CHILDREN'S MENTAL HEALTH CAMPAIGN

MSPCC - BCH - HCFA - HLA - PPAL - MAMH

October 17, 2022

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street #810
Boston, MA 02118

Sent by email to kevin.beagan@mass.gov and rebecca.butler@mass.gov

Re: Comments Regarding Chapter 177 of the Acts of 2022 – Community-Based Treatment

Dear Deputy Commissioner Beagan and General Counsel Butler,

On behalf of the Children's Mental Health Campaign (CMHC), thank you for holding listening sessions and written comment opportunities on various provisions of Chapter 177 of the Acts of 2022, *An Act addressing barriers to care for mental health.* The CMHC is led by an Executive Committee of six organizations: the Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital, the Parent/Professional Advocacy League, Health Care For All, Health Law Advocates and the Massachusetts Association for Mental Health (MAMH). The CMHC network includes over 200 organizations across Massachusetts.

Please find below responses to questions the Division of Insurance ("Division") has asked stakeholders on the requirement for health insurance carriers to cover certain community-based behavioral health services. Please do not hesitate to contact us with any questions or to discuss our comments further.

Thank you,

Mary McGeown
Executive Director, MSPCC
On behalf of the Children's Mental Health Campaign

THE CHILDREN'S MENTAL HEALTH CAMPAIGN is a large statewide network that advocates for policy, systems, and practice solutions and shared responsibility among government and institutions to ensure that all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way.

The CMHC Executive Committee consists of six highly reputable partner organizations: The Massachusetts Society for the Prevention of Cruelty to Children, Boston Children's Hospital, the Parent/Professional Advocacy League, Health Care for All, Health Law Advocates, and the Massachusetts Association for Mental Health. The CMHC network includes more than 200 organizations across Massachusetts.

Responses from the Children's Mental Health Campaign Regarding Chapter 177 Session 2 Questions

> *1) Are the definitions of "community-based acute treatment," "intensive community-based treatment" and "mental health acute treatment" understood or do certain terms need clarification?*
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> *a. Do any of these listed items need further clarification?*
> *b. Are there specific services that are provided that should be identified so it is clear that those services are normally provided in any of these settings?*
> *c. How do these services differ from services that carriers are currently making available through Behavioral Health for Children and Adolescent programs?*

In considering the discussion during the listening session on October 7, 2022, the CMHC finds a need to clearly define "community-based acute treatment," "intensive community-based treatment" and "mental health acute treatment." CMHC advises adoption of current state agency definitions for those terms and usage of existing resources that clarify these terms. The Division and the Department of Mental Health (DMH) included definitions for "community-based acute treatment" and "intensive community-based treatment" in Bulletin 2018-07 entitled, "Access to Services to Treat Child-Adolescent Mental Health Disorders,"[1] referred to as Behavioral Health for Children and Adolescents (BHCA). The Massachusetts Behavioral Health Partnership (MBHP) also has performance specifications for "community-based acute treatment" that include a comprehensive definition of these services. These performance specifications were last updated in May 2022.[2]

Because these are existing benefits that have been covered by MassHealth for years, and should have also started to be covered by health insurance carriers, we request that the Division work to help ensure that consumers who have had these benefits under MassHealth can continue to access them seamlessly under their private insurance. Likewise, we recommend that providers understand that coverage of the BHCA benefits will continue. We also recommend that the Division issue guidance advising carriers to adopt the generally accepted standards of care[3] for determining medical necessity, *as currently in use* by MassHealth. These standards are substantiated by clinical practice and widely adopted by CBAT/ICBAT and acute mental health care providers. In contrast, allowing carriers to develop a variety of their own individualized standards for determining medical necessity would likely not be in accord with the requirements of M.G.L. c. 176O, § 16(b). Further, a variety of differing standards would create undue and unreasonable confusion for providers and barriers for patients, especially children in mental health crises and their families or caregivers. Guidance from the Division could advise carriers that the existing medical necessity standards used by MassHealth are presumptively appropriate, unless carriers wish to

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[1] Division of Insurance and Department of Mental Health. Bulletin 2018-07. Access to Services to Treat Child-Adolescent Mental Health Disorders. Available at: https://abh.memberclicks.net/assets/docs/BHCA/BULLETIN%202018-07%20%28Child-Adolescent%29.pdf.

[2] Massachusetts Behavioral Health Partnership/Beacon Health Options. Performance Specifications: 24-Hour Diversionary Services Community-Based Acute Treatment (CBAT) for Children and Adolescents. May 2022. Available at: https://www.masspartnership.com/pdf/PerfSpec-CBAT.pdf.

[3] "Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: … (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice;" M.G.L.A. 176O, § 16(b); "Medical Necessity or Medically Necessary means health care services that are consistent with generally accepted principles of professional medical practice…." 958 CMR 3.020.

use a more permissive standard, and unless the carrier furnishes reasonable evidence that a more restrictive medical necessity standard is supported by clinical evidence.

We further suggest that the Division, in consultation with the Department of Early Education and Care (DEEC) and DMH, develop a document for consumers with a clear explanation of the services provided in each of these types of placements, any differences in levels of care, how to access to each type of placement, including specific qualifications, and what to expect upon discharge from each program. This information may currently exist in various places, but having it in a centralized place that allows for comparison among the programs would be helpful.

The following is information about the different licensing agencies and their staff contacts, should it be helpful for the Division to contact them related to these services:

- DEEC licenses all "community-based acute treatment" and "intensive community-based treatment" programs in the Commonwealth. For more information, the contacts for DEEC licensing are: Christina Wescott, Commissioner's Liaison (Christina.Wescott@mass.gov); Kelly Buckley, Residential and Placement Licensing Supervisor (Kelly.Buckley@state.ma.us); and Timothy Keane, Residential and Placement Licensing Supervisor (Timothy.Keane@state.ma.us).
- DMH licenses all private psychiatric units and hospitals, which are the locations where consumers receive "mental health acute treatment." For more information, the DMH contacts for licensing are: Janet Ross, Assistant Commissioner for Clinical and Professional Services/ Director of Licensing (Janet.Ross@state.ma.us) and Jay Potter, Director of Community Licensing/ Program Evaluation (Jay.Potter@state.ma.us).

2) The definitions for "community-based acute treatment" and "intensive community-based treatment" refer to "services for children and adolescents." There is not such a difference to children and adolescents in "mental health acute treatment." Is there a difference in eligibility for "mental health acute treatment" than for "community-based acute treatment" and "intensive community-based treatment"?

We understand this question to be asking about any age limitations to eligibility for these programs. It is our understanding that "Community-based acute treatment (CBAT)" is provided to children and adolescents up to the age of 21. The Massachusetts Association for Mental Health (MAMH) manages Network of Care Massachusetts for the Commonwealth. MAMH receives licensing data from DEEC to populate the CBAT/ICBAT portion of the Network of Care Massachusetts service directory. According to the data MAMH received for 2021, CBATs were licensed to serve youth ranging in ages from 3 to 21. "Mental health acute services" are for individuals of all ages. When DMH licenses private psychiatric hospitals and units, they license child, adolescent, adult, and older adult beds.[4]

We gather from this question that the Division is interested in identifying features that distinguish these programs from one another. In addition to addressing eligibility differences related to age, the Division may choose to recognize other distinctions of consumers accessing each of these programs. For example, child, adolescent, or adult patients who are treated on an involuntary basis in a mental health hospital unit may require a locked door setting, while youth who go to a CBAT should be appropriate for an unlocked setting. One might identify other features of these units that distinguish them, particularly features that distinguish hospital-based settings from community-based settings.

[4] Department of Mental Health. DMH Licensed Hospitals. October 2022. Available at: https://www.mass.gov/doc/dmh-licensed-hospital-list-1/download.

3) When referring to "services for children and adolescents," is it clear which age groupings would fall into the categories of "children and adolescents?"

The CMHC recommends that the Division further clarify and ensure a consistent approach among insurers and providers to defining the age ranges to be served in particular program models. This would avoid adding barriers to this benefit based arbitrarily upon age. Chapter 177 does not define the terms "children and adolescents." While the previously enacted state mental health parity law does use the term "adolescent" in one section in a manner that implies a specific age range,[5] any potential inconsistency the term "adolescents" might pose is mooted by the broad mandate under M.G.L. c. 176G, § 4M, for carriers to cover all services to treat mental health conditions at all intermediate levels of care for all insured persons. Under this section of the law, all persons, regardless of age, would be eligible for treatment in a CBAT or ICBAT so long as that level of intermediate treatment is clinically appropriate for a person of that age.

As referenced above, some CBATs are licensed to serve persons aged 3 to 21. Based on well-established current medical practice in the state, carriers should be required to, at a minimum, cover services for persons aged 3 to 21, consistent with current DEEC licensing of CBAT/ICBAT providers. Within this broad age range, there are some differences in specialization by individual CBAT providers, in that different CBATs treat children and adolescents of different ages. For instance, Walker - The Cottage in Needham has the capacity to serve 16 youth, ages 3 through 14; St. Ann's - Williams Center in Methuen has the capacity to serve 15 youth, ages 5 through 21. In light of the practice of establishing treatment programs that target expertise to particular age groups, the Division should ensure that the carriers determine which age groups are served and develop an adequate supply of services in their provider networks to ensure sufficient provider capacity specialized to treat each of the specific age ranges in need of care.[6] The Division also should require carriers to acknowledge such specialized groups of age ranges in the development of the carrier's medical necessity guidelines.

4) The law applies as policies are issued or renewed within or without the Commonwealth. Is this clear or would it be helpful to do a Q&A with examples of what this means? The law also applies to insured health plans. Would it be helpful to do a Q&A with examples of what this means? How will covered persons and providers know whether or not the law applies to them?

Yes, the CMHC recommends that the Division develop a Q&A on fully-insured versus self-funded plans. This type of clarification would also be helpful for other topics covered under this Division listening session series, for instance coverage for annual mental wellness exams. Perhaps an overall, or umbrella, Q&A would be helpful for all new covered benefits under Chapter 177 of the Acts of 2022. Separate Q&As might be indicated for specific covered services.

We also recommend that the Division issue regulations to require health insurance carriers to include a designation of whether the plan is fully-insured or self-funded on all newly issued member ID cards and all newly issued Evidence of Coverage documents.[7] This recommendation is also applicable to numerous

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[5] M.G.L. c. 176G, § 4M refers to "children and adolescents under the age of 19…."

[6] See M.G.L. c. 176O, § 15(h): "(h) A carrier shall provide coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services."

[7] The Division has the express authority to require this disclosure in the Evidence of Coverage documents under M.G.L. c. 176O, § 6(a)(15): "(a) A carrier shall issue and deliver to at least one adult insured in each household residing in the commonwealth, upon enrollment, an evidence of coverage and any amendments thereto. Said evidence of coverage shall contain a clear, concise and complete statement of: … (15) such other information as

topics covered under this listening session series. Such designation would help consumers, providers and those assisting consumers know whether their plan is required to comply with the state requirements, and where to go to file a parity complaint. In the context of mental health acute services under Chapter 177, it would also help providers understand if they need to meet preauthorization requirements (also see Question 8 below).

We greatly appreciate the Division and DMH's efforts to develop Information for Consumers about Access to BHCA Services, which includes phone numbers for different carriers.[8] We also understand the EPIA process includes resources to facilitate quick contact with the appropriate persons at different health plans. In considering these enhancements, we still recommend a designation of fully- versus self-insured on members' health insurance ID cards. The aforementioned documents and processes exist for specific services, and still require multiple steps for consumers and providers to understand if a plan is fully- or self-insured. A designation on members' health insurance ID cards would greatly contribute to transparency and be a tremendous aid in helping consumers and providers navigate processes and requirements across different health insurance plans.

> *5) It is noted that the provisions apply to coverage that "is considered creditable coverage under section 1 of chapter 111M." Would it be helpful to include information within a Q&A to explain what creditable coverage is and which plans are considered to be creditable coverage?*

Perhaps. The mandate under Chapter 177 to cover acute care and CBAT/ICBAT services extends to HMO plans, Blue Cross and Blue Shield plans, and traditional policies of accident or sickness. However, Chapter 177 only makes reference to "creditable coverage" under the latter group of plans that are covered under a "policy of accident and sickness insurance" in M.G.L. Chapter 175.[9]

We recommend that the Division first ensure that the various stakeholders engaged in implementation of Chapter 177 are clear about the intent and impact of this provision, as it appears there may be conflicting interpretations. To the extent that some types of limited "accident and sickness" health insurance plans are not required to cover these benefits, such a limitation should be clearly indicated in the plan's consumer-facing documents. We would welcome the Division's efforts to help clarify this information for the insured members in these plans through a carefully written Q&A document that spells out for consumers how to determine if their plan is such a plan that may not include coverage for these benefits.

The Q&A should explicitly state which plans this particular provision applies to. The Division could collaborate with advocacy organizations working to help educate consumers and providers about access to these benefits to devise a publication with information about the number of persons who are covered under "policies of accident and sickness" as compared to HMO and traditional Blue Cross/Blue Shield plans. With agreed upon language in a publication, advocates can assist in educating consumers accurately and responsibly about any possible limits on the types of "sickness."

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the commissioner may by regulation require." We respectfully assert that this authority implies that the Division could also require this disclosure on the annually issued plan membership ID card.

[8] Division of Insurance and Department of Mental Health. Information for Consumers about Access to BHCA Services. Available at: https://www.mass.gov/doc/information-for-consumers-about-bhca-services/download.

[9] Chapter 177, § 51 applies to policies of "accident and sickness insurance" governed by M.G.L. 175, as compared to Chapter 177, §§ 55 (M.G.L. 176A, traditional Blue Cross plans), 58 (M.G.L. 176B, traditional Blue Shield plans) and 67 (M.G.L. 176G, HMO-style plans).

As a matter of health equity, in order to prevent future medical debt, we request that the Division consider the following steps in order to give plan members in such limited 'sickness insurance' plans adequate notice that their plan does not include these benefits:

- Ensuring the carrier's customer service staff have easy and instant access to determine, plan member by plan member, whether these benefits are included in their plan;
- Requiring carriers to furnish plan members with direct notice that these benefits are not included in their plan; and
- Requiring carriers of such plans to include prominent notice in the plan documents that their plan does not include these benefits.

6) The law does not include any provisions related to cost-sharing. Would it be helpful to include information within a Q&A to explain that plan deductibles, coinsurance or copayments may apply to such services?

The CMHC urges the Division to make consumer cost-sharing expectations transparent. It should be clear to consumers and providers how to get information from their carrier about whether cost-sharing applies - and the amount of cost-sharing applicable - for a particular service, including CBAT/ICBAT and acute services. In addition to a statement in a Q&A that cost-sharing may apply, it would be helpful to include a brief statement about calling one's carrier to get information about cost-sharing obligations for a particular service. The cost-sharing requirements for any acute care inpatient admission, ICBAT admission, or CBAT admission should also be clearly displayed in any documents that typically list cost-sharing obligations, such as a Schedule of Benefits or a Summary of Benefits and Coverage (SBC). The Division also should ensure that any cost-sharing requirements for these behavioral health benefits are compliant with the parity obligations for quantitative treatment limitations (QTLs) under federal parity law.

7) Does there need to be clarity about how to bill carriers for the noted services?

As a general statement, the CMHC suggests it is helpful to streamline and align billing practices across carriers to reduce administrative complexity and burden while facilitating more accurate billing practices. To help ensure that consumers can continue to access services after they may be forced to change health plans due to changes in employer, or changes in income, we recommend that the Division work with MassHealth to institute standardized and consistent descriptions and billing codes for these services.

8) It is noted that there "shall not require a preauthorization before the administration of such treatment; provided, however, that the facility shall notify the carrier of the admission and the initial treatment plan within 72 hours of admission."
a. Is it clear that providers do not need to contact an insured health plan prior to the patient being admitted?
b. Does there need to be any clarity about the method that facilities must use to notify a carrier of the admission and the initial treatment plan?
c. What happens if a provider does not notify a facility within 72 hours of admission?

The language in Chapter 177 is clear that providers do not need to request preauthorization before rendering services. However, it would be helpful to clarify in guidance or Q&A document that this means that while the facility is not required to obtain preauthorization or contact the carrier prior to admission, they are required to notify the carrier of the admission and treatment plan within 72 hours of admission.

In consideration of the feedback from the listening session, it is also evident that providers and facilities providing CBAT/ICBAT and acute mental health services need additional information from carriers about the information the post-admission notification must contain. As with other carrier requirements, alignment among carriers on these requirements would reduce administrative complexity and the potential for errors.

> *9) The law is clear that preauthorization is not required. What provisions should apply to concurrent and retrospective review*?

The CMHC strongly recommends that the Division issue clarifying guidance on the appropriate process for any concurrent review process initiated by a carrier after an admission. We also suggest that any "retrospective review" is implicitly prohibited by the statute's ban on pre-authorization review. This guidance should clarify the carrier's obligations to communicate to the insured member about:

- The basis for the denial, explained in sufficient clarity and detail as required under state regulation 211 CMR 52.07(6) et. seq, and federal regulation 29 C.F.R. § 2560.503–1(g) et seq.
- The member's appeal rights, including the right to access ongoing coverage pending their internal appeal.
- Any resources available to assist consumers with understanding and navigating the appeals process, such as the Massachusetts Office of Patient Protection.

Chapter 177 states that coverage for "medically necessary care" is required. The definition of medical necessity should be based on national, evidence-based guidelines and standards, be consistent across all carriers, and be made transparent. It is both a burden to the provider and to the consumer for health insurance carriers to issue retroactive denials. Section 75 of Chapter 177 establishes a special commission to study medical necessity determinations for behavioral health; the commission must submit its recommendations to the Legislature within one year of the effective date of the act (approximately November 10, 2023). The Division should ensure that the guidance it promulgates around medical necessity is commensurate with the future recommendations put forth by this commission.

> *10) What types of provider and member education may be helpful to educate providers and members about the availability of these services?*

The CMHC recommends that the Division post easy-to-understand materials on its website and that carriers include clear information on their websites and web portals about these new services. The Division also should engage organizations that work directly with individuals and families on health care issues to inform them about the benefits that Chapter 177 requires to be covered. For example, as we previously commented, during the roll-out of "Behavioral Health for Children and Adolescents," key stakeholders such as the Children's Mental Health Campaign (including HCFA and HLA), the Autism Insurance Resource Center, the Federation for Children with Special Needs, and the Parent/Professional Advocacy League were at the table with the Division, DMH, and MassHealth to discuss consumer-facing materials and implementation considerations. The Division should consider working with these groups and others (such as the MA League of Community Health Centers, MA Chapter of the American Academy of Pediatrics, Association for Behavioral Healthcare, MA Association for Mental Health, National Alliance on Mental Illness - MA, National Association of Social Workers - MA, MA Psychological Association, MA Psychiatric Society, MA Medical Society, etc.) to develop clear and consistent messaging for consumers to help them understand these benefits and who to contact if they have problems accessing these services.

These types of organizations also can be helpful in developing outreach plans to ensure that the messaging is understandable to different audiences, and also that it is broadly disseminated through various channels.

11) Are there any barriers or privacy concerns that should be considered?

The CMHC appreciates the Division's inclusion of this question. With respect to barriers, the most likely barrier will be the lack of adequate networks of available providers of these specialized services for children. Provider willingness to join carrier networks is often a function of two primary factors– the sufficiency of the reimbursement rate for the services provided, and the degree of administrative requirement associated with the carrier's authorization and billing procedures. We hope that the Division will inquire into these two issues as the carriers create their networks of acute care, CBAT and ICBAT providers, and that the Division will regularly review the carrier practices in these two areas in their ongoing enforcement of federal parity law and in their implementation of various parity provisions in Chapter 177.

With respect to privacy concerns, provision of these community-based treatment services should follow all established privacy protections currently required under law, regulation, and/or as required by codes of ethics and practice requirements for providers and professionals. These protections should be shared with consumers, including minors, when appropriate.

Consistent with such privacy protections, we also would suggest that the Division collect data from carriers that would allow inquiry regarding who is or is not accessing these services. It is important both to ensure that each service is described clearly so that it is easily understood and accessible to people of diverse backgrounds and to ensure that certain groups, particularly historically marginalized populations or persons residing in geographically isolated areas of the state, are not unintentionally deprived of access to such services. Conversely, this data collection could also seek to identify the numbers of youth involved with state agencies in these programs, including youth served by the Department of Children and Families (DCF), youth in DCF custody, youth in foster care, youth served by the Department of Youth Services (DYS), and youth in DYS custody, etc., to see if these populations are overrepresented.