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September 14, 2021

The Honorable John Lawn
Chair, Joint Committee on Health Care Financing
24 Beacon Street, Room 445
Boston, MA 02133

The Honorable Cindy Friedman
Chair, Joint Committee on Health Care Financing
24 Beacon Street, Room 208
Boston, MA 02133

RE: Testimony in support of H.1302/S.781, *An Act relative to applied behavioral health clinic rates*;
S.769, *An Act relative to collaborative care*;
S.770, *An Act relative to primary care for you; and*
H.1240, *An Act to Ensure MassHealth Rate Parity for Inpatient Behavioral Health Providers*

Dear Chair Lawn, Chair Friedman, and Honorable Members of the Committee:

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.1302/S.781, *An Act relative to applied behavioral health clinic rates*; S.769, *An Act relative to collaborative care*; S.770, *An Act relative to primary care for you; and* H.1240, *An Act to Ensure MassHealth Rate Parity for Inpatient Behavioral Health Providers.* 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 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.1302/S.781, *An Act relative to applied behavioral health clinic rates*

Significant disparities exists nationally and in Massachusetts, in particular, between the reimbursement rates

for behavioral health and physical health services. The 2019 Milliman Research Report analyzed commercial preferred provider organization (PPO) health plans for the period of 2013- 2017, comparing office-based services reimbursement rates for behavioral health care providers to reimbursement rates for primary and specialty physical care providers. The report produced both national and state-level data.

On the national level, the Milliman Report found that average in-network reimbursement rates for behavioral health office visits were lower than for medical/surgical office visits and that this disparity has increased between 2015 and 2017. As of 2017, primary care reimbursements were 23.8% higher than behavioral reimbursements, an increase from the 20.8% disparity reported in 2015. The reimbursement rates for medical/surgical specialists reflected a similar pattern; 2017 reimbursement rates for these specialists were 18.9% higher than behavioral health reimbursement rates. As with primary care, the differential with respect to physical health specialists rose from 2015, when the disparity was 17.0%.

With respect to Massachusetts, the Report's data for 2017 office visits showed an even greater disparity between physical and behavioral health care reimbursement rates than that found at the national level. In the Commonwealth, primary care office visits were reimbursed in 2017 at a 59.6% higher reimbursement rate than were behavioral care office visits. That statistic placed Massachusetts well above the 23.8% national disparity and with just ten other states that provided reimbursement for primary care office visits at a rate at least 50% higher than reimbursement for behavioral health office visits. Likewise, Massachusetts' rate for reimbursement of medical/surgical specialists in 2017 was 65.9% higher than behavioral rates, well above the 18.9% national average for disparity. Moreover, both of these Massachusetts reimbursement rate disparities grew between 2015 and 2017.[i] The time is now to address discrimination in reimbursement rates to further access to timely, outpatient behavioral health services.

S.769, *An Act relative to collaborative care*

The Collaborative Care Model (CoCM) is an evidence-based approach to integration of behavioral health and primary care. Primary care providers, care managers, and behavioral health consultants collaborate to provide care and monitor patients' progress. Since the development of the Collaborative Care Model 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."[ii] 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.[iii,iv,v] In a book chapter that I 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 collaborative care.[vi]

While the Collaborative Care Model is most often applied to adults with multiple health conditions, there is also significant data on the effectiveness of the elements of this model in the integration of pediatric primary care and behavioral health care here in Massachusetts. The earliest of these demonstrations is found in the SAMHSA and MassHealth funded LAUNCH and MYCHILD programs, evaluated by Abt Associates and the Institute for Urban Health Research at Northeastern University. 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.[vii]

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 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. Furthermore, the Richard and Susan Smith Family Foundation's and The Klarman Family Foundation's TEAM UP for Children Initiative is supporting transformation to integrated pediatric primary care at seven federally qualified health centers. "Early results from the TEAM UP evaluation indicate important gains in access, quality, cost, and satisfaction. More than half of children see a therapist on the same day a concern is identified. The percent of children prescribed three or more psychotropic drugs has been cut nearly in half. (Moreover), TEAM UP pediatricians report less burnout and greater satisfaction."[viii]

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.[ix] One of these barriers is inadequate reimbursement for the core service delivery elements of the Collaborative Care Model.

S.769, *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.[x]

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 began paying physicians for integrated behavioral health services using CPT code 99484, activating the three codes to support collaborative care management. 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.[xi]

S.769, *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.

S.770, *An Act relative to primary care for you*

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. MAMH supports this proposed increase in primary care expenditures. Currently, both behavioral health and primary care represent too small a portion of total medical expenditure in the Commonwealth.

MAMH is particularly concerned about primary care because child and adolescent mental health conditions emerge early, when young people are seen routinely by pediatric primary care clinicians. 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.[xii] 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.[xiii] Increased investment in primary care offers more opportunity for screening for mental health, substance use 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 age 75 and over were related to mental health.[xiv]

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. Investments in upstream health care services, like primary care and behavioral health, will also help prevent exacerbation of behavioral health symptoms and disabling conditions, increased demand for intensive treatment, and associated higher costs of care. We wish to underscore that investing in a health system that ensures timely access to appropriate care can prevent these adverse outcomes and improve the wellbeing of individuals, families, and our communities.

H.1240, *An Act to Ensure MassHealth Rate Parity for Inpatient Behavioral Health Providers*

H.1240 would require that MassHealth ensure its contracted MCO's and Behavioral Health Management firms reimburse network inpatient mental health and substance use providers not less than the MassHealth contracted per diem rate. The Baker Administration implemented this policy earlier this year and the inpatient mental health providers began receiving comparable payments on July 1, 2021. Prior to this policy, there were

often substantial variances between the MassHealth rate and the MCO and Behavioral Health (Carve Out firms) payments.

Although the provisions of H.1240 are currently being implemented, passing H. 1240 would memorialize this provision and make it a durable policy. In closing, H.1240 helps to substantiate the importance of fair and consistent reimbursement policies.

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. I urge you to report H.1302/S.781, *An Act relative to applied behavioral health clinic rates*; S.769, *An Act relative to collaborative care*; S.770, *An Act relative to primary care for you; and* H.1240, *An Act to Ensure MassHealth Rate Parity for Inpatient Behavioral Health Providers* favorably out of committee. Thank you.

Sincerely,

Danna Mauch, PhD
President and CEO

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