Member Advisory Council Minutes
Western Slope – 12/5/22

Western Slope Medicaid Client Council: RAE 1: Quarterly Meeting

12/5/22 9:30 AM-4:00 PM at the Mesa County Workforce Center

Present:

Members:

Janice Curtis
Tom Keller
Tim Hudner
Meighen Lovelace
Bianca Ochoa
Herberta Silas
Nina Kazazian
Lynn Jolley
Henry Grater

Remote

Rochelle Larson
Joe Barrows
David Nelson
Ian Engle

Regrets

Jen Oberling
PTISAWQUAH

Guests:

Michelle Trujillo
Marivel Kluckman
Shawn Bodiker
Adela Flores-Brennan

Rocky Staff:

Meg Taylor
Patrick Gordon
ReNae Anderson
Maureen Carney
Todd Lesley
Sally Henry

Facilitator: Julie Reiskin

Guests included Michelle Trujillo who is with a new connector program at the health department and Allison from Parallel Path who was present for organizing a photo shoot so Rocky would have real clients to use in their images and promotional materials. This was in direct response to members' feedback.

Our opening question was what are our desires for the new year. Most common was unity for the community but also included collaboration, more acceptance, more communication, open hearts, open minds and creating space we all need to be in community and truly shift power, more positivity and working together for positive outcomes. Dave also mentioned that there is a need for a new veteran program

REPORTS AND UPDATES:

PIAC: Tom reported that there is some funding that is separate from Medicaid and one time funds that are available. The PIAC will vote on how to use it but the voting members are recommending two projects:

1) Application assistance for SSI and SSDI. There would be people that would help people prepare packets, advise on how to proceed, give accurate information and not advise people to stop working. The proposal was for 5 different navigators to start with and it will be a one year with renewal option.
2) Funds for emergency needs like housing and other necessities not covered by Medicaid.

Tomorrow the PIAC will vote on percentages for each–the total is $500K. Emergency needs could go very quickly. Both are important, one is more short term and one is longer term.

At the last statewide meeting on 16th they discussed updating performance indicators —which is different from performance metrics. Another exciting thing is paying members of PIAC who are not already pai. Tom is also on the mindsource advisory board and they do this—this pay is above mileage and travel. Finally, there is a lot of talk and work on the phase three roll out. One priority is Behavioral Health transformation. They will have their annual retreat later this month going into 2023.

Ian said that the State keeps talking about regional accountability/MCO. This is because of behavioral health being incorporated this is now being talked about. Managed care is a bad word but with the right organization it can work. Rocky Prime is an example.

Question: What are the Key Performance Indicators for Mental Health? There are long standing trust issues and they need to be evaluated by clients. We need either provider changes or a lot or more providers.

Dave said Integrated health case managers have scripted notes, worry about them faking notes, accountability should include making sure notes are not canned. Integrated health is a large corporation buying up Mental health Centers.

Meeting with Rocky Management: Patrick and Meg:

What do we want?
Vouchers

More choices
Values and culture of who is doing the work. Are they consistent with the community?

Many concerns (again) about Mindsprings were raised by members. They felt that there is an ongoing need to shed light on bad actors and showcase what is working.

Nina said that Co Mt Medical and Vail Health merged and care has been better since then. Other people said they had not had a better experience and it seems that the issue may be that adult services are better but not children's services. Nina also said it might have been because she came in as private insurance.

Accountable care means outcomes expected, anticipated and enjoyed. Are people being served receiving outcomes anticipated? Clients do not know what they should be expecting

We need to do much more educating people on what they should expect, for example treating people with dignity, free from retaliation, etc.

Peer mentoring and advocacy needs to come in from the beginning and we need buy in from all providers, if advocacy and peer support is seen as a threat by providers otherwise things fall apart–if this is a confrontational thing it will never work, if this happens it gives all the power to the people who are getting no results.

Co Mt Medical is working but not sure if they take new Medicaid or not –need to find out
Large corporations hire students right out of school and take fresh students and bring them on board. We want there to be students so they can learn but the supervision needs to be done carefully and not part of an assembly line.

There is a local program called FIT, software, it measures outcomes and this goes against data and changes the nature of discussion.

There is a need for more transparency especially around community mental health centers. The centers say they are doing peer support and serving those with high needs. The answer is to get more peer support outside of mental health centers. If they are claiming they are doing peer support and they are meeting high needs clients they are not presenting themselves correctly. Peer support often happens on the phone at 2 am and often happens through other groups like CIL, friends, etc. This requires heart, time, and investment. David said that Axis used to claim services provided by the Independent Living Center were their services to try to get more money. Ian said there are the same issue with DHS

Client perspective peers students, interns, some clients might enjoy new perspective of a student, are they being driven out by bad supervision

How to get the right peer support when people do not want to hire us

Tracy asked if Mindsprings was still open, yes it is.
Sally shared about a crisis program and will send Julie information that all people can share. Tracy and others said that kids being sent out of town and no one knows where they are or what is happening

Transparency–know what you are getting into and the knowing is it really happening
People do not know what is happening. Also clients should feel respected enough so providers share what info is being shared about the client with the client.

Psych evaluations for some programs in coming in –some tools that can be used and insightful more than just talk therapy, -may be way to bridge the gap

Choose evaluators that will evaluate w dignity and outcome does not limit service

Brain and Body is an evaluation company and it is not a good company. They kicked out a kid for being disruptive while evaluating them for a disruptive disorder. Meg said that 50 providers just completed intensive training for people with IDD–need to get them into a better directory
Meighen asked if evaluators come to a more safe and familiar space to get a more accurate picture?

Tracy said that there is no communication with a family when the kid is sent out of town, she spoke of a situation where the family was trying to get it resolved for years and now the state has control. In this situation a care coordinator should be involved. The kid is likely in the Division of Youth Corrections but Todd and his team can find out who is involved, find who can get the release for guardian, etc. This kid was in a facility in Delta where he was doing OK and suddenly he was moved to Colorado Springs away from family.

How do we deal with two organizations that have such different outcomes, showcase what is working versus what is not example Prime vs Denver Health

Could there be an easier way to get to Rocky or any RAE feedback using a google form? **Yes we can do that and we were asked to submit the fields we wanted.**

Need to look beyond just the RAE but also providers, different counties etc Which providers or care coordinators listened, understood, shared info appropriately (or not), called me back versus sent me somewhere else. Etc.

There is training on things like disability awareness, culture of poverty, etc. How do you measure all of this..BHA articulated a simple metric to evaluate which is to use a Net promoter score. Simply ask "Would you refer or recommend a friend or family member for this service?"
They will see it first with BHA and hope HCPF will follow it.
Where are domains where you can provide feedback?
What are the orgs we want to collect info on? The bigger an org gets the more bureaucratic. Janice told a story about a friend of hers that has endured 4 months and 7 specialty visits for a broken toe.

Meg said there is a quality email box where one can ask for a care coordinator. She said Rocky needs to get info as soon as possible, as soon as you know there is a problem you should report it. If there is a quality of care issue, like someone being bedridden due to a broken toe, this needs to be routed for quality of care. There are many ways this can be reported. David said they still do not have a way to get neuropsychological evaluations in the four corners. Meg said they tried to find a neuropsych and got nowhere–looking for assistance. She said they eliminated prior authorization for neuropsych but if there are any providers we can recruit let her know. She said there is also a problem finding providers to serve people with eating disorders. She also said she was interested in building more peer support into the Rocky system.
Someone asked if we can operationalize this step of peer to bridge care coordinator gap–
Need to have time to build trust. The 1:1 piece for complex cases is important. A peer can say let's split this up so it is not so overwhelming. This takes some pressure off care coordinators

Meighen talked about a care coordinator that really built relationships and ran interference in more complex components and became an advocate. This individual understood who we were and what we needed and helped us get to the next step. The group agreed care coordinators need to be advocates. Also, consistency is important

Can there be a pool of traveling evaluators?

Need the people who do a good job to be a trainer (e.g. Meighen's care coordinator)

We need to make sure hospitals use the Rural Auxiliary Services program for interpreters. Some refuse such as Delta. **Staci will email Meg about the specifics with Delta Hospital.** Tracy also shared about not getting CART in a rehab class from Community Hospital.

Clients often do not report due to a fear of retribution. Psychological safety is very important and people need to be able to freely express opinions and should be measured in health care the way it is in employment. We need to measure experience and roll into a metric

Medicaid Eligibility and the End of the Public Health Emergency:

Julie introduced Marivel Kluckman and Shawn Bodiker who are with medicaid eligibility. They are both long standing allies of our community and advocates. Marivel provided a PowerPoint but we discussed the following points:

1) End of the public health emergency will likely be in April. ALL clients will be redetermined. We need people to respond to their notices.
2) There was a discussion about member experience and the following should help:
   a) Ex Parte redetermination, if the system has the info they will not ask the client.
   b) Continuous coverage for children.
3) Once the emergency ends people are no longer “locked in” to Medicaid. People will have protections as they go through the renewal process. If your regular time to renew is September you are on Medicaid until that time, in September, when you get a renewal (and if you are still eligible you will stay on Medicaid).
4) Meighen brought up an issue and Julie was asked to connect Meighen and Marivel.

It was mentioned that rural counties often don't know the rules–people felt the lock in was not necessarily applied in rural areas. Marivel said they were beefing up training. In January of 2022 they went through a huge rewrite of rules which increased accountability. Julie said that CCDC and other advocacy organizations strongly supported these changes. They have a team now that addresses issues quickly and engages in corrective action that can involve taking back money if the county does not respond.

Tracy asked if the rules distinguish between regular and WAD (working adults with disabilities) Medicaid? She turned 65 and redetermination was a real headache and she could not get an answer about coverage. They asked for a bunch of info and didn't understand the buy in. She said there is a problem with peak and Mesa county. Julie said the problem might have been that she turned 65 in June and over 65 was added to the buy-in as of July 01. However there should not be a difference.

Self employment is not verified through the interface. They also have to look at disabilities which may be in the SSA system.

Question: Is the renewal packet accessible online? It should be accessible—Marivel will verify
Counties were having trouble with buy in so they went through Denver health for all buy-in cases and that works better but counties still need to understand the basics.

There will soon be a process to submit comments and feedback about counties —this will help the state monitor and act.

Lynn went to the IL center for help after 3 times turning her packet into Mesa county. They keep saying they did not get it and supervisors say PEAK does not work. She ended up doing her renewal three times on paper and 2 times on PEAK.

County workers are hard pressed and training needs to be individualized for workers and use case studies. Marivel said that trusted relationships in the community is key for outreach.
Modernization of PEAK renewal a year ago. There is a lot of implicit bias by county worker clients need a trusted person

Renewal Changes:

1) Enhanced ex parte
2) Reformatted to make it easier to read and clearer.
3) The renewal WILL need a signature which is new. Clients can sign online or do a telephone signature but if they use paper it MUST be signed.

Marivel reviewed the timeline for renewals. She also went over what they are doing to shore up the capacity of county workers, the overflow processing center. The Train the trainer program is added as well. It was suggested that they start honoring the workers who are excellent and Lynn offered to send Julie some names of people who were excellent for Julie to pass on to HCPF.

One member was told the child waiver is based on parental income -this is NOT true, for waivers they look at child income only.

Marivel also mentioned their campaign to update addresses. They also have a toolkit to prepare for the renewals (for community advocates and partners) and a video series. Julie said this group did receive the address update information.

The group asked Julie to invite counties and CMS to attend this meeting.

ADELA FLORES-BRENAN –NEW MEDICAID DIRECTOR

Julie introduced Adela who has a history of excellent advocacy and is now the Medicaid director. She worked with the Colorado Center on Law and Poverty, The Exchange when it was starting (Connect for Health), and the Colorado Consumer Health Initiative.

She is still on a learning curve and her goal is to make Medicaid work better for members. She wanted to know what we wanted to see?

Lynn: equipment provided that does not take 7 months to get and multiple denials and appeals. People with a lifelong disability shouldn't have to work this hard to get medically necessary equipment that is a lifelong need.

Meighen—dream is that all folks participating in Medicaid have access to treatments, resources, and supports they need to live, healthy, thriving lives in their own communities, feel accepted, all services provided with dignity, providers paid equitably and timely, we have access to vouchers (especially in behavioral health) to use services when no Medicaid provider is available. Often services are not available in rural and frontier communities but if they could buy services they would be able to get care. Vouchers would save money, time and resources, and work together to get there on all aspects. She would also like to make sure we are able to communicate with each other, with HCPF, peer support written into every contract and operationalized and funded. She wanted to support kids who are falling through cracks earlier.

Janice agrees with Meighen and would also like to see Medicaid cover things not covered by insurance such as alternative care. Identify outcomes based on data, programs educating and supporting people with diabetes to put it in remission. Some alternative care can cure issues that are just managed by insurance. (Example diabetics getting help with healthy food as opposed to pills).

She said we need to quit doing what we have always done and getting things we do not want and try new things even if they don't work.

Advocate for access at all levels.

People on the front line are better trained in humane ways to treat clients, there is lots of discrimination and comments that put people off by front line staff (counties, front desk staff in doctors offices, call centers, etc).

Provider bias is an issue and increased quality is not always about increasing pay. She is working to increase peer support and wants to hear more about choice.

How do we move to celebrate what works and hold badactors accountable?

Vouchers are better than single case agreements that can take months, then they wait months more to get paid. Small providers cannot do online reporting because they do not have a large practice. Providers who would lean in and help a few people will not go through the burden,
Administratively we must think differently about how to approach providers.

We do not need protection, we need respect and to be believed

We are not allowed to pay a non-Medicaid provider privately and this puts us in a conundrum. Acupuncture and movement therapy worked well but are not covered under Medicaid. People are always afraid of breaking rules but just want to get care. Julie explained the history behind the rule of not allowing private pay because it would exploit people but you can pay for services that are not Medicaid covered services like acupuncture.

Several spoke of the overwhelming fear of retaliation —not with Rocky but elsewhere. People wished that other entities would have the open dialogue we have with Rocky to make changes and have leaders that are not threatened by people speaking out.

We need consumer direction in mental health. In other states it worked better. We have to do something different to get different results, this is not just Medicaid it is all over health care.

We have Money Follows the Person and now Community First Choice. We need to do this and implement more consumer direction instead of spending all the federal money figuring out how to spend money.

We need a better, more streamlined channel for consumer feedback –there are so many meetings and people feel input to HCPF is a black hole. Groups like this one work better but it takes time. Groups have to be a reasonable size and have investment of leadership and follow up. Member engagement that is real and meaningful is needed for success in any program.

MEETINGS FOR 2023

All meetings are from 9:30 am-4:00 pm with a lunch break. Unless we decide to do a meeting in a different location, meetings will be in Grand Junction at the Workforce Center.

- March 13
- June 12
- Sept 11
- December 11

PIAC meetings will always be the next day from 10:00 am-1:00 pm and all members are welcome

The meeting ended shortly after 4:00 PM