

September 30, 2015

Ms. Kate McEvoy  
Director, Division of Health Services  
Connecticut Department of Social Services  
55 Farmington Avenue  
Farmington, CT 06105

RE: Comments of National Alliance on Mental Illness, Connecticut (NAMI Connecticut) to proposed Medicaid Quality Improvement and Shared Savings Program (MQISSP) Concerning Children

Dear Kate,

As the Child and Adolescent Policy Manager for NAMI Connecticut, my comments are focused on MQISSP as it relates to children, particularly those with mental health concerns, who are Medicaid beneficiaries in Connecticut.

I appreciate all your hard work regarding Connecticut's State Innovation Model (SIM) test grant and the Department of Social Services' (DSS) dedication to providing improved care to Medicaid beneficiaries, through programs such as MQISSP the goal of which is to improve healthcare outcomes and care experiences for Medicaid beneficiaries, both children and adults, while reducing costs of care.

My review of the MQISSP Concept Paper dated August, 26, 2015 and related relevant documents, as well as my attendance at MAPOC Care Management meetings as an advocate, indicate that children will be included among the beneficiaries of the July 16, 2016 roll out of MQISSP. A frequent argument that has been voiced for excluding children from the roll out has been the possibility of underservice (as with adults) and their vulnerability combined with their inability to advocate on their own behalf. While I agree these are relevant issues, I want to raise the following additional concerns that I believe should be addressed and may compel exclusion of children with serious mental health conditions from the first roll out.

1. Inclusion of children in MQISSP may not align with current efforts to improve the children's mental health system in Connecticut. As described in the PA 13-178 Children's Behavioral Health Plan dated October 1, 2014 (Children's Plan), care coordination for high-needs children with mental health conditions has been a critical missing piece in Connecticut's system of care for children. Under PA 15-27, the Children's Behavioral Plan Implementation Advisory Board has been created to oversee the implementation of the Children's Plan which recommends, among other things, that a care management entity be created to address this critical need (see below discussion of duplication of services). As a result, several questions are raised concerning care coordination for children: does MQISSP promote the creation of the essential care coordination piece for children who are Medicaid beneficiaries as contemplated

by the Children's Plan? Has the Advisory Board given input on inclusion of children in MQISSP as it relates to the Children's Plan implementation?

2) Participation in MQISSP may not meet the unique care coordination needs of children.

Research shows that better mental health outcomes are achieved for children who have the benefit of care coordination specific to children, particularly for children who are involved in the child welfare and juvenile justice systems, i.e., the wraparound model that utilizes community based services. MQISSP appears to be primarily focused on adults and national best practices for adults;

3) Participation in MQISSP's enhanced care coordination model may put the "cart before the horse" concerning meeting the mental health needs of children. The primary need for children with serious mental illness who are covered by Medicaid is greater access to appropriate care coordination through initiatives such as the Hartford Care Coordination Collaborative (HCCC) and the Clifford Beers Guidance Clinic (CBGC), not general "enhanced" care coordination. These initiatives specifically address the mental health needs of children and their families using an integrated approach (HCCC) and in the primary care setting (CBGC). Person-Centered Medical Homes (PCMH) and Behavioral Health Homes (BHH) are also designed to provide care coordination for children with severe mental illness, though it appears that the current focus of these programs is more on adults than children, at least to start (in the BHH, adults will be auto-enrolled through their Local Mental Health Authority (LMHA); there is no LMHA counterpart in the children's system). If successful, these programs could be expanded which may obviate the need for another costly layer of care coordination for children through MQISSP;

4) MQISSP appears to be duplicative of care coordination services in the children's context. For example, DCF has recently contracted with ValueOptions to provide wraparound care coordination for children through a Care Management Organization for Medicaid beneficiaries. ValueOptions is currently the ASO for children's behavioral health, providing administrative coordination of claims. If the CMO is created and implemented, it seems that MQISSP care management enhancement would be duplicative of CMO care coordination. The Behavioral Health Partnership Oversight Council should be consulted, if it hasn't already, on this issue.

5) MQISSP may be too complex and unworkable for parents at this stage in the development of MQISSP, SIM, and the current/changing children's mental health system in Connecticut. DSS is working to develop "a process and tools to notify beneficiaries" regarding MQISSP, but more than notification is necessary. Telling parents about MQISSP and presenting them with opting out options seems far too complex and unrealistic for most parents who start from a place of not knowing how to access behavioral health for their children. In addition, it is difficult to have confidence that DSS will overcome these obstacles when the MQISSP proposal is heavily focused on adult mental health, and gives very little attention to children and how MQISSP affects our bifurcated systems of children and adult mental health. It would be helpful for committee members and the public, as well as for design purposes, for DSS documents to give greater

detail on MQISSP as it relates to children's mental health, and provide concrete examples of what attribution, eligibility, monitoring etc. would look in the children's versus the adult context.

Thank you very much for providing me the opportunity to provide comments to you. I would be happy to answer any questions you may have.

Best regards,

Susan Kelley