

BEHAVIORAL HEALTH URGENT CARE: A VISION FOR MASSACHUSETTS AND OPPORTUNITIES TO IMPROVE ACCESS

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Author's Note

The research for and drafting of this brief were completed prior to the COVID-19 pandemic. At the time of release of this paper, Massachusetts and the nation are experiencing severe public health and economic impacts stemming from the COVID-19 pandemic. These circumstances have negatively affected many people's behavioral health, surfacing new barriers and challenges for people with existing mental health and/or substance use disorders. At the same time, shelter-in-place policies—while critical public health measures—are linked to social isolation and loneliness, which can also cause poor mental health outcomes even among those without pre-existing mental health conditions.¹ Finally, job loss and employment uncertainty may also contribute to anxiety, depression, and higher rates of substance use disorders. In this environment, it is reasonable to anticipate increased demand for behavioral health care services generally, as well as for urgent behavioral health care services in particular.²

Some policies Massachusetts enacted in an effort to enhance access to health care services during this pandemic, like the temporary expansion in availability of telehealth across all payers, may begin to address some of the existing barriers to providing behavioral health urgent care. However, many of the challenges noted in this brief will likely be exacerbated with greater demand for behavioral health services. These difficult times have exposed some critical weaknesses in the health care delivery system. At the same time, however, they have also highlighted the political will and ability of the government, health care providers, and other stakeholders to identify and swiftly implement solutions to provide needed health care services in the Commonwealth.

Prior to the onset of COVID-19, the state launched an initiative to improve the ambulatory behavioral health care system in Massachusetts. This demonstrates the state's commitment to ensuring that a comprehensive and coordinated behavioral health care system is available to meet the needs of Massachusetts residents. The impacts of the COVID-19 public health emergency and economic downturn will only further elevate the importance of this initiative, with a robust set of behavioral health urgent care services that provide a critical component of the broader behavioral health care system. Accomplishing this vision for a reformed behavioral health care system will require some of the same tenacity and collaboration evidenced in the effort to combat the spread of COVID-19.

1 Panchal, N.; Kamal, R.; Orgera, K. et al. (2020, April 21). The Implications of COVID-19 for Mental Health and Substance Use. Kaiser Family Foundation. Available at <https://www.kff.org/health-reform/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.

2 Armout, S. (2020, April). U.S. Moves to Strengthen Mental-Health Services as Coronavirus Crisis Exposes Systemic Strains. *The Wall Street Journal*. Available at www.wsj.com/articles/u-s-moves-to-strengthen-mental-health-services-as-coronavirus-crisis-exposes-systemic-strains-11586520146?mkt_tok=eyJpIjoiT0RBeU5EVmpNalkwTmpZNCIsInQiOiJtNWl4d2xPUFB5R3AwMndpZUhlVlwwOHNZcTR5SFVoMHPicm5xZThlcG5WeGMzT25MK1kxSTVxUStcL1NXMjE3d0U-5WDRqNIRkeUJON1FtNDFiaFdSRE1RVHVlUUDNG5CV2t4MjYyUjFkd3p4eW9xWjFBM0lWemZLQTUoc241RlhKln0%3D.

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I. INTRODUCTION

The health care system in Massachusetts is not well structured to respond to individuals with urgent behavioral health¹ needs. Gaps in the health care system, including lack of accessibility and availability of community-based behavioral health services, exacerbate the need for urgent care. Adults seeking urgent care for a behavioral health condition often rely on emergency departments for treatment.^{2,3} Alternatively, adults may avoid or delay treatment because of barriers they face, such as long wait times for community-based behavioral health care services and difficulty paying for services because they lack comprehensive coverage for services or cannot find providers who accept their insurance.⁴ This can lead to worsening health conditions, poor health outcomes, and potentially avoidable use of emergency or other health care services.

In its continuing efforts to identify opportunities to improve the behavioral health care system in Massachusetts, the Blue Cross Blue Shield of Massachusetts Foundation (the Foundation) is examining barriers that impede the development and delivery of behavioral health *urgent* care services for adults in the Commonwealth.⁵ Disentangling behavioral health urgent care from issues that persist in the broader behavioral health care delivery system (for instance, access to outpatient behavioral health services) is challenging, yet this brief proposes a framework for behavioral health urgent care for adults and provides policy and programmatic recommendations to address barriers to implementation. This brief complements the Foundation's Behavioral Health Urgent Care grant program, through which the Foundation is supporting efforts to bolster the capacity of Emergency Services Programs (ESPs)⁶ to deliver behavioral health urgent care services in Massachusetts. Six ESPs have been awarded grants and have been working with the Foundation for the past two years to develop a vision for behavioral health urgent care and implement operational and organizational enhancements required to achieve this vision such that behavioral health urgent care services are accessible and coordinated with other services that are part of the care continuum necessary for a comprehensive and robust behavioral health services system.⁷ That work, and insights from other stakeholders collected through key informant interviews,⁸ informed the urgent care framework proposed in this brief and the recommended policy and programmatic actions to facilitate greater access to and availability of behavioral health urgent care.

II. BEHAVIORAL HEALTH URGENT CARE FRAMEWORK

Currently Massachusetts has no widely accepted definition of behavioral health urgent care. According to an analysis of key informant and ESP grantee feedback, behavioral health urgent care is characterized by the provision of a set of clinical and care coordination services and supports delivered *at the right time* and *in the right time frame*. It requires the organization of certain behavioral health care services and providers who can treat an individual whose condition would likely require emergency services without timely intervention. Behavioral health urgent care does not include ongoing behavioral health treatment (that is, it is time-limited and not meant to be a routine or ongoing source of care). This brief seeks in part to fill the definitional gap by proposing the following vision for behavioral health urgent care.⁹

The provision of high-quality, culturally competent care to those with mental health conditions, substance use disorders (SUD), and co-occurring disorders that is both clinically effective and cost effective. This care is provided by rapidly assessing and treating patients, supporting referral and access to appropriate services in the least restrictive setting, stabilizing an acute condition or circumstance while promoting safety and recovery, and providing medical clearance support and triage to divert people from the emergency department and inpatient psychiatric units.

Urgent Care vs. Crisis Care

Defining and distinguishing behavioral health urgent care from crisis care—and even emergency care—can be difficult. Some professionals consider it crisis care when the person poses an imminent risk of self-harm or poses risk of physical harm to others.¹⁰

Both urgent and crisis care are characterized by the expedient delivery of time-limited services, such as triage, stabilization, referral, and other supportive services to prevent a condition from escalating. This timely provision of care is intended to quickly assess a condition and potentially avoid an emergency situation that requires immediate treatment.

In most cases, providers are unable to ascertain if a condition requires urgent attention or crisis services until an assessment is performed. An individual in crisis may require more immediate attention and specific crisis intervention services, while someone requiring urgent care may be able to wait longer before receiving additional services.¹¹

In addition, urgent care and crisis services may be organized differently. For example, there are specific crisis services and settings for stabilizing people and for which there are defined treatment protocols and service and billing codes, such as Crisis Stabilization Services. These crisis services are beyond the scope of urgent care, though referrals to them may be made through urgent care, and some providers of behavioral health urgent care may also provide crisis services.

To realize the vision for behavioral health urgent care across settings and as a level of care that is part of a continuum of services in the behavioral health services system, organizations must be able to offer adults timely¹² access to specific clinical services and supports within the scope of urgent care and availability of the appropriate providers to deliver that care. Organizations may need to assess their current capabilities to determine if operational enhancements or care-delivery modifications are necessary to implement and sustain behavioral health urgent care. The following is a list of key elements of behavioral health urgent care against which organizations should evaluate themselves. While it is not necessary for an organization to have in place all of these elements in order to provide behavioral health urgent care, the more elements the organization has in place, the more effective it will be in providing behavioral health urgent care.

1. Organizational commitment to serving individuals with mental health conditions, SUDs, and co-occurring disorders
2. Ability to provide medical clearance¹³ outside of the emergency department
3. Operation of community-based locations with extended operating hours (for example, nights and weekends) with all staff, including providers able to prescribe medication, necessary to provide the care needed
4. Provision of or referral to stabilization and treatment services, including immediate access to treatment that the urgent care provider may not perform (for example, medication-assisted treatment [MAT])
5. Telehealth capabilities¹⁴
6. Strong relationships with recovery communities and SUD services
7. Ability to provide short-term care management and follow-up
8. Ability to identify individuals' social-determinants-of-health needs and connect them to social services or supports to address the identified needs
9. Strong relationships with law enforcement to assist with jail diversion for individuals with behavioral health conditions
10. Ability to provide medical triage support through additional medical staffing
11. Data and analytics capability to track quality and performance measures around client experience, nature and duration of follow-up, time to access referrals outside of behavioral health urgent care, and number of individuals with primarily SUD or co-occurring diagnoses

These care-delivery components will facilitate timely access to urgent care, as there is an emphasis on availability of services within and outside traditional operating hours. In addition, these components help support referral to other services that are part of the broader behavioral health care continuum. The vision and key elements described above highlight the organizational and structural resources and clinical services that a behavioral health urgent care provider should be equipped to deliver, including triage,¹⁵ assessment, stabilization, short-term intervention, and immediate treatment (that is, brief medication management, induction of MAT, and therapy), and referral to additional treatment. Importantly, providers and staff should all understand and provide trauma-informed¹⁶ care to facilitate trust and help to avoid further traumatization in responding to an urgent need. It may also be necessary for providers to recruit additional clinicians and build relationships with community supports. Implementing behavioral health urgent care requires a multidisciplinary care team of clinical providers and supports, including prescribers, social workers, certified peer specialists and recovery coaches,¹⁷ trained addiction specialists, and security personnel. The care team should help individuals navigate the array of available services and treatment options and support transitions of care across the behavioral health care continuum. This assistance includes following up with individuals to help them manage the different aspects of their care plan and communicating with treatment providers to ensure that needs are being met. Care coordination, which is also a critical element, could include a handoff to an individual's primary outpatient provider, who would coordinate ongoing care and treatment if the individual is not working directly with a behavioral health provider to manage ongoing care.

Developing and sustaining the key elements of behavioral health urgent care across different settings will provide adults with more options for timely access to care and offer alternatives to emergency departments and inpatient hospitalizations. The behavioral health urgent care framework proposed in this brief is applicable across different care settings. Existing models of care in Massachusetts can be leveraged and enhanced to implement behavioral health urgent care services in a more robust and consistent manner throughout the state. ESPs, which are described in the spotlight below, represent an opportunity to expand behavioral health urgent care services for adults. It should be noted that behavioral health urgent care services could be provided in a variety of settings on the continuum of community-based behavioral health settings; ESPs are one such setting, and outpatient behavioral health programs are among others. There are also other models that offer guidance for implementing urgent care. See Appendix IV for additional state and national approaches to providing behavioral health urgent care.

Spotlight: Emergency Services Programs (ESPs) in Massachusetts¹⁸

Currently, Massachusetts ESPs provide rapid assessment, response, and treatment to individuals experiencing a behavioral health crisis or in need of emergency services.¹⁹ ESP crisis services include mobile crisis intervention (MCI)²⁰ for children and adults and community crisis stabilization (CCS) for adults. ESPs may support individuals by phone to determine if additional care could be provided in the community in order to divert them from the emergency department. ESPs are building and strengthening relationships with first responders, hospitals, social service agencies, and community providers who have contact with individuals with substance use and mental health disorders to assist in providing care and referrals to other services and supports.

MassHealth (the state's Medicaid and Children's Health Insurance Program [CHIP]) contracts with the Massachusetts Behavioral Health Partnership (MBHP) to manage the ESP network. MassHealth managed care organizations (MCOs) in Massachusetts are required to include ESPs as a covered service; commercial insurers are not required to do so, though some do cover assessment and referral services performed by ESPs. In addition, accountable care organizations (ACOs) that hold contracts with MassHealth or with MassHealth MCOs are required to facilitate "immediate and unrestricted access to Emergency Services Program and Mobile Crisis Intervention services at hospital emergency departments and in the community, 24 hours a day, seven days a week."²¹

With support from the Foundation's grant program, six ESPs are building capacity to provide behavioral health urgent care and enhance ESP services to align with the key elements of the proposed behavioral health urgent care framework described earlier in this section of the brief.

III. BARRIERS TO BEHAVIORAL HEALTH URGENT CARE

The state has made investments to improve the ambulatory behavioral health care system—investments that can both facilitate greater access to behavioral health urgent care and potentially reduce the demand for it.²² For example, in 2019, the Executive Office of Health and Human Services (EOHHS) engaged in a public process to inform the development of a behavioral health ambulatory treatment system, inclusive of urgent care. As part of this process, EOHHS held a series of listening sessions throughout the state and released a Request for Information (RFI).²³ The RFI contained questions related to aspects of behavioral health urgent care, including medication-assisted treatment. There were also questions about the workforce and provision of urgent care and about engaging law enforcement personnel in advancing better care and treatment for individuals with mental health and substance use disorders. EOHHS plans to release a policy road map in 2020 based on this stakeholder engagement process and lessons learned from the COVID-19 pandemic. In addition, Governor Charlie Baker introduced an *Act to Improve Health Care by Investing in VALUE* in October 2019. The proposal includes specific attention to policies related to behavioral health urgent care, such as the requirement that urgent care centers, which have traditionally focused on physical health care services, provide behavioral health services and treat MassHealth members.²⁴ The state senate also passed the *Mental Health ABC Act: Addressing Barriers to Care (ABC)* in February 2020, which includes several provisions intended to improve access to behavioral health services, including requiring all commercial payers to provide coverage for ESPs.²⁵

Despite the Commonwealth's focus on behavioral health and related policy guidance or changes,²⁶ barriers persist and impede efforts to operationalize the behavioral health urgent care framework proposed in this brief. These barriers impact the provision of timely access to care and the development of resources and capacity to implement core capabilities and clinical services of urgent care, including short-term care coordination. Difficulty recruiting and retaining critical personnel also hinders the implementation of behavioral health urgent care services. These barriers may impact multiple elements of the behavioral health urgent care framework. Without further modifications to clinical or payment policies, providers may find that operationalizing a behavioral health urgent care framework is infeasible or unsustainable. Details related to each of the identified barriers and the implications for implementing behavioral health urgent care are described below. Again, these barriers were informed by interviews with key informants in Massachusetts and the ESP grantees. Notably, some of the identified barriers may be the result of the current regulatory structure, while others may have grown from longstanding practice or operational norms or assumptions.

A. WORKFORCE BARRIERS

Retention and recruitment challenges make it difficult to develop and sustain a workforce that can support behavioral health urgent care. Workforce barriers influence every aspect of the behavioral health urgent care framework as they impede efforts by critical personnel to deliver timely care. They also create challenges for providers seeking to build and sustain operations to deliver behavioral health urgent care. For example, many ESPs have tried over time to bolster their capacity to deliver urgent care but have experienced challenges finding qualified personnel ready to provide this care. Many clinicians and staff who are providing behavioral health urgent care services are new to the field or in training. Yet they are treating and caring for individuals who have urgent, and often complex, behavioral health care needs, which require experience in a fast-paced, multidisciplinary, and time-pressured care setting. An analysis of the interview feedback and literature review that informed this brief found that the following factors contribute to workforce-related challenges:

- There is a significant pay disparity in what community-based providers, like ESPs or outpatient behavioral health clinics, can offer licensed clinicians versus what larger hospital systems can offer. As a result, the larger hospital systems, specifically those with emergency departments, become the default setting for behavioral health urgent care by virtue of having critical personnel such as psychiatrists and security personnel on site.²⁷

- Community-based providers, including ESPs, often serve as training grounds for clinicians seeking licensure. Some key informants indicated that once clinicians are licensed, many of them leave for higher pay and/or predictable and flexible schedules and a less demanding environment. High staff turnover adds to the challenge of fully implementing behavioral health urgent care because of concerns about sustaining operations.
- The demands of a behavioral health urgent care setting and the timing of some shifts (nights, weekends) can lead to stress and burnout among clinicians, creating additional barriers to recruiting and retaining qualified staff.
- Scope-of-practice regulations limit clinical supervision of personnel to those within the same profession, making it challenging to diversify the clinical workforce. For example, a licensed certified social worker (LCSW) may not provide any clinical supervision to a mental health professional of another discipline (for example, a licensed mental health counselor) as that would be considered practicing out of scope. However, an LCSW is permitted to provide nonclinical supervision (nonclinical case management, organizational and administrative supervision, etc.) to an individual of another professional discipline.²⁸ These restrictions may further inhibit recruitment and retention of an adequate workforce for behavioral health urgent care.

B. CLINICAL BARRIERS

This brief identifies key elements for implementing behavioral health urgent care, yet challenges remain for providers seeking to build and sustain these critical services. The following are specific clinical barriers related to behavioral health urgent care, as described by key informants, ESP grantees, and in the literature reviewed for this brief:

- Medical clearance in the context of behavioral health care is a process of evaluating an individual's medical condition prior to admission to a psychiatric, substance use, or other behavioral health inpatient or residential facility. According to the ESP grantees and other key informants, inpatient psychiatric treatment facilities and substance use treatment facilities in the state typically will not admit an individual in need of inpatient or residential treatment until a physician has established that the person does not have an underlying medical condition that the intake facility is not adequately staffed to treat. However, there is no specific law or regulation that dictates this practice. ESPs are generally not staffed to provide medical clearance or are unable to administer all of the tests an individual may need for clearance and therefore may have to refer the individual to an emergency department. This common practice has thus contributed to a system of organizing services around emergency-department care, rather than community-based care. Furthermore, when an assessment has been made that admission to a facility is the next step in someone's treatment, immediate access to that next level of care is crucial. Without a uniform set of medical clearance policies or practices, inpatient facilities may impose different requirements for medical clearance prior to admitting or treating someone, which leaves behavioral health urgent care providers navigating different rules.
- An effective behavioral health urgent care response includes the capacity of clinicians to induce MAT and provide short-term medication management, including timely access to psychotropic medications. While ESPs are generally able to provide access to psychotropic medications, ESPs and many other outpatient providers do not have staff certified to prescribe and dispense MAT.²⁹ In order to obtain MAT certification, providers must obtain a waiver from the federal Drug Enforcement Agency (DEA). Providers have indicated that this is a cumbersome process with restrictions on the number of patients to whom a provider can prescribe MAT. As a result, the demand for MAT in Massachusetts outpaces the supply of providers with waivers to prescribe the treatment. Providers also cite confusion over the separate federal and state requirements.³⁰

- More broadly, a key element of a behavioral health urgent care service model is the ability to facilitate entry or re-entry to other services and levels of care within the behavioral health care system. Providers report experiencing challenges connecting individuals to the next level of appropriate care due to capacity constraints; this may include, for example, both bed shortages for inpatient services and waitlists for outpatient treatment. Massachusetts must continue its work to address these system capacity issues in order to enable providers working in the urgent care setting to effectively transition individuals to the right level of care needed and in the right time frame that the appropriate level of care is needed.

C. PAYMENT BARRIERS

Implementing and sustaining capacity for providers and systems to develop behavioral health urgent care requires adequate funding and reimbursement, including a sufficient base rate that covers service costs, start-up costs, personnel costs (such as training and enhanced rates for weekends and nights) and infrastructure (such as capacity for telehealth, physical space). Rate increases alone may not be sufficient to encourage or sustain behavioral health urgent care, particularly if they're merely small increases to already inadequate rates.³¹ New models and approaches to paying for services are also needed to facilitate implementation of and access to behavioral health urgent care services. As described in this brief, the behavioral health urgent care framework extends beyond a core set of clinical services to encompass other organizational and operational elements, like timely access to care and key nonmedical personnel, which the current fee-for-service payment model does not support or sustain. Payment that is only provided when there are distinct, reimbursable service codes is inconsistent with providing behavioral health urgent care. The following describes specific payment barriers to behavioral health urgent care that were identified by ESP grantees and other key informants. These suggest a different payment model for behavioral health urgent care services is needed.

- An inherent feature of urgent care is that patient volume is unpredictable and visits are typically unscheduled. For behavioral health urgent care providers, this means a physician or other clinician needs to be ready to treat an individual without knowing if or how many other people may need care. Hiring a clinician to work at night or on weekends when volume varies means the provider organization is paying a clinician whether or not that person sees patients. As a result, the organization may be paying for urgent care services but not bringing in revenue to cover the costs. This happens if the clinician does not see anyone or the service rendered is not a covered, reimbursable service (as is the case when the patient is uninsured, or the patient's insurance does not provide coverage for these services). For behavioral health care providers, this is an unsustainable financial model under which to offer urgent care services.
- The current fee-for-service payment structure for behavioral health urgent care services does not take into account the significant role of care coordination, according to interviewees.
- Many interviewees indicated that security personnel are needed as well, especially during nontraditional operating hours such as nights and weekends, when there are fewer staff on site to assist and intervene should an individual's condition or behavior raise safety concerns. The cost of security personnel is not a reimbursable service under the current fee-for-service payment model.
- Peer specialists and recovery coaches³² are underutilized, according to ESP grantees and key informants; and they provide important and valuable services for which there is not consistent reimbursement across all payers.³³

D. ADMINISTRATIVE BARRIERS

Behavioral health urgent care requires the provision of timely access to a set of services and supports. Care is provided by a multidisciplinary team of clinicians and support staff. Burdensome administrative requirements impact providers' ability to deliver timely care. Specific barriers reported by key informants include:

- While some prior authorization rules imposed across different payers have changed to enable better access to behavioral health services, providers continue to face hurdles accessing the next level of care.³⁴ Interviewees noted that prior authorization limits their ability to prescribe certain medication in the short term. Examples of medications for which various payers, including MassHealth, may have different prior authorization requirements include benzodiazepines and other anti-anxiety agents and certain brand-name drugs.³⁵ Insurers may also limit the number of pills a provider may prescribed, or the size of the dose.

The administrative burden of prior authorization is not just limited to prescription drugs. Depending on the insurer, other requirements may dictate where an individual may receive certain services or how many treatment visits an individual may receive, according to interviewees. If administrative delays prevent a behavioral health urgent care provider from offering short-term treatment or a referral to the next level of care, the opportunity to support someone may be lost. As outlined in this brief, behavioral health urgent care is treatment *at the right time* and *in the right time frame*. The time it takes to receive prior authorization together with administrative delays in granting approval may impede the ability to provide care in the right time frame. Navigating the different and complex rules of multiple payers also takes time away from patient care.

- Administrative requirements for reimbursement of follow-up care can impose burdens on providers, while also failing to bring particular benefits to individuals. Behavioral health urgent care is time limited in that it is not a source of routine or ongoing care. A behavioral health urgent care provider intervenes for short-term care and then assists individuals with finding an ongoing source of care or treatment. Until routine care is established, the urgent care provider may need to provide follow-up care to ensure that the person remains stable. In practice, ESPs noted, these follow-up visits may require the provider to develop a new treatment plan with each visit in order to be reimbursed. This time-consuming process is rarely necessary for either providers or individuals, given the short time frame between visits.

IV. RECOMMENDATIONS TO ADDRESS BARRIERS

The following recommendations seek to mitigate barriers to implementing behavioral health urgent care. These recommendations are interconnected, and many pertain to expanding access to care to make it easier for providers to respond in a timely manner—a cornerstone of urgent care. For example, increasing payment to behavioral health urgent care providers may increase their ability to hire key urgent care personnel.

RECOMMENDATION 1: DEFINE BEHAVIORAL HEALTH URGENT CARE

Lack of a standard definition for behavioral health urgent care for adults and children creates confusion for patients, providers, payers, and policymakers. EOHHS, as part of its behavioral health ambulatory treatment system initiative, should lead a process to define behavioral health urgent care in order to create operational consistency and allow providers and care settings to organize services and supports according to the same standards. A clear definition of a service is also critical for payment. Defining care and services would also enable the state to monitor the capacity of the system to provide behavioral health urgent care and establish performance standards based on experience. This brief offers a definition informed by the input of key stakeholders and provides an operational framework of key elements for building and sustaining behavioral health urgent care.

RECOMMENDATION 2: REQUIRE ALL PAYERS TO COVER BEHAVIORAL HEALTH URGENT CARE

With the development of a standard definition for behavioral health urgent care, which should include the elements described in this brief, the state should require all payers to cover and adequately reimburse urgent care, including

services delivered in the community. This may call for an expanded set of services and supports, as described in this brief, to be reimbursed in order for the model to be sustainable. These services and supports include but are not limited to the following:

- **Certified peer specialists and recovery coaches:** Peer specialists and recovery coaches play key roles in behavioral health urgent care, yet the services they provide are not routinely reimbursed. When an urgent need presents, the experience and perspective of peers or recovery coaches with their own personal stories can help individuals who may be in a vulnerable state understand different treatment options and may provide motivation without pressuring individuals to seek treatment. Based on their lived experience, peers and recovery coaches are often able to more effectively communicate to individuals who are skeptical about medical models of treatment. Currently, all ESPs use certified peer specialists in some capacity; there is less use of recovery coaches.³⁶
- **Follow-up services:** Another service that is not currently reimbursable for adults but which many ESP grantees provide nonetheless is coverage for up to seven days of follow-up for intervention and stabilization as part of mobile crisis intervention. Under the Children’s Behavioral Health Initiative (CBHI), mobile crisis intervention services for children specifically include a seven-day follow-up period. All insurers are required to cover those services for children. Establishing the same requirement and payment for providing these services to adults and recognizing the need for short-term care coordination to ensure stabilization would give providers of behavioral health urgent care greater financial security for building and sustaining urgent care operations.

RECOMMENDATION 3: REFORM PAYMENT AND PAYMENT MODELS

This recommendation consists of two parts: 1) enhancing payment rates and/or providing supplemental payments, and 2) developing new payment models that would support and advance the goals of behavioral health urgent care.

- **Payment rates and supplemental payments:** An increase in payment rates would address many of the barriers described in this brief. Increased rates could take the form of increases to existing payment rates and/or a supplemental “differential” payment that behavioral health urgent care providers could use to facilitate timely delivery of care, for example, by expanding their hours. This would increase their ability to offer competitive salaries, or cover costs for ongoing training (which is in part due to high turnover) and supervision required to operationalize the behavioral health urgent care framework. Increased rates and/or supplemental payments might also alleviate recruitment and retention barriers and ensure that the community urgent care response is adequate to reduce avoidable emergency department use or delays in care that could cause an urgent condition to escalate.

For example, Stanley Street Treatment and Resources (SSTAR)³⁷ is participating in the Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC)³⁸ grant program. Leveraging this supplemental grant funding is enabling them to bolster capacity for same-day treatment and walk-in appointments, which are particularly critical for individuals seeking behavioral health urgent care. However, a financial approach that relies on grant funding does not guarantee long-term sustainability of this service delivery model. Another positive step is that as of January 1, 2020, MassHealth increased its investment in ESPs—in the form of rate increases—to expand access to community-based treatment, including mobile services.³⁹

- **Adoption of new payment models:** Payment models that are flexible and offer predictable sources of income can support broader implementation of behavioral health urgent care. Adequate financing⁴⁰ (as described above) is required to build, operationalize, and sustain the elements of behavioral health urgent care as proposed in this brief and must take into account the nonclinical components of behavioral health urgent care, such as peer specialists, that are often not reimbursable through a fee-for-service payment

model. Examples of different payment models that may support the delivery of behavioral health urgent care services include a prospective payment based on projected spending, which is reconciled to actual costs (inclusive of those services for which there is not currently reimbursement), or a capitated per member per month payment model that includes a set of services and encompasses all the costs needed to effectively operate behavioral health urgent care. Each of these payment models would provide the flexibility to cover administrative and infrastructure costs to ensure personnel are available 24/7. They also take into account that demand is unpredictable and volume fluctuates.

Payment that is prospective and comprehensive provides a measure of certainty for providers; payment that is retrospective (i.e., after a service is provided), such as fee-for-service, is driven by a specific individual-provider interaction. Payment for behavioral health urgent care requires a prospective financing model that will cover the cost of clinicians and other staff when utilization fluctuates, and even when there is no utilization of services. One notable challenge with respect to a new prospective payment model is determining an appropriate estimated caseload for a given provider of behavioral health urgent care services or, put another way, attributing individuals and patients to a specific provider of behavioral health urgent care services. There are ways to overcome this challenge. For example, estimating the cost of services needed by region or geography based on population or, permitting a provider to estimate the costs of care or average monthly volume of care based on the prior year's utilization.

RECOMMENDATION 4: DEVELOP A PSYCHIATRY CONSULTATION PROGRAM FOR ADULTS

Based on the success of and learnings from the Massachusetts Child Psychiatry Access Program (MCPAP),⁴¹ the state should develop a MCPAP-like model for adults. By facilitating increased access to timely psychiatric care, the model may address both a workforce issue and the issue of timely access to care, both of which are critical to behavioral health urgent care. Currently MCPAP providers consult with pediatricians to assist with screening, identification, and assessment; treatment of mild to moderate behavioral health disorders in pediatric patients; and referrals to community-based behavioral health services. MCPAP also operates a targeted MCPAP for Moms program that supports obstetricians, gynecologists, nurse midwives, and nurse practitioners to identify and treat postpartum depression.⁴² In early 2019 the state launched another consultation program, the Massachusetts Consultation Service for the Treatment of Addiction and Pain (MCSTAP), which offers real-time phone consultation to providers on safe prescribing and managing care for adults with chronic pain and/or SUDs.⁴³ Finally, in 2020 a MCPAP program to support individuals with autism spectrum disorders and intellectual disabilities was created for mobile crisis intervention teams.⁴⁴ A similar model for adults could be developed and funded to assist behavioral health urgent care providers performing short-term medication management, prescribing psychotropic medications to their adult patients, and referring to ongoing treatment. ESPs and other providers of behavioral health urgent care could leverage these services to enhance their capacity to support psychiatric care, especially urgent psychiatric care.

RECOMMENDATION 5: SUPPORT WIDESPREAD ADOPTION OF TELEHEALTH

Treatment of urgent behavioral health needs through telehealth holds the potential to facilitate more timely access to behavioral health services, including those services envisioned for behavioral health urgent care. MassHealth reimburses providers using telehealth for psychopharmacology diagnostic evaluations, initial ESP evaluations and reassessments, opioid treatment counseling, outpatient counseling, and prescribing.⁴⁵ While some commercial insurers, such as Blue Cross Blue Shield of Massachusetts, pay for telehealth to

COVID-19 and Telehealth Expansions

In response to the public health crisis brought on by COVID-19, MassHealth and commercial health insurance carriers are required to reimburse all medically necessary and clinically appropriate covered services delivered through telehealth. These policy changes went into effect in March 2020 and will remain in effect either until rescinded or until the end of the state of emergency initiated in response to COVID-19. In order to maintain the gains in telehealth capacity that have occurred during this period, the state should consider making some of these policy changes permanent.

Sources: MassHealth All Provider Bulletin 289 March 2020; Massachusetts Office of the Governor, "Order Expanding Access to Telehealth Services and to Protect Health Care Providers," March 15, 2020.

support the provision of behavioral health urgent care, prior to the COVID-19 pandemic, adoption of telehealth was not widespread in the state and Massachusetts did not require health plans to cover services provided through telehealth.⁴⁶ Key informants and ESP grantees indicated that acquiring the right technological capabilities and finding appropriate space to deliver services via telehealth will be necessary to implement telehealth. To promote implementation of telehealth, the state could create a technical assistance program for providers. The assistance would focus on MassHealth payer billing requirements, vendors that offer telehealth, and the regulatory parameters for utilizing telehealth. Such information could facilitate different providers and programs to fully realize the benefits of telehealth.

RECOMMENDATION 6: CONVENE PROVIDERS TO CLARIFY MEDICAL CLEARANCE REQUIREMENTS

As described in this brief, several issues related to medical clearance in the context of behavioral health care impact the provision of urgent care, specifically in the community. This issue is not unique to Massachusetts, according to at least one interviewee. There should be an option to use the clinical judgement of trained medical professionals, such as nurses, to screen individuals to determine if labs and other medical tests are needed. A case in point is the Carolina Outreach Behavioral Health Urgent Care centers in North Carolina, which are described in more detail in Appendix IV. These centers have a medical assistant or nurse perform a physical health assessment to ensure there are no immediate physical health needs that require attention.

To address the variation, confusion, and operating assumptions around medical clearance, the state should convene a multidisciplinary group of outpatient providers, inpatient providers, advocates, behavioral health clinicians, state officials from the Departments of Public Health, Mental Health, and MassHealth, emergency medical services (EMS), the Centers for Medicare and Medicaid Services (CMS), and others to discuss medical clearance and determine if a standard rule should be adopted or guidance issued to bring clarity and consistency to the practice statewide. The experience of the Boston Public Health Commission and Boston EMS in implementing their Emergency Triage, Treat, and Transport (ET3) program, funded by CMS is intended to enable ambulance-based providers to use their clinical judgment to identify the most appropriate site to which the individual should be transported for treatment (e.g., an emergency department, an urgent care clinic, or on site using telehealth). This program may provide important lessons to informing this discussion and in the development of evidence-informed clinical standards for medical clearance.⁴⁷

RECOMMENDATION 7: ASSIST PROVIDERS IN OFFERING MEDICATION-ASSISTED TREATMENT

Continued training of physicians, advanced nurse practitioners, and physician assistants on the DEA waiver process and on the clinical benefits of MAT can help overcome the barriers to MAT that were previously described in this brief. Specifically, the state should encourage more providers to become licensed to provide MAT services. To support this effort, the state and/or provider organizations or associations with expertise in navigating the DEA waiver process could convene providers with interest or experience in treating patients with SUDs, provide professional education on the clinical benefits of MAT, and share processes and best practices for completing the waiver process and maintaining MAT certification.

At a minimum, behavioral health urgent care providers, including ESPs, should be able to refer, or provide a warm hand-off to, sites and providers that can deliver substance use treatment medication.⁴⁸ In addition, building the capacity of ESPs and other behavioral health urgent care sites to deliver MAT directly may be another—more direct—mechanism to expand access to MAT.

V. CONCLUSION

A delivery system that is organized to provide behavioral health urgent care promotes effective treatment, sustained recovery, and improved outcomes and serves as a critical component of the broader behavioral health care services system. There are opportunities to address the workforce, clinical, payment, and administrative barriers that prevent implementation of a robust set of behavioral health urgent care services described in this brief. Providing high-quality and whole-person care requires building capacity across non-emergency services for adults seeking timely care for behavioral health needs. The Commonwealth is positioned to improve access to behavioral health urgent care services. It can best do so by building out from existing care settings and programs to expand behavioral health urgent care services and ensure that the key elements of this level of care are in place. These elements include timely access to a set of core clinical services and supports, provision of care by a multidisciplinary team, and short-term care coordination.

APPENDIX I. METHODOLOGY

The Blue Cross Blue Shield of Massachusetts Foundation commissioned Bailit Health to assist with this policy project. Bailit Health is also supporting the Foundation’s ESP behavioral health urgent care grant program. Bailit Health synthesized and analyzed information acquired through key informant interviews, ESP grantee focus groups, and research into urgent care for behavioral health to develop this brief. Bailit Health conducted 19 interviews between August and November 2019 with payers, advocates, providers, associations, and state officials in Massachusetts using a structured interview guide. Interviewees were selected with the goal of obtaining multiple and varied perspectives. (See Appendix II for the list of key informants interviewed for this work and Appendix III for the interview guide.) Bailit Health also performed a review of limited research and analysis into best practices and different delivery models and approaches for providing behavioral health urgent care.

Together, the ESP grant program, review of the literature, key informant interviews, including input from the grantees, and Bailit Health’s experience developing policy options to improve behavioral health care informed the development of this brief.

APPENDIX II. KEY INFORMANT INTERVIEWS AND FOCUS GROUPS

INTERVIEWEES

1. Advocates
2. Association for Behavioral Healthcare (ABH)
3. Beacon Health Options
4. Beth Israel Deaconess Hospital (BID)—Plymouth
5. Blue Cross Blue Shield of Massachusetts
6. Clinical & Support Options (CSO)
7. Community Counseling of Bristol County
8. Health Care for All
9. Lahey Behavioral Health Services
10. Massachusetts Association for Mental Health (MAMH)
11. Massachusetts Behavioral Health Partnership (MBHP)
12. Massachusetts Department of Mental Health (DMH)
13. Massachusetts Department of Public Health, Bureau of Substance Addiction Services (BSAS)
14. Massachusetts League of Community Health Centers
15. Massachusetts Organization for Addiction Recovery (MOAR)
16. MassHealth
17. Middlesex County Sheriff’s Department
18. National Alliance on Mental Illness (NAMI) of Massachusetts
19. Transformation Center/Western MA Recovery Learning Community (RLC)

ESP GRANTEE FOCUS GROUPS

1. Bay Cove Human Services, Inc.
2. Boston Medical Center
3. Brien Center for Mental Health and Substance Abuse Services
4. Community Healthlink, Inc.
5. Clinical and Support Options (CSO)
6. Lahey Behavioral Health Services

APPENDIX III. URGENT CARE POLICY BRIEF INTERVIEW GUIDE

The Foundation has commissioned Bailit Health to assist with a project identifying barriers to implementing behavioral health urgent care services (inclusive of mental health and substance use disorder services) for adults in the Commonwealth. As part of the project, we are interviewing select stakeholders, including payers, advocates, providers, associations, and state officials to inform a policy brief describing regulatory, policy, and other barriers that impede the development of a comprehensive and sustainable behavioral health urgent care program for adults. The brief will also identify specific policy recommendations that could address the issues.

This policy project supports the Foundation's focus on behavioral health care and complements its grantmaking program which is investing in the capacity of Emergency Service Providers (ESP) to deliver urgent behavioral health care services. The Foundation seeks to understand, in part, the extent to which there are health care models and/or infrastructure, including ESPs, which could be leveraged to deliver behavioral health urgent care that can treat and stabilize adults needing such services.

First, we are interested in understanding from you what you think constitutes behavioral health urgent care.

1. What specific needs would a behavioral health urgent care program address and for whom?
2. What should the purpose of behavioral health urgent care for adults be (e.g., services should include short-term care, stabilization, a recommended treatment plan, and follow up with the goal of avoiding a potential emergency)?
3. What would you describe as the critical components of behavioral health urgent care?
 - a. What specific services would be offered?
 - b. What providers/clinicians/practitioners are essential in the provision of behavioral health urgent care?
 - c. What are the characteristics of the setting?
4. How would urgent care for behavioral health fit into the current delivery system to achieve desired results and optimal effectiveness for adults?
5. What service delivery options could be leveraged/considered/optimized to establish a behavioral health urgent care delivery system for adults in the Commonwealth (e.g., primary care integration, mobile crisis intervention)?
 - a. ESPs are providing some behavioral health urgent care services—what do you think about that as a model? What are the strengths? Limitations?
 - b. What are other models that should or should not be leveraged and why?
6. The Foundation is currently working with six ESPs through a grant program to support the development of BH urgent care. Through that process, we have worked with the grantees to develop a vision for BH Urgent Care that builds off of the role of an ESP. The ESP BH urgent care model would enhance ESP services in the following ways:
 - Place more emphasis on serving individuals with SUD and co-occurring issues
 - Increase ability to provide medical clearance outside of the ED
 - Increase community-based locations with BHUC and expand their operating hours
 - Provide more immediate access to treatment beyond stabilization
 - Offer telemedicine
 - Offer MAT or immediate access to MAT through referral
 - Create more linkages to SUD services including recovery communities
 - Provide short-term care management and follow-up

- Identify SDOH needs and identify resources
- Enhance relationships with law enforcement to become a stronger alternative to jail
- Provide medical triage support through additional medical staffing
- Increase all staffing with a goal for 24/7/365 BHUC availability
- Track quality and performance measures around client experience, nature and duration of follow-up, time to access referrals outside of BHUC, the number of individuals with primarily SUD or co-occurring diagnoses

Does this vision make sense to you? How might you suggest modifying it?

BARRIERS TO IMPLEMENTING BEHAVIORAL HEALTH URGENT CARE IN MASSACHUSETTS

Now we will turn to questions about perceived or existing legal, regulatory, and/or other policy barriers to establishing a robust and sustainable behavioral health urgent care delivery system in the Commonwealth.

7. What are the top three barriers to developing and implementing behavioral health urgent care for adults in the Commonwealth?
8. What are potential solutions to addressing those barriers?
 - a. Short-term solutions (e.g., changes that could be implemented relatively immediately—e.g., process changes)
 - b. Long-term solutions (e.g., legislative action, State budget development)
9. What changes to the current legal and regulatory structure are needed to more effectively enable the provision of behavioral health urgent care for adults in the Commonwealth?
 - a. What existing laws and/or regulations *impede* efforts to build an effective and sustainable BH urgent care program for adults in the Commonwealth? For example, are there specific regulations pertaining to licensing, credentialing, supervision or other staffing requirements that create barriers to implementation? Are there other requirements that are problematic?
 - b. What current policies could help facilitate the development and implementation of a robust and sustainable model of care for adults needing urgent behavioral health care services?
 - c. What type of private/public investment is needed to support the implementation of behavioral health urgent care?
10. What financial and reimbursement structure would best support a sustainable model of behavioral health urgent care?
11. How could the current activities and efforts to transform health care in the Commonwealth be leveraged to support the provision of behavioral health urgent care for adults (e.g., ACOs, MCOs, opioid urgent care centers, other DSRIP initiatives)?
12. Are there examples of best practices or approaches in Massachusetts or other states that you are aware of which we should look at for this project?
13. Are there any other comments you would like to add?

APPENDIX IV: BEHAVIORAL HEALTH URGENT CARE MODELS AND APPROACHES

URGENT CARE CLINICS

Urgent care clinics today typically treat physical health conditions and do not have capacity to respond when the primary need is behavioral health care. In general, urgent care clinics do not have behavioral health clinicians on site, so individuals needing urgent behavioral health care do not seek care at these clinics. In addition, while urgent care clinics may offer prompt access to care during traditional operating hours, there are fewer options during nontraditional operating hours such as nights and weekends. However, there are some examples of urgent care clinics operating with a focus on behavioral health, as described below.

Opioid Urgent Care Centers (Massachusetts): The Massachusetts Bureau of Substance Addiction Services (BSAS) is piloting three opioid urgent care centers (OUCC) through June 30, 2020, at Boston Medical Center, Community Health Link, and Stanley Street Treatment and Resources.⁴⁹ The OUCCs are walk-in clinics focused on the delivery of ambulatory care in a dedicated medical facility other than a traditional emergency room. OUCCs provide walk-in medical clearance, addiction assessment, and triage, and facilitate referrals to inpatient and outpatient treatments. Similarly, Brigham and Women’s Health operates a “bridge clinic” for individuals with substance use disorders. Bridge clinics offer timely access to care until individuals are connected with permanent outpatient or ongoing care (that is, they are intended to “bridge the gap”).⁵⁰

Carolina Outreach Behavioral Health Urgent Care (North Carolina):⁵¹ Carolina Outreach operates community-based urgent care centers in four counties in North Carolina. The urgent care centers were designed to support individuals with mental health conditions, including substance use disorders, by providing walk-in services for assessments, short-term medication, and crisis counseling. Carolina Outreach also helps individuals connect to ongoing services. Specifically, individuals seeking support from Carolina Outreach will be:

- assessed by a medical assistant or a nurse to ensure an individual does not have any physical health concerns that require immediate attention;
- offered crisis counseling and psychiatric services, including medication initiation or refills;
- evaluated for mental health and substance use needs;
- referred to a local provider for ongoing therapeutic, psychiatric, or other ongoing routine care with a treatment plan for continued access to medications and services;
- offered case management to assist in making connections to community resources and ensuring a smooth transition to ongoing care; and
- assessed for discharge planning.

Carolina Outreach contracted with Alliance Behavioral Healthcare, North Carolina’s behavioral health managed care organization (MCO) to provide urgent care services for the MCO’s Medicaid members. Individuals with private insurance or who live outside the service area can pay out of pocket to access its services.

MOBILE CRISIS SERVICES

The American Psychiatric Association Task Force defines mobile crisis services as having the “capacity to go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility,” along with a staff including “a psychiatrist available by phone or for in-person assessment as needed and clinically indicated.”⁵²

Mobile Crisis Intervention (Massachusetts): The state’s ESPs provide short-term mobile crisis intervention (MCI) services to young people (ages 0–20) experiencing behavioral health crises. MCI is a mobile, on-site, face-to-face therapeutic response that includes crisis assessment, intervention, stabilization, and care coordination.⁵³ MassHealth requires insurers to cover MCI services for young people 24 hours a day, seven days a week. Adult MCI services are provided in an individual’s home or another community location, though capacity is limited for ESPs to travel into the community for adults. From 8 p.m. to 7 a.m., adult MCI services are delivered in residential programs, emergency departments, and other supervised settings. There is no parallel MassHealth requirement that insurers cover MCI for adults.

COLLABORATION WITH LAW ENFORCEMENT

Engaging law enforcement in nonpunitive and nonjudgmental responses can facilitate greater access to care for individuals needing urgent behavioral health care. Many police departments are hiring social workers on staff or training officers to enable them to better understand and respond to the true needs of individuals in distress. For example, awareness among law enforcement officials of stabilization and behavioral health treatment options in the community may divert some people from visits to an emergency department and ensure that they get needed care. In Massachusetts, there are many examples of collaboration among ESPs and law enforcement, including ride-along programs, in which clinicians travel with police in the community.⁵⁴

Middlesex County Restoration Center Commission (Massachusetts): The Massachusetts legislature has tasked Middlesex County with piloting a program to create a restoration center in the county and support data-driven initiatives that connect correctional facilities with community service providers, such as hospitals, to facilitate the provision of behavioral health care services.^{55,56} Through an information-gathering period, the Commission found that as many as half of those who have been sentenced or are awaiting trial have a mental health condition. The Commission also found that more than three-quarters of those individuals have a SUD or co-occurring condition. The Commission is working with 54 local police departments to gather and share data to help improve behavioral health care services for those individuals involved with the justice system. The Commission found that jail diversion specialists, funded by the Department of Mental Health, support municipalities in their jail diversion efforts. These trained specialists can accompany police as co-responders to help avoid escalation of problems.⁵⁷ During the course of their work, the Commission determined that the restoration center would be a critical addition to the system but must be open 24 hours a day, seven days a week, to have an impact. They have received a second year of funding and will work on determining the services a restoration center should offer, such as psychiatric care, substance use services (such as MAT and a safe place for individuals who need to sober up), immediate access to treatment and outpatient care, and assistance with social determinants of health. The second year of the Commission’s work will focus on the details of staffing, costs, and transportation to and from the restoration center.

The Center for Health Care Services—The Restoration Center (Texas):⁵⁸ The Restoration Center in San Antonio, Texas, launched to fill a critical gap in treatment services for individuals with mental health, substance use, or co-occurring disorders who were increasingly relying on emergency

departments or routinely interacting with the criminal justice system, often resulting in incarceration. The Restoration Center was conceived of and implemented to address the criminalization of individuals with behavioral health conditions. The Restoration Center provides psychiatric care, substance use services (such as a detox room, sobering unit, and extended observation unit), outpatient health care, and transitional housing. It also operates programs for women who are pregnant who need crisis services, opioid addiction treatment services, and outpatient transitional services. Partnering with law enforcement, first responders, and emergency departments was critical to the implementation of The Restoration Center.

PEER-RUN PROGRAMS

Peer-run programs are nonclinical settings that offer a safe, welcoming, and home-like space for individuals in times of distress. They may complement behavioral health urgent care by offering adults a space and supports to avoid escalation of a behavioral health condition. They are not designed to provide behavioral health urgent care, as proposed in this brief, but they share the goal of preventing a condition from escalating to the extent that crisis or emergency services are needed. In general, staff at peer-driven programs are familiar with the landscape of clinical services available to adults and, if needed, can transport an individual immediately (with consent) to a location to receive treatment.

The Living Room (Massachusetts): Individuals can access the Living Room without a referral and talk with peer specialists who have experience living with a mental health condition or substance use disorder. The support is voluntary, nonclinical, nonjudgmental, and focused on trust and mutual respect. People can stay for up to three nights at the Living Room. Staff can refer and transport individuals who wish to access clinical care or treatment and can educate individuals about available treatment options. Behavioral Health Network, Inc.⁵⁹ and Advocates⁶⁰ operate Living Room models in Massachusetts.

ENDNOTES

- 1 For the purposes of this brief, behavioral health is inclusive of mental health, substance use disorders (SUD), and co-occurring mental health disorders and SUDs.
- 2 See “Reforms to strengthen and improve behavioral health care for adults.” EOHHS. November 3, 2017. Available at www.mass.gov/files/documents/2018/01/24/bh-system-restructuring-document_1.pdf. Accessed February 13, 2020.
- 3 Berard, P. (2018, January 1). “Emergency department visits for behavioral care on the rise.” Available at www.nepsy.com/articles/leading-stories/emergency-department-visits-for-behavioral-care-on-the-rise/. Accessed February 13, 2020.
- 4 For recommendations and opportunities to address broader behavioral health care system gaps, see *Ready for Reform: Behavioral Health Care in Massachusetts*. Blue Cross Blue Shield of Massachusetts Foundation. Available at https://bluecrossmafoundation.org/sites/default/files/download/publication/Model_BH_Report_January%202019_Final.pdf.
- 5 Although the need for behavioral health urgent care has been identified for both pediatric and adult populations, this project focused specifically on adults’ needs. For more information on pediatric behavioral health urgent care in Massachusetts, see the Children’s Mental Health Campaign 2019 report: <https://documentcloud.adobe.com/link/track?uri=urn:aaid:scds:US:59ce2a16-6a02-4376-a7ad-8848d3733df6>.
- 6 Emergency Services Programs provide rapid assessment, response, and treatment to individuals experiencing a behavioral health crisis or in need of emergency services. (See the box on page 3 for more information.)
- 7 Throughout the remainder of this brief, these six ESPs will be referred to as “ESP grantees.”
- 8 See Appendices I and II for the methodology and a list of organizations interviewed for this brief.
- 9 This vision was initially developed by the six ESPs participating in the Foundation’s Behavioral Health Urgent Care grant program. It was modified to reflect the feedback of other key informants.
- 10 Children’s Mental Health Campaign (January, 2019). “Report on Pediatric Urgent Behavioral Health Care.” Available at www.mamh.org/assets/files/V10-URGENT-CARE-MODELS-Report.pdf; and Goldstein, A.B., and Findling, R.L. (2006). “Assessment and evaluation of child and adolescent psychiatric emergencies.” *Psychiatric Times*, 23(9), 76-76.
- 11 Some key informants indicated that the time frame for receiving urgent care may be longer than would be needed for someone experiencing a crisis.
- 12 Timely access to care means an individual can obtain care needed to treat their behavioral health condition within a reasonable time frame to prevent the condition from worsening.
- 13 Medical clearance in the context of behavioral health care is a process of evaluating an individual’s medical condition prior to admission to a psychiatric, substance use, or other behavioral health inpatient or residential facility. Available at www.commbuys.com/bso/external/bidDetail.sdo;jsessionid=F3F1B0900CCD46620D23D5F9FD5CD396?bidId=BD-16-1031-BSAS0-BSA01-00000005356&parentUrl=activeBids.
- 14 Telehealth is the provision of remote clinical services. Telehealth services can facilitate expedient access to assessment and treatment, which are necessary components of behavioral health urgent care. In addition to clinical services, telehealth may also be used for remote provider training, continuing medical education, etc. See www.fcc.gov/general/telehealth-telemedicine-and-telecare-whats-what.
- 15 Behavioral health urgent care triage should be led by a skilled clinician with experience assessing clinical and social indicators to ensure a comprehensive view of an individual’s needs.
- 16 According to the Substance Abuse and Mental Health Services Administration (SAMHSA), a trauma-informed model of care “emphasizes the need for behavioral health practitioners and organizations to recognize the prevalence and pervasive impact of trauma on the lives of the people they serve and develop trauma-sensitive or trauma-responsive services.” SAMHSA also identifies key elements of trauma-informed care including a safe, collaborative environment; building on the strengths and resilience of individuals; and others. Center for Substance Abuse Treatment (US). *Trauma-Informed Care in Behavioral Health Services*. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. (Treatment Improvement

Protocol (TIP) Series, No. 57.) Chapter 1, Trauma-Informed Care: A Sociocultural Perspective. Available at www.ncbi.nlm.nih.gov/books/NBK207195/.

- 17 Certified peer specialists, recovery coaches, or others with lived mental health and/or SUD experience were frequently mentioned as key personnel by the ESP grantees and interviewees and in the literature review. They can assist individuals to identify and articulate their needs when seeking urgent care. They can offer nonjudgmental support to many individuals who are difficult to engage or distrust the clinical and medical model of care. They also help individuals connect to services and supports as part of their ongoing treatment plan and can serve as a gateway to nonclinical supports and the larger recovery community. More information about the role of peer specialists and recovery coaches in Massachusetts can be found at <https://transformation-center.org/>.
- 18 Massachusetts Behavioral Health Partnership (MBHP) is the entity with which the state contracts to provide behavioral health care services, including ESP services for MassHealth members. For more information about MBHP's ESP services, see www.masspartnership.com/member/ESP.aspx.
- 19 This is a general description of the services that ESPs are contractually obligated to provide.
- 20 MBHP generally defines MCI for children as “a short-term service that is a mobile, onsite, face-to-face therapeutic response to youth (ages 0-20) experiencing a behavioral health crisis. MCI provides crisis assessment, intervention, stabilization, and care coordination.” MCI for children specifically covers up to seven days of follow-up for intervention and stabilization services; psychiatric consultation and urgent psychopharmacology intervention; onsite, face-to-face therapeutic response; and referrals and linkages to all medically necessary behavioral health services and supports. MBHP has implemented MCI for children consistent with the requirements of the Children’s Behavioral Health Initiative (CBHI). Commercial insurers are also required to cover CBHI services, including MCI, which may or may not be provided by ESPs. Importantly, MCI for adults, as provided by MBHP, does not cover the seven days of intervention, stabilization, and care coordination. MBHP generally defines adult MCI in terms of its mobile capacity, meaning that an ESP will travel to a location in the community to provide care. See Emergency Services Program (ESP) Overview at www.masspartnership.com/pdf/ESPOverview.pdf. Accessed February 3, 2020.
- 21 MassHealth MCO Administered ACO Model Contract, www.mass.gov/files/documents/2017/11/17/mco-administered-aco-model-contract.pdf. MassHealth Primary Care ACO Contract, www.mass.gov/files/documents/2017/11/17/primary-care-aco-model-contract.pdf. Accessed on March 18, 2020.
- 22 Between fiscal year 2016 and fiscal year 2022, the state will have invested more than \$1.9 billion to improve the availability of and access to behavioral health treatments and supports. See www.mass.gov/files/documents/2019/06/13/bh-presentation_0.pdf.
- 23 Commonwealth of Massachusetts Executive Office of Health and Human Services “Creating a Behavioral Health Ambulatory Treatment System.” *Request for Information*. Bid number: BD-20-1039-EHS01-EHS02-45986.
- 24 H4134. *An Act to Improve Health Care by Investing in VALUE*. 2019.
- 25 S2519. *An Act Addressing Barriers to Care in Mental Health*. 2020.
- 26 For example, in 2018 the Department of Mental Health and the Division of Insurance issued a joint bulletin clarifying the types of services that are to be covered by commercial health plans in accordance with state-mandated benefits for child-adolescent services. The bulletin called specific attention to services that must be provided in response to an urgent behavioral health care need, including mobile crisis intervention. See *Bulletin 2018-07; Access to Services to Treat Child-Adolescent Mental Health Disorders; Issued 12/14/18*.
- 27 Sirkin, J.T., Olsho, L., Sheedy, K., McClellan, S.R., and Kenney Walsh, K. (2017). Access to Outpatient Mental Health Services in Massachusetts: A Summary of Findings. The Blue Cross Blue Shield of Massachusetts Foundation. Available at www.bluecrossmafoundation.org/sites/default/files/download/publication/Outpatient_MH_Access_SUMMARY_v05_final.pdf.
- 28 258 CMR 12: Scope of Practice (2017). In addition, “frequency and extent of supervision must conform to the licensing standards of each discipline’s Board of Registration, as cited in 130 CMR 429.424.”
- 29 MAT, including opioid treatment programs, combines behavioral therapy and medication to treat substance use disorders.
- 30 For more information on MAT barriers in Massachusetts, see findings and information from the state’s Medication Assisted Treatment Commission at www.mass.gov/orgs/medication-assisted-treatment-mat-commission.

- 31 The State of Behavioral Health Care in Massachusetts: Perceptions of Persons With Lived Experience and Providers Focus Group Report. Health Care For All. March 2017. Available at www.hcfama.org/sites/default/files/focus_group_report_0.pdf.
- 32 The term “peers” used in the context of this brief is meant to include peer specialists and recovery coaches—individuals with lived experience who offer nonclinical support. In practice, peer specialists typically have supported individuals with mental health conditions, and recovery coaches have supported individuals with SUDs.
- 33 MassHealth’s daily case rate includes peer recovery coaches, and MassHealth, MBHP, and some private insurers cover certified peer specialists. See www.mass.gov/files/documents/2019/03/20/Peer%20Support%20Worker%20Comparison%20Chart%203.14.pdf.
- 34 Note: MassHealth does not require prior authorizations during an urgent or emergent visit or an inpatient hospital stay. For a visit characterized as non-emergent, prior authorizations may be required and are determined within 24 hours. Nonetheless, in practice, interviewees generally reported challenges associated with the process of navigating prior authorization requirements across all payers.
- 35 For a list of drugs that require prior authorization after completion of a lengthy form, see the MassHealth Drug List and forms, available at <https://masshealthdruglist.ehs.state.ma.us/MHDL/pubpa.do>. Note that MassHealth pharmacy providers have the ability to use Emergency Override codes at the point of sale to bypass any prior authorization if the prescriber and/or pharmacist deem such override is necessary. In addition, MassHealth’s prior authorization criteria for behavioral health classes of prescription drugs includes a safety clause where all members with documented harm to self or others and/or recent hospitalization are granted a three-month provisional approval for their prior authorization request to ensure access to necessary therapy during the acute disease exacerbation. Finally, MassHealth has provided guidance to managed care plans regarding MAT prior authorization restrictions, which can be found here: <https://www.mass.gov/doc/managed-care-entity-bulletin-13-coding-systems-for-medications-for-addiction-treatment-0/download>.
- 36 ESPs are still working to increase their focus on SUD services. In addition, according to interviewees, the current workforce of trained recovery coaches is not able to keep up with the demand for their services.
- 37 SSTAR is a nonprofit health care and social service agency based in Fall River, Massachusetts.
- 38 CCBHCs are behavioral health providers that are participating in a national, state-based demonstration in eight states to provide a comprehensive set of behavioral health services to vulnerable individuals. Entities in those states that have become certified receive an enhanced reimbursement rate, administered prospectively, based on anticipated costs of expanding services and capacity. CCBHCs must provide or contract to provide these nine types of services: crisis mental health services; screening, assessment and diagnosis; patient-centered treatment planning; outpatient mental health and substance use services; primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer support, counseling and family support services; and services for veterans. In addition to the state-based demonstration, providers in several states are participating individually through a SAMHSA CCBHC grant. In addition to SSTAR, several Massachusetts provider organizations—including, for example, Behavioral Health Network, Clinical Support Options, Community Counseling of Bristol County, and Gandara Mental Health Center—have received CCBHC grants. See <https://www.samhsa.gov/grants/awards/2020/SM-20-012> for more information. Taken together, these services and flexible payments facilitate greater and more timely access to care, including behavioral health urgent care.
- 39 See www.mass.gov/doc/letter-from-secretary-sudders-november-15-2019/download.
- 40 Interviewees consistently stated that it is important that new payment structures not be built on inadequate or low payment rates, or not appropriately trended or increased over time, as they may not achieve the desired flexibility and favorable outcomes if payment does not reasonably reimburse costs.
- 41 For more information about MCPAP, including the history and goals, see www.mcpap.com/About/OverviewVisionHistory.aspx.
- 42 For more information about MCPAP for Moms, see www.mcpapformoms.org/.
- 43 For more information about MCSTAP, see www.mcstap.com/About/About.aspx.
- 44 This is based on correspondence with MassHealth in August 2020.
- 45 See MassHealth All Provider Bulletin 281 (January 2019) for additional information, including specific terms for prescription of narcotics, such as methadone.

- 46 Lacktman, N.M., Acosta, J.N., & Levine, S.J. (2019). 50-State Survey of Telehealth Commercial Payer Statutes. Foley & Lardner LLP. Available at www.foley.com/-/media/files/insights/health-care-law-today/19mc21486-50state-survey-of-telehealth-commercial.pdf.
- 47 For more information about the ET3 program, see: <https://innovation.cms.gov/innovation-models/et3>.
- 48 This is one of the contemplated enhancements of the ESP grantees receiving support from the Foundation through the Behavioral Health Urgent Care grantmaking program.
- 49 For more information on the OUCCs, see www.commbuys.com/bso/external/bidDetail.sdo;jsessionid=F3F1B0900CCD46620D23D5F9FD5CD396?bidId=BD-16-1031-BSAS0-BSA01-00000005356&parentUrl=activeBids.
- 50 See www.brighamandwomens.org/psychiatry/brigham-psychiatric-specialties/brigham-health-bridge-clinic.
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- 52 Substance Abuse and Mental Health Services Administration (2014). *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (page 18). HHS Publication No. (SMA)-14-4848.
- 53 See www.masspartnership.com/pdf/ESPOverview.pdf.
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