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October 19, 2021

The Honorable Brendan P. Crighton
Chair, Joint Committee on Financial Services
Massachusetts State House, Room 520
Boston, MA 02133

The Honorable James M. Murphy
Chair, Joint Committee on Financial Services
Massachusetts State House, Room 254
Boston, MA 02133

Submitted online via *MyLegislature*

Dear Chair Crighton, Chair Murphy, and Honorable Members of the Committee:

RE: In Support of H.1040/S.672: *An Act to Require Health Care Coverage for Emergency Psychiatric Services*

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for the opportunity to submit testimony today. H. 1040/S.672: *An Act to Require Health Care Coverage for Emergency Psychiatric Services* would help ensure critical protections and advance access to crisis services for people with behavioral health conditions and their families.

Formed over a century ago, MAMH is dedicated to promoting mental health and well being, while preventing behavioral health conditions and associated disability. We are committed to advancing prevention, early intervention, effective treatment, and research for people of all ages. We seek to eliminate stigma and discrimination and advance full inclusion in all aspects of community life. This includes discrimination affecting not only people with behavioral health conditions, but also people who face unequal burdens and barriers to the protections and benefits of citizenship due to their race, ethnicity, gender identity, or disability status. MAMH has a demonstrated track record of furthering its mission by convening stakeholders across the behavioral health and public health communities; disseminating emerging knowledge; and

providing subject matter expertise to inform public policy, service delivery, and payment methodologies.

MAMH is grateful for Representative Balser's and Senator Friedman's leadership in filing *An Act to Require Health Care Coverage for Emergency Psychiatric Services,* which requires the Group Insurance Commission and commercial insurers to coverage medically necessary emergency behavioral health service programs on a non-discriminatory basis. These emergency services are delivered by Emergency Service Providers (ESPs) through mobile teams of clinicians that serve individuals in crisis in community settings. This program offers a cost-effective alternative to hospital emergency departments (EDs). The goal is to deliver high quality, culturally competent, integrated community-based behavioral health crisis assessment, intervention, and stabilization services that promote resiliency, rehabilitation, and recovery.

Currently, coverage of emergency services varies widely in Massachusetts by payor type. As illuminated in the January 2019 BCBSMA Foundation report, MassHealth and some commercial plans (i.e., Aetna Health Inc., BCBSMA HMO Blue Inc., Health New England Inc., Minuteman Health Inc., Harvard Pilgrim Health Care Inc., and ConnectiCare of Massachusetts Inc.) cover emergency services in full, while other carriers provide partial or no coverage.[1]

Clearly, people with all types of insurance experience behavioral health emergencies. Carriers, therefore, should not be permitted to deny access to these critical services. Yet, the current refusal of some carriers to cover ESPs may result in members experiencing a behavioral health crisis not receiving services, with potentially life-threatening consequences. Carrier refusal to cover ESP could alternatively result in members receiving care than isn't optimal for someone in a behavioral health crisis. For example, members may face extended stays in a hospital ED waiting for appropriate services.

This bill is essential because it will break the troubling pattern of people relying on EDs to address behavioral health emergencies. Each year, more and more people turn to EDs in times of crisis and, once there, they face mounting difficulties. The Massachusetts Health and Hospital Association recently reported that as of October 4, 2021, 716 people in need of behavioral health care were awaiting psychiatric evaluation and boarding in Massachusetts EDs in the previous week.[2]

[1] BCBSMA Foundation and Manatt. The Massachusetts Behavioral Health Care System: Strengths, Gaps, and Opportunities for Improvement. January 2019, https://www.bluecrossmafoundation.org/publication/ready-reform-behavioral-health-care-massachusetts.

[2] https://mhalink.informz.net/mhalink/data/images/21-10-08BHreportNEW.pdf at 2.

This most recent report is just the latest data in a clear and alarming trend of increasing numbers of people boarding in Massachusetts EDs. Data from the Massachusetts College of Emergency Physicians (MACEP), which conducts a biannual point-in-time survey, shows that on July 19, 2021, with 75% of hospitals responding, there were 282 people boarding in hospital EDs across the state while awaiting inpatient beds for behavioral health care. (The total number surely would be substantially higher, if the last 25% of facilities were to respond to the survey.) These patients each boarded for 60 hours on average. This compared to 244 people boarding just six months earlier, for an average of 45 hours each. Likewise, the total number of hours psychiatric patients boarded in EDs as of July 2021 was 15,307, the highest ever recorded and nearly 1 ½ times higher than the total six months earlier (10,527), which itself had set a record for highest total hours.[3] In February 2021, EOHHS also reported that ED boarding for psychiatric beds had increased since June 2020 by 200-400% over the previous year, based on Department of Mental Health (DMH) data.[4]

The financial costs of inpatient stays are overwhelming. The total hospital costs in Massachusetts for hospitalizations for serious mental illness exceeded $290 million in 2014.[5]

Not only does failure of carriers to cover ESPs mean that more people end up in EDs, it also places financial pressure on "existing programs to operate at or near capacity at all times" in order to compensate for the high number of behavioral health patients.[6] This dynamic – both the high numbers of people in mental health crisis in EDs and the need to accept others -- strains the resources of our EDs and hospitals for all patients.

Yet, the predicament we face makes no sense. SAMHSA recently noted that crisis services provided outside of hospitals not only provide better outcomes, but they also save money:

> For mental health crisis response, we can see the impact of comprehensive approaches in lives saved from suicide and people cared for effectively and more efficiently via mobile crisis visits or brief respite stays that might cost $300 per day versus inpatient rates of $1,000 per day. This approach better connects the individual to his or her community while minimizing disruption in the person's

[3] MACEP, Point in Time Data Collection Summary (July 2021), https://us02web.zoom.us/j/83809853537?pwd=eTF5amxnMG0wcW1XRGxJQ3JHTWFBQT09; https://www.wbur.org/news/2021/02/02/emergency-department-er-inpatient-beds-boarding; see also https://commonwealthmagazine.org/health-care/lack-of-mental-health-beds-means-long-er-waits/.
[4] https://www.wbur.org/news/2021/02/02/emergency-department-er-inpatient-beds-boarding
[5] Heun-Johnson, Hanke et al., USC Schaeffer, THE COST OF MENTAL ILLNESS: MASSACHUSETTS FACTS AND FIGURES (2019), https://healthpolicy.usc.edu/wp-content/uploads/2019/05/MA-Chartbook-v3-2019.pdf at 26.
[6] Ibid.

community connections.[7]

Expanding ESPs would be one important step to pursuing such cost savings.

There is another reason as well to expand coverage of ESPs at this time. As you know, the Commonwealth is embarking on the process of reimagining community mental health through its Roadmap for Behavioral Health Reform. This effort will involve a range of changes to improve access to timely community-based behavioral health and substance use treatment. Among the reforms is more convenient community-based alternatives to the ED for urgent and crisis intervention services, including at Community Behavioral Health Centers (CBHCs) and other community provider locations and a stronger system of 24/7 community and mobile crisis intervention. To effectuate these changes, the state is investing heavily in publicly-funded services. Beyond these public sector expenditures, the success of this critical statewide effort depends on commercial insurers also committing to and investing in the proposed reforms. One of the services that must be provided by commercial insurers for the Roadmap to succeed is emergency services in the form of mobile crisis teams.

There is a final reason to act quickly to ensure ESPs are covered by all payors. The Commonwealth will soon be undertaking efforts to implement the National Suicide Hotline Designation Act of 2020, which establishes a 988 hotline for suicide prevention and behavioral health crisis intervention, set to take effect in July 2022. The hotline will connect callers to a range of services, including emergency crisis services. The federal government has already designated funding to support and expand of mobile crisis response teams and crisis intervention. Legislation is pending at the state level to support 988 implementation and establish a sustainable funding mechanism for the 988 crisis response system. This system will require robust ESP services, fully funded by all insurers. It is therefore particularly essential that the ESP legislation is enacted in advance of 988 implementation.

For all these reasons, we urge you to take swift action to favorably report these bills out of committee.

Thank you for your consideration.

Sincerely,

Danna Mauch, PhD
President and CEO

[7] SAMHSA, Crisis Services: Meeting Needs, Saving Lives (2020), https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-08-01-001%20PDF.pdf at 37.