ACCESS TO OUTPATIENT MENTAL HEALTH SERVICES IN MASSACHUSETTS

Navigating the Outpatient Mental Health System in Massachusetts:

CONSUMER AND STAKEHOLDER PERSPECTIVES

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The mission of the Blue Cross Blue Shield of Massachusetts Foundation is to expand access to health care for low-income and vulnerable individuals and families in the Commonwealth. The Foundation was founded in 2001 with an initial endowment from Blue Cross Blue Shield of Massachusetts. It operates separately from the company and is governed by its own Board of Directors.

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1. BACKGROUND AND STUDY OVERVIEW

Many individuals seeking mental health services confront barriers to connecting with effective, affordable, and equitable outpatient treatment.[1–3] Despite a greater per capita supply of mental health providers[4] and a lower rate of uninsured adults and children in Massachusetts relative to other states,[5,6] individuals and providers report delays and wait lists associated with accessing outpatient mental health services.[7] There are limited publicly available data and few studies on actual wait times or experiences accessing outpatient mental health services in Massachusetts.

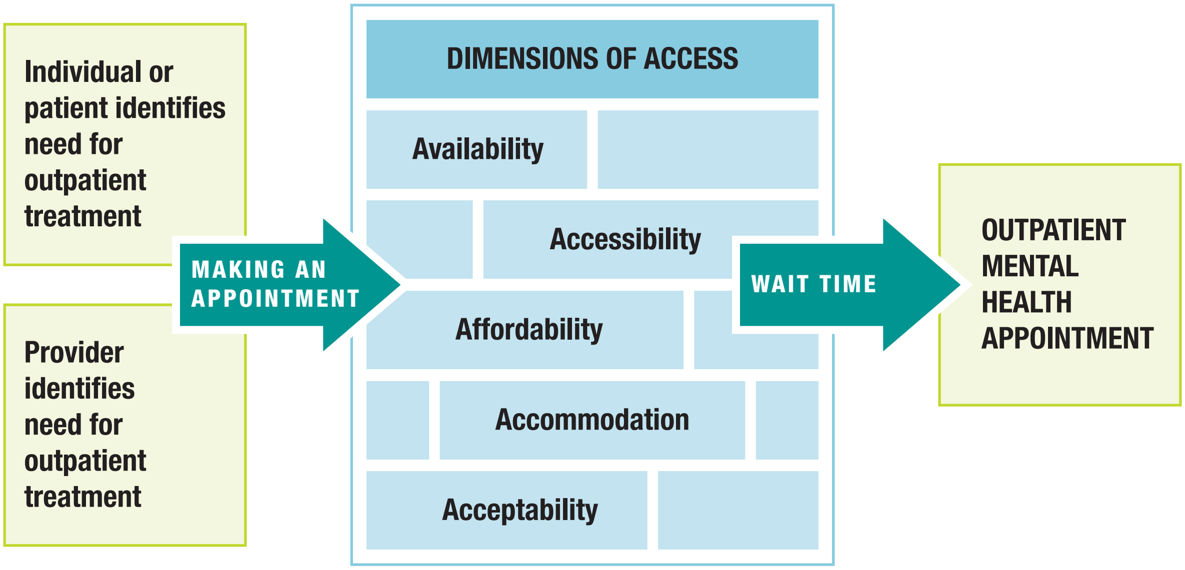
Historically, low reimbursement rates, high workforce turnover, and fragmented service systems have impacted access to mental health services. Simultaneously, over the past decade, since the passage of the Affordable Care Act and mental health parity legislation, the demand for services has increased.[8] Safety-net settings are disproportionately impacted by low reimbursement and high provider turnover. In the Association for Behavioral Healthcare 2017 survey of its community-based mental health and addiction treatment provider organization members, 96 percent of respondent organizations reported losing money delivering outpatient mental health services during fiscal year 2016, which represents a 10 percent increase from the previous year in members that reported a loss (in 2015, the proportion was 86 percent).[9] The challenges persist even with the passage of sweeping state and federal reforms—most notably the Affordable Care Act, Massachusetts Medicaid expansion, and the Mental Health Parity and Addiction Equity Act[10,11]— that aim to improve access through expanded insurance coverage and elimination of inequities in insurance coverage of mental health services as compared with physical health services.

Given the limited contemporary data available pertaining to actual experience accessing outpatient mental health services in Massachusetts,[12–14] this study engaged a diverse group of stakeholders, providers, and service users to better identify and understand access issues from varying perspectives. The report addresses the following three research questions (RQs):

- **RQ1:** What do stakeholders and individuals and/or parents seeking services think are clinically appropriate wait times for outpatient mental health visits, and are providers and organizations able to meet clinically appropriate standards?
- **RQ2:** What is the experience of Massachusetts adults and children seeking an outpatient mental health appointment?
- **RQ3:** What factors impact the experience of adults and children in Massachusetts seeking outpatient mental health services?

To evaluate these questions, a conceptual framework based on Penchansky and Thomas' model of access to health care treatment was used.[15] This framework identifies five dimensions that can influence an individual's access to services. Time to actual receipt of services is influenced by *availability, accessibility, affordability,* and *acceptability* of care, as well as *accommodation* of individual client needs. A detailed depiction of the conceptual framework and its core domains of access can be found in Exhibit 1 below and are described in more detail in Appendix A.

EXHIBIT 1. CONCEPTUAL FRAMEWORK FOR ACCESS TO OUTPATIENT MENTAL HEALTH SERVICES



In order to address the three RQs, the research team employed a mixed-methods approach that relied on primary data collected through surveys of providers, interviews with stakeholders, and focus groups of individuals seeking services. This report summarizes qualitative findings from the interviews with stakeholders and focus groups of individuals seeking services, conducted in the summer and fall of 2016. The Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) has released a companion report summarizing the results of data from the provider surveys.[16] The remainder of this section provides an overview of the qualitative research methods used to conduct the interviews and focus groups. Additional details about the methods are included in Appendix B.

STAKEHOLDER INTERVIEWS

The research team conducted 21 interviews with a total of 24 stakeholders between July and October 2016 to learn more about factors that impact access to outpatient mental health services. As outlined in Exhibit 2, stakeholders included clinical leaders, health system administrators, state administrators and policymakers, and representatives from payers, associations of safety-net providers, and mental health advocacy organizations. These semi-structured interviews captured stakeholder perspectives on wait times, clinical appropriateness of wait times, and facilitators and barriers impacting access as identified in the conceptual framework (Appendix A).

The research team conducted 21 interviews with 24 stakeholders, including clinical leaders; health system administrators; state administrators and policymakers; and representatives from payers.

EXHIBIT 2. STAKEHOLDER INTERVIEWS BY TYPE OF STAKEHOLDER

Stakeholder type	Number of interviews	Number of individuals
Clinical leaders	5	5
Health system administrators	4	5
State administrators and policymakers	3	4
Representatives from payers	3	3
Representatives from associations of safety-net providers	2	3
Representatives from mental health advocacy organizations	4	4
Total	**21**	**24**

FOCUS GROUPS OF INDIVIDUALS SEEKING SERVICES

The research team also conducted four focus groups of service users in October 2016. These groups were composed of publicly and commercially insured individuals and parents who had sought services from an outpatient mental health provider for themselves or their child within the past six months.* All participants received a $50 gift card and a public transportation voucher for participating in the 90-minute discussion. The goals of the focus groups were to explore individual and family perspectives on the following:

Four focus groups included a total of 20 participants, composed of publicly and commercially insured individuals and parents who had sought services from an outpatient mental health provider for themselves or their child within the past six months.

- The process of seeking an outpatient mental health appointment;
- Wait times that participants experienced;
- Facilitators and barriers encountered when attempting to acquire an appointment, including how the pathways to outpatient mental health services may vary by type of insurance coverage or other factors; and
- What is working well and what can be improved in the health care system to increase access to mental health services.

Findings in this report are organized by research question and key theme. For each theme, the report summarizes relevant findings and includes data from stakeholder interviews and/or focus groups of service users. Direct quotations from participants are presented in italicized text.

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* Throughout this report, the terms “individual” and “adult” are used to refer to adults who sought services for themselves, and the term “parent”’ is used to refer to parents who sought services on behalf of a child.

2. CLINICALLY APPROPRIATE WAIT TIMES

RQ1.

What do stakeholders and individuals and/or parents seeking services think are clinically appropriate wait times for outpatient mental health visits, and are providers and organizations able to meet clinically appropriate standards?

When asked to consider what constitutes a clinically appropriate wait time for outpatient mental health services and whether Massachusetts providers are able meet standards for "clinically appropriate" time-to-care, stakeholders and/or focus group participants suggested the following:

- Current wait times are, in general, longer than clinically appropriate for the majority of individuals seeking services, regardless of their clinical presentation. Definitions of clinically appropriate wait times for outpatient mental health services vary based on diagnosis and diagnostic complexity;
- Individuals with emergent or urgent needs tend to receive timelier access to care; and
- Complex co-morbidities may delay access to providers with the appropriate specialization; individuals and parents of children with complex diagnoses and/or specialized service needs experienced particularly long wait times and challenges navigating the system.

Each of these key themes is discussed in more detail below.

As mentioned above, this report is organized by research questions and then by key themes pertaining to each of those questions. For each theme, the subsection summarizes perspectives of stakeholders and focus group participants, when applicable, that support findings.

KEY THEME:

Current wait times are, in general, longer than clinically appropriate for the majority of individuals seeking services, regardless of their clinical presentation. Definitions of clinically appropriate wait times for outpatient mental health services vary based on diagnosis and diagnostic complexity.

STAKEHOLDER PERSPECTIVES

There was variation among stakeholders in their definition of clinically appropriate wait times for outpatient mental health services. Many stakeholders, particularly health system administrators and payers, associated clinically appropriate time-to-care with payers' contractual obligations. Massachusetts' Medicaid plan, MassHealth, provides mental health services for many of its beneficiaries through the Massachusetts Behavioral Health Partnership (MBHP). MBHP is a managed behavioral health organization that administers mental health benefits for more than 430,000 individuals and works with a network of over 1,200 behavioral health providers.[17] MBHP's contracted providers are expected to comply with performance specifications for outpatient services, and many stakeholders equated aspects of these standards with the capacity of their organization or members to provide clinically appropriate care.[18] Stakeholders reported that commercial insurers have contractual standards similar to those of MBHP for outpatient mental health services but that information is not publicly available. Research conducted as part of this project revealed that contractual standards are hard to enforce across all insurer types.

Most stakeholders noted that MBHP's two-week standards for routine care do not reflect *actual* wait times for outpatient services in Massachusetts, particularly for new clients, who often wait longer than those already receiving services from a mental health provider. A mental health advocate noted that *"wait times have not been appropriate for a really long time and are at least weeks and more . . . sometimes months, depending on the region."* When asked how they enforce their standards for routine care, all payers said that performance specifications for routine care are difficult to track and enforce.

Many stakeholders and focus group participants also reported that wait times are particularly long in safety-net settings (see Section 4.1) and for individuals searching for a psychiatrist, especially children (see Section 4.2).

MBHP Performance Specifications for Outpatient Mental Health Services

- **Emergency service providers response time:** Within 1 hour
- **Urgent care:** Within 48 hours
- **Outpatient appointment post-inpatient discharge:** Within 7 calendar days
- **Mental health routine care:** Within 14 calendar days* of the request
- **Routine pharmacological care post-inpatient discharge:** As soon as clinically indicated and within 14 calendar days* from date of discharge.

* MBHP indicates mental health routine care performance specification of 10 business days, which has been interpreted here to equal 14 calendar days.

KEY THEME:

Individuals with emergent or urgent needs tend to receive timelier access to care.

STAKEHOLDER PERSPECTIVES

In contrast to health system administrators and payers, clinical leaders and mental health advocates principally defined clinically appropriate wait times based on clinical urgency of need. Although these stakeholders framed their responses around actual clinical need, the idea that providers and organizations should triage based on urgency is consistent with payer contractual standards: members in need of urgent care (and not experiencing a mental health or substance use disorder [SUD] emergency) should have access to an outpatient appointment within 48 hours.[18] Consistent with these guidelines, payers and clinical leaders expect that providers will prioritize appointments for existing clients based on urgency of client need and that intake procedures will include an assessment of treatment urgency. Health system administrators reported that most outpatient providers are able to successfully meet urgent outpatient service needs, particularly for their existing clients, in a time frame that generally corresponds with the 48-hour payer standards.

FOCUS GROUP PARTICIPANT PERSPECTIVES

Adults and some parents reported having more timely access to care when the need was truly emergent or urgent. One adult with public coverage suggested that it was appropriate for emergent mental health issues to receive priority and that if someone *"use[s] the word suicide, there is so much attention—the world stops,"* implying a provider or organization immediately prioritizes these emergent cases and facilitates an appointment. Nonetheless, an emergent appointment does not necessarily facilitate timely follow-up outpatient care for individuals with complex needs.

KEY THEME:

Complex co-morbidities may delay access to providers with the appropriate specialization; individuals and parents of children with complex diagnoses and/or specialized service needs experienced particularly long wait times and challenges navigating the system.

STAKEHOLDER PERSPECTIVES

While urgency of clinical need may facilitate access to services in some cases, particularly for individuals already engaged with a system of care, stakeholders suggested that individuals with complex physical, mental health, or SUD co-morbidities often have a more difficult time finding outpatient mental health services. There are fewer health care providers who have the resources and training to care for the unique needs of these individual patients. Clinical leaders working in safety-net settings reported challenges getting clients with multiple chronic conditions and other social service needs access to routine outpatient mental health services. Additionally, clinical leaders and mental health advocates suggested some providers *"cherry-pick the very best patients"* and avoid taking on those with more complex conditions and co-morbidities. The suggestion that mental health providers may *"cherry-pick,"* or routinely deny individuals who are most vulnerable, is consistent with concerns reported in prior reports on the Massachusetts mental health care system.[12]

One clinical leader noted that wait times are *"dramatically worse"* for clients with co-occurring mental health conditions and SUDs. She referenced stringent "no-show" policies at many outpatient clinics, such as policies that do not allow individuals who have regularly missed appointments to schedule subsequent visits, and she suggested that such policies make it difficult for clients with complex psychosocial needs to find consistent outpatient services. These no-show policies are common in a system that is primarily fee-for-service (FFS), because providers and organizations lose money when they are unable to bill for time that was reserved for a patient visit.[19]

Similarly, other clinical leaders reported that some organizations place clients who are deemed difficult to treat—e.g., people experiencing homelessness or with co-occurring SUDs who do not consistently show up to appointments—on a *"do-not-fly list."* Again this means these clients are unable to schedule visits because they are unable to comply with organizational policies around attending appointments or providing adequate cancellation notice. A payer representative noted that clients who are aggressive, have a history of assault, or need a trauma specialist also have longer wait times because they are perceived as *"harder patients"* and consequently, fewer providers are willing or able to take them on as clients.

FOCUS GROUP PARTICIPANT PERSPECTIVES

Many focus group participants experienced challenges navigating the system if the individual, or the parent's child, had complex psychosocial needs. In particular, individuals in need of treatment from providers with specialized training (e.g., co-occurring disorders, trauma, pediatric and adolescent psychiatry) had a hard time finding a covered provider with the appropriate specialization. Two adults who self-identified as having relatively complex needs said they thought that their diagnostic complexity increased the time it took them to find a provider. An adult with commercial insurance said she experienced what she perceived as *"providers [who] cherry-pick patients,"* which is similar to what stakeholders reported. She had a very difficult time finding a psychiatrist, which one provider told her was due to the complexity of her diagnosis and medications.

One parent shared that her son was partially hospitalized and treated in a dialectical behavioral therapy program to help him through a crisis. He was diagnosed with major depression, anxiety, and panic disorder, but the specialized outpatient provider who was recommended did not accept her insurance plan. For her son to see the recommended outpatient provider, she would have had to self-pay $200 per hour (i.e., without any insurance coverage or reimbursement). She searched to find an in-network provider with the recommended specialization, which delayed her son's treatment. Ultimately, she had to settle for a provider without the appropriate specialization but who accepted her insurance.

3. EXPERIENCES SEEKING OUTPATIENT APPOINTMENTS

RQ2.

What is the experience of Massachusetts adults and children seeking an outpatient mental health appointment?

This section focuses on the experience of adults and parents, with different types of insurance coverage, seeking outpatient mental health services. Highlighted below are some of the key themes or recurring challenges characterizing the experience of seeking outpatient mental health services, as noted by stakeholders and/or focus group participants. The key themes are organized by those pertaining to the role of insurance coverage in influencing access to care and wait times and, subsequently, those reflecting a need for services in a language other than English, culturally competent care, or other considerations that were identified as barriers to care.

Insurance coverage:

- Regardless of coverage type, individuals seeking services are frustrated by the onerous process of finding a mental health provider;
- Adults with public coverage reported experiencing longer wait times, on average, than did adults with commercial coverage. In contrast, parents of children with public coverage experienced shorter wait times, on average, than parents of children with commercial coverage; and

- Lack of insurance coverage (being uninsured) increases wait times or may limit one's ability to obtain an appointment altogether; however, capacity to self-pay can decrease wait time for services.

Language, cultural competency, and other factors:

- Wait times are longer for outpatient mental health services in languages other than English;
- Organizations recognize the value of culturally competent outpatient mental health care, but stakeholders suggest that limited training resources and capacity to diversify the workforce continue to impose barriers in achieving it; and
- Individuals and parents seeking mental health services prefer a provider who is the right "fit" and who is nonjudgmental and non-stigmatizing, but they sometimes have to balance or forgo that preference because of their need for timely care.

Each of these findings is discussed in more detail below.

3.1. INSURANCE COVERAGE

KEY THEME:

Regardless of coverage type, individuals seeking mental health services are frustrated by the onerous process of finding a mental health provider.

FOCUS GROUP PARTICIPANT PERSPECTIVES

Regardless of their insurance coverage type or actual time-to-service, individuals who were on wait lists or searching for a provider were equally frustrated. Focus group participants reported that insurance plans' online resources are not kept up to date with provider availability and network changes. Consequently, adults and parents needed to make many phone calls to find a provider who would accept their insurance or check on their or their child's status on a wait list with a given provider or organization.

Most adults reported *"not even receiving a courtesy call back"* when a provider did not have availability. Parents with all types of coverage had experienced repeatedly going back to the referral source (usually a pediatrician or an administrator) to get updates about the referral process or their child's spot on a wait list. Parents reported that either it took multiple follow-up attempts to get information or they received a dismissive response such as *"I'll get back to you."* A parent whose child had both commercial insurance and supplemental MassHealth said it took *"five or six phone calls"* to find a provider who accepts insurance.

KEY THEME:

Adults with public coverage reported experiencing longer wait times, on average, than did individuals with commercial coverage. In contrast, parents of children with public coverage experienced shorter wait times, on average, than parents of children with commercial coverage.

FOCUS GROUP PARTICIPANT PERSPECTIVES

Exhibit 3 provides the range of wait times focus group participants reported. Adults with public insurance experienced wait times of two to six months for routine therapy or counseling and reported that waits for psychiatry appointments were longer, on average. Adults with commercial insurance waited between two weeks and three months for an appointment. The adult with commercial insurance who connected to outpatient services within two weeks was referred from an inpatient setting (see Section 4.4 for a discussion of referral source). Another adult with commercial coverage noted that a university health center put her on what they described as the *"fast track"* for her appointment—but even the fast track had a wait time of three weeks for university mental health services, and ultimately, the provider did not meet her needs.

In contrast to the experience of adults, parents of children with public insurance reported shorter wait times (ranging from two to six months) than parents of children with commercial coverage (ranging from four to nine months). All parents, however, agreed that wait times for children are unacceptable.

EXHIBIT 3. FOCUS GROUP PARTICIPANTS' REPORTED TIME WAITING FOR OR SEEKING AN OUTPATIENT MENTAL HEALTH APPOINTMENT

	REPORTED WAIT TIMES/TIME SEEKING APPOINTMENT	
PRIMARY INSURANCE TYPE	Adults	Parents
Public Coverage	2–6 months	2–6 months
Commercial Coverage	0–3 months	4–9 months

Across the focus groups, there was a distinction between the predominant type of service setting within which individuals and parents with commercial insurance and those with public coverage primarily sought care. Most individuals with commercial insurance ultimately connected with an outpatient provider in an independent practice, and a few were seeing at least one provider (i.e., psychiatrist or therapist) in an outpatient practice within a larger health system. Adults and parents with public coverage had mainly connected with service providers in community health centers and community mental health centers, and a few were seeing at least one mental health provider within a larger health system. Adults with public insurance perceived that their options were limited beyond their community health center; some adults and parents with MassHealth coverage had faced barriers navigating the system, and others had not attempted to seek mental health care outside their community primary-care settings.

Parents with commercial plans sought services for children in a variety of settings, including schools, hospitals, independent practices, and youth counseling centers. For parents, the process of navigating the system led to delays because of challenges finding a provider who both accepted their child's insurance and was *"a match"* for their child. Additionally, multiple parents said that searching for a provider with a particular specialization (e.g., gender specialist, post-traumatic stress disorders) contributed to longer wait times. In many of these cases, the child ended up seeing a provider without the preferred specialization or training because a nonspecialized provider was the first available who took their child's insurance type. This is discussed in more detail below.

Regardless of insurance type, parents emphasized the need to advocate strongly on behalf of their children to get them timely access to services. Despite their efforts, parents with public coverage, in particular, reported that they struggled to have their voice heard and, as a result, felt disempowered and lacked trust that the system was operating in the best interests of their child.

KEY THEME:

Lack of insurance coverage (being uninsured) increases wait times or may limit one's ability to obtain an appointment altogether; however, the ability to self-pay can decrease wait times for services.

STAKEHOLDER PERSPECTIVES

Stakeholders who worked in safety-net settings reported that individuals without insurance are limited in the types of setting in which they can seek care. A health system administrator noted that uninsured individuals in Massachusetts may seek care in federally qualified community health centers and emergency departments—settings that are mandated by law to accept clients regardless of insurance coverage.[20,21] Nonetheless, the same stakeholder noted that lack of insurance and inability to self-pay for services—either on a sliding scale or full-fee basis—increases the wait time for a mental health visit, and in some places, lack of coverage means that you *"simply cannot get seen."*

Stakeholders alluded to a two-tiered system of access for those who can afford to self-pay versus those who must wait for an open slot with a provider who accepts their insurance type. Individuals who can afford to self-pay for services are not limited to finding an in-network provider who is covered by a specific insurance plan. This may expedite access to services.

3.2. LANGUAGE, CULTURAL COMPETENCY, AND OTHER FACTORS

KEY THEME:

Wait times are longer for outpatient mental health services in languages other than English.

STAKEHOLDER PERSPECTIVES

Most stakeholders, particularly those working in safety-net settings, indicated that language is a major barrier to access and that clients who need services in languages other than English have longer wait times than

English-speaking clients. The majority of stakeholders interviewed said that there are insufficient outpatient mental health providers available to deliver services in *any* language other than English. Among clients with limited English proficiency, Spanish-speaking clients tend to fare the best when attempting to access services in their native language. Representatives from mental health advocacy organizations and payers indicated that access for non-English and non-Spanish speakers is especially limited; demand for services in certain languages (e.g., African languages, American Sign Language, and Arabic) far exceeds provider supply.

One clinical leader explained that there are resource and other barriers for minority individuals, including those who are multilingual, to enter the mental health field. However, when multilingual individuals do become mental health providers, they are in great demand and are quickly hired by high-paying organizations, such as hospitals. In the words of this clinical leader:

> *It's almost at a point [in our industry] when you find a competent Spanish-speaking clinician, and you can get your patient in with them, you don't tell anybody about it; it's almost like being a parent and finding a good babysitter! You don't want anyone else to steal that person from you.... There is such a shortage of people who can provide these services in other languages. It's a big issue.*

Clinical leaders and payers discussed some short-term, patchwork solutions that have been implemented to address these challenges, including the use of in-person, phone, and virtual interpreters (e.g., telemedicine with translators, translation through a FaceTime interface) and increasing recruitment efforts for multilingual providers.

One payer reported that translation services vary in quality, availability, and cultural acceptability:

> *We can use translators, but that's difficult because different cultures have different feelings about mental health, translation is not always accurate, and there's stigma—so having a third intermediary makes it more problematic.*

Clinical leaders reported using family members as translators in resource-limited settings, while representatives from associations of safety-net providers reported that some non-English speaking clients decide to record their appointments to later show someone who can translate, though this practice is discouraged.

KEY THEME:

Organizations recognize the value of cultural competency, but stakeholders suggest that limited training resources and capacity to diversify the workforce continue to impose barriers in achieving it.

STAKEHOLDER PERSPECTIVES

There was a consensus among stakeholders that *"cultural competency"* is a crucial part of outpatient mental health care and that while language proficiency and translation services are important and necessary, cultural competency extends beyond these. Many clinical leaders and system administrators expressed a desire to better accommodate clients from different backgrounds.

Stakeholders cited a lack of resources and a limited understanding of how to improve cultural competency universally. A payer talked about how organizations struggle to form a definition of cultural competency and how to increase it: *"Organizations are in their infancy in understanding both what it [cultural competency] means and being able to deliver on it."*

When asked about the availability of trainings in their organization, responses from clinical leaders varied from saying training was not available at all to describing quite extensive offerings. They noted that some organizations provide orientation and trainings that emphasize a general openness to cultural differences. The goal of these trainings is to improve the cultural awareness of providers:

> *We look to language and the written word, and if we can accommodate that [need from our clients], we feel pretty good about it. But to have a meaningful understanding of the culture is different and very difficult. The cultural competency training we go through actually steers you away from trying to be "experts" in every culture—you can't do that—but [focuses instead on] raising awareness about not making assumptions about our patients and having them explain to us where they are coming from.*

A representative from a mental health advocacy organization mentioned that community mental health centers that treat clients with diverse backgrounds and language needs have built cultural competency solidly into their mental health practice. However, in many other settings, cultural competency is often viewed as an "add-on" for which organizations do not have the funding.

KEY THEME:

Individuals and parents seeking mental health services prefer a provider who is the right "fit," and who is nonjudgmental and non-stigmatizing, but they sometimes have to balance or forgo that preference because of their need for timely care.

FOCUS GROUP PARTICIPANT PERSPECTIVES

While stakeholders talked about cultural competency in relation to a client's language preferences and cultural background, focus group participants from diverse backgrounds interpreted culture more broadly. The discussions about culture evolved to conversations about provider "fit" and focused on the importance of respect, openness, and understanding of clients' needs and preferences. Focus group participants also noted that stigma and stigmatizing attitudes continue to serve as a barrier to accessing mental health care.

Individuals across different groups prioritized provider preferences differently—e.g., expertise or specialty, years of experience, gender, age, cultural background, or personality. Many female focus group participants expressed a desire for a female provider. Adults with either public and commercial coverage reported that finding *"a provider who fits me"* was important to them, by which they meant someone with whom they felt comfortable and to whom they could relate. They reported that the process involved extensive research (particularly for those with commercial insurance), making multiple calls, and long waits for an initial appointment. Finding a provider who met their preferences was not always an option for individuals and parents.

Parents with all insurance types prioritized knowing and feeling comfortable with the provider's qualifications and experience. They described the tension between finding a qualified provider with whom their children connected and wanting the child to receive services as soon as possible. For example, a parent with commercial insurance described the difficulty of finding the *"right"* provider for her transgender son. She wanted to find her son *"a therapist with expertise in gender nonconforming identity issues"* before he began hormone replacement therapy. When she finally found a therapist with expertise and with whom her son felt comfortable, her insurance would not cover that provider. She ultimately had to choose a provider for her son without the expertise that she was seeking, in order for her insurance plan to cover the service.

Other individuals and parents with commercial coverage corroborated that trying to find the right provider could also delay access to services. As one client in the commercial group reported, *"It's so difficult to get an appointment, and then you can try several people [before] finding the right one."* Many focus group participants, particularly parents with either coverage type, described *"settling"* for a provider who had availability to avoid having to navigate the system again.

Similarly, individuals with public insurance voiced concern that being too selective resulted in longer wait times for themselves or their child. Changing a provider once one was assigned required going back to the bottom of the wait list to *"start the process [of searching for a provider] all over again."*

Finally, focus group participants reported that stigma continues to be a major barrier to accessing care. Individuals with public insurance reported experiencing stigma associated with having public insurance. Other individuals reported stigma due to their sexual orientation or gender identity. In all instances, stigma shaped individuals' feelings about seeking and engaging in care.

Several focus group participants discussed the stigma they experience from providers and administrators while seeking services, and how these experiences served as a deterrent to seeking care. One parent described feeling discouraged about the process of seeking services for her child:

> *I just really dislike the feeling that even the clinics make the parents feel like we're doing something wrong. Can we erase that feeling, please? We're just trying to get services for our kids.… There needs to be more comfort, less intimidation, more 'hold my hand because I need help through this.'*

An adult with public insurance reported feeling judged because of a past history of homelessness and a need for psychotropic medications. She asked that health care providers respect her as an individual instead of making judgments based on her life circumstances. In her words, *"Judge us on who we are and what we tell you we've been through, rather than just putting [us] in a slot. It's not fair."*

Some focus group participants discussed the stigma they had experienced as individuals who identify as lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ), noting that while the availability of LGBTQ-competent services has greatly improved since the 1990s, LGBTQ mental health care is still *"in need of improvement."* As one client with public insurance reported, *"I've been through many decades, and mental illness is still a very hush-hush topic. Then you throw in homosexuality and transgender and it gets very hard."* While individual experiences were different, several focus group participants had experienced stigma as a barrier to either seeking services or finding a provider who could accommodate their needs.

4. FACTORS IMPACTING ACCESS TO OUTPATIENT MENTAL HEALTH SERVICES IN MASSACHUSETTS

RQ3.

What factors impact the experience of adults and children in Massachusetts seeking outpatient mental health services?

Many factors impact access to outpatient mental health services in Massachusetts. While previous sections discussed perceptions of clinically appropriate wait times and reported individual experiences navigating the outpatient mental health system, this section provides an in-depth discussion of factors that impact other dimensions of access—such as accessibility to, affordability of, and availability of—care. Highlighted below are factors that stakeholders and/or focus group participants identified as impacting these access dimensions. The following section characterizes these factors as related to or resulting from reimbursement rates and insurance processes; provider supply and retention; geography, travel time, and office schedule; and referral source.

Reimbursement rates and insurance processes:

- Insufficient reimbursement rates are a primary factor in diminishing the affordability and accessibility of mental health services; and
- Providers are frustrated with insurance plan processes (e.g., prior authorization, utilization review, and credentialing requirements), prompting some to opt out of insurance participation and thereby limiting the pool of providers available to most individuals.

Provider supply and retention:

- Psychiatrists are the most difficult providers to access. Stakeholders and focus group participants reported relatively long wait times for psychiatry services and mental health providers with particular expertise; and
- Provider supply by setting (e.g., community mental health centers or private offices) is impacted by billing and reimbursement practices. While current billing policies may attract some providers to safety-net settings initially, current reimbursement arrangements also make the retention of experienced staff particularly challenging for safety-net organizations.

Geography, travel time, and office schedule:

- The supply of providers outside Boston and the MetroWest area is limited and may contribute to geographic variation in wait times across the Commonwealth; and
- Distance and travel time to an appointment are factors individuals considered in selecting a provider, but other considerations pertaining to provider fit and office hour availability tended to be of greater importance.

Referral source:

- While a referral—providing a client with assistance in connecting to outpatient mental health services—was perceived by stakeholders as expediting access to care, focus group participants did not voice consensus regarding the role of a referral in impacting access to care; and
- Nonetheless, both stakeholders and focus group participants agreed that "self-referral," or seeking care on their own, was a frustrating process exacerbated by outdated provider lists that did not accurately capture providers currently covered by a plan or their availability to take on new clients.

Each of these themes is discussed in more detail in the sections that follow.

4.1. REIMBURSEMENT RATES AND INSURANCE PROCESSES

KEY THEME:

Insufficient reimbursement rates are a primary factor in diminishing affordability of and accessibility to mental health services.

STAKEHOLDER PERSPECTIVES

Stakeholders overwhelmingly reported that reimbursement rates for mental health services are not adequate in Massachusetts. Several noted that the rates of reimbursement, in many cases, do not cover the actual costs of providing services and this is *"extremely problematic"* for providers. Clinical leaders, mental health advocates, and representatives from associations of safety-net organizations reported that reimbursement rates for outpatient mental health services under MassHealth are generally lower than those for commercial insurers. State reports also suggest that reimbursement for mental health services is too low.[12,13,22]

Stakeholders noted several consequences of insufficient reimbursement rates on access to mental health services. These included:

- The reliance on a FFS payment schedule, and the inadequacy of rates for mental health services therein, poses challenges for organizations in offering competitive salaries to attract and retain mental health clinicians;
- Some organizations are reluctant to expand capacity for mental health services because reimbursement does not align with care delivery costs, resulting in operating losses; and
- Some providers "opt out" of accepting health insurance, thereby diminishing the number of providers from whom individuals can afford to access care.

According to several stakeholders interviewed, reliance on a FFS payment schedule creates challenges for organizations to attract and retain mental health providers. This was cited as a problem particularly for safety-net organizations, as they have less diversity in their payer mix (i.e., the portion of payers that are commercial versus public payers) and, as noted above, reimbursement for outpatient mental health services by MassHealth is generally lower than that provided by commercial payers. One clinical leader explained that reimbursement for mental health clinicians has not evolved favorably over time:

> *First, community mental health centers never had access to health care safety-net [funding], so margins are very tight. Most clinicians, even in agencies, get paid on a FFS basis. When I started in the field, providers were salaried, they were state positions, and there were block grants and subsidies. When that went away, everyone went to FFS.*

According to those interviewed, the FFS payment approach, and the current rates embedded within it, make it challenging for organizations to offer competitive salaries to mental health clinicians.

Stakeholders suggested that the inadequacy of reimbursement for mental health services may cause organizations that provide these services to operate at a financial loss. They indicated this may be especially pronounced in safety-net settings serving a relatively high proportion of MassHealth clients, as greater client service needs are coupled with relatively low reimbursement rates. One stakeholder from a mental health advocacy organization noted that even when community mental health centers are meeting productivity targets, they are still operating at a financial loss. The 2017 Association for Behavioral Healthcare survey of their member organizations (community-based mental health and addiction treatment organizations in Massachusetts) reinforced this concern.[9] One interviewee clearly summarized the impact of insufficient rates on access to care; in his words:

> *The problem is that every unit of service [mental health clinicians] provide, they lose money on.… [Community mental health centers] are not incentivized to expand access because the more access they create, the worse it is for their bottom line. As perverse as it sounds … the biggest barrier to access is the financing.*

Stakeholders suggested that even *"good"* reimbursement rates are below the payment rates available to clinicians who opt out of the insurance market (i.e., requiring clients self-pay the provider directly, not through a health insurance plan). Consequently, many providers either do not accept insurance or work part-time in private practice where they do not accept insurance. Stakeholders suggested this situation may be contributing to *"the perception of provider shortages,"* as most individuals are not able to self-pay for services.

Regardless of whether there is a true shortage of providers—or a shortage of providers willing to accept insurance—most stakeholders agreed that lack of insurance acceptance has served to reduce the overall availability of mental health providers such that there are insufficient affordable providers, or providers accepting insurance, to meet demand. One stakeholder explained the consequences of this situation as follows:

> *Massachusetts doesn't lack behavioral health providers, population-wise, but what it does lack is people who are willing to work with insured patients in general… the traditional community provider wants their schedule full, they want to have the patients deal with the insurance through self-pay and getting reimbursed, or would rather not have to deal with insurance at all. I think it takes a significant amount of access out of the system. It diminishes the general access for those who aren't in a position to pay out of pocket, which is most people.*

As described in Section 3.1 from the perspective of focus group participants, stakeholders also identified another consequence of low reimbursement rates and decisions to opt out of insurance participation: a two-tiered system of access for those who can afford to self-pay and for those who must wait for an open appointment with a provider who takes their insurance. A clinical leader and a payer both said that some providers in the private domain are *"unwilling to take insurers of any type"* due in part to the belief *"they do not pay adequately for mental health services."*

KEY THEME:

Providers are frustrated with insurance plan processes (e.g., prior authorization, utilization review, and credentialing requirements), prompting some to opt out of insurance participation and thereby limiting the pool of providers available to most individuals.

STAKEHOLDER PERSPECTIVES

As noted in Section 3.1, both publicly and commercially insured focus group participants indicated that it was difficult to find an in-network provider, which limited the accessibility, affordability, and availability of mental health providers. Stakeholders provided insights into factors that contribute to this circumstance. In addition to the reimbursement concerns noted above, many clinical leaders discussed the challenges providers encounter when trying to keep up with various payer authorization, documentation, and other administrative requirements. These include, for example, different processes for prior authorization and reauthorization of services as well as varying restrictions on covered visits.

Clinical leaders indicated that variation in credentialing requirements among plans has also deterred providers from participating in a health plan's network.[23,24] While many of these insurance-related processes or administrative requirements are also applicable to physical health providers, they may be particularly burdensome to mental health clinicians, who more often operate independent practices and manage their own billing. Payers did point out that relatively high rates of nonparticipating providers in insurance networks is unique to mental health, and that this contributes to delays in initiating and interruptions in mental health treatment. The literature supports the finding that the rates of insurance network participation among psychiatrists are declining.[25]

4.2. PROVIDER SUPPLY AND RETENTION

KEY THEME:

Psychiatrists are the most difficult providers to access. Stakeholders and focus group participants reported relatively long wait times for psychiatry services and mental health providers with particular expertise.

STAKEHOLDER PERSPECTIVES

The majority of stakeholders indicated that while there are relatively more mental health providers in Massachusetts than other states,[4] the demand for services significantly outpaces the supply of providers, particularly among providers accepting insurance and those with certain expertise. Stakeholders consistently stated that psychiatrists have the longest wait times and are the most difficult providers to access, especially for children and adolescents. Most stakeholders mentioned that psychiatrists are harder to bring and keep on staff; many organizations cited being able to bring on a psychiatrist for only a half-day or one day a week.

As a result, stakeholders reported that children with complicated physical and mental health needs can face long wait times for a psychiatrist. Primary care providers (PCPs) have acted as stopgaps for psychiatry by providing prescriptions for mental health–related medications, and they often prescribe for individuals or children with attention deficit hyperactivity disorder, anxiety, or depression.[26] However, clinical leaders noted that PCPs are often not comfortable prescribing medications for more complex psychiatric conditions without additional support and consultation.

A few stakeholders noted that licensing designations for psychologists make it challenging to determine what specialized training or expertise, if any, a provider might have (e.g., cognitive behavioral therapy, training to work with adolescents). For those seeking specialty services or particular experience, this lack of clarity can complicate and extend the process of finding an appropriate provider.

Mental Health Providers and Authority to Prescribe

Not all mental health providers are able to prescribe medication. Psychiatrists and certain advance practice nurses are able to prescribe medications. Social workers, counselors, and some other therapists (e.g., licensed marriage and family therapists) who are able to provide outpatient mental health services and counseling are not able to prescribe medications.

FOCUS GROUP PARTICIPANT PERSPECTIVES

Parents similarly reported long wait times for psychiatrists and providers who specialize in treating children and adolescents. Parents with public insurance agreed that there is a *"big difference"* between the wait for a therapist and the wait for a child psychiatrist. Several parents with public insurance reported waiting four to five months to get a child psychiatry appointment. One parent with both commercial and public insurance noted that before her child could see a psychiatrist, she had to *"go through a lot of red tape,"* which she described as *"hard and frustrating."* Adult focus group participants with commercial insurance also described long delays due to challenges finding a psychiatrist with an opening.

KEY THEME:

Provider supply by setting is impacted by billing and reimbursement practices. While current billing policies may attract some providers to safety-net settings initially, current reimbursement arrangements also make retention of experienced staff particularly challenging for safety-net organizations.

STAKEHOLDER PERSPECTIVES

Stakeholders reported that the ability of a provider to bill for services may vary by insurance type (e.g., Preferred Provider Organization [PPO] and Health Maintenance Organization [HMO]). This variability in who can bill for services has impacted the supply of providers in particular settings and consequently wait times for services.

For example, many stakeholders pointed out that unlicensed trainees working toward a degree (and license) in social work or mental health counseling can bill MassHealth if they are working under the direct supervision of a licensed clinician.[27] They are not, however, permitted to bill most commercial plans, and therefore these providers-in-training overwhelmingly work in community mental health centers. One mental health advocate described the implications of these regulations on provider availability in the following way:

> *MassHealth products allow unlicensed clinicians [to provide outpatient services] with licensed supervision. Most commercial payers require licensed clinicians.… The more stringent the credentialing, the worse the access is. [Commercial payers] are trying to use licensure as a proxy for quality—and I get that—but if they would allow lower level licenses [to bill], then they would get better access for their members.*

Along these lines, another mental health advocate and clinical leader suggested that clients with public insurance seeking an appointment at an outpatient clinic may encounter shorter wait times than their commercially insured peers, as the latter cannot be seen by unlicensed staff. However, as described in Section 3.1, focus group participants suggested that adults with public insurance experience longer wait times for a mental health visit than adults with commercial coverage.

While the billing practices described above were cited as a facilitator of access in safety-net settings, stakeholders also suggested safety-net organizations' greater reliance on public payers for billing and reimbursement has posed challenges to hiring and retaining mental health providers. Not surprisingly, this may also adversely impact access. As one stakeholder explained,

> *It is almost impossible to hire licensed independent clinical social workers … [they] quickly get into higher-level roles, or find settings like hospitals that can pay more than community-based providers, or they [move] into private practice. It is really difficult to hire anyone with a license. We work with existing staff to absorb patients from those who leave—which puts burden on them. But what it really means is that if they have to take on someone else's patients, they aren't taking any new patients. The wait gets longer.*

Another stakeholder reiterated the challenge of staff retention for community-based organizations. Expressing a sentiment similar to that captured above, he suggested that community-based organizations have in some ways become a *"feeder system"* for higher-paying organizations within the delivery system once providers are licensed:

> *It's almost a pecking order of who can pay what for various levels of staffing, and historically community mental health centers have been toward the bottom of the pecking order. Hospitals' more generally—medical centers'—ability to pay enhanced salaries is also well documented. The "feeder system" is important [to note]. An individual may [work] a few years in a community mental health center and come out a fully trained, well-seasoned veteran who has been dealing with the some of the most complex members in the state. If opportunity comes along to enhance their career, pay more, etc.—the feeder system tends to be a logical place from which people end up moving up from.*

While billing and reimbursement practices might initially favor safety-net settings in bringing staff on board early in their careers, and thereby expand the pool of providers to which individuals have access, reimbursement practices also create staff retention challenges down the road for these organizations. As described in earlier sections, these circumstances have differing impacts on wait times for services.

4.3. GEOGRAPHY, TRAVEL TIME, AND OFFICE SCHEDULE

KEY THEME:

The supply of providers outside Boston and the MetroWest area is limited and may contribute to geographic variation in wait times across the Commonwealth.

STAKEHOLDER PERSPECTIVES

The majority of stakeholders suggested that clients seeking services outside Boston and the MetroWest area—particularly those residing in Western and Southeastern Massachusetts and the Cape and Martha's Vineyard and Nantucket—face longer wait times due to provider shortages in those areas, and have to travel farther to appointments. Multiple interviewees indicated that the wait times were *"directly related to . . . [the] sheer number of providers."* Stakeholders indicated these regions do not have a sufficient number of practitioners to meet the demand for services, leaving patients unable to see providers in a timely manner.

According to stakeholders, psychiatrists and therapists with specialized training to treat particular conditions (e.g., SUDs, anxiety disorders, eating disorders) are particularly scarce in these and other more geographically remote areas. Almost half of the stakeholders brought up the *"shortage of [child] psychiatrists"* in these regions, and clinical leaders talked about how this has increased the burden on PCPs in Western Massachusetts to prescribe medication for their clients.

In addition to longer wait times, stakeholders reported that individuals who live outside the Boston and MetroWest regions often have to travel farther for their appointments. Public transportation in many of these areas is limited, and even for individuals with access to a car or a family member to transport them, the travel time can be burdensome.

To accommodate clients, providers in Central and Western Massachusetts are increasingly conducting home visits, which are covered for children with MassHealth coverage,[28] so their clients no longer have to *"take three buses"* to get to an appointment. While beneficial for clients, home visits place a burden on the provider. A social worker in Central Massachusetts reported that she is only reimbursed an additional two dollars for the extra time she spends driving to homes. Still, she would rather perform home visits than have a client's transportation issue result in a no-show at a clinic, and thus the loss of a billable visit. It merits noting that this arrangement—the provision of and reimbursement for in-home therapy and services—is available through MassHealth's Children's Behavioral Health Initiative (CBHI).[29] Several stakeholders noted that CBHI provides more comprehensive coverage for behavioral health services, including home- and community-based services, than other payers do.

The **Children's Behavioral Health Initiative (CBHI)**, a result of the *Rosie D.* litigation, was a major contributing factor to coverage expansion and comprehensive MassHealth benefits package for children. Through CBHI, primary care providers serving children with MassHealth coverage must offer standardized behavioral health screenings at well-child visits and mental health providers are required to use a standardized behavioral health assessment tool. Additionally, CBHI provides new or enhanced home- and community-based behavioral health services for children.

KEY THEME:

Distance and travel time to an appointment are factors individuals considered in selecting a provider, but other considerations pertaining to provider fit and office hour availability tended to be of greater importance.

FOCUS GROUP PARTICIPANT PERSPECTIVES

Individuals from all focus groups identified distance and travel time to appointments as less critical than other factors in finding the right provider and specialty. It is important to note that focus group participants resided in Boston or MetroWest, and these findings do not represent the perspectives of individuals from other regions of Massachusetts. One adult discussed how she chose a provider who *"was a little further away"* because the provider's specialty aligned with her needs. She indicated that even though it can take up to an hour to get to her appointment, *"in the end, it's more worth it to go"* to that particular therapist. Another adult with commercial insurance noted, *"I stopped caring about distance because I [had] been so unsuccessful in my search."*

Specific schedule preferences varied based on need. Parents expressed a desire for out-of-school appointment hours. They found it challenging to find providers who were able to accommodate children's school schedules; parents agreed that they should not be expected to pull their children out of school in order for them to see a provider. One parent with commercial coverage talked about the disruption caused by pulling a child out of school for appointments:

> *[The provider my child needs is] only there one day a week [from] 9 a.m. to 2 p.m., and for a youth counseling center that caters to youth in school, it's completely inadequate. I've had to pull [my child] out of school, and that only increases his anxiety for having to leave school, having to make up assignments, the stigma of leaving school early. You need afternoon, evening, and weekend appointments if you're going to serve [youth]. That's been really difficult.*

Similarly, almost all adults with commercial coverage emphasized the importance of evening hours because of work or university schedules. There were, however, a few individuals with commercial coverage who reported that once they connected with a provider, they were able to easily find a time that worked with their schedule.

4.4. REFERRAL SOURCE

KEY THEME:

While a referral—providing a client with assistance in connecting to outpatient mental health services—was perceived by stakeholders as expediting access to care, focus group participants did not voice consensus regarding the role of a referral in expediting access to care.

Both stakeholder interviews and focus groups included discussions about whether a referral served as a facilitator or a barrier to care and if/how this differed based on the referral source (e.g., a PCP, a school, or a state agency).

STAKEHOLDER PERSPECTIVES

Stakeholders generally indicated that a referral from a PCP helped facilitate the referral process and allowed clients more efficient access to mental health services. They said this facilitation was more common in instances where a primary care practice was either affiliated with or had a preferred referral arrangement with a mental health provider.

Stakeholders indicated that time to an appointment was shorter for individuals referred from higher levels of care (e.g., an emergency room or an inpatient or residential treatment facility) and, in some cases, perceived to have more acute treatment needs than those referred from primary care. One stakeholder from an association of safety-net providers indicated that individuals coming from inpatient facilities were mandated to receive an outpatient appointment within seven days of discharge to meet the Healthcare Effectiveness Data and Information Set (HEDIS) follow-up after hospitalization measure, a quality measure that some plans and accountable care organizations (ACOs) use to track performance.[30] This may create an additional incentive for organizations to provide more timely services for individuals being discharged from inpatient facilities. At the same time, however, stakeholders also commented on continued challenges in establishing effective referral relationships between inpatient and outpatient settings, noting a lack of comprehensive discharge planning and a high rate of no-shows for recommended follow-up outpatient care.

Finally, stakeholders were asked about the role of schools and state agencies in facilitating access to mental health services for children and clients. In response to these inquiries, stakeholders suggested that schools often play an important role in identifying a need for mental health services but may not have the capacity to directly refer children to a provider or have sufficient knowledge of a family's health insurance coverage to help. Consequently, families must navigate the process of accessing mental health services on their own.

FOCUS GROUP PARTICIPANT PERSPECTIVES

Focus group participants were more mixed in their perspectives. When asked about whether a referral from a PCP impacted access to care, many focus group participants focused their comments on the requirement in some types of health insurance plans that a PCP must authorize a referral for services in order for them to be covered. This was viewed as a barrier to accessing services and a process that increased the wait time for an appointment. Those with public coverage, for example, emphasized the need for proactive and persistent follow-up with their referral source in order to obtain the documentation needed to ensure service coverage.

Focus group participants were asked about the role of schools in facilitating access to mental health services. Parents also noted that the need for mental health services is often identified through the schools, but indicated that getting referral support for mental health services from a school is more complicated than it is through a clinical provider (e.g., a PCP). Parents also suggested schools lack the resources and expertise to assist families with the process of connecting to mental health services.[31]

KEY THEME:

Nonetheless, both stakeholders and focus group participants agreed that “self-referral,” or seeking care on their own, was a frustrating process exacerbated by outdated provider lists that did not accurately capture providers currently covered by a plan or their availability to take on new clients.

STAKEHOLDER PERSPECTIVES

Advocates and health system administrators reported that individuals making a self-referral find the process of connecting with services frustrating because of outdated provider lists. Self-referring clients are often faced with the challenge of selecting a particular provider from a lengthy list or verifying that a particular provider is included in their health insurance plan’s network. Consumer advocates said these *“lists can be overwhelming”* for individuals seeking services, and the process of navigating through the list delays appointments. One advocate noted that families frequently rely on word of mouth and the experiences of peers when they are seeking a mental health provider for their child.

FOCUS GROUP PARTICIPANT PERSPECTIVES

Focus group participants agreed with stakeholders about the self-referral process. As discussed in Section 3.1, individuals with either commercial or public coverage mentioned various frustrations related to the process, including a lack of clarity about whether providers accept a particular insurance, scarcity of available appointments, and nonresponsiveness of providers (i.e., not returning phone calls). An adult with commercial coverage said she had *“contacted close to sixty providers and under ten replied,”* and only a few of those who called back had availability to schedule an appointment. The commercial-group participants talked about the challenge of *“identifying a provider with an opening.”* Both adults and parents often turned to trusted friends and colleagues for provider recommendations.

5. STAKEHOLDER POLICY RECOMMENDATIONS

Stakeholder interviews included discussion of current or future policy reforms in the Commonwealth that might address the core domains of access—availability, accessibility, affordability, accommodation, and acceptability—to improve the process of finding a mental health provider and diminish wait times for services. The following points highlight policies and recommendations that stakeholders suggested would help address the issues discussed in the previous sections and would improve access to mental health services. Discussion of these policies and recommendations is organized according to these categories: payment and delivery systems; insurance processes and provider directories; office scheduling and geography; and workforce.

Payment and delivery system reform:

- Address issues of rate inadequacy for mental health services; and
- Support the movement to global payment and other payment and care models that move away from FFS, and encourage enhanced integration and coordination of care.

Streamlining insurance processes and improving provider directories:

- Reduce insurance-related administrative burdens;
- Reform the formal intake assessment requirement; and
- Improve the accuracy of provider directories and ensure they are regularly updated.

Improving office scheduling and responding to geography:

- Encourage the adoption of open access scheduling models; and
- Increase coverage of teletherapy services, particularly for clients in geographically remote regions.

Developing the workforce:

- Create professional development and training opportunities to encourage multilingual providers from diverse racial and ethnic backgrounds to enter the workforce.

Each of these policy options or recommendations is discussed in the sections below.

5.1. PAYMENT AND DELIVERY SYSTEM REFORM

KEY THEME:

Stakeholders generally agreed that it is necessary to address issues of rate inadequacy for mental health services.

Most stakeholders suggested increasing reimbursement for mental health services. Most of the clinical leaders and mental health advocates emphasized the importance of increasing rates under all MassHealth plans, but stakeholders also suggested that commercial rates are variable and often too low. This assessment could not be evaluated because commercial rates are considered proprietary. Further exploration is needed to examine commercial insurance rate variation and the impact of potential rate disparities.

KEY THEME:

While acknowledging the need to address underlying issues of rate inadequacy for mental health services, stakeholders also voiced support for global payment and other payment and care models that move away from FFS, and encourage enhanced integration and coordination of care.

There is a sense of guarded optimism that these changes can help improve current access issues. While stakeholders made clear their concerns over addressing the inadequacy of mental health rates as part of the process of moving to alternative payment and delivery system models of care, there was general support in moving toward a *"payment mechanism to incentivize coordination for providers."* Stakeholders remain hopeful that payment and delivery reforms will help address access issues that are tied to a system that pays for volume (i.e., FFS) instead of coordination. Stakeholders noted that most prevailing payment arrangements silo physical and mental health services, so while there may be a clinical need to coordinate services and facilitate access across settings, there are limited incentives supporting staff time to help clients navigate the system or connect with needed services. Designing quality and payment incentives to make these connections—introduced by way of global payment, ACOs, and other care models—holds promise in improving individuals' access to mental health care.

Policymakers referenced the Commonwealth's Medicaid 1115 Waiver, together with the movement toward ACOs and community partners, as a reform intended to improve coordination of care and improve access to both physical and mental health services.[31] The language in the 1115 Waiver requires ACOs to formally affiliate with community partners,[31] and these *"community partners will have responsibility for care coordination, care management, care transitions for individuals who have significant mental health and substance treatment needs."* One state policymaker explained how this will lead to more effectively aligned incentives:

> *It is incumbent upon the ACO and community partners to figure out how this person has access to that resource. How do you go about doing that? There are many ways … mobile staff, telemedicine, technology, co-location with or being able to work from other health systems or health locations, such as a physician office or a clinic. We want to incent creativity into the process. Ultimately, ACOs and their partners will need to work with community partner entities to ensure that the entire region has coverage.*

Stakeholders acknowledged that ACOs are not a panacea. Unless ACOs accept financial risk for mental health services and examine the quality of mental health services provided to meet members' needs,[32] services will continue to be delivered in silos with insufficient resources. It merits noting that the new MassHealth ACO model includes behavioral health services in the total cost of care at the outset to begin to address this issue.

Other anticipated challenges reflect those noted in the literature, including cherry-picking healthier patients, the lack of capacity for existing communication systems to manage risk, and the lack of robust and evidencebased quality measures related to mental health.[33] Despite these concerns, policymakers remain hopeful that reforming incentives and accountability to reduce costs for a defined population will improve access to services, reduce stigma around mental health needs, and reduce health care access disparities.

5.2. STREAMLINING INSURANCE PROCESSES AND IMPROVING PROVIDER DIRECTORIES

KEY THEME:

Reduce insurance-related administrative burdens.

Stakeholders often cited administrative, or "paperwork," burdens as barriers to provider participation in insurance networks. Clinical leaders and mental health advocates suggested that administrative processes designed to manage utilization should be streamlined in an effort to encourage participation in insurance networks among providers who have opted out of insurance panels/networks because of administrative burdens.

Along these same lines, another stakeholder felt that insurers, particularly commercial ones, could expand their networks by improving conditions for providers through *"better payment structure, easier credentialing, recruiting, [and] expediting paperwork,"* which the stakeholder argued are essential to creating a more *"favorable climate for providers."*

KEY THEME:

Reform the formal intake assessment requirement.

Intake processes are often inefficient and repetitive, but a formal psychosocial assessment at intake is required by most payers for routine behavioral health services. The Department of Public Health requires mental health providers conduct an intake assessment for individuals with MassHealth coverage prior to billing for an outpatient mental health appointment; for MassHealth members under the age of 21, a Child and Adolescent Needs and Strengths (CANS) assessment must be completed during the individual's initial assessment, and then again at least every 90 days thereafter.[34,35] Many organizations utilize an intake provider, often not the individual's assigned clinician, to take a medical history. Though this centralizes the intake process, several stakeholders—a health system administrator, clinical leaders, and a payer representative—reported that the process is an *"antiquated system"* and may add an emotional burden and extra steps for clients seeking service, as it requires that they *"repeat their story and their history again to every new clinician they meet."* Multiple stakeholders have found that the rigid billing structure that currently exists is an obstacle to improving the intake process and delays access to care. As these regulations determine a provider's ability to bill for services, providers are not able to reform the intake process on the delivery system side.

KEY THEME:

Improve the accuracy of provider directories and ensure they are regularly updated.

Many stakeholders and focus group participants commented on the challenges of connecting with a mental health provider when relying on a provider directory alone. These directories are often out of date and fail to include pertinent information pertaining to provider specialty, expertise, or willingness to assume new patients. Some commercial insurers indicated they are trying to develop and implement a more effective solution to keep online directories up to date and accurate, but they did not provide details about these improvements.

5.3. IMPROVING OFFICE SCHEDULING AND RESPONDING TO GEOGRAPHY

KEY THEME:

Encourage the adoption of open access scheduling models.

Open access scheduling—wherein providers retain a certain number of open appointment slots in their daily clinical calendar to accommodate same-day scheduling requests—can facilitate access.[36] While many stakeholders lauded the benefits of this model, such as increasing access for those who need urgent appointments and reducing no-shows, they also identified obstacles in implementation. One clinical leader commented that open access scheduling actually leads to more appointments for existing clients in critical circumstances but not for new clients. A representative from an association of safety-net providers described open access as financially unviable under FFS payment models, offering an anecdote about an organization that was *"so good at open access that their [financial] losses tripled over a few years."* Providers cannot bill for their time if clients do not fill the open appointment slots, thus losing revenue. With the movement toward new payment and delivery system models, open access scheduling may become financially more viable.

KEY THEME:

Increase coverage of teletherapy services, particularly for clients in geographically remote regions.

Many payers and other organizations discussed the potential of teletherapy to ease the pressure on the delivery system, particularly in settings with long wait times due to provider shortages. Some commercial plans and MassHealth recently began covering teletherapy. Yet stakeholders identified several challenges to implementation. First, there is no *"reimbursement for [providers] to be trained in and purchase these technologies,"* making it a costly endeavor for many organizations. Clinical leaders said it is difficult to ensure that teletherapy providers have the same credentials as clinicians in their own organization's practice, which is necessary to comply with Massachusetts' Board of Registration of Allied Mental Health and Human Services Professions policy guidelines.[37] While several stakeholders cautioned that teletherapy should not replace face-to-face appointments, they acknowledged it could help support accessibility for geographically remote clients, reduce no-shows, and support organizations with long wait lists.

5.4. DEVELOPING THE WORKFORCE

KEY THEME:

Create professional development and training opportunities to encourage multilingual providers from diverse racial and ethnic backgrounds to enter the workforce.

Stakeholders acknowledged that the current pipeline of individuals receiving training to provide mental health services is insufficient to meet client demand. The high cost of education, coupled with low reimbursement rates for providers entering the field, contributes to this workforce shortage.[38] In addition, as highlighted in this report, there are pronounced shortages of multilingual providers and providers trained and experienced in the provision of mental health care to clients with diverse cultural backgrounds. Multiple clinical leaders suggested scholarships or loan forgiveness programs as a long-term solution to attract and retain a diverse mental health workforce to help address the lack of financial and institutional support for cultural competency and diversity training. Many emphasized that diversifying the workforce was a necessary but longer-term solution to address provider availability and acceptability *(fit)* for clients.

As a preliminary step toward increasing organizational capacity to treat clients from diverse backgrounds, stakeholders from mental health advocacy organizations recommended that practices establish partnerships with local community and social service organizations. The purpose of these partnerships would be to expand individuals' access to organizations experienced in serving clients from diverse cultural and socioeconomic backgrounds. One way to address cultural barriers in the current system is to engage outreach workers, peers, recovery coaches, family partners, and faith-based or cultural leaders. The stakeholders also suggested that practices consider hiring more paraprofessionals, such as community health workers, and invest in peer support to provide culturally appropriate services to communities.[39] Family caregivers and other types of peer support workers can be certified to work in the mental health field and offer support to individuals navigating the system themselves or for a child.[40,41] Mental health providers are often part of a larger health care and social service workforce, and engaging other types of staff could help clients more effectively navigate the system and connect with providers more efficiently.

6. CONCLUSION

This study sought to better understand access to outpatient mental health services in Massachusetts from a variety of perspectives. Qualitative data was collected through interviews with stakeholders and focus groups of individuals who sought outpatient mental health services in the summer and fall of 2016.

Stakeholders reported that current wait times for routine outpatient mental health care are longer than clinically appropriate for the majority of adults and children seeking outpatient mental health services in Massachusetts. Factors such as complex co-morbidities, the need for providers with particular specializations (e.g., psychiatry, SUD treatment, and/or trauma-informed care expertise), geography, language and cultural preferences, and providers' office schedules may delay access to outpatient mental health treatment.

Regardless of insurance coverage type (i.e., commercial or public), adults and parents seeking services for their children are frustrated by the onerous process of searching for an outpatient mental health provider and by long waits for appointments with providers who meet their needs. Being uninsured and unable to self-pay for services may limit an individual's capacity to get timely outpatient care, whereas individuals who are able to self-pay for services may have access to providers who have opted out of the insurance market, expediting their access to services relative to those without the ability to pay out of pocket for these services. Some suggested this may be creating a two-tiered system of access for those who can afford to self-pay and those who must wait for an opening with a covered provider.

Stakeholders report that insufficient reimbursement rates and burdensome insurance plan processes (e.g., prior authorization, utilization review, and credentialing requirements) are factors contributing to the limited supply of mental health providers who accept insurance. Stakeholders identified certain specialties (e.g., psychiatry) and regions of Massachusetts (outside Boston and MetroWest) in which providers are in particularly short supply.

Addressing these reimbursement- and administrative-related insurance issues may help improve access to outpatient mental health services. In addition, stakeholders acknowledged that payment and delivery system initiatives under way in Massachusetts that are designed to move away from FFS payment arrangements may encourage enhanced integration, improve coordination of care, and create greater accountability for managing costs. These reforms hold promise in helping to address some of the existing barriers to access. All the same, the Commonwealth needs to explore ways to augment the mental health services workforce—in particular, to diversify the provider community, improve retention in safety-net settings, and increase the availability of multilingual providers.

This study shares the strengths and limitations of other qualitative studies with purposeful sampling.[42] Individuals selected for stakeholder interviews and focus groups do not necessarily represent the perspectives or experiences of other individuals in the Commonwealth; however, the methodological approach of stratified purposeful sampling enabled the study team to capture varied experiences, identify themes, and to understand patterns and how they interact in a given context.[42,43] By capturing the perspectives of parents and adults with public and private insurance, for example, the research team was able to draw inferences about the ways in which type of insurance coverage can shape an individual's access to and wait times for services. The use of rigorous qualitative techniques and triangulation—by interviewing a diverse set of stakeholders and conducting focus groups of clients with different types of insurance to obtain a range of perspectives—

provided corroboration for the study findings. Finally, while these qualitative results provide critical insight into the perspectives of stakeholders and individuals seeking services, they should be coupled with the findings from the companion statewide provider and organizational surveys[16] to obtain a more comprehensive picture of wait times and factors impacting access to outpatient mental health services. Together, the results from the qualitative and quantitative studies make clear that many individuals experience challenges in finding a mental health provider and endure long wait times for outpatient mental health visits.

While initiatives under way in the Commonwealth hold promise for improving access to outpatient mental health services, continued attention to and monitoring of access to mental health services is imperative. Adults and parents are facing the barriers described in this report at a time when they are likely to be particularly vulnerable, making it all the more important that the process of seeking care not be onerous and challenging.

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APPENDIX A. CONCEPTUAL FRAMEWORK

The access dimensions in Exhibit 1 represent a core set of factors contributing to outpatient mental health service access after an individual, family member, or provider identifies the need for an appointment. These *domains of access,* to varying degrees, can inhibit or facilitate access to a mental health provider, as well as increase or decrease wait times, for outpatient mental health services.

Availability refers to the adequacy of the supply of both service providers and service locations in an individual's geographic area. Research has established that rural areas often face shortages of health care providers and facilities, and mental health service providers are no exception.[44] The supply of providers available to individuals residing within a geographic region can impact their decision to seek service, the types of providers from whom they choose to seek service, and their decision to remain in care.[45] In Massachusetts, an abundance of mental health providers (especially psychiatrists) are concentrated in the Boston metropolitan area, whereas comparatively few providers are available in more rural areas.[4] Massachusetts mental health providers also represent an aging workforce;[38] their departures in the coming years stand to impact the availability of providers to treat individuals seeking service. Availability of providers is also impacted by provider empaneling. For example, many psychiatrists do not take any insurance, or they take only commercial insurance and not public insurance.[46]

Accessibility refers to individuals' ability to physically obtain the services they seek. Accessibility includes factors such as physical distance, transportation resources, travel time, and total cost to the service user. Distance to service is a well-documented and frequently reported barrier to accessing mental health services.[47,48] Accessibility also involves health literacy or the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[49] Health literacy also encompasses proficiency in navigating health insurance and the health system, such as knowledge of how to find providers, coverage options, networks, and how to access and use information about available services.

Affordability is the cost of services to the service user, including cost as it relates to the perceived value of care. Research has demonstrated that out-of-pocket costs associated with mental health care vary significantly by service users' health insurance status, and that individuals without insurance, as well as those with commercial insurance, may face higher service costs than those with public insurance.[50] This can pose challenges for individuals accessing outpatient mental health services. The costs of care may be opaque to the individual or family seeking treatment, even for those with higher levels of health insurance literacy. The individual may also face a deductible, co-pay, or co-insurance that is not necessarily well specified in advance of receiving treatment.

Accommodation refers to the extent to which services are tailored to meet the needs of or are otherwise made more convenient to the service user. Accommodation represents the relationship between client needs and the manner in which resources are organized to meet those needs. For example, the hours that a facility operates (e.g., evenings and weekend hours) and the availability of walk-in or telephone services may impact working adults or parents' capacity to access services. Provider office hours are particularly important for children in school and adults who need to arrange appointments around a daytime work schedule. Cultural and language preferences may be a facilitator or a barrier to finding providers and organizations that meet a client's needs; language differences between provider and patient can pose challenges to accessing outpatient mental health services.[51–53]

Acceptability is clients' assessment of and satisfaction with the services they receive. It includes patient attitudes and preferences about a provider's gender, race, ethnicity, or cultural background, the perceived cultural competency of the provider organization, and the style of practice.

The study's data collection methods are designed to assess these key domains of access from the perspective of stakeholders and clients.

APPENDIX B. QUALITATIVE METHODS

This appendix includes an analysis of qualitative data collection methods. The research team collected primary data to gather information on wait times and client experience in accessing outpatient mental health services in Massachusetts through the following methods:

- **Stakeholder interviews:** Key stakeholders across Massachusetts were interviewed to better understand barriers to access from the perspectives of payers, providers, and other service organizations.
- **Client focus groups:** Qualitative data were gathered about barriers to access from the perspective of adults and parents of children seeking mental health services.

STAKEHOLDER INTERVIEWS: INSTRUMENT DEVELOPMENT AND DATA COLLECTION

STAKEHOLDER INTERVIEW GUIDE DEVELOPMENT

The conceptual model, research questions, and Massachusetts policy context informed the content and structure of the stakeholder interview guides. The Foundation and other project advisors provided insight and feedback on the interview guide questions and content to address the study's key research questions and the five domains of access: availability, accessibility, affordability, accommodation, and acceptability. The semi-structured guide addressed key research questions for different respondents while allowing interviewers flexibility to pursue additional relevant themes that interviewees introduced.[54,55]

The research team prioritized questions based on the type of interviewee (e.g., representatives from consumer advocacy organizations, payers, or professional associations) in preparation for each interview.

STAKEHOLDER RECRUITMENT APPROACH

The research team used purposive sampling techniques[56,57] to select a range of service providers, payers, and organizational leaders to interview who are knowledgeable about access to outpatient mental health services in Massachusetts. In collaboration with the Foundation and other project advisors, the research team developed a list of relevant stakeholders and prioritized the list of stakeholder interviewees.

DATA COLLECTION

The research team conducted 21 key informant interviews with a total of 24 stakeholders (some interviews had multiple participants) from July through October 2016, to understand factors that impact access to outpatient mental health services. As outlined in Exhibit 2, stakeholders included state agency representatives and policymakers, clinical leaders, health system administrators, and representatives of payers, mental health advocacy organizations, and associations of safety-net providers. Potential participants received an introductory email with background information on the study and an invitation to participate in the stakeholder interviews. A team of two qualitative researchers conducted each interview with a technical expert leading and an analyst taking notes.

The interviews lasted approximately 45–90 minutes and were conducted in person or by phone, depending on the preference of the stakeholder.

FOCUS GROUPS: INSTRUMENT DEVELOPMENT AND DATA COLLECTION

FOCUS GROUP DISCUSSION GUIDE

Similar to the instrument development process for the stakeholder interview guides, the conceptual framework informed the domains of inquiry, content, and structure of the client focus group guide. The focus group discussion guide addressed the key research domains and questions and allowed facilitators the flexibility to pursue additional relevant themes that participants introduced in the discussion.[55]

To generate discussion during the focus group, the research team asked participants to rate various aspects of their experience accessing outpatient mental health services. Participants filled out paper handouts asking them how easy or difficult it was to find an outpatient mental health professional who met various needs (i.e., location, insurance type, language, culture/ethnic background, works with primary care provider). The research team collected the handouts at the conclusion of the focus group and utilized the data in our analysis.

FOCUS GROUP RECRUITMENT APPROACH AND MATERIALS

In collaboration with the Foundation and other project advisors, the research team developed criteria for focus group participants. To be eligible to participate in the focus group, the individual or parent/guardian (for his/her child) must have tried to get an appointment or started care with a therapist, counselor, social worker, or psychiatrist within the last six months. The researchers developed recruitment materials such as paper flyers to display at health care organizations and in community spaces to promote the focus groups. The recruitment materials also included ones optimized to post on social media and community listservs.

- **Focus group flyer:** The recruitment flyer contained information about the study and clearly stated requirements for participation. It included the recruitment coordinator's contact information at the bottom and on tear-off tabs. The research team also optimized a version of the flyer for various types of social media and the Abt Associates website, so organizations could post on Facebook, Twitter, or LinkedIn or link to the Abt site.
- **Focus group study frequently asked questions (FAQ) sheet:** The research team developed a study FAQ that contained detailed information about the study and the risks and benefits of participating, and it addressed potential concerns about confidentiality. The researchers shared the FAQ sheet with recruitment sites.

The research team recruited adults and parents of children seeking outpatient mental health services through paper flyers posted in public spaces and communities (e.g., public libraries, parks, public bulletin boards), health care organizations, and social service agencies in greater Boston. Electronic flyers were also posted on community listservs, through social media, and by leveraging organizational networks to share promotional material broadly.

Recruitment coordinators monitored a designated phone line and email address to screen potential participants for eligibility and answer questions. Once the researchers identified 5–10 individuals interested in each of the four focus groups, the recruitment coordinator scheduled the focus groups at a time that was most convenient for the majority of participants. All eligible participants were invited to participate in the groups, and the recruitment coordinators continued to recruit until the scheduled date of the groups.

FOCUS GROUP PARTICIPANTS

The table below details the focus group participant selection framework and the number of participants in each group. The research team recruited both adults and parents of children seeking services in Massachusetts within the preceding six months; the researchers conducted separate focus groups for those with public (e.g., MassHealth, Medicare) plans and those with commercial insurance as the primary payer for mental health services.

PARTICIPANT SELECTION FRAMEWORK FOR FOCUS GROUPS

	CLIENTS: ADULTS/PARENTS OF CHILDREN SEEKING SERVICES	
PRIMARY CLIENT INSURANCE TYPE	**Adults**	**Parents**
Public plans (e.g., MassHealth, Medicare) or uninsured*	Focus Group 1 (6 participants)	Focus Group 2 (3 participants)
Commercial insurance (e.g., employer-sponsored, Health Connector plans)	Focus Group 3 (5 participants)	Focus Group 4** (6 participants)

* While uninsured individuals were eligible, there were none in any focus group.

** Focus Group 4 was a mix of publicly and commercially insured parents: Two parents had commercial insurance, two parents had public insurance, and two parents had commercial insurance with supplemental MassHealth.

FOCUS GROUP LOGISTICS

The research team held four 90-minute focus groups in October 2016, with a total of 20 participants. A team of three, led by a health services researcher/technical expert, conducted focus groups in person at the Abt Associates office in Cambridge, Massachusetts. The Abt office, with free parking and access to public transportation, was a convenient and neutral location for participants.

All participants received a $50 gift card as an incentive for participation and a Charlie Card with two pre-loaded rides on the Boston-area public transportation system. Participants signed a written consent form before participating in the group. Names and contact information collected for purposes of recruitment were not linked to any of the focus group notes or findings provided in the reports to the Foundation.

QUALITATIVE DATA MANAGEMENT AND ANALYSIS

The qualitative analyses examined factors that impacted the experience of adults and parents of children seeking outpatient mental health care in Massachusetts. The research team also explored the concept of “clinically appropriate” wait times from the perspective of clients and stakeholders to understand variation across sectors and among service users.

QUALITATIVE DATA MANAGEMENT AND ANALYSIS

After conducting interviews and focus groups, the research team cleaned up and reviewed the interview notes. The team analyzed the stakeholder interview and focus group data using the NVivo 10 software package. Two trained NVivo coders cross-coded the first set of interview and focus group notes, refined the codebook, and continued to cross-code and revise until coding was consistent.[42] The research team mapped emerging themes to the access framework to produce an “issue-focused” analysis for this report of qualitative findings. This approach protected the anonymity of respondents and highlighted themes that occurred across and within key domains.[55]

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