

# Behavioral Health Safety Net Framework

To create a comprehensive proposal to strengthen and expand the behavioral health safety net system in Colorado

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# Agenda

- Background on SB 19-222
- Foundations & Challenges
- Model Overview
- Model Details
- Special Populations
- Next Steps



# SB 19-222, Statutory Directives for the Safety Net

- The comprehensive safety net system proposal must, at a minimum:
  - Identify **what behavioral health services each community must have access to** in each region of the state;
  - **Develop a funding model** to ensure viability;
  - **Address behavioral health provider licensing and regulations, housing, transportation, workforce**, any other barriers; and
  - Set forth **criteria and processes, for when the needs of an individual referred to a safety net provider exceed the treatment capacity.**
- **The safety net system must:**
  - **Proactively engage hard-to-serve individuals** with adequate case management and care coordination throughout the care continuum;
  - **Utilize adequate networks for timely access to treatment**, including high-intensity behavioral health treatment and community treatment for children, youth, adults and other individuals;
  - Require **collaboration with all local law enforcement and counties** in the area
  - **Triage individuals who need alternative services** outside the scope of the safety net system;
  - Promote patient-centered care and cultural awareness;



# Building on Behavioral Health Foundations

*“The safety net system must have a network of behavioral health care providers, CDHS shall consider community mental health centers, managed service organizations, contractors for the statewide behavioral health crisis response system, and other behavioral health community providers as key elements in the safety net system.*”

- Accountable Care Collaborative & Managed Care
  - RAEs, care coordination, quality incentives, regional model
- MSOs, ASOs and Crisis System
- Comprehensive Mental Health Services (CMHCs)
- Family First Prevention Services Act
- Expanded SUD services and benefits
  - Medicaid residential
  - Grants: SIM, SOR/STR expanding recovery and MAT
  - Criminal Justice (co-responder, JBBS)
- Health information technology infrastructure, aligned data



**Basic BH Outpatient Provider (FFS)**

MH or SUD indiv., group and family therapy  
 Integrated primary care  
 Screening and assessment  
 Minimal regulations and reporting outside of clinical license

**Specialty & Enhanced Services Provider (FFS + VBP)**

MH or SUD or co-occurring populations, SDoH-focus  
 Specialty populations (ex: criminal justice/re-entry, homeless, IDD, TBI, medically complex, child welfare)  
 Community outreach, harm reduction, home-based care, SEPs  
 CCBs, co-responders  
 Enhanced benefit services covered (wrap around, care coordination, case management)  
 Providers include peers/non-clinical  
 Some reporting/quality req.

**Comprehensive Safety Net Care Providers (VBP)**

Serves SMI/SED populations  
 CMHC and CMHC-like  
 Must accept all populations, regardless of payer, history, or diagnosis  
 Enhanced benefit and value-based payment  
 High-intensity and community-based care, outpatient certs  
 Family-based care models and respite

**Acute Services and Safety Net Supports (FFS + VBP)**

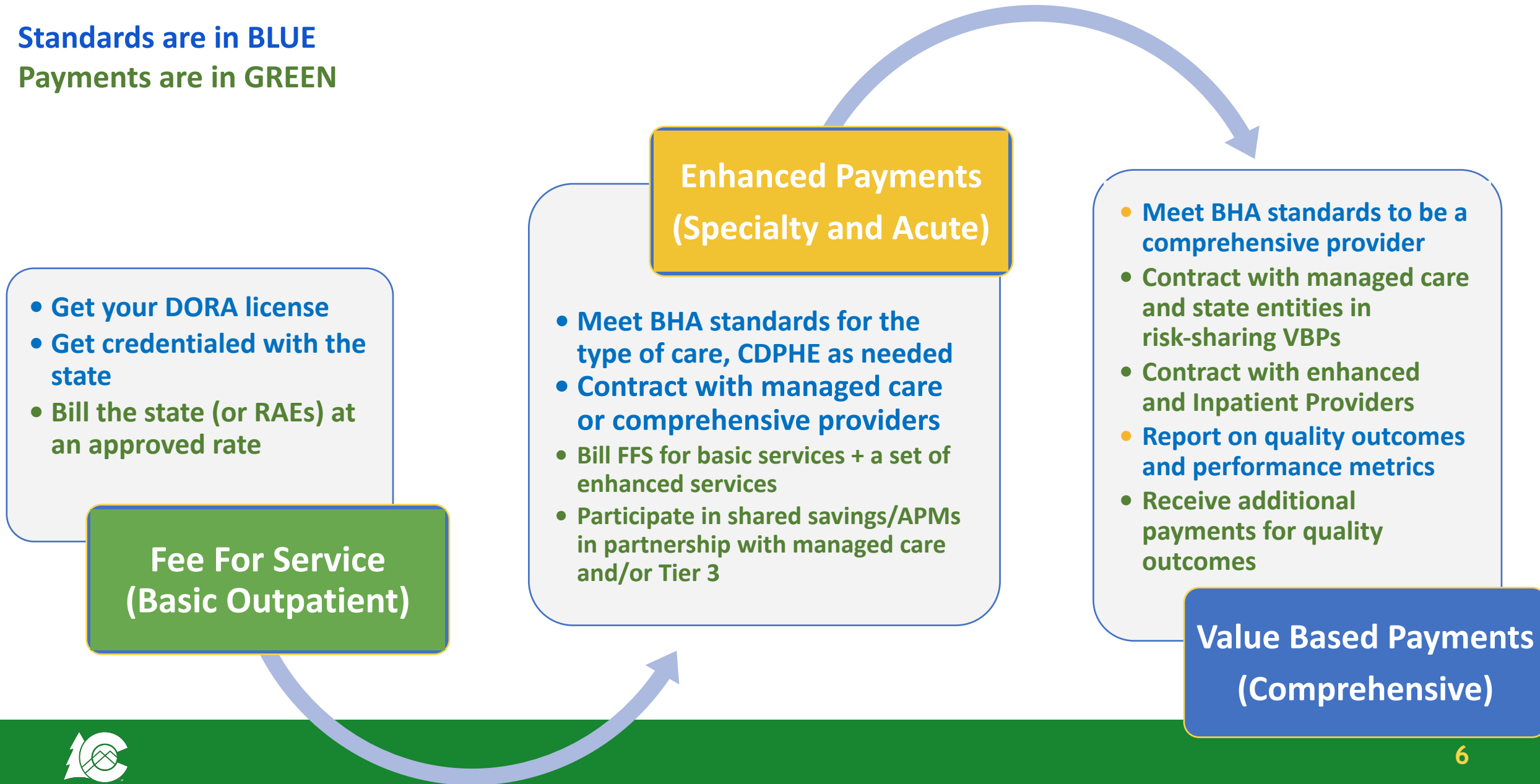
Crisis hotline and virtual crisis support  
 Consultation and technical assistance for specialty populations  
 Hospitals and Emergency Departments  
 MHIs, Freestanding Psych hospitals and 27-65 facilities  
 Walk-in services  
 Detox, CSUs and ATUs



# Standards and Payment Models

Standards are in BLUE

Payments are in GREEN



# What does this change?

- Guaranteed access for individuals with complex needs
- Expands “the middle”: services for and connection to community based services
- Potentially non-clinical SDoH providers can bill Medicaid/BHA
- Serving populations
  - Opportunity to grow “Centers of Excellence” for speciality populations or conditions, including co-occurring conditions, aggressive/personality disorders, IDD
  - Better integration of non-CMHC speciality providers
- Increases funding flexibility for whole-person care and social determinants of health
- Expands the SUD role of the comprehensive community behavioral health centers, while increasing accountability
- New network adequacy standards, accountability requirements for CMHCs and CMHC-like entities in exchange for more flexible, value-based payments



# What does this mean for the RAEs, Contracting, and Care Coordination?

- RAEs are managed care entities, meaning HCPF pays them to manage the Medicaid benefit regionally, with a set of expectations
- The standards outlined here would be integrated into the RAE contracts, including network adequacy standards.
- The BHA could use a managed care/care coordination model that could align with the BHA or it could provide a direct payment model
- This model allows for flexibility for case management, care coordination, and care navigation

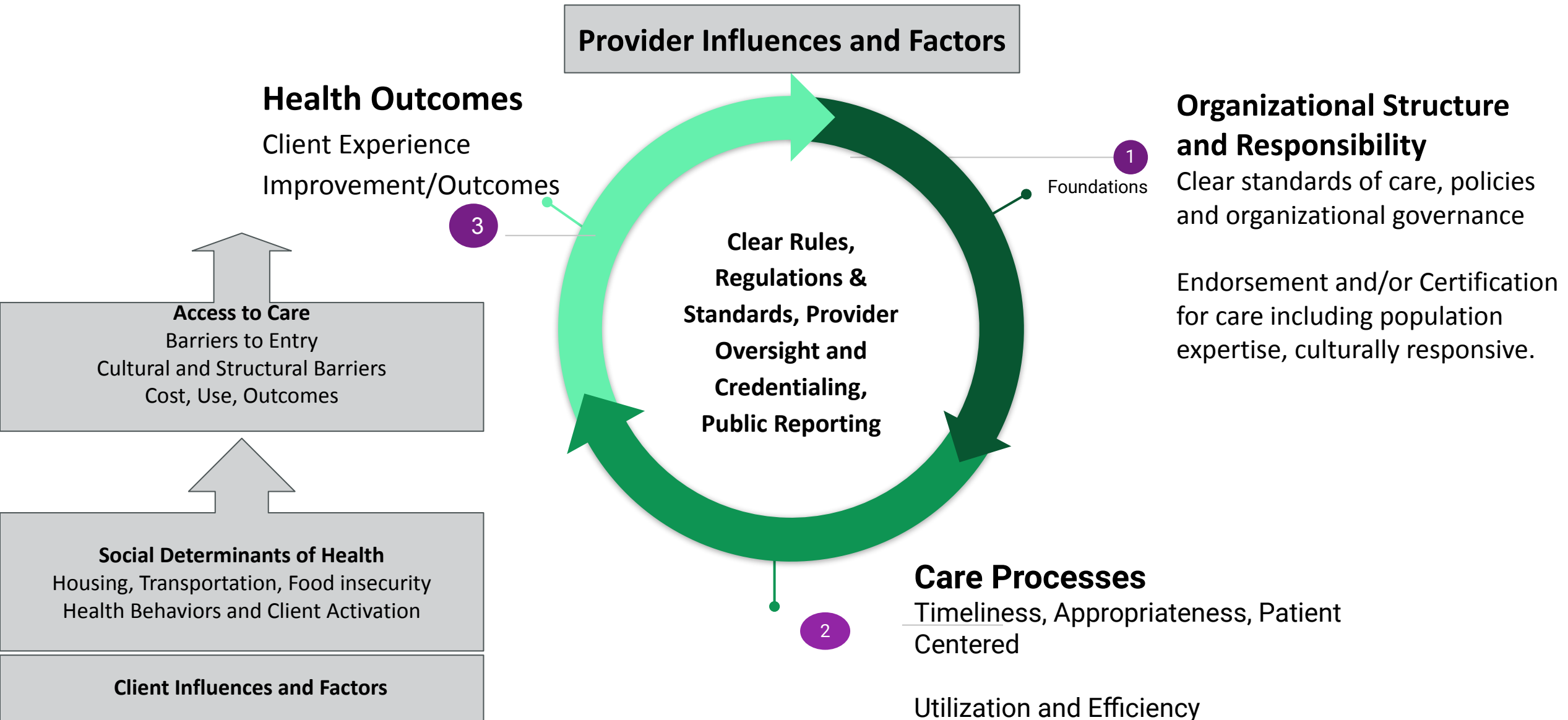




# Service Array & Standards Example: Children and Youth

	<b>Basic BH Outpatient Provider</b>	<b>Specialty &amp; Enhanced Services Provider</b>	<b>Comprehensive Safety Net Care Providers</b>	<b>Acute Services and Safety Net Supports</b>
<b>Child/Youth/Family Profile</b>	Low Complexity	Moderate Complexity	Complex Needs/High Acuity	Emergent and Urgent Acuity
<b>Service Array</b>	Primary Care Integrated services Basic Outpatient Services School Based Services	Child and Family specialization- Families First EBPs care coordination/wraparound Recovery services Alternative workforce	Respite service Intensive In Home services Alternative Interventions Substance Use Treatment (IOP) Treat individuals with ID/DD and MH/SUD	Psychiatric Consults Developmental Consults Child Crisis Services-paired responses for child welfare cases QRTP/ATU for youth
<b>Program Standards</b>	<ul style="list-style-type: none"> <li>● Integrated with medical home or school based clinic</li> <li>● Minimal state standards</li> <li>● Clinical license to practice independently</li> <li>● Individual and family therapy</li> <li>● Care Navigation and care coordination</li> <li>● Clinic or home based care</li> <li>● Telehealth</li> <li>● Family and developmental training</li> <li>● Basic TIC training</li> <li>● Parenting supports</li> </ul>	<ul style="list-style-type: none"> <li>● Mental Health Entity license/designation</li> <li>● EBP or Promising Practice</li> <li>● Case management and care coordination available</li> <li>● Linked to psychiatric consultation</li> <li>● Treatment Foster Homes</li> <li>● Family and developmental development training</li> <li>● Advanced TIC interventions</li> <li>● EBP/PPs: Child First, MST, FFT, PCIT, DBT, Play Therapy,</li> </ul>	<ul style="list-style-type: none"> <li>● Family and developmental training</li> <li>● Dedicated child/youth/family programming and interventions</li> <li>● Family system interventions</li> <li>● Advanced TIC interventions</li> <li>● EBPs: Child First, MST, FFT, PCIT, DBT,</li> </ul>	<ul style="list-style-type: none"> <li>● Implemented TIC model</li> </ul> <div style="border: 1px solid black; background-color: #ADD8E6; padding: 10px; margin-top: 10px;"> <ul style="list-style-type: none"> <li>● Individuals with Disabilities</li> <li>● Criminal Justice</li> <li>● BIPOC</li> <li>● Individuals Experiencing Homelessness</li> </ul> </div>

# Health Care Improvement Framework



<b>System Levers for Improved Oversight, Accountability and Transparency</b>		
<b>Levers</b>	<b>State Investments and Strategies</b>	
<b>Care Coordination Infrastructure</b>	<b>Care Navigation and single entry point for Access Standards for Care coordination and Navigation, Monitoring for Access and Adverse events</b>	
<b>Workforce Supports and Technical Assistance</b>	<b>Learning Management System Free Training for Workforce Publicly Available Resources/Tools Structural Supports for Technical Assistance</b>	<b>State and Regional Reporting</b>
<b>Health IT infrastructure</b>	<b>Improved Care Coordination, Standards for data collection, reduced fragmentation and measures sets Capacity Tracking and Registries</b>	<b>Patient and Client Outcomes</b>
<b>Standard tools and Risk</b>	<b>Population specific tools: CANS, LSI, ANSA, SMI/SED, ASAM, Health-Quality of Life</b>	<b>Provider Level Outcomes</b>
<b>Aligned and Transparent Standards</b>	<b>Population and Provider Specific Standards of Care, Quality improvement Focus Policies, Planning and Governance</b>	
<b>Analytics and Public Reporting</b>	<b>Public Reporting on Provider and Client Outcomes and Experience of Care</b>	
<b>Payment Models/Cost and Utilization</b>	<b>Cost of Care, Utilization, Payment linked to Outcomes, Value-based payments</b>	

# NEXT STEPS

- Whirlwind Tour (Camille and Cristen, April to mid-May)
  - Looking for feedback, support, gaps
- Review, share and give feedback!
  - <https://cdhs.colorado.gov/behavioral-health-reform>
  - [Read the draft proposal](#)
  - [Submit feedback on draft proposal by May 15, 2021](#)
- Model Due June 30, 2021, required to be implemented by 2024
  - Expect a budget and legislative agenda to support this in the next two cycles
  - ACC 3.0 will be designed by 2024, re-contracted by 2025
- Review the Needs Assessment
  - <https://cdhs.colorado.gov/2020-behavioral-health-needs>



# APPENDIX

# What is this model looking to solve?

- SB-222 is about providing better **Community-Based and High Intensity Behavioral Health Services to those who are at risk of being institutionalized**
- The framework provides better community based care that can help **prevent the need for institutionalization and create a better environment to maintain wellness and recovery**
  - Looking to decrease use of inpatient resources by those that can be served in the community, creating more inpatient capacity
- **Reduce fragmentation and reliance on primary vs secondary diagnostic criteria** that keep people from getting the care they need
- More **sustainable funding for essential safety net providers**, more funding for high-benefit low cost services that keep people healthy
- More **proactive and alternative support programs** for hard to serve individuals and populations that need specialty services



# What is not included in this model?

- Statutory definitions
  - Behavioral health = substance use disorders, serious psychological distress, suicidal ideation, and other mental health disorders.
  - An intellectual or developmental disability is insufficient to either justify or exclude a finding of a behavioral health disorder.
- Model will increase capacity for individuals with complex needs, but hard to place individuals that need long-term inpatient care will still face challenges.
  - Ex: Co-occurring SUD/MH needs AND organic brain injury or disorders due to TBI, overdose, dementia, or other cognitive conditions.
  - There will always be a need for inpatient psychiatric services.
- This will not solve for arrests and the criminalization of mental health and substance use disorder.



# High Intensity Behavioral Health Treatment Program

## **Safety Net Subcommittee Definition:**

High Intensity Behavioral Health Treatment (High Intensity Treatment) is a community-based, client and family centered approach that is specifically designed to engage adults and youth with severe mental health and/or substance use conditions who are at risk for or experiencing complicating problems such as physical health problems, developmental challenges and/or involvement in criminal and juvenile justice systems. This community-based approach to treatment provides individualized support to reduce risk for worsening problems, ensure continuity of care across the service system, and prevent adverse outcomes such as homelessness, criminal justice involvement and physical or behavioral health crisis.

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# Defining the safety net

- In this model, a safety net provider is any provider that serves the safety net population.
  - **The Colorado safety net population is any individual that is covered by public funds**
  - BHA will set standards and provide capacity building support for this network.
- By defining the providers, we can better tailor what is required for each region, better support mid-level providers, and strengthen community partnerships across local agencies.



# Relevant Models and Frameworks

- Socio-ecological Model
- Social Determinants of Health
- Intercept Model
- Public Health Pyramid & Hierarchy of Needs
- Systems of Care/ High-Fidelity Wrap-Around
- Evidence Based Practices for Children and for Adults
- Tiered model of public health prevention
- Health Equity Framework
- PRECEDE/PROCEED Model
- Framework for Alternative Payment Models
- The Standard Framework for Levels of Integrated Healthcare



	Basic	Enhanced	Comprehensive	Acute/Statewide Supports
<b>Program Standards</b>	Background check, RAE credentials,	Standards for serving specialty populations, criteria for ensuring outreach and engagement to populations, RAE credentials	Standards for serving complex and high acuity populations, ASAM level standards, 27-65 and involuntary holds (inpatient and outpatient), RAE credentials	Variable, both licensing and practice standards(ie 27-65/ASAM), <i>RAE credentials</i> , physical health system oversight for hospitals
<b>Payment Opportunity</b>	FFS- limited services.	Mixed FFS and Value-based payment models.  Expanded billable codes to include reimbursement for care coordination/case management to address SDOH, etc.	Value-based payments, provider at risk  Shared Savings- opportunity to invest in innovation/technology  Partial Capitation or full capitation	State-run services and state-managed vendors.  Tie to comprehensive provider and managed care payments.  Potential contract for shared savings
<b>Licensing Credentialing</b>	DORA license, Medicaid enrolled	Medicaid enrolled, RAE contracted as much as possible, BHA certified	Medicaid enrolled, RAE required contracted CDPHE Facility licensure (24-hour operations) BHA certified	Certified/Endorsed for specialized service, CDPHE BHE Facility licensure (24-hour operations), 27-65
<b>Data reporting</b>	Claims/BHA encounter data	Claims data, minimum quality reporting, specialty quality reporting as appropriate.  Calculate clinical quality Measures via reported data	Claims data plus comprehensive quality reporting  Payment tied to Outcomes	Claims data, minimum quality reporting, specialty quality reporting as appropriate.