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July 27, 2021

The Honorable Brendan Crighton  
Chair, Joint Committee on Financial Services  
24 Beacon Street, Room 520  
Boston, MA 02133

The Honorable James Murphy  
Chair, Joint Committee on Financial Services  
24 Beacon Street, Room 254  
Boston, MA 02133

**RE: Testimony in support of H.1062/S.646, *An Act for supportive care for serious mental illness*;  
S.645, *An Act for medical necessity fairness*;  
S.675 *An Act relative to mental health parity implementation*;  
H.1057, *An Act relative to collaborative care*; and  
H.1039/S.636, *An Act providing continuity of care for mental health treatment***

Dear Chair Crighton, Chair Murphy, and Honorable Members of the Joint Committee on Financial Services:

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for strong and steadfast leadership in advancing the health of people with behavioral health conditions and their families across the Commonwealth. I am writing to respectfully submit this testimony in support of H.1062/S.646, *An Act for supportive care for serious mental illness*; S.645, *An Act for medical necessity fairness*; S. 675 *An Act relative to mental health parity implementation*; H.1057, *An Act relative to collaborative care*; and H.1039/S.636, *An Act providing continuity of care for mental health treatment*. Together, these bills protect people with behavioral health conditions from discriminatory treatment and ensure access to critical services and supports.

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.

**H.1062/S.646, *An Act for supportive care for serious mental illness* (Rep. Decker, Sen. Cronin)**

Assertive Community Treatment (ACT) is “a multidisciplinary service team approach to providing intensive, community-based, and recovery-oriented psychiatric treatment, assertive outreach, rehabilitation, and support to

individuals with severe and disabling mental health conditions... The ACT team is the single point of clinical responsibility and assumes accountability for assisting individuals in getting their needs met while achieving their goals for recovery. The PACT team provides all clinical nonacute behavioral health and substance use disorder interventions in addition to linking individuals to community-based self-help resources and providing direct rehabilitation, vocational, and housing-related services. Services are delivered in the individual's natural environment and are available on a 24-hour, seven-day-a-week basis. Services are comprehensive and highly individualized. They are modified as needed through an ongoing assessment and treatment planning process."<sup>i</sup> Services are intensive, vary based on the needs of the individuals served, and follow national Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines."<sup>ii</sup> The evidence for ACT demonstrates that the program is economical – reduced inpatient hospitalization days and emergency room visits – and yield other positive outcomes for the individuals including increased housing stability, improved quality of life, fewer symptoms, increased social functioning, and higher individual and family satisfaction."<sup>iii</sup>

I (Danna Mauch, PhD) submit this testimony on the effectiveness of ACT services, and ACT's utility as the underpinning of Coordinated Specialty Care, as a former state mental health authority (SMHA) division director in Massachusetts and Rhode Island, where I implemented ACT statewide as the core service to effectively treat and support recovery of adults with disabling behavioral health conditions. As CEO of Magellan Public Solutions, I had the further opportunity to implement ACT services for Medicaid members in multiple states across the country. I can attest that not only is the service grounded in scientific evidence, but it is feasible to implement on a broadscale basis, and it is successful for the individuals engaged in the team based services.

"Coordinated Specialty Care (CSC) is a recovery-oriented treatment program for people with first episode psychosis (FEP). CSC promotes shared decision making and uses a team of specialists who work with the individual to create a personal treatment plan. The specialists offer psychotherapy, medication management geared to individuals with FEP, family education and support, case management, and work or education support, depending on the individual's needs and preferences. The individual and the team work together to make treatment decisions, involving family members as much as possible. The goal is to link the individual with a CSC team as soon as possible after psychotic symptoms begin."<sup>iv</sup> Like ACT, the evidence for CSC is also strong. Studies have shown improvements in scores for symptoms, occupational functioning, and social functioning scales of the Global Assessment of Functioning (GAF), increased education and employment rates, and decreased hospitalization."<sup>v</sup>

Onset of psychotic conditions including schizophrenia typically occurs between 15-25 years of age. These conditions can "derail a young person's social, academic, and vocational development and initiate a trajectory of accumulating disability." However, early intervention with evidence-based therapies such as CSC and ACT can and do make a difference. The Recovery After Initial Schizophrenia Episode (RAISE) research project of the National Institute of Mental Health (NIMH) reports these programs "offer real hope for clinical and functional recovery."<sup>vi</sup>

Unfortunately, these services are extremely difficult to access in the Commonwealth. There are private pay programs in Massachusetts, but they are exorbitant in price and well out of reach for most families. Families can also access publicly-funded ACT and CSC programs. First, one must apply for and be accepted as a client of the MA Department of Mental Health (DMH). The Department must then authorize ACT or CSC services for the individual based on clinical need and service availability or capacity. The Commonwealth should not stand alone in bearing responsibility for providing effective treatment and rehabilitative benefits to our residents in need.

H.1062/S.646, *An Act for supportive care for serious mental illness*, will require private insurance carriers and Group Insurance Commission (GIC) plans to cover ACT and CSC services. At its core, this is a parity issue. Individuals with severe and potentially disabling physical health conditions – like certain types of cancer – would receive cancer treatment services covered by private carriers. It is discriminatory that individuals with severe and potentially disabling behavioral health conditions do not receive the same coverage and access for the services they need. Not only would H.1062/S.646 help to balance public and private resources that are spent on ACT and

CSC, but these bills would help individuals with some of the greatest behavioral health needs get timely, evidence-based, and therapeutic clinical care and related social supports.

### **S.645, *An Act for medical necessity fairness* (Sen. Cronin)**

The impetus for S.645, *An Act for medical necessity fairness*, stems from the landmark *Wit v. United Behavioral Health* class action lawsuit from 2019. Essentially, the court ruled that United Behavioral Health – the largest managed behavioral health care company in the United States – used internally developed coverage determination guidelines and level of care guidelines to deny care for its members, and that these criteria were more restrictive than generally accepted standards of care for behavioral health conditions.<sup>vii</sup>

MAMH took the first parity action on behalf of residents of the Commonwealth in the 1980s, in suing a private insurer to guarantee a minimum outpatient mental health treatment benefit. MAMH continued the fight for parity in leading advocates in working with the Legislature and Administration for passage of the 2000 and 2008 parity bills. Despite these efforts, and the federal parity laws of 2008 and 2010, full implementation has proven elusive and state action is demanded.

To reiterate, even though mental health parity laws have been passed at both the federal and state levels, they have not been fully implemented and disparities in coverage between behavioral health and medical care persist. S.645, *An Act for medical necessity fairness*, would put the intent of the *Wit v. United Behavioral Health* decision into statute to protect the individuals with behavioral health conditions in Massachusetts from similar discrimination.

S.645, *An Act for medical necessity fairness*, requires private insurance carriers, MassHealth, and Group Health Insurance (GIC) plans to follow existing, established independent guidelines for determining medical necessity of behavioral health care, where they exist. For example, the bill requires medical necessity and utilization management determinations for substance use and co-occurring substance use and mental health treatment to be made in accordance with the criteria and guidelines established by the American Society of Addiction Medicine (ASAM) or by current criteria and practice guidelines developed by a comparable nonprofit professional association for the relevant clinical specialty of addiction medicine.

When existing, established independent guidelines do not exist, S.645 requires private carriers, MassHealth, and GIC plans to create guidelines that: 1) account for different treatment approaches for different age groups, like children and adolescents; 2) aim to treat the underlying condition, and not just acute or short-term symptoms; 3) follow "generally accepted standards of behavioral health condition care;" and 4) require that if a lower level of care is not available, the next highest level of care should be approved. The bill also prohibits carriers from limiting benefits or coverage for treatments that do not 'cure' behavioral health conditions. Some behavioral health conditions are chronic in nature and have not outright 'cure,' yet individuals can and do achieve recovery. I must point out that no one would accept the suggestion that the inability to cure Diabetes or Cancer would invalidate insurance coverage for those conditions.

The bill also attempts to level the playing field for individuals who are forced to go to court to challenge a denial or decision by a private carrier or a GIC plan by requiring the court to review the case 'de novo,' that is, without any initial presumption that the plan was correct. Finally, it allows the Division of Insurance (DOI), MassHealth, and the GIC to assess civil penalties of \$5,000 for violations, up to \$10,000 for willful violations, plus repayment of individual costs caused by a violation, such as an individual seeking care on a cash basis after a denial based on a violation of medical necessity criteria requirements.

In the words of Patrick Kennedy and Jim Ramstad, former U.S. Representatives and mental health advocates, "What this case (the *Wit v. United Behavioral Health*) really boils down to is discrimination and the perpetuation

of a separate and unequal system of care that would never be tolerated for the treatment of cancer or heart disease.”<sup>viii</sup> S.645, *An Act for medical necessity fairness*, will help protect the people of Massachusetts from similar injustices and will help ensure people with behavioral health conditions can access the care they need.

### **S.675, *An Act relative to mental health parity implementation* (Sen. Friedman)**

Parity is the law and justice is overdue for people who need behavioral health services. Despite passage of parity legislation at both the state and federal levels, coverage and access to mental health and substance use services remain more restrictive than coverage and access to physical health services. In November 2019, a landmark 2017 Milliman Research Report was replicated and again found nonquantitative treatment limitations (NQTLs) as a “key trouble area” in the enforcement of parity statutes. The study specifically identified disparities in both out-of-network utilization patterns and reimbursement rates (proxies for network adequacy and provider fee level NQTLs) for behavioral health providers in comparison to medical/surgical providers. Both national and Massachusetts state-level data reveal disparities and concerns related to NQTLs compliance.<sup>ix</sup> In fact, the 2019 study found widening disparities in network use (insured people being forced to go out of network to find available practitioners) and in provider reimbursement (behavioral health provider reimbursement was found to be even lower compared to their professional peers paid for physical health treatments).<sup>x</sup>

Similarly, in 2018 The Kennedy Forum released a technical paper assessing the relative strength of state parity laws in ensuring to effective parity enforcement. The Satcher Health Leadership Institute at the Morehouse School of Medicine and The Kennedy Forum developed a Statutory Coding Instrument (SCI) that evaluated state laws across 10 dimensions, including coverage of mental health and substance use services, requirements for NQTLs, state agency enforcement and reporting, etc. Massachusetts scored a 61 out of a total of 100 points, earning a grade “D.” Fifteen states currently score better than our Commonwealth, including Alabama, Kentucky, and Texas.<sup>xi</sup> We know we can do better, and S.675 helps us do just that.

The Massachusetts Office of the Attorney General has also taken legal action for violations in the Commonwealth. In December 2018, Aetna Health Insurance Company and two affiliated companies reached an agreement with the Attorney General’s Office to help members access mental health and substance use services. Part of the agreement requires Aetna to disclose to its members that it does not require prior authorizations for routine behavioral health visits, and to disclose to its members any circumstances where it does require prior authorizations for any behavioral health services. The ruling helps ensure transparency and addresses once discriminatory barriers for people with behavioral health conditions and their families.<sup>xii</sup>

In February 2020, the Massachusetts Attorney General reached settlements with Harvard Pilgrim Health Care and United Behavioral Health d/b/a Optum; Fallon Community Health Plan and Beacon Health Strategies; AllWays Health Partners; Blue Cross Blue Shield of Massachusetts; and Tufts Health Plan for violations of the Mental Health Parity and Addiction Equity Act. The settlements include a range of assurances that the companies will improve access to behavioral health care, including changing how they determine reimbursement rates for outpatient behavioral health services; limiting prior authorization requirements; and making extensive changes to improve the accuracy of their provider directories.<sup>xiii</sup> In addition, the companies paid \$1 million to a fund to expand programs to prevent substance use conditions and increase access to behavioral health services.

While MAMH applauds steps taken to address provider directory gaps (including ghost networks), selected provider reimbursement rate improvements, and some elimination of discriminatory prior approvals, the job is not finished, and parity needs to become not only the law but the reliable reality. Residents of the Commonwealth need fair, reliable, and usable insurance benefits to protect and treat their mental health and behavioral health needs, just as they now enjoy for all other health conditions.

MAMH strongly supports S.675, *An Act relative to mental health parity implementation*, as it will create more

equitable access to behavioral health care by improving parity enforcement through enhanced carrier self-reporting; addressing barriers such as onerous approval processes; applying parity across payers, including the Group Insurance Commission; ensuring compliance through regular market conduct examinations; enhancing opportunities and resources for individuals and families to assert parity rights; and establishing network adequacy standards and requiring parity of reimbursement rates between behavioral health and medical providers.

MAMH is proud to stand with Children's Mental Health Campaign in support of S.675. This broad-based support points to the timeliness and urgency of this bill and the critical need it addresses in our Commonwealth.

### **H.1057, *An Act relative to collaborative care***

Since the development of the Collaborative Care Model (CoCM) in the 1990s, more than "90 randomized controlled trials and several meta-analyses have shown the model to be more effective than usual care for patients with depression, anxiety, and other behavioral health conditions. CoCM is also shown to be highly effective in treating co-morbid mental health and physical conditions such as cancer, diabetes, and HIV."<sup>xiv</sup> The model has also been shown to have strong economic benefits. Systematic reviews reveal cost savings due to reduced health care utilization, enhanced productivity, and even lower outpatient health services costs.<sup>xv, xvi, xvii</sup> In a book chapter I (Danna Mauch, PhD) co-authored on the subject, which was based on a systematic review of safety net health system implementation sites for integration of behavioral health in primary care or specialty care, we found well established evidence for the feasibility, affordability, and effectiveness of integrated and collaborative care.<sup>xviii</sup>

There is also significant data on the effectiveness of the Collaborate Care Model here in Massachusetts. In my former role as Senior Fellow/Principal Associate at Abt Associates, I (Danna Mauch, PhD) led an evaluation MYCHILD; likewise, the Institute for Urban Health Research at Northeastern University led an evaluation of LAUNCH. LAUNCH/MYCHILD is an evidence-based model of early childhood mental health (ECMH) integration in pediatric primary care. The model includes 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. The behavioral health clinician and family partner 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 of the model 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.

As measured by evidence-based tools, LAUNCH/MYCHILD resulted in statistically significant reductions in parental stress and depression symptoms, as well as improved child mental health and social emotional wellness. The 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. Likewise, children enrolled in MYCHILD were also more likely to receive appropriate, non-stigmatizing diagnoses.<sup>xix</sup>

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. The result was improved access to behavioral health services (both timeliness of care and engagement in care). Southborough was also able to address language and cultural barriers to care and document improved communication between families and providers.

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 misuse services in pediatric primary care through a partnership with the Adolescent Substance Abuse Program (ASAP) at Children's; the Foundation has secured John Snow, Inc. to analyze the impact of the model on access to care. Furthermore, the Richard and Susan Smith Family Foundation's TEAM UP for Children Initiative is supporting transformation to integrated pediatric primary care at seven federally qualified health centers. The Smith Family Foundation is partnering with the Robert Wood Johnson Foundation and Boston University on an evaluation of the initiative to assess real-time cost and quality outcomes.

Despite the evidence base for the Collaborative Care Model and pockets of innovation here in Massachusetts, integrated behavioral health care is far from universal. In 2015, the Blue Cross Blue Shield of Massachusetts (BCSBMA) Foundation commissioned Bailit Health Purchasing, LLC, to conduct a thorough review of reports and other secondary sources, agency regulations and checklists, as well as key informant interviews and a focus group. The report, "Barriers to Behavioral and Physical Health Integration in Massachusetts," summarizes key issues and opportunities to facilitate the integration of physical and behavioral health care.<sup>xx</sup> One of these barriers is inadequate reimbursement for the core service delivery elements of the Collaborative Care Model.

H.1057, *An Act relative to collaborative care*, requires private insurance carriers to reimburse providers for the following current procedural terminology (CPT) billing codes established by the American Medical Association (AMA): 99492 (initial psychiatric collaborative care management, first 70 minutes in first calendar month); 99493 (subsequent psychiatric collaborative care management, first 60 minutes in subsequent month); and 99494 (Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month). In calendar year 2018, Medicare began making payments for integrated care to providers using these CPT codes.<sup>xxi</sup>

As part of the EOHHS Roadmap to Behavioral Health Reform, and in anticipation of MassHealth's upcoming 1115 demonstration extension, effective July 1, 2021, MassHealth also began to paying physicians for integrated behavioral health services using CPT code 99484. MassHealth reimburses physicians for integrated care provided to MassHealth members under CPT code 99484 when that service is rendered by a non-physician mental health professional employed or supervised by the physician, such as a social worker.<sup>xxii</sup>

H.1057, *An Act relative to collaborative care*, essentially requires private carriers to follow suit. This bill is important in that it prevents the public system from carrying the burden of paying for Collaborative Care. Likewise, for the many providers that contract with both public and private payers, ensuring that all payers are reimbursing for integrated care services will help spur and sustain transformation in health care delivery.

**H.1039/S.636, *An Act providing continuity of care for mental health treatment* (Rep. Balsler, Sen. Comerford)**

There are many reasons why mental health providers may elect to stop accepting a particular insurance carrier. When this occurs, individuals with behavioral health conditions are adversely impacted if the therapeutic alliance they have with their mental provider becomes severed. The literature not only demonstrates the importance of a strong alliance between the provider and individual on positive therapeutic outcomes but suggests that "quality of the alliance is more predictive of positive outcomes than the type of intervention."<sup>xxiii</sup>

H.1039/S.636, *An Act providing continuity of care for mental health treatment* (Rep. Balsler, Sen. Comerford), would allow an individual who is engaged in a course of treatment with a mental health provider, who is either voluntarily or involuntarily disenrolled from a health plan (for reasons other than quality or fraud), to continue receiving treatment from that mental health provider through an out-of-network option. The bill acknowledges that the individual may pay a higher co-payment for the out-of-network option but does offer the individual financial protection by prohibiting carriers from requiring additional charges, costs, or deductibles.

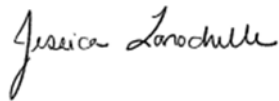
Mental health treatment is too often disrupted due to churn in the insurance market. Carriers already have structures in place for covering out-of-network services. The nature of mental health treatment and the importance of the therapeutic alliance calls for continuity to be more firmly established and protected.

Please do not hesitate to be in contact should you have questions, would like additional information, or if MAMH can serve as a resource to your critical work at [dannamauch@mamh.org](mailto:dannamauch@mamh.org) and [jessicalarochelle@mamh.org](mailto:jessicalarochelle@mamh.org). We urge you to report H.1062/S.646, *An Act for supportive care for serious mental illness*; S.645, *An Act for medical necessity fairness*; S. 675 *An Act relative to mental health parity implementation*; H.1057, *An Act relative to collaborative care*; and H.1039/S.636, *An Act providing continuity of care for mental health treatment* favorably out of committee. Thank you.

Sincerely,



Danna Mauch, PhD  
President and CEO



Jessica Larochelle, MPH  
Director for Public Policy and Government Relations

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<sup>i</sup> Massachusetts Behavioral Health Partnership. *Medical Necessity Criteria: Program of Assertive Community Treatment*. Last review 2 September 2020. Retrieved from: <https://www.masspartnership.com/pdf/MNC-PACT.pdf>

<sup>ii</sup> Substance Abuse and Mental Health Services Administration. *Assertive Community Treatment Evidence-Based Practices Kit*. DHHS Pub. No. SMA-08-4345, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.

<sup>iii</sup> McLaughlin, J. J. (2013). Assertive community treatment: An evidence-based practice and its continuing evolution. In J. Rosenberg & S. J. Rosenberg (Eds.), *Community mental health: Challenges for the 21st century* (pp. 197–214). Routledge/Taylor & Francis Group.

<sup>iv</sup> National Institute of Mental Health. What is Coordinated Specialty Care (CSC)? Retrieved 22 July 2021 at:

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-coordinated-specialty-care-csc>

<sup>v</sup> Nossel I, Wall M, et. al. Results of a Coordinated Specialty Care Program for Early Psychosis and Predictors of Outcomes. *Psychiatric Services*, 15 May 2018.

<sup>vi</sup> Recovery After Initial Schizophrenia Episode (RAISE) research project of the National Institute of Mental Health (NIMH). *Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care*. Retrieved 22 February 2021 at:

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/evidence-based-treatments-for-first-episode-psychosis-components-of-coordinated-specialty-care>

<sup>vii</sup> United States District Court, Northern District of California. *David Wit, et al., Plaintiffs, v. United Behavioral Health, Defendant*. Case No. 14-cv-02346-JCS. Filed 3 November 2020. Available at:

<https://storage.courtlistener.com/recap/gov.uscourts.cand.277588/gov.uscourts.cand.277588.491.0.pdf>

<sup>viii</sup> Kennedy P and Ramstad J. *Landmark Ruling Sets Precedent for Parity Coverage of Mental Health and Addiction Treatment*. 18 March 2019. STAT. Available at: <https://www.statnews.com/2019/03/18/landmark-ruling-mental-health-addiction-treatment/>

<sup>ix</sup> Melek SP, Perlman D, Davenport S. *Milliman Research Report: Addiction and Mental Health vs. Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates*. Commissioned by Mental Health Treatment and Research Institute, LLC, a nonprofit subsidiary of The Bowman Family Foundation, December 2017.

<sup>x</sup> Melek SP, Davenport S, Gray TJ. *Milliman Research Report: Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement Rates*. Commissioned by Mental Health Treatment and Research Institute, LLC, a nonprofit subsidiary of The Bowman Family Foundation, November 2019.

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- <sup>xii</sup> Office of Attorney General Maura Healey. *Press Release: Aetna Agrees to Make Substantial Improvements to Behavioral Health Care Access*. 12 December 2018.
- <sup>xiii</sup> Office of Attorney General Maura Healey. *Press Release: AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More Than One Million Residents*. 27 February 2020.
- <sup>xiv</sup> AIMS Center for Advancing Integrated Mental Health Solutions, University of Washington, Psychiatry and Behavioral Sciences. *Evidence Base for Collaborative Care Model*. Retrieved 22 July 2021 at: <https://aims.uw.edu/collaborative-care/evidence-base-cocm>.
- <sup>xv</sup> Jacob V, Chattopadhyay SK, Sipe TA, et al. *Economics of Collaborative Care for management of depressive disorders: a community guide systematic review*. *Am J Prev Med*. 2012;42:539-549.
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- <sup>xvii</sup> Simon GE, Katon W, Lin EHB, et al. *Cost-effectiveness of systematic depression treatment among people with diabetes mellitus*. *Arch Gen Psychiatry*. 2007;64:65-72.
- <sup>xviii</sup> Mauch D. and Bartlett J. *Systems of Care Integration Initiatives in FQHCs and CMHCs* in *Essentials of Integrated Care: Connecting Systems of Care, Clinical Practice and Evidence-based Approaches*; Editors Talen and Valeras; **Springer** Science + Business Media, June 2013
- <sup>xix</sup> 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.
- <sup>xx</sup> Bailit Health Purchasing, LLC. *Barriers to Behavioral and Physical Health Integration in Massachusetts*. (2015 June). Commissioned by the Blue Cross Blue Shield of Massachusetts Foundation.
- <sup>xxi</sup> Medicare Learning Network, CMS. *Behavioral Health Integration Services*. March 2021. Available at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>
- <sup>xxii</sup> Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. *MassHealth Physician Bulletin 103. July 2021*. Available at: <https://www.mass.gov/doc/physician-bulletin-103-integrated-behavioral-health-service-code-description-and-billing-requirements-0/download>
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