicroft, E. Brohan, A. Kassam, and E. Lewis-Holmes. *Reducing Stigma and Discrimination: Candidate interventions.* International Journal of Mental Health Systems, 2:3 (2008).

[40] An additional strategy would be to require plans to give patients control of their psychiatric information (psychiatric information not protected by HIPAA, including psychiatric information in the notes of primary care providers, psychiatric diagnoses, and psychiatric medications) and with which providers that information is shared. This is particularly important for interactions with new providers. Patients may get more accurate diagnoses. When the patient feels

We support the use of telehealth for behavioral health care services *with provisos.* (Report 10a) Patients should continue to have the right to receive in-person care without additional costs beyond those incurred for telehealth services. Telehealth providers should not be relied upon to meet network adequacy standards. Telehealth providers should not be reimbursed at a lower rate than providers who render their services in-person. Finally, telehealth providers should be licensed to practice in Massachusetts and should be aware of available resources, both medical and supports of social determinants of health, in the communities of their clients.

Alternative Payment Methods

Health care costs obviously can be reduced if insurers deny coverage for medically necessary services or providers refuse to recommend it. In the 1990s, health maintenance organizations were faulted for doing just this.[41] Of course, the HPC has no interest in

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comfortable with the provider, he or she can share their psychiatric information. Issues with medication interaction can be dealt with by the prescriber entering the proposed medication into a database that checks medication conflicts without revealing psychiatric medications. If the system alerts the prescriber of a conflict, then the prescriber can speak with the patient and refuse to prescribe the new drug without having access to information about which drug is causing the warning.

Privacy and control over personal information is crucial to many people, especially teens. Kenneth Ginsburg, *Earning a Teenager's Trust* (April 1, 2013), *available at* http://www.medscape.com/viewarticle/781366. The willingness of teens to seek and stay in care, as well as disclose sensitive information increases significantly with assurances of confidentiality. Carol A. Ford, et al., *Influence of Physician Confidentiality Assurances on Adolescents' Willingness to Disclose Information and Seek Future Health Care,* 278 J. AM. MED. ASSOC. 1029 (1997). *See also,* Debra J. Rickwood, et al., *When and how do young people seek professional help for mental health problems?*, 187 MED. J. AUSTL. S35 (2007) "Confidentiality remains of utmost importance when engaging young people, and this is particularly important in the context of accessing alcohol and other drug services." *Id*. at S57. Disclosure of sensitive medical information may lead adults to avoid care or withhold information from providers as well. See William A. Yasnoff, *The Health Record Banking Model for Health Information Infrastructure, in* HEALTHCARE INFO. MGT. SYSTEMS: CASES, STRATEGIES, AND SOLUTIONS 336-37 (C.A. Weaver et al. eds., 2016). The mere use of an EHR system by a mental health therapist during intake both impairs the therapeutic alliance and reduces the likelihood the client will continue care. D. Rosen, et al., *The impact of computer use on therapeutic alliance and continuance in care during the mental health intake*, 53 PSYCHOTHERAPY 117 (2016).

[41] *See, e.g.*, Jacqueline Kosecoff *et al*., *Prospective Payment System and Impairment at Discharge: The "Quicker-and-Sicker" Story Revisited*, 264 J. AM. MED. ASS'N 1980 (1990). In a study with a sample size of over 10,000 patients, in which the hospitals were paid a fixed amount per patient rather than being reimbursed based on the patient's actual cost of care, the patients

reducing costs by reducing quality of care. The Commission should therefore carefully scrutinize financial incentives to cut care.[42] Engaging front-line health care providers in cost-cutting efforts through financial incentives are very likely to result in a return to the experience of health maintenance organizations in the 1990s.[43]

Outcome measurements will not fully address the negative impact of financial incentives. Unfortunately, most measures of quality, such as hospital readmission rates, are crude. We cannot depend upon commonly-used outcome measurements, such as reduced hospital admissions, to guarantee quality of care. [44]

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were repeatedly discharged sooner and in less stable condition. *Id.* "[O]ne (17%) of six patients was discharged with at least one instability, two (39%) of five patients . . . [had] at least one measure of sickness, and one (24%) of four patients had an abnormal last laboratory [test result]." *Id.* at 1980-81.

[42] *See, e.g.,* B. Kaufman, *et al., Impact of Accountable Care Organizations on Utilization, Care, and Outcomes: A Systematic Review,* Med. Care Research and Rev. 1, 16 (Nov. 2017)("The evidence for the effect of ACOs on care processes and outcomes is mixed…."); H. Hennig-Schmidt, *et al., How payment systems affect physicians' provision behavior – An experimental investigation,* 30 J. Health Eco. 637 (2011) (Physicians provide 33% fewer services under capitation than under fee-for-service. Patients in intermediate or bad health suffer a larger benefit loss under capitation than those in good health.)

[43] See Hennig-Schmidt, *supra* n. 3. Physicians were given the exact same scenarios that varied only by the financial incentives to the physician. Where the provider's remuneration would be reduced by providing services, the providers recommended about a third fewer services. Managed care provided cost-cutting incentives to the detriment of patients. These findings strongly suggest that bringing front line health care workers into cost-cutting efforts will alter their recommendations and damage care, not to mention public trust in the health care system.

[44] Hospital readmission rates can be kept low simply by denying readmission or coverage of readmission. Furthermore, certain mental health conditions do not necessarily result in admissions or readmission. An individual with such conditions may instead become homebound, homeless or incarcerated.

> When financial consequences are linked to the outcome, unintended effects could occur. For example, hospitals may try to reduce their readmission to escape the penalty of exceeding the readmission rate by lowering admissions, moving readmissions after the 30-day window, or risk avoidance in regards to high risk groups. These gaming efforts might reduce the focus on the actual intention: improving quality of hospital care.

C. Fischer, *et al., Is the Readmission Rate a Valid Quality Indicator? A Review of the Evidence,* 9 PLOS ONE e112282. doi:10.1371/journal.pone.0112282 (2014)(unrelated correction Feb. 2015: https://doi.org/10.1371/journal.pone.0118968).

Even quality-related financial incentives can have ironic results. For example, **pay for performance** usually results in some improvement, at least temporarily, in the practices for which payment is made. However, studies show that those items not measured or incentivized often experience a decrease in the quality of care, sometimes resulting in an overall reduction in care quality.[45]

The common presumption that a focus on value as well as cost efficiencies will promote better care is also flawed.

The problem with "value-based" care is that it usually represents the priorities of the payers and providers, not the recipients of care. As with pay for performance, the measurements of value are decided without seeking or giving due regard to input from patients or those engaged in health care advocacy[46] on patients' behalf. [47]

Failing to adequately consider patient input will result in the valuing of insurer and payer-preferred treatments without adequate consideration of social costs. For example, the

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In addition, hospital readmission can be due to numerous factors. Some payers, while condoning certain readmissions, do not necessarily provide full coverage of the readmission. For example, providers have expressed concern that under BCPI Advanced, CMS' recent bundled care initiative, fewer of the services rendered during a readmission will be separately reimbursed, even if the readmission is unrelated to the original admission. See, e.g., https://www.beckershospitalreview.com/finance/bpci-advanced-ten-key-differences-from-original-bpci.html (last accessed 3/17/2019)

[45] One study of pay for performance with primary care providers in England found that while the payments accelerated improvements in quality for two of the three chronic conditions targeted, the rate of improvement slowed and the quality of those aspects of care not associated with the incentive actually declined. Campbell *et al*., *Effects of Pay for Performance on the Quality of Primary Care in England*, 361 New Eng. J. Med. 368 (2009). In addition, pay for performance is often instituted at a point in time where the practice being incentivized is already being adopted without any bonus payment.

[46] The patient representatives on some ACO boards do not represent typical members and their interests. For example, the representative is spectacularly wealthy or was a former health care executive. Patient input should come from persons representative of patients or whose work has been dedicated to patient advocacy.

[47] MHLAC lauds the HPC in its move toward using patient reported outcome measures for ACO certification. However, even PROMS will not reflect patient perspectives on quality of care if the wrong questions are asked. The need for true patient advocates to have a seat at the table remains after a system of outcome measurements is chosen.

failure to solicit patient preferences for alternatives to medication may result in over-valuing the use of pharmaceutical mental health interventions and under-valuing alternatives. If treatments preferred by consumers are not highly valued, and thus not appropriately supported and priced, consumers may avoid treatment altogether. Untreated patients tend to generate higher and avoidable acute care costs. Social costs will increase as these persons are unable to maintain steady employment and become reliant on public programs. Limiting recovery options also increases criminal justice costs when behavior results in arrest, court-processing, and imprisonment. By contrast, research shows that health care systems offering a wide array of treatment options appealing to a greater number of patients with varying preferences reduce costs and improve outcomes.[48]

Two-sided risk (Report #11a) may reduce costs but will not improve health outcomes. As explained above, current outcome measures do not successfully control the financial incentive to deny care and have unintended consequences. Two-sided risk will just exacerbate the problem of clinical decisions being influenced more by financial gain or avoidance of loss than by the health and well-being of the patient.

Bundled payments (Report #11c), like capitation (ACOs, HMOs), focus on cost, not on person-centered care or quality. The latest CMS model for bundled payments, Bundled Payments for Care Improvement Advanced (BCPI Advanced), places only 10% of the payment at risk for quality.[49]

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[48] J. Swift and J. Callahan, *The impact of client treatment preferences on outcome: a meta-analysis,* 65 J. Clinical Psychology 368-381(2009); O. Lindhiem, *et al., Client preferences affect treatment satisfaction, completion, and clinical outcome: A meta-analysis,* 34 Clin. Psych. Rev. 506 (2014); Q. Le, *et al., Effects of treatment, choice, and preference on health-related quality-of-life outcomes in patients with posttraumatic stress disorder (PTSD)*, Qual. Life Res. (2018)(https://doi.org/10.1007/s11136-018-1833-4); R. Williams, *et al., Patient preference in psychological treatment and associations with self-reported outcome: national cross-sectional survey in England and Wales,* BMC Psych. 4 (2016)(patients who had preferences for type of therapy and were not offered adequate choice were around six times less likely to agree that they had been helped by the treatment than those who were offered their choice).

[49] Three of the seven measures CMS uses to measure quality apply to all bundles: hospital readmission, advance care planning (advance directives), and patient safety indicators. https://innovation.cms.gov/initiatives/bpci-advanced (last accessed 3/17/2019) None of these are worthy measures of quality.

The problems with using hospital readmissions have previously been discussed herein.

Advance care planning does not reflect quality of the treatment rendered. While communication between the provider and the patient about treatment is essential to person-centered care, a conversation about advance care planning does not reflect incorporation of a patient's goals for

Reducing health care costs and improving outcomes

Instead of relying upon alternative payment arrangements which are reminiscent of managed care of years gone by or shifting costs to consumers, innovative approaches to healthcare must supplement and replace our limited traditional approaches to illness and recovery. It is not possible to save substantially on health care while doing the "same old, same old."

Everyone's path to recovery is different. Reform of behavioral health care practices requires accepting input from the recipients of care.[50],[51] One of the key problems with our current health care delivery system is that it fails to address individual preferences and needs.[52]

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current treatment or a provider's full description of the treatment itself, its ability to meet patient goals, or alternative ways to meet patient goals.

Safety standards also are poor tools to measure the quality of care under new payment methodologies. Hospitals are already attentive to the CMS patient safety indicators, such as rate of falls, pressure sores, wound ruptures along a surgical incision. Medicare has a long-standing Hospital-Acquired Condition (HAC) Reduction Program that links payments to these measures. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/HAC-Reduction-Program-Fact-Sheet.pdf These benchmarks are incorporated into current care standards and patient harm caused by failing to follow these standards are difficult to explain away. Providers are more likely to be exposed to malpractice actions where the standard of care is clear and the possible causes of the harm are few. However, providers are more able to find explanations for denying treatments, imaging, and medication whenever there are multiple rationales for refusing the services or for the cause of harm. Outcome measurements fail to control financial incentives in these circumstances.

[50] Shared decision-making has been found to reduce inpatient hospitalization costs, a large driver of overall health care costs. J. Lofland, *et al.*, *Shared decision-making for biologic treatment of autoimmune disease: influence on adherence, persistence, satisfaction, and health care costs*, 11 Patient Pref. Adherence 947, 956 (2017)(patients who did not engage in shared decision-making had inpatient hospitalization costs 2.6 times greater than those who did). `

[51] D. Cooper, *et al.*, *Association Between Mental Health Staffing Level and Primary Care-Mental Health Integration Level on Provision of Depression Care in Veteran's Affairs Medical Facilities*, 45 Adm. Policy Mental Health 131, 138 (2018)("[I]t is important to identify patient preferences for care, and to ascertain how current care addresses these….").

[52] Person-centered care requires a broad array of treatment options. I. Kovacevic, *et al.*, *Self-care of chronic musculoskeletal pain – experiences and attitudes of patients and health care providers,* 19 BMC Musculoskeletal Disorders 76 (2018)(Patients "lack individualized care from conventional medicine.")

Giving adequate regard to patient preferences is a requisite to reducing costs. There are alternatives that are both cheaper and more effective. An example of a service that has proven to be low cost and is preferred by many patients is peer respite. This is exactly the kind of service that is "high value, low cost" and that will prevent unnecessary hospitalizations.[53] Peer respite offers a safe haven for people experiencing psychiatric crises. Preferably, it is run by persons who have had psychiatric challenges, i.e., peers. It also is staffed with peers. Many people with psychiatric challenges would prefer peer respite over an emergency room or a psychiatric inpatient facility.

In studies with a control or comparison group, respite guests were 70% less likely to use inpatient or emergency services and average psychiatric hospital costs were $1,057 for respite users compared with $3,187 for non-users.[54] Investment in and use of peer respite is thus especially pertinent to the reduction of hospital utilization, first on the list of HPC's spending reduction scenarios.[55] A study in the October 2018 issue of Psychiatric Services concludes:

If a broad array of options are not available, persons may reject substance use disorder (SUD) and mental health (MH) services altogether or may turn to self-medication, ultimately increasing both health care and social costs. For example, we know that a large portion of persons who become addicted to opioids start with prescription medication for pain. A. Wilson-Poe and J. Morón, *The dynamic interaction between pain and opioid misuse*, Brit. J. of Pharmacology 1 (May 9, 2017)(nearly half of persons with chronic pain and SUD reported the SUD began with an opioid prescription for pain). Therefore, person-centered care should include, among other things, complementary and alternative treatments for pain control, which often is not covered by insurers. For example, while not producing statistically significant results, acupuncture resulted in less intra-operative and post-operative morphine equivalent usage, lower average pain scores and fewer days at home taking less opioids following gynecological surgery. E. Yoselevsky, *et al., A prospective randomized, controlled, blinded trial of pre-operative acupuncture in the management of pain in gynecologic surgery*, Am. J. Obs. & Gyn, S.890 (Feb. 2018). Mindfulness meditation also has been shown to result in enhanced pain control. A. Wilson-Poe and J. Morón, *The dynamic interaction between pain and opioid misuse*, Brit. J. of Pharmacology 1 (May 9, 2017).

[53] Additional means to prevent hospital utilization is to provide evening and weekend office hours, without an additional co-pay for urgent care; to allow walk-in care, which has had the fortuitous effect of reducing no-shows for one clinic that implemented the policy; and to provide peer support.

[54] http://www.peerrespite.net/research/ (last accessed 3/8/18).

[55] See n. 4 for concerns about using hospital readmissions as an outcome measurement. Similar concerns exist in relation to relying on readmission denials as a means to reduce costs as the motivation behind denying a readmission may not place the patient's best interests in the forefront.

> Clients who received peer-staffed crisis respite services demonstrated lower rates of hospitalization and Medicaid expenditures in the month of and immediately following receipt of these services compared with a comparison group. The findings provide evidence that implementing peer-staffed crisis respites to divert individuals from hospitalization can achieve savings in Medicaid expenditures and reduce reliance on hospital services.[56]

Although DMH Commissioner Joan Mikula believes in the efficacy of peer respites, only two peer-run peer respites exist in Massachusetts[57],[58] and, as a rule, peer respite is not covered by insurance. This is absurd as peer respite is considerably less expensive than inpatient hospitalization.

Another example relates to food. Certain healthy diets reduce the severity, or prevent the onset of, mental health conditions, cognitive impairments, and even physical ailments.[59] Payer subsidies for the costs of healthy foods may be less expensive in the long and perhaps even the short-run than many of the medications prescribed for psychiatric and cognitive conditions and have fewer side effects.

Service animals are another tool that could be used to reduce healthcare expenditures, including medication expenditures that the HPC lists as a significant cost driver. The former Chief Medical Director of the District of Columbia's Department of Mental Health, Colonel (Ret.) Elspeth Cameron Ritchie, M.D., attests that when persons with posttraumatic stress disorder are given service dogs, they frequently are able to

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[56] E. Bouchery, *et al.*, *The Effectiveness of a Peer-Staffed Crisis Respite Program as an Alternative to Hospitalization*, 69 Psych. Serv. 1069, 1073 (Oct. 2018). The 20 to 30 peer staff in each New York City peer respite centers were supervised by three to five nonpeers. Clients are full participants in treatment decision-making. *Id.* at 1070.

[57] "Afiya is located in a residential neighborhood in Northampton, Massachusetts and is central to a variety of community resources. It is available to anyone ages 18 and older who is experiencing distress and feels they would benefit from being in a short-term, 24-hour peer-supported environment with others who have 'been there.' Typical stays at Afiya range from one to seven days." http://www.westernmassrlc.org/afiya (last accessed 3/8/2017).

[58] Advocates opened "The Living Room" in September 2018. Located in Framingham, it is peer-run seems structured for shorter term stays than Afiya. The Living Room has reclining chairs for sleeping while Afiya provides beds for its guests.

[59] See F. Jacka, *et al.*, *Food policies for physical and mental health*, 14 BMC Psych. 132 (2014).

successfully discontinue medication.[60] Again, despite the abundance of evidence supporting the efficacy of pet therapy and service animals for mental health conditions, insurers generally refuse to cover their provision.

"Housing First" is another approach that is under-utilized because it does not fit into the traditional medical model of healthcare.[61] It is based on the premise that the physical and mental health care needs of the homeless cannot be addressed until they are provided a home. Instead of requiring sobriety or compliance with medication to obtain an apartment, the homeless individual is provided a place to live and must only abide by the requirements of any tenant: do not disturb the neighbors and do not destroy the premises. Several cities that have instituted this program have realized significant reductions in overall expenditures, including for health care and even housing.[62] Nevertheless, once

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[60] Presentation of Col. (Ret.) Ritchie, M.D. at MHLAC training held Nov. 15, 2016, Massachusetts Continuing Legal Education, Boston, MA.

[61] Local pilots exist in Massachusetts. See, Boston Public Health Commission's description of their program at http://www.bphc.org/whatwedo/homelessness/homeless-services/Pages/Housing-First-Initiative.aspx, as well as http://www.fobh.org/what-we-support/housing-first/.

[62]The costs of homelessness include hefty health care costs, leading Denver's Housing First Program, Road to Home, to link funding through government and private entities.

> Detox admissions for homeless substance abusers fall 84 percent when they are targeted for housing and services, said Jamie Van Leeuwen, a Denver Department of Human Services official who is manager of Denver's Road Home. Those homeless were each averaging 70 detox admissions a year, which means the savings are substantial.

M. Booth, *Four years into a 10-year plan to end homelessness in Denver, the mayor cites the cost savings as 1,500 units have opened up*, Denver Post (May 15, 2009, updated May 6, 2016). The cost of homelessness bears directly on health care costs and health care entities and insurers should participate monetarily as it is in their interest to reduce health care expenditures.

> Living on the streets isn't cheap: Each chronically homeless person in Central Florida costs the community roughly $31,000 a year...The price tag covers the salaries of law-enforcement officers to arrest and transport homeless individuals —largely for nonviolent offenses ... —as well as the cost of jail stays, emergency-room visits and hospitalization for medical and psychiatric issues. In contrast, providing the chronically homeless with permanent housing and case managers … about $10,000 per person per year, saving taxpayers millions of dollars during the next decade....The findings are part of an independent economic impact analysis….
> "The numbers are stunning," said the [Florida] homeless commission's CEO, Andrae Bailey. "Our community will spend nearly half a billion dollars [on the chronically homeless], and at the end of the decade, these people will still be homeless. It doesn't make moral sense, and now we know it doesn't make financial sense."

again, health insurers and provider organizations do not regularly cover, contribute to the funding of, or offer these services.[63, 64]

Health plans do not uniformly cover massage, acupuncture and meditation,[65] low cost interventions that are underused. Each of these modalities can reduce pain and lessen the reliance of addictive pain medication. The expenses related to substance use disorder far outweigh the cost of these alternative services.

Peer supports also show promise for increasing the quality of care and reducing costs.[66,67] A use of peers that has not been aggressively pursued yet reduces healthcare expenditures

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K. Santich, *Cost of Homelessness in Central Florida? $31K Per Person,* Orlando Sentinel (May 21, 2014). In Denver, the estimate of savings ran about $23,000 per homeless person. M. Booth, *Ibid.*

[63] Supported housing also reduces use of expensive inpatient services, thereby having the long-term potential of saving insurers and taxpayers money. National Center on Family Homelessness, The Minnesota Supportive Housing and Managed Care Pilot: Evaluation Summary (March 2009), at 17 (inpatient behavioral health service costs were lower for pilot participants than comparison group; inpatient medical costs for adults in families also were lower). In addition, positive health outcomes were achieved, e.g. reduction in mental health symptoms of and substance use by participants and life-saving treatment of unaddressed medical needs. *Id.* at 12 and 18.

[64] "Partnering" with community organizations that merely refer patients to underfunded public programs, like Section 8 for housing, does not come close to addressing social determinants of health. Rather, insurers need to cover the costs of social determinants of health because they are health care costs and affect their bottom line

[65] The National Health System of England guidelines for recommends for generalized anxiety disorder the use of "applied relaxation," which focuses on applying muscular relaxation in certain situations. It usually consists of 12 to 15 weekly sessions, each lasting an hour. https://www.nice.org.uk/guidance/cg123/chapter/1-Guidance (last accessed Oct. 10, 2018).

[66] See, e.g., E. Kelly, *et al., Integrating behavioral healthcare for individuals with serious mental illness: A randomized controlled trial of a peer health navigator intervention,* 182 Schizophrenia Research 135 (2017)(finding that, as compared to the control group, patients with peer providers showed a decreased preference for emergency and urgent care, an increased preference for primary care clinics, improved detection of chronic health conditions, and reductions in pain).

[67] The National Health System of England guidelines for common mental health conditions recommends "befriending" for all mental health conditions. Befriending is defined as meeting and talking with someone with a mental health problem usually once a week….The befriender may accompany the befriendee on trips to broaden their range of activities and offer practical support with ongoing difficulties." https://www.nice.org.uk/guidance/cg123/chapter/1-Guidance

is the use of either peer support[68] or home companions to encourage persons to exercise. We have an obesity epidemic in this country, which results in numerous conditions like diabetes, heart disease, and joint issues. Exercise has been identified as a key component to improving health generally and a major contributor to lowering health care costs[69]. In fact, exercise is sometimes identified as the most promising approach to dealing with mental and medical conditions. For example, the medication used to treat dementia is extremely expensive and has very modest, if any, success. Exercise, on the other hand, has been shown to improve the cognition of persons with dementia.[70] Yet, at best, most physicians will do nothing more than recommend exercise in passing and without any support for or particulars about how to actualize the recommendation. This approach is ineffective. Motivating exercise using home companions and peer support[71] is much more likely to result in compliance at considerably less expense than, for example, treatment for cardiac conditions.[72]

Conclusion

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and https://www.nice.org.uk/guidance/cg123/chapter/Appendix-E-Glossary (last accessed Oct. 10, 2018).

[68] A. Muralidharan, *et al., Impact of Online Weight Management With Peer Coaching on Physical Activity Levels of Adults With Serious Mental Illness,* 69 Psych. Serv. 1062 (Oct. 2018) (finding that the use of peer coaches significantly increased total physical activity over usual care and over a Web-based weight management program).

[69] A key distinguishing characteristic of the health behavior of persons with lower health care costs was participation in active or competitive sports, consistent with the role of physical activity in slowing the impacts of biological aging and consequently suppressing medical expenditure growth. F. Navarro, *Medical Expenditure Effects from Increasing Behavioral Conformity to Patterns of Health-Related Behavior*, 1, 12 (Oct. 2015).

[70] C. Grout, *et al., The effect of physical activity on cognitive function in patients with dementia: A meta-analysis of randomized control trials,* 25 Ageing Research Rev. 13 (2016).

[71] Exercise groups that foster social connections and are appropriate for the individual are key to exercise adherence. C. Farrance, *et al., Adherence to Community Based Group Exercise Interventions for Older People: A mixed-methods systematic review*, 87 Preventive Med. 155 (2016).

[72] V. van der Wardt, *et al., Adherence support strategies for exercise interventions in people with mild cognitive impairment and dementia: A systematic review*, 7 Prev. Med. Rep. 38 (2017)(reminders and support to overcome exercise barriers among the strategies to promote adherence); *see also*, H. van Alphen, *et al., Barriers, motivators, and facilitators of physical activity in dementia patients: A systematic review*, 66 Arch. Geron. and Geriatrics 109 (2016).

In performing its function to lower health care spending growth, the Commission should always be cognizant of fissures in the logic behind popular health care myths. Financial incentives and shifting costs to insureds to reduce expenditures by payers and insurers in the short-term often result in higher medical expenses in the long-term and reduction in the quality of care and quality of life for Massachusetts residents. Instead, the Commission should encourage the use of innovative services and practices by continuing to expand the overly-narrow definition of what constitutes medical care. We also recommend that the Commission scrutinize claims made about the quality and costs of delivery systems, like integrated care and tiered networks, and establish systems to monitor the impact of these systems on specific populations, like persons with psychiatric diagnoses, before promoting the universal adoption of particular care delivery structures.

MHLAC and MaMHCA look forward to working with the HPC in helping the Commonwealth reach the goal of affordable high quality care.

Sincerely,

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