Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 6D, § 8

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The Number of Lives Impacted by Behavioral Health Conditions Is Growing

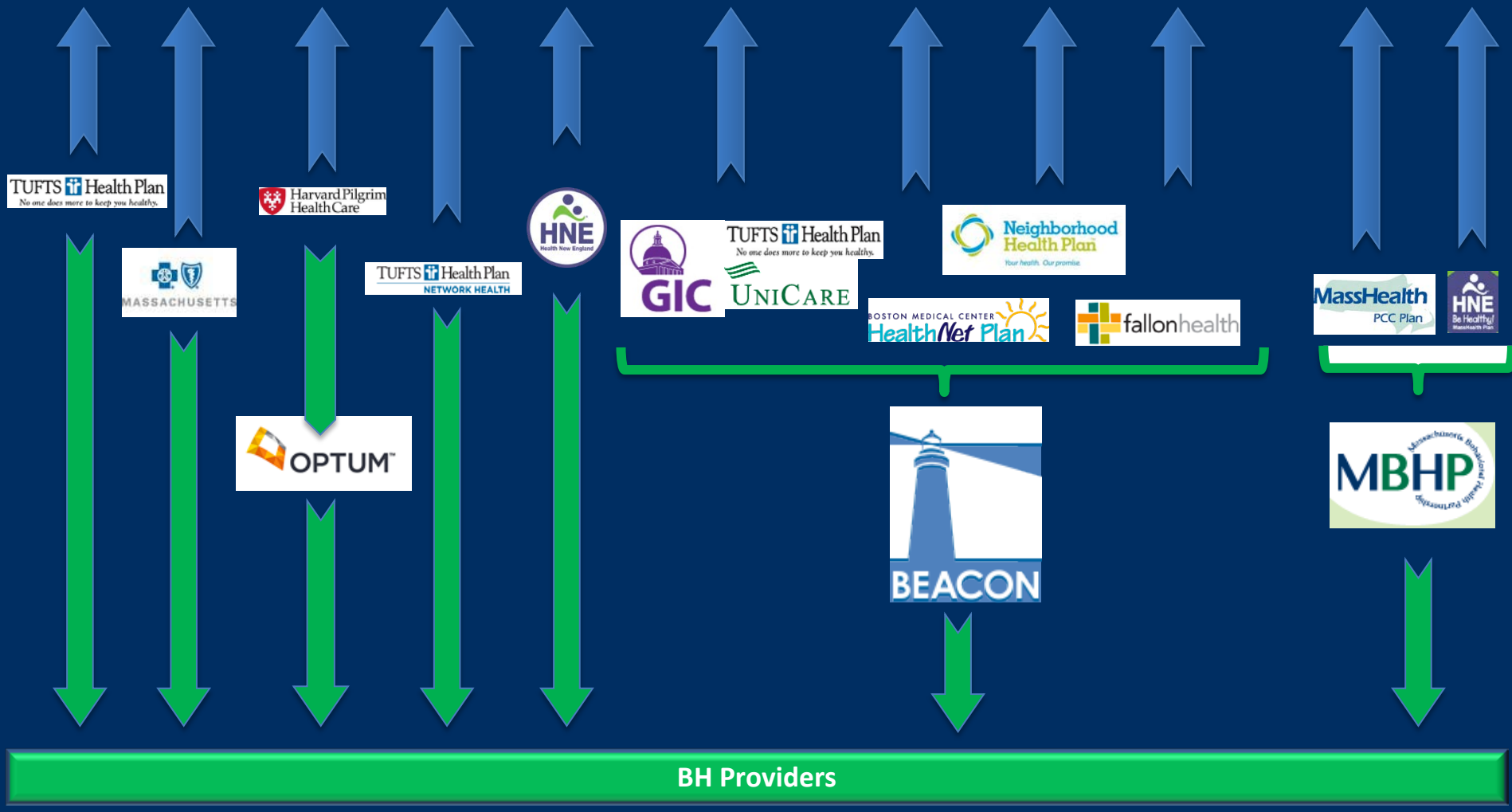
- While overall inpatient discharges at general acute care hospitals have decreased 5% from 2010 to 2013, total discharges for behavioral health conditions has increased 2%.
- In 2013, behavioral health diagnoses were the top primary diagnostic category for males aged 15-44 and females aged 5-44 (excluding discharges for child birth.
- HPC reports increase spending for patients with comorbid behavioral health and chronic medical conditions that exceeds the simple combination of each condition's independent effect.

The Importance of Care Coordination

- A key goal of health care reform is to better coordinate patients' care over time and across settings, which should raise quality and lower costs.
- Examples of major reform initiatives designed to improve care coordination:
  - Development of PCMHs and ACOs
  - Expansion of alternative payment methodologies
  - Improving patient communication and experience of care transitions

Current approaches separate "behavioral health" and "medical" care, resulting in a ripple effect that impacts the integration of behavioral health and medical care and impedes market analysis.

The Landscape for Managing and Reimbursing Behavioral Health Services Is More Complex than for Non-Behavioral Health Services



A Substantial Portion of Behavioral Health Benefits Are Managed by MBHOs

2013 Percent of Member Months by Behavioral Health Benefit Manager and Reimbursement Structure				
	Health Plan Risk and Admin (Fully-Insured)	**Health Plan Admin-Only (Self-Insured)**	**MBHO Risk and Admin**	**MBHO Admin-Only**
Commercial	30.8%	38.5%	15.3%	15.3%
Commonwealth-Subsidized Programs	21.0%	n/a	75.9%	3.1%

Notes:
Self-insured accounts retain the risk for their health care claims (including behavioral health). Thus, even if a self-insured account retains BCBS (who does not contract with an MBHO) as a third party administrator to administer its employees' health care benefits, BCBS would not be at risk for any claims, including behavioral health claims. That population would be reflected in the Health Plan Admin-Only column. All self-insured membership is reflected in how the third party administrator ("TPA") approaches behavioral health benefits, except GIC membership. Although THP manages behavioral health benefits in-house, GIC separately contracts with Beacon to manage the behavioral health benefits for GIC's THP and Unicare members, and thus GIC's THP members are reflected in MBHO Admin-Only. However, as discussed above, a small number of self-insured accounts separately carve out the administration of behavioral health benefits. If those accounts finance behavioral health in a way that differs from the approach taken by their TPA, those variances are not reflected in the chart above.
"Commonwealth-Subsidized Programs" do not include members in Medicaid FFS, Medicare, Dual Eligible, Senior Care Options, Program for All-Inclusive Care for the Elderly, Medical Security Program, or Veteran Affairs plans.

Where A Medical Patient's Experience of Care Delivery Can Already Be Complex . . .

55 year old overweight man with high blood pressure and chronic low back pain

Medicaid MCO Health Plan

Behavioral Health Manager

PCP

Pain Specialist

Cardiologist

Cardiologist

Pain Specialist

Cardiologist

Stable Condition

Chest Pain

Discharge

Chiropractor

Orthopedist

Hospital ED, admitted for chest pain and cardiac catheterization

Internist

PCP

. . . Adding a Behavioral Health Condition Further Complicates the Picture

55 year old overweight man with high blood pressure, chronic low back pain and opioid addiction

Medicaid MCO Health Plan

Behavioral Health Manager

PCP

Pain Specialist

Psychiatrist/ Addiction Specialist

Psychiatrist/ Addiction Specialist

Behavioral Health Case Manager

Health Plan case manager for prescription

Therapist

Cardiologist

Stable Condition

Addiction Relapses

Discharge

Therapist

Addiction counselor

Orthopedist

Hospital #1 ED transfer to Hospital #2 Inpatient SA Unit

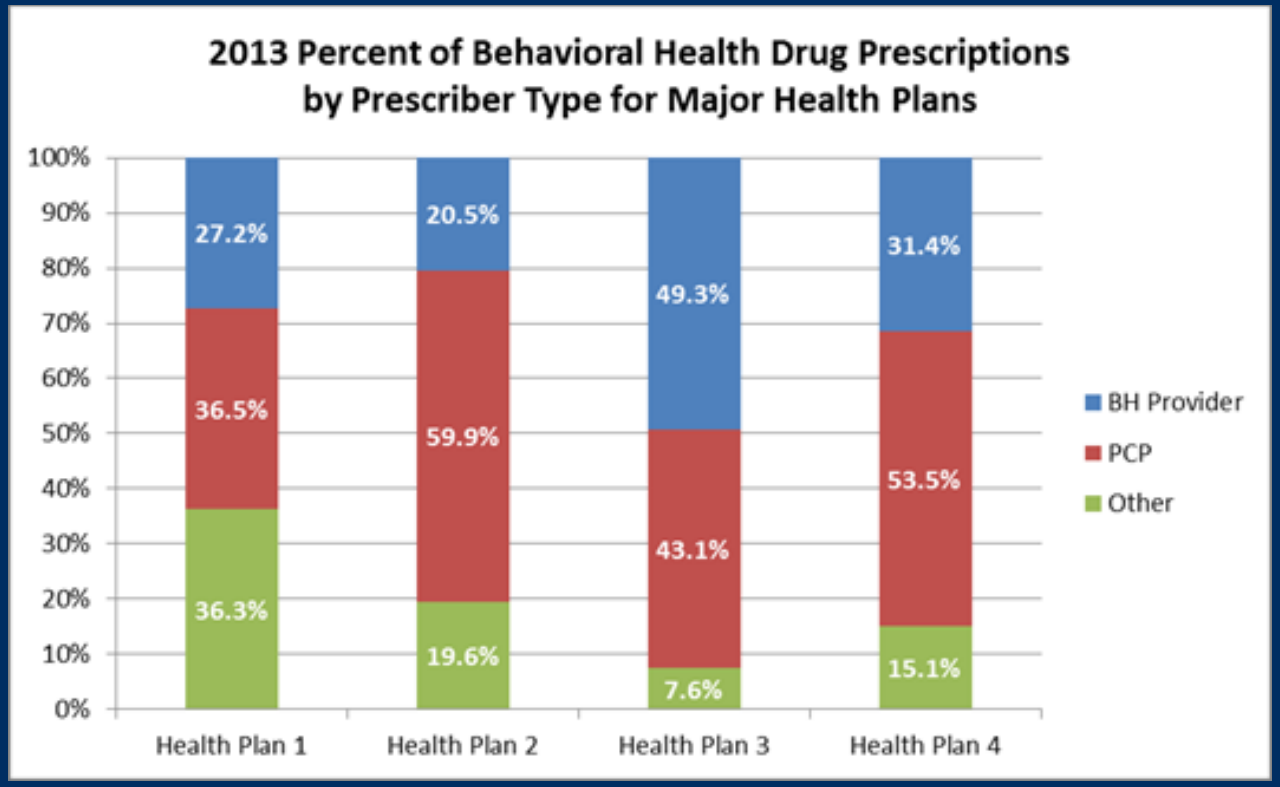
Internist

Pain Specialist

Intensive Outpatient Program

I. CURRENT APPROACHES TO MANAGING BENEFITS AND REIMBURSEMENT POSE CHALLENGES FOR CARE COORDINATION

Current Approaches to Managing Behavioral Health Benefits Challenge Data Communication



Note:

1. Behavioral health drugs are defined as all benzodiazepines, anti-depressants (e.g., tricyclics, selective serotonin reuptake inhibitors, selective serotonin norepinephrine reuptake inhibitors, serotonin modulators), anti-psychotics (e.g., phenothiazines, butyrophenones, atypical anti-psychotics), sleeping medications (e.g., ramelteon, zaleplon, zolpidem), antimanic agents (e.g., lithium), anorexigenic agents (e.g., amphetamine derivatives), alcohol use deterrents (e.g., disulfiram), and any others the health plans consider a behavioral health drug.

Current Financial Arrangements Offer Limited Incentives to Coordinate Care Across Behavioral Health and Medical Services

- MBHOs and payers contracts can include care coordination objectives, but lack any material financial incentives to do so.
- Global budgets often exclude risk for behavioral health services.

Complex Arrangements Challenge Efforts to Improve Low Reimbursement Rates

- For general acute hospitals that reported inpatient margins, from 2010-2013 cumulative margin for commercial and government business was a negative 39%, and for those that reported outpatient margins, the cumulative margin was a negative 82%
- Current MBHO and payer financing structures promote precise adherence to capitated budgets

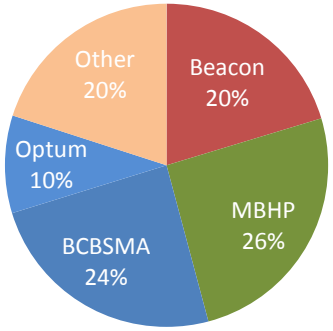
II. BEHAVIORAL HEALTH DATA LAGS COMPARED TO ADVANCES IN DATA FOR OTHER HEALTH SERVICES

Lack of Comparable Data on Utilization, Price, and Quality Constrains Analysis

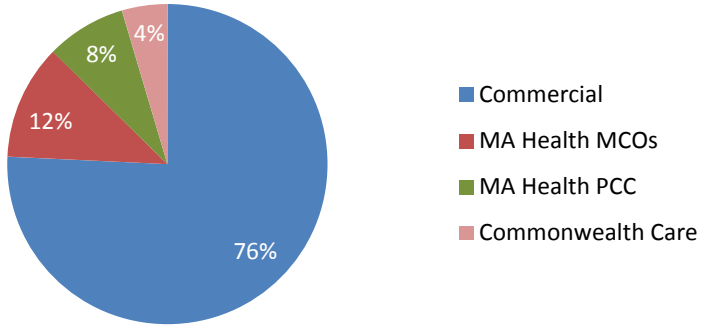
- Neither the HDD nor APCD include complete BH information
- Unable to adjust payment rates for case complexity
- Payers do not closely track differences in payment levels across providers
- Industry lacks standardized outcome measures for behavioral health services
- Quality improvement initiatives that do exist are not tied to meaningful financial incentives

Where Behavioral Health Spending Is Reported, Inconsistent Definitions and Methodologies Impede Analysis Of Behavioral Health Trends.

2013 Estimated Expenditures for Behavioral Health Services by Managing Entity



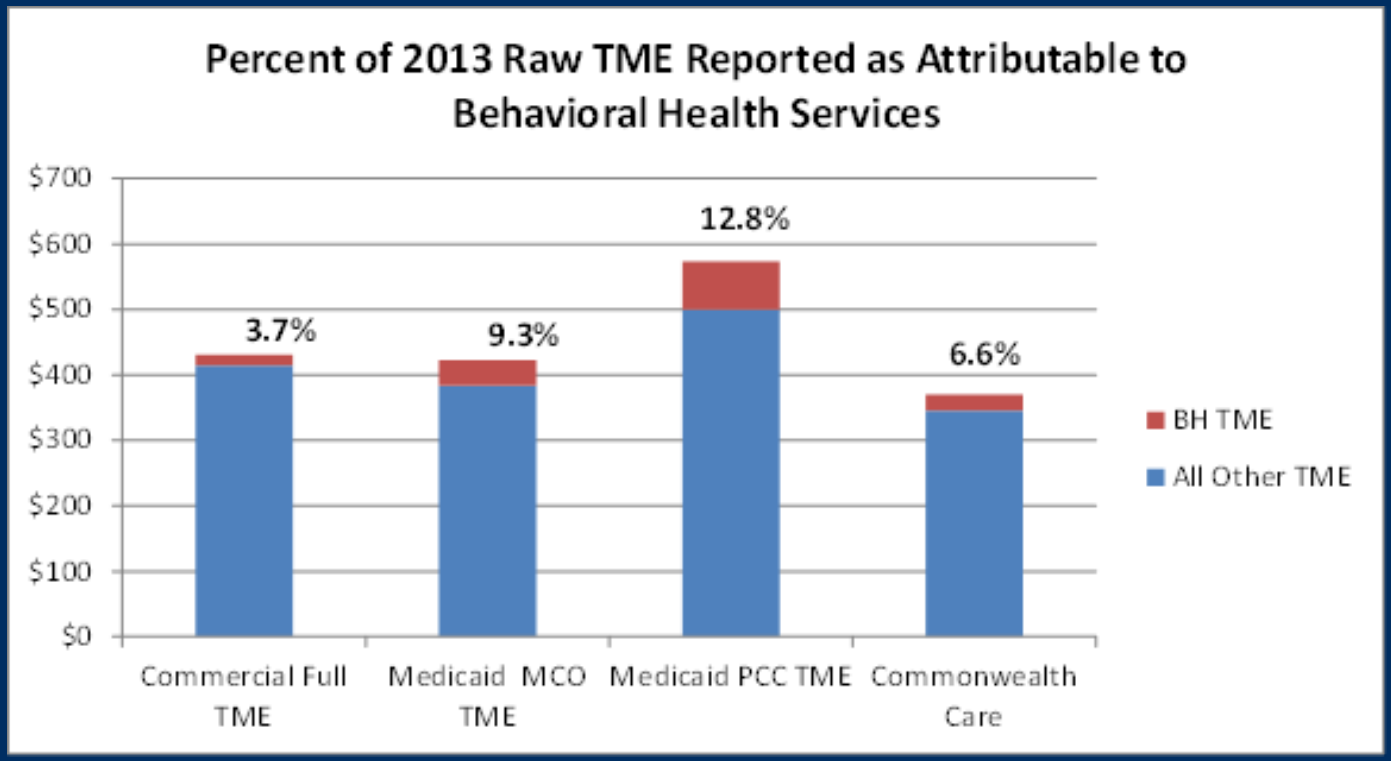
2013 Estimated Membership Distribution by Market



Notes:

1. Includes expenditures reported to the AGO as expenditures on behavioral health services.
2. Since risk share is minimal, risk share to MBHOs is excluded.
3. Health plans that subcontract with MBHOs reported MBHO spending on claims.
4. Excludes pharmacy spending.
5. Excludes Medicaid FFS, Medicare, Dual Eligible, Senior Care Options, Program for All-Inclusive Care for the Elderly, Medical Security Program, and Veteran Affairs populations.
6. Excludes Children's Behavioral Health Initiative ("CBHI") benefits that MassHealth provides to eligible children. Total 2013 spending on CBHI benefits for all eligible children was approximately $198 million.

Initial Review of Spending Data Raises More Questions than Provides Answers



Note:

1. Based on reported behavioral health expenditures. Reported data varies, but does not include prescription drugs, CBHI benefits, or behavioral health services provided by non-behavioral health providers (e.g., PCPs)..

Recommendations

- Take a close look at payment rates for behavioral health services and the effect those have on the availability of services statewide
- Reassess the financial arrangements that often lack meaningful incentives to integrate behavioral health and medical care
- Work to improve data reporting for behavioral health