Massachusetts General Court Mental Health Advisory Committee Report Phase I and Phase II

Final

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Prepared for:
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1. Acknowledgements

Abt Associates (Abt) and the Technical Assistance Collaborative (TAC) wish to thank Speaker Pro Tempore Haddad and Senator Keenan, co-chairs of the Massachusetts General Court's Mental Health Advisory Committee (MHAC), and their staff members, Ms. Robles and Mr. Alves, for their assistance in conducting the study. Representative Balser, Senator Brewer, Representative Dempsey, Representative Malia, Senator Moore, Representative O'Connell, Senator Ross and Representative Walsh, serving as members of the MHAC, contributed their deep experience and informed perspectives in the Committee deliberations and report reviews. Leadership and members of the MHAC have been generous with time and information.

Members of the MHAC offered their expertise, facilitated access to programs, and provided sources of data on the key questions under study as detailed in this report. Senior officials of the Executive Office of Health and Human Services, Department of Mental Health, Department of Public Health, MassHealth and Division of Insurance were instrumental in providing access to program staff, service delivery sites, and administrative reports referenced in this document. The MHAC membership incorporates a broad range of mental health system stakeholders, who brought to the effort their deep experience and diverse perspectives regarding the mental health care system in the Commonwealth. These stakeholders include care recipients, their families, provider organizations, labor unions, professional societies, health plans, insurers and advocates. The full membership of the MHAC is listed in Attachment 1.

We further express our appreciation to the consumers, peer leaders, family members, and advocates who provided us with the critical perspectives, concerns, and insights of those who depend on the public and private care systems. Provider organizations, labor unions, professional societies, clinical leaders, program managers, and board members from across Massachusetts extended to us the value of their experience and commitment to improving services in the Commonwealth by offering data, advice, and proposed solutions. Payers and policymakers from the public and private sectors also provided data, reports and program information that were integrated into this report. We are grateful to leaders and staff from Massachusetts government agencies, membership organizations, and advocacy organizations, who provided critical context and information for this report. A full list of key informants and program sites reviewed may be found in Attachment 2.

2. Executive Summary

2.1 Introduction, Overview and Purpose of the Study

The Mental Health Advisory Committee (MHAC) commissioned a study of selected aspects of the mental health care system in Massachusetts, pursuant to legislative language embedded in the Department of Mental Health budgets for FY2013 and FY2014.

Referenced herein as Phase I, the initial focus of the MHAC study was both on the impact of planned closure of Taunton State Hospital on Southeastern Massachusetts and selected regulatory, financing and service delivery issues on the statewide care system.

Phase I:

- *Examine the current and required continuing care bed capacity in the context of the larger system of inpatient, outpatient emergency and home and community based services; and outline the anticipated impact of the closure of Taunton State Hospital on the mental health needs of the southeastern region of Massachusetts.*
- *Examine insurance benefit design, coverage rules and reimbursements; address parity, Medicaid churn and private coverage gaps.*
- *Analyze the effectiveness of emergency services and identify gaps and impact of access, admission policies and related system factors.*

In 2013, DMH amended the scope of work in response to Chapter 38 of the Acts of 2013. Referenced herein as Phase II, the expanded focus of the MHAC study includes examination of the feasibility of developing selected program initiatives on the Taunton State Hospital campus or in the southeast region of the Commonwealth to meet the needs of several special needs populations.

Phase II:

- *Examine the feasibility of establishing crisis stabilization units at the current campus of Taunton State Hospital, or elsewhere in the region; assess the feasibility of a state-operated pilot crisis stabilization unit to provide evaluation, stabilization and referral to behavioral health patients who may otherwise be boarded in emergency rooms or spend longer periods in continuing and acute care units in the DMH Southeast Area.*
- *Examine the feasibility of units at Taunton State Hospital for the diversion of non-violent offenders and/or civilly committed women from corrections facilities; assess the extent to which persons in need of mental health treatment are sentenced or confined to reside within correctional facilities, either by criminal convictions for non-violent offenses, or for civil commitment under substance abuse and mental health statutes. The assessment will include an examination of: the extent to which state agencies are able to provide adequate mental health services to this population; the capacity for DMH or other state agencies to evaluate, divert, and hold custody of incarcerated or committed individuals in non-correctional facilities; the suitability of the facilities at Taunton State Hospital for pilot programs towards this purpose, and; whether such programs present net benefits with regard to the treatment and rehabilitation of such persons.*

Pursuant to the original legislative instructions, the Committee membership includes representatives from a diverse range of stakeholders in the Massachusetts mental health system, including individuals who use care, their families, legal advocates, providers, payers and professional societies. From its inception, the focus of the study was of necessity expanded to accommodate the broad range of interests represented among the members of the MHAC, as mandated by the legislative language. In order to examine the questions under study, one had to examine the larger system context in which those questions arose.

Consequently, this report not only addresses the discrete questions posed in the legislation, but also assesses the legal, regulatory, financing and operating conditions that impact consideration of and solutions to the issues.

2.2 Key Findings on the Massachusetts Care System

a. Organization and Delivery of Care to Meet a Range of Needs, including Complex User Needs

Massachusetts residents who are at risk for or have developed mental health conditions need timely and robust prevention, treatment and recovery support services. Individuals with lived experience of mental health conditions, who reside in stable housing, attend school or work at jobs, and enjoy relationships with their family, friends and fellow community members have taught us that people recover and treatment works.

As noted above, although the Mental Health Advisory Committee (MHAC) was nominally established to address the planned closure of Taunton State Hospital, the Committee also aimed to evaluate conditions in the State's mental health care system as a whole. Among the issues under review are recent capacity concerns in home and community-based services (HCBS), where patients and providers reported wait lists for and/or delays in accessing outpatient, intensive community-based treatment (ICBT), community-based flexible supports (CBFS, residential services, continuing care (CC) and acute inpatient hospital care. At the same time, emergency departments (EDs) reported boarding levels that exceed acceptable standards, with boarding often lasting for days rather than hours. Additionally, reports indicated that uncounted numbers of children, adolescents and adults in family homes, homeless shelters and/or otherwise ill-fitting services await access to appropriate HCBS. For those able to access the benefit, the Children's Behavioral Health Initiative (CBHI) shows promise in early assessment and care intervention, individualized wrap around services, and reduction in out-of-home services use.

b. Financing of Care and System Resource Base

While implementation is not yet complete, Massachusetts continues to lead the nation in universal insurance coverage, service delivery innovations, and payment reforms designed to address the whole health of individuals at risk for or with behavioral health conditions. Building on the achievements of the 2006 health insurance reforms that produced near-universal insurance coverage, State policymakers are implementing the next round of reforms to address long-standing concerns about health care cost growth, and critical gaps in the coordination and quality of care. Pursuant to Chapter 224 of the Acts of 2012 and

the Affordable Care Act (ACA), the Commonwealth is tackling additional state health care payment and service delivery reforms, including examination of the impacts of reform on individuals relying on the public and private mental health care system in the Commonwealth. System players are also implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act of 2010. Reports are pending to the Department of Insurance and the Center for Health Information and Analysis, documenting health plans' compliance with parity mandates and penetration, utilization, cost and quality measures of the provision of care to persons with behavioral health conditions. Massachusetts Executive Office of Health and Human Services (EOHHS) and the Department of Mental Health, among other departments, are actively implementing the Community First Olmstead Plan to provide residents with home and community based alternatives to institutional care in keeping with the Americans with Disabilities Act (ADA).

Despite these considerable achievements and a deep portfolio of pending initiatives, fiscal conditions in the Commonwealth in recent years have led to a reduction in State-supported behavioral health services capacity, while demand for care rose due in part to expanded rates of insurance coverage among State residents. Concomitant stagnation in MassHealth and commercial insurance reimbursement rates for outpatient and inpatient services created additional pressures. At the same time, Medicare prospective payments have declined. System stresses were revealed in reported service delays, housing shortages, and emergency department and inpatient backlogs.[1,2]

c. Capacity and Accountability Issues

Massachusetts has a mature, relatively well developed mental health system that is composed of elements that are consistent with the direction in which other states are moving with their mental health system policy and service delivery approaches. Massachusetts' early healthcare reform provided benefits in nearly universal coverage through expanded eligibility for MassHealth benefits and parity in private insurance coverage. Shifts in payer and regulatory relationships attending healthcare reform, however, increased fragmentation of authority and accountability for care in the system. As noted above, the economic downturn in 2007 drove continuous reductions in the DMH budget for all but one year since, depleting resources needed to sustain the public mental health system in the Commonwealth and concomitant growth in MassHealth spending for mental health services, does not supplant all losses in capacity and resources.

Multiple state agencies oversee and/or regulate portions of the Commonwealth's mental health system, including the Department of Mental Health (DMH), Department of Public Health (DPH), Department of Children and Families (DCF), MassHealth, and Department of Insurance (DoI). In addition, certain federal agencies, including the Centers for Medicare and Medicaid Services (CMS) and the Department of Justice (DOJ) promulgate regulations that impact the care system. There are multiple payers in the mental health system, including DMH, DCF, MassHealth, Medicare, and commercial insurers. There are also several federal government agencies that provide financing through public insurance and grant programs that support mental health services in the Commonwealth, including CMS, the Department of Housing and Urban Development (HUD), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Capitated managed care entities (MCEs) and MBHP also function as purchasers and payers of mental health services.

The complexity of the regulatory and payer structures is exacerbated by the numerous, sometimes overlapping and competing public and private providers of mental health inpatient, outpatient and community support services. The services system is composed of hundreds of providers delivering a broad array of services. This diversity and complexity gives consumers additional options, but it makes accountability difficult to assign and monitor. Moreover, it makes management of boundaries between and among the various overlapping service components very important. This boundary management issue is true at the consumer/point of service level, but also at the provider and payer levels. Because of the now primary role of MassHealth as a payer, and the growing participation of commercial payers and MCEs, DMH has a significantly diminished financing role and a somewhat diminished span of responsibility and control than it had in the past.

Specifically, DMH does not have the authority or resources to manage and coordinate care for people across these complex payer and provider boundaries. The locus of financial and care management responsibility in the public sector has shifted since the late 1980s from the Department and State budget appropriations to EOHHS and Medicaid, and it Medicaid managed care carve-out contractor, currently MBHP. In the last decade, with a push to move MassHealth recipients into managed care plans, EOHHS and Medicaid managed care entities (MCEs) or health plans are also significant players in the public insurance system. In the last few years, with universal coverage in Massachusetts and the passage of federal parity and health care reform, commercial insurers and the Department of Insurance (DoI) are also more significant players in the system. This disruption in the traditional system leadership role, with DMH serving as the "single point of clinical and fiscal accountability" for many of those most impacted by mental health conditions and/or most economically dependent, needs to be addressed, with roles and responsibilities of the many payers and several regulators clarified in order to advance system reforms and assure system accountability.

d. Transparency and Management Issues

There is not currently available in the Commonwealth a central source of consumer/provider/payer service utilization data that could be used for service tracking and accountability across multiple payers and providers for individuals accessing preventive, treatment and recovery services in the mental health system. Commercial and MCE payers did not historically report mental health services utilization or cost data consistently, indicating in several cases that some data, particularly rate-related information, are proprietary. Under Chapter 224, both public and private health plans must report claims data and information on benefits, premiums and costs to the All-Payer Claims Database (APCD), managed by the Center for Health Information and Analysis (CHIA).[3] In its March 2014 report on the status of the APCD, CHIA notes that carriers across insurance programs have contributed data and data are standardized by place of service, type of service, type of provider and ICD-9 CM Procedure and Diagnosis Codes, as well as member and provider addresses by county.[4] These data will be instrumental in generating aggregate comparative analyses of service utilization, care cost and quality performance across public and private payers. However, as CHIA notes in its reports, claims reports for services that have been carved out may be incomplete, since plans that push risk to the carve out entity may not receive the data sought for the APCD, leading CHIA to impute values for its overall system cost reports.[5] Since mental health/behavioral health benefits have so commonly been carved out, reports of performance across payers and public and private systems may lack detail needed to assess performance, identify need or predict demand.

There is no uniform set of definitions for data elements to be tracked and reported in the Commonwealth, nor is there a standard set of consumer outcomes or system/provider performance measures that could be used to assess the quality and effectiveness of the system across all payers and providers. Although many providers and plans adhere to NCQA measures, there are few that apply to mental health or behavioral health services. For example, an issue of critical concern to all – ED boarding – cannot be fully examined and precisely defined because there is no consistent standard for measuring the length of time for boarding in EDs by payer sources for non-DMH, non-MBHP consumers. Even if there were identifiable points of accountability in the system with the authority to enforce performance and quality improvement across the various elements of the system, there are insufficient data that could be used to support/facilitate such efforts.

2.3 Recommendations

The system and service delivery challenges addressed in this report are not the result of a poorly developed, immature or old fashioned care system. As will be illustrated and discussed in further detail, the challenges result from a system that is in structural transition in an environment characterized by challenging economics and shifting authorities. Findings are based on the realities of what it takes to make a modern, mature and diverse mental health system function properly for all participants (consumers, families, providers, payers, and regulators).

To achieve the promise of universal coverage provided at parity other health benefits, individuals must be assured access to the right services at the right time, and in the right amounts—effective services and supports available to Massachusetts residents at all levels of care—in a restored, robust and integrated care system that addresses prevention, early intervention, treatment, rehabilitation and recovery support. An integrated system includes not only the public and private mental health care system elements, but also broader behavioral healthcare, primary care and specialty healthcare. Executive and legislative action to exercise State budgeting and regulatory authority are needed to repair gaps and restore system infrastructure frayed by the program cuts and rate stagnation that accompanied the economic downturn from 2007 to the present.

Recommendation	Executive or Administrative Action	Regulatory or Legislative Action	Budgetary Action
Recommendations Related to Psychiatric Inpatient Treatment and Capacity			
1. Accelerate placement of 120 people in DMH continuing care beds into appropriate community settings.	X		X
2. Reduce average lengths of stay in Continuing Care Beds to facilitate admission of new patients having clinical needs for continuing care in a DMH facility.	X		
3. Institute efficient and transparent DMH practices to facilitate speedy access to continuing care for people needing that level of care.	X		
4. Reduce the elapsed time from application for continuing care to movement into DMH operated continuing care beds to 30 days or less.	X		
5. Publish a weekly DMH report of people referred to continuing care; the number approved for continuing care; and the average elapsed time from application to movement to continuing care.	X		
6. Use DMH licensing authority in approving new psychiatric inpatient capacity to assure that the new inpatient beds are fully accessible to the types of patients currently experiencing long wait times for inpatient admission in hospital emergency departments. These include people with co-occurring substance use and/or people with multiple co-morbid health and behavioral health issues.	X	X	
Recommendations Related to Emergency Service Programs and Emergency Department Boarding			
1. Increase visibility and use of peer support services in respite, community crisis stabilization and for mobile crisis and improve crisis prevention and response across the continuum.	X		X
2. Implement a centralized and unified psychiatric inpatient bed search capacity must be in place and supported and used by all payers, all hospitals; all EDs; and all ESPs.	X	X	
3. Expand and enhance crisis diversion and crisis respite resources, particularly in southeastern Massachusetts. Allow Medicaid billing for follow-up mobile crisis intervention for adults similar to billing allowed for children and adolescents.	X	X	X
4. Improve processes to facilitate weekend discharges to allow for weekend admissions.	X	X	
5. Enforce no reject provisions in hospital contracts.	X	X	
6. Engage DPH and its vendors as active partners in any initiative to reduce ED boarding. Access to treatment for substance use disorders should also be increased across levels of care throughout the Commonwealth.	X	X	X
7. Increase reimbursement for psychiatric inpatient care.		X	X
8. Increase use of separate psychiatric EDs within community Hospitals.	X	X	
9. Clarify issues around the need for a Section 12 for medical transportation.	X		
10. Include, in data tracking and reporting, analyses by payer source of trends related to: psychiatric hospital admission and diversion rates; inpatient lengths of stay for both acute and continuing care; and ED boarding by type of patient and elapsed time for boarding.	X		
Recommendations Related to Prior Authorization for Psychiatric inpatient Treatment			
1. Discontinue application of Prior authorization for psychiatric inpatient care, considering the mental health parity issue, with the following caveats:	X		
a. Engage all payers, including commercial insurers and Medicaid MCEs, in developing policies and procedures to replace current prior authorization practices;	X		

Recommendation	Executive or Administrative Action	Regulatory or Legislative Action	Budgetary Action
b. Include, in new policies and procedures for processing admission to psychiatric inpatient care, a continued role for ESPs in emergency departments as well as in other settings;	X		
c. Include, in data tracking and reporting, analyses by payer source of trends related to the rate of payer de-certification of inpatient treatment following admission.	X		
Recommendations Related to the Continuing Use/Re-use of Taunton State Hospital (TSH)			
1. Analyze any possible expanded use or re-use of TSH in the context of risks to the state presented by the Medicaid IMD exclusion and the Medicaid and Department of Justice mandates for provision of services in integrated community settings.	X		X
2. Consider integrated community settings rather than the TSH campus for crisis diversion and crisis respite services.	X		
3. Consider the TSH campus as the site for a pilot program for criminal justice offenders with mental illness who have a low risk offense profile and who can be safely diverted from incarceration in County Jails.	X	X	X
4. Consider the TSH campus as the site for a residential treatment program designed for women committed under Section 35. One purpose of this program would be to end the practice of committing women under 35 to MCI Framingham.	X	X	X
5. It must be emphasized that potential re-use of TSH for criminal justice diversion and/or treatment of women under Section 35 has not been reviewed or approved by applicable state agencies. Nor has it been discussed with or approved by the TSH neighborhood and Taunton community.	X	X	X

2.4 Conclusion

The Mental Health Advisory Committee Report provides an analysis of interlocking issues related to the public outpatient, inpatient and home and community-based mental health system in Massachusetts. The Report incorporates findings and recommendations related specific issues such as hospital bed capacity, emergency department boarding and the adequacy of community mental health services. As emphasized throughout the report, these findings and recommendations should be viewed as a whole. Changes cannot be made in one component of the mental health system without affecting many other parts of that system. At the same time, improvements to access and quality of care in one part of the system cannot be implemented without collaboration and cooperation from other parts of the system.

Although the questions posed in the Mental Health Advisory Committee's legislative charge focus on a select set of mental health system issues, answers require broader examination of the system context in which they arise. The primary problem in the Massachusetts public mental health system, for example, is not an absolute lack of psychiatric inpatient capacity. However, there are gaps in community services for people with complex long term behavioral health disabilities, and these gaps are exacerbated by limited funding and poor reimbursement rates for both inpatient and outpatient services. These resource gaps undercut the system's capacity to effectively prevent and manage crises and to effectuate speedy and successful return to the community for people who are hospitalized. The financial realities of public and

private funding for mental health services cause inpatient and outpatient providers to deliver the least amount of services while primarily responding to crises. There are limited incentives to provide better quality care with follow-up care for recovery and prevention of acute crises.

The ability to utilize existing inpatient, outpatient and community services more effectively is constrained by the many funding and service management silos in the system. More importantly, because of the diffusion of funding, there is currently no single point of clinical and administrative authority in the system to assure that people with serious mental illness receive the right services at the right time. The diffusion of funding and clinical responsibility also results in poor data collection, reporting and analysis. The lack of complete and comparable data results in reduced transparency and accountability related to access, responsiveness, equity, and effectiveness in the mental health system. This lack of data makes it difficult to pinpoint the causes of difficulties in the system and also to track efforts to improve access and quality across the system.

Finally, there are few incentives in the system to coordinate care among mental health, substance use, and primary and specialty health services. As noted throughout this report, substance use and general health issues are among the most important causes of ED boarding, and thus solutions to these issues must include better coordination and service access within these other systems. In addition, there are clear needs for improved coordination and access related to affordable housing and within the criminal justice system.

The specific findings and recommendations contained within this report point the way towards addressing many issues within the mental health system as well as across multiple other systems that affect and are affected by the mental health system. Implementation of some or all of these recommendations will take concerted and collaborative leadership and effort among several state agencies, abetted and at the same time held accountable by the Great and General Court of the Commonwealth of Massachusetts.

3. Overview and Background for the Report

3.1 Overview

Systems of care targeted to meet the needs of people who have mental health conditions are in transition and under construction pursuant to major changes in the scientific, legal, regulatory and financing environments that shape health services delivery. Changes in the roles, responsibilities and rights of care consumers, providers, institutions, government agencies and private insurers, combined with new evidence about the effectiveness of prevention and the science of recovery, are reshaping the landscape of mental health care in the Commonwealth and across the nation. As an early adopter of a number of financing, service delivery and care management reforms, Massachusetts has been challenged by stresses that accompany major shifts in the roles, resources and expectations held by system stakeholders. The issues identified by stakeholders and embedded in the Legislative mandate for this report do not arise in isolation, but rather are tied to conditions in an evolving care system that is impacted by economic conditions.

For this report, the study team was charged with answering selected questions. To understand more fully the context in which those questions arose, the Abt/TAC study team gathered and evaluated qualitative and quantitative information about mental health needs and system response conditions in the Commonwealth. The report is organized to provide the reader with perspective on the context in which change in Massachusetts' care systems is unfolding, the characteristics of individuals in need of care, the evidence-based and promising practices designed to meet those needs, and data on performance of selected parts of the systems as detailed in the legislative mandate for the study. Because the selected elements of these systems under study are interdependent with other system elements, solving performance challenges in one will require both cross-cutting and targeted solutions, as outlined in the recommendations chapter at the end of the report.

3.2 Legislative Mandate for the Report

Pursuant to Massachusetts General Law (MGL) Chapter 186 of the Acts of 2012, and Chapter 38 of the Acts of 2013, the MHAC contracted with Abt Associates Inc.(Abt), and the Technical Assistance Collaborative (TAC) to identify and evaluate current public and private mental health care services available to residents of the Commonwealth. To this end, the team conducted several targeted analyses to assess "the ability of the existing public mental health care system to meet its statutory requirements, and the ability of the public and private mental health system in Massachusetts to meet the clinical needs of residents in the most timely and appropriate manner."[6]

3.3 Purpose of the Study and Objectives for the Report

In late 2012, the Massachusetts Department of Mental Health (DMH) published a Request for Quote on behalf of the MHAC addressing Chapter 186 of the Acts of 2012 and soliciting assistance with the review and assessment of factors and conditions impacting the State's mental health care delivery system. Referenced herein as Phase I, the initial focus of the MHAC study was to assess the impact of the planned closure of Taunton State Hospital (TSH) on Southeastern Massachusetts and selected regulatory, financing and service delivery issues on the statewide care system.

Phase I:

- *Examine the current and required continuing care bed capacity in the context of the larger system of inpatient, outpatient emergency and home and community-based services; and outline the anticipated impact of the closure of Taunton State Hospital on the mental health needs of the southeastern region of Massachusetts;*
- *Examine insurance benefit design, coverage rules and reimbursements; address parity, Medicaid churn and private coverage gaps; and*
- *Analyze the effectiveness of emergency services and identify gaps and impact of access, admission policies and related system factors.*

In 2013, DMH amended the scope of work in response to Chapter 38 of the Acts of 2013. Referenced herein as Phase II, the expanded focus of the MHAC study includes examination of the feasibility of developing selected program initiatives on the TSH campus or in the southeast region of the Commonwealth to meet the needs of several special needs populations.

Phase II:

- *Examine the feasibility of establishing crisis stabilization units at the current campus of TSH, or elsewhere in the region, and assess the feasibility of a state-operated pilot crisis stabilization unit to provide evaluation, stabilization and referral to behavioral health patients who may otherwise be boarded in emergency rooms or spend longer periods in continuing and acute care units in the DMH Southeast Area; and*
- *Examine the feasibility of using units at TSH for the diversion of non-violent offenders and/or civilly committed women from corrections facilities, and assess the extent to which persons in need of mental health treatment are sentenced or confined to reside within correctional facilities, either by criminal convictions for non-violent offenses, or for civil commitment under substance abuse and mental health statutes. This assessment includes an examination of: the extent to which state agencies are able to provide adequate mental health services to this population; the capacity for DMH or other state agencies to evaluate, divert, and hold custody of incarcerated or committed individuals in non-correctional facilities; the suitability of the facilities at TSH for pilot programs towards this purpose, and whether such programs present net benefits with regard to the treatment and rehabilitation of such persons.*

3.4 Principles that Guided the Analysis

In analyzing the questions under study, Abt and TAC researchers considered five principles that have guided our work during Phase I and Phase II.

3.4.1 Treatment in the Most Integrated Setting

The Americans with Disabilities Act, as interpreted by the 1999 U.S. Supreme Court *Olmstead* decision requires states to serve people in the least restrictive, most integrated settings possible. This issue challenges states to strike an appropriate balance of resources allocated to inpatient and community-based settings. Since 2008, the Commonwealth of Massachusetts has been implementing its *Community First Olmstead Plan* to "empower and support people with disabilities and elders to live with dignity and independence in the community."[7] In line with Massachusetts' Community First policy, in our analysis we considered what impact maintaining or closing TSH would have on the civil right of residents from

Southeastern Massachusetts to live in the most integrated settings. Similarly, we considered the matter of treatment provided in the most integrated setting in addressing the legislative charge to examine alternatives, including pilot programs at TSH, for individuals in need of crisis stabilization services, civilly committed individuals now residing in correctional facilities, and non-violent persons with mental illness currently serving sentences in correctional facilities in the Commonwealth.

3.4.2 Access to a Full Array of Prevention, Treatment, Rehabilitation and Recovery Support Services

Mental health conditions include a long list of diagnoses with distinct courses and durations of illness and disability, which demand a comprehensive system of prevention, treatment, rehabilitation and recovery support services. A comprehensive system promotes timely access to clinically appropriate outpatient treatment, community treatment teams, emergency intervention, crisis stabilization, and partial hospital or inpatient care. This system includes continuing care beds for those who need a higher level of care until they can be served in less restrictive settings, which is not only imperative from an ethical and clinical perspective but also relieves pressure for needed acute care beds. In our analysis, for example, we attempted to understand the impact that maintaining or closing TSH would have on access to continuing care beds for residents of Southeastern Massachusetts. Similarly, we address the array of services that individuals with mental illnesses who are at risk for, involved with, or adjudicated in the criminal justice system require to mitigate risk, divert from adjudication or incarceration, and prevent or reduce recidivism after release from jail or prison.

3.4.3 Preservation of Family and Community Ties in Access to Care

For individuals who are served in continuing care settings, preserving ties with family and the community are important to one's recovery and reintegration back into the community. In our analysis, we considered the impact that closure of TSH would have on family ties, the ability of DMH Southeast Area providers to remain engaged in patients' treatment and the patients' ability to access community-based services during transition planning and upon discharge. Concerns about preservation of family and community ties are not confined to Southeastern Massachusetts. Similar concerns exist, for example, in access to HCBS services, residential treatment and inpatient care for children, adolescents and adults from areas across the Commonwealth.

3.4.4 Use of Evidence-Based and Quality Care

Individuals in need of mental health care should have access to quality, evidence-based services throughout the continuum of inpatient and community-based services. In our analysis of Phase I questions, we attempted to explore what impact maintaining or closing TSH would have on quality of care for residents of Southeastern Massachusetts who: a) are in need of continuing care; and b) access community-based services or acute inpatient care. In our analysis of Phase II questions, we similarly addressed service delivery models that are science-based and offer promising practices designed to provide clinically effective care.

3.4.5 Efficiency in Services Cost and Resource Allocation

Because systems are funded with public dollars, the administration and organization of the public mental health system must strive to allocate its resources in a cost efficient manner. In our analysis of Phase I questions, we conducted a limited assessment related to the costs associated with operating TSH and their potential impact to other parts of the system. In addressing Phase II questions, we reference the cost implications of options under discussion.

3.5 Study Methods and Approach

As previously noted, the MHAC aims to:

- Examine the current and required continuing bed capacity in the context of the larger system of inpatient, outpatient, emergency and HCBS services; outline the anticipated impact of the closure of TSH on the mental health needs of the southeastern region of Massachusetts;
- Examine insurance, benefits design, coverage rules and reimbursement; address parity, Medicaid churn and private coverage gaps; and
- Analyze the effectiveness of emergency services and identify gaps and impact of access, admissions policies, and related system factors.

To address these issues, the Abt/TAC team employed both qualitative and quantitative methods in our data collection efforts, as illustrated in **Exhibit 1** below. Data collection efforts address the statewide aspects of our study for the MHAC as well as region-specific data for Southeastern Massachusetts, drawing input from multiple sources and data sets including a variety of stakeholders and system experts concerned with the delivery of care in this area of the Commonwealth.

3.5.1 Qualitative Data Collection

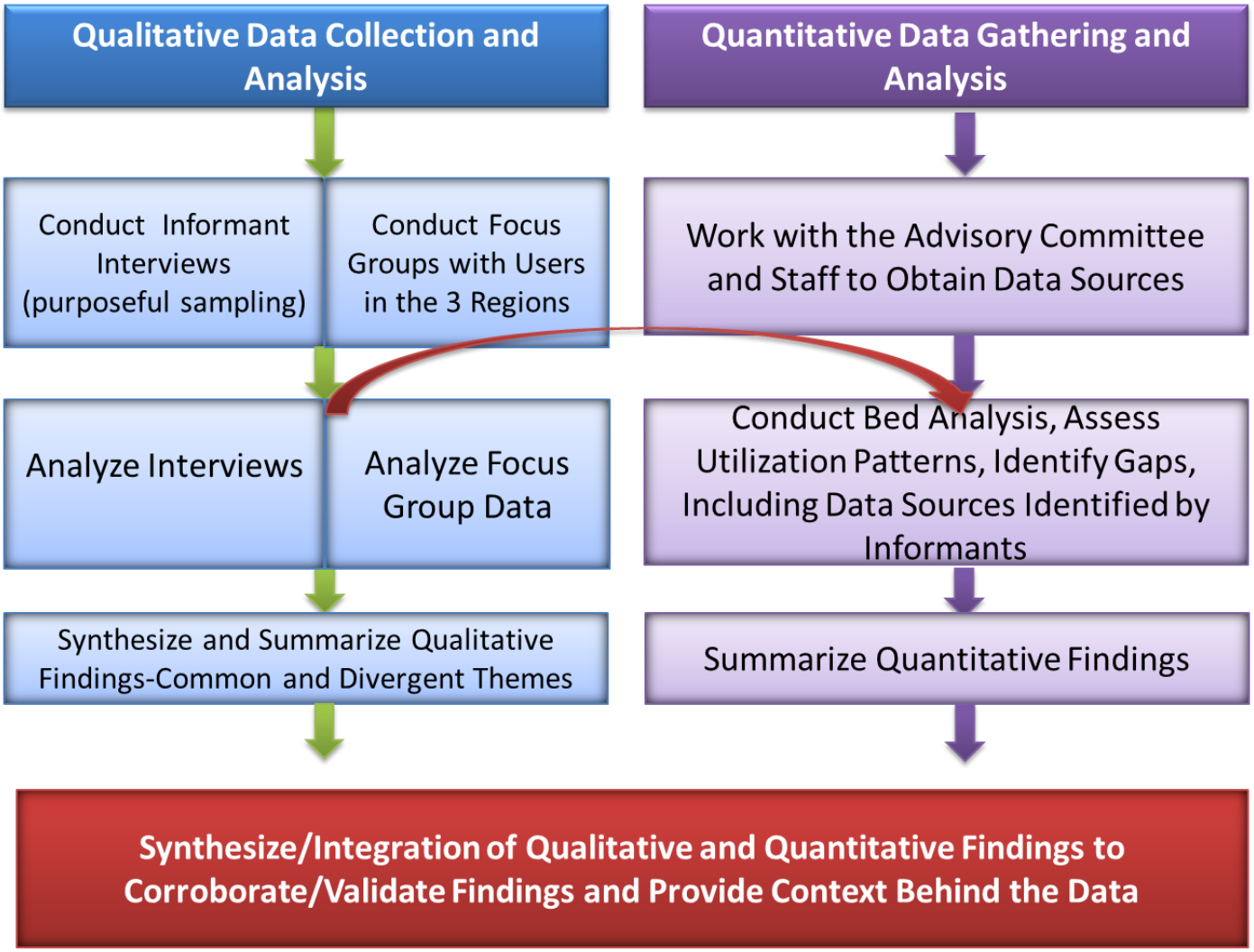
As illustrated and detailed in Appendix A of this report, Abt/TAC team members met in individual and small group meetings and larger membership organization forums to gather input from key stakeholders in the public and private mental health care systems.

3.5.2 Quantitative Data Collection

As detailed in Appendix B of this report, numerous Massachusetts' policy, budget, and advocacy documents were gathered and analyzed to inform the findings of this report. The Abt/TAC team submitted written data requests to DMH and MassHealth Behavioral Health. Responses were provided to our written requests and leadership staff from the respective entities spoke with our team members to discuss the details of the data. Data collection was iterative and in some cases data received led the team to further refine data requests.

Exhibit 1 depicts our overall approach to data collection, analysis and synthesis. We used a two-pronged approach, illustrated in the exhibit, to address each of the above stated aims. As noted earlier, the results of our analyses of both the quantitative and qualitative data appear in chapters throughout this report.

Exhibit 1. Overall Approach to Data Collection, Analysis, and Synthesis



3.5.3 Integration of Phase I and Phase II Activities

To avoid redundancy in reporting and to address the Massachusetts mental health system in a more holistic fashion, the study team has integrated its analyses and reporting across Phase I and Phase II. To avoid additional administrative burden on government agencies and system stakeholders, we did not ask for updated information, including FY14 data, on questions answered in Phase I of the study.

4. Massachusetts Context

From Dorothea Dix's impassioned plea to the Massachusetts Legislature in 1843 calling for the humane care of individuals with mental illness, to President Kennedy's passage of the Community Mental Health Centers Act in 1963, the Commonwealth and its leaders have been progressive and proactive in the establishment of what is now a continuum of community-based treatment, rehabilitative services, housing and recovery supports for individuals with mental illness. Individuals with lived experience of mental health conditions, who reside in stable housing, attend school or work at jobs, and enjoy relationships with their family, friends and fellow community members have taught us that people recover and treatment works. While implementation is not yet complete, Massachusetts continues to lead the nation in universal insurance coverage, service delivery innovations, and payment reforms designed to address the whole health of individuals at risk for or living with behavioral health conditions.

In 2006, Massachusetts implemented health insurance reforms that produced near-universal insurance coverage, with studies documenting between 96 percent and 98 percent coverage for State residents.[8,9] State policymakers are now poised to consider a new round of reforms to address long-standing concerns about health care cost growth, and critical gaps in the coordination and quality of care. Building on health care reform legislation enacted in 2008 and 2010 that was designed to promote data transparency and expand reporting requirements to provide information to manage growing health insurance premium and care costs, the General Court of the Commonwealth passed Chapter 224 of the Acts of 2012. Chapter 224 was established to tackle additional state health care payment and service delivery reforms,[10] and work includes examination of the impacts of reform on individuals relying on the public and private mental health care systems in the Commonwealth. These reforms in the Commonwealth are currently underway, and system players are also implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and the Patient Protection and Affordable Care Act of 2010.

Despite these considerable achievements, fiscal conditions in the Commonwealth in recent years have led to a reduction in State-supported behavioral health services capacity, while demand for care rose due in part to expanded rates of insurance coverage among State residents. Concomitant stagnation in MassHealth and commercial insurance reimbursement rates for outpatient and inpatient services created additional pressures. System stresses were revealed in reported service delays, housing shortages, and ED and inpatient backlogs.[11,12] To achieve the promise of universal coverage provided at parity with other health benefits, individuals must be assured access to the right services at the right times, and in the right amounts—effective services and supports available to Massachusetts residents at all levels of care—in a restored, robust and integrated care system that addresses prevention, early intervention, treatment, rehabilitation and recovery supports. An integrated system includes not only public and private mental health care system elements, but also broader behavioral health care, primary care and specialty health care services. These broader elements of the larger health care system are essential to addressing prevention and early intervention opportunities, improving coordination of care for individuals with co-occurring mental health and substance use conditions, and reducing morbidity and mortality for those with multiple chronic health conditions.[13] Legislative committees and commissions are actively engaged in promoting examination and reform of the care system, including parity and system adequacy. These considerations are central to the concerns of the MHAC.

Although the MHAC was nominally established to address the planned closure of TSH, the Committee also aims to evaluate conditions in the State's mental health care system as a whole. Among the issues

under review are recent capacity concerns in State HCBS services, where patients and providers have reported wait lists for and/or delays in accessing outpatient, intensive community-based treatment, community-based flexible supports, and residential services. At present, more than 120 continuing care patients await discharge to HCBS services; recent studies have also reported a growing percentage of acute hospital patients awaiting discharge to HCBS or continuing care services, as will be detailed in subsequent chapters of this report. Additionally, uncounted numbers of children, adolescents and adults residing in family homes, homeless shelters and/or receiving otherwise ill-fitting services await access to appropriate HCBS services. For those able to access the benefit, however, the Children's Behavioral Health Initiative shows promise in early assessment and care intervention, individualized wrap around services, and reduction in out-of-home services use.

At the same time, EDs have reported boarding levels that exceed acceptable standards, with boarding often lasting for days rather than hours. While this may be due to challenges and inefficiencies in the bed-finding process, it can also be attributed to a lack of timely and/or appropriate discharge to HCBS or inpatient services, particularly during weekend hours, as illuminated in data outlined in subsequent chapters of this report. Some hospitals and community providers refuse to admit or discharge on weekends.

> ***"There is public acknowledgment in Massachusetts that our transportation infrastructure is crumbling…. and that we need significant investment to restore it. The same is true of our behavioral health infrastructure."***
>
> *Deborah Ekstrom, CEO*
> *Community HealthLink*

Troublingly, patients and providers have also reported refusals to admit patients with high acuity/needs profiles and/or discharge delay risks, even when open beds were available, suggesting some providers may have limited capacity and appetite for accepting patients with social complexities, or dual diagnoses of substance abuse, intellectual disabilities, medical comorbidities and/or disruptive behaviors. Available beds may also be ineffectively distributed by specialty or geographic location. As a growing number of adult beds are converted to geriatric beds, fewer child and adolescent beds remain available. This is problematic, as child and adolescent bed demand tends to vary sharply by season (peaking in the winter and falling in the summer months). Proposals to manage this problem are under consideration but have not yet been implemented by payers. Juvenile psychiatric patients may be inappropriately assigned to pediatric medical beds due to lack of space in general hospital settings, necessitating assignment of security or special staff and lacking the ability to deliver a program of psychiatric treatment in a single medical bed. In specialty psychiatric hospitals, child and adolescent patients may be consolidated from otherwise separate programs to a single unit to manage a drop in census.

At the same time, many services have experienced diminished capacity to provide robust care and seasoned clinicians due to a depleted rate structure. Providers report delays in screening and approval with some payers, and have expressed concern that the screening and review process may be redundant in some EDs. Hospitals report high and unsustainable use of Administratively Necessary Day (AND) reimbursement at low rates for inpatients who no longer meet medical necessity criteria for acute inpatient care but have no discharge options. Lack of discharge options is due to gaps in community housing, treatment and support capacity or long delays in processing admission to DMH continuing care beds, which are similarly unable to place discharge-ready patients because of the lack of community-based services. As subsequent sections and chapters of this report will address, more effective alignment

of DMH and Department of Public Health (DPH) regulatory authority and wielding of health plan and payer contract authority is needed to fix the problems of inpatient capacity and admission denials.

However, the challenge of limited HCBS service capacity and management must also be addressed. Rate adequacy for outpatient, inpatient and other HCBS services is also a major consideration in the Massachusetts environment. Rates for behavioral health services are low, across payers. For example, there is little ability to cross-subsidize from commercial rates to cover gaps in Medicaid rates as is typical in some other medical specialties and in some other jurisdictions. In the Commonwealth, Medicaid gaps between cost and reimbursement rates are high. Until the beginning of 2014, when some relief was provided, there was an estimated average three percent increase in five years for inpatient providers under contract with MassHealth. At the same time, Medicare prospective payments have declined and some commercial insurance rates for selected psychiatric services were cut in the last year.

DMH reimbursement for home and community-based housing and support services was effectively reduced in recent years through community-based flexible supports (CBFS) restructuring and with the loss of outpatient wrap/gap financing. State budgeting and regulatory authority are needed to repair gaps and restore system infrastructure frayed by the program cuts and rate stagnation that accompanied the economic downturn from 2007 to the present.

4.1 Massachusetts has a Mature Mental Health System Impacted by Health Care Reform, Economic Conditions and Fragmented Authorities

Massachusetts has a mature, relatively well-developed mental health system that is composed of elements that are consistent with the direction in which other states are moving with their mental health system policy and service delivery approaches. Massachusetts' early health care reform provided benefits and nearly universal coverage through expanded eligibility for MassHealth benefits and parity in private insurance coverage. Shifts in payer and regulatory relationships attending health care reform, however, increased fragmentation of authority and accountability for care in the system. As noted above, the economic downturn in 2007 drove continuous reductions in the DMH budget for all but one year since, depleting resources needed to sustain the public mental health system in the Commonwealth. Concomitant growth in MassHealth spending for mental health services, some of which covers costs associated with eligibility expansion and increased demand, does not supplant all losses in DMH services capacity and program resources.

The Massachusetts' community support system developed and funded by DMH and MassHealth represents relatively good, evidence-based practices as compared to many other states. This does not mean that the community support system is adequately funded or has adequate capacity, but the range and depth of service delivery approaches provided in the public system offers a solid foundation. For example, despite some reported operational challenges, the statewide mobile crisis/emergency services programs (ESP) model represents preferred practices that are being emulated in many other states.

The DMH service system offers a continuum of care for children, adolescents, and adults. Available adult services are recovery-oriented, including CBFS with contracted and state-run residential and supported housing programs, programs for assertive community treatment (PACTs), and state-run and Massachusetts Behavioral Health Partnership (MBHP)-contracted ESPs. Brocton Multi-Service Center and Dr. John C. Corrigan Mental Health Center, run by DMH, also provide a variety of services as does the DMH/Harvard-run Massachusetts Mental Health Center and Dr. Solomon Carter Fuller Mental Health Center. MBHP contracts for a variety of services, such as ESPs, PACTs and partial hospital programs as

well. MassHealth, through fee-for-service or managed care entities (MCEs) and commercial insurers reimburse providers across the State for a variety of outpatient mental health services.

Community-based services for children and adolescents, which have been enhanced through the Children's Behavioral Health Initiative, include child and adolescent residential programs, child and adolescent respite services, intensive residential treatment programs (IRTPs), clinically intensive residential treatment programs (CIRTPs), child mobile crisis intervention (MCI) services, and child and adolescent case management. These services are primarily provided by community providers contracted by DMH, MBHP, or the Department of Children and Families (DCF). MassHealth plans and commercial insurers also include some of these services in their benefits packages.

The "system" was simpler to manage and change when the players were DMH and a handful of commercial insurers, with DMH as the dominant regulator. Although system advocates and critics alike continue to point to DMH as the key to the mental health care system in the Commonwealth, the shift in focus of financial and care management responsibility in the public sector has shifted since the late 1980s from the Department and State budget appropriations to EOHHS and MassHealth, and its managed care carve-out contractor, currently MBHP. In the last decade, with a push to move MassHealth recipients into managed care plans, EOHHS and Medicaid MCEs or health plans are also significant player. In the last few years, with the establishment of universal coverage in Massachusetts and the passage of federal parity and health care reform, commercial insurers and the Department of Insurance (DoI) are also more significant players in the system. This disruption in the system's traditional leadership role, with DMH serving as the "single point of clinical and fiscal accountability" for many of those most impacted by mental health conditions and/or most economically dependent, has not been addressed.

As noted above, pursuant to State healthcare reform, Massachusetts has seen health insurance coverage expand for several years. As a result, there are very few uninsured people in the Commonwealth, with fewer residents who rely heavily on state-funded mental health and safety net services. In Massachusetts, MassHealth covers most people with serious and disabling mental health conditions, and most services for people with these conditions are covered by MassHealth. Consequently, Medicaid is a more significant payer of mental health services than in most other states. Medicare is similarly a major payer of inpatient services and a growing payer for outpatient services. With parity laws in Massachusetts reinforced by federal law and regulation, commercial insurance is also a growing part of the revenue sources upon which providers depend.

Because of widespread insurance coverage, Massachusetts has been able to shift most acute psychiatric treatment (inpatient and outpatient) to the private sector. Publically-operated, state-financed facilities and programs play a smaller role in the Commonwealth than in most other states, given more universal insurance coverage and incentives to capture reimbursement that are not available to some public inpatient care facilities, as will be discussed in detail later in this report. In Massachusetts, the acute care safety net is embedded in the community and in the private sector.

The system and service delivery challenges addressed in this report are not the products of a poorly-developed, immature or old-fashioned care system. As will be illustrated and discussed in further detail, these challenges result from a system that is in structural transition in an environment characterized by challenging economic conditions and shifting channels of authority. Findings are grounded in an understanding and acknowledgement of the realities required to make a modern, mature and diverse

mental health system function properly for all participants (consumers, families, providers, payers, and regulators).

4.2 Massachusetts has a Complex Mental Health System Shaped by Multiple Regulators, Payers and Providers

Multiple state agencies oversee and/or regulate portions of the Commonwealth's mental health system, including DMH, DPH, DCF, MassHealth, and DoI. In addition, certain federal agencies, including the Centers for Medicare and Medicaid Services (CMS) and the Department of Justice (DOJ) promulgate regulations that impact the care system. There are multiple payers in the mental health system, including DMH, DCF, MassHealth, Medicare, and commercial insurers. There are also several federal government agencies that provide financing through public insurance and grant programs that support mental health services in the Commonwealth, including CMS, the Department of Housing and Urban Development (HUD), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Capitated MCEs and MBHP also function as purchasers and payers of mental health services.

The complexity of the regulatory and payer structures is overshadowed by the numerous, sometimes overlapping and competing public and private providers of mental health inpatient, outpatient and community support services. The services system is composed of hundreds of providers delivering a broad array of services. Some are small, providing a single service, while others are large, vertically- and horizontally-integrated service delivery organizations providing most elements of a continuum of care. There is some degree of fungibility or substitution effect between and among services in the system. For example, intensive outpatient treatment can work as well as residential treatment under some circumstances. When operating optimally, such a system works more like a series of overlapping Venn diagrams than a series of discrete service silos.

This diversity and complexity gives consumers additional options, but it makes accountability difficult to assign and monitor. However, it makes management of boundaries between and among the various overlapping service components very important. This boundary management issue is true at the consumer/point of service level, but also at the provider and payer levels. Because of the now primary role of MassHealth as a payer, and the growing participation of commercial payers and MCEs, DMH has a significantly diminished financing role and a somewhat diminished span of responsibility and control than it had in the past.

Specifically, DMH does not have the authority or resources to manage and coordinate care for people across these complex payer and provider boundaries. DMH is no longer the "single point of clinical and financial accountability" for even those individuals with serious and disabling mental health conditions. Moreover, a number of the individuals once considered the exclusive responsibility of DMH have multiple chronic health conditions, among which substance use disorders (SUDs) stand out as a frequently co-occurring condition. A striking illustration of the problem that individuals with complex conditions experience in an environment of fragmented authority and accountability is found in the ED at most hospitals. Individuals with co-occurring SUDs are those most frequently reported with delayed admission to inpatient units, driving long ED stays. And, although access to, utilization of, and payment for most essential SUD services are beyond the control of DMH, most concerned with long ED waits point to DMH as the problem. DPH, which funds some substance abuse services, and MBHP and MCEs under parity, are the key planners regulators and/or payers of these services, and must play a role in solutions. As we discuss later in this report, this issue is critical to address if progress is to be made

regarding ED boarding, inpatient bed availability, and effective treatment, diversion and step down alternatives.

4.3 There are Numerous Data Points and Anecdotes but Little Useful Information Related to the Performance and Effectiveness of Massachusetts' Overall Mental Health System of Care

Currently available sources of consumer/provider/payer service utilization data that could be used for service tracking and accountability across multiple payers and providers in the mental health system have not yet been utilized or studied carefully by the Commonwealth. Under Chapter 224, both public and private health plans must report claims data and information on benefits, premiums and costs to the All-Payer Claims Database (APCD), a repository managed by the Center for Health Information and Analysis (CHIA). In its March 2014 report on the status of the APCD, CHIA noted that carriers across insurance programs have already contributed data, and that such data includes standard metrics with respect to place of service, type of service, type of provider, ICD-9 CM Procedure and Diagnosis Code, and member and provider addresses by county. However, CHIA reports that it has not yet received data from the MassHealth behavioral health carve-out vendor, the Massachusetts Behavioral Health Partnership.

APCD data will be instrumental in generating aggregate comparative analyses of service utilization, care cost and quality performance across public and private payers. To date neither CHIA nor any other state agencies have completed specific analyses or profiling of the mental health data in the APCD. Recently, the Health Planning Council began an effort to use the APCD to help understand mental health utilization in the Commonwealth. Separately from the APCD, CHIA also calculates system-wide spending and utilization trends. These reports are based on data that may in some cases exclude carved out services such as mental health. Since mental health/behavioral health benefits have so commonly been carved out, reports of performance across payers and public and private systems may lack detail needed to assess performance, identify need or predict demand. It is also useful to consider, as CHIA indicates, that the purpose of CHIA's reports on "Total Health Care Expenditures" are not designed to assess performance, identify need, or predict demand. Data sources, beyond the APCD, need to be developed to answer those critical questions.

There is no uniform set of definitions for data elements to be tracked and reported in the Commonwealth, nor is there a standard set of consumer outcomes or system/provider performance measures that could be used to assess the quality and effectiveness of the system across all payers and providers. Although many providers and plans adhere to NCQA measures, there are few that apply to mental health or behavioral health services. For example, an issue of critical concern to all – ED boarding – cannot be fully examined and precisely defined because there is no consistent standard for measuring the length of time for boarding in EDs by payer sources for non-DMH, non-MBHP consumers. Even if there were identifiable points of accountability in the system with the authority to enforce performance and quality improvement across the various elements of the system, there are insufficient data that could be used to support or facilitate such efforts.

4.4 Despite the Relative Maturity and Completeness of Massachusetts' Mental Health System, Elements of the System Remain Underfunded, and Current Financial Incentives are Somewhat Perverse

Community service providers are reimbursed or funded so poorly that few can provide basic outpatient services to children and adults with mental health conditions without incurring significant losses or deficits. Hospital inpatient rates do not incentivize development of additional capacity and in the main

cannot support effective care for individuals with complex or intensive needs. Low inpatient administratively necessary day (AND) payment rates, combined with lack of system capacity to timely step individuals down from inpatient care, act as de facto barriers to hospital admission for people with complex conditions, since they are trying to avoid extended AND stays pending continuing stay approval and/or community placement.

The dominant managed care approach to Medicaid and commercial mental health services sometimes creates barriers to timely care. Having a good payer source with few managed care impediments (e.g., Medicare) can facilitate entry to inpatient care. However, even with relatively better rates and no prior approval requirement, Blue Cross Blue Shield of Massachusetts (BCBSMA) patients also sit for long stays in EDs, even when beds are available, due to the disinclination of some providers to accept what they perceive to be challenging or complex patients. In recent statements to the MHAC, a BCBSMA Medical Director commented that despite the plan's efforts to remove barriers to access, including prior authorization, some of the plan's patients experienced long stays in EDs without notification to the plan, which has contractual authority to address admission refusals. Other payers and ED physicians provided testimony to the MHAC about their efforts to contact health plans with news of "stuck" patients, only to find these providers offered no weekend coverage or responded that the ED should wait for DMH crisis team to find a bed. Access should be based on clinical necessity, not on payer source.

5. National Context

Massachusetts is an influential national leader in the design, operations and financing of modern best practice mental health services. At the same time, mental health system development and operations in Massachusetts are substantially influenced by the national health care and mental health policy, practice and financing context. This chapter describes the major national trends and policy/financing constructs that both constrain and provide opportunities to the Massachusetts mental health system.

5.1 Expanded Role of Medicaid as a Payer for Inpatient and Outpatient Services

In recent years, Medicaid has become the single largest payer for mental health and substance use services throughout the United States. In 1986, Medicaid spending for behavioral health services was $6.6 billion, whereas in 2005 it was $35.7 billion. In 2005, Medicaid paid for 26 percent of all behavioral health services, and only 17 percent of all other health care services.[14] As a corollary, in 2005, over 11 percent of all Medicaid spending was for behavioral health services, while behavioral health accounted for only 7 percent of all other health care services costs for non-Medicaid payers.

At the same time as the absolute amount of Medicaid payments was rising, the amount of state general funds paid for behavioral health services was decreasing. In 1986 state general funds constituted 28 percent of all behavioral health spending. By 2005 that proportion had decreased to 21 percent.[15]

This conversion from state general funds to Medicaid reimbursements for behavioral health services has continued rapidly. Although fully validated figures are not available for years after 2005, Medicaid was expected to equal at least 66 percent of all behavioral health expenditures by 2017.[16]

The fact that Medicaid has become the dominant payer for mental health services has caused many substantial changes in public mental health systems of care. As will be described in more detail below, one major change has been the shift away from state-operated mental health institutions. Because they provided care in segregated settings and were ineligible for Medicaid reimbursement for persons aged 21 to 64 because of the Institutions for Mental Disease (IMD) rule, as discussed below. Another major change has been in the roles and responsibilities of state mental health agencies. Because of the expansion of Medicaid reimbursements, state Medicaid agencies are now more responsible for the purchasing, delivery and oversight of community mental health services than they had been in the past. In many states it is the Medicaid agency, not the mental health agency, which specifies provider and practitioner qualification requirements to receive reimbursement, as well as the "medical necessity" criteria which define the amount, duration and scope of services that individual Medicaid beneficiaries may receive.

Except for certain non-medical specialty services such as long term residential care, most community mental health providers now receive payments from multiple payer sources (Medicaid, Medicare, and commercial insurance) and no longer depend solely on the State mental health agency for either policy leadership or financial support. Because of the shift towards Medicaid-reimbursable inpatient psychiatric acute care in general hospitals as opposed to IMDs (see below), most state mental health agencies do not license or monitor the majority of inpatient care provided within their states. In Massachusetts, for example, although DMH does license psychiatric inpatient units within general hospitals as well as private psychiatric hospitals, it has few resources for monitoring these services. More important, because

DMH is not the payer for these services, it has little leverage to control how the general hospital (and private psychiatric hospital) units actually function within the overall system.

5.2 Budget Cuts at State Mental Health Authorities (SMHAs)

Primarily as a consequence of substantial state revenue short-fall from 2007 through 2012, the general fund budgets of most state mental health agencies have been severely reduced in recent years. The National Alliance on Mental Illness (NAMI) reported in 2011 that over $1.6 billion had been cut from state budgets for mental health services.[17] The National Association of State Mental Health Program Directors has tabulated more than $4.35 billion in overall state mental health care budget cuts between 2008 and 2012.[18] The Massachusetts DMH had budget cuts totaling over $50 million, an 8.1 percent budget cut, during this time frame.[19]

These budget cuts have, of course, negatively affected mental health consumers throughout the United States. They have also further reduced the influence and authority of state mental health agencies vis-à-vis state mental health systems. This loss of authority is not just related to reduced payments for services but also to increased provider reliance on other payers such as Medicaid and commercial insurance. The budget cuts have also resulted in substantial reductions in clinical and program quality management capacity among state mental health agencies. The consolidation of smaller Area Offices into Regions, and then the consolidation of Regions into ever larger geographic area in Massachusetts is one example of the consequences of these budget reductions. As will be discussed later in this report, this loss of clinical and programmatic leadership and capacity through the designated state mental health agencies has hindered efforts to assure that mental health consumers receive the right services at the right time in the right amount to prevent crises and over-reliance on ED and hospital resources.

5.3 Diminished Role and Span of Authority at State Mental Health Authorities (SMHAs)

As noted in the preceding subsection, the role and authority of SMHAs has been disrupted not only by budget reductions, but also by fragmentation of payer sources and regulatory authorities. However, enabling legislation remains in effect in many parts of the country suggesting that the SMHAs continue to have responsibility in areas where they now lack the fiscal resources or regulatory authority to execute those responsibilities. While the role of Massachusetts DMH has diminished, and in fact legislation has narrowed DMH's original mission, the perception remains that DMH maintains its original enabling mandate in MGL Chapter 19 and operating responsibilities in MGL Chapter 123, in which DMH had broad authority and responsibility for the mental health of the residents of the Commonwealth. In Chapter 599 of the Acts of 1986, which split DMH into separate departments of mental health and mental retardation, a narrower mission was framed for DMH. That narrower mission is to "provide for services to citizens with long term or serious mental illness and research into the causes of mental illness." Subsequently, DMH revised its regulations in 104 CMR to outline the Department's revised authority, mission and organizational structure. Additional provisions are outlined in those regulations for licensing and operational standards for inpatient facilities and community programs (both state operated and privately operated facilities and programs), as well as standards for service planning, fiscal administration, research, investigation procedures, and citizen participation. DPH, under 105 CMR, licenses clinics, including mental health clinics, and as the integration of behavioral health and primary care expands, DPH will be increasingly involved in regulating community mental health services. In the Commonwealth, as MassHealth has grown more dominant as a payer and enrollment of beneficiaries in

MCEs has advanced, MBHP and Medicaid MCEs manage care. These organizations have the responsibility for care management and network oversight to ensure delivery of effective care, as well as the authority to assure standards of access and practice for the children and adults – once the purview of DMH.

As will be discussed in greater detail in Chapter 6, the statutory context for operating the public and private mental health care system in the Commonwealth is complex and has evolved in the last decade, with key changes in parity and health care reform legislation moving to the regulatory and implementation compliance phases during the last year. Given this churn in the regulatory and financing environment, the fragmentation of authority and lack of regulatory and financing alignment among public and private payers, as cited in the discussion of the Massachusetts Context in Chapter4, above, is not surprising, however challenging for those engaged in the care system in Massachusetts. ..

5.4 Changes in the Roles and Functions of State Psychiatric Hospitals

In 1950 in the United States there were over 500,000 state/county public psychiatric hospital beds. As of 2010 there were fewer than 44,000 such beds throughout the United States.[1] In 1955 there were 340 public psychiatric beds per 100,000, and by 2005 this number was down to 17 beds per 100,000: a 95 percent reduction.[20] At the same time, the number of psychiatric beds in general hospitals increased from virtually none in the late 1940's to over 54,000 by 1998 (note: this number has been reduced to about 40,000 today). In the late 1940's over 94 percent of psychiatric inpatient care was provided in public mental health facilities: by 1998 almost 50 percent of such care was provided in general hospital psychiatric units. In addition, the number of private psychiatric facility beds increased from less than 15,000 in 1970 to almost 45,000 in 1990.[21]

This shift was in large part driven by humane and clinical concerns about quality of care and the negative effects of long term institutionalism on people with mental illness. The Community Mental Health Centers Act of 1963 was expected to be a remedy for long term institutionalization. The Act was amended over the years to add essential services needed to supplant the multiple functions of institutional care. The introduction of psychotropic medications also allowed many previously hospitalized to function effectively in the community. In addition, the enactment in 1980 of the Civil Rights of Institutionalized Persons Act (CRIPA) enabled legal challenges to involuntary long term institutionalization and to inadequate care in large public facilities. CRIPA predated the American's with Disabilities Act (see below), and resulted in the closure or downsizing of many state hospitals. The Brewster Consent Decree related to Northampton State Hospital in Massachusetts resulted from a CRIPA lawsuit. Finally, the enactment of Medicaid in 1965, with its parallel allowance for inpatient psychiatric care in general hospitals and prohibition of reimbursement for IMDs (see below), fostered the development of general hospital alternatives to state-operated inpatient care. The end result of all these complementary forces was to significantly reduce the need and demand for state operated inpatient psychiatric care.

Today, in most states acute psychiatric care is provided via mental health crisis programs (mobile and residential) and in general hospitals. The remaining state hospital beds generally provide forensic services (evaluation, restoration to competency and long term commitment for people found not guilty by reason of insanity) and continuing care for people not ready for discharge to the community after a short

[1] Data aggregated from NASMHPD.

term acute hospitalization. In fact, these are the primary uses of the remaining state-operated psychiatric facility beds in Massachusetts.

5.5 Institution for Mental Disease (IMD) Exclusion

"Section 1905(a) of the Social Security Act prohibits the federal government from reimbursing states under the Medicaid program for services rendered to a Medicaid beneficiary who is a patient in an institution for mental disease (IMD)."[22] In accordance with this statutory prohibition, CMS has have defined an IMD as: "…a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care for people with mental disease…."[23]

The IMD exclusion does not apply to people 65 and older or to youth under age 21. Nor does it apply to facilities with 16 or fewer beds. Typically, the IMD exclusion applies to private inpatient psychiatric treatment facilities, such as McLean Hospital, as well as to public mental health inpatient facilities. However, Massachusetts has a special Medicaid 1115 waiver that allows some payments under the waiver's global cost caps for certain IMDs. Several DMH facilities, including Taunton State Hospital, are included as approved providers under this waiver.[2] The 1115 waiver is due to expire June 30, 2014, and at this point it is not known whether the IMD waver portion of the overall 1115 waiver will be included in any new CMS waiver approvals.

As currently configured, the DMH inpatient service at Taunton State Hospital is an IMD, and thus Medicaid will not reimburse for care and treatment provided to Medicaid beneficiaries between the ages of 22 and 64 who are patients at the hospital. A similar prohibition would apply to any mental health inpatient or residential program operated by DMH under the aegis of TSH. Vendor operated programs, such as the Department of Youth Services (DYS) secure detention program on the TSH campus do not fall under the CMS IMD exclusion. The IRTP operated by a vendor in the Cain building at TSH also is not an IMD because, although it provides mental health treatment, it is only for youth 21 years-of-age or younger.

The Highpoint substance use treatment program about to open at TSH might be considered by CMS to be an IMD. The CMS State Policy Manual states:

> "***Chemical Dependency Treatment Facilities:*** The ICD-9-CM system classifies alcoholism and other chemical dependency syndromes as mental disorders. There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs. At the other end of the spectrum of care are facilities that are limited to services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment.[24]"

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[2] Worcester State Hospital is also an approved provider under the waiver, so if inpatient beds are transferred from TSH to WSH there should be no loss of revenue under the waiver.

This could become an issue for potential re-use of Taunton State Hospital (TSH) re-use, given the potential to expand substance use treatment programming at TSH.

As noted above, all states in the US, including Massachusetts, have made serious efforts to shift the costs of mental health services away from state general fund appropriations and towards Medicaid services that, at a minimum, receive 50 percent federal reimbursement. In parallel with quality of care and clinical effectiveness motivations, one of the primary reasons for states to shift care away from large state operated inpatient facilities has been the IMD exclusion. As a practical matter, a decision to operate facility-based care and treatment in an IMD, or a facility that is likely to be treated as an IMD by CMS, is a decision to forego federal reimbursements for the services.

In the past, many states, including Massachusetts, have used Medicaid Disproportionate Share (DSH) payments to partially fund services in public mental health IMD facilities. In this way, states have at least partially mitigated the loss of federal revenues attendant to providing care in IMDs. However, under the ACA, DSH payments to states are being phased down over the next few years. Once the phase down of DSH payments is complete (effective 2021), states will have only minimal DSH resources from the federal government.[3] States continuing to operate IMDs will thus be forced to use primarily general funds appropriations to support these facilities after 2021.

5.6 Americans with Disabilities Act (ADA) and Olmstead Decision

Title II of the Americans with Disabilities Act (ADA) specifies that people with disabilities must be afforded opportunities to live in the least restrictive setting appropriate to their abilities. According to a recent federal DOJ policy brief, integrated settings are characterized as:

> "*Integrated settings are located in mainstream society; offer access to community activities and opportunities at all times, frequencies and with persons of an individual's choosing; afford individual's choice in their daily life activities; and, provide individuals with disabilities to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered site housing with supportive services are examples of integrated settings. By Contrast, segregated settings often have qualities of an institutional mature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individual's ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities*."[25]

Based on the 1999 Supreme Court decision in ***Olmstead v. L.C.***, states have an affirmative obligation to assure that people with disabilities who choose to live in integrated community settings have maximum opportunities to do so consistent with the resources available to the State. The fact that a given state might have resources committed to institutional settings and thereby claims to have insufficient resources to provide community alternatives has been found in many courts to be no defense.

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[3] As the law currently stands, DSH payments to states are supposed to return to their 2014 levels effective in 2023. However, there is no assurance that such payments will in fact be restored.

There are 12 states with active *Olmstead*-related mental health settlement agreements or investigations. These are: Arizona, Connecticut, Delaware, Georgia, Illinois, Kentucky, Mississippi, New Hampshire, New Jersey, New York, North Carolina, and Oregon.

In concert with the ADA/*Olmstead* mandate for community living in the most integrated settings, CMS recently issued guidance [26] on community settings in which it is allowable to provide HCBS services for Medicaid recipients. In its final rules setting requirements for HCBS, CMS made it clear that publicly or privately owned facilities providing inpatient treatment are presumed not to be community based. The salient characteristics of integrated settings are:

- "The setting is integrated in and supports full access of individuals …into the greater community, including opportunities to seek employment and work in competitive settings, engage in community life, control personal resources, and receive services in the community…
- Ensures the individual's rights of privacy, dignity and respect and freedom from coercion and restraint; and
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, [such as] daily activities, physical environment and with whom to interact." [27]

In combination, the Medicaid IMD exclusion and the ADA Title II and *Olmstead* mandate to provide services for people with disabilities in the most integrated settings provide powerful incentives to select integrated community settings for the care and treatment of people with mental illness. As will be discussed further in Chapter 14, both the IMD exclusion and the ADA/*Olmstead* mandate constrain options for re-use of Taunton State Hospital.

5.7 Affordable Care Act (ACA) and Mental Health Parity and Addiction Equity Act (MHPAEA) Implementation

The 2010 enactment of the Affordable Care Act (ACA) signaled significant changes in health care delivery and financing throughout the United States. Two years previously, in 2008, the Paul Wellstone Mental Health Parity and Addictions Equity Act (MHPAEA) was enacted, requiring insurance plans to cover mental health and substance use services at parity with general health services. In combination the two acts promise to expand overall health insurance or Medicaid coverage, and to assure that covered individuals have equitable access to mental health and substance use services.

In 2006, Massachusetts enacted its own version of health reform, mandating and assuring health insurance or Medicaid coverage for all citizens of the Commonwealth. As of 2012, over 95 percent of the citizens of Massachusetts had enrolled in either commercial insurance or Medicaid, or already had coverage through Medicare. In addition, Massachusetts had a Medicaid 1115 waiver that allowed many high-risk, high-cost childless adults to enroll in Medicaid even before health reform was enacted. In 2008, Massachusetts enacted its own mental health parity act. Thus, in many ways Massachusetts had anticipated health and mental health reform at the national level, and had become one of the earliest adopters of both universal coverage and mental health insurance parity. One consequence of this widespread Medicaid and commercial insurance enrollment is that very few people with mental illness were uninsured, and thus very few needed services funded by general fund appropriations as opposed to Medicaid, Medicare or commercial insurance. One positive of this change for Massachusetts has been the opportunity to re-direct state general fund dollars into non-Medicaid services that are critical to assisting individuals to live in integrated community settings.

The ACA strengthened health reform in Massachusetts, but did not substantially change its focus or direction. The early health reform activities carried out by Massachusetts are among the reasons that both Medicaid and commercial insurance plans are substantial payers for mental health inpatient and outpatient services in Massachusetts today.

The final federal rules for parity are detailed in the subsequent section of this report. Other provisions impacting Massachusetts, despite its early health care reform are the relationship between expansion of eligibility for Medicaid and essential health benefits coverage, demonstrations to manage better the care of persons who are dually eligible for Medicaid and Medicare, and initiatives for long-term care rebalancing.

There are two major policy initiatives incorporated in the ACA that accompany Medicaid and commercial insurance coverage expansions and benefits reforms. These are: (a) health care integration; and (b) long term care rebalancing. Health care integration refers both to the blending of primary and specialty health care with mental health and substance use services, and to the implementation of mechanisms to integrate and coordinate care for individual participants at the point of service level.[4] Long term care rebalancing refers to several complementary strategies aimed at reducing high health care costs associated with facility-based long term institutional care. The Massachusetts One Care program, one of 15 state level demonstration projects for people who are dually eligible for Medicare and Medicaid, is an example of both of these types of initiatives. One Care will integrate care across physical and behavioral health, and will seek to reduce facility-based inpatient and long term care through prevention, care coordination and disease management strategies.

The health care integration and long term care rebalancing initiatives promise better and more cost effective care for people with mental illness and other health conditions. As will be discussed in Chapter 9 on crisis services and emergency room boarding, it is well documented that people with multiple disabilities or health conditions are difficult to serve and difficult to move along from ED presentations. Access to coordinated care entities for people with mental illness should, over the long term, both reduce ED and acute hospital care, and provide a single point of clinical responsibility that can assist to effectuate more appropriate dispositions. However, as these initiatives are being developed, there could be additional diffusion of accountability. In the near term there could also be some confusion about who the payer will be for certain types of services. The challenges of assigning and assuring accountability for continuity of care and appropriate payment for appropriate services, which are discussed in greater detail in Chapter 13, may be exacerbated during the implementation phases of these various initiatives.

5.8 Impact of National Policy, Legal and Financing Changes on Massachusetts

National policy and financing contexts have a number of consequences for Massachusetts. These include:

- Increased Medicaid financing and authority for mental health services, with consequent reduction to the span of control and authority of DMH;

[4] In addition, the SAMHSA has funded a number of provider level efforts to coordinate behavioral health with physical health within community mental health centers, federally qualified health centers, or community health centers. Two of these demonstration projects have been funded in Massachusetts.

- A diffusion of resources and authority, which has dispersed the system's capacity to exercise clinical and programmatic leadership and accountability throughout Massachusetts;
- Slow uptake and adherence to federal parity requirements, due to late promulgation of rules and regulations, which has delayed commercial insurers implementation of more robust rehabilitative and recovery support services, including residential services (most noticeably in the Commonwealth with children and adolescents who are privately insured, in need of residential treatment, and utilizing the majority of DMH-funded IRTP beds, limiting flow of publicly insured children and adolescents out of inpatient settings);
- An overall shift to Medicaid and commercial insurance coverage for inpatient and outpatient psychiatric care, and consequent reduction in the demand and need for publically operated facility based care in Massachusetts; and
- The combined effects of the Medicaid IMD exclusion and the ADA/*Olmstead* community integration mandate, which militate against any expansion of state operated inpatient or related facility-based services under the aegis of a state mental health hospital.

These themes and consequences that are driven by the national policy and financing provide the context within which this report addresses issues and problems in the Commonwealth's mental health system. They also provide both direction for and limitations to the solutions and recommendations issues presented in this report. Understanding this significant policy and financing imperatives is critical to assessing the feasibility and potential cost effectiveness of the various mental health system reform and improvement options presented in this report for consideration by the Legislative Committee.

6. Statutory Context

Massachusetts' mental health care system operates under a statutory and regulatory framework informed by State and Federal laws. These include, but are not limited to:

- MGL Chapter 19, Section 1 – DMH Enabling Legislation
- MGL Chapter 123 – Massachusetts Commitment Laws
- MGL Chapter 80, Acts of 2000; Chapter 256, Acts of 2008 – Massachusetts Parity Laws
- MGL Chapter 58, Acts of 2006 – MA Health Care Reform Law
- MGL Chapter 224, Acts of 2012, follows Chapter 288 of 2010 – Massachusetts Quality and Cost Reforms
- Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 – Federal Parity Law
- Affordable Care Act (ACA) of 2010– Federal Health Care Reform Law
- Olmstead and Americans with Disabilities Act (ADA)

6.1 MGL Chapter 19, Section 1 – DMH Enabling Legislation

DMH operated pursuant to enabling legislation that, as noted earlier, was amended in 2009 to narrow its mission to serving persons with long-term or serious mental illness, while preserving language that DMH consider broader issues and concerns affecting the mental health of all citizens of the Commonwealth, as follows:

> *"The department shall take cognizance of all matters affecting the mental health of the citizens of the commonwealth; provided that the primary mission of the department shall be to provide for services to citizens with long-term or serious mental illness, early and ongoing treatment for mental illness, and research into the causes of mental illness. The department shall have supervision and control of all public facilities, for mentally ill persons and of all persons received into any of said facilities and shall have general supervision of all private facilities for such persons; provided, however, that this sentence shall not be deemed to interfere with or supersede any other provision of general or special law which grants or confers supervision and control of certain public facilities for mentally ill persons and persons admitted to such facilities or which grants or confers supervision over certain private facilities for such persons, to any other department of the commonwealth or to any political subdivision." (Citation)*

6.2 MGL Chapter 123 – Massachusetts Commitment Laws

The laws governing commitment to psychiatric treatment facilities in the Commonwealth are found in MGL Chapter 123. There are numerous provisions of the commitment laws, with individual sections of the law pertaining to different circumstances or facilities, as well as differences between civil commitments and commitments of persons charged with, convicted of or under sentence for violations of the criminal code. Outlined below are those sections covering:

- *Civil commitment and retention of dangerous persons under Sections 7 and 8:* Section 7 provides for civil commitment to and retention of dangerous persons at DMH facilities or Bridgewater State Hospital; provisions address the filing of petitions, notice hearing, in Juvenile and District Courts ; hearings must occur within 14 days ; Section 8 details required proceedings to commit persons who are dangerous to themselves or others by reason of mental illness; the Section outlines notice requirements, hearings, orders, and jurisdiction; provides for an initial 6 month and subsequent 1 year commitment;
- *Voluntary and Involuntary Admission under Sections 10, 11 and 12:* Section 10 provides for voluntary admission of a person aged 16 or older, and outlines provisions for consultation with an attorney; voluntary commitment is to public and private psychiatric hospitals and VA hospitals; Section 11 describes additional provisions of voluntary admission, including withdrawal and required notice to leave; restrictions may apply, and 3 day notice is required; Section 12 covers Involuntary Admission, including emergency restraint and admission of a person posing risk of harm to self or others by reason of mental illness; commitment is for a three day period, unless the superintendent pursues a Section 7 or Section 8 commitment.
- *Commitments to Bridgewater State Hospital under Section 13 and 14:* Section 13 details provisions for transfer of dangerous males who have mental illness to Bridgewater State Hospital; transfer is for a period of 5 days, unless Section 7 or Section 8 petitions are filed; Section 14 covers transfer from Bridgewater to state hospitals or facilities designated by the Commissioner; transfers are to be executed within 30 days.
- *Competency to Stand Trial and Findings of Continuing Incompetence or Not Guilty by Reason of Mental Illness under Sections 15 and 16:* Section 15 covers evaluation for competency to stand trial; the period of confinement can be up to for 50 days, and can be followed by a petition under Section 8 for commitment for 6 months; Section 16 covers the hospitalization of persons incompetent to stand trial or found not guilty by reason of mental illness.
- *Hospitalization of Prisoners with Mental Illness:* Section 18 provides for hospitalization of mentally ill prisoners, covering requirements for hearing, voluntary admission, reduction in sentence aligned with length of time hospitalized, and discharge. Alternatives are discussed in Chapter 14 of this report.
- *Section 35 Commitment of Persons with Addictions:* Permits the commitment of persons with a substance use disorder; this civil commitment is carried out in correctional facilities in the Commonwealth. Alternatives are discussed in Chapter 14 of this report.

6.3 MGL Chapter 80, Acts of 2000, Chapter 256, Acts of 2008 Massachusetts Parity Law and Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 – Federal Parity Law

Chapters 80 and 226, the State Mental Health Parity laws, provided certain authorities to the DMH Commissioner and expanded coverage from a specific list of "biologically based" disorders to include substance use disorders, eating disorders, post-traumatic stress disorder and autism.

Chapter 224, Sections 23 and 254, provided for the DoI to implement and enforce the Federal Parity law, MHPAEA, in Massachusetts, regulating and auditing commercial health plan activities, including

examination of care authorization and medical necessity review criteria employed by health plans. This review is currently underway at the DoI, with a report anticipated before the end of the fiscal year.

Federal parity, closely aligned with Massachusetts' parity law, now focuses on ending discrimination in covered diagnoses, covered benefits, administrative rules and patient costs, including treatment and financial limitations associated with use of behavioral health services. Final Federal Parity Regulations were issued in late 2013 and require:

- Full implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, eliminating in health plans any discriminatory co-pays, deductibles and visit limits that may be more restrictive for mental health/substance abuse disorders benefits than they are for medical/surgical benefits;
- Applying parity to intermediate levels of care received in residential treatment or intensive outpatient settings;
- Ensuring transparency in health plans' disclosure of the rights of plan participants under the law;
- Clarifying that parity applies to all plan standards, including geographic limits, facility-type limits and network adequacy; and
- Eliminating earlier provisions permitting insurance companies to make an exception to parity requirements for certain benefits based on "clinically appropriate standards of care," determining that that earlier provision was both confusing and open to potential abuse.[28]

6.4 ADA Olmstead Decision and Massachusetts' Community First Initiative

DMH created its Community First Initiative to champion people's right to live as independently as possible in the community. The DMH Plan aligns with the 2008 Executive Office of Health and Human Service (EOHHS) Community First Olmstead Plan, a roadmap and action steps to ensure that people with disabilities and elders have access to community living opportunities and supports that address each individual's diverse needs, abilities and backgrounds.

The Commonwealth's Olmstead Plan is designed to:

- Help individuals transition from institutional care;
- Expand access to community-based long-term supports;
- improve the capacity and quality of community-based long-term supports;
- Expand access to affordable and accessible housing with supports; and
- Promote employment of persons with disabilities and elders.

6.5 Section 113 of Chapter 58 of the Acts of 2006: Medicaid Managed Care Alignment

Section 113 of Chapter 58 of the Acts of 2006 ensures that DMH maintains a role in the design of behavioral health care under the State's Medicaid Plan and Waivers, specifying DMH review and approval of plans and provisions adopted under Title XIX/Medicaid and Title XXI/Children's Health Insurance Program (CHIP). All managed care organizations, including any specialty behavioral health

managed care organizations contracting or delivering behavioral health services to Medicaid or CHIP recipients, must obtain the DMH Commissioner's approval of behavioral health benefits; policies, protocols, standards, contract specifications; utilization review and utilization management criteria; and outcome measurements.[29]

7. Major Observations

7.1 Needs of Massachusetts Residents for Mental Health Prevention, Treatment and Recovery Support

The National Institute for Mental Health (NIMH) notes that 26.2 percent of adults ages 18 and older have a diagnosable mental disorder in any given year. NIMH also notes that 13 percent of youth between the ages of 8 and 15 have a diagnosable mental disorder in any given year. A recent study cites the prevalence of child and adolescent mental disorders as ranging from 13 to 20 percent.[30] Risk factors for development of mental disorders in children include parental depression,[31] abuse and neglect and other adverse childhood events.[32,33] Sequelae of mental illness untreated mental illness in children include suicide,[34] addiction, impaired social school and social functioning, and lower earning potential as adults.[35]

DMH cites in its State Plan that children and youth, while making significant gains in access through the Child Behavioral Health Initiative, have outstanding needs for access to timely treatment, educational supports, family engagement, and transitional services to young adulthood. DMH similarly cites in its State Plan that adults and elders have significant outstanding needs for timely access to treatment, housing and recovery supports, including employment. And, across the lifespan, DMH indicates that disparities persist in access to appropriate and timely care for persons from racial, cultural and linguistic minorities in Massachusetts.

In 2010, DMH provided services to 27,813 people. 19,981 of these people met the federal definition for serious mental illness or serious emotional disturbance as determined through the DMH service authorization process and are authorized to receive DMH services.[36] In testimony to the Joint Hearing of the House and Senate Committees on Ways and Means in February of 2014, the DMH Commissioner reported that the current number of children, adolescents and adults served through the DMH network is approximately 21,000.[37] Opportunities for prevention and early intervention argue for greater integration of behavioral health in primary care settings, schools, and community support organizations. Similarly, complex medical and behavioral conditions found co-occurring among adults and elders argue for greater integration of behavioral health in primary care settings, and collaborative care initiatives between behavioral health and other medical specialties. SAMHSA reports that more than 8.9 million persons in the US have co-occurring mental health and substance use conditions. [38] In another SAMHSA report, indicators for co-occurring behavioral health and other chronic health conditions include findings that among the estimated 20.3 percent of the community-dwelling population aged 18 to 64 in the US who have behavioral health conditions, significant numbers had co-occurring asthma and hypertension. [39]

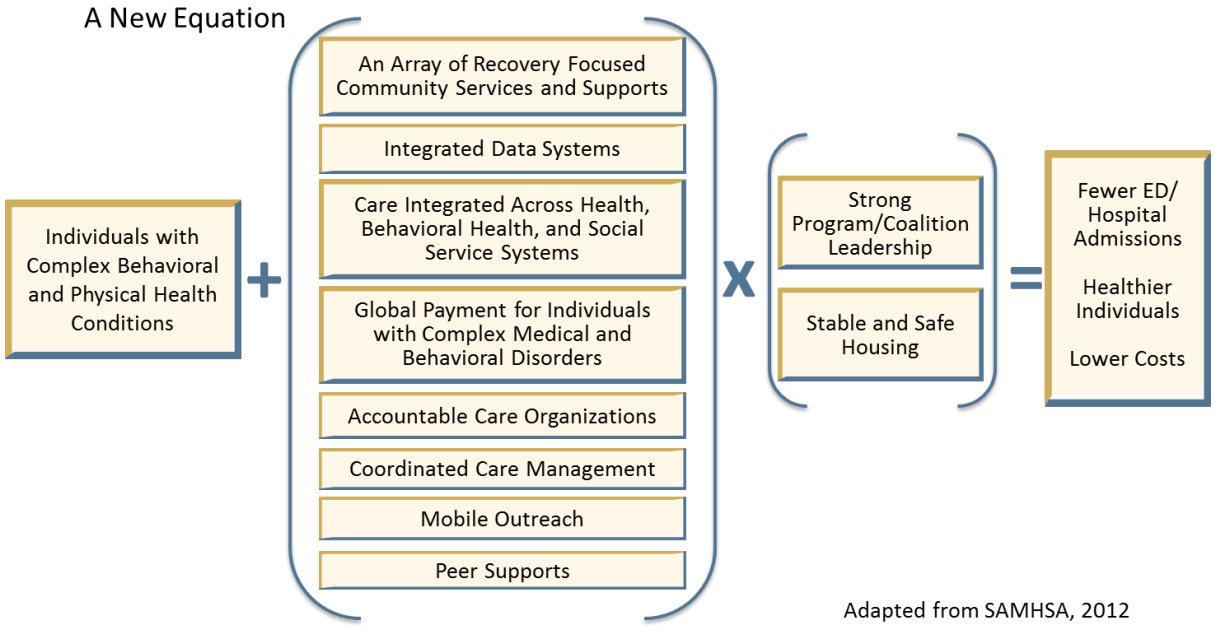
Preventive, treatment, rehabilitative and recovery support services are key for publicly- and privately-insured persons. The Massachusetts system of care emphasizes treatment, clinical services, rehabilitation and recovery. The central aim of service delivery is to integrate public and private services and resources to provide optimal community-based care and opportunities for clients. The Massachusetts system has a goal to reduce the need for unnecessary hospitalization and out of home placement by improving integration of acute diversion with community support services for children and adults with serious and disabling conditions.

7.2 Need for Effective, Integrated Care System Response to Complex Health Conditions

An estimated 23 percent of the US population of children and adults are affected by mental health and/or substance use disorders (MH/SUD) each year.[40] The onset of these conditions is often in childhood and adolescence. Co-occurrence with another behavioral health condition and/or other medical conditions is common, yet long delays between onset of behavioral health conditions and diagnosis and treatment is characteristic. Delays between diagnosis and treatment range from 6 to 8 years for individuals who eventually received treatment for mood disorders and between 9 and 23 years for those who sought treatment for anxiety disorders.[41] These delays combined with low rates of treatment result in unnecessary morbidity, disability and mortality, Research scientists find that most people (about 90 percent) receive behavioral treatment in the primary or general medical setting, while 68 percent get no treatment or get under-treatment for their behavioral health conditions.[42] Other findings indicate that an estimated 29 percent of individuals with chronic health conditions have mental health problems, yet most receive little behavioral health treatment and have poorer outcomes for all of their health conditions.[43,44]

As illustrated in **Exhibit 2** below, for individuals with complex behavioral and physical health conditions, an effective, integrated care system with timely access to a comprehensive array of health services, tied to stable and safe housing can reduce cost and improve outcomes.

Exhibit 2. "A New Equation to Overcome High Cost, Poor Quality, Siloed Care"



7.3 Meeting Complex Needs Requires Focused Interagency and Interorganizational Collaboration

Collaboration among DMH, MassHealth, and Medicaid MCEs is essential to assure an adequate and coordinated network of appropriate options in the public mental health system. Collaboration between DMH, MassHealth, DoI and MCEs/Health Plans serving the commercial insurance market is essential to assure balance and continuity across the public and private systems.

Children and adolescents rely on collaboration between DMH, EOHHS, DCF, and Department of Education (DOE) to ensure alignment and continuity of goals and services across settings throughout the developmental period. Adults depend on DMH and the DPH Bureau of Substance Abuse Services (BSAS) collaboration to address the high rates of comorbid mental health and substance use conditions, planning with MassHealth on procurements designed to integrate care. Collaboration between DMH, BSAS and MassHealth with Departments of Corrections and Youth Services (DOC and DYS), Public Safety and the Courts is critical to preventing criminal justice involvement, jail diversion, improved treatment alternatives, re-entry services and sound management of forensic services.

7.4 Statewide Capacity Concerns and Considerations

Statewide capacity concerns and considerations will be further detailed in subsequent chapters of this report. The capacity issues include, but are not limited to:

- Child and adolescent services targeted to those with emerging and serious emotional disturbances, who may be covered under either public insurance programs or private insurance plans;
- Housing, community-based treatment and recovery support services for adults with serious mental illnesses and co-occurring chronic health conditions, with particular concern about capacity to treat those with dual mental health and substance use conditions;
- Outpatient services to both those who are publicly insured and those who are privately insured, particularly if these individuals are in need of specialized or intensive services that require skilled, seasoned clinicians;
- Acute psychiatric inpatient care for children, adolescents, adults and elders who may be clinically, behaviorally or medically complex; and
- Diversion and reintegration services for youth and adults at risk of and involved in the criminal justice system, particularly in addressing the high prevalence of dual mental health and substance use conditions.

8. Findings and Recommendations: Inpatient Acute and Continuing Care Bed Need and Implications for Taunton State Hospital

8.1 Overview and Questions to Be Addressed

The purpose of this chapter is to address questions related to inpatient psychiatric treatment capacity in Massachusetts, with a special focus on capacity located in the southeastern portion of the State. This work was completed in Phase I of the study in 2013. As emphasized throughout this report, the number of psychiatric beds needed and used in an overall system of care is dependent on many factors. These include the availability of community alternatives to inpatient treatment and long term care; state level efforts to comply with the community integration mandate of the American's with Disabilities Act; and the extent to which financial incentives such as managed care modalities are employed in each jurisdiction. The relative supply and accessibility of private sector acute and specialty psychiatric inpatient facilities and beds is also a major determinant of the overall adequacy of inpatient treatment capacity in each state.

Abt/TAC conducted an exhaustive literature review related to inpatient psychiatric care. There are no peer reviewed studies or evaluations that would support conclusions about the adequacy of or a formula for psychiatric bed supply for a given population. Nor are there any reliable studies that support a relationship between bed supply, admission rates or lengths of stay (LOS) and other factors such as quality of life and positive health and mental health outcomes for people with mental illness. There are many anecdotal and media reports linking the closing of public mental health facilities to increased homelessness and incarceration, but these typically also identify the failure to develop community alternatives to hospitalization as contributing factors. The peer reviewed studies that have been done strongly support using community alternatives to institutionalization, as long as adequate resources are available for community services.[45]

The adequacy of the supply of public and private psychiatric inpatient capacity cannot be analyzed in an objective scientific context: it must be analyzed in the context of myriad state and local environmental and systemic factors that in combination provide a more or less balanced system of mental health inpatient (acute, specialty, forensic and continuing care) and outpatient (physician, medication, clinic, rehabilitation, and community support) services.

All of the discussion below must be interpreted in the context of the above discussion. The data presented point to certain conclusions, but there are many caveats and variables to be considered. More importantly, Abt/TAC was unable to obtain inpatient data for acute inpatient care provided under Medicaid managed care organizations (MCOs) or commercial insurers, with the exception of aggregate data reported by MBHP. We have no data for psychiatric inpatient admissions, lengths of stay, discharge destinations, or re-admissions from these payers. Absent these data we are unable to assess the degree to which these insured populations access and utilize available psychiatric bed capacity in Massachusetts or in the southeastern region. Nor can we identify the extent to which these covered populations are among the numbers of people described as boarding in hospital EDs awaiting an inpatient bed. We believe that commercially- and MCO-covered people are a substantial portion of the "demand component" for inpatient psychiatric care, but we cannot document the degree to which they actually access and use current bed capacity. This will be identified later in this report as an important area for additional data collection and analysis on an on-going basis.

The specific questions to be addressed in this chapter are:

- How does Massachusetts compare to the nation with regard to the availability of psychiatric inpatient beds?
- How many psychiatric inpatient beds are located in Southeastern Massachusetts?
- What psychiatric inpatient utilization patterns can be described using data from DMH?
- How do DMH continuing care beds function within the overall system of care in Massachusetts?

8.1.1 How does Massachusetts Compare to the Nation with Regard to the Availability of Psychiatric Inpatient Beds?

Massachusetts has a total of 3,052 psychiatric inpatient beds.[5] Six hundred and fifty-one of these are operated as continuing care and forensic beds by DMH. The remaining 2,426 beds are included in 66 facilities throughout the Commonwealth with psychiatric beds licensed by DMH. **Table 1** presents a summary of these inpatient beds by type.

Table 1. Licensed Psychiatric Inpatient Beds in Massachusetts in 2013

	Adult Inpatient beds	Child-Adolescent Inpatient Beds	Geriatric Inpatient Beds	Total
Private beds licensed by DMH	1,740	313	373	2,426
DMH operated Beds	651[6]			651
Total	2,391	313	373	3,077

Table 2 contains the 2013 adult, elder and child adolescent population of Massachusetts, the year in which Phase I of this study was completed.[46] These population numbers are used to calculate beds per 1,000 for each population sub group. It should be noted that: (a) there is no national data that is comparable on beds per 1,000 for the population sub groups; (b) there are no peer reviewed evaluation studies that support determination of the "correct" number of beds per 1,000 for each population group; and (c) even within Massachusetts there are some variations in terms of which population sub-groups are served within each category. For example, some adolescent units serve youth up to age 21, while other serve youth up to age 18. Also, some adult beds may also be used for geriatric inpatient treatment.

[5] Unless otherwise noted, all data in this chapter are from DMH.

[6] DMH has 60 beds at Worcester State Hospital that are inactive because of lack of funding.

Table 2. Psychiatric Inpatient Beds per 1,000 in Massachusetts in 2013

Population Category	Estimated 2013 Population	Number of Psychiatric Inpatient Beds	Beds per 1,000
Adults	4,321,000	2,391	.55
Children/adolescents	1,414,000	313	.22
Elders	965,000	373	.39
Total	6,700,000	3,077	.46

As noted above, comparisons of beds per 1,000 between Massachusetts and other jurisdictions or national averages is questionable. National data on psychiatric inpatient capacity are untested and often dated. And, the definitions of categories/types of beds and sub-populations served vary by state and frequently are not disaggregated. The most recent data from the CMS and the SAMHSA shows a total of .425 beds per 1,000 for the total population.[47] This figure includes acute and continuing care beds as well as beds operated in both the public and private sectors. The data are not disaggregated by elders and children/adolescents and adults. The national average number of .425 beds per 1,000 is very close to the Massachusetts average of .46 beds per 1,000. When looking at acute psychiatric beds minus state operated and continuing care beds, Massachusetts has 0.355 beds per 1,000, as compared to .205 beds per 1,000 nationwide.[7] The higher number of private beds per 1,000 explains why Massachusetts, with a smaller than average complement of state hospital beds, still has an equivalent number of overall psychiatric beds compared to national averages.

The primary conclusion to be drawn from these figures is that there is no evidence, either from research or from comparisons with national averages, that Massachusetts has either too few or too many psychiatric inpatient beds. Rather, Massachusetts appears to be close to the median in terms of overall psychiatric bed availability, yet with a higher number of beds in the private sector. This is consistent with very high insurance and Medicaid coverage/participation rates in Massachusetts, which facilitate commercial insurance and Medicaid payments for inpatient acute care. In states with larger proportions of publically operated inpatient facility beds, it is more common for state general fund appropriations to be used for inpatient care, particularly to cover the larger uninsured population.

8.1.2 What is the Distribution of Psychiatric Inpatient Beds in Southeastern Massachusetts?

Abt/TAC assembled inpatient bed data to document the extent to which Southeastern Massachusetts has a proportionate share of current inpatient bed capacity. **Table 3** shows the inpatient facilities in Southeastern Massachusetts with the number of licensed beds by type for 2013.

[7] Data are from the American Hospital Association – includes beds in general hospital psychiatric units and beds in free-standing private psychiatric hospitals.

Table 3. Licensed Psychiatric Inpatient Beds in Southeastern Massachusetts by Type

Facility	Beds	Occupancy Rate[8]
Arbor – Fuller South Attleboro	74 adult 14 adolescent	93% 81%
Brockton Hospital Brockton	22 adult	86%
Cape Cod Hospital Hyannis	20 adult	80%
Good Samaritan Medical Center Brockton	16 geriatric	80%
High Point Treatment Center Plymouth	16 adult	94%
Jordan Hospital Plymouth	19 geriatric	85%
McLean Southeast Brockton	25 adult	85%
Morton Hospital Taunton	15 geriatric	94%
Pembroke Hospital Pembroke	78 adult 19 geriatric 18 adolescent	90%
St. Anne's Hospital Fall River	16 geriatric	85%
St. Luke's Hospital New Bedford	30 adult	85%
Total	265 adult 32 adolescent 101 geriatric	Not Applicable

In addition to the above licensed beds in private facilities, there are 45 adult beds at Taunton State Hospital (TSH) and 16 adult beds each at Corrigan and Pocasset mental health centers. This results in a grand total of 475 psychiatric inpatient beds located in the southeastern region of Massachusetts. This represents 15.4 percent of the total supply of 3,077 psychiatric inpatient beds in Massachusetts in 2013.

DMH has developed "planning population" estimates for each of its service areas and corresponding regions of the State. This planning population includes the estimated number of people with serious mental illness who are the demand component/need population for inpatient and outpatient mental health services. According to DMH, 19.7 percent of the planning population for Massachusetts resides in the southeast region. Based on these calculations, the southeastern region has a somewhat lower proportion of psychiatric inpatient beds than the rest of the State as a whole.[9] In practice, access is managed on a statewide basis for both private and public inpatient psychiatric beds. Patients come into Southeastern Massachusetts to obtain care in the same way as citizens of Southeastern Massachusetts go to hospitals in

[8] 2011/2012 data from DMH point in time study – occupancy rates over 80% generally mean that the units are full a large portion of the time.

[9] To a certain extent this is driven by the high concentration of psychiatric inpatient beds in the greater Boston area. For example, the DMH Central/West Area is reported to have 25.9% of the planning population, but only 14% of the private/general hospital psychiatric beds are located in the Central/West Area.

other parts of the state to obtain care. Thus, a regional analysis of total available beds is somewhat misleading. Nonetheless, the information presented above suggests that Southeastern Massachusetts does not have too many inpatient beds comparably, and may in fact have slightly fewer than their fair share based on population.

8.1.3 How are DMH Psychiatric Inpatient Beds Used, and Are There Differences Related to Southeastern Massachusetts?

As noted in the introduction to this Chapter, Abt/TAC was unable to obtain data from commercial insurers and Medicaid MCOs related to private sector psychiatric inpatient admissions and utilization. However, we were able to obtain a substantial amount of data from DMH about the operations of its inpatient system. In this section of the report we present information on admissions, discharges and average lengths of stay for DMH facilities. In each case we present specific information relative to DMH inpatient utilization in the southeastern region.

Admissions to DMH Facilities

Table 4 includes information on admissions to DMH facilities by legal status. As can be seen in the table, a very high proportion of DMH inpatient admissions is used for forensic admissions (44 percent in 2012 and 42 percent in 2013). With the exceptions of Corrigan and Pocasset (both in the southeastern region), most of the remaining admissions are for continuing care. As will be detailed later in this section, most of the admissions to Corrigan and Pocasset are for acute psychiatric treatment.

Table 4. Admissions to DMH Facilities by Legal Status: 2012 and 2013

Facility	2012 Admissions	2012 Forensic	2012 % Forensic	2013 Admissions	2013 Forensic	2013 % Forensic
Worcester	322	208	64.6	405	241	59.5
Tewksbury	166	51	30.7	205	54	26.3
Shattuck	171	55	32.2	161	48	29.8
SC Fuller	228	200	87.7	270	247	91.5
Parkview	31	6	19.4	37	10	27.3
Taunton	225	197	77.3	125	92	73.6
Corrigan	206	0	0.0	248	0	0.0
Pocasset	239	0	0.0	184	0	0.0
Total	1,618	717	44.3%	1,635	602	42.3%

It should be emphasized that Taunton State Hospital (TSH) no longer accepts forensic admissions. This change does not yet appear in the admission data, because these data are for calendar years, not fiscal years. The data for 2014 should show a significant reduction in forensic admissions to TSH, with concurrent increases in other DMH facilities. Overall, TSH had a reduction of 100 admissions from 2012 to 2103, a 44 percent reduction. At the same time, admissions increased at Worcester Recovery Center and Hospital (WRCH) by over 20 percent, and forensic admissions increased by 26 percent at Solomon Carter Fuller. These changes reflect the opening of the new Worcester Recovery Center and Hospital

(WRCH) and the beginning trend away from forensic admissions at TSH. These changes have resulted in TSH now operating with a census of 45 continuing care beds.

Table 5 shows overall admissions to DMH facility by the origin of the patients admitted. Data from 2010 through 2013 is presented to identify any regional changes in admissions to DMH facilities.

Table 5. Admissions to DMH Facilities by DMH Areas for 2010, 2011, 2012 and 2013

Calendar Years	Southeast Area	Metro Boston Area	Northeast Suburban Area	Central/West Area	Unknown	Total
2010 admissions	598	364	421	263	28	1674
2010 % of admissions	36%	22%	25%	16%	1%	100%
2011 admissions	633	362	346	274	33	1648
2011 % of admissions	38%	22%	21%	17%	2%	100%
2012 admissions	608	351	350	263	46	1618
2012 % of admissions	38%	22%	21%	16%	3%	100%
2013 admissions	611	355	363	225	81	1635
2103 % of admissions	37%	22%	22%	14%	5%	100%
Percent of Planning Population in Area	19.7%	14.3%	40.1%	25.9%	NA	100%

The data show that there have been only minimal changes in overall and Area-based admission rates from year to year. Although there were some shifts between admissions to DMH facilities, as shown above, there have been virtually no changes in the proportion of admissions accounted for by each DMH region. The more important information in the table is the variation between Area admission percentages and the percentage of the planning (demand/risk) population in each DMH region. For example, the Southeast Area accounts for 37 percent of the admissions per year, but has only 19.7 percent of the planning population. The Metro Boston Area also has higher admissions than its planning population (22 percent and 14 percent respectively). Conversely, the Northeast Suburban Area has 40 percent of the planning population and 22 percent of the admissions, and the Central/West Area has 14 percent of the admissions and 25.9 percent of the planning population.

This information has implications for future planning for inpatient capacity in the southeast portion of the Commonwealth. The higher than proportional admission rates might be an indication of the need for improved access to and performance of ESPs in the region[10]. It may also be evidence of the need for enhanced crisis diversion and crisis respite capacity.

Table 6 shows admissions to all DMH facilities originating from the Southeast Area. Information in this table emphasizes the point that DMH facilities function to a certain degree as state-wide as opposed to regional resources.

[10] The corollary need for improved and enhanced outpatient services is discussed in a separate chapter.

Table 6. Admissions to DMH Facilities from the Southeast (SE) Area in 2012 and 2013

Facility	2012 Admissions	2012 Admissions from SE Area	Percent Admissions from SE Area	2013 Admissions	2013 Admissions from SE Area	Percent Admissions from SE Area
Worcester	322	33	10.3	405	82	20.3
Tewksbury	166	6	3.6	205	15	7.3
Shattuck	171	55	32.16	161	14	8.7
SC Fuller	228	20	8.8	270	25	9.3
Parkview	31	0	0.0	37	0	0.0
Taunton	255	112	43.9	125	65	52.0
Corrigan	206	198	96.1	248	235	94.8
Pocasset	239	231	96.7	184	175	95.1
Total	1,618	608	37.6%	1,635	611	37.4%

These data show an almost 50 percent increase in admissions to WRCH from the southeast region between 2012 and 2013. As noted above, this reflects to a certain degree the opening of the WRCH and the reduction in census at TSH over time. Shifts in forensic admissions will be more apparent once 2014 admission data is available.[11] Unlike other parts of the Commonwealth, the Southeast Area has two DMH operated inpatient facilities, Corrigan and Pocasset. These account for 67 percent of all admissions from the Southeast Area, meaning that the preponderance of admissions to DMH from the Southeast Area actually occur within the Southeast Area. When the 65 admissions to TSH from the Southeast Area are added to this total, the proportion of admissions both originating in and being admitted within the Southeast Area rises to almost 78 percent. At the same time, less than 5 percent of all admissions to Corrigan and Pocasset over the two year period originated outside of the Southeast Area. This confirms that Corrigan and Pocasset are DMH inpatient resources that are primarily dedicated to the Southeast Area.

[11] As noted above, these are calendar year data, not fiscal year data, and thus do not yet fully display the evolving changes at TSH. However, preliminary data from DMH do show that only seven forensic admissions were made to TSH from July to December, 2013, indicating that the policy initiative to divert forensic admissions from TSH has for the most part been implemented.

Discharges from DMH Facilities

Tables 7 and **8** display information on discharges for DMH facilities for 2012 and 2013.

Table 7. Discharges from DMH Facilities: 2012

Facility	Total Discharges	Discharge to Community	Percent Discharge to Community	Discharge to Court	Percent Discharge to Court
Worcester	328	71	21.7	162	49.39
Tewksbury	162	91	56.2	39	24.07
Shattuck	168	103	61.3	31	18.45
SC Fuller	229	27	12.0	149	65.07
Parkview	Discharge	Data	Incomplete		
Taunton	283	43	15.2	136	48.06
Corrigan	205	191	93.2	0	0.0
Pocasset	244	208	85.3	0	0.0
Total	1,650	737	44.67%	517	31.33%[12]

Table 8. Discharges from DMH Facilities: 2013

Facility	Total Discharges	Discharge to Community	Percent Discharge to Community	Discharge to Court	Percent Discharge to Court
Worcester	337	81	24.0	180	53.4
Tewksbury	169	103	61.0	38	22.5
Shattuck	165	82	49.7	30	18.2
SC Fuller	272	42	15.4	180	66.2
Parkview	38	3	7.9	Data not available	
Taunton	222	36	16.2	82	36.9
Corrigan	248	222	89.5	0	0.0
Pocasset	183	161	88.0	0	0.0
Total	1,634	730	44.7%	510	32.2

[12] Total does not equal 100% because of deaths and discharges to medical facilities such as nursing homes.

As with the admission data presented in **Table 8**, there are few notable changes from year to year in these data. As would be expected, the number of discharges to the court from TSH decreased, reflecting reduced numbers of forensic admissions. Nonetheless, only 16 percent of the discharges from TSH during 2013 (and 15 percent in 2012) were to community settings. This shows that forensic activity was still a substantial portion of TSH's overall function for 2012 and early 2013. It should also be noted that for both years there were no discharges to the court from either Corrigan or Pocasset, further evidence of their roles as acute psychiatric treatment facilities dedicated to Southeastern Massachusetts.

Lengths of Stay in DMH Continuing Care Beds[13]

Table 9 shows average end of year[14] lengths of stay for 2010, 2011, 2012 and 2013. Lengths of stay are important because the longer a person stays the longer that bed is not available for the next person that needs it. If beds are not readily available in DMH's continuing care system, then more people are likely to be waiting in general or private hospital acute units, which in turn reduces the effective supply of acute beds as well. Long lengths of stay are also indicators that there are blockages in other parts of the system that reduce the flow of people out of higher levels of care. DMH currently reports a wait list of 120 people awaiting community placements from DMH inpatient facilities.[48]

Table 9. Average Year End Lengths of Stay for DMH Continuing Care Patients: 2010 - 2013

Facility	2010	2011	2012	Average per Facility 2010 - 2012	Average per Facility 2013
Worcester	553.7	535.2	402.9	497.3	301.4
Tewksbury	438.1	477.3	446.4	453.9	394.2
Shattuck	590.5	649.2	615.5	618.4	604.9
SC Fuller	206.3	228.7	266.9	234.0	264.8
Parkview	183.3	259.7	343.9	262.3	303.6
Taunton	1039.9	901.2	883.6	941.6	757.4
Average for CC Patients	501.9	508.5	493.2	501.2	437.8
Corrigan	31.06	28.4	29.4	29.6	23.8
Pocasset	32.6	18.1	24.0	24.9	23.5
Average for Acute Care Facilities	31.8	23.2	26.7	27.3	23.6

These data show that the average year end length of stay for people in TSH was more than double the average for all facilities in 2010. However, TSH has made progress in reducing lengths of stay, and in

[13] Lengths of stay for forensic admissions are not reported because they are dependent to a large degree on interactions with various courts throughout Massachusetts.

[14] End of year length of stay us used because many patients were not discharged during the given year long time period, and some inpatients were in the hospital on the first day of the year and were still in the hospital on the last day of the year.

2013 the 757.4 year end length of stay is 27 percent lower than in 2010. This reduction in lengths of stay has assisted TSH to achieve a steady state continuing care census of 45 for the past year. However, both statewide and at TSH, the long lengths of stay point to the need for increased development of community alternatives coupled with enhanced discharge planning activities. Reducing these lengths of stay, as noted above, should result in some reductions in the elapsed time people spend in acute psychiatric beds waiting for a continuing care bed.

Wait Times for Access to DMH Continuing Care Beds

Wait times for access to DMH operated continuing care beds has been identified as an issue affecting overall psychiatric inpatient care in Massachusetts. People waiting for continuing care tend to remain in acute psychiatric inpatient units; thereby occupying a bed that otherwise would be available to provide acute psychiatric inpatient care. DMH has recognized the importance of this issue, and had assigned liaisons to facilitate the process for approval and placement of people needing continuing care in a DMH facility. While this intervention appears to have had some effect, there continues to be a backlog of people waiting for continuing care, and a portion of these people have been waiting for greater than 30 days.

Exhibit 3 below shows the percentages of people waiting more than 30 days for continuing care. For example, the chart shows that in July 2009, 40 percent of the people already approved for continuing care waited for more than 30 days for a placement. In January 2010, that percentage went down to zero, meaning that all approved patients were successful placed in continuing care within 30 days. By October of 2011, over 80 percent of all people approved for continuing care waited for more than 30 days, and by July 2013, 100 percent of people approved for continuing care waited greater than 30 days. By April of 2013, DMH's assignment of liaisons and other factors had brought the percentage waiting for more than 30 days down to under 20 percent. However, by May of 2013, the proportion of people waiting for greater than 30 days had already increased to over 60 percent.

Exhibit 4 displays a graph of total referrals for continuing care in parallel with the number of people waiting for greater than 30 days for placement in continuing care. The chart shows that there is a very close relationship between the total number of referrals for continuing care and the number awaiting continuing care for greater than 30 days. The higher proportion waiting for continuing care when demand for such care is high (as reflected in larger numbers of people being referred) is perhaps not surprising. However, it may also be an indicator of inelasticity in DMH's continuing care system. This inelasticity could be related to limited capacity to conduct clinical assessments and determine appropriateness for continuing care as well as the difficulty of finding an available continuing care bed when demand is high.

Exhibit 3. Percent of People Waiting for DMH Continuing Care: 2009 – 2013

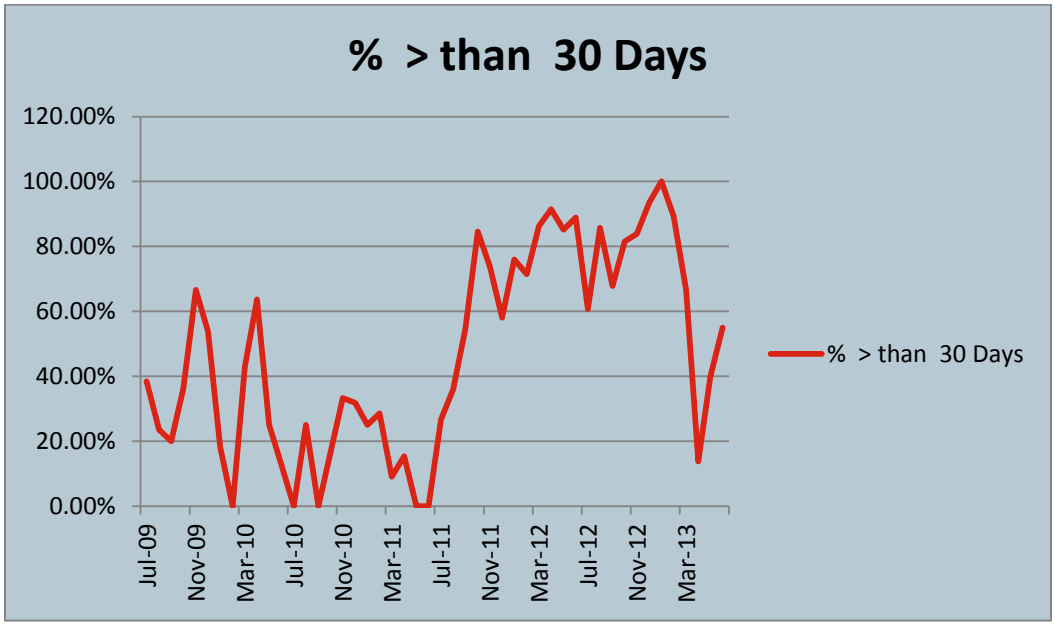
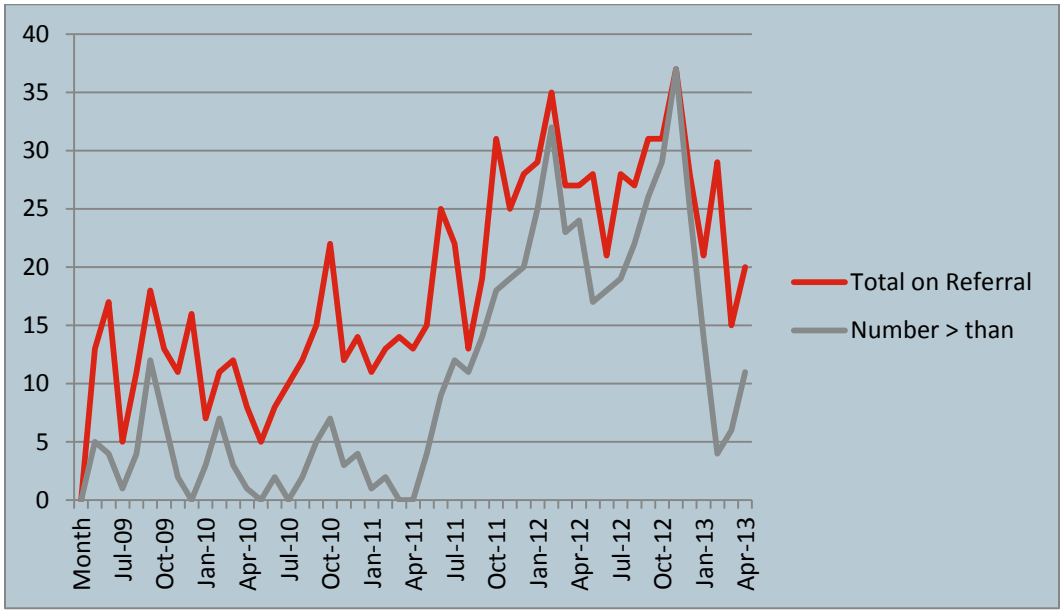


Exhibit 4. Total Referrals for Continuing Care and the Number Waiting Greater than 30 Days for Admission to a DMH Continuing Care Bed



Readmission Rates for DMH Facilities

Readmissions to inpatient treatment, particularly if such readmissions occur within 30 days of discharge, are considered to be indicators of service gaps or service accountability issues in the community. One of the first national performance standards and financial incentives to be implemented under the Affordable

Care Act (ACA) is based on re-hospitalizations within 30 days of discharge. This national measure applies to all types of hospital discharges, not just discharges for psychiatric inpatient treatment.

The issue of readmissions to the hospital is most relevant to acute care. With regard to mental health services, readmission within 30 days may indicate a failure to be connected with needed community outpatient/aftercare services and in some cases may indicate discharge before the person was able to be successful at home or in other community settings. In Massachusetts, virtually all acute care is provided in general hospitals or private psychiatric hospitals. With the exceptions of Corrigan and Pocasset, no acute admissions are done to DMH facilities. Thus, re-admission data is not particularly relevant to DMH facilities as opposed to general hospital and private psychiatric inpatient treatment units.

It would be more relevant to analyze admission and readmission data related to these general and private hospital facilities. However, as noted in the introduction to this chapter, Abt/TAC was not able to obtain such data from Medicaid MCOs and commercial insurers, and thus we have no reliable way to assess the degree to which readmissions or readmissions with 30 days of discharge may be occurring in the non-DMH inpatient sector. As will be discussed later in this report, we recommend that comparable data on admissions, discharges, and lengths of stay and re-admission rates be collected and reported for all inpatient occurrences in the Commonwealth.

Although we do not consider data on readmissions to DMH facilities to be important indicators of overall system performance, we did analyze readmission data related to DMH facilities for 2010 through 2013. **Table 10** presents a summary of this information.

Table 10. Readmissions to DMH Facilities by Reason for Readmission: 2010 through 2013

Year	Transfer from Court	Transfer from Another Mental Health Facility	Transfer from a Medical Facility	Readmission from Absence Without Authority	Readmissions for Other Reasons	Total Readmissions
2010	48	118	34	14	66	280
2011	40	59	31	7	52	189
2012	41	62	26	6	56	191
2013	31	125	17	11	80	264
Total	160	364	108	38	254	924
Percent of total	17.3%	39.4%	11.7%	4.1%	27.5%	100%

As can be seen from the above data, almost 70 percent of all readmissions to DMH facilities between 2010 and 2013 were from either the court or from a mental health or medical facility. These types of readmissions are typically planned and expected, and do not result from problems elsewhere in the mental health system. Less than one third of the total can be considered to be un-planned readmissions.

8.2 Findings

Based on the data presented above, the overall supply of psychiatric inpatient beds in Massachusetts appears to be sufficient for necessary and clinically appropriate inpatient care. And, although the southeastern region has a slightly lower proportion of inpatient beds than the Boston regions, it has a substantially higher proportion of inpatient beds than the northern, central and western regions. In addition, the southeast has two state operated 16 bed psychiatric acute units, Corrigan and Pocasset, which are resources not available in other parts of the state. Again, we emphasize that data from Medicaid MCOs and private insurers was not available for this study, so it was not possible to tabulate actual inpatient bed day utilization for all payers on a statewide or regional basis. The all payer claims database may eventually support this type of analysis.

The point has been made that Massachusetts has a relatively large proportion of private sector psychiatric inpatient beds when compared to other jurisdictions. However, as many stakeholders have noted, these facilities face poor reimbursement rates, extended waits for people to access continuing care and other factors influencing the financial viability of the units. This is reported to cause the private facilities to be more risk averse; to avoid highly complex patients; and to deny admissions to patients they deem will be difficult to discharge or place following the inpatient stay. This in turn is likely to result in longer ED boarding times for people with complex conditions.

As emphasized throughout this report, the utilization and therefore effective supply of hospital beds is interdependent with the supply and utilization of community resources, including crisis response, crisis diversion, housing, residential rehabilitation services, and outpatient treatment. Elevated hospitalization rates and long lengths of stay in continuing care as documented in this report are indicators that strategies to improve crisis response and community resources are particularly important in the southeastern region of the Commonwealth.

The data point to two substantial issues with the DMH inpatient system in general and TSH in particular. These issues, which are firmly intertwined, are: (a) long wait times to access DMH continuing care beds; and (b) very long lengths of stay in DMH continuing care beds. Taken together, these factors create barriers to discharging people from acute psychiatric inpatient care in general and private hospitals. This in turn constrains the supply of acute psychiatric inpatient beds, thereby resulting in increased competition for scarce beds and longer wait times in hospital EDS to find inpatient beds. The solution to these interrelated issues is not to open more inpatient beds but rather to facilitate discharges to appropriate community settings for people currently residing in continuing care beds, and to assure more efficient movement from inpatient acute care to continuing acre in a DMH facility when clinically appropriate.

8.2.1 Recommendations

As noted above, DMH has 120 individuals in continuing care who have been identified as ready for discharge. The following recommendations are made:

- Recommendation: *Move individuals to community settings currently detained unnecessarily in DMH continuing care beds and free up capacity for those are awaiting transfer from acute inpatient programs.*

Almost 20 percent of DMH's overall capacity for continuing care is occupied by people with no clinical reason to be there. As continuing care beds are freed up by effectuating community placements, more people can move more quickly from acute care to continuing care.

At the same time, DMH should be more aggressive, transparent and accountable when managing the flow of people from acute psychiatric inpatient beds to continuing care beds when necessary.

- Recommendation: *Wait times of greater than 30 days for movement to continuing care should be considered unacceptable in the system, and should be eliminated.*

The assignment of DMH liaisons to facilitate this process may have improved the situation somewhat, but it has clearly not corrected the problem.

- Recommendation: *DMH should publish a weekly report of the number of people referred to continuing care; the number approved for continuing care; the number successfully transferred to a DMH continuing care bed or other clinically appropriate alternative; and the weekly average elapsed times between these milestones. This real time data should be the basis for decisions about whether further interventions are needed to facilitate the flow of people into continuing care.*

- Recommendation: *DMH and MAPHS report that proposals to license as many as 200 new inpatient beds are under review. Any psychiatric or behavioral health bed expansion should be managed to address the unmet needs of individuals who are now too often denied access to inpatient care, including children and youth with complex needs; adults with substance use histories and/or intellectual disabilities co-occurring with mental health conditions; persons with high medical needs; or individuals with histories of aggression who require a differently staffed unit.*

9. Findings and Recommendations: Emergency Services

9.1 National Context for Psychiatric Emergency Services

Massachusetts is not alone in facing long emergency department (ED) lengths of stay and the issue of ED boarding, nor are these issues new or limited to individuals with psychiatric disorders.[49] Nationally, ED boarding impacts children as well as adults alike. Psychiatric boarding has been shown to be costly for hospitals, [50] with an average length of stay at one academic medical center approximately 18 hours longer with an average financial loss in 2007 to 2008 dollars of $2,264 per individual boarded. On the other hand, it has been argued that prior to the Affordable Care Act hospitals had little financial incentive to decrease ED lengths of stays because higher ED bed turnover increased the risk of providing more uncompensated care.[51] Long ED wait times can lead to iatrogenic crises and increased risk of serious incidents.[52]

A Massachusetts based study found significant psychiatric boarding, with an average ED length of stay of 11.5 hours. Toxicology screens were associated with an additional 6.2 hours in the ED as compared with individuals without toxicology screens. Use of restraints lengthened ED stays by over 4 hours and orders for imaging increased stays by over three hours.[53] Another recent Massachusetts study has shown that ED boarding continues across the Commonwealth.

There are a number of strategies with potential to reduce psychiatric boarding in EDs. Addressing mental health crises using person-centered, strengths-based approaches, including use of peer counselors, in the least restrictive setting possible can assist individuals to gain control and facilitate crisis resolution.[54],[55] Care coordination and self-directed crisis planning can also reduce readmissions for frequent utilizers of EDs.[56] Use of separate psychiatric emergency centers has shown promise in reducing ED boarding.[57] CMS encourages use innovative practices to reduce ED use in individuals with mental and substance use disorders.[58] Examples cited by CMS include medical homes for individuals with SUDs as well as housing and case management programs for homeless individuals who are frequent ED users.

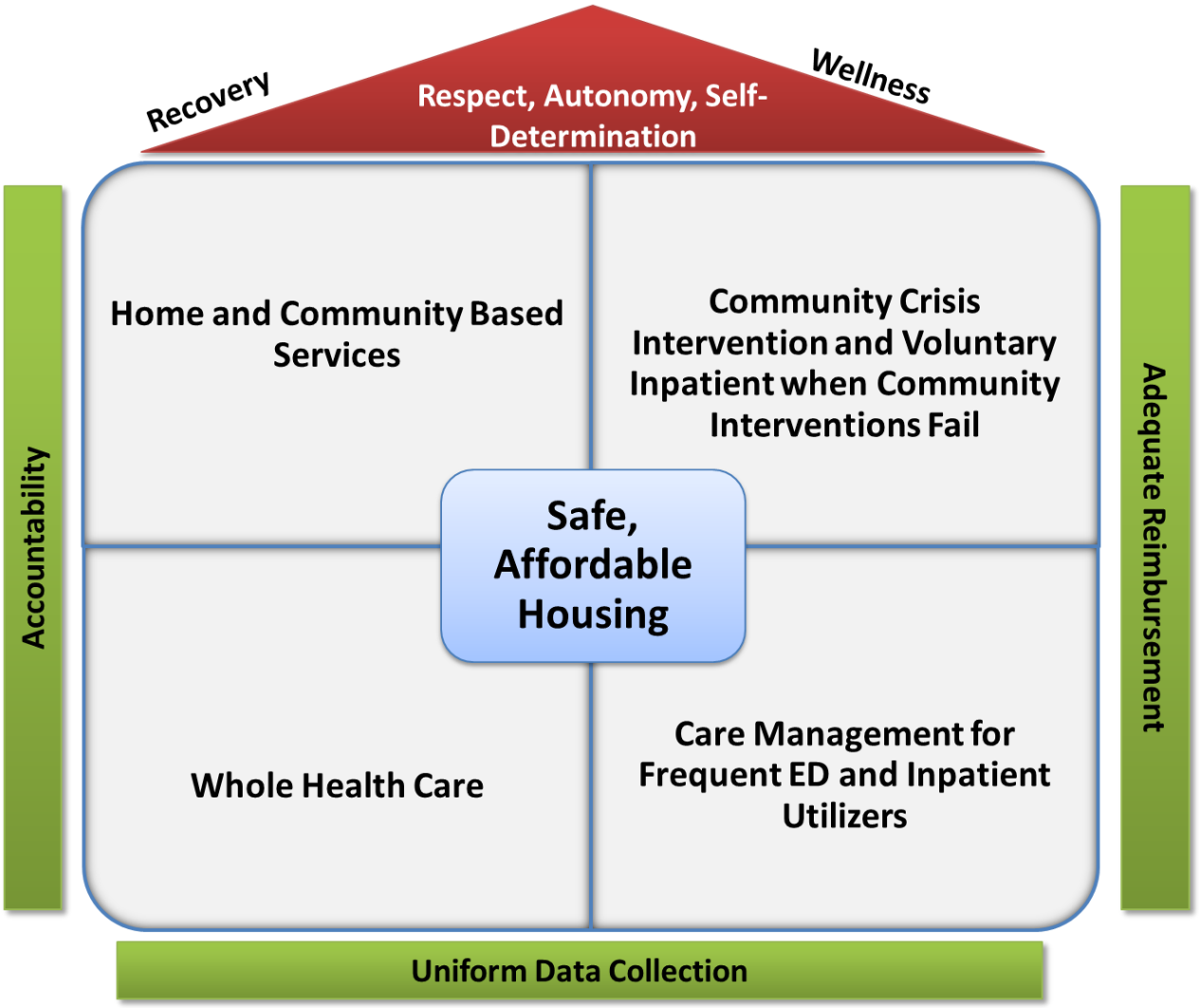
Another possible strategy to decrease ED boarding is the use of private (under federal rules, state and county IMDs are not eligible) IMDs for the provision of emergency psychiatric services. IMDs have previously been excluded from billing Medicaid for inpatient services for adults aged 21to 64. CMS has provided Medicaid funding to 11 states and the District of Columbia under Section 2707 of the Affordable Care Act as part of the Medicaid Emergency Psychiatric Demonstration.[59] An evaluation of the demonstration project is in process with findings not available at this time.[60]

In 2011, a workgroup of the North Carolina Divisions of Mental Health, Developmental Disabilities, and Substance Abuse Services provided a number of recommendations regarding crisis diversionary services, ED procedures, and post crisis services and supports with potential to reduce ED lengths of stay. These recommendations included enhancing mobile crisis services, increasing diversionary beds, establishing a psychiatric bed registry, increasing access to addictions treatment services, ensuring stable housing and establishing a uniform system of care.

Crisis prevention and stabilization do not exist within a vacuum. Quality community-based services, including housing, are the frontline of crisis prevention.[61,62] Crisis prevention and intervention activities are conducted daily by community staff, clinicians, and family members, and by individuals themselves, as they learn to manage their symptoms and everyday stressors. Best practices for crisis intervention

include coordination with health and social services, schools, police, and other community providers.[63] As such, when addressing ED wait times it is crucial to focus on the community system as a whole and not just "high-end" services (see **Exhibit 5**).

Exhibit 5. Components of Crisis Prevention and Stabilization



9.2 Statewide Emergency Service Program Data

ESP encounters have been increasing across the State between FY 2009 and FY 2013. Over the same period, community-based ESP encounters have been trending down in proportion to encounters in hospital EDs for all ages. According to the DMH ED LOS and Psych Bed Access Workgroup data summary, bed search time increased from FY 2010 to FY 2011 across the state, but decreased in the first seven months of FY 2012 as compared to FY 2011.

> *"We need to recreate a system that includes more than a 50-minute therapy hour or an inpatient bed. We will require a significant investment in this infrastructure to have any hope of adequately meeting the behavioral health care needs of the population."*
>
> --Deborah Ekstrom

ESP response time also increased between FY 2012 and FY 2013 for all but DMH clients, as demonstrated in **Table 11**.

Table 11. ESP Response Time Data FY 2011 to FY 2014

Population	First Six Months FY 2014 Response Time					
	Community		ED		Total	
	YTD avg	Trend	YTD avg	Trend	YTD avg	Trend
ESP/MCI: All Ages	29 min.	Up	50 min.	down	43 min.	down
ESP: Adults	28 min.	Up	51 min.	down	45 min.	down
MCI: Youth 0-20	31 min.	Up	43 min.	up	37 min.	up
DMH population (all ages)	28 min.	Up	45 min.	up	38 min.	up
Uninsured population	25 min.	Down	51 min.	down	46 min.	down
Population	**FY 2013Response Time**					
	Community		**ED**		**Total**	
	YTD avg	Trend	YTD avg	Trend	YTD avg	Trend
ESP/MCI: All Ages	29 min.	Up	50 min.	up	44 min.	up
ESP: Adults	28 min.	Up	51 min.	up	47 min.	up
MCI: Youth 0-20	31 min.	Up	43 min.	up	34 min.	up
DMH population (all ages)	28 min.	Up	45 min.	down	38 min.	down
Uninsured population	25 min.	Down	51 min.	up	46 min.	up
Population	**FY 2012 Response Time**					
	Community		**ED**		**Total**	
	YTD avg	Trend	YTD avg	Trend	YTD avg	Trend
ESP/MCI: All Ages	27 min.	Down	54 min.	up	45 min.	up
ESP: Adults	27 min.	Down	56 min.	up	48 min.	up
MCI: Youth 0-20	28 min.	Down	44 min.	up	35 min.	down
DMH population (all ages)	28 min.	Down	50 min.	up	41 min.	flat
Uninsured population	24 min.	Down	51 min.	up	48 min.	flat
Population	**FY 2011 Response Time**					
	Community		**ED**		**Total**	
	YTD avg	Trend	YTD avg	Trend	YTD avg	Trend
ESP/MCI: All Ages	27 min.	Down	51 min.	down	44 min.	down
ESP: Adults	27 min.	Down	53 min.	down	46 min.	down
MCI: Youth 0-20	28 min.	Down	44 min.	down	36 min.	down
DMH population (all ages)	26 min.	Flat	46 min.	up	37 min.	down
Uninsured population	25 min.	Flat	52 min.	down	46 min.	down

MBHP ESP/MCI MONTHLY SUMMARY REPORTS TO DMH AND OBH. All the reports are for MBHP members: PCC Plan (about 350,000); children with MassHealth secondary to commercial insurance (about 50,000); and children in state custody (DCF and DYS).

9.3 Emergency Department Boarding

From FY 2008 to FY 2009 and FY 2011 to FY 2013, MBHP has tracked the top ten hospitals with the highest number of MBHP members waiting for inpatient behavioral health beds. Hospitals in Southeastern Massachusetts have been among the top ten hospitals with the greatest number of people waiting for inpatient beds. However, hospitals in Boston, Central and Western Massachusetts have consistently placed in the top ten as well. In FY 2008, Cape Cod Hospital ranked 5th in volume of people awaiting inpatient admissions. No Southeastern Massachusetts hospital placed in the top ten in FY 2009.

In FY 2011 Brockton Hospital, Cape Cod Hospital, Good Samaritan, St. Luke's Hospital, and South Shore Hospital placed in the top ten among hospitals with the highest number of people awaiting acute behavioral health inpatient beds. Cape Cod Hospital dropped from the top ten in FY 2012 but was back in 7th place in FY 2013. St. Luke's Hospital was among the top ten hospitals with MBHP members waiting for inpatient beds in FY 2011 and FY 2012 rising to 4th place in FY 2013 among hospitals the most members waiting for inpatient admission. For FY 2011 to FY 2013 UMass Memorial Hospital, Baystate, and Brockton Hospital had the highest volume of individuals with ED waits for inpatient beds. Baystate had the largest volume in FY 2011 and FY 2012, while UMass Memorial had the highest volume of people waiting in the ED for inpatient beds in FY 2013. Clearly, ED boarding has been a problem across the state. The data also show that ED boarding has been a problem before the Taunton State Hospital downsizing occurred.

Anecdotal reports from EDs, ESP providers, consumers, and families indicate that ED wait times are serious problem on weekends, when many hospitals do not discharge or admit patients. These anecdotal reports support Monday morning reports by some Southeastern Massachusetts hospital EDs of individuals waiting in the ED for an acute inpatient beds. Anecdotal reports from these same informants highlighted barriers to acute hospital admissions faced by people with co-morbid medical conditions, assault risk, past sexual assault, or no insurance. Family members and ESP providers have noted that individuals with MassHealth and DMH clients have lower wait times for beds. Family members also reported that their adult children were often hospitalized out of area. Consumers cited their preference for peer respite beds as a viable and effective crisis resolution, hospital diversion, and hospital step down alternative. Consumers noted the effectiveness of this model, which is now in operation in Western Massachusetts, and recommended this as one solution to ED backlog and acute inpatient discharge delays, should peer respite be developed in Southeastern Massachusetts. ESP providers also noted the need for diversionary services such as respite and crisis stabilization units. MBHP has also recommended an increase in ESP team capacity for Community Crisis Stabilization. Because we have no data on actual bed censuses over time, time for disposition determination to discharge for individuals awaiting acute inpatient beds, or specifics of individual cases, we are unable to make conclusions as to the causes for out of area hospitalizations.

The Executive Office of Health and Human Services has proposed several promising strategies to address ED boarding statewide. These strategies include increased licensing oversight of inpatient units, financial incentives for rapid admissions, and elimination of prior authorization for inpatient care.

9.3.1 Data Provided by Hospitals

Several reports with data from different time frames, with some common barriers to acute inpatient care. A statewide report from MBHP with data from the first part of FY 2012 indicates that among adult MBHP members pre-certified for inpatient care, "medical co-morbidity" and "other" were the most common barriers to admission, followed by intellectual disability and assault risk. A second data report for adult MBHP members, for the period from 2/11/12 to 1/21/13, shows that medical co-morbidity is the top barrier with assault risk as the second most common barrier. The data from the first part of FY 2012 confirm that statewide adult MBHP members with ED admissions on Friday through Sunday had the longest wait times for an inpatient bed. One hospital was able to provide aggregate data for calendar years 2012 and 2013. These data show that while overall ED volume decreased slightly, ED admissions for behavioral health concerns increased by a small margin of 0.02 percent or by 107 admissions.

Although ED volume changes were not significant, reported wait times for acute inpatient admissions, either at the same hospital or another facility, increased by almost three hours.

9.3.2 Massachusetts College of Emergency Physicians ED Wait Time Study[15]

In an attempt to collect objective data on ED boarding, the Massachusetts College of Emergency Physicians (MACEP) conducted their own ED wait time study. Using purposeful sampling by region, presence or absence of an inpatient psychiatric unit, and hospital size, MACEP collected data from 10 EDs over a two week time period January to February 2013, with a 100 percent response rate. Data collected for the study were used to examine ED wait times for individuals with a psychiatric assessment, focusing on those individuals in need of an acute inpatient admission. Within the two-week period the ten EDs saw 899 individuals. Average time to final disposition for individuals in need of acute inpatient psychiatric admission was 20 to 22 hours. This finding is similar to data collected from informants from individual EDs. MACEP notes that the average time to final disposition for medical/surgical patients is five hours. **Exhibit 6** shows selected finding from the MACEP study. These are preliminary findings. Conclusive findings are forthcoming from MACEP.

Exhibit 6. Selected Findings from the MACEP Study

Shorter Wait Times	Longer Wait Times
Tuesday, Wednesday, Thursday	Friday, Saturday, Sunday
No/Few Comorbidities	Active Substance or ETOH Abuse, *Comorbid Medical Conditions**
No/Few Behavior Management Issues	Aggression, Prior Psychiatric Admission, Sexual Offense Acting Out (small N)
7-3 Shift	11–3 Shift (only slightly lower than 7–3)
Medicare	MassHealth (MBHP, MCEs, FFS)
Region I (Mean 13.5)	Region V (Mean 21.2)

Pearlmutter, Massachusetts College of Emergency Physicians, et al. 2013 unpublished. DO NOT CITE WITHOUT PERMISSION.
*Not significant but trended toward longer wait times.

9.3.3 Comparison to MBHP and DMH Data

MBHP data align fairly closely with data from the MACEP ED wait time study. Longest waits for beds occur on Friday through Sunday (reports that this is related to inpatient unit staffing and admission policies, not absolute supply of beds). At the same time, most inpatient admission acceptances occur between 7:00 AM and 3:00 PM. As stated earlier in this report, presence of medical comorbidities, substance use, behavioral disorders, assault risk, homelessness, and or legal involvement all play a role in increasing wait times. MBHP data show barriers for individuals with autism and other developmental

[15] Pearlmutter, Massachusetts College of Emergency Physicians, et al. 2013 unpublished. DO NOT CITE WITHOUT PERMISSION.

disabilities, especially for children. According to the DMH ED LOS and Psych Bed Access Workgroup data summary, males are also more likely to experience long ED wait times. Individuals with mobility issues and those requiring a single room also experience longer ED wait times. Individuals are being hospitalized out of their local areas, even for acute stays.

9.3.4 Diversionary Services Utilization and Capacity

Data on diversionary services were provided by MBHP. These data represent services to MBHP members, children in DCF custody, children with MassHealth secondary to commercial insurance, and PCC plan members. Diversionary services include mobile crisis stabilization, currently only available for children and adolescents, family crisis stabilization for children and adolescents and services through community-based crisis stabilization units. The Commonwealth also contracts for Intensive Community-Based Treatment for Children and Adolescents (ICBAT). ICBATs served 318 children and adolescents in FY 2012. Community-Based Treatment for Children and Adolescents (CBAT) programs served 1,851 children and adolescents during the same period. In FY 2011, 257 children received ICT services, while 1, 639 children received CBAT services.

Community Crisis Stabilization units served 2,796 members in FY 2012, up from 2,626 members in FY 2011, while partial hospitalization programs served 2,039 MBHP members in FY 2012. This was a decrease from 2,207 members who received partial hospitalization services in FY 2011.

According to MBHP data for FY 2013, youths who receive mobile crisis services in the community are 13.83 percent more likely to receive diversionary services than youths seen in the ED. Clinical data are not available to provide context for severity of symptoms/problems seen in youths served in both locations. However, the data on community mobile crisis intervention are promising. Community-based mobile crisis intervention is much less common for adults. Even among adults, however, MBHP and DMH-run ESP are more likely to divert adults to crisis stabilization units or other diversionary services when individuals are seen in the community rather than the ED.

Community Crisis Stabilization

Community crisis stabilization provides an opportunity for hospital diversion when utilized early, before an individual meets the requirements for hospital level of care. These community crisis stabilization beds have been helpful in reducing the need for hospitalization.[64] Data are not available to assess their effectiveness in reducing the need for ED admissions. Community crisis stabilization services capacity is displayed in **Table 12**, below.

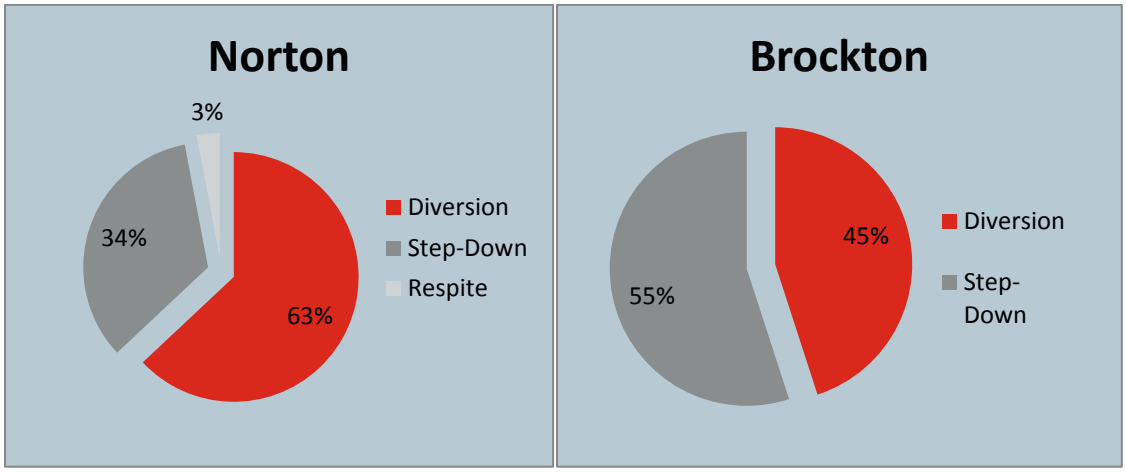
Table 12. Community Crisis Stabilization Capacity as of March 2014

MBHP Region	ESP Catchment Ares	Bed Capacity
Metro Boston	Boston	14 (Solomon Carter Fuller location)
		6 (Mass Mental Health Center location)
	Cambridge Somerville	6
	Norwood	6
	South Shore	6
Western	Berkshires	6
	Greenfield	4
	Northampton	6
	Southern Pioneer Valley	13
Central	MetroWest	6
	North County	8
	South County	7
	Worcester	8
Northeast	North Essex / Salem	6
	Lawrence	6
	Lowell	6
	Tri-City	6
Southeast	Southern Coast	12
	Brockton (DMH)	6
	Cape & Islands (DMH)	10
	Corrigan (DMH)	5
	Taunton / Attleboro/Norton (DMH)	7
Statewide Total		160

Data are not uniformly available for CCS utilization. Data provided by the Brockton ESP and Taunton/Attleboro satellite at Norton for July through December 2013 show that added respite and

community service capacity could allow for greater use of their CCSs to provide community intervention and stabilization. Average lengths of stay were 13.5 days for Brockton and 10 days at Norton. Individuals stepped down from inpatient level of care had longer lengths of stay than individuals admitted for inpatient diversion. The CCSs serve a key role in assisting to connect individuals with housing and other key services, including application for DMH eligibility where warranted. CCSs also assist individuals to manage a number of physical co-morbidities. An informant mentioned the need to add part-time medical staffing, such as a family practice nurse practitioner or family practitioner to assist individuals to stabilize their overall health. Increased use of peer support specialists is also needed, according to informants. As shown in **Exhibit 7**, CCS beds were frequently used for inpatient step down. Reduced use of CCSs for step down could potentially allow the CCSs to focus on admissions for inpatient diversion. The potential use of TSH for community crisis stabilization is addressed in Chapter 14.

Exhibit 7. Use of Brockton and Norton CCSs for Diversion and Step-Down July-December 2013



Respite Services

DMH contracts for respite services. As shown in **Table 13,** utilization of respite services for adults has increased between FY 2010 and FY 2013. Respite utilization for children and adolescents has decreased over time, in part because of the increase in mobile crisis and crisis stabilization services. According to MBHP data, utilization of community-based mobile crisis services for youth (ages 0-20) has been trending up over FY 2013 across all contracted payers. This includes an increase in home-based interventions. According to the Governor's FY 2015 budget, each area of the state will receive funding for five to six additional respite beds. Southeastern Massachusetts will receive 30 respite beds, in the form of six respite facilities with five beds each. Informants have suggested that one respite focus on individuals with co-occurring substance use disorders to address the lack of substance abuse services in the community. Peer staff could play key roles in such respite services, as in the successful Northampton peer run respite[65] and others across the United States.[66]

Table 13. Respite Capacity and Persons Served by Division and Fiscal Year

			Metro Boston	Central	Metro Suburban	North East	Southeast	Western	Statewide
Adult Respite (Site Based & Mobile)	Current Capacity		0	33	53	66	15	96	263
	Current #Providers		0	3	4	3	1	4	14 (Undup.)
	Current #Contracts		0	6	4	5 (1 State Op)	1	6	22 (1 State Op)
	# Served	FY 10	0	122	116	237	0	190	665
		FY 11	0	122	187	270	0	244	823
		FY 12	0	166	237	270	50	241	964
		FY 13	0	182	236	295	85	257	1,054
C/A Respite (Site Based & Mobile)	Current Capacity		0	25	0	35	0	8	68
	Current #Providers		0	1	0	4	0	3	8
	Current #Contracts		0	2	0	4	0	4	10
	# Served	FY 10	1	88	0	43	0	60	192
		FY 11	0	84	0	41	0	69	194
		FY 12	0	35	0	40	0	69	144
		FY 13	0	32	0	31	1	69	133

9.4 Stakeholder Consensus and Divergence of Opinions on Solutions to ED Wait Times

9.4.1 Areas of Consensus

There is consensus among stakeholders that ED wait times are excessive and detrimental to the welfare of patients and families. There is a general consensus as well that reimbursement for community and inpatient services do not meet costs. There is some consensus that the bed finding process is inefficient. ESPs must call many individual hospitals to seek beds and make the case for the individual to be admitted. The bed finder tool is useful but does not replace phone calling. The bed finding process is different across payers and also between hospitals. There is anecdotal information that some hospitals may exercise discretion with regard to who they admit, which makes the bed search even more complicated.

9.4.2 Areas of Divergence

There remains considerable disagreement on the causes of excessive wait times. Available data only go so far to address these disagreements. **Exhibit 8** shows the diverging perspectives on the cause of long ED stays. Different stakeholders experience different components of the problem. For example, EDs lose a considerable amount of money on long ED waits. They want control over the admissions process. For individuals, long ED waits can lead to iatrogenic crisis or exacerbation of symptoms, as well as stress and at times additional trauma. Family members also experience lengthy waits times as extremely stressful. ESPs experience pressure to place individuals, and the lack of ability to place individuals in inpatient beds, when necessary, can tie up the ESP's response to others in crisis.

Divergence also occurs in where individuals might be best stabilized. MBHP data show that individuals seen in the community are less likely to be hospitalized. Therefore, increased capacity for community crisis stabilization may reduce pressure on both ED front and back doors. Informants representing EDs and psychiatric inpatient units, however, argue that stabilization should take place in ED-based crisis stabilization units. Consensus among stakeholders may never occur, but more consistent and standardized reporting of wait times across all payers, including Medicare, commercial insurers,

MassHealth MCEs, and MBHP could assist the Commonwealth to further identify solutions that will best meet the needs of Commonwealth residents who experiences psychiatric crises.

Exhibit 8. Different Stakeholder Perspectives on Causes of Excessive ED Wait Times[16]

Examples of Stakeholder Perspectives by Stakeholder Group			
Areas of Disagreement/Agreement	**Hospitals**	**Community Providers**	**Individuals and Families**
Differing Causes of ED Wait Times			
Back-ups for Continuing Care	X		X
Loss of Acute Care Capacity	X	X	X
Prior Authorization	X		
No Clear Standards for Medical Clearance		X	
Low Reimbursement Rates for Acute Inpatient	X		
Cherry Picking	X	X	
No One Party Accountable for Placement	X	X	
Individuals with more Complex Presentations Get "Stuck"	X	X	
No Reject Policy not Enforced	X	X	X
Mobile Crisis is Rarely able to do Direct Admissions		X	
No Reimbursement for Follow-up Mobile Crisis Visits for Adults		X	
No Separate Reimbursement for Treatment in the ED	X		
Not Enough Continuing Care Beds	X		X
Public and Families Unaware of ESPs Despite Social Marketing		X	X
Outpatient Providers Reinforce Use of EDs		X	
Disagreement about Services that can Fill Gaps in Mental Health Systems			
Safe, Stable Housing		X	X
CSUs in EDs	X		
More CSU Beds in the Community		X	
More Peer Services Including Respite		X	X
More Residential Capacity for People with Medical Complexities		X	
Reimbursement for Follow-Up Mobile Crisis Visits		X	
More Acute Inpatient Beds Distributed Across the State	X		X
Better Training and Support for Residential Staff			X
Structured Supports such as Employment, Day Treatment, Etc.		X	X
More Continuing Care Beds	X		X
Increased Reimbursement for Mental Health Services	X	X	X

[16] Not all representatives for identified stakeholder groups identified perspectives listed. Rather, an "X" signifies that informants for within the stakeholder group identified the issue as a problem.

Examples of Stakeholder Perspectives by Stakeholder Group			
Areas of Disagreement/Agreement	Hospitals	Community Providers	Individuals and Families
Disagreement about Who Should do Stabilization			
Crisis Stabilization Units have Psychiatry and Nursing Capacity to do a Significant Amount of Stabilization		X	
ESPs Should Only Do Community Diversion	X		
Stabilization Should Occur in a Medical Setting	X		
Peers can have a Positive Influence on Stabilization and Diversion		X	X

9.5 Issue: No Common Metrics across Payers

ESP response time is a very small piece of the puzzle in our understanding of the causes of long ED wait times. Common metrics across payers and across hospitals are lacking. There is also no consensus on "when the clock starts ticking" to measure ED wait times: when an individual is medically cleared; when a determination about the need for inpatient care is made; or when an ESP is called. Lack of clarity remains concerning requirements for timeliness of private insurers in providing prior approval.

Reasons individuals are rejected by certain inpatient units have been documented for a large percentage of inpatient admissions by MBHP. As noted earlier, MBHP indicates that individuals with co-occurring substance abuse histories, intellectual disabilities, and/or other medical conditions, as well as those with histories of assault and medication noncompliance, are most often rejected.[67] The lack of standardized documentation of "refusals" has led to speculation and anecdotes about individuals being too ill for acute inpatient. Another reason for "refusal" identified by informants is that the individual did not "fit in" with the inpatient milieu, which may be a euphemism for the unit rejecting the individual. Certainly, some individuals require single rooms, either because of their behaviors or other privacy needs (such as a female who has experienced sexual assault). Some units have double rooms, reducing their flexibility to take individuals of different genders. At present, there are no national quality metrics or measures for ED wait times for behavioral health.

9.6 Populations of Concern

9.6.1 Frequent Users of ED Services

Frequent ED and inpatient utilizers eventually experience hospitals refusing to admit them. Based on interviews, these individuals may be homeless, have co-occurring medical and substance use conditions, and may not be able to access or to have their needs met effectively in the community. In Southeastern Massachusetts, these individuals board in EDs awaiting admission to State-run Corrigan and Pocasset hospitals. In other areas of the State, the larger hospitals end up eventually admitting these individuals because they are rejected by other facilities. Some argue that these individuals need continuing care. Another explanation is that frequent ED users need more responsive community services to prevent crises and to support them once stabilized. Mobile crisis intervention could be useful with these individuals, as would stable housing, community treatment options for addictions, and integrated medical care for physical health concerns.

9.6.2 Individuals with Substance Use Disorders

There are few addictions treatment facilities in the community and almost none for individuals with co-occurring mental and substance use disorders, despite the well-documented prevalence of the co-occurrence of both disorders. EDs often discharge individuals with addictions issues to their own care or the streets, where they are sometimes homeless. Individuals who present with acting out or suicidal behaviors, and who require toxicology screens, spend longer time in the ED, and are reported by informants as among the most difficult individuals to place once the need for a hospital level of care is determined. There are clear gaps in community addictions services.

9.6.3 Individuals with Co-Occurring Physical Health Concerns

Informants reported that psychiatric inpatient units are loath to do any "hands on" physical health care. For example, one informant mentioned that an individual was denied inpatient admission because they were incontinent, despite the fact that the individual managed their incontinence on their own at home. Informants repeatedly stressed that individuals with even the most stable medical disorders were consistently denied admissions. Another case reported involved an individual who had recovered from a stroke. This individual was boarded for days while awaiting a hospital that would accept them, even though the individual presented with no new neurological deficits. Informants reported that pregnancy at any stage could be an obstacle to admission. In Southeastern Massachusetts, it was reported that only one hospital accepts pregnant women for acute psychiatric inpatient care. A woman with no insurance reportedly remained in an ED until she gave birth, and then was admitted to a medical unit. A process is needed to review each admission denied on grounds of physical health conditions. At this time only anecdotal reports are available. Data are needed to determine if only certain hospitals are denying care or if this is a systematic problem. That said, these anecdotal reports of denied admissions for pregnant women and individuals with physical health concerns arise in multiple areas of the state.

9.6.4 Children and Adolescents

With the implementation of the Children's Behavioral Health Initiative, more children and adolescents with mental disorders receive comprehensive services within the community. Children and adolescents at times require higher levels of care than ICBAT can provide. There are a limited number of beds available statewide, yet parents want choice in determining where children should receive services. Children face boarding when a parent turns down the first available bed and there is no other available. One informant mentioned that parents are given one refusal. Another reported that DCF is informed when parents turn down several inpatient offers. According to family and child advocacy informants, parents need better information about services as well as available inpatient and alternative treatment options, if they are going to be empowered to effectively direct their children's care. Finally, informants reported that schools at times still send children to EDs rather than requesting mobile crisis intervention.

A centralized bed search process could help to increase transparency around bed availability and aid parents to make more informed choices when turning down beds. While mobile crisis intervention has been implemented statewide, with increasing numbers of interventions taking place in the community, outreach to and collaboration with schools can divert unnecessary ED admissions.

9.6.5 Individuals with a History of Assaultive Behavior

Individuals with a history of physical or sexual assault or active assaultive behaviors are difficult to place. In some cases, these individuals may require specialized care. One informant in Southeastern Massachusetts reported that group homes sometimes brought individuals to the ED after they were

assaultive. These individuals were boarded over several days even though they were not assaultive in the ED. It was reported that in some cases group homes refused to take an individual back after they stabilized in the ED. Mobile crisis intervention to group homes, and use of diversionary services such as respite or CCS, might be effective in reducing boarding for DMH clients who are served by group homes.

9.7 Recommendations

- Recommendation: *Develop a centralized bed search process.*

Creating a unified and centralized bed search process with transparent reporting of hospital adherence to "no reject" policies could reduce the elapsed time between authorization for admission and effectuation of that admission through finding an available bed.

- Recommendation: *Improve processes to facilitate weekend discharges to allow for weekend admissions.*

A significant issue related to ED boarding is reported to be the mismatch between the times that individuals present in psychiatric crisis and the times that inpatient units are available to admit them. If inpatient admissions were to proceed at a normal weekday pace over the weekend as well, the overall amount of boarding time could be substantially reduced. This may require additional weekend resources at inpatient units and HCBS service providers to enable inpatient units to discharge patients no longer in need of acute hospital care.

- Recommendation*: Reassess the need to medical clearance processes, especially for well-known individuals.*

Medical clearance processes add time and costs to the psychiatric hospitalization process. Reassessing requirements for medical clearance, when individuals and their medical co-morbidities are well known to practitioners, may ease ED wait times and facilitate timely admissions when inpatient stays are needed.

- Recommendation: *Enforce no reject provisions in hospital contracts.*

Based on the qualitative data collected, individuals boarded for long periods of time in EDs are most often frequent utilizers, individuals with co-occurring substance use disorders, individuals with intellectual disabilities, individuals with no insurance, pregnant women, or individuals with stable medical conditions. EDs are not well equipped to board these individuals for extensive periods of time. Moreover, there is an implicit compact that insurers build within their provider networks the capacity to care for all members. Common guidance is needed on admission, inclusion, and if permitted, rejection criteria. Responsible agencies and health plans could then follow through when hospitals reject individuals based on level of care considerations. Routine and consistent data collection across payers can assist agencies and health plans to take action when hospitals reject individuals based on agreed upon criteria. Clear criteria and additional levels of inpatient care capacity would contribute to ending rejection of individuals because they are "too sick" for acute inpatient admission.

- Recommendation: *Increase use of peer support services in respite, community crisis stabilization, and mobile crisis interventions.*

Peer support services, including peer respite and peer staff attached to ESPs, could be utilized to provide early diversion services, reduce stress, and advocate for the needs of individuals awaiting hospital admission.

- Recommendation: *Increase access to treatment for substance use disorders.*

Throughout the mental health care system, the behavioral health care system, and the larger health care system in the Commonwealth, poor access to treatment for substance use disorders (SUDs) confounds users of care, providers of care and system administrators. Untreated co-morbid substance use conditions are a major factor in crisis and emergency services use, inpatient admissions, and criminal justice involvement for persons with mental illnesses in the Commonwealth.

- Recommendation: *DPH and its vendors should be active partners in any initiative to reduce ED boarding.*

Lack of community interventions for individuals with SUDs and co-occurring SUDs and mental illness contributes to unnecessary ED admissions and boarding. DPH should increase access to community treatment for SUDs at all levels of care. Informants noted that SUD treatment facilities had refused multiple admissions to more intensive community services when individuals with SUDs had relapsed. Individuals with SUDs, as with mental illnesses, are susceptible to every day stresses and triggers for relapse. These illnesses can be cyclical. Individuals may relapse, and when they do, they require community treatment options so the ED does not remain the only available option for assistance.

- Recommendation: *Increase the visibility of available diversionary services*.

A need for social marketing for community-based crisis intervention remains. Most families refer individuals for crisis services and these families see EDs as safe locations for crisis assessment. Similarly, individuals see EDs as a place to go to receive medications when they miss appointments and/or run out of needed prescriptions. Once individuals are admitted to an ED, however, they are more likely to be admitted to an inpatient program. Mobile crisis assessment and intervention may be successful in diverting individuals from acute inpatient.

- Recommendation: *Increase the capacity of mobile crisis teams and their ability to bill for stabilization services.*

Two things can assist ESPs to be more successful and flexible in providing community-based diversionary services. First, mobile crisis teams should be authorized to bill for follow-up stabilization visits to adults, just as they are authorized to bill for such services to youths. Second, crisis stabilization unit capacity should be increased, especially in Southeastern Massachusetts. Inclusion of peer staff on all teams can facilitate recovery-oriented diversion, maximizing focus on individual strengths and personal goals in crisis resolution.

- Recommendation: *Increase reimbursement for psychiatric inpatient admissions.*

MassHealth reimbursement for psychiatric inpatient stays should be increased to allow units to cover the costs of staffing and coordination for the needs of a variety of individuals with complex conditions. Case-mix adjusted rates can also be utilized.

- Recommendation: *Increase use of separate but adjacent psychiatric EDs within the hospital.*

Psychiatric EDs within existing community hospitals, where individuals can receive treatment and have real beds, should be established where possible. Examples are the psychiatric EDs at Baystate and UMASS Memorial Hospitals. While crisis stabilization units will remain a community-based service, EDs are responsible for treating patients with all conditions. One informant used a broken leg as an example. EDs would not wait for an inpatient bed to open up before setting a fracture. Individuals with psychiatric disorders should not have to wait for inpatient admission to receive urgent treatment.

- Recommendation: *Allow Medicaid billing for follow-up mobile crisis intervention for adults similar to billing allowed for children and adolescents.*

Mobile crisis intervention has proven successful in reducing hospitalizations for children and adolescents. Use of follow-up mobile crisis interventions for adults and older adults could be similarly useful in stabilizing crisis in the community.

- Recommendation: *Clarify issues around the need for Section 12 commitments for medical transportation.*

Informants reported that hospitals use Section 12 commitment papers as documentation of medical necessity and ambulances often require Section 12s to be filed to transport individuals. Yet, these same informants reported that many individuals would have been classified as voluntary admissions if hospitals and ambulance companies had not required the paperwork. Under Massachusetts law, it is the individual's right to consent to a voluntary admission. Practices that bypass that right, even if designed to facilitate reimbursement, transportation or admission, abridge an individual's legal rights. Research has also shown that individuals have a greater stake in their recovery if they are given more control and participation in decision-making about their own care. Updated guidelines would help to clarify when Section 12 commitment is actually required, in cases where the individual is seeking inpatient admission.

- Recommendation: *Examine ways to improve crisis prevention and response across the continuum.*

As noted at the beginning of this chapter, psychiatric crises do not erupt from a vacuum. Crisis planning is integral to community-based services and individual recovery and wellness. As one informant noted, typically something happens to trigger a crisis—an individual loses housing, stops taking their medications, relapses on drugs/alcohol, and/or experiences escalating conflict or stress. These events are often predictable in some way, with known crisis precipitators. Individuals engaged in services, either through CBFS, or through non-DMH supported treatment, should be encouraged to develop and regularly update crisis plans. Care management would also be useful for frequent ED and hospital utilizers, whether or not they are actively engaged with treatment. Historically, both DMH and MBHP developed population analyses identifying high risk/high user client cohorts, and implemented diversion interventions. Mobile crisis intervention for adults, similar to mobile intervention through the Children's Behavioral Health Initiative (CBHI), can be used to divert group home residents' admissions to EDs, and to re-engage and stabilize individuals who have disengaged from services, whether they are DMH clients or MassHealth recipients. Many periodically experience a crisis and planning for potential crises is part of recovery. Much like chronic physical health conditions, routine and preventative care can reduce individuals' use of EDs for "ambulatory care" sensitive conditions. Most would agree that an ED is not

the ideal location in which to receive mental health treatment, no matter how dedicated and skilled the staff. Costs and emotional toil can be reduced by shoring up existing continuums of care.

- Recommendation: *Collect and utilize data to analyze trends in hospital admissions, diversions, and ED boarding across payers and populations.*

Data tracking and reporting must include analyses by payer source of trends related to: psychiatric hospital admission and diversion rates; inpatient lengths of stay for both acute and continuing care; and ED boarding by type of patient and elapsed boarding time. Such data are needed to identify and address the root causes of ED boarding.

For reasons of economy and recognition of relatively short lengths of stay in acute inpatient settings, bed access is managed on a statewide basis rather than for purposes of continuity of care in the Commonwealth. This policy, however fiscally sound on its surface, creates challenges, particularly for those children, adolescents and adults who are repeatedly hospitalized and suffer the consequences of discontinuity in their inpatient and home and community-based care.

"The individuals who are the most vulnerable and have the most complex needs must start over each time they are admitted to a hospital."

--Stuart Komen

Walden Behavioral Care - Discussing Bed Finding, Inpatient Treatment and Discharge Planning Challenges

10. Findings and Recommendations: Prior Authorization for Psychiatric Inpatient Care

The issue of prior authorization for psychiatric inpatient treatment has received much discussion and analysis during this project. There are four questions related to this issue. These are:

1. To what degree are the requirements and process for prior authorization adding to the elapsed time between presentation and disposition for people in psychiatric crisis presenting in hospital EDs?
2. To what degree are requirements for prior authorization inconsistent with the spirit and intent of mental health parity?
3. To what degree are requirements for prior authorization an effective deterrent to inappropriate psychiatric hospitalization?
4. What are the possible consequences of eliminating the prior authorization process?

10.1 Elapsed Time

As noted in Chapter 9 of this report, anecdotal information from ED physicians suggests that the prior approval process accounts for about 1 to 1.5 hours of the overall time necessary to process an ED presentation and achieve a successful disposition for adults in psychiatric crisis. However, this average figure is reported by some ED physicians to mask longer elapsed times for people with complex medical or substance use issues in addition to psychiatric crises.

MBHP maintains 24/7 staffing for timely response to prior authorization requests. There are no reliable data on the elapsed time necessary to obtain prior authorization from the Medicaid MCOs and the commercial insurers. Anecdotal information suggests that in some cases the ED must wait for the next business day to obtain prior authorization from some commercial insurers. In addition, there is no data available that would confirm the hypothesis that elapsed times for admission to inpatient care following an ED presentation is shorter for the two health plans (Blue Cross/Blue Shield and Tufts) that do not require prior authorization for psychiatric hospitalization.

Although there are no comparable data on prior authorization approval rates across Medicaid MCOs and commercial payers, there is a general perception that approval is granted more than 95 percent of the time when prior authorization is requested for psychiatric hospitalization. A number of ED physicians and others have argued that very high approval rates support the argument that the process is superfluous and burdensome without producing positive results. As will be discussed below, it is not known whether years of practice working with prior authorization requirements have honed the ability of EDs to present for approval only those people clearly meeting the admission standards. People not likely to meet the admission criteria may be diverted from admission before a request for prior authorization is made.

Given the lack of empirical data that are comparable across payers, the prior authorization process has become symbolic of the overall issue of ED boarding for adults in psychiatric crisis. From the data that is available, it appears obtaining prior authorization is a substantially smaller contributor to the overall ED boarding elapsed time than issues such as Friday through Sunday admission difficulties, and the problems associated with finding beds for people with substance use and/or medical co-morbidity. Nonetheless, in the face of these other difficulties, the need to obtain prior authorization is correctly perceived as adding

more steps and more time to the overall process of obtaining psychiatric inpatient services for people in EDs with psychiatric crises.

10.2 Mental Health Parity

There is no specific prohibition of prior authorization requirements for psychiatric inpatient care in either the federal or Massachusetts mental health parity laws. However, the case is frequently made that requiring prior authorization for psychiatric inpatient treatment, when such prior authorization is not required for hospitalization related to other medical conditions, violates the principles of mental health parity. ED physicians, mental health consumers, families and advocates have reported to the MHAC that people presenting in EDs with cardiac or respiratory conditions, injuries, etc. are admitted to the hospital immediately with no need for authorization from the person's insurance carrier or Medicaid. State and national reports indicate that this is not entirely true, in that some individuals with medical conditions wait for beds to open or for insurers' approval. Moreover, hospitals are at increasing risk for decertification from Medicare and other payers, but these reports also cite that individuals with substance abuse and/or mental health conditions wait more frequently and for longer periods. People point out that requiring prior authorization for psychiatric inpatient treatment exacerbates the stigma of mental illness at a time when full integration of mental health and physical health treatment is being sought at the policy and practice levels. The perception that prior authorization requirements are de facto discriminatory compounds the perception that they are time consuming and superfluous, thereby contributing to the overall desire to eliminate prior authorization for psychiatric admissions.

On the other side of this issue, some people in the field point out that admissions for medical crises such as heart attacks are not clinically equivalent to admissions for mental health crises. There are no community alternatives for many medical emergencies, whereas there are clinically effective community alternatives for responding to psychiatric crises. If mental health admissions are not clinically equivalent to other types of admissions of medical emergencies, then the concept of parity may not apply to prior authorization. In addition, many mental health consumers have had unsatisfactory experiences with psychiatric hospitalization, and believe that the prevention of hospitalization when community alternatives are available and appropriate is a positive policy goal.

10.3 Deterrent to Inpatient Hospitalization

Historically, prior authorization requirements for inpatient psychiatric treatment have been instituted in most states and by multiple payers. These have been based on the understanding that community alternatives to psychiatric hospitals are frequently clinically appropriate and can result in reduced disruption and loss of community supports and housing on the part of psychiatric patients. Despite this widespread history of implementation, Abt/TAC has been unable to find any research studies or peer reviewed articles that analyze the actual results for people or systems of the implementation of prior authorization standards and procedures. In Massachusetts, there are data from some payers on the rate of diversion from inpatient hospitalization, but there are no data on which people with what conditions and with what availability of housing and community supports can be successfully diverted. Nor are there any data that compare clinical and social indicators of positive outcomes for people who are diverted as compared to people for whom a psychiatric admission is authorized. As noted above, two health plans in Massachusetts (Blue Cross/Blue Shield and Tufts) do not require prior authorization for psychiatric hospitalization. However, at this point there are no publically reported data on the effects of removing

prior authorization requirements on either hospitalization rates, subsequent decertification of care, or outcomes.

As noted above, some people in the mental health field presume that EDs have become skilled over time in discerning which patients will be successfully approved for psychiatric inpatient treatment. It is presumed that people who might not get approved for inpatient treatment are never presented for approval, thereby explaining the very high prior authorization approval rates for psychiatric hospitalization. Under this scenario, the presence of prior authorization requirements may act as a deterrent to hospitalization without the necessity for a payer to deny the inpatient admission. However, there are no reliable data to support these presumptions.

10.4 Possible Consequences

There is a commonly held assumption[17] in the mental health field that prior authorization does, in fact prevent unnecessary hospitalization, and does increase the proportion of successful diversions to community-based care. There is a corollary assumption that the requirement for prior authorization reinforces the ability of mobile crisis teams to intervene and arrange for community placement as appropriate. There is an assumption that absent the prior authorization requirement, there would be less incentive to engage mobile crisis services and other crisis stabilization resources, resulting in a larger proportion of people presenting in psychiatric crisis being admitted to the hospital.

A related issue, discussed in more detail in Chapter 9, is that the majority of adults presenting in psychiatric crisis in EDs have no connection to the Commonwealth's community mental health system. Absent the prior authorization requirement, opportunities to link these individuals to community mental health services might be lost.

The major concern related to removal of prior authorization requirements is that the current supply of acute psychiatric beds would fill up more easily and quickly, thereby exacerbating ED waiting time for a larger number of people. In Chapter 9, the correlates of long waiting time for psychiatric admissions are discussed in detail. The available data show that people with substance use and/or complex medical co-morbidity are more difficult to place in psychiatric inpatient beds. The data also show that people with Medicare as their primary payer are admitted more quickly, whereas people with Medicaid and commercial payers may experience longer wait time for admission. The data also show that people presenting in psychiatric crisis on Friday or Saturday wait, on average, much longer for a psychiatric inpatient bed. It is not clear how removal of the requirement for prior authorization will correct any of these difficulties.

Instead, the removal of prior authorization may make it easier for "favored" patients (e.g., those with Medicare and those with less complex conditions or the absence of substance use), some of whom may be appropriate for diversion, to access available psychiatric inpatient beds, thereby increasing the competition for available beds for these other populations. If this phenomenon occurs, long wait times in EDs may be exacerbated rather than improved as a consequence. This may also inflate the perceived need for more inpatient beds.

[17] Anecdotal information only – there are no studies on this topic.

Another concern, expressed by hospital personnel in particular, is that un-constrained admissions could result in a larger number and proportion of de-certifications of inpatient care soon after the admission is accomplished. Payers such as MCOs and commercial insurers could employ criteria for approval of continuing stay in the inpatient setting that are very similar to the criteria now used for prior authorization. In this scenario, inpatient psychiatric units might have to effectuate a larger number of discharges closer to the admission date than is now the case. The consequence could be increased costs for hospitals and more inefficient use of existing psychiatric inpatient capacity. It should be noted that de-certification of a patient in a psychiatric inpatient bed only results in the loss of payment for that patient, not in the actual discharge of the patient.

In addition, if people are admitted without prior authorization, there could be additional pressure to move people to DMH's continuing care beds. This could be a result of the difficulty of finding appropriate community discharge dispositions for people who have been de-certified. It could also simply result from higher overall inpatient unit census numbers resulting from the removal of prior authorization requirements.

Finally, removal of the necessity for prior authorization also removes the person's MCO/payer source from the discussion about good clinical interventions for people in psychiatric crisis. In many cases the MCO or other payer functions as the person's clinical home or clinical care coordinator. If the MCO/payer is not involved in prior authorization, they may not even be aware their member is at risk of hospitalization. Clinical home/care coordinator functions related to finding clinically appropriate interventions other than hospitalization would be excluded, as would be care coordination efforts related to early discharge planning and aftercare coordination.

In brief, removal of prior authorization requirements could create increased pressures on the psychiatric inpatient system that is already operating, in aggregate, close to its licensed capacity. Some pressure could be taken off ED functions related to responding to psychiatric crises and effectuating hospital admissions. The result could be that pressure would be shifted to hospital psychiatric inpatient units, which will have to absorb increased numbers of admissions and pressures for quick discharge to either the community or to continuing care beds.

10.5 Discussion of Options

As can be seen from the above discussion, there are compelling reasons to eliminate requirements for prior authorization for psychiatric inpatient treatment. At the same time, there are substantial risks and potential costs to such removal, most particularly to hospitals that provide acute psychiatric inpatient treatment, which may face increased numbers of inpatient de-certifications and increased pressures for community placements.

It is unlikely that elimination of prior authorization requirements will repair the difficult and chronic issues of ED boarding and of finding the right treatment for people with multiple and complex conditions at the right time in the right setting and geographic location. These issues are very likely to persist until other substantive changes are made across multiple parts of the overall mental health system. For example, removal of prior authorization is not an intervention that will correct the difficulty of finding psychiatric inpatient beds for already-approved people on Fridays and Saturdays.

Despite the potential risks and costs, and despite knowledge that many additional system issues need to be addressed and corrected, Abt/TAC is persuaded that efforts should be made to remove prior authorization

from the process of responding to psychiatric crises in hospital EDs. On balance, we believe the parity argument is telling. This is in part because parity is a mechanism to attain fairness and equity of access to health benefits for people with mental illness in the same way as they access other medical benefits. Parity is also a mechanism to eliminate the stigma of mental health treatment, and to foster full integration of mental health within health care systems.

In addition, removal of prior authorization may eliminate some of the "mythology" about the causes of ED boarding, providing greater clarity on problems in the system that can be objectively identified and addressed. If EDs and emergency services teams are not using valuable clinical time obtaining prior authorization, it may be possible to focus more on psychiatric inpatient service barriers related to substance use, clinical co-morbidity, and payer source.

We do not recommend elimination of prior authorization without first taking a number of steps to: (a) assure that other problems associated with psychiatric inpatient treatment are corrected to relieve pressure on the inpatient system[18] before opening the door wider for new admissions; and (b) defining data elements and data sources to be collected and analyzed to track the extent to which negative consequences of the change are being experienced by people, inpatient and outpatient providers, and the mental health system as a whole. For example, it is important to track admission rates and whether there is any increase in the number of de-certifications shortly following admission. It will also be necessary to track ED presentations and dispositions for all payers to discern whether the positive changes are occurring.

All payers and all MCO intermediaries need to be involved in any strategy to eliminate prior authorization. Parity and equity of access means that all people with similar conditions have equal access to psychiatric inpatient treatment regardless of payer source or intermediary. MCOs and commercial insurers will have to assure network adequacy for inpatient treatment on parity with other payers, and will also have to participate in all data reporting and analysis on an equitable basis.

Abt/TAC has one substantial concern about the possible consequences of eliminating the prior authorization requirement: that the important functions of ESPs in the overall mental health system going forward may be diminished. As noted above, ESPs have been successfully diverting more than one half of all psychiatric crisis presented from hospitalization. These diversions are beneficial to mental health consumers, because admission to the hospital is not necessarily a good or preferred clinical outcome for people in mental health crisis. Nor is it an appropriate fail-safe for unavailable or inadequate community-based alternatives. If admission as opposed to diversion becomes the de facto practice for EDs, then mental health consumers will be lose opportunities to attain better clinical and personal outcomes than had been available for them in the past.

Diverting more than one half of the psychiatric crisis presentations also benefits hospitals, since it is difficult to imagine that they could absorb a large additional infusion of admissions if the diversion process is substantially reduced. In addition, it is likely that a patient capable of being diverted to an appropriate community alternative would be de-certified for inpatient treatment quickly. As noted above, such de-certifications are likely to increase clinical time and effort and also financial risk for the admission hospitals.

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[18] For example, steps to improve access to CC beds should be implemented to assure that psychiatric acute inpatient beds are not partially filled with people awaiting continuing care if increased admissions to current inpatient capacity are to be effectively accommodated.

Absent the need for prior authorization, some hospital EDs may no longer see the need or benefit of engaging the ESP team in efforts to resolve the psychiatric crisis and avoid unnecessary hospitalization. Unless hospitals voluntarily contact ESPs, there would be no formal mechanism for them to become actively involved. In these cases people in psychiatric crisis in EDs would not have access to appropriate diversion resources, such as crisis residential and crisis respite programs.

In the long run it will be beneficial for ESPs/mobile crisis teams to carry out most of their work in home and community settings before a person is taken to the ED. This has already occurred to a certain extent for children in psychiatric crisis in Massachusetts. In most months over 50 percent of mobile crisis intervention (MCI) contacts are in community as opposed to ED settings. In addition, the child/adolescent MCI program has regularly attained almost 80 percent diversions from inpatient hospitalization.[68] This success rate is highly beneficial to youth and their families, but it also assists to reduce ED presentations and boarding issues for youth.

The adult ESPs need to emulate this emphasis on community-based "upstream" interventions and the success rate in securing appropriate home and community-based alternatives. As with the MCI program for youth, it will take significant effort and time to enhance the ESPs practice approaches and to increase ESP acceptance and perception of value on a statewide basis. While those improvements are being implemented, it remains important for the ESPs to be directly involved with hospital EDs and with ED based efforts to divert from hospitalization when clinically appropriate. Eliminating prior authorization without at the same time enhancing the capacities and functions of the ESPs could have negative consequences for the entire public and private mental health system.

10.6 Recommendations

- Recommendation: *Application of prior authorization for psychiatric inpatient care could be viewed as a mental health parity issue, and for this reason should be discontinued.*

In order to eliminate prior authorization in a manner that conforms with parity, the following considerations must be addressed:

  - All payers, including commercial insurers and Medicaid MCEs, must be involved in developing policies and procedures to replace current prior authorization practices;
  - New policies and procedures for processing admission to psychiatric inpatient care must include a continued role for ESPs in EDs as well as in other settings; and
  - Data tracking and reporting must include analyses by payer source of trends related to: the rate of payer de-certification of inpatient treatment following admission.

11. Findings and Recommendations: Home and Community-Based Services

Home and community-based services (HCBS) are the backbone of the Massachusetts mental health care system, regardless of individual need or payer source. Efforts to answer the discrete questions posed by the Phase I and Phase II questions outlined in the MHAC legislative language - whether about continuing care bed capacity, insurance changes, emergency services, feasibility of crisis stabilization units, or alternatives for civilly and criminally committed persons with behavioral health conditions in our jails and prisons – share a common denominator in gaps in the capacity or management of the HCBS system. As detailed earlier in this report, a combination of economic conditions and reform priorities conspired to reduce resources and fragment authority in the care system. Consumers, family members, providers and government officials providing testimony to the MHAC are in agreement about those gaps.

In the recently published Behavioral Health Barometer, SAMHSA provided lead indicators of behavioral health needs in the Commonwealth. Among the agency's findings for the past year (2012 - 2013) among youth and adults with mental health conditions are the following:

- Major depressive episodes were reported by 8.3 percent of persons aged 12 to 17;
- Of those, only 42.6 percent report receiving treatment, leaving 57.4 percent of youth experiencing a major depressive episode without treatment;
- Among persons aged 18 or older, 3.9 percent report serious thoughts of suicide;
- Among persons aged 18 or older, 3.7 percent report having a serious mental illness;
- Of persons aged 18 or older with any mental illness, 49.1 percent report receiving treatment, leaving 50.9 percent without treatment; and
- Among those receiving treatment, 72.2 percent of adults and 57 percent of youth report improved functioning as a result of treatment.[69]

In sum, in spite of near universal health insurance coverage, more than half of Massachusetts residents reporting a mental health condition and in need of treatment did not receive treatment. However, the majority of those receiving treatment report functional improvement as a result of treatment.

11.1 Current Landscape in Massachusetts

Table 14 details HCBS services funded in the DMH budget. The period under review is FY 2010 through FY 2013, the period available when this assessment was performed during Phase I of the MHAC study in 2013. Across these years, DMH received modest year over year increases of a low of 1.6 percent in FY 2011 and a high of 4.5 percent in FY 2012. Neither of these sums allows DMH to grow, and with wage and capital inflation in programs, DMH had to reduce and restructure services to live within the bounds of these budgets.

Table 14. DMH Budget by HCBS Service Type: FY 2010 to FY 2013

DMH Service Type	FY 2010	FY 2011	FY 2012	FY 2013
ADULT RESIDENTIAL SERVICES	$3,426,081	$872,234	$614,636	$685,265
COMMUNITY BASED FLEXIBLE SUPPORT	$231,019,652	$238,932,726	$251,373,407	$259,070,584
CHILD/ADOL RESIDENTIAL SERVICE	$22,062,359	$21,224,780	$20,614,214	$19,549,662
INTENSIVE RESIDENTIAL TREATMENT	$13,937,257	$14,001,197	$14,865,392	$14,990,990
CLINICALLY INTENSVE RESID TREATMENT	$1,986,286	$1,936,286	$1,936,286	$1,936,286
TOTAL FUNDING	**$272,431,635**	**$276,967,224**	**$289,403,935**	**$296,232,787**

11.1.1 MA DMH System Capacity – Adult Services

As noted earlier in this report, the DMH system provides for an array of services across the continuum. DMH services are voluntary, and recovery-focused. One concern mentioned by family members, is that they cannot refer their adult children for services. The referral process is opaque, with no official wait list for services. Individuals with lived experience of mental health conditions cited similar challenges with accessing new services. They reported that it is difficult to find new services or change levels of service unless they had a case manager or care manager to assist in the process. As shown in **Table 15** below, capacity for these DMH services has declined since 2010. This is particularly notable in terms of case management services. Case management is one service that has often supported individuals from falling through any cracks in the system. Case management has also traditionally served to coordinate services to ensure timely hospital discharges and appropriate community services such as housing. While case management dollars were rolled into CBFS, the case management function still has a necessary role in the continuum of services. Massachusetts health reform has increased the number of individuals with MassHealth, and MBHP, through MassHealth, contracts for some of these services, such as PACT. Therefore, the net decline in access, based on available data is difficult to ascertain at this time.

Table 15. Adults Served By Service, Division, and Fiscal Year (Run Date: 10/10/13)

			Metro Boston	Central	Metro Suburban	North East	Southeast	Western	Statewide
CBFS	**Current Capacity**		**2,868**	**1,266**	**1,711**	**2,361**	**1,592**	**2,000**	11,798
	Current #Providers		**3**	**3**	**8**	**5**	**5**	**4**	
	Current #Contracts		**4**	**6**	**11** (2 State Op)	**9** (1 State Op)	**12** (4 State Op)	**9**	**51** (7 State Op)
	# Served	FY 10	3,240	1,437	1,872	2,657	1,847	2,408	13,461
		FY 11	3,220	1,440	1,888	2,716	1,898	2,341	13,503
		FY 12	3,194	1,456	1,867	2,732	1,880	2,272	13,401
		FY 13	3,160	1,417	1,884	2,689	1,856	2,199	13,205
Adult Case Mgmt	**Current Capacity**		**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Current # Sites		**4**	**3**	**4**	**5**	**6**	**6**	**28**
	# Served	FY 10	961	1,177	1,011	1,546	1,376	1,217	7,288
		FY 11	704	903	793	1,153	1,144	795	5,492
		FY 12	806	1,001	773	1,232	1,037	815	5,664
		FY 13	766	916	762	1,256	985	796	5,482
PACT	**Current Capacity**		**70**	**120**	**130**	**290**	**305**	**50**	**965**
	Current #Providers		**1**	**1**	**2**	**2**	**4** (1 State Op)	**1**	**10** (Undup.)
	Current #Contracts		**1**	**2**	**2**	**4**	**5** (1 State Op)	**1**	**15** (1 State Op)
	# Served	FY 10	132	135	132	228	334	60	1,021
		FY 11	83	136	131	255	351	0	956
		FY 12	76	140	144	288	378	0	1,026
		FY 13	84	135	147	309	393	23	1,091

11.1.2 MA DMH System Capacity – Child and Adolescent Services

DMH provides a continuum of services for children and adolescents. Across the nation, children's services, including research on effective interventions, has lagged behind those available to adults. Similarly, across the nation, states are working to reduce residential placements, often outside the child's local community, in favor of community-based services and supports. CBHI has been working to strengthen children's services in Massachusetts across the continuum of care. DMH provides for IRTP, CIRTP, child/adolescent residential and case management services, as well as crisis services described in Section 8.

As shown in **Table 16** below, numbers served through downstream services has declined since 2010. This may be due to an increase in upstream services mandated as part of Rosie D (*Rosie D. v. Romney, January 26, 2006*) and operationalized as part of CBHI. Mobile crisis intervention has assisted parents to address challenging behaviors in the home and community. The goal of the development of a rich array of community-based services and supports remains a work in progress, as mental health advocates and program administrators continue to report challenges for children, adolescents and their families at the intersection of the public and private insurance sectors. Selected statements from informants to the MHAC include:

- Private or commercial insurers currently depend upon publicly financed care infrastructure without contributing to its costs. For example, an estimated 72 percent of those using IRTP programs are children and youth with private insurance. An estimated 75 percent of those using MCPAP services are practitioners treating privately-insured children and youth, although the program is publicly financed.

- Despite the needs of children and youth, private payers refuse to include school-based health clinics in their networks, contrary to CBHI policies.
- Families with private insurance who are trying to gain access to intensive services for their children and adolescents with serious emotional disturbances often move their children to MassHealth to qualify for more robust benefits.
- On a recent day at Children's Hospital in Boston, 10 children were in the ER awaiting acute inpatient placement, an additional nine were being boarded on medical units awaiting acute inpatient placement, 16 were in psychiatric inpatient beds at the hospital, and five more were waiting to be discharged to DMH IRTP or continuing care beds. A Children's Hospital representative noted that a number of the "stuck" cases were privately-insured children, some of whom were "stuck" despite beds available in the system because their insurers did not have network affiliations/contracts with the hospitals that had available beds.[70]

Table 16. Children and Adolescents Served By Service, Division, and Fiscal Year (Run Date: 10/10/13)

			Metro Boston	Central	Metro Suburban	North East	Southeast	Western	Statewide
IRTP	**Current Capacity**		**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**72 + State Op**
	Current #Providers		n/a	n/a	n/a	n/a	n/a	n/a	**6** (1 State Op)
	Current #Contracts		n/a	n/a	n/a	n/a	n/a	n/a	**6** (1 State Op)
	# Served	FY 10	17	14	14	25	25	15	110
		FY 11	27	12	10	25	21	10	105
		FY 12	28	13	10	26	28	9	114
		FY 13	20	16	15	21	26	5	103
CIRTP	**Current Capacity**		**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**24 + State Op**
	Current #Providers		n/a	n/a	n/a	n/a	n/a	n/a	**3** (1 State Op)
	Current #Contracts		n/a	n/a	n/a	n/a	n/a	n/a	**3** (1 State Op)
	# Served	FY 10	2	1	0	1	1	19	24
		FY 11	2	1	0	1	0	21	25
		FY 12	2	0	0	1	0	22	25
		FY 13	2	0	0	1	0	21	24
C/A Residential	**Current Capacity**		**67**	**29**	**92**	**92**	**19**	**106**	**405**
	Current #Providers		**6**	**6**	**10**	**14**	**7**	**10**	**33** (Undup.)
	Current #Contracts		**12**	**15**	**17**	**29**	**15**	**10**	**98**
	# Served	FY 10	87	35	125	131	15	289	682
		FY 11	86	31	126	125	11	266	645
		FY 12	81	32	118	104	14	259	608
		FY 13	80	25	127	84	20	212	548
C/A Case Mgmt	**Current Capacity**		**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
	Current # Sites		**1**	**3**	**4**	**5**	**6**	**6**	**25**
	# Served	FY 10	189	89	189	256	194	304	1,221
		FY 11	156	74	173	233	178	254	1,068
		FY 12	132	72	172	189	188	256	1,009
		FY 13	137	82	172	178	184	229	982

11.1.3 Outpatient and Related Community Services Data from the Massachusetts Behavioral Health Partnership

MBHP is the primary payer for most outpatient and related Medicaid reimbursable community services in Massachusetts. Abt/TAC received data from MBHP for FY 2011, FY2012 and the first quarter of 2013 showing service utilization and costs for outpatient services provided during those time frames. No data on similar utilization or expenditures for outpatient mental health services was forthcoming from the Medicaid MCEs or private commercial insurers.

The benefit design for community mental health and substance use services is quite expansive, and represents of the types and modalities of outpatient behavioral health services considered to be important components of modern community-based systems. The benefit design also includes an array of crisis response and diversion services, including specialized diversion services for children and adolescents. The data does not include sub-state or regional disaggregations, and thus it is not possible to discern differences among the DMH regions with regard to utilization or costs of services.

In addition, there are no national or research-based standards or norms defining the appropriate amount of mental health and substance use outpatient treatment services needed for standard populations or prevalence-defined demand populations. Thus there are no benchmarks with which to assess the relative adequacy of the Massachusetts outpatient service utilization and cost. In other sections of this report Abt/TAC notes that: (a) most respondents consider outpatient services to be too limited and too difficult to access throughout Massachusetts; and (b) that rates for some outpatient services are considered by providers to be too low to provide incentives to expand coverage to meet the need/demand for such services.

In testimony to the MHAC, providers reported considerable and consistent financial losses associated with the delivery of outpatient treatment services. These losses occur across several payers, but are most acute for MassHealth and Medicaid MCE contracts. These losses are greater since DMH reduced its role as a payer of last resort for outpatient services and cut supplemental payments for complex outpatient cases that covered the costs of collateral services delivered to those patients. Among the statement provided to the MHAC at its June 2013 meeting were the following:

- 84 percent of providers lost money delivering outpatient mental health services during the last fiscal year, with the average loss being 25 percent of the total cost of delivering care.[71]
- Waits in outpatient programs for medication consults with psychiatrists are 4 to 8 weeks long and providers lost as much as $248 per episode for these consults in FY14.[72]

Table 17 below summarizes data from MBHP on certain categories of services for MBHP-enrolled members. The categories used in the table represent aggregations of a variety of different service types. For example, outpatient service includes individual and group therapy, medication visits and psychological testing, among other sub-types of services. The average costs per discharge and average unit rates reflect all these different service modalities, and should not be considered to be the actual unit rate paid to providers for services.

Table 17. MBHP Services Utilization and Costs for Select Service Categories for FY 2011, 2012 and 2013[19]

Service Category	2011 Units per 1,000 member months[20]	2011 average cost per discharge	2011 Average unit rate	2012 Units per 1,000 member months	2012 average cost per discharge	2012 Average unit rate	2013 Units per 1,000 member months	2013 average cost per discharge	2013 Average unit rate
All outpatient services[21]	11,575	NA	$45.41	11,545	NA	$47.42	11,233	NA	$47.06
Partial hospital	6.57	$1,057	$116.18	5.56	$1,529	$117.73	4.93	$1,530	$119.39
All diversionary services[22]	2,583	$ 2,109	$ 80.66	2,822	$2,109	$74.62	Not	Comparable [23]	

There do not appear to be substantial changes from year to year in these data. The average utilization per 1,000 member months and the costs per discharge and average unit rates for these categories of services appear to be relatively stable. This does not mean that there have been no changes in relative access and utilization in some communities within the Commonwealth. Nor does it mean that there have been no changes within sub-types or modalities within the categories of services. However, as with the hospital data presented in Chapter 8, there is evidence that the system is operating at "steady state," with few variations over time.

11.2 Recommendations for and Flexibility of Solutions to Fill Gaps in Services

- Recommendation: *Fill gaps in the care system and reverse the depletion of clinician competence and fragmentation of care responsibility.*

Among the service gaps to be filled are:

- Housing and Residential Support (CBFS);
- Clinical Treatment and Recovery Services;
- Child, Adolescent and Young Adult Services; and
- Adult and Elder Services.

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19 First quarter only

20 Units per 1,000 member months is a more accurate comparison across fiscal years than unduplicated users" because we only have service user data for the first quarter of 2013.

21 Includes substance use as well as mental health outpatient services

22 Includes specialized diversion services for children/adolescents as well as regular crisis diversion services for adults. Also includes substance use diversionary services as well as mental health diversionary services.

23 The definitions of services included within this category changed between FY 2012 and FY 2013.

There is an urgent need to reduce wait times for services that will not only meet individual needs more timely but will also mitigate backup in EDs and inpatient units. In order to achieve this, key gaps in the care system must be filled, and the depletion of clinical competence and fragmentation of care responsibility must be addressed. These steps are essential to accountable operation of the mental health care system in Massachusetts.

The call in 2009 for a "robust community-based system" that emerged from the DMH Inpatient Study Commission has not yet been met. [73] Since that time, as noted earlier in this report, resources have been cut from the system, particularly adult services funded through the DMH budget, and as will be addressed in subsequent sections of this report, reimbursement rates for CBFS , outpatient and inpatient services lag costs of delivering care. Per the Commonwealth's Community First Olmstead Plan and consistent with the testimony from all constituents to the MHAC, steps include:

- Improve transitions from institutional to community care;
- Improve transitions across levels of community-based care;
- Expand access to community-based living and treatment supports;
- Improve the capacity and quality of community-based treatment, rehabilitation and recovery supports; and
- Expand access to affordable housing and employment services.

- Recommendation: *Collect and utilize data from all payers to guide system improvements.*

The following data analyses should guide system improvements:

  - Measurement of demand for care by age group and need level;
  - Inventory of services supply by age group and service type across all providers; and
  - Measurement of system spending by service type across all public and private payers.

- Recommendation: *Utilize DOI report to inform benefits design, care management, and care authorization to achieve parity.*

Parity issues remain in access to habilitative, rehabilitative and continuing care services in the private insurance sector. Further study, pending receipt of the DoI Report, is needed regarding benefits design, care authorization and care management.

  - Insert pending update to MHBP community system data
  - Insert updated information on reimbursement rates for Outpatient Services

12. Findings and Recommendations: System Financing and Rate Structures

12.1 Current Landscape in Massachusetts[74]

As noted earlier in this document, from 2007 to 2013, reimbursement rates for a range of mental health services delivered in the Commonwealth were largely stagnant. For example, inpatient reimbursement rates provided by the MassHealth program increased a total of 3 percent over a 5 year period. Similarly, outpatient rates have in some cases received modest increases under MassHealth and several commercial insurance payers that do not keep pace with rates of inflation and in others have been reduced, driving a number of providers into deficit positions in delivering outpatient care. [75]

Moreover, the time period described, which has been tied to the economic downturn in the Commonwealth, followed a 20 year period during which there was no uniform or comprehensive review of rates for contracted health and human services in the Commonwealth leading to the passage of Chapter 257 of the Acts of 2008.[76] Chapter 257 set a four-year timeline for implementing a new rate setting process, to be complete in January of 2014.

During this period, the Commonwealth has been concerned, as part of its universal health care reform initiative, with moderating the cost of delivering health care. A number of rate restructuring and related payment reform initiatives are underway. A call for rate relief may seem contrary in this environment. However, the larger goal in the Commonwealth's health care reform is to improve access to clinically effective as well as cost efficient care – consistent with value based purchasing principles. Solving problems of poor or delayed access to outpatient and inpatient care, because providers do not have the resources to deliver timely or intensive care under the current rate structures requires some rate relief, in addition to administrative and regulatory steps described in the subsequent section of this report.

12.2 Existing Research and Findings on the Topic

- With EOHHS and MBHP cooperation, PCG compared the delivery cost per unit for inpatient and outpatient services to the effective MBHP rate for various levels of care in 2012. PCG identified the gap as the "Delta" displayed in **Table 18** below.

Table 18. MBHP Study of Selected Mental Health Services Rates: FY 2013

Level of Care	Rate Delta per Unit	% Delta
Diagnostic Services	$ (40.81)	-36.1%
Individual & Family Therapy	$ (3.95)	-8.2%
Group Therapy	$ (7.63)	-44.8%
Medication Management	$ (26.01)	-37.4%
Family Consultation	$ (11.74)	-24.5%
Community Based Acute Treatment	$ (23.00)	-5.2%
Inpatient	$ (188.19)	-20.9%

12.3 Recommendations for and Feasibility of Selected Solutions to System Financing and Rate Problems

- Recommendation: *Repair rate inadequacies in the MassHealth program, including MBHP and Medicaid Health Plans. Consider findings of the recent PCG study to guide the effort.*
- Recommendation: *Repair rate inadequacies in the employer and commercial Health Plans, providing those plans with results of efforts in the public insurance sector.*

In testimony to the MHAC, providers of inpatient care provided information that underscored the rate problems identified, and reported above in this document, by the outpatient care providers. Comments at the June 2013 MHAC meeting include:

- Massachusetts hospitals reported that ER charges for care at levels 1 through 5 are reimbursed at $40 to $350 per episode. These fees barely cover costs of simple cases. When special staffing is required, these costs are not covered. Steward Hospital estimated 2013 losses for the delivery of ER services in its hospitals at $2 million for three hospitals with the busiest EDs and $3 million across all of its hospitals.
- Hallmark Health Systems, which operates 90 psychiatric inpatient beds, reported high MassHealth use and the loss of an estimated $342 per day on MassHealth patient care, totaling approximately $1.2 million per year. Hallmark reported that on any given day between 40 percent and 60 percent of the inpatients are awaiting discharge, often being reimbursed while they wait at reduced AND rates.
- Providence Health Systems operated two-thirds of the psychiatric inpatient capacity available to Western Massachusetts, with 126 beds. Half of its revenue for these beds is from MassHealth and because of the depleted rates, the Providence operations require annual supplemental funding of approximately $7 million from the Distressed Hospital Fund to survive.
- Arbor Hospitals reported refusing medically complex patients because the rate structure does not cover the costs of expensive medications, including those for HIV/AIDS treatment. General Hospital psychiatric units are unable to get reimbursed for medical care required by complex patients. [77]

Pursuant to the Public Consulting Group Study commissioned by MBHP identifying the scope of gaps in inpatient and other service rates, MassHealth authorized a one-time supplemental payment of $5 million in FY14. These gains must be preserved and additional assistance provided to cover gaps in reimbursement and assure the quality and sustainability of services.

13. System Reform, Accountability and Alignment Opportunities

13.1 Fragmentation of Authority and Loss of Single Point of Accountability

- Recommendation: *Reestablish a single point of clinical authority and accountability for individuals served in the public and private care systems. Redefine and align roles of system players across payers.*

This is a critical need, particularly for those with more serious and potentially disabling conditions, to have their care and the resources associated with the provision of their care, closely coordinated by those who can be not only responsible but also accountable for resource allocation applied toward good results.

Changes in the role of DMH and other players fragmented and frayed the single point of clinical authority and accountability and care management functions are not consistently defined to replace the former approach to ensuring responsible and accountable care.

13.2 Care Management Infrastructure Alignment

- Recommendation: *Specify respective roles of public and private sector players for care management. Review care and utilization management protocols to identify needs for better alignment to avoid gaps in care, cost shifting and disparities affecting those in need.*

There is no longer a single point of clinical, care and financial responsibility in the public sector, with DMH, MassHealth and Medicaid MCEs playing roles in the sector, and the private sector, while becoming a stronger player in behavioral health care is not well integrated with the public sector.

DMH Area and Central Office staff have always performed care and utilization management functions, monitoring the flow and capacity of the system; however, DMH is not considered a managed care entity and much of the system is no longer, as noted, under its purview.

As system financing and responsibility has fragmented, and public and private systems converge, DMH, MassHealth, MBHP, and the Medicaid and Dual Eligible health plans, as well as health plans serving privately insured persons might consider aligning efforts, collaborating and sharing data to manage together the gaps and backups in the current care system.

13.3 Reporting and Performance Measurement

- Recommendation: *Establish standard access, utilization, cost and quality measures and performance benchmarks. Implement reporting requirements for both public and private insurance programs and payers. Set periodic reviews of these reports to determine system performance in comparison to benchmarks and to identify opportunities for system improvements.*
  - Consult CHIA on defined reporting elements for the APCD as a starting point for a unified measurement and reporting system, pursuant to the intent of Chapter 224.
  - Consult the Health Policy Commission on selected Chapter 224 authorities and studies, as well as grants that may support the development of behavioral health system measures and reporting.

- Consult the Massachusetts Attorney General on selected grant opportunities and regulatory authorities that may support the development of behavioral health system measures and reporting.
- Align public and private insurance reporting through health planning and regulatory authority of DoI, DMH, DPH and MassHealth to eliminate burden, streamline reporting, and gain cross-cutting usable data for system performance monitoring and management.

13.4 System Mandates and Reforms

13.4.1 Utilizing National Mandates and Reforms

- Chapter 224 provides regulatory authority to monitor and enforce benchmarks for health care cost growth, promote alternative payment methods, wellness and prevention, and integrated care.
- Chapter 224 also provides for health resource planning and assessment of parity compliance.
- CHIA, for example is collecting data across payers by service category and payment methodology that could inform these assessments; and CHIA will study underinsured and uninsured groups that disproportionately contain those with mental health risk.
- The Health Policy Commission has pending reports on these and related cost trend issues that could shape recommendations for mental health and behavioral health system reform.

13.4.2 Utilizing MA Legislation

- The Behavioral Health Integration Task Force report is pending review and analysis.
- Work of the Commission to review Public Payer Reimbursement Rates pending review and analysis.
- ACA reforms reinforce MHPAEA, and note that State parity mandates that exceed MHPAEA rules will rule.
- DOI examination of parity in medical necessity and utilization review criteria, as well as other health plan administrative and cost provisions will be informative.
- DPH Office of Patient Protection Reports reveal an increased rate of appeals on behavioral health denials; these remain the largest category of appeals.

13.4.3 Utilizing ACA Legislation

- Depressed behavioral health rates in public and private sectors pose threats in implementing global payments strategies and ACOs, with risks that subcapitation for behavioral health services will be set on too low a base.
- Low reimbursement rates for Dual Eligible demonstrations delay implementation of this promising strategy for integration and coordination of care for individuals with complex conditions.

13.4.4 Utilizing MHPAEA Legislation

- DOI assessment of MHPAEA compliance among Massachusetts' Health Plans is pending completion.

- Parity issues are under further review by the Health Policy Commission for implementation of Chapter 224 initiatives

13.5 Confluence of Public and Private Systems

- Recommendation: *Employ Chapter 224, DOI, DMH and MassHealth authorities to improve alignment across the public and private insurance systems supporting mental health services in the Commonwealth.*

14. Assessment of Reuse Potential and Issues for Taunton State Hospital (TSH)

14.1.1 Introduction and Purpose of the Chapter

Abt/TAC have noted throughout this report that there are two significant issues that confront discussions of future uses for the TSH campus. First, the facility is an IMD, and thus services provided under the aegis of TSH cannot in most circumstances qualify for Medicaid reimbursements for people between the ages of 22 and 64. Second, the facility is not an integrated community setting, and thus is subject to scrutiny under Title II of the ADA and the *Olmstead* decision.

As discussed in Chapter 5, Massachusetts depends on Medicaid revenues to support virtually all mental health services in the Commonwealth. Massachusetts currently has a Medicaid Section 1115 waiver that allows limited payments for psychiatric inpatient treatment at TSH and several other state hospitals, including the Worcester Rehabilitation Center and Hospital (WRCH). However, these revenues are subject to the overall cost caps in the waiver, and may not be renewed after the June 30, 2014 end date for the waiver. If the specific waiver provision regarding IMDs is not extended, Medicaid reimbursement will not be available for any services provided under the aegis of TSH.

It is not clear whether CMS would continue to consider TSH to be an IMD if the 45 continuing care beds at TSH were to be closed and the services transferred to WRCH. As noted in Chapter 5, CMS considers chemical dependency treatment facilities to also be IMDs[24], and the 40 bed Highpoint substance use treatment program being opened at TSH might suffice to continue the IMD designation even if the psychiatric treatment beds are discontinued. Adding new substance use treatment beds, such as is being considered with regard to women committed under Section 35, could increase the risk of continued IMD designation.

In addition to the concern regarding potential loss or foregoing of Medicaid revenues for services operated on the TSH campus, there are also concerns about the institutional nature of the facilities. As discussed in Chapter 3, people with disabilities, including mental illness and/or substance use disorders, have a right to receive treatment in the most integrated community setting possible. States that elect to provide treatment services in non-integrated settings are at risk of being investigated and possibly sued by people with disabilities and their representatives, including DOJ. States such as Massachusetts that have made deliberate efforts to move as much care and treatment as possible to integrated community settings have, to date, successfully inoculated themselves from such legal actions.

CMS has recently issued regulations for Medicaid HCBS services[25] that comport with ADA Title II requirement for treatment in integrated community settings. In these regulations, any service provided on the grounds of a state facility such as TSH is presumed to be not provided in an integrated community setting unless the state can prove otherwise. Such hospital based settings will also be subject to "heightened scrutiny" by CMS to assure that the community integration mandate is being met.

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[24] 42 CFR 440.2(b)

[25] 42 CFR Parts 430, 431, 435, 436 440, 441, and 447

In combination, the IMD issue and the ADA community integration mandate constrain considerations for future uses of the TSH campus. Electing to develop new or enhanced services in small[26], integrated settings as opposed to institutional settings such as TSH is the preferred strategy to both maximize available Medicaid revenues and to avoid litigation related to services provided in non-integrated settings. If new or enhanced services are being considered for TSH, then the possible loss of revenues and the potential exposure to litigation should be among the factors analyzed before final decisions are made.

14.1.2 Cross-cutting Issues Related to TSH

Abt/TAC have noted throughout this report that there are two significant issues that confront discussions of future uses for the TSH campus. First, the facility is an IMD, and thus services provided under the aegis of TSH cannot in most circumstances qualify for Medicaid reimbursements for people between the ages of 22 and 64. Second, the facility is not an integrated community setting, and thus is subject to scrutiny under Title II of the ADA and the *Olmstead* decision.

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CMS has recently issued regulations for Medicaid home and community-based services[79] that comport with ADA Title II requirement for treatment in integrated community settings. In these regulations, any service provided on the grounds of a state facility such as TSH is presumed to be not provided in an integrated community setting unless the state can prove otherwise. Such hospital based settings will also

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[26] Sixteen beds or fewer.

be subject to "heightened scrutiny" by CMS to assure that the community integration mandate is being met.

In combination, the IMD issue and the ADA community integration mandate constrain considerations for future uses of the TSH campus. Electing to develop new or enhanced services in small[27], integrated settings as opposed to institutional settings such as TSH is the preferred strategy to both maximize available Medicaid revenues and to avoid litigation related to services provided in non-integrated settings. If new or enhanced services are being considered for TSH, then the possible loss of revenues and the potential exposure to litigation should be among the factors analyzed before final decisions are made.

14.1.3 Current Facility Conditions at Taunton State Hospital

Abt/TAC has conducted a brief overview and analysis of the TSH campus as a prelude to assessing options for new or additional uses for the campus. It must be emphasized that: (a) our review was not an engineering study; (b) we did not assess the costs to rehabilitate or maintain any of the buildings on campus; (c) there was no current planning or analysis from the Massachusetts Division of Capital Asset Management and Maintenance (DCAMM); and (d) there was no attempt to obtain input regarding future uses of the TSH campus from the Taunton community.

Overview

Taunton State Hospital is similar to other state hospital facilities in Massachusetts and throughout the United States. Like most other state hospital facilities, the buildings are primarily over 50 years old and have consequent physical facility limitations related to design, utilities (particularly electrical and HVAC), and maintenance costs. Several building spaces on the TSH campus have been rehabilitated, but much of the operational building capacity on campus would need significant capital improvements to be useable as modern treatment facilities. As with many state hospital campuses throughout the United States, the campus has been "re-colonized" by other uses as the need for mental health inpatient treatment capacity has decreased over time. These new uses will be summarized below. Unlike many state hospital facilities in other jurisdictions, which are typically located in exurban and rural communities, TSH is embedded in a residential neighborhood within a mid-sized city. The location of the TSH campus increases the importance of community involvement in any planning for future uses of the facility.

Current Status of TSH Buildings

The following is a brief summary of the current and planned utilization of the existing buildings on the TSH campus.

Gifford Building

The Gifford Building currently houses DMH's Southeast Area Office staff. DMH is in the process of moving the Area Office staff into rented space in the community, and plans to vacate the Gifford Building within six months. Once the Area Office staff move out of the building, it will be mothballed.

At this point there are no plans for future use of the Gifford Building. Facility management staff at TSH reported that the building is not in good enough condition to be used for patient care or residential treatment programs.

[27] Sixteen beds or fewer.

Recreation Building

The Recreation Building has a gym and related facilities. TSH management staff report that the building is used frequently by community groups for a variety of purposes, and is considered to be a valuable community resource by the greater Taunton community. The Recreation building is not currently used by any of the DMH or other programs located on the TSH campus.

Murray Building

The Murray Building currently houses a DYS secure detention program. That program is in the process of moving to the Goss Building. Once vacated, the Murray Building is scheduled to be demolished. The building is reported to be in too poor condition for rehabilitation for any possible future use.

Goss Building

As noted above, the Goss building will be the new site of the DYS secure detention building. DYS plans to occupy the entire building, and also plans to have exclusive use of a secure inner courtyard for recreational purposes for incarcerated youth. There are no other plans for re-use of the Goss building at this time.

Chambers Building

The Chambers Building currently houses the TSH administrative and clinical leadership staff. The south wing of the third floor is used as a training facility for many different types of programs in south eastern Massachusetts. The north wing of the third floor is vacant and used for storage.

The second floor is currently being renovated for use as a 40 bed substance abuse residential treatment program operated by Highpoint under a contract from the Massachusetts DPH. Women stepping down from a Section 35 involuntary commitment are among the priority populations to be served in this new unit. The Highpoint residential treatment program will occupy the entire second floor, except for some DMH TSH staff offices in the central wing.

The first floor of the Chambers building is currently unoccupied. DMH has stated its intention to maintain the vacant inpatient service wards on the first floor as emergency inpatient space for use if another DMH inpatient facility needs to be vacated for a period of time because of a crisis/catastrophe.

Besse Building

The Besse Building currently has a variety of uses. The third floor is vacant, and the second floor is also vacant except for the hospital information technology (IT) department in the front. The first floor houses the newly renovated rehabilitation wing, which is used for skill building and related rehabilitation services for DMH inpatients in CC units. Some medical staff and rehabilitation program staff occupy offices on the first floor as well. The basement of the Besse building contains a medical clinic for DMH inpatients only (not IRTP, DYS or Highpoint clients) and an area for storage of old medical records.

Glass Building

The Glass Building, situated between the Besse and Cain buildings, has the newly renovated entry way and foyer for the hospital. This building also has public areas such as a waiting room, family visiting rooms, and a cafeteria.

Cain Building

The Cain Building is the newest and most modern building on the TSH campus. This building comes closest to what are considered to be appropriate inpatient hospital clinical treatment and residential (sleeping, eating, etc.) areas.

The third floor of the Cain building has two 15-bed units for continuing care for DMH inpatients. The second floor has another 15-bed continuing care unit, which, together with the units on the third floor, comprises the 45-bed continuing care capacity currently in operation at TSH. Also on the second floor is a 15-bed IRTP for youth operated under a contract from DMH to a private vendor.

The first floor of the Cain building has Department of Education school program for the residents of the IRTP program. The first floor also has a large commercial kitchen and large common dining area. The kitchen and dining area have substantially higher capacity than is currently used by programs on the TSH campus. The basement of the Cain building has a computer room and recreation facility for use by DMH inpatients.

General Observations about the Buildings on the TSH Campus

With the exception of the Cain building, Abt/TAC does not believe any of the currently occupied or vacant space in the other buildings would be appropriate as inpatient space without significant and expensive renovations. Infrastructure improvements (water, electrical, HVAC) improvements would likely be necessary as well as substantial reconfiguration of space to meet standards and good practice for inpatient mental health treatment.

The Cain, Besse, Goss, Glass, Chambers buildings constitute an interconnected complex and share a central courtyard. In addition to the common entryway in the Glass building, and the inpatient capacity in the Cain building, there are sufficient other uses in the overall complex to militate against mothballing or surplusing the buildings. The DYS, IRTP and Highpoint residential substance use treatment services operating in the complex are likely to continue into the future.

14.2 Issue 1: On-Site Crisis Diversion and Step-down Program

14.2.1 Background on Crisis Stabilization Services for Diversion and Step-down

Over the past forty years, crisis stabilization units (CSUs) have been utilized to avoid admission to or reduce the length of inpatient stays through step-downs.[80] These programs, operated across the country, offer an alternative to hospitalization for individuals who are experiencing a crisis but whose crisis can be managed and resolved in a less restrictive setting than inpatient level of care. Services provided as part of crisis stabilization include psychiatric assessment, nursing services, medication stabilization, referral to community services, counseling, and peer support services. Site-based services are most frequently provided by community agencies in community settings or within units of private hospitals. Admissions usually range from 3-14 days,[81,82,83] with longer stays in some cases. In Massachusetts,[84] there is no stated maximum length of stay. As noted in Section 9 above, individuals with longer lengths of stay often have unmet housing and other community service needs.

Best practices include stabilization in the least restrictive setting possible, use of peers and use of strengths based and holistic approaches that support a shared responsibility for crisis resolutions.[85] There has been interest at CMS in increasing use of crisis diversion and stabilization services. As mentioned in Section 9, CMS initiated a demonstration program under Section 2707 of the ACA to allow IMDs in 11

states and the District of Columbia to utilize EDs in IMDs for crisis diversion and stabilization. IMDs have historically been excluded from billing Medicaid for inpatient services for adults aged 21-64. Public IMDs, including state psychiatric hospitals, however, are excluded from the CMS demonstration.

In Massachusetts, crisis stabilization units, or CCSs, are located within the community, in keeping with principles of recovery. Peer-run respite services are included in the Massachusetts state plan. Peer support staff work in ESPs as well, as part of mobile crisis and CCS teams.

14.2.2 Taunton/Attleboro/Norton CCS Needs

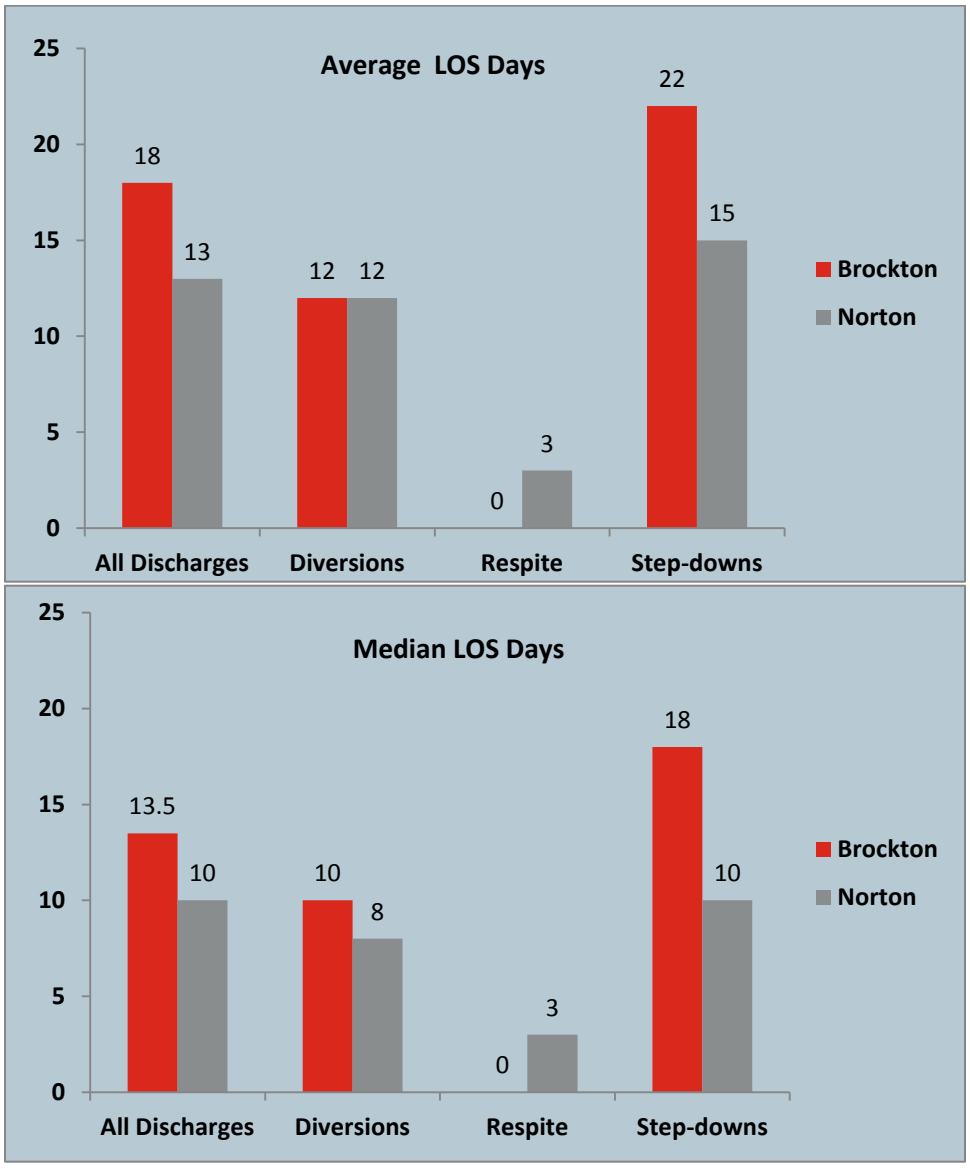
Given the interest in TSH as a site for a CCS interviews were conducted with local area and crisis programs. The current Norton ESP is located in a community setting. When driving to the Taunton/Attleboro ESP one cannot tell that there is a mental health facility located in the plaza. It looks like any generic retail space in the community.

The majority of admissions at Norton in the first six months of FY 2014 were for diversion (63%) from inpatient care. In FY 2013, the statewide percentage of diversions from inpatient admission was slightly less than 44 percent. Diversion outcomes were lower for assessments completed in EDs (39.26%) as opposed to assessments that took place in the community (52.68%). Diversions from inpatient disposition have be increasing since up since FY 2012, which may reflect an upward trend in community assessments and interventions.

The current Norton CCS bed capacity is seven. The average lengths of stay at Brockton and Norton CCSs are 18 days, and 13 days respectively (See **Exhibit 9**). Statewide, individuals stepping down from inpatient services have the longest lengths of stay at both units. As reported by staff at the CCS, an increase in respite capacity, as outlined in the Governor's FY 2015 budget, could potentially increase the CCS's diversionary function, as some individuals stepping down from inpatient level of care could be supported through respite instead of CCS services. Norton ESP staff identified the need for respite or CCS capacity to stabilize individuals with co-occurring substance use and mental health crises. Staff noted the dearth of community treatment options for individuals with co-occurring conditions. The lack of available community services for individuals with co-occurring disorders puts pressure on the front door of the CCS. As mentioned in Section 9, such front door pressure would be relieved if community treatment and rehabilitation services for co-occurring addictions and mental illness were available.

Norton ESP staff have also identified the need for more space, especially for a children's waiting area. A larger space could allow for greater flexibility to serve both children and adult walk-ins to the ESP site. Additional peer staff were also identified as a need. Currently, the Norton ESP has only one peer staff who serves on both the mobile crisis and CCS teams. During our visit to the Norton site, staff noted that the ability to bill for mobile outreach to homes and group homes with follow-up for short-term stabilization would assist the team to divert acute admissions. These diversions would be for individuals awaiting admission to partial hospital programs, and in cases where behavioral consultation to group home staff is needed. As part of crisis prevention and planning, they could arrange planned admissions into CCS around anniversary dates, such as birthdays and anniversaries of significant losses or trauma; stressful events; and for medication adjustments, thus preventing escalation into full-blown crisis.

Exhibit 9. Average and Median Lengths of Stay by Reason for Admission for Brockton and Norton CCSs



Morton Hospital staff reported that individuals from group homes with behavioral health problems were at times left in the ED awaiting hospitalization for several days, even after their behavioral health crises had resolved. The increased ability for mobile crisis to make repeated visits to the group home for stabilizing interventions and staff consultation could potentially provide beneficial stabilization in the community while at the same time supporting group home staff. If such a service were available, group home staff could proactively contact the ESP for in-home crisis stabilization and long-term crisis planning. Person-centered crisis plans, another best practice of crisis intervention,[86] can be used for early intervention, before an individual acts out. Individuals, their clinical providers, and residential staff, can work together to develop crisis plans that maximize the autonomy of the individual and proactively address identified crisis triggers.

14.2.3 Considerations Regarding the Use of TSH for On-Site Crisis Diversion or Step-down

One possible reuse for a TSH unit is crisis stabilization or inpatient step-down. The advantage of such a reuse plan is that the unit is set up to maximize the safety of individuals, with adequate space to allow for private rooms and additional areas for rehabilitation activities. An additional site dedicated to inpatient step-downs could also free up CCSs to put their full attention and resources to hospital diversion. In the first half of FY 2014, Brockton and Norton CCSs had 51 admissions for inpatient step-down services. Elimination of these admissions would free up beds for hospital diversion. In addition, locating a CSU at TSH might provide relief for the Morton Hospital ED. If group home staff are encouraged to proactively address crisis by using a local CSU for respite or stabilization before an individual's behavior escalates, ED admissions for behavioral outbursts could be diverted. The result would be decreased pressure on the ED and an increased use of a less restrictive setting for an individual's crisis to be stabilized. Thus both, use of costly ED resources would be minimized and client rights protected.

When weighing the potential benefits and disadvantages of using TSH for CCS, several issues come to light. Community crisis stabilization best occurs in the community, rather than within institutions.[87] As noted in Section 3.4.1, Massachusetts has implemented a *Community First Olmstead Plan*,[88] in line with the *Olmstead* decision that requires states to serve individuals in the least restrictive, most integrated settings possible. Placement of community crisis stabilization services in a unit of a hospital could be interpreted as being in conflict with the spirit of *Community First*. In addition, use of any CSS sited at TSH might also be impacted by the perception that the CSS is still a part of the state hospital. This concern is borne out by the history of the Norton satellite of the Brockton ESP. The ESP was previously located at TSH. Staff report that individuals did not utilize the ESP while at TSH because of lack of accessibility and stigma associated with the facility. Staff interviewed report that utilization of the ESP and its CCS has increased since it was relocated to Norton, in a location integrated within the community.

The Norton CCS location has space limitations. These can be remedied, however, by leasing abutting retail space. Informants reported that increased CCS and respite capacity, as well as reimbursable mobile crisis intervention similar to that established for children under the CBHI, could reduce unnecessary ED admissions for adults. They noted that once individuals reach the ED they are often tracked for admission using a Section 12, even in cases where the individual could be voluntarily admitted or when they could potentially benefit from CCS. Increased use of true mobile crisis intervention, as implemented for children and adolescents, has potential to reduce ED and subsequent inpatient admissions. Mobile crisis intervention could also support group home staff to better prevent and manage crises.

As noted earlier in this chapter, if TSH remains classified as an IMD, the State would have to forgo Medicaid reimbursement for services provided through any CCS unit sited there. If a CCS were to be sited at TSH, the Cain building would be the most appropriate of the buildings for the purpose because a unit could be re-used without need for substantial renovation. In order to promote a least restrictive environment, however, it would be useful for individuals served through such a CCS to have access to a recreational facilities/area separate from any areas used for inpatient purposes.

14.2.4 Recommendations

- Recommendation: *The use of the TSH campus for crisis diversion and crisis respite services is not recommended.*

The Abt/TAC team, taking the above factors into consideration, has concluded that placement of a CCS or respite at TSH would not be the most appropriate reuse of the space. Placement of a CCS at TSH

could actually be counterproductive for the goal of accessible, consumer-driven, recovery-oriented crisis prevention and intervention. In addition, the state may not be able to recoup CCS costs through Medicaid if such services were placed at TSH. The needs of Morton Hospital could be addressed by outreach and increased use of mobile crisis intervention to group homes and outreach to promote proactive use of respite and CCS. Expanding the Norton CCS by installing additional beds could both improve access for crisis stabilization and allow Medicaid billing for services received. Norton CCS bed capacity should be examined using common data elements, to assess how best to deploy resources for program alternatives to the inpatient level of care. In addition, it is recognized that Morton Hospital could benefit from additional social services staff to provide services 24 hours a day, seven days a week. Additional staff could assist in data collection to quantify cases of boarding and the sources for ED admissions that lead to boarding.

As mentioned throughout the report, comparable data on mental health interventions by intervention sites and across payers is lacking. Collection of uniform data, across payers, on hospitalizations that could have been diverted if an appropriate CCS service were available would assist in planning for additional capacity and tailoring of CCS services. These data could also be used to hold providers and health plans accountable for making services-- including acute inpatient and diversionary services-- available within their networks.

14.3 Issue 2: Facility/Treatment for Nonviolent Offenders

Pursuant to the legislative charge to examine alternative uses for TSH, including potential for provision of treatment services to individuals who are not dangerous and have mental illnesses, the Abt/TAC team studied the needs of incarcerated Massachusetts residents with a particular focus on institutions in Southeastern Massachusetts. Given the Massachusetts convention, that individuals convicted of crimes and given longer sentences (typically sentences of 2.5 years or greater) are inmates in Department of Corrections (DOC) facilities, the team also made a closer study of individuals in three County Houses of Correction in Southeastern Massachusetts and the Suffolk County Jail. Individuals who are convicted of crimes and given shorter sentences (under 2.5 years) or those awaiting trial, are typically assigned to County Houses of Correction or Jails. We suggest that these individuals with shorter sentences or those awaiting trial have greater potential for release to treatment programs as alternative settings for diversion or completing one's sentence.

14.3.1 Incidence and Prevalence of Persons with Mental Health Conditions among the Jail and Prison Population – in the Nation and in Massachusetts

Prior research and evaluations have documented the "overrepresentation" of individuals with mental health conditions among U.S. jail and prison populations. Such assessments have estimated that as many as 50 percent of individuals currently incarcerated have at least one mental health condition, and as many as 15 percent of these individuals have a severe mental illness (SMI).[89,90] Among incarcerated individuals with a SMI, one study found that female inmates were twice as likely to be diagnosed as their male counterparts.[91] In Massachusetts, existing surveys of state prisons and county houses of correction estimate that anywhere from 5 percent to 20 percent of inmates suffer from "schizophrenia, bipolar disorder, or another major mental illness."[92,93] Among youthful offenders, researchers estimate that as many as 66 percent of males and 75 percent of females currently detained in the U.S. juvenile justice system meet criteria for one or more psychiatric disorders,[94] and as many as 20 percent of these individuals meet criteria for a diagnosis of serious emotional disturbance (SED).[95]

Massachusetts Department of Corrections (DOC)

As noted above, DOC facilities contain inmates with sentences of greater than 2.5 years, inmates with convictions for violent crimes, and civilly committed inmates with addictions, who are sent to these facilities under MGL Chapter 123 Section 35. The Massachusetts DOC statistical reports published in 2013 indicate that rates of behavioral health conditions are high among civilly and criminally committed prisoners. The percentages of DOC inmates with open mental health cases, as illustrated in **Table 19,** below, are as follows:

- 24 percent of males with open mental health cases, and 18 percent of males on psychiatric medications; and
- 59 percent of females with open mental health cases, and 49 percent of females on psychiatric medications.

According to the DOC, between 2012 and 2013, its pre-trial population increased by 13 percent, while the criminally sentenced and civilly committed populations experienced a decrease of 4 percent and 8 percent, respectively.[96]

Few counties have the capacity to serve females awaiting trial or under sentence, driving women awaiting trial, as well as those with shorter sentences, from most counties into DOC facilities at MCI Framingham.

Table 19. Massachusetts DOC Custody Population: January 1, 2013

MA	DOC Custody Population	Criminal	Pretrial	Civilly Committed	Nonviolent Governing Offense All Admits	Nonviolent Governing Offense 2012 Admits	Sentence < 3 Years	Open Mental Health Case
All Inmates	11,127	9,877	690	560				
Male Inmates	10,381	9,403	433	545	44%	51%	4%	24%
Female Inmates	746	474	257	15	55%	79%	40%	59%

The Massachusetts Department of Corrections (DOC) reports that approximately 20,000 prisoners are released and return to communities each year in the Commonwealth. Of these individuals, national estimates indicate that as many as 62 percent of those released from incarceration will reoffend within three years.[97] Critically, a significant percentage of individuals who reoffend have substance use and/or mental health conditions and lack reliable access to treatment post-release. Recidivism rates in Massachusetts are lower than these national figures, with DOC reports indicating that the most recently available three-year recidivism rate (calculated for 2008) is 42 percent for males and 35 percent for females.[98] Massachusetts prisoner re-entry programs coordinated though Regional Re-entry Centers (RRCs) are designed to smooth transitions and reduce recidivism, providing released individuals with access to a range of services, including mental health and substance abuse treatment. RRC services are a collaborative initiative that includes, among other public and private agencies and departments, DMH, DPH, and MBHP for behavioral health services. RRCs also arrange for housing, transitional assistance

and employment through the Department of Transitional Assistance (DTA), Division of Employment and Training (DET), Sex Offender Registry Board, and the Massachusetts Housing and Shelter Alliance (MHASA).

Table 20. Massachusetts DOC Populations Trends / Civil Commitments: 2012

Institution	Female	Male	Total / Percent
Massachusetts Alcohol and Substance Abuse Center	0	1,679	**1,679 / 64%**
Bridgewater State Hospital	0	539	**539 / 21%**
MCI-Framingham	367	0	**367 / 14%**
Massachusetts Treatment Center	0	40	**40 / 2%**
Total	**367**	**2,258**	**2,625**

As detailed in **Table 20**, above, the majority of 2012 admissions to DOC facilities under civil commitment provisions were committed under Section 35 for substance abuse treatment to either MASAC for males or MCI Framingham for females. These cases will be discussed in detail in the next subsection of this report, as we address options for alternative services for inmates committed under Section 35. There continue to be a large number (539) of new admissions to Bridgewater State Hospital for treatment of males considered dangerous and in need of secure psychiatric treatment. However, recent reviews of conditions at Bridgewater State Hospital suggest that some patients incarcerated there are in need of safer, treatment-oriented alternatives.

County Houses of Correction – Southeastern Massachusetts

As noted earlier, in the main, County Houses of Correction in Massachusetts serve persons who are awaiting trial and those who are under sentence for fewer than 2.5 years. In interviews with medical staff at three County Houses of Correction – Barnstable, Bristol and Plymouth – rates of mental health and c-morbid substance use conditions are reportedly higher among the jail population. Reports from Bristol County Correctional Facility indicate that in 2012, 33 percent of the population qualified as have a mental health condition, while in 2013, 34 percent met this qualification.[99] Reports on numbers of inmates who were receiving DMH services at the time of booking are pending.[100]

One indicator of the prevalence of these conditions is found in a Fiscal Year 2011 report provided by the Barnstable County Sheriff's office detailing inmate pharmacy costs. These findings are displayed in **Table 21**, below.

Table 21. Barnstable County Inmate Pharmacy Costs: Fiscal Year 2011

FY	Total Drug Costs	Mental Health Drug Costs
FY10	$243,412.89	$60,853.22
FY11	$233,353.79	$58,338.45
FY12	$183,160.27	$45,790.07
FY13	$390,860.67	$65,143.45
TOTAL	**$1,050,787.62**	**$230,125.18**

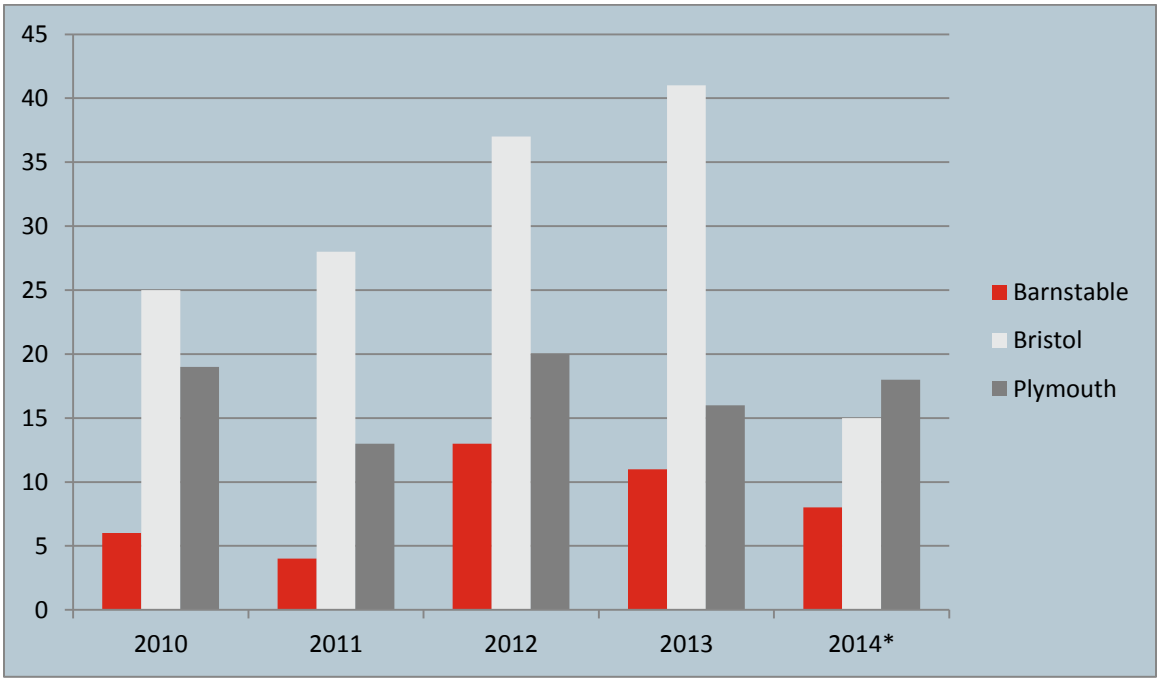
Note: Joined SOPS in Early FY11 (October 2010)

Other data concerning the mental health needs of County jail inmates in Massachusetts include the number of cases of released inmates assigned to Forensic Treatment Teams, displayed in **Exhibit 10,** below. FTT cases are not always DMH clients, but all are persons identified as having a mental illness.

These data, as provided by the Sheriff's office, do not differentiate between pre-trial detainees and sentenced inmates, and may have some duplicated reports on individual inmates, as the data include "events" of incarceration, such as booking and release.

Exhibit 10. FTT Cases Released from Southeastern MA Jails: 2010 to 2014

*Note: 2014 includes released cases and those currently in custody to date.



Suffolk County's Nashua Street Jail and South Bay House of Correction

The Nashua Street Jail serves pre-trial detainees and the South Bay House of Correction serves individuals sentenced to fewer than 2.5 years. These Suffolk County facilities together serve between 1,800 and 2,000 inmates each year, with an average length of incarceration of 10 months for women and 14 months for men. Women are a small portion (about 70 individuals) of the population. An estimated 85 percent of the inmates have substance use disorders, with 42 percent having a mental health condition, and 26 percent estimated to have a major mental illness.[101]

During a site visit to Suffolk County's programs, the daily census was approximately 1,090 inmates, of whom more than half, an estimated 550 individuals, had mental health conditions. Of those individuals, 80 were DMH clients. The mental health staff at the facilities works daily to provide medication and counseling to inmates. Those staff members collaborate with DMH liaisons, with whom they manage referrals to post release care. The Suffolk County Sheriff and mental health staff report high rates of recidivism in the population, citing gaps in dual diagnosis treatment, intensive residential treatment, and care transitions to outpatient treatment.

14.3.2 Issues Driving Individuals with Mental Health Conditions into the Criminal Justice System

As U.S. jail and prison populations continue to grow, one may expect corresponding increases in the size of subgroups within the general population; individuals with mental health conditions are no exception. Additionally, some socioeconomic factors that disproportionately affect people with behavioral health conditions (e.g., homelessness and poverty) place individuals with mental disorders at higher risk of incarceration[102] or, more accurately, the "experience of people with mental illness is often contextualized in disadvantaged social settings."[103] While Massachusetts is working to reduce its jail and prison populations, these vulnerable individuals remain at higher risk for incarceration.

Some clinical factors also place individuals with mental health conditions at higher risk of incarceration. Specifically, individuals with mental health conditions often present with co-occurring substance use disorders (SUDs). In 2001, the Bureau of Justice Statistics reported that 83 percent of U.S. inmates with mental health diagnoses were dually-diagnosed with a SUD.[104] In 2004, a study by Hartwell et al. found that 70 percent of Massachusetts inmates with a diagnosis of serious mental illness (SMI) reported they had a history of substance abuse;[105] further analyses determined that among this population, dually-diagnosed Massachusetts inmates were disproportionately female, and "more likely to have a history of being on probation and of using mental health services."[106]

14.3.3 Strategies to Prevent, Divert and Reduce Recidivism

Improving access to HCBS treatment, rehabilitation and recovery supports for individuals with SMI upon discharge from the criminal justice system is critical. Prior studies have demonstrated that mandatory mental health treatment in an outpatient setting (e.g., involuntary outpatient commitment (IOC)) can "reduce hospital readmissions and total hospital days when court orders are sustained and combined with intensive treatment, particularly for individuals with psychotic disorders,"[107] and can reduce the probability of re-arrest among individuals with SMI and "with a prior history of multiple hospitalizations combined with prior arrests and/or violent behavior"[108] as well as the "severity" of said re-arrest.[109] Such treatment also stands to reduce individuals' "criminal victimization indirectly by increasing [their] long-term participation in community treatment and services [which improves] their mental health and social functioning and eventually lower their risk of exposure to crime and violence."[110] Notably, mental health diversion programs for non-violent offenders do not appear to increase public safety risk.[111]

In order to effectively treat and reduce recidivism among individuals with a SMI who are involved in the criminal justice system, one must establish and/or reinforce linkages to mental health treatment services and supports. Upon release from incarceration, offenders with SMI often encounter significant barriers to treatment services (e.g., transportation, case management, medication coordination and oversight, and housing supports) in the community; all too often "individuals with such histories [are] viewed as 'problem patients' or as 'treatment-resistant' by community health care and residential services staff," and face significant disruptions in care planning and provision as a result.[112]

Moving forward, enhancing linkages to and coordination of community-based mental health and support services for such offenders will prove critical. To do so, one must strengthen program capacity to treat criminally-involved individuals with co-occurring conditions by better aligning mental health, substance abuse and criminal justice services. Such strategies must clearly define discharge planning and follow-up procedures for diverted offenders,[113] and ensure continuous access to needed medications,[114] and establish clear channels of communication across care providers.

In recent years, traditional Assertive Community Treatment (ACT) models for mental health service teams have been adapted and tailored by state and federal agencies to meet the needs of individuals with SMI and histories of criminal justice involvement. Though still in their early stages, these programs have reported reductions in re-arrest and mean jail time among participants, as well as "improvement in global functioning and economic self-sufficiency relative to those who received treatment as usual."[115]

14.3.4 Meeting Greater Demand for Implemented Evidence-based and Best Practices in Prevention, Diversion and Recidivism Reduction Services

As detailed in recent testimony before the Senate Ways and Means Committee, the Massachusetts DMH currently operates or funds several programs designed to prevent criminalization, divert individuals from the criminal justice system, and provide for those stepping down from jails and prisons to reduce or eliminate recidivism. Program and services interventions include:

- *Jail Diversion Programs and partnerships with first responders and local law enforcement organizations* in 24 programs covering a range of cities and towns, including training of public safety personnel, partnerships with clinical programs, and Crisis Intervention Team training to enable public safety and mental health staff to implement alternative to arrest and incarceration;
- *Forensic evaluation and treatment services* to an estimated 8,000 to 9,000 youth and adults who are referred from the Juvenile, District and Superior Courts
- *Support to two mental health treatment courts and two veterans treatment courts* in the State, complemented by clinical consultation and technical assistance to the Massachusetts Judiciary;
- *Veteran-focused, trauma-informed court-based program* for alternative treatment to prevent incarceration, in collaboration with the Trial Court, Office of the Commissioner of Probation, and Veterans Administration;
- *Step-down treatment for civilly committed patients in transition from Bridgewater State Hospital*; and
- *Re-entry supports for inmates with SMI as they step down from jail or prison.* (FACT)

The Governor's FY2015 budget increases funding by $1M for training programs for law enforcement officials who are in contact with and need to de-escalate situations with persons with mental health conditions. Increases proposed will also double the number of treatment courts targeted to persons with mental illnesses, with an emphasis on diversion from court to treatment programs.

Options to provide alternative settings for nonviolent offenders in Massachusetts include a range of tested, evidence-based and promising practices, many of which, as noted, are in place in limited supply in the Commonwealth. These are outlined below in **Exhibit 11.**

Exhibit 11. Community-Based Forensic Services Models: Research Findings

Model	Populations Served	Findings
Forensic Assertive Community Treatment (FACT)		
Project Link (NY)	Individuals with SMI involved in the CJ system	• Significant reductions in jail days, arrests, hospitalizations and hospital days.[116] • Reduction in average yearly service cost per client served.[117] • Improvements in psychosocial function and engagement in substance abuse treatment.
Thresholds State-County Collaborative Jail Linkage Project (IL)	Non-violent offenders with SMI	• Reduction in numbers of jail days and hospital days.[118] • Reduction in total jail and hospital costs.
Mentally Ill Offender Crime Reduction (MIOCR) Program (CA)	"Low-level" offenders with mental health conditions recently released from jail/prison	• Reduction in numbers of jail days and arrests.[119,120] • Reduction in probability of psychiatric hospitalization and/or multiple crisis visits, shorter hospital stays if admitted. • Increase in probability of receiving outpatient medication services, medications. • Reduction in multiple conviction rates, incarceration rates.
Modified Therapeutic Community (MTC)		
Untitled Colorado Dept. of Corrections MTC (CO)	Male inmates with mental illness and chemical abuse (MICA) disorders	• Reduced incidence of relapse (alcohol and/or drug use) at 12-months post-prison release across all subtypes of drug-addicted offenders.[121]
Integrated Dual-Disorder Treatment (IDDT)		
Mentally Ill Offender Community Transition Program (MIOCTP) (WA)	Inmates with SMI	• 50% reduction in felony re-arrests and convictions.[122] • Reduced incidence of relapse. • Reduced incidence of community corrections violations (Ibid).
Untitled IDDT	Male inmates with co-occurring SMI and SUD and a felony conviction	• Reductions in incidence of re-arrest 3-months post-prison release.[123] • Increased incidence of compliance with medication and abstinence from substances 3-months post-prison release.
Untitled IDDT	Individuals with co-occurring SMI and SUD	• Significant reductions in the incidence of psychiatric hospitalization and arrest.[124]

14.3.5 Recommendations

- Recommendation: *Some individuals with mental health conditions involved in the criminal justice system (i.e., those under sentence who have a low-risk offense profile and those awaiting trial*

who can be safely diverted from incarceration in County Jails) may be served by a pilot program for such offenders, to be developed on the TSH campus.

The Abt/TAC study team recommends pursuit of a model alternative treatment program for nonviolent offenders with mental health and comorbid substance use conditions. These individuals have the fewest options for intensive treatment and recovery support services either in jail and prison, in re-entry and transition programs, and in the community – as most programs are targeted to addressing *either* mental health conditions *or* substance use conditions, but not both. They reportedly fair poorest within correctional settings and are at highest risk for recidivism because of limited treatment opportunities at release. As noted earlier, individuals who are inmates of these Southeastern Massachusetts County Houses of Correction, awaiting trial or under shorter sentences, may be the most appropriate and feasible candidates for alternative treatment programs.

An alternative treatment setting could be operated on the grounds of Taunton State Hospital and should meet residential treatment standards of care. Given the substantial health issues and treatment needs of the target population, the staffing of the program should include medical, nursing and behavioral health professionals with not only clinical credentials but also deep experience delivering dual diagnosis treatment, rehabilitation and recovery programming.

Precedents exist in moving inmates awaiting trial, civilly committed or under sentence from the County Houses of Correction and DOC Facilities to treatment programs. MGL Section 15, Section 16, Section 18, and Section 35 commitments for those pretrial and sentenced inmates needing, respectively, competency evaluations, hospitalization of those incompetent to stand trial or found not guilty by reason of mental illness, hospitalization for mental illness, and substance abuse treatment are well known examples. Another example is the transfer of women jail inmates who are pregnant and have substance use conditions to a treatment program operated by Spectrum House in Worcester. Massachusetts General Laws permit a correction authority to grant a pregnant inmate liberty or discharge for an indefinite period of time under MGL Chapter 127 § 142. [125] Spectrum Health Systems, Inc. operates a 15 bed program in Worcester that provides a range of substance abuse and mental health treatment, prenatal care and counseling, parenting, nutrition and work release services designed to promote healthy births and families and reduce recidivism. This program was previously operated at the Dimock Health Center in Roxbury.

The language in MGL Chapter 127 § 142 specifies the opinion of a physician in a prison or other place of confinement that the best interests of a pregnant inmate and her unborn child require granting of a permit to be at liberty or discharged. The physician must certify this finding to the parole board or other officer empowered to grant permits for imprisoned persons. The board or officer may set terms and conditions on the release to the treatment program. According to the superintendent of the Bristol County House of Corrections, pregnant prisoners who are released to the Spectrum House program may stay postpartum at the program with their child(ren) until their sentence expires.[126]

Among the steps that need to be taken to establish an alternative treatment program for nonviolent inmates with mental health and comorbid substance use conditions are the following:

- Examine the need for legislation to govern release to the program.
- Assess the inmate population to identify needs of inmates who are not dangerous and have mental illnesses, as well as co-morbid addiction and other chronic health conditions.
- Design the program using evidence-based practices.

- Design the pilot as a Forensic Intensive Residential Treatment programs. Hospital level of care is available to DOC and County House of Correction inmates in DMH Forensic Hospital facilities under Sections 7 and 8, and 15 and 16.
- Develop staffing model, program operations and facility requirements for budgeting, implementation and recruiting purposes.
- Establish admission criteria.
- Reassess the inmate population to identify a cohort of eligible inmates for admission.
- Consider limiting bed capacity to 16 or fewer in a single program, if garnering reimbursement is an objective.
- Embed the program in a continuum of community-based re-entry, forensic and behavioral health services to ensure linkages and continuity of care upon discharge.
- Ensure that terms of treatment do not exceed terms of incarceration.
- Plan for and execute community siting plan to address considerations of the Taunton and Southeastern Massachusetts communities.

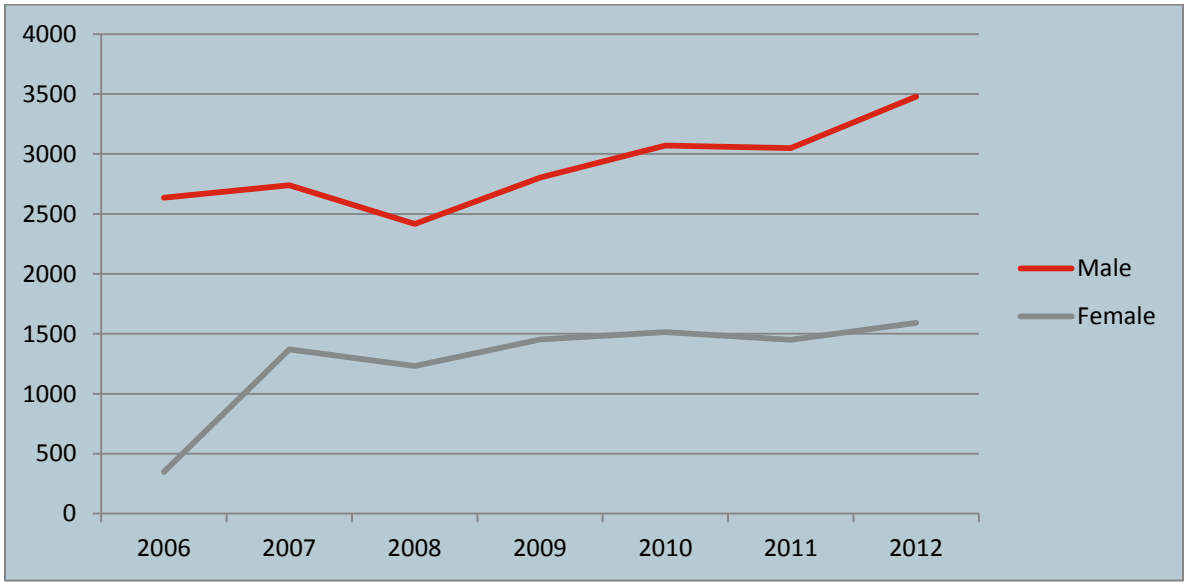
14.4 Issue 3: Facility/Services for Women Committed under Section 7 of MGLA Chapter 111b, and/or Section 35 of MGLA Chapter 123

14.4.1 Overview of Section 35 Data

Massachusetts General Laws Chapter 123, Section 35 permits the courts to involuntarily commit people for whom alcohol or drug use crates a danger to themselves or others. In 2012 there were 5,070 civil commitments under Section 35.[28] One thousand five hundred and ninety-one (1,591) of these, or 31.4 percent, were for women. Section 35 Commitments in Massachusetts have increased over the past few years. **Exhibit 12** shows the number of Section 35 commitments for both men and women for the period 2006 through 2012.

[28] All of the data in this section, unless otherwise noted, are extracted from the Massachusetts Department of Public Health: Bureau of Substance Abuse Services ***FY 2012 Year End Report***.

Exhibit 12. Male and Female Section 35 Admissions: Fiscal Years 2006 to 2012[29]



There are two facilities in Massachusetts that receive Section 35 commitments of women from the Courts. The Women's Addiction Treatment Center (WATC) in New Bedford, which is operated by Highpoint under a contract from DPH, is reported to have 84 beds available to serve women committed under Section 35. MCI Framingham is reported to have approximately 20 beds for women under Section 35. Of the female commitments under Section 35, 1,247 (78.4 percent) were committed to the WATC,[30] and 310 (19.5 percent) were committed to MCI Framingham.[31] It should be noted that MCI Framingham does not have facilities or clinical staff to provide substance use treatment other than detoxification for women committed to MCI Framingham.

Most women committed under Section 35 have no criminal charges or contempt of court or bail. **Table 22** shows the percentage of Section 35 commitments to both MCI Framingham and WATC that had no criminal charges or contempt/bail.

[29] Testimony to the MHAC, Massachusetts Legislature, June, 17, 2013.7

[30] The WATC is operated by Highpoint, and is located in New Bedford.

[31] Two percent of the total female Section 35 commitments went to either the Public Acute Treatment Service (ATS) or one of the youth stabilization programs.

Table 22. Percent of Section 35 Commitments to MCI Framingham and WATC with No Charges

Fiscal Year	MCI Framingham Percent Commitments without Charges	WATC Percent Commitments without Charges
2006	39.5	WATC Not Open
2007	20.1	59.7
2008	25.7	58.7
2009	35.8	61.2
2010	56.4	65.0
2011	53.5	62.4
2012	71.4	62.1

As can be seen from these data, the proportion of commitments without charges has increased substantially for MCI Framingham, and has been relatively stable at WATC. Last year, MCI Framingham had 220 civil commitments of women under Section 35 for whom no charges or bail were present. At the same time, criminal justice system involvement is not uncommon for women committed under Section 35. Almost 27 percent of all female Section 35 commitments in 2012 reported arrests within the prior 30 days, and over 15 percent were on parole violation.

There is substantial variation among court systems in Massachusetts with regard to the number of Section 35 commitments done. **Table 23** shows the percentage of Section 35 commitments for men and women by region of the Commonwealth.

Table 23. Percent of Section 35 Commitments for Men and Women by Region

Region	Percent of Male Section 35 Commitments	Percent of Female Section 35 Commitments	Percent of Overall Commitments
West	16.5	19.0	17.5
Central	9.0	9.6	9.3
North East	10.1	8.8	9.6
Metro-West	20.6	21.8	21.1
South East	33.5	29.3	31.8
Boston	7.3	8.3	7.9
Unknown	2.8	2.6	2.7

It can be seen that for both women and men the preponderance of Section 35 commitments originate in Southeastern Massachusetts courts. Three courts in the Southeastern Region (Brockton, Plymouth and New Bedford) are among the top five courts in the Commonwealth for Section 35 commitments.

There are no published data on the cost per bed, cost per episode of care, or outside revenues received related to Section 35 commitments at MCI Framingham. Typically, Medicaid and other payers do not

reimburse for services provided within a correctional institution. At WATC, the overall cost per bed is almost $210.00 per day. In 2012, the average length of stay (episode) at WATC was just over 20 days, so the average cost per episode was approximately $4,200. The WATC receives Medicaid and third party revenues from a variety of payers. Close to one third (62.0 percent) of revenues for WATC comes from outside sources. Over one quarter (27.5 percent in 2012) of WATC's total revenues is from MBHP.

Fifty-three percent (53 percent) of the total number of women committed under Section 35 in 2012 were on a psychiatric medication at the time of admission, 44 percent report a psychiatric diagnosis, and 14 percent reported having a prior psychiatric hospitalization. In combination with the data showing a very high proportion of Section 35 commitments with no criminal charges, contempt of court or bail, these data suggest the need for sophisticated multi-disciplinary clinical treatment for the majority of women committed under Section 35.

14.4.2 Discussion of Options Related to Section 35 Commitments for Women

As with virtually all the issues and recommendations in this report, there are overall system implications and consequences for any specific recommendations. Actions taken to improve treatment for women committed under Section 35 must be viewed in the context of other events and conditions throughout the Massachusetts Mental Health system.

For example, one option would be to stop allowing Section 35 commitments to be sent to MCI Framingham, and to divert those commitments to expanded capacity at TSH. This option would expand treatment opportunities for women with multiple and complex substance use and mental health issues, and would facilitate the use of MCI Framingham solely for criminal incarceration functions. A new Section 35 capacity at TSH could be operated under the aegis of the Massachusetts DPH, and could either be directly operated and staffed as a public facility or be contracted to a vendor as is the case now with WATC and step-down capacities treatment facilities.

However, as noted throughout this report, TSH is an IMD and thus does not qualify for Medicaid reimbursements for treatment services for people ages 22 to 64. Placing a new Section 35 unit at TSH might endanger the types and levels of reimbursements now realized by the WATC in New Bedford. If the current 45 beds of continuing care continue to be maintained at TSH, it is highly likely that substance use and related treatment services provided on campus would not qualify for Medicaid reimbursements.[32]

An additional concern might be the high concentration of substance use treatment resources in the southeastern region of Massachusetts. The Massachusetts Alcohol and Substance Use Center (MASAC) in Bridgewater is the primary receiving facility for men committed under Section 35. The WATC is in New Bedford, and DPH is opening 40 new beds of step-down substance use treatment at TSH through a contract with Highpoint. Highpoint also operates a substance use treatment facility in Brockton that accepts Section 35 commitments of youth. The location of these treatment facilities within southeastern Massachusetts may in part explain why a high proportion of Section 35 commitments originate in southeastern Massachusetts courts. In addition, the concentration of resources for people committed under Section 35 in southeastern Massachusetts results in decreased access for citizens of other regions of Massachusetts.

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[32] This may be true even if the campus no longer contains psychiatric treatment services. See Chapter 5 for a brief discussion of IMD issues related to substance use treatment facilities.

Based on the above considerations, a decision to relocate Section 35 treatment for women from MCI Framingham to TSH could also be a decision to forego Medicaid and other reimbursements for the care, and would not address the imbalance of access to Section 35 treatment facilities throughout the rest of Massachusetts. Such a decision might also provide incentives for courts in southeastern Massachusetts to continue to utilize Section 35 commitments at higher rates than most other courts in the Commonwealth.

Conversely, it might be possible for DPH to operate or contract for small Section 35 treatment facilities for women under Section 35 in other sections of the Commonwealth. Such units, if limited to 16 beds or fewer, would not be at risk of losing Medicaid or other third party revenues, and could increase treatment access and community discharge opportunities for women and their families in other parts of Massachusetts.

14.4.3 Recommendations

- Recommendation: *Under some circumstances it might be appropriate to develop on the TSH campus a residential treatment program designed for women committed under Section 35. One purpose of this program would be to end the practice of committing women under 35 to MCI Framingham.*

The Abt/TAC team is persuaded that eliminating the commitment of women to MCI Framingham under Section 35 is a desirable policy option. This is particularly true because MCI Framingham does not offer substance use treatment beyond detoxification for women committed to the facility, and thus there is no clinical treatment reason for them to remain involuntarily at the facility.

However, we are not persuaded that relocating such services to TSH is the most desirable option. The fact that TSH has potentially available space for a Section 35 treatment facility for women is not sufficient justification for choosing that location. At the very least, serious consideration should be given to opening smaller treatment facilities for women in other parts of the Commonwealth. This option would enhance treatment options for women and their families in other parts of the State and improve the potential for Medicaid and third party revenues, and to.

If the preferred option as outlined above is determined to be infeasible, then the use of TSH for such services could be considered. Assuming the 45 beds of continuing care for DMH patients migrate to WRCH over time, the three inpatient units remaining at TSH might be available for treatment for women committed under Section 35. Co-location with the Highpoint step-down facility located on the TSH campus might also present some opportunities for more carefully titrated treatment and community discharge functions. The most likely implication of this decision would be foregoing potential Medicaid and other third party revenue for the treatment services.

15. Conclusion

The primary system problem is that there are limited integrated and accountable mechanisms to get the right people to right level of care at the right time to produce the right results. This situation leaves consumers, families, providers and payers all scrambling to access whatever might be immediately available that someone might pay for. There is substantial inefficiency in this system, which exacerbates the competition for appropriate resources. Most of the recommendations in this report are intended to increase accountability and to reduce the inefficiency that prevents people from getting to the right service at the right time.

The primary problem in the public and private mental health system in Massachusetts is not an absolute lack of acute inpatient or continuing care inpatient beds or HCBS treatment services. As noted in this report, there are significant questions about gaps in HCBS services, particularly for the treatment and recovery of individuals with complex of multiple chromic conditions. These gaps are preventing the care system from effectively managing its users, resolving crises by diverting to intensive community treatment, and delaying acute and continuing care inpatient providers from making timely discharges.

There are similar questions about the capacity of the current inpatient beds and the appetite of the current inpatient providers to treat timely many of the children and adults presenting for inpatient care. Resource constraints and concerns about the ability to discharge are most often cited as the reasons for refusing to fill available beds. Adding new inpatient beds, without addressing the capacity of existing beds to treat those in need, will not address many of the systems problems identified in this report. If the systems issues are not corrected, adding new bed capacity will only result in more beds being filled for too long with people who need different services and a different level of care, with the result that the inpatient access and ED boarding problems of today will continue into the future.

The financial realities of public and private funding for mental health care have caused both the public and private mental health provider systems to deliver the least amount of service at the least cost while responding primarily to acute crises. There are limited financial incentives in the system to provide better quality care with appropriate follow up and supports for recovery and/or to reduce re-occurrence of acute crises. Nor are the financial incentives to focus resources on the prevention of crises, particularly for people not connected to the DMH system of care[33]. The lack of adequate funding and consequent limitation of capacity in the outpatient mental health system reduces the ability of the system to provide adequate pre- and post-acute care services.

The combination of the American's with Disabilities Act/Olmstead decision and the Medicaid IMD exclusion substantially reduces the potential for TSH[34] or any other public or private psychiatric inpatient facility from being the locus for expanded continuing care and diversion resources in Massachusetts. These two overlapping requirements drive system planning and solution formulation towards small scale private sector initiatives.

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[33] Available data suggest that more than one half of all the psychiatric crisis presentation at hospital EDs are of people not connected to the DMH system.

[34] If 47 CC inpatient beds remain in use at TSH, it will qualify as an IMD, which would reduce the potential for Medicaid reimbursements for other state-operated services on campus.

There are numerous opportunities to improve the current public and private mental health system in Massachusetts. These include:

- Make better use of current resources in the mental health system – particularly through managing movement through levels of care in the system (acute – hospital diversion – inpatient - continuing stay – step down – community support). Reducing the length of time to approve and effectuate movement from acute inpatient care to continuing care beds if clinically necessary should be the first step in this process.
- Forge effective relationships with and access to substance use services for both crisis diversion and post-acute care and recovery supports.
- Implement feasible and no/low cost strategies to improve access to care, such as assuring weekend admissions to inpatient units and coordinating bed finding functions/activities. Enhanced community intervention (as opposed to ED) practices among existing ESP providers could also increase diversions and reduce the overall demand for acute inpatient admissions. These types of enhanced practices have already proven successful with regard to child/adolescent mental health.

There are also opportunities to ameliorate conditions and improve care for persons committed to, awaiting trial at, and in some cases incarcerated at Massachusetts correctional facilities and county jails/houses of correction. Alternative services for several populations could be sited on the grounds of Taunton State Hospital, providing opportunities for reuse of the facility. These include:

- Develop residential treatment services for women committed under Section 35, enabling them to avoid incarceration at a jail or prison.
- Develop residential treatment services for women and men with mental health conditions, who are nonviolent, do not require an inpatient level of care, and need dual diagnosis treatment. The program may serve as pretrial diversion for those individuals who may be awaiting trial or an alternative medical program for those under sentence at a county house of correction or jail.

And, there are steps that can be taken by policymakers, payers and regulators to ameliorate system alignment resource and performance issues, as detailed in the preceding chapters.

Appendix A: List of MHAC Members

Committee/Organization Represented	Member
Advisory Committee – Co Chair, Senate	Senator John F. Keenan
Advisory Committee – Co Chair, House	Speaker Pro Tempore. Patricia A. Haddad
Ways and Means, Senate Chair	Senator Stephen M. Brewer
Ways and Means, House Chair	Representative Brian S. Dempsey
Health Care Financing, Senate Chair	Senator Richard T. Moore
Health Care Financing, House Chair	Representative Steven M. Walsh
Mental Health & Substance Abuse, Senate Chair	Senator John F. Keenan
Mental Health & Substance Abuse, House Chair	Representative Elizabeth A. Malia
Senate Minority Appointee	Senator Richard J. Ross
House Minority Appointee	Representative Shaunna L. O'Connell
Executive Office of Health and Human Services	Dr. JudyAnn Bigby, Secretary Dr. Ann Hwang, Appointee for Secretary John Polanowicz
Department of Mental Health	Commissioner Marcia Fowler
Department of Public Health	Dr. Lauren Smith, Commissioner
Division of Insurance	Joseph G. Murphy, Commissioner
Office of Medicaid	Dr. Julian Harris, Director Mr. Christopher Counihan, Appointee for the Director
Office of Behavioral Healthcare	Vic DiGravio, President/CEO
Massachusetts Association of Behavioral Health Systems	Gary Gilberti, President; David Matteodo, Executive Director
Massachusetts College of Emergency Physicians	Dr. Gregory Volturo, President
Massachusetts Hospital Association	Lynn Nicholas, President/CEO; Anuj Goel, Vice President
Massachusetts League of Community Health Centers	Dr. James W. Hunt, President/CEO
Massachusetts Medical Society	Dr. Richard V. Aghababian, President
Massachusetts Psychiatric Society	Dr. Alex Sabo, President
Massachusetts Nurses Association	Karen Coughlin, Vice President
American Federation of State, County, and Municipal Employees (AFSCME)	Jim Durkin, Legislative Director
Blue Cross Blue Shield of MA	Andrew Dreyfus, President/CEO
Massachusetts Association of Health Plans	Lora Pellegrini, Esq., President/CEO
Health Law Advocates	Matt Selig, Executive Director
National Alliance on Mental Illness of Massachusetts (NAMI)	Laurie Martinelli, Executive Director
Massachusetts Society for the Prevention of Cruelty to Children	Mary McGeown, President/CEO

Appendix B: List of Key Informants, System Stakeholders and Sites Visited

Respondent Group	Respondent(s)	Discussions on Southeastern Massachusetts	Discussions on the Commonwealth
Advocates	CEO		X
Association for Behavioral Healthcare	President/CEO, Member CEOs, and Program Directors	X	X
Barnstable County Sheriff's Office and House of Corrections	County Sheriff, Medical and Clinical Directors	X	
Behavioral Health Network	Vice President and ESP Director		X
Blue Cross Blue Shield of Massachusetts	Medical Director		X
Boston Medical Center	Vice President, CMO for Behavioral Health, BEST Leadership, and Medical Director	X	X
Bristol County Sheriff's Office and House of Corrections	County Sheriff, Medical and Clinical Directors	X	
Cambridge Health Alliance	Board Member		X
Center for Public Representation	Staff Attorney		X
Cole Mental Health Resource Center	President	X	X
Community Health Link	Executive Director and ESP Director		X
Department of Mental Health	DMH Commissioner, Deputy Commissioners for Mental Health and Children's Services, Assistant Commissioners for Mental Health and Forensic Services, Directors, Area Director for Metro/Southeast, and Southeast Area Director of Community Services	X	X
Department of Mental Health, Corrigan	Corrigan Staff from Outpatient, Inpatient, and ESP	X	
Department of Mental Health, Taunton/Attleboro, Norton ESP	Site Director Brockton Multi-Service Center and Norton ESP Director,	X	
Division of Insurance	Deputy Commissioner on Behavioral Health Study		X
Fellowship Health Resources Fall River	Director of Peer Recovery Services	X	X
Labor Unions	Representatives of Unions at Taunton and in Southeast MA,	X	

Respondent Group	Respondent(s)	Discussions on Southeastern Massachusetts	Discussions on the Commonwealth
	including MNA, NAGE, AFSCME, and SEIU		
Madenwald Consulting	President		X
Massachusetts Association of Behavioral Health Systems	Executive Director	X	X
Massachusetts Association of Health Plans	President/CEO, Vice President		X
Massachusetts Association for Mental Health	Executive Director and Deputy Director	X	X
Massachusetts Behavioral Health Partnership	CEO, Vice President		X
Massachusetts Children's Mental Health Advocacy Group	Executive and Program Leaders from Children's Hospital, MSPCC, PPAL, and DMH		X
Massachusetts College of Emergency Physicians	President		X
MassHealth	Behavioral Health Program Director	X	X
Massachusetts Health Policy Commission	Commission Member	X	X
Massachusetts Hospital Association, Massachusetts College of Emergency Physicians, Massachusetts Association of Behavioral Health Systems, Massachusetts Medical Society, and Massachusetts Psychiatric Society	Executives, Clinical Directors and Department/Division Chairs from Tufts, Hallmark, South Shore, Milford, Baystate, Beth Israel Deaconess, MGH, Steward, UMass Memorial, McLean Hospital and Partners Healthcare, Physician Health Service, and Professional Society Executives and Presidents	X	X
Massachusetts Nurses Association	Statewide Leadership and Membership Representatives (20+)		X
M-Power	Peer Leaders	X	X
Massachusetts State Senate	Chief of Staff, Senator Pacheco	X	X
Morton Hospital and Medical Center	Director of Case Management	X	
National Alliance on Mental Illness Massachusetts	Members from Fall River and the Cape and Islands, Other Members, Criminal Justice Project Director , and Board Members	X	X

Respondent Group	Respondent(s)	Discussions on Southeastern Massachusetts	Discussions on the Commonwealth
National Empowerment Center	Executive Director		X
Plymouth County Sheriff's Department and House of Corrections	County Sheriff, Medical and Clinical Directors	X	
Southcoast Hospital	Hospital Official	X	
Southeast Recovery Learning Community (RLC) Fall River	Director	X	X
South Shore Mental Health Center	President/CEO	X	X
Southeastern Massachusetts Recovery Learning Community	Director	X	
South Middlesex Opportunity Council	CEO		X
Steward Health System	Executive VP, VP/CMO, and Research Staff	X	X
Suffolk County Sheriff's Department and Jail	County Sheriff, Mental Health Director		X
Taunton State Hospital	Management Team	X	
University of Massachusetts Memorial Medical Center, Behavioral Health and Emergency Department	Executive Director, Vice Chair, Adult Psychiatry Clinical Services, and Nursing Director		X
Walden Behavioral Care	CEO		X

Appendix C: Quantitative Data Sources

DMH Data Received

Dataset or Report Received	Date or Date Range
Admissions to all DMH facilities from the Southeast Region by Admitting Facility	FY 2010 – FY 2012
Average Daily Census of Forensic Evaluation Patients	January 2012 – January 2013
Brockton Taunton CCS Utilization	July 2013 – December 2013
CCS Capacity List	March 5, 2014
Charts from the DMH Legislative Budget Testimony Commissioner Fowler Request	FY 2014
Cover Letter and Report with MBHP Response to EOHHS Proposed Strategies	January 2013
DART Monthly Referrals	FY 2010 – FY 2013
DART Summaries of Referrals/Waitlist Data from Acute General Hospital and Private Psychiatric Hospital Units and Referral/Waitlist Data for Corrigan and Pocasset	December 31, 2011 – February 22, 2013
Disposition Roll-up	N/a
DMH Adult Acute and Continuing Care Admissions by Area/Division	FY 2010 – FY 2012
DMH Adult Acute and Continuing Care Admissions by Legal Status at Time of Admission (Includes Pocasset and Corrigan)	FY 2010 – FY 2012
DMH Adult Acute Admissions Average Year End Length of Stay on Discharge (Pocasset and Corrigan)	FY 2010 – FY 2012
DMH Adult Acute and Continuing Care Discharges by Facility and by Discharge Destination	FY 2010 – FY 2013
DMH Adult Acute and Continuing Care LOS	FY 2010 – FY 2012
DMH Adult Acute and Continuing Care Readmission Details	FY 2010 – FY 2013
DMH Adult Continuing Care Administrative DSC ADC	February 25, 2013
DMH Adult Continuing Care Inpatient Bed Capacity (Compared to Patients Accepted for Transfer)	February 2006 – July 2013
DMH Forensic Evaluation Census by Facility	January 2012 – January 2013

Dataset or Report Received	Date or Date Range
DMH Group Living Environments for CBFS Programs	October 10, 2013
DMH Inpatient Capacity	FY 2010 – December 31, 2013
DMH Inpatient Study Commission Report and Recommendations	June 30, 2009
DMH Licensed Acute Units in General Hospitals Adult and Geri-Psychiatric Units Point in Time Review of Licensed Capacity Compared to Average Daily Census as Reported by Hospitals on *PatientCareLink.org*	May 2012
DMH Licensed Hospitals Number of Licensed Beds by Facility	January 2010 – December 2012
DMH Licensed Private Psychiatric Hospital Units License Capacity Compared to Daily Census	N/a
DMH/EOHHS Taskforce on ED Wait Times Possible Solutions	N/a
Encounters for State-Operated ESPs in Southeastern MA	January 2013
Inpatient Study Report for the General Court	March 2004
Licensed Adult Residential Beds	FY 2013
Licensed Outpatient Clinics, Community Mental Health Clinics, and SUD-Trained Clinics	N/a
Map of DMH Facilities by Region	N/a
MCI Reports: Child/Youth – With FY 2013 Goals Interventions, Locations, Response Times and Dispositions, Ages 0-20	FY 2013 – FY 2014
Median LOS for Continuing Care Beds	February 2012 – January 2013
Operated or Contracted Adult Acute and Continuing Care Inpatient Facilities	FY 2010 – December 31, 2013
Taunton State Hospital Adult Continuing Care Admissions, Discharges and ADCs	January 2012 – January 2013
Taunton State Hospital Downsizing Report with Data on Community Beds and Talking Points	N/a

MassHealth Data Received

Dataset or Report Received	Date Range
Acute Inpatient Mental Health Capacity Assessment Report 2012	N/a
Cognos Reports including ESP ED Response Times and Ages	July 2011 – March 2012
DMH ED LOS and Psychiatric Bed Access Workgroup Data Summary for Meeting May 26, 2011	May 7, 2012; July 2009 – January 2012; September 2011 – February 2012
ESP Performance Summaries	N/a
DMH/EOHHS ED Wait Time Taskforce *The Issue of Individuals Seeking Psychiatric Services Who Wind Up Waiting Extensively in EDs for Inpatient Admission, and What Can Be Done* Report	N/a
ESP Statewide Reports	FY 2010 – FY 2012
ESP Utilization Quality Indicators by MCE, All Ages	FY 2010 – FY 2013
MBHP Analysis for EOHHS Proposed Strategies to Address ED Boarding	N/a
MBHP Cover Letter to Ann Hwang on January 2, 2013 Presentation	January 25, 2013
MBHP ESP/MCI Monthly Summary Reports	FY 2010 – FY 2012
Partnership Emergency Services Provider Report	FY 2010 – FY 2012
PowerPoint Presentation on ED LOS Issues for Behavioral Health Patients	January 2, 2013
Snapshot of Time from Disposition Determination to ED Discharge by Payer	N/a

Other Data Received

Data Source	Dataset or Report Received	Date Range
ABH	Report of the Safety Task Force	N/a
ABH	Feedback to EOHHS on ED LOS Report	N/a
Barnstable County Sheriff's Office	Barnstable County Sheriff's Office Inmate Drug Costs	FY 2010 – FY 2013
Barnstable County Sheriff's Office	FTT Cases Released in Calendar Year by SE Jail/HOC Facility	CY 2010 – CY 2013
Baystate	ED Statistics	January 2012 – December 31, 2013
Cape Cod Hosp.	Average Number of Behavioral Health Boarders by Day of Week	October 2011 – February 2013
Cape Cod Hosp.	Boarder Hours	October 2010 – December 2012
Cape Cod Hosp.	ED Data	FY 2012 – FY 2013
Cape Cod Hosp.	Frequent Users Volume by Diagnosis	N/a

Data Source	Dataset or Report Received	Date Range
Cape Cod Hosp.	Inpatient Date on Average Daily Census, LOS	FY 2009 – FY 2013
Cape Cod Hosp.	Summary of IP Psychiatric Daily Census as Presented in the Daily Scorecard	FY 2009 – FY 2012
Cape Cod Hosp.	Total Visits by Frequent Users	FY 2008 – FY 2013
MACEP	2011 Psychiatric Boarding Study Report	2011
MACEP	Initial Findings from 2012 Report	2012
MBHP	MBHP Response to EOHHS Proposed Strategies	2011 - 2012
MHA	Coalition Letter to MassHealth on Mental Health Parity	N/a
South Shore Hosp.	ED Psychiatric Data	January 2013
U. Mass Memorial	ED and Psychiatric Utilization Data	January 1, 2010 – December 31, 2012

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