ABH

251 West Central Street
Suite 21
Natick, MA 01760

T 508.647.8385
F 508.647.8311
www.ABHmass.org

Lydia Conley PRESIDENT / CEO
Diane E. Gould, LICSW CHAIR

ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE

Request for Information (RFI)
Creating a Behavioral Health Ambulatory Treatment System
For: General Public, Trade Organizations and Health Insurance Plans

BACKGROUND

Since the start of 2015, the Baker-Polito Administration has prioritized the importance of improving access to behavioral health services across the spectrum of treatment for mental illness, addictions and co-occurring illnesses. In addition to significant policy changes, between FY16 and FY22, more than $1.9 billion will have been invested to improve availability of and access to behavioral health treatment and supports.

While we are making important strides in the implementation of parity laws, integration of behavioral and physical health and expansion of treatment capacity, deep-rooted structural challenges remain. There is no ambulatory behavioral health treatment system in the Commonwealth nor is there a continuum of behavioral health treatment for children, youth or adults. Ambulatory behavioral health treatment is fragmented and often insufficient to meet the specific treatment needs of patients and their families. These challenges persist across primary care, specialty treatment, urgent care, crisis care and across payers. Moreover, the fact that a significant percentage of the behavioral health providers who operate in the state do not accept third party insurance compounds access concerns.

For context, according to Mental Health in America 2020, Massachusetts is ranked second in the country with regard to "access to mental health care". This measure is based on insurance access, treatment access, quality, insurance cost, access to special education, and workforce availability. Examining the components of this measure is illuminating: although Massachusetts ranks first for "Mental Health Workforce Availability" (at 180:1 consumers to providers) and has the lowest rate of uninsured adults with a mental illness in the country (2.7%), 52% of adults with a mental illness received no treatment, and 54.5% of youth with depression did not receive any mental health treatment.

EOHHS received significant feedback during the eight listening sessions held between June-August 2019. During the sessions, many themes emerged, these include:

- **There are barriers to obtaining timely access to behavioral health treatment.** Finding treatment practitioners can be difficult, outpatient treatment requires an insurance referral and often involves long wait lists. Additionally, families struggle to pay the costs of treatment under high deductible plans. Significant frustration was expressed that there is a two-tiered system in the Commonwealth – appointments for cash only and long waits for individuals with insurance coverage.
- **There is a behavioral health workforce shortage**. Despite having the most providers per capita in the country, Massachusetts Behavioral health organizations

report trouble with recruitment, retention, training and turnover. Caregivers who depend on longer term services and supports expressed significant frustration with how frequently providers change, causing treatment disruptions. Proposed solutions included increasing salaries, implementing loan forgiveness, and incentivizing students to enter the field.

- **Provider reimbursement by third party payers is often insufficient** to cover the cost of providing care, resulting in "ghost networks"— insurer directories containing lists of treatment practitioners who don't accept insurance.
- **The fee-for-service model does not support patient-centered care.** The fee-for-service model creates staffing issues and disincentivizes providers from taking on patients who may not show up to appointments, including populations who need care the most. Also, the fee-for-service model results in little or no funding for care coordination and other non-billable but essential services.
- **Improvements are needed in care continuity and integration**. Addiction and mental health services should be better integrated, and behavioral health treatment should be integrated into the primary care setting. Additionally, early intervention/prevention should be incentivized and reimbursed, and risk factors (especially in the pediatric population) should be a qualifier for care (e.g., witnessing trauma, community violence). Trauma and its effects are under-recognized and under-treated. More training for providers and practitioners is needed to ensure that individuals are not inadvertently retraumatized.
- **A true community-based, trauma-informed crisis care system is needed.** Hospital Emergency departments remain a major source of crisis care. 24/7 urgent care should be expanded to provide behavioral health treatment in a setting other than the Emergency Department.
- **Availability of evidence-based treatments, specifically tailored to an individual's needs, is inconsistent.**
- **Enhanced coordination among state agencies is needed.** When providing services to the same consumers, state agencies should coordinate assessments and services. State agency documentation requirements should be streamlined.
- **There is a need for increased public awareness and effort to reduce stigma**. There is a lack of public education on the benefits of seeking mental health treatment. Additionally, parents with behavioral health needs often don't seek help due to fear of losing custody of their children.
- **Peer supports are a vital part** of effective behavioral health treatment. Peers such as certified peer specialists, recovery coaches, family partners and therapeutic mentors should be available more broadly, including in primary care settings.
- **There is a need for increased cultural competence and language accessibility**. Examples of this are specific needs of the LGBTQ community and the deaf and hard of hearing community.
- **The needs of certain populations are not widely understood.** There is a need for increased cultural competence and language accessibility. Certain populations, such as children and older adults have unique needs that must be addressed in the behavioral health system. Behavioral health as it intersects with the criminal justice

system requires more attention, including the training and support for police and support for those leaving incarceration.

A. RFI Respondent Information

1. What is your name, agency/organization, address, and URL?

   Name: Lydia Conley

   Agency/Organization: Association for Behavioral Healthcare

   Address: 251 West Central Street, Natick, MA 01760

   Website (URL): www.abhmass.org

2. What is your affiliation or interest?

The Association for Behavioral Healthcare (ABH) is a statewide association representing 80 community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 81,000 Massachusetts residents daily, 1.5 million residents annually, and employing over 46,500 people. Many of our members operate outpatient clinics licensed by the Department of Public Health to provide mental health and/or addiction treatment services in Massachusetts.

Re-envisioning behavioral health ambulatory treatment services requires short- and long-term infrastructure and service investment in the existing behavioral health system and in new models of service delivery, including new payment structures that do not rely on fee-for-service volume and productivity standards for clinic viability, and regulatory changes. ABH supports the following principles for the behavioral health ambulatory treatment system.

ABH supports a BH ambulatory treatment system in which: 1) Individuals and families can enter through any care setting and transition to appropriate levels of care; 2) A robust, appropriately resourced, specialty behavioral health care system provides integrated treatment for mental health, substance use, and co-occurring disorders with urgent and walk-in access; 3) A 24/7 behavioral health crisis response system supports stabilization and successful transitions and promotes access to the least restrictive level of care appropriate to a person's needs; 4) Primary care practices and specialty behavioral health clinics are incentivized to work together to meet the treatment and recovery needs of individuals and families; 5) Individuals are supported with teams offering a range of clinical and nonclinical interventions and such teams include individuals with lived experience such as Recovery Coaches, Certified Peer Specialists and Family Partners; and 6) Clinical and nonclinical staff view community-based behavioral health roles as desirable and know that if they enter the field, they can enjoy a career that is family-sustaining.

B. General Questions

3. What would a **single front door** for accessing outpatient mental health and substance use treatment look like to you?

There is no other area in health care in which individuals are expected to self-determine which level of care or treatment intervention they need. Like community health centers in primary care, community behavioral health clinics should be organized as the front door to access all behavioral health services. Once a person enters through that door, these clinics must be resourced to deliver, either on their own or through strong partnerships with other community providers, a comprehensive set of appropriate treatment and recovery services to that individual.

The current state of ambulatory behavioral health services is fee-for-service and volume-driven. It is poorly resourced and unable to keep up with demand or new evidence bases in treatment. The amount of available resources and the current payment structure does not support a transition to a comprehensive system which affords open access to high-quality, evidence-based services and promotes integration with primary care.

To re-imagine mental health and addiction ambulatory services, the Commonwealth must adopt an alternative payment methodology that supports (1) open access to initial and ongoing services, (2) a coordinated and comprehensive array of services, and (3) strong bridges between specialty and crisis services and primary care.

The federal Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration is dramatically increasing access to services because the model provides payment that adequately covers the cost of doing business. Participating clinics have been able to transform and expand access to both traditional and innovative ambulatory care in their communities. In a recent National Council for Behavioral Health presentation, data showed that CCBHCs have increased access by reducing wait times and increasing the number of individuals served. In 2017, 87% of CCBHCs surveyed reported that they had seen an increase in the number of individuals served. Additionally, within one year of implementation, 17% of CCBHCs have seen a greater than 50% increase in their number of *new* patients with addiction.

Significant, ongoing funding is needed to substantially enhance services and support the recruitment and retention of the staff needed to operate these programs. Funding must support needed infrastructure, e.g., Emergency Notification System (ENS) incorporation and telehealth technology, physical plant changes (e.g., exam rooms, etc.) and staffing and clinical pathway changes (e.g., embedding additional psychiatry and nursing, etc.). An alternative payment methodology that does not remedy current outpatient losses and build in new anticipated costs will not bring the transformation envisioned.

ABH strongly endorses a model that both moves away from fee-for-service and reimburses for actual costs such as the Prospective Payment System (PPS) methodologies currently

in use under the Section 223 CCBHC Demonstration. Unlike traditional fee-for-service, CCBHCs use one of two Alternative Payment Models that include bundled payments and require reporting on quality measures. The federal CCBHC payment structure is similar to the payment structure of federally-qualified health centers. This payment structure had the potential to bring the same availability and parity to the system.

4. What are the **top three challenges** with the way in which **outpatient behavioral health** treatment is delivered today?

Challenge 1: Inadequate Funding

Despite the Commonwealth's recent investments to stabilize outpatient behavioral health services, ABH data show that member organizations struggle with increasing outpatient losses and significant staff vacancies, particularly for prescribers, which combine and translate to long wait times for initial and ongoing access. A BH ambulatory treatment system that is adequately resourced can serve individuals well by offering open access, urgent and routine care, and as-needed prescribing. This is not the current state.

In FY19, ABH members responding to an ABH survey reported a financial loss on outpatient services. The average reported loss was $667,759 (up from $582,057 in 2017). To mitigate losses, providers: 1) Implemented wait lists; 2) Reduced staff; or 3) Reduced or narrowed access in clinic sites or closed programs.

In FY19, roughly 50% of responding members reported one or more unfilled prescriber positions. A total of 52% reported wait times for children of more than 1 month for routine assessments with a psychiatrist/nurse prescriber, 12% were not accepting new referrals for children, 60% reported wait times for adults of more than 1 month for routine assessments with a psychiatrist/nurse prescriber and 8% were not accepting new referrals for adults.

Additional short-term investment is needed urgently to prevent more attrition before system transformation can begin. For example, two member organizations have recently notified ABH about intentions to close or reduce in-home therapy services. ABH recommends a CY2020 increase to MassHealth fee-for-service and managed care BH clinic rates to shore up services as design development proceeds.

Once the system is stabilized, substantial new investment is needed to pay for the actual costs of service delivery, to help providers develop the clinical and administrative infrastructure needed for new care models, and to build sufficient incremental financing into alternative payment designs to address both current deficits and desired innovations.

Challenge 2: Workforce Shortage

Complex and pervasive clinical and nonclinical workforce challenges are driven significantly by low reimbursement, i.e., pay, but are also complicated by supply and

demand, burnout, extensive administrative and documentation requirements, student loan burden, and the cost of living in Massachusetts.

While workforce challenges are complex and multi-sectored, the high vacancy and turnover rates in community-based behavioral health provider organizations threaten existing services and the viability of new services. Experienced clinicians who achieve independent licensure leave the community-based public-sector setting for significantly higher compensation in state agencies and healthcare systems, as documented by the 2017 Gallagher Survey comparing behavioral healthcare compensation versus hospital compensation in Massachusetts.

Key safety net workforce challenges identified in a 2016 Health Resources and Services Administration (HRSA) report include (1) chronic underfunding of the behavioral health safety net, (2) historically low wages and high caseloads which lead to high burnout and turnover rates, (3) no real-time data on the number of mental health professionals, licensure differences and lack of consistent definitions from state to state which makes recruitment difficult, (4) low reimbursement rates for behavioral health services in Medicaid and Medicare, and (5) lack of reimbursement for critical services like care coordination.

Challenge 3: Complicated and Arduous Regulatory Environment

Actual and perceived regulatory barriers such as limitations on same-day and outreach services, inability to provide short-term interventions, outdated staffing patterns, privacy and information sharing restrictions, and others continue to make it difficult for providers to operationalize desired changes to the care delivery system.

Outpatient behavioral health clinics are currently limited to billing only for traditional behavioral health services. Clinics cannot bill for nursing support (health screenings and health coaching) or peer support (neither 1:1 nor groups). Additionally, regulations must change to expand the provider types that work in these environments. MassHealth regulations only allow a narrow set of mental health and addiction professionals to render billable services in these settings. Changes must be made to allow for more provider types and care coordination, support services, shorter episodes of care and delivery of limited medical services. In addition, MassHealth should seek federal authority to remove the limitation on outreach services delivered by clinics.

EOHHS and MassHealth should continue to take an active role in streamlining operations for providers so clinicians can focus on treatment not paperwork. Ideas include: 1) Universal MassHealth behavioral health benefit; 2) Require all MassHealth payers to adhere to universal performance specifications; 3) Require all MassHealth payers to participate in a universal credentialing process so providers do not have to credential with each payer individually, as proposed in the Governor's healthcare bill; 4) Develop and standardize a universal consent form that captures the needs of both HIPPA and 42 CFR Part 2 for the use of both medical and behavioral health providers. 5) Complete consent process at MassHealth enrollment; and 6) Explore a singular licensure structure within DPH

for when a clinic has both mental health, addiction treatment, and co-occurring competencies and delivers integrated behavioral health services.

- How would you suggest that those challenges for **adults** (ages 19 and up) be addressed?

Community behavioral health clinics function as the training grounds for the next generation of licensed behavioral health professionals, but they have never been resourced to offer levels of supervision beyond the minimum requirements. Quality training and supervision leads to higher quality care and improved staff retention, but does have a cost and these costs must be fully incorporated into rate development. To mandate new requirements without new funding will result in a situation where providers cannot fulfill expectations. In a future state, all community behavioral health clinics must be resourced to provide robust supervision to enhance connections between new staff and community services as well as provide a renewed focus on the adoption and implementation of evidence-based practices.

Additionally, highly specialized, highly localized, or smaller volume behavioral health clinics will always play a critical role in creating a responsive, accessible ambulatory behavioral health system for adults and children. MassHealth should mandate a payment increase across all of its payers that differentiates between clinic and group practices. All clinics provide value in terms of training and supervising the workforce of tomorrow, connection to a wider range of specialized, localized community services, and access to multidisciplinary treatment teams. MassHealth should support the added value that clinics bring to its members as well as the infrastructure clinics need to continue to bring value through an increased rate.

The Commonwealth should build on the DSRIP Statewide Investment's Student Loan Repayment, Primary Care/Behavioral Health Special Projects and CMHC Recruitment Fund Programs as part of its system design to encourage early career providers to enter and stay in the field. In addition, high performing clinics and/or clinics serving underserved populations should be allocated student loan repayment slots so that they can recruit key staff.

The future system should also include the flexibility to offer shorter-term and/or briefer interventions, reductions in duplicative paperwork, and the ability to offer services outside of the clinic walls in in the community.

A phased approach to regulatory flexibility will assist in planful systems change. In 2016 and again in 2018, ABH proposed a comprehensive regulatory revision (https://tinyurl.com/wuslaaj) that would add a broader array of provider types to the community mental health center framework, allow for service delivery in natural environments, and create the flexibility providers need to establish short-term interventions essential to integration with physical health care, crisis and urgent care. The Commonwealth should adopt these changes now to enable provider organizations to prepare for systems change. These proposed revisions would expand access in clinics

that are likely to remain traditional behavioral health clinics and those that might enhance their capacity around urgent care and connections to primary care.

Better integrated care will also require provider types billable through a mental health clinic to be expanded to include RNs, APRNs, pharmacists, peer supports, health coaches, etc. who will be important additions to the clinical model that promotes new clinical and nonclinical services and pathways between primary care and community behavioral health clinics.

- How would you suggest that those challenges for **youth** (ages 0 to 18) be addressed?

The recommendations above for adults are equally applicable for youth; however, our members report that recruitment and retention of staff for child-serving behavioral health organizations is particularly challenging given the intensive nature of working with families, non-traditional service hours to meet family availability and staff lack of familiarity with or preparation for in-home services. Rather than designing new, separate services, this re-envisioning of the BH ambulatory system should focus on stabilizing and enhancing the existing system. Funding must support salaries that are livable and incentivize behavioral health providers to stay in the field. Additionally, there should be increased efforts to educate and prepare people entering the field about the community-based system of care and in-home services.

Once the existing system is stabilized through adequate funding, the child/adolescent behavioral health system should be built upon to offer better coordinated, consistent and streamlined access to appropriate levels of care for youth and families. CSAs should be expanded to serve more children and adolescents. Currently, the medical necessity criteria for ICC is restrictive and many families that need assistance in system navigation, care coordination, and transitions of care do not qualify for this service, nor need this intensity of service. As a result, families are left to navigate the complex system on their own.

As noted by the Children's Mental Health Campaign in their recent report on urgent behavioral health care, in physical health, the management of chronic illness is a routine part of care, however in behavioral health the closest equivalent is ICC and it is not always offered or available to children and families. Expanding ICC to offer a tiered system of care coordination services depending on the intensity of the youth's and family's level of needs, will improve timely access to appropriate levels of care by having a highly specialized and experienced provider to help guide families and reduce confusion, frustration, and preventable crises by assisting families in identifying and accessing appropriate resources before behavioral health conditions worsen.

Additionally, the service continuum should be enhanced to ensure that in a crisis, there is adequate access to diversionary services for the family. Expansion should include building additional staffing, including nursing, into MCI to support more robust community-based locations, expanding services to include access to MassHealth-funded youth crisis stabilization and youth respite services. Adult-serving providers view the availability of

DMH-funded respite to be a vital part of the continuum. Respite should be available to youth as well. Additionally, MCI should be funded to provide enhanced follow-up care in the community for children and families in crisis, youth stepping down from higher levels of care, and youth at risk of hospitalization.

Building upon the existing behavioral health system once it is stabilized and enhanced, regulations and payment methodologies will need to change to allow for more specialty behavioral health providers to provide services in schools and pediatric practices as well as to offer family-friendly hours as needed.

5. What are the **top three challenges** with the way in which **behavioral health crisis services** are delivered in the Commonwealth today?

Challenge 1: ED-Focused Payment and Care Delivery Model

Lack of access to outpatient services, medication assisted treatment, same-day prescribing and other step-down levels of care drive people to the continue to seek care in the ED. The current ESP funding structure is a volume-based payment model that requires ESPs to focus resources on the ED as that is where the current volume of encounters exist.

ABH endorses EOHHS's vision to increase community diversion and stabilization through the Emergency Services Program (ESPs) with new investments. There is significant opportunity for better care delivery, but there is risk of destabilization of current services. ABH cautions MassHealth to consider systematically how and why individuals choose the ED for their care. Encouraging and supporting a significant change in the behavior of MassHealth members is essential to build the capacity of the crisis system to innovate and expand beyond their current community capacity. Before this behavior change can happen though, we must ensure that when a family chooses this alternative to the ED, the service can deliver what the family needs. Additionally, a strong crisis system must be supported by an outpatient system to divert individuals to as appropriate. Attempting to move away from the emergency departments without first shoring up the outpatient system will be unsuccessful.

ABH understands that MassHealth has plans for a public awareness campaign on the benefits of ESPs. The timing of the campaign is vital. If this occurs before ESPs are able to deliver more community interventions or before upstream and downstream access issues are resolved, stakeholders could be permanently dissuaded from using ESPs. If the campaign occurs too late, volume may never materialize in the community to help sustain the new model. ESPs alone cannot drive encounters to the community.

Challenge 2: Lack of immediate access to diversionary, outpatient services, and inpatient services

Investment in the community outpatient treatment system is critical to meet current treatment demand, and it is also vital for securing buy-in from stakeholders, including EDs, law enforcement, schools, health plans, primary care practices and others to divert individuals from the ED. If the crisis system is not able to connect individuals to stabilizing supports, individuals, families and stakeholders will have no reason to continue to engage with them in the community.

Substantial investments are needed in community-based behavioral health, including: 1) strengthening the outpatient system to end service waitlists and access delays, prevent additional service reductions, and stop substantial financial losses; 2) supporting the development of additional behavioral health workforce professionals; and 3) increasing rates to cover actual costs.

We strongly support maintaining individuals in the community when possible. To do this, crisis providers must have immediate access to diversionary and outpatient levels of care in a manner and capacity that does not currently exist. The existing outpatient system must be first stabilized and then enhanced through new funding to offer greater access. However, our members also recognize the acuity of an individual may exceed that which can be treated appropriately in today's community-based system. Despite the state's significant efforts to address the ED boarding crisis, recent data shows the number of children boarding has increased in recent months. Significantly strengthening the ambulatory system through investment and regulatory changes will help to keep children in their homes and communities. We recognize that in some instances, inpatient level of care is appropriate. ABH members report difficulty in accessing the existing inpatient system due to inconsistent receptivity to accepting individuals with complex behavioral health presentations and the workforce shortage. Rather than creating more inpatient beds and additional competition for scarce clinical expertise, existing facilities should be supported to meet current needs in conjunction with continued community investment.

Challenge 3: Regulatory barriers to providing short-term interventions

Regulatory and payment barriers make it difficult for ESPs and mental health clinics to provide short-term interventions and get paid for these services.

The current Mental Health Center Manual (130 CMR 429.400) requires clinicians to complete a full clinical assessment for all patients, even for short term interventions (429.436). This is a barrier to care as the ability to complete short-term interventions that last only a few sessions is necessary in emergency and urgent care models. The DPH Clinic regulations also include requirements for a long, comprehensive assessment that is not practical when serving individuals on a short-term, urgent basis (105 CMR 140.520). Providers also note that these assessments make it difficult to serve the family members of clients who may need a short-term intervention or group support. These comprehensive assessments are also required prior to a psychiatry visit, which directly hinders the ability to provide immediate access to medication.

In contrast, short-term interventions are quite common in medical practices where the "treatment plan" might be very brief and focused on a specific problem and behavioral health providers need the same flexibility. In addition, behavioral health providers are now working in integrated care settings in medical practices and a full evaluation may not be appropriate and may actually be a barrier to integrating behavioral health into primary care sites.

- How would you suggest that those challenges for **adults** (ages 19 and up) be addressed?

Individuals and families use medical urgent care facilities because of convenience; local access, shorter wait times, and immediate solutions. ABH believes that both ESPs and enhanced community-based behavioral health clinics should be resourced to offer urgent care capacity. This complementary capacity to meet urgent BH needs is vital to ensure that for consumers there is no wrong door to care. The Commonwealth should build on existing outpatient and crisis services, not create standalone urgent care centers that would further segment the system.

Access to urgent BH care cannot expand without first investing in the stabilization of the existing system. We appreciate MassHealth's recent commitment to increasing rates for ESPs and CCS. This investment is a vital first step of a longer process that should contemplate changes to the ESP payment structure to support true 24/7/365 crisis capacity and new urgent care capacity which would be extremely difficult to achieve with an encounter-based model.

MassHealth and its payers must resource ESPs to be able to accomplish the same types of successful interventions in the community for this new model to be successful. The ESP Community Based Locations (CBLs) must receive enhanced funding to offer new services and supports. ESPs must be given expanded clinical authority to place individuals in diversionary and outpatient services.

To achieve the future state, BH clinic system must also have same-day urgent care capacity. These clinics and crisis providers should be required to have agreements to ensure that after-hours crisis services are available and to ensure for smooth care transitions. This must include the ability for an individual to see a clinician and/or prescriber quickly. In its reimagining of specialty outpatient services, the Commonwealth must require through regulatory and performance standards that enhanced community-based behavioral health clinics with urgent care capacity have strong partnerships with ESP/crisis providers.

After the crisis and ambulatory systems are stabilized through investment and regulatory changes the Commonwealth should consider strategies to move the crisis system toward 24/7/365 on-site staff capacity, much like a firehouse is prepared for other types of emergencies. This approach will likely require an alternative payment models, such as through a capitation payment. This service must be available to all individuals, regardless

of insurance coverage. The Commonwealth might consider a model similar to MCPAP that assesses commercial carriers based on the number of their members who access services through CBLs. The forthcoming renewals of the Section 1115 Waiver as well as the PIHP contract held by MBHP provide a time and a runway for more radical reimagining of the crisis response system and financing.

Enhanced community-based behavioral health clinics and crisis providers must closely partner to serve urgent needs and to triage individuals to appropriate care. Depending on which door the individual entered, the enhanced community-based BH clinic or the crisis provider may be in the best position to provide follow-up care in the community. With new crisis and ambulatory resources, the expectation should be that the crisis provider helps individuals' transition to the enhanced community-based BH clinic after crisis.

- How would you suggest that those challenges for **youth** (ages 0 to 18) be addressed?

The re-envisioning of the BH ambulatory system should focus on stabilizing and enhancing the existing system. There are a number of levels of care that exist today in between outpatient and emergency departments including MCI, CBAT, ICBAT, and partial hospitalization programs (PHP). While the services exist, the various services' capacity and flexibility to be responsive to children and families is lacking.

ABH recommends enhancing the existing MCI service, CBAT/ICBAT service, and PHP network to be able to provide robust support to children and families in crisis.

The current MCI rate methodology has not been updated since 2009 and fundamental flaws to the initial methodology exist today. Specifically, as a 24/7/365 service, MCI needs to have on- call and relief staff built into the model. Gaps in coverage result in staff burnout, low morale, and delayed and then rushed services to families. Additionally, the proposed $11 million investment in ESPs does not directly include MCI. In order to provide an enhanced alternative to the ED, MCI providers will need funding to significantly enhance their community-based locations including funding for security costs, nursing support, and physical plant expansion.

We want to thank EOHHS for the investment of $3 million to help stabilize I/CBAT programs, which are a vital part of today's service continuum. We recommend this level of care be stabilized by removing the stringent medical necessity criteria and onerous authorization processes to access this level of care. At the same time that families and providers report inability to access CBAT for children and youth who need it, CBATs across the state have been closing due to difficulty maintaining census. Similar to ESPs' ability to divert adults to Community Crisis Stabilization beds, MCIs should be able to divert children and adolescents to I/CBAT without the requirement of prior authorization from insurance companies.

Some children and families may not need 24-hour crisis stabilization, but continue to need significant structure when stepping down from an inpatient stay. Partial hospitalization

programs offer a non-24-hour diversionary treatment program that is hospital-based or community-based. PHP may be appropriate when a child does not require the more restrictive and intensive environment of a 24-hour inpatient setting but does need up to eight hours of clinical services, multiple days per week. PHP is used as a time-limited response to stabilize acute symptoms. There is an opportunity to expand partial capacity for youth, which today is very limited.

Lastly, families and providers across the state's listening sessions voiced a need for respite services for children, adolescents, and parents in order to avoid crises and/or unnecessary trips to the ED. This level of care exists already for adults and ABH recommends this be considered for children as well.

Are there behavioral health crisis system models that you would recommend the Commonwealth adopt?

- *If yes, please* describe the **Youth Crisis Models** you would recommend for ages 0-18 (consider 24/7/365 operation, ED diversion strategies, staffing required for youth specific resources, and mobile deployment of staff).

ABH envisions a system of urgent and emergent mental health and addiction care which includes evaluation, stabilization and referral that is available at a community-based crisis center 24/7/365. Expanded Crisis/MCI services would be properly resourced to also play a larger role in the behavioral health ambulatory system as the connective tissue bringing together disparate parts of the system and serving an essential role in bridging populations that have traditionally gotten "lost" during care transitions to diversionary and outpatient services until the transition "sticks".

In a re-envisioned state, Crisis/MCI teams will be enhanced to serve an expanded capacity in the community as a diversion point for police and EMT drop-off. ESP/Crisis also maintains and expands the current crisis stabilization programs to offer community-based, 24-hour treatment and respite capacity for youth. Expanding Mobile Integrated Health (MIH) programs would support this vision.

To fulfill the functions listed above, ESP/MCI crisis providers must be resourced to support 24/7/365 capacity, much like a community firehouse, so that their community-based locations are appropriately staffed and physically equipped to offer an alternative to the ED. There will never be sufficient volume to support this model with an encounter-based payment approach. Staffing will need to include nursing staff to triage minor medical issues and CBLs will need to be enhanced and expanded to provide an appropriate and family-friendly environment. ABH strongly recommends the transition to a fire house model be implemented through stages that first focuses on stabilizing the current system and then enables crisis providers to build up their CBLs, staffing, and other key elements needed for a responsive community-based location through additional funding.

- *If yes,* please describe the **Adult Crisis Models** you would recommend for ages 19 and up (consider 24/7/365 operation, ED diversion strategies, staffing required for adult specific resources, and mobile deployment of staff).

ABH envisions a system of urgent and emergent mental health and addiction care which includes evaluation, stabilization and referral that is available at a community-based crisis center 24/7/365. Expanded Crisis/ESP services would be properly resourced to also play a larger role in the behavioral health ambulatory system as the connective tissue bringing together disparate parts of the system and serving an essential role in bridging populations that have traditionally gotten "lost" during care transitions to diversionary and outpatient services until the transition "sticks".

Crisis/ESP teams must include a mobile capacity to serve individuals when and where they need it, including in the home, in schools, and primary care offices, and serve an expanded capacity in the community as a diversion point for police and EMT drop-off. ESP/Crisis also maintains and expands the current crisis stabilization programs to offer community-based, 24-hour treatment capacity for adults. Expanding Mobile Integrated Health (MIH) programs would support this vision.

To fulfill the functions listed above, ESP and crisis providers must be resourced so that their community-based locations are appropriately staffed and physically equipped to offer an alternative to the ED, 24/7/365, much like a community's firehouse.

Additionally, ESPs should provide services to the adult population beyond the first day. This would allow ESPs to provide urgent behavioral health care access and maintain stabilization for individuals served. ESPs could then fill a current gap in the system of bridging individuals from various levels of care until they can successfully transition to clinic-based services. This support for transitions of care afforded to Behavioral Health Community Partner (BHCP)-enrollees is proving to be successful but less than 3% of MassHealth individuals are enrolled in a BHCP. Expanding this important support to individuals will be an important component to an enhanced ambulatory treatment system. The Commonwealth should also consider whether ESPs can assist individuals receiving Medication Assisted Treatment (MAT), and access other short-term prescribing as they await transition to outpatient services.

7. What types of support services provided from individuals with lived experience (e.g., family partners, peer supports, recovery coaches, recovery support navigators) are the **most helpful to your patients**?

- In what settings are these support services the most effective?

Peer supports are a vital part of the behavioral health system. In a future state, it is essential that peer supports be a component of enhanced community-based behavioral health clinics

and included in any bundled services rate. These roles are not currently supported in outpatient clinics.

Peer supports, including Certified Peer Specialists, Recovery Coaches, Recovery Support Navigators, Family Partners, and Peer Mentors, have proven invaluable to families and individuals navigating mental health and substance use disorders and accessing care.

ABH applauds MassHealth for recognizing the value of Recovery Coaches, Recovery Support Navigators and Family Partners via direct reimbursement and of Certified Peer Specialists as team members in CPs, ESPs and psychiatric day treatment programs.

Family Partners and Peer Mentors have proven to play significant roles in treatment for children and families in CBHI, DCF, and DMH services. Often, because of the trust established in the peer role, Family Partners and Peer Mentors can be required to help a youth and families navigate situations beyond their lived experience, so it is crucial that they have the training, supervision, and support to work through those challenging situations.

ABH recommends EOHHS convene a work group with the various peer communities to discuss how best to integrate their roles into the re-envisioned behavioral health ambulatory system while preserving their unique relationships with the client-served**.** A similar exercise was undertaken with the establishment of the Recovery Coach Commission under Governor Baker's signing in to law of chapter 208, section 101, of the Acts of 2018 which included a panel of recovery coaches. The contributions of the recovery coaches was invaluable to this commission and ABH recommends the feedback from the commission be considered.

8. What should the relationship between **law enforcement** and **behavioral health crisis providers** look like in order to avoid arrest and incarceration of individuals in behavioral health crisis?

ABH strongly supports a future state in which law enforcement and Mobile Integrated Health (MIH) programs could divert individuals to ESP Community Based Locations (CBLs), but this will require significant investment, regulatory change and cultural shifts. Currently, application costs for MIH are prohibitive. ABH recommends EOHHS consider funding the MIH Program to adequately cover the staff positions needed to process applications, rather than passing that on to applicants working in many cases with limited resources.

Today, ABH members, particularly ESP providers, engage with law enforcement officials in their communities. We strongly support the work of the Department of Mental Health who offers technical assistance and funding for police training, including Mental Health First Aid, CIT and the co-responder model. Research shows that police officers working in departments with jail diversion programs report greater tolerance and acceptance of

individuals living with mental illness in their communities and more strongly endorse their role in managing persons with illness than their counterparts in non-jail diversion program departments. EOHHS should continue these investments and focus more resources on connecting these programs with existing crisis support systems, like ESPs.

MassHealth has also procured two pilot programs of specialized case management for the criminal justice involved population. The Behavioral Health Supports for Justice Involved Individuals (BH-JI) Project is based on the highly successful WISR Model in Worcester County. WISR showed decreases in recidivism, decreases in emergency services accompanied by an increase in outpatient treatment engagement and increases in housing and economic stability.

ABH is also a member of the Middlesex Restoration Center Commission and we are grateful for the Commonwealth's commitment to that project and working with all stakeholders to ensure this new program is built to fit into the current service landscape and not duplicate services that already exist. Any restoration center should be built in strong partnership with the enhanced community-based behavioral health clinic and ESP system.

ABH and our members do remain concerned about the barriers created by the commercial insurance system. Law enforcement should never be in the position where they must know an individual's insurance status in order to access services, but providers must be compensated so they can operate payer blind in these situations.

9. Is there need for **24/7 crisis stabilization** units that provide respite care for **youth** (ages 0-18) with acute behavioral health treatment needs as an alternative to psychiatric hospitalization?

- *If yes,* what clinical and support services should be made available in that model of care?

If used appropriately, I/CBAT are currently designed for children and adolescents with serious behavioral health disorders who require a 24-hour-a day, seven-day-a-week, staff-secure (unlocked) treatment setting. The primary function, according to the MBHP performance specifications, of I/CBAT is to provide short-term crisis stabilization, therapeutic intervention, and specialized programming in a staff-secure environment with a high degree of supervision and structure, with the goal of supporting the rapid and successful transition of the child/adolescent back to the community. In effect, /I/CBAT are the 24/7 crisis stabilization level of care for youth in today's system. As mentioned previously, many families and providers experience significant difficulty in getting authorization from insurance companies for this level of care due to the stringent medical necessity criteria and erroneous perception that it is an inpatient level of care. ABH recommends allowing MCI to refer to I/CBAT without prior authorization from insurance plans to alleviate this bottleneck in the continuum for youth and adolescents, as is the case for ESP referrals to CCS beds.

Throughout the EOHHS hosted listening sessions, families and providers spoke of a need for respite services for children, adolescents, and parents in order to avoid crises and/or unnecessary trips to the ED. This level of care exists today for adults and ABH recommends EOHHS consider the creation of this level of care for children as well.

10. Are there ways that public agencies involved in the behavioral health care of children (e.g., MassHealth, Department of Mental Health, Department of Public Health, Department of Children and Families, Department of Developmental Services) could better **coordinate** or **streamline** their services?

- What would you suggest to improve that coordination?

While significant cross-agency collaboration exists today, this voluntary collaboration often relies on personalities and relationships—even if a strong and stable meeting structure is in place. Additionally, as evidenced by the joint DMH/DCF procurement Caring Together, while in theory, an integrated service continuum is ideal, even with the best intentions there are a number of external factors that get in the way of family-centered service delivery. The creation of Community Service Agencies and Intensive Care Coordination was intended to provide a single entity responsible for ensuring coordination of a child's and family's care across services. ICCs are required to provide intensive care coordination to small numbers of youth and families and do not have other (non-ICC related) job responsibilities; facilitate the development of a Care Planning Team (CPT); convene CPT meetings; coordinate and communicate with the members of the CPT to ensure the development and implementation of the ICP; work directly with the youth and family to implement elements of the ICP; coordinate the delivery of available services; and monitor and review progress toward ICP goals and update the ICP in concert with the CPT. The Care Planning Team is comprised of both formal and natural support persons, including the youth and caregiver, representatives of child-serving state agencies, and school personnel. While improved cross agency collaboration is encouraged, ABH recommends the state use ICC for its original intent to fulfill the care coordination responsibility, rather than creating multiple care coordination teams in various state agencies. CSAs should also be expanded to be the true Community Partners (CPs) for children and adolescents. Currently, the medical necessity criteria for ICC is restrictive and many families that need assistance in system navigation, care coordination, and transitions of care do not qualify for the service, nor need that intensity of service.

11. What resources, trainings, or policy changes are needed to allow schools to most effectively respond to students with behavioral health treatment needs?

EOHHS should provide support to schools to offer training for school personnel on prevention, early intervention, trauma-informed practices, and the community-based behavioral health system. This would make a tremendous impact on the behavioral health system. Youth Mental Health First Aid is an evidence-based practice endorsed by the

National Council for Behavioral Healthcare. ABH recommends this training be implemented across all school districts. This training is 8 hours and can be completed during the course of an in-service day. Not only does this training give basic skills on behavioral health to school faculty, but it also teaches individuals how to make referrals.

While the Baker Administration's requirement that all schools screen for substance use disorders is a major step forward, what happens following that screening varies school by school and student by student depending on training and resources.

According to a recent report on access to urgent behavioral healthcare by the Children's Mental Health Campaign, the Commonwealth might learn from the success of school-based health centers in its creation of a behavioral health ambulatory system. According to the report, access to school-based health care was correlated with lower hospitalization and emergency room expenses for children with Medicaid compared to children with Medicaid without access to school-based health centers. While embedding clinicians into a school offers important urgent access, it is also important that school-based mental health services collaborate closely with community-based providers in order to assure that youth have access to the full continuum of behavioral health services year round. As the study also pointed out, a current shortcoming of the embedded health center model is that it is fee-for-service and does not allow for flexibility to provide urgent intervention or crisis response.

- What models of school-based behavioral health service delivery are working well in the Commonwealth today?

In today's environment, a student's access to behavioral health services through school varies widely. Currently, out the 406 school districts in the state, 14 schools are participating in school-based brief intervention programs offered through the Bureau of Substance Addiction Services and 18 schools are participating in intensive school-based intervention programs. Expanding these programs to every school would have a major impact. Our members report that one of the biggest barriers to substance use treatment for youth is the parental stigma associated with sending your child "away" for treatment and also the voluntary nature of residential substance use programs. Our members report that school-based substance use intervention programs are very successful and we recommend these community-based treatment options and resources be expanded.

Additionally, the Bridge for Resilient Youth in Transition (BRYT) program is a school-based intervention program to help youth transitioning back to school. The BRYT model is now utilized in over 80 programs across the state and has proven successful in keeping youth in the classroom, improving attendance rates, improving well-being, and increasing graduation rates.

- What is **working** in regards to the relationship between the Emergency Services Program (ESP) and Mobile Crisis Intervention (MCI) and schools today?

ESP/MCI is an effective tool for those schools that understand what the service is and its potential value to keeping children in the community. This is achieved when schools participate in their local Community Crisis Intervention teams, School Resource Officers are trained on ESP/MCI and behavioral health treatment, and key staff including the principal, adjustment counselors, and the school psychologist and social workers meet regularly with the ESP team. Through this regular communication and training, key school personnel understand how MCI works and are more likely to use Safety Planning Meeting prior- and post-interventions, inform parents about an MCI assessment prior to MCI arrival at the school, ensure that staff with knowledge of the child and situation are available, and understand how MCI follow up is individualized to the child, and situation, all of which contribute to a more positive experience and outcome.

- What is **not working** in regards to the relationship between the Emergency Services Program (ESP) and Mobile Crisis Intervention (MCI) and schools today that could be improved?

Currently, relationships between school districts and even individual schools and ESPs vary widely. The fact that most commercial payers do not pay for mobile services makes it very difficult for schools to rely on the ESPs.

The Commonwealth has few levers available to compel self-insured insurance products to cover vital benefits like ESP services, but a model does exist to cover both child vaccinations and to fund the MCPAP program. In these models, state regulations determine and assess a surcharge on health plans to cover these services offered to all insured individuals. It is our understanding this covers self-insured plans too. The Legislature should establish this system so that insurance covers these vital emergency services.

Additionally, the competing demands for both time and resources faced by schools make it difficult to successfully offer these services within the school day. Schools are appropriately focused on learning time making it difficult for providers to deliver behavioral health services during the school day.

12. Should the Commonwealth consider mandating **standard behavioral health screenings** within **primary care**?

Yes.

- *If yes,* please explain why the Commonwealth should consider mandating standard behavioral health screenings within primary care.

As required through the Children's Behavioral Health Initiative, screening for behavioral health conditions in primary care during well-child and other office visits is effective in early identification and intervention for children. A 2017 literature review on screening for behavioral health conditions in primary care settings published in the Journal of General Internal Medicine found mounting evidence that early recognition and treatment of

behavioral health disorders can prevent complications, improve quality of life, and help reduce health care costs. Mandating standard behavioral health screenings within primary care creates an additional access point for services, identifies individuals who might not have sought treatment on their own, decreases the stigma of seeking help, and also holds primary care practices accountable to integration.

13. What **behavioral health assessment and treatment** services **should be available in the primary care setting**?

N/A

14. Should the Commonwealth **require primary care practices** to deliver **medication-assisted treatment (MAT) for addiction**?

- *If no,* please explain why not.

No. While ABH supports primary care practices having the option to deliver MAT for addiction treatment, we do not recommend making this mandatory. Mandating MAT services will not make doctors feel confident or competent to treat addiction disorders. As a doctor would refer someone with severe heart disease to a cardiologist, PCPs should have a strong network of specialty addiction treatment providers to refer patients to as appropriate. Following the hub and spoke model, specialty addiction treatment providers who have the specialized training and experience crucial to effectively work with individuals with addiction, should function as the hub of addiction treatment. Primary care physicians and other community-based providers should be structured and funded to set up strong partnerships to seamlessly link clients to these specialty providers. In a 2014 study published in the Annals of Family Medicine on barriers to primary care physicians prescribing Buprenorphine, the top-cited barriers were lack of psychosocial support, time constraints, and lack of specialty back up. Unless PCPs are able to connect to counseling support, bill for time spent counseling patients, and connect with specialty providers, and trained in addiction, it is not advised to mandate this service. EOHHS may consider providing support to specialty providers and primary care physicians to resource the infrastructure to set up these clinical connections.

C. Questions about Behavioral Health Urgent Care

15. In your experience, are patients able to access **after-hours treatment** for a behavioral health condition in a location that is **not the emergency department**? *Please explain your response.*

No, the fee-for-service financing model does not support robust after-hours treatment in clinic settings and the encounter-based model for emergency services program community-based locations makes it extremely challenging. ESPs should expand walk-in access to 24/7/365 to be readily accessible to children, youth and adults in crisis. This enhanced

access would create an important alternative to the ED during non-business hours. While the enhanced community-based encounter rate for ESP endeavors to better support CBLs, it falls short in supporting a true firehouse model.

ESP/Crisis providers *and* enhanced community-based behavioral health clinics should be resourced to have complementary capacity to meet urgent behavioral health needs. This dual access model is essential to meet the Commonwealth's access goals and ensure there is no wrong door to care. The Commonwealth should build on community behavioral health clinics with enhanced urgent care capacity and ESP/crisis services, not create separate, new urgent care centers, which would further segment the system.

Allowing and encouraging the proliferation of urgent care centers paid in a fee-for-service model will divert and dilute needed funds for supporting the 24/7/365 capacity of responsive ESPs.

ESPs should also be resourced to provide services to the adult population beyond the first day. This is a critical component to the ambulatory treatment system that will provide urgent behavioral health care access and maintain stabilization for individuals served. This would enable ESPs to fill a current gap in the system of *bridging* individuals from various levels of care until they can successfully transition to clinic-based services. This support for transitions of care afforded to BHCP enrollees- is proving to be successful however less than 3% of MassHealth individuals are enrolled in a BHCP. The Commonwealth should also consider whether ESPs can assist individuals on MAT as they await transition to outpatient services.

After stabilization of crisis services and emergence of a more robust ambulatory treatment system, EOHHS should move towards a future state in which crisis care is paid for through an alternative payment model that does not rely on encounter volume.

16. What does the term **behavioral health urgent care** mean to you? How would you define it?

ABH supports the EOHHS definition of behavioral health urgent care as walk-in access to integrated treatment for mental health, behavioral health, substance use and co-occurring disorders. Through strong partnerships between ESP/crisis providers and enhanced community-based behavioral health clinics, individuals will be able to access same-day walk-in services for treatment outside of typical business hours and providers will offer brief interventions including psychopharmacology, peer support, MAT induction, care coordination, individual and group therapy, and bridging to other levels of care. As previously mentioned, to function in this new role, ESP/crisis providers will need to be funded to offer these enhanced interventions in community-based locations.

17. On a scale of **1** to **5**, with 1 being “not at all important” and 5 being “very important”, how important are each of the following services in an urgent care setting? *Please select a response for each item.*

	Not at all Important 1	**2**	**3**	**4**	**Very Important 5**
Same-day and walk-in access to **therapy**					X
Same-day and walk-in access to a **prescriber**					X
Walk-in access to crisis evaluation, rapid stabilization, and triage					X
Full comprehensive array of addiction, mental health, and co-occurring outpatient services					X
Care coordination to support transitions of care and linkages to external providers					X
Evidence-based behavioral health treatment practices					X
Measurement and documentation of clinical outcomes					X
Primary care screenings and medical monitoring of key health indicators					X
Other (*please specify*) _____					

18. What are your experiences with medical urgent care providers handling behavioral health treatment needs?

N/A

19. What **lessons from physical health urgent care** should be applied to behavioral health urgent care?

In physical health, urgent care is a volume-driven model. As a result, there is a limit to how many urgent care providers can operate in a geographical location in a sustainable way. While we do not yet know what the volume will be in the Behavioral Health urgent care model, we recommend building urgent care capacity within the existing behavioral health provider network rather than creating new, freestanding urgent care centers.

Additionally, physical health urgent care is not one-size-fits-all. In physical health, there are pharmacy or retail walk-in clinics, urgent care centers owned by a hospital, group of doctors, or independent investors, and free-standing Emergency Rooms. Depending on the location of the urgent care, there are varying hours of walk-in access and varying capacity to handle more acute conditions. This will likely be the case in behavioral health urgent care. Through partnerships, ESP/crisis providers and enhanced behavioral health clinics with urgent care capacity should have complementary, not identical capacity to handle urgent behavioral health needs. Fundamental will be strong linkages and partnerships between the two to ensure the individual is connected to the appropriate urgent care resources.

Connection to specialty behavioral health providers is necessary as behavioral health care is reliant on longitudinal treating relationships as opposed to a cold or sprained wrist that requires a one-time intervention. The existing ESP/MCI system already has community-based locations, which could be augmented along with enhanced community-based behavioral health centers to offer urgent, walk-in access.

After know the service demand and volume, we recommend EOHHS consider a PMPM as opposed to an encounter-based funding model to ensure viability.

D. Questions about Workforce

20. Please describe the specific position types that are facing the most pressing workforce issues.

ABH members report pressing workforce issues across all provider types, particularly independently licensed clinicians, prescribers (including psychiatrists), and direct care staff. A recent survey of ABH members discovered 47% of organizations had an unfilled position for a psychiatrist at their outpatient clinic, while 60% had the same opening for an advanced practice nurse. Anecdotally, ABH hears from members that the training and licensing of recovery coaches and LADCs have not kept up with the need for these professionals. The new DMH-funded Adult Community Clinical Service (ACCS) program and the BH CP program have both included large expansions in the need for licensed clinicians and the

number of graduates and newly licensed staff willing to work in community settings has not keep pace with the demand for these staff members.

21. Please describe what you see as the **primary reasons** why there are significant workforce challenges in behavioral health.

Substantial new investment is needed to pay for the actual costs of service delivery and to support market salaries for staff to make a career in behavioral health desirable and sustainable. In a recent exercise reviewing CBHI rate methodologies, ABH found that when market salaries were incorporated into the methodology, the rates nearly doubled across the board. Accurate and adequate salary modeling would make a substantial impact on providers' ability to recruit and retain staff.

Arduous documentation requirements in behavioral health also play a role in driving people from the field. Our members report that in the collaborative care model in physical health, masters-level clinicians working with primary care physicians do not have anywhere near the requirements for documentation or assessment that exist on the behavioral health clinic side.

ABH and William James College held a series of focus groups with over 100 staff from 49 member organizations last year to discuss workforce challenges. The primary challenges noted in the focus groups included:

1.) High turnover rates and high vacancy rates lead to staff burnout and more turnover;
2.) Low pay means providers compete with other minimum wage jobs that don't have mandated overtime or similar risks;
3.) Wages aren't enough to pay student loans and living expenses for all staff, particularly masters-level clinicians;
4.) Limited number of mid- and senior level positions at many organizations make personal advancement difficult; and
5.) Continuously losing higher level staff to competitor entities, including hospitals, schools, community health centers, state agencies, and insurance companies who can pay more and have better benefits.

The lack of a behavioral health career pipeline is also an important factor. The financial investment that is needed to finish a master's degree is not worth the current return as pay is so low. This drives people away from even considering the field.

- What are the most important steps that should be taken to address these workforce challenges?

The ability to pay staff what is required for their skills and training in the community setting is the most important step that should be taken. Payment methodology development must

factor into increased, market-based salaries for community behavioral health clinic staff, including new or enhanced roles such as nursing, as well as more robust clinical supervision. Supervision costs should be expressly identified in service pricing.

In a future system, rates must also account for recruitment and retention costs of clinicians with cultural and linguistic capacity who meet the needs of the community, including services for children, families, and special populations including the deaf and hard of hearing. Additionally, provider rates should account for the interpretation services needed for deaf and hard of hearing clinicians to coordinate with other members of the team, a cost to providing culturally competent care that is currently not covered. In pricing rates, the Commonwealth should consider salary differentials for bilingual clinicians. The Commonwealth could also consider the invaluable role of specialty community behavioral health clinics similar to the three specialized CBHI Community Service Agencies.

The Commonwealth should build on the DSRIP Statewide Investment's Student Loan Repayment, Primary Care/Behavioral Health Special Projects and CMHC Recruitment Fund Programs as part of its ambulatory BH treatment system design to encourage early career providers to come to and stay in the field. In addition, high performing clinics and/or clinics serving underserved populations should be allocated student loan repayment slots so that they can recruit key staff.

22. Please describe administrative burdens or other challenges that you believe **prevent behavioral health professionals from providing behavioral health treatment**?

Pay continues to be the primary barrier to providing BH services to insured individuals, but regulatory and payer requirements also pose challenges.

Many services remain fee-for-service and some services require providers to document all services provided by the 15-minute rate. The requirement to document and justify every 15 minutes of work is a significant administrative burden that takes away from time with clients, and places undue stress on an already demoralized workforce.

The requirement for prior authorizations for certain services and medications is not only a barrier to individuals accessing treatment but also a significant burden for BH providers. Our members report clinicians spend significant amounts of time obtaining service authorization, which takes time away from providing services to families and is a deterrent to working in the field.

Behavioral health providers also contract with multiple insurance companies to serve MassHealth members. An individual who is enrolled in MassHealth should have a standard set of benefits they can access, regardless of their insurance company, but this is not always the way it works in practice. While there are exceptions, insurance companies establish their own performance specifications and medical necessity criteria for each level of care, and these specifications can vary widely.

Each MassHealth-contracted insurance company also establishes different processes and paperwork requirements to credential staff so they can bill for services. Community agencies are required to submit slightly different versions of the same information to different credentialing departments at each payer. This process can be very confusing and time consuming for community providers, and can sometimes result in long delays before fully-licensed staff are able to serve individuals in the community. Community BH providers are under-resourced and do not have the capacity or funding necessary to successfully navigate this system. The Governor's healthcare bill's proposal to create a standardized credentialing form is welcome first step to addressing this administrative burden.

- What solutions do you propose?

Establishing universal performance specifications across MassHealth payers would ensure that all MassHealth members receive the same quality and intensity of service. MassHealth has begun to move in this direction in recent years by mandating universal specifications for services in (CBHI, the Residential Rehabilitation Services, and Recovery Coach and Recovery Support Navigator services. This standardization would also decrease the administrative complexity that programs encounter when trying to serve MassHealth members with different insurance coverage in the same program.

Establishing universal credentialing across MassHealth payers would significantly reduce the time and difficulty of behavioral health providers becoming credentialed by the various payers. In other states, a central organization completes this function for all payers. This would streamline the process for both providers and payers so each side only works with one, independent entity to complete the credentialing process.

Data collected by BSAS following the implementation of Chapter 258 has shown that expanding access to care by allowing clinicians, not insurance companies, to decide if and when individuals should step down from services has decreased the number of individuals who cycle through detoxification. Clinicians should be able to use their clinical judgement to ensure consumers are able to access as much care as needed.

Creating and implementing a universal consent form used by all providers and payers in the Commonwealth would help tremendously to address the administrative complexity faced by providers and would protect individuals' privacy. Section 207A of Chapter 224 required the Division of Insurance (DOI) to implement a universal prior authorization form across all payers. DOI formed a working group with stakeholders to finalize this document. ABH suggests a similar approach with the development of a universal consent form. Behavioral health providers must be at the table during any discussions of this kind.

23. Please describe administrative burdens or other challenges that you believe **prevent behavioral health professionals from serving specific populations.**

In the current system, an individual with specific language needs may turn to an organization where their language needs can be met in a culturally-competent manner, even if the appropriate level of care may not be available within that organization. In the future system, rates must incorporate the costs of recruitment and retention of clinicians with linguistic capacity who meet the needs of the community, including services for the deaf and hard of hearing. In pricing rates, the Commonwealth should consider salary differentials for bilingual clinicians. The Commonwealth could also consider the invaluable role of specialty community behavioral health clinics similar to the three specialized CBHI Community Service Agencies.

The service that typically bridges ATS and residential treatment services, Clinical Support Services, has not expanded to deliver services to those with co-occurring disorders. It is essential for MassHealth to establish CSS programs that specialize in serving individuals with co-occurring disorders so that they have access to a complete continuum of care.

The requirement of long, in-depth assessments to take place before a behavioral health provider is able to provide services, is an administrative burden unique to behavioral health. Children's behavioral health providers are required to complete and update the CANs regularly and then input this into the virtual gateway. This is regularly cited by children's providers as a barrier to hiring and retaining staff. There is also a lack of recognition of the team-based care that is necessary to serve children and adolescents.

Children's behavioral health providers often operate programs outside of business normal hours including evenings and weekends. Without appropriate pay to incentivize this work, staff will often leave for more consistent work schedules in less stressful environments. Additionally, lack of supervision leads to child-serving staff to feel less supported in the intensive nature of in-home work.

- What solutions do you propose?

In the future system, rates must incorporate the costs of recruitment and retention of clinicians with linguistic capacity who meet the needs of the community, including services for the deaf and hard of hearing. In pricing rates, the Commonwealth should consider salary differentials for bilingual clinicians. The Commonwealth could also consider the invaluable role of specialty community behavioral health clinics similar to the three specialized CBHI Community Service Agencies.

We hear frequently from ABH members that physicians, nurses, and clinicians who live in neighboring states must undertake the cumbersome, confusing process of securing their Massachusetts license. Our member organizations lose qualified staff who would like to work in Massachusetts because of the time and steps it takes to secure licensure. Granting reciprocity to practitioner and clinician licenses from neighboring states would increase overall access and reciprocity for licenses from Puerto Rico would create a greater

opportunity for providers to enhance their bilingual staff and increase access to vital services for Spanish-speaking residents.

Additionally, EOHHS should consider consolidating assessments so that families working with multiple providers are only required to complete one assessment, as has been allowed through the hub-services and hub-dependent services of CBHI. This should be broadened so that regardless of the services, only one comprehensive assessment is required.

24. Please describe administrative burdens or other challenges that you believe **cause behavioral health professionals to leave the field**?

Rates that do not support viable salaries of a qualified workforce nor allow staff to sustain their families is the primary reason behavioral health professionals leave the field. In addition, there are a number of issues that put undue administrative burdens on behavioral health professionals at licensed mental health and substance abuse clinics.

The current Mental Health Center Manual (130 CMR 429.400) requires clinicians to a complete a full clinical assessment for all patients, even in the case of short-term interventions (429.436). The DPH Clinic regulations also include requirements for a long, comprehensive assessment that is not practical when serving individuals on a short-term basis (105 CMR 140.520). Providers also note that these assessments make it difficult to serve the family members of clients who may need a short-term intervention or group support.

Physical health providers are only required to engage clients on topics relevant to the reason they have accessed care and are able to address issues quickly in these settings. In contrast, BH providers must do a full intake and evaluation, frequently over multiple sessions, before they can begin to address the reason a client has presented for care.

Additionally, behavioral health providers have to navigate and comply with multiple state regulatory frameworks depending on the array of services they provide including MassHealth, Department of Public Health (DPH), Bureau of Substance Addiction Services (BSAS), Department of Mental Health (DMH), Department of Children and Families (DCF), and Department of Early Education and Care (DEEC).

- What solutions do you propose?

There is unequal access to behavioral health benefits within MassHealth today. MassHealth members who are in fee-for-service, which currently includes the majority of DMH ACCS members, do not have access to the same benefit array as other MassHealth members, including Community Support Program (CSP), PHP, Structured Outpatient Addiction Program (SOAP), and Intensive Outpatient Program (IOP). Only PCC Plan members have access to Program for Assertive Community Treatment (PACT) services

through their health plans. Youth who have MassHealth Family Assistance do not have access to ICC, Family Partners, In-Home Behavioral Services or Therapeutic Mentors.

ABH recommends that the behavioral health ambulatory treatment system be re-conceptualized so as to afford universal access to service types for all MassHealth members, regardless of aid category or benefit type. As has occurred with CBHI services and with certain behavioral health services under the ACO/MCO behavioral health covered services contract, MassHealth must mandate that plans pay no less than the minimum rate set by and in accordance with the payment methodology established by the Commonwealth.

Establishing universal performance specifications across MassHealth payers would ensure that all MassHealth members receive the same quality and intensity of service regardless of their insurance carrier. MassHealth has begun to move in this direction in recent years by mandating universal specifications for services in CBHI, the Residential Rehabilitation Services, and Recovery Coach and Recovery Support Navigator services. This standardization would also decrease the administrative complexity that programs encounter when trying to serve MassHealth members with different insurance coverage in the same program.

Moving to an alternative payment model that values treatment and outcomes over documentation and process would significantly improve staff morale and retention as was seen in the CBHI ICC day rate.

25. How could the Commonwealth maximize the existing workforce, including those providers who do not accept third-party payments? (300-word limit) 201 words

- Where is the most strain in the workforce?

ABH data show that member organizations are struggling with significant staff vacancies, particularly for prescribers, which combine and translate to long wait times for initial and ongoing access. In FY19, roughly 50% of responding ABH members reported one or more unfilled prescriber positions.

- 52% reported wait times for children of more than 1 month for routine assessments with a psychiatrist/nurse prescriber
- 12% were not even accepting new referrals for children.
- 60% reported wait times for adults of more than 1 month for routine assessments with a psychiatrist/nurse prescriber.
- 8% were not accepting new referrals for adults.

The Commonwealth should support and fund adequate rates that allow providers to pay their workforce market salaries. In addition to adequate rates, EOHHS can also work to maximize the workforce that is currently in the field. This could include continuing to expand

access to telehealth, encouraging and paying for more team-based services instead of specific credentialing requirements, paying for consults and collaborative care, and expanding the roles non-licensed staff can take in both the commercial and Medicaid space.

Student Loan Repayment Programs and recruitment packages would help to encourage people to enter the field and paying a clinical differential that supported strong supervision would help to keep new staff in the field.

E. Questions about Health Insurance

26. Are there **specific behavioral health medications** that you have difficulty accessing for your patients because of **prior authorization** rules?

- *If yes,* which medications do you have trouble accessing?

Too often, overly restrictive policies by insurers that deny access to necessary medication pose difficult treatment decisions for psychiatrists and jeopardize patient care. For example, clients discharged from inpatient care and seen in the community post-discharge who appear to respond well to medication prescribed in the hospital may then not have that medication approved for their continued care on an outpatient basis as the medication may not be in the insurer's formulary or the insurer requires that alternatives be tried first.

This can place the psychiatrist or nurse practitioner in the difficult position of either discontinuing effective medication or financially burdening the client.

- Please describe the prior authorization rule or protocol that causes the difficulty.

N/A

27. What care **coordination functions** should **Health Insurance Plans** (MassHealth and commercial plans) play to ensure that members can access behavioral health treatment and successfully navigate their treatment plan?

Community-based behavioral health providers are best positioned to provide hyper-localized and individualized care coordination to individuals with behavioral health conditions. Rather than move care coordination functions to Health Insurance Plans that are removed from an individual's local community, we recommend creating opportunity for Health Insurance Plans and MassHealth to leverage the expertise and capabilities of existing community-based organizations serving populations with behavioral health needs as has been done through the Behavioral Health Community Partner program and Community Service Agency Intensive Care Coordination program. BHCPs and CSAs are better able to attract staff who are representative of populations served, outreach to

individuals more easily, and have knowledge of services and providers that allow for member choice.

To ensure access to services in the treatment plan for MassHealth members, ABH recommends universal access to service types for all members, regardless of aid category or benefit type. To ensure more meaningful access, MassHealth must mandate that plans pay no less than the minimum rate set by and in accordance with the payment methodology established by the Commonwealth, as has occurred with CBHI services and with certain behavioral health services under the ACO/MCO behavioral health covered services contract.

28. Are there current **utilization management processes** (e.g., prior authorization) in MassHealth or commercial plans that **pose a barrier** to accessing same day prescribing or other outpatient treatment for behavioral health conditions? *Please explain our response.*

Prior authorization and service registration requirements in the health plan IVR systems both pose an unnecessary administrative burden on providers and could be eliminated with little to no financial impact on payers, but with great gains in parity.

29. Should commercial plans be **required to reimburse** for services provided by **master's level clinicians**, who are in training and working to obtain licensure, when they are supervised by a licensed clinician? *Please explain your response.*

Yes. Certain commercial plans have already recognized the value of allowing for master's level clinicians, under the supervision of a licensed clinician, to provide services. As a recent example, commercial insurance plans that were recently required to begin coverage of certain child and adolescent behavioral health services are all allowing for masters-level clinicians to provide these services. We wholeheartedly endorse Governor Baker's proposed requirement to insurers to reimburse non-licensed behavioral health professionals working in clinical settings.

The value of a team-based model that includes professionals and paraprofessionals with specific attention to the role of individuals with lived experience as part of a recovery-oriented service model must be retained and enhanced.

A re-envisioned BH ambulatory treatment system must work for Massachusetts residents regardless of health coverage type. MassHealth members, particularly children, have access to a broad array of behavioral health services, including innovative multidisciplinary team-based and/or home-based service models. Individuals with commercial health coverage face barriers to accessing a broader array of services due to low rates, credentialing criteria, more restrictive medical necessity criteria, and minimal adoption of ambulatory services beyond traditional psychotherapy and medication management.

- *If yes,* what impact would this have?

This would significantly broaden access. The choice of some commercial plans to require licensed clinicians is a significant barrier to individuals accessing services. ABH is aware of one managed behavioral health organization that does allow for service delivery to commercially insured individuals by non-licensed individuals working under the supervision of a licensed professional. This model has been in place for some time with no ill-effect.

- *If no*, please explain your response.

30. Please provide any additional thoughts or suggestions about how to improve the delivery of behavioral health treatment services in the Commonwealth.

A strong behavioral health system depends on the ability to be flexible in when, where, what and how services are delivered to meet the unique needs of each individual served. To truly increase access, expand the service continuum, and integrate care, behavioral health providers must be paid for the cost of delivering services. Lack of adequate funding continues to be the most pressing issue facing the community-based behavioral health system.

ABH strongly endorses a model that both moves away from fee-for-service and reimburses for actual costs such as the Prospective Payment System (PPS) methodologies currently in use under the Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration.
Similar to how the creation of Federally Qualified Health Centers (FQHCs) transformed the system of community-based primary care services, a CCBHC-like construct can transform and expand access for behavioral health. The federal CCBHC payment structure is similar to the FQHC payment structure and has the potential to bring parity to the safety net system and similar service availability.

Increasing and expanding the current behavioral health workforce has been one of the truly transformative components of the CCBHC Demonstration. Early results show major workforce expansions at CCBHC locations across all demonstration states. CCBHCs nationwide reporting they have hired a total of 1,160 new staff, including 72 psychiatrists and 212 staff who specialize in addiction care. This access expansion has been driven by a payment structure that supports recruitment and retention of clinical and nonclinical staff into community settings at unprecedented rates.

The community system must be funded to hire and retain the staff needed to provide that level and quality of care. The state must support the payment of market salaries. A 2017 report on Massachusetts salaries salary found a 22.8% pay gap between behavioral health organizations and acute care hospitals.

A successful crisis and urgent behavioral health system also depends on a healthy outpatient behavioral health system. Despite the Commonwealth's recent investments to stabilize outpatient behavioral health services, substantial new investment is needed to pay for the actual costs of service delivery in the current system. In an FY19 survey of ABH members, the average reported loss for an outpatient clinic was $667,759 (up from $582,057 in 2017).

Once the current system is stabilized additional funding will be crucial to substantially enhance services and support the recruitment and retention of the staff needed to operate these programs. Funding must support needed infrastructure like ENS incorporation and telehealth technology, facility changes (exam rooms, etc.) and staffing and clinical pathway changes, e.g., embedding additional psychiatry and nursing, etc. An alternative payment methodology that does not remedy current outpatient losses and fund new anticipated costs will prevent transformation.

A successful ambulatory behavioral health treatment system needs buy-in across the health care system. The Commonwealth must clearly articulate how this redesign will interface with the new ACO models which are shifting payment and care delivery strategies. Each of the16 ACOs varies in how it manages clinical and financial responsibilities and the network of health care providers offered to members. In a no wrong door behavioral health system, it will be essential that ACO processes and networks align with this vision.

Additionally, a strong behavioral health system prioritizes quality measures and health outcomes over process and documentation. In today's system, standardized measures and processes to risk-adjust populations, evaluate results of services, and move toward a value-based system of care are lacking. These issues limit the capacity of the system or individual providers to identify what is working and to improve effectiveness of interventions. Standard measurable assessments and outcome metrics are needed, not lengthy assessments that are focused on process.

Because access delays and barriers were the predominant theme of listening sessions, ABH recommends that EOHHS considers the timely access requirements of the CCBHC Demonstration. Such measures include, but are not limited to, 1) service delivery immediately or within 3 hours at crisis; 2) service delivery within 1 business day for urgent needs; and 3) service delivery within 10 business days for routine needs;

30. Are you responding to this RFI **on behalf of a health insurance plan**? No

Thank you for taking the time to respond to this RFI.