Stakeholder Feedback Summary: Medicaid System of Care

HOST: "Hello everyone, and thank you for joining us today. Before we get started, I would like to invite our Spanish and ASL interpreter to introduce themselves and explain how to access live interpretation services. Samantha, please go ahead."

Thank you Samantha. Hans is our spanish interpreter, Hans can you please introduce yourself.

INTERPRETER (In Spanish): "Hi everyone, my name is Hans, and I will be providing Spanish interpretation services. In a moment, this service will be activated. To listen to live Spanish interpretation of today's event, select the 'interpretations' pod from the Zoom toolbar and then select 'Spanish.' You will have the option to select 'mute original audio' if you want to hear only Spanish. This interpretation pod will be activated momentarily.

Mi nombre es Hans y brindaré servicios de interpretación en español. En un momento, este servicio estará activado. Para escuchar la interpretación en vivo en español del evento de hoy, seleccione el módulo 'interpretaciones' en la barra de herramientas de Zoom y luego seleccione 'Español.' Tendrás la opción de seleccionar 'silenciar audio original' si deseas escuchar solo español. Este módulo de interpretación se activará momentáneamente.

Thank you!

The Department of Health Care Policy and Financing deeply appreciates the people of Colorado for their engagement, feedback and invaluable experiences shared throughout this process. The voices of children, youth and family stakeholders have been instrumental in shaping this work and the impact will continue to be vital beyond today. HCPF is excited to continue collaborating with you and looks forward to sharing future opportunities together.

Goals for the Meeting

- Quick review of proposed System of Care for Medicaid Members
- Overall Themes
- Feedback
  - Population Specific
  - System of Care services
  - Agency Roles
  - Rollout
  - Continuous Quality Improvement
- Discussion

Project Webpage

Check the webpage for regular updates and for the original summer 2024 presentation

Quick Review

SOC's 7 Key Parts: Details

Identification Tool

Screening tool to determine who needs an assessment.

Standardized Assessment

Standardized assessment (CANS) to uniformly determine a child's needs and service type.

Intensive Care Coordination

Hands-on care coordination with High-Fidelity Wraparound approach to services and progress monitoring.

Stabilization Services

Intensive short-term in-home services and mobile crisis services w/in crisis system.

Intensive Home-based Treatment

Evidence supported, intensive behavioral health intervention in the home.

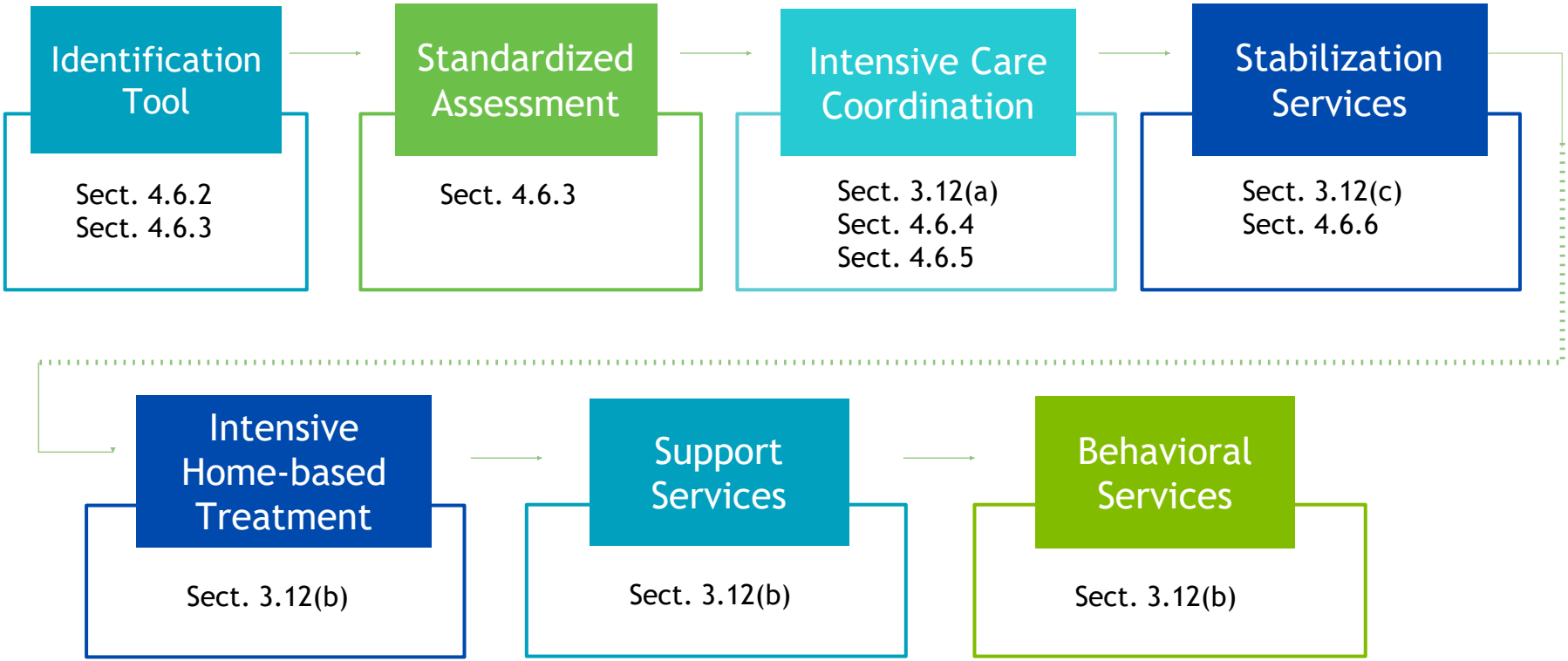
Support Services

Longer-term in-home services to meet the support needs of children and their families.

Behavioral Services

Behavioral e-consult via doc-to-doc consultation from a behavior specialist to the treating provider.

Agreement Requirements via SOC [Sect. 4.6.1]



Feedback

Overall Takeaway and Themes

- Held over 35 sessions, both in-person and virtual
- The in-person sessions covered the entire state
- By and large, the feedback and input on the proposed system of care was positive. Most participants appreciated that the proposed structure is reflective of what has worked in other states that are having success with system of care.
- Many questions focused on the need for a clearer explanation from HCPF, which will be addressed in the Implementation Plan.
- There was a lot of input regarding whether reimbursement rates will be sufficient to cover provider costs for several of the proposed interventions.
- Workforce shortage concerns were a theme across all meetings.
- There were many questions about how existing organizations and providers fit into the system of care, which will be addressed through outreach and a multidisciplinary approach to High Fidelity Wraparound.

3 Advisory Committees

1. Lived Experience Advisory Committee (youth and families):
2. Implementation Advisory Committee
3. Statewide Leadership Advisory Committee

Feedback: For people with lived experience, there needs to be a process beyond just reaching out to the same consumer advocacy organizations to garner interest in joining the Lived Experience Advisory Committee.
Response: HCPF is finalizing the process for soliciting interest in committee membership. This will include outreach to existing consumer advocacy organizations, as well as other organizations known to HCPF. Additionally, an email will be sent out to individuals who attended last summer's presentation to gather names of those interested in joining the committee.

Population Specifics

Population Specifics

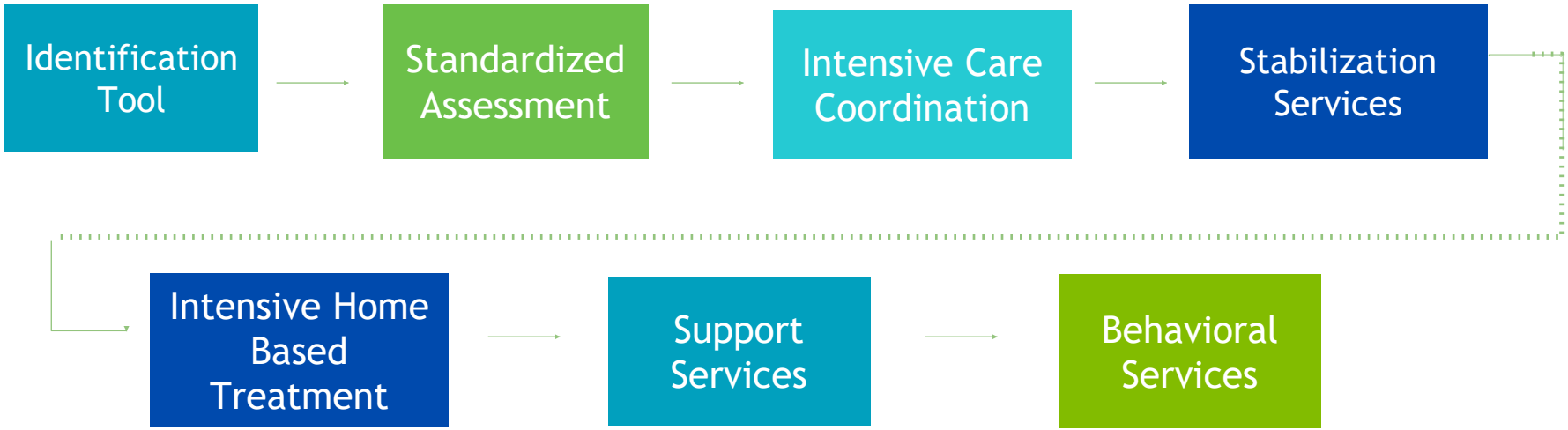
Feedback: There is a desire for clarity on how these services are available to children in foster care, juvenile justice, or those who are homeless?
Response: The services are available to any Medicaid Member under the age of 21 who is in a family-like setting. In response to feedback, HCPF is working with CDHS to update the Treatment Foster Care Plan required by HB24-1038. Additionally, protocols will need to be developed for referring individuals who are experiencing homelessness to accessing care.

Feedback: Interventions for very young children are often delivered to the parents rather than directly to the child. The proposed approach appears to be child centered.
Response: The proposed plan is focused on the Medicaid member under the age of 21. This does not prohibit a parent who is a Medicaid member themselves from accessing approved services through their own benefits. HCPF is working with stakeholders to identify child/parent interventions where the medical necessity is for the young child.

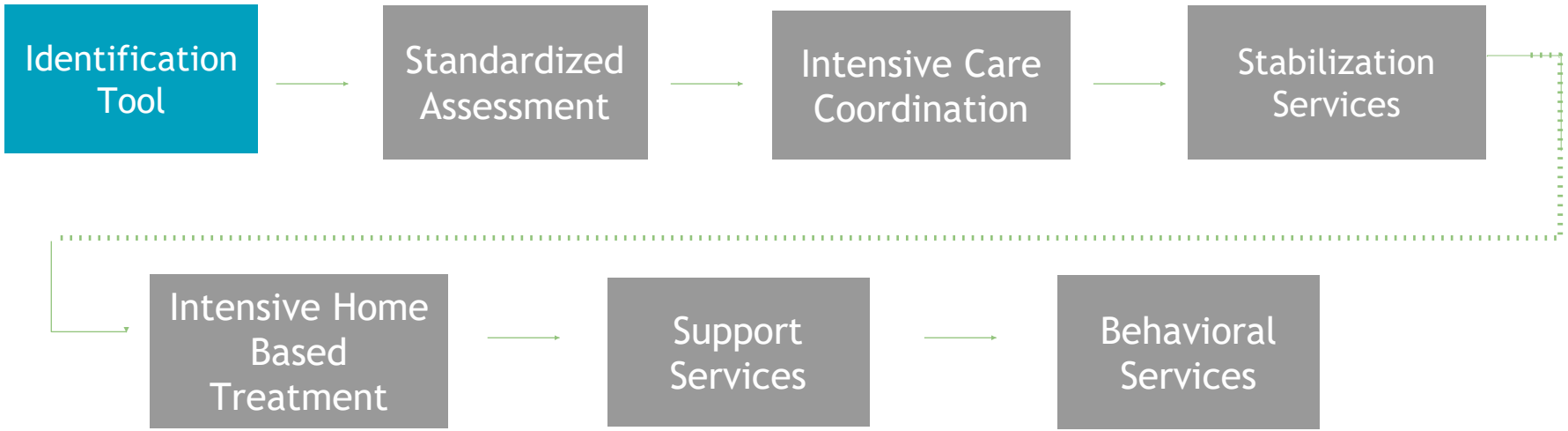
Feedback: What about services for the parents?
Response: The proposed plan is for the Medicaid member under the age of 21. However, this does not prevent a parent who is a Medicaid member from accessing approved services through their own benefits.

System of Care Structure

System of Care Has 7 Key Parts



Part 1: Identification Tool

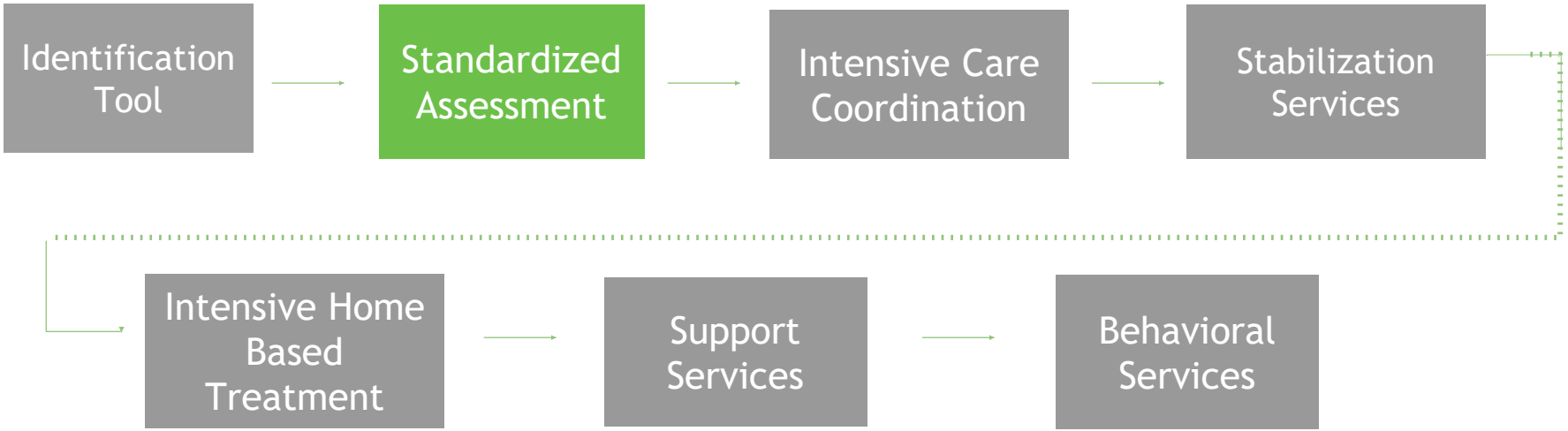


Identification Tool

Feedback: Be clear on the definition of “complex mental health needs.” There are concerns around variance in the interpretation of this definition.
Response: We agree that consistency is key. That’s why HCPF and BHA are working with Univ. of Kentucky/John Lyons to ensure the tool used is a byproduct of the development of the assessment (CANS) and has a low threshold for a positive result. Additionally, the same tool will be applied across all RAE regions to maintain consistency.

Feedback: Will the state track the screens?
Response: Yes, the state intends to collect data to track the screens. However, there is still work to be done to determine how to do this without significant cost or administrative burden. The Identification Tool will not be used in Phase 1.

Part 2: Standardized Assessment



Enhanced Standardized Assessment

Feedback: There are concerns about the acronym “SA” as it is associated with assault.
Response: The acronym has been changed to “ESA” (Enhanced Standardized Assessment)

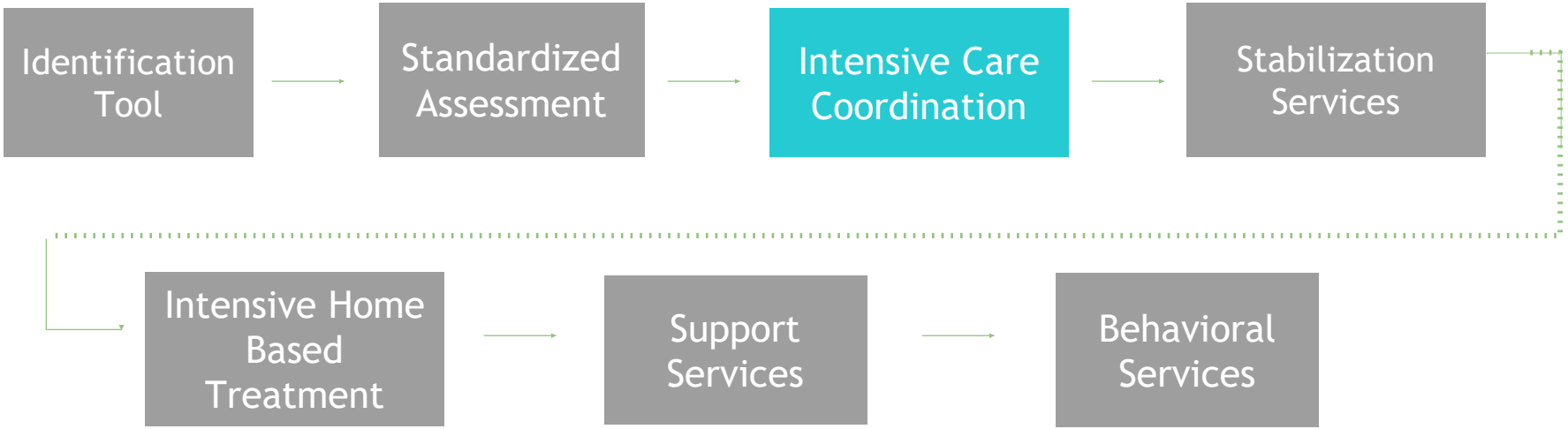
Feedback: There are concerns about the timeliness of access to services. What is the maximum time to complete the assessment and how long does after completion does it take to access services?
Response: The ESA must be completed within 14 calendar days, and services must be accessed within 3 business days after the ESA is completed. It is important to point out that services can begin before the ESA is fully completed.

Feedback: Want stakeholder input for the Standardized Assessment?
Response: There is a working group and leadership group involved in the development and expansion of the CANS.

Feedback: Concerns CANS may not be appropriate for specific populations (i.e., IDD or children under 8).
Response: HCPF/BHA will work with the creators of CANS to discuss these specific populations and explore if CANS has additional modules that can be used to assess the needs of these specific population.

Feedback: Concerns that there will be too many different assessments across various agencies.
Response: All behavioral health assessment across agencies will use the same CANS. However, additional requirements may be added based on the specific needs of the agency.

Part 3: Intensive Care Coordination



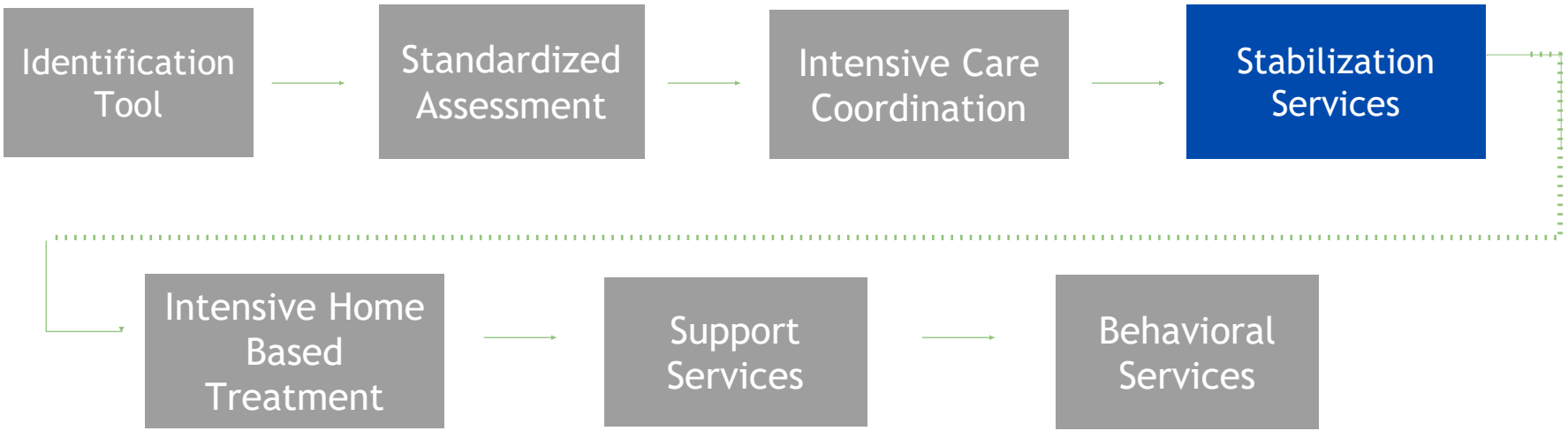
Intensive Care Coordination (ICC)

Feedback: Concerns about existing wraparound services available in the state.
Response: Other wraparound services can continue to exist, but in the long run, HCPF plans to only pay for models that are certified by the state.

Feedback: Concerns about who delivers the care coordination, specifically the desire for conflict-free intensive care coordination. This includes interest in organizations other than government agencies or managed care entities.
Response: The plan proposes that counties and RAEs cannot serve as the intensive care coordinator, although they can be a part of the multidisciplinary team led by the coordinator. There is still a determination to be made regarding whether the in-home provider can also serve as the ICC. After hearing about concerns about provider availability in rural areas, HCPF is considering the possibility of rural waivers for these policies.

Feedback: Agencies wanted to ensure there will be an opportunity for existing providers to become the Community Service Agency (the ICC organization).
Response: HCPF decided to re-evaluate and slow down the decision making process on CSAs. It wants to balance the desire to have existing organizations (other than counties or RAEs) to be CSAs and also make sure a community has enough referrals to be fiscally logical for those organizations.
*1.15.2025: Based on feedback HCPF has decided to renamed CSAs to “System of Care (SOC) Certified Intensive Care Coordination Provider (ICC Provider)”. This is reduces confusion on what the role is and states it needs to be a provider no necessarily an entity.

Part 4: Mobile Response Stabilization Services



Crisis Mobile and Resolution ~~Response Stabilization~~ Services

Mobile Crisis Response (MCR)

Feedback: Concerns about reports of no in-person responses in some areas, or that distance is a deciding factor. There are also concerns that the current mobile crisis response is too much of a generalist approach.
Response: HCPF has given this feedback to BHA to follow up on.

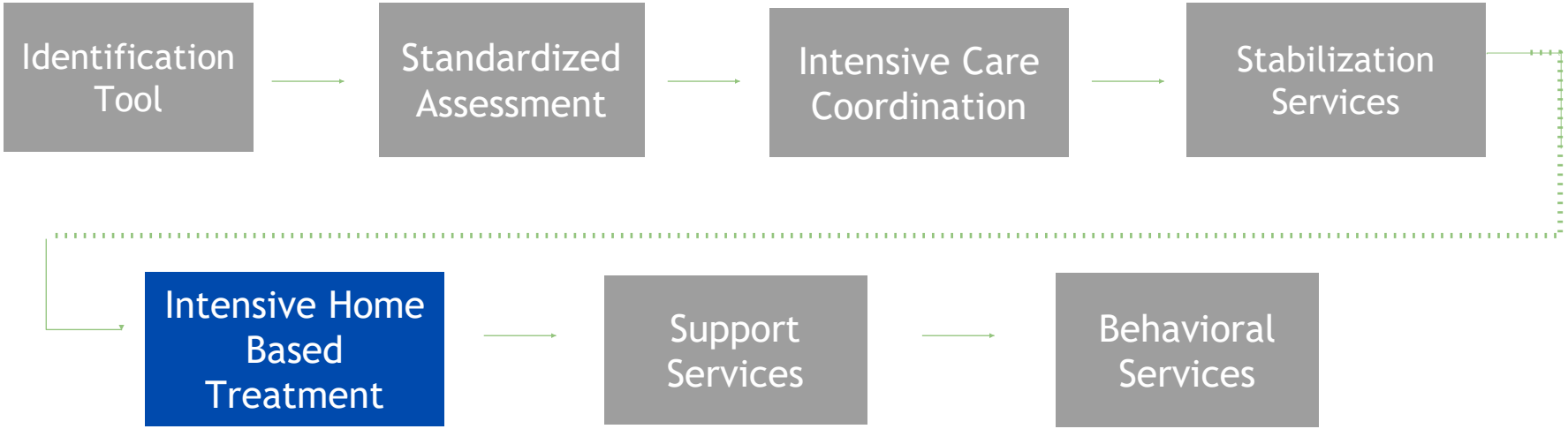
Feedback: Concerns that MCR is currently a generalist approach and lacks sufficient child, youth and family or other specific expertise.
Response: HCPF and BHA are reviewing the current training and will enhance it as needed.

Feedback: Workforce is going to be a challenge, especially if child trained experts are required.
Response: The plan has been adjusted to modify the national MRSS model to better suit Colorado's needs, so MCR teams will have access to a child/youth trained professional without the need to employ one directly.

CSU

Feedback: Concerns that access is limited to the Denver metro area.
Response: HCPF will review data and collaborate with BHA to identify areas where services are needed, recognizing that demand exists outside the Denver metro area as well. HCPF will also consider solutions for areas where there are not enough referrals to sustain an entire unit.

Part 5: In-Home Intensive Treatment



Intensive Home Based Treatment

Feedback: Population specific interventions and proposed models for:

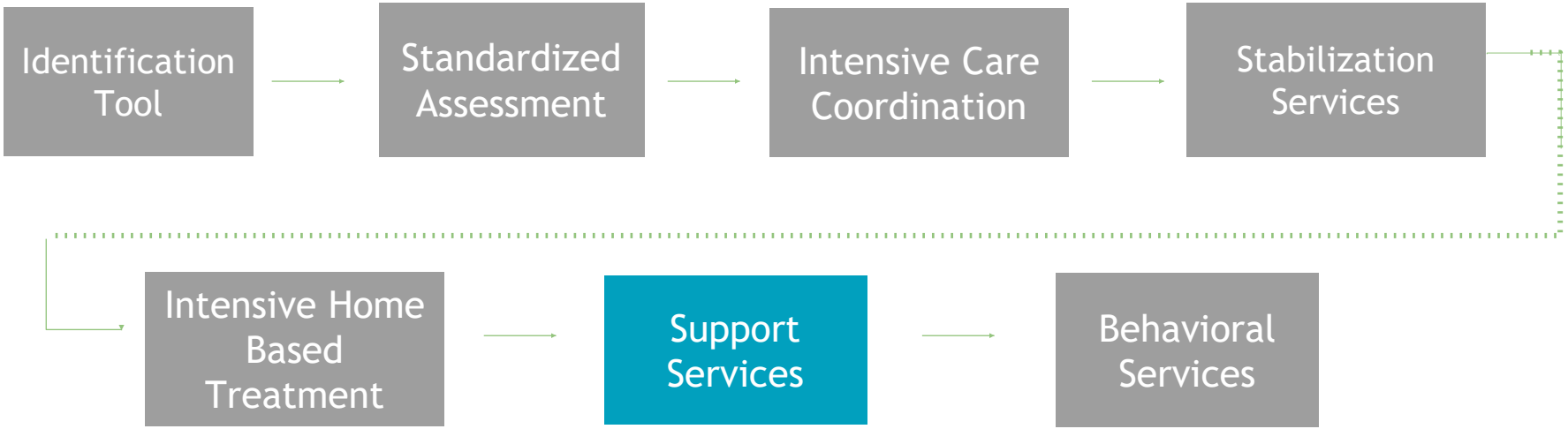
1. Children under eight years old
2. Young adults (18 to 21 years old)
3. Individuals with Intellectual and/or Developmental Disabilities

Response: In response, HCPF held additional meetings focused on the populations of children under 8 and individuals with IDD. For all 3 populations, HCPF has decided to conduct further research and engage with stakeholders. As a result, no decision has been made, and HCPF will spend the next 12 to 18 months working with invested parties to develop more detailed, appropriate interventions.

Feedback: Rates must cover the true costs of delivering services; otherwise, it will not be a sustainable model for providers.
Response: We agree. HCPF is currently reviewing approaches that recognize true costs and the additional requirements that accompany the application and intensity of these models. This may include the creation of new billing codes.

Feedback: We want to make sure chosen interventions are culturally responsive.
Response: HCPF will review the cultural responsiveness of MST and FFT or research existing literature on the topic.

Part 6: Support Services



Support Services

Family Peer Supports

Feedback: Ensure that family peers are paid as a professional service.
Response: HCPF agrees. The plan is to explore competitive rates and establish appropriate ratios for family peer supports to families/members.

Respite Services

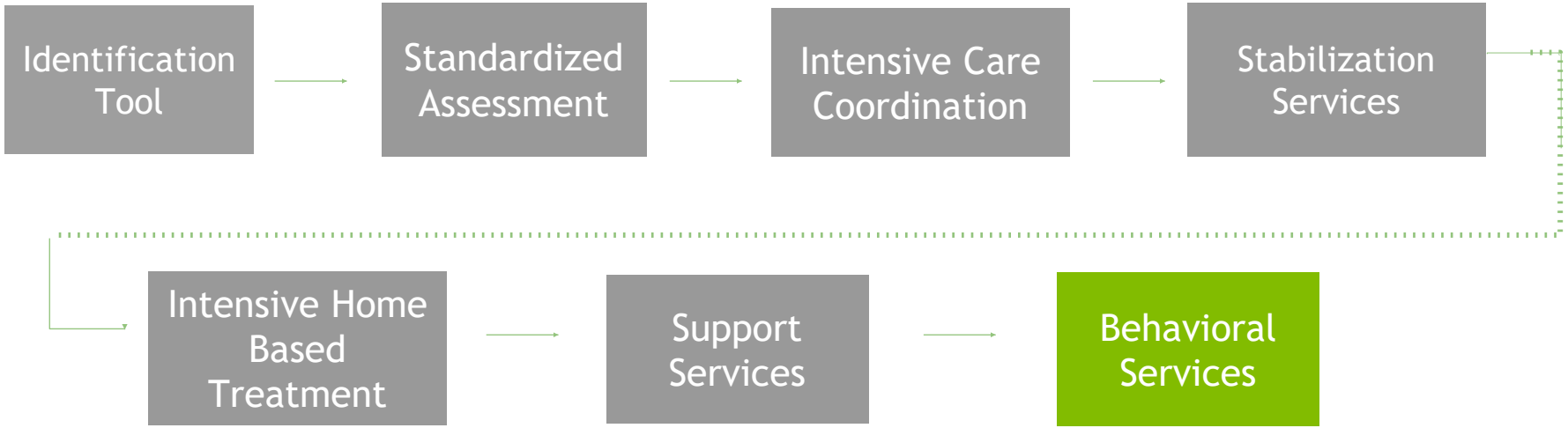
Feedback: Workforce challenges continue to be an issue, particularly in having enough providers.
Response: HCPF agrees and intends to engage invested parties further to identify both a viable funding approach and flexibility regarding who qualifies as a provider.

Therapeutic Mentoring

Feedback: Why don't we just use peers instead of introducing this new service?
Response: After careful consideration, the decision was made to keep Therapeutic Mentoring. While mentors have lived experience, it is not a requirement. Therapeutic Mentoring also serves as an entry-level position in the behavioral health workforce pipeline.

Feedback: More family supports are needed, such as education.
Response: In response, HCPF has engaged a national consultant to review the issue and make recommendations.

Part 7: Behavioral Consultation Services

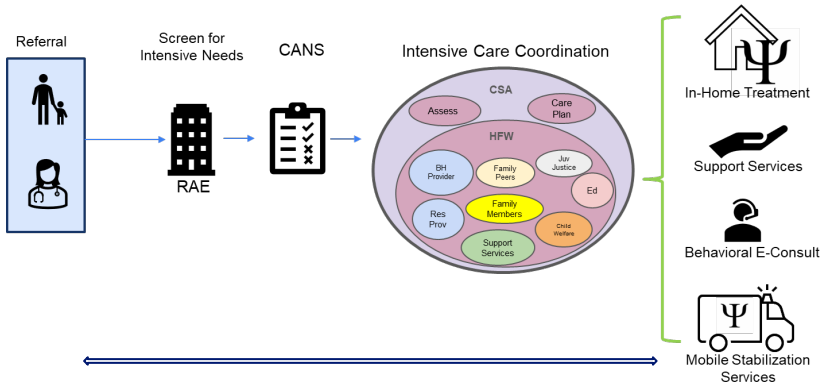


BEHAVIORAL SERVICES

Feedback: A number of participants had concerns with the ABA model and recommended looking at considering other models.

Response: HCPF will ensure that any consultant is not limited to the ABA model and is familiar with, and able to speak to, other behavioral interventions as well.

Medicaid System of Care Flowchart



Feedback: What happens if the Identification Tool or assessment determines a person is not eligible for M-SOC?
Response: The person will continue to work with the RAE and receive traditional care coordination services.

Feedback: What if the person is not Medicaid eligible? Where do they go?
Response: HCPF has been working with BHA and sharing feedback on cross-system concerns. The two departments are collaborating to ensure clear contract language in the RAE and BHASO contracts, so no person is missed due to entering through one door and not the other.

Agency Roles

Regionable Accountable Entity (RAE), Community Service Agency (CSA), & Case Management Agency (CMA)

Feedback: Concerns about families falling through gaps between the intensive care coordinator and/or providers.
Response: HCPF is completing work with the contracts team to ensure that expectations in contracts for the RAEs are explicitly clear, including a requirement that RAEs prevent gaps in care coordination.

Feedback: How will network adequacy be defined? How will it be determined if there are enough providers, especially for rural areas, to meet the needs?
Response: In the plan, HCPF will include expected ratios of families to providers for each type of service. HCPF is working with BHA to determine whether these expectations should be outlined in rule or contract language. This process will require a data analysis to predict demand by community.

Feedback: There are a lot of different agencies doing some type of coordination.
Response: In response to this input, HCPF is reviewing existing care coordination expectations to identify any overlaps. More details will be determined as this process unfolds. HCPF is also examining how other states use CSAs and how they are rolled out or certified by the state. HCPF will hold future meetings before any final decisions are made.
*1.15.2025: Based on feedback HCPF has decided to renamed CSAs to “System of Care (SOC) Certified Intensive Care Coordination Provider (ICC Provider)”. This reduces confusion on what the role is and states it needs to be a provider not necessarily an entity.

WORKFORCE CAPACITY CENTER (WCC)

Feedback: Concern about workforce shortages statewide, particularly in rural areas. With the significant demand for services, there is concern about having enough workforce.
Response: HCPF has raised workforce concerns with BHA and will strategize on solutions. The plan will leverage the workforce pipeline that BHA is developing. Additionally, HCPF is reducing the number of licensed clinicians required without compromising care. Several positions will be entry-level, aimed at keeping people in their communities while providing a first step into the behavioral health workforce pipeline. HCPF will collaborate with BHA to discuss workforce strategies with invested parties.

Feedback: There are many entities providing behavioral health training, including colleges and universities across Colorado.
Response: HCPF will ensure any institute selected to lead the workforce capacity center is also required to work with other educational institutions.

Feedback: Concerns that only new graduates are available to provide services in some areas.
Response: HCPF is selecting intervention models that include a high level of supervision and is exploring mechanisms to cover all costs for these models. This approach will help ensure that new graduates are appropriately trained, supervised and able to provide interventions with fidelity.

Rollout

Phase 1 for Medicaid SOC Services

Identification Tool

NOT INCLUDED IN PHASE 1

Standardized Assessment

Funded for initial assessments and follow-up as needed

Intensive Care Coordination

High Fidelity Wraparound for 600 kids

Stabilization Services

Coordinate with existing mobile crisis and Crisis Resolution Teams

Intensive In-Home Treatment

Use existing models in MultiSystemic Therapy and Functional Family Therapy

Support Services

NOT INCLUDED IN PHASE 1

Behavioral Services

NOT INCLUDED IN PHASE 1

Rollout Phases

Feedback: For Phase 1, there are existing providers in MST and FFT. Will the state be using those providers and will Phase 1 be statewide?
Response: In response to feedback, HCPF is identifying providers who are already certified in MST, FFT and/or high fidelity wraparound. The next step will be to meet with the ACC 3.0 RAE organizations to determine which providers are in their network. The current proposal for Phase 1 includes a smaller population scope but is not limited geographically.

Feedback: For all phases, what if a provider is already certified in COACT for high fidelity wraparound or MST or FFT, will they need to start over?
Response: Regarding COACT, HCPF is working with BHA to minimize the need for complete retraining. Options being explored include an abbreviated version of the training or requiring a refresher course that focuses on the specifics of the proposed system of care. MST and FFT are credentialed through national organizations.

Continuous Quality Improvement

Oversight and measures

Feedback: Stakeholders and partners want a way to provide input on the providers selected or their performance. Community members in some areas of the state have indicated that some of their providers do not offer high-quality services or are not responsive.
Response: In response, HCPF is exploring ways to gather continuous feedback from community partners on the quality of the System of Care. It is reviewing processes that could be used to collect this feedback in a structured manner. HCPF is also looking into collecting similar feedback from the families receiving the services.

Feedback: How does the state plan intend to have a continuous process for updating and soliciting feedback from invested parties?
Response: HCPF will include in the implementation plan the steps to ensure regular and diverse opportunities for invested parties to provide input on the rollout of services.

Discussion

Thank You!

We encourage stakeholders, families, and community partners to stay informed. Sign up for the Medicaid System of Care for Children and Youth Behavioral Health newsletter and visit the website for meeting links, agendas, updates, and resources.