Meeting Chat 08/21/23

KENDRA NEUMANN:	You can follow along with captioning with this link, which opens in a separate window: www.streamtext.net/player?event=hcpf
SUMAN MATHUR (SHE/HER) - CHI:	English and Spanish versions of the presentation for today are available here -
KENDRA NEUMANN:	Again, you can follow along with captioning with this link, which opens in a separate window: www.streamtext.net/player?event=HCPF
KENDRA NEUMANN:	For members, you can fill out this link to receive compensation for your time today: https://forms.gle/vQSEjRQgZ8r55Kto7
ALLIE MORGAN (SHE/HER) | CHI:	https://hcpf.colorado.gov/accphase2
KENDRA NEUMANN:	For members, you can fill out this link to receive compensation for your time today: https://forms.gle/vQSEjRQgZ8r55Kto7
ALLIE MORGAN (SHE/HER) | CHI:	Vision Stage Summary is available here: https://hcpf.colorado.gov/sites/hcpf/files/ACC%20Phase%20III%20Vision%20Engagement%20Summary.pdf
SUMAN MATHUR (SHE/HER) - CHI:	BHA = Behavioral Health Administration, APM = Alternative Payment Models
ALLIE MORGAN (SHE/HER) | CHI:	Reminder for attendees that you are welcome to submit questions during the presentation using the Q&A icon at the bottom of your screen, if you have it accessible. We are also closely monitoring the chat and will record questions/comments shared here.
ALLIE MORGAN (SHE/HER) | CHI:	Thanks all for the questions coming in through the Q&A! Some will receive written answers (2 have been answered so far) while others will come up during the discussion portion.
SUMAN MATHUR (SHE/HER) - CHI:	And, we will share out all questions and written answers with the slides.
ATTENDEE:	I have to hop off for another meeting, but thank you for this presentation! I popped a question in the Q+A and am happy to discuss it further, my email is [email address removed] ☺
SUMAN MATHUR (SHE/HER) - CHI:	Thank you! We appreciate the question.
SUMAN MATHUR (SHE/HER) - CHI:	And, keep an eye out for the recording on the HCPF website.
KATIE LONIGRO:	PACK = Payment Alternatives for Colorado Kids
SUMAN MATHUR (SHE/HER) - CHI:	And re-upping:
	BHA = Behavioral Health Administration, APM = Alternative Payment Model FQHC = federally qualified health center
KENDRA NEUMANN:	Re-upping this link. Members can fill out this form to receive compensation for their time today: https://forms.gle/vQSEjRQgZ8r55Kto7
ATTENDEE:	That was my question, thanks Dave, makes sense.

ATTENDEE:	Appreciate your thoughts.
ATTENDEE:	Great, thanks!
KENDRA NEUMANN:	You can register for upcoming meetings here: https://hcpf.colorado.gov/acc-phase-iii-stakeholder-engagement
ALLIE MORGAN (SHE/HER) | CHI:	Link to online Concept Stage feedback survey: https://forms.gle/osQRvmZFwa1aRRJA7
ALLIE MORGAN (SHE/HER) | CHI:	Link to open feedback form

Questions and Answers

Question	Answer
From the answers given it seems that the department sees member input as "grievances and complaints", is this what they expect from the MEACs they want to require? Will they monitor suggestions for improvements?	Summary of live answer: HCPF wants member experience woven throughout the program, both at the Dept and at the RAE level. Will require them to have advisory councils, move forward with equity task forces. Dept continues to identify new ways to expand outside of the MEAC and find new ways to hear from members.
Has HCPF thought about how in ACC 3.0, the RAEs can possibly improve on helping members access oral health services? Given the striking disparities in oral health in our state, especially in our rural communities, this is something I am thinking about.	We have considered oral health and currently promote collaboration through our incentive program. We will continue to have the RAEs work with the Medicaid Dental Administrative Service Organization to help members access services.
Has there been any consideration to align RAEs with provider network vs geography?	The Department has taken into consideration a wide variety of factors when looking at establishing regions, which has included various provider networks. Unfortunately, there are many different networks that overlap.
How will the health equity personnel be chosen? Will members have input on the job descriptions, interview processes?	The RAEs will be responsible for establishing job descriptions, conducting interviews, etc. The Department will not be involved in those processes. We will just set high-level requirements and roles for the position.
If care coordination is delegated to community-based organizations, will the Dept. set PMPM rates for each tier or will that be up to the RAE?	The RAEs will be responsible to identify rates based on different providers, CBOs, the services they can provide. HCPF wants them to have that flexibility and will encourage them to appropriately support those activities.
Is there not already standard UM practices? NCQA/URAC?	Summary of live answer: Yes, there are standard utilization management practices. However, there are multiple standards. HCPF intends to align and select the most appropriate standards for our network. Part of the goal is to ensure that the

	standards align with the way providers are currently working within the network.
It sounds as though more work is being put onto the RAEs. Will there be accountability measures built into the contract to ensure they are upholding these new functions AND the care coordination activities they are supposed to be doing currently? I have heard from a number of PCMPs that care coordination being removed from the clinic (with the RAEs) is ineffective, confusing for members, and the PCMPs would like to see accountability for the dollars RAEs receive for these activities and encourage HCPF to consider moving more dollars to the clinic level for clinics already doing this for their patients.	Summary of live answer: HCPF prioritizes flexibility for each RAE and provider to set the arrangement that works best for their partnership. HCPF intends to set clearer expectations with the three tiers of care coordination. HCPF is agnostic as to who does the care coordination as long as quality services are being provided. Our goal is to be more transparent with clearer standards and clearer differentiation to support transparency and accountability. Every person's care coordination needs are different which makes this hard to standardize, but we are looking at appropriate measures, e.g., hospitalizations and transitions of care.
What considerations will ACC Phase III have for members eligible for Medicaid and Medicare? APM 2 reimbursements at Medicare rates could further align efforts to coordiante and provide primary care and behavioral health for this vulnerable and high cost population.	Summary of live answer: HCPF is focused on the thousands of dual-eligible members enrolled in both Medicaid and Medicare. The dual special needs program is intended to align the benefits for dual-eligible members. The next phase of contracts will have a single entity responsible for providing services to this population. We are excited about the new approach to the dual special needs program contracts to simplify the structure for our members who are also enrolled in Medicare.
When will the concept paper be released and will it go into more detail than the (good) general principles being presented today?	The concept paper is currently in our final review and clearance process. I expect that it will be posted in the next few weeks. We'll send an email announcement to our newsletter subscribers as soon as it's posted on the ACC Phase III website. The paper does go into more detail on everything discussed in this presentation.

Why can't we just get rid of the RAEs? Every RAE has different pre-auth processes, forms, contracts, reimbursement amounts, UR, audits, provider credentialing, etc... keeping all that separate takes a ridiculous amount of effort and time, especially for smaller providers.	Summary of live answer: HCPF staff understand the admin burden with the delivery system. There's ample evidence that the burden in a purely FFS/admin structure doesn't benefit individuals, and that plans are beneficial + the ability to provide wraparound services and supports is essential. It does add some admin functions to ensure appropriate and effective spending, but overall, the majority of US health care comes with a layer of admin support that is provided through health plans. In addition, HCPF acknowledges that not all Medicaid services should come from a central office as it would lose some collaboration, community focus, and oversight. They are aiming to create similar regional models that will remain focused on a consistent experience for members in terms of access, quality, and cost. Don't feel that discarding the regional model would be as productive as making the current system better/more consistent.
Will there be mechanisms in place to ensure member concerns are addressed by the RAEs? Or is the only requirement that they meet with members?	Summary of live answer: HCPF is working on several improvements to the member grievances and appeals process. The intent is to improve our ability to provide transparent information and hold the RAEs accountable. In ACC Phase 3, the intent is to clarify expectations around quality of care complaints and improve transparency of these processes. Our goal is to ensure members' voices are heard!
With regards to RAE and practice contracting, has it been decided to keep contracting as-is (ie based on practice address and what RAE covers that location) or will it be based on patient location, requiring that practices contract with multiple RAEs if/when serving patients in various regions?	Summary of live answer: HCPF is requiring the RAEs to contract with all PCMPs in their geographic region. Members will primarily be assigned based on where they've received services in the past (appropriate for about 75% of members based on utilization history). For the rest, HCPF has used "geographic attribution" based on a member's home address, but that process will not continue in Phase III as it's been shown to be ineffective. Going forward, those w/o history will be attributed to the RAE and the RAE will in turn work with them to find a PCMP who meets their needs. So, it's a little bit of both. It's more difficult on the behavioral health side as more providers serve members throughout the state. The move to a 4-region model should help reduce the need for as many behavioral health providers to contract with multiple RAEs.