



Meeting Summary Colorado Accountable Care Collaborative Program Improvement Advisory Committee (PIAC)

These are the meeting minutes from the forty-ninth community meeting to discuss the RCCO RFP, the future structure of the ACC Program, and any future waiver filing. The meeting took place at the Colorado Department of Health Care Policy and Financing on December 16th, 2015.

Colorado Capitol Complex, HCPF Offices
303 E. 17th Ave., 11th Floor Conference Rooms

December 16, 2015, 9:30 A.M.

1. Attendees:

A. Voting PIAC members

- Anita Rich
- Aubrey Hill
- Brenda L. VonStar
- Carol Plock
- Dave Myers
- Donald Moore
- Dr. David Keller
- Harriet Hall
- Ian Engle
- Jean Sisneros
- Morgan Honea
- Pam Doyle
- Polly Anderson
- Rich Spurlock
- Shera Matthews
- Todd Lessley

A quorum of voting members was present.

B. Non-voting members and other attendees¹

- Adam Bean
- AJ Diamontopoulos
- Becky Encizo
- Brandi Nottingham
- Brooke Powers
- Carol Bruce-Fritz
- Casey with Kaiser
- Christian Koltonski
- Cynthia Doty
- Deb Foote
- Hanna Schum
- Jenny Nate
- Katie Jacobson
- Katie Mortenson

¹ From meeting sign-in sheet



- Kevin J.D. Wilson
- Lori Roberts
- Mark Queirolo
- Marty Janssen
- Matt Armet
- Matt Lanphier
- Nina Roumell
- Rachel Hutson
- Russ Kennedy
- Sheeba Ibidunni
- Stephanie Phibbs
- Susan Mathieu
- Tracy Johnson
- Van Wilson

2. Review and Approval of Meeting Summaries

Minutes from the October meetings of the PIAC were reviewed. The approval of the minutes was moved, seconded, and sustained.

3. ACC Phase II Policy Discussion: Health Teams

HCPF Staff Contact:

Mark Queirolo

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Dave Myers introduced Mark Queirolo, HCPF Behavioral Health Integration Specialist, and Hanna Schum, Project Implementation Specialist, to lead a policy discussion on Health Teams in Phase II of the ACC Program. [Draft updated language, derived from the ACC 1.0 RFP was presented to the Committee for discussion – materials are available here.](#)

- The presentation, and the Concept Paper on which it is based, are both intended to be starting points for a conversation. Will revise, refine, and expand upon the concepts.
- Mark Queirolo introduced proposals and discussed:
 - Health Team makeup
 - Health Team functions
 - Health Team support from the Regional Accountable Entity (RAE) and from the Department.
- DISCUSSION:
 - Question: What is the Health Team, exactly?
 - Mark Queirolo: We are visualizing the Health Team as having at its core the client (and client's family) and the client's PCMP. At its minimum, this is the Health Team. Other providers who have an ongoing relationship with the client may also be included; these may include providers of comprehensive, intensive, ongoing behavioral health interventions; long-term services and supports case management agencies; and certain intensive specialists who provide the majority of a client's care.



- Mark Queirolo: How should the Health Team be set up? Particularly around specialists? Should be a specialty care provider involved in regular care on a regular basis, but how do (or should) we define these providers?
- Comment: Think about kids. Revise language around families and kids.
- Question: Can the definition still be influenced / revised?
- Yes.
- Comment: In children's case, much impact comes from parents. Actually having a conversation is not something that can be pulled from claims data.
- Comment: If you try to only use claims data, you'll realize most sub-specialists function in groups. Further, some families have multiple interactions with ER physicians. But you wouldn't consider them to be part of the ongoing health team. Put the family at the center.
- Comment: Include a broader scope of individuals in the provision or coordination of care: criminal justice, social services, housing, HCP, anyone who's involved in the care. Parents. Anyone involved in caregiving.
- Hanna Schum: Who defines who is on the Health Team?
- Question: [Referring to Section 4 (a)]. The RAE and or Health Team will be required to provide data to BIDM. How do these intersect if a Health Team is inclusive of all of the folks who we just discussed?
- Hanna Schum: Details of a care coordination tool have not yet been ironed out. The Concept Paper suggested that RAEs provide a care coordination tool to their networks.
- Question: Is there alignment with PHR work?
- Hanna Schum: Yes. Care coordination and data sharing are two of the biggest pieces of getting the Health Team to work. Data sharing will be important both to allow for provider identification as well as to create cohesiveness in the Health Team.
- Comment: Is there a need to define the members of the Health Team? Fact finding process of determining who is around the client and creating access for data sharing will require will require a face-to-face meeting.
- Mark Queirolo: Trying to set some parameters. As much as we want to have broad BIDM access when it makes sense, we are assuming that we need to set some restrictions. Need to determine who meets the threshold of being intimately involved enough in care to see the full picture. May want to start with a smaller group of providers and then expand as the program matures, and when needs and capacity increase.
- Comment: May have an issue of double scope creep. Perhaps reframe, there are two issues being discussed: minimum standards for



care coordination and definition of the Health Team. These may bleed into one another. One of the minimum standards may be inclusion of the family as a part of the Health Team. Also looking for shared info and structure of the Health Team. May end up crossing ourselves. Inclusion of the family and family-centeredness should be discussed at P&CI rather than in this discussion.

- Comment: The Department should not identify the Health Team. The Health Team needs to be identified by the family or the patient themselves. "These are the people I want to have direct my care along with me."
- Hanna Schum: Agreed. However, we still need to know who they are if we're to support them and share data with them. Who should be working with the family? Should the RAE be responsible for feeding the data to the Department?
- Comment: Contrast between Health Team and Health Neighborhood would be helpful.
- Comment: Care coordinators often say that families don't have any idea where to start. Having them choose isn't always a perfect solution. PCMPs and care coordinators don't always have perfect info, but it's important to have them as players.
- Comment: Want to note that this document didn't include Community Care Teams (CCTs from RCCO1, for example) as "one or more of the following." It's included, through a broad definition, in the Concept Paper. Need to include in your Health Team document. It's essential for our community.
- Mark Queirolo: This was an omission from the list and not intentional; any structure a RCCO or community can currently pursue, RAE should be able to do, too.
- Comment: On the topic of "how do you determine a specialist's level of involvement?" Would assume that with a major condition, specialist would need to be involved. Since you have both claims data and condition data, could you assume that a certain specialist should be on the Health Team? For example, with heart failure, one would expect a cardiologist to be on the team.
- Comment: Seems like the Department is doing a Venn diagram. Social, physical, behavioral needs. Access or requirement should exist where these things overlap. Overlapping space will be different for different populations, but should still connect all of these different domains.
- Comment: Please consider geographic areas. In Limon, specialists may be in Denver. How will that work for the Health Team when members are not all in the same space? Just remember this.
- Comment: Want to ensure that it's understood that most Medicaid members don't need a Health Team. Be careful if payment is attached



to a Health Team in a certain way, as members of a Health Team may end up caring for many people when they aren't truly members of the Health Team. Services may be transactional, not relational. Look at that when determining how to structure payment to ensure that the system stays whole.

- Hanna Schum: To reiterate, Core of Health Team should be the family, client, and PCMP. Beyond that, it should just follow client need. Not everyone would need an extensive Health Team.
- Comment: Should there be case management for everyone? That would involve ridiculous bean counting. Specialty care should include hospitals because of pediatrics. In particular, because of Children's Hospital.
- Comment: To offer the MMP perspective: it's important to ask the question of who needs a Health Team. The MMP has required assessments of everyone and learned that not everyone needs an assessment. Conference in October focused on improving teams. We have often used the metaphor of a team (perhaps a football team). There is a role for the coach that the RAE can play — someone who can coordinate the players involved. Teams are dynamic; RAE needs to create the conditions for a team to flourish and provide care in a dynamic way. The current RCCOs work best as coaches. Having conversations with clients and helping them to structure their teams accordingly.
- Comment: Need to coordinate with CCBs and centers for independent living with requirements like this.
- Comment: Partnership with family is included under specialists. Could also include social component at the same time. Add as additional members of the core team.
- Comment: We are providing feedback as individuals and as members of the PIAC. If the Committee wants to take formal action and make a recommendation, it will need to take a formal vote.
- Comment: Sometimes providers don't want to talk with one another. How do you nudge without turning this into an immense push? What is the end goal of trying to create a care team?
- Mark Queirolo: We're trying to facilitate stronger whole-person care. Improving coordination among key providers and ensuring that each provider has the right information is one of the main goals.
- Comment: The point of the care team is to provide care. If you keep the patient and family at the center of this, then you'll be close.
- Comment: How do you facilitate care for those who need more help without making this into an onerous or bureaucratic process?
- Comment: In an ideal world, you'd want an inter-disciplinary team as you have in PACE. But we're not paying for a PACE-like model. Keep that in mind. Challenging for specialty care to get to be a part of the



team in a robust way that would be excellent for the patients' care when we still reimburse on a FFS basis. Medicaid reimbursement levels are not competitive with commercial insurance. The way care is paid for influences the way care is delivered. If there's not a form to help incentive providers, it's difficult to get the multi-disciplinary outcomes we're hoping for.

- Comment: Bridging systems focus was originally adults who are high-risk or frequently utilizers. If we could have a constant system, get a flag on the front page of their EHR – let us know their risk and who they're working with, that would be a great start. Needs to be easy to make connections.
- Comment: Who's the captain of the team? The PCP and care coordinator. Someone needs to be designated to have all of the information.
- Question: Hypothetical patient has multiple organ failure. Family, specialists, behavioral health issues all involved. We understand that the RAE has a stake in all of this. As a provider, do I know what that actually means? Is the RAE going to talk with the family? How it actually functions, I read this to mean, the RAE creates systems of support for those who want to access them. But it also says that the RAE will act upon information obtained [...] to improve outcomes. What does that mean to me as a provider? What authority do you give to the RAE to direct my actions? What obligations do I have to report back to the RAE?
- Mark Queirolo: To clarify, this practice support is from the original RCCO RFP. We're curious to know if this practice support is still useful. RAE should be there to provide the system and support. RAE is there to assist when a client or PCMP needs assistance. All of the decisions around care should be between provider and client. RAE is looking at population-level.
- Comment: For highly-sophisticated practices, how does this relate as far as RAE function goes? Adding another layer of administration for fully-integrated practices. Adding a requirement for the RAE may bleed down the line administratively
- Comment: The frame doesn't have much flexibility. Teams will change over time based on conditions that are either solved or not, and whatever presents itself. Teams will evolve.
- Comment: Also need to accept that the captain of the team may not be the PCMP. May be a case worker at the CCB. Patient at center of care? Then they define the relationships.
- Comment: Fully integrated, grant-based non-profit: we can't take on much more data reporting for the purpose of feeding the State. Great philosophical concept, but can't expect practices to keep delivering information. There are so many strict requirements. We're already



- Medicaid-reimbursed. The Department needs to be extremely respectful of the amount of money invested already.
- Comment: Case manager / care coordinator could be the center of the team. Person who is providing the care needs to know what's happening. Would be useful what the provider knows what the person is receiving. But the provider doesn't need any more work. Communication needs to go to the provider.
 - Comment: Talking about three different categories in need of differentiation. 1. Those who don't need a care team. 2. Those for whom it's working well. 3. Those who need a care team and don't have one. Need flexibility for those three categories.
 - Comment: KPIs and payment could be structured in a way that's more focused on a care team, not just on a single individual provider.
 - Comment: Regarding technology, we can't have a second login for a care coordination tool or for a tool that identifies members of the Health Team.
 - Comment: The biggest challenge is specialty care access.
 - Comment: Different instances of the same software package. It is exceptionally complicated. Very concerned reading page 4 [that the Department may] require the sharing of clinical data. That's a huge process which requires a lot of resources.
 - Hanna Schum: These requirements were aspirational, even at that time. Requirements could take a lot of different forms. Could be aligning with SIM, could be using CORHIO. This could be structured in such a way to limit administration.
 - Comment: 38 different EHRs are connected to CORHIO. There are a lot of platforms in the market.
 - Question: What does the Department want from this group by way of guidance from this group?
 - Mark Queirolo: How can we set some parameters around the definition, particularly regarding specialists? Need a tighter definition of the Health Team. What are the criteria or pieces of information needed to determine that?
 - Comment: Before you go down this road, tackle adequacy. Provider reimbursement rates limit the specialty care network.
 - Mark Queirolo: If we're giving them the support they need via the Health Team structure, hoping to ease some of the access to care issues in this domain.
 - Comment: Need to move away from the concept of number of visits. Team should be determined by client need.
 - Comment: Do we want to refer the issue of Health Teams to a subcommittee? Is a subcommittee focus needed? Discussed timing of the draft RFP. Next 2-3 meetings of PIAC will matter for getting input. Did the Department get what it needed?



- Mark: Still struggling in getting to exact answers here. Would appreciate a way to look into this more deeply. Whether through subcommittees or another forum.
- The Provider and Community Issues Subcommittee volunteered to take on responsibility for addressing the Health Team issue.
- The chair delegated the issue of Health Teams to the P&CI subcommittee.
- Motion: The ACC should develop a mechanism by which clients and / or families can designate the members of the Health Team in collaboration with the RAE and primary care provider.
 - Comment: Sometimes will have a member who doesn't want care coordination. Need to work to get their confidence. Concerned about the language.
 - Comment: No "must" or "shall" in the motion.
- Votes: in favor 8; against: 3.
- The ayes have it, the following recommendation was rendered to the Department.
- **"The ACC should develop a mechanism by which clients and families can designate the members of the Health Team in collaboration with the RAE and primary care provider."**
- More information about ACC Phase II and upcoming stakeholder opportunities can be found online here:
www.CO.gov/HCPF/ACCPhase2

4. Other Committee Business

The PIAC moved on to discuss subcommittee updates, the emergency room KPI, and ACC alignment with the State Innovation Model (SIM).

5. Discussion and Concluding Remarks

With no further items for discussion and time expired, the meeting of the PIAC was adjourned. The next meeting will be on Wednesday, January 20, 2016.

