COLORADO
Department of Health Care Policy & Financing

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

May 12, 2022, 8:00-9:30 A.M.

1.Introductions & Approval of February and April Minutes (handout)

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

A. **Voting members**: Joanna Martinson (P&CE Co-Chair, KPJ First Services), Carolyn Green MD (Retired), Jennie Munthali (Colorado Department of Public Health and Environment (CDPHE), Pat Cook (CO Gerontological Society (CGS)), and Andrea Loasby (CU School of Medicine & Children's Hospital Colorado). A quorum was not established, the minutes for February, April, and May will be voted on at the next meeting in June.

B. **Non-Voting Members:** Brooke Powers (HCPF, liaison to P&CE), Callie Kerr (HCPF), Erin Herman (HCPF), Nikole Mateyka (Colorado Community Health Alliance (CCHA) Regional Accountable Entity 6 (RAE 6)), Jen Hale-Coulson (NHP/RAE2), Donald Moore (Pueblo Community Health Center), Audrey Oldright (Rocky Mountain Health Plans (RMHP/RAE1), Nicole Konkoly (RMHP/RAE1), Courtney Phillips (HCPF), Matthew Wilkins (Health Solutions/Health Colorado/RAE4), Tina Gonzales (Health Colorado/RAE4), Katie Mortenson (CCHA, RAE 6&7), Ashley Clement (NHP/RAE2), Diane Seifert (CCHA/RAE7), Brittany Hampton (CCHA/RAE7), Brandon Arnold (CAHP), Emily DeFrancia (COA), Megan Comer (HCPF), Brittany Deyoe (HCPF).

2. P&CE Follow-up Items and Housekeeping

Joanna Martinson, P&CE Co-Chair

- Reminder: 2 open voting member seats, 1 for a hospital representative and 1 for a behavioral health representative. The P&CE subcommittee follows HCPF's PIAC membership/procedures. The application has been posted. The committee encourages, all of those who currently participate in the P&CE meetings to apply for both of the open voting member seats. The application can be found here. Both of the voting member seats have been open for a few months now, we are looking forward to filling the position. This coming year is going to be really interesting, especially with the care coordination and the eConsult project. Please reach out with any questions.

3. STATE ACC PIAC-UPDATE

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

As always, please 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. A reminder: PIAC meetings are always held from 9:30 AM- 12:15PM, usually the third Wednesday of the month, please visit the site for the date of the next meeting.

Joanna gave some highlights from the PIAC meeting on April 20th:

- The PIAC started looking at data from the ACC in the past and what it looked like starting from the old Regional Care Collaborative Organization (RCCO) days and what going forward into ACC 3.0 should look like. At the June 2022 meeting, the PIAC is looking to take a deeper dive into ACC 3.0.

- Tracy Johnson, HCPF Medicaid Director announced that she is leaving HCPF at the end of May.

- PIAC looked at the Health Equity Plan, May 16th and another in June 2022, **June 2 (12-1 p.m. MDT)** - Registration Link, to hear about this plan and give more information, please attend. Aaron Green has been doing a SWAT analysis and what the strategic goals will be, more emphasis on diversity. HCPF is looking to hire a Behavioral Health Advisor. The desire is to look for an inclusivity with behavioral health and physical health.

- eConsults is moving forward, and they will return to the P&CE when they get further and have an update.

- Public Health Emergency (PHE) unwind included focus on continuity of coverage and the least minimal impact on members. Focused populations include Medicare eligible and former foster care youth. The renewal packets have been a big focus and making the communication readable, fast, and easy. Link to HCPF PHE unwind planning webpage.

- Department of Corrections (DOC) gave an update on the importance of the data sharing agreement that was done in 2018 and what a difference that has made on the process and the coverage with care coordination. Joanna would be interested in learning about the daily roster feeds that go to the RAEs and how that is working.

- The PIAC is interested in the ARPA funding and collaborating with their feedback and knowledge like they have done in the past.

- For the ARPA project HCPF is hiring internal and external position (consultant) to help us better define care coordination best practices and case management best practices. Encouraging SEP and CCBs to attend this meeting to provide feedback to the contactor of that project. Work defining roles and responsibilities, interesting

work to tease out.

- Updates from other subcommittees:
    - P&CE: Joanna spoke that there are 2 open seats within the P&CE subcommittee, please consider applying. Joanna presented the Member Transition of Care Coordination (RAE-to-RAE) Form that was a recommendation the P&CE more than a year ago that the PIAC approved. Unfortunately, there wasn't time to discuss. Hoping to bring it back in the future. Joanna spoke on some suggestions that the P&CE members had given on updates on the form. To be reviewed at a later date.

4. Members with Complex Care Needs

Joanna Martinson, P&CE Co-Chair

ACC PIAC Provider & Community Experience Subcommittee Presentation on the Statewide Approach to Addressing Member Health & Cost through Population Management.

Population Management Framework, teasing out the Complex Care Management top portion of the pyramid. Focus on members with complex care needs.

Complex Care Management: Members who have more complex needs that may require more intense levels of care coordination, also referred to as Extended Care Coordination.

Background on Members with Complex Care Needs Definition: As of July 1, 2021, the Department defined members with complex care needs as those whose annual cost of $25,000 or higher. This definition did not include behavioral health utilization or cost from other systems. This definition was in effect until December 31, 2021. On January 1, 2022, most RAEs transitioned to either their own definition of members with complex needs (which was subject to Department approval) or to four or more chronic conditions for adults. The Department retained the $25,000 or higher criteria for pediatrics until a more robust definition is developed.

Most of the RAEs proposed an alternate definition to complex care needs in their region as of January 1, 2022.

P&CE invited the RAEs/MCOs, to discuss the Complex Care definitions:

RAE1 Slides, RAE2/RAE4 Slides, RAE3/RAE5 Slides, RAE6/RAE7 Slides, Denver Health Medicaid Choice Slides

Highlights from the RAE presentations of Complex Care Definitions:

RAE 1-Rocky Mountain Health Plans (RMHP)- Violet W.

- Impact Pro Risk Engine. Looks at 1130 markers of risk, comes up with a score. Looks at the most recent 12 months of claims. Calculates member relative risk and probability using: 1. Total Cost—3 mo, 12 mo, 18 mo. 2. Impatient Stay probability—3 mo, 12mo. 3. ER probability—12 mo. 4. Behavioral Health costs—12 mo. 5. Social Determinants of Health models. Once the calculation is complete it produces a Member Marker Profile, Care Management Risk Summary, and Underwriting Risk Summary for each member. Members identified as having complex care needs if their risk score within the top 2.82% of the below populations: 1. RAE Only Adults (21+) 2. RAE Only Young Adults/Peds (0-20) 3. Prime Adults (21+) 4. Prime Young Adults/Peds (0-20)

RAE 4-Health Colorado -Kaylanne Chandler

- Using predicative analytics, using clinical data to predict risk scores. Complex care definition cohorts that are looked at: 1. Low-cost moving to high cost 2. Persistent high-cost members 3. Members with five (5) or more ER admissions in the last twelve (12) months 4. Members with two (2) or more ER admissions in the last twelve (12) months 5. High-risk pregnancy members 6. Multiple newborn deliveries 7. Members with premature conditions 8. Members without PCMP utilization with five (5) or more ER visits in the last twelve (12) months 9. Members diagnosed with renal disease or end-stage renal disease. Some of the positives of the delegated community-based model, is that most of the care managers live in the rural communities and have boots on the ground to assist members.

RAE6/RAE7- Colorado Community Health Alliance (CCHA)- Katie Mortenson

- Used data analytics and research of members to come up with complex care definition. 1. Diagnosis of diabetes with a comorbid behavioral health and physical health needs. 2. Members with asthma with a comorbid behavioral health and high physical health needs 3. Pregnant members 4. Members under the age of 2, born prematurely 5. Members who were incarcerated within the last year 6. Members involved in foster care 7. Pediatric members with more than $25K spend in a year 8. Adults with more than $25K in one year plus another condition including TBI, spinal cord injury, congestive heart failure, history of homelessness, serious mental illness. 9. Members who screen positive for multiple elements in High Impact Social Determinants, High Impact Behavioral Health, Functional Limitations.

RAE3/RAE5-Colorado Access (CoA)- Dr. Bill Wright

- Proposed Regional Adult Definition: 4 of the 8 Chronic Conditions. 1. Hypertension 2. Diabetes 3. Heart Failure-refined to be CVD 4. COPD 5. Asthma 6. Chronic Pain 7. SUD-F code diagnosis captured in regional behavioral health benefit 8. Anxiety or Depression. For the pediatric definition, RAE3/RAE5 would like to move away from the $25K (cost-based) definition with a need-based approach. To identify patients with escalating needs, which could indicate future high costs. And also

incorporating social needs. Proposed Regional Pediatric Definition: 3 of 11 Chronic Conditions. 1. Hypertension 2. Diabetes 3. Heart Failure 4. COPD 5. Asthma 6. SUD- F code diagnosis captured in regional behavioral health benefit 7. Anxiety or Depression 8. Obesity- based on provider feedback 9. Pervasive Developmental Disorder- based on significance in data 10. Social Determinants of Health Diagnosis

RAE2-Northeast Health Partners (NHP)- Ashley C.

- Using the Department's guidelines that complex members are at or above the 75th percentile of annual cost, be at least as large as the complex definition defined by cost only but no more than 5% of the total RAE population and be impactable. Northeast Health Partners new complex member definition covers roughly 4.45% of our total Medicaid population and is nearly double the size it was previously. Northeast health Partners wanted to identify those who are most likely to benefit from care management interventions: 1. Members with comorbid conditions (physical health and behavioral health and/or SUD) 2. Members struggling with a condition that is "poorly controlled/non-adherent" 3. Members with Social Determinants of Health (SDoH) concerns 4. Members with gaps in care (observed difference between the optimal care and the care received). Pregnant members, members who are incarcerated within the last year, children in foster care all fall under the complex care definition. NHP prioritizes programs with an integrated model for addressing medical and social risk as well as care management efforts focusing on enhancing member self-management as a basic construct.

Denver Health Medical Plan-Jeremy Sax

- Complex Care= 4 chronic conditions for adults and >$25K for children and 10 winnable conditions for Colorado. Denver Health does not receive data from HCPF because they are a managed care organization (MCO). Denver Health has not developed their own definition and the continue to align with HCPF. Denver Health has developed a risk stratification tool to "cone and hone" to identify members for outreach. The outreach team outreaches members who have been identified as higher risk.

Please join us the for the meeting on June 9, 2022 from 8:00 AM- 9:30 AM

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.