Rosie D. and Mental Health Screening

A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit

TeenScreen® National Center for Mental Health Checkups at Columbia University

1775 Broadway, Suite 610 | New York, NY 10019 | 1-866-TEENSCREEN (1-866-833-6727)
E-mail: TeenScreenInfo@childpsych.columbia.edu | www.teenscreen.org

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Abstract — *Rosie D. v. Patrick*

The 2006 court ruling in *Rosie D. v. Patrick* resulted in the establishment of a requirement to use standardized screening tools in the implementation of a long-standing federal Medicaid directive to provide mental health screening at well-child visits. As part of the remedial plan drafted by the Commonwealth of Massachusetts and accepted by the federal District Court in *Rosie D.*, it was agreed that the Massachusetts Medicaid program (MassHealth) would take steps to ensure that mental health screening was offered at all well-child visits and that the rate of screening would be monitored and reported. In the first quarter of reporting in 2008, just 14 percent of well-child visits reported including a mental health screen; by the fourth quarter of 2009, 58 percent of all well-child visits did. MassHealth's success in improving reported mental health screening rates was due to several key factors, including:

- Establishing clear implementation polices;
- Approving separate reimbursement for mental health screens;
- Offering a resource for clinical consultation and referral assistance in child psychiatry; and
- Engaging primary care providers and advocacy groups in the planning and implementation process.

As expert consensus and quality guidelines nationally have begun to place greater emphasis on the importance of mental health screening, other health plans and provider organizations can benefit from the lessons learned in Massachusetts.

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- Emily Sherwood, director of the Children's Behavioral Health Inter-Agency Initiative in the Massachusetts Executive Office of Health and Human Services;
- Barbara Leadholm, MS, MBA, commissioner of the Massachusetts Department of Mental Health;
- Joan Mikula, assistant commissioner for Children's Services in the Massachusetts Department of Mental Health;
- John Straus, MD, vice president of Medical Affairs at the Massachusetts Behavioral Health Partnership;
- Irene Tanzman, Massachusetts Child Psychiatry Access Project data analyst at the Massachusetts Behavioral Health Partnership;
- Karen Hacker, MD, MPH, executive director of the Institute for Community Health;
- Michael Yogman, MD, chair of the Children's Mental Health Task Force at the Massachusetts Chapter of the American Academy of Pediatrics;
- Lisa Lambert, executive director of the Parent/Professional Advocacy League;
- Karen Darcy, RN, MSN, director of Child and Adolescent Mental Health Advocacy at Children's Hospital Boston.

Key Published Resources Included

- The Center for Public Representation: website and document library at www.rosied.org;
- The Commonwealth Fund Report *The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care — Case Study: High Performing Health Care Organization* prepared by Wendy Holt of DMA Health Strategies;
- *Rosie D. and Me:* a blog by David Keller, MD available at http://olddockeller.blogspot.com.

Introduction: Medicaid, Mental Health Screening and *Rosie D.*

The 2006 court ruling in *Rosie D. v. Patrick** resulted in the establishment of a requirement to use standardized screening tools in the enforcement of a long-standing federal Medicaid directive to provide mental health screening at well-child visits. More than 40 years ago, the United States Congress and President Lyndon B. Johnson recognized that comprehensive preventive care was needed to improve outcomes for children enrolled in the Medicaid program. As a result, federal Medicaid law has provided for coverage of regular well-child visits to assess both physical and mental health since the establishment of the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit in 1967. The Omnibus Reconciliation Act (OBRA) of 1989 later strengthened this benefit by establishing participation goals and reporting requirements for EPSDT visits by state Medicaid programs. Together, these statutes have provided a long-standing directive to state Medicaid programs to offer regular well-child screenings, diagnostic and assessment services, and any medically necessary care, services or treatment (within the definition of covered Medical Assistance under the federal Medicaid Act) to correct or ameliorate problems uncovered in the course of screening and diagnosed through a clinical assessment.

Despite data showing that publicly insured children are at elevated risk for mental, emotional and behavioral disorders[1] and overwhelming evidence affirming the value of preventive care, many state Medicaid programs have failed to take any steps to ensure that a mental health assessment is offered at the well-child visit. Available evidence indicates that this service is frequently overlooked: a quality review of Minnesota's EPSDT services in 2000 found that just 27 percent of children received a developmental or mental health screening,[2] and a 2001 survey of state Medicaid programs found that 23 states did not include a single prompt or question addressing mental health in their EPSDT tools for primary care providers.[3] More recently, a 2010 report from the Department of Health and Human Services Office of Inspector General found that nearly 60 percent of children across nine states who attended a Medicaid well-child visit were not offered a complete screening.[4] Unfortunately, it is the case today that many children with mental health disorders are never screened, diagnosed or offered the treatment services to which they are entitled under the Medicaid EPSDT benefit.

More than 40 years ago, the United States Congress and President Lyndon B. Johnson recognized that comprehensive preventive care was needed to improve outcomes for children enrolled in the Medicaid program.

The 2006 decision in *Rosie D. v. Patrick* (hereafter referred to as *Rosie D.)* was a watershed. It marked the first instance of a court-ordered requirement for a state Medicaid program to ensure that mental health screening is offered at all well-child visits as required by the EPSDT benefit, as well as to record and report the rate of screening. The ruling in *Rosie D.* also required that Massachusetts' Medicaid program, MassHealth, offer a specific set of home and community-based services for children with serious mental illness. Mental health screening rates as reported through provider billing practices have risen from just over 14 percent when reporting began to 58 percent by the fourth quarter of 2009.[5] This is a considerable accomplishment, and actual screening rates may be higher than reported since, while providers do not receive additional reimbursement without reporting the screen on the claim form, they are not otherwise penalized at this point for failing to report screenings. MassHealth's experience can provide valuable insight to other state Medicaid programs and provider groups, as they seek to fulfill the obligation to provide required EPSDT services and comply with the standard of care.

In addition to the legal obligation, there will be growing pressure on other state Medicaid programs and providers to offer mental health screening using an evidence-based screening tool as the standard of care. In 2009, the U.S. Preventive Services Task Force (USPSTF) recommended that annual depression screening begin at age 12, and the American Academy of Pediatrics' (AAP) *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* recommends a psychosocial and behavioral assessment at every well-child visit. The AAP Task Force on Mental Health strengthened this recommendation in

* Between the date the suit was filed and its resolution, there were a number of turnovers in the Governor's Office and Executive Administration. Consequently, the lawsuit has been variously titled, *Rosie D. v. Swift*, *Rosie D. v. Romney*, and *Rosie D. v. Patrick*.

June 2010 with the release of new guidelines and tools to improve the incorporation of mental health screening tools into pediatric practice. The USPSTF and AAP guidelines are the gold-standard in pediatric preventive care. The new federal health reform laws — the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act (ACA) — give special recognition to these guidelines by requiring that all new health plans provide preventive services recommended by these groups at no cost to enrollees for plans years beginning on or after September 2010.

Growing agreement on the need for providers and health plans participating in federal health care programs to report clinical quality measures also will make it increasingly important to ensure that medical practice is aligned with recommendations for quality care. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and ACA include provisions to both ensure the development of appropriate quality measure sets and expand quality measure reporting. Given the expert consensus on the need to provide a mental health assessment at the annual well-child visit, state Medicaid programs, health plans, and even individual providers may soon find that they are required to report the rate at which this service is provided.

Finally, state Medicaid programs would do well to implement mental health screening proactively, rather than pursuant to a court order. Historically, successful lawsuits brought against states for failure to provide required services under the EPSDT benefit often have led to the imposition of a greater financial and regulatory burden than would have been required by voluntary compliance.

In short, the need to comply with quality care recommendations and to provide federally mandated services will result in growing pressure for state Medicaid programs and other health providers to offer mental health screening using a standardized tool at the well-child visit. Massachusetts has set a new standard for comprehensive mental health screening and follow-up services. Their experience can offer valuable lessons and insight for other state Medicaid programs, health care plans, and providers as they consider ways to improve upon the mental health assessment component of the well-child visit.

Despite data showing that publicly insured children are at elevated risk for mental, emotional and behavioral disorders and overwhelming evidence affirming the value of preventive care, many state Medicaid programs have failed to take any steps to ensure that a mental health assessment is offered at the well-child visit.

The Lawsuit

Filed in U.S. District Court in 2001, *Rosie D.* was brought against the Commonwealth of Massachusetts by the Center for Public Representation, the law firm of Wilmer Cutler Pickering Hale and Dorr, and the Mental Health Legal Advisors Committee on behalf of eight children who were seeking home and community-based mental health services from the Massachusetts Medicaid program. The Plaintiffs were ultimately deemed to be representative of a class of approximately 15,000 children in the Commonwealth, who were eligible for and in need of mental health services under Medicaid, but unable to access services.

According to the complaint in *Rosie D.*, the Plaintiffs had been screened and diagnosed with behavioral, emotional, or psychiatric disabilities, but were not being provided with the preventive and rehabilitative treatment required by the federal Medicaid program. The complaint further asserted that the small group of named Plaintiffs were part of a class that included "thousands of children who [had been] hospitalized or [were] at risk of hospitalization because of the absence of intensive home-based services. The individual plaintiffs and those like them [were] either forced to leave their families and communities in order to obtain the very limited, episodic mental health services which [had been] made available by the defendants, or [were] compelled to forego these limited and unduly restrictive services altogether, leaving them with inadequate treatment and supports."[6]

Rosie D. sought to help redress this situation by ensuring that all children covered by the Massachusetts Medicaid program would have access to medically necessary mental health services in home and community-based settings, in addition to the inpatient, outpatient, emergency and diversionary mental health services available at the time the suit was filed. The Plaintiffs brought the suit on the

The Two-Fold Value of Mental Health Screening: Improved Outcomes and Lower Costs

As many as 20 percent of young people suffer from a diagnosable mental disorder, and one in 10 suffers significant impairment due to mental illness.[7] Epidemiological research has found that three-quarters of all lifetime mental illnesses begin by age 24, with half beginning by age 14.[8] Yet, in the United States today, fewer than 20 percent of all youth with a diagnosable mental disorder receive evaluation or treatment services.[9]

The costs of this failure are substantial. According to a 2009 report from the Institute of Medicine (IOM), the annual quantifiable cost of mental illness among young people is more than $247 billion annually.[10] While the financial toll is staggering, the human toll is far more compelling. Suicide is the third leading cause of death for youth ages 10 to 24,[11] and mental illness accounted for more hospitalizations among young people ages 13 to 17 than any other condition in 2000.[12] Mental illness in adolescence also has been demonstrated to result in significantly poorer long-term outcomes across a range of quality-of-life indicators, including physical health,[13,14] educational attainment[15,16] and socio-economic status.[17,18]

Mental health screening using validated tools provides an effective, evidence-based approach to increasing early identification and intervention,[19,20] which can both improve outcomes and reduce the costs of mental illness. The IOM and World Health Organization hold that early intervention in adolescence can reduce or even eliminate the manifestations of some mental disorders.[21,22] Studies also have shown treatment of mental health disorders in youth to be effective at reducing rates of substance abuse;[23] improving school performance;[24] decreasing physical or somatic health complaints;[25] and reducing morbidity and mortality.[26] According to data cited by the National Institute of Mental Health, covering mental illness on the same basis as medical illness would cost $6.5 billion, but this spending would result in savings of $8.7 billion to U.S. taxpayers.[27] By expanding access to mental health screening as a routine component of preventive care, the United States could significantly improve access to early intervention and reduce both the human and financial toll exacted by mental illness.

grounds that the state had failed to provide the preventive and rehabilitative services required by federal Medicaid law establishing the EPSDT benefit (Title 42, Chapter 7, Subchapter 19 of the U.S. Code, §1396a et seq.).

As described by the statutes in §1396d(r)1-2, the EPSDT well-child visit is required to take place at intervals meeting reasonable standards of medical practice and shall include "a comprehensive health and developmental history (including assessment of both physical and mental health development)." The EPSDT benefit also requires that coverage for Medicaid-eligible children up to age 21 include "such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan" in §1396d(r)5. These sections of the Medicaid statute provided grounds for suing the Commonwealth for the alleged failure to provide mental health screening and medically necessary follow-up services. Provisions of Medicaid law requiring reasonable promptness for access to services were also important to the Plaintiffs' suit.

The Plaintiffs proposed that the Defendants be required to take a number of specific actions to improve the identification of children in need of mental health services and to improve access to those services. Very broadly, the lawsuit sought to ensure that the Defendants be required to:

- Enhance activities to inform eligible Medicaid beneficiaries and their families of their right to services under the EPSDT benefit.
- Require primary care providers to offer mental health screening* to all eligible Medicaid beneficiaries and provide MassHealth coverage for any medically necessary services described in the remedial plan, including case management, mobile crisis intervention and intensive home-based services within a reasonably prompt timeframe.
- Require mental health specialists to utilize a standardized assessment tool to assist with diagnosis and treatment planning.

* The term behavioral health screening was used in the *Rosie D.* proceedings. For the purposes of this case study, the terms mental health screen and behavioral health screen can be used interchangeably and both refer to the administration of an evidence-based, standardized screening questionnaire such as the Pediatric Symptom Checklist (PSC), Parents' Evaluation of Developmental Status (PEDS), Patient Health Questionnaire 9 (PHQ-9), etc.

- Provide reimbursement rates adequate to ensure a sufficient number of available providers and eliminate the DMH waiting list for case management services for Medicaid eligible children.*
- Report on implementation of the remedy on a semi-annual basis to allow the Court to monitor compliance.
- Meet with the Plaintiffs quarterly to discuss the implementation of the judgment and any obstacles to its full and timely implementation.

After a six-week trial, Judge Michael A. Ponsor issued a decision in the *Rosie D.* case in January 2006 stating, "the court finds that Plaintiffs have proved, by far more than a fair preponderance of the evidence, that Defendants have failed to comply with the EPSDT and 'reasonable promptness' provisions of the Medicaid Act." In the decision, the court clearly reinforced that the Commonwealth is responsible for informing Medicaid-eligible children of their EPSDT rights, as well as arranging for screening and medically necessary follow-up services, including home and community-base services, in a reasonably prompt manner.

As noted earlier, the impetus for the creation of the EPSDT benefit in 1967 was the desire to eradicate preventable diseases that had their roots in childhood. In a message to Congress that year, President Johnson described the importance of Medicaid's preventive care provisions saying: "The problem is to discover, as early as possible, the ills that handicap our children. There must be a continuing follow-up and treatment so that handicaps do not go neglected . . . Ignorance, ill health, personality disorder — these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation. Our nation must rid itself of this bitter inheritance. Our goal must be clear — to give every child the chance to fulfill his promise."[28]

Judge Ponsor stressed the inadequacy of MassHealth's efforts to fulfill this promise in his decision. He noted that a large number of children suffering from serious emotional disturbance (SED) had never received an assessment of their mental health, and concluded that it was difficult to characterize this as an entirely unintentional failing stating: "The simplest way to escape

* It should be noted that the Court did not find that MassHealth had violated the "equal access" provision, which requires MassHealth to pay providers an amount sufficient to ensure that these providers are as available to MassHealth members as they are to the general public.

> "The court finds that Plaintiffs have proved, by far more than a fair preponderance of the evidence, that Defendants have failed to comply with the EPSDT and 'reasonable promptness' provisions of the Medicaid Act."
>
> —Judge Michael A. Ponsor

the challenge of serving an SED child is to avoid conducting the sort of in-depth, comprehensive assessment that will reveal the extent of the child's medical needs. Whether conscious or unconscious, this is the strategy being employed by the current system as regards many of the SED children in the Commonwealth at this time." Because early identification and intervention are key to improving outcomes, the legal remedy stressed the need to improve mental health screening and assessment.

Consequently, this case study will focus on the introduction of mental health screening and referral services by MassHealth, rather than the establishment of the intensive home and community-based mental health services mandated by the court. Reforming a mental health services system is a complex and time-consuming challenge, whereas mental health screening and referral are comparatively simple, yet significant steps toward improving care. As the implementation timeline in the Massachusetts case will demonstrate, the introduction of mental health screening can improve the rates of early identification and intervention for mental illness in the absence of a complete overhaul of the existing mental health services system.

The Legal Remedy: A Blueprint for Comprehensive EPSDT Services

To assure that the court judgment resulted in effective changes to MassHealth's provision of EPSDT services going forward, both the Plaintiffs and Defendants were asked to work together to submit a proposed remedial plan. Unable to agree on a joint proposal, the Defendants and Plaintiffs submitted separate remedial plans in late 2006. Judge Ponsor ultimately accepted the remedial plan submitted

by the Defendants with several stipulations in July 2007. This plan laid out a blueprint for how the Commonwealth would provide mental health screening and follow-up services to Medicaid-eligible children, and included provisions to monitor compliance.

The first section of the remedial plan listed a number of steps to be taken by MassHealth to comply with the EPSDT mandated benefit:

- All Medicaid recipients, providers and the public must be notified of the availability of mental health screening and other services under Medicaid.
- **Mental health screening using one of a menu of standardized tools must be offered to all Medicaid beneficiaries at well-child visits, and providers must be offered training in the use of these tools.**
- Children screening positive can be evaluated and, if necessary, treated by the primary care physician or referred to a specialist for a mental health assessment using the Child and Adolescent Needs and Strengths (CANS) tool. Referrals remain unnecessary in order to access Medicaid mental health services.
- Children diagnosed with SED will be offered intensive care coordination and covered treatments including home and community-based services and crisis management.
- A community service agency (CSA) must deliver "intensive care coordination" using the Wraparound model of care planning and delivery for each region as defined by the Executive Office of Health and Human Services, with a minimum of 15 regions.

Screening and assessment services are required by the remedy to be offered to all Medicaid-eligible children. For children referred to behavioral health services, the remedy requires MassHealth to ensure that these children receive a mental health assessment using the Child and Adolescent Needs and Strengths (CANS) tool, a standardized clinical information collection tool. Mental health services do not require a referral and are a covered service when medically necessary.* Each of the new home and community-based services outlined by *Rosie D.*, however, has specific Medical Necessity Criteria, developed by MassHealth and used by MassHealth's contracted health plans. Eligibility for intensive care coordination requires that children meet the definition of SED** provided by the Individuals with Disabilities Education Act, the Substance Abuse and Mental Health Services Administration, or both. Intensive care coordination is provided according to the Wraparound model of care planning and implementation, in which a care coordinator works with the child and their family, caregivers, health care providers, and others to form a care planning team and develop a strengths-based, comprehensive and individualized plan of care.

The remedial plan also set out a timeline for implementing each component of the remedy. Implementation was divided into four main projects, which were phased in over time:

- Behavioral health screening, informing and noticing improvements;
- CANS development, training and deployment;
- Development of a service delivery network; and
- Information technology system design and development.

Mental health screening was the first service to be implemented, beginning on December 31, 2007. The introduction of screening preceded the implementation of the other service components by nearly a year; CANS assessments were implemented on November 30, 2008 and intensive care coordination, family mentoring, in-home therapy and in-home behavioral services, therapeutic mentoring, and mobile crisis intervention were implemented over a four month period between

* Massachusetts defines medically necessary services, in part, as "reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the members that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness and infirmity." A full definition is available in 130 C.M.R. §450.204.

** SAMHSA defines SED as follows: "Pursuant to section 1912(c) of the Public Health Service Act "children with a serious emotional disturbance" are persons: (1) from birth up to age 18 and (2) who currently have, or at any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R. Federal Register Volume 58 No. 96 published Thursday May 20, 1993 pages 29422 through 29425."

IDEA defines SED as: "Emotional disturbance is defined as follows: (i) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors. (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (C) Inappropriate types of behavior or feelings under normal circumstances. (D) A general pervasive mood of unhappiness or depression. (E) A tendency to develop physical symptoms or fears associated with personal or school problems. (ii) The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance." (34 C.F.R. §300.7).

July and October 2009. All components except crisis stabilization are now operational; the Commonwealth sought state plan approval for this service from the Centers for Medicare and Medicaid Services (CMS), which was denied. The Commonwealth has requested that CMS approve, and therefore participate in payment for the service, through a waiver.[29]

To ensure that the services outlined by the remedial plan were provided to eligible beneficiaries, a number of measures on screening, evaluation and follow-up services were designated for collection and reporting. The remedial plan also required the designation of a Compliance Coordinator for the Commonwealth and an impartial court-appointed Monitor, who would work with the Plaintiffs and with the Commonwealth during the implementation of the remedy. Taken together, these components of the remedial plan were designed to ensure that MassHealth provides comprehensive mental health screening and follow-up services to eligible Medicaid beneficiaries.

MassHealth: Implementation Policy

While the court judgment and remedial plan provided a blueprint for implementing mental health screening and medically necessary follow-up services, they did not provide a detailed plan for implementation. A significant amount of decision-making about how to implement the various components of the remedy was left to MassHealth and the executive administration of the Commonwealth.

Complicating the start of the implementation work was the change in executive administration following the 2006 elections. The preliminary judgment in the case was issued at the end of 2006, shortly after the election of Deval Patrick as Governor. Following his inauguration in January 2007, Governor Patrick appointed JudyAnn Bigby, MD as secretary of the Executive Office of Health and Human Services (EOHHS). Recognizing the risk that the remedial plan might create yet another separate "silo" of children's services, Secretary Bigby created an interagency EOHHS initiative, the Children's Behavioral Health Initiative (CBHI), to provide a broader, cross-agency policy context to implementation of the remedial plan. As specified in the remedial plan, Secretary Bigby designated a Compliance Coordinator for the Commonwealth. She appointed Emily Sherwood, who she had chosen to act as director of the Children's Behavioral Health Inter-Agency Initiative and who reports directly to the Secretary. Ms. Sherwood was able to hire four staff members for CBHI. Key staff vacancies at MassHealth were also filled in summer and fall of 2007, including the hiring of Suzanne Fields, MSW, LICSW to serve as director of the Office of Behavioral Health. These two staff groups at the Office of Behavioral Health and CBHI, working as a joint team, have had primary responsibility for designing and implementing the remedial plan.

Secretary Bigby asked her Commissioner of Mental Health, Barbara A. Leadholm, MS, MBA to convene an Executive Committee to oversee CBHI. The Executive Committee includes the Medicaid Director, the Commissioners of the Departments of Children and Families, Public Health, and Youth Services, as well as senior program and legal staff. Additional input was obtained from the court-appointed Monitor and the public. For example, a Request for Information was issued in the fall of 2007 to solicit suggestions from families, advocates, health care professionals and others, and a series of stakeholder meetings were held across the state. Karen Snyder, court monitor in the *Rosie D.* case, also served as a critical resource in the design process for implementation, making national experts in each of the remedial services available to both the Commonwealth and the Plaintiffs.

Screening Tools

One of the first tasks facing MassHealth was to establish policies and procedures for the implementation of mental health screening by MassHealth primary care providers. Staff in MassHealth's Office of Acute and Ambulatory Care (OAAC) have had primary responsibility for implementing mental health screening. Working in consultation with medical professional and provider groups, OAAC staff identified a list of approved screening tools to be added to the MassHealth provider manual. Feedback was solicited from the Massachusetts Chapter of the American Academy of Pediatrics, the Massachusetts Medical Society, the Massachusetts Association of Family Practitioners, the Massachusetts League of Community Health Centers, and the Massachusetts Association of Health Plans. Based on input from these organizations, the initial set of standardized, evidence-based screening questionnaires included eight tools (see appendix 1 of this document for a list).

These mental health screening tools were added to Appendix W of the MassHealth provider manual, which includes information on EPSDT periodicity schedules and services. As set forth by the court judgment, primary care providers* are required to offer eligible patients a mental health screening using one of the eight tools during well-child visits. MassHealth regulations (130 CMR 450.140 through 450.150) and provider publications, as well as those of contracting Medicaid managed care organizations (MCOs), were amended to reflect the policy changes required to implement mental health screening and referral.

Education

To ensure that eligible patients and their parents or guardians are made aware of the availability of mental health screening and follow-up services, MassHealth updated its member notices and handbooks to make direct reference to the availability of mental health screening, assessment and follow-up services. Member notices describing EPSDT benefits are sent to members upon enrollment; upon re-enrollment; and annually, on or around the member's birthday. Fact sheets about the new services were distributed to primary care clinics, and customer service agents for MassHealth and its MCOs were educated about the availability of the new services and the necessity to inform members.

MassHealth and its contracting MCOs also held in-person training forums for MassHealth primary care providers across the state in the months preceding the mandated start date for screening. These forums provided an overview of the research on mental health screening, an introduction to the screening tools, and best administrative and clinical practices for implementing screening in primary care settings. Seven primary care provider training forums were held between fall 2007 and summer 2008 — from Taunton to Hyannis — with attendance averaging between 100 and 150 physicians.

*Primary care providers are defined by MassHealth as general practitioners, family physicians, internal medicine physicians, obstetrician/gynecologists, pediatricians, independent nurse practitioners and independent nurse midwives practicing in an individual or group practice, in an outpatient department of an acute or chronic and rehabilitation hospital, or in a community health center. Screening requirements do not apply to these practitioners when providing emergency or post-stabilization services in a hospital or other setting.

Primary care providers have professional latitude to override a positive or negative score on a mental health screen after discussion with the patient and/or family. This policy appropriately recognizes that mental health screens are not diagnostic tools; rather, they are a valid, effective method of identifying when further discussion or evaluation is indicated.

Reimbursement and Reporting

In order to fulfill the reporting requirements for mental health screening set out by the remedial plan, MassHealth chose to use Current Procedural Terminology (CPT) payment codes to determine the number of well-child visits; the number of mental health screens provided; and the number of children who were reported as having screened positive for a possible mental health disorder. Well-child visit codes were already available from payment data, but MassHealth's decision to use a payment code to provide data on the number of screens and the rate of positive screens necessitated revised payment policies for the administration of standardized mental health screens. Notably, it was MassHealth's decision to report data required by the remedial order using payment codes — and not the remedial order — that helped necessitate the policy change authorizing payment for this service. MassHealth also realized at the outset that payment would prove helpful in encouraging primary care providers to offer the screening, and state law would later make this reimbursement mandatory.

To allow primary care providers to bill for mental health screening, MassHealth updated Appendix Z of the provider manual and designated the use of CPT code 96110, which denotes "developmental testing; limited, with interpretation and report." As determined by MassHealth, providers authorized to bill for the administration and scoring of a standardized mental health screen include physicians, independent nurse practitioners, and independent nurse midwives, as well as nurse practitioners, nurse midwives or physician's assistants under the supervision of a physician. As of October 2009, reimbursement for this code was set at $9.73 and was limited to payment for the administration of one standardized screening per beneficiary, per day, regardless of the number of screenings administered.

A series of payment modifiers were created for use with the 96110 code in order to allow MassHealth to report on the number of positive screens and the type of provider administering the screening. Odd-numbered modifiers signify that no behavioral health need was identified and even-numbered modifiers indicate that, in the professional judgment of the clinician, a behavioral health need was identified. In other words, primary care providers have professional latitude to override a positive or negative score on a mental health screen after discussion with the patient and/or family. This policy appropriately recognizes that mental health screens are not diagnostic tools; rather, they are a valid, effective method of identifying when further discussion or evaluation is indicated.

To encourage the reporting of these payment modifiers, MassHealth policy required that they be included with the 96110 code in order for payment to be authorized beginning July 1, 2008. As of April 2010, claims are not yet being denied for lack of a payment modifier, although written communications from MassHealth continue to note that it is a required element. Despite the decision to delay the start of claims denials for lack of billing modifiers, reporting of the modifier with the billing code has improved markedly since the rollout of screening on December 31, 2007. In the first quarter of 2008, the modifiers were included with the 96110 code 67 percent of the time, but by the fourth quarter of 2009 the rate had climbed to more than 80 percent.[30]

Follow-Up Services

In contrast to the changes required to implement mental health screening, MassHealth policy addressing follow-up and referral by primary care providers is short and straightforward. MassHealth states that if a behavioral health need is identified, the primary care clinician must offer to either: 1) provide the necessary services or 2) refer the patient to a specialist.

Primary care providers who choose to refer a MassHealth patient to a specialist must assist with the referral process. Resources and assistance with the referral process are available from MassHealth MCOs, the Massachusetts Behavioral Health Partnership, and the MassHealth Customer Service Center. The CBHI website also provides links and information about outside referral resources, such as the Massachusetts Child Psychiatry Access Project, and highlights programs at Cambridge Health Alliance and Children's Hospital Boston as examples of how to successfully implement mental health screening.

The policies and procedures that MassHealth outlined in order to implement mental health screening set a clear path for providers and highlighted the benefits to patients. However, MassHealth does not directly provide services and its success in complying with the court mandate is dependent upon the cooperation of participating health care providers.

Changing Clinical Practice: Keys to Success in the "Real World"

From the date the remedial plan was finalized on July 16, 2007, MassHealth had fewer than six months to roll out mental health screening statewide on December 31, 2007. In this short span, MassHealth was challenged to overcome widely cited hurdles to the implementation of mental health screening as a standard component of the well-child visit including: a lack of time and resources on the part of primary care providers; the need for additional training of primary care providers in mental health; and a shortage of specialty mental health providers. Several key factors would prove crucial to ensuring that mental health screening and referral services were, in fact, implemented successfully in primary care offices across the state.

Initially, the court-ordered requirement to offer mental health screening at the well-child visit met with a cool reception from primary care providers. For the reasons just noted, most primary care providers in the United States do not use standardized screening tools to assess mental health at the well-child visit, despite data showing that informal interview techniques will fail to identify about 50 percent of all patients suffering from mental illness.[31] A 2005 survey of pediatricians found that 71 percent always or almost always rely on a clinical assessment rather than using a standardized screening instrument.[32] Another survey of both pediatricians and family physicians found that just 23 percent routinely screen their adolescent patients for mental disorders.[33] The *Rosie D.* ruling, then, constituted a legally mandated, yet unwelcome, shift in standard operating procedure for many primary care practices in Massachusetts.

"We have been helped immeasurably by a whole cadre of physician-leaders in Massachusetts who have brought their passion, commitment and expertise to the effort to inform, encourage and assist clinicians in adopting behavioral health screening in primary care."

—Emily Sherwood, director of the CBHI

Engaging Providers in Decision-Making

One of the keys to overcoming this reticence and gaining the buy-in of primary care providers was MassHealth's decision to engage medical professional groups in the planning and implementation process. The court-mandate to offer standardized mental health screens was imposed on the medical community by the legal system, which contributed to its initial unpopularity. Recognizing the importance of involving the medical professional community in shaping implementation, MassHealth held physician-led trainings on mental health screening and has engaged in ongoing consultation with Massachusetts medical professional groups to inform its decision-making process. These groups have proven to be invaluable partners, that can speak credibly about the importance of mental health screening; assist in identifying barriers to implementation; and help propose solutions. Emily Sherwood, director of the Children's Behavioral Health Inter-Agency Initiative states, "We have been helped immeasurably by a whole cadre of physician-leaders in Massachusetts who have brought their passion, commitment and expertise to the effort to inform, encourage and assist clinicians in adopting behavioral health screening in primary care."

The Massachusetts Chapter of the AAP and its Children's Mental Health Task Force (CMHTF) — a coalition of pediatricians, child psychiatrists, psychologists, social workers, nurses, policy advocates, insurance representatives, commissioners, legislators, employer groups, and groups from the education and correctional services communities — has been a particularly active and influential partner in helping to champion mental health screening and to address ongoing provider concerns. Michael Yogman, MD, a pediatrician and chair of the CMHTF states, "Crucial to the success of pediatric screening has been the initial consultation and ongoing involvement in implementation by practicing pediatricians." For instance, with feedback from the AAP and others, MassHealth has made changes to the menu of approved screening tools, such as replacement of the Achenbach Child Behavior Checklist with the Strengths and Difficulties Questionnaire tool in 2009. It also has led to an ongoing discussion of whether the current mental health screening tools are sufficiently appropriate for use with infants and whether postpartum depression screening might be of greater utility.

Reimbursing Providers for Mental Health Screening

MassHealth's decision to approve reimbursement for the use of CPT code 96110 (developmental testing; limited) in addition to the well-child visit code was a crucial factor in overcoming primary care providers' reluctance to offer mental health screening. While the administration of most mental health screening tools takes just five to 10 minutes, a 2005 survey of pediatricians found that lack of adequate time (83 percent); office staff (49 percent); and reimbursement (46 percent) were the top three impediments to standardized screening.[34] Increased demands on time and resources must be met with increased reimbursement, whether provided separately or in the form of an increase in a bundled payment for the well-child visit.

The relative value unit (RVU) and payment assigned to the 96110 code are reflective of the small time and resource commitment necessary to provide screening, but do represent a real cost to providers. Given that Medicaid reimbursement rates for primary care are already low when compared with private insurance and Medicare — Medicaid averages just 66 percent of Medicare rates for primary care nationally and 78 percent of Medicare rates in Massachusetts[35] — it was especially important that MassHealth adjust the payment for the well-child visit to ensure adequate reimbursement. Dr. Yogman explains, "Given the many valuable and competing priorities for time in a pediatric well child visit, insurance reimbursement for behavioral health screening increases the perceived value, importance and priority of these screens to pediatricians."

"... insurance reimbursement for behavioral health screening increases the perceived value, importance and priority of these screens to pediatricians."

— Michael Yogman, MD, chair of the Children's Mental Health Task Force at the Massachusetts Chapter of the American Academy of Pediatrics

Offering Free Clinical Consultation and Referral Resources

Another key to MassHealth's success was the ability to draw on an existing, state-funded clinical consultation and referral resource in child psychiatry for primary care providers. A significant proportion of primary care providers report that they are hesitant to offer mental health screening due to a shortfall in their mental health training and uncertainty about the availability of referral resources. A 2007 survey of pediatricians confirmed that lack of time (77 percent) and inadequate reimbursement (50 percent) were important barriers to offering mental health screening, but this survey also reported that many pediatricians lacked confidence in their training (65 percent) and ability (62 percent) to treat mental health problems in children and adolescents. Another 61 percent of pediatricians in this survey cited the lack of competent/qualified mental health providers for referral as an impediment to the adoption of mental health screening.[36]

The Massachusetts Child Psychiatry Access Project (MCPAP)* has played a critical role in overcoming the hurdle posed by primary care providers' concerns about their ability to administer mental health screening and provide or connect patients to necessary follow-up services. Originally conceived as a pilot project to respond to the increasing recognition and treatment of mental health disorders in the primary care setting, MCPAP employs regional teams of psychiatrists offering telephone consultation and clinical guidance to primary care providers diagnosing and/or treating pediatric patients with mental health disorders. This service aims to respond to calls within 30 minutes and is free of charge for primary care providers regardless of a patient's insurance status. Although MCPAP is designed as a clinical consultation model for primary care providers, the service also addresses the perceived mental health provider shortage by providing assistance with the referral process, as well as transitional services when necessary.

By the time MassHealth began mental health screening in 2008, more than 1,050 PCPs and 360 nurse practitioners in 344 practices throughout Massachusetts were enrolled with MCPAP.[37] To enroll, primary care practices complete an orientation, which includes information about MCPAP services and mental health screening. Because MCPAP is organized into regional hubs based in academic medical centers, they are able to build relationships with the enrolled primary care providers. According to John Straus, MD, FAAP, a pediatrician who led the design and planning of MCPAP, who serves as the senior executive of the Project, and who is the senior vice president of medical affairs at the Massachusetts Behavioral Health Partnership, "Our teams have visited practically every pediatric practice and most family practices that treat children in the state. Eighty-five percent of our enrolled practices use our services within a given year . . . The teams' close relationships with each primary care provider allow them to tailor the level and sophistication of their advice to the level of knowledge and comfort of the particular primary care provider."

During the rollout of screening pursuant to *Rosie D.*, MassHealth recognized the need to address questions about mental health screening, diagnosis and referral. MassHealth decided to use the MCPAP infrastructure to introduce four screening consultants to aid in the transition. These consultants helped to create the Primary Care Behavioral Health Screening Toolkit for MassHealth, which is available on the MCPAP and CBHI websites and has been downloaded nearly 2,000 times from the MCPAP site alone. MCPAP screening consultants also provided telephone, email, and in-person consultation on mental health screening. Irene Tanzmann, a data analyst for MCPAP, states that "In the beginning of the screening process, primary care providers expressed reluctance to screen. They were worried that they would not have the referral resources to triage the patient with a positive screen. MCPAP helped to ease that worry because we assured them that we would be there to help."

During the consultants' employ between January 1, 2008 and June 30, 2009, they reported 327 encounters with primary care clinicians — 153 telephone consultations; 27 in-person meetings; 43 presentations to large practices; and 48 emails. Karen Hacker, MD, MPH, who specializes in adolescent medicine and serves as executive director of the Institute for Community Health, was one of the consultants. She notes that: "Our role as screening consultants provided needed technical assistance to practices as they launched screening efforts. I think that this was a valuable service in which practical strategies could be shared and we could better understand the challenges to screening at the

*The 2010 Commonwealth Fund Report *The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care — Case Study: High Performing Health Care Organization* prepared by Wendy Holt of DMA Strategies is recommended for a fuller description of MCPAP.

practice level." Although the use of screening consultants was a temporary measure meant to ease the transition to wide-scale mental health screening for MassHealth patients, MCPAP continues to assist with screening questions as part of their regular service.

The driving force behind the creation of MCPAP was a desire to offer clinical guidance on psychiatric issues to primary care providers serving children in the Commonwealth. The most frequent outcome for MCPAP inquiries, approximately one-third of all inquiries, is follow-up care provided by the primary care provider.[38] Testifying to the success of the educational model, MCPAP has noted that the complexity of primary care providers' inquiries has increased over time. According to Dr. Straus, "Our MCPAP regional hubs report that our MCPAP enrolled primary care providers' levels of knowledge have increased as a result of the help that they received through MCPAP. The calls we receive now are rarely about a straightforward ADHD [attention deficit hyperactivity disorder] case. Usually the calls are more complex. For instance, 'I have a patient who has been diagnosed with ADHD, but now I think it is possible that the patient also has depression.'"

While there has been an increase in primary care providers' willingness to address mental health disorders in the primary care setting, MCPAP also continues to frequently assist with referral and care coordination. A case-study of MCPAP published by the Commonwealth Fund shows that MCPAP encounters for the period between July 2008 and June 2009 resulted in consultation with a care coordinator nearly one-third of the time, and patients were referred to a therapist or psychiatrist in a little more than one-fifth of cases.[39] Other, less frequent outcomes included such services such as psycho-pharmacological evaluation (5.4 percent), emergency consultation (0.5 percent), or in-patient treatment (0.1 percent).[40]

In June 2009, MCPAP surveyed primary care providers about their experiences screening for, diagnosing and providing treatment for (either directly or via referral) pediatric patients both pre- and post-MCPAP. The results provide a strong affirmation of the effectiveness of MCPAP services. The number of primary care physicians who felt that they had adequate access to child psychiatry for their patients went from 5.9 percent who either "agreed" or "strongly agreed" before MCPAP to a total of 34 percent following MCPAP's introduction.[41,42] Finally, the MCPAP survey also found that a majority of primary care providers

> "We hypothesize that because MCPAP is assisting primary care providers with diagnosing and treating less severe behavioral health issues within primary care, more appointment slots may be available in the community for the more severely involved youth. Families also are learning that the first stop for help with a behavioral health issue does not need to be a child psychiatrist."
>
> —John Straus, MD, vice president of Medical Affairs at the Massachusetts Behavioral Health Partnership

felt better able to utilize behavioral health screening tools as a result of the service. Perhaps more importantly, the number of primary care providers who felt that "with existing resources, I am usually able to meet the needs of children with psychiatric problems" rose from 8.4 percent who "agreed" or "strongly agreed" to 63.1 percent.[43,44]

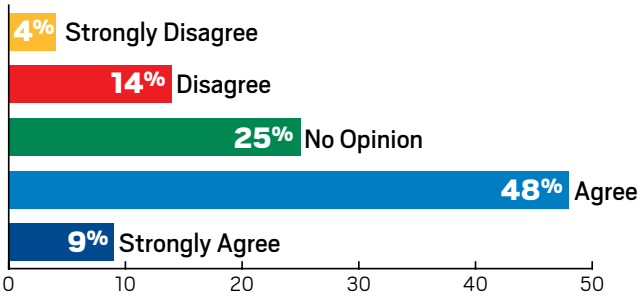
This substantial increase in the proportion of primary care providers who felt that they had adequate access to child psychiatry and could meet the needs of their patients, resulted from improved coordination and use of existing resources — rather than from an increase in the number of specialty mental health providers. This suggests that the perceived shortage of mental health providers may partially result from poor access to and coordination of resources, i.e., existing provider shortages are exacerbated by an inability to locate and connect patients to the appropriate provider. Blue Cross Blue Shield of Massachusetts Foundation issued a report on workforce capacity proposing that this may be the case in the Commonwealth, noting that they have the highest per capita supply of psychiatrists and social workers in the country and emphasizing, "the issue is not just about supply, but also the match between providers and clients. Parents need to find the "right" provider for their child's age, need, and severity, who accepts the specific type of insurance, has openings during hours when the child and family are available, and is located conveniently for an ongoing course of treatment." [45]

Dr. Straus at MCPAP points to this improved care coordination in explaining the improved ability to meet patients' needs, but also points to the role primary care providers have played in treating psychiatric disorders directly. He states, "Our MCPAP care coordination teams are available to help MCPAP enrolled primary care physicians find the right resources for families. Although

MCPAP care coordination teams do face the challenges of a system with a shortage of available resources, our teams are relentless in our attempts to find the right resource for the patients of our MCPAP enrolled primary care clinicians. Because we are there to find the right resources, families may not perceive the shortages in the way they would if they were left to do the care coordination on their own." However, Dr. Straus also notes the importance that primary care providers themselves play in easing the shortage of mental health specialists as they become more comfortable treating psychiatric problems. He explains: "We hypothesize that because MCPAP is assisting primary care providers with diagnosing and treating less severe behavioral health issues within primary care, more appointment slots may be available in the community for the more severely involved youth. Families also are learning that the first stop for help with a behavioral health issue does not need to be a child psychiatrist."

MCPAP has been exceptionally effective in overcoming the challenges of screening for, diagnosing and treating mental health disorders in primary care settings. According to Peter Kenny, MD, a pediatrician enrolled with MCPAP, "Access to MCPAP child psychiatrists and services has been absolutely essential for getting timely professional mental health care for the children in our practice. I cannot imagine how we would be able to effectively serve children with emotional problems without the wonderful support of the MCPAP Program." This success has helped lead to the establishment of similar programs in New York, Illinois, Arkansas, Texas, Washington, and Maine, with planning underway in additional locations.

"I have increased my ability to use behavioral health screening tools."



Source: Massachusetts Child Psychiatry Access Project (MCPAP) June 2009 survey of primary care providers in Improving Access, *Pediatrics*, accepted for publication, 2010.

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When funded at full capacity, MCPAP requires approximately $3 million in funding from the Commonwealth of Massachusetts annually. However, the sustainability of the program would be greatly improved if the model were funded by insurers on a proportionate basis. During the recent economic downturn, funding was cut to $2.5 million, resulting in a reduction in child psychiatry hours. If the service were reimbursed by private and public payers, the Massachusetts Behavioral Health Partnership estimates that it would cost just 18 cents per child, per month.[46]

Advocates for Quality Health Care

Finally, strong social and political support for improving children's mental health services in Massachusetts also contributed to MassHealth's success in implementing *Rosie D.* services. Patient and family advocacy groups, medical professional associations, and political leaders in Massachusetts have all played a part.

For instance, the Children's Mental Health Task Force at the Massachusetts' Chapter of the AAP and others advocated for the expanded adoption of mental health screening at the well-child visit well before the decision in the *Rosie D.* case. As a result, many of the private health plans in the state agreed to reimburse for mental health screening at the well-child visit prior to MassHealth's decision to do so. Dr. Yogman, chair of the Task Force recounts that: "The Child Mental Health Task Force of the MCAAP had long been advocating with insurers to reimburse for these screens. Because of budget constraints, MassHealth was one of the last payers to reimburse for mental health screening until the court mandated it." This created an environment favorable to the promotion of mental health screening as a standard component of all well-child visits, because primary care providers can now be confident that, regardless of payer, they are likely to be reimbursed for providing mental health screening.

Political support for advocates' goals has also played a role. A coalition of medical professional and patient

advocacy groups came together under the banner of the Children's Mental Health Campaign to advocate for further improvements to children's mental health care, following the successful passage of state health care reform in Massachusetts in 2006. Children's Hospital Boston, Health Care for All, Health Law Advocates, the Massachusetts Society for the Prevention of Cruelty to Children, and the Parent Professional Advocacy League were all members of the Campaign, and the legislation that they proposed and helped to shape, *An Act Relative to Children's Mental Health*, was passed by the legislature and signed into law by Governor Deval Patrick in 2008.

Commonly referred to as Yolanda's Law, in honor of a teenager who testified about her struggle with mental illness and who later died by suicide, *An Act Relative to Children's Mental Health* was designed to expand early screening and treatment options for children and promote mental health consultations and training. Specifically, the law created new reporting requirements on the number of children wait-listed for mental health services; established new protections for individuals with private insurance; provided a statutory requirement for reimbursement of mental health screenings conducted by MassHealth; and established the *Children's Behavioral Health Advisory Council*.

This Council is charged with making legislative and regulatory recommendations to the Governor, the Secretary of Health and Human Services, relevant commissioners, and the committees of jurisdiction in the Legislature on a number of issues, including:

> "(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."

These responsibilities intersect with the implementation of *Rosie D.* remedial services, and Yolanda's Law has provided advocacy and medical professional groups with a formal role in shaping both public and private mental health services in Massachusetts.

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"Accountability is an important aspect of implementing the *Rosie D.* remedial plan and the Council provides the appropriate forum to support achievement of that objective," according to Barbara A. Leadholm, MS, MBA, Department of Mental Health Commissioner and ex-officio Chair of the Council. She continues: "The Council bridges the broad spectrum of interested stakeholders and the Administration and provides the platform to discuss, identify issues, oversee and forward the agenda for improving access to behavioral health services for children and families. The complex issues addressed by the *Rosie D.* remedy require diverse understanding of our system and the changes we need to make. The Council offers diversity of opinion, background and knowledge in making recommendations."

This strong representation on the Council helps to ensure accountability for improving mental health services, and it serves as an important complement to the Court's monitoring of the *Rosie D.* remedial plan implementation. The Council's charge to submit an annual report of legislative and regulatory recommendations to the Governor, the Secretary of Health and Human Services, the legislature, and other policymakers with jurisdiction serves as an especially strong mechanism for ensuring that improvements in children's mental health services continue to be achieved.

Early Results

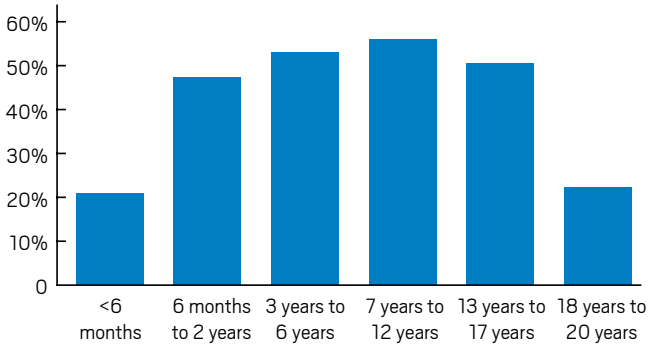
Given the short timeframe for implementation of the requirement to offer a mental health screening at all Medicaid well-child visits, MassHealth has been remarkably successful in increasing the rate at which this service is offered by primary care providers. Mental health screening was not offered universally beginning on the court-ordered start date of December 31, 2007, and, even

today, not every child is offered a mental health screen at the well-child visit. Nevertheless, the rate of mental health screening has risen substantially, as has the number of young people offered early intervention services.

Overall rates for the number of reported mental health screens provided at well-child visits climbed from just 14.46 percent in the first quarter of 2008 to 58 percent in the fourth quarter of 2009.[47] In addition to reporting overall screening rates, MassHealth reports screening rates by age. Although overall participation in well-child visits drops significantly as children age — meaning that adolescent youth, the age group most at risk for mental illness, are most likely to miss preventive visits — mental health screening rates are fairly constant across age groups for those youth who do attend a well-child visit. However, there is a significant drop-off in mental health screening rates at each extreme of the age-bracket of patients eligible for EPSDT screenings. A summary of the screening rates by age between January 1, 2008 and December 31, 2009 appears in the graph that follows.

According to provider feedback, the low screening rate

Mental Health Screening Rates by Age



Source: MassHealth Quarterly Screening Data.[48]

for children under six months of age can be explained by the lack of an appropriate screening tool. Primary care providers continue to advocate for the substitution of postpartum depression screening for a child mental health screen at visits for children less than six months of age. While the requirement to offer mental health screening to children in this age group remains in place, Massachusetts recently passed a law requiring health plans to report on the rate at which postpartum depression screening is provided. This law also authorized the creation of a commission to determine the best way to prevent, detect and treat postpartum depression and to recommend changes in public policy. At the other end of the age spectrum, screening rates are likely lower among 18 to 20 year-olds because they are frequently seen in adult care, rather than pediatric settings, where providers are more often unfamiliar with the screening requirement.

As screening rates have increased, the number of children who have screened positive for a mental health disorder has increased from 1,533 in the first quarter of 2008 to a cumulative total of 50,535 by the third quarter of 2009.[49] Despite this large increase in the overall number of children screening positive, the proportion of positive mental health screens is well within the expected range. According to a 1999 Report of the Surgeon General, approximately one in ten youth, i.e., ten percent, suffer from serious mental illness that causes significant impairment in their lives at home, in school and with peers.[50] Among MassHealth EPSDT beneficiaries, 9.38 percent of all screens provided between January 2008 and September 2009 were judged to be positive for a mental health disorder (this includes developmental, socio-emotional and behavioral health disorders).[51] For children two years of age and older, the rate of positive mental health screens holds fairly steady at 11 or 12 percent, while the proportion of children screening positive is substantially smaller in the youngest patients; 2.09 percent of children less than six months of age and 6.1 percent of children between six months and two years of age.*

While the data show a clear increase in the number of youth who have screened positive for a mental disorder, good measures of outcomes or the rate at which these youth are connected to medically necessary follow-up services are more difficult to come by. MassHealth data indicate that between July 1, 2009 and January 31, 2010, 4,135 youth received intensive care coordination; 3,206 received family support services; 4,029 received in-home therapy; 64 received in-home behavior services; 1,176 received therapeutic mentoring; and 5,504 received mobile crisis intervention.[52] However, these data only capture youth meeting the admission criteria for these services, and not all youth in need of mental health services will be reflected in these numbers. For instance, when looking at MCPAP data, it becomes apparent that

* The percentage of positive screens is based upon the number 96110 CPT codes reported to MassHealth with a positive modifier, divided by the number of overall 96110 codes reported with any modifier. This gives a fairly good picture of the overall rate, but does not take into account the approximately 20 percent of screens where no modifier (and thus no outcome) was reported.

not all children who screen positive for a mental health disorder will even be referred for specialty mental health services; many such youth are managed in the primary care setting. Consequently, it is difficult to determine from currently available data how well the system is working to improve receipt of early intervention services and what kinds of outcomes are being achieved.

For youth enrolled in the Primary Care Clinician (PCC) Plan, a Medicaid plan in which the primary care provider agrees to coordinate care, some data on follow-up is being collected. Specifically, MassHealth is looking at the rate of follow-up on a positive screen by either the primary care provider or mental health provider within 60 days. However, this data has not been made publicly available, and the PCC plan represents a minority of MassHealth beneficiaries. Better data, such as referral and referral completion rates or tracking of mental health screening outcomes over time, would be helpful in determining the degree to which youth identified as in need of mental health services are receiving care. This need for improved reporting measures on referral and receipt of mental health services has been noted by the Plaintiffs in their status reports to the Court. Screening is obviously not an end in itself. MCPAP screening consultant and physician Karen Hacker MD, MPH states: "While screening is an important element of child mental health care, we also need to make sure we are improving entrance into care and subsequent outcomes, not just identification."

Despite the lack of data showing exactly what proportion of youth who screen positive on a mental health screen are receiving mental health services, cost figures provide an indication that there has been a sizable increase in the rate at which youth are connected to follow-up care outside of the primary care setting. Officials at MassHealth have reported a significant increase in overall mental health care spending on youth following the introduction of the remedial services. This increase should be somewhat offset by decreases in the need for inpatient psychiatric care as home and community-based services are made more accessible. An earlier, small pilot program in Massachusetts that similarly proposed to provide "a seamless organized system of care for children and youth with serious emotional disturbance and behavioral problems" resulted in a three-fold reduction in hospital inpatient days among Medicaid managed care patients — from .15 days per member, per month (pmpm) in the prior 12 months to .05 days pmpm in the first 12 months of the program.[53] This pilot also showed a nearly three-fold reduction in residential stays, which went from 1.29 days pmpm to 0.45 days pmpm.[54] However, an overall increase in mental health spending may persist, due to the resource-intensive nature of the services required by *Rosie D.*, such as home-based therapy, mobile crisis stabilization, family mentoring, and intensive care coordination.

Reductions in *total* public spending by state and federal agencies, however, can be reasonably expected over the long-term. Numerous studies have shown that cost reductions in physical health spending can be expected following the introduction of mental health services, in some cases more than offsetting the cost of mental health services.[55,56] Effective mental health interventions also have been repeatedly demonstrated to result in improved school performance, reductions in substance abuse, increased productivity, and reductions in involvement with the criminal justice system — all of which results in tremendous cost savings to both state budgets and society.[57,58,59] A 2004 report from the Disease Control Priorities Project — a joint effort of the World Bank, the Fogarty International Center of the National Institutes of Health, the Bill & Melinda Gates Foundation, and the World Health Organization — reviewed 38 studies on the national aggregate costs of mental illness and concluded that the negative economic consequences of mental illness far exceed the direct cost of treatment.[60] So while MassHealth spending on mental health services may always reflect an increase over previous spending as a result of the *Rosie D.* services, overall public spending should fall.

More importantly, MassHealth's efforts to improve early identification and intervention for youth with mental illness can be expected to improve outcomes for thousands of children. After decades of research, we now know that there is a window of opportunity of two to four years between the first symptoms and the onset of the full-blown diagnosable disorder, when treatment is most effective at reducing the severity of specific disorders.[61] Mental health screening holds the potential to intervene early, and in some cases, to prevent fully developed mental, emotional and behavioral disorders.[62] If all children were given the opportunity to have a mental health checkup at the yearly well-child exam, the identification of mental illness at its earliest stages would be greatly increased and the cost to the individual and society — an estimated $247 billion annually — would be greatly reduced.[63]

Conclusion

Federal law has long required that Medicaid EPSDT well-child visits include an assessment of mental health, and there is now consensus among expert panels and medical professional groups that well-child visits should include an age-appropriate, evidence-based mental health assessment as the standard of care. The World Health Organization, the Institute of Medicine, the American Medical Association, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners, the U.S. Preventive Services Task Force (USPSTF), and the Society for Adolescent Medicine all recommend mental health screening at preventive visits in the primary care setting, as do specialty mental health providers including the American Academy of Child and Adolescent Psychiatry and the American Psychological Association.

Federal health care reform under ACA has placed particular importance on the recommendations of the AAP and the USPSTF. Under ACA, all preventive services recommended by the AAP's *Bright Futures Guidelines* and the USPSTF must now be provided by new health plans at no cost to beneficiaries; both sets of guidelines recommend mental health screening. The USPSTF recommends that depression screening be offered annually beginning at age 12. The AAP *Bright Futures Guidelines* call for a psychosocial and behavioral health assessment at each well-child visit and state that "one of the most efficient ways for health care professionals to improve the recognition and treatment of psychosocial problems in children and adolescents is by using a mental health screening test . . ." Furthering this guidance, in 2010 the AAP Task Force on Mental Health released algorithms to enhance pediatric mental health care that recommend the use of a pre-visit questionnaire, incorporating validated screening instruments, in order to assess mental health at each well-child visit.

The overwhelming consensus that mental health screening should be incorporated into the well-child visit as the standard of care may also be reflected in quality reporting guidelines in the near future. The HITECH Act and ACA include provisions that will expand the use of quality reporting and measurement, and legislation reauthorizing CHIP in 2009 (CHIPRA) established a core set of pediatric quality measures for voluntary use by Medicaid and CHIP programs. The initial CHIPRA core set of pediatric quality measures will assess the rate of developmental screening in young children, but does not yet address mental health screening in older youth. However, a project is currently underway at the National Quality Forum (NQF) to assess measures for possible use in the CHIPRA core set, and at least six separate measures that would assess the rate of depression screening have been nominated for endorsement.

If all children were given the opportunity to have a mental health checkup at the yearly well-child exam, the identification of mental illness at its earliest stages would be greatly increased and the cost to the individual and society — an estimated $247 billion annually — would be greatly reduced.

All state Medicaid and CHIP programs, provider groups, and health plans should begin taking proactive steps to meet the standard of care and improve the rate of mental health screening. Massachusetts' experience in implementing mental health screening in their Medicaid program is the best available example of a large scale effort to ensure that mental health screening is offered at all well-child visits. Their experience offers valuable insight on both the hurdles to successfully implementing mental health screening and the keys to overcoming them. The *Rosie D.* remedial plan and MassHealth policy established a clear path for implementation. Further, MassHealth ensured success by engaging health care providers and advocates in the planning and implementation process; reimbursing for mental health screening; and providing clinical consultation and referral support to primary care providers.

Appendix 1: MassHealth Approved Screening Tools

- Ages and Stages Questionnaire: Social Emotional (ASQ:SE)
- Brief Infant Toddler Social-Emotional Assessment (BITSEA)
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Parents Evaluation of Developmental Status (PEDS)
- Pediatric Symptom Checklist (PSC, PSC-Y)
- Patient Health Questionnaire-9 (PHQ-9)
- Strengths and Difficulties Questionnaire (SDQ)*
- CRAFFT (substance abuse risk tool)

* Based on ongoing provider feedback, the Strengths and Difficulties Questionnaire (SDQ) replaced the Achenbach Child Behavior Checklist Youth/Adult (CBCL) on the menu of approved screening tools, effective November 1, 2009.

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TeenScreen® National Center for Mental Health Checkups at Columbia University

The TeenScreen National Center for Mental Health Checkups at Columbia University is a non-profit, privately funded mental health initiative committed to early identification of mental illness in adolescents and prevention of teen suicide. The mission of the National Center is to expand and improve early detection of mental illness by mainstreaming mental health checkups as a routine procedure in adolescent health care, schools, and other youth-serving settings. The National Center offers youth mental health checkups through two major national efforts, TeenScreen Primary Care and TeenScreen Schools and Communities. Voluntary screening is provided in more than 1,200 sites in 45 states through the National Center's efforts. The National Center is an affiliate of the Columbia University Division of Child and Adolescent Psychiatry.

TeenScreen® Primary Care

TeenScreen Primary Care is an initiative of the National Center for Mental Health Checkups designed to assist health care professionals with integrating mental health checkups into routine health care for adolescent patients. TeenScreen Primary Care provides free evidence-based screening tools to medical providers to help them determine if their adolescent patients are suffering from depression, anxiety or other conditions and ascertain if they are at risk for suicide. TeenScreen Primary Care offers instruction on how to: administer a screen, score and interpret screening results, develop mental health referral networks, code and reimburse for screening, and prepare office staff to implement mental health checkups.

TeenScreen® Schools and Communities

TeenScreen Schools and Communities is a national mental health and suicide risk screening program for middle and high school age adolescents. This flagship program of the National Center for Mental Health Checkups assists communities throughout the country in developing locally operated and sustained screening programs. Screening can take place in schools, clinics, shelters and a variety of other youth-serving organizations and settings. TeenScreen Schools and Communities offers free program development and implementation materials, screening questionnaires, and technical assistance to communities that wish to implement their own screening programs using the TeenScreen Schools and Communities model.

Contact TeenScreen National Center for Mental Health Checkups:

1-877-TeenScreen (1-877-833-6727)

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