Accountable Care Collaborative Program

RCCO 4 – Community Meeting – Program Improvement Advisory Committee

22 April, 2014

These are the meeting minutes from the fourth 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 4 on April 22, 2014.

RCCO 4 Meeting in Pueblo, Pueblo County.
Location: ICHP Office 503 N. Main St. Pueblo, CO 81003

Attendees: [Advocates, providers, clients, health centers, CMHCs, FQHCs, RCCO, vendors.]

Amie Adams, Andrea Carlstrom, Anita Sefanich, Augustine Estrada, Ava Hoffman, Brandi Phillips, Cathy Michopoulos, Charmayne Sandoval, Chelle Deman,Chloe Baily, Cindy Jimenez, Cindy VanOstrand, Claire Chadwell-Bell, David Lockert, Donald Moore, Donna Mills, Dr. Broderick,Haline Grublak, Heather White, Jackie Anna, Jackie Brown, Jason Brokaw, Jason Greer, Jay Brooke, Jeff Johnson, Jeremy White, Jessica Medina, Justin McCarthy, Kami Cohoon, Kathryn Jantz, Katie Jacobson, Lisa Keenan, Lori Roberts, Melissa Richardson, Michele Lueck, Michelle East, Mona Allen, Myron Unruh, Nora Leist, Scott Jones, Susan Mathieu, Tina McCrory, Tom McCabe, Wendell Matthews.

ITEM #	ISSUE	DISCUSSION
1	**Introductions**	Donna Mills, ICHP, introduced Michele Lueck of the Colorado Health Institute (CHI) and staff in attendance from the Department of Health Care Policy and Financing.
2	**CHI Presentation**	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. • 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, integrated and coordinated supports and services," and "leveraging efficiencies to provide better quality care at lower costs to more people."

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		• 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, 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**	• Comment: Medicaid does not clearly communicate what is covered to clients. The RFP should address this through new and better client education efforts. • Comment: Need to look more broadly at health outcomes as they derive from social determinants of health. • Comment: Want to see a solid commitment to the regional/RCCO model. Health care being so local in a very diverse state; need to pull together medical and non-medical entities for each community.

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		• Comment: Regarding payment reform, there are many brilliant ideas but it's just not working. "Seeing disaster everywhere." Providers are frustrated, because of a lack of communication. Providers grew up with old model – EHR will not reach older providers, only new providers will be interested. • Comment: Messaging to providers should include a "binder" with policies, coding advice, etc. • Comment: Clients often don't know where to go for service, so they'll often go to emergency rooms. But federal marketing restrictions make it difficult to reach out to people, even with information that might avert some of this. • Comment: Many initiatives placed on the RCCOs right now, expanding their role from where it originally was. Much of it is useful, but since it isn't comprehensively detailed, it leads to provider / contractor / client confusion. • Comment: Regarding integration, as a non-FQHC PCMP, still having to do most behavioral health referrals to CMHCs. • Comment: Regarding IT / HIT, the ICHP software has been very useful. Need to expand and be able to see what other providers and entities are doing. For example Healthy Communities: log in, put Medicaid ID in, Healthy Communities is a provider, see if any care coordinators have been working with this particular client. Nothing too clinical necessarily – no SUD data, diagnoses, etc. Will be working from CORHIO to get data, but right now, data are keyed in – to track ER use. State should set a standard about how much to interact between entities. • Comment: Appreciate that standards are being provided, but some programs need teeth – e.g. COUP program referral. This tool is desperately needed, but ceased to work or was taken away. SDAC is robust, but people can't see data if a client is not attributed. Go through steps to ensure information is corrected. • Question from the Department: What tools can the state provide to help work with clients more efficiently? • Comment: Lock-in functionality would be very helpful.

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		• Comment: Faster attribution would be very helpful to allow providers to see their panels. • Comment: Near-immediate attribution would also be very helpful for intervening with parolees after release from prison. • Comment: Not only faster attribution, but also a lead care coordinator. Records should show who this person is, and requirements should make it clear that there is a primary coordinator. • Comment: The Department should evaluate all the RCCO requirements and deliverables to see what adds value; that is, what is working and what is "busy work." There are a lot of expectations. • Comment: "Need to coordinate care coordination." Discharge from hospitals creates a fragmented episode for a patient. Who does the work: case manager, discharge planner? The RCCO is supposed to help to facilitate at the system-level. But there are no incentives for hospital systems to not discharge to a clinical environment. This is simply due to liability. The finances and legal obligations need to shift slightly. • Comment: Practice support from RCCOs is actually creating more work on the administrative end for some practices. The scope of RCCO responsibilities needs to dovetail with what practices are already trying and, throughout, it should build off what has been established in research and the literature to work. • Comment: Understand that there is an active discussion of the number of RCCOs and the maps / boundaries of those RCCOs. Geography, balance of patients, risk, etc. In RCCO 4, there is a natural area that is grouped together. Communities are connected. • Comment: When looking at the map, remember the patterns of care and the patterns of work. Many people who live down here [Pueblo County] get their care in Summit County because that is where they work every day. Not sufficient to look at health care utilization patterns. • Comment: A lot of bleed-over between here are RCCO 7.

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		• Comment: Cross-RCCO boundary issues are rampant in urban areas; lots of crossing for providers, hospitals, specialists. Makes it difficult to manage quality indicators. In the future, take steps to facilitate communication between practices. Simplify the process for the provider. • Comment: Cross-RCCO standards are difficult. It is somewhat like dealing with multiple insurance companies. Hoping that things resolved at the state level get resolved in each RCCO, so as to minimize the different policy issues from region to region. Echoing attribution comments; should be solved by [the SDAC]. • Comment: Providers and bidders need to know more about what competition will look like. "Two or more RCCOs per region would be a disaster." Each bidder will have to design payment reform that's unique, and providers will have an even greater number of entities with which to contract. • Comment: Allow PCMPs to work more closely with a lower number of RCCOs. In some cases, increasing competition is good, but it also creates inefficiencies in many cases. On the integration question, remember the RCCO and BHO interactions. • Department and CHI: Before we wrap up, please give us a brief snapshot—in six words or less—of your advice for us as we move forward. Perhaps call out core principles that you would like the Department to focus on. • Comment: Payment reform. • Comment: Everything meets and focus on Triple Aim. • Comment: Standards, bottom-up (not top-down), patient, local, state. • Comment: Patient, community, health care is local. • Comment: Patient-centered, payment-reform, sensible measures. • Comment: Services connect with patients and system (MH, others). • Comment: Rules of the game (what are they?). • Comment: Reduce system limitations.

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		• Comment: Intelligent requirements that improve outcomes. • Comment: Continued BH/PH collaboration. • Comment: Incentivize wellness and prevention. • Comment: Consistent scorecard, attribution, pay for quality. • Comment: Know your rural communities' limitations and resources. • Comment: Payment reform and current technology. • Comment: Creating risk will drive innovative structures. • Comment: Strategic plan and support to providers. • Comment: Take care of patients; payment reform.
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.