COLORADO
Department of Health Care Policy & Financing

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

Colorado Department of Public Health and Environment
4300 Cherry Creek South Drive, Building A, Room A2A
Denver, CO 80246

February 13, 2020, 8:05-9:30 A.M.

Participant Dialing Instructions:
Video URL: meet.google.com/aqi-qndk-fxs
Call-in: 240-490-4583
PIN: 534 985#

1. Introductions

Anita Rich, P&CE Chair, 5 minutes (8:05-8:10)

In Person:
Anita Rich (PC&E Chair), Brooke Powers (HCPF), Kate Mortenson (CCHA), John Salvino (COA), Keri-Ann Rugg (CDPHE), Lila Cummings (CHA), Becky DiOrio (CDPHE)

On the Phone:
Matthew Jacobs (HCPF), Andrea Skubal (CCHA), Andrea Loasby (CHCO), Dede de Percin (MHHA), Elina Navarro (COA), Carlos Madrid (Kaiser Permanente), Lisa Harrison (HMA), Carl Brimner (Healthcare Consultant), Louisa Wren (RMHP), Wendy Nading (TCHD), Ben Harris (HCPF), Suprena Crawford (DentaQuest), Joanna Martinson (NCHA), Jamie Haney (STRIDE), Tammy Arnold (Northeast Health Partners), Vicente Cardona (Mile High Health Alliance), Jared Bateman (HCI), Katie Price (Primary Care Partners), Allison Kessler (SCL Health), Cathryn Griffith (family of Medicaid member), Shera Matthews (Doctors Care), Jessica Zider (CCHA)

Voting Members:
Anita Rich (PC&E Chair), Cathryn Griffith (family of Medicaid member), Shera Matthews (Doctors Care), Lila Cummings (CHA), Jamie Haney (STRIDE), Wendy Nading (TCHD)

2. Approval of Minutes from January Meeting (handout)

Anita Rich, P&CE Chair, 5 minutes (8:10-8:15)

- Anita Rich solicited a motion for approval of the January Meeting Minutes. A concern was expressed regarding a typo of "NAME" under the list of attendees. The word "NAME" was listed where a participant was not clearly identified. Anita provided an

opportunity to express if anyone was missed, but no one claimed to be this participant. The meeting minutes were approved without revisions or abstentions.

3. State PIAC Update

Dede de Percin, State PIAC member 5 minutes (8:15-8:20)

- Focus was largely around where the Department (HCPF) is moving on Key Performance Indicators (KPIs) and working with the RAEs. Also, the approach to complex care condition. Overview of the allocation of money that comes from KPI incentives along with money that is not earned which moves into a flexible performance pool. If all the RAEs earned the top Tiers for their KPIs, then all that money would be gone, but that doesn't happen. Overflow of the KPIs not earned goes into the Performance Pool. The Performance Pool is used by HCPF to deploy incentives that are a little nimbler and more responsive to what is currently going on and HCPF's priorities.
- Wendy – HCPF did a great job reporting on enrollment numbers across the state that Matt Lanphier put together. It helps provide a better understanding to the decline in Medicaid. This document is on the website under the January PIAC Meeting within the Operational Dashboard link.
- Shera shared how HCPF is going to study the decline and report findings in the next 2 months.
- Dede shared how major changes to the KPIs have been pulled back with a focus on the Performance Pool priorities to include high cost patients, potentially avoidable costs, and areas where HCPF plans to focus time and energy. Reiterates how there is a lot of material in the presentation and encourages everyone to take a closer look.
- Anita reiterates where to find the meeting agenda, minutes, and supplemental documents on the website.
- Dede provides two updates:
    - Hospital Transformation Program (HTP)
        - Public comment period closed February 9th.
        - Centers for Medicare and Medicaid Services (CMS) has posted a Medicaid Fiscal Accountability Rule (MFAR) which could have an impact on the mechanism that creates dollars for HTP.
        - The Governor's office and CHA both submitted comments on the MFAR.
    - In March, Tracy Johnson (HCPF Medicaid Director) is scheduled to present the Payment Error Rate Measurement Audit (PERM) to the PIAC.
        - CMS has set a benchmark rate of 3% and if states do not meet this benchmark, CMS will take back Medicaid dollars.
        - Colorado's PERM audit ended June 30th, and this report may be out by March.
        - Concerns with 3% being unattainably low.
        - **Question** – do you we know how many dollars 3% affects? Dede responds with we do not know as this is new. Concerns with error

rate being consecrated as fraud when they are different. Overall this benchmark addresses a waste in taxpayer money; however, an error may sometimes reflect an error somewhere in the process.
- Hospitals are already receiving PERM audit requests for additional information.
- Ben Harris - scheduling challenge for Tracy in March, and as a result, will be presenting to PIAC next week, February 19th.

4. Follow-up to prior Discussions/Action Items

Anita Rich, P&CE Chair, 10 minutes (8:20-8:30)

- P&CE Tracking document & Quarterly report to State PIAC
    - Anita plans to report out to PIAC next week on the workgroups and voting membership.
    - Brooke shares that Anita will be reporting out to PIAC the first week of each quarter. Brooke also reiterates the goal of improvement is geared towards the Accountable Care Collaborative (ACC) program improvement.
- P&CE Voting Membership
    - According to charter, if a member doesn't attend at least 75% of meetings, the member is at risk of losing voting privileges. Also, a member cannot be a voting member of more than one PIAC subcommittee. P&CE needs additional members with an interest to be voting members. Specially looking for Oral Health, Pediatrics, and Long-Term Services and Supports. Senior Health and Behavior Health representation is also a need.

5. Care Coordination in the ACC

Ben Harris & Brooke Powers, HCPF, 30 minutes (8:30-9:00)

- Presentation
- Review of HCPF mission and level set ACC pillars and focus areas.
    - Pillars: a) Medical Home, b) Behavioral Health, c) Regional Coordination, and d) Data.
    - Focus Areas: a) Department focus on member health improvement, b) Governor's health care affordability, and c) Medicaid Cost Control goals.
- Discussion of the care coordination evolution – four quadrants stratification to a pyramid model. Shifting from evaluating two variables, Behavioral Health and Medical, within a four-quadrant stratification to holistically looking at populations

across the state with an emphasis on acute, complex, and high-risk, high-cost patients.

- Pyramid model addresses the need to have a comprehensive understanding of the stratified population. Three tiers of pyramid from top to bottom: a) Complex Care Management, b) Condition Management, and c) Prevention Support and Resources.

- **Question** – Do you have a percentage of what the cost populations are across each pyramid tier? Working with RAEs to identify who is at the top through a risk stratification and definition. Middle tier is fairly straight forward because of the use of disease codes. Anyone who doesn't meet the top two tiers will automatically fall into the bottom tier. The bottom tier will likely encompass approximately 80% of the population. The middle and top tiers portray variations. Middle tier has reported anywhere from 13% to 17% while the top tier ranges from 3% to 7%. It will be interesting to watch this evolve as new dimensions are added and from the RAEs' feedback on what they are seeing in their community.

- **Question –** How do the interventions addressed in Prevention Support and Resources skew numbers in other areas? Discussion of the need to address Prevention Support and Resources, such as social supports, that may place an individual into the top tier if not addressed (i.e. housing). Important to understand why social screenings aren't being done. Dede reiterates some of the reasons why providers may not be conducting socials screenings. For example, interventions may not be readily available. Ben expresses the importance of the RAEs' Health Neighborhoods development to be that connection across systems. As a result, a provider should not feel uncomfortable about screening because their RAE potentially has a relationship with a community partner that can address social needs. The Department is also striving to bring in other data sets to inform the RAEs and their work. For example, collaborating with the Department of Corrections (DOC) and the Department of Housing (DOH) to better evaluate this type of risk. Dede reiterates why providers may avoid screenings for issues that are currently not solvable. The network may not be the issue, but more so a lack of resources.

- Carlos expresses caution with conflating the absence of data about social screening with the absence of social screening taking place. We often rely on claims and coding to identify activity and unsure if we have enough incentives to code correctly while submitting claims for screening activities. As a result, we may be underestimating the extent of this occurring.

- Brooke addresses expectations of the RAEs when delivering effective care coordination for members across each tier.

- **Question –** Lila shared how In June 2019, HCPF started the inpatient hospital review program, so prior authorization for inpatient surgeries or any inpatient admissions which is an industry standard – modernizing Medicaid. Hospitals are

currently submitting on day four of an inpatient stay on current case review. What are RAEs doing with this information and if this is being used? The system/technical portal is cumbersome. If there have already been specific diagnoses in the ACC that RAEs are focusing on, is there really more opportunities on just those specific diagnoses or what needs instant review from the hospital side? Brooke expresses how HCPF can certainly ask the RAEs to address this. Lila shares that maybe the RAEs aren't using this information because changes are coming.

- Anita reiterates the importance of a shared responsibility between the RAE, providers, and other entities to conduct care coordination. Good communication is key across all parts of the system. Brooke reiterates the importance for RAEs to share what is working and best practices with one another. Ben reiterates the importance of RAEs sharing best practices regarding communication across systems. Brooke also adds how there is a lot to focus on and the advantage of focusing efforts to achieve actionable and achievable items.

- Joanna – without addressing the social determinants of health in a very broad sense. Yes, housing is huge, but there are also many issues that screenings pick up. Impact of social determinants makes a big difference in assisting the top tier and at a preventative level. Addressing social determinants at a preventable level prevents members from moving up on the pyramid.

- Becky shares programs already in place through CDPHE to support RAEs for diabetes members under the condition management tier.

- Shera – concerns with figuring out who these people are. **Question** – Is there something more concrete to utilize when identifying members and receiving information on them outside of our own clinical records? Ben shared how each RAE addresses this differently and this data is available at the RAE level. Not shared with everyone due to concerns with HIPAA.

- Joanna – found that collaborative agreement plans really help care managers in complex situations.

- Evolution of the ACC program and need for community feedback. This is a starting point and not the ending point.

- **Question -** Can anyone speak about data points? RAEs report on population breakdown quarterly. Also, looking into how RAEs are allocating their financial resources towards interventions. Discussion of RAE deliverables that address care coordination.

- **Question** – Was there any discussion of pediatric preventable measures for children under the care of complex patients? Still a little uncertain about how to go about this but will be able to provide a breakdown of cost and member by demographics between peds and adults. Looking at particular populations

initially. For example, looking at children in the welfare system and what they are experiencing. Have not yet made a broad connection to other adult groups or adult cohorts that because of their risk factors may affect their children. One that comes to mind is individuals that come out of state prisons and the impact on a family's well-being. Ben encourages providing recommendations as we delve into exploring these areas.

- Anita shares the importance of differences between child and adult care coordination.
- **Question** – Was pediatric asthma included? Yes, it is there.
- **Question** – What is the thinking around providers identifying complex members? Recommendation for high cost members be flagged rather than being on an ad hoc list. Ben shares how HCPF is exploring different system change requests to support this concern.

6. Subcommittee Objective Areas/Next Steps/Workgroups

Anita Rich, P&CE Chair, 20 minutes (9:00-9:30)

- Access to Specialty Care Work group
    - Need more people and a co-chair, currently only have four volunteers.
    - Lila discussed the scope of work and next steps of the group.
        - Understanding the data sources for access to specialty care.
    - Overview of CMS listening session to monitoring access to care.
- Creation of Care Coordination Work group
    - Joanna is interested in leading but requested a co-chair to help.
- Within the next 10 days, email Anita to volunteer to participate in workgroups.
- Another work group meeting prior to next P&CE meeting and will report out.

Next meeting: March 12, 2020, 8:00-9:30 A.M.
Colorado Department of Public Health and Environment

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 make arrangements.