COLORADO
Department of Health Care Policy & Financing

Meeting Minutes
Behavioral Health and Integration Strategies PIAC Subcommittee

Virtual Meeting

May 4, 2022, 9:00 AM – 10:30 AM

1. Introductions

Facilitators:

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

Voting Members:

- Sue Williamson (Co-Chair) — Colorado Children's Health Care Access Program
- Amanda Jones — Community Reach Center
- Tom Keller — Regional MEAC & PIAC, Statewide PIAC
- Mary Ellen Benson — Diversus Health
- Taylor Miranda Thompson — Colorado Community Health Network
- Elizabeth Freudenthal — Children's Hospital Colorado
- Charles Davis — Crossroads Turning Points
- Nina Marinello — SCL Health
- Monique McCollum — Parent Family Advisor
- Karen Masters — West Pines Behavioral Health
- Imo Succo — Southwestern Colorado Area Health Education Center

Other Attendees:

- Allyson Gottsman — University of Colorado
- Alyssa Rose — Rocky Mountain Health Plans
- Ashley Clement — Northeast Health Partners
- Suzanne Kinney — Colorado Community Health Alliance

• Deb Hutson	Office of Behavioral Health
• Maureen Camey	Rocky Mountain Health Plans
• Brandon Arnold	Colorado Association of Health Plans
• Matt Morrison	Colorado Access
• Jane Flournoy	Colorado Dept. of Public Health and Environment
• Matthew Dodson	Axis Health Systems
• Laura Don	Tri-County Health Department
• Marjorie Champenoy	Rocky Mountain Health Plans
• Mattie Brister	Mile High Health Alliance
• Mona Allen	Health Colorado, Inc.
• Joseph Anderson	Colorado Access
• Audrey Oldright	Rocky Mountain Health Plans
• Jennie Munthali	CO Dept. for Public Health & Environment
• Ashleigh Philips	Centura Health
• Kelly Bianucci	The Child and Family Therapy Center of Denver

2. Housekeeping

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

Minutes from the month of April 2022 were approved. Amanda Jones makes the motion to approve minutes. Imo Succo seconds. No opposing votes or abstentions.

Matt Pfeifer provided a COVID-19 update; the Public Health Emergency has been extended to July 15, 2022. The federal government will provide notice 60 days in advance. 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

3. Department of Corrections (DOC) metric update, goal setting continued (Matt Pfeifer)

There is no DOC metric information to share for this month's meeting. This is due to a change in the process for RAEs/MCOS to submit claims which has delayed the metric calculation.

The intention is to continue reporting the metric monthly.

In follow-up from the last meeting, Matt received confirmation that MAT services are generally included in the DOC metric. Some additional considerations include:

- The DOC population is increasing, and releases continue to decrease.

- During the heigh of the pandemic, early releases often included members with high behavioral health needs and willingness to engage. Current releases seem less acute and less willing to engage.

Imo Succo inquires as to why the DOC population is increasing.

- Matt provides context that we are coming back out of the COVID-related pause that had an impact on the volume of individuals the justice system intersects with. This is not an all-encompassing rationale but does provide some context.

Daniel notes the importance of understanding the methodology behind the metric; this is integral to monitoring the metric.

4. Behavioral health provider network discussion (Matt Sundeen)

- Matt Sundeen has joined the May BHIS meeting to discuss the behavioral health (BH) provider network as the ACC program evolves as this group provides expertise on this subject.
- Increased attention on the behavioral health provider networks has led HCPF to engage with more stakeholders about how HCPF monitors the network.
- Matt presents data on the number of contract behavioral health practitioners over time in each Regional Accountable Entity (RAE) network.
- Practitioner has a specific definition – individual providers
- Facilities are measured a different data set
- The RAEs are required to contract with a statewide network; RAEs can contract with multiple practitioners to fulfill their contract.
- The data shows a growth in RAE provider networks. The general picture is that when ACC Phase II began in 2018 the RAE networks were much smaller than they are now.
- Across the state networks have grown significantly.
- Providers enrolling in the independent provider network (IPN) are adding the growth to the network (as opposed to Community Mental Health Centers).

  Questions are posed to the group to prompt discussion:
  - How would you measure capacity?
  - How appropriate/useful is the "raw" number of the providers as a measure?
  - How does the issue of quality intertwine with capacity?
  - If quality is considered, what is an appropriate way to measure quality?

  Voting members share:
  - Another consideration is providers opening and closing their panels. Is there any way to get a handle on the correlation between increased number of

providers and the actual access to care that Medicaid members are experiencing?
    - Matt Sundeen confirms that in the Network Adequacy reports we require from the RAEs, we collect how many providers are accepting new members. However, it's challenging to keep that number accurate over time. Some RAEs require that network providers notify them when they are going to not be accepting new members. RAEs have shared that this notification doesn't always happen.
- What is the difference between contracted providers and those that are providing services?
    - If a provider wants to work with Medicaid, the first step is they enroll as a Medicaid provider. HCPF has a team that enrolls providers. Then, the behavioral health provider contracts with the RAE, which is where they bill for their services rendered.
    - Providers may be contracted with multiple RAEs. There are providers that enroll in Medicaid and aren't in any RAE networks; there are providers who might be in some RAE networks and not all RAE networks. The RAEs report on this in quarterly network adequacy reports. The RAE has an array of services they must provide to members.

- Regarding panel availability, the opening and closing of panels is dynamic. The group would like to see access to specialty care. Raw numbers in general are not helpful. The group is interested in access to specialty care such as SUD, MAT, and pediatric services.
- The goal is ultimately to provide services to members. Geographic accessibility needs to be a part of the measure. In-person services still need to exist although telehealth is expanding. The growth of the number over time implies inherent goodness. Its not necessarily good or bad it's just a number that has changed over time.
- Questions that participants suggested the Department consider included:
    - What is the goal for how do we know if members are being served?
    - Is there a rate of change goal? What is the rate of change over time?
    - What is the denominator?
- The behavioral health penetration rates for Medicaid statewide are comparable or better for BH services for Medicaid than what HCPF is hearing for commercial.
- Equity is a foremost concern and is a clear example of a why a raw number won't be helpful. Equity processes shouldn't be driven top-down. Has HCPF explored member engagement processes to develop these goals?
- Is a distribution chart possible? Ensuring availability of equity-minded services to Medicaid members and ensuring we have the whole continuum as accessible as possible is the north star.

- Which RAEs get that information from their providers about accepting new Medicaid patients or not, and why not?
    - HCPF will investigate this question and get back to the group.
- The group can't just look at raw numbers to assess the situation; the group needs to take a population health approach to these metrics. For example, pediatric needs and services are very different than adults. Suggestion that requirements and measures need to be different for different populations.
- Using national standards is best and appropriate.

5. ACC 3.0 initial discussion (Mark Queirolo)

Mark Queirolo joins the meeting to have initial discussions with BHIS about ACC Phase III planning.

- Planning is in the research phase.

- Fiscal Year (FY) 2021-2022 is focused on strategic goal setting, initial research, and initial stakeholder idea gathering in preparation for a FY 2025 – 2026 "Go Live" date.

- There will be extensive stakeholder engagement on the Request for Proposals (RFP) for Phase III.

- More targeted discussions will happen in July and August of 2022 to dig in on topics such as payment models and health homes. The BHIS group is looking forward to continuing discussions and is eager to provide input.

The voting members of the BHIS group participate in a feedback-gathering activity (via JamBoard). Questions posed to the group are:

1. What aspects of ACC Phase II related to behavioral health are working well?

2. Which aspects of ACC Phase II related to behavioral health have the greatest need for improvement?

Voting members are invited to fill out the JamBoard now or following the meeting; discussion of the questions ensue. What is working well?

- Elizabeth Freudenthal calls out the need for flexible funding to use for programs that improve health but are not directly billable fee for service (FFS).

- Amanda Jones calls out the importance of Member choice and network adequacy to support those choices.

- Sue Williamson notes the forward momentum of the 6 short term behavioral health visit benefit. This is a benefit that could be improved upon and expanded.

- Daniel Darting notes the comprehensive nature of the behavioral health benefit and how it continues to grow. There still needs to be more done around specialty care.

Mark asks the group what could be improved upon.

- The group points out that integration is really hard to achieve with a bifurcated payment model.

- The establishment of the Behavioral Health Administration (BHA) and the focus on how the State purchases BH services is a large area of opportunity.

- From the provider perspective, there have been varying expectations around contract requirements and expectations in different providers in the network. Looking at consistency around those expectations is something to be reviewed.

- Current program tracking seems diffuse. Planful and structural tracking/monitoring is needed. If the program is going to have impact from a physical health standpoint, measuring everything and tracking everything needs to be clear and the project needs to stick to it.

- There is a sense of constant shift of metrics and requirements; metrics and requirements need to be a lot more stable and last a longer time. The Plan-Do-Study-Act model is referenced.

- Is the State considering expanding benefits? Specifically for those with a physical health condition co-occurring with significant behavioral health components, is there integrated care coding that can be used?

Conversations about ACC Phase III are also taking place at the larger Program Improvement Advisory Committee; attendees of this meeting are welcome to join there.

The next meeting is scheduled for June 1, 2022. The meeting was adjourned.