HMA

HEALTH MANAGEMENT ASSOCIATES

Project to Facilitate Consensus on Data Collection and Reporting Strategies for SIM Bi-Directional Integration Demonstration Pilot Sites

Guidance Document with Recommendations

PREPARED FOR

THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

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Introduction

The Colorado Department of Health Care Policy and Financing (the Department) contracted with Health Management Associates (HMA) to facilitate a consensus process across the four State Innovation Model (SIM) program bi-directional integration pilot sites to recommend data collection and reporting strategies on the attribution of patients, clinical quality measures, and participating providers.

The four bi-directional integration pilot sites are Mental Health Partners, Jefferson Center for Mental Health, Community Reach Center and Southeast Health Group.

To prepare for facilitating the consensus process among the four Community Mental Health Centers (CMHCs), HMA gathered background information through three meetings with the SIM project evaluation team from Tri West, staff from the Colorado Behavioral Healthcare Council (CBHC) and key SIM staff from the Department; key informant interviews with representatives from the four CMHC pilot sites; and, a review of background documents provided by the SIM office and CBHC. (see Appendix 1 for a summary of background information).

HMA facilitated four meetings of the CMHCs via WebEx on the following dates: May 9, 2017, May 16, 2017, May 30, 2017 and June 6, 2017. The first meeting of the group focused on generating ideas for reporting attribution, including an exploration of potential problems or barriers as well as necessary guiding principles or "rules" to govern how the four CMHCs handle attribution. The second meeting of the group focused on finalizing consensus on recommendations for attribution. The third meeting of the group focused on consensus recommendations for reporting on participating providers, and the beginning of a discussion on reporting clinical quality measures (CQMs). The final meeting focused on recommendations for reporting on CQMs.

Based on these four meetings, HMA drafted recommendations and presented these to the four sites, CBHC, the Colorado SIM Office and data and evaluation partners supporting the SIM project. An additional meeting was convened to discuss the recommendations, with a particular focus on the recommendation for the attribution methodology.

Final Recommendations

Attribution of patients and standardization of reporting patient lists to the Center for Improving Value in Health Care (CIVHC)

Determining the most useful methodology for attribution proved to be a challenge. Given the importance for the CMHCs to demonstrate impact on a broad, systems level to reflect the significant investment made by CMMI for the bi-directional pilot, a recommendation that the four pilot sites report attribution as those patients *eligible* for integrated care delivery who are receiving care at their designated SIM site(s) was considered. This recommendation would align the pilots with the SIM goal that 80 percent of Coloradans will have *access* to integrated care and more closely mirrors what the primary care sites are doing in terms of the entire clinic being included in the attribution. Also important in considering attribution is the opportunity for the pilot sites to think about how they would run attribution as a provider of primary care services under Medicaid PMPM cost allocation and how these

pilots could be used in the future to show readiness for value based payment. There was concern that a broader definition of their attributed population would not reflect the data necessary to determine the effectiveness of integrated care in a behavioral health home. To accurately capture this, the four sites agreed that a stricter definition of attribution was necessary. The sites understand that there are pros and cons to both approaches but reached consensus on the definition of attribution as follows.

Recommendation: The four pilot sites will report attribution as those patients who are receiving primary care services at their designated SIM site(s). Specifically, for each CMHC:

- Mental Health Partners will report all those with a diagnosis of serious mental illness (SMI) who receive primary care services at the Ryan Wellness Center location.

- Community Reach will report all those with a diagnosis of SMI who receive primary care services at the Commerce City Clinic location.

- Jefferson Center for Mental Health (JCMH) will report all patients who received primary care services at the Jefferson Plaza Health Home.

- Southeast Health Group will report all patients who received primary care services at any of the four clinic sites (La Junta, Rocky Ford, Lamar and Las Animas) that provide primary care.

Guiding Principle 1: SMI will be defined using the SAMHSA definition. This will apply to Community Reach and Mental Health Partners.

- "a serious mental illness is a condition that affects 'persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities' such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation".[1]

- This list of diagnosis will include but is not limited to schizophrenia, schizoaffective disorder and bipolar disorder and includes those with lower levels of functioning per the SAMHSA definition.

Participating providers and the accurate and consistent reporting of the providers participating in the SIM program

Recommendation: The four pilot sites will report on participating providers with a National Provider Identifier (NPI) number who are providing primary care or behavioral health services to the attributed population (see definition above). Specifically, for each CMHC:

[1] http://www.nrepp.samhsa.gov/Docs/Literatures/Behind_the_Term_Serious%20%20Mental%20Illness.pdf

- Mental Health Partners will report providers with an NPI number (which includes unlicensed providers), who are providing behavioral health or primary care services for the attributed population of patients with SMI at the Ryan Wellness Center.

- Community Reach will report providers with an NPI number who are providing behavioral health or primary care services for the attributed population of patients with SMI at the Commerce City Clinic.

- JCMH will report providers with an NPI who are providing behavioral health or primary care services to the attributed population of patients at the Jefferson Plaza Health Home.

- Southeast Health Group will report providers with an NPI providing behavioral health or primary care services to the attributed population of patients at their four designated SIM sites. For evaluation purposes, CIVHC will need to scrub the data to avoid duplication in attribution (patients might go to more than 1 of the 4 sites occasionally).

Clinical Quality Measures and agreement about data sources, population and data collection methods

Recommendation: The four pilot sites will report on the current six simplified CQMs (additional CQMS for pediatrics will be collected for the Jefferson Plaza Health Home only) for those patients in the attributed list at their designated SIM site(s) (the population specified in their proposals to the SIM office).
Six Simplified CQMS:

1. Depression Screening
2. Diabetes: HgA1c Control
3. Hypertension
4. Obesity
5. Substance Use Disorder: Alcohol and other drug dependence
6. Substance Use Disorder: Tobacco

Pediatrics (Jefferson Plaza Health Home Only)

1. Depression Screening (adolescents)
2. Obesity: Adolescent
3. Maternal Depression
4. Developmental Screening

Guiding Principle 1: Each organization will extract the clinical data from their medical record for reporting on the CQMs. The numerator and denominator for each measure will be collected per previous guidelines by CQM type (see Colorado State Innovation Model Clinical Quality Measure Specifications Guidebook).

Additional Guidance and Conclusions

Additional Recommendation

To truly measure the cost and effort that goes into bidirectional integrated care, the Colorado SIM office and its partners need to identify a standard way to capture data on non-billable activities. The most

common non-billable activities are phone calls, care coordination, tracking patients, and transportation services. Each of the SIM sites has some ability to track these interactions in the EMR. For instance, MHP codes these as 800 codes in their EMR; Community Reach uses Information Only coding; JCMH uses General Notes coding; and, Southeast Health Group captures this data but was unsure about what they call the codes. Regardless of what the sites are using, the information is blended in with other types of services that may not be directly related to the bidirectional SIM pilot initiative.

The technical assistance providers for the Colorado SIM office and the four pilot sites need to consider the specific considerations for those CMHCs who are interfacing with Federally Qualified Health Center (FQHC) partners. Ground rules will need to be established regarding which entity is pulling the data related to the above recommendations for attribution, participating providers and CQMs. Additionally, if the FQHC is a participant in the SIM primary care cohort, guidelines will need to be determined to ensure attribution and CQM reporting isn't duplicated between the primary care cohort data collection and the bi-directional pilot site data collection.

Reporting Period

The sites agreed to collect data under this new guidance from January to June 2017 with reporting in August 2017. CQMs will then be collected quarterly on the following schedule: July-September with reporting in October, October-December with reporting in January, January- March with reporting in April, April-July with reporting in August.

Conclusions

The four SIM sites successfully reached agreement on Attribution, Providers and CQMs during this process per guidance from the SIM office. The four SIM sites expanded the list of providers as well to those who could refer patients for integrated services and provide either primary care or behavioral health services. There are factors to be considered among the SIM data and evaluation partners and providers of TA regarding operationalizing these recommendations. At a minimum, the SIM office will need CBHC to work with the four sites to submit work plans that include how these sites are recruiting new patients to the health home over the time period of the grant to significantly increase the participants in the agreed upon attributed population. Numbers served are vital to future guidance in negotiations for payment options as these numbers of patients per site (potentially a percentage of total enrolled patients) may be used to determine a PMPM or other funding structure for these CMHCs (and the other 11 in Colorado) in an ACC 2.0 environment. Three of the four sites that interface with FQHCs will need to determine guidelines for data collection and reporting to ensure there is not duplication in reporting attribution and CQMs. In addition, it is clear there is a significant missing piece to assessing the true cost of the provision of bidirectional integrated care due to lack of a tracking system for the many non-billable services.

An aspirational goal of bidirectional integrated care would be to increase alignment in traditional behavioral health settings with key health home approaches and processes to better address the significant health disparity in patients with behavioral health conditions. Currently there is no equivalent formulation in traditional behavioral health to the 10 Building Blocks of Primary Care although many of these principles could be applied (and some currently are part of care). For traditional CMHC delivered behavioral health to move along the continuum towards bidirectional integrated care

and true behavioral health homes, and align with value based payment, critical analysis of what is needed to transform the delivery of care will be required.

Appendix 1: Background Information

Documents Reviewed

- Original proposal narratives from the four CMHCs
- CBHC Quarterly Reports and Mid-Year report to the SIM Office
- Minutes from the June and July 2016 SIM Bi-Directional Weekly Operations Calls where there was significant discussion regarding attribution and the reporting of CQMs
- CMHC Attribution Overview outlining the role each partner organization plays in the attribution process of the bi-directional health homes, and how each will interact with the data
- CMHC Patient Panel Reporting Parameters defining the parameters for inclusion in the patient panel of each of the four SIM bi-directional integrated health homes
- Minutes from the Data Roadmap Conversation from June 2016
- Power Point Presentation on attribution, CQM reporting and criteria for participating providers
- Power Point Presentation with a CQM crosswalk for adult and pediatric patients

Meetings with SIM Office, Tri West and CBHC

Three meetings were held with the three agencies providing oversite to the implementation and evaluation of the SIM Bi-Directional Integration Pilot.

- Kick off meeting at which the scope of work for the project was discussed and methods for gathering information were determined
- April 27th meeting at which the team reviewed themes from HMA's interviews with representatives of the four CMHCs and discussed the facilitation approach for the facilitated meetings with the four CMHCs
- May 12th meeting at which the team discussed the outcomes and questions from the first facilitated meeting with the four CMHCs in preparation for the remaining meetings

Additional Meetings

- May 16th, HMA met with Health Team Works, the organization tasked with providing Practice Facilitators to the four CMHCs to add to the background information collected regarding what the sites are struggling with and able to achieve regarding attribution, practicing providers and CQM reporting
- May 18th, HMA met CORHIO's Clinical HIT Advisors to gather additional background information on the reporting of CQM's by the four CMHCs

Key Informant Interviews with CMHCs

Common Themes

- Four very different approaches – SMI in PBHCI cohort only, SMI in CMHC focused, co-located private primary care in CMHC setting open to community, fully integrated behavioral health and primary care on site with pediatrics/family focus open to the community
- All sites are open to and welcome the idea that attribution should have a broader definition
- Concept of who the providers are will likely follow the decision made regarding attribution
- There is mostly agreement that providers are defined by those providing the integrated service and are involved with carrying out the care plan, and not everyone in the CMHC
- General satisfaction with the six CQM metrics being a good representation of integrated measures although tracking on a larger attribution seems burdensome and difficult
- Very satisfied with technical assistance from the practice facilitators (Health Team Works)

Concerns

- The communication has been unclear and inconsistent about expectations
- Lot of players at the table – how to best utilize everyone? (assume this means CBHC, SIM, TA, and Tri West)
- Concerns that SIM is so primary care focused the impact of bidirectional will get "lost" or underestimated
- Will the four pilots be "compared" to each other?
- What is the "end game" with data collection? How is it going to be used and how will it get reported? Is there a "data map" for sites to look at?
    - Feeds into core metrics for CMMI reporting (aggregate CQM values, # of beneficiaries attributed to SIM practices, # of providers participating in SIM), feeds into evaluation efforts, Centers not penalized based on any data submitted, more for internal monitoring, tracking progress toward SIM goals, what's working/what's not. CBHC/CMHCs will help set "accountability targets" for the CMMI metrics and what they are aiming to achieve over the course of SIM
- Will the data make us "look bad"?
- Will the data inform payment reform in Colorado?
- Will SIM help us with payment reform and understanding what the payers will ultimately want so we can get prepared and not lose what we have started?
- How will data be used – will only have HQROL and CCAR data on a large number of attributed consumers and will have CQM's on a small portion. What will different data sets tell us about the success of the model?

Summary of Background Information

The four CMHCs struggled with attribution which had been the topic of many discussions prior to HMA engagement. It had been difficult to determine the reporting of practicing providers in the SIM project and CQMs as a result of unresolved decisions on the attribution methodology. Understanding what conversations have taken place, what agreements have been made, and where the four CMHCs continue to struggle was helpful to shaping HMA's approach to facilitating agreements about attribution and the reporting of practicing providers and CQMs.

The four CMHCs were hesitant to move forward with agreements because they were seeking clearer direction from CMMI on exactly what the expectation was for attribution. The sites experienced significant delays in budget approvals when CMMI rejected other components of their project plans and this contributed to their hesitancy. The four CMHCs also experienced challenges with what they saw as conflicting goals of incorporating the SIM goal of reaching 80 percent of the Colorado population with SIM initiatives (including but not limited to practice integration) and their preferred goal of improving clinical care for patients with mental health issues. This was at the root of the struggle to determine an attribution methodology. There was also a concern that broader attribution would lead to having to administer the CCAR and the HRQoL to different sets of patients where it would prove much more difficult (HRQoL to specialty behavioral health patients and CCARs to patients only coming to the primary care clinics for primary care and not for behavioral health).

The SIM office was clear that CMMI does not have strict guidance or expectations regarding attribution. The bi-directional demonstration pilot is unique and other SIM funded states are not doing this, providing an opportunity for the four CMHCs to define the value of the bi- directional health home. What is important is for the CMHCs to demonstrate impact on a broad, systems level that reflects the significant investment made by CMMI for this project. In addition, the attribution process for primary care is not to be applied to these pilots and should not be compared.

In light of changes to how Colorado approaches accountable care collaboratives with implementation of ACC 2.0, CMHCs should use this opportunity under SIM to think about how they would run attribution as a provider of primary care services under Medicaid PMPM cost allocation and how these pilots could be used in the future to show readiness for value based payment.