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Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02109

Dear Commissioners:

This testimony expands upon the verbal testimony of Mental Health Legal Advisors Committee[1] (MHLAC) at the October 22, 2019 Health Policy Commission (HPC) hearing on annual health cost trends.[2] MHLAC offers suggestions to reduce cost and improve care quality based upon its lengthy interaction with and representation of persons with lived experience of psychiatric challenges and deep understanding of how health care policy affects our clients. MHLAC also offers suggestions on reducing health care costs through means that respect patient preferences and improve outcomes.[3]

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[1] 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 regarding the barriers people with psychiatric diagnoses have with respect to accessing health care services and obtaining quality care once those services are obtained.

[2] This written testimony speaks to issues raised by HPC in its most recent Health Cost Trends Report, as well those raised in the October hearings.

[3] Detailed support for each recommendation will be forwarded within the week as Appendix A.

Integrated care[4] can endanger access to adequate physical health care for persons with psychiatric diagnoses due to provider bias toward persons with psychiatric challenges and diagnostic overshadowing.

Proposals:

- Integrated care systems must be monitored closely to ensure that persons with psychiatric diagnoses are getting physical health care comparable to persons without behavioral health diagnoses.[5]
- Peer workers in health care settings[6] and "Open Notes" should be utilized to lessen implicit bias.
- Patient control of psychiatric information, beyond that protected by HIPAA, should be explored.

Demand-side incentives[7] financially burden patients, are of questionable efficacy in reducing overall health care costs, and harm quality of care. Patient out-of-pocket expenditures have grown far more than expenditures by employers and insurers and more than the inflation rate.

- Transparency of prices will not relieve the financial burden on patients because people do not shop for medical care like typical consumer goods.
- Tiering criteria are not open to public review, are primarily based on cost and not quality, are insufficiently granular to ensure optimal care, and do not account for the individual characteristics of each patient.

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[4] Health Policy Commission recommendation #10.

[5] A standard set of quality indicators across healthcare systems could inform efforts to improve health and disability outcomes in persons with psychiatric diagnoses. System factors, such as perceived bias of provider, adherence of care to clinical guidelines, stage of diagnosis for conditions like cancer, number of contacts with physical health care providers, insurer, and other pertinent factors like race and gender, should be correlated.

[6] Health Policy Commission recommendation #9.

[7] Health Policy Commission recommendation #6.

- Higher patient costs lead to avoidance of appropriate use of care, which ultimately leads to more expensive modalities of treatment.[8]

Proposals:

- Lower health care costs through the use of alternative providers of care, like peer respite, recovery coaches and peer counselors.
- Expand coverage of traditionally non-medical tools like meditation, exercise, support animals, and transportation to activities that increase social engagement to promote prevention and recovery.
- Require insurers to address social determinants of health by financially supporting, either through coverage or specified contribution, corrective measures.

Insurer funding and coverage of measures that **address social determinants of health** will reduce the cost of health care overall. Limited definitions of what is health-related and minor expenditures by insurers to refer patients to underfunded and unavailable public services are insufficient to change the trajectory of Massachusetts' health care system.

Proposals

- Require insurers, including ACOs, to cover and financially contribute to improving access to broadly defined social determinants of health[9].
- Simultaneously, CHIA or another public partner should engage in a long-term study of strategies used by insurers and health care providers to address social determinants of health.

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[8] 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).

[9] Improving access must be more than just referring patients to public programs.

Alternative and innovative services[10] and treatments offer the opportunity to lower health care costs. Unfortunately, insurers rarely cover these services, often claiming that they are not "evidence-based." Yet offering patients a broad array of options from which to choose increases patient engagement and the potential for recovery, ultimately saving insurers money.

- Providing people with the services they desire increases engagement and the potential for recovery as compared to involuntary or undesirable treatment.
- Meditation, massage, and acupuncture lessen reliance on pain medication, thereby reducing the likelihood of addiction.
- Peer respites reduce unnecessary hospitalization.
- Animal therapy and emotional support and service animals promote and sustain recovery inexpensively.
- Multi-generational housing can facilitate hospital to home transitions and reduce post-discharge expenses.

Proposals

- ➢ 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.
- ➢ Practice evidence should be included in determining whether a modality of treatment is "evidence-based."
- ➢ Insurers should cover meditation, massage, acupuncture, peer respites, animal therapy, and emotional support and service animals, all of which have been shown to have applications that improve outcomes and/or reduce health care costs.

Alternative payment arrangements[11] and shared risk are not without negative effects 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.

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[10] Health Policy Commission recommendation #10.

[11] Health Policy Commission recommendation #11.

  - Outcome measurements currently relied upon do not control harmful practices spurred by capitation and shared risk.
  - The ability of patients to effectively contest denials of care is limited, if not eradicated, when doctors make decisions based on personal financial interest or organizational pressure.

Proposals

- ➢ Pilot and promote best practices for prevention, maintenance, and recovery that are developed with the participation of persons with lived experience of the conditions to which the practices apply. Options preferred by patients will include low-cost "fixes" that will promote patient engagement and lower health care costs.
- ➢ Free providers to make medical decisions based on the best interests of their patients. To start, achieve this by encouraging the use of salaried health care professionals who can decide what is medically necessary for their patients.

With respect to organizations that engage in "alternative payment arrangements":

- ➢ Ensure that patients have the ability to appeal denials of care by their providers to an independent agency and to have access to independent second opinions at no charge, without which the right to appeal would be a charade.
- ➢ Use and develop outcome measures, like PROMs, with the participation of relevant patient populations.
- ➢ Require individual providers and accountable care organizations to disclose financial incentives under which they operate.

Treatment protocols[12] and the designation of services and pharmaceuticals as "low-value"[13] are problematic.

- Treatment protocols ignore individual circumstances and patient preferences, weakening patient engagement and amenability to provider treatment recommendations.

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[12] Health Policy Commission recommendation #2.

[13] Health Policy Commission recommendation #7.

- The bases for designating services as "low-value" are often flimsy and tainted by financial conflicts of interest.
- Treatment protocols are subject to bias because the data and assumptions upon which they are based exclude or devalue historically disempowered populations (e.g., people of color, women, people with disabilities, the elderly).

Proposals

- ➢ Do not permit the rigid use of treatment protocols to deny coverage of services and other care.
- ➢ Monitor the impact of artificial intelligence tools on appropriate diagnoses and care.
- ➢ Systematically review treatment protocols to ensure that they are based on data that includes for all target populations.
- ➢ Do not use QALYs to determine "value" and include a robust representation of persons with lived experience of the condition for which the service/medication would be used in the evaluation of value.
- ➢ Do not financially penalize patients who reasonably use a medication that does not have a generic equivalent of equal efficacy for the individual.

Administrative complexity[14] experienced by patients and providers due to unnecessary utilization review and unwarranted denials should be addressed, while quality measures to control financial incentives should be strengthened.

Proposals

- ➢ Financial consequences should be imposed on insurers for ill-considered denials of care.
- ➢ Quality measures that are weakly tied to outcomes should be replaced with patient-reported outcome measurements and outcome measurements that are less amenable to manipulation.

MHLAC appreciates the work HPC and CHIA have done to further the equitable reduction of health care costs while maintaining quality of care. We submit these

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[14] Health Policy Commission recommendation #1.

comments to inform and support your efforts. MHLAC hopes you will avail yourself of our services and expertise in your future endeavors.

Sincerely,

Susan Fendell

Susan Fendell
Senior Attorney

APPENDIX A

TO

MHLAC COMMENTS ON ANNUAL HEALTH COST TRENDS

2019

Need for Confidentiality of Psychiatric Information Beyond HIPAA – Patient Concerns, Implicit Bias and Inadequate Physical Health Care:

Otto F. Wahl, *Mental Health Consumers' Experience of Stigma*, 25 SCHIZOPHRENIA BULLETIN 467, 467-78 (1999). In a survey of 1,301 mental health consumers, the majority tried to conceal their illnesses due to associated stigma and "worried a great deal that others would find out about their psychiatric status and treat them unfavorably."

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).

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.")

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) (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.)

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) (Disclosure of sensitive medical information may lead adults to avoid care or withhold information from providers.)

C. Campos-Castillo and D. Anthony, *The double-edged sword of electronic health records: implications for patient disclosure*, 22 J. Am. Med. Inform. Assoc. e130, e137(2015).

Ronald M. Salomon, et al., *Openness of Patients' Reporting With Use of Electronic Records: Psychiatric Clinicians' Views*, 17 J. AM. MED. INFO. ASS'N, 54-60 (2010) (Majority of mental health clinicians surveyed said they would not want their own personal psychiatric record included with their general medical record.)

45 C.F.R. § 164.501 Privacy Rule permits disclosure to any person providing health care to a patient, *without the patient's authorization*, of the following mental health medication prescription and monitoring, counseling session start and stop times, modalities and frequency of

treatment furnished, results of clinical tests, and any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

H. Fernandez Lynch, *Discrimination at the Doctor's Office*, 368 N. Engl. J. Med. 18 (2013) (Despite prohibitions against discrimination in professional ethics, as well as state and federal laws that make overt discrimination rare, implicit biases affect care. "[W]e should be particularly vigilant against the sort of subtle discrimination that can fly under the radar.")

E. Glicksman, *Your diagnosis was wrong. Could doctor bias have been a factor?*, Washington Post (Nov. 18, 2019) (People with mental illness may be affected the most by implicit assumptions overall…." Physicians focused on mental health may not notice a heart problem or may tie abdominal pain to depression or anxiety without testing.)

Graham Thornicroft et al., *Discrimination in Health Care Against People with Mental Illness,* 19 INT'L REV. PSYCHIATRY 113 (2007).

M. De Hert, *et al.*, *Physical illness in patients with severe mental disorders*, 10 World Psychiatry 52(2011) (Patients with SMI do not receive adequate risk screening for metabolic syndrome, obesity, or blood pressure. Even oral health is affected by the attitudes of dental health teams. Integration of physical and mental health care will not solve the problem of inferior care: "…stigmatization, discrimination, erroneous beliefs and negative attitudes associated with SMI will have to be eliminated to achieve parity in health care access and provision.")

S. Jeffery, *Psychiatrists Not Immune to Mental Health Bias,* Medscape (May 21, 2013)(report on inferior physical health care delivered to persons with serious mental illness delivered as Abstract NR12-12, American Psychiatric Association's 2013 Annual Meeting).

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 Dec. 30, 2019) (Among all physicians who said bias affected treatment, 72% said that emotional problems had a negative effect on treatment.)

D Khullar, *The Largest Health Disparity We Don't Talk About*, N.Y. Times (May 30, 2018) (Disparity in life expectancy of Americans with serious mental illnesses compared to those without mental illness is *larger than for race, ethnicity, geography or socioeconomic status.* Clinician bias contributes to disparity. Therapeutic pessimism results in tests and treatments not offered or pursued. Diagnostic overshadowing attributes physical symptoms to mental illness.)

E. McGinty, *et al.*, *Quality of medical care for persons with serious mental illness: A comprehensive review,* 165 Schizophrenia Research 227 (2015) (Medicaid programs, including health homes and ACOs, should be required to collect and report standardized quality indicators for care of somatic (physical) conditions for enrollees with serious mental illness, since disparity in quality of care greater among Medicaid recipients with SMI.)

SAMSHA, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf (Stigma-related concerns were cited by 28% of respondents for not obtaining mental health treatment.)

S. Eskelinen, *Physical health of patients with schizophrenia: Findings from a health examination study* (2017) https://www.researchgate.net/publication/318787232_PHYSICAL_HEALTH_OF_PATIENTS_WITH_SCHIZOPHRENIA_FINDINGS_FROM_A_HEALTH_EXAMINATION_STUDY (last accessed 12/30/19) (Individuals with schizophrenia less often admitted to hospital care or receive invasive procedures for heart disease than those without mental illness. Prescription rates for basic preventive medications for cardiac conditions inferior in patients with schizophrenia. Visiting a doctor within 12 months did not reduce the need for somatic interventions.)

Allison L. Smith & Craig S. Cashwell, *Stigma and Mental Illness: Investigating Attitudes of Mental Health and Non-Mental Health Professionals and Trainees,* 49 J. HUMANISTIC COUNSELING, EDUC. AND DEV. 189, 189-202 (2010)

A. Llerena et al., *Schizophrenia stigma among medical and nursing undergraduates*, 17 EUR. PSYCHIATRY 298, 298-99 (2002)

H. Rao et al., *A Study of Stigmatized Attitudes Towards People with Mental Health Problems Among Health Professionals,* 16 J. OF PSYCHIATRIC AND MENTAL HEALTH NURSING 279, 279-84 (2009)

M. Hugo, *Mental Health Professionals' Attitudes Towards People Who Have Experienced a Mental Health Disorder,* J. OF PSYCHIATRIC AND MENTAL HEALTH NURSING, 419, 419-25 (2001).

C. A. Ross & E.M. Goldner, *Stigma, Negative Attitudes and Discrimination Towards Mental Illness within the Nursing Profession: A Review of the Literature,* 16 J. OF PSYCHIATRIC AND MENTAL HEALTH NURSING 558, 558-67 (2009).

Patrick Corrigan, *et al.*, *Mental health stigma and primary health care decisions*, 218 Psych. Res. 35 (Aug. 2014) (doctors less likely to refer patients with mental illness to specialists or renew prescriptions).

Babak Roshanaei-Moghaddam & Wayne Katon, *Premature Mortality From General Medical Illnesses Among Persons With Bipolar Disorder: A Review*, 60 Psychiatric Services 147, 147-54 (2009) (discussing recent evidence which has shown an increased risk of premature mortality for bipolar patients).

Joseph Hayes, *et al.*, *A systematic review and meta-analysis of premature mortality in bipolar affective disorder,* 131 Acta Psych. Scandinavia 417 (2015) (study found persons with bipolar

disorder had double the all-cause risk of death than the general population, and natural deaths are 1.5 times greater, although data from 1935 to 2010 showed that all-cause mortality for persons with bipolar disorder has improved over time).

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 Psychiatry 30 (2017) ("Although [persons with SMD] have two times as many health care contacts, they receive less physical check-ups and screenings, less prescriptions and procedures, and less cardiovascular and cancer diagnoses, even though they have a higher risk of dying from these conditions." Persons with severe mental disease die of respiratory diseases at two to six times the rate of the general population, even after controlling for tobacco smoking and substance abuse." "[S]tudies clearly demonstrate the role of factors beyond disorder-specific and lifestyle behaviours in excess mortality") While the authors attribute this to many intersecting causes, including failure to address medication side effects and poverty, they note that "poorer health outcomes could be related to providers' negative beliefs and attitudes towards persons with SMD, including beliefs about the causes of illnesses, ability of persons with SMD to maintain an active and health lifestyle, or other beliefs about functioning. Mental health and primary care providers' attitudes towards patients with SMD appear related to treatment…." Authors also now that there are few randomized trials on the impact of mental and physical care coordination on aspects of physical health care for persons with SMD.)

'Diagnostic overshadowing': worse physical health care for people with mental illness, 118 ACTA PSYCHIATR. SCAND. 169 (2008).

BEHAVIORAL HEALTH INTEGRATION TASK FORCE, REPORT TO THE LEGISLATURE AND THE HEALTH POLICY COMMISSION 69, 82, 85-86 (2013) (listing Behavioral Health Integration Task Force forums, including April 30, 2013 communication and privacy forum). The task force was established under Chapter 224, Section 275 of the Massachusetts Acts and Resolves of 2012 to provide recommendations to the legislature on behavioral and mental health care treatment and service delivery. Act of Aug. 6, 2012, ch. 224, § 108, 2012 Mass. Acts 901. (Task Force held forums for public testimony, including April 30, 2013 communication and privacy forum. Numerous persons with psychiatric challenges recounted their inability to get appropriate physical health care because their providers were aware of their psychiatric histories.)

S. Jones, *'Diagnostic overshadowing': worse physical health care for people with mental illness*, 118 ACTA PSYCHIATR. SCAND. 169 (2008).

H. Stuart, *What we need is person-centred care,* 6 PERSPECT. MED. EDUC. 146 (2017) ("Psychiatric labels may also get in the way of appropriate physical care as clients are triaged as 'psychiatric' regardless of their physical needs and presenting complaint.")

S. Parle, *How does discrimination affect people with mental illness?* 108 NURSING TIMES 28:12-14 (2012).

B. Osumili, *The economic costs of mental health-related discrimination,* 134 ACTA PSYCHIATR. SCAND. Sup. 446, 34 (2016).

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.)

J.E. Tintinalli, et al., *Emergency Medical Evaluation of Psychiatric Patients,* 23 ANN. EMERGENCY MED. 859, 859-62 (1994) (Eighty percent of those "medically cleared" by emergency department for psychiatric hospitalization an illness should have had a physical illness identified.)

R.R. Reeves et al., *Inappropriate Psychiatric Admission of Elderly Patients with Unrecognized Delirium*, 103 SOUTHERN MED. J. 111–15 (2010) (finding patients in psychiatric rather than medical units less likely to undergo full diagnostic assessment).

Roy R. Reeves, *et al., Unrecognized physical illness prompting psychiatric admission*, 22 ANNALS OF CLINICAL PSYCH. 180, 184 (2010), *available at* https://www.aacp.com/pdf%2F0810%2F0810ACP_Reeves.pdf (The vast majority (85%) of inappropriate admissions to psychiatric facilities due to missed physical diagnoses were people who already had a psychiatric diagnoses in their medical records. Researchers concluded physical symptoms of patient with mental-illness history are more likely attributed to psychiatric-illness).

R. Hall, *Physical Illness Manifesting as Psychiatric Disease*, 37 ARCH. GEN. PSYCHIATRY 989 (1980) (Forty-six percent of patients evaluated for study suffered from physical, medical illnesses previously undiagnosed by their physician and which physical, medical illnesses either directly caused or greatly exacerbated their psychiatric symptoms. An additional 34% of patients were found to be suffering from at least one other undiagnosed physical, medical illness requiring treatment though unrelated to their psychiatric symptoms.)

S. Wattenberg, *Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange,* SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, U.S. HEALTH AND HUMAN SERVICES 1, 13, *available at* http://www.samhsa.gov/healthprivacy/docs/ehr-faqs.pdf (describing stricter confidentiality provisions for sharing mental health information, including with other providers, could accommodate exceptional circumstances using a "break the glass" provision whereby physician overrides patient consent requirement to access medical records).

Talya Miron-Shatz, et al., *To Serve and Protect? Electronic Health Records Pose Challenges for Privacy, Autonomy and Person-Centered Medicine,* 1 INT'L. J. PERS. CENTERED MED. 405 (2011) ("…the system needs to secure patients' consent to transfer records or data to a third party, *even if it is another medical caretaker*. One recommendation we adopt from the custodianship approach is that patients should have the ability to control the flow of their clinical data and to grant access to it.")

Reducing Stigma - Peers as Colleagues and Open Notes:

G. Thornicroft, et al., *Evidence for effective interventions to reduce mental-health-related stigma and discrimination*, 387 Lancet 1123 (2016) (Review indicated that social contact most effective intervention in reducing stigma in the short-term.)

S. Knaak, *et al., Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions,* 30 Healthcare Management Forum 111(2017) (With social contact, persons with lived experience of mental illness are seen as educators, not patients. Social contact has been shown to disconfirm stereotypes, heighten empathy, and improve understanding of recovery.)

N. Sartorius, *Iatrogenic stigma of mental illness: Begins with behavior and attitudes of medical professionals, especially psychiatrists,* 324 BMJ 1470 (2002) (Doctors must communicate mental health diagnoses in a careful and restrained manner due to prejudices of healthcare professionals.)

C. Walsh, *Revising the language of addiction*, Harvard Gazette (Aug. 28, 2017) (Terms used to describe person or condition can elicit implicit bias.)

L. Kowalezyk, *Doctors' Notes on Mental Health Shared with Patients,* Boston Globe, April 8, 2014, *available at* http://www.bostonglobe.com/lifestyle/health-wellness/2014/04/07/beth-israel-deaconess-mental-health-providers-share-visit-notes-with-patients/2nVs4SSYCzh2ABleJgbCYK/story.html.

OPEN NOTES, www.myopennotes.org (last visited 12/31/19).

Kahn, *et al., Let's Show Patients Their Mental Health Records,* 311 J. AMER. MED. ASSOC. 1291 (2014).

Fosa, *et al., OpenNotes and share decision making: a growing practice in clinical transparency and how it can support patient-centered care*, 25 J. Am. Med. Info. Assoc. (June 2018) (finding OpenNotes improved patient satisfaction, adherence and medical decision making). Health and Human Services recently published guidelines concerning patient access stating that access may only be denied if it is "reasonably likely to endanger the life or physical safety of the individual or another person." This standard ought to be "narrowly construed."

Health and Human Services, HIPAA Guidance at http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html (last accessed Jan. 21, 2016). ("General concerns" about patients' reactions to data (e.g. they "will not be able to understand the information or may be upset") are insufficient to withhold medical records, as is the "mere possibility" of harm. Access may only be denied if it is "reasonably likely to endanger the life or physical safety of the individual or another person." This standard ought to be "narrowly construed." NOTE: In practice, this standard is not narrowly construed and psychiatric information is regularly withheld from patients.)

T. Esch, *et al., Engaging patients through open notes: an evaluation using mixed methods,* 6 BMJ Open (2016) at https://bmjopen.bmj.com/content/bmjopen/6/1/e010034.full.pdf (last accessed 12/31/19) (fully transparent medical records led to better relationships with doctors, better adherence to treatment, improved self-care, and improved understanding of health information).

S. O'Neill, *et al., Embracing the new age of transparency: mental health patients reading their psychotherapy notes online*, 28 J. Mental Health 527 (2019) (Nearly all survey respondents (94%) agreed having open therapy notes were a good idea and 87% wanted it to continue, reporting that access was very important to self-care, trusting their providers, and feeling in control of their treatment. There were minimal adverse effects.)

R. Cromer, *et al., Online access to Clinical Notes Affects Patients' Trust of Mental Health Clinicians,* 68 Pysch. Serv. 520 (2018) (Accurate documentation of session, respectful notes that documented patient strengths, and lack of diagnoses that clinician had not revealed to patient were key factors in whether access to clinic notes strengthened the therapeutic relationship. NOTE: Requirements that clinicians write notes that are accurate, respectful, and strength-based, and that clinicians do not withhold pertinent information from their clients, effectively change how medical professionals perceive people with psychiatric challenges.)

J. Walker, *et al., OpenNotes After 7 Years: Patient Experiences With Ongoing Access to Their Clinicians' Outpatient Visit Notes*, 21 J. Med. Internet Research (2019) at https://www.jmir.org/2019/5/e13876/ (last accessed 12/31/19) (Of the 20,982 patient respondents, over 72% found it very important for helping take care of their health, over 69% feeling in control of their care and over 65% in remembering the plan of care. Very few were confused (3.3%) or more worried (4.83%) after reading the notes. Hispanic patients, and individuals who usually did not speak English at home, were most likely to report major benefits. Nearly all respondents (98.46%) thought web-based access to visit notes were a good idea. Mental health specialties were included in the provider groups that shared clinical notes.)

Integrating Care – Varied Outcomes and Independent Variables:

R. Capp, *Coordination Program Reduced Acute Care Use and Increased Primary Care Visits Among Frequent Emergency Care Users*, 36 Health Aff. 1705 (2017) (While six-month program reduced emergency department use and increased primary care visits, study excluded persons with serious mental illness and persons with substance use disorder, as well as persons with a psychiatric hospitalization during the previous 180 days. Model of care included up to eight home visits within first 60 days of ED visit or hospital discharge, including a community health worker who interviewed patient to determine patient's goals. Plans are individually tailored and addressed social determinants like housing and transportation. Study did not examine clinical outcomes or patient-reported outcomes, although 70% of graduates agreed to advocate for the program. Hospital use data was from two hospitals and did not account for use of nearby hospitals. Primary care data limited to one federally qualified health center that served more than half of Medicaid and uninsured patients using hospital that referred patients to program.)

Financial burdens on insureds and harm to care:

C. Girod, *et al., The 2018 Milliman Medical Index* (May 2018), http://www.millimanriskadjustment.com/uploadedFiles/insight/Periodicals/mmi/2018-milliman-medical-index.pdf (last accessed 12/31/19) (Employee share of health care costs have grown compared to employer share in nine of the past 10 years.)

eHealth, *Average Individual Health Insurance Premiums Increased 99% Since 2013, the Year Before Obamacare, & Family Premiums Increased 140%, According to eHealth.com Shopping Data* (Jan. 23, 2017) (Excludes shoppers receiving government subsidies under the ACA from November 1 through December 31, 2016. Plans chosen vary from year to year. Authors note that prior to the ACA, plans offered more limited benefits and coverage and were not required to cover pre-existing conditions.)

SAMSHA, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.ppf (Costs or lack of insurance coverage most cited reasons for not receiving mental health treatment (65%)).

G. Shaw, *Studies Rebut Anthem's Retrospective ED Denials*, 41 Emergency Med. News 8 (2019) (Anthem Blue Cross Blue Shield denies coverage for emergency department visits retrospectively classified as nonemergent. Legislator noted denials caused families stress due to potential bills and appeal paperwork. Harvard Pilgrim will require insureds treated at an emergency room for nonemergent conditions to pay a deductible and 50% coinsurance after the deductible is met. Doctors noted that patients do not have perfect information and that these policies require patients to be their own doctors. NOTE: MGL ch. 175 §47u limits the ability of insurers to deny coverage to insured.)

Limited networks and tiering:

The National Council on Disability repeatedly emphasizes the need to protect continuity of care when designing health care systems. http://www.ncd.gov/publications/2013/20130315/20130315Ch3

(last accessed Nov. 16, 2015) (NOTE: Limited networks disrupt the therapeutic alliance when the network or the patient's insurance changes. Limited networks also hamper an individual's ability to find a geographically accessible provider in a timely manner with whom the person can establish a therapeutic relationship. The same is true for tiering when it makes providers unaffordable.)

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).

J. Sharf, et al., *Dropout and Therapeutic Alliance: a Meta-Analysis of Adult Individual Psychotherapy,* 47 Psychotherapy Theory, Research, Practice, Training, 637-645 (2010).

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."; outcomes and patient well-being is considerably enhanced with a better collaborative relationship and goal consensus).

J. Browne, *et al.*, *The relationship between the therapeutic alliance and client variables in individual treatment for schizophrenia spectrum disorders and early psychosis: Narrative review*, 71 Clin. Psych. Rev. 51 (2019)(recovery, less severe symptoms, and better functioning, insight, and social support were all related to better provider/client alliance).

G. Tryon and A. Kane, *The Helping Alliance and Premature Termination,* 3 Counseling Psychology Quarterly 233-238 (1990).

J. Ross and A. Werbart, *Therapist and relationship factors influencing dropout from individual psychotherapy: A literature review*, 23 J. Psych. Research 394 (2013).

R. Kluft, et al., *Treating the Traumatized Patient and Victim of Violence,* in Psychiatric Aspects of Violence: Issues in Prevention and Treatment (2000) ("Continuity of care is an important aspect of long-term treatment, and the object constancy and reliability of the therapist may be one of the most important factors in treatment success.")

R. Capp, *et al.*, *Coordination Program Reduced Acute Care Use and Increased Primary Care Visits Among Frequent Emergency Care Users*, 36 Health Aff. 1705 (2017) (Authors cited continuity of care in the outpatient setting was one of the three reasons for success of the program.)

H. 907/S. 555, *An Act Relative to the Continuity of Care of Mental Health Treatment*, 191st Mass. General Court (2019).

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SAMSHA, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf (Fear of commitment or forced treatment one of the reasons respondents listed for not obtaining mental health treatment.)

National Coalition for Mental Health Recovery, *Enhancing the Effectiveness of Psychiatric Care and Other Services and Supports: Guidelines for Promoting Recovery Through Choice and Alternatives* (April 2011), at http://www.ncmhr.org/press-releases/4.28.11.htm (last accessed 12/31/19)(Supporting choice from a wide array of services and supports, including alternatives to traditional medical options as a means to promote recovery.)

Faulty Foundations for "Evidence-Based" Care, Protocols, and Practice Guidelines:

Andrew Admon, *Appraising the Evidence Supporting Choosing Wisely® Recommendations*, 13 J. Hosp. Med. 688 (2018) (Study showed that only 22% of recommendations relied on primary research, while 7.8% cited case series, review articles, editorials, or lower quality data. The majority of recommendations relied on Clinical Practice guidelines.)

J. Kung, *Failure of clinical practice guidelines to meet institute of medicine standards: two more decades of little, if any, progress,* 172 Arch. Intern. Med. 1628 (2012, correction for competing interests of guidelines on alteplase, BMJ (2013) at https://www.bmj.com/content/346/bmj.f3998) (survey found that 71% of chairs of clinical policy committees and 90.5% of co-chairs had financial conflicts).

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Funding of Alternatives:

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California Health Facilities Financing Authority, *Peer Respite Care Grant Program* (2016), at https://www.treasurer.ca.gov/chffa/imhwa/peer.asp (last accessed 12/31/19).

Wisconsin Department of Health Services, *DHS Awards Grant to Fund New Peer-Run Respite for Veterans* (March 27, 2019), at https://www.dhs.wisconsin.gov/news/releases/032719.htm (last accessed 12/31/19).

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Alternative Modalities of Care:

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D. Fancourt and S. Finn, *What is the evidence on the role of the arts in improving health and well-being?* World Health Organization, Health Evidence Network Synthesis Report 67 (2019) (Referencing over 900 publications, including 200 reviews covering over 3,000 further studies, report concluded that the arts contributed to core determinants of health and to prevention of mental illness and age-related physical decline. Arts also supported the treatment or management of the aforementioned health issues, noncommunicable diseases, neurological disorders, and acute and end-of-life care. Policy recommendations included implementation of art interventions and further research on scaling art interventions to larger populations.)

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Coffey, Kimberly, A., Marilyn Hartman, and Barbara L. Fredrickson. *Deconstructing Mindfulness and Constructing Mental Health: Understanding Mindfulness and its Mechanisms of Action.* 1 Mindfulness 235 (Dec. 2010)

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C. Carr, *The Tyranny of Metric and Weapons of Math Destruction*, 33 MIE J. 18 (Fall 2019) (discussing falsification and manipulation of outcomes to meet metrics; risk of harm to vulnerable populations; effect of underlying criteria of algorithms and metrics on study results and policy; need for representative group of affected people in establishing metrics and evaluating outcomes; potential for "evidence-based" criteria to squelch innovation).

National Coalition for Mental Health Recovery, *NCMHR Policy Priorities and Recommendations, 2018*, at http://www.ncmhr.org/priorities.htm (last accessed 12/31/2019) (Proposing that a majority of all state planning councils members consist of persons with lived mental health and/or substance use experience, and that they meaningfully participate in the allocation of state mental health and substance use funding and grants.)

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S. Guthrie, *et al., What do we know about grant peer review in the health sciences?* (https://doi.org/10.12688/f1000research.11917.2) (2018) (Noting that innovative research, even controlling for proposal quality, is discouraged due to, among other things, lack of preceding work, risk-averse peer reviewers and funders, and elsewhere noting cronyism. One suggested "fix" suggested that innovation could be an assessment criterion.)

Negative Effect of Financial Incentives on Care:

S. Woolhandler,, et. al., *Financial incentives may sap motivation, undermine quality.* Health Affairs Blog. (October 12, 2012). http://www.pnhp.org/news/2012/october/financial-incentives-may-sap-motivation-undermine-quality-health-affairs-article (last accessed October 30, 2013).

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T. Doran, *et al., Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework,* 372 *Lancet* 728 (2008) (Studies of and reports for financial incentives can be manipulated by inaccurate reporting of success and by excluding unfavorable patient populations.)

Y. Shen, *Selection Incentives in a Performance-Based Contracting System*, 38 Health Serv. Research 535 (April 2003) (Warning of unintended provider behavior such as misreporting to make performance look better without actually improving quality.)

K. Grumbach, *et al.*, *Primary Care Physicians' Experience of Financial Incentives In Managed-Care Systems*, 339 N. Engl. J. Med. 1516 (1998) (Fifty-seven percent of the physicians reported that they felt pressure from the managed-care organization to limit referrals (17 percent said they believed such pressure compromised patient care), and 75 percent felt pressure to see more patients per day (24 percent believed such pressure compromised patient care). The physicians who reported that their financial arrangements included an incentive based on referrals were more likely than others to have felt pressure to limit referrals in a manner that compromised care (adjusted odds ratio, 2.5; 95 percent confidence interval, 1.2 to 5.0), and physicians with an incentive based on productivity were more likely to have felt a pressure to see more patients that they believed compromised care.

J.P. Morrissey, *et al.*, *Service Use and Health Status of Persons with Severe Mental Illness in Full-Risk and No-Risk Medicaid Programs*, 53 Pysch. Services 293 (2002) (Patients with serious mental illness in the managed care system with capitated payments suffered poorer mental health and physical health outcomes than those in fee-for-service groups.)

S. Sussman & B. Brennan, *Global capitation at a women's health referral center: the challenge of patient selection*, 96 Obstet. Gynecol. 1018 (2000).

R. McDonald, et al. *Pay for performance in primary care in England and California: comparison of unintended consequences*. 7 Annals of Family Medicine 122 (2009) (leading to avoidance of sicker patients, exacerbation of disparities, and neglect of types of care for which quality is not measured).

A. Ault, *ACOs Failing to Deliver, Says CMS in Issuing Proposed Overhaul,* Medscape (Aug. 10, 2018) at https://www.medscape.com/viewarticle/900551 (last accessed 12/31/19) (CMS proposed more rapid movement of ACOs to a shared-savings-only payment model. The president of the National Association of ACOs responded by saying, "The administration's proposed changes to the ACO program will halt transformation to a higher quality, more affordable, patient-centered health care industry, stunting efforts to improve and coordinate care...."

A. Markovitz, *et al.,* Performance in the Medicare Shared Savings Program After Accounting for Nonrandom Exit: An Instrumental Variable Analysis, 171 Ann. Intern. Med. 27 (2019) (After adjustment for clinicians' nonrandom exit from the program, the Medicare Shared Savings Program was not associated with improvements in spending or quality.)

S. Sivey, *et al.*, *The effect of financial incentives on the quality of health care provided by primary care physicians*, The Cochrane Library 2011, Issue 9 (2011) (Providers ignore disease areas for which quality is not measured, resulting in delayed or missed diagnoses.)

Pay-For-Performance Programs May Worsen Medical Disparities. RAND Corporation News Releases (May 4, 2010), at http://www.rand.org/news/press/2010/05/04.html (RAND

Corporation study reported that pay for performance "could end up widening medical disparities experienced by poorer people and those belonging to racial and ethnic minorities" because physicians under pay for performance programs that serve "vulnerable populations would likely receive lower payments than other practices." Researchers found that when simulating a pay for performance program on primary care physicians in Massachusetts, the average-sized practices serving the highest proportion of vulnerable populations would receive less annually than other practices.)

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Financial Incentives and Formularies

N. Sartorius, *Iatrogenic stigma of mental illness*, 324 BMJ 1470 (2002) ("Governments sometimes support the use of cheaper treatments even when the side effects are profoundly disturbing or painful. Medical practitioners accept such policies….")

A. Hung & E. Perfetto, *What Are the Incentives for Medicare Prescription Drug Plans to Consider Long-Term Outcomes and Cost?*, 22 J. Manag. Care Spec. Pharm. 773 (2016) (Prescription Drug Plans have few quality measures or other incentives to consider long-term outcomes and cost when developing formularies.)

Protocol Development and Application to Formularies

C. Kelly, *et al.*, *Key challenges for delivering clinical impact with artificial intelligence*, 17 BMC Med. 195 (2019) (discussing risks of artificial intelligence, including algorithms that magnify societal biases against already disadvantaged groups).

Matthew K. Wynia & David C. Classen, *Improving Ambulatory Patient Safety: Learning from the Last Decade, Moving Ahead in the Next,* 306 J. AM. MED. ASS'N 2504 (2011) (The American Medical Association report on patient safety in ambulatory care found that health care technology brings risks in addition to purported benefits, including the use of diagnostic support tools that encourage "automatic behavior" rather than careful reasoning and analysis.)

D. Recker, *et al., "Inactive" ingredients in oral medications*, 11 Sci. Translational Med. (2019) at https://stm.sciencemag.org/content/11/483/eaau6753 (last accessed 12/31/19) (a majority of medications contain inactive ingredients that could cause adverse reactions).

Medical Necessity, Denials, and Appeals:

Ellison, *Aetna, Cigna and BCBS hit with fines over improper denials in California*, Beckers Hosp. Rev. (Dec. 23, 2019), at https://www.beckershospitalreview.com/payer-issues/aetna-cigna-and-bcbs-hit-with-fines-over-improper-denials-in-california.html (last accessed 12/31/19) (Insurers contracted with medical group that used company with a special team whose goal was to pressure high-cost enrollees out of medical group.)

G. Shaw, *Studies Rebut Anthem's Retrospective ED Denials*, 41 Emergency Med. News 8 (2019) (Anthem Blue Cross Blue Shield and Harvard Pilgrim deny any or full coverage for emergency department visits retrospectively classified as nonemergent. In one state, Anthem overturned 62% of denied claims and similar results were found in other states.)

H.1723, An Act to Further Define Medical Necessity Determinations, 191st Massachusetts General Court (2019)

S. Worthy, *et al., Now or Never: The Urgent Need for Action against Unfair Coverage Denials for Quality Health Care,* 48 Loy. U. Chi. L.J. 1041 (2016-2017).

The Appendix is a partial list of sources supporting MHLAC's comments and recommendations.