



MASSACHUSETTS
HEALTH POLICY COMMISSION

**EMERGENCY DEPARTMENT
BOARDING IN THE
COMMONWEALTH OF
MASSACHUSETTS**

MARCH 2026

CHAPTER 126 OF THE ACTS OF 2022:

SECTION 145. Notwithstanding any general or special law to the contrary, the health policy commission established in chapter 6D of the General Laws shall conduct an analysis and issue a report on the ongoing effects of the COVID-19 pandemic on behavioral health-related boarding in acute care hospital settings including, but not limited to, boarding in emergency departments, medical surgical units or observation units in the commonwealth. The study shall consider emergency department visits in the commonwealth classified as mental health, behavioral health, substance use disorder or other alcohol-related diagnosis and shall review: (i) length of stay for boarding; (ii) primary reason for wait (iii) level of care required; (iv) type of insurance coverage; (v) payer reimbursement to care for boarders in emergency departments, medical surgical units or observation units; (vi) available data on patient age, race, ethnicity, preferred spoken language, gender and homelessness; (vii) the ability to facilitate care coordination among health care providers; (viii) effects of COVID-19 on length of stay; (ix) effects of COVID-19 on workforce and any workforce shortages; and (x) other factors related to COVID-19 affecting the: (a) increased burden on acute care hospitals as a result of behavioral health-related boarding; (b) outcomes and quality of care for patients boarded in acute care hospitals; (c) resources provided by health plans to care for boarders. The health policy commission shall also review behavioral health-related boarding in other states and actions taken and any best practices to address the pressure on acute care hospitals as a result of the effects of the COVID-19 pandemic on behavioral health-related boarding. Not later than July 1, 2023 the health policy commission shall submit to the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint committee on mental health, substance use and recovery and the joint committee on healthcare financing its report, including recommendations on how to address: (i) the burden on acute care hospitals; (ii) outcomes for patients with behavioral diagnoses; (iii) quality of care for patients boarded in acute care hospitals; and (iv) payer reimbursement to care for boarders in acute care hospitals.

INTRODUCTION

Behavioral health (BH) emergency department (ED) boarding has been a challenge in the Massachusetts health care system for well over a decade. When a patient seeking care in the ED for their BH condition has to wait an extended period of time in the ED before being (1) admitted to an inpatient setting or (2) discharged with a coordinated plan for outpatient or community care, it is considered BH ED boarding (for more detail on definitions of BH ED boarding see **Defining Behavioral Health Emergency Department Boarding**). In 2014, the Massachusetts Legislature required that the Center for Health Information and Analysis (CHIA) convene a group of stakeholders tasked with identifying both data challenges in tracking ED boarding and policy solutions to the ED boarding crisis. Ten years later, progress has been made on some of the policy solutions the group identified, but BH ED boarding remains a crisis for patients, their families, non-BH patients awaiting care in the ED, and hospital staff. EDs are designed to quickly triage and stabilize patients. As such, most EDs do not have the resources to provide appropriate treatment for patients with BH diagnoses experiencing boarding, and boarding often results in delays to therapeutic BH care.

This report analyzes data and trends in ED boarding from 2020-2024 in Massachusetts, highlights policies that aim to decrease BH ED boarding in the Commonwealth, and presents policy recommendations based on the data, other states' experiences with ED boarding, and stakeholder conversations.

BACKGROUND

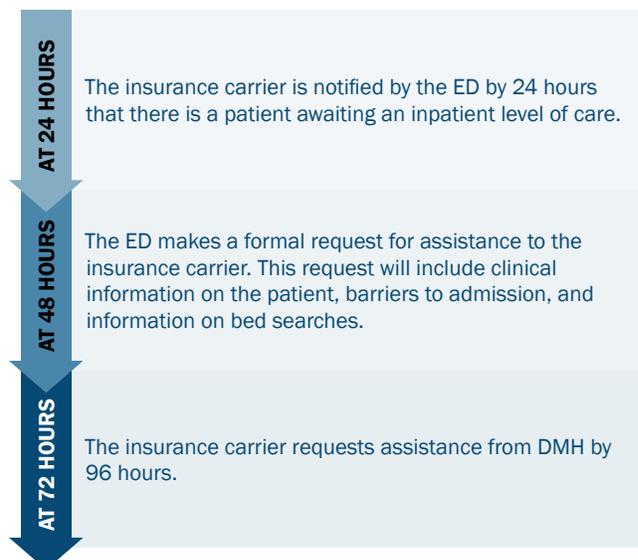
The percentage of ED visits that last 12 or more hours has been increasing for both medical (non-behavioral health) visits and BH visits since 2020.¹ EDs are structured to evaluate and stabilize patients for their next place of care, ideally within 4 hours of arriving.² Spending extended time in the ED due to crowding and capacity challenges has been associated with longer lengths of stay in the hospital, poorer health outcomes, and increased mortality for patients with medical conditions.^{3,4,5} For patients with BH conditions, loud and bright EDs can further exacerbate existing symptoms and emotional dysregulation. Some BH patients do require emergency department levels of care, such as those who are at immediate risk for harming themselves or others, or experiencing severe medication side effects. However, for many BH patients, the ED is not the best care setting. One study found that quickly transferring patients from an acute care hospital ED to a dedicated psychiatric emergency intervention team greatly reduced the need for inpatient levels of care.⁶

State Action on Behavioral Health Emergency Department Boarding

The state and other health care stakeholders, including hospitals and payers, have been working on interventions to address ED boarding for over a decade. As mandated in Section 230 of Chapter 165 of the Acts of 2014, CHIA convened stakeholders, including representatives from state agencies and medical and mental health organizations to create a set of policy recommendations to address psychiatric ED boarding.⁷ The recommendations included that CHIA expand data reporting on ED boarding and that there should be an Executive Office of Health and Human Services (EOHHS)-led convening to develop a strategy to reduce psychiatric ED boarding.

Following this recommendation, in 2017, EOHHS partnered with the Department of Mental Health (DMH), MassHealth, the Department of Public Health (DPH), and the Division of Insurance (DOI) to form the Expedited Psychiatric Inpatient Admission Task Force.⁸ This task force also included payers (commercial health insurance companies), hospital providers, hospital and carrier trade associations, and professional associations. In a 2018 joint bulletin issued by DOI, DMH, and DPH, the task force established the Expedited Psychiatric Admissions Policy (EPIA), which requires that carriers facilitate inpatient psychiatric admissions for difficult-to-place patients 7 days a week.⁹ The EPIA policy established clear lines of accountability for hospitals, payers, and DMH for patients who spend over 24 hours in ED (**Exhibit 1**).

Exhibit 1. Expedited Psychiatric Inpatient Admissions policy



Sources: Massachusetts Executive Office of Health and Human Services. Expedited Psychiatric Inpatient Admission (EPIA) Policy. Available at: <https://www.mass.gov/info-details/expedited-psychiatric-inpatient-admissions-epia-policy>

DEFINING BEHAVIORAL HEALTH ED BOARDING

For the purposes of this report, the legislature has defined ED boarding as “waiting not less than 12 hours” after being assessed in the ED to be placed in an appropriate therapeutic setting. For patients with BH needs, an appropriate therapeutic setting could mean an inpatient unit, crisis stabilization unit or community-based acute treatment (CBAT) unit, a residential setting, or connecting the patient to outpatient services (for more information on types of BH services, see **Appendix A**). However, different organizations have different challenges and concerns when evaluating the impact of BH boarding on patients, staff, and services. Through stakeholder interviews and literature review, HPC researchers identified additional BH ED boarding definitions.

The **Massachusetts College of Emergency Physicians** defines ED boarding as any visit that lasts over four hours in the ED regardless of final disposition (e.g. sent home or sent to inpatient). This is a definition based on the premise that a fully functional ED should be able to triage, treat, and provide a disposition to any patient within four hours. Emergency physicians and other staff in the ED are trained to triage, assess, and treat patients in need of emergency care. Patients who are boarding, whether for medical or BH conditions, may not have seamless access to specialists for their conditions after the ED has stabilized the patient. This definition of four hours is also commonly used in academic research and supported by the American College of Emergency Physicians.^{10,11}

The **Massachusetts Hospital Association** (MHA) tracks BH ED boarding by assessing the number of BH patients in the ED or a medical/surgical hospital bed at an acute care hospital every Monday morning. This definition does not measure how many patients are experiencing boarding or for how long but does allow for a point-in-time count of how many ED and medical/surgical beds are occupied by BH patients. These surveys also allow hospitals to highlight the elevated difficulty in placing patients awaiting an inpatient level of care over the weekend.

The DMH-led **Expedited Psychiatric Inpatient Admission** (EPIA) policy defines patients experiencing BH ED boarding as any psychiatric patient spending 24 or more hours in the ED awaiting an inpatient bed. This definition only includes patients needing an inpatient level of care and sets clear steps and responsibility for escalating cases (**Exhibit 1**).

Prior **Health Policy Commission** research on BH ED boarding defined a patient spending twelve or more hours in the ED as boarding.¹² This definition of twelve hours is between the American College of Emergency Physicians and the EPIA protocol definitions.

For purposes of this report and except where otherwise specified, the following analyses will define boarding as 12 or more hours in the ED as indicated in Chapter 177 of the Acts of 2022.ⁱ

i The MA HPC relies on the data collected by the Center for Health Information and Analysis in their Acute-Care Hospital Case-mix Databases to identify ED boarding. Currently this data contains information on total length of time spent in the ED, but does not contain time to disposition (e.g., after a psychiatric or other assessment identifies the next care setting for the patient).

Since the creation of the EPIA in 2018, there have been several updates to the policy and additional DOI bulletins to improve upon and clarify the expectations of both hospitals and carriers in the expedited psychiatric admissions process. In 2021, DOI released a bulletin re-iterating the payer and hospital role in the EPIA.¹³ In Chapter 177 of the Acts of 2022, the legislature created an EPIA advisory council charged with investigating and recommending policies and solutions regarding BH ED boarding. Since 2021, policy updates were needed to address the rapid increase in numbers of individuals referred to payers and DMH as part

of the EPIA process. The increase in boarding also spurred the Massachusetts Hospital Association to begin their own weekly reporting of ED boarding in October 2021.¹⁴

There was increasing need for BH care from March 2020 through 2022, high levels of boarding patients, and growing media attention on the problem of BH ED boarding.¹⁵ The legislature mandated the HPC conduct a study on BH ED boarding pursuant to Section 145 of Chapter 126 of the Acts of 2022.

TIMELINE OF BEHAVIORAL HEALTH EMERGENCY DEPARTMENT BOARDING POLICIES



UNDERSTANDING BEHAVIORAL HEALTH EMERGENCY DEPARTMENT BOARDING IN THE COMMONWEALTH

Although the ED is rarely the best setting of care for the majority of patients seeking treatment for their BH conditions, patients with BH conditions may end up boarding in an ED for several reasons related to both inflow and outflow problems as illustrated in the diagram below.

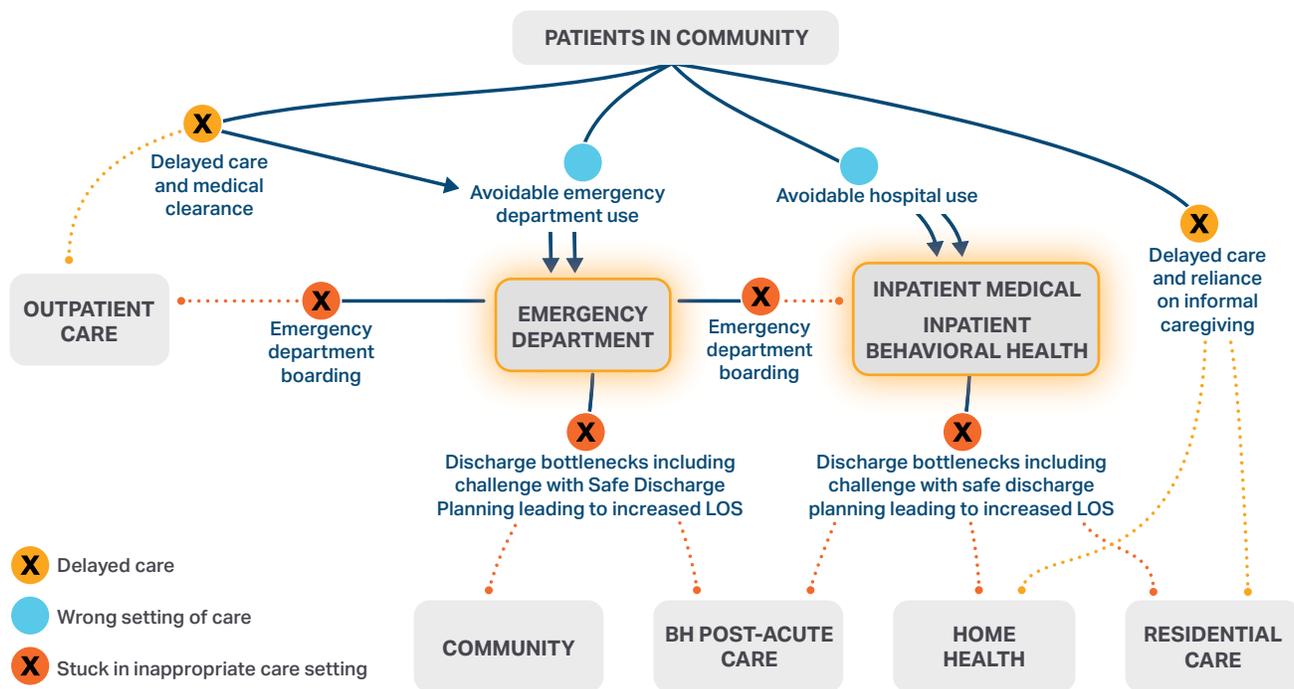
Arriving at the emergency department (inflow)

Patients may show up in the ED who do not need emergency department levels of care (potentially preventable inflow) because they lacked access to outpatient levels of care, were unaware of community-based crisis intervention services, were told to go to the ED to gain medical clearanceⁱⁱ before being admitted to an inpatient level of care, or were brought to the ED by emergency services while experiencing a BH crisis.

Time spent in the emergency department (inflow to inpatient, outflow to community)

Once patients are in the ED, they may end up boarding because of shortages of available inpatient beds; shortages of residential beds; lack of facilities that can treat patients with certain co-occurring condition (such as pregnancy), medical complexities, or behaviors; concerns about their ability to be discharged from inpatient levels of care (e.g. patients needing foster care, persons with unstable housing); delays in transportation (i.e. ambulance services) to available beds; or other state system involvement (e.g. Department of Children and Family, Department of Development Services). Even patients who are determined to be safe to be discharged to home or other care in the community (e.g. partial hospitalization programs or CBAT) may experience ED boarding if the patient does not have primary care to support care coordination and medication management outside of the ED and a coordinated discharge plan has not been finalized.

Exhibit 2. Patient pathways and barriers to care continuity for patients seeking behavioral health care



ii Medical clearance refers to any evaluation and testing needed to determine that the patient has short term medical stability to be transferred to another location for treatment. According to [a letter jointly authored by MACEP and Massachusetts Psychiatric Society](#): “Any patient with psychiatric complaints who is examined by the emergency physician should be assessed for significant contributing medical cause of those complaints”.

DEFINITIONS:

Unless otherwise specified, the HPC defines **behavioral health ED boarding** as any ED visit with a BH primary diagnosis that lasts for **12 or more hours in the ED**.

Behavioral health includes mental health and substance use disorders as well as other behaviors or disorders that impact an individual’s well-being or ability to interact with the world. For most of this report analyses that examine “behavioral health” include all diagnoses for mental health, substance use disorder and a few additional diagnoses (e.g. attention-deficit hyperactivity disorder). For this report, HPC uses the AHRQ HCUP Clinical Classifications software mental, behavioral, and neurodevelopmental disorders classification.ⁱⁱⁱ

Mental health includes depressive disorders, psychotic disorders, personality disorders, and other conditions that affect a person’s thinking, feeling, or mood.

Substance use disorder includes diagnoses for persistent use of drugs or alcohol despite harm and adverse consequences.

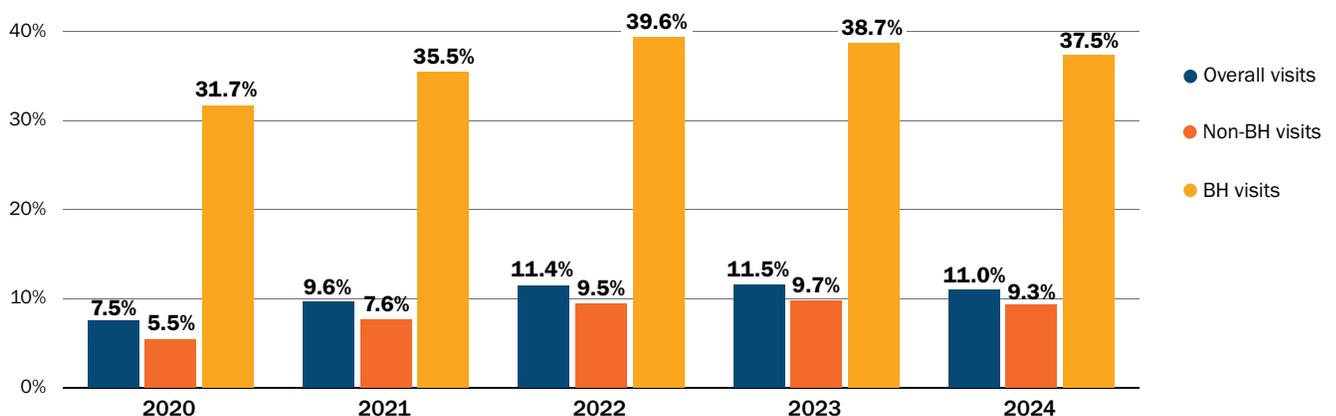
Inability to discharge in a timely manner from the inpatient setting (outflow)

There may be bottlenecks in discharging patients admitted to inpatient settings to post-acute care settings and residential care due to lack of capacity in those settings. Patients who could be routinely discharged may need to remain in inpatient settings if there is no safe discharge plan due to a lack of caregivers, unstable housing, or homelessness. The inability to discharge patients from inpatient levels of care reduces the availability of inpatient care beds and contributes to patients spending more time in the ED as they wait for inpatient beds to become available.

Trends in emergency department boarding in Massachusetts

Although overall rates of ED boarding (for patients seeking BH or medical care) increased in Massachusetts from 2020-2024, ED boarding for BH patients increased much more quickly than for patients in the ED for non-BH reasons. Overall, the percentage of visits to the ED that resulted in boarding rose from over 7% in 2020 to 11% in 2024, consistent with national rates and trends.¹⁹ (**Exhibit 3**) However, the percentage of BH-related visits that boarded increased from 32% in 2020 to a high of 40% in 2022. By 2024 this percentage has come down slightly to 37.5%. In absolute terms, there were 4,500 fewer patients who experienced BH ED boarding in 2024 compared to 2023.

Exhibit 3. Percent of emergency department visits that boarded (visits that were ≥ 12 hours in the ED) by type of visit, 2020-2024



Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Analysis includes both “treat and release” ED visits as well as ED visits ultimately admitted to a higher level of care. Includes both Massachusetts residents and non-Massachusetts patients. Behavioral health emergency department visits, observation stays, and inpatient stays were identified using AHRQ’s CCSR for the primary diagnosis (BH: MBD001-MBD034). Some observation stays at MGB hospitals were reported as ED visits prior to 2022 per CHIA findings. HPC analysis of impact to the overall state boarding numbers, it was determined to keep MGB hospital discharge data in these analyses.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix Hospital Inpatient, Observation, and Emergency Department databases, FY2020 to preliminary FY2025

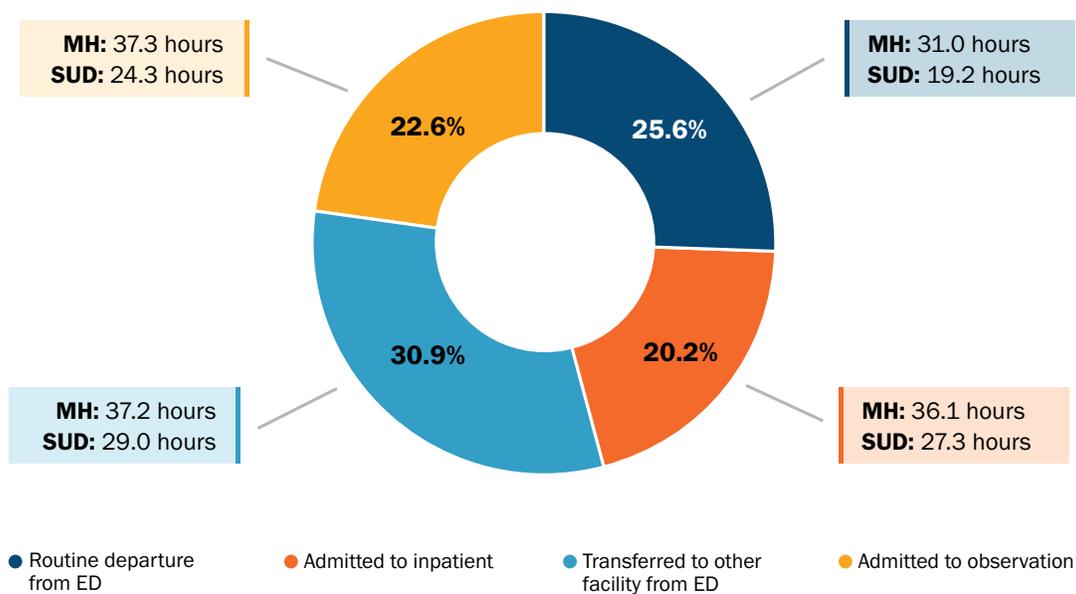
ⁱⁱⁱ The Agency for Health Research and Quality releases the Healthcare Cost & Utilization Project: Clinical Classification Software Refined (HCUP CCSR) annually. This is a tool that groups many ICD-10 diagnoses codes into higher categories. It is routinely used by the HPC and other health researchers.

For both categories of visits, the increase occurred almost entirely between 2020 and 2022 with boarding rates remaining flat for non-BH visits between 2022 and 2024 and a slight decrease in 2023 and 2024 for BH visits. There was an observed increase in BH ED boarding during the COVID pandemic in which there was an increase in both BH ED boarding as well as individuals referred via the EPIA policy during 2021 and 2022. In 2022, the legislature mandated that HPC analyze these trends. The volume of EPIA referrals reached their highest point in January 2022 at 924 (up from 45 in January 2019). However, after the end of the public health emergency in 2023, referrals to the EPIA have decreased likely due to a combination of factors including MassHealth policy changes, additional inpatient psychiatric beds, increases in use of observation beds for BH patients, changes in hospital COVID protocols, and changes within hospital protocols (e.g. Boston Children’s hospital admitting patients to non-psychiatric beds to relieve ED crowding).

Length of stay for boarding & level of care required

Not all patients who visit the ED and experience boarding require an inpatient level of care. As of 2024 almost 26% of patients who experience BH ED boarding are ultimately discharged home or to their routine place of residence (51.5% are ultimately discharged to either a free-standing psychiatric hospital, an acute care hospital, or other facility). Patients who were discharged home after boarding spent less time in the ED (e.g. 31.0 hours, on average, for those with mental health conditions) than patients moved into observation (37.3 hours), patients admitted to an inpatient stay within the same hospital (36.1 hours), or transferred to another facility (37.3 hours). See **Exhibit 4** for more details on average length of stay and median length of stay by condition (e.g. mental health or SUD). The length of time spent waiting in the ED among those patients who boarded decreased from 2023 to 2024.

Exhibit 4. Behavioral health-related ED visits that boarded (visits that were ≥12 hours in the ED) by departure status and average lengths of stay (hours), 2024



Notes: Visits that left against medical advice, eloped, or had another departure from the ED accounted for approximately 1% of visits each year and are not shown. The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Analysis includes both “treat and release” ED visits as well as ED visits ultimately admitted to a higher level of care. Does not include visits by non-Massachusetts residents. Behavioral health ED visits, observation stays, and inpatient stays were identified using AHRQ’s CCSR for the primary diagnosis. BH visits were identified using CCSR categories MBD001-MBD034, MH visits were identified using CCSR categories MBD001-MBD013 and MBD027, and SUD visits were identified using MBD017-MBD025 and MBD028-MBD033. Visits with diagnosis codes identified as MBD026 or MBD034 were categorized as mental health-related or substance use disorder-related based on categorizations from CHIA Massachusetts Acute Care Hospital Emergency Department Data – Quarterly Update methodology (November 2023).

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix databases, FY2022 to preliminary FY2025.

A small, but growing, group of patients who experience boarding are admitted to “observation” status (20.4% in 2023, 23% in 2024). A patient in observation status receives hospital outpatient services while a clinical determination is made as to whether the patient needs an inpatient level of care. The CHIA Outpatient Observation Database (OOD) Reporting dashboard shows an increasing number of BH stays moving into observation status, from roughly 6,000 patients per quarter in 2019 to more than 9,000 in 2024.²⁰ Some hospital stakeholders explained that they move BH patients that present to the ED into observation status when it is clear that the patient would need time to stabilize or to find an inpatient bed. One provider stakeholder reported that they now immediately place patients into observation status if they come into the ED as a patient with an involuntarily hold status. Some hospitals have areas distinct from the ED for observation, while other hospitals have observation co-located within the ED. Observation status may be reimbursed at a higher rate than an ED stay. It should be noted that patients who are moved to observation prior to 24 hours in the ED are not counted in the boarding data. As a result, even though these patients are also waiting for the most clinically appropriate site of care, they are not considered “boarding.”

Demographics of patients who experienced emergency department boarding

Using hospital discharge data, the HPC examined age, race/ethnicity, sex, payer, community income, and housing status for residents who came to the ED for BH concerns. At the time of this study, there was no data available to the HPC to examine how patient’s language related to their ED boarding status.

Using this data, HPC investigated concerns that patients on MassHealth, patients who did not have permanent housing, and children were more likely to board. HPC found that patients who were covered by MassHealth or were unstably housed were disproportionately represented among residents who both 1) came to the ED for any BH problem, and 2) boarded in the ED for more than 12 or 24 hours. As shown in the table below, these groups are more likely to come to the ED for BH treatment in the first place and experience boarding at higher rates. The HPC also found that persons living in the lowest income areas of the state, of a race/ethnicity other than white non-Hispanic, or who were male were also more likely to board (**Table 1**).

Table 1. Demographics of MA residents that experienced ED boarding, 2024

	Overall MA Residents	BH ED Visits	BH ED Visits that Boarded 12+ hours	BH ED Visits that Boarded 24+ hours
Age				
Under 18 years	20%	9%	9%	11%
18-64 years	63%	81%	81%	78%
65 years and over	18%	10%	10%	11%
Male	49%	59%	58%	57%
Income				
Lowest Quintile	20%	33%	34%	35%
Highest Quintile	20%	10%	10%	10%
Payer				
Commercial	57%	23.4%	20.0%	18.1%
MassHealth	24%	45%	48%	47%
Medicare	19%	22%	24%	27%
Race/Ethnicity				
Asian, NH	7%	2.0%	1.8%	1.7%
Black, NH	7%	14%	14%	15%
Hispanic	13%	14.6%	14.5%	14.9%
White, NH	68%	66%	67%	66%
Unhoused	<1%	17%	18%	18%

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix Hospital Inpatient, Observation, and Emergency Department databases, FY2023- preliminary FY2025; ACS 2023 5 year files; CHIA Annual Enrollment Trends; HUD homelessness report.

Notes: NH= non-Hispanic

For example, children comprised 20% of MA residents, but less than 10% of ED BH visits. While HPC found children were not disproportionately presenting in the ED, once they did present in the ED with a BH diagnosis, they were slightly more likely to board for over 24 hours. Examining time spent in the ED alone may not fully capture the amount of time children in particular wait for the most appropriate setting for their care. For example, Boston Children’s Hospital has published on its boarding interventions which include moving patients to inpatient medical/surgical beds so that pediatric patients are not spending time in the ED, but these children may still be waiting for psychiatric inpatient units.²¹

Analysis of EPIA referral data shows that after more than 24 hours of boarding, children and seniors take much longer to be placed than people ages 18 to 64. In particular, children, especially children under 12, and adults over 65 take much longer to be placed.^{iv}

Patients awaiting inpatient placement for over 24 hours

While HPC found that ED boarding overall was increasing, the percentage of patients who needed an inpatient level of care and took over 24 hours to place started to decrease from 2022 to 2024. By 2024, 61% of adults and 70% of children who came to the ED for a BH problem were placed in an inpatient setting of care by 24 hours (Exhibits 5 & 6).

Exhibit 5. Time until admission to a psychiatric bed among behavioral health-related ED visits for adults, 2020-2024

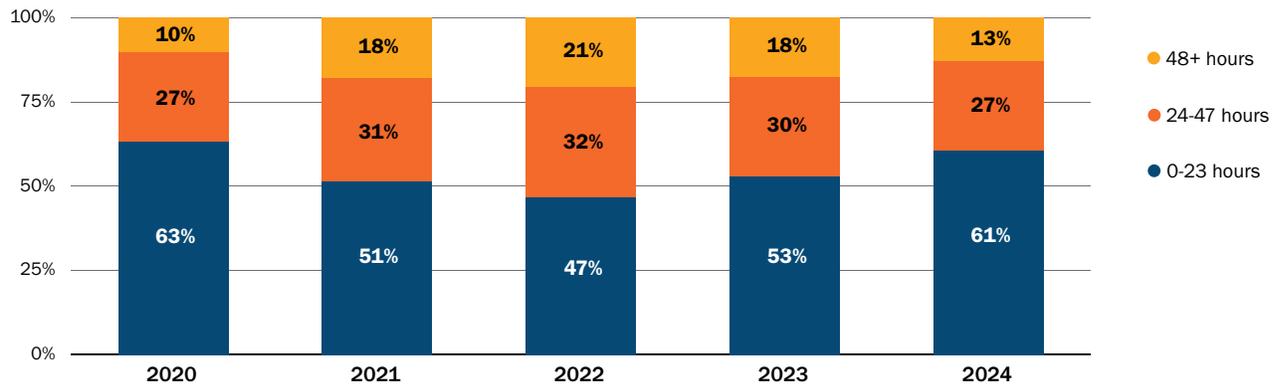
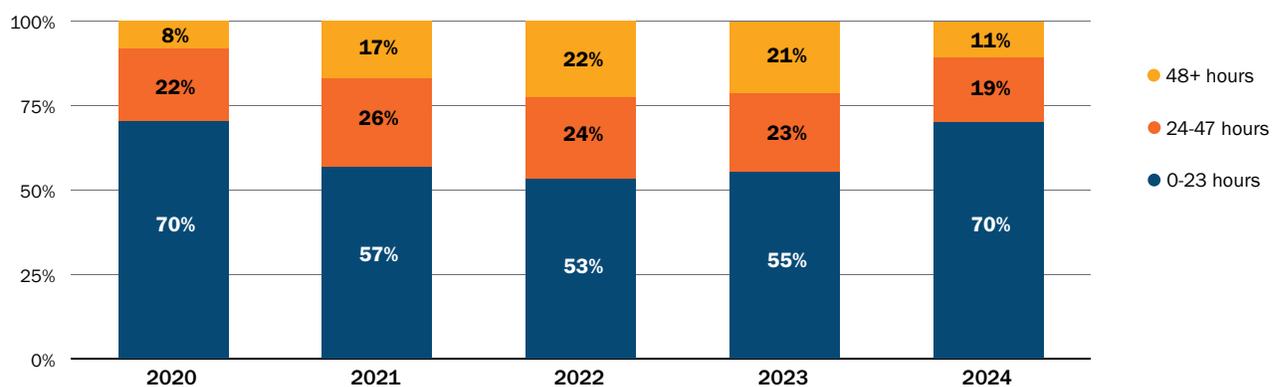


Exhibit 6. Time until admission to a psychiatric bed among behavioral health-related ED visits for children, January 2020 to May 2024



Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Analysis includes both “treat and release” ED visits as well as ED visits ultimately admitted to a higher level of care. Behavioral health ED visits, observation stays, and inpatient stays were identified using AHRQ’s CCSR for the primary diagnosis (MBD001-MBD034). Some observation stays at MGB hospitals were reported as ED visits prior to 2022 per CHIA findings. After HPC analysis of impact to the overall state boarding numbers, it was determined to keep MGB hospital discharge data in these analyses.

Sources: HPC analysis of Center for Health Information and Analysis (CHIA) Case Mix databases, FY2019 to preliminary FY2025

iv In the annual EPIA report, children 0-12 years of age spent the longest time awaiting placement (average time to placement 4.7 days) followed by children 13 to 17 years old (4.1 days), and then adults over 65 (3.8 days). Adults 23 to 64 spent the shortest time at 2.1 days on average.

Over this time period, EPIA reported a decrease in the absolute number of patient referrals (that is patients who spent over 24 hours in the ED) (**Exhibit 7**).

Primary reason for long wait times and barriers to inpatient placement

The HPC interviewed ED physicians, hospital administration, inpatient psychiatric facility leadership, and others about their views on why patients experienced BH ED boarding. The top reasons identified included: lack of available inpatient beds, excessive time until an assessment is made by the provider, excessive time to stabilize the patient if they were experiencing behavioral dysregulation or symptoms of substance use and waiting for medical clearance to be admitted to psychiatric facility. Of these reasons, stakeholders with ED experience expressed the most concern about the practice of BH providers sending patients to the ED for medical clearance. The American College of Emergency Physicians has noted that “medical screening or ‘clearance’ that requires automatic, perfunctory testing of all ED psychiatric patients before they can be seen at community or referral psychiatric facilities is not supported by the evidence.”²² Furthermore, MassHealth, DMH, and DPH evaluated practices in other states and engaged community-based and inpatient BH stakeholders to create a community-based medical screening checklist. This “Community-Based Medical Screening Checklist for Individuals with Psychiatric Symptoms and Low Medical Risk” was published in December 2022 and can be administered by a wide array of medical clinicians including RNs, EMTs, and LPNs in addition to MDs/DOs and advanced practitioners.

Stakeholders were also asked about the impact of the COVID public health emergency on BH ED boarding. Several interviewees mentioned the regulations during the public health emergency that would result in longer than usual waits in the ED included needing to create space for infection control, changing inpatient rooms that originally held 2 to 4 patients into single occupancy, and keeping COVID positive patients for 10 days in the ED before being able to transfer them into psychiatric unit or hospital.

For patients who meet the EPIA criteria of needing an inpatient level of care and spending 24 hours or more in the ED, DMH collects information on barriers to inpatient placement. The top barriers listed for adults were no bed available (26%), disposition status/potential challenges for discharging patients (e.g. unstable housing, need for nursing care post discharge) (18%), aggression (17%), unit acuity (17%), and medical acuity (14%). The top barriers for youth included aggression (40%), no bed available (18%), and an autism diagnosis (12%).²³ For both adults and children, patients with autism spectrum disorder had some of the longest average time to placements (8.9 days for children, 4.7 days for adults).²⁴

The length of boarding time for BH patients varied by whether the patient was in the ED primarily for either mental health, or substance use disorder-related reasons, as indicated by the primary diagnosis at the time of the visit. Almost half of patients visiting the ED with a primary diagnosis for mental health experienced boarding by the beginning of 2024 compared to 19% of those who visited for substance use related disorders. According to stakeholders, some of this difference could come from hospitals’ ability to involuntarily hold a patient with a primary diagnosis of mental

Exhibit 7. Number of referrals to the Expedited Psychiatric Inpatient Program, January 2021 – November 2024



Source: Massachusetts Executive Office of Health and Human Services. Expedited Psychiatric Inpatient Admission (EPIA) Dashboards. EPIA External Report October 2024. Available at: <https://www.mass.gov/lists/expedited-psychiatric-inpatient-admission-epia-dashboards>.

health (i.e., Section 12).^v Patients who come to the ED seeking substance use treatment (including detoxification treatments or medications for substance use disorders) may not meet the criteria for these involuntarily holds. Despite a 2018 law that stated all EDs should be able to initiate treatment medications for opioid use disorder, some stakeholders indicated that patients in EDs were not always able to access substance use related treatments in a timely manner. This may also result in such patients leaving the ED without treatment in less than 12 hours.^{vi}

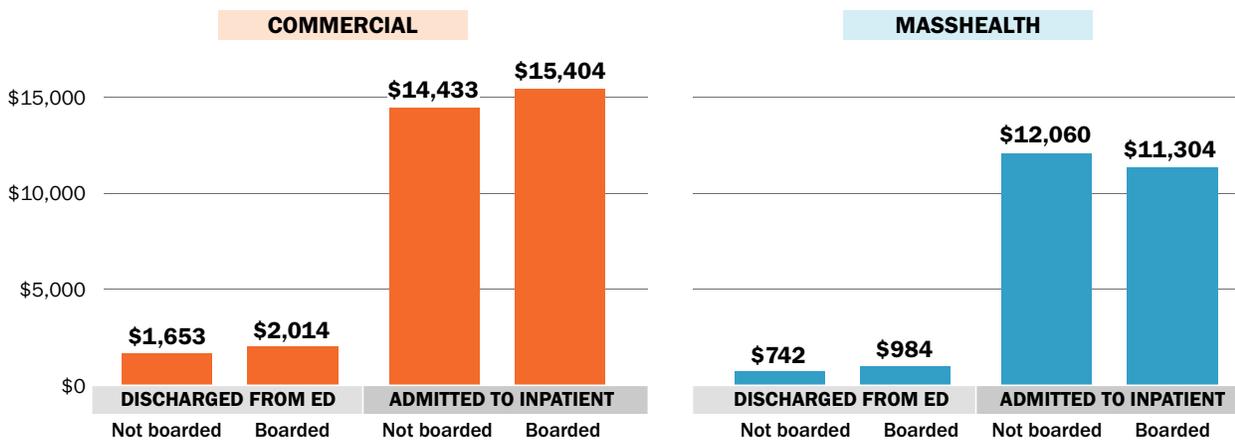
Payment and payment policies for emergency department boarding

Tracking detailed services provided and spending for BH ED boarding is difficult for several reasons. First, for many payers, any services provided in the ED often fall under the ED evaluation and management code (e.g. 99282-99285) and may not result in additional procedure codes recorded in claims data. Hospitals may move patients from the ED into observation status immediately

upon realizing that the patient is likely to be waiting for an inpatient bed and for other providers patients may be moved into observation to receive additional payments,^{vii,25,26} however, patients may not even know they have been “moved” from an ED to an observation status as hospitals may not have an observation unit separate from their ED. For inpatient stays, many commercial payers and MassHealth pay on a per diem basis starting on the day of a patient’s ED stay if the ED finds the patient a bed within the same hospital. In that situation, any time spent in the ED would appear in the claims data as additional inpatient days (e.g., additional per diem payments). However, some commercial payers pay on a DRG basis for acute care hospitals.^{viii}

With those caveats, the HPC examined total payments as observed in claims data for mental health-related ED episodes by boarding status. Both commercial payers and MassHealth paid more for ED visits that boarded and were ultimately discharged from the ED into the community (22% and 33% more, respectively) than for visits that did not involve boarding (**Exhibit 8**).

Exhibit 8. Average allowed amounts for mental health-related ED episodes among commercially-insured and MassHealth-insured residents by admission and boarding status, 2022



Notes: Excludes episodes with duration and/or spending greater than the 90th percentile duration for the overall category (i.e., discharged from the ED or admitted to inpatient). The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Mental health-related emergency department visits were defined as any ED visit or observation or inpatient stay that resulted from an ED visit with a primary diagnosis code in AHRQ CCSR categories MBD001-MBD013 or MBD027 in the Case Mix datasets. Data shown are for ED visits from the Case Mix databases that were matched (same person, same date) to commercial or MassHealth APCD claims data.

Sources: HPC analysis of Massachusetts Acute Case-Mix Databases, CY2022, All-Payer Claims Database, V2022, 2022.

- v In Massachusetts, a licensed physician, licensed psychologist, licensed advanced practice registered nurse, or police officer who has determined an individual would create a serious harm due to mental illness can authorize involuntary hospitalization of the individual for up to three days. <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123/Section12>
- vi [Chapter 208 of the Acts of 2018](#), An Act for Prevention and Access to Appropriate Care and Treatment of Addiction, mandates that EDs should have protocols and offer treatments to patients experiencing substance use disorder. However, HPC is not able to track initiation of medications for opioid use disorder (MOUD) in the ED setting as the codes were not in use until 2023 and data quality concerns. MassHealth initiated a billing code for initiation of MOUD in the ED as of [Oct 1, 2023](#).
- vii Hospitals may receive not only the ED visit payment, but an additional observation stay payment along with additional services that can be billed during the course of that observation stay.
- viii Medicare pays on a DRG basis for acute care hospitals, per diem for psychiatric hospitals.

For episodes that were ultimately admitted to an inpatient stay, boarded commercially-insured patients had slightly higher average spending (\$15,404) than non-boarded patients (\$14,433). However, residents covered by MassHealth had slightly less spending among those who experienced boarding (\$11,304 versus \$12,060 for those who did not board). Overall, mental health patients with commercial insurance who had an ED visit and were ultimately admitted to an inpatient stay had an average length of stay of fourteen days, regardless of boarding status. However, patients with MassHealth who experienced boarding spent an average of four days longer when they were admitted to an inpatient setting compared to those who did not board (17 versus 13 days).

Payments for commercial observation stays followed a similar pattern where those with boarding incurred more spending on average (\$5,869 for those who experienced boarding compared to \$4,982 for patients who did not experience boarding). However, payments for MassHealth patients in observation did not substantially differ by boarding status (\$1,986 for those who experienced boarding compared to \$2,022 for patients who did not experience boarding, data not shown).

State policy changes that aim to improve behavioral health emergency department boarding and payment

In addition to billing, there have been several BH payment and policy changes since 2022 that may have impacts on both length of time in the ED as well as payment.^{ix} For the fully-insured commercial plans, DOI has required increased payments for certain BH services.^x In 2021, DOI issued a bulletin for commercial insurers and hospital providers emphasizing that they arrange payments for specialty needs (known as “specializing”).^{xi} This could include additional services such as an individual room or 1:1 staff/patient ratio. Specializing as a service was raised during multiple stakeholder interviews; however, some providers expressed that even with payment there were challenges to having adequate staffing to implement some specializing requirements.

As of September 2023, in accordance with “*An Act Addressing Barriers to Care for Mental Health*”, section 78 of chapter 177 of the Acts of 2022, DOI expected commercial carriers to reimburse acute care hospitals for ongoing monitoring and stabilization

ix This study did not directly evaluate the impact of these policies on ED boarding, including new inpatient beds that have opened.

x MassHealth sets the payment policy for their membership and DOI oversees fully-insured commercial membership. The self-insured and Medicare FFS populations are not subject to these payment policies. As such, some stakeholders expressed frustration some state policy changes (e.g. specializing) do not apply to all their patients. Due to data limitations as a result of the *Gobeille vs Liberty Mutual* supreme court ruling, the HPC does not have access to the majority of self-insured commercial claims in the Commonwealth.

for patients awaiting inpatient psychiatric placement at a rate “at least equivalent to crisis intervention services as reimbursed by MassHealth”.^{xi} Some provider stakeholders emphasized that even these increases in payments do not keep up with the level of services they provide for some patients, including 1:1 monitoring in the event that patient needs that level of care.

MassHealth also implemented several policies that aim to impact ED boarding over the past several years:

- Starting October 2022, MassHealth pays an additional per admission rate for weekend admissions and admissions for harder-to-place patients such as children.^{xi} Stakeholders noted that finding inpatient placements on weekends and holidays was especially challenging.
- As of January 2023, MassHealth managed care entities pay hospitals directly for crisis evaluations instead of requiring patients to be first evaluated by Emergency Service Providers (ESP) and Mobile Crisis Intervention (MCI) teams to determine the right level of care. This payment is in addition to the standard ED payment (e.g. for facility and professional services in the ED).^{xi}
- As of 2023, MassHealth will pay for crisis management services for individuals in both the ED and inpatient settings (including in medical/surgical beds) who have ongoing needs related to a BH crisis on days after the initial BH evaluation. This regulation also updates the minimum rate for members younger than 21 with autism spectrum disorder or intellectual disability (ASD-ID) in specialized ASD-ID settings and for eating disorders in specialized eating disorder facilities. In the ED, MassHealth payers are required to pay hospitals for both initiation of medication for opioid use disorder (MOUD) and recovery support navigator provided in the ED or inpatient (including in medical/surgical beds).
- As of January 2023, Community BH Centers (CBHCs) started to provide community and mobile crisis intervention services twenty-four hours a day and 7 days a week with an aim to divert people from EDs. CBHCs also have community crisis stabilization care beds which offer 24 hour care on an unlocked unit.

Overall, these policies aim to reduce ED boarding for patients by facilitating earlier crisis assessments, facilitating emergency treatment in a community setting, incentivizing expedient inpatient placement for harder-to-place patients, or allowing patients to receive services that were otherwise only paid for if the patient was in a psychiatric inpatient bed.

xi MassHealth Managed Care Entity Bulletin 93, November 2022.

Patient follow-up care and care communication

An important part of any visit to the ED for a BH condition is ensuring follow-up care. The National Quality of Care Alliance (NCQA) has four quality measures used to track follow-up for care after an emergency room or inpatient visit for a BH condition. While the HPC could not replicate these measures exactly, the HPC did seek to understand whether patients receive any follow-up care as evidenced by some service use within seven days after an initial visit for a BH condition.

Tracking follow-up care after an ED visit or hospitalization for mental illness in claims data is challenging as some people may pay entirely out of pocket for non-covered services (which would therefore not be observable in claims data). HPC estimated from commercial and MassHealth data what percentage of BH ED clients received services within 7 days of discharge from an ED or an inpatient BH setting (**Exhibit 9**). Regardless of boarding status or payer, patients discharged from the ED were more likely to receive additional services within 7 days than those that had an inpatient stay (see **Exhibit 9**).^{xii} These data indicate that between 26% to 41% of people are exiting care without receiving services within seven days. Several stakeholders commented that there was

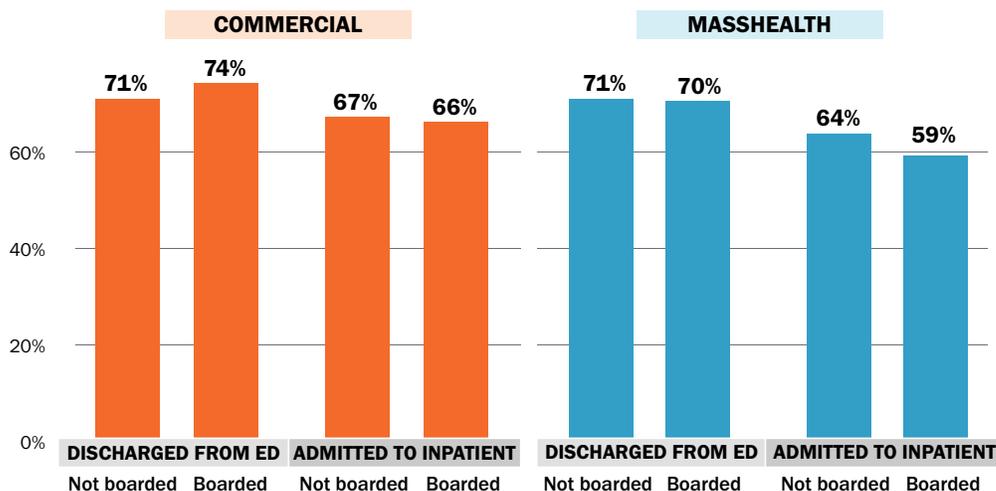
a need for better follow-up care in the community and that while CBHCs may be helping alleviate some patient volume going into the ED, hospitals were still having a hard time discharge planning for patients who do arrive in their ED.

These HPC findings are similar to a 2024 CHIA report on quality of care found that around 77% of members aged 6 or older with an ED visit for mental illness had a follow-up visit with a mental health provider within seven days of their ED visit. For those who were hospitalized for mental illness, CHIA reported 62% had a follow-up visit with a mental health provider within seven days of their discharge.³⁰

Impact of behavioral health workforce and emergency department capacity on emergency department boarding

Several stakeholders cited difficulty in admitting patients and bed capacity due to staffing concerns that existed before COVID and were exacerbated during COVID. In particular, stakeholders cited that there was a lack of support staff for care provided in inpatient settings while acknowledging overall BH workforce capacity concerns. As part of Chapter 28 of the Acts of 2023, the legislature authorized the creation of a state BH workforce center.

Exhibit 9. Percent of mental health-related ED episodes that incurred at least one medical claim for any service within seven days by boarding status and discharge destination, 2022



Notes: The HPC defines ED boarding as greater than or equal to 12 hours in the hospital ED. Restricted to residents with 12 months of coverage in 2022. Mental health-related ED visits were defined as any ED visit or observation or inpatient stay that resulted from an ED visit with a primary diagnosis code in AHRQ CCSR categories MBD001-MBD013 or MBD027 in the Case Mix datasets. Data shown are for ED visits from the Case Mix databases that were matched (same person, same date) to commercial or MassHealth APCD claims data.

Sources: (1) HPC analysis of Massachusetts All-Payer Claims Database, V2022, 2022. (2). Center for Health Information and Analysis. Quality of Care in the Commonwealth: Select Clinical Quality and Patient Experience Measures: 2020-2022. August 2024. Available at: <https://www.chiamass.gov/a-focus-on-provider-quality-selected-clinical-measures>.

xii Rates of care within 7 days were even higher for those who were discharged from observation status versus those discharged to home or to an inpatient stay (82% not boarded; 72% boarded for commercial patients and 81% not boarded; 70% boarded for MassHealth patients, data not shown).

The [Behavioral Health Workforce Center](#) was formed in partnership with the MA HPC and EOHHS. This center aims to conduct research and make data-informed policy recommendations to strengthen the BH workforce in Massachusetts, including efforts to improve education and training pipelines, increase diversity and cultural competency, enhance opportunities for professional growth, and retain BH providers in the workforce. More research on the BH workforce will be forthcoming as part of the center.

In addition to staff in BH care settings, several stakeholders cited that lack of ambulance services to transport patients from the ED into other inpatient settings created a barrier to discharge. Many patients are placed in the first bed available, even if that bed is a substantial distance from the ED. However, placing patients at far away hospitals introduces logistical challenges where EMS resources can take several hours to transport the patients. South Shore Hospital and Lowell General Hospital have started to use alternative transport services to help patients move from the ED to facilities with open inpatient beds to help transport patients in a timely manner to their inpatient destination.³¹ Boston Children’s Hospital has also invested in alternative transport services primarily for their BH patients to alleviate BH ED boarding as well as strained ambulance resources.

Recent innovations in Massachusetts to impact ED boarding

Preventing ED boarding

In early 2023, Massachusetts launched the Roadmap for Behavioral Health. This roadmap had several components that aimed to increase access to “front door” services for BH care. One of the aims of these services was to help decrease BH ED boarding by treating people seeking BH care in their community. The Behavioral Health Helpline (BHHL), Community Behavioral Health Centers (CBHCs), and Behavioral Health Urgent Care providers (BHUCs) seek to allow people to be connected to and received treatment quickly.^{xiii} In January 2023, Community Behavioral Health Centers (CBHCs) started to provide community and mobile crisis intervention services twenty-four hours a day and 7 days a week.³² Some of these CBHCs also opened crisis stabilization service beds to offer 24 hour level of care. As of July 2025, there were [27 CBHCs operating across the state](#).

CBHCs are required to conduct screenings for health indicators based on member presentation.³³ The goal of the screening is to

xiii While some behavioral health urgent care centers existed prior to the implementation of the BH roadmap, BH UCCs were an important part of the roadmap. Some BH UCCs are co-located or managed with community behavioral health centers (CBHCs) and community health center (CHCs).

allow patients to be admitted into a higher level of care, inpatient or crisis stabilization services, without seeking additional medical clearance. However, stakeholders have expressed that not every CBHC has staff to conduct these screenings so that patients are often sent to the ED for medical clearance despite having sought care at a CBHC. Patients who need an inpatient level of care but who must wait for an inpatient bed cannot always safely wait at a CBHC and so they may also be transferred to an ED. Additionally, stakeholders report that CBHCs are new and may not have contracts with all commercial payers, but could be more helpful at diverting commercial patients from the ED as use increases.

Expediting inpatient admissions from the ED

Once a patient in the ED is determined to need an inpatient level of care, there may be several obstacles to overcome in order to get that patient into care including requirements for prior authorization, finding an appropriate bed, and medically appropriate transport to the appropriate inpatient bed.

Policies that impact payers

Payers are integral partner in the EPIA process and are required to help find an inpatient placement for their member starting at 24-48 hours. Payers are responsible for having dedicated resources for these placements, and payer representatives interviewed state that all payers have teams who work to implement the EPIA protocol.

Under Chapter 26 of the Acts of 2022, prior authorization is not required to admit patients to an inpatient level of care for a mental health disorder, but ongoing medical necessity reviews are permitted.^{xiv} However, prior authorization may still be required for some intensive outpatient and partial hospitalization programs, which may delay discharge from the ED into outpatient care.

Expediting treatment in the community

Several stakeholders spoke about the need for treatment to start in the ED or observation prior to an inpatient stay. Multiple stakeholders discussed the time in the ED or observation as a point at which intervention could allow for the patient to be discharged back to their community rather than requiring an inpatient stay. Some EDs are seeking to initiate such interventions by expanding their existing emergency room staffing with additional expertise in BH including psychiatric nurse practitioners to help manage patients with psychiatric medication management. As of 2023, there has also been a change in policy for MassHealth members that allows

xiv This act is the first act that eliminates prior authorization for plans that the DOI regulates for mental health conditions. In 2015 Governor Baker signed Massachusetts Chapter 258, “An Act to Increase Opportunities for Long-Term Substance Abuse Recovery,” which eliminated prior authorization and evaluation of continuing medical need for substance use-related inpatient stays up to 14 days. It is important to note that these regulations do not apply to self-insured commercial plans or Medicare.

patients to be assessed in non-medical settings or within CBHCs as a means of diverting patients from the ED.³⁴

Other state efforts

In February of 2025, EOHSS in partnership with MassHealth and DMH launched the Behavioral Health Treatment and Referral Platform (BHTRP) which aims to streamline referrals to inpatient beds and keep a real-time inventory of available inpatient beds. The BHTRP seeks to minimize communication challenges in the EPIA process by allowing communication to occur in one platform.^{xv}

In addition to the BH roadmap, some providers are working on various ED diversion programs that try to intervene with patients immediately before they enter the ED. Mount Auburn Hospital and Boston Medical Center both have programs to redirect patients seeking BH care to a BH urgent care or a substance use clinic. Massachusetts Association for Mental Health along with the Middlesex Sheriff’s office has been working to open an ED diversion program where patients in BH crisis are directly transported by ambulance or police to a facility instead of an ED.^{xvi}

Ongoing challenges

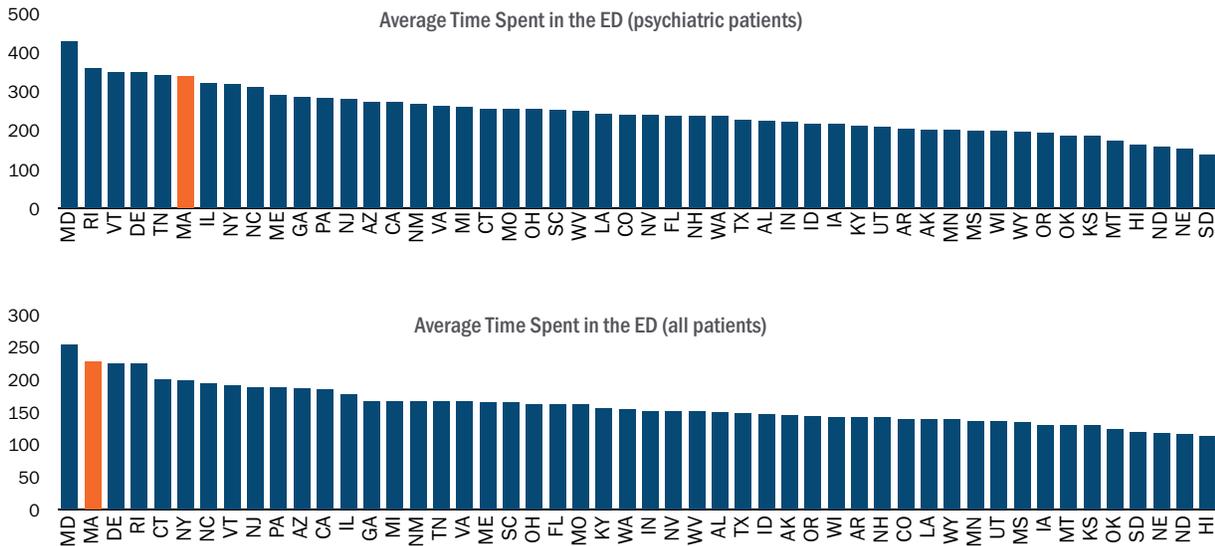
Stakeholders commented that some inpatient hospitals continue to rely on EDs to perform medical assessments before admitting new patients, thereby slowing the admission process from EDs

to inpatient care. There may also be a culture that leans towards hospitalization on locked inpatient units as an initial step for patients who could be treated in less intensive settings (i.e. CSS beds). Hospitals with both inpatient psychiatric beds and EDs will give priority admission to patients in their EDs as opposed to patients in other EDs or from the community. Stakeholders also commented that patients that are unhoused, with medical complexity, patients who will need residential care post-discharge, or who are behaviorally dysregulated are the hardest to place. They say that this problem is compounded due to limited DMH resources to accept the hardest-to-place patients.^{xvii} Freestanding psychiatric hospitals may not be able to handle patients with even lower levels of medical complexity or pregnant patients.

Behavioral Health ED boarding and related policy innovations in other states

BH ED boarding is not a problem that is unique to Massachusetts. Prior national research has shown that adult ED visits for mental health conditions are more likely to spend more than four hours in the ED compared to adults without mental health disorders.³⁵ As of 2024, Massachusetts had the second longest time spent in the ED for any type of ED visit and sixth longest for BH visits (**Exhibit 10**).

Exhibit 10. Average time (in minutes) spent in the ED until discharge home for all patients & psychiatric patients, 2024



Notes: Results exclude District of Columbia and U.S. territories. Reporting is Jan. 1, 2024 through Dec. 31, 2024.
Sources: HPC analysis of CMS Timely and Effective Care National Data Set, 2024

xv [BHTRP](#) allows ED coordinators, admission coordinators, payer case managers, DMH/DDS to communicate about a patient placement in one platform.
 xvi [Middlesex County Restoration Center](#) is a project to establish the first law enforcement focused crisis diversion facility in the Commonwealth.
 xvii As of Fall 2025 [DMH hospitals had a total of 708 operational adult beds and 30 adolescent beds](#) with 715 adults patients in active treatment and 24 adolescent patients are in active treatment. DMH reports there are continuous wait lists for these beds from both houses of corrections (e.g. court-ordered, forensic patients) and for civilian placements.

Several other states or state hospital associations have issued reports on ED boarding.^{36,37} Some states have set up innovative pilots or state-wide programs with the aim of easing ED boarding. Many of these states cite the need for improved data, lack of access to BH care, workforce shortages, and inability to divert care as drivers of behavioral health emergency department boarding.

Maryland

As of 2024, Maryland was the state with the longest ED boarding times. Maryland’s Health Services Cost Review Commission issued a report that focused on solutions to their ED boarding crisis, especially for pediatric patients, including children with development disabilities.³⁸ As part of their work, the Maryland Health Department set up a bed registry and referral system, embedded behavioral health navigators in EDs as part of a pilot program, and expanded residential treatment capacity. The report cited that BH ED boarding was often related to the inability to move children and adolescents out of the inpatient beds into lower levels of care (e.g. there were many “overstayers”). In addition to these programs, Maryland sought to strengthen community-based care by working on Collaborative Care Model (CoCM) programming; creating 24-hour regional crisis centers; supporting hospital diversion programs to prevent BH ED visits; developing a state health plan for acute psychiatric services; and investing in case-managers focused on readmission reductions for patients with BH conditions. Maryland also worked on increasing payment rates for a behavioral health hospital and continuing their Medicaid Institutions for Mental Disease Waiver.^{xviii}

Despite the amount of state, system, and provider level activity focused on reducing BH ED boarding in Maryland, the report cited lack of data, uncertainty of ongoing grant funding, legal challenges with moving patients to specific settings (e.g. children under state supervision), and support to maintain and expand the behavioral workforce shortages as major ongoing challenges.

Rhode Island

As of 2024, Rhode Island was the state with the second highest ED wait times for patients with BH conditions. The Mental Health Association of Rhode Island (MHARI) issued “The State of Behavioral Healthcare in Rhode Island” report in 2020.³⁹ While this report examines BH care across all settings, they examined BH ED boarding through the Rhode Island Behavioral Health Open

xviii The Medicaid Institution for Mental Disease (IMD) waiver allows Medicaid reimbursement for inpatient stays in IMDs for Medicaid-eligible patients. As of 2025, 37 states had this waiver for substance use disorder treatment including Massachusetts (5 states pending), 15 states had this waiver for mental health treatment (10 pending, including Massachusetts). Massachusetts has had the IMD exclusion waiver since 2016 for SUD: <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>

Beds (BHOB) system^{xix} that is maintained by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals and Rhode Island Quality Institute. As part of their policy recommendations, they recommend that health insurers should be responsible for notifying mental health providers when their patients/clients are seen in the ED and that they should invest in a network of peer support specialists to be paired with patients who are discharged from EDs.

Connecticut

In 2024, the Connecticut Emergency Department Boarding and Crowding Workgroup released a report to the Connecticut Department of Public Health and Connecticut State Legislatures on ED boarding for both medical and BH patients in the state.⁴⁰ This workgroup proposed that increased Medicaid reimbursement for mental health providers may lead to an increase in the number of mental health care providers across all settings. In addition, they proposed that hospitals begin tracking the duration of time spent boarding solely due to lack of availability of the clinically appropriate inpatient placement, which would help to estimate the need for additional beds and inpatient facilities in the state (e.g. more pediatric inpatient beds for patients with severe eating disorders).

New Hampshire

New Hampshire’s Department of Health and Human Services launched their Mission Zero project aimed at eliminating hospital ED psychiatric boarding in 2023.⁴¹ This effort focuses state efforts into three domains: patients who could have avoided the ED if there was access to community services; inpatient bed supply and fragmentation of inpatient care; and inability to discharge patients safely. New Hampshire has been ordered to end ED boarding for patients based on a lawsuit brought by the ACLU of New Hampshire in 2018 alleging violations of patient rights. As of May 2023, a US District Court ruled that New Hampshire could not hold patients involuntarily in EDs for more than 6 hours.⁴²

Minnesota

Minnesota has one of the lower average lengths of stay for BH ED patients. The Minnesota Medical Association and Minnesota Chapter of the American College of Emergency Physicians produced the report, *Emergency Department Boarding of Patients with Psychiatric Diagnoses*, in May of 2023.⁴³ In this report, they examine ED boarding defined as any ED visit with a length of stay over 6

xix The [Rhode Island Open Beds website](#) tracks available beds for ASAM levels of care, specialized units (e.g. BH Geri-Psych) through residential and recovery housing. Most services are updated daily while some are updated weekly. In addition the tracker follows the number of individuals awaiting at bed with an ED (e.g. as of 4/10/2025 7:53am there were 2 patients waiting for inpatient care at Westerly hospital).

hours. This collaborative report presented a model of a congested highway with a focus on inflow factors (why patients end up in the ED), stalling (problems that arise while patients wait for care in the ED), and outflow factors such as challenges discharging patients from beds. They propose a variety of policy recommendations for each of these including exploring emergency transport diversion to EDs in hospitals with BH inpatient beds, emergency facilities that focus on patients with psychiatric diagnoses, and increases in residential and intensive residential treatment facilities.

Other innovative programs

As highlighted above, there are several innovative efforts nationwide to send patients in behavioral health crisis to locations other than the ED (e.g. CBHCs, home crisis intervention). Alameda county in California has a program that allows EMS to take patients with BH emergencies directly to a psychiatric emergency service facility and bypass the ED. This program was found to be safe and effective.⁴⁴ Oregon also has a diversion program where EMS personnel partner with a non-licensed mental health counselor to assess, intervene, and voluntarily transport patients to a variety of care settings.⁴⁵

Summary

BH ED boarding remains a challenge in the Commonwealth. Although referrals to the EPIA program have decreased from their high in January 2022, there are still many individuals seeking BH care that continue to wait in EDs for 12 or more hours. More recent policy changes in payments and state-led resources such as the behavioral health help line may help more patients with “front door access” to behavioral health care in the Commonwealth as well as inpatient admissions, but there are still challenges with inpatient admissions as well as discharging patients. HPC will continue to monitor BH ED boarding within the state as well as track other state developments in ED boarding policies.

POLICY RECOMMENDATIONS

Behavioral health ED boarding remains a complex policy challenge in the Commonwealth in part because the causes of boarding are multifactorial. Despite a decrease in the total numbers of patients referred to the EPIA, the HPC found high numbers of BH patients spending twelve or more hours in the ED regardless of their discharge destination (e.g. community-based treatment, inpatient treatment).

The legislature required the HPC to develop recommendations designed to ease the burden on acute care hospitals, improve outcomes and quality of care for patients with BH diagnoses who experience boarding, and to address payer reimbursement to care for boarders in acute care hospitals. The following set of policy recommendations were developed through consultations with other state agencies, stakeholder interviews, review of analytic results, and research of policies in other states.

Data collection, continued reporting, and research that will allow monitoring of ED boarding, outcomes for these patients, and quality of care for these patients.

1. While Massachusetts is one of the few states that collects information on time spent in the ED regardless of the patient’s final disposition (e.g., discharged to home/place of residence, inpatient), **more can be done to understand the time spent in the ED as well as the use of observation status for patients experiencing a BH crisis.**
 - a. **Collect information in CHIA’s Acute Hospital Discharge Databases on changes in the determination of level of care and publicly report as part of DMH reporting on referrals.** A patient’s initial determination for level of care (e.g. inpatient) may change throughout a patient’s time in the ED or in observation status where a patient who initially was waiting for an inpatient bed no longer needs that treatment. These changes also make it challenging for policy makers to understand the burden on EDs as the DMH EPIA process only collects information on patients who are being held for over 24 hours and end up in an inpatient bed. CHIA should work with hospitals to collect data on changes in level of care determination.
 - b. **Revision of EPIA notification and data reporting to include patients with observation stays and admitted to medical/surgical beds for over 24 hours since entering the ED.** There should be continued public reporting from the Behavioral Health Referral and Treatment Platform. As several hospitals reported moving patients in the ED

to observation status while awaiting an inpatient bed, the HPC recommends that the EPIA policy change to also count patients awaiting inpatient placement in observation or in non-psychiatric inpatient beds. In addition to these changes, DMH should continue reporting monthly on patients experiencing BH boarding within the Behavioral Health Referral and Treatment Platform.

2. Additional behavioral health planning studies. One of the factors leading to boarding for BH patients is the lack of availability of certain inpatient, outpatient and residential services. While the HPC has been tasked with a mandated study concerning pediatric BH planning,^{xx} interest in better understanding the availability of BH services encompasses adult services as well. HPC's BHC and [Office of Health Resource Planning](#)^{xxi}, in conjunction with EOHHS, DMH, and DPH should conduct a broader behavioral health planning study to understand (a) psychiatric bed types, (b) the number of psychiatric beds that can hold patients with co-occurring substance use or medical conditions, (c) the number of beds that can hold patients with autism spectrum disorders or other developmental disorders, (d) the number of beds needed for forensic patients, (e) staffed and available capacity in residential treatment facilities for behavioral health patients, (f) the capacity of partial hospitalization services in the Commonwealth and their payer mix, (g) estimated need for these facilities and programs including workforce and staffing needs, and (h) the quality and outcomes of these programs. Additionally, this study should identify potential barriers to both freestanding psychiatric facilities and other outpatient programming, including administrative barriers such as determination of need (DON) processes. This study should also examine admissions policies and regulations regarding the ability of facilities and programs to admit and treat co-occurring conditions.

3. Study of freestanding psychiatric facilities. HPC and CHIA should work together to produce a study on freestanding psychiatric admission and discharge practices including: facility-specific medical clearance requirements, challenges with safe discharge planning, ability to treat patients with substance use and co-occurring medical conditions, workforce needs, payment rates and incentives. This study should also include data from the Behavioral Health Case-Mix including detail on admission days and times for freestanding psychiatric hospitals.

xx Chapter 177 of the Acts of 2022 instructs HPC to conduct a Pediatric Behavioral Health Planning Report.

xxi The HPC's Office of Health Resource Planning, established in the [Acts of 2024 Chapter 343](#), is charged with evaluating the supply and distribution of health care resources across the Commonwealth.

Practices and policies that support the admission and transition of behavioral health patients into more clinically appropriate care that should reduce ED boarding in acute care hospitals while improving outcomes and quality of care for patients.

- 1. Identify best practices for patients who face placement challenges.** Multiple stakeholders reported that there were challenges finding appropriate care settings for patients displaying violent behavior, patients with co-occurring medical conditions, and patients with developmental and autism spectrum disorders. HPC echoes prior recommendations, including those recently released by the EPIA task force, highlighting the need for best practice models for harder-to-place patients.
- 2. Convene stakeholders to focus on safe discharge options.** Ensuring that patients have the ability to be safely discharged is a cause of ED boarding, particularly for patients who are unhoused, have transportation challenges, and other SDOH factors. While the EPIA focuses on expediting admissions to an inpatient level of care, more must be done to enable patients to be safely discharged.^{xxii} This could include exploring Home and Community Based Services (HCBS) and their workforce for behavioral health patients.
- 3. Continue to promote and enable access to community-based behavioral health care through the Behavioral Health Road Map including the Behavioral Health Help Line (BHHL) and Community Behavioral Health Centers (CBHCs).**
 - a. Continue to promote the BHHL, CBHCs, and BH urgent cares.** As shown in the report, approximately 48% of patients who experience BH boarding end up leaving the hospital without being admitted to an inpatient setting of care. It is likely that many of these patients did not need an emergency department level of care. Such patients may have benefited from a referral from the BHHL, treatment at a CBHC, or a BH urgent care.
 - b. Keep public information on CBHCs up-to-date and include list of services (including the ability to do medical clearance).** A large number of CBHCs have opened as part of the Behavioral Health Road Map. The

xxii DMH regulation 104 CMR 27.00 states: "(1) Discharge Procedures. (a) A facility shall arrange for necessary post-discharge support and clinical services. Such measures shall be documented in the medical record. (b) A facility shall make every effort to avoid discharge to a shelter or the street. The facility shall take steps to identify and offer alternative options to a patient and shall document such measures, including the competent refusal of alternative options by a patient, in the medical record."

services provided, the relationships with local hospitals and community-based organizations, and the staffing can vary substantially by CBHC. Providing clear and current information about staffing and services provided could increase CBHC use while reducing ED use.

4. Support direct admissions from the community. Requiring patients that need an inpatient level of care for BH condition to first go to the ED for medical clearance is a factor in ED boarding. Any requirement for medical clearance by a BH inpatient facility should be transparent and follow existing guidance by the state as indicated in the “Community-Based Medical Screening Checklist for Individuals with Psychiatric Symptoms and Low Medical Risk” published by DMH, DPH, and MassHealth.^{xxiii} For patients who are voluntarily seeking inpatient admissions, providers and hospitals should support treatment on unlocked units (e.g. CSS) unless a patient is determined to need a more intensive care setting.

5. Regulation review and development of ED diversion for patients experiencing behavioral health emergencies.

a. Review and revise regulations regarding ambulance diversion for patients in behavioral health crisis to hospitals with inpatient psychiatric units. The requirement that EMS providers are required to take BH patients to the nearest ED, even if the hospital does not have inpatient psychiatric beds, is a factor in boarding. DPH, in consultation with DMH, MassHealth, and stakeholders, should review regulations for ambulance diversions for patients who are in BH crisis for the feasibility of enacting diversions to EDs in hospitals with appropriate inpatient beds.

b. Review and revise regulations regarding ambulance diversion to non-acute care hospitals for patients in behavioral health crisis. EMS pilots in Massachusetts and in other states support the use of ED diversion to non-acute care EDs for certain patients. DPH should convene stakeholders, including DMH, MassHealth, Massachusetts Association of Mental Health to review such EMS diversion pilots and consider developing policies allowing ambulances

^{xxiii} This checklist was developed by several state agencies and stakeholders after consulting other state policies and professional organizations. As noted earlier, the [American College of Emergency Physicians does not support routine medical clearance for behavioral health patients](#): “Medical screening or ‘clearance’ that requires automatic, perfunctory testing of all ED psychiatric patients before they can be seen at community or referral psychiatric facilities is not supported by the evidence. Focused screening may be appropriate in selected cases, and the approach should be coordinated and standardized across the community. Any medical testing should be guided by the patient’s history and physical examination.”

to transport patients experiencing a BH crisis to non-acute care settings.

6. Support the development of alternative transportation options for patients experiencing behavioral health crises. Waits for appropriate transport between the ED and inpatient facilities was reported as a factor leading to boarding. HPC recommends that DPH explore models and programs similar to the pilots mentioned in the report to develop alternative transport methods for quickly getting patients who present in an ED to the first available inpatient bed.

7. Create and expand supports for discharge to prevent bottlenecks. Challenges with discharging patients to intensive community-based services from inpatient care is one factor leading to BH ED boarding. HPC recommends providers invest in and payers support adequate payments for home-based services, partial hospitalization services, and other community-based services that would allow patients to be safely discharged from acute-care settings in a timely manner. HPC further recommends exploring programs that create links from the ED and inpatient settings to appropriate discharge programming, such as HPC’s Health Care Transformation and Innovation team program with the Executive Office of Aging & Independence Promoting Appropriate Transition to Home (PATHways) program.^{xxiv} This program aims to connect patients safe to discharge to home with an Aging Services Access Points (ASAP) employee to ensure patients are connected to needed community resources before being discharged. Similar programs have been shown to expedite and facilitate successful discharges.

Ensure adequate reimbursement for services provided to patients experiencing BH boarding.

1. Clarify payment rules for services provided in the ED prior to inpatient admissions. Acute hospitals face challenges getting appropriate reimbursement for patients who board in the ED. While the DOI and MassHealth have made several changes to increase payments for BH services starting in the ED and continuing through inpatient admission, including incentive payments for admissions and “specialing”, providers may still find these payments confusing to access. HPC recommends that DOI and MassHealth work with payers and providers to clarify payments around ED boarding.

^{xxiv} For more information on this program, see [HPC’s October 2025 Board Meeting Presentation](#).

2. Continue to examine rates paid to behavioral health providers.

The HPC's BHWC is mandated to publish a report assessing BH rates in the Commonwealth across payer types and services. Providing transparency on BH payments is an important component in examination of factors contributing to access for patients to BH care across the continuum.

3. Encourage adequate payments for stepdown care and community-based care that can keep patients out of inpatient settings.

To ensure sustainability and quality for these types of services, providers and payers should work together to ensure these levels of care are paid for adequately, including exploring value-based payments, to strengthen and maintain care delivery capacity throughout the Commonwealth.

Invest in BH workforce to improve access for patients needing BH care

1. Continue to explore the needs of the behavioral health workforce in order to improve working conditions for existing providers and increase investments in the clinical training pipeline to strengthen and diversify the future workforce.

The work of the BHWC includes tracking BH rates and compensation, identifying workforce gaps across care settings, exploring barriers to certification and licensure, and assessing the BH training pipeline can provide insights to support the Commonwealth's effort in eliminating BH ED boarding. HPC and the BHWC will continue develop data-driven policy recommendations to sustain the BH workforce.

ACKNOWLEDGEMENTS

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HPC staff Dr. Laura Nasuti and Diana Vascones conducted the analyses, stakeholder interviews, and prepared the report. The Research and Cost Trends department led by Dr. David Auerbach and the Behavioral Health Workforce Center led by Amy Doyle provided review and contributed to the policy recommendations. Additional HPC staff contributed significantly to the report from the HPC's Office of the Chief of Staff, led by Hannah Kloomok, and Office of the General Counsel, led by Lois Johnson.

The HPC acknowledges the significant contributions of other government agencies in the development of this report, including the Department of Mental Health (DMH); the Division of Insurance (DOI); Center for Health Information and Analysis (CHIA); and the Office of MassHealth and the Commonwealth's Executive Office of Health and Human Services (EOHHS). The HPC received valuable assistance from many other organizations and providers who engage in efforts to reduce behavioral health boarding and would like to thank the market participants and stakeholders who provided insightful input and comments.

APPENDIX A. SELECTED CRISIS BEHAVIORAL HEALTH SERVICES

- **Behavioral health help line (BHHL)** provides 24 hours a day, 7 days a week front door access to individuals and families seeking BH services including crisis services.
- **Community Behavioral Health Centers (CBHCs)** offer crisis, urgent, and routine SUD and mental health services, care coordination, peer supports, screening and coordination with primary care to children, youth and adults as an alternative to EDs. These services include same or next day evaluations, mobile crisis intervention, and community crisis stabilization.
- **Community Crisis Stabilization (CCS)** is an alternative to inpatient psychiatric hospitalization that can occur in a community setting for patients seeking 24 hour levels of care. Care received in a CCS must be voluntary.
- **Behavioral Health Urgent Care Centers (BHUC)** provide community-based access for urgent behavioral health needs with same day or next day outpatient appointments.
- **Community Based Acute Treatment (CBAT)** is a voluntary service for youth in BH crisis that takes place in a secure group setting.

For more information on behavioral health crisis services, please see the [Roadmap for Behavioral Health Reform](#).

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