Danna E. Mauch, PhD
President and CEO

Ambassador (ret.) Barry B. White
Chairperson of MAMH Board of Directors

April 7, 2022

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

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

The Honorable Harriet Chandler
Vice Chair, Joint Committee on Health Care Financing
24 Beacon Street, Room 333
Boston, MA 02133

The Honorable Jay Livingstone
Vice Chair, Joint Committee on Health Care Financing
24 Beacon Street, Room 146
Boston, MA 02133

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

Re: Testimony in support of Governor Baker's Health Care Bill, S.2774, *An Act Investing in the Future of Our Health*

On behalf of the Massachusetts Association for Mental Health (MAMH), thank you for the opportunity to provide written testimony in support of Governor Baker's Health Care Bill, S.2774, *An Act Investing in the Future of Our Health*, to the Joint Committee on Health Care Financing.

We are pleased that the Committee is focused on the needs of people with behavioral health conditions and their families. As you know, we are experiencing a surge in demand for behavioral health services and crisis care in the Commonwealth. All indicators point to the fact that the surge will continue to increase in the coming months and years due to the pandemic. COVID-19 also illuminated the grave dangers posed by holding people with behavioral health conditions in suboptimal congregate settings including jails, homeless shelters, nursing homes, and hospitals when alternative housing and diversion services would better and safely meet their needs. MAMH has long tracked the disparate treatment and outcomes for people with behavioral health conditions, ranging from poor access to early intervention and prevention, to a lack of options for behavioral health care and social services in the community, to the criminalization of people with behavioral health conditions.

S.2774 contains meaningful approaches to address the persistent obstacles facing people with behavioral health needs in the Commonwealth. Among its noteworthy provisions, the bill calls for historic investments in behavioral health and primary care in response to the health and economic impacts of chronic underinvestment in these areas.

We provide this testimony to underscore our support for S.2774. We also respectfully propose certain modifications of language in the provisions on the health care workforce, the Quality Measurement Alignment Taskforce, and emergency department boarding. Finally, we suggest further deliberations on the provisions regarding regulation of certified peer workers and regarding scope of practice and licensure standards.

Requirement that health care providers and payers increase expenditures on primary care and behavioral health by 30% over three years

Historically, both primary care (PC) and behavioral health (BH) care have been vastly underfunded, resulting in an inability to treat individuals effectively, preventatively, and timely before behavioral health conditions arise or deteriorate to a crisis. This provision would begin to rectify that imbalance by establishing a benchmark for measurement and a reasonable target for increased spending. The legislation is flexible in several regards. It does not prescribe how the providers and payers achieve the target. For instance, it could be through increased rates to PC/BH providers, expanding PC/BH networks, increasing hours of access, or increasing access to telehealth. MAMH notes that the bill also allows providers and payers to determine whether the increase will be focused on primary care or behavioral health care spending. Given the substantial underfunding of behavioral health services, even relative to primary care, MAMH advocates a proviso that "an increase in a health care entity's behavioral health spending shall not be less than 30% of the baseline for their behavioral health spending." Over three years, ending in 2024, this legislation will help to rebalance funds in the health care system, effectively investing approximately $1.4 billion into primary care and behavioral health.

MAMH strongly supports this provision to increase spending by 30% over three years, ending in 2024. First, under this proposal, health care entities are given plenty of time to ramp up their PC and BH spending. If a health care entity has a baseline PC and BH expenditure of $10 in 2019, that health care entity would have until 2024 to achieve the 30% increase in PC and BH spending (30% increase on $10 = $13 by 2024). This is a 30% increase by the third year, not each year.

Likewise, payers and provider organizations with a patient panel <15,000 and that represent <$25,000,000 in annual net patient service revenue -- the same definitions/entities subject to the cost growth benchmark analysis -- are exempt from this provision. Many providers including independent community health centers and behavioral health provider organizations that exclusively provide primary care and/or behavioral health services are not subject to this spending target. This is a commonsense approach to reform.

Parity

MAMH supports the provisions in S.2774 that better equip the Division of Insurance (DOI) to enforce the federal Mental Health Parity and Addiction Equity Act and state mental health parity laws. Specifically, the bill requires payers to: 1) reimburse evaluation and management office visits by licensed behavioral health providers at a rate no less than the average rate of reimbursement for evaluation and management office visits by licensed primary care providers in the same geographic region during the prior calendar year; 2) submit utilization reports that document the number of requests, approvals, denials, and denial appeals for covered behavioral health services and the number of requests, approvals, denials, and denial appeals for covered non-behavioral health services; and 3) submit the number of approved covered out-of-network services for behavioral health services and the number of approved covered out-of-network services for covered non-behavioral health services. The bill also requires the Center for Health Information Analysis (CHIA) to collect information from payers on claims and non-claims-based payments to providers for the provision of primary care and behavioral health services, including mental health and substance use services. Combined with the behavioral health parity provisions in the Senate Mental Health ABC 2.0 bill, these requirements would provide significant support to ensure residents of the Commonwealth have the same coverage, benefits, and access to behavioral health services as physical health/medical services.

Primary Care and Behavioral Health Equity Trust Fund

MAMH likewise supports the establishment of a fund to provide enhanced funding to primary care and behavioral health providers serving Medicaid members. Approximately 20% of the funds will be earmarked for grants to high public-payer providers in underserved communities. Payments will fund projects designed to advance health equity within local communities. Communities of color and people with disabilities already experienced worse health outcomes prior to the viral pandemic; COVID-19 further exacerbated these disparities. MAMH appreciates the targeted support to communities though this fund to advance health equity and wellness.

Urgent care

This legislation defines "urgent care services" and requires entities providing urgent care services to be licensed as a clinic and accept MassHealth members**.** MAMH particularly supports the provision in S.2774 that requires urgent care clinics to coordinate with individuals' primary care providers. This increases the likelihood of follow-up, promotes continuity of care, and helps to decrease fragmentation in the system.

Health care workforce

This bill directs CHIA to conduct a study of the health care workforce in the Commonwealth, including how it is changing over time, the supply of and demand for workers, demographic characteristics of the workforce including race, ethnicity, language, and age, geographic variations, job satisfaction, retention, and turnover, and other issues affecting the Commonwealth's health care workforce. *We applaud this proposal and urge that the language be amended to require the study to include a discrete examination all these issues and factors with respect specifically to all aspects and levels of the behavioral health care workforce.* The behavioral health care workforce, severely strained before the pandemic and now under even more serious stress, has its own characteristics, problems, and solutions. It requires its own, specific evaluation.

Quality Measurement Alignment Taskforce

We support the codification of the existing EOHHS Quality Measurement Alignment Taskforce and suggest that the legislative language be modified to ensure the representation of people with lived experience in the behavioral health system on the taskforce. Currently, the legislation designates eight public official members, and, at a minimum, 14 members appointed by the governor. Two of these 14 appointed members must be representatives of persons with lived experience in the health care system – one is a representative for "persons with complex health conditions," and one is a representative for "consumers." *We believe that it is important that the taskforce include a person with lived experience in the behavioral health system. To ensure this goal, we suggest either that the consumer representative be designated as a person with lived experience in the behavioral health system or that an additional slot be added to the taskforce for such a representative.*

Regulation of certified peer workers

MAMH recognizes the value of having a diverse peer workforce, including a broad range of types of peer workers. We also believe that peer workers should be reimbursed fairly. In fact, there is already reimbursement for peers in some settings. We support this provision to the extent that it would provide a means of reimbursement for those certified peers serving as part of clinical teams. At the same time, we acknowledge that there are other peer roles; some peers function without the need for documentation and without accountability to a clinical lead. These peers may need to be reimbursed in another way.

We acknowledge that there are still details being debated among different peer groups and within peer groups about how best to effectuate such reimbursements. We encourage decisionmakers to continue to listen to those

various voices to reach agreements regarding licensure and reimbursement.

Emergency Department (ED) boarding

This provision, which directs the Department of Public Health (DPH) to draft regulations governing their licensed acute care hospitals, supports the laudable goal of ensuring that these facilities have qualified behavioral health clinicians available for evaluation and stabilization of persons with behavioral health needs admitted to their EDs. This requirement would help address the problem of patients who are stuck in EDs because no clinician is available to provide services. If implemented, the qualified behavioral health clinicians could initiate treatment in the ED during the period of boarding to promote clinical stabilization.

We suggest that language be added to ensure that these regulations reinforce the principle that individuals who present in EDs should have timely access to both medical and behavioral health care, as needed, and that individuals exhibiting a "behavioral health presentation" are not diverted from medical examination and treatment for the purpose of mental health care. In adding such language, we seek to protect against the phenomena of diagnostic overshadowing and implicit bias, which may result in medical care that is suboptimal or even not provided.[1]

Scope of practice and licensure standards

This legislation expands the definition of a "licensed mental health professional" contained in G.L. c. 175, s. 47B to include "clinicians practicing under the supervision of licensed professional, and working towards licensure, in a clinic licensed under [G.L.] chapter 111" to be considered a "licensed mental health professional." The provision covers clinicians working under a physician specializing in psychiatry, psychologist, licensed independent clinical social worker, licensed mental health counselor, licensed nurse mental health clinical specialist, licensed alcohol and drug counselor I, or licensed marriage and family therapist.

Providing some behavioral health services through a system of supervision of trainees, as a means of addressing the serious gaps in the behavioral health workforce, is an approach that merits attention. This proposal would benefit from certain additional detail. We suggest that discussion might yield additional language to ensure quality services. For example, the legislation might dictate: the educational and practice level of clinicians that may work under the proposed supervision; the types of services which could be rendered; and the degree of involvement of the supervising professional. We also seek to ensure that any such provision supports parity in the delivery of behavioral health and physical health services.[2]

[1] For a discussion of the impacts of diagnostic overshadowing and implicit bias in the medical care of people with psychiatric disabilities, see Testimony of Susan Fendell, Esq., Mental Health Legal Advisors Committee to the Health Policy Commission (Mar. 25, 2021), https://www.mass.gov/doc/mental-health-legal-advisors-committee-2021-benchmark-testimony/download

[2] We note that Chapter 175 does not allow for supervised trainees to perform the services of certified nurse midwives (G.L. c. 175, s. 47E), certified diabetes health care providers (G.L. c. 175, s. 47N), certified registered nurse anesthetists or nurse practitioners (G.L. c. 175, s. 47Q), individuals licensed as speech-language pathologists or audiologists under chapter 112 (G.L. c. 175, s. 47X), licensed physicians or a licensed psychologists related to the treatment of Autism Spectrum Disorders (G.L. c. 175, s. 47AA), or of other medical professionals.

Thank you for considering our requests with respect to S.2774. Please do not hesitate to be in touch should you have any questions or would like additional information at dannamauch@mamh.org.

Sincerely,

Danna Mauch, PhD
President and CEO

cc: The Honorable Karen Spilka, President, Massachusetts Senate
The Honorable Ron Mariano, Speaker, Massachusetts House of Representatives
The Honorable Julian Cyr, Chair, Joint Committee on Mental Health, Substance Use, and Recovery
The Honorable Adrian Madaro, Chair, Joint Committee on Mental Health, Substance Use, and Recovery