CYBHWG Behavioral Health Integration (BHI) subgroup

Date: August 30, 2022
Time: 10 a.m. to noon

Leads: Kristin Houser and Sarah Rafton

Behavioral Health Integration

Successful Referrals: Systematic Approach to Warm Mental Health Referrals from the Primary Care Medical Home

Mary Ann Woodruff and Rachel Lettieri, Pediatrics Northwest

Highlights

- We ask people how they want to be contacted (phone, e-mail, text), as preferred communication is important.
- Rethinking the goals for mental health referrals by collaborating with families to co-create a process that is individualized and can be replicated.
- Plan-Do-Study-Act is making small changes and then seeing how they work.
- The Pediatric Collaborative Care Model provides an average of 3-6 months of weekly meetings for mild to moderate depression and/or anxiety; no referral needed.
- For subacute needs, they are guided through the Child & Teen Referral Service request and then receive follow-up with Community Health Workers (CHWs).
- Next step: Emergency Department visit follow-up and missed appointment follow-ups.

Q&A/Comments

- Referral Service: referrals for individuals with private insurance is taking 20-30 outreach calls with an average of 18 days to find a single provider who is taking new patients.
- Working with Seattle Children's to develop a mental health curriculum for children ages 2 & 3.

Value-based payments for kids BH

Sarah Walker, University of Washington CoLab

Highlights

- Used the method of engagement with content, policy, and practice experts to learn of actionable recommendations.
- Alternative Payment Models and clinical severity in pediatric mental/behavioral health

Q&A/Comments

- How do we take what Sarah's found works and implement it?
  Requirement to use evidence-based Health Effectiveness Data and Information Set (HEDIS) measures, although HEDIS measures are not working well for pediatric mental health.

Supporting kids before / without a diagnosis

Dan Walter, American Academy of Pediatrics

See page 4 for slide

Highlights:

- New bulletin from Center for Medicaid Services (CMS) – Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Behavioral Health (BH) Services (8/18)

Advocacy for Children's Mental Health (North Carolina)

Dr. Marian Earls, Cone Health Medical Group

See page 7 for slides

Highlights

- North Carolina Medicaid changes – initial 6 visits without DSM diagnosis (use of non-specific code or Z-code) and up to 26 unmanaged visits in a calendar year up to 21 years
- To meet the capacity need it would take >4500 community mental health (MH) clinicians to be enrolled with Medicaid immediately.
- Issue: MCOs often declined to credential clinicians.
- There are many measures proposed for adult mental health, but not so for pediatrics.
- Working on data dashboard that will facilitate other measures.
- Bright Futures has just recommended a social-emotional wellness assessment at every well-child visit.

Short-term BH Services in Primary Care

Amine Kailani, Washington Chapter of the American Academy of Pediatrics

Highlights

- On 7-1-2022 a policy changed allowing 2,018 members on Colorado's Medicaid Program help First Colorado to receive short-term behavioral health services provided by a licensed behavioral health commission.
- Additional billing codes used were shared; while the codes are helpful this practice is not significant or sustainable since there are still several services that do not fit in these codes.

Review of priorities

See page xx for slide

Chat:

CMS EPSDT/Medicaid and CHIP Behavioral Health Informational Bulletin:

Attendees:

Kailani Amine, Washington Chapter of the American Academy of Pediatrics (WCAAP)
Marta Bordeaux, Child and Adolescent Clinic
Cora Breuner, Seattle Children's
Rachel Burke, Health Care Authority (HCA)
Phyllis Cavens, Child and Adolescent Clinic
Rachel Dumanian, Childhaven
Marian Earls, Cone Health Medical Group, NC
Madi Eggerding, WCAAP
Kiki Fabian, HCA
Todd Fraley
Leslie Graham, University of Washington (UW)
Bob Hilt, Seattle Children's Hospital
Whitney Howard, Molina Healthcare
Marissa Ingalls, Coordinated Care
Avreayl Jacobson, King County Behavioral Health and Recovery
Michelle Karnath, Clark County Juvenile Court and FYSPRT parent tri-lead
Rachel Lettieri, Pediatrics Northwest
Laurie Lippold, Partners for Our Children
Connie Mom-Chhing, Community Health Plan of Washington (CHPW)
Sheryl Morelli, Seattle Children's
Julia O'Connor, The Washington Council
Liz Perez, HCA
Wendy Pringle, HopeSparks
Tatiana Sarkhosh, UW
Mary Stone Smith, Catholic Community Services
Amber Ulvenes, Advocate
Sarah Walker, UW
Dan Walter, American Academy of Pediatrics (AAP)
Gabby Ward
Cindi Wiek, HCA
Mary Ann Woodruff, Pediatrics Northwest

CMS EPSDT Behavioral Health Informational Bulletin August 18, 2022

Dan Walter
AAP State Advocacy
August 30, 2022

American Academy of Pediatrics
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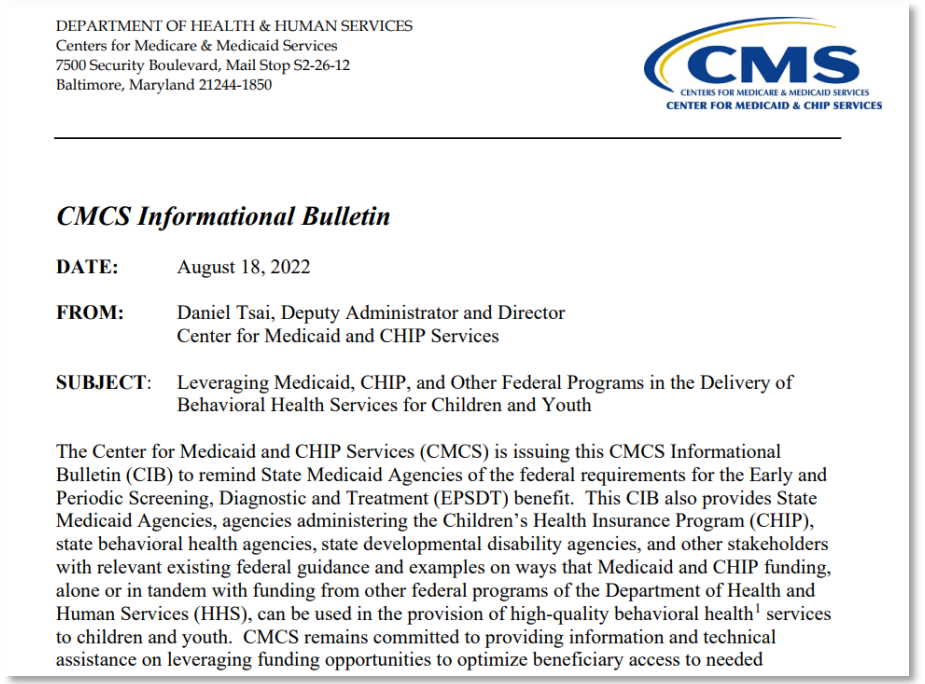
EPSDT Behavioral Health Services CMCS Info Bulletin (CIB)

- Recently enacted **Bipartisan Safer Communities Act** included AAP-sought EPSDT and mental health provisions
- CIB Reminds states of **responsibilities under EPSDT** – including for behavioral health
- CMS highlights **existing authority states can utilize** to fund a "comprehensive array" of behavioral health services:
  - CHIP Health Services Initiatives (HSI)
  - Medicaid Home and Community Based Services (including ARP FMAP bump)
- **Increase payment** for behavioral health services
- CMS recognizes and promotes **state innovation and strategies** to expand and strengthen behavioral health care:
  - **Avoid need for behavioral health diagnosis** for services



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: August 18, 2022

FROM: Daniel Tsai, Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth

The Center for Medicaid and CHIP Services (CMCS) is issuing this CMCS Informational Bulletin (CIB) to remind State Medicaid Agencies of the federal requirements for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This CIB also provides State Medicaid Agencies, agencies administering the Children's Health Insurance Program (CHIP), state behavioral health agencies, state developmental disability agencies, and other stakeholders with relevant existing federal guidance and examples on ways that Medicaid and CHIP funding, alone or in tandem with funding from other federal programs of the Department of Health and Human Services (HHS), can be used in the provision of high-quality behavioral health[1] services to children and youth. CMCS remains committed to providing information and technical assistance on leveraging funding opportunities to optimize beneficiary access to needed

EPSDT Behavioral Health Services CMCS Info Bulletin

- Strategies for states, continued…
  - Utilize **age-appropriate diagnostic criteria**
  - Increase access to behavioral health **across the care continuum**
  - Implement or expand **crisis stabilization services**
  - Increase use of **behavioral telehealth care**
  - Expand use of **health homes** to provide enhanced care coordination to children with medical complexity
  - Support **Project ECHO**
  - Increase **primary care integration through specific models of care** (ie, collaborative care model, others)
  - Participate in **Pediatric Mental Health Care Access Program**
  - And more…

Advocacy for Children's Mental Health

North Carolina

And

AAP

Marian F Earls, MD, MTS, FAAP
August 30, 2022

The North Carolina Advocacy Effort (2001)

- 24-month process; regular meetings with Medicaid Director; cross sector collaboration

- Setting: recent increase for Medicaid rates to parity with Medicare (1/1999); Medicaid eligibility for one year rather than month to month

- Issues: MH parity; access; requirement of definitive diagnosis for payment; those with Medicaid required to utilize public MH services (often without MH professionals trained to serve children); poor coordination between MH and medical systems; lack of payment for non face-to face services; enhanced payment for pediatricians with subspecialty training

Foy JM, Earls MF, Dorowitz D, "Working to Improve mental Health Services: The North Carolina Advocacy Effort," PEDIATRICS, Vol 110, No. 6, December 2002.

NC Medicaid Changes 2001

- Payment to MH clinician for initial 6 visits without a DSM diagnosis (use of non-specific code or Z-code) and up to 26 unmanaged visits in a calendar year for Medicaid recipients up to age 21 years (later modified to 16 unmanaged visits)

- Direct Medicaid enrollment of independently practicing LCSWs, licensed psychologists, and advanced practice nurses allowing them to bill for services delivered in their offices; and to bill for services delivered in school sites

Impact

- Increased Capacity
  - >400 community MH clinicians enrolled with Medicaid by 2002
  - Education of pediatricians - referrals and warm handoffs, coding
  - “Mixers” – community MH clinicians with community pediatricians
- Allowed for Integration of MH clinicians in primary care
  - Initially able to bill “incident to” the PCC, and later changed to direct billing of brief psych codes
  - 100+ pediatric practices with integrated MH clinicians
  - Technical support through regional CCNC staff during CHIPRA Grant (2010-2015) implementation

Challenges

- Move to carve-out MH services and regional MCOs led to change in billing process for practices. MCOs often declined to credential integrated and other community MH clinicians
  - Successful advocacy by NC Chapter, because of long-term relationship with Medicaid leadership, facilitated credentialing and continued billing by integrated MH clinicians

- Keeping community MH clinicians credentialed with MCOs

Promising Developments in NC

- Merging of Medicaid and CHIP which will give CHIP beneficiaries EPSDT (2023)
- Medicaid payment at parity with Medicare
- Medicaid recognition of DC:0-5
- NC PAL – NC Child Psychiatry Access Program
- Reorganization and formation of the Division of Child and Family Well-being which includes child and adolescent mental health services
- Committment to, and development of, a pediatric mental health data dashboard (2023)
- Cross-sector efforts – Early Well; NC ZTT IECMH Work Group (2015-present)

“Wish List” Discussions 2022 – AAP Advocacy

- Use of non-specific codes
- More funding for HRSA PMHCA (child psychiatry access programs)
- Same day billing
- Same day billing for Medicaid *and* CHIP
- Medicare and Medicaid parity

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Highlights

- Increase MH payment rates to ensure adequate access: *network adequacy*
- Eliminate administrative barriers for providers enrolling/credentialing across managed care plans
- Eliminate prior authorization for MH services
- Do not require a MH diagnosis for provision of EPSDT services; utilize non-specific codes
- Utilize age-appropriate diagnostic criteria – DC:0-5 for young children
- Telehealth to increase access, including in schools
- Ensure coverage intensive in-home, partial hospitalization, crisis stabilization (mobile crisis – FMAP incentive)

CMCS Informational Bulletin August 18, 2022

- Increase integration of MH in primary care: PCBH model, Collaborative Care Model
- Incorporate MH screenings into well-child exams
- Provide payment for complex/longer visits; care coordination
- Remove prohibition on same day billing

- Support Project ECHO
- Participate in PMHCA (Child Psychiatry Access Programs)