MASSACHUSETTS RESPONDS TO

The Crisis in Children's Behavioral Health

MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

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About MAHP and Acknowledgments

For more than three decades, the Massachusetts Association of Health Plans (MAHP) has been the leading voice for health plans in Massachusetts. MAHP is a nonprofit organization committed to promoting high-quality, affordable, and equitable health care in Massachusetts through advocacy, education, and health policy research. MAHP represents 16 health plans and two behavioral health organizations, all of which provide health care coverage to nearly 3 million Massachusetts residents. All MAHP members are dedicated to making health care affordable and improving the health of all citizens in the Commonwealth.

We would like to offer a sincere thank-you to everyone who participated in this project as well as to everyone who is working to improve the lives of the Commonwealth's children and families. We look forward to further collaboration with stakeholders and state government on improving access to and the delivery of behavioral health care services for children and their families.

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LIST OF INTERVIEWEES

HEALTH PLANS

Beacon Health Options
WellSense Health Plan
Fallon Health
Point32Health
AllWays Health Partners
Health New England
Optum Behavioral Health

PROVIDERS

Riverside Community Care
Tufts Children's Hospital
Boston Children's Hospital
Bournewood Health Systems
Clinical & Support Options (CSO)
Brien Center
Massachusetts Association for Behavioral Health Systems (MABHS)
Association for Behavioral Health (ABH)
Massachusetts Medical Society
Children's Mental Health Network
Judge Baker Children's Center
Advocates

STATE AGENCIES

Department of Mental Health
Executive Office of Health and Human Services (EOHHS)[i]

SCHOOLS

Boston Public Schools
Methuen School District

ORGANIZATIONS

Parent/Professional Advocacy League (PPAL)
Blue Cross Blue Shield Foundation
Massachusetts Association for Mental Health (MAMH)
Institute for Innovation and Implementation at the University of Maryland

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Executive Summary

There is a long-standing crisis in children's behavioral health in Massachusetts. Pre-pandemic research studies indicate that approximately one in five children and adolescents experienced a behavioral disorder each year and showed major increases in certain mental health symptoms, including depressive symptoms and suicidal ideation.[ii] Massachusetts isn't alone; this is a nationwide crisis. According to the American Academy of Pediatrics, rates of childhood mental health concerns were already on the rise over the past decade.[iii] However, the COVID-19 pandemic along with the issue of racial inequality has dramatically impacted and changed children's worlds across the country. The pandemic exacerbated the issue and took an unprecedented toll on their mental health and intensified challenges in accessing care.

The problems are multifaceted, stemming from the biological, societal, and environmental factors that interact to shape the mental health of children. During the pandemic, social isolation and the loss of school supports increased stress for youth and their families. Access issues also worsened, due to increased demand for services and a diminished supply of providers. All these stressors disproportionately affected low-income families and communities of color, which exacerbated inequities across the system.

These problems of youth mental health have been universally recognized — and actions have been initiated — by the Biden administration, the Baker-Polito administration, Attorney General Maura Healey, the Massachusetts Legislature, and multiple advocates and experts in children's mental health care. One of the most significant actions was the development of the Behavioral Health Roadmap (Roadmap), a comprehensive plan for the state's behavioral health system spearheaded by Massachusetts Executive Office of Health and Human Services (EOHHS) Secretary Marylou Sudders. The overall goals of the Roadmap are to create a "front door" to make it easier for patients and families to access care, to advance health equity, and to expand the overall capacity of the behavioral health system.

MAHP initiated the research for this report in order to understand the current state of children's mental health in our communities; to inform elected officials, policymakers, and the community at large of the challenges we face; and to identify concrete steps that will address the ongoing problems and improve the lives of children and their families.

In completing this work, MAHP conducted 25 interviews of representatives from health plans, providers, advocates, and individuals in state government and collected and analyzed quantitative data from the health plans on youth and the services they receive. We gained important insights into how the behavioral health system is organized, including its intersection with primary care, how schools can play a more significant role and how they might be integrated with the behavioral health delivery system, the status of innovative programs the interviewees have developed, and the interviewees' thoughts on new state initiatives.

Throughout the course of our interviews, we identified eight major areas of concern. Part two of this report outlines these areas; summarizes the state, federal, and private sector initiatives designed to address them; and sets forth specific recommendations for what more can be done. The eight areas are shown on the opposite page.

Given the importance and complexity of the crisis, the breadth of initiatives already underway, and the forthcoming political transition, the goals of our report are to help maintain and build on the progress that is being made in Massachusetts and to identify additional opportunities for improvement. Recognizing the large amount of work that has already been done, a critical next step is to prioritize completing the work that is currently underway. Stakeholders universally supported these policies and believed that they formed a solid foundation for addressing the identified challenges. MAHP pressed interviewees to identify additional practical measures that could complement the ongoing work or pinpoint problems that have not been addressed. Above is a prioritized list of recommendations for immediate action to improve youth behavioral health in the Commonwealth.

EIGHT AREAS OF CONCERN

1. Lack of Connection and Coordination Among Agencies, Services, and Providers
2. Inadequate Availability of Crisis Services
3. Emergency Department Boarding
4. Inadequate Availability of Easily Accessed Outpatient Services
5. Challenges and Opportunities for Primary Care Provider (PCP) Integration
6. The Uneven and Untapped Potential for School-Based Mental Health and Wellness Programs
7. New Opportunities for Children's Behavioral Health Initiative (CBHI)/Behavioral Health for Children and Adolescents (BHCA) Services
8. Workforce Issues

RECOMMENDATIONS

1. Fully implement the Behavioral Health Roadmap
2. Create a public education campaign regarding the availability of urgent care and crisis services
3. Develop and support specialty services for high-need children
4. Widen the scope of children's behavioral health programming to incorporate school-based behavioral health
5. Coordinate care for children receiving services from multiple agencies
6. Integrate behavioral health into pediatric primary care settings

PART ONE

An Overview of the Crisis in Children's Behavioral Health

For more than a decade, advocates, researchers, and policymakers have been increasingly concerned about the behavioral health of America's children and the inadequacy of resources and systems to care for them.[iv]

Even before COVID-19, behavioral health challenges were the leading cause of disability and poor life outcomes in young people. Pre-pandemic research studies indicate that approximately one in five children and adolescents experienced a behavioral disorder each year. Half of all adults who reported having a behavioral or emotional problem said that these problems began during their youth.[v]

A Centers for Disease Control and Prevention (CDC) study of federal children's behavioral health surveys compiled from 2013 to 2019[vi] found that:

- Within a one-year period, about 10% of children aged 3 to 17 received at least one consultation or treatment session with a behavioral health professional, while 5% received a behavioral health consultation from a general physician.
- About 8% of children received medication for behavioral health issues, and 25.9% received either specialty or non-specialty services.
- Among children aged 3 to 17, ADHD and anxiety were the most prevalent disorders, each affecting about one in 11 children.
- For those between the ages of 12 and 17, one-fifth had experienced a major depressive episode (MDE).
- Among high school students surveyed in 2019, 36.7% reported feeling persistently sad or hopeless in the past year and 18.8% had seriously considered attempting suicide.
- Of note is the fact that parents and health care providers report major depressive episodes among adolescents at a much lower rate (3%–4%) than adolescents self-report either having had an MDE at any time (20.9%) or having had an MDE in the past year (15.1%).
- For children who had elevated behavioral health symptoms or diagnoses, 22.1% were served by school-based behavioral health services, 20.56% were served in outpatient settings, 9.93% were served in primary care settings, 9.05% were served in inpatient settings, 7.9% were served in child welfare, and 4.05% were served in the juvenile justice system settings.[vii]

Another CDC study reported that after a stable period from 2000 to 2007, the rate of suicide among those aged 10 to 24 increased dramatically — by 56% — between 2007 and 2017, making suicide the second-leading cause of death in this age group, following accidents like car crashes.[viii]

The numbers are alarming, especially given what we know about the immediate and long-term effects of poor behavioral health has on physical health, chronic disease, social relationships, education, and employment.

COVID-19 made a bad situation even worse

Using data from the first six months of 2021, the CDC reported that "[d]isruptions and consequences related to the COVID-19 pandemic, including school closures, social isolation, family economic hardship, family loss or illness, and reduced access to health care, raise concerns about their effects on the mental health and well-being of youths."[ix]

In December 2021, the U.S. surgeon general issued a comprehensive report on the growing behavioral health needs of children and how these needs escalated during the COVID-19 pandemic.[x] "Protecting Youth Mental Health," which highlights both biological and environmental factors shaping behavioral health, reports that since the start of the pandemic, 25% of youth surveyed experienced depressive symptoms and 20% reported feeling anxious — in both cases, more than double the pre-pandemic rate.

In early 2021, emergency room visits for suspected suicide attempts were reported to be 51% higher for adolescent girls and 4% higher for adolescent boys than for the same period in 2019.[xi]

These increases in distress are not necessarily evenly distributed among all children. Low-income children, children of color, children experiencing more adverse childhood experiences, and those who had behavioral health challenges before the pandemic were more adversely affected. Taken together, these data points draw special attention to social determinants of health and the deleterious effects of poverty, racism, and trauma.

An Overview of Children's Behavioral Health in Massachusetts

The most recent reports on children's behavioral health in Massachusetts rank Massachusetts better than most states on some measures and highlight challenges on others. "America's Health Rankings 2022," compiled and published by the United Health Foundation, published the following results based on 2021 data.[xii] When comparing incidents of behavioral health diagnoses across the states, it is important to note that Massachusetts is one of only a few states that require screening for behavioral health conditions for children and adolescents in the Medicaid program.

Massachusetts is lower than the national average for:

- **Adverse childhood experiences (ACEs)**, which are stressful or traumatic events that occur in the lives of many children and are associated with adverse long-term outcomes in a person's emotional, cognitive, social, and biological functioning.
- **Teen suicide.** In the U.S., the rate of teen suicide for those aged 15 to 19 years is 11.2 deaths per 100,000 people. Massachusetts and New Jersey have the lowest reported rate at 5.4 deaths per 100,000. In contrast, the highest rate (Alaska) is 44.9 per 1,000.

Massachusetts is higher than the national average for:

- **Anxiety.** A two-year estimate of the percentage of children aged 3 to 17 with anxiety problems was 12.3% for Massachusetts versus 9.1% nationally.
- **Depression.** The percentage of children aged 3 to 17 with depression was 5.5% for Massachusetts versus 4% nationally.
- **Alcohol use.** The percentage of children aged 12 to 17 who reported having a drink in the past month in Massachusetts was 10.2% versus 9.2% nationally.
- **Illicit drug use.** The percent of children aged 12 to 17 who reported using illicit drugs within the past month was 11% in Massachusetts versus 8.4% nationally.

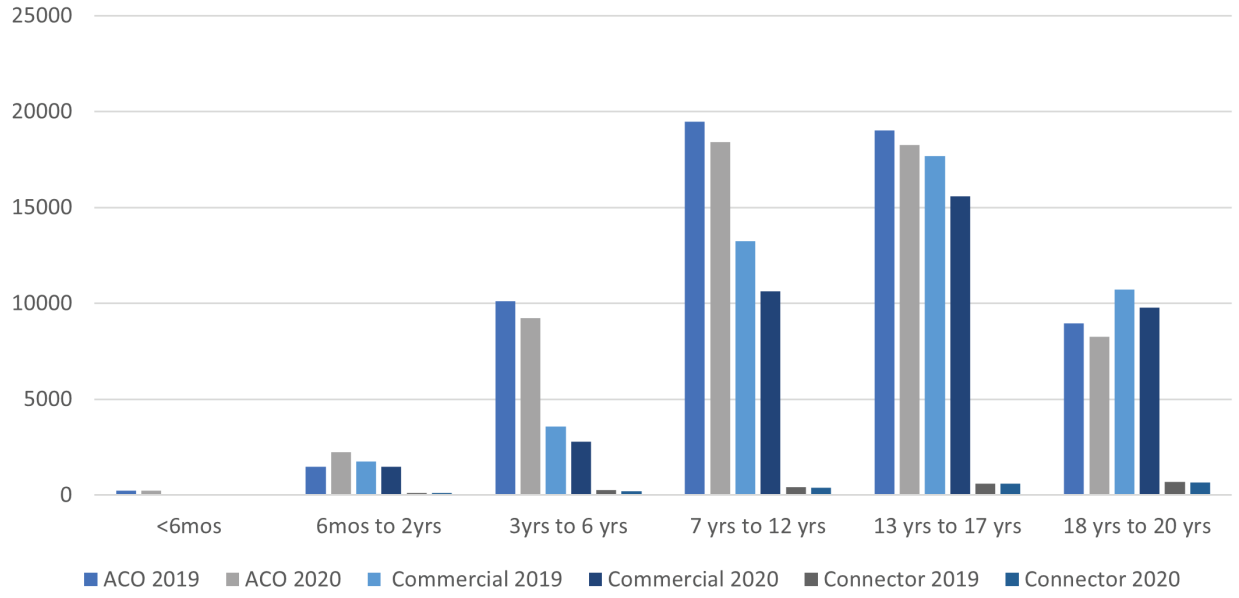
Massachusetts is also profiled in a 2023 report by Mental Health America, a national community-based organization that tracks and reports on behavioral health and on the service delivery system.[xiii] Its report gathers data from many sources and synthesizes it into state rankings on mental health, substance use, and access to treatment.

- **Insurance coverage.** Massachusetts is fourth in the nation in regard to the percentage of children (5.70%) whose private insurance does not cover care for behavioral or emotional problems.

- **Incidence.** Approximately 84,000 children in Massachusetts (17.74%) reported having at least one major depressive episode in the past year, 32,000 (6.77%) reported a substance use disorder, and 40,000 (8.80%) reported coping with severe depression.
- **Failure to receive needed services.** In Massachusetts, 63.90% of children with severe depression do not receive any behavioral health treatment, versus 59.80% nationally. Nationally, only 28.00% of children with severe depression receive consistent treatment (seven to 25 visits/year), while in Massachusetts 46.30% of children with severe depression are receiving consistent treatment.
- **Depression:** For children aged 12 to 17 with major depressive episodes, Massachusetts ranks fifth in the percentage of children reporting a major depressive episode (8.80%) and 41st in the percentage of those children who did not receive any behavioral health treatment for major depression (63.90%). Massachusetts ranked fifth in the percentage of children with major depression who received some consistent care (46.30%).

[For children's behavioral health data from MAHP-member health plans, see Appendix.]

Figure 1: Youth with Primary Behavioral Health Diagnosis in Massachusetts. Refer to Appendix for details.



Advocates' Call for Action

National

In the fall of 2021, three national organizations, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association, jointly declared a "national emergency" in children's behavioral health. The coalition, called Sound the Alarm, now includes more than 60 major behavioral health associations, provider associations, and educational and community groups.[xiv] Their key policy principles are to bolster prevention; ensure access to screening, diagnosis, and treatment; build robust systems of care; recognize and address the needs of disproportionately impacted communities; support the pediatric mental health workforce; reach children and families where they are; relieve the emergency department boarding crisis; expand youth suicide prevention; improve access to telehealth; enhance data collection; and advance mental health parity.

Massachusetts

The Children's Mental Health Campaign (CMHC), founded in 2007, is a statewide network that advocates for policy, systems, and practice solutions for issues affecting children. Its executive committee consists of six partner organizations: Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital (BCH), Parent/Professional Advocacy League (PPAL), Health Care for All (HCFA), Health Law Advocates (HLA), and the Massachusetts Association for Mental Health (MAMH). Their approach emphasizes the interlaced systems and structures within which children reside: home, school, and community. The CMHC has contributed analyses and supported legislation on critical issues in children's behavioral health, including a 2014 report on safe and supportive schools, a 2017 report on child boarding in emergency departments,[xv] and a 2020 report on urgent care.[xvi]

Current areas of concern for the CMHC are emergency department boarding, school-based behavioral health, and workforce issues. In each of these areas, they are supporting and facilitating specific policy and practice changes to address systemic problems within the behavioral health system.

Addressing the Crisis in Children's Behavioral Health

Executive Action by the Biden Administration

In March 2022, as part of his State of the Union address, President Joe Biden outlined a strategy to address our national behavioral health crisis, and in May, the administration elaborated on the strategy's three principal objectives: strengthening system capacity, connecting more Americans to care, and supporting Americans by creating healthy environments.[xvii]

- Strengthening system capacity including using federal funds for training behavioral health providers, training paraprofessionals, building a national certification for peer specialists, promoting the mental well-being of our frontline health workforce, strengthening crisis care and suicide prevention infrastructure, expanding evidence-based community behavioral health services, and investing in research on new practice models.
- Connecting more Americans to care by supporting the integration of behavioral health and substance use treatment into primary care; expanding access to tele- and virtual behavioral health care options; expanding access to behavioral health support in schools, colleges, and universities; embedding and co-locating behavioral health and substance use providers into community-based settings; and increasing behavioral health navigation resources.
- Supporting Americans by creating healthy environments, especially through stronger protections for young people using online platforms, products, and services; strengthening children's privacy and banning targeted advertising for children online;

expanding early childhood and school-based intervention services and supports; training social and human services professionals in basic behavioral health skills; and establishing a federal research action plan on behavioral health.

In May 2022, the administration announced additional initiatives related to children's behavioral health. These include supporting student success through hiring mentors and tutors trained in evidence-based practices; providing funds for crisis intervention and red-flag laws; and additional funds for strengthening the behavioral health workforce, at all levels and for all settings, including school behavioral health.[xviii]

Executive Action by the Baker-Polito Administration in Massachusetts

Over the past three years, the Massachusetts EOHHS has developed and is now implementing an ambitious set of policies and initiatives to redesign and strengthen the Commonwealth's public behavioral health system. Most of these initiatives will also affect behavioral health care for privately insured individuals and families.

Behavioral Health Roadmap

The Behavioral Health Roadmap (Roadmap) is a comprehensive plan for the state's behavioral health system. The Roadmap, spearheaded by EOHHS Secretary Marylou Sudders over several years, was based, in part, on concerns and ideas gathered at listening sessions held across the Commonwealth. The overall aim is to create ease of access, advance health equity, and expand the behavioral health system. Both private and public systems are included. The Roadmap addresses many of the most challenging inadequacies of the current system and includes:

- A 24/7 Behavioral Health Help Line to be available in early 2023.
- Procurement of the Community Behavioral Health Centers (CBHCs). Procurement results were announced in June 2022 and programs will go live in January 2023. The EOHHS will provide up to $10 million in start-up grants for entities that are selected to become CBHCs.
- Coverage for preventive behavioral health services in primary care and other settings.
- More community-based alternatives to emergency departments for urgent and crisis intervention services.
- Rate increases for behavioral health providers.
- Increased inpatient and other 24-hour beds.

MassHealth Section 1115 Demonstration Waiver

On September 28, 2022, the Centers for Medicare and Medicaid Services (CMS) approved the Massachusetts Request to Extend the MassHealth Section 1115 Demonstration Waiver to the CMS. The five-year extension represents a $65 billion agreement that supports the state's transformation initiatives. The overall goals for the waiver period are consistent with the development of a transformed, integrated, and universally available health care system, including behavioral health. Specific goals are:

- Continue and strengthen accountable care organizations (ACOs).
- Reform and invest in primary care, behavioral health care, and pediatric care that expands access and moves away from fee-for-service payment.
- Advance health equity and address social needs, including care for justice-involved individuals.
- Support the Commonwealth's Health Safety Net.
- Maintain near-universal health care coverage.

Several provisions of the waiver are aimed at improving access to comprehensive and coordinated behavioral health care. They include:

- A new sub-capitation requirement aimed at integrating behavioral health screening and treatment into primary care practices.
- Diversionary behavioral health and substance use disorder services will be renewed and expanded.
- Two behavioral health-focused student loan repayment programs will be funded for 90 new providers a year for four years.
- Care coordination requirements for children with medical complexity will be enhanced.

Accountable Care Organization Re-procurement

MassHealth completed a re-procurement of its ACO program, awarding bids to 17 ACOs, 15 Accountable Care Partnership Plan (ACPP) ACOs, and two Primary Care ACOs (PCACOs) on November 3, 2022.[xix] The new ACO contract period includes many new programs and requirements that will affect behavioral health care for children enrolled in the MassHealth program. Key provisions of the procurement include:

- New provider network requirements for behavioral health services to ensure that participating network providers have the requisite expertise to treat specialty populations and conditions.
- Increasing integration and coordination among all providers, including behavioral health, long-term services and supports, and health-related social needs.
- New requirements for ACOs to implement the primary care sub-capitation payment model, which will facilitate behavioral health integration into primary care.
- Requirements for ACOs to contract with Community Behavioral Health Centers.
- Requirements for network behavioral health providers related to the use of Child and Adolescent Needs and Strengths (CANS) tools.
- New requirements for care coordination and risk stratification.
- Requirements for behavioral health clinical assessment and treatment planning for all MassHealth members initiating treatment.
- Requirements to enhance members' choice of providers.
- Promotion of health equity, including increasing the cultural and linguistic appropriateness of members' care.

Behavioral Health Community Partner Procurement

Behavioral Health Community Partners (BHCPs) provide supports to certain MassHealth and Department of Mental Health members with significant behavioral health needs, including serious mental illness and addiction. This program knits together the work of the ACOs and community-based behavioral health organizations by requiring communication protocols and quality metrics to be developed and met by the partnering organizations. MassHealth will procure BHCPs, and ACOs and managed care organizations (MCOs) will be required to contract with a minimum number of BHCPs to deliver MassHealth-defined supports.

Community Behavioral Health Center Procurement

Beginning in January 2023, Community Behavioral Health Centers will serve MassHealth members throughout the Commonwealth. On July 8, 2022, MassHealth announced the designation of 25 CBHCs, which will incorporate and expand statewide emergency and crisis services and increase availability of outpatient services. Specific services include:

- Youth Community-Based Mobile Crisis Intervention and Youth Crisis Stabilization 24-hour services.
- Adult Community-Based Mobile Crisis Intervention (currently called ESP) and Adult Crisis Stabilization 24-hour services.
- Outpatient services including triage; same-day access for intake; urgent appointment and psychopharmacology access; evidence-based interventions; coordination with primary care; care coordination; support for members with autism; peer and recovery services; and expanded operating hours, including evenings and weekends.

Managed Behavioral Health Vendor and Behavioral Health Specialty Program Procurement

EOHHS' goals for the procurement include expanding access to behavioral health services through the development, implementation, and oversight of the CBHCs; development and oversight of the new 24/7 Behavioral Health Help Line; increasing integration and coordination among providers, including integration of physical health and addiction services; promoting health equity; increasing the quality of care through evidence-based care; and contracting with providers using value-based payments. MassHealth released the procurement on March 17, 2022, and the operational start date of the vendor was January 3, 2023.

Behavioral Health Treatment and Referral Platform

EOHHS contracted with Collective Medical Technologies (CMT) for the creation of a Behavioral Health Treatment and Referral Platform to improve operational efficiencies among providers, health insurance carriers, and the state. The platform will be designed to move patients seeking behavioral health (BH) treatment more quickly through the emergency department evaluation and referral process, reducing the length of stay in the emergency department (ED). It will enable the electronic transmission of standardized admissions information, replacing a largely manual process, and will create a real-time, transparent view of behavioral health patients referred to inpatient psychiatric treatment and community-based acute treatment.

These state initiatives are intended to strengthen and harmonize the many aspects of behavioral health care for MassHealth members, Department of Mental Health (DMH) members, and uninsured individuals. Some of the new services, such as the Behavioral Health Help Line, will be available to everyone in the Commonwealth. The initiatives also provide new opportunities for commercial insurers to contract with these reconfigured systems and providers. It is our hope that the state's positive efforts will continue through to the next administration and the recommendations outlined in this report will complement and coordinate with these efforts.

The Massachusetts Behavioral Health Law

Comprehensive legislation addressing behavioral health care was signed into law by Governor Baker in August 2022. Chapter 177 of the Acts of 2022, An Act Addressing Barriers to Care for Mental Health, includes provisions aimed at reducing wait times for care, reducing ED boarding, addressing workforce capacity needs, and supporting behavioral health care services in schools. Key provisions of the law related to children's behavioral health include:

- **An online portal** to facilitate the coordination of services for children and adolescents who are ED boarding, awaiting residential disposition, or hospitalized in the care or custody of state agencies. The portal will collect data on average wait times, BH diagnoses, state agency status, insurance coverage, and race/ethnicity/language data for these children. It will also provide information on bed availability and enable real-time bed searches.
- **BH promotion in schools,** aimed at strengthening and expanding school-based programs. Key provisions include:
    - A statewide program to provide technical assistance for implementing behavioral health services in each school district.
    - Requiring each school committee to ensure that all schools have written medical and behavioral health emergency response plans.
    - Directing the state to develop performance standards for prohibiting or significantly limiting the use of suspension and expulsion in all licensed early education and care programs.
- **Pediatric planning report.** The Health Policy Commission, in collaboration with the Department of Public Health (DPH), the Department of Mental Health, and the Department of Developmental Services to DPH, will prepare a pediatric behavioral health planning report every three years that details the availability of pediatric

beds; workforce capacity; and any statutory, regulatory, or operational factors that may affect ED boarding.

- **Complex case resolution panel.** A new interagency mechanism will review and resolve cases involving individuals under 22 who are either disabled or have a complex behavioral health need or special need and who qualify or may qualify for services from one or more state agencies. The lack of coordination or clear responsibility for complex cases is frequently cited as a contributor to ED boarding or other delays in placement.
- **Expedited Psychiatric Inpatient Admission Initiative (EPIA).** Chapter 177 codifies EPIA in state law with some important updates. The EPIA Advisory Council will be required to complete an annual report to the legislature including data on the number of patients who are boarding, and include further recommendations for reducing ED boarding, including whether to require 24/7 admissions and discharges, which is viewed as a significant opportunity to reduce bottlenecks across the system. Other requirements for patients under the age of 18 include notification of DMH after a patient has waited 48 hours for admission and notification of the ED boarding patient's pediatrician or treating BH clinician. Improved communication among providers is critical for ensuring appropriate diagnosis and treatment as well as successful transitions of care following discharge from the ED.
- **BH services in the emergency department.** The law requires acute care hospitals to provide for licensed behavioral health professionals in the ED to evaluate and stabilize a person with a BH presentation and make a referral for follow-up care. Individuals under the age of 22 must receive an expedited evaluation and stabilization process. This requirement is expected to not only promote better overall care but also help reduce wait times for admissions, reduce inpatient length of stay, and even reduce the need for inpatient care.
- **Wellness exams.** The law requires health plans to provide coverage for an annual behavioral health wellness exam performed by a licensed behavioral health professional or primary care provider. The BH exam can be combined with the annual physical health preventive visit, which could encourage better integration of behavioral health care into primary care.

New Federal Funding for Children's Behavioral Health

The American Rescue Plan Act (ARPA), signed by President Biden in March 2021, provides Massachusetts with federal aid to help relieve the public health and economic impact of the COVID-19 public health emergency. At the end of the year, Massachusetts allocated $2.5 billion of federal ARPA funds to health care, housing and homeownership, workforce development, and other key priorities as part of a $4 billion state spending plan, pursuant to Chapter 102 of the Acts of 2021. Of the $4 billion, $400 million has been allocated for funding behavioral health care for both children and adults. Please refer callout box on page 14 for itemized funding allocations.

The ARPA also provides incentives for states to introduce or expand mobile crisis services by offering an enhanced Federal Medical Assistance Percentage (FMAP) of 85% for three years of the service, beginning April 1, 2022. [xx] In addition to the ARPA, Congress passed the 2022 Bipartisan Safer Communities Act, which provides funding to encourage states to support a variety of initiatives to enhance school safety, behavioral health programs, and violence prevention.[xxi]

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(ARPA Legislation: $400M in mental and behavioral health funding)

- $198.65M to the Behavioral Health Trust Fund.
- $110M for loan repayment program, including $21M for psychiatrists; $12M for psychologists and primary care physicians, $35M for master's degree-level mental health and primary care professionals including nurse practitioners (NPs), Physician Assistants (PAs), Advanced Practice Registered Nurses (APRNs), pediatric clinical nurse specialists, and licensed BH providers; $20M for bachelor's degree-level mental health and primary care professionals including community health workers, recovery coaches and family partners; $14M for inpatient NPs; and $8M for inpatient mental health workers.
- $1.5M to expand community-based pediatric behavioral health urgent care, particularly for children with complex needs such as involvement with the child welfare or juvenile justice systems, or children with autism spectrum disorders.
- $15M for programs that promote primary care workforce development, recruitment, and retention at community health centers.
- $11.6M for a psychiatric mental health NP fellowship program to recruit and retain psychiatric mental health nurse practitioners at community health centers.
- $10M in grants for assertive community treatment, a model of community-based care for persons with serious mental illness, with $5M of this total dedicated to services for people under age 22 who have been unable to be successful with less intensive levels of care.
- $7M for expansion of behavioral health urgent care services at a federally qualified community health center.
- $5M for an online resource to help find appropriate behavioral health placements for people who are "boarding" (stuck) in emergency departments.
- $5M for a public campaign to promote awareness and use of behavioral health services.
- $5M for grants to Massachusetts public colleges and universities for student behavioral health services.
- $1M to create a school-based behavioral health technical assistance center.

PART TWO

Analysis and Recommendations from the Massachusetts Behavioral Health Community

In addition to compiling the information in Part One of this report, MAHP interviewed 25 behavioral health experts representing Massachusetts health plans, agencies, advocacy groups, educators, and providers. The goal of our interviews was to understand the key issues facing the children's behavioral health system, to learn of specific challenges our interviewees face, and to uncover creative recommendations for change, based on the ideas and experiences of those closest to children.

We gained important insights into how the behavioral health system is organized, including its intersection with primary care; opportunities for improving children's behavioral health, including innovative approaches the interviewees have developed; and their thoughts on new state initiatives.

In this section, we report on eight major areas of concern to our interviewees, the major state and federal initiatives designed to address them, and specific recommendations for what more can be done.

EIGHT AREAS OF CONCERN

1	Lack of Connection and Coordination Among Agencies, Services, and Providers
2	Inadequate Availability of Crisis Services
3	Emergency Department Boarding
4	Inadequate Availability of Easily Accessed Outpatient Services
5	Challenges and Opportunities for Primary Care Provider (PCP) Integration
6	The Uneven and Untapped Potential for School-Based Mental Health and Wellness Programs
7	New Opportunities for Children's Behavioral Health Initiative (CBHI)/ Behavioral Health for Children and Adolescents (BHCA) Services
8	Workforce Issues

KEY CONCERN

I. Lack of Connection and Coordination Among Agencies, Services, and Providers

Interviewees described the challenges related to the current structure of children's behavioral health services in the Commonwealth: how to know what is available, how to access the system, how to navigate through the many child-serving agencies and programs, and how to know that the services are appropriate and of high-quality.

Coordinating Care Across Systems Presents Difficulties

Many of our interviewees noted the excellent work done by many participants in the children's behavioral health system. At the same time, the lack of coordination was a major concern.

- Each program may assign a care manager, leading to multiple care managers for a single child. This is both redundant and confusing.
- The multiagency approach inadvertently supports system fragmentation. Depending on the program and the setting, providers follow the requirements of the agencies with which they work, but the agencies themselves are not always coordinated at a higher level.
- Challenges were reported by pediatricians who often don't have access to their patients' behavioral health records and may not know the full range of medications or treatments they are receiving. This is especially important when young people are being evaluated or treated in urgent and emergency settings. With access to their patients' behavioral health records, pediatricians might be able to provide information about prior or ongoing treatment that could be useful to helping the child in crisis or making decisions about post-emergency department admissions.
- It is difficult to share behavioral health data across agencies and within the larger health care system due to technical challenges as well as hesitancy, stigma, and inconsistency in the interpretation of privacy rules. Entities understandably err on the side of maximum privacy protection. This lack of — or lag in — sharing relevant clinical information poses challenges to care management and coordination.

What is Being Done?

State Initiatives

The EOHHS initiatives outlined in Part One of this report present a vision of a behavioral health system that is easy to access, child and family friendly, non-stigmatizing, and providing the right care at the right location at the right time. The new programs also attempt to make it easier for patients and families to enter the system. Initiatives that support these goals include:

- The new 24/7 Behavioral Health Help Line.
- The Massachusetts Behavioral Health Access website, which provides a searchable database of providers and services, including availability.
- An online portal that supports data exchange between stakeholders and provides real-time access to bed availability.
- Creation of Community Behavioral Health Centers with requirements for timely access, expanded hours, and coordination.

- Family Resource Centers where children and families can find information and support.

- Requirements for collaborative care (an ACO requirement), to bring screening and treatment for behavioral health into the primary care and pediatric setting.

- A new ACO requirement to develop and implement value-based payments for plans and providers. Value-based payments replace fee-for-service billing and can allow more flexibility for providers in designing, implementing, and coordinating services.

Health Plan Initiatives

Massachusetts health plans have implemented various measures and programs to help their members navigate the behavioral health care delivery system and ensure that care is high quality and coordinated.

- Health plans in both commercial and Medicaid programs cover collaborative care codes that reimburse primary care for providing care management support for patients who are receiving BH treatment and for coordinating care through a BH specialist. This helps improve care coordination across treating clinicians.

- Health plans provide access to recovery coaches and recovery support navigators, including recovery coaches on staff at the health plan, who help members with acute behavioral health needs get appropriate services.

- Health plans identify high-risk members and provide access to nurse case managers, behavioral health case management, and appropriate programs.

- Health plans offer programs to help members who have been discharged from the ED comply with their treatment plans.

- Some health plans provide 24/7 access to a Substance Use Disorder Helpline to guide them and their families to evidenced-based treatment.

What More Can be Done?

The recommendations outlined below respond to the challenges described by the interviewees related to the current structure of children's services in the Commonwealth, including difficulty in knowing what services are available, how to access the system, how to navigate through the many child-serving agencies and programs, and how to know that the services are appropriate and of high quality. Recommendations include:

- **Fully implement the Roadmap for Behavioral Health.** This is a priority for the behavioral health community, including providers, agencies, insurers, and consumers. Many elements of the Roadmap address ease of access to services and improve the coordination of services across the behavioral health system.

- **Implement the Behavioral Health Helpline with child-trained staff.** The staff answering the new 24/7 Behavioral Health Help Line must be comprised of professionals who understand the clinical and social needs of children and their families. They need to be able to identify the ways that children present with behavioral health needs, understand developmental differences, and be familiar with the numerous programs for which they are eligible. Examples are referral to a Community Behavioral Health Center for crisis stabilization services and evaluation, referral to a private practitioner or agency, referral for urgent or emergency care, or linkage to DMH or other state agencies and resources.

- **Centralize information and resources.** As part of the help line, information and resources will be available through multiple channels (e.g., telephone, text, web chat, email, website) for families, pediatricians, and schools. The Network of Care, a searchable online directory of behavioral health information, will be available along with other resources through the new help line vendor's provider directory.

    - Having a single location for families, pediatricians, schools, and other users to enter the system and match resources

with patients based on their needs will be invaluable.

- It is critical that resources be culturally and linguistically competent and that they have the capacity to help connect patients and families with social supports.

- Pediatricians need to have information readily available on behavioral health resources and programs such as the Massachusetts Child Psychiatry Access Project. This requires educational efforts that engage pediatricians and ensure that they have access to a centralized inventory of available resources.

- **Improve care coordination across state agencies.** This has been a long-standing — often frustrating — goal of agencies, providers, insurers, and consumers. Currently, treatment can be delayed by indecision and ambiguity about who oversees a case. The Massachusetts Legislature's 2022 Mental Health Bill, Chapter 177, establishes an interagency team to work on complex cases. Interviewees also discussed challenges associated with conflicting or redundant requirements across state agencies charged with licensing or regulating the delivery system. To address these concerns:

  - Create a straightforward process for providing case management services for children and adolescents to better coordinate and streamline services provided across multiple agencies. The goal should be to decrease the redundant application and paperwork process and provide families with a single point of contact.

  - Review provider and program requirements across agencies and insurers to identify and resolve redundancies, unintentional conflicts, and inefficiencies. This should free up resources to support implementation of new programs.

  - Include cross-agency reviews of new programs as part of planning and implementation in order to ensure that consumers will experience a coordinated behavioral health system.

- **Improve integration and sharing of health records.** Care across systems also requires better sharing of data and information. Pediatricians need to be notified when their patients come to an emergency department or seek crisis services and be consulted on the best treatment and placement for their patient. Subject to applicable laws, information on behavioral health conditions and treatments and more general health information needs to be readily available to all who are involved in a child's care. Massachusetts should adopt recommendations from the 2019 Massachusetts Digital Health Council Report to unify patient health records across health care systems and provide patients with access to integrated medical records.[xxii]

- **Align quality measures with policy goals.** Quality metrics and outcome measures should guide policymakers and insurers in decisions about what programs to continue, which to alter, and which to discontinue. Common quality/outcome measures are especially important across state agencies to ensure alignment of requirements and incentives across programs.

KEY CONCERN

II. Availability of Crisis Services

Children with urgent or emergent needs for behavioral health care face a confusing set of choices as to where to go. Finding off-hours, weekend, and holiday walk-in care has historically been difficult, and families in crisis naturally think of the emergency department at the nearest hospital as their first choice.

If an ambulance is called through 911, the child will be taken to an emergency department. This is the case even though the state has funded, for more than 20 years, emergency services that provide community-based and mobile interventions. For children seen in a hospital emergency department, many move next to inpatient care. When children are seen at home or at a community location, they are less likely to move to inpatient care. Even allowing for potential differences in acuity, it is likely that evaluation and initiation of treatment outside the ED is preferable in terms of avoiding trauma and decreasing the likelihood of an avoidable inpatient hospitalization.

Interviewees discussed the need for more same-day access to appointments and more urgent care. There was general agreement that the number of children going to inpatient care could be reduced if timely community-based crisis care or urgent care capacity is available.

What is Being Done?

State Initiatives

- **Urgent Care Centers.** In December 2021, EOHHS announced a Behavioral Health Urgent Care program that includes Mental Health Centers (MHCs) that serve MassHealth members in ACOs or through the Behavioral Health Vendor, currently the Massachusetts Behavioral Health Partnership (MBHP). MBHP administers an attestation process to designate MHCs as Behavioral Health Urgent Care providers. These providers are required to offer same-day diagnostic evaluations, same- or next-day urgent appointments for current clients, urgent psychopharmacology appointments, Medication for Addiction Treatment evaluations within 72 hours, extended appointment hours, and follow-up appointments within 14 days. MassHealth-contracted Managed Care Entities, ACOs, and the Behavioral Health Vendor are required to pay a minimum uniform rate increase over negotiated rates for the specified services provided by Mental Health Centers designated as Behavioral Health Urgent Care provider sites.

- **Pediatric Behavioral Health Urgent Care Centers.** In June 2022, EOHHS announced a new grant program to support and extend pediatric behavioral health urgent care. This $1.5 million program will support the development of after-school and evening services focused on serving MassHealth members under 21. Applicants had to be Mental Health Centers, designated as Behavioral Health Urgent Care providers, that serve MassHealth members in cities and towns that were hardest hit by COVID-19. Grants were awarded to the following providers:

    - Behavioral Health Network, Inc.
    - Center for Human Development
    - Clinical and Support Options, Inc.
    - Gandara Mental Health Center, Inc.
    - Italian Home for Children
    - The Bridge of Central Massachusetts, Inc.
    - Trinity Care Associates, Inc.

- **Crisis consultation for children with autism spectrum disorder.** This is a statewide program, launched in 2020, that provides consultations to Emergency Service Programs (ESPs) and mobile crisis intervention (MCI) teams regarding children with autism or intellectual

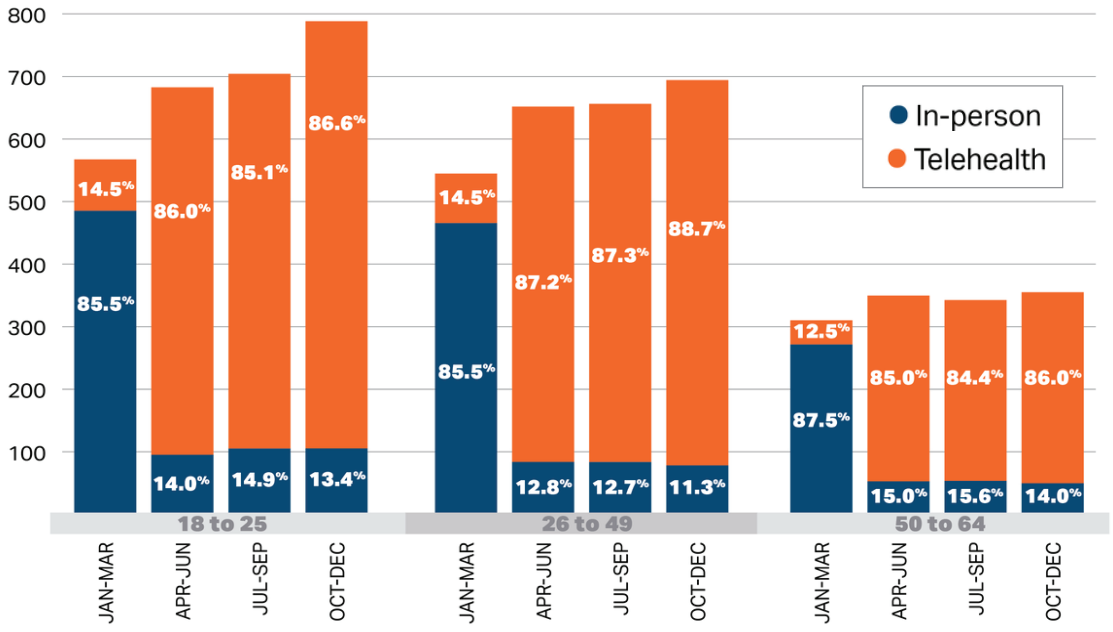
disability who present for emergency care. It offers initial consultations with a licensed behavioral analyst, follow-up consultations with physicians, and seven-day follow-ups. This program is publicly available and not dependent on insurance status.[xxiii]

- **Community Behavioral Health Centers.** The new CBHC model, implemented in January 2023, requires CBHCs to provide Adult Community-Based Mobile Crisis Intervention (replacing the current Emergency Services Program), Youth Mobile Crisis Intervention (expanding the current Mobile Crisis Intervention program), and both Youth and Adult Community Crisis Stabilization services (24/7). CBHCs will also be required to provide urgent outpatient and psychopharmacology services. These requirements are similar to the separately (and earlier) designated Urgent Care Centers and community-based ESPs.

- **Telehealth.** As a response to the COVID-19 pandemic, the Massachusetts health care delivery system made a quick pivot to providing telehealth services, including behavioral health. There was considerable agreement among interviewees regarding the value of telehealth in improving access to behavioral health care services, with one noting, "It was the only good thing that came from COVID." There was broad support for the continued utilization of telehealth for individuals with low to moderate needs and it was viewed as a way to expand access to care and provide greater flexibility for patients and families who could face barriers to in-person care due to a lack of transportation or having other commitments during the day. The Health Policy Commission analysis noted that mental health visits increased during 2020, especially for young adults, with the vast majority delivered via telehealth.[xxiv]

- **Hospital-based services.** Pursuant to Section 32 of Chapter 177, beginning January 1, 2023, hospitals are required to provide or arrange for crisis services in their emergency departments and provide access to a behavioral health clinician for evaluation, treatment, and referral.[xxv] Additionally, MassHealth is requiring that hospitals be responsible for ED-based crisis evaluations and interventions, and disposition determinations.[xxvi]

Figure 2: Total psychotherapy visits per 1,000 members by age group and quarter, 2020



Notes: Includes individuals ages 18-64 with 12 months of enrollment in 2020. Therapy claims identified using Current Procedural Terminology (CPT) codes 90832, 90833, 90834, 90836, 90837 and 90838. Telehealth claims identified using professional claims place of service code 02, CPT code modifiers GT, 95, GQ, and G0.
Sources: HPC analysis of the Center for Health Information and Analysis (CHIA)All-Payer Claims Database, 2020, V 10.0

This is a change from the current ESP or designated emergency department evaluation process. Hospitals will be able to contract with ESPs for services but will retain responsibility for affording crisis services to people who present at the ED.

Health Plan Initiatives

- **Telehealth payment parity.** Beginning March 12, 2020, payment parity was established between telehealth and in-person care for all health services until at least December 31, 2022; for chronic disease management until two years after the end of the state emergency declaration (June 2023); and permanently for behavioral health services.[xxvii]
- **Contracting with Community Behavioral Health Centers.** Beginning in the rate year 2023, health plans operating in the MassHealth and Connector programs are required to contract with CBHCs to provide access to behavioral health services, including crisis services.[xxviii]
- **Urgent Care Centers.** Health plans in the commercial and MassHealth programs contract with urgent care centers. This will be expanded through further implementation of the Roadmap.
- **Incentives to expand access.** Health plans have developed and continue to develop alternative payment methods (APMs) to incentivize providers to expand hours to help address needs after hours and reduce utilization of emergency services.
- **Funding for 24-Hour Behavioral Health Helpline and Crisis Services.** Chapter 126 of the Acts of 2022 (FY23 budget) establishes a Behavioral Health Access and Crisis Intervention Trust Fund, administered by EOHHS, that will pay for the behavioral health access line to connect individuals to behavioral health services, including clinical assessment and triage, and behavioral health crisis intervention services in mobile and community-based settings. Chapter 126 imposes a $33.7 million assessment on health plans to fund the programs for two years.[xxix]

What More Can Be Done?

With initiatives underway to expand access to 24/7 urgent care and crisis services, next steps should center on educating the public about the availability of these services and strengthening after-hours telehealth services to avoid unnecessary ED visits. The following recommendations seek to achieve these objectives.

- Create and sustain a public education campaign about the availability of urgent and crisis services as the new services become available. This was mentioned by several interviewees, who noted that the current culture in health care makes it easier to think of going to an emergency room than going to a community-based location or seeking mobile help. It will take time for habits to change, and some discussed this as similar to other public health initiatives (e.g., ones centered on tobacco use) that take time and require ongoing effort.
- Establish a clear definition for what counts as "crisis services," what community-based services are available, and what urgent behavioral health services are available. There also needs to be alignment between MassHealth and commercial insurers about what constitutes crisis services.
- Continue to build capacity in community-based services to meet increasing demand. The state should collect data on utilization of these services and work with stakeholders to ensure sufficient capacity.
- Health plans should educate members on the availability of urgent care services for behavioral health and consider plan design and provider contracting strategies that will incentivize providers to offer 24/7 urgent care and encourage patients to use these services.

KEY CONCERN

III. Emergency Department Boarding

Boarding in emergency rooms is perhaps the most visible and upsetting indicator of the crisis in children's behavioral health. According to data published by the Massachusetts Hospital Association, there can be anywhere from 30 to over 300 children in a given week boarding in hospital emergency departments, awaiting transfer to inpatient or other settings.[xxx] Other children may be waiting on medical floors in hospitals where psychiatric care is stretched to its limits. Or they may be taken home by their families after waiting too long. Our interviewees raised numerous concerns:

- Emergency room experiences can be unfamiliar at best and traumatic at worst. Staying in an emergency room for days and sometimes weeks is harmful for children and their families.
- The type of issues a child is dealing with can influence the likelihood of their waiting in the ED. The more acute a child's condition is, the more difficult it is to get appropriately placed.
- Children with autism spectrum disorder, medical illness, language or cognitive issues, or aggressive behavior, as well as transgender and nonbinary youth, all face challenges in receiving inpatient care.
- Emergency departments often don't know what options for care are available, and most do not initiate psychiatric care within the emergency department.
- There is an overall lack of beds, despite the state's licensing and funding efforts since 2020. Some beds are licensed but not open due to staffing. Interviewees were concerned about the closing of Tufts Children's Hospital's inpatient unit, which, while not a psychiatric unit per se, did provide care for children presenting at the emergency department and waiting for an admission.
- While most facility contracts require that admissions be open to anyone who presents for care, this often does not happen in practice. Children needing inpatient admission can be judged as "too acute" or in need of services beyond those that a typical inpatient unit offers.
- Once admitted, children who need continuing care (under the jurisdiction of the Department of Mental Health) or residential care, group home, or foster care placement (per the Department of Children and Families) can remain stuck in an inpatient setting because there are no continuing care or residential beds available.
- While they were positive about the goals of the state's Expedited Psychiatric Inpatient Admission (EPIA) initiative,[xxxi] some voiced concerns that the program may be overly focused on data gathering and does not appear to have the "muscle" to make placements happen.

What is Being Done?

State Initiatives

- The EPIA was launched in 2018 and has since been revamped with the input of state agencies, insurers, and providers. Its purpose is to improve communication across stakeholders, to decrease emergency department boarding for patients needing inpatient care, to ensure no one is boarding without an advocate, and to establish baseline information for monitoring and policy purposes. It provides an escalation process that goes into effect when a patient has been waiting in an emergency department for 24 hours, first involving commercial and MassHealth insurers and

then moving to involve DMH if no placement has been secured by 48 hours. DMH then works with EDs/Emergency Services Programs, insurance carriers, and other state agencies (where appropriate) to secure a bed. Special Services Billing Codes are available for services such as single rooms, one-to-one support, and extra staff. Chapter 177 codified the EPIA program into law and created an advisory committee.

- New financial incentives for inpatient and alternative 24-hour behavioral health care beds supported the addition of 288 new beds in 2021, 100 of which are for children. An additional 200 beds, with 33 for children, were scheduled to open in 2022.

- DMH now provides an Emergency Department Diversion Program, partnering with hospitals and providers to offer alternative services where care can be provided at home. These services are now also available through MassHealth.

Youth Villages

Youth Villages, a private, nonprofit organization with locations throughout the U.S. and five locations in Massachusetts, serves children with emotional and behavioral problems and their families. The organization is one of several community-based providers partnering with hospitals to provide diversion services as part of the DMH Emergency Department Diversion Programs, and operates in 13 hospitals. When a youth arrives at the ED of a participating hospital with a mental health crisis, a hospital clinician evaluates them, then calls Youth Villages for another evaluation. If the youth does not need hospitalization and has a safe home environment, the youth is sent home, and a caseworker partners closely with the family, visiting between three and seven times a week for an average of 130 days. The caseworker may develop safety plans, work with parents and teachers, and help the child find a therapist. The services are paid for by DMH.

- EOHHS also procured a vendor to create a Behavioral Health Treatment and Referral Platform, an online portal that will help match patients with open beds by making it easier to see what is available and who is waiting.

EMERGENCY DEPARTMENT (ED) DIVERSION PROGRAMS

Keeping Kids Out of the ED Who Don't Need to Be There

DMH has implemented ED diversion programs aimed at reducing ED boarding by identifying and providing alternative services to youth and adults experiencing behavioral health crises who can be treated more appropriately in community-based settings or with in-home therapy services. Diversion is not appropriate for every patient; however, a significant percentage of individuals who arrive in the ED with behavioral health symptoms could be treated more effectively in an outpatient setting — if the services were available. The diversion programs connect EDs with community-based providers to determine their capacity to deliver the services outside the ED. Treatment is ultimately rendered more quickly and in a more appropriate and less expensive setting.

The DMH Emergency Department Diversion Programs provide programs in 47 hospitals and have provided services to over 482 youth and 1,102 adults, as of December 9, 2022. In addition to DMH funding, in February 2022, MassHealth expanded the intensive crisis intervention services and in-home therapy services. Hospital emergency department diversion programs will relieve long-standing challenges with ED boarding, which escalated during the pandemic, while expediting behavioral health treatment for youth and support for their families.

- New services and approaches that will accompany the Behavioral Health Roadmap are designed to directly and indirectly reduce ED boarding. The emphasis on crisis services, urgent care, and same-day services is designed to provide "upstream" care that will reduce the need for hospitalization.

Initiatives by Providers and Health Plans

Providers are implementing innovative approaches, like telehealth programs for children waiting in emergency rooms so they can begin treatment while awaiting placement.

MAHP-member health plans, in both the Medicaid and commercial programs, have implemented a variety of measures to address emergency department boarding, including:

- Having dedicated teams to implement internal policies and protocols for the EPIA, in order to find appropriate placements for their members, reduce wait times in the ED, support members and families in crisis, and ensure that members have access to the care that they need.
- Providing 24/7 telephone access as part of the EPIA process to respond to notifications of ER boarding and requests for assistance.
- Authorizing and paying for "special services" such as single rooms, extra staffing, one-to-one care, and high-cost medications.
- Partnering with Applied Behavior Institute to offer up to eight hours of autism consultation to families waiting in an emergency department for autism spectrum disorder services.
- Implementing care management services to coordinate care following discharge.
- Working with EDs to establish payment mechanisms that ensure appropriate reimbursements for EDs providing BH treatment and services to patients while they are boarding.
- Partnering with network providers to expedite placement, provide diversion, and expand access to upstream treatment and services in order to prevent ED admissions.

What More Can Be Done?

Interviewees had multiple suggestions for addressing ED boarding. They can be grouped into those that focus on the community and those that are aimed at earlier access to care, diversion, and ensuring an appropriate supply of inpatient beds to meet the needs of the Commonwealth's children. Some of the recommendations were ultimately included in whole or in part in the Massachusetts Legislature's 2022 Mental Health Bill, Chapter 177, as noted below.

Community Initiatives

- Interviewees expressed hope that with the greater availability of crisis services coming through the Community Behavioral Health Center procurement will lead to greater use of mobile crisis intervention (MCI) instead of EDs. This will require education of pediatricians, schools, and parents about how MCI works and when they should call.
- The state should implement requirements (included in Chapter 177) for timely notification of pediatricians and other treating clinicians whenever a child is in an emergency room in order to ensure that the people who are most familiar with the patient are involved in care decisions. This can potentially reduce the time spent in the ED, help find appropriate treatment after an ED discharge, and ensure timely follow-up care.
- Conduct a thorough assessment when children use crisis services to determine whether they can be directed to non-inpatient options like at-home diversion services, crisis stabilization beds, and intensive day treatment at partial hospitalization programs. Also, expand these emergency department diversion programs.
- Improve identification and management of low-to-moderate-need children. Children with low-to-moderate needs will benefit when providers/ACOs can offer them outpatient services appropriate to their situations.

Providing easy access to information and treatment, monitoring situations that could become acute, and intervening, when necessary, can help prevent problems from becoming acute.

- Improve identification and proactive intervention for children at high risk of hospitalization to make sure appropriate services are in place. For children with multiagency involvement, the precrisis designation of a clear "lead" care manager with decisional authority and responsibility could help prevent disagreements and delays from arising in these situations.

System and Access Initiatives

- Ensure access to specialty beds using data on the populations that are more likely to face longer wait times — for example, children with autism spectrum disorder, higher levels of acuity, developmental disabilities, aggressive behavior, and complex medical needs.
- Convene a discussion with stakeholders to address funding and a rate structure to fund higher-intensity beds.
- Use the Determination of Need program to encourage and approve new beds targeting inadequate services.
- Require hospitals to initiate behavioral health care treatment in their EDs, with minimum requirements defined by DPH (included in Chapter 177).
- Expand virtual partial hospitalization programs for patients waiting in emergency departments.
- Support more community-based care and avoid ED admissions by changing state regulations that require ambulances to bring patients to an emergency department. Allow them to bring patients to other levels of care, enable CBHCs and urgent care centers to perform medical clearance, and require freestanding acute psychiatric hospitals to allow for community admissions.

KEY CONCERN

IV. Access to Behavioral Health Outpatient Services

Interviewees universally described the difficulties in accessing outpatient services as a major concern. Factors affecting this include a shortage of behavioral health providers overall; providers who will not accept insurance; an overdependence on a traditional "assess, diagnose, and individually treat" model that medicalizes some issues that could be addressed in other ways and settings, including schools; and a BH system configuration that has limited after-hours and walk-in capacity. We heard about long waitlists and unavailable providers, even when they are listed as network members for insurers.

COVID-19 exacerbated these issues but also led to an increase in telehealth services that made access easier. Interviewees hoped that telehealth can continue and grow and stressed that it needs to be compensated at the same rates as in-person services. Providers also mentioned the limitations of telehealth in treating children, noting difficulties in establishing a strong therapeutic alliance without face-to-face sessions and difficulties in assessing clinical progress when limited to on-screen facial observations.

What is Being Done?

State Initiatives

The Behavioral Health Roadmap will provide several ways to improve outpatient access.

- The Behavioral Health Help Line is intended to make it easier to find available resources.
- Community Behavioral Health Centers will be required to provide same-day access for intakes and urgent appointment access.
- Treatment will have to be goal oriented, trauma informed, and evidence based. This emphasis should make treatment more efficient and effective, freeing up capacity for those in need.

The Roadmap, the ACO procurement, and the MassHealth waiver all require that pediatricians and primary care physicians assume more responsibility for the behavioral health of the children they serve. Screening, brief integrated treatment, and "warm handoffs" to behavioral health specialists are all intended to serve children and families in less stigmatizing settings and reduce demand on the specialty behavioral health system.

Initiatives by Providers and Health Plans

Providers responded creatively to the unique challenges of COVID-19. Rapid expansion uncovered both the advantages and shortcomings of telehealth. Some providers used telehealth and group therapy as a bridge to connect with children in need while waiting for an individual therapist to become available. In some instances, these sessions were sufficient to meet the child's needs and did not convert to individual therapy.

- **Reimbursement rates for providers.** The Massachusetts Legislature's 2022 Mental Health Bill, Chapter 177, requires health plans to establish a base fee schedule for the reimbursement of behavioral health providers for evaluation and management codes that is not less than the base fee schedule used for evaluation and management services for primary care providers.
- **Expansion of telehealth.** Health plans have expanded access to behavioral health care services through innovative online and technology-based applications.
- **Provider directories.** MAHP and our member plans have participated in the Massachusetts Provider Directories Task Force with the goal of implementing comprehensive and accurate provider directories for consumers in Massachusetts to ensure that members can access comprehensive and accurate information about providers in their network.

Riverside Life Skills Centers are supportive therapeutic programs for adolescents ages 12–18 who are experiencing significant emotional difficulties or a psychiatric diagnosis as well as disruptions in their home, school, or community. These centers are designed to accommodate teens with significant mental health issues and learning challenges, including but not limited to:

- Anxiety and depressive disorders
- Attention and learning disorders
- Mood and psychotic disorders
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Dual-diagnosis conditions

Clinical & Support Options (CSO) aims to provide responsive and effective interventions and services to support individual adults, children, and families committed to the values of open-access, trauma-informed care. CSO provides same-day walk-in visits for outpatient and crisis services in all CSO locations. CSO runs Family Resource Centers that are free and available to any child or family. Programs covered by CSO include:

- Family support programs
- Community-based programs
- Mental health and addiction recovery programs
- Crisis programs
- Housing and homelessness programs

What More Can Be Done?

Actions can be taken to increase the number of available providers and/or to develop and support new ways of providing outpatient services.

- **Alternative payment methods (APMs) for behavioral health providers.** To increase the availability of outpatient services for insured patients, providers that do not now accept insurance could be incentivized to join networks through the development of new behavioral health ACOs or provider organizations that bring together groups of providers that would accept some form of APM to be responsible for a patient's overall BH needs. Outpatient services could also be thought of more broadly to include nontraditional services and providers, including family partners, peers, therapeutic mentors, and others. This will require developing models for how to fund these services, including value-based payments.
- **Alternatives to individual therapy.** Outpatient services can be increased through services provided in school settings and greater use of family therapy and group services as alternatives to individual therapy. Support for parents should be integrated into care for children. Health plans should work with network providers on practice management to assist practices and in developing updated models of care.
- **Integration of behavioral health into primary care.** Access will also be broadened by further development of collaborative care with pediatricians and PCPs partnering with behavioral health professionals. One goal of these models is to provide behavioral health care for persons with low-to-moderate needs within the primary care setting, thus decreasing demand for more traditional outpatient services.
- **Expansion of telehealth and technology-based applications.** The state should convene a forum to study and develop standards for the appropriate use of telehealth and digital tools for behavioral health. Health plans can play a role in working with digital health companies to pilot programs and develop evidence-based data to evaluate the appropriateness and effectiveness of such programs for behavioral health.
- **Evidence-based treatment.** The state should work with stakeholders to develop and implement evidence-based treatment standards for the delivery system.
- **Participation in MassHealth.** The state could also require Massachusetts-licensed professionals to participate in MassHealth to some degree. This idea is incorporated into the proposals for student loan repayment for behavioral health professionals that is part of the waiver.

KEY CONCERN

V. Primary Care Provider Integration

Integrating pediatric and primary care with behavioral health care is seen as a goal for much of the health care system. These models, which are supported by research, shift responsibility for behavioral health screening, providing brief treatment and referral from behavioral health specialty providers to the primary care setting. They are designed to identify problems earlier and to provide more timely care, hopefully before problems escalate.[xxxii]

Interviewees were mostly positive about this approach. Several did note that moving behavioral health providers into pediatric practices might make the provider shortage worse, and certainly no better. However, staffed with appropriate child-trained providers to conduct screening, assessments, referrals, and some treatment, pediatricians can improve access to care for low-to-moderate-need children, thus freeing up resources and capacity elsewhere in the delivery system.

What is Being Done?

State Initiatives

- The Roadmap, the ACO requirements, and the MassHealth waiver all support integrated care. Currently, PCPs (including pediatricians) are required to perform periodic behavioral health screening for all MassHealth members under 21. Standardized screening tools are required, and positive screening results must be followed up with counseling, further screening, or referral to specialty services. Also, starting in 2015, MassHealth offered training and support to both PCPs and BH providers in how to develop collaborative care services.

- Commercial health plans, MassHealth MCOs, and MassHealth ACOs cover the psychiatric collaborative care model provided to members through PCPs. These services can be billed by a primary care practice utilizing a set of codes, as prescribed in Chapter 177.[xxxiii] This model will help improve care coordination across treating clinicians.

- The Massachusetts Child Psychiatry Access Program (MCPAP) is an important resource available to pediatricians, providing real-time consultation support for assessment, use of behavioral health medications, and referral assistance. This statewide program is available to all pediatricians and children, regardless of insurance plan.

Health Plan Initiatives

- Health plans work with providers to encourage integration of behavioral health and primary care. MCOs participating in the Medicaid program work closely with their ACO partners to integrate BH into primary care practices. While the experience was reported to be difficult initially, progress is being made each year. Health plans that have put in place requirements for integration have reported greater success with achieving integration.

- MCOs and ACOs utilize data to identify members for BHCPs referrals and identify members for targeted outreach for BH services, discharges, and coaching to improve member coordination and care.

- Health plans work closely with primary care providers and pediatricians to support the integration of behavioral health into the primary care and pediatrician offices.

Example

One of the MAHP member health plans has embedded health plan care managers into pediatric practices to provide on-site and telephonic behavioral health services. The care managers, through access to electronic health records and coordination with the practice staff, connect patients and families to community-based services and help them access the delivery system.

What More Can Be Done?

Health plans, PCPs, and providers can work together to support and build upon the initiatives in the Behavioral Health Roadmap for primary care and behavioral health integration. As mentioned above, screening and treatment in the PCP setting can identify and address issues at an earlier stage.

- **Alternative payment methods (APMs) to incentivize transformation.** Health plans can incentivize and support practice transformation and integration through the use of alternative payment methods linked with integration requirements and through sharing data and analytics with practices.

- **Support investments in primary care and behavioral health.** The proposal to increase funding for primary care and behavioral health by 30% over the course of three years, if implemented, can provide needed resources to support building integrated programs. MAHP has supported this proposal as a way to facilitate transformation by providing more resources to primary care and behavioral health.

KEY CONCERN

VI. School-Based Behavioral Health and Wellness Programs

Broadening the scope of interviews to include school-based professionals provided important information about children's behavioral health challenges and opportunities. Because virtually all children are attached to school systems and because school experiences and relationships are so important to their development, schools have unique opportunities to affect children's behavioral health.

The Massachusetts Department of Elementary and Secondary Education (DESE), local school systems, and Boston Children's Hospital (BCH) all provide resources and direction for schools. Interviewees told us about the extensive screening and behavioral health wellness education (including suicide prevention) that takes place in many schools. Also, at school, social needs of children and their families are observed and schools attempt to meet these needs.

Schools employ social workers, psychologists, and other health professionals to meet needs for screening and treatment. Some also establish relationships with community providers who provide treatment in school settings. Funding and billing for services are not uniform and schools often have to rely on philanthropy and hospitals to support programs.

Health plans were reported as both helpful and limiting. Health plans reimburse for covered services provided to their members, but benefits may differ between fully insured health plans, self-insured health plans, and government programs, and members can move from plan to plan. Also, health plan involvement requires that the child be seen in the "assess, diagnose, and refer to treatment" framework that some described as not optimal for addressing children's issues. The most positive descriptions about school behavioral health involved using professionals who were hired by the school system and who were not dependent on insurance billings, and who were thereby not limited to a "screen, diagnosis, treat" medical model. Therefore, school-based programs have more flexibility to design and implement programs that meet the needs of their students.

Interviewees also spoke of the significant contribution of social factors to the stresses and behavioral health challenges for children, all of which were exacerbated by COVID-19. One interviewee noted that issues of race, poverty, stigma, and family insecurity impact many children, especially those in urban settings. They discussed how we must view the whole community, not just the individual child, as the client when thinking about children's behavioral health.

What is Being Done?

State, School, and Hospital Initiatives

DESE, the Department of Mental Health (DMH), BCH, the Massachusetts School Mental Health Consortium, and local school districts are all actively involved in improving school mental health services.

- DESE, through community organizations, has offered free professional development and training in school mental health and well-being services. The Youth Mental Health First Aid training program provides teachers, school staff, parents, and others with tools to recognize, support, and refer children who are experiencing and exhibiting signs of mental distress. Follow-up technical assistance is available to help schools develop multitiered systems for student support.
- With DESE, the Massachusetts School Mental Health Consortium manages the Collaborative Improvement and Innovation Network. Selected school districts work in a learning collaborative framework, facilitated by the National Center for School Mental Health, to

support the establishment of comprehensive school mental health systems. As of 2022, 11 schools throughout the state are participating in the program.

- DMH funds several programs involving schools. The Intensive Residential Treatment Program combines DMH and DESE efforts to provide both education and treatment for children with serious emotional disturbances. DMH also provides therapeutic after-school programs.
- Boston Public Schools' Behavioral Health Services Department, in collaboration with Boston Children's Hospital and the UMass Boston/ School Psychology Program, has implemented a Comprehensive Behavioral Health Model (CBHM) that integrates tiered supports and services within a school according to student needs and utilizes family and community partnerships. Currently there are 76 schools that have joined CBHM. The program offers an extensive set of behavioral health services, provided by more than 100 school psychologists, 150 school social workers, and 20 behavioral health partners. The model includes an outline for school districts to provide behavioral health services for all students. Social-emotional learning and universal screening are combined to identify students at elevated risk for developing social, emotional, or behavioral health issues, then the program organizes and monitors targeted interventions.
- The Boston Children's Hospital Neighborhood Partnerships Program works with urban schools and health centers. They provide group work, crisis intervention, and teacher training in partnership with the Boston Public Schools and support the Bridge for Resilient Youth (BRYT) program, providing a bridge back to school for students who have had a long absence from school due to emotional disturbances. The BRYT program, originally developed at the Brookline Center for Community Mental Health, is used at many Massachusetts schools and is now a national model for meeting the needs of this group of high-risk children.
- Boston Children's Hospital funded the creation of the Behavioral Health Integrated Resources for Children (BIRCh) project at the University of Massachusetts. The BIRCh project is funded through a $5 million grant by Boston Children's Hospital distributed to 16 funded partners through its Collaboration for Community Health. The program includes professional development and online training for school mental health professionals on evidence-based school mental health interventions, social-emotional learning practices, universal screening, and more. The BIRCh project is also performing a resource-mapping project to identify regional assets and needs, provide information to schools and families, and guide advocacy.

What More Can Be Done?

- **Defining roles and funding sources.** Better defining available funding and responsibilities of schools, insurers, and state agencies would allow schools to maximize the resources available to help students. This involves questions about who will fund screening, wellness education, and brief treatment in the school setting. It could also involve more joint projects within schools, staffed by professionals from different organizations. School-based services can be further strengthened by connections to pediatricians and the behavioral health delivery system to promote integration, care coordination, transitions of care, and data sharing.
    - A statewide taskforce made up of school districts, health centers, payers (MassHealth and commercial), and DESE could be convened to address specific issues such as what services are provided, coordination with the delivery system, and funding.
- **Staffing support.** Supporting schools in their efforts to recruit and retain behavioral health professionals is essential. Ideally, schools would employ or have access to a social worker, a psychologist, and other health professionals. Additionally, keeping school staff up to date on evidence-based treatments and new approaches will increase their effectiveness.
- **Schools as communities.** Broadening the view of what schools can do is another opportunity for action. Envisioning schools as communities where both individual and family needs are considered and addressed, including social needs (e.g., food, housing), could provide a strong platform for providing care.

KEY CONCERN

VII. New Opportunities for CBHI/BHCA Services

In 2009, the Children's Behavioral Health Initiative (CBHI) services became available to MassHealth members in response to the "Rosie D" lawsuit regarding community-based care for children with serious emotional disturbances.[xxxiv] The CBHI program is limited to children who are MassHealth members. CBHI is a wraparound program of intensive home- and community-based children's and family services, including mobile crisis intervention and universal screening by pediatricians to identify children who are eligible for the services. The program continued, mostly unaltered, under the supervision of the court monitor until June 19, 2021, when Judge Richard Stearns issued an opinion that found that the state was in compliance with the court's 2007 remedial order, thereby terminating the order.

In 2019, commercially insured children became eligible for a similar program, Behavioral Health Services for Children and Adolescents (BHCA), when the Division of Insurance (DOI) expanded requirements for health plan coverage of behavioral health care services for children and adolescents. The DOI required fully insured Massachusetts health plans to cover the following services: In-Home Behavioral Services, Family Support and Training, In-Home Therapy, Therapeutic Mentoring, Mobile Crisis Intervention, Intensive Care Coordination, Community-based Acute Treatment for Children and Adolescents (CBAT), and Intensive Community-based Acute Treatment for Children and Adolescents (ICBAT).[xxxv]

We were interested in learning what interviewees thought about the success of CBHI/BHCA and what its future should hold. First, all interviewees expressed positive perceptions about the overall usefulness of the program and thought it important that it continue. Second, they did see areas for improvement, including assessment tools, outcomes monitoring, administrative procedures, integration with schools, fee scales for CBHI/BHCA clinicians, and making it easier to find the most appropriate services, especially where agencies supply only one or two of the program services. Third, several interviewees voiced a concern that absent the court monitor, fidelity to the model might begin to erode and services might be pushed aside as other programs come online, especially if there is competition for the limited pool of trained staff who provide these services.

What is Being Done?

In response to the COVID-19 pandemic, MassHealth updated its telehealth policy to enable initial CBHI assessments to be done by telephone.

What More Can Be Done?

Interviewees offered positive perceptions about the overall usefulness of the program and thought it important that it continue. Now that the court has released the state from continued monitoring, interviewees saw an opportunity for improvement and modification of certain programmatic requirements to build upon the successes and ensure continued access to services.

- **Update CBHI requirements.** Interviewees expressed interest in working collaboratively with the state and each other regarding reviewing and adjusting the CBHI/BHCA procedures. Suggestions for improvement included:
    - Modify the requirement that a clinical professional must call each family on the waiting list every two weeks.

While checking in with families was seen as useful, it was suggested that this function could be performed by a non-licensed staff person.

- Expand the pool of providers able to deliver CBHI/BHCA services by modifying the levels and kinds of staff allowed to provide some services while monitoring accountability. An example of this would be using family partners more frequently.

- Broaden CBHI/BHCA to include school staff in some new capacity.

- Make it easier for families to find the most appropriate services, especially where agencies supply only one or two of the program services.

- Review payment levels for CBHI/BHCA staff to make them more competitive with other service opportunities within the behavioral health system.

- Improve coordination and alignment between CBHI and BHCA programs.

KEY CONCERN

VIII. Workforce Issues

Workforce issues were among the most frequently discussed topics in our interviews with respondents from all parts of the health care system. Although Massachusetts is fortunate in both the size and the expertise of the behavioral health provider community, the consensus among organizations, consumers, advocates, and providers is that the system needs more providers, more specialists, more facilities, and more programs and services.

Experienced professionals are increasingly hard to find and competition for them is stiff. Each new program or facility that is built depends on the same pool of practitioners. Providers who do not accept insurance — commercial, MassHealth, or both — are available only to patients who can afford to pay out of pocket for all or part of their treatment. For every 10 clinicians entering the workforce in Massachusetts behavioral health clinics, 13 clinicians leave. Children and adolescents spend an average of 15 weeks on a waitlist before starting ongoing therapy.[xxxvi]

Providers described the challenges of both recruiting and retaining staff due to the difficulty of the work and the relatively low pay. We heard of the inordinately long time it takes to fill open positions and the diminishing number of applicants. Provider stress, low pay, student loans, and difficult work, especially when entering the field, were all cited as growing problems. In some instances, licensed inpatient beds cannot be opened due to a lack of staff or programs have to be curtailed.

- Some providers are leaving the field for other careers or moving to states with lower costs of living.

- New programs and new requirements result in staff moving from one program to another, leaving the older program short-staffed. Surprisingly, school programs reported an easier time recruiting staff compared to behavioral health providers and institutions.

- A significant number of behavioral health providers do not accept insurance. They cite administrative requirements and their ability to charge higher rates as reasons for choosing to only accept private payment.

Interviewees cited specific provider shortages, especially providers who accept insurance, including prescribing providers (nurse practitioners and child psychiatrists), autism specialists, providers who are persons of color, multilingual providers, providers who use American Sign Language (ASL), and providers with expertise in caring for LGBTQ+ patients. The Blue Cross Blue Shield of Massachusetts Foundation report on the behavioral workforce identified opportunities to increase supply for the Massachusetts behavioral health workforce and enhance its diversity to meet the needs of the state.[xxxvii]

The Challenges of New Programs

As noted in the report, the state is currently procuring many new programs and making more financial resources available to develop them. Our interviewees were enthusiastic and positive about most of these efforts. However, they also pointed out that when new programs are added, with the attendant new requirements for staffing and programming, older requirements may be changed, reduced, or eliminated. This can lead to difficulties in staffing and resource use if new programs are more attractive or have higher-paying positions than those already in place. Providers did not think it likely that the overall pool of qualified, interested behavioral health workers at any level would expand sufficiently to meet these needs.

What is Being Done?

State Initiatives

MassHealth will use federal funding under the American Rescue Plan Act (ARPA) to enhance, expand, and strengthen certain Medicaid home- and community-based services (HCBS) and behavioral health services.

- EOHHS used additional funds available from ARPA and Medicaid to provide rate increases from July 2021 through June 2022 to support HCBS and behavioral health workforce development. These investments are aimed at strengthening and stabilizing the state's HCBS and behavioral health workforce in response to the COVID-19 public health emergency. According to the quarterly spending plan, since 2021, the state has infused approximately $966 million gross ($526 million net) into the behavioral health system. The state plans to make investments in three rounds of funding to support the HCBS workforce, access to and promotion of HCBS services and supports, and HCBS technology and infrastructure. The $526 million will be funded using the enhanced federal ARPA HCBS dollars, and the remainder will be funded through traditional Medicaid dollars.[xxxviii]

- The state also provided student loan repayment to behavioral health professionals under the current MassHealth waiver of up to $50,000 for a four-year commitment to work in community-based settings. In the new MassHealth waiver, the state proposes to make available two behavioral health student loan repayment programs for 90 new providers a year for four years. Licensed BH clinicians can receive up to $50,000 if they make a four-year obligation to work in community-based settings that serve MassHealth members. Psychiatrists or prescribing nurse practitioners can receive up to $300,000 per clinician if they make a four-year commitment to maintain a patient panel or work in an organization where at least 40% of the panel are MassHealth members or uninsured.

- It is also anticipated that training funds will become available to higher-level institutions for training behavioral health providers. Some providers are working to partner with these institutions to develop pipelines to positions within their organizations.

- To help address provider administrative requirements, the Roadmap also includes initiatives that will reduce administrative and payment burdens, with the aim of encouraging providers to accept insurance and broaden insurance coverage, including streamlining the credentialing process in the Medicaid program. Massachusetts health plans have implemented standardized credentialing since 2006. Using a common vendor, Health Care Administrative Solutions, Inc. (HCAS), health plan provider credentialing became centralized and streamlined. HCAS provided a single point of entry for providers to submit credentialing information that HCAS participating health plans use to verify a provider's qualifications prior to network participation. HCAS participating health plans partner with CAQH® to collect and store a provider's credentialing information. Information is collected one time from providers, reducing the need to submit multiple applications to different sources. While providers continue to report credentialing delays, the issues stem from the MassHealth credentialing process and not the plans, therefore it is important that MassHealth participate in the uniform credentialing process going forward.

- Throughout the state's current re-procurement, expectations are incorporated about the necessity of developing alternative payment mechanisms to move away from fee-for-service billing. These changes can potentially improve a provider's cash flow and reduce the stresses of depending chiefly on producing billable hours. APMs can also encourage the use of peers, recovery coaches, and bachelor's degree-level staff to provide more flexible services. MassHealth coverage is expected to be expanded to cover such staff.

- As of January 2023, independent social workers and psychologists are able to bill MassHealth, an important change that will expand the availability of providers who accept public insurance for behavioral health conditions.

Health Plan Initiatives

Health plans have implemented several policy changes and initiatives aimed at expanding access to providers and improving care.

- As part of the response to the COVID-19 pandemic, health plans implemented policies to fast-track provider credentialing.
- Health plans today reimburse for services provided by recovery coaches and peer supports.
- Chapter 177 requires health plans to reimburse providers who are working toward licensure, as a means to expand access to providers.

What More Can be Done?

Immediate solutions to workforce shortages in behavioral health are hard to find, whether the challenge is supporting and retaining current providers or finding additional providers. However, interviewees made the following recommendations:

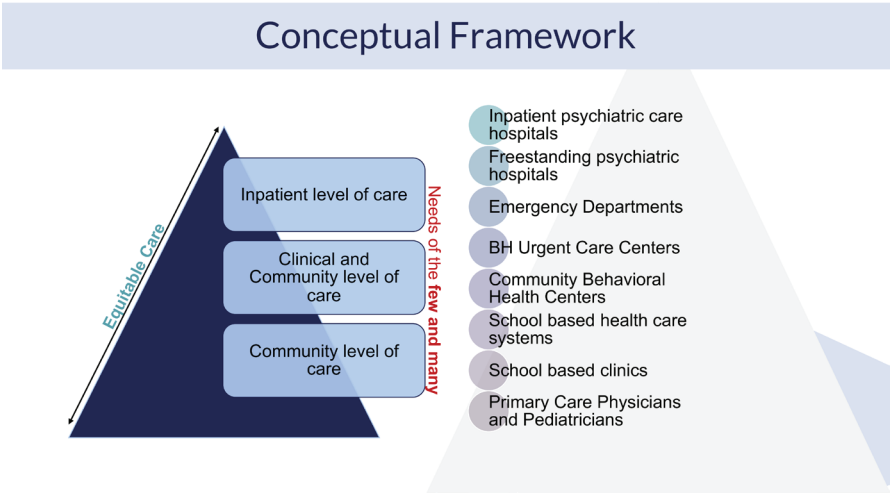
- **APMs for behavioral health.** Supporting and retaining current providers could include developing more satisfying work environments by modifying the fee-for-service billing element of most behavioral health jobs. Value-based payments can provide a platform for more flexible work. For inpatient BH providers, providing safer and more predictable work environments would also improve staff satisfaction.
- **Hybrid telehealth programs.** More providers, including specialty providers, could be made available through innovative hybrid models of telehealth/in-person services. One example involves bringing specialty providers to a site once every six weeks or so to see patients in person and then providing telehealth sessions in between. Another method for expanding access could include contracting with companies that provide care for persons needing more specialized services.
- **Expanded use of peers.** Expand the use of peer services and other nontraditional providers.
- **Continued expansion of telehealth.** Continue to utilize telehealth, where appropriate, to increase the capacity and availability of providers.
- **Credentialing.** Continue to fast-track provider credentialing and state licensure applications.
- **State programs.** Continue and expand state programs and resources for loan forgiveness, grants, training, and provider-school partnerships designed to train and recruit providers, especially in underserved communities.

Conclusions and Summary Recommendations

Throughout our interviews, and from reviewing the many initiatives underway by the state and provider community, we were impressed and encouraged by the dedication to improving the behavioral health of children in the Commonwealth. When we spoke to organizations outside the state, they pointed out that Massachusetts is seen as a leader with more resources and expertise than many other states.

We began this initiative by asking how the behavioral health system could meet the needs of all of our state's children (the many) as well as the needs of those children with severe emotional conditions (the few). The chart below illustrates how a properly working and coordinated system might be organized, with a sufficiently resourced and staffed primary care and school-based system addressing the needs of the many, thereby ensuring capacity at the top of the triangle for children with higher needs.

Figure 3: Conceptual Framework for Behavioral Health Delivery System



At the same time, Massachusetts is vulnerable to the national crisis in behavioral health. EOHHS has set forth a comprehensive approach to alleviating this crisis and supporting the development of a newly invigorated behavioral health system. The state's vision is expressed in the Behavioral Health Roadmap, which calls for changes throughout the system. In Chapter 177, the legislature addressed the need to improve access to behavioral health care, enhance data collection and communication, reduce wait times, and streamline the state's delivery of services.

Much has been done in Massachusetts through both state and private actions to address behavioral health services for children, and there are numerous programs and services available for children and families. However, a frequently heard concern was that patients, families, and providers need to be better informed and educated about available programs and services and that services need to be better coordinated, integrated, and connected in order to provide seamless care and ensure that patients don't fall through the cracks.

While interviewees brought with them different perspectives and priorities, there was a strong consensus about the need to continue improving the ways behavioral health care services are delivered across the Commonwealth. Recognizing the vast amount of work that has already been done, we asked interviewees for recommendations on additional changes or reforms to improve the system. While their recommendations are reported in detail above, we recognize that identifying a place to start is often daunting. Following are the steps that we believe policymakers could begin immediately.

SUMMARY RECOMMENDATIONS

- Fully implement the Behavioral Health Roadmap.
- Create a public education campaign regarding availability of urgent care and crisis services.
- Develop and support specialty services for high-need children.
- Widen the scope of children's behavioral health programming to incorporate school-based behavioral health.
- Coordinate care for children receiving services from multiple agencies.
- Integrate behavioral health into pediatric primary care settings.

We would like to extend our sincere appreciation to everyone who participated in this project, and we look forward to further collaboration on improving access to and the delivery of behavioral health care services for children and their families.

Appendix

MAHP surveyed and collected data from six MAHP-member commercial health plans for calendar years 2019 and 2020 around enrollment, children with behavioral health as a primary diagnosis, and utilization trends. The data was collected across five regions — Boston/Metro Boston, Western, Central, Northeast, and Southeast regions, respectively — and by age. For the purposes of the below findings, MAHP-member plans refer to the six commercial health plans that shared their data for the study, which are:

- AllWays Health Partners
- WellSense Health Plan
- Connecticare
- Fallon Health
- Health New England
- Point32Health

Children and youth enrolled in MAHP-member plans

Our survey found that 54% of children were covered by MAHP-member MassHealth ACOs and MCOs, 41% were covered by commercial insurance, and 5% were covered by Connector plans.[xxxix]

- In 2020, enrollment in MAHP-member commercial and Connector plans decreased by an average of 6% while enrollment in MAHP-member MassHealth ACOs and MCOs decreased by 0.2%.
- In 2020, the highest rates of children enrolled in the MAHP-member MassHealth ACOs and MCOs are from the Boston/Metro Boston region (23%) followed by the Northeast region (22%).
- The Western region had the lowest rates of covered children under commercial health plans (7%) and the Connector (8%) plans.
- Five percent (5%) of the total kids enrolled in Massachusetts plans are either living out of state or do not fall into any of the five regions.

Geographical distribution of children with BH diagnoses

- The highest percentage of children receiving BH services covered by MAHP-member MassHealth ACOs and MCOs were from the Western region (25%), followed by the Boston/Metro Boston region (22%).
- For the commercial-only plans, the highest percentage of children were from the Boston/Metro Boston region (29%) followed by the Central region (20%).
- The Western region had the lowest rates for commercial-only (8%) and Connector (10%) plans. In 2020, 11% of children were enrolled in commercial MA plans but either were based out of state or did not fall into any of the five regions that had primary BH diagnoses.

Age distribution of children with BH diagnoses

- A majority of children with primary BH diagnoses were aged 13 to 17 across all lines of business, followed by children aged 7 to 12.
- MAHP-member MassHealth ACOs and MCOs saw an increase in children aged 6 months to 2 years with primary BH diagnoses.
- Commercial-only plans saw a decrease in children with primary BH diagnoses across all regions and ages.

Figure 4: Youth with Primary BH Diagnosis 2019–2020 by Region

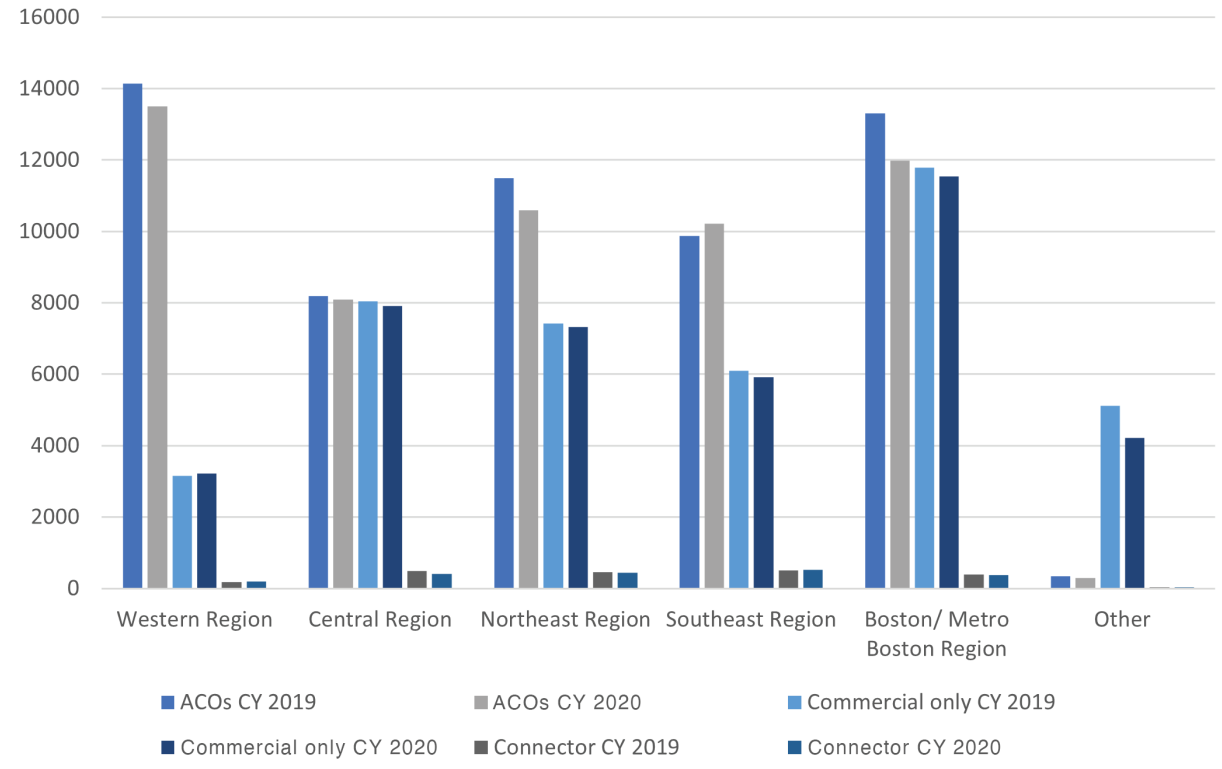
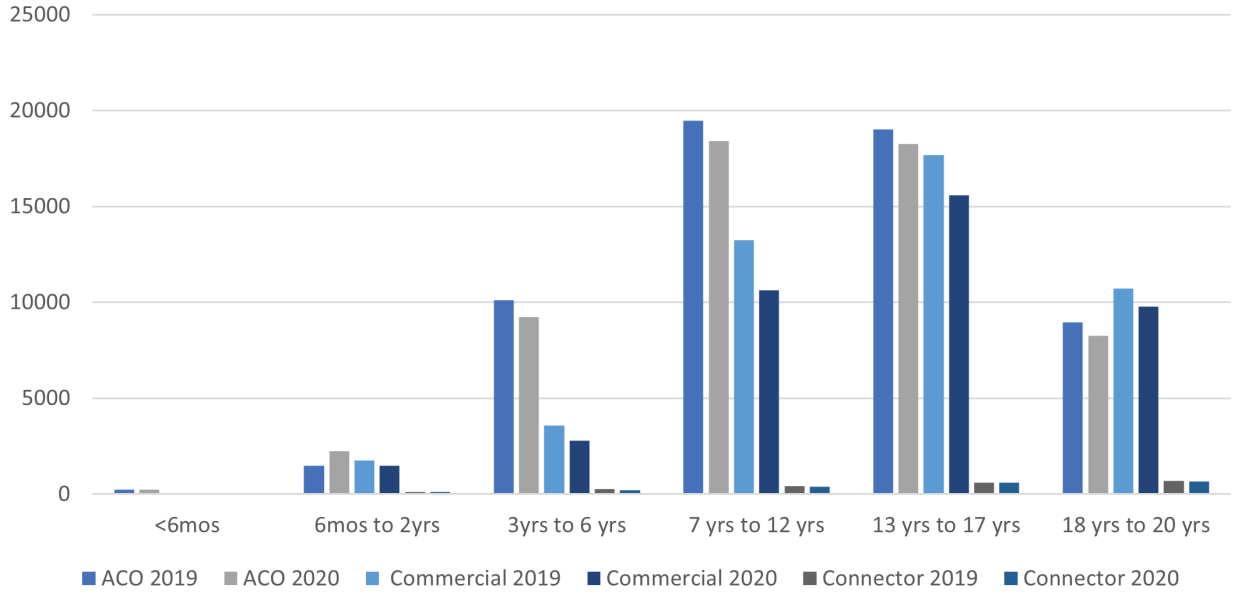


Figure 5: Youth with Primary BH Diagnosis 2019–2020 by Age



Behavioral Health Spending for the State

- Overall behavioral health spending was $2.2 billion in 2020, increasing 9.1% from $2.1 billion in 2019.

- For pediatric members, total per member per month (PMPM) spending decreased from 2019 to 2020, and primary care PMPM decreased over the two years by 12.0%.[xl]

The MAHP-collected data also provides a snapshot of the utilization of children's behavioral health care and the needs of a substantial subsection of the Commonwealth's children during the pre-pandemic and pandemic periods.

Utilization of MAHP-member commercial behavioral health services

In 2020, the utilization of inpatient psychiatric services saw a decrease driven by the impact of the COVID-19 pandemic followed by a spike in utilization at the end of 2020, primarily driven by the flexibility provided by the health plans. Utilization of 24-hour diversionary services remained relatively flat and unaffected during the COVID-19 pandemic.[xli]

The findings suggest that while the use of outpatient psychiatric services decreased dramatically at the height of the COVID-19 pandemic, utilization increased and remained relatively stable for the remaining months of 2020. The utilization of outpatient diversionary and emergency room services remained relatively stable, with an increase by the end of 2020. The definitions for the services are shared in the footnotes.[xlii]

Figure 6: Utilization of Inpatient Services — 2020

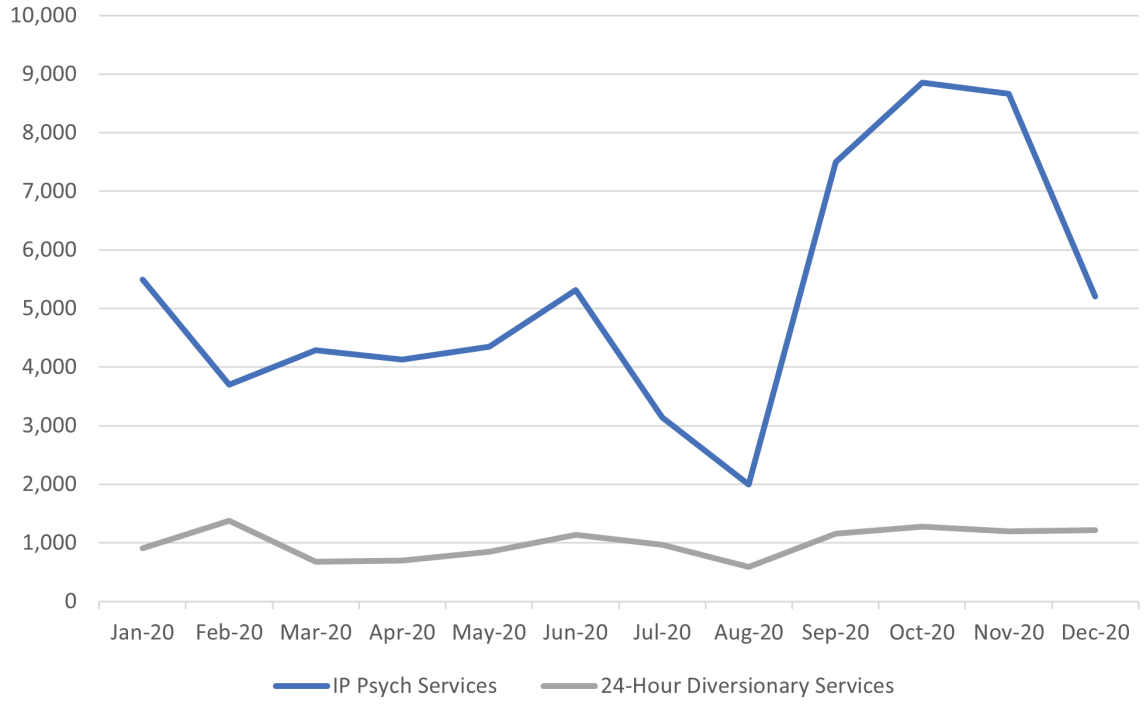


Figure 7: Utilization of Outpatient Psychiatric Services — 2020

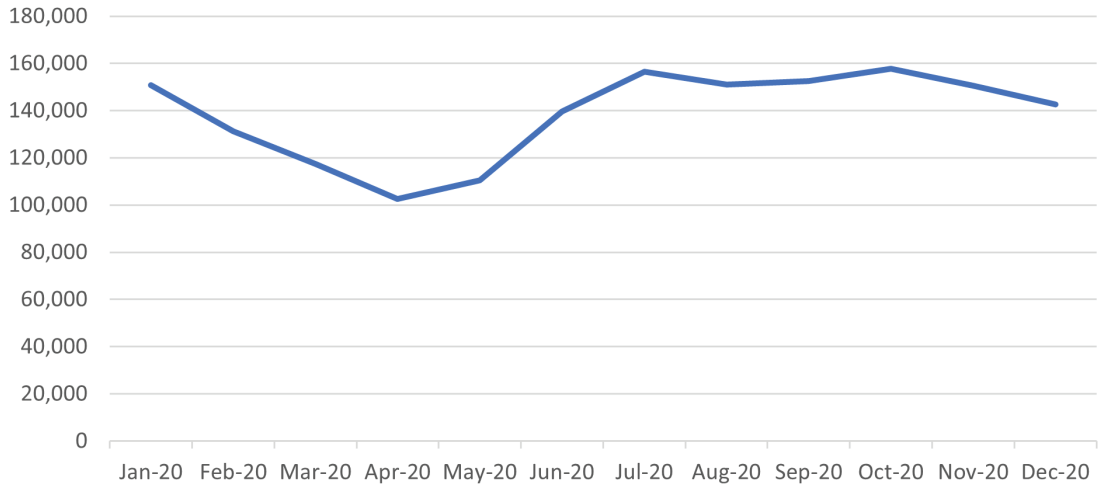
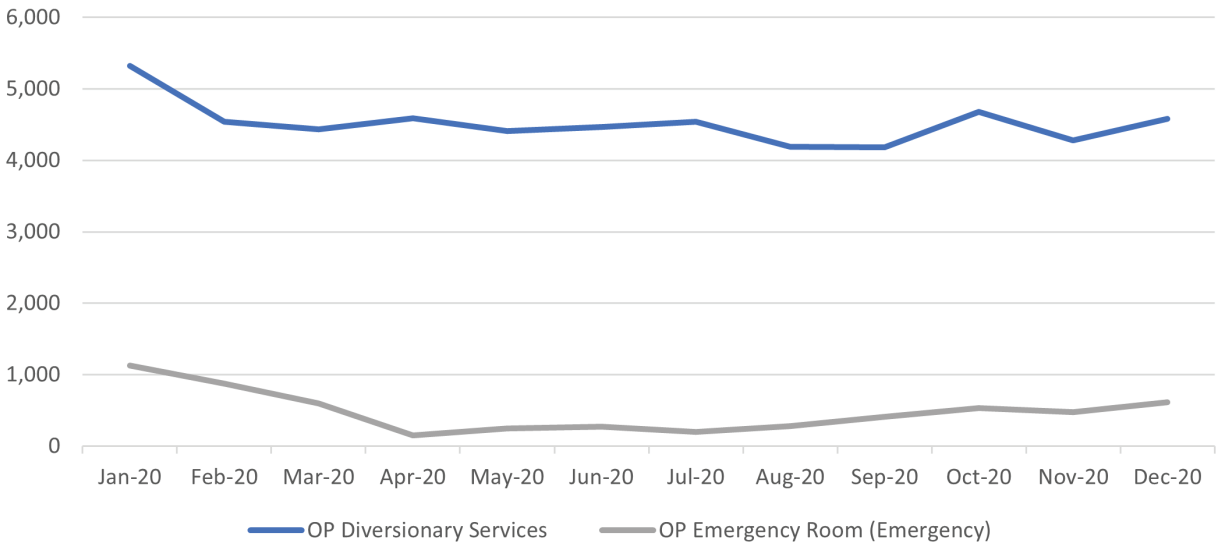


Figure 8: Utilization of Outpatient Diversionary Services and Emergency Room — 2020



Endnotes

i. Provided written feedback

ii. The U.S. Surgeon General's Advisory. Protecting Youth Mental Health. (2021). Retrieved from https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

iii. American Academy of Pediatrics. (2021). A declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association. https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

iv. Prevalence of Mental Health Disorders among youth. Youth.gov. Retrieved from https://youth.gov/youth-topics/prevalence-mental-health-disorders-among-youth

v. National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; O'Connell ME, Boat T, Warner KE, editors. Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities. Washington (DC): National Academies Press (US); 2009. Summary. Available from: https://www.ncbi.nlm.nih.gov/books/NBK32776/

vi. Bitsko RH, Claussen AH, Lichstein J, et al. Mental Health Surveillance Among Youth — United States, 2013–2019. MMWR Suppl 2022;71(Suppl-2):1–42. DOI: http://dx.doi.org/10.15585/mmwr.su7102a1

vii. Duong MT, Bruns EJ, Lee K, Cox S, Coifman J, Mayworm A, Lyon AR. Rates of Mental Health Service Utilization by Youth and Adolescents in Schools and Other Common Service Settings: A Systematic Review and Meta-Analysis. Adm Policy Ment Health. 2021 May;48(3):420-439. doi: 10.1007/s10488-020-01080-9. Epub 2020 Sep 17. PMID: 32940884. https://pubmed.ncbi.nlm.nih.gov/32940884/

viii. Curtin, S.C. & Heron, M. (2019). Death Rates Due to Suicide and Homicide Among Persons Aged 10–24: United States, 2000–2017. NCHS Data Brief. Retrieved from https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf

ix. Jones SE, Ethier KA, Hertz M, et al. Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021. MMWR Suppl 2022;71(Suppl-3):16–21. DOI: https://www.cdc.gov/mmwr/volumes/71/su/su7103a3.htm.

x. Protecting Youth Mental Health, the US Surgeon General's Advisory (2021). Page 8. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

xi. Yard, E et al. (2021). Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. Morbidity and Mortality Weekly Report. Retrieved from https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7024e1-H.pdf

xii. America's Health Rankings. (2022). https://www.americashealthrankings.org/. Retrieved on July 27, 2022.

xiii. Reinert, M, Fritze, D. & Nguyen, T. (October 2022). "The State of Mental Health in America 2023" Mental Health America, Alexandria VA. https://mhanational.org/issues/state-mental-health-america

xiv. American Academy of Pediatrics (2021). A declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association. https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/

xv. Pediatric Psychiatric Boarding: Using Data to develop Policy Solutions. 2017. Children's Mental Health Campaign. https://3kozyt2hoxl130a3go16kkwu-wpengine.netdna-ssl.com/wp-content/uploads/CMHC-Pediatric-Psychiatric-Boarding-Paper.pdf

xvi. Pediatric BH Urgent Care. 2020. 2nd Edition. Children's Mental Health Campaign. https://3kozyt2hoxl130a3go16kkwu-wpengine.netdna-ssl.com/wp-content/uploads/Pediatric-Behavioral-Health-Urgent-Care-2nd-Ed._0.pdf

xvii. The White House. Fact Sheet: President Biden to Announce Strategy to Address our national mental health crisis as a part of unity agenda in his first state of the union. (2022) https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

xviii. Fact Sheet: Biden Harris Administration highlights strategy to address mental health crisis. May 31, 2022. The White House. https://www.whitehouse.gov/briefing-room/statements-releases/2022/05/31/fact-sheet-biden-harris-administration-highlights-strategy-to-address-the-national-mental-health-crisis/

xix. The health care organizations selected include: Atrius Health with Fallon Health; Baystate Healthcare Alliance with Health New England; Beth Israel Lahey Health Performance Network with WellSense Health Plan; Boston Accountable Care

Organization with WellSense Health Plan; Boston Children's Health Accountable Care Organization with WellSense Health Plan; Cambridge Health Alliance with Tufts Health Public Plans; Community Care Cooperative; East Boston Neighborhood Health Center with WellSense Health Plan; Health Collaborative of the Berkshires with Fallon Health; Mass General Brigham ACO with Mass General Brigham Health Plan; Mercy Health Accountable Care Organization with WellSense Health Plan; Reliant Medical Group with Fallon Health; Signature Health with WellSense Health Plan; Southcoast Health Network with WellSense Health Plan; Steward Health Care Network; Tufts Medicine with WellSense Health Plan; UMass Memorial Health Care with Tufts Health Public Plans

xx. Impact of the American Rescue Plan Act on the Massachusetts Health Care System. October 2021. BCBSMA Foundation. https://www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2021-10/ARPA_Impacts_final_0.pdf

xxi. Estimated Budgetary Effects of S. 2938, Bipartisan Safer Communities Act, as Amended by Senate Amendment Number 5099. Congressional Budget Office. Cost Estimate. June 2022. https://www.cbo.gov/system/files/2022-06/S2938.pdf

xxii. MA Digital Health Council Report. (July 2019). https://massdigitalhealth.org/sites/default/files/2022-04/MA%20Digital%20Health%20Council%20Report%20FINAL_WEB%2009102019.pdf

xxiii. MCPAP for ASD-ID. Retrieved from https://www.mcpap.com/ASDID/overview.aspx

xxiv. 2022 Healthcare Cost Trends Hearing. Data Presentation Dr. David Auerbach. Slide 34. Retrieved from https://www.mass.gov/doc/hpc-data-presentation-impact-of-price-and-spending-trends-on-health-care-affordability-and-equity-in-massachusetts/download

xxv. Chapter 177, An Act addressing barriers to care for mental health. Section 32. Retrieved from https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177

xxvi. Notice of Final Agency Action. EOHHS. (2022). Page 71. Retrieved from: https://www.mass.gov/doc/notice-of-final-agency-action-masshealth-payment-for-in-state-acute-hospital-services-and-out-of-state-acute-hospital-services-effective-october-1-2022-0/download

xxvii. Chapter 260 of Acts of 2020. An Act promoting a resilient health care system that puts patients first. Section 69. 76, 78. https://malegislature.gov/Laws/SessionLaws/Acts/2020/Chapter260

xxviii. Roadmap for Behavioral Health Reform: FAQs. Retrieved from https://www.mass.gov/info-details/roadmap-for-behavioral-health-reform-faqs

xxix. Chapter 126 of Acts of 2022. An Act making appropriations for FY 2023 for the maintenance of the departments, boards, commissions and institutions, and certain activities of the Commonwealth, for interest, sinking fund and serial bond requirements, and for certain permanent improvements. Retrieved from https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter126#:~:text=AN%20ACT%20MAKING%20APPROPRIATIONS%20FOR,AND%20FOR%20CERTAIN%20PERMANENT%20IMPROVEMENTS

xxx. The development of the online portal and the BH Treatment Platform should help provide the state with complete and accurate data on boarding, including who is boarding and the reasons for the admission delay in a clear and transparent manner.

xxxi. 2020 EPIA Dashboard. https://www.mass.gov/lists/expedited-psychiatric-inpatient-admission-epia-dashboards#2022-epia-dashboards-

xxxii. Pediatric Behavioral Healthcare Integration boosts care access. (2022). Patient Engagement HIT. https://patientengagementhit.com/news/pediatric-behavioral-healthcare-integration-boosts-care-access Evidence Base for COCM. AIMS Center. https://aims.uw.edu/collaborative-care/evidence-base-cocm

xxxiii. Section 84 of Chapter 177 of Acts of 2022, Reimbursement for the psychiatric collaborative care model include, but not be limited to, the CPT billing codes established by the AMA 99492, 99493 and 99494. Retrieved from https://malegislature.gov/Laws/SessionLaws/Acts/2022/Chapter177

xxxiv. MassHealth Children's Behavioral Health Initiative. Retrieved from https://www.mass.gov/service-details/learn-about-cbhi

xxxv. Bulletin 2018-07. Division of Insurance. Re: Access to Services to Treat Child-Adolescent Mental Health Disorders. Retrieved from https://www.mass.gov/doc/bulletin-2018-07-access-to-services-to-treat-child-adolescent-mental-health-disorders-issued/download

xxxvi. Outpatient mental health access and workforce crisis: Issue Brief. Association of Behavioral Health. February 2022. https://www.abhmass.org/images/resources/ABH_OutpatientMHAccessWorkforce/Outpatient_survey_issue_brief_FINAL.pdf

xxxvii. Creating a robust, diverse, and resilient behavioral health workforce in Massachusetts. (2022). BCBSMA Foundation. Retrieved from https://www.bluecrossmafoundation.org/publication/creating-robust-diverse-and-resilient-behavioral-health-workforce-massachusetts

xxxviii. Massachusetts Home and Community-Based Services (HCBS) Quarterly Spending Plan Narrative. American Rescue Plan Act (ARPA) Enhanced Federal Funding October 2021. Executive Office of Health and Human Services. https://www.mass.gov/doc/october-2021-quarterly-spending-plan-

and-narrative-submitted-to-cms-on-october-15th-2021-0/download

xxxix. The data does not include youth enrolled in the traditional Medicaid program. Medicaid MCO/ACO-A membership represents approximately one-third of MassHealth enrollment. As of July 2022, MassHealth covered approximately 629,919 youth through their programs. See https://www.mass.gov/doc/masshealth-caseload-snapshot-and-enrollment-summary-july-2022-0/download.

xl. Primary Care and Behavioral Health Expenditures. Center for Health Information and Analysis. September 2022. https://www.chiamass.gov/primary-care-and-behavioral-health-care-pcbh-expenditures/#pcbh-expenditure-dashboard

xli. During the onset of the COVID-19 pandemic, the Division of Insurance issued bulletins that relaxed certain health plan administrative procedures including forgoing prior authorization and concurrent review for any scheduled behavioral health and non-behavioral health admissions at acute care and mental health hospitals. DOI Bulletin 2020-15, April 30, 2020. DOI Bulletin 2020-21 June 25, 2020

Description of Appendix Data

* Inpatient services were categorized into psychiatric services and 24-hour diversionary services. Outpatient services include outpatient psychiatric services, outpatient diversionary services, and outpatient emergency room services*

* Inpatient psychiatric services include inpatient mental health services, inpatient substance use disorder (SUD) services (Level 4), observation/holding beds, administratively necessary day services, and inpatient professional fees (as applicable).

* 24-hour diversionary services include Community-Based Acute Treatment for Children and Adolescents (CBAT); Intensive Community-Based Acute Treatment (ICBAT); Community Crisis Stabilization; Acute Treatment Services for SUD (Level 3.7) (ATS); Clinical Support Services for SUD (Level 3.5); Residential Rehabilitation Services for SUD (Level 3.1); and Transitional Care Unit (TCU).

* Outpatient psychiatric services include Family Consultation, Case Consultation, Diagnostic Evaluation, Dialectical Behavioral Therapy (DBT), Psychiatric Consultation on an Inpatient Medical Unit, Medication Visit, Couples/Family Treatment, Group Treatment, Individual Treatment, Inpatient-Outpatient Bridge Visit, Assessment for Safe and Appropriate Placement (ASAP), Collateral Contact, Acupuncture Treatment, Opioid Replacement Services, Ambulatory Detoxification (Level 2WM), Psychological Testing, Special Education Psychological Testing, and Applied Behavioral Analysis for members under 21 years of age (ABA Services).

* Outpatient diversionary services include Community Support Programs (CSPs), Partial Hospitalization Programs (PHPs), Psych Day Treatment, Structured Outpatient Addiction Programs (SOAPs), Intensive Outpatient Programs (IOPs), Recovery Support Navigators, Recovery Coaches, and the Program for Assertive Community Treatment (PACT).

* Outpatient emergency room services include emergency care performed in an outpatient hospital facility (including psych consult on medical floor) that does not result in an inpatient admission and does not result in outpatient surgery, including all ancillary services (lab, radiology) performed on the same day by the facility (not professional).