



**COLORADO**

Department of Health Care  
Policy & Financing

## **Meeting Summary of the Accountable Care Collaborative Phase II Program Improvement Advisory Council**

November 18, 2015, 9:00 A.M. – 2:00 P.M.

Colorado Department of Health Care Policy and Financing  
303 East 17th Avenue  
Denver, CO 80203

### **Desired Outcomes:**

1. Build a shared understanding of the Accountable Care Collaborative (ACC) Phase II
2. Gather feedback from clients, client family members, providers, stakeholders, etc. to inform Phase II regarding:
  - Health Information Technology
  - Stakeholder Advisory Role/Program Maximization
  - Payment

### **1. Attendees:**

55 individuals attended in person  
12 individuals participated by phone/webinar  
For a list of attendees, please see Attachment I.

### **2. ACC Phase II Overview**

Kathryn Jantz presents an overview of [Phase II of the ACC Program](#). In an effort to ensure all stakeholder have access to the same information about Phase II, specific question and answers from this meeting will be incorporated in to Frequently Asked Questions (FAQs). The ACC Phase II Team looks forward to posting FAQs in January 2016.

### **3. Health Information Technology**

#### **DISCUSSION TOPICS**

##### **HOW TO UTILIZE STATEWIDE DATA ANALYTICS CONTRACTOR DATA**

- 1) *How do you use the information? How do you or your organization use the information provided by the Statewide Data Analytics Contractor (SDAC)?*
  - a) *What is missing? What additional info do you want that is not currently provided?*

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- b) *Useful training and tools? What training and/or tools are useful to understand and use health and claims-based data (could be from the Department, other state agencies, private insurers). What tools/training could the Department or Regional Accountable Entities offer to providers?*
- c) *How to improve? What can the Department do to make the claims data more useful and actionable? Are there different ways to present the data?*

### **HOW TO USE INFORMATION FROM OTHER DATA RESOURCES**

- 1) *Other data resources? What other data resources do you or your organization use other than SDAC and Electronic Health Record (to stratify patient panels, develop care plans, and/or perform care coordination)?*
- 2) *Data resource utility? Of the data resources discussed above, which are most important for which activities (e.g. stratify patient panels, develop care plans, and/or perform care coordination)?*
- 3) *Why not Accessing Emergency Department information through RCCOs? What can the Department do to make it more usable?*

### **CARE COORDINATION TOOL**

- 1) *Essential Data Fields? Which data fields are most useful for communicating among care team providers and tracking coordination activities?*

### **SHARE OUT (HIT)**

- Social determinants of health MUST be included
- Trust is needed to collect info on social determinants of health
- Flexibility is important
- Dental history/health is important
- Data streams and access for larger providers
- Real-time, actionable data (need age appropriate dashboard)
- Care coordinators need access to real-time data (e.g., hospitalizations, job loss)
- Real-time eligibility data is needed
- RAEs need to risk stratify
- Behavioral Health
  - Behavioral health info is still missing
  - Integrated plan – conflicting regulations
- Make data more user friendly – minimal utilization due to lack of knowledge/training
- Provider report card
- ER visits → push notification to entire care team
- Data sources: dental systems, behavioral health, etc.
- Need info on facility accessibility for clients (ADA) physical, programmatic, communication
- Centralized data warehouse
- Data merging in a meaningful way
- Clarity of definition of “Care Coordination” – Integrated Plan
- Interactive tools for linking data
- Patient and family goals should be shared



- Core Team – who has access to the data?
- Conflicting releases
- Providers need access to broad scope of info to inform explanations of informed consent
- Re: Accessibility. Provider office accessibility for people with disabilities and seniors. CMS is working on a long-term push to get providers of Medicare to register three key components of accessibility (Physical, Communication, and Programmatic). This should be on the requirements wish list. This is difference of life or death for people with disabilities. Accessibility is a priority for the LTSS community and this should be built into the HIT requirements.
- Consider the different needs and experiences of small and large practices
- Building a tool that can meet the needs of members is more important than being building it around what needs to be fed upward.
- “We don’t feel we can do justice to the data element questions in this restricted timeframe.”

## 4. Program Oversight and Maximization

Overview of stakeholder engagement structures at Department and local levels

Susan Mathieu (ACC Program Manager) shares **Department structure for stakeholder engagement**

- PIAC – meets monthly. 23 appointed representatives and Department representatives. Would like to have more client voice. Three sub-committees that bring ideas/issues to PIAC:
  - Program and community issues
  - Bridging systems
  - Health impact on lives
  - Medicaid/Medicare group – will be incorporated into the others

Carol Bruce Fritz (RCCO Region 7) shares **local structure for stakeholder engagement**

- PIAC meets quarterly – includes providers within RCCO, providers outside of RCCO, consumer representatives, consumers. Struggle to get adequate consumer voice. Group helps design customer feedback form and review client newsletters and communication materials.

Kathryn Jantz discusses the two components of sound administration that are the topic of the table discussions: program oversight and program maximization

### DISCUSSION TOPICS (STAKEHOLDER ADVISORY ROLE)

- 1) *What requirements regarding stakeholder oversight should the Department consider implementing for the Regional Accountable Entities? (i.e. number of clients, types of stakeholder groups represented)*
- 2) *Do you have any experience with resources, training, or other supports that the Department and Regional Accountable Entities should consider implementing in ACC Phase II to enable stakeholders to be more effective in their advisory role?*



- 3) *Department utilization of stakeholders to monitor and guide ACC Phase II*
- a) *What role do you view the advisory committees performing for the current ACC? What value do you see them providing the program?*
    - i. *Are there program activities or deliverables you think should be reviewed by the advisory committees?*
    - ii. *Are there any barriers or issues you foresee in being able to review these types of information?*
  - b. *What aspects of the current advisory committee model do you think are most effective?*
  - c. *What do you see as the gaps or challenges with the current advisory committee model?*
  - d. *What changes would you make to the current advisory committee model?*
  - e. *Are there additional models the Department should consider adopting instead of or in addition to the current advisory committee model?*
- 4) *Based on your experience, what recommendations would you make to most effectively engage clients in program advisory committees at both the Department and Regional Accountable Entity levels? (i.e. training, presentation of materials, incentives/stipends)*
- 5) *Is there value in having topic-specific advisory committees, such as Primary Care Medical Providers, Specialists, Care Coordination?*

### **SHARE OUT (STAKEHOLDER ADVISORY ROLE)**

- Difficulty of community partner participation
- Flexible advisory group
- PIAC members wear multiple hats
- Subject matter experts for expert commentary
- Challenge to convene diverse stakeholders (due to scheduling)
- Challenge to organize and disseminate timely feedback in meaningful ways
- Potentially helpful tool for patient engagement measurement: AIR
- Data needs and technology
- Need better client representation and input at stakeholder meetings (rural, tele-health, duals)
- Social determinants should be reflected in RAE assessments
- How to identify and meet the needs of high-risk populations

### **DISCUSSION TOPICS (PROGRAM MAXIMIZATION)**

- 1) *What types of technical assistance do you need now and in the future to provide team-based, person-centered care?*
- a. *What approaches and formats for technical assistance have you found most effective? Does it vary by topic area (data usage, system coordination)*
  - b. *Who is the most effective provider of technical assistance? Department? RAE? Trade association? Academic Institution?*



- c. *What else does the Department need to consider when facilitating or making technical assistance available to providers, Regional Accountable Entities, and health neighborhoods?*
2. *What are different methods the Department should consider to facilitate rapid cycle improvement of the program?*
3. *How can the Department and/or RAE capture and disseminate local or regional best practices for improving the health system? (i.e. building relationships with county sheriff offices, partnering with Local Public Health Agencies, utilizing data streams from health information exchanges, chronic disease management programs)*
  - a. *Who should disseminate these best practices?*
4. *The ACC has been designed as a collaborative. What requirements should the Department consider for creating a stronger learning collaborative environment?*
  - a. *What should be the processes and requirements for sharing results of different activities and best practices among all of the RAEs?*
  - b. *Are there perceived barriers to using this information?*

### **SHARE OUT (PROGRAM MAXIMIZATION)**

- Discussions & questions answered in timely manner (empower RAEs)
- Appeals process
- Learning collaborative/community to share best practices
- Intentional learning collaborative move beyond internal best practices
- Minimal level of understanding of claims denial and eligibility
- Create forum or utilize PIAC structures to address all of the above
- Technical Assistance (existing) is considered and aligned
- Focus on commonalities, high tech is preferred
- Technical Assistance: data, reporting, and understanding
  - Rapid Cycle – should participation be required?
  - Training
  - Stakeholder input
  - Massive transparency
    - Evaluation is requested
    - Seems as though goal posts move
- More flexible benefits package
- Tie claims data and clinical data
- Invest in transforming care models
- Require Department participation at the local PIAC meetings
- Attribution – where people access care
- Payments to sustain team model
- Training on poverty and health impact
- Standardized messaging across RAEs
- Training and education to understand Medicaid system – need basic understanding of structure
- Understanding rapid-cycle improvement, what does good care coordination look like?
- Local differences and state oversight built into expectations and flexibility
- Front-end requirements reward bidders for local connection



- Broader diversity of stakeholders to advise RAEs
- Goals and performance indicators must be meaningful and can be impacted – RAEs need the tools to accomplish these
- Outcomes include meaningful aspects for clients
- Be transparent and explain reasoning for goals
- Team-based care – not one-size fits all
- Incorporate NON-encounter based payment. *“Payment methodology to support team-based care. All of the technology assistance in the world won’t change the fact that team-based care requires time away from patients.”*

## 5. Payment

### DISCUSSION TOPICS (PAYMENT)

Tables self-divide into three groups by area – Providers; RCCOs & BHOs; Other.

1. *What resources/reimbursement do practices need to deliver coordinated, team-based, person-centered care? (i.e., additional money for EHRs, staffing, quality improvement projects)*
  - a) *What is the best method to make these types of investments in practices?*
  - b) *How can ACC Phase II best support smaller practices in a meaningful way?*
2. *In order to best support practices in providing integrated, coordinated, team-based care, what are vital medical home activities that are not currently eligible for reimbursement? (i.e., team huddles, proactive outreach to clients)*
3. *What parameters should the Department put in place regarding the RAE’s payment for Health Teams?*

### SHARE OUT

- **Providers:**
  - Consistent template of payment distribution
  - Ability for PCMPs to participate in multiple RAEs
  - Feedback mechanism for PCMPs to raise concerns re: inconsistencies among RAEs
  - Key Performance Indicators improvement based on risk scores
  - Establish threshold for how much of total payment must be distributed to practices (%)
  - Differentiate between adults and children for KPIs
  - Create some kind of rural practice factor
  - Create some method to recognize small practices. Small dollar amounts
  - Research / listen to model primary care practices – could donate technology, collaboratives, share best practices
- **RCCOs & BHOs:**
  - What is a practice? Define it.
  - Thresholds for smaller and larger practices – look at financial models, allow for making decisions at regional level
  - Should care coordination happen in a practice (are all practices equipped for that?)

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- Are there codes that are open for some and not for others? Confidentiality reqs.
- Parameters for RAEs should be flexible and high-level in terms of how they pay, who they pay, and what they pay for
- **Others (state agencies, partners, client advocates & representatives):**
  - Resources – funding for physical plants/equipment; care coordination and staffing
  - Best methods: have proposals and adequate rates to support needed investments
  - for smaller practices
    - Open more codes to improve integration & coordination
    - Getting paid for care coordination
    - Allow greater flexibility (one size doesn't fit all)
    - Focus on small practices strengths
  - RAEs need flexibility in funding to support smaller practices
  - Activities not currently reimbursed:
    - Risk stratification process
    - Data analysis
    - Outreach for care coordination
    - Tobacco cessation counseling
    - Substance use disorders
    - Mental health disorders
    - Be able to screen entire family, not just child
    - Previewing patient records (for complex cases)
    - Scheduling processes for complex cases
    - Language interpretation services
  - The Right Questions:
    - Is this the right payment model?
    - Are we expecting managed care outcomes but not doing managed care?
    - Will the RAE have the tools it needs to be successful?
    - Are we bifurcating the provision of care from care coordination?
  - Need to separate upfront from ongoing costs (shouldn't have to chose between them)
  - Keep advance practice criteria
  - Incentives should be aligned
  - Payment should be risk-stratified
  - Not tied to NCQA requirements
  - Certain screenings should not be face-to-face encounters, price authorizations, collaborative care, team meetings, referrals, tech costs are NOT covered
- **Measuring Success:**
  - Focus still heavily on process not outcomes
  - Concept paper seems very prescriptive of what should be done in care coordination, without clarity of desired outcomes

## 6. Discussion and Concluding Remarks

Kathryn highlights some ideas that emerged from the discussion.

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- Behavioral health data - changing payment model should allow for this.
- Social determinants of health data (Federal Poverty Level, family relationships, transportation data). Should be possible to do some of this.
- CORHIO – need to think about state role in helping facilitate access to that data
- Provider Portal – Several RCCOs referenced some better reports. Use those as a model and incorporate those into the BIDM and distribute them back to providers.
- Think about 4-quadrant model and provide some interpretation/analysis

### **Program Maximization**

- Learning collaboratives & technical assistance.
  - National assistance
  - High-touch (not just a webinar), help with data once they have it in house
- Define care coordination and clarify the goals around it
- (Discrete idea) having a department representative at local PIAC meetings

### **Payment**

- % of the RAE payment dedicated to the health team
- Suggestions for in-kind support (self-management tools, how to support infrastructure development, costs)
- Scheduling and practice support to promote efficiencies

The presentation, and the [ACC Phase II Concept Paper](#) on which it is based, are both intended as starting points for a conversation. With stakeholder feedback, Department will revise, refine, and expand upon the concepts.



# Attachment 1: Attendees

## In Person

- Jill Atkinson
- Adam Been
- Susan Buttress
- Carol Bruce-Fritz
- Diane Brunson
- Amber Burkhart
- Drew Compton
- Coral Cosway
- Julie DeSaire
- Josie Dotsie
- Cynthia Doty
- Jen Dunn
- Joshua Ewing
- Rick Farr
- Stephanie Farrell
- Deb Foote
- Jennifer S. Hale-Carlson
- Harriet Hall
- Aubrey Hill
- Rachel Hutson
- Mindy Klowden
- Todd Lessley
- Leroy Lucero
- Laurel Karabastos
- David Keller
- Nancy King
- Sean-Casey King
- Gretchen McGinnis
- Michelle Mares
- Barbara Martin
- Susan Mathieu
- Shera Matthews
- Donald Moore
- Dustin Moyer
- Brandi Nottingham
- Mike Pattinson
- Stephanie Phibbs
- Carol Plock
- Steve Poole
- Brooke Powers
- Janet Rasmussen
- Dave Rastatter
- Randy Rattriff
- Anita Rich
- Brittany Rogers
- Shannon Secrest
- Tina Smith
- Shelly Spaldin
- Matt Sundeen
- John Talbot
- Sadaf Tehrani
- Elena Thomas-Faulkner
- Brenda Vonstar
- Marija Weeden
- Sue Williamson

## Phone/webinar:

- Rick
- Elaina Holkaday
- Elizabeth Forbes
- Sheela Miles
- Becky Enzo
- Jean Cisneros
- Pam Doyle
- Morgan
- Jason Greer
- Tracy Johnson
- Kelly Vivian
- Loiuise Delgado

