



COLORADO

Department of Health Care
Policy & Financing

MEETING SUMMARY FOR THE ACC Program Improvement Provider & Community Issues Sub-committee

Colorado Department of Public Health and Environment
4300 Cherry Creek South Drive, Rachel Carson Conference Room

February 11th, 2015

1. Announcements

There were no announcements this month.

2. Approval of Minutes

Minutes were motioned for approval. Minutes were approved.

3. Consumer Input/ Client Experience

There were no issues presented this month.

4. PIAC Update

Todd Lessley: Big discussion about ACC 2.0. Specifically around best way to engage stakeholders and best way to have advisory structure. Talked about what's working in current structure and if there's a role for an advisory committee. Also talked about the PIAC at the RCCO and state level. Another number of issues were discussed, including the ER KPI and some possible changes to that.

5. ER KPI Modification

JD Belshe: The Department is looking for areas where we can make real headway and have more success in addressing unnecessary ER utilization. We're looking to split the ER KPI in two and give RCCOs the option to find a smaller population for which they can make more headway in specific areas. We believe a more targeted KPI would be more helpful. In a RCCOs population we would look for cohorts. These cohorts must be either 7.5% of the RCCO population or 7.5% of ER spend. RCCOs would propose this to the Department and include ROI in their pitch. The idea is that every region would be able to tune the ER KPI to their region. One key point is that providers may find this difficult especially in dealing with multiple



RCCOs. Department would take this into consideration as part of their review of RCCO proposals.

Casey King: One question we brought up before was "can the cohort be specific to a single PCMP?"

JD Belshe: I don't think we can get down to enough detail for individual practices.

Anita Rich: Do you envision doing this on a RCCO basis when patients cross RCCO boundaries. How does one provider deal with all of those intersecting pieces?

JD Belshe: We understand that this may be difficult and will take this into consideration when reviewing proposals.

Anita Rich: In the SDAC - if I'm a family practice, I can't separate my kids from my adults to see who is a problem. It would be easier if we could see that.

JD Belshe: The SDAC is an area we are working on. Our hope is that the RCCO would identify these populations from a RCCO level and work with those practices whose panel contains those targeted populations. If you're seeing things in your practices that you think would be useful, what specific things you think you could have most impact in? It might be worth it to reach out to the RCCOs and telling them.

Donald Moore: Has the Department worked with the hospitals to see how they might be able to help with this of the ER KPI generally.

JD Belshe: This is just beginning our stakeholder process. That's a good suggestion, and we will look into it.

Todd Lessley: There's a certain feeling of defeat among providers and I would second that initiative to involve hospitals. Without their involvement it will be difficult to make any movement.

Shera Matthews: We've been doing this, and the hospitals are popping up stand-alone ERs on every other corner. Medicaid patients don't know what a PCP medical home is. That whole concept isn't even known. We can't do these ER incentives without participation from ERs.

Todd Lessley: Any feedback or recommendations regarding this issue?

Casey King: I'd like to make the recommendation to have the ability to drill down to the PCMP level so the RCCO can target those PCMPs and work with them to make an impact.

Janet: I would second that.



Shera Matthews: I Love that we're honing in on populations, but RCCO needs to get behind the whole concept of engaging the client to inform them of the concept of a medical home and involving the ERs in this.

Todd Lessley: PCMP collaboration with RCCOs to work on performance improvement projects with specific populations.

Jessie Israel: What policy changes from the ERs are you looking for?

Todd Lessley: Having a hospital partner at the table to discuss strategy is most important. They haven't been at the table so far. Changing the way co-pays are administered is another idea.

Anita Rich: Would really also like the data from the nurse call system. How many of the calls end up in the ER.

Jessie Israel: The battle is that when they call PCP or their nurse advice line, they send them to the ER. The way to redesign population health is by going practice to practice. It ultimately comes down to identifying the practices who are willing to make the change.

Molly Markert: It seems like we're trying to row the boat up the river. Patients go where the service is convenient. We need to ask why patients are using the ER and think about what we can do to complement that rather than trying to fight reality. We need to look at the behavior of consumers and accept that we need to replicate or work with this rather than try to change what's happening. If the hospitals don't see this as a problem, we're not going to get anywhere by working with them.

Donald Moore: A lot of time and energy is being put into how to pay primary care and mental health providers, and a lot of stakeholder engagement is being done on this issue. Lesson we should learn from that is getting a provider group engaged is to start talking about the way they're paid. I'm not suggesting we pull the payment rug out from them, but we won't get significant engagement from the hospitals until we start talking about their revenue as it pertains to the KPIs that we're trying to improve to support the triple aim goals. Talking about the way people are paid is a good way to get people engaged on that topic. One example is the big announcement made by the department regarding the payment of CMHCs in ACC 2.0.

Josh Ewing: As far as ED utilization, we're bound by federal law to screen and stabilize people who show up at the ED. As far as the payment concern, even if you change payment, we still have to treat those individuals and that creates an equity issue in my mind.



Donald Moore: I agree federal regulation – including MTALA - is a major barrier, but what about readmissions? Post-partum visits? Those are other goals we're working on that don't have similar type barriers. In many communities hospitals are the central organizing principle of health care in the community and we want their help.

Jessie Israel: Hospitals do listen when there is risk or shared savings involved.

Todd Lessley: Maybe we can formulate recommendations before PIAC?

Heather Logan: University School of Medicine has a grant where they are surveying patients in the ED that came inappropriately and they're trying to tie a dollar amount to the convenience factor and there might be a potential to use some of that material down the road. We might need to address the marketing materials used by the ERs as well and the incentives being used by the free-standing ER rooms such as a Starbucks gift card for clients coming in for the first time.

Todd Lessley: One recommendation that has come from this is regarding consumer behavior, getting hospital partners, using RCCOs and hospitals to educate clients, looking at data from the nurse advice line, consumer behavior – why are they using it, and payment reform.

Jessie Israel: Claims for urgent care we've found are billed as primary care visits when they're healthy and then are billed as emergency visits when they are sick. Can that be changed?

Susan Diamond: We understand that if it's hospital owned it has to be billed as an ER visit and an institutional claim.

Todd Lessley: Have we considered tele-health options?

JD Belshe: We're looking at that right now.

Casey King: The triage you're talking about is something that Kaiser provides but is not billable to Medicaid.

Susan Diamond: You should make it billable.

JD Belshe: That's something we are exploring.

6. ePCMP Factors

Rachel DeShay: The enhanced PCMP program has been in place since 2014. The factors were developed with stakeholder engagement and using NCQA factors. 269 practices were awarded incentive payments. We asked RCCOs to submit supporting documents for 7 enhanced PCMPs and we are in the process of reviewing these supporting documents. We've done some initial analysis on the factors and the



number of times they are being reported. For SFY 16-17 we're not planning on having any changes to the factors.

Erin Miller: Marty spoke to the coalition and mentioned that there would be the possibility of making some tweaks to this during the 16-17 fiscal year.

Rachel DeShay: That is true and that was the intention of the reviews. But after reviewing them we found that there wasn't enough time for stakeholder engagement with the information that we had. We felt it would be premature to change the factors without that process.

Erin Miller: As you think about potential tweaks – someone suggested in addition to a graduated payment methodology making one of the factors a required factors. As a suggestion the integration of behavioral health care.

Rachel DeShay: Definitely something we want to look at.

Janet Rasmussen: I appreciate the stakeholder engagement process. Any change in payment we would like to have a lot of lead time.

Molly Markert: A lot of the concerns I get is that those dollars that were paid are not singled out in the remittance process. If this is incentive, the dollars need to look special and not be folded in to other payments.

Rahcel DeShay: Point well taken.

7. COUP Warning Letter

Kyle Huelsman: HCPF has operated a lock-in program for clients who have demonstrated some level of mis-utilization of services and then locked them into a single provider or pharmacy. Up until six years ago we discontinued because in our MMIS system we couldn't have them in the lock-in program and the ACC program simultaneously so we discontinued it. We have an obligation in our state plan to control over-utilization and mis-utilization of services. Four years ago we were audited and it became clear we weren't actually locking anybody in. We were essentially sending letters but nothing was happening. The Department committed to making the systems changes necessary to allow someone to be locked in while also being in the ACC program. We have an obligation to continue this program. We've been redeveloping it because of the larger concern coming out of the governor's office and other venues we've decided to focus on high-risk drugs. Specifically looking at predicting overdoses. The finalized criteria – 5 or more ER visits, 5 or more prescribers, 5 high risk drugs, and 1 overdose in past 2 years. Narrowed it down to about 400 clients. In May we'll have the technical capacity to move forward with the program. We'll send out the first warning letter in March, at which time the RCCOs will do a clinical review of those folks, and affirm that we're



not bringing in terminal folks or people who shouldn't otherwise be locked in. RCCOs will verify and we will verify via drug utilization review program. In terms of outreach to providers, we'll figure out those pieces in the next few weeks. We're hoping to get your opinion on our contact points with the clients. The two letters presented are templates based on what we used years ago for the lock-in letter. These two really hit on the piece of this is your RCCO, your PCMP, and the nurse advice line. Really it's just saying we've noticed how you're showing up in the system and here's some resources for you. From the provider point of view, what are the pieces that the client absolutely needs to know regarding what we're trying to communicate? To have them be ready and understand what the program is and where we're going with this.

Casey King: Will they need to have a referral from the PCP? Member will need to know that also? Who will be financially responsible?

Rachel DeShay: We're still working on it. The idea is that there would be a referral needed. This won't prevent ER utilization.

Casey King: We would need to know how that referral piece is going to work.

Todd Lessley: I would also want to know from a client stand point what that really means? What are the implications of having claims denied? What does it mean for the provider who accidentally serves these clients?

Anita Rich: I would also hope that the provider is receiving notification of this client being in the program along with the client. As much information as you can give to the providers as necessary and I would include their phone number.

Next meeting 3/10/16.

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4300 Cherry Creek South Drive, Room A2A

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