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Children's Mental Health Campaign (CMHC)
Summary Recommendations:
Health Policy Commission ACO Certification Program

On behalf of the Children's Mental Health Campaign (CMHC), thank you for the opportunity to submit recommendations regarding the certification of ACOs. Despite incremental improvements over the last decade, children diagnosed with behavioral health disorders and their families still often find themselves navigating a maze of fragmented care, workforce shortages, and limited coverage.

As you may know, half of all lifetime mental illnesses begin by age 14; three quarters by age 24. Suicide is now the second leading cause of death for youth ages 10 to 24, and the Centers for Disease Control estimates that the economic impact of mental health challenges among youth under age 24 is $247 billion annually.

Payment and delivery system transformation presents an important opportunity to provide a high quality health care system that recognizes children's behavioral health needs as an essential component of their overall health. Broadly, care and reimbursement structures must recognize the need for integrated behavioral health within pediatrics across the prevention-intervention continuum. More specifically, children and youth with serious emotional disturbance (SED) have complex needs that cannot be adequately addressed in a system built for adults. We know that if their needs do not get met, they are more likely to grow into adults with complex and costly health care needs. With that in mind, The CMHC offers the following recommendations and concerns specific to pediatric behavioral health for your consideration as you proceed with defining ACO certification criteria.

Quality Measures

- Promote quality measures for pediatric behavioral health (criterion #8, #9): Measuring the quality of children's behavioral health care will require a combination of process and outcomes measures. While there are numerous methods in place to measure the efficacy of physical health care, no national benchmarks for child mental health that apply to all children with mental disorders currently exist. The Massachusetts Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality demonstration grant project has developed a set of quality measures. While they are not yet validated, they do serve as a good starting point.
    - The CMHC supports the development of a dashboard for tracking outcomes in related child-serving systems. A dashboard that accounts for school absenteeism, grade

progression, completion of support programs, and juvenile justice involvement and re-arrest data would provide a more complete view of behavioral health outcomes.
    - As public health shifts to address the social determinants of health, quality metrics should follow suit. For children and youth with behavioral health conditions, making a friend, being invited to a birthday party, or having a positive plan for the future may all be better outcome measures than those that are traditionally tracked.

- Promote patient-centered quality measures (criterion #14): ACOs should include patient or family-reported outcomes measures and measures that capture members' views regarding the care they received. Family satisfaction surveys should be part of evaluating the quality of behavioral health care children receive within the ACO structure.

Consumer protections

- Ensure robust appeals and grievances procedures (criterion #19): It is essential that ACOs have a clear and comprehensive appeals and grievance process for enrolled members. While ACOs can allow creative and useful collaboration among providers, financial incentives may lead to the denial of necessary care, especially when needed care is available outside the ACO's network. Provider payment structures, while generally designed not to affect decision-making in individual patient cases, can have unintended consequences on in-network provider behavior. It is therefore vital to have a transparent and workable appeal/grievance system in place so patients may challenge medically inappropriate decisions made within the ACO. The following are some of the key elements the CMHC believes an ACO appeals/grievance system should have:
    - Reporting by ACOs with regard to their appeals/grievance process so that implementation and impact may be monitored.
    - Appeals must be decided by independent and qualified medical professionals.
    - A clear articulation of what events may give rise to an appealable action, taking an inclusive approach.
    - ACOs must provide timely, complete and understandable notices regarding the appeal/grievance system.
    - Grievance and appeal deadlines should be generous given how new the ACO system will be to members.
    - ACOs should be required to provide consumers with reasonable assistance in filing grievances and appeals.
    - The grievance/appeals process should allow for full transparency and access to information for patients disputing ACO decisions regarding their care.

- Network adequacy: Access must start with an adequate network of care. Significant workforce shortages persist and impact families' ability to access care across the care spectrum. Until such time as those workforce issues are addressed and sufficient networks exist, community based behavioral health providers should not be limited in the number of ACOs they may contract with. The process for contracting should be simplified, as significant administrative burdens often result in a barrier to provider participation.

- Attribution methods should account for family choice: Attribution methods should allow for families to enroll their children in the same ACO. This is especially important for families with more than one child with special needs. Families should have the option to designate their child's behavioral health provider as their primary care provider within the ACO structure when appropriate, based on the child's needs.

- Ensure Transparency: Families need access to a detailed database of provider information, including training, modalities of practice, years of experience working with children, and quality ratings. Similar information is available for physical health providers, but not for behavioral health care. Community-based organizations need the resources to conduct evaluation of services and measure outcomes in order to provide that data to families

Access to services and care delivery

- Promote the integration of behavioral health services: It is time to move away from viewing behavioral health as something separate from overall health. Behavioral health should be co-located within pediatric primary care settings wherever possible in order to decrease current barriers to access (e.g. stigma, long wait times, and slow and/or lacking communication). For most, co-location is an opportunity to support healthy emotional development and mental wellness in the primary care setting where children and families are most likely to receive care. For those with mild or moderate behavioral health conditions, care may be provided within the pediatric practice, reducing the need for specialty care. For those diagnosed with a significant behavioral health disorder, families should be ensured access to the care coordination and supports they need. Co-located models may be achieved by employing behavioral health specialists within a practice or by partnering with a community-based behavioral health agency. The cost of care should be "carved in" rather than "carved out."

- Promote coordination across systems and agencies: Children with significant behavioral health needs are frequently engaged in two or more systems, including child welfare and juvenile justice, and may be getting services from any or all of those systems. The Departments of Children and Families (DCF), Mental Health (DMH), Developmental Services (DDS), Youth Services (DYS), Elementary and Secondary Education (DESE), the Bureau of Substance Abuse Services (BSAS) within the Department of Public Health (DPH), among others, all provide some degree of care for children with behavioral health diagnoses.
    - The CMHC urges the HPC to consider how the state may hold those systems accountable for helping to care for complex youth who are attributed to an ACO. The CMHC recommends that ACOs establish an ombudsperson to take on assisting youth, especially those with complex physical and behavioral health care needs, in the transition from pediatric to adult care.
    - The CMHC supports exploration of unique health homes for kids in DCF custody, and those involved in the juvenile justice system. It is important that these children receive

timely medical screening, comprehensive evaluations, and well child visits. The increasing demands of medically complex cases, the high percentage of children in foster care on psychotropic medications and the unacceptably long gaps in accessing treatment experienced by foster children remain critical areas to address.

- Prioritize prevention and early intervention: Children are uniquely positioned to benefit from prevention practices because of their resilience. ACOs should focus on prevention and early intervention, with the goal of reducing the need for children and youth to engage in more intensive behavioral health services. Furthermore, intervention with children, even those with significant illness, can be seen as preventive given their age. Even a small positive change in a child's trajectory will generate cost savings for the rest of their life. There is a need to rethink how the current workforce is structured to achieve those goals, while ensuring that an adequate network of care exists for those who do require a more extensive array of services.
    - *Infant and Early Childhood Mental Health (IECMH):* Addressing the unique and specific mental health needs of infants and young children is prevention in the best sense of the word. Ensuring the availability of appropriate interventions for IECMH has the potential to make the biggest impact on long-term outcomes in the overall mental health of the population. A growing body of research supports the need to develop expertise and capacity to assess and treat IECMH needs in a variety of settings, including EEC and primary health care.
    - *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0-5):* The DC:0-5 is a developmentally based system for diagnosing mental health and developmental disorders in infants and toddlers. Its diagnostic categories reflect the consensus of a multidisciplinary group of experts in early childhood development and mental health. It is regarded as the most effective diagnostic classification system for that work with very young children that are available today. Fourteen states use crosswalks between the DC:0-5 and DSM 5 and ICD 9 to facilitate its use in billing for clinical services. The CMHC urges the development of a Massachusetts crosswalk as a strategy for ensuring effective mental health treatment and positive clinical outcomes for very young children.
    - *Increased Utilization of Screening Tools:* ACOs should be incentivized to implement universal screenings for mental health, substance use, and trauma. Currently, CBHI reimburses for one required mental health screen per year. The CMHC endorses the use of, and reimbursement for, a set of developmentally appropriate screenings, including but not limited to requiring post-partum depression screens for pediatric visits through 6 months, and substance abuse screenings for adolescents.
    - *Enhance the Massachusetts Child Psychiatry Access Project (MCPAP):* As primary care has taken on a greater role in children's behavioral health due to the shortage in the availability of children's behavioral health providers, MCPAP has been a useful – and successful - consultation model for pediatricians. ACOs should leverage MCPAP to provide support for patients with complex behavioral health needs. In turn, MCPAP should be enhanced to allow for more intensive, and extensive, interaction with ACOs.
    - *Evidence-Based Early Intervention Practices for youth with SED:* There is growing evidence of the promise of early intervention for youth showing signs of psychotic illness. Given the long-term risks and costs associated with lifelong psychotic illness, ACOs should consider requiring the use of these and other preventive interventions as they are developed.

- Children's Behavioral Health Initiative: The CBHI care system must be connected to ACOs as part of the continuum of behavioral health care. The robust network of services provided under CBHI will be essential to meeting behavioral health needs of kids in ACOs, especially those with the highest level of need. MassHealth will need to determine how to manage accountability and risk for CBHI services contracted to ACOs.

Invest in care coordination, and individual and family supports

- Invest in peers support (criterion #27): Peer mentors, family partners, care coordinators, and navigators may all play an essential part of the behavioral health team for children and their families, depending on the complexity and acuity of the child's behavioral health care needs. They may be primarily responsible for the time-consuming but critical work of collateral contact with schools, family, and other care providers which is essential, unique from working with adults, and which previously has been unreimbursed. These teams should work together with the primary care team, but should not be responsible for coordinating primary care services. A navigator or care coordinator with a behavioral health background or expertise should be available on an on-call basis 24 hours a day for all patients.

- Care coordination is essential to behavioral health integration for children and youth (criterion #23-26): ACO models should include an appropriate level of care coordination and individual and family supports based on the identified level of need for each child. To that end, ACO models need a clear algorithm to determine and designate "top of the pyramid" patients who require specialty care.
    - Tier I: Children in Tier I have a diagnosable behavioral health disorder or severe emotional disturbance (SED) and require Intensive Care Coordination and a high level of family support, as well as significant engagement in behavioral health care services. The care coordination team for children in Tier I should include the roles of care coordination, navigation, and parent support, and requires explicit training and supervision. Cross-disciplinary expertise is required, as children in Tier I often present with co-occurring disorders, including substance use disorders (SUD), intellectual and developmental disabilities (IDD), and physical illness. The team should include at least one master's prepared clinician or a nurse to lead the team. While the CMHC is not the best source to define staffing ratios, we do know that children with SED require more care coordination than adults because many of them are involved with several agencies.
        - In addition to the care coordination team, children and their families in Tier I should have the benefit of expedient access to child psychiatry services, outpatient services, and mentors. Behavioral Health Coordinated Care is recommended for children with chronic, persistent behavioral health disorders. The CMHC is concerned that while many individuals need to be a part of coordinating care and supporting families, there needs to be a straightforward and clear definition of roles to avoid confusion and ensure positive outcomes.
    - Tier II: Children in Tier II have a mild or moderate behavioral health condition that may occasionally require acute care. Family partners should have lived experience navigating the behavioral health system, and there should be preference toward certification, or working toward certification, with professional supervision. Care coordinators should have training in behavioral health. Access to home- and community-based services and

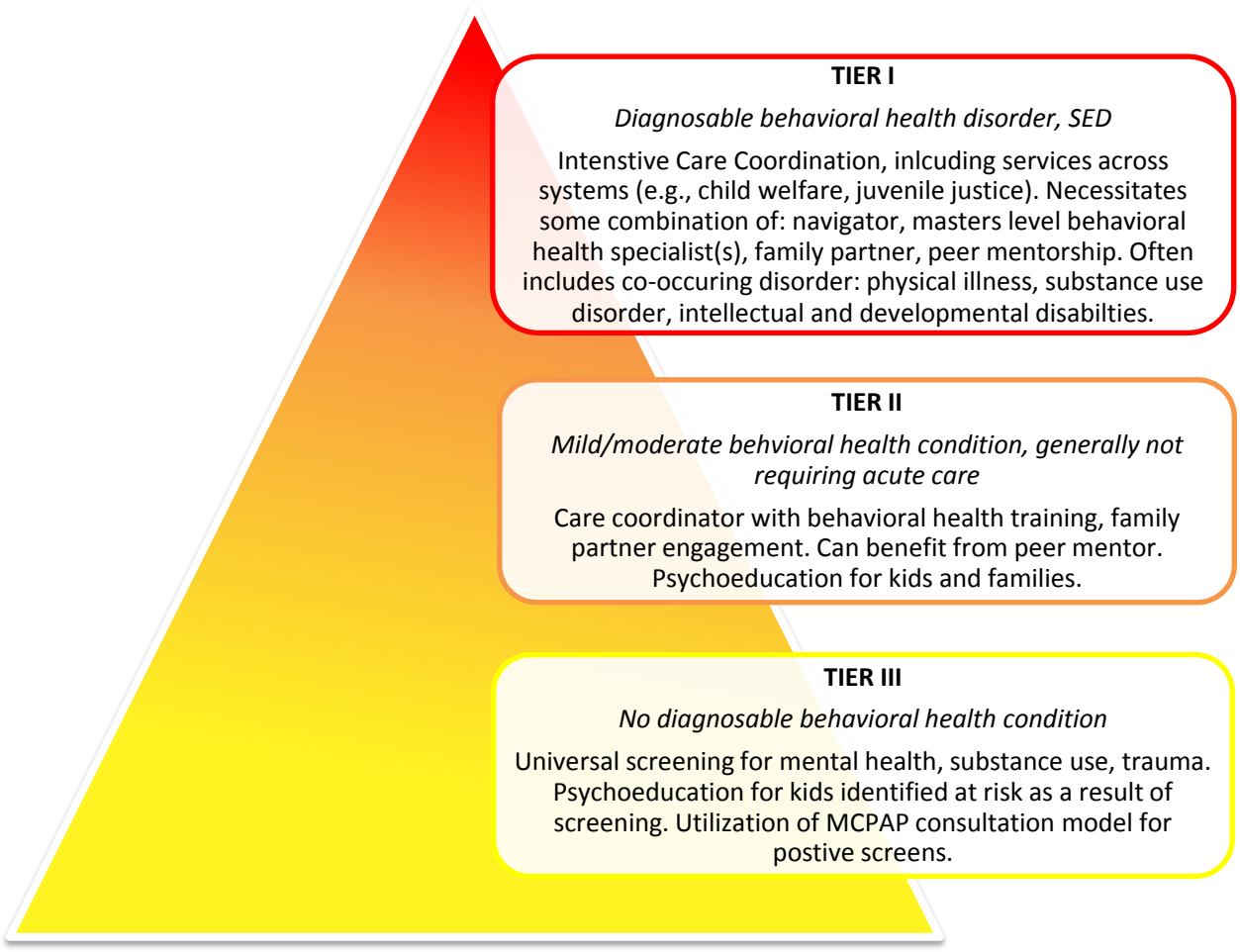
psycho-education services should be available to enhance understanding and management of the child's behavioral health condition.
    - Given their resilience and ongoing development, recovery should be a core component of the work done with children in Tier II and Tier III. Unlike adults, serious behavioral health conditions in children can often be permanently resolved, or the long-term severity can be minimized.
- Tier III: Children in Tier III have no diagnosable behavioral health condition. This does not mean, however, that they do not have behavioral health needs. Universal screening using validated screening tools for behavioral health conditions should be a requirement of ACOs. Children in Tier III who screen positive, are identified as being at higher risk for developing behavioral health problems, or who demonstrate early warning signs, should receive a referral to a co-located or community-based professional for follow-up and further assessment. Parent partners may be helpful for those rising to the top of Tier III after a positive screen to ensure follow-through with referrals and assessments.

Financial incentives and payment methodologies

- Shared accountability for multiple-systems involved children: The CMHC has a great deal of concern about the financial modeling for behavioral health within the ACO. Historically, behavioral health disorders are untreated or undertreated, so retrospective claims analysis is an unreliable measure of the cost of care. For those children who are receiving services, a significant portion are not reimbursed, including case management, care coordination, services provided by school, DCF, DMH, DYS, BSAS, and other agencies and systems that provide behavioral care and supports, but do not bill MassHealth.
    - The CMHC recommends the HPC explore the option of having pooled money to care for highly complex children and youth who touch multiple systems. It might make sense to have a default cost-sharing model in order to minimize the "hot potato" effect of kids who need services from a range of agencies/providers.
    - A clear and consistent mechanism is required for holding these agencies accountable for helping to care for complex children and youth attributed to an ACO. To that end, precaution must be taken to ensure that payment reform does not incentivize the destabilization of the network of community-based social services that provide care and support to children and youth.

- Short term care, long term savings: The CMHC urges the HPC to consider long term and short term benefits when developing incentives. For kids, the financial savings are often realized many years late, as fewer services are required in the long term for behavioral health conditions that are moderated or resolved, and fewer comorbid conditions present mental and physical health challenges.

Thank you for your consideration. Please contact Courtney Chelo, CMHC Manager, at 617-587-1513 or cchelo@mspcc.org to set a time to meet with the CMHC Executive Committee to talk about these and other campaign priorities.


TIER I
Diagnosable behavioral health disorder, SED
Intenstive Care Coordination, inlcuding services across systems (e.g., child welfare, juvenile justice). Necessitates some combination of: navigator, masters level behavioral health specialist(s), family partner, peer mentorship. Often includes co-occuring disorder: physical illness, substance use disorder, intellectual and developmental disabilties.
TIER II
Mild/moderate behvioral health condition, generally not requiring acute care
Care coordinator with behavioral health training, family partner engagement. Can benefit from peer mentor. Psychoeducation for kids and families.
TIER III
No diagnosable behavioral health condition
Universal screening for mental health, substance use, trauma. Psychoeducation for kids identified at risk as a result of screening. Utilization of MCPAP consultation model for postive screens.