



Beyond Parity:
Mental Health
and Substance Use
Disorder Care under
Payment and Delivery
System Reform in
Massachusetts

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Colleen L. Barry, Ph.D., M.P.P.
Associate Professor
Department of Health Policy and Management
Johns Hopkins Bloomberg School of Public Health

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I. Executive Summary

In 2006, Massachusetts achieved near-universal health insurance coverage for its residents. Following this major policy achievement, which resulted in coverage for 98 percent of the state's population, residents have continued to experience substantial growth in premiums and increased state spending on health care. State policymakers are now poised to consider a next round of reforms to address long-standing concerns about health care cost growth, and critical gaps in the coordination and quality of care. In July 2009, a Special Commission on the Health Care Payment System Report was released recommending reform of the state health care payment system. In February 2011, Governor Deval Patrick introduced legislation aimed at tackling payment and delivery system reform within the Commonwealth. The state is also grappling with implementing major health care changes with passage of the Patient Protection and Affordable Care Act in 2010 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

It is important to examine how these policy initiatives will impact care for individuals and families with mental health and substance use disorders. Reforms hold the promise of improving long-standing coordination and quality of care problems. Lack of integration between primary care and specialty behavioral health care and poor coordination for patients with coexisting mental health and substance use disorders are endemic problems within the state's health care delivery system, and are exacerbated by prevailing financing arrangements. Lack of coordination comes at a high price. People with mental illness and substance use disorders have higher rates of other illnesses and die earlier, on average, than the general population. Questions remain about how to effectively transform the state's payment and delivery system to best meet the behavioral health prevention, treatment and recovery needs of individuals living in the state.

The purpose of this report is to describe the policy context and to offer preliminary recommendations to initiate a community conversation about how these major policy changes might be implemented with the goal of improving mental health and addiction care in Massachusetts. Preliminary recommendations are that:

- 1) Payment and delivery system reform should be assessed on the basis of how the heterogeneous population of individuals with behavioral health care needs living in the state might be affected.
- 2) Payment and delivery system reform should improve access to behavioral health prevention and early identification services.

- 3) Payment and delivery system reform should facilitate greater engagement of consumers and family members in shared decision-making with clinicians.
- 4) Carefully developed risk adjustment methods should accompany payment and delivery system reform to mitigate incentives to avoid enrolling consumers with behavioral health disorders.
- 5) Payment and delivery system reform should include provider workforce training, information technology linkages and other mechanisms to strengthen connections between behavioral health providers and the rest of the medical care system. It is critical to improve behavioral health providers' "readiness" to be part of a more integrated health care system in the state.
- 6) Payment and delivery system reform should include well-vetted, standardized performance measures for rewarding high-quality, consumer-centered behavioral health care.
- 7) Payment and delivery system reform should require the involvement of behavioral health consumers and providers in the governance of new accountable care organizations.
- 8) Payment and delivery system reform should explicitly recognize the ongoing need for state and federal resources to directly fund behavioral health prevention, treatment and recovery support services.
- 9) Payment and delivery system reform should be designed to take strategic advantage of the numerous federal funding opportunities currently available to improve integration of behavioral health care.
- 10) Payment and delivery system reform should be designed to reduce racial and ethnic disparities in access to behavioral health care.
- 11) Payment and delivery system reform should ensure that mechanisms are in place to protect the privacy of individuals with behavioral health conditions.

II. Introduction

In 2006, Massachusetts achieved near-universal health insurance coverage for its residents with enactment of Chapter 58, *An Act Providing Access to Affordable, Quality and Accountable Healthcare*. Components of this law served as a model for the Patient Protection and Affordable Care Act (ACA) enacted by the U.S. Congress in 2010. Now, policymakers in the state are considering a next round of reforms to address long-standing concerns about health care cost growth, and gaps in the coordination and quality of care. In July 2009, a Special Commission on the Health Care Payment System Report was released recommending reform of the state health care payment system. In February 2011, Governor Deval Patrick introduced a bill entitled *An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments*, aimed at tackling payment and delivery system reform within the Commonwealth. The state is also grappling with implementing major health care changes with passage of the ACA and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The federal parity law was implemented in 2010 and additional regulatory provisions took effect in 2011.¹ It is critical to examine how these major policy deliberations will impact care for individuals with mental health and substance use disorders. Importantly, these discussions are occurring within a challenging fiscal environment in Massachusetts that has included debates over health-related budget cuts (including cuts to mental health and substance use disorder services). Reforms hold the promise of improving long-standing coordination and quality of care problems; however, critical questions remain about how to effectively transform the state's payment and delivery system to best meet the behavioral health prevention, treatment and recovery needs of individuals living in the Commonwealth of Massachusetts.

In this briefing paper, current policy initiatives are described in the context of opportunities and challenges for improving behavioral health care. The term 'behavioral health' is used to refer jointly to care for mental health and substance use disorders. The focus is on the working age population ages 18 to 64 with behavioral health treatment needs or at risk for developing such a disorder.* The group is quite diverse with behavioral health conditions ranging from more to less severe diagnoses. A large share have co-occurring mental health and substance use disorders, and many also have chronic medical conditions further complicating effective delivery of care. After assessing how proposed reforms might affect this heterogeneous group, a

* It is important to note that many of these issues have relevance also for both children and the aged population. Similar to the working age population, mental health and substance use disorders are seriously under-detected and under-treated among children and elderly adults. However, given important differences in the systems that finance and deliver care to these populations, such as school-based health services and the Medicare program, addressing the policy issues related to the behavioral health care of these groups is beyond the scope of this report.

number of payment and delivery system initiatives in Massachusetts are described in the context of their implications for behavioral health care. This report concludes by offering preliminary recommendations on how payment and delivery system reform might be structured to protect and improve the quality of behavioral health care in Massachusetts.

III. Background

Payment and Delivery System Reform Efforts in Massachusetts

Since passage of the Massachusetts health reform law in 2006, efforts have been under way in the state to begin a dialog about how to address cost containment and improvements in the efficiency and quality of care delivered. This reform achieved nearly universal coverage, insuring 98 percent of the state’s population.² It was not designed to address other pressing challenges facing the state’s health care system, however, and residents have continued to experience substantial growth in premiums, provider capacity constraints and increased state spending on health care.³ These trends have generated renewed pressures among state policymakers to control costs. In 2008, the Massachusetts Legislature passed a cost containment law mandating creation of a Special Commission on the Health Care Payment System.⁴ In July 2009, this Special Commission released a report recommending reform of the state payment system to move away from volume-based fee-for-service (FFS) payment and to consider alternative payment arrangements to “support safe, timely, efficient, effective, equitable, patient-centered care and both reduce per capita health care spending and significantly and sustainably slow future spending growth.” This report did not mention any specific implications of proposed payment reforms on the financing and delivery of behavioral health care.

Following release of the Special Commission’s report, Governor Deval Patrick filed *An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Care Systems and Payments* in February 2011. The stated goal of this legislation was to promote access to care by reducing health care costs, and to improve health outcomes by encouraging increased care coordination and a focus on quality. This bill included specific provisions related to behavioral health care, requiring that:

- integrated care organizations proposed under the bill provide behavioral health either internally or by contract;
- the Commissioner of Mental Health be included on a Coordinating Council to set up rules for accountable care organizations;
- the Health Care Innovation Advisory Committee to be set up under the bill include a behavioral health perspective; and
- a behavioral health task force be appointed by the Coordinating Council to report on “how to integrate behavioral health in accountable care organization services, how current prevailing reimbursement methods and covered behavioral health benefits may need to be modified to achieve more cost-effective, integrated and high quality behavioral outcomes, and the extent to which alternative payment methods apply to behavioral care.”

While no other specific requirements in the bill related to behavioral health care, various additional provisions might also have an impact on this group, such as the requirement that individuals who have a disability and chronic illness must receive appropriate specialty care under an accountable care organization.

Recent Federal Reforms Affecting Mental Health and Substance Use Disorder Care

Proposed delivery system and payment reform in Massachusetts is being debated within a dynamic national health care policy context. A number of recent federal policy changes have the potential to affect the care of those with behavioral health treatment needs living in the Commonwealth. Changes under the new federal parity law and the ACA law are particularly relevant to current state reform efforts. First, passage of the federal parity law in 2008 was the culmination of a decades-long effort both in Massachusetts and nationally to improve private insurance coverage for mental health and addiction treatment. Parity aims to rectify inequity in the insurance benefits offered under most private health plans for behavioral health and general medical care. Coverage for behavioral health care has typically required a higher level of cost sharing (e.g., coinsurance of 50 percent compared to 20 percent for outpatient medical services) and special service limits (e.g., twenty outpatient visits and thirty inpatient days per year).^{5,6} Limits on insurance benefits date back to the inception of third-party payment for mental health services.⁷ Prior to passage of the federal parity law, the Massachusetts legislature had taken steps to address the limits on mental health benefits under private insurance. The Massachusetts Mental Health Parity Act was enacted as Chapter 80 of the Acts of 2000. It required commercial health plans to cover nine biologically-based mental disorders on a non-discriminatory basis such that a health plan may not impose any annual or lifetime dollar or unit of service limitations for treatment of mental health services. The conditions specified were schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, and affective disorders.* In 2009, this law was expanded to include four new conditions (i.e., eating disorders, post-traumatic stress disorder, substance abuse and autism) to the list of “biologically-based” mental disorders that must be covered for adults to the same extent as physical illnesses. The reach of the Massachusetts parity law was limited by the Employee Retirement Income Security Act (ERISA) of 1974, which exempts employers that self-insure from state insurance mandates. The Kaiser Family Foundation estimated that between 33 and 50 percent of U.S.

* Under the law, non-discriminatory coverage also extended to non-biologically based mental, behavioral, or emotional disorders for children and adolescents under age 19 that substantially interfered with or limited functioning and social interactions, including but not limited to an inability to attend school as a result of such a disorder, the need to hospitalize the child or adolescent as a result of such a disorder, and a pattern of conduct or behavior caused by such a disorder that poses a serious danger to self or others.

employees were in self-insured plans in 2000 and thus, in accordance with ERISA, would not be covered by state parity requirements.^{8,9}

Given the limited reach of state parity laws due to ERISA, consumer advocates pushed for a federal parity law that would extend more broadly to the privately insured population. Passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act by the U.S. Congress in October 2008 extended parity to all privately insured individuals in Massachusetts covered by firms with 50 or more employees. Under the law, which was implemented in 2010, if an employer offers behavioral health coverage, all financial requirements (deductibles, copayments and coinsurance) and treatment limits (number of inpatient days and outpatient visits) for behavioral health benefits must be equal to those for medical/surgical benefits. The federal law covers all medically necessary mental health and addiction treatment services as defined by the insurer (as opposed to the Massachusetts parity law which applied only to certain diagnoses). The federal parity law also went beyond the Massachusetts parity law by requiring that health plans providing out-of-network coverage for medical/surgical benefits must provide equal out-of-network coverage for behavioral health benefits. According to the law, employers are not required to provide behavioral health benefits (i.e., it is not a coverage mandate), but if they do choose to cover these services, they must offer them at parity. It includes protections for state parity laws such that Massachusetts could impose additional parity requirements on health plans that are more stringent than required under the federal law. The law applies to Medicare Advantage coverage offered through a group health plan, Medicaid managed care, the State Children's Health Insurance Program, and state and local government plans. Federal interim regulations released in 2010 prohibit the use of so-called non-quantitative treatment limitations for behavioral health benefits unless the processes or standards used in applying these limits are comparable to those used for medical/surgical benefits. Examples of non-quantitative treatment limitations are medical management standards, such as medical necessity determinations; prescription drug formulary design; step therapy protocols requiring the use of less expensive therapies before a plan will cover more expensive therapies; standards for provider admission to participate in a network, including provider reimbursement; plan methods for determining usual, customary and reasonable charges; and conditioning benefits on completion of a course of treatment.

Second, efforts in Massachusetts to implement key provisions of the ACA also have the potential to affect how care is provided to those with behavioral health conditions. While other states are focused on the ACA provisions related to broadening access to be implemented in 2014 (e.g., establishing state insurance exchanges, Medicaid expansion), this is less of an issue for Massachusetts given the insurance expansions under the 2006 state health reform law. Nonetheless, numerous provisions of the ACA that would affect behavioral health care

are relevant to Massachusetts. First, the ACA mandates that both Medicaid benchmark plans — alternative plan options created under the Deficit Reduction Act of 2005* — and plans operating through the state-based insurance exchange cover behavioral health services at parity in compliance with an essential health benefits (EHB) package, which will establish a lower bound for the benchmark. By mandating parity, this provision goes beyond the requirements of the 2008 federal parity law, which only required private employers to offer behavioral health services at parity if they chose to provide insurance benefits for these services. Mental health and substance abuse disorder services must be part of the EHB, although the U.S. Department of Health and Human Services (DHHS) has not yet released information on the specific behavioral health services deemed essential. A recently released report by the Institute of Medicine recommended a process to the DHHS for defining and updating the EHB package, including advising the secretary to permit states to “adopt variants of the federal EHB package, provided that modifications are consistent with the federal package, not significantly more or less generous, and are subject to public input.”¹⁰

In addition, the federal law includes a number of provisions with federal funding attached aimed at addressing care fragmentation problems in state Medicaid programs. The law created a Medicaid “health home” option that states could choose to implement for people with multiple chronic conditions, including those with mental health and substance use disorders, which will pay for services that have not traditionally been reimbursable. Care management, health promotion, post-inpatient transition care, referral to social support services, and information technology to link services together will be reimbursed at a 90 percent federal matching rate for the first two years after a health home is established. Medicaid agencies in other states have begun submitting health home state plan amendments. For example, Missouri Medicaid submitted an amendment to establish a community mental health center-focused ‘health home’ initiative aimed at improving care for individuals with either a severe mental illness or a co-morbid mental health and substance use disorder. A key principle of the Missouri initiative is that addressing the medical needs of this population in the specialty mental health sector has the same priority as meeting their behavioral health needs. The Missouri health home amendment proposes to use funding to pay for key components of coordinated care, including nurse care managers and primary care physician consultation.

The ACA funded a variety of other initiatives relevant to individuals with behavioral health conditions. It authorized about \$100 million through fiscal 2014 for the Substance Abuse and

* The Deficit Reduction Act of 2005 allows states to vary the Medicaid benefit packages available to Medicaid beneficiaries. States now have the option to provide different “benefit packages” to certain populations. These benefit packages do not need to follow Medicaid’s traditional rules requiring statewideness, freedom of choice, or comparability. The coverage can be modeled on “benchmark” or “benchmark equivalent” plans as defined by the Centers for Medicare and Medicaid Services. <https://www.cms.gov/DeficitReductionAct/Downloads/Flexibility.pdf>

Mental Health Services Administration (SAMHSA) to provide co-location grants to integrate services for adults with mental illness and coexisting medical conditions within community-based behavioral health treatment settings, which a number of specialty mental health provider organizations in Massachusetts and elsewhere in New England have received. The law made improvements to the Medicaid 1915(i) option, expanding states' ability to provide home- and community-based services (e.g., day treatment and psychosocial rehabilitation) to specific populations, including those with serious mental illnesses. The ACA extended the Money Follows the Person Rebalancing Demonstration Program, which was set to expire in 2011, providing Medicaid beneficiaries living in a nursing home or other institution opportunities to live in the community with additional services and supports. Massachusetts was awarded a major grant under this program in 2011. The ACA also includes an accountable care organization initiative, the Medicare Shared Savings Program, to better coordinate services for Medicare FFS beneficiaries, invest in infrastructure development and redesign processes of care, scheduled to be implemented in January 2012. Finally, the law includes a variety of preventive care and wellness provisions including coverage of screening for alcohol misuse.

IV. Payment and Delivery System Reform Proposals in Massachusetts: Potential Implications for Behavioral Health Care

This section reviews health care payment and delivery system reform proposals currently under discussion in Massachusetts, and examines how proposed changes could affect individuals with behavioral health conditions. Both the 2009 Special Commission report on payment reform and the Governor's bill identified the predominance of FFS payment as a primary contributor to cost growth and uneven quality, and recommended fundamental reform to shift toward a payment and delivery system that rewards high quality, well coordinated and efficient care rather than the volume of care provided.¹¹ While not explicitly noted in the Special Commission report or the Governor's bill language, the absence of financial incentives under FFS reimbursement to efficiently provide high quality, evidence-based behavioral health care has also been well-documented.¹²

Both the Special Commission report and the Governor's bill identify alternative payment arrangements as critical to controlling cost growth and creating incentives to improve care. The Special Commission report specifically identified global payment models as the recommended direction for future payment reform. It also explored the advisability of adopting episode-based payment, an alternative bundled payment option, but concluded that there was too little operational experience with episode-based payments to implement this change quickly enough, and that episode-based payment might be insufficient to curb incentives to increase care volume. As envisioned in the Special Commission report, global payments would prospectively compensate providers for all (or most) of the care provided to a fixed population over a contracted time period. This approach is analogous to giving providers a budget. Global payments would reflect the expected costs of covered services based on prior year costs and actuarial assessment of future risk, and would be risk adjusted to reflect differences in the underlying characteristics and health conditions of a provider's patient population. The Special Commission recommended that global payment be combined with complementary payment mechanisms, most notably performance incentives, aimed at enhancing coordination, shared decision making and quality of care.

In conjunction with payment reform, the Governor's bill encouraged the growth of so-called integrated care organizations, commonly referred to as Accountable Care Organizations (ACOs), which operate consistent with the principles of medical homes, as the primary

approach to reforming the health care delivery system in Massachusetts. Similar to the ACO model proposed for Medicare under the ACA described above, the Governor's bill envisions that these new organizational entities would involve providers organizing by corporate affiliation, contract or otherwise to make decisions with the goal of achieving better care for individuals, better health for populations and slower cost growth through improvements in care. While ACO models can be structured using FFS payment arrangements, the intent of the Governor's bill was to use these arrangements to create a care delivery infrastructure to facilitate a significant reduction in the reliance on FFS reimbursement. ACOs would be certified by the Division of Health Care Finance and Policy (DHCFP), with financial oversight by the Division of Insurance (DOI); and the DHCFP would be charged with developing standardized alternative payment methodologies. ACOs could be formed from multi-specialty group practices; primary care clinics; networks of providers linked by contractual agreements; a joint venture or other organization that combines providers; or a fully integrated system that controls hospitals, physicians and other providers. Some characteristics of a robust ACO model might include full clinical, financial and organizational integration; establishment of clinical protocols, policies and procedures that cross specialties and levels of care; use of clinical, quality and performance standards through incentives and penalties; ability to manage and tolerate risk; creation of an information technology infrastructure to measure and monitor level and quality of care provided; and consistent performance standards, measures and payment systems among payers.

Payment and delivery system reform under consideration in Massachusetts offers both opportunities and challenges for behavioral health care. Bundled payment models can provide opportunities to fund evidence-based behavioral health care services not typically reimbursed under commercial and public insurance. The case of the collaborative care model for treating clinical depression in primary care serves as an illustrative example. Over the last 15 years, a robust research base has developed, providing compelling evidence that collaborative care interventions can improve detection and treatment of depression in a cost-effective fashion.^{13,14,15,16,17,18,19} Elements of evidence-based collaborative care for treating depression include use of practice guidelines and screening tools for primary care physicians, introduction of care management and psychiatric consultation services, and adoption of computerized clinical depression registries to track patient outcomes and initiate follow up care. This care delivery model has been applied to other areas of behavioral health also, including anxiety care, alcohol dependence treatment and medication-assisted treatment for opioid addiction.²⁰ However, clinical interventions that have been successful in controlled research environments have proved difficult to sustain in routine practice settings, most notably in the absence of payment mechanisms under FFS reimbursement for care management and psychiatric consultation.^{21,22} The Medicaid Health Home option subsidy under the ACA is directly aimed at the problem of sustaining these elements of collaborative care. Other services not reimbursed on

an FFS basis that could be financed through a bundled payment arrangement include primary care nurses co-located in specialty mental health settings to assess the medical care needs of consumers with severe mental illness, and certified peer specialists who have themselves sought treatment for mental health or substance use disorders and have been trained to aid other consumers in navigating complex systems of care. Bundled payment models could also be helpful in improving care transitions, a critical aspect of behavioral health care, including emergency department transition care and post-discharge care. Given that an estimated 20 percent of commercial plan payments for physicians in Massachusetts are made using some form of global payment,²³ one critical initial step will be to assess the extent to which behavioral health services are included in global payments and how individuals with behavioral health conditions have fared under these arrangements.

In addition, the behavioral health sector could benefit from the emphasis on improved integration and coordination under Massachusetts payment and delivery system reform proposals. Behavioral health has historically been separated from the rest of the medical care system in both Massachusetts and nationwide, and the mental health and substance use disorder treatment systems themselves have operated quite separately. Lack of integration between primary care and specialty behavioral health care, and poor coordination for patients with coexisting mental health and substance use disorders, are endemic problems within the state's health care delivery system and are exacerbated by prevailing financing arrangements. Lack of coordination comes at a high price. People with serious mental illnesses have higher rates of other illnesses and die earlier, on average, than the general population, largely from treatable conditions associated with risk factors such as smoking, obesity, substance use and inadequate medical care.²⁴ And mental health and substance use disorders often go untreated in primary care.^{25,26} Delivery system reform, alone or in combination with payment reform, has the potential to help reduce system-level care fragmentation for individuals with behavioral health conditions. Better care integration can improve access and detection and receipt of evidence-based treatment, and can also facilitate stronger ties with the general medical sector. This is critical given that behavioral health care is often initiated within primary care.

One important challenge will be to target ACOs, medical homes or other delivery system integration efforts at the points where individuals with behavioral health care needs interface with the delivery system. That means improving detection and treatment of mental health and addiction disorders in the primary care sector — and addressing the medical needs of people with severe mental illnesses in the specialty mental health sector. Proposed delivery system reforms focus on primary care as a critical nexus of coordinated, patient-centered care. As noted above, there is extensive evidence on effective approaches to screening and treating behavioral health conditions within primary care.²⁷ Less evidence is available on improving

care coordination for people with disabling behavioral health disorders who would probably be best served by a medical home within the specialty mental health and substance abuse sector, although some promising approaches are being developed.²⁸

Another concern relates to setting bundled payment rates for ACOs to temper any incentives to dissuade individuals with behavioral health conditions from joining. The fundamental concern is that ACOs operating within a competitive health care market will not function well for this population due to adverse selection. In an insurance context, adverse selection occurs when health plans that offer better benefits attract individuals who are more likely to use services and thus place the plans at a price disadvantage with regard to premiums. Adverse selection, an issue for all health insurance, may be especially serious in the behavioral health context because mental illness and substance use disorders are often both costly and chronic. Research suggests that using mental health services predicts high health spending in future years, and mental health and substance use service users utilize both behavioral health and general medical services at higher rates compared to otherwise similar individuals.^{29,30} McGuire and Sinaiko found, for example, that among individuals with fair or poor self-reported mental health, average total health care costs were \$5,370, compared to only \$2,077 for those with excellent, very good or good self-reported mental health.³¹

In the context of ACOs, medical groups at risk for the total health care costs of a population might face particularly strong incentives to avoid enrolling those with mental illness. Risk adjustment has been proposed as the primary strategy for addressing selection incentives in ACOs; however, the type of risk adjustment methods adopted matters. For example, one recent study examining risk adjustment in the context of state insurance exchanges under the ACA found that certain risk adjustment methods performed much better than others in terms of compensating plans with a larger share of enrollees with mental health conditions.³² Even with sophisticated risk adjustment methods that account for a range of socioeconomic and clinical factors, some medical groups may find it profitable to dissuade individuals with behavioral health conditions from enrolling. Well-developed diagnosis-based risk adjustment methods might be combined with other mechanisms including reinsurance (e.g., a stop-loss threshold), mixed payment models (e.g., using risk corridors approaches) and selective contracting to further mitigate selection incentives. It will also be important to carefully consider how payment arrangements might be modified if risk adjustment does not work well for individuals with mental health and substance abuse disorders.

Another potential challenge involves use of behavioral health performance measures in the context of payment and delivery system reform. The Special Commission report emphasized that bundled payment arrangements might be combined with pay-for-performance (P4P). The

Governor's bill would specifically require that quality measures include consumer experience satisfaction and engagement measures. There has been substantial activity in the area of behavioral health quality measurement initiatives in recent years, with one study documenting over forty different behavioral health quality measurement initiatives in the United States.³³ P4P programs implemented in the behavioral health field have been somewhat more limited. In a recent review of P4P in behavioral health, it was noted that depression was the most common behavioral health condition targeted, the financial incentives tended to be relatively small, many of the programs struggled with challenges associated with obtaining accurate and valid data on quality and outcomes, and results tended not to be publicly reported.³⁴ In late 2010, in the context of implementing the ACA, the DHHS Secretary released a notice in the Federal Register recommending an initial core set of 51 health quality measures for Medicaid-eligible adults, including 11 specifically related to behavioral health disorders. The Institute of Medicine, in a follow up report to the landmark 2001 *Crossing the Quality Chasm*, issued a report focused on the quality of behavioral health care in 2006, and described a "less well-developed" infrastructure for measuring, analyzing and reporting publicly the quality of care received by consumers with behavioral health conditions.³⁵ Additional work is needed to develop standardized, well-vetted behavioral health performance measures that can be incorporated into P4P initiatives.

Another consideration relates to how ACOs will function within the multi-commercial payer insurance system that exists in the state. Medical groups will face challenges in integrating care if consumer populations are divided across multiple payers with different benefit packages, provider networks, performance incentives and care protocols. While this challenge is not distinct to behavioral health care, the issues posed by a multi-payer system with conflicting protocols and incentives are exacerbated in the context of the often-complex needs of this consumer population.

Likewise, the rules governing an ACO's provider network will be important for ensuring access and care continuity. Concerns have been raised about limiting behavioral health provider networks as a strategy to dissuade those with more costly mental health treatment needs from joining a health plan.³⁶ It will be important to ensure that medical groups do not use restrict provider networks as a tool to cherry-pick the healthiest enrollees. In addition, creating options to allow consumers to maintain therapeutic relationships with trusted behavioral health providers over time can help avoid continuity of care problems, which can threaten functioning and recovery.

The historical separation of mental health and addiction treatment from the rest of medicine also poses workforce challenges. Both in Massachusetts and nationally, behavioral health

care providers are more often solo and small-group practitioners compared to other medical care sectors. Evidence indicates that behavioral health providers have lagged behind other specialists in adopting information technology,³⁷ and will need to make changes to survive in this new environment, including developing information technology capacities that facilitate integration and, in some cases, beginning to adopt third-party billing. Behavioral health providers were excluded from the information technology adoption incentives in the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. This makes it particularly critical to identify methods of encouraging information technology investments in order to facilitate the linkages needed for a behavioral health sector that is well-integrated with the broader medical care system in the state.

Payment and delivery system reform will affect the widespread practice in the state among both public and commercial insurers of “carving out” mental health and substance use disorder benefits to managed behavioral health carve out companies.³⁸ Carving out behavioral health benefits is a dominant method for delivering services both under private insurance in the state and for MassHealth members, including those who select the Primary Care Clinician Plan. Carve-outs operating in the state specialize in delivering behavioral health care and have been at the forefront of the development of performance metrics. Carve-out arrangements can also be helpful in mitigating selection incentives if structured at the payer rather than the plan level. Concerns have been raised that these arrangements have the potential to reinforce system fragmentation, however. Careful thought will need to be given to how these arrangements might be altered to facilitate care integration under payment and delivery system reform.

Finally, it will be important to determine how these new organizational entities will interface with public agencies charged with protecting the welfare of those with behavioral health conditions living in Massachusetts — including the Department of Mental Health, the Department of Public Health Bureau of Substance Abuse Services, the Department of Developmental Services, Department of Correction and the Department of Children and Families.

V. Payment and Delivery System Initiatives in Massachusetts

This section describes payment and delivery system initiatives within Massachusetts in the context of their implications for behavioral health. Various pilot efforts with the potential to improve behavioral health care by realigning payment incentives and care delivery systems are being developed in the state. The aim of this section is not to provide a comprehensive review of such initiatives or to assess which efforts are likely to be the most successful or sustainable. Rather, the goal is to provide some flavor of a range of different approaches that state agencies, insurers and provider groups are initiating to improve care.

Integration of Medication-Assisted Treatment for Opioid Addiction into Community Health Centers

Opioid addiction is a chronic disease that can be effectively treated in primary care settings with buprenorphine hydrochloride in combination with regular counseling.^{39,40,41,42,43} A recent study found that total spending was lower and clinical outcomes (i.e., relapse and mortality rates) were better for patients in buprenorphine maintenance treatment than for comparable patients in non-medication addiction treatment.⁴⁴ Despite evidence on effective care options, research indicates that less than 25 percent of individuals addicted to opioids receive *any* addiction treatment.^{45,46} While medication-assisted treatment with buprenorphine constitutes an important primary care-based alternative to daily dose methadone hydrochloride or non-medication treatment provided in specialty addiction treatment settings, it has been difficult to gain access to buprenorphine treatment in Massachusetts. A Massachusetts Bureau of Substance Abuse Services grant-funded program initiated in 2003 has aimed to broaden access to buprenorphine treatment. Currently, over 15 community health centers across the state have initiated office-based opioid treatment programs based on the collaborative care approach to chronic disease management.^{47,48} These programs typically include a full-time nurse program director, nurse care managers, a program coordinator, and generalist physicians with specialized training in prescribing buprenorphine. The nurse care managers funded by the Bureau perform a range of patient care and coordination activities, including assessing a client's appropriateness for office-based opioid treatment, educating patients, obtaining informed consent, developing treatment plans, overseeing medication management and monitoring treatment, as well as communicating with prescribing physicians, addiction counselors and pharmacists. Nurse care managers also address a range of other needs (e.g., housing, employment, health insurance) to help maintain this population in treatment. These efforts have increased the number of community health center physicians trained to prescribe buprenorphine from less than 25 to over 150 over the last five years in Massachusetts, and over 5,000 patients have been enrolled. One key to

sustainability and replication will be to identify long-term third-party payment mechanisms under public and private insurance for components of the model, including the nurse care manager function.

Global Payment and Care Coordination in Atrius Health

Atrius Health, a multi-specialty group practice serving nearly 1 million adult and pediatric clients in Massachusetts, has been using global payment for over 40 years and has extensive experience integrating care as a prototypical ACO. In the past decade, the major health plans that cover Atrius' patients have opted against including behavioral health in global payment arrangements. Atrius has made progress in recent years in improving coordinated care for consumers with complex care needs, including those with behavioral health conditions. Pilot efforts include co-location of behavioral health providers in primary care, increased availability of “curb-side” psychiatric consultation, same-day access for primary care consumers to behavioral health specialists, and more rapid follow-up care after a psychiatric hospitalization. Like other organizations initiating these types of integration approaches, Atrius has experienced challenges sustaining these services, which are not reimbursable under FFS reimbursement.

Integrating Primary Care within Specialty Mental Health at Community Healthlink

The Wellness Center at Community Healthlink has developed an innovative program in Worcester, Massachusetts aimed at embedding primary care within the specialty behavioral health treatment sector. As noted above, clinical trials and other demonstrations integrating mental health in primary care have been studied extensively; however, much less is known about how to co-locate primary care within behavioral health. Under this initiative, which was launched in 2010, two full-time registered nurse care managers conduct wellness assessments; work with consumers on wellness goals related to nutrition, physical activity, smoking cessation and stress management; and coordinate care with clinicians in primary care (who may or may not be directly affiliated with the clinic), as well as mental health and addiction care. The Wellness Center employs one part-time primary care provider, an advanced practice nurse practitioner, to provide primary care to program enrollees; and one certified peer specialist to work with enrollees on their wellness plans in individual and group settings. Mental health and primary care electronic medical records are separate but linked. Over 100 consumers with schizophrenia, severe depression, post-traumatic stress disorder, opioid addiction and other behavioral health diagnoses have been enrolled in the program to date, including many with co-occurring mental health and addiction disorders. All consumers enrolled have serious acute and chronic medical conditions, as well as risk factors for developing diabetes, heart disease, liver disease, and many other conditions. This program was developed with external pilot grant support by SAMHSA. Most components of the initiative are viewed as sustainable from a funding perspective. Resources to support the nurse care management function pose the most

serious long-term funding challenge. Given enrollees' serious health needs, having a registered nurse-level care manager in this position is viewed as essential. While this care manager function is not reimbursed on an FFS basis, bundled payment was considered a viable approach to paying for the components of this model, including care management on a sustained basis.

Integrating Addiction Screening and Brief Intervention in Health Care Settings

In 2004, the United States Preventive Services Task Force (USPSTF) recommended screening and behavioral counseling interventions in primary care to reduce alcohol misuse.⁴⁹ The USPSTF reported that screening in primary care settings could accurately identify patients whose patterns of alcohol consumption do not meet criteria for alcohol dependence but put them at risk for increased morbidity and mortality, and that brief behavioral counseling interventions with follow-up for this population could reduce short-term and longer term alcohol consumption. As a grade “B” USPSTF recommendation, health plans are now required to begin covering this screening under a provision of the ACA. While less evidence is available, screening, brief intervention and referral to treatment (SBIRT) also appears helpful in improving detection and treatment initiation for drug abuse.^{50,51} In Massachusetts, a recent federally funded project aims to increase SBIRT for risky alcohol and drug use in a broad range of health care settings. Since 2007, 147,000 screenings have been conducted under the project in hospital inpatient, outpatient, emergency and urgent care settings, and in five Boston-area community health centers; and 25,000 brief interventions have been provided to individuals whose substance use indicated a threshold level of risk. Among patients with follow-up data, 6 percent reported abstinence at the time of the initial screen while 31 percent reported being abstinent at the six-month follow-up. This outcome is in line with results from other state SBIRT projects where drug and heavy alcohol use were found to decrease significantly from admission to follow-up.

Integration Incentives under the Massachusetts Behavioral Health Partnership

The Massachusetts Behavioral Health Partnership (MBHP) has managed mental health and substance abuse services for MassHealth members who select the Primary Care Clinician Plan since 1996. Since its inception, the MBHP has worked in coordination with MassHealth to use financial and non-financial incentives to improve the quality of care provided to members. Recent initiatives provide useful models for enhancing care coordination and improving member outcomes. The Massachusetts Child Psychiatry Access Project (MCPAP), a collaborative effort with the Department of Mental Health, aims to make child psychiatry services universally accessible to primary care providers in the Commonwealth. MCPAP provides primary care clinicians with timely access to child psychiatry consultation and, as necessary, transitional services and assistance with access to ongoing behavioral health care. MCPAP is available to all children and families, regardless of insurance status, as long as the

point of entry is through their primary care provider. Currently, over 95 percent of primary care clinicians who serve youth are enrolled in MCPAP. Under another pilot program, large community mental health centers are rewarded financially for the ‘community tenure score’ of their population, which refers to the total number of days following a behavioral health hospitalization discharge that a person is maintained in behavioral health treatment within the community over an established period. The MBHP provides data and technical assistance to community mental health centers to support this effort. To further support improved community tenure, MBHP has also initiated reimbursement rate changes to encourage timely follow up care after a person’s psychiatric hospital discharge, including incentive payments if an outpatient visit occurs within 7 days after discharge; if a medication visit occurs within 14 days after discharge; and if additional visits occur within a specified period. The MBHP also used financial incentives to encourage peer community support visits to individuals in inpatient psychiatric facilities.

Global Payment under the BCBSMA Alternative Quality Contract

In 2009, the state’s largest insurer, Blue Cross Blue Shield of Massachusetts (BCBSMA), began a new initiative, the Alternative Quality Contract (AQC), a new way to reimburse providers that combines a global budget with the potential for medical groups to receive bonuses based on performance on quality measures.^{52,53} Provider groups who agree to an AQC contract are responsible for all the care for BCBSMA HMO and POS members who have selected a primary care physician in their group. These provider organizations include primary care physicians and specialists; and in some cases a hospital may be a party to the contract and share in the responsibility for the population of patients. This accountability by the organization includes the costs for all care received by these patients and the quality of care they receive, as well. Their global budget covers most or all of the continuum of care (primary care and specialist physician services, hospital services, prescription drugs, and laboratory services, etc.), and it is a long-term contract, not just a one-year arrangement. Currently, provider groups participating in the AQC provide care to over 450,000 Blue Cross members. It is anticipated that more than 70 percent of BCBSMA HMO and POS members will have a PCP in the AQC by 2012. This model of reimbursement and responsibility for a population of patients is viewed as a model of an accountable care organization. BCBSMA provides regular consultation and data reporting to provider organizations to help them identify opportunities to improve efficiency and quality. No information is available to date, however, on how enrollees with behavioral health conditions have fared under these arrangements. In the initial implementation year (2009), only a subset of the AQC contracts (3 of 8 medical groups) included risk for behavioral health care. Accountability for behavioral health is now described as a standard component of the AQC contract. Of the 62 performance-based quality measures, two are related to behavioral health care — antidepressant medication use during the acute phase and antidepressant medication use during the continuation phase of depression treatment.

Integrating Medicare and Medicaid for Individuals with Dual Eligibility

MassHealth is submitting a proposal to CMS to test and evaluate a model of care delivery for dually eligible adults ages 21-64, to fully integrate Medicare and Medicaid financed services. This initiative aims to overcome the fragmented, unmanaged and uncoordinated care to this population. In 2008, 64 percent of MassHealth dual eligible adults ages 21-64 experienced chronic mental illness or substance use disorder.⁵⁴ Under this proposed model, Massachusetts would offer care coordination and expanded behavioral health services, involving a broad array of diversionary services aimed at avoiding psychiatric hospitalizations that includes crisis stabilization, community support programs, partial hospitalization, structured outpatient addiction services, intensive outpatient services and inpatient-outpatient bridge visits. These services are intended to provide clinically appropriate alternatives to inpatient services, facilitate individuals' transitions to the community after a hospitalization, and support maintained functioning in the community. Consistent with broader care integration efforts, this model would identify one entity accountable for the delivery and management of all covered health and support services for an enrollee who is dually eligible, and would use a single global Medicare/Medicaid payment combined with performance incentives for providing high quality care.

VI. Preliminary Recommendations

This section offers preliminary recommendations for adopting payment and delivery system reform, with the aim of protecting and improving the well-being of those with behavioral health conditions in Massachusetts.

Payment and delivery system reform should be assessed on the basis of how the heterogeneous population of individuals with behavioral health care needs living in the state might be affected. Mental health and addiction disorders include depression, anxiety, psychoses, alcohol and drug abuse and dependence, and many other conditions. It will be critical for the architects of health reform in the state to consider and monitor the impact of reform on this diverse group, through a comprehensive assessment of the reform components under consideration.

Payment and delivery system reform should improve access to behavioral health prevention and early identification services. The current health care system in the state and nationally does not adequately support prevention and early detection of behavioral health conditions. The onset of three-fourths of all mental health disorders occurs by age 24;⁵⁵ and research demonstrates that early detection, treatment initiation and engagement is cost effective and can greatly improve quality of life and long-term outcomes.⁵⁶

Payment and delivery system reform should facilitate greater engagement of consumers and family members in shared decision-making with clinicians. ACOs should be structured to involve consumers and family members as partners in the care team; and payment systems including performance metrics should be structured to reward medical groups that excel in this domain. The consumer movement in mental health and addiction care has a wealth of experience in this area, expertise that can be used in designing ACOs consistent with the philosophy of a patient-centered medical home.

Carefully developed risk adjustment methods should accompany payment and delivery system reform to mitigate incentives to avoid enrolling consumers with behavioral health disorders. Even using sophisticated risk adjustment methods, ACOs may face incentives to dissuade individuals with behavioral health conditions from enrolling. Additional policies and practices should be considered — including reinsurance, risk corridors, and selective contracting to further mitigate selection incentives.

Payment and delivery system reform should include provider workforce training, information technology linkages and other mechanisms to strengthen

connections between behavioral health providers and the rest of the medical care system. It is critical to improve behavioral health providers’ “readiness” to be part of a more integrated health care system in the state. To take full advantage of the opportunities available under reform to reduce system fragmentation, workforce training and infrastructure investments should be directed toward enabling behavioral health providers to position themselves to be part of a more integrated care delivery system in the state. It will be critical for behavioral health providers to develop the capacity to exchange data within and outside their organization, use data as a routine part of clinical work, institute performance review practices, manage new payment structures (including P4P) and involve themselves in local health information exchanges. Workforce training should also extend to the primary care sector, to better equip primary care providers to address the behavioral health needs of clients served.

Payment and delivery system reform should include well-vetted, standardized performance measures for rewarding high-quality, consumer-centered behavioral health care. The field of behavioral health performance measurement is currently in flux; a plethora of different measures are being used in a manner that is not well-coordinated, with insufficient attention to measure validation. It will be critical to design measurement systems that do not contribute to incentives to avoid individuals with complex behavioral health care needs. Massachusetts has been an innovator in the development of performance measures tied to financial incentives in the public sector. The state now has an opportunity to lead in developing behavioral health performance measurement and payment that could be replicated in other states.

Payment and delivery system reform should require the involvement of behavioral health consumers and providers in the governance of new ACOs. The Governor’s bill requires that ACOs include consumer and provider representatives; however, this requirement does not apply specifically to behavioral health. Given the unique challenges to integrating behavioral health, it will be important to ensure that governing boards include the expertise of behavioral health consumers and providers.

Payment and delivery system reform should explicitly recognize the ongoing need for state and federal resources to directly fund behavioral health prevention, treatment and recovery support services. It will be critical to preserve state direct-service dollars to fund preventive and wrap-around services that are not typically reimbursed under public and commercial insurance. Safety net funding is also needed to provide services to individuals in the state who continue to be uncovered, a group likely to have behavioral health care needs. For example, while only 2 percent of the state’s population

remains uninsured, 21 percent of those seeking detoxification services were uninsured at the point of initial treatment contact in 2010, according to preliminary reports from the Bureau of Substance Abuse Services, Massachusetts Department of Public Health.⁵⁷ Agencies' roles may change as implications related to ACA become apparent. The ability of state agencies to oversee and protect the most vulnerable remains an important role as the system evolves.

Payment and delivery system reform should be designed to take strategic advantage of the numerous federal funding opportunities currently available to improve integration of behavioral health care. As noted above, the ACA includes funding, primarily although not exclusively through the Medicaid program, to support improving integration and coordination of behavioral health care. The state has positioned itself to take advantage of many but not all of these opportunities; additional initiatives (e.g., the Medicaid health home option) should continue to be explored as options.

Payment and delivery system reform should be designed to reduce racial and ethnic disparities in access to behavioral health care. Both nationally and in Massachusetts, evidence suggests that racial and ethnic minorities are less likely than whites to use mental health services and psychotropic medications even after adjustment for socioeconomic and other factors.^{58,59,60,61,62} Payment and delivery system reforms including behavioral health performance incentives should be designed with an eye to reducing these disparities, improving care and monitoring results.

Payment and delivery system reform should ensure that mechanisms are in place to protect the privacy of individuals with behavioral health conditions. These reforms will necessitate the development of information systems that facilitate clinical information sharing across multiple providers. It will be essential to identify parameters of participation and protection that support systems development within the state (in conjunction with national efforts organized through SAMHSA) to address individual, state, federal and provider issues and regulations related to privacy and confidentiality. The objective is to foster improved communication among service team while protecting individuals' privacy.

VII. Conclusion

Massachusetts is at a critical crossroads as state leaders weigh the opportunities and perils of moving to the next phase of health care reform. The 2006 health reform law solidified the state's role in the eyes of many as a leader in advancing health policy objectives; therefore, any changes initiated on the payment and delivery system side will be watched closely both within and outside the Commonwealth. In this dynamic policy environment, it will be critical to ensure that no groups fall through the cracks. An ongoing conversation about re-designing systems of care to better meet the needs of individuals with behavioral health conditions will be an essential element to the success of broader state reform efforts.

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