Member Advisory Council Minutes
Western Slope – 6/12/23

Rocky Mountain Health Plans Western Slope Medicaid Client Council

June 12, 2023

The meeting began at 9:40 am.

Present:

Members: Meighen, Bianca, Ptisawquah, Nina, Ian, Shawn, Monique, Rochelle, Janice, Danielle H., Tracy, Mary Lou, Tim, Herberta, Sheila, Henry, Danielle A, Tom, Lynn, Diana, Susie, David, Lynn,

Rocky Staff: Meg, Patrick, Sheila, ReNae

Facilitator: Julie

Guests noted in the minutes.

Part One: Meeting with behavioral health administration leaders:

We welcomed our first guests from the Behavioral Health Administration (Ryan Templeton who is over policy and external affairs and Megan Shelton who directs community engagement) both leaders in the newly created BHA. and Meighen gave an overview about how the BHA is engaging with the community. She said that they are redoing the rules now. Once the rules are made it is what they will follow but they will review them in a year or so to see if other changes are needed. She explained that the BHA created an entity called a BHASO (Behavioral health administrative service organization) and this will work like a RAE. However, it is separate from HCPF because this is for people who are not yet in Medicaid but they work together because of the work. When we did introductions, people explained why they care about mental health, issues include inability to get services, abuse by hospitals and other providers, culturally inappropriate or harmful services, family and personal need, lack of communication with families when child is in care, children's care in general cannot get help especially from Indigenous perspective. The areas represented on the committee include Olathe, Delta, Grand Junction, Fruita, Durango, Towaoc, Vail, Eagle, Steamboat/NW Colorado, Cortez,

Ryan and Megan said that they care about access and accountability and appreciate access to the minds in this room. They said they can write laws and regulations but need help on what community needs, how services should look, how do we hold providers accountable, for all of us. The BHA was created to establish a single state agency responsible for behavioral health. There are many programs, but they are not coordinated and therefore not effective. The big question is how to have one entity responsible for this massive issue? We have a long way to go! Some of the questions they are addressing include:

- How do the "one off" programs all fit together?
- What do grievances look like?
- How do we get to a place where you can call and get an answer, the law is only words on paper, we need to get this right
- How to work in the community to come up with what people need?

Different issues in different communities mean that communities need to be engaged. No small group of people in Denver, no matter how smart and well-intentioned, can figure out programs for the whole state without an engaged community involved in all levels of the process.

The BHA is broken into different categories all based on the law.

1) Safety net system—legislature says there are 15 core systems but did not say how to break it down. Questions include
    a. What do regions mean?
    b. What do communities need?
    c. What should be statewide versus local?
    d. What is core that everyone should have access to?
    e. How do we define community?

They revamped what subcommittees that used to be part of the statewide will be. The BHASOs will be intermediaries. The state will contract with them. We need to come up with what does service delivery looks like. We have not come up with the right breakdowns. They are not using the old maps that outlined two or three regions. However, they do need to identify regions and explain what they are. The BHA will contract directly for some services and get block grants for some services.

2) Direct Services. They currently have several other areas of direct services. The MSO (substance abuse) and ASO (crisis) and direct contracts with Community Mental Health Centers (CMHC) specialty providers will go directly to BHASOs and they will subcontract for services in the region. This means there will be no more contracts between the state and providers to get rid of conflict of interest. This has been delayed for a year to get this right.

We discussed the pros and cons of either dismantling a system that has been put in place to start over, or evaluate the current system and identify improvements and make changes based on wisdom of experience and support what is working? People did not want the BHA to undo what is working well with the RAE system. (There had been talk of changing the RAE regions to match the BHA maps which are no longer on the table). How does BHA streamline and make it more user friendly versus adding services, supports, systems, and gatekeepers? RAES have set up networks, we have advised on peer support in the communities, infrastructure is in place and needs building on. Overall people did not want to start over and develop new relationships. They did want improvements in quality. One BIG QUESTION is: "Who is going to do what and how to avoid the department of redundancy?"

The BHA staff said that they do not want to dismantle what is working well. This is about collaborative government. When talking about RAEs we need to be lock step, so systems are aligned and talking to each other and working in collaboration. Do not replace things just to replace things. Need comprehensive system with quality behind it—how to know what is needed?
Another BIG QUESTION is "How do RAE and BHASO interplay with users and providers in a way that makes it work for clients to get what they need?"

3) Care coordination: What does care coordination structure look like? A person needs to know what they get from the provider, from the intermediary, etc. What does direct care coordination even mean? The goal of care coordination is so standardized, so you do not know which one you are getting it from. The goal is to have the BHA system be umbrella. It was mentioned that individuals should not have to know all the intricacies of funding. However, several people including Lynn said that we (clients) do need to understand how the systems works and provider accountability. Ryan said that part of BHA accountability is to have dashboard and let people know what is available and what is and is not working. As BHA licenses and approves the providers make sure there are quality to make sure there are services in all non-hospital kinds of providers. They are still trying to figure out how big of provider organization is needed, some can be overseen by DORA via licensing process? How big does a group practice need to be to have BHA have oversight? They seek a balance between accountability and not having it so burdensome.

Someone asked what area of the state they are contracting with and the answer is that they contract all over the state. In Grand Junction they said they have a contract with Mindsprings for mental health and with Rocky for the crisis system. Colorado laws break into three separate areas with separate requirements for

- Mental health
- Crisis
- Substance use disorders.

The goal is to merge these so there is a BHASO to do all three to one unified system. Current contracts may not be the same as BHASO will do the contracts once they are established.

<u>Comments and questions:</u>

- ✓ Someone said that they have no behavior health on the reservation, no one that treats the Native American community with what they need, like sweat lodges, they have nothing, kids under 5 have no providers except Axis and they do not treat us well.

- ✓ Someone said it is important to not create any barriers. Is there a way to make it so mental health needs trumps anything else and stop criminalizing it? She said Eagle county is a huge problem. Minor criminal charges stopped person from getting care, refused rehab for kid who asked for help because they had a minor criminal charge, served 18 months in youth corrections for alcohol at a party. This young person attempted suicide and got arrested upon discharge from Mindsprings.

You are treated differently based on where you live –if you live in certain trailer parks in the Mountains you are treated badly. Must have mental health above everything else. Until that is treated it will continue until people get the help they need.

- ✓ Someone mentioned that the RAE is starting to break barriers to care but we need this for mental health as well. The problems often begin when people are young and they do ask for help, but the problems get progressively worse as no one provides help, then they end up in the system. Kids are getting diagnosed in school, doctors start with medication before they know what is causing the problem and they decline. Then when kids are more violent, they get criminalized.
- ✓ They do not do neuro or psychological testing, just keep extending sentence. Why not do a good evaluation early?
- ✓ Someone said that too many licensed therapists do not understand any marginalized populations. They have had complaints that white therapists say they do not feel safe with BIPOC populations when they share their truth. Ignacio had only Native therapist and waiting list was a year long and they retired. We need BIPOC therapists and white people need to be trained. We do not talk about disability culture. We have been fighting Axis for years and they are horrible. People who do not want to work for people should be fired.
- ✓ They said that we (this council) have people that can do training for administrators and providers. Many people here that do disability training, school to prison pipeline, BIPOC trainings,
- ✓ People are trying to survive especially when part of multiple identities –BH can be doing so much more. Mindsprings is mostly bad also. How do these things get addressed?
- ✓ Someone said that what you hear today you may not see in current data and the challenge is to create metrics to truly reflect person centered care that they are working hard to make a reality. If data is only given by people in power who are fine with how things work now you will measure success wrong. They said Mindsprings is the most dangerous place on the Western slope, metrics should come from clients, not providers who benefit financially from system.
- ✓ Child welfare gets involved inappropriately, Eagle Valley Behavioral health calls child welfare first then looks at mental health issues and this is now so common that people refuse to call. Metrics should reflect are we passing people through criminal justice, CPS, unnecessarily because we have operationalized these punitive systems. We need to use different evaluations and data.
- ✓ The providers and evaluators and administrators need training on implicit bias, harassment, etc.
- ✓ Someone said we have these conversations with the RAEs—then we go to PIAC and put this in the contracts. It would be good to have a side by side of what BHASO vs RAE do with issues. Contracts, relationships with care coordinators, clients, councils, providers, when we get together with individual providers it goes better and we come to common ground. Who will facilitate these discussions, and can we combine? Who are we talking to and what will we do about it?
- ✓ Someone mentioned that funding so fragmented especially for complex conditions, There has never been anyone to look at someone holistically and connect people to the different services. We should empower case managers to pay and chase. Here is what you need, then behind the scenes get the service paid for, is this in the works? Ryan sees this as the BHA purpose.
- ✓ A member said please believe us—these things are real and contraindicated for physical and emotional health. We are not exaggerating. She would like Mindsprings to reinstate peer support.

The BHA should provide training and also support peer support training and provide funding for services on the reservations.

- ✓ A member is concerned with someone who had crisis in a place like Mindsprings. You stay for 72 hours or are turned out immediately. People do not get processed as regulations dictate, they are given a list to figure out Medicaid. There needs to be an appointment after coming out of Mindsprings or Department of Corrections. Two weeks is too long, one week is the max. There are no consequences to anyone for not getting services to people even when the person dies. When they leave crisis need to be on Medicaid first and then get into services immediately with right person, get them supports including technology to get this.
- ✓ Is RAE and BHASO different? Yes,
- ✓ Is there a flowchart? No. The group asked for this.
- ✓ We need to be able to pay staff to stop creating burnout. People will not move to or work in rural areas to work for minimum wage. We need to look at the overall system and change from top down with the expectation that staff need to be paid a living wage. The workforce will always be a problem. We need a truly open market where it is easier for people to see anyone they want to see.
- ✓ If someone does not have an advocate what happens? Even when we (advocates) are there it is a nightmare. People are pleased with a better relationship with OBH and advocates. We see OBH/BHA and see BHA and United push back against state to say just because someone who has always provided services does not mean they always should.
- ✓ Services on reservation are hard to get because you must go through tribal council to provide services on site. It is also important to remember that many Native American people do not live on reservations and want culturally responsive services throughout the region.
- ✓ Cultural competency needs to include peer support.
- ✓ Client engagement must be real, cannot just be a survey, people are not going to respond. To get real engagement we must address retaliation as it is real, especially in rural areas and especially in mental health.
- ✓ People expressed concern about the idea of regional subcommittees because people are not going to talk if there is a county commissioner there.
- ✓ Feedback loop is needed.
- ✓ Do they know how often kids are moved? Right now, no one is aware, but they want to track this better.
- ✓ Why did child welfare get back in the picture this year with legislation transferring it back to CDHS from BHA? Because it was not supposed to be moved, that was an error that was fixed this year. There were separation kids' facilities, staying with CDHS/ residential outside of kids with BHA.
- ✓ We need special services to address youth who are foster children and then adopted –knowing the history that they will need help throughout their life.
- ✓ BHASO needs to have a robust member advisory council to get good feedback. This will not happen with the BHAC as it is currently formulated.
- ✓ Ryan said that the BHA is responsible for approving trauma informed care, if there is hold the provide must have designation from BHA so there is a nexus. He said we need actual rules and

regulations for providers, right now there is no real regulatory oversight for community providers. We need rules that have meaning and are enforceable, need licensing structure to support quality.

- ✓ Vouchers –we support them, Ryan said that they are trying to build system that works for all, felt vouchers were one step early and if they can get the system right, they will not be needed as there will be naturally large enough network and network that is easy to join. If people can get what they need inside the system, we agreed vouchers would not be needed but for that to happen we would need to have pay equity and not have CMHCs getting much higher rates and then not being able or willing to serve everyone in the right way.

Wrap up: The BHA is meeting with different groups on the rules, and they announced an upcoming meeting in Grand Junction. We also discussed the need to increase the workforce and the group expressed deep appreciation that Ryan and Megan came to Grand Junction for this meeting.

Part two: Rocky Leadership update with Meg and Patrick

- ✓ Meg showed the video about someone who used mental health services to support a transition and pictures from the photo shoot. Patrick said that this is about keeping programs authentic, and they are rolling these out to humanize the program and the people. He would appreciate other ideas about stories to tell. This is an opportunity to use a different approach to show clients in a powerful way, showing the wisdom and diversity of the council. It was mentioned that we can use the photos in other places to show the program to help newer people feel empowered. Some are vocal enough to say their truth and others are not.
- ✓ A member got a letter, and it made no sense and it seemed that her case was mixed up with someone else's. There was one digit off on her client number and it showed the wrong care provider and the wrong diagnoses –there were then three letters that all had misinformation. She knew she could get it fixed for herself but was concerned about other people who do not read or understand it. She called the caseworker and asked how she determined the diagnosis and was told it was based on medication but has yet to say what the medication was. This is concerning as medications are used for different things. She said Sheila helped sort this out, but this seems to be a systemic problem and wants to be sure this is sorted out for others.
- ✓ There was a long discussion about problematic letters coming from the state. Examples include people getting letters after death, which is upsetting to survivors, letters asking about proving bank accounts closed over a decade ago are no longer active. How do you know which letter to believe, state or county? They are contradictory. Rocky said they can help sort out which is accurate. Rochelle also said CCDC can help with this. If we ask the county, they deny sending it. Who do you ask at the state? People want to know if they get contradictory letters do you believe the county or state? Julie suggested believing the most recent but said any denial or termination should be appealed. Meg said they are hearing more about notice problems. She said this is helpful for them to know about the different programs, they do not know all the trip ups on the way,

this is a way for Rocky to have more opportunities to hear from people about real issues, want to continue to bring in this kind of education for our teams. Need teams to know these are things that happen.

- ✓ There is a need to tell people it is a mess and hard. Encourage people to connect with care coordinators, IL centers, and others who can help with navigation but NOT to ignore the letters. It was mentioned if you are using WAWD (working adults with disabilities) AKA the Buy-In you should go to the Colorado Medical Assistance Program at Denver Health no matter where you live, NOT the counties. PEAK will take you there or you can reach out to CCDC, and they will help you send the application to the right people. Rochelle: When you get a denial from Buy In program get in touch with her –this is what she does. Often a call or letter can fix it. You can reach the CCDC team at www.ccdconline.org
    - We are very concerned because in the first full month in our region they redetermined 11000 and 6800 lost eligibility.
    - People do not act, or they think they act but do not. The counties overwhelmed with paper, always better to try to do electronic if possible but people said PEAK is too hard to use and people are still advised to avoid PEAK. Rocky is trying to bring assisters into the organization to be able to help people immediately instead of referring. Rocky needs to see letters to diagnose. People often get stopped during the PEAK process.
    - Issues with PEAK include:
        - Password changes
        - Caseworkers say they cannot access info, so you get the letters asking for things you already submitted.
        - People said that it is confusing using the same application for everything when people just want Buy In and do not want to be automatically enrolled or apply for other programs. This is when we get all these other requests for other info, resources, etc.
        - People do not make changes when they get the packet—because it always causes problems.
        - PEAK also messes things up for people in address confidentiality program, this needs to be made known.
- ✓ It was mentioned that primary care practices are still asking for applications. Please send these to Rocky as they are trying to stop this and need to show them proof that this is happening.

<u>Part Three: PIAC Update with Tom and Ian</u>

Big topic is the BHA –the BHA initially tried to divide into 3 regions then wanted and make the RAE regional map follow the BHA

Ian was advocating for not blowing up the RAE regions and letting the BHA follow the RAE and is glad that that BHA is slowing down. The group expressed support for BHASO and RAE being the same organization where appropriate—they should not have to be the same but should not be prohibited from

being the same. Nothing done in a hurry turns out well. We do not want to be behind the curtain we need to know what they are doing—when we are dealing with RAE and BHASO we need to know who they are and what they do. We would like them to work with us –peer support, training staff, could add value to RAE work and target areas to put in rules –clarify role and expectations.

Phase three accountable care collaborative is happening. Some providers have legit issues about how difficult it is to get paid. Workforce shortage is still an issue. Ian keeps bringing up LTSS. If the BHA can play a role in monitoring quality –how community agencies operate and have conversations, real member advisory councils, not putting kids in cop cars, culturally appropriate providers, etc. this is where BHA can be value add by making these rules.
How do we fix the CMHC problem where they get such high rates but do not provide quality services or guarantee no reject/no eject which means they are not functioning as a true safety net?

- Need rules that are enforced.
- Need to have more peer support.
- Higher rate for 2nd language
- Higher rate for community led organizations.
- Needs to be in both ACC and BHA
- Oversight with private mental health providers

Someone said a long time provider said they needed to go virtual because they are getting paid more if they do a zoom visit and they will not support in person even when desired.

Part Four: Legislative Session Recap

Conversation with Senators Dylan Roberts, Janice Rich

Lots of legislation around behavioral health, most of it passed, some bills start in Senate and if it fails in the house they do not know right away
Good session as far as health care,

- ✓ Behavioral health followed on historic investments last year, on Medicaid concern about PHE ending, passed legislation to make that a little smoother if they no longer qualify for Medicaid.
- ✓ Also increased provider rates -to keep workforce in CO.
- ✓ Some progress on health insurance strengthening Colorado option which is important for those who lose Medicaid.
- ✓ Disability rights –several pieces of legislation

Ian expressed concern about the end of the public health emergency –6800 of Rocky clients in the first month lost their Medicaid. Many reasons for this, the ask is that we slow down and exercise patients with system.
Somone mentioned that Increased provider reimbursement does not guarantee that people will be better trained or better paid, and it does not mean there will be peer support. Improved quality will require some sort of expectations and clarifying what is expected with the increase.

Group health insurance, still tough in Rout and Moffat County
Discussed housing laws:
Highlights of the session:

Sen Rich loves when a constituent comes with specific issue, former teacher brought bill to teach CRP to high school kids

She also did rural opportunity office bill for workforce SB 6

Sen Roberts: Development of more housing, more stock, SB 1 give local governments and nonprofits and private developers ability for public private partnerships for little used land to create housing,

What is it that they look for in testimony?

- ✓ Senator Rich says she listens, and testimony changes her mind, may hear something I have not thought about relatable to the specific issue, wants to hear personal testimony, from people directly affected, not scripted. They focus on districts they represent.
- ✓ Senator Roberts said that they know people are rolling off Medicaid. They work with local county DHS—they are backed up and need support.
- ✓ Senator Rich asks Jill Cowart and the person in Delta to reach out; what you support or oppose on local level is about those who you represent. Lots of associations take a position.
- ✓ Sen Roberts tries to meet with all human services directors; they could always use more support, always looking to better support them. Appreciate engagement directly from district about bills and how it will impact community.

Major rural issues for housing involve water and land use and how does money land in rural communities?
There were lots of controversial housing bills but also good bipartisan progress on bills like these. It was also a good session on water and more money into conservation than ever before. Someone suggested a secret shopper (testing) program to root out housing discrimination so we can identify problems, so you do not have punitive rules for everyone. Someone mentioned that workforce housing is going in but still too expensive. Also, they cannot use HUD vouchers because it is above the payment standard. People who have put into system their whole lives and now on disability they cannot live in in any of the affordable housing. Absentee corporate landlords are coming in to make money and not caring about the community.

- ✓ If we give money to companies that do not invest in our land, do we continue to develop for housing which we need without forcing developers to come up with their own water? We want workforce housing specific to behavioral health. Senator Rich is always thinking about local impact. For example, water rights have been a discussion and concern. Water speculation was one of the major concerns with the land use bill. It was mentioned if we do more density on the front range, it uses less water which helps agricultural lands.
- ✓ Diana mentioned that local trailer parks are trying to kick people out and resell and they are seeing low-income disabled people losing their home. Park owners are changing their business model.

There was a law passed that gives mobile home residents the right of first refusal to buy the parks. One place in Steamboat used this law. It is hard to organize and get the down payment.

- ✓ There is a legal defense fund for evictions through the state—Colorado Legal Services was able to help some people. It was mentioned that we need affordable housing, but the concern is that if you build a lot of low income in an apartment pack people in too tightly –instead of trailer or duplex or house. Also, if it is for low income how can they charge $2000 a month?
- ✓ Tim mentioned we need to not alienate the landlords as most on the Western Slope are mom and pop, he said we used to be too landlord friendly and now too tenant friendly.

Conversation with Representative Julie McCluskie (Speaker of the House)

She said this was one of the most productive sessions she has been a part of, taking reins as Speaker meant being able to bring a high-level focus in new and more meaningful ways, knowing challenges with health care we know there is so much more work to do. She said affordability of housing, health care, childcare, environment all has unique and special meaning in the high country and western slope.

Health care highlights

- ✓ SB 2 community health workers, help community workers navigate to coverage, find Medicaid reimbursements for these workers, CPDHE will be working on this.
- ✓ HB 1228 bill that completely changes how we reimburse nursing facilities, more transparency, members with more complex needs are receiving better care and support, 3-year stake holding process to create sustainable flexible and innovative facilities do not want to lose more in rural Co
- ✓ Health insurance companies leaving state—passed bill to allow those companies to be covered by guaranteed association, this makes sure their failure does not hurt consumers.

Ian, no one wants to be in a nursing facility or needs to be in one, people better served at home. They bill 24-hour care but cannot provide it. People can do better with the money given to them. Bianca agreed saying that her grandmother is getting horrible care in a nursing home, and it is difficult for her to get people at home because she is pending on Medicaid. Janice said that feeding a diabetic food that does not work is criminal, also knew someone who fell and broke femur while in a facility, she was in a wheelchair so why was she in a situation to fall? We must make better care in the community for people the priority.

Speaker McCluskie said that last year we got a lot of federal resources to address these resources, HCPF had to come up with a plan to strengthen and improve HCBS in part because they know the model of nursing facility does not meet the needs Some of that work was innovative—how to improve and strengthen workforce. Depletion of workers significant, state has increased pay, but it is not nearly enough for expectations of the job—she agrees and for some they are there due to no immediate choice. She said that Bonnie Silva has been a good partner trying to improve in facilities. One of the components in the bill is more transparency.

- ✓ Lynn spoke about CDASS and how great it is that she can hire her own workers. Because of the lack of overhead CDASS workers are paid more than they would get in nursing homes or home health agencies. Future dollars should go to HCBS and CDASS as that goes to the care providers. Others agreed that the CDASS model is the best model and should be taken to other health care services including behavioral health.
- ✓ ReNae said she was glad to see transparency —some people are in abusive situation and need to get somewhere to get out of the situation.
- ✓ Mary Lou said as a caregiver the biggest challenge includes benefits and retirement, nothing for people under CDASS in the end, no retirement or health insurance.

Rep McCluskie invited the group to contact her with ideas. Julie.mccluskie.house@coleg.gov

Topics for future meetings:

- Sheila youth group
- Counties -Panel, of DHS directors
- Eligibility update
- Case management and LTSS
- CDASS rural issues
- Bonnie Silva DOJ and Nursing home
- Youth aging out of foster care

The meeting adjourned a bit after 4:00 PM

Notes by Julie Reiskin, facilitator.