

**Commonwealth of Massachusetts
Executive Office of Health and Human Services**

**THE CHILDREN'S BEHAVIORAL
HEALTH
ADVISORY COUNCIL**



Annual Report 2014



Massachusetts Association for Mental Health

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October 1, 2014

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Hon. Steven M. Walsh, House Chair, Joint Committee on Health Care Financing
Hon. Stephen M. Brewer, Chair, Senate Committee on Ways and Means
Hon. Brian S. Dempsey, Chair, House Committee on Ways and Means

On behalf of the Children's Behavioral Health Advisory Council (Council), established under the provisions of Chapter 321 of the Acts of 2008, I am pleased to transmit its 2014 Annual Report.

A listing of the Council's membership is attached as *Appendix A*.

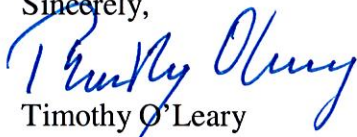
We hope readers of this Report come to know and understand the seriousness of emotional disorders and that the best and most cost effective treatment for behavioral disorders is through the development of integrated delivery of health care systems, with attention to preventative care.

- Approximately one in five children and adolescents experiences the signs and symptoms of a diagnosable mental health disorder during the course of a year. Among children ages 9 to 17, 11 percent experience "significant impairment" and 5 percent experience "extreme functional impairment."
- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.

Without intervention, child and adolescent psychiatric disorders frequently continue into adulthood and are increasingly associated with disability and increased medical costs. For example, research shows that when children with coexisting depression and conduct disorders become adults, they tend to use more health care services and have higher healthcare costs than other adults. Thus, while children are not “cost drivers” our failure to intervene or engage in preventative measures result in bringing them to adulthood, where their medical needs and costs become significantly higher.

We know we can improve outcomes, lower long term costs and do better by our children and adolescents with behavioral disorders and their families. This Annual Report contains information and recommendations which we believe are clinically effective, cost efficient and will contribute to the well-being of all our children.

Sincerely,

A handwritten signature in blue ink, appearing to read "Timothy O'Leary".

Timothy O'Leary
Children's Behavioral Health Advisory Council

cc: John Polanowicz, Secretary, Executive Office of Health and Human Services
Marcia Fowler, Commissioner, Department of Mental Health

I. INTRODUCTION AND PRELIMINARY STATEMENT

Section 1 of Chapter 321 of the Acts of 2008 amended Chapter 6A of the Massachusetts General Laws, by inserting Section 16Q and established the Children’s Behavioral Health Advisory Council (Council) and placed the Council, “within but not subject to control of, the executive office of health and human services.” Additionally, the language of section 16Q (a) states the Council is to, “advise the governor, the general court and the secretary of health and human services.” The scope and breadth of the Council’s advisory role is best evidenced in subparagraph (d) of Section 16Q, which authorizes the Council to make recommendations in the following areas:

- (i) best and promising practices for behavioral health care of children and their families, including practices that promote wellness and the prevention of behavioral health problems and that support the development of evidence-based interventions with children and their parents;
- (ii) implementation of interagency children’s behavioral health initiatives with the goal of promoting a comprehensive, coordinated, high-quality, safe, effective, timely, efficient, equitable, family-centered, culturally-competent and a linguistically and clinically appropriate continuum of behavioral health services for children;
- (iii) the extent to which children with behavioral health needs are involved with the juvenile justice and child welfare systems;
- (iv) licensing standards relevant to the provision of behavioral health services for programs serving children, including those licensed by entities outside of the executive office of health and human services;
- (v) continuity of care for children and families across payers, including private insurance; and
- (vi) racial and ethnic disparities in the provision of behavioral health care to children.

This particular Report will be the last filed during the Governor Patrick Administration. We note this because as we have stated in previous reports, the Council believes it is vital to its mission, and ultimately to the families and children of the Commonwealth, that its members, policy makers and others keep in mind that the Council was established as an independent advisor to *both* the Executive and Legislative branches. Our credibility as an advisory body depends upon our independence and ongoing commitment to advocate for legislation, policies, practices and procedures that best serve the families and children of the Commonwealth with emotional disorders and behavioral health needs. While our policy recommendations may be tempered by fiscal realities, they should not depend upon who is governor, who is the EOHHS Secretary or which political party represents the majority in the Legislature. Our recommendations should be guided by our expertise, experience, and our commitment to the families and children of the Commonwealth. To do anything less would be a disservice to both branches, as well as to those children and families. We hope this Report and its recommendations become part of the framework for the next Administration – Republican or Democrat - and the next Legislative Session

– as we continue toward an integrated health care system and address the behavioral health needs of our children and adolescents.

Because of the *Rosie D* litigation (See below), considerable attention has been paid to the public delivery of care system and to the creation, and penetration of the new services created as part of the remediation plan under that litigation. While the Council shares that interest and gives it due attention, we are very much aware that those new services are only available to families and children covered under MassHealth, and, as the enabling provisions of the law that created us makes clear, our purview is much broader than the *Rosie D*. case and the Children’s Behavioral Health Initiative. **Accordingly, we need to focus appropriate attention on ALL the families and children of the Commonwealth, including those covered by commercial carriers.**

This is particularly true where the Commonwealth, indeed the nation, is beginning the implementation of the Affordable Care Act. As terms such as integrated care, medical homes and accountable care organizations become part of our health care nomenclature, we need to pay attention to and understand their impact on children’s mental health.

In its 2013 Annual Report, the Council restated its recommendations to the Behavioral Health Integration Task Force established under section 275 of Chapter 224 of the Acts of 2012. We believe those recommendations, outlined later in this Report, are clinically and cost effective and we urge policy makers within the executive and legislative branches to adopt these recommendations as the Commonwealth implements the Affordable Care Act and we move to a more integrated health care system tied to patient outcomes.

II. COUNCIL’S ACTIVITIES IN 2014

Generally, the Council meets on the first Monday of each month. During the period covered by this Report, (October 2013 through September 2014) the Council met ten times, including a gathering at the Worcester Recovery Center and Hospital as part of the Children’s Behavioral Health Knowledge Center Symposium and Gailanne Reeh Lecture. During the course of the year there were presentations by outside groups on a variety of topics, followed by robust conversation and an exchange of ideas, opinions and suggestions for “next steps. The topics examined and discussed include:

- A CANS update, outcome data, and directions forward.
- Early Childhood Mental Health: Interagency Collaboration
- A discussion on the development and implementation of a Uniform Prior Authorization form
- MassHealth Updates: CMS Final Regulations on Mental Health Parity, Health Homes
- Children’s Behavioral Health Workforce Collaborative Leadership Team Update
- Children’s Behavioral Health Initiative (CBHI) impact on Acute Care
- A presentation by the Commonwealth’s Center for Health Information and Analysis (CHIA)
- Integrating *Family Talk* with South Shore Mental Health’s IHT Program

- Examining the Implementation of Behavioral Health Screening for MassHealth Children
- Progress Towards the Triple-Aim: Behavioral Health and Care Coordination Integration
- Reforms at MA Department of Children and Families
- CBHI Update
- Update on Health Homes
- CHIPRA Grant and the Child Health Quality Coalition

III. ROSIE D. V. PATRICK (F/K/A ROSIE D. V. ROMNEY)

In 2001, a class action lawsuit, *Rosie D. v. Romney*, was filed in the federal court by **parents on behalf of children with serious emotional disturbance (SED)**. In January 2006, the Court ruled the Commonwealth was in violation of the federal Medicaid law by failing to provide home-based services to an estimated 15,000 children with serious emotional disturbances. The Commonwealth was also found to be lacking in the provision of services specifically required by Medicaid – early and periodic screening, diagnostic and treatment services (EPSDT).

To its credit, the Patrick Administration decided not to appeal the decision, which would have delayed change for years. Instead, it set about the task of fashioning a remediation plan to comply with the Court’s decision. In February 2007, the Court approved a modified version of the Commonwealth’s plan, and incorporated it into a final judgment with strict timetables. A court monitor was appointed to oversee the implementation of the remedy.

We understand as with any adversarial proceeding, disagreements exist between the Plaintiffs and the Defendant as to the degree of success or shortcomings in how the remediation plan is being implemented, the penetration rate of the new services as well as how does one (or when does one) begin to assess whether or not the new services are having a positive impact on the children and families they are designed to serve. However, we are encouraged that while not agreeing that the Commonwealth is in full compliance with the Court Judgment, the Plaintiffs have acknowledged the considerable progress that has been made over the past seven years.

At the status conference on June 27, 2014, the Court applauded the parties’ joint efforts to address four longstanding challenges to complying with the Rosie D. Judgment, and encouraged them to focus on developing concrete solutions. The four areas are: (1) Intensive Care Coordination (ICC) (described by the Court as “the heart” of the decision); (2) the adequacy of outpatient therapists providing service coordination and treatment planning; (3) the availability of system-wide outcome data for youth receiving remedial services; and (4) the high percentage of youth who receive Mobile Crisis Intervention in emergency departments.

The Court scheduled another status conference in October 2014, at which point it will hear detailed updates on the parties' efforts to redress these systemic deficiencies. The Court will then decide whether to extend the Court Monitor's role beyond the current termination date of December 31, 2014.

We have indicated in previous Annual Reports the professionalism, dedication, energy and commitment we have observed in those charged with the responsibility of implementing the remediation plan. This is important, complex work being performed under tight guidelines and the unblinking eye of a federal court. While much remains to be done, we believe all who have been involved at every level of the transformation that is occurring should be congratulated for what has been accomplished to date, particularly when one considers it is being done in an economic environment that could have produced failure but for their efforts.

IV. THE CHILDREN'S BEHAVIORAL HEALTH KNOWLEDGE CENTER

www.mass.gov/dmh/cbhknowledgecenter

On May 7, 2014, the Council supported the Department of Mental Health as it launched the Children's Behavioral Health Knowledge Center (Center), as part of a symposium the Council held in Worcester. The Center was a requirement of the same enabling legislation that created the Council (Chapter 321, Acts of 2008) and its stated mission was to ensure that:

- the workforce of clinicians and direct care staff providing children's behavioral health services are highly skilled and well trained,
- the services provided to children in the Commonwealth are cost-effective and evidence-based, and
- the Commonwealth continues to develop and evaluate new models of service delivery.

The Center's design and agenda were guided by conversations with state agency leaders, researchers, service providers, consumer advocates, and stakeholders throughout Massachusetts. Leaders of similar centers in other states provided invaluable advice.

We anticipate the Center will build upon and not duplicate the rich array of research organizations throughout Massachusetts. Its activities will connect:

- Community-based and institutional service providers, public and private payers, consumers and consumer advocates, research centers, and state agencies.
- Research, policy, and practice.
- Massachusetts to national leaders in innovation and best practice.

No resources have been provided for the Center, yet the Council is optimistic it will become an important resource for the children's behavioral health network and we expect to include more information on its activities in next year's Report.

V. RECOMMENDATIONS

With the enactment of Chapter 224 of the Acts of 2012, Massachusetts appropriately signaled the importance of health care cost containment and the integration of primary and behavioral health care. Section 275 of that Act established a Behavioral Health Integration Task Force and charged it with providing recommendations on a number of important questions. The Council was asked to and did provide to the Task Force its recommendations with respect to behavioral health care for children and adolescents.

All of the Council's recommendations, including our rationale were stated in the 2013 Report. We want to use this year's report to highlight the following:

Ensure behavioral health screening for all children.

- Require all payers to reimburse primary care providers (PCP) for administration, scoring, and interpretation of behavioral health screening at every well child visit for children up to age 21.
- Require all payers to reimburse pediatric primary care providers for administration, scoring, and interpretation of post partum screening at well child visits for children ages 0 to 6 months.
- Allow reimbursement for both a mental health screening and a substance abuse screening in a single visit when the Primary Care Provider deems necessary for a youth's health.

Behavioral health consultation should be readily accessible to primary care providers.

- A range of arrangements supporting strong working relationships should be allowed, including co-location to facilitate access and ongoing collaboration.

Peer supports, including family partners and youth mentors, should be a standard service that is readily available and reimbursed.

- Peer supports are critical to initial and on-going engagement for families and youth who may be reluctant to or lack knowledge about/skills for engaging in behavioral health care.

Care coordination should be a standard of care and reimburseable for all children receiving both primary and behavioral health care.

- Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

Ensure all reimbursement policies support integrated delivery of primary care and behavioral health care.

- Eliminate any restrictions on same-day billing between behavioral health and primary care providers.
- Waive any preapproval requirement for first visits to non-emergency behavioral health services so issues identified in a primary care visit can be referred and addressed by a behavioral health specialist that same day.
- Allow for units of billing to be as short as ten minutes to reflect the brief consults that will be needed.
- Pay primary care clinicians, child and adolescent psychiatrists, and mental health professionals for sessions with parents without their child present when the focus of the visit is the child's healthcare needs.

Fully enforce state and federal parity laws.

- Clear guidance for both providers and consumers and enforcement regarding parity will remain necessary as new health care delivery arrangements are developed.
- There must be a full array of community-based behavioral health services available regardless of payer. Currently, MassHealth offers a richer array than do private insurers.
- Rates paid for behavioral health services should be set on par with rates for primary care.

Develop performance measures.

- Reliable and useable measures must be developed to study the quality and cost effectiveness of integration mechanisms. Key process milestones towards good clinical outcomes (e.g., behavioral health and post partum screenings conducted, timely access to care, reduced missed appointments, patient satisfaction) should also be measured. Payment methods should provide reimbursement for PCPs to collect and use data to improve their performance.

Enhance the service array based on both innovation and research evidence.

- Reimbursement methods should support the adoption of evidence-informed treatments as well as opportunities to develop and test innovative treatment approaches.
- An effective integrated system must incorporate empirically supported treatment approaches as well as invest in building empirical evidence for new models of care.

Develop protocols that allow information to be shared among care providers while protecting privacy.

- Integrated healthcare requires integrated health information. The MA Child Health Quality Coalition's Communication and Confidentiality Task Force has been identifying issues impacting communications and confidentiality as well as resources that can help in addressing those issues.

Link pediatric care with care for parents.

- Care coordination for children's health care should be prepared to develop linkages with the parents' medical care, in conjunction with the parent and the child's PCP, as needed. Family Partners could be helpful in making these linkages.

Explore healthcare financing across child-serving systems.

- Children access behavioral health care services through primary care and schools. However, funding is siloed and healthcare reform doesn't impact some of the financing sources for school-based care. Methods that integrate healthcare financing across these two systems might allow for even more effective healthcare delivery integration and reduced healthcare costs.

Invest in prevention and wellness.

- The Prevention and Wellness Trust Fund, created by Chapter 224, should take a strategic long-term approach by investing, in part, in children's well-being. The Prevention and Wellness Fund offers an opportunity to promote connections between social services initiatives and primary and behavioral health care organizations.

The Council would be pleased to meet and work with any policy member or group including transition teams, legislative caucuses or advocates to discuss these recommendations or any issues pertaining to the emotional well-being of the Commonwealth's children.

VI. THE YEAR AHEAD

We anticipate the Council will be very much engaged in the Commonwealth's work to integrate behavioral health and primary care, including Primary Care Payment Reform and MassHealth's Health Homes Initiative. Both initiatives aim to improve care for adults facing Serious and Persistent Mental Illnesses (SPMI) and children / youth with Serious Emotional Disturbance (SED) by better integrating and coordinating care across the behavioral health and primary health systems. The Department of Mental Health and MassHealth have done great work to create proposed health home models with the intent to submit a State Plan Amendment. The current vision is a health home model for adults and another for children and adolescents.

The Council's continued focus on behavioral health and primary care integration builds on its recommendations to the Behavioral Health Integration Taskforce (see above). Support for strategies such as care coordination and increased involvement of family or parent partners has been articulated in every Annual Report. We hope as these initiatives are developed, careful attention is paid to:

- Understanding and addressing the needs of children whose parents have mental illnesses and are served in the adult medical home or health home.
- Better defining and supporting the role of parent partners in the medical homes and health homes for children and adolescents

- Broadening medical necessity definitions or protocols to recognize the reality that SED is a chronic condition that needs attention throughout a child's development.

The development of the services as part of the remediation plan under the Rosie D Case (commonly referred to as the Children's Behavioral Health Initiative) were by necessity targeted at the children most in need of high intensity services. As previously stated, the Council admires the good work that has resulted from these services. However, it is excited by the opportunities accorded to the Commonwealth under the Affordable Care Act to expand the discussion to more kids and, ultimately, we hope, also develop a framework for those covered by commercial carriers and their families.

CONCLUSION

We are grateful for the assistance and support we received from Marcia Fowler, Commissioner of the Massachusetts Department of Mental Health and Council Chair, EOHHS Secretary John Polanowicz, Chris Counihan, Director of Behavioral Health/MassHealth, Emily Sherwood and Jack Simons, Office of Children's Behavioral Health Interagency Initiatives, and the other wonderful people at EOHHS, DMH and the child serving agencies within EOHHS. Special thanks to Joan Mikula, Susan Maciolek, Lester Blumberg and Stephen Cidlevich from DMH, for their professionalism, patience and graciousness in helping the Council and for all they do for the children and families of the Commonwealth.

APPENDIX A

The Children’s Behavioral Health Advisory Council (the Council) was established under the provisions of Chapter 321 of the Acts of 2008. The Council is a unique public-private partnership representing child-serving agencies, parents and professionals with expertise in the issues of children’s mental health. The membership of the Commission is as follows:

Marcia Fowler, Chair Commissioner Department of Mental Health	Gail Garinger The Child Advocate Office of the Child Advocate
Robert Wentworth Department of Children and Families	David Matteodo Massachusetts Association of Behavioral Health Systems Representative
Janet George Department of Developmental Services	Carla Saccone Association for Behavioral Healthcare Representative
Christopher Counihan Office of Medicaid	Erin Bradley Children’s League of Mass Representative
Anita Moeller Department of Early Education and Care	Peter Metz, M.D. New England Council of Child and Adolescent Psychiatry Representative
Nancy Schwartz Division of Insurance	Barry Sarvet, M.D. Massachusetts Psychiatric Society Representative
Marcia Mittnacht Department of Elementary and Secondary Education	Michael Yogman, M.D. Mass Chapter of the American Academy of Pediatrics Representative
Robert Turillo Department of Youth Services	Eugene D’Angelo, Ph.D. Massachusetts Psychological Association Representative
Jennifer Tracey Department of Public Health	Carol Trust, LICSW National Association of Social Workers – Massachusetts Chapter Representative
William R. Beardslee, M.D. Massachusetts Hospital Association Representative	Dalene Basden Parent/Professional Advocacy League Representative
Timothy O’Leary Massachusetts Association for Mental Health Representative	Lisa Lambert Parent/Professional Advocacy League Representative
Emily Sherwood/Jack Simons Director Executive Office of Health and Human Services Children’s Behavioral Health Interagency Initiative	Mary McGeown Massachusetts Society for the Prevention of Cruelty to Children

Sarah Gordon Chiaramida Massachusetts Association of Health Plans Representative	Jeffrey Simmons, M.D. Blue Cross Blue Shields of Massachusetts Representative
Kermit Crawford, Ph.D. Professional in human services workforce development Boston Medical Center	John Straus, M.D. Massachusetts Behavioral Health Partnership Representative
Alison Hunt Young Adult Policy Team	Katherine Flores Young Adult Policy Team
Joel Goldstein, M.D. Cambridge Health Alliance	Jill Lack Neighborhood Health Plan
Amy Carafoli-Pires Boston Medical Center HealthNet Plan	Erin Goodrich 4/9/13 Beacon Health Strategies
John Sargent, M.D.	Gisela Morales-Barreto, Ed.D.
Roxana Llerena-Quinn, Ph.D.	Midge Williams
Paul Shaw	Mary Ann Gapinski
Toni Irsfeld	Yolanda Coentro
Robin Risso	