MENTAL HEALTH LEGAL ADVISORS COMMITTEE
The Commonwealth of Massachusetts
Supreme Judicial Court
24 SCHOOL STREET - 8th FLOOR
BOSTON, MASSACHUSETTS 02108
TEL: (617) 338-2345
FAX: (617) 338-2347
www.mhlac.org

PHILLIP KASSEL
EXECUTIVE DIRECTOR

Testimony of Mental Health Legal Advisors Committee Regarding Potential Modification of the 2018 Health Care Cost Growth Benchmark

This testimony is submitted on behalf of Mental Health Legal Advisors Committee (MHLAC), 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. MHLAC presented oral testimony at the March 8, 2017 benchmark modification hearing.

In considering an appropriate benchmark for growth in healthcare costs, the Health Policy Commission (HPC) looks at potential drivers of costs as well as practices that will reduce healthcare expenditures. MHLAC directs its comments to these factors rather than to the specific level at which HPC should set the benchmark. MHLAC recommendations also pertain to the imposition and enforcement of performance improvement plans for entities that exceed the benchmark. Key points addressed below are:

- Financial incentives to reduce costs often have unintended results and should not be pursued without careful scrutiny and transparency.
- Innovative approaches to health care that are not covered by insurance or included in traditional medical models of care are fundamental to reducing health care costs.
- Health care delivery systems, like integrated care, should not be assumed to be beneficial for all persons or to result in decreased health care expenditures.
- The administrative costs of private insurance should be included in the examination of health care cost drivers.

Financial Incentives

Health care costs obviously can be reduced through the denial by insurers of coverage for medically necessary services and by provider refusal to recommend necessary treatment. In the 1990's, health

maintenance organizations were faulted for doing just this.[1] Of course, the HPC has no interest in reducing costs by reducing quality of care. For this reason, financial incentives which place providers in the place of insurers by giving them financial incentives to cut care should be carefully scrutinized. Unfortunately, most measures of quality, such as hospital readmission rates, are crude.[2]
We cannot depend upon how come measurements to guarantee quality of care.

In addition, 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. FN: insert In addition, pay for performance is often instituted at a point in time where the practice being incentivized is being adopted without any bonus payment.

Shifting costs to consumers through mechanisms like tiering of providers are ineffective and counterproductive. People do not shop for healthcare like they shop for appliances; much more is at stake, the need for the service is often immediate. This precludes leisurely shopping. A patient in this position is not emotionally or physically able to undertake the research necessary. Considerations about choice of provider are complex. And fundamental information, like the financial incentives under which the healthcare provider operates, is not public information.

Similarly, increased co-pays or deductibles for certain medications and services have been found to result in avoidance of medically necessary care or "non-compliance" with physician recommendations.[3] For instance, the elderly cut their medications in half to make them last longer. The ultimate result is not higher quality care or even lower cost care, rather it is low-income people ending up in the hospital or with more serious illnesses that require treatment, thus *increasing* morbidity, mortality, and costs.

For a full discussion of the unintended results of alternative payment arrangements, please see the attached MHLAC white paper, "The Unintended Results of Payment Reform."

Innovative Services

Instead of relying upon alternative payment arrangements which are reminiscent of managed care of years gone by or shifting costs to consumers, innovate to approaches to healthcare must supplement

---

[1] *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 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.

[2] 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 homeless or incarcerated.

[3] *See*, J. Piette, et al., Cost-Related Medication Underuse Among Chronically Ill Adults, 94 Am. J. Pub. Health 1782 (2004); B. Briesacher, et al., *Patients at Risk for Cost-Related Medication Nonadherence*, 22 J. Gen. Intern. Med. 864 (2007) (Up to 32% of elderly take less medication than prescribed to avoid costs). Research has established consistent links between medication nonadherence due to costs and financial burden, and to symptoms of depression and heavy disease burden.)

and replace our limited medical model approach to illness and recovery. We cannot possibly save any substantial amounts on health care by doing the "same old, same old."

This is particularly true with our approach to behavioral health care. A good beginning point to reform health care practices would be to ask the recipients of behavioral health services what services they think are helpful. One example of such a service is peer respite. Peer respite is a safe haven for people experiencing psychiatric crises. It is run by persons who have had psychiatric challenges, i.e., peers. Many people with psychiatric challenges would prefer peer respite over an emergency room or a psychiatric inpatient facility. Although DMH Commissioner Joan Mikula has spoken favorably of peer respites' efficacy, only one peer respite exists in Massachusetts[4] and, as a rule, peer respite is not covered by insurance. This is absurd as peer respite is considerably less expensive than inpatient hospitalization.

Service animals are another tool that could be used to reduce healthcare expenditures, including medication expenditures which the HPC report on health care expenditures notes is a significant cost drive. 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 successfully discontinue medication.[5] Again, despite the abundance of evidence supporting the efficacy of pet therapy and service animals for mental health conditions (see list of studies accompanying this testimony), 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.[6] It is based on the premise that the physical and mental health care needs of the homeless cannot be addressed in till 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 the cost of housing.[7] Nevertheless, once again, health insurers and provider organizations do not regularly cover, contribute to the funding of, or offer these services.

---

[4] "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).

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

[6] 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/ .

[7] 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

Another healthcare approach that reduces healthcare expenditures involves do use of either peer support 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. In fact, exercise is sometimes identified as the most promising approach to dealing with a mental or medical condition. 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 reduce the likelihood of an progress of dementia. Yet, at most, most physicians will make a recommendation for exercise in passing. We know from our own experience or the experience of our loved ones and friends, that a physician recommendation to exercise, without more, will not inspire action. Home companions and peer support can result in this recommendation's effectuation. Home companions and peer support are far less expensive over time than hospitalization and treatment for cardiac conditions or problems due to dementia and are clearly less expensive than nursing homes.

When considering performance improvement plans, MHLAC suggests that whether or not innovative services such as those listed above and others are being provided or covered.

Health Care Delivery Systems

Some tout evidence-based services, resulting in the disregard of promising practice-based approaches which do not have behind them the same powerful financial interests that can undertake extensive studies. On the other hand, the structure of financial incentives and their efficacy in reducing cost AND improving care or not required to meet the same evidenced-based tests. In addition to the problems with pay-for-performance noted above, integration of physical and mental health services have been promoted without the attention to critical evidence.[8] The healthcare of persons with psychiatric diagnoses does not necessarily improve if a person's mental health and physical health providers share information. This is due to the stigma associated with psychiatric diagnoses and the problem of diagnostic overshadowing, where in a person's physical symptoms are attributed to mental health issues

---

on health care costs and health care entities and insurers should participate monetarily as it is in their self 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."

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.*

[8] Studies show very variable results from 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. For more information, please contact Susan Fendell at Mental Health Legal Advisors Committee.

if the person has a history of mental illness or treatment. Attached is a white paper on this issue entitled "EHR: Healthy for Whom?," which details the impact sharing of physical and mental health information can have on the physical health care provided to persons with psychiatric diagnoses.

Administrative costs

The cost of payment systems should be included in evaluating cost drivers, as noted by Dr. Berwick at the March 8, 2017 HPC hearing. The cost of private insurance as compared to a public model is important to investigate,[9] as some estimates of the additional administrative costs of privatized health care run as high as 46%.[10] Other models of health care delivery permit costs reductions without directing these budget cutting efforts at denying care or shifting costs to patients:

> The lessons of Canadian national health insurance are as straightforward as they are neglected. Having a single government-operated insurance plan greatly reduces administrative costs and complexity. It concentrates purchasing power to reduce prices, enables budgetary control over health spending, and guarantees all legal residents, regardless of age, health status, income, or occupation, coverage for core medical services. Canadian Medicare charges patients no copayments or deductibles for hospital or physician services. Controlling medical spending does not, the Canadian experience demonstrates, require cost sharing that deters utilization.[11]

While such a single-payer solution may not be politically viable at this moment in time, it is important that *all* the drivers of health care costs be examined and on public display. This examination is within the purview of the HPC .

Conclusion

In performing its function to lower health care spending growth, HPC should always be cognizant utilization itself does not necessarily drive costs. Financial incentives that reduce medically necessary care in the short-term often result in higher medical expenses in the long-term or a reduction in the quality of care and quality of life for Massachusetts residents. Rather, HPC should encourage through performance improvement plans the use of innovative services and practices by expanding the overly-narrow definition of what constitutes medical care. Finally,we recommend that the HPC scrutinize claims made about the quality and costs of delivery systems and the contribution of administrative costs to overall healthcare expenditures.

---

[9] See, e.g., M. Robinson, *Universal Healthcare Coverage Around the Globe: Time to Bring It to the United States?,* J. Health Care Finance at 1-10 (Winter 2016).

[10] S. Woolhandler and D. Himmelstein, *Single-Payer Reform*, Annals of Intern. Med. at 1 (Feb. 21, 2017).

[11] J. Oberlander, *The Virtues and Vices of Singer Payer Health Care*, 374 N. Engl. J. Med. 1401, 1402 (2016)(citations omitted).

MHLAC looks forward to working with the HPC in helping the Commonwealth reach the goal affordable high quality care .

Sincerely,

Susan Fendell, Esq

Susan Fendell
Senior Attorney

Attachments