Draft Contract Primary Care Medical Provider Meeting, 2/12/2024

Chat Comments and Question and Answer Log

Meeting Chat

CHI: Here is the link to the compensation form for Health First Colorado Members: https://forms.gle/vQSEjRQgZ8r55Kto7
CHI: Here's the website for all things Draft Contract: https://hcpf.colorado.gov/accountable-care-collaborative-phase-iii-draft-contract
CHI: Here's the Draft Contract Review Guide: https://hcpf.colorado.gov/sites/hcpf/files/ACC%20Phase%20III%20Draft%20Contract%20Review%20Guide.pdf
CHI: As a reminder, please feel free to share comments in the chat, and questions in the Q and A throughout today's presentation. If you are unable to access the Q and A, you are welcome to use submit comments or questions via chat. In another couple minutes, we will open it up for verbal comments or questions.
CHI: *comments or questions on this section of the presentation. We will have additional comment periods throughout today's presentation following each "mini-presentation".
CHI: SHIE refers to the social health information exchange. and CMMI refers to Center for Medicare and Medicaid Innovation DOI = Division of Insurance HRSN = health=related social needs
Attendee: I am curious why the State VBP's are administered through the State vs the RAE's? The bifurcated payment program lends itself to inefficiencies
Attendee: Will HCPF/RAEs be supporting the cost of connecting small practices to the SHIE including costs to the EHR vendor for changes?
Attendee: tag you're it is totally not acceptable, and I appreciate that you are trying to take a new approach
Attendee: There is a presumption that members understand RAEs. That was not the experience during COVID and probably not true going forward as the RAEs will change. Is there a way to add a strong emphasis on RAEs providing funding to clinics to help with community outreach?
CHI: [In response to the previous chat] Thanks for this perspective and suggestion. It is noted.
Attendee: Thank you for your response, I am just hopeful that HCPF will ensure appropriate safeguards that the warm hand off from RAE to PCMP

is truly a warm handoff and not just a dump to allow the RAE to shift responsibility of that patient to a PCMP.
CHI: For reference EPSDT refers to Early and Periodic Screening, Diagnostic and Treatment. PHQ-9 refers to Patient Health Questionnaire CANS = Child and Adolescent Needs and Strengths IA = Independent Assessment
Attendee: In Tier 2 some diagnoses may not have a medical need for quarterly meeting with member and team. Pediatric patients with Mild Persistent Asthma generally can be managed appropriately with 2 visits per year.
Attendee: It's not appropriate to do all the screenings in order, when we know the contextual situation of the patient as well to best get to a treatment plan. Questionnaire fatigue, I appreciate the idea of a menu
Attendee: [In response to previous chat] In existing behavioral health programs we have protocols that may give us information without needing to use the CANS. It would be important to allow programs to make determinations based on criteria that would align with CANS but not necessarily require its use.
CHI: [In response to the two previous chats] Thanks for this input. It's always helpful to hear from providers about their experience. We will take this feedback back to the Department.
Attendee: Will the IA only be provided by a BH specialist or can a PCMP provide this IA using the CANS tool?
HCPF: [In response to the previous chat] The BHA will be responsible for identifying providers who can perform the IA and are trained in using the CANS tool.
Attendee: Minimum viable performance vs best case scenario, also consider how the decision tree and the movement of patient care need to also be adaptive to care service availability
Attendee: Also, remember there is a depression screening and follow up overlap
Attendee: The amount of depression screenings is depressing
CHI: You can find upcoming meetings here: https://hcpf.colorado.gov/acc-phase-iii-stakeholder-engagement
CHI: Here is the form to provide feedback on the Draft Contract: https://forms.gle/cdfUR24eJNeWbfCS8 Here is the form to provide feedback on the Offeror Questions: https://forms.gle/VJ4tba71W3RbtehT6
Attendee: Does my feedback here also get included in the feedback Public feedback recording
CHI: [replying to the previous chat] Yes, we are also capturing all feedback in the chat to share with HCPF

Question and Answer Log

Questions	Answers
What is the definition of non-utilizer vs utilizer as per HCPF (especially when they are designated in the data as a non-utilizer)	Summary of Live Answer: For non-utilizers, we are thinking of members who have never accessed any services, including emergency care, and have no claims history. We wait until someone accesses the health care system in any form and then consider them a utilizer. For members who use just emergency care but no regular outpatient care, RAEs will help monitor use, and RAEs will engage members who regularly use emergency care and try to connect them to medical homes.
How are health equity measure performance being financially incentivized for practices?	Summary of Live Answer: The final structure has not been totally decided, but the quality metrics for PCMPs will be the same as what has been listed in the recent DOI regulations. The RAEs will have a slightly wider measure set that encompasses perinatal and behavioral health. The DOI list is aligned with metrics identified in HCPF's health equity plan. We have about twenty metrics in our health equity plan, and we are focusing on those in our various programs.
You had mentioned removing family attribution, could you elaborate on that piece? Thanks	Summary of Live Answer: Currently, if someone has no claims history, and someone in their family has a provider,

	family members can be attributed to that provider. Today, we sometimes run into problems when children are attributed to adult providers and adults are attributed to pediatricians. We are trying to solve that problem, which is why we are moving toward using claims history for attribution, but we will confirm this final decision.
What accountability is noted in the draft contract that holds HCPF accountable to improving the accuracy and speediness of reporting data to RAEs so performance improvement/continuous improvement can be capitalized on?	Summary of Live Answer: We recognize that practices receiving data on a quarterly basis, at minimum, is necessary to thinking about how to improve care. We are also weighing more real-time metrics to drive information, even if they can't drive reimbursement.
How are members connected as a family unit when you talk about attribution? Are RAEs able to see that connection to use for population health? How are individual PCMPs able to leverage this to help with attributing members?	This is not my exact area, and it has been a while since I was involved with family attribution. That said, our current methodology is imperfect which I believe relies on reviewing members located at the same address and then compares last name. RAEs have the member information and can try and make the same connection to try and support families. But I will follow up with internal staff on if data has improved for us to more clearly identify family units.
Thanks [facilitators] for that info on family attribution. Our preference would be to be able to keep sibling together, which would especially be helpful for newborns attribution. Would you be able	Thanks for sharing your experience and for this suggestion. We will definitely take this back to the right people at the Department.

to keep that component of the methodology for pediatric practices?	
I am curious why the State VBP's are administered through the State vs the RAE's? The bifurcated payment program lends itself to inefficiencies	Summary of Live Answer: We have different payment arrangements on the physical versus behavioral health sides, so we have explored a variety of models about the role of the RAEs in value-based payments. We are doing a lot of work on VBPs in primary care, and, as we think about ACC Phase III, we didn't think it was the right time to move toward managed care for physical health, because of the disruptions of the system. We felt that we were in the best place to manage some of this VBP work right now, as opposed to handing this off to a third party. We want RAEs to help wraparound supports, so providers can be successful.
Will RAE's be able to pay outside organization that are giving similar support to providers	I may need clarification on what types of outside organizations you are referring to. That said, we are encouraging the RAEs to consider financial support for organizations that may offer services across the continuum of care coordination. For other types of support to providers, it would be up to the RAE to consider how an organization supports achievement of contract requirements and the goals of the ACC.
How are HCPF and/or RAEs going to financially support small practices in getting connected and using the SHIE? Will there be cost limits applied? There	Summary of Live Answer: In the Draft Contract, we talk about how RAEs are responsible for helping providers learn

are financial considerations for practices to use technology that are not always obvious.	about the SHIE. WE are still trying to understand all the supports that are required, and we expect to see changes over the next few years, because this is a developing program. The per-member per-month payment is intentionally flexible, so RAEs can help providers meet needs as they come up, such as needs in using the SHIE. HCPF is also thinking through a payment model that will allow smaller practices to participate.
Is there some financial payment is built into the contract to the RAEs to account for the technical assistance required to help PCMPs catch up in the informatics/digital space in order to support smaller practices to leverage PMPM incentives and PT incentives?	Current RAE contracts require that RAEs provide practice transformation support to help providers work with Medicaid. Often this can include technical assistance. We anticipate continuing practice transformation requirements in ACC phase 3.
Now that CHWs will be a paid service, how does that change the definition or expectations for care coordination at the RAE and provider levels, if at all?	Summary of Live Answer: I'm not sure that this will change the definition or expectations of care coordination, but community health workers are an adjunct who can help members with care. These community health workers can help with things like interpretation services on site, social workers in the home, transportation support, and more that facilitate trust with the care team. The case manager is responsible for working with the right people, which may include working with community health workers.

	From a payment standpoint, the RAEs' tiering of providers will look at whether providers have CHWs or whether RAEs may wrap around to provide CHW supports. The RAEs may need to contract with community-based organizations to have CHWs do outreach to people not accessing care. CHWs will show up in a variety of ways and sometimes may be reimbursed directly and other times reimbursed by RAEs.
Is HCPF encouraging the RAEs to better partner with practices/delegate to practices in order to move care coordination work forward, allowing it to be closer to the medical home?	Summary of Live Answer: RAEs can describe different models that they believe to be the best fit. This may be dependent on the level of staff, or type of staff, at the provider level. it can be a combination of office staff providing certain services, with RAEs providing other services. If it's a really small practice, maybe they are more fully supported by the RAE. We want the best service for the member, and are looking to evaluate all kinds of models. We acknowledge that coordination provided close to the point of care, assuming providers have the capacity to do so.