



**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

October 8<sup>th</sup>, 2015

### **1. Introductions**

#### **A. In-person Attendees**

Todd Lessley (Salud), Anita Rich (CCHAP), Matthew Lanphier (HCPF), Josie Dostie (CCHA), Casey King (KP), Meredith Henry (CDPHE), Barb Martin (CDPHE), Nicole Konkoly (RMHP), Mindy Klowden (JCHC), Brooke Powers (ClinicNet), Josh Ewing (CHA), Alice Gibbs (CCHN), Kathryn Jantz (HCPF), Jessica Provost (ICHP), Coral Cosway, Lisa McCann, Pat Flanagan

#### **B. Phone Attendees**

Pamela Doyle (Pueblo Stepup), Brenda VonStar, Barb Young, Chelle Denman (ICHP), Ashley Philips (Porter Hospital), Jill Atkinson, Marceil Case (HCPF), Jennisfer West (CCCC), Donald Moore (PCHC), Leslie Reeder, Jen Dunn (CRHC), Molly Markert (COA), Heather Logan (MCPN), Kristen Trainor (CCHA), Susan Mathieu (HCPF), Terri Hurst (CCJRC), Ryan Biehle (AFP)

### **2. Announcements**

There were no announcements this month.

### **3. Approval of Minutes**

Minutes were motioned for approval. Minutes were approved.

### **4. Consumer Input/ Client Experience**

There was no consumer input issues this month.



## 5. PIAC Update

Todd Lessley: Our recommendations for care coordination were unanimously approved with 2 edits. We agreed to amend the bullet around standardization. The PIAC agreed that standardization was important, but they also wanted to take into account unique regional solutions. The second was that if care coordination is going to happen at the point of care that the payment solution should be built to support that.

## 6. ACC Phase II Discussion

Kathryn Jantz: The next phase of the ACC will combine RCCOs and BHOs, and will be called Regional Accountable Entities (RAEs). These RAEs will be responsible for building health teams for their clients. We're also making a number of changes, including to the map and the enrollment method. Clients in the future program will be enrolled based on where they seek care instead of their county address. We are also thinking about how to address accountability, starting with clients and moving up to the RAE level. Clients will be mandatorily enrolled, and then will potentially be triaged with a health and social risk screen. We are looking at patient engagement strategies as well as client incentives.

Casey King: What will the obligation of the RAE be with regard to securing access to the specialty and hospital care?

Kathryn Jantz: We are thinking about strategies to support the system from all angles. We're thinking about strategies on how we can incentivize hospitals to engage as well as requirements on how the RAE engages with hospitals. We're also looking at telehealth, eConsult strategies, and ECHO-like programs. We're looking at new technologies and models to increase specialty access. We want RAEs to have enhanced responsibilities around tracking specialist availability within their region.

Casey King: What metrics would you be using to measure specialty access within their region?

Kathryn Jantz: We aren't necessarily at the measure level yet. That's something we will need intense stakeholder input on. There will be heightened expectations on accountability, transparency, and reporting

Mindy Klowden: How are you looking at controlling the cost of psychiatric hospitalization? Thus far those costs have been controlled through the sub-capitated payment to the Community Mental Health Centers.

Kathryn Jantz: We're still flushing out a lot of those details. We will have to have some utilization management strategies around behavioral health. On the physical



health side, we have a UM vendor, and we're exploring doing a parallel structure on behavioral health. We're thinking about a couple of other strategies to align hospital goals with our own.

Mindy Klowden: So you'd be having a vendor do utilization management rather than the Regional Accountable Entity?

Kathryn Jantz: It depends on the payment model. We're exploring the possibility of not doing a capitation. The utilization management activities would likely follow whoever makes the payment.

Todd Lessley: Regarding the map – does this mean the Larimer/Weld border will remain the same?

Kathryn Jantz: It will stay the same, but the enrollment/attribution methodology will solve a great deal of the problems.

Todd Lessley: Around the language talking about screening at enrollment, can you talk about what that would look like?

Kathryn Jantz: The way we've been thinking now is that all clients enrolled in the RAE will be screened and those questions will be administered in a variety of different ways. We want to make it as easy as possible to allow opportunities for clients to complete the survey. We are thinking of having the questions on the PEAK application, having the PCMP do it, or potentially having the RAEs be responsible for reaching out to get the questions answered via technology. We understand that we'll never get to 100% completion on these surveys, but we want to engage as many clients as possible.

Meredith Henry: Will you do the same screening for adults that you will do for children?

Kathryn Jantz: We'll be looking for stakeholder input on that. We want to keep it very simple, but we also want to look at whole family systems. Our thinking is that



we want to have some quick and dirty way to identify client needs such that we can understand our client population better than we can with claims data.

Mindy Klowden: Will the assessment be used as a gateway? Will they be able to access services regardless of their answers on the assessment?

Kathryn Jantz: Yes. We are not thinking of the assessment as a gateway. We want every client to be able to access any services they need. We will of course have UM strategies to manage costs.

Todd Lessley: Can you elaborate on what the incentive program will look like?

Kathryn Jantz: In terms of accountability, we feel that a big part of client accountability is that clients have the tools and resources to manage their own health. Clients are experts in their own health. We're thinking we should have an incentive program that's statewide for all clients. We don't know what the best thing to incentivize would be, so we are seeking stakeholder input in that regard. We are seeking federal authority to offer incentives to a greater extent than what's currently federally allowable.

Casey King: You mentioned enhanced oversight of the RAEs and additional transparency. Can you elaborate on what that looks like?

Kathryn Jantz: We're specifically interested in having greater financial transparency, to give an example. The contract management model will be more robust – using a team rather than a single individual. And we're thinking about the role of stakeholders in helping us to monitor the program. We want to think about reengineering some of the stakeholder input mechanisms.

Molly Markert: In thinking about the role of the sub-committees, what is the timeline to give feedback on these issues?

Kathryn Jantz: We will be releasing the draft RFP around March. Prior to that we will be submitting our requests for federal authority to CMS.

Anita Rich: How are you looking at getting input from the sub-committees and other stakeholders? We only meet twice before a lot of this stuff is happening, and PIAC is on a similar calendar. How then can we get you the information you need from us?

Kathryn Jantz: We have the PIAC retreat, which is a half day retreat. We will have two public forums in the evenings, we are looking into doing another half day retreat as well. We will also be releasing the complete concept paper in mid-



October. Not every question will be answered, but I'm hoping the reaction from that paper will spur some questions as well.

Casey King: It might help to follow a member through the process and get more details on what some of the payment mechanisms look like. Perhaps a process map could be made available to us?

Kathryn Jantz: A lot of that information will be released in the draft RFP, but we also hope to get feedback in the interim on the bigger picture/broad structure aspects in the meantime.

Coral Cosway: I would love to see how integration is going to be paid for. If the capitation is going away, we need to know how the state intends to support all of the things currently being paid for by the BHOs and CMHCs that aren't covered by open Medicaid codes.

## 7. Specialty Access/Health Alliances

Lisa McCann: CCMU runs a network of health alliances. There are twenty five regional health alliances and three that are statewide. The alliances are generally geographically based, but sometimes are based on special populations. They work towards improving population health, and to foster strategic shared learning between local health collaborative efforts in Colorado. There is a publication that CCMU has online studying the health alliances. The Mile High Health Alliance was formally established in January, and it came out of Denver's community health improvement plan. Like many health alliances, our partners include providers – big, small, behavioral, and physical health, as well as government partners and community organizations.

We are working to create a referral network to connect those who need this care to providers in Denver. Access to specialty care is a major challenge that hasn't been solved by the expansion in coverage. In Denver there are 75,000 more people on Medicaid now than there was in 2013. A large chunk of the previously uninsured have gained insurance, but they aren't getting specialty care. The group studied several referral systems in other cities. We've created and published a skeleton plan of what the referral network should look like. In December 2014 we held a stakeholder meeting to vet this plan, and we are now receiving a grant to write a more sophisticated implementation plan. We've engaged with Colorado Health Institute to help write this plan, and we'll have another round of fundraising for implementation funds later in the year.

Todd Lessley: One area of focus for our subcommittee is specialty access. I'm curious how health alliances statewide can mobilize to look at specialty access, or



what we can learn from health alliances to assist us in our charge to look at specialty access.

Lisa McCann: One thing we are doing is we are in close communication with our colleague alliances – Boulder and Aurora – so that whatever we're creating is aligned with one another. The biggest thing that has to happen is that specialists need to agree to take Medicaid. One in five Coloradans are now on Medicaid. How that happens – incentives or otherwise – remains to be seen.

Todd Lessley: Do you have any perspective on how we as a subcommittee can support the broader network of health alliances?

Lisa McCann: We have meetings of the networks periodically, and we have regional meetings as well. Everyone is welcome to attend.

## 8. Enrollment w/Non-contracted Providers Discussion

Matthew Lanphier: The Department has asked for input on its current policy proposal regarding enrollment. Under the new policy – outlined on the P&CI website [here](#) – the Department will begin enrolling members into the ACC program who are currently excluded due to their relationship with a non-contracted provider. This policy would affect roughly 17,000 clients and would have a minor effect on attribution rates. If you have any input on this policy, please submit it to Matthew Lanphier at [Matthew.Lanphier@sate.co.us](mailto:Matthew.Lanphier@sate.co.us) no later than November 15<sup>th</sup>, 2015.

Josie Dostie: Will we still be able to receive a list of the clients who are seeing non-contracted providers and have their providers identified?

Matthew Lanphier: Yes.

## 9. Provider Cap Discussion

Matthew Lanphier followed up on a discussion from last week. Specifically, it was asked whether the RCCOs could receive notification if their PCMPs are approaching their panel limits. Matthew explained that the Department is looking into this, but that receiving notices for each practice may be resource intensive. Alternatively, the Department would be able to provide RCCOs with a comprehensive list of providers who have exceeded their panel limits. This would allow the RCCOs to outreach those providers and potentially have those limits increased or removed.



## 10. ACC 2.0 Documents

Todd Lessley: I think we should discuss the cube document and the proposed assessment discussed earlier. I'm a little concerned about the goal of having each member do an assessment and I don't think it's necessarily possible. I would therefore propose a workgroup to discuss these documents.

The group agreed instead that the agenda for next month's meeting would be focused around these documents in order to provide feedback to PIAC.

Next meeting 11/12/15. PLEASE NOTE THE CHANGE FOR OUR NEXT MEETING. WE WILL NOW BE MEETING ON THE SECOND THURSDAY OF THE MONTH, AND THE ROOM WILL BE CHANGING.

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