COLORADO
Department of Health Care Policy & Financing

# Meeting Minutes
# Behavioral Health and Integration Strategies PIAC Subcommittee

Virtual Meeting

July 7, 2021 9 AM – 10:30 AM

## 1. Introductions

**Facilitators:**

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

**Voting Members:**

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| • Sue Williamson | Colorado Children's Health Care Access Program (Co-Chair) |
| • Amanda Jones | The Center for Mental Health |
| • Tom Keller | Regional MEAC & PIAC, Statewide PIAC |
| • Tammi Philips | Larimer County Department of Human Services |
| • Stephanie Salazar-Rodriguez | Connect for Health Colorado |
| • Imo Succo | Southwestern Colorado Area Health Education Center |
| • Mary Ellen Benson | Diversus Health |
| • Andrea Mercier | Parent of child with special needs, lived experience |

**Other Attendees:**

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| • Marjorie Champenoy | Rocky Mountain Health Plans (RAE 1) |
| • Cris Matoush | Rocky Mountain Health Plans (RAE 1) |
| • Taylor Miranda Thompson | Colorado Community Health Network |
| • Kellen Roth | Colorado Access (RAE 3 & 5) |
| • Camila Joao | Colorado Community Health Alliance (RAE 6 & 7) |
| • Tina Gonzales | Beacon Health Options (RAE 2 & 4) |
| • Moses Gur | Colorado Behavioral Healthcare Council |
| • Sandra Grossman | Health Care Policy & Financing (HCPF) |
| • Erin Herman | Health Care Policy & Financing (HCPF) |
| • Amy Luu | Health Care Policy & Financing (HCPF) |
| • Megan Comer | Health Care Policy & Financing (HCPF) |
| • Victoria Laskey | Health Care Policy & Financing (HCPF) |
| • Courtney Phillips | Health Care Policy & Financing (HCPF) |
| • John Laukkanen | Health Care Policy & Financing (HCPF) |
| • Jo Donlin | Health Care Policy & Financing (HCPF) |
| • Kate Taylor | Creative Treatment Options |
| • Karen Masters | West Pines SCL Health |

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| • Bob Dyer | Front Range Health Partners |
| • Ryan Larson | Colorado Access (RAE 3 & 5) |
| • Christine Anderson | Beacon Health Options (RAE 2 & 4) |
| • Charles Davis | Crossroads' Turning Points, Inc. |
| • Susan Garrett | The Health Education and Resources Institute |
| • Doug Muir | Centura Health |

## 2. Housekeeping

Daniel Darting called the meeting to order at 9:03 AM. Minutes from the month of June were approved. No abstention.

A reminder was provided that meeting materials are posted and available on the BHIS website.

Matt Pfeifer presented the January 2021 Department of Correction (DOC) Behavioral Health (BH) BH engagement rate metric data, as part of the group's standard review. Overall trend of the ACC program is increasing (dotted line in the middle). All information is from the rolling 12-month average. Performance rate is at 13.26% in January 2021 (target rate is 13.39%). Of note:

- Continuing as a Department, in collaboration with the RAEs and DOC, to discuss what makes sense for this fiscal year and the target rate. The target needs to be realistic but still indicate progress.

- Daniel poses a question about what the data would look like if analyzed per capita. For example, there is a cluster around the Denver Metro area. Matt indicates the Department can look at including that in this analysis.

Matt presents the 30-day BH engagement rate. There is more of a spread in this data, and the trend continues to increase. Presents breakdown by race and gender; females have a higher engagement rate than males. White Members have a higher rate of engagement than Members of color. Desired trend is that those numbers move closer together to close the gap of disparity.

## 3. COVID-19 updates

Matt Pfeifer provided COVID-19 updates. There are ongoing vaccine outreach efforts and work to address disparities. There are updates on the American Rescue Plan Act (ARPA), which includes a 10% increase in federal match for Home and Community Based Services (HCBS). Additional information available on HCPF website: hcpf.colorado.gov/arpa.

Daniel Darting notes there are still a lot of challenges in the wake of the pandemic and this committee is a space to discuss those ongoing challenges. Vicki Allen-Sanchez asks that the group consider the affect that this is not only having on the community but the workforce as well. Group to consider supports for staff retention and staff feeling supported as it is a heavy lift right now. There is a great deal of exhaustion and burden. The strategies could include ARPA-invested resources. Indicators show that BH needs and acuity has significantly increased.

## 4. Short Term Behavioral Health (STBH) Services update – John Laukkanen, HCPF

John Laukkanen presents on the STBH benefit. The benefit was implemented July 1, 2018 and meant to increase access to BH services for low-acuity conditions (e.g. general anxiety, mild to moderate depression), and offer early interventions in a primary care setting. To achieve this, six chosen codes were opened. The claims didn't have to go under CAP or RAE claim system, could be billed FFS from the primary care office. There was a limit of six sessions in a 12-month period, which did not need a covered diagnosis. Benefit did not add new codes and was not meant to solve for integration of BH and physical health. This was not intended to continue the State Innovation Model (SIM) work but was intended to allow for different options and access. The benefit loosens covered diagnoses requirement, increases access, and increases member options.

The Department now has two years of data after this rollout. John presents the monthly trends by age groups. Those in the 21-64 age range are the highest utilizers, followed by those who are between 13-20 years of age. This data makes sense because we were limiting the benefit to six visits in a year. Utilization goes up, then goes down when the fiscal year starts and ends and is not necessarily as sporadic as the data trends look like. Of note, in 2019-2020 for the 21-64 age group, the data has a high starting point, then goes down, then when it came back up again, it didn't get back up as high as the analysts would have expected.

In terms of interpreting the data on the slide, the orange line is the visit count, blue line is the member count. Generally, the average member is using the average number of visits.

John presents the data on visits per provider. There are roughly five provider types where benefit can be billed. The most utilization is coming from the Federally Qualified Health Centers (FQHCs). There were 24,000 visits that were claimed in an FQHC. Claims in general clinics is second highest. Presented as a ratio, we have 2.5 as many times members using this benefit at an FQHC than at a traditional independent clinic. In FY19-20 there was an increase in clinic usage (increase in both). Significant increase in utilization at the clinical level then dip in FQHC. John encourages the

group to keep COVID-19 in mind. When in-person visits had to end, that may be why the data shows a deep dip in the FQHCs rate.

John clarifies that there were no required diagnoses for these claims so could have been for behavioral or mental health. For examples, could have been regarding a broken arm and the anxiety around having a broken arm, or a new diagnosis of diabetes and trying to help a Member adjust to treatment plan. The benefit must have been billed in a primary care setting. If there was a contract that a Primary Care Physician (PCP) made with a therapist, that could have been possible, but the must be possible in primary care setting. Imo Succo shares personal experience from rural perspective.

John presents data on if the benefit is working. The Department looked at how many Members who had a short term BH visit also had a BH visit under the service capitation (through the RAE). The data shows that for those who had one BH visit that the RAE paid for, there was not significant utilization in the short-term BH visit data. For those with two or more BH visits that were paid for by the RAE in the previous year and utilized 6 visits, 47% of the Members fell into that category. 28% of those folks had utilized under six visits. The interpretation is that Members who were using BH services before used the full 6 visits. For Members with no BH claims paid for by the RAE, 46% used 6 or more visits for the BH. 64% of the folks with no prior BH utilization made at least one BH visit once the benefit was offered. Analysis indicates that members who were not engaged in BH increased in utilization once the BH benefit is offered. Indication that we are increasing access to a segment of the population who may not have sought services in another setting before. That grew from first year of the benefit to second year of the benefit.

The follow-up is where the FQHCs come in. Department is investigating data by diagnoses as the benefit was designed for low-acuity conditions. 46.37% of Members with no previous BH capitation visit (paid for by the RAE) engaged in under 6 visits under the benefit. Members who needed 6 or less sessions to address their concerns is the target population.

John notes the different responses to the benefit; it is clear there is one way how FQHCs are using the benefit and one way that clinical settings are using the benefit. There is confusion around billing. Again, the benefit is not intended to resolve for integrated care. A lot of clinics are doing integrated care, but this was not explicitly intended for that. Benefit in general has been perceived as desirable. Been up to HCPF on how to measure the impact. That's where the Department is at now.

Challenges of the analysis include: the absence of an original benchmark, prevention being hard to measure, and cost shifting vs. cost savings. Additionally, there was no consistent model (FQHC vs. clinic).

As a next step, the Department is now looking into the population, what diagnoses were being used when applicable, and if the benefit was being used as designed. Additionally, there may be benefit from this benefit, that the Department didn't consider. Improvement considerations include addressing the episode of care, addressing integrated care concerns, and designing the benefit for two business models (FQHC and clinical).

Sue Williamson reflects there was a lot of confusion when the benefit was first implemented and thanks John for being an advocate and resource. There are opportunities to expand and tweak the benefit, so it is more effective.

The Department is committed to this benefit and will lean in to make it better.

## 5. Legislative update – Jo Donlin, HCPF

Jo Donlin from HCPF provides a recap of the 2021 legislative session and relevant notes. There was a big focus on BH this legislative session:

- HB21-1097 Establish Behavioral Health Administration. Signed into law in April. Recommendation of BH taskforce. Meant to consolidate BH resources under one roof as much as possible. Currently focused on building a plan and a report that will go back to the legislature.
- SB21-137 Behavioral Health Recovery Act. – Related to Medicaid in that the bill includes work on utilization management, audits on denials, and care coordination. Bill has been signed and has a lot of near-term funding going toward current programs.
- HB21-1119 Suicide Prevention, Intervention, & Postvention.
- HB21-1085 Secure Transportation Behavioral Health Crisis. Directs Department of Human Services (DHS) and HCPF to work together to ensure people are getting to the services they need, when they need them, where they need them
- HB21-1166 Behavioral Health Crisis Response Training. Focused on workforce development.
- SB21-194 Maternal Health Providers. Expands post-partum services from 60 days to 12 months. PPD instances go without treatment.

Jo confirms some of the American Recovery Plan Act (ARPA) funding will be going toward BH.

Daniel Darting asks if there is a forum for communication around what the Department needs for ARPA allocation. Jo confirms there are a lot of moving parts right now and the Department is just getting implementation going.

Daniel encourages the group to think about things that we may not have been able to invest in and fund. This can be a forum where we discuss those ideas.

Doug Muir recommends consideration for infrastructure dollars as folks aren't positioned well for sustainability and long-term growth. For example, peer programs and groups like Catholic Charities. If the State could consider infrastructure and technical assistance for providers, that would be meaningful. This support needs to come from the State because of regulatory issues.

## 6. Wrap up and next steps

The group to continue discuss what to dig in on in a similar way to the work on the DOC metric and the crisis-service recommendations.

The next meeting is scheduled for August 4, 2021. The meeting was adjourned.