



COMMONWEALTH OF MASSACHUSETTS

CHARLES D. BAKER
GOVERNOR

KARYN E. POLITO
LIEUTENANT GOVERNOR

BULLETIN 2018-01

To: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc.,
and Health Maintenance Organizations

From: Gary Anderson, Commissioner of Insurance
Joan Mikula, Commissioner of Mental Health
Monica Bharel, Commissioner of Public Health

Date: January 3, 2018

Re: Prevention of Emergency Department Boarding of Patients with Acute Behavioral
Health and/or Substance Use Disorder Emergencies

The Division of Insurance (“Division”), the Department of Mental Health (“DMH”), and the Department of Public Health (“DPH” and together with the Division and DMH, the “Agencies”) jointly issue this Bulletin to provide information to Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations (“Carriers”) offering insured health coverage in the Commonwealth of Massachusetts about the Agencies’ expectations regarding changes to Carriers’ systems for coordinating inpatient admissions from Emergency Departments (“EDs”).

Emergency Department Boarding

Individuals who are in psychiatric crisis are often brought to general hospital EDs for medical clearance and screening to determine whether psychiatric hospitalization is necessary. Patients requiring inpatient psychiatric hospitalization usually wait within the ED until a bed is found for the admission and transfer arrangements are completed.

Too frequently behavioral health patients requiring inpatient hospitalization or other diversionary disposition have remained within EDs for extended periods of time, often many hours and days. – referred to as ED Boarding – even after the ED has determined the appropriate discharge disposition. This happens most often when the patient requires an inpatient admission. The reasons for such boarding situations vary, but the data shows the most frequent reasons given are: high behavioral acuity (of the patient or the receiving units); specialty needs (most often for patients with intellectual or developmental disabilities, substance use disorder, or co-occurring medical conditions); or age (most often children and youth).

DMH, in collaboration with representatives from MassHealth, DPH, commercial payers, and hospital providers, is developing regulations and guidelines that establish the expectation that any patient meeting the criteria for psychiatric hospitalization under M.G.L. c. 123, § 12 will be admitted to an appropriate inpatient psychiatric facility within a reasonable period of time. Under these guidelines, inpatient psychiatric facilities will be expected to admit all such patients, so long as they have the capacity (an available bed) and the capability (ability to meet the clinical needs of the patient). As the licensing authority for inpatient psychiatric facilities, it is DMH's expectation that there will be few situations where a clinical determination is made that the facility does not have the capability to accept an admission. Carriers will be expected to arrange payments for all medically necessary care for these patients within the inpatient psychiatric facilities, including such care as may be required to enable the facility to accept a patient with specialty needs (such as a 1:1 staff member/patient ratio, payment to convert a double occupancy room into a single, etc.).

Coverage for Behavioral Health Care

Carriers offering insured health plans in Massachusetts are mandated to include coverage for medically necessary behavioral health treatment according to the requirements of M.G.L. c. 175 §, 47B; M.G.L. c. 176A, § 8A; M.G.L. c. 176B, § 4A; and M.G.L. c. 176G § 4M. In addition, behavioral health and substance use disorder coverage are Essential Health Benefits under the provisions of the federal Patient Protection and Affordable Care Act ("ACA").

Under the federal Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA," or the "federal parity law"), group health plans and insurers that offer insured behavioral health and substance use disorder benefits must provide coverage with no more quantifiable or non-quantifiable limits than would apply to non-behavioral health benefits in the same plan. The Division is required to enforce MHPAEA for insured health benefit plans according to M.G.L. c. 26, § 8K.

Medical Necessity in Relation to ED Boarding

Pursuant to M.G.L. c. 176O, §16(b), Massachusetts-issued insured health plans are required to provide coverage for health care services if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. Carriers that are accredited by the Division as managed care companies under M.G.L. c. 176O may employ utilization review systems for insured health plans in making decisions about whether services are medically necessary. Utilization review is defined in M.G.L. c. 176O as "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings." In establishing its utilization review criteria, the Carrier is expected to base the criteria on the following provisions of M.G.L. c. 176O, §16(b):

A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as

generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to insureds, prospective insureds and health care providers consistent with [M.G.L. c. 176O, §12(a)].

Covered members requiring hospitalization should not spend extended periods of time in hospital EDs while waiting for admission to an inpatient facility. Carriers may not have utilization criteria that could lead to a patient remaining in an ED for an excessive time while waiting for appropriate transfer to an inpatient facility. Carriers are expected to establish appropriate criteria that do not cause inappropriate delays or denials of inpatient admissions for covered members with acute behavioral and substance use disorder needs. Carriers shall not establish medical necessity criteria or procedures that may lead to delays in approval of inpatient treatment for patients with acute behavioral health conditions after the Carrier has received appropriate notification that the patient is in the ED and in need of inpatient treatment. The Carrier shall approve the patient's inpatient treatment unless the Carrier has secured alternative medically appropriate placement of the patient.

Due to the nature of their behavioral health conditions, certain patients may need special resources or accommodations at an inpatient psychiatric facility in order for treatment to be appropriate during the inpatient stay. As an example, some patients may present in the ED with such acute behavioral health and/or substance use disorder conditions that they may need an individual inpatient room or specially trained staff dedicated to their care. Carriers' medical necessity criteria will be considered acceptable only if they permit approval of such special services in accordance with accepted practice and/or federal and state standards.

Carriers shall establish minimum medical necessity criteria for members to be eligible for an individual psychiatric and/or substance use disorder inpatient admission, and such medical necessity criteria will be subject to the Division's review. Factors to consider should include, without limitation: the member's diagnosis and level of acuity, the level of care required for the member, the member's ability to benefit from treatment through participation in therapeutic programming.

When the member meets the Carrier's medical necessity criteria for an individual inpatient room or any other special services, then the Carrier shall arrange for these special services to be covered when provided to the member.

Assisting with Placement of Patients Requiring Inpatient Admissions

Each Carrier is expected to have identified staff or departments that will be responsible to coordinate communications between the Carrier and the ED for the placement of patients requiring inpatient admissions. Carriers will maintain lists for use by all Massachusetts EDs of these identified staff or departments and the best methods to contact these persons.

When an individual being evaluated within an ED by an Emergency Services Provider ("ESP") or other ED staff member who determines that the individual requires an inpatient psychiatric hospital level of care and the patient is waiting for an inpatient bed more than 24 hours after arrival in the

ED, the ESP/ED will notify the relevant Carrier that one of its members is still waiting for an inpatient bed at the 24-hour mark. At this point, the Carrier will cooperate with the ED to determine if there is useful information that can be provided to the ESP/ED in the placement process.

At any time after the decision to admit the individual to a psychiatric hospital level of care has been made, the ESP or ED may contact the Carrier with a Request for Assistance which will provide the Carrier with clinical information about the individual, barriers to admission, evidence of the bed searches to date and what individual psychiatric units said when asked to admit the individual. If this patient continues to be waiting in the ED by the 48-hour mark, then the ED/ESP is required to send a Request for Assistance to the Carrier. An appropriate person from the Carrier will respond to the ED's or ESP's Request for Assistance within a reasonable time – no later than two hours during normal working hours and no later than the next morning outside normal working hours – to identify that the Carrier is meaningfully engaged and to provide the name of the person who is coordinating the Carrier's activity to locate an acceptable hospital bed for the individual.

The purpose of the Request for Assistance is to engage the Carrier's help in determining the hospital(s) most appropriate to meet the needs of the member at that time and finding placement. The more targeted and specific the Request for Assistance is, the more efficient and effective the Carrier's response will be. As an example, the Request for Assistance can include the following information:

- Specific providers who may be willing to take the individual but require additional supports or resources
- A specific provider who does not have an immediate bed but will have one within the next 24 hours
- Authorization issues for successful placement are required
- Out of network requests
- Notification that the Carrier needs to call specific providers for bed availability

Once a Request for Assistance is sent to a Carrier, the Carrier is expected to provide assistance, working with the ED/ESP to avoid duplication, in the placement of the Carrier's member in the appropriate inpatient bed with appropriate additional supports or resources needed by specific facilities to allow for admission. The Carrier will be expected to use its own internal escalation process in an active and strategic advocacy process, including senior leadership and/or medical directors where appropriate, when engaging with appropriate high-level clinical and administrative leadership within network hospitals. If the specific hospital that is deemed most appropriate for the patient does not have an immediate bed, but will have one within 24-48 hours, the Carrier will seek priority for this bed. If there are not any network hospital beds anticipated to be available within the 24-48 hours after receipt of the Request for Assistance, the Carrier will seek placement in appropriate out-of-network facilities.

Once a Carrier has exhausted its network options and has explored all appropriate out-of-network options, or after another 48 hours has passed and the Carrier's member has not secured a placement in an inpatient psychiatric level of care, the Carrier is required to make an appropriate contact to DMH. The Carrier is also responsible for informing hospitals deemed appropriate to admit the individual that the process is being escalated to DMH.

When a Carrier contacts DMH, the Carrier is to use a standardized template to explain the clinical status of the patient, all the actions that the ED/ESP and then the Carrier have taken to identify an appropriate placement, and any barriers that have prevented the patient from obtaining appropriate placement. The Carrier shall use the standardized template so that DMH has all necessary information to understand the status and be able to consider next steps. The Carrier's medical director or designee should also be available to discuss the patient's status and initiate a clinical conversation as needed. If a payment concern is discovered, a discussion between the Carrier and the Division shall take place in order to allow for resolution to allow for the appropriate placement of the patient.

Network Adequacy and Carriers' Coordination of Placements

Managed care plans are expected under 211 CMR 52.03 to have networks of providers that provide adequate and available access to covered health services within a reasonable time. Managed care disclosure materials are required under M.G.L. c. 176O, §6(a)(4) to clearly explain "the locations where, and the manner in which, health care services and other benefits may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network..."

When the Division determines that a Carrier's provider network does not provide adequate and available access to facilities/practitioners to deliver certain types of care, a Carrier is required to cover treatment at the in-network benefit level for medically necessary services even when delivered by out-of-network providers until such time as the Carrier re-establishes what the Division considers to be adequate and available access to those certain types of providers.

When a Carrier's network is found to be inadequate and the Carrier's member is admitted to an out-of-network facility, the Carrier shall then be obligated to pay all in-patient hospital costs at the out-of-network facility until the member is discharged or until it is legally permissible and clinically appropriate to transfer the patient to a facility that is part of the Carrier's network.

Please note that this Bulletin is in no way intended to create any barrier that could limit or jeopardize access to behavioral health and substance use disorder treatment. Instead, these directives are intended to protect members for whom the normal emergency admissions process may break down. Carriers are advised that they should be prepared to implement the directives in this Bulletin by no later than February 1, 2018.

If you have any questions about this Bulletin, please contact the Division's Kevin Beagan, Deputy Commissioner for Health Care Access, at 617-521-7323 or Tracey McMillan, Director of Bureau Managed Care, at 617-521-7347.