



COLORADO

Department of Health Care
Policy & Financing

MINUTES FOR THE ACC Program Improvement Provider & Community Issues Sub-committee

Colorado Department of Public Health and Environment
4300 Cherry Creek South Drive, Rachel Carson Conference Room

June 18th, 2015

1. Introductions

A. In-person Attendees

Todd Lessley (Salud), Anita Rich (CCHAP), Elizabeth Forbes, Matthew Lanphier (HCPF), Casey King (KP), Lila Cummings (HCPF), Josh Ewing (CH), Meredith Henry (CDPHE), Heather Brozek (CCHN), Erin Miller (HCPF), Barb Martin (CDPHE), Marija Weeden-Osborn (CCHN), McKenzie (CCHN), Brenda Von Star, Nicole Konkoly (RMHP), Torrey Powers (ADT), Marceil Case (HCPF), Megan Deslisle (HCPF), Janet Rasmussen (Clinica Family Health)

B. Phone Attendees

Jill Atkinson, Donald Moore (Pueblo CHC), Shera Matthews (Doctors Care), Mindy Klowden (JCMH), Jessica Provost (IHP), Jenn Dunn (CRHC), Hanna Schum (HCPF), Jen Davis (Mountain Family), Brooke Powers (ClinicNet), Barb Young (CCCC), Jennifer West (CCCC), Ken Davis (mountain Family), Pam Doyle (Pueblo Stepup), Chelle Denman, Katie Jacobson, Leslie Reeder

2. Announcements

There were no announcements this month.

3. Approval of Minutes

Minutes were approved.

4. Consumer Input/ Client Experience

Marceil: State has a lot of rules about what can and can't be done. In the ACC, we want to make sure people are aware of member and provider rights. We had a question of whether or not a provider can turn a client away for the inability of a

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client to pay a co-pay. The answer is no, there is a state rule which precludes this. But the member is still liable for the co-pay. You can bill the client if you want to.

Casey: What happens if they rack up a lot of \$2 bills over time and they are sent to bill collectors?

Marceil: They are still liable. We would want to outreach that client in the ACC to figure out what is going on with that, and the provider can always waive the co-pay and eat the cost if they don't want to deal with the hassle.

Todd: With Medicaid population, we've learned that co-pays are not always demanded at the hospital, but we always ask for it in primary care.

5. Workgroup Reports (Care Coordination)

Todd: Care coordination workgroup met and had a really great discussion. We didn't formulate any formal recommendations, but we did circulate a draft summary document of our conclusions as a workgroup. We will meet again before we make any formal recommendations.

Todd listed the recommended actions from the care coordination document and solicited input.

Mindy Klowden: Few things I would like to call out – one thing that is alluded to is the standardization of delegation. This suggests that we want the RCCOs to delegate to the point of care as frequently as possible. One thing that should be mentioned is focusing care for those clients who have more complex health care conditions so that we can focus care management resources accordingly.

Todd: Should we amend the recommendations?

Mindy: Document is missing a level of specificity. There has to be a focused effort on care management, and you therefore have to focus the resources accordingly. That should be an addition. And you could also mention delegating to the point of care as an addendum to the bullet on standardization of delegation.

Donald: I would echo Mindy's point about care management happening at the point of care. More weight should be given to proposals where case management happens at the point of care and not necessarily in a call center.

Casey: Specificity should include a social determinants of health metric. Is the goal of the care coordination in the program to facilitate cost savings, or to enhance member experience? Those two goals will have very different approaches. The Department should therefore provide guidance on what the goals for the program going forward are.



Shera: One problem I had related to our most recent audit was the lack of specificity. We were told that the state is really looking for complex care coordination, and we can't fulfill that need for them in a primary care setting. So population based strategies almost need to have something for primary care as opposed to different settings.

Leslie Reeder: While I think the closer we get to the point of care the better, some primary care clinics aren't set up to deal with those complex cases.

Mindy Klowden: For those practices that do see patients with complex care needs, they should be paid accordingly. I suggest that if we want it to be outcome focused, we need to target the dollars accordingly.

Shera: We work very hard with the social determinants trying to keep our primary care people out of the ER, but because they're not complex, very little is recorded. We need to be more specific about outcomes and expectations.

Janet Rasmussen: We should be careful about how we implement something that pays more for complex care coordination so that we aren't forgetting about the lower acuity clients who could potentially jump to a higher level if they are ignored.

6. Workgroup Report (NEMT)

Todd: workgroups recommendation were presented to PIAC yesterday and approved unanimously. They will go to the Department for response. We also met with Total Transit GM and Doug Van Hee (Total Transit contract manager) and had a very good conversation. We talked about some of the things the Department is already working on. We are getting closer to having realistic action items.

7. PIAC Report

Todd: No significant updates. Our recommendations for transportation were approved. There was a conversation about the payment reform sub-committee. This sub-committee has historically been very active, but has also had long periods of inactivity. There were a number of options presented for how to deal with the sub-committee. We discussed parceling out the work to the different sub-committees. The decision was made, however, to form an ad-hoc sub-committee whose focus will be to prioritize topics of discussion concerning payment reform which can then be brought to the PIAC.

There was also a discussion about the RFP. We discussed the BHO and RCCO enrollment process. There was a conversation around what it would look like if the ACC were to do automatic enrollment similar to how the enrollment process currently works in the BHOs. Since attribution is a focus of this sub-committee, we have agreed to look at this as it relates to the RFP.



Nicole (ADT) asked clarifying questions about care coordination as it currently exists in the program.

8. CHP+ Attribution

Matt: The Department has approved a process whereby the RCCOs can work with CHP+ providers in their region to have children attributed to their providers as PCMPs. The Department will provide RCCOs with the current attribution methodology from which RCCOs can derive their own. If the Department approves of the RCCOs attribution methodology, those clients will be attributed to their providers using the provided CHP+ encounters. Colorado Access is the only RCCO to have used the process currently, but it is available to all RCCOs. Access did not receive a lot of attributions using this method, and we suspect it is because it is too resource intensive given the net benefit. Access is working with RCCO 4 on their process as well.

9. Attribution Policy Proposal

Erin: We brought this proposal to the sub-committee in March regarding a change in how we re-run the methodology. The change would allow us re-attribute clients who have changed their utilization patterns and now have a stronger relationship with a provider who they are not currently attributed to. The change would not affect clients who have chosen their provider. We've been taking stakeholder feedback on this since March, which we will continue to do until next Wednesday – at which time we will distribute our policy decision and our rationale for our decision. We are leaning towards implementing some form of this policy. We were previously looking at re-running this methodology every month, but after hearing feedback, we're instead considering running this less frequently.

Casey: The concept of member selection vs. auto-attribution. For the folks that are auto-assigned it makes sense to run at periodic intervals it might make sense, but for those who have chosen their PCMP it does not make sense.

Erin: We will not be re-attributing people who have chosen their PCMP.

Elizabeth Forbes: Are you informing clients of who their new PCMP is and allowing them the option of choosing a different PCMP?

Hanna: Yes they receive a letter.

Anita: Would the practice be notified? Is this something that is possible?

Todd: How many clients is this affecting?



Erin: 64k

Todd: Can we run a pilot with a smaller number of people?

Erin: We've discussed this and there is somewhat of a logical disconnect in doing it that way. If we agree that the methodology is good for one subset of the population, we would have to agree that it is also good for the broader population. It's also hard to identify which group to do it to in a way that would be equitable especially considering there will be a lot of exchange between providers in the re-attribution process.

Elizabeth Forbes: How long would a client have to have a relationship with a new provider before they are re-attributed?

Erin: We are not changing the attribution methodology, and we are still doing a 12 month lookback. The client would only be re-attributed if they exhibit a stronger relationship with a new PCMP based on their claims history.

Anita: One question is UPI. UPI looks all the same.

Hanna: We use rendering IDs to do attribution for UPI physicians and then it gets rolled up in one billing ID. But people shouldn't be attributed based on specialty claims with UPI.

Katie: Can PCMPs get a list of clients who are going to be re-attributed so they can perhaps make a case for why these clients shouldn't be re-attributed.

Hanna: We will add that to our feedback. We'll have to think from a resource standpoint about what that would look like. Some providers would have one or two re-attributions and it might make more sense to have some sort of threshold around that.

Katie: A number threshold is one way to do it, but also think about those practices who have delegated care coordination as another threshold.

Hanna: We don't have a comprehensive list of delegates, because all RCCOs do it a little differently and it could get a little tricky. Also, rather than making a case for a particular client based on a list, it might make more sense to have the client call HealthColorado when they are at the practice receiving care.

Janet: So for anybody who made the phone call, they would never be attributed again?



Erin: Correct. Also, if their claims history is with a non-contracted provider, they won't be re-attributed.

Hanna: If they're a non-user for the year, we're also not going to move them.

Brenda: If someone goes to see an OBGYN more than she sees me in a year, will that provider get the attribution?

Hanna: If that client has more E&M claims with that provider and the provider is a contracted PCMP, then yes. It's also important to note that there are a lot of clients being seen by your practices for which you are not receiving a PMPM for.

Donald: Will this help clients who are unattributed currently?

Hanna: We're already running re-attribution monthly for unattributed clients, but this will be an entirely different process.

Donald: Clearly the Department is leaning a certain way based on a good principle. The hand wringing comes from the fact that there will be a significant bolus of change and we don't have a handle on what the impact will be. In our region, there will be 14k re-attributions, and we don't know if 80% of that will happen to one or two practices or if it will be a small impact. We spend a lot of time and money organizing our infrastructure around our panel of patients. If there's any way to estimate the impact I think that would be great.

Hanna: We do know the impact. We have estimates for every single provider that will be affected by this change.

Donald: If a RCCO wanted a list of every PCMP in their region and what the impact would be, would that be possible?

Hanna: Absolutely, we've thought about that, and we think that the RCCO might be the best avenue for outreaching those providers.

10. Specialty Access

Janet: Whose responsibility is it to develop specialty access for Medicaid?

Marceil: My newly formed unit is taking the lead on this, but we definitely depend on the RCCOs and our partners for help. I can serve as the point of contact for initiatives which are aimed at increasing specialty access.



Todd: Specialty access is an area of focus for this sub-committee. Perhaps we should have this a topic for next month.

Next meeting 7/16/15.

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