

**Children’s Behavioral Health Advisory Council
Recommendations to the Behavioral Health Integration Task Force
Executive Summary**

The Children’s Behavioral Health Advisory Council has provided a range of recommendations to the Behavioral Health Integration Task Force on the issues identified in Section 275 of Chapter 224 as they affect behavioral health care for children. Our full report responds to each of the six questions posed by the Legislature in Section 275. This executive summary organizes our recommendations at the service delivery, organizational and systems levels.

It would be easy, but a mistake, to overlook the needs of children in the context of the healthcare reform efforts required by Chapter 224. Children are not “cost drivers” when compared to some groups of adults, e.g. adults eligible for both Medicaid and Medicare.

- 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.”ⁱ
- Half of all lifetime mental illnesses begin by age 14; three quarters by age 24.ⁱⁱ
- Approximately 36% of youth with any lifetime mental health disorder received services, and only half of these youth who were severely impaired by their condition received professional mental health treatment. The majority (68%) of the children who did receive services had fewer than six visits with a provider over their lifetime.ⁱⁱⁱ

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.^{iv} Moreover, the Adverse Childhood Events literature underscores the impact that the untreated consequences of childhood toxic stress can have on adult physical health care morbidity, mortality and costs.^v

I. SERVICE DELIVERY STRATEGIES

Strategies to improve what and how services are provided, beginning with access and engagement, and extending to how providers work together with and on behalf of children and their families.

Ensure behavioral health screening for all children.

1. 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.
2. 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.
3. Educate primary care providers in the adult system who care for young adults (18 to 21) about their obligation to provide behavioral health screening.

4. 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 might be reluctant to or lack knowledge about/skills for engaging in behavioral health care.

Care coordination should be a standard of care and reimbursed 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.^{vi vii}

1. Eliminate any restrictions on same-day billing between behavioral health and primary care providers. Allow both primary care and behavioral health providers to bill for overlapping time.
2. Waive any preapproval requirement for first visits to non-emergency behavioral health services so that issues identified in a primary care visit can be referred and addressed by a behavioral health specialist that same day. Allow for brief intervention services to be billed before a full assessment is completed.
3. Allow for units of billing to be as short as ten minutes to reflect the brief consults that will be needed.
4. Set rates for consultation time to a PCP commensurate with rate for direct care provision.
5. 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.

Ensure full and appropriate funding for MCPAP

The Massachusetts Child Psychiatry Access Program (MCPAP) provides broad access to child psychiatry consultation to any PCP regardless of a child's insurance source. Over half all consults provided were for children covered by commercial insurance (FY2009).^{viii} To date, DMH has been the sole source of funding. Commercial insurers should be required to pay commensurate with their PCPs' use of MCPAP.

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.

II. ORGANIZATIONAL STRATEGIES

Strategies to strengthen the capacities of healthcare providers, insurers, regulators, and policy-makers manage, monitor, and continuously improve the quality and cost of healthcare.

Ensure family and youth consumer voices are fully represented in healthcare reform conversations at the systems and service delivery levels from the beginning.

ACOs should appoint to their governing structure more than the one consumer representative required by Chapter 224. At least one should represent families whose children receive both primary and behavioral health care and one should represent transition age youth. Healthcare organizations not specifically required to do so should consider including consumers in their governance structure.

Graduate programs and credentialing bodies must take a leadership role in preparing the healthcare workforce.

Training programs to produce skilled behavioral health specialists to work in primary care settings are needed, as are training programs for pediatricians in working with behavioral health specialists. Licensing standards and continuing education requirements must reflect the knowledge and competencies required to be effective in an integrated healthcare system.

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. Integrating primary care and behavioral health care in a manner that is effective in achieving better outcomes will require more than a reorganization of existing treatment services. An effective 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. The Council encourages their continued work to address the tension that exists between promoting communication among all members of a child's care team and ensuring that confidentiality and privacy protections are in place.

III. MULTI-SYSTEMS STRATEGIES

As a multi-disciplinary Council, we take a broad view of children's healthcare to include prevention and wellness. Transforming the children's healthcare system should include connecting it with other systems that impact / contribute to children's health and well-being.

Link pediatric care with care for parents.

Parents of children with a behavioral health condition are often under great stress and /or burdened with their own physical and/or psychological disorders. This impedes their ability to fully care for and manage care for their children. 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.

Alternative financing methods across child-serving systems should be explored. 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 landmark Adverse Childhood Experiences (ACE) study has demonstrated dramatic links between adverse childhood experiences and risky behavior, psychological issues, serious illness and the leading causes of adult deaths. The Prevention and Wellness Trust Fund, created by Chapter 224, should take a strategically long-term approach by investing, in part, in children’s well-being. The Council recognizes that responding to ACEs and childhood trauma is not solely the purview of the healthcare system but also of the broader social services and public health systems. The Prevention and Wellness Fund offers an opportunity to promote connections between social services initiatives and primary and behavioral health care organizations.

In addition, the MA Department of Public Health should explore the feasibility of incorporating the ACE questions in its annual Behavioral Risk Factor Surveillance System (BRFSS) survey, as several other states have done. This data, along with other sources, could then guide the Fund’s grant-making.

ⁱ Mental Health: A Report of the Surgeon General, National Institute of Mental Health, 1999

ⁱⁱ NIMH, Mental Illness Exacts Heavy Toll, Beginning in Youth, June 2005.

ⁱⁱⁱ NIMH. Science Update, Majority of Youth with Mental Disorders May Not Be Receiving Sufficient Services, January 04, 2011

^{iv} Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251

^v http://vetoviolence.cdc.gov/childmaltreatment/phl/resource_center_infographic.html

^{vi} The Economics of Behavioral Health Services in Medical Settings: A Summary of the Evidence. A. Blount, R. Kathol, M. Thomas, M. Schoenbaum, B. L. Rollman, W. O’Donohue. *Professional Psychology: Research and Practice*. 2007. Vol. 38, No. 3, 290-297.

^{vii} Improving Mental Health Services in Primary Care: Reducing Administrative and Financial Barriers to Access and Collaboration. American Academy of Child and Adolescent Psychiatry, Committee on Health Care Access and Economics, Task Force on Mental Health, *Pediatrics* 2009; 123; 1248-1251

^{viii} The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care.