

**February 5, 2014**

On behalf of the Massachusetts Hospital Association and the Massachusetts Association of Behavioral Health Systems, we appreciate the opportunity to submit a joint set of comments from the hospital community in response to the Health Planning Council's recent Health Resource Planning for Behavioral Health Services request for information. Listed below are considerations for each question as outlined in the RFI. Should you have any questions on these comments please do not hesitate to contact either Anuj Goel (781-262-6034 or [agoel@mhalink.org](mailto:agoel@mhalink.org)) or David Matteodo (617-855-3520 or [dmatteodo@aol.com](mailto:dmatteodo@aol.com)).

**1. How do you anticipate health resource planning for Behavioral Health to help you in your work? How do you expect to use the information resulting from the effort?**

Over the last few years, there have been several statewide committees, workgroups, and special legislative hearings that have all looked at the many causes and issues surrounding this problem, such as: inadequate inpatient bed capacity, prior authorization and other administrative reviews by public and private payers, and lack of care coordinators in the community to assist a patient with accessing continuing care to prevent readmission to an inpatient level of care. While the state has adopted laws and regulations seeking to implement mental health parity, there have been no concrete proposals or planning to address any of the issues listed above.

Despite the varied efforts, we do believe that health resource planning could significantly improve providers' ability to strategize about how to meet the clinical needs of the patients they treat. However, the planning needs to start on a service delivery level and not focused solely on provider functioning as it is now. This planning must first look at the factors contributing to the present fragmented system that is both inadequate in its size (poor access) and at times under-qualified for the tasks at hand (quality). The owner of the network is the insurer or its carve out company that brokers that network to employers as well as the state, therefore it is very important that lack of access should be discussed in view of the inadequate network.

In addition, reimbursement formulas and coverage policies established by public/private payers for behavioral health have hamstrung providers' ability to grow to meet demand and access has suffered. Behavioral health providers also have many external managers and few, if any of these managing organizations assume the responsibility to build a system that aligns incentives to insure access to the clinical services needed by the citizens of the Commonwealth.

**The key consideration from our respective members is to develop a process that will help identify possible solutions to the current bottleneck and patient flow issues for behavioral health patients boarded in the emergency department awaiting inpatient level of care,**

**patients who are stuck in inpatient units due to the lack of community placements or continuing care beds, and the lack of community services to move patients out of state continuing care beds.**

The hope would be that health resource planning would help to reduce the disparity of resources available to behavioral health patients and help identify areas of specific need and referral networks for those populations. More specifically, we are also hoping this planning process will support ongoing efforts by multiple statewide committees to make even more evident the desperate need for resources in behavioral health (covering both mental health and substance abuse services).

General considerations of how the health resource plan focusing on behavioral health can assist providers include:

- show the geographic array of clinical services and the types of service gaps that exist in different regions of the state;
- facilitate the process for thinking about more “non-traditional” approaches to delivering care –particularly in more remote areas of the state (telemedicine, clinician extenders, etc);
- Implementation of the recommendations for the appropriate supply and distribution of resources, programs, capacities, technologies and services will increase needed capacity and enhance access to all levels of Behavioral Care.
- demonstrate the insufficient adolescent and adult Mental Health capacity and/or access (due to Insurers management and denials) includes acute inpatient psychiatric beds, acute residential beds, partial hospital programs, diversionary services and outpatient services community based supports including respite services, care management/patient navigators, DMH residential , partial hospital and outpatient psychopharmacology and treatment etc.
- demonstrate the insufficient adolescent and adult substance abuse capacity and/or access to care (resulting from Insurers management and denials) includes acute inpatient substance abuse beds, short and long term residential substance abuse and dual diagnosis beds, suboxone programs, substance abuse partial hospital/day treatment programs, outpatient substance abuse providers and community support programs including sober homes, diversionary services, etc.

To this point, all hospitals are actively seeking out resources for community based services and placements to help move our patients to appropriate locations once they are discharged from an acute level setting. In addition, all hospitals conduct needs assessment and community planning process, so planning in coordination with a state plan rather than in isolation will make it more likely the local plan will be tied to shared goals and resources. Therefore, anticipating that the report will underscore the importance of improving quality, developing innovative health care delivery and alternative payment models, we could integrate the information from the health resource plan into our operational strategic planning process.

Data that prioritizes the needs of the communities we serve will play an important role in guiding us in enhancing our existing services and developing services we need to deliver in meeting these needs. We hope that any resource plan could (in collaboration with our community

partners, State agencies and payers) assist the overall effort of Chapter 224 in implementing strategies and allocate resources needed to improve the behavioral health care delivery system in ways that improve outcomes and quality at lower cost.

**2. Are there specific services within Mental Health & Substance Abuse that you would like to see studied, and were not already included in the list of services on page 6? Please describe with as much specificity as possible. Please indicate how they can be addressed through health resource planning**

While the list of services on Page 6 of the RFI is very comprehensive, we have listed below several ideas that our respective members feel should be further specified as an additional category or within a named service:

- Health Plan Considerations:
  - There needs to be a specific listing of the services and coverage options provided by the public and private insurers in the state, consider including any information provided to the Division of Insurance recently by the health plans for mental health parity,
  - Description of plans and their contractors that have behavioral health coverage in each region/county of the state policies;
  - A review of the contracted providers to each plan in each region/county and a corresponding list of available non-contracted providers when services are not immediately available; and
  - A list of care coordination services covered by the payers to follow patients through appointments and services to ensure medication compliance and follow up with discharge instructions (appointments among others).
- Emergency Department:
  - Given extensive discussions over the past year or two, there must be a discussion or inclusion on the list about behavioral health patients that are boarded in the ED while awaiting placement, as there is no other acute medical condition where an individual who comes to an emergency room with an acute illness will have this experience. The most acute patients are evaluated and often treated in EDs across the state, but the RFI only recognizes the ESP system which they provide many important services in the community, but does not reflect the specific ED Boarding problem.
- Outpatient/Primary Care Services:
  - A list of outpatient or community based services available by payer in each service area provided by that plan;
  - Specific focus on psychiatric services within primary care setting as patients lack access to psychiatry for medication management it then falls to the PCP by default, who isn't equipped to adequately prescribe. One model is for psychiatrists to train primary care and mid-levels to prescribe and also require payers to reimburse for such services.

- TF- CBT
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) there is a large amount of evidence base for this service, but does not seem recognized in the list of services
- Legal Considerations:
  - Providers statewide have been promoting the importance of completing health care proxy forms which can help in getting mental health patients treatment quickly and effectively without delays due to court reviews among others. There should be some consideration of standardized forms and promoting such administrative ideas that would help access to care. Examples of scenarios where this would help include:
    - Patients who come to our emergency room and determined to lack capacity. If they don't have a health care proxy that they completed at some other visit to us or any other provider, sometimes it's difficult to move them onto the care they need. Of course if they are a danger to themselves or others, we can do a section 12, however, many do not need to be committed, but we can't transfer them without someone to give consent. Some of them have family/friends who, if they were identified as health care agents at prior facilities or doctors' offices, would have the authority to approve certain kinds of treatment or transfers.
    - If those patients had health care proxy forms from receiving care elsewhere, we could provide services without having to seek a Rogers Guardianship. The Rogers Guardianship process can be very lengthy and significantly impede proper clinical care on locked psychiatric units where patients can go untreated for weeks while the hospital waits for Court approval.
    - This would also help with the homeless population who often stay at the same homeless shelter, is there a way for the state to work with the shelters to get health care proxy forms on the clients, so then when they come into the emergency room we have a way to identify someone who can make decisions for them and help them get the mental health care they need.
- Special Populations:
  - While not a specific service per se, we request that the report provide some focus on access to various services listed for special populations, including individuals with Intellectual Disabilities, Autism Spectrum Disorders, complex medical conditions that may prevent them from moving to other levels of care, Mental health and substance abuse dual diagnosis (adult, child and adolescent), and problematic behaviors to include dangerous behaviors.
  - Part of this review should also include the need to review/update/change current admission criteria (i.e. do they need to be DDS involved – if not, little options).
  - How do the services take into account patients with current criminal charges that do not meet criteria for forensic services – may not have mental health issues but are anti-social and would not benefit from acute psychiatric treatments, medications, therapies.

- As the commonwealth ages the number of elders seeking behavioral health services (acute) is increasing, so how are the various services listed impacting geriatric care. For example, the issue of dementia, its related disease (Alzheimer's), and elders with aggressive behaviors is growing exponentially. The council should explore the prevalence of these needs and projections of planning for addressing geriatric psychiatry services, including the ability of nursing homes to treat the geriatric behaviorally complicated patients.
- Inpatient mental health services:
  - Should provide special consideration of services for:
    - CBAT and ICBAT beds
    - DMH programs – BIRTs, ICBs
    - Expanding access to intermediate care beds for both public and private insured patients
    - Inpatient of Seasonal Fluctuations on behavioral health hospitals and units
    - How are the increasing acuity of patients on the units being recognized by the state and payers
  - Need to evaluate the true reasons that beds are in short supply:
    - Regarding inpatient acute psychiatric capacity: there were 310 beds in 2007; current capacity is 252, a 20% reduction. Some of the 252 beds have been “off line” as hospitals are unable to fully staff units so they reduce the beds considered open.
    - In 2013, DMH reduced IRTP beds from 85-75 with the launch of the joint DCF-DMH procurement, we need to get a better sense of the impact as a result
    - It is very difficult to place patients with co-morbid medical conditions and patients who have been violent.
    - Inadequate “diversionary” programs as alternatives to hospitalization (e.g. crisis stabilization)
    - Insurers limited network contracts make bed-finding more difficult and it is difficult in obtaining insurance authorizations for inpatient care
    - Inadequate number of treatment programs in the community in general that would prevent patients from coming to the ED in the first place.

**3. Given the importance of prevention and also “post-acute” services for mental health & substance abuse, what critical evidence-based services & programs are available, should be expanded, or need to be developed? Are there specific models you suggest we study?**

- Increased capacity or services in the following areas are needed:
  - DMH Level Services:
    - Ensure continued funding to support the current number of DMH Continuing Care beds; and allow DMH to move to the Community those patients who no longer need a State Hospital bed;
    - Establish a central registry of available DMH beds (inpatient and continuing care) whereby providers can look for the next geographically

suitable bed on the list and make arrangements for transfer, similar to MBHP current bed tracking site;

- Also develop a tracking system so providers can identify where a patient is on the list, how long until a possible transfer, and issues with the patient information that may delay the transfer further;
- Develop a process for DMH to track readmission of patients who are discharged from continuing care bed, and readmitted to an acute care hospital – this would allow providers to determine reasons (general policy or local service delivery) for readmissions and what the state/provider community can work on together. MBHP and UBH currently provide reports on general readmissions numbers, but nothing specific as to where the patient was initially discharged or services that they received prior to acute readmission
- Develop a targeted timeline within which DMH will determine a decision on a referral, with performance reporting by region publicly reported to the Executive Office of Health and Human Services (EOHHS) as well as providers;
- Establish a standard for the number of days from the Approval of the Packet to the movement of the patient to the Continuing Care Bed. We recommend a five day standard;
- Develop an appropriate payment rate for patients stuck in psychiatric inpatient units or boarded in the ED/inpatient medical units while awaiting a Continuing Care bed beyond five days following the approval; Currently hospitals provide a significant number of uncompensated care for this population while they wait for a state placement, these patients are often stuck for several months with no coverage options while they are awaiting placement.;
- Work with the Office of Medicaid and the Division of Insurance to require MCEs to eliminate the AND status and pay for all stuck cases until the transfer occurs;
- Development of a holding unit at the Worcester Recovery Center for patients who will be going to an ICF but have exceeded the 5 day length of state on the acute care units;
- Expansion of DMH shelter beds for the homeless for patients who cannot tolerate a regular shelter and need the additional supports of a DMH shelter;
- The state supported OP delivery system has decreased significantly since the time when the state actually partnered with OP clinics to insure community access. When DMH moved the emergency service team contracts from a DMH contract to a Managed Care third party contract ,the state’s support for urgent care immediately ended . Many believe this was an un-intended consequence of a desire to create additional federal matching dollars. Regardless, neither DMH, Medicaid, nor the third party entity has sought to remedy this mistake. Patients who are in established treatment are now infrequently offered urgent access. Patients not in

established treatment are almost never offered access at point of need. This is especially true for children and adolescents.

- Review of admission/eligibility criteria for CBAT beds, what are the various policies and regulatory requirements that should be removed or amended to enhance access to these beds
  - Review admission and eligibility for sober homes and other community resources as a covered service or alternative step down location for patients
  - Expansion of DBT housing for the severely personality disordered patients;
  - Expansion of intermediate care beds with particular attention to populations who often need sustained specialized inpatient treatment, such as severe eating disorder patients;
  - Expansion of Step-Down substance abuse programs, EATS, and detox; and ability of patients to access these services through Insurer approval;
  - Developing detox level services for pregnant women;
  - Expansion of nursing home beds to take patients with behavioral issues in need of long term care, many nursing homes will refuse patients with a history of suicidal behavior or other behavioral issues;
  - More inpatient beds in single bed rooms able to accept patients on precautions (such as MRSA) or with disruptive behavior that would be unacceptable to a roommate but not require a seclusion room; and
  - Improved coordination of services for patients with a history of trauma who has difficulty dealing with the highly fragmented system.
  - Focus on pediatric beds needed for children with physical disabilities or are autistic
- Evidence based youth prevention while generally understood as a priority is not funded at a robust level. Consideration and review of funding opportunities for local communities instead of focusing on one program or one approach. There are many resources and skilled professionals in Massachusetts who know how to do this work but there is not a good resource to tie them together to provide funding, services, ideas to be used at the community level.
  - Opiates use and overdoses are a serious problem. Providers are seeing more adults, teens, and babies with addiction. The state should expand its opiate overdose prevention program – include programs such as prescription monitoring, teaching pain management alternatives to opiates, and provider/prescriber education.
  - Development of criteria for referral and admission to substance abuse programs—those you can self-refer from home, those that require referral while in ED—what is needed for medical clearance as well as psychiatric clearance, different criteria for each plan that makes it difficult to coordinate care for the same patient issue but who has different plans.
  - ED Boarding Concerns:
    - Redesigning the resources and services provided for high emergency room utilizers would improve their overall health status and reduce the utilization of avoidable ED visits.
    - Provide additional supports and funding to the emergency service program (ESP) to expand community-based services in order to decrease avoidable inpatient and ER utilization and thus reduce costs and enhance recovery. The ESP should be

incentivized to coordinate with hospitals to develop coordinated treatment/crisis plans for recidivist patient populations. ESP's would continue to provide essential mobile outreach, community based ER/hospital diversion, urgent care crisis stabilization beds and care management.

- Develop a better overview of the actual linkages within each “service line” listed on page 6 and across them--in order to assist provider consider better integration of care models:
  - Within behavioral health as clinical and rehabilitative services have been structurally disconnected;
  - Smooth transitions of care from one level to another are often impeded by limited communication and barriers to sharing records;
  - The capacity to provide integrated mental health and substance abuse is hindered by organizational differences in training, regulation and reimbursement; and
  - Within outpatient behavioral health there is wide variability in provider type and approach to treatment (i.e., lack of uniformity in implementation of evidence-based practice).
- Study the effectiveness and availability of services that support recovery from addiction
  - Gambling addiction as a result of increased casinos in the Commonwealth
  - Recovery coaches, recovery community centers, recovery high schools, collegiate recovery support groups (See “The Anonymous People” documentary for wonderful examples of how people recover from addiction)
  - Rethink the approach to care that tends to treat addiction as an acute illness rather than a chronic illness
- There is growing evidence that motivational interviewing, cognitive behavioral treatment (CBT), dialectical behavior therapies(DBT), behavioral activation, clinical algorithms and virtual visit technologies can improve outcomes and reduce costs, which should be included in any statewide resource planning.
- Integration of mental health, primary care and medical care within the patient centered medical homes or primary care provider office are critically important in providing coordinated care for patients with medical and co-occurring behavioral health conditions. There are currently DPH Regulations and insurer medical necessity policies which must be re-visited to remedy current barriers to providing behavioral health services in a traditional primary care practice.
- Expanding the capacity of and access to cognitive behavior therapy (CBT) and dialectical behavior treatments (DBT) for patients with mood and anxiety disorders and brief intervention and referral to treatment (SBIRT) for patients with substance use disorders would be useful for acute and post acute services.
- Need to consider need for additional replacement units and “ guaranteed access” beds through state-private contracts should be reviewed; the "No Reject" policy should be re-visited as for years it has proved to be an ineffective tool;
- Youths who have No State Agency involvement (NASA) should be reviewed in terms of what needs they have that are going unmet and what can be part of the state plan.
- There should be an analysis of the need for flexibility to structure services more effectively for both locked and unlocked settings. Where regulations impede access, they must be reviewed and determined if they are optimal for the patients we serve.
- Ensuring appropriate coverage for Telemedicine (“telepsychiatry”) that can (for certain populations) enhance services provided, currently MassHealth does not allow or cover

any telemedicine services and the private payers (despite Chapter 224) do not cover telemedicine unless the provider is part of a plan's limited and recognized telehealth network

- Expanding coverage and Insurer authorization for residential services which are not covered by insurance and that for many patients is a huge barrier to receiving adequate post-acute care.
- Overview of available transportation and housing under public programs or through private plans
  - Adults and adolescents need treatment in a residential facility in order to be free of triggers in the environment. Many patients can refrain from drug use long enough to produce a negative urine sample; a few days of sobriety does not equate with cure, nor does it indicate that a patient is ready for outpatient treatment. But when a patient has finally determined they need residential treatment to be turned away because of a negative urine test can be a major setback.
- Workforce Development
  - The state needs to re-evaluate its funding and programs that would assist with increasing workforce training and certification of key staff that are not going into behavioral health areas, including:
    - Psychiatrists; Hospitals throughout the state struggle greatly to fill psychiatric coverage currently; there are great fears this problem could continue to grow;
    - social workers,
    - advanced practice nurses
    - ancillary support, i.e. mental health workers, recovery coaches to provide care coordination for this patient population
- How do we provide better information and resources for special needs populations:
  - Children with autism and DD services with worrisome mental health co-morbidities, they are seeing:
    - Waits for evaluations range from 6-12 months,
    - Insurers refusing to authorize evaluations to do an evaluation
- There is a gap in levels of service, between “brief intervention” (minutes of counseling provided during routine healthcare) and “outpatient treatment” generally seen as suitable for patients with severe substance use disorder. Adolescents with mild and moderate substance use disorders would benefit from “brief treatment” – more counseling that can be provided in a brief intervention, but targeted at those with less severe disorders. This level of service is virtually non-existent at this time. Specific models suggested for study: Building an infrastructure for this level of care and placing it where teens can easily access it – schools, community centers and medical homes – could start to address this problem.
- Any provider who is seeking to expand and provide behavioral health services in an area of need should not be impeded by local community restrictions: all providers should have protections similar to the Dover amendment.
- State should consider incentivizing local communities to accept needed behavioral health services.
- Provide a review of the impact of CBHI on inpatient child/adolescent care

**4. Obtaining capacity, workload/volume, and demand data for outpatient & community mental health & substance abuse services is a challenge. Do you have ideas for data sources or suggestions for collecting data now or in the future? Are there specific “data gaps” that you feel are important for future data collection?**

- Many states conduct a youth prevention survey. One of the best captures data on risk and protective factors. Communities That Care, Prevention Needs Assessment Survey, are just 2 of the brands, but the science underlying them is the same. While Massachusetts conducts the youth risk behavior survey on a sampling basis, it does not provide local data that is actionable. Ideally the YRBS and PNAS (or CTC) would be conducted locally on alternating years.
- One suggestion for collecting estimated demand data in the future for outpatient and community mental health and substance abuse services would be to use the SG2 Model for forecasting population growth and epidemiology, payment policy and economic factors, systems of care and population health management innovative technology can help project forward trend.
- Suggest the use of a registry for programs that treat addiction, which would also facilitate identification of both under and high performing programs that could enhance practice models and improve the effectiveness and efficiency of care. (The identification of performance would be supported by an automated patient-reported outcomes data collection process using standardized validated non-proprietary measures where data would be archived.)
- Need more data on homeless patients and specific needs.
- Need more data on veterans and TBI, PTSD, addiction
- Our current reporting methods place an emphasis on meeting statistical targets of “success” that while helpful for certain payer management functions often obscure treatment failures and gaps in service while at the same time creating systemic pressure on providers, payers and state agencies to avoid certain high risk patients. For Example:
  - A payer can improve specific statistical measures of success such as reducing time to follow-up appointments by inducing providers to create meaningless one-time encounters;
  - A state agency can monitor waiting list times for services as an indicator of need while referrers alter the demands to adjust to the limited access.
- With the development of solid, new indicators, all parties should be incentivized to organize themselves to comply with the needs of the patient regardless of the impact on the organization in which the services are supported or provided. In a fragmented system, this often leads to efforts to shift costs and responsibility and a collective withdrawal from the care of persons and situations that place providers and payers at most financial risk. A few examples of meaningful indicators for systemic problems in serving individual persons include:
  - Availability of disposition services for patients presenting for emergency mental health care by monitoring:
    - Emergency level services for behavioral health:
      - Once the evaluation is complete and the decision to hospitalize is made:

- Review regional networks ability to accept and then admit patients within established time frames.
- Review regional access – e.g., % of patients receiving care within 20 miles, 50 miles etc. In no other specialty would patients or families accept involuntary transportation out of region
- Review patient Boarding in EDs
- Specifically review adequacy of services for individuals with intellectual disabilities and Autism Spectrum Disorders
- Inpatient Step down
  - Availability/quality of outpatient and step down residential services at discharge from inpatient services as reported by hospital SW. Having this measure reflect on the hospital is reasonable when the patient is in an existing delivery system with access. However, when a patient is not in a system and the insurer’s network is inadequate, the measure should be of their regional network’s adequacy not the inpatient unit’s discharge planner. Hospitals cannot be held accountable to create something that they have no control over
- Outpatient:
  - In addition to the above, surveying patients who have accessed care about their experiences about adequacy. Groups like PPAL often poll parents about outpatient access. Their findings repeatedly contradict the reports generated by payers
- Continuing Care.
  - Establish a standard of access and monitoring use of beds, e.g., 5 days after decision to transfer is approved a patient will be transferred. Once standard is set measure the State’s ability to transfer to continuing Care Beds within these time frames. Our present system does not allow timely access to Continuing Care and while the provider’s milieu, LOS and finances are impacted there is no adequate monitoring of access to Continuing Care. Lengths of care for many of the DMH Wait List clients in the acute system are approaching the desired length of stay for continuing care.

**5. While not part of the specific level of question, our respective members would like to request suggested changes to the Maps that were recently released:**

- List resources by name and type with specific information that can be used as a referral tool for clinicians. Or, list resources by county which would allow clinicians to make referral reference for their own institution. In other words, have the research that went into the map be utilized in a tool to help clinician’s access care for patients; and
- The current maps are very hard to read and confusing: where are the sites, what does each site provide (capacity and services), insurer and patient utilization at each site.