COLORADO
Department of Health Care Policy & Financing

MINUTES
Accountable Care Collaborative
Provider and Community Experience (P&CE) Subcommittee

April 13, 2023, 8:00-9:30 A.M.

1. Introductions & Approval of March Minutes (handout)

Kathie Snell, P&CE Co-Chair, called the meeting to order. The following people were in attendance:

Voting members: Kathie Snell (P&CE CO-Chair, Aurora Mental Health Center), David Keller, MD (P&CE Co-Chair, State PIAC Member), Theresa Anselmo (Delta Dental of Colorado Foundation), Carolyn Green, MD (retired), Pat Cook (Colorado Gerontological Society), Marc Ogonosky (Medicaid member), Angie Goodger (CDPHE), Mark Levine, MD (retired, State PIAC Member) and A quorum was established.

Non-Voting Members: Brooke Powers (HCPF, liaison to P&CE), Callie Kerr (HCPF), Erin Herman (HCPF), Nikole Mateyka (CCHA/RAE6), Jen-Hale-Coulson (NHP/RAE2), Lexis Mitchell (HCPF), Donald Moore (Pueblo Community Health Center), Chris Anderson (HCPF), Kourtney Richards (Colorado Rural Health Center), Brittany Romano (COA), Kellen Roth (COA), Lauren Landers-Tabares (HCPF), Jessica Zaiger (CCHA), Natasha Lawless (RAE2), Mona Allen (Health Colorado, RAE4), Sandi Wetenkamp (HCPF), Ashely Clement (RAE2), Bill Wright (COA), Marius Nielsen (HCPF), Katie Mortensen (CCHA, RAE6/RAE7), Sarah Hamilton (RAE1), Andrea Skubal (CCHA, RAE6/RAE7), Mark Queirolo (HCPF), Shera Matthews (Doctors Care), Jamie Zajac (Colorado Access, RAE3/RAE5), Matthew Sundeen (HCPF), Matthew Pfeifer (HCPF), ReNae Anderson (Rocky Mountain Health Plans), Christina Brown (HCI/RAE 4), Marissa Kaesemeyer (COA, RAE3/RAE5), Suman Mathur (Colorado Health Institute), Emilee Kaminski (CHCO & University of CO Department of Peds), Tamara Keeney (HCPF), Andrea Skubal (CCHA), Jessica Johnson-Simmons (Denver Health), Brandon Arnold (CAHP), Blue Parish (HCPF), Alyson Williams (Health District of Northern Larimer County), Johnathan Savage (Care of Location Telehealth), Alison Keesler (Intermountain Healthcare), Shoshi Preuss (Colorado Community Health Network), and Christine Andersen (RAE4).

Kathie Snell asked voting members to vote on the March 2023 meeting minutes. A quorum was established, and the March meeting minutes were approved.

2. P&CE Follow-up items and Housekeeping

Kathie Snell, P&CE CO-Chair

- eConsult updated provided by Brooke Powers
    - The eConsult program is a Statewide Medicaid Electronic Consultation

platform. The platform will be used to promote the Departments mission to improve health equity, health care, equity, access, and outcomes for people served.

- The eConsult platform will enable asynchronous clinical communications between primary care providers and a specialty provider. The PCMP will be able to transmit an electronic clinical question to a specialty provider and medical information will be reviewed by that specialty provider. The specialty provider will be able to review the case without the member being present. The specialty provider then provides the electronic medical consultative guidance, which assists the PCMP in the diagnosis or the management of the members health care needs or facilitates, an appropriate referral for a face-to-face visit with the specialty provider.
- Stakeholder engagement will resume in the late spring, early summer. Once the contract that we have has been approved by CMS.
- Estimated (TBD) implementation date: winter 2024. Go live with implementation activities in the summer and fall of this year (2023).

- Two open voting member seats: Behavioral Health and Long-term Services and Supports
  - If interested or know someone who may be interested, please fill out the Voting member application

3. State ACC PIAC Update

David Keller, MD, P&CE Co-Chair/State PIAC Member

- March 2023 meeting
  - Department updates including a briefing on Managed Care and RAE Contract amendments. Action item to take away: Desire to have the BHA join future PIAC meetings, to discuss RAE contracts and make sure that the new RAE/MCO contracts align with the BHA.
  - Stakeholder Engagement: Child and youth priority and in particular an initiative to coordinate care for children with complex, mental illness and develop a pathway that RAEs could follow and how it would fit in with the BHAs work and how it would fit with the CCBs.
    - *Some feedback that the PIAC provided was that there is more to children and youth than the kids with complex behavioral health needs and we need to spend more time talking about the other problems of children and youth in the future.*
  - Key Performance Indicators (KPIs): Which ones will be used likely in the next contract and what is missing? Specifically, member experience was missing. There was a discussion on health equity and what a KPI on that would look like.

4. ACC Phase III Stakeholder Engagement

Health Equity conversation facilitated by Tamara Kenney, HCPF

- Specific question regarding health equity from the providers point of view.
    - At your practices at the practice level, and at a health system level, how much are you all getting guidance on health equity? Things like equity training, requirements, equity staffing requirements. The Department is wondering how much the guidance of health equity right now is coming from the practice level or health system level versus insurers?
        - *Our organization started by renaming our Chief Quality Officer's title to Chief of Quality Outcomes and Equity Officer. This change was made because we realized that our data was terrible and if we can't measure the data, then the issues cannot be fixed. The data collection needed to be standardized, in order to allow us to look at it and improve equity within our system. Additionally, we launched a campus-wide initiative called The Captains of Inclusion. Where we as an organization were asked to identify a champion for equity within their unit and those individuals go to specific training and are a part of a group within the organization to raise issues of equity and try to address them. Within my personal unit we now have a JEDI council (Justice, Equity, Diversity, and Inclusion) meeting regularly to look at processes. They got a small grant to start to look at doing focus group with community members on things we can do in our clinic to make it more equitable and welcoming to folks who have a variety of different backgrounds. Those are only the things I know about in my organization, there is a huge push from leadership within the organization. It is always one of the topics at the leadership meetings. One of the biggest success stories we have is a recent complete refurbishment of our Car Seat Loan Program to make it more accessible to folks. There were some unequitable rules that made it easier for some to get a car seat and more difficult for others, that has been reestablished to make it more equitable for all. The challenge of writing it in to contracts would be making it standardized across the state.*
        - *The 20 FQHCs in Colorado have a strong health equity focus. Both from a requirement standpoint and ingrained into our culture. HRSA grantees, has a very systematic way of collecting outcome data on patients that we serve. We look at the data that is collected, that HRSA collects. The data aligns closely with CMS, The Department, Medicare and many private payers. We look at outcomes such as diabetes, hypertension, asthma. We are reporting on ethnicity, income, class, gender, housing status and various ways to slice the data. We have a data warehouse in which our EHR data goes into that we can resource. Each health center has access to the data. There is a linkage between that organization and the data warehouse to support our value-based contracting performance improvement measures.*

- *Question about data access:*
  - *concerned about data access such as income. It is very challenging to obtain and the silos that we see in addressing equity. Every health plan, every health system, every hospital, each have their own plan. But maybe there could be a way to look at it through a community level rather than an individual level. What is the state doing to foster community level addressing of equity which would also help to address some of the systematic issues that lead to inequity? Pivot from individual approach to community approach?*
  - *From a data perspective we have the tools, but I think the question is the approach. It is a compelling idea, to think about this from a community perspective, that we could look at.*
  - *Linking data across data systems, is not easy, but would hold all accountable.*
  - *In behavioral health it is also a strong focus as well. Health equity is present in the quality criteria. We have implemented an electronic platform, to describe the outcomes our clients are achieving and tying those with other client characteristics. Look at the equity piece with clinical outcomes. Long standing DEI (Diversity, Equity, Inclusion) council, 3rd year anti-racism summit, 300-400 people per session. Looking at client population and at the organization.*
  - *Equity within HCBS. Do people know about HCBS? The Department found that the Hispanic community was unaware of HCBS. I think we could incorporate this work into this same equity work.*

Proposed Behavioral Health Administrative Service Organization (BHASO) and Regional Accountable Entity (RAE) Regional Map Alignment conversation facilitated by Mark Queirolo, HCPF & CO Health Institute (CHI)

- Discussion on the geographic alignment of the following two entities:
  - Regional Accountable Entities (RAEs)-managed by the Department of Health Care Policy & Financing; new contracts go live 07/2025
  - Behavioral Health Administration Service Organizations (BHASOs)-managed by the Behavioral Health Administration; go live 07/2024
- The Department of Health Care Policy & Financing and the Behavioral Health Administration are committed to a shared map that aligns the RAEs and BHASOs.
  - The final map has not yet been decided.
  - Projected timeline:
    - Fall 2022- begin stakeholder activities to assist with program development
    - Spring-Summer 2023: Concept Papers
      - Ongoing community engagement to collect feedback and refine design
    - November 2023: Draft RAE Request for Proposal

- Revise draft request for proposal based on stakeholder feedback
- Begin operational implementation

- April 2024: RAE Request for Proposal
  - Proposal review
  - Implementation work
- September 2024: Vendor Awards
  - Vendor transition activities
  - Member and provider transition preparation
- July 1, 2025: GO LIVE

Feedback so far? How do stakeholders feel about simplification? Stakeholders are supportive of changes that simplify systems through standardization and centralization.

Stakeholders hope the ACC will be aligned with the BHA.

- Stakeholders expressed concern about building two entirely separate systems and emphasized that alignment through procedures and geography was important.
- However, the Department recognizes that physical health needs for the Medicaid population may not perfectly align with behavioral health needs.

Current Proposals and Analysis:

- Guiding Principles:
  - Ensure populations are large enough to effectively manage risk
    - Include at least 2 population centers
  - Support and promote existing member utilization patterns and existing care infrastructure
    - Minimize disruption to providers and Medicaid members
  - Support value of community-based care
  - Factors Considered:
    - Geography/number of counties
    - Populations demographics
    - Behavioral health needs
    - Continuum of behavioral health services
    - Medicaid utilization patterns
      - Utilization in member's home county vs adjacent counties
  - Provider networks
  - Stakeholder feedback

Three-Region Proposals Stakeholder Questions:

- Are there data points or key considerations that we've missed that should be examined in the process of determining these regions?
- Should any of the regions be further subdivided to have multiple RAE regions?
    - *1. I can appreciate how difficult the boundary setting decision is and appreciate the thoughtfulness the Dept is undertaking. Thank you. 2. I recommend giving due weight and prioritizing natural use patient patterns and provider/community care continuum networks and balancing this with the need for sufficient population numbers. 3. Minimize administrative complexity associated with working with multiple RAEs and BHASOs.*
    - *The concept of making sure that there are two populations centers in each region. That will somewhat obscure the difference between urban and rural. There may be entirely different risk concerns in those two things. And if the population centers diffuse, the attention on the rural issues, I wonder if we don't risk the disadvantaging, the rural communities? There might be something to be said for making population centers in rural areas, completely different. So, you can look at the risk factors that are associated with each.*
        - *This makes sense, will bring back to the Department*
    - *Challenges in providing care in rural areas are very different. They're very, very different, particularly for kids. There's just a real lack of resources so I'm not sure how we would make sure that they that you know? Trying to figure out how to prioritize small subpopulations within the BHASOs and assure that they're getting the same quality of services, is something that's got to be built into those contracts.*
    - *Does this imply any changes with attribution model or is that to be a later discussion?*
        - *This will be a later discussion*
    - *Can we have an example how a RAE might interact with a BHASO?*
        - *Aware of two instances: Looking at the population that turns on and turns off Medicaid. Members that have services paid for by the BHASOs and then services paid for by Medicaid. There are services that Medicaid cannot pay for such as room and board and residential programs. There needs to be a close partnership between the RAEs and BHASOs and the ability to coordinate providers who are working in a similar manner.*
    - *Where might payment reform goes in the future and how that might impact how you're looking at the new RAE proposal? Paying attention to where systems are that may be contracting for that kind of care in the future and whether they're trying to straddle too many different kinds?*
    - *Proposed Region 3 is a large population. What is the State looking to indicate that 1 RAE would be able to manage that region? Two RAEs are currently managing that region. One region would provide consistency because of no RAE boundary issues, but I can't image keeping track of that case load as a care manager. Having 1 entity managing 830,000 people seems to be too large of a*

population.

- *From a provider's perspective, it is difficult to have different managing RAEs. It is one thing to manage different contracts but different approaches as far as what is paid and what isn't paid has required some providers to not be able to take members from different RAEs because payment is too difficult. To ensure equitable access provides a difference.*
- *How much were the RAEs part of the stakeholder process?*
  - *Feedback mostly with the BHA stakeholder engagement has informed a lot of the collaboration. Developing at least a structure that will give enough flexibility to the uniqueness of the ACC and being a good partner to the BHA—trying to find the balance.*
- *Feedback from some of the smaller RAE members has been they appreciate the smaller area and being able to work a little bit closer with their providers and being involved in the whole process. How can we maintain efficiency around that?*
  - *This will be a part of future discussions and future considerations*
  - *Understanding how new regional boundaries will impact the number of RAEs and contractual responsibilities.*
  - *Considering how to ensure a regional focus on care and access within larger geographic boundaries.*

Any additional comments, feedback, suggestions—please reach out to MathurS@coloradohealthinstitute.org

ACC Phase III Feedback Survey: https://www.surveymonkey.com/r/ACCMeetingFeedback

7. Open Discussion

- *I'm confused why the BHASO doesn't align with current of future RAE's. Also, the issue in BH is access to care and that doesn't seem to be addressed.*
  - *The RAEs deal with most of the BH needs of the Medicaid population and the BHASOs will be covering services that Medicaid doesn't cover. The BHASOs will typically be covering non-Medicaid members, all BH services in the State. The BHASOs will have oversight of care.*
  - *The current BHA has contracts for partly general funds dollars to support services for people who are not eligible for Medicaid, they also have programs where they serve a broader population and can serve the Medicaid population so there is cross over.*
    - *Colorado Crisis Services System is administered through the BHA, supports services across the board and as well as Medicaid members.*
    - *The Managed Service Organizations for SUD.*
    - *Cross-over, especially the quality standards that are required for under licensing and auditing practices across the BHA*
- *When you say that the BHASOs are going to create their own rules and regulations*

etc. Could the relationship that the providers have with their current RAEs change with the oversight of a new organization (BHASOs). Where everyone would be regulated more by the BHASOs rather than their own contractual relationship with their RAE? Is there potential for that in the future?

  - *The BHASO isn't creating the regulations, it's the BHA. The BHASOs will be implementing them in their regions. The BHA creates rules for the entities that are licensed under the BHA. A new licensure process, that started about a year ago, currently sits with the Department of Public Health and Environment will be transitioning to the to the BHA and those rules govern those behavioral health entities, not the broader system beyond that.*

- *Seems like there are two things driving how to set up BHASOs. One of them is service delivery function and the other is regulatory function. It would make sense to have 7 BHASOs and just have them aligned with the RAEs from the service delivery function. I see the desire to consolidate because the service delivery, is largely focused on urban and that may be a problem.*
- *Circling back on a discussion of behavioral health integration, which was a topic a couple of weeks ago at a sister subcommittee, Behavioral Health Integration Subcommittee (BHIS). Hoping to have a Department SME come to the next meeting have that discussion on May 11.*
  - *It was a good discussion, but I think there are two points of view to talk about. Help define what we mean by behavioral health integration. It helps if we understand all the different models that are being used.*
  - *So much emphasis on integrating health care, but there are no appointment-based models. If you don't have a non-appointment-based model and you're not an FQHC, it does worry me about sustainability. Flexibility makes for success.*
  - *What is the funding model? Does the FFS structure support, that type of team-based care model. Or do you think it's a different sort of payment mechanism and model that needs to be able to support flexibility. It might be one of the biggest questions to think about.*
- Please see the P&CE website for the handouts/presentations for our discussions.
- Next meeting: **May 11, 2023, 8:00-9:30 A.M.**

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify Brooke Powers at 303-866-2184 or brooke.powers@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting to plan.

Acronym Key:
ACC-Accountable Care Collaborative
ARPA- American Rescue Plan Act
BHA-Behavioral Health Administration
BH-Behavioral Health
BHASO-Behavioral Health Administrative Service Organization
BUS-Binary Unit System
CBO-Community Based Organizations
CCHA-Colorado Community Health Alliance

CC-Care Coordination
CDPHE-Colorado Department of Public Health & Environment
CHCO-Children's Hospital of Colorado
CHI-Colorado Health Institute
CMA-Case Management Agency
CMS- Centers for Medicare & Medicaid Services
COA-Colorado Access
CYCHCN-Children and Youth with Special Health Care Needs
DHMP-Denver Health Medical Plan
D-SNP-Dual Eligible Special Needs Plans
FFS-Fee-For-Service
FQHC-Federally Qualified Health Centers
HCBS-Home and Community Based Services
HCPF- Department of Health Care Policy and Finance
HTP-Hospital Transformation Program
HQuIP-Healthcare Quality Improvement Platform
LTSS-Long Term Supported Services
KPI-Key Performance Indicators
MAT-Medication Assisted Treatment
MCE-Managed Care Entity
MCO-Managed Care Organization
MPH-master's in public health
NEMT-Non-Emergency Medical Transportation
NHP-Northeast Health Partners
OCL-Office of Community Living
OOS-Out of State
P&CE-Provider and Community Experience Subcommittee
PCP-Primary Care Physician
PCMP-Patient Centered Medical home
PMME-Performance Measurement and Membership Engagement Subcommittee
PMPM-Per Member Per Month
PHE-Public Health Emergency
PHQ-9-Patient Health Questionnaire
PIAC-Program Improvement Advisory Committee
RAE-Regional Accountable Entity
RMHP-Rocky Mountain Health Plans
SDoH-Social Determinants of Health