



**COLORADO**

Department of Health Care  
Policy & Financing

## **MINUTES OF THE MEETING OF THE ACC PROGRAM IMPROVEMENT ADVISORY COMMITTEE (PIAC)**

These are the meeting minutes from the sixteenth community meeting to discuss the ACC RFP and any potential waiver filing. The meeting took place at the Colorado Department of Health Care Policy and Financing on January 21st, 2015.

Colorado Capitol Complex, HCPF Offices  
225 E. 16th Ave., 1st Floor Conference Room

**January 21, 2015**

### **1. Call to Order**

Dave Myers called the meeting to order.

### **2. Roll Call**

Dave Myers called the roll. There were sufficient members for a quorum.

#### **A. Participants (Present and on Conference Call)**

Anita Rich, Annette Fryman, Aubrey Hill, Brandi Nottingham, Brenda L. VonStar, Carol Bruce Fritz, Carol Bruce-Fritz, Chavanne Lamb, Chelsea Hanson, Christian Koltanski, Dave Myers, Dave Rastatter, Dave Rastatter, Donald Moore, Donna Mills, Elizabeth Baskett, Elizabeth Forbes, Ethel Smith, Jean Sisneros, Kathryn Jantz, Katie Jacobson, Kevin J.D. Wilson, Leah Jardine, Lila Cummings, Lori Roberts, Marceil Case, Mark Queirolo, Marty Janssen, Matt Lanphier, Mindy Klowden, Morgan Honea, Pamela Doyle, Raquel Rosen, Richard Spurlock, Ryan Westrom, Sarita Reddy, Shera Matthews, Susan Mathieu, Todd Lesley, Tom Clay.

### **3. Approval of Minutes**

The previous month's minutes were reviewed. There was a motion to approve the minutes; the motion was seconded and sustained. There were no comments and the minutes were approved as submitted.



## 4. Subcommittee Updates

- The subcommittee chairs in attendance were called to provide the PIAC with updates. In cases where a committee chair was unable to attend, state staffers were called before the committee for the same purpose.

### A. ACC: MMP Committee

Elizabeth Baskett, manager of the Department's Program Innovation Section, provided the committee with an update of the ACC: Medicare-Medicaid Program's committee.

Subcommittee has met once since the last PIAC meeting. Money is being withheld from RCCO payment, working on the KPIs. Will be going to the Quality subcommittee for review of the KPIs.

- A training for care coordinators is being conducted on long terms services and supports. Work with your RCCOs to get information on the training.
- Will be meeting with the ACC: MMP soon to discuss how to evaluate the program.
- The KPIs for the ACC: MMP are not the ACC KPIs. Looking at readmissions, potentially preventable conditions and depression screening.

### B. Quality Subcommittee

Rachel DeShay will be the ACC staff person coordinating the subcommittee. The next meeting is January 28th. The meeting will focus on creating the charter and voting membership

### C. Payment Reform Subcommittee

Subcommittee has not met in a couple of months. Lila Cummings will be the ACC staffer coordinating the subcommittee.

### D. Provider and Community Relations / Issues Subcommittee

Actively working on charter and membership.

### E. Bridging Systems Subcommittee

Our mission is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.  
[www.colorado.gov/hcpf](http://www.colorado.gov/hcpf)



HCPF is working to bring this committee online.

## 5. ACC RFP and Request for Information Update

Kevin Dunlevy-Wilson of the Department's ACC Strategy Unit provided an update to the committee on the forthcoming RFP, as well as the recently-completed public Request for Information.

- Kevin J.D. Wilson: Thank you to the committee for your help and feedback with the RFI. There were 121 individual submissions that totaled almost 4,000 pages of responses. They captured feedback from a larger group of individuals including many clients and providers.
- This would not have been possible without focus groups hosted by the Colorado Coalition for the Medically Underserved, as well as regional and other advisory committees.
- The presenter shared a "wordcloud" infographic from the RFI. Some of the common words were: health, integrated, family, clients, process, flexible, and outcomes.
- A lot of respondent material falls into these areas: changes in the delivery system, RCCO or program structure, health equity and self-sufficiency, enhances state/stakeholder oversight, payment reform, and data sharing / HIT infrastructure. The state received many recommendations about the medical neighborhood, a larger role for hospitals in the program, primary and specialty care investments, RCCO alignment with other agencies, regional configuration, and supporting clients, families, and communities in managing health and non-health needs.
- This is not a comprehensive summary of all responses. This is a high level review and compilation of some actionable recommendations we heard.
- What is working well: the ACC is local and flexible, strong focus on primary care, KPIs, the Triple Aim focus, and the data from SDAC has been useful.
- What is not working well: payment, KPIs change too frequently, data sharing and data availability, need multi-system and real-time data, differences between the RCCOs, attribution, PCMPs need to know who is providing care coordination services, more info needed for special populations, differences between care coordination.
- What is working in the BHO system: success using evidence based programs, making moves towards integration, community relationships, and containing costs.



- What is not working in the BHO system: provider shortages, payments are too low, and the requirements to submit encounters effectively preserves an FFS system, and covered diagnosis model doesn't allow for prevention, integration, or health promotion.
- Next steps in integration: RCCO and BHO integration is occurring too slowly; differences in payment methodologies and delivery system need to change; RCCOs and BHOs should be combined and procured together; health and behavior codes should be opened.
- Barriers to integration: reimbursement, rules around data sharing, covered diagnosis list model, and staff capacity.
- Care coordination requirements: best done at point of care, face-to-face, there shouldn't be set ratio of clients to care coordinators built into RCCO contract requirements. Also, large practices are more comfortable with specific requirements, smaller practices more hesitant with specific requirements, RCCOs should have a larger role in social determinants of health.
- We asked what the most important non-medical things to be coordinated were. Response: translation services, health literacy, and transportation services.
- However, throughout the RFP, three social determinants came up time and again:
  1. Transportation
  2. Housing
  3. Economic self-sufficiency
- Care coordination requirements: specific requirements for special populations, and requirements for long-term vs. short-term care coordination needs.
- Many respondents called for 12-month continuous eligibility for adults. It appears that moving to 12-month continuous eligibility could mean the 100% federal match for expansion population may be forfeited, but the State continues to research investigate.
- Feedback that the benefits package needs to move more towards wellness and prevention.
- The universe of services out there need to be clearly defined, communicated, and coordinated.
- There were a number of questions regarding general program structure.
- A number of recommendations to combine the BHOs and RCCOs.
- Heard that it would be complicated to have multiple RCCOs operating in the same region. There was also strong sentiment that the Denver metro area is



different and needs to be looked at differently because of all the players in the area.

- A number of responses said that PCMPS should be allowed to choose which RCCO their clients are attributed to.
- One of the strengths mentioned throughout the responses is the strong local focus.
- A lot of responses indicated that the bidders need to have community relationships already in place.
- Program oversight: A lot of calls for increased oversight, transparency and accountability. On the other hand there were a lot of responses saying the current RCCO contracts are too burdensome. Suggestion to hire secret shoppers to help with oversight.
- Stakeholder engagement: Generally speaking responses wanted greater stakeholder engagement. A division over self-directed vs. prescriptive stakeholder engagement. There is a call for clear communication plans regarding how the RCCOs engage with stakeholders through multiple communication channels.
- Responses on practice support were diverse, but most tools were identified as useful. One common theme is HIT and IT. A lot of respondents thought the RCCOs need to have a stronger role in supporting practices but that role should not be too prescriptive.
- Large section on network adequacy. What was heard is there aren't enough specialists and there needs to be more coordination with hospitals. Also, provider training and practice transformation are necessary to developing integrated clinics.
- 78% of respondents want community health workers to be a part of the program but most thought they shouldn't be required.
- Heard that HCPF needs to move towards paying for health. At the same time there were concerns that capitation could complicate operations for providers. Many providers are not interested in capitation or cannot thrive in a capitated environment. Also heard that there needs to be more pay-for-performance and that physical, behavioral, and oral care should be paid for together.
- There were a lot recommendations about opening specific codes.
- A common theme in the responses is that PMPM should be paid differently based off of how sick people are and what their social needs are.
- Heard that the KPIs have been difficult to move because the dollar value tied to them is too low. Suggestions to allow RCCOs to pay providers.
- There should be 1-7 KPIs.



- The number of KPIs should be larger for RCCOs than it should be for PCMPs.
- The state needs to track and report more measures than what's tied to payment.
- KPIs should be paid at the practice level and should generally be the same across the RCCOs with a small degree of flexibility.
- KPIs need to be based on data that can be provided to RCCOs and providers monthly.
- Recommendations that the RCCOs need to be responsible for population health measures.
- Big push in responses to focus more on client experience.
- There is an even distribution between the types of tools that State should use to measure client experience but CAHPS came out slightly highest.
- Suggestions for a statewide tool that can push out and take in the health information that is out there and to make it easy for providers to interpret.
- Important for HIT to support behavioral health integration.
- There are gaps, not everyone is using the same platform or collects the same data. There is tension between having greater standardization and more flexibility.
- Client facing HIT looks like it will have the most growth in use amongst provider respondents.
- Technologies that seem to be most important are ones that can be integrated into clinical care.
- Nearly 70% of respondents said there needs to be statewide shared care management tool.
- The care management tool needs to be usable by everyone, be real-time, and be able to interface and function with other available tools as well as be mobile ready, and have access to contact information.

After concluding the presentation, Kevin J.D. Wilson and Kathryn Jantz offered two requests to the Committee:

- **Request of the PIAC:** When we are looking at the regional maps we heard a lot of different and competing priorities. We would like to ask your help in terms of how we weigh these different considerations. Maps need to align with referral or care patterns, location of community health centers, locations of FQHCs, align with local public health agencies, CCB, and SEP areas. We need your help



ranking these items in order of importance to the committee and those you represent.

- **Second request of the committee:** How do we evaluate care coordination requirements? When we are looking at designing the requirements we need help sorting out the tension between prescriptive requirements and allowing flexibility. What kind of process requirements should there be for special populations, social needs, and short-term vs. long-term needs. How can we start to look at making requirements that get at outcomes?
- We'll request feedback on both of these items at the next meeting of the PIAC.
- An executive summary of the RFI responses and full text of responses will be published in the spring of 2015. It will be available to the public as part of ongoing stakeholder engagement.
- Send an email to [RCCORFP@state.co.us](mailto:RCCORFP@state.co.us) with any questions you might have.
  
- Question: In what format do you want the feedback on these items?
- Kathryn Jantz: We would prefer feedback in a written format.
- Question: Why is the RFP process hurried, even though there has been an extension?
- Kathryn Jantz: Even though the extension was granted, the re-procurement timeline has not changed that much. We are looking at options for waiver development this spring.

## 6. State Innovation Model (SIM) Presentation

Vatsala Pathy, Colorado SIM Director, provided an update to the committee on the SIM project.

- The State Innovation Model (SIM) is a big initiative, a joint collaboration between CMS, CDC, and the Office of the National Coordinator. SIM is an initiative to drive big health care reform.
- Colorado received a two year planning grant. A proposal was submitted in summer of 2014 for a broad scale effort to integrate behavioral health and primary care.
- 65 million dollar award received in December. It is a cooperative agreement and dependent on annual appropriations. All that is in hand is the first year of funding.



- Overall objective is greater financial and operational alignment. How do we both incent providers and systems of care to do things differently and help support them on the ground?
- Stakeholders, policy makers, and advocates have been working in this space for a very long time.
- SIM fits nicely into all aspects of the Governor's State of Health.
- SIM also fits nicely into the work of the ACC and the Comprehensive Primary Care Initiative.
- CO has relatively low per capita funding for substance abuse and mental health and there are significant behavioral health issues the state faces, such as extremely high rates of suicide and drug related deaths.
- The State has been working on SIM for about two years. Even without federal support the State knew it had to continue down this path. There are four workgroups that meet on four different topic areas.
- 2015 is the ramp up year. By the end of the grant the goal is to have 400 practices statewide onboard.
- Another big component of the project is around population health. This is similar to the work that the RCCOs and health alliances are doing.
- Payment reform is another primary component. Working towards value based payments.
- There is a tremendous amount of support from commercial payers.
- If you can't measure it you can't improve it, therefore building HIT is a critical component of SIM.
- There is a huge evaluation component to the project.
- Morgan Honea: How do you see the work being done with SIM paralleling with the work of the ACC Program?
- Vatsala Pathay: I don't have an answer for you as of today but the Medicaid strategy is critical to this work and something we are working on.
- Leah Spielberg: Medicaid is the driver behind the push towards integration. The ACC is a critical part of SIM.
- Dave Myers: Who is making the decisions?
- Vatsala Pathy: The Governor's office does not have the capacity to administer a grant of this size. HCPF has been the lead administrative agency on the project so they will provide much of the back office support. This is new ground for state government. All the health related state agencies have a role to play. There will be an appointed board that will be providing advice on the project. The board could be looked at as the equivalent of the PIAC.



- Morgan Honea: Payment reform is scattered throughout the RFI responses. I am familiar with the challenges working with CMS to do payment reform. Because Colorado is a SIM grantee do you think it will give us more flexibility with CMS or is it status quo?

Vatsala Pathy: I think there is a little opening to be more flexible but when I'm more of a realist I would say things haven't changed that much but we are pushing hard.

## 7. Public Comment and Future Agenda Items

- The PIAC discussed its 2015 areas of focus.

## 8. Adjourn and Next Meeting

With no further items on the agenda, the meeting of the PIAC was adjourned. The next scheduled meeting of the ACC Program Improvement Advisory Committee is at 10:00 a.m. on Wednesday, March 18, 2015 in the 1st floor conference room of 225 E. 16th Avenue, Denver, CO.

Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the PIAC Committee Coordinator, Erin Miller, at 303-866-3097 or [Erin.Miller@state.co.us](mailto:Erin.Miller@state.co.us) or the 504/ADA Coordinator [hcpf504ada@state.co.us](mailto:hcpf504ada@state.co.us) at least one week prior to the meeting.

