

# **Special Commission on Access to Behavioral Health Services for Children and Families**



**Amy Rosenthal, MPH, MPA  
Undersecretary for Health  
Executive Office of Health and Human Services**

**February 25, 2026  
9:30 - 11:00 am**

**Virtual / Zoom**



# Agenda



1. Welcome
2. Approval of 1/21/2026 Meeting Minutes
3. Challenges & Recommendations Workgroup Update
4. Discussion of Commission Deliverables
5. Next Steps



# Overview of Challenges & Recommendations



# Challenges & Policy Recommendations



## Working Group 2: Initial review of challenges and recommendations completed

PROGRESS STATUS: ● *In progress*

February 2026 | Status as of Feb 24

### Key Findings to Date

1. Challenges
  - Sheer number and overlapping/cross-sector nature of challenges
2. Policy Recommendations
  - Establish a unified, child- and family-centered access system for behavioral health services – a single point of entry, i.e., front door.
  - Improve meaningful cross-agency and cross-sector collaborations among health care (physical and behavioral), child welfare, schools, juvenile justice, and payors (Medicaid, private insurers), etc.
  - Implement a coordinated workforce strategy to address provider shortages and improve culturally responsive care.

### Commission Questions & Gaps

1. General feedback on the recommendations the group has pulled together?
2. How can we streamline the recommendations that touch multiple topic areas?

### Next Steps

1. Continued discussion with Commission during next meeting (3/18/2026)

**Members:** Carmel Craig, Kristen McKinnon, Pam Sager, Leigh Simons, Aimee Smith-Zeoli, Charlene Zuffante



# Challenge: Access, Entry & Navigation



## Access, Entry, & Navigation

- No clear starting place; inconsistent entry, referral, and intake pathways
- Families lack clear information on services, roles, and eligibility
- Caregiver burden + barriers from requirements, hours, transportation, transitions

### Policy

### Key Elements

Reduce unnecessary burdens and service delivery delay by ensuring access, entry, and navigation system design is family centered and family driven.

- Utilize existing behavioral health groups and agencies to gather significant and widespread information from families and other stakeholders
- Utilize the Children’s Behavioral Health Advisory Council or an extension of this Special Commission to develop and make recommendations gathered from stakeholder input

Provide clear information to families, providers, professionals, and the community about state agency (or community-based program/service, such as CBHC or CBHI) roles and services.

- Engage users of services to design and maintain

Create a clear starting place for obtaining children’s services.

- Single point of entry with family-centered trained staff
- Single pool of funds
- Create an interagency centralized data dashboard
- Market this single-entry door in a family centered manner

Standardize application and referral processes and eligibility criteria across system

- Standard, digitized referral & application process
- Align eligibility criteria & train staff

Ensure access for children with complex needs that spans agencies through collaboration and clear service pathways.

- Improve cross-agency and cross-sector collaboration
- Set targeted goals for collaboration
- Single point of entry and pooled funds

Clarify MassHealth and commercial coverage—and which providers accept each—to reduce confusion and improve access.

- Align language on services between MassHealth & commercial insurers
- Align accepted insurers across service providers
- Educate families and all stakeholders about coverage



# Challenge: Coverage, Affordability, Administrative Barriers & Financing/Sustainability



## Coverage, Affordability, Admin Barriers & Financing/Sustainability

- Coverage gaps/denials, cost-sharing, reimbursement issues block access
- Admin complexity (eligibility, auth, billing) delays care
- Financing/payment rules (rates, grants) affect sustainability and provider participation

Policy	Key Elements
<p>Reduce and/or eliminate insurance coverage gaps and denials so that children promptly receive appropriate and timely services</p>	<ul style="list-style-type: none"> <li>• Gather and publish stakeholder and family feedback on BHCA utilization, access, and reimbursement gaps.</li> <li>• Conduct market review and surveys to assess compliance with mandated benefits and timely access.</li> <li>• Strengthen coverage by eliminating cost-sharing for home-based services and expanding Medicaid early screening.</li> <li>• Increase transparency (e.g., clarify MA law applicability on insurance cards).</li> </ul>
<p>Reduce administrative complexity (e.g., eligibility, authorizations, billing, etc.) within child-serving systems for families, providers, agencies, and payors.</p>	<ul style="list-style-type: none"> <li>• Identify administrative barriers across child-serving systems that delay access (e.g., eligibility, prior auth, billing, credentialing).</li> <li>• Gather stakeholder input and streamline processes to improve timely service access.</li> </ul>
<p>Maximize the impact and sustainability of funding across child-serving agencies and programs</p>	<ul style="list-style-type: none"> <li>• Incentivize PCPs to deliver behavioral health and use data to guide reinvestment and scale-up.</li> <li>• Conduct fiscal analysis to ensure sustainable growth (short- vs. long-term costs, neutrality, prevention offsets).</li> <li>• Align and coordinate Medicaid, CBHI, and other state/federal funding; standardize rates where appropriate.</li> <li>• Sustain IECMH and culturally responsive workforce investments with legally aligned funding strategies.</li> </ul>



# Challenge: Workforce Capacity, Stability & Training



## Workforce Capacity, Stability & Training

- Shortages and closures reduce availability and continuity
- Turnover (wages, burnout, competition) undermines stability and responsiveness
- Training gaps & lack of diverse/bilingual workforce limits appropriate care (ASD/IECMH)

Policy	Key Elements
Address workforce shortages across settings to ensure availability and continuity of care, as well as reducing waitlists, limited capacity, and service gaps.	<ul style="list-style-type: none"> <li>• Address the root cause of workforce declines (e.g., salary, scheduling, caseloads).</li> <li>• Create and sustain a Mental Health Talent/Workforce pipeline.</li> <li>• Develop a program/cohort of providers and students that meet regularly.</li> <li>• Provide incentives to finance MA-level programs for staff.</li> </ul>
Reduce high turnover and instability that disrupt relationships, responsiveness, and care continuity.	<ul style="list-style-type: none"> <li>• Strengthen workforce retention through HPC Behavioral Health Workforce Center and related efforts (e.g., MA Repay reinvestment, targeted scholarships to diversify and place providers in high-need communities).</li> <li>• Simplify licensing processes and reciprocity from other states/US territories/etc.</li> </ul>
Enable the children’s behavioral health delivery system to serve children and families by eliminating training and specialization gaps.	<ul style="list-style-type: none"> <li>• Expand cross-agency child behavioral health training, including ASD and complex needs.</li> <li>• Remove access barriers (e.g., CBHI Hub requirement) to maximize existing workforce.</li> <li>• Grow workforce through paraprofessionals, creative credentialing, and expanded fellowships/residencies.</li> <li>• Provide compensation for clinical and reflective supervision.</li> <li>• Increase access to linguistically and culturally competent care through rate differentials.</li> <li>• Pursue legislative changes to broaden ASD diagnostic authority and reduce bottlenecks.</li> </ul>



# Challenge: System Design, Fragmentation & Coordination



## System Design, Fragmentation & Coordination

- Multiple agencies/payors with limited coordination and accountability
- Inconsistent care coordination processes create gaps and duplication
- Limited cross-system integration; unclear roles/leadership (incl. ASD coordination)

Policy	Key Elements
<p>Create and empower a leadership hub to facilitate consistency and alignment across children’s behavioral health systems</p>	<ul style="list-style-type: none"> <li>• Incentivize PCPs to provide behavioral health services and use data (e.g., BHHL) to guide reinvestment.</li> <li>• Conduct fiscal analyses to support sustainable scale-up, including short- vs. long-term costs, budget neutrality, and prevention offsets.</li> <li>• Align Medicaid, CBHI, and other state/federal funding streams; standardize rates across agencies.</li> <li>• Coordinate funding to strengthen workforce and culturally responsive care, ensure legal/regulatory alignment, and sustain IECMH beyond short-term grants.</li> </ul>
<p>Create a “front door” system through which children access the care they need, regardless of the point of entry.</p>	<ul style="list-style-type: none"> <li>• Identify entity/individuals to serve as the “front door” (e.g., Family Partners, Systems Navigator, Family Resource Centers; NJ model).</li> <li>• Improve transparency and accountability for BH managers (e.g., DOI directory requirements, key contact).</li> <li>• Participate in MassHealth ACO / integrated care payment model.</li> </ul>



# Challenge: Equity & Population-Specific Gaps



## Equity & Population-Specific Gaps

- Persistent inequities by race, language, geography, income, disability, identity
- Insufficient language access and culturally responsive care
- Systems don't fit high-need groups (ASD/DD, medical complexity, DCF/homelessness; ACEs)

Policy	Key Elements
Require an Equity Impact Framework across all publicly funded children's behavioral health services.	<ul style="list-style-type: none"> <li>• Implement a cross-agency equity accountability framework with standardized, disaggregated reporting; embed equity metrics in contracts, rate-setting, and procurement, with measurable disparity thresholds and corrective action plans.</li> <li>• Mandate routine equity impact reviews of access, referrals, waitlists, and placement decisions, and publish an annual public equity report/dashboard.</li> </ul>
Establish enforceable language access standards across the behavioral health continuum.	<ul style="list-style-type: none"> <li>• Work with ORI and relevant agencies to establish and enforce language access standards across child-serving systems, including interpreter access, translated materials, prohibition of untrained interpreters, funding bilingual clinicians, and compliance oversight.</li> </ul>
Prioritize culturally responsive care as a reimbursable, measurable standard of quality.	<ul style="list-style-type: none"> <li>• Require culturally responsive practices and documented partnerships with community-based organizations serving historically marginalized populations.</li> <li>• Fund identity-affirming, community-rooted providers (e.g., BIPOC-led, immigrant-serving, LGBTQIA+ affirming).</li> <li>• Embed family and youth voice in program design, evaluation, and oversight.</li> <li>• Ensure ongoing training in culturally responsive and anti-racist practices.</li> </ul>
Create specialized pathways for children and youth whose needs do not fit traditional service models.	<ul style="list-style-type: none"> <li>• Establish a formal interagency pathway and regional multidisciplinary teams for multi-complex youth (e.g., ASD/DD, medical complexity, cross-system involvement) to expedite placement and align funding.</li> <li>• Require inpatient/residential providers to demonstrate disability competence and trauma-responsive, integrated care; prohibit denial of admission; and implement enhanced reimbursement tiers for high-acuity youth.</li> </ul>



# Challenge: Equity & Population-Specific Gaps Cont. -



Policy	Key Elements
Establish a unified, child- and family-centered access system for behavioral health services.	<ul style="list-style-type: none"><li>• Develop a centralized, real-time bed/service tracking system and a single point of entry for behavioral health referrals; standardize level-of-care criteria across agencies and plans.</li><li>• Require warm handoffs and transition planning, prohibit discharge to “no services available,” fund regional family navigation, and monitor maximum wait-time standards with escalation protocols.</li></ul>
Modernize adolescent inpatient and residential systems to emphasize continuity, equity, and recovery.	<ul style="list-style-type: none"><li>• Require discharge planning within 72 hours, begin individualized transition planning at admission with family engagement, and confirm step-down appointments prior to discharge.</li><li>• Expand and support step-down services; monitor disparities in admissions, LOS, restraints, and readmissions; and align payment to incentivize successful community reintegration over occupancy.</li></ul>
Implement a coordinated workforce strategy to address provider shortages and improve culturally responsive care.	<ul style="list-style-type: none"><li>• Expand loan repayment and scholarships for bilingual, culturally responsive clinicians and build pipeline partnerships with public higher education.</li><li>• Expand MassHealth reimbursement for peer specialists and family partners; require annual training in trauma-informed, disability-inclusive, and culturally responsive care for state-contracted providers.</li></ul>
Mandate cross-agency coordination with shared outcomes and data systems.	<ul style="list-style-type: none"><li>• Formalize an interagency Children’s Behavioral Health Council within EOHHS with representation from state agencies (i.e., MassHealth, DMH, DCF, DPH, DYS, EEC, DESE, and housing and homelessness agencies)<ul style="list-style-type: none"><li>• Require shared accountability for wait times, placement stability, and family experience</li></ul></li><li>• Issue annual public reports on system performance and equity outcomes</li><li>• Oversee data-sharing agreements across agencies</li><li>• Coordinate braided funding strategies for high-need youth</li><li>• Include youth and family representatives in governance structures</li></ul>



# Challenge: Service Capacity, Wait Times & Crisis Dependence



## Service Capacity, Wait Times & Crisis Dependence

- Demand exceeds capacity across community and inpatient settings
- Long waits and evaluation backlogs delay diagnosis and treatment
- Limited community options drive ED use and boarding (beds/workforce/step-down limits; acuity)

Policy	Key Elements
Enhance/expand the existing Behavioral Health Treatment and Referral Platform (BH TRP)	<ul style="list-style-type: none"> <li>• Publicly report boarding data, including data on those who tend to board the longest</li> <li>• Data elements should include age, diagnosis, demographics, geography, and payer</li> </ul>
Strengthen transition services and communication channels for children/families	<ul style="list-style-type: none"> <li>• Expand bridge programs (e.g., BRYT, BIRCh) across agencies, schools, and ages to support transition back to school.</li> <li>• Leverage BH TRP expansion to CBHCs to strengthen ED–community communication and feedback loops.</li> <li>• Enhance interagency collaboration by aligning goals and reducing conflicting regulations, funding, and eligibility requirements, centering youth and family voice.</li> </ul>
Divert children from EDs to community-based services when appropriate	<ul style="list-style-type: none"> <li>• Expand intensive home- and community-based services (crisis/stabilization, in-home, care coordination) and ensure access to CBHI FIT.</li> <li>• Refer children engaged with MCI to appropriate follow-up services (e.g., CBHI, YCCS).</li> </ul>
Expand residential and inpatient care capacity (including psychiatric residential treatment facilities) and increase psychiatric services/supports/competencies in other state agency residential treatment settings (DCF, DMH, DDS, DYS)	<ul style="list-style-type: none"> <li>• Conduct a system needs study, including alternative models for children with complex medical/psychiatric needs, especially those involved with state agencies.</li> <li>• Expand eligibility across agencies and develop new services to create a full continuum of care; fund models for needs that are not adequately addressed in existing inpatient, CBAT, and residential settings</li> <li>• Reimburse congregate programs to hold beds during off-site treatment</li> <li>• Reduce regulatory/reimbursement barriers to support community-based care for co-occurring medical and BH needs.</li> </ul>



# Discussion of Commission Deliverables



## Examples for Commission Review



- MOVA 2021-2024 Strategic Plan
- Department of Early Education Strategic Plan: 2026-2030
- MA Health Connector Strategic Plan
- Special Commission on State Institutions Overview and Recommendations
- Pathways to Promise – Special Legislative Commission to Study Poverty



# Commission's Charge



**Legal Authority:** FY2026 Budget 4000-0300 ([link](#))

**Summary:** The Commission shall study and report on recommendations for improving access to behavioral health services for children and families, including:

**(aa)** a list of the behavioral health services, including services and treatment for substance use disorder and for autism spectrum disorder, available to children and adolescents under 22 years of age;

**(bb)** a list of common challenges that children, adolescents and families face in seeking behavioral health services including, but not limited to, challenges associated with program eligibility criteria, affordability and cost-sharing, insurance or state program denials, application processes and service authorization processes, staffing, wait times and geography;

**(cc)** recommended policies to address challenges identified under clause (bb) and for streamlining access to behavioral health services for children, adolescents and families including, but not limited to, adolescent continuing care inpatient and residential treatment services;

**(dd)** a review of state funding dedicated to behavioral health services for children across state agencies and MassHealth and an examination of the impact of how such funding is used to maximize the delivery of services and available federal resources;



# Commission's Charge (cont.)



**(ee)** analysis of the feasibility and effects of creating a single integrated children's behavioral health agency;

**(ff)** a 3-year strategic plan for the delivery of behavioral health services for children and families that considers all providers and payers; and

**(gg)** any matters deemed relevant by the commission

## **Report**

Not later than June 30, 2026, the Commission shall submit its report to the Joint Committee on Mental Health, Substance Use and Recovery, the Joint Committee on Children, Families and Persons with Disabilities, the Joint Committee on Health Care Financing, and the Senate and House Committees on Ways and Means.



# Upcoming Meetings



	Date	Time	Location
✓	Wednesday, November 19	9:30 – 11:00 am	Virtual / Zoom
✓	Wednesday, December 17	9:30 – 11:00 am	Virtual / Zoom
✓	Wednesday, January 21	9:30 – 11:00 am	Virtual / Zoom
✓	Wednesday, February 25	9:30 – 11:00 am	Virtual / Zoom
	Wednesday, March 18	9:30 – 11:00 am	Virtual / Zoom
	Wednesday, April 29	9:30 – 11:00 am	Virtual / Zoom
	Wednesday, May 20	9:30 – 11:00 am	Virtual / Zoom
	Wednesday, June 3	9:30 – 11:00 am	Virtual / Zoom
<b>Tuesday, June 30, 2026 – Submission of Report to the Legislature</b>			



# Proposed Meeting Agendas



Date	Proposed Tasks for Discussion
<b>February 25</b>	<ul style="list-style-type: none"><li>• Review of additional reports/speakers from 1/21</li><li>• Review of Workgroup initial findings: Challenges and Policy Recommendations (charges bb and cc)</li><li>• Discussion of Commission deliverables</li></ul>
<b>March 18</b>	<ul style="list-style-type: none"><li>• Continuation of Workgroup 2's presentation</li><li>• Review of Workgroup 3's findings: Single Agency (charges ee)</li><li>• Presentation from the Interagency Review Team for Complex Cases</li></ul>
<b>April 29</b>	<ul style="list-style-type: none"><li>• Continued discussion of Commission's recommendations</li></ul>
<b>May 20</b>	<ul style="list-style-type: none"><li>• Continued discussion of Commission's recommendations</li><li>• Review of draft report</li></ul>
<b>June 3</b>	<ul style="list-style-type: none"><li>• Review of draft report</li></ul>
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# Appendix



# Commission's Charge



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## Commission's Charge (cont.)



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# Review of Key Challenges (bb)



## Access, Entry, & Navigation

- No clear starting place; inconsistent entry, referral, and intake pathways
- Families lack clear information on services, roles, and eligibility
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## Coverage, Affordability, Admin Barriers & Financing/Sustainability

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## Equity & Population-Specific Gaps

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## Workforce Capacity, Stability & Training

- Shortages and closures reduce availability and continuity
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## System Design, Fragmentation & Coordination

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# Workgroups & Proposed Action Plan



## Workgroups

- 1. Landscape and Funding** – charges (aa) & (dd); initial presentation 1/21
  - 2. Challenges & Policy Recommendations** – charges (bb) & (cc); initial presentation 2/25
  - 3. Strategic Plan & Feasibility** – charge (ee); initial presentation 3/18
- 

## Workgroups' Action Plan

1. Work will build upon previously completed work and best practice recommendations
2. Presentation at designated meeting to present additional resources, surface initial insights related to recommended paths forward, and provide space for entire Special Commission feedback and discussion
3. Refine findings based on presentation feedback for further presentations and/or submission to final report due in June



# Commission Webpage



## Webpage

Meeting notifications and copies of meeting materials, such as approved minutes for each of the Commission's meetings, will be posted on the Commission's Mass.gov webpage:

<https://www.mass.gov/special-commission-on-access-to-behavioral-health-services-for-children-and-families>