*Accountable Care Collaborative Program*

**RCCO 3 & 5 – Community Meeting – Program Improvement Advisory Committee**

6 May 2014

**These are the meeting minutes from the sixth 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 5 on May 6, 2014.**

**RCCO 3 & 5 Meeting in Denver.**
Location: CO Access Office 10065 E. Harvard Ave #600 Denver, CO 80231

**Partial attendee list:** [Advocates, clients, FQHCs, health networks, hospital representatives, long-term care providers, mental health providers, pediatric practices, physical health providers, potential bidders, public health agencies, RCCO, specialists, vendors.]

Amy Fitzgerald, Ann Kokish, Anna Vigran, Carol Reagan, Carrie Bandell, Deb Parsons, MD, Ed Berman, MD, Elizabeth Baskett, Jennifer Conrad, LCSW, Jessica Sanchez, Kathryn Jantz, Lynn Parry, Mario Harding, Mark Queirolo, Mark Wallace, MD, Melissa Kulasekere, Michele Lueck, Polly Wilson, RN, Roberta Capp, MD, Sam Seligman, Todd Lessley, Wes Sykes, William Burman, Zim Olsen.[1]

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| **1** | **Introductions** | The RCCOs' PIAC introduced Michele Lueck of the Colorado Health Institute (CHI) and Kathryn Jantz of the Colorado Department of Health Care Policy and Financing (HCPF). |
| **2** | **CHI Presentation** | Kathryn Jantz and Michele Lueck 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.<br>• There are three primary goals of 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 only a partial attendee list. Persons in attendance who were not on Colorado Access' minutes, as well as non-PIAC members, and participants calling in are not included on this list.

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | integrated and coordinated supports and services," and "leveraging efficiencies to provide better quality care at lower costs to more people."<br><br>• The Strategic Plan is divided into five domains:<br><br>• Delivery System Redesign (provide care in a more integrated and patient-centric way),<br><br>• State Administrative Improvements (invest in improvements that support better quality and functionality),<br><br>• Information Technology (leverage technology to evaluate, learn, and to adapt the system),<br><br>• Payment Reform (test and innovate new models to pay for quality and value), and<br><br>• Benefit Design (design the benefit package in a way that moves from a medical model to a health model).<br><br>• 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.<br><br>At the conclusion of the presentation, the conversation was opened to questions, comments, and discussion. |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| **3** | **Discussion of RFP** | • Question: Should there be more than 1 RCCO per region?<br>• Comment: This could only be sustained in areas with enough enrollees. Mostly major metro regions.<br>• Comment: 1 RCCO per region is preferred.<br>• Comment: My practice spans 4 RCCOs. In terms of structure, RCCOs are somewhat aligned with private ACOs, but while a practice could only contract with a single ACO, in the ACC many practices are associated with multiple RCCOs. We appreciate the program and understand that RCCOs should be based on geographic regions, for example rural vs. metropolitan areas. The needs of communities diverge significantly. But as RCCOs have evolved, their structure and requirements have drifted away from homogeneity. As a supplier in the market, we're in a complicated spot and the situation creates fragmentation. Following different rules at different locations, or thinking about the different incentives when helping different patients. It's hard to build a cohesive, integrated system that makes sense.<br>• Comment: Risk at the primary care level would help.<br>• Comment: Regarding integration of behavioral health and physical health, the fee-for-service system makes it hard for BH to work with PH. This is especially true as physical health providers are paid per visit. There are arbitrary time limitations and the divisions result in fragmented care.<br>• Question: Will HCPF revisit the question of geography?<br>• Kathryn Jantz: Pursuant to HB-12-1281, we are required to re-evaluate the regional maps. That process is being conducted alongside the RCCO RFP.<br>• CHI and the Department: Returning to the comment about primary care risk: are you suggesting some kind of capitation or sub-capitation to providers who elect for that model, and if so, does it involve primary care and specialty care?<br>• Comment: Yes, perhaps something like that. |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | • Comment: The divergent requirements of RCCOs are not too bad today, but we're looking to the future. If RCCOs are asked to do more, or are given further autonomy, they will have increasingly diverse requirements.<br>• Comment: Would be nice if RCCOs more aligned. My primary care practices work with four RCCOs. More similar, easier for practice to transform to meet one set of expectations.<br>• Department and CHI: Help us to understand that. One of the premises of the ACC is local control of RCCOs. Different decisions based on the community served. Is that still an important premise? Or should we think about standardizing at the state level in some way?<br>• Comment: Some flexibility is critical, but homogeneity in some areas would be helpful. For example, care coordination, expectation for medical homes, and standards.<br>• Comment: The most challenging thing is when one RCCO wants the practice to do care coordination, and the RCCO next door wants to do it all in-house.<br>• Comment: Returning to the integration question, as a program director for a mental health provider, I see several problems with trying to put behavioral health providers in the primary care clinic setting. The current FFS medical system doesn't integrate well when trying to have behavioral health providers working with primary care providers. The incentive is to see people for a shorter period of time. Insufficient flexibility to have behavioral health involved. FFS leads to fragmented care.<br>• Comment: Perhaps open additional BH codes.<br>• Comment: Payment reform at provider level is needed. Allow for more flexibility.<br>• Question: The BHOs were just re-procured. What is plan for syncing up BHOs with RCCOs? Are you looking at truly carving everything back in? Or lining it up?<br>• Department and CHI: We're all very interested in integration that provides the best care, but no decisions have been made about how that looks in practice. We would like |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | to ask you all about that. What makes sense? Meetings like these help to structure how we translate the ideal of "integration" into a specific set of requirements.<br>• Comment: Regarding BH integration and barriers that are there; I would like to see reimbursement for consultation. Not co-treating, but a workforce / specialists able to do curbside consultation. It's an ideal way to access specialty care through primary care, but there's no way to reimburse that right now.<br>• Comment: As an advocate for individuals with disabilities, and the "duals" population more generally, "behavioral health integration all sounds good and well." But where do these programs actually exist? The sense is that they are few and far between. A big gap between the ideal and what actually exists for people with disabilities and the notion of BH integration.<br>• Comment: System of FQHCs in Colorado. Payment reform is necessary for behavioral health integration, I want to echo that. Payment should follow the patient whenever it can. If a patient chooses to get behavioral health care in primary care environment, that payment should follow him or her into that environment. Or vice versa in a specialty behavioral health setting.<br>• Department and CHI: To what extent should the state manage the flow of these dollars? How do we retain accountability and flexibility in this model?<br>• Comment: Difficult question. Only answer is just to look at ways that are innovative and different than the current model. While we don't have a specific answer to that, I do think that moving payment towards general BH integration is the right direction.<br>• Comment: Current system is focused on critical cases only, and payment is part of the reason.<br>• Comment: Levels of acuity vary considerably by region.<br>• Comment: CMHCs are accountable to OBH and must follow OBH rules.<br>• Comment: Different regulatory structures are not conducive to an integrated model. The state should work to fix that division. |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | • Comment: In our office, we do have some BH providers, including one employee of Arapahoe-Douglas Mental Health. But can't see a Medicaid patient in our office because that person needs to be seen in a different office where her supervisor is.<br>• Question: What about engaging hospitals? They are a huge player in our health care system. Address barriers to getting clinics to partner with hospitals; need to move things forward on readmissions, ER utilization, etc.<br>• Department and CHI: What steps make sense to you? How can we address these barriers?<br>• Comment: Ultimately, there needs to be accountability. Some data sharing policy needs to be eased up by the state. Also need to address HIPPA regulations, etc. But it won't work to have 10 clinics sending 10 coordinators into hospitals, instead, need a shared model between hospitals and clinics.<br>• Comment: Agreed. Hospitals are quite important. Admission, discharge, and transfer data is very important to us as an FQHC. We cannot address admissions or ER use if we do not know it's going on.<br>• Comment: As an ER physician, we recognize that oftentimes, patients simply don't know primary care providers. 30-40% of our patients don't have a primary care doctor assigned. They're often Medicaid patients, and if we look it up, the data is often wrong. This should be addressed as well.<br>• Comment: We're an NP clinic in Aurora and we never get records from the hospital directly, so we know our patients have been in the hospital. Sometimes patients even hand [providers in the hospital] my card. But I never get discharge notes from anyone in the hospital, unless a hospital-based provider is kind enough to call. Maybe we could tie hospital Medicaid payments to this communication issue?<br>• Comment: Take what is working well and build on that. We are working with hospitals on Bridges to Care. Difficult to work out agreements, but they're in place and working. We can get a care coordinator to hospital, enroll them in program. Can bring down ER utilization 74% |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | • Comment: I work closely with that program. But there are absolutely hoops to jump through. These are often tremendous and it's still not totally working. I want to stress this: "HIPPA, HIPPA, HIPPA," this makes things very difficult.<br>• Department and CHI: Bridges to Care is a great program, but it also gets a lot of grant funding; more, in fact, than the state could cover under our current systems. We need to learn from you how we can develop economies of scale or bring out the most important parts of programs like this. The same level of funding would be about $2,000 PMPM, which is far outside of the budget. What can we as the state do to replicate these successes?<br>• Comment: Pediatric clinic, I agree with the comments on collaboration. We really need to know who is attributed to us and an efficient way to transition them to other providers when we need to.<br>• Comment: Dismissal process, transfer process.<br>• Comment: Advocate organization, if patients could pick their PCMP at time of enrollment in Medicaid that would help a lot.<br>• Comment: KPIs matter a lot, too.<br>• Department and CHI: What kind of quality metrics or KPIs should we use in the future?<br>• Comment: Immunization rates. For kids, immunization rates. For adults, immunization rates.<br>• Comment: Patient satisfaction measures.<br>• Department and CHI: We are currently using the CAHPS tool. Are there additional tools you recommend for gauging client satisfaction?<br>• Comment: We use "our patients don't leave." Measure long-term rates of attribution / utilization.<br>• Comment: Public health measures are also important. Blood pressure, for example. |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | • Comment: Related to all of this, perhaps having a point person. If a provider in one system or silo calls a provider in another system, did each provider offer a point of contact? We need clinicians to be talking with one another.<br>• Comment: Maintain the focus on the patient.<br>• Comment: The relationship, too. Both matter.<br>• Comment: With any hospitalization, there is often a hole because the patient's primary care provider does not have rights in the hospital. This can be so chaotic and frustrating for both the provider and the patient. We're not given much choice in the hospital. "They" make decisions for "us." For example, when we send people to rehab when they could go home for care.<br>• Comment: I represent in-home service providers for people with disabilities. From our perspective, mutually-exclusive domains between medical and social services. Let me explain, we have concerns with the words "integrated" and "coordinated." Medical model managing social services? My community does not want to be integrated at all with the medical home or the medical model. So how to do coordination? Delegate responsibilities between two domains that don't work well together with each other? So quality metrics such as quality of life and experience of care would add metrics that would link those two worlds in a new way. We need to talk about how these two domains will co-exist in new RCCO RFP in order to serve most vulnerable and most costly patients.<br>• Comment: We need some symmetry in this platform. Often, a minimum wage worker won't challenge a "professional" even if that worker sees a need in someone's home. We need to build platform for stable and equal relationships between the parties. "Don't want to impose medical thinking that can't jive with the needs of people." Need to have conversation about how that platform is built and maintained. Need to have that conversation with HCPF.<br>• Comment: Maybe this is part of that conversation. Many patients or clients are worried about how their info will be shared beyond behavioral health and physical health. But if we integrate services further, now there's something in their record used by housing, life insurance, membership to a gym, and so forth. There are repercussions |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | beyond integration that we hope are generally good. Variety of things that impacts that person's life. Huge issues. Respecting privacy and data sharing while gathering the relevant information. This will be a big job.<br>• Comment: Returning to the payment reform conversation, we really need to pay specialists competitively so they'll see Medicaid patients. That is a huge problem. We have a waiting list of about 12 people who need to see a rheumatologist. We've used up a couple of places for orthopedics, "Denver Health is one year out for orthopedists." We have to have a place to send people for specialty care.<br>• Comment: Data sharing piece for one quick moment. One of the concerns was getting the communication to the patients. Working directly with skilled nursing facilities, hospice, etc. to be able to get that information from hospitals 24 hours a day, 7 days a week. Talking about matching, need to match patient to PCP. Can't have that info routed without it. RCCOs need to have alerts. My hospice doctors say the same thing; we need to know when patient comes to an ED. Working with HCPF, LTSS, and duals to apply what we've learned. And soon, working on patient portals.<br>• The Department and CHI shared the timeline for the RCCO re-procurement, discussed the upcoming RFI (anticipated to be released in late summer 2014), and took final comments before turning the meeting back over to Colorado Access, RCCOs 3 & 5.<br>• Michele Lueck: Before we close for the night, please give us some brief parting wisdom. In six words or less—or a haiku, if you're so inclined—let the Department know what it should be focusing on as it moves into the RFI and RFP phases of redesigning the ACC. What are the most important things for them to take from this meeting?<br>• Comment: I'm a medication nihilist; savings in looking at medications we use.<br>• Comment: Refine care management.<br>• Comment: Yes, refine care management.<br>• Comment: Pay for telehealth in all forms.<br>• Comment: Build the health information superhighway. |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | • Comment: Continue toward whole-person care.<br>• Comment: Cover the continuum of behavioral health screening.<br>• Comment: Look at traditional managed care models; they work.<br>• Comment: Not integrated care without integrated data.<br>• Comment: Wraparound services; they cost, and they save.<br>• Comment: Do consider capitation as a model.<br>• Comment: Open health and behavior codes now.<br>• Comment: Better payment for BH integrated with medial.<br>• Comment: More patient navigators.<br>• Comment: More effective communication between providers and BHOs.<br>• Comment: Effective communication.<br>• Comment: Care for the elderly in skilled communities.<br>• Comment: More community-hospital partnerships.<br>• Comment: Continue to get feedback.<br>• Comment: Standardize the quality reporting metrics across regions in CO.<br>• Comment: Expand payment reform models.<br>• Comment: Identifiable integrated care teams that listen to what matters to patient.<br>• Comment: Allow attribution during enrollment.<br>• Comment: The rules and the payment and the data all need to align.<br>• Comment: Add mid-level names to hospital databases.<br>• Comment: Practice facilitation and community based care teams that provide services to public health community and medical model. |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | • Comment: Promote community health collaborations.<br>• Comment: Listen and listen carefully; do not discount prematurely.<br>• Comment: Use quality-of-life metrics and single care plans, especially for vulnerable populations with multiple providers.<br>• Comment: Personal respect and choice for persons with disabilities. And no wait lists.<br>• Comment: With communications, have it set up so instead of having to go to hospital database have it so you only have to know your patient's number, so revamp everything. Start with the patient, not the system.<br>• Comment: Drive payment reform and pay for quality.<br>• Comment: Payment reform around behavioral health in primary care.<br>• Comment: Payment codes for behavioral health services.<br>• Comment: Save resources by keeping kids healthy.<br>• Comment: Integrate social services with primary care to try to prevent child abuse.<br>• Comment: Real-time admission, discharge and transfer data.<br>• Comment: Create a statewide system of NP-run pain management centers for payment for alternative care for pain management.<br>• Comment: Better, more accessible resources for elderly transitioning back into community.<br>• Comment: Maximize competition in RFP process.<br>• Comment: Consider cost savings and outcomes across systems.<br>• Comment: Enforce collaboration between hospitals and clinics.<br>• Comment: Make data available to BHOs.<br>• Comment: Use Rhode Island as example for HI system. |

| ITEM # | ISSUE | DISCUSSION |
|---|---|---|
| | | • Comment: Payments and money will influence behaviors.<br>• Comment: Medical homes are sometimes with behavioral health.<br>• Comment: Integrated data, integrate data, integrate data.<br>• Comment: Remember patients are individuals with their own voice.<br>• Comment: Fund brief behavioral health consultations in pediatric visit with or without doctors present.<br>• Comment: Education in-services for different therapy needs.<br>• Comment: Effective communication.<br>• Comment: No integrated care without integrated data.<br>• Comment: Explore patients' incentives and dis-incentives to access care appropriately.<br>• Comment: Customer service, customer service, customer service.<br>• Comment: Keep telling people what you want, the only way things happen.<br>• Comment: Expand behavioral health services in the schools. |
| **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**<br><br>The community meeting proceeded to finalize other business and was subsequently adjourned. |