# Kids Are Waiting

## CHILDREN'S BEHAVIORAL HEALTH SERVICES CRISIS AND COLLAPSE

DECEMBER 2023

ISSUE BRIEF

ABH

ASSOCIATION FOR BEHAVIORAL HEALTHCARE

# Introduction

In October 2021, the U.S. Surgeon General declared a national emergency in child mental health. Leading pediatric organizations have also recognized a national crisis in child and youth mental health[1] , and Massachusetts is experiencing the same[2]. Rates of depression, anxiety, trauma, and loneliness are increasing among children and adolescents.[3] Suicide rates rose in 2021 after two years of decline, and new data show an increase in suicide rates among Black adolescents and young adults (ages 10-24) of 36.6% from 2018 to 2021.[4] Suicide is the second leading cause of death for young people nationally.[5]

On paper, Massachusetts has a robust continuum of mental health services for children from birth through 20 years old, including specialty services delivered in the home and in the community called **Children's Behavioral Health Initiative (CBHI)** services for children with MassHealth, and **Behavioral Health for Children and Adolescents (BHCA)** services for children with private health coverage. Many children and adolescents, however, cannot access these vital services. The mental health workforce crisis has diminished access to critical services at a time of soaring need. Staffing challenges detailed in our **Outpatient Issue Brief** are even more significant in the home-based children's behavioral health system.

State officials have recognized these challenges with an infusion of approximately $70 million into the CBHI system as of August 2023. However, the staff vacancy rate within CBHI services is intensifying and the entire delivery system has reached a critical juncture. If staff vacancies cannot be mitigated, then children and families do not receive services.

## RESPONDENTS OVERVIEW

**30** provider organizations responded

**208** sites represented across Massachusetts

**15,540** children and adolescents served from July 1, 2022 to May 31, 2023 by survey respondents

## SURVEY BACKGROUND

Staffing challenges make it more difficult for families to access mental health care for their children when they need it. ABH surveyed our members to learn about the depth of these challenges in August 2022 and followed up again in July 2023[6]. Information from respondents was supplemented and updated with publicly available data to give additional context to the issues facing children and families accessing specialized in-home behavioral health care.

## TERMINOLOGY QUICK LOOK UP

Even mental health terminology can be inaccessible. Here are terms important to know for this report:

**BEHAVIORAL HEALTH** – Mental health, substance use and/or emotional disorders.

**BEHAVIORAL HEALTH FOR CHILDREN AND ADOLESCENTS (BHCA)** – home and community-based behavioral health services available to children and youth with certain private health coverage regulated by the Massachusetts Division of Insurance.

**CHILDREN'S BEHAVIORAL HEALTH INITIATIVE (CBHI)** – home and community-based behavioral health services available to MassHealth-enrolled children and youth.

**CLINICIAN** – A qualified professional who provides direct mental health care to individuals.

**EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)** – a federally required program for all Medicaid-eligible children under the age of 21 that provides screening, diagnosis and treatment of all physical and mental health conditions.

**MASSHEALTH** – Massachusetts Medicaid and Children's Health Insurance Program.

**SERIOUS EMOTIONAL DISTURBANCE (SED)** –a diagnosable mental, behavioral, or emotional disorder of sufficient duration that results in functional impairment or substantially interferes with or limits a child's role or functioning in family, school, or community activities.

## SUMMARY

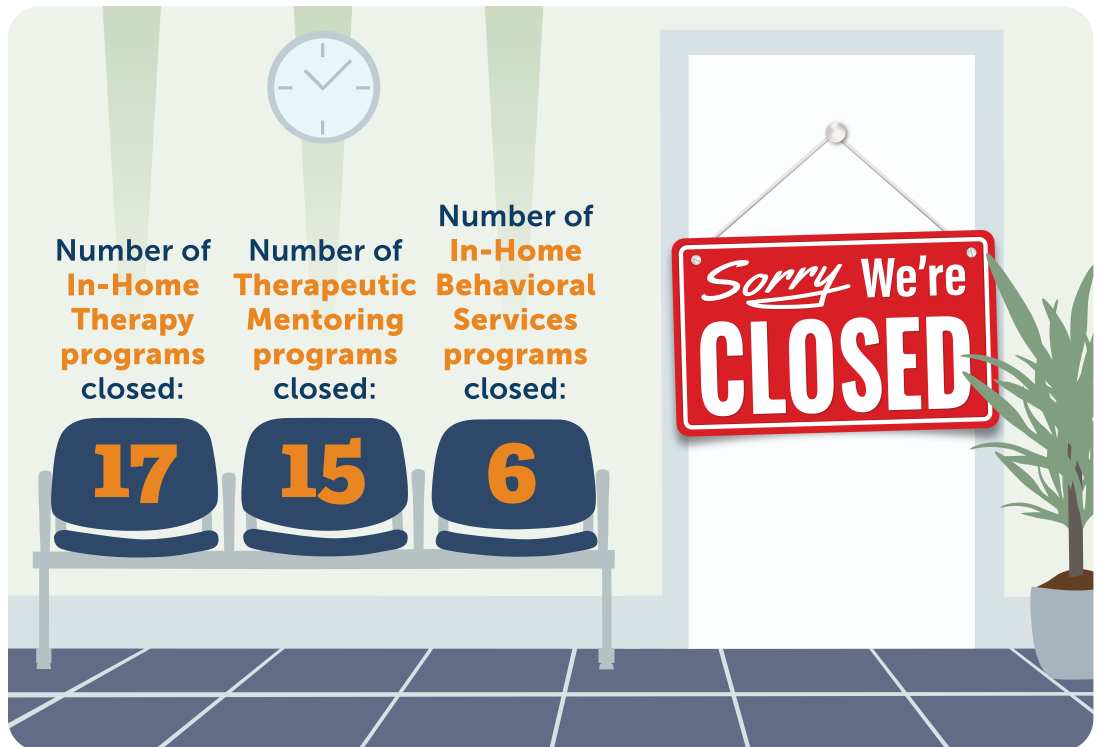
Our member organizations report worsening difficulty recruiting and retaining staff due to inadequate compensation and benefits, resulting in large wait lists for services for children. The 2022 survey responses showed as many as 3,302 children on wait lists across all home- and community-based services. By 2023, the number of children waiting increased to 4,214.

For example, the 2022 survey responses for In-Home Therapy, one of these specialty behavioral health services, showed a waitlist of 1,630 children with wait times of 16 weeks for children with MassHealth and 20 weeks for children with private insurance coverage.

Service access has since continued to deteriorate. As of May 2023, ABH members providing In-Home Therapy services reported:

- **the number of children waiting for these services had increased to 2,297, an increase of 41%;**
- **with a 20.5-week wait for MassHealth enrolled families;**
- **a 26.5-week wait for families with private health insurance; and**
- **a 35% total position vacancy rate across these services.**

Financing and workforce pressures are forcing program closures. Survey respondents reported that from Fiscal Year 2019 through eleven months of Fiscal Year 2023:




### WHO WE ARE

The Association for Behavioral Healthcare (ABH) is a statewide organization of 81 community-based mental health and substance use disorder treatment provider organizations. Our member organizations are the Commonwealth's safety net for behavioral health services. ABH members deliver a suite of Medicaid-funded behavioral health services for children and youth known collectively as Children's Behavioral Health Initiative or CBHI services. Our members deliver 100% of Intensive Care Coordination services and are significant providers of In-Home Therapy, In-Home Behavioral Services, Family Partner, and other CBHI services.

# Overview of Services

Under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, all states must screen eligible children, diagnose conditions found through the screening, and furnish appropriate treatment to correct or ameliorate physical and mental illnesses. These services must be provided promptly and for as long as needed. In 2008, the Massachusetts Medicaid program implemented the Children's Behavioral Health Initiative (CBHI) as a multi-agency remedy to a court case and order known as *Rosie D.*[7] After monitoring CBHI for more than a decade, the court found the state substantially complied with the order and terminated oversight in 2021.

**Recovering post-pandemic has been challenging. During the pandemic monies/funds given additionally helped with retention of current staff. Increased compensation for outreach/community-based work would assist in recruitment/retention. It is important and challenging work that is done in the evening and this schedule is a barrier to recruiting/retaining employees. Rates need to be increased to help better serve the community.**

**– Survey Respondent**

## CHILDREN'S BEHAVIORAL HEALTH INITIATIVE (CBHI) SERVICES FOR MASSHEALTH MEMBERS

MassHealth-enrolled children and adolescents under the age of 21 with Serious Emotional Disturbance (SED) whose needs cannot be met in traditional outpatient settings can access CBHI services. Services are unlike most other behavioral health services because they are delivered to families in their homes and in communities during evenings and weekends. There are 5 CBHI services intended to meet the unique needs of each child.[8] CBHI services include:

» **1 INTENSIVE CARE COORDINATION (ICC) – a team-based service that facilitates care planning and coordinates services for children and adolescents who meet the medical necessity criteria for this service.**

» **2 FAMILY PARTNER – a service that provides structured, one-to-one, strength-based support to the child's caregiver to provide for the child's needs. This service is delivered by a Family Partner who has lived through the experience of raising a child with serious emotional disturbance. Family Partner service is technically authorized as Family Support and Training.**

» **3 IN-HOME THERAPY (IHT) – a service consisting of a structured, consistent, strength-based therapeutic relationship between a clinical team, a child, and the child's family for the purpose of treating the child's behavioral health needs.**

» **4 IN-HOME BEHAVIORAL SERVICES (IHBS) – a service designed with clinical flexibility to offer highly individualized behavioral support services to children with a broad array of emotional and developmental conditions, including those with more than one mental health diagnosis.**

» **5 THERAPEUTIC MENTORING SERVICES (TM) – a structured, one-to-one support service that supports children to develop and improve age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution, and engagement with others.**

MassHealth maintains a network of providers to deliver these behavioral health services to eligible children up to the age of 21. According to the most recent publicly available data, in Fiscal Year 2020, approximately 33,718 children and adolescents enrolled in MassHealth received CBHI services.

## BEHAVIORAL HEALTH FOR CHILDREN AND ADOLESCENTS (BHCA)

Beginning in 2019, fully-insured Massachusetts health plans were required to cover five services that are substantially similar to the CBHI services described above.[9] During the implementation planning process, these services available to children with private health coverage became known as "Behavioral Health for Children and Adolescents."

**15,540** children received home and community based services through ABH members

## DIMINISHING ACCESS TO CRITICAL SERVICES AT A TIME OF INCREASING DEMAND

As of December 4, 2023, 59 children were waiting in hospitals emergency departments for an in-patient psychiatric bed.[10] Timely access to care is critical to supporting children and families in need of treatment and to diverting families from use of emergency departments as primary points of behavioral health care. Early, appropriate treatment may also prevent the need for more intensive services such as hospitalization.

In-home and community services are a critical lifeline to children with complex behavioral and mental health challenges and to their families, helping to prevent exacerbation of illness and unnecessary use of emergency departments. While ABH survey and other data show the number of families using home- and community-based services has strikingly decreased, data show amount of time to access care has increased in length. This is because of spiraling workforce recruitment and retention challenges.

ABH survey data show that over the course of the COVID-19 public health emergency, the number of families accessing CBHI services dropped significantly because providers who make referrals were unable to see families, and people's work, school, and home lives were significantly disrupted. To date, utilization of these services has not rebounded, due to diminished provider capacity. When surveyed by ABH, CBHI service organizations reported that the number of families receiving CBHI services as of Massachusetts Fiscal Year 2022 (end of June 2022) was about 17% less than pre-pandemic levels. By the end of May 2023, respondents reported approximately 32% fewer children and families than pre-pandemic levels received these same services as Table 1 demonstrates.

**TABLE 1**

**Number of MassHealth Children by CBHI Service from FY 2019 through 5/31/2023[11]**

| CBHI Service | Fiscal Year 2019 Children | Fiscal Year 2022 Children | 7/1/2022-5/31/2023 Children |
|---|---|---|---|
| Intensive Care Coordination | 6,746 | 4,692 | 3,986 |
| In-Home Behavioral Services | 1,011 | 1,461 | 817 |
| In-Home Therapy | 7,854 | 7,035 | 5,555 |
| Therapeutic Mentoring | 7,207 | 5,658 | 5,182 |
| Total Children: | 22,818 | 18,876 | 15,540 |

## WAIT TIMES INCREASE AS SERVICES CONSTRICT

Survey responses show that as the number of children and families receiving services declined post-pandemic, waitlists for children's home- and community-based services grew. Survey respondents reported as many as 3,300 families were waiting to receive services at the end of Fiscal Year 2022.[12] The following table reflects the number of families waiting and average wait time by CBHI service captured:

> Non-Third Party Liable commercial cases are not prioritized due to poor reimbursement, lack of allowable billable activities and the program loses money.
>
> – Survey Respondent

**TABLE 2**

### Number of families waiting and average wait time by service as of June 30, 2022[13]

| CBHI Service | Number of families on waitlist | Average wait time to start service for families with MassHealth | Average wait time to start service for families with private health coverage |
|---|---|---|---|
| **Intensive Care Coordination** | 324 | 7.0 weeks | 7.6 weeks |
| **In-Home Therapy** | 1,630 | 15.8 weeks | 20.5 weeks |
| **In-Home Behavioral Services** | 493 | 11.7 weeks | 15.7 weeks |
| **Therapeutic Mentoring Services** | 855 | 11.6 weeks | 15.3 weeks |

In-Home Therapy services had the largest number of MassHealth families waiting for services, with **an average wait time to begin services of almost 4 months**.

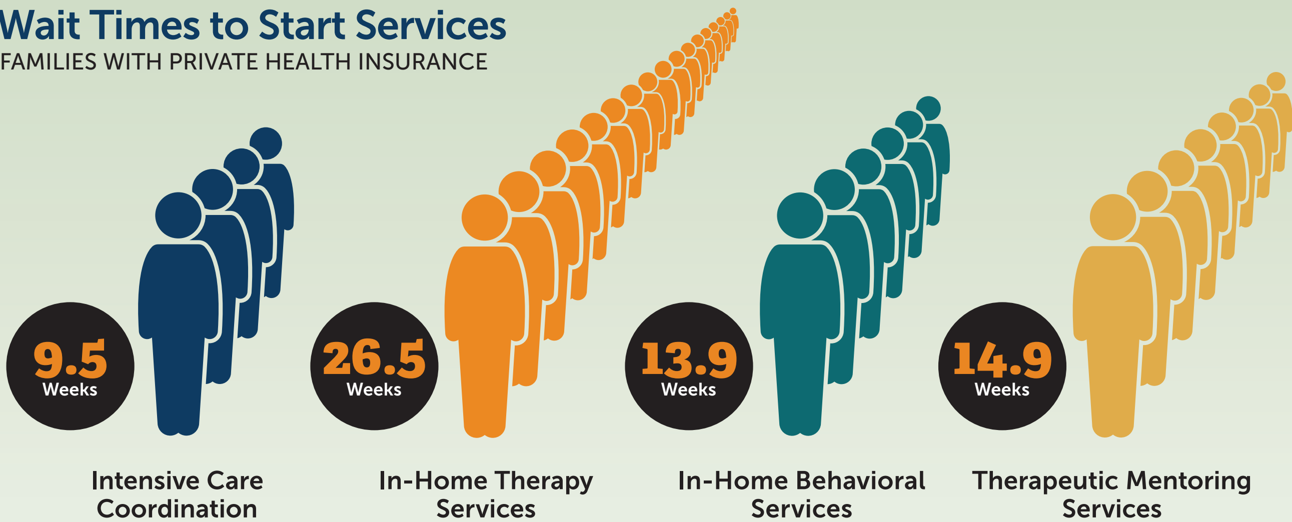
Survey respondents reported families with commercial insurance wait an *additional* 1 to 4 weeks to access services. The primary reason reported for waitlists across insurance types was staff shortages. For commercial insurance, an additional reason for the excessive wait times related to challenges in determining if services were covered by the family's health plan.

When ABH surveyed providers again on waitlists for the period of July 1, 2022 through May 31, 2023, overall waitlist numbers had increased by almost 28% from the end of Fiscal Year 2022 to 4,214 families waiting for services. Meanwhile, In-Home Therapy services reflected an **average wait time to begin services of more than 5 months**. (See Table 3 below).

**TABLE 3**

### Number of families waiting and average wait time by service from 7/1/22 – 5/31/23[14]

| CBHI Service | Number of families on waitlist | Average wait time to start service for families with MassHealth | Average wait time to start service for families with private health insurance |
|---|---|---|---|
| **Intensive Care Coordination** | 562 | 7.6 weeks | 9.5 weeks |
| **In-Home Therapy** | 2,297 | 20.5 weeks | 26.5 weeks |
| **In-Home Behavioral Services** | 509 | 12.5 weeks | 13.9 weeks |
| **Therapeutic Mentoring Services** | 846 | 13.6 weeks | 14.9 weeks |




Families with private health insurance continued to have additional wait times compared to MassHealth families, with most waiting an additional 1 to 6 weeks to access services. When asked about the variation between wait times for those with MassHealth and those with commercial insurance, several organizations commented that not all activities and/or clinical teams are able to be billed to certain commercial insurers, which leaves providers under-reimbursed for the services. Further, families and providers often have challenges determining whether the family health plan is required to cover these services. The additional wait time for those with commercial insurance reflects that children and families with MassHealth experience better access to CBHI services. There is less incentive to accept families with commercial insurance, creating a two-tier system as to who accesses and receives CBHI services within the Commonwealth.

As children and families wait for these beneficial services, symptoms can and often do worsen, leading to behavioral health crises and the need for inpatient hospitalization.

For every **10** staff that left, just **8** were hired

## STAFFING EXODUS LEADING TO SIGNIFICANT WAIT TIMES

The departure of critical clinical staff has resulted in providers' inability to offer timely access to services for children and families who seek immediate assistance with challenging behavioral health needs. Limited staffing has substantially increased the wait times for families. Across the CBHI system, survey respondents reported more than 756 staff vacancies as of May 31, 2023, with clinician staff vacancies representing 35% of total vacancies.

CBHI staff require a specialized skill set and a desire to work with families in their homes and communities. At a time when employment options are multiplying, providers report staff are leaving in unprecedented numbers for other settings such as schools, private practices, primary care practices, state agencies, and hospitals. These settings offer appropriate and competitive wages, and, in many cases, lower caseloads, family-friendly hours, fully remote work, and fami-lies with lower complexity.

ABH surveyed members in 2022 and again in 2023. Departures across all positions were trou-bling. Since September 2021, 1,546 child-serving professionals left their agencies.[15] For every **10 staff that left, just 8 were hired**.

# Intensive Care Coordination

| NUMBER OF FAMILIES ON WAITLIST: | AVERAGE WAIT TIME TO START SERVICE FOR FAMILIES WITH MASSHEALTH: | AVERAGE WAIT TIME TO START SERVICE FOR FAMILIES WITH PRIVATE HEALTH INSURANCE: |
|---|---|---|
| **562** | **7.6 weeks** | **9.5 weeks** |

Note: from 7/1/22 – 5/31/23[16]

## WHAT IS INTENSIVE CARE COORDINATION?

Intensive Care Coordination is designed to develop a collaborative relationship between a youth with serious emotional disturbance, their family, and any involved systems of care to support the parent/caregiver in meeting their child's needs. An intensive care coordinator organizes and matches the child to care across providers and child-serving systems to maintain and improve a child's ability to experience successful outcomes at home, in school, and in the community. Intensive Care Coordination assigns one dedicated care coordinator to work intensively with children and their families to ensure that services and supports are coordinated across systems and providers.

**FAMILY PARTNERS** The Family Partner service is offered in conjunction with Intensive Care Coordination or separately, and provides a structured, strength-based relationship between a caregiver with lived experience (Family Partner), and a parent/caregiver so that they can improve their ability to parent their child. The Family Partner works one-on-one with a parent/caregiver and maintains regular, frequent contact. The Family Partner educates parents/caregivers on how to navigate the child-serving systems for themselves and access available informal/community resources.

> **"[We have] Difficulty hiring Independently Licensed staff and master-level staff for this program; there are higher paying options and more telehealth options available vs. community-based work. [Barriers include] Administrative burdens and intensity of program, needing master-level support for assessments and triage."**
>
> **– Survey Respondent**

## SHRINKING WORKFORCE

The contracted provider organizations that deliver Intensive Care Coordination services report service and employment data to MassHealth each month. These monthly reports demonstrate a precipitous decline in the Intensive Care Coordinator and Family Partner workforce.[17]

**TABLE 4**

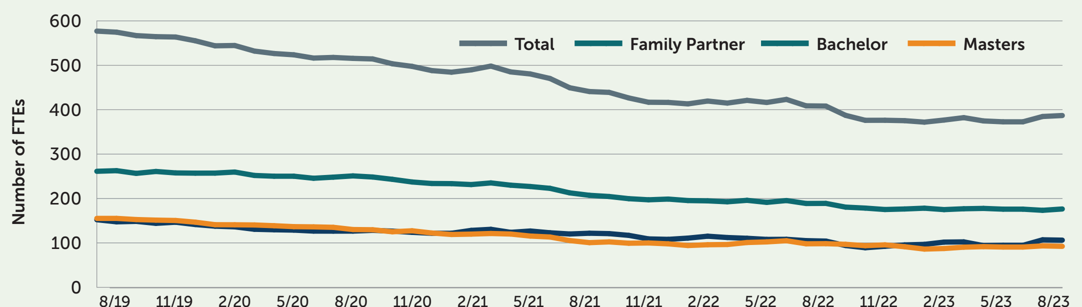
| Position | July 2019 | August 2023 | Percentage Decrease |
|---|---|---|---|
| **Bachelor Level Coordinator** | 152.2 FTE | 106.2 FTE | 30.2% |
| **Master Level Coordinator** | 155.2 FTE | 92.3 FTE | 40.5% |
| **Family Partner** | 261.3 FTE | 176.4 FTE | 32.5% |
| **Total FTEs** | 568.7 FTE | 374.9 FTE | 34.4% |

The survey data above show that more than one-third of the workforce has been lost.

**FIGURE 1**

### Shrinking Workforce

JULY 2019 - AUGUST 2023



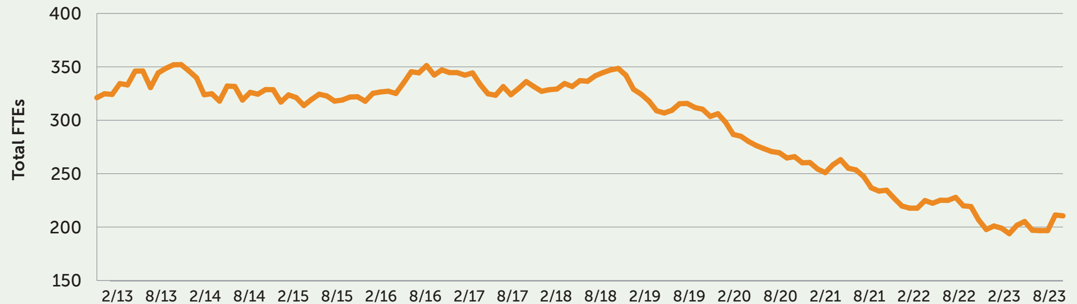
## ACCELERATING STAFFING LOSS

The staffing loss is particularly concerning when looking at the history of these home- and community-based services over the past decade. As the figure above shows, over the past five years, the pace of staffing decline has accelerated rapidly.

FIGURE 2

### Accelerating Workforce Exodus

JANUARY 2013 - AUGUST 2023



**We cannot fill vacancies due to lack of pay and high paperwork demand. We do not have master-level staff and cannot fill supervisor positions as we cannot get a licensed person to apply due to lack of salary, needing to carry a caseload (due to low reimbursement rate, and too much paperwork)....**

**–Survey Respondent**

## ALARMING STAFFING GAPS

Intensive Care Coordination providers report difficulty in retaining and recruiting essential staff. For the period ending May 31, 2023, respondents reported a:

- **Licensed Supervisor Position vacancy rate is 29%. Since July 1, 2022, for every 2 Licensed Supervisors who left, only 1 was hired.**
- **Master Level clinician vacancy rate is 33%. Since July 1, 2022, for every 10 Master Level staff who left, only 7 were hired.**
- **Bachelor Level clinician vacancy rate is 41%. Since July 1, 2022, for every 12 Bachelor Level staff who left, only 10 were hired.**
- **Family Partners vacancy rate is 26%. Since July 1, 2022, for every 5 Family Partners who left, only 4 were hired.**

## WAITS AND LOST ACCESS

It is not surprising that fewer families make their way into care. From July 2019 through May 2023, Intensive Care Coordination providers have served 31% fewer families. Provider organizations delivering Intensive Care Coordination reported that at the end of May 2023, the wait time for families with MassHealth to receive services was 7.6 weeks while families with commercial insurance waited 9.5 weeks.

Intensive Care Coordination providers report that hiring care coordination staff with clinical expertise has decreased. This is troubling because experienced clinical staff bring important skills and oversight to this intensive service, and they deliver the required supervision needed for less experienced staff to also deliver services.

# In-Home Therapy

| NUMBER OF FAMILIES ON WAITLIST: | AVERAGE WAIT TIME TO START SERVICE FOR FAMILIES WITH MASSHEALTH: | AVERAGE WAIT TIME TO START SERVICE FOR FAMILIES WITH PRIVATE HEALTH INSURANCE: |
|---|---|---|
| **2,297** | **20.5 weeks** | **26.5 weeks** |

Note: from 7/1/22 – 5/31/23

**The only reason we've been able to see a turnaround in hiring since the last survey [i.e., October 2022] has been to drastically increase salaries ($25,000 above the benchmarked rate for an In-Home Therapy clinician). This is not realistic or sustainable, but was done out of dire need in addition to spending thousands of dollars (over $28,000) in sponsored postings just to get applicants. We had not been able to hire an In-Home Therapy clinician in 15 months prior to doing all of this.**

**– Survey Respondent**

## WHAT IS IN-HOME THERAPY?

In-Home Therapy consists of a strength-based therapeutic relationship between a clinician, a child, and their family for the purpose of treating the child's behavioral health needs. Interventions are designed to enhance and improve the family's capacity to improve the child's functioning in the home and community and may prevent the need for an inpatient hospital, psychiatric residential treatment facility or other treatment-setting admission. These interventions utilize clinical judgment and evidence-based practices to assist a family to move toward their preferred vision for their child. In-Home Therapy is the most widely used CBHI service.

## WHO DELIVERS IN-HOME THERAPY?

Two types of professionals deliver In-Home Therapy as part of a team.

**IN-HOME THERAPY CLINICIANS:** An In-Home Therapy clinician, in collaboration with the child and their family, assesses needs and strengths, develops an understanding of the family's culture, works with the child and family to select treatment goals and objectives, and helps the family carry out actions that have been collaboratively identified. The In-Home Therapy clinician develops a treatment plan for the child and their family.

**THERAPEUTIC TRAINING & SUPPORT STAFF:** Therapeutic Training & Support staff support implementation of the In-Home Therapy treatment plan. Therapeutic Training & Support staff may teach a child to understand, manage, and control feelings and emotional responses to situations; assist a youth to build skills of self-care and independent living; or help the child's family to seek out and utilize community resources and build networks of support.

## ALARMING STAFFING GAPS

For the period ending May 31, 2023, In-Home Therapy respondents reported difficulty in retaining and recruiting essential staff:

- **Licensed Supervisor position vacancy rate is 26%. Since July 1, 2022, for every 2 Licensed Supervisor that left, only 1 was hired.**
- **Master Level clinician vacancy rate is 36%. Since July 1, 2022, for every 10 Master Level staff that left, 8 were hired.**
- **Therapeutic Training & Support staff vacancy rate is 35%. Since July 1, 2022, for every Bachelor Level staff that left, 1 was hired.**

In May 2023, In-Home Therapy providers were serving 29% fewer families than in July 2019. At the end of May 2023, the wait time for families with MassHealth to receive In-Home Therapy services was 20.5 weeks; families with commercial insurance waited 26.5 weeks.

Program management under these conditions has become unsustainable. Providers reported that from Fiscal Year 2019 through the eleven months of Fiscal Year 2023, **17 of 96 (18%) In-Home Therapy programs that ABH members operate closed.**[18]

# In-Home Behavioral Services

| NUMBER OF FAMILIES ON WAITLIST: | AVERAGE WAIT TIME TO START SERVICE FOR FAMILIES WITH MASSHEALTH: | AVERAGE WAIT TIME TO START SERVICE FOR FAMILIES WITH PRIVATE HEALTH INSURANCE: |
|---|---|---|
| **509** | **12.5 weeks** | **13.9 weeks** |

Note: from 7/1/22 – 5/31/23

## WHAT ARE IN-HOME BEHAVIORAL SERVICES?

In-Home Behavioral Services treat challenging behaviors that interfere with a child's successful functioning. In-Home Behavioral Services are designed with the clinical flexibility to offer highly individualized behavioral support services to children with a broad array of emotional and developmental conditions, including those with more than one behavioral health diagnosis. These services are appropriate when additional clinical expertise is needed to address a child's behavioral challenges or to reinforce the behavioral support a family provides to their child.

**Very low rates...are not attracting/retaining BCBA [Board Certified Behavior Analyst] or behavioral clinicians. This is a specialized field, and the rates are lower than IHT [In-Home Therapy] work, while the industry salary standard for behavioral clinicians is much higher. We need higher reimbursement rates...... This is the reason why IHBS programs are closing across the state, as they are not currently financially sustainable w/ these low rates.**

**– Survey Respondent**

## WHO DELIVERS IN-HOME BEHAVIORAL SERVICES?

A team of professionals delivers In-Home Behavioral Services. There are two types of professionals delivering care.

**IN-HOME BEHAVIORAL THERAPIST:** An In-Home Behavioral Therapist conducts a behavioral assessment and develops a Behavior Support Plan in conjunction with a child and their family. The Behavioral Therapist oversees the implementation of the plan, measuring the effectiveness of the behavioral change strategies, and proposes modifications as needed.

**IN-HOME BEHAVIORAL SUPPORT MONITOR:** An In-Home Behavioral Support Monitor is supervised by and works closely with the In-Home Behavioral Therapist. The Behavioral Support Monitor models appropriate behaviors for a child, observes and supports families, and provides feedback to the therapist on family engagement and behavioral plan implementation.

## ALARMING STAFFING GAPS

In-Home Behavioral Services providers report difficulty in retaining and recruiting essential staff. For the period ending May 31, 2023, In-Home Behavioral Services respondents reported the:

- **Licensed Supervisor Position vacancy rate is 48%. Since July 1, 2022, for every 4 Licensed Supervisors that left, only 1 was hired.**
- **Master Level Clinician vacancy rate is 61%. Since July 1, 2022, for every 6 Master Level Clinicians that left, 7 were hired.**
- **Bachelor Level staff vacancy rate is 51%. Since July 1, 2022, for every 16 Bachelor Level staff that left, only 13 were hired.**

At the end of May 2023, the wait time for families with MassHealth to receive In-Home Behavioral Services was 12.5 weeks; families with commercial insurance waited 13.9 weeks.

In May 2023, ABH providers of In-Home Behavioral Services reported that they served 19% fewer families than in Fiscal Year 2019 and 45% fewer families than in Fiscal Year 2022.

As with other Children's Behavioral Health Initiative Services, this service has become challenging to maintain with significant staffing vacancies. **Survey respondents reported 6 closures of 25 (24%) member programs statewide since July 2019.**[19]

# Therapeutic Mentoring

| NUMBER OF FAMILIES ON WAITLIST: | AVERAGE WAIT TIME TO START SERVICE FOR FAMILIES WITH MASSHEALTH: | AVERAGE WAIT TIME TO START SERVICE FOR FAMILIES WITH PRIVATE HEALTH INSURANCE: |
|---|---|---|
| **846** | **13.6 weeks** | **14.9 weeks** |

Note: from 7/1/22 – 5/31/23

## WHAT IS THERAPEUTIC MENTORING?

Therapeutic Mentoring offers structured, one-to-one support services between a Therapeutic Mentor and a child for the purpose of addressing daily living, social, and communication needs identified in a treatment plan. Therapeutic Mentors work with children on age-appropriate behaviors, interpersonal communication, problem-solving skills, and conflict resolution in a home- and community-based environment.

**The [Therapeutic Mentors] have worked to provide quality services to our communities and deserve to have wages that reflect their dedication and passion for this work. Some staff have families that they are caring for where higher wages would keep them afloat and not needing to take on additional jobs to make ends meet. This role is critical to youth-specific success/outcomes, and yet grossly undervalued as the lowest reimbursed CBHI service.**

**– Survey Respondent**

## WHO DELIVERS THERAPEUTIC MENTORING SERVICES?

These services are delivered by a paraprofessional known as a Therapeutic Mentor. The Therapeutic Mentor works directly with the child, family, and referring provider (Intensive Care Coordination, In-Home Therapy, or Outpatient Therapy) to address a child's needs in a manner that is strengths-based and culturally competent and helps families to implement their child's treatment plan. With the family's consent, the Therapeutic Mentor collaborates with other behavioral health services and other supports.

## ALARMING STAFFING GAPS

As of May 31, 2023, Therapeutic Mentoring providers reported that they have served 28% fewer families than in Fiscal Year 2020. At the end of May 2023, the wait time for families with MassHealth to receive services was 13.6 weeks, families with commercial insurance wait 14.9 weeks.

Therapeutic Mentor providers report difficulty in retaining and recruiting essential staff:

- **Licensed Supervisor position vacancy rate is 31%. Since July 1, 2022, for every 14 Licensed Supervisors that left, only 5 were hired.**
- **Bachelor Level position vacancy rate is 36%. Since July 1, 2022, for every Bachelor Level staff that left services, approximately 1 was hired.**

Finally, workforce and financing pressure is forcing program closures. Survey respondents report that maintaining services has become extremely challenging to the point of unsustainable. **From Fiscal Year 2019 through May 31, 2023, respondents reported that 15 of the 89 (17%) ABH member programs offering Therapeutic Mentoring services closed.**[20]

**THESE SERVICES ARE DELIVERED TO FAMILIES** in their homes and in communities during evenings and weekends. It is exceptionally challenging to attract and retain staff into these roles. Reversing the shrinking access to children's behavioral health services requires short-, mid- and long-term strategies and necessitates partnerships between both the public and private sectors. While the Commonwealth remains a leader in behavioral health, and implementation of the state's **Roadmap for Behavioral Health Reform** will provide more help, particularly for those experiencing a behavioral health crisis, the access barriers and decimation of the CBHI workforce show that more work needs to be done to meet the behavioral health treatment needs of children and their families in their homes and in our communities. Our recommendations follow:

# 1 Immediate Action to Increase Access

## IMMEDIATE AND SUBSTANTIAL RATE INCREASES

The Massachusetts Health Policy Commission's 2023 Annual Health Care Cost Trends Report and Policy Recommendations call for increased behavioral health service access "in particular among children, young adults and people of color."[21] The report recommends a series of commonsense strategies to improve access.[22] However, none of them will be effective without adequate wages. The home- and community-based delivery system is collapsing. Providers' ability to provide effective, high quality behavioral health care is directly related to the Commonwealth setting and paying appropriate rates for these essential services. Low reimbursement rates and staffing challenges for positions that require home- and community-based service delivery around the schedules of children and families have resulted in high vacancy rates, frequent turnover, months-long waitlists, and the permanent closure of certain programs. The Commonwealth has recently infused approximately $70 million in emergency rate increases into these services, and providers deeply appreciate the urgent help. Early indications, however, are that this is insufficient to incentivize individuals to work in this challenging service system that requires being in people's homes and communities at the times that work best for families, rather than office-based or remote work during traditional business hours.[23]

When the Commonwealth prices these services, benchmarked salaries used in rate development are not market salaries. In developing rates for the new Community Behavioral Health Centers outlined in the Roadmap, the Commonwealth used benchmark salaries at the 75th percentile of Bureau of Labor Statistics or above for relevant positions. For home- and community-based services, the Commonwealth used a much lower benchmark.

Of course, service delivery and access concerns are not limited to Medicaid as a recent report from the Massachusetts Association of Health Plans reflects.[24] Providers interviewed for the report saw opportunities to improve coordination and alignment between CBHI and Behavioral Health for Children and Adolescents (BHCA) services. Specific to these services, those interviewed expressed a need to review salary levels for CBHI/BHCA staff to make them competitive with other services within the behavioral health system. Because reimbursement rates drive compensation, commercial health plans should assess their rates of payment. ABH recommends further review to assess reimbursement in the context of the entire delivery system as a counter to historic under-valuing.

In its 2023 Health Care Cost Trends Report, the Health Policy Commission recommends that the state consider "policy changes supporting enhanced wages for under-resourced sectors."[25] Use of competitive wage benchmarks in rate setting is one of the essential strategies needed to achieve wage equity. For these children's services, the 75th percentile of Bureau of Labor Statistics wage benchmarks is closer to market rate and reflects what providers are already paying staff and/or must pay to retain them. Rates must also account for salaries for the next two years. We fear that without further significant investment into the home-based behavioral health system, crucial services for children and families will dissolve.

## MAXIMIZE THE EXISTING WORKFORCE

The recent Massachusetts Association of Health Plans report noted that interviewees recommended expanding the pool of available CBHI/BHCA providers by modifying

the levels and kinds of staff who can provide some services while still monitoring accountability.[26] One such example is to use paraprofessional staff more frequently. In MassHealth, to ensure more families receive Family Support & Training and Therapeutic Mentoring Services, it should eliminate the existing requirement that children must be referred to these services through another provider called a "hub provider", e.g., providers delivering In-Home Therapy or Intensive Care Coordination services. Without this referral dependency, families could access these services directly and continue engagement in the event other CBHI services conclude. Providers report that families may still require services but when hub services cease, the family must be discharged from *all* CBHI services. The elimination of the hub requirement would also align with "family voice, family choice," whereby a caregiver may feel that a now hub-dependent service such as Therapeutic Mentoring is more appropriate for their child and is preferred. Allowing the parent/caregiver who best knows their child to choose a fitting service will lead to longer treatment engagement and improved behavioral health outcomes.

### INCREASE CULTURAL, ETHNIC, AND LINGUISTIC COMPETENCE OF SERVICES

Providers reported that 7% to 9% of individuals on waitlists were attributable to family preference for clinicians that could deliver linguistically or culturally competent care. To improve access to services for individuals and populations disproportionately affected, the Commonwealth should fund and develop programming that is culturally, ethnically, and linguistically diverse. This includes paying a rate differential for services offered in a language other than English.

### INVEST IN OUTPATIENT SERVICES

Fast, easy, and ongoing access to outpatient mental health services, such as psychotherapy and medication management, particularly when it happens early enough, can help some families avoid more intensive Children's Behavioral Health Initiative services. Right now, it is a challenge for children and youth to access outpatient mental health when they need it. New Community Behavioral Health Centers hold tremendous promise in expanding access, particularly in crisis and urgent situations. However, 26 centers statewide are not adequate to meet the ongoing treatment demands of families across the Commonwealth. A robust and healthy outpatient system of care is needed to ensure access for families before symptoms exacerbate and Community Behavioral Health Centers need to have treatment and referral partners. Outpatient clinics offer families therapy and medication management that insurance covers, and they also play a key role in training future behavioral health professionals. Pending legislation would require MassHealth to invest more in these behavioral health access and workforce engines.[27]

## 2 Improve Workforce Recruitment and Retention

### CONTINUE AND REINVEST IN RETENTION INITIATIVES

The Student Loan Repayment Program funded through the Massachusetts Delivery System Reform Incentive Payment Program was an effective recruitment and retention tool, made available to certain individuals, including those delivering Intensive Care Coordination. Its state-funded counterpart, the Massachusetts Repay program, provided loan repayment awards to behavioral health and primary care staff in exchange for time-limited commitments to work in safety-net settings such as community health centers, community mental health centers, and inpatient psychiatric units and facilities.[28] The Commonwealth should continue to re-invest in the Massachusetts Repay program and include dedicated resources for Children's Behavioral Health Initiative professionals as part of a strategy to retain a clinically experienced workforce to serve children with serious emotional disturbance.

### IMPLEMENT PIPELINE STRATEGIES

Many individuals who wish to enter the behavioral health workforce cannot do so, because they must continue to work and cannot afford to take on educational loans to pay for school. This is particularly true of staff for whom English is not their primary or preferred language, individuals fluent in ASL, and individuals who are BIPOC . Recognizing the need to create a larger, more representative workforce, the Behavioral Health Trust Fund Advisory Commission recommended creating and funding a scholarship program that enables colleges and universities to

develop a workforce pipeline that provides a clear path to careers in behavioral health for individuals seeking bachelor's- and master's-level degrees.[29] This scholarship program would also prioritize diverse applicants and placements in areas of highest need, including by engaging in recruiting efforts in underrepresented communities.[30] Some of these recommendations were included in the Fiscal Year 2024 state budget to expand behavioral and primary care workforce programs into scholarships and paid internships and supervision. In its 2023 Health Care Cost Trends and Policy Recommendations report,[31] the Health Policy Commission recommends that the state "provide upfront support to alleviate the financial burden of education and training, including for advanced degrees and for the period between education and licensure for licensed roles, and should otherwise reduce barriers to entry." *ABH strongly endorses continued investment in strategies that reinforce the behavioral health pipeline.*

### IMPLEMENT A PERMANENT BEHAVIORAL HEALTH WORKFORCE CENTER

No single entity at the state level is charged with addressing behavioral health workforce issues. Given the exodus of staff leaving home- and community-based work, a permanent center of excellence, staffed by experts, should be established to conduct long-term planning, including establishing baseline needs and developing recommendations and strategies to meet these needs. The Fiscal Year 2024 state budget included $1.8 million to create a behavioral health workforce center to recruit, retain and develop a diverse, experienced workforce. It is vitally important that a permanent center be supported with ongoing appropriations.

Pending legislation would create such a center,[32] and the Blue Cross Blue Shield of Massachusetts Foundation has recommended a behavioral health workforce center.[33] While there are multiple potential pathways, *ABH strongly recommends making a behavioral health workforce center permanent as soon as possible.*

### REDUCE UNNECESSARY ADMINISTRATIVE BURDEN

Behavioral health providers experience administrative burdens that can include lengthy forms or documentation requirements, unclear processes to navigate for authorization and approval of services, and unclear reasons for denials. In both the October 2022 and July 2023 surveys, respondents commented that documentation burden and administrative requirements are key factors in staff turnover, in particular with master's-prepared clinicians. Addressing administrative burdens could reduce time spent on non-reimbursable activities, allowing for more time providing clinical services, resulting in higher retention rates and job satisfaction. *ABH supports continued and stronger efforts by MassHealth and private health plan insurers to reduce and streamline administrative requirements for behavioral health providers.*

## 3 Improve Access for Kids with Private Health Coverage

### MAKE IT EASY FOR FAMILIES TO KNOW IF HOME-BASED BEHAVIORAL HEALTH SERVICES ARE COVERED

Providers report that families and providers spend a considerable amount of time establishing whether their private health insurance covers these home-based services. Coverage uncertainty delays access to care. *ABH supports pending legislation that would require insurance companies to add information to member insurance cards indicating whether the member's health plan is subject to Massachusetts insurance laws like the requirement to cover these home-based services.*[34]

### ELIMINATE COST SHARING FOR HOME-BASED BEHAVIORAL HEALTH SERVICES FOR CHILDREN

The Health Policy Commission's 2023 Cost Trends Report found that annual health care spending for Massachusetts families averaged nearly $25,000.[35] Strikingly, 42.7% of Massachusetts residents with commercial insurance had high-deductible plans, up from 15.5 % in 2013.[36] This dramatic increase reflects intentional efforts to shift rising costs to employees. High deductible health plans as well as high cost sharing are barriers to families accessing needed

services. In the substance use delivery system, some commercial health plans have waived co-pays for medication-assisted treatment, which often require frequent encounters with treating providers. Health plans should consider eliminating cost sharing, including co-payments or deductibles for behavioral health services as part of the Commonwealth's ongoing strategy to improve health equity and strengthen behavioral health, particularly for children.

### ASSESS COMMERCIALLY INSURED FAMILIES' ACCESS

In overseeing the implementation of the Behavioral Health for Children and Adolescents mandate, the Division of Insurance played a key role in convening stakeholders, coordinating information requests and responses, and publishing practical information for families, providers, and carriers. The Division of Insurance should convene stakeholders to solicit feedback on the implementation and assess whether children and families have timely access to mandated benefits.

## 4 Rebalance Health Care Spending Toward Behavioral Health and Primary Care

Undergirding all ABH's recommendations in this and other recent briefs is the chronic, pernicious, and persistent underfunding of behavioral healthcare. *ABH strongly supports rebalancing health care expenditures toward behavioral health and primary care.* ABH recommends a rebalancing framework be pursued and leveraged to provide substantial new financial investment in community-based behavioral and primary health care to support new service design and enhancements. The Center for Health Information and Analysis's 2022 Report *Behavioral Health & Readmissions in Acute Hospitals* notes that growing evidence "indicates that patients with comorbid behavioral health conditions have higher readmission rates and have higher overall hospital utilization and cost."[37] By improving access to lower cost, community-based services, use of high-cost health care, such as unnecessary emergency department visits and inpatient admissions and readmissions, can be greatly reduced and lead to improved health outcomes.

In 2019, the Commonwealth reported that available data suggested "that less than 15% of total medical expenses in Massachusetts was spent on primary care and outpatient behavioral health services combined."[38] As noted, the 2023 Cost Trends Report and Policy Recommendations include numerous recommendations related to improving behavioral health quality and access, including "increasing reimbursement to behavioral health providers."[39] The recommendations also speak to the tension between investments and policy objectives for staying within a total health care cost growth benchmark. Expenditure benchmarks are extremely important, and it is likely that investment in behavioral health can mitigate costs in other areas. However, the legacy of under-investment in and undervaluing of behavioral healthcare needs to be aggressively remedied. Unless we move toward rebalancing, there will be no mitigation of ongoing access challenges. Vital health equity legislation currently pending would begin to remedy this imbalance over three years and should be seriously considered.[40]

**MASSACHUSETTS HAS AN IMPRESSIVE SYSTEM** of home- and community-based mental health services for families with public and commercial health coverage, but that system is on paper only. Children are suffering because we are failing to invest in services and in the workforce. There are solutions that will improve service access, but they require commitment to multiple short- and long-term strategies.

# Endnotes

1. Lydie A. Lebrun-Harris, et al., Five-year trends in U.S. Children's Health and Well-being, 2016-2020. JAMA Pediatrics, July 2022, 176(7). Five-Year Trends in US Children's Health and Well-being, 2016-2020 - PMC (nih.gov); American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association, A Declaration of a National Emergency in Child and Adolescent Mental Health, October 19, 2021. AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health.

2. Association of Behavioral Healthcare, Outpatient Mental Health Access and Workforce Crisis: Issue Brief, February 2022. Outpatient survey issue brief (abhmass.org).

3. Lebrun-Harris, 2022.

4. Deborah M. Stone, et al., Notes from the Field: Recent Changes in Suicide Rates, by Race and Ethnicity and Age Group — United States, 2021. MMWR Morb Mortal Wkly Rep 2023;72:160–162. DOI: http://dx.doi.org/10.15585/mmwr.mm7206a4.

5. CDC WONDER: Underlying Cause of Death, 1999–2019. US Department of Health and Human Services, CDC; 2020. https://wonder.cdc.gov/Deaths-by-Underlying-Cause.html.

6. 29 provider organizations responded to the ABH survey in 2022. 30 provider organizations responded in 2023.

7. *Rosie D. v. Romney*, 410 F. Supp 2d 18 (D. Mass. 2006).

8. MassHealth Children's Behavioral Health Initiative (CBHI), CBHI for Families, revised March 2019. https://www.mass.gov/info-details/cbhi-for-families.

9. Required services include In-Home Behavioral Services, Family Support and Training, In-Home Therapy, Therapeutic Mentoring, and Intensive Care Coordination; *See* Division of Insurance Bulletin 2018-07: Access to Services to Treat Child-Adolescent Mental Health Disorders, December 14, 2018. https://www.mass.gov/doc/bulletin-2018-07-access-to-services-to-treat-child-adolescent-mental-health-disorders-issued/download.

10. Massachusetts Health & Hospital Association, Capturing a Crisis Massachusetts Behavioral Health Boarding Metrics, (11/14 - 11/27/23), https://mhalink.informz.net/mhalink/data/images/20231204BehavioralHealthReport.pdf

11. Association for Behavioral Healthcare, CBHI Services Access and Workforce Survey (2023 Update), July 2023.

12. Association for Behavioral Healthcare, ABH CBHI Services Access and Workforce Survey, September 2022. Note: A family may be waiting for more than one service, and reported data were aggregate and not unduplicated.

13. ABH CBHI Services Access and Workforce Survey (2023 Update).

14. ABH CBHI Services Access and Workforce Survey (2023 Update).

15. Survey respondents reported 790 staff departing between September 2021 and June 2022 and additional 756 departing during the 11-month period of July 2022 to May 2023.

16. ABH CBHI Services Access and Workforce Survey, 2023.

17. Massachusetts Behavioral Health Partnership. CSA Monthly Report for February 2020 (3/30/20); CSA Monthly Report for August 2023 (10/3/23). Note: CSAs or Community Service Agencies are the MassHealth providers contracted to deliver Intensive Care Coordination service.

18. ABH CBHI Services Access and Workforce Survey, 2023.

19. ABH CBHI Services Access and Workforce Survey, 2023.

20. ABH CBHI Services Access and Workforce Survey, 2023.

21. Massachusetts Health Policy Commission, 2023 Annual Health Care Cost Trends Report and Policy Recommendations, September 2023. https://www.mass.gov/doc/2023-health-care-cost-trends-report/download.

22. Recommended Roadmap-related strategies include "Ensuring the right treatment when and where people need it, including increasing inpatient beds for behavioral health patients (including pediatric patients), investing in community-based alternatives to the emergency department, and aligning the behavioral health workforce with current needs, by increasing reimbursement to behavioral health providers, developing targeted recruitment and retention strategies, and using telehealth and innovative care models to extend capacity and ensure that patients have equitable access to the appropriate level of care based on their needs." Massachusetts Health Policy Commission, 2023 Annual Health Care Cost Trends Report and Policy Recommendations at 58.

23. Effective January 1, 2023, EOHHS issued emergency rates for In-Home Therapy Services, applying an adjustment of 35% increase to prior rates. As noted above, as of May 31, 2023, ABH members delivering In-Home Therapy Services reported that the vacancy rate for master-level clinicians was 36% and the vacancy rate for Therapeutic Training & Support staff was 35%.

24. Massachusetts Association of Behavioral Health Plans, Massachusetts Responds to the Crisis in Children's Behavioral Health, January 2023. https://www.mahp.com/wp-content/uploads/2023/01/bh-report-20230113.pdf.

25. Massachusetts Health Policy Commission, 2023 Annual Health Care Cost Trends Report and Policy Recommendations at 57-58.

26. Massachusetts Association of Behavioral Health Plans, Massachusetts Responds to the Crisis in Children's Behavioral Health, 2023.

27. H. 2006, S. 760, An Act relative to behavioral health clinic rates.

28. Behavioral Health Trust Fund Advisory Commission, Final Report: Findings and Recommendations, May 3, 2023. https://malegislature.gov/Reports/16660/(2)BHAC_FInal_Report_May_2023.pdf.

29. Behavioral Health Trust Fund Advisory Commission, Final Report: Findings and Recommendations, 2023.

30. Behavioral Health Trust Fund Advisory Commission, Final Report: Findings and Recommendations, 2023.

31. Massachusetts Health Policy Commission, 2023 Annual Health Care Cost Trends Report and Policy Recommendations at 57.

32. H.1275/S.829 - An Act establishing a behavioral health workforce center of excellence.

33. Mindy Lipson, et al., Creating a Robust, Diverse, and Resilient Behavioral Health Workforce in Massachusetts, Blue Cross Blue Shield of Massachusetts Foundation. September 2022. https://www.bluecrossmafoundation.org/publication/creating-robust-diverse-and-resilient-behavioral-health-workforce-massachusetts.

34. H.937/S.602 An Act relative to transparency of consumer health insurance rights.

35. Massachusetts Health Policy Commission, 2023 Annual Health Care Cost Trends Report and Policy Recommendations at 13.

36. Massachusetts Health Policy Commission, 2023 Annual Health Care Cost Trends Report and Policy Recommendations at 13.

37. Center for Health Information and Analysis, Behavioral Health and Readmissions in Massachusetts Acute Hospitals SFY2020, October 2022. https://www.chiamass.gov/assets/docs/r/pubs/2022/Behavioral-Health-Readmissions-2022-Report.pdf.

38. Press Release, Baker-Polito Administration Announces Health Care Legislation Aimed at Addressing Key Challenges, October 18, 2019. https://core.ac.uk/download/pdf/232600855.pdf.

39. Massachusetts Health Policy Commission, 2023 Annual Health Care Cost Trends Report and Policy Recommendations at 58.

40. H. 1250/S.799, An Act to advance health equity. See also standalone rebalancing legislation S.. 1248, An Act to increase investment in behavioral health care in the Commonwealth. The policy shift represented by these bills is what is required to remedy the structural challenges at the root of behavioral health access shortages.