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

Low Acuity/Low Complexity | Medium Acuity/Complexity | High Acuity/Complex Needs | Emergent/Urgent Acuity

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

- Get your DORA license
- Get credentialed with the state
- Bill the state (or RAEs) at an approved rate

Fee For Service (Basic Outpatient)

Enhanced Payments (Specialty and Acute)

- Meet BHA standards for the type of care, CDPHE as needed
- Contract with managed care or comprehensive providers
- Bill FFS for basic services + a set of enhanced services
- Participate in shared savings/APMs in partnership with managed care and/or Tier 3

- Meet BHA standards to be a comprehensive provider
- Contract with managed care and state entities in risk-sharing VBPs
- Contract with enhanced and Inpatient Providers
- Report on quality outcomes and performance metrics
- Receive additional payments for quality outcomes

Value Based Payments (Comprehensive)

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

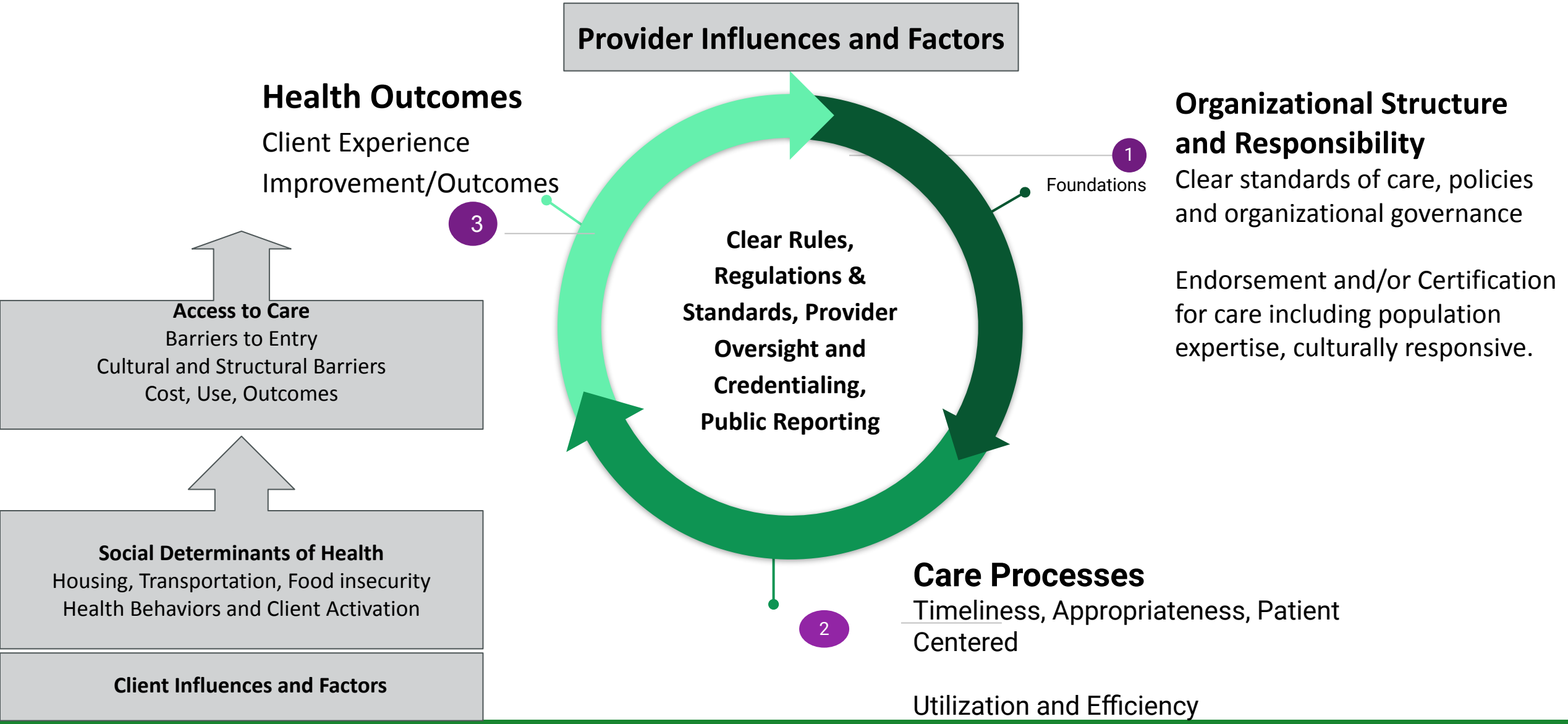
What does this mean for the RAEs, Contracting, and Care Coordination?

- 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

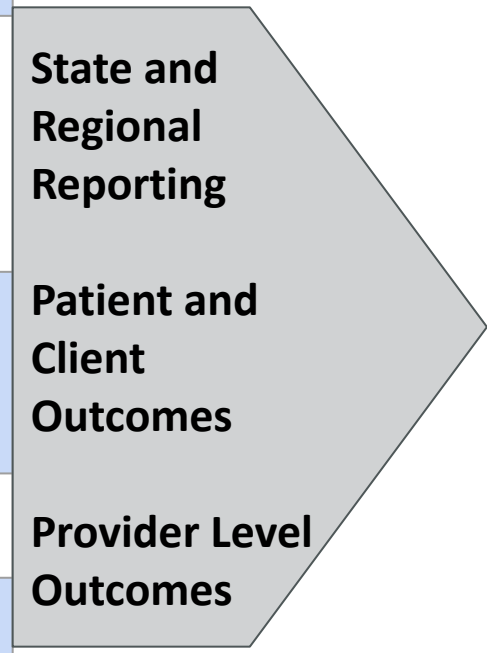
	Basic BH Outpatient Provider	Specialty & Enhanced Services Provider	Comprehensive Safety Net Care Providers	Acute Services and Safety Net Supports
Child/Youth/ Family Profile	Low Complexity	Moderate Complexity	Complex Needs/High Acuity	Emergent and Urgent Acuity
Service Array	Primary Care Integrated 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
Program Standards	• Integrated with medical home or school based clinic • Minimal state standards • Clinical license to practice independently • Individual and family therapy • Care Navigation and care coordination • Clinic or home based care • Telehealth • Family and developmental training • Basic TIC training • Parenting supports	• Mental Health Entity license/designation • EBP or Promising Practice • Case management and care coordination available • Linked to psychiatric consultation • Treatment Foster Homes • Family and developmental development training • Advanced TIC interventions • EBP/PPs: Child First, MST, FFT, PCIT, DBT, Play Therapy,	• Family and developmental training • Dedicated child/youth/family programming and interventions • Family system interventions • Advanced TIC interventions • EBPs: Child First, MST, FFT, PCIT, DBT,	• Implemented TIC model • Individuals with Disabilities • Criminal Justice • BIPOC • Individuals Experiencing Homelessness

Health Care Improvement Framework



System Levers for Improved Oversight, Accountability and Transparency

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



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

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.

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
Program Standards	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), *RAE credentials*, physical health system oversight for hospitals
Payment Opportunity	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
Licensing Credentialing	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
Data reporting	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.