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June 2, 2025

The Honorable John Lawn
Chair, Joint Committee on Health Care Financing
24 Beacon Street, Room 236
Boston, MA 02133

The Honorable Cindy Friedman
Chair, Joint Committee on Health Care Financing
24 Beacon Street, Room 313
Boston, MA 02133

RE: Testimony in support of S.867, *An Act relative to primary care for you* (Sen. Friedman); H.1370, *An Act relative to Massachusetts primary care for you* (Rep. Haggerty); and H.1396/S.874, *An Act strengthening mental health centers* (Rep. O'Day/Sen. Keenan)

Dear Chair Lawn, Chair Friedman, and Honorable Members of the Joint Committee on Health Care Financing:

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. We are writing to respectfully submit this testimony in support of S.867, *An Act relative to primary care for you* (Sen. Friedman); H.1370, *An Act relative to Massachusetts primary care for you* (Rep. Haggerty); and H.1396/S.874, *An Act strengthening mental health centers* (Rep. O'Day/Sen. Keenan). Together, these bills help people with behavioral health conditions access the care and support they need to protect and promote their overall health and wellness.

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 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.

S.867, *An Act relative to primary care for you* (Sen. Friedman)

Increased investment in primary care and integrated behavioral health in primary care

Primary care services -- like behavioral health services -- have long been underfunded, which has resulted in limited capacity in care settings, wait lists, and low reimbursement rates.[i] The low reimbursement rates in turn drive low salaries and underfunding of expenses in provider programs, financial losses for providers offering

significant volume of primary care services, and problems in recruitment and retention of qualified staff.

Failure to provide both primary care and behavioral health services when and where they are needed leads to preventable symptoms and conditions, increased demand for intensive treatment, and associated higher costs of care. In the most tragic cases, delays in access to needed care led to preventable deaths. Investing in a health care system that ensures timely access to appropriate care can prevent these adverse outcomes and improve the well being of individuals and families.

Section 6 of S.867, *An Act relative to primary care for you*, requires the Massachusetts Health Policy Commission (HPC) to establish an aggregate primary care expenditure target, which is set to increase as a percentage of total health care expenditures as follows: 8% for 2027, 10% for 2028, and 12% for 2029. From 2030 onwards, the HPC can recommend modifications to these targets, provided they do not fall below 12%. MAMH strongly supports these increases in primary care expenditures.

MAMH is particularly concerned about primary care because child and adolescent mental health conditions emerge early, when pediatric primary care clinicians routinely see young people. Opportunities for mental health promotion, prevention, early diagnosis, and intervention are significant to the long-term health and well being of children and youth and to mitigating unnecessary disability associated with late diagnosis and treatment. Fifty percent of all mental health conditions onset by age 14 and seventy-five percent onset by age twenty-four.[ii] Reaching children and families early is critical to optimizing opportunity over the life course, and the pediatric medical home is an effective point of entry for behavioral health as it is a non-stigmatized and trusted source of care.[iii] Increased investment in primary care offers more opportunity for screening for behavioral health and social service needs, as well as early identification of symptoms and conditions.

Primary care is similarly important for addressing mental health concerns across the lifespan. Data from the National Center for Health Statistics indicate that "20 percent of all visits to primary care physicians included at least one of the following mental health indicators: depression screening, counseling, a mental health diagnosis or reason for visit, psychotherapy, or provision of a psychotropic drug." The percentage of mental health-related visits to primary care physicians actually increased with age; approximately one-third of all primary care visits for adults aged 75 and over were related to mental health.[iv]

Integrating behavioral health capability in primary care settings is our best hope of closing the estimated 11-year gap between onset of behavioral health conditions and treatment for those conditions.[v] The gold standard for behavioral health integration in primary care settings is the Collaborative Care Model (CoCM). This model was developed at the University of Washington to treat common mental health conditions in medical settings like primary care. CoCM requires a team of providers. Trained primary care providers (PCPs) work with embedded behavioral health care managers (BHCM) to provide evidence-based psychosocial and/or medication treatments. The PCP and BHCM are supported by a psychiatric consultant with regular case consultation as needed. CoCM is effective; the model has now been tested in more than 90 randomized controlled trials (RCTs) in the US and abroad. It leads to significantly better clinical outcomes, greater patient and provider satisfaction, improved functioning, and reduces health care costs.[vi] Collaborative Care is literally a lifesaving method of integrating behavioral health in primary care, as demonstrated in several recent RCTs. This includes a study of approximately 250,000 Kaiser Permanente health plan members, where those enrolled in CoCM had a 25% reduction in suicides; a study at UPenn Medicine that found a 52% reduction in suicide risk; and a Concert Health study that documented a 56% reduction in suicide risk for patients enrolled in CoCM.[vii]

Work is happening at both federal and state levels to advance CoCM adoption. Here in Massachusetts, you and your colleagues in the Legislature led efforts to pass Chapter 177 of the Acts of 2022, a historic statute that requires carriers to provide reimbursement of mental health and substance use benefits delivered via CoCM using CPT billing codes. There are also pockets of excellence in CoCM adoption. Blue Cross Blue Shield of

Massachusetts (BCBSMA) pays enhanced rates for CoCM codes and the BCBSMA Foundation has awarded grants to promote CoCM. Mass General Brigham (MGB) also launched a CoCM initiative in October 2023 with 400 of its primary care practitioners. In the first three months after launch, MGH primary care practices enrolled 1,200 patients into CoCM with strong growth since in the numbers of enrolled patients.

Increased investment in primary care will help to foster early assessment, intervention, and lifesaving care across the lifespan, and support uptake of the Collaborative Care Model mentioned above by providing practices with more administrative and clinical resources to develop infrastructure, hire and train new staff, develop new workflows, and promote collaboration across multidisciplinary teams. Importantly, it will allow providers to care for the whole person as somatic symptoms (e.g., stomachaches and headaches) can sometimes mask or accompany mental health symptoms and conditions.

Increased investment in primary care and integrated behavioral health in primary care will achieve critical goals of the Commonwealth's healthcare system – improving equitable access to timely care and reaping the clinical, cost, and lifesaving benefits of integrated behavioral health and primary care.

Technical fix to the definition of "emergency services programs"

MAMH particularly supports Section 15 of S.867, which includes a technical fix to Chapter 177 of the Acts of 2022. Section 15 expands the definition of "emergency services programs" that are required to be covered by health plans regulated by the MA Division of Insurance (DOI) to include "behavioral health crisis assessment, intervention and stabilization services 24 hours per day, 7 days per week, through: (i) mobile crisis intervention services for youth; (ii) mobile crisis intervention services for adults; (iii) emergency service provider community-based locations; (iv) emergency departments of acute care hospitals or satellite emergency facilities; (v) youth community crisis stabilization services; (vi) adult community crisis stabilization services; and (vii) a mental health center designated as a community behavioral health center pursuant to section 13D of chapter 118E, including outpatient behavioral health bundled services delivered by these centers."

When Chapter 177 of the Acts of 2022 was signed into law, Youth Community Crisis Stabilization services (YCCS) were not yet in existence. YCCS is a core component of the Commonwealth's Roadmap for Behavioral Health Reform. YCCS is provided to youth up to and including the age of 18 with behavioral health symptoms that require a 24-hour-per-day, seven-day-per-week, staff-secure (unlocked) treatment setting. "The primary function of YCCS is to provide one to five day crisis stabilization, therapeutic intervention, and specialized programming with a high degree of supervision and structure. YCCS provides active treatment that includes restoration of functioning; strengthening the resources and capacities of the youth, family, and other natural supports; and ensuring a timely return to previous living environment."[viii] Adult Community Crisis Stabilization (Adult CCS) was included in definition of "emergency services programs" in the mental health omnibus law, so clearly the intent would also have been to include YCCS had the service been in existence at the time.

Payor agnostic access to the full continuum of behavioral health crisis services

Sections 13, 16, 18, 20, and 23 of S.867 are additionally important because they add "outpatient behavioral health services" delivered by Community Behavioral Health Centers (CBHCs) to the definition of "emergency services programs" and require that they be covered as a bundled rate encounter with no prior authorization and cost sharing. Behavioral health crisis services, as envisioned by the Roadmap for Behavioral Health Reform, do not include just the initial crisis assessment. According to the performance specifications for Youth Mobile Crisis Intervention (YMCI), the service includes "up to seven days of crisis intervention and stabilization services including therapeutic response, psychiatric consultation, and urgent psychopharmacology intervention, as needed."[ix] For Adult Mobile Crisis Intervention (AMCI), the performance specifications require "up to 72 hours (three days) of daily post-stabilization follow-up to link the individual with needed supports

and confirm transition to and engagement with aftercare."[x]

As part of a pilot program to foster partnerships between CBHCs and schools, MAMH has learned that schools can be reluctant to call YMCI for youth experiencing crises that have commercial insurance. The initial crisis assessment is payor agnostic as part of the Behavioral Health Access and Crisis Intervention Trust Fund. However, subsequent services, including follow-up care for up to seven days for youth through the CBHC are either not covered for children with commercial insurance or are covered with prohibitive cost sharing. This can place a significant financial burden on the family. Commercial insurers should be following the example of MassHealth and covering outpatient behavioral health services at CBHCs through the bundle so that their members may have access to the full array of crisis services and follow-up supports as envisioned by the Roadmap. No one should ever forgo emergency mental health services for fear of financial burden.

Payor agnostic access to behavioral health urgent care services

Sections 13, 17, 19, 21, and 24 of S.867 are finally critical because they require the Group Insurance Commission (GIC), and commercial insurers regulated by the MA Division of Insurance (DOI) to cover medically necessary behavioral health urgent care services with no prior authorization or cost sharing. Additionally, these sections require payment for any services provided by a behavioral health urgent care provider to include a rate add-on of at least 20 percent over any negotiated fee schedule.

MAMH has long been invested in the addition of urgent care as a new behavioral health service type for the Commonwealth. In 2019, MAMH with the Children's Mental Health Campaign released a brief that included recommendations for a model of pediatric behavioral health urgent care for Massachusetts.[xi] We then strongly advocated for the addition of urgent care as a new level of behavioral health services, which was ultimately included in the Roadmap for Behavioral Health Reform. Now we manage a grant program that fosters partnerships between CBHCs and schools to offer behavioral health urgent care to K-12 students. Our hypothesis is that urgent care will reduce the number of calls to 911 and will reduce student absenteeism.

In addition to urgent care offered by the CBHCs, the Roadmap included an opportunity for behavioral health providers to apply to become behavioral health urgent care providers through a MassHealth attestation process. Qualifying behavioral health urgent care providers receive a 20 percent rate bump, which has been critical to ensuring that providers can offer standing staff capacity to address walk-in appointments.

There are close to 80 provider locations in the Commonwealth that have completed the MassHealth attestation process to offer behavioral health urgent care services.[xii] All of these sites accept MassHealth patients, however there is incredible variation in commercial coverage. This patchwork of insurance coverage makes it incredibly difficult for individuals and families to navigate and access urgent care services. Furthermore, urgent care services are designed to help individuals avoid more costly levels of care, such as Emergency Department (ED) visits and potentially hospitalization. Coverage of behavioral health urgent care by commercial insurers not only makes sense from a health and wellness perspective, but it also helps avoid unnecessarily utilization of more costly acute and inpatient care. All payer participation was always the intent of the Roadmap and Chapter 177 reforms.

H.1370, *An Act relative to Massachusetts primary care for you* (Rep. Haggerty)

Similar to S.867, MAMH also supports H.1370, *An Act relative to Massachusetts primary care for you*. The goal of H.1370 is to reverse the historic underinvestment in primary care and rebalance total medical expenditures in a way that incentivizes screening, early intervention, and addressing problems at their root cause. Investing upstream also prevents avoidable and more costly acute, specialty, and emergency care. The proposed investment in primary care finally represents an important step toward a comprehensive health system that

acknowledges and addresses the critical intersection between physical and behavioral health.

This bill creates a timeline and process for increasing investment in primary care expenditures, using the Health Policy Commission's existing cost growth benchmark and annual Cost Trends hearings to guide the process. It also includes "integrating behavioral health with primary care" as one of the primary care transformers based on the evidence that the transformer improves health, patient experience, and clinician experience, and decreases total medical expenses. MAMH supports this proposed increase in primary care expenditures as both behavioral health and primary care represent too small a portion of total medical expenditures in the Commonwealth.

H.1396/S.874, *An Act strengthening mental health centers* (Rep. O'Day/Sen. Keenan)

MAMH finally strongly supports H.1396/S.874, which requires MassHealth to: (1) increase rates paid for behavioral health outpatient services by 5%; and (2) ensure that rates paid to mental health centers licensed by the MA Department of Public Health (DPH) are not less than 20% above rates paid for comparable services delivered by an independent behavioral health practitioner. The covered behavioral health outpatient services include evaluation, diagnosis, treatment, care coordination, management, and peer support of patients with mental health, developmental, or substance use conditions.

The need for the 5% increase for outpatient behavioral health services is a parity issue and has been extensively documented. Behavioral health services have long been grossly underfunded. An April 2024 RTI study documented significant disparities in rates paid for behavioral health services compared to rates paid for medical/surgical services. Specifically, in Massachusetts in 2021 the average reimbursement for medical/surgical clinician office visits was 44.8% higher than the average reimbursement for behavioral health clinician office visits. The study also documented that psychiatrists and psychologists had lower reimbursement rates than medical/surgical physician assistants. When providers are offered low reimbursement rates from health plans, they are less likely to participate in insurance networks; this creates significant financial access barriers for individuals seeking mental health and substance use services.[xiii]

There is also a strong need to fund mental health centers at rates 20% above comparable services delivered by independent behavioral health practitioners. Mental health centers include the approximately 80 community-based mental health and substance use treatment provider organizations that make up the membership of the Association for Behavioral Healthcare (ABH). These entities serve 81,000 Massachusetts residents each day.[xiv] Mental health centers also include the hundreds of additional clinics in the Commonwealth that are licensed by the MA Department of Public Health (DPH) and contract with MassHealth.

If we don't adequately fund our mental health centers, staff will continue to leave to make more money in other behavioral health settings, including private practice. Mental health centers are the primary providers of community-based, publicly funded behavioral health care services in the Commonwealth. If mental health centers are unable to recruit and retain their workforce, this will reduce the number of community-based practitioners in the Commonwealth accepting MassHealth and exacerbate access issues for people with the lowest incomes. Additionally, mental health centers offer a safety net for people who are uninsured, a population including a disproportionate number of people of color. Black and Hispanic individuals in Massachusetts are twice as likely to be uninsured as white individuals.[xv] Loss of clinicians at community mental health centers will therefore exacerbate racial and ethnic disparities in access to behavioral health care.

Raising mental health center rates is also necessary to support critical functions of these providers, which have specific requirements above and beyond other outpatient settings. MA DPH and MassHealth regulations require mental health centers to have a psychiatrist, therapists, a medical director, a mandatory range of therapy services, staffed after-hours coverage, and requisite operating hours. Mental health centers are also

required to offer extensive treatment planning for clients, staff trainings, referral systems, and coordination with medical/surgical care. Finally, mental health centers serve as the primary training ground for the behavioral health workforce. When staff leave, they take invested experience and expertise with them.

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. We urge you to report S.867, *An Act relative to primary care for you* (Sen. Friedman); H.1370, *An Act relative to Massachusetts primary care for you* (Rep. Haggerty); and H.1396/S.874, *An Act strengthening mental health centers* (Rep. O'Day/Sen. Keenan) 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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