Meeting Summary

On October 26, 2018, the Department of Health Care Policy and Financing (Department) convened stakeholders for a public discussion on the implementation of House Bill 18-1136. This legislation adds inpatient and residential substance use disorder (SUD) treatment as a benefit under Health First Colorado (Colorado's Medicaid program). Key themes raised include: 1) leveraging existing community assets, 2) building a strong continuum, and 3) ensuring provider capacity is understood and accounted for in the building of a benefit. A summary of stakeholder priorities is outlined below:

Administrative Structures	
Office of Behavioral Health (OBH)	• Share relevant data, including from Managed Service Organization (MSOs) administrators • Work on streamlining assessment/intake • Ensure quality requirements for MSOs
Department of Regulatory Agencies (DORA)	• Focus on workforce career pathways • Evaluate opportunities to ease oversight rules (related to capacity)

Regional Accountable Entities (RAEs)	• Serve as administrator
	    ○ UM will be critical function to ensure appropriate service use
	    ○ Need specific criteria so providers know what to expect
	• Fill gaps in care (rural and frontier areas, i.e. use telehealth)
	• Ensure quality care through measurement
	• Support evaluation of access/capacity needs

Statewide Crisis System	• Serve as entry point/referrals • Interface with law enforcement/criminal justice
Benefit Design and Rates	
Continuum of Services	• Ensure full continuum of care including for co-occurring illnesses • Look at SBIRT and Special Connections related to overall design and consider areas to fold in or complement • Consider impacts of provider capacity and access to ensure design is achievable
Non-Medicaid	• Cover non-covered Health First Colorado services: childcare, room and board, transportation (OBH funds)
Telehealth	• Engage partners who are building out robust tele-psychiatry • Determine capacity to build out SUD treatment in telehealth • Evaluate activities of partners (Children's, Health One, Centura, UC)
Rates	• Set rates at a level that ensures adequate staffing for all beds and access for special populations • Evaluate specialty population needs (kids, pregnant women) • Maximize OBH funding to support non-medical services (STR and opioid grants)
Provider Capacity (define type – Site, Workforce, Resources)	
Rural	• Consider telehealth options

	• Consider whether quality measures for urban areas could be punitive for rural providers • Opportunity for RAEs to support
Broad strategies	• Integrate co-located services, i.e. physical health care at MAT sites, SUD specialists in primary care sites • Be mindful that benefit structure will dictate/impact provider readiness • Ensure focus on youth early intervention and referral process
Analysis/data	• Match OBH provider networks & Health First Colorado enrolled providers • Assess current utilization of members served by OBH providers and/or Health First Colorado providers • Assess current and potential provider capacity (including MAT providers)
Access	• Ensure timely access to the full continuum of services, not just higher levels of care • MAT providers want assurances they can effectively refer to withdrawal management and residential • Conduct assessment of access that includes timeliness of admittance and geographic proximity • Contracts should ensure providers have capacity to accept patients in timely fashion • Leverage OBH work to streamline the historically burdensome intake process
Workforce	• Conduct a multi-level workforce assessment (leverage CDPHE's work) • Assess and consider loan repayment activities to increase addiction counselors, particularly in rural areas • Engage career pathways workgroup – DORA • Explore regulatory/licensure challenges (including telehealth) • Consider peer workforce opportunities • Align with IT MATTRS trainings to encourage Medicaid enrollment
Provider Contracting	
Alignment	• Requirements/standards aligned across entities (OBH, HCPF, MSOs, RAEs)
Ensure appropriate care	• Create administrative requirements (at RAE) that ensure members are in right level of care (avoid shift to high acuity treatment for low acuity patients) • Maximize appropriate use of outpatient services • Control episode of care/ensure accountability • Ensure accountability for quality, timely care (extends to RAEs)
Monitoring & Evaluation	
Defining success	• Consider defining the goal and what success is and then create measures • Define at both the individual and population level • Expand measures of success beyond recidivism or relapse (jobs, better functioning in society, stability factors, etc.)

Measurement	• Include process measures around the continuum (e.g., referrals, step downs, account for rural capacity, timeliness of care access)
	• Consider for inclusion:
	   ○ Stability factors post treatment
	   ○ Physical health outcomes
	   ○ ER/Potentially avoidable visits
	   ○ Social Determinants outcomes/process evaluations
	• Evaluate member services prior to residential (outpatient, integrated)

Communications	
During development	• Include family voice/members in building the benefit • Establish one-stop shop website as resource for stakeholders • Department should provide monthly updates via distribution list • Use topic-specific workgroups to gather expertise/not burden community experts
During program implementation	• Ensure effective referral system through broad communication • Promote non-punitive treatment messaging including public health campaign (focus on de-stigmatization) • Message service availability for co-occurring conditions