Learnings Related to Behavioral Health Network Adequacy for Children Birth to Five in Coordinated Care Organizations & Opportunities for Improvements

Background: The Oregon Pediatric Improvement Partnership (OPIP) is dedicated to building health and improving outcomes for children and youth in Oregon. A key area of focus within OPIP is on improving social-emotional health care services for young children. This includes a number of community-based improvement efforts focused on how to enhance the network of quality behavioral health services that Coordinated Care Organizations (CCOs) can contract with, enhancements to the skill sets and abilities of primary-care based behavioral health clinicians, and improvement pilots that train front-line providers how to identify children with social-emotional health issues and referral and engagement pathways to services. This community-based improvement work informed and guided OPIP's development of incentive metrics for CCOs focused on social-emotional services, including the System-Level Social-Emotional Health metric (within the CCO set from 2022-2024) and the 2025 Young Children Receiving Social-Emotional Issue-Focused Intervention/Treatment Services metric. Through the ground-level improvement work with primary care practices and assessing their health plan contracts, particularly in Oregon's Transforming Pediatrics for Early Childhood [1]project (OR TPEC), we identified a number of barriers to the current network adequacy of behavioral health services in CCOs and opportunities for the Oregon Health Authority (OHA) to support improvements. The purpose of this memo and the requested meeting with the OHA team focused on behavioral health is to share our key learnings, recommend solutions, and inform OHA's efforts to oversee CCOs, with a focus on enhancing the behavioral health workforce available for CCOs to contract.

Context Related to Medicaid/CHIP Insurance and Healthcare-Based, Evidence-Based Services for Children Birth to Five:

CCOs are a critical part of the health system for children in our state, with nearly one in two children receiving health care supported by the Oregon Health Plan (OHP), and over 93% of those children insured in a CCO. Medicaid provides insurance for most children of color in our state. Eighty percent of children enrolled in CCOs have some level of health complexity, comprised of medical and/or social complexity, which impacts their health and can have lifelong consequences. Specifically for children birth to five insured through Medicaid/CHIP, more than **one in four** have indicators of social complexity based on previous services accessed that would indicate a need for behavioral health assessment and most likely at least a brief intervention. And yet, only one in ten children with these known factors have received EPSDT-recommended assessments or services. Clinically recommended, health care-based services for young children are dyadic in nature (meaning services require engagement and work with the parent/caregiver and focus on their attachment) and can be provided in outpatient settings such as specialty behavioral health agencies, by behavioral health experts within primary care, or by CCO-contracted community-based organizations.

Since 2022, CCOs have been incentivized to focus on understanding their current network of contracted behavioral health providers, reviewing available services, and engaging community partners to inform improvement priorities. Starting in 2025, the CCO incentive metric is focused specifically on the proportion of children aged 1-5 who receive issue-focused intervention/treatment services.

Learning #1: OHA Should Require and Support CCOs to Understand their Behavioral Health Network Adequacy for Children Birth to Five

- The provision of a global budget to CCOs is anchored to their demonstration of network adequacy for the entire population covered.
- The current methods required by OHA and strategies used by CCOs do not accurately tell them whether their contracted behavioral health providers serve children birth to five, despite this being a priority population for OHA and one for which continuous enrollment has been secured. Given these children often don't incur high-cost events, the global budget creates a financial disincentive to invest in services for this population, which is why ensuring there is network adequacy for physical, behavioral and dental care services across all age groups is necessary and critical.
- OPIP developed a standardized strategy that could support CCOs in better understanding their behavioral health network for children birth to five that was included in the CCO System-Level Social Emotional Health Metric as part of Component 2. As a reminder, all 16 CCOs successfully attested to and met this metric in 2022, 2023 and 2024.
    - There are modifications that OPIP would suggest to this model if used within the context of contracting and to asses for network adequacy, but this model could be offered as a solution to CCOs in how to enhance their contracting and better understand if their contracted partners truly serve the population.
    - Rooted in OPIP's subject matter expertise, we reviewed what CCOs submitted to meet this metric, and it is clear that there are significant issues with CCOs knowing how to assess for network adequacy within their system and how to assess the face validity of the accuracy of what was reported: providers listed as serving birth to five who cite modalities and tools that are not applicable or evidence-based for young children, and capacity reporting that has significant face validity issues. Subsequently, OPIP met with multiple CCOs and ascertained the need for more assistance and potentially contractual requirements to support CCOs in attaining network adequacy. The asset maps and corresponding Action Plans clearly indicate that CCOs still need support in how to accurately assess the level of their network adequacy and contracting models that ensure network adequacy.
    - Furthermore, a majority of the CCOs reported on factors that would help determine if there are culturally and linguistically matched services. While it is unclear given data provided by some CCOs, for those that accurately completed the tool, there are significant gaps in the availability of services as compared to population demographics. For example, there are large gaps in the availability of dyadic services by providers that speak languages other than English. This is particularly important given the barriers to the use of translators in the context of dyadic therapy.

Proposed Solution:

- Require CCOs to report on behavioral health network adequacy in a way that is specific to each population covered by the global budget. Ensure network adequacy for state priority populations (i.e. children birth to five, families with cultural or linguistic needs).

- For example, require that they include in their contract specific information about the providers' ability to see birth to five and the specific training and modalities used, to help ensure quality assurance and clarity. If CCOs only ask if the provider serves "children," the organization won't provide accurate information for birth to five. Then require that CCOs assess whether providers who noted they serve young children have ever actually billed for services in the last year, as a quality check on this attestation.

Learning #2: A summary of available, evidence-based modalities for specialty behavioral health is needed for CCOs

- Coordinated Care Organizations need more coaching and support regarding what evidence-based services are for young children and how they can incentivize and support enhancements to the services.

Proposed Solutions:

- OPIP recommends that OHA provides a summary of links to existing evidence-based resources that are outlined in the modality overview included in the System-Level Social Emotional Health Metric**.**
- Then, OPIP recommends providing a link to what the modality is and if there are local or regional opportunities for training**.**
- Currently we understand the OHA website lists resources specific to just PCIT, Generation PMTO and CPP. OPIP is curious why these three modalities were identified as priority, particularly as these three are the most common currently modalities offered. Based on OPIP's review of what CCOs submitted and regional improvement projects, OPIP could offer suggestions of additional modalities to consider for investments. IN particularly, given the health complexity data, OPIP recommends modalities that target children who experience delays as a result of adverse child experiences and services provided to families with these factors that acceptable and offered in a setting that parents would want to access.

- Coordinated Care Organizations need subject matter experts on CCO contracting models for behavioral health to provide coaching and tailored customized support on how CCOs could incentivize their specialty behavioral health workforce.
- OPIP has led a number of efforts focused in this area and provided a summary of strategies in our webinar for CCO that can be accessed here. That said, OPIP has found most CCOs need tailored technical assistance that takes into account their region, array of providers, and contracting models.
- Every region that OPIP has successfully expanded network adequacy has been the result of independent behavioral health organizations and community-based organizations that obtained a COA with the CCO. OPIP has not ever found successful expansion of services within a community mental health organization and, in fact, has found systemic barriers to services in this setting. Any state policies that prioritize services in this setting will likely have unintended negative consequences for young children.

Learning #3: Training Supports are Needed for Behavioral Health Clinicians Integrated in Patient Centered Primary Care Homes in Order to Build the Behavioral Health Workforce

- Over 90% of young children access primary care in the first five years of life.
  - In Oregon, we have several priorities focused on Patient Centered Primary Care Homes and enhancing behavioral health in primary care.
  - Integrated behavioral health in primary care is an ideal place to target workforce investments for young children as this is where "car seats are parked," and it is where parents expect and desire for this type of care to be provided, given the location and reduced stigma to accessing services.
  - That said, throughout OPIP's efforts across the state, we have learned from integrated behavioral health providers that a majority have not received specific training on assessments and brief interventions for young children and therefore do not provide those services for young children, even when they are the only BH provider in their practice.

Proposed Solutions:

- A regularly updated summary of applicable programs and training courses for integrated behavioral health providers would be useful. Stipends and support to cover the time away from clinic for integrated behavioral health to attend these trainings would be invaluable.
- OPIP has been leading efforts over the last ten years on best match training and implementation strategies for enhancing integrated behavioral health providers' ability to serve the birth to five population. These training courses have been informed by surveys of integrated behavioral health providers to understand their needs and gaps in knowledge. Evaluation results from the trainings have been extremely positive. Future training efforts should include provider surveys on desired topics, and include guidance on how to appropriately bill for services and address payment barriers.
- Support to implement new workflows that leverage integrated behavioral health staff with skills to see children birth to five can be crucial. Sites where OPIP has also provided practice facilitation support related to implementation have demonstrated increased provision of services.
- OPIP feels that a statewide Training and Learning Collaborative targeted towards integrated behavioral health in primary care is needed at this time. The Learning Collaborative should include an in-person learning session and webinars that focus on common social-emotional issues. Continuing Medical Education/Continuing Education Units should be provided.

Learning #4: Supports for Referral Pathways Are Needed and Understanding Root Cause Barriers to Closed Loop Referrals

- A key barrier to children successfully accessing intervention/therapy services in specialty behavioral health is the ability for the primary care provider to refer and provide crucial clinical and contextual information to the referral entity and the lack of closed loop communication. In most communities OPIP has worked with, a majority of available specialty behavioral health providers don't accept direct referrals. In the OR TPEC project in Portland Metro, we saw that practices prioritized three specialty behavioral health providers who did accept referrals, which significantly limited the options available for children and yielded long wait lists.

- While many CCOs noted in their Action Plans leveraging Unite Us for referral pathways, further examination on whether behavioral health providers can ACCEPT referrals on Unite Us in each region (meaning Unite Us could be used to refer to the issue-focused interventions) is needed. Based on interviews with various CCOs who noted use of Unite Us, it is clear that behavioral health providers are NOT ACCEPTING referrals on the platform, and therefore Unite Us is not a solution to closed loop referrals for behavioral health. Furthermore, one CCO (PacificSource Community Solutions of Central Oregon), noted a specific investment and pilot on using Unite Us for behavioral health providers to accept referrals that was not successful.

Proposed Solutions:

- Provide training and examples for specialty behavioral health providers on appropriate referral forms and processes for young children (OPIP has examples from past projects).
- Consider revisions to OARs that may currently disincentivize referrals for populations with limited staffing. The current OARs, particularly for county mental health agencies, requiring assessments within 14 days of referral is often cited as a reason specialty behavioral health agencies do not accept direct referrals for children.
- Support CCOs to provide payment models that account for the time and effort needed to provide outreach, care coordination and closed loop communication for specialty behavioral health referrals. On the primary care side, this can be provided through PMPM models. A model that is anchored to referrals received could be used to incentivize connections.

Learning #5: There are Barriers to Sustainable Payment and APM/VBPs provided by CCOs to Integrated Behavioral Health in Primary Care that Will Impact Whether and How This Workforce can be Part of the Solution to Ensuring Network Adequacy

- In working with primary care practices to enhance their integrated behavioral health services for young children, a number of payment barriers have been identified that impact sustainability. At a high-level, below is a summary of key payment barriers that OPIP can provide more detailed explanations for in the meeting.

Payment Barrier #1: Some CCOs/Payors Require a Formal Diagnostic Assessment to be Billed Before Covering Treatment Services

- A formal diagnostic assessment claim is sometimes required by some payors before treatments services can be billed and covered. For example: Psychiatric Diagnostic Evaluation (90791) or Mental health assessment, by non-physician (H0031).
- Within primary care, given their context and role, evidence-based strategies often allow them to make a diagnosis based on screening tools and clinical observation. Therefore, treatment could be provided **without** needing additional diagnostic assessments.
- The requirement for a diagnostic assessment to occur before treatment services can be covered creates an additional visit and process that often is not family-centered.
- These policies may have been created based on an assumption that children receiving treatment services would all be referred to an external organization that does not have the clinical history with the patient and would require a formal diagnostic assessment. As

integrated behavioral health services within primary care become more readily available, evidence-based support provided in a process and setting that may be more appropriate for young children and their families should be covered.

Payment Barrier #2: Many CCOs/Payors Lack Coverage for Diagnostic and/or Treatment Services in a Primary Care Setting

Numerous clinics shared significant barriers to coverage of treatment services, particularly those deemed "behavioral health," as they had been "carved out" by the health plan (including within CCOs) to be eligible for reimbursement only when used by specialty behavioral providers within the CCO/Health Plan. Below is a list of common claims that have been reported to be denied in the past when submitted by applicable behavioral health staff located within primary care.

- Psychiatric Diagnostic Evaluation *(90791)*
- Individual Psychotherapy *(90832-90838)*
- Family Psychotherapy *(90846, 90847)*
- Group Psychotherapy *(90849, 90853)*
- Multi-Family Group Training Session *(96202-3)*

Payment Barrier #3: Many CCOs Lack Coverage for Treatment Services in Primary Care Settings When Claims Codes Are Paired with Z or R Diagnosis Codes

- Even when treatment codes are covered in primary care (see Barrier #3), they are sometimes not covered when paired with Z or R diagnosis codes, which are often the most clinically appropriate diagnoses for young children.
- Of the practices who report receiving coverage for treatment services described in #3, a number report that the payment coverage was only for when the claim was paired with F diagnosis codes, representing a diagnosed mental health disorder. For young children needing social-emotional intervention and treatment services, they likely will not carry a mental health diagnosis yet, but should receive appropriate treatment interventions to prevent or delays diagnosis.
- As is outlined in OHA's Oregon Early Childhood Diagnostic Crosswalk**,** many evidence-based, applicable diagnostic codes for young children are Z and R codes. Lack of coverage prevents practices from providing and young children from receiving appropriate treatment services.

Payment Barrier #4: Many CCOs Don't Pay the OHA posted fee rates for Services Rendered

- Many primary care practices shared that they do not receive payment aligned with the OHA posted fee rates for issue focused-interventions. This is particularly true when billed by staff who have a Licensed Clinic Social Worker (LCSW) degree, even though they have the appropriate skill set to provide evidence-based interventions to this young population for these services. Paying a lower rate for LCSW creates a barrier to sustaining this workforce in primary care. Therefore, we recommend payment parity with integrated behavioral health providers.
- CCOs don't provide enhanced rates for people with infant mental health certification.

Payment Barrier #5: Some CCOs don't provide Upfront Investments of APMs that support workforce enhancements.

- Providers currently have no incentive to receive the training or certification to serve birth to five; therefore, it is cost prohibitive to take steps to gain expertise to serve this populations.
- PMPM support of behavioral health staff for non-covered services often don't take into account the significant amount of work needed to engage a parent and young child in services and to support the provider in system navigation to find applicable resources given the limitations.
- CCOs report, given their contractual funds, limited funds to be able to support the kind of trainings that would enhance the skill set of the existing workforce.

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