Examination of Health Care Cost Trends and Cost Drivers

Pursuant to G.L. c. 6D, § 8

JUNE 30, 2015

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Executive Summary

This is the Office of the Attorney General's ("AGO") fourth report examining health care cost trends and cost drivers in Massachusetts. In our 2010 and 2011 Reports, the AGO identified market dysfunctions that resulted in escalating health care costs that are not explained by the value of services provided. Since those Reports, the legislature has increased health care transparency and established new infrastructure to measure and oversee market changes. Likewise, health plans, providers, and purchasers have taken steps to lower costs, promote efficiency, and improve health care delivery. In our 2013 Report, the AGO found that some of these steps can be in tension, or work at cross-purposes, and suggested ways that regulators can help the market address some of these tensions.

This Report examines how approaches to the administration of behavioral health benefits and reimbursement for behavioral health services intersect with the goals of health care reform. Specifically, how are we doing on our mission to better coordinate care, raise quality, and lower costs for individuals with behavioral health needs? To begin answering this question, we set out to bring transparency to current spending trends and how behavioral health care is financed and administered.[1] This Report documents our findings, focusing on the impact of complex financial arrangements on patients and providers (Part I) and the lack of consistent and available data on behavioral health services and payment (Part II).

Our principal findings are:

1. Current approaches to managing behavioral health benefits and reimbursing providers for behavioral health services pose challenges for effective care coordination.
   a. Providers treating behavioral health conditions lack necessary data.
   b. Providers and managed behavioral health organizations currently have little to no financial incentive to coordinate care.
   c. Complex approaches to managing behavioral health benefits challenge efforts to improve historically low behavioral health reimbursement rates.
2. Behavioral health data lags compared to advances in data for other areas of health expenditures, challenging efforts to improve analysis and promote behavioral health parity.
   a. Lack of comparable and reliable data on behavioral health capacity and utilization constrains effective resource planning.
   b. Inconsistent information on prices and payment methodologies constrains our ability to evaluate payment levels and trends.
   c. Where behavioral health spending is reported, inconsistent definitions and methodologies impede analysis of behavioral health trends.
   d. Gaps in behavioral health quality metrics hinder effective quality measurement and analysis.

1 The AGO issued civil investigative demands pursuant to G.L. c. 12C, §17 to twenty-three health plans, managed behavioral health organizations, general acute hospitals, and behavioral health specialty hospitals. We gathered detailed cost, quality, financial, and operational information pertaining to behavioral health, including contracts and financial settlements; behavioral health cost, utilization, and spending data; and information on quality metrics and performance. In addition, we conducted nearly three dozen interviews and meetings with providers, health plans, health care experts, consumer advocates, and other key stakeholders. To assist in its review, the AGO engaged consultants with extensive experience in the Massachusetts health care industry, including an actuarial consulting firm and experts in the areas of payer-provider contracting, health care quality measurement and evaluation, and behavioral health systems.

Introduction

Mental health and substance use disorders[2] impact millions of lives across the Commonwealth every year, crossing age, sex, and socioeconomic categories. As has been reported in national surveys, from 2012 to 2013, 19% of adults in Massachusetts suffered from a mental health condition, and 9% suffered from a substance use disorder.[3] Further, as detailed below, data suggests that the number of lives impacted by behavioral health issues is growing.

While overall inpatient discharges at general acute care hospitals have decreased over time, total discharges with behavioral health as the primary diagnosis has *increased*. Specifically, according to hospital discharge data reported to the Center for Health Information and Analysis ("CHIA") and obtained from the Massachusetts Health Data Consortium ("MHDC"), overall discharges from general acute hospitals decreased by 5% from 2010 to 2013, while total discharges that were for behavioral health conditions increased by 2%. While equivalent discharge data is not available for behavioral health specialty hospitals (e.g., Bournewood Hospital, Arbour Hospital),[4] data from 403 Cost Reports for general acute and behavioral health specialty hospitals indicates that in 2013, more than half of behavioral health discharges were at general acute care hospitals, demonstrating that trends at these general acute hospitals are important to examine.[5]

Not only is the proportion of behavioral health discharges increasing at general acute hospitals, but behavioral health is the top primary diagnostic category for most age groups 44 and under. Specifically, in 2013, behavioral health diagnoses[6] were the top primary diagnostic category for males aged 15-44 and females aged 5-44 (excluding discharges for childbirth). This suggests, at minimum, an increased reliance on general acute hospitals for behavioral health care and, perhaps, an increasing need for behavioral health services.[7]

This Report examines approaches to managing behavioral health benefits and paying for behavioral health services for commercial as well as government payer populations. These

2 Collectively referred to as "behavioral health."

3 SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL SURVEY ON DRUG USE AND HEALTH: COMPARISON OF 2011-2012 AND 2012-2013 MODEL-BASED PREVALENCE ESTIMATES (50 STATES AND THE DISTRICT OF COLUMBIA), at 48, 40, *available at* http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2012-2013-p1/ChangeTabs/NSDUHsaeShortTermCHG2013.pdf.

4 General acute hospitals submit quarterly patient-level data identifying charges, days and diagnostic information for all acute inpatient discharges to the Hospital Discharge Database. However, behavioral health specialty hospitals, among other specialty and non-acute hospitals, do not. Each of these hospital types, however, does report discharge statistics on 403 Cost Reports. *See* CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS HOSPITAL PROFILES, TECHNICAL APPENDIX: DATA THROUGH FISCAL YEAR 2013, at E-1, E-14, E-25 (Jan. 2015) [hereinafter CHIA MA HOSPITAL PROFILES APPX.], *available at* http://chiamass.gov/assets/docs/r/hospital-profiles/2013/hospitalprofiletechappendix.pdf.

5 *See* CTR. FOR HEALTH INFO. & ANALYSIS, MASSACHUSETTS HOSPITAL PROFILES: DATA THROUGH FISCAL YEAR 2013 (Jan. 2015) [hereinafter CHIA COMPLETE HOSPITAL PROFILES], *available at* http://www.chiamass.gov/assets/docs/r/hospital-profiles/2013/acutehospsfulldocumentoptimized.pdf.

6 Behavioral health diagnoses represent the combination of primary diagnostic categories "Mental Illness" and "Alcohol/Drug Use." Diagnostic categories included: Male Reproductive, Circulatory System, Digestive System, Musculoskeletal System, Respiratory System, Nervous System, Kidney & Urinary Tract, Endocrine System, Mental Illness, Infectious & Parasitic, Skin, Subcutaneous Tissue, Hepatobiliary and Pancreas, Female Reproductive, Injuries and Poisoning, Blood, Alcohol/Drug Use, Ear, Nose, Throat, Mouth, Health Status, Myeloproliferative, HIV Infections, Eye, Multiple Significant Trauma, and Burns.

7 The inpatient trends noted above may also be impacted by the expansion of coverage for behavioral health benefits pursuant to federal and state parity laws.

different payer populations have distinct socioeconomic and risk profiles. MassHealth members are typically low-income or disabled, and/or have complex, long term health needs.[8] As reported by the Health Policy Commission ("HPC"), MassHealth members had nearly twice the proportion of mental illness and substance use diagnoses as commercial members from 2008 to 2012.[9]

Within MassHealth there are distinct member subgroups that are determined by eligibility rules and member-selected benefit plans. Approximately two thirds of MassHealth members are in managed Medicaid plans:[10] the Primary Care Clinician Plan ("PCC Plan") or a Managed Care Organization Plan.[11] MassHealth directly manages PCC member benefits while separate organizations referred to as "MCOs" (e.g., Network Health, BMC Healthnet Plan) contract with MassHealth to manage MCO member claims for a predetermined monthly payment ("capitation amount").[12] MCOs in turn contract with a network of medical, behavioral health, and ancillary providers to care for their MassHealth members. The PCC Plan serves a greater proportion of MassHealth disabled members than all of the MCOs combined.[13] Because its members, particularly its PCC Plan members, are more likely to have behavioral health needs than commercial members, MassHealth in particular has begun to grapple with ways to address some of the access and cost concerns related to behavioral health services.

An underlying goal of health care reform is to improve the coordination of patient care over time and across settings, which should raise quality and lower costs. These efforts are premised on the importance of care for the whole patient, for behavioral health and medical[14] conditions alike. As the HPC has documented, Massachusetts commercial and public payers spend on average 2 to 2.5 times as much on patients who have a comorbid chronic medical condition and a behavioral health condition than on patients who have a chronic medical condition alone.[15] While the presence of an additional condition would be expected to increase spending, the concurrent presence of a behavioral health and a chronic medical condition is associated with a compound increase in spending.[16] This compound increase exceeds the simple combination of each condition's independent spending effect.[17]

8 HEALTH POLICY COMM'N, MASS., 2013 COST TRENDS REPORT, JULY 2014 SUPPLEMENT, at 10 (July 2014), *available at* http://www.mass.gov/anf/docs/hpc/07012014-cost-trends-report.pdf.

9 Id. at 18 tbl.A.5 (citing SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., NATIONAL SURVEY ON DRUG USE AND HEALTH, 2008-2011 (revised 10/13), and 2012).

10 CTR. FOR HEALTH LAW & ECON., UNIV. OF MASS. MEDICAL SCHOOL, MASSHEALTH: THE BASICS – FACTS, TRENDS & NATIONAL CONTEXT, at 14 (April 2014) [hereinafter UMASS MASSHEALTH: THE BASICS], *available at* http://bluecrossmafoundation.org/sites/default/files/download/publication/PDF%20National%20comparisons%20chartpack%20june%202012.pdf.

11 Other MassHealth members' claims are generally not "managed," and merely reimbursed on a fee-for-service basis. These members are mostly in long term care or have other primary insurance, such as an employer-sponsored plan.

12 MassHealth members are assigned different Rating Categories based on eligibility criteria (e.g., disabled members are generally in Rating Category 2) and capitated reimbursement amounts are based on these assigned Categories. Since patients who experience similar levels of complex health care needs tend to be eligible for MassHealth in similar ways, this acts as a form of risk adjustment.

13 UMASS MASSHEALTH: THE BASICS, *supra* note 10, at 18.

14 Although it is generally accepted in the industry to refer to non-behavioral health care services as "medical" or "physical" services, we understand that behavioral health services are also medical in nature and at times address the physical needs of a patient.

15 HEALTH POLICY COMM'N, MASS., 2013 COST TRENDS REPORT, at 45 fig.4.3 (2013) [hereinafter HPC 2013 COST TRENDS REPORT], *available at* http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-full-report.pdf.

16 *Id.*

17 *Id.*

The compound effect that comorbid medical and behavioral health conditions have on spending underscores the heightened complexity of treating multiple, interacting health conditions, where the presence of one condition can impact efforts to treat another (e.g., a patient with depression may stop taking diabetes medication due to a major depressive episode, resulting in higher costs to treat diabetes). It also underscores the need for consistent and reliable data for both behavioral health and medical services to enable policymakers and stakeholders to assess these complex effects and evaluate progress in integrating care for the whole person. This Report sheds light on how current benefit management structures and payment rates for behavioral health services fall short of our health care reform goals and are often in tension with efforts to integrate treatment of behavioral health conditions into care for the whole person.

I. Efforts to Better Coordinate Patient Care Should Not Leave Behind Behavioral Health Care.

Approaches to managing behavioral health benefits and reimbursing behavioral health services have significant implications for consumers. As shown below, navigating the health care system can already be complex for consumers with chronic medical conditions. Because the landscape for managing and administering behavioral health benefits is fragmented, the presence of a behavioral health condition further complicates a consumer's experience. This fragmentation frustrates communication between entities trying to coordinate care and provides little to no financial incentive to integrate care delivery. Further, current approaches impede efforts to improve historically low behavioral health reimbursement rates, which ultimately impacts access to behavioral health services.

A. The Landscape for Managing Behavioral Health Benefits and Reimbursing Providers for Behavioral Health Services Is Complex.

Generally speaking, health plans pay providers directly for delivering non-behavioral health services. In other words, health plans, including commercial and public payer plans, select hospitals and other providers to care for their members' health needs, negotiate payment arrangements with those providers, and pay them for those services under the terms of the arrangements. However, most health plans in the Commonwealth "carve out" behavioral health benefits from the rest of medical health benefits and subcontract the management and administration of behavioral health benefits to specialized companies called managed behavioral health organizations ("MBHOs").[18] In addition, a small number of self-insured employers elect to contract directly with an MBHO to administer their employees' behavioral health benefits, separate from the health plan/third party administrator with which they contract to administer medical benefits for their employees.

Under these arrangements with health plans and select self-insured employers, MBHOs manage and administer behavioral health benefits for plan members and contract with and pay providers for behavioral health services separately from health plans' management of medical benefits.[19] Thus, for consumers covered by these plans, separate entities are responsible for managing their behavioral health and medical benefits, including authorizing services and contracting with providers, even though the provider contracts themselves often include behavioral health and medical integration objectives.

18 MBHOs were introduced in Massachusetts in 1992 in an effort to control costs and bring behavioral health-specific expertise to the management of behavioral health services. These companies were created to provide specialized knowledge and innovative thinking to help coordinate care, contain costs, and generate better outcomes for patients with behavioral health needs. See Donald S. Shepard, et al., *Managed Behavioral Health Care: Lessons from Massachusetts*, 32 ADMIN. & POL'Y MENTAL HEALTH 311-9 (2005).

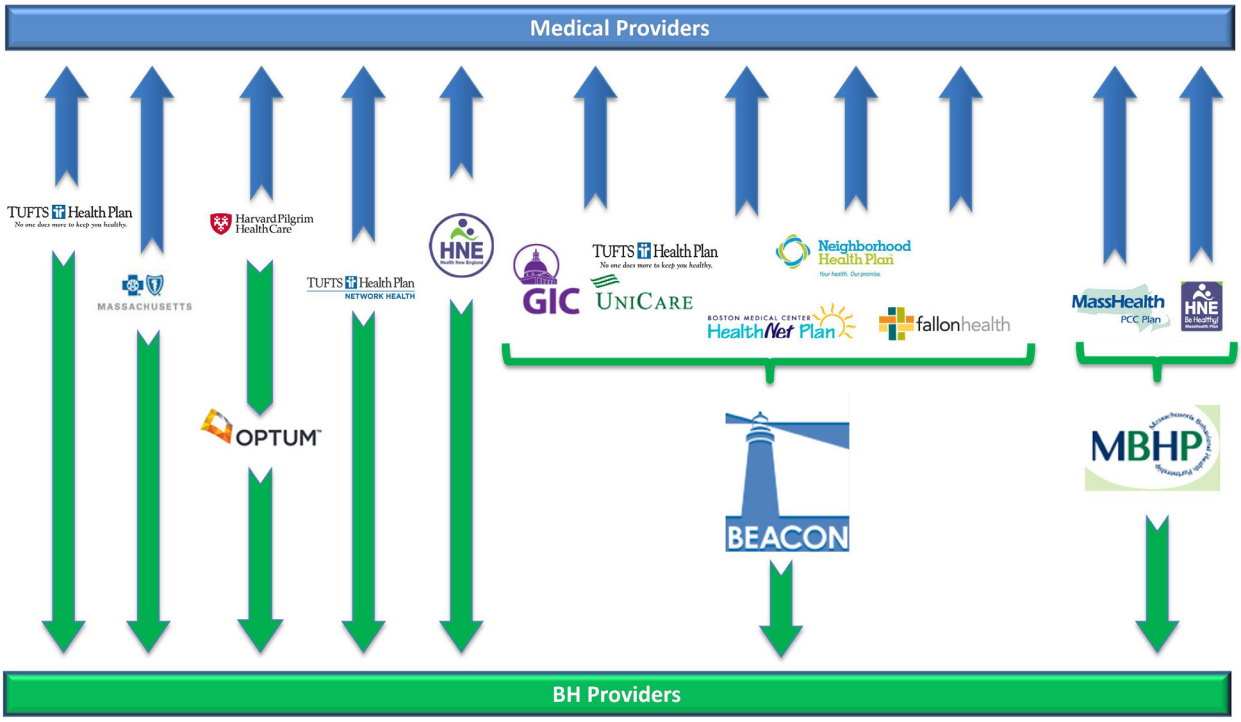
19 As discussed *infra* in note 21, the benefits carved out to MBHOs differ by health plan. This results in not only fragmentation of medical and behavioral health care, but also differences between and within administrators of behavioral health benefits.

The following graphic depicts the landscape for reimbursing behavioral health services for commercial, the Group Insurance Commission ("GIC"),[20] and managed Medicaid plans. As shown, health plans (commercial and MCO) that directly manage behavioral health benefits reimburse medical and behavioral health providers alike for delivering behavioral health services (e.g., Blue Cross Blue Shield of Massachusetts ("BCBS")). Alternatively, for those health plans that subcontract with an MBHO (e.g., Harvard Pilgrim Health Care ("HPHC"), who subcontracts with Optum), the responsibility for paying providers for behavioral health services is split. The MBHO, Optum, pays behavioral health providers in its network out of a "global budget" or "capitated amount" that it has negotiated with its health plan client, HPHC. However, since medical providers also often provide behavioral health services (e.g., primary care providers), HPHC, and not Optum, pays for the behavioral health services those medical providers provide to members.[21]

20 The GIC administers the Commonwealth's self-insured health benefit plan.

21 Health plans and MBHOs may contract with some of the same provider groups and general acute hospitals, but for different services. For example, generally speaking, a health plan will contract with a general acute hospital for non-behavioral health services while an MBHO will contract with the same general acute hospital for inpatient stays where behavioral health is the primary diagnosis or for outpatient behavioral health services.

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



Notes:

1. Not all providers are in each of the payer (health plan, MBHO) networks listed above. Each payer separately negotiates with providers, and MBHOs and health plans maintain their own networks that frequently do not overlap. If a health plan carves out the management of behavioral health benefits, that plan would not contract with behavioral health providers or acute care hospitals for behavioral health services. Instead, those hospitals and providers would separately negotiate with the MBHO to be a part of the behavioral health network.
2. GIC contracts with Beacon directly for the management of behavioral health benefits for GIC's Tufts Health Plan ("THP") and UniCare members.
3. Health New England ("HNE") contracts with MBHP for the administration of benefits for HNE's MCO population only. HNE directly administers behavioral health benefits for its GIC population.
4. As mentioned supra on p.5, a small number of self-insured accounts carve out the management and administration of behavioral health benefits to MBHOs. While GIC, represented here, is one example of a self-insured account that carves out behavioral health benefits, no other self-insured accounts are reflected in this chart.
5. MBHP is a subsidiary of Value Options, and Beacon is a subsidiary of Beacon Health Holdings. In December 2014, Value Options merged with Beacon Health Holdings, and now both Value Options and Beacon Health Holdings are independently operated subsidiaries of Beacon Health Options.

The majority of behavioral health benefits that are carved out to MBHOs are for members in Commonwealth-subsidized programs, as compared to members in commercial plans. MBHOs manage behavioral health benefits through arrangements that vary by administrative responsibility, incentives, and amount of risk transferred for behavioral health claims. For example, an MBHO may be responsible for the administration of all of a health plan's behavioral health benefits, but only be at financial risk for claims for a portion of that health plan's population. As shown below, in 2013, the behavioral health benefits for 69% of commercial members were managed directly by health plans while the behavioral health benefits for members in Commonwealth-subsidized programs were primarily managed by MBHOs (79%).[22]

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:

1. 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.
2. 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.
3. "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.

22 No health plan or MBHO is at risk for self-insured claims, including behavioral health claims. In other words, where a self-insured account contracts with a health plan to be a third party administrator, the self-insured account retains the risk for its members'/employees' claims, even where those claims are carved out to an MBHO.

Just as health plans may elect to carve out the administration of behavioral health benefits to MBHOs, self-insured accounts may also choose to carve out the administration of behavioral health benefits for their employees. The four major health plans each report that in 2013, approximately 1 to 3 self-insured employer accounts separately carved out the administration of behavioral health benefits. For example, the GIC contracts with THP and Unicare (among other health plans) to administer its employees' medical health benefits. For GIC members who elect those THP or Unicare plans, GIC separately contracts with Beacon to administer those members' behavioral health benefits.

As a result of this parallel system where different entities pay for behavioral health care (depending on whether the behavioral health service is delivered by a medical provider or a behavioral health provider), MBHOs manage most, but not all, behavioral health benefits available to members, particularly for members in Commonwealth-subsidized plans. This parallel system contributes to the difficulty in assessing total behavioral health spending and cohesively managing the care of patients who access these separate systems.

B. This Complex Landscape Impacts Patients Seeking Treatment for Behavioral Health Conditions.

While a consumer suffering from chronic medical conditions may experience complex care delivery, the presence of a behavioral health condition further complicates his or her experience. At minimum, that consumer may interact with additional providers and administrative organizations that have varying capacity to communicate with one another. The examples that follow illustrate consumers' experience in this complex landscape.

Example 1

> Sam is 55, overweight, and under treatment for high blood pressure and low back pain. After an orthopedic consultation for his back pain, Sam visits a pain specialist, who provides a steroid injection, and then Sam sees his chiropractor. He also sees a cardiologist for an adjustment to his blood pressure medications. Despite his treatment, Sam awakens with chest pain, and is hospitalized for an evaluation of possible heart attack. In the hospital, a cardiologist, internist and pain specialist all see Sam and provide treatment. After discharge, Sam follows up with his primary care provider ("PCP") and cardiologist. Sam's care is complex, and care coordination is a challenge among his providers. Yet payment for his care is through one health plan, which maintains all administrative data about Sam's care.

Example 2

> Ron, like Sam, is 55, overweight, and under treatment for high blood pressure and low back pain. However, Ron also suffers from addiction to prescription opioid medication. He regularly sees multiple providers: his PCP, orthopedist, psychiatrist, pain specialist, and addiction counselor. In addition, he regularly speaks with his health plan's case manager, who ensures his prescriptions are authorized and helps with care coordination. Ron suffers a relapse in opioid use, is seen at an acute hospital emergency department ("ED"), and is then transferred to an inpatient substance abuse unit ("SA unit") at another acute hospital. While there, multiple providers treat him for his addiction, his pain, and his blood pressure. After discharge, he continues with an intensive outpatient addiction program and a behavioral health case manager, as well as his regular providers. Ron's care is complex, and care coordination is a challenge, particularly since he has significant medical and behavioral health conditions. Payment for his care is through one health plan, where his medical case manager and behavioral health case manager have the same information available to them to help manage Ron's care.

Example 3

> Tom, like Ron, is 55, overweight, and under treatment for high blood pressure, low back pain, and opioid addiction. Tom's health plan subcontracts his behavioral health benefits to an MBHO. He regularly sees multiple providers and regularly speaks with his health plan's case manager regarding prescriptions and care coordination. Tom suffers a relapse in opioid use, is seen at a hospital ED, and is then transferred to an

inpatient SA unit at another hospital. While at the SA unit, multiple providers treat him for his addiction, his pain, and his blood pressure. After discharge, he continues with an intensive outpatient addiction program and a behavioral health case manager from his MBHO, as well as his regular providers. Payment for his care is divided between his health plan and the MBHO and care coordination is a challenge, particularly as his case managers, part of separate organizations with separate information systems, face challenges keeping up with all information necessary to effectively coordinate his care.

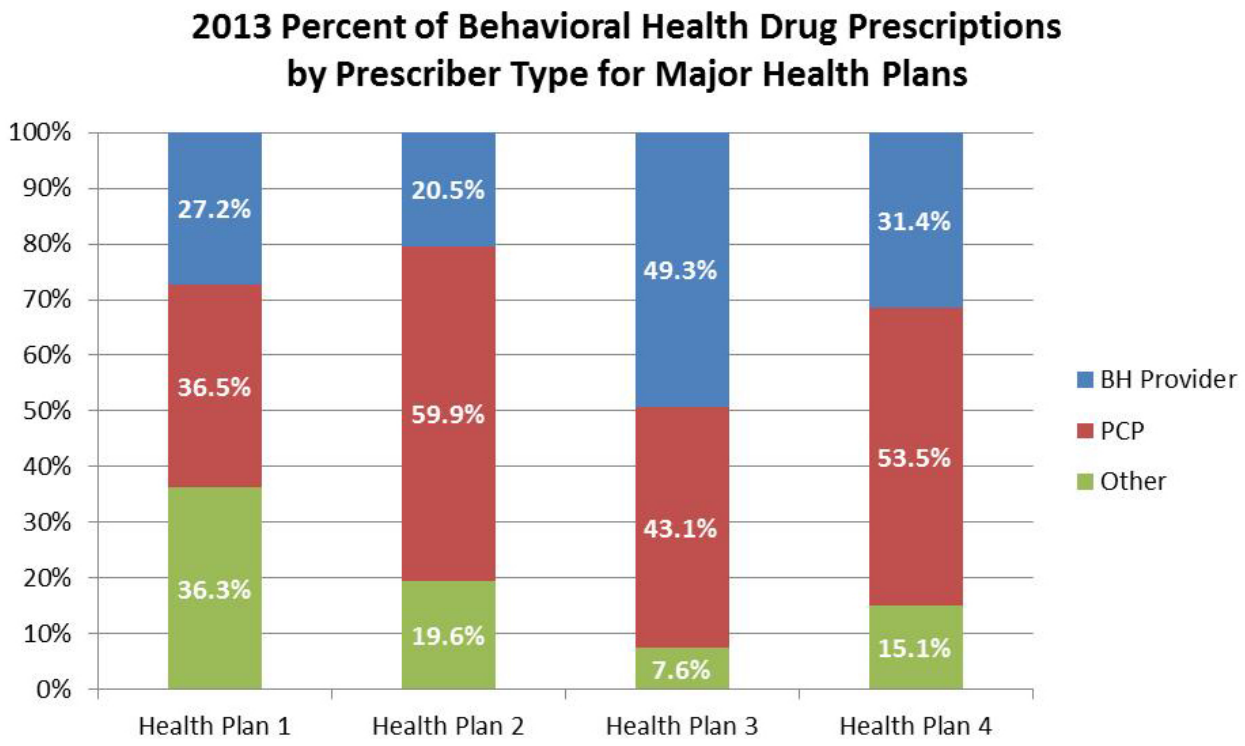
The above examples illustrate the complexity that patients with multiple health care needs must navigate. Even so, Tom and Ron's experiences assume the best case scenario in terms of access -- that each has access to the different levels of care that they need and both are enrolled in care management programs at their health plan and MBHO. Even with access to services, they may experience varying levels of communication between providers and, for Tom, between health plan and MBHO case managers. As discussed further below, fragmented benefit management has negative implications for efforts to improve care coordination and historically low behavioral health reimbursement rates.

C. Current Approaches to Managing Behavioral Health Benefits Result in Data Communication Challenges.

Currently, providers in health plan and MBHO networks deliver behavioral health services via administrative processes that are often parallel rather than integrated. This results in barriers to timely communicating health information that is critical to coordinating patient care.

Generally speaking, an MBHO is responsible for administering a benefit when the claim is a behavioral health service *delivered by a behavioral health provider in the MBHO's network*. However, not all behavioral health services are provided by behavioral health practitioners. For example, a PCP who treats a patient's anxiety can bill for an office visit and will be reimbursed directly by the patient's health plan, regardless of whether that health plan carves out behavioral health benefits, and regardless of whether the PCP bills a behavioral health diagnosis code. Similarly, the four major health plans report that in 2013 at least half of all behavioral health prescriptions were written by non-behavioral health providers, with more than one third of them written by PCPs.[23]

23 Although behavioral health drugs may be prescribed to treat non-behavioral health conditions, the data still suggests that a significant number of behavioral health services are being provided outside the scope of health plan-MBHO risk arrangements and outside MBHO provider networks.



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.

In short, management of behavioral health conditions straddles two administrative spheres, depending on whether and when a medical provider or a behavioral health provider delivers care. Where these two systems do not communicate, critical information about related care authorized by one system does not reach those providers in the other network that are also responsible for managing the patient's care. For example, one MBHO reports challenges in ensuring timely initiation of alcohol and other drug dependence treatment due to lack of access to information on diagnoses of substance use disorders that occur in the medical setting. MBHOs typically only receive real time information about a diagnosis related to alcohol or drug dependence if the member presents with that issue to a provider in the MBHO's network.[24] If the member presents instead to an emergency department, for example, the MBHO may not learn of the diagnosis (or may only learn of it months later via claims data sent by the health plan).

At the same time, medical providers' efforts to manage the cost and quality of their patients' care are also frustrated by the lack of real time information regarding important behavioral health status changes or setbacks that patients might experience. Because health plans and

24 Real time access to patient data even within a payer's network can be challenging depending on the electronic medical record ("EMR") and claims submission capabilities of the provider.

MBHOs have separate claims management systems, medical doctors and case managers experience challenges in learning of important behavioral health events in time to intervene and address their patient's medical care plan appropriately. These difficulties in exchanging patient data add another layer of complexity in an already fragmented system for delivering behavioral health services.[25]

D. Current Approaches to Reimbursing Providers for Behavioral Health Services Provide Little Financial Incentive to Coordinate Care Across Services.

Fragmented approaches to benefit management and reimbursement provide little to no financial incentives to coordinate care across the continuum of services. For example, global budgets that exclude behavioral health omit a critical segment of care from their financial structure. Similarly, in our review of health plan and MBHO contracts, we found that often times neither entity has meaningful financial incentives to coordinate care across medical and behavioral health benefits.

As described in our 2013 Report, providers deliver care pursuant to an increasingly complex array of contracts.[26] These contracts include fee-for-service ("FFS"), global payment arrangements, and hybrids of both global and FFS arrangements. Under a global payment arrangement, a health plan and provider negotiate a "global budget" for the care of members covered by this risk budget. The budget is a targeted maximum amount the health plan will pay for the cost of all of the care these members receive in a given year, including the cost of care the members receive from other providers. Some of these global budget contracts, like BCBS's Alternative Quality Contract include financial responsibility for the cost of behavioral health services. Others "carve out" responsibility for behavioral health costs to MBHOs or other behavioral health providers.

Global budgets that carve out behavioral health raise questions that policymakers and stakeholders should consider. How can providers be held accountable for the overall care of patients when they are not financially integrated into an important aspect of some patients' care? Consider, for example, the myriad of clinical and financial implications of a patient's mental illness for his or her compliance in managing a chronic medical condition.

Similarly, most MBHOs have limited financial incentives to engage in integration efforts across the care continuum. MBHOs are not at risk for the spending on medical (as opposed to behavioral health) services that may result from underlying behavioral health issues. Although contracts between health plans and MBHOs frequently include care coordination objectives, most incentives that are in place for these goals tend to be in the form of nominal bonus payments or financial penalties, and/or are encompassed in administrative capitation payments made to MBHOs.

25 Although not the focus of our examination, we understand there are concerns that historic cultural divides in practice, proprietary EMR systems that are unable to communicate with one another, and underlying privacy law restrictions also complicate communication and data exchange between providers.

26 OFFICE OF ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS & COST DRIVERS PURSUANT TO G.L. C. 6D, § 8: REPORT FOR ANNUAL PUBLIC HEARING, at 46-51 (April 24, 2013) [hereinafter AGO 2013 REPORT], *available at* http://www.mass.gov/ago/docs/healthcare/2013-hcctd.pdf.

Given the goals of health care reform, market participants must find better ways to incentivize coordination across the continuum of care. Global payment arrangements should account for the indivisible nature of patients' medical and behavioral health needs. And, if payers are going to continue to carve out behavioral health benefits, those relationships need to meaningfully incentivize coordination across services in a way that does not exclude a patient's behavioral health needs.

E. These Complex Approaches to Managing Behavioral Health Benefits Can Challenge Efforts to Improve Historically Low Behavioral Health Reimbursement Rates.

As policymakers and market participants contemplate improvements to historically low behavioral health reimbursement rates, they will need to consider the current patchwork of financial arrangements for behavioral health benefits and services. Some of these arrangements involve the transfer of some or all risk for behavioral health claims from the health plan to the MBHO. As currently structured, these payment arrangements promote precise adherence to capitated budgets that can leave little room for improvement to provider rates. Ultimately, low rates affect providers' ability to invest in services, which, in turn, impacts consumer access to care.

1. Behavioral Health Is a Negative Margin Business for General Acute Hospitals.

Consistently negative margins for behavioral health services across all types of general acute hospitals are indicative of historically low behavioral health reimbursement rates. Certainly, not all providers who provide behavioral health services run negative margin businesses. Indeed, many behavioral health providers and behavioral health specialty hospitals are for-profit companies. However, most of these providers, in contrast to general acute hospitals, do not provide emergency services, and thus theoretically have the ability to accept or reject patients based on insurance coverage.[27]

Focusing on general acute care hospitals, which account for more than half of behavioral health discharges,[28] evidence suggests that they frequently operate their inpatient and outpatient behavioral health units at a loss. Among 18 general acute care hospitals that reported inpatient behavioral health margins for commercial and government business from 2010 to 2013 - including academic medical centers, teaching hospitals, community hospitals, and disproportionate share hospitals across all geographies - the cumulative margin for all of these hospitals over those four years was *negative 39%*.[29] Similarly, margins for outpatient behavioral health services during this time frame reflect significant losses. Among general

27 One general acute care hospital explained in an interview that when it attempts to transfer patients from its emergency department to an inpatient behavioral health bed, one of the factors it considers when calling other providers to find a placement is whether or not the patient's insurance is "reasonable." The hospital explained that some providers perceive particular insurance companies as presenting more authorization hurdles than others. The provider felt that this perception limited other providers' willingness to accept the transfer of certain patients.

28 CHIA COMPLETE HOSPITAL PROFILES, *supra* note 5.

29 *See, e.g.,* HEALTH POLICY COMM'N, MASS. EXEC. OFFICE FOR ADMIN. & FINANCE, 2014 HEALTH CARE COST TRENDS HEARING, PRE-FILED TESTIMONY (Oct. 2014), *available at* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/annual-cost-trends-hearing/2014/testimony/.

acute care hospitals that reported outpatient behavioral health margins, the cumulative margin for commercial and government business for 2010 to 2013 was *negative 82%*. The margin for these hospitals' commercial outpatient behavioral health business alone was negative 58%. These consistently negative margins signify not only low reimbursement levels, but also broader implications for behavioral health services.

Consistent losses on behavioral health business discourage investment in behavioral health care,[30] ultimately impacting consumer access to these important services. Although other lines of business such as cardiology and radiology may generate positive margins, which help to offset some of the negative impact that behavioral health services have on a hospital's overall financial stability, the financial instability of behavioral health services will continue to impact investment in this area. Continued pressure on overall health care costs may also affect the profitability of those services that currently cross-subsidize behavioral health, which may further discourage expansion and investment in behavioral health services.

As the Commonwealth and market participants move forward with expanded coverage under behavioral health parity laws, funding of and access to services must be carefully considered. A key factor in providing services to this growing population of eligible consumers is the investment that providers are able to make in delivering behavioral health care. Without appropriate levels of reimbursement, a provider's ability to accept and treat patients will be strained. In the next section, we examine how current financing approaches to behavioral health benefits can impede efforts to address the consequences of behavioral health being a negative margin business.

2. Financing Approaches to Behavioral Health Benefits Vary and May Impede Improvements to Rates.

As currently structured, MBHOs manage behavioral health benefits pursuant to contracts that promote precise adherence to capitated budgets. As a result of spending that is controlled to these budgets, these arrangements can leave little room for MBHOs to improve provider reimbursement rates.

Risk contracts between health plans and MBHOs contain many of the same types of complex provisions that are found in risk contracts between health plans and medical providers.[31] However, because the MBHO is an administrative intermediary as opposed to a direct supplier of behavioral health services, the arrangements necessarily differ. MBHOs negotiate FFS prices or other alternative payment arrangements[32] with physicians, hospitals, and other behavioral health providers, manage demand-side (consumer) authorizations, as well as determine the medical necessity of services provided by physicians, hospitals, and other providers. The discounts they are able to obtain on each unit of service delivered, combined with their effectiveness at reducing the total number of units consumed, will determine their ability to stay within the budget they negotiated with the health plan and avoid a full or

30 One general acute care hospital explained in an interview that behavioral health is one of the few specialties where there is a significant unmet need for services, yet no providers are looking to grow their product because they lose money on every visit and therefore can never make up their losses.

31 *See* AGO 2013 REPORT, *supra* note 26, at 47-49 for an overview of such provisions

32 Alternative Payment Models have not yet gained traction from MBHOs to providers.

partial loss of any amounts spent over their budget. The amount of surplus or loss to the MBHO depends on the level of risk they have negotiated with the health plan. Importantly, from 2010 to 2013, most MBHO-managed behavioral health claims did not exceed allotted capitation amounts, and only small returns have been made to health plans as a result of spending less than the negotiated budget.

In most health plan-MBHO risk contracts, MBHOs are paid two capitation amounts: one for administrative costs and one for claims costs. The administrative capitation amount is intended to cover the MBHO's administrative costs, which include margins for these for-profit companies. Meanwhile, the MBHO may be at risk for claims capitation amounts, which are broken out by population type (e.g., Medicaid rating category, commercial). As a result, each population group has a different PMPM capitation rate assigned to it, and overall claims capitation paid to the MBHO each month is the sum of each unique claims capitation PMPM multiplied by the number of members in that specific population, a rudimentary form of claims risk adjustment. Given that MBHOs' claims costs have not exceeded their claims capitation amounts for most major health plans and Medicaid MCOs, and only small returns have been made to health plans, incentives as currently structured appear to promote precise spending by the MBHOs that remains at or close to the contracted capitation rates.

Policymakers seeking to improve access to behavioral health services should consider the impact of these health plan-MBHO risk arrangements on provider rates. For example, how can stakeholders improve rates if additional intermediaries (MBHOs) are tied to arrangements that capitate their spending on behavioral health claims? Is there room for improvements to rates? Is there sufficient room for expansion and investment in behavioral health services? Policymakers should consider these and other questions pertaining to financing arrangements as they seek to make behavioral health parity a reality.

II. Behavioral Health Data Lags Compared to Advances in Data for Other Areas of Health Expenditures, Challenging Efforts to Improve Analysis and Promote Parity.

Reporting on behavioral health data varies widely from payer to payer, and generally lags reporting on other categories of medical services that can be found in key health care databases. These data constraints affected our ability to perform analytics and will continue to hinder important policy and health planning functions. Specifically, the Commonwealth lacks key measures of behavioral health utilization, price, spending, and quality. These metrics are important to understanding how and where we are investing our health care dollars and the drivers of underlying spending trends. This is particularly important in behavioral health given the compound increase in health care spending associated with individuals with comorbid chronic medical and behavioral health conditions.[33] The Commonwealth has made significant advances in the availability of health care data for medical services, which has allowed for unique and informative analysis of health care trends. To continue to be a leader in health care reform, Massachusetts policymakers and stakeholders need to give the same attention to advancing behavioral health data and reporting.[34]

A. Lack of Comparable and Reliable Data on Behavioral Health Capacity and Utilization Constrains Effective Resource Planning.

Two statewide databases are key to understanding health care utilization, and ultimately, spending trends: the Hospital Discharge Database (the "HDD") and the All Payer Claims Database (the "APCD"). Neither of these databases currently includes complete behavioral health information. Additionally, to move forward with effective resource planning, the Commonwealth needs information on capacity for inpatient and outpatient behavioral health services, such as ED wait times for patients waiting for behavioral health beds and availability of outpatient and community-based services.

First, detailed inpatient discharge data for behavioral health diagnoses is not available across general acute and specialty hospitals. Almost half of behavioral health discharges are at behavioral health specialty hospitals.[35] Behavioral health specialty hospitals are not required to report to the HDD, and instead report discharge data only in 403 Cost Reports. Discharge data reported in 403 Cost Reports is aggregated into bed type and payer type categories, rather than the individual discharge by diagnosis and payer type available in the HDD.[36]

33 HPC 2013 COST TRENDS REPORT, *supra* note 15.

34 The Task Force on Behavioral Health Data Policies and Long Term Stays will also address behavioral health data. *See* 2014 Mass. Acts, ch. 165, § 230.

35 *Supra* p.2.

36 CHIA MA HOSPITAL PROFILES APPX., *supra* note 4 (noting the distinctions between the HDD and 403 Cost Reports).

The APCD is another critical repository of statewide health care data. This database has the potential to shed light on trends across the continuum of behavioral health care settings (e.g., residential treatment programs, outpatient treatment programs, addiction counseling). The Commonwealth and market participants should support efforts to include all claims data in the APCD, including current efforts to include MBHP data, to enable analysis of behavioral health services, claims, and spending.

Finally, health resource planning requires careful consideration of community health care needs and capacity to provide services. For example, if utilization of community-based support services increases, the Commonwealth and market participants would need to consider existing capacity to deliver those services in determining whether to invest additional resources. Given the prevalence of behavioral health conditions but lack of data on behavioral health utilization and capacity, particular attention should be given to developing databases to support this work.

B. Inconsistent Information on Prices and Payment Methodologies Constrains Our Ability to Evaluate Payment Levels and Trends.

To fully document behavioral health reimbursement rates and understand how they compare to medical reimbursement rates and across providers and payers, we need better data on payment levels and methodologies. At this time, payment methodologies for hospitals and other providers are inconsistent, making it impossible to compare prices. The lack of consistent data and methodologies constrained our ability to conduct a meaningful analysis of the rates paid to providers for behavioral health services.

As currently structured, inpatient and outpatient rates for behavioral health services are not comparable. Providers are largely reimbursed for inpatient services on a per diem basis that is not adjusted for case complexity. To compare these rates in a reliable, apples-to-apples manner, we need to adjust them for differences in patient complexity, which we are unable to do with currently available data.

Outpatient prices are similarly complex. For most payers, providers are reimbursed using either the payer's standard outpatient fee schedule or one of any number of unique, negotiated schedules. Although payers can identify that non-standard fee schedules exist, they cannot efficiently identify which providers in their network are on these non-standard fee schedules, or in what way the non-standard fee schedules differ from the standard rates.[37]

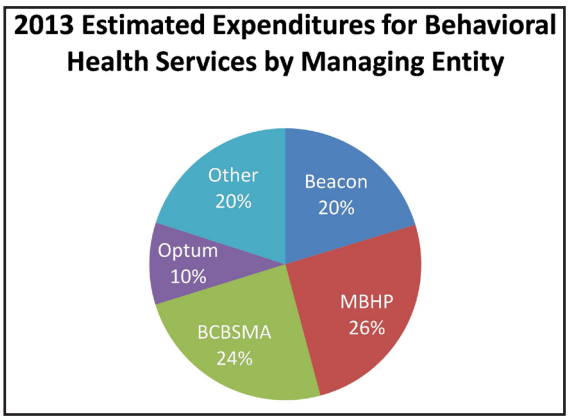
More comparable reimbursement methodologies across the industry and better tracking by payers of reimbursement levels is necessary to advance further analysis of the rates paid for behavioral health services.

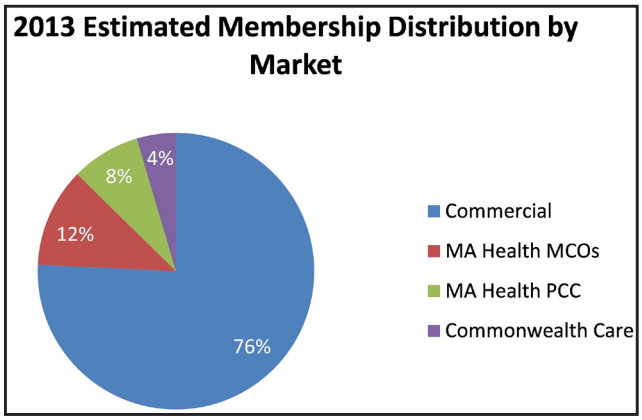
37 Reimbursement for services along the full continuum of behavioral health care warrants further consideration. Provider fee schedules for at least one payer are based on relative value units ("RVUs"). RVUs are a health care industry-wide standard way of reimbursing professional providers based on the relative value of one service to the next, established by the Center for Medicare & Medicaid Services. When health plans pay physicians on an RVU basis, they often associate a multiplier to the RVU of the service, meaning that on a relative basis, the proportional difference between reimbursing for service A and service B will remain the same, but the actual dollar amounts may differ across providers. However, other payers do not employ the same level of reasoning to behavioral health reimbursement rates. For example, one payer reimburses psychotherapy crisis codes at the same payment levels as general psychotherapy appointment codes, even though the crisis code is to treat more severe patients and requires higher levels of provider qualifications.

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

We need consistent, reliable data on non-behavioral health and behavioral health spending to understand what is driving compound increases in total medical expenditures ("TME") for patients with comorbid behavioral health and medical conditions. This means not only data on utilization, capacity, and price, described above, but also comparable data on spending.

Based on payer reporting of the behavioral health expenditures of commercial and managed Medicaid populations, about 80% of expenditures are managed by three companies. Nearly 50% of expenditures are managed by Beacon Health Options companies, largely for the care of Medicaid populations that account for only about 20% of the total population studied.



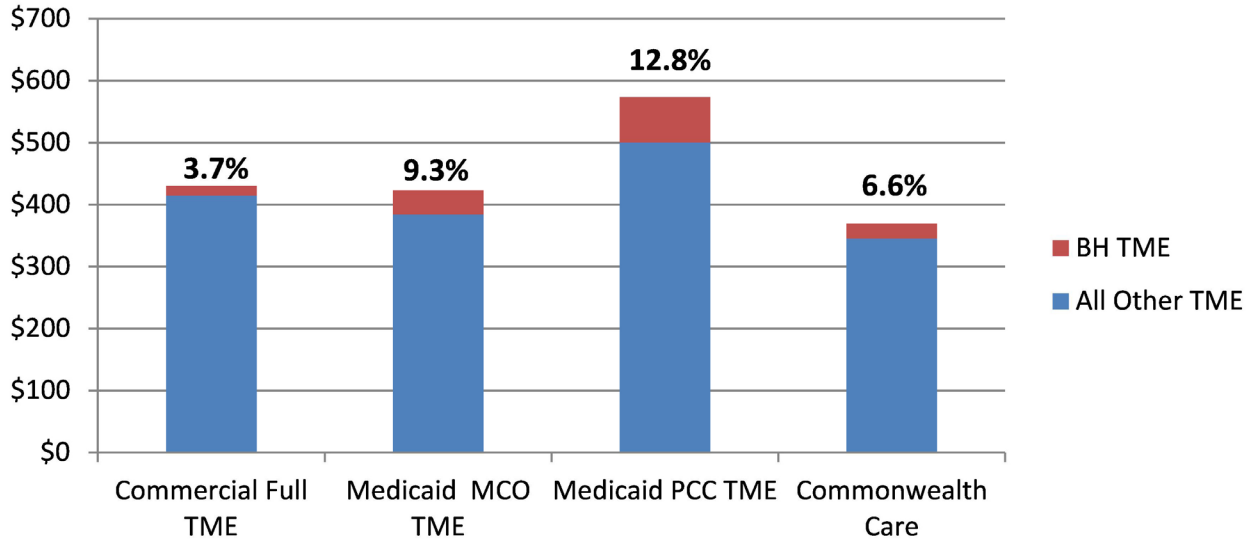


Notes:

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. Because of the contracted differences in benefits managed by MBHOs, the values reported are not on an apples-to-apples basis. For example, one health plan does not carve out medically indicated detoxification to its MBHO subcontractor, while most other health plans do.
4. Excludes pharmacy spending.
4. Excludes Medicaid FFS, Medicare, Dual Eligible, Senior Care Options, Program for All-Inclusive Care for the Elderly, Medical Security Program, and Veteran Affairs populations.
5. Excludes Children's Behavioral Health Initiative ("CBHI") benefits that MassHealth provides to eligible children. CBHI benefits are community-based outpatient services that MassHealth pays on a fee-for-service basis for MCO members. MBHP is at-risk for CBHI claims they administer, including for PCC members and members with other primary coverage (commercial, Medicare). Total 2013 spending on CBHI benefits for all eligible children was approximately $198 million.

Our initial look at spending data begs more questions than provides answers. Below is the estimated proportion of raw TME attributable to spending on behavioral health services by member population. The total height of the bar reflects raw TME for the member population on a PMPM basis. These TME levels are not adjusted for differences in member complexity or acuity. This means that one bar may be higher than another in part because it reflects expenditures for a more complex population. The red portion of the bar and the percentage indicated is the portion of TME that reflects reported spending on behavioral health services. For the Massachusetts commercial population, approximately 4% of raw TME is spent on behavioral health services. About 9% percent of raw TME is spent on behavioral health services for the MCO population and about 13% of raw TME is spent on behavioral health services for the PCC population.

Percent of 2013 Raw TME Reported as Attributable to Behavioral Health Services



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).

We need more and better information to be able to explain the differences in the proportion of raw TME for each member population spent on behavioral health services. For example, the differences in spending may be explained by differences in the health status of each population. As discussed earlier, Medicaid populations tend to have a greater prevalence of disabled and financially needy members. These members are likely to have more complex (and thus resource-intensive) behavioral health needs when compared to commercial populations. A behavioral health-specific health status adjustment tool would help us quantify and compare the impact of differences in member health status on behavioral

health spending.[38] As another example, differences in access to behavioral health services and in benefits covered for each member population could also explain differences in expenditures.[39] To answer these and other questions, we need consistent, reliable data, including adequate risk adjustment tools.

D. Gaps in Behavioral Health Quality Metrics Hinder Effective Quality Measurement and Analysis.

There are many metrics that payers and providers use to measure the quality of behavioral health services and benefit administration. However, very few of these metrics are standard across the industry and gaps exist, particularly for outcome measures. As a result, behavioral health is an area ripe for more standardization and development of new measures.

In the absence of industry-wide standards, payers and providers in the Commonwealth have pursued a wide variety of measures to evaluate the quality of behavioral health services.[40] These measures are far from universal, though small pockets of consistency do exist. Most measures that are consistent across payers focus on the quality of the process of managing benefits, measuring things such as network availability, timeliness of response to questions, and claims processing. Many payers and providers also analyze some aspects of behavioral health clinical quality by using a select number of Healthcare Effectiveness Data and Information Set ("HEDIS")[41] measures that assess factors such as hospitalization follow up rates, readmission rates, medication management for ADHD and depression, and initiation and engagement of members for treatment of alcohol or other drug dependence issues.[42] The state's Standard Quality Measure Set ("SQMS")[43] uses 17 behavioral health related

38 Current risk adjustment tools are not behavioral health-specific. The tools that do exist are imperfect when applied generally to all health care claims and do not fully reflect relative and absolute changes in the morbidity of patient populations over time. *See* OFFICE OF ATT'Y GEN. MARTHA COAKLEY, EXAMINATION OF HEALTH CARE COST TRENDS & COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½(B): REPORT FOR ANNUAL PUBLIC HEARING, at 45 (JUNE 22, 2011), *available at* http://www.mass.gov/ago/docs/healthcare/2011-hcctd-full.pdf; *see also* SOC'Y OF ACTUARIES, A COMPARATIVE ANALYSIS OF CLAIMS-BASED TOOLS FOR HEALTH RISK ASSESSMENT (2007), *available at* http://www.soa.org/Files/Research/Projects/risk-assessmentc.pdf. These tools have less accuracy when applied to behavioral health claims alone. *See*, *e.g.*, Susan L. Ettner, et al., *Risk adjustment of capitation payments to behavioral health care carve-outs: How well do existing methodologies account for psychiatric disability?*, 3 HEALTH CARE MGMT. SCIENCE 159-69 (2000); *see also* Colleen L. Barry, et al., *Risk Adjustment in Health Insurance Exchanges for Individuals with Mental Illness*, 169 AM. J. PSYCHIATRY 704-9 (2012) (finding risk adjustment reduces but does not resolve underpayment/overpayment across all health claims (behavioral health and medical) associated with share of enrollees with mental health problems).

39 By way of example, while MassHealth plans cover Community Support Programs, which provide community-based supports to help individuals transition to community services after acute residential treatment, most commercial plans do not. CTR. FOR HEALTH INFO. & ANALYSIS, ACCESS TO SUBSTANCE USE DISORDER TREATMENT IN MASSACHUSETTS, at 21, 42 (April 2015), *available at* http://chiamass.gov/assets/Uploads/SUD-REPORT.pdf (describing Community Support Programs and its coverage by payer type (Appendix Three)).

40 Our sample of stakeholders alone revealed over 300 unique quality measures. These metrics assess similar areas of performance, but are frequently unique in their design and cannot be compared across entities.

41 The National Committee for Quality Assurance's HEDIS measures are used by more than 90 percent of health plans in the nation to measure performance on important dimensions of care and service.

42 The initiation and engagement of treatment measure assesses whether or not treatment has been (1) initiated once a member has been identified as having a new episode of alcohol or other drug dependence and (2) continued for at least two additional services within 30 days of the initiation visit.

43 CHIA is tasked with developing a SQMS for uniform reporting on each health care provider facility, medical group, or provider group in the Commonwealth. MASS. GEN. LAWS ch. 12C, § 14 (2012). CHIA uses SQMS for uniform reporting, and health plans are required to use SQMS as quality criteria for small group tiered network products. MASS. GEN. LAWS ch. 176J, § 11 (2012).

process measures mostly drawn from HEDIS and National Quality Forum measures (e.g., depression screening) with one unique process measure (unhealthy alcohol use screening and counseling).

Outside of the few HEDIS measures identified above, significant gaps exist as to the use and development of standard outcome based measures for behavioral health services. This may be in part due to the inherent difficulty in defining a "successful" outcome for a behavioral health patient. Such definitional issues are evident in assessing quality of performance as it relates to wait times in emergency departments. While providers are individually assessing their performance in this area, a number of different definitions of "wait time" are in use, making it difficult to analyze and compare performance. As a result of these limitations, quality improvement initiatives related to clinical outcomes are not meaningfully incentivized. Currently, minimal dollars are tied to performance on behavioral health metrics, and what little money is at risk is frequently tied to payer performance on process based initiatives.

Some payers are beginning to look at innovative ways of assessing quality performance. For example, MBHP considered and implemented quality measures related to community tenure. This measure was intended to be a proxy for the health of a member, and tracked a member's stay in the community following discharge from inpatient services. Metrics such as this are a step in the right direction to advance the conversation about how to assess quality on a more comprehensive basis. The industry will benefit from more consistent and robust measures that can provide the basis for meaningful analysis of quality improvement and development of incentive programs.

III. Conclusions and Recommendations

We found that current approaches for managing and administering behavioral health benefits complicate efforts to better coordinate patient care over time and across settings. Although health plans and MBHOs draw distinctions between what benefits are "behavioral" versus "medical," for patients there is no such bright line between where one begins and the other ends. As the Commonwealth and market participants work to de-stigmatize mental health and substance use disorders, the current system continues to separate behavioral health from medical care. This separation does not exist for any other health care specialty. We recommend the following in moving forward:

1. Payers and other stakeholders should consider addressing barriers to improving historically low behavioral health reimbursement rates and the ability of all types of providers to invest in behavioral health services, as this will ultimately impact consumers' ability to access behavioral health care on an equal basis.
2. To advance care for the whole person, stakeholders should consider developing meaningful financial incentives for providers and payers to integrate the delivery of medical and behavioral health services. Arrangements as currently structured silo financial responsibility for behavioral health and medical care and do not achieve this goal.
3. Stakeholders should reconsider the features of the current parallel systems for medical and behavioral health care that prevent providers and care management organizations from accessing information necessary to support timely and effective patient care.
4. Data on behavioral health care should at least mirror the scope of information available on price, utilization, quality, and spending for medical services. Specifically, policymakers and market participants should consider implementing:
    a. Consistent, industry-wide reporting requirements for reimbursement methodologies;
    b. A more consistent definition of what constitutes "behavioral health services" to standardize what is reported as behavioral health spending; and
    c. More robust quality measures that can provide the basis for meaningful analysis and comparison of providers. For example, stakeholders may consider looking to MassHealth and the Commonwealth's Standard Quality Measure Set to develop a core set of quality and performance measures in behavioral health.

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