Stakeholder Feedback Summary: Medicaid System of Care

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.

Goal for 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 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 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.

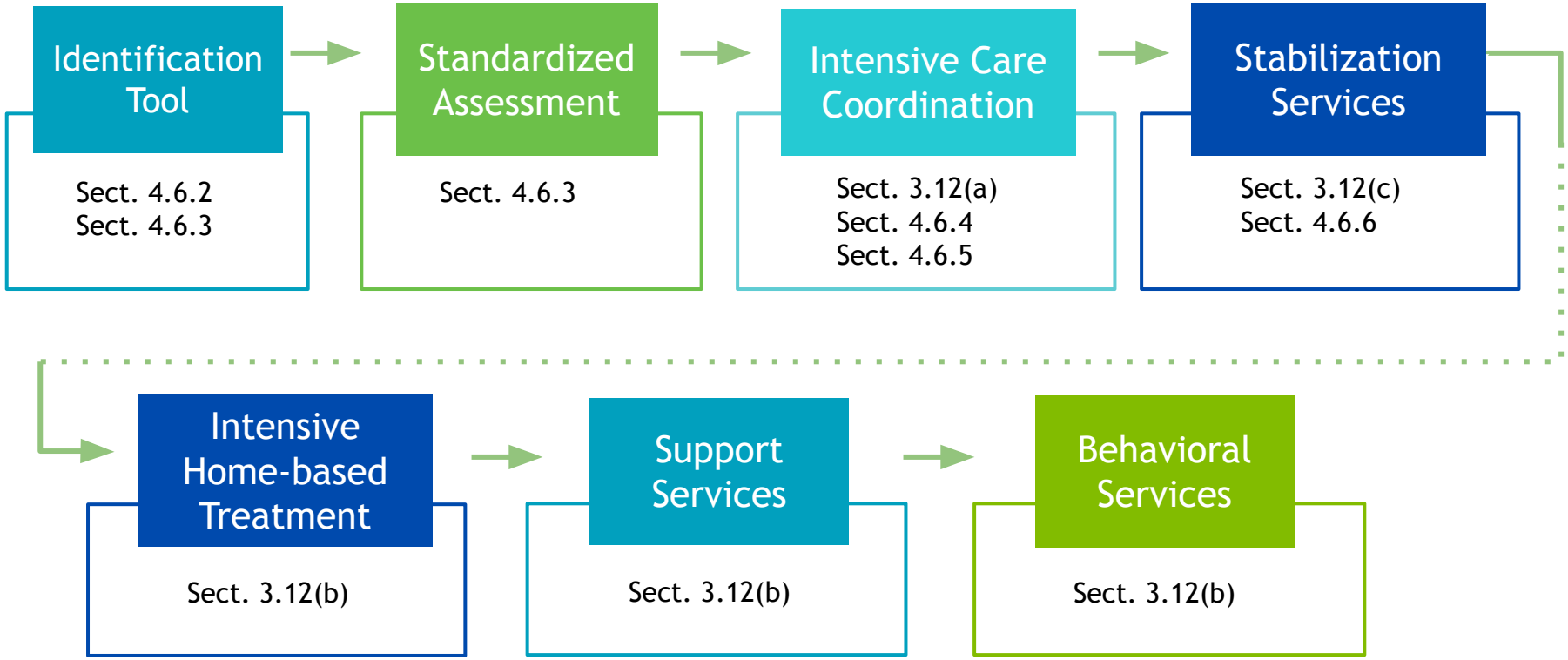
Support Services

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

Behavioral Services

Behaviorist 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 between in-person and virtual
- In-person covered the entire state
- By in large the feedback and input about the proposed system of care was positive. Most participants liked 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 clearer explanation from HCPF, which it will addressed in the Implementation Plan.
- A lot of input about whether reimbursement rates will be sufficient to cover provider costs for several of the proposed interventions.
- Workforce shortage concerns was a theme across all meetings.
- Lots of questions on how existing organizations and providers fit into the system of care (addressed through outreach and 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 other than just going to the same consumer advocacy organizations to garner interest in being a part of the Lived Experience Advisory Committee.

Response: HCPF is in the process of finalizing how it will solicit interest for being on the committee. This includes approaching existing consumer advocacy organizations and other organizations known to HCPF. In addition, an email will be sent out to anyone that attended the presentations last summer to gather names of those interested in being on the committee.

Population Specifics

Population Specifics

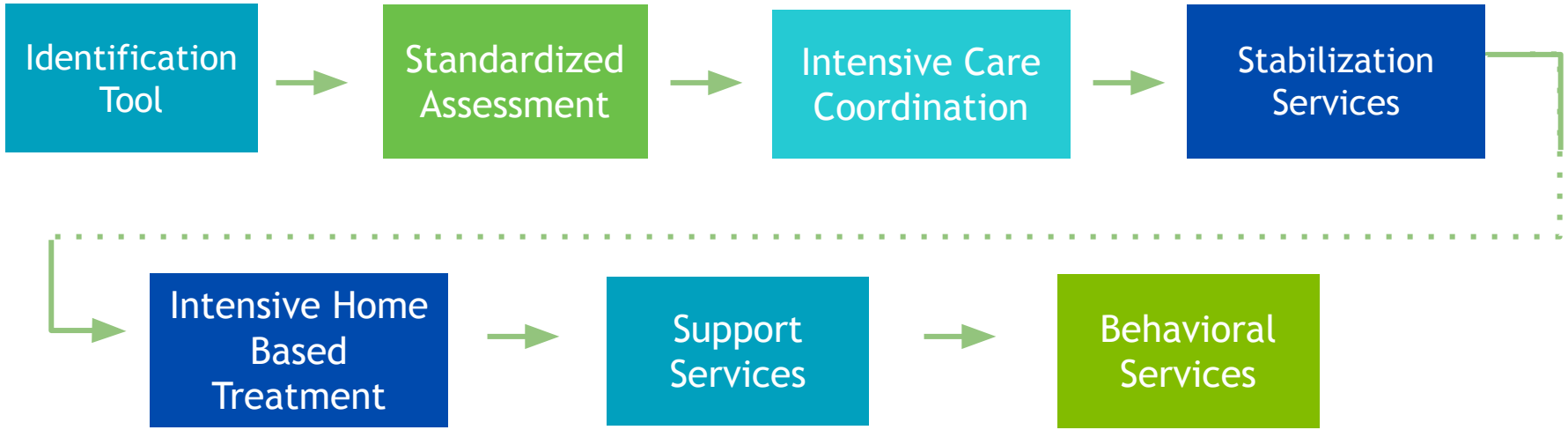
Feedback: Wanting clarity on how these services are available for children who are in foster care, juvenile justice, or are homeless?
Response: The services are available to any Medicaid Member under the age of 21 who is in a family-like setting. In response to feedback, HCPF is working with CDHS to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

Feedback: Interventions for very young children are often delivered to the parents and not the child, the proposed approach appears to be child centered.
Response: Unfortunately, the proposed plan is for the Medicaid member under the age of 21. This does not prohibit a parent who is a Medicaid member themself and want to access approved services through their benefits. HCPF is working with invested parties to identify child/parent interventions in which the medical necessity is for the young child.

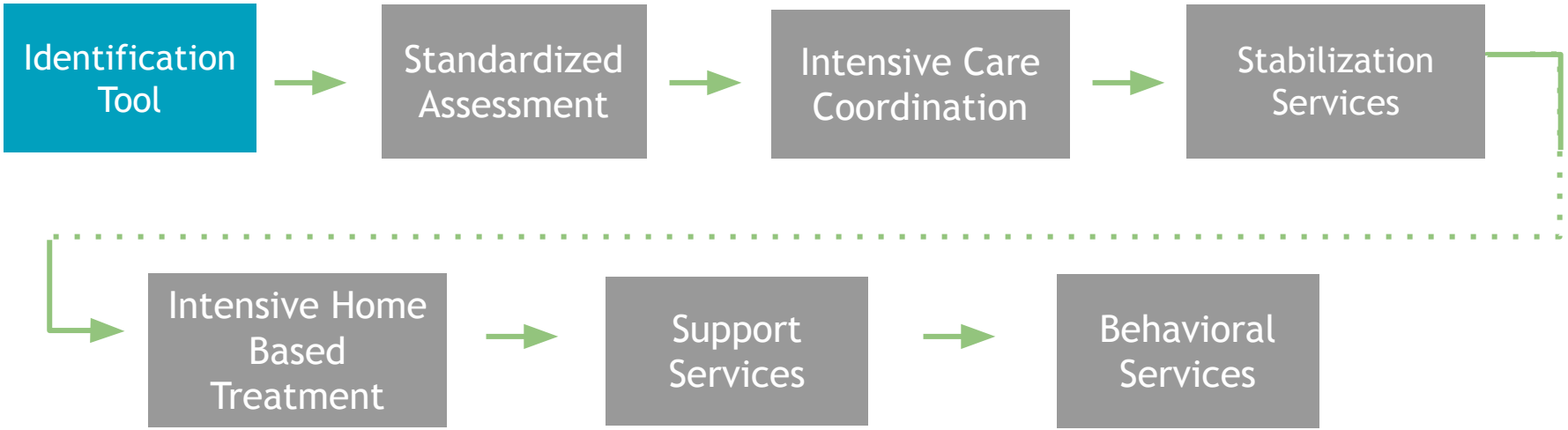
Feedback: What about services for the parents?
Response: Unfortunately, the proposed plan is for the Medicaid member under the age of 21. However, this does not prohibit a parent who is a Medicaid member themselves from accessing approved services through their own benefits.

System of Care Structure

System of Care Has 7 Key Parts



Part 1: Identification Tool

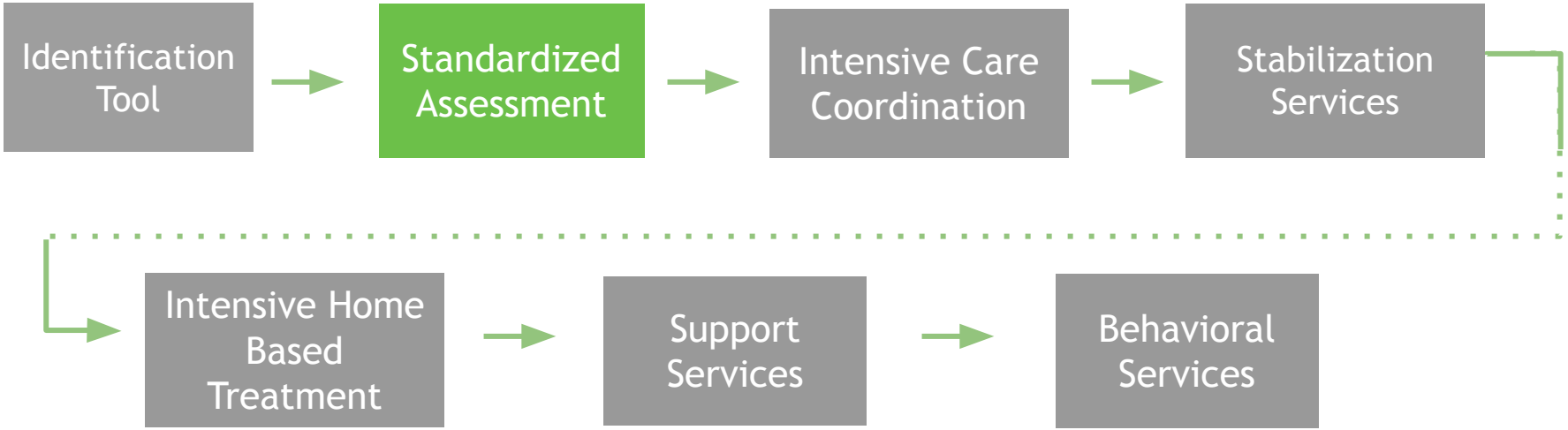


Identification Tool

Feedback: Be clear on what is the definition of “complex mental health needs.” Concerns around variance in interpretation of this definition.
Response: Agree that a consistency is key here. That is why HCPF and BHA are working with Univ. of Kentucky/John Lyons on making sure the tool is a byproduct of the development of the assessment (CANS) and has a low threshold for a positive result. In addition, the same tool will be applied to all RAE regions for consistency.

Feedback: Will the state track the screens?
Response: Yes the state intends to collect data to track the screens. There is still quite a bit of work to be done to determine how to make that happen without significant cost or administrative burden. The Identification Tool will not be used in Phase 1.

Part 2: Standardized Assessment



Enhanced Standardized Assessment

Feedback: Concerns around the acronym SA as it is associated with assault.
Response: Changed to ESA (Enhanced Standardized Assessment)

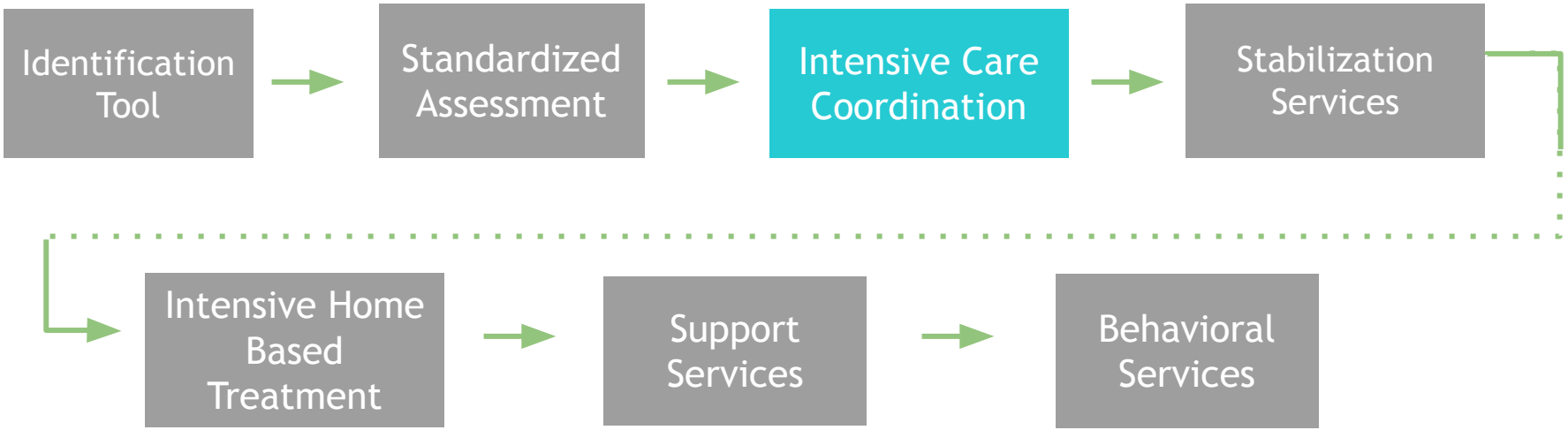
Feedback: Concerns about timeliness of access to services. How long is the maximum time to complete the assessment and what is the maximum time to access services once completed?
Response: ESA must be completed in 14 calendar days and services accessed within 3 business days after ESA completed. It is important to point out that services can start before the ESA is completed.

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

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

Feedback: Concerns that there will be too many different assessments across varying agencies.
Response: Any behavioral health assessment across agencies will use the same CANS. Those assessments may have additional requirements added on top based on agency needs.

Part 3: Intensive Care Coordination



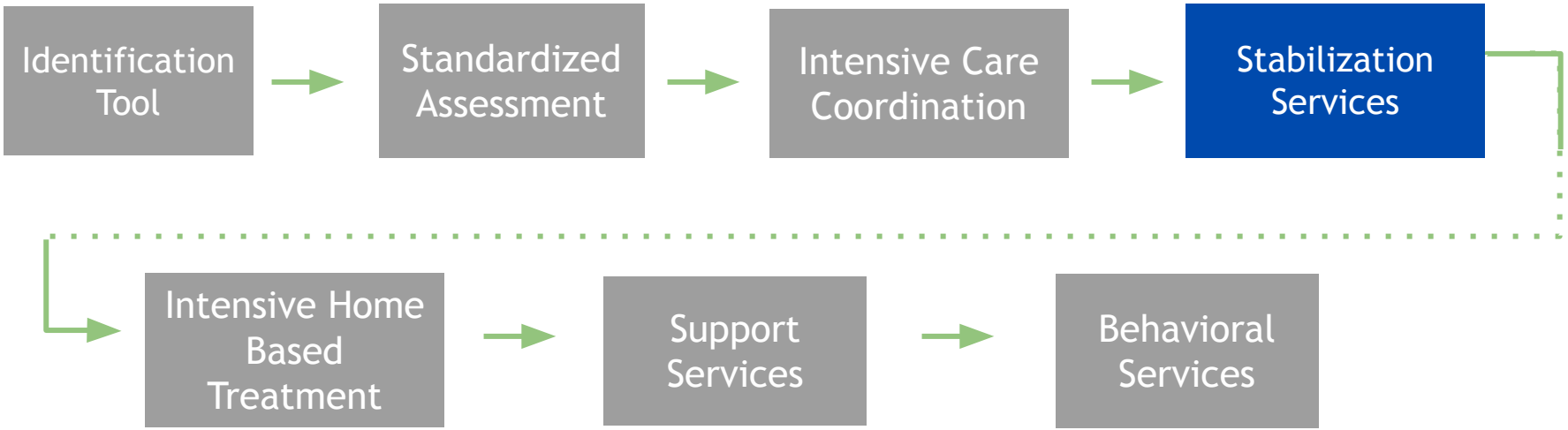
Intensive Care Coordination (ICC)

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

Feedback: Concerns about who delivers the care coordination. Specifically, desires for conflict free intensive care coordination were expressed. This included organizations other than government agencies or managed care entities.
Response: The plan proposes that counties and RAEs can not be the intensive care coordinator, although they can be a part of the multidisciplinary team lead by the coordinator. There is a determination to be made if the in-home provider can be ICC too. After hearing about concerns about provider availability in rural areas, HCPF is entertaining the concept of rural waivers for such policies.

Feedback: Agencies wanted to ensure that there will be 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.

Part 4: Mobile Response Stabilization Services



Crisis Mobile and Resolution ~~Response Stabilization~~ Services

Mobile Crisis Response (MCR)

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

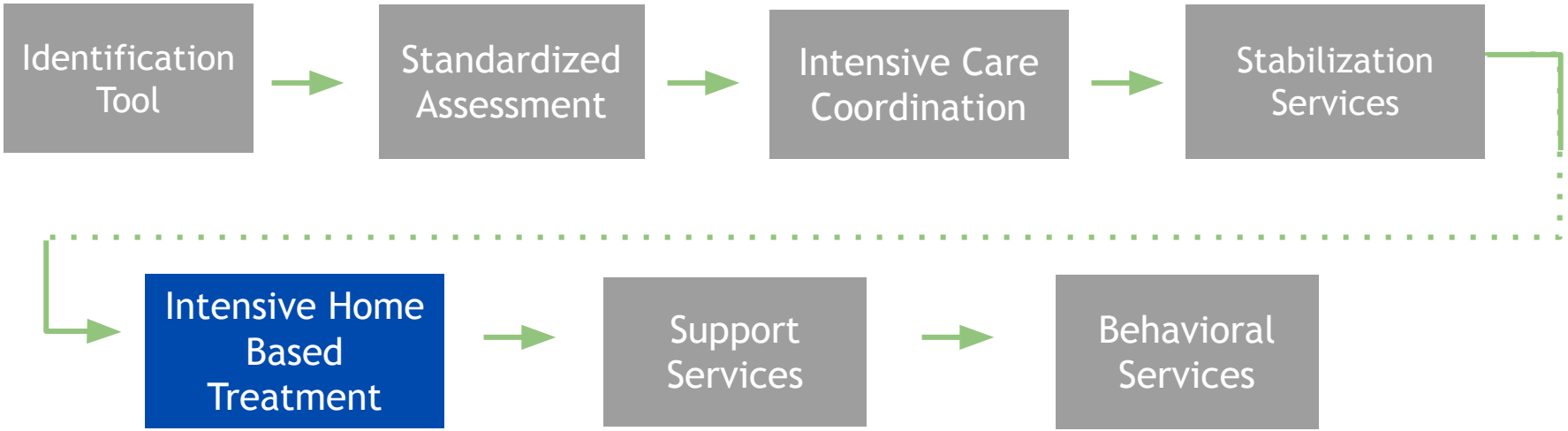
Feedback: Concerns that MCR is currently a generalist approach and not enough child, youth and family or other specific expertise.
Response: HCPF and BHA are reviewing current training and will enhance accordingly.

Feedback: Workforce is going to be a challenge, especially if child trained experts are required.
Response: The plan was adjusted to not follow the national MRSS model and modify to CO, so that MCR teams will have access to a child/youth trained professional but not have to employ them.

CSU

Feedback: Concerns access is limited to denver metro area.
Response: HCPF will review data and work with BHA to identify areas where services are needed, understanding that it is a need outside of 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:

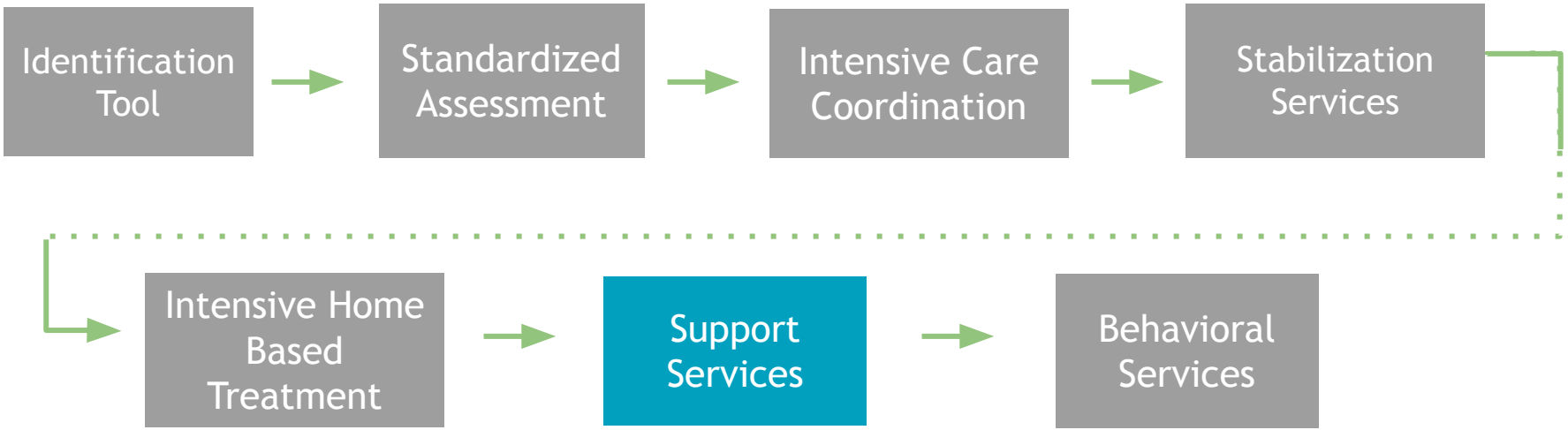
1. Under eight years old
2. Young adults (18 to 21 years old)
3. Intellectual and/or Developmental Disabilities

Response: In response, HCPF held additional meetings for populations specific to under 8 and IDD. For all 3 populations, HCPF decided to have further research and engagement, therefore no decision was made and it will spend next 12 to 18 months working with invested parties to flush out in greater detail the appropriate interventions.

Feedback: Rates have to be there to cover true costs of delivering services otherwise it is not sustainable model for providers.
Response: Agreed. HCPF is currently reviewing approaches that recognize true costs and the additional requirements that accompany the application and intensity of these models. This includes potentially creating new billing codes.

Feedback: Want to make sure chosen interventions are culturally responsive.
Response: HCPF will review MST and FFT for their cultural responsiveness or research existing literature on it.

Part 6: Support Services



Support Services

Family Peer Supports

Feedback: Want to make sure family peers are paid as a professional service.
Response: HCPF agrees. The plan is to explore competitive rates and work to identify appropriate ratios for family peer supports to families/members.

Respite Services

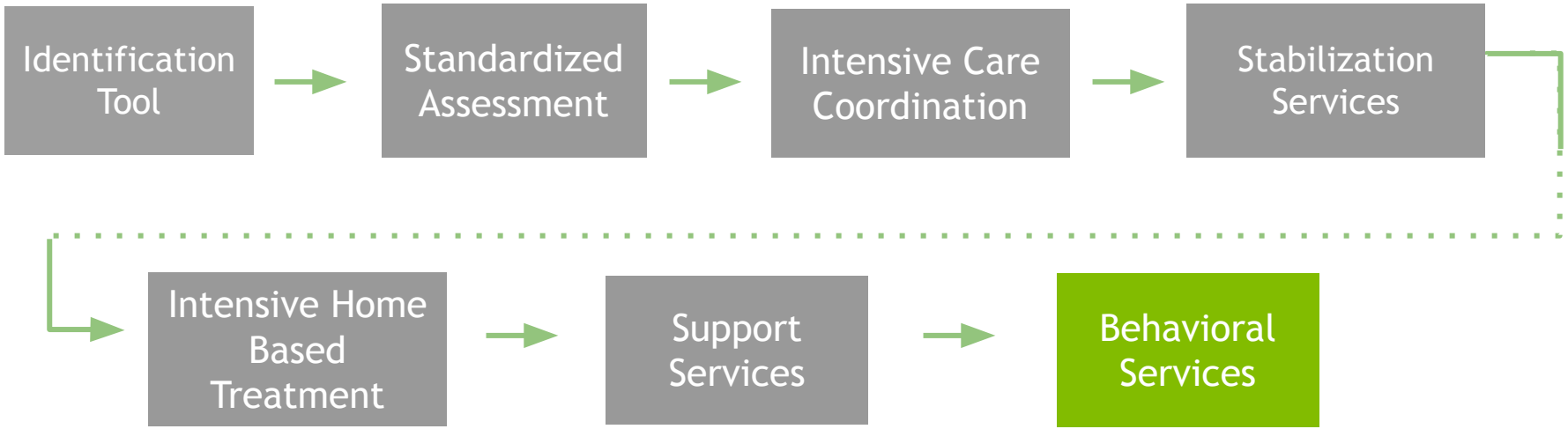
Feedback: Workforce challenges have continued to be an issue with have enough providers
Response: HCPF agrees and wants to engage invested parties further to find both a viable funding approach and flexibility on who is a provider.

Therapeutic Mentoring

Feedback: Why don't we just use peers instead of introducing this new service.
Response: After consideration, decision was to keep Therapeutic Mentoring. Mentors can be people with lived experience but not required. Therapeutic Mentoring creates an entry level position into the Behavioral Health workforce pipeline.

Feedback: More family supports are needed, such as education.
Response: In response, HCPF has a national consultant reviewing and make recommendations.

Part 7: Behavioral Consultation Services

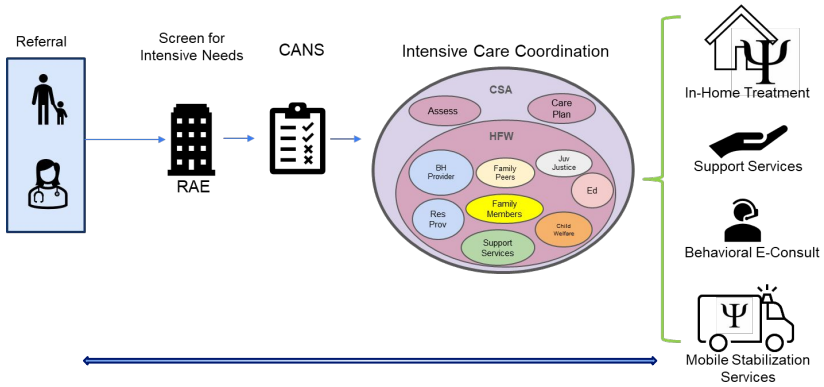


BEHAVIORAL SERVICES

Feedback: A number of participants had concerns with the ABA model. And recommended looking at different models.

Response: HCPF will work to make sure that any consultant is not limited to ABA model and is familiar and can speak to other behavioral interventions as well.

Medicaid System of Care Flowchart



Feedback: What happens if identification tool or assessment determine 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 working on having clear contract language in RAE and BHASO contracts to avoid any person being missed because they came in 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 any gaps between the intensive care coordinator and/or providers.
Response: HCPF is completing ongoing work with the contracts team to ensure expectations in contracts for the RAEs are explicitly clear, including that one of the requirements for the RAEs' roles is to prevent gaps from being created.

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 provider for each type of service. HCPF is working with the BHA to determine if those expectations should live in rule or in 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: As part of receiving this input, HCPF is internally reviewing what care coordination expectations exist and how they may or may not overlap. More to be determined as this unfolds. HCPF is also taking another look on 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.

WORKFORCE CAPACITY CENTER (WCC)

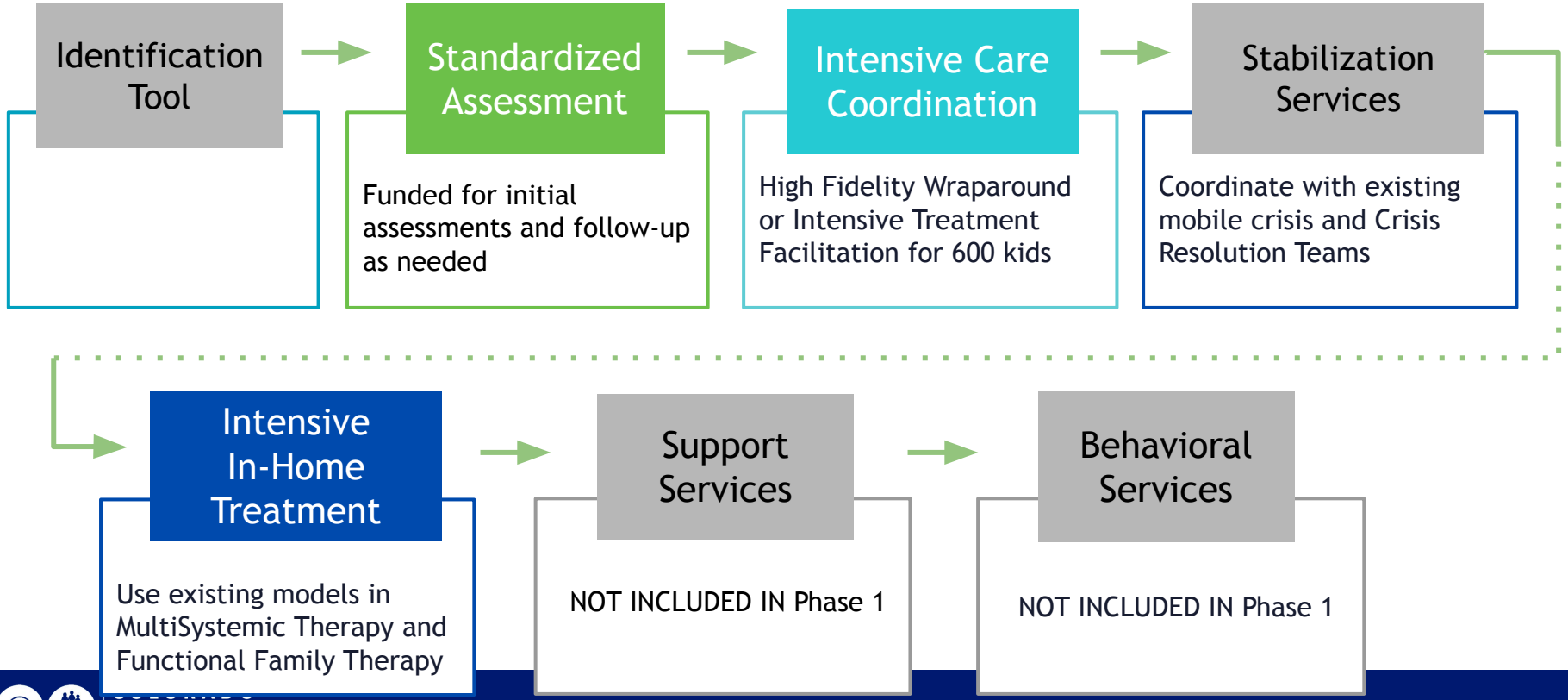
Feedback: Concern about workforce statewide, but especially for rural areas. With a significant amount of services, concern about enough workforce.
Response: HCPF brought back workforce concerns to the BHA and will strategize on solutions. The plan will capitalize on the workforce pipeline BHA is creating. In addition, HCPF is minimizing the number of licensed clinicians that is required but will not compromise care. Several of the positions are entry level in an effort to keep people in their communities while also taking a first step in the Behavioral Health workforce pipeline. HCPF will work with BHA to discuss potential workforce strategies with invested parties.

Feedback: There are many entities who provide Behavioral Health training, including colleges and universities across Colorado.
Response: HCPF will add requirements for any institute selected to lead the effort on the workforce capacity center, that they are also required to work with other educational institutions.

Feedback: Concerns that often only new graduates are available to provide services in some areas.
Response: HCPF is selecting intervention models that have high amounts of supervision and looking at mechanisms to cover all the costs for these models. This will help ensure new graduates are appropriately trained, supervised and provide interventions to fidelity.

Rollout

Phase 1 for Medicaid SOC Services



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 who is in their network.
The current proposal for Phase 1 includes a smaller population scope and not limited geographically.

Feedback: For all phases, what if someone has already been certified in COACT for high fidelity wraparound or MST or FFT, will these providers have to start over?
Response: Specific to COACT, HCPF is working with BHA to minimize any need to be completely retrained. Options being explored include taking an abbreviated version or just requiring a refresher training that highlights specifics for the proposed system of care. MST and FFT are credentialed through national organizations.

Continuous Quality Improvement

Oversight and measures

Feedback: Stakeholders and partners want to have a way to provide input on the providers selected or performance. Community members in some areas of the State indicated that some of their providers do not offer high-quality services and/or are not responsive.
Response: In response, HCPF is looking at ways it can get continuous feedback from community partners on the quality of the System of Care. It is examining different processes that it may be able to use to get this feedback in a structured manner. HCPF is looking at the same thing from families who are receiving the services.

Feedback: How does the state plan to have continuous process for updating and soliciting feedback from invested parties.
Response: HCPF is going to add to the implementation plan the steps to have regular and various opportunities for invested parties to provide their 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.