COLORADO
Department of Health Care Policy & Financing

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

May 11, 2023, 8:00-9:30 A.M.

1. Introductions & Approval of April Minutes (handout)

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

Voting members: David Keller, MD (P&CE Co-Chair, State PIAC Member), Theresa Anselmo (Delta Dental of Colorado Foundation), Andrea Loasby (CU School of Medicine/Children's Hospital Colorado), Karma Wilson (Southeast Colorado District Hospital, Pat Cook (Colorado Gerontological Society), Marc Ogonosky (Medicaid member), Angie Goodger (CDPHE), Mark Levine, MD (retired, State PIAC Member). 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), 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), Jamie Zajac (Colorado Access, RAE3/RAE5), Christina Brown (HCI/RAE 4), Marissa Kaesemeyer (COA, RAE3/RAE5), Emilee Kaminski (CHCO & University of CO Department of Peds), Jessica Johnson-Simmons (Denver Health), Brandon Arnold (CAHP), Blue Parish (HCPF), Alyson Williams (Health District of Northern Larimer County), Johnathan Savage (Care of Location), Alison Keesler (Intermountain Healthcare), Shoshi Preuss (Colorado Community Health Network), Christine Andersen (RAE4), Cassi Niedziela (OeHI), Gabby Elzinga-Marshall (OIT), John Laukkanen (HCPF), Tami Hinesh (VitalHearts), Amy Yutzy (CCHA), Lauren Phillips (HCPF), and Leanne Rupp (National Association of Social Workers-Colorado Chapter).

A quorum was established, and the voting members approved the April 2023 meeting minutes.

2. P&CE Follow-up items and Housekeeping

David Keller, P&CE CO-Chair

- Reminder: 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

- April 2023 meeting
  - Bulk of discussion was the discussion of alignment of the RAEs/BHASO regions in ACC Phase III.
    - The BHASO contract finalization moved out a year and now aligns with ACC Phase III contract.
    - Initial proposal so far is 3 RAEs and 3 BHASOs. Some of the BHASOs would have multiple RAEs.
    - Concerns expressed about the rural/urban needs and different concerns. Should be considered when developing the new RAE/BHASO geographic locations. Align by need, not geographic location.
    - These ideas are just in the proposal stakeholder stage and nowhere near finalized.
  - An Integrated Care Benefit presentation. Future discussions will happen.

4. Office of eHealth Innovation (OeHI) Social Health Information Exchange (SHIE)

Cassi Niedziela & Gabby Elzinga-Marshall, OeHI

- Social Health Information Exchange (SHIE) care coordination project is currently in the solicitation stage. OeHI tentative timeline is the SHIE contract executed by late summer 2023, and then begin a more formal discovery process with the vendor(s) to better understand current workflows and challenges.
- OeHI Mission: Accelerate technology-driven health transformation by aligning public and private initiatives to support Colorado's commitment to become the healthiest state in the nation.
- OeHI goals:
  - Equitable access to health information
  - Coordinated in-person, virtual, and remote services
  - Inclusive and innovative use of trusted health solutions
    - Patient Data Sharing 1.0: Health Information Exchanges (HIEs):
      - System-dependent
      - Analytics gaps
      - Hospital-centric
      - EHR change→ workflow reconfiguration

- Emerging needs and how SHIEs came into existence:
    - Public health data modernization
    - Patient/client empowerment
    - Automated reporting/analytics
    - Non-clinical data sources
- Patient Data Sharing 2.0: SHIEs
    - System agnostic
    - Flexible
    - Data flows when/where needed for care coordination
    - Patient-centric
- SHIE Vision
    - Two-Pronged Approach:
        - Vendor agnostic ecosystem
        - Focus on interoperability and data governance
        - Build upon existing regional successes
    - Goals:
        - Providers stay in their preferred system
        - Reduced duplication of screenings
        - Reduced burden of social care delivery
    - What's different with SHIE?
        - Case managers and providers do not need to:
            - Leave their preferred system
            - Re-screen the client or ask them to recall their full health history and recent changes
            - Request medical or other care records
                - The client has already consented to share all data in the system
    - Referral organizations do not need to:
        - Leave their preferred resource management tool
        - Ask for a comprehensive health history
        - Follow up to get more info because not enough was provided to complete the referral
        - Fax anything
    - Impact on people & families
        - Reduced:

        - Trauma
        - Duplicative services
        - Time spent on own case management
    - Improved:
        - Relationship with the safety-net system
        - Treatment outcomes
        - Access to information
- Prescribe Programs, Not Just Pills

5. ACC Phase III Stakeholder Engagement

Integrated Care Benefit proposal presented by John Laukkanen, HCPF

The term Integrated Care can be defined as merging physical health and behavioral health, in most likely a single setting. The Department has had a history of trying to merge these two, specifically in 2018 when ACC Phase 2, bringing together physical and behavioral health in one administrative organization, under the RAEs. Proposal for the Integrated Care Benefit:

- Whole person care in ACC Phase 3
- The Department would like to see distinct care considerations for members with higher acuity conditions (SMI/SUD)
- HCPF is looking to design a distinct Integrated Care Benefit (ICB) that's considers the current reimbursement structures of key PH and BH providers (i.e., FQHCs, CMHCs, PCPs, etc.) This new benefit will fold in the current Short-Term Behavioral Health (STBH) benefit (6 visits benefit). Bring both benefits together, to form 1 true benefit for Integrated Care.

History on the options considered:

- 2703 Health homes for SUD-Opted out
- ACC Phase 2 merged PH and BH under the RAEs
- The state's participation with the State Innovation Model (SIM)
    - BH Providers integrated into a PH clinic
- The implementation of the 6 Short Term Behavioral Health (STBH) benefit
- 1302 grant pilot funding to promote PH and BH integration
- Specific care considerations for high acuity conditions, serious mental illness/substance use disorder (SMI/SUD)

Proposed Approach for ICB:

The ICB will start with a mechanism to identify PH settings who are operating as IC providers

1. Behavioral Health Entities (BHEs) would stand up a PH clinic onsite/embedded in their practice (as done in SIM)

- Address the specific care needs of the SUD/SMI populations where BHE is the primary providers connected to members
- Consider the scope of BH services on member attribution here, which would give the outcome of a health home
- Design distinct metrics/outcomes for PMPM or incentives related to members with high-acuity BH conditions

2. There are multiple models of integration when adding BH services to medical settings. Distinct BH services would be added/billed in this setting and require a licensed BH practitioner who is enrolled with Medicaid be employed or contracted by the IC location

Policy Parameters:

1. The ICB is intended for early intervention, pre-diagnosis, lower acuity, and maintenance level encounters
2. There would be no limit to contacts per year. The number of contacts with a member would be determined by the member, the Integrated Practioner's, the condition being treated, and the business model of the IC setting
3. The Integrated Practitioner (medical staff or BH staff) would only see patients established (attributed members or enrolled with the practice) at the host agency (i.e., PH clinic/setting or BHE)
4. MAT services should be encouraged and incentivized in practices where it is appropriate

Payment Components:

1. The Integrated Practitioner would bill codes for each encounter. RECOMMEND SUNSETTING THE STBH BENEFIT FOR PCMPS. Replace with a full bundle of codes designed for Integrated Care Models.

   a) Adding a distinct line of business (BH) to a PH setting requires more than a PMPM or APM financial investment. This needs a distinct set of codes and a clear, identifiable billing pathway.

   b) Using billable codes directly links payment to a service provided that is trackable and has a direct financial impact to the location for those services. PMPMs alone risk being absorbed by unrelated business expenses.

2. IC Providers would participate in a PMPM for additional resources, which is linked to established care metrics.

3. HCPF would design data, metric, and outcome measures for these providers [before the benefit is created in order to determine ROI and value, etc.] and in both contexts: PCMP with BH or within BH.

4. HCPF would offer incentives (BHIP?) for the RAEs to recruit/contract with a certain percentage of IC practices.

Decisions:

- Since these services will be provided in physical health settings, the medical

services will be billed FFS [current process]. Would it be better (for cost, care, administrative burden, etc.) to allow the ICB codes to also be billed FFS? If we wanted the distinct BH encounters billed under the Cap, RAEs could be required to automatically include the ICB codes in the IC contracts. If we wanted some services covered under each (FFS/CAP) we could develop a "staircase" for this benefit to identify what and when a service is billed to each.

- How to address providers who have a cost-based reimbursement structure (i.e., FQHCs—already have a staffing and billing model for both PH/BH encounters)

Questions:

- How will the BH integration look in the frontier counties and the clinics that serve the people there?
    - There currently is a 1302 pilot funding, and the Department has heard that many rural clinics applied for the funding to help invest in integrated care.
    - Telehealth and screening for diagnosis

Please see the P&CE website for the handouts/presentations for our discussions.

- Next meeting: **June 8, 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
BHE-Behavioral Health Entities
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
CMHC-Community Mental Health Center
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
HIEs- Health Information Exchanges
HTP-Hospital Transformation Program
HQuIP-Healthcare Quality Improvement Platform
ICB-Integrated Care Benefit
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
OeHI-Office of eHealth Innovation
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
PH-Physical Health
PHQ-9-Patient Health Questionnaire
PIAC-Program Improvement Advisory Committee
RAE-Regional Accountable Entity
RMHP-Rocky Mountain Health Plans
SDoH-Social Determinants of Health
SHIE- Social Health Information Exchange
SIM- State Innovation Model
STBH-Short-Term Behavioral Health benefit
SUD-Substance Use Disorder