CHILDREN'S MENTAL HEALTH CAMPAIGN

MSPCC - BCH - HCFA - HLA - PPAL - MAMH

April 22, 2021

Daniel Tsai
Assistant Secretary for MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted via email

Re: MassHealth Section 1115 Demonstration Waiver Renewal

Dear Assistant Secretary Tsai,

On behalf of the Children's Mental Health Campaign (CMHC), thank you for your commitment to ensuring that the unique needs of children, youth, and families are considered in MassHealth's Section 1115 Demonstration Waiver Renewal, including in the provision of behavioral health care. The CMHC is a large statewide network that advocates for policy, systems and practice solutions to ensure all children in Massachusetts have access to resources to prevent, diagnose, and treat mental health issues in a timely, effective, and compassionate way. The CMHC Executive Committee consists of six highly reputable partner organizations: The Massachusetts Society for the Prevention of Cruelty to Children (MSPCC), Boston Children's Hospital, the Parent/Professional Advocacy League, Health Care For All, Health Law Advocates, and the Massachusetts Association for Mental Health. The CMHC network includes more than 200 organizations across Massachusetts.

The behavioral health needs of children, youth and families have increased substantially during the COVID-19 pandemic. These needs are not going to diminish – and in fact may further escalate – in the years following the end of the public health emergency. Along with the Behavioral Health Roadmap, the 1115 waiver renewal presents a timely opportunity to improve behavioral health care throughout the continuum and levels of care, from promotion and prevention through acute inpatient treatment. The CMHC appreciates that improvements to primary and pediatric care, with a focus on integration of behavioral health, simplifying the behavioral health benefit, increasing patient access and advancing health equity are among the top goals for the waiver renewal. We ask the Executive Office of Health and Human Services (EOHHS) and MassHealth to consider the following recommendations to further strengthen pediatric-focused aspects of the 1115 waiver proposal.

Integration of Behavioral Health in Primary Care

The CMHC supports the overall framework for MassHealth's primary care reforms, especially integration of behavioral health; inclusion of behavioral health clinicians and family partners,

peers and community health workers on the care team; and specific care delivery expectations for children, youth and families. We are optimistic that these features of the proposed primary care sub-capitation program will enhance care for children and families enrolled in ACOs, increasing the opportunity for early intervention and removing some of the pressure on the specialty behavioral health system.

Promotion & Prevention: Care without a Diagnosis

Behavioral health promotion and prevention are important aspects of a more upstream approach to addressing mental health, substance use, and developmental health. Behavioral health promotion seeks to foster and increase protective factors and healthy behaviors that can help reduce risk factors that lead to the development of a diagnosable condition. Whether universal or more narrowly indicated, prevention efforts focus on children and families who have risk factors that could lead to behavioral health disorders, including relational health of caregivers and children. Siblings, in particular, may be at increased risk for developing behavioral health concerns. Several states allow Medicaid reimbursement for behavioral health care, including promotion and prevention services, without a diagnosis. Most notably, California has implemented a policy that allows family therapy for children and families without a diagnosis, based on a broad array of identified risk factors. The CMHC appreciates that the MassHealth primary care reforms seek to give practices the flexibility to provide integrated care services that meet their patients' needs, including by providing currently non-reimbursable services. We urge MassHealth to clarify and ensure that behavioral health interventions such as several therapeutic appointments for a child/family, without a diagnosis, are allowable and incentivized.

Screenings & Follow Up

The CMHC appreciates that pediatric behavioral health and developmental, as well as maternal postpartum depression, screenings and follow up are included as baseline expectations in the primary care model. Screenings are key to catching problems early. However, screenings should not be done without appropriate follow up, such as warm handoffs, referrals to outside providers/resources, and ongoing care coordination and navigation. We ask MassHealth add follow up screening and assessment after an initial positive Screening, Brief Intervention and Referral to Treatment (SBIRT) screen and social-emotional screening (e.g., the Survey of Well-being of Young Children) either as part of or in addition to developmental screenings.

The CMHC is also currently supporting legislation that would establish an advisory working group to update, amend, and recommend tools and protocols for the screening of all children for the mental health impacts of trauma, including in pediatric health care settings and children in the care and custody of the Department of Children and Families. Should this concept move forward, we would work with MassHealth to implement the advisory working group's recommendations, including in the primary care sub-capitation program, if applicable.

Early Childhood Diagnosis

The work underway to create a Massachusetts-specific crosswalk of DC:0-5, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, with the ICD-10 and DSM-5 is a step forward in appropriately assessing infant and early childhood mental health (IECMH) and relational health needs. Our partners at MassHealth, the Department of Mental Health, MSPCC, and MassAIMH, among others, are collaborating on this

crosswalk and training providers on use of the tool, as well as other efforts to build the IECMH workforce. We ask MassHealth to consider ways to encourage primary care practices to utilize the DC:0-5 and provide guidance and resources for how to appropriately use the tool, such as an expectation that integrated behavioral health clinicians use the tool, starting in Tier 2.

Team-based Primary Care

We support MassHealth's goal to incentivize team-based primary care. Reimbursement rates must be reflective of the requisite staffing needs, especially of those roles that have previously been largely unreimbursed in the primary care context, including community health workers, family partners, and peers. While integrated behavioral health clinicians are currently able to receive reimbursement for most services, other components of successful integrated care are not always compensated, such as warm handoffs, brief interventions, support with school issues and socioeconomic needs, and reflective supervision. Including fair payment for family partners, peers and community health workers is important as an equity issue, as these roles are critical to engaging families in meaningful and ongoing care. Family partners and peers have valuable lived experience and can help families feel more comfortable and welcome in medical settings.

Infrastructure & Capacity Building

Many primary care practices will need some form of infrastructure and capacity building support to engage in payment and practice transformation efforts. We are hopeful that the tiered approach will enable different types of practices to participate in the primary care sub-capitation program and successfully integrate behavioral health staff and services. However, we recognize that some practices may not have as many resources at their disposal to enter the primary care sub-capitation program or to move up tiers. With the phasing out of the Delivery System Reform Incentive Program (DSRIP) funding, we ask MassHealth to consider other funding mechanisms to obtain resources that can be dedicated to practice transformation technical assistance, at the primary care practice level and at the ACO level, for those ACOs equipped and interested in provided practice transformation support directly to the primary care practices within their networks. Primary care practices can be held accountable for use of these funds by demonstrating how they will be used to participate in the primary care sub-capitation program or move up in the tiers.

Care Coordination

Pediatric primary care practices play a critical role in working with families to coordinate care, navigate the health care system, and make connections to other sectors, such as education, parenting support, social service agencies, and more. While closed-loop coordination with the Children's Behavioral Health Initiative (CBHI) is a current expectation, we have heard from both primary care and CBHI providers that this is rarely the case. In addition, CBHI is a time-limited service and care coordination needs for young people with significant behavioral health needs often extend beyond that time. Also, Intensive Care Coordination (ICC) usually only coordinates the services outlined in their specifications. For instance, if the primary care physician adds occupational therapy, coordination of that service would not be included in ICC work. There are limits to this model and reliance on ICC for ongoing care coordination.

Improvements can be made in care coordination expectations among all types of providers and the CMHC supports more streamlined, family-centered coordination and navigation across all

levels of behavioral health care. Families will benefit from having primary care team members who are equipped to help families connect to and coordinate with CBHI on an ongoing basis and Family Resource Centers, as well as the new levels of care and provider types created through the Behavioral Health Roadmap, such as Community Behavioral Health Centers. The CMHC also strongly supports efforts to improve connections between school-based behavioral health services, primary care, and the broader behavioral health system.

Quality & Accountability

Accountability mechanisms are necessary to ensure that primary care providers participating in the sub-cap program are meeting care delivery expectations and the overarching goals of primary care payment reform, and to protect members from underservice. One way to hold practices accountable is through quality measures tied to payment. In addition, the CMHC asks MassHealth to consider supplementing current metrics with additional pediatric-specific metrics, such as screening follow up (including caregiver screenings) and effectiveness of integrated behavioral health. We also understand that there are long-standing efforts in the Commonwealth to align quality metrics across payers and that metrics must be carefully considered for their ability to meaningfully measure care quality and inform payment policies. At the same time, MassHealth can be a leader in utilizing more pediatric and family-focused measures that support the goals of the primary care sub-cap program. In addition to quality metrics, the CMHC urges MassHealth to ensure that primary care reimbursement adequately supports pediatric care, taking into account any differences with adult-focused care, including configurations of care teams and the additional time it takes to complete certain services.

Investment in Pediatrics

Increased investments in pediatric care are needed at all levels to make significant delivery system reforms. As suggested by the Massachusetts Chapter of the Academy of Pediatrics-led ACO Child and Adolescent Health Initiative (CAHI), MassHealth could utilize ACO and Managed Care Organization (MCO) contracts as vehicles to require minimum expenditures in pediatric care, akin to the Governor's proposal of increasing investments in primary care and behavioral health by 30%. In addition, as short-term cost savings from providing better quality, child and family-centered pediatric care does not accrue in the health care system, but rather in sectors such as education and juvenile justice. The investment in children is an investment in longer-term health outcomes and multi-sector outcomes.

Health Equity & Health-Related Social Needs

The CMHC appreciates that MassHealth includes addressing health equity and health-related social needs among its priorities for the 1115 waiver proposal. One tangible way to start to address health equity is to collect information. We support efforts to implement systems that appropriately collect member demographic data stratified by race, ethnicity, language, disability and other factors, including age, sexual orientation, gender identity, and psychiatric diagnosis. This data should be used to understand health disparities within and across the MassHealth program, with a focus on ACOs and develop policies that aim to reduce health inequities in outcomes, access and quality of care.

The CMHC also supports the continuation of Flexible Services Program (FSP) and other features of the ACO program meant to increase the health care system's role in supporting MassHealth

members' health-related social needs (HRSN), such as housing and food insecurity. These factors are not only important contributors to physical and behavioral health outcomes overall, but are important drivers of racial health inequities. As such, we urge MassHealth to both continue and to expand the reach of the Flexible Services Program (FSP) and seek new avenues for committing resources toward HRSN interventions. In particular, the CMHC requests that MassHealth add assistance with school issues as an allowable domain for FSP funding and interventions. This is especially important as children return to school, as the full breadth of the disruption and need for services caused by the pandemic is not yet evident. The CMHC also recommends that MassHealth include FSP and other HRSN support initiatives in the 1115 waiver that can be provided on the family/household level. For example, food supports provided to one MassHealth member are likely shared with the entire household, and would be far more effective if provided for an entire family unit or household.

MassHealth Behavioral Health Benefit

Behavioral Health Network

As MassHealth considers new options to manage the behavioral health benefit, potentially with a single network or vendor, we urge you to incorporate these principles:

- Promote continuity of care for members who shift between plans, allowing continuation of current provider relationships without needing to take additional steps;
- Increase access to care through the development of broader, robust network(s), with special attention to sub-populations, such as children and youth, including young children, people with co-occurring intellectual, developmental and/or other disabilities, Black, Indigenous and other People of People of Color (BIPOC), LGBTQ+, people with language access needs, and geographic diversity (e.g., Western Massachusetts);
- Ensure network adequacy at all levels of care;
- Implement consumer protections, such as a simple exceptions process, to allow members to go outside of the established behavioral health network if there is not capacity within the network to meet their needs; and
- Enforce federal mental health and addiction parity laws to ensure that administrative barriers to accessing behavioral health care are no more restrictive than those used to access medical treatment.

We are pleased to see that independent clinicians will be included in the proposed standard behavioral health network. An ongoing access issue with the MassHealth fee-for-service benefit has been the lack of coverage for independent psychologists and social workers who are not based at or bill through a community-based behavioral health clinic or community health center. Ensuring that these providers are included in the network will increase the availability of providers for members who utilize the fee-for-service network through primary or secondary coverage.

Administrative Simplification

The CMHC is hopeful that, along with other changes, administrative simplification will increase access for MassHealth members by maintaining in-network providers and bringing new providers in network. There are also efforts underway in the commercial insurance space, such as through the Mass Collaborative, to streamline administrative forms requirements that

MassHealth could align with to simplify across payers, if it does not result in inhibiting access for members, and adhere to the principles outlined above. Utilization management and medical necessity criteria should not be any stricter than today; in fact, there are opportunities to strengthen consumer protections from unnecessary denials of behavioral health care and reinforce mental health and addiction parity laws.

Behavioral Health Rates

The CMHC acknowledges and thanks the administration for making significant investments in MassHealth behavioral health rates for both community-based providers and the recent rate enhancement for inpatient care, to help address the Emergency Department boarding crisis. Even with these adjustments, there is still work to do to adequately address the longstanding underinvestment in behavioral health care. Sufficient rates are important not only to support providers doing the work but also to ensure a strong provider network that is able to serve all MassHealth members. At the same time, targeted investments must be made to build a behavioral health system and corresponding workforce that is able to meet the needs of a diverse patient population both in terms of level of need and factors such as age, race, ethnicity, language, co-occurring disorders, developmental stage, and disability.

Eligibility

The CMHC supports efforts to simplify MassHealth eligibility and coverage renewals to help promote continuity of care and services. The CMHC applauds MassHealth's waiver amendment proposal to extend postpartum coverage from 60 days to 12 months. Inadequate postpartum care may contribute to persistent racial and ethnic disparities in maternal and infant health outcomes. In the year following pregnancy, multiple health issues may arise, including both physical and behavioral health issues, such as postpartum depression and substance use disorders. These all require uninterrupted ongoing care, and this policy change will help reduce barriers to that care.

Further, while MassHealth has made considerable efforts in the past several years to address coverage gaps, families still experience this problem. As MassHealth is developing policy and programmatic changes through the 1115 waiver, the CMHC asks that the agency also consider filing a State Plan Amendment for 12 month continuous eligibility for children. Many other states have already taken up this option. Continuous eligibility would help Massachusetts further its payment and care delivery reform goals more effectively and ensure that children and adolescents avoid gaps in coverage or care. While continuity of care is important for all populations and types of health care, it is especially crucial for children's behavioral health. With the ongoing impacts of the pandemic and the acceleration of the ED boarding crisis, now is a critical time to consider all available levers to mitigate access barriers. Any disruptions in behavioral health care could cause an escalation of symptoms, necessitating increasingly acute interventions in an already overburdened system; adding to family stressors; and impacting the ability of children and youth to engage in school and community activities.

Thank you for the opportunity to submit comments on MassHealth's Section 1115 Demonstration Waiver Renewal and for EOHHS's leadership to improve access to behavioral health care for children and families across the Commonwealth. Should you have any questions or wish to discuss the CMHC's recommendations further, please contact Suzanne Curry at Health Care For All at scurry@hcfama.org or Courtney Chelo at MSPCC at cchelo@mspcc.org.

Sincerely,

Mary A. McGeown, Executive Director, MSPCC
On behalf of the Children's Mental Health Campaign

Cc: Commissioner Brooke Doyle, Department of Mental Health
Amanda Cassel Kraft, Deputy Medicaid Director
Aditya Mahalingam-Dhingra, Chief, Office of Payment and Care Delivery Innovation
Mohammad Dar, MD, Senior Medical Director
Clara Filice, MD, Associate Medical Director for Payment & Care Delivery Innovation
Kate Ginnis, Senior Director, Child, Youth & Family Policy and Programs
Ryan Schwarz, MD, Director of Policy for Accountable Care
Martha Farlow, Senior Manager, ACO Policy & Contracts