



January 28, 2020

The Honorable Cindy Friedman
Chair, Joint Committee on Health Care Financing
24 Beacon Street, Room 413-D
Boston, MA 02133

The Honorable Daniel Cullinane
Vice Chair, Joint Committee on Health Care Financing
24 Beacon Street, Room 236
Boston, MA 02133

RE: Testimony regarding H.4134, "An Act to improve health care by investing in VALUE"

Dear Chair Friedman, Vice Chair Cullinane, and Honorable Members of the Committee:

Thank you for the opportunity to offer testimony regarding Governor Baker's health care bill, H.4134, "An Act to improve health care by investing in VALUE." I am grateful to the Chair, Vice Chair, and honorable members of the Joint Committee for your leadership and dedication to strengthening the behavioral health of the people of the Commonwealth.

My name is Dr. Danna Mauch, and I am the President and CEO of the Massachusetts Association for Mental Health (MAMH). I am presenting this testimony on behalf of the Children's Mental Health Campaign (CMHC), a large statewide network that advocates for policy, systems and practice solutions to ensure all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way. The CMHC Executive Committee consists of six highly reputable partner organizations: The Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital, the Parent/Professional Advocacy League (PPAL), Health Care For All (HCFA), Health Law Advocates (HLA), and MAMH. The CMHC network includes more than 160 organizations across the Commonwealth, all unified in our commitment to safeguard the mental and emotional health and wellness of all children and adolescents in Massachusetts.

As such, we appreciate the opportunity to share testimony on how different provisions in H.4134 would affect the behavioral health and well-being of children and their families:

Thirty percent increase over three years on behavioral health and primary care spending

The CMHC strongly supports this proposed increase on behavioral health and primary care expenditures. Behavioral health services and supports represent too small a portion of total medical expenditure (TME) in the Commonwealth given the high prevalence of these conditions in the population, the high stakes of failing to address the onset of the vast majority of serious and disabling conditions between ages 14 and 24, and the serious impacts on individuals, families and communities in multiple chronic health conditions, poverty, homelessness and incarceration resulting from our neglect. According to the Substance Abuse and Mental Health Administration (SAMHSA), only a fraction of those needing treatment for an illicit substance use condition (13.0%) and any mental health condition (42.6%) receive treatment (SAMHSA, National Survey on Drug Use and Health, 2017). Given the limits in resources for and workforce challenges in behavioral healthcare, we routinely miss important opportunities with children, adolescents and their families to treat emerging conditions before clinical status and life functioning deteriorate to threaten healthy development.

In addition to timely treating emerging conditions, investing upstream in behavioral health and primary care can help prevent potentially avoidable and more costly acute, specialty, and emergency care. This rebalancing of TME, with judicious investments in gaps in specialty care, expansion of integrated behavioral health and primary care, and attention to inadequate reimbursement rates could simultaneously emphasize the importance of screening, early intervention, and address problems at their root cause. The proposed increase represents an important first step toward sufficient investment in a comprehensive health system that acknowledges and addresses the critical intersection between physical and behavioral health. The two are inextricably linked, and for too long the silos and fragmentation in our health care system have failed to address whole person health. The proposal to increase spending on behavioral health and primary care by 30% over three years is critical to reining in health care spending and advancing the health of the people of our Commonwealth. It has the CMHC's full and strongest support.

H.4134 is purposely vague on how this 30% increase will be achieved and measured, leaving room for consideration of the local contexts in which changes in health care resources distribution will be carried out. While some stakeholders are concerned about the level(s) at which the health care delivery system will be held accountable (e.g., individual practice, individual hospital, health system, ACO, etc.) to results, others are already articulating a path to rebalancing resource allocation in a way that addresses the defined increases in behavioral health and primary care spending with evidence-based practices designed to produce cost savings in chronic disease, emergency services and inpatient care management.

For those stakeholders or provider entities who require guidance to meet the 30% objective, there could be a framework established to outline approaches to addressing key questions. These might include: guiding principles for how the 30% increase in spending should be achieved; evidence-based practices in health promotion, prevention or integrated care instrumental in responsive rebalancing; or establishing interim spending parameters to ensure rebalancing aligns with the Legislature's and Administration's visions for systemic reform, that

is, a stronger community-based system that addresses access, integration, and whole person care.

No process undertaken, or guidance developed should delay the legitimate efforts of service delivery systems to promptly move forward on the 30% objective. However, for those needing definitive guidance, the CMHC recommends that these unanswered questions be addressed by bringing together the best thinking of the Legislature, Administration, and stakeholders across the behavioral health and primary care communities. Note that there is ample scientific evidence and practice transformation experience to inform deliberations. The CMHC recommends adding legislative language to create a Task Force to build consensus based on existing evidence, identify practice transformation technology to support the implementation of system rebalancing efforts, and set terms of evaluation of compliance with the 30% objective. The Task Force itself should build on existing structures in the Commonwealth, and its charge should be clear and time limited.

Sample legislative language for a Task Force follows for your consideration:

(a) Under the direction of the secretary of Health and Human Services, the health policy commission and center for health information and analysis shall establish a task force to develop parameters and principles for implementation of the aggregate primary care and behavioral health target.

(b) The task force shall consist of: the secretary of Health and Human Services or a designee, who shall serve as chair; the executive director of the health policy commission or a designee, the executive director of the center for health information and analysis or a designee; the senate chair of the joint committee on health care financing or a designee; the house chair of the joint committee on health care financing or a designee; and 11 members to be appointed by the two co-chairs, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of Massachusetts Association of Behavioral Health Systems, 1 of whom shall be a representative from the Association for Behavioral Healthcare, 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, 1 of whom shall be from a mental health advocacy organization, 1 of whom shall be from a health consumer advocacy organization, 1 of whom shall be a peer or individual with lived experience, 1 of whom shall be a family representative, and 1 of whom shall be from an employer group.

(c) The task force shall make recommendations on the guiding principles and practice specifications by which health care entities are required to meet the aggregate primary care and behavioral health expenditure. These may include, and are not limited to, the adoption and dissemination of evidence-based practices; person-centered and integrated whole person care delivery; non-medical supports such a recovery coaches and peer specialists in care transformation efforts; and emphasis on ambulatory and community-based services.

(d) The task force shall complete its work no later than 90 days after passage of this legislation.

Increasing access to integrated behavioral health and primary care

The CMHC recommends legislating three provisions to help ensure the widespread adoption of evidence-based primary care and behavioral health integration across the Commonwealth:

- 1) Children are getting left behind in health care delivery and financing efforts to integrate physical and behavioral health care. As total medical expenditures (TME) for children are generally less than TME for adults, there may be less incentive in the short term to transform care for our youth. However long-term benefits are proven for stronger health promotion, early identification and treatment, and effective intervention.

There are pockets of excellence in integrated behavioral health in pediatric primary care across the Commonwealth. The LAUNCH/MYCHILD integration model has been shown to result in statistically significant reductions in parental stress and depression symptoms, as well as improved child mental health and social emotional wellness. An Abt research team additionally used Medicaid data to compare health care expenditures for children enrolled in MYCHILD with a matched comparison group. Looking at all MassHealth costs over a 12-month period following the index date, MYCHILD costs were \$164.21 less per child per month versus children in the control group. This is \$1,970.52 saved per child per year. Likewise, children enrolled in MYCHILD were also more likely to receive appropriate, non-stigmatizing diagnoses.¹

There have been additional investments in early childhood mental health integration in pediatric primary care that have further contributed to a body of knowledge in this field. The Metrowest Health Foundation, for instance, supported the Southborough Medical Group in implementing pediatric integrated behavioral health care. Related, the Pediatric Physicians' Organization at Children's (PPOC) has successfully integrated mental health care throughout its practices. PPOC also received a grant from the Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation to integrate substance use services in pediatric primary care through a partnership with the Adolescent Substance Abuse Program (ASAP) at Children's; the Foundation secured John Snow, Inc. to analyze the impact of the model on access to care. The largest investment has come from the Klarman Foundation and the Richard and Susan Smith Family Foundation's TEAM UP for Children Initiative, which is supporting transformation to integrated pediatric primary care at three federally qualified health centers. The Klarman and Smith Family Foundations are partnering with the Robert Wood Johnson Foundation and Boston

¹ Mauch D. and Allen D. Use of Medicaid Data to Evaluation Effect of Integration of Early Childhood Mental Health into Pediatric Medical Homes through the Massachusetts Young Children's Interventions for Learning and Development (MYCHILD). (2015 November 4). Lecture presented at the American Public Health Association Annual Conference.

University on an evaluation of the initiative to assess real-time cost and quality outcomes.

The challenge is to bring these pockets of excellence to scale across all pediatric primary care practices in the Commonwealth. MAMH recommends the creation of a Center for Integrated Pediatric Practice Transformation for Massachusetts, modeled after the Advancing Integrated Mental Health Solutions (AIMS) Center in Washington State. Practice transformation is difficult, and many pediatric practices do not have the resources and supports they need to achieve full integration. A Center would provide practices with resources, tools, training, and consultation when needed to advance transformation in a way that is grounded in the evidence.

- 2) One of the key barriers to advancing behavioral health integration in pediatric primary care is the lack of certification standards and a cost reimbursement model for the Family Partner (FP) role. Integrated pediatric care models include both a mental health clinician and a Family Partner, or an adult experienced in navigating the health and social services systems for his/her own child, embedded in the primary care team. Behavioral health clinicians and Family Partners attend regular team meetings and case conferences, participate in daily huddles, receive children and families by way of warm hand offs from primary care clinicians, and are integral in the development of care plans. The goals are to promote healthy relationships between parents/caregivers and their children, prevent concerning behaviors and reduce stress on families, and identify behavioral health concerns early and make referrals for therapeutic intervention.

There are already a number of efforts underway in the Commonwealth to elevate the roles of non-clinical behavioral health staff on primary care teams. In addition to Family Partners, these roles include community health workers, recovery coaches, certified peer specialists, and older adult peer specialists. MAMH recommends that a central role or function be created within EOHHS to certify these non-clinician members of the care team and develop cost models for reimbursement so that they become sustainable. What's striking is that a lot of the training and competencies are similar across these different roles. We recommend a core training component across all non-clinical behavioral health staff with the ability to specialize by substance use and mental health (note the need to end the split and siloing of these competencies), older adults, children/families, etc. The result would be a more efficient (and less fractured) way to elevate these lay professionals. In the case of Family Partners, training, certification, and reimbursement for these staff are critical to the future success of care integration efforts.

- 3) The CMHC supports the provisions in H.4134 that prohibit payers from denying coverage or imposing additional costs for same-day behavioral health coverage. Passage of same-day billing provisions would support the widespread dissemination of integrated behavioral health and primary care in the Commonwealth. We strongly believe that children and their families should be able to access the behavioral health care they need, when they need it, and in the most appropriate settings.

Parity in reimbursement rates for behavioral health professionals

The CMHC supports administrative and regulatory actions to set fair reimbursement rates, at parity with other health care practices, and to reduce administrative burdens, again at parity with other health care practices. H.4134 does, for example, outline a requirement to do this for licensed mental health professionals delivering services in primary care settings. H.4134 would amend Section 8K of chapter 26 of the General Laws, directing the DOI commissioner to require insurance carriers to establish “similar rates of reimbursement for evaluation and management office visits whether the evaluation and management office visits were provided by primary care providers or licensed mental health professionals.”

The intent of the framers in the Governor’s Administration is that the reimbursement rates provided to licensed mental health clinicians track comparable rates for primary care practitioners at each of those practice levels. The Administration has referenced in its printed materials describing the bill a “rate floor” based on “in-network rates for comparable services.” For example, a licensed physician who specializes in the practice of psychiatry and provides office visits under evaluation and management codes is to be reimbursed in an amount like that provided to a physician who is a primary care practitioner. As of 2017, according to findings of the Milliman Study, Massachusetts psychiatrists were reimbursed at approximately 56% of the Medicare allowed rate provided to primary care practitioners for Office Visits – reimbursement paid for the same service to two different physician classes, ironically paying the longer trained specialist (psychiatrist) considerably less than the primary care practitioner.

Provisions on urgent care centers

The CMHC supports Sections 52A and 52B in H.4134, related to the licensing of urgent care clinics. Specifically, we applaud licensing provisions that would require coordination by urgent care centers with patients’ primary care providers and require application and participation (if approved) to participate as a MassHealth billing provider. We also support the promulgation of regulations that require behavioral health services in clinics licensed to provide medical, mental health, substance use, or urgent care services.

In recognition that this legislative effort is focused on freestanding urgent care centers, and that EOHHS is working on Ambulatory Care Redesign to address urgent care in the safety net, we offer these recommendations to further the provision of high-quality behavioral health services and protect the rights and dignity of people with behavioral health conditions. The CMHC recommends that some principles for these regulations be included in legislative language. We suggest these principles include, but not be limited to quality at the point of care, continuity of care, adherence to evidence-based practices, standards of human dignity, and compliance with the ADA.

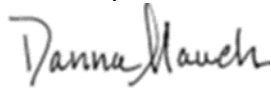
Sample legislative language follows for your consideration:

Section 52B. The department, in consultation with the department of mental health, shall promulgate regulations regarding provision of behavioral health care in clinics licensed pursuant to section 51 of chapter 111. Such regulations shall require clinics

licensed to provide medical, mental health, substance use, or urgent care services to provide or arrange for qualified behavioral health clinicians to evaluate and stabilize a person seeking care with a behavioral health presentation, and to refer such person for appropriate treatment in the community or inpatient admission, when necessary. Such regulations shall be constructed to advance quality at the point of behavioral health care delivery; ensure continuity of behavioral health care between clinics and patients' primary care or behavioral health providers; ensure adherence to evidence-based practices in behavioral health evaluation and stabilization; and, ensure services are delivered in a way that meet standards of human dignity and in compliance with the Americans with Disabilities Act (ADA).

Thank you, again, for your commitment to children's behavioral health. Please reach out to us with any questions. We are happy to further discuss any of these items.

Sincerely,

A handwritten signature in cursive script that reads "Danna Mauch".

Danna Mauch, PhD

President and CEO, Massachusetts Association for Mental Health (MAMH)

Executive Member, Children's Mental Health Campaign (CMHC)