Member Advisory Council Minutes
Larimer County – 5/4/23

Larimer Client Council
May 4, 2023 Meeting

Present at meeting: Dave Hedge, Kathy Hartman, Pat Chamberlain, Kim Jackson, Mary Michael Justice, ReNae Anderson, George Cunningham, Alison Sbrana, Alison Dawson, Guests from the Western Slope Group included Tim Hudner, Ian Engle, Monique Terpstra, , Meighen Lovelace, Meg Taylor, Jo Carroll

We launched right into the discussion of the Accountable Care Collaborative 3.0. Julie framed the discussion and explained that there had been talks recently of changing the regions and Larimer came up as some had asked that Larimer be moved with Weld County. That would take it away from Rocky or whomever was the RAE 1 contractor. One reason is because RAE 2 which includes Weld and Northern Colorado is too small to be effective but moving Larimer would cause the same problem for RAE 1. These discussions had been happening and there was no inclusion of clients so folks from HCPF were invited to this meeting. In addition to the issue of boundaries, HCPF is getting ideas now for what should be included or changed in the 3.0 version. Julie reviewed the pre-reads she had sent.

Terms used in this discussion:

ACC: Accountable Care Collaborative: This is the Colorado version of an accountable care organization model. This comes from a Medicare program which defines this as "Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program."

In Colorado we call it an accountable care collaborative which is the overall structure of how we provide care. It blends a managed care model for mental health with a managed fee for service model Managed fee for service means that people can see any doctors they want and have care coordination available to help manage care. The plan also works with primary care practices to help them coordinate care. Managed care means that there is a pre-approved network of care providers, and you have to use that network. Saved money is shared with providers and some with the community by investing in programs and resources desired by community members.

ACC 3.0 This is the third contract period (each lasting about 5 years and each bid competitively). This started 10 years ago. ACC 3.0 will be bid next year to start the following year (2025)

RAE: Regional Accountable Entity: The organizations that are contracted to provide accountable care collaborative services. Rocky is the RAE for Region 1

Regions: Blocks of the state -there are 7 regions and 5 RAEs (2 have 2 regions) and the map of the current regions is here. It is about halfway down the page.

Network Adequacy: This means there are enough providers to meet the needs of the community. This refers to managed care where it is the responsibility of the RAE (or whatever health plan is in place) to find and have enough providers.

MIAC: We call these client councils but in HCPF speak this stands for Member Improvement Advisory Council. This is what you are. The advisory councils for clients.

PIAC: Program Improvement Advisory Council. This is the advisory council for the whole region that includes clients, providers, community leaders, and the RAEs

Julie introduced the people from HCPF Mark Queirolo and Katie LoNigro. Mark is the planning and implementation manager. Katie is on his team. Mark said that based on state procurement rules, every 5-7 years they need to reprocure any vendor, including the RAE. The RAEs will need to apply to take on the roles and responsibilities. The current contracts end on 6/30/25 and HCPF needs new contracts in place for 7/1/25. Whenever they do this, they think of how to make improvements, better serve members, better experience for members and providers, and changes in the Medicaid landscape. They also ask, can we do more to address the social landscape like housing and food, what do we want to do here? What can RAEs do? At the same time the BHA was created last year, and the two agencies are to complement each other and work closely. The BHA is establishing BHASOs (Behavioral health administrative service organizations) which will also have regions. They had a July 01, 2024, start date for that (this has since been pushed back a year)–they are responsible for crisis, SUD, etc. They do NON-Medicaid. They establish behavioral health standards of care. How do we align with BHA and Medicaid? Already lots of complexity so how do we make it easier. BHA has been working on a map and HCPF is trying to align the rough geographic outlines of regions so members and providers will work with similar processes.

HCPF said they are getting complaints about having to contract with 7 RAEs and that services are different in different regions. Initially the BHA proposed having only 2 regions and then they went to a proposal for 3. HCPF is now asking does 3 work for Medicaid or more needed? There are discussions that are specific to some specific counties, and one of those has been Larimer County. Should Larimer be connected to NE or Western Slope? HCPF staff said that Rocky has done a great job and established relationships but

said as we think about this do not think about Rocky relationship because if a new vendor came in that would change everything. Members can access services anywhere in the state now. There was a question about how we hold relationships as we have been working on this since inception.

Ian said choice without options not choice and that maybe we need to know procurement better. He said it makes no sense to dismantle what we built over years, aligning is great, but dismantling is not. He said that we have been building on evidence based KPI for years, built provider networks, community-based organizations, care coordination. He said people develop a trusting relationship and to dismantle it because it sounds good is different from improving the current situation. Go to people with whom we established relationships and have standardization rather than relationships. Do not change everything because of the BHA idea. How does the BHASO line up with what we have in place?

Kim: I moved from Denver to Weld to Larimer–most providers in Denver but found PCP in Weld and kept that PCP. So even though she lives in Larimer her RAE is in Weld. Learned that UCH and Banner do not talk to each other. Clients do not understand distinction between systems and may have providers in both; providers do not really talk to each other, need care coordinators to do complex care coordination. She said no one follows up –people do not have the energy to fight, often referrals are not appropriate, and no one is coordinating. Patients then give up. Patients feel small and insignificant, and no one cares if it is complicated. Increased care coordination would lead to better health outcomes, Medicaid is not like private insurance because people get off when they are complex.

Mark said they are working with the office of community living on relationship between RAE/SEP/CCB

Alison said she is a disabled Medicaid member living in Fort Collins. Before she became disabled, she was a care coordinator for NCHA so she sees both sides. She said that the main problem is in the world of health policy there is a wall between Weld and Larimer because the RAEs are different but for clients there is no wall. She said specialty offices are sometimes in Loveland and sometimes in Greeley and sometimes in Denver, the walls are a problem because the RAEs are different. No one knows who to call, or how to answer that specific issue. The solution is not squash the RAEs together or reduce but have a more supportive referral process, no wrong door,

Monique from the Ute Mountain Ute Community said that combining RAEs do not work in rural areas, services move from close to far away due to provider shortage. The issue is how to make sure there is not lapse in services or duress due to a change? Some areas are hard to attract providers to deliver services and RAEs can leverage to pay providers differently. She said DO NOT alienate rural communities, do not reduce RAEs. She said it is already hard to build trust with Native American communities, it is hard for

tribal members to travel. She said we need Rocky for tribal members–changing that will disrupt trust we have built over several years.

Mark asked what should be put into the contract? A suggestion was having Native American people hired to be navigators (Rocky is doing this voluntarily now).

Kim said the goals in public health are to address lack of providers. Health care has money and resources and an interest in fixing Social Determinants of Health or SDOH. Public health gets less money for that. Is there a way to talk with local public health and health boards and include public health into a new model as they move forward to a next level? If we do not take care of SDOH everything suffers. What are unique partnerships we can leverage.

Solution must be taking down more barriers: Instead of making RAE larger can they take down barriers by having care coordinators to not be connected to particular provider or money goes into a pot and care coordinators are more independent with statewide resources? Rocky has innovated with care coordinators and allowed them to really help where other RAEs have had care coordinators say NO we cannot do x. It is also important that care coordinators have in depth training on Medicaid and Medicaid buy in.

Comments and Questions:

1) Why is the current number of RAEs compromising member services? Care coordination looks different in different regions.
2) Children with complex needs -how does this fit?
3) You cannot guarantee that fewer RAE would help.
4) In Larimer there is a competitive market —people switched RAEs and bad policies changed due to competition, Competition is good.

Other ideas and needs identified by the group: These should be in the new contract.

1. Warm handoffs
2. Face to Face visits have to be reinstituted for those who want it.
3. Care coordinators need more time for high needs clients.
4. Caseloads need to be adjusted and hire people dedicated to service, this is not someone who can enter data but can do service, regular meetings with to address solutions–peer case reviews

5. Executive action committee, anyone who is supervisor whose job is to remove obstacles for care coordinators.

The group suggested that HCPF meet with some of the excellent care coordinators about what they need and how they excel –excellent care coordinators should be defined and identified by clients. There was discussion about how to measure trusted relationships. Asking the client is one way.

There is a need for transparency –have people who share who is being investigated, get input, and then say what you do with the input. Rocky does this with our councils.

If regions are larger then it is harder to access care –NEMT is a joke, so we need to have localized care coordination and provider. Transportation is a major issue and traveling in a crisis is terrifying. This is particularly acute in rural communities.

Creativity of RAE 1 is built over time, built over trust and relationships, it would be horrible to dismantle due to BHASO that does not exist yet. You cannot recreate what is there today because you do not know if you can get it back.

We thanked Mark and Katie and finished our other business.

Alison gave her report as the PIAC representative:

1) The Public Health Emergency is ending. We all have renewal dates –they will stick with dates we already have so if your annual renewal is in July, you will stay as is until that time. HCPF is taking the whole 14 months to do the renewal. There was discussion about lack of coordination between LTSS and PEAK. HCPF is trying to have the RAEs reach out to make sure people get their paperwork in but there is some computer issue because the RAEs are getting information too late, and people also said they are not necessarily receiving their renewal notices at the correct time. As a reminder to stay on the Medicaid buy-in program you need to have paid employment. It can be self-employment and can be minimal, but you will have to prove employment.
2) They had training about LGBTQ issues of gender diversity with an excellent facilitator.
3) There are two exciting projects happening with the community reinvestment money. One is a fund to meet the social determinants of health needs to pay for things that address barriers to care. There are 15-20 proposals working their way through the system. They are still accepting applications. There is also a program funding social security disability

and SSI application assistance. This is operational in Larimer County and people can reach out to DRS to get direct assistance.

Other announcements:

1) Mary Michael reminded us about the CSU option to post a job to the regular student job board if you want to hire a caregiver. They will put us to professional board called handshake which gets a better response.
2) Elias transportation now has a wheelchair van and also is now serving SW and providing nonmedical transportation needs with excellent customer services.

Our next meeting is July 06, 2023. PLEASE REACH OUT TO JULIE TO EXPRESS IF YOU WANT TO TRY TO MEET IN PERSON. The new mental health facility will not be ready for visitors until September or later so we will meet there and do a tour once it is ready. We can choose to stay remote in July or find a place in Larimer County that can accommodate a hybrid meeting.