Children's Behavioral Health Plan Implementation
Alternative Payment Methodology and Measurement-Based Care Workgroup Report

EXECUTIVE SUMMARY

In recognition of the existing and growing behavioral health needs of children in the state, as well as the opportunity to leverage federal funding, the Department of Children and Families (DCF) identified the need for furthering the implementation of the state's Behavioral Health Plan for Children originally approved in 2014, and established workgroups to support such work, including the Alternative Payment Methodology (APM) and Measurement-Based Care (MBC) Workgroup (workgroup). The workgroup identified the following three goals: (1) review approaches toward alternative payments and measurement-based care in behavioral health; (2) review current and planned state initiatives in alternative payments and measurement-based care (e.g., 1115 Waiver, Integrated Care for Kids (InCK), evidence-based treatment performance incentives, CCBHC provider grants); and (3) make recommendations to the Children's Behavioral Health Plan Implementation Advisory Board and the 12 state Department Commissioners for further follow-up and implementation.

The workgroup reviewed existing literature to identify best practices, and heard multiple presentations from both in-state and out-of-state presenters working on APM models with at least a partial focus on behavioral health. Due to the very early stage of learning and implementation of APMs in behavioral health across the country (particularly in *children's* behavioral health), and the numerous options available to states and payers in structuring such approaches, the Workgroup focused its recommendations on overall guidelines and principles rather than offering a specific and detailed APM model for implementation. After considering the literature, lessons learned, and best practices, the workgroup developed the following recommendations.

Recommendation 1: Raise reimbursement rates to more adequately meet costs with opportunities to further enhance payments to providers through an APM.

Recommendation 2: Develop a more detailed APM implementation plan that clearly describes the goals, target population(s), risk categories, provider technical assistance, and quality and outcome metrics of an APM program.

Recommendation 3: Establish a multi-year glide path that builds provider and system capacity for APM, guided by best practice readiness tools. Introduce an APM model with upside risk only, with downside risk to providers introduced only when supported by the readiness tools.

Recommendation 4: Tie the APM to improvement of child/family- and provider-level outcomes as well as critical system-level outcomes including but not limited to the following options: improvements in child and family clinical outcomes, improvements in health equity, reduction in ED volume, reduction in total inpatient days, improved connect-to-care rates, increased use of Mobile Crisis, implementation of evidence-based treatments, and behavioral health/primary care integration.

Recommendation 5: Ensure data collection and reporting capacity exists from the outset of APM implementation, that providers have access to raw data for the purposes of monitoring key metrics and measures, and that financial and technical support resources are available to providers to implement the data system without adding data collection and reporting burden to consumers and providers.

Recommendation 6: Support continued learning and innovation by initiating or joining a multi-state learning community focused on APM in children's behavioral health.

I. Background

Connecticut's Behavioral Health Plan for Children was a part of the legislative response to the Sandy Hook tragedy and was developed with extensive input from families, providers, state agencies, researchers, community members, and other stakeholders. It was approved by the state legislature in 2014 and has provided a blueprint to ensure that the state's children's behavioral health system and its services promote well-being and meet the mental, emotional, and behavioral health needs for all children in the state. More recently, DCF identified the need and opportunity for collaboration across stakeholders to *further* support implementation of the goals of the Plan and provide recommendations to its Implementation Advisory Board. Workgroups were established to support these efforts, including the Alternative Payment Methodology (APM) and Measurement-Based Care (MBC) Workgroup (workgroup).

APM models (also referred to as value-based payment models) are an alternative to traditional fee-for-service payment models that incentivize volume of services. Instead, APM approaches tie payments to the quality and outcomes of the care that is provided. The structure can result in long-term benefits to states and payers in the form of reduced costs, benefits to the providers in the form of increased flexibility in service delivery and payment for services that are otherwise non-billable, and benefits to consumers in the form of improved quality and outcomes. APM has become fairly commonplace for physical health, but has had limited application in behavioral health, and particularly children's behavioral health.

In light of the growing evidence of the importance of behavioral health to overall health and wellness, states, Medicaid, private insurers, and managed care entities have begun to incorporate behavioral health goals and metrics within their physical health methodologies, or in some instances have developed models specifically for behavioral health service delivery. This remains an emerging strategy, with many states still in the planning or early implementation phase, and many still learning and modifying their models to adapt to lessons learned. Connecticut also has examples of early stage APM approaches (e.g., Integrated Care for Kids, Certified Community Behavioral Health Clinics (CCBHC), 1115 Substance Use Disorder Demonstration Waiver) that may offer guiding principles, lessons learned, and opportunities for scaling, at least to the extent that these examples are relevant to the unique characteristics of children's behavioral health services. There are, therefore, many opportunities for peer learning and innovation within Connecticut, and in partnership with other states. Given this set of circumstances, the workgroup focused its efforts on identifying best practices and offering general guidance for future development of APM in behavioral health rather than offering a very specific and detailed APM program.

The workgroup was comprised of stakeholders from hospitals, the state's behavioral health partnership, community-based provider agencies, child and family advocacy organizations, and state agencies (Department of Mental Health and Addiction Services (DMHAS), Department of Social Services (DSS), the Office of Policy and Management (OPM), the Office of the Child Advocate (OCA), as well as DCF). The list of individual workgroup participants is included in the report as Attachment 1. The workgroup was tasked with accomplishing the following three goals:

1. Review approaches toward alternative payment methodologies and measurement-based care in behavioral health.
2. Review current and planned state initiatives in alternative payment methodologies and measurement-based care (e.g., 1115 Waiver, Integrated Care for Kids (InCK), evidence-based treatment performance incentives, CCBHC provider grants).

3. Make recommendations to Children's Behavioral Health Plan Implementation Advisory Board and the 12 state Department Commissioners for further follow-up and implementation.

The subsequent sections of the report provide additional information on workgroup process, achievement of each of the goals above, and the workgroup's recommendations for consideration by the Advisory Board and the twelve state Department Commissioners.

II. Workgroup Process and Accomplishments

The Workgroup held a total of seven meetings between June and December, 2021. To support the first two identified Workgroup goals, the meetings included multiple presentations on Connecticut initiatives and out-of-state efforts to inform the workgroup's knowledge of best practices and lessons learned. These presentations included:

- **Overview of Principles and Current (Connecticut) State Efforts in Alternative Payment Methodology**
  Bill Halsey, Department of Social Services and Bert Plant, Ph.D., Beacon Health Options
- **Integrated Care for Kids (InCK) Initiative and the InCK APM**
  Jennifer Richmond and Melanie Rossacci, Clifford Beers Clinic; Hope Glassberg (HG Consulting)
- **Mirah, Measurement-Based Care, and APM**
  Jack Lu, Ph.D., Child Health and Development Institute; Daniel Bryant, LPC, CCTP, Community Health Center, Inc.; and Shari Fanelli, MS, LPC, ATR, Trauma-Focused CBT Coordinator, Child Guidance Center of Southern CT
- **Connecticut Office of Health Strategy's Prospective Primary Care Payment Model**
  Victoria Veltri, JD, LLM, Office of Health Strategy
- **APM Modeling for Pediatric Populations (BE-InCK NY)**
  Henry Chung, MD, Consultant, Montefiore Care Management Organization
- **Behavioral Health APM Models in Pennsylvania and Oregon**
  Amanda Roth, Director - Bureau of Quality Management & Data Review, Office of Mental Health & Substance Abuse Services, Department of Human Services, Commonwealth of PA
  Lori Fertall, Director of Value-Based Programs, Community Care Behavioral Health (PA)
  Amy Marten-Shanafelt, Executive Director, Blair County HealthChoices (PA)
  Brett Miller, CSBBH Program Director, Blair Family Solutions (PA)
  Laura Sisulak, Children's Health Policy Analyst, Oregon Health Authority
- **Review of Draft APM Workgroup Report**

The workgroup was especially attuned to the in-state APM efforts of the InCK initiative and the 1115 Waiver as current in-state examples of APM that incorporated behavioral health. The Center for Medicare and Medicaid Services (CMS) awarded the InCK grant to DSS and Clifford Beers, with Connecticut being one of only eight awardees nationally, and the only with a behavioral health lead organization. InCK is in the second year of a seven-year grant that includes two years of planning and five years of implementation. The grant is not for direct services, but is intended to develop a local system of care (in this case, in the New Haven area) for children and families. The primary goals of InCK are to: 1) strengthen early identification and reduce out-of-home placements; 2) help children and families meet integrated physical and behavioral needs; and 3) develop and implement an APM within Medicaid. The APM component of the initiative will facilitate reimbursement through Medicaid for care coordination services that are not otherwise billable.

The 1115 Substance Use Disorder (SUD) Demonstration Waiver was submitted by Connecticut DSS in collaboration with DCF and DMHAS, to CMS in August, 2021 to support improvements in care for individuals with opioid use disorders (OUD) and substance use disorders (SUD). The additional flexibility in Medicaid payments will support the following goals: (1) increased rates of identification, initiation and engagement in treatment for OUD and other SUDs; (2) increased adherence to and retention in treatment for OUD and other SUDs; (3) reductions in overdose deaths, particularly those due to opioids; (4) reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services; (5) fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs; and (6) improved access to care for physical health conditions among beneficiaries with OUD and other SUDs.

These two projects were highlighted as relevant to the workgroup's efforts, both as learning opportunities for the types of goals and strategies that can be supported by a behavioral health APM, as well as opportunities for potential alignment and statewide expansion. Importantly, the workgroup identified that the 1115 SUD Waiver and many elements of the CCBHC model are primarily adult-focused; nevertheless, the workgroup benefitted from the discussion as a means for identifying general principles and approaches that could be relevant to the structure of an APM in the children's behavioral health system. The full list of presentations offered tremendous insight into the planning, design, provider engagement, rollout, implementation, and metrics/outcomes of APM. What follows below are the design elements and practices that were elevated through these presentations and subsequent workgroup discussions.

Elements of an APM

The primary elements of any APM include, at minimum, goals, target population(s), risk categories, metrics and outcomes, provider technical assistance, and rollout strategies.

Goals. Establishing clear goals for an APM drive all other APM elements, and is critical for ultimately achieving improvements in quality and better outcomes for children. Behavioral health goals can vary widely for a state. Examples include improving child and family outcomes, decreasing high-end utilization and costs (e.g., EDs, inpatient psychiatric hospitalization) reducing symptoms for targeted diagnoses such as depression or substance use disorder, and improving prevention and treatment of behavioral health needs in primary care settings.

One critical goal area for the state is health equity. The APM offers an opportunity to leverage and strengthen the state's commitment to reduce disparities across racial and ethnic groups and increase health equity. In national literature, disparities exist between Black and Latinx youth and white youth in the areas of access to services, quality of interventions, and treatment outcomes.[1] State agencies and many community-based providers have developed health equity plans with specific action steps for reducing disparities within programs and utilizing data to track progress and identify areas for improvement. Implementation of an APM allows the state to not only include health equity goals within contract requirements, but to directly incentivize ongoing monitoring of and progress toward health equity.

[1] Alegria, M., Vallas, M., Pumariega, A. Racial and Ethnic Disparities in Pediatric Mental Health. *Child and Adolescent Psychiatric Clinics of North America* (2010) 19:759-774.

It is important to note that, as Connecticut continues to learn from other states and even from some Connecticut-based APM approaches, the structure and service delivery of the children's behavioral health system differ in significant ways from the adult system; therefore, selected goals must be very specifically targeted to the unique needs of children and families, and the systems and services in place to address those needs. To ensure that the APM goals result in tangible benefits to children and families, it is critical that individuals with lived experience in the children's behavioral health system be directly engaged in the process to select APM goals.

The workgroup identified a number of possible goals, although the list was not intended to be exhaustive. Furthermore, and as noted above, selected goals should incentivize health equity and reduce disparities, and be developed and finalized with family/consumer participation. With those caveats in mind, the workgroup identified the following as potential goals for an APM program:

- Primary care and behavioral health care integration;
- Increased access to behavioral health care;
- Increased use of evidence-based treatments;
- Increased treatment utilization, engagement, and completion rates;
- Integration across levels of care that incorporate hospital and community-based providers to ensure accountability (e.g., reduce rates of emergency department use and inpatient readmission, increase follow up and connection-to-care, reduce re-admission to inpatient psychiatric hospitalization, etc.);
- Increased continuity of care and the delivery of care coordination services (e.g., avoiding provider or clinician changes related to payment or workforce challenges, ensuring continuity of care across services or organizations);
- Engagement of schools as key stakeholders in children's behavioral health;
- Incorporating/integrating behavioral health care with social determinants of health.

Target Population. Target populations vary across states and models, and are closely linked to goals. Approaches to selecting a target population are frequently setting-based and/or condition-based. For example, states may select only children who are high utilizers of the system, children with co-occurring physical and behavioral health disorders, all children receiving outpatient services, or all children receiving integrated behavioral health and primary care services. The workgroup recognized the benefits of taking a universal approach in which population health goals around promoting health and preventing behavioral health conditions are emphasized, as well as a targeted approach in which the APM selects children and families with high needs and/or those with a history of utilizing high-cost care. The workgroup also identified the potential for an APM to support two-generational care approaches, given that many children with high needs are being raised in families in which one or more caregivers also have service needs. Critical to the selection of a target population in most APM approaches is the notion of provider attribution. APM approaches in Connecticut should ensure that target population selection includes the identification of a provider entity that is responsible for coordinating a child's behavioral health care. This can be done in a way that also respects the right for caregiver choice in selecting the services delivered, and the providers delivering those services.

One consideration in identifying an appropriate target population for an initial demonstration project would be to learn from other efforts that have identified high need utilizers of behavioral health services, such as the Five Hundred Familiar Faces initiative. This initiative identified individuals with high utilization across multiple state agencies and systems, with plans to develop a service delivery approach

to address their unique needs (although the pandemic disrupted the service delivery plans). A similar approach could be taken in children's behavioral health to identify youth with high utilization/high costs, design interventions to address their needs, and support service delivery through an APM. Target population selection should be intentional in supporting the APM goal(s) related to health equity, and ensure that the target population has the potential to demonstrate improvement in health equity.

Risk Categories. APMs can be designed to incorporate one or more risk categories that offer various combinations of payment incentives and disincentives. What follows are the common categories, with increasing risk and reliability on outcomes. Note that within these categories there remains considerable room for flexibility and variation in design depending on the goals and target population.[2]

1. Fee-for-Service with Links to Quality: traditional payment plan with additional payments for incorporation of quality enhancements (e.g., care coordination services, implementation of evidence-based treatments, timely reporting of metrics, etc.).
2. Pay for Performance: fee-for-service with bonus payments for achieving pre-determined outcomes (e.g., treatment completion rates, reduced ED and/or inpatient utilization).
3. Bundled Payment Approaches: payment model that allows for flexibility in interventions by applying a rate that covers billable and non-billable services. This can be helpful for funding otherwise non-billable interventions such as prevention efforts, care coordination services and interventions to address social determinants of health.
4. Shared Savings (No Downside Risk): payment structure that provides an "upside risk" only to the provider for achieving specific metrics that are tied to cost savings (e.g., payment for reducing readmission rates), and sharing those savings between payer and provider.
5. Shared Savings with Downside Risk: payment structure that provides an "upside risk" to the provider for achieving specific metrics that are tied to cost savings, but also includes a "downside risk" to providers if they do not achieve specific metrics (e.g., lower payments if the provider does not achieve the pre-determined quality or outcome metrics).
6. Full Risk Capitation Models: payment model that attributes clients to providers and provides a per member per month (PMPM) rate for a given period of time (often with risk-based adjustments to the PMPM rate). The potential downside risk to providers is based on their own performance and the total cost of care for all attributed clients, and is also driven by quality and costs throughout the network.

Consistent with available literature and best practices shared by presenters, the workgroup strongly recommended Connecticut's behavioral health APM risk categories focus on upside risk only, at least for an initial period of time, as the system and the provider network build capacity to fully implement APM. The incorporation of downside risk may be considered after several years, and only after key targets are achieved within the system. There was provider concern expressed around the option of a full risk capitation model in children's behavioral health.

Metrics and Outcomes. The selected quality and outcome metrics should be closely aligned with the identified goals. Selection of trackable and reportable metrics allows for timely, reliable, and accurate

[2] Center for Health Care Strategies, Inc. National Council for Behavioral Health. Behavioral Health Provider Participation in Medicaid Value-Based Payment Models: An Environmental Scan and Policy Considerations. Retrieved from https://www.chcs.org/media/behavioral-health-provider-participation-in-medicaid-value-based-payment-models-an-environmental-scan-and-policy-considerations.pdf.

monitoring of the factors that are connected with payment. It is best practice to not only have regular reporting of metrics, but to utilize a shared-data platform for real-time tracking and reporting so that providers can be engaged in ongoing quality improvement efforts that support both child outcomes and higher provider payments. Metrics should be identified at the child/family, staff, program/provider, and system levels and should be available for ongoing provider monitoring as well as state/payer tracking. Platforms for tracking and reporting metrics should have the capacity to be integrated with provider electronic health records or other existing data platforms to reduce burden on families and providers. In discussions regarding metrics, the workgroup identified the following considerations:

- User/member experience is an important metric. For children's services, the state, in consultation with families/consumers, will need to consider how this should be captured, including consideration of family-level metrics.
- Select metrics that can be used to promote and enhance health equity and reduce disparities.
- Incorporate metrics related to behavioral health screening, such as screening for exposure to trauma/ACEs and the effects of trauma exposure.

In an APM metrics selection process, in addition to the selection of child/family and provider/program level outcomes, Connecticut should consider the system-level metrics and measures identified in the Data Integration Workgroup that was convened simultaneously to support Behavioral Health Plan implementation. Several of these metrics may be relevant to include in an APM. Also consistent with the Data Integration Workgroup's recommendation and efforts, monitoring of cross-system metrics may be supported through requests to the state's P20 WIN initiative which provides integration of data across systems/state agencies. Following is a sample of the cross-system metrics that could be included.

- Juvenile justice involvement;
- Foster care placements and placement disruptions;
- Out-of-home treatment;
- Use of exclusionary discipline by schools.

Provider Technical Assistance. Workgroup members supported the inclusion of infrastructure supports that would allow providers to fully engage in an APM. Related to the collection of metrics and outcomes to support an APM, the workgroup believed that financially supporting a data collection system was important, as data collection systems frequently come at significant cost. In addition, the workgroup emphasized building from existing data systems and ensuring that no additional data collection burden is placed on families or providers. Furthermore, the workgroup recommended that the data collection infrastructure be in place at the outset of APM implementation, rather than building it over time. This recommendation was grounded in the importance of providers having access to raw data, and capacity for analytics, to continually monitor the metrics and measures that will be used to calculate payment. Finally, the workgroup discussed the importance of having a third party responsible for collecting, analyzing, and reporting data on a routine basis, and working with providers to engage in continuous quality improvement efforts that will enhance the quality and outcomes of services, thereby maximizing their revenue opportunities.

Rollout. The rollout of an APM cannot be ahead of the system's readiness. To be successful, an APM must be developed and rolled out as a partnership between state agencies, community-based providers, and families. In Pennsylvania, prior to rollout, providers were administered a readiness assessment, which supported them in preparing for the shift in payment structure, but also provided the state with critical information that informed the structure and timing of a phased rollout. Utilization of a readiness

tool that assesses consumer, provider, payer, and system readiness can reduce the subjective nature of "readiness" and identify concrete indicators of preparedness for APM adoption across stakeholders.

Because of the significant shifts required by all stakeholders in both the mechanics and culture of the payment methodology, a structured, phased, and deliberate rollout of a model was universally recommended. Incremental implementation of the APM allows for additional time for all stakeholders to prepare, and offers an opportunity to learn from prior phases of rollout before beginning the next. Phases may be incremental with respect to desired outcomes, reporting requirements, and how much financial risk is taken on by providers. Reaching full implementation is anticipated to take no less than five years. In addition, the workgroup encouraged implementation efforts to consider ways to support a structure of local or regional coordination in children's behavioral health that is similar to the local mental health authority structure of the adult behavioral health system, or the county-based structures that exist in many other states implementing APMs. State, community, and family collaboration supporting implementation and rollout was also recommended.

Finally, provider and state infrastructure will need to be sufficient to support and sustain the rollout. As noted above, the state will need to invest in a technological and data infrastructure to support effective metric tracking and reporting. It will need to engage providers effectively in technical assistance and quality improvement supports in order to ensure readiness across the provider community. Finally, current staffing and reimbursement rate challenges in the state present barriers to full APM implementation. The workgroup recommended increasing the baseline rates for services to stabilize the workforce, then layering an APM on top of this to enhance payments further for achievement of quality, outcome, and cost goals. Addressing these needs first underlie the success of a new payment structure.

III. Workgroup Recommendations[3]

In light of the process and findings described above, the workgroup arrived at the following recommendations to present to the Children's Behavioral Health Plan Implementation Advisory Board and the twelve state Department Commissioners for further follow-up and implementation. It is the expectation of the workgroup that design and implementation of the APM will be completed as a partnership between state agencies, community-based providers, and individuals/families with lived experience.

Recommendation 1: Raise reimbursement rates to more adequately meet costs with opportunities to further enhance payments to providers through an APM.

Recommendation 2: Develop a more detailed APM implementation plan that clearly describes the goals, target population(s), risk categories, provider technical assistance, and quality and outcome metrics of an APM program.

Recommendation 3: Establish a multi-year glide path that builds provider and system capacity for APM, guided by best practice readiness tools. Introduce an APM model with upside risk only, with downside risk to providers introduced only when supported by the readiness tools.

[3] The workgroup reached consensus on many of the issues raised in regard to need as well as the recommended BHUC and CSU model components included in this report. That does not mean, however, that each workgroup participant explicitly endorsed each of the report's recommendations. Through a process of intensive review and open debate, the included set of recommendations emerged.

Recommendation 4: Tie the APM to improvement of child/family- and provider-level outcomes as well as critical system-level outcomes including but not limited to the following options: improvements in child and family clinical outcomes, improvements in health equity, reduction in ED volume, reduction in total inpatient days, improved connect-to-care rates, increased use of Mobile Crisis, implementation of evidence-based treatments, and behavioral health/primary care integration.

Recommendation 5: Ensure data collection and reporting capacity exists from the outset of APM implementation, that providers have access to raw data for the purposes of monitoring key metrics and measures, and that financial and technical support resources are available to providers to implement the data system without adding data collection and reporting burden to consumers and providers.

Recommendation 6: Support continued learning and innovation by initiating or joining a multi-state learning community focused on APM in children's behavioral health.

IV. Next Steps – Implementation and Monitoring

The first round of workgroup activities correspond to the first stage of implementation: exploration. Following this stage is installation, early implementation, and full implementation. [4] To make progress on the recommendations of this workgroup, additional workgroup activity focused on installation should begin. The major task would be to design the APM utilizing the recommendations in this report and associated best practices within a defined timeframe and with clearly identified responsible parties. It is expected that the workgroup engage in a process with accountability and transparency, and that they regularly report back to the Children's Behavioral Health Plan Implementation Advisory Board. With adoption of the recommendations described in this report and continued progression through all stages of implementation, over time the state will ensure increased flexibility in payment and service provision, increased cost effectiveness, and improved behavioral health quality and outcomes for children in the state.

[4] National Implementation Research Network. What Are Implementation Stages. Retrieved from https://nirn.fpg.unc.edu/module-4/topic-1-implementation-stages-overview/what-are-stages.

Attachment 1: Workgroup Participants

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