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

This testimony is submitted on behalf of Mental Health Legal Advisors Committee (MHLAC), an agency under the Massachusetts Supreme Judicial Court that provides representation to low-income persons with psychiatric challenges. MHLAC also provides information and advice to any Commonwealth resident, including the legislature, other agencies and commissions on mental health legal matters. MHLAC presented oral testimony at the March 28, 2018 benchmark modification hearing.

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

- Financial incentives to reduce costs often have unintended results and should not be pursued without careful scrutiny and transparency.
- Innovative approaches to health care that are not covered by insurance or included in traditional medical models of care are fundamental to reducing health care costs.
- Health care delivery systems, like integrated care, should not be assumed to be beneficial for all persons or to result in decreased health care expenditures.[1]

[1] D. Cooper, *et al.*, *Association Between Mental Health Staffing Level and Primary Care-Mental Health Integration Level on Provision of Depression Care in Veteran's Affairs Medical Facilities*, 45 Adm. Policy Mental Health 131 (2018)(finding level of integration of primary care and mental health did not significantly affect likelihood of adequate psychotherapy for patients with either new or chronic depression or adequacy of antidepressant treatment); E. Stuart, *et al., Effects of accountable care and*

- The administrative costs of private insurance should be included in the examination of health care cost drivers.

Financial Incentives

Health care costs obviously can be reduced through the denial by insurers of coverage for medically necessary services and by provider refusal to recommend necessary treatment. In the 1990s, health maintenance organizations were faulted for doing just this.[2] Of course, the HPC has no interest in reducing costs by reducing quality of care. For this reason, financial incentives which place providers in the place of insurers by giving them financial incentives to cut care should be carefully scrutinized.[3]

Outcome measurements will not fully address the negative impact of financial incentives.

Unfortunately, most measures of quality, such as hospital readmission rates, are crude.[4] We cannot depend upon commonly-used outcome measurements to guarantee quality of care.

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payment reform on substance use disorder treatment: evidence from the initial 3 years of the alternative quality contract, 112 Addiction 124 (2017)(finding accountable care model did not lead to substantial changes in use of substance use disorder services).

[2] *See, e.g.,* Jacqueline Kosecoff *et al., Prospective Payment System and Impairment at Discharge: The "Quicker-and-Sicker" Story Revisited,* 264 J. AM. MED. ASS'N 1980 (1990). In a study with a sample size of over 10,000 patients, in which the hospitals were paid a fixed amount per patient rather than being reimbursed based on the patient's actual cost of care, the patients were repeatedly discharged sooner and in less stable condition. *Id.* "[O]ne (17%) of six patients was discharged with at least one instability, two (39%) of five patients . . . [had] at least one measure of sickness, and one (24%) of four patients had an abnormal last laboratory [test result]." *Id.* at 1980-81.

[3] *See, e.g.,* B. Kaufman, *et al., Impact of Accountable Care Organizations on Utilization, Care, and Outcomes: A Systematic Review,* Med. Care Research and Rev. 1, 16 (Nov. 2017)("The evidence for the effect of ACOs on care processes and outcomes is mixed....")

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

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

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

> Reducing the amount of money spent on a health service without considering value can lead to false economies and be self-defeating [16]. With a focus on achieving the most value for patients, rather than focusing on cost reduction or efficiency, it is hoped that healthcare professionals, managers, and other stakeholders may be able to work towards a common aim of providing value in healthcare ….[5]

In addition to ignoring the value of particular services to patients, cost effectiveness often excludes **social costs** of not providing particular services. For example, offering only pharmaceutical interventions for mental health problems, especially if those interventions are coercive, fails to recognize patient discomfort surrounding side effects of psychiatric medications. Some portion of persons who are coerced to take medications or believe medication is all that the mental health system offers will avoid any mental health care. Limited recovery options ultimately increase costs of the health care system as well as increase reliance on public programs due to the decreased ability to function in the workplace when people, who might benefit from alternative modes of care, avoid the mental health system because of a lack of choice of treatment options. Limiting recovery options also increases criminal justice costs as scorned behavior results in imprisonment. When the health care system offers supports which are preferred by individuals, health and social costs decrease and outcomes are better[6].

Even quality-related financial incentives can have ironic results. For example, **pay for performance** usually results in some improvement, at least temporarily, in the practices for which payment is made. However, studies show that those items not measured or incentivized often experience a decrease in the quality of care, sometimes resulting in an overall reduction in care quality.[7]

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[5] S. Gentry and P. Badrinath, *Defining Health in the Era of Value-based Care: Lessons from England of Relevance to Other Health Systems*, 9 Cureous 2017 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5383371/ (last accessed 3/8/18).

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

[7] One study of pay for performance with primary care providers in England found that while the payments accelerated improvements in quality for two of the three chronic conditions targeted, the rate of improvement slowed and the quality of those aspects of care not associated with the incentive actually declined. Campbell *et al.*, *Effects of Pay for Performance on the Quality of Primary Care in England*,

Patient Reported Outcome Measures (PROMS) are a move in the right direction, measuring the value of services from the patient perspective.[8] Health outcomes should not be defined just as clinical outcomes or cost-efficiency and should include the holistic well-being of an individual.

> The World Health Organization defines health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'. Improving health includes broader aims, such as tackling the social determinants of health, allowing people the 'freedom to lead lives they have reason to value.'[9]

As discussed below, offering a broader array of services, including those that are innovative and address social determinants of health, are necessary to produce the consumer engagement that will lead to better overall outcomes.

Cost shifting to patients is ineffective and counter-productive.

Shifting costs to consumers are either ineffective in the short-term or counter-productive in the long-term.

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

Increased **co-pays or deductibles** for certain medications and services have been found to result in avoidance of medically necessary care or "non-compliance" with physician recommendations.[10] For instance, some elderly cut their medications in half to make them

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361 New Eng. J. Med. 368 (2009). In addition, pay for performance is often instituted at a point in time where the practice being incentivized is already being adopted without any bonus payment.

[8] S. Gentry and P. Badrinath, *Defining Health in the Era of Value-based Care: Lessons from England of Relevance to Other Health Systems*, 9 Cureous 2017 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5383371/ (last accessed 3/8/18) ("One example of a move toward value-based outcome assessment in the English NHS is Patient Reported Outcome Measures….").

[9] S. Gentry and P. Badrinath, *Defining Health in the Era of Value-based Care: Lessons from England of Relevance to Other Health Systems*, 9 Cureous 2017 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5383371/ (last accessed 3/8/18).

[10] *See*, J. Piette, *et al.*, Cost-Related Medication Underuse Among Chronically Ill Adults, 94 Am. J. Pub. Health 1782 (2004); B. Briesacher, et al., *Patients at Risk for Cost-Related Medication Nonadherence*, 22

last longer. The ultimate result is not higher quality care or even lower cost care, rather it is low-income people ending up in the hospital or with more serious illnesses that require treatment, thus *increasing* morbidity, mortality, and costs.

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

For these reason, presumptions concerning alternative payment modalities and cost shifting must be monitored using more than cost-effectiveness and process measurements. Rather, actual outcomes, using patient-reported outcomes, functional assessments, and social costs, as well as clinical measures, should be tracked.

Innovative Services

Instead of relying upon alternative payment arrangements which are reminiscent of managed care of years gone by or shifting costs to consumers, innovative approaches to healthcare must supplement and replace our limited medical model approach to illness and recovery. We cannot possibly save any substantial amounts on health care by doing the "same old, same old."

This is particularly true with our approach to behavioral health care. A good beginning point to reform health care practices would be to ask the recipients of behavioral health services what services they think are helpful.[11],[12] Everyone's path to recovery is different and one of the key problems with our current health care delivery system is that it fails to address individual preferences and needs.[13]

J. Gen. Intern. Med. 864 (2007) (Up to 32% of elderly take less medication than prescribed to avoid costs). Research has established consistent links between medication nonadherence due to costs and financial burden, and to symptoms of depression and heavy disease burden.)

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

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

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

One example of a service that is low cost and preferred by many patients is peer respite. Peer respite is a safe haven for people experiencing psychiatric crises. It is run by persons who have had psychiatric challenges, i.e., peers. Many people with psychiatric challenges would prefer peer respite over an emergency room or a psychiatric inpatient facility. Although DMH Commissioner Joan Mikula has spoken favorably of peer respites' efficacy, only one peer respite exists in Massachusetts[14] and, as a rule, peer respite is not covered by insurance. This is absurd as peer respite is considerably less expensive than inpatient hospitalization. In studies with a control or comparison group, respite guests were 70% less likely to use inpatient or emergency services and average psychiatric hospital costs were $1,057 for respite users compared with $3,187 for non-users.[15] Investment in and use of peer respite is thus especially pertinent to the reduction of hospital utilization, first on the list of HPC's spending reduction scenarios.[16]

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

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

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

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

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

frequently are able to successfully discontinue medication.[17] Again, despite the abundance of evidence supporting the efficacy of pet therapy and service animals for mental health conditions (see list of studies accompanying this testimony), insurers generally refuse to cover their provision.

"Housing First" is another approach that is under-utilized because it does not fit into the traditional medical model of healthcare.[18] It is based on the premise that the physical and mental health care needs of the homeless cannot be addressed until they are provided a home. Instead of requiring sobriety or compliance with medication to obtain an apartment, the homeless individual is provided a place to live and must only abide by the requirements of any tenant: do not disturb the neighbors and do not destroy the premises. Several cities that have instituted this program have realized significant reductions in overall expenditures, including the cost of housing.[19] Nevertheless, once again, health

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

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

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

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

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

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

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

insurers and provider organizations do not regularly cover, contribute to the funding of, or offer these services.[20]

Peer supports show promise for increasing the quality of care.[21] Another healthcare approach that reduces healthcare expenditures involves use of either peer support or home companions to encourage persons to exercise. We have an obesity epidemic in this country, which results in numerous conditions like diabetes, heart disease, and joint issues. Exercise has been identified as a key component to improving health generally. In fact, exercise is sometimes identified as the most promising approach to dealing with a mental or medical condition. For example, the medication used to treat dementia is extremely expensive and has very modest, if any, success. Exercise, on the other hand, has been shown to improve the cognition of persons with dementia.[22] Yet, at best, most physicians will make a general recommendation to exercise in passing. We know from our own experience or the experience of our loved ones and friends, that a physician recommendation to exercise, without more, will not inspire consistent efforts.[23] Home companions and peer support can help effectuate a recommendation of exercise for persons with cognitive impairments.[24] Home companions and peer support are far less

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

[21] See, e.g., P. Corrigan, *et al., Using Peer Navigators to Address the Integrated Health Care Needs of Homeless African Americans with Serious Mental Illness*, 68 Psych. Serv. 264 (2017)(finding significant impact compared to control group with respect to general health status, psychological experience of physical health, recovery, and quality of life); P. Corrigan, *et al., Using Peer Navigators to Address the Integrated Health Care Needs of Latinos with Serious Mental Illness,* https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201700241 (last accessed 3/8/17); E. Kelly, *et al., Integrating behavioral healthcare for individuals with serious mental illness: A randomized controlled trial of a peer health navigator intervention,* 182 Schizophrenia Research 135 (2017)(finding that, as compared to the control group, patients with peer providers showed a decreased preference for emergency and urgent care, an increased preference for primary care clinics, improved detection of chronic health conditions, and reductions in pain).

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

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

[24] V. van der Wardt, *et al., Adherence support strategies for exercise interventions in people with mild cognitive impairment and dementia: A systematic review*, 7 Prev. Med. Rep. 38 (2017)(reminders and support to overcome exercise barriers among the strategies to promote adherence); *see also*, H. van

expensive over time than hospitalization and treatment for cardiac conditions or problems due to dementia and are clearly less expensive than nursing homes.

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

Health Care Delivery Systems

Some tout evidence-based services, resulting in the disregard of promising practice-based approaches which do not have behind them the same powerful financial interests that can undertake extensive studies. On the other hand, financial incentives and payment reforms are not required to meet the same evidenced-based tests with respect to their efficacy in reducing cost AND improving care.[25]

In addition to the problems with pay-for-performance noted above, integration of physical and mental health services have been promoted without the attention to critical evidence.[26] The healthcare of persons with psychiatric diagnoses does not necessarily improve if a person's mental health and physical health providers share information. This is due to the stigma associated with psychiatric diagnoses and the problem of diagnostic overshadowing, wherein a person's physical symptoms are attributed to mental health issues if the person has a history of mental illness or treatment. Attached is a white paper on this issue entitled "EHR: Healthy for Whom?," which details the impact sharing of physical and mental health information can have on the physical health care provided to persons with psychiatric diagnoses.

Furthermore, the research on delivery systems that show improvements in care or cost savings often cannot attribute the improvements to the delivery model itself. Rather

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Alphen, *et al., Barriers, motivators, and facilitators of physical activity in dementia patients: A systematic review,* 66 Arch. Geron. and Geriatrics 109 (2016).

[25] See, e.g., fn. 1, *supra.*

[26] Studies show very variable results from the integration of mental and physical health care, both in terms of cost savings and quality. In those studies where improvements are seen, the improvements result from the addition of added resources or from other factors not related to integration per se. See, e.g., S. Hetrick, *et al., Integrated (one-stop shop) youth health care: best available evidence and future directions,* https://www.researchgate.net/profile/Alan_Bailey/publication/321169071_Integrated_one-stop_shop_youth_health_care_best_available_evidence_and_future_directions/links/5a139d200f7e9b1e573092ba/Integrated-one-stop-shop-youth-health-care-best-available-evidence-and-future-directions.pdf (2017) (finding a portion of youth showed no benefit or decline in condition and study deficiencies like the lack of a control group or ability to control for services offered, which varied between setting and individual clinicians within settings) (last accessed 3/8/18). For more information, please contact Susan Fendell at Mental Health Legal Advisors Committee.

improvement may be attributable to additional or altered services that have been incorporated and which could be incorporated in other delivery systems without adopting potentially damaging payment incentives.

Administrative costs

The cost of payment systems should be included in evaluating cost drivers, as noted by Dr. Berwick at the March 8, 2017 HPC hearing. The cost of private insurance as compared to a public model is important to investigate,[27] as some estimates of the additional administrative costs of privatized health care run as high as 46%.[28] Other models of health care delivery permit costs reductions without directing these budget cutting efforts at denying care or shifting costs to patients:

> The lessons of Canadian national health insurance are as straightforward as they are neglected. Having a single government-operated insurance plan greatly reduces administrative costs and complexity. It concentrates purchasing power to reduce prices, enables budgetary control over health spending, and guarantees all legal residents, regardless of age, health status, income, or occupation, coverage for core medical services. Canadian Medicare charges patients no copayments or deductibles for hospital or physician services. Controlling medical spending does not, the Canadian experience demonstrates, require cost sharing that deters utilization.[29]

While such a single-payer solution may not be politically viable at this moment in time, it is important that *all* the drivers of health care costs be examined and on public display.[30] This examination is within the purview of the HPC.

Social determinants of health

We can no longer expect to reduce health care costs unless social determinants of health are addressed.[31] As noted in the Massachusetts Health Policy Commission's summary of

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

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

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

[30] An example of a valid investigation that might be undertaken was raised at the March 28 hearing by Rep. Gentile and Commissioner Altman with respect to whether pharmaceutical benefits managers drain money from health care without providing sufficient value.

its 2016 cost trends hearing: "Properly addressing social determinants of health requires investment but has the potential to produce long-term cost savings and increase overall wellness."[32] At the March 28 hearing, Commissioner Sudders suggested that we look to outcomes in other countries. A recent study from Canada found that spending on social determinants of health produces better outcomes than increases in spending on traditional health care.[33]

This requires insurers to cover expenses not within the medical model of care.[34],[35] Given that insurers ultimately will also benefit from reduced health care expenditures, it is reasonable to require them to invest in and cover the costs that will result in these reduced expenditures.

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[31] See, e.g., F. Jacka and M. Reavley, *Prevention of Mental Disorders: evidence, challenges, and opportunities,* 12 BMC Med. 75 (2014).

> "… in the case of mental health, the determinants of poor mental health largely exist outside of the health sector…."
> "…there is a need for governments, other policy makers and business leaders to fully recognize the impact of poverty and social disadvantage, environmental determinants of health and educational and workplace policies on the mental health of the population."

[32]Massachusetts Health Policy Commission, Annual Health Care Cost Trends Hearing, 2016 CTH Executive Summary, at 6. See also, M. Bush, *Addressing the Root Cause: Rising Health Care Costs and and Social Determinants of Health,* 79 N.C. Med. J. 26 (2018). The Commission's report also noted that capitated budgets, which are based on current services that do not include addressing social determinants of health, are a barrier to addressing these cost drivers. *Ibid.* at 11.

[33] D. Dutton, *et al., Effect of provincial spending on social services and health care on health outcomes in Canada: an observational longitudinal study,* 190 Canadian Med. Assoc. J. e66 (Jan. 2018). The findings in this study and n. 33 *infra* are pertinent to Rep. Ultrino's question concerning whether increased spending on health care has resulted in better health outcomes.

[34] While some responsibility lies with the government, e.g. employment protection laws, access to firearms, and progressive taxation policies, responsibility for other social determinants that result in lower mortality rates and better health outcomes in other countries could be part of insurers' responsibility, e.g. promoting physical activity, providing social support through peer services, housing and food support. See, e.g., M. Avendano and I. Kawachi, *Why Do Americans Have Shorter Life Expectancy and Worse Health Than Do People in Other High-Income Countries?,* 35 Ann. Rev. Pub. Health 307 (2014) for social determinants of health that improve outcomes in other countries.

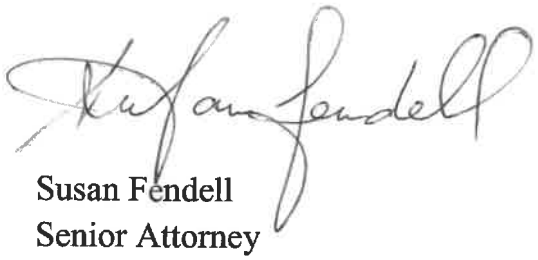
[35] In addition to insurer contributions, "community benefits" payments, as well as payments rendered in the Determination of Need process, which are typically used at present for capital improvements could be redirected to fund the programs and services that address social determinants of health.

Conclusion

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

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

Sincerely,



Susan Fendell
Senior Attorney

Attachments

Electronic Medical Records – Healthy for Whom?

Susan Fendell, Esq.*

Reform of how healthcare is delivered, whether through state or federal initiatives, insurer protocols, or provider action, is proceeding rapidly and with insufficient attention to how it affects the recipients of health care. The motivation for health care reform is primarily to control health care costs, and secondarily to improve quality of care. Policy makers have repeatedly touted the efficacy of electronic health records. Electronic health records may have unintended results which are detrimental to patients, and persons with psychiatric challenges in particular.

Providers are encouraged to adopt electronic medical records by state and federal law, and by private and public insurers.[1] While electronic medical records have some merits, persons with psychiatric challenges have a legitimate concern about their adoption.[2] Persons with psychiatric

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[1] Health Information Technology for Economic and Clinical Health (HITECH) Act, 42 U.S.C. § 13101- 13424 (2012). The HITECH Act of 2009 essentially mandates that physicians and hospitals adopt electronic records by 2014, or face penalties in the form of reduced Medicare/Medicaid payments. *Id.* The Patient Protection and Affordable Care Act also encourages the adoption of electronic health records, partially for research purposes and partially for the delivery of health care services. 42 U.S.C. § 18001 et seq. (2012). Section 108 of Chapter 224 of the Massachusetts Acts of 2012 requires doctors to demonstrate proficiency in electronic health records to be licensed. Act of Aug. 6, 2012, ch. 224, § 108, 2012 Mass. Acts.

[2] *See* 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." *Id.* at 467. Strong verification of this point comes from mental health clinicians themselves; the majority of those surveyed for one recent study said they would not want their own personal psychiatric record included with their general medical record. *See* 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). The Massachusetts legislature was familiar with the social, vocational, familial, legal, physical wellness and psychiatric consequences of the release of similar types of health care information when it barred such disclosures as a matter of law. *See* MASS. GEN. LAWS ch. 111, § 70F (2012) (barring disclosure of HIV/AIDS test results); § 70G (barring disclosure of genetic testing); 105 MASS. CODE REGS. 127.020 (D) (barring disclosure of mammogram reports). The concern of persons with psychiatric diagnoses is not primarily about rampant security breaches, although they do exist. *See, e.g.*, Nicole Perlroth, *Digital Data on Patients Raises Risk of Breaches*, N.Y. TIMES, Dec. 18, 2011 at B2; Patrick Ouellette, *Heartbleed Bug Lessons Learned: Having a Remediation Plan*, HEALTH IT SECURITY (April 28, 2014), http://healthitsecurity.com/2014/04/28/heartbleed-bug-lessons-learned-having-aremediation-plan. *See generally, Breaches Affecting 500 or More Individuals*, U.S. DEP'T. OF HEALTH & HUMAN SERVS., *https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf* (last visited April 7, 2015). Medical records are an

challenges are concerned about electronic health records because electronic health records facilitate the sharing of information, and persons with psychiatric challenges lack control over which of their health care providers may see their psychiatric information.[3] Of course, the more persons with whom information is shared, the greater the likelihood of unauthorized releases of private information. The larger concern, however, is not about these illegal disclosures, but rather about disclosures permitted by state and federal law.[4] The Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule provides insufficient protection of mental health information as it only prevents disclosure of psychotherapy notes without patient consent.[5] The Privacy Rule narrowly defines psychotherapy notes as "notes recorded by a [mental health professional] documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the [patient's] medical record."[6] Thus, the 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

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unusually attractive target of hackers, as they reap more on the Internet black market than other personal information. *See* Dan Tynan, *The Next Data Theft Target: Your Medical Records*, YAHOO! TECH, (Feb. 18, 2014), https://www.yahoo.com/tech/the-next-data-theft-target-yourmedical-records-77113382628.html. The medical records of nearly 30 million Americans have been compromised since 2009. Jeff Goldman, *30 Million Americans Affected by Medical Data Breaches Since 2009*, ESECURITY PLANET (Feb. 17, 2014), http://www.esecurityplanet.com/networksecurity/30-millionamericans-affected-by-medical-data-breaches-since-2009.html.

[3] Wahl, *supra* note 2, at 467. Patients with psychiatric conditions may be concerned about the stigma associated with mental health conditions. *Id.*

[4] *See id.*

[5] *See* 45 C.F.R. §§ 164.102 – 164.106 (2013) (defining security and privacy); 45 C.F.R. §§ 164.500 – 164.532 (2013) (regulating protected information).

[6] *See* 45 C.F.R. § 164.501.

status, treatment plan, symptoms, prognosis, and progress to date.[7]

Most people presume that sharing medical records will enhance quality of care.[8] However, for persons with psychiatric diagnoses, this is often not the case.[9] In fact, due to stigma, providers often give poorer health care to persons whom they know or infer have psychiatric diagnoses.[10] Stigma against persons with psychiatric histories exists in the medical profession. Physicians, psychiatrists, nurses, other mental health professionals, and medical/mental health students are among those who manifest stigmatizing bias.[11] Nurses, according to researchers, can act as

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[7] *See id.*

[8] *See* Nir Menachemi and Taleah H. Collum, *Benefits and Drawbacks of Electronic Health Record Systems*, 4 RISK MGMT. HEALTHCARE POL'Y 47 (2011), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3270933/pdf/rmhp-4-047.pdf.

In general, the impact of health IT is mixed. One study of hospitals found that "health IT does not impact outcomes for patients with mean severity," while health IT "reduces mortality for those pneumonia patients requiring more care coordination and those with greater information management requirements" and those patients with acute myocardial infarction (AMI) whose comorbities require coordination across multiple specialties. No such reduction in mortality was found for other AMI patients. J. McCullough et al., *Health information technology and patient outcomes: the role of information and labor coordination*, 47 RAND J. ECO. 207 (2016). The same article cites five studies between 2010 and 2014 that found no impact of health IT on average hospital quality and one that found a modest decrease in infant mortality when birth certificate records were linked to county-level health IT adoption rates. *Id.* Smaller practices also have inconsistent results in achieving quality measures after the adoption of electronic health records. C. McCullough, et al., Quality Measure Performance in Small Practices Before and After Electronic Health Record Adoption, 3eGEMs (Generating Evidence & Methods to improve patient outcomes) 2015, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4371508/pdf/egems1131.pdf (last accessed Oct. 25, 2016).

[9] *See* Graham Thornicroft et al., *Discrimination in Health Care Against People with Mental Illness,* 19 INT'L REV. PSYCHIATRY 113 (2007). "There is strong evidence that people with a diagnosis of mental illness, for example, have less access to primary health care and also receive inferior care for diabetes and heart attacks.. . ." (*citations omitted*). *Id.* at 118. *See also* M. Heron, et al., *Deaths: Final Data for 2006,* 57 NAT'L VITAL STATISTICS REPORTS (April 2009), *available at* http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf. Life expectancy for people with major mental illness is 56 years while the "average" American life expectancy is 78 years. *Id.*

[10] Thornicroft, *supra* note 9 (discussing discrimination in health care against people with mental illness); 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). Among all physicians who said bias affected treatment, 72% said that emotional problems had a negative effect on treatment. C. Peckham, *Medscape Psychiatry Lifestyle Report 2016: Bias and Burnout 2016*, Slide 7, available at http://www.medscape.com/features/slideshow/lifestyle/2016/psychiatry (last accessed April 13, 2016).

[11] *See generally*, 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*

"stigmatizers" because they believe that individuals with mental health issues are dangerous, weak and to blame information for symptoms.[12] They often do not respect or give credence to patients with psychiatric diagnoses, believing them to be poor historians, unreliable, and uncooperative.[13] Partially as a result of this stigma, persons with psychiatric histories on average die twenty-five years earlier than the general population and sixty percent of those who die prematurely die of preventable or treatable conditions.[14] Cardiovascular disease is the predominant cause of premature death among this population, and many studies have shown that individuals with psychiatric histories tend to receive less care when they present with symptoms of cardiovascular disease.[15]

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); Jeffery, *supra* note 10.

[12] *See generally* 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).

[13] *See id.* The disbelief of patients with psychiatric diagnoses is even more concerning as doctors rely more heavily on clinical decision support systems (CDSS). For instance, a study of Brigham and Women's CDSS found that four errors in the CDSS went undiscovered, one for over a year and one that led to the suggestion of ordering anti-platelet medication for those already taking it. Adam Wright, *et al., Analysis of Clinic Decision Support System Malfunctions: a case series and survey,* J. AM. MED. INFORM. ASSOC. (Oxford Univ. Press 2016).(Of the 29 Chief Information Medical Officers responding to the authors' survey, only two did not report an error in their CDSS in the past year.) A person with a psychiatric diagnosis who objects to taking additional medication recommended by a CDSS is more likely to be ignored than a patient without such a diagnosis.

[14] *See supra* note 9 (discussing life expectancy of individuals with mental illness). *See generally* 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). A study that used the Western Australian Linked Database, found that persons with mental illness have mortality rates that are 2.5 times higher than the general population. David Lawrence & Rebecca Coghlan, *Health Inequalities and the Health Needs of People with Mental Illness*, 131 NSW PUBLIC HEALTH BULLETIN 155 (2002). A more recent 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. Joseph Hayes, *et al., A systematic review and meta-analysis of premature mortality in bipolar affective disorder,* 131 Acta Psych. Scandinavia 417 (2015). The review looked at data from 1935 to 2010 and found that all-cause mortality for persons with bipolar disorder has improved over time. *Id.* at 424.

[15] *See* BARBARA MAUER, NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS. MED. DIRS. COUNCIL, MORBIDITY AND MORTALITY IN PEOPLE WITH SERIOUS MENTAL ILLNESS 4, 6-7, 11-15 (Joe Parks et al. eds. 2006). Sixty percent of premature deaths in persons with serious mental illness are due to "natural causes," the front-runner being cardiovascular disease. *Id.* at 4, 11-15; *see also* Hayes, *supra* note 14 (persons with bipolar disorder have double the risk of death from circulatory illnesses than the general population).

The impact of stigma on the quality of care of persons with psychiatric histories is not limited to cardiac conditions.[16] Clinician bias against persons with mental illness often adversely affects medical. management and leads to poor quality care.[17] In order to learn more about this disparity, Massachusetts' Behavioral Health Task Force held public forums on the topic.[18] Numerous

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These persons face problems such as patient fearfulness, system fragmentation, and significantly, provider stigma, in accessing health care for treatable conditions. MAUER at 6-7. In fact, persons with serious mental illness have lower rates of cardiovascular procedures compared to the general population for these reasons. *Id.* at 7. In one study of patients presenting with chest pain, for example, only 40% of patients with behavioral or mental health diagnosis were referred for coronary angioplasty. *See* Susan Jeffrey, *Psychiatrists Not Immune to Mental Health Bias*, MEDSCAPE (May 21, 2013), http://www.medscape.com/viewarticle/804499#1. In addition, persons with a serious mental illness and a cardiovascular condition receive about half the number of follow-up interventions, such as bypass surgery or cardiac catheterization, following a heart attack than do normal cardiac patients with no serious mental illness. *See* Juliann Garey, *When Doctors Discriminate*, N.Y. TIMES (Aug. 11, 2013), http://www.nytimes.com/2013/08/11/opinion/sunday/when-doctorsdiscriminate.html?pagewanted=all&_r=0. *See also*, C. Woodhead, et al., *Cardiovascular disease treatment among patients with severe mental illness: a data linkage study between primary and secondary care,* BR. J. GEN. PRAC. (June 2016) (Study found a significant shortfall in the prescription of beta blockers and ACE inhibitors or angiotensin receptor blockers for persons with serious mental illness and heart failure/coronary heart disease. The shortfall could not be accounted for by number of visits with doctors.)

[16] *See, e.g.*, MAUER, *supra* note 15, at 24 (explaining diabetics with mental disorders do not receive standard of care diabetic monitoring); Casey A. Boyd et al., *The effect of depression on stage at diagnosis, treatment, and survival in pancreatic adenocarcinoma*, 152 SURGERY 403 (2012) (national, population-based study shows that pre-existing depression in patients with pancreatic cancer is associated with advanced stage at diagnosis, decreased likelihood of receiving adequate treatment, and poor survival). A British study did not find that mental health diagnoses overall resulted in late stage diagnosis of cancer, but nonetheless did find that survival rates were much lower than persons without mental health disorders. The finding of diminished survival rates for persons with psychiatric diagnoses is mirrored in Swedish, Canadian, Australian and United States studies. At least some of the reduction in survival rate is due to fewer interventions, like surgery and chemotherapy. C. Chang, et al., *A cohort study on mental disorders, stage of cancer at diagnosis and subsequent survival,* BMJ Open 2013 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3913023/ last accessed Oct. 25, 2016). The articles, while not providing a definitive conclusion, notes studies in other countries that found later or no diagnosis of cancer for persons with mental health diagnoses: Australia - higher proportion of metastasis at cancer presentation for psychiatric patients than general population, especially breast and lung cancer ; United States – later diagnosis of colon cancer (49.7% vs. 53.3%) or no diagnosis at death (4.4% vs. 1.1%); and United States – history of major depression associated with a delayed diagnosis of breast cancer resulting in an almost ten-fold increased risk. *Id.*

[17] *See* Jeffrey Jackson & Kurt Kroenke, *Difficult Patient Encounters in the Ambulatory Clinic: Clinical Predictors and Outcomes*, 159 ARCH. INTERN. MED. 1069, 1072-73 (1999); Mark Graber et al., *Effect of a Patient's Psychiatric History on Physicians' Estimation of Probability of Disease*, 15 J. GEN. INTERN, MED. 204 (2000); Lawrence, *supra* note 14, at 157. Mental disorder is a predictor of patient encounters being perceived as "difficult" by clinicians, and this perception has negative care consequences. Jackson, *supra*, at 1069, 1072. One survey of 300 family physicians determined that "past psychiatric history influences physicians' estimation of disease presence and willingness to order tests." Graber, *supra*. Recognizing that stigma is one root of the "difficulty" problem, it has been argued that "[i]t is possible that difficulty could be reduced by recognizing and treating mental disorders and by improving physician skills or attitudes toward addressing psychosocial problems or patient's serious illness concerns." Jackson, *supra*, at 1073.

[18] *See* BEHAVIORAL HEALTH INTEGRATION TASK FORCE, REPORT TO THE LEGISLATURE AND THE

persons with psychiatric challenges recounted their inability to get appropriate physical health care because their providers were aware of their psychiatric histories.[19]

Reports from people with psychiatric histories on their experiences with health care providers ranged from ordinary rudeness to refusal to treat serious medical conditions ultimately confirmed as real.[20] In the experience of people with mental health diagnoses, some clinicians incorrectly attribute physical symptoms to psychiatric conditions because they tend to generalize negatively about the capacity of people with mental illness to describe physical symptoms reliably.[21] One article notes people with mental illness:

> reported professionals as being dismissive or assuming that physical presentations were "all in the mind". This can result in reluctance to return for further visits, which can have a detrimental effect on physical health. This is especially significant, as evidence suggests people with mental illness are at greater risk from physical health problems, including cardiovascular disease, diabetes, obesity and respiratory disease. . . .[22]

HEALTH POLICY COMMISSION 69 (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.

[19] *See* BEHAVIORAL HEALTH INTEGRATION TASK FORCE, *supra* note 18, at 82, 85-86 (summarizing comments regarding privacy of mental health electronic medical records).

[20] *See generally* Peter Byrne, *Stigma of Mental Illness and Ways of Diminishing It*, 6 ADVANCES IN PSYCHIATRIC TREATMENT 65 (2000) (stating "[a]ny list of stigmatizers includes.. . health care professionals."). Byrne also notes a study showing that psychiatrists themselves are not immune to prejudice based on a mental health diagnosis, as evidenced by increased value judgments and diagnostic differences once a person had been labeled with a particular mental health diagnosis. *Id.* at 68-69.

[21] *See e.g.,* E. Koranyi, *Morbidity and Rate of Undiagnosed Physical Illnesses in a Psychiatric Clinic Population*, 36 ARCH. GEN. PSYCHIATRY 414-19 (1979). In a study of 2,090 psychiatric patients, 43% suffered from at least one major medical illness, of which, almost half or 46% remained undiagnosed by the referring physician. *Id. See also* Wahl, *supra* note 2. One interviewee commented on her medical school experience: "The treatment of psych patients in all rotations was awful. They would laugh at them, poke fun at them on rounds, disbelieve any physical complaint they had." *Id. See also,* Lawrence, *supra* note 14, at 157 (noting mental health practitioners "may regard complaints of physical illness as psychosomatic.")

[22] *See* S. Parle, *How does discrimination affect people with mental illness?* 108 NURSING TIMES 28:12-14 (2012) (citations omitted). Another study indicates that persons with psychiatric diagnoses who experience discrimination in the health care system may incur higher health care costs, and a reduction over time in health care use and leisure activities that can assist recovery. B. Osumili, *The economic costs of mental health-related discrimination,* 134 ACTA PSYCHIATR. SCAND. Sup. 446, 34 (2016). *See also,*; S. Evans-Lacko, *et al.*, *How much does mental health discrimination cost: valuing experienced discrimination in relation to healthcare care costs and community*

Several studies also demonstrate the prevalence of this failure to appropriately treat persons with mental illness.[23] One study of 1,953 patients reviewed inappropriate admissions to psychiatric facilities where physical diagnoses were missed. The vast majority of patients inappropriately admitted (85%) already had mental illness documented in their medical records.[24] The researchers concluded:

> the results presented here raise concerns as to whether, in some scenarios, patients with a known history of mental illness receive the medical assessment and treatment they need, or if, in some cases, their physical symptoms are misattributed to their mental illness.[25]

Another study confirmed that documentation of a past psychiatric diagnosis contributes to an incorrect diagnosis of delirium, which often is due to such factors as a severe or chronic medical illness, medication, infection, surgery, or drug or alcohol abuse.[26] Veteran's Administration

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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.)

[23] In one study, approximately 80% of persons brought to a psychiatric research ward had physical illness requiring treatment that had been undiagnosed by their physicians, more than half of which either caused or greatly exacerbated these patients' psychiatric conditions. R. Hall, *Physical Illness Manifesting as Psychiatric Disease*, 37 ARCH. GEN. PSYCHIATRY 989-95 (Sept. 1980). One hundred patients were intensively evaluated for the presence of unrecognized medical illnesses that might have affected their hospitalization. *Id.* Forty-six percent of these patients suffered from physical, medical illnesses previously undiagnosed by their physician and which physical, medical illnesses either directly caused or greatly exacerbated their psychiatric symptoms. *Id.* 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. *Id. See also*, 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. *Id. See also* R.R. Reeves et al., *Inappropriate Psychiatric Admission of Elderly Patients with Unrecognized Delirium*, 103 SOUTHERN MEDICAL JOURNAL, 111–15 (2010) (finding patients in psychiatric rather than medical units less likely to undergo full diagnostic assessment).

[24] Roy R. Reeves et al., *Unrecognized physical illness prompting psychiatric admission*, 22 ANNALS OF CLINICAL PSYCHIATRY 180, 184 (2010), *available at* https://www.aacp.com/pdf%2F0810%2F0810ACP_Reeves.pdf (concluding physical symptoms of patient with mental-illness history are more likely attributed to psychiatric-illness).

[25] *Id.*

[26] Yasuhiro Kishi et al., *Delirium: Patient Characteristics that Predict a Missed Diagnosis at Psychiatric Consultation,* 29 GEN. HOSPITAL PSYCHIATRY 442 (2007). Past psychiatric diagnosis and pain contributed to missed diagnosis of

doctors who were presented identical vignettes, the only difference being that one person had stable schizophrenia, were less likely to refer the person with schizophrenia for either weight management or a sleep study, though both were indicated.[27]

Further, undue disclosure of psychiatric information can lead to negative public health consequences, including the avoidance of necessary care[28] and the undermining of research results intended to develop treatment and design best practices.

> Accurate and complete information cannot be obtained by force. We know from the California HealthCare Foundation's National Consumer Health Privacy Survey of November 9, 2005 that 1/8 patients or 12.5% of the population avoids their regular doctor, asks doctors to alter diagnoses, pays privately for a test, or avoids tests altogether. If we do not restore patient control over [protected health information], we can expect electronic health data to have error and omission rates of up to 12.5%. The breakthroughs and benefits possible with technology-enhanced research will never be replaced with such a high rate of errors and omissions.[29,30]

Another concern is that erroneous and stigmatizing information can be rapidly

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delirium in 46% of psychiatric consultations. *Id.*

[27] Dinesh Mittal, *Understanding Provider Decision-Making*, IIR 08-086, U.S. DEP'T OF VETERANS AFF. (2013).

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

[29] *Ensure "Meaningful Use" by Giving Consumers Control*, CONSUMER ACTION (June 2009), http://www.privacy-information.org/articles/ensure_meaningful_use_by_giving_consumers_control_over_their_health_inform.

[30] The fact that a provider uses an electronic records system increases the likelihood that a patient will withhold information, particularly if the patient has a stigmatizing health condition like mental illness. 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).

distributed.[31] Because diagnoses and medications are not protected from other providers, this information may be peppered throughout one's medical records, even when erroneous, outdated, or irrelevant to the presenting issue or particular provider. In addition, state and federal law unfortunately impedes the ability of persons with psychiatric histories to correct errors by permitting providers to limit patient access to certain mental health records.[32]

Electronic medical records do not necessarily improve health care.[33] Because electronic

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[31] P. Hsieh, *Can You Trust What's in Your Electronic Medical Records?* Forbes (Feb. 24, 2014) *available at* http://www.forbes.com/sites/paulhsieh/2014/02/24/electronic-medical-record/ (last accessed April 7, 2015).

[32] *See* 45 C.F.R. § 164.508(a)(2). HIPAA does not provide patients a right to their own psychotherapy notes. *Id.* This is particularly concerning to persons with psychiatric diagnoses as the level of errors in electronic health records is significant. *See* Jordan Robertson, *Digital Health Records' Risks Emerge as Deaths Blamed on System,* BLOOMBERG (June 25, 2013), http://www.bloomberg.com/news/2013-06- 25/digital-health-records-risks-emerge-as-deaths-blamed-on-systems.html (finding doubling of reported electronic medical record errors between 2010 and 2011). *See also* Trevor Bertsch, Letter to the Editor, *Why We Must Keep Track of Errors in Electronic Medical Records,* SCIENTIFIC AMERICAN, Oct. 15, 2013, *available at* http://www.scientificamerican.com/article/why-we-must-keep-track-of-errors-in-electronicmedical-records/ (warning of unintended consequences of electronic medical records). Pennsylvania created a mandatory reporting system for all medical errors in June 2004. This system has uncovered thousands of e-record problems—from misreported laboratory tests to incorrect prescriptions. *Id. See also,* Price *et al., Assessing Accuracy of an Electronic Provincial Medication Repository,* 12 BMC Medical Informatics and Decision Making 42 (2012) (84% of pharmacist collected "best possible" medication histories has at least one error, 48% of which were deemed clinically significant). While some providers participate in pilot projects which electronically share mental health notes with patients, participation of providers is voluntary and mental health providers have the option to lock portions of their notes from patient view. Liz 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. *See also* OPEN NOTES, www.myopennotes.org (last visited April 7, 2015); Kahn, *et al., Let's Show Patients Their Mental Health Records,* 311 J. AMER. MED. ASSOC. 1291 (2014). Giving people greater access to their mental health records has been endorsed on the federal level as well. 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." 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, as is the "mere possibility" of harm. *Id.*

[33] *See* 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, 2505 (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. *Id.* "Drop-down menus of so-called best practices" fail to account for individual characteristics of patients. Milt Freudenheim, *The Ups and of Electronic Medical Records,* N.Y. TIMES, Oct. 9, 2012, at D4 (also noting the problem of cut-and-paste documentation rather than individualized patient notes). A study of the impact of IT on some Texas hospital showed some reduction in mortality, but also noted that "the lack of statistical significance among certain associations may simply indicate that clinical information technology is not a panacea for all disease conditions." R. Amarasingham, *Clinical Information Technologies and Inpatient Outcomes,* 169 ARCH. INTERN. MED. 108, 114 (2009). ALLIANIn fact, increases in the automation of notes and records score were associated with statistically significant increases in the odds of complications for heart failure. *Id. at 113. See also* Neil Chesanow,

medical records often result in the storage of inaccurate, incomplete and outdated information,[34] patients must be able to retain control over providers' access to their mental health information, including psychiatric diagnoses, discharge summaries, psychiatric medication lists and psychiatrist/psychotherapist progress notes.[35] Indeed, given the high number of errors in records, one might question why patient consent to share is problematic, particularly if break-the-glass provisions are in place in emergencies where patient can't respond.[36] In addition, having a

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Doctors Are Talking: EHRs Destroy the Patient Encounter (May 22, 2014), *available at* http://www.medscape.com/viewarticle/825369_3; Sue Bowman, *Impact of Electronic Health Record Systems on Information Integrity: Quality and Safety Implications,* PERSPECTIVES IN HEALTH INFO. MGT. (Fall 2013), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797550/; Hsieh, *supra* note 30 (noting errors and a reduction in time spent with the patient); FOJP Service Corp., *Electronic Health Records: A Status Report,* infocus 1, 5-10 (Summer 2013) *available at* http://fojp.com/sites/default/files/Infocus_Summer2013_EHR.pdf; Ken Terry, *Meaningful Use Not Correlated with Quality*, MEDSCAPE (April 14, 2014), http://www.medscape.com/viewarticle/823602. A study of clinics associated with Brigham & Women's Hospital in Boston found that, among other things, meaningful use of electronic health records resulted in worse treatment for depression. *Id.*

[34] Health information technology and compliance experts contend that electronic medical records are sufficiently subject to error and manipulation that they should not be used as evidence in legal proceedings without verification. B. Drury, *et al.*, *Electronic Health Records Systems: Testing the Limits of Digital Records' Reliability and Trust,* 12 AVE MARIA L. REV. 257-289 (2014).

[35] Alex Nixon, *Errors in Default Settings of Electronic Medical Records Systems Raise Risks for Patients,* PITTSBURGH TRIBUNE-REVIEW, Sept. 6, 2013, *available at* http://triblive.com/business/headlines/4654582- 74/errors-patient-patients#axzz30PH2Zldz (reporting errors in medical records). The Pennsylvania Patient Safety Authority, a state agency that researches health care quality, found more than 300 instances of medication errors at hospitals across Pennsylvania over the last 10 years because computers did not have the correct settings. *Id. See also* James Ritchie, *Report Shows Serious Errors Resulting from Electronic Medical Records,* CINCINNATI BUSINESS JOURNAL, Apr. 8, 2013, *available at* http://www.bizjournals.com/cincinnati/blog/2013/04/report-shows-serious-errors-resulting.html (reporting results of survey). In all, the nonprofit ECRI Institute learned of 171 health care IT mix-ups that led to or could have led to harm at 36 hospitals that volunteered for the study. *Id.* The project lasted just nine weeks. *Id. See also* Richard FitzGerald, *Medication Errors: The Importance of an Accurate Drug History,* 67 BRIT. J. CLINICAL PHARMACOLOGY 671, 673 (2009) (finding inaccuracies in documentation of pharmaceutical histories in general records). A review of recent studies found 10-61% of medication lists were erroneous by omission and 13-22% had errors by commission. *Id.* Physicians and other health care providers must check those lists with patients and pharmacists for accuracy. *Id.* at 673-74. A study of records in the Veterans Health Administration's EHR system found that 84 percent of progress notes contained at least one documentation error, with an average of 7.8 documentation errors per patient. C.R. Weir, et al., *Direct Text Entry in Electronic Progress Notes: An Evaluation ofInput Errors,* 42 METHODS OF INFO. IN MED. 61 (2003).

[36] *See* Sarah W. 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 "break the glass" provision whereby physician overrides patient consent requirement to access medical records). Such exceptional circumstances might include "the emergency room scenario" in which an unconscious patient suddenly arrives. *Id.* Where the patient is unable to communicate and has a condition that puts her life in imminent danger, the principle of patient control over the confidentiality of her medical health records is commonly overridden with a "break the glass" exception. *Id.*

conversation at the outset of treatment that includes consent to obtain mental health information will lead to more trust and open communication between doctor and patient. Patient-centered care requires just such respectful communication.[37] Though doctors may have an ethical duty to disclose patient information to other medical providers in some circumstances, such disclosure should only happen after an informed discussion with the patient regarding his or her preferences and concerns.[38] Happily, today's information technology systems can provide the levels of granularity

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[37] Allowing anyone other than patients themselves to approve disclosure of personal medical records inherently erodes trust. By doing this, the message to patients is, in essence, "other people are going to determine who should be able to see your medical records because they understand what's in your interest better than you do." It is inherently difficult for patients to understand why, if a given disclosure is in their interest, their consent should not be obtained. Not seeking patient consent clearly leads to suspicion that the disclosure is in fact not in the interest of the patient, but rather benefits whoever is deciding that records will be shared.

William A. Yasnoff, *The Health Record Banking Model for Health Information Infrastructure, in* HEALTHCARE INFO. MGT. SYSTEMS: CASES, STRATEGIES, AND SOLUTIONS 336 (C.A. Weaver et al. eds., 2016). *See* Wendy Levinson, et al., *Developing Physician Communication Skills for Patient-Centered Care*, 29 HEALTH AFFAIRS 1310-18 (2010). Patient-centered care is "characterized by continuous healing relationships, shared understanding, emotional support, trust, patient enablement and activation, and informed choices. Communication skills are a fundamental component of this approach to care." *Id.* at 1311.

[38] Patients want to maintain control over which doctors see their sensitive information, even though a majority would share such information with their primary care physician. Kelly Caine & Rima Hanania, *Patients Want Granular Privacy Control Over Health Information in Electronic Medical Records*, 20 J. AM. MED. INFORM. ASSOC. 7 (2013). The American Medical Association recognizes patient reluctance to disclose certain medications and suggests reassuring patients that only other health care providers will be notified of the information. *The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles*, AM. MED. ASS'N, http://bcpsqc.ca/documents/2012/09/AMA-The-physician%E2%80%99s-role-in-MedicationReconciliation.pdf (last visited May 18, 2014). However, for the reasons noted above, it may be precisely these other providers that the patient is concerned about. Person-centered care requires a paradigm shift to a "culture of custodianship" of 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, 407 (2011).

> . . . while health systems hold confidential information about patients, it is not the system's right to use this information as it chooses. Rather, 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.

Id. (emphasis added). *See also Health Record Banking Alliance Fact Sheet* http://www.healthbanking.org/docs/HRBA%20Principles%20&%20Fact%20Sheet%202008%20FINAL.pdf (last accessed Nov. 1, 2016). *But see,* Nicholas Bakalar, *Sharing Psychiatric Records Helps Care*, N.Y. TIMES, Jan. 8, 2013, at D6. The article creates the false impression that record sharing between behavioral and non-behavioral doctors leads to better patient outcomes. *Id.* Review of the underlying report does not support this premise. Among other things, the study, which was based on a very limited sample size, looked at readmissions, which other studies have questioned as a reliable indicator of quality of care. *Id.* Over a 30-day period, the length of stay was virtually identical between those facilities that shared records and those that did not. *Id.* The authors of the study itself state that further research is necessary to come to a definitive conclusion, including an analysis of the participants' race, ethnicity, and income, and that other factors not directly controlled in the study, such as social support and availability

required to segregate psychiatric information from the rest of one's medical record.[39]

Doctors often cite concerns about medication interactions in justifying unrestricted access to medical records.[40] Prescribers therefore want access to their patients' full medication lists. Of course, the utility of these lists is questionable given their error rates.[41] Even if one concedes the need for this information, use of existing databases that flag the possibility of such interactions obviate the need to see the full medication list to check for conflicts.[42] Now, as electronic medical record systems are being modified to accommodate capitated payment programs and associated quality

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of local follow-up care, which may affect readmission rates. *Id.*

[39] MENTAL HEALTH LEGAL ADVISORS COMM., *Consumer Control of Mental Health Information,* 5-6 (Feb. 4, 2013), *available at* http://www.power2u.org/downloads/EHR-Privacy-White-Paper-2.4.13.pdf.

> For our purposes, the term "granularity" means "the extent to which smaller elements of a larger dataset may be retrieved or withheld without accessing other information from an individual record or the larger data set" . . . . The technology already exists to permit varying levels of access to information in electronic medical records. Indivo and Microsoft Health Vault are just a few examples of programs with this capacity.

Id. at 6. "In the past, patients exercised some degree of granularity by just going outside an insurer's network to avoid the stigma of mental illness or the sharing of "embarrassing" test results." *Id.* at 6 n.20. *See*, e.g., Adida, et al., *Indivo X: Developing a Fully Substitutable Personally Controlled Health Record Platform*, AMIA Symposium Proceedings, 9 (2010) http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041305/pdf/amia-2010_sympproc_0006.pdf (last visited May 18, 2014). The symposium paper details various features of the health record platform, including access authorization and ability to customize the application with relative ease. Programs also allow records to be audited to track unauthorized access to behavioral health information. HEALTHVAULT, http://www.microsoft.com/en-us/healthvault/ (last visited May 18, 2014). "It's your HealthVault account. You decide who can see, use, add, and share info, and which health apps have access to it." *Id.* The technical capacity exists to give patients control over which providers see their records. *See, e.g.,* Melissa Chase, *Multi-Authority Attribute Based Encryption*, in THEORY OF CRYPTOGRAPHY 515-534 (Vadhan ed. 2007); Arpana Mahajan & Yask Patel, *Enhancing PHR Services in Cloud Computing: Patient-centric and Fine Grained Data Access Using ABE*, 2 INT'L J. COMPUTER SCI. INFORMATION TECH. & SECURITY 1130 (Dec. 2012). Another option is to create community "health record banks" that are independent organizations that provide a secure electronic repository for storing an individual's medical records from multiple sources and over which the individual has complete control over who accesses what information. William A. Yasnoff, *The Health Record Banking Model for Health Information Infrastructure, in* HEALTHCARE INFO. MGT. SYSTEMS: CASES, STRATEGIES, AND SOLUTIONS 342 (C.A. Weaver et al. eds., 2016).

[40] *See e.g.* Benjamin Grasso, *Reducing Errors in Discharge Medication Lists by Using Personal Digital Assistants,* 53 PSYCHIATR. SERV. 1325 (2002). *See* Nir Menachemi and Taleah H. Collum, *Benefits and Drawbacks of Electronic Health Record Systems,* 4 RISK MGMT. & HEALTHCARE POL'Y 47, 48 (2011) (noting electronic health records can reduce medication errors).

[41] *See supra* notes 32-35 and accompanying text (detailing the likelihood of errors contained in electronic health records).

[42] *See infra* note 42 (showing websites that can be used to check for conflicts).

requirements, is the time to incorporate software that provides a warning message to any provider when she types in the medication she wishes to prescribe or fill. There are many common software programs that can currently check for drug interactions by typing in the patient's name and the medication to be prescribed.[43]

More importantly, a computerized warning would compel the doctor to check in with her patient. That conversation could begin as follows: "I see that there is information here that I am not privy to, and while that is your choice, this is why I feel that I need this information today in order to help you make the best treatment decisions." This would require providers to ask their patients for consent when they feel access to mental health information is necessary for optimal treatment, providing an important opportunity for discussion between the provider and patient – with the provider explaining why consent would benefit the patient and the consumer using the opportunity to express her privacy concerns as they relate to her treatment.

To protect the confidentiality of mental health records, separate signed releases should be required from any health care providers wishing to access a person's mental health information, with few exceptions.[44] Persons with psychiatric histories are all too familiar with the repercussions

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[43] *See, e.g.*, DRUGS.COM, *Drug Interactions*, http://www.drugs.com/drug_interactions.php (last visited May 18, 2014). Walgreens pharmacy also has a database to check for drug interactions that consumers can use on its website. WALGREENS, *Check Drug Interactions,* https://www.walgreens.com/pharmacy/library/checkdrug/selectfirstdrug.jsp (last visited May 18, 2014). More inventive technology exists to check for potential drug interactions and return a warning without accessing a patient's full medical history as well. *See, e.g.*, U.S. Patent No. 8229765 B2 (filed Apr. 23, 2009) (detailing patent for automatically assessing drug interactions while protecting patient privacy).

[44] In Australia, the government has established a personally controlled electronic health record that allows patients to specify who may access their information and specify which documents each provider may see.

> You can control who accesses the information in your My Health Record. Access controls that are available include:
>
> - Setting a record access code (a code you give to your healthcare providers to allow them to view your record, and prevent other healthcare providers from access unless in an emergency)
> - Flagging specific documents in your record as 'limited access', and controlling who can view these documents

of being told that physical ailments are "all in the head," from a diagnosis of anxiety when presenting with the rapid breathing of anaphylactic shock to the fatal diagnosis of depression when presenting with the fatigue of congestive heart. Persons with psychiatric histories and their advocates should be closely involved in developing privacy policies. While we look forward to a day when stigma against persons with psychiatric challenges disappears, just as affirmative action laws were (and are) necessary to combat existing racial and gender discrimination, the physical health of persons with psychiatric challenges must be protected by statutory and regulatory assurances that their psychiatric information will not be shared without their consent.

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rev. November 5, 2016

Authorised representatives and full access nominated representatives also have the ability to change the access controls of your My Health Record. Only your healthcare provider has the ability to upload clinical information into your My Health Record. There is also a section of private notes that is only accessible to you or an authorised or nominated representative.

https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/privacy?OpenDocument&cat=Access%20and%20Invitation%20Codes (last accessed Oct. 25, 2016). Formerly, any document could be hidden, but now, once the patient gives access to a provider, the patient is unable to hide certain documents, including medication lists and a summary of health issues. The patient's only option is to opt-out of the system or deny the provider any access to the record. Review of the Personally Controlled Electronic Health Record, Addendum 2 at 54 (2013).
(2014), available at
https://health.gov.au/internet/main/publishing.nsf/Content/17BF043A41D470A9CA257E13000C9322/$File/FINAL-Review-of-PCEHR-December-2013.pdf (last accessed Oct. 25, 2016).

The Unintended Results of Payment Reform

Susan Fendell, Esq.*

Reform of how healthcare is delivered, whether through state or federal initiatives, insurer protocols, or provider action, is proceeding rapidly and with insufficient attention to how it affects the recipients of health care. The motivation for health care reform is primarily to control health care costs, and secondarily to improve quality of care. Healthcare reform often relies heavily on financial incentives, and policy makers have repeatedly touted the efficacy of electronic health records. Financial incentives and electronic health records produce unintended results that may be detrimental to patients, and persons with psychiatric challenges in particular. This paper examines some of the pitfalls of payment reform and electronic health records.

Financial incentives

Healthcare is moving away from fee-for-service and towards a system of capitation and risk sharing.[1] Experiments with financial incentive systems, such as global capitation, bonus payments, and profit-sharing, are being promoted as a means to decrease the cost of healthcare while increasing the quality of healthcare.[2] Individual providers or provider groups receive financial incentives for: reduction of medication costs, sometimes through the use of formularies or protocols that favor lower cost drugs; reduction of imaging and laboratory services; reduction of frequency or length of services; reduction in the recommendation or authorization of certain other types of

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[1] *See* Robert A. Berenson et al, *US Approaches to Physician Payment: The Deconstruction of Primary Care*, 25 J. GEN. INTERN. MED. 613 (2010) (outlining why fee-for-service reform is needed to support primary care in the patient-centered medical home).

[2] Harold D. Miller, *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform,* The Commonwealth Fund (Sept. 2007).

services; reduction of referrals to specialists; overall reduction in practice/entity costs; increases in the number of patients seen by each clinician (panel size); increase in favorable outcomes; execution of particular processes (pay for performance); and providing lower cost equipment.[3] Accountable Care Organizations (hereinafter "ACOs"), which have garnered much attention in recent years, use many of these financial incentives.[4]

ACOs and other risk-bearing organizations often trill about efficiency, quality and the freedom to innovate allegedly provided by the new payment arrangements.[5] These same proponents fail to address the practical implications of these measures for patients. These financial incentives are questionable with respect to their ability to control costs, allocation of resources, quality of care, adequacy of care, innovation in treatment, access to care, and cherry-picking of patients.[6]

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[3] *See* Lori Melichar, *The Effect of Reimbursement on Medical Decision Making: Do Physicians Alter Treatment in Response to Managed Care Incentive*, 28 J HEALTH ECON 902 (Mar. 28 2009) (stating MCO physicians reducing the number of procedures to patients increase income). Studies show physicians spend less time with their capitated patients than with their non-capitated patients. *See also Lower Costs, Better Care: Reforming Our Health Care Delivery System*, CENTERS FOR MEDICARE & MEDICAID SERVICE (January 30, 2014), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-30-03.html. The Affordable Care Act also aims to end fraudulent attainment of coverage to limit costs of health care for all. *Id. See, e.g.*, Robert Seifert and Rachel Gershon, *Chapter 224 of the Acts of 2012: Implications for MassHealth*, MASS. MEDICAID POL. INST. (Sept 2012). Chapter 224 provides financial incentives for providers to accept MassHealth payment from alternative payment methodologies. *See also* Dennis Domrzalski, *UnitedHealthcare Steps Up its Move Away From Fee-For-Service Model*, BIZJOURNALS.COM (Jul. 10, 2013, 9:34 a.m.), http://www.bizjournals.com/albuquerque/news/2013/07/10/unitedhealthcare-less-fee-for-service.html. UnitedHealthcare announced an increase in bundled payments to providers from $20 billion to $50 billion. *Id.*

[4] Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 Health Affairs 32 (2011) (outlining ACOs and the financial incentives to reduce Medicare Costs).

[5] *More Partnerships between doctors and hospitals strengthen coordinated care for Medicare beneficiaries*, CENTERS FOR MEDICARE & MEDICAID SERVS. (2013), *available at* http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-12-23.html (touting ACO benefits of lower costs and increases in quality and efficiency).

[6] *See infra* note 7 and accompanying text. See L. Page, *Why 'Cherry-Picking' Patients Is Gaining Ground*, Medscape, Dec. 19, 2013.

The primary driver behind payment reform is to lower costs. Although in the short-term these incentives appear to cut costs, in reality unintended health related consequences result in higher expenditures.[7] For example, shorter hospital stays, while less costly up front, are more likely to result in complications, which ultimately are more expensive.[8]

Additionally, many existing health care costs are due to administrative expenses, which are unlikely to be reduced or impacted by these financial incentives.[9] Some provider groups relish the idea of eliminating the administrative cost of dealing with insurance companies. In reality though, many of these financial incentives, such as

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[7] Paul Glasziou, et. al. *When financial incentives do more good than harm: a checklis*t, BMJ (Aug. 14, 2012). The literature indicating the efficacy of financial incentives ignores alternative explanations for the positive results found. *See* Robert Coates, *The New Jersey Gainsharing Experience*, PHYSICIAN EXEC. J. (Jan./Feb. 2014), *available at* http://www.acpe.org/docs/default-source/pej-archives-2014/the-new-jersey-gainsharing-experience.pdf?sfvrsn=4. One article that reported cost savings from gainsharing incentives noted, "Many of the cost-saving measures that we used to succeed in gainsharing were expansions of programs that we had already instituted in an effort to save costs. Therefore it is hard to say to what extent the program, by itself, led to the cost savings." *Id.* Gainsharing programs give doctors a financial incentive to decrease the use of specific medical devices and supplies, switch to specific products that are less expensive, or adopt certain clinical practices or protocols that reduce costs by giving them a portion of any savings attributable to the doctors' activities. W.P. Carey Sch. of Bus., *Gainsharing in Health Care: Cost-Saving Kick Start...or Kickback?*, KNOWWPC (Nov. 23, 2005) *http://knowwpcarey.com/article.cfm?aid=864.*

[8] *See generally*, Sunil Eappen, et. al. *Relationship between occurrence of surgical complications and hospital finances,* 309 J. AM. MED. ASS'N. 1599 (2013).

[9] *See* Palmer Evans, M.D. and Steven Hester, M.D., *Addresses at the Massachusetts Health Care Forum: Accountable Health Care Delivery-Models and Policy Actions for Massachusetts* (Nov. 30, 2010) available at http://masshealthpolicyforum.brandeis.edu/forums/forum-pages/AccountableHealthCareDelivery.html. Such administrative costs included "huge executive salaries, fancy office buildings, and layers of bureaucracy to micro-manage doctors and argue with providers to deny or delay payments." *Id.* There is not much reason to believe that ACOs, run by corporate entities, will behave differently from HMOs. *Id.* Even not-for-profit HMOs exhibited the "arrogance and unaccountability, typical of large insurance companies, towards health care providers and enrollees" *Id.* Running an ACO requires formidable investment in technology and administration to ensure that the ACO remains financially viable. *Id. See also.* Robert Calandra, *The ACO Gamble*, Managed Care (June 2015) available at http://www.managedcaremag.com/archives/2015/6/aco-gamble (average start-up cost for an ACO is $2 million; average operating costs in subsequent years is $1.5 million).

global capitation, may actually increase a provider's administrative costs.[10] Recent evidence suggests that financial incentives are ineffective at limiting health care costs because physicians ignore those that do not provide a hefty enough financial incentive.[11] A survey of studies on doctors given financial incentives to increase preventive care yielded mixed results, leading to the conclusion that the incentives were not large enough to motivate the necessary provision of services.[12] The cost of "effective" financial incentives thus counterbalances any savings that might be achieved.

In addition to lowering costs, financial incentives are purported to increase the quality of care that patients receive, though few studies provide informative findings of explicit links between the quality of care and financial incentives for providers.[13] The

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[10] *See* Samuel H. Zuvekas & Joel W. Cohen, *Paying Physicians by Capitation: Is the Past Now Prologue?* 9 HEALTH AFFAIRS 1661, 1664 (2010) (discussing recent history of capitation and implementation on current payment reform measures). From 1980 to 2007, "[H]MOs may also have abandoned provider capitation because of the administrative complexity of calculating and negotiating capitation rates, and because capitation might not have delivered on its promise of cost containment." *Id. See also Capitation and Risk Contracting Survey*, AM. MED. GRP. ASS'N. 1, 11 (2008), http://amcp.org/WorkArea/DownloadAsset.aspx?id=11758 (last visited May 18, 2014). One survey of providers participating in capitated arrangements found that over half of those providers had a department dedicated to reconciling and administering risk pools and settlements. *Id.* The survey concluded that such risk contracts required "significant investment" in contract administration and oversight. *Id.* at 30.

[11] *See* Lauren A. Petersen et al., *Does Pay-for-Performance Improve the Quality of Health Care?* 145 ANNALS OF INTERNAL MED. 265, 269 (2006) (reviewing studies on outcomes of physician capitation plans). *See* Anthony Scott et al., *The effect of financial incentives on the quality of health care provided by primary care physicians*, 9 COCHRANE COLLECTION 1, 21 (2011) (noting physicians' contracting decisions with health plan may be dependent on existence of financial incentive). The survey review focused exclusively on primary care physicians. *Id.* at 2.

[12] *See* Robert Towns, et al., *Economic Incentives and Physicians' Delivery of Preventive Care: A Systematic Review,* 28 AM. J. OF PREVENTATIVE MED. 234, 234 (2005). Six studies that met the inclusion criteria were identified, which generated eight different findings. *Id.* The literature is sparse. *Id.* Of the eight financial interventions reviewed, only one led to a significantly greater provision of preventive services. *Id.* The lack of a significant relationship does not necessarily imply that financial incentives cannot motivate physicians to provide more preventive care. *Id.*

[13] Petersen, *supra* note 11, at 270. Financial incentives may over or under reward providers. *See Id.* at 269-70. Additionally, the design of the incentive can sometimes cause ambiguity in that the measures do not take into account factors outside the control of the incentivized party. *See, e.g.,* Molly Doyle and Elyse Pegler, *Medicare Advantage Star Ratings: Where Do We Go From Here?*, HEALTH DIALOG (Sept 2010), *available at* http://www.healthdialog.com/Libraries/Research_Documents/Medicare_Advantage_Star_Ratings.sflb.ashx (illustrating that location of the provider as a factor outside the control of the incentivized party). "Success with a measure such as 'Ease of Getting Needed Care and Seeing Specialists' is more challenging for plans

studies that found financial incentives improve quality often ignore data manipulation by providers, who seemingly demonstrate high levels of success through selection bias and choosing participants who best fit the study.[14] Additionally, patients requiring services that fall outside the clinical targets could be adversely affected if practices devote all of their efforts to meeting the goals for the target population.[15]

While the efficacy of many of these financial incentives has been called into question generally, incentives tend to have a greater negative effect on vulnerable populations, and especially on persons with mental illness. The following sections will discuss several financial incentives often implemented to reduce costs and improve

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serving rural and poorer areas with fewer primary care physicians and specialists." *Id.* at *5. G. Flodgren, et al. *An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes.* THE COCHRANE LIBRARY 2011, Issue 7. Art. No.: CD009255. (July 2011) (noting "[w]e found no evidence from reviews that examined the effect of financial incentives on patient outcomes"). For example, quality improvement initiatives were instituted prior to the adoption of the incentive scheme being studied. "Evidence suggests that quality for some aspects of care was already improving before 2004, and could have been approaching its achievable limit in affluent areas, which would mean that the incentive scheme was introduced at a time when inequalities had already peaked." *See* 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 728-736 (2008). The evidence regarding quality improvements is mixed, with some studies showing financial incentives neither lower nor improve quality of care. *See id.*

[14] Doran, *supra* note 13, at 728-736. Providers reporting high levels of achievement create a façade of improvement. *Id.*

> [T]he results assume consistent and accurate recording of activity by practices, which were given a financial incentive to report high levels of achievement. Improvements might have been stimulated by over-reporting numerators –e.g. by claiming a missed target had been achieved – or by under-reporting denominators – e.g. by inappropriately excluding difficult patients or excluding them from disease registers.

Id. At the same time, the performance based contracting system might cause some unintended provider behavior such as misreporting, which could make performance look better without actually improving the treatment quality. Y. Shen, *Selection Incentives in a Performance Based Contracting System*, 38 HEALTH SERV'S RESEARCH 535, 536 (2003). A different study noted that there can be a substantial risk of bias in most studies, because many do not address the issues of selection bias as a result of the ability of primary care physicians to select into or out of the incentive scheme or health plan. 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; 12 (2011).

[15] Doran, *supra* note 13, at 735. "[T]he activities we assessed were mainly concerned with secondary prevention in people,with existing chronic disease, and inequalities could have widened for activities that were not subject to an incentive, especially in practices that were devoting all their efforts to meeting the targets." *Id.*

quality of care and examine the disparately negative impacts of these measures on individuals with psychiatric challenges.

Capitation

Though capitation payment systems have existed since the 1930s, the movement to shift the financial risk to health care clinicians is relatively new.[16] Under traditional fee-for-service, payments are made to providers for each service provided. However, under global capitation, ACOs are paid a flat fee per patient, thus placing financial risk on ACOs and their providers to control costs.[17] The shifting of financial risk of providing care to clinicians is allegedly moderated where the clinician or ACO is responsible for the full range of outpatient and inpatient services.[18] The incentive, however, is to provide just enough care to obviate the need for more costly interventions.[19] Capitation "essentially turns the doctor into an insurance company, often without adequate actuarial spreading of the risk."[20] Therefore, the more treatment the doctor withholds, the more money he or she earns.[21] In terms of the ethical implications

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[16] *See* Mark Hagland, *How Does Your Doctor Get Paid? The Controversy Over Capitation*, PBS FRONTLINE (May 11, 2014), *available at* http://www.pbs.org/wgbh/pages/frontline/shows/doctor/care/capitation.html (discussing the differences and controversies between fee-for-service and capitation payment systems).

[17] *Id.* Bundled payments and global capitation shift the financial risk of providing care to the providers because the providers' income is dependent upon reducing their cost to provide health care below the capitated payment amount. Even ACOs that reimburse some of their providers on a fee-for-service basis are able to limit care with methods formerly used by managed organizations: financial incentives to "gatekeepers," cash bonuses, threat of expulsion from the network, fee "withholds," contract limitations, the delay of authorization for treatment, and utilization review. Russ Herman, et. al., Westlaw Database: 5 Litigating Tort Cases § 62:2, HMO Litigation (last updated August 2013). The author has represented clients whose mental health care providers were subjected to onerous utilization reviews, including requests for records dating back for years, because these providers actively participated in the appeal of denial of service authorization.

[18] *See* Herman, *supra* note 17.

[19] *Id.*

[20] MYRNA C. GOLDSTEIN AND MARK A. GOLDSTEIN, CONTROVERSIES IN THE PRACTICE OF MEDICINE, 125, 2001.

[21] *Id.* Because under a capitation system a doctor is paid a flat monthly payment for each patient they see, that doctor is paid the same for a patient who requires four visits a month and a patient who hasn't been to

of capitation, "large [financial] incentives may create conflicts of interest that can in turn compromise clinical objectivity. It is unethical to do unnecessary procedures to reap financial gain and unethical to limit medical care for financial gain."[22] Financial incentives related directly to performance of processes and outcomes do not effectively address this conflict.[23] Ultimately, the conflict between the provider's and the patient's interests could negatively affect the creation and maintenance of therapeutic alliances and the efficacy of care.[24]

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the doctor in years. *Id.* Thus, there is a positive relationship between the treatment the doctor withholds and the money that doctor makes. *Id.* While stop-loss protection or reinsurance may mitigate some of the danger to providers, including small providers, of assuming financial risk, many may not have it. *Id. See* Peter S. Wehrwein, *Reinsurance and Stop-Loss Coverage: Are You on a Firm Footing?*. MANAGEDCAREMAG.COM, http://www.managedcaremag.com/archives/9802/9802.reinsurance.html (last visited May 18, 2014). "A 1995 [American Medical Association survey] . . . [found] that 86 percent of primary care physicians had no reinsurance on any capitated contract" to limit the physician's financial exposure. *Id.*

[22] Robert Kuttner, *Must Good HMOs Go Bad? – The Search for Checks and Balances*, 338 NEW ENG. J. MED. 1635, 1637-38 (1998).

[23] *See* Carine Chaix-Couturier et al., *Effects of Financial Incentives on Medical Practice: Results from a Systematic Review of the Literature and Methodological Issues*, 12 INT'L J. FOR QUALITY IN HEALTH CARE 133, 136-39 (2000). Studies show that any form of capitation decreases the use of services. *Id.* at 139. For instance, total volume of prescriptions decreased by 0-24% and hospital days decreased by up to 80% under a capitation system compared with fee-for-service. *Id.* at 136-37. Little difference could be found in the outcomes of care, except with respect to elderly and poor patients, whose outcomes were better under fee-for-service. *Id. at 137.* Because financial incentives create a conflict of interest between providers seeking revenue and their patients, quality, productivity, and severity of patient adjustments must be made to financial incentives. However, such adjustments can be difficult to make "and have been shown to result in increased inequities between patients." *Id.* at 139.

[24] *See* LAURA THOMPSON & ROSE MCCABE, BMC PSYCHIATRY, THE EFFECT OF CLINICIAN-PATIENT ALLIANCE AND COMMUNICATION ON TREATMENT ADHERENCE IN MENTAL HEALTH CARE: A SYSTEMATIC REVIEW 5-7 (2012). The therapeutic alliance, a strong clinician-patient relationship, is the best predictor of adherence in mental health treatment and good mental health outcomes. *Id.* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL. POL'Y & L. 661, 680 (1998).

> [While] [m]any . . . regard transfer of financial risk to clinicians as a necessary condition for resource conservation . . . it is hardly clear that the physician's personal remunerative interests should be the main mechanism by which this is achieved. . . . [I]t is equally prudent to avoid incentives that place clinicians at such high personal risk that they must weigh their clinical decisions in terms of their own interests and needs.

Id.

Although capitated payment systems were discredited in the 1980s and 1990s due to their propensity to encourage the denial of medically necessary care, today's ACOs essentially use the same payment methodology.[25] Even with consumer protections, this model has proven problematic as exhibited by similar systems in Europe.[26] The European experiences illustrate the underlying issue with capitation, namely that providers have responded by cutting or reallocating care rather than by controlling care for the purpose of better outcomes.[27]

Specialist services, which are generally more expensive than primary care, are also negatively affected by capitation because doctors in capitated systems feel more pressure to limit referrals, sometimes even compromising patient care.[28] One study that

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[25] Austin Frakt, *Health Care Cost Control is Hard, And Humbling*, KAISER HEALTH NEWS (Nov. 3, 2010), http://www.kaiserhealthnews.org/Columns/2010/November/110310frakt.aspx. *See also* James Roosevelt, Jr., President and Chief Executive Officer, Tufts Health Plan, *Address at Health Law Advocates Law and Policy Forum: The Health Care Cost Containment Law: A first step in controlling costs* (October 18, 2012). As Jim Roosevelt commented, the capitation of today and the capitation of the 1980s and 1990s is the "same thing in essence, hopefully done better." *Id.*

[26] *See* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. OF HEALTH POL., POL'Y & L. 661, 681 (Aug. 1998). In the United Kingdom, for example, capitation has led to "perverse effects" such as "underprovision of many types of valuable services" and the inappropriate shifting of work (and costs) to entities that were not part of the capitated system. *Id.* The author of the article states, "Money is a significant motivator in most realms of activity and we would do well to link financial incentives more directly to our aspirations for quality improvements." *Id.* However, there is no solid research that shows that paying for quality improvements controls the deleterious effects of capitation. Experience with pay for performance is checkered at best. *See* Jeroen N. Struijs & Caroline A. Baan, *Integrating Care through Bundled Payments – Lessons Learned from the Netherlands*, 364 N. ENGL. J. MED. 990, 990-991 (2011) *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1011849. Additionally, from 2007 to 2010, the Dutch system experienced extreme price variations in the amount that capitated care groups were reimbursed for diabetes care bundles. *Id.* This persistence in price variations indicated that insurers were interpreting the Dutch Diabetes Federation Health Care Standard guidelines in ways "to stint in order to contain costs." *Id.*

[27] *See supra* note 26.

[28] *See generally* D. Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 155-197 (1996). A Canadian study of fee-for-service and capitated primary care physicians found fewer referrals to specialists and imaging by the fee-for-service PCPs. Clare Liddy et al., *What is the Impact of Primary Care Model Type On Specialist Referral Rates? A Cross-Sectional Study*,15:22 BMC FAMILY PRACTICE 1, 1-8 (2014), *available at* http://www.biomedcentral.com/1471-2296/15/22. As a result, physicians will keep the patient within their limited knowledge of care and delay the patient from receiving necessary and specialized treatment. *See* E. Pelligrino, *Rationing Health Care: The Ethics of Medical Gatekeeping* 2 J. CONTEMP. H. L. & POL'Y 23, 31 (1986), *available at* http://heinonline.org/HOL/Page?handle=hein.journals/jchlp2&div=6&g_sent=1&collection=journals#37.

examined the practice behavior of primary care physicians indicates that the number of referrals to specialists decreased by eight percent in a physician group under a capitated payment system.[29] Another experiment concluded that physicians choose significantly fewer services under capitation than under fee-for-service.[30] Generally, under capitation systems, doctors discharge patients from the hospital post-surgery "quicker and sicker."[31]

In the case of persons with mental illness, the goal is to prevent hospitalization or acute residential care.[32] However, for this population in particular, avoiding hospitalization, while an admirable goal if appropriately pursued, does not necessarily equate to total wellness. Delayed or denied services or tests may simply result in a longer period of physical or emotional pain and discomfort, but not a worsening of the medical condition itself. A study of six Ohio mental health centers shows a negative correlation between capitation, or capitation-like financing mechanisms, and outcomes for severely mentally ill patients.[33] Outcomes for patients under the capitated system were worse than

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For example, an internist might not consult a cardiologist about a patient with coronary artery disease quickly enough, resulting in exacerbation of the coronary artery disease because of the delay in consultation. *See id.*

[29] T. Godsen, et al., *Capitation, Salary, Fee-For-Service and Mixed Systems of Payment: Effects on the Behavior of Primary Care Physicians (Review)*, COCHRANE DATABASE SYST. REV. (2006). "To date, capitated systems [principally capitated primary care practices] have achieved savings largely by blocking specialist referrals and hospital admissions altogether." Kuttner, *supra* note 22 at 1559.

[30] H. Hennig-Schmidt, R. Selton, & D. Wieson, *How Payment Systems Affect Physicians' Provision Behaviour--An Experimental Investigation,* 30 J. HEALTH ECON. 637 (2011).

[31] *See* Jacqueline Kosecoff et al., *Prospective Payment System and Impairment at Discharge: The "Quicker-and-Sicker" Story Revisited.* 264 J. AM. MED. ASS'N. 1980, 1980 (1990). In a study with a sample size of over 10,000 patients, in which the hospitals were paid a fixed amount per patient rather than being reimbursed based on the patient's actual cost of care, the patients were repeatedly discharged sooner and in less stable condition. *Id.* "[O]ne (17%) of six patients was discharged with at least one instability, two (39%) of five patients . . . [had] at least one measure of sickness, and one (24%) of four patients had an abnormal last laboratory [test result]." *Id.* at 1980-81.

[32] Charles A. Kiesler, *Noninstitutionalization as Potential Public Policy for Mental Patients*, 37 AM. PSYCHOLOGIST 349, 349 (1982).

[33] The study compared a Case Rate Pilot (CRP) group financed by capitation, with a fee-for-service (FFS) group. *See* Mina Chang, et. al., *The Impact of Managed Care: Comparison of Case Rate and Fee-for-Service Financing for Persons With Severe Mental Illness,* MEDSCAPE (2003), *available at* http://www.medscape.com/viewarticle/466934_2.

those within the fee-for-service group. Any improvements observed were only significant for patients in the FFS group. Once the capitated group was discontinued, treatment outcomes for severely mentally ill patients showed improvement.[34] Another study had similar results when the health status outcomes of persons with severe mental illness in managed care organizations financed through capitation and no-risk fee-for-service were compared.[35] These discrepancies are likely attributable to the financial risk capitation imposes on providers, which eliminates incentives for providers to promote preventive services.[36]

In addition, capitation and similar financial incentives can also actually impede the adoption of quality improvements. For example, increasing the use of peer-run mental health alternatives/services or expanding the definition of medically necessary services to include work and supportive services will improve the quality of care. ACOs may be fearful of adopting innovative peer services until they are the routine standard of care and definitively proven to reduce cost.[37] Some criticize ACOs generally for restricting innovation in medicine by limiting entrepreneurial ventures.[38]

Global capitation incentivizes higher patient caseloads, and as caseloads increase, the time that clinicians spend with their patients is reduced.[39] The incentives inherent in

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[34] *Id.*

[35] 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 PSYCHIATRIC SERVICES 293, 293-98 (2002).

[36] *See Capitation*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options/capitation.page (last visited May 18, 2014) (explaining physicians' assumption of risk in using capitation versus fee-for-service).

[37] Scott Gottlieb, *Accountable Care Organizations: The End of Innovation in Medicine?* AM. ENTER. INST. FOR PUB. POLICY RESEARCH, Health Policy Outlook No. 3 (Feb. 2011), *available at* http://www.aei.org/files/2011/02/16/HPO-2011-03-g.pdf.

[38] *Id.*

[39] *See* AM. MED. ASS'N *supra* note 36 (defining capitation). Under global capitation, physicians are paid on a per patient basis. *See* Hagland, *supra* note 16 (defining and comparing global capitation with other

prepaid plans undoubtedly result in a reduction of time spent with the patient.[40] Additionally, providers are encouraged to schedule patients for returning appointments at extensive intervals, which further delays the patient's care.[41]

The caseload and time impact of incentives is particularly severe for persons with behavioral health issues.[42] For example, under revisions imposed by Massachusetts Medicaid's capitated mental health manager, the time allotted for a standard medical

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physician payment methods). One of the key factors in misdiagnosis and hence malpractice claims is a failure of communication. Hardeep Singh & Saul N. Weingart, *Diagnostic Errors In Ambulatory Care: dimensions and preventive strategies*, 14 ADVANCES IN HEALTH SCI. EDUC. 57–61 (2009) (listing "provider-patient encounter" as first "dimension[] of ambulatory care from which errors may arise"). The time pressures under which clinicians operate in ambulatory settings contribute to this communication issue because of the brevity of a physician-patient encounter in an ambulatory setting. *Id.* In a study that compared high-volume and low-volume physicians, "high-volume physicians had visits that were 30% shorter." S.J. Zyzanski et al., *Trade-offs in High Volume Primary Care Practice*, 46 J. FAM. PRAC. 397-02 (1998). In another study, researchers who analyzed 46,320 doctor-patient visits found that shorter visits are associated with capitation, even after controlling for HMO enrollment status, race, and location. H. Balkrishnan et al., *Capitation Payment, Length of Visit, and Preventive Services*, 8 AM. J. OF MANAGED CARE 332-40 (2002). *See also,* Estella M. Geraghty et al., *Primary Care Visit Length, Quality, and Satisfaction for Standardized Patients with Depression*, 22(12) J. GEN. INTERNAL MED.1641–47 (2007). (practicing in an HMO was one key factor in shorter visits). If high caseloads are the norm, there is a potential for delays in care. *See* Zyznski, *supra* (highlighting relationship between high caseloads and accompanying risk of lower-quality care). If a person must go out-of-network, that diminishes an ACO's controls over cost, which is its primary function. *See* Gottlieb, *supra* note 37 (discussing ACOs in the context of the Patient Protection and Affordable Care Act).

[40] K.B. Wells et al., *Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-For-Service Care*, 262 J. AM. MED. ASS'N 3298 (1989) (explaining that "[prepayment] care [patients] . . . were . . . less likely to have depression detected . . . than . . . fee-for-service [patients]."). *See also* Lori Melichar, *The Effect of Reimbursement on Medical Decision Making: Do Physicians Alter Treatment In Response to a Managed Care Incentive*, 28 J. HEATH ECON. 902 (2009).

[41] D. Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155 (1996). Doctors "may schedule return appointments at intervals between appointments that are too long." *Id.* at 161. Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 30 (1986) (noting "negative and positive financial incentives" force a physician to "conserve . . . referrals for consultation"). Not surprisingly, high caseloads and the concomitant lack of time to adequately provide services affects quality of care and outcomes. Frank Davidoff, *Time,* 127 ANNALS INTERNAL MED. 483, 483 (1997). Davidoff reports "41% of physicians . . . reported that the amount of time they spent with their patients . . . decreased." *Id.*

[42] Shorter visits with doctors directly affects patients' health. Davidoff, *supra* note 41 at 483. In one study, high-volume doctors had lower up-to-date rates of preventive services, and scheduled one third fewer patients for well care. Zyzanski, *supra* note 39. One study found that drug treatment programs with a lower ratio of counselors to clients are associated with better drug use and crime outcomes. Michael L. Prendergast et al., *Program Factors and Treatment Outcomes in Drug Dependence Treatment*, 35 SUBSTANCE USE & MISUSE, 1931, 1958 (2000). In yet another study, researchers linked shorter visits to lower rates of detection of depressive disorders. Wells, *supra* note 40.

management visit was reduced from 30 minutes to 15 minutes.[43] In this quarter hour, Medicaid recipients must report their current mental health status, including reactions to current medications and personal factors that might be affecting their health.[44] They also must receive information about new medication, how to administer it and potential side effects.[45] This obviously leaves little time for questions or for the patient and provider to develop the sort of relationship that is so important for the successful treatment of persons with psychiatric challenges.[46]

In a capitated system, where prices for an episode of care are fixed or where a provider group is responsible the individual's total care, providers can hold down expenses by "creaming" or "cherry-picking" patients with less severe diseases that require low-cost treatment over "high-cost" patients, in order to contain treatment costs and increase profits.[47] Not only does capitation run the risk of compromising patient care, but it can lead to a denial of access to care because of provider incentive for pre-selection.[48] The impact of this "cherry-picking" can be especially severe for persons with long-standing, severe mental illness whose treatment requirements are often complicated and long-term.

Shared Savings

[43] Mental Health Legal Advisors Comm., *Consumer Control of Mental Health Information,* 6 (Feb. 4, 2013), *available at* http://www.power2u.org/downloads/EHR-Privacy-White-Paper-2.4.13.pdf.
[44] *Id.*
[45] *Id.*
[46] M.W.J. Doherty et al., *Levels of Physician Involvement Psychosocial Concerns of Individual Patients: A Developmental Model*, 25 FAM. MED. 337, 337-42 (1993)(explaining practitioners' involvement with patients' psychosocial concerns increased with length of visit).
[47] Chang, *supra* note 33.
[48] *Id.*

Shared savings, an example of an incentive used to cut health care costs, is meant to ensure greater accountability by providers in the delivery of care.[49] With this type of incentive, providers receive a percentage of the costs saved by reducing services, labs, and referrals, utilizing cheaper medical devices, and limiting the doctor's choices for certain clinical products.[50] This type of arrangement most commonly occurs when a target is set for spending and cost savings or overruns relative to the target are shared between the parties, e.g., physician groups and ACOs or managed care organizations and physicians.[51] Shared savings, however, inadvertently threaten a patient's quality of care. In passing the civil monetary penalties statute for health care fraud and abuse, Congress recognized that providing incentives to reduce care was unethical and could lead to reduced quality of care.[52]

Shared-savings incentives may have a plethora of other unintended results, such as encouraging providers to refer patients to low-cost hospitals to receive a percent of the savings or bonuses.[53] These hospitals may or may not be proficient in the care the individual needs. Similarly, less expensive medical devices and services, which frequently are less effective or appropriate for the individual, are used in place of more

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[49] Gail R. Wilensky et al., *Gain Sharing: A Good Concept Getting a Bad Name?*, 26 HEALTH AFFAIRS 58, 58-67 (Dec. 5, 2006), *available at* http://content.healthaffairs.org/content/26/1/w58.full. *But see.* W.P. Carey Sch. of Bus., *supra* note 7.

[50] See *Gainsharing,* MED. DEVICE MANUFACTURERS ASS'N., ,www.medicaldevices.org/?page=gainsharing&terms="gainsharing" (last visited May 18, 2014).

[51] *See* David Muhlestein, *Continued Growth of Private and Public Accountable Care Organizations*, HEALTH AFFAIRS (Feb. 19, 2013), http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/.

[52] *See The Ethics of Health Care Reform: Issues in Emergency-Medicine-An Information Paper*, AM. COLL. OF EMERGENCY PHYSICIANS, http://www.acep.org/Content.aspx?id=80871 (Last visited May 15, 2014) (explaining ethical implications of several provisions of the Patient Protection and Affordable Care Act).

[53] Katherine Ho and Ariel Pakes, *Do Physician Incentives Affect Hospital Choice? A Progress Report*, (Nov. 2010), *available at* http://kebijakankesehatanindonesia.net/sites/default/files/Makalah%20Katherine%20Ho.pdf.

expensive medical devices.[54] Doctors have also often reported feeling that quality of care is comprised due to these incentive systems.[55]

The problem of ineffective low-cost substitutes is especially notable for persons with psychiatric challenges, whose complaints of inefficacy and pain are frequently attributed to their diagnoses. The generic drug Budeprion XL, prescribed in place of the anti-depressant Wellbutrin, provides an apt example of the disparate effect low-cost substitutes can have on individuals with mental illness. The generic, approved by the FDA in 2006, was plagued by complaints. Patients stated that it was not as effective as the name brand, but the FDA ignored those complaints, likely attributing them to the normal ups and downs of depression.[56] It was not until October of 2012, six years after

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[54] *Hearing on Gainsharing*, Subcommittee on Health, Committee on Ways and Means, U.S. House of Rep. at 66-68, (Oct. 7, 2005), *available at* www.gpo.gov/fdsys/pkg/CHRG-109hhrg26377/html/CHRG-109hhg26377.htm (hereinafter "*Hearing on Gainsharing*"). The Medical Device Manufacturers Association testified that gain sharing promotes higher incidents of medical complications, re-admittance into the hospital, follow-up surgeries, and malpractice liability. *Id.* Thirteen other groups, including the National Mental Health Association and the American Association of People with Disabilities also announced their opposition to gain sharing. *Device Industry Opposes Medical Gainsharing at Hearing*, HCPRO (Oct. 10, 2005), *available at* http://www.hcpro.com/HOM-52204-3587/Device-industry-opposes-medical-gainsharing-at-hearing.html. At the hearing, Congressman Pete Stark commented as follows:

> I recall 20 years ago in this Subcommittee we examined this gain sharing. We called it "kickbacks" in those days. We decided that wasn't such a good idea, to encourage profit sharing at the expense of beneficiaries, taxpayers, because they suffered. When the hospital prospective payment system was implemented, hospitals began enlisting physicians through incentive plans to help contain costs. But this created inducements for the docs to withhold care or create early discharge. We enacted new penalties in Title 9 of the Social Security Act. Bluntly stated, what we are going to talk about today is whether to turn back time [and] allow kickbacks, which will benefit nobody but either the doctor or the hospital, but saves money. The taxpayers, the beneficiaries will suffer.

Hearing on Gainsharing, supra at 5.

[55] Kevin Grumbach, et al., *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516, 1516 (1998) (finding 17 percent of doctors believed the pressure of incentive systems compromised patient care).

[56] *See In re* Budeprion XL Mktg. & Sales Litig., E.D. Pa., No. MDL 2107, 2010 WL 2135625. In 2009 and 2010 a series of class action complaints were brought regarding the efficacy and side effects of Budeprion XL. These cases were consolidated and heard in the Eastern District of Pennsylvania. *Id. See also* Meghan M. Grady & Stephen M. Stahl, *A Horse of a Different Color: How Formulation Influences Medication Effects*, 17 CNS SPECTRUMS 63 (2012), *available at*

the introduction of this generic on the market, that the FDA conceded the drug was not the bioequivalent of its name brand.[57]

Performance Incentives (Pay-for-Performance)

Performance incentives, or "Pay-for-Performance," provides higher payments for the execution of certain procedures or achievement of certain outcomes, but are often problematic because of their effect on outcomes or processes that are not incentivized.[58]

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http://onlinedigeditions.com/article/A+Horse+Of+A+Different+Color%3A+How+Formulation+Infl+Uences+Medication+Effects/1120847/119216/article.html. Generic drugs do not always have the same properties as the name brand. *Id.*

[57] *Questions and Answers Regarding Market Withdrawal of Budeprion XL 300 mg Manufactured by Impax and Marketed by Teva*; U.S. FOOD & DRUG ADMIN., http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm322160.htm#q1 (last visited May 18, 2014). The FDA acknowledged that two of the generic substitutions for brand-name extended release methylphenidate (Concerta), used to treat attention deficit disorder, were not necessarily bio-equivalents and could not be automatically substituted for the brand name drug be pharmacies. These generics had been approved 2012 and 2013 as automatic substitutes for Concerta. The FDA altered its position in November 2014. (http://www.fda.gov/Drugs/DrugSafety/ucm422569.htm , last accessed March 24, 2016); Katie Thomas, *Generic Drug, Found Flaw, Still in Use*, NYT (June 17, 2015), at B1. The plaintiffs in a class action lawsuit against a pharmacy that distributed the generics alleges that consumer complaints to the FDA about the effectiveness of the generics began shortly after they were approved by the FDA. http://cookcountyrecord.com/stories/510649346-class-action-alleges-osco-drug-knew-generic-adhd-drugs-they-were-distributing-were-less-effective-than-brand-name-version (last visited March 24, 2016).

[58] *See* Stephen J. Gillam, et al., *Pay-for-Performance in the United Kingdom: Impact of the Quality and Outcomes Framework: A Systematic Review*, 10 ANN FAM MED. 461, 463 (2012). A recent study found that achievement for conditions outside the incentive worsened relative to those within, and that the person-centered nature of the care and continuity of care generally suffered. *Id.* For example, under the PPACA, Medicare pays Medicare Advantage plans differentially based on performance measures derived from CMS administrative data, HEDIS measured data provided by plans, and beneficiary surveys. *See* Robert A. Berenson, et al., *Achieving the Potential of Health Care Performance Measures*, TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES at 6, (May 2012) *available at* http://www.urban.org/UploadedPDF/412823-Achieving-the-Potential-of-Health-Care-Performance-Measures.pdf.

> [While the measures are broad] there are gaps in important areas of health plan performance, such as the health plan's performance related to patients with acute, serious health care problems (which are obviously common in the Medicare population). For example, none of the measures relate to whether patients are informed about the advisability of referral outside of the MA plan's provider network for patients with unique clinical circumstances, such as particular cancers best cared for in a specialized cancer center.

When reimbursement requires identification of specific diagnoses, providers become too focused on identifying these conditions and ignore other disease areas for which quality is not measured. This process could result in a delayed or missed diagnosis of a disease that could have been prevented or treated earlier.[59]

In the short-run, targeted outcomes like prescribing aspirin for cardiac patients may superficially improve care, but long-term overall quality of care may be negatively affected.[60] One frightening study demonstrated 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."[61]

Id. See also Health Policy Brief: Pay-for-Performance, HEALTH AFFAIRS (Oct. 11, 2012), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78 (describing limited effect of pay-for-performance on quality improvements and concerns about its use).

[59] Sivey, *supra* note 14.

[60] Pay for performance systems are flawed because there is "no consensus about the best way to design a pay for performance program." Melony E. Sorbero, et al., *Assessment of Pay for Performance Options for Medicare Physician Services: Final Report*, RAND CORPORATION, xiv (May 2006), *available at* http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR391.pdf. *See also* R.W. Bremer et al., *Pay for Performance in Behavioral Health,* 59 PSYCHIATRIC SERV. 1419, 1427 (December 2008). One study of pay for performance with primary care providers in England found that while the payments accelerated improvements in quality for two of the three chronic conditions targeted, the rate of improvement slowed and the quality of those aspects of care not associated with the incentive actually declined. Campbell et al., *Effects of Pay for Performance on the Quality of Primary Care in England*, 361 New Eng. J. Med. 368 (2009). A RAND corporation literature review found that no literature on pay for performance programs provide a "reliable basis for anticipating [its] effects . . . in Medicare [on] . . . directing financial incentives for health care quality at physicians, physician groups, and/or physician practice sites." Sorbero et al., *supra*. Few studies provide informative findings of explicit links between the quality of care and financial incentives for providers. Petersen, supra note 11, at 270. Some studies were not rigorous enough to draw definitive conclusions from because they were not generalizable, too short in duration, lacked control groups, or had too small of a sample size. R. Adams Dudley, *Pay for Performance Research: How to Learn What Clinicians and Policy Makers Need to Know*, 294 J. AM. MED. ASS'N. 1821-23 (2005).

[61] *Pay-For-Performance Programs May Worsen Medical Disparities in Medical Care*, RAND CORPORATION (May 4, 2010), http://www.rand.org/news/press/2010/05/04.html (News Release). Researchers found that when simulating a pay for performance program on primary care physicians in Massachusetts, the "average-sized physician practices serving the highest proportion of vulnerable populations would receive about $7,100 less annually than other practices." *Id.* "That difference could be even larger if greater amounts of money are put at stake in future pay-for-performance programs." *Id.*

As with capitation, pay-for-performance creates an incentive to cherry-pick patients. In a performance-based system, funding is dependent on the overall performance of the provider or provider group for the year, and a set of clear indicators are used to measure the performance of the providers.[62] As a result, doctors screen and select less severely ill patients, which adversely affects patients with more serious diagnoses.[63] This "cherry-picking" obviously hurts the elderly and the chronically ill, but it also hurts the poor because certain cost drivers like readmission rates are related to socio-economic status.[64] Because persons with psychiatric challenges are more likely to be poor, cherry-picking further affects this patient population.[65]

Based on "effectiveness," "efficiency," and "special population standards," providers in one study measured their overall performance with outcome measures such as clients remaining drug free thirty days prior to termination, remaining free from arrest, maintaining employment, reducing absenteeism on the job and reducing the number of

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[62] Jeffrey S. Berns, M.D., *P-4-P and Dialysis Centers: A Look Beyond URR*, (Jan. 30, 2012), *available at* http://www.medscape.com/viewarticle/757433. Harvard public health professor Ashish Jha thinks too much time is spent on quality measures "just because they can be measured, not because they're necessarily the right metrics." Dan Gorenstein, *Paying doctors for value instead of volume*, MARKETPLACE HEALTH CARE (Feb. 25, 2014), http://www.marketplace.org/topics/health-care/paying-doctors-value-instead-volume. "If you have a patient who comes in with pneumonia, yes, you want to make sure that patient doesn't die, but one of the most important things is that patient can go back to work, play with their families and lead a meaningful life. Well, how do you measure all of that? That takes work," Jha says. *Id.*

[63] Berns, *supra* note 62 *citing* N. Tangri et al., *Both Patient and Facility Contribute to Achieving the Centers for Medicare and Medicaid Services' Pay-for-Performance Target for Dialysis Adequacy,* 22 J. AM. SOC. NEPHROL. 2296-2302 (2011). Performance-based funding can either be renewed or increased if levels of performance increase, however funding can be decreased or terminated as a result of lower levels of performance. *Id.* Outcomes are therefore highly dependent upon patient mix. *Id.* For example, Ninety percent of the variability in hemodialysis units' ability to meet quality goals could be explained by patient mix. *Id.* If quality goals are tied to patient mix, providers will avoid those patients who would diminish their ability to enhance the providers' finances. *Id.*

[64] Berenson, *supra* note 58 (discussing readmission related to socio-economic status).

[65] G. Sullivan, et al., *Pathways to Homelessness Among the Mentally Ill*, 35 SOC. PSYCHIARTY PSYCHIATRIC EPIDEMIOLOGY, 444, 444-45 (2000), *available at* http://www.brown.uk.com/homeless/sullivan.pdf (stating homeless individuals with mental illness have a "'double dose' of disadvantage").

issues with their employer, spouse/significant other, and family members.[66] This study utilized the "special population standard" in order to control for the possibility that the clinic would specifically target clients who were easier to treat.[67] However, even with the control, the providers engaged in activities aimed at attracting less severe clients and selected less severe clients in order to improve their performance ratings for optimization of funding.[68]

Alternatives to Capitation and Other Financial Incentives

Capitation and other financial incentives that encourage denial of care are hard to control through alternative incentives, like pay for performance, as these alternative incentives also have unforeseen consequences. Rather than focus on incentives that limit necessary medical care and the tools used for accurate diagnosis like MRIs, attention might be paid to alternative avenues for controlling costs, such as public health initiatives like reintroducing physical education as a daily part of school and soda/sugar taxes to discourage consumption of unhealthy foods, as well as exploration of alternative and up and coming modes of mental health care like meditation, peer services[69] and Open

[66] Yujing Shen, *Selection Incentives in a Performance-Based Contracting System*, 38 HEALTH SERVICES RESEARCH 535, (2003), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360913/ (stating objective as "whether a performance-based contracting provides incentives . . . to select less severe clients").
[67] *Id.*
[68] *Id.*
[69] See, e.g., J. Repper and T. Carter, *A review of the literature on peer support in mental health services*, 4 J. MENTAL HEALTH 392-411 (2011); SAMHSA, Peer Support and Peer Providers: Redefining Mental Health Recovery (Sept. 21, 2010); N. Pistranq, *et al.*, *Mutual Help Groups for Mental Health Problems: a review of effectiveness studies*, 42 AM. J. COMMUNITY PSYCHOL. 110-21 (2008).

Dialogue,[70] which emphasize social connection rather than medication and institutionalization.[71]

[70] J. Seikula and M. Olson, *The Open Dialogue Approach to Acute Psychosis: Its Poetics and Micropolitics*, 42 FAM. PROC. 415, 403- 418 (2003)(use of Open Dialogue resulted in fewer hospitalizations, less medication use, better employment status, and fewer symptoms at two-year follow-up).

[71] Cost-saving targeted interventions are also possible for chronic issues like obesity that cause multiple physical ailments. See, e.g., G. Daumit, M.D., *et al.*, *A Behavioral Weight-Loss Intervention in Persons with Serious Mental Illness*, 368 NEW ENG. J. MED. 1594-602 (2013).