Designing Alternative Payment Methodologies with Value Based Payment for Behavioral Health Comprehensive Safety Net Providers

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COLORADO
Department of Health Care Policy & Financing

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Introduction

The following provides an overview of the process for forming an alternative payment methodology (APMs) with a value-based payment (VBP) for future designated comprehensive safety net providers in Colorado.

Alternative Payment Models are ways of paying providers for the services they render using methodologies other than fee-for-service; moving away from paying for individual services as they are rendered allows providers the flexibility to focus on what a patient needs instead of what is going to result in a billable service. Some types of APMs have the added advantage of supporting provider financial stability by providing more consistent revenue streams. Examples of APMs include paying for bundles of services, or paying for all care a patient needs on a periodic basis (e.g., per-member-per-month).

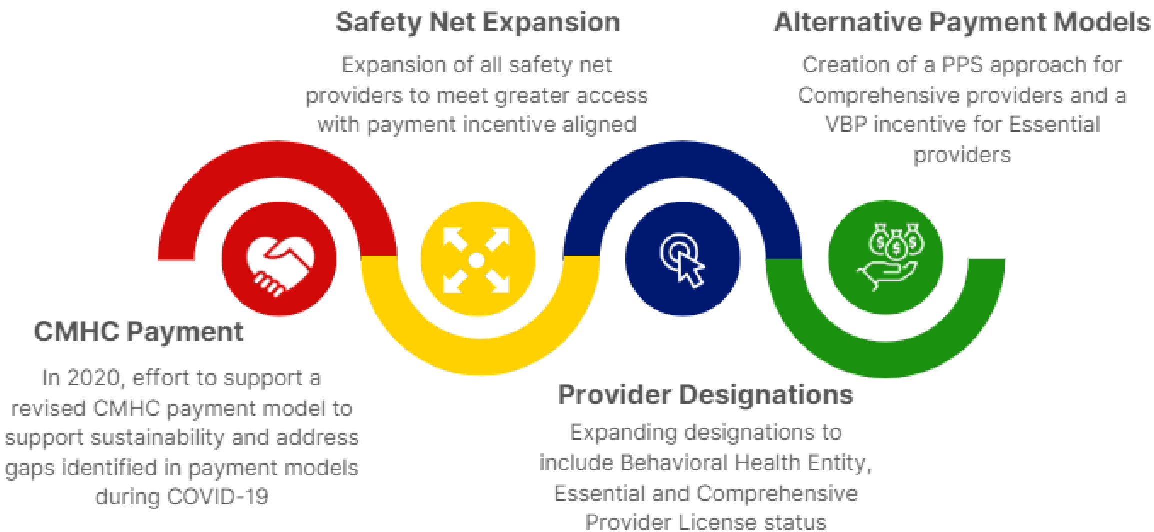
Value-based payments are payments that are tied to outcomes or quality instead of to the actual services rendered. For example, providers might earn an incentive payment when their patient panel uses the emergency room less than it did in the past. The focus is on the patient outcomes and not the services the provider rendered to achieve the outcome. When APMs have a VBP component, it becomes a powerful tool to support access to care, quality and innovation, and provider financial sustainability.

In 2019, the Senate passed the bill "Individuals at risk for Institutionalization" (SB-19-222) which required the Department to work collaboratively with managed care entities (such as the Regional Accountable Entities, RAEs) to create incentives for behavioral health providers to work with individuals with Medicaid and who have complex needs. Since 2021, the Department has been working with stakeholders including managed care entities and provider organizations (among others) to develop an alternative payment model for Community Mental Health Centers (CMHC)–now expanded for the new provider designation of Comprehensive safety net providers to increase provider sustainability and financial flexibility to result in improved outcomes for the safety net.

As part of the Comprehensive Plan to Expand the Safety Net (as required from SB-19-222), the Department is working with the Behavioral Health Administration (BHA) to align payment incentives with the proposed safety net provider expansion including the Comprehensive Safety Net Providers and the Essential Safety Net Providers.[1] The BHA is responsible for licensure of providers and has the authority to determine what providers will be approved as Comprehensive and Essential safety net providers. The following payment methodology discussion is designed for the designation of Comprehensive Providers.

[1] The BHA is in the process of a rule revision and approval process for new licensure types including the comprehensive and essential safety net providers which will not be finalized until end of calendar year 2023. Current definitions of the provider licensure types can be reviewed here.

Figure 1. Evolution of Focus of Payment Reform



Comprehensive Provider Payment as a Prospective Payment System

The Prospective Payment System (PPS) model was selected as the foundational APM for comprehensive behavioral health providers. The general underlying concept of a PPS model is that a provider is paid a standard rate for any qualifying encounter with a patient, independent of what specific services were rendered. There are numerous ways to design a PPS model, but the underlying concept maintains the balance of tying payment to improved access and therefore higher rates of utilization of care while creating distance from the standard fee-for-service model (payment for each service).

The PPS model provides greater financial flexibility for providers than traditional fee-for-service procedure code billing but remains tied to demonstrated improved access for services (or utilization). The challenges witnessed in the COVID pandemic as well as increasing behavioral health demand have highlighted the importance of creating payment models within behavioral health that provide financial sustainability and flexibility to deliver more effective and efficient care balanced with improved accountability for outcomes and access.

The PPS model is not a significant incentive or change in payment for most providers who will be approved as Comprehensive safety net providers. In many cases, these providers are already paid based on the costs of delivering care, however it will offer a more sustainable funding model which will allow

providers to be more strategic and purposeful in efforts to expand services, develop team based or other forms of care and improve care for specific populations.

Prospective payment systems have been used successfully to reimburse community health centers (CHCs). At a national level, the State Demonstrations for Certified Community Behavioral Health Clinics (CCBHCs) use a PPS model that based on the costs of providing services, as well as costs related to operating efficiency and improvement, like technology.

The design process focused on balancing the benefits of a PPS approach with mitigating the inherent financial and access to care risks. Increased sustainability and financial flexibility provide opportunity for less restrictive and even innovative service delivery design, improved workforce flexibility, long-term sustainability to improve strategic growth and improvements, and improved efficiency. However, the financial flexibility can introduce perverse incentives for providers resulting in providers changing clinical care to general encounters (increasing volume of low-value services to generate encounters), providing care that is less than what an individual needs by delivering a less expensive service (underserving patients through lower-cost services), or serving less complex patient populations. The design process needs to account for these potentials and manage the risks through effective accountability and monitoring for quality and access.

Other Important Design Considerations:

- Model design needs to **accommodate for provider variation** (work for smaller, rural and frontier (critical but low volume providers)
- Model design needs to be cognizant of **administrative burden of accountability measures** and related costs
- Model design needs to **address current challenges in equity such as service delivery outside of member regions.**
- Model design will **ideally reduce administrative complexity**

The PPS model supports the movement towards improved quality and accountability of providers by promoting greater access and sustainability; however, it is important to note that unlike a value-based payment, the PPS payment is not dependent upon meeting specific quality measures. As the BHA and HCPF work together to create a performance monitoring program for behavioral health services, the providers receiving a PPS will be expected to meet specific quality outcomes related to improved access, enhanced service delivery and there may be specific expectations of the kinds of outcomes Comprehensive providers can achieve. These expectations will serve as the basis for a VBP element that complements the PPS model. Additionally, performance standards could serve as a basis for ongoing eligibility to participate in the PPS model.

Stakeholder Engagement

Working Group

Central to the design of the APM with a VBP was stakeholder feedback on both elements of the design—the payment model as well as the quality and accountability approach. From March to July of 2022, the Department convened a broad group of stakeholders who met twice a month to review development of the APM, provide feedback on design components, inform and suggest alternative perspectives to the

Department. Cross sector stakeholders represented State agencies (HCPF and Behavioral Health Administration), providers (Community Mental Health Centers, substance use providers and safety net providers who could potentially become comprehensive safety net providers), Regional Accountable Entities (RAEs), County Commissioners, mental health and disability advocates, provider associations including the peer run provider association, and independent consultants.

The working group was divided into payment and quality sub-committees to allow for specific feedback on both elements of the model design while sharing input in each session to ensure there was alignment of payment and quality components. The following are some of the topics reviewed and informed by stakeholders:

Table 1. Working Group Focus Areas

Payment Model Components
Duration of Service to inform Encounter Rate based -- Prospective Payment Model (PPS) encounter rate based on a daily rate, weekly rate, or a monthly rate.
Scope of services—clearly defining the set of specific services that are included in the encounter rate and informing risks or challenges with including or excluding specific services.
Rate Cohorts—Considering rates that vary by population cohorts (e.g., children versus adults).
Risk management—Discussing how to reduce risk of increased financial flexibility leading to reduced services.
Inform a retrospective analysis as a learning phase.
Input on further analysis needed of three PPS stratification options: • Separate PPS rates for each managed care rating cohort • Separate PPS rates for four tiers of service categories • No stratification
Quality Model Components
Review national quality measures—Review of national BH quality sets including Centers for Medicare and Medicaid Services (CMS) behavioral health core set measures, Substance Abuse Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) quality measures, and other state examples of quality measures for APMs.
Create balance of CMS core set and new outcome measures—The Department is required to report on the CMS core set which is a significant development process. Balancing resources for meeting the federal requirement with the desire to reach additional access and quality outcome measures to monitor BH.
Focus on measures of access to care –reviewed National Frameworks for Access to Care and metrics as well as local access measures used across RAEs.
Build quality accountability over time—Leveraging CMS core set as the base for an initial phase while adding increased specific access and quality outcomes over time. **Informed core principles for setting quality in BH including:** • Ensure some measures are meaningful to general public • Use an equity lens; manage unintended consequences to minimize harm • Align payment and expectations • Improve and build objectivity into reporting • Reduce administrative burden for providers • Leverage national measures when possible, for benchmarking and to align with national standards

- Select measures that counter perverse incentives
- Need to be achievable and reasonable, payment needs to be aligned for reporting requirements
- Not everything needs to have a payment tied to it, can tie payment to limited set of measures and expand over time (progressive)
- Bundle measures

Build expectation for stratification of data and use of administrative claims analysis for outcomes—Considering data analysis by sub-population and by acuity level as well as building reports from existing claims data that could monitor quality and performance and provide a check on some of the APM perverse incentives.

Additional Stakeholder Engagement

Separate from the working group meetings, there were additional opportunities for stakeholder engagement.

- A facilitated **convening with all the RAEs** to review the working group progress, feedback on model design and an update about how the Department planned to test potential model components. RAEs were given an opportunity to share additional thoughts and feedback and ask questions.
- **A provider convening** to raise awareness among all behavioral health providers about the Department's planned movement to APMs and VBP and the planned evolution starting with comprehensive providers and moving ultimately to essential safety net providers. This session was geared more towards connecting safety net licensure reform efforts with payment reform and was an introductory session for many providers about the concepts of VBP.
- **Small focus group meetings** (3-5 individual groups) with provider organizations to understand provider readiness for APMs including experience with VBPs, thoughts on quality measures, potential barriers to implementation and infrastructure needs. The focus groups were organized as following:
    - Potential comprehensive safety net providers (CMHCs and larger providers)
        - Smaller and rural potential comprehensive safety net providers
    - Substance use providers who potentially could be comprehensive or essential safety net providers.
    - Independent providers.

Provider Feedback:

- Generally, minimal experience with VBPs
- Concerns about reasonable expectation on measures that can be impacted by providers. For example, influencing emergency department (ED) use is meaningful but challenging when ED data is not shared with providers.
- Overall need for bidirectional and timely data for providers to reach alternative payment goals.
- Consider the volume of providers and then their impact on long-term measures such as acute care use.
- Thoughtful selection of measures with attention to national standards and considering reduction of measures as other are added to address administrative burden.

State Agency Quality Visioning

Following the working group sessions, the Department and the Behavioral Health Administration (BHA) met for seven facilitated discussions on a shared vision for a behavioral health quality framework. These were initial conversations that will continue as part of the BHA's development of a Performance Management Plan for 2024 in collaboration with the Department. This plan will be the foundation for how the agencies work together to move behavioral health services towards improved access, changes in clinical innovation and ultimately continuous quality improvement with enhanced benchmarking over time. The group discussed components of an ultimate and long-term shared vision for a behavioral health safety net quality framework including a clear understanding of entities and their specific roles regarding ensuring quality of service delivery and outcomes, a clear set of objectives for the program, a vision for how to hold providers and intermediaries accountable for meeting objectives, as well as the supportive infrastructure required by the state to facilitate provider and intermediary success. The group also focused on the short-term goal of the quality plan for the initial APM in 2024 including meaningful provider level measures that align with state-level outcomes of interest such as suicide, overdose, and whole person care.

The meetings focused on solving for a number of considerations raised throughout the payment design process and through stakeholder engagement including:

- Reach vision of safety net reform and federal requirements for state agencies
  - Balancing resource intensive development of federally required CMS core set with desire to build additional quality measures and analysis.
  - Improve quality and accountability for behavioral health and reach genuine outcome measurement for the safety net.
- Review stakeholder feedback on implementation of payment reform
  - Improving accountability for outcomes while providing adequate incentive for provider engagement.
  - Selecting the right measures to align with state priorities on outcomes.
  - Demonstrate improvement on improving access to care and meeting priority population needs in the state.
- Select measures that providers can impact (high and low volume providers)
  - Leverage quality and a full framework to use multiple levers of accountability to reduce unintended consequences introduced in an APM.

Learning Phase and Subsequent Model Design

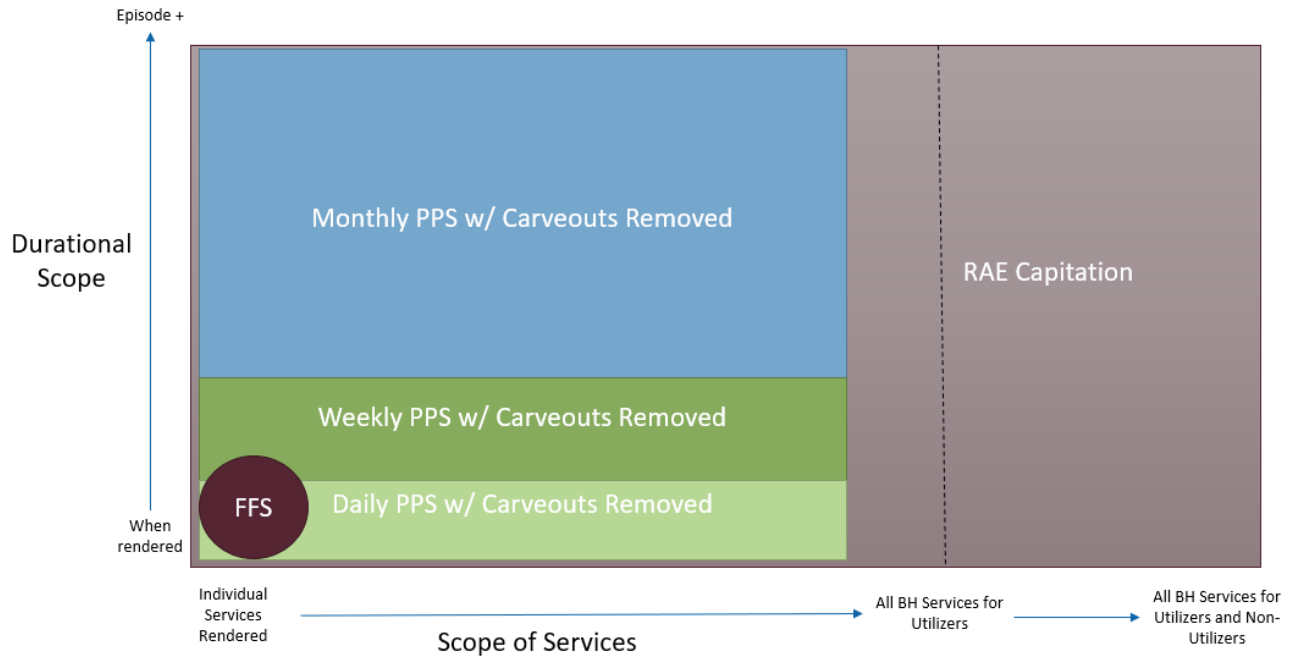
Internal Department design work as well as stakeholder engagement led to a trial phase to try to use quantitative data to inform final decisions. To explore the rate stratification options for the PPS, the Department's actuary conducted a retrospective analysis applying various payment approaches to inform decisions. The goal of the learning phase was to provide input on how the model, if applied, would impact payment levels; however, no payment was changed or impacted as a result. Three versions of the encounter-based model (all with provider-specific rates) were applied.

1. Stratification by populations: Daily encounter rate for each managed care cohort
2. Stratification by services: Daily encounter rate for four categories of service
   a. Level 1 Community Supportive Services
   a. Level 2 Psychotherapy Services
   b. Level 3 Evaluation and Management Services

c. Level 4- Intensive Outpatient Services

3. No stratification—Single daily/monthly encounter rate

Figure 2. Learning Phase: Retrospective Analysis of Alternative Payment Structure—Scope of Services and Duration Analysis



The findings of the retrospective analysis did not indicate enough consistent variation to warrant stratifying the PPS rates. Following review of the findings, the Department decided on a single PPS rate with carveouts for select services (likely high acuity services) and utilization management strategies in addition the encounter rate structure such as quality incentives, program integrity oversight, and other regulatory mechanisms to monitor quality and mitigate perverse incentives.

In addition to a PPS rate, a VBP purchasing element will be paired with the model, to create incentives and financing to support improved quality and to assist in mitigating perverse financial incentives inherent in the PPS structure. The Department will be requiring RAEs to engage in value-based purchasing arrangements with comprehensive providers under a standardized framework, but the RAEs will have some flexibility in the specific risk parameters applied (amount of incentives and whether there would be penalties, not just upside risk).

While the Department will monitor a broader set of measures (see Appendix B) to monitor the delivery system and ensure payment models are promoting quality and access, the Department determined the following metrics would be the *initial* set of quality measures for the PPS program that would be explicitly tied to payment through value-based purchasing:

Statewide Metrics for the Value-Based Payment:
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (CCBHC measure)
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (CCBHC measure)
Depression Remission at Twelve Months (CCBHC measure)
Time to Services (I-SERV; CCBHC measure)

Follow-Up After Hospitalization for Mental illness: Ages 6+ (NQF 0576)
Follow-Up After Emergency Department Visit for Mental illness: Ages 6+ (NQF 3489)

The model design continues to be enhanced with detail and implementation components. Based on current status, the key roles of the partners would include:

BHA: The BHA will be responsible for licensure of behavioral health safety net providers, approval of providers as Comprehensive safety net providers and monitoring of the providers to meet regulatory expectations and to be in good standing.

HCPF: The Department is responsible for determining what services will be carved out of the encounter rate, setting the PPS rate, establishing cost based rates annually, finalizing the quality measures used to inform payment and adapting the methdology including measures over time. The Department will also create monitoring metrics for the RAEs and report on the implementation and outcomes of the program to the public and legislature. Lastly, the Department will serve as payer for members utilizing behavioral health services, but are not assigned to a managed care plan; payments will be made under the same PPS methodology as used in managed care.

RAEs: Process and pay PPS encounters to providers as appropriate, negotiate with providers on payment policy for services not included in the PPS, and create a structure of risk for the value-based payment outside of the PPS. Risk may be tied to performance improvement or quality measures tracked by each RAE. The RAEs will also be responsible for monitoring program integrity including analyze the quality metrics.

Providers: Service delivery, cost reporting and quality measure reporting. Providers will negotiate with the RAEs on rates for services carved out of the PPS and compliance with additional quality measure or monitoring requirements (regulatory audits, performance review, etc.).

Critical Planning Consideration- Provider Licensure Transition

The Department's efforts to develop alternative payment methodologies with value-based purchasing are predicated on an understanding of the current delivery system and known changes on the horizon such as changes to provider licensure requirements. The future state of the delivery system is still being developed and it is unclear which and how many providers will ultimately be designated as Comprehensive and Essential providers. This creates challenges for planning and implementation as changes in underlying assumptions (e.g., will there even be comprehensive providers) could require changes in the payment policies developed to date. Successful implementation will require the Department to actively partner with the Behavioral Health Administration to monitor system developments and respond accordingly in real time.

Implementation Timelines and Key Milestones

Background and Progress To-date

Following the aforementioned external stakeholder engagement process that was used to inform the general payment model framework, the Department began an extensive internal stakeholder engagement process to develop the comprehensive policy design and high-level implementation strategy. Department staff utilized the Implementation Domain Planning Tool in Appendix A to inform conversations with subject matter experts from the multiple areas of the Department that have a role in

implementing the PPS model. The tool identifies the key policy questions for each implementation domain, provides context and considerations to inform the decision-making process, and solicits implementation milestones for implementation decisions once they are made. To-date, the Department has nearly completed the policy development across all implementation domains and has engaged the internal project management office to support the project implementation. Appendix B contains a listing of the granular policy decisions across implementation domains.

Primary Implementation Work Streams

The following sections summarize the primary work streams to implement the comprehensive provider PPS payment model. High-level implementation timeline considerations are noted where applicable but will require refinement with subject matter expert input via the work breakdown structure development process. Table 2 below illustrates the active periods for each body of work through 2024.

Policy Refinement and Finalization

Subject matter experts reviewed and provided feedback regarding the granular outstanding policies found in Appendix A and summarized in Appendix B. The Department will need to ensure the policies recommended by the subject matter experts are validated and approved. **This is a mission critical implementation step that should occur immediately as project implementation will be impacted by changes to policy decisions at this stage.**

When finalizing polices, context provided in Appendix A can serve as a useful reference.

Work Breakdown Structure Development

As the Department is nearing completion of the policy refinement process, subject matter experts will need to work with project management staff to identify all required steps to implement the policies from each implementation domains and document milestones and timelines in a project management work breakdown structure. **This is a mission critical implementation step that should occur immediately.**

Note that Appendix A contains initial thoughts on milestones and general timeline considerations that may be helpful for the development of the work breakdown structure.

Cost Reporting Guidance Activities

The PPS rate model is predicated on provider-specific cost reporting. While the Department currently utilizes cost reports from CMHCs for managed care rate development and fee-schedule development for fee-for-service, the change in underlying payment structure will require modifications to the current process. Additionally, the cohort of comprehensive providers is unknown. Processes to set rates for providers that do not currently produce cost reports must be implemented. The Department has engaged a contractor to assist with process development related to the cost report changes and policies.

The implementation plan assumes that updated cost reporting guidance and related pricing policies will be fully completed by 12/31/2023 as providers will need sufficient notice to update accounting practices for future cycles. Rate subject matter experts will need to coordinate with the Department's actuary and cost reporting contractor to identify appropriate rate setting strategies for FY 2024-25 rates.

Rate Setting Activities

The rate setting process for PPS rates relies on inputs from multiple other processes. Additionally, the PPS rate setting process is an integral input in the managed care rate setting process. PPS rates would ideally be developed early in Q1 of 2024. Given likely information gaps, the Department should include

contingency planning for alternative pricing strategies as part of the work breakdown structure development process.

Authority Activities

Multiple authority related activities must occur prior to implementation of the PPS rates.

A **State Plan Amendment** (SPA) must be submitted by the last day of the quarter that the PPS rates are effective (Sept 30, 2024) for fee-for-service payments. Given the significant change in payment policy, the Department should consider submitting well in advance of this deadline to mitigate the risk of CMS rejecting the SPA and having to adjust provider payments; consequently, the high-level implementation plan assumes SPA-related activities will be complete by 6/30/2024, in advance of the effective date.

State rules must be modified to account for the change in payment policy. Rules must be approved prior implementation.

State statute requires the Department to notify the Legislature in advance of implementing payment reforms. Because the Department intends to implement the policy in fee-for-service, the Department must satisfy payment reform notification requirements. While there are two opportunities to do so, the implementation plan assumes the Department would notify the Legislature in November as part of any resource request to support the program.

Directed payment authority is required for the Department to mandate that Regional Accountable Entities pay comprehensive providers using the PPS methodology (as a minimum payment level). The directed payment submission would be due on March 31, 2024.

Budgetary authority for any resources required to implement the PPS methodology is required if not budget neutral. The Department would request budgetary authority through the Executive and Legislature budget processes. That process has already begun and continues through signing of the appropriations bill in Q2 of 2024.

Oversight Activities

Oversight activities include a monitoring strategy to ensure the PPS is not being abused and that the RAEs are actively managing the model.   Department staff have coordinated to outline a monitoring strategy through Program Integrity. RAE contracts will need to be updated to reflect new accountabilities for oversight specific to the model and data reports will need to be developed for independent Program Integrity monitoring. The implementation plan assumes both activities will be complete by Q2 of 2024.

Quality Strategy Implementation Activities

HCPF and BHA are continuing to work together to inform the BHA's Behavioral Health Performance Management Plan for safety net providers which will provide the foundation for behavioral health quality that will inform HCPF's value-based payments and will inform expectations and accountability for Comprehensive safety net providers. . Together, they will set a vision for quality and accountability gained through various avenues (not merely metric reporting). State agency goals (HCPF and BHA) along with stakeholders are aligned in wanting quality measurement to shift from process measures to meaningful outcomes. Specifically, getting to outcomes that monitor or account for the risk of perverse

incentives in alternative payment (e.g., a PPS rate). In addition, however, is working to ensure that the quality framework takes into account key provider considerations such as volume and making sure that the outcomes that can be attributed to and impacted by providers. Other components that will need additional work as the quality framework evolves include timely data sharing with providers and determining what outcomes come from what is already collected (e.g., administrative claims analysis, penetration by risk tier or episode of care grouping). These activities will continue through 2024.

Systems Changes

System changes will be required to pay under a PPS methodology in fee-for-service. While infrastructure exists for making encounter payments to Federally Qualified Health Centers, implementing this functionality for comprehensive providers will take time and will compete for resources with other Interchange projects. **Initiating systems change processes and validating prioritization to ensure completion prior to 7/1/2024 is a mission critical item that should occur immediately.**

In addition to systems changes to pay through fee-for-service, modification to the managed care encounter data intake process may be required. Department staff should assess this need and document required process steps in the work breakdown structure.

Stakeholder Engagement Activities

Implementation of a PPS model is a complex endeavor that will significantly impact RAEs and providers. The implementation will require extensive, ongoing stakeholder engagement leading up to, during, and after implementation.

Table 2: Workstream Activities Timeline

Primary Work Streams	2023				2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Policy Refinement								
Work Breakdown Structure Development								
Cost Reporting Guidance Activities								
Rate Setting								
Authority Activities								
Oversight Activities								
Quality Strategy Implementation Activities								
Systems Changes								
Stakeholder Engagement Activities								

Upcoming Essential Provider Policy Development and Safety Net Provider Supports

The next phase of APM and VBP for behavioral health safety net providers includes development of a general VBP framework for the Essential Provider designation. The Department is also launching a year of extensive safety net provider training and technical assistance to support providers in readiness for implementation of safety net requirements and APM with a VBP. The training and technical assistance will be tailored to cohorts of providers based on readiness and will focus on core elements of behavioral health reform including:

- Readiness for new provider designations (comprehensive and essential safety net provider status).
- Understanding contracting and particularly the drafted Universal Contract Provisions created by the BHA and HCPF in collaboration with other state agencies.
- Cost reporting and other activities needed to be effective in moving to a PPS APM approach.
- Understanding quality and accountability requirements; and other items identified by providers to support the transition.

Appendix A

Implementation Domains Development Tool

February 15, 2023

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Implementation Domains Development Tool

Introduction

This document was provided to the Department in February 2023. The document outlines all of the major operational domains, critical decision points, key considerations that should inform the decision points, and a basic timeline framework. This framework was used to support both internal and external decision making and project management development necessary to implement the PPS model. As of the submission of this report, the Department has completed the review preliminary decision making on all major decision points (see Appendix B). The Department has not yet completed the more granular, subject matter expert-informed process mapping that could be used to develop a detailed project plan.

Overview

The following sections contain a detailed assessment of outstanding decision points and operational strategy for major payment reform implementation domains. The Department will need to coordinate with internal and external parties to refine the strategy based on resource and process-related timing constraints. The following 20 domains are included in the analysis:

- Comprehensive Provider Prospective Payment System Model
- Comprehensive Provider Prospective Payment System Pricing
- Cost Report Changes and Audit Process
- Essential Provider Value-based Purchasing Structure
- Quality Measurement Strategy
- Financing for PPS and Essential Provider Models
- Billing Mechanisms and Standards
- Provider-level Data Exchange
- Managed Care Data Intake and Encounter Adjudication
- Provider Technical Assistance
- Communication Strategy
- Prospective Payment System Rate Setting
- Managed Care Rate Setting
- Budgetary Authority
- Legislative Authority
- Federal Authority
- Rules and Regulations
- Regulatory Oversight/Program Integrity
- Certified Community Behavioral Health Clinic intersection planning
- Project Management and Readiness Review

Implementation Domains

Prospective Payment System Model

The Prospective Payment System (PPS) model was selected by stakeholders to move forward as the foundational model for comprehensive behavioral health providers. Prospective payment systems have been successfully used to reimburse community health centers (CHCs) and Certified Community Behavioral Health Clinics (CCBHCs) based on the cost of services. Under this form of PPS, clinics receive a payment for each day or month based on delivery of services.

The model provides more flexibility than traditional fee-for-service procedure code billing but remains tied to utilization. Stakeholders acknowledged the necessity of financial flexibility but reinforced the need to counter the financial flexibility provided with accountability for outcomes and access. This accountability can be incorporated in the model directly by using rate stratification strategies and/or financial incentives, through the licensure requirements, or through other regulatory oversight and contracting mechanisms.

To explore the rate stratification options, the Department's actuary conducted a retrospective analysis of several different models proposed by stakeholders. The analysis did not show significant variation across the proposed model stratifications; consequently, the Department's preliminary decision was to move forward with a daily PPS with no service or population stratification.

A value-based purchasing element is meant to be included with the model, in addition to PPS payments, to create incentives and financing to support improved quality and to assist in mitigating perverse financial incentives[2] inherent in the PPS structure. The initial proposal was to have up to 3% in bonus payments made from the Behavioral Health Incentive Program funding and up to 3% at risk for performance that would be implemented as a reduction to future year PPS rates.

Key Outstanding Program, Policy, or Operational Questions

- What stratification/tiering will be included in the PPS design?
- Which rendering provider types (peer, licensed, etc.) can trigger an encounter?
- Which services will be carved out of the PPS rate for comprehensive providers?
- How is risk structured for the quality incentive portion of the model?
    - Will the risk structure change over time (e.g., no downside risk initially)?
- What is the rate setting cycle and related policy?

Decision-making and Timing Considerations

PPS Structure

- If oversight mechanisms cannot be put in place to ensure the perverse incentives are adequately mitigated, the PPS must mitigate the perverse incentives through tiering and/or other core model design elements.
- While the actuary's model analysis did show the type of variation needed to justify the proposed model stratifications (cohort or service tiers), the results are retrospective and likely do not

[2] Since the same daily encounter rate is paid for complex or simple cases, PPS methods have some potential for discouraging service for higher-needs patients.

reflect utilization and cost patterns that would form should the Department proceed with a tiered model.

Quality Incentive Risk Structure

- Because of recent and ongoing changes in licensure, data infrastructure, payment models, and cost reporting, providers are not well positioned to take downside risk in the first year(s); especially providers being added to alternative payment models for the first time.
- Paying below costs for poor performance could result in further reduced performance.
- The financing mechanism for the payments could limit the possible payment model design.

Major Activities and Timing

Activity	Timing
Explore alternative stratification internally at HCPF	Early February/March
Develop rate setting cycle proposal	
Bring two proposals back to RAEs with relevant oversight mechanisms for each model including draft carveout and triggers and quality incentive structure	Late March
Bring RAE refined proposal to providers and other stakeholders	Early April
Final revisions to model based on stakeholder feedback	Late April

Prospective Payment System Pricing

The current cost based relative value unit (RVU) pricing methodology used to price some providers' utilization is complex and creates perverse incentives to focus on rendering high RVU services, which may or not be high value for patients in need. Transition to an encounter-based model will require changes to the cost reporting process and represents a significant opportunity to reduce operational complexity and administrative costs inherent in the current process.

Key Outstanding Program, Policy, or Operational Questions

- How will the costs be used in development of the PPS rate?
- How will the state implement the transition from current cost reporting methodologies to one that supports the PPS rate development?
- How will CMHCs that are not licensed as comprehensive providers get paid?
- How will PPS rates be set for providers that have not previously completed cost reports (providers that are licensed as comprehensive providers, but not subject to CMHC pricing in the past)?
- How will the PPS rate be used when final licensure as an essential or comprehensive provider may not be aligned with the start of the payment program (will there be a presumptive status)?
- How frequently will cost-based rates be set/rebased?
- How will the trend from the last cost report period to the projection period be accommodated?

Decision-making and Timing Considerations

- Providers have indicated that operating under two cost-reporting frameworks simultaneously is not administratively viable.

- Providers and RAEs have indicated a strong desire to move away from the RVU cost-reporting structure.
- For a provider to transition to a new accounting methodology, they will need time to make system modifications and may not be able to retroactively implement changes; cost report related decisions must be made as quickly as possible.
- Cost structures may change in ways that are not reflected in current cost reports due to the implementation of the new regulatory and licensure framework for comprehensive providers.
- How will non-CMHC providers who will be eligible for comprehensive provider types be identified in order to support them in building capacity for cost reporting?

Major Activities and Timing

Activity	Timeframe
Identify cost reporting oversight mechanisms	Determined at HCPF project management level
Verify model structure with stakeholders	
Internal decision on cost reporting strategy	
Implementation strategy	
Provider engagement (ongoing for all activities)	
Provider readiness assessment	

Cost Report Changes and Audit Process

PPS pricing decisions will drive downstream operational process changes to the cost reporting and auditing process.

Key Outstanding Program, Policy, or Operational Questions

- This will need to be evaluated once the PPS pricing strategy decision has been made.

Decision-making and Timing Considerations

- See considerations outlined in the PPS pricing strategy section. The activities and timelines recommended below will need to be evaluated in the context of the PPS pricing decision.

Major Activities and Timing

Activity	Timeframe
Stakeholder engagement to understand impact of transitioning to a specific cost reporting methodology	Determined at HCPF project management level
Develop implementation timeline for transition to new cost report structure	
Update cost reporting guidelines	
Update audit contracts to reflect new standards/expectations	
Provider readiness assessment	

Essential Provider Value-based Purchasing Structure

While comprehensive providers will operate under a PPS, essential providers would continue to operate under FFS models with quality incentives. The current assumption is the providers that are eligible would have access to quality incentives through the Behavioral Health Incentive Program – passed through by the RAEs. There has been no discussion to-date regarding the specific risk structure or operational strategy for this set of providers.

Key Outstanding Program, Policy, or Operational Questions

- What is the risk structure for essential providers?
    - The current assumption is the providers that are eligible would have access to quality incentives through the Behavioral Health Incentive Program – passed through by the RAEs. The specific amounts of the potential upside risk have not been defined.
- What is the timing for the risk structure changing for essential providers?
- Does risk apply to all essential providers or are there exceptions such as low volume?

Decision-making and Timing Considerations

- Essential providers are not likely to have any VBP experience. The ramp-up to accountability may need to be longer for this group than for comprehensive providers.
- Small essential providers may not have sufficient volume for meaningful quality outcome measurement. This is potentially solved through structural/process measures that are also geared at supporting practices in participating in broader VBP/APMs in the future.
- Administrative burden is a serious concern for providers. Any potential gains in outcomes must be weighed against the administrative burden that could impact access to care.
- The authority mechanism used could leave decisions about which essential providers the incentive structure applies to in the hands of the RAEs (e.g., the state could set a VBP penetration rate target in the BHIP instead of setting specific eligibility criteria and use the directed payment authority mechanism)

Major Activities and Timing

Activity	Timeframe
Draft proposal for RAE and other stakeholder review	Determined at HCPF project management level
Solicit feedback from stakeholders	
Provider survey – licensure status being pursued	
Update based on feedback	
Verify with stakeholders	
Share final draft as standardized policy for RAEs	

Quality Measurement Strategy

HCPF and the BHA met for seven sessions to discuss a quality framework for behavioral health to create foundational decisions to inform policy and provider accountability. Although the short-term goal of the sessions was to reach specific metrics to align with an enhanced payment for comprehensive providers, the sessions also provided an initial opportunity to discuss the full spectrum of quality levers for the behavioral health safety net in Colorado. Building on national quality frameworks, such as the National

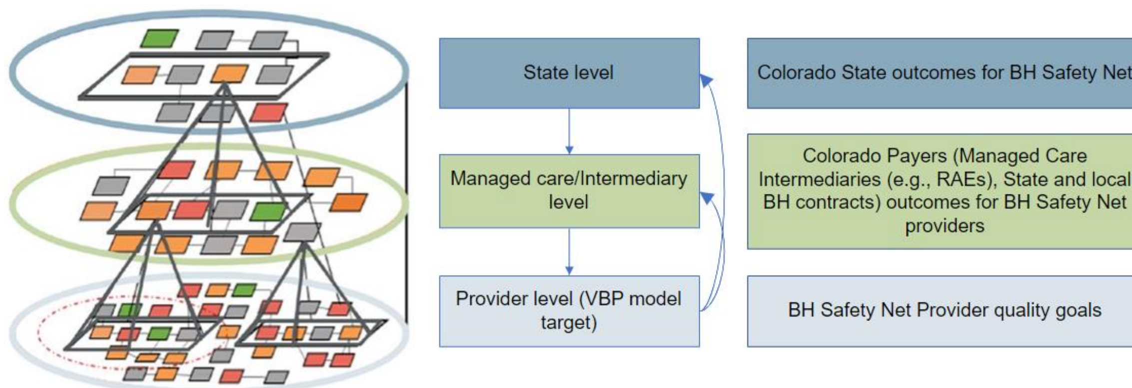
Association of Healthcare Quality (NAHQ) framework, HCPF and BHA discussed how to use different forms of quality accountability for the safety net to meet ultimate goals and to reduce duplication between levers. For example, the alignment of regulatory licensing and designation with quality measures and as well as the role of data analysis at various levels (individual impact, regional impact and population impact).

National Association of Healthcare Quality, Healthcare Quality Competency Framework

In addition, HCPF and BHA discussed the roles of the state agencies, intermediaries and providers within a quality framework. Using the National Committee for Quality Assurance (NCQA)'s Behavioral Health Framework, the goal was to clearly delineate the roles of both HCPF and BHA and where they have distinct activities for quality oversight as well as to clearly identify areas of shared oversight. Additionally, HCPF and BHA reviewed the intermediaries' roles in furthering the state vision for quality and the specific activities intermediaries play in setting quality, monitoring and data analytics. Similar discussion occurred on the role of the providers.

The National Committee Quality Assurance (NCQA) Behavioral Health Framework

"Purposeful alignment and coordinated quality measurement activities that consider each entity's sphere of influence while keeping a line of sight to shared goals can empower stakeholders to make informed decisions and minimize burden."



Draft Roles and Responsibilities:

Entity	Roles and Responsibilities

State HCPF	• Oversee and operate Health First Colorado (Medicaid), Child Health Plan Plus (CHP+), and other public health care programs
	• Payment
	    ◦ Implementation of VBP/APM funding and oversight for model measures/metrics (i.e., what providers are responsible for reporting)
	    ◦ Securing federal and Joint Budget Committee approval for financing and administration of payment model
	    ◦ Directing RAEs/intermediaries on payment
	• Policy
	    ◦ Informing legislature and relevant state entities on overall policy strategy and objectives
	    ◦ Set and enforce health equity plan
	    ◦ Set and enforce expectations for care transitions/coordination
	    ◦ Define data collection standards and tools to minimize duplication/validity challenges and maximize benefit across entities (joint effort with BHA)
	    ◦ Engage in continuous monitoring of burden associated with quality and reporting requirements set in both intermediary and provider contracts
	    ◦ Providing information and assistance to providers related to quality reporting, tools, and infrastructure
	• Accreditation, Certification, Quality Measurement, Quality Improvement
	    ◦ Setting quality strategy and improvement objectives for state, including informing relevant state entities who are impacted
	    ◦ Program development to support quality strategy
	    ◦ Support and coaching to providers on quality standards, metrics, and measures
	    ◦ Enforce performance improvement processes and align efforts with BHA
	• Data Analytics (Multiple uses)
	    ◦ Collection of data – for multiple purposes- external reporting, internal feedback
	    ◦ Evaluate data needs for metrics/measures (partnering with BHA to understand gaps)- data evaluation and acquisition plan
	    ◦ Transparent display of quality information for system accountability and for consumer use (joint effort with BHA)
	    ◦ Continuously assess the degree to which collected data is adequate for measuring the quality vision and goals set forth by the state

State BHA	• Coordinate and collaborate across state entities and agencies to address behavioral health needs • Regulatory ◦ License providers (not specific to SN providers)

	- Specific to SN providers, license in accordance with relevant statute
	• Policy and Payment
	  - Set universal contracting provisions, standard payment methodologies
	  - BHASO implementation- ensure alignment with SN services, payment, and contract development
	  - Define continuum of care at state level- basic care that all individuals should have access to
	  - Define data collection standards and tools to minimize duplication/validity challenges and maximize benefit across entities (joint effort with HCPF)
	  - Engage in continuous monitoring of burden associated with quality and reporting requirements set in both intermediary and provider contracts
	  - Providing information and assistance to providers related to quality reporting, tools, and infrastructure
	• Accreditation, Certification, Quality Measurement, Quality Improvement
	  - Ensuring quality via licensing regulations and auditing process
	  - Technical assistance and quality improvement in variety of areas (e.g., care coordination, provider trainings)
	  - Working in partnership to set quality measures/metrics and benchmarks for various programs
	  - Set quality measures/metrics for BHASO
	  - Work with communities to understand their needs, gaps, and explore how to individualize care at community level
	  - Support and coaching to providers on quality standards, metrics, and measures
	  - Enforce performance improvement processes and align efforts with HCPF
	• Data Analytics (Multiple uses)
	  - Monitoring collected measure/metric performance to identify areas for quality improvement and technical assistance
	  - Collection of various data for multiple purposes (e.g., external reporting, internal feedback)
	  - Establishing reporting requirements and frequency to receive data to assess performance against standards
	  - Set analytic plans for full system (micro to macro), including what equity looks like at state level, how to measure it, and opportunities for improvement
	  - Transparent display of quality information for system accountability and for consumer use (joint effort with HCPF)
	  - MMIS encounter data system rollout and TA to users
	  - Continuously assess the degree to which collected data is adequate for measuring the quality vision and goals set forth by the state

HCPF Intermediary:	• Coordinate and ensure high quality care for Health First Colorado members

Regional Accountable Entities	• Policy and Payment
	  ◦ Responsible for contracting with providers, supporting universal contract
	  ◦ Use credentialing processes to identify high quality providers
	  ◦ Manage payments for behavioral health services and payment to providers
	  ◦ Use funds to help resource network appropriately
	  ◦ Set and enforce quality requirements for their population and network
	  ◦ Report 'narrative deliverable' to state to describe which interventions were used for which populations
	• Quality
	  ◦ Ensuring adequate and comprehensive network
	  ◦ Monitoring quality of services through performance measures/metrics
	  ◦ Technical assistance and quality improvement efforts for providers and network
	  ◦ Audit providers and services within network
	  ◦ Coordinate care across behavioral and physical health providers. Identify complex members and deploy quality interventions to improve care outcomes.
	  ◦ Coordinate SDOH services for individuals
	  ◦ Engage individuals in "Health Neighborhoods"
	  ◦ Engage with DOC and state to ensure post-release health care and wraparound supports for individuals returning to the community from justice-involved settings
	• Data Analytics (Multiple uses)
	  ◦ Collecting and using high quality, complete, and timely data for quality purposes, as defined by the state (RAE sends raw data to the state)
	  ◦ Stratification and meaningful analysis of data to identify complex populations for interventions
	• Collecting and using data from providers to develop population health metrics and help guide decision making around care (including SDOH, e.g., housing pilots)

BHA Intermediary: Managed Service Organizations, Administrative Service Organizations and Future BH Administration Service Organizations	Manage SUD funds and programming (MSO) and the state's comprehensive BH crisis system (ASO) through the BHA.
	• Policy and Payment
	  ◦ Expansion of programs and workforce
	  ◦ Responsible for ensuring workforce adequacy and training providers
	  ◦ Credentialing and building network, beyond baseline requirements (e.g., background checks)
	• Quality
	  ◦ Ensuring adequate and comprehensive network
	  ◦ Coordinate care for population
	• Data Analytics (Multiple uses)

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Collecting and using high quality, complete, and timely data for quality purposes, including linking relevant state datasets to provide comprehensive picture of care
Use data to make recommendations and provide insights around population served- both for internal use and back to state for resource supports/improvements (Should be collecting data for use in equity analyses (e.g., R/E data))
Collect demographic data and align data with Medicaid – intentional linkages and standardization to improve data utility

Note: Some discussion had about still unclear role of BHASOs.

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<tr>
<td>Provider: BH Safety Net Providers</td>
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Policy and Payment

Understand quality standards and metrics included in payment or policy arrangements
Participation in development of policies and recommendations – active engagement
Participation in development of quality measurement activities/requirements
Updating information for provider directories (in addition to maintaining network information for adequacy conversations)

Accreditation, Certification, Quality Measurement, Quality Improvement

Understand quality standards and metrics either required or available for monitoring care quality
Train staff on quality
Put in place population management tools to assess and continuously improve on quality within their patient population (using QI best practices and tools)
Participate in PIPs
Measure progress and performance around key care delivery processes (including network adequacy data collection and use)
Maintain substantial compliance with the specific rules for the base and any endorsement granted (licensing and contracting with UC and intermediaries)

Data Analytics (Multiple uses)

Identification and communication of quality gaps or quality assessment/improvement resource needs back to intermediary/payer and state (HCPF, BHA)
Provide data and deliverables/reports to intermediary/payer and state (HCPF, BHA)

Understand reporting requirements, standards, data requirements etc.
MMIS- submitting encounter data- participate in and solicit input on questions/challenges encountered

Network adequacy data

Care Delivery

Providing quality services to patients
Care coordination, care continuity, facilitation of whole person care

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HCPF continues to work with the BHA to discuss a robust framework for quality and accountability of the safety net as part of the BHA's design of a performance management plan. This will include finalizing shared population health goals that will inform a long-term quality measurement plan for safety net providers and intermediaries to align with payment incentives.

Key Outstanding Program, Policy, or Operational Questions

- How will the quality measures used for the VBP component of the payment reforms for comprehensive providers evolve in a progressive manner to shift from process to outcomes?
- Which quality measures will be used for the VBP component of the payment reforms for essential providers and how will they evolve to be more aligned with outcomes?
- What is the state-wide/regional target for each measure?
- What is the definition of successful performance?
- How will analysis and evolution of metrics account for lower volume providers and align with appropriate impact?
- If the state proceeds with a CCBHC demonstration and is awarded a planning grant, how will required measures under CCBHC be addressed and how will the CCBHC demonstration sites be similar or different from the larger safety net reform efforts?
- As the state advances measures to outcomes, what elements of the quality program can be done with current and existing data sources rather than new data collection (e.g., administrative claims analysis, penetration by risk tier or population or episode of care grouping)?
- Will measurement based care be part of the quality framework and support a shift to outcomes.
- How will risk stratification and sub-population level data be added over time to provide input on access to care and quality outcomes by priority population?
- How will providers be able to participate in bonus incentive activity - such as demonstration of improvements in pilots or other innovations?

Decision-making and Timing Considerations

- Selecting quality measures may require compromises between ease of data collection and alignment of measures with state goals.
- Selection of measures will need to take national benchmarks and local variation into consideration to spur meaningful but realistic goals for improvement.
- Because the RAEs would make the payments from BHIP funds, the provider and RAE measurement strategies have to be closely aligned.

Major Activities and Timing

Activity	Timeframe
Draft set of quality measures for PPS	Finalized
Stakeholder feedback on measures (RAE, provider and broader stakeholders)	Finalized
Building out data plan with data sources and definitions for analysis	Finalized
Audit provider capacity to deliver quality measures	Ongoing

Identify training needs for providers to meet quality expectations and reporting standards	Fall 2023
Identify RAE level quality measures that align with provider metrics	Fall 2023
Identify RAE level versus state level analysis of quality measures	January 2024

Billing Mechanisms and Standards

With a transition to a PPS, the Department will need to implement a standard billing format that all RAEs can align with. This billing standard will include procedure code/revenue code standards that align with the PPS categories (if applicable), requirements for billing line items detail that adjudicated at a zero paid amount, etc.

Key Outstanding Program, Policy, or Operational Questions

- How will encounters be billed and what are the specifications of related policies?
- How will service details be consistently and accurately captured for encounters to allow for accurate federal reporting (e.g., T-MSIS, CMS-64, or otherwise)?
- Will HPCF pay encounter rates to comprehensive providers billing FFS directly through the state?
    - How will utilization be priced if an FFS payment is retained?

Decision-making and Timing Considerations

- Billing standards (e.g., codes, modifiers, payment triggers and limitations, etc.) must be consistently operationalized across RAE regions.
- FQHCs currently bill behavioral health encounter rates. This should serve as a starting point for billing policy considerations to ensure consistency.
- If HCPF does not pay encounter rates in FFS, it should continue the RVU methodology just to support that small subset of utilization.
- If HCPF does pay encounter rates to providers in FFS, it will need to initiate MMIS updates to accommodate this policy change, and this should be added as a high priority item to the operational plan and timeline.

Major Activities and Timing

Activity	Timeframe
HCPF coding team drafts proposal, informed by FQHC billing policies	Determined at HCPF project management level
Convene RAE technical teams for refinement	
Convene provider technical teams for refinement	
Finalize standardized policy all RAEs will use	
Contract changes as applicable	

Provider-level Data Exchange

With an increase in transparency and accountability for outcomes, the state may need to collect new types of information from providers. Additionally, providers may need to receive new types of data/analytics to improve their ability to manage patient care.

Key Outstanding Program, Policy, or Operational Questions

- What data will be collected from providers?
- Who will collect it?
- How will the data be collected and in what format?
- What is the cadence of data exchange?
- Who is responsible for developing the standardized data format and maintaining it?
- What data and analytics will be provided to providers?
- Who will provide information to providers?
- What is the process by which the information is provided, and on what platform?

Decision-making and Timing Considerations

- It will take time and resources to create data reporting processes.
- Providers are at different places in their ability to report different types of data.
- Given licensure and payment transition activities, the state needs to be cautious about adding initial provider-level administrative burden.
- Providers need actionable data to improve quality; the type of data will depend on what the providers are held accountable for.
- Data exchange formats and requirements need to be standardized regardless of the entity providing or sending the data. Fragmentation will reduce the reliability of the data and will increase the administrative burden.
- Data demands of providers and outcomes identified for incentives should align with the services providers bring to the community.
- How will state support real time or meaningful data for providers? What data is needed for providers to be able to change course or improve models?
    - How does data flow back to providers? What data and what cadence?

Major Activities and Timing

Activity	Timeframe
Identify provider to RAE, provider to state, RAE to provider, State to RAE, state to provider data exchange needs	Determined at HCPF project management level
Use stakeholder engagement process to evaluate existing data exchange infrastructure and conduct gap analysis	
Use stakeholder process to develop gap closure process	
Implement gap closure process	
Data reporting manual development and dissemination	

Managed Care Data Intake and Encounter Adjudication

The Department is required to collect detailed encounter data from managed care plans. Historically the Department collected flat file data from plans but was working to collect data directly through MMIS. Regardless of the data intake process used, process modifications and/or system changes will be necessary to ensure encounters for comprehensive providers are processed correctly and the data record is complete.

Key Outstanding Program, Policy, or Operational Questions

- See data specification design.

Decision-making and Timing Considerations

- If MMIS processing is required, system changes may be required to receive encounters correctly.
- Any provider-side changes to ensure complete and accurate data is collected will need to be communicated as early as possible.

Major Activities and Timing

Activity	Timeframe
Identify needed flat file specification changes	Determined at HCPF project management level
Update RAE guidance	
Change internal algorithm for data processing	
Identify system requirements	
Follow HCPF internal system change process	

Provider Technical Assistance

Providers are actively navigating a new licensure, payment model, and financing structure changes, and new levels of accountability - all on the tails of a pandemic that has driving increased need and pent-up demand for behavioral health services. The state (BHA and HCPF in collaboration) should determine if there are critical unmet technical assistance needs related to the payment reform efforts that can be addressed prior to implementation.

Key Outstanding Program, Policy, or Operational Questions

- What technical assistance needs exist?
- Who should provide the technical assistance?
- Using what format?
- How will the assistance be resourced?
- Will there be funds to support provider infrastructure development (e.g., EHR, changes to EHR or additional licenses, cost reporting, etc.) to encourage the expansion of the safety net?

Decision-making and Timing Considerations

- Different types of providers might need different types of technical assistance.
- Examples of technical assistance include support for financial modeling of reimbursement changes, assistance with planning and implementation considerations for data collection and reporting and providing access to information on evidence-based practices.

Major Activities and Timing

Activity	Timeframe
Use stakeholder process to identify and prioritize provider-level technical assistance needs	Determined at HCPF project management level
Identify potential resourcing strategy for prioritized needs	
Implement strategy	

Communication Strategy

Implementation of payment reform intersects with a variety of other state policies and involves or impacts virtually all actors in the behavioral health delivery system. A clear communication strategy that ensures everyone has the information they need to implement the elements they are responsible for in a timely manner is important for ensuring the payment model implementation is not disruptive to patient care.

Key Outstanding Program, Policy, or Operational Questions

- What is the general communication strategy for all stakeholders (providers, RAEs, and others)
- Consideration of communication tools for implementation (manuals (new or updates), bulletins, websites, etc.
- Initiative progress and updates as standing agenda item for recurring/standing RAE and Provider meetings.
- Opportunities to communicate changes and benefits (QA) to external stakeholders such as legislature, advocates, etc.
- Development of Performance Comparison or Performance Summary tools to disseminate to providers for a closed-loop approach and internal comparative benchmarking.

Decision-making and Timing Considerations

- Clear communication of operational requirements that allows practices, RAEs, and state agencies time to make system modifications, accounting practice changes, and other large-scale operational changes is critical and must be done in time for the changes to be made, tested, and implemented before July 2024.

Major Activities and Timing

Activity	Timeframe
Communication strategy plan developed with timelines, strategies, and persons responsible	Determined at HCPF project management level
Procure resources as necessary	
Implement	

Prospective Payment System Rate Setting

Once developed, the PPS system rate setting will need to be incorporated into the managed care rate setting process.

Key Outstanding Program, Policy, or Operational Questions

- See Prospective Payment System Model.
- Who will set the rates?
- On what timeframe?
- What processes will be included to allow for provider review and appeal?

Decision-making and Timing Considerations

- It might be possible to integrate the PPS rate setting into the FQHC rate setting contract with M&S.
- The cost reporting cycle (including audit activities) will drive the rate setting cycle.

Major Activities and Timing

<table>
<tr><th>Activity</th><th>Timeframe</th></tr>
<tr><td>Review existing cost-reporting structure and identify strengths and opportunities for improvement as well as any needs for regulatory revision</td><td rowspan="6">Determined at HCPF project management level</td></tr>
<tr><td>Conduct meetings with CMHC and other provider CFOs and accounting staff to identify pain points and concerns around existing rate setting methodology</td></tr>
<tr><td>Identify points of divergence between CMHCs and other essential provider accounting and reporting structures that will need to be addressed</td></tr>
<tr><td>Revise and adapt existing methodology to allow for cost-neutral carve-out of value-based components</td></tr>
<tr><td>Present draft materials to providers, RAEs, and other stakeholders for review</td></tr>
<tr><td>Finalize reporting instructions and methodology and update regulations and state plan as needed</td></tr>
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Managed Care Rate Setting

The Department will need a strategy for incorporating provider rates into the managed care rate process.

Key Outstanding Program, Policy, or Operational Questions

- See Prospective Payment System Model, Prospective Payment System Rate Setting, Cost Report Changes and Audit Process
- Rate integration strategy – assumptions for how existing data will be used by actuaries to set RAE rates based on the PPS structure adopted and cost-reporting methods used.

Decision-making and Timing Considerations

- A similar strategy to the one currently used (rates set using historical information and then adjusted late in the rate setting process using provider specific scaling adjustments based on audited cost reports) in the future process.

Major Activities and Timing

Activity	Timeframe
Develop rate integration strategy	After cost report policy/strategy developed, but before required for rate setting (state to ID specific date)

Budgetary Authority

Deviation from current budget authority will require requesting additional (or less) spending authority from the legislature through the standard budgetary process.

Key Outstanding Program, Policy, or Operational Questions

- Will the Department request additional resources to operationalize the model (state or provider resources)?
- Will HCPF be using a cost-neutral approach or targeting an increase for providers to address access or incentive quality in a more meaningful way than the current approach?

Decision-making and Timing Considerations

- A budget request can be used to meet the payment reform notification requirements noted in the next section.
- A budget action submitted in November 2023 would not be approved until Spring 2024, which is well past all major implementation steps, including 2024 rate setting. If budgetary authority is required, a phased in plan that is not disruptive to patient care may be required.

Major Activities and Timing

Activity	Timeframe
Determine if a decision item is required	Late Spring
Decision item development	Late Spring through Early Fall 2023 (refer to HCPF internal budget development timelines)
Decision item submission	November 1, 2023

Legislative Authority

Colorado statute requires the Department to notify the legislature of payment reform efforts prior to implementation.

Key Outstanding Program, Policy, or Operational Questions

- Which legislative reporting mechanism will be used?

Decision-making and Timing Considerations

- The Department can use the budget process to support the requirement, even if budget neutral.

Major Activities and Timing

Activity	Timeframe
Decide on reporting mechanism	Late Spring 2023
Submit report	November 2023 or by the end of March 2024

Federal Authority

CMS and the Office of the Actuary (OACT) will review the managed care rate setting process, which will include adjustments for the PPS model. The state and its actuary will need to defend the appropriate of the adjustments, likely with quantitative analysis. A state plan amendment for changes to the payment methodology used for providers may also be required in addition to contract/OACT approval.

Additionally, if the Department pursues directed payment authority to require RAEs to pay comprehensive providers under the PPS structure, additional federal authorization will be required.

The Department must also decide how it will pay comprehensive providers under the FFS benefit. If changes are made to payment here, additional federal authority will be required.

Key Outstanding Program, Policy, or Operational Questions

- Will the state use directed payment authority to require RAEs to pay the PPS rate to comprehensive providers?
- How will the state pay providers through the FFS program?
- Are changes to the State Plan, 1915b waiver, or managed care contract authority required for implementation of the PPS?

Decision-making and Timing Considerations

- There is little flexibility when using directed payment authority and it comes with extensive additional reporting requirements for the state. It is administratively burdensome.
- Likewise, amendments to 1915b waivers are complex, administratively burdensome, and require cost-neutrality calculations to be updated. Unlike state plan amendments, they cannot be done retroactively.
- There are limits to what specific things can be implemented through directed payments.
- If optional, RAEs will need to have a high level of buy-in and commitment to adhering to common standards across RAEs.
- Directed payments and state plan changes have different timing requirements. A State Plan amendment can be applied retroactively to the quarter in which it was submitted, but the managed care rate changes must be submitted 90 days prior to the effective date of the rates.

Major Activities and Timing

Activity	Timeframe
HCPF standard SPA process	Determined at HCPF project management level
Directed payment process	
1915b waiver amendment	

Rules and Regulations

The Department may need to put elements of the PPS rate setting process and appeals process in rule. This is almost certain if the FFS program pays under the PPS and/or if the Department leverages a directed payment authority.

Changes to the BHIP may require rule changes as well.

Key Outstanding Program, Policy, or Operational Questions

- What will need to be put in rule related to the PPS or BHIP?
  - Which components may be referenced in rule but addressed through contract or manual?
- When would the rule process occur?

Decision-making and Timing Considerations

- Introducing rules to target potential waste and abuse behavior under the PPS could be useful for enforcement.

Major Activities and Timing

Activity	Timeframe
HCPF standard rule process	Determined at HCPF project management level

Regulatory Oversight/Program Integrity

Managed care entities are required to have program integrity (PI) programs in place, but the Department is also required to conduct PI activities in addition to the managed care environment. Because the PPS model introduces incentives for waste and abuse, there is a benefit to proactively developing a PI strategy related to the model and subsequently communicating that strategy to providers. This will make it clear that they would be at risk of losing funding if they deviate from patient centered, efficient care delivery standards.

Key Outstanding Program, Policy, or Operational Questions

- What is the PI strategy related to the PPS model?
- What is the delineation of accountability between the Department and the RAEs?
- Contract change considerations?
- What metrics will be tracked for PI – FWA, pervasive incentive events, lack of improvement in performance for an identified period, etc.

Decision-making and Timing Considerations

- Early conversations with the RAEs' and Department PI staff to better understand how PI can be leveraged to mitigate waste and abuse risk would help inform PPS model development as waste and abuse incentives are key concerns for several types of stakeholders.

Major Activities and Timing

Activity	Timeframe
PI meeting	Late January to inform model development
Standards development	Determined at HCPF project management level

Oversight strategy development	
Oversight strategy implementation	

Certified Community Behavioral Health Clinic (CCBHC)

The Department has applied for a CCBHC planning grant. If awarded, the state will get resources to invest in model development and provider readiness to support providers in meeting the CCBHC requirements. Ensuring that the model would work with the CCBHC structure would be helpful for operational efficiency and inclusivity of providers.

Key Outstanding Program, Policy, or Operational Questions

- Pending planning grant
- Will the Department offer differential payment for comprehensive providers that already implemented CCBHC requirements using federal grants?

Decision-making and Timing Considerations

- Implementation would occur after 7/1/2024 payment reform initiatives would have path dependency. The Department may need to pursue flexibility with CMS that are not currently contemplated in CCBHC.
- Federal grantees will lose funding that was used to raise their practice to the CCBHC standard prior to CCBHC going live (if it does in Colorado).

Major Activities and Timing

Activity	Timeframe
Pending grant award	Determined at HCPF project management level

Project Management and Readiness Review

Given the operational complexity of the policy and need for robust stakeholder management, the state should consider leveraging a project manager that can coordinate across all impacted areas. A cross area readiness review for the Department and RAEs should be included (addressed elsewhere for providers).

Key Outstanding Program, Policy, or Operational Questions

- Who will be the project manager?
- What support will they need?
- What is the process for engaging RAEs in readiness review?
- What is the internal readiness review process?

Decision-making and Timing Considerations

- The project manager should have sufficient context in the different implementation areas to be able to do the work.

Major Activities and Timing

Activity	Timeframe
Develop project plan (building on draft from HMA)	Determined at HCPF project management level

Appendix B – Department Implementation Planning Decision Matrix

Decision Point for Implementation Planning	Implementation Domain	Department Policy Decision as of 7/14/2023
How will encounters be billed and what are the specifications of related policies?	Billing Mechanisms and Standards	CMHC cost reports for RAE rate-setting – Optumas is working on construction of the PPS rates under a separate task order from HCPF direction CMHC encounter data to the RAEs - Provider type code and procedure code will be the main focus, plus we can work with John L. to come up with billing guidance for the RAEs and have them configure their system to ID these PPS encounters.
Will HPCF pay encounter rates to comprehensive providers billing FFS directly through the state?	Billing Mechanisms and Standards	Yes, we will need to talk to HIO about a timeline to configure our system to ID these PPS encounters.
What services under FQHC (injections, etc.) don't trigger an encounter rate? What cost for services can be built into PPS?	Billing Mechanisms and Standards	Resolved following HCPF/BHA meeting week of 9/11/23
How will service details be consistently and accurately captured for encounters to allow for accurate federal reporting (e.g., T-MSIS, CMS-64, or otherwise)?	Billing Mechanisms and Standards	Resolved following HCPF/BHA meeting week of 9/11/23
How will utilization be priced if an FFS payment is retained?	Billing Mechanisms and Standards	Will likely resort to RVU system as backup if FFS is retained.
Do we let the RAEs negotiate outside of the PPS? The proposed solution is singular PPS for tiered model. (ACT	Billing Mechanisms and Standards	RAEs will only negotiate outside of the PPS for specific FFS services not already indicated.

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codes as a part of a CCS?)		
What services in/out on the low end? What services covered under PPS, but doesn't trigger the encounter?	Billing Mechanisms and Standards	Resolved following HCPF/BHA meeting week of 9/11/23
Will HCPF be using a cost-neutral approach or targeting an increase for providers to address access or incentive quality in a more meaningful way than the current approach?	Budgetary Authority	Emphasis to address access and incentivize quality through VBP measures
Will the Department request additional resources to operationalize the model (state or provider resources)?	Budgetary Authority	Yes, the Department will need to submit a budget request through JBC due to needing additional resources for actuarial support, FTE for FFS rate setting, and auditing.
Will the Department offer differential payment for comprehensive providers that already implemented CCBHC requirements using federal grants?	Certified Community Behavioral Health Clinic (CCBHC)	No intention to provide differential payments in this way at this time. They have received federal grant funds to accomplish what they have so far and meeting the CCBHC/comprehensive provider requirements would already make them eligible for higher payments than other providers.

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What is the distinction between state-collected and clinic-collected measures?	Certified Community Behavioral Health Clinic (CCBHC)	A state-lead measure is calculated by the state for each BHC, usually relying on administrative data. A BHC-lead measure is calculated by the BHC and sent to the state. The measures are not aggregated by the state and the real distinction is who is designated to perform the data analysis and calculation.
Consideration of communication tools for implementation (manuals (new or updates), bulletins, websites, etc.	Communication Strategy	HMA should contact Trish from Comms to strategize along with the SME to decide on the appropriate communication plan.
What is the general communication strategy for all stakeholders (providers, RAEs, and others)	Communication Strategy	HMA should contact Trish from Comms to strategize along with the SME to decide on the appropriate communication plan. In addition to communicating the changes with the providers and RAEs, internal communication strategy is important (leadership, all staff, etc). They will need to know what changes are occurring, how it impacts HCPF, and how it impacts the providers/RAEs. Example communications plan can be found here: https://drive.google.com/file/d/1CwCS05Ke5UtP9bTZ3VBrIzZR1xR-zk98/view?usp=sharing
Initiative progress and updates as standing agenda item for recurring/standing RAE and Provider meetings	Communication Strategy	ACC RAE ops / Dave D's team would likely provide support for ongoing meetings. If it has to do with a certain group, there is likely a HCPF point person that should be engaged (EX: John Laukkanen for the independent provider network project) Connect with Trish initially to discuss plan and determine best strategy.
Development of Performance Comparison or Performance Summary tools to disseminate to providers for a closed-loop approach and	Communication Strategy	HMA should contact Trish from Comms to strategize along with the SME to decide on the appropriate communication plan (what needs to be created and who needs to create it). Then if there is some collateral content created that can go into a newsletter, etc., HMA/SME would keep in touch with Trish to go out through the communication vehicles. Connect with Trish initially to discuss plan and determine best strategy.

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internal comparative benchmarking		
Opportunities to communicate changes and benefits (QA) to external stakeholders such as legislature, advocates, etc.	Communication Strategy	HMA should contact Trish from Comms to strategize along with the SME to decide on the appropriate communication plan. Iris and Jo would need to be engaged to communicate with the legislature. It would depend on which advocates are being engaged as to which HCPF team/staff should be engaged - there are specific HPCF staff that are point of contacts for certain advocacy groups. EX: IP network would be engaged through John Laukkanen.
What is the timing for the risk structure changing for essential providers?	Essential Provider Value-based Purchasing Structure	HMA is developing TA for CSN providers with risk, and networks with risk. Essential SNP is an ongoing conversation with BHA regarding licensing
Does risk apply to all essential providers or are there exceptions such as low volume?	Essential Provider Value-based Purchasing Structure	Initial risk mechanisms will likely be paid for reporting due to lack of previous measurement periods. This is a topic for stakeholder engagement on how to best get new providers to take on some risk.
Current assumption is that the providers that are eligible would have access to quality incentives through the Behavioral Health Incentive Program – passed through by the RAEs. The specific amounts of the potential upside risk have not been defined.	Essential Provider Value-based Purchasing Structure	The BHIP is an incentive program outside of the capitated rates. For RAEs, if the BHIP measure is not earned by them, they would still have to pay the VBP to providers according to quality measures
What is the risk structure for essential providers?	Essential Provider Value-based Purchasing Structure	Risk structure will involve an enhanced fee schedule for ESNP and RAES have the option to do anything beyond that for VBP if they would like, however payments will be based on reporting requirements and not actual outcomes.

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Are changes to the State Plan, 1915b waiver, or managed care contract authority required for implementation of the PPS?	Federal Authority	The State Plan will need to be updated to include the PPS as the payment methodology for Comprehensive providers. The 1915(b)(3) Waiver must be updated to include directed payment authority. The RAE and Denver Health contracts must be updated to require that comprehensive providers pay using the Department established PPS.
Will the state use directed payment authority to require RAEs to pay the PPS rate to comprehensive providers?	Federal Authority	Yes. The State will pay comprehensive behavioral health safety net providers the same PPS in FFS.
Will we pay CMHCs the PPS in state SFY 2025; will RAEs and DH have to offer contracts to all of the CMHCs in their region; will RAEs and DH have to offer contracts to all of the CMHCs in their region?	Federal Authority	Under current rules, RAEs/DH have to contract with or offer contracts to every CMHC. The PPS will serve as a functional fee schedule that will ensure that even if at RAE doesn't contract directly with a Comprehensive Safety Net provider, the payment amount is already set, and a single case agreement isn't necessary.
How will the state pay providers through the FFS program?	Federal Authority	For the Comprehensive and Essential safety net providers, the PPS or enhanced fee schedule will be loaded into the FFS payment system. They will be applied directly in the case of a FFS payment.
Which legislative reporting mechanism will be used?	Legislative Authority	Joint Budget Committee (JBC) - HCPF needs to prepare for JBC on November 1, 2024 (for implementation July 2025)

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Rate integration strategy – assumptions for how existing data will be used by actuaries to set RAE rates based on the PPS structure adopted and cost-reporting methods used	Managed Care Rate Setting	Updated task order to Optumas to provide actuarial analysis. Previous year's cost reports and a count of encounters will be used to set a base PPS rate. This will be adjusted as necessary to account for trend, etc. into the future period.
Who will be the project manager? What supports will they need?	Project Management and Readiness Review	HCPF is working directly with EPMO office, Benjamin Langenbauer and August Runke to track ongoing work and proposed stakeholder management. EPMO will work directly with BH PPS team to coordinate existing and needed opportunities for stakeholder engagement. Supports needed: Timeline tracking, questions that define the scope. and meeting agendas
What is the process for engaging RAEs in readiness review?	Project Management and Readiness Review	RAEs would have directed payment authority, process encounters appropriately, contract appropriately, calculate and analyze the quality metrics, and ensure providers and HCPF are ready.
What is the internal readiness review process?	Project Management and Readiness Review	Transition to EPMO with system changes. New provider types, comprehensive and essential providers, see fee for essential providers payment models, rule development within system, building licensure rules from BHA, MOO verifies provider type, and draft contract language with Emma O.
What stratification/tiering will be included in the PPS design?	Prospective Payment System Model	No initial stratification or tiering. Certain services will be excluded from the PPS for later inclusion in a tiering method.
Which rendering provider types (peer, licensed, etc.) can trigger an encounter?	Prospective Payment System Model	Provider types to mirror FQHC provider types
Which services will be carved out of the PPS rate for comprehensive providers?	Prospective Payment System Model	High acuity services from Tier 4 likely carve outs

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How is risk structured for the quality incentive portion of the model?	Prospective Payment System Model	Risk structured by each RAE for each participating provider
Will the risk structure change over time (e.g., no downside risk initially)?	Prospective Payment System Model	Not initially. Risk may be tied to performance improvement or quality measures tracked by each RAE
What is the rate setting cycle and related policy?	Prospective Payment System Model	The rate-setting cycle for PPS rates will coincide with the fiscal year for consistency. The Department will trend the PPS rates forward into the projection period using standard trend factors
How will the PPS rate be used when final licensure as an essential or comprehensive provider may not be aligned with the start of the payment program (will there be a presumptive status)?	Prospective Payment System Pricing	The decision on a presumptive status is still pending. This is unlikely due to the provider needing to be registered with Medicaid under the appropriate provider type in order to receive enhanced payment. In the case that final licensure doesn't align with payment model timing, the State is exploring a "statewide" PPS rate for comprehensive providers.
How will the trend from the last cost report period to the projection period be accommodated?	Prospective Payment System Pricing	Trend the PPS rates forward into the projection period using standard trend factors
How will the state implement the transition from current cost reporting methodologies to one that supports the PPS rate development?	Prospective Payment System Pricing	The State has updated cost reports to allow for the counting of encounters as a transition method.
How will CMHCs that are not licensed	Prospective Payment System Pricing	Either as Essential Safety Net providers or as independent providers

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as comprehensive providers get paid?		
How will PPS rates be set for providers that have not previously completed cost reports (providers that are licensed as comprehensive providers, but not subject to CMHC pricing in the past)?	Prospective Payment System Pricing	To be included as part of HMA TA tracks for new providers under PPS payment model
How frequently will cost-based rates be set/rebased?	Prospective Payment System Pricing	Rebase cost-based rates for comprehensive providers once per year.
How will the costs be used in development of the PPS rate?	Prospective Payment System Pricing	Dependent upon the building of the PPS parameters. Costs will be included to align.
Who will set the rates? On what timeframe?	Prospective Payment System Rate Setting	HCPF in alignment with our actuaries, or other vendors
What processes will be included to allow for provider review and appeal?	Prospective Payment System Rate Setting	Likely be included in provider contracts with each RAE network
What technical assistance needs exist?	Provider Technical Assistance	Conduct needs assessment. Defer to HMA expertise here for provider TA
Who should provide the technical assistance? Using what format?	Provider Technical Assistance	HMA is contracted to begin 7/1/2023 to develop widespread and detailed TA to providers to educate and workflow updates to include quality incentive payments in step with HCPF implementation.
How will the assistance be resourced?	Provider Technical Assistance	HMA TA contract in detail for this
Will there be funds to support provider infrastructure development (e.g., EHR, changes to EHR or additional	Provider Technical Assistance	HMA is contracted to begin 7/1/2023 to develop widespread and detailed TA to providers to educate and workflow updates to include quality incentive payments in step with HCPF implementation. Possible BHA or ARPA grant funding available to support safety net expansion

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licenses, cost reporting, etc.) to encourage the expansion of the safety net?		
How will the data be collected and in what format?	Provider-level Data Exchange	Helen and Nicole to follow up with Sally Langston regarding data and reporting
What data and analytics will be provided to providers?	Provider-level Data Exchange	Helen and Nicole to follow up with Sally Langston regarding data and reporting
Who will provide information to providers?	Provider-level Data Exchange	Helen and Nicole to follow up with Sally Langston regarding data and reporting
What data will be collected from providers?	Provider-level Data Exchange	HCPF won't need 2nd validation because we already validate data before RAE pays. Awaiting confirmation from Helen/Nicole and HCPF data team
Who will collect data from providers?	Provider-level Data Exchange	HCPF won't need 2nd validation because we already validate data before RAE pays. Awaiting confirmation from Helen/Nicole and HCPF data team
What is the cadence of data exchange?	Provider-level Data Exchange	HCPF won't need 2nd validation because we already validate data before RAE pays. Awaiting confirmation from Helen/Nicole and HCPF data team
Who is responsible for developing the standardized data format and maintaining it?	Provider-level Data Exchange	HCPF won't need 2nd validation because we already validate data before RAE pays. Awaiting confirmation from Helen/Nicole and HCPF data team
What is the process by which the information is provided, and on what platform?	Provider-level Data Exchange	Helen and Nicole to follow up with Sally Langston regarding data and reporting
Will each RAE measure performance for their population and payout?	Quality Measurement Strategy	
Which quality measures will be used for the VBP	Quality Measurement Strategy	Combine measures 4 and 5, add measures 6 and 7, and include time to service as the selected core measures

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component of the payment reforms for comprehensive providers?		
What is the state-wide/regional target for each measure?	Quality Measurement Strategy	
What is the definition of successful performance?	Quality Measurement Strategy	
Who will calculate each measure and what is the data source? (Overlap with data exchange domain)	Quality Measurement Strategy	Helen and Nicole to follow up with Sally Langston regarding data and reporting
How will required measures under CCBHC be addressed and how will the CCBHC demonstration sites be similar or different from the larger safety net reform efforts?	Quality Measurement Strategy	Awaiting CCBHC update of I-SERV measure (estimated date of Aug 1. 2023)
Will providers have choice or a menu of measures to work on?	Quality Measurement Strategy	
Will lower volume providers have the same measures or will there be process measures they report on?	Quality Measurement Strategy	

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What are elements of the quality program that can be done with current and existing data sources rather than new data collection (e.g., administrative claims analysis, penetration by risk tier or population or episode of care grouping)?	Quality Measurement Strategy	Helen and Nicole to follow up with Sally Langston regarding data and reporting
Will quality expectations be phased in or started at once?	Quality Measurement Strategy	Quality Expectations will likely follow a pilot model, to help inform and give HMA TA training more traction
How will providers be able to participate in bonus incentive activity - such as demonstration of improvements in pilots or other innovations?	Quality Measurement Strategy	Will likely follow a pilot model (Gina Lasky to set up review of CO Access model) late summer, 2023 with Colorado Access and Aurora Mental Health Center
Which quality measures will be used for the VBP component of the payment reforms for essential providers?	Quality Measurement Strategy	Helen and Nicole to follow up with Sally Langston regarding data and reporting
What is the delineation of accountability between the Department and the RAEs?	Regulatory Oversight/Program Integrity	RAEs will ascribe to contract requirements, namely the provision for VBP services effective 7/1/23; as well as possible directed payment efforts by HCPF
Contract change considerations?	Regulatory Oversight/Program Integrity	Update RAE contract – the section on Fraud, Waste, and Abuse reviews – some sort of quality audit would be needed.

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What metrics will be tracked for PI – FWA, pervasive incentive events, lack of improvement in performance for an identified period, etc.	Regulatory Oversight/Program Integrity	The SME that works on program integrity is Sarah Geduldig. Her input on this was essentially that we could monitor it similar to how we monitor FQHC entities. But, since we won't be directly contracting with the Comprehensive providers, it will really be up to the RAEs to monitor PI. We can provide suggestions or put conditions in the contract but likely won't do direct monitoring.
What is the PI strategy related to the PPS model?	Regulatory Oversight/Program Integrity	General process for getting PI effort in place: Update RAE contract. The state will need to establish the monitoring metrics for the RAEs The SME that works on program integrity is Sarah Geduldig. Her input on this was essentially that we could monitor it similar to how we monitor FQHC entities. But, since we won't be directly contracting with the Comprehensive providers, it will really be up to the RAEs to monitor PI. We can provide suggestions or put conditions in the contract but likely won't do direct monitoring. Thanks,
What will need to be put in rule related to the PPS or BHIP?	Rules and Regulations	BHA in alignment with HCPF quality measures, but needs more review
Which components may be referenced in rule but addressed through contract or manual?	Rules and Regulations	BHA in alignment with HCPF quality measures, but needs more review
When would the rule process occur?	Rules and Regulations	Likely dependent on BHA conclusion of rules and promulgation timeline Jan 1, 2024
Stakeholder engagement to understand impact of transitioning to a specific cost reporting methodology	Cost Report Changes and Audit Process	HCPF strategic goals with Myers and Stauffer task

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Develop implementation timeline for transition to new cost report structure	Cost Report Changes and Audit Process	HCPF strategic goals with HMA Technical Assistance
Update cost reporting guidelines	Cost Report Changes and Audit Process	In conjunction with HMA TA work, HCPF will update cost reporting guidelines to reflect quality measures that include VBP incentives. Possible RAE contract update
Update audit contracts to reflect new standards/expectations	Cost Report Changes and Audit Process	In conjunction with HMA TA work, HCPF will update cost reporting guidelines to reflect quality measures that include VBP incentives. Possible RAE contract update
Provider readiness assessment	Cost Report Changes and Audit Process	Joint strategic goals with HMA Technical Assistance. HMA will develop implementation plan that will inform provider readiness to adopt VBP

Appendix C – HCPF Quality Framework

Number	Reported Measure	Measure	Collected	Guidance	Guidance
1	Yes	Comprehensive Diabetes Care: Hemoglobin Alc (HbAlc) Control for Patients with Diabetes (HBD-AD)	State Collected	N/A	New Measure, Required for QBP
2	Yes	Depression Remission at Six Months (DEP-REM-6)	Clinic	Optional QBP measure (12 mo.)	Measure changed from 12-month version, changed to required QBP measure
3	Yes	Time to Services (I-SERV)	Clinic Collected	N/A	New Measure, Required for QBP
4	Yes	Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	State Collected	Required QBP measure	Unchanged, required QBP measure
5	Yes	Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (child/adolescent) (FUH-CH)	State Collected	Required QBP measure	Unchanged, required QBP measure
6	Yes	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	State Collected	Required QBP measure	Unchanged, required QBP measure
7	Yes	Follow-Up After Emergency Department Visit for Substance Use (FUA-CH and FUA-AD)	State Collected	N/A	New Measure, Optional QBP Measure
8	Yes	Plan All-Cause Readmissions Rate (PCR-AD)	State Collected	Optional QBP measure	Unchanged, optional QBP measure
9	Yes	Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-C1,5	State Collected	Optional QBP measure	Unchanged, optional QBP measure
10	Yes	Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Clinic Collected	N/A	New optional QBP measure

11	Yes	Screening for Depression and Follow-Up Plan (CDF- CH and CDF-AD)	Clinic Collected	Optional QBP measure	Child measure added, optional QBP measure
12	No	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-C)	Clinic Collected	Required QBP measure	Changed to optional QBP measure
13	No	Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-A)	Clinic Collected	Required QBP measure	Changed to optional QBP measure
14	No	Controlling High Blood Pressure (CBP-AD)	Clinic Collected	N/A	New Optional QBP measure
15	No	Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)	Clinic Collected	N/A	New Optional QBP measure