COLORADO
Department of Health Care Policy & Financing

Meeting Minutes
Behavioral Health and Integration Strategies (BHIS) PIAC Subcommittee

Virtual Meeting

December 7, 2022, 9:00 AM – 10:30 AM

1. Introductions

Facilitators:

- Sue Williamson — Colorado Children's Healthcare Access Program
- Daniel Darting — Signal Behavioral Health Network
- Matt Pfeifer — Health Care Policy & Financing (Dept. Liaison)

Voting Members:

- Amanda Jones — Community Reach Center
- Tom Keller — Statewide PIAC
- Deb Hutson — Behavioral Health Administration
- Elizabeth Freudenthal — Children's Hospital
- Charlie Davis — Crossroads Turning Points
- Taylor Miranda Thompson — Colorado Community Health Network
- Imo Succo — Indigenous Wellbriety Program/CAHEC

Other Attendees:

- Shandra Brown Levey — University of Colorado
- Karen Master — West Pines Behavioral Health
- Jamie Zajac — Colorado Access
- Alan Girard — Front Range Health Partners
- Bridget Anshus — Mental Health Colorado
- Sherrie Bedonie — Colorado Access
- Suzanne Kinney — Colorado Community Health Alliance
- Mona Allen — Health Colorado, Inc.
- Milena Castaneda — Colorado Center on Law and Policy

• Christina Walker	Healthier Colorado
• Ryan Larson	Colorado Access
• Allie Morgan	Colorado Health Institute
• Suman Mathur	Colorado Health Institute
• Kendra Neumann	Colorado Health Institute
• Terri McCraney-Powell	Denver Indian Health and Family Services
• Chelsey Sterling	Health Colorado, Inc.
• Emily Holcomb	Health Care Policy & Financing
• Cris Matoush	Rocky Mountain Health Plans

2. Housekeeping

Daniel Darting called the meeting to order at 9:03 AM.

Daniel calls the group to approve the October 2022 BHIS minutes. There are no minutes from November 2022; the meeting was cancelled. Sue Williamson motions to approve; Deb Hutson seconds. There are no objections or abstentions. October 2022 meeting minutes are approved by voting members.

Matt Pfeifer provided a COVID-19 update. The Public Health Emergency (PHE) is likely to be extended through April 2023.

- The Department continues to focus on vaccine outreach and work to address disparities. More information can be found at covid19.colorado.gov.

- HCPF is also focused on planning for the end of the Public Health Emergency: https://hcpf.colorado.gov/phe-planning.

Department of Corrections (DOC) Metric update: Behavioral Health Engagement for Members Releasing from State Prisons

- HCPF recently transitioned to a new process for RAEs/MCOs to submit claims which has delayed the metric calculations. There continue to be challenges in the data, but accuracy is improving.
    - Matt explains the relationship of this data lag to the larger behavioral health evaluation.

- June 2022 rate appears likely to be in the 18.65-19.15% range. The target rate is 19.14%. Monthly updates will continue.

3. ACC Phase III Feedback (Facilitated by Colorado Health Institute)

Allie Morgan, Suman Mathur, and Kendra Neumann from the Colorado Health Institute (CHI) join BHIS to facilitate a continued ACC Phase III discussion. Susan Mathieu from the Farley Health Policy Center is also in attendance to help facilitate.

CHI notes that the organization is contracted to support the Department with these conversations; CHI is not able to speak on behalf of the Department.

The conversation is framed as an early stage of the Phase III work. Currently focused on vision, high-level concepts, and direction setting.

Voting BHIS members invited to share feedback using platform called Mentee.

Preparing for Phase III

- Underway as of fall 2022
- Focal points for creating ACC Phase III:
    - Build on strengths of ACC Phase II
    - Align with advances made by other state agencies such as the Behavioral Health Administration (BHA) and the Department of Human Services (DHS)
- Incorporate input received over the past several years
- Identify opportunities for improvement
    - Focus on priority initiatives

A timeline of Phase III implementation is on the HCPF website.

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 cost to protect member coverage and benefits and provider reimbursements

What will carry forward from Phase II:

- Compliance with federal guidance supporting paying for value
- Regional Accountable Entities (RAE) regions will continue (seven of them)
- Hybrid managed care model; capitated behavioral health benefit and fee-for-service (FFS) for physical health
- Ongoing collaboration with state agencies

Charlie Davis asks about standardization across the RAE model and how that is being considered for ACC Phase III.

- Matt Pfeifer notes that part of the standardization is one of the trade-offs and benefit that a regional approach has. There is regional flexibility within the ACC model.

Priority Initiatives to Address Opportunities (outlined in the ACC Phase III fact sheet posted online)

- Member communication and support
- Accountability for equity and quality
- Improving referrals to community partners (leveraging contracted community providers)
- Alternative payment methodologies
- Care coordination
- Children and youth (including care givers and people navigating system)
- Behavioral health transformation
- Technology and data sharing

BHIS members note the importance of working within the system to improve children and youth health, and also understanding how the system operates from a Member perspective.

The conversation today will focus on a few of the priority areas listed above.

Behavioral health transformation:

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

Questions posed to the group; participants provided feedback via Mentee:

1. What are examples of successful integrated care payment models and lessons learned?

    - Colorado State Innovation Model, behavioral health Fee-for-Service (FFS) benefits, hospital initiatives
    - Challenge to capture volume of "brief behavioral health interventions" that occur in medical settings but aren't billable
    - Refine, build on, and improve behavioral health Fee-for-Service (FFS) benefits
    - Encounter rate program
    - Reducing pre-authorization requirements has been helpful in SUD treatment
    - Billable behavioral health codes may vary depending on RAE
    - Many voting members echo that integration is difficult when reimbursement happen in two different systems, especially when needs are complex and involve both physical and behavioral health care
    - Timeliness for behavioral health authorizations based on RAE and patient needs has been difficult
    - Member experience and focus on western-based scientific models
    - Increasing the number of participating providers
    - Medicaid "cliff" when there is no step-down process for people who will no longer be eligible for Medicaid. There should be a stair-step process for people who can transition off Medicaid.

- Expanding peer and unlicensed workforce
- Expanded funding access (not just community grants) and streamlining certification needs for programs; it is challenging to become a certified organization in order to provided needed resources for the community

2. How should ACC Phase III align with the BHA and behavioral health administrative services organizations (BHASOs)? How should the RAEs align with the BHASOs? Note the BHASO definition is being finalized.
    - Keep services as local as possible
    - No wrong door and no one turned away
    - Suggest RAEs having the same, if not extremely similar process, for prior authorizations for behavioral health treatment
    - Patient-centered care is priority. When there are multiple entities trying to do care coordination, important to incorporate patient choice based on relationship and efficiency
    - Idea that all Medicaid clients are our clients to serve, it's not about region
    - There are challenges that come with the split system (payment)
    - RAEs and BHASOs should be same organization whenever possible. The fewer organizations a member must deal with the better
    - Aligning metrics, definition, and reducing administrative burden
    - Joint governance model/shared staff
    - BHASOs have an important role in serving with the population who are not able to be covered by Medicaid
    - Higher incentives for complex needs

Care coordination:

Opportunity: Establish care standards

1. What populations require greater consideration for care coordination? What requirements should RAE care coordinators meet for these populations?

- English as a Second Language (ESL)
- Pregnant people
- Clients coming out of institutions, prisons, jails
- Intellectual and developmental disabilities (IDD) and behavioral health diagnosis
- Levels of care coordination needed; intensity increased based on level of client need
- Members with cross system engagement who might benefit from more care coordination
- Medical home model, increasing RAE capacity in this role
- Unhoused persons, substance using persons, rural/frontier/native populations
- Trauma impacted youth
- Care coordination and outreach as a prevention strategy

Conversation opened for non-voting members to participate.

- Alternative Payment Models (APMs) need to be based on accurate data, which may require big changes.
- New reimbursement models are shifting all financial risk to the provider and unsustainable services and agencies are being lost
- Workforce shortages are present across the system

Next steps outlined by CHI:

- ACC Phase III Post-Presentation feedback form
- Public listening sessions
- Ongoing updates will be provided to this group

4. Wrap up and next steps (HCPF)

Upcoming conversations: behavioral health alternative payment model and value-based payment updates, BHA care coordination strategies

The next meeting is scheduled for January 4, 2023. The meeting was adjourned.