Accountable Care Collaborative Program

RCCO 1 – Community Meeting – Program Improvement Advisory Committee

9 May 2014

These are the meeting minutes from the seventh community meeting to discuss the RCCO RFP. These stakeholder meetings are a collaboration of the Colorado Health Institute, the Colorado Department of Health Care Policy and Financing, clients, the Region, providers, advocates, and interested members of the public. The meeting took place in Region 1 on May 9, 2014.

RCCO 1 Meeting in Fort Collins.
Location: Foothills Gateway Building 301 Skyway Dr., Fort Collins, CO 80525

Attendees: [Advocates, clients, providers, county staff, CCB, FQHC, health networks, hospital representatives, mental health providers, physical health providers, RCCO, SEP, specialists, vendors.]

Anna Vigran, Austin Bailey, Bruce Cooper, Carol Plock, Cyndi Dodds, Department of Human Services (Larimer County) staff, Dr. Jim Sprowell, Jenny Nate, Jill, Karen Spink, Kelly Morrison, Kevin Dunlevy-Wilson, Lauren Barker, Laurie Metts, Marty Janssen, Matt Lanphier, Michele Lueck, Mike Huotari, Patrick Gordon, Randall, Randy Ratliff, SEP staff, Steven Thompson, Todd Lessley, Tyler Nichols.[1]

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1	**Introductions**	Patrick Gordon, Associate Vice President Rocky Mountain Health Plans, RCCO 1, introduced Michele Lueck of the Colorado Health Institute (CHI) and Kevin Dunlevy-Wilson of the Department's ACC Strategy Unit.
2	**CHI Presentation**	Michele Lueck and Kevin Dunlevy-Wilson provided an overview of the current ACC Program, discussed the RCCO RFP, and the Department of Health Care Policy and Financing's Strategic Plan for the ACC. • There are three primary goals for the next iteration of the ACC: "transforming our systems from a medical model to a health model," "moving toward person-centered,

[1] Please note this is not an exhaustive list of attendees.

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		integrated and coordinated supports and services," and "leveraging efficiencies to provide better quality care at lower costs to more people." • The Strategic Plan is divided into five domains: • Delivery System Redesign (provide care in a more integrated and patient-centric way), • State Administrative Improvements (invest in improvements that support better quality and functionality), • Information Technology (leverage technology to evaluate, to learn, and to adapt the system), • Payment Reform (test and innovate new models to pay for quality and value), and • Benefit Design (design the benefit package in a way that moves from a medical model to a health model). • While the Department is committed to adhering to the core principles of each domain, the manner through which the principles are operationalized into contract requirements is very open. Stakeholder meetings, such as this one, are intended to mold the commitments into concrete requirements. At the conclusion of the presentation, the conversation was opened to questions, comments, and discussion.
3	**Discussion of RFP**	• Department and CHI: From your perspective, what is working, and what is not working in the current ACC System? • Comment: In our region, one of the big things that is working is RMHP, the vendor. "It's frightening that there will be a new RFP and that could change. It would be hard to change the partnership mid-stream."

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		• Comment: RMHP when they got bid came in and listened to community. Figured out what would fit for Larimer County. Good listeners: that set the tone for working well together. Getting good outcomes. "RMHP is also very pro-BH integration. I love that." • Comment: "We understand the state procurement rules, but we have spent thousands of hours creating something that works for our community. It was very specifically planned. We required all practices to make changes. This, in turn, required RMHP to make a significant investment in the community." We came together to pool money to have payment go further. In RCCO RFP process you need to find a way to hear from the community. If HCPF changes our partners every three years, we are not going to want participate. We have made so much progress. • Comment: When looking at regions, also need to understand the diversity within a county. We are able to look at Larimer County and have two different plans, one in southern Larimer, and one in northern Larimer. That works well for our community. • Comment: I represent a primary care group in Ft Collins. We had historically been predominately in the commercial market. The opportunity to participate here has really brought our clinic into discussion about how to care for Medicaid patients in our area. It allowed us to partner and interact with people we haven't in the past. It opened our providers up to be willing to provide Medicaid care. We have always taken care of some clients with Medicaid, but until recently it was a relatively small part of our practice. Eight clinics in northern Colorado now. Medicaid is small piece of our business, but nonetheless an important part that requires a lot of these efforts and this collaboration. • Comment: Also CPCI practices, we currently have three. We are involved with a lot of these things. Closer work with behavioral health. We have new partnerships. • Department and CHI: Can you talk to us a bit about these community-developed, community-driven solutions? • Comment: The biggest example, in my mind, is the care team we assembled. It is a community-based care team. Not located in, or owned by, any particular practice or any particular party. Being able to pool dollars would take us much further than each

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		practice keeping their PMPM. What we've noticed is that patients tend to "float" between practices. It is easier to have care managers with them irrespective of which practice they go to. Because people go back and forth between Larimer and Weld, community-based team is huge. • Comment: One other concrete example is [a RCCO 1] group. We are getting a lot of data, patient data, high cost metrics, so many ER visits – etc. – potentially preventable events. [A RCCO 1] group came to me and said "we see these patients and here are the top 20 where the expenses are highest. Let's look at those with consistent doctors and care coordinators." Had behavioral health there to say if they had patient involved in their care. Got in touch with PCPs, called those patients and said we want to get you care management. Were able to move them toward care management. Not only high risk patients, but also those individuals with high cost. • Comment: The partnerships we've built have been invaluable. We're able to hone in our resources on relatively small group of Medicaid patients with lots of cost and lots of need. Unique and innovative model in this community. Team-based out of University of Colorado health, we can stay involved long-term because we're not billing. These people often have mental health diagnoses and substance use issues – and consequently need long term support. We can stay involved with some for going on two years now. Admittedly, there will probably always be a need. • Comment: That team is trans-disciplinary. Social workers and behaviorists hired by Touchstone – two organizations contributing to team – have records from hospitals, Touchstone, PCPs. There is an advanced practice nurse on the team, too. Based on targeting into individuals who need it. • Comment: My group is on the Loveland side of the county and I see our partners that we meet with a couple times a month. While going through the audit process and reading through charts, we saw partnerships and cooperation [detailed in] through those records. When looking at adult protection – worked hand-in-hand with RCCO case managers. Those two working together have helped homeless, mentally ill folks into housing. Similarly when partnering with the Single Entry Point. Sometimes you don't know how to navigate the system quickly, but they can help us do that.

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		• Department and CHI: Talk to us for a bit about the HIT / IT infrastructure here. What's working? What's the status when it comes to keeping care coordinated? • Comment: "It working for us, or us working around it?" Health information exchange is huge. We have different systems and we are working around it. Right now, we need a complete solution or platform. "People are banking on CORHIO to go live and save the world." • Comment: Regarding the existing systems we have today, SDAC is a powerful tool but it is foundational. It helps build context or start a conversation. Real-time data is, without question, worth its weight in gold. • Comment: [A RCCO 1staffer] and [a hospital network] did the hard work of figuring out how we get real-time hospital data to care management team in a way that respects both hospitals' need for privacy and our data needs. "Knowing Mrs. Smith was in the ER on Friday and calling her on Monday" is different than looking in the SDAC. SDAC is incredibly foundational, but they are symbiotic, not exclusionary. They have to exist together. No way to do daily work without real time data, and SDAC as foundational info. CORHIO sounds like another wonderful tool we can use, but not a population-level resource. • Comment: The work done with [a hospital network] is work that has to be done all over the state with every single hospital system. • Comment: I want to underscore what a big deal that is. We used to try to chase down data and patch together what we can. One day, [a hospital network staffer and a RCCO staffer] calls and said "we have daily admission, discharge, transfer (ADT) data we can send you." • Comment: It's useful to the care teams. Other regions could experiment with that same model. • Comment: Hospitals have developed daily ADT feeds distributed to multiple RCCOs,

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		• Comment: The volume-based model is not sustainable in the long-term. We need to do things differently in the future. That's why the coordination with hospitals is so important. • Comment: Regarding data sharing, one thing that would be helpful for state to do is "create some waivers around PHI." We have a lot of risk around managing patients and moving them across different provider types – including behavioral health. There is a risk for providers any time they engage in data sharing. We are trying to coordinate that care. If there is any waiver with CMS about personal health info (PHI) that would be helpful. • Question: What does that mean exactly? • Comment: Not having to get the patient to waive his or her right to restrict data sharing. • Question: Is this just around substance abuse / SUD services and sharing data with primary care? • Comment: That and behavioral health / physical health. • Comment: We are a family practice clinic, and we do a lot of behavioral health. However, we do not get credit or pay for it. Four years ago, if a mental health patient needed mental health service, give a phone number or referral. Now we have embedded in our practice a Touchstone employee that our doctors and nurses can contact. They are the primary contact when people need behavioral health services. We do intake in our office. Also have a full-time behavioral health licensed counselor in our office doing a variety of short-term counseling activities. In difficult cases we refer out to team, but we have the initial triage embedded – patients get access much more quickly. • Comment: Payment should allow for this type of intervention. • Comment: I see it as bilateral work between behavioral health, mental health, substance use disorder providers, and primary care. Whatever pairs are present in the care for an individual patient. In an ideal world, there are behavioral health specialists in primary care practices. People can present with wide range of behavioral health

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		conditions. Specialty behavioral health clinics also have primary care embedded there – and onsite care management – for those patients. • Comment: Virtual integration is another way to bring this array of services to various sites. • Comment: We would like to see [additional] billing codes opened [for integrated services]. • Comment: Broaden the payer model to allow us to serve people without behavioral health diagnoses, but to treat early in order to prevent the onset of a serious problem. Need to look at how we pay people. • Comment: Current system is set up to manage serious mental health crises, not to provide preventative or maintenance care that everyone needs. • Comment: There are different types of integration, much of what we see is just co-location. • Comment: Right. I think there are two layers to this integration of behavioral health and physical health. One is an entry level kind of thing – "how do I know what meds you are taking" before I prescribe others. The other layer here is tougher. For those patients who have significant physical health issues and serious mental illness, whether diagnosed or undiagnosed. For example, we had one patient, a woman with palpable anxiety, who had yet to be diagnosed, much less treated. She had spent the better part of three months, prior to intervention, calling 911 or in the emergency room for her COPD or there in a panic state. We recognized one of the things we wanted to do was partner with mental health, but without a payment structure to intervene with these people when they aren't diagnosed, things can't get very far. • Question: To what extent are other practices doing this? • Comment: It is becoming the standard in FQHCs, but less so in private practice primary care. • Comment: We are not tied to all of the restrictions BHOs are tied to. On our care coordination team for the ACC, we have come to realize that we are not just doing care

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		coordination. We are moving from one behaviorist, to three behaviorists on our team. When you think about who is doing care coordination, and what the focus of care coordination should be, we need more behavioral health care involved. • Comment: Our clinic has had a mental health center residency training program. Partnerships with local health districts really can expand behavioral health in clinics. • Comment: When funding these programs, we fragment some of the care delivery by payment type. If there were a way to reform that, so as to centralize or payment and administration, that helps with alignment downstream to the level of the provider. • Question: How will HCPF look at BHOs and their years of experience in managing risk, and how that strength can build with RCCOs? Modified payment structures that would build on that are best. In the next RFP, or even before, we want community mental health centers to be primary care medical homes. • Comment: CMHCs can be PCMPs for people who seek most of their care there. Especially if they have integrated or co-located PH services on-site. • Comment: The thing I think is stopping us from making more progress is the data we have available. We have made incredible progress in so many ways. SDAC data is great. Thinking about information for clinics and hospital, can we figure out what people need? There are addiction issues. In Colorado in the past, we have had a lousy approach to putting enough money towards attacking addiction the way it needs to be attacked. We have evidence-based practices, but don't have enough money or high enough standards. • Comment: We need parity for Medicaid substance use treatment. Need enough money to put people in residential care if they need it, then evidence-based care when they get out. We need to recruit trained psychiatrists comfortable with this type of work. That is the thing that nobody ever talks about. • Comment: We cannot solve these complex problems in two months for the most expensive patients. That's a problem with total cost of care, perhaps. We don't have the tools we need to help them. All this talk about frequent users, and these are the same people; SUD and high utilizers. Often this population has addiction-related

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		issues. These are long-term, serious medical conditions that have been given short treatment up to this point at great cost to the system as a whole. Perhaps the best idea I've heard so far is to pool money from Health and Human Services / Department of Human Services [with Medicaid funding]. • Question: How is capacity looking? • Comment: From an FQHC standpoint, there are many new individuals with Medicaid, but these people were often already getting treatment. So not so much of a capacity issue at present. However, we do need correct, faster attributions. • Comment: Our system is hiring enough staff fast enough to provide the care. We estimated 20% growth over whole year for capacity development. We are renting additional properties. In a way, we are becoming less efficient as we try to get facilities and staff to serve need. Working on a long-term solution with FQHC partners. • Comment: Our center staffed up as best we could. The fundamentals of Medicaid economics haven't changed; we have to be realistic. There are more people than primary care and still a serious payer mix issue around primary care. Need to maximize FQHC resources. Capacity could be enough if utilization were more even. That can be looked at in a number of ways, through the lens of a number of different issues, like with substance abuse disorders or social gaps, not just "high utilizers." • Comment: From the hospital perspective – one of the issues that is really bad is that it isn't just the cost you see in primary care. High utilizers come into hospital with medical problems due to substance abuse. When you evaluate your data analytics capacity, you need to be able to show cost of second and third DRG – substance abuse, alcoholism, - not just the "car crash injury" . If you want to reduce readmissions, that needs to happen on the outpatient side. If we have already grabbed the low-hanging fruit, then we need to work on high utilizers. • Comment: Primary care has to take the responsibility to move more rapidly to team-based care. We are still thinking about "capacity" in a traditional model, in a traditional setting, with a traditional provider. Patients-per-provider is not as useful a ratio as it once was. Not all Medicaid patients are the same, there are plenty of healthy

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		Medicaid patients. So you need to use resources to give people what they need at that point. To put it bluntly, in my opinion, "does everybody need medical home? No. But do some? Yes, absolutely." • Comment: I often tell people that Colorado saw an answer to rising health care costs in care management. The tricky part to all this is not the medicine; it is how to get the plan you made in the clinic to the person's home. One loop not yet closed is with pharmacy. 75% of visits to provider end up in prescription; patients need to take [that prescription] somewhere to fill, and they also need to know how to use it. I never hear about this problem until they come in next month. Perhaps there's an IT loop needs to be closed. • Comment: Taking all of this down to the grassroots of care managers and care coordinators. If you want to help with our time management we need to look at transportation. This is an area of tremendous failure. We try to get same-day access for our members, but we often cannot get medical transport. The time [care coordinators] spend on the phone trying to get transportation set up is unbelievable. When you consider that Medicaid folks often rely on cell phones with a limited number of minutes, sitting on the phone 30, 40, or 50 minutes to get a simple appointment for a ride... it's highly problematic, no wonder there is so much use of the ER. • Comment: Unless transportation / NEMT is fixed, you will have to hire CMAs to help people with the phone. It's as simple as that. • Comment: We need explicit permission for RCCOs to pay for transportation. That will solve this problem. Same for cell phone minutes. Allow flexibility for that to happen. • Department and CHI: You three mentioned non-emergency medical transportation (NEMT). We've heard a lot about these issues in other regions, too. Is it sufficient to give regions flexibility to pay for transportation? Or are their other elements involved? How big is the issue, and is it with the broker, or with all providers? Give us more insight into how this problem plays out in Larimer County. • Comment: Thanks. First, it's virtually impossible to get somebody on the phone. Transportation brokers and providers need to understand that it is not reasonable to spend more than 5 minutes on hold. Doctors, care coordinators, managers, everyone is

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		wasting an inordinate amount of time. Even with appointment for transportation set, the service is often unreliable. Drivers are too early, too late, or they no-show. • Department and CHI: Are problems similar with the 9-county vendor as well as with counties / providers? • Comment: It's the vendor. • Comment: Also counties. • Comment: Vendor, but less of an issue here. The bigger problem is the ridiculous rigidity. They won't let a second child ride along for first kid's appointment. What is the parent supposed to do? Especially if the transportation provider doesn't make this clear up-front. • Comment: From the hospital system's perspective, when discharging patients going east of Greeley this is a complete nightmare for dialysis patients. People are spending an entire day at dialysis unnecessarily. If Medicaid could understand how something as cheap as a cab ride could save $50,000 of readmission per person… • Comment: It's not just the centralized vendor. Calling for referral for a ride doesn't work. "We need to put wheels on care managers," and let BH providers, FQHCs, RCCOs lease vehicles. We can do that. • Comment: It could be built into PMPM or into a sub-capitation as part of a solution for high utilizing patients. The hospitals have a role to play here. • Comment: This is a huge problem here as you can tell. It would really help decrease ER visits. Many people call 911 because they cannot get a transportation appointment for two or more days. Even though it's not in Medicaid's purview, Colorado's rules need to change immediately. • Department and CHI: How much of the next RFP should allow RCCOs to facilitate socioeconomic interventions? We hear about substance abuse and the social determinants of health a lot. Help us think about how to write that in. Are there specific measures we could be tracking?

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		• Comment: I don't know exactly how you're going to measure this. Not so much what you're paying for, as what you're saving by doing it. Painful thing to try to measure. • Comment: That's right. We're all already paying for this, it's just that costs are diffuse. • Department and CHI: Would a PMPM addition for transportation and socioeconomic intervention / coordination work? • Comment: If you took 90% of what is being spend on transportation now and gave it to RCCOs, I think the RCCOs could make that money go much farther. • Comment: I came from Las Vegas where we had a voucher program. A person could call the taxi service and the ride would be half price. • Comment: Returning to the regulation and rules question, if we're going to use cabs, we need to buff up the cab service. In Weld County in our adjacent RCCO, there are perhaps 2 cabs outside Greeley. • Comment: Bringing us back to the conversation about capacity, it's important to understand in this part of the world we don't have as many primary care docs willing to accept Medicaid. Need to get payments up, or help safety net clinics expand. • Comment: I would say expand FQHCs and residencies; they know what they're doing. • Department and CHI: Let's finish the conversation about KPIs and measurement. What we should be measuring in next iteration in terms of quality? Currently measuring ED, high cost imaging, readmissions, and well child visits. As you all know, those are being revised [in July 2014]. What would you like to see measured? How to measure health/wellness? • Comment: We have watched our KPIs go in the wrong direction, ED and readmissions go up, but at the same time a drop in total cost of care. That says to me we are measuring the wrong things, or the way we are measuring ED visits and 30-day readmissions need some tweaking. At least if total cost of care is the future. That's because those are clearly not driving the cost of care. Something else is that's not tangible. Total cost of care should be one of those measures.

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		• Comment: Outcomes and total cost of care are better than process measures. • Comment: Some patients require more time-intensive interventions, but when you get everything right, it is amazing. Amazing to see these people finally get what they need. That is a true health measure, but it is not measured anywhere. It is like we don't recognize it for what it is. I want something to look at that population of people, health status, and quality of life. Develop that into a KPI. • Question: Is there a way to measure compliance? We hear people are discharged from hospital, then repeatedly no-show at PCP. Is there a way to measure showing up with visits at PCP or behavioral health? • Comment: How about the number of primary care visits? Measure if it's stable, also a [can be used as a] measure of when [a patient is] spiraling out of control. Remember, not everybody calls 911. • Comment: Cost of prescriptions – breaking into categories? Opiates? Others? • Comment: What about case management based on severity of illness? • Comment: Not to take us too far afield, but we need money for equipment in skilled nursing facilities for bariatric patients. It is difficult to get people into a different level of care. Some patients stay in the hospital because, at more than 500 pounds, no SNF would take them. They would need really good equipment to do this. The lack of up-front investment is driving up spending. Data should bear this out. • Comment: Returning to the social needs conversation, this is more common than you might think. You could buy someone a house for the number of days spent in the hospital [because of housing insecurity]. We need to get at both the cost and the quality of life. • Michele Lueck: Before we conclude today, I would like to invite you to offer some brief words of wisdom for the Department. In six words or less, share with them your suggestions for the upcoming RFP. What is the most important thing for them to focus on? • Comment: ADT data for RCCO and PCMPs.

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		• Comment: Things are better now, please don't close the program down, we can still do more. • Comment: Integration, team based care, payment reform, expanded substance abuse treatment benefit. • Comment: Maintain effective partnerships, state-of-the-art addictions interventions. • Comment: SNF equipment for bariatric patients. • Comment: Focus on transitions and handoffs of care. • Comment: We need real-time hospital data. • Comment: Payment reform, shared savings. • Comment: Let us maintain our relationship with RMHP. • Comment: Expanded funding and increased flexibility. • Comment: RMHP committed to this service area and we remain committed. • Comment: Spend time with care management. • Comment: Identify the lead coordinator. • Comment: Fix transportation in the RFP, please. • Comment: Establish expectation of info sharing. • Comment: Easier information sharing. • The Department and CHI turned the meeting over to RCCO 1 to conclude business.
4	**Closing Remarks**	Attendees were thanked for their participation. Those in attendance were welcomed to send additional comments and questions to **RCCORFP@state.co.us** The community meeting proceeded to finalize other business and was subsequently adjourned.