

READY FOR REFORM: BEHAVIORAL HEALTH CARE IN MASSACHUSETTS

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ABOUT BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

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BEHAVIORAL HEALTH CARE ACCESS IN MASSACHUSETTS TODAY

Massachusetts is a national leader in health care reform. It was among the first states to require coverage of mental health services, in 1973; first in the nation to create a framework for state-based universal health coverage, in Chapter 58 of the Acts of 2006, the model for the Affordable Care Act (ACA); a leader in broadening parity laws to require coverage of a greater number of mental health conditions, in Chapter 256 of the Acts of 2008; a trailblazer in implementing a comprehensive approach to controlling health care cost growth and improving health care quality, through Chapter 224 of the Acts of 2012; and an innovator in Medicaid coverage and delivery system and payment reform through its long-standing MassHealth 1115 demonstration waiver. The results of these efforts are impressive. Massachusetts has the lowest rate of uninsured residents in the country, at 4 percent; has driven health care cost growth below Chapter 224's growth benchmark and national cost growth trends; and is consistently ranked as one of the healthiest states in which to live across multiple measures.¹

Massachusetts ranks high among states on behavioral health care quality and access measures, as it does on most physical health care measures.² The state has a high density of primary care physicians (PCPs)—the health care system's front line, who are often the first to identify and treat individuals with behavioral health needs—and of child and adult psychiatrists.³ However, despite the high numbers of providers, Massachusetts consumers experience significant challenges in accessing behavioral health care services.

Massachusetts state leaders are strongly committed to improving access to behavioral health care services (inclusive of mental health and substance use disorder-related services) and have invested significant time and financial resources, particularly over the past five years, to addressing some of the greatest barriers to care:

- State funding for behavioral health care services provided by the Department of Mental Health (DMH) and the Department of Public Health (DPH) increased by nearly 20 percent in state fiscal year (SFY) 2019. This enabled the state to enhance community-based mental health services for adults with serious mental illness and support additional substance use disorder (SUD) inpatient treatment beds and enhanced SUD treatment for incarcerated individuals.
- Through its MassHealth 1115 waiver, Massachusetts expanded access to community-based residential treatment, care management, and recovery supports for MassHealth members with SUDs and, through the waiver's Delivery System Reform Incentive Payment (DSRIP) program, committed a large portion of the \$115 million (over five years) that was dedicated to statewide infrastructure and workforce development initiatives to behavioral health care improvements.
- The administration also has made significant investments in expanding the affordable housing stock in Massachusetts, including a \$10 million Housing Choice Initiative in 2017, which provides municipalities with incentives, grants, and technical assistance toward creating 135,000 new housing units by 2025, and \$1.8 billion Housing Bond legislation in 2018, which provides long-term capital support for the further production and modernization of affordable housing.⁴

Despite these efforts, there remain critical gaps in access to needed services throughout the behavioral health care continuum (see Figure 1). Consumers consistently report long waits for appointments, lack of inpatient bed availability, and difficulty finding providers who take insurance. Data from the 2018 Massachusetts Health Reform Survey indicates that 38.7 percent of adults who sought mental health and/or SUD care in Massachusetts in the previous twelve months reported unmet need for such care.⁵

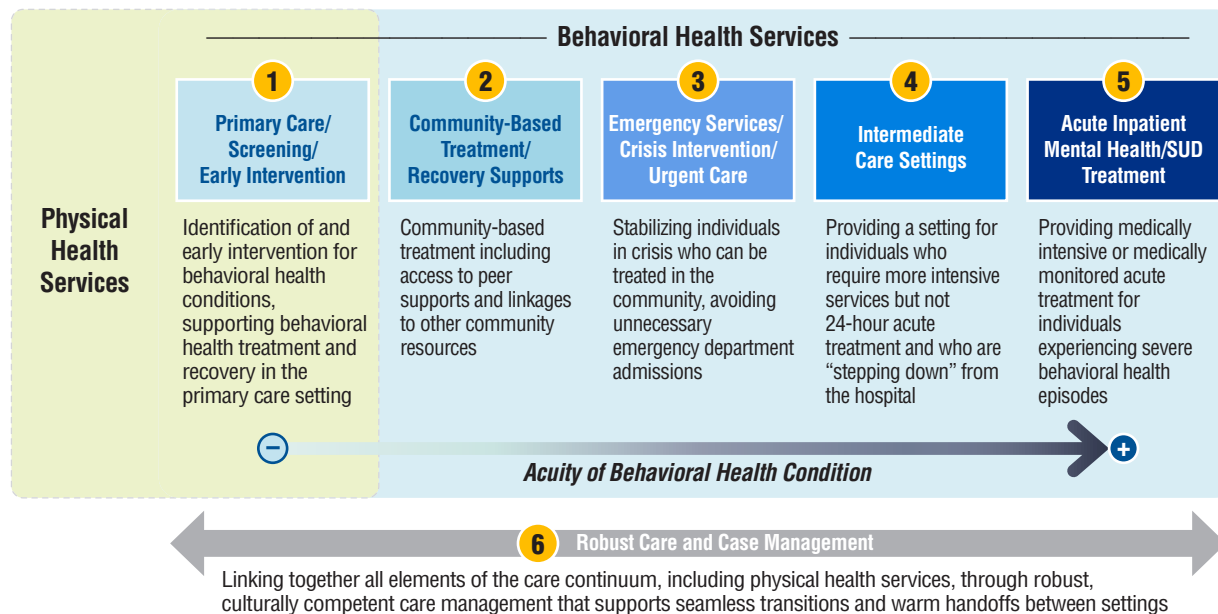
PROJECT GOAL AND METHODOLOGY

The Blue Cross Blue Shield of Massachusetts Foundation engaged Manatt Health to document and describe the current behavioral health (inclusive of mental health and substance use disorder [SUD]) care system for children, adolescents, and adults in Massachusetts, including its strengths and weaknesses; describe a vision for behavioral health care in the Commonwealth; and develop recommendations for moving from the current state to the vision.

To accomplish this goal, Manatt Health:

- Interviewed 11 behavioral health experts and facilitated two discussion groups on the topic of Massachusetts behavioral health care with state and national stakeholders and thought leaders.
- Conducted a comprehensive landscape scan of the current public and private behavioral health care system in Massachusetts, including mental health and SUD services (the “as is”).
- Developed a recovery-focused conceptual model for behavioral health care that would ensure timely access and adequate inpatient and outpatient service capacity, care coordination, and quality for residents of the Commonwealth across all payers (the “to be”).
- Identified gaps between the “as is” and “to be” systems.
- Crafted a new vision for behavioral health care and a strategic approach and recommendations— informed by examples from the field—through which Massachusetts can advance the vision and reform behavioral health care for all residents of the Commonwealth.

FIGURE 1. OVERVIEW OF THE BEHAVIORAL HEALTH CARE CONTINUUM AND KEY IDENTIFIED GAPS IN MASSACHUSETTS



Key Gaps in the Continuum

1	2	3
<ul style="list-style-type: none"> Lack of appropriate training among primary care and other physical health providers in techniques for identifying individuals with behavioral health needs, treating those who can be managed in a primary care setting, and providing appropriate referrals for more complex cases. 	<ul style="list-style-type: none"> Long wait times for outpatient mental health and SUD treatment, regardless of insurance type. Lack of attention to and expertise in treating co-occurring mental health and SUD needs and co-occurring behavioral and physical health conditions. Inadequate supply of evidence-based treatment modalities, including medication-assisted treatment. 	<ul style="list-style-type: none"> Emergency Services Programs (ESPs), mobile crisis interventions, and other urgent care programs are underfunded and struggle to hire qualified staff. Services are not widely covered by commercial insurance. Emphasis of ESPs has historically been on treating those with mental health conditions, as opposed to SUDs or co-occurring conditions.
4	5	6
<ul style="list-style-type: none"> Long wait times for partial hospitalization and intensive outpatient programs. Financial viability for these programs remains a challenge; this is driven in part by burdensome staffing and licensure requirements. 	<ul style="list-style-type: none"> Lack of specialized beds for children with autism and individuals of all ages with intellectual and developmental disabilities, driven in part by difficulty hiring and retaining adequate clinical staff. Lack of clinical knowledge about care options across the continuum among community-based providers (e.g., PCPs), leading to a large number of referrals to acute settings that could be managed in the community. 	<ul style="list-style-type: none"> Patients are often “lost” in navigating the transition between settings. Lack of interoperability and ability to exchange data across entities hinders seamless care management.

A CALL TO ACTION: ADVANCING THE NEW VISION FOR BEHAVIORAL HEALTH CARE

These problems show no signs of abating. Behavioral health conditions continue to have major adverse impacts on millions of individuals and families throughout the Commonwealth, with more than 20 percent of Massachusetts residents experiencing a mental illness and 10 percent experiencing an SUD between 2016 and 2017,⁶ and 23 percent seeking care for mental health and/or an SUD for themselves or a family member in 2018.⁷ Massachusetts experienced a 69 percent increase in drug deaths between 2012 and 2017, and had the third highest increase nationally in the rate of drug deaths between 2015 and 2018.⁸ Behavioral health conditions have a huge adverse impact on individuals' health status and life expectancy. Poor management of these conditions also adversely impacts the health care system as a whole through potentially avoidable use of and extended stays in hospital emergency departments and inpatient care settings.⁹ The human and economic costs are exponentially worse for individuals with co-occurring mental health and SUDs. According to the 2017 Massachusetts State Health Assessment, 52 percent of treatment admissions reported to DPH's Bureau of Substance Addiction Services (BSAS) had a history of mental health treatment.^{10,11}

As in other states, the problems inhibiting access to behavioral health care in Massachusetts are driven by a wide range of interdependent factors (described below), and the extent of the access barriers can vary dramatically depending on a person's insurance coverage, severity of condition(s), type of service(s) needed, and geographic location. These problems are long standing and well documented in prior reports,¹² and validated in discussion groups with the Massachusetts behavioral health experts who informed this report. The bottom line is that behavioral health care services in Massachusetts are organized from the perspective of providers, provider organizations, and state administrative structures and not from the perspective of people needing and seeking services for themselves or their families. That must change in order to truly have an accessible, high-quality behavioral health care system in the Commonwealth.

Care fragmentation. Individuals and providers often do not know where to start when seeking or attempting to refer someone to the appropriate level of behavioral health care in Massachusetts. Once consumers connect with care, siloed physical health, mental health, and SUD treatment care settings; poor information-sharing across providers; and inadequate care management across settings of care—particularly between hospital-based and community-based care—result in suboptimal or no ongoing care as people become disconnected from the health care system. Exacerbating these problems, many physical health providers, who could play a much greater role in the early identification and treatment of behavioral health conditions than they do now, lack the training to appropriately screen for behavioral health conditions.¹³

Workforce shortages and burden. Workforce shortages across the behavioral health care continuum and other workforce challenges create additional access barriers for consumers. While Massachusetts overall has a high density of child and adult psychiatrists, there is a severe shortage of psychiatrists who accept insurance and who serve children and adolescents in more rural areas of the state.¹⁴ Stakeholders also report that outpatient clinics, emergency services/crisis stabilization programs, and inpatient and residential facilities are struggling to attract professionals with specialized behavioral health skill sets, including in treating children with intellectual and developmental disabilities (I/DD) and autism, seniors with co-occurring medical and behavioral health conditions, active substance users, and individuals with co-occurring mental health and SUD conditions.¹⁵ Additionally, solo and small practices, in particular, report they do not have the supports to

manage the administrative aspects of insurance participation.¹⁶ These workforce issues can be attributed to a number of factors, including low payment rates, bureaucratic licensure and credentialing processes, a lack of specialized training opportunities, salaries for certain types of professionals that are not competitive with those in other industries, and challenging work environments.¹⁷ Workforce capacity issues have ripple effects across the continuum. These contribute to overutilization of emergency departments, which often have lower clinical value relative to other care settings, and to a lack of transparency about the true capacity in the system to meet the needs of Massachusetts residents.

Insufficient insurance coverage of key benefits.

Inconsistent coverage of behavioral health care services across payers exacerbates access barriers and leads to disparities in treatment based on the type of insurance one has. High-value services, such as care management, diversionary services, and residential treatment, are covered by MassHealth but are less commonly covered by commercial payers.¹⁸ The Commonwealth has taken steps to address this problem by working to align commercial benefits for children with those provided through the MassHealth Children's Behavioral Health Initiative (CBHI).^{19,20} But disparities in benefits and access for adults persist, especially for those with commercial coverage.²¹ In part due to this dynamic, MassHealth is the state's largest single payer for behavioral health care services, and was responsible for 48 percent of total behavioral health care expenditures in Massachusetts in 2013.²²

Housing instability. Lack of access to low-threshold, affordable, and stable housing for individuals with behavioral health conditions impedes treatment and recovery. Without stable housing, those with the highest behavioral health needs end up admitted to the emergency department or an inpatient unit when their condition could have been managed in a less intensive setting. This exacerbates upstream capacity issues such as emergency department overcrowding and backlogs for inpatient beds.

Poor data on capacity, demand, and quality.

The Commonwealth lacks basic information and robust measurement tools for understanding the gaps in the current behavioral health care continuum. This lack of data undermines the development of targeted strategies to improve access and care delivery and the ability to hold providers and payers accountable for delivering high-quality care. It applies particularly to outpatient mental health, SUD treatment, and treatment for co-occurring disorders, as there are considerable barriers for measuring outpatient capacity in a systematic, reliable way.²³ Furthermore, there are no uniform standards for measuring and assessing quality of behavioral health outcomes.²⁴

Massachusetts has the political will, substantive expertise, and ingenuity to overcome these challenges and advance a new vision for behavioral health care that ensures equitable access and quality care for all resi-

The **Children's Behavioral Health Initiative (CBHI)**, a result of the *Rosie D.* litigation filed in 2001 was a major contributing factor to coverage expansion and comprehensive MassHealth benefits package for children. Through CBHI, primary care providers serving children with MassHealth coverage must offer behavioral health screenings at well-child visits. Additionally, CBHI provides new or enhanced home- and community-based behavioral health care services for children.

For more information, visit https://bluecrossmafoundation.org/sites/default/files/download/publication/Rosie-D_Issue-Brief-WEB.pdf

Low-threshold treatment settings and other services (for example, housing) are oriented toward harm reduction and do not require individuals to abstain from substance use in order to access services. In contrast, **high-threshold** programs require individuals to satisfy certain conditions, such as abstaining from drug use or participating in counseling.

For more information, visit www.ncbi.nlm.nih.gov/pubmed/23567101.

dents of the Commonwealth. For more detail on the current state of the Massachusetts behavioral health care system, see *The Massachusetts Behavioral Health Care System: Strengths, Gaps, and Opportunities for Improvement* chartpack,* which was released as a companion to this report.

This paper is intended to be a call to action for Massachusetts policymakers and stakeholders to significantly improve consumer experience in behavioral health access, coverage, and quality in the Commonwealth regardless of the consumer's age or insurance status. This will require the state to embrace a new vision for a behavioral health care system focused on the people needing and seeking care and characterized by the following key principles:

- **Accessible to all.** Offers a continuum of care that is easy for all consumers to understand, enter, and navigate and is responsive to the cultural and linguistic needs of the Commonwealth's diverse population.
- **Adequately staffed and funded.** Is characterized by sustainable payment, an infrastructure of supportive resources that enhance provider practice (including navigation and training), and a low administrative burden related to provider licensure, credentialing, and practice.
- **Whole-person responsive.** Includes integrated care management and service delivery to address consumer needs with respect to physical health, mental health, substance use, co-occurring disorders, long-term services and supports (LTSS) needs as applicable, and social factors influencing health at every level of care.
- **Quality-outcomes driven.** Is defined by the widespread implementation of coverage and payment models that promote defined clinical, health and well-being, and consumer experience outcomes; and continual measurement and improvement against a set of outcomes-based quality metrics.

The "call to action" is for sustained commitment to this vision among stakeholders across all sectors of the Massachusetts health care system, combined with the political will and leadership of the administration and legislature, to enact meaningful and lasting behavioral health care reform in the Commonwealth.

* Available at https://bluecrossmafoundation.org/sites/default/files/download/publication/MA_Behavioral_Health_System_Chartpack_Jan2019_FINAL.pdf.

ACHIEVING THE NEW VISION FOR BEHAVIORAL HEALTH CARE: RECOMMENDATIONS

Achieving the new vision for behavioral health care delivery in the Commonwealth is possible, yet it will require a comprehensive, sustained effort by a committed team. To this end, this report recommends that the Commonwealth pursue a series of reforms that make important administrative and legislative changes to behavioral health care policy, administration, and payment, and develop the foundation for broader reform efforts. These include recommendations focused on **five key priorities** and an approach that will engender commitment and accountability for driving behavioral health care reforms in a transparent way:



1

Make it easier for people to seek and access behavioral health care services.



2

Ensure the availability of a comprehensive, person-centered behavioral health care continuum of services for all individuals regardless of payer, service needs, or age.



3

Invest in workforce development and capacity efforts to attract and retain behavioral health care professionals and support the development of a culturally competent and linguistically diverse workforce.



4

Develop a plan for better aligning and consolidating behavioral health care administrative, regulatory, and purchasing functions across state agencies.



5

Establish a Behavioral Health Reform Team (BHRT) charged with developing and implementing a three-year action plan to advance solutions to key behavioral health care challenges in the state that require additional research and stakeholder engagement.

Discussed below are the specific reforms that would support accomplishment of these priorities. Reforms associated with priority area numbers one through four are targeted reforms. The Commonwealth can and

should accomplish these in the near term, through administrative or legislative action, to make immediate and foundational improvements to behavioral health care in Massachusetts and set the state on the course to achieving its vision for behavioral health care delivery reform. The reform issues assigned to the BHRT are those that will need to be addressed as part of a longer-term initiative.



Make It Easier for People to Seek and Access Behavioral Health Care Services

Stakeholders and experts around the state have noted that individuals with behavioral health needs often have significant difficulty determining how and where to access services, particularly outpatient and other community-based services, in a timely fashion. Providers also have difficulty directing individuals to the right level of care once they have engaged in treatment. These challenges can lead to individuals delaying treatment until their condition becomes acute. Further, individuals can get “lost” during transitions between providers and care settings, when they are particularly vulnerable to non-adherence with treatment or medication plans. The following recommendations are designed to ensure that Massachusetts has a navigable person-centered behavioral health care system in which there are no “wrong doors” for accessing services:

- **Promote behavioral health screening and prevention.** The Commonwealth should consider fully activating and promoting the use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) billing codes in MassHealth—and, potentially, across all payers—to ensure that providers are reimbursed for time spent screening individuals for behavioral health issues, particularly SUD, and directing them to the appropriate treatment setting. This recommendation is not new, but Massachusetts continues to lag behind many other states in deploying this validated, standardized assessment tool for identifying people needing or at risk of needing behavioral health treatment.²⁵ Activation and promotion of SBIRT must be accompanied by provider education and training and a review of any other regulatory barriers (for example, restrictions on the types of providers who can provide SBIRT) or administrative ones (for example, workforce or staffing policies) that may discourage provider utilization of the codes.²⁶ According to several studies, costs associated with implementing SBIRT can be offset by savings realized from a reduction in injury or in the use of higher-cost services.²⁷
- **Expand the use of telemedicine.** The Commonwealth should consider improved state policies and regulatory requirements to encourage broad adoption of tele-behavioral health to help alleviate some of the state’s workforce challenges. These include changes to telemedicine licensing and practice standards, coverage and reimbursement, eligible care settings, provider types

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as “a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders (SUD), as well as those who are at risk of developing these disorders.” It includes three components: screening, in which a health professional quickly assesses the severity of substance use and identifies the appropriate level of treatment for a patient; brief intervention, which involves engaging patients showing signs of substance use in a short conversation with the goal of creating awareness of their condition and motivating behavioral change; and referral to treatment, in which the professional provides a referral to the appropriate level of SUD treatment.

For more information, visit www.samhsa.gov/sbirt/about.

EXAMPLES FROM THE FIELD:
Ohio SBIRT Project

The Ohio SBIRT Project is a five-year, \$10 million cooperative agreement between the Ohio Department of Mental Health and Addiction Services (Ohio MHAS) and SAMHSA designed to spread and maintain the practice of SBIRT in medical facilities throughout the state. The program provides services directly through several federally qualified health centers (FQHCs) and also provides training, technical assistance, and support to non-grant-funded providers that are interested in implementing SBIRT. Training resources focus on key SBIRT principles, using different SBIRT screening tools, motivational interviewing, and the brief negotiated interview model. The project places a strong emphasis on technology and data sharing and requires that all grant-funded sites update their electronic medical records with applicable screening tools and join the statewide health information exchange. The project has also contracted with a statewide tele-treatment provider to help individuals who are unable to access local services.

For more information, visit <https://mha.ohio.gov/Treatment/SBIRT>.

EXAMPLES FROM THE FIELD:
Alaska Frontline Remote Access Clinic

Alaska faces acute behavioral health workforce challenges, due in part to its geographic size and numerous small, remote communities. In an attempt to address this problem, the state established a pilot program in 2003 to expand access to tele-behavioral health in these communities and has since expanded the program—now known as the Alaska Frontline Remote Access Clinic—to approximately two dozen towns and villages across the state. The program contracts with behavioral health providers who maintain availability for virtual “walk-in” hours for psychiatry services, outpatient psychotherapy, and mental health assessments. To further streamline the delivery of these services, the state has worked to create a regulatory environment that is conducive to telemedicine. In 2014, the state passed legislation stipulating that physicians are permitted to prescribe controlled substances without a physical examination under certain circumstances. It has also published guidance clarifying rules and regulations for providers around the provision of tele-behavioral health services.

For more information, visit www.dhss.alaska.gov/dbh/Pages/api/remote_access.aspx.

(including out-of-state providers), and permissible technologies. Massachusetts is generally regarded as lagging behind most states in its use of tele-behavioral health.²⁸ While the Massachusetts Behavioral Health Partnership (MBHP)²⁹ and some MassHealth managed care organizations (MCOs) provide coverage of telehealth services, there is no coverage under the MassHealth fee-for-service program and inconsistent coverage across commercial plans.

- **Expand Massachusetts Child Psychiatry Access Project to adults.** It is well established that there is a large nationwide shortage of psychiatrists, and Massachusetts is no exception to this trend.³⁰ As a result, PCPs, even those who are not trained in psychiatry, find themselves treating individuals who are in need of psychiatric care but who are unable to access needed services in a timely fashion. To address this problem for children, Massachusetts established the Massachusetts Child Psychiatry Access Project (MCPAP) in 2005 to provide PCPs treating children with quick access to psychiatric consultation and referral facilitation. Today, MCPAP is widely used by PCPs who treat children, and it is now available for all children and families regardless of insurance.³¹ The state should consider building on the successes of MCPAP by expanding the program to PCPs treating adults in Massachusetts.
- **Incentivize providers to build same-day or walk-in appointment capacity.** Consumers and their families continue to report that accessing outpatient behavioral health services is difficult, and that wait lists are often long, even for individuals with insurance coverage.³² Providers also report that missed appointments, which are commonplace among individuals with behavioral health conditions, result in significant lost billings and wasted appointment slots that could otherwise be used for individuals willing and able to engage in treatment.³³ Massachusetts should consider establishing in MassHealth and requiring commercial payers to establish payment models that reward providers for building capacity for same-day or walk-in appointments. This would help make treatment more accessible to many while reducing the burden of missed appointments on behavioral health providers.

2



Ensure the Availability of a Comprehensive, Person-Centered Behavioral Health Care Continuum, Regardless of Payer, Service Needs, or Age

Massachusetts stakeholders report that timely access to services across the continuum of behavioral health care varies substantially by type of insurance, type of service needed, and age. This is due to a range of cross-cutting factors, including varying levels of insurance coverage across payers and workforce shortages that disproportionately impact certain parts of the continuum (for example, psychiatry). To address these challenges and enhance access for all people in Massachusetts, the Commonwealth should consider the following strategies to ensure uniform access to the entire continuum of behavioral health care services for all residents of the state.

- **Enhance the availability of Emergency Services Programs and similar programs.** Emergency Services Programs (ESPs), behavioral health urgent care, crisis intervention services, and similar programs are critical components of the continuum in that they provide an opportunity to stabilize individuals in behavioral health crisis in the community without an emergency department visit or inpatient admission. To adequately meet the needs of individuals and their families, these programs should have the capability to work with people with mental health conditions, SUDs, and co-occurring disorders.

However, according to stakeholders, the programs are underfunded, struggle to hire qualified staff, and are not widely available to individuals with commercial coverage. The ESP model, which calls for rapid response during crisis events, functions most effectively when programs have sufficient capacity to respond to all crisis events, even during times of high demand.³⁴ Due to the fluctuating nature of demand for crisis services, this would require programs to operate below capacity for much of the time. Low reimbursement rates and a lack of coverage by many commercial plans place considerable financial pressure on existing programs to operate at or near capacity at all times. The state should consider rate increases or alternative payment methods to ensure that ESPs, behavioral health urgent care, and similar programs are adequately financed such that they are able to respond to all behavioral health crisis events in a timely fashion. Alternative payment methods, such as bundled payments that cover hospital (inpatient or emergency department) and ESP services, can help promote program sustainability while also promoting seamless and timely transitions of care across these settings, when individuals are particularly susceptible to getting disconnected from treatment.

- **Expand medication-assisted treatment access.** As Massachusetts continues to struggle with the opioid epidemic, stakeholders report persistent barriers for individuals attempting to access evidence-based treatment, particularly medication-assisted treatment (MAT). A robust literature provides an evidence base for MAT as highly effective in treating individuals suffering from SUD,³⁵ and policymakers and experts across the country have called for broadening its availability.³⁶ Massachusetts lawmakers have already taken some steps to broaden access to MAT. Chapter 208 of the Acts of 2018, signed by Governor Baker in August 2018,

Medication-assisted treatment

is defined by SAMHSA as the use of medications in combination with counseling and behavioral therapies, to provide a “whole-person” approach to the treatment of SUDs.

For more information, visit www.samhsa.gov/medication-assisted-treatment.

contained a number of MAT-focused provisions, including broadening MAT access for incarcerated individuals, requiring emergency departments and Section 35 facilities* to offer MAT, requiring that the Division of Insurance (DOI) and MassHealth issue guidance to providers on MAT reimbursement, and establishing a special commission to study and make recommendations regarding the use of MAT in the Commonwealth. While still recognizing that not all individuals with SUD seek MAT services, Massachusetts should consider building on these requirements to further enhance access to MAT for all residents, including by:

- Creating incentives for more physicians, nurse practitioners, and physician assistants to seek buprenorphine waivers, which permit qualified practitioners to dispense or prescribe buprenorphine (one of several MAT modalities) in settings other than opioid treatment programs (OTPs).³⁷
- Ensuring commercial payers are providing robust access to MAT through network adequacy requirements, through benefit alignment with MassHealth, and by eliminating unnecessary barriers to treatment (including cost sharing and prior authorization requirements).
- Conducting a public health campaign advertising the benefits of MAT with the goal of reducing stigma.
- Considering mechanisms, such as Pennsylvania’s “hub-and-spoke” model, to link less experienced prescribers with SUD treatment experts who can provide guidance on administering MAT.

EXAMPLES FROM THE FIELD:

Pennsylvania’s Hub-and-Spoke Model

In 2015, Pennsylvania established 45 Centers of Excellence (COEs) designed to better support frontline providers in delivering integrated behavioral and primary care services, including MAT, to individuals with SUDs. The COEs, funded through combined state behavioral health and Medicaid dollars, rely on a “hub-and-spoke” model. Each COE contains a hub, which houses a care team responsible for delivering MAT, care coordination, peer supports, and other services. In this model, the hub, which uses a care team of health care providers, certified recovery peer specialists, and navigators, also provides support to PCPs and other community-based providers who treat people with SUD (the spokes). The model seeks to encourage physicians with less direct experience treating SUD to offer MAT by providing them with expert support through the hub. Preliminary results of the model are promising. In 2017, the COEs engaged 71 percent of the individuals they saw in treatment, retaining 62 percent of these individuals in treatment for 30 days, compared with 48 percent and 33 percent, respectively, prior to implementation of the program.

For more information, visit www.manatt.com/getattachment/c2238cf1-368f-4fc7-878c-00c2cccf4c92/attachment.aspx.

- **Improve commercial behavioral health care insurance coverage.** As noted earlier, there is wide variation in behavioral health benefit packages across payers and age groups. For both children and adults, MassHealth currently provides a more robust behavioral health care benefit than most commercial payers, including outpatient, emergency, 24-hour/non-24-hour diversionary, and care management services. Although the state is currently working to align children’s benefits in commercial coverage with those available through CBHI, there is no such effort in place for adults.³⁸ The state should consider additional mechanisms, including enhanced behavioral health parity monitoring and enforcement and incentives, to standardize the behavioral health benefit package across all commercial and public payers and ensure that both children and adults have access to the same robust set of behavioral health benefits regardless of their insurance coverage.

* Section 35 is a Massachusetts law that allows a person to request a court order requiring someone to be civilly committed and treated involuntarily for an alcohol or substance use disorder. A “Section 35 facility” refers to a facility designated by the Department of Public Health (DPH) as licensed and approved to treat people committed under Section 35.

- Expand payer networks to include nontraditional behavioral health providers.** As prior behavioral health reports have recommended, the Commonwealth should consider requiring insurers to expand their provider networks to include nontraditional behavioral health providers, such as community health workers, certified recovery coaches/peer specialists, who can uniquely facilitate access to treatment for people with behavioral health needs.³⁹ These paraprofessionals are trusted resources for individuals with behavioral health needs—often coming from the same neighborhoods, cultures, and backgrounds as the individuals with whom they work. They connect individuals to care in a timely fashion, sustaining their engagement with treatment providers and adherence to care plans, and playing a large role in preventing relapse or recidivism. These workers are well established in Massachusetts’ health care system, with the state creating a Certified Peer Specialist training program in 2006, a Board of Certification for community health workers in 2010, and a Certified Addictions Recovery Coach (CARC) program in 2017.
- Revamp behavioral health care timely access standards.** The state should consider mechanisms to revamp and more stringently enforce timely behavioral health care access standards. While providers and payers generally perceive that they are complying with standards of timely access to care, consumers continue to report long wait times for a variety of outpatient treatment providers, including psychiatrists, child and adolescent providers, and providers who participate in MassHealth.⁴⁰ The state should consider conducting a comprehensive analysis, using the results of the behavioral health care capacity surveys and needs assessment described as part of priority number five, to determine the extent to which timely access standards are being met and how these vary across treatment settings, populations, and insurance types. As part of the BHRT’s regulatory streamlining work, the state should consider options for revamping timely access standards, including potentially aligning standards across all payers with MBHP guidelines.⁴¹

Massachusetts Behavioral Health Partnership (MBHP) providers are required to provide access to appropriate treatment services on a timely basis or provide a referral to another MBHP provider. For most services, care must be provided within 14 calendar days. Urgent care services must be provided within 24 hours. ESP services must be provided immediately on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present, including covered individuals, uninsured individuals, and persons covered by Medicare only. Emergency services shall be provided immediately (respond to call with a live voice; face-to-face within 60 minutes) on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present at any qualified provider, whether a network provider or a non-network provider.

For more information, visit www.masspartnership.com/pdf/BHPPProviderManual.pdf.



Invest in Workforce Development and Capacity to Attract and Retain Behavioral Health Care Professionals

The state’s licensure and health plan credentialing requirements and processes are burdensome, time consuming, and slow to completion. A staggering number of behavioral health care providers elect to forgo participation in health insurance.⁴² For example, one national study found that just 55 percent of office-based psychiatrists accepted health insurance, and a 2017 focus group of Massachusetts behavioral health care providers validated that providers are choosing to forgo participation in health insurance because of admin-

istrative burdens and the perceived low reimbursement, among other issues.⁴³ In addition to licensure and credentialing burdens, behavioral health care providers face challenges not unlike those faced by consumers attempting to navigate the Commonwealth's complex array of services, benefits, and care settings across the continuum of physical health, mental health, and SUD care. Providers who care for the most vulnerable individuals with behavioral health needs often experience vicarious trauma and often lack the support services they themselves need.

The state should consider an array of initiatives to address these and other workforce barriers to make Massachusetts an ideal place for behavioral health care providers to practice, and to create a behavioral health care workforce that is culturally and linguistically competent and responsive to Massachusetts individuals' and families' needs. The following recommendations are designed to revitalize and support behavioral health practice in Massachusetts to attract and retain providers and encourage broader insurance participation.

- **Review, streamline, and centralize credentialing.** Stakeholders consistently cite the burden of credentialing across numerous health plans as a key reason why some providers (particularly those in higher-paying specialties facing acute workforce shortages, such as psychiatry) do not participate in insurance networks, exacerbating access challenges for individuals who are not able to self-pay. While all medical practitioners in the state must be licensed, or operate under the supervision of a licensed professional, health plans often require providers to separately verify their credentials before they can participate in the plan's provider network. While most state-based health insurance plans in Massachusetts utilize a centralized and uniform credentialing process provided by HealthCare Administrative Solutions, not all carriers licensed to provide insurance in the state use this platform. This may mean verification

EXAMPLES FROM THE FIELD: Centralized Credentialing

Several states have begun to implement centralized provider credentialing processes in order to reduce administrative burden and encourage provider insurance participation. The following examples have been implemented in Medicaid managed care but are models that may be scaled across all payers.

Texas. In 2015, Texas lawmakers passed legislation requiring the State Health and Human Services Commission to establish a centralized web-based tool for streamlining the Medicaid provider enrollment and managed care credentialing processes. Through a process led by the Texas Association of Health Plans, the state researched best-practice models and ultimately executed a contract with a third-party vendor to serve as a common credentialing verification organization (CVO). Effective April 1, 2018, the contracted CVO manages operations of the common credentialing platform, including receiving applications and attestations and verifying primary source documents. All Texas Medicaid managed care organizations (MCOs) are required to utilize the CVO as part of credentialing and re-credentialing, but may require providers to furnish them with additional information.

North Carolina. North Carolina is transitioning its predominantly fee-for-service Medicaid program to a managed care structure, which will launch for most enrollees in late 2019. As part of this transition, the state is establishing a centralized credentialing process, including a standardized provider enrollment application and qualification verification process. To implement this process, the state will procure through a competitive bid a third-party CVO, which will establish a single electronic application for enrolling in Medicaid fee-for-service and managed care. Medicaid MCOs in the state will be required to accept verified information from the CVO and will not be permitted to require any additional credentialing information from providers.

For more information, visit <https://hhs.texas.gov/sites/default/files/documents/about-hhs/communications-events/meetings-events/mmc/6-provider-presentation-march-14-2018.pdf> and https://files.nc.gov/ncdhhs/documents/Credentialing_ConceptPaper_FINAL_20180320.pdf.

requirements and time frames differ across health plans, leading to considerable administrative burden for providers participating across multiple commercial plans and MassHealth.⁴⁴ To address this problem, the Commonwealth should review the existing credentialing process and consider expanding the use of this or a similar platform so there is a centralized, mandatory all-payer credentialing platform for behavioral health care providers.

- **Invest in workforce development, training, and support services.** Massachusetts should consider investing in an array of new workforce development and training programs to attract and keep behavioral health professionals practicing in the Commonwealth, such as loan forgiveness and professional development programs for individuals considering entering behavioral health specialties. The state has started to invest in behavioral health workforce initiatives as part of its MassHealth DSRIP program, but these efforts should be expanded across payers. The state could target certain programs, such as loan forgiveness, in ways that enhance linguistic and cultural diversity in the Commonwealth. For example, the state could develop targeted loan forgiveness programs to Spanish-speaking providers or LGBTQ providers to promote a more diverse workforce that may be able to better meet the linguistic and cultural needs of Massachusetts individuals and families seeking services. The state also could develop new training, education, and support services for behavioral health care providers and workers, including funding for:
 - Screening and assessment (including SBIRT) training for PCPs and frontline emergency department staff.
 - Workplace safety- and self-care-related support services for behavioral health care providers experiencing vicarious trauma.
- **Implement targeted payment improvement strategies.** According to many stakeholders, the single biggest barrier to timely access to behavioral health care in Massachusetts is inadequate provider reimbursement, by both MassHealth and commercial payers. This takes the form of low reimbursement rates for particular services and providers, and lack of payer coverage for critical treatment modalities. The Commonwealth should consider implementing targeted rate increases for select services, informed by an analysis of current reimbursement rates relative

Approximately 6 percent of DSRIP funding (\$115 million over five years) is dedicated to supporting health care delivery system capacity building. Key behavioral health workforce investments include:

- **Student Loan Repayment.** Eligible providers include LICSWs, LCSWs, LMHCs, LMFTs, and LADC1s* who agree to serve for four years in a community health center (CHC) or community mental health center (CMHC).
- **Behavioral Health Special Projects Program.** This provides one-year \$40,000 grants to support projects related to accountable care for CHCs, CMHCs, ESPs, Behavioral Health Community Partners (CPs), and other providers to enhance behavioral health care provider retention rates.
- **Behavioral Health Recruitment Fund.** MassHealth will make available “recruitment packages” that include loan repayment and funding for special projects for CHCs and CMHCs to increase the number of psychiatrists and nurse practitioners with prescribing privileges.
- **Peer Specialist Training Capacity Expansion Grants.** MassHealth will offer one-year grants to approved peer specialist training programs.
- **Recovery Coach Supervisor Training Incentive Fund.** MassHealth will fund salary replacement and training fees to enable recovery coach supervisors to complete the Recovery Coach Supervisor Training.

For more information, visit www.mass.gov/files/documents/2018/02/28/DSRIP%20Statewide%20Investments%20Overview%20Feb%202018.pdf.

* LICSW = Licensed Independent Clinical Social Worker;
LCSW = Licensed Clinical Social Worker;
LMHC = Licensed Mental Health Counselor;
LMFT = Licensed Marriage and Family Therapist; and
LADC1 = Licensed Alcohol and Drug Counselor I.

to service costs. Stakeholders have identified several services that are most in need of rate increases, including outpatient psychiatry/psychotherapy, ESP/mobile crisis intervention, and specialized services for children with autism and I/DD. Tying a rate strategy to a detailed rate analysis and to the results of the capacity survey and statewide needs assessment described below would ensure effective and efficient use of health care dollars by prioritizing the providers most in need and services most in demand. The state also should consider developing risk-adjusted behavioral health provider reimbursement rates that factor in behavioral health acuity levels or diagnoses, for example, to recognize and reimburse providers appropriately for serving high-need or complex populations.

The above recommendations are designed to support behavioral health care professionals and encourage broader insurance participation in the Commonwealth. To the extent these initiatives fall short of incentivizing enhanced insurance participation by behavioral health professionals, the state should consider requiring insurance participation, including in MassHealth, as a condition of behavioral health licensure in Massachusetts.



4

Develop a Plan for Better Aligning and Consolidating Behavioral Health Care Administrative, Regulatory, and Purchasing Functions Across State Agencies

Multiple state agencies—including DMH, DPH, MassHealth, and DOI—currently oversee, regulate, and fund mental health and SUD providers and services. As a result, it is often difficult to identify a true comprehensive system of behavioral health care and services are often unnecessarily hard for consumers to access and for providers to deliver. Segregation of public mental health and SUD service administration leads to challenges in strategy alignment, policy priorities, contracting practices, and provider regulations. While significant cross-agency collaboration exists today, relying on voluntary collaboration and coordination across disparate agencies—even if a strong and stable meeting structure is in place—is dependent on personalities and relation-

EXAMPLES FROM THE FIELD:

Connecticut Behavioral Health Administrative Consolidation

Many states divide responsibility for mental health and SUD oversight, regulation, and purchasing across different state agencies. Recognizing that this can serve as a barrier to the effective delivery of integrated, coordinated behavioral health care, many states are starting to consolidate some or all of these functions in a single agency. Connecticut has been a trailblazer on this front. In 1995, the state began the process of consolidating administration of its mental health and SUD delivery systems by establishing a new Department of Mental Health and Addiction Services (DMHAS) as a successor to the Department of Mental Health and the addiction services component of the former Department of Public Health and Addiction Services. This agency now administers state-funded mental health and SUD programs and provides oversight of all behavioral health providers and facilities. The state has also historically utilized a decentralized network of organizations to evaluate the delivery of DMHAS-funded services, ensure effective service planning, and advocate on behalf of beneficiaries. Beginning in 2018, the state reorganized these organizations, known previously as Regional Mental Health Boards (RMHBs) for mental health and Regional Action Councils (RACs) for SUD, into five Regional Behavioral Health Action Organizations. These new organizations will continue to perform the statutory functions of the RMHBs and RACs while working across the entire behavioral health care continuum.

For more information, visit www.ct.gov/dmhas/cwp/view.asp?a=2899&q=334082 and www.ct.gov/dmhas/cwp/view.asp?q=601578.

ships, which change over time and with new administrations. The following recommendations are intended to address these challenges and formalize a more integrated system and structure to effectively meet the needs of individuals with mental health conditions, SUDs, and co-occurring disorders. That system could then more effectively collaborate on integration with physical health care services.

- **Launch an immediate stakeholder engagement process (led by the Executive Office of Health and Human Services [EOHHS]) including consumers, providers, advocates, and other stakeholders to identify specific options for integrating and consolidating behavioral health administrative, regulatory, and purchasing functions that are currently distributed across DMH and BSAS within DPH, including the option of combining BSAS and DMH. This effort should also include an intentional strategy to better align these functions with the MassHealth program.** In identifying options for streamlining and consolidating, it is imperative that any structural changes proposed ensure continued and enhanced access to services currently provided by these respective agencies and that any change preserves what is necessary for these agencies to continue and enhance their ability to fulfill their missions to the populations (including those with co-occurring mental health and SUD needs) and stakeholders they serve. While recognizing some of the differences (in terms of agency sizes, populations that may be served, cultures, etc.), in assessing approaches for consolidation, a key consideration should be to enable the organizations to more effectively provide integrated services to consumers and to enhance alignment across payers for providers, ultimately improving access to behavioral health care services for individuals and families.
- **Streamline state regulations and requirements.** Myriad and complex Massachusetts licensing and practice regulations, promulgated by multiple state agencies (including MassHealth, DPH, and DMH), regulate staffing, facilities, scope of practice, and clinical services across primary care, outpatient mental health and outpatient substance use providers, and federally qualified health centers. These regulations are duplicative and at times in conflict, and have long been identified by providers and other stakeholders as creating barriers to integration of physical and behavioral health and moving toward a whole-person-responsive health care system. Key challenges include: Separate primary care and mental health licensure and regulations for primary care settings seeking to co-locate a mental health provider; burdensome facility-related requirements for providers seeking to integrate, including separate waiting rooms for primary care and behavioral health services; promulgation of discrete staffing regulations for primary care, mental health, and SUD treatment settings; and high-threshold treatment plan⁴⁵ requirements and documentation for SUD treatment providers.

EXAMPLES FROM THE FIELD:
New York Integrated Licensure Project

In 2015, New York state revamped the licensure processes for certain outpatient mental health, substance use, and primary care providers in order to reduce administrative burden and encourage further integration of primary care and behavioral health service delivery for individuals with co-occurring disorders. Prior to this initiative, providers who delivered services overseen by multiple state agencies—including the State Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and the Department of Health—were often required to obtain multiple licenses for each service location. Beginning in 2011, the state embarked on a cross-agency collaboration to align on clinical standards, staffing requirements, and license application and review processes for outpatient providers under the jurisdiction of each of these agencies. The collaboration ultimately resulted in the establishment of a new licensure category titled “Integrated Outpatient Services.” This new category permits providers to deliver a range of integrated behavioral and physical health services under a single license.

For more information, visit https://omh.ny.gov/omhweb/clinic_restructuring/integrated-services.html.

In order to address these problems and ensure that the state is providing incentives for delivering integrated whole-person behavioral health care, the state should consider conducting a comprehensive review of Massachusetts licensing and practice regulations that impact primary care and behavioral health care providers, culminating in a proposal and implementation plan for regulatory reforms that support the new vision for Massachusetts' behavioral health care system. As part of its review, the state should conduct a thorough analysis of state licensure requirements and develop proposals for streamlining them in order to reduce provider burden.

ADMINISTERING BEHAVIORAL HEALTH CARE DELIVERY IN MASSACHUSETTS

MassHealth, the Massachusetts Medicaid program, is the primary payer for health care services, including mental health and SUD treatment, for low-income residents of the Commonwealth. MassHealth is also responsible for ensuring that providers are in compliance with federal Medicaid rules and exercises significant contractual authority over Medicaid managed care organizations and Medicaid accountable care organizations to advance the state's policy priorities.

The Department of Mental Health (DMH) is the single state mental health agency (SMHA) and serves several key functions in the delivery of behavioral health care in the Commonwealth. It serves as a complement to MassHealth by serving as the payer of last resort for mental health services for adults, adolescents, and children with serious mental illness or serious emotional disturbance who are uninsured or for whom services are not covered by insurance. DMH funds a variety of programs including Adult Community Clinical Services (ACCS), which recently replaced the Community-Based Flexible Supports (CBFS) program and serves as the primary state-funded program for adults served by DMH who live in or are transitioning to the community. DMH also regulates providers, treatment facilities, and other elements of the delivery system by establishing and monitoring operational and program standards for community mental health services, licensing all acute private and general hospitals with psychiatric units and certain residential facilities, establishing patient safety standards, and monitoring and supporting mental health training and research in the state. Finally, it operates several mental health care facilities, including four continuing care facilities and five community mental health centers.

The Department of Public Health (DPH) operates a variety of programs to prevent disease and promote wellness in the Commonwealth, and it regulates, licenses, and provides oversight of a wide range of behavioral health professions and services. It houses the **Bureau of Substance Addiction Services (BSAS)**, the single state agency for SUD services, which is responsible for overseeing and providing SUD prevention and treatment services. BSAS is the payer of last resort for individuals who are uninsured or for whom certain behavioral health care services are not covered by insurance. DPH is also responsible for monitoring and licensure of various SUD treatment providers and facilities through the Bureau of Health Professions Licensure and the Division of Health Care Facility Licensure and Certification. DPH also houses the Bureau of Hospitals, which provides acute and chronic hospital medical care to individuals for whom community facilities are not available or where access to health care is restricted. The bureau currently operates four facilities and the State Office of Pharmacy Services.

The **Executive Office of Housing and Economic Development (EOHED)** and its **Office of Consumer Affairs and Business Regulation (OCABR)** also play a role in regulating the behavioral health care system. The Division of Professional Licensure within OCABR regulates individuals and businesses in 167 trades and professions, including psychologists, allied mental health professionals, and social workers. The Division of Insurance within OCABR is responsible for regulating and licensing health insurers and risk-bearing provider organizations.



Establish a Behavioral Health Reform Team to Tackle Broader System Transformation

The Commonwealth should consider creating and appropriating funding for a Behavioral Health Reform Team (BHRT) modeled on New York State's Medicaid Redesign Team, which guided the development, implementation, and oversight of a multiyear Medicaid reform plan. The BHRT would be a responsible, accountable, and transparent body in charge of developing and implementing a three-year action plan to transform behavioral health care in Massachusetts. The BHRT would have 18 months to develop the action plan, and craft a related comprehensive behavioral health care delivery reform bill, akin to Chapter 58 for health care coverage reform or Chapter 224 for health care cost containment. Upon passage of a comprehensive package of behavioral health care reforms, the Massachusetts' BHRT would play a key role in planning for and overseeing implementation of the three-year action plan. The BHRT would tackle issues related to: creating a process to assess and monitor behavioral health care capacity; developing Health Information Exchange (HIE)/data-sharing innovations; launching a behavioral health care innovation and outcomes center that will focus, in part, on developing a comprehensive behavioral health payment reform strategy; and improving access to safe, affordable and stable housing and related supports for high-need behavioral health populations.

The BHRT would be a joint public-private structure and process to develop and implement a three-year action plan that advances bold solutions to the particularly complex challenges highlighted above. It would include a manageable number (for example, up to 20) of representatives from across state government—including MassHealth, DMH, DPH, DOI, the Division of Professional Licensure (within the Office of Consumer Affairs and Business Regulation), the Department of Housing and Community Development, and the state legislature—and stakeholders representing all sectors of the health care delivery system. Private-sector representation would include consumers and families, consumer advocates,

EXAMPLES FROM THE FIELD:

New York State Medicaid Redesign Team

The New York State Medicaid Redesign Team (MRT) was established by Governor Andrew Cuomo in January 2011 to develop a roadmap for Medicaid reform. Along with MRT staff, an initial group of 27 stakeholders from around the state, representing hospitals, payers, policy experts, and consumer advocates, aligned on a series of 78 recommendations aimed at reducing Medicaid spending during SFY 2011–2012, including establishing a global Medicaid spending cap. These initial reforms ultimately resulted in \$2.2 billion in savings to the state during SFY 2011–2012. During the first phase of work, the MRT also established a number of work groups to develop recommendations across a wide range of program areas, including finance and rate setting, long-term care, eligibility and enrollment, pharmacy, supportive housing, care management, and behavioral health.

The work groups developed a comprehensive plan to transform New York's Medicaid program through a new Section 1115 waiver demonstration. The waiver, approved in 2014, authorized the state's Delivery System Reform Incentive Payment (DSRIP) program, which allows the state to make incentive payments to provider-led organizations that meet certain delivery system transformation and health care quality milestones.

While the stakeholder work groups have largely disbanded, MRT staff continue to implement a wide range of recommendations that the work groups proposed. To date, the MRT has acted on over 400 policy recommendations, nearly 300 of which have been implemented.

For more information, visit www.health.ny.gov/health_care/medicaid/redesign/.

community-based organizations, behavioral health and physical health providers, commercial health plans, employer groups, and consumer groups. The BHRT would have an executive director (for example, the Secretary of EOHHS or her designee) and be staffed and have funds budgeted. Specific multi-stakeholder work groups would drill down into the most complex issues which are discussed in further detail below. The work groups would be tasked with developing innovative solutions in these areas, ultimately developing recommendations that would feed into the three-year action plan.

The BHRT's initial charge would be to develop and drive implementation of the three-year action plan, which would include longer-term administrative recommendations that could be implemented without additional legislative authority and also a series of initiatives that would be packaged in comprehensive behavioral health care reform legislation that provides authority and funding for bold action but are beyond the specific recommendations included as part of priorities one through four in this report. The BHRT would then turn to implementing administrative initiatives and overseeing implementation of the statutory initiatives once the reform bill is enacted. Below are major issues and initiatives that the BHRT would need to tackle in the three-year action plan. These recommendations are not exhaustive but represent the highest-priority areas identified in discussions with state and national experts through interviews and discussions groups conducted for this report.

- **Create a process to assess and monitor behavioral health care capacity.** Behavioral health stakeholders in Massachusetts have devoted considerable time and resources to developing a better understanding of how consumers access and providers deliver behavioral health care. Despite these efforts, critical gaps in the information available to key decision-makers remain, particularly around behavioral health treatment capacity across settings and how such capacity compares with demand. This challenge is most acute for outpatient treatment settings, for which there are currently no agreed-upon, reliable measures of treatment capacity.⁴⁶ These information limitations impede consumers from knowing where to access services and hinder the ability of policymakers and other key stakeholders to understand where gaps in the behavioral health care system exist and the strategic, targeted investments needed to fix them. To start to close these data gaps, the state should consider the following policy options:
 - **Capacity surveys.** The state should work to develop a comprehensive understanding of behavioral health care service capacity across the continuum. Massachusetts could accomplish this by conducting regular surveys of treatment capacity across settings and localities to identify the number of available beds in inpatient and residential settings, the number of open slots in intermediate care programs, and outpatient providers who are accepting new patients.
 - **Statewide needs assessment.** Ideally, the capacity surveys would be informed by a statewide needs assessment that would provide a more nuanced understanding of the population that needs behavioral health services and inform key decisions around the appropriate mix of behavioral health benefits, services, and providers. Behavioral health needs assessments typically estimate prevalence of different behavioral health conditions and service utilization across a number of factors, including region or locality, income, insurance status, and age group. Such an analysis can be conducted from public data sets, but the state should consider supplementing this with its own data. The state could designate one of its agencies (for example, DOI or the Center for Health Information Analysis [CHIA]) to conduct this analysis, or could task the BHRT with issuing a request for proposals to procure a vendor to conduct such an analysis.

- **Develop Health Information Exchange/data-sharing innovations.** A combination of federal and state privacy laws and technological obstacles to electronic data exchange among providers and care managers create challenges related to behavioral health care access and quality in Massachusetts. Like most of the gaps identified in this report, the problems with behavioral health data sharing are well documented⁴⁷ and include:

- **Privacy issues.** An array of federal privacy statute and regulations (HIPAA, 42 CFR Part 2) and state law requirements limit providers’ ability to share information regarding individuals’ behavioral health conditions and treatment.⁴⁸ Additionally, providers tend to conservatively and sometimes incorrectly interpret these laws, including with regard to consent, which further impedes information sharing among physical health, mental health, and SUD providers.

- **Technology issues.** Many behavioral health care providers and key community organizations responsible for care coordination and management (like the Behavioral Health Community Partners in MassHealth’s Accountable Care Organization initiative) lack electronic health records (EHR), and insufficient interoperability among provider and care manager EHR systems also inhibits data sharing. Those providers that do have EHRs are not broadly adopting information exchange through the Massachusetts Health Information Hwyay, Massachusetts’ health information exchange.⁴⁹

Potential solutions to these problems are also well documented and provide a solid foundation on which a BHRT HIE/Data-Sharing Innovation work group can build to craft and implement a comprehensive plan that will facilitate behavioral health care data sharing while preserving critical consumer privacy protections. This plan will necessarily include clarification of or amendment to state law to improve information exchange, initiatives that can be implemented within the state’s current regulatory framework, and initiatives and funding that foster EHR adoption and interoperability and Mass HIWay adoption among behavioral health providers across the care continuum. The HIE/Data-Sharing work group should include participants who can inform and drive implementation of specific solutions to both the privacy and technology barriers, and leverage the Commonwealth’s rich private-sector information technology hub by engaging those experts in the work group.

- **Launch a Behavioral Health Center for Quality Outcomes Innovation.** As part of the three-year action plan, the Commonwealth should consider launching a Behavioral Health Center for Quality Outcomes Innovation (CQOI)

**EXAMPLES FROM THE FIELD:
New York Health and Recovery Plans
Value-Based Payment Pilots**

New York has been a national leader in advancing value-based payment (VBP) models, including those focusing on behavioral health. As part of its “VBP Roadmap,” the state established a VBP Innovator program, which provides opportunities for provider organizations to test out new value-based arrangements that include accountability for total cost of care and quality. Beginning in 2017, two pilot organizations entered into value-based contracts with Health and Recovery Plans (HARPs), which are specialized managed care products that launched in 2015 for adults with serious mental illness or SUD. The pilots are responsible for total cost of care and quality performance across their attributed HARP members. The pilot quality measures cover a variety of clinical domains, including a number focused on behavioral health, and can be either pay-for-reporting or pay-for-performance. New York has also included a number of behavioral health–focused measures that are clinically relevant but have not yet been sufficiently tested for validity and reliability. Pilots are required to report these measures so that the state can evaluate whether to expand their use in the future, but performance on these measures will not impact incentive payments.

For more information, visit www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2018/2018-03-08_vbp_pilot.htm.

specifically focused on developing and testing initiatives to improve behavioral health care quality and outcomes, treatment for co-occurring mental health and SUD conditions, physical and behavioral health care integration, and a comprehensive behavioral health payment reform strategy that supports whole-person care. The CQOI could be modeled on the federal Center for Medicare and Medicaid Innovation established through the ACA and could focus on developing new payment models across payers and services, rapidly evaluating and adjusting those models, and socializing successful models broadly across all payers in the Commonwealth. The CQOI would also be the locus for developing a uniform set of behavioral health care quality and outcomes metrics, including integration of physical and behavioral health outcomes, and measures for special populations, such as individuals with autism and I/DD. The CQOI would be responsible for testing and evaluating both models and metrics, and could be given the authority to scale both, mandatorily, to all payers statewide.

- ***Improve access to safe, affordable, and stable housing for high-need populations.*** According to stakeholders, the lack of access to stable, affordable housing, including housing options that have embedded supportive services (flexible wraparound services such as recovery and employment support services) is a significant barrier to treatment and recovery for Massachusetts residents with serious mental illness, addiction, and co-morbid physical and behavioral health conditions. Stakeholders emphasize the importance of providing a range of appropriate housing for individuals with behavioral health conditions, including specialized arrangements for individuals with SUD, and transitional and supportive housing for individuals leaving acute settings of care, in addition to generally increasing the stock of housing available to low-income individuals throughout the Commonwealth.⁵⁰

The BHRT should establish a Housing Innovations work group to develop and implement housing-related solutions. The membership of this work group should include representatives from core state and local agencies that have accountability for and fund housing-related initiatives in the Commonwealth, including the Department of Housing and Community Development, the Boston Housing Authority, and MassHealth, and also community-based organizations, such as Boston Health Care for the Homeless, that provide critical access to health care and housing and other supports to some of our most vulnerable residents. Collaboration, information sharing, and solution development among these entities are essential, including to identifying opportunities to “braid financing,” or combine funding from these groups, to support solutions. This work group would be charged with developing initiatives to promote safe, affordable, and stable housing and related services for high-need behavioral health populations, which could include:

- ***Expand social impact bond (SIB), or “pay for success,” initiatives to develop affordable housing options for people with significant behavioral health needs, including individuals with active substance use.*** SIB, or pay for success, initiatives are public-private partnerships in which investors fund solutions to a defined community need—in this case, affordable supportive housing—and are repaid with a return on their investment based on the success of the solution.⁵¹ The Commonwealth has a model and possible foundation on which to build this effort in the Home and Healthy for Good (HHG) program, a pay for success initiative that provides 500 units of stable supportive housing to 800 chronically homeless individuals. HHG was started in 2014, and a 2018 evaluation of the initiative indicates that it has exceeded targets and “placed over 656 high-need individuals into stable, supportive housing, with 92 percent remaining housed after one year. This measure results in a payment of dividends to investors.”⁵² The Commonwealth could replicate and build on this successful model to fund development of housing units specifically for individuals with behavioral health conditions.

CONCLUSION

Massachusetts has the opportunity to once again generate landmark policy that not only dramatically improves health care coverage, access, delivery, and outcomes in the Commonwealth but also provides a national model for behavioral health care delivery. State leaders and behavioral health stakeholders are committed to improving consumer experience, coverage, access, and outcomes for all adults and children in Massachusetts in need of behavioral health care services, regardless of insurance status.

This report provides a new whole-person-oriented vision for behavioral health care, an organizing framework, and short-term and long-term recommendations to achieve reform. This new vision for behavioral health care in Massachusetts addresses some of the most pressing challenges impacting how behavioral health care is delivered in the state today, including barriers to accessing and navigating the behavioral health care continuum, inadequate coverage of behavioral health care services across payers, workforce shortages and capacity issues, unnecessary regulatory burden and redundancy, fragmented administrative and payment functions, lack of monitoring and accountability for behavioral health outcomes, barriers to behavioral health information sharing, and lack of affordable housing options. The creation of the BHRT will provide a locus of responsibility, accountability, and transparency for addressing these systemic issues. The state's history of progressive health care reforms and current political will supporting bold solutions to its most pressing challenges provide a strong platform for ambitious, comprehensive reform of how providers deliver and individuals and their families experience behavioral health care in Massachusetts.

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