

Moving to the Vanguard on Pediatric Care:

Child and Adolescent Health Initiative
Recommendations for the MassHealth Section
1115 Waiver Renewal

Massachusetts Child and Adolescent Health Initiative
September 2020



Moving to the Vanguard on Pediatric Care: Child and Adolescent Health Initiative Recommendations for the MassHealth Section 1115 Waiver Renewal

Table of Contents

| | |
|---|----|
| Executive Summary..... | 3 |
| Moving to the Vanguard on Pediatric Care..... | 5 |
| Background and Context..... | 10 |
| The Opportunity: Redesigning MassHealth to Meet Child and Family Needs..... | 11 |
| Child and Adolescent Health Initiative (CAHI) | 12 |
| Common Themes & Cross-Cutting Recommendations..... | 13 |
| Detailed Recommendations & Examples to Improve MassHealth Enrolled Children & Families’ Outcomes..... | 15 |
| Appendix | 28 |

Executive Summary: Child and Adolescent Health Initiative Recommendations for the MassHealth Section 1115 Waiver Renewal

Critical Opportunity. With the [MassHealth Section 1115 waiver](#) slated to expire in June 2022, the Massachusetts Chapter of the American Academy of Pediatrics has supported a multi-sector Child and Adolescent Health Initiative (CAHI) to review how the upcoming waiver renewal can be used to strengthen care for the [one in three](#) Massachusetts' children enrolled in MassHealth. CAHI includes leading MassHealth accountable care organization (ACO) pediatric providers and other child health experts, experts in social needs and community health, family members with lived experiences and parent engagement experts, educators, and behavioral health experts. The initiative's recommendations are designed to accomplish the following:

- **Ensure that the Section 1115 waiver renewal includes a robust focus on the needs of children, youth, and their families**, allowing for more investment in upstream and primary prevention that managed care entities otherwise are unlikely to make;
- **Adopt a pediatric-specific approach to financing care for children**, reflecting that most investments in pediatric care generate longer-term or cross-sector savings that do not lend themselves to traditional value-based payment models focused on short-term shared savings;
- **Recognize the primary role of parents and other primary caretakers in the health of children** by addressing their needs and supporting the parent-child relationship; and
- **Assist in tackling the social and economic challenges, including systemic racism and inequality**, that have an outsized impact on child health and well-being.

The COVID-19 pandemic and spotlight on racial inequities have exposed and intensified the immense pressure on Massachusetts' families, making this a critical time to re-make and strengthen the role of MassHealth in supporting children. Although MassHealth cannot solve all of the difficulties confronting our children, it can support a family-based approach to pediatric care; help to tackle social issues, economic challenges, and systemic discrimination; elevate and integrate behavioral health into the way that care is provided; expand the use of community health workers; and systematically reflect the experiences and voices of the families served by MassHealth. Along with specific programmatic changes, CAHI also recommends additional investments in pediatric care and the use of innovative value-based payment models that can appropriately reflect the long-term and cross-sector benefits of investing in children and their families.

MassHealth Recommendations. The CAHI White Paper provides specific recommendations for the waiver renewal. It also describes actions that EOHHS could take now using existing authority to strengthen care for children and their families; the below table highlights the top ten recommendations developed by CAHI. Other leading states have already adopted some of the recommendations, but, in many instances taking these steps would put Massachusetts once again in the vanguard on innovative health system reform.

MassHealth has an exceptional opportunity to take leadership on child and adolescent healthcare as it works on the Section 1115 waiver renewal. CAHI calls for collaboration of MassHealth leadership and relevant stakeholder communities to implement the full set of CAHI recommendations.

Contact Information. For additional questions or feedback, reach out to the CAHI Leadership Team: Dr. Jim Perrin (jperrin@mcaap.org), Professor of Pediatrics at MassGeneral Brigham; Dr. Greg Hagan (ghagan@mcaap.org), Chief of Pediatrics at Cambridge Health Alliance; and Dr. Charlie Homer (charlie.homer@gmail.com), Chief Improvement Officer at EmPATH.

| Ten Primary CAHI Recommendations to Strengthen Pediatric Care for Children and Adolescents Enrolled in MassHealth | | | |
|---|--|--|--|
| No. | Recommendation | Intervention Element | Implementation |
| 1 | Require Optimal & Equitable Investment in Pediatric Care | Require minimum expenditures in pediatric care in ACO/MCO contracts to reflect no less than 60% of the proportion of the plan’s population through age 21 and support an increase in primary care spending for pediatrics, consistent with the Governor’s proposal , of 30% over three years | ACO/MCO Contract Reprocurement |
| 2 | Support Advanced Pediatric Primary Care | Provide enhanced per-member per-month funding to providers that offer advanced pediatric primary care and meet quality standards, such as (but not limited to): <ul style="list-style-type: none"> ▪ Integrated mental and behavioral health care ▪ Clear family focus ▪ Attention to social, economic, educational, and equity needs ▪ Care coordination with children with chronic health conditions and/or medical complexities and their families ▪ Including community health workers in teams | Section 1115 Waiver Renewal |
| 3 | Expand Flexible Services Program & Community Partners Initiative | <ul style="list-style-type: none"> • Expand total funding, eligibility, and scope of focused services directly and with Community Partners to address social determinants of health in families • Broaden definition of social risk to include “rising risk” • Expand eligible services to include: <ul style="list-style-type: none"> • Employment services, transportation, and other essential whole family needs; Enrollment in public benefits (e.g., SNAP, EITC) • Parenting supports and interpersonal/intimate partner violence services | Section 1115 Waiver Renewal |
| 4 | Establish Regional Networks of Community-Based Organizations (CBOs) | Two distinct networks should <ul style="list-style-type: none"> • Facilitate services to address <u>health-related social needs</u> that compromise children’s health and well-being • Help children and families with <u>medical, developmental, and behavioral health needs</u> access child-specific care and coordinate with the complex health care system | Section 1115 Waiver Renewal |
| 5 | Establish a Pediatric-Specific Approach to Value-Based Payments | Provide enhanced payment to providers of advanced pediatric primary care (see above) and modify ACOs’ shared savings calculation and quality metrics to incentivize investments in children | Section 1115 Waiver Renewal |
| 6 | Establish Continuity of Eligibility for Children | Create a three year period of continuous eligibility for MassHealth children (under age 21) | Section 1115 Waiver Renewal |
| 7 | Revise the Complex Medical Condition Definition to Provide Financial Incentives to Improve Care | <ul style="list-style-type: none"> • Utilize nationally-recognized algorithm for children with “complex medical conditions” • Provide children with CMCs the option to secure appropriate subspecialty care through academic medical centers regardless of ACO assignment • Incentivize care coordination and collaboration between pediatric primary care providers and academic medical centers | Section 1115 Waiver Renewal |
| 8 | Enhance Collaboration & Interface Between Health & Education Sectors | <ul style="list-style-type: none"> • Coordinate among MassHealth and other governmental agencies for better care • Improve access to and consultation for mental health supports for preschool children • Help young families access early childhood education resources, including parent support and training • Expand school-based health clinics to address behavioral and developmental concerns | MassHealth Existing Authority |
| 9 | Develop a Pediatric-Specific Dashboard & Ongoing Measurement Task Force | Collect and share data, including by race and ethnicity, on key trends in pediatric care such as enrollment, quality outcomes, health equity, expenditures, and use of advanced pediatric primary care and Flexible Services Program for children and youth | MassHealth Existing Authority |
| 10 | Engage in Ongoing Review of Child and Adolescent Care, both at ACO Plan Level & Statewide | Conduct ongoing, regularly scheduled meetings with stakeholders (e.g., parents, youth, providers, payors, advocates, policy makers) specific to child and adolescent health issues, and include child/adolescent health and family representation on key MassHealth and ACO advisory and technical committees | ACO/MCO Contract Reprocurement & MassHealth Existing Authority |

Moving to the Vanguard on Pediatric Care: Child and Adolescent Health Initiative Recommendations for the Section 1115 Waiver Renewal

Massachusetts has adopted far-reaching changes in MassHealth in recent years, relying in part on a major Medicaid Section 1115 waiver to support new investments in care and accountable care organizations (ACOs). With the [MassHealth Section 1115 waiver](#) slated to expire in June 2022, the Massachusetts Chapter of the American Academy of Pediatrics has supported a Child and Adolescent Health Initiative (CAHI) to review how the upcoming waiver application can be leveraged to strengthen care for children and adolescents. CAHI included stakeholders from several current MassHealth Accountable Care Organizations as well as child health experts, advocates, and family advocates who participated in the workgroup to develop policy recommendations. MassHealth leadership was invited to attend meetings throughout the process to stay abreast with CAHI's ongoing work and recommendations. In this white paper, CAHI offers specific recommendations for the upcoming waiver renewal, as well as background information and context on why the proposed changes are critical to the health and well-being of the 667,000 Massachusetts children enrolled in Medicaid or the Children's Health Insurance Program (CHIP) – nearly one in three of the Commonwealth's children and over 40 percent of MassHealth enrollees.^{1,2} Outside of the Section 1115 waiver, the CAHI also has developed a number of directly related actions that EOHHS can take to strengthen coverage for children and adolescents using its existing statutory and regulatory authority.

Summarized in the chart below, the CAHI waiver recommendations seek to strengthen and expand the re-making of MassHealth, focusing on providing primary care for children that is family-centered, integrates behavioral health, considers the social, economic, educational, and equity issues confronting families, and supports coordination and integration of care across sectors. Many of the recommendations are aimed at developing an advanced model for pediatric primary care, reflecting a core belief that significantly more can be done to prevent children from developing costly and life-diminishing conditions over time and optimize physical and developmental outcomes, and that primary care providers are well positioned to play a central, critical role. Many children appear healthy for the moment, but may be at risk for serious physical and behavioral health issues later in life due to unaddressed food, housing, and economic insecurity during childhood; racism and discrimination; exposure to trauma; and families in which caretakers lack access to resources to address their own mental and physical health issues. In addition, children with medical complexities are often most vulnerable for many health and non-health related social concerns and needs, including appropriate care coordination/integration among the pediatric primary care provider and subspecialist providers. While MassHealth cannot solve all of these difficulties confronting our children, it can support new approaches to pediatric care that offer concrete assistance to families with food, housing, and other economic issues; strengthen family resilience to cope with the inevitable challenges; acknowledge and seek to address the impact of racism and discrimination on children; and better knit together supports for families across healthcare, education, and other sectors.

Along with describing a new approach to pediatric primary care, the CAHI recommendations aim to establish value-based payments and financial incentives – at both the provider and ACO/managed care organization (MCO) level – that reflect the unique needs of children and the pattern of expenditures associated with their current and future care. Medicare has driven much of the conversation regarding value-based payment in recent years, resulting in strategies that are best suited to improving the efficiency of care provided to high-cost adults with conditions that are “impactable” in terms of a short-term return on investment. With some notable exceptions, most children are relatively healthy and inexpensive to serve, making it impossible to generate short-term medical savings by improving the quality and efficiency of their care. Accordingly, CAHI recommends additional investments in primary and preventive care provided by pediatric providers, as well as value-based payment strategies that reflect the longer time horizon to see a return on such investments and the fact that such returns cut across both health and non-health related sectors.

¹ Kaiser Family Foundation. [Monthly Child Enrollment in Medicaid and CHIP](#). (March 2020).

² Blue Cross Blue Shield of Massachusetts Foundation: Massachusetts Medicaid Policy Institute. [Faces of MassHealth: Portrait of a Diverse Population](#). Manatt Health, Health Care For All. (May 2019).

Other leading states have taken some of the steps outlined below, but, in many instances adopting these recommendations would put Massachusetts in the vanguard on innovative health system reform for children and adolescents. By adopting strategies that systematically recognize the unique needs of children and reflect the importance of a pediatric-specific approach to value-based payment, Massachusetts can continue its tradition of adopting reforms that improve care for Massachusetts residents and lead the way for states around the country.

| MassHealth Section 1115 Waiver & Related Pediatric Recommendations | | |
|--|--|--|
| Recommendation | Intervention Elements | Potential Implementation Approach |
| PART 1: Section 1115 Waiver Recommendations | | |
| Support Advanced Pediatric Primary Care | <p>Provide enhanced funding to providers that offer “advanced pediatric primary care” and meet quality standards, such as:</p> <ul style="list-style-type: none"> • Function: <ul style="list-style-type: none"> ○ Integrate behavioral health and physical healthcare ○ Assess caretakers’ strengths as well as risks or indicators of depression, anxiety, or other conditions that affect parent-child relationship; support or refer as needed ○ Coordinate care with families with children with chronic health conditions and/or medical complexities ○ Leverage team-based care, inclusive of community health workers (along with mental and behavioral health [MBH] providers and nurses or care coordinators) ○ Allow warm hand-offs, closed loop referrals, and health promotion and prevention activities by teams ○ Use population health approaches to identify and outreach to patients that are due/overdue for appropriate preventive services and chronic disease management. Mechanisms such as registries, EMR-embedded care gap reminders and patient portals support timely provision of care ○ Identify and address directly or with community partners, social, economic, educational, and equity issues affecting a child’s health ○ Expand current screening practices and reimbursement for additional screenings, such as the Screening, Brief Intervention and Referral to Treatment (SBIRT) • Community Coordination and Collaboration: <ul style="list-style-type: none"> ○ Partner with culturally specific community-based organizations and cross-sector care, to address mental/behavioral health, specialized services for children with complex medical conditions and health related social needs, with consideration of family-led organizations ○ Coordinate and partner with home visiting initiatives ○ Improve connections, referrals, and training in the advanced pediatric primary care offices to improve coordination and | <ul style="list-style-type: none"> • Seek expenditure authority in Section 1115 waiver to finance infrastructure investments and ongoing technical assistance for advanced pediatric primary care practices • Provide additional per-member per-month payment to qualified practices that meet quality standards for the advanced primary care model (on top of fee-for-service payments or other payment arrangements) • Over time, evaluate whether to transition to shared savings model for advanced pediatric primary care practices |

| MassHealth Section 1115 Waiver & Related Pediatric Recommendations | | |
|---|---|---|
| Recommendation | Intervention Elements | Potential Implementation Approach |
| | <p>referrals with behavioral health providers in the community, including the Children’s Behavioral Health Initiative (CBHI) agencies and providers and other acute mental health services</p> <ul style="list-style-type: none"> • Capability: <ul style="list-style-type: none"> ○ Offer services through telehealth ○ Meet high standards for providing culturally and linguistically competent care ○ Meet quality standards | |
| <p>Expand Flexible Services & Community Partners Initiatives to Families with Children for Health-Related Social Needs</p> | <p>Expand total funding, eligibility criteria and scope of needs addressed for the Flexible Services Program and Community Partners initiative to better meet the needs of children and families, including:</p> <ul style="list-style-type: none"> • Broaden definition of risk to include multiple social risk exposures without concurrent high cost medical conditions for children • Expand eligible services to include: <ul style="list-style-type: none"> ○ Food, housing, and other essential whole family needs (e.g., employment services, transportation) ○ Parenting supports addressing the entire family, such as social-emotional learning and caretaker support for SUD/ODU treatment, with special consideration of family-led organizations ○ Facilitate enrollment in public benefits (e.g., SNAP, EITC) ○ Interpersonal and intimate partner violence services | <p>Seek expenditure authority in Section 1115 waiver to provide infrastructure support and development; broaden eligibility criteria to include rising risk without current high cost conditions; expand the Flexible Services Program to encompass a broader scope of pediatric and family-specific services</p> |
| <p>Establish Regionally-Based Networks of Community-Based Organizations</p> | <p>Establish Regionally-Based Networks of Community-Based Organizations for two distinct domains of need that require two distinct, regional networks:</p> <ul style="list-style-type: none"> • One entity to facilitate and coordinate services to address the health-related social needs that compromise the health and wellbeing of children and families • A separate entity to help children and families with medical, developmental and behavioral health needs access child- and family-centered services through community-based organizations, as well as to navigate the complex health care system by coordinating and facilitating appropriate consultation, referral, and follow-up (see below re children/youth with complex chronic conditions) <p>These entities must demonstrate the competency and expertise to meet the range of needs of children and families in their respective domains. MassHealth ACOs would establish contractual relationships with at least one organization in each domain, such that these essential services would be accessible for all children and families enrolled in MassHealth, in the context of the advanced pediatric primary care practice.</p> | <ul style="list-style-type: none"> • Seek expenditure authority in Section 1115 waiver to establish and operate on a transitional basis regional “hubs” or networks of organizations that provide high-quality child and family-specific services. • Request 90/10 Health Information Technology (HITECH) administrative funding for technology required to support the network and connections with pediatric providers. |

| MassHealth Section 1115 Waiver & Related Pediatric Recommendations | | |
|---|---|--|
| Recommendation | Intervention Elements | Potential Implementation Approach |
| | All networks should ideally include personnel with lived experience and appropriate cultural/linguistic competence. | |
| Align Fiscal Incentives to Create a Pediatric-Specific Approach to Value-Based Payments | <ul style="list-style-type: none"> • Modify ACOs’ shared savings calculation to reflect increased investment in pediatric primary care • Discount reported costs on pediatric enrollees to reflect estimate of present value of the longer-term return associated with investments in pediatric care • Integrate pediatric-specific quality and performance measures linked to ACOs’ shared savings | Renew existing Section 1115 waiver authority for shared savings payments |
| Revise the “Complex Medical Condition” (CMCs) Definition & Care Standard with Financial Incentives | <ul style="list-style-type: none"> • Utilize nationally-recognized algorithm for children with “complex medical conditions” for pediatric populations to focus on service utilization including much use of subspecialty care (rather than the Medicaid disability indicator) • Provide children with CMCs the option to secure appropriate subspecialty care through academic medical centers regardless of ACO assignment • Incentivize care coordination and collaboration between pediatric primary care providers and academic medical centers • Provide additional enhanced per-member per-month payments to advanced pediatric medical home providers serving children with CMCs, regardless of whether the provider is based in a local, community practice or is an academic medical center subspecialty provider that provides substantial and described coordination of care for CMCs and their families | <ul style="list-style-type: none"> • Seek expenditure authority in Section 1115 waiver to finance infrastructure investments and ongoing technical assistance for collaboration • Review existing rate setting and risk adjustment practices to reflect use of CMCs definition, care standards, and additional enhanced care coordination payments (e.g., per-member per-month) • |
| Establish Continuity of Eligibility for Children | Create a three year period of continuous eligibility for MassHealth children (under 19) | Pursue Section 1115 waiver authority to authorize continuous coverage |
| Evaluate Demonstration’s Longer Return on Investment with Pediatric Care | Develop a 10 year Section 1115 waiver demonstration evaluation | Seek expenditure authority in Section 1115 waiver for an extended demonstration evaluation to evaluate long-term return on investment and cross-sector savings |

| MassHealth Section 1115 Waiver & Related Pediatric Recommendations | | |
|---|--|--|
| Recommendation | Intervention Elements | Potential Implementation Approach |
| PART 2: Related Recommendations Outside Section 1115 Waiver | | |
| Require Optimal & Equitable Investment in Pediatric Care | Require ACOs/MCOs to increase investment in all pediatric care, at a minimum increasing their investments in primary care and behavioral health services for pediatric enrollees by 30 percent over three years, consistent with the Governor’s proposal in House Bill 4134, “An Act to Improve Health Care by Investing in Value.” Investment in pediatric care should reflect no less than 60% of the proportion of the ACO population that is ≤age 21 (e.g., an ACO having 35% of its enrollment pediatric will invest at least 21% of total dollars in pediatric care). | Require minimum expenditures in ACO/MCO contract or through State law (see H.4134) |
| Engage Families in Decision Making | Require proportional and sufficient parent and youth/adolescent representation on ACO/MCOs’ Patient and Family Advisory Committees that reflects the percent of pediatric care in the health plan and demographic diversity amongst members | Establish standards for family engagement in ACO/MCO contracts |
| Require ACOs/MCOs to Address Health Equity | Require ACOs/MCOs to establish and implement a plan-wide roadmap to respond to health disparities and inequities affecting MassHealth enrolled children, parents/caretakers, and families with children | Require health equity plan aimed at children and families in ACO/MCO contract |
| Develop a Child/Adolescent Health-Specific Dashboard | Collect and share data on key trends in pediatric care and disaggregated by sub-populations, such as: <ul style="list-style-type: none"> • Enrollment (e.g., age, race, ethnicity, family in same ACO/MCO) • Child and family-centered quality measures on physical, behavioral health, and health related services • Health equity (e.g., use of services and quality measures including outcomes by race, ethnicity, language [both child and family], sexual orientation, gender identity, education, employment, etc.) • Expenditures • Use of advanced pediatric primary care • Use and impact of Flexible Services Program for children and families | <ul style="list-style-type: none"> • Use existing MassHealth data resources and website to establish dashboard • Prioritize CMS Child Core Measures and other validated measures reflecting Child and Adolescent Health initiative priorities • Establish an ongoing Child and Adolescent Health quality measure group, aligned with both the ongoing Child/Adolescent MassHealth advisory group and the broader MassHealth measure alignment task force • Request 90/10 Health Information Technology (HITECH) administrative funding for technology required to establish data linkages with human services, child welfare, education and other state data systems |
| Require DC:0-5 Code Utilization for Young Children & Their Families | <ul style="list-style-type: none"> • Adopt Massachusetts-specific diagnostic crosswalk being developed utilizing the Zero to Three DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood for age-appropriate diagnoses for young children • Enhance provider training on the DC:0-5 codes | <ul style="list-style-type: none"> • Modify MassHealth provider manual to require/permit DC:0-5 codes that correspond to existing ICD-10 codes • Issue MassHealth provider guidance encouraging DC:0-5 codes and collaborate internally and externally on provider training and engagement |
| Permit Short-Term Behavioral Health Interventions Without a Formal Diagnosis | <ul style="list-style-type: none"> • Provide preventive and short-term behavioral health interventions for children without requiring a formal diagnosis • Expand use of family therapy and dyadic treatment without the requirement of a formal diagnosis, including expanding providers able to provide the service • Require pediatric providers to coordinate with the parent/caretaker’s provider | <ul style="list-style-type: none"> • Use existing MassHealth authority to open up codes to allow preventive behavioral health services for children, including family-centered care (e.g., greater use of Z codes) |
| Coordinate Subspecialty Care for Children with Complex MBH Conditions | <ul style="list-style-type: none"> • Provide reimbursement for provider-to-provider eConsults between pediatric primary care providers, behavioral health specialists, and CBHI agencies | <ul style="list-style-type: none"> • Provide reimbursement for provider-to-provider eConsults and conduct outreach to providers on options to bill for eConsults |

| MassHealth Section 1115 Waiver & Related Pediatric Recommendations | | |
|---|---|---|
| Recommendation | Intervention Elements | Potential Implementation Approach |
| | <ul style="list-style-type: none"> Strengthen partnerships between CBHI providers and pediatric primary care providers Ensure bi-directional communication and collaboration at all levels of care, including outpatient, inpatient/CBAT and urgent care. | <ul style="list-style-type: none"> Use existing MassHealth authority to ensure program care coordination Issue provider guidance and training, as well as member education regarding any new levels of care, such as pediatric behavioral health urgent care |
| Revise Auto-Assignment Algorithm to Promote Family-Based Enrollment | <ul style="list-style-type: none"> Continue to conduct outreach to families encouraging them to select their own ACO/MCO to avoid auto-assignment; if auto-assignment occurs, allow families a period of time to switch plans Prioritize family-centered enrollment of siblings in the same ACO/MCO in the auto-assignment algorithm, unless it disrupts established provider arrangements and/or creates coverage gap | Modify MassHealth policy on ACO/MCO auto-assignment algorithm |
| Enhance Collaboration & Interface Between Health & Education Sectors | <ul style="list-style-type: none"> Coordinate between MassHealth and Massachusetts Department of Public Health, Department of Early Education and Care; Department of Elementary and Secondary Education; and Children, Youth, and Family Services educational agencies to ensure HIPAA and FERPA consistent privacy frameworks for PHI Improve access to and consultations for mental health supports for young children in the preschool age group Help young families access early childhood education resources in the community, including parent support and training Expand school-based health clinics to address developmental concerns Support families as children age out of Early Intervention services and transition to receiving services through the local public school system Bolster the role, funding, and training of school nurses in public schools | <ul style="list-style-type: none"> Pursue a State Plan Amendment to provide funding for infant mental health consultations to coach teachers. Use existing MassHealth authority to engage with other agencies and issue joint policy and guidance Maximize use of MassHealth reimbursement for appropriate services related to education |
| Convene MassHealth Stakeholders on Pediatric Issues | Conduct ongoing, regularly scheduled meetings with MassHealth stakeholders (e.g., parents, youth, providers, payors, advocates, policy makers) specific to child and adolescent health issues to advise MassHealth leadership | Use existing MassHealth authority |
| Assure Child/Adolescent Health Representation on all Key MassHealth Oversight and Technical Committees | For its various advisory and technical committees (e.g., DME, measurement), MassHealth should include members with child/adolescent health expertise, in proportion to the percentages of children/youth in MassHealth. | Use existing MassHealth authority |

Background and Context

MassHealth has launched important and far-reaching initiatives to improve population health in its move to an ACO model for the program, including integration of mental and behavioral healthcare with primary care, attention to and programs addressing social determinants of health (SDOH) and health-related services, and improved coordination of care for people with chronic health conditions. These changes, implemented primarily through the [MassHealth Section 1115 waiver](#) approved in July 2017, allowed EOHHS to change how hospitals, clinics, doctors, and other healthcare professionals are paid. EOHHS required health systems to create ACOs which receive a fixed amount of money for each patient assigned to that ACO. If the ACO spends less money and still meets certain quality metrics and performance

requirements, then it can keep some of the “profit.” Similarly, if it spends more money than Massachusetts considers an appropriate target amount, it may lose money. This model of “shared savings” drove early arrangements and contracts with the 17 ACOs that now operate across the Commonwealth.

MassHealth also required important changes in what healthcare systems must do when providing care and with whom they must partner to meet patient needs. MassHealth’s Flexible Services Program in the current waiver demonstration requires that ACOs assess the social, as well as the medical needs of its patients—such as not having enough food and/or lack of stable housing. In addition, MassHealth mandates that ACOs establish partnerships with community-based organizations and develop processes to connect patients with social needs to these organizations. MassHealth also supports health systems in placing mental health experts (e.g., social workers, psychologists) in primary care offices and clinics so that patients can more easily receive mental health treatment. For people with chronic health conditions, MassHealth supports care coordination and requires that health systems form partnerships with community-based organizations to provide services for people who need long term services and supports, such as home health aides and home nursing services.

In addition, separate from the Section 1115 waiver, MassHealth several years ago enacted critical behavioral health reforms for MassHealth enrolled children (up to age 21) with social and emotional disturbance through the [Children’s Behavioral Health Initiative \(CBHI\)](#). Following the Rosie D. class action lawsuit in 2006, Massachusetts created CBHI to provide intensive home and community-based (HCBS) mental health services to MassHealth children and assessment of early intervention for mental health services. CBHI services are provided through Community Service Agencies – community-based organizations providing pediatric behavioral health care coordination – including outpatient therapy for the child and in-home therapy for the family. CBHI leverages [Family Partners](#), inclusive of Massachusetts parents or caregivers of children with special health care needs that are trained as family advocates, who may join the CBHI care team. Unfortunately, the emphasis on behavioral health integration in the 2017 Section 1115 MassHealth demonstration did not extend to children, and the community-based organizations providing care coordination and long term care and services did not have sufficient child health expertise. While the CBHI program is essential for meeting children’s serious behavioral health needs, it is critical that MassHealth expands its focus toward prevention by identifying “rising risk,” with interventions, whenever possible, with appropriate services and supports before children receive a diagnosis of serious emotional disturbance.

The Opportunity: Redesigning MassHealth to Meet Child and Family Needs

Although highly supportive of the many changes undertaken in the MassHealth ACO, pediatricians and child and family health advocates in Massachusetts have observed that the design and implementation of the 2017 MassHealth Section 1115 waiver does not specifically address the needs of children and their families. The focus on shared savings, reducing costs, and improving care for high cost, low income adults with chronic physical or mental health concerns does not account for the unique needs of children and youth or the preventive healthcare they receive, nor reflect the experience that shared savings do not sufficiently support child and adolescent healthcare. Children’s healthcare does not generate similar adult care costs, with the benefits of excellent pediatric primary care taking longer to appear. These benefits often accrue to other sectors—education, child welfare, criminal justice, employment—rather than exclusively healthcare.

EOHHS has begun to develop Massachusetts’ next Section 1115 waiver proposal in anticipation of its June 2022 expiration. The Massachusetts Chapter of the American Academy of Pediatrics supported the development of CAHI to review how the MassHealth ACO program can be improved for the child and adolescent population and propose changes for the upcoming waiver application.

Children, youth, and families have substantial needs in the Commonwealth. MassHealth has had a major role in providing health insurance to large numbers of low-income children and youth, and with several Medicaid expansions,

increasingly to their parents. Massachusetts' commitment to children and families is evident by the uninsurance rate, the lowest in the country, with 99 percent of children under the age of 18 enrolled in health insurance and 97 percent of the total Massachusetts population enrolled.^{3,4} COVID-19 and the subsequent economic downturn have highlighted the needs of our communities, along with demonstrating the racial and ethnic injustices that many MassHealth enrollees experience in the healthcare system, including Massachusetts' children and youth.

Child and Adolescent Health Initiative (CAHI)

CAHI represents a diverse group of stakeholders interested in child and adolescent health and the MassHealth program (see Appendix for a list of participants). This group first convened in December 2019 and initially agreed on a vision statement and fundamental principles to guide their work.

Vision Statement

All Massachusetts children and youth will develop to their full potential in safe and nurturing families, schools, and communities. The healthcare system will help achieve this vision not only through the provision of preventive and therapeutic clinical care, but also by remaining focused on these essential principles:

- Children are not little adults.
- Care for children must account for the integral role of parents, caregivers, and families, including through attention to the health of parents and guardians.
- Investments in children and families results in improved child and family outcomes across a broad array of systems (e.g., education, employment, criminal justice, child welfare, and health), but benefits may accrue over a longer period of time than current healthcare policy requires, and so need to be uniquely incentivized.
- Addressing the social conditions in which children live is essential to promote health and wellbeing. Child health is inextricably tied to the conditions in which their families live.
- Approach to child health and healthcare must be tailored to account for family and community characteristics, and systems of care must be flexible enough to adapt to variable needs.
- Children, including children with special healthcare needs, are not a homogenous group. Attention need be paid to development stage/capacity, presence and severity of health conditions (including mental health and oral health), geography, and more. Providers should have specialized expertise in addressing children's needs.
- Mental and socio-emotional health are essential aspects of child health that have historically lacked parity with physical health. Preventive and early mental health services, often in the context of primary care and other settings (such as early care and education) can prevent the development of later more serious (and more costly) mental and physical illness.
- Access to both primary care and (sub) specialty care are essential to address the health needs of the entire child health population.

Initiative Methods

Using the vision statement and principles outlined above, CAHI organized sub-workgroups to address specific areas requiring further work and analysis:

- **Unique Needs of Children and Youth**, including the need for investment, setting standards for long term return on investment, asking for parent and pediatrician representation in governing groups for the ACOs/MCOs and MassHealth, and proposing an advanced pediatric community-based medical home.
- **Integrated Mental and Behavioral Health in Primary Care**, emphasizing strengthening the capacity of community practices to identify and manage mental and behavioral health needs.

³ Kaiser Family Foundation. [Health Insurance Coverage of Children 0-18](#). (2018).

⁴ Kaiser Family Foundation. [Health Insurance Coverage of the Total Population](#). (2018).

- **SDOH and Health Related Services**, and the important fact that children and families are impacted by more than their annual interaction with a primary care provider.
- **Children and Youth with Complex Medical Conditions** and other chronic conditions, and organizing care coordination and access to specialized services.
- **Interface Between Healthcare and Education**, including early education and intervention, and other services and linkages to community-based organizations and resources.

Each sub-workgroup described optimal models of care, how to measure and evaluate the models, and recommendations for accelerating change through the MassHealth waiver renewal. Their detailed recommendations and analysis are described below. Later sub-workgroups also convened to consider payment arrangements and measures to support CAHI and its recommendations to MassHealth.

Common Themes & Cross-Cutting Recommendations

The CAHI sub-workgroups identified a wide variety of themes and concerns that underlie efforts to strengthen MassHealth for children, a number of which were identified by more than one sub-workgroup and contributed to cross-cutting recommendations:

- **Foundational role of pediatric primary care.** Child health providers are a trusted source of care for families, and most children have at least a yearly well-child visit. There are even more touchpoints in early childhood, as children see their pediatrician at least 12 times in the first three years of life.⁵ Therefore, pediatric primary care is well-suited for promotion, prevention, early identification, and intervention/treatment of mental, developmental, and behavioral health problems, as well as an assessment of socio-economic needs for the entire family.
- **Integration of behavioral and physical care.** Primary care plays a pivotal role in children’s physical and behavioral care. By integrating behavioral healthcare screening and treatment into pediatric primary care, early intervention and identification may prevent the onset of children’s more serious behavioral health concerns and disorders by mitigating a bifurcated system that often considers mental health concerns and their lifelong impacts secondary to physical healthcare.
- **Importance of addressing social, economic, educational, equity, and other cross-sector issues.** Improving the health, development, and well-being of children will not occur without substantial investment and strengthening

Importance of Addressing Health Equity

MassHealth disproportionately represents people of color who have historically experienced health disparities in access, treatment, and care due to centuries of discrimination and systemic racism creating an inequitable healthcare. Over [17 percent](#) of MassHealth enrollees identify as Black in a State where only [eight percent](#) of the population is Black.

In addition to racism, other structural inequities – including sexism, xenophobia, homophobia, transphobia, ableism – negatively affect health outcomes and poor social and economic outcomes, all of which influence each other in an integrated manner:

- *Health Related Outcomes*
 - Increased exposure to environmental hazards;
 - Higher rates of chronic conditions (e.g., asthma, hypertension)
 - Reduced access to health services.
- *SDOH & Social Outcomes*
 - Decreased social capital and impact on socio-economic status;
 - Reduced education opportunities and lifelong success;
 - Diminished access to food, transportation, and housing; and
 - Increased risk to safety and exposure to violence.

The [Massachusetts Health Policy Commission](#) recently outlined recommendations to advance health equity in Massachusetts’ healthcare system, including MassHealth, including investigating and reporting trends/insights, partnering with community groups and organizations, convening stakeholders, and monitoring and intervening to assure high-quality market performance. Any effort to improve pediatric care should be inextricably linked and part of these broader, statewide efforts.

⁵ American Academy of Pediatrics. [Bright Futures Preventive Pediatric Health Care Periodicity Schedule](#). (March 2020).

of the social and economic environments in which children live, learn, and play. Addressing the deep rooted structural inequities in wealth, housing and education, continued residential segregation, and generations of discrimination and racism that have fueled injustice and disparities requires inputs from multiple sectors, including health, education, housing, social services, and others.⁶

- **Community health workers and community-based organizations are key to change.** Expanding the team-based approach and integrating a community-based lens is critical to improving children and families' well-being. Community health workers, peer navigators, and family coordinators possess critical knowledge of community resources and connections to community-based organizations, all of which can support practices by providing links to referrals for health and non-health related issues facing Massachusetts' families, including food insecurity, housing instability, and violence prevention. In addition, community health workers often reflect the communities they serve and have shared lived experiences that can increase their effectiveness in working with clients and their families.
- **Family-centered approach.** The health and well-being of children is inextricably linked to their caregivers, making it critical for healthcare providers and systems to consider children in the context of their families. Ensuring that parents and caretakers are receiving care for physical and behavioral health is important for a child and family's well-being; for example, screening and treating parents and caretakers for depression, substance use disorder (SUD), and anxiety can directly improve the lives of children. At the policy and program implementation level, it is important that families be actively involved in discussions and decision-making to ensure that it reflects their needs and values.
- **Align financial incentives and adopt a pediatric-specific approach to value-based payment.** It is important to establish financial incentives at both the ACO/MCO and provider level to encourage advanced pediatric primary care, recognizing that a traditional "shared savings" approach does not adequately reflect the longer-term and cross-sector return on investment associated with investments in children.
- **Establish continuity of coverage.** Currently, it is not uncommon for children in Medicaid – both nationally and in the Commonwealth – to churn on and off coverage, making it difficult for families to establish and maintain a relationship with their provider and eliminating much of the already-limited fiscal incentive that health plans might otherwise have to invest in better primary and preventive care for children.
- **COVID-19 is creating additional stress for families.** The pandemic and subsequent economic downturn are impacting families who are experiencing increased levels of trauma, stress, anxiety, and generally an increase in mental health needs and economic challenges. MassHealth enrollees are more likely to be essential workers, live in more crowded housing, and have higher rates of infection and severe disease. In addition, these families are navigating the concurrent economic impact of the pandemic, including job loss and with that, loss of health insurance.
- **Address rural and other underserved areas of the Commonwealth.** Rural Massachusetts – particularly Western Massachusetts and some southeast communities, have smaller pediatric primary care provider practices and clinics that might not have the resources and bandwidth for investing in critically important components of the proposed advanced pediatric primary care model. As such, a regionally-based network supporting pediatric providers could share supports, resources, and personnel (e.g., community health workers, family navigators) across practices ensuring that MassHealth children statewide receive preventive primary care.
- **Need for additional data, evaluation, and ongoing monitoring.** The implications for children of the MassHealth reforms adopted to date are difficult to discern because of a lack of detailed, child-specific data in MassHealth.

⁶ See the National Academies of Sciences, Engineering, and Medicine (NASEM) report for more detail, [Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health](#). (September 2019).

Given the changes recommended here, MassHealth will need to establish an ongoing mechanism for tracking the extent to which providers and health plans/ACOs are achieving desired practices and activities; how these changes affect expenditures for children across ACOs and MassHealth; and the impact of these practices, activities, and expenditures on child as well as family outcomes. As the COVID-19 pandemic impact has shown profound inequity on people of color in the Commonwealth, the child and family data must be able to be analyzed by critical sub-populations in order to identify and address inequities. With many of these recommendations breaking new ground if implemented and generating a chance to test theories on the long-term return on investment associated with investments in children, MassHealth should also pursue an extended evaluation of the pediatric components of the Section 1115 waiver demonstration.

Detailed Recommendations & Examples to Improve MassHealth Enrolled Children & Families' Outcomes

This section provides detailed recommendations for addressing the challenges and opportunities outlined above, as well as suggestions for potential implementation approaches and examples from other states. While all of the recommendations are important and, in some instances, build upon each other, we have separated them into two sections with Part One set of recommendations likely requiring Section 1115 waiver authority while the Part Two recommendations likely could be implemented in the absence of a federal waiver. As EOHHS continues its work on pediatric initiatives and engages with the Centers for Medicare and Medicaid Services (CMS) on the Section 1115 waiver renewal, it is quite possible that it will become apparent that some of the Section 1115 waiver options could be implemented under state plan authority and vice versa.

PART ONE: SECTION 1115 WAIVER RECOMMENDATIONS

Establish Advanced Pediatric Community-Based Medical Homes for MassHealth Children (up to age 21)

- **Intervention.**
 - Invest in and offer enhanced payment for providers that meet standards for providing “advanced pediatric primary care.” To be classified as providing advanced pediatric primary care, a provider would need to meet EOHHS-defined standards with respect to the following:
 - **Function**
 - Integration of behavioral health with physical healthcare in pediatric primary care. For larger practices/systems with a sufficiently large MassHealth pediatric panel, this would require inclusion in the care team of certified behavioral health specialists. For smaller practices, it might require a detailed contracting arrangement with a regional hub of behavioral health providers that can provide staff that is onsite (or available via telehealth) for a specified portion of visits and/or period of time per week.
 - Assess caretakers’ strengths as well as risks or indicators of depression, anxiety, or other conditions that affect parent-child relationship; support or refer as needed
 - Coordinate care with families with children with chronic health conditions and/or medical complexities to ensure services are not duplicative and are meaningful.
 - Establish and leverage team-based care, including MBH staff and care coordinators, as well as community health workers to ensure that referrals and screening follow-up occur with culturally specific community-based organizations (where applicable), and assist with routine parenting challenges (e.g., breastfeeding assistance, behavioral concerns and mitigation, sleep patterns, access to community child-care).
 - According to the American Public Health Association, community health workers are defined to include “a frontline public health worker who is a trusted member of

and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A community health worker also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.”⁷

- Use population health approaches to identify and reach out to patients who are due/overdue for appropriate preventive services and chronic disease management. Mechanisms such as registries, EMR-embedded care gap reminders and patient portals support timely provision of care.
- Identify and address directly or with community partners, social, economic, educational, and equity issues affecting the family, including food, transportation, housing, and interpersonal violence, and follow up. Practices could be expected to work with regional networks of community-based organizations when issues are identified and to monitor the outcome of referrals, as screening alone would not be sufficient.
- Expand current screening practices and reimbursement for additional screenings, such as the Screening, Brief Intervention and Referral to Treatment (SBIRT) for adolescents for early intervention of illicit drug or alcohol use. In addition, expand SUD/opioid use disorder (OUD) outreach and identification for parents and caregivers.
- Community Coordination and Collaboration
 - Partner with community-based organizations and cross-sector care across all sectors affecting children in Massachusetts to limit silos in the healthcare sector, including departments/agencies of education, child welfare, criminal justice, public health, as well as other MassHealth related-programs (e.g., secondary insurance, CBHI). Trained personnel (e.g., community health workers, family navigators) should serve as the point of contact for families to connect to critical social services and community supports. Using a hybrid model, advanced pediatric primary care providers could hire onsite personnel to help families navigate and access immediate assistance for social services (e.g., legal assistance, enrollment in other public benefits) and addressing SDOH (e.g., food, housing, transportation, education), whereas other providers (e.g., rural practices, non-qualifying pediatric primary care providers, clinics with less MassHealth pediatric/family enrollment) can leverage a regionally-based SDOH navigation model to access the same necessary services.
 - Integration of home visiting initiatives to ensure services are not duplicative and visit findings are shared with a child’s pediatric primary care provider. Qualified pediatric providers would not be expected to operate or finance home visiting initiatives, but would be expected to coordinate with them by entering into memorandums of understanding (MOUs) and setting up the ability to exchange data and information (with parental consent). This would not preclude a physician or nurse from conducting a house visit, if needed.
 - Improve connections, referrals, and training in the advanced pediatric primary care offices to improve coordination and referrals with behavioral health providers in the community, including connecting children with CBHI agencies and other acute mental health service providers, such as the Massachusetts Child Psychiatry Access Program (MCPAP).
- Capability
 - Offer services, where applicable, via telehealth capabilities to expand access to families and patients.

⁷ See American Public Health Association’s definition of [Community Health Workers](#).

- Meet high standards as established by MassHealth for providing culturally and linguistically competent care that meets the needs of the patient and their family while being cognizant of the community.
- Meet and report quality standards as established by MassHealth that focus on improving the quality of pediatric primary care, as opposed to volume-based services and care.
- Qualifying standards could be implemented over time, and requirements could be varied for rural or smaller practices. Practices will require infrastructure investment to put the systems in place to provide advanced pediatric primary care, as well as ongoing technical assistance and support.
- As discussed below, practices meeting the standards for advanced pediatric primary care must be provided with a per-member per-month (PMPM) payment for each child served, reflecting that many of the costs associated with operating advanced pediatric primary care (e.g., team-based care; integration of physical and behavioral health) require resources not linked directly to volume of services.
 - Over time, particularly if children can be enrolled in three years of continuous coverage, it may make sense to evaluate whether shared savings is a viable option for advanced pediatric primary care practices. Historically, however, shared savings have been challenging for pediatric populations because of the longer-term and cross-sector return on investment associated with pediatric investments.
 - Any additional payment (e.g., the recommended PMPM) should be conditioned on performance on metrics designed to evaluate the quality and effectiveness of advanced pediatric primary care.
- **Potential Implementation Approach.**
 - Seek expenditure authority for infrastructure investments and technical assistance to advanced pediatric primary care practices. MassHealth might also be able to use the Medicaid administrative match for some of these expenditures.
 - As necessary, secure approval for a directed PMPM payment to advanced pediatric primary care practices. Advanced pediatric primary care models could be assessed one of two ways:
 - Option 1: All-In Model. Practices are only eligible for the enhanced PMPM payment if they meet all the specified criteria and service provisions (see example criteria above).
 - Option 2: Tiered Approach. Practices are assessed and receive payment based on a tiered approach, with advanced pediatric primary care providers meeting baseline criteria and services receiving a reduced, but still enhanced PMPM payment. Practices meeting more than baseline criteria will receive a higher PMPM payment. (see Oregon example below and in Appendix). CAHI recommends a tiered approach.
 - If, over time, shared savings with advanced pediatric primary care practices are adopted, ensure that they are included in any Section 1115 waiver language authorizing expenditure authority for such initiatives.⁸
- **State Examples.**
 - [Oregon](#): Established Patient Centered Primary Care Homes (PCPCHs) for all beneficiaries, including children, through the Coordinated Care Organizations (CCOs), with providers qualifying for enhanced payments if they meet specified criteria, using a 5-tier payment approach. See Appendix for more detail.
 - [Colorado](#): Using a primary care case management (PCCM) model, provides an enhanced fee-for-service reimbursement to primary care providers that offer at least five out of nine State-approved services, including onsite, integrated behavioral health services. See Appendix for more detail.
 - [New Mexico](#): Requires in New Mexico’s Medicaid managed care contract that MCOs must engage with community health workers and that they serve *at least* three percent of enrolled members.
 - [Oregon](#) and [New York](#): Currently designing and/or implementing metrics to measure the impact of various pediatric initiatives on SDOH and readiness for kindergarten.⁹

⁸ For example, the current [MassHealth Section 1115 waiver](#) includes expenditure authority for the following: “Expenditures for shared savings payments to participating ACOs and Pilot ACOs that include risk-based (upside and downside) payments to these ACOs, and that may allow or require ACOs to distribute some portion of shared savings to or collect shared losses from select direct service providers, that are outside of the ranges for ICMs provisions and/or are not otherwise authorized under [42 CFR § 438](#).”

⁹ Oregon’s CCO incentive metrics also noted in the [2020 Oregon Health Plan Services Contract](#) and [Oregon Health Authority’s 2020 CCO Metrics](#)

Expand Flexible Services & Community Partners Initiatives to Families with Children for Health-Related Social Needs

• **Intervention.**

- Expand funding for the MassHealth Section 1115 waiver Flexible Services Programs, and expand the scope of services to include child and family-centered services not otherwise covered through MassHealth or other federal or State benefit programs, such as:
 - Housing supports for families with children that considers factors particularly important to children’s well-being, such as continuity of school and home remediation to address common causes of childhood conditions (e.g., lead abatement or asthma);
 - Employment supports for families with children in order to improve outcomes for children, including pre-employment and employment sustaining services (e.g., job training and coaching, person-centered employment planning, individualized job development and placement);
 - Enrollment assistance in Massachusetts services supporting families (e.g., Supplemental Nutrition Assistance Program (SNAP); Women, Infants, and Children (WIC); Earned Income Tax Credit (EITC));
 - Parenting support and resources (e.g., social-emotional development and learning, parent coaching, SUD/ODU mitigation);
 - Access to medical-legal partnerships;
 - Intimate partner violence connections and resources with community-based organizations;
 - Dyadic treatment, to the extent not otherwise covered by MassHealth; and
 - Community-level violence prevention interventions.
 - Require advanced pediatric primary care practices to screen families for social, economic, educational, and equity challenges, making it easier to identify families in need of the Flexible Services Program.
 - These practices should use risk assessment to not only identify those with high levels of social needs, such as hunger or homelessness, but also those with “rising risk.”
 - Rising risks include evolving food insecurity, housing instability and overcrowding, unemployment, and isolation.
 - In all cases, assessments identifying risk should be paired with efforts to highlight the assets individuals, families and communities have to help them overcome these challenges.¹⁰
 - Families should control whether or not they wish to receive services to address the needs identified through these assessments.
- Expand eligibility for children to receive Flexible Services Benefits such that multiple social needs without specific high risk/cost medical conditions are sufficient.
- Help young families access early childhood education resources, especially community-led parent supports and training. This could include parenting coaching or classes available for early childhood services.
- Expand the existing MassHealth Section 1115 waiver Community Partners initiative to establish regionally-based networks of community-based organizations that can provide child and family-specific services, per next recommendation.

• **Potential Implementation Approach.**

- Seek expenditure authority in the Section 1115 waiver to maintain the Flexible Services Program, expanding funding and definition of the program’s role and goals, and provide infrastructure support and development.
- As an alternative, Massachusetts could seek to leverage the ACO/MCO contract re-procurement process to encourage ACOs/MCOs to offer value-added services of importance to families with children or require plans to dedicate a share of profits to such services.¹¹

¹⁰ See the Economic Mobility Pathways’ (EMPath) [Bridge to Self-Sufficiency](#) for more details on a comprehensive approach for risk analysis considering family stability, well-being and health, financial management, education and training, and employment and career management.

¹¹ See Strategy 1 (starting on page 13) of the [Fostering Social and Emotional Health through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change](#) for more detailed descriptions on using value-added services and promoting investing in pediatric primary care through managed care contract procurements.

- **State Examples.**

- [North Carolina](#): North Carolina has secured a Section 1115 waiver that allows the State to use federal Medicaid matching funds to provide food, housing, transportation and family/child-specific services to Medicaid beneficiaries. It is modeled in part on Massachusetts' Flexible Services Program and similar initiatives in Washington ([Foundational Community Supports](#)), Maryland ([Assistance in Community Integration Services](#)), Hawaii ([Behavioral Health Services](#)), and other select states, but, notably, it includes child and family-specific services such as parenting programs, dyadic therapy, and community-level anti-violence initiatives and broadens child eligibility criteria as well.¹² Although the waiver has not yet been implemented due to delays in the launch of North Carolina's Medicaid managed care transformation and the COVID-19 pandemic, the approved waiver offers a useful precedent.
- [Virginia](#): In July 2020, Virginia received CMS approval for a Section 1115 waiver providing housing and employment supports to adults (age 18 and up) with at least one needs-based criterion (e.g., behavioral health, medical complexity) and at least one risk-based criterion (e.g., homelessness, criminal justice involvement, SUD). The High Needs Supports benefit includes assessments for housing needs, assistance in securing safe housing and/or stable employment, job training and coaching.

Establish Regionally-Based Networks of Community-Based Organizations

Intervention.

Two distinct domains of need require two distinct regional networks (or perhaps a single network hub with the demonstrated ability to adequately address both domains of need):

- An entity to facilitate and coordinate services to address the health-related social needs that compromise the health and wellbeing of children and families, and
- An entity to support navigation and connection with the relevant community-based supports, as well as within the complex health care system, for children/youth with more complex chronic conditions and their families, including mental and behavioral health conditions. As noted below, advanced pediatric practices can carry out much coordination of care directly, but these regional hubs will provide additional services, including coordination for practices not capable of coordination and including LTSS and other enabling services.

These entities must demonstrate competency and expertise to meet the range of needs of children and families in the respective domains.

Social Needs Network

- Establish and fund a hub or network of community-based organizations to provide the flexible services designed for children and families. The hub will provide consultation, referral, and follow-up with community-based organizations and personnel with expertise in addressing the needs of children and families. Such networks should include personnel with lived experience and demonstrate cultural/linguistic competency. Family-led organizations should be considered among these.

Participating community-based organizations could include:

- Food and housing organizations that work with families;
- Transportation providers;
- Interpersonal violence agencies;
- Early intervention services;
- Parenting support providers;
- Medical-legal partnerships;
- Employment support services; and
- Other services that respond to the needs identified in the region or community.

Medical, Developmental and Behavioral health service network

¹² See Service Definitions (starting on page 4) of North Carolina's [Healthy Opportunities Pilot Service Fee Schedule](#) for more detailed descriptions of allowable services in the Healthy Opportunities Pilot program.

- Children and families with medical, developmental and behavioral health needs are routinely confronted with challenges in accessing child- and family-centered services through community-based organizations, as well as to navigate the complex health care system by coordinating and facilitating appropriate consultation, referral, and follow-up. This entity would support the patient and family in navigating these complex systems, while also fostering patient and family self-advocacy.

MassHealth ACOs would establish contractual relationships with at least one organization in each domain in each region of the state in which they operate, such that these essential services would be accessible for all children and families enrolled in MassHealth, in the context of the advanced pediatric primary care practice.

By establishing these networks, MassHealth would avoid the need for each individual ACO/MCO to establish its own relationship with the diverse range of community-based organizations that provide relevant child and family services. This would facilitate quality and consistency of service provision, streamline contracting, and allow for meaningful data sharing among the community-based organizations, MassHealth and pediatrics practices. All networks should include personnel with lived experience and appropriate cultural/linguistic competence.

All ACOs/MCOs and pediatric providers would be required to work with the networks to connect families with needed services.

MassHealth would support the creation of an IT infrastructure to allow for the exchange of referral and follow up information among pediatric providers, ACOs/MCOs, and participating community-based organizations.

- **Potential Implementation Approach.**
 - Request expenditure authority in the Section 1115 waiver to cover the infrastructure costs associated with establishing regional networks or hubs to provide high-quality child and family-specific services.
 - Request 90/10 HITECH administrative funding for technology required to support the network and connections with pediatric providers.
- **State Example.** [Washington](#): The Accountable Communities of Health (ACH), approved from Washington’s Section 1115 waiver, is a regional, collaborative network of self-governing organizations that partner with managed care health plans, providers, and community-based organizations. Washington established nine ACHs across the State that are focused on integrating physical and behavioral healthcare, implementing population health, improving health equity, addressing SDOH, and converting a majority of Medicaid provider payments to reward outcomes – instead of volume. Quality metrics that ACHs must report include a focus on reproductive and maternal/child health through screenings and assessments, access to oral health services, addressing OUD through holistic care, improve care coordination to “coordinate the coordinators”, and reduce avoidable admissions, readmissions, and jail use.

Align Fiscal Incentives to Create a Pediatric-Specific Approach to Value-Based Payment

- **Intervention.** Establish financial incentives at the ACO/MCO organizational level to invest in advanced pediatric primary care and other efforts to address the social, economic, educational, and equity challenges confronting low-income families, including:
 - Adjust the shared savings calculation to reduce an ACO’s reported costs by the amount of the PMPM payments made to advanced pediatric primary care providers to support their work;
 - For ACOs that perform well on pediatric-specific measures related to providing care consistent with the new approach, discount reported costs on child beneficiaries to reflect an estimate of the present value of the longer-term return on investment associated with investments in children (for example, \$100 spent on a child’s care could be discounted to \$97.50 for an ACO meeting pediatric-specific quality standards to reflect the longer-term return on investment associated with high-quality pediatric investments); and/or
 - Integrate more pediatric-specific measures into the calculation that determines the percent of shared savings available to an ACO.

- **Potential Implementation Approach.** Pursue language in the Section 1115 waiver that permits shared savings calculations to reflect the approaches outlined above. The language in the existing [MassHealth Section 1115 waiver demonstration](#) approving expenditure authority for the current shared savings calculations appears to offer enough flexibility to cover these options. It provides for “expenditures for shared savings payments to participating ACOs and Pilot ACOs that include risk-based (upside and downside) payments to these ACOs, and that may allow or require ACOs to distribute some portion of shared savings to or collect shared losses from select direct service providers, that are outside of the ranges for Integrated Care Models (ICMs) provisions and/or are not otherwise authorized under [42 CFR § 438](#).”
- **State Examples.**
 - [Minnesota](#): Hennepin County – serving the Minneapolis metropolitan area – developed Hennepin Health, an ACO dedicated to the county’s Medicaid enrollees up to age 64. Hennepin Health provides integrated care focused on physical care, behavioral health, and social service/health-related needs with a multidisciplinary care coordination team inclusive of social workers and community health workers to best serve enrollees. This ACO started as a Section 1115 waiver demonstration before transitioning in 2016 to an ACO serving families and children countywide.¹³
 - [Oregon](#):¹⁴ CCOs also required to report quality metrics developed by the Oregon Health Authority. These measurements include [HEDIS](#) metrics and [CMS Child Core Set Measures](#), as well as Oregon-specific measures. The CCO incentive measures are linked to CCOs’ annual performance and the State’s pay-for-performance quality improvement program.

Revise the “Complex Medical Condition” (CMCs) Definition & Care Standard through Financial Incentives

- **Intervention.**
 - Utilize the [Pediatric Medical Complexity Algorithm](#) (or a similar nationally-recognized definition or standard) to identify the pediatric population requiring enhanced services, funding, and care coordination, as opposed to the Medicaid disability indicator, which usually reflects Social Security Insurance (SSI) eligibility criteria.
 - Allow children with CMCs to secure subspecialty care through academic medical centers, and other specialty or subspecialty providers for children with co-occurring developmental/behavioral/mental health diagnoses, regardless of ACO assignment, when determined by the family, in consultation with the child’s primary care provider or care team, to be appropriate
 - Provide an additional enhanced PMPM to providers serving children with CMCs due to higher care coordination requirements. Incentivize care coordination and collaboration between pediatric primary care providers and academic medical centers by allowing sharing of care coordination dollars where the AMC provides documented and substantial care coordination.
- **Potential Implementation Approach.**
 - Pursue expenditure authority in the Section 1115 waiver to expand coordination between pediatric primary care and specialty care providers.
 - Review existing rate setting and risk adjustment practices to reflect use of CMCs definition, care standards, and additional enhanced care coordination payments (e.g., PMPM)

Establish Three Years of Continuous Medicaid Eligibility for MassHealth Children

- **Intervention.** Provide three years of continuous eligibility to children under 19, improving continuity of care and allowing providers and plans to build a relationship with families. This proposal builds on the existing State Plan authority to provide 12 months of continuous coverage to children currently being used by [23 states](#) (Massachusetts is not one of them). As with the existing State Plan option, there would be a few circumstances under which coverage would not continue (e.g., the child moves out of state), but the child otherwise would remain eligible even if their family income fluctuates, their family structure changes, or they move within Massachusetts. At the end of

¹³ See Commonwealth Article [Hennepin Health: A Care Delivery Paradigm for New Medicaid Beneficiaries](#) (October 2016) for more details.

¹⁴ Oregon’s CCO incentive metrics also noted in the [2020 Oregon Health Plan Services Contract](#) and [Oregon Health Authority’s 2020 CCO Metrics](#).

the three-year period, the children should be reevaluated for continued eligibility in accordance with standard renewal requirements.

- **Potential Implementation Approach.** Pursue expenditure authority in the Section 1115 waiver to provide three years of continuous eligibility for MassHealth children.
- **State Example.** No state has yet actively pursued continuous coverage beyond a year, but states such as Washington are considering doing so. In the past, CMS has used Section 1115 waiver to allow for 12-months of parent eligibility (see [Montana](#) and [New York](#)); [Massachusetts](#) currently provides 12-months continuous coverage for individuals enrolled in the State’s Student Health Insurance Plan.

Evaluate the Demonstration’s Longer Return on Investment with Pediatric Care

- **Intervention.** Develop a ten year evaluation to track and analyze the Section 1115 waiver demonstration’s impact on children and their families across health and non-health sectors to identify if health-related investments have a long-term impact on children’s health outcomes and well-being. A ten year evaluation has the potential to provide a groundbreaking assessment of children’s outcomes.
- **Potential Implementation Approach.** Request expenditure authority to finance a longer-term and cross-sector evaluation in the Section 1115 waiver evaluation plan; typically, a five year demonstration is aligned with the waiver’s timeline.
- **State Example.** We are not aware of other states undertaking the type of long-term and cross-sector analysis described here.

PART TWO: RELATED RECOMMENDATIONS OUTSIDE SECTION 1115 WAIVER AUTHORITY

Require Optimal & Equitable Investment in Pediatric Care

- **Intervention.** Require MCOs/ACOs that serve a mixed population of children and adults to increase investment in all pediatric care, at a minimum increasing their investments in primary care and behavioral health services for pediatric enrollees by 30 percent over three years, consistent with the Governor’s proposal in House Bill 4134, “[An Act to Improve Health Care by Investing in Value.](#)” ACOs should spend an appropriate level of premium dollars on pediatric care, pediatric primary care and/or pediatric behavioral healthcare, at least in proportion to the numbers of recipients under age 21 in the ACO/MCO compared with the adult numbers. ACOs/MCOs should invest no less than 60 percent of that percentage in the pediatric population; for example, if 35 percent of an ACOs/MCOs’ enrollees are under age 21, then the ACO/MCO should document expenditures of no less than 21 percent on pediatric care.
 - In addition, this approach can also be leveraged to increase resources to support families’ social needs by requiring MCOs/ACOs to spend a minimum amount of premium dollars on community supports and related services for families with children.
- **Potential Implementation Approach.**
 - EOHHS could include a provision in its contracts with ACOs/MCOs to establish the minimum primary care spending requirement. As long as any rates for ACOs/MCOs are actuarially sound, it does not appear that MassHealth would need a Section 1115 waiver to establish minimum expenditure requirements.
 - Drawing on the proposal in Governor Baker’s [recently proposed legislation](#) that would require Massachusetts providers and payers – including MassHealth – to increase behavioral health and primary care spending by 30 percent over three years,¹⁵ EOHHS could advocate for a revised approach for ensuring pediatric care spending meets optimal and equitable levels as appropriate to ACO/MCOs’ MassHealth pediatric panel.
- **State Examples.** According to [American Academy for Family Physicians](#), at least four states (Colorado, Delaware, Oregon, Rhode Island) include mandatory minimum thresholds for the percentage of medical spending dedicated to

¹⁵ See [H.4134](#), An Act to Improve Health Care by Investing in Value.

primary care.¹⁶ Oregon seeks that ACO's will build towards 1% of their global budget to address social needs and also requires that community care organizations implement new value-based payments (VBPs) in maternity care and children's health care. The specifications require that through their children's health care VBPs, CCOs begin to develop payment models that address social determinants of health (including trauma related to adverse childhood experiences), thus supporting long-term positive health outcomes.¹⁷

Engage Families in Decision-Making

- **Intervention.** Further ensure that ACOs/MCOs are engaging families in the community in decision-making at the organizational level by including a sufficient number of parents/caretaker and youth/adolescent representation on the ACOs/MCOs' Patient and Family Advisory Committees that are reflective of the community.
- **Potential Implementation Approach.** MassHealth can leverage current authority to require ACOs/MCOs to include a proportional and sufficient number of parents/caretaker and youth/adolescent representation on the ACO/MCO Patient and Family Advisory Committees. Youth representatives serving on these councils would need to be an appropriate age, but have lived and recent experience with pediatric primary care providers (e.g., ages 19 – 21).
- **State Example. Illinois:** Each MCO in Illinois must establish a Family Leadership Council to provide direct feedback to MCO leadership related to pediatric behavioral healthcare, such as care coordination and family-centric care. The Family Leadership Council is co-chaired by a young adult (or parent of a young adult) with lived experience with the State's child-serving public systems and entities (e.g., mental health, welfare, education) and a member of the MCOs' leadership team. The Council's majority membership must include enrollees or parents of enrollees that have interacted with the State's child-serving entities.

Require ACOs/MCOs to Address Health Equity

- **Intervention.** Health disparities and inequities are a product of the systemic racism that has existed in our nation's healthcare system for centuries, building upon itself and making it more challenging for families impacted by structural inequities to receive appropriate and timely access to care and treatment.¹⁸
- **Potential Implementation Approach.** MassHealth should require ACOs/MCOs to address and improve health equities amongst MassHealth enrolled children and families with children by developing and implementing a health equity plan.
- **State Example. Oregon:** CCOs are required per contract to develop and submit to the Oregon Health Authority for approval an annual SDOH and Health Equity (SDOH-HE) plan that focuses on one of four SDOH-HE domains: economic stability; neighborhood and built environment; education; and social and community health. The CCO must include the Oregon Health Authority designated statewide priority – currently housing related services and supports – as well as one of the four domains, and contract with SDOH-HE partners.

Develop a Child/Adolescent Health-Specific Dashboard

- **Intervention.**
 - Develop a child and adolescent health-specific dashboard, publicizing metrics related to children and their families on a regular (e.g., quarterly) schedule. Dashboard indicators should include, but are not limited to:
 - Enrollment (e.g., by age, race, ethnicity, family in same ACO/MCO)
 - Expenditures (e.g., by ACO, region, CMC status)
 - Child and family-centered quality measures reflecting processes and outcomes related to physical, behavioral health, and health related services

¹⁶ See [Primary Care Spending Rate – A Lever for Encouraging Investment in Primary Care](#) from Christopher Koller and Dr. Dhruv Khullar in the New England Journal of Medicine for more details. (November 2017).

¹⁷ See [Oregon Health Authority CCO 2.0 recommended policies and implementation expectations](#)

¹⁸ See the Massachusetts Health Policy Commission's [Health Equity Framework](#) for more details and additional recommendations. (July 2020).

- Health equity (e.g., expenditures, use of services and quality measures stratified by race, ethnicity, language [both child and family], education, employment, etc.)
- Access to and use of advanced pediatric primary care
- Use and impact of Flexible Services Program for children and families
- Furthermore, MassHealth should improve their current data systems and tracking capabilities to enable assessment and coordination of family needs and the tracking of key outcomes for children and families across Massachusetts' public agencies and sectors (e.g., education, criminal justice, child welfare).
- **Potential Implementation Approach.** Leverage existing MassHealth authority to improve data systems and alignment, and establish a publicly accessible dashboard hosted on a MassHealth website.
 - MassHealth to prioritize the selection of its child health quality measures from the CMS Child Core Measurement set as these will be mandated for state reporting regardless by 2024. MassHealth should also include other validated measures in order to reflect the Child and Adolescent Health initiative priorities (viz., behavioral health integration, equity, multi-sector integration)
 - Prior to waiver submission, establish an ongoing Child and Adolescent Health quality measure group, aligned with both the ongoing Child/Adolescent MassHealth advisory group and the broader MassHealth measure alignment task force to develop a recommended measurement set.
 - Clearly differentiate which measures are used for practice level accountability (e.g., advanced pediatric practice certification) vs. ACO level accountability (e.g., successfully addressing social needs)
 - Massachusetts request 90/10 Health Information Technology (HITECH) administrative funding for technology required to establish data linkages with human services, child welfare, education and other state data systems to present a more comprehensive perspective of child well-being and the impact of effective health services for children and families.
- **State Example.** [New York](#): The Department of Health in New York State has developed a Prevention State Dashboard with State, county, and sub-county level data aligned with the State's [Prevention Agenda 2019 – 2024](#), tracking and publicizing performance indicators associated with 84 prevention goals. One sub-category includes over a dozen metrics aimed at maternal, infant, and children's health, with each metric showing the aimed goal in 2024 compared with the most current data, and options to separate metrics by socio-economic data (where available), such as age, education, race/ethnicity, Medicaid status, and marital status.

Require DC:0-5 Code Utilization for Young Children & Their Families

- **Intervention.**
 - Adopt the Massachusetts-specific crosswalk being developed with ICD-10 codes, based on the [Zero to Three DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood](#), aimed at utilization of diagnostic codes more appropriate for behavioral health and developmental concerns in young children, allowing providers to use diagnostic codes for young children that permit them and their caregiver (as needed) to receive critical behavioral health supports, such as for complicated grief disorder of infant/early childhood, atypical eating disorder, social anxiety disorder, overactivity disorder of toddlerhood, and posttraumatic stress disorder.
 - Enhance provider training and support in the use of the DC:0-5 approach to ensure providers understand and adopt use of DC: 0-5.
- **Potential Implementation Approach.** There are a number of approaches Massachusetts can leverage in order to adopt the use of DC:0-5, including updating the MassHealth provider manual to permit and/or require DC:0-5 codes and issuing guidance to MassHealth pediatric providers encouraging them to utilize DC:0-5 codes. Collaborate and support interagency, cross-sector and stakeholder provider training and support efforts.
- **State Examples.**
 - [Minnesota](#): The Minnesota Department of Human Services' (DHS) Medicaid Provider Manual's Diagnostic Assessment states that Children's Therapeutic Services and Supports providers will utilize the DC:0-5

diagnostic system. DHS also coordinates regular statewide trainings for mental health professions on DC:0-5 utilization.

- [Arkansas](#): In 2016, the Arkansas legislature approved the [Behavioral Health Transformation](#) which required Medicaid providers to use the DC:0-3R (precursor to the DC:0-5) for children up to age four.

Permit Short-Term Behavioral Health Intervention Without a Formal Diagnosis

- **Intervention.**

- Provide preventive and short-term behavioral health interventions for children without requiring a formal diagnosis.
- Expand family therapy and dyadic treatment inclusive of child and additional family member (e.g., mother, father, sibling, caregiver) without the requirement of a formal diagnosis, including considering the providers who can provide the service, by targeting the parent/caregiver for therapeutic services that directly affect and impact the child's health and well-being.
- Require pediatric providers to coordinate with the parent/caretaker's provider, as applicable.

- **Potential Implementation Approach.** Leverage current MassHealth authority to open up new CPT codes, Z-codes (used as a primary diagnosis for CPT codes), and/or behavioral health prevention H-codes related to family therapy and/or short term behavioral health services and provide guidance that a formal diagnosis is not required for service.

- **State Examples.**

- [California](#): Provides up to five family therapy visits to children and adults enrolled in Medi-Cal based on a wide range of risk factors (e.g., death/separation from a parent/caregiver, history of child welfare, food insecurity) without a formal diagnosis. Family therapy may include group therapy or dyadic (e.g., child and mother) and must be provided by a psychologist, licensed clinical social worker, licensed professional clinical counselor, or marriage and family therapist.
- [Colorado](#): Permits primary care practices with a licensed behavioral health clinician onsite to provide up to six short-term behavioral health visits per year for Colorado enrollees without a formal diagnosis code, in order to address and mitigate short-term episodes of care of low-acuity conditions.

Coordinate Subspecialty Care for Children with Significant Mental/Behavioral Health Conditions

- **Intervention.** Coordinate comprehensive care across the pediatric care delivery spectrum for children with complex mental and behavioral health conditions, including:

- Provide reimbursement for provider-to-provider eConsults to encourage communication between pediatric primary care, specialty behavioral health providers, and CBHI agencies.
- Strengthen partnerships between CBHI providers and pediatric primary care providers, including streamlining the experience of care plan sign-off and fostering more understanding of services provided by CBHI providers.
- Ensure bi-directional communication and collaboration at all levels of care, including outpatient, inpatient/Community-Based Acute Treatment (CBAT) and potential new models of care, such as pediatric urgent care.

- **Potential Implementation Approach.**

- Provide reimbursement for provider-to-provider eConsults between pediatric primary care providers and behavioral health specialists and conduct outreach to providers on options to bill for eConsults.
- Leverage existing MassHealth authority to issue guidance and requirements related to improving partnerships among pediatric providers of physical and behavioral health services, utilizing the permitted reimbursement for eConsults as a financial incentive.

- **State Examples.**

- [California](#): California's Medicaid agency, Medi-Cal, expanded telehealth to include eConsults between providers as a subset of "store-and-forward" video technology, permitting a new CPT code to be billed by

providers discussing a patient's care (e.g., pediatric primary provider calling behavioral healthcare provider for patient care coordination and details).

- [Connecticut](#): The State opened up multiple CPT codes for eConsult reimbursement for a primary care provider connecting with over 40 healthcare specialists, including 16 pediatric-specific specialists ranging from pediatric surgery, child and adolescent psychiatry, pediatric oncology, and developmental behavioral pediatrics.

Revise Auto Assignment Algorithm to Promote Family-Based Enrollment

- **Intervention.**

- As occurs now, continue to use auto-assignment only after encouraging families to select their own ACO/MCO. If they are auto-assigned, provide families with a period of time to change the selection and to do so under extenuating circumstances.
- Continue to meet federal requirements detailed in [42 CFR § 438.54\(d\)\(6-8\)](#) for auto-assignment that prioritizes existing provider-enrollee relationships (when possible) and continue to prioritize assignment of newborns to the same plans as their mothers when necessary to avoid coverage gaps.
 - Modify the MassHealth auto-assignment algorithm to add to the hierarchy of considerations the existing enrollment of a sibling in an ACO/MCO without always requiring such enrollment; there still will be circumstances when it is important for siblings and/or parents/caretakers to be enrolled in different ACOs/MCOs (e.g., child welfare, medical complexity).
 - Per federal requirements detailed in [42 CFR § 438.54\(d\)\(7\)\(ii\)](#), Massachusetts may consider additional criteria when developing the auto-assignment algorithm, such as “including the enrollment preferences of family members.”
 - Track and report data on family-centered enrollment to evaluate the extent that all children in a family and parent/caretakers are enrolled in the same ACOs/MCOs and, if they are not, the reason why.

- **Potential Implementation Approach:** Use EOHHS discretion to modify the auto-assignment algorithm, taking advantage of existing [MassHealth MCO contract](#) language that states
 - “The Contractor shall provide EOHHS with additional updates and materials that, at its discretion, EOHHS may reasonably request for purposes of providing information to assist Members in selecting a health plan, or to assist EOHHS in assigning a Member who does not make a selection.”
 - “EOHHS shall have the right in its sole discretion to increase or decrease enrollment of Members over the term of the Contract for the following reasons: Changes in EOHHS’s methodology by which assignments are made to MassHealth managed care plans or ACOs.”
- **State Example. [Michigan](#):** Incorporates a plan’s performance on quality metrics into its auto-assignment algorithm, including metrics related to children (i.e., immunization rates, well-child visits in first 15 months of life and three to six years, timeliness of prenatal and postpartum care), illustrating the flexibility available to states to design auto-assignment algorithms that reinforce their priorities.

Enhance Collaboration & Interface Between Health & Education Sectors

- **Intervention.**

- Coordinate between MassHealth and Massachusetts’ educational agencies, parents, and teachers to develop common privacy frameworks, based on Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA), as well as an interagency plan to improve confidence in protections for Protected Health Information (PHI) in an educational setting.
- Improve access to age and developmentally appropriate mental health supports for young children with emotional and behavioral regulation in the preschool age group, particularly working with preschool educators and providers; community mental health professionals; and advanced pediatric medical home

- providers and care team members. For example, consultations with infant and pediatric mental health providers and specialists can provide coaching for educators and staff, as opposed to direct services.
- Expand school-based health clinics to address developmental needs of school-aged children and their families.
- Support families as children age out of Early Intervention services and transition to receiving services through academic programs in Massachusetts public schools to improve the child's continuity of care, and coordination and communication among the family, pediatric primary care provider and care team, intervention coordinators, and local educators. This is a role for the community health worker or family navigator member of the advanced pediatric practice team.
- Bolster the role, funding, training, and supports of school nurses.
- **Potential Implementation Approach.**
 - Pursue a State Plan Amendment to provide funding for infant mental health consultations to coach teachers.
 - Leverage current MassHealth authority to partner with Massachusetts Department of Public Health; Department of Early Education and Care; Department of Elementary and Secondary Education; and Children, Youth, and Family Services to issue joint policy, guidance, and requirements in order to enhance coordination and collaboration with MassHealth.
 - Maximize use of MassHealth reimbursement for appropriate services related to education.
- **State Example. [Ohio](#):** Columbus, Ohio's Nationwide Children's Hospital partners with Ohio educators to provide the On Our Sleeves initiative to transform pediatric mental health with many groundbreaking programs aimed at educators, parents, and communities:
 - Ohio Preschool Expulsion Prevention Partnership: Assists young children's childcare providers with behavior concerns that may pose potential expulsion.
 - PAX Good Behavior Game: Teacher-driven program in Ohio elementary schools that helps students manage their emotions and behavior in order to prevent suspension and expulsion.
 - Positive Parenting Program (Triple P): Provides parents of children ages birth to age eight with new skills and mitigation practices to assist with behavioral concerns.
 - Signs of Suicide Program: Provided to children starting in grade six and through secondary schooling, the program aims to reduce suicide attempts by youth and adolescents by assisting teachers, staff, and students in recognizing signs of distress.

Convene MassHealth Stakeholders on Pediatric Issues

- **Intervention.** Conduct ongoing, regularly scheduled meetings with MassHealth stakeholders including parents, youth, providers, payors, advocates, and policy makers with a focus on pediatric and family-related issues to advise MassHealth leadership on equitable, collaborative, and meaningful policy changes.
- **Potential Implementation Approach.** Leverage current MassHealth authority to convene a MassHealth stakeholder council/committee focused on children and families. Massachusetts could consider a similar group being convened by the Governor and/or State legislature.
- **State Example. [California](#):** In 2019, Governor Gavin Newsom convened the Early Childhood Policy Council to advise on the development of the State's Master Plan for Early Learning and Care. The Early Childhood Policy Council meets monthly and includes appointees of the Governor, California Senate, California, Assembly, and the Superintendent of Public Instruction. Council representatives include State and county officials in early education, child health, and social services, as well as academics, pediatricians, child care providers, advocates, and parents.

Assure Child/Adolescent Health Representation on all Key MassHealth Oversight and Technical Committees

- **Intervention.** For its various advisory and technical committees (e.g., DME, measurement), MassHealth should include members with child/adolescent health expertise, in proportion to the percentage of children/youth in MassHealth.
- **Potential Implementation Approach:** Use current MassHealth authority to assure adequate representation.

Appendix

A. CAHI Members and Sub-Workgroup Participation

| Name | Organization | CAHI Sub-Workgroup Membership |
|---|--|---|
| Alexy Arauz Boudreau, MD, MPH | MassGeneral Brigham | Social Determinants of Health, Measurement |
| Allison Bovell-Ammon, MDiv | Children’s Health Watch | Social Determinants of Health; Community/School Interface |
| Eileen Costello, MD | Boston Medical Center | Unique Needs of Children/Youth; Behavioral Health |
| Suzanne Curry | Health Care For All | Unique Needs of Children/Youth; Behavioral Health; Complex Medical Conditions |
| Chad d’Entremont, PhD | The Rennie Center for Education Research & Policy | Behavioral Health; Community/School Interface |
| Yaminette Diaz-Linhart, MSW, MPH | Brandeis University | Community/School Interface |
| Lloyd Fisher, MD | Reliant Medical Group; MA Chapter, American Academy of Pediatrics | Unique Needs of Children/Youth |
| Joshua Greenberg, JD | Boston Children’s Hospital | Unique Needs of Children/Youth; Social Determinants of Health |
| Greg Hagan, MD | Cambridge Health Alliance; Co-chair, MCAAP Medicaid ACO Task Force | Unique Needs of Children/Youth; Behavioral Health; Community/School Interface |
| Charles J. Homer, MD, MPH | EmPATH; senior advisor, MCAAP Medicaid ACO Task Force | Social Determinants of Health, Measurement |
| Lisa Lambert | Parent Professional Advocacy League | Behavioral Health; Community/School Interface |
| Mike Lee, MD, MBA | Boston Children’s Hospital | Complex Medical Conditions |
| Patricia Nemia | Federation for Children with Special Needs | Complex Medical Conditions; Community/School Interface |
| James M. Perrin, MD | MassGeneral Brigham; Co-chair, MCAAP Medicaid ACO Task Force | Unique Needs of Children/Youth |
| Dan Slater, MD | Atrius Health Care | Behavioral Health; Complex Medical Conditions, Measurement |
| Michael Tang, MD, MBA | Dimock Community Health Center | Behavioral Health |
| MassHealth Leadership Attendees | | |
| Clara Filice, MD, MPH. MHS | | |
| Kate Ginnis, MSW, MPH | | |
| Aditya Mahalingam-Dhingra, MPH | | |
| Several other child/adolescent health professionals helped in the subgroups, including Drs. Rich Antonelli (Boston Children’s Hospital), Mark Mandell (Steward Health), Jack Maypole (Boston Medical Center), Matt Sadof (Baystate Medical Center), and Michael Yogman (Mental Health Task Force) | | |

Additional Detail on Pediatric Initiatives in Select States

- [Oregon](#):¹⁹ Through Section 1115 waiver authority, CCOs are required to establish PCPCHs for all beneficiaries (including children) which qualify for enhanced payments.
 - CCOs are rated on a range of five tiers with Tier 5 (5 STAR) being the highest rank achievable. The CCOs have flexibility to pay a PMPM rate via fee-for-service or value-based payment.²⁰
 - Tiers 1 through 4 must meet all 11 “must-pass criteria” for PCPCH recognition and are then scored based on a varied point range to identify their tier. The following are the “must-pass criteria”:
 1. Provide continuous access to clinical advice by telephone.
 2. Track one quality metrics from the core/menu set of PCPCH Quality Measures.
 3. Report that it routinely offers critical medical services (e.g., preventive services, chronic disease management with care coordination).
 4. Strategy for screenings for mental health, SUD, developmental conditions, and provide onsite or local referral resources.
 5. Report the percentage of active patients assigned to a personal clinician or team.
 6. Report the percentage of patient visits with assigned clinician or team.
 7. Maintain a health record for each patient with critical medical details (e.g., immunizations, preferred language).
 8. Written agreement with hospital providers or provides routine hospital care.
 9. Process to offer/coordinate hospice and palliative care/counseling for patients, as needed.
 10. Offer and/or use providers who speak a patient/family’s language or provide trained interpreters.
 11. Survey a sample of patients and families at least every two years on their experience of care.
 - Tier 5, (5 STAR) designation requires the PCPCH to meet the above 11 mandatory criteria, as well as 11 out of 13 specified criteria measures and complete a verified site visit. The following are the specific criteria measures for 5 STAR designation:
 1. Offer in-person care at least four hours weekly outside traditional business hours.
 2. Implement a clinic-wide improvement strategy with performance goals derived from patient, family, caregiver, and team feedback, as well as reported measures.
 3. Implement a cooperative referral process with specialty mental health, substance abuse, and developmental providers.
 4. Provide integrated behavioral health services, including population-based, same-day consultations.
 5. Meet a benchmark (80 percent) in the percent of patients visits assigned clinician or team.
 6. Demonstrate that healthcare team members have defined roles in patients’ care coordination and communicate this to patients.
 7. Demonstrate the process for identifying and coordinating the care of patients with complex care needs.
 8. Develop an individualized written care plan for patients and families with complex medical or social concerns.
 9. Track referrals to consulting specialty providers ordered by its clinicians.
 10. Active involvement and coordination of care when patients receive care in specialized settings.
 11. Track referrals and cooperate with community service providers outside of the PCPCH (e.g., dental, education, social services, foster care, public health, non-traditional health workers, pharmacy).
 12. Translate written patient materials into all languages spoken by more than 30 households or five percent of the practice’s patient population.
 13. Survey a sample of its population at least every two years on their experience of care using one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement processes *or* meets benchmarks on the majority of the domains.

¹⁹ PCPCH requirements also noted in the [2020 Oregon Health Plan Services Contract](#).

²⁰ PCPCH rankings and Tier 1-5 requirements provided in more detail in the [Technical Specifications and Reporting Guide](#) (see pages 10-11).

- [Colorado](#): Uses a PCCM model and provides an enhanced fee-for-service reimbursement to primary care providers that offer at least five of the State-approved Enhanced Primary Care Medical Provider services.
 - The following State-approved services include:
 1. Extended hours through weekend appointments and/or after typical office hours appointments.
 2. Timely clinical advice via telephone or secure electronic message both during and after typical office hours.
 3. Data use and population health (e.g., proactively address identified special populations' health needs).
 4. Behavioral health integration via onsite access to behavioral health providers.
 5. Behavioral health screening (e.g., SUD, developmental screening).
 6. Patient registry of those receiving care coordination.
 7. Specialty care follow-up that tracks patients' referral status.
 8. Consistent Medicaid provider (e.g., accepts new Medicaid clients for majority of the year).
 9. Patient-centered care plans developed through patient, family, or caregiver collaboration.
 - To promote integrated care, Colorado also pays for a select number of behavioral health visit provided in pediatric primary care settings outside the behavioral health MCOs otherwise responsible for such care.