



COLORADO

Department of Health Care
Policy & Financing

Meeting Summary

Colorado Accountable Care Collaborative Program Improvement Advisory Committee (PIAC)

March 16, 2016, 9:30 A.M. - 12:15 P.M.

1. Attendees:

A. Voting PIAC members

- Anita Rich
- Aubrey Hill
- Brenda L. VonStar
- Carol Plock
- Donald Moore
- Dr. David Keller
- Elisabeth Arenales
- Harriet Hall
- Leroy Lucero
- Mick Pattinson
- Pam Doyle
- Shannon Secrest
- Shera Matthews
- Stephanie Farrell
- Todd Lessley
- Ian Engel

A quorum of voting members was present.

B. Non-voting members and other attendees¹

- Amber Burkhart
- Anne Jordan
- Brandi Nottingham
- Carol Bruce-Fritz
- Casey King
- Chavanne Lamb
- Christian Koltonski
- Cassidy Smith
- Deb Foote
- Elizabeth Baskett
- Gary Montrose
- Jan Tapy
- Jeff Bontrager
- Jennifer Hale-Coulson
- John Talbot
- Joshua Ewing
- Julie DeSaire
- Katie Jacobson
- Katie Mortenson
- Laurel Karabatsos
- Lesley Reeder
- Lori Roberts
- Marija Weeden-Osborn
- Mark Queirolo
- Matthew Lanphier
- Mindy Klowden
- Rachel DeShay
- Rachel Hutson
- Rich McLean
- Shelly Spalding
- Sophie Thomas



2. Review and Approval of February Meeting Summary

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

3. Regulatory Efficiency Review: 8.709 Quality Improvement

Aubrey Hill introduced Katie Mortenson, Policy Analyst for Quality Health Improvement with the Department, to provide an overview for the proposed regulatory efficiency rule changes which can be found online [here](#).

- Katie Mortenson: The Department has reviewed the state regulatory efficiency rules and is proposing a few updates to more accurately reflect our current system and to be more inclusive of the ACC. The proposed rule changes have gone through an external quality review process.
- Please send comments or feedback to Katie Mortenson at Katie.Mortenson@state.co.us

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 recommendation to the PIAC regarding the emergency room utilization key performance indicator (KPI) for the next fiscal year. The recommendation can be found [here](#).

- DISCUSSION:
 - Question: How do we ensure PCMPs are choosing appropriate populations, and not avoiding certain populations?
 - Response: Currently, large PCMPs work across multiple RCCOs. We wanted to give large PCMPs the opportunity to standardize populations across RCCOs, and not have different quality projects for different RCCOs.
 - Comment: PCMPs have to commit to a reduction in the KPI regardless of the population they choose.
 - Comment: It is an option for the RCCOs to continue with the same methodology, or do a hybrid KPI. We recently rebased the ER KPI to 2014 data, which makes the benchmark more current. When we did that, all the RCCOs met the ER KPI, either tier 1 or tier 2. It is currently looking like most RCCOs will continue with the overall KPI, and not do a hybrid KPI. This discussion and the feedback that you've



provided has been appreciated and we are still going to allow it as an option, but it may be considered more feasible to do next year.

- Comment: Any intervention we do to impact the ER metric going to take time to see changes in utilization, we will not see changes in one year. At this time, there is a need to further study and understand what is going on with the current ER metric at the RCCO level and State level. The HIL subcommittee does not agree that PCMPs should be allowed to choose their own cohort for this KPI.
- Question: Can we see data on the Nurse Advice Line? It would be helpful to find out what patients are being advised to go to the ER.
- Response: We will request a Nurse Advice Line presentation for April's meeting.
- Comment: Bridges to Care has great data on their work around reducing ER utilization. I would encourage this group to look at their findings to see if we can replicate their model.
- Comment: Bridges to Care is in RCCO 6. RCCO 6 also has a pilot with hospitals using hot-spotting techniques to understand this issue. We are conducting research on both projects so we can compare their results.
- Comment: Hot-spotting has shown to be really effective for small cohorts, but difficult to use for a state-wide metric. High utilizer populations change often, which makes this technology difficult to use.
- Comment: I suggest we remove people with disabilities in the ER analysis so we can understand how to improve accessibility for that population.
- Comment: Most RCCOs have been employing some form of hot-spotting for many years. With hot-spotting, you get immediate results, but you cannot ignore the issue of the regression to the mean.
- Question: Have any of the RCCOs conducted research on alcohol, drug abuse or overdose, in relation to psychosis and depression? I'd like to understand the impact this population has on ER utilization?
- Response: From the RCCO 6 perspective, we want to expand the hot-spotting alliance to cover substance use, but it is very expensive. We need to think about this in the context of ACC Phase II so we're able to pay for the wrap services for people with high behavioral health and substance use disorders.
- Comment: It sounds like the Department's decision pulls bullet one off the table, so we would need to amend the recommendations to reflect that.



- Response: This is an option for the RCCOs, but at this point, it sounds like the RCCOs may not pursue a special cohort population. Still waiting for to hear back from one or two RCCOs. We are leaving the option for next year as well.
- Comment: Access to the ER is so easy because of benefit design.
- Comment: I suggest we accept the recommendations as written and give more time for discussion.
- 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 Provider and Community Issues subcommittee's recommendation was adopted by the PIAC and is transmitted to the Department.**

Health Impact on Lives: Health Improvement

Aubrey Hill introduced Dr. David Keller who provided an update to the committee.

- Dr. David Keller: We had two presentations at last month's meeting from Colorado Health Institute (CHI) and the Department on ER utilization to better understand the metric. This presentation was helpful to explain the methodology on the current metric. We saw a chart on ER utilization trends over time and would like to recommend that be included in the SDAC moving forward.
- The CHI presentation focused on necessary vs. unnecessary utilization of the ER. Claims data doesn't tell us the degree of urgency of the problem, or what the perception of the problem was that led to the ER visit.
- After both presentations, the Subcommittee felt that they were not ready to make a recommendation on the ER KPI, and would like to continue the discussion.

The remaining Subcommittee updates will be provided at the end of the meeting.

5. ACC Phase II Policy Discussion- Linking Clients to a Provider for the Length of Enrollment

Aubrey Hill introduced Chavanne Lamb, ACC Policy Analyst, and Laurel Karabatsos, Deputy Medicaid Director with the Department, to follow-up on the discussion regarding strengthening the PCMP and client relationship.

- Chavanne Lamb: The goal of this is to connect a client to a PCMP and strengthen that relationship. We want to make the medical home a focal point of care. We also want providers to have more knowledge about their



panel and for whom they are responsible.

- We want to clarify that linkage will be for the entire year until the next enrollment period. There would be payment tied to this linkage, so we will not be paying claims for providers that are not a client's PCMP; excluding specialty care.
- Is this something the department should consider? What are the pros and cons of this specific policy? What impact will it have on clients? What impact will it have on providers? Are there other considerations?
- DISCUSSION:
 - Question: If a client in the ACC goes to a PCMP that not their assigned PCMP, the provider won't be paid?
 - Response: Correct, we would expect the provider to check client's attribution before services are provided.
 - Question: Are you talking about individual provider or a practice?
 - Response: Attribution at the clinic level not the provider level.
 - Question: What happens when a person is away from home but needs a visit?
 - Response: These are the types of issues we want to think through with you all. We would have for-cause scenarios such as a client moves, religious or moral objections, third-party insurance, etc.
 - Comment: The Department should give special consideration for transient populations, especially homeless people and migrants who move through the state. There are lots of scenarios where people change location, and those are significant considerations.
 - Response: We've heard some through the RFI process that it's challenging for a provider in a medical home when that linkage isn't always respected.
 - Comment: My concern is that you have something for payment reduction in the legislature which will have an impact on how much providers are paid. Also, providers don't turn away sick kids. Those two things will impact what you're trying to do.
 - Response: We hear the Department shouldn't pay per-member per-month for clients that aren't on a provider's panel. We're trying to come forth with solutions and we want your input.
 - Comment: I think it would be good to have the PCMP listed on the Medicaid card.
 - Comment: This proposal would lower our income dramatically because we see many patients that are not attributed to us. My suggestion is to



- focus on well-care in the medical home.
- Comment: The Department should consider reasons a client can fire their provider. I worry this proposal limits patient choice and creates more barriers.
 - Response: We have this now, and consider this an important piece to this proposal.
 - Comment: Should consider barriers around parolees using the DOC corporate headquarters address on their Medicaid eligibility paperwork.
 - Question: What if we tier the co-pay? For example, if a client goes to their attributed provider, it's cheaper than if they go somewhere else.
 - Comment: If you're going to do this, the attribution methodology needs to be cleaned up. Also, there are very few unique codes for primary care.
 - Comment: We see many patients after hours that aren't attributed to us, but they come to us because we have availability after hours.
 - Question: Is it possible to have a provider bill the client's attributed PCMP for services rendered?
 - Response: This idea is similar to the behavioral health program. The challenge with doing this in a primary care setting is that there are so many different providers, the relationships wouldn't be manageable. I think what's underlying your solution is that we need more accurate and accessible information on client attribution.
 - Comment: You need to make it easy for providers to fix issues with attribution. The patient has no incentive to fix their attribution.
 - Response: It sounds like there's not a lot of enthusiasm for this, despite the feedback we got from the RFI.
 - Comment: Many of the solutions we're talking about shift the burden to the client, not the PCMP. I suggest we bring this conversation to client groups and consider focus interviews.
 - Comment: If we're going to move the program to greater accountability, attribution needs to be fixed. Patient choice and flexibility needs to be taken into account.
 - Comment: We need to continue to work on strengthening the relationship between client and PCMP. We spend a lot of resources on attribution so we like this proposal and think we should continue to work through these issues.
 - Response: I hear we need to strengthen the relationship and give providers a tool to do so, but restricting payments to non-attributed providers seems like a no-go.



- Comment: Need client education on a medical home.
- Response: We're looking at the levers a PCMP has to ensure the medical home.
- Comment: We're not saying don't pursue the idea. We've put many ideas forward such as: listing PCMP on the Medicaid card, making it easier to change attribution, educating clients on the medical home concept, and including incentives for clients.

6. ACC Phase II Policy Discussion: Behavioral Health Payment Framework

Aubrey Hill, introduced Chavanne Lamb, ACC Policy Analyst; Mark Queirolo, Integration Specialist; and Laurel Karabatsos, Deputy Medicaid Director with the Department, to lead a policy discussion on the proposed behavioral health payment framework for ACC Phase II. The handout that was discussed can be found [here](#).

- Laurel Karabatsos: Today, we are presenting a high level model of behavioral health payment in ACC Phase II. A major goal of Phase II is to integrate physical and behavioral health and we're doing that by procuring one Regional Accountable Entity (RAE).
- Our goals for behavioral health are to increase access and ensure quality services. We need to maintain some capitation in order to ensure we have the continuum of services that we currently have now, called the b3 services.
- We're also trying to limit covered diagnosis where possible to remove barriers to care. There are some situations where it's not possible to limit, and we expect to continue to use covered diagnosis for hospitalizations, ER, and labs.
- We also plan to shift funding for behavioral health into primary care setting. We want to define integrated care services so it's easier for providers to bill and will need to create a new definition of integrated care services.
- DISCUSSION:
 - Question: Are you including Substance Use Disorder (SUD) when you talk about behavioral health services?
 - Response: Yes.
 - Question: How does this resolve issues for individuals who are dually diagnosed with I/DD and behavioral health?
 - Response: Removing covered diagnosis should help that, but likely won't completely solve that in the inpatient arena. There are other tools and resources that we need to look at to address those concerns. We will also expand access to lower level services which should help prevent hospitalization.



- Question: Can we track this issue in ACC Phase II to ensure clients are getting the services they need?
- Response: Yes, we'll take that suggestion back and discuss how we can measure and address it.
- Comment: Providers need to work together as a team outside of patient contact. I encourage you to think about how that arrangement is reimbursed.
- Question: When a primary care clinic has staff from a community mental health center (CMHC) providing integrated care, would the services be paid to the primary care clinic or CMHC?
- Response: We want to encourage practices hiring their own behavioral health staff as well as co-location. If it's a staff visit, it would be billed as an integrated care visit from the practice. If it's co-location, there needs to be an agreement between the two practices. Once a client goes beyond the number of units allowed, it would be billed as a capitation.
- Comment: I suggest the Department set-up a workgroup of providers who are already providing integrated services because they're all doing it differently and could provide guidance and help with troubleshooting.
- Response: We're challenged with staff right now, but we like your idea for a workgroup. It may take some time to set-up, but we will work towards that.
- Question: How do you bill for services that are not clearly physical or behavioral health?
- Response: We want to define integrated care services so services that are not clearly physical or behavioral can potentially fit within this category. However, this is an iterative process.
- Question: What about expanding primary care in the behavioral health setting?
- Response: We're allowing CMHCs that meet the PCMP requirements to become a PCMP. We're also providing assistance to CMHCs to help them bill for primary care services.
- Comment: The Department provided guidance in September 2014 to CMHCs on this matter. We would like to know if there are still barriers to this level of integration.
- Question: Am I correct to make an assumption that the dollar amount of the cap will go down? I think we're heading in the right direction, but it seems like it going to be more complicated on the billing side.



How are you going to prevent double paying?

- Response: We need to have actuarially sound rates developed with CMS, so I'm not sure I can say the rates will go down. Regarding your billing question, we are hoping it will be easier because of the new MMIS system and the RAE, but we need to dig into the details a bit more.
- Comment: Many of the integrated care services we're talking about are not being provided under the cap now and they have the potential to reduce costs and improve outcomes on the medical side, not necessarily on the behavioral health side. We should be able to be paid both on the behavioral health side and the physical health side.

7. ACC Phase II Policy Discussion: Pay for Performance

Aubrey Hill, introduced Chavanne Lamb, ACC Policy Analyst and Laurel Karabatsos, Deputy Medicaid Director with the Department to discuss pay for performance in ACC Phase II. The handout discussed can be found online [here](#).

- Chavanne Lamb: Currently, the ACC has 3 Key Performance Indicators (KPIs) and they're paid on a quarterly basis based on regional performance.
- In ACC Phase II, we're looking to potentially have 9 KPIs. Six would be stable and outlined in the RFP while the remaining 3 measures would be flexible, selected by the RAE. The flexible KPIS would be revisited annually.
- DISCUSSION:
 - Question: Will any of the KPIs reflect the needs of those with disabilities? If not, how will their needs be factored into KPI selection? How will people be paid on KPIs moving forward?
 - Response: We want to keep special populations in mind and we're still developing KPIs. We want to make sure we're aligning with other state-wide initiatives.
 - Response: We don't have all the specifics on payment, but our vision is that the Department pays the RAE and the RAE is responsible for payments to PCMPs and health teams, including the incentives.
 - Comment: I think tying KPIs to triple aim is a wonderful idea. I caution changing KPIs every year, it's hard to see success in one year.
 - Response: Yes, we heard that in the RFI which is why the majority of the KPIs will be fixed and outlined in the RFP. We also need flexibility, so we're trying to strike a balance.
 - Question: Is payment methodology and incentives going to be the same across RAEs or will each RAE determine their own methodology?



- Response: That's something we're still trying to figure out.
- Comment: I'm glad you're embracing the triple aim for KPIs. I suggest you develop very clear criteria for the basis of reassessing a KPI so, when changes need to be made, they don't seem arbitrary.
- Comment: When you're considering changes, please be flexible with our limitations on reporting. We've made significant investments in EMR and changes in reporting can be difficult for us to adopt.

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

8. Continued Subcommittee Updates

MMP Advisory Committee

Aubrey Hill introduced Elisabeth Arenales, Liaison to the MMP Ad Hoc Advisory Subcommittee, to provide an update.

- Elisabeth Arenales: The MMP committee is working on recommendations for the ACC Phase II team. We will present our recommendations to PIAC in April. The MMP committee has learned quite a bit over the course of this project. We want to make sure lessons learned carry forward.
- Topics for discussion include: accessibility, care coordination, notice and appeals, ombudsman program, payment reform issues, lock-in, behavioral health, and the transition between the demonstration and the general ACC.

Improving and Bridging Systems

Aubrey Hill introduced Carol Plock, member of the Improving and Bridging Systems Subcommittee member to provide an update.

- Carol Plock: At the last meeting, we looked at the charge of the group, representation, and identified key issues for our group. We also discussed having a systematic process for identifying important issues.

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, April 20, 2016.

