



COLORADO

Department of Health Care
Policy & Financing

Meeting Summary

Colorado Accountable Care Collaborative Program Improvement Advisory Committee (PIAC)

February 17, 2016, 9:30 A.M.

1. Attendees:

A. Voting PIAC members

- Anita Rich
- Aubrey Hill
- Brenda L. VonStar
- Carol Plock
- Donald Moore
- Dr. David Keller
- Dr. Rich Spurlock
- Elisabeth Arenales
- Harriet Hall
- Ian Engle
- Jean Sisneros
- Leroy Lucero
- Mick Pattinson
- Morgan Honea
- Pam Doyle
- Polly Anderson
- Shannon Secrest
- Shera Matthews
- Stephanie Farrell
- Todd Lessley

A quorum of voting members was present.

B. Non-voting members and other attendees¹

- Adam Bean
- Amber Burkhart
- Anne Jordan
- Becky Encizo
- Brandi Nottingham
- Brooke Powers
- Carol Bruce-Fritz
- Casey King
- Chavanne Lamb
- Christian Koltonski
- Cynthia Doty
- David Ducharme
- Deb Foote
- Dustin Moyer
- Elena Thomas-Faulkner
- Ellen Kaufmann
- Gabrielle Mendez
- Gretchen McGinnis
- Jeff Bontrager
- Jennifer Hale-Coulson
- Jenny Nate
- Joel Dalzell
- Joshua Ewing
- Katie Jacobson
- Katie Mortenson
- Kevin J.D. Wilson
- Lesley Reeder
- Lori Roberts
- Matt Armet
- Matthew Lanphier
- Nicole Sherwood
- Nina Roumell
- Patrick Gillies
- Rachel DeShay

¹ From meeting sign-in sheet



- Rachel Hutson
- Russ Kennedy
- Shelly Spalding
- Sophie Thomas
- Stephanie Phibbs
- Tracy Johnson
- Victoria Gersuk
- Zach Lynkiewicz

2. Review and Approval of Meeting Summary

Aubrey Hill, co-chair of the Committee, asked that the meeting summary from the January meeting of the PIAC be reviewed. The approval of the minutes was moved, seconded, and sustained.

3. ACC Phase II Update: Timeline and Behavioral Health Payment Methodology

Aubrey Hill introduced Kevin J.D. Wilson, policy analyst for long-term strategy with the Department, to provide an update on ACC Phase II. The discussion topic was an amendment to the ACC Phase II Concept Paper.

[The February announcement involving the procurement timeline and behavioral health payment methodology can be found online here.](#)

- Kevin J.D. Wilson: Following stakeholder feedback and guidance from the Centers for Medicare and Medicaid Services, the Department has moved the start date for ACC Phase II to July 1, 2018. The timeline has been postponed a year, and the Department is confident this will give us all additional space to fully vet the upcoming delivery system.
- The RCCOs and BHOs will continue their work for an additional year.
The Department has adjusted the proposed payment methodology for behavioral health services. The payment methodology must include alternative services, also known as (b)(3) services. Payments must ensure accountability for continuity of care and should also enable flexibility.
- A modified capitation payment methodology will be retained to finance core behavioral health services. The capitation will be paid to the RAEs. The capitation will differ from the current capitation administered by the Behavioral Health Organizations (BHOs). Differences include:
- Adjustments to the diagnosis and services parameters to help clients access behavioral health services and reduce barriers to care; New value-based purchasing incentives that promote accountability for physical and behavioral health outcomes; and, Shifts in funding to create flexibility to pay for integrated behavioral health services within primary care settings.
- DISCUSSION:



- Question: Are there plans to constructively engage with stakeholders to build out details?
- Response: Yes, the Department will need the help of stakeholders to develop and vet details. Stakeholder meeting dates will be posted to the ACC Phase II website.
- Comment: Please update the Committee with final dates.
- Question: What is included in "core behavioral health services?"
- Response: Details are still being developed and stakeholder input from providers, clients, and advocates will be necessary. We expect some items, like (b)(3) alternative services to be retained similar to the current BHO capitation.
- Question: Are there specific expectations about savings that will be generated? What about conversations we've been having about gainsharing, shared savings?
- Response: The Department does expect administrative savings in integrating the administrative functions of the RCCO and BHO. I cannot speak to specific projected budgetary savings. We know that integrated services provide better outcomes and better long-term cost savings.
- Question: Do you expect that there will be a medical loss ratio included in the capitated portion of the RAE's reimbursement?
- Response: I have not been a party to those conversations, however I would have that expectation. The Department has used medical loss ratios in many recent contracts that include a capitation.
- Question: Will current capitation payments change prior to ACC Phase II go live?
- Response: There are a number of incremental changes planned between now and the go-live for ACC Phase II. These include cost savings measures, financial transparency, and more pay-for-performance. We expect to make incremental improvements in the current contracts.
- Question: Are there opportunities for us to be involved in the development of the specifics of payment?
- Response: I would refer to the ACC Phase II webpage. We can follow-up with the Committee once dates are finalized.
- Question: You've mentioned integrated services, do you have any sort of list of what services would be included?
- Response: Not at this time. We will need help from our stakeholders



to get to that level of detail and we encourage recommendations.

- Question: Will these services be paid for capitation or fee-for-service?
- Response: I don't know the answer to that question. The Department has expressed a desire to avoid opening too many codes, but may not be ideal to have these services financed out of capitation.
- Question: Can you talk a bit about why the Department tries not to open new codes? We've run into this before.
- Response: I cannot speak to the Department's ordinal rankings among the factors that play into whether or not a code is opened. There are both fixed and variable costs associated with opening codes.

More information about ACC Phase II and upcoming stakeholder opportunities can be found online here: www.CO.gov/HCPF/ACCPhase2

4. Sub-Committee Updates

Provider and Community Issues

- Aubrey Hill introduced Todd Lessley who provided an update from the Provider and Community Issues Subcommittee (P&CI). The Subcommittee brought a draft recommendation to the PIAC regarding the Emergency Room utilization key performance indicator (KPI) for the next fiscal year.
- Subcommittee emphasized importance of standardization, education, and performance improvement projects. Tackled questions involving: How can we mitigate the impact on providers in multiple RCCOs? Are the target reductions appropriate or achievable? Is the 7.5% threshold appropriate?
- Did not have 100% agreement with all subcommittee members. We intend to bring a formal document to PIAC in March.
- DISCUSSION:
 - Question: Does the Department have a timeline for adjusting the KPI?
 - Response: Language needs to be finalized in time to be included in the July contract amendment. March should give us sufficient time.
 - Comment: Expect a formal recommendation next month.
 - Question: The proposal says "PCMPs will be allowed to choose their own target populations." Can you discuss this further?
 - Responses: The Departments proposal involved each RCCO picking their target population, which may impact PCMPs that serve clients from multiple RCCOs.



- Comment: The Health Improvement subcommittee believed that the common metric is more important. Was pushing in the opposite direction.
- Question: Is the Department's position that each PCMP could pick its own metric?
- Response: Each RCCO would choose its own target population. The PCMP could pick whichever RCCOs' ER measure it wanted, but that will be up to RCCOs and PCMPs to discuss on their own.
- Comment: Committee desires standardization.
- Comment: Primary care providers should have one metric for ER.
- The HIL and P&CI subcommittees will discuss coordination and timing offline.

Health Impact on Lives: Health Improvement

- Aubrey Hill introduced Dr. David Keller who provided an update and a recommendation to the committee regarding the measurement of patient/client experience of primary care in ACC Phase II. The recommendation is located [here](#).
- Regarding measuring patient/client experience in the ACC, CAHPS has been administered since 1998, on a statewide sampling basis.
- In CAHPS, not a lot of variation across RCCOs. 57% reported they received care from their PCMP, 72% reported their care was coordinated.
- To ensure this data is actionable, it needs to be linked to primary care practices. To do that must involve the RAEs.
- Recommendations:
 - RAEs must use a validated, common survey.
 - Annual administration of surveys.
 - Survey results should be analyzed at both the provider and regional levels.
 - Needs to be administered through the RAEs.
 - The RAEs and large provider systems should work collaboratively to administer surveys to make use of what's already in place. Warning about survey fatigue.
 - Results of survey should be public and shared in forums and the HCPF website.
 - Should develop incentives for improving client experience of primary care.



- Guiding principles: Needs to be patient/client-family focused. Data should be tied to actionable outcomes. Core set of standard measures to compare across different plans and different states. CAHPS should be complementary to qualitative data.
- The Subcommittee asks the PIAC to adopt this as an addition to the ACC Phase II recommendations.
- DISCUSSION:
 - Comment: Needs to be a lot of input into what kinds of questions are asked and how many questions are asked.
 - Comment: Hopefully we take the questions to focus groups.
 - Question: What is the baseline?
 - Response: Didn't address that in recommendation. We would want a year of baseline information gathering.
- The motion before the Committee was the adoption of the Subcommittee's recommendation. It was seconded, a voice vote was taken, and the motion was passed.
- **The Health Impact on Lives (Health Improvement) subcommittee's recommendation was adopted by the PIAC. It will be transmitted to the ACC Phase II team at the Department.**

MMP Advisory Committee

- Aubrey Hill introduced Elisabeth Arenales, Liaison to the MMP Ad Hoc Advisory Subcommittee, to provide an update.
- Subcommittee has not met since the last meeting of the PIAC.
- Currently discussing how to incorporate this advisory structure into ACC PIAC. Committee will discuss ways to disseminate lessons learned from the MMP.

5. ACC Access-KP Payment Pilot – Update

Aubrey Hill introduced David Ducharme, Acting Program Innovation Manager with the Department, to present on the ACC Access-KP Program. The handout can be located [here](#).

- The program is scheduled to launch in July 2016 in RCCO 3. The initiative is a limited benefit, capitated primary care model. Colorado Access will be sub-contracting with KP to serve as the provider network.
- The enrolled population will be those living in Adams, Arapahoe, and Douglas counties who are using Kaiser Permanente as their PCMP.



- Benefits will include primary care services, preventative services, and some specialty services. KP will provide care coordination.
- The Department has received CMS approval for the State Plan Amendment.
- The Department is making final changes to MMIS. CO Access and Kaiser are finalizing changes to their systems.
- DISCUSSION:
 - Question: Regarding specialist access, what are you testing here and how was that decision reached?
 - Response: We designed the benefit package to align with KP's business structure which is largely focused on primary care, preventative care, and a small subset of specialty care services.
 - Question: Are people locked in to the primary care provider? What kind of referral capacity / network adequacy is in place?
 - Response: KP has a robust specialty care network to meet contract requirements with HCPF. If the specialty care service is only available out-of-network, then we execute an agreement for that service. If a member needs a referral, they get it from their PCMP.
 - Question: Sometimes people need specialty care immediately. How long does this generally take?
 - Response: Pursuant to the contract, people with special health care needs must have access to care from their existing provider until such time as a suitable in-network specialty care provider can be found.
 - Question: And if a client suddenly develops a need for a specialist?
 - Response: If we don't have a specialty in-house, we still provide it out-of-network. KP will pay the claims.
 - Question: Can you discuss payment in these cases?
 - Response: KP will pay all associated claims, not MMIS. In the event that a specialist is not a KP specialist, we would have the billing authorization conversation.
 - Comment: Clients will be identified in the provider eligibility portal as being enrolled in this managed care program.
 - Question: What is in place to keep a client from seeking care outside of this system?
 - Response: The payment structure. Out-of-network providers will not be paid for services that are contained in this benefit package.
 - Question: That may be a problem for providers who are unaware of



this program. How will providers know?

- Response: Providers are responsible for checking insurance status in the provider portal. Colorado Access and KP will engage in outreach to other practices.
- Comment: Pass along language that will be used. Record webinars with screenshots of the provider portal. Post webinars on website.
- Question: What kinds of materials are going to be sent to clients?
- Response: KP will send out two letters, a membership card and member guidebook within the first 30 days of enrollment. Spanish translation available. Clients will have 90 days to opt-out. We are being careful to only enroll clients with KP utilization and KP as their PCMP.

6. ACC Phase II Policy Discussion: Strengthening the PCMP-Client Relationship

Aubrey Hill, introduced Kevin J.D. Wilson and Matthew Lanphier, both of the ACC Operations section of the Department, to lead a policy discussion on strengthening the PCMP-client relationship in ACC Phase II.

- Kevin J.D. Wilson provided an overview of the proposed attribution and enrollment methodology changes that were outlined in the Concept Paper. Changes include: automatic, expedited enrollment; auto-assignment to a PCMP; PCMP attribution will drive the enrollment into a RAE.
- DISCUSSION:
 - Question to the Committee: Should the attribution to the PCMP be for the length of the enrollment period? What kinds of changes in the connection make sense?
 - Comment: Providers can't enforce that kind of relationship. We need to ensure clients are attributed to the place they're seeking care. The system needs flexibility so client can switch providers if they want.
 - Comment: The attribution methodology in place is unreliable. Our suggestion is to run the attribution algorithm regularly.
 - Question: The Phase II team is interested in having a larger number of people served by Medicaid self-select their PCMP. How often do you go back to people to ask them if "this is still your PCMP?"
 - Comment: Need a better way for clients to update their information with the Department. Health Colorado has long wait times.
 - Question: Attribution methodology has improved, but is still imperfect. Are there are tweaks you can think of that would make it better?



- Comment: Yes, attribution by Well Child Checks for kids. Also provides an incentive for practices to provide preventive care.
- Comment: This sounds like an annual lock-in, but there's no teeth unless you also look at denial of payment for a lack of referral. What is the intention for trying to improve connectedness?
- Response: Goals we are seeking to achieve (from the Concept Paper):
 - Fostering a medical home; Strengthen relationship between PCMP and clients/families; Continuity of care; Enabling providers to commit and plan services and resources more effectively; Enhance comprehensive primary care and complex chronic disease management; Greater accountability for outcomes and more pay-for-performance opportunities
- Response: This would provide better insight into who's involved in influencing the care a person receives. Need to promote consistency for payment reform and accountability.
- Comment: What does it mean to a client to be attributed? Starting off, clients knowing who they're attributed to. What does that really mean? Why do we encourage the use of one provider?
- Comment: As a client, I've never received any kind of communication indicating my PCMP.
- Question: Let's discuss the language we're using here. Are we talking about attribution to a provider or to a practice?
- Response: Attribution to a practice.
- Comment: We need to define "practice" in some way.
- Question: If we look at practice location – a brick and mortar physical location – is that a useful level of analysis?
- Comment: Many providers use multiple locations.
- Comment: Rural providers with multiple physical locations, but only one group of providers who travel from location to location. How you treat those will be interesting.
- Comment: This may create differences between Medicaid and the private market. Need to be mindful of the churn population.
- Comment: Locking people into a PCMP may affect the client's outcomes and quality of care. Stigma associated with participating in Medicaid may be enhanced when we create a structure that makes it different from private insurance.
- Comment: To what degree does attribution matter to a patient? We



need to drill down to what patient level accountability looks like.

- Comment: Need to know what the Department wants to accomplish.
- Response: Beyond the goals that we've discussed?
- Comment: Is it about patient engagement? Or is it about payment?
- Response: Do those two need to be in conflict? How important is it for PCMPs to have tools to keep clients within their practice?
- Comment: I'm not certain it's possible to satisfy both needs. You may need to decide on which goal to pursue and structure everything around that. Locking someone into a PCMP when they're not locked into Medicaid for a 12 month period is really flippant.
- Comment: Why does Medicaid have to be different than commercial insurance? It would be great to see data from commercial plans. There are not enough primary care providers to provide medical home level care to everyone. Clients seek care when they need it. We may be trying to force something that doesn't happen naturally.
- Comment: What is the average length on Medicaid, 7-9 months?
- Response: Average time covered by Medicaid was slightly longer the last time I checked, but I cannot speak to the exactly length.
- Comment: We need to discuss churn and continuous eligibility.
- Comment: My commercial insurance has the name of my PCP on the insurance card. Why not list the contact on the Medicaid card?
- Comment: The point of attribution is to move towards alternative payment models. If we're in wholly FFS, there is no point in attributing people.
- Question: Would the Department like to come back with the next set of proposals or questions?
- Comment: Yes, I think we will want to come back to the Committee with several of the issues we addressed today. We'll take this back to the ACC Phase II team and invite them to discuss this further with the Committee in the future.

More information about ACC Phase II and upcoming stakeholder opportunities can be found online here: www.CO.gov/HCPF/ACCPhase2

7. Department Legislative Update

Aubrey Hill introduced Zach Lynkiewicz, Legislative Liaison at the Department, to discuss legislative priorities for HCPF during this legislative session.



- Zach Lynkiewicz: The Department has three bills on its legislative agenda this session:
- Medicaid Transportation Providers
 - The bill creates a new category of limited regulation carriers that allows providers of nonemergency transportation (NEMT) to Medicaid clients to operate under a limited regulation permit from the public utilities commission (PUC) rather than a "certificate of public convenience and necessity." We believe this may help to improve access to NEMT for Medicaid clients.
- Medicaid Option For Prescribed Drugs By Mail
 - This bill allows Medicaid clients the option to receive prescribed medications used to treat chronic medical conditions through the mail.
- Removing Obsolete Reporting for HCPF
 - This measure would remove several reports which are no longer necessary, or reports on program which no longer exist.
- We are tracking a number of bills, including SB-120 which regards an explanation of benefits to clients. We don't have a position on the measure.
- DISCUSSION:
 - Question: Is a fiscal note available for the bill yet?
 - Response: As of February 17, no.
 - Question: We have concerns about privacy concerns. Cases involving domestic abuse, family planning, mental health. Will notices go to a particular household member?
 - Response: Only accessible if you're the client, but for children, I would assume parents could access.

Comment: Hope there's consideration of keeping mental health, SUD, etc. out of the EOB.

8. State IT Infrastructure – interChange (MMIS) and BIDM – Update

Aubrey Hill introduced Joel Dalzell, manager of the Health Data Strategy Section of the Department, to discuss the state's IT infrastructure.

- Joel Dalzell: Regarding the MMIS timeline, HP is tracking toward a 10/31 implementation. In the event of a delay, the Department has funding for its legacy vendors, who must be notified 6 months in advance of delay.
- Regarding provider revalidation, more than 20,000 providers have begun or



finished the provider enrollment process and about 14,000 have been approved or are in final review. We have added resources to work the backlog of provider questions and issues related to revalidation.

- CMS has extended the federal deadline for revalidation. However, providers that have not revalidated by the time the interChange goes live cannot be paid by Medicaid.
- The BIDM project has 3 stages:
 - 1) March 2016 launch of our legacy historical data (internal to the Department),
 - 2) November 2016 launch of functionality to support the interChange go-live, and
 - 3) 2017 launch of additional functionality and business intelligence tools for Department and external entities like RCCOs, providers and case managers.
- The BIDM will encompass all SDAC/ACC supporting functionality in Stage 3. Truven (our vendor) is developing a stakeholder engagement plan for this effort. We will share those results in late March or early April.
- DISCUSSION:
 - Question: Do you know if we'll be able to retain the benchmarking we have today? How about total cost of care?
 - Response: It is unlikely that we'll be able to reproduce what we've used in the past. Our work in the past has been structured around limitations of our systems.
 - Comment: The past was often a black box. We'd appreciate getting anything that makes sense.
 - Response: To date, we've seen much of what Truven does as being without a black box. Specific to the KPIs, we'll try to map out similar methodologies.
 - Question: Will CRGs still be used?
 - Response: Because it's not 3M, I believe the system will use DCG risk adjustment figures.

9. 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, March 16, 2016.

