

# **THE MASSACHUSETTS BEHAVIORAL HEALTH CARE SYSTEM: STRENGTHS, GAPS, AND OPPORTUNITIES FOR IMPROVEMENT**

JANUARY 2019

# TABLE OF CONTENTS

<b>Introduction and Background</b>	<b>2</b>
Project Overview	3
Why Focus on Behavioral Health?	4
Facts and Figures on Behavioral Health Conditions in Massachusetts	5
<b>Key Elements of a Model Behavioral Health Care System (The “To Be”)</b>	<b>12</b>
<b>The “As Is” Behavioral Health Care System in Massachusetts</b>	<b>16</b>
Behavioral Health Care Continuum	17
Administration and Regulation	23
Coverage and Payment	27
Workforce	33
<b>Assessing the Massachusetts Behavioral Health Care System</b>	<b>40</b>
Strengths of the Behavioral Health Care System in Massachusetts	42
Weaknesses of the Behavioral Health Care System in Massachusetts	43
<b>Appendices</b>	<b>44</b>
A. Terms and Definitions	44
B. Behavioral Health Providers and Key Service Types	47
C. Federal and State Administrative and Regulatory Authorities	50

# INTRODUCTION AND BACKGROUND

## PROJECT OVERVIEW

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) 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 substance use disorder 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 ages and payers (the “to be”);
- Identified gaps between the “as is” and “to be” systems; and,
- 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.

**This chartpack represents the results of the landscape scan, along with high level observations with respect to a model behavioral health care system.** These findings have been used to inform a separate final [report](#) containing a detailed action plan for the Commonwealth to move from the current state toward the model system.

## WHY FOCUS ON BEHAVIORAL HEALTH?



**Behavioral health (BH) conditions continue to have adverse impacts on many individuals and communities in Massachusetts.**

- One in five adults age 18 or older reports living with a mental health (MH) disorder, including 4.2% who have a serious mental illness.
- Opioid-related overdose deaths have more than quadrupled since 2000.



**The BH system still falls short in providing the right care at the right time in the right setting.**

- Emergency department (ED) utilization has increased substantially for all BH conditions, increasing the burden on limited health care resources.
- Massachusetts struggles to provide adequate access to psychiatry services and other outpatient, community-based treatments.



**BH conditions are expensive to treat—both for the state and for individuals with BH conditions.**

- Patients with BH conditions—and particularly those with comorbid, chronic, physical health conditions—are significantly more expensive to treat.
- Patients with BH conditions are more likely to spend an extended length of time in expensive care settings, such as hospital EDs.



**Massachusetts has the political will to create a BH system that offers access and quality for all.**

- Massachusetts already ranks high on most measures of BH care system quality compared with other states.
- State funding for BH services increased by nearly 20% in state fiscal year (SFY) 2019.
- Massachusetts has developed a number of initiatives—such as MassHealth BH Community Partners (CPs) and the new Adult Community Clinical Services (ACCS) program—that may serve as building blocks for future reforms.
- Since 2007, the state has administered the Children's Behavioral Health Initiative (CBHI) which delivers an enhanced behavioral health benefit for children through MassHealth. The state remains committed to ensuring the services meet the needs of children and their families and are easy for families to find and access.

Sources: <http://www.chiamass.gov/assets/docs/r/pubs/16/Behavioral-Health-Readmissions-2016.pdf>; <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2110027>; <https://www.mass.gov/files/documents/2018/03/28/2017%20CTR%20Chartpack.pdf>; <https://www.samhsa.gov/disorders/substance-use>; [http://budget.digital.mass.gov/bb/gaa/fy2019/app\\_19/dpt\\_19/hhdmh.htm](http://budget.digital.mass.gov/bb/gaa/fy2019/app_19/dpt_19/hhdmh.htm); <https://www.mcpap.com/About/OverviewVisionHistory.aspx>; <https://www.mass.gov/files/documents/2018/02/28/DSRIP%20Statewide%20Investments%20Overview%20Feb%202018.pdf>.

## PREVALENCE OF BEHAVIORAL HEALTH CONDITIONS IN MASSACHUSETTS

Today, BH conditions impact more than 20% of Massachusetts residents and their families.

### Prevalence of BH Conditions

More than **one in five** adults in Massachusetts experienced mental illness in 2016–2017.



More than **one in ten** Massachusetts adults experienced a SUD over the same time period.

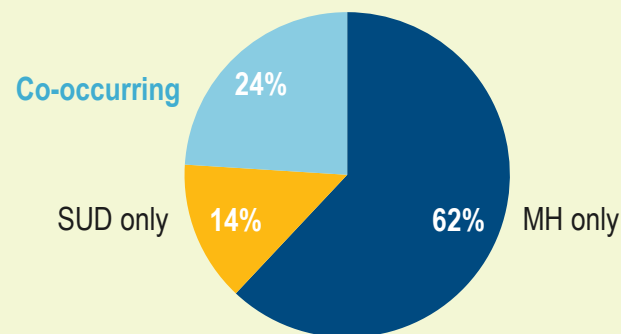


### Co-occurrence of MH Condition and SUD

**40%** of patients admitted to acute care hospitals in 2014 were diagnosed with a BH condition. Of those, **24%** have a co-occurring MH condition and SUD.



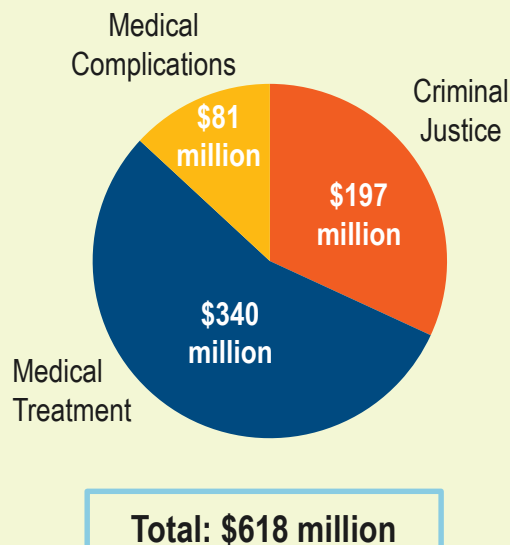
BH Diagnoses in Acute Care Hospitals, Massachusetts, 2014



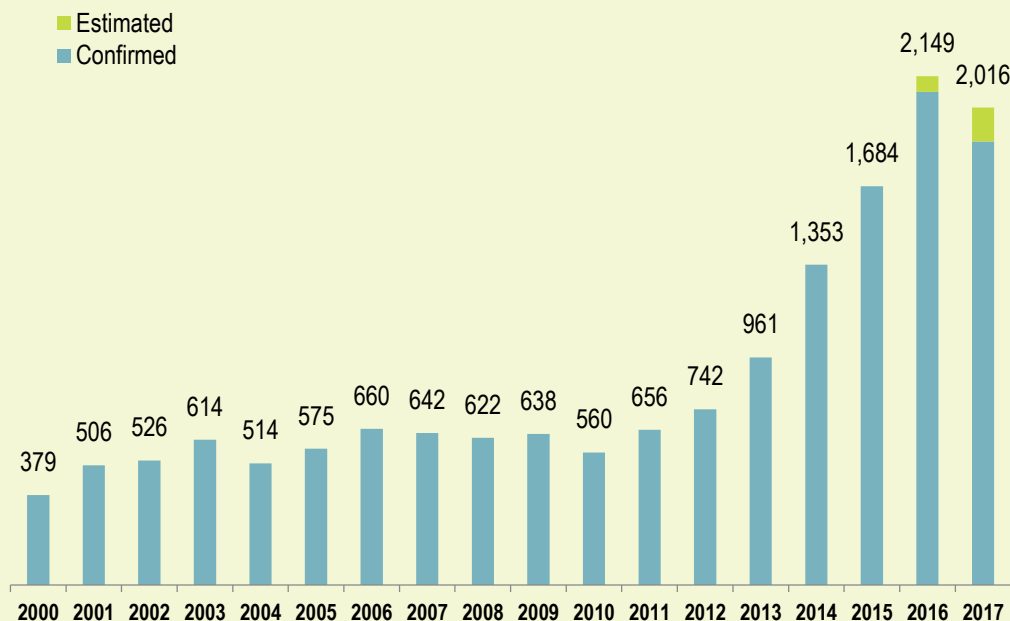
## THE OPIOID EPIDEMIC IN MASSACHUSETTS

The opioid epidemic has accelerated in recent years, presenting new prevention and treatment challenges and straining limited resources in Massachusetts.

**Estimated Spending Related to  
Opioid Abuse, Massachusetts, 2015**



**Opioid-Related Deaths, All Intentions,\*  
Massachusetts Residents, 2000–2017**



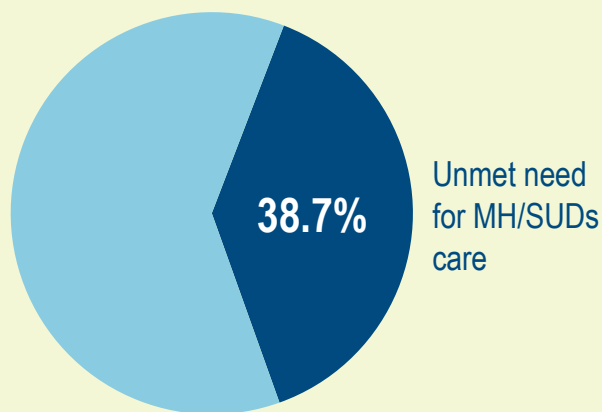
\* Includes unintentional, undetermined cause, and suicide.

Sources: <https://www.bostonfed.org/publications/new-england-public-policy-center-policy-report/2018/the-fiscal-impact-of-the-opioid-epidemic-in-the-new-england-states.aspx>;  
<https://www.mass.gov/files/documents/2018/05/22/Opioid-related%20Overdose%20Deaths%20among%20MA%20Residents%20-%20May%202018.pdf>.

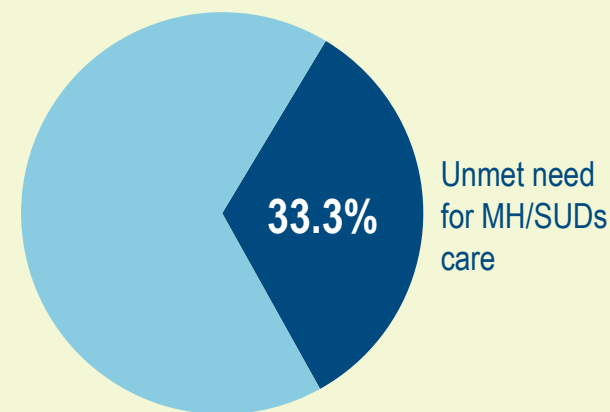
## UNMET BEHAVIORAL HEALTH TREATMENT NEED

More than one-third of non-elderly adults who sought BH care in 2018 reported unmet treatment need — this number did not meaningfully change even for those insured for the entire year.

**Any Unmet Need for MH/SUDs Care,  
Massachusetts Adults Ages 19 to 64  
who Sought MH/SUDs Care, 2018**



**Any Unmet Need for MH/SUDs Care,  
Full-Year Insured Massachusetts Adults  
Ages 19 to 64 who Sought MH/SUDs Care, 2018**



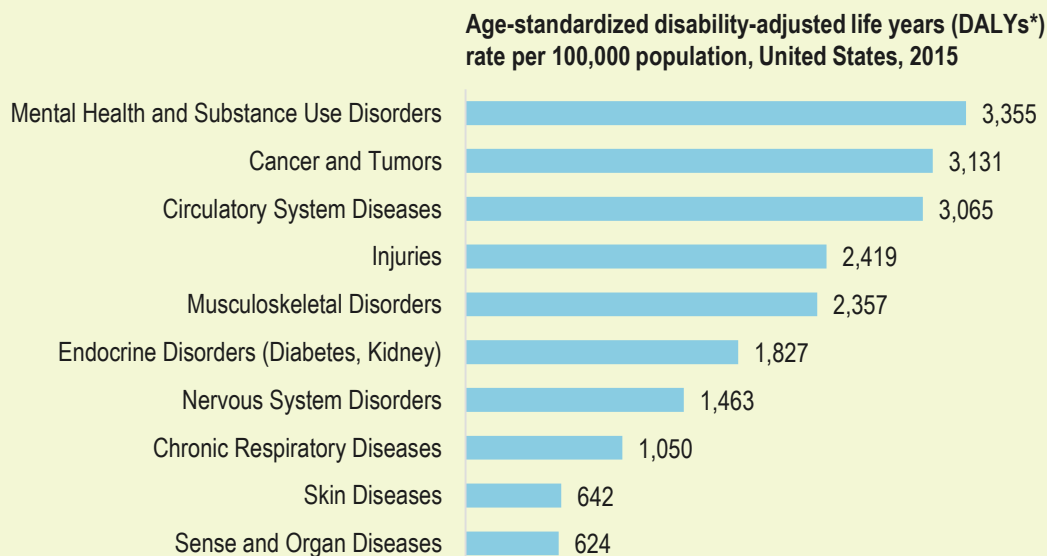


## THE HUMAN COST OF BEHAVIORAL HEALTH CONDITIONS

BH conditions carry considerable human cost for affected individuals and families, including a decline in health status and life expectancy.

### Disease Burden

Individuals with BH conditions lose more years to disability than those with any other condition.



### Mortality

**10  
years**

Median reduction  
in life expectancy  
for individuals with  
**mental illness**

**9–17  
years**

Average reduction  
in life expectancy  
for individuals with  
**SUDs**

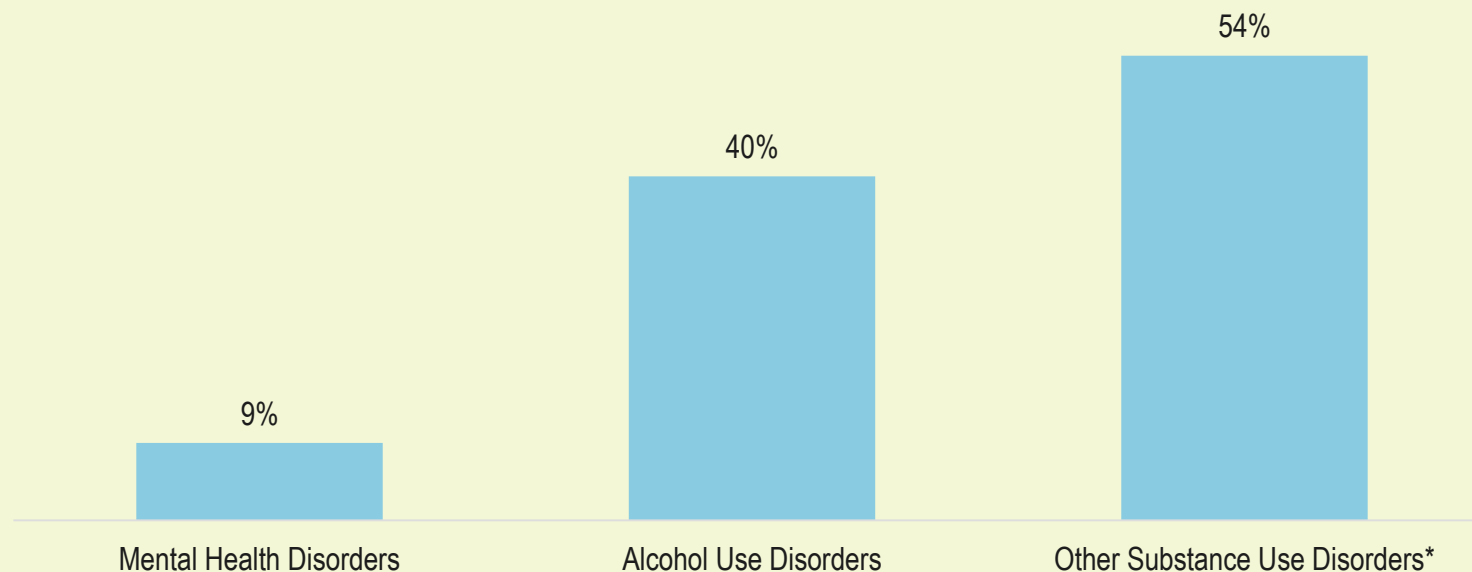
\* DALYs: number of years lost due to ill health, disability, or early death.

Sources: [https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/?\\_sf\\_s=mental#item-30-percent-adults-serious-mental-illness-not-receiving-mental-health-treatment](https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/?_sf_s=mental#item-30-percent-adults-serious-mental-illness-not-receiving-mental-health-treatment); <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2110027>; <https://www.samhsa.gov/data/sites/default/files/NSDUHsaeSpecificStates2016A/NSDUHsaeMassachusetts2016.pdf>; <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>; <https://www.ncbi.nlm.nih.gov/pubmed/21440382>.

## IMPACT OF FAILING TO PROVIDE THE RIGHT BEHAVIORAL HEALTH CARE AT THE RIGHT TIME IN THE RIGHT SETTING

Emergency department (ED) utilization in Massachusetts has increased substantially for all BH conditions since 2011, but particularly for SUDs.

Change in Number of Behavioral Health–Related ED Visits in Massachusetts by Diagnosis Category, 2011–2016



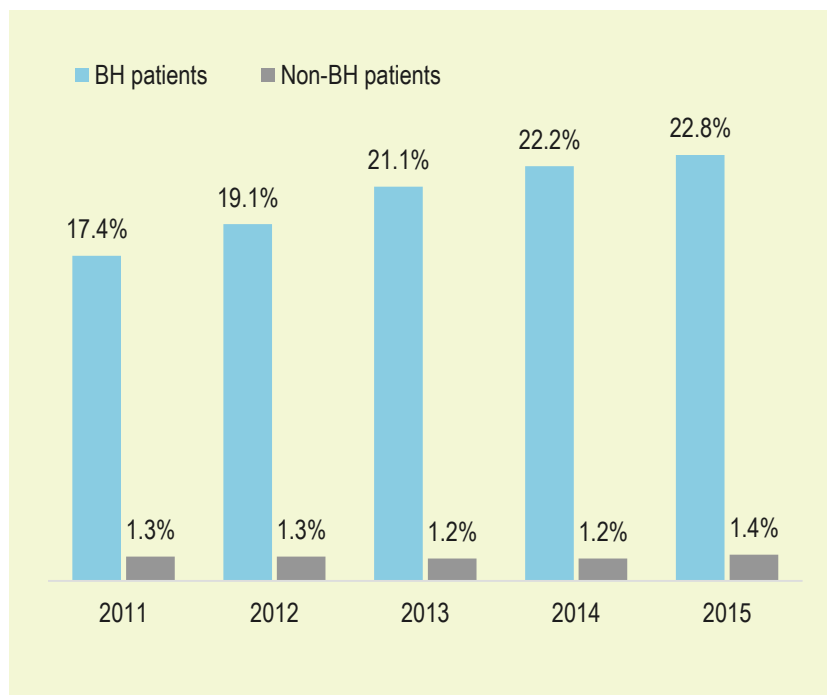
\* "Other" SUDs include, for example, those related to opioids, hallucinogenics, cannabis, etc.

Sources: [https://www.mass.gov/files/documents/2018/03/28/2017\\_CTR\\_Chartpack.pdf](https://www.mass.gov/files/documents/2018/03/28/2017_CTR_Chartpack.pdf); <https://www.samhsa.gov/disorders/substance-use>.

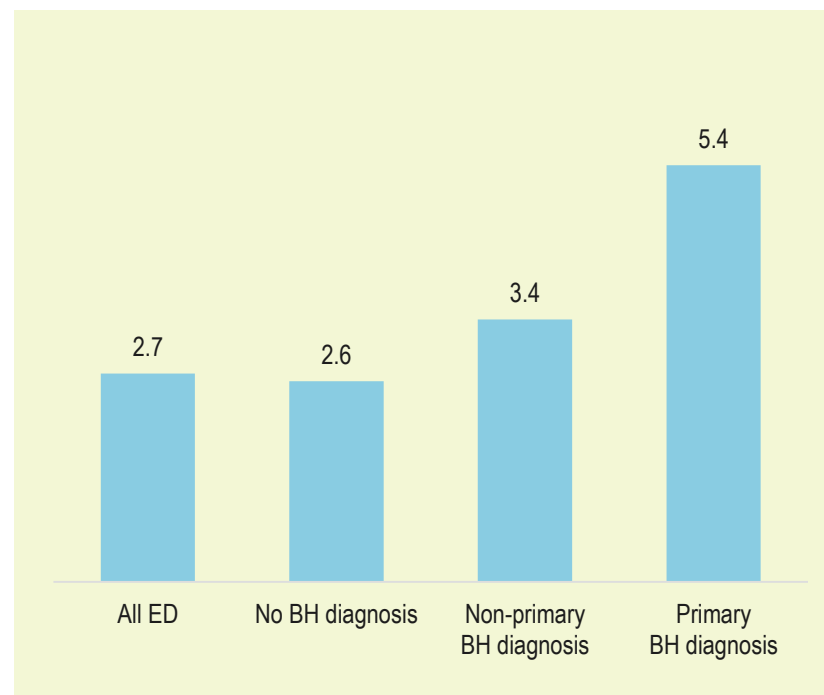
## IMPACT OF FAILING TO PROVIDE THE RIGHT BEHAVIORAL HEALTH CARE AT THE RIGHT TIME IN THE RIGHT SETTING

Patients with BH conditions are more likely to have lengthy stays in hospital EDs, and these may meet some patients' needs less well than other care settings.

**Percent of Patients Admitted to the ED with a Length of Stay of 12 Hours or More, Massachusetts, 2011–2015**



**Median Length of Stay in the ED (Hours), Massachusetts, 2015**

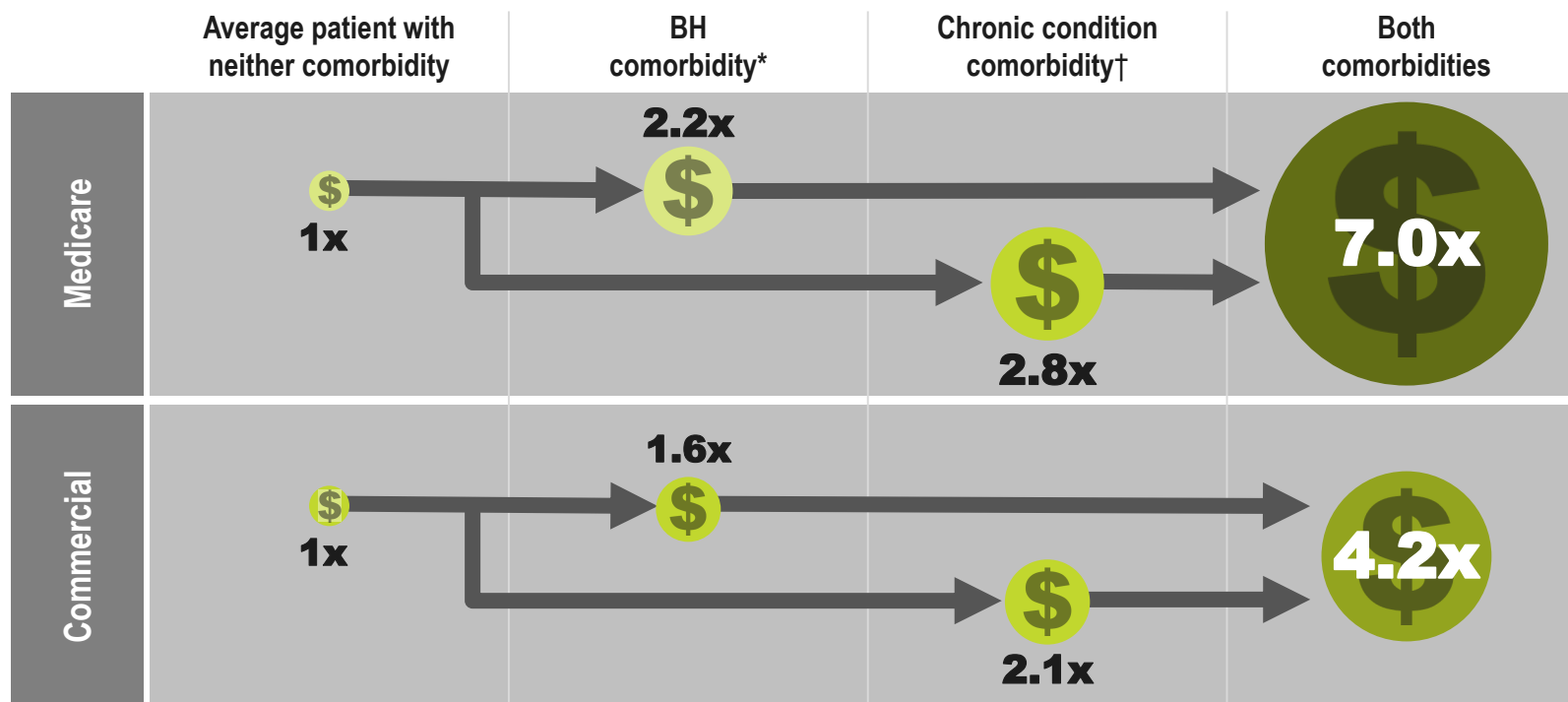


Source: [https://www.mass.gov/files/documents/2017/05/zx/2016\\_Cost\\_Trends\\_Report.pdf](https://www.mass.gov/files/documents/2017/05/zx/2016_Cost_Trends_Report.pdf).

## COST OF TREATING BEHAVIORAL HEALTH CONDITIONS

Patients with BH conditions—and particularly those with one or more comorbid chronic conditions—are significantly more expensive to treat than others.

Average Spending Per Patient Based on Behavioral Health and Chronic Condition Comorbidities, Massachusetts, 2010



\*Behavioral health comorbidities include child psychology, severe and persistent mental illness, psychiatry, and SUD.

†Chronic condition comorbidities includes arthritis, epilepsy, glaucoma, hemophilia, sickle-cell anemia, heart disease, HIV/AIDS, hyperlipidemia, hypertension, multiple sclerosis, renal disease, asthma, and diabetes.

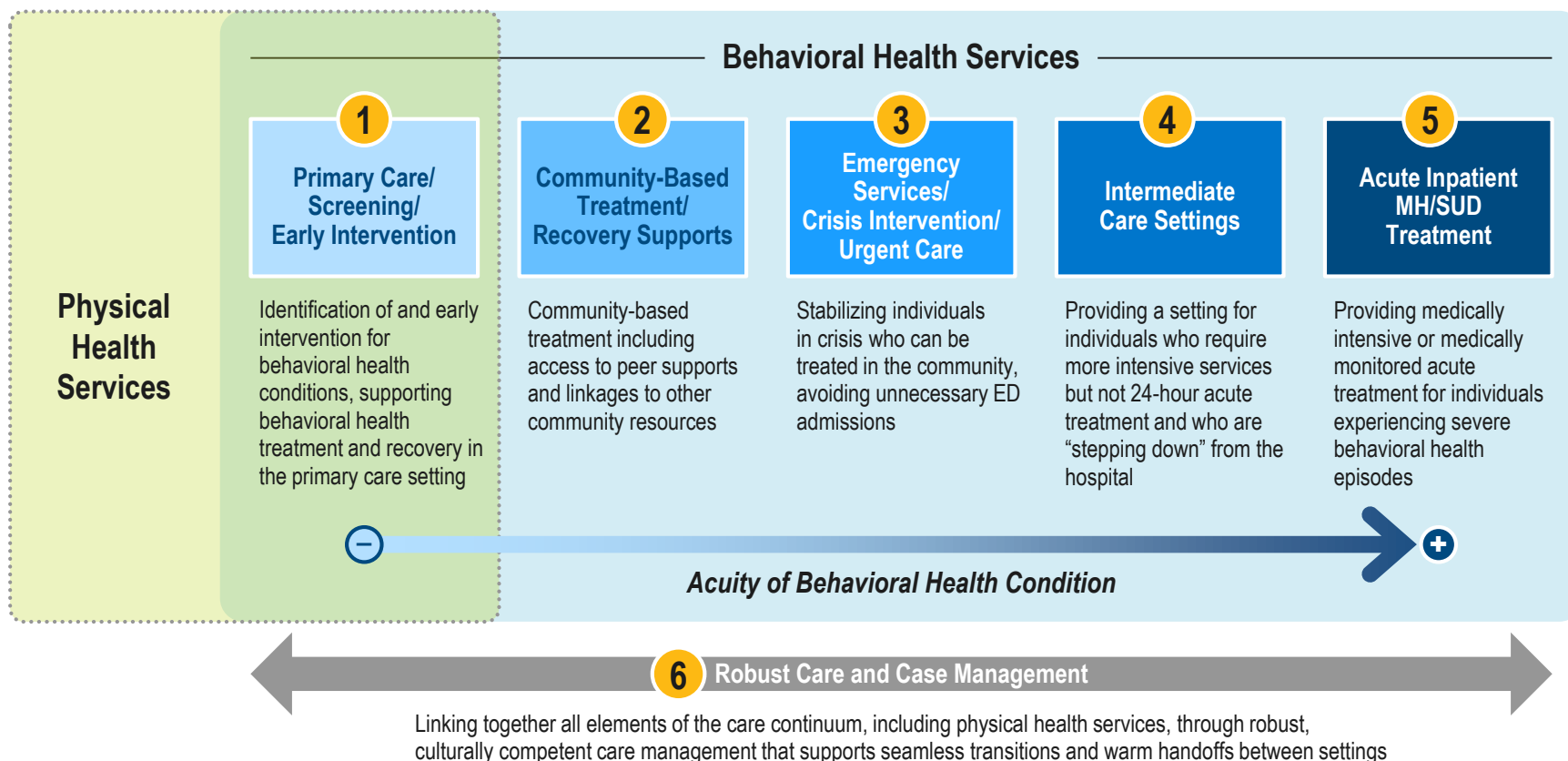
Source: <https://www.mass.gov/files/documents/2016/07/16/2013-cost-trends-report-full-report.pdf>.

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# KEY ELEMENTS OF A MODEL BEHAVIORAL HEALTH CARE SYSTEM (THE “TO BE”)

## OVERVIEW OF A MODEL BEHAVIORAL HEALTH CARE SYSTEM

Effective treatment of BH conditions requires a full continuum of services with robust and seamless coordination between each level of care (including physical health settings).



Note: See Appendix B for a full list of types of BH services.

## OVERVIEW OF A MODEL BEHAVIORAL HEALTH CARE SYSTEM

- 1 **Primary Care/Screening/Early Intervention:** Team-based primary care that integrates care for BH and physical health needs, provides robust care management, facilitates identification and early intervention for individuals at-risk for developing MH and/or SUD conditions, and provides prevention and harm reduction services.
- 2 **Community-Based Treatment/Recovery Supports:** The team-based primary care or BH home coordinates and integrates the care provided by community-based treatment settings, community-support agencies, and residential care, and provides access to rehabilitative services, recovery supports, supportive housing, vocational rehab, and peer support services.
- 3 **Emergency Services/Crisis Intervention/Urgent Care:** After-hour care for urgent/crisis event, acute treatment of BH crises, and streamlined disposition of individuals to the appropriate level of treatment, including to inpatient and community-based settings.
- 4 **Intermediate Care Settings:** Facility-based, intensive treatment settings for individuals who are “stepping down” from acute inpatient treatment or who require more intensive treatment than can be provided by community-based treatment and recovery support programs; includes residential treatment settings, partial hospitalization, day treatment, and intensive outpatient levels of care.
- 5 **Acute Inpatient MH/SUD Treatment:** Acute inpatient psychiatry and substance use treatment capacity to allow for timely transfer from the ED or other settings to intermediate levels of care.
- 6 **Continuum Supported by Robust Care and Case Management and System Navigation:** In close coordination with the primary care or BH home, all patients should be assigned a single care manager that coordinates and manages the patient’s care across settings and levels of care, ensuring that necessary treatment and warm hand-offs are occurring at the appropriate level of care, and that individuals with co-occurring MH/SUD conditions are receiving holistic treatment and/or appropriate referrals across all levels of the BH care continuum.

Note: See Appendix B for a full list of types of BH services.

## A NEW VISION FOR THE BEHAVIORAL HEALTH CARE SYSTEM

Massachusetts should pursue equity of consumer experience in access, coverage, and quality, regardless of whether an individual requires physical or BH care.

### Principles for the New Vision of Behavioral Health Care



**Accessible to all.** Easy for all consumers to understand, enter, and navigate and responsive to the cultural and linguistic needs of the Commonwealth's diverse population.



**Adequately staffed and funded.** Sustainable payment, an infrastructure of supportive resources that enhance provider practice, and low administrative burden related to provider licensure, credentialing, and practice.



**Whole person—responsive.** Integrated care management and service delivery to address physical and MH, SUD, 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.** Widespread implementation of (1) coverage and payment models designed to drive better outcomes; and (2) continual measurement and improvement against a set of outcomes-based quality metrics.



# THE “AS IS” BEHAVIORAL HEALTH CARE SYSTEM IN MASSACHUSETTS

## ▶ THE BEHAVIORAL HEALTH CARE CONTINUUM

ADMINISTRATION AND REGULATION

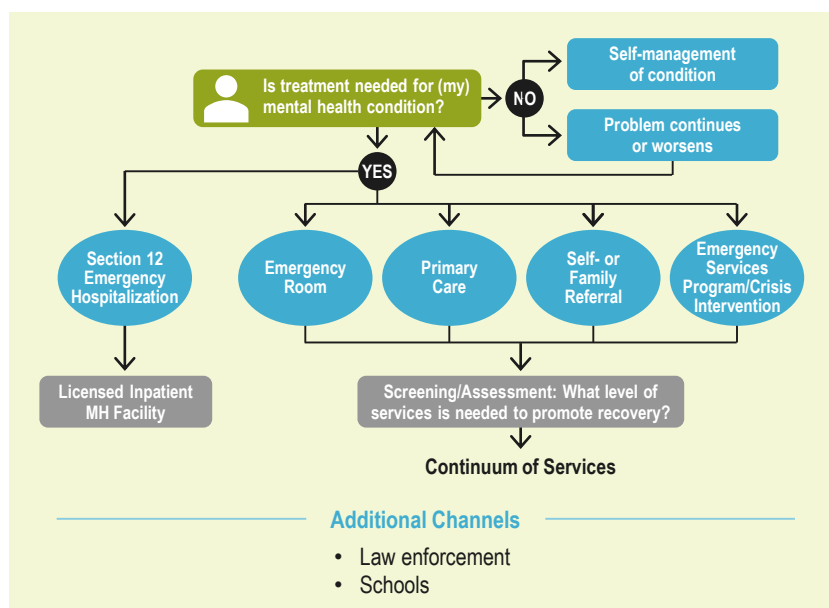
COVERAGE AND PAYMENT

WORKFORCE

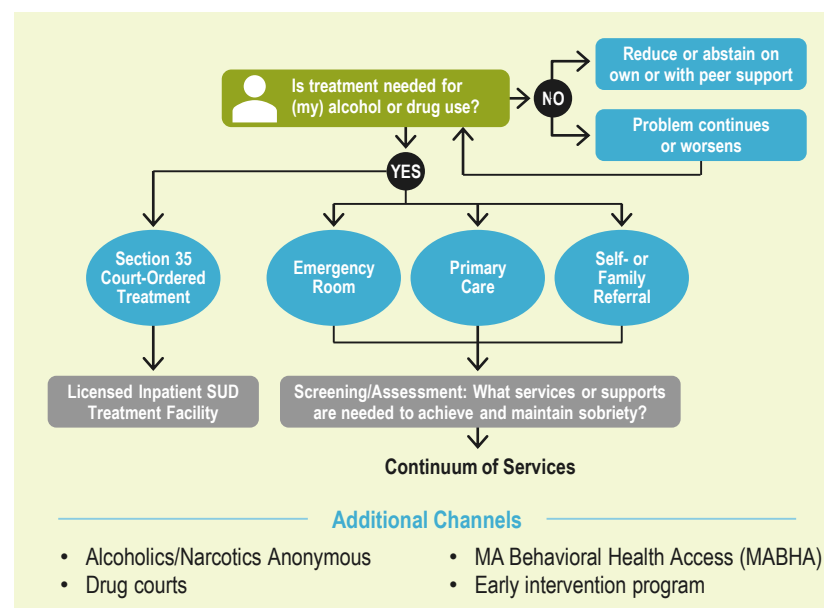
# 1 PRIMARY CARE / SCREENING / EARLY INTERVENTION

Consumers access the BH care system for screening through multiple channels. The system is challenging to navigate, not designed to treat individuals with co-occurring MH and SUD conditions, often deterring patients from receiving critical early interventions.

## Mental Health



## Substance Use Disorder



Patients and providers report that individuals with BH needs often have significant difficulty “knowing where to start” for all types of BH needs.

## 2 COMMUNITY-BASED TREATMENT / RECOVERY SUPPORTS

Individuals with BH needs face barriers to accessing community-based psychiatry and other treatment and recovery services. This creates demand and capacity limitations for more intensive services.

### Mental Health

#### Access Observations

- Complicated and onerous process of navigating web of available community-based services.
- Consumers consistently report long wait times for outpatient mental health services.
  - Longer wait times for psychiatrists relative to other MH providers.
  - Longer wait times for BH professionals with expertise in treating children and adolescents.
  - Longer wait times for adults with MassHealth coverage.
- Regional disparities in wait times.
- Providers more likely to accept individuals who self-pay and those with commercial coverage.
- Challenging to connect with providers with appropriate expertise.

### Substance Use Disorder

#### Access Observations

- MH and residential SUD treatment facilities lack availability of medication-assisted treatment (MAT); individuals often have to leave facility to receive MAT.
- Providers indicate that low reimbursement limits their ability to offer additional SUD treatment capacity.
- Commercial plans generally adhere to MassHealth standard wait times for different levels of patient acuity, but consumers and families consistently report excessive wait times.

“There is no standard or reliable method for measuring outpatient capacity, limiting the ability to effectively analyze system adequacy.”

3

## URGENT CARE / CRISIS INTERVENTION / EMERGENCY SERVICES

Emergency services programs (ESPs) and similar programs for stabilizing individuals in crisis are a critical component of the continuum, but they are underfunded, struggle to hire qualified staff, and are not widely available to individuals with commercial coverage.

### Mental Health



### Substance Use Disorder

#### ESP Capacity

- MassHealth enrollees and people who are uninsured are eligible for ESP services.
  - ESPs offer BH crisis assessment, intervention, and stabilization 24 hours per day, 365 days per year;
  - 21 nonprofit ESPs contract with the Massachusetts Behavioral Health Partnership (MBHP), each covering a different region.
- MassHealth reimbursement may not be sufficient.
- The vast majority of individuals with commercial coverage do not have ESP coverage.
- ESPs report more capacity and experience treating individuals with MH conditions (versus SUD conditions).
- Anecdotal evidence suggests that existing programs are struggling to maintain financial viability.



Lack of access to ESPs and similar programs may result in avoidable ED admissions for individuals who could otherwise be well managed in a less intensive setting.

## 4 INTERMEDIATE CARE SETTINGS

Anecdotal evidence points to access challenges for the more intensive services, such as partial hospitalization, day treatment, and intensive outpatient.

### Mental Health

### Substance Use Disorder

#### Access Observations

- Commercial plans tend to favor hospital-based settings for services such as partial hospitalization and intensive outpatient (IOP) care.
- MassHealth provides a greater share of coverage than commercial plans for free-standing services at facilities not affiliated with an acute hospital.
- Providers generally indicate that wait times for partial hospitalization and IOP are within plan guidelines; however, patient and consumer groups indicate that wait times remain a problem.

The state licenses only some of these services (day treatment, intensive outpatient), so less is known about overall capacity at this level of care.

## 5 ACUTE INPATIENT MH / SUD TREATMENT

While inpatient bed capacity is growing across the state, access remains a challenge in certain settings and for discrete populations.

### Mental Health

Program Type	Total DMH Operational Licensed Capacity as of 11/11/17	Change Since 1/1/15
Adult Psychiatric	2,012 beds	<b>+230 beds</b>
Geriatric Psychiatric	457 beds	<b>+58 beds</b>
Adolescent and Child Psychiatric	263 beds	<b>+11 beds</b>

Anecdotal evidence suggests that there are shortages of inpatient MH beds, particularly for children/adolescents and patients with intellectual and developmental disabilities (I/DD).

### Substance Use Disorder

Program Type	Total DPH Operational Licensed Capacity as of 11/11/17	Change Since 1/1/15
Acute Treatment Services (ATS) (Levels 4 & 3.7), Adult	1,073 beds	<b>+227 beds</b>
Clinical Stabilization Services (CSS)	671 beds	<b>+374 beds</b>
Transitional Support Services (TSS)	382 beds	<b>+43 beds</b>
Adult Residential Recovery	2,336 beds	<b>+36 beds</b>
Youth Stabilization Beds	48 beds	<b>0</b>
Second Offender Residential	58 beds	<b>0</b>
Adolescent/Transitional Youth Residential Beds	101 beds	<b>-43 beds</b>
Family Residential	110 families	<b>0</b>
Outpatient Treatment Program (OTP)—Medication-Assisted Treatment (MAT) Programs (Methadone)	44 programs	<b>+5 programs</b>
Outpatient Counseling and Outpatient Detox Programs	218 programs	<b>+28 programs</b>
Office-Based Outpatient Treatment (OBOT) (buprenorphine)—MAT Sites funded by DPH	42 programs	<b>28 programs</b>
Section 35 Men's Beds	359 beds	<b>+101 beds</b>
Section 35 Women's Beds	167 beds	<b>+77 beds</b>

Note: DMH = Department of Mental Health; DPH = Department of Public Health.

Sources: <https://www.mass.gov/files/documents/2016/08/nr/csac-access-to-substance-use-disorder-treatment-in-mass.pdf>; <https://www.mass.gov/files/documents/2017/11/15/2017-annual-update-action-items-gov-working-group.pdf>.

## 6 ROBUST CARE AND CASE MANAGEMENT

Access to care management is uneven across payers and programs. Where it does exist, lack of clarity on roles and responsibilities creates confusion for providers, individuals, and families.

### Mental Health

### Substance Use Disorder

#### Access Observations

- Individuals receiving publicly funded BH services from MassHealth or other state agencies have access to multiple care and case managers; roles and responsibilities often are unclear and duplicative.
- Commercial market coverage of care management is much less robust.
- Anecdotal evidence suggests that individuals struggle in particular with care transitions between hospital-based and community settings.

There is little publicly available data measuring care management capacity.

# THE “AS IS” BEHAVIORAL HEALTH CARE SYSTEM IN MASSACHUSETTS

## THE BEHAVIORAL HEALTH CARE CONTINUUM

### ► ADMINISTRATION AND REGULATION

COVERAGE AND PAYMENT

WORKFORCE



## OVERSIGHT OF THE BEHAVIORAL HEALTH CARE SYSTEM

Numerous state and federal entities oversee, regulate, and fund BH providers and services, fragmenting the BH care system and inhibiting development of a cohesive and coordinated system.

### Federal Oversight

- **U.S. Department of Health and Human Services (HHS):**
  - **Medicare and Medicaid.** Provide health insurance coverage for low-income individuals, the aged, individuals with disabilities, and certain others.
  - **Substance Abuse and Mental Health Services Agency (SAMHSA).** Leads nationwide BH prevention and treatment efforts through grantmaking and regulatory oversight.
- Other agencies such as the **Office of National Drug Control Policy (ONCDP)**, the **Food and Drug Administration (FDA)**, and the **Department of Justice (DOJ)** provide varying levels of regulatory oversight and enforcement.
- Federally Qualified Health Centers (FQHCs) must be reviewed every three years by the **Health Resources and Services Administration (HRSA)** and must meet extensive compliance standards.

### State Oversight

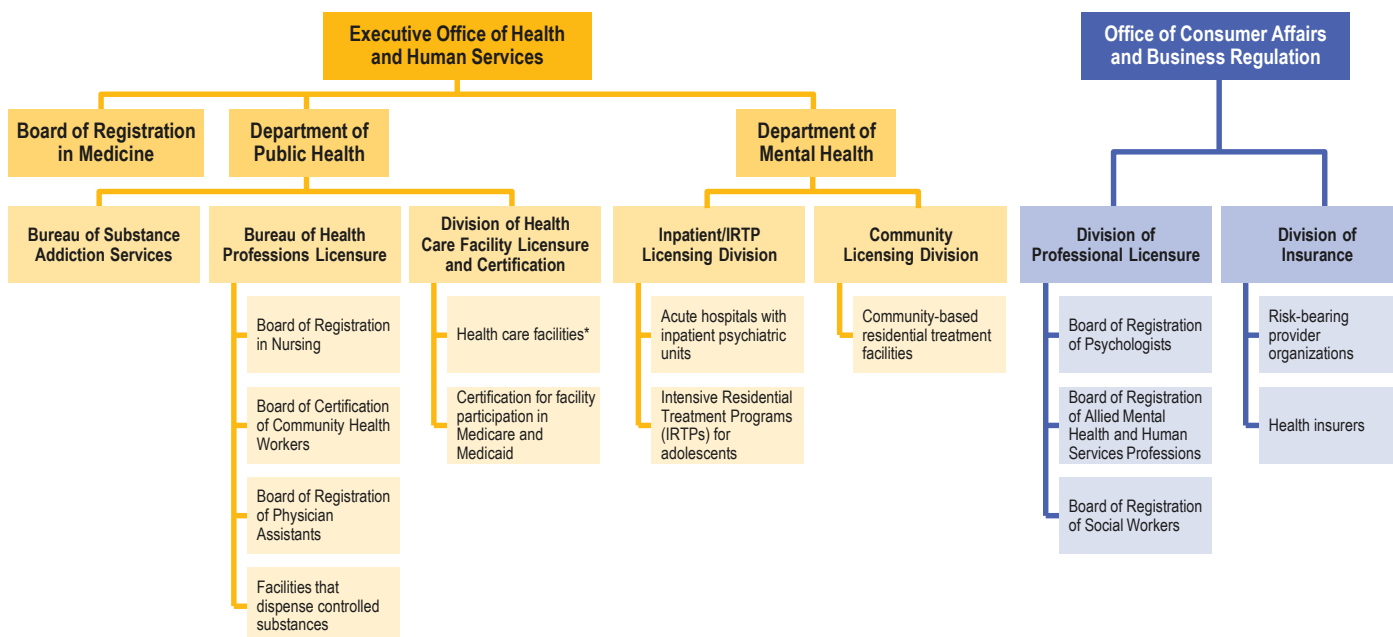
- **Department of Mental Health (DMH):** Designated as the State Mental Health Agency (SMHA) for Massachusetts. Key functions include:
  - Serving as the payer of last resort for the uninsured and underinsured.
  - Operating a number of MH treatment facilities.
  - Regulating and licensing treatment facilities.
- **Department of Public Health (DPH):** Provides regulatory oversight and operates programs aimed at preventing disease and promoting wellness.
  - **Bureau of Substance Addiction Services (BSAS).** Designated as the Single State Agency (SSA) for SUD services.
  - **Bureau of Hospitals.** Operates four public hospitals and the State Office of Pharmacy Services.
  - Regulating and licensing certain health professions and facilities.
- **MassHealth:** Oversees BH care system through management of its managed care entities (MCEs), including managed care organizations (MCOs), accountable care organizations (ACOs), Massachusetts Behavioral Health Partnership (MBHP), and others.
- Other offices including the **Division of Professional Licensure** and the **Division of Insurance** regulate other aspects of the BH delivery system.

Note: See Appendix C for a detailed overview of federal and state regulatory and administrative authorities.

## LICENSURE AND CREDENTIALING REQUIREMENTS ARE BURDENSOME

Current licensure and credentialing requirements for BH professionals and organizations create challenges for coordinated care.

### Health Care Licensure Bodies in Massachusetts



### Licensing Challenges

- Extensive documentation and variation in licensing requirements make licensing processes time-consuming.
- No common understanding of when a new or updated license is required.
- Co-located BH and physical health providers must meet both kinds of licensing requirements (i.e., a BH provider must also meet physical health licensing requirements).

### Insurer Credentialing Challenges

- MassHealth MCEs and commercial plans have separate credentialing requirements for BH professionals.

\*The Division of Health Care Facility Licensure and Certification within the Department of Public Health is responsible for licensing adult day health programs, ambulatory surgical centers, clinics, clinical laboratories, home health agencies, hospices, hospitals, and long-term care facilities.

## STATE POLICY INNOVATIONS IN BEHAVIORAL HEALTH

Stakeholders across the Commonwealth are invested in improving the BH care system, but the wide range of initiatives would benefit from a unified strategy and deployment of resources.

### MassHealth

#### Children's Behavioral Health Initiative (CBHI)

- Remedy from the *Rosie D.* class-action lawsuit, which was filed on behalf of MassHealth-enrolled children and youth with serious emotional disturbance (SED).
- Implemented through MassHealth, which:
  - Pays for an enhanced continuum of home- and community-based BH services;
  - Requires that providers screen for BH conditions;
  - Standardizes BH screening requirement for children and adolescents.

#### Section 1115 Waiver Demonstration

- As part of the state's Section 1115 waiver demonstration approved in 2016, the state is shifting reimbursement of residential treatment services from BSAS to MassHealth.
- The waiver will expand access to a broad spectrum of recovery-oriented SUD services, including care management and recovery support services.
- Accountable Care Organization (ACO) demonstration:
  - Provides incentives for providers to join risk-bearing ACOs;
  - ACOs are required to coordinate with Community Partners (CPs) that manage and coordinate care for individuals with significant BH and LTSS needs.

### DMH

#### Adult Community Clinical Services (ACCS) Program

- Primary service for adults served by DMH who live in or are transitioning to the community.
- Replaced the Community-Based Flexible Supports (CBFS) program effective July 1, 2018, with the goal of promoting more integrated, coordinated care for individuals with serious mental illness to learn the skills to support full participation in the community.
- Model elements:
  - All patients assigned to a primary care clinician supported by an integrated care team that stays with individual across all settings;
  - Care teams may include SUD counselors and recovery coaches and must coordinate with a care management entity;
  - Standardized screening and assessment tools;
  - Standardized rate-setting methodology (contracts varied under CBFS);
  - Standardized approach to data collection and quality monitoring;
  - Data sharing with MassHealth.

Sources: <https://www.mass.gov/service-details/learn-about-cbhi>; <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-stcs-11042016.pdf>; <https://www.mass.gov/files/documents/2017/11/03/ma-1115-waiver-summary.pdf>.

# THE “AS IS” BEHAVIORAL HEALTH CARE SYSTEM IN MASSACHUSETTS

THE BEHAVIORAL HEALTH CARE CONTINUUM

ADMINISTRATION AND REGULATION



**COVERAGE AND PAYMENT**

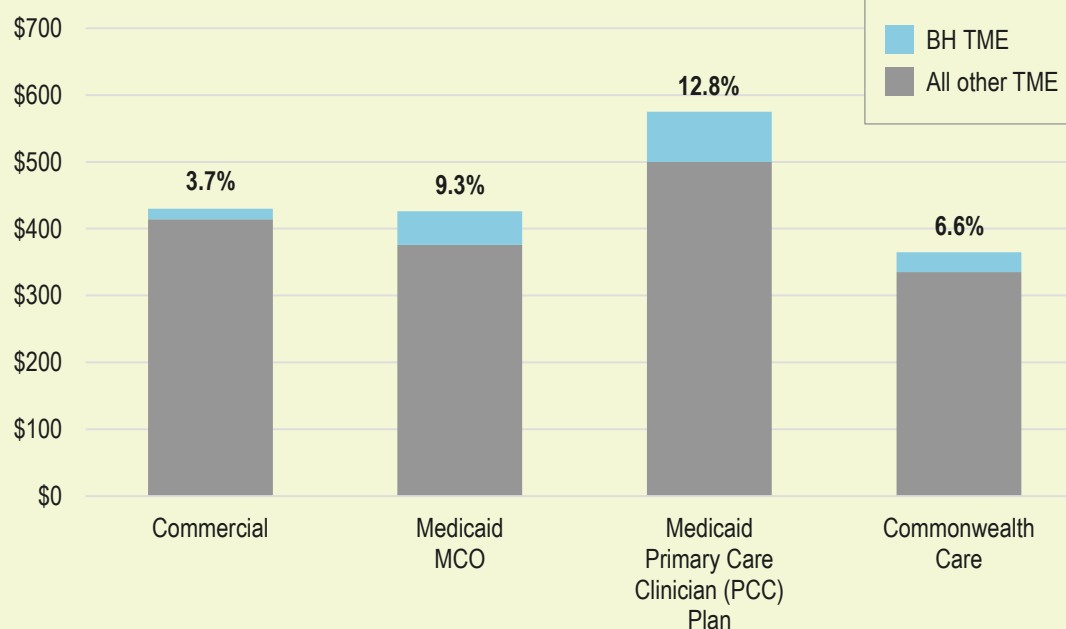
WORKFORCE

## ROLE OF MEDICAID IN TREATING BEHAVIORAL HEALTH CONDITIONS

Much of the obligation for treating individuals with BH conditions falls to the Medicaid program. In Massachusetts, MassHealth is the largest single payer for BH services.

**Share of Total Medical Expenditures (TME) Attributable to BH Conditions by Payer, Massachusetts, 2013**

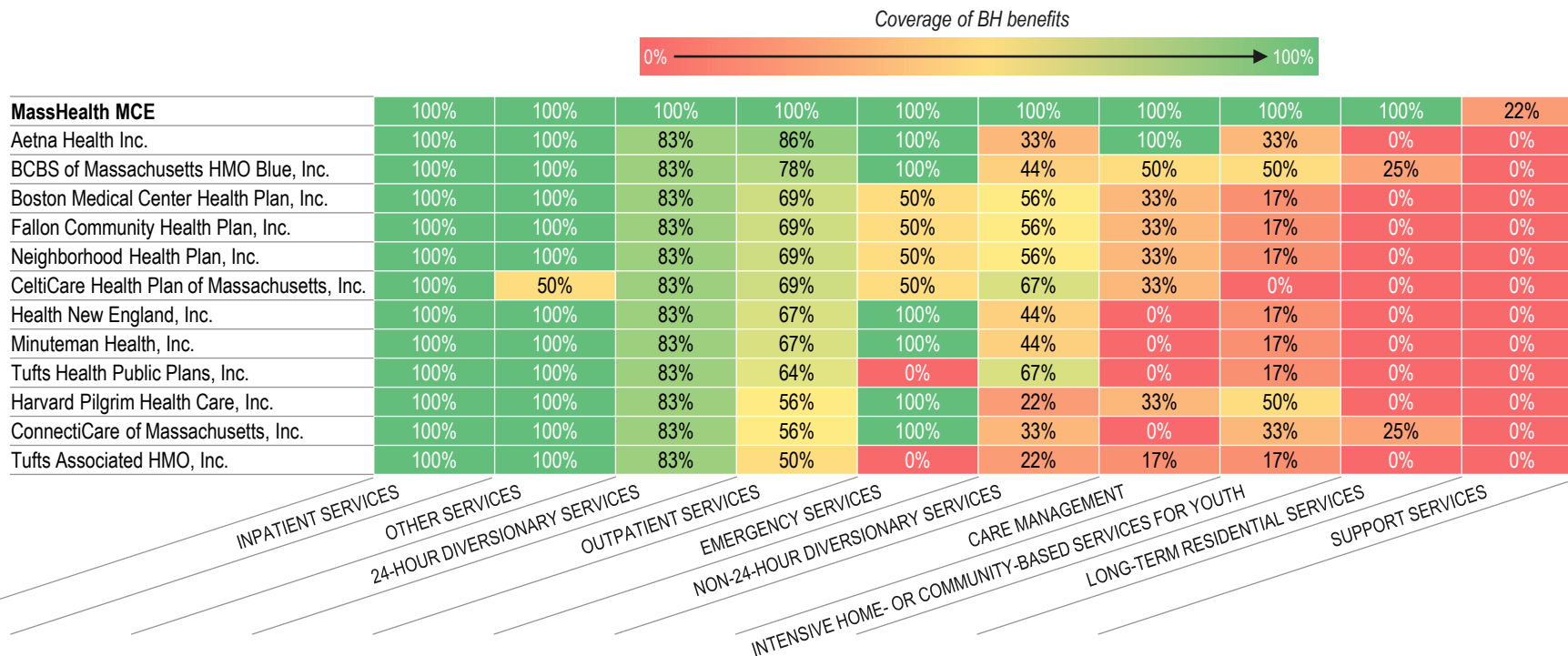
MassHealth covered 48% of total BH expenditures in Massachusetts in 2013 (federal and state dollars).



Sources: <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program—People-Use-and-Expenditures.pdf>; <https://jamanetwork.com/journals/jama/fullarticle/2594716>; [https://bluecrossmafoundation.org/sites/default/files/download/publication/Future-of-MassHealth\\_Webversion\\_FINAL.pdf](https://bluecrossmafoundation.org/sites/default/files/download/publication/Future-of-MassHealth_Webversion_FINAL.pdf); <https://www.mass.gov/files/documents/2016/08/qz/hc-ct-cd-06-2015.pdf>.

## COMPARING COVERAGE BY PAYER

Coverage of BH benefits varies widely by payer, leading to disparities in access based on insurance. MassHealth provides a far more robust behavioral health benefit than commercial payers, including long-term residential treatment, care management, diversionary services, and other services not covered by commercial plans.



Notes: Percentages reflect share of services covered by the corresponding plan within each service category.

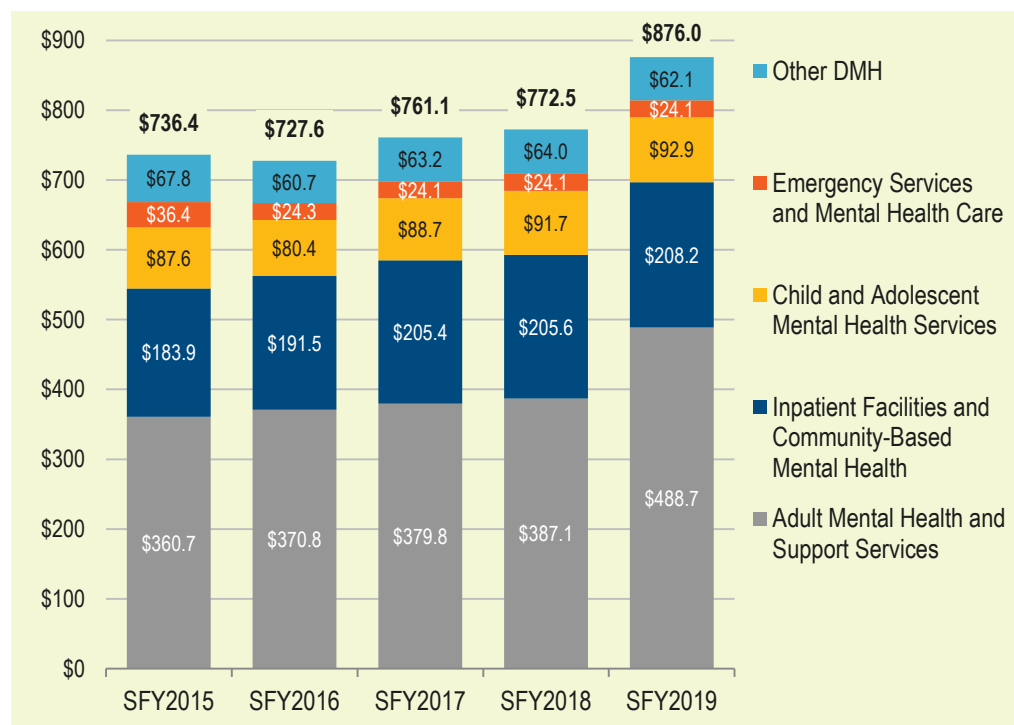
Source: Massachusetts Division of Insurance, "Inpatient, Outpatient, Community Services Behavioral Health Survey," November 10, 2017, available at

<https://www.mass.gov/files/documents/2017/11/10/Catalogue%20of%20Carrier%20Coverage%20of%20Inpatient%2C%20Outpatient%20and%20Community%20BH%20Services%20Survey.xlsx>.

## STATE-FUNDED PROGRAMS: MENTAL HEALTH

Above and beyond MassHealth, the Commonwealth is a substantial funder of BH services, and lawmakers have committed significant new funds to state programs in recent years.

**Massachusetts Department of Mental Health General Appropriations, SFYs 2015–2019 (millions)**

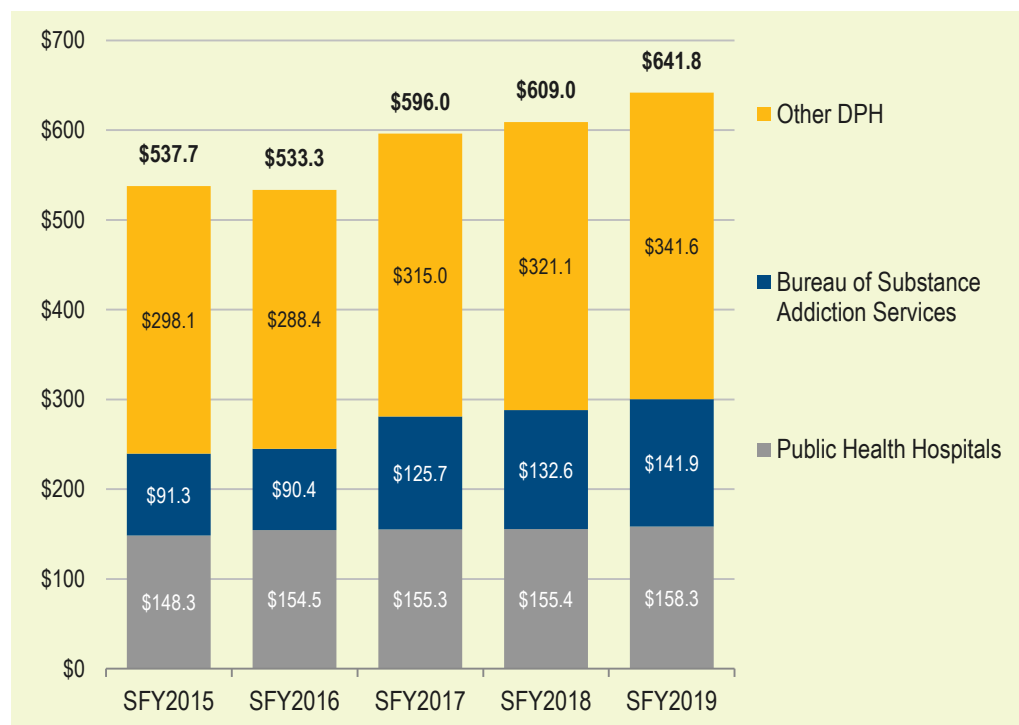


- The state approved 2,341 applications for MH service authorization in 2016 for 26,000 individuals.
- Overall funding for DMH has increased by nearly 19% since 2015, including 13% from SFY 2018 to 2019.
- The SFY 2019 enacted budget increased the appropriation for adult MH and support services by 26% over SFY 2018.
- This increase includes \$83.8 million for the new Adult Community Clinical Services (ACCS) program, which provides enhanced community-based services for adults with serious mental illness.

## STATE-FUNDED PROGRAMS: SUBSTANCE USE DISORDER

The state is also investing substantially in SUD prevention and treatment programs, primarily in DPH inpatient bed capacity.

**Massachusetts Department of Public Health General Appropriations, SFYs 2015–2019 (millions)**



- Overall funding for DPH has increased by over 19% since 2015, including 5% from SFY 2018 to 2019.
- Since SFY 2015, funding for the BSAS has increased by 55%.
- The SFY 2019 budget includes \$13.2 million to support 45 additional SUD treatment beds at Taunton State Hospital and \$10.8 million to support enhanced SUD treatment for incarcerated individuals.



## SYSTEM NAVIGATION CHALLENGES

Evidence from providers, patients, and families suggests that a complex payment and coverage paradigm creates barriers to connecting individuals with needed BH services.

- ▶ Families and patients often lack the necessary knowledge of the BH care delivery system to even begin the process of finding available services.
- ▶ The inability to secure needed services leads to “problem pileup,” exacerbating the effects of individuals’ existing BH conditions.
- ▶ Multiple agencies providing / paying for services creates confusion among consumers and families as to what services are covered and where.
- ▶ Complicated processes make it difficult for providers to initiate referrals to supplemental state-funded services.
- ▶ Not even individuals with appropriate insurance coverage have a centralized way to locate providers who are accepting new patients or have openings for appointments.
- ▶ Differential coverage of crisis intervention services often leads individuals to call the police or take a person experiencing a crisis to an ED when the individual might have remained in the community.

# THE “AS IS” BEHAVIORAL HEALTH CARE SYSTEM IN MASSACHUSETTS

THE BEHAVIORAL HEALTH CARE CONTINUUM

ADMINISTRATION AND REGULATION

COVERAGE AND PAYMENT

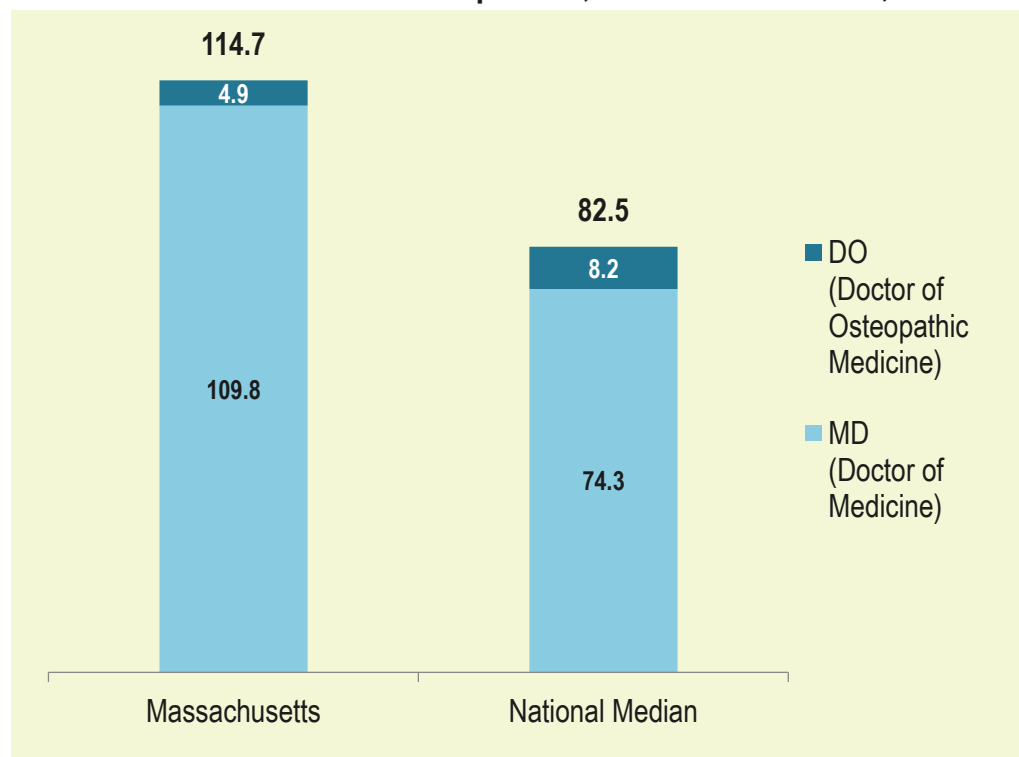


**WORKFORCE**

## PRIMARY CARE CAPACITY

Primary care may serve as an access point to BH screening and services. Relative to other states, Massachusetts has a high proportion of primary care physicians (PCPs), but anecdotal evidence suggests many feel ill-trained to respond to BH-related issues.

### Active Patient Care\* PCPs per 100,000 State Residents, 2016



### Massachusetts Primary Care Capacity Facts

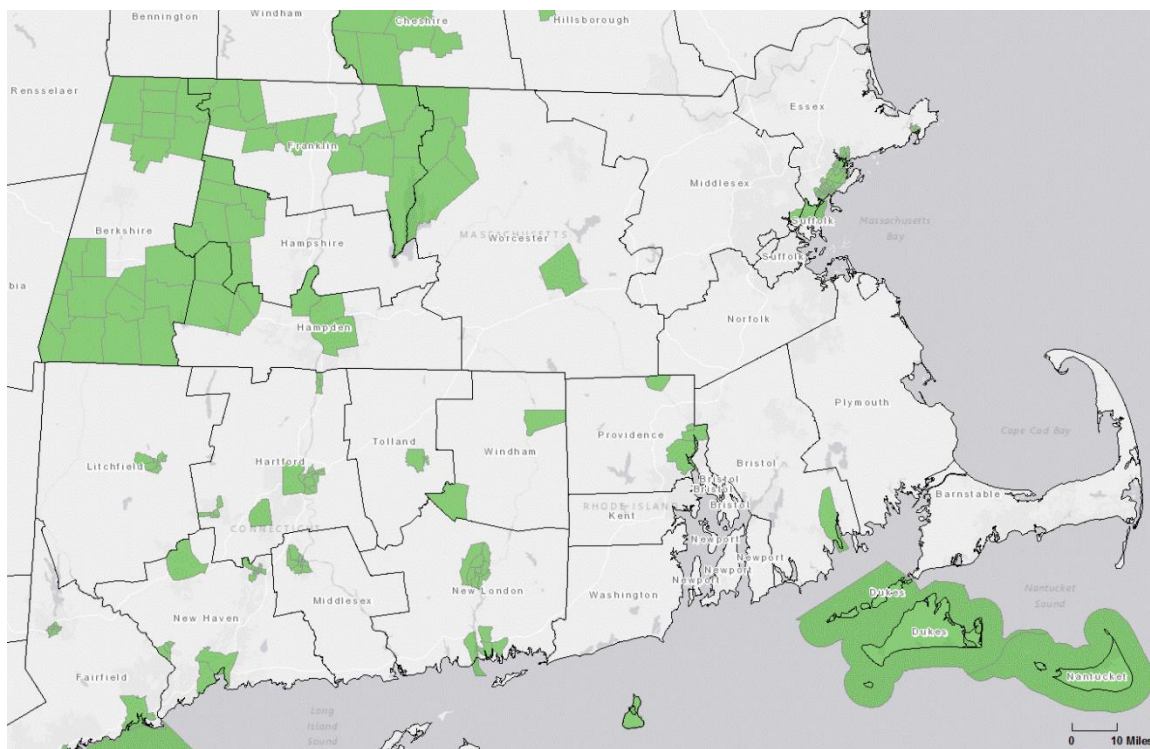
- ▶ **7,814 active PCPs** as of 2016
- ▶ **3rd highest PCP density** in the nation
- ▶ **39% more PCPs** per 100,000 residents than the median state

\*Comprises only those physicians whose self-reported type of practice is direct patient care (i.e., excludes physicians doing research or teaching).

Sources: <https://members.aamc.org/eweb/upload/2017%20State%20Physician%20Workforce%20Data%20Report.pdf>; Manatt stakeholder interviews.

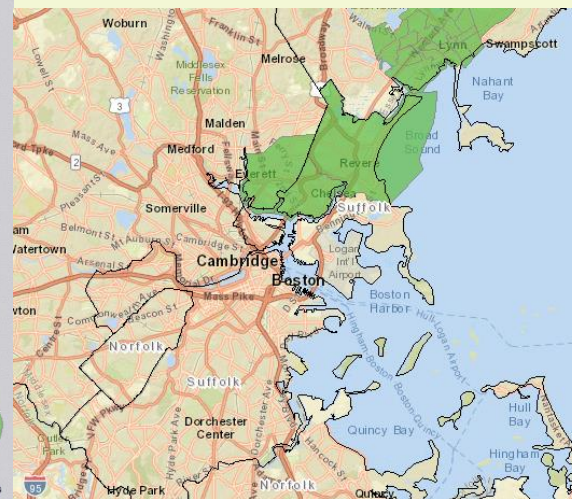
## PRIMARY CARE CAPACITY

The state faces shortages of PCPs in Western Mass., the North Shore, and the Islands—parts of which are federally designated Health Professional Shortage Areas (HPSAs).



### Primary Care HPSAs

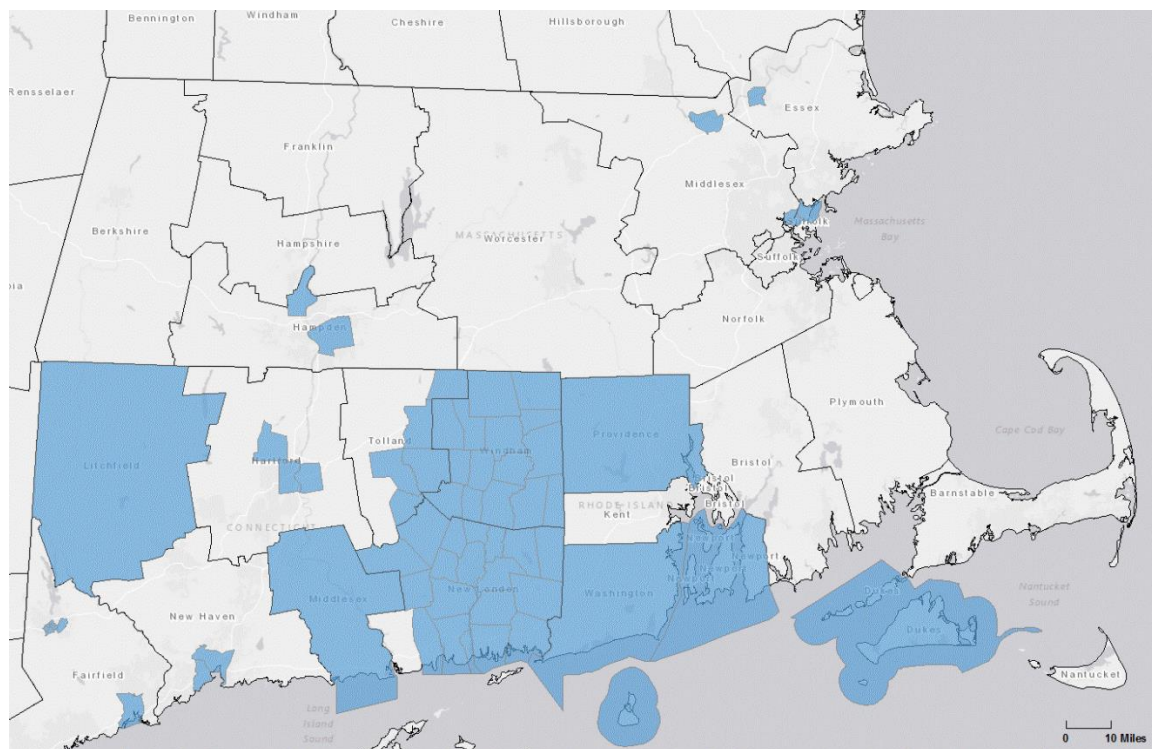
Designated by the U.S. Health Resources and Services Administration as having a shortage of PCPs in a defined geographic area. (See Appendix A for full definition.)



Source: <https://datawarehouse.hrsa.gov/Tools/MapTool.aspx>.

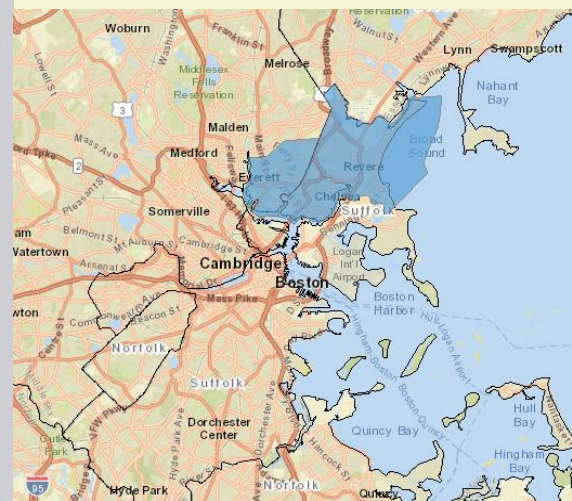
## MENTAL HEALTH CAPACITY

Massachusetts has relatively robust levels of MH workforce capacity compared with other states, but certain regions, including the North Shore and Martha's Vineyard, face shortages. Anecdotal evidence suggests patients there struggle to access community-based treatment and recovery services.



### Mental Health HPSAs

Designated by the U.S. Health Resources Administration as having a shortage of MH providers in a defined geographic area.  
(See Appendix A for full definition.)



Sources: <https://datawarehouse.hrsa.gov/Tools/MapTool.aspx>; [https://ersrs.hrsa.gov/ReportServer/?/HGDW\\_Reports/BCD\\_HPSA/BCD\\_HPSA\\_SCR50\\_Qtr\\_Smry\\_HTML&rc:Toolbar=false](https://ersrs.hrsa.gov/ReportServer/?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false).



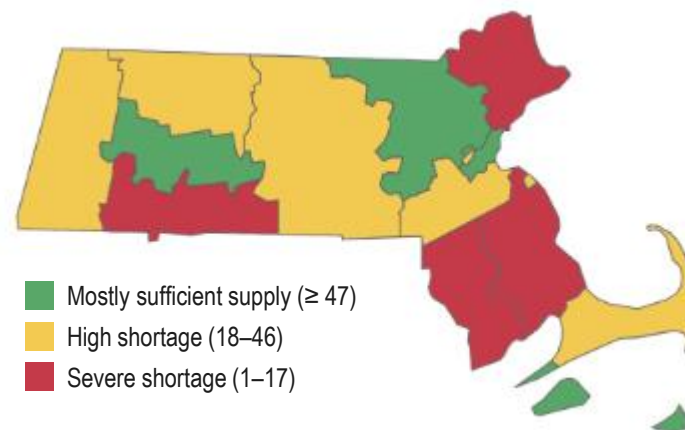
## ACCESS TO PSYCHIATRISTS

Like many states, Massachusetts struggles to provide adequate access to psychiatry services, particularly for children and adolescents and in rural areas.

### Barriers to Psychiatry Access

- The capacity of practicing psychiatrists is limited statewide, but the shortage is more severe in rural areas.
- Psychiatrists are much less likely than other providers to accept insurance.
- Wait lists, particularly for children and adolescents, are long. This sometimes leads individuals to seek care out of state.

### Practicing Child and Adolescent Psychiatrists per 100K Children Under Age 18, Massachusetts, 2012–2016



Between April 1, 2016, and March 31, 2017, **psychiatrists were the second most-recruited specialty nationwide** (behind family medicine). This is up from **ninth in 2007**.

## ACCESS TO TELE-BEHAVIORAL HEALTH SERVICES

State regulations currently restrict the provision of and access to tele-BH services; expanding access to tele-BH could help to alleviate workforce shortages.

### Barriers to Wider Use of Tele-BH Services

- MassHealth does not currently reimburse for tele-BH services, although private payers are permitted to do so.
- Tele-BH providers must be licensed in Massachusetts. Out-of-state providers may not provide services to Massachusetts residents.
- The state encourages tele-BH providers to conduct in-person evaluations before providing services electronically.

*Anecdotal evidence from providers suggests that Massachusetts places more restrictions on the use of tele-BH services than do most other states.*

## CURRENT STATE EFFORTS ON WORKFORCE DEVELOPMENT

Massachusetts has targeted initiatives to address BH workforce shortages but not a comprehensive, system-wide workforce development strategy.

### Massachusetts Child Psychiatry Access Project (MCPAP)

- Goal is to improve PCPs' access to child psychiatry services across the state.
- Provides real-time access to psychiatric consultation, building competencies around:
  - Screening and assessment;
  - Treating mild to moderate BH conditions;
  - Making effective referrals and coordinating care.
- Available to all children and families regardless of insurance status.
- Free to PCPs.
- The number of children served by MCPAP nearly tripled from 2006 to 2015.

### ACO Statewide Investments

Approximately 6% of DSRIP funds (\$115 million over five years) is dedicated to supporting health care delivery system capacity building. Key BH 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).
- **BH Special Projects Program.** This provides one-year \$40,000 grants to support projects related to accountable care for CHCs, CMHCs, ESPs, BH CPs, and other providers to enhance BH 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 (NPs) 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.

Note: 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.  
Sources: <https://www.mcpap.com/About/OverviewVisionHistory.aspx>; <https://www.mass.gov/files/documents/2018/02/28/DSRIP%20Statewide%20Investments%20Overview%20Feb%202018.pdf>;  
<https://www.mcpap.com/Docs/MCPAP%20Strategic%20Planning%204-20-16.pdf>.



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# ASSESSING THE MASSACHUSETTS BEHAVIORAL HEALTH CARE SYSTEM

## STRENGTHS OF THE BEHAVIORAL HEALTH CARE SYSTEM IN MASSACHUSETTS

Massachusetts has one of the most robust BH care systems in the country.

- ▶ High rates of insurance coverage.
- ▶ Relatively high levels of BH workforce available to provide BH services in the system compared with other states (e.g., Massachusetts has the highest density of child and adolescent psychiatrists of any state).
- ▶ High overall density of PCPs, who could be leveraged to provide BH services.
- ▶ Improved coordination of BH care and primary care integration spurred by the BH Integration Task Force and by recent reform efforts, including ACO program and ACCS program, among others.
- ▶ Political will of state leadership to improve the BH care system for all Massachusetts residents.

## WEAKNESSES OF THE BEHAVIORAL HEALTH CARE SYSTEM IN MASSACHUSETTS

People with BH needs don't receive the right BH care at the right time, in the right setting; capacity gaps in one part of the continuum impact resource use in other parts.

1

### Primary Care/ Screening/ Early Intervention

- Many PCPs feel ill-trained to treat BH conditions in a primary care setting.
- Access to PCPs remains a challenge in certain underserved regions of the state.

2

### Community-Based Treatment/Recovery Supports

- Gaps in outpatient treatment capacity, particularly for children and adolescents, impede access to care.
- Workforce shortages persist, particularly of psychiatrists who are willing to accept non-private pay patients.

3

### Emergency Services/ Crisis Intervention/ Urgent Care

- Gaps in capacity and funding for adequate ESPs, crisis intervention, and respite services drive individuals in crisis to the ED and inpatient settings.

4

### Intermediate Care Settings

- Funding may be inadequate to support intermediate levels of care, such as day treatment.

5

### Acute Inpatient MH/SUD Treatment

- Populations with complex specialized needs, such as individuals with I/DDs and children and adolescents with autism, face particular challenges accessing inpatient services.

6

### Care and Case Management

- Access to care management is fragmented across programs and payers and less robust in the commercial space. Note: MassHealth BH CPs are a new initiative that may mitigate the fragmentation and confusion.

## WEAKNESSES OF THE BEHAVIORAL HEALTH CARE SYSTEM IN MASSACHUSETTS

While the Commonwealth and other stakeholders have devoted considerable resources to understanding the BH care system in depth, critical gaps in data on all parts of the continuum remain.

### Key Information Gaps

#### Understanding supply

- There are no commonly accepted measures of outpatient treatment capacity.
- Bed availability data is not readily accessible to patients and providers, other than for beds primarily within MBHP's provider network (i.e., through the MABHA website).
- Capacity gaps have mostly been identified through anecdotal interviews with patients and providers, making comparisons across service types, populations, and geographies challenging.

#### Understanding demand

- Measuring demand for services is challenging and influenced by a variety of factors including capacity gaps and differential coverage by payers, among others.



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# APPENDICES

## ▶ APPENDIX A: TERMS AND DEFINITIONS

APPENDIX B: BEHAVIORAL HEALTH PROVIDERS AND KEY SERVICE TYPES

APPENDIX C: FEDERAL AND STATE ADMINISTRATIVE AND REGULATORY  
AUTHORITIES

## KEY DEFINITIONS

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**Behavioral Health Conditions:** These include both **Mental Health Conditions** and **Substance Use Disorders**.

**Mental Health (MH) Condition:** Changes in thinking, mood, and/or behavior that affect how individuals relate to others and make choices. Common MH conditions include anxiety disorders; attention deficit hyperactivity disorder; bipolar and related disorders; depressive disorders; disruptive, impulse control, and conduct disorders; obsessive-compulsive and related disorders; schizophrenia spectrum and other psychotic disorders; and trauma- and stressor-related disorders.

- **Serious Mental Illness (SMI):** In persons 18 years and older, a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities, experienced at any time during the past year. Examples include major depression, schizophrenia, and bipolar disorder.
- **Serious Emotional Disturbance (SED):** In children and youth, a diagnosable mental, behavioral, or emotional disorder experienced in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

**Substance Use Disorder (SUD):** Recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Diagnoses are defined as mild, moderate, or severe, based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

**Co-occurring MH Condition and SUD:** The coexistence of a MH condition and a SUD. People with MH disorders are more likely than people without MH disorders to experience an alcohol or other SUD, and in many cases, people receive treatment for one disorder while the other disorder remains untreated. Undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or other early death.

## HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) DEFINITIONS

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**Mental Health HPSA:** Federal regulations stipulate that in order to be considered as having a shortage of providers, a designated area must have a population-to-provider ratio that meets or exceeds a certain threshold. Areas may qualify for a mental health (MH) designation based on the ratio of population to psychiatrists, the ratio of population to core MH providers (psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists), or the ratios of population to both psychiatrists and core MH providers. For most MH geographic designations based on the ratio of population to psychiatrists, the ratio must be at least 30,000 to 1, while for population designations or geographic designations in areas with unusually high needs, the threshold is 20,000 to 1. For most MH geographic designations based on the ratio of population to core MH providers, the ratio must be at least 9,000 to 1, while for population designations or geographic designations in areas with unusually high needs, the threshold is 6,000 to 1. For most MH geographic designations based on the ratios of both population to psychiatrists and population to core MH providers, the ratios must be 20,000 to 1 (psychiatrists) and 6,000 to 1 (core MH providers), while for population designations or geographic designations in areas with unusually high needs, the thresholds are 15,000 to 1 (psychiatrists) and 4,500 to 1 (core MH providers). For correctional facilities, the threshold is generally 2,000 to 1, but takes into account the average length of stay and whether or not intake examinations are routinely performed. For state mental hospitals, the calculation is based on workload units, which are a function of the average daily inpatient census and the number and type of admissions. For correctional facilities and state mental hospitals, psychiatrists are the only provider type counted.

**Primary Care HPSA:** Federal regulations stipulate that in order to be considered as having a shortage of providers, a designation must have a population-to-provider ratio that meets or exceeds a certain threshold. For most primary care geographic designations, the population to provider ratio must be at least 3,500 to 1. For primary care population designations or geographic designations in areas with unusually high needs, the threshold is 3,000 to 1. For correctional facilities, the threshold is generally 1,000 to 1 but takes into account the average length of stay and whether or not intake examinations are routinely performed.

Source: [https://ersrs.hrsa.gov/ReportServer?/HGDW\\_Reports/BCD\\_HPSA/BCD\\_HPSA\\_SCR50\\_Qtr\\_Smry\\_HTML&rc:Toolbar=false](https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false).

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AUTHORITIES



# KEY COMPONENTS OF THE BEHAVIORAL HEALTH WORKFORCE

## ASSESSMENT AND THERAPY

### Psychologists (PhD, PsyD)

- Trained to provide evaluation, make diagnoses, and provide therapy

### Counselors, clinicians, therapists (LPC, LMFT, LADC)

- Trained to provide evaluation and therapy

### Clinical social workers (LICSW, LCSW, ACSW)

- Trained to provide evaluation, therapy, case management, and advocacy

## PRESCRIBE AND MONITOR MEDICATION

### Psychiatrists (MD, DO)

- Licensed medical doctors who have completed psychiatric training
- Can make diagnoses, prescribe and monitor medications, and provide therapy

### Primary care physicians (MD, DO)

- Licensed medical doctors who specialize in internal medicine, family medicine, pediatric medicine, or other primary care specialties
- Can make diagnoses and prescribe medication

### Psychiatric or mental health nurse practitioners (NP) (MS or PhD in nursing; other nursing certifications)

- Trained to provide assessment, diagnosis, and therapy
- NPs are permitted to prescribe scheduled drugs in Massachusetts but there must be written guidelines between the NP and a physician

### Physician Assistants

- Can provide assessment and evaluation and prescribe medication under the supervision of a psychiatrist

## ASSESSMENT AND THERAPY

### Certified peer specialists, recovery support specialists (with appropriate training and work experience)

- People with lived experience with behavioral health conditions.
- Assist in recovery by helping the patient set goals and providing mentoring and guidance.

### Social workers (bachelor's degree)

- Provide case management, inpatient discharge planning services, and placement services

Note: LPC = Licensed Professional Counselor; LMFT = Licensed Marriage and Family Therapist; LADC = Licensed Alcohol and Drug Counselor; LICSW = Licensed Independent Clinical Social Worker; LCSW = Licensed Clinical Social Worker; and ACSW = Academy of Certified Social Workers.

Sources: <https://www.nami.org/Learn-More/Treatment/Types-of-Mental-Health-Professionals>; [https://www.ama-assn.org/sites/default/files/media-browser/specialty\\_group/arc/ama-chart-np-prescriptive-authority.pdf](https://www.ama-assn.org/sites/default/files/media-browser/specialty_group/arc/ama-chart-np-prescriptive-authority.pdf); <http://www.mentalhealthamerica.net/national-certified-peer-specialist-ncps-certification-get-certified#What>.

# BEHAVIORAL HEALTH SERVICES RECOGNIZED BY THE MASSACHUSETTS DIVISION OF INSURANCE

## INPATIENT SERVICES

- Inpatient Mental Health Services
- Inpatient Substance Use Disorder Services (Level IV)

## 24-HOUR DIVERSIONARY SERVICES

- Community Crisis Stabilization
- Community Based Acute Treatment (CBAT)
- Acute Treatment Services (ATS) for SUD (Level III.7)
- Enhanced Acute Treatment Services
- Clinical Support Services for SUD (Level III.5)
- Transitional Support Services (TSS)

## NON-24-HOUR DIVERSIONARY SERVICES

- Adult Day Health Programs
- Community Support Program (CSP)
- Community Support for Persons Experiencing Chronic Homelessness (CSPECH)
- Day Habilitation
- Partial Hospitalization Programs (PHP)
- Psychiatric Day Treatment
- Structured Outpatient Addiction Program (SOAP)
- Program of Assertive Community Treatment (PACT)
- Intensive Outpatient Program (IOP)

## INTENSIVE HOME- OR COMMUNITY-BASED SERVICES FOR YOUTH

- Family Support & Training
- Intensive Care Coordination (ICC)
- In-Home Behavioral Therapy (IHBT)
- In-Home Therapy (IHT)
- Therapeutic Mentoring
- Family Stabilization Team

## OUTPATIENT SERVICES

- Office-Based Urgent Evaluation
- School-Based Outpatient Therapy (or therapy in another community-based setting)
- Parent-Infant Mental Health Consultation
- Family Consultation
- Case Consultation
- Diagnostic Evaluation
- Dialectical Behavioral Therapy (DBT)
- Medication Visit
- Medication Administration
- Couples/Family Treatment
- Outpatient Group Therapy Services
- Outpatient Individual Therapy Services
- Inpatient-Outpatient Bridge Visit
- Assessment for Safe and Appropriate Placement (ASAP)
- Collateral Contact
- Acupuncture Treatment
- Opioid Replacement Therapy
- Ambulatory Detoxification (Level II.d)
- Psychological Testing
- Neuropsychological Testing
- Special Education Psychological Testing
- Telemedicine Activity
- Medically-Assisted Therapies
- Intensive Outpatient Programs (IOP)
- BSAS Clinical Outpatient Services (i.e., H0004) Opioid Individual Counseling
- BSAS Clinical Outpatient Services (i.e., H0005) Opioid Group Counseling
- BSAS Clinical Outpatient Services (i.e., T1006) Opioid Couple/Family Counseling
- BSAS Clinical Outpatient Services (i.e., 90882) Outpatient Case Consultation
- BSAS Clinical Outpatient Services (i.e., H2019) In-Home Counseling
- BSAS Clinical Outpatient Services (i.e., H0006) Alcohol and/or Drug Services Case Management
- BSAS Clinical Outpatient Services (i.e., H2027) Psychoeducational Services
- BSAS Clinical Outpatient Services (i.e., H0001) Alcohol and Drug Assessment
- Day Treatment (i.e., H0015)
- Recovery Support Outpatient Services (i.e., H0038)
- Recovery Support Outpatient Services (i.e., H2015)
- BSAS Opioid Treatment Program (i.e., H0020)

## EMERGENCY SERVICES

- Emergency Services Program (ESP)
- Mobile Crisis Intervention (MCI)

## LONG-TERM RESIDENTIAL SERVICES

- BSAS Transitional Support Services (H0018)
- Residential Rehabilitation Services (H0019)
- Residential Rehabilitation Services (Level III.1)
- BSAS Statewide Secure (H0047, H0011, H0010, H0018)

## CARE MANAGEMENT

- Aftercare Planning
- Intensive Case Management
- Family Support Program
- Peer Support Program
- Targeted Case Management
- Therapeutic Behavioral Supports

## SUPPORT SERVICES

- Clubhouse Services
- Peer-Operated Respite
- Site-Based Respite Services
- Psychosocial Education
- Recovery Learning Community (RLC)
- Supported Employment
- Supportive Home Care Aides
- MFP (Money Follows the Person) Community Living
- MFP (Money Follows the Person) Residential

## OTHER SERVICES

- Applied Behavioral Analysis
- Electroconvulsive Therapy
- Repetitive Transcranial Magnetic Stimulation (rTMS)
- Transcranial Magnetic Stimulation

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AUTHORITIES**

# FEDERAL ROLE IN THE BEHAVIORAL HEALTH CARE SYSTEM

Numerous federal entities oversee, regulate, and fund the BH care system.

## U.S. Department of Health and Human Services (HHS)

- **Medicare and Medicaid:**  
Provide health insurance coverage for low-income individuals, the aged, individuals with disabilities, and certain others. Both Medicare and Medicaid include comprehensive coverage for mental health and SUD services.
- **Substance Abuse and Mental Health Services Agency (SAMHSA):**  
Leads public health efforts to advance the behavioral health of the nation; administers Mental Health Block Grants and Substance Abuse Block Grants, which are substantial sources of funding for state programs.
- **Health Resources and Services Administration (HRSA):**  
Determines whether a health center meets compliance requirements to serve as a “Section 330 Health Center” in order to be eligible for certain federal funding.

## Other Key Federal Agencies and Regulatory Bodies

- **Office of National Drug Control Policy (ONDCP):**  
Leads and coordinates the development, implementation, and assessment of U.S. drug policy.
- **Food and Drug Administration (FDA):**  
Regulates and approves controlled substances.
- **Department of Justice (DOJ):**
  - Bureau of Justice Assistance (BJA): Drug courts, Mental Health courts, and other programs targeting BH.
  - DOJ Civil Rights Division: Enforcement of THE Americans with Disabilities Act (ADA) and *Olmstead*.

# STATE ROLE IN THE BEHAVIORAL HEALTH CARE SYSTEM: DEPARTMENT OF MENTAL HEALTH

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## Massachusetts Department of Mental Health (DMH)

DMH is the federally designated State Mental Health Agency (SMHA) for Massachusetts. It serves several key functions in the state's BH care delivery system:

- Payer of last resort. Funds MH services for adults, adolescents, and children with SMI or SED who are uninsured or for whom services are not covered by insurance; serves as a complement to MassHealth.
- Operates four continuing care facilities and five community MH centers across the state.
- Regulates providers, treatment facilities, and other elements of the delivery system:
  - Establishes and monitors operational and program standards for community MH services.
  - Licenses all acute private and general hospitals with psychiatric units and Intensive Residential Treatment Programs (IRTPs) for adolescents.
  - Establishes policies to promote human rights and protect patients from mistreatment.
  - Monitors and supports MH training and research.

### DMH-Operated Facilities

- ▶ Continuing Care Facilities
  - Worcester Recovery Center
  - Taunton State Hospital
  - The Hathorne Units at Tewksbury State Hospital
  - Metro Boston MH Units at Lemuel Shattuck Hospital
- ▶ Community Mental Health Centers
  - Pocasset Mental Health Center
  - Brockton Multi-Service Center
  - Corrigan Mental Health Center
  - Solomon Carter Fuller Mental Health Center
  - Massachusetts Mental Health Center

# STATE ROLE IN THE BEHAVIORAL HEALTH CARE SYSTEM: DEPARTMENT OF MENTAL HEALTH

## Department of Mental Health (DMH)-Provided Services

### Adult

#### **Adult Community Clinical Services (ACCS) Program:**

- Respite Services
- Program of Assertive Community Treatment (PACT)
- Clubhouses
- Recovery Learning Communities (RLCs)
- DMH Case Management
- Homelessness Services

### Child, Youth, and Family

- Child/Adolescent Case Management
- Individual and Family Support Services
- Day Services
- Caring Together Services
- Clinically Intensive Residential Treatment (CIRT)
- Intensive Residential Treatment Programs (IRTPs)
- Parent and Family Support Services
- Transition Age Youth
- School and Community Therapeutic Support
- Juvenile Forensic Court Services
- Continuing Care Inpatient Services
- Massachusetts Child Psychiatry Access Program (MCPAP)

### ACCS Program

- ▶ Primary service for adults served by DMH who live in or are transitioning to the community.
- ▶ Replaced the Community-Based Flexible Supports (CBFS) program effective July 1, 2018, with the goal of promoting more integrated, coordinated care for individuals with serious mental illness to learn the skills to support full participation in the community.
- ▶ Model elements:
  - All patients assigned to a primary care clinician supported by an integrated care team that stays with individual across all settings;
  - Care teams may include SUD counselors and recovery coaches and must coordinate with a care management entity;
  - Standardized screening and assessment tools;
  - Standardized rate-setting methodology (contracts varied under CBFS);
  - Standardized approach to data collection and quality monitoring;
  - Data sharing with MassHealth.

# STATE ROLE IN THE BEHAVIORAL HEALTH CARE SYSTEM: DEPARTMENT OF PUBLIC HEALTH/ BUREAU OF SUBSTANCE ADDICTION SERVICES

## Massachusetts Department of Public Health (DPH)

DPH regulates, licenses, and provides oversight of a wide range of health care-related professions and services, and it operates programs to prevent disease and promote wellness. It houses the Bureau of Substance Addiction Services (BSAS), the federally designated Single State Agency (SSA) for SUD services responsible for overseeing and providing SUD prevention and treatment services.

### ***Bureau of Substance Addiction Services (BSAS):***

- Payer of last resort. Funds prevention, intervention, treatment, and recovery services, workforce programs, and other services for individuals who are insured or for whom services are not covered by insurance.
- Regulates SUD treatment providers and facilities:
  - Monitors and oversees prevention and treatment services.
  - Licenses outpatient, detoxification, and residential treatment programs and counselors.
  - Tracks SUD trends in the state.

### **Programs**

- ▶ SUD/ODU Prevention
  - Massachusetts Opioid Abuse Prevention Collaborative
  - Overdose Prevention and Naloxone Access Program
  - Prescription Drug Dropbox Program
  - Massachusetts Overdose Prevention Collaborative Grant Program
- ▶ Treatment and Recovery Services
  - Detoxification
  - Crisis stabilization
  - Enhanced Acute Treatment for Individuals with Co-occurring MH conditions and SUDs Short-term stabilization
  - Long-term residential rehabilitation
  - Family services
  - Youth intervention and treatment
  - Outpatient treatment (counseling / day treatment, opioid treatment services, medication-assisted treatment, and others)
  - Partial hospitalization
  - Recovery supports
  - Criminal justice interventions

## STATE ROLE IN THE BEHAVIORAL HEALTH CARE SYSTEM: OTHER ENTITIES

### DPH, Bureau of Hospitals

- Provides medical care to individuals for whom community facilities are not available or access to health care is restricted, at acute and chronic hospitals:
  - Lemuel Shattuck Hospital
  - Pappas Rehabilitation Hospital for Children
  - Tewksbury Hospital
  - Western Massachusetts Hospital
  - State Office of Pharmacy Services

### DPH, Bureau of Health Professions Licensure

- Oversees and supports the Drug Control Program and 10 boards of registration and certification in health professions, including for RNs, APRNs, and nurse practitioners.

### Office of Consumer Affairs and Business Regulation, Division of Professional Licensure

- Oversees 39 boards of registration that license and regulate more than 167 trades and professions.
- Behavioral Health Licensure:
  - Board of Registration of Allied Mental Health and Human Services Professions
  - Board of Certification of Community Health Workers
  - Board of Registration of Social Workers

### General Appropriations, Massachusetts DPH and DMH, SFY 2015–2019 (millions)

	2015	2016	2017	2018	2019
<b>Department of Public Health</b>	<b>\$537.7</b>	<b>\$533.3</b>	<b>\$596.0</b>	<b>\$609.0</b>	<b>\$641.8</b>
• Public Health Hospitals	\$148.3	\$154.5	\$155.3	\$155.4	\$158.3
• Bureau of Substance Addiction Services	\$91.3	\$90.4	\$125.7	\$132.6	\$141.9
• Other DPH	\$298.1	\$288.4	\$315.0	\$321.1	\$341.6
<b>Department of Mental Health</b>	<b>\$736.4</b>	<b>\$727.6</b>	<b>\$761.1</b>	<b>\$772.5</b>	<b>\$876.0</b>
• Adult Mental Health and Support Services	\$360.7	\$370.8	\$379.8	\$387.1	\$488.7
• Inpatient Facilities and Community-Based Mental Health	\$183.9	\$191.5	\$205.4	\$205.6	\$208.2
• Child and Adolescent Mental Health Services	\$87.6	\$80.4	\$88.7	\$91.7	\$92.9
• Department of Mental Health Administration and Operations	\$28.1	\$28.7	\$27.4	\$27.4	\$27.9
• Emergency Services and Mental Health Care	\$36.4	\$24.3	\$24.1	\$24.1	\$24.1
• Other DMH	\$39.7	\$31.9	\$35.8	\$36.6	\$34.2

Sources: <https://www.mass.gov/orgs/departments-of-public-health>; [http://budget.digital.mass.gov/bb/gaa/fy2019/app\\_19/dpt\\_19/hhdmh.htm](http://budget.digital.mass.gov/bb/gaa/fy2019/app_19/dpt_19/hhdmh.htm).





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