

**Present:** Beverly Winters, Elizabeth Hogan, Haline Grublak, Jim Dean, Louise Boris, Rob Kepplinger, Rolf Kotar, Tina Gonzales, Marceil Case, Matt Ulrich, Erica Alikchihoo, Sarah Hoerle, Susan Mathieu, Kathryn Jantz

**On Phone:** Libby Stoddard, Janine and Barb from Ombudsman’s office, Tina from SEP clinic in Colorado Springs

**Absent:** Rose Romero, Zim Olson, Lacey Berumen, Jerry Ware, Beverly Hirsekorn

**Next Meeting: May 24, 2012 - 9:00am – 10:30am (225 16<sup>th</sup> St., 1<sup>st</sup> floor)**

ITEM #	ISSUE	DISCUSSION	FOLLOW-UP	RESPONSIBLE PERSON(S)	DUE DATE
1	<p style="text-align: center;"><b>AwDC Implementation Update</b></p> <p style="text-align: center;"><b>Susan Mathieu</b></p>	<p>Susan reported that AwDC applications are being accepted as of April 1<sup>st</sup>, and everyone determined eligible is moved into wait list mode. In mid-May, we’ll be doing a “lottery” to choose the initial 10,000 enrollees. We have processed and approved just over 2600 people and are surprised that the volume is much lower than expected. We’re doing work/outreach with our community partners to reach more people. We did 30 more outreach sessions around the state, and we’re open to places we might have missed. Colorado Coalition for the Homeless is working diligently to get their clients enrolled. Because the enrollment is lower than expected, we’re continuing to tell people to apply. One potential barrier is that for CICIP category Z clients there are no co-pays – the AwDC <i>does</i> have co-pays. However, the CICIP program is generally not comprehensive a program as the AwDC full Medicaid benefit.</p> <p>Jim commented that he thought services could not be denied if clients are not able to meet their co-pay. Susan confirmed that this is true at the point of service, but the provider <i>can</i> refuse to make another appointment or fill another prescription.</p>			

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		<p>Susan also confirmed that clients on the AwDC waiting list can remain eligible for CICIP.</p> <p>Jim inquired about the Department's intentions if 10,000 applications are not received. Susan responded that the Department can choose to enroll all qualified applicants, or can enroll a portion and leave some slots open for future applications. The Department has the authority to raise the income limit up to 60% of Federal Poverty Level (FPL) but wants to first ensure that outreach has been done and that we are tracking applications accurately. We want to be sure that people at the lowest income levels are enrolled first.</p> <p>Louise requested that those who applied on time and meet eligibility requirements should get the benefits and not be placed into a hold or pending situation.</p>			
2	<p><b>Accountable Care Collaborative Overview and Discussion</b></p> <p><b>Kathryn Jantz</b> <b>Marceil Case</b></p>	<p>Kathryn introduced herself as a RCCO Contract Manager in the ACC program that Marceil now manages and noted that her Powerpoint slides are available on the HCPF Web site.</p> <p>The ACC was developed this program out of the goals and needs of Colorado: 85% of Colorado Medicaid was fee for services (FFS), we have experienced a 42% increase in enrollment, and per capita costs are rising. A 2009 survey found that 87% of the ER visits were not appropriate, and if clients had a primary care provider, ER usage might be reduced. Our goal is to improve health outcomes and reduce costs by ensuring that every</p>			

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		<p>client in the program has a focal point of care, using data analytics, the RCCOS, and primary care medical providers (PCMPs). The vendors who received the RCCO contacts are wide ranging, including MH providers, hospitals, and community organizations. Everything about this program is outreach-focused. RCCOs have the latitude to use the resources available in their regions and their organizational experience. They have to develop a network of PCMPs, support their providers, both with their clinical needs and/or admin, so that all clients in the region receive medical coverage and a medical home. RCCOs are also held accountable for certain key performance indicators.</p> <p>PCMPs are medical homes, but are not required to have electronic health records. We currently have about 1800 individual practitioners in the ACC program, and although some areas are not covered as robustly as others, we are now statewide. The number of PCMPs in the program represents provider entities; the number of individual practitioners is much higher.</p> <p>Prior to the implementation of the Statewide Data Analytics Contractor (SDAC) our ability to pull meaningful data from our MMIS was very limited. Data from the SDAC helps providers to provide care coordination for their clients and address quality issues. Access to a Web portal permits providers to see numbers of ER visits, client info, other data; the information is not truly timely, but we're looking at ways to improve that. The RCCO contract includes a referral requirement for seeing</p>			

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		<p>providers other than the PCMP. Currently we do not deny claims for specialist visits if the referring provider's billing ID is not on the claim and are not getting a high degree of participation. The Department's goal is that PCMP and specialists share information and coordinate care, and we are looking at the best way to accomplish this goal.</p> <p>Rob asked about RCCO performance on certain benchmark measures, e.g. reduction in things like ER visits, cost of care, etc. Kathryn reported that RCCOs currently receive a flat per member per month (PMPM) payment but that starting in July 2012, \$1 will be held back from each PMPM and will be used to pay out incentives for RCCOs who meet or exceed the performance measures.</p> <p>The Department is still considering measures involving X-rays/imagery and emergency services. We are also responsible to the legislature and at the end of May we'll have our first cost of care report, and we'll be working with the state budget office on that.</p> <p>Clients are assigned to PCMPs based on a claims history with a provider currently participating in the program. We're concentrating on adults because they are less likely to have a focal point of care. We are planning on enrolling dual eligibles as early as January 2013 via a passive enrollment process. Clients are notified 30 days before they are enrolled and have 60 days to opt out. Our opt-out rate is currently less than 5%. Some people are now coming up to their annual opt-out date, but</p>			

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		<p>we're not seeing many taking that option.</p> <p>RCCOs do not assign patients to providers. Unattributed clients can choose a provider by calling Health Colorado or using the fax-in form. We have a working group looking at the attribution issue. We have about 20,000 clients not linked to providers, so we're going to look into that in the next 6 months, and see if they've been to see a PCMP. If they have, we'll enroll them with that provider. The program is in its initial phase but has met its goal of 123,000 people; the expansion phase will probably begin this summer, based on anticipated cost savings.</p> <p>Barb asked if there has there been any clarification on the grievance process and the coordination of care between the BHOs and the RCCOs. Kathryn said that there has been some conversation, but there won't be any contracts between the two.</p> <p>Jim asked about incentives for dollars saved and was told that we do not have structure in place now, but are exploring various payment reform options under 1281. She encouraged everyone to participate in the robust ACC advisory structure, as there is much work still to be done. We have quarterly large advisory meetings, and three sub-committees – payment reform, quality and health improvement, and provider/community relations. Anyone is welcome to join any advisory group.</p> <p>Question - If someone is already getting services from their community MH center under their BHO</p>			

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		<p>and are satisfied with their services, does the RCCO have a role?</p> <p>Kathryn – yes, we expect that these clients also need physical health care, so the RCCOs are expected to help with those issues. if clients have community needs above and beyond the MH system, then the RCCOs are there to coordinate that. ACC clients may also access assistance from the Ombudsman for Managed Care; information about the Ombudsman is included in client handbooks.</p>			
3	<p><b>MI Waiver Update</b></p> <p><b>Sarah Hoerle</b></p>	<p>CMS has submitted questions on the waiver, but we feel really great because most other states that have submitted renewal applications have gotten 60+ questions and we've only gotten 23. Our response will go into clearance and a successful renewal is expected by July 1, 2012. When we begin looking at waiver amendments, I will come back and ask for input so that we can improve the waiver via amendment.</p> <p>Jim asked if the current policy that waiver clients lose waiver eligibility due to not receiving one service within 30 days applies to people who are hospitalized – either at Fort Logan or in a medical hospital. Sarah promised to research this question, but confirmed the policy is in place. Jim requested that people be “suspended” in these situations rather than dropped from the program. Sarah’s email is <a href="mailto:sarah.hoerle@state.co.us">sarah.hoerle@state.co.us</a>.</p>			
4	<p><b>HCPF Updates</b></p>	<p>Zim had suggested an agenda item but we will defer discussion until he can attend.</p>			

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	<p><b>Matt Ullrich</b></p>	<p>Matt initiated a discussion of the role and purpose of the MH Advisory Committee, commenting that the Department expects and encourages the committee to suggest agenda topics and bring issues to the Department for consideration. Last month's meeting was cancelled due to a light agenda, and we received only 1-2 questions for Kathryn on the ACC prior to her presentation. MHAC members represent the community and stakeholders, so we need to know what your concerns are so that we can address them.</p> <p>Louise remarked that members may not know enough about the ACC to ask questions. In addition, when this committee originated, she anticipated that the Department would have issues that they needed advice from us on, but it evolved to where it became a "partnership" instead of coming to us with questions and asking for advice. So, this is not what it originally was intended to be. Elizabeth confirmed this understanding and expressed an interest in the committee doing a lot more advising than hearing "updates". Rob also noted that over the years, it's not been uncommon to cancel meeting once or twice a year.</p> <p>Matt thanked the group for the comments, commenting that the Department hasn't really had a lot of "advisory" issues but probably will have more as we move forward to the amendments and new RFPs.</p> <p>Sarah was asked about what sort of input might be desired for upcoming waiver amendments. She</p>			

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		<p>replied that they are looking at changing some waiver services, depending on budget constraints, but that she will bring more information to the July meeting. Rob asked that information about this topic accompany the agenda so that members have time to prepare before the meeting.</p> <p>Jim formally request that his issue be to a future meeting agenda. He would also like to raise the issue of the difficulty of accessing MH services for children with multiple diagnoses, e.g. DD or autism. Louise commented that when started with the MHAC, she participated in a subcommittee that developed an MOU for the MH system and other groups. The focus was on how systems could work together to ensure access to services for clients with multiple needs. This group was supposed to review progress on an annual basis, but may not have done so.</p> <p>Elizabeth asked if agendas could be prepared further in advance so that attendees can prepare. Perhaps the last five minutes of each meeting could be devoted to setting a tentative agenda for the next meeting.</p>			