COLORADO
Department of Health Care Policy & Financing

Meeting Minutes
Behavioral Health and Integration Strategies (BHIS) Program Improvement Advisory Committee (PIAC) Subcommittee

Virtual Meeting

October 2, 2024, 9:00 AM – 10:30 AM

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1. Introductions

Facilitators:

- Daniel Darting — Signal Behavioral Health
- Lexis Mitchell — Health Care Policy & Financing (HCPF Liaison)

Voting Members:

- Monique McCollum — Parent of Special Needs Children on Medicaid
- Deb Hutson — Behavioral Health Administration
- Taylor Miranda Thompson — Colorado Community Health Network
- Nina Marinello — Intermountain Health
- Charles Davis — Crossroads' Turning Points, Inc.
- Marisa Gullicksrud — Child First
- Elizabeth Freudenthal — Children's Hospital Colorado
- Amanda Jones — Community Reach Center
- Imo Succo — Southwestern Colorado AHEC
- Thomas Keller — Medicaid Member

2. Housekeeping

Daniel Darting calls the group to approve the September 2024 BHIS minutes. Elizabeth Freudenthal motions to approve; Charles Davis seconds. Committee members voted to

approve the September 2024 minutes. There are no objections. There are no abstentions. September 2024 meeting minutes are approved by voting members.

3. Department of Corrections (DOC) Update

Matt Pfeifer, HCPF, presented an update on the metric for behavioral health engagement for Members releasing from state prisons.

- The definition of the metric is the percentage of members releasing from a DOC facility with at least one billed behavioral health capitated service or short-term behavioral health visit within 14 days. This is a statewide metric that is part of the performance pool incentive funds with a six-month delay for claims runout.

- There is a data sharing agreement between DOC and HCPF. DOC ensures members are enrolled prior to release and sends a roster to HCPF multiple times a week. Rosters include scheduled release date, actual release date (if different) and clinical information. HCPF sends rosters to RAEs daily and the RAEs collaborate to outreach Members and ensure they have direction to access care upon release.

- Initial rate in June 2019 was 9.02%. The target rate for FY23-24 is 23.90%, and HCPF is exceeding this target with the last measurement in March 2024 at 32.33%. Individual RAEs range from 22.76% to 36.66% for the 14-day follow up in their regions. When you look at 30-day follow up, there is about a 10% increase in engagement rates, with the lowest being 29.67%.

- Generally, there are higher rates of engagement for non-white women than there are for white women, with non-white men having the lowest engagement when looking at the metric by demographic groups. Individuals who do not identify their race or ethnicity generally have the lowest engagement rates.

- The committee had some conversation regarding the differences in engagement across demographic groups. There are several factors potentially driving this, one of those being the variation in incarceration rates for the different demographic groups.

4. Prospective Payment System (PPS)

Steven Ihde, HCPF, presented on the Prospective Payment System (PPS) model that HCPF has recently implemented for behavioral health safety net services.

- PPS models set a daily or monthly rate for a defined set of services using

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historical cost information. The model considers the number of encounters historically experienced (an encounter is any number of services being utilized over a period of time) and takes those costs and projects them forward.

- Benefits of a PPS are that it creates a more stable payment methodology for safety net providers, encourages value over volume, uses a prospective nature to invest in interventions and increase access, appropriately reimburses for high acuity services, and value-based proposition can be attached.

- In Colorado, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are reimbursed via a PPS model. It will also be used to reimburse new comprehensive providers as defined in statute from HB 22-1278 and it has been applied for Certified Community Behavioral Health Centers (CCBHCs). There are some differences in the PPS models for CCBHCs versus Comprehensive Providers, as CCBHCs are a federal designation, while Comprehensive Providers are defined in state statute.

- HCPF has applied for a grant that would allow us to become a demonstration state, which would allow us to pay under a CCBHC model. This would give us funding to help organizations get their systems up to date to meet reporting requirements, as well as an 85% federal match for two years.

- To develop the PPS concept, HCPF did extensive stakeholder engagement with potential providers and payers and opted to use a "straw man" model to discuss design. Pricing exercises were completed by actuaries and then a final model and reasoning behind it were provided. Further stakeholder engagement was conducted and technical assistance was provided for the provider community.

- The PPS is a cost-based rate over nine categories of services, which are typically pretty broad. In each category, you must provide at least one of the services. If you provide a more expensive service, your costs are higher, and therefore your PPS will be higher. If providers are new and there is no cost history, there is a statewide rate they can use while they establish cost history.

- CSU/ATU per diem is not included in the per diem for the PPS, as it would cause costs to skew dramatically. CSU and ATU were pulled out of the PPS and rates were established for each site that provides these services.

    - Services provided under a PPS are predominantly outpatient services. Most of the providers covered under a PPS do not offer inpatient or residential services.

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- Comprehensive PPS service definition aligns with statute and BHA rules, and Safety Net Cost Reports are used to gather costs for services across all payers. Daily encounters are verified by EHR information, then costs are divided by encounters, which results in the base PPS. PPS is then trended forward to the appropriate period to ensure rates are adequate.

- There was a comment from the committee that the PPS has been beneficial from a payment perspective, but not necessarily an administrative perspective. HCPF is open to having further discussion with partners to learn more about administrative burden and how to reduce it, but unfortunately billing codes must be tracked to understand services provided and the cost associated with those services.

- The committee expressed the value of using EHR data for the PPS because it is very comprehensive. There was a question regarding the scope of EHR data and the ability to use EHR data for value-based payment models. Unfortunately, this is not very feasible due to HIPAA restrictions and the ability to access EHR data for individuals with commercial payers.

5. Behavioral Health Quality Metrics

John Laukkanen, HCPF, presented on the Behavioral Health Incentive Program (BHIP) recommended performance measures for ACC Phase III.

- BHIP is funded under an administrative program through CMS, and HCPF can pay up to 5% over RAE capitations as an administrative payment to incentivize quality. Since the capitations are approximately $1B per year, the pool is about $50M. There are 5 measures, each worth 1% and the dollars are matched at 50% from the federal government. HCPF chooses measures to focus on areas where improvements are needed.

- Historically, the 5 measures HCPF has used were not national standards. However, HCPF is moving in this direction so we can more easily see how HCPF is comparing to the national standards for care and other states who are using these measures. CMS core measures are national standards for care that are used to measure the quality of care provide to patients. These measures are based on scientific evidence and designed to improve patient outcomes by reducing complications and preventing recurrences.

- The current BHIP performance measures are:
    1. Initiation and engagement of substance use disorder treatment
    2. Follow-up after hospitalization for mental illness
    3. Follow-up after ED visit for alcohol and other drug abuse or dependence

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4. follow-up visit after a positive depression screen
5. BH screening or assessment for children in the foster care system

- The new BHIP performance measures are:

1. Initiation and Engagement of Substance Used Disorder Treatment
    - Measure Description: Percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:
        1. Initiation of SUD treatment: the percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
        2. Engagement of SUD treatment: the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

2. Follow up after Hospitalization for Mental Illness
    - Measure Description: percentage of discharges for beneficiaries age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health provider. Two rates are reported:
        1. Percentage of discharges for which the beneficiary received within 30 days after discharge
        2. Percentage of discharges for which the beneficiary received within 7 days after discharge

3. Follow-Up after ED Visit for Alcohol or Other Drug Abuse or Dependence
    - Measure Description: Percentage of emergency department (ED) visits for beneficiaries age 13 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:
        1. Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit
        2. Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit

4. Follow-up after ED visit for Mental Illness (NEW)
    - Measure Description: Percentage of ED visits for beneficiaries age 6 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental

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illness. Two rates are reported:
    1. Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).
    2. Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).

5. Screening for Social Drivers of Health (SDoH) (NEW)
    - Measure Description: The Social Drivers of Health (SDoH) measure calculates the percentage of members 18 years and older screened for the following:
        1. Food insecurity
        2. Housing instability
        3. Transportation needs
        4. Utility difficulties
        5. Interpersonal safety

- There was a comment from the committee that youth and adolescent substance use and mental health is underrepresented in these measures. In the definitions, substance use treatment would apply to individuals aged 13 years and older, and mental health would apply to individuals aged 6 years and older.

- Another comment from the committee pointed out the similarities between performance measures 2 and 4, and suggestion that one of those could potentially be replaced to increase representation of youth in these measures.

- There was a question about what constitutes "follow up" for these measures. This information is specified in the specifications document and includes codes that would count as "follow-up." HCPF is happy to share this spec document if committee members would like to review it and learn more. The CMS standard under the 1115 waiver is follow up within 72 hours, which is obviously an even shorter timeframe than these BHIP performance measures.

6. Wrap Up and Next Steps

There was a recommendation/request to discuss the ACC Phase III care coordination model at a future BHIS meeting from the committee.

The next BHIS meeting will be November 6, 2024.

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