COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Behavioral Health and Integration Strategies PIAC
Meeting Minutes: January 6, 2021

Introductions:

Facilitators:

- Daniel Darting — Signal Behavioral Health Network (Co-Chair)
- Matt Pfeifer — Health Care Policy & Financing Department Liaison

Voting Members:

- Sue Williamson — Colorado Children's Health Care Access Program (Co-Chair)
- Amanda Jones — Center for Mental Health
- Terri Hurst — Colorado Criminal Justice Reform Coalition
- Dr. Vicki Allen-Sanchez — Colorado Springs FD
- Thomas Keller — Regional MEAC & PIAC, Statewide PIAC
- Camille Harding — CDHS: Office of Behavioral Health
- Stephanie Salazar-Rodriguez — Mile High Health Alliance
- Mary Ellen Benson — Aspen Pointe
- Dr. Heidi McMillan — Pediatric Partners of the Southwest
- Tammy Phillips — Larimer County DHS

Other Attendees:

- Cris Matoush — Rocky Mountain Health Plans
- Joseph Anderson — Colorado Access (RAE 3 & RAE 5)
- Krista Cavataio — Rocky Mountain Health Plans (RAE 1)
- John Carlson — Health Colorado (RAE 4)
- Pam Treloar — Shiloh House
- Mindy Klowden — Colorado Behavioral Health Council
- Tina McCrory — Health Colorado (RAE 4)
- Clay Cunningham — Community Reach Center

• Jenn Conrad	Signal Behavioral Health Network
• Susan Todd	STRIDE Community Health Center
• Alyssa Rose	Beacon Health Options (RAE 2 & RAE 4)
• Jessica Kell	AspenPointe
• Louisa Wren	Rocky Mountain Health Plans (RAE 1)
• Camila Joao	Colorado Community Health Alliance (RAE 6 & 7)
• Matthew Wilkins	RAE 4
• Imo Succo	Regional Health Connector, Southwest Colorado, Durango, CO
• Nancy Jackson	Arapahoe County Commissioner
• Kim Fairley	Regional Health Connector, CAHEC
• Jeremy White	Beacon Health Options (RAE 2 & 4)
• Tonya Wheeler	Advocates for Recovery Colorado
• Doug Hainley	Weld County DHS
• Karlee Tebbutt	Colorado Association of Health Plans
• Karen Masters	West Pines
• Doug Muir	Centura Health
• Sandra Grossman	Health Care Policy & Financing
• Matt Sundeen	Health Care Policy & Financing
• Milena Guajardo	Health Care Policy & Financing
• Jeff Eggert	Health Care Policy & Financing
• Courtney Phillips	Health Care Policy & Financing
• Ben Harris	Health Care Policy & Financing

Housekeeping

Daniel Darting called the meeting to order at 9:02 AM. Minutes from the previous months of October, September, and December were approved. No abstention.

COVID-19 updates

Matt Pfeifer provided COVID-19 updates. There will be no copays on vaccinations for Medicaid members as they become available. It was requested for the Department to follow up on the question of how behavioral health facilities, such as respite care, crisis stabilization and residential are being prioritized in terms of vaccinations. How are their personnel and individuals potentially seeking care being prioritized? Another question was asked about the prioritization of those released from the Department of Corrections (DOC), and into Medicaid and the community. There is uncertainty if there was priority for this population and if there was a way to prioritize these individuals released from the

DOC. In response, this is being actively discussed by the Department and other state agencies. A follow up on this discussion will occur.

There is some behavioral health funding included with the recently passed federal COVID relief package. There is $4.25 billion allotted for mental health and substance use disorder. There will be a block grant type of distribution. The breakdown of behavioral health funds in the relief package was provided. The new relief package includes $4.25 billion in funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) beyond regular fiscal year 2021 spending. That funding will be split between various SAMHSA programs. Examples include: $1.65 billion for the Substance Abuse and Prevention Treatment Block Grant program; $1.65 billion for the Community Mental Health Services Block Grant program; $600 million for Certified Community Behavioral Health Clinics; $50 million for various suicide prevention programs; $50 million for Project AWARE; and $240 million in emergency grants to states.

The Public Health Emergency (PHE) is slated to go through January 21 in which the maintenance of effort and enrollment requirements go until the end of the quarter of when the PHE is slated to end, and so would not end until March 31, 2021. (UPDATE: Continuous enrollment requirements end the last day of the MONTH in which the public health emergency ends. Also, the public health emergency has been extended an additional 90 days to April 20, 2021)

Doug Muir with Centura Health shared that Centura is a participating in the distribution of COVID 19 vaccinations. As behavioral health providers become eligible for COVID vaccines Centura intends to devote additional effort to vaccinating behavioral health providers who might not be associated with a larger healthcare system. Participants can contact him for additional information and he will work to help as well as he can in light of vaccine availability.

DOC Metric Review

Matt Pfeifer presented on the performance and trends of the DOC engagement Metric. (Information can be found in the meeting slides posted on the BHIS webpage.) The data presented was from June 2020.

The 14 Day BH Engagement metric was presented, and it was noted that members with no Regional Accountable Entity (RAE) involvement were engaged with behavioral health services at a very low rate. To clarify, these are Medicaid members whom have yet to be assigned to a RAE.

The trends seen amongst the RAEs in this the 30 Day BH Engagement metric were similar to the trends seen in the 14 Day metric.

Engagement is defined by any behavioral health service that is billed within the specific time frame. This includes any covered capitation services and the six short-term behavioral health services available through fee-for-service in a primary care setting. A question was asked of the volume of

members attributed to RAEs and if this was distributed equally across RAEs. Members are not attributed by the standard attribution process which does not result in equal distribution between RAEs. RAEs 3 and 5 are in the Denver Metro Area and receive about 250 members per month, RAE 7 is in the 150 range, and other RAEs generally receive about 100 members per month. The percentage on the right is the engagement rate for individual RAEs. If it reads 25% then that would mean 25 of 100 members. Participants continued to address the context for the numbers (a few additional members engaged in services can make a significant increase in the percentage), and options for refining the metric in the future by focusing on types of services utilized (ex. outpatient vs. emergency department).

Additional comments were made that DOC continues to require members to access services via the Approve Treatment Provider (ATP) network which is a barrier, and that DOC has also taken steps to support the use of Medicaid providers.

A response was provided to a question regarding the reasoning for June 2020 data being presented. It takes about 3-4 months for claims and encounters data is submitted to the Department. This can be further delayed if there are timely filing issues. Data then needs to be cleaned and analyzed. So, there is a minimum of about five months of wait time to receive data. There is data available for July 2020 but getting the data to be usable and correcting any human errors are some factors involved. HCPF also confirmed that BH data provided by telehealth is included in the data.

The metric on 14 Day BH Engagement by Race and Gender was presented. This was broken down into white and non-white categories. A thought shared was that the trends were not surprising and are problematic when seen through the lens of equity, diversity and inclusion, and access to health care services. A question was asked if the trends mirror what trends would be with non-white members coming out of the DOC system and members not in the DOC system. This distinction could help determine if engagement strategies need to be focused on the population of members exiting DOC or if it is a statewide need. HCPF has not completed that analysis but continues to dig into the data and ask these types of questions. A participant also asked if the ratio of services provide by ATP providers compared to Medicaid providers was shifting in the direction of Medicaid providers as intended. This shift should show up in the budget of DOC via expenditures for ATP services. Participants expressed the need to determine if community-based connections are culturally competent for this population and comparing it to the overall Medicaid population.

The DOC Re-Entry Care Cascade is the cascade of seeing an increase from 2014 where there was a population not eligible for Medicaid. The increase was due to the expansion of Medicaid. As policy decisions and initiatives were made, there was an increasing number of referrals and the hope is that behavioral health engagement continue to increase.

Reactions from the group were solicited on the review of DOC metrics. Participants requested to review the DOC metrics as often as the data was available and to have discussions as often trends in

the data can be seen. There was a desire to revisit the target questions and scope that the committee wants to address. Another suggestion was to set time aside quarterly for a more detailed discussion to look at targets and trends of the data, discuss what is working and is not working, and to do so through an equity lens. The Department pointed out that the data can help understand how the delivery system is reshaping itself and lead to strategies for tackling a variety of issues. Using the 30 Day BH Engagement data as an example, a question to ask is why CCHA RAE 7 has gone from last place to first place on this metric. The department explained that it would be helpful to have stakeholders in this subcommittee participate in these conversations. A Participant also suggested that having some targeted questions and discussion framework presented to participants ahead of meetings could help facilitate a more valuable discussion. Another participant expressed an interest in understanding the impact of COVID, how it has pushed the utilization of telehealth, and how this may have increased engagement among the DOC population. Another participant added that the issue of telehealth also might have an impact on equity which warrants some additional analysis. A participant from Southwestern Colorado shared that hiring more diverse behavioral health and medical professionals should be a priority. The participant shared that clients frequently comment that they would like to see more diverse health care professionals which would allow them to open up more. The issue of workforce development was discussed, specifically with cultural and linguistic issues. Another participant explained how a Peer Recovery Coach model is being utilized in various ways. This has proven to be very successful, especially as an alternative when appointments are not able to be made with credentialed providers (e.g., LCSW) within nine months. It was noted that the Office of Behavioral Health recently completed a statewide behavioral health needs assessment that has some rich gender and racial disparity data with a high-level summary. The assessment identifies the need for more focus on cultural competency and in working with populations that are not currently getting their behavioral health needs met. The Health Needs Assessment is available on the Colorado Department of Human Services website.

The agenda item concluded with the consensus that DOC metric data would be shared with the subcommittee regularly and that more detailed discussions can take place on a quarterly basis.

Crisis Service System

In December Daniel Darting, Sue Williamson, and Matt Pfeifer updated the Program Improvement Advisory Committee (PIAC) on the crisis service system recommendations. The feedback received from PIAC was around consistently pushing for improved equity, diversity and inclusion for providers; incorporating schools in coordination efforts; concern that member support is more difficult to access; and that data sharing might be easier in the future if proposed Federal Health & Human Services rules are adopted.

The ideal state agreed upon by the subcommittee is “To have behavioral health systems (Medicaid, crisis services, providers, community resources, etc.) working together to ensure Medicaid members

have appropriate access to all levels of behavioral health services as needed. Behavioral health systems will appreciate, understand, communicate, collaborate and align with each other." The components necessary to reach the ideal state are effective communication to members; aligning metrics; routinely sharing data; and ensuring that equity, diversity and inclusion are reflected in policy and workforce.

The recommendation around "Meet" was to have some consistencies in things like shared agenda items and for HCPF to develop policy guidance for RAE coordination with ASOs. The "Replicate" recommendation involved replicating other models and service systems already occurring in Colorado Springs, Greeley, Douglas and El Paso counties. The recommendation of "Participate" is to have representatives from PIAC, BHIS, HCPF, RAEs and ASOs participate in the Behavioral Health Task Force implementation work. The implementation of these three recommendations are interrelated. The "meet" and "replicate" recommendations align with the Behavioral Health Taskforce work but can also be implemented regardless of the Taskforce's status. It was also noted that this subcommittee is a forum where it is appropriate to share information about the proposed Behavioral Administration.

The next steps are to finalize the edits to the recommendation and submit to PIAC in the March meeting.

Discussion on BHIS Priorities

In the interest of time, this discussion was omitted.

Wrap up and next steps

Meeting materials will be promptly posted onto the website. The next meeting is scheduled for February 3, 2021. The meeting was adjourned.