Advancing Children's Behavioral Health During a Time of Transition in DC's Medicaid Program

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INTRODUCTION

The District of Columbia continues to work towards improving the public behavioral health system for children and families. However, significant challenges remain for children, youth, and families in accessing high-quality care and services. As the District contemplates substantive changes to the behavioral health system, several organizations, including The Center for Community Resilience, The Center for Health and Health Care in Schools, Children's Law Center, Children's National Hospital, District of Columbia Behavioral Health Association, Early Childhood Innovation Network, Health Alliance Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, SPACEs In Action, and Total Family Care Coalition have partnered together to discuss challenges and opportunities, and combinations of these organizations have produced three papers.[i] The goal of these efforts is to develop a robust set of recommendations and strategies to elevate the provision of appropriate, equitable, inclusive, and high-quality behavioral health services throughout the continuum of care for children and families in the District.

To this end, we offer the following set of preliminary recommendations, which are particularly relevant during the District's ongoing transition to a fully managed Medicaid program.[1] Recognizing this is not a fully comprehensive set of recommendations – which we intend to publish later in 2021 – these preliminary recommendations are informed by the collective expertise of families, youth, family advocates, behavioral health care providers, pediatric primary care providers, legal advocates, and community members who are represented by the organizations publishing this document.

GROUNDING PRINCIPLES

A core set of principles and values should guide our collective decision-making regarding changes to the children's behavioral health system. *The Principles and Values to Guide Child and Adolescent Public Behavioral Health Care System Transformation in the District of Columbia* (June 2019) outlines a set of values and principles intended to serve as a guideline for delivering effective, accessible, and acceptable community-based services and supports for children, youth, and families with or at-risk for behavioral health concerns. Principles DBH and DHCF should consider adopting include: normalizing behavioral

[1] The information provided herein was submitted to the Departments of Health Care Finance and Behavioral Health in September 2020, in response to their public *Request for Information: Medicaid Behavioral Health Transformation in the District of Columbia: A Roadmap to Integrated Care*.

health and creating a safe and trusting environment for families to convey their needs; supporting family-driven care and increasing effective community engagement; increasing access to services; and strengthening the workforce capacity (e.g., ensuring there are enough licensed providers and including non-traditional approaches, such as peer supports; enough providers that can provide care to a family in their native and preferred language). Increasing access to care includes ensuring timely access, such as by reducing the time it takes to receive treatment after making an appointment; ensuring that families have access to adequate broadband support, especially for telehealth services; and ensuring there is a robust network of providers. It also includes implementing strategies that address the impact of poverty and living in low-income households on access to high-quality mental health services for children and families.

Finally, the next iteration of our behavioral health system must also explicitly address systemic racism, inclusivity (e.g., non-English speaking and immigrant families, families caring for a child with a co-occurring learning, intellectual, and/or developmental disability), and the impact of trauma on health. As a core determinant of child and adolescent health (physical, emotional, and behavioral), ameliorating racism must be included as a key guiding principle, especially due to its link to chronic stress and the development of mental health problems. To that end, as the District works to improve the behavioral health system, they must ensure that the strategies, policies, and services considered for implementation are being evaluated through a racial equity lens.

MANAGED CARE DELIVERY SYSTEM CONSIDERATIONS[2]

As the District advances towards a system where Medicaid Managed Care Organizations (MCOS) play a more significant role in the delivery and payment of behavioral health care services, we encourage consideration and action on the following points:

- **Existing DC Code and Regulations.** Certain parts of the existing DC code and regulations that did not anticipate a fully managed care environment may undermine the transition. Regulations need to be reframed for a fully managed care environment with MCOs playing a greater role in care coordination, linkages, and paying for more care. One example of DC code that will need to be revisited, considering the transition, is certain sections of the Mental Health Information Act that limit health information exchange and data sharing. It may also be the time to consider restructuring the Core Service Agency model. DC will need to ensure that relevant DC Code and Regulations are revised in a timely manner to support implementation.

- **Network Adequacy**. Networks are already inadequate, and this may continue to be a challenge without strong oversight and enforcement. There is a scarcity of behavioral health care providers that are able to provide services for children and youth in DC, particularly for very young children (under 5 years), families whose first language is not English, and children with Autism Spectrum Disorder or developmental delays, which are among the special populations that must be given extra attention. Providers for children and youth require specialized training, training in specific evidence-based practices, and prior experience in order to serve these specific populations.

[2] For additional context and recommendations to consider during the implementation of the transition to a fully managed Medicaid program, please see: *Addressing Children's Behavioral Health Needs Through Changes to DC's Medicaid Program (February 2020)*, at https://www.childrenslawcenter.org/resource/Addressing-Children-Behavioral-Health-Needs-Through-Changes-to-DC-Medicaid-Program

Currently, the shortage of child-serving providers in DC results in long wait times for initial appointments and significant delays in obtaining treatment. Addressing network adequacy will be paramount to a successful transition and meetings the needs of DC's children and families.

- **Integrated Corporate Model**. Currently, Medicaid MCOs in DC have the ability to carve out behavioral services to another corporate entity. The benefits of an integrated delivery system may not be fully realized under this model, particularly if behavioral health services are carved out to an unrelated corporate entity.

INITIAL RECOMMENDATIONS

The following section outlines our initial recommendations intended to strengthen the following areas of the public behavioral health system for children and families: service delivery, quality of care, workforce development, network adequacy, billing and reimbursement, and services tailored to specific settings and specialty populations. These recommendations are not necessarily in rank order.

SERVICE DELIVERY & SPECIAL POPULATIONS

- **Establish Full Continuum of Psychiatric Care for Children and Youth including Acute Care, Crisis Stabilization, and Intensive Outpatient Care.** The District currently does not have a full panoply of services for children and youth in need of acute psychiatric care. While the following services are not expressly prohibited or unauthorized under DC Medicaid, other factors, likely due to financing and reimbursement, have served as barriers to implementation. We recommend the District work towards establishing these types of programs so families do not need to travel to Virginia, Maryland, or farther distances to access medically necessary services: 1) Intensive Outpatient Supports (IOP/PHP) such as Intensive Outpatient programs and/or Partial Hospitalization programs; 2) Crisis Stabilization Unit such as a youth crisis stabilization unit or pediatric comprehensive psychiatric emergency program; 3) Bridging Clinic for youth who are being discharged from inpatient psychiatric units without established outpatient therapy and medication providers.

- **Improve Treatment Options for Youth At-Risk for or Diagnosed with Substance Use Disorders (SUD).** While the District does have SUD treatment options available, anecdotal evidence suggests that very few adolescents receive meaningful treatment. We recommend the District place special emphasis on working with youth, families, and providers to explore solutions to improve screening, assessment, referral and treatment, and options for improved integration of SUD prevention and treatment services into easily accessible locations, such as primary care and schools.

- **Improve Assessment, Diagnostic and Treatment Services for Children with Autism and other Developmental Disabilities**. In the 1115 Behavioral Health Transformation Demonstration Waiver, the District carved out services associated with screening and treatment for Autism Spectrum Disorder (ASD) from the services authorized under the waiver, with the caveat they would consider other policy interventions for increasing access to more comprehensive ASD services. Children with ASD and other developmental disabilities continue to face challenges in accessing care. We recommend the District prioritize comprehensive policy solutions for children at-risk for or diagnosed with Autism Spectrum Disorder.

- **Continue Appropriate Screening, Assessment and Referral Practices.** Medicaid Managed Care Organizations should be following, and continue to follow, behavioral health screening requirements as mandated by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit and the Department of Health Care Finance. While every child (0-21) should be screened through their pediatric primary care provider annually with a validated tool, we recommend a degree of continued flexibility in order to allow health care providers to implement screeners that fit their particular practice demographics, infrastructure and workflow. Ethical screening practice requires that referrals made for further assessment, diagnosis, and treatment must be immediately available, further underscoring the need for robust networks. This is especially critical when considering the implementation of screening related to trauma or adverse childhood experiences; ample health care practice-specific training, staff buy-in, and referral mechanisms must be in place to attend to needs that arise from the screening.

QUALITY OF SERVICES

- **Agreement and Accountability on Meaningful Measures**. Broad stakeholder agreement on a set of measures allows the District to benchmark our progress towards a responsive behavioral health care system that meets the needs of children and families in a high-quality and timely manner. The attendant challenge in inclusive and broad agreement is the potential for outcomes to become narrowly defined and reduced to proxies of cost savings or more easily quantifiable metrics, such as hospitalization and/or emergency department use. These types of measures, however important, are inadequate for any population of the behavioral health system, but especially for children. A comprehensive, fully integrated system will meaningfully improve quality of life and functioning. Therefore, measurement of the system's success must track essential components of a system of care, as well as clinical and functional outcomes, which are distinct from crisis utilization.

- **Establish Quality of Care Measures**. MCOs should work with DHCF and DBH to propose quality of care standards and measures and increase those standards and enforcement over time. MCOs should be allowed to disqualify/disenroll providers who do not meet quality of care standards agreed upon by DHCF and DBH.

- **Establish Standard Format and Process for Collecting Data**. DHCF and DBH should work with the MCOs to establish a standard format and process for collecting data. This includes making decisions regarding what data should be collected, the types of measures and metrics to be used, and establishing a public reporting schedule of this data. For example, metrics could include service utilization rates and population specific data, such as dollars per child spent on behavioral health services. Having a standard process for data collection and public reporting would be beneficial in ensuring quality of care standards are being met.

- **Ensure Proper Clinical Expertise in Medical Necessity Determinations.** DHCF and DBH should ensure that individuals with the proper clinical, developmental, and treatment expertise are involved in the decision making regarding medical necessity determinations, prior authorization decisions, denials, grievances, and appeals regarding care for children. Additionally, medical necessity determinations must align with generally accepted standards of care.[ii] The credential of any clinician denying care

should be at least equal to the credential of the recommending clinician and based on relevant clinical experience.

NETWORK ADEQUACY & WORKFORCE DEVELOPMENT

- **Require Universal Contracting for Critical Providers to Ensure Initial Network Adequacy**. DHCF and DBH should first require universal contracting for critical providers to ensure network adequacy. This means that any provider who is licensed, credentialed, and willing to accept the plan's contract terms would initially be offered a contract. DBH-certified providers, in addition to other types of providers (i.e., Adolescent Community Reinforcement Approach [ACRA] providers, Adolescent Substance Abuse Treatment [ASTEP] providers, Federally Qualified Health Centers [FQHCs], Psychiatric Residential Treatment Facilities [PRTFs], and hospitals) are included as critical providers. MCOs should be required to offer at least an initial contract to all other child-serving providers, to ensure there is an adequate network for children immediately following the transition.

- **Enable Integration of Peer Specialists, Community Health Workers and Other Behavioral Health Practitioners.** The District has provided strong leadership regarding integration of certified peer (adult and youth) specialists into Mental Health Rehabilitation Services (MHRS) settings through training, certification, and Medicaid reimbursement. Now is the time to advance the next generation behavioral health workforce by robustly incorporating non-licensed workforce extenders, including paraprofessionals, peers, navigators, and community health workers into primary care, specialty behavioral health care, early learning, and other community-based settings. Peer operated centers, family-run organizations, and other natural and informal supports must be recognized for the vital contributions they already make to the lives of District residents with behavioral health conditions and turned to as the necessary complement that they already are to the behavioral health workforce continuum. This type of integration, which also includes adequate reimbursement, compensation, and training/education for this workforce, bolsters accessibility through a team-based approach that includes the individuals who many community members contact first and trust the most.

FINANCING

- **Avail Primary Care with Payment & Reimbursement Infrastructure to Optimize Integrated Care.** Child, adolescent, and family mental health care requires team-based care approaches. These types of care must also support promotion and prevention in addition to treatment (when clinically appropriate in primary care) and timely referral mechanisms when a higher level of care is necessary. We recommend the District enable the following:
    - ***Psychiatric Collaborative Care Management (PCCM) through CPT Codes 99492- 99494***. The Psychiatric Collaborative Care Management model is an evidence-based framework that integrates a behavioral health care manager and psychiatric consultant into the primary care team with the goal of building primary care provider (PCP) capacity to manage patients' behavioral health conditions. Research demonstrates the model is effective with publicly insured and minority populations and can reduce health disparities. PCCM has dedicated CPT codes (99492-99494) used to bill for services on a monthly basis. These codes are currently not on the District's Medicaid fee schedule but are used in other states.

- ***Coverage of Discrete Z-codes to Promote Mental Health and Prevent Mental Health Disorders.*** Health care providers often see children who do not meet the full criteria for a mental health diagnosis but who are experiencing conditions and family circumstances that place them at high risk for the development of significant mental health disorders. Health care providers should not have to wait until a child has a full-blown psychiatric diagnosis before effective interventions can be delivered. Further, given the stigma still associated with mental health diagnoses, we should enable providers with reimbursable codes and services that bolster the promotion and prevention end of the care continuum. California and Oregon are examples of states that incorporate coverage of Z-codes via Medicaid.
- ***Flexibility and Innovation in Care Coordination***. Effective care coordination, provided by individuals who are trusted by the community, is a bedrock of a high-functioning behavioral health care system. The District should consider flexible and innovative approaches to care coordination, such as decentralization of care coordinators to environments children and families frequent on a regular basis and trust (e.g., pediatric primary care, schools or family-run organizations).
- ***Continue Adequate Funding of DC Mental Health Access in Pediatrics (DC MAP)***. DC MAP is a rapidly growing, evidence-based consultation model that supports integrated mental health in primary care and is currently funded by the DC Department of Behavioral Health. The program successfully supports pediatricians in addressing the mental health needs of their patients through real-time access to child psychiatrists, psychologists, and care coordinators, which frees up DC's specialized mental health resources to serve youth who truly need a higher level of care. DC should also explore opportunities for expansion of DC MAP services. Model programs to consider implementing include the Adolescent Substance Use and Addiction Program at Boston Children's Hospital-Massachusetts Child Psychiatry Access Program (ASAP-MCPAP) Consultation Line.[iii]

- **<u>Advance Value-Based and/or Alternative Payment Methodologies and Accountable Care Models Specific to Child and Adolescent Behavioral Health.</u>**
  - ***Consider Establishing Certified Community Behavioral Health Clinics (CCBHCs).*** These clinics are designed via federal legislation to provide a comprehensive range of mental health and substance use disorder services to under-resourced individuals and receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of complex populations. Recent data from states that have implemented CCBHCs demonstrate drastic reduction or elimination of waitlists for services within a few years of initiating their CCBHC work. Additionally, each state was able to leverage the model to reach under-resourced populations, with improvements in children's services frequently mentioned as a key advancement.[iv]
  - ***Develop Value-Based and Alternative Payment Models that Prioritize Children's Social and Emotional Health*.** As the District considers value-based payment models, we encourage a focus on advancing value-based or alternative payment models that incorporate a focus on child and family behavioral health, including early childhood social and emotional development. These might take the form of bundled payments, episodes of care, or other models. In particular, we recommend the recent paper, *Alternative Payment Models to*

Support Child Health & Development: How to Design and Implement New Models as a starting point for design considerations.[v]

- **Phase-In of Payment Changes**. During the transition of behavioral health services from the purview of DBH to MCOs, changes to payment terms should be phased in gradually, with initial payment rates at least matching the Medicaid fee-for-service fee schedule.

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[i] Previous papers informing these discussions include the three papers produced by Children's Law Center, Children's National Hospital, DC Behavioral Health Association, the Early Childhood Innovation Network, and MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry include, *Behavioral Health in the District of Columbia for Children, Youth, and Their Families: Understanding the Current System (February 2019)*, at https://www.childrenslawcenter.org/resource/behavioral-health-district-columbia-children-youth-families-understanding-current-system; *The Principles and Values to Guide Child and Adolescent Public Behavioral Health Care System Transformation in the District of Columbia (June 2019)*, at https://www.childrenslawcenter.org/resource/principles-and-values-guide-child-and-adolescent-public-behavioral-health-care-system; *Addressing Children's Behavioral Health Needs Through Changes to DC's Medicaid Program (February 2020)*, at https://www.childrenslawcenter.org/resource/Addressing-Children-Behavioral-Health-Needs-Through-Changes-to-DC-Medicaid-Program.

[ii] National Council for Behavioral Health, *Position Statement on Generally Accepted Standards of Care for Behavioral Health*, August 19, 2019. Retrieved 18 February 2021 from https://www.thenationalcouncil.org/wp-content/uploads/2019/08/MDI-Wit-v-UBH-Position-Statement.pdf?daf=375ateTbd56.

[iii] For more information on the ASAP-MCPAP Consultation Line, see https://www.mcpap.com/pdf/ASAP.MCPAP.Announcement.pdf.

[iv] National Council for Behavioral Health and NASMHPD, Behavioral Health Commissioners Summit, September 10, 2020.

[v] Roiland, R., Singletary, E., Saunders, R., Dentzer, S., Counts, N., & Pereira, N. et al. (2020). *Alternative Payment Models to Support Child Health & Development: How to Design and Implement New Models* [PDF]. Duke- Margolis Center for Health Policy. Retrieved 14 September 2020, from https://healthpolicy.duke.edu/sites/default/files/2020-06/apms_for_kids_final.pdf.