Massachusetts Association for Mental Health

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June 28, 2023

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

By email to jointcmte-financialservices@malegislature.gov

The Honorable Paul Feeney
Chair, Joint Committee on Financial Services
24 Beacon Street, Room 215
Boston, MA 02133

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

> **Re: Testimony in support of H.989/S.610, *An Act for supportive care for serious mental illness*, H. 936/S.657, *An Act providing continuity of care for mental health treatment*, H.937/S.602, *An Act relative to transparency of consumer health insurance rights*, and H.1108/S.613, *An Act relative to Community Behavioral Health Centers***

On behalf of the Massachusetts Association for Mental Health (MAMH), I write to respectfully submit this testimony in support of the above-referenced bills, heard by your Committee on June 26, 2023.

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.

We provide the following support for each of these bills.

H.989/S.610, *An Act for supportive care for serious mental illness* (Rep. Decker/Sen. Cronin)

This bill requires coverage by commercial and GIC health insurance plans of two evidence-based practices for first episode psychosis: Coordinated Specialty Care (CSC) and Assertive Community Treatment (ACT).

Psychosis typically first appears in youth between the ages of 16 and 22. Often, these young people end up in hospitals as their symptoms emerge. Once discharged, it may take many months to access appropriate treatment, if they do in fact receive such care. In the meantime, these conditions can "derail a young person's social, academic, and vocational development and initiate a trajectory of accumulating disability."[1]

Currently, commercial insurance does not cover these critical programs even though the ACA requires health insurers to cover dependents until age 26 and we have strong mental health parity laws requiring that mental health care should be comparable to physical health care. As a result of commercial carriers' lack of provision of coverage, young people typically end up receiving treatment paid for by taxpayer-funded programs, and usually only after a substantial delay. Similarly, GIC plans are not required to offer this coverage. It is not only discriminatory but also counterproductive to recovery, signaling that mental health conditions consign one to public insurance and public services rather than the same level and type of services the individual would expect to receive under their commercial or GIC insurance for any other health condition.

Programs are community-based, interdisciplinary, and multi-faceted

Coordinated specialty care is a treatment program for people with first episode psychosis. The goal is to link the individual with services as soon as possible after psychotic symptoms begin. CSC uses a multi-disciplinary team of specialists. Services include psychotherapy, medication management, family education and support, case management, and work or education support.[2] Using shared decision-making, the individual and the team make treatment decisions together, involving family members as much as possible.[3] CSC services are wrap around and available 24/7.

Assertive Community Treatment 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."[4] The team provides comprehensive nonacute behavioral health and substance use disorder treatment as well rehabilitation,

[1] Heinssen, R., Goldstein, A., & Azrin, S. (2014). Evidence-based treatment for first episode psychosis: Components of coordinated specialty care. National Institute of Mental Health. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/evidence-based-treatments-forfirst-episode-psychosis-components-of-coordinated-specialty-care

[2] 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

[3] 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

[4] 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

vocational, and housing-related services.[5] Services are delivered in the individual's own community and home and are available 24/7.[6] Services are intensive, vary based on the needs of the individuals served, and follow national Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines.[7]

In recent years, both these programs have consistently incorporated evidence-based, person-centered techniques including Open Dialogue and certified peer support specialists into the multi-disciplinary team.

These services show clinical efficacy

Research has shown that these services are effective when implemented consistent with clinical standards. 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."[8] This legislation requires such fidelity.

Studies of CSC 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.[9]

ACT reduces inpatient hospitalization days and emergency room visits and yields other positive outcomes including increased housing stability, improved quality of life, fewer symptoms, increased social functioning, and higher individual and family satisfaction.[10]

These services provide better outcomes for the individual than alternatives as coverage of these treatment programs *at the onset of a crisis* prevents clinical deterioration, functional disability, and the need for more intensive treatment.

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[5] 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

[6] 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

[7] 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.

[8] 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

[9] 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.

[10] 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.

These services demonstrate cost efficacy

Commercial insurance benefits that focus on acute inpatient care[11] are the most expensive and least effective over the long term. Both CSC and ACT are provided in the community and reduce the use of expensive hospitalization.

A 2018 study of a CSC service known as Specialized Treatment Early in Psychosis (STEP), offered at a U.S. community mental health center, found that the patients who received the service "were significantly less likely to have any inpatient or ED visits; among individuals who did use such services in a given period, the associated costs were significantly lower for STEP participants at month 12." The researchers further noted that they "did not observe a similar effect with regard to other healthcare services." These researchers conclude that their findings were promising with regard to the value of STEP to third-party payers.[12]

Similarly, research since the 1970's has shown that ACT is more cost effective than other types of care.[13]

H.936/S.657, *An Act providing continuity of care for mental health treatment* (Rep. Balser/Sen. Keenan)

Continuity of care for mental health services is an essential part of the treatment and recovery process, but continuity can be disrupted when a provider leaves a carrier's network (either voluntarily or Involuntarily), or when a patient switches health plans and the new health plan does not include the patient's existing provider in its network. This bill requires health insurers to continue to provide coverage for care even if the member's provider is no longer in network.

Current law provides only for limited continuity of care when a provider or physician is *involuntarily disenrolled* from a carrier's network. This bill would amend Section 15 of Chapter 176O to require that an insurer continue coverage of treatment through an out-of-network option in these situations.

This bill costs insurers nothing. Insurers would only pay licensed mental health care professionals the usual network per-unit reimbursement rate for the relevant service and provider type or, alternatively, the median reimbursement rate if more than one rate exists. If it costs the insurer more to use a non-network provider and the insurer can provide an actuarial demonstration of those increased costs, the insurer may require the covered person to pay a higher co-payment.

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[11] Blue Cross Blue Shield of Massachusetts Foundation. The Massachusetts Behavioral Health Care System - Slide 29. 2020, https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2020-09/MA_Behavioral_Health_System_Chartpack_Jan2019_FINAL.pdf

[12] Sean M. Murphy *et al.*, An Economic Evaluation of Coordinated Specialty Care (CSC) Services for First-Episode Psychosis in the U.S. Public Sector, 21 J. Mental Health Policy and Economics (Sept. 1, 2018), pp. 123-130, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6314808/

[13] Latimer, E., Economic considerations associated with assertive community treatment and supported employment for people with severe mental illness, J Psychiatry Neurosci. 2005 Sep; 30(5): 355–359; Bond, G.R., Drake, R.E., Mueser, K.T. et al., Assertive Community Treatment for People with Severe Mental Illness. Dis-Manage-Health-Outcomes 9, 141–159 (2001). https://doi.org/10.2165/00115677-200109030-00003.

H.937/S.602, *An Act relative to transparency of consumer health insurance rights* (Rep. Balser/Sen. Creem)

This bill requires health insurance cards to indicate, when applicable, that the health plan is fully-insured and subject to all Massachusetts insurance laws. The card also would include the names of the carrier and the insured's specific health plan, as well as any information necessary to identify the insured's plan.

This information allows plan members, providers, and advocates to instantly determine whether the many Massachusetts statutes enacted to improve health insurance coverage or appeal rights and procedures apply to the member's type of plan. This information dictates outcomes about service coverage, prior authorizations, and billing protocols. However, this information is incredibly difficult to find, directly impacting the delivery of services. This bill will allow members to pursue their rights regarding coverage, which currently is extremely difficult.

The bill provides an effective solution to the current lack of clarity. Insurance cards will indicate plans that are subject to Massachusetts health insurance laws. Such plans must offer state mandated benefits. It will also become clear through this requirement if plans are not subject to Massachusetts law, but instead are subject to federal law. These include self-funded plans, out-of-state fully-insured plan subject to other state laws, or public employer plans. In this way, individuals more easily ascertain their rights. This knowledge will promote good health outcomes.

The Legislature has already mandated commercial coverage of services that they deemed crucially important to the health and wellbeing of Commonwealth residents. Requiring plan information on an insurance card is a small change that would eliminate massive inefficiencies in our healthcare system and ensure statutorily required coverage of behavioral health care.

H.1108/S.613, *An Act relative to Community Behavioral Health Centers* (Rep. O'Day/Sen. Cronin)

Since January 2023, 25 new Community Behavioral Health Centers (CBHCs) have provided a range of evidence-based, integrated mental health and addiction treatment for all ages, including behavioral health urgent care, community crisis response, same day assessments and referrals, and follow-up appointments. MassHealth and their managed care entities cover this entire suite of CBHC services, but commercial carriers are only mandated to cover *crisis services*. This bill would mandate **c**ommercial coverage for all behavioral health services delivered through CBHCs.

CBHCs are the central element of the Commonwealth's Roadmap to Behavioral Health Reform, a plan that envisions a system in which there is "no wrong door" to mental health and substance use services and addresses existing gaps in care. However, without the ability to deliver payer-agnostic services, this system cannot serve all individuals equitably. As it currently stands, individuals with commercial insurance are unable to access the entire suite of services that MassHealth members are provided.

This differential access to CBHC services based on insurance type causes confusion among providers and individuals served. Those with commercial coverage who enter a CBHC in a behavioral health crisis can be assessed and stabilized, but cannot be connected to urgently delivered psychiatry, therapy, and peer services. Further, individuals who are commercially insured will not be covered for ongoing support including case management to provide housing support; coordination with a child's school, primary care, and other social services; recovery coaching who support individuals with substance use disorder

through lived experience; and nurse-led wellness interventions with corresponding lab work. Instead, commercially insured individuals are likely routed through the traditional outpatient mental health system and may face long wait times to see a therapist and/or psychiatrist.

H.1108/S.613 would mandate that commercial insurers cover *all services* delivered in CBHCs. This ensures that all individuals that walk through the doors of a CBHC can be offered on-demand and payor-agnostic behavioral healthcare. In addition to reporting these bills out favorably, we respectfully request that the bills be sent to the Center for Health Information and Analysis (CHIA) for a mandated benefit review to better understand the impact of the legislation on the commercially insured population.

Thank you for your ongoing commitment to addressing the behavioral health needs of the people of Massachusetts and for your consideration of this written testimony. On behalf of MAMH, I urge you to report out each of these bills favorably. If we can provide any additional information, please do not hesitate to contact me at dannamauch@mamh.org.

Sincerely,

Danna Mauch, PhD
President and CEO

c: Representative Marjorie Decker
Senator John Cronin
Representative Ruth Balser
Senator John Keenan
Senator Cynthia Creem
Representative James O'Day