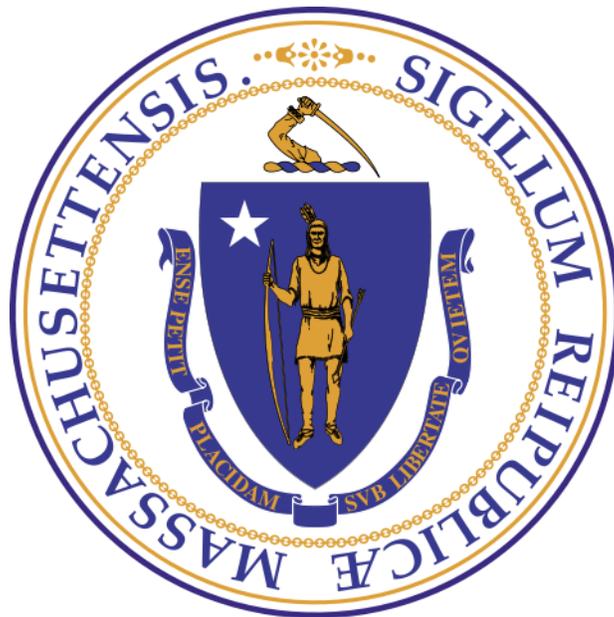


Report of the
Mental Health Advisory Committee
in accordance with
Section 186 of Chapter 139 of the Acts of 2012
and
Chapter 38 of the Acts of 2013



Submitted June 30, 2014

Committee Members

Committee Co-Chairs

- Speaker Pro Tempore Patricia A. Haddad
- Senator John F. Keenan

Legislative Members

- Representative Brian S. Dempsey
- Representative Elizabeth A. Malia
- Representative Ruth B. Balsler
- Representative Shaunna L. O’Connell
- Senator Stephen M. Brewer
- Senator Richard T. Moore
- Senator Richard J. Ross

Administration Members

- Dr. Ann Hwang, appointee of the Executive Office of Health and Human Services
- Christopher Counihan, appointee of the Office of Medicaid
- Marcia Fowler, Commissioner, Department of Mental Health
- Lydie Ultimo-Prophil, Department of Public Health
- Nancy Schwartz, appointee of the Division of Insurance

Professional Expertise and Advocacy Organizations

- Vic DiGravio, Association for Behavioral Healthcare
- David Matteodo, Massachusetts Association of Behavioral Health Systems
- Dr. Matthew Mostofi, Massachusetts College of Emergency Physicians
- Anuj Goel, Massachusetts Hospital Association
- Patricia Edraos, Massachusetts League of Community Health Centers
- Dr. Luis Sanchez, Massachusetts Medical Society
- Dr. Benjamin Liptzin, Massachusetts Psychiatric Society
- Karen Coughlin, Massachusetts Nurses Association
- Stella McGilvray, Service Employees International Union
- Jim Durkin, AFSCME Council 93
- Dr. Ken Duckworth, Blue Cross Blue Shield of Massachusetts
- Sarah Gordon Chiaramida, Massachusetts Association of Health Plans
- Laura Goodman, Health Law Advocates
- Lauri Martinelli, National Alliance on Mental Illness
- Nancy L. Allen Scannell, Massachusetts Society for the Prevention of Cruelty to Children

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Background

The Mental Health Advisory Committee was formed pursuant to Section 186 of Chapter 139 of the Acts of 2012. The primary impetus, at inception, was to explore the causes of boarding of behavioral health patients in emergency departments across the Commonwealth, recognizing that such exploration would require a review and analysis of the broad range of in-patient and out-patient behavioral health services offered by the State. The Committee was also charged with exploring the impact of the reduction of services at Taunton State Hospital, and making recommendations relative to the further disposition of that hospital, with a particular focus on bed capacity and the availability of community placements in the southeast region of the Commonwealth.

Chapter 38 of the Acts of 2013 expanded the scope of the Committee's review, to include providing recommendations on the potential future use of the Cain building at Taunton state hospital or elsewhere in the southeast area for purposes including the development of state-operated pilot crisis stabilization units as an alternative to emergency department boarding, the development of a pilot program for nonviolent offenders with mental health diagnoses currently serving their sentences in state or county correctional facilities, the development of a pilot program for females committed under section 7 of chapter 111B of the General Laws or section 35 of chapter 123 of the General Laws, the development of interagency coordination between state agencies, authorities, departments and programs currently providing services or benefits to individuals who would be deemed eligible for any of the above pilot programs, the availability of existing resources, including the Cain building at Taunton state hospital or elsewhere in the southeast area to address gaps in behavioral or mental health services for southeast area residents as well as inmates or individuals receiving court-ordered treatment, and the projected costs and benefits of each of the above pilot programs.

To support the review and analysis process the Committee, through the Department of Mental Health, solicited competitive bids for a consulting group. Two responses were received – from DMA Health Strategies, and from Abt Associates working with the Technical Assistance Collaborative (TAC). The Committee heard presentations from both, and by majority vote selected Abt/TAC for the project.

The committee held a total of 10 meetings during FY13, and an additional 5 meetings during FY14 after receiving a revised mandate and scope of work, to include one meeting held at MCI-Framingham. These meetings allowed for discussion, expert and advocate testimony, and consideration of various interim documents submitted by the consultant, as well as an ongoing dialogue among Committee members, and between members and the consultant. These meetings, along with the report of the consultant, which is attached in full, have shaped the following recommendations, which the Committee respectfully submits for the consideration of the General Court.

Recommendations

Issue 1: Continuing Care Capacity and Taunton State Hospital

Committee Recommendation:

➤ (1a) Maintain the current level of continuing care services at Taunton State Hospital.

First, it is the opinion of the chairs that a further reduction in services, through the elimination of 45 remaining continuing care beds at Taunton State Hospital, is not appropriate at this time. Analysis conducted for this report has not identified an ideal number of beds per population, nor has it identified any reliable model or metric to make such a calculation. However, the consultant indicates that the Commonwealth is near the national median for psychiatric inpatient bed availability, and that there is “no evidence, either from research or from comparisons with national averages, that Massachusetts has either too few or too many” such beds.¹ The report further specifies 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.”²

This result should be weighed within the broader context of behavioral health care across the Commonwealth. Over the course of numerous discussions and testimony from experts, we have identified significant backlogs in patient flow, delays in service, and obstacles to access. Inpatient capacity is only one among several interrelated factors to consider,³ and the consultant review indicates that increasing this capacity would not directly address the most pressing system challenges.⁴ Nonetheless, any further reduction in services would only exacerbate existing challenges, and therefore should not occur before other reforms are put in place to alleviate the delays, pressures and obstacles we currently experience within our behavioral health care system.

¹ Page 30 ******All page references are to the Phase I and Phase II Report issued by Abt Associates and TAC.***

² Page 32

³ Page 28: “...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.”

⁴ Page 97: “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.”

To this end, a number of potential reforms are described in the remaining list of recommendations from the committee to the Legislature. Each recommendation is summarized, and presented with reference to relevant excerpts and references from the report of the consultant.

Issue 2: Appropriate Patient Placement and Authority to Resolve Conflict Cases

Committee Recommendations:

- **(2a) Establishment of a single point of authority that can make a final determination when a patient’s course of treatment is in dispute, or when a patient is frequently refused for admission, and such circumstance results in extended boarding or otherwise inappropriate placement. In consideration of the overlapping scope and responsibilities between DMH, DPH, and MassHealth, this authority should be established at the level of the EOHHS Secretary, and a revision of existing regulatory authority must be conducted to avoid duplication and conflict.**
 - ❖ **In making the above recommendation, it must be stated that such an authority would be to determine placement for a patient and assign responsibility for a patient’s care to an appropriate provider; not to make specific medical recommendations on the treatment to be provided.**
- **(2b) Along with the above recommendation, establishment of clear criteria for when this authority may be exercised, in a manner that protects against over-reliance on one authority, and encourages resolution at the lowest level as the preferred course of action.**
- **(2c) Review of utilization and opportunities to improve and expand access to a centralized bed search tool, to provide system-wide assistance in finding an appropriate placement for a behavioral health patient as quickly as possible.⁵**
- **(2d) Promulgation of regulations by the Department of Mental Health, in conjunction with the Department of Public Health and other agencies having**

⁵ Page 50: “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...The bed finding process is different across payers and also between hospitals.”

purview over the licensure and operation of hospitals and treatment facilities, for defined terms and more transparent reporting of reasons that a patient is denied by any facility that is licensed by the DMH to maintain inpatient psychiatric beds.

The Commonwealth’s behavioral health system, through the variety of overlapping state and federal requirements and programs, operates with a highly decentralized authority. This supports the creation of diverse programs, and expanded consumer choice – both positive outcomes of this structure.

However, the decentralized nature of the system also allows for lost or non-existent accountability when it comes to some of the patients with the most complex medical, behavioral and addiction treatment needs.⁶ Delays in appropriate placement and services for these high acuity patients manifest through disagreements between providers and carriers, or between sending- and receiving- providers, or a variety of other tensions that allow all parties to decline service to a patient, without placing the authority or responsibility on any single point in the system to organize appropriate services for the patient.

While disagreement or conflict ensues over deciding the *most* appropriate placement or service for the patient, the practical outcome is that patients remain in what is clearly the *least* appropriate setting – an emergency department – for an extended period of time.⁷

Another consequence of this shortfall in authority – or what the consultant report refers to as “fragmentation of authority and loss of single point accountability” – is the possibility that providers “cherry pick,” or routinely deny patients for reasons that tend to disadvantage precisely those individuals who are most vulnerable and most in need of services.⁸

The Committee notes that the recommendations presented in this section should be considered in conjunction with those offered under Issue 3. While a mechanism to resolve placement issues is necessary and should be centralized, the establishment of the resources described under Issue 3 will also help alleviate difficult placement issues, and will provide a placement option for patients who cannot be appropriately treated elsewhere.

⁶ Page 10: “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.”

⁷ Page 14: “This loss of clinical and programmatic leadership...has hindered efforts to assure that mental health consumers receive the right services...to prevent crises and over-reliance on emergency department and hospital resources.”

⁸ Page 52: “The lack of standardized documentation of “refusals” leads to speculation and anecdotes about individuals being too ill for acute inpatient.”

Issue 3: High Acuity and Dual Diagnosis Resources

Committee Recommendations:

- **(3a) Prompt consideration and passage of House Bill 1788, which would provide for licensure of beds designated for “difficult to manage” patients, along with consideration of amendments to the same bill to ensure that any such beds are also accessible to patients in commercial systems.**
- **(3b) Consideration of Taunton State Hospital, or other suitable sites, for pilot programs that divert high acuity and dual diagnosis patients away from Emergency Departments. Components of a pilot model could include:**
 - **Specialty licensure models for beds that divert patients from the ED;**
 - **Improved identification, data collection, and care coordination for patients who meet criteria for a high-acuity or dual-diagnosis diversion;**
 - **Improved communication with EMS and ESP teams, as well as first responders, to facilitate diversion before transport to the ED, and;**
 - **Rate structures, developed through interagency collaboration between DMH and DPH, to incentivize performance by high-acuity and dual-diagnosis diversion providers.**
- **(3c) Further study and consideration of licensure for units that divert patients who are civilly committed under “Section 35” and who are not criminally involved away from correctional facilities.**
- **(3d) Further study on the possibility of a non-violent offender diversion pilot.**

As noted earlier, general inpatient bed capacity is not the only factor impacting access to care. Review by the consultant, and examination by committee members, has identified other procedural and policy obstacles to care, and specific capacity needs that should be addressed. This section and the two sections that follow (“Weekend Backlog” and “Funding for Community Level Care”) address what appear to be the most urgent and immediate process and capacity needs.

Patients with high acuity needs, or with a dual diagnosis of both behavioral and substance abuse conditions, present a particular challenge to our behavioral health system. Although the challenge may be partially a result of “cherry picking” (See “Appropriate Placement and Authority to Resolve Conflict

Cases” section above), it also reflects gaps in service capacity, and an opportunity to improve our assessment and treatment processes.

On the capacity side, the consultant report identifies the “particular concern about capacity to treat those with dual mental health and substance use conditions.”⁹ Our current licensure scheme does not adequately provide for dual diagnosis individuals,¹⁰ nor does it allow for sufficient distinction between high-acuity patients and those that present with lower complexity.¹¹

On the process side, we should explore options that allow for assessment and diversion at the community response level. One contributor to concerns about extended boarding is that emergency departments become the default option even for patients who would be more appropriately treated under different programs, indicating that diversion is a better option for at least some patients. Data suggests that such diversionary services are a more likely outcome when patients, both youth and adult, are seen in their communities, before they arrive in an emergency department.¹²

The consultant report also opined favorably on the possibility of additional pilot programs at Taunton State Hospital or in other suitable facilities, including a diversion program for non-violent offenders. Further, committee members reached consensus on the importance of ensuring that patients who are civilly committed pursuant to Section 35 of Chapter 123 of the MGL are not sent to correctional facilities, and would support further consideration of establishing additional beds for this purpose.

Further, with regard to diversionary services, the consultant report cites the possibility of receiving federal reimbursement, under Section 2707 of the Affordable Care Act, for emergency psychiatric services provided by facilities that are otherwise excluded as institutions of mental disease (IMD).¹³ This presents the possibility that a private or other non-state IMD facility could be used in conjunction with a diversion program to alleviate pressure on emergency departments, if such funding were pursued under the Section 2707 demonstration program.

Issue 4: Weekend Backlogs

Committee Recommendation:

- **(4a) That regulations be promulgated by the Division of Insurance (relative to insurance carriers), the Department of Public Health (relative to hospitals and**

⁹ Page 27

¹⁰ Page 53: “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...”

¹¹ Page 45: “...common barriers to acute inpatient care...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.”

¹² Page 47

¹³ Page 42: “Another possible strategy to decrease ED boarding is the use of private IMDs for the provision of emergency psychiatric services...under Section 2707 of the Affordable Care Act as part of the Medicaid Emergency Psychiatric Demonstration.”

healthcare facilities) and the Department of Mental Health (relative to licensed psychiatric beds) that require appropriate staffing levels, and the removal of procedural barriers or prohibitions that prevent patient transfers and admissions on weekends.

Extended waiting times in an emergency department are not always caused by a shortage in capacity. Inefficiencies in processing discharge or admission authorizations also contribute to these wait times. The consultant report identifies a significant shortcoming - that admissions slow or stop altogether on weekends, despite the fact that patients present at an equal or even greater rate on weekends.¹⁴

In offering this recommendation, the committee recognizes that a regulatory mandate alone cannot overcome certain resource constraints that also contribute to a weekend backlog. It is therefore critical that this recommendation be considered in conjunction with those offered under Issue 5 and Issue 6, which are aimed at addressing certain resource and capacity shortfalls.

Issue 5: Funding for Community Level Care

Committee Recommendations:

- **(5a) New investment in community level behavioral health services, which should supplement, rather than come at the expense of funding for continuing and acute levels of inpatient care.**
- **(5b) To facilitate investment and create appropriate participation by commercial carriers in a full spectrum of care, the establishment of a Behavioral Health and Addiction Services Trust dedicated to funding community level care.**
 - ❖ **Said fund would be established and replenished annually by a surcharge on commercial carriers – in a manner similar to MCPAP funding streams.**
- **(5c) Development of a specific plan by the Commonwealth, and public and commercial insurers, to strengthen the outpatient behavioral health system.**

A clear message of the consultant report has been that the backlog of patients boarding in an ED, or who are unable to find placement in more appropriate levels of care, is significantly impacted by a shortage

¹⁴ Page 54: “If inpatient admissions were to proceed at a normal weekday pace over the weekend as well, the overall amount of boarding time could be reduced substantially.”

of community level placements for otherwise discharge-ready patients.¹⁵ This is a gap in services that is uniformly recognized by every member of the committee, yet our current rate and appropriation structures are insufficient to develop the community level capacity that would address this gap.¹⁶

At the same time, inclusion of community level services is an evidence-based best practice for behavioral health treatment,¹⁷ and should be considered a medically necessary course of treatment for certain individuals as assessed by their health providers. However, this portion of the spectrum of care is not commonly covered by commercial insurance, and large carriers stand behind an assertion that community level services are entirely the responsibility of the state. The committee, with some exceptions, disagrees with that assertion, and would advise steps that generate financial support for community level services from the commercial carriers whose patients need such services. This step would be a partial solution and a method of sharing responsibility; a step that does not preclude the need for public funding of community services.

The committee recommends steps to generate immediate investment in community level services, but also notes that future steps to annualize such funding can and should be paired with the efforts of the Commonwealth's Health Planning Council, established under Chapter 224 of the Acts of 2012, and their ongoing review of the geographic distribution of health resources.

Issue 6: Coverage and Reimbursement Policies

Committee Recommendations:

- **(6a) Legislation to supersede out-of-network restrictions, so that a patient who is boarding in an emergency department can access any available bed immediately regardless of their covered network. Any such provision should allow for transfer to an in-network bed upon availability, if the treating provider believes the patient is suitable for transfer.**
- **(6b) A requirement for increased participation by commercial insurance carriers in a bed search and placement, when a patient is boarded in the emergency department, along with increased reimbursement to the provider who must board the patient in their facility.**

¹⁵ Page 7: "At present, more than 120 Continuing Care (CC) patients await discharge to Home and Community Based Services (HCBS); recent studies have also reported a growing percentage of Acute Hospital patients awaiting discharge to HCBS or CC."

¹⁶ Page 11: "Community service providers are reimbursed or funded so poorly that few can provide basic outpatient services...without incurring significant losses..."

¹⁷ Page 8: "The Massachusetts' community support system...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."

- **(6c) A requirement for increased support by all payers to find adequate services, and put in place an alternative reimbursable treatment plan, whenever the provider-recommended service is denied for any reason.**
- **(6d) Legislation and/or regulation to define terms and require more transparent reporting of reasons that a patient is denied, by the insurance carrier, a behavioral health service or treatment that has been recommended or requested by the provider, and the criteria relied upon for the denial.**
- **(6e) Legislation and/or regulation to define the appropriate use of Administratively Necessary Day (AND) reimbursement rates, and to restrict overuse of this coding when a patient is boarded at an inappropriate level of care but still requires treatment.**
- **(6f) Exploration of further possibilities to enhance reimbursement rates relative to behavioral health services.**

The preceding three sections have described specific process and capacity needs within our behavioral health systems. In making these recommendations, the committee notes that any discussions of capacity and process improvements must be paired with a discussion of the underlying fiscal and policy decisions that would support such improvements. This section and the two sections that follow (“Parity Enforcement” and “Data Collection”) are offered in that context.

Critical improvements to the Commonwealth’s behavioral health care system must involve cooperation by managed care organizations and commercial insurance carriers. We cannot rely solely on the appropriation of public funds to cover shortfalls in services.

The Committee has heard frequently about obstacles to obtaining services, many of them resulting from the current commercial insurance landscape. The elected members of the Committee are also familiar, through the nature and volume of calls from constituents seeking assistance, with these obstacles. The recommendations listed above reflect the Committee’s understanding of the most common obstacles or gaps in reimbursement.

There has also been nearly unanimous consensus that reimbursement rates, both public and private, are inadequate to cover the costs of effective behavioral health services. This can be further exacerbated by over reliance on AND rates keeping reimbursement rates artificially low.¹⁸

Issue 7: Parity Enforcement

Committee Recommendations:

- **(7a) That the Department of Mental Health make expanded use of its authority to review and approve behavioral health benefits for all Managed Care Organizations, including specialty carve outs.**
- **(7b) That said review and approval authority be expanded to include a review and determination on the suitability and accessibility of all commercial carrier behavioral health benefits.**
- **(7c) That to implement this recommendation, the Department should establish a Parity Review office or commission, that will work with the Division of Insurance to define a minimum standard or mandated behavioral health benefits to comply with state parity requirements.**
- **(7d) That the Commonwealth establish an Ombudsmen program, through the Division of Insurance, the Office of Patient Protection, or another appropriate authority, to give patients expanded access to assistance in navigating insurance coverage and reimbursement policies.**
- **(7e) That the commercial insurance grievance process be updated, to reflect a renewed focus on mental health parity, by requiring a clear description of the criteria used to deny a behavioral health service to a patient, and of how such criteria is in keeping with parity requirements.**

¹⁸ Page 11: “The low inpatient administratively necessary day (AND) payment rates combined with lack of system capacity to timely step individuals down from inpatient care act as a de facto barrier to hospital admission”

With few exceptions, there is consensus among the committee members that the Commonwealth has not achieved a reasonable standard of parity between medical/surgical care, and behavioral and substance abuse care. Several trends are noted – indicators that achieving parity will require a renewed effort.

For example, emergency department physicians note that behavioral health patients with different insurance coverage will be treated differently, because of disparate criteria employed by each carrier. Physicians routinely, and of necessity, must ascertain a patient’s behavioral health insurance coverage before determining a course of treatment in the emergency department. The same is not true regarding patients with a physical ailment or injury.

Average time to final disposition also appears to be significantly greater for behavioral health patients than for other patients.¹⁹ Patients may be turned away by a facility when they are found to be “too ill” for admission, another challenge that is less common with regard to physical illness or injury.²⁰ Further, complaints and appeals around behavioral health care represent a disproportionate majority of the Office of Patient Protection’s caseload.²¹

The Division of Insurance has been charged with a review of behavioral health benefits, but it is the Commissioner of Mental Health who is charged with ensuring access and quality broadly across the Commonwealth’s behavioral health systems,²² and who already has the authority and responsibility to review and approve all Managed Care Organizations’ behavioral health benefits.²³ Further, a process to review benefits and processes to ensure that parity is upheld should not be limited to a one-time review or report, but rather should exist as an ongoing process, led by the agencies with the most relevant expertise in treatment and the provision of behavioral health services.

Given the landscape, and the various obstacles that still exist to receiving appropriate behavioral health care, it is also important to provide more information and assistance to patients on an individual basis. The Commonwealth should explore options to give individual support and guidance, through an ombudsman or similar program, to patients who seek care, and should ensure that patients who are denied a service are given a clear explanation of the reasons they are denied care.

Issue 8: Data Collection, Transparency and Performance Measurement

Committee Recommendations:

¹⁹ Page 46

²⁰ Page 52 (See note 8)

²¹ Page 74

²² MGL Chapter 19, Section 1: “The department shall take cognizance of all matters affecting the mental health of the citizens of the commonwealth.”

²³ See Chapter 58, Acts of 2006, Section 113

- **(8a) Legislation to require disclosure of relevant public and commercial insurance and managed care information, to include the managed care organizations providing public behavioral health coverage. This would include data about utilization rates and outcomes; publication of medical necessity criteria; and disclosure of rate setting methods.**
- **(8b) In line with the above recommendation, prompt consideration and passage of House Bill 3665, and House Bill 3704²⁴ – bills relative to transparency by mental health insurance carriers.**
- **(8c) Promulgation by the Department of Mental Health, in consultation with CHIA, of uniform definitions and standards for reporting on certain metrics and outcomes for adults and children in the area of behavioral health, to include performance targets for (i) emergency department wait times; (ii) length of time to process application for DMH services; (iii) length of time to transfer a patient after a determination is made; (iv) length of time to return a prior authorization request; and others considered appropriate by the Department.**
- **(8d) Regular reporting by the DMH on patient flow data relating to persons referred to continuing care, approved for said care, and successfully transferred to continuing care or to another clinically appropriate alternative.**

Critically important to any current and future analysis of the Commonwealth’s behavioral health care system is the availability and quality of data maintained about all components of the system – i.e. across all providers, all payors, and at every level of care. The consultant review has been significantly hindered by several gaps in data, yet this experience itself provides guidance for future reforms.^{25,26}

²⁴ House Bill 3704 was engrossed only by the House at the time this report was initially drafted. It has since been engrossed by the Senate, and as of this report’s final edits on June 29, 2014 the bill is enacted and before the Governor for approval.

²⁵ Page 11: “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.”

²⁶ Page 29: “...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.”

One major obstacle to appropriate data collection and monitoring is that commercial carriers and managed care organizations will not disclose such data.^{27,28} Current statute allows carriers to claim proprietary protections over information that is critical to a thorough system analysis.

A second major obstacle is that no clear criteria exist for performance measurement, or even for outcome reporting, by providers in the area of behavioral health.²⁹ Those providers who voluntarily, and on good faith, report on measures such as wait times are doing so under varied criteria that makes comparison across payors and providers unreliable.³⁰

The consultant also offers that the DMH should be more effective and transparent in managing patient flow into and out of continuing care services, and makes a specific recommendation for weekly reporting by the Department on patient flow measures.³¹

Support for Ongoing Efforts of the Commonwealth

Members of the Committee applaud efforts by both the House and the Senate to support mental and behavioral health services in the fiscal year 2015 budget. The budget proposals protect current service levels at Taunton State Hospital, while also providing funding to open the 52 continuing care beds that are currently unutilized at the Worcester Hospital and Recovery Center.

Proposals in the budget also prioritize spending on community-level placements for adults in need of behavioral health resources at that level. This funding targets the issue, identified by this committee, that many patients are maintained in continuing care beds despite being ready for discharge because of the difficulty in finding an appropriate step-down service at the community level.

Both the House and Senate have also protected funding for the Massachusetts Child Psychiatry Access Project, and continue to support a policy that requires the commercial carriers and providers whose patients benefit from this project to share the costs of funding the project.

The Committee is pleased to see these issues prioritized for the Commonwealth's budget, and hopes that efforts to improve our mental and behavioral health systems, including the consideration of recommendations offered in this report, will remain a priority for both chambers of the Legislature for the remainder of this session, and for the upcoming session as well.

²⁷ Page 11: "CHIA reports that it has not yet received data from the MassHealth behavioral health carve-out vendor, the Massachusetts Behavioral Health Partnership."

²⁸ Page 11: "...reports of performance across payers and public and private systems may lack detail needed to assess performance, identify need or predict demand."

²⁹ Page 11: "There is no uniform set of definitions for data elements to be tracked and reported in the Commonwealth, nor...provider performance measures that could be used to assess the quality and effectiveness of the system..."

³⁰ Page 52: "Common metrics across payers and across hospitals are lacking. There is no consensus on when the clock starts ticking: when an individual is medically cleared; when a determination of the need for inpatient is made; or when the ESP is called."

³¹ Pages 40-41

Summary of Recommendations

Issue 1: Continuing Care Capacity at Taunton State Hospital	(1a) Maintain current level of continuing care service.
Issue 2: Appropriate Placement and Authority to Resolve Conflict Cases	(2a) Establishment of a single point of authority at EOHHS that can make a final determination when a patient's course of treatment is in dispute.
	(2b) Clear criteria for employment of said authority, in a manner that encourages resolution at the lowest level as the preferred course of action.
	(2c) Seek opportunities to expand and improve utilization of a centralized bed search tool
	(2d) Defined terms and more transparent reporting of reasons that a DMH licensed facility denies admission to a patient.
Issue 3: Process and Capacity Needs – High Acuity and Dual Diagnosis Resources	(3a) Passage of House Bill 1788 - relative to a "difficult to manage" unit, with consideration of amendment as indicated.
	(3b) Consideration of Taunton State Hospital, or other suitable sites, for pilot programs that divert high acuity and dual diagnosis patients away from Emergency Departments.
	(3c) Further study and consideration of units to divert Section 35 civilly committed persons out of correctional facilities.
	(3d) Further study on the possibility of a non-violent offender diversion pilot.
Issue 4: Process and Capacity Needs – Weekend Backlog	(4a) Regulations by DOI, DPH and DMH, applied to respective regulated organizations and facilities, to address appropriate staff levels and removal of other barriers to processing discharge and admission authorizations on weekends.
Issue 5: Process and Capacity Needs – Funding for Community Level Care	(5a) New investment in community level behavioral health services, which should supplement, rather than come at the expense of funding for continuing and acute levels of inpatient care.
	(5b) Establishment of a Behavioral Health and Addiction Services Trust dedicated to funding community level care, funded by a surcharge on carriers that do not otherwise offer community level benefits.
	(5c) Development of a specific statewide plan to strengthen outpatient behavioral services.

Issue 6: Fiscal and Policy Matters – Coverage and Reimbursement Policies	(6a) Limitations on out-of-network restrictions during boarding situations.
	(6b) Increased participation by commercial insurance carriers in a bed search and placement, and increased reimbursement to the provider who must board the patient in their facility.
	(6c) Increased support by all payers to find adequate services, and put in place an alternative reimbursable treatment plan, whenever the provider-recommended service is denied.
	(6d) Defined terms and more transparent reporting of reasons and criteria for denial, by insurance carriers, of a behavioral health service.
	(6e) Limitations against overuse or inappropriate use of AND reimbursement rates for patients who are in need of services.
	(6f) Exploration of further possibilities to enhance reimbursement rates relative to behavioral health services.
Issue 7: Fiscal and Policy Matters – Parity Enforcement	(7a, 7b, 7c) Leverage DMH authority to review and approve all behavioral health benefits, by establishing parity review team.
	(7d) Provide access to ombudsmen to assist patients and ensure provisions of parity are upheld.
	(7e) Require a description of denial criteria, and statement of compliance with parity requirements, given to the patient with each denial issued through a grievance process.
Issue 8: Fiscal and Policy Matters – Data Collection, Transparency and Performance Measurement	(8a) Require disclosure of relevant public and commercial insurance and managed care information.
	(8b) Passage of House Bill 3665, and House Bill 3704 – bills relative to transparency by mental health insurance carriers.
	(8c) Promulgation by the Department of Mental Health, in consultation with CHIA, of uniform definitions and standards for reporting on certain metrics and outcomes in the area of behavioral health.
	(8d) Regular reporting by the DMH on data relating to patient flow for continuing care services.

Appendix A: Summary of Committee Vote

Summary of Committee Vote

The following denotes all votes recorded in opposition to, or members abstaining/reserving their votes on particular matters. Unless indicated, all other votes recorded were in the affirmative.

NOTE: Members of the committee who represent an agency, department or secretariat of the Executive Branch abstained from all votes, but have stated that this should not be taken as an indication of opposition or otherwise as an expression of any official position on the part of the Executive.

<u>Item</u>	<u>Opposed</u>	<u>Abstain / Reserve</u>
1a		
2a	MAHP	MABHS
2b	MAHP	MABHS
2c	MAHP	MABHS
2d	MAHP	MABHS
3a		
3b		
3c		
3d		
4a		MABHS
5a	MAHP, BCBS	
5b	MAHP, BCBS	
5c	MAHP, BCBS	
6a	MAHP, BCBS	
6b	MAHP, BCBS	
6c	MAHP, BCBS	
6d	MAHP, BCBS	
6e	MAHP, BCBS	
6f	MAHP, BCBS	
7a	MAHP	BCBS
7b	MAHP	BCBS
7c	MAHP	BCBS
7d	MAHP	BCBS
8a	MAHP, BCBS	
8b	MAHP, BCBS	
8c	MAHP, BCBS	
8d	MAHP, BCBS	

MAHP = Massachusetts Association of Health Plans

MABHS = Massachusetts Association of Behavioral Health Systems

BCBS = Blue Cross Blue Shield of Massachusetts

HOUSE No. 1788

By Mrs. Haddad of Somerset, a petition (accompanied by bill, House, No. 1788) of Patricia A. Haddad, Sarah K. Peake and Denise C. Garlick relative to creating a difficult to manage unit within the Department of Mental Health. Mental Health and Substance Abuse.

The Commonwealth of Massachusetts

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In the Year Two Thousand Thirteen
—————

An Act relative to creating a difficult to manage unit within the Department of Mental Health.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 19 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by adding the following section: - Section 25. There shall be, within the department of mental health, a specific difficult to manage unit, so called, for men and a specific difficult to manage unit, so called, for women. Units within the department shall be clearly designated as such. Units shall address and consider issues relative to the difficult manage, so called, populations within the department.

Summary: This bill would create within DMH separate difficult to manage units for men and women, to be located at a central location. The units would be consistent with the former difficult to manage unit at Taunton State Hospital.

HOUSE No. 3665

The Commonwealth of Massachusetts

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In the Year Two Thousand Thirteen
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An Act relative to behavioral health managed care organizations.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 113 of Chapter 58 of the Acts of 2006 is hereby amended by inserting after the first sentence the following sentence:-

“The Division shall require managed care organizations to file with the Division any contracts or subcontracts for the management and delivery of behavioral health services by specialty behavioral health organizations to MassHealth members, and the Division shall disclose such contracts upon request.”

Summary: This bill makes the terms and conditions of contracts for services to MassHealth members between managed care organizations and behavioral health managed care organizations subject to freedom of information requests under the public records statute.

HOUSE No. 3704

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act relative to enhancing access to services for mental health treatment.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 304 of Chapter 224 of the Acts of 2012 is hereby amended by striking out “October 1, 2015” and inserting in place thereof the following:— August 1, 2014

Summary: This bill would expedite the effective date of the important transparency provisions adopted as part of Chapter 224 of the Acts of 2012, the Health Reform Law, thereby giving consumers important information about how health plans are making decisions about authorizing or denying access to care.