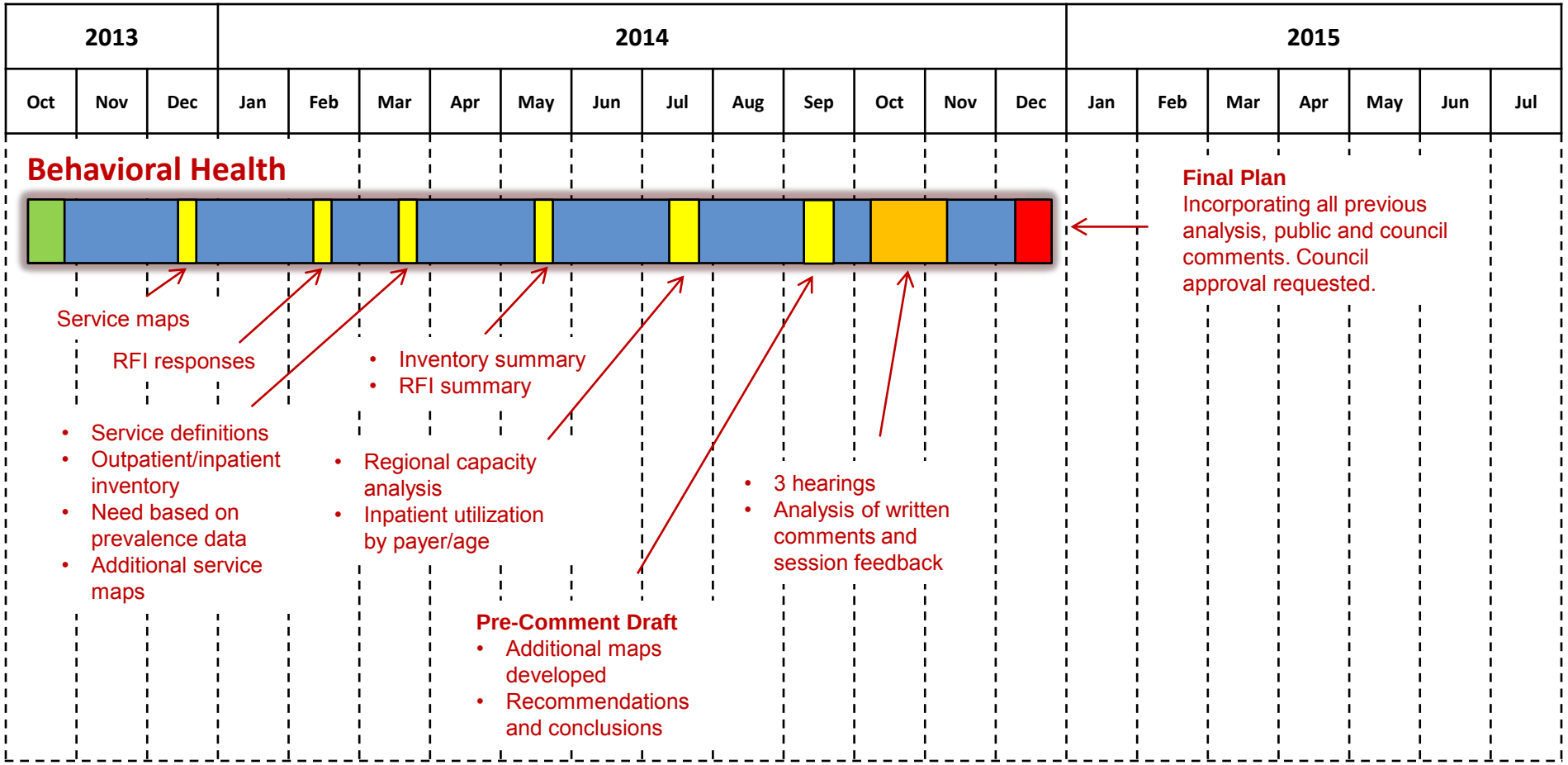
State Health Plan

Behavioral Health

Massachusetts
Department of Public Health
December 2014
www.mass.gov/dph/ohpp

Commonwealth of Massachusetts
Department of Public Health

Health Planning Life Cycle



Council approval of service line

Data collection and analysis

Draft reports presented at Council meetings

Public comments collected (written and hearings)

Final report approved (pending)

Analytic Road Map and Framework – Report

- What is the capacity of Massachusetts' behavioral healthcare system to serve those in need?
- Needs based upon national prevalence and survey data.
- Demand for services in behavioral health is highly elastic and data such as wait lists are not readily available. Many people meeting diagnostic criteria are not "ready" for treatment. Interviews, document review and comparisons of claims levels will help us comment on demand.
- Use data came from five primary sources: DPH-BSAS; DMH; MassHealth; Medicare 5%; APCD commercial data.
- Provider inventory is available primarily for licensed programs and is covered in this presentation.

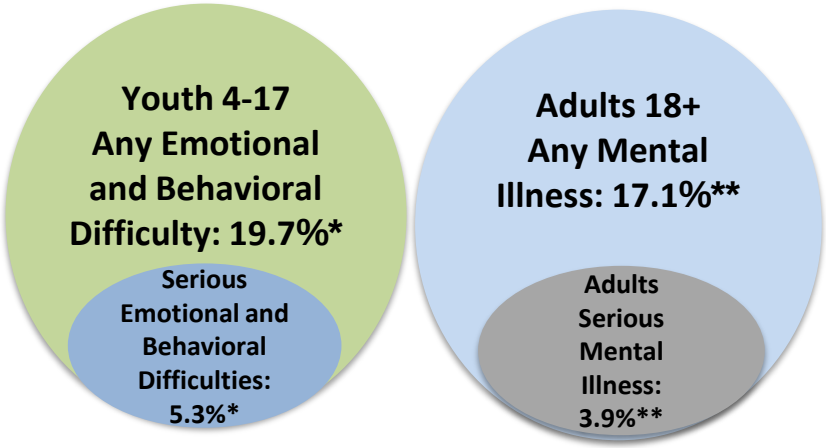
Estimation of Need

Summary: Need

- People with any signs of mental illness comprise 17-19% of the population; more serious conditions are reported for 4-5% of the population.
- People with substance use disorders are roughly 10% of the population, but national data suggest only 11% of these actually receive services.

Mental Health Conditions

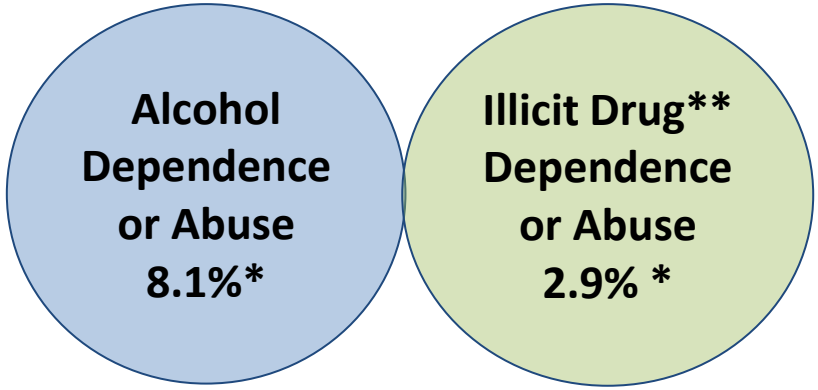
NSDUH and National Health Information Survey



* National Health Information Survey 2011
** National Survey of Drug Use and Health 2008-11 (rev 10/13) and 2012
***2014 population projections from UMass Donahue Institute

Substance Dependence and Abuse (MA)

(2008-11 and 2012 NSDUH Combined)



**Dependence or Abuse Past Year Ages 12+* – NSDUH 2008-11 (rev 10/13) and 2012
***Illicit Drugs* include cocaine, heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics and marijuana used non-medically
***NSDUH 2012
2014 population projections from UMass Donahue Institute

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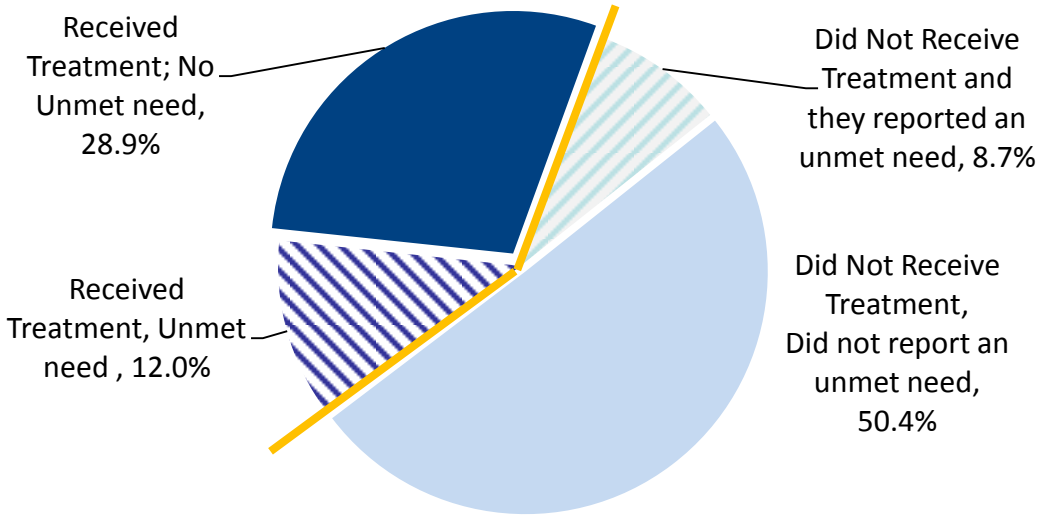
Significant Number of People with Any Mental Illness (AMI) Did Not Get Treatment and Did Not Report an Unmet Need

Unmet Need for Treatment in the Past Year and Receipt of Treatment, Among those with AMI, Ages 18+ in the US, 2012



Received Treatment?	Unmet Need? Yes	No
Yes	12.0%	28.9%
No	8.7%	50.4%

Respondents who were identified as having AMI were asked "was there any time when you needed mental health treatment or counseling for yourself but didn't get it?"

- 9% did not get treatment and yet they reported an unmet need
- Half of people reporting a mental illness did not get treatment, and did not report an unmet need (despite being identified with a mental illness)
- 12% got treatment, and reported an unmet need
- 29% who met the criteria for any mental illness were receiving treatment with no unmet need.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011 and 2012
http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect1peTabs2012.htm - Tables 1.1A , 1.24A , 1.39A
Source on Massachusetts: Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Massachusetts, 2013. HHS Publication No. SMA-13-4796MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857, p.9

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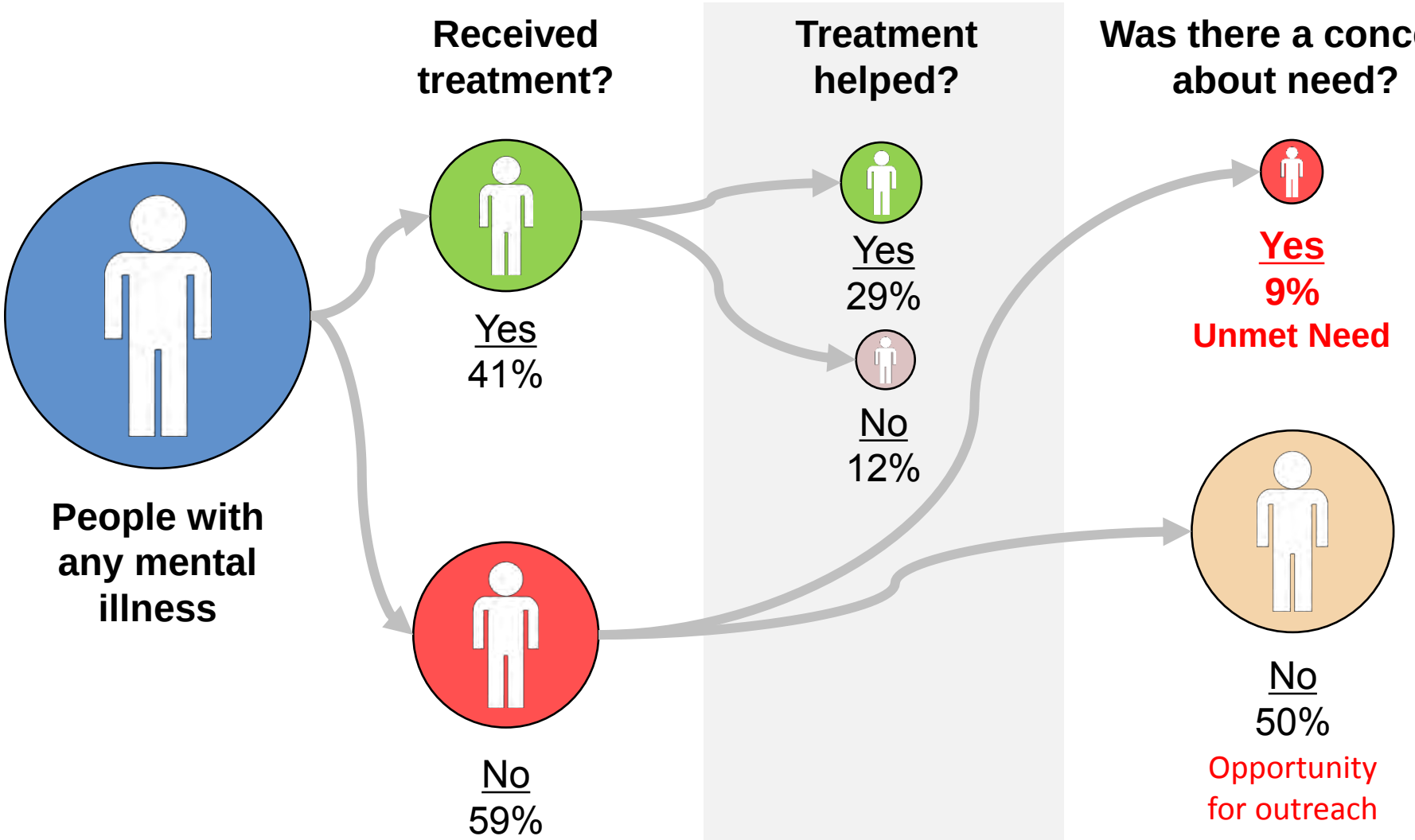

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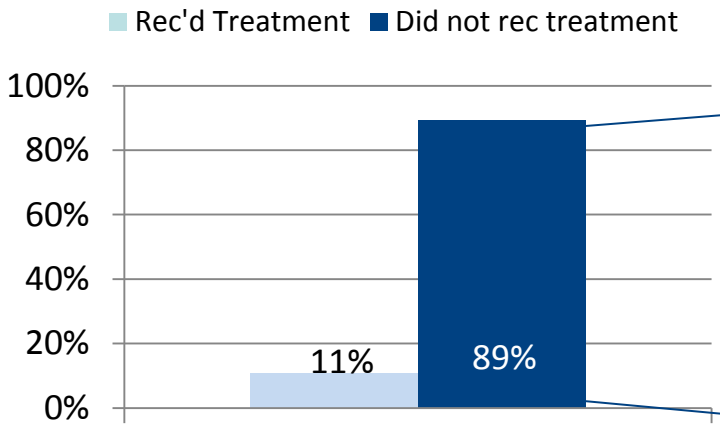
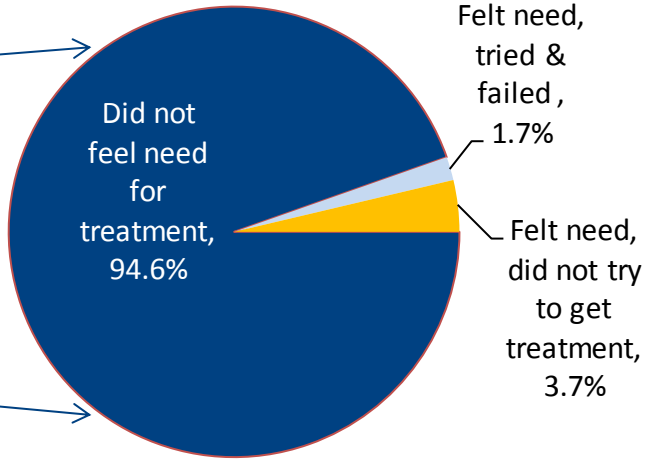
Significant Number of People with SUD Do Not Feel a Need for Treatment

Percentage of People with SUD who Received Treatment

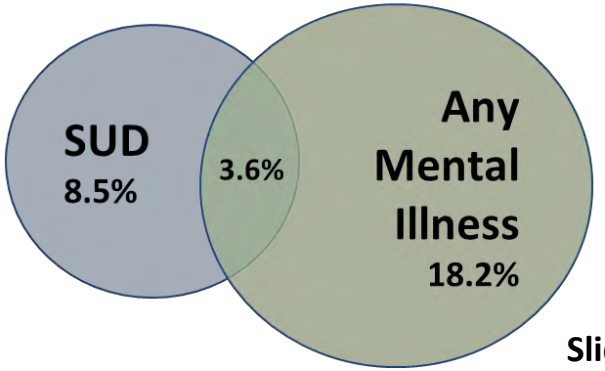


Percentage of People who did Not Receive Treatment by Perceived Need and Attempts to Get Treatment



- **Only 11% of people reporting an SUD received treatment**
- **Of the remaining 89%, most of these (95%) did not "feel the need for treatment" (awareness).**
- **3.6% of the 18.2% with AMI or 8.5% with SUD had co-occurring conditions**

Co-occurring Substance Use Disorder & Mental Illness Conditions (US – 2012)**



Source on Need for and Receipt of Treatment: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011 and 2012 - Table 5.51A , Table 5.53A - http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/DetTabs/NSDUH-DetTabsSect5peTabs1to56-2012.htm

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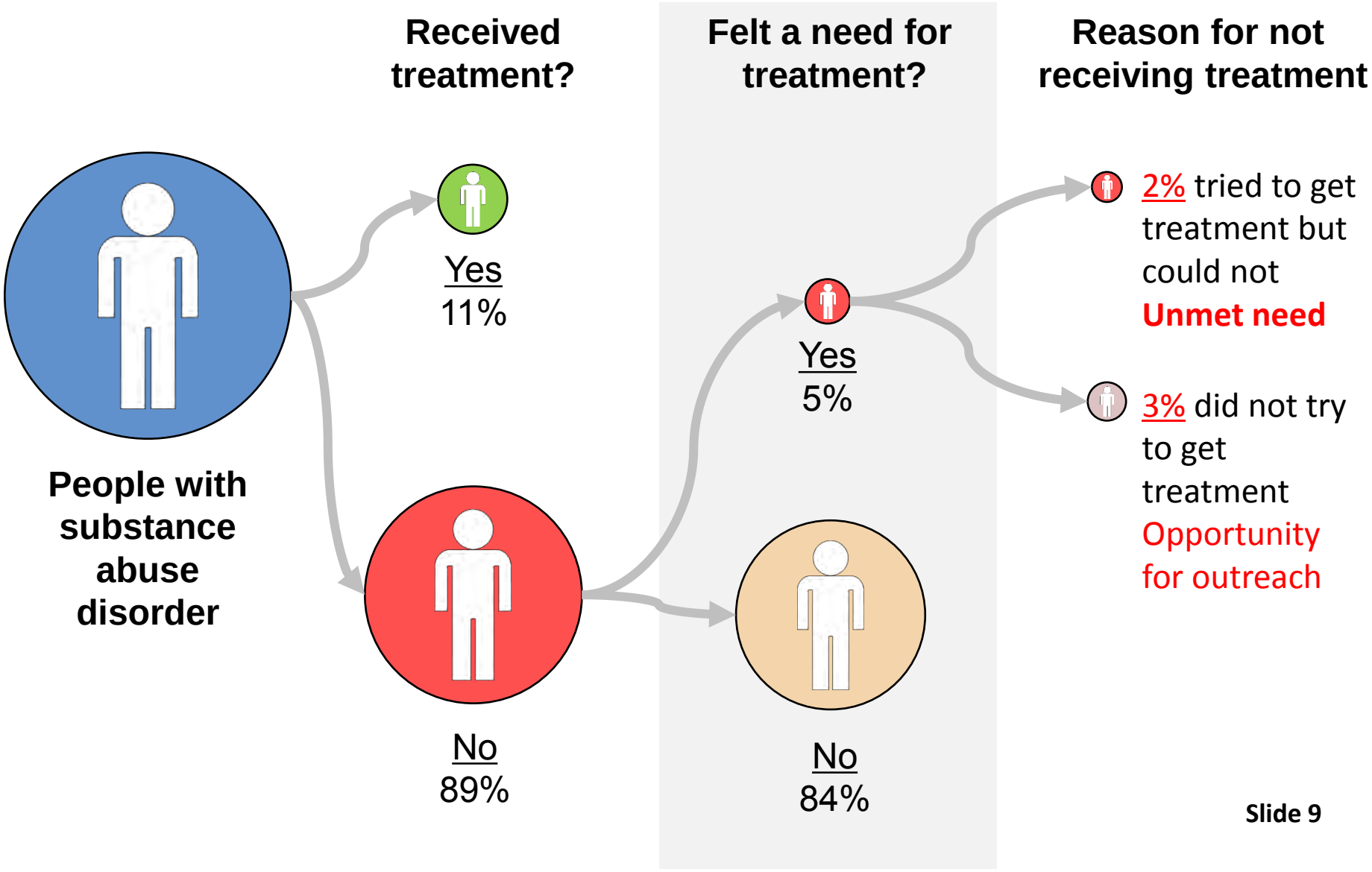
Significant Number of People with SUD Do Not Feel a Need for Treatment



Population Growth

- The Donahue Institute at UMass Boston developed population projections for Massachusetts that projected a modest 1.8% overall increase in the state's population over the next 6 years (in 2020 - see next page).
- Metro Boston showed the highest growth rate at 3.6% over that period, while the Cape and the Islands showed a minor decrease in population.
- Data were not readily available for racial and ethnic groups for the HPC regions and for utilization data.
- **These estimates have a very small impact on the capacity projections and the regional variation is also very small.**
- An increasingly aging population and improvements in health and wellness may in fact increase number of people with SMI and SUDs requiring long-term services and supports

HPC Region	2014 Estimates	2020 Estimates	% Increase
Western MA	821,826	826,758	0.6%
Central MA	763,769	787,434	3.1%
Northeast	1,401,973	1,410,555	0.6%
Metro West	660,610	667,763	1.1%
Metro Boston	1,575,595	1,632,689	3.6%
Metro South	820,790	838,931	2.2%
South Coast	340,404	342,096	0.5%
Cape and Islands	243,352	242,567	-0.3%
Total	6,628,319	6,748,792	1.8%

Source: UMass Donahue Institute – Special Analysis for Health Planning Council November 2013.

Informational Surveys and Interviews

Informational Survey and Interviews

Selected interviews with state agencies, advocacy organizations, trade associations and others were conducted to supplement the survey results and better describe perceptions of need and service demand.

Informational Survey

- Distributed via email to over 1000 stakeholders on 1/24 with response due by 2/5
- Informational Survey content:

I. Background of the statute & introduction to Health Resource Planning

II. Brief overview of Behavioral Health services in MA & listing of services under consideration for planning

III. Four questions for response

Informational Survey

Four questions for response:

- 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?

- 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.

- 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?

- 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?

Summary Findings: Survey and Interviews

Summary of findings from two sources:

- The Request For Information (RFI) was released by DPH in January 2014. The majority of the 27 RFI responses came from provider organizations, with smaller numbers from statewide organizations and government agencies;
- Key Informant Interviews (March through April 10). Health Planning Council staff and consultants conducted 18 key informant interviews. The interviewees include state leaders, representatives of payors, managed behavioral health organizations, consumers, and other providers.

Summary Findings

Summary of Interview and Responses by Category

	Interviews	RFI Responses	Total	
			Number	Percent
Consumer/Family Association	5	2	7	16%
Government	3	3	6	13%
Payers and plans	3	3	6	13%
Provider	1	17	18	40%
Provider Association	6	2	8	18%
Total	18	27	45	100%

Most RFI respondents and interviewees are providers or stakeholders and offer their perspective from within the system, which may contain biases (though not always in the same direction). In order to minimize the impact of this bias on the findings of the report, feedback from consumers and observations of others, including experts on the Health Planning Council and Advisory Group, will complement findings from the RFI responses and interviews in the final report.

Stakeholder Feedback Process

DPH released a request for information in January 2014. There were 27 responses and 18 additional interviews were held with state leaders, payors, consumers and provider associations.

The following 5 points summarize the stakeholder input:

1. Compared to public payors, commercial insurers currently provide more limited coverage of residential recovery or treatment and other community services for mental health and substance abuse care.
2. Patient access to an optimal continuum of mental health and substance abuse care is seriously reduced by the limited capacity of residential and community care and of some types of inpatient care.
3. Low payment rates and funding are reported to adversely affect system capacity and access.
4. Divided responsibilities and a lack of statewide planning capacity have inhibited comprehensive understanding and improvement of behavioral services.
5. Data sources available to document the extent of the unmet demand for community services are in need of further development

Inventory

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The Framework: Service Definitions

The Health Planning Workgroup organized services into eight major service categories that include all mental health and substance abuse services provided in the state. These service categories, which differ only slightly between mental health and substance abuse, provided a framework for thinking about the state's inventory and the utilization of services.

MENTAL HEALTH SERVICES		SUBSTANCE ABUSE SERVICES	
Service Group	**Definition**	**Service group**	**Definition**
Inpatient and Continuing Care	Acute or extended inpatient psychiatric hospitalization services	**Inpatient and Other Acute Care**	Care in hospitals and non-hospital settings for acute detoxification, stabilization and other substance abuse treatment
Intermediate Care	Services provided as a step-down or alternative to inpatient care	**Intermediate Care**	Care provided as a step-down or alternative acute care
Residential Care	Care provided in a 24-hour residential program	**Residential Care**	Rehabilitation services with a planned care program in a 24-hour residential setting
Community and Outpatient Care	Care in an ambulatory setting such as a mental health center, hospital outpatient clinic or a professional's office	**Community and Outpatient Care**	Care in an ambulatory setting such as a community health center, substance abuse treatment program, hospital outpatient department, a professional's office, or a patient's home
Care Management	Services to manage mental health care or to coordinate with other health or social services	**Case Management**	Discrete services to manage substance abuse care or to coordinate with other health or social services
Bundled Services	A coordinated array of mental health and supportive services for people with mental illness living in the community		
Recovery and Family Support Services	Programs to help people support each other in their recovery from mental illness and to support families of children with mental illness	**Recovery Support Services**	Programs to help people maintain their recovery and support each other in recovery
Emergency Services	Care provided in hospital emergency departments and in specialized programs of emergency mental health services	**Emergency Response**	Care and other services provided for substance abuse-related emergencies

Mental Health Inventory

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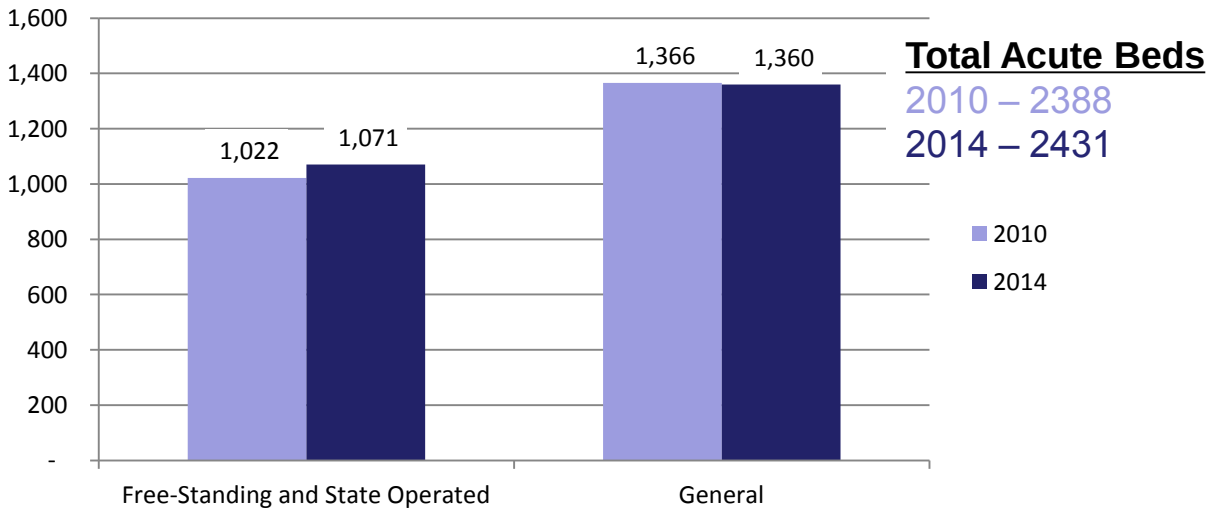
Inpatient Psychiatric Beds 2010 & 2014

There are a total of 67 acute hospitals or psychiatric units across the state, with 2,431 acute beds across different hospital groups.

- These facilities include 15 free-standing acute psychiatric hospitals, 50 psychiatric units in general hospitals, and two psychiatric units in state mental health facilities. Of the 2,431 beds, 43% are in free-standing hospitals, 56% in general hospitals, and 1% in state facilities.
- These 2,431 beds receive clients from a statewide population of 6.6 million residents, for a ratio of beds to population of 37 beds per 100,000 population.
- For age groups, 10% of beds are for children and adolescents, 73% of beds are for adults, 17% of the beds are in specialized geriatric units.

Inpatient Psychiatric Beds in Free-Standing Psychiatric Hospitals, General Hospitals and State-Operated Units, 2010 and 2014

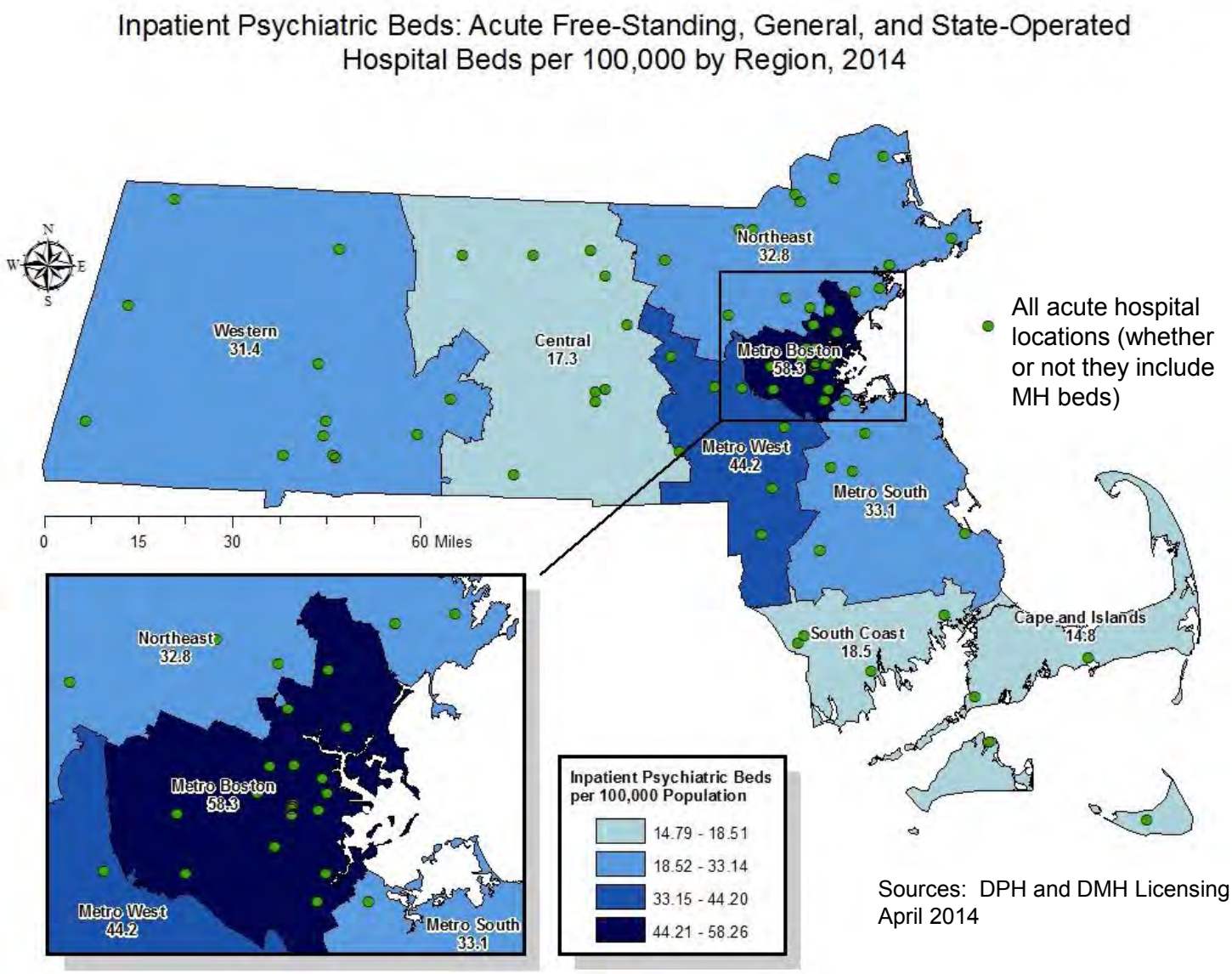


From 2010 to 2014, bed capacity has grown 5% among the free-standing hospitals and 2% among all hospitals.

Free-standing hospital bed growth of 5% over the last four years contrasts with no growth for general acute hospital psychiatric beds that may provide care for more complex, medically involved cases.

Source: DPH and DMH licensing data, March 2014 (prior to the closing of North Adams Hospital)

MH Inpatient Beds: 8 Regions



Bed density based on data from entire MA population.

Metro Boston has the highest concentration of beds while Cape and Islands, Central, and South Coast regions are the lowest.

Sources: DPH and DMH Licensing data, April 2014

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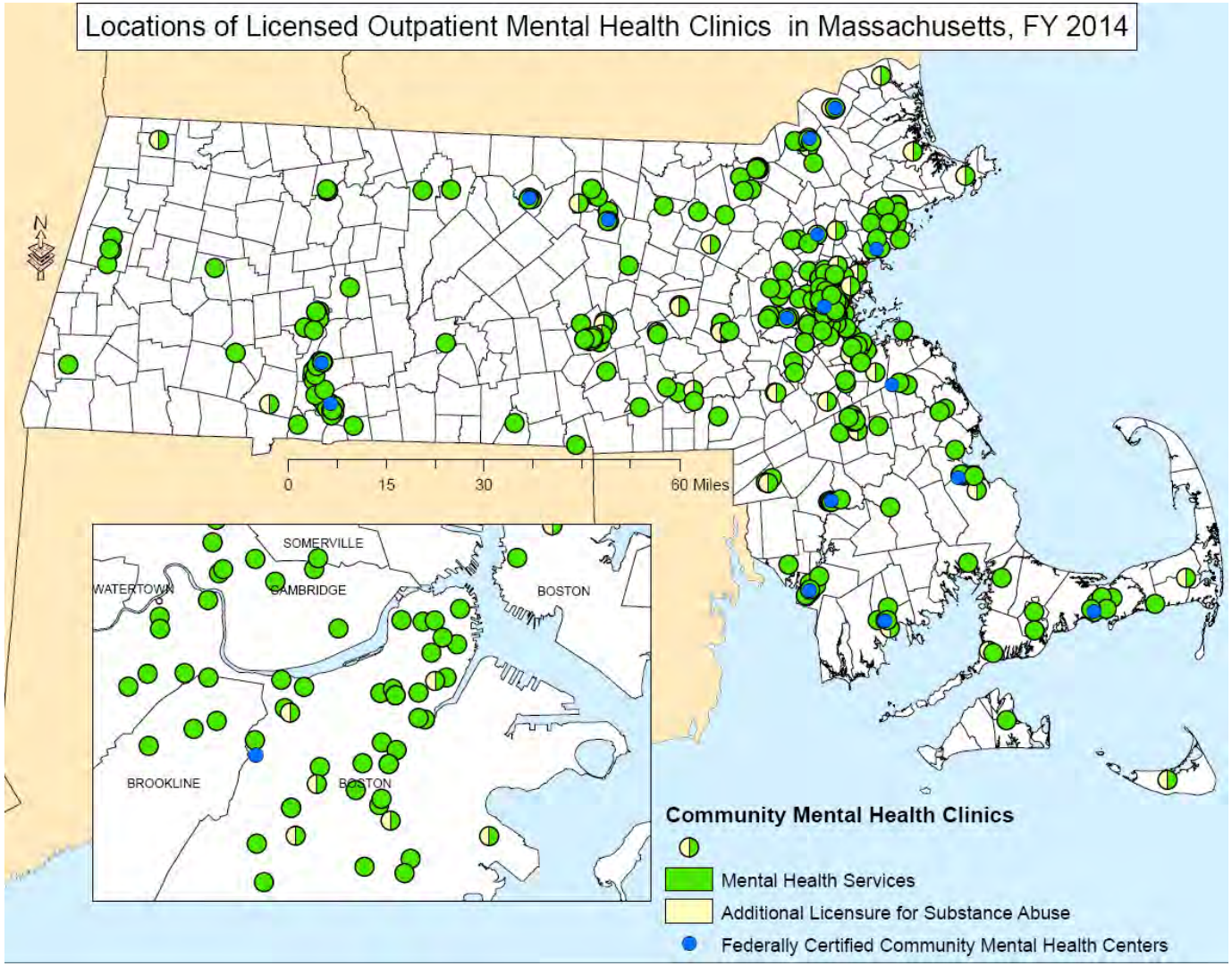
Service Map:
Outpatient Mental Health Clinics



Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Outpatient Mental Health Clinics

- Outpatient mental health clinics deliver comprehensive diagnostic and psychotherapeutic treatment services in interdisciplinary team under the medical direction of a psychiatrist. Services include: diagnosis and evaluation; medication management; consultation; and individual, family and group treatment for people with Mental Health or Substance Abuse disorders.
- The green/yellow dots represent clinics licensed by the Department of Public Health (DPH), Bureau of Health Care Safety & Quality. Blue dots represent locations that meet federal requirements for mental health centers. Although any of the locations may treat individuals with a "dual diagnosis" of mental health & substance abuse, a subset of the clinics receive additional specific licensure from the DPH, Bureau of Health Care Safety & Quality to treat substance abuse. The dots do not represent any of the "private practitioners" who offer mental health or substance abuse treatment nor the clinics that are separately licensed by the DPH, Bureau of Substance Abuse Services.
- Services are available to people with public insurance or to those with private insurance that contract with these providers.

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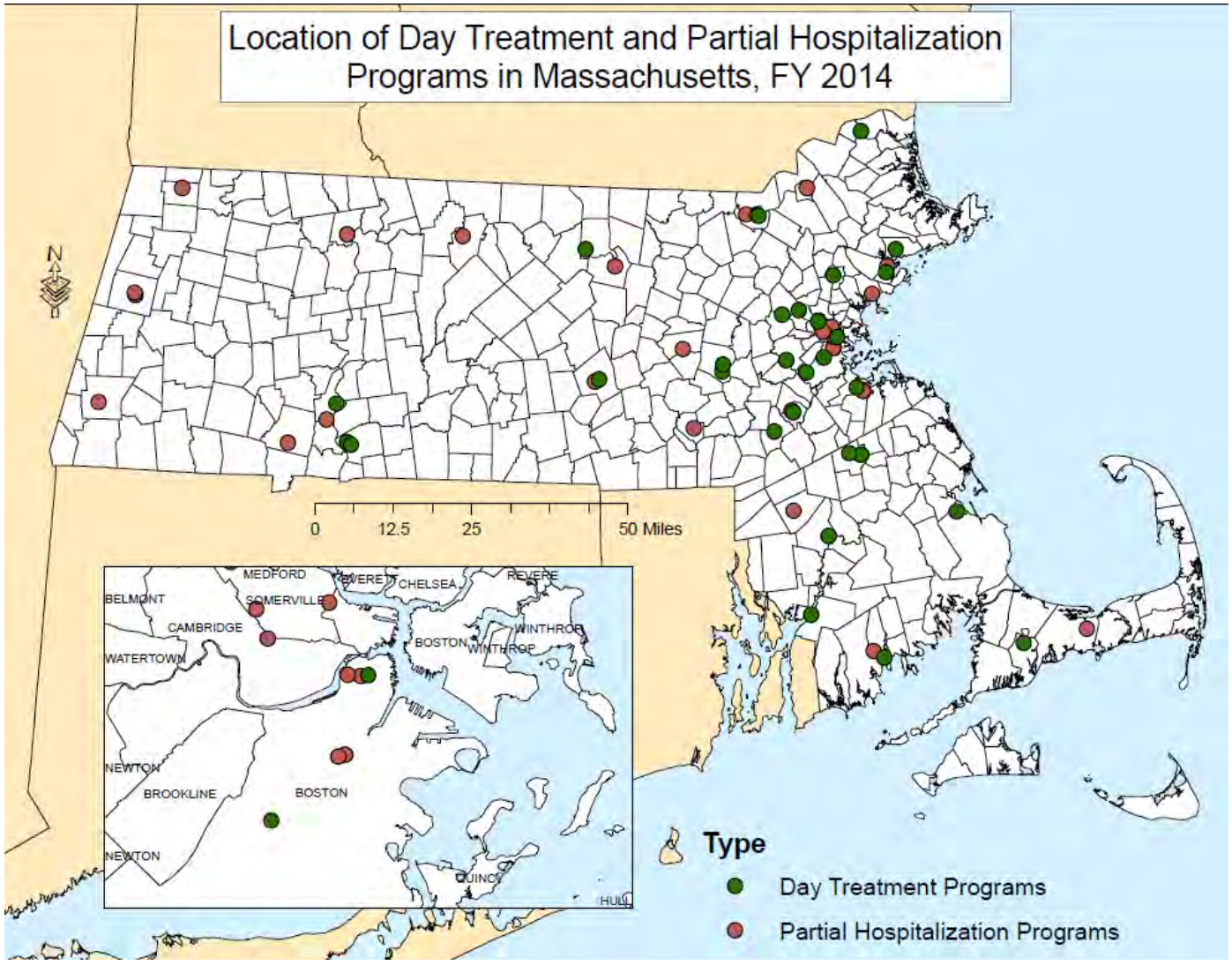
Service Map: Diversionary Services - Partial Hospitalization & Day Treatment Programs



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Partial Hospitalization Programs

- Partial Hospitalization programs provide intensive short-term psychiatric outpatient day-treatment to individuals as a step-down from inpatient services or to prevent an inpatient admission. These programs are typically associated with acute inpatient psychiatric units/facilities .
- Each dot represents a facility that provides partial hospitalization services, licensed by the Department of Mental Health (DMH).
- These services are typically covered by private and public insurance.

Psychiatric Day Treatment Programs

- Psychiatric Day Treatment programs provide a coordinated set of therapeutic supportive services to individuals who need more active or inclusive treatment than is typically available through traditional outpatient mental health services. The service is less intensive than partial hospitalization programs and typically of longer duration.
- They provide rehabilitative, prevocational, educational, and life-skill services to promote recovery and attain adequate community functioning .
- Each dot represents a provider organization that offers a psychiatric day treatment program, licensed by the Department of Public Health (DPH).
- These services are covered by public insurance and some private insurance plans.

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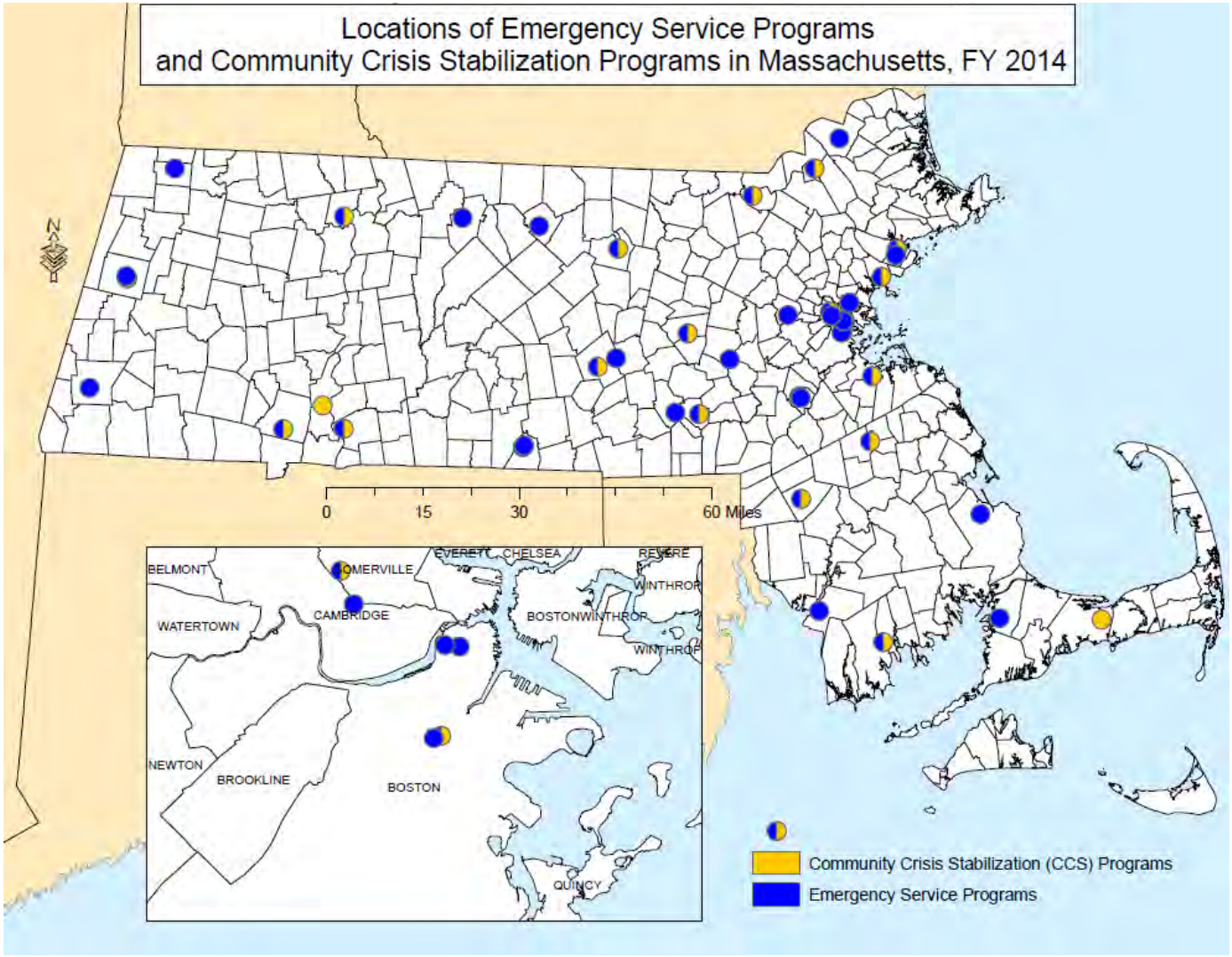
Service Map: Diversionary Services- Emergency Service Programs & Community Crisis Stabilization Programs



Emergency Service Program (ESP)

- ESPs are a statewide network of emergency service providers providing a comprehensive, integrated program of crisis behavioral health services, including behavioral health crisis assessment, intervention and stabilization services.
- ESPs are distributed to community-based locations and emergency departments.

Community Crisis Stabilization (CCS)

- CCS programs are ESP components that provides a staffed, secure treatment beds in the community as an alternative to inpatient psychiatric services. Length of stay is typically shorter than acute care.
- Dots represent organizations funded via the Department of Mental Health (DMH) & MassHealth through a competitive process and found in the Massachusetts Behavioral Health Partnership Directory. And, DMH directly operates two ESPs in the Southeast Region.
- Services are available to people with public insurance, no insurance, or to those with private insurance that contract with these providers.

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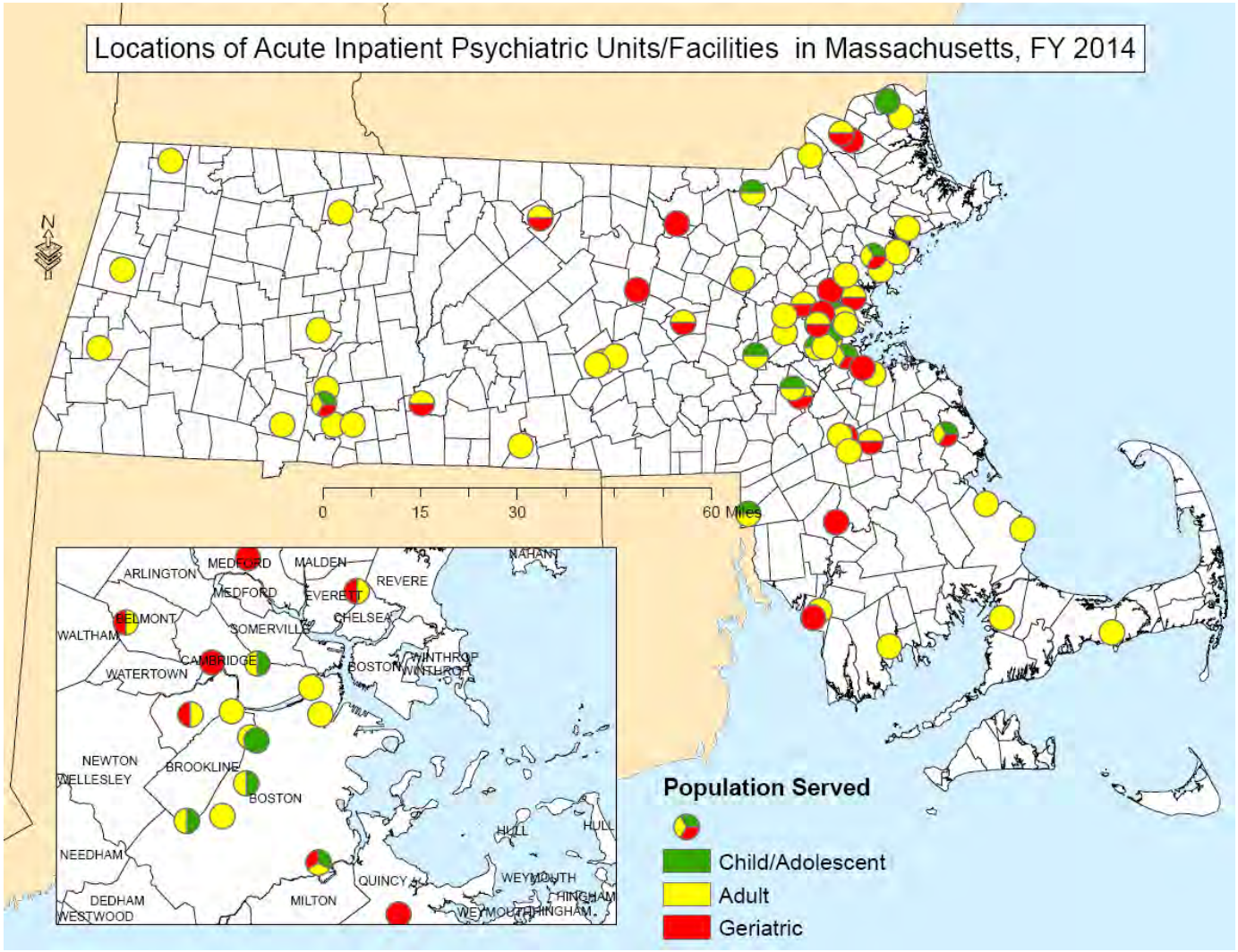
Service Map:
Acute Inpatient Psychiatric Units/Facilities



Acute Inpatient Psychiatric Units/Facilities

- Most individuals who need psychiatric inpatient care receive such services at an acute inpatient psychiatric unit in a general hospital or a private psychiatric facility.
- Psychiatric units in general hospitals and private psychiatric hospitals provide short-term, intensive diagnostic, evaluation, treatment and stabilization services to individuals experiencing an acute psychiatric episode.
- The dots represent the general hospital psychiatric units and private acute psychiatric hospitals licensed by the Department of Mental Health (DMH). In addition, DMH operates two inpatient units at Community Mental Health Centers in the Southeast region.
- Services are available to people with public insurance and to those with private insurance that contract with these providers.

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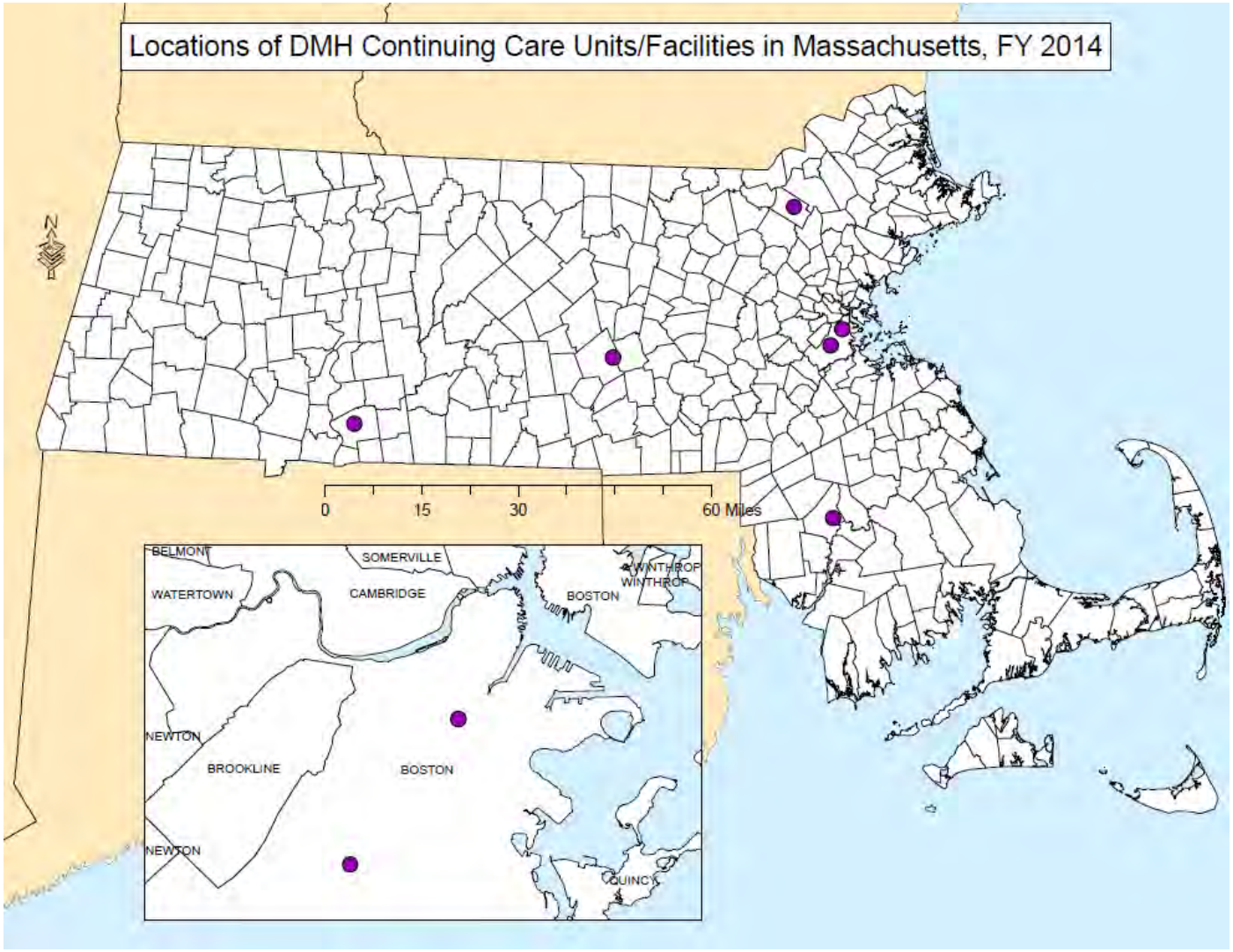
Service Map:
DMH Continuing Care Units/Facilities



Department of Mental Health (DMH) Inpatient Continuing Care

- DMH funds or operates 6 inpatient units or "state hospitals" that provide ongoing treatment, stabilization and rehabilitation services to a small number of individuals with serious and persistent mental illness who need longer term hospitalization.
- Services are available when a referral is made to the DMH facility by a transferring hospital. Individuals are generally transferred to DMH after the conclusion of a course of treatment in an acute inpatient psychiatric unit or facility and are admitted to the first available bed in a DMH-operated inpatient unit or state hospital.
- Like private hospitals & units, the facilities are accredited by the Joint Commission and certified by the Center for Medicare and Medicaid Services (CMS).
- The dots represent the 6 state-funded Inpatient Units or facilities.

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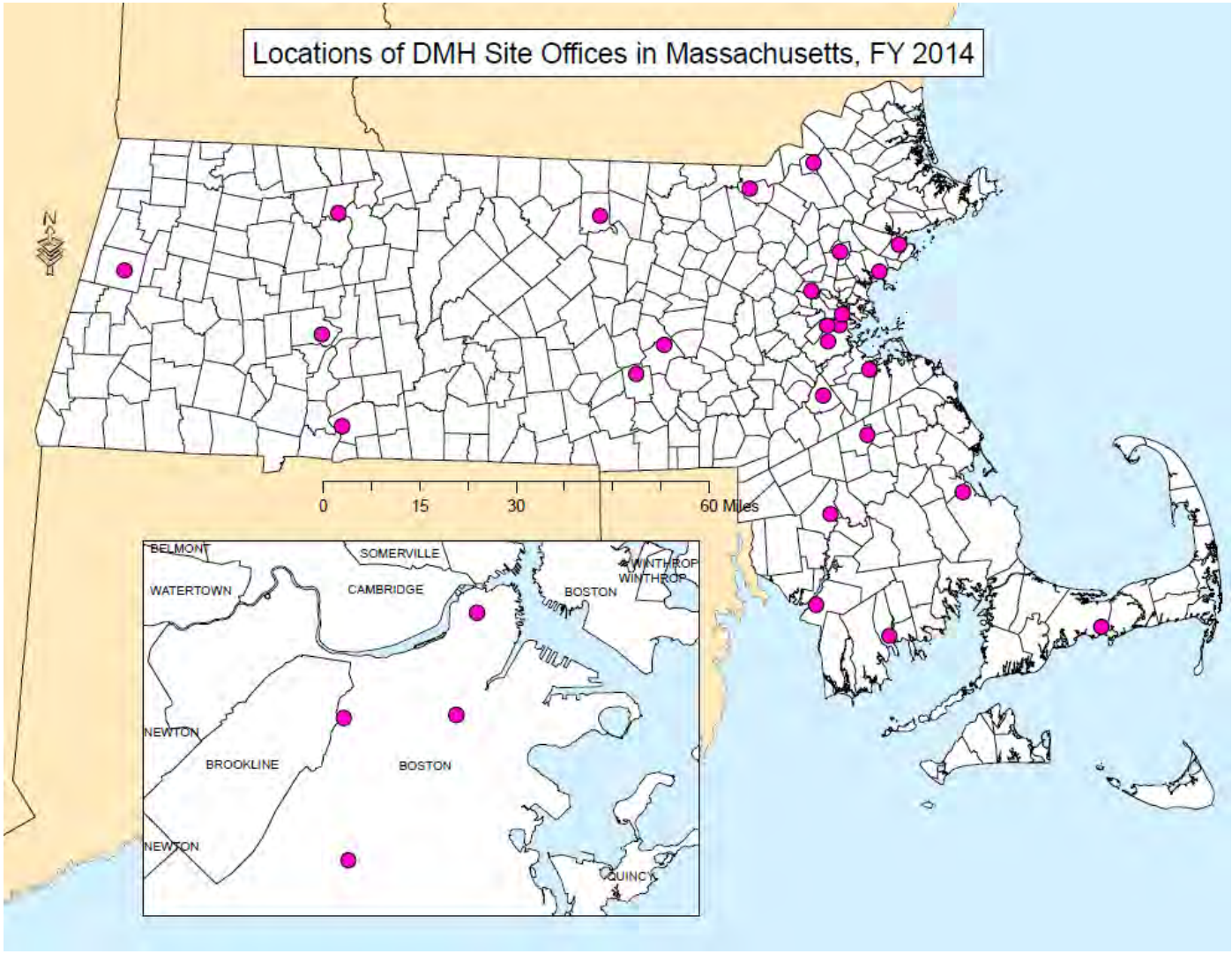
Service Map: DMH Site Offices



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Department of Mental Health (DMH) Site Offices

- DMH provides services through 27 site offices within 25 locations across Massachusetts. The site offices provide case management and oversee an integrated system of community rehabilitative and recovery-based services for adults and youth.
- Individuals must apply to DMH to receive community-based services to determine they have a "qualifying mental disorder" as the primary disorder requiring treatment, and meet functional impairment and other criteria. There are "needs & means" criteria, in addition to clinical criteria, as part of the review for access.
- Services are delivered flexibly, often in individuals' homes and local communities. Services are designed to meet the behavioral health needs of individuals of all ages, enabling them to live, work, attend school and fully participate as valuable, contributing members of our communities.
- DMH also offers a range of supports to parents and people receiving mental health services through peer and parent support organizations. Individuals and families do not need to be authorized for services to access these supports.

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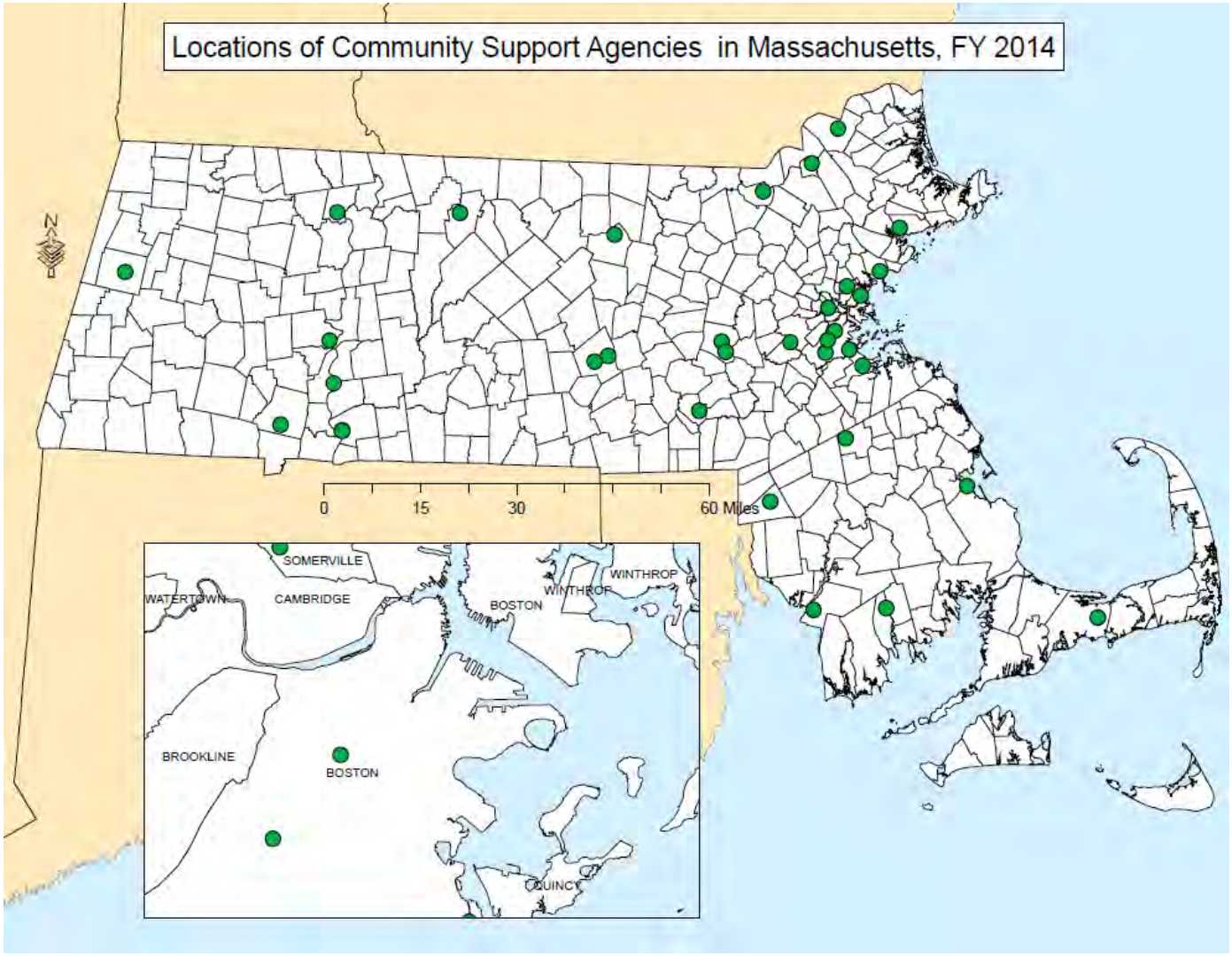
Service Maps: Community Support Agencies



Community Support Agencies (CSA)

- CSAs are a statewide network of community-based organizations that facilitate access to, and ensure coordination of, care for youth with serious emotional disturbance (SED) and their families who require or are already utilizing multiple services or are involved with multiple child-serving systems (e.g., child welfare, special education, juvenile justice, mental health).
- Dots represent service providers funded by MassHealth through a competitive process. Services are available only to residents with MassHealth. Services are coordinated with the Department of Children & Families (DCF).
- Dots do not represent any independent services available for youth with private insurance.
- Dots represent the 32 CSAs: 29 that are geographically consistent with the current 29 service areas for the Department of Children and Families and three culturally and linguistically specialized CSAs to address the needs of specific cultural or linguistic groups in Massachusetts.

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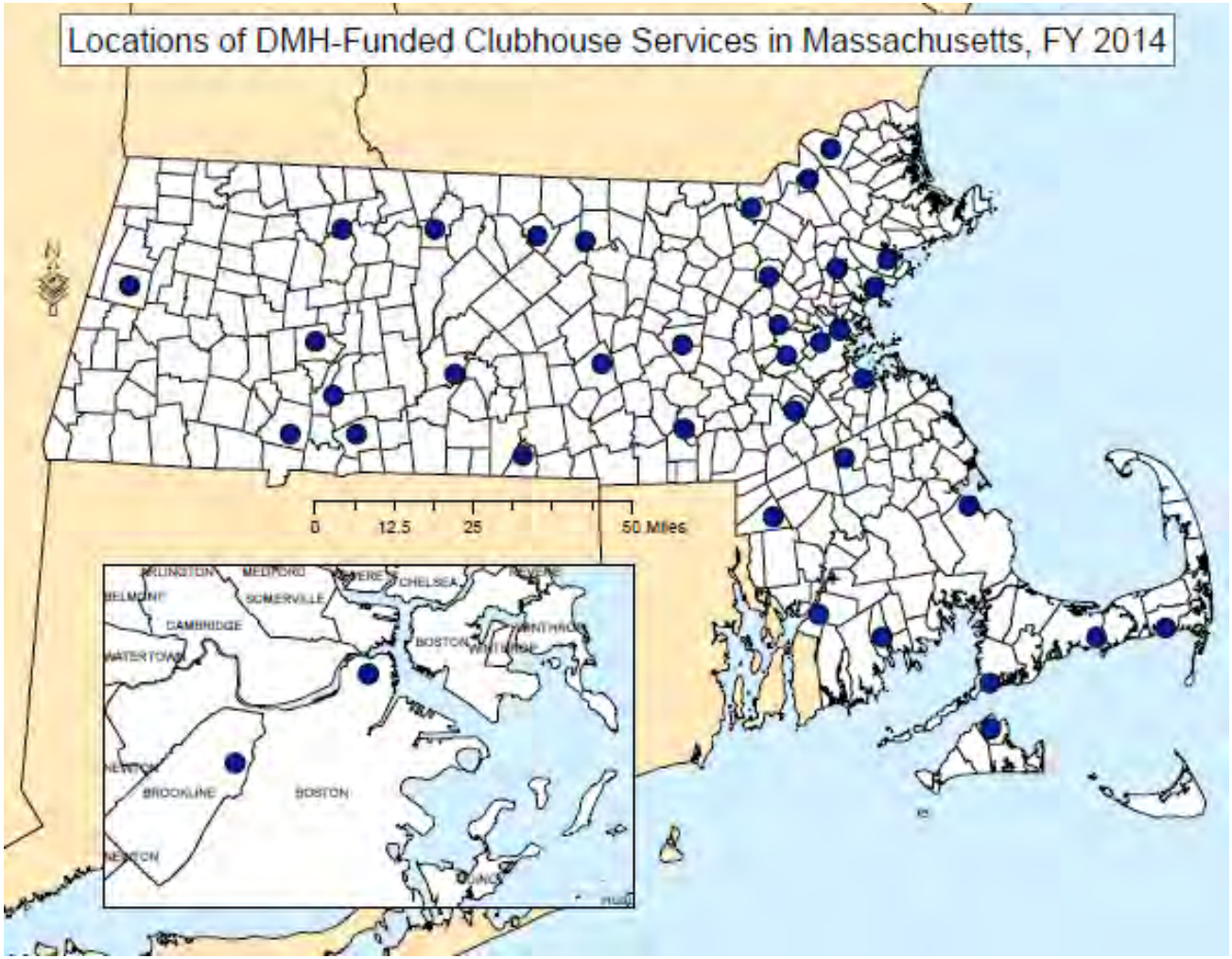
Service Map: DMH-Funded Clubhouse Services



DMH-Funded Clubhouse Services

- Clubhouse Services, a psychosocial rehabilitation service, provide supports through a membership-based community center. Clubhouse Services assist people served to recognize their strengths, develop goals, and enhance the necessary skills for living, working, learning, and fully participating in their communities. The Clubhouse offers a daily schedule of activities, and works with people to connect them with jobs, school, interests and social activities within their own community.
- Each dot represents one of the 37 Clubhouse locations.
- Clubhouse services are available to people with a serious and long-term mental illness.

Data reflects a point in time and is updated as of 1/28/14
Dots represent location; not reflective of capacity or volume

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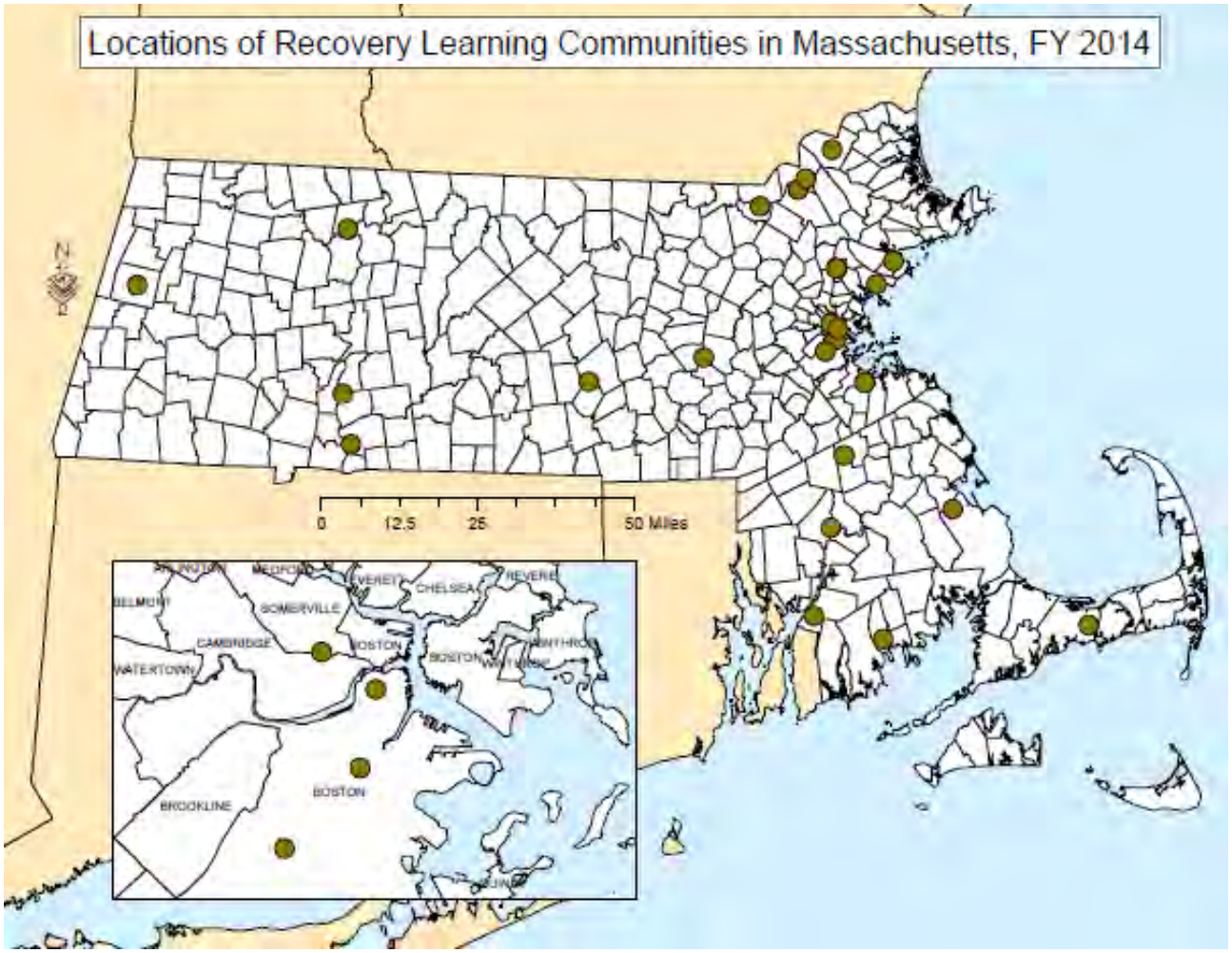
Service Map: Recovery Learning Communities (RLC)



Data reflects a point in time and is updated as of 1/28/14
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Recovery Learning Community (RLC)

- The RLC provides a wide range of peer-to-peer support and resources to individuals with serious mental illness. Further, RLCs support the peer providers though training, continuing education, and consultation. Additionally, RLCs link with other peer-operated services and supports
- Supports may be offered in a variety of settings including, but not limited to the RLC site. Other settings include community mental health centers, inpatient hospitals, generic community settings, town hall, fairs, shopping mall, etc.
- Each dot represents one of 24 RLC network locations.
- RLCs are open to anyone seeking support

DMH Community Redesign: Policy Context

- DMH began a re-design of its community services in 2009
  - Supports the Administration's Community First initiative
  - Promotes recovery and resiliency, flexible and individualized services
- Redesigned services include:
  - Adults: Community Based Flexible Supports, Respite, Clubhouse
  - Child and Adolescent: Caring Together (DMH-DCF joint residential); Individual and Family Flexible Support Services (IFFSS or "Flex")
- Redesigned services and additional community funding resulted in new community placements and less reliance on inpatient and other intensive services
- Result for 2011-2013: decreased continuing care beds and increased capacity of community-based services

Licensed MH Clinics

- 380 clinics statewide licensed by DPH provide MH services – two-thirds of the total clinics*
- Among the 558 clinics providing medical care, mental health care or both:
  - 51% provide mental health care only
  - 17% provide both mental health and medical care
  - 32% provide medical care only
- MH Clinics can provide both mental health and substance abuse services

* Numbers of clinics include license-holding clinics and their satellite clinics, each counted separately. Among the excluded clinics are those that provide only dental, pharmacy, physical rehab or MRI services. Also not included are physician-owned offices, which are not licensed by DPH.

HPC Regions and DMH Site Offices

- DMH funded services are contracted or operated from 27 local site offices. Most of these services are provided within the person's own community, often in the home or other settings chosen by the client
- DMH capacity data reflect the region with the location of the site office where the contract is held or service is operated
- DMH site offices do not align with the HPC regions. The DMH system of site offices has been built around community boundaries while the HPC regions are based upon hospital service areas and hospital referral regions. Some HPC regions have multiple site offices, some have none.

Continuing and Intermediate Care

- 626 continuing care beds provide ongoing treatment, stabilization and rehabilitation for the relatively few people needing more inpatient care after an acute inpatient hospital stay
- Other important services that complement the use of the hospital include:
  - 39 partial hospitalization programs
  - 30 day treatment programs
  - 22 crisis stabilization programs
  - 42 emergency services programs

Continuing Care
Mental Health Services

Continuing care provides ongoing care in a hospital setting for the relatively few people needing more inpatient care after an acute inpatient hospital stay.

Statewide continuing care beds, 2011-2013

Year	Continuing care beds
2011	671
2012	626
2013	626

Notable changes include:

- Worcester State Hospital closed in 2011-2012, eliminating 136 beds
- 124 beds were reduced at Taunton from 2011-2012
- Worcester State Recovery Center and Hospital opened in August, 2012 (+156 beds) and expanded in 2013.

Other Mental Health Services

- Community Based Flexible Supports, the "cornerstone" of the DMH community mental health system for adults with serious mental illnesses
  - provides services in partnership with clients and their families to promote and facilitate recovery
  - Point-in-time capacity in 2013: 11,814 individuals
  - Includes rehabilitative and support services to manage psychiatric symptoms and medical conditions in the community and that support independent living, wellness and employment
- Other important DMH services include: adult respite, intensive residential treatment programs for children, case management, and recovery learning centers

Inpatient Psychiatric Beds

Inpatient Psychiatric Beds in Free-Standing and General Hospitals by Region, 2014

Region	Number of Hospitals or Psychiatric Units*				Number of Beds				Population	Beds per 100,000	Ratio to Statewide Average
	Free-Standing	General	State-Operated	Total	Free-Standing	General	State-Operated	Total			
Western	1	9	0	10	30	228	0	258	821,826	31	0.8
Central	0	6	0	6	0	132	0	132	763,769	17	0.5
Northeast	3	10	0	13	163	297	0	460	1,401,973	33	0.9
Metro West	2	3	0	5	177	115	0	292	660,610	44	1.2
Metro Boston	5	14	0	19	490	428	0	918	1,575,595	58	1.6
Metro South	4	5	0	9	179	93	0	272	820,790	33	0.9
South Coast	0	2	1	3	0	47	16	63	340,404	19	0.5
Cape and Islands	0	1	1	2	0	20	16	36	243,352	15	0.4
Statewide Total	**15**	**50**	**2**	**67**	**1,039**	**1,360**	**32**	**2,431**	**6,628,319**	**37**	1.0
Percent	22%	75%	3%	100%	43%	56%	1%	100%			

*For free-standing and general hospitals, each hospital with psychiatric beds is counted once. The two state-operated psychiatric units, Corrigan in Fall River and Pocasset on Cape Cod, are located within state mental health centers.

Changes in Inpatient Psychiatric Beds: 2010-2014

Number of Inpatient Psychiatric Beds in Free-Standing Psychiatric Hospitals, General Hospitals and State-Operated Psychiatric Units, 2010-2014

	Number of Beds					Change 2010-2014	
Hospital Type	2010	2011	2012	2013	2014	Number	Percent
Free-Standing	990	1,005	1,025	1,034	1,039	49	5%
General	1,366	1,353	1,353	1,354	1,360	-6	0%
State-Operated	32	32	32	32	32	0	0%
Total	2,388	2,390	2,410	2,420	2,431	43	2%

- Freestanding hospital bed growth (5%) over the last four years contrasts with no growth for general acute hospital psychiatric beds that may provide care for more complex, medically involved cases.

DPH-Licensed Clinics

DPH-Licensed Outpatient Clinics Providing Mental Health and Medical Services by Region, 2014

Region	Numbers of Licensed Clinics Providing Indicated Services				
	Mental Health	Mental Health Only	Mental Health *and* Medical	Medical Only	Total Three Types of Clinics (MH only, MH and Med., Med. only)
Western	56	51	5	27	83
Central	45	34	11	39	84
Northeast	71	50	21	36	107
Metro West	21	20	1	21	42
Metro Boston	105	61	44	21	126
Metro South	46	41	5	22	68
South Coast	20	18	2	7	27
Cape and Islands	16	12	4	5	21
Total Statewide	**380**	**287**	**93**	**178**	**558**
Share of All Clinics	**68%**	**51%**	**17%**	**32%**	**100%**

Notes: The clinics described in this table are ambulatory care providers licensed by the DPH Division of Health Care Quality for specific services such as medical care or mental health care. The numbers of clinics include both license-holding clinics and their satellite clinics, each counted separately. Data from April 25, 2014.

The counts of clinics in this table represent only a subset of the clinics licensed by DPH: Clinics that do not provide either mental health or medical services were excluded.

In addition, because DPH regulation excludes from its licensing requirements those medical offices and group practices wholly owned and controlled by their physicians, such offices and practices are also not included in the table.

DMH Community Based Flexible Support Services

Community Based Flexible Services, Capacity by Region, 2011-2013

Region	2011	2012	2013	Population 2013	2013 Capacity/ 100,000	Ratio to state average
Western	1,810	1,995	2,000	821,002	244	1.4
Central	1,629	1,664	1,667	759,774	219	1.2
Northeast	2,448	2,421	2,421	1,400,532	173	1.0
Metro West	350	356	360	659,412	55	0.3
Metro Boston	3,405	3,368	3,368	1,565,936	215	1.2
Metro South	1,242	1,248	1,264	817,737	155	0.9
South Coast	433	433	436	340,118	128	0.7
Cape and Islands	294	298	298	243,483	122	0.7
Statewide	**11,611**	**11,783**	**11,814**	**6,607,993**	**179**	**1.0**

Note: The capacity is the fixed number of people who can be served at any point in time.

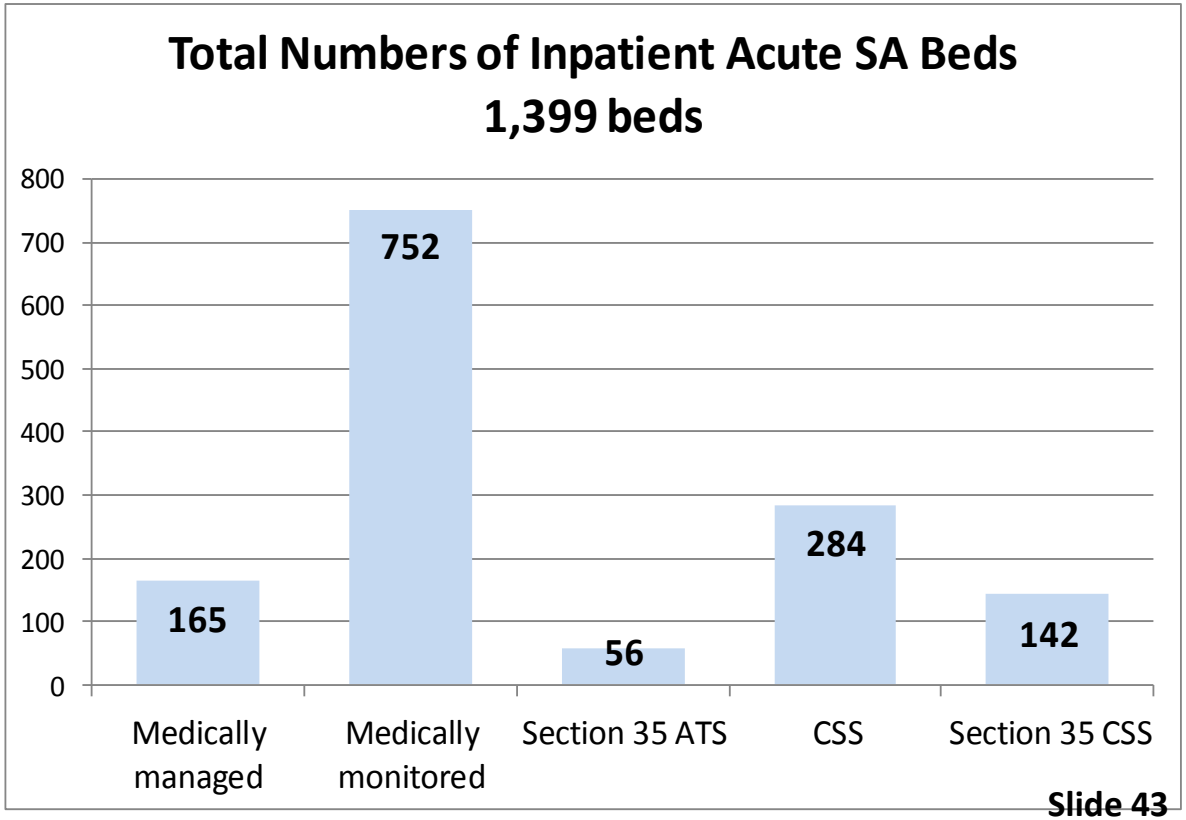
Substance Abuse Inventory

Commonwealth of Massachusetts
Department of Public Health

Substance Abuse Inpatient and other Acute Services

Inpatient and other acute substance abuse services inventory includes a total of 1,399 beds. These 1,399 beds receive clients from a statewide population of 5.6 million residents 13 years and older, for a ratio of beds to population of 25 beds per 100,000 population. A variety of acute substance abuse care beds serves people with different levels of need.

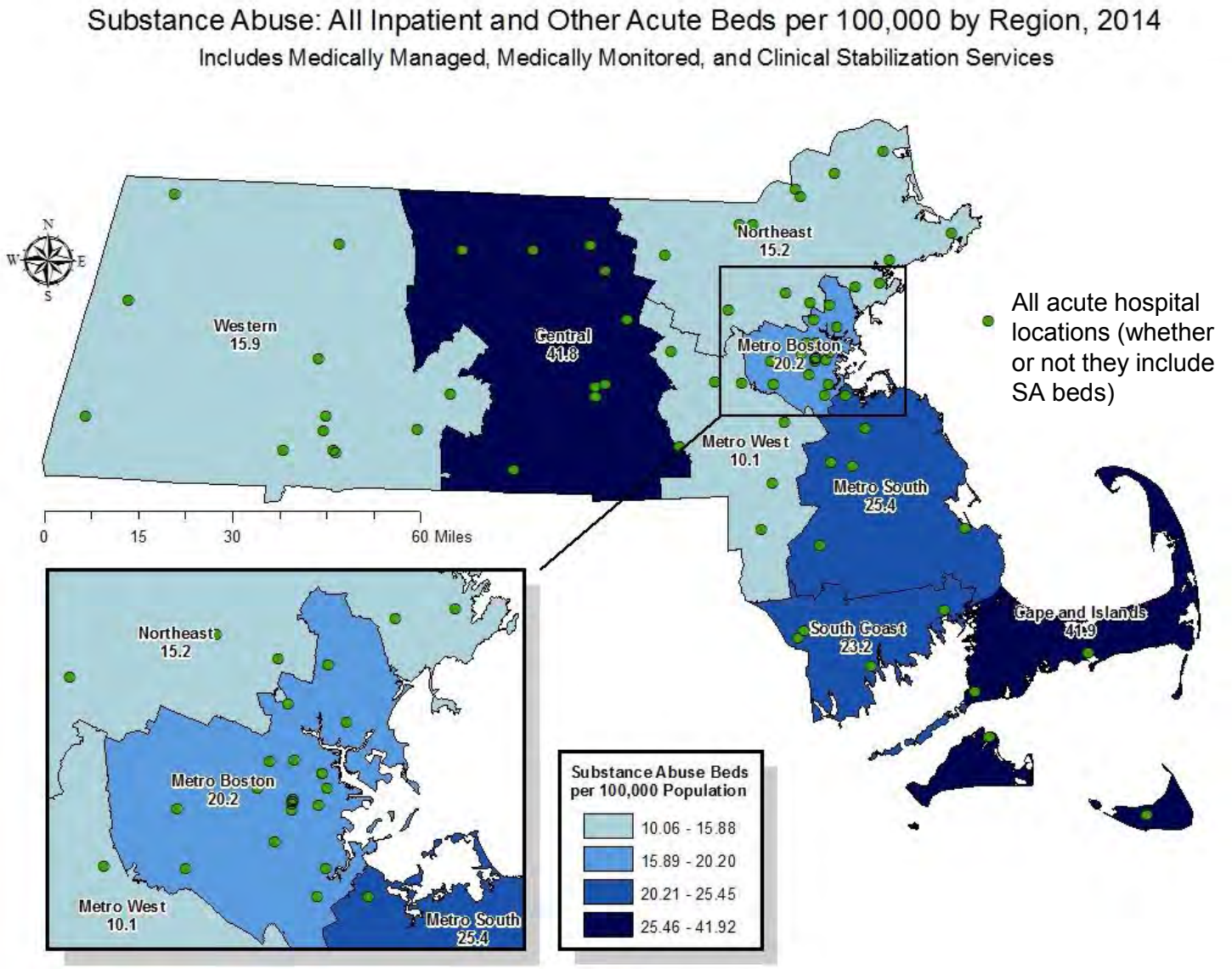
The medically managed and medically monitored beds involve the highest level of medical oversight. ATS means acute treatment services. Section 35 is the state statute for court-ordered treatment of substance abuse conditions. CSS means clinical stabilization services. Note that Sec. 35 CSS programs preferentially admit Section 35 ATS discharges for longer term stabilization services.



Source: DPH licensing data, March 2014

Commonwealth of Massachusetts
Department of Public Health

SA Inpatient and Other Acute Service Beds

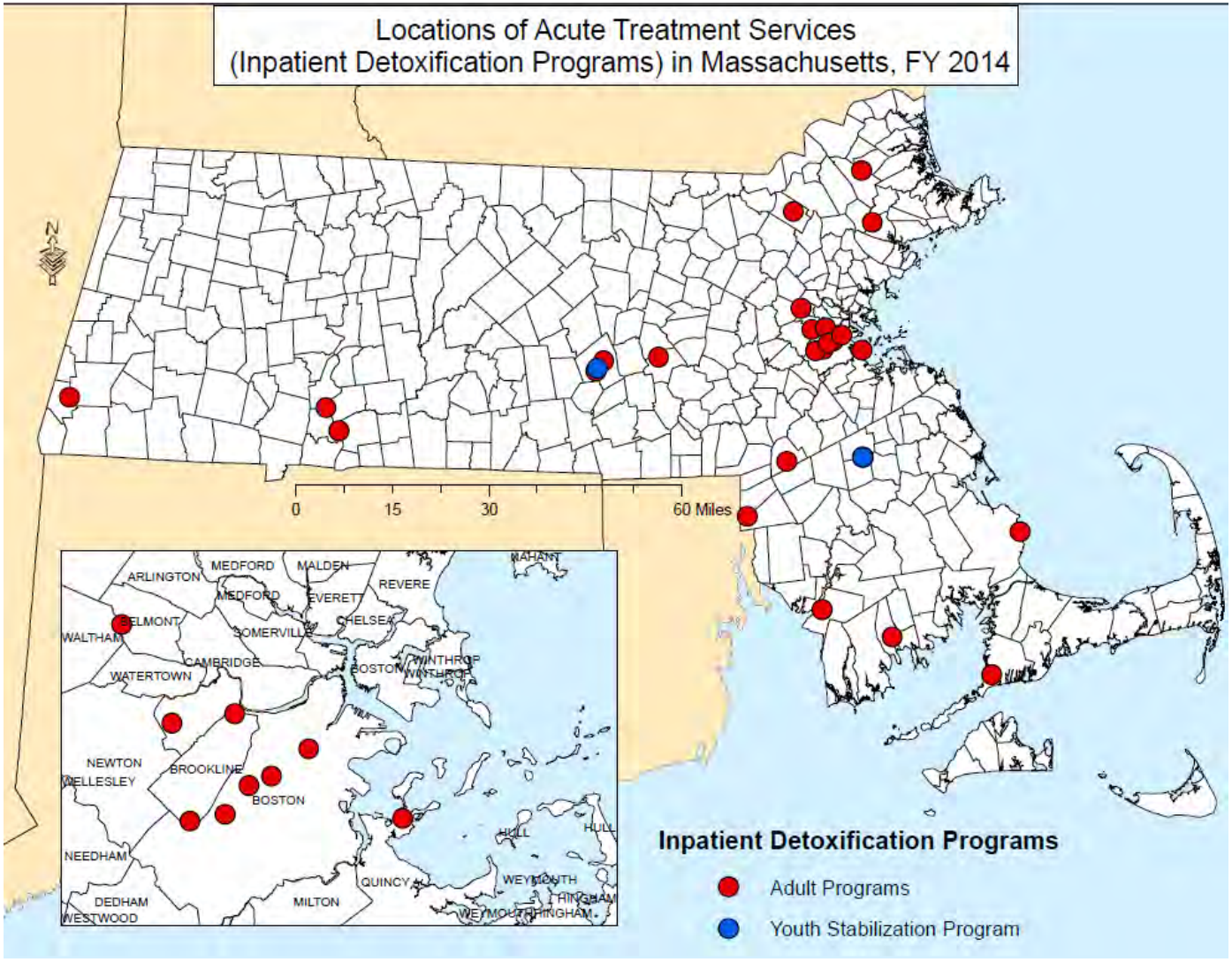


Bed density based upon MA population data for ages 13+.

Central Mass and Cape Cod have the highest concentration of beds while Metro-West region is the lowest.

Commonwealth of Massachusetts
Department of Public Health

Service Map : Acute Treatment Services (Inpatient Detoxification Programs)



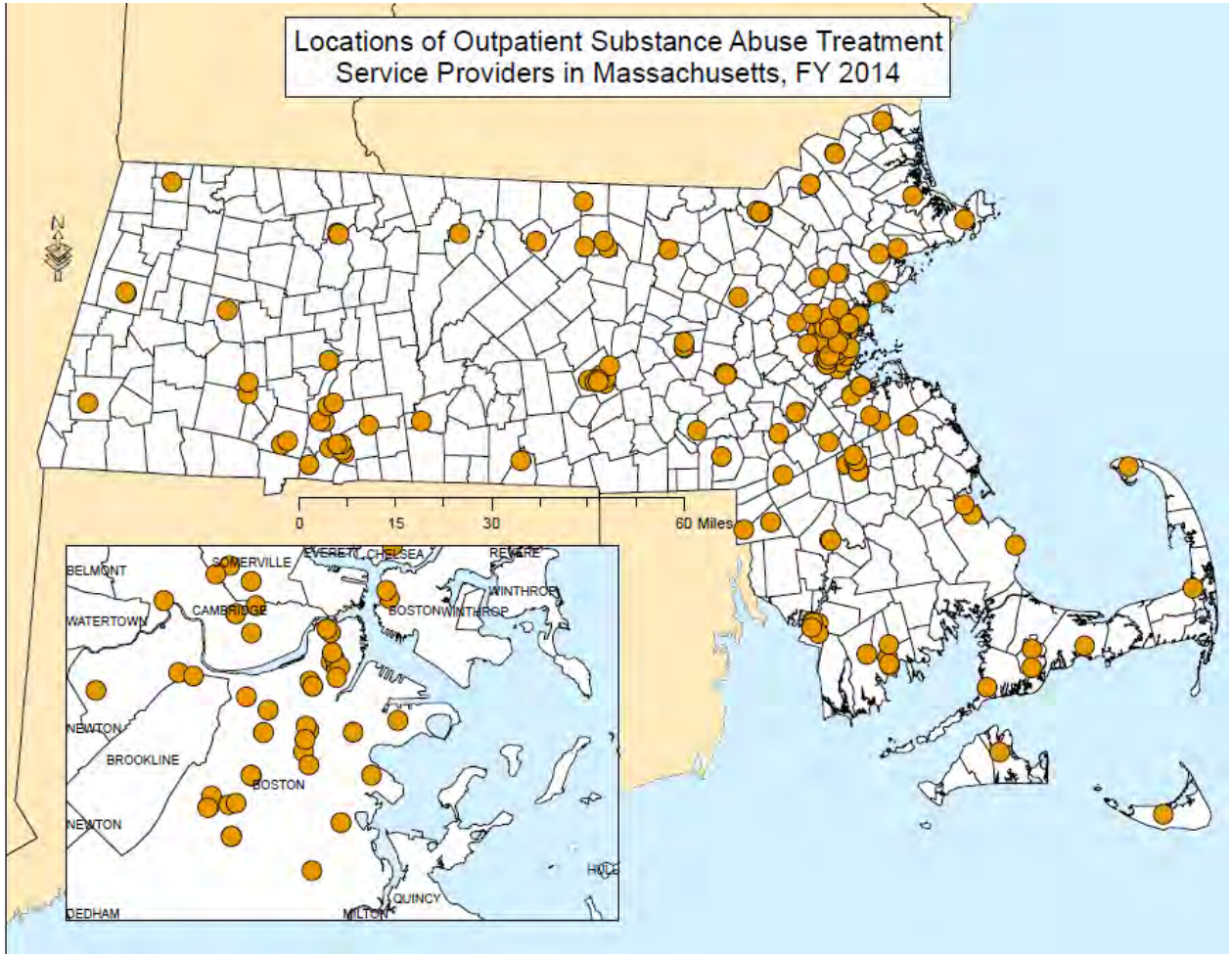
Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Acute Treatment Services (ATS)

- ATS programs are commonly referred to as inpatient detoxification programs. These programs operate in free standing and hospital based settings. The primary purpose of ATS programs is to medically treat withdrawal symptoms in persons who are dependent upon alcohol and/or other drugs.
- Specialized inpatient services are available to adolescents under 18 years of age who require ATS services. These services are referred to as Youth Stabilization Programs.
- All adolescent and adult programs encourage individuals who complete detoxification to continue receiving addiction treatment in other settings such as residential rehabilitation or outpatient settings.
- Services are available to people with public insurance, and to those with private insurance that contract with these providers.
- Dots represent the Department of Public Health (DPH), Bureau of Substance Abuse Services (BSAS) licensed Substance Abuse Acute Treatment Services (including adult & adolescent) either as units in a hospital or a freestanding facility .

Commonwealth of Massachusetts
Department of Public Health

Service Map:
Outpatient Substance Abuse Treatment



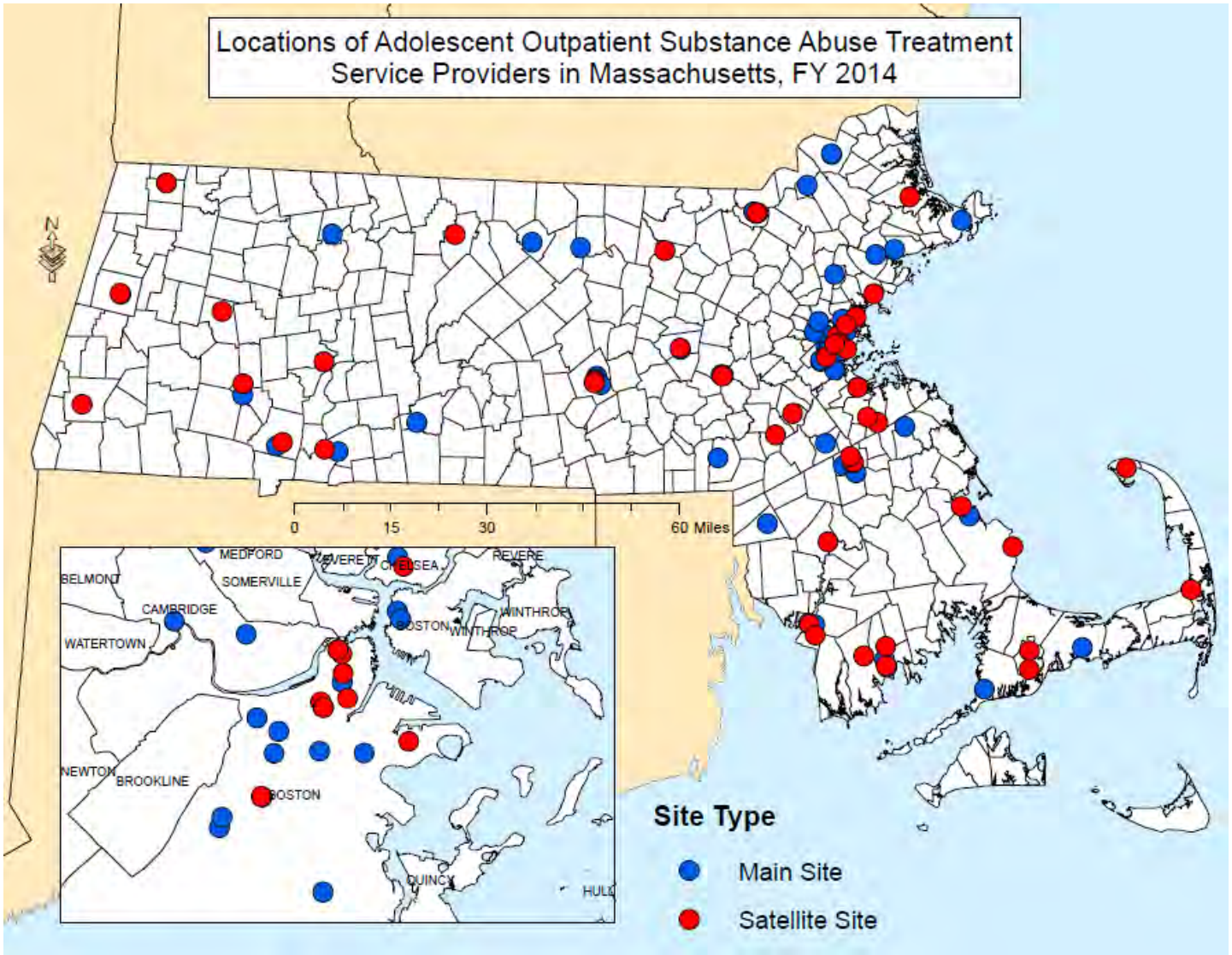
Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Outpatient Substance Abuse Treatment

- Outpatient Substance Abuse Treatment is provision of in-person addiction counseling services to individuals, aged 13 and older, who are not at risk of suffering withdrawal symptoms and who can participate in organized services in an ambulatory setting such as a substance abuse treatment program, mental health clinic, hospital outpatient department or community health center.
- Services may include individual, group and family counseling, intensive day treatment and educational services for persons convicted of a first offense of driving under the influence of drugs or alcohol. Some outpatient substance abuse treatment programs meet additional regulatory requirements to provide these services to specialty populations including adolescents, age 13-17, pregnant women, persons with co-occurring mental health disorders, persons age 60 or older and persons with disabilities
- Services are available to people with public insurance, and to those with private insurance that contract with these providers.
- Dots represent programs that are either licensed or approved by the Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS).
- Although any of the locations may treat individuals with a “dual diagnosis” of substance abuse and mental health, a subset of the clinics receive additional specific licensure from the DPH, Bureau of Health Care Safety & Quality to treat persons with primary mental health problems.
- Of note, licensed mental health clinics may provide addiction counseling services to persons with primary addictive disorders under their outpatient mental health clinic licensure. Those clinics are not represented on this map. The map also does not represent any of the “private practitioners ” who offer substance abuse treatment & counseling.

Commonwealth of Massachusetts
Department of Public Health

Service Map: Adolescent Outpatient Substance Abuse Treatment (Subset)



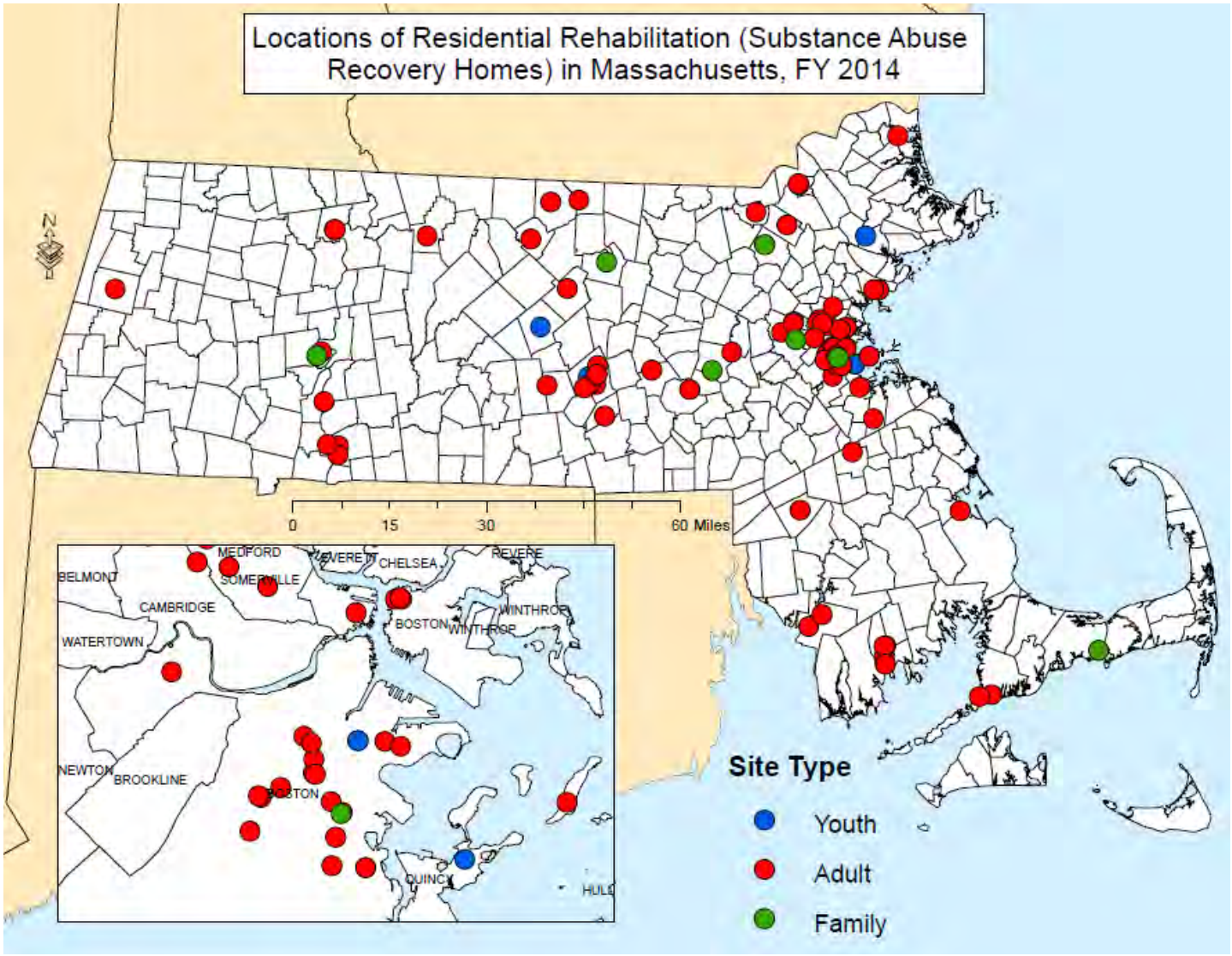
Adolescent Outpatient Substance Abuse Treatment (Subset)

- These licensed outpatient substance abuse treatment providers have met additional, regulatory requirements to provide services to adolescents, 13-17 years old.
- Of note, licensed mental health clinics may provide addiction counseling services if they maintain compliance with the Department of Public Health (DPH), Bureau of Substance Abuse Services (BSAS) regulations. However, they are not required to seek BSAS licensure or approval. Therefore this map does not represent the outpatient mental health clinics that may be providing addiction treatment services under their mental health clinic licensure.
- Dots do not represent any of the "private practitioners " who offer substance abuse treatment & counseling services.

Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Commonwealth of Massachusetts
Department of Public Health

Service Map: Residential Rehabilitation (Substance Abuse Recovery Homes)



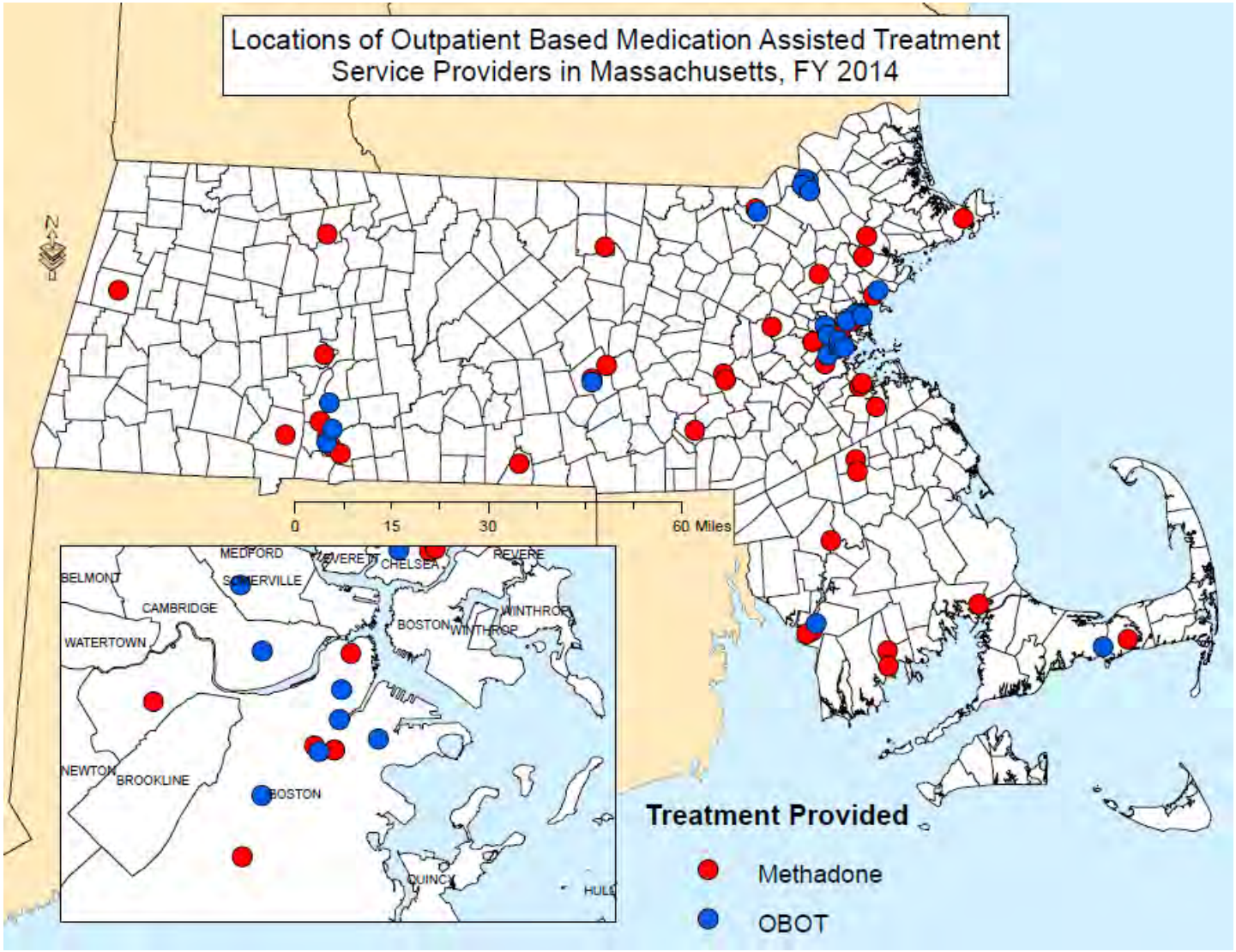
Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Residential Rehabilitation Substance Abuse Treatment

- Residential rehabilitation programs are organized substance abuse treatment and education services featuring a planned program of care in a 24-hour residential setting in the community. They are staffed 24 hours a day.
- Services are provided in permanent facilities where clients in the early stages of addiction recovery, who require safe and stable living environments in order to develop their recovery skills, reside on a temporary basis.
- Types of residential rehabilitation services include programs for adults age 18 and older, adults with their families, adolescents age 13-17 and Transitional Age Youth who are 16-24 years old. Adolescents typically receive treatment for 3 months, while adults typically receive treatment in this setting for 6-12 months.
- Dots represent facilities that are licensed by and primarily funded by the Department of Public Health (DPH), Bureau of Substance Abuse Services.

Commonwealth of Massachusetts
Department of Public Health

Service Map: Outpatient Based Medication Assisted Treatment Providers



Data reflects a point in time and is updated as of 12/27/13
Dots represent location; not reflective of capacity or volume

Opioid Treatment Programs

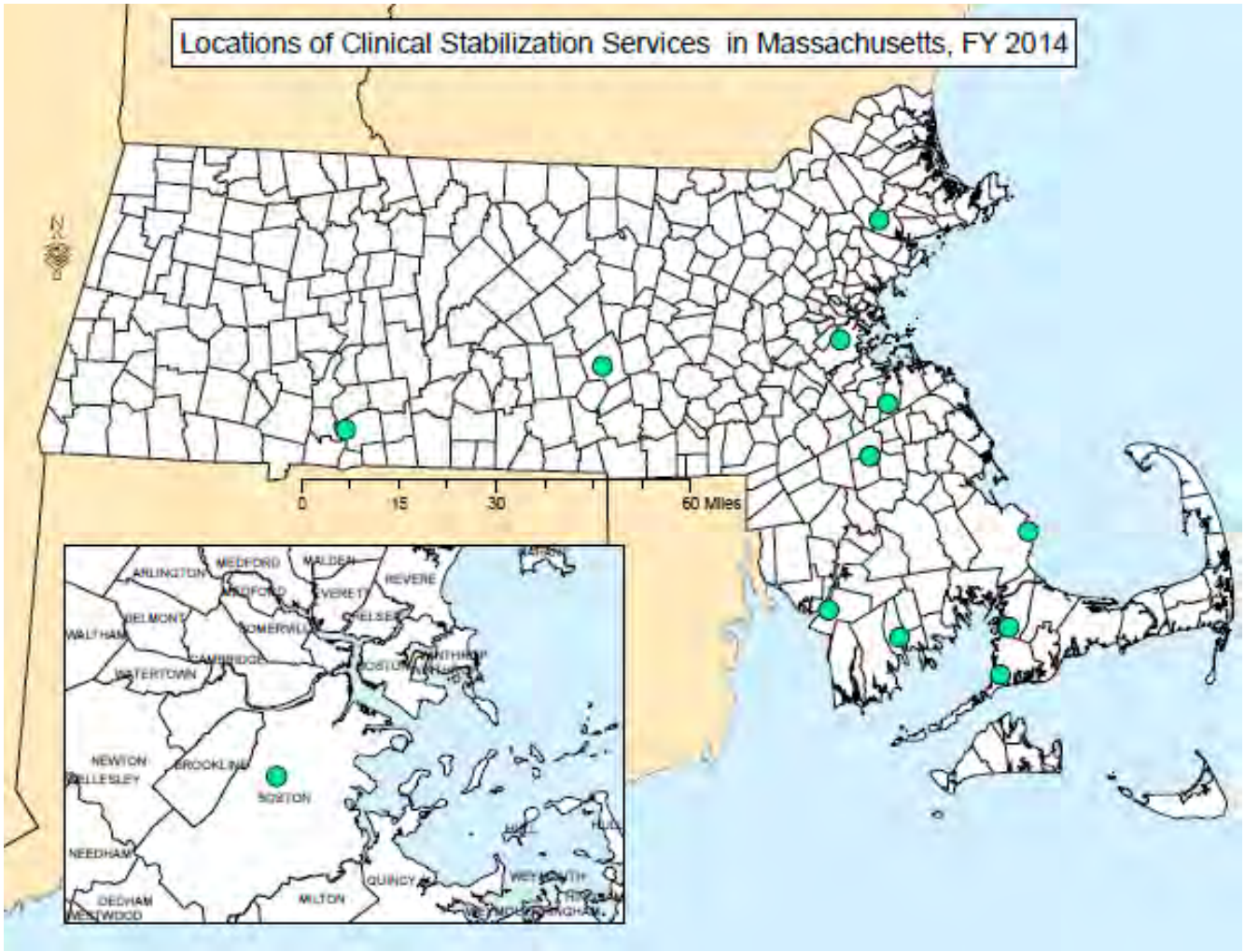
- The Department of Public Health, Bureau of Substance Abuse Services (BSAS) licensed opiate treatment programs provide medication, such as methadone, along with a comprehensive range of medical and rehabilitative services in an ambulatory setting to individuals to alleviate the adverse medical, psychological or physical effects incident to opiate addiction. Opioid treatment includes both maintenance and detoxification.

Office Based Opiate Treatment (OBOT) Programs

- BSAS funds 14 OBOT programs in community health centers across the state. These programs provide medication (buprenorphine) for the treatment of opiate addiction in a primary care setting. Buprenorphine treatment includes both maintenance and detoxification. This treatment does not require BSAS licensure.
- Dots represent only the 14 BSAS-funded OBOT programs and does not reflect the hundreds of physicians who are able to provide this treatment in their medical practices.

Commonwealth of Massachusetts
Department of Public Health

Service Map: Clinical Stabilization Services (CSS)



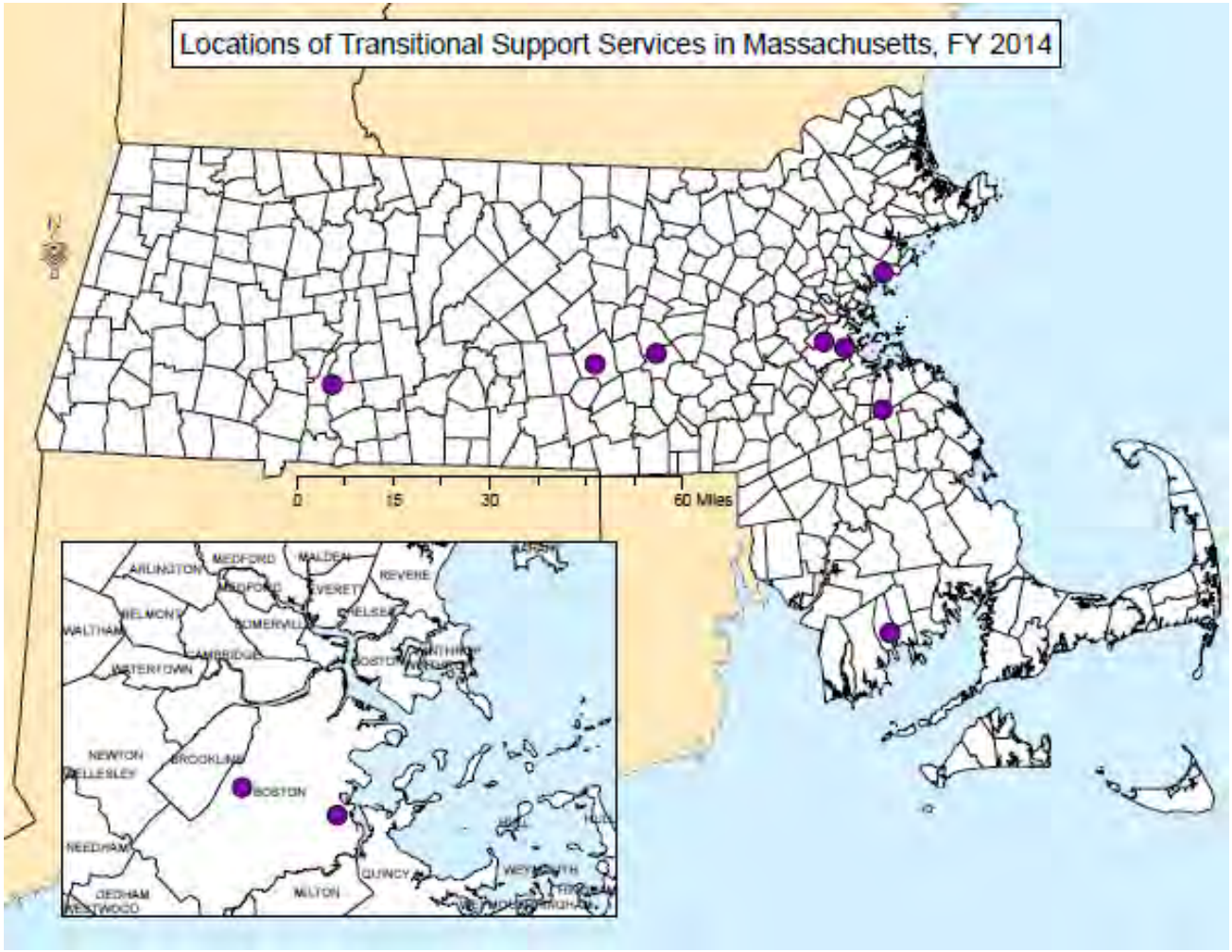
Data reflects a point in time and is updated as of 1/28/14
Dots represent location; not reflective of capacity or volume

Clinical Stabilization Services (CSS)

- CSS offer 24-hour treatment, usually following Acute Treatment Services (ATS) for substance abuse. Typically clients stay in the program for 10-14 days, during which they receive a range of services including nursing, intensive education and counseling regarding the nature of the addiction and its consequences, relapse prevention and aftercare planning for individuals beginning to engage in recovery from addiction
- These programs provide multidisciplinary treatment interventions and emphasize individual, group and family. Linkage to aftercare, relapse prevention services, and self-help groups, such as AA and NA, are integrated into treatment and discharge planning.
- This service is not intended as a step-down service from a psychiatric hospitalization level of care or psychiatric stabilization service. It is intended for individuals with a primary substance use disorder
- This service is covered by some insurance plans including MassHealth. As payer of last resort BSAS pays for uninsured clients.
- Clients are generally accepted from many settings including Acute Treatment Services (detoxification) programs, residential rehabilitation programs, outpatient including opioid treatment services, as well as self-referral. All CSS clients must meet an ASAM Level 3.5 criteria.

Commonwealth of Massachusetts
Department of Public Health

Service Map: Transitional Support Services (TSS)



Data reflects a point in time and is updated as of 1/28/14
Dots represent location; not reflective of capacity or volume

Transitional Support Services (TSS)

- TSS are defined as 24-hour short-term residential treatment up to 30 days, providing nursing, case management, psycho-educational programming, and aftercare planning.
- Services are provided to primarily bridge the gap between Acute Treatment Services and residential rehabilitation. Programs provide intensive case management in order to prepare clients for long-term residential care
- TSS clients are accepted from BSAS funded Level 3.7 Acute Treatment Services program or Level 3.5 Clinical Stabilization Services program. Upon medical clearance, clients can also be accepted from a public homeless shelter.
- BSAS is the primary payer for TSS services.

DPH: The Role of Bureau of Substance Abuse Services

- Single State Authority
- The Bureau of Substance Abuse Services (BSAS):
  - Oversees substance abuse prevention, intervention, treatment and recovery support services for adults and adolescents (available to youth and adults 13 years of age and older)
  - Licenses treatment facilities and alcohol and drug counselors
  - Funds a continuum of programs and services including detoxification, step-down services, residential rehabilitation, outpatient counseling, medication assisted treatment and community-based recovery support.
  - Tracks substance abuse trends in the state

DPH Licensing Responsibilities

- BSAS licenses substance abuse treatment programs, e.g., day treatment, methadone programs.

- The Division of Health Care Quality (DHCQ) licenses general hospitals and outpatient clinics, some of which provide substance abuse treatment services.

Substance Abuse Service Inventory

Service Group	Tables by Service
All	Overview of All Beds
All Inpatient and Other Acute Care	Number of All Acute and Other Beds and CSS Beds by Region, 2014
Inpatient and Other Acute Care	Number of Acute Level IV Inpatient Beds by Region, 2014
	Number of Acute Level III.7 Treatment Service Beds by Region, 2014
	Number of Clinical Stabilization Service Beds by Region, 2014
Intermediate Care	Number of Transitional Support Services Beds by Region, 2014
Residential Care	Number of Residential Beds by Region, 2014
Outpatient Care	Opioid Treatment Programs by Region, 2014

Note: Additional tables provided in a comprehensive set of tables on all services.

Additional detail on the inventory of services above is being developed by the team. This will include other important SA services: Day Treatment, Outpatient Substance Abuse Counseling, Recovery Support Services, Recovery High School, Naloxone distribution.

Overview of Licensed Beds

Summary of All Beds to Treat Substance Abuse Licensed by DPH

Major Service Group	Service	Beds	Beds per 100,000
Inpatient and Other Acute	Medically-managed	165	3
Inpatient and Other Acute	Medically-monitored	752	14
Inpatient and Other Acute	Clinical Stabilization Services	284	5
Inpatient and Other Acute	Section 35 (May 2014)		
	Medically monitored	56	1
	Clinical Stabilization Services	142	3
A) Inpatient & Other Acute Care	Total of services listed above	1399	25
B) Intermediate Care	Transitional Support Services	291	5
C) Residential Care	Residential Services	2341	42
	TOTAL BEDS (A + B + C)	**4031**	**73**
	Eligible population, all persons 13 years of age and older, 2010	*5,554,121*	

Note: All data except otherwise noted is based on March 2014 reports.
Note: 117 families are also served by DPH, these numbers are not noted on this overview table.

Intermediate Substance Abuse Services

- Transitional Support Services (may follow inpatient detox):
  - 7 programs
  - 291 beds
  - 5 beds per 100,000
- 49 day treatment programs
  - These 49 programs fall under the 120 licensed outpatient programs.
  - Programs must be licensed as an outpatient program to provide day treatment.

Residential Rehabilitation Services

- 2,341 residential beds
  - 42 beds per 100,000
  - 94% single adult beds
  - Gender breakdown an important planning issue
  - Proportion of beds by gender (May 2014):
    - 56% men only
    - 28% women only
    - 16% co-ed
- Additional capacity to serve 117 families in residences

BSAS licensing data as of March 27, 2014

Outpatient Care

- 120 counseling programs
- 50 medication-assisted treatment programs
  - 36 DPH-licensed opioid treatment programs (methadone)*
  - According to SAMHSA, there are 72 office based opioid treatment (OBOT) programs providing Buprenorphine in Massachusetts.
  - BSAS funds 14 OBOT programs
  - See the SAMHSA Treatment Locator for more information
    http://dpt2.samhsa.gov/treatment/directory.aspx
  - Limited capacity information

* BSAS licensing data as of March 27, 2014

Opioid Overdose Intervention

- Intervention Programs funded by DPH
  - Naloxone distribution programs for bystanders and first responders (14 programs with 19 sites)
  - Learn to Cope (one program with 12 sites)

Provides training on overdose prevention, recognition and response; distribute naloxone kits to people in the community who are likely to witness an overdose. Likely bystanders include opioid-users, their friends and family members, and human services providers who serve opioid-users.

Other Substance Abuse Services

- Recovery and support programs
  - 4 recovery high schools
  - 7 recovery support centers

- Case management to assist people in maintaining their recovery through supportive housing, community engagement and peer support

Overview of All Beds Substance Abuse Services

All Inpatient and Other Acute Beds, 2014

Includes Medically Managed (Level IV), Medically Monitored (Level III.7), and Clinical Stabilization Services

Region	Beds	Population	Beds per 100,000
Western	111	698,807	16
Central	258	617,789	42
Northeast	172	1,132,698	15
Metro West	58	576,314	10
Metro Boston	270	1,336,899	20
Metro South	175	687,721	25
South Coast	67	289,198	23
Cape and Islands	90	214,695	42
Total Statewide	**1201**	**5,554,121**	**22**

Total Section 35-Medically Monitored and CSS	**198**	**5,554,121**	**4**

All Inpatient and Other Acute	**1399**	**5,554,121**	**25**

Note: Data as of March 27, 2014. Numbers may not sum to total due to rounding.

Note: This includes all medically managed and medically monitored beds including Section 35 beds, as of May 5, 2014.

Acute Inpatient Medically Managed Substance Abuse Services

Acute Inpatient Beds (Level IV), Medically Managed in a Hospital, by Region, 2014

Region	Beds	Population	Beds per 100,000
Western	0	698,807	0
Central	114	617,789	18
Northeast	31	1,132,698	3
Metro West	0	576,314	0
Metro Boston	20	1,336,899	1
Metro South	0	687,721	0
South Coast	0	289,198	0
Cape and Islands	0	214,695	0
Total Statewide	**165**	**5,554,121**	**3**

Note: Data as of March 27, 2014.

Commonwealth of Massachusetts
Department of Public Health

Acute Medically Monitored Substance Abuse Services

Acute (Level III.7) Treatment Medically Monitored Service Beds in Community Facilities by Region, 2014

Region	Beds			All Ages	
	Adults	Adolescents (13-17)	Total	Population	Beds per 100,000
Western	81	0	81	698,807	12
Central	90	24	114	617,789	18
Northeast	118	0	118	1,132,698	10
Metro West	58	0	58	576,314	10
Metro Boston	196	0	196	1,336,899	15
Metro South	89	24	113	687,721	16
South Coast	37	0	37	289,198	13
Cape and Islands	35	0	35	214,695	16
Total Statewide	**704**	**48**	**752**	**5,554,121**	**14**

Section 35 ATS-only beds:

Metro South	32		32	5,554,121	0.6
South Coast	24		24	5,554,121	0.4
Total	**56**		**56**	**5,554,121**	**1**

Note: Data as of March 27, 2014.

Note: The Section 35 beds listed on this table are ATS-only beds and represent only a portion of the beds funded by DPH. This data is as of May 5. 2014.

Clinical Stabilization Services
Substance Abuse Services

Clinical Stabilization Services, Beds by Region, 2014

Region	Beds	Population	Beds per 100,000
Western	30	698,807	4
Central	30	617,789	5
Northeast	23	1,132,698	2
Metro West	0	576,314	0
Metro Boston	54	1,336,899	4
Metro South	62	687,721	9
South Coast	30	289,198	10
Cape and Islands	55	214,695	26
Total Statewide	**284**	**5,554,121**	**5**

Section 35 CSS beds:

Metro South	76	5,554,121	1
South Coast	66	5,554,121	1
Total	**142**	**5,554,121**	**3**

Note: Data as of March 27, 2014.

Note: The Section 35 beds listed on this table are CSS beds and represent only a portion of the beds funded by DPH. This data is as of May 5. 2014.

Transitional Support Substance Abuse Services

Transitional Support Services Beds by Region, 2014

Region	Beds	Population	Beds per 100,000
Western	27	698,807	4
Central	72	617,789	12
Northeast	25	1,132,698	2
Metro West	0	576,314	0
Metro Boston	71	1,336,899	5
Metro South	60	687,721	9
South Coast	36	289,198	12
Cape and Islands	0	214,695	0
Total Statewide	**291**	**5,554,121**	**5**

Note: Data as of March 27, 2014.

Note: This list includes beds that are made priority for Section 35 court-ordered treatment.

Commonwealth of Massachusetts
Department of Public Health

Residential Rehabilitation Substance Abuse Services

Region	Adults			Beds			Calculation		Capacity to Serve Families
	Male	*Female*	*Co-Ed*	Adults	Transitional Age and Adolescents	Both	Population	Total Beds per 100,000	
Western	113	65	71	249	16	265	698,807	38	21
Central	163	97	164	424	33	457	617,789	74	12
Northeast	35	83	58	176	41	217	1,132,698	19	15
Metro West	179	35	0	214	0	214	576,314	37	22
Metro Boston	586	181	60	827	45	872	1,336,899	65	34
Metro South	72	23	0	95	0	95	687,721	14	0
South Coast	70	85	0	155	0	155	289,198	54	0
Cape and Islands	28	38	0	66	0	66	214,695	31	13
Total Statewide	**1246**	**607**	**353**	**2206**	**135**	**2341**	**5,554,121**	**42**	**117**
	56%	**28%**	**16%**	**100%**					

Note: Data as of March 27, 2014.

Opioid Treatment Services
Substance Abuse Services

Opioid DPH-Licensed Treatment Programs and Office-Based DPH-Funded Treatment Programs, 2014

This list does not include satellites.

Region	Opioid Treatment Programs, Licensed by DPH, (methadone programs)	Office-Based Opioid Treatment Programs, Funded by DPH (suboxone programs)	Both program types
			Number
Western	7	2	9
Central	4	1	5
Northeast	6	3	9
Metro West	2	0	2
Metro Boston	8	6	14
Metro South	3	0	3
South Coast	5	1	6
Cape and Islands	1	1	2
Total Statewide	**36**	**14**	**50**

Note: Data as of March 27, 2014.

Note: This is a partial list of the opioid treatment programs in Massachusetts, based on programs either licensed or funded by DPH.

DPH licenses opioid treatment programs providing methadone treatment, but does not license OBOT programs.

DPH funds 14 OBOT programs, but there are more than 14 such programs in Massachusetts. A complete list is not publicly available.

Doctors in each state must have waivers to prescribe buprenorphine/suboxone, which is used in OBOT.

According to the DEA, there are 72 programs representing 606 physicians certified for buprenorphine treatment.

Not all certified physicians may be actively treating patients with buprenorphine and/or be accepting patients.

BSAS Services

- Note that residents from regions that appear to have no substance abuse treatment capacity do receive substance abuse treatment services.
  - Substance abuse treatment is a statewide system.
  - Providers accept and provide services to individuals from across the state and across health planning regions.

Utilization and Access

Commonwealth of Massachusetts
Department of Public Health

Payor Groups: Data sources and limitations

Medicare: From Medicare 5% sample

- Medicare: Small cell size in the Medicare under-65 population may be statistically unstable. Data were limited to FFS only (Medicare Parts A & B eligible ; Medicare HMO participation). Enrollment was defined by member months and available from an eligibility feed.

Medicaid: From MassHealth

- MassHealth: Data included claims where Medicaid was the primary insurer; in addition, third party liability claims were included to capture all service use associated with Medicaid patients. Crossover claims were attributed to Medicare (the primary insurer) and therefore excluded from Medicaid. Enrollment (i.e., member months by gender and age group) was provided by MassHealth. MassHealth data includes data for members for whom MassHealth may be a partial or third party payer, which could skew utilization results.

Commercial: All Payer Claims Database from Center for Health Information & Analysis (CHIA)

- Top 17 commercial carriers were identified based on number of behavioral health service utilizers in 2012. Enrollees aged 65 and over were excluded because they are covered by Medicare. Enrollment (i.e., member months) was obtained from CHIA's eligibility file.

Claims identified on the basis of having a behavioral-health related primary diagnosis. Differences across payers in the data fields on claims and changes in coding could result in inaccuracies in the reported utilization. There are also significant differences in coverage and benefits, and case mix severity, across plan types. Because only medical service claims were considered, and not self pay or pharmacy claims, these data likely underestimate the number of behavioral health utilizers.

The 2012 data from the three sources above cover an estimated population of 5,852,795 MA residents, or 89% of the 2014 population.

Data Sources and Methods

- Utilization data was collected from five main sources: MassHealth; Medicare; Commercial All Payer Claims Data; DMH and BSAS.
- The sample was limited to claims with primary diagnosis codes shown in the list. This range of codes includes the dementias, even though these disorders are generally thought of as neurological conditions rather than mental illness.
- Data from 2010-2012 was analyzed.
- Data was de-identified as specified in the data use agreements

ICD9-CM Diagnosis Codes	
Mental Health	
290	Dementia (senile, presenile, vascular, and other senile psychotic conditions)
293	Delirium due to conditions classified elsewhere
294	Amnestic disorder in conditions classified elsewhere
295	Schizophrenic disorders
296	Bipolar disorders
297	Paranoid states, delusional disorders
298	Psychosis
299	Autistic disorder, childhood disintegrative disorder, other pervasive developmental disorders
300	Anxiety disorders
301	Personality disorders
302	Psychosexual disorders
306	Psychophysiological malfunction
307	Eating disorders, disorders of sleep, chronic motor or vocal tic disorders, psychogenic pain, other and unspecified special symptoms or syndromes not elsewhere classified
308	Predominant disturbance of emotions, consciousness, or psychomotor function; other acute reactions to stress
309	Adjustment disorders
310	Nonpsychotic mental disorders following organic brain damage
311	Depressive disorder not elsewhere classified
312	Conduct disorders
313	Emotional disturbances of childhood or adolescence
314	Attention deficit disorder, hyperkinetic syndromes
315	Reading, learning, speech, and language disorders; other developmental disorders
316	Psychic factors associated with diseases classified elsewhere
Substance Abuse	
291	Alcohol withdrawal, alcohol-induced mental disorders, idiosyncratic alcohol intoxication
292	Drug withdrawal, drug-induced mental disorders, pathological drug intoxication
303	Acute alcoholic intoxication in alcoholism, other and unspecified alcohol dependence
304	Drug dependence
305	Nondependent alcohol or drug abuse

Data Methods:
Inclusion Criteria & Population Definitions

The inclusion criteria used for the MA Behavioral Health Analysis were as follows:

- Claims:
  - ICD9-CM primary diagnosis codes in the range of 290 – 316;
  - Year of service equal to 2010, 2011, or 2012
- Eligibility:
  - Residence of MA, as defined by MA zip code

Note that there are significant differences in coverage and benefits, and case mix severity across the plan types.

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Enrollment Totals – Payer Groups

MEDICARE ENROLLMENT

FFS only

	2010	2011	2012
0 - 17	20	20	20
Male	20	20	20
Female	NA	NA	NA
18 - 25	5,305	5,862	5,968
Male	2,630	3,052	3,373
Female	2,675	2,810	2,595
26 - 64	166,493	174,950	184,982
Male	85,220	89,807	94,873
Female	81,273	85,143	90,108
65 & over	584,295	603,368	615,855
Male	236,568	246,705	254,667
Female	347,727	356,663	361,188
All ages	756,113	784,200	806,825
Male	324,438	339,583	352,933
Female	431,675	444,617	453,892
TOTAL	756,113	784,200	806,825

MassHealth ENROLLMENT

	2010	2011	2012
0 - 17	489,666	504,146	518,381
Male	251,391	258,768	265,866
Female	238,275	245,378	252,515
18 - 25	139,548	142,285	143,364
Male	57,443	59,825	61,618
Female	82,106	82,460	81,746
26 - 64	501,936	530,567	554,477
Male	210,905	226,548	239,165
Female	291,031	304,019	315,312
65 & over	134,173	136,701	139,440
Male	42,498	43,998	45,806
Female	91,676	92,703	93,634
All ages	1,265,352	1,313,713	1,355,672
Male	562,251	589,146	612,460
Female	703,101	724,567	743,212
TOTAL	1,265,352	1,313,713	1,355,672

APCD ENROLLMENT

Top 17 Plans

	2010	2011	2012
0 - 17	827,130	799,699	808,048
Male	421,990	407,635	411,718
Female	405,139	392,064	396,330
18 - 25	466,863	488,995	496,966
Male	230,523	243,866	249,979
Female	236,340	245,129	246,988
26 - 64	2,360,549	2,335,618	2,385,285
Male	1,127,445	1,115,339	1,140,470
Female	1,233,104	1,220,279	1,244,814
65 & over	NA	NA	NA
Male	NA	NA	NA
Female	NA	NA	NA
All ages	3,654,542	3,624,311	3,690,298
Male	1,779,958	1,766,839	1,802,166
Female	1,874,583	1,857,472	1,888,132
TOTAL	3,654,542	3,624,311	3,690,298

The 2012 data from the three sources above cover an estimated population of 5,852,795 MA residents, or 89% of the 2014 population. All enrollment is expressed as member months divided by 12 to standardize the rates and minimize duplication between plans.

Commercial – APCD Top 17

Top 17 APCD Plans *						
Rank	Plan ID	Plan Name	2012 Enrollment***	As % of total enrollment	2012 Members who Used BH Services**	As % of total members who used BH services
1	291	Blue Cross Blue Shield of Massachusetts	1,284,768	32%	235,197	37%
2	300	Harvard Pilgrim Health Care	597,208	15%	111,976	17%
3	8647	Tufts Health Plan	426,515	11%	66,539	10%
4	10932	United Healthcare Insurance Company - United Behavioral Health	111,611	3%	34,275	5%
5	10632	WellPoint, Inc.	247,781	6%	28,097	4%
6	3735	Neighborhood Health Plan	89,896	2%	19,814	3%
7	10441	Aetna Life Insurance Company	82,483	2%	17,549	3%
8	301	Health New England, Inc.	103,079	3%	17,298	3%
9	296	Fallon Community Health Plan	101,157	3%	16,343	3%
10	10444	United Healthcare Insurance Company - Harvard Pilgrim	142,603	4%	16,302	3%
11	312	United Healthcare Insurance Company	195,566	5%	14,679	2%
12	295	Connecticut General Life Insurance Company - Medic	192,653	5%	14,326	2%
13	3505	Boston Medical Center HealthNet Plan	47,050	1%	14,245	2%
14	302	Health Plans, Inc.	24,445	1%	7,571	1%
15	8026	Fallon Health and Life Assurance Company	18,272	0%	2,924	0%
16	7789	United Healthcare Student Resources	11,692	0%	2,749	0%
17	10353	Aetna Life Insurance Company - Aetna Student Health	13,519	0%	2,596	0%
		Top 17 sub-total	3,690,299	92%	622,480	97%
		Total APCD	4,016,529	100%	643,648	100%

*Top plans by number of behavioral health client counts in 2012

**Members who used BH Services refers to number of unique clients with an ICD9 diagnosis in the 290 - 316 range

***Enrollment = member months/12 (may under count members as some Commercial enrollees are not enrolled for full 12 months)

Note: Sample shown in slide are filtered by following criteria: MA residents only (based on members zip codes); age = 64 years old and under; Commercial plans only (not Medicare, Medicaid, Medigap)

Source: APCD Release 2.0 Medical Claims and Medical Eligibility files, 2012

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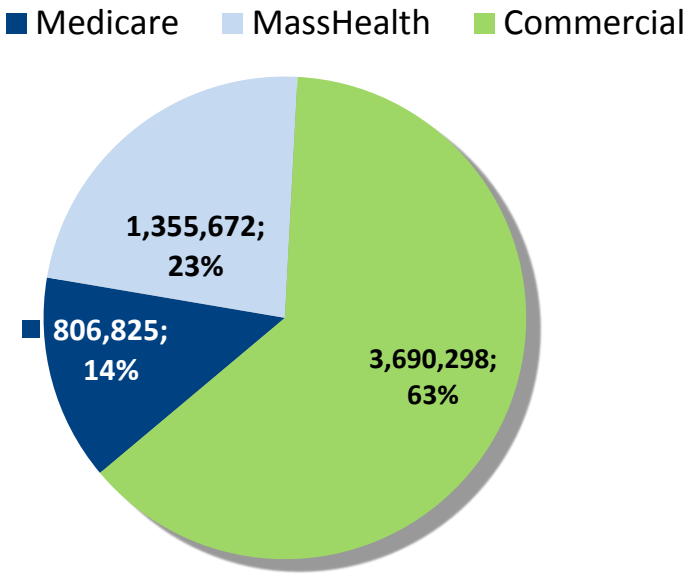
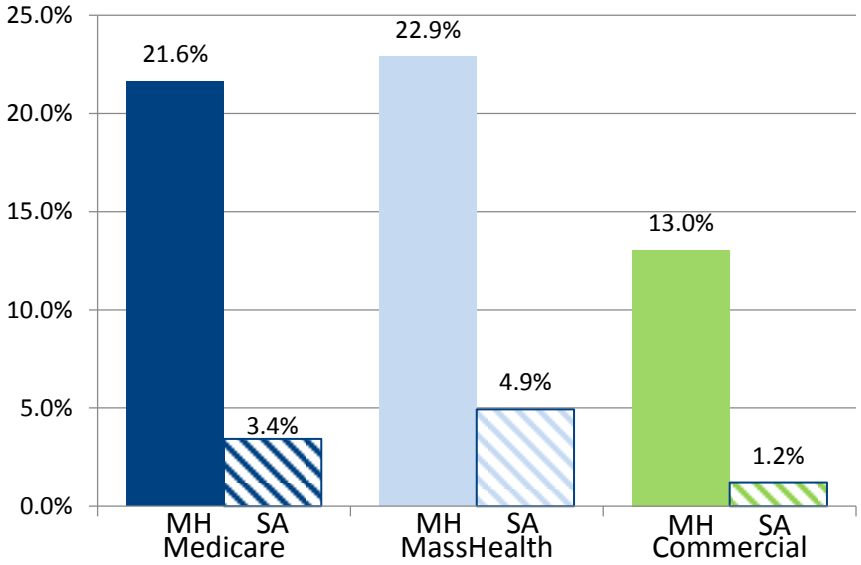
Summary: Access to care by Payor Group

2012 Study Population: Enrollment by Payor



2012 BH Penetration Rates



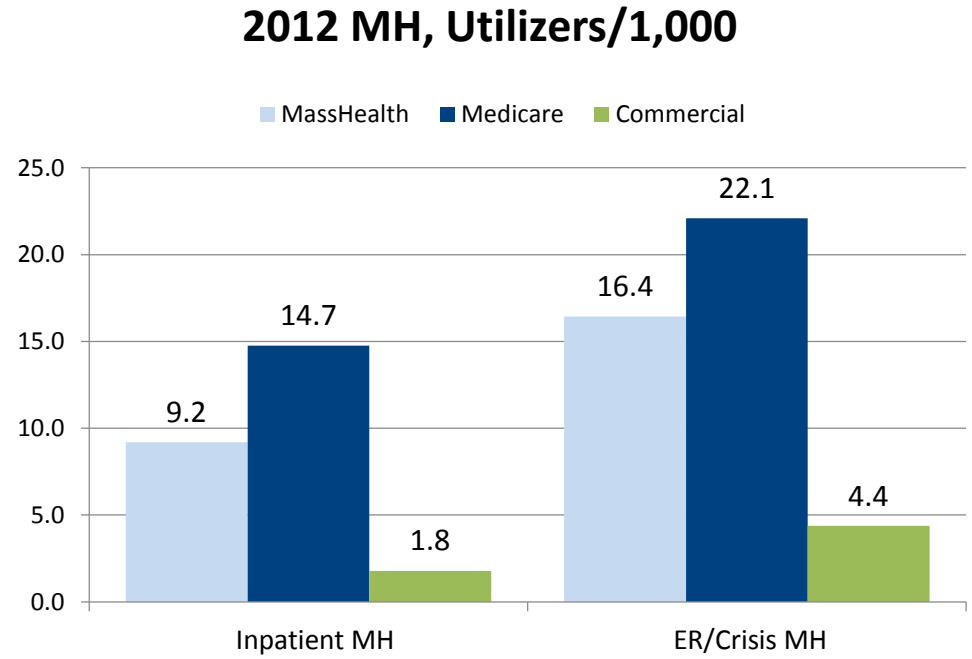
Overall mental health penetration rates were 13% to 23% for different payors, in the range expected from the NSDUH needs data. Substance abuse penetration rates were 1% to 5%, a rate lower than the prevalence rate. Medicare (1.7x) and MassHealth (1.8x) had higher mental health utilization rates than Commercial plans. Medicare substance abuse penetration rates were 2.8x commercial rates; MassHealth was 4x. These differences likely reflect differences in populations and severity of conditions.

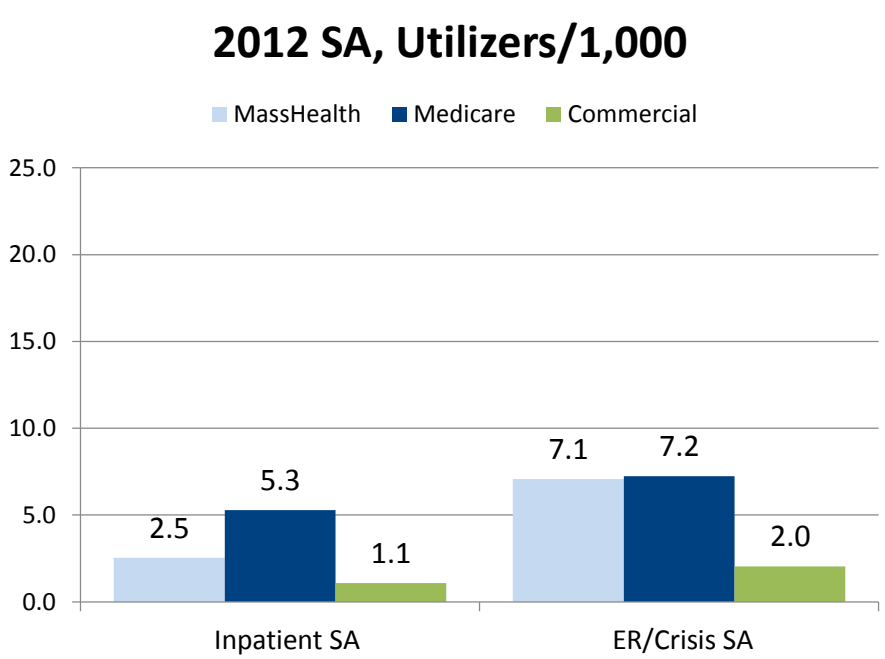
Source: Medicare 5% sample, MassHealth, APCD

* Penetration rates are shown as the number of clients accessing BH services who have a diagnosis, divided by the number of enrollees (member months divided by 12). Enrollment = member months divided by 12 (because some members are not enrolled in an individual plan for all 12 months, these data likely underestimate enrollment)

Commonwealth of Massachusetts
Department of Public Health

MH and SA Inpatient and ER
Service Utilizers per 1,000 Enrollees





- Medicare FFS had the highest rates of utilizers/1000 for inpatient and emergency room visits for both mental health and substance abuse. MassHealth utilization rates for mental health inpatient services were 5 times the Commercial rates.
- MH and SA inpatient days decreased over the three-year period, though the magnitude varied across payor groups.
- Utilization of ER visits appeared to increase among Medicare enrollees; this trend was not seen among MassHealth and Commercial enrollees.
- Age cohorts for each payer showed important differences
- The handling of claims for dual eligibles skews the results on this and subsequent slides.

Source: Medicare 5% sample, MassHealth, APCD

Inpatient and Acute Treatment Services: 2010-2012

Utilization of MH and SA inpatient days decreased over the three-year period, though the magnitude varied across payor groups.

INPATIENT ACUTE & PYSCH HOSPITAL								
MENTAL HEALTH								
RATES								
	Days/1000				**Patients/1000**			
	2010	2011	2012	Avg. Annual % change	2010	2011	2012	Avg. Annual % change
MassHealth	219.4	204.7	194.2	-5.7%	9.6	8.9	9.2	-2.2%
Medicare	412.0	393.0	358.7	-6.5%	16.4	17.0	14.7	-5.0%
Commercial	23.7	23.9	22.9	-1.7%	1.9	1.9	1.8	-3.3%
SUBSTANCE ABUSE								
RATES								
	Days/1000				**Patients/1000**			
	2010	2011	2012	Avg. Annual % change	2010	2011	2012	Avg. Annual % change
MassHealth	21.4	21.4	20.0	-3.3%	2.4	2.5	2.5	1.9%
Medicare	70.3	69.1	70.2	-0.1%	5.4	5.4	5.3	-1.1%
Commercial	9.3	10.4	10.0	3.9%	1.0	1.1	1.1	4.8%

Emergency and Crisis Services: 2010-2012

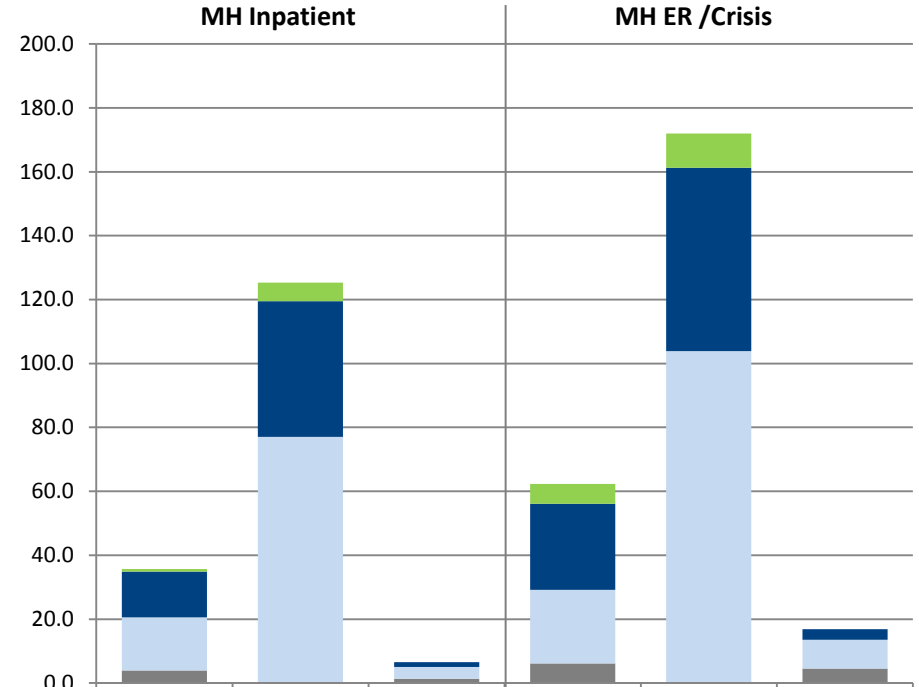
Utilization of ER visits appeared to increase among Medicare enrollees; this trend was not seen among MassHealth and Commercial enrollees.

EMERGENCY ROOM/CRISIS								
MENTAL HEALTH								
RATES								
	Encounters/1000				**Patients/1000**			
	2010	2011	2012	Avg. Annual % change	2010	2011	2012	Avg. Annual % change
MassHealth	39.3	36.6	39.5	0.2%	17.2	16.0	16.4	-2.3%
Medicare	46.8	47.5	56.2	10.0%	21.1	22.5	22.1	2.3%
Commercial	6.9	6.8	6.8	-1.2%	4.4	4.3	4.4	-0.5%
SUBSTANCE ABUSE								
RATES								
	Encounters/1000				**Patients/1000**			
	2010	2011	2012	Avg. Annual % change	2010	2011	2012	Avg. Annual % change
MassHealth	18.4	17.1	18.9	1.4%	7.4	6.9	7.1	-2.3%
Medicare	21.6	21.9	24.1	5.7%	7.5	7.5	7.2	-1.7%
Commercial	4.0	4.1	4.1	0.6%	2.0	2.0	2.0	1.0%

Commonwealth of Massachusetts
Department of Public Health

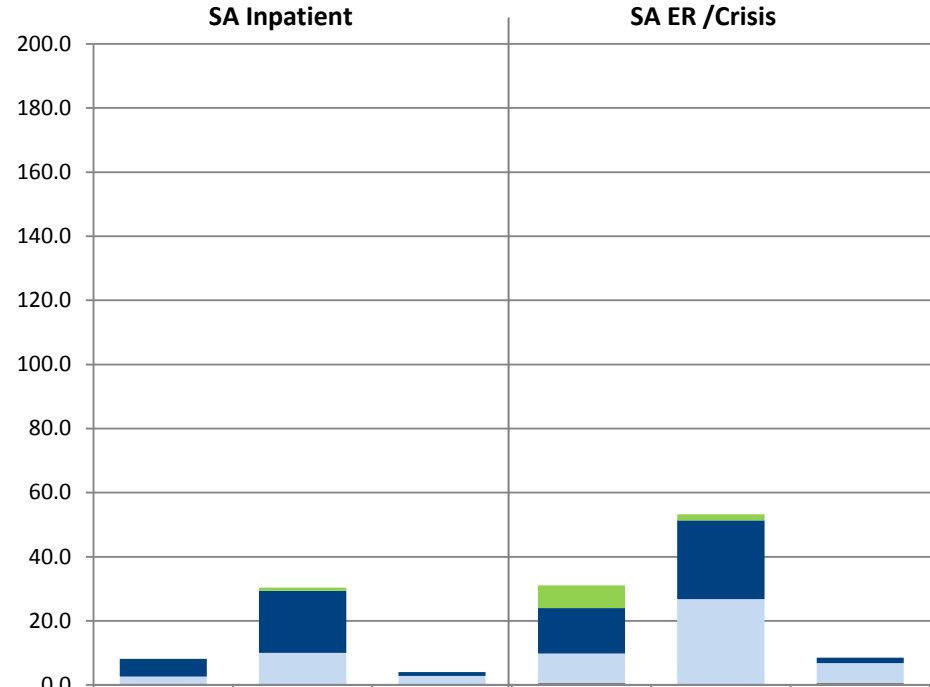
Inpatient & ER Utilizers/1,000 by Age Group, 2012

Service Users/1,000 by Age Group, 2012



	MassHealth Inpt	Medicare Inpt	Commercial Inpt	MassHealth ER/Crisis	Medicare ER/Crisis	Commercial ER/Crisis
65+	0.8	5.8	0.0	6.2	10.7	0.0
26-64	14.3	42.4	1.5	26.9	57.4	3.3
18-25	16.6	77.1	3.7	23.1	103.9	9.0
0-17	4.0	0.0	1.4	6.1	0.0	4.6

Service Users/1,000 by Age Group, 2012



	MassHealth Inpt	Medicare Inpt	Commercial Inpt	MassHealth ER/Crisis	Medicare ER/Crisis	Commercial ER/Crisis
65+	0.1	1.0	0.0	7.1	1.9	0.0
26-64	5.4	19.4	1.2	14.2	24.5	1.7
18-25	2.6	10.1	2.7	9.2	26.8	6.2
0-17	0.1	0.0	0.1	0.6	0.0	0.6

Commonwealth of Massachusetts
Department of Public Health

Inpatient & ER Utilizers/1,000 by Age Group, 2012

Mental Health Inpatient and ER Utilizers Per 1,000 Covered Lives by Payer, 2012			
	MassHealth	Medicare	Commercial
Age 0-17			
Inpatient	4.0	0.0	1.4
ER	6.1	0.0	4.6
Age 18-25			
Inpatient	16.6	**77.1**	1.4
ER	23.1	**103.9**	4.6
Age 26-64			
Inpatient	14.3	**42.4**	1.5
ER	26.9	**57.4**	3.3
Age 65+			
Inpatient	0.8	**5.8**	0.0
ER	6.2	**10.7**	0.0

Substance Abuse Inpatient and ER Utilizers Per 1,000 Covered Lives by Payer, 2012			
	MassHealth	Medicare	Commercial
Age 0-17			
Inpatient	0.1	0.0	0.1
ER	0.6	0.0	0.6
Age 18-25			
Inpatient	2.6	**10.1**	2.7
ER	9.2	**26.8**	6.2
Age 26-64			
Inpatient	5.4	**19.4**	1.2
ER	14.2	**24.5**	1.7
Age 65+			
Inpatient	0.1	**1.0**	0.0
ER	7.1	**1.9**	0.0

Medicare FFS has high utilization rates largely as a result of the under 65 disabled population. Medicare MH utilization for individuals 26-65 was 5.5x (ER) and 7.5x (Inpt) more likely than for those 65 and older. For SA services, the differences were even higher at 12.9x (ER) and 19.1x (Inpt). Small sample sizes may contribute to these findings.

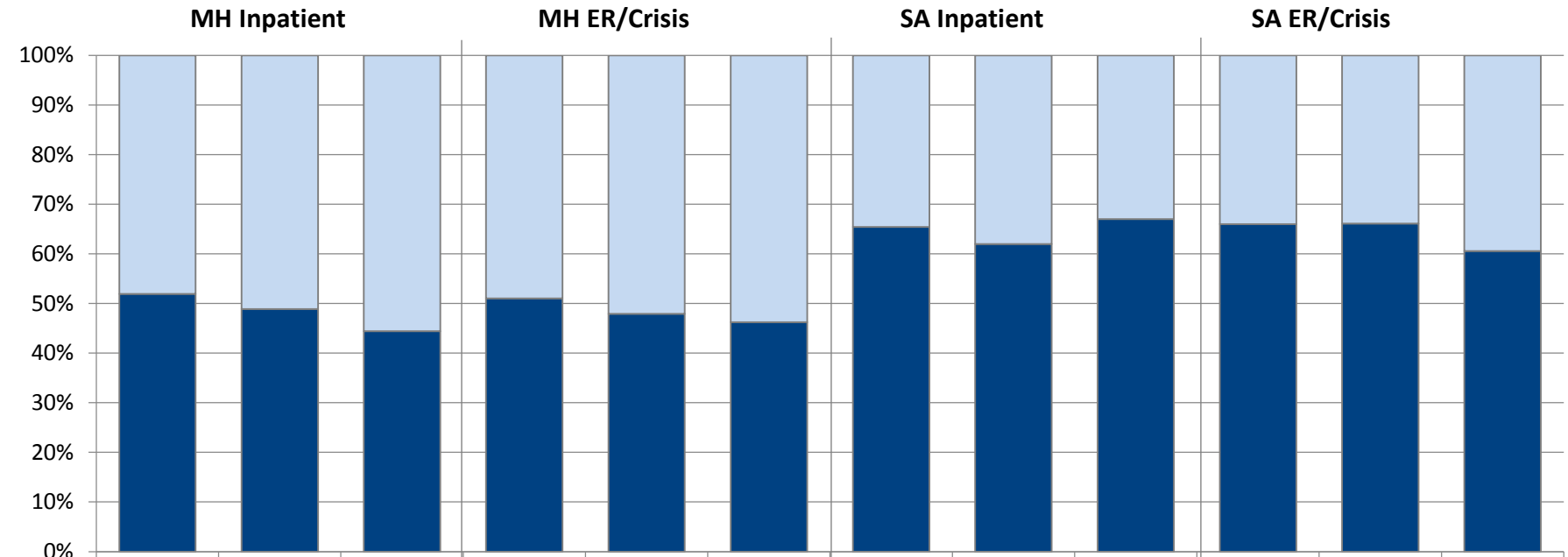
Not shown, females had slightly higher MH service use rates than males, however males were significantly higher than females for substance abuse treatment services.

Source: Medicare 5% sample, MassHealth, APCD

Commonwealth of Massachusetts
Department of Public Health

Inpatient/ER Service Users by Gender, 2012

Inpatient/ER Utilizers by Gender, 2012



	MH Inpatient			MH ER/Crisis			SA Inpatient			SA ER/Crisis		
	MassHealth	Medicare	Commercial	MassHealth	Medicare	Commercial	MassHealth	Medicare	Commercial	MassHealth	Medicare	Commercial
Female	5,991	6,080	3,663	10,908	9,280	8,677	1,186	1,620	1,425	3,259	1,980	2,977
Male	6,475	5,820	2,927	11,366	8,540	7,463	2,247	2,640	2,893	6,332	3,860	4,578

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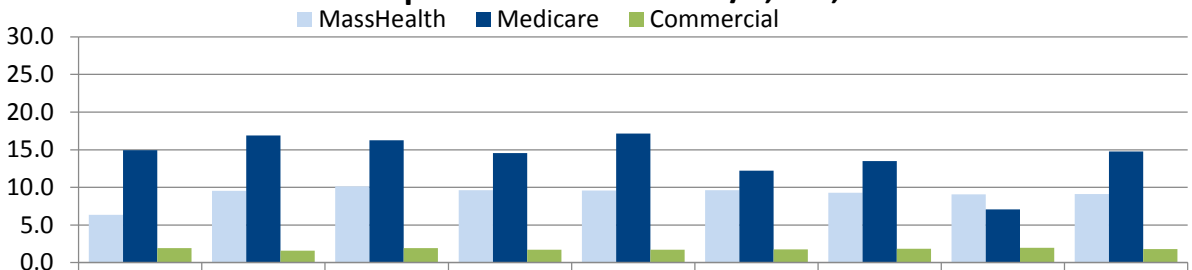
Department of Public Health

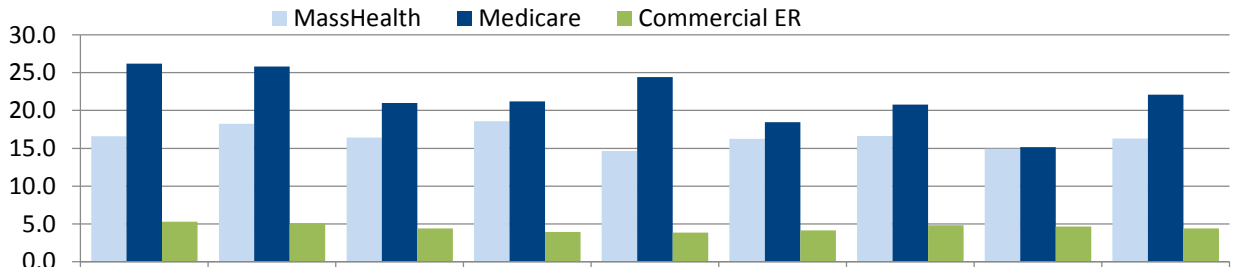
MH Service Users/1,000
2012 Regional Variation

Mental Health - Inpatient Service Users/1,000, 2012



	Westrn MA	Central MA	NEast MA	Metro West	Metro Boston	Metro South	South Coast	Cape & Islands	Total
MassHealth	6.4	9.5	10.1	9.6	9.6	9.6	9.3	9.1	9.1
Medicare	14.9	16.9	16.3	14.6	17.1	12.2	13.5	7.1	14.7
Commercial	1.9	1.6	1.9	1.7	1.7	1.7	1.8	2.0	1.8

Mental Health - ER/Crisis Service Users/1,000, 2012



	Westrn MA	Central MA	NEast MA	Metro West	Metro Boston	Metro South	South Coast	Cape & Islands	Total
MassHealth	16.6	18.3	16.4	18.6	14.6	16.2	16.6	14.9	16.3
Medicare	26.2	25.8	21.0	21.2	24.4	18.5	20.8	15.2	22.1
Commercial ER	5.3	5.1	4.4	3.9	3.8	4.1	4.8	4.7	4.4

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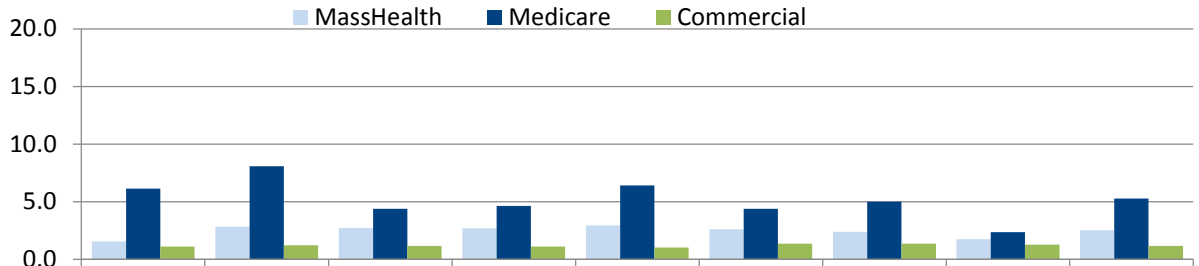
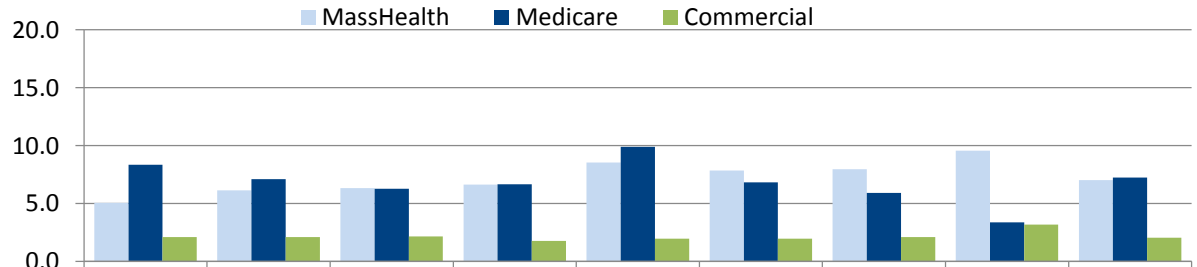
Substance Abuse Service Users/ 1,000 2012 Regional Variation

Substance Abuse - Inpatient Service Users/1,000, 2012



	Westrn MA	Central MA	NEast MA	Metro West	Metro Boston	Metro South	South Coast	Cape & Islands	TOTAL
MassHealth	1.5	2.8	2.7	2.7	2.9	2.6	2.4	1.7	2.5
Medicare	6.1	8.1	4.4	4.6	6.4	4.4	5.0	2.4	5.3
Commercial	1.1	1.2	1.2	1.1	1.0	1.4	1.4	1.3	1.2

Substance Abuse - ER/Crisis Service Users/1,000, 2012



	Westrn MA	Central MA	NEast MA	Metro West	Metro Boston	Metro South	South Coast	Cape & Islands	TOTAL
MassHealth	5.1	6.1	6.3	6.6	8.5	7.9	8.0	9.6	7.0
Medicare	8.3	7.1	6.3	6.7	9.9	6.8	5.9	3.4	7.2
Commercial	2.1	2.1	2.2	1.8	2.0	2.0	2.1	3.2	2.1

Inpatient Occupancy Rates

Massachusetts Psychiatric Hospital Data

- Free standing occupancy rates average slightly less than 84%.[6]
- Acute general hospital rates are around 90%.[7]
- Snapshot on a single day in August 2014 from MABHAccess website shows occupancy rates are higher, with variation by population and region.[8]
- Qualitative research shows that hospitals aim for 90-95% occupancy, and are nearly fully utilizing all licensed beds.

Occupancy Benchmarks

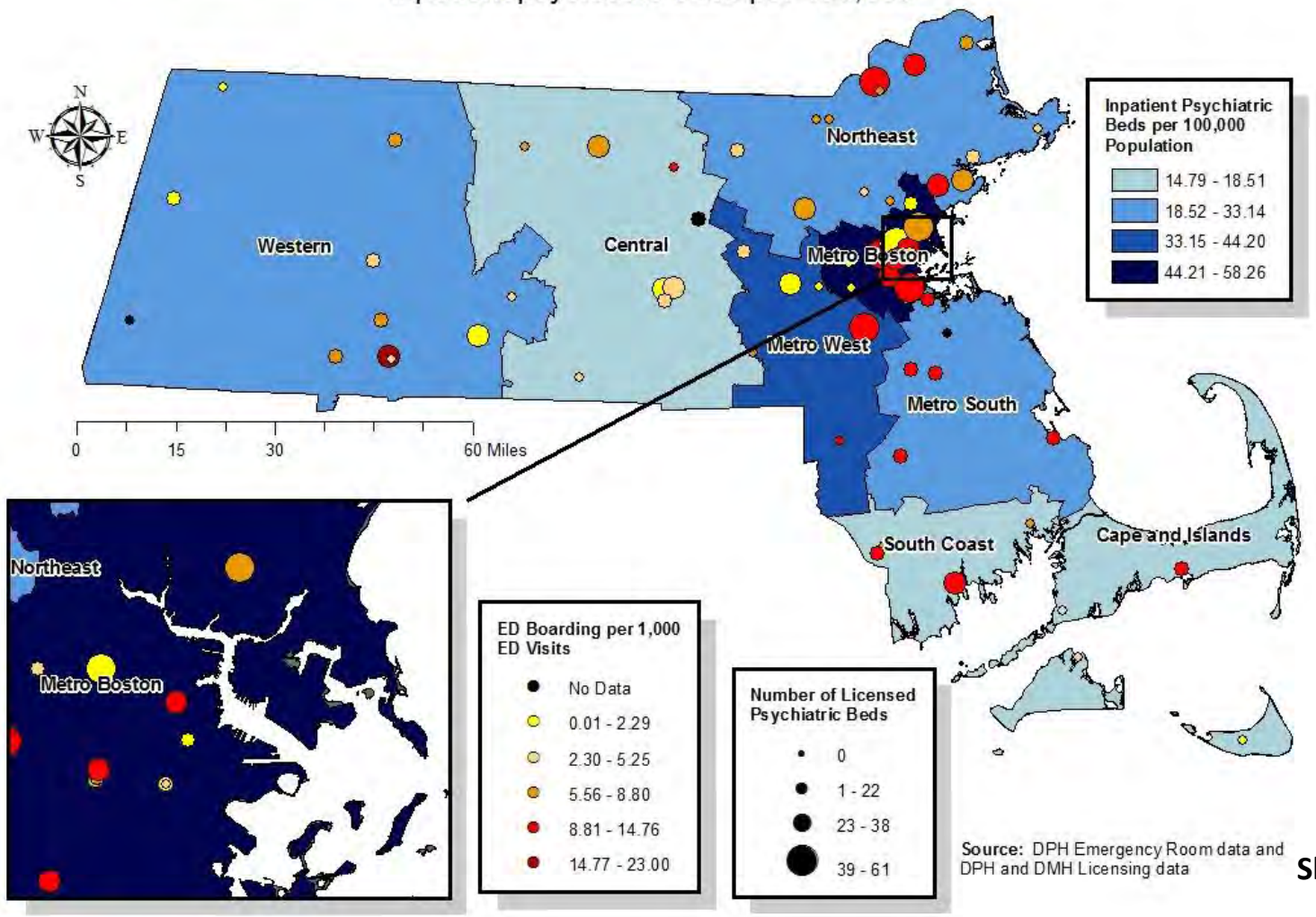
- One commonly cited study states that above 85% occupancy, bed shortages occur in hospital emergency departments.[1] [2]
- Several state health plans use figures from 70% to 85% occupancy rates as thresholds to demonstrate need for increased psychiatric capacity.[3] [4] [5]

Conclusion: Multiple sources of data suggest that both free-standing and psychiatric units at general hospitals are operating at or above full capacity.

1. Adrian Bagust, Michael Place and John W Posnett, "Dynamics of bed use in accommodating emergency admissions: stochastic simulation model," *BMJ* 319 (1999): 155–8.
2. Royal College of Psychiatrists, "Do the right thing: How to judge a good ward," June 2011.
3. *South Carolina State Health Plan 2012-2013*, "Chapter IV: Psychiatric Services," http://www.scdhec.gov/Health/docs/2012-2013%20SC%20Health%20Plan.pdf.
4. *Mississippi State Health Plan 2014*, "Chapter 3 – Mental Health," http://www.msdh.state.ms.us/msdhsite/index.cfm/19,5619,184,pdf/Chapter_3_Mental_Health.pdf.
5. Florida Administrative Code, 59C-1.040. Hospital Inpatient General Psychiatric Services, http://florida.eregulations.us/rule/59c-1.040; Florida Administrative Code, 59C-1.041, Hospital Inpatient Substance Abuse Service, http://florida.eregulations.us/rule/59c-1.041.
6. Center for Health Information and Analysis, Massachusetts Hospital Profiles: Data Through Fiscal Year 2012 - Non-Acute Hospital Data Appendix (March 2014).
7. Massachusetts Hospital Association, Inc., *PatientCareLink,* http://patientcarelink.org/.
8. Massachusetts Behavioral Health Partnership, *Massachusetts Behavioral Health Access*, http://www.mabhaccess.com/.

Emergency Department Utilization

Number of patients (per 1,000 ED visits) with a behavioral health diagnosis with an ED stay >=12 hours after a disposition decision has been made in 2013 overlaid with inpatient psychiatric beds per 100,000



Source: DPH Emergency Room data and DPH and DMH Licensing data

DMH and BSAS Utilization

- DMH and BSAS both reported on the number of clients served for most services (see next slide) but each agency uses two or more data systems with significant limitations on some of these systems. DMH payment methods and their data systems do not permit the agency to easily track clients' utilization of multiple services and some data is limited to authorization data not actual use. Most of the clients reported by DMH and BSAS are included in other client counts from MassHealth, Medicare or Commercial coverage.
- DMH and BSAS fund an extensive array of recovery and rehabilitation services in community settings for anyone meeting the need. They are not available from most other payers. CBFS services are an example of the kind of payment reforms needed for the system but cross agency data are needed to understand the levels of inpatient and ER use for these clients when paid from MassHealth or Medicare.
- The majority of services reported by each agency are active rehabilitative treatment options, long-term residential support services or step-down levels of care (e.g., CSS and TSS services) that are not fully funded by most other payers. BSAS also pays for services for the uninsured.

Commonwealth of Massachusetts
Department of Public Health

DMH / BSAS Utilization: Client Use of Services by Year

DMH

DMH - Clients Served by Service and by Calendar Year, 2011-2013

	CY2011	CY2012	CY2013	Avg Annual Change
Continuing Care	1,595	1,607	1,639	1%
CBFS	14,153	13,608	13,487	-2%
Clubhouse*	N/A	N/A	3,710	N/A
Adult Case Management	5,760	5,763	5,581	-2%
C/A Case Management	1,097	1,010	945	-7%
PACT	997	1,095	1,128	6%
IRTP	145	151	141	-1%
Flex	1,364	1,706	2,387	32%
Adult Respite	1,236	1,335	1,438	8%

*Contracts began 7/1/13, utilization reflects 6 months.

BSAS

BSAS Clients Served by Service and by Calendar Year, 2011-2013

Service Group	Service	CY2011	CY2012	CY2013	Avg Annual Change
Inpatient and Other Acute Care	Acute Treatment Services (ATS)	20,992	21,891	23,276	5%
	Section 35	2,906	2,918	3,026	2%
	Clinical Stabilization Services	5,504	5,305	5,485	0%
Intermediate Care	Transitional Support Services	3,823	3,596	3,848	1%
	Day Treatment	5,054	4,612	3,742	-14%
Residential Care	Residential	7,645	7,997	8,174	3%
Outpatient Care	Counseling	25,422	24,706	24,331	-2%
	Methadone	18,631	19,342	20,100	4%
	Office-Based Opioid Treatment (OBOT)	2,617	2,782	2,621	0%

Notes for Table 3

ATS includes Detox level iii.7 licensed programs including Youth Stabilization Programs. OBOT service only contains data from the 14 BSAS-funded programs.

Definition of measures Clients received treatment service in the calendar year funded by MassHealth, BSAS and other payors.

Source: BSAS treatment data prepared on June 18, 2014 by the Office of Data Analytics and Decision Support, Bureau of Substance Abuse Services, Massachusetts Department of Public Health. Data as of May 13, 2014.

Commonwealth of Massachusetts
Department of Public Health

DMH and BSAS: Clients by Gender, Race and Age, CY2013

DMH

	DMH												
	Gender			Race/Ethnicity					Age (years)				
	Male	Female	Transgender	White, Non-Hispanic	White, Hispanic	Non-White, Non-Hispanic	Non-White, Hispanic	Unknown	0 to 17	18 to 25	26 to 64	65+	Unknown
Continuing Care	1,058	581	N/A	933	462	136	66	42	49	295	1,213	86	
CBFS	7,533	5,954	N/A	9,108	797	2,401	121	1,060	0	1,419	11,090	978	N/A
Clubhouse	2,282	1,428	N/A	2,520	173	516	33	468	0	295	3,208	207	N/A
Adult Case Management	3,076	2,505	N/A	3,714	435	944	64	424	0	934	4,323	324	N/A
FLEX - Children and Youth	1,338	1,049	N/A	917	276	323	57	814	2,089	298	0	0	N/A

BSAS

	BSAS												
	Gender			Race/Ethnicity					Age (years)				
	Male	Female	Transgender	White, Non-Hispanic	White, Hispanic	Non-White, Non-Hispanic	Non-White, Hispanic	Unknown	13 to 17	18 to 25	26 to 64	65+	Unknown
Acute Treatment Services (ATS)	16,094	7,170	12	18,314	606	1,956	259	2,141	540	5,035	17,658	92	119
Section 35	1,764	1,262	-	2,658	32	165	22	149		1,001	1,990	33	8
Clinical Stabilization Services (CSS)	3,841	1,643	*	4,435	96	505	76	373		1,213	4,265	*	22
Transitional Support Services (TSS)	2,503	1,340	*	3,203	54	375	36	180		997	2,857	*	*
Residential	5,352	2,815	7	6,404	201	825	101	643	321	1,976	5,862	18	28
Methadone	11,453	8,645	*	16,195	727	1,037	218	1,923	N/A				
Office-based Opioid Treatment (OBOT)	1,606	1,015	0	1,771	101	180	40	529	*	324	2,282	15	*
Day Treatment	2,384	1,356	*	2,800	99	448	49	346	44	819	2,845	21	15

Notes for BSAS

General Notes

Utilization Demographic tables, Table 2: A-H are available for the following service lines from the Bureau of Substance Abuse Services Treatment System: ATS, CSS, TSS, Section 35, Residential. Clients Served measures are available for Methadone, OBOT and Day Treatment

* = counts less than or equal to 5 are suppressed for confidentiality reasons

N/A = not applicable

Age

Age represents the age of the client at admission.

The age group 65+ represents ages 65 to 90. Unknown Age represents clients with invalid ages.

A client could be multiple ages in one year if he was admitted multiple times before and after his birthday; this person would be counted in multiple age-bands.

Race/Ethnicity

For Unknown Race/Ethnicity, either the race was unknown (Invalid, Missing, Not Applicable, Not Collected, Other, Unknown, Refused) or the Hispanic indicator was missing

Services

Service line categories are based on previous Service Definition work from Health Planning Workgroup.

The service line, ATS, contains Detoxification level iii.7 licensed programs including Youth Stabilization Programs.

The service line, Residential includes Adult and Youth Residential programs.

Section 35, CSS, and TSS service definitions consist of adult treatment programs.

OBOT service only contains data from the 14 BSAS-funded programs.

Definition of measures Clients Served: Patients that received care in the calendar year.

Source: BSAS treatment data prepared on June 18, 2014 by the Office of Data Analytics and Decision Support, Bureau of Substance Abuse Services, Massachusetts Department of Public Health. Data as of May 13, 2014.

Outpatient Services: Factors adding to variation

Outpatient claims were analyzed and marked inconsistency in encounter rates was found between payers. ***As a result, further analysis of outpatient service has been deferred to develop consensus on data reporting conventions and to more accurately interpret the findings.***

The key factors affecting variations in the observed levels of use are:

- Underlying population characteristics including factors such as employment status, poverty, age and disability. The data were not case-mix adjusted for these factors
- Significant differences in coding and benefit plans between payer groups, including:
  - A variety of unique codes in MassHealth providing a broad range of community based support services in 15 minute billing intervals.
  - A range of special services in MassHealth for youth such as Therapeutic Behavioral Services, targeted case management and self-help/peer support.
  - Broad use and coverage of methadone dosing and counseling in MassHealth but not in other health plans.
- Future work will be done to identify outpatient services and service providers.

Summary

Summary

- The Health Planning Council's work has produced a first-of-its-kind review of inventory, need and utilization across all payers. This report should serve as a baseline for future analyses and establishes a framework for the state to utilize in evaluating capacity.
- Data has been provided on need for services, the inventory of providers and types of service and the utilization of services. These data cover 89% of the MA population and include all licensed facilities/programs/clinics.
- A low proportion of licensed clinics integrate mental health and medical services (17%). DPH operates the Behavioral Health Integration Initiative Committee (IIC) designed to improve the current limitations on integration.
- Obtaining reliable data on the inventory, capacity, and utilization of outpatient services remains challenging and further work is needed.
- The data on the behavioral health system are particularly weak for the community outpatient system of clinics, independent professionals, group practices and other specialty organizations not under contract with the state.
- This is one of the first instances of using the Health Policy Commission (HPC) regions* for health planning across all payer groups. Historically neither DMH or BSAS have used these regions, but future work should benefit from this foundation.

* http://www.mass.gov/anf/docs/hpc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf

Summary: Inventory

- There are 2431 psychiatric inpatient beds in Massachusetts.
- Relative to other states there is a generally high level of inpatient MH beds and a slight increase from 2010-2012. Hospital occupancy rates are also high in both freestanding and acute general hospital beds.
- There does not appear to be a regional association of ED boarding with bed inventory, suggesting that other factors are involved.
- There are 917 Level 4 and Level 3.7 beds or 16.5 beds/100,000. This does not include 482 CSS and Section 35 beds. Relevant comparison points for substance abuse bed capacity are not available because of differences in reporting.

Summary: Utilization

- Overall inpatient utilization declined slightly from 2010 to 2012, but Medicare MH emergency room and crisis utilization increased.
- 18-25 year olds have disproportionately high utilization levels for inpatient and crisis services (both MH and SA) compared to other age groups for Medicare and Commercial plans.
- Access or penetration rates for substance abuse services are much lower than mental health services as a percent of estimated need.
- Males are 60% or more of the substance abuse treatment utilization population.
- Regional variation did not show a consistent pattern.

Note: Supporting analysis can be found here: http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/ohpp/hpc/2014-hpc-meetings.html

Recommendations

Recommendations: Data Collection and Analysis

- Expand data collection and reporting on hospital and community capacity. For example:
  - Improve data collection about occupancy rates
  - Where possible, leverage the Registration of Provider Organization (RPO) process to streamline data collection efforts
  - Explore making information about service availability more publicly accessible
  - Examine opportunities to collect data through professional licensing renewal processes
- Continue to analyze outpatient and APCD data.
- Implement a Behavioral Health Data Planning group with staff from key agencies, including DPH, DMH, MassHealth, CHIA, and HPC.

Recommendations: Ensuring Access

- Continue the work of the Massachusetts Department of Public Health's Behavioral Health Integration Initiative Committee* (IIC) to address the current Agency regulatory barriers that may restrain development of the integration of mental services, substance abuse, and primary care.
- Support the behavioral health integration initiatives of health reform through expanded data collection and continued iterative heath planning.
- Support a robust community system with the resources and capabilities to: 1) keep people healthier, preventing the need for more acute levels of care, 2) divert patients from emergency departments and inpatient services, when clinically appropriate 3) provide patients with strong post-discharge supports, thus enabling timely discharges, and 4) provide timely post-discharge follow-up care.

* http://www.mass.gov/dph/integration

Public Feedback

Public Comment Questions

Access and Availability

- What challenges are patients/family members/providers encountering as they are trying to help people access behavioral health care (including in inpatient, outpatient and community settings)?
- The data presented show that many people have a mental health or substance use disorder but don't seek treatment. What are some of the things that might prevent people from seeking and obtaining treatment? What can we do to address those barriers?

Quality and Best Practices

- What are the best practices to ensure high quality, timely behavioral health care?
- How can the Plan's analysis and recommendations best be used to promote these best practices in behavioral health services?
- Is screening for mental health and substance abuse problems happening? If so, where? If not, why not?

Public Comment Questions

Information and Data

- As a patient moves through the behavioral health care system, what happens during transitions of care? Are there smooth hand-offs?
- What additional information do consumers, providers, and policymakers need to make the best decisions around behavioral health care delivery and planning?

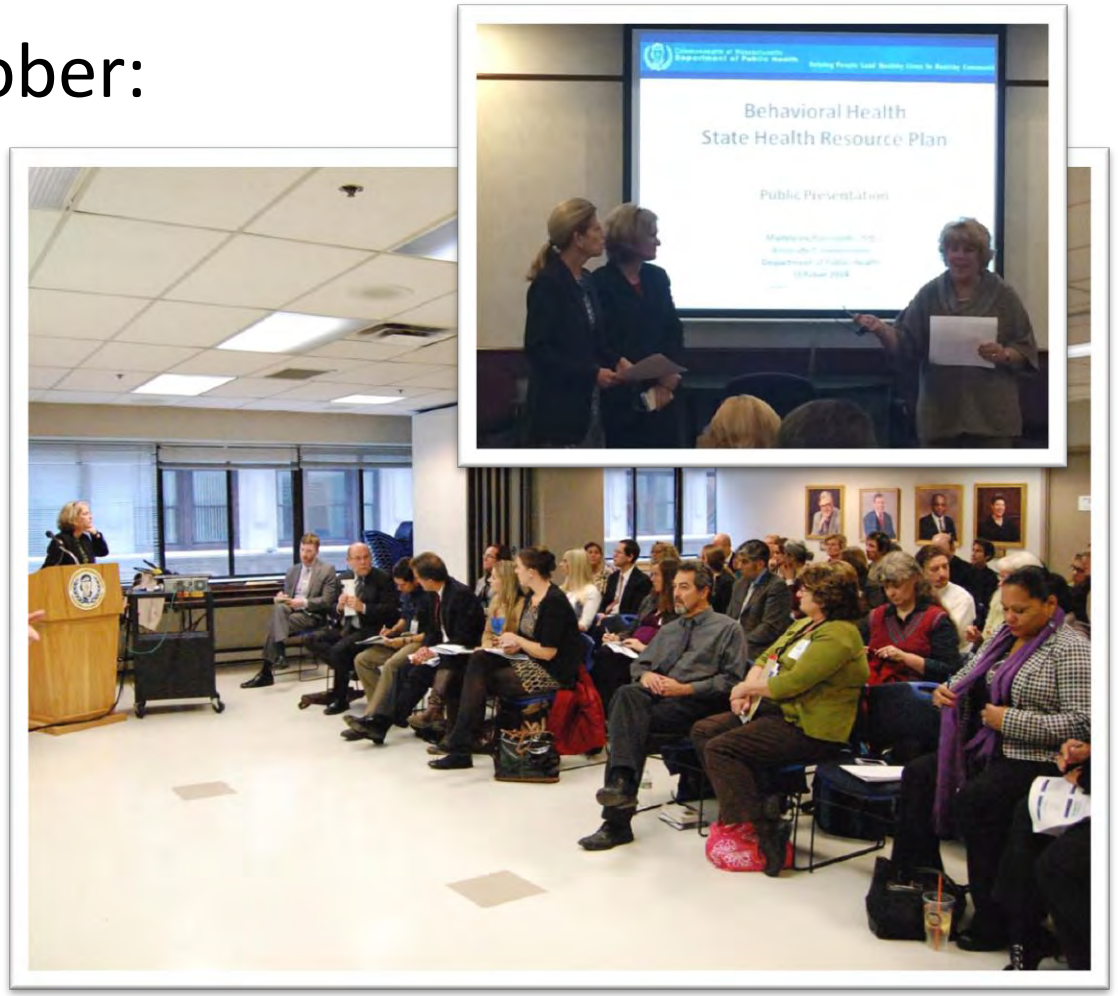
Public Feedback

Three hearings in October:

- Springfield: 24
- Fall River: 25
- Boston: 54
- **Attendees: 103**

Written comments: 23

Feedback from providers, advocates, consumers/family members.



Asked for feedback about:

- Access and Availability
- Quality and Best Practices
- Information and Data

Public Feedback

Access and Availability

- **Access**
  - Long wait times (especially for intermediate and community-based care – such as clinics and addiction treatment centers)
  - Lack of outpatient resources create access problems and force patients into higher levels of care
  - Lack of access and adequate staff in rural areas
  - Substance use patients sometimes occupy mental health beds
- **Community Care**
  - Need for more community-based care, especially to allow patients to step down from inpatient care
  - Lack of peer support resources

Public Feedback

Access and Availability (cont'd)

- **ED Boarding**
  - Homeless population a significant proportion of ED boarders
  - High medical acuity patients more challenging to place because can only be admitted to acute care hospitals
  - Ability to access open beds challenging during evenings and weekends
- **Stigma**
  - Stigma around mental health causes many people to avoid seeking help
  - Many people will not go to behavioral health clinician if referred

Access and Availability (cont'd)

- **Insurance/Reimbursement**
  - Prior and on-going authorizations still a barrier
  - Medical necessity clauses and utilization policies can become a barrier to care, especially if vague
  - Patients had difficulty identifying in-network providers (especially if insurers do not update online directories)
  - High deductibles and copays of some plans limit access to care
  - Medicare cap of one service per billing day creates barriers
  - Patients reliant on insurance often cannot access private practice clinicians
  - Clinicians have difficulty getting on insurance panels, or low reimbursements discourage clinicians from joining panels
  - Fee-for-service model encourages seeing high number of patients
  - Although MassHealth plans differ in coverage, generally cover more services than commercial plans

Public Feedback

Access and Availability (cont'd)

- "Behavioral health care must be better integrated into primary care settings, school based settings, settings that are easy access points and also eliminate or reduce the fear of stigma and address the stigma (normalization)." *- Dawn Casavant, Heywood Healthcare*
- "Association for Behavioral Healthcare supports the overarching principle that medical cost savings can be achieved through more accessible and effective behavioral health services, but outpatient services must be the first option for this vision to succeed." *- Vicker DiGravio, Association for Behavioral Healthcare*
  - *Note:* Analysis from the Health Policy Commission indicates that average spending for patients with behavioral health comorbidities is 1.6x to 2.2x than that of the average patient. *(Health Policy Commission 2013 Cost Trends Report)*

Access and Availability (cont'd)

- Factor contributing to ED boarding: "The lack of less intensive services within the behavioral health continuum to receive discharged inpatients (slows the [ability to transition patients out] of inpatient beds and impacts ED stays)."
  – Tim Osner, Sisters of Providence Health System
- "The ongoing and extraordinary difficulty of finding outpatient services for patients with health insurance coverage, and the extremely limited availability of outpatient providers participating in public and private health plans for behavioral health services."
  - *William Greenberg, Beth Israel Deaconess Medical Center*

Quality and Best Practices

- **Behavioral Health Integration**
  - Primary care should be thought of as the most effective setting for behavioral health care delivery, given that primary care is often the only setting where behavioral health care occurs
  - Primary care doctors need training in order to assess and treat behavioral health issues
  - Barriers to integration should be reduced, and incentives needed to encourage integration
- **Pilots and Evaluation**
  - Grant-funded pilots reveal best practices, and providers need further state and federal resources to evaluate and disseminate these best practices

Quality and Best Practices (cont'd)

- **Screening**
  - Need adequate time, proper incentives, and sufficient training to ensure screening happens in various settings
  - Behavioral health screening should happen in prisons
- **Transitions and Coordination**
  - Because a patient's clinician changes as level of care changes, time is needed to allow for coordination and communication by clinicians (warm hand-offs)
  - Lack of funding/reimbursement for coordination activities
  - Regulatory and financial barriers impede providers from doing follow up and outreach activities
  - Because care happens at different sites sometimes far from home, lack of transportation is a barrier to care

Quality and Best Practices (cont'd)

- "The need for planning and supporting behavioral health services in primary care is highlighted when we realize that it is the only venue in which the vast majority of behavioral health needs of minority, immigrant and other stressed and vulnerable populations can be identified and treated." *- Alexander Blount, UMass Medical School*
- "It seems that many providers seek private or federal or other state funding to create pilots. These often have great outcomes, then the funding ends and the programs go away. It seems it's a great opportunity to leverage grant money as start up for ongoing state-funded programs." *- Katherine Wilson, Behavioral Health Network, Inc.*

Quality and Best Practices (cont'd)

- "We need to show that we as a society value the people who provide mental health services by investing in financial incentives, training, and supports to ensure that the most experienced and skilled clinicians can continue to provide high quality, timely, behavioral health care to those in need." *- Dianne Corbin, Merrimack Valley Trauma Services*
- "Incentives for treatment of complex patients with mental health, substance use and medical comorbidities; Screening is incentivized in medical care settings by using measures such as the PHQ9; Incentives to provide a full array of mental health services in an integrated medical care system; Facilitation of easy communication across systems/providers if not integrated." *- Massachusetts Psychiatric Society*

Quality and Best Practices (cont'd)

- "Increase reimbursement for care coordination and systems navigation services for the region. This will assure agencies have the appropriate supports in place to assist individuals in navigating the complex system and receiving warm hand-offs between organizations if needed, ultimately maximizing the use of resources." *– Kerrie D'Entremont, Greater Lowell Health Alliance*

- *Consumer comments* touched on topics including the lack of community supports, concerns about stigma, and the importance of providing current information about which providers are available and in-network.

Public Feedback

Information and Data

- **Data Needs**
  - Outpatient data is a critical missing piece of health plan
  - Pharmacy data should be included in future analysis
  - More data about disparities in behavioral health care needed
  - Data in health plan should be broken down by age to highlight needs and services for children/adolescents
  - Data on primary care behavioral health care is crucial, to assess the amount of care that happens in primary care settings
  - More information about ED boarding needed
  - National level need data might not reflect Massachusetts experience
  - Problem gambling not addressed in plan

Public Feedback

Information and Data (cont'd)

- **Quality Metrics**
  - Need better outcome measures for behavioral health
  - Reimbursement rates sometimes tied to performance measurements which do not accurately measure quality
  - Disconnect between quality metrics and best practices, including concerns over reporting metrics that increase provider liability
- **Reporting**
  - Insurance companies should report more data about utilization and coverage
  - Existing reporting requirements should be reviewed and streamlined
  - Often difficult for smaller providers to collect data
- **Benchmarks**
  - Data on other states should be included in plan for comparison

Information and Data (cont'd)

- "Inpatient Care is only one component of the Behavioral Health system and the Step Down, Outpatient, and Community resources should also be analyzed in order to get an accurate assessment of the availability and access to behavioral health services." *- David Matteodo, Massachusetts Association of Behavioral Health Systems; Anuj Goel, Massachusetts Hospital Association*
- "We strongly encourage the Health Planning Council to take a closer look at the outpatient system before drawing conclusions about the state of the Commonwealth's behavioral health system."
  - Vicker DiGravio, Association for Behavioral Healthcare
- "The health resource planning process has not addressed the significant and specific needs of children, adolescents, and their families distinct from the needs of adults, nor have we seen inclusion of transitional services." *- Nancy Allen Scannell, Children's Mental Health Campaign*