# HB22-1302 Integrated Care Legislative Report

*Integrated Care and Why it Matters*

**January 13, 2025**

**Submitted to:**

COLORADO
Department of Health Care Policy & Financing

## Contents

## Executive Summary

Pursuant to HB22-1302 Health-care Practice Transformation, the Department of Health Care Policy and Financing (HCPF), in collaboration with the Division of Insurance (DOI) and the Behavioral Health Administration (BHA), is submitting recommendations on best practices for sustaining integrated care models. A supplemental report with grantee data will be published in 2025 to include data from grantees on quality and outcomes.

Integrated Care (IC) is the practice of having primary care providers and behavioral health care providers integrated into the same care delivery team, collaborating and working in tandem, and has shown positive health outcomes and cost benefits. Benefits associated with IC include a reduction in emergency department utilization and improved care delivery with potential to reduce costs. While the ideal state of IC is a fully integrated team, there are many levels of integration that improve patient outcomes and experience.

Colorado has a history of working to advance IC for the past decade, including implementation of the federal State Innovation Model (SIM) grant, a four-year $65 million initiative aimed at transforming health care delivery and payment structures through the integration of physical and behavioral health across Colorado. However, coordinated state activities and funding for IC largely ceased when the SIM initiative ended in 2019. While the SIM participants and HCPF continued to make strides to support care coordination between physical and behavioral health, HB 22-1302 was a call to action to build a more sustainable reimbursement structure in Colorado for these essential services. This legislation, grant program, and sustainability report were also a result of Colorado's Blueprint for Behavioral Health and the legislative Behavioral Health Transformation Task Force, both of which identified integrated care, whole-person care coordination, improved access, and workforce development as key practices required for behavioral health transformation in Colorado.

In preparing this report, HCPF conducted robust stakeholder engagement, engaging with HB22-1302 grantees, the DOI and BHA, integrated care practices, Regional Accountable Entities (RAEs), and private payers to develop and refine recommendations to sustain IC. Major and consistent themes from feedback identified the need for the following types of practice support:

- Providing seed funding to build structure and capacity to deliver high-quality IC, such as grants.
- Opening applicable codes for fee for service (FFS) reimbursement, or receiving payment for each service billed, including the Collaborative Care Management (CoCM) and Health and Behavioral Assessment and Intervention (HBAI) codes.
- Providing flexible, sustainable funding through a combination of FFS and a per member per month (PMPM) payments based on the level of integration of a practice.

Acknowledging the diversity of practices across the state (with varying resources, capacities, and patient populations), as well as the diversity of patient needs (from light touch to more intensive interventions), the following recommendations provide opportunities to support providers in delivering IC that best meets patients and families where they are. For HCPF specifically, opening CoCM and HBAI codes and developing a per member per month payment will be feasible next step in sustaining IC. Additionally, there are other components to this model that could further strengthen sustainability of these services that HCPF will continue to explore and which are not included in this recommendation. These areas include developing integration levels for practices, seed funding, and evaluating additional FFS codes. Colorado's ability to sustain IC at a statewide level will also require ongoing alignment across all payers, both public and private, a theme that is also highlighted in the following recommendations. Most private payers already support IC in primary care, and the HCPF recommendations align with other payers for similar coding and workflows.

## Introduction

The definition HCPF utilized in developing this report was

> "The care a patient experiences as a result of a team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance use conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.[1] The care can also take a

[1] https://integrationacademy.ahrq.gov/about/integrated-behavioral-health

prevention approach, utilizing tools to identify needs early on and address those needs using health promotion strategies. The physical and behavioral health services occur in the same care setting to the extent possible."

HCPF has determined the Agency for Healthcare Research and Quality definition for IC, as well as stakeholder recommended additions, serves as a thorough foundation to define IC.[1]

IC plays a significant role in supporting all Coloradans, especially for those with co-occurring conditions. Research has shown a host of benefits including:

- making it less likely that health conditions escalate into more severe conditions.[2]
- provides greater access to services for those with chronic conditions.[3]
- increase access for rural communities by utilizing providers more efficiently and leveraging telemedicine to fill in gaps.[4]
- reduces transportation costs and emergency services visits.[5] [6]
- supports in reducing stigmas regarding accessing behavioral health services.[7]
- increases care coordination by encouraging collaboration between care teams to address interrelated physical health, behavioral health, and social determinants of health concerns.[8]

Additionally, IC has evidence for cost savings. Research suggests programs integrating behavioral health can save 5-10% in health care costs for patients with behavioral health conditions.[9] [10] Additionally, some IC code sets such as the Collaborative Care Model (CoCM) and Health Behavior assessment and Intervention (HBAI) codes have shown savings and promoted better outcomes in patients.[11]

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[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9957689/

[3] https://aspe.hhs.gov/reports/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-progress-lessons-first-0

[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7296432/

[5] https://acrjournals.onlinelibrary.wiley.com/doi/full/10.1002/acr2.11391

[6] https://www.researchgate.net/publication/327868630_The_impact_of_integrated_care_for_people_with_chronic_conditions_on_hospital_and_emergency_department_utilization_a_rapid_review

[7] https://aspe.hhs.gov/reports/evaluation-medicaid-health-home-option-beneficiaries-chronic-conditions-progress-lessons-first-0

[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6554552/

[9] https://www.civitasforhealth.org/wp-content/uploads/2022/08/milliman-report-economic-impact-integrated-implications-psychiatry-1.pdf

[10] http://www.aha.org/content/14/milliman_economicimpact_behavhealthcare2014.pdf

[11] https://www.apaservices.org/practice/reimbursement/health-codes/2022-health-behavior-assessment-codes-factsheet.pdf

Colorado has made several attempts to fund and support IC over the past decade. The State was awarded $65 million in 2014 by the Centers for Medicare and Medicaid Services (CMS) State Innovation Models Initiative (SIM). SIM supported IC initiatives in 344 primary care practices and 4 Community Mental Health Centers across the state.[12] The Colorado SIM Final Report demonstrates key benefits of IC that mirrored outcomes across other states, including a reduction in emergency department utilization, lower rates of 30-day hospital re-admissions for mental health conditions, and improved care delivery.[13] There is concern some benefits seen by SIM could not be sustained due to the lack of continued funding after SIM grants expired. The Colorado SIM Final Process Evaluation Report reflected this concern, identifying a lack of funding as a primary barrier to sustaining IC.[14]

In 2018, under the second phase of the Accountable Care Collaborative (ACC), HCPF implemented the 6 Short-Term Behavioral Health (STBH) Benefit. While this benefit was not designed as a solution to support IC, practices and providers turned to it for IC as there was a lack of alternatives. The STBH benefit used standard psychotherapy codes to provide additional access to behavioral health services for short-term episodes of care for low-acuity conditions. This may include grief and adjustment conditions, as well as medical conditions where behavioral interventions can support treatment adherence and wellness (such as obesity and diabetes).[15] These visits could be over a twelve-month time span and required a behavioral health provider conduct the visit in a primary care setting.

In July 2022, HCPF received $29 million to distribute as grants to practices wanting to establish or expand IC through capacity-building measures such as hiring, construction, and training.[16] While HB22-1302 provides invaluable capacity-building funding, it does not provide any means of sustaining day-to-day costs that come from providing such services outside of standard billing and use of the STBH benefit. As of January 2025, 79 clinics are participating in the HB22-1302 grant program. Grantees operate a total of 145 sites in 31 counties and serve over 800,000 Medicaid and CHP+ members. Grantees range from brand new organizations that haven't begun serving

[12] https://medschool.cuanschutz.edu/practice-innovation-program/previous-initiatives/state-innovation-model

[13] https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20SIM%20Final%20Report_0.pdf

[14] https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20SIM%20Final%20Process%20Evaluation%20Report_0.pdf

[15] https://hcpf.colorado.gov/sites/hcpf/files/Short-term%20Behavioral%20Health%20Services%20in%20Primary%20Care%20Fact%20Sheet%20Jan%202019.pdf

[16] https://leg.colorado.gov/sites/default/files/2022a_1302_signed.pdf

clients to large federally qualified health centers (FQHCs) serving nearly a quarter of a million patients (Appendix A). Of the 145 sites participating in the HB22-1302 grant program, 51 sites also participated in SIM. HB22-1302 grant funding concludes in December 2026.

## Stakeholder Feedback

HCPF, in collaboration with the BHA and DOI and pursuant of HB22-1302, had a robust stakeholder process in 2024 with community members that was valuable in developing the recommendations outlined in later sections. In February 2023 HCPF created a HB22-1302 Steering Committee to provide input into grant application requirements, provide feedback and direction on data collection standards and review, and engage with community partners. The committee included staff from HCPFs Behavioral Health Initiatives and Coverage (BHIC) office, Payment Reform division and Cost Control and Quality Improvement (CCQI) office as well as stakeholders from the BHA, the DOI, health care practices, and other key partners. Additionally, HCPF created an Integrated Care Recommendation Work Group with the goal of consulting on IC decisions. This group included staff from HCPF's BHIC office, Payment Reform division, the BHA, and the DOI.

HCPF has engaged a variety of external stakeholders to gather recommendations on recommendations for sustaining integrated care including contracting with the Colorado Health Institute (CHI) for the following:

- 3 working sessions to solicit recommendations. Stakeholders in the working sessions included HB22-1302 grantees, Substance Use Disorder and Medication Assisted Treatment practices, Federally Qualified Health Centers, pediatric practices, rural practices, independent practices, and the Primary Care Payment Reform Collaborative.
- Key Informant Interviews with key stakeholders including the Colorado Cross-Disability Coalition, the Colorado Community Health Network, and the Colorado Behavioral Health Administration.
- 2 Public webinars where all HB22-1302 grantees were invited and encouraged to invite any other stakeholders.
- A meeting with Regional Accountable Entities to discuss proposed recommendations and solicit new recommendations.

In addition to the CHI outreach, HCPF conducted stakeholder engagement with several private payers (Rocky Mountain Health Plans, Kaiser, United Health Care, Colorado Health Plans) and the Youth Healthcare Alliance.

In total, HCPF has spent 4,389 hours engaging 114 individuals representing 53 organizations during stakeholder engagement. Appendix B notes stakeholders HCPF engaged and collaborated with.

## General Themes and Feedback

Throughout HCPF's stakeholder engagement, key themes emerged that guided HCPF in designing and refining recommendations for sustaining IC. While some comments were specific to HCPF, others are more broadly generalizable across all payers.

### *Insufficient Current State of Integrated Care*

Stakeholders spoke strongly about shortcomings in the current state of IC. The 6 STBH Benefit implemented by HCPF in 2018 does not offer codes short enough to cover briefer interventions (e.g. a 15-minute intervention or encounter) and more complex patients often need more than 6 visits that are reimbursed FFS. Additionally, while stakeholders commented the 6 STBH visits promote co-location, or simply having a behavioral health provider on location with primary care, or vice versa, stakeholders also commented on the need for further integration and codes to support closer collaboration between behavioral and physical health teams.

Other codes available to practices also fall short. Medicaid stakeholders mentioned the Screening and Brief Intervention and Referral to Treatment (SBIRT) codes, which are currently reimbursed by HCPF, are too niche to apply to IC and do not reimburse enough. Several stakeholders noted that while they provide services that could be coded and billed with the SBIRT codes, due to these reasons they do not bother. Ultimately, there was clear feedback that current codes will not sustain IC and any new payment model will be irrelevant if funding is not adequate.

Stakeholders also felt strongly that using psychotherapy codes under the current STBH Benefit promotes a reactive approach to care, providing services after there is a significant problem rather than focusing on proactive, preventative approaches such as brief interventions earlier in the scope of care.

### *Funding Challenges*

Two core challenges consistently identified by stakeholders in relation to sustaining IC are: 1) no model will work if it does not pay enough; and 2) grant funding is not a sustainable source of revenue for providers. Stakeholders strongly recommend an IC reimbursement model that provides a sustainable funding. When asked about a preferred approach for HCPF, stakeholders noted that FFS or a PMPM payment alone will not suffice. Several practices commented on their desire for a payment methodology similar to what practices currently use (primarily FFS) in an effort to promote adoption of the model and simplify administrative complexity.

Many stakeholders also commented on the need for practices with small populations such as rural practices and practices with niche specialties (e.g. School Based Health Centers or pediatrics) to be able to participate in the model. Feedback was clear that a PMPM is unlikely to work well for these practices.

Lastly, while discussing seed funding, stakeholders mentioned practices will vary on the amount of time needed for their IC programs to become sustainable. One stakeholder mentioned their practice could take more than 2 years to achieve sustainability, noting that implementing new practices, hiring new staff, and learning new workflows is a long-term project. Stakeholders mentioned that the Rocky Mountain Health Plans (RMHP) model where practices request an amount for seed funding to stand up their program and over time roll off of seed funding and over to billing codes could serve as a template.

### *Multi-payer Alignment*

Stakeholders emphasized the importance of all payers aligning with an IC funding model. Many practices do not exclusively serve Medicaid members and noted having multiple funding models erodes practices capacity to stand up and sustain IC. Several private payers indicated they reimburse for some or all of the codes in the CoCM and HBAI code set as part of their IC initiatives, or had plans to do so in the future.

Stakeholders noted a need for IC to cover all Coloradans and not only the members receiving care under Medicaid. An emphasis was placed on providing whole family care, especially in regards to pediatric members.

### *Workforce Shortages*

A recurring concern from stakeholders and HB22-1302 grantees was the difficulty in hiring and retaining qualified behavioral health providers to sustain their IC efforts and meet the needs for coverage. A key piece is practice's ability to generate revenue to pay salaries. This concern is amplified for rural and pediatric practices. More than 60% of the HB22-1302 grant requests were for hiring certified clinical staff. Additionally, there is currently a shortage of behavioral health professionals. Several HB22-1302 grantees have resorted to utilizing out-of-state behavioral health telehealth providers to supplement their staff. Lastly, several grantees have noted difficulties in their ability to hire students or providers that are not credentialed yet due to the shortage of behavioral health professionals that can provide supervision. Stakeholders noted that workforce shortages are having an impact on access to care, notably for Medicaid patients. This is one reason CoCM codes are so essential for sustainable services – they allow for providers to connect with addiction medicine physicians and psychiatrists, including smaller practices that don't have the volume of patients to support a full time or part time position. This also makes good use of limited physician specialist resources, allowing these providers to serve multiple practices.

### *IC Integration Levels*

Stakeholders expressed a desire to have an approach to IC that supports all levels of integration, which would allow practices to join the program at their current level of integration and progress toward more robust integration over time or as needed. Additionally, not all practices have the resources to provide all behavioral health services (e.g. psychiatric interventions); support for different levels of integration would allow practices to cater services to their patient and practice needs. Stakeholders also expressed a desire to ensure an IC model supports integration beyond simply co-locating behavioral health providers in proximity to primary care providers.

## Recommendations for Sustaining Integrated Care

Through policy analysis and utilizing stakeholder feedback, HCPF has developed two recommendations to sustain IC past the end of the HB22-1302 grants in 2026; 1) opening the CoCM and HBAI codes to bill FFS and 2) developing a PMPM to pay through

the RAEs. While these recommendations are primarily applicable to HCPF, they were developed in consultation with private payers, and with the goal of advancing payer alignment to support IC. These recommendations aim to provide sustainable funding, flexibility to practices, and cover a variety of IC services including:

- Screening and brief interventions
- Behavioral health provider availability for immediate support/brief intervention
- Behavioral health care coordination and care management
- Collaboration and consultation with a team of providers (team-based care) to support patients with whole person care

### *CoCM and HBAI Codes*

HCPF's first recommendation is to open CoCM and HBAI codes to be billed FFS (receiving payment for each service billed). FFS provides financial support for distinct services provided to support providers starting implementation of IC as well as a baseline support for higher integrated practices while broadly aligning with other payers for consistency and reducing administrative burden.

CoCM codes focus on providing psychiatric care to an individual in a primary care setting through the use of a behavioral health care manager and a consulting psychiatrist in collaboration with a primary care provider.[17] As of 2022, twenty two state Medicaid programs have adopted CoCM codes while Medicare and some commercial payers also cover CoCM codes. CoCM codes also allow psychiatrists to leverage telehealth which increases efficiency as well as access to providers during a workforce shortfall. This benefit is especially impactful for rural populations.[18]

HBAI codes focus on assessment and interventions to address behavioral health issues in a medical setting. HBAI services are led by a behavioral health provider in collaboration with a medical provider. HBAI codes can be billed in fifteen minute

[17] https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf

[18] https://mmhpi.org/wp-content/uploads/2022/11/Behavioral-Health-Care-for-Youth-CoCM-Expansion-Nov2022.pdf

increments and allow for individual, family, or group interventions.[19] As of 2022, twenty one state Medicaid programs have adopted HBAI codes.[20]

Both the CoCM and HBAI code sets have shown savings and promoted better outcomes in patients as well as being broadly supported by stakeholders for increasing access to services and flexibility. HCPF has submitted a budget request for FY 2025-26 that includes opening the CoCM and HBAI codes to be billed FFS while moving the 6 STBH benefit services to the behavioral health capitation. In the Department's R-12 Integrated Care Benefits Request, HCPF estimated this proposal would have an annual cost of $1,575,367 total funds including $368,170 General Fund.

***Per Member Per Month Payment***

HCPF's second recommendation is a non-provider specific PMPM to more integrated practices. A PMPM would support sustaining IC in two key ways. First, a PMPM provides a stable revenue source with minimal administrative burden on practices. Second, a PMPM supports access to IC by setting up a funding model where practitioners are open and available to provide services when needed instead of by appointment and can help cover services that are not billable under a FFS reimbursement model or services that are not practical to bill such as a five minute intervention

To better understand the need for a PMPM payment in supporting and sustaining IC, the University of Colorado Anschutz Medical Campus' Eugene S. Farley, Jr. Health Policy Center (Farley Center) supported HCPF in conducting a time study analysis to inform a PMPM payment. The Farley Center research looked at 11 highly integrated practices and included time behavioral health providers, primary care providers, and other staff spent on IC that would not be billable services including time spent on care team meetings, consultation with other care team members, consultation with psychiatry or other behavioral health providers, patient phone calls or communication, among others. The Farley Center found the following:

- Behavioral health providers spend on average 273.55 minutes per day at a cost of

[19] https://www.apaservices.org/practice/reimbursement/health-codes/health-behavior

[20] https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-health-behavior-assessment-and-intervention-hbai-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

    - $166.32 per day ($43,243.20 per year) for Licensed Clinical Social Worker.
    - $261.82 per day ($68,073.20 per year) for psychologists.
- Primary care providers spend 27.56 minutes per day at a cost of $62.97 per day ($16,372.20 per year).
- Other staff (care coordinator, nurse, etc) spend 49.25 minutes per day at a cost of $31.46 per day ($8,179.60 per year).

From the Farley Center's findings (Appendix D), practices can have significant costs maintaining IC that is not tied to billable services. A PMPM will support IC work and costs in this regard.

HCPF is negotiating a required increase in RAE PMPM payments to practices with IC as a part of the Accountable Care Collaborative Phase 3 Contracts.

## Areas for Further Exploration

In addition to the recommendations outlined above, HCPF has identified promising areas that warrant further exploration. These areas are likely to have positive fiscal impacts and further research would be needed to determine specific policy recommendations if funding were to become available.

### *Additional FFS Codes*

HCPF has identified additional codes that might supplement the CoCM and HBAI codes. These codes include assessments and services such as social determinants of health assessments, screening to determine eligibility for admission to treatment, behavioral health education, crisis intervention, and mental health assessments by a non-physician. Appendix C outlines codes applicable to IC that HCPF has researched or is continuing to evaluate.

### *Seed Funding*

Seed funding to practices for starting their IC programs could prove a pivotal step in setting up IC programs, especially for smaller practices. Starting IC has a high barrier to entry due to the costs of hiring a behavioral health professional, creating space for staff, etc. The Farley Center research suggests startup facility and equipment cost

$35,500 and an estimated annual cost of providing IC in a typical practice between $360,000 and $475,000. (Appendix D). Providing seed funding, similar to the HB22-1302 grants and SIM initiatives, would continue to support practices with these costs as they stand up their IC programs.

### *Integration Levels*

Utilizing a universal assessment to gauge integration levels of practices could support practices in aligning with other models and payers and ease administrative burden on practices. One such assessment is the Building Blocks of Behavioral Health Integration, which was utilized in SIM initiatives.[21] The goal of integration levels is to gauge a practice's eligibility for seed funding and PMPM payments. Practices at a lower level of integration, such as practices starting their IC programs, would be eligible for seed funding while practices that have built the capacity and infrastructure for IC would move away from seed funding and to a PMPM payment. Continued engagement with stakeholders and development from HCPF staff is needed to find and align an assessment to IC operations.

### *Areas Outside of HCPF*

There are several areas for continued development that are outside the scope of this report but still impact sustaining IC. First, the recommendations described here do not account for Coloradoans without insurance. Second, while the recommended model outlined in this report is specific to HCPF, it was developed in consultation with private payers and is directionally aligned with current payer approaches. Ongoing collaboration and multi-payer alignment will be important priorities in sustainably advancing IC, in a manner that reduces provider burden and effectively meets the needs of Coloradans.

## Conclusion

IC has shown to be a promising direction in health care that will support all Coloradans through improved health outcomes, improved workforce capacity, and decreased long-term cost of physical and behavioral health care. Though the State has had previous IC initiatives, those initiatives ended when funding dried up. The State

[21] https://wellbeingtrust.org/wp-content/uploads/2022/06/BHI-Framework-Report-June-2022.pdf

again faces the opportunity to fund IC by leveraging the recommendations laid out in this report.

This report has met the requirements of HB22-1302 in providing recommendations for best practices for sustaining IC in collaboration with the BHA and DOI. HCPF will publish a supplemental report on HB22-1302 grantee data relating to clinical quality improvement and access to care in calendar year 2025 when data is available.

## Appendix A

# HB1302 Integrated Care Grant

# Final Awardee Report

HealthTech Solutions (HealthTech) appreciates the opportunity to partner with the Department of Health Care Policy and Financing (the Department, or 'HCPF') in support of the HB22-1302 Integrated Care Grant.

This Final Awardee Report details the number of applications reviewed, scored, and approved by the Department. This report also gives an overview of the provider awardees and members who will be impacted by the HB 22-1302 grant.

## Project Scope

HealthTech will assist the Department with reviewing all applications for HB 22-1302 Integrated Behavioral Health Grant Program and engage with the Department and Steering Committee on goals and scoring tools to identify the top grant grantees. HealthTech will perform an analysis on the data collected in the applications and scoring rubric to make recommendations. These recommendations will include a modality for weighted scoring, score automation, full and partial awards. HealthTech will collaborate with the Department to ensure grant applications comply with the stated Request for Application (RFA) technical requirements as defined in the agreed upon Statement of Work (SOW).

### Revision History

| Date | Version | Author(s) | Notes |
|---|---|---|---|
| 07/31/2023 | 1 | HealthTech Solutions | Final Awardee Report Deliverable |

| HealthTech Resources: | |
|---|---|
| Project Lead | Dr. John Langefeld |
| Project Oversight | Chris Clark |
| Project Manager | Randy McCleese |
| Project Coordinator | Ashley Cornett |
| Additional Support | Cierra Childs, Amanda Smith, and Jennifer Cook |

**Project Materials:**

- House Bill 22-1302
- HB 22-1302 Fact Sheet
- HB 22-1302 Applications
- Application Guidance
- Requests for Applications (RFA) Document

# HB1302 Integrated Care Grant Application Review Final Awardee Report

**July 31st, 2023**

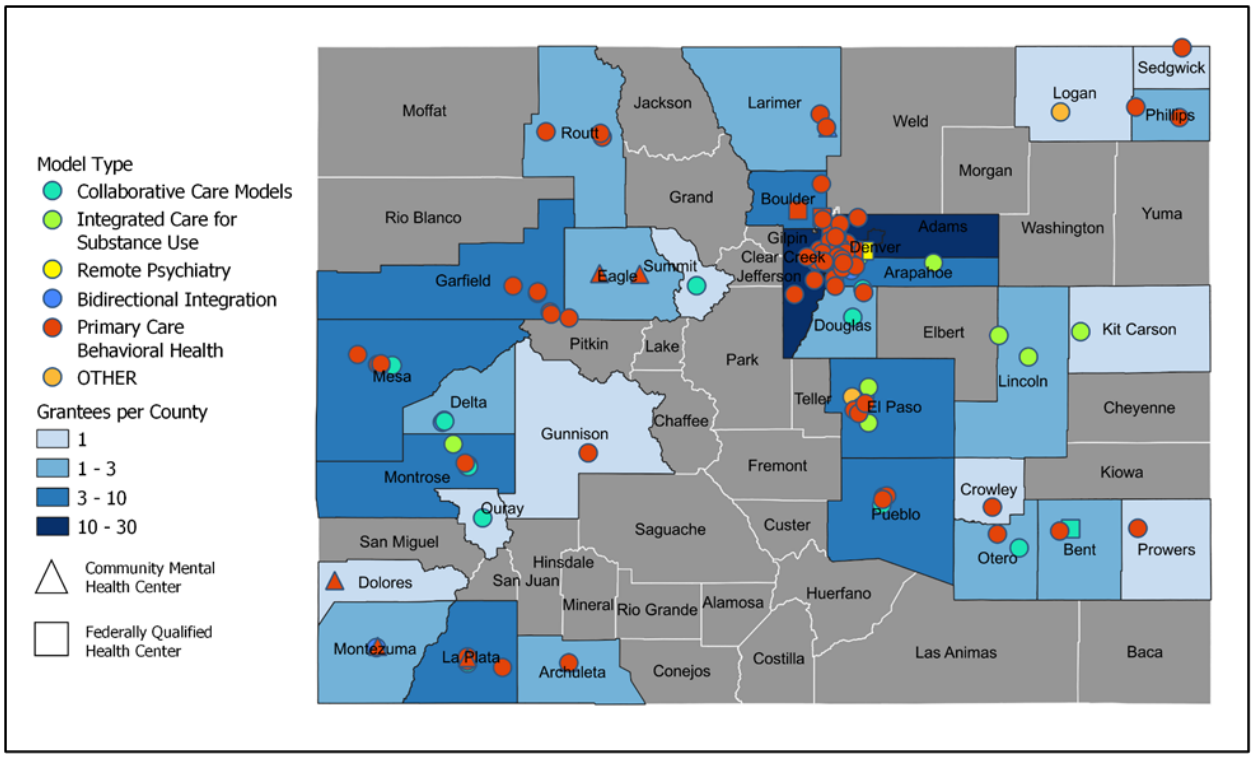
## Number of providers affected by the grant program

- Total awarded funding amount for the 81 Grantees = **$28,660,370**
- 81 Grantees had a weighted score of **70.57** or higher,
- The Average *weighted score* for all eligible applicants was **74.47**

## List of the Final Awardees

- Please see Appendix A for the full list of provider awardees
- 81 Awardees represents **77%** of all eligible applicants (81/105)
- Number of sites = **145** (74% of eligible sites)
- Total Patients served (all populations): **822,051** (68% of eligible applicants)

## Final Awardee Site Locations and Models



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## Total Healthy Steps Requests from grantee applications

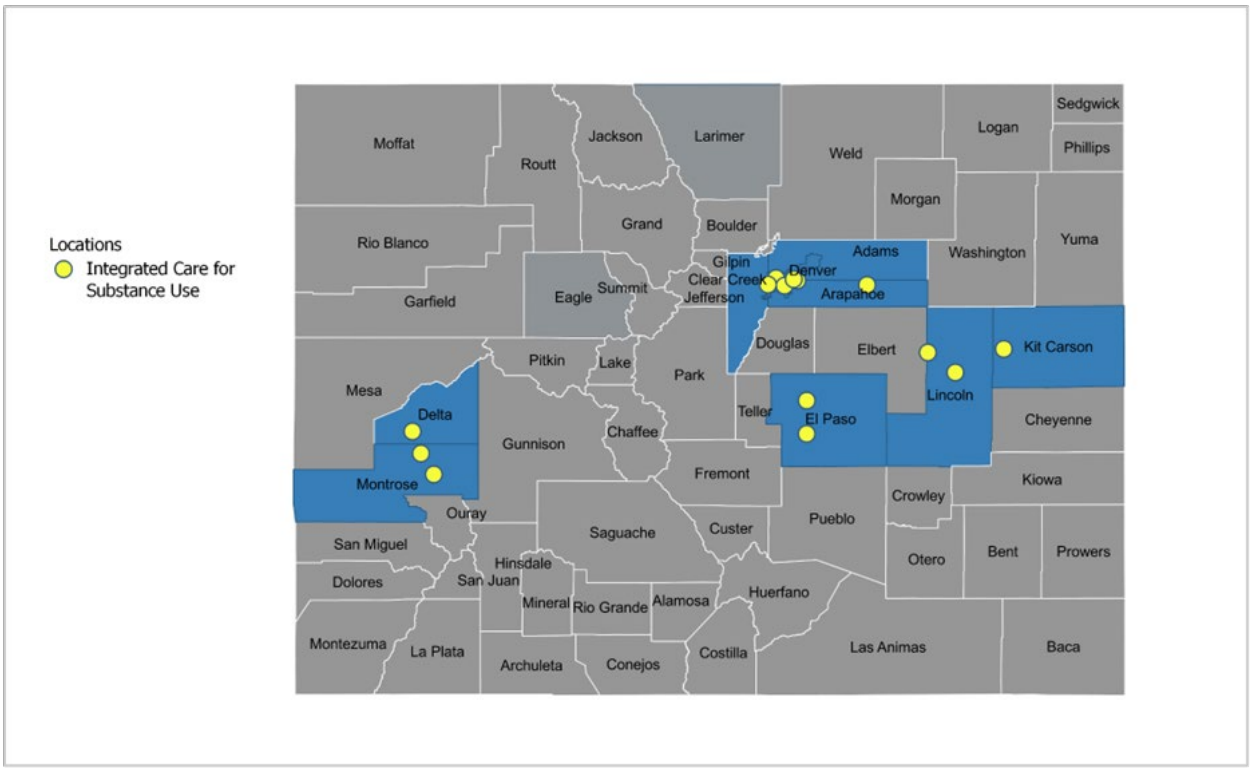
7 awardees stated, “Healthy Steps” in their application:

- Altitude Pediatrics
- Denver Health and Hospital
- Doctors Care
- Lowry Pediatrics
- Primary Care Partners
- Sapphire Pediatrics, PC
- KidsFirst Pediatrics Prof LL

## Models Proposed by the 81 Grantees

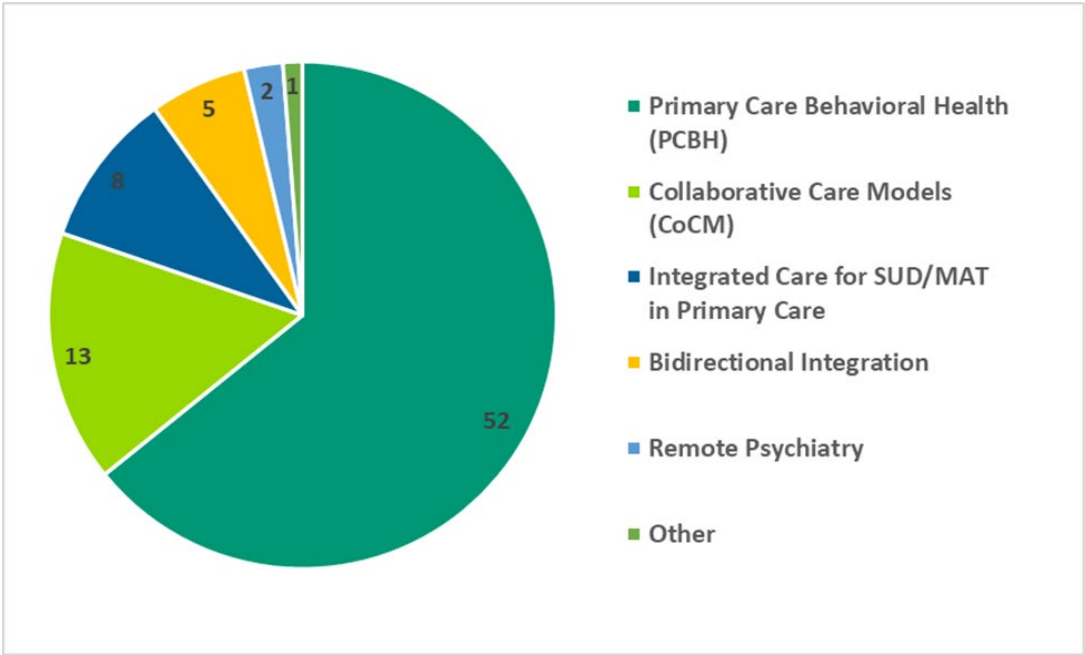
| Proposed Evidence-based Models | # forApplicants Above Cut-off |
|---|---|
| **Primary Care Behavioral Health (PCBH)** | **52** |
| **Collaborative Care Models (CoCM)** | **13** |
| **Integrated Care for SUD/MAT in Primary Care** | **8** |
| **Bidirectional Integration** | **5** |
| **Remote Psychiatry** | **2** |
| **Other** | **1** |
| **Total** | **81** |

## Site location of Integrated Care for Substance Use Focus




This map identifies the locations of provider sites which have been identified as primarily using the Integrated Care for Substance Use (SUD/MAT) model of care.

## Distribution of Models Used by Grantees




## New-implementer versus Expansion Track



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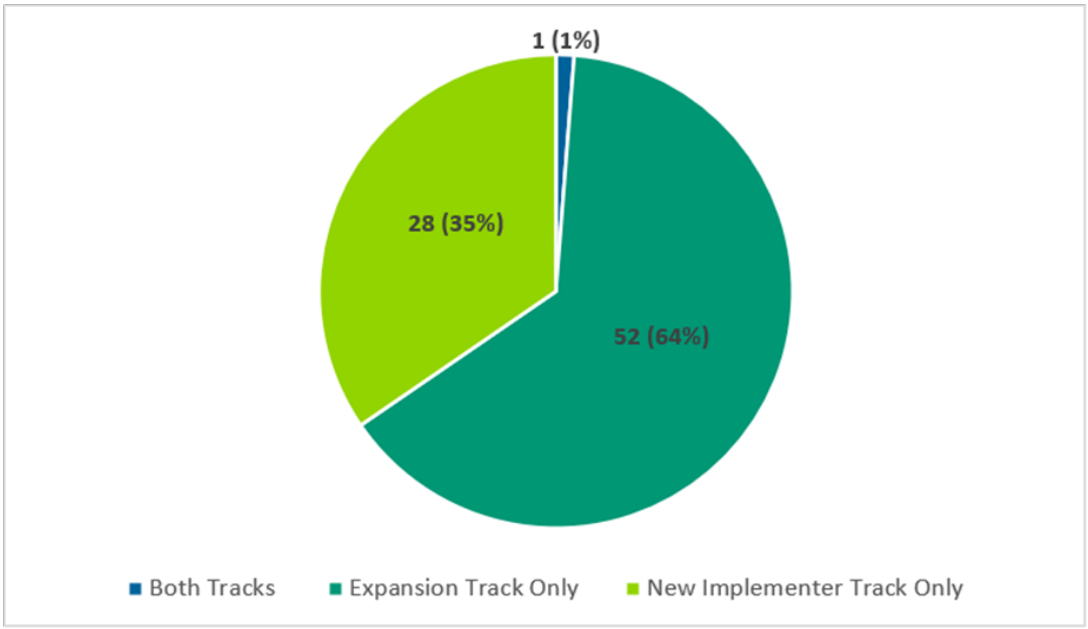



- 52/81 grantees **(64%)** are on the Expansion Track
- 28/81 grantees **(35%)** are on the New Implementer Track.
- 1/81 grantees **(1%)** are both.

## Models approved as "other"

- 51/81 grantees **(63%)** are primarily using the PCBH model.
- 14/81 grantees **(17%)** are primarily using the CoCM model.
- 7/81 grantees **(8.5%)** are primarily using the Integrated Care for Substance Use model.
- 5/81 grantees **(6%)** are primarily using bidirectional integration.
- 2/81 grantees **(2%)** are primarily using remote psychiatry.
- 2 are listed as "other" models.

## CMHC Grantees[22]

- Axis Health Systems
- SummitStone Health Partners
- Mental Health Partners
- Eagle Valley Behavioral Health

[22] https://bha.colorado.gov/get-behavioral-health-help#CMHC-ASO-MSO-Map

## FQHC Grantees

The following **13 Federally Qualified Health Centers** (FQHC's) applied for the HB22-1302 grant (all were selected as a recommended grantee):

1. **Clinica Campesina**
2. **Colorado Coalition for the Homeless**
3. **Denver Health Hospital Authority (Campus Sites)**
4. **Denver Health Hospital Authority (Family Health Centers)**
5. **Denver Indian Health and Family Services**
6. **La Clinica Tepeyac**
7. **Marillac Clinic**
8. **Mountain Family Health Centers**
9. **Olathe Community Clinic**
10. **Southwest Colorado Mental Health Center dba Axis Health System**
11. **STRIDE Community Health Center**
12. **Summit Community Care**
13. **Valley-Wide Health System**

## Percentage of Medicaid Patients served

The average HB22-1302 grantee serves about 48% Medicaid and CHP+ clients, though the percentage ranges from 11% at the lowest to 100% at the highest.

- 33/81 grantees serve greater than 50% Medicaid populations.

## Total positions supported

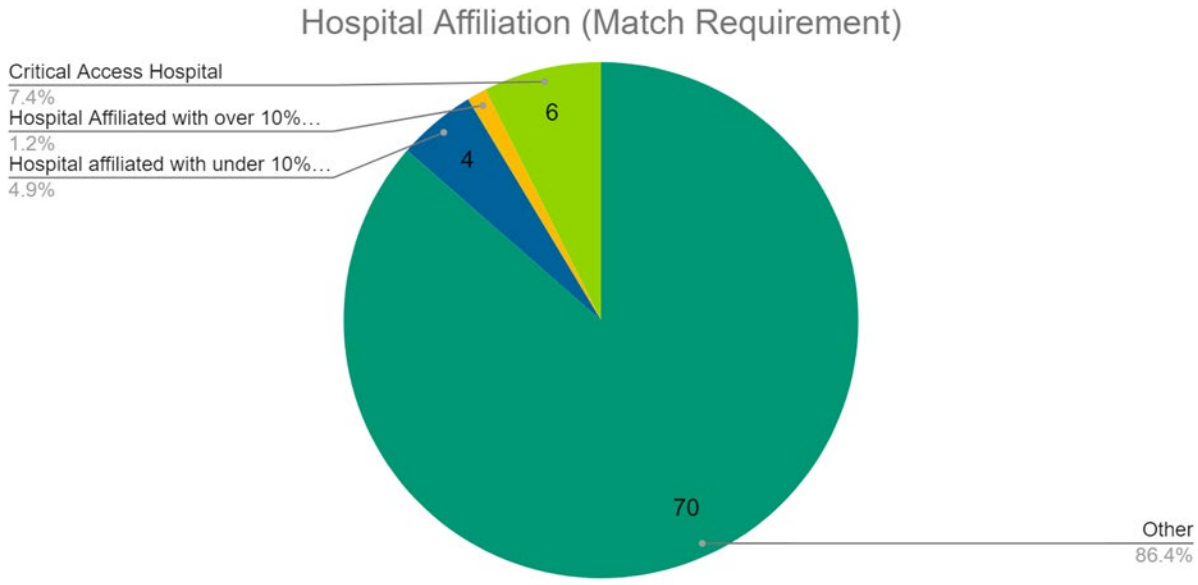
**TOTAL Physical Health Providers for all eligible sites:**

- **3 eligible applicants selected 0 FTEs (None)**
- **27 eligible applicants selected 1 - 3 FTEs**
- **22 eligible applicants selected 4-6 FTEs**
- **12 eligible applicants selected 7-10 FTEs**
- **17 eligible applicants selected 10+ FTEs**

**TOTAL Behavioral Health for all eligible sites:**

- **12 eligible applicants selected 0 FTEs (None)**
- **30 eligible applicants selected 1 - 3 FTEs**
- **21 eligible applicants selected 4-6 FTEs**
- **11 eligible applicants selected 7-10 FTEs**
- **7 eligible applicants selected 10+ FTEs**

## Number owned or affiliated with for-profit, non-profit, and community hospitals



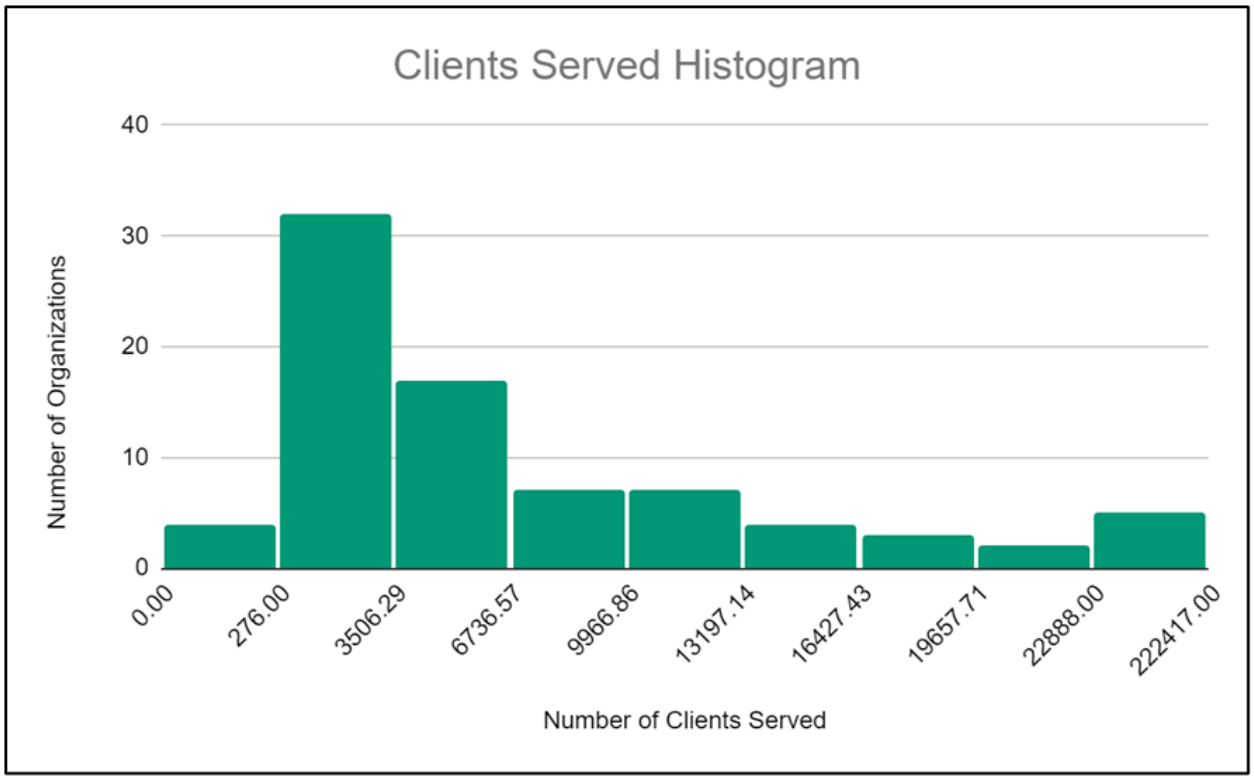

- 6 grantees (7.4%) are affiliated with a Critical Access Hospital, 4 have a hospital affiliated with under 10% of their proposed project, and only 1 has a hospital affiliated with over 10% of their project. The remaining 70 grantees have no or other affiliation status and match requirements.

## Serving children and youth

- 69/81 grantees (85%) say they serve children and youth.

## Size of clinic (bands of population served)

- HB22-1302 grantees serve a total of **822,051** patients in Colorado, ranging from brand new organizations that haven't begun serving clients, to small organizations serving just over 60 patients, to large FQHCs serving nearly a quarter of a million patients. The following histogram shows a right skew, indicating that most organizations are relatively smaller in size, serving 300-3500 clients.




## Long-term expectations for Grant funds

The Department has outlined strategic priorities and goals for the long-term expectations for the 1302 grant project. The top priority areas for funding include rural providers and those expanding SUD/MAT services to members in their regions.

> *"Funding is designed to support, improve, and expand integrated behavioral health services in Colorado by:*
>
> - *Developing infrastructure for primary care practices including family medicine, general pediatrics, general internal medicine, obstetrics/gynecology (where comprehensive services are provided), and behavioral health professionals to better serve individuals with behavioral health needs in outpatient health care settings;*
> - *Increasing access to quality health care for individuals with behavioral health needs;*
> - *Expanding prevention and early intervention tactics that reduce escalation and exacerbation of behavioral health conditions;*
> - *Addressing the shortage of the behavioral health care workforce;*
> - *Implementing processes to participate and succeed in alternative payment models;*
> - *Supporting for small capital expenditures, including IT and data-sharing technology; and*

- *Training primary care and behavioral health providers in trauma-informed care, adverse childhood experiences, and trauma recovery.*

*Priority areas: Serving rural/frontier clients, Expanding SUD/MAT services"*

Source: 1302 Evaluation Plan Logic Model

In addition, the scoring method for this grant prioritized two categories: "impact" and "readiness and sustainability". Awards were distributed to those applicants who best demonstrated an ability not only to make use of the award, but to sustain the changes they would be able to make with the funds into the long term. In addition, applicants serving rural communities were considered to have higher impact, thus ensuring that 1302 grant funds will have a listing impact on rural clients across Colorado.

## Future Considerations

The impact of this grant on the San Luis Valley (SLV) looks at first glance to be minimal, with few to no grantee sites located within the SLV. Whether this is entirely the case is somewhat unclear, as applicants located in Pueblo and other surrounding areas may serve the SLV via telehealth or mobile clinics, but these data are not available. One future consideration is to increase outreach to providers within the region. A further consideration for future work is to survey grantees not only on their locations, but their service areas as well, to fully capture their served communities.

## Appendix A - Awardees

List of the highest scoring eligible applicants (FQHCS, and CMHCs)

1. 4 Corners Children's Clinic, Inc
2. Adult Medicine Specialists, P.C.
3. Aggie Pediatrics, LLC dba The Children's Health Place
4. Altitude Pediatrics, LLC
5. Andy M. Fine, MD PC/Colorado Primary Health Care
6. Aurora Therapy Center, LLC
7. Autism West Behavior Partners
8. Castillo Primary Care
9. Castle Valley Children's Clinic
10. Cedar Point Health, LLC
11. Center Pointe Family Medical Group, LLC
12. Center Pointe Family Medicine, LLC
13. Clinica Campesina Family Health Services dba Clinica Family Health
14. Colorado Coalition for the Homeless
15. Colorado Health Network, Inc.dba Colorado AIDS Project
16. Community Dental Clinic, Inc. DBA The PIC Place, Partners in Integrated Care
17. Complete Care Pediatrics
18. Comprehensive Behavioral Health Center, Inc
19. Denver Health and Hospital Authority #1
20. Denver Health and Hospital Authority #2
21. Denver Indian Health and Family Services Inc.
22. Doctors Care
23. Dr. Lu Family Medicine, PLLC
24. Eagle Valley Mental Health dba Eagle Valley Behavioral Health
25. East Phillips County Hospital DBA Melissa Memorial Hospital or Family Practice of Holyoke
26. Family Care Specialists, P.C.
27. Family Medicine Clinic for Health Equity - CAHEP
28. Forte Health and Wellness Inc
29. Fountain Valley Healthcare, LLC
30. GFMA ACQ, LLC D/B/A Geriatric and Family Medicine Associates
31. Guardian Angels Health Center PC
32. Gunnison Valley Health Foundation
33. Haxtun Hospital District, DBA Haxtun Health
34. Highlands Integrative Pediatrics
35. Himalaya Family Medicine Clinic
36. Hopelight Medical Clinic
37. Integrated insight Therapy, LLC
38. Kids First Health Care
39. KidsFirst Pediatrics prof LLP
40. La Clinica Tepeyac dba Tepeyac Community Health Center
41. Lafayette Pediatrics and Internal Medicine
42. Lincoln Community Hospital/ Lincoln Health

43. Lowry Pediatrics LLC
44. Mainstreet Pediatrics
45. Marillac Clinic, Inc. DBA MarillacHealth
46. Medical Center Corp
47. Mental Health Center of Boulder County Inc. dba Mental Health Partners
48. Midvalley Family Practice
49. Mile High Treatment and Recovery, Inc
50. Mountain Family Health Centers
51. Northeast Colorado Family Medicine Associates P.C.
52. Olathe Community Clinic, Inc. dba River Valley Family Health Centers
53. Parker Pediatrics and Adolescents, PC
54. Peak Family Medicine, LLC
55. Peak Pediatrics LLC
56. Pearl Family Medicine PC
57. Pediatric Partners of the Southwest
58. Pediatrics of Steamboat Springs, PC
59. Pediatrics West, P.C.
60. Primary Care Partners Western Colorado Pediatrics
61. Project Ember Initiative
62. Radiant Healthcare LLC, dba Rocky Ford Family Health Center
63. Rocky Mountain Planned Parenthood, Inc., dba Planned Parenthood of the Rocky Mountains, Inc. (PPRM)
64. Rocky Mountain Youth Medical and Nursing Consultants, Inc. dba Every Child Pediatrics
65. Saint Anthony's North Family Medicine Residency
66. Saint Luke's Medical Clinic
67. Sapphire Pediatrics, PC
68. Sedgwick County Memorial Hospital dba Sedgwick County Health Center
69. Skills Academy Vocational Center
70. Southwest Colorado Mental Health Center Inc, dba Axis Health System** (FQHC and CMHC)
71. STRIDE Community Health Center
72. Summit Community Care Clinic
73. Summit Primary Care, PLLC
74. SummitStone Health Partners
75. Sunrise Health Care PC
76. Upper San Juan Health Service District dba Pagosa Springs Medical Center
77. Valley View Hospital Association dba Valley View
78. Valley-Wide Health Systems, Inc.
79. Vivent Health
80. Wayne Hudson DO Integrated Medical Practice PLLC
81. Well Nourished LLC

## Appendix B - Denied Eligible Applications

**The 24 eligible applicants *below the threshold* (in order of *highest to lowest* score) include:**

***3** eligible applicants below the cut-off score are located in a Rural county*

1. Catholic Health Initiatives Colorado (Rural)
2. Southeast Denver Pediatrics
3. Thompson River Pediatrics and Urgent Care
4. All is Well Family Practice
5. Regents of the University of Colorado Denver #2 out of 3
6. Family Medicine Associates
7. Bailie Cronin APRN, Peak Interactive Wellness (Rural)
8. Compass Colorado Health Care Systems
9. Health Now Family Practice + Walk In
10. Drs. Cooper and Aptekar, Partners in Women's Health
11. Hai Phong Bui, MD, Lakewood Medical Center
12. Portercare Adventist Health System
13. Behavioral Health and Wellness
14. St. Mary's Hospital Foundation
15. Fort Collins Youth Clinic
16. Greenwood Pediatrics
17. Partners in Pediatrics
18. Aspen Valley Hospital (Rural)
19. Thrive Medical Group
20. Boulder Medical Center
21. Regents of the University of Colorado Denver
22. Mauricio Waintrub MD, Rocky Mountain Internal Medicine
23. Robert P Vogt, The Family Practice
24. Heartlight Family Clinic

## Appendix B

### HCPF Outreach

The Department of Health Care Policy and Financing would like to thank the following for their support, feedback, and participation in stakeholder engagement.

Erin Wester, Colorado Behavioral Health Administration

Joy Hart, Colorado Behavioral Health Administration

Yusuf Ali, Colorado Behavioral Health Administration

Debra Judy, Colorado Department of Regulatory Agencies, Division of Insurance

Jason Lapham, Colorado Department of Regulatory Agencies, Division of Insurance

Jill Mullen, Colorado Department of Regulatory Agencies, Division of Insurance

Laura Mortimer, Colorado Department of Regulatory Agencies, Division of Insurance

Tara Smith, Colorado Department of Regulatory Agencies, Division of Insurance

Vincent Plymell, Colorado Department of Regulatory Agencies, Division of Insurance

Cedra Etesam, Southern Ute Indian Tribe

Cassana Littler, American Academy of Pediatrics

Stephanie Allred, Axis Health System

Rob Bremer, Bremer Consulting

Christine Gage, Carelon Behavioral Health

Nathan Koller, Carelon Behavioral Health

Pamela Boehm, Carelon Behavioral Health

Robert McAlonan, Carelon Behavioral Health

Tina Gage, Carelon Behavioral Health

Sonja Madera, Centers for Medicare and Medicaid Services

Christopher Stille, Children's Colorado

Emilee Kaminski, Children's Colorado

Steve Poole, Children's Colorado

Andrea Loasby, Children's Hospital Colorado

David Keller, Children's Hospital Colorado

Kate Odenwald, Christ Clinic Fort Collins

Erica Pike, Colorado Academy of Family Physicians

Beckie Lagerborg, Colorado Access

Jane Reed, Colorado Access

Jo English, Colorado Access

Sarrah Knause, Colorado Access

Alok Sarwal, Colorado Alliance for Health Equity and Practice

Lynee Jones, Colorado Association of Family Medicine Residencies

Dani Odekirk, Colorado Community Health Alliance

Katie Mortenson, Colorado Community Health Alliance

Clara O'Connor, Colorado Community Health Network

Kate McElwain, Colorado Community Health Network

Polly Anderson, Colorado Community Health Network

Stephanie Brooks, Colorado Community Health Network

Taylor Miranda Thompson, Colorado Community Health Network

Michael Feldmiller, Colorado Community Managed Care Network

Isabel Cruz, Colorado Consumer Health Initiative

Julie Reiskin, Colorado Cross-Disability Coalition

Kendra Dunn, Colorado Department of Early Childhood

Josh Benn, Colorado Department of Personnel & Administration

Brandon Arnold, Colorado Health Plans

Phyllis Albritton, Colorado Safety Net Collaboration

Kristin Weissinger, Contexture

Lauren Girard, Contexture

Megan Reilly, Contexture

Kathy Rivera Butler, Doctors Care

Merry Hummell, Every Child Pediatrics

Christina Mulkey, Geriatric and Family Medicine Associates

Marsha Thorson, Gunnison Family Physicians

Jennifer Birnie , Gunnison Valley HealthColorado

Christina Brown, Health Colorado

Claire Reed, High Plains CHC

Jay Brooke, Hudson Clinic

Amy Conley, Kaiser Permanente

Gretchen Stasica, Kaiser Permanente

Laura Patke, Kaiser Permanente

Shannon Groves, Kaiser Permanente

Stephanie Heller, Kaiser Permanente

Tkeyah Pollard, Kaiser Permanente

Jim Bumgardner, Kids 1 Peds

Kayla Ortiz, Kids First Healthcare

Nicole Gartner, Kids First Healthcare

David Dreitlein, Marilla C Health

Lisa Snyder, Mental Health Colorado

Brian Robertson, Northeast Health Partners

Kari Snelson, Northeast Health Partners

Alex Schackel, Pediatric Partners of the Southwest

Amanda Harrison, Pediatric Partners of the Southwest

Ceceli Fraley, Pediatric Partners of the Southwest

Cindi Terra, Physician Health Partners

Lisa Price, Physician Health Partners

Kellie Jackson, Primary Care Partners

Casey Payne, River Valley Family Health Centers

Glenda Field, River Valley Family Health Centers

Pam Motley, River Valley Family Health Centers

David Moklaizky, Rocky Mountain Health Plans

Kimberly Herek, Rocky Mountain Health Plans

Meg Taylor, Rocky Mountain Health Plans

Patrick Gordon, Rocky Mountain Health Plans

James Wilson, Southern Ute Indian Tribe

Rebecca Gale, Southern Ute Indian Tribe

Raj Kadari, Summit Medical Consultants

Casey Canright, SummitStone Health Partners

Donna Goldstrom, SummitStone Health Partners

Amber Griffin, Thompson River Pediatrics

Molly Lalonde, Thompson River Pediatrics

Amy Scanlan, Trinsic

Kylanne Briggs, UHC - Rocky Mountain Health Plans

Barbara Bishop, United Healthcare

Bronte Smith, United Healthcare

Allyson Gottsman , University of Colorado

Ayelet Talmi, University of Colorado

James Barry, University of Colorado

Lauren Hughes, University of Colorado

Melissa Buchholz, University of Colorado

Sarah Staron, University of Colorado

Stephanie Gold, University of Colorado

Kala Bettis, Vail Health

Barbra Corcoran, Valley View

Rebecca Gostlin, Youth Healthcare Alliance

Andrew Rossway, MarillacHealth

Dawn Fetzko, Colorado Primary Care Clinic

Honglan Lu, Dr Lu Family Medicine Prof LLC

Lisa Rothgery, Pearl Family Medicine

Raisa Katanova, Mile High Treatment & Recovery

## Appendix C

| Proposed ICB Codes | | Medicare Covered | Medicare Rate |
|---|---|---|---|
| Health and Behavior Assessment and Intervention Codes "HBAI Codes" (HCPF Proposed) | | | |
| 96156 | Health Behavior assessment or reassessment | YES | Non-Facility Price: $97.25; Facility Price $86.12 |
| 96158 | Health Behavior Intervention, individual, face-to-face; initial 30 mins | YES | Non-Facility Price: $65.82; Facility Price $57.63 |
| 96159 | [Add on to 96158] Health Behavior intervention, individual, face-to-face; each additional 15 mins | YES | Non-Facility Price: $22.27; Facility Price: $19.32 |
| 96164 | Health Behavior intervention, group (2 or more patients), face-to-face; initial 30 mins | YES | Non-Facility Price: $10.15; Facility Price: $9.17 |
| 96165 | [Add on to 96164] Health Behavior intervention, group (2 or more patients), face-to-face;each additional 15 mins | YES | Non-Facility Price: $4.58; Facility Rrice: $3.932 |
| 96167 | Health Behavior intervention, family (with patient present), face-to-face; initial 30 mins | YES | Non-Facility Price: $69.42; Facility Price: $60.90 |

| | | | |
|---|---|---|---|
| 96168 | [Add on to 96167] Health Behavior intervention, family (with patient present), face-to-face; each additional 15 min | YES | Non-Facility Price: $24.89; Facility Price: $21.61 |
| 96170 | Health Behavior intervention, family (without patient present), face-to-face; initial 30 mins | YES | N/A - Services offered when the patient is not present are not typically covered by Medicare. |
| 96171 | [Add on to 96170] Health Behavior intervention, family (without patient present), face-to-face; each additional 15 mins | YES | N/A - Services offered when the patient is not present are not typically covered by Medicare. |
| Collaborative Care Management "CoCM Codes" (HCPF Proposed) | | | |
| 99484 | Care Management Services for Behavioral Health Conditions (General BHI Guidance) (at least 20 minutes of clinical staff time) | YES | Non-Facility Price: $54.03; Facility Price $42.90 |
| 99492 | Initial Psychiatric CoCM (first 70 minutes in the first calendar month) | YES | Non-Facility Price: $150.62; Facility Price $91.36 |
| 99493 | Follow Up Psychiatric CoCM (first 60 minutes in a subsequent calendar month) | YES | Non-Facility Price: $137.53; Facility Price $99.87 |
| 99494 | Initial and Subsequent Psychiatric CoCM (each additional 30 minutes in a calendar month) | YES | Non-Facility Price: $58.29; Facility Price $39.95 |

| | | | |
|---|---|---|---|
| G0323 | Care Management Services for Behavioral Health Conditions (at least 20 minutes per calendar month) | YES | Non-Facility Price: $54.03; Facility Price $42.57 |
| G2214 | Initial and Subsequent Psychiatric CoCM (first 30 minutes in a calendar month) | YES | Non-Facility Price: $56.32; Facility Price $37.33 |
| **There are other CoCM codes specific to FQHC/RHC** | | | |
| **Codes Currently in the Short-Term BH Benefit/Psychotherapy Codes** | | | |
| 90791 | Psychiatric diagnostic evaluation | YES | Non-Facility Price: $169.29; Facility Price $145.06 |
| 90832 | Psychotherapy with patient, 30 mins | YES | Non-Facility Price: $76.95; Facility Price $67.13 |
| 90834 | Psychotherapy with patient, 45 mins | YES | Non-Facility Price: $101.51; Facility Price $88.74 |
| 90837 | Psychotherapy with patient, 60 mins | YES | Non-Facility Price: $149.64; Facility Price $130.98 |
| 90847 | Family psychotherapy with member present, 50 mins | YES | Non-Facility Price: $100.53; Facility Price $99.87 |
| 90846 | Family psychotherapy without the member present, 50 mins | YES | Non-Facility Price: $95.94; Facility Price $95.61 |

| Codes Currently "Open" under FFS and which align with Integrated Care but not included in the proposed benefit | | | |
|---|---|---|---|
| 99408 | Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 mins | YES | $33.41 |
| 99409 | Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 mins | YES | $65.51 |
| H0049 | Alcohol and/or drug screening | YES | $24.00 |
| G8510 | Screening for depression documented as negative, a follow-up plan is not required | NO | |
| G8431 | Screening for depression is documented as being positive and a follow-up plan is documented | NO | |
| 96127 | Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument | YES | Non-Facility Price: $4.83 |
| T1026 | Intensive, extended multidisciplinary services provided in a clinic setting to children with complex medical, physical, mental and psychosocial impairments, per hour as maintained by CMS falls under Screenings, Assessments, and Treatments, Individual and Family. | NO | |

| | | | |
|---|---|---|---|
| 97550 | Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes | YES | Non-Facility Price: $52.06; Facility Price $44.53 |
| 97551 | Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (list separately in addition to code for primary service) (Use 97551 in conjunction with 97550) | YES | Non-Facility Price: $25.87; Facility Price $23.90 |
| 97552 | Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (eg, activities of daily living [ADLs], instrumental ADLs [iADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers | YES | Non-Facility Price: $21.94; Facility Price $10.48 |
| Additional Codes that could be included in the ICB, but not included in the proposed benefit | | | |

| | | | |
|---|---|---|---|
| G0136 | Administration of a standardized, evidence-based SDOH assessment, 5–15 minutes, not more often than every 6 months. | YES | Non-Facility Price: $18.66; Facility Price $8.84 |
| H0002 | Behavioral health screening to determine eligibility for admission to treatment program | NO | |
| H0004 | Behavioral Health counseling and therapy per 15 minutes. | NO | |
| H0023 | Behavioral health outreach service (planned approach to reach a targeted population) | NO | |
| H0025 | Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude and/or behavior) | NO | |
| H0031 | Mental health assessment, by non-physician | NO | |
| H2011 | Crisis intervention service, per 15 minutes | NO | |

## Appendix D

Farley Health Policy Center at the University of Colorado School of Medicine

### Cost Estimates for Delivering Integrated Care in Primary Care Settings

This appendix presents the cost findings developed by the Farley Health Policy Center at the University of Colorado School of Medicine to provide information to the

Colorado Department of Health Care Policy and Financing as it explores policies to support integrated care in primary care settings. Specifically, the Farley Center conducted two activities to provide information on the cost primary care practices incur to deliver integrated care:

1. An environmental scan of the literature estimating the cost of integrating behavioral health care services into primary care settings.
2. Analysis of time-driven activity based costing (TDABC) information the Farley Center collected from 11 Colorado primary care practices with different models of integrated care delivery and levels of experience integrating behavioral health care services in their practices.

Knowing what it takes and costs to implement and sustain integrated care in primary care settings is essential for practices and health systems to inform their decisions to deliver integrated care, and for payers (including Health First Colorado) deciding to pay for integrated care. While the time and compensation of a licensed behavioral health provider (BHP) integrated into a primary care setting represents the most direct cost, the effective delivery of integrated care requires time and effort from the entire care team and other practice staff. Although they are already engaged in care delivery, the time these practice personnel are engaged in integrated care delivery represents an important opportunity cost that must be included in the analyses of what it takes and costs to deliver integrated care. Specifically, the time all practice personnel are involved in the delivery of integrated care could have been focused on other work that generates revenue and this represents an opportunity cost to the practice of adding and delivering integrated care. In addition to personnel cost, starting and continuing to deliver integrated care involves other costs to the practice, including start up, facilities, and other overhead. We include a discussion of these non-personnel costs in both the environmental scan and TDABC sections of this appendix.

## A1.1 Environmental Scan

There are a very limited number of publicly available studies of the cost of integrating behavioral health care services into primary care settings. We reviewed peer-reviewed publications and other publicly available documents as part of the environmental scan. Four studies were identified that included information relevant to understanding what it takes to deliver integrated care in primary care settings. Each study used different approaches in measuring and reporting cost information, and we are reporting findings that are as closely comparable as possible. In addition, we have converted dollar amounts from the original study to 2023-dollar equivalents using the seasonally adjusted, quarterly Personal Consumption Expenditures for

Health Care Services (chain-type price index) from the U.S. Bureau of Economic Analysis.

Table 1 presents a summary of the findings from the four studies that provide somewhat comparable cost estimates.

**Table 1: Average Cost Estimates from the Environmental Scan (Converted to 2023 dollars)**

| Study<br>Cost Measure | Dodoo et.al.[23] | Wallace et.al.[24] | Miller et.al.[25] | SHAPE[26] |
|---|---|---|---|---|
| Practice Startup | $2,576 | $77,608 | $28,024 | |
| Ongoing Operational per Behavioral Health Encounter | $80 | $54 | $46 | |
| Ongoing Practice Operational Cost per Week | | | | $8,248 |

As noted above, the estimates presented in Table 1 are not directly comparable. However, the wide variation in practice startup costs likely reflect both the small number of practices included in each study and the differences in practice experience with implementation of advanced primary care services. For example, SHAPE included only six practices with one to five BHPs with a mean of 2.17 and a median of 1.5 providers. While the results reported in Dodoo et.al. included 29 practices, these practices were all members of practice-based research networks and experienced in implementing other advanced primary care services.

[23] Dodoo MS, Krist AH, Cifuentes M, Green LA. Start-up and incremental practice expenses for behavior change interventions in primary care. Am J Prev Med. 2008 Nov;35(5 Suppl):S423-30. doi: 10.1016/j.amepre.2008.08.007. PMID: 18929990.

[24] Wallace NT, Cohen DJ, Gunn R, Beck A, Melek S, Bechtold D, Green LA. Start-Up and Ongoing Practice Expenses of Behavioral Health and Primary Care Integration Interventions in the Advancing Care Together (ACT) Program. J Am Board Fam Med. 2015 Sep-Oct;28 Suppl 1:S86-97. doi: 10.3122/jabfm.2015.S1.150052. PMID: 26359476.

[25] Miller CJ, Griffith KN, Stolzmann K, Kim B, Connolly SL, Bauer MS. An Economic Analysis of the Implementation of Team-based Collaborative Care in Outpatient General Mental Health Clinics. Med Care. 2020 Oct;58(10):874-880. doi: 10.1097/MLR.0000000000001372. PMID: 32732780; PMCID: PMC8177737.

[26] Ross, K. M., Gilchrist, E. C., Melek, S. P., Gordon, P. D., Ruland, S. L., & Miller, B. F. (2019). Cost savings associated with an alternative payment model for integrating behavioral health in primary care. Translational Behavioral Medicine, 9(2), 274–281. https://doi.org/10.1093/tbm/iby054

The existing literature does not provide any evidence that could directly inform the development of a per-member, per-month (PMPM) payment structure. The first three studies provide some indication of the range of startup cost for a primary care practice to begin delivering integrated behavioral health services. However, based on the written description of their study methods, we are not able to translate the ongoing operational cost per behavioral health encounter to a PMPM payment structure. We can roughly estimate a range of PMPM costs from the available information based on the SHAPE study along with some additional assumptions around the number of patients included in the panel of a primary care provider (PCP).

The number of PCPs in the six practices participating in SHAPE ranged from one to 17, with a mean of 7.33 PCPs, and the number of BHPs ranged from one to five, with a mean of 2.17. Unfortunately, there is a lack of information on the size of PCP patient panels and estimates in the literature have ranged from less than 1,000 to more than 2,500, the latter of which has been disputed. Table 2 translates the average monthly cost from SHAPE presented in Table 1 to a range of PMPM costs for four different values of the number of patients in a PCP's panel ranging from 1,000 to 1,750.

**Table 2: Estimates of PMPM costs from the SHAPE Intervention for Different Panel Size Assumptions based on 7.33 PCPs**

| Panel Size | 1,000 | 1,250 | 1,500 | 1,750 |
|---|---|---|---|---|
| Estimated PMPM Cost | $4.84 | $3.87 | $3.23 | $2.76 |

The results in Table 2 indicate the estimated PMPM is very sensitive to panel sizes. With the lack of estimates for the cost of delivering integrated care across practice size suggests that additional information is needed before proposing a PMPM payment structure for integrated care in primary care settings.

## A1.2 Farley Center Time Driven Activity Based Costing Analysis Results

With the lack of comparable estimates of the cost of delivering integrated care in primary care settings, the Farley Center identified 11 Colorado primary care practices that were currently delivering behavioral health care in their practice. The 11 primary care practices included four pediatric practices, three Federally Qualified Health Center (FQHC) practices, and four family medicine practices. Practices were located in six of the seven Regional Accountable Entity (RAE) regions, only RAE Region 7 was not represented. The Farley team collected time and cost data from 14 clinic locations: a single location for eight practices and two locations for three practices. In reporting results, we have combined locations and report findings for the 11 practices.

### *Characteristics of Practices*

Practice personnel for these 11 practices, on average, included 8.0 Full-Time Equivalent (FTE) physicians, 5.6 FTE physician assistants, and 3.9 FTE nurse practitioners. On average, these practices employed 3.7 licensed BHPs and 1.2 BHP trainees, with 2.1 and 0.6 FTE, respectively. Only two clinics reported having contracted BHPs providing integrated care, including contracted BHPs increases the average FTE across the 11 clinics to 2.5 FTE. The most common licensed BHP employed by clinics were Licensed Clinical Social Workers (LCSWs). Two practices reported employing licensed psychologist with a PhD or equivalent degree with an average 1.25 FTE for this category of BHP. Two practices also reported having 0.3 FTE of a psychiatrist and two other practices reported employing an average of 0.75 psychiatric nurse practitioners.

The 11 practices reported an average payer mix of 35% Medicaid, 35% commercial insurance, 17% Medicare, and 13% self-pay. The pediatric practices reported the highest percentage of patients with Medicaid (58%) and FQHCs reported the highest percentage of self-pay or uninsured patients (32%). Family medicine practices had the highest percentage of patients with a commercial insurance payer (51%).

### *Time-Driven Activity Based Costing Data Collection*

To provide standardized and consistently reported information on what it takes and what it costs to deliver integrated care in primary care settings, the Farley team applied TDABC methods, which is a type of micro-costing that estimates the cost of performing an activity from the ground up by measuring and assigning a cost to each input needed to complete an activity. TDABC methods are increasingly used in healthcare settings to provide information on the cost of providing health care services. At its core, TDABC is a process-based approach to identifying, describing, measuring, and valuing all human and other resources required to complete a set of activities.

This approach to collecting cost and resource information begins with the development of process maps that, in this case, reflect all practice workflows involved in the delivery of integrated care. Using these process maps we developed data collection methods for both direct and indirect resources used in each activity. We collected time data using direct observation of workflows in the 11 practices, which is considered the gold-standard for TDABC studies. Two Farley Center team members visited practices with two or more BHPs working during the observation period and one team member visited practices with a single BHP working during the observation period for a total of 126 BHP observation days. Team members shadowed a BHP for an entire day recording the amount of time BHPs engaged in activities related to patient encounters and activities that did not involve a patient encounter on the day of observation. In addition to recording the BHP's time, team members

also recorded the time BHPs were interacting with other practice staff for both patient encounters and non-patient encounter activities. These observations included the practice members' role and the amount of time each practice member interacted with a BHP related to the provision of behavioral health services. Valuing the cost of personnel time requires consideration of individual's total compensation consisting of salary, bonuses, and fringe benefits. Measures of these components were obtained from the U.S. Bureau of Labor Statistics Occupational Employment and Wage data for Colorado. Our team developed and used a set of semi-structured key informant interviews to obtain information on non-personnel resources and costs.

### *Time-Driven Activity Based Costing Results*

The process maps developed for integrated care delivery in primary care identified two categories of patient encounters (scheduled and warm-handoff) that followed an established workflow and a range of non-encounter activities that were not amenable to a structured workflow as these activities were completed in between patient encounters. During our observations we identified four additional types of patient encounters: PCP and BHP co-visits, group visits, unscheduled in-person visit (walk in), and an unscheduled telehealth visit.

### *Patient Encounter Personnel Activity and Cost*

There was substantial variation across practices in the average number of completed scheduled behavioral health encounters per BHP per day ranging from 0 to 8.0 completed scheduled encounters with an average of 3.01 encounters. Table 3 presents the average number of minutes per patient for the three roles we observed engaging in scheduled behavioral health visits. We recorded time spent on eight specific activities for each encounter; however, for reporting purposes we have combined all pre-visit activities together and combined all post-visit activities together.

**Table 3: Average Per Patient Time (minutes) Estimates for Scheduled Behavioral Health Encounters**

| Role<br>Activity | BHP | PCP | Care Coordinator | Total |
|---|---|---|---|---|
| Pre-visit | 2.33 | 0.38 | 0.00 | 2.71 |
| Visit with Patient | 30.41 | 0.00 | 0.00 | 30.41 |

| | | | | |
|---|---|---|---|---|
| Post-visit | 3.37 | 0.12 | 0.02 | 3.51 |
| EHR/ Documentation | 7.10 | 0.00 | 0.00 | 7.10 |
| Total | 43.21 | 0.50 | 0.02 | 43.73 |

There was similar variation across practices in the number of warm handoffs per BHP per day ranging from 0 to 8.25 with an average of 3.27 encounters. Table 4 presents the average number of minutes per patient encounter for the four practice staff roles we observed being involved in warm handoff encounters. As was the case with Table 2, we have collapsed eight categories of activities into the four groups shown in the table. This table only represents the amount of time during the encounter following the warm handoff and does not include any time spent by clinic staff prior to the handoff.

**Table 4: Average Per Patient Time (minutes) Estimates for Warm Handoff Behavioral Health Encounters**

| Role<br>Activity | BHP | PCP | Care Coordinator | MA/Nurse | Pharmacist | Total |
|---|---|---|---|---|---|---|
| Handoff | 3.32 | 1.33 | 0.01 | 0.19 | 0.00 | 4.85 |
| Visit with Patient | 19.32 | 0.17 | 0.00 | 0.00 | 0.00 | 19.49 |
| Post-visit | 4.58 | 0.90 | 0.00 | 0.00 | 0.01 | 5.49 |
| EHR/ Documentation | 5.44 | 0.20 | 0.00 | 0.00 | 0.00 | 5.64 |
| Total | 32.66 | 2.60 | 0.01 | 0.19 | 0.01 | 35.47 |

One pediatric practice provides combined physical health and behavioral health encounters (co-visit). We observed four visits of this type (40% of all observed behavioral health encounters in this one practice) and the average time across these four encounters for the three clinic personnel involved are presented in Table 5.

**Table 5: Average Per Patient Time (minutes) Estimates for PCP-Behavioral Health Co-Visit Encounters**

| Role<br>Activity | BHP | PCP | MA/Nurse | Total |
|---|---|---|---|---|
| Pre-visit | 4.75 | 3.00 | 6.00 | 13.75 |
| Visit with Patient | 31.00 | 10.00 | 0.00 | 41.00 |
| Post-visit | 6.25 | 5.50 | 0.00 | 11.75 |
| EHR/ Documentation | 13.50 | 0.00 | 0.00 | 13.50 |
| Total | 55.50 | 18.50 | 6.00 | 80.00 |

In addition, we observed three other types of visits. Two practices delivered one group visit each during our observation periods that were attended by three to five patients. One group visit was a 45-minute session and the second was a 60-minute session. One practice had an unscheduled in-person visit where the BHP spent 85 minutes including time with the patient and post-visit activities. Finally, one other practice had an unscheduled telephone encounter with a patient where the BHP talked to the patient for eight minutes.

To convert these estimates of time to dollar cost for each type of encounter, we used the U.S. Department of Labor, Bureau of Labor Statistics 2022 Occupational Employment and Wage Statistics Survey and the Employer Cost of Employee Compensation Survey. The former survey provides state level information on the mean hourly compensation for specific occupations and the latter provides national level information on the cost of fringe benefits as a percentage of hourly compensation. We also used the same price index noted above to express costs in 2023 dollars.

Table 6 presents the estimates of the cost per encounter for each of the three types of behavioral health visits. We used the compensation information for a LCSW for the BHP, a family medicine physician for the PCP, a care manager for the Care Coordinator, a medical assistance for the MA/Nurse, and a pharmacist for the Pharmacist. In addition, to examine the sensitivity of these cost estimates to the credentials of the BHP, we also calculated the cost assuming the BHP role was filled by a psychologist.

**Table 6: Average Clinical Personnel Cost Per Encounter for Scheduled, Warm Handoff, and Co-Visit Encounters**

| | Scheduled | Warm Handoff | Co-Visit |
|---|---|---|---|
| Average Personnel Cost (BHP=LCSW) | $29.61 | $26.50 | $80.61 |
| Average Personnel Cost (BHP=Psychologist) | $45.93 | $38.17 | $100.44 |

**Non-Patient Encounter Personnel Activity and Cost**

Integrated care also requires performance of numerous activities not related to a specific patient encounter on the day of that encounter. Our observation of a BHP for a workday enabled our team to record the time spent by a BHP on these activities, as well as the amount of time other clinic staff spent interacting with BHP on activities related to the provision of behavioral health services in these primary care practices. Table 7 presents the time our team recorded for the 13 activities listed in the first column of the table by each of the clinical staff roles listed in the top row of the table. To average these times across practices, the entries in the table represent the amount of time per BHP day.

**Table 7: Average Amount of Time (minutes) Spent on non-Encounter Activities per BHP Day**

| Role / Activity | BHP | PCP | Medical Assistant/ Nurse | Care Coordinator | BH Manager | Practice Manager | Medical Records | Front Desk | Total |
|---|---|---|---|---|---|---|---|---|---|
| Care Team Meetings | 20.28 | 18.01 | 18.09 | 7.61 | 0.00 | 0.00 | 0.00 | 0.00 | 63.99 |
| Consultation with Other Care Team Members | 18.42 | 8.49 | 1.70 | 3.77 | 0.86 | 0.00 | 0.14 | 0.03 | 33.41 |
| Patient Phone Calls/ Communications | 16.84 | 0.00 | 0.00 | 4.45 | 0.00 | 0.00 | 0.00 | 0.00 | 21.29 |
| Patient HRSN Support | 0.42 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.42 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Chart Review & Documentation (non-encounter) | 47.00 | 0.00 | 0.00 | 3.01 | 0.00 | 0.00 | 0.00 | 0.00 | 50.01 |
| Consultation/ eConsult with Psychiatry or other BHP | 4.70 | 0.36 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 5.06 |
| Administrative/ Supervision | 25.10 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 25.10 |
| Other Meetings | 26.11 | 0.62 | 0.00 | 0.45 | 0.89 | 2.30 | 0.00 | 0.00 | 30.36 |
| Training/ Continuing Education | 14.86 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 14.86 |
| Other Work | 99.82 | 0.08 | 0.00 | 5.95 | 0.00 | 0.00 | 0.00 | 0.00 | 105.85 |
| Total | 273.55 | 27.56 | 19.79 | 25.24 | 1.75 | 2.30 | 0.14 | 0.03 | 350.36 |

To convert these time estimates to costs, we used the same occupational compensation data as in Table 6. Table 8 presents the estimated contribution of each practice role and the estimated total cost of non-encounter personnel costs for a BHP day. Similar to the patient encounter cost, we measured the BHP cost for a LCSW and a psychologist.

**Table 8: Average non-Encounter Activity Personnel Cost per BHP Day**

| Role<br><br>BHP Credential | BHP | PCP | Medical Assistant/Nurse | Care Coordi-nator | BH Manager | Practice Manager | Medical Records | Front Desk | Total |
|---|---|---|---|---|---|---|---|---|---|
| LCSW | $166.32 | $62.97 | $9.12 | $16.54 | $2.48 | $3.25 | $0.06 | $0.01 | $260.75 |
| Psychol-ogist | $261.82 | $62.97 | $9.12 | $16.54 | $2.48 | $3.25 | $0.06 | $0.01 | $356.25 |

### Integrated Care Personnel Activity and Cost

To provide an overall picture of the amount of time practice personnel spend directly supporting integrated care, Table 9 presents the estimated average number of minutes in a day per BHP work day by clinic personnel role. This table presents

minutes spent on scheduled encounters, warm handoffs, other types of encounters, and non-encounter activities. Other types of encounters aggregates co-visits, group encounters, and "walk-in" encounters. In calculating the time spent per BHP day for the three encounter types, we used our observed average number of encounters per day:

- The average number of scheduled encounters in a BHP day is 3.01
- The average number of warm handoff encounters in a BHP day is 3.27
- The average number of other types of encounters in a BHP day is 0.3.

Clinic personnel roles are listed in the rows and the types of encounters or activities are listed in the columns.

**Table 9: Average Amount of Time (minutes) Spent on Integrated Care Activities per BHP Day**

| Activity / Role | Scheduled Encounters | Warm Handoff Encounters | Other Types of Encounters | Non-Encounter Activities | Total |
|---|---|---|---|---|---|
| BHP | 130.07 | 106.81 | 16.65 | 273.55 | 527.07 |
| PCP | 1.49 | 8.49 | 5.55 | 27.56 | 43.09 |
| Medical Assistant/Nurse | 0.00 | 0.63 | 1.80 | 19.79 | 22.22 |
| Care Coordinator | 0.07 | 0.04 | 0.00 | 25.24 | 25.35 |
| BH Manager | 0.00 | 0.00 | 0.00 | 1.75 | 1.75 |
| Practice Manager | 0.00 | 0.00 | 0.00 | 2.30 | 2.30 |
| Medical Records | 0.00 | 0.00 | 0.00 | 0.14 | 0.14 |
| Pharmacist | 0.00 | 0.02 | 0.00 | 0.00 | 0.02 |

| | | | | | |
|---|---|---|---|---|---|
| Front Desk | 0.00 | 0.00 | 0.00 | 0.03 | 0.03 |
| Total | 131.63 | 115.99 | 24.00 | 350.36 | 621.98 |

To convert the time estimates in Table 9 to costs, we used the same occupational compensation data as in Table 6. Table 10 presents the estimated personnel cost for each type of encounter and non-encounter activities for a BHP day. As above, we have calculated cost for two types of BHPs: a LCSW and a psychologist.

**Table 10: Estimated Personnel Cost of Integrated Care per BHP Day**

| BHP Credential | Scheduled Encounters | Warm Handoff Encounters | Other Encounters | Non-Encounter | Total |
|---|---|---|---|---|---|
| Monthly Personnel Cost (BHP=LCSW) | $89.13 | $86.66 | $24.18 | $260.75 | $460.71 |
| Monthly Personnel Cost (BHP=Psychologist) | $138.25 | $124.82 | $30.13 | $356.25 | $649.45 |

As shown in Table 10, based on the observation of the 11 sites included in this analysis, the largest personnel cost to deliver integrated care in primary care settings derives from non-patient encounters, which represents 57% of total cost per BHP day when a LCSW is providing integrated care and 55% of total cost when a psychologist is providing integrated care in a primary care practice. For a practice that employed the average number of BHP (2.5 FTEs) the personnel cost per five-day work week would be $5,752.15 if the BHPs were all LCSWs and $8,118.15 if the BHPs were clinical psychologists.

***Sensitivity Analysis***

To assess the extent to which personnel time is sensitive to the experiences of a single practice, we implemented a version of the "jackknife resampling" method. While this method is most appropriate for larger numbers of observations, it provides a measure of the extent to which the average across practices is influenced by a single practice. Specifically, the jackknife resampling method excludes one observation and calculates the average of a measure over the remaining observations. It then excludes a different observation after adding the previously excluded

observation back into the sample and calculates averages again. In this case with 11 practice observations, we calculated 11 different jackknife samples and examined the average time and cost measures across the 10 remaining practices in each jackknife sample.

Table 11 reports various time measures from the 11 jackknife samples. For each measure, the table reports the mean, minimum, median, and maximum value across the 11 samples. The mean across the jackknife samples is, by construction, equal to the overall mean value across all 11 observations and is included in the table for reference.

**Table 11: Sensitivity Analysis of Time Results using Jackknife Resampling Method**

| Measure | Mean | Minimum | Median | Maximum |
|---|---|---|---|---|
| Schedule Visit BHP Time per Patient Visit | 43.21 | 41.73 | 43.21 | 45.81 |
| Schedule Visit PCP Time per Patient Visit | 0.49 | 0.28 | 0.52 | 0.57 |
| Schedule Visit Total Personnel Time per Patient Visit | 43.73 | 42.32 | 43.73 | 46.41 |
| Warm Handoff Visit BHP Time per Patient Visit | 32.66 | 31.45 | 32.66 | 33.95 |
| Warm Handoff Visit PCP Time per Patient Visit | 2.60 | 2.28 | 2.60 | 2.83 |
| Warm Handoff Visit Total Personnel Time per Patient Visit | 35.47 | 34.04 | 35.47 | 36.94 |
| Non-Encounter BHP Time per BHP Day | 273.55 | 261.16 | 273.53 | 280.48 |

| | | | | |
|---|---|---|---|---|
| Non-Encounter PCP Time per BHP Day | 27.56 | 20.70 | 28.64 | 30.11 |
| Non-Encounter Total Time per BHP Day | 350.36 | 330.40 | 351.81 | 364.53 |
| BHP Time Integrated Care per BHP Day | 527.07 | 506.26 | 527.04 | 546.04 |
| PCP Time Integrated Care per BHP Day | 43.09 | 34.55 | 44.26 | 46.63 |
| Total Time Integrated Care per BHP Day | 621.98 | 593.09 | 623.42 | 649.02 |

The results presented in Table 11 suggest the personnel time results presented above are not substantially influenced by one practice. While the 11 practices represented a convenience sample, the range of findings in this table suggest these results are indicative of the personnel time needed to deliver integrated care in primary care settings.

***Non-personnel Costs***

The cost reported in Table 10 does not include non-personnel costs related to delivering integrated care in a primary care practice and our team conducted key informant interviews to obtain information on non-personnel costs. In addition to recording the amount of time BHPs engaged in activities related to patient encounters and activities that did not involve patient encounters, our team administered and collected a "Beginning of Visit" questionnaire. This questionnaire included cost questions to help inform the observation data collected and to obtain additional information regarding the direct and indirect costs associated with implementing and sustaining integrated care in primary care settings.

Practices were given multiple opportunities to answer these questions, responses were collected through one or more of the following qualitative methods:

- *Semi-structured informational interviews:* Farley Center team members completed these interviews during one of the site visit days with one or more of the following practice staff: practice manager; lead BHP; lead physical health provider.

- *Open-ended responses:* Practices were provided the questionnaire a week before the scheduled site visit and were able to provide written responses to the cost questions detailed in Table 12.
- *Follow-up emails:* Following completion of the site visits, the Farley Center team sent follow-up emails to practices to address any incomplete cost questions. Practices were encouraged to provide responses to outstanding questions and furnish additional information based on their earlier responses.

If information was not readily available, we indicated to the practice that they did not need to spend an inordinate amount of time collecting it.

Table 12 includes the questions posed and a summary of the responses we received to the cost questions.

**Table 12. Non-Personnel Cost Interview Questions and Responses**

| Question | Summary of Responses |
|---|---|
| Does your practice have any ongoing additional administrative costs that you pay just because you are delivering integrated care services (e.g., additional time of staff dealing with billing issues)? If so, what are these additional costs and about how much are they per month/year? | • Nine of 11 practices indicated there were additional administrative costs, most were unable to provide an estimate of the additional costs.<br>• Four practices provided an estimate: $6,000, $20,000, $145,000, and $100,000-$150,000 annually. |
| Does your practice have any ongoing additional overhead costs that you pay just because you are delivering integrated care services (e.g., software license fees, additional insurance). If so, what are these additional costs and about how much are they per month/year? | • Ten of 11 practice indicated there were additional overhead costs that included licensing fees, malpractice insurance, Continuing Medical Education, travel, and training.<br>• Of the 10 practices, only five could provide an estimate of these costs that ranged from $200, $1,200, $5,500, $10,000, and $69,500 annually. |

| | |
|---|---|
| Did your practice need to purchase any equipment or exam room furnishing to deliver integrated care services? If so, how much did this cost? | • Ten of 11 practices indicated they had this cost. Items included new chairs, lighting, therapy tools/materials, and repainting rooms.<br>• Of the 10 only four could provide an estimate of these costs that ranged from $3,500, $5,000, $10,000, and $30,000 annually. |
| Did your practice need to convert and dedicate any exam rooms to deliver integrated care services? If so, how many exam rooms were dedicated to BHI services? | • Seven of 11 practices reported converting and dedicating rooms for BH services.<br>• The number of rooms reported ranged from one to five. |
| Did your practice need to modify, build, or leasing additional space to deliver integrated care services? If so, how much did it cost to modify or acquire additional space? | • Six of 11 practices reported modifying or acquiring non-exam room space for integrated care services. One reported converting the Medical Director's office into a consult room, one reported building modifications in all three of its clinic locations.<br>• Four of the six provided a cost estimate that ranged from $800, $12,000, $44,400, and $50,000 annually. |
| Did your practice need to purchase additional electronic medical record software or other information technology to deliver integrated care services? If so, how much did this cost? | • Four of 11 practices reported needing to purchase additional EHR modules and the costs are included above as part of overhead costs. |

| | |
|---|---|
| Did your practice have any other expenses when you first started delivering integrated care services? If so, how much did this cost? | • Eight of 11 practices reported start-up costs, however, they could not provide an estimate as they had started several years ago. They mostly cited significant administrative costs and indicated they underestimated these costs at the time. |
| When you first started delivering integrated care services, how long did it take for your practice to develop and implement the workflows and culture to provide integrated care to your patients? | • Four of 11 practices provided an answer ranging from 6 months, 1 year, 5 years, and 6-7 years. |
| Did your cost vary over time after you first started delivering integrated care services? If so, what caused this variation and how did it differ from your costs today? | • Two clinics said that their costs have increased recently due to provider shortages and need to pay higher salaries. |
| Are there any additional costs that we have not already discussed that need to be considered when developing a payment model for integrated care? If so, what are the types of cost and how much are they in a month or over a year? | • Grant or other funding was essential to get started as reimbursement usually doesn't cover on-going costs much less provide any resources to recover the upfront investment.<br>• Current labor market is resulting in increased hiring and training costs.<br>• One practice reported an additional $250,000 - $400,000 annually on increased back office support for integrated care. |

The responses summarized in Table 12 indicate there are additional non-personnel costs incurred in delivering integrated care above and beyond delivery of physical health services. However, the range of estimated cost and our approach in collecting this data to minimize the burden on practices suggest a more structured data collection process is needed to obtain reliable estimates of these non-personnel costs.

While the cost estimates in Table 12 are not as reliable as our estimates of personnel costs, the responses to the first two questions indicate there are additional ongoing operating costs associated with delivering integrated care in primary care settings. Using the median of the reported estimates would hint at an estimate of approximately $60,000 in additional administrative costs and an additional $5,500 in overhead costs per year. Similarly, the responses also indicate that there are costs associated with facilities and equipment needed to deliver integrated care. Taking the median of the reported costs hint that these additional costs would be in the range of $7,500 in equipment and $28,000 in facility costs. As these are one-time costs, amortizing these over five years would suggest an annual addition cost in the range of $7,100 for these two costs combined.

### A1.3 Conclusion

The results from the analysis of the TDABC data collected from the 11 primary care practices in Colorado are consistent with the findings identified in our environmental scan. Our rough estimate of the startup facility and equipment cost of $35,500 is within the range reported in Table 1 from the three studies that provided estimates developed at the time practices were just beginning to implement integrated care.

Our estimates of costs per patient encounter are lower compared to the range reported in Table 1, however, those studies captured cost when practices were first starting to deliver integrated care. Our 11 practices had experience in providing this type of care and we would expect our estimates to be lower because of this experience.

Overall, combining our estimated personnel costs for a typical practice of $5,752.15 if the BHPs were all LCSWs and $8,118.15 if the BHPs were clinical psychologist with the non-personnel costs yields an estimated annual cost of providing integrated care in a typical practice between $360,000 and $475,000. This range brackets the estimated annual ongoing cost from the SHAPE study of $412,000, assuming a 50 week work year in both cases.