COLORADO
Department of Health Care Policy & Financing

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

September 14, 2023, 8:00-9:30 A.M.

1. Introductions & Approval of August Minutes (handout)

David Keller, MD, 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; Children's Hospital Colorado), Kathie Snell (P&CE Co-Chair; Aurora Mental Health & Recovery), Carolyn Green, MD (retired), Andrea Loasby (CU School of Medicine/Children's Hospital Colorado), Karma Wilson (Southeast Colorado District Hospital), Pat Cook (Colorado Gerontological Society), Angie Goodger (CDPHE), Mark Levine, MD (retired; State PIAC Member) and Marc Ogonosky (Medicaid member). A quorum was established.

Non-Voting Members: Brooke Powers (HCPF; liaison to P&CE), Callie Kerr (HCPF), Megan Billesbach (CCHA), Sabrina Voltaggio (CCHA), Crystal Brown (HSAG), Katie DeFord (CCHA), Christine Andersen (RAE4), Nikole Mateyka (CCHA), Jen-Hale-Coulson (NHP), Alyssa Rose (RAE1), Lindsey Markham (National Jewish Health), Jennifer DeBrito (Carelon), Elizabeth Freudenthal (Children's Hospital Colorado), Elise Cooper (COA), Lexis Mitchell (HCPF), Donald Moore (Pueblo Community Health Center), Chris Anderson (HCPF), Shera Matthews (Doctors Care), Kourtney Richards (Colorado Rural Health Center), Brittany Romano (COA), Jessica Zaiger (CCHA), Bill Wright (COA), Sarah Hamilton (RAE1), Jeremy Sax (DHMP), Blue Parish (HCPF), Matt Lanphier (HCPF), Abbey Sukeena (HCPF)

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

2. P&CE Follow-up items and Housekeeping

Kathie Snell, 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

- August 2023 Meeting topics
    - Behavioral Health subcommittee gave an update to the PIAC about their initiative to help people coming out of incarceration get enrolled in Medicaid. Streamlining the process for enrollment and improve access to substance abuse.
    - ACC Phase III content and discussion on the Concept Paper from the Department.

4. eConsult Platform Update

Matthew Lanphier, Emily Woessner & Abbey Sukeena, HCPF

- Overview
    - eConsults provide asynchronous (store and forward) electronic clinical communication between a primary Care Medical Provider (PCMP) and Specialty Provider.
    - eConsults allow PCMPs to submit electronic clinical questions through an eConsult platform to Specialty Providers without having to submit a referral when they feel that they cannot provide the direct specialty care a member may need during an appointment.
    - The Contract was awarded to Safety Net Connect, Inc.
    - CMS approved contract in May 2023
    - Domain name approved: www.ColoradoMedicaideConsult.com
- Timeline (Please note that the timeline is subject to change without prior notice and is only provided as a reference)
    - Fall/Winter 2023-Implementation Activities
        - HIE Integrations
        - Platform Design
        - Stakeholder Engagement
        - RAE/Provider Training
    - Winter/Spring 2024-eConsult Platform Go Live
        - Operational Go-Live: February 2024
        - HIE Integrations
        - Stakeholder Engagement
        - Provider Training
- Discussion

- HIE integration will take place before EHR integration. Single sign on means that you will have the ability to sign on to one platform and then you will be able to jump into the eConsult platform by way of the initial platform.
- A license and a sign on to the platform will be needed.
- Has the Department considered a coding and billing system through existing platforms? *Yes, it was considered and still in discussions. Possibly in future iterations of the platform. In order to be reimbursed physicians will have to use the platform, in order to receive reimbursement.*
- Duel-eligible, will they be able to access it?
- Do you have a timeline for the EHR integration? *Yes, a phased approach with 2-4 EHR integration per year. The Department will be utilizing stakeholder engagement to decipher which EHRs would be integrated first.*

5. Health Neighborhood & Community continued

Brooke Powers, HCPF

- Contract Language
- Bi-annual report templates narrative & spreadsheet
- Highlights from RAEs (Slides) All of the RAEs/MCOs gave a presentation last meeting (September 2023) except for Denver Health.
  - Denver Health:
    - FindHelp Organization: Provide an electronic community resource social care platform for their staff and patients at Denver Health and members at DHMP, in order to better meet their health-related social needs and track the referrals that are made.
    - Available on MyChart as a self-service referral option, as well as in Epic (EHR) for staff.
    - Members can use the platform, AuntBertha, when needing help to find providers and services.
    - This work helps support Denver Health's social determinants of health organizational metrics and is in alignment with the anchor institution work.

6. ACC Phase III Concept Paper Stakeholder Engagement

Matthew Sundeen and Katie Lonigro, HCPF

Stakeholder Activity Timeline

- Summer 2023
    - Concept Paper:
        - Ongoing community engagement to collect feedback and refine design.
- November 2023
    - Draft RAE Request for Proposal
        - Revise draft 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 and preparation
- July 1, 2025
    - GO LIVE!

Before the release of the Concept Paper, the Department heard:

Working Well:

- Most of the members are getting the care they need.
- Providers engaged with RAEs appreciate resources and support.
- Regional model acknowledges different parts of Colorado.
  have different needs.
- Care coordination for those who are actively engaged.
- Existing member engagement councils

What Needs Improvement:

- Process and administrative barriers
- Inconsistency across 7 regions
- Alignment with other entities in midst of statewide challenges
- Care capacity and access

- Services for children and youth

Goals for ACC Phase III

1. **Improve quality care for members.**
    - Align strategic objectives.
    - Standardize incentive payment measures.
    - Standardize children's benefit.
    - Children and youth intensive care coordination
    - Behavioral Health Transformation
2. **Close health disparities and promote health equity for members.**
    - Implement existing regional health equity plans.
    - Use equity-focused metrics.
    - Equity requirements for RAEs
    - Explore expansion of permanent supportive housing services
    - Explore providing food related assistance and pre-release services for incarcerated individuals.
    - Leverage social health information exchange tools.
3. **Improve care access for members.**
    - Clarify care coordination roles and responsibilities.
        - Create tiered model for care coordination.
    - Strengthen requirements for RAEs to partner with community-based organizations (CBOs)
    - Explore innovations to current behavioral health funding system to fill gaps in care (Behavioral Health Transformation)
4. **Improve the member and provider experience.**
    - Enhance Member Attribution process to increase accuracy and timeliness.
    - Increase the visibility of and clarity role of the RAE.
    - Reduce administrative burden on providers through BH transformation efforts.
    - Reduce total number of regions.
5. **Manage costs to protect member coverage, benefits, and provider reimbursements.**
    - Improve administration of behavioral health capitation payment
    - Improve alignment between ACC and Alternative Payment Models

- Implement new Alternative Payment Models

The Department is looking to take a deep dive and for more stakeholder engagement on specific topics.

Deep Dive: Enhance Member Attribution process to increase accuracy and timeliness.

- Members without existing PCMP relationship assigned to RAE only based on their address.
- RAEs support members in establishing care with PCMP or with engaging in preventative services.
- Expand provider types that can serve as PCMPs (such as Comprehensive Safety Net Providers)

Discussion:

1. What are the potential unintended consequences of these proposals?
2. Will PCMPs be willing and able to take on new members when RAEs identify those who could benefit from having a focal point of care?
3. How can our attributed process best meet the needs of members actively engaged in behavioral health care with minimal primary care engagement?

Feedback:

- Only about 50% of the established patients that the 4 practices at Children's Hospital sees are attributed to them. Some of the geographically attributed patients that they receive money for are attributed to them. By shifting some of the payments to the RAEs instead of the PCMPs or practices. Have the practices work with HCPF and or the RAEs on the data validation aspect when it comes to attribution. So that they can establish where the members are who they have established claims history with are attributed.
  - Leakage is a common theme. Members go back to a PCMP whom they have established a relationship with instead of the practice or PCMP they are attributed to. Or when practices get a PMPM for members that are not utilizing the services.
- The geographic attribution is making up for the members that go to the practice even though they are not attributed to the practice, that payment makes up for those members who they are treating who are not attributed.
  - The provider can still bill the State for the member.
  - The only thing that the provider can do is to tell them to call the enrollment broker and have them change their attributed PCMP.
- Has the Department considered asking the member who their PCMP is? Have we asked the members to identify who they consider to be their primary contact.

- It would be helpful if attribution dashboard was on the PEAK Website.
- A lot of the members don't know that they are attributed to a provider, a lot of members don't know what a RAE is or who there RAE is? How much responsibility do we want to put on the RAEs, to make sure that they know the answers to the questions?
- Valid arguments either way on the issue.
- As a member, attribution is not super intuitive, it is not easy to do. Messaging to members and easier pathways are necessary. Not put attribution on Members alone, allow PCMPs or practices to help the member get attributed to the provider they would like to be with.
- It would be beneficial to support the mental health members, sometimes they don't have a primary care provider. They only see their specialist.
- Behavioral health providers also need to take responsibility for the whole health of the members.
- The challenge is to understand the criteria for mental health. A partnership, care coordination with the provider that has the attribution. Total care should be considered.
- Middle adult ages—statistically don't go to a primary care physician. Flowing in the wind.
- A shared payment idea? Between Behavioral Health and PCMPs

Deep Dive: Care Coordination: Create a 3-tier care coordination model, aligned with the BHA, to improve quality, consistency, and measurability of interventions.

Tier	Target Population	Care Coordinator	Activities
Level 3	• Uncontrolled conditions • Multiple diagnoses • Multi-system involvement • Difficult to place • Private Duty Nursing • Client Overutilization Program	Clinical Care Coordinator	• Care plan • Specific assessments based on population type/need • Monthly coordination with Member/treatment team • Long-term monitoring and follow up
Level 2	Condition management (heart disease, diabetes, depression/ anxiety, asthma/COPD, maternity)	Clinical Care Coordinator	• Care plan/assessments TBD (possibly just pull from their provider) • Quarterly coordination with member/treatment team • Long term monitoring and follow up
Level 1	Anyone	Not clinical, no staffing ratio	• Brief needs screening (Health Needs Survey) • Support accessing services and benefits • Determining need for higher level of care coordination • Brief monitoring and follow up

Discussion:

1. Does the proposed three-tier care coordination model align with the current state of care coordination in your community?
    - If not, what would need to happen in your community to move towards that model?
    - What are potential unintended consequences that should be considered?

Feedback:

- The tier approach is the right way for care coordination. The needs of the family change, and flexibility is important with a tiering approach. Especially in kids, we may need to move them up or down the tier. Desire to keep members where they feel most comfortable.
- Desire for improved responsibility for sharing data and connection with the status of the patient-for those receiving care coordination. There seems to be a disconnect.
- Desire to help with the confusion in the community, who is responsible for the care coordination?

Deep Dive: Health-Related Social Needs

Explore opportunities to address members' health-related social needs.

- Support connection to food-related assistance
    - Support member enrollment in SNAP and WIC
    - Explore other opportunities (e.g., medically tailored meals)
- Explore new federal (CMS) opportunities:
    - Expand permanent supportive housing services.
    - Expanding continuous coverage for eligible children and adults
    - Pre-release services for incarcerated individuals
- Leverage social health information exchange tools.

Discussion:

1. What kind of support is needed from the RAEs to assist members with social needs?
2. What makes your current relationships with RAEs effective? What are the challenges?
3. Given limited resources, how do we clearly define roles so that there is no duplication or role confusion?

Feedback:

- Very little, if any knowledge in the rural areas to what a RAE was in hospitals. So, the community doesn't know about them either.

- Create a connection behind the scenes.
- Connections with community agencies, discussions with each other. Especially with warm handoffs of care coordination with members. Working together, team meetings.

Next steps to providing additional steps:

- Full Concept Paper is available online.
- Online survey open through October 31 — responses will be made publicly available (without names)
- Open feedback form will remain open through April 2024

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

- Next meeting: **October 12, 2023, 8:00-9:30 A.M.**

Reasonable accommodation 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
CDHS-Colorado Department of Human Services
CDPHE-Colorado Department of Public Health & Environment
CHCO-Children's Hospital of Colorado
CHI-Colorado Health Institute
CHRP-Children's Habilitation Residential Program
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
QRTP-Qualified Residential Treatment Program
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