COLORADO
Department of Health Care Policy & Financing

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

January 13, 2022, 8:00-9:30 A.M.

1.Introductions & Approval of December Minutes (handout)

Kathy Snell, P&CE Co-Chair, called the meeting to order and Brooke Powers, Health Care Policy and Financing Department (HCPF) took voting member attendance. The following people were in attendance:

A. **Voting members**: Joanna Martinson (P&CE Co-Chair, KPJ First Services), Kathy Snell (Aurora Mental Health Center), Anita Rich (Retired/Community Member), Jennie Munthali (Colorado Department of Public Health and Environment (CDPHE), Carolyn Green, MD (retired), Shera Matthews (Doctors Care), Michelle Hoy (Mind Springs Health), Pat Cook (CO Gerontological Society (CGS)), Andrea Loasby (CU School of Medicine & Children's Hospital Colorado) and Marc Ogonosky (Health First Colorado Member). A quorum was established.

B. **Non-Voting Members:** Brooke Powers (HCPF, liaison to P&CE), Callie Kerr (HCPF), Jessica Zaiger (Colorado Community Health Alliance (CCHA)), Nikole Mateyka (CCHA), Elaine Wood (Community Options-CCB (Community Centered Boards)), Rejan Ricottone (Pueblo County-SEP (Single Entry Points agencies)), Linda Byers (NW Options for Long Term Care), Katie Mortenson (CCHA), Brent Basham (Mountain Valley Developmental Services), Angie Goodger (CDPHE, Children& Youth with Special Health Care Needs Section), Angela Berry (Kit Carson/Cheyenne/Lincoln SEP), Dede de Percin (Mile High Health Alliance (MHHA), Jennifer McIntyre (Developmental Pathways), Rachel Artz-Steinberg, CCMCN), Diane Seifert (RAE 7), Kidron Backes (HCPF-Office of Community Living (OCL)), Julia Duffer (Health CO), Dyann Walt (Rocky Mountain Health Plans (RMHP)), Andrea Skubal (CCHA), Nicole Konkoly (RMHP), Delaine Dunning (RN, Prowers/Baca OLTC-SEP), Donald Moore (CEO-Pueblo Community Health Center), and Sara Gallo, PA-C.

Kathie Snell asked for a motion to approve the December 2021 Meeting Minutes, through a poll. A quorum was established, and the December 2021 meeting minutes were approved.

2. P&CE Follow-up Items and Housekeeping

Joanna Martinson, P&CE Co-Chair

- Open voting member for a hospital representative. The P&CE subcommittee will follow HCPF's PIAC membership/procedures. The application has been posted. The

committee encourages, those who represent a hospital who currently participate in the P&CE meetings to apply for the hospital open voting member seat. The application can be found here.

3. STATE ACC PIAC-UPDATE

Joanna Martinson, State ACC Program Improvement Advisory Committee (PIAC) member.

Joanna suggested that attendees visit the ACC PIAC Website; there is a lot of valuable information located on the website, including the minutes from the PIAC meetings as well as handouts.

- No new updates on the end of the PHE as of the January 13th meeting. The renewal packet is being revised for Medicaid members to fill out for redetermination of benefits. If you have contact with members, please remind them to give HCPF their correct address. If the correct address is not on file, then they will not get the redetermination pack in the mail and it could prevent members continuing with their benefits.

- Aaron Green the new EDI Officer presented at the PIAC meeting and it was extremely informative and helpful. Joanna encourages everyone to look at his presentation on the PIAC Website.

    - The new EDI Officer position evolved from Governor Polis's executive order, D2020-175. The guiding principles that were discussed were that they are value driven, has intentionality for what is desired for our members, data driven, and based on collaboration.

    - Aaron Green spoke of his role and scope and where he wants to go with this program and his department which aligns nicely with HCPF's vision and PIAC's vision. Which in turn trickles down to the other subcommittees. Ultimately it includes: Decreasing disparity and inclusion for all members.

    - The presentation can be helpful if anyone else is giving a presentation. It includes definitions, so if your definitions align with the Department, Aaron Green has laid it out very nicely. We would love to have him at one of our meetings.

- Colorado Access (COA, Regions 3 and 5) did a nice presentation on their priorities and challenges.

- The Behavioral Health and Integration Strategies subcommittee (BHIS) gave a presentation on their updates on their priorities, which is utilizing their membership as experts to monitor and improve their previous initiatives such as Crisis Service Recommendations. There second priority is access and engagement, looking at best practices, opportunities, and recommendations for improving the overall behavioral health program and access to the ACC. And the behavioral health reform to provide expertise at the Statewide level

for the initiative. The things they continue to work on is the Department of Corrections (DOC) metrics and initiatives to expand. Opportunities in access for youth and children. In the future they want to go to the workforce.

- Pat Cook brought up a redetermination letter that was sent to members and was concerned about how the letter read. Members were calling her concerned that their benefits may be affected soon. Brooke asked for someone to send her the letter, and then she can distribute it to the group.
    - Dede de Percin said that she doesn't believe that the new redetermination package was sent out yet, just information that Colorado was developing a new redetermination package and there are a few more hurdles to get redetermination done, including a wet signature.
- One of the big requests that the PIAC committee has made of the P&CE subcommittee is to look at the workforce issues from the behavioral health lens and what other scopes of work that impact the members and the ACC.
    - Brooke put together a survey for the P&CE meeting, that was shared with everyone on the meeting today. There is an opportunity to provide PIAC and in turn the Department helpful information. The hope is to prepare a report that is helpful in decision making on what direction can the ACC go in helping some decisions or recommendations or programs. The PIAC would like to look at the surveys, so that they can understand the challenges on each of your perspectives from the workforce. What barriers, locations? Cause and effect. What are the recommendations for short term, median term, and long-term solutions?
    - Kathy Snell reminded attendees that this survey has been asked of P&CE and BHIS, so in this subcommittee we will address the primary care side more.
    - The survey is open ended, and the survey results will be shared at the next PIAC meeting on January 19th. Twenty minutes was given during the meeting for people to fill out the survey and it will be closed at noon.

4.Care Coordination

Kidron Backes, Management Care Coordination Specialist Case, OCL, HCPF

American Rescue Plan Act Information sites: ARPA MEMO, ARPA Newsletter, ARPA Press Release

Presentation for level setting on the Long-Term Services and Supports and Case Management Agencies (LTSS/CMAs) and Waivers

Core CMA Responsibilities

- Determine eligibility for long-term services and supports (LTSS)

- Develop and monitor Service Pan
- Coordinate long-term services and supports
- Aid in determining appropriate services and level of care
- Assist individuals in identifying the waiver that best meets the needs
- Assist in identifying necessary supports in service planning regardless of funding source, tied into the community.

CMA responsibility to the member

- Determine level of care for functional eligibility to access Home and Community Based Services (HCBS) waiver services
- Assist with development of a service plan
    - Assessed needs
    - Assessed goals
- Help members navigate the LTSS system and understand all their service options to make informed choices
- Help connect members with providers
- Maintain contact with members regularly and monitor and adjust services as needed according to the member's changing needs.

Accountable Care Collaborative (ACC)

- Four main goals:
    - Expand access to comprehensive primary care
    - Ensure access to a focal point of care for all members (medical home)
    - Ensure a positive Member and provider experience
    - Apply an unprecedented level of statewide data and analytics functionality

ACC Phase II

Focus on the following objectives:

- Join physical and behavioral health under one accountability entity
- Strengthen coordination of services by advancing Team-Based care and Health Neighborhoods
- Promote member choice and engagement
- Pay providers for the value they deliver
- Ensure greater accountability and transparency

Regional Accountable Entities (RAEs)

- 7 RAEs across the state assigned to geographic regions
- Care coordination focuses on patients with acute, high-risk, and complex needs,

but available to all members

- Models vary across RAEs—care coordination can be provided by a RAE or delegated to partner (e.g., PCMP, Integrated Community Care Team, etc.)

Core RAE Responsibilities

- Develop and maintain network of Primary Care Medical Providers (PCMP) to serve as a medical home for members
- Develop and maintain statewide network of behavioral health benefit
- Onboard new members
- Promote population health initiatives and member engagement
- Coordinated care for members across health neighborhood and community to address whole-person health
- Utilization management of covered behavioral health services
- Ensure that care coordination is available to members across health neighborhood and community to address complex needs

CMA and RAE Intersection

Care Coordination

- Aligned with Population Management Framework
- Deliberate and organized activities to support health and social services
- Care Coordination should not duplicate services through LTSS and HCBS Waivers
- Coordination should address care transitions between health systems
- Collaborative efforts between providers, social, educational, justice, and other community agencies. A complete wrap around between CMAs and RAEs, utilize resources together

Future Plans

- Training, communication, and coordination at HCPF and for all community partners.
- Leverage ARPA funding to identify:
    - Definition of Best Practices regarding Case Management/Care Coordination
    - Identify and solidify roles of collaboration for RAEs and CMAs serving the same member
    - Create a new Care Coordination Collaboration system and measure outcomes for members
- Stakeholder engagement

Discussion

- Shera Matthews expressed concern over the amount of complex care patients that PCMPs are seeing now, and the lack of specialty care providers that are available for those patients. Kidron spoke to the ARPA projects that are going to align with those concerns and hopefully find some relief for the PCMPs.
- Pat Cook would like to be involved when a third-party vendor comes in, especially with the gerontological population. Subcommittees will be leveraged for the stakeholder engagement; The Department will utilize the current meeting spaces.
- Donald Moore asked for any insight on hospice for members and if they are integral in LTSS. Pat Cook said that people who are dual-members, Medicare/Medicaid don't usually run into problems, but those who only have Medicaid or who are on SSI Pension run into problems finding them services. Agencies in rural, often won't take Medicaid patients. Pat Cook would like to help close the gaps and develop an informational booklet that would answer all questions pertaining to how programs are paid. People think that if they have a waiver, hospice is covered, which it is not.
- Anita Rich would like to see an emphasis on prevention of complex needs along with an emphasis on members who are already dealing with complex needs.
- Nikole Mateyka (CCHA) spoke on how prevention is key for early intervention. How they are addressing it is to try get people integrated in care coordination. Addressing them not only on the physical health side, but on the behavioral health side and all sides.
- Anita Rich suggests that we include "prevention" within the definition of care coordination. The language needs to read the preventative part of care, get people in for their well-ness visits. Prevention is important, early intervention. *Kidron pointed out the fourth deliverable (below) "Cross-Agency Person Centered Facilitation and Planning"—Although it is not spelled out, this deliverable directly correlates with prevention. The ARPA Department recognizes the need for the preventative side of healthcare.

Kidron presented a loosely proposed (not exact) timeline: ARPA "Best Practices Project" is hoping to align the RAE responsibilities and CMA responsibilities with the care coordination definition and case management definition. Currently in Phase 1 of the timeline.

- Contract Procurement: 1/30/2022
- CM Redesign/ACC 3.0: 1/1/2023-12/31/2023
- Environmental Scan: 6/30/2022
- Stakeholder Engagement-PIAC/MEAC: 6/30/2022
- Case Management and Care Coordination Core Competencies: 6/30/2022
- Cross-Agency Person Centered Facilitation and Planning: 6/30/2022
- Roles and Responsibilities Crosswalk: 6/30/2022

- Cross-Agency Documentation (Agency association, comorbidities, high support need): 6/30/2022
- Identification and Recommendation of Rule and Contract Changes: 6/30/2022
- Rule and Contract Changes: 6/30/2022
- Efficacy of Pilot: 6/30/2022
- Pilot Development and Training: 7/1/2022-12/31/2022
- Implementation and Payment: 1/1/2023
- Evaluation and Assessment: 1/1/2024-6/30/2024

Kidron encourages people to please come to the meetings and invite others to the meetings. We need all the input for the projects, and we welcome all to come. Sign up here.

Next meeting is on February 10th, 2022 from 8:00am to 9:30am