COLORADO
Department of Health Care Policy & Financing

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

August 10, 2023, 8:00-9:30 A.M.

1. Introductions & Approval of June 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), Kathie Snell (Aurora Mental Health and Recovery), Carolyn Green (Retired Physician), 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), 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/RAE6), Jen-Hale-Coulson (NHP/RAE2), Alyssa Rose (RAE1), Lindsey Markham (National Jewish Health), Jennifer DeBrito (Carelon), Elizabeth Freudenthal (Children's Hospital Colorado), Elise Cooper (COA), Aaron Green (HCPF), 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), and Blue Parish (HCPF)

A quorum was established, and the voting members approved the June 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/State PIAC Member

- June 2023 meeting
    - Recommendations for well-childcare that came out of the PMME.
    - Review of the BHIS data, shows an uptick in BH services since COVID. Harder to get follow-up care from the ED.
    - Overview of the Legislative session that just ended
    - PIAC took July 2023 off

4. HCPF Health Equity Plan Update

Aaron Green, HCPF Slides

- Health Equity Plan Updates
    - Health Equity Dashboard is LIVE! (Department use only at this time)
    - Health Equity Plan Measure Specification Documents
    - Health Equity Measures have been shared with RAE/CHP+ Plans
    - RAE/MCO/CHP+ Health Equity Plans due to the Department December 31, 2023
    - Statewide Health Equity Task Force (convening since July 2022)- Recommendations to HCPF by Q1 2024
    - Health Equity Public Town Halls (2000+ stakeholders, On track for 18 by October 2023)
    - The Department continues to explore and improve alignment in our policy goals and incentive metrics (Possible changes for FY24/25)
- Health Equity Priorities

  In addition to current health equity short term and long-term goals and projects, the Department will move forward with the following 7 concepts:
    - Changes to Medicaid Application
        - Changes include optional self-identification questions.
        - Provide capability to identify and make informed program/policy & investment decisions
        - Improve access to quality demographic data.
        - Include a more robust ability to stratify data by race/ethnicity, gender identity, sexual orientation, language, and housing status.
        - Proposed questions are added to online and paper applications by October 2024.
        - Current programs or resources: Quality Data Team, Need:

Proposal dependent on collaboration and support of CDHS partners (pending), CMS Approval TBD.

- Spanish-Speaking Maternity Advisory Council (MAC)
    - Inform policy for pregnant and birthing people who speak Spanish.
    - Help identify what is working.
    - Provide recommendations to help improve member experience.
    - Focus on Prenatal and postpartum access to quality care.
    - Current programs, resources or needs: English-speaking MAC; As this group is developed, they will help inform the Department on challenges, opportunities and policy initiatives in this space.
- Prescriber Tool, Phase III
    - Empower providers with information on prescription drug costs and affordable alternatives for members.
    - Improve and enhance the utilization of the tool, Opisafe Module.
    - Increase outcomes for members and reduce disparities.
    - Current programs, resources or needs: Currently accessible through most electronic health record (EHR) systems; Tool is not mandatory at this time; Office of eHealth Innovation (OeHI) and HCPF in the process of phase III bidding; We have designed the Prescriber Tool APM which will give incentive payments from a shared savings pool generated by the tool. It is scheduled to start in July 2023.
- Comprehensive Behavioral Health Providers.
    - Improve ability to screen for social determinants of health.
    - Demonstrate consistent use of validated screening tools.
    - Referrals to support resources (and in some cases, immediate access to care).
    - Current programs, resources or needs: Identifying additional domains.
- Chronic Care Management & Preventative Care
    - Childhood Immunizations
    - Adolescent immunizations
    - Dental Care and Oral Health
    - Improve Diabetes HbA1c Control
    - Providers to screen for preventative care

    - Current programs, resources or needs: Plans due December 31st (FY23/24)
- Equity Study for People with Disabilities
    - Internal Data Analysis
    - External Feedback and Recommendations
    - Implementation Planning
    - Improve access to Home and Community-Based Services (HCBS)
    - Stakeholders currently in process; Sustainability Plan: Upon completion of the Equity Study, the Department will consider the options to operationalize inclusion efforts.
- Tribal Relations and Health Equity Study
    - Research and stakeholder interviews
    - Explore Medicaid best practices, challenges and opportunities
    - Focal point to supporting health care access and outcomes for Tribal Nations and American Indians/Alaska Native enrollees.
    - This study will investigate specific areas of best practices, such as benefits, delivery system, eligibility, care coordination and other areas that impact access and outcomes for Tribal members with a large focus on exploring how other state Medicaid programs serve this population.
        - This information will be used to inform future efforts to improve Colorado Medicaid's support and focus on disparities this population experiences, who has suffered from historical traumas and inequities that the Department is committed to addressing.

- Community Engagement

  Task Force

    - 60+ Ambassadors across the state; 5 workgroups
        - Access to Care, Prevention, Behavioral Health, Maternity, Vaccinations
    - Provide specific recommendations to the Department and engage in health equity-related initiatives and policy. Due Jan/March 2024

  Town Halls

    - 18 focused public stakeholder events in the community by October 2023
        - ~2,000 stakeholders, target populations include Black/African American, Asian American Pacific Islander, Disability, Hispanic/Latino, American Indian/Alaska Native

- Overall Measurement of Success
    - Alignment with Health Equity Commission and other State Department Efforts.
    - CMS Medicaid Quality Core Measures - enhance ability to report.
    - Focus on preventive services, perinatal care, behavioral health, and immunizations (includes COVID as well)
        - Gap closure methodology (regional vs. statewide metrics)
        - Leverage initiatives that measurably reduce disparities
        - Increased access to quality care for all members, reduced cost and affordability
    - Timeline around progress: FY 23/24, Monthly updates from Subject Matter Experts, Project leads (Status 6/30/24)
    - Version 2 Report Published by June 30, 2024
- Questions/Feedback
    - Read the Maternal Health Equity (MHE) report
    - The data that the Department is hoping for will be relevant, and we will be able to get a data rollup. The hope is for the data lag will not be too far out and will be able to be useful.
    - Right now they are looking at the data to see if there can be a breakdown of the demographics of all of the attendees of the Health Equity stakeholder meetings, to be able to supply that information to those who would like to look at it.
    - Exploring with the BHA the gaps with clinicians in rural areas be available. Incentives, investments, conversations—so that members don't have to drive hours to get supportive services. How can we broaden that area?
    - Adolescence aging out—outline different strategies. How can we leverage policy and mechanisms as people age out and how can we make sure that members don't fall through the cracks. We look forward to those strategies get outlined in our next published report.
    - Concerns over pediatric vaccine in rural areas, there is no one to give vaccines. There is a gap in the vaccines not happening—sometimes members must go 50 miles—which can be unattainable. There may be a lag in places available for children to get vaccinated which will impact vaccine coming out with children. Some hospitals are trying to cover the gap. Unsure of other counties that are in the same boat?
    - The Department is open and expects collaboration with the stakeholders with equity lenses. What is the mutual beneficial partnership that the Department is creating? A targeted and genuine strategy is a hope for the

Department and being forward thinking. Going out into the community and developing ways that we can get them their needs met. The Department is dedicated to fulfilling members' needs.

5. Health Neighborhood & Community

Brooke Powers, HCPF

- Review of contract Language
- Bi-annual report templates narrative & spreadsheet
- Highlights from RAEs (Slides)
    - RAE1:
        - Colorado Specialty Care Connect (CSCC): Advancing the curbside consult to improve care.
            - Improving care with PCP and Specialty Providers. Use a tool for a specialty provider for next steps of care. Can create a enhanced referral that can be accessed by the PCP and the specialty provider.
            - Keep care local: collaborating with local providers and that be the 1st choice for receiving and answering eConsults generated Primary Care Providers. Through a partnership with Confirmed, actively developing a Colorado Networks of Specialty Reviewers available to answer your eConsult questions.
            - Structured Reimbursement: Primary Care Providers can bill RMHP for CPT code 99452 for this service and be reimbursed at 1.04 RVU rate per Medicare Fee Schedule. Specialty Care Providers will be reimbursed at a per eConsult rate managed by Confirmed.
            - Specialized training: Specialty Care Providers will train in workflow design and best practices for answering eConsults. Primary Care Providers will be trained on the CSCC platform, provided suggested workflows to integrate eConsults into daily practice and will have ongoing support.
    - RAE2:
        - Wide variety of community liaisons and partnerships, we group in 4 categories, but often they are fluid.
            - Clinical Partners: The Hospital Transformation Program (HTP) has really pushed forward the Clinical Partners with the Eastern Hospitals in general. Developing better workflows, especially with the members who have been

seen in the ED or higher levels of care, to ensure there aren't any rapid re-emissions.

- Non-Clinical Partners: SEPs/CCBs, different county partnerships
- Community Partners: Ambassadors to ensure that health equity goals are being met.
- Oral Health Partners: Dental at Your Door, Dentaquest partnerships.

- RAE3/RAE5:
  - Access Health Connections Program (AHC)-Multi-year partnership between hospitals and primary care providers those incentives improved transitions of care specifically for in-patient stays where the diagnosis in a chronic condition. Practice support is working with primary care providers and collaborating with peer learning. Collaborating and community engagement.
- RAE4
  - Health Neighborhood Strategy Highlights:
    - Community Reinvestments Grants:
      - Dental, Well Visits, Condition Management, Maternal Health, Behavioral Health and SUD Access, Support and Recovery, and SDOH. Grants 2022 and 2023 HCI invested over $2 million dollars across 30 organizations.
    - Specialty Care Strategies:
      - Diabetes PCMP Work Group
      - Hospital Transformation Program (HTP)
      - Performance Measure Action Plan (PMAP) Workgroups
    - Care Coordination:
      - Improved notification and communication workflows with providers
      - Standardized Condition Management programming
      - The Care Navigation tier targeted at members with conditions who have key care gaps.
- RAE6/RAE7:
  - Community Incentive Program (CIP)-Through financial support of community organizations, CCHA's Community Incentive Program (CIP) aligns the health neighborhood with the goals of the ACC &

provides Social Determinates of Health supports to members.

- Since the program's inception in 2019, CCHA has had 49 Awardees across 8 counties with a total of $6.8 million awarded over 4 years. Awardees implement their proposals during the next calendar year. Based on the amount, organizations report back on a quarterly, semiannual or annual basis.
    - 2022 highlights: 22 Awardees, $1.4 million; spread across Behavioral Health Focus, Physical Health Focus, Education & Training Focus, System Improvement Focus and Social Determinates of Health Focus.
    - 2023 highlights: 34 Awardees, $2.9 million; across both regions with programs focused on PHE unwind activities, Diversity, Equity, and Inclusion (DEI) activities, behavioral and physical health access, supports and services for children & families, and social determinants of health (SDOH). These programs began implementation in January 2023.

- Denver Health:
    - FindHelp Organization: Provide an electronic community resource social care platform for our 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.
    - This work helps support Denver Health's social determinants of health organizational metrics and is in alignment with the anchor institution work.

6. Open Discussion

- Health Neighborhood conversation to continue at the next meeting, Denver Health will present.

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

- Next meeting: **September 14, 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