RAE1 Regional Program Improvement Advisory Council (PIAC) December 2022

December 6, 2022, 10:00am-1:00pm

Location:

In-person at the Mesa County Workforce Center, 512 29 1/2 Road, Grand Junction, CO 81504 in Conference Room D. **If you plan to attend in-person, please RSVP to ReNae Anderson renae.anderson@uhc.com by Friday, December 2, 2022 for an accurate headcount for lunch.**

NOTE: If you have specific dietary requirements, please note as such in the RSVP email. We will accommodate vegetarian and gluten free options.

Zoom platform for remote participation

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Agenda

1. ***10:00am-10:15am:*** Introductions/Welcome
   ReNae Anderson, Community Solutions Specialist, RMHP

2. ***10:15am-10:50am:*** Executive Leadership Overview
   Meg Taylor, Vice President Behavioral Health

   MSO
   BHA
   ACC 3.0

3. ***10:50am-11:10am:*** Key Performance Indicators and Behavioral Incentives
   Jeremiah Fluke, Director, Contract Administration, Community Integration, RMHP

4. ***11:10am-11:30am:*** Hospital Transformation Program
   Alex Barreras, *Program Manager/Consultant, Colorado Market* **APM Relations**

5. ***11:30am-12:30pm:*** Colorado Health Institute Stakeholder Engagement
   Sumn Mathur, Allie Morgan, Kendra Neumann.

6. ***12:30pm-12:45pm:*** RAE1 Membership Advisory Council Updates
   Larimer County -**Alison Sbrana**

   Western Slope -**Tom Keller**

7. ***12:45pm-1:00pm:*** Community Investment Funding Next Steps
   ReNae Anderson, Community Solutions Specialist, RMHP

Regional RAE1 PIAC Meeting Minutes

Location: Mesa County Workforce Center and Zoom
Date: Tuesday, December 6, 2022
Time: 10:00am-1:00pm

Attendees

RMHP:

ReNae Anderson ^ ,Maureen Carney, Krista Cavataio, Jeremiah Fluke, Patrick Gordon, Kendra Peters, Meg Taylor ^, Sarah Vaine

External:

Scott Aker, Kim Campbell, Sherri Coree, Janice Curtis ^, Dan Darting, Dan Davis, Shawn Davis ^, Caitlin DeCrow, Ian Engel, Dana Erpelding, Jen Fanning, Jaime Fitzsimons, Alyssa Franklin, Shaunelle Fruit, Cristina Gair, Mason Hohstadt, Kellie Jackson *, Michelle Jonjak, Tan Hybeck, Jessica Jensen, Alison Keesler, Tom Keller ^* , Tracy Klunker ^, Meighen Lovelace ^, Claudette Mondragon, Wade Montgomery ^ , Robert Nelson, Melissa Obuhanoick, Bianca Ochoa ^*, Julie Reiskin ^, Sheila S., Melinda Sandgren, Sylvia Santana ^ , Allison Sailor, Alison Sbrana *, Rebecca Schickling, Namrata Shrestha, Cindy Sears, Herberta Silas ^*, Imo Succo, Staci Russell, Andy Tillman ^, Brian Trujillo, Holly Vanderseller, Brittney Wilburn, Janet Wolfson,

Key: *^-In person attendee*

**-Voting member*

Organizations Represented: Aspen Hospital, Centura Health, Colorado Cross Disability Coalition, DentaQuest, Family Health West, Garfield County DHS, GI Hospital, Grand County Rural Health, Grand River Health, Loving Beyond Understanding, Mountain Family Health Centers, Native American Resource Center, NCC Health Partnerships, Northwest Colorado Center for Independence, Pagosa Springs Medical Center, PDF Consulting, Primary Care Partners, Quality Health network, SCL Health, Signa LBHN, State of Colorado, Southwest Colorado Area Health Education Center, Southwest Health System, Summit County DHS, Vail Health, Valley View Hospital, Visible Voices,

Agenda Items:

Meeting Call to Order: Meg Taylor, Vice President Rocky Mountain Health Plans shortly after 10:00am, after some technical issues. In-person attendees introduced themselves and virtual attendees placed their information in Zoom chat. Introduced ReNae Anderson, new team member and facilitator for PIAC. Explained Nicole Konkoly has moved to different areas within United and we may still see her periodically.

Executive Leadership Report – Meg Taylor, RMHP

- Review Agenda
- Colorado Health Institute will be joining us for part of the time. HCPF has hired Colorado Health Institute to convene stakeholder sessions about ACC 3.0. or the accountable care collaborative 3.0. It is the next coming iteration of whatever the RAE's and Medicaid will look like in state of Colorado. They are joining our PIAC today to solicit stakeholder feedback from you all.
- Hospital Transformation work will also be talked about.
- Key Performance Indicators. We heard loud and clear that you want these easier to understand, so we will have a brief performance overview.
- Final voting on Community Reinvestment Funding of $500,000. PIAC voting members determined where the funding will go.
- Introduce Sarah Vaine, Vice President, Community Integration, Rocky Mountain Health Plans
- Meg Taylor is shifting to new role, focusing on behavioral health.
- MSO or Managed Service Organizations
- Update on ACC 3.0
- Questions about BHA if needed.
- Rocky is hoping to focus more on LGTBQ on western slope.

    - Andi from Loving Beyond Understanding asked to say a few words regarding their work.
    - Loving beyond understanding Love first, understand later
    - New nonprofit in Grand Junction. Creating safe spaces and supports for LGTBQ teens, parents, trans people, elders, etc.

    - Provide safe shopping, safe medical, trans affirming careers
    - Latino groups, moving into rural communities, with some pilots occurring in certain rural areas.
    - Curriculum created with Dr. Jessie Smith, Salt Lake City, to train mental health and medical providers for residency and gender comprehending and understanding. Fundamental foundation training and deeper training for clinics, both behavioral health and medical practitioners.
    - Working closer with organizations within Grand Junction that serve this population, finding the gaps and working on closing those gaps.
    - Developing a training for trainers, eventually going statewide with training. This will be about 20 hours of training.
    - Loving Beyond Understanding is focusing on clients and patients to start getting affirming care, then, also looking at the system to see where the barriers are and see how they can be removed. Want to get more resources in a way that works with them while also maintaining that secrecy and privacy.
    - They are also working on a window sticker for businesses to show they are a safe environment to enter. Businesses will be certified with training and will need to renew each year.
    - Shawn Davis added that Rocky has health equity focus with LGTBQ Plus, which means integrating into everything and the communities, hopefully through the 22 counties, in working with providers with behavioral and physical health. This is a key part of Rocky's mission and since we elevated it, we are working with 8 counties so far and will have goal of expanding to all 22 counties.
- Meg Taylor -Checking in on inclusivity with ReNae Anderson. Crating a power point slide and realizing that is not accessible to someone who can't see it. Let's keep thinking on how to do this betterer and I have never considered Power points before inclusivity is important. It is broad.
    - Meg asked ReNae Anderson does it help when an entire group of people, when they go around and introduce themselves, to self-describe what they look like? She said, no, it doesn't have anything to do with the meeting, so it is not important. She likes to know who is in the room around her but doesn't care that she is wearing a jean jacket.
    - How we do this better collectively and how we do this as an organization…Am I going to make every slide compliance or that it is totally readable, if doing it the night before, probably not, but we have to keep working toward this.
    - Shawn Davis adds: It speaks to what is health equity and how we talk all a lot about it, but it is taking small steps and being intentional with everything you do, thinking about the different populations and how they are affected, by our decisions. One or two small steps help as it turns into focusing on a whole.
- Managed Service Organizations (MSO)
    - It is an entity in Colorado that serves people in need of further supports peer supports, treatments for substance use disorders. These are still a niche contract in Colorado.
    - They will be a part of the bigger BHASO's in the coming year.
    - MSO divides region into two regions, Region 6, but include all 21 counties on western slope. The MSO does not include Larimer. Larimer has different MSO.

- Contract to occur on January 1, 2023. Rapid procurement. West slope CASA currently holds contract for MSO. They notified the state that they would not renew their contract. Rocky bid on the contract and got the contract. This deals with substance use.
- Recovery services, recovery housing, peer support all fall under RAE for SUD
- Whole person care
- Room and board are the only covered treatment on Medicaid. This will include more.

Q: Julie Reiskin: Is it possible to have the same regions so we didn't have all these different things?
A: Meg Taylor: I think so.

Julie Reiskin: It can get confusing for clients if you don't work in the area to have someone you are trying to get help for, and it is very hard to figure out if you are not in this field.

Meg Taylor: Well, we know that CMA's are not originally align. These are the case management agency. Single entry points for long time services and support. Community center boards for Intellectual and development disabilities, both provide case management services. CMA for those two agencies will be combined.
Meg: A new CMA with RFP to drop on 12/25 or 1/1.

Q: Meighen Lovelace: Lake County isn't in here, but most people that live in Lake County, work in and recreate in Summit and Eagle counties. SEP identified person in either Summit or Eagle county. Is there a way to bring Lake in or what?
A: Meg Taylor: CMA regions are not going to align. There are 20 regions. I do think it is possible for the BSASO's, but not the RAE. HCPF most recent PIAC released a FAQ of were sticking with regions, but didn't necessary say what the geography is. That is what my hope is.

Meg: MSO umbrella will be under Behavioral Health Administration ASO.
This is what is thought, that regions are more aligned or will become more aligned.

Q: Meighen Lovelace. Is there a flow chart for those of us that are not embedded in it?
A: Meg Taylor: That is a good question and a good idea. It would be helpful for those that get contracts also. That is really good and no there is not.

Meg suggests send out a diagram shared last PIAC to include about the MSO. (See attached document)
Very valid point especially since Larimer County is not a part of it.
Showed diagram of MSO region.
Questions from chat: Will it show the chain of command? Yes

Andi Tillman: Most LGTBQ people go to Salt Lake for treatment. It is safe services. It is way easier to get to than Denver. Working a lot with Utah agencies as there is a lot of overlap. United is national?

Meg Taylor: That is good to know, especially for a contract perspective,

Andi Tillman: Medical and behavioral because they just can't get it here. We are working really hard on changing that.

Meighen Lovelace: True Gender Identity at Children's hospital in Denver.

Andi Tillman: This is true, but Denver is a long way from here. Especially if you don't have a car or a job. Or safe means of travel. Denver is really overloaded. It is easier to get services in Salt Lake. 18 month waiting list for behavioral health, with 82% needing it and 60% denied.

Meighen Lovelace: 3 year wait at the True Center in Denver. Too long of a health risk.

Meg Taylor: Andi/ReNae, have this as one of our conversations at next PIAC. Bring in Loving Beyond Understanding, Western Pride, Safe Space, etc.

What we do, who contracted with, Funding is transitioning from West Slope Casa. We will get to a point where can expand.

Currently focusing on Youth Navigator, which Rocky is trying to hire.

ACC 3.0

- HCPF Member communications
- Equity and care coordination
- Behavioral Health Administration
- Technology and date. Include link to FAQ sheet.
- Time Line
- Concept Paper due next spring
- Draft request for proposals
- Actual drop for requests for proposals will drop in spring 2024
- Live contracts for RAE in July 2025

Julie Reiskin: Concept Paper comes out in March, which is same time budget drops with ton of lobbying going on right now about what is going to look like. Lots of influence and interest out there trying to influence that. People need to know that. One narrative is that this model doesn't work, that it should be either total managed care or total fee for service. It is very Denver-centric.

> Q: Meighen Lovelace: Who is pushing really hard right now and what sort of traction do they have around being able to influence what ends up in the concept paper?
> A: Julie Reiskin: With half the legislature new, I can't answer that. HCPF does not want to until we have a Joint Budget Committee with only 1 person that has any experience with the budget. More new legislatures than had in a very long time. We don't know. There are some powerful interests that are saying different things. Realize it is going to be for the whole state and Rocky prime works, but Denver Health, same model, is a nightmare. Flexibility to do what works in each community is important.
> Q: Meighen Lovelace: Who is writing the concept paper?
> A: Julie Reiskin: HCPF Humans and they want as is right now. Always room for improvement but would hate to lose momentum we have. Don't want more like Denver Health but want to have same programming to work within each community.

Tracy Klunker: Dual plan with Rocky works great and would like to see it all over the state.

Meg Taylor: That is great! I believe that there is an advisory council to have under the dual plan. Trying to figure how to coordinate that here. Allow for it. Alyssa Rose, who is over Rocky Dual program, a special needs plan, is trying to run down. Doesn't make sense to have it separate. Several on client council are on dual plan.

Questions:

Q: What is chain of command in decision making process with Behavioral Health Administration? Between HCPF, BHA, CDHS and how are they communicating interdepartmentally? How are they communicating outwardly and whom is responsible at the end and for those decisions that are being made across sector? What is the operational structure currently where the BHA lies?

A: BHA is a cabinet position, head of HCPF and head of CDPHE…all equal. If there is a conflict, it is the governor's office. They make decision, as all report to governor.

A: HCPF and BHA are working to align with each other and what this looks like. Not everything is going to be the same for Medicaid and the RAE's as it will be for BHASO but there is a strong and a lot of work going on to align.

Q: Will funding align and bridge gap for funding?

A: It is not going to align perfectly, as funding comes from 40 different resources. Big challenge to make this work. That is the goal but naïve to say it will all align perfectly, and communication is going to work. Dealing with humans and headbutting will occur.

Shawn Davis: Sub populations are focused on health equity, all state agencies, BHA, HCPF, HSS, all are required to have a health equity plan. All have a health equity person, and all are required to be in mind. All of them have representation and health equity committee. They are trying to align, but lots of big wheels turning very slowly.

Julie Reiskin: For complex situations, if there is not an advocate involved, it will be harder to have person get services. Need really, really good care coordinator to get services aligned.

Goal is to have ordinary person get services, without care coordination or advocate. A lot of coordination will need to happen to work.

Key Performance Indicators -Jeremiah Fluke, RMHP

- Behavioral Health Incentive Program
- Matrix incentivized for the RAE
- Give current matrix for fiscal year
- Written into contracts quality and access measures primarily the seven-day access and psychiatrist before 30 days. Different incentives for this.
- HCPF value-based contracts revising. Adopt our quality measures recommended to HCPF for Rocky's qualities.
- Must be a clinical appointment.

Q: What attributes does each provider have? A: These are listed in directories

- Take this away for care coordination.
- Telehealth expanded options and will still be option for those if telehealth doesn't work for the person.
- Some information will change as HCPF changes.

Colorado Health Institute Presentation: Kendra Newman, Allie, and Suman

Their role on this project is as an independent nonprofit research center that is in Denver but serves all of Colorado. Contracting with HCPF to lead stakeholder engagements efforts for next couple of years to form design of the Accountable Care Collaborative 3.0.

Act as neutral facilitator so interested in hearing from all of you to take all information and share take aways and take back to HCPF. Not to speak on their behalf, so, there may be questions they have that they cannot answer.

ACC 3.0

- 8 initiatives from HCPF
- Opportunity to participate on computer or smart phone.
- What is most pressing issues
- Equity consideration questions
- Additional feedback on areas
- Close out with next steps.

ACC for department to deliver cost efficient care to Medicaid members with ultimate goal of improving health of Coloradoans with 1 in 4 Coloradoans are covered through Medicaid.

ACC through RAE's coordinates regionally for medical, physical and behavioral health services

Ensure access to timely, appropriate, and effective health care.

They are building on what is already there.

What works well. Leveraging strengths.

Also, align with partners at other state agencies, lots happening in state government and other areas in Colorado

Want to incorporate input from several years and stakeholder's process.

Want to identify areas of improvement.

This is the vision stage right now.

- 8 high level priority initiatives

1) Improve quality care
2) Working to close health disparities
3) Promote health equity, with specific equity considerations.
4) Improve access to care
5) Improve member experience.
6) Managing costs to protect coverage for members

Commitments to continuity

These are off the table for phase 3.

Paying for value

Continue coordinated physical, behavioral health and community-based services model through regional delivery model. With existing 7 RAE regions.

- Continue hybrid care managed care model.
- Managed fee for service
- Managed care capitations PRIME
- Importance with aligning with other efforts. Looking to collaborate with other state agencies.

Provide high quality, whole person care to improve health equity and overall health.

Staff at HCPF will write Concept Paper. This will be a series that will be released over several months.

Q: Tracy Klunker: Are you working with ADA compliance. Could not be answered but will take back to department.

Q: Value Based services definitions question. M: Not answered, as wanted to have it come from HCPF for answer.

Q: Are values and outcomes connected? Q: Yes, probably

Definition value is important for HCPF to define.

Quality dignified care definition. No one agreed in prior days membership meeting.

Clients need to understand what somethings should look like or it doesn't mean much.

Could CHI ask HCPF for glossary of terms used in ACC 3.0? If it already exists, perhaps needs modernization from HCPF.

Working on definitions as part of the engagement with stakeholders.

Accountability for next steps

Q: Are any RAES being allowed to make these decisions? A: Other RAES don't use Membership Advisory Councils or PIAC as this matter.

(See ACC 3.0 Fact Sheet and Outline attached)

NOTE At this point, technical difficulties occurred, deleting part of the recorded presentation. A discussion ensued, regarding the presenter's inability to answer questions. Format of presentation, including using mobile phone for prioritizing. It was pointed out that this was not accessible for all involved, especially for the blind. Many were concerned regarding accountability.

Sarah Vaine impressed on how held accountable

Membership Advisory Council Reports

1. Larimer County Advisory Council -Alison Sbrana
    - Explained what was discussed at the last council meeting, held in November.
    - Chronic pain. Not being served adequately. Consumed over our meetings each time.
        - Details of what hearing and experiencing.
        - Physical therapy is not adequate with members with chronic pain. Needs to be available for those that need PT to maintain baseline.
        - Issues with providers, PAR, Explore for over limit with specific diagnosis.
        - HCPF discussed many times to work through areas and policies that need to change.
        - Not allowed to "cash pay" for Medicaid covered services. More clarification with HCPF
        - Barriers face around chronic pain is that providers are afraid to increase medication with limits.
        - Need solutions and they are not going to be simple.
        - Connecting data with lived experience. To what we are seeing in data.

Questions: Is data reflecting lived experience? A: Yes, and is the proposal to create matrix that are additional component to existing data or replace some matrix with more appropriate data.

Allison: no level yet. Able to bring lived experience to table and what barriers are facing. Open to changing matrix.

- Medication to control chronic pain.
    - Insurance says no, how to cover this.
    - Barriers have been less for insurance for medication, but mostly with volitive life policies and opioids.
    - No one will take client on because they are on opioids.
    - Trouble filling scripts because of controlled substances.
    - "Cash pay" and "medication pay" especially in rural and alternative therapies. Can no longer see provider for anything else if pay cash.
    - Getting clarification on "cash pay" for Medicaid covered services. When Medicaid covered service having many barriers but are not able to cash pay because of Medicaid covered service.
    - Quality of care keeps some people to go without for medication

2. Western Slope Membership Advisory Council Report -Tom Keller
    - ACC 3.0
    - Rocky approach to changes
    - HCPF eligibility director and invited people to show up at our meeting.
    - HCPF wants to talk to all.
    - CMS snobbish as to who they want to talk to.
    - CMS says to deal with state and everyone else deal with us.

Spanish Membership Advisory Council -Shawn Davis/Julie Reiskin

- Bianca Ochoa new leader
- Oversees whole region.
- Build relationships.
- Facilitate and dedicated CCDC bilingual advocate.

RMHP Reinvestment Funding -ReNae Anderson (RMHP)

- After voting on the proposals at last meeting in September, it is determined that two projects will be funded; Social determinants of health and SSI/SSDI Navigators. A quorum of the voting members voted to what percentage the $500,000 allotted funding would be dispersed to each proposal. Below is the results.
- 41.25% for Social Determinants of Health Funding Resources
- 58.75% for SSI/SSDI Navigators

Further information will be attached to this document.

Questions:

Q. With the SSI/SSDI Navigators, where will they be housed?

A. Probably through Center for Independence. They have trained staff and are up on what to do. Independent living centers don't want to be only person in town to do it. Need second option.

New director at CFI in Grand Junction

Q: Will navigator be along with client for whatever is needed for access to funding? A: That is the plan

Sarah Vaine email and phone shared with group.
Sarah.vaine@uhc.com
970-333-1782
Sarah shared her gratitude for effort and show how members engage. Asks hard questions and give opportunity for Rocky to improve.

Meeting adjourned at 1:00pm

Next Meeting on Tuesday, March 14, 2023, 10:00am-1:00pm via the hybrid; In person at Mesa County Workforce Center and on Zoom.

Managed Service Organization (MSO)

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What is a Managed Service Organization?

- An entity designated by the Colorado Behavioral Health Administration to manage substance use services for adults and adolescents who are uninsured or underinsured in a specific region of the state
- Provides systems and financial management, data and tracking systems, and quality assurance functions.
- MSOs may subcontract with provider agencies for a variety of direct services.

Beginning January 1, 2023 Rocky will be the MSO for the following counties:

Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, and Summit

Managed Service Organization (MSO)

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What do Managed Service Organizations do?

- Promote access to substance use services and help people locate care
- Fund substance use services for people who are low income and uninsured
- Contract with providers (often through capacity funding arrangements) to offer withdrawal management (detox), residential treatment, medication assisted treatment and outpatient treatment to individuals with substance use conditions who are unable to pay for care
- Monitor quality and access to care
- Fund recovery support services such as recovery living, peer support and community organizations supporting recovery
- Fund substance use services for families involved with child welfare to enhance and complement substance use core services funding
- Administer funds to build substance use treatment and recovery support capacity throughout their regions

MSO Services and Providers

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- Funded Services and Programs (*not* exhaustive *see Appendix A)
  - Involuntary Commitment Services
  - Medication Assisted Treatment and Overdose Prevention
  - Outpatient and Residential Treatment Services
  - Withdrawal Management Services
  - Recovery Residences
  - Peer Navigators
- Contracted Providers (*not* exhaustive *see Appendix B)
  - Axis South
  - Advocates for Recovery
  - Community Compassion Outreach
  - In the Weeds
  - Mind Springs Health
  - Oxford House
  - Recovery Resources

Appendix A - MSO Services

Services & Programs Funded by State Funds and Block Programs	
Involuntary Commitment Services	HB19-1287 Building SUD Treatment Capacit Program
Medication Assisted Treatment and Overdose Prevention	SB 16-202 - Increasing Access to Effective SUD Services Act
Offender Outpatient Services	Coronavirus Response and Relief Supplemental Appropriations Act
Strategic Individualized Remediation Treatment (STIRT)	Recovery Residences
Opioid Treatment Program	High Risk Families Cash Fund
Outpatient Treatment Services	Recovery Support Services
Residential Treatment Services	Individualized Placement & Support
Special Connections	Recovery Support Services in Treatment Programs
Treatment Enhancement Services	Recovery Living Expansion
Withdrawal Management Services	Workforce Expansion
Women's Treatment Services	Peer Navigator for High Acuity Clients
Community-Based Circle Program	Child, Youth, and Family Behavioral Health and SUD Care Navigation, Treatment, and Recovery Services
Southern Colorado Co-Occurring Program	Substance Use Disorder Pre-Release Case Manager
Services & Programs Funded by State Opioid Response (SOR) Grants	
Medication Assisted Treatment	Residential Treatment Services
Naloxone Distribution	Individual Placement and Support (IPS)
Peer Navigators for Treatment Engagement	Mobile Health Units for MAT
Peer Navigator Program Manager	Recovery Residence Expansion
Family Services	Recovery Residence Rent
Community Reinforcement Approach	Peer Supports at Recovery Community Organizations (RCOs)

Appendix B - MSO Contracted Providers

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- Axis North
- Axis South
- 7 Cedars
- Advocates for Recovery
- Astepup
- Axis Health System
- Colorado Counselor Training
- Community Compassion Outreach
- Front Range Clinic
- Grand Junction Metro Treatment
- In The Weeds
- Kings & Priests (Discovery Café)
- Memorial Regional Health
- MidValley Family Health
- Mind Springs Health
- NW Colorado Community Health Partnership
- Odyssey Training
- Oxford House
- Peer 180
- Recovery Resources
- River Valley Family Health Cent
- Summit County
- The Recovery Center
- Young People in Recovery

ACC 3.0

The Department of Health Care Policy and Financing (HCPF) Areas of Opportunity:

- Member Communication and Support
- Accountability for Equity and Quality
- Referrals to Community Partners
- Alternative Payment
- Care Coordination
- Child and Youth
- Behavioral Health Transformation
- Technology and Data Sharing

FACT Sheet

- ACC Phase III Fact Sheet November 2022.pdf (colorado.gov)

ACC 3.0 Timeline

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COLORADO
Department of Health Care Policy & Financing

1

Behavioral Health Administration (BHA)

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RMHP Key Performance Indicators and Behavioral Health Incentive Metrics

December 6th, 2022

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Key Performance Indicators (KPI)
Performance Metrics for FY 22/23

As a reminder, here are the FY 22/23 Metrics for KPI's

(*physical health metrics for July 2022 to June 2023*)

- Behavioral Health Engagement (full population)
- Emergency Visits (PKPY) (per member/per month) (full population)
- Well Visits Part 1-1 (First 15 months)
- Well Visits Part 1-2 (15-30 months)
- Well Visits Part 2 (3-21 years)
- Oral Evaluation, Dental Services (age 21 and under)
- Prenatal Visits (those eligible in full population)

Behavioral Health Incentive Program (BHIP) Performance Metrics for FY 22/23

As a reminder, here are the FY 22/23 Metrics for BHIP's

(*behavioral health metrics for July 2022 to June 2023*)

- Engagement in Outpatient Substance Use Disorder (SUD) Treatment
- Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition
- Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder
- Follow-up after a Positive Depression Screen
  - Gateway metric for this indicator – Regional Depression Screening Rate
- Behavioral Health Screening or Assessment for Children in the Foster Care System

Metric Performance

KPI Performance:

	FY21/22 (July 2021 to June 2022)						
Metric	**Baseline**	**Goal Tier 1 (T1)**	**Goal Tier 2 (T2)**	**Q1**	**Q2**	**Q3**	**Q4** (Preliminary if listed)
Behavioral Health Engagement	(FY19/20 15.28%	15.43%	16.04%	**Met**	**Met**	**Met**	TBD
Dental Visits	(FY19/20 39.35%	39.74%	41.32%	**Met**	**Met**	**Met**	Prelim Met
Prenatal Visits	(FY19/20 55.42%	55.97%	58.19%	**Met**	**Met**	**Met**	Prelim Met
Emergency Department (PKPY)	(FY19/20 556.1 PKPY	550.5 PKPY	528.3 PKPY	**Met**	**Met**	**Met**	Prelim Met
Potentially Avoidable Complications	N/A	100% points met		**Met**	**Met**	**Met**	**Met**
Well Visits Part 1-1 (First 15 months)	CY 2020 45.71%	Q1: 45.57% Q2: 47.42% Q3: 48.28% Q4: 49.14%		**Unmet**	**Unmet**	**Unmet**	TBD
Well Visits Part 1-2 (15-30 months)	CY 2020 54.23%	Q1: 54.87% Q2: 55.52% Q3: 56.16% Q4: 56.81%		**Unmet**	**Unmet**	**Unmet**	TBD
Well Visits Part 2 (3-21 years)	CY 2020 31.20%	Q1: 32.42% Q2: 33.64% Q3: 34.86% Q4: 36.08%		**Met**	**Met**	**Unmet**	TBD

*Due to claims lag and run-out, FY22/23 (July 2022 to June 2023) data is unavailable at this time.

United Healthcare Community Plan

Rocky Mountain Health Plans A UnitedHealthcare Company

BHIP Performance:

Metric	FY 21/22 (July 2021 to June 2022)			FY 22/23 (July 2022 to June 2023)		
	Baseline (FY20/21)	Goal	Preliminary performance	Baseline (FY20/21)	Goal	Preliminary performance (Avg of July 2022 to Oct 2022)
Indicator #1: Engagement in Outpatient Substance Use Disorder (SUD) Treatment	47.90%	49.06%	Unmet	47.90%	49.06%	Unmet
Indicator #2: Follow-up within 7 days of an Inpatient Hospital Discharge for a Mental Health Condition	44.48%	47.78%	Unmet	44.48%	47.78%	Unmet
Indicator #3: Follow-up within 7 days of an Emergency Department (ED) Visit for Substance Use Disorder	32.46%	33.23%	Met	32.46%	33.23%	Met
Indicator #4: Follow-Up after a Positive Depression Screen	57.49%	61.32%	Unmet	57.49%	61.32%	Unmet
Indicator #5: Behavioral Health Screening or Assessment for Children in the Foster Care System	16.39%	18.39%	Unmet	16.39%	18.39%	Unmet

*Indicator 4 is dependent upon meeting the gateway metric for regional depression screen rate. Data calculation for this gateway metric is unavailable at this time.

****All performance data shown on this slide is preliminary** and subject to change with receipt of finalized calculations from HCPF.

Banner Health

Hospital Transformation Program

Banner Health

Banner Hospital Transformation Program Team

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Banner Health

What is the Hospital Transformation Program (HTP)?

The goal of the HTP is to improve the quality of hospital care provided to Health First Colorado (Colorado Medicaid) members.

Five-Year program (2021 - 2026) that will incentivize high performing hospitals who focus on **improving quality, demonstrating meaningful community engagement and improve health outcomes over time.**

Key activities and quality measures for HTP are consistent across the state, yet flexible enough to allow hospitals to **work with their communities** on the best interventions and approaches that serve them.

WHICH MEASURES DID WE SELECT?

Banner Health

HTP Measure	Measure Name	BFCMC	MMC
SW-RAH1	Readmissions Ratio	X	X
SW-PH1	Severity adjusted LOS ratio	X	X
SW-BH1	% of mental illness/SUD diagnosed patients with discharge plan	X	X
BH1	% of ED patients >=12 scanned for alcohol/substance use with appropriate intervention/referral to treatment (SBIRT)	X	X
SW-CP1	% with Social Needs Screen and Follow Up	X	X
BH2	Patients with Opioid use disorder with Medical Assisted Treatment MAT initiated during ED visit	X	X
SW-BH3	Opioid and Alternatives to Opioids usage	X	X
SW-COE1	Hospital Index	X	X
RAH2	Follow up within 30 days from ED discharge		
RAH4	Ischemic Stroke DC's on Statin		X
CP1	Readmission Rate for a High Frequency Chronic Condition 30 day (Adult)		X
CP5	% of Neonatal w/ unexpected Complications		
CP6	% Pregnant scanned for Perinatal/post-partum anxiety/depression		
CP7	% of visits with specialist physician contracted/employed by Banner		

Behavioral Health/Substance Abuse | Social Needs

SW-BH1 - Notifying community-based organizations of patients with behavioral health or substance abuse needs

BH1 – Screening, Brief Intervention and Referral to Treatment

SW-CP1 – Screening and referring patients for Social Needs

BH2– Providing patients with opioid use disorder MAT (Buprenorphine/Buprenorphine-Naloxone)

SW-BH3 – Appropriate decrease of Opioids and increasing of Alternative to Opioids (ALTO)

Chart created by - Elizabeth Torres, Senior Process Engineering

SW-CP1

Social Needs Screening and Notification

Hospitals Involved – All Hospitals

Population – Adult and Pediatric Medicaid Patients

Data Sources - Hospital Self-Report

DEFINITION

Number of **Medicaid patients discharged home** from an inpatient admission who have **social needs screening done** within 12 months of admission or time of visit. **If positive**, **referral** to an appropriate entity and **notification** to the RAE utilizing a mutually agreed upon process

Screening Domains -

1.)Housing **2.) Food** **3.)Transportation**

4.) Utility **5.) Interpersonal Safety**

Current Banner Efforts

1. **A system-wide initiative has been kicked off to relook at how we document and collect SDoH information.**
2. **Meetings with Cerner have been occurring to see what capabilities exist to optimize our SDoH workflow**
3. **Simultaneous conversations with our IT teams and the HIE (Contexture) have been occurring to see how Z-Codes can be sent in to the HIE for notification purposes.**
4. **Vendor vetting has also been occurring to see if any can assist with this initiative**

Current Work-throughs

1. **Team is currently working through establishing a process to thoroughly gather non-duplicative SDoH information using a validated screening.**
2. **Exploring technological innovations to see if an automated self-administered format can be utilized.**
3. **Choosing a system-wide screening tool to be used for SDoH**

*** EMCH and SRM are currently using PRAPARE form on patients to determine SDoH needs**

Banner Health

BH1

Screening, Brief Intervention, and Referral to Treatment (SBIRT) in the ED

Hospitals Involved – BFCMC, MMC
Population – Adult/Pediatric Medicaid (primary) patients

Data Sources - Hospital Self Report

DEFINITION

The percent of Medicaid ED patients age 12 years and older who are screened for alcohol or other substance use at the time of an ED visit and those who score positive have also received a brief intervention during the ED visit.

Current Banner Efforts

1. **SBIRT is currently being done on the inpatient side, but team is currently working through how to implement in the ED.**
2. **Conversations have begun with system-wide leadership to see how SBIRT can be implemented in the ED**
3. **1:1 meetings with Peer Assistance Services have also occurred to get best practices when it comes to SBIRT.**

Current Work-throughs

1. **Team is currently vetting different SUD Assessments to see which screening would be best for SBIRT.**
2. **Exploring technological innovations to see if an automated self-administered format can be utilized for screening.**
3. **Team is looking at current staff bandwidth to determine the best workflow for SBIRT.**

Banner Health

SW-BH1

Develop/Implement mutually agreed discharge planning and notification process with RAE for with diagnosis of Mental Illness or Substance Abuse.

Hospitals Involved – All Hospitals

Population – Adult Medicaid (primary) patients

Data Sources - Hospital self-report

DEFINITION

Percentage of eligible **Medicaid patients 18 years or older** discharged from the hospital or emergency department to home with a **principal or secondary diagnosis of mental illness or SUD** with a collaboratively **mutually agreed upon discharge planning and notification process** with or **to the RAE within one business day**.

Current Banner Efforts

1. **Team is currently looking for a standardized process to screen for Behavioral Health. (Currently there are a lot of areas of EMR which captures this information).**
2. **Bi-Weekly meetings with IT leadership to figure out a HIE (Contexture) connection for patients diagnosed with a Mental Illness/Substance Abuse Diagnosis**
3. **Continuing to grow relationships with stakeholders (CO-SLAW/NCHA/ETC.)**

Current Walkthroughs

1. **Continue meeting with HIE to produce automated process to send Mental Illness/SUD Diagnoses**
2. **Gathering data on current volume of Medicaid patients who have one of these diagnoses to determine efforts to be successful**
3. **Working with the RAE's to establish a possible closed-loop system to ensure patients receive the support they need.**

***NECO Hospitals are already sending some Bx Health/SUD information directly to the RAE**

Banner Health

BH2

Initiation of Medication Assisted Treatment (MAT) in ED or Hospital Owned Provider Based Rural Center

Hospitals Involved –MMC, BFMC

Population – All payor patients with OUD diagnosis

Data Sources - Hospital Self Report

DEFINITION

% of ED visits where the patient diagnosed with an **opioid use disorder (OUD)** and who in at least **acute mild active opioid withdrawal** for whom **MAT with Buprenorphine** is initiated during an emergency department visit or hospital-owned certified provider-based rural health center or through the provision/prescription of a home induction.

Current Banner Efforts

1. **There are currently some EMR workflow changes (Power forms) being looked at to make documentation of MAT easier**
2. **A charter has been created (still being revised) to engage in this effort**
3. **Team is currently working on gathering data to be able to see our MAT induction rate**
4. **Currently meeting with stakeholders (I.E., CO-SLAW) to see if MAT and SBIRT can work together in its process**

Current Banner Workthroughs

1. **Team is continuing to validate data to ensure it's accuracy**
2. **Team is continuing to work through process of SBIRT and MAT to see if both can be interconnected**
3. **Efforts being made with screening will help to be able to capture patients who may need MAT.**

Banner Health

SW-BH3

Using Alternative to Opioid's (ALTOS) in Hospital Emergency Departments

Hospitals Involved – All Hospitals

Population – All adult patients 18 and older

Data Sources - Hospital Self Report

Current Banner Efforts

1. **A charter has been created in tandem with MAT charter to continue looking at Opioid and ALTO usage.**
2. **Over the past few years ALTO' and Opioid usage has been heavily looked at which has led to favorable outcomes.**

SCORING

Two Part Measure: Decrease use of opioids = 60%, increase use of ALTO = 40%

Decrease use of Opioids - Total morphine milligram equivalent (MME) of medications administered listed in Opioids of Interest per 1,000 Emergency Department (ED) Visits for patients 18 and older

Increase use of ALTO - Total number of ALTO medications administered listed in ALTO of Interest per 1,000 Emergency Department (ED) visits for patients ages 18 years and older.

Current Banner Workthroughs

1. **Team is currently working on getting data to look at ALTO's more closely**
   - ***Still waiting on confirmation of MME conversions from the state to begin building out the data***

Banner Health

Accountable Care Collaborative

Phase III

RAE 1: Program Improvement Advisory Committee

12/6/22

Agenda

1. Preparing for ACC Phase III
2. ACC Phase III Overview
3. Priority Initiatives and Discussion on Equity Considerations
4. Additional Feedback
5. Next Steps

Preparing for ACC Phase III

Accountable Care Collaborative

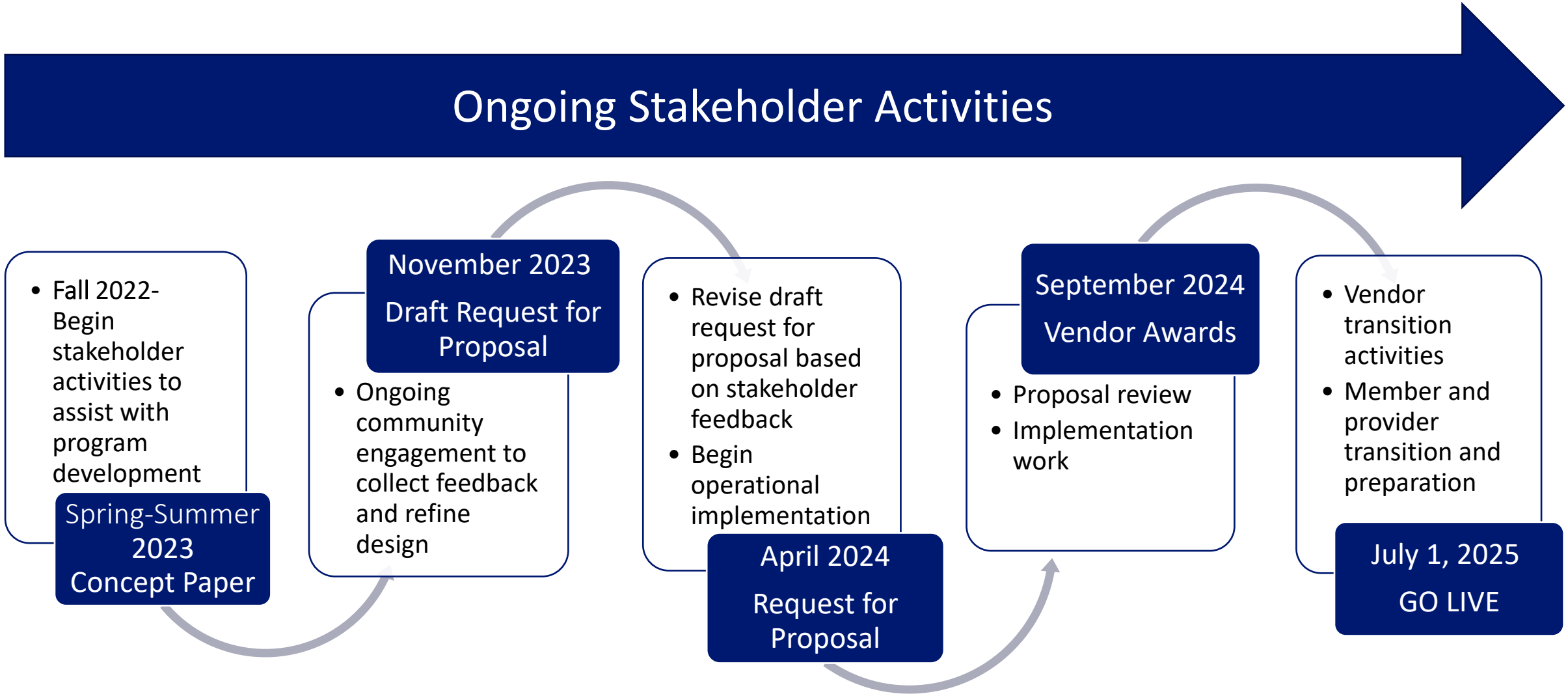
- Delivers cost-effective, quality health care services to Colorado Medicaid members to improve the health of Coloradans.

- Coordinates regional physical and behavioral health care services to ensure member access to appropriate care.

Creating ACC Phase III

- Build on strengths of Phase II
- Align with advances made by other state agencies
- Incorporate input received over the past several years
- Identify opportunities for improvement
  - Focus on Priority initiatives
- We need your input!

Timeline


Ongoing Stakeholder Activities
Fall 2022- Begin stakeholder activities to assist with program development
Spring-Summer 2023 Concept Paper
November 2023 Draft Request for Proposal
Ongoing community engagement to collect feedback and refine design
Revise draft request for proposal based on stakeholder feedback
Begin operational implementation
April 2024 Request for Proposal
September 2024 Vendor Awards
Proposal review
Implementation work
Vendor transition activities
Member and provider transition and preparation
July 1, 2025 GO LIVE

ACC Phase III Overview

ACC Phase III Goals

- Improve quality care for members
- Close health disparities and promote health equity
- Improve care access
- Improve the member and provider service experience
- Manage costs to protect member coverage and benefits, and provider reimbursements

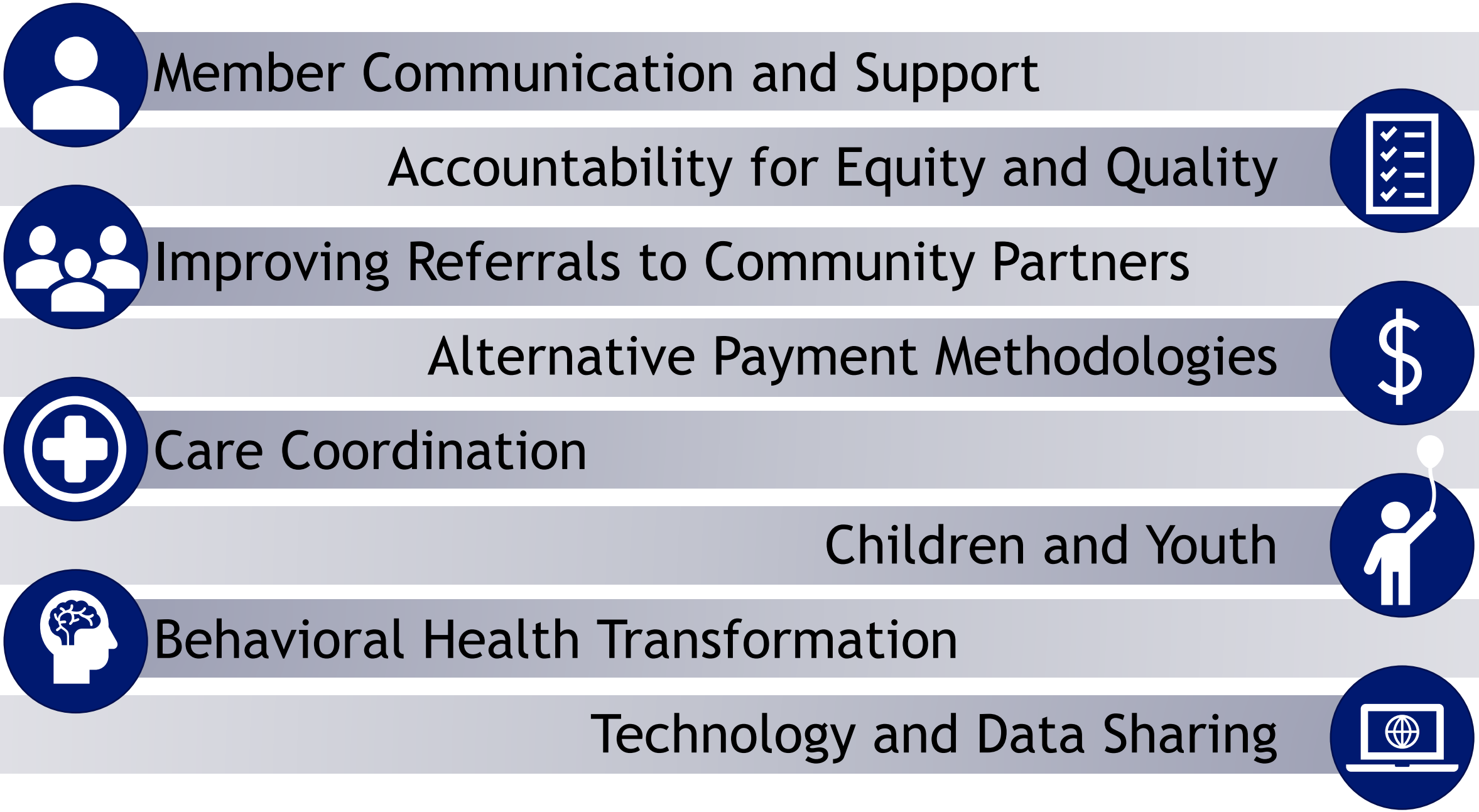
Commitments to Continuity

- Compliance with federal guidance supporting paying for value
- Coordinated behavioral, physical and community-based services through a regional delivery system with the existing seven regions
- A hybrid managed care model to allow for robust benefits and member supports by improving the capitated behavioral health benefit and innovating the managed fee-for-service infrastructure for physical health
- Collaboration with state agencies to provide high quality, whole-person care that improves health equity and the overall health of Medicaid members

Comments?

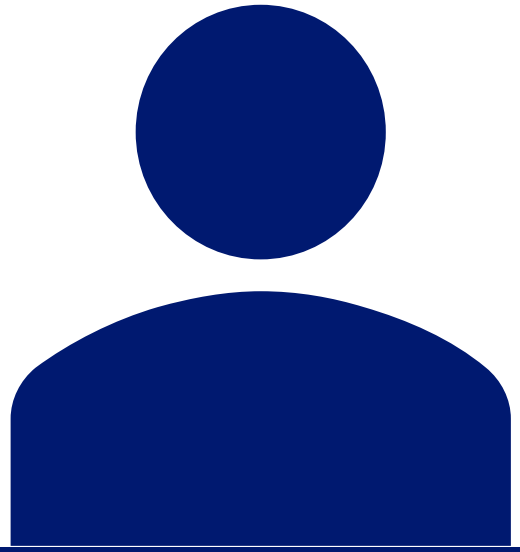
Priority Initiatives to Address Opportunities

- Member Communication and Support
- Accountability for Equity and Quality
- Improving Referrals to Community Partners
- Alternative Payment Methodologies
- Care Coordination
- Children and Youth
- Behavioral Health Transformation
- Technology and Data Sharing



Discussion: Closing Disparities and Promoting Equity

Member Communication & Support



- **Opportunity:** Improve coordination of services and supports for members so they can more easily and readily access needed resources by better leveraging the contracted partners most closely aligned with members. Improve clarity of communication so members can more easily understand and access their benefits.

Accountability for Equity & Quality

- **Opportunity:** Enhance primary care and behavioral health accountability for both providers and RAEs, with the goal of closing health disparities, improving health care quality and outcomes, and driving affordability.

Improving Referrals to Community Partners

- **Opportunity:** RAEs connect members to community supports outside of Medicaid covered services to better address their health-related social needs.

Alternative Payment Methodologies

- **Opportunity:** Implement member incentives and advance alternative payment models across the spectrum — such as primary care, maternity care, behavioral health, prescription drug, specialty care, and more — to enhance quality care, close disparities and improve member health outcomes while driving affordability.

Care Coordination

- **Opportunity:** Establish standards for care coordination for populations with unique needs, such as pregnant people and individuals with disabilities.

Children & Youth

- **Opportunity:** Improve access and outcomes for children and youth, particularly those in child welfare, involved with the justice system, or with special health care needs. Improve the experience of the caregivers and providers who support them.

Behavioral Health Transformation

- **Opportunity:** Align with and support the work of the Behavioral Health Administration to achieve shared goals, increase overall care access, and implement a more effective system of safety net behavioral health services. Increase access to culturally competent community-based services by addressing gaps in the continuum of mental health and substance use disorder services.

Technology & Data Sharing

- **Opportunity:** Leverage technology to improve access to services and data sharing among HCPF, the RAEs, and providers to enhance coordination, reduce duplication, and propel data-driven decision-making.

Additional Reactions & Ideas

Next Steps

Upcoming Stakeholder Activities

- More to say? Fill out our post-meeting feedback survey: https://www.surveymonkey.com/r/ACCMeetingFeedback

- Public Listening Sessions:
  - December 20, 12pm
  - January 10, 6pm

- Online survey coming soon

- Future state and RAE 1 PIACs and Member Advisory Councils

Website and ACC Updates Newsletter:
Colorado.gov/HCPF/accphase3

Thank You for Your Engagement!

Allie Morgan, Colorado Health Institute

Kendra Neumann, Colorado Health Institute

Suman Mathur, Colorado Health Institute

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Colorado's Accountable Care Collaborative

Phase III

A Brief Overview

COLORADO
Department of Health Care Policy & Financing

Background

The Department of Health Care Policy & Financing (the Department) created the Accountable Care Collaborative (ACC) in 2011 to deliver cost-effective, quality health care services to its Colorado Medicaid members and to improve the health of Coloradans.

The ACC features Regional Accountable Entities (RAEs) operating in seven regions. RAEs are responsible for coordinating physical and behavioral health care for members and administering Health First Colorado's capitated behavioral health benefit. The RAEs develop, contract, and manage a network of primary care physical health providers and behavioral health providers at the direction of the Department to ensure member access to appropriate care. The ACC provides the platform leveraged by other Medicaid health care initiatives to better serve members, create value, and achieve shared goals.

Current contracts between the Department and the RAEs will end on June 30, 2025. The Department has developed goals and priority areas for improvement and innovation intended to better align with our modernized mission, advances made by our sister agencies, and stakeholder input received over the past several years.

To support the design of ACC Phase III, the Department will begin engaging stakeholders in conversations in the fall of 2022. There will be various opportunities for stakeholders to help inform the policies and programs to be implemented as part of Phase III, including reviewing a draft Request for Proposals.

ACC Phase III Advancements Align with the Department's Mission.

The mission of the Department of Health Care Policy & Financing is to improve health care equity, access, and outcomes for the people we serve while saving Coloradans money on health care and driving value for Colorado. The ACC Phase III features are designed in support of achieving this mission.

Goals for ACC Phase III

Improve quality care for members

Close health disparities and promote health equity for members

Improve care access for members

Improve the member and provider service experience

Manage costs to protect member coverage, benefits, and provider reimbursements

Continuity for ACC Phase III Design

The next phase of the ACC will continue to build upon the following elements:

- Compliance with federal guidance supporting paying for value — the right care, in the right place, at the right time, for the right cost, and the right outcome
- Coordination of behavioral, physical, and community-based services through a regional delivery system with the seven RAE regions as currently defined
- A hybrid managed care model to allow for robust benefits and member supports by improving the capitated behavioral health benefit, leveraging behavioral health transformative investments, and innovating the managed fee-for-service infrastructure for physical health
- Collaboration with state agencies to provide high quality, whole-person care that improves health equity, and the overall health of Medicaid members

Key Dates and Milestones

Concept Papers for Priority Initiatives: Spring — Summer 2023

Draft Request for Proposals for Public Comment: November 2023

Request for Proposals Published: April 2024

Partners Apply to Become a RAE: Spring — Fall 2024

ACC Phase III Begins: July 2025

Our Invitation

Your input is needed to design ACC Phase III. We are committed to receiving input from diverse perspectives through accessible, equitable, and productive engagement.

There are many forums to share your thoughts. You can find more information and details about upcoming stakeholder engagement opportunities at www.Colorado.gov/HCPF/ACCphase3.

Priority ACC Phase III Initiatives to Address Opportunities

Through robust and ongoing conversations with stakeholders over the past four years, the Department has identified the following priority initiatives for Phase III. This work builds upon the solid foundation of earlier phases of the ACC while offering opportunities for continued improvement and innovation.

Member Communication and Support

Opportunity: Improve coordination of services and supports for members so they can more easily and readily access needed resources by better leveraging the contracted partners most closely aligned with members. Improve clarity of communication so members can more easily understand and access their benefits.

Accountability for Equity and Quality

Opportunity: Enhance primary care and behavioral health accountability for both providers and RAEs, with the goal of closing health disparities, improving health care quality and outcomes, and driving affordability.

Referrals to Community Partners

Opportunity: RAEs connect members to community supports outside of Medicaid covered services to better address their health-related social needs.

Alternative Payment

Opportunity: Implement member incentives and advance alternative payment models across the spectrum — such as primary care, maternity care, behavioral health, prescription drug, specialty care, and more to enhance quality care, close disparities, and improve member health outcomes while driving affordability.

Care Coordination

Opportunity: Establish standards for care coordination for populations with unique needs, such as pregnant people and individuals with disabilities.

Children and Youth

Opportunity: Improve access and outcomes for children and youth, particularly those in child welfare, involved with the justice system, or with special health care needs. Improve the experience of the caregivers and providers who support them.

Behavioral Health Transformation

Opportunity: Align with and support the work of the Behavioral Health Administration to achieve shared goals, increase overall access and implement a more effective system of safety-net behavioral health services. Increase access to culturally competent community-based services by addressing gaps in the continuum of mental health and substance use disorder services.

Technology and Data Sharing

Opportunity: Leverage technology to improve access to services and data sharing among the Department, the RAEs, and providers to enhance coordination, reduce duplication, and propel data-driven decision-making.