November 21, 2022

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street, #810
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Sent by email to kevin.beagan@mass.gov and rebecca.butler@mass.gov

Re: Comments Regarding Chapter 177 of the Acts of 2022 – Emergency Services Programs (ESPs)

Dear Deputy Commissioner Beagan and General Counsel Butler:

On behalf of Health Care for All and the Massachusetts Association for Mental Health, thank you for holding listening sessions and for the opportunity to comment on various provisions of Chapter 177 of the Acts of 2022, *An Act addressing barriers to care for mental health*. Please find below responses to the questions the Division of Insurance ("Division") has asked stakeholders to respond to in developing further guidance on the requirement for health insurance carriers to cover Emergency Services Programs (ESPs).

We look forward to working with the Division to ensure effective and impactful implementation of these benefits. Please do not hesitate to contact us with any questions or to discuss our comments further. Thank you.

Sincerely,

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1) *Is the definition of "Emergency Services Programs" understood or does it require additional clarification?*

The definition of "Emergency Services Programs," commonly known as "ESPs," requires additional clarification, especially in the changing behavioral health landscape, envisioned under the EOHHS Roadmap for Behavioral Health Reform ("Roadmap") and other recent and upcoming initiatives. As we have stated in previous comments, all state agencies and payors should use common terminology to describe the same benefits or services, which will promote common understanding across agencies, payors, providers, and consumers.

While the term "Emergency Services Programs" ("ESP") is included in Chapter 177 of the Acts of 2022, in practice it represents a historical program, not a billing code, and the term is being phased out. For example, in its recent regulatory changes regarding Community Behavioral Health Centers (CBHCs), MassHealth no longer uses the term "ESP." Instead, MassHealth refers to "Adult Mobile Crisis Intervention" ("AMCI"), "Youth Mobile Crisis Intervention" ("YMCI"), "Adult Community Crisis Stabilization" ("Adult CCS)," and "Youth Community Crisis Stabilization" ("YCCS"). Please see MassHealth proposed regulation 130 CMR 448.000: Community Behavioral Health Center Services here: https://www.mass.gov/doc/proposed-regulation-date-filed-september-30-2022-0/download.

Also of note, the definition of ESP in Chapter 177 also does not include YCCS services. When the Legislature drafted and the Governor signed Chapter 177 earlier in 2022, the YCCS level of care did not exist in our Commonwealth. YCCS services will come online as part of the Roadmap with the launch of the CBHCs in January 2023, which represents a very exciting and important development in the continuum of services for youth in crisis and their families. YCCS is a critical element in helping to address the crisis of youth emergency department (ED) boarding, by diverting youth from EDs and hospitalization in the first place, and by creating a step-down level of care for youth post-hospitalization to facilitate successful transitions back to the community. In forthcoming DOI bulletins or regulations, we recommend that YCCS be included with AMCI, YMCI, and Adult CCS as a mandated benefit as part of the overall vision for a comprehensive system of crisis and emergency services for people of all ages in the Commonwealth.

2) *In Section 2WWWWW of Chapter 29 of the Acts of 2022, it is noted that "[t]here shall be a Behavioral Health Access and Crisis Intervention Trust Fund to be administered by the secretary of health human services...[and t]he secretary may expend money from the fund, without further appropriation, to support a statewide, payor-agnostic community behavioral health crisis system including, but not limited to, all necessary costs to support: (i) a behavioral health access line to connect individuals to behavioral health services, including clinical assessment and triage; and (ii) a statewide system to deliver behavioral health crisis intervention services 24 hours per day and 7 days per week in mobile and community-based settings, available to all residents without regard to insurance." How does the statewide system to deliver behavioral health crisis intervention services work in relation to the mandate for Emergency Services Programs?*

The Behavioral Health Access and Crisis Intervention Trust Fund ("Trust Fund") was created as part of the Massachusetts FY23 state budget, Chapter 126 of the Acts of 2022. Each surcharge payor is responsible for paying a portion of the total $33.7M total behavioral health surcharge amount. Monies will be used for the two purposes described above: i) the Behavioral Health Help Line; and ii) a statewide

system to deliver behavioral health crisis intervention services, 24/7 in mobile and community-based settings, available to all residents, without regard to insurance. This last part, "without regard to insurance," is particularly important as not all plans have historically covered behavioral health emergency services in mobile and community-based settings.

Regarding (ii) above, the statewide system to deliver behavioral health crisis intervention services, the dollars that surcharge payors contribute to the Trust Fund are intended to cover "first touch" or "first 24-hour" crisis assessment services that occur in community-based settings.

The model for the Behavioral Health Access and Crisis Intervention Trust Fund is CBHC-centric. It's clear from the statute that the Trust Fund applies to mobile and community-based settings, not hospital-based settings such as EDs and inpatient hospital stays. The "first touch" or "first 24-hour" services occur through the AMCI, YMCI, Adult CCS, and YCCS services provided by the CHBCs.

Hospital ED encounters are paid for separately than the Trust Fund and the coverage mandate in Chapter 177. Hospital ED encounters have always been paid for, whereas behavioral health emergency services in mobile and community-based settings have not. These are not new costs for hospitals, and hospitals now have crisis intervention billing codes. Setting is a determining factor related to the Trust Fund and the coverage mandate in Chapter 177. If the crisis services are provided in mobile or community-based settings, they are covered by the payor assessment to the Trust Fund and coverage mandate in Chapter 177. If the crisis services are provided in hospital settings, they are covered by separate billing codes, not through the Trust Fund or through the Chapter 177 coverage mandate.

According to MassHealth proposed regulation 130 CMR 448.000: Community Behavioral Health Center Services, follow-up periods are required for behavioral health crisis services:

- AMCI: Requires continued crisis intervention and stabilization services, including follow-up care, as clinically indicated, for up to 72 hours after the initial day of service;
- YMCI: Requires continued crisis intervention and stabilization services, including follow-up care, as clinically indicated, for up to seven days after the initial day of service;
- Adult CCS and YCCS are also intended to be multi-day or multi-week services. They "are community-based programs that serve as a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provide short-term staff-secure, safe, and structured crisis stabilization and treatment services." Please see: https://www.mass.gov/doc/proposed-regulation-date-filed-september-30-2022-0/download.

Payors pay for "first touch" or "first 24-hour" AMCI, YMCI, Adult CCS, and YCCS services through the payor surcharge to the Trust Fund. After the "first touch" or "first 24-hours" of services, members' health insurance coverage picks up; payors are required to cover AMCI, YMCI, and Adult CCS for their members after the "first touch" or "first 24-hours" of services through the coverage mandate in Chapter 177. As stated above, that is up to 72 hours for AMCI, up to seven days for YMCI, and upon evaluation and assessment of readiness for discharge by the multi-disciplinary team for Adult CSS.

As noted in our response to Question #1, YCCS was not included in the definition of ESP in Chapter 177 as the service does not come online until January 2023. We strongly recommend that DOI include it as a requirement of the coverage mandate. Otherwise, plans will pay for "first touch" or "first 24-hour" YCCS

services through the payor surcharge to the Trust Fund, but they will not be required to cover the ongoing YCCS services that the child/adolescent and family need for the remainder of that episode.

While the applicability of the payor surcharge to the Trust Fund and the mandate in Chapter 177 are both clear by setting, that is mobile and community-based settings, we believe the construct around "first touch" and "first 24-hours" is less clear. We encourage DOI to work with EOHHS to clarify for plans, providers, individuals, and families what is meant by "first touch" and "first 24-hours" related to AMCI, YMCI, Adult CCS, and Youth CCS. As part of the FY23 budget construction, the Administration calculated $33.7 million as the "total behavioral health surcharge amount" (Section 65 of the FY23 state budget, Chapter 126 of the Acts of 2022). It is important to articulate to various stakeholders what is included as "first touch" or "first 24 hour" in the $33.7 million calculation. That way, it will be clear which services apply to the payor surcharge through the Trust Fund, and which services apply to the mandate in Chapter 177. The requirements – payor surcharge and coverage mandate – are meant to wrap around each other so that individuals and families in the Commonwealth receive seamless and full coverage for AMCI, YMCI, Adult CCS, and YCCS. The legislative intent of Chapter 177 and one of the goals of the Roadmap is to expand access, for individuals of all ages in the Commonwealth, to a comprehesive array of behavioral health emergency and crisis services.

3) *Is it clear what "programs subject to contract between the Massachusetts Behavioral Health Partnership and nonprofit organizations for the provision of community-based emergency psychiatric services" means?*

   i. Is there a list of which programs would fit these programs?

   ii. Are there standards or certifications that such programs are to meet so that they are to be included within this mandate?

   iii. Where the law identifies that the programs "are subject to contract", does this require that they are under contract with the Massachusetts Behavioral Health Partnership (MBHP) or that they just be eligible to contract with MBHP?

   iv. Is it understood that all Emergency Services Programs are non-profit organizations?

   v. Is there anything more that should be understood about Emergency Services Programs whithin evolving changes in care delivery systems?

As referenced above, the Roadmap includes the creation of CBHCs. The Massachusetts Behavioral Health Partnership (MBHP) administered the procurement and selection process of CBHCs for MassHealth and manages the contracts with these entities. Therefore, as currently constructed, provider entities must be contracted with MBHP to be designated as a CBHC. CBHCs will be implemented beginning January 1, 2023. A list of entities chosen to be CBHCs, and the associated procurement documents, including provider specifications, can be found here: https://www.masspartnership.com/provider/cbhcrfp.aspx.

MBHP is the entity that has managed the MassHealth behavioral health carve out for decades. MBHP is now managing the contracts with the CBHCs for MassHealth and was selected in recent weeks by MassHealth to continue managing comprehensive behavioral health services to certain MassHealth members, provide support to EOHHS in the management of the Primary Care Clinician (PCC) Plan, as well as to develop and maintain the 24/7 Behavioral Health Help Line. While we do not anticipate any

changes, DOI should consider whether to name a company subject to MassHealth procurement in regulations.

It is preferred that CBHCs offer AMCI and YCMI services directly; however, it is possible for the CBHC to subcontract with another organization to provide AMCI or YMCI services in the CBHC's catchment area (Please see Procurement for CBHC programs, Page 8: https://www.masspartnership.com/pdf/CBHC-RFP-2-1-22FIN.pdf). Also, CBHCs not operating their own YCCS are required to ensure access to and develop formalized agreements with regionally located CBHCs who are providing YCCS services (Please see Procurement for CBHC Programs, Page 7: https://www.masspartnership.com/pdf/CBHC-RFP-2-1-22FIN.pdf). While a single CBHC agency must serve as lead agency with MBHP, ensuring all contractual obligations, performance standards, and quality metrics, when developing bulletins and regulations, DOI should consider that a CBHC might enter into subcontracted and/or formalized agreements with other entities to provide behavioral health emergency and crisis services.

We note that many of the organizations selected to be CBHCs have historically been contracted to provide the ESP program and will be required to offer a broader range of services as they transition to CBHCs.

4) *It is noted that emergency services programs provide "community-based emergency psychiatric services, including, but not limited to, 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 providers community-based locations; and (iv) adult community crisis stabilization services."*

   a) Is it clear what is included within "community-based psychiatric services"?

      i. Are there known standards for what is to be considered "community-based services"? There is a list of what is to be included. Should other items be added for clarity?

      ii. Is it understood what constitutes "behavioral health crisis assessment, intervention and stabilization services 24 hours a day, 7 days per week"?

      iii. Is it understood what constitutes "mobile crisis intervention services for youth"? Are there standards that a provider is expected to meet when providing this level of care?

      iv. Is it understood what constitutes "mobile crisis intervention for adults"? Are there standards that a provider is expected to meet when providing this level of care?

      v. Is it understood what constitutes "emergency service provider community-based locations"? Are there standards that a provider is expected to meet when providing this level of care?

      vi. Is it understood what constitutes "adult community crisis stabilization services"? Are there standards that a provider is expected to meet when providing this level of care?

The term "community-based services" is meant to describe services that are provided in the community (including by mobile crisis teams); these services therefore exclude services provided in a hospital/ED settings. As stated above in our response to Question #2, setting is an important determining factor related to the Trust Fund established in the FY23 state budget and the coverage mandate in Chapter 177. If the crisis services are provided in mobile or community-based settings, they are covered by the

payor assessment to the Trust Fund and coverage mandate in Chapter 177. If the crisis services are provided in hospital settings, they are covered by separate billing codes, not the Trust Fund nor through the Chapter 177 coverage mandate. Hospitals now have crisis intervention billing codes.

While ESP services were previously available in hospital EDs to conduct assessments, due to the changes in Chapter 177 and the Roadmap, we understand that this will no longer be the case. In fact, Chapter 177 requires acute care hospitals to have mental health professionals available during all ED operating hours to evaluate a person presenting with a mental health concern (Sections 32 and 87). Further, to benefit all behavioral health stakeholders, the Roadmap explicitly create a comprehensive, payor agnostic system of mobile and community-based crisis services for the express purpose of diverting individuals and families away from hospital-based settings to alleviate the ED boarding crisis.

For definitions and standards for AMCI, YMCI, Adult CCS, and YCCS, please see the Request for Proposals for CHBCs and community-based behavioral health crisis services programs (https://www.masspartnership.com/provider/cbhcrfp.aspx) and MassHealth proposed regulation 130 CMR 448.000 (https://www.mass.gov/doc/proposed-regulation-date-filed-september-30-2022-0/download).

5) *Are health plans and providers to enter into new contracts to provide the services of the "Emergency Services Programs"?*

It is likely that health plans will need to enter into new contracts with the newly formed CBHCs for emergency services and the other services CBHCs will provide. It is our understanding that MassHealth will pay CBHCs through a bundled, encounter-based payment structure, rather than a fee-for-service model, which we would encourage commercial payors also to consider. We note that the Health Connector is requiring carriers who sell plans through the Health Connector (both ConnectorCare and non-ConnectorCare plans) to contract with CBHCs for the earliest plan year in which they are available. See: https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2022/03-10-22/2021-Proposed-Seal-of-Approval-031022.pdf.

6) *For plans providing benefits through a network of providers, are all "Emergency Services Programs" to be available as in-network providers under an insured's health plan?*

Since these are all emergency services, all "Emergency Services Programs" should be in-network. The goal is to divert people from EDs, and this requires coverage to work as intended. Also, with the new CBHC program, providers are available regionally, serving people in specific cities/towns; if a carrier serves a certain region of the state, or is available to members statewide, they will need to contract with all CBHCs to ensure network adequacy for their members.

7) *The law applies as policies are "delivered, issues 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 this law applies to them?*

Yes, Q&As with examples would be helpful, and it would be particularly helpful if Q&As were tailored to different audiences – payors, providers, and consumers. As with other services required only under state law, it is important to make information clear to consumers about the benefits available to them,

distinguishing between fully insured/state-regulated and self-insured plans, and to ensure consistency of definitions and terms used to describe services across payors. This information is also very important for providers. Payors should ensure this information is clear in all plan documentation and on patient portals and ensure proper training for customer service representatives. We reiterate the comments we have made in previous listening sessions about written communications regarding consumer education, including being part of the process of developing said communications, and paying attention to language accessibility.

8) *The law does not include any provisions related to cost sharing. Does Bulletin 2000-14 - download (mass.gov) - apply to these services? Would it be helpful to include information within Evidence of Coverage, plan websites, and a Q&A to explain plan deductibles, coinsurance, or copayments in relation to these services?*

Bulletin 2000-14 and Chapter 141 of the Acts of 2000 appear to apply to emergency services provided in hospital EDs, rather than in community settings. Part (b) of Section 17(a) of Chapter 141 states: "…the division (MassHealth) or its designee may enter into contracts with hospitals or emergency physician groups, or both, for the provision of emergency services."

Yes, it would be helpful to include information in each plan's Evidence of Coverage, carrier websites, and patient portals, and to develop a Q&A to explain cost-sharing in relation to these services. This information should be clear, concise, and include phone number(s) and website(s) to consult for further information. We reiterate our previous comments on this issue.

9) Does there need to be any clarity about utilization review for care provided through the "Emergency Services Program" of care? *Does Bulletin 2000-14 - download (mass.gov) - apply to these services? Would it be helpful to include information within Evidence of Coverage, plan websites, and a Q&A to explain plan deductibles, coinsurance, or copayments in relation to these services?*

Yes, it will be helpful to include information about utilization review in Evidence of Coverage and other plan documents and plan websites, and to develop a Q&A regarding these services in a concise, understandable, and aligned way across carriers. We reiterate our comments from Question #8 and previous written comments on this question.

10) *Does there need to be clarity about how to bill carriers for any care provided through the "Emergency Services Program"?*

From the listening session, it does appear there needs to be clarity about how to bill for these services and to make the billing and reimbursement process as streamlined as possible, with aligned procedures across payors.

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

The Roadmap and Chapter 177 were designed to reform the behavioral health emergency and crisis services so that any resident of Massachusetts, regardless of insurance type, can access high-quality and timely treatment in community-based settings. This will benefit individuals and families, as EDs are typically not therapeutic behavioral health treatment environments. These reform efforts will also benefit hospitals by reducing ED boarding and health plans by shifting care to lower-cost settings.

We recommend that DOI issue guidance or a bulletin for plans to disseminate a clear and consistent message to their members that they should call the Behavioral Health Help Line in the event of a behavioral health crisis. Private carriers will already be paying for the Behavioral Health Help Line and "first touch" or "first 24-hour" services through AMCI, YMCI, Adult CCS, and YCCS through the payor surcharge to the Trust Fund. All plans – both public and private – must come together and play an active role in diverting their members from EDs to mobile and community-based treatment. If MassHealth, the Group Insurance Commission, and private carriers are all communicating the same guidance to members on steps to take in the event of a behavioral health crisis, Massachusetts can fundamentally transform its crisis system and advance the goals of providing timely, community-based, appropriate, and therapeutic crisis services to those in need.

Education should include information in appropriate health plan documents, such as the schedule of benefits, Q&As, and other documents. Plans should provide specific telephone numbers and web addresses for the Behavioral Health Help Line and where consumers can obtain more information through their plan. Information should also be made available to providers about how to provide and arrange for coverage for these services. Information should also be included on insurance cards. As with consumer-facing materials overall, options should be available for people with Limited English Proficiency to receive the appropriate information. Providers will also need to be educated about how to bill for their services and about which services are universally available due to the payor assessment and Trust Fund (see above) and which are available due to the coverage requirement in Chapter 177. Again, with the rollout of the Behavioral Health Help Line and CBHCs, the Commonwealth will need to work in an integrated manner across agencies, and with payors, providers, consumers, and other stakeholders to ensure clarity regarding what is available to whom and any costs associated with services for the various stakeholders.

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

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 DOI 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. This is particularly important for historically marginalized populations and persons residing in geographically isolated areas of the state, to ensure that they 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 served by the Department of Youth Services (DYS), etc., to see if these populations are overrepresented.